2016 Rhode Island Kids Count Factbook

Rhode Island KIDS COUNT is a children's policy organization that provides information on child well-being, stimulates dialogue on children's issues, and promotes accountability and action. 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, Nellie Mae Education Foundation, Neighborhood Health Plan of Rhode Island, Blue Cross & Blue Shield of Rhode Island, Delta Dental of Rhode Island, UnitedHealthcare Community Plan, Hasbro Children's Fund, van Beuren Charitable Foundation, and CVS Health.

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 *2016 Rhode Island Kids Count Factbook* are available for $20.00 per copy. Reduced rates are available for bulk orders. To receive copies of the *Factbook*, please contact:

Rhode Island KIDS COUNT
One Union Station
Providence, RI 02903
(401) 351-9400
rikids@rikidscount.org

Visit our website at www.rikidscount.org.

Factbook design by Greenwood Associates.
Illustrations by Gail Greenwood.

2016 Rhode Island Kids Count Factbook

Table of Contents

Overview

The *2016 Rhode Island Kids Count Factbook* is the twenty-second 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 *2016 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, government leaders, elected officials, businesses, faith organizations, and parents 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 *2016 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 *2016 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 20% between 2010 and 2014, during which time there were 43,144 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. Between 2010 and 2014, 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

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 1,055,173 Rhode Island residents in 2014. Children under age 19 make up 20% of the population. Between 2000 and 2014, Rhode Island's child population decreased by 14% from 247,822 to 212,555.[1,2] Between 2010 and 2014, there were 120,413 households with children under age 18 in Rhode Island, representing almost one-third (29%) of all households.[3] Twenty-six percent of Rhode Island children were under age five, 27% were ages five to nine, 29% were ages 10 to 14, and 18% were ages 15 to 17.[4]

In Rhode Island between 2010 and 2014, 125,687 (58%) children under age 18 lived in married-couple households with their parents, 70,567 (32%) children lived in single-parent households, and 17,299 (8%) children lived with relatives, including grandparents and other relatives. A total of 2,953 (1%) children lived with foster families or other non-relative heads of household. There were 878 (<1%) children and youth under age 18 who lived in group quarters and 42 (<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]

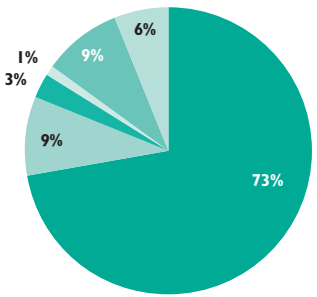
Between 2010 and 2014, there were 8,578 foreign-born children under the age of 18 living in Rhode Island, representing approximately 4% of the child population.[12] Of Rhode Island children ages five to 17, 77% speak only English at home, 16% speak Spanish, 4% speak another Indo-European language, 2% speak an Asian or Pacific Island language, and 1% speak some other language at home.[13]

Sexual orientation is another important facet of diversity among youth. According to the *2015 Youth Risk Behavior Survey*, 9.8% 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, 2010-2014

By Race/Ethnicity*

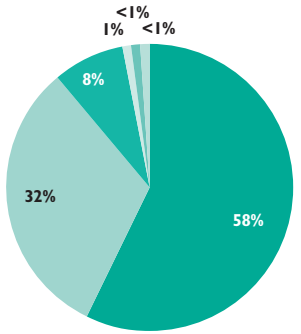
73%	White
9%	Black
3%	Asian
1%	American Indian and Alaska Native
9%	Some Other Race
6%	Two or More Races



n=217,426

By Family Structure

58%	Married-Couple**
32%	Single-Parent**
8%	Other Relatives
1%	Foster Family or Other Unrelated Household
<1%	Group Quarters
<1%	Child is Head of Household



n=217,426

**Hispanic children may be included in any race category. Of Rhode Island's 217,426 children, 47,663 (22%) were Hispanic.*

Source: U.S. Census Bureau, American Community Survey, 2010-2014. Tables B01001, B01001A, B01001B, B01001C, B01001D, B01001E, B01001F, B01001G, and B01001I.

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

Source: U.S. Census Bureau, American Community Survey, 2010-2014. Table B09001, B09002, and B09018.

◆ **In 2014, children under age 18 made up 20% of Rhode Island's population. Of the 212,555 children under age 18 in Rhode Island in 2014, 51% were male and 49% were female.[15]**

◆ **Between 2010 and 2014, 60% of children in Rhode Island lived in owner-occupied housing units and 40% lived in renter-occupied units.[16]**

◆ **Of children ages three to 17 enrolled in school in Rhode Island between 2010 and 2014, 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, 2014. Table S0201.

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

[3] U.S. Census Bureau, American Community Survey, 2010-2014. Table S1101.

[4,9] U.S. Census Bureau, American Community Survey, 2010-2014. Table B01001.

[5] U.S. Census Bureau, American Community Survey, 2010-2014. Table B09002.

[6] U.S. Census Bureau, American Community Survey, 2010-2014. Table B09018.

[7] U.S. Census Bureau, American Community Survey, 2010-2014. Table B09001.

[8] U.S. Census Bureau, Census 2000 Redistricting Summary File. Table QT-PL.

[10] O'Hare, W. (2011). *The changing child population of the United States: Analysis of data from the 2010 Census.* Baltimore, MD: The Annie E. Casey Foundation.

[11] U.S. Census Bureau, American Community Survey, 2010-2014. Table B01001I.

[12] U.S. Census Bureau, American Community Survey, 2010-2014. Table B05003.

[13] U.S. Census Bureau, American Community Survey, 2010-2014. Table B16007.

[14] Rhode Island Department of Health, *2015 Youth Risk Behavior Survey.*

[16,17] U.S. Census Bureau, American Community Survey, 2010-2014. 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 196,254 children living with one or more parents in Rhode Island between 2010 and 2014. Of these, 36% (70,567) were living with an unmarried parent, up from 32% of children between 2005 and 2009.[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 two-parent families.[3,4]

Between 2010 and 2014, 77% of children living in poverty in Rhode Island were living in single-parent families. Children in single-parent families in Rhode Island were nearly six times more likely to be living in poverty than those in married-couple families. Between 2010 and 2014 in Rhode Island, 40% of children in single-parent households lived in poverty, compared to 7% of children in married-couple households.[5]

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.[6,7] 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.[8,9] 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.[10,11] Regardless of whether children grow up with one or two parents, parenting quality is an important predictor of children's well-being.[12]

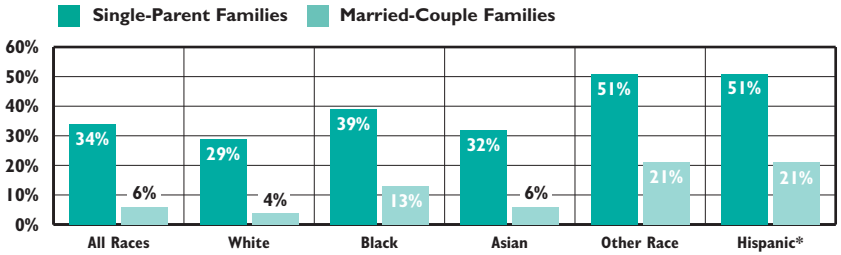
Single-Parent Families

	2004	2014
RI	39%	39%
US	31%	35%
National Rank*		*47th*
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, 2010-2014



Source: U.S. Census Bureau, American Community Survey, 2010-2014. Tables B17010, B17010A, B17010B, B17010D, B17010F, B17010I. *Hispanics may be in any race category.

◆ **Hispanic single-parent families in Rhode Island are more than one and a half times 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.[13]**

Economic Well-Being and Family Structure

◆ **Family structure influences children's social, emotional, and cognitive development. Children born into married parent families have a higher rate of economic, social, and psychological stability compared to children in single-parent families. Children living in single-parent households are more likely to face educational challenges and are more likely to live in poverty than children in married-couple families.[14]**

◆ **Approximately one-third (35%) of cohabitating parents still live together five years after the child's birth and less than half of them are married.[15]**

◆ **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.[16]**

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.

References

[1] U.S. Census Bureau, American Community Survey, 2010-2014. Table B09002.

[2] U.S. Census Bureau, American Community Survey, 2005-2009. Table B09002.

[3,6,12] Waldfogel, J., Craigie, T., & Brooks-Gunn, J. (2010). Fragile families and child wellbeing. *The Future of Children, 20*(2), 87-112.

[4,7] Child Trends Data Bank. (2015). *Family structure.* Retrieved January 8, 2016, from www.childtrendsdatabank.org

[5] U.S. Census Bureau, American Community Survey, 2010-2014. Table B17006.

[8,9] Barajas, M. S. (2011). Academic achievement of children in single parent homes: A critical review. *The Hilltop Review, 5*(1), 13-21.

[10] Blackwell, D. L. (2010). Family structure and children's health in the United States: Findings from the National Health Interview Survey, 2001-2007. *Vital and Health Statistics, 10*(246). Hyattsville, MD: Centers for Disease Control and Prevention.

[11] Mather, M. (2010). *U.S. children in single-mother families.* Washington, DC: Population Reference Bureau.

[13] U.S. Census Bureau, American Community Survey, 2010-2014. Tables B17010, B17010A, B17010B, B17010D, B17010F, B17010I.

(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 of parental divorce or economic challenges or they have a parent who is unemployed, incarcerated, ill, struggling with substance abuse, or coping with other problems.[2]

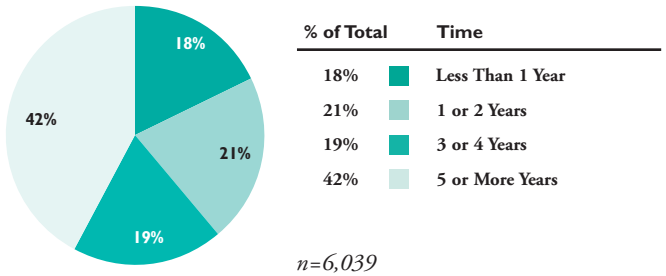
Grandparents who are financially responsible for their grandchildren have higher rates of poverty compared to other adults. Twenty-two percent of grandparent caregivers live below the poverty line, compared to 10% of the population age 50 and over.[3,4]

Many grandparent and other relative caregivers have informal custody arrangements and are not involved with child welfare agencies, often receiving fewer services than traditional foster parents.[5] Compared to the general population, children in informal kinship care are less likely to be covered by health insurance and are more likely to have physical and mental disabilities.[6]

Grandparents and other relative caregivers often are isolated and lack information about the support services, resources, programs, benefits, laws, and policies available to them.[7] 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.[8]

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.[9,10,11] Grandparents make up the largest percentage of relative caregivers, but aunts, uncles, cousins, siblings, and other relative caregivers may face similar obstacles.[12]

Rhode Island Grandparents Financially Responsible for Their Grandchildren, by Length of Time Responsible, 2010-2014



Source: U.S. Census Bureau, American Community Survey, 2010-2014. Table B10050.

◆ **Between 2010 and 2014, there were a total of 13,012 children in Rhode Island living in households headed by grandparents.[13] During this time period, there were 6,039 grandparents who were financially responsible for their grandchildren, 61% of whom had been financially responsible for three or more years.[14]**

◆ **In 2010, 6% (13,968) of all children in Rhode Island lived with a grandparent caregiver and 2% (4,398) lived with other relatives.[15]**

◆ **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. Only 42% of eligible children in kinship care receive Medicaid coverage.[16]**

◆ **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.[17] On December 31, 2015, there were 747 children under age 19 in DCYF care who were in out-of-home placements with a grandparent or other relative. These children made up 37% of all children in out-of-home placements in Rhode Island.[18]**

◆ **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.[19] 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.[20]**

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.

References

[1,4] Livingston, G. (2013). *At grandmother's house we stay.* Washington, DC: Pew Research Center.

[2,3] Murphey, D., Cooper, M., & Moore, K. A. (2012). *Grandparents living with children: State-level data from the American Community Survey.* Washington, DC: Child Trends.

[5] Walsh, W. A. (2013). *Informal kinship care most common out-of-home placement after an investigation of maltreatment.* Durham, NH: Carsey Institute, University of New Hampshire.

[6,8,9,16] KIDS COUNT. (2012). *Stepping up for kids: What government and communities should do to support kinship families.* Baltimore, MD: The Annie E. Casey Foundation.

[7] American Association of Retired Persons. (n.d.). *About Grandfacts.* Retrieved December 23, 2015, from www.aarp.org

[10,19] Generations United. (2011). *Grandfamilies: Challenges of caring for the second family.* Washington, DC: Generations United.

[11] Vandivere, S., Yrausquin, A., Allen, T., Malm, K., & McKlindon, A. (2012). *Children in nonparental care: A review of the literature and analysis of data gaps.* Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[12,13] U.S. Census Bureau, American Community Survey, 2010-2014. Table B09018.

(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 also 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 2010-2014, Rhode Island mothers with a high school degree or less had a higher infant mortality rate (6.1 per 1,000) than mothers with more education (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, on average, earn higher 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]

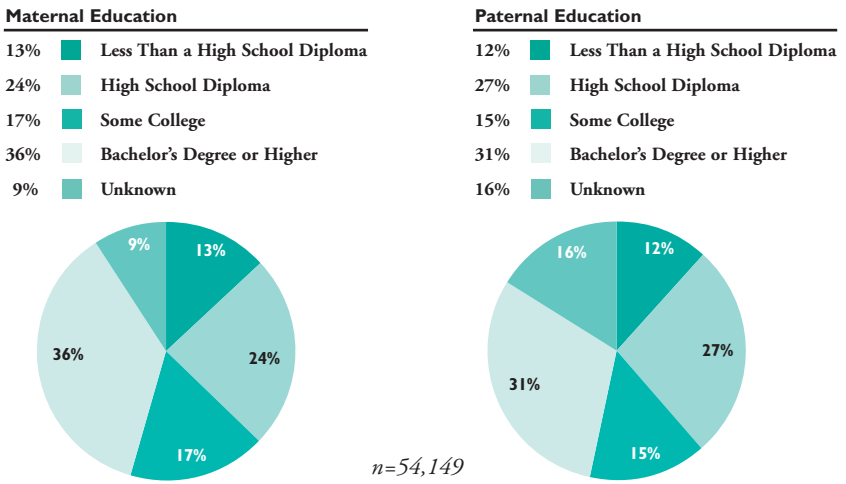
Between 2010 and 2014, 13% of Rhode Island births were to mothers with less than a high school diploma and 36% were to mothers with a bachelor's degree or higher.[11] Nationally, mothers with infants are more educated than ever before. In 2013, 12% of all U.S. births were to mothers with less than a 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	17%
Providence	23%
Woonsocket	20%
Four Core Cities	*22%*
Remainder of State	*6%*
Rhode Island	*13%*

Source: Rhode Island Department of Health, Hospital Discharge Database, 2010-2014.

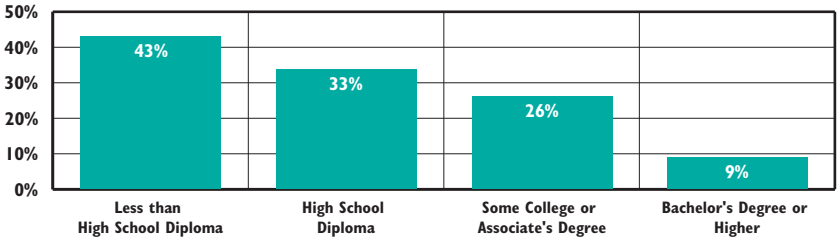
Births by Parental Education Levels, Rhode Island, 2010-2014



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Hospital Discharge Database, 2010-2014.

◆ **In Rhode Island between 2010 and 2014, 37% 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 (compared with 39% for both mothers and fathers from 2009-2013).[13]**

Poverty Rates for Families Headed by Single Females by Educational Attainment, Rhode Island, 2010-2014



Source: U.S. Census Bureau, American Community Survey, 2010-2014. Table S1702.

◆ **The poverty rate among families headed by single females is related to the mother's educational level. In Rhode Island between 2010 and 2014, 43% of families headed by single females with less than a high school diploma were poor, compared with 9% of those with a bachelor's degree or higher.[14]**

Table 4.

Births by Education Level of Mother, Rhode Island, 2010-2014

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	503	393	78%	44	9%	31	6%	6	1%
Bristol	778	403	52%	154	20%	145	19%	34	4%
Burrillville	632	216	34%	151	24%	179	28%	42	7%
Central Falls	1,619	121	7%	209	13%	527	33%	588	36%
Charlestown	260	116	45%	58	22%	48	18%	16	6%
Coventry	1,417	641	45%	322	23%	283	20%	86	6%
Cranston	3,887	1,713	44%	730	19%	852	22%	310	8%
Cumberland	1,613	890	55%	284	18%	238	15%	68	4%
East Greenwich	552	386	70%	64	12%	59	11%	10	2%
East Providence	2,453	1,018	42%	444	18%	619	25%	181	7%
Exeter	256	127	50%	35	14%	55	21%	25	10%
Foster	163	70	43%	36	22%	35	21%	6	4%
Glocester	342	165	48%	71	21%	61	18%	16	5%
Hopkinton	357	151	42%	81	23%	82	23%	23	6%
Jamestown	117	81	69%	10	9%	8	7%	2	2%
Johnston	1,282	521	41%	265	21%	303	24%	94	7%
Lincoln	901	450	50%	185	21%	156	17%	54	6%
Little Compton	79	44	56%	12	15%	15	19%	2	3%
Middletown	834	440	53%	138	17%	160	19%	36	4%
Narragansett	373	210	56%	64	17%	49	13%	13	3%
New Shoreham	56	30	54%	10	18%	12	21%	2	4%
Newport	1,295	609	47%	156	12%	248	19%	143	11%
North Kingstown	1,020	576	56%	151	15%	159	16%	53	5%
North Providence	1,582	667	42%	347	22%	358	23%	88	6%
North Smithfield	412	217	53%	74	18%	77	19%	19	5%
Pawtucket	4,941	1,151	23%	881	18%	1,491	30%	838	17%
Portsmouth	573	333	58%	106	18%	85	15%	13	2%
Providence	12,890	2,937	23%	1,916	15%	3,624	28%	2,995	23%
Richmond	348	190	55%	54	16%	59	17%	15	4%
Scituate	331	180	54%	67	20%	56	17%	9	3%
Smithfield	593	365	62%	83	14%	91	15%	18	3%
South Kingstown	897	517	58%	130	14%	128	14%	47	5%
Tiverton	528	234	44%	97	18%	113	21%	25	5%
Warren	458	180	39%	95	21%	114	25%	42	9%
Warwick	3,831	1,833	48%	770	20%	766	20%	221	6%
West Greenwich	241	118	49%	50	21%	47	20%	9	4%
West Warwick	1,789	532	30%	364	20%	535	30%	238	13%
Westerly	959	346	36%	208	22%	259	27%	78	8%
Woonsocket	2,946	504	17%	493	17%	1,018	35%	603	20%
Unknown	*41*	*25*	*NA*	*6*	*NA*	*5*	*NA*	*1*	*NA*
Four Core Cities	*22,396*	*4,713*	*21%*	*3,499*	*16%*	*6,660*	*30%*	*5,024*	*22%*
Remainder of State	*31,712*	*14,962*	*47%*	*5,910*	*19%*	*6,485*	*20%*	*2,044*	*6%*
Rhode Island	*54,149*	*19,700*	*36%*	*9,415*	*17%*	*13,150*	*24%*	*7,069*	*13%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Hospital Discharge Database, 2010-2014. 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 parental education levels are not included in this table. Between 2010 and 2014, maternal education levels were unknown for 4,815 births (9%).

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

References

[1,8] Egerter, S., Braveman, P., Sadegh-Nobari, T., Grossman-Kahn, R., & Dekker, M. (2011). *Issue brief #5: Exploring the social determinants of health: Education and health.* Retrieved January 29, 2016, from www.rwjf.org

[2] Urban Institute. (2012). *Poor parents' education is key in their children's escape from poverty.* Retrieved January 29, 2016, from www.urban.org

[3,12] Hernandez, D. J. & Napierala, J. S. (2014). *Mother's education and children's outcomes: How dual-generation programs offer increased opportunities for America's families.* New York, NY: Foundation for Child Development.

[4] Gakidou, E., Cowling, K., Lozano, R., & Murray, C. J. L. (2010). Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: A systemic analysis [Abstract]. *The Lancet, 376*(9745), 959-974.

[5,11,13] Rhode Island Department of Health, Center for Health Data and Analysis, Hospital Discharge Database, 2010-2014.

[6] Executive Office of the President of the United States. (2015). *The economics of early childhood investments.* Retrieved February 1, 2016, from www.whitehouse.gov

[7] *Early school readiness.* (2015). Washington, DC: ChildTrends.

(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 2014, 52% of all U.S. children were non-Hispanic White.[4] 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]

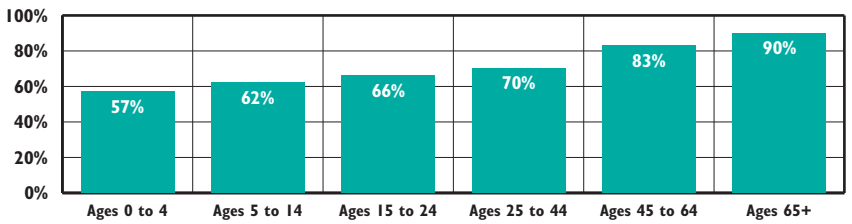
More than two-thirds (67%) of all minority children in Rhode Island live in Rhode Island's four core cities of Central Falls, Pawtucket, Providence, and Woonsocket. Almost three-quarters (74%) of children living in the four core cities are minority children.[8]

Between 2010 and 2014, there were 8,578 foreign-born children living in Rhode Island, 31% of whom were naturalized U.S. citizens.[9] Of Rhode Island's immigrant children, 22% were born in Central or South America, 25% were born in the Caribbean, 24% were born in Asia, 17% were born in Africa, 10% were born in Europe, and 2% were born in North America (Canada, Bermuda, or Mexico).[10]

Between 2010 and 2014, 23% of children between the ages of five and 17 living in Rhode Island spoke a language other than English at home, 95% of whom spoke English well or very well.[11]

Diversity presents both opportunities and challenges to schools, child care providers, health care providers, social service agencies and other community organizations, in terms of adapting current practices to meet the needs of a changing population.[12]

Percent of Population Identified as Non-Hispanic White, by Age, Rhode Island, 2014



Source: U.S. Census Bureau, Population Estimates, 2014.

◆ **Young children in Rhode Island are less likely to be identified as non-Hispanic White than any other age group. Fifty-seven percent of Rhode Island children under age five identify as non-Hispanic White, compared with 70% of adults ages 25 to 44 and 90% of people age 65 or over.[13]**

◆ **The median age of Hispanic Rhode Islanders in 2014 was 26 years, compared with 45 years for White Rhode Islanders, 34 years for Native American Rhode Islanders, 32 years for Black Rhode Islanders, 31 years for Asian Rhode Islanders, and 20 years for Rhode Islanders who identify as Two or more races.[14]**

◆ **Ninety-six percent of children in Rhode Island were born in the U.S.[15] 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); the U.S. rate is 24%.[16] Nearly all (98%) children in Rhode Island immigrant families have parents who arrived in this country more than five years ago.[17]**

◆ **Nineteen percent of Rhode Island children in non-immigrant families are poor, compared with 21% of children in immigrant families.[18] Two-thirds (68%) of Rhode Island's poor children live in families with U.S.-born parents.[19]**

◆ **Limited English proficiency can be a barrier to employment opportunities, higher earnings, access to health care, and parental engagement with education.[20] 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."[21]**

Table 5.

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

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

References

[1] Federal Interagency Forum on Child and Family Statistics. (2015). *America's children: Key national indicators of well-being, 2015.* Washington, DC: U.S. Government Printing Office.

[2] O'Hare, W. (2011). *The changing child population of the United States: Analysis of data from the 2010 Census.* Baltimore, MD: The Annie E. Casey Foundation.

[3,6,7,8] U.S. Census Bureau, 2000 and 2010 Census.

[4] The Annie E. Casey Foundation KIDS COUNT Data Center. (2014). *Child population by race.* Retrieved January 11, 2016, from www.datacenter.kidscount.org

[5] Frey, W. H. (2011). *America's diverse future: Initial glimpses at the U.S. child population from the 2010 Census.* Washington, DC: The Brookings Institution.

[9] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2010-2014. Table B05003.

[10] Population Reference Bureau analysis of 2010-2014 American Community Survey PUMS data.

[11] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2010-2014. Table B16004.

[12] *Strategic plan: Fiscal years 2010-2015.* (2011). Washington, DC: U.S. Department of Health and Human Services.

[13,14] U.S. Census Bureau, Population Estimates, 2014.

[15] The Annie E. Casey Foundation KIDS COUNT Data Center. (2014). *Child population by nativity.* Retrieved January 11, 2016, from www.datacenter.kidscount.org

[16] The Annie E. Casey Foundation KIDS COUNT Data Center. (2013). *Children in immigrant families.* Retrieved January 11, 2016, from www.datacenter.kidscount.org

(continued on page 170)

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 deep poverty in early childhood, are more likely to have health, behavioral, educational and social problems.[2,3] Between 2010 and 2014, 20% 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]

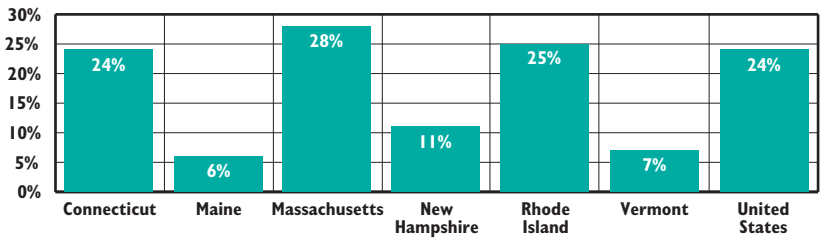
Black and Hispanic families were disproportionately impacted by the economic recession. In the U.S. between 2010 and 2013, White families' net worth rose by 2% while the net worth of Black and Hispanic families fell by 15% and 34%, respectively. The median net worth of White households is more than 10 times greater than Black or Hispanic families.[10] In Rhode Island, Black and Hispanic families have higher rates of unemployment, earn lower wages, and have lower household income than White families.[11]

Residential Segregation and Its Impact on Education

◆ **In the U.S., Black and Hispanic students are now more segregated from White students than forty years ago.[12] 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]**

◆ **Students in high-poverty, high-minority schools have unequal educational opportunities, with classmates who generally have more absences and lower graduation rates and teachers who have less teaching experience and are more likely to teach outside their subject area of expertise. Students living in poverty often face a host of challenges outside the classroom that can negatively impact academic performance, including inadequate housing, lower parental educational levels, and fewer opportunities for enriching after-school and summer activities.[14,15]**

Percentage of Children Living in Immigrant Families, New England and United States, 2014



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

◆ **Children in immigrant families are defined as children under age 18 who are foreign-born or who have at least one foreign-born parent, regardless of citizenship status or year of arrival in the United States. In 2014, 25% (54,000) of Rhode Island children were living in immigrant families.**

◆ **In Rhode Island, the median family income for children in immigrant families ($44,000) is lower than that of children living in U.S.-born families ($71,100).[16]**

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

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Children in Poverty	15%	41%	36%	15%	57%	20%
Births to Mothers with <12 Years Education	8%	27%	17%	9%	28%	13%
Unemployment Rate	5%	9%	12%	NA	NA	6%
Median Family Income	$79,418	$32,207	$39,454	$69,677	$25,941	$73,217
Homeownership	65%	28%	31%	49%	22%	60%

Sources: *Children in Poverty* data are from the U.S. Census Bureau, American Community Survey, 2010-2014. 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, 2010-2014. *Unemployment Rate* data are from the Bureau of Labor Statistics, Local Area Unemployment Statistics, 2015. *Median Family Income* data are from the U.S. Census Bureau, American Community Survey, 2010-2014, Tables B19113, B19113A, B19113B, B19113C, B19113D & B19113I. *Homeownership* data are from the U.S. Census Bureau, American Community Survey, 2010-2014, 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 2010 and 2014 in Rhode Island, 20% of all children, 41% of Hispanic children, 57% of Native American children, 36% of Black children, 15% of Asian children, and 15% of White children in Rhode Island lived in families with incomes below the federal poverty level.[17]**

◆ **Between 2010 and 2014 in Rhode Island, White households were the most likely to own their homes while Native American, Hispanic, and Black households were the most likely to live in rental units.[18]**

◆ **In 2015 in Rhode Island, the unemployment rate among White workers was 5.2%, compared to 12.2% for Black workers and 9.1% for Hispanic workers. Nationally, the unemployment rate for White workers in 2015 was 4.6%, compared to 9.6% for Black workers and 6.6% for Hispanic workers.[19]**

◆ **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.[20] 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.[21]**

Health Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Children Without Health Insurance	2.6%	4.7%	6.2%	7.6%	NA	3.3%
Women With Delayed Prenatal Care	10.3%	15.5%	18.5%	14.9%	13.7%	12.4%
Preterm Births	8.5%	9.6%	11.4%	9.1%	10.1%	9.1%
Low Birthweight Infants	6.6%	7.8%	11.2%	9.0%	10.8%	7.5%
Infant Mortality (per 1,000 live births)	4.8	6.1	10.8	6.4	NA	6.2
Asthma Hospitalizations (per 1,000 children)	1.2	2.2	4.3	1.0	NA	1.6
Births to Teens Ages 15-19 (per 1,000 teens)	11.6	45.9	33.2	11.5	53.6	18.6

Sources: All data are from the Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014 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, 2010-2014, Tables B27001A, B27001B, B27001D, B27001I, & CP03. *Asthma Hospitalizations* data are from the Rhode Island Department of Health, Hospital Discharge Database, 2010-2014 and refer only to hospitalizations due to primary diagnoses of asthma. Data on Preterm Births are not comparable to prior years. 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, P12, P14. 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. Minority children are more likely to die in infancy than White children. Hispanic and Black youth are more likely than White and Asian youth to give birth as teenagers.[22]**

◆ **Black and Hispanic children in Rhode Island are more likely to be hospitalized as a result of asthma than White children.[23] Nationally, Blacks and Native Americans are the most likely of all racial and ethnic groups to have asthma.[24]**

◆ **In 2014, 94% of U.S. children had health insurance coverage, an historic low. Hispanic (90%) and Native American (86%) children have the lowest rates of coverage.[25]**

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)	2.6	10.0	20.2	3.0	12.4	5.5
Children of Incarcerated Parents (per 1,000 children)	9.3	16.4	80.7	4.0	28.5	14.8
Children in Out-of-Home Placement (per 1,000 children)	6.5	13.0	19.8	3.6	15.6	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 2015. *Children of Incarcerated Parents* data are from the Rhode Island Department of Corrections, September 30, 2015 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, 2015. 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.[26] Rhode Island's juvenile justice system has some of the widest residential placement disparities between White and minority youth in the nation.[27]**

◆ **Black, Native American, and Hispanic children in Rhode Island are more likely than their White, and Asian peers to be placed out-of-home through the child welfare system.[28] 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.[29]**

◆ **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.[30]**

Education Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
3rd Grade Students Meeting Expectations in Reading	48%	18%	22%	47%	17%	37%
3rd Grade Students Meeting Expectations in Math	46%	18%	21%	52%	13%	36%
Students Attending Schools Identified for Intervention	3%	37%	30%	18%	19%	14%
Four-Year High School Graduation Rates	87%	76%	77%	89%	65%	83%
% of Adults Over Age 25 With a Bachelor's Degree or Higher	33%	12%	18%	41%	11%	31%

Sources: *Third Grade Students Meeting Expectations in Reading and Math* data are from the Rhode Island Department of Education, *Partnership for the Assessment of Readiness for College and Careers (PARCC),* 2015. *Students Attending Schools Identified for Intervention* and *Four-Year High School Graduation Rates* data are from the Rhode Island Department of Education, 2014-2015 school year. *Adult Educational Attainment* data are from the U.S. Census Bureau, American Community Survey, 2010-2014, Tables B15003, 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, Native American, Hispanic, and Black children are less likely to meet expectations in reading and mathematics in third grade than White or Asian children.[31] Native American, Hispanic, and Black adults living in Rhode Island are less likely to have a bachelor's degree than White or Asian adults.[32]**

◆ **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. In Rhode Island during the 2014-2015 school year, minority students received 56% of all disciplinary actions, although they made up only 40% of the student population.[33]**

◆ **During the 2014-2015 school year, Rhode Island's Hispanic and Black children were almost 12 times as likely as White children to attend schools identified for intervention.[34]**

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.[35]**

◆ **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.[36]**

Economics

◆ **In 2014, 38% percent of Rhode Island's Hispanic children were living in poverty, compared to the national rate of 32%.[37] The median family income for Hispanics in Rhode Island was $32,207, compared to $73,217 overall for all races in Rhode Island.[38]**

Health

◆ **In Rhode Island between 2010 and 2014, 15.5% percent of Hispanic babies were born to women who received delayed or no prenatal care, compared with 12.4% of all babies in the state.[39]**

◆ **Between 2010 and 2014, 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 (45.9 per 1,000 Hispanic teens ages 15 to 19 compared to 18.6 per 1,000 for all teens).[40,41]**

Education

◆ **The four-year high school graduation rate among Hispanic youth in the class of 2015 was 76%, lower than Rhode Island's four-year high school graduation rate of 83%.[42]**

◆ **The achievement gap between White and Latino students in Rhode Island is among the largest in the U.S.[43]**

References

[1] U.S. Census Bureau, 2010 Census Redistricting Data, Summary File, Tables P1, P2, P3, P4, & H1.

[2] Aber, L., Morris, P., & Raver, C. (2012). Children, families, and poverty: Definitions, trends, emerging science and implications for policy. *Sharing Child and Youth Development Knowledge, 26*(3).

[3] Ratcliffe, C. & McKernan, S. (2010). *Childhood poverty persistence: Facts and consequences.* Washington, DC: The Urban Institute.

[4,17] U.S. Census Bureau, American Community Survey, 2010-2014. Tables B17001, B17020A, B17020B, B17020C, B17020D, B17020H & B17020I.

[5] *Data snapshot on high poverty communities.* (2012). Baltimore, MD: The Annie E. Casey Foundation.

[6,36] U.S. Census Bureau, 2010 Census Redistricting Data.

[7] Kneebone, E., Nadeau, C., & Berube, A. (2011). *The re-emergence of concentrated poverty: Metropolitan trends in the 2000s.* Washington, DC: The Brookings Institution.

[8] Logan, J. R. & Stults, B. J. (2011). *The persistence of segregation in the metropolis: New findings from the 2010 Census.* Providence, RI: Brown University.

[9] US2010 Research Project. (n.d.). *Dissimilarity index: White-Hispanic/Hispanic-White all.* Retrieved February 22, 2012, from www.s4.brown.edu

[10] *Investing in tomorrow: Helping families build savings and assets.* (2016). Baltimore, MD: The Annie E. Casey Foundation.

[11] *State of working Rhode Island 2015: Workers of color.* (2015). Providence, RI: The Economic Progress Institute.

[12] Orfield, G., Kucsera, J., & Siegel-Hawley, G. (2012). *E Pluribus…Separation: Deepening double segregation for more students.* Los Angeles, CA: The Civil Rights Project/Proyecto Derechos Civiles at University of California Los Angeles.

[13,14] McArdle, N., Osypuk, T., & Acevedo-Garcia, D. (2010). *Segregation and exposure to high-poverty schools in large metropolitan areas: 2008-2009.* Retrieved March 6, 2015, from www.diversitydata.org

[15] Rothstein, R. (2014). The racial achievement gap, segregated schools, and segregated neighborhoods- A constitutional insult. *Race and Social Problems, 6*(4).

[16,37] The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org

[18] U.S. Census Bureau, American Community Survey, 2010-2014. Tables B25003, B25003A, B25003B, B25003C, B25003D & B25003I.

[19] *Employment status of the civilian noninstitutional population by sex, race, Hispanic or Latino ethnicity, and detailed age, 2015 annual averages - Rhode Island and United States.* (2015). U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics.

[20] Bloom, D. & Haskins, R. (2010). *Helping high school dropouts improve their prospects.* Princeton, NJ: The Future of Children.

[21,22,39,40] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014.

[23] Rhode Island Department of Health, Hospital Discharge Database, 2010-2014.

[24] National Health Interview Survey. (2014). *Table C-1a. Age-adjusted percentages (with standard errors) of ever having asthma and still having asthma for children under age 18 years, by selected characteristics, United States, 2014.* Retrieved January 27, 2016, from www.cdc.gov

[25] Alker, J. & Chester, A. (2015). *Children's health insurance rates in 2014: ACA results in significant improvements.* Washington DC: Georgetown University Center for Children and Families.

[26] Mendel, R. A. (2011). *No place for kids: The case for reducing juvenile incarceration.* Baltimore, MD: The Annie E. Casey Foundation.

[27] The W. Haywood Burns Institute. (n.d.). *Unbalanced justice.* Retrieved March 2, 2016, from data.burnsinstitute.org

[28] Rhode Island Department of Children, Youth and Families, RICHIST, December 31, 2015.

(continued on page 170)

Economic Well-Being

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 2014, the median family income for Rhode Island families with their own children was $61,605.[1] Rhode Island had the 16th highest median family income nationally and the 4th highest in New England.[2]

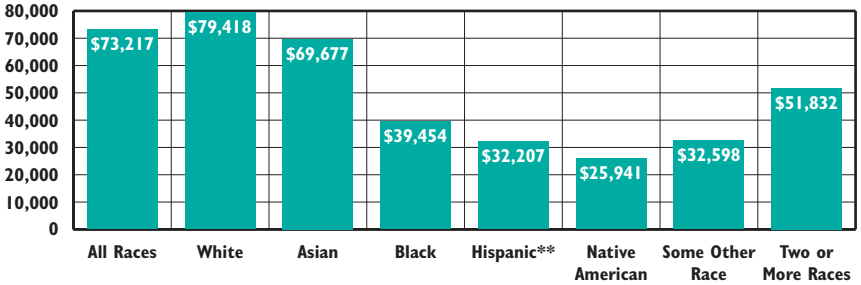
Between 2010 and 2014, Rhode Island's median income for families with their own children differed significantly by family type. The median family income for married two-parent families ($97,517) was more than two and a half times that of male-headed single-parent families ($37,610) and more than three and a half times that of female-headed single-parent families ($26,071).[3]

Rhode Island had one of the nation's highest unemployment rates in 2014 (7.7%), but by July 2015 the state's unemployment rate had decreased to 5.8%, closer to the U.S. rate of 5.3%.[4] Despite declines in unemployment, Rhode Island continues to have large gaps in unemployment rates by race and ethnicity. In 2015, the unemployment rate for White workers was 5.2%, while it was 9.1% for Black workers and 12.2% for Hispanic workers.[5]

While the national unemployment rate declined to 5% in 2015, the underemployment rate and percentage of low-wage jobs remains high.[6] More than 23 million people in the U.S. work in low-wage jobs where they are paid $10.50 or less. Conditions at low-wage jobs, such as fluctuating work hours, lack of paid time off, and strict attendance policies can harm children's development by making it difficult for parents to find and keep affordable high-quality child care and education for their children.[7]

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.[8]

Median Family Income by Race and Ethnicity, Rhode Island, 2010-2014*



Source: U.S. Census Bureau, American Community Survey, 2010-2014. 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 for Black, Hispanic, and Native American families.[9]**

◆ **Educational attainment is strongly associated with economic well-being. Rhode Islanders who have achieved a Bachelor's degree or higher have nearly double the wages of residents who have only completed high school. More than one in three Hispanic and more than one in four Black adults in Rhode Island, lack a high school diploma, compared to one in ten White adults.[10]**

◆ **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.[11]**

◆ **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.[12]**

Table 6. **Median Family Income, Rhode Island, 2010-2014**

CITY/TOWN	1999 MEDIAN FAMILY INCOME FOR FAMILIES WITH CHILDREN UNDER AGE 18 (ADJUSTED TO 2014 DOLLARS*)	2010-2014 MEDIAN FAMILY INCOME FOR FAMILIES WITH CHILDREN UNDER AGE 18	
		ESTIMATES WITH HIGH MARGINS OF ERROR**	ESTIMATES WITH LOWER, ACCEPTABLE MARGINS OF ERROR
Barrington	$126,206		$143,469
Bristol	$75,797		$91,767
Burrillville	$78,294	$72,688	
Central Falls	$31,281		$27,601
Charlestown	$78,287		$74,233
Coventry	$87,206		$94,078
Cranston	$80,879		$80,987
Cumberland	$97,064		$99,255
East Greenwich	$154,293		$166,944
East Providence	$69,468		$54,314
Exeter	$104,097		$109,099
Foster	$90,091	$86,375	
Glocester	$86,613		$92,270
Hopkinton	$83,957		$90,921
Jamestown	$113,101	$158,950	
Johnston	$80,506		$82,188
Lincoln	$91,633		$88,085
Little Compton	$80,560	$114,167	
Middletown	$78,601		$85,244
Narragansett	$97,006		$105,313
New Shoreham	$77,952	$108,295	
Newport	$61,295	$53,750	
North Kingstown	$94,924		$107,697
North Providence	$71,767		$67,534
North Smithfield	$101,008		$107,026
Pawtucket	$47,703		$40,304
Portsmouth	$95,762		$115,201
Providence	$34,888		$32,558
Richmond	$90,215		$122,540
Scituate	$98,264		$98,269
Smithfield	$95,300		$96,339
South Kingstown	$97,027		$105,365
Tiverton	$90,709		$86,984
Warren	$76,101		$60,694
Warwick	$81,070		$77,375
West Greenwich	$99,706		$103,074
West Warwick	$59,454		$50,688
Westerly	$73,872	$67,885	
Woonsocket	$48,986		$32,711
Four Core Cities	*NA*		*NA*
Remainder of State	*NA*		*NA*
Rhode Island	*$71,858*		*$67,119*

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 2014 constant dollars by multiplying 1999 dollar values by 1.42133224 as recommended by the U.S. Census Bureau.

The 2010-2014 data come from a Population Reference Bureau analysis of 2010-2014 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).

References

[1] U.S. Census Bureau, American Community Survey 1-Year Estimates, 2014. Table B19125.

[2] U.S. Census Bureau, American Community Survey 1-Year Estimates, 2014. Table R1902.

[3] U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2010-2014. Table B19126.

[4,10] *State of working Rhode Island 2015: Workers of color.* (2015). Providence: Rhode Island: The Economic Progress Institute.

[5] *Employment status of the civilian noninstitutional population by sex, race, Hispanic or Latino ethnicity, and detailed age, 2015 annual averages - Rhode Island and United States.* (2015). U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics.

[6] Wiedrich, K., Sims, L., Jr., Weisman, H., Rice, S., & Brooks, J. (2016). *The steep climb to economic opportunity for vulnerable families.* Washington, DC: Corporation for Enterprise Development.

[7] Vogtman, J. & Schulman, K. (2016). *Set up to fail: When low-wage work jeopardizes parents' and children's success.* Washington, DC: The National Women's Law Center.

[8] McNichol, E., Hall, D., Cooper, D., & Palacios, V. (2012). *Pulling apart: A state-by-state analysis of income trends.* Washington, DC: Center on Budget and Policy Priorities & Economic Policy Institute.

[9] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2010-2014. Tables B19113, B19113A, B19113B, B19113C, B19113D, B19113F, B19113G, & B19113I.

[11,12] *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 Area Median 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 2013, 24% of Rhode Island's 154,568 working households spent more than half of their income on housing costs, making Rhode Island the state with the highest cost burden in New England.[6]

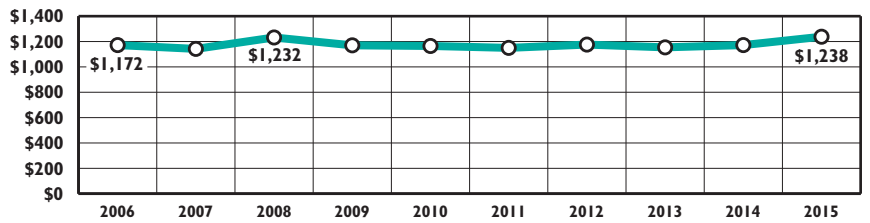
In 2015, a worker would have to earn $23.81 an hour and work 40 hours a week year-round to be able to afford the average rent in Rhode Island without a cost burden. This hourly wage is more than two and a half times the 2015 minimum wage of $9.00 per hour.[7] In 2015, Rhode Island had the 17th highest hourly wage needed to afford the rent for a two-bedroom home of any state.[8]

In 2015, the Area Median Income for families in Rhode Island was $75,644.[9] Families with this income can afford to purchase a median-priced, single-family home in 17 of the 39 communities in the state.[10] In 2014, the median cost of a single-family home in Rhode Island was $215,000, 10% higher than in 2012, but still 37% lower than the 2005 peak.[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, 2006-2015



Source: Rhode Island Housing, Annual Rent Surveys, 2006-2015. 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 2006 and 2015, the average cost of rent in Rhode Island remained fairly stable, increasing from $1,172 to $1,238, 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 47% in 2006 to 53% in 2014. The percentage of homeowners who had a cost burden due to their mortgages decreased between 2006 and 2014, from 43% to 37%.[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 2014, 31,088 low-income Rhode Island families received heating assistance through LIHEAP.[21]**

Table 7.

Cost of Housing for Very Low-Income Families, Rhode Island, 2015

	FAMILY INCOME		HOMEOWNERSHIP COSTS		RENTAL COSTS		
CITY/TOWN	2015 POVERTY LEVEL FAMILY OF THREE	2015 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	$20,090	$33,500	$3,053	109%	$1,336	80%	48%
Bristol	$20,090	$33,500	$2,326	83%	$1,325	79%	47%
Burrillville	$20,090	$33,500	$1,635	59%	$1,183	71%	42%
Central Falls	$20,090	$33,500	$983	35%	$960	57%	34%
Charlestown	$20,090	$33,500	$2,212	79%	$1,318	79%	47%
Coventry	$20,090	$33,500	$1,447	52%	$1,288	77%	46%
Cranston	$20,090	$33,500	$1,530	55%	$1,193	71%	43%
Cumberland	$20,090	$33,500	$2,009	72%	$1,220	73%	44%
East Greenwich	$20,090	$33,500	$3,283	118%	$1,396	83%	50%
East Providence	$20,090	$33,500	$1,417	51%	$1,252	75%	45%
Exeter	$20,090	$33,500	$2,041	73%	$1,673	100%	60%
Foster*	$20,090	$33,500	$1,909	68%	$944	56%	34%
Glocester	$20,090	$33,500	$1,679	60%	$1,474	88%	53%
Hopkinton	$20,090	$37,350	$1,618	52%	$1,036	62%	33%
Jamestown	$20,090	$33,500	$2,934	105%	$1,590	95%	57%
Johnston	$20,090	$33,500	$1,428	51%	$1,313	78%	47%
Lincoln	$20,090	$33,500	$2,127	76%	$1,262	75%	45%
Little Compton*	$20,090	$33,500	$3,489	125%	$944	56%	34%
Middletown	$20,090	$40,900	$2,553	75%	$1,406	84%	41%
Narragansett	$20,090	$33,500	$2,600	93%	$1,393	83%	50%
New Shoreham*	$20,090	$37,350	$7,556	243%	$979	58%	31%
Newport	$20,090	$40,900	$2,974	87%	$1,468	88%	43%
North Kingstown	$20,090	$33,500	$2,330	83%	$1,487	89%	53%
North Providence	$20,090	$33,500	$1,507	54%	$1,211	72%	43%
North Smithfield	$20,090	$33,500	$1,786	64%	$1,632	97%	58%
Pawtucket	$20,090	$33,500	$1,250	45%	$1,140	68%	41%
Portsmouth	$20,090	$40,900	$2,396	70%	$1,414	84%	41%
Providence**	$20,090	$33,500	$1,010	36%	$1,197	71%	43%
Richmond*	$20,090	$33,500	$1,911	68%	$944	56%	34%
Scituate	$20,090	$33,500	$1,973	71%	$1,379	82%	49%
Smithfield	$20,090	$33,500	$1,868	67%	$1,302	78%	47%
South Kingstown	$20,090	$33,500	$2,271	81%	$1,434	86%	51%
Tiverton	$20,090	$33,500	$1,819	65%	$1,467	88%	53%
Warren	$20,090	$33,500	$1,837	66%	$1,196	71%	43%
Warwick	$20,090	$33,500	$1,392	50%	$1,346	80%	48%
West Greenwich*	$20,090	$33,500	$2,127	76%	$944	56%	34%
West Warwick	$20,090	$33,500	$1,365	49%	$1,151	69%	41%
Westerly	$20,090	$37,350	$2,006	64%	$1,227	73%	39%
Woonsocket	$20,090	$33,500	$1,277	46%	$1,050	63%	38%
Four Core Cities	*$20,090*	*$33,500*	*$1,130*	*40%*	*$1,149*	*69%*	*41%*
Remainder of State	*$20,090*	*$34,464*	*$2,240*	*78%*	*$1,296*	*77%*	*45%*
Rhode Island	*$20,090*	*$34,365*	*$1,689*	*59%*	*$1,238*	*74%*	*43%*

Source of Data for Table/Methodology

2015 poverty level for a family of three as reported in: *Federal Register, 80*(14), January 22, 2015, pages 3236-3237.

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 Area Median Income and is calculated separately for each of the three metropolitan areas comprising Rhode Island. Reported by Rhode Island Housing (2015). *2015 Rhode Island income limits for low- and moderate-income households.* Retrieved February 18, 2016, from www.rhodeislandhousing.org

Data on typical monthly housing payments are from *2015 Housing fact book.* (2015). Providence, RI: HousingWorks RI. They are based on the median selling price of a single-family home using year-end 2014 data and calculated based on a 30-year mortgage at a 4.17% 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*, 2015. Average rents are based on a survey of rents in Rhode Island between January and December, 2015. 2015 rents are adjusted using HUD's utility allowance of $248 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 2015 *Rent Survey* data are not available. Average rent used for these communities is the HUD 2015 Fair Market Rent for the metropolitan area as reported by the U.S. Department of Housing and Urban Development.

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 weighted community data from RI Housing.

**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]

Homeless children are at a higher risk of abuse and exposure to violence. This trauma can lead to an increase in developmental delays and emotional distress and a decrease in academic achievement.[6,7] When homeless children are exposed to multiple traumatic events, they may have increased levels of anxiety, poor impulse control, and difficulty developing trusting relationships.[8,9]

Families who 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.[10]

In 2015, 482 families with 988 children stayed at an emergency homeless shelter, domestic violence shelter, or transitional housing facility in Rhode Island. Children made up 23% of the people who used emergency homeless shelters, domestic violence shelters, and transitional housing in 2015. Half (47%) of these children were under age six, not yet school age.[11] Other families are on the state's family shelter waiting list, awaiting placement when a slot opens up.

In 2015, United Way 211 received 48,461 calls from individuals and families seeking emergency shelter, 60,798 seeking affordable housing, and 7,140 related to foreclosure prevention.[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]**

◆ ***Zero: 2016* is a national campaign focused on helping communities across the U.S. end chronic and veteran homelessness by the end of 2016. Rhode Island has also set a target of ending family homelessness by the end of 2017.[14,15,16]**

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.[17]**

◆ **The federal *McKinney-Vento Homeless Assistance Act (McKinney-Vento 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.[18]**

◆ **The *McKinney-Vento Act* defines a child as homeless if he or she does not have a "fixed, regular, and adequate nighttime residence."[19] During the 2014-2015 school year, Rhode Island public school personnel identified 1,031 children as homeless, up from 1,023 the year prior. Of these children, 63% lived with other families ("doubled up"), 28% lived in shelters, 8% lived in hotels or motels, and 2% were unsheltered.[20]**

◆ **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.[21]**

Table 8. **Homeless Children Identified by Public Schools, Rhode Island, 2014-2015 School Year**

SCHOOL DISTRICT	TOTAL ENROLLMENT	# OF CHILDREN IDENTIFIED AS HOMELESS BY PUBLIC SCHOOL PERSONNEL
Barrington	3,288	*
Bristol Warren	3,358	18
Burrillville	2,408	41
Central Falls	2,683	90
Chariho	3,305	29
Coventry	4,854	16
Cranston	10,457	10
Cumberland	4,543	16
East Greenwich	2,412	0
East Providence	5,280	29
Exeter-West Greenwich	1,645	*
Foster	284	0
Foster-Glocester	1,121	10
Glocester	529	0
Jamestown	500	0
Johnston	3,116	*
Lincoln	3,084	*
Little Compton	248	0
Middletown	2,285	120
Narragansett	1,340	*
New Shoreham	118	0
Newport	2,072	53
North Kingstown	4,088	29
North Providence	3,560	20
North Smithfield	1,775	0
Pawtucket	9,057	45
Portsmouth	2,563	12
Providence	23,907	127
Scituate	1,419	0
Smithfield	2,372	31
South Kingstown	3,321	*
Tiverton	1,871	0
Warwick	9,277	85
West Warwick	3,417	12
Westerly	3,022	72
Woonsocket	5,995	100
Charter Schools	*5,445*	*20*
State-Operated Schools	*1,801*	*17*
UCAP	*139*	*0*
Four Core Cities	*41,642*	*362*
Remainder of State	*92,932*	*632*
Rhode Island	*141,959*	*1,031*

Source of Data for Table/Methodology

Rhode Island Department of Education, Public School Enrollment in grades preschool to 12 on October 1, 2014.

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 Valley Prep Mayoral Academy, Kingston Hill Academy, Paul Cuffee Charter School, Sheila C. "Skip" Nowell Leadership Academy, 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

[1,4] Bassuk, E. L., DeCandia, C. J., Beech, C. A., & Berman, F. (2014). *America's youngest outcasts: A report card on child homelessness.* Needham, MA: The National Center on Family Homlessness.

[2,5,10] *The characteristics and needs of families experiencing homelessness.* (2011). Needham, MA: The National Center on Family Homelessness.

[3] Aratani, Y. (2009). *Homeless children and youth: Causes and consequences.* New York, NY: Columbia University, Mailman School of Public Health, National Center for Children in Poverty.

[6] American Academy of Pediatrics. (2013). Providing care for children and adolescents facing homelessness and housing insecurity. *Pediatrics, 131*(6), 1206-1210.

(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 2015, Rhode Island's unemployment rate was 5.4%, higher than the U.S. unemployment rate of 5.0%, and the nineteenth highest in the nation. However, it was considerably lower than at the height of Rhode Island's recession in December 2009, when the unemployment rate was 11.2%.[3,4]

In 2014, Rhode Island had the highest rate of children with at least one unemployed parent (9%), compared to the U.S. average of 7%.[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 2010 and 2014, 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] In the workforce, low-income individuals tend to have few opportunities for development, limited benefits, and an overall lack of economic security. In addition, despite gaining experience and seniority, many low-income workers never move out of low-wage jobs.[10]

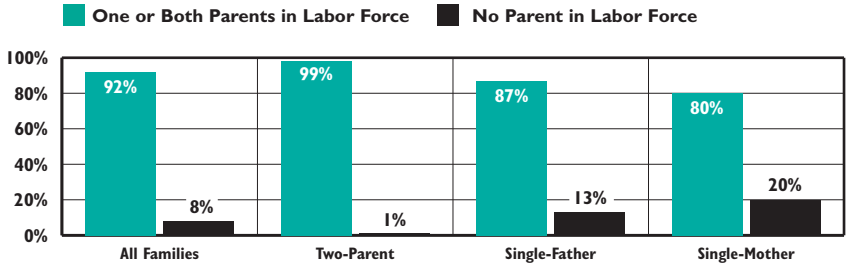
Children Living in Families Where No Parent Has Full-Time, Year-Round Employment

	2009	2014
RI	31%	32%
US	31%	30%
National Rank*		*33rd*
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

Employment Status of Parents by Family Type, Rhode Island, 2010-2014



Source: U.S. Census Bureau, American Community Survey, 2010-2014. Table B23008.

◆ **The majority of children living in Rhode Island between 2010 and 2014 had one or both parents in the labor force. Children living with a single parent were 20 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 2010 and 2014, there were 16,603 Rhode Island children living in families with no parent in the labor force. Children living in families with a single parent represented 91% (15,136) of families with no employed parents.[12]**

◆ **Between 2010 and 2014, 15% (3,835) 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 2013, 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 25%.[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]**

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 that 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 leave.[23]

◆ Limited education also can be a barrier to sustained employment. Between 2010 and 2014 in Rhode Island, adults without a high school diploma were nearly four times as likely to be 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]

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 ($26,155) would have to spend 49.2% 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 income-eligible working families. During the 2007 legislative session, eligibility for child care assistance was rolled back from 225% to 180% of the federal poverty level ($36,288 for a family of three in 2016).[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. It lifted 6.2 million people, over half of them children, out of poverty in 2013.[30,31]

◆ 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 2015, the Rhode Island General Assembly passed legislation that increased the state's EITC from 10% to 12.5% of the federal EITC. In 2014, 84,091 Rhode Island working families and individuals received a total of $190 million in EITC tax credits for tax year 2013.[33]

References

[1] Federal Interagency Forum on Child and Family Statistics. (2015). *America's children: Key national indicators of well-being, 2015.* Washington, DC: U.S. Government Printing Office.

(continued on page 171)

Paid Family Leave

DEFINITION

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

SIGNIFICANCE

Rhode Island's Temporary Caregiver Insurance (TCI) program, established 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]

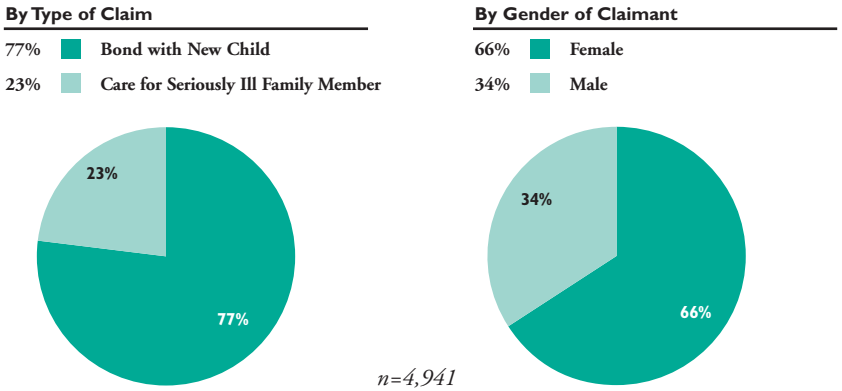
Almost all advanced, industrialized nations guarantee paid leave for new mothers and many include new fathers. In many European countries, families receive at least six months of paid leave to care for a new baby.[2] The U.S. requires employers with 50 or more workers to offer 12 weeks of leave for workers 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 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 and child abuse, improves breastfeeding rates and duration, and increases 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.[7,8] Providing time off from work for new parents gives babies time to form secure attachments, which form the foundation for future relationships and development.[9]

Rhode Island's Temporary Disability Insurance (TDI) program 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.[10,11] TCI supplements TDI; women who give birth are eligible for both.

Approved Temporary Caregiver Insurance (TCI) Claims, Rhode Island, 2015



Source: Rhode Island Department of Labor and Training, TCI Program, 2015.

◆ **There were 4,941 approved claims for TCI during 2015 (up from 3,870 in 2014); 77% were to bond with a new child and 23% were to care for a seriously ill family member.[12]**

◆ **Of the 3,803 approved claims to bond with a new child, 99% were for a newborn child, 1% were for a newly adopted child, and 1% were for a new foster child. Thirty-four percent of claims to bond with a new child were filed by men and 66% were filed by women.[13]**

◆ **Of the 1,138 approved claims to care for a seriously ill family member, 51% were to care for a spouse or domestic partner, 30% were to care for a parent or parent-in-law, 18% were to care for a child, and <1% were to care for a grandparent. Thirty-two percent of claims to care for a seriously ill family member were filed by men and 68% were filed by women.[14]**

Temporary Disability Insurance for Pregnancy Complications & Childbirth

◆ **In 2015, there were 729 approved TDI claims for disabling pregnancy complications and 3,187 TDI claims to recover from childbirth.[15] 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. 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).[16]**

Table 9. **Approved Temporary Disability Claims for Childbirth & Temporary Caregiver Insurance for Paid Family Leave, Rhode Island, 2015**

	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	5	29	34	27	11	38
Bristol	5	53	58	71	24	95
Burrillville	9	43	52	39	13	52
Central Falls	11	53	64	54	15	69
Charlestown	2	25	27	24	16	40
Coventry	26	110	136	146	54	200
Cranston	56	213	269	319	102	421
Cumberland	14	86	100	90	31	121
East Greenwich	4	47	51	44	12	56
East Providence	33	130	163	173	60	233
Exeter	4	13	17	18	5	23
Foster	3	10	13	11	4	15
Glocester	7	23	30	34	11	45
Hopkinton	4	18	22	25	8	33
Jamestown	*	*	*	8	4	12
Johnston	22	73	95	141	48	189
Lincoln	17	68	85	77	23	100
Little Compton	*	*	*	*	*	*
Middletown	4	37	41	23	8	31
Narragansett	2	11	13	23	12	35
Newport	15	52	67	51	11	62
New Shoreham	*	*	*	*	*	*
North Kingstown	16	67	83	71	26	97
North Providence	25	78	103	108	37	145
North Smithfield	7	34	41	32	8	40
Pawtucket	47	234	281	275	64	339
Portsmouth	5	37	42	37	17	54
Providence	144	521	665	555	135	690
Richmond	*	*	*	9	3	12
Scituate	6	26	32	41	23	64
Smithfield	11	39	50	62	19	81
South Kingstown	16	59	75	70	18	88
Tiverton	7	30	37	33	4	37
Warren	3	28	31	35	11	46
Warwick	77	289	366	370	119	489
West Greenwich	*	*	*	13	6	19
West Warwick	31	84	115	145	36	181
Westerly	3	58	61	63	15	78
Woonsocket	27	92	119	90	26	116
Out-of-State	*56*	*391*	*447*	*392*	*98*	*490*
Four Core Cities	*229*	*900*	*1,129*	*974*	*240*	*1,214*
Remainder of State	*444*	*1,896*	*2,340*	*2,437*	*800*	*3,237*
Rhode Island	*673*	*2,796*	*3,469*	*3,411*	*1,040*	*4,451*
Total Program Claims	*729*	*3,187*	*3,916*	*3,803*	*1,138*	*4,941*

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, 2015.

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.

*Data for any town with less than 10 approved claims are suppressed by the Rhode Island Department of Labor and Training.

References

[1] The State of Rhode Island and Providence Plantations, Department of Labor and Training. (2014). *Temporary Caregiver Insurance [Brochure].*

[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).

[6,9] *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.

[8] Klevens, J., Luo, F., Xu, L., Peterson, C., & Latzman, N. (2016). Paid family leave's effect on hospital admissions for pediatric abusive head trauma. *Injury Prevention.*

[10] *Annual statistical supplement to the Social Security Bulletin, 2014.* (2015). Washington, DC: Social Security Administration, Office of Retirement and Disability Policy.

[11,16] *Existing temporary disability insurance programs.* (2015). Washington, DC: National Partnership for Women and Families.

[12,13,14] Rhode Island Department of Labor and Training, 2015.

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.

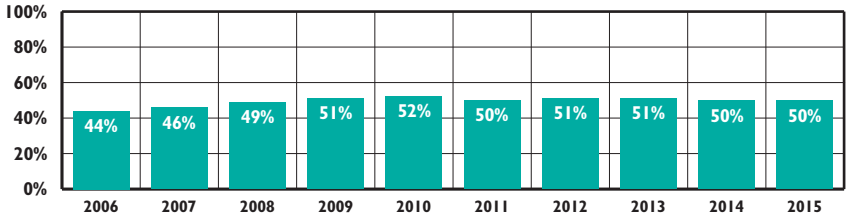
SIGNIFICANCE

Child support is a major part of the safety net for children and families. In 2014, nearly one in four U.S. children (16.3 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. 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.[8,9]

Non-Custodial Parents With Court Orders Who Pay Child Support on Time and in Full, Rhode Island, 2006-2015



Source: Rhode Island Department of Human Services, Office of Child Support Services, 2006-2015.

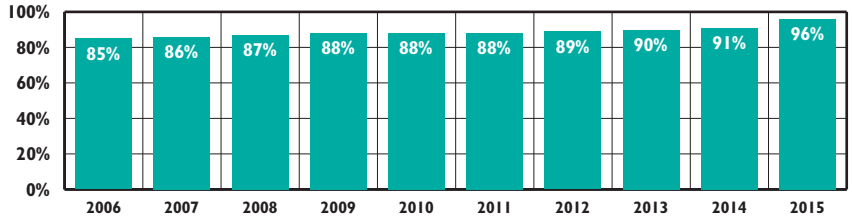
◆ **As of December 1, 2015, there were 74,672 children in Rhode Island's Office of Child Support Services system, including private, interstate and IV-D cases (i.e., families receiving RI Works, RIte Care or child-care assistance). Forty-seven percent of the children in the Child Support system with 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 2015, the Rhode Island Office of Child Support Services collected $95.0 million in child support, an increase of $2.7 million over the previous year. Collections go toward both child support and medical support. Eighty-five percent ($80.5 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) 2014, the Rhode Island Office of Child Support Services collected $5.55 for every $1.00 Rhode Island spent on administering the program.[12]**

◆ **During FFY 2015, there were 19,915 court orders for non-custodial parents to provide medical insurance and 12,929 orders for non-custodial parents to contribute funds toward medical coverage. More than $6.4 million in payments (known as "cash medical") was retained by the state to offset the cost of RIte Care, while approximately $2.0 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, 2006-2015



Source: Rhode Island Department of Human Services, Office of Child Support Services, 2006-2015. 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 85% of children in 2006 to 96% of children in 2015.[14]**

◆ **When applying for cash assistance, child care assistance, or RIte Care health coverage, 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 2014, Rhode Island had the lowest rate of court orders established for child support in New England (Maine – 94%; Vermont – 90%; Massachusetts – 86%; New Hampshire – 85% Connecticut – 81%; Rhode Island – 71%). The national average for cases with child support orders established is 85%.[17] In FFY 2014, Rhode Island had the highest case/staff ratio in New England at 831 cases per person, more than five times that of the lowest state, Vermont.[18] High caseloads and a low number of full time staff affects the Office of Child Support Services' ability to establish court orders for child support.**

References

[1] U.S. Office of Child Support Enforcement, Administration for Children & Families. (2015). *FY 2014 preliminary report.* Table P-93. Retrieved January 25, 2016, from www.acf.hhs.gov

[2] U.S. Office of Child Support Enforcement, Administration for Children & Families. (n.d.). *OCSE fact sheet.* Retrieved January 25, 2016, from www.acf.hhs.gov

(continued on page 172)

Child Support and Rhode Island Works

◆ **As of December 1, 2015, Rhode Island's Office of Child Support Services system included 6,335 children enrolled in Rhode Island Works (RI Works).[19]**

◆ **In 2015, the average child support obligation for children enrolled in RI Works was $262 per month, compared to an average child support obligation of $380 per month for children in non-RI Works families.[20] (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 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. The remainder of the payment is retained by the federal and state governments as reimbursement for assistance received through RI Works.[21]**

◆ **In FFY 2015 in Rhode Island, an average of 654 families received at least one "pass-through" payment each month, for a total of $379,402 paid to families enrolled in RI Works during FFY 2015.[22]**

◆ **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.[23] Rhode Island has not implemented this option.[24]**

◆ **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.[25]**

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 2015, the federal poverty threshold was $19,096 for a family of three with two children and $24,036 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, more than twice 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]

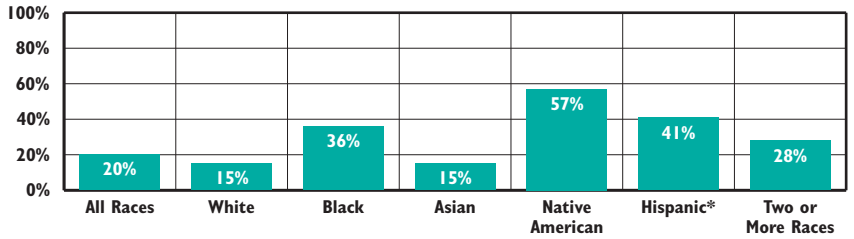
Children in Poverty

	2011	2012	2013	2014
RI	21.9%	19.5%	21.5%	19.8%
US	22.5%	22.6%	22.2%	21.7%
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, 2011-2014. Table R1704.

Children in Poverty, by Race and Ethnicity, Rhode Island, 2010-2014



Source: U.S. Census Bureau, American Community Survey, 2010-2014. Tables S1701, B17020A, B17020B, B17020C, B17020D, B17020G and B17020I. *Hispanic children may be included in any race category.

◆ **Between 2010 and 2014, 20% (43,144) of Rhode Island's 214,441 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 2010 and 2014, 57% of Native American, 41% of Hispanic, and 36% of Black children in Rhode Island lived in poverty, compared to 15% of White children and Asian children.[13,14]**

◆ **Between 2010 and 2014, of all children living in poverty in Rhode Island, 53% were White, 16% were Black, 2% were Asian, 2% were Native American, 18% were Some other race, and 8% were Two or more races.**

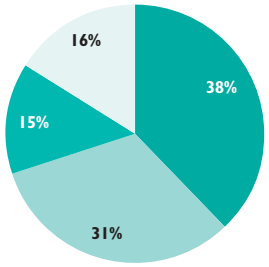
◆ **Between 2010 and 2014, 45% of Rhode Island's poor children were Hispanic. Hispanic children may be included in any race category. The Census Bureau asks about race separately from ethnicity, and the majority of families who identify as Some other race also identify as Hispanic.[15]**

◆ **In 2014, nearly one in five (19.8%) children in Rhode Island (a total of 41,629 children) lived in poverty.[16]**

Rhode Island's Poor Children, 2010-2014

By Age

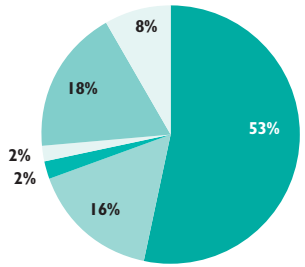
38%	Ages 5 and Younger
31%	Ages 6 to 11
15%	Ages 12 to 14
16%	Ages 15 to 17



n=43,144

By Race*

53%	White
16%	Black
2%	Asian
2%	Native American
18%	Some Other Race
8%	Two or More Races

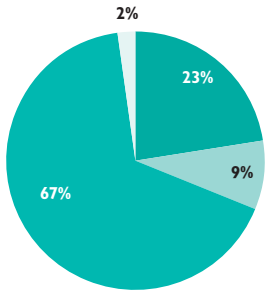


n=43,144

**Hispanic children may be included in any race category. Between 2010 and 2014, 19,460 (45%) of Rhode Island's 43,144 poor children were Hispanic.*

By Family Structure

23%	Married Couple Family
9%	Unmarried Male Householder
67%	Unmarried Female Householder
2%	Not in Related-Family Households



n=43,114

Source: U.S. Census Bureau, American Community Survey, 2010-2014. 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, 2010-2014

CITY/TOWN	NUMBER IN POVERTY	PERCENTAGE IN POVERTY	NUMBER IN EXTREME POVERTY	PERCENTAGE IN EXTREME POVERTY
Central Falls	2,361	41.9%	968	17.2%
Pawtucket	5,120	32.1%	2,449	15.4%
Providence	15,894	39.7%	7,522	18.8%
Woonsocket	4,036	42.0%	1,934	20.1%
Rhode Island	*43,144*	*20.1%*	*19,449*	*9.1%*

Source: Population Reference Bureau analysis of 2010-2014 American Community Survey data.

◆ **Between 2010 and 2014, 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, or $9,548 for a family of three with two children and $12,018 for a family of four with two children in 2015.[17,18]**

Young Children Under Age Six in Poverty, Four Core Cities and Rhode Island, 2010-2014

CITY/TOWN	NUMBER	PERCENTAGE
Central Falls	1,099	47.1%
Pawtucket	2,026	36.3%
Providence	5,682	42.6%
Woonsocket	1,711	46.7%
Rhode Island	*16,530*	*24.8%*

Source: Population Reference Bureau analysis of 2010-2014 American Community Survey data.

◆ **Between 2010 and 2014, 24.8% (16,530) of Rhode Island children under age six lived in poverty.[19] Children under age six are at higher risk of living in poverty than any other age group.[20] Exposure to risk factors associated with poverty, including inadequate nutrition, 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.[21,22]**

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.[23,24]

◆ 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.[25,26]

◆ In 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.[27]

◆ 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.[28]

◆ 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.[29,30,31]

◆ 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.[32]

◆ 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.[33,34]

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 U.S. children out of poverty.[35]

Health Coverage and Access to Care

◆ Low-income people are the most likely to be uninsured; some because of job loss, some are ineligible for coverage through their employers because they work part-time, and others cannot afford the cost.[36] Children with health insurance are more likely to have a regular and accessible source of health care than uninsured children.[37]

Affordable Quality Child Care

◆ In Rhode Island, in 2015, the average cost of center-based child care for one infant was $12,091. Child care subsidies can help poor families afford high-quality child care, which can help parents maintain employment and support children's development.[38,39]

Educational Attainment

◆ Fifty-two percent of Rhode Island children whose parents lack a high school diploma and 32% of those whose parents have only a high school diploma live in poverty.[40] By 2020, 71% of all jobs in Rhode Island will require education beyond high school.[41]

Affordable Housing

◆ In 2015, the average rent for a two-bedroom apartment in Rhode Island was $1,238.[42] In Rhode Island, a family of three with an income at the federal poverty level would need to spend 74% of its income on rent to pay this amount, well above the recommended percentage of 30%.[43,44] Nationally, only one in four low-income families eligible receive rental assistance to help them afford the high cost of housing.[45]

Child Support

◆ As of December 1, 2015, there were 74,672 children in Rhode Island's Office of Child Support Services system.[46] Child support helps reduce poverty. Custodial parents who receive steady child support payments are less likely to rely on public assistance and more likely to find work faster and stay employed longer than those who do not.[47] Among poor custodial parents that received full child support in 2011 in the U.S., these payments represented 66.7% of their mean personal income.[48]

Table 10. **Children Living Below the Federal Poverty Threshold, Rhode Island, 2000 and 2010-2014**

	CHILDREN UNDER AGE 18 LIVING BELOW POVERTY, 2000		CHILDREN UNDER AGE 18 LIVING BELOW POVERTY 2010-2014			
			ESTIMATES WITH HIGH MARGINS OF ERROR*		ESTIMATES WITH LOWER, ACCEPTABLE MARGINS OF ERROR	
CITY/TOWN	N	%	N	%	N	%
Barrington	127	2.7%			68	1.5%
Bristol	436	10.0%			183	5.5%
Burrillville	236	6.0%	354	10.8%		
Central Falls	2,210	40.9%	2,361	41.9%		
Charlestown	78	4.7%	326	22.5%		
Coventry	481	5.9%			873	12.4%
Cranston	1,496	9.1%			2,380	15.4%
Cumberland	237	3.1%			586	7.9%
East Greenwich	147	4.1%	228	7.1%		
East Providence	1,126	10.8%			1,670	17.3%
Exeter	112	7.5%	84	7.4%		
Foster	32	2.9%	88	11.0%		
Glocester	178	6.7%			79	4.4%
Hopkinton	115	5.9%	70	5.2%		
Jamestown	17	1.4%	122	13.7%		
Johnston	527	9.0%			683	12.7%
Lincoln	329	6.5%			438	9.2%
Little Compton	8	1.0%	47	7.4%		
Middletown	264	6.2%			357	9.3%
Narragansett	235	8.6%			105	4.7%
New Shoreham	19	10.2%	9	8.9%		
Newport	1,267	24.4%	582	16.4%		
North Kingstown	663	9.7%			753	12.2%
North Providence	579	10.1%			734	14.5%
North Smithfield	72	3.0%			132	5.6%
Pawtucket	4,542	25.3%			5,120	32.1%
Portsmouth	118	2.8%			238	6.6%
Providence	18,045	40.5%			15,894	39.7%
Richmond	82	4.2%	119	6.5%		
Scituate	113	4.3%	175	8.4%		
Smithfield	153	3.9%			79	2.2%
South Kingstown	324	5.3%			396	8.1%
Tiverton	92	2.8%			259	8.9%
Warren	205	8.4%	240	12.0%		
Warwick	1,243	6.7%			1,319	8.9%
West Greenwich	40	2.7%			72	4.3%
West Warwick	1,186	18.1%	1,219	21.3%		
Westerly	534	10.0%	666	14.3%		
Woonsocket	3,494	31.8%			4,036	42.0%
Four Core Cities	*28,291*	*35.9%*			*27,411*	*38.5%*
Remainder of State	*12,871*	*7.8%*			*15,733*	*11.0%*
Rhode Island	*41,162*	*16.9%*			*43,114*	*20.1%*

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 2010-2014 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.

[2,4,21] Moore, K. A., Redd, Z., Burkhauser, M., Mbwana, K., & Collins, A. (2009). *Children in poverty: Trends, consequences, and policy options.* Washington, DC: Child Trends.

[3] *Children in Poverty.* (2015). Washington, DC: Child Trends.

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

[6] U.S. Census Bureau. (2014). *Extracurricular activities of school age children—Characteristics of families and households with children age 6-17: 2011.* Survey of Income and Program Participation (SIPP), 2008 Panel, Wave 4. Table D14. Retrieved February 9, 2016, from www.census.gov

(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]

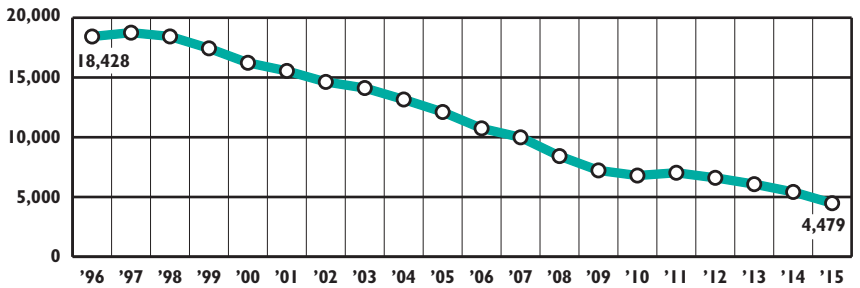
RI Works cash assistance recipients must participate in an employment plan unless they meet specific criteria for an exemption. This employment plan must take into account the parent's skills, education, and family responsibilities as well as local employment opportunities and should outline a process 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 2015, the average hourly wage of working parents enrolled in RI Works was $10.19 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, 1996-2015*



Source: Rhode Island Department of Human Services, InRhodes Database, December 1, 1996-2015. 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 2010-2015 caseload data. Comparisons to earlier years should be made with caution.

◆ **Since 1996, when the program began, the Rhode Island cash assistance caseload had been steadily declining. Between 2014 and 2015, the caseload decreased by 17%, from 5,422 to 4,479 families.[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]**

◆ **From December 2006 to 2014, the RI Works caseload decreased by 56%, while the number of unemployed people in Rhode Island increased by 36%.[12]**

◆ **In December 2015, there were 2,967 adults and 7,675 children under age 18 enrolled in RI Works. More than two-thirds (72%) of RI Works beneficiaries were children, and 43% 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 2014, 19,151 children in Rhode Island lived in extreme poverty, yet only 7,675 received cash assistance in 2015.[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. For two-parent families, one or both parents must participate in work activities for an individual or combined total of 35 hours per week.[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 1, 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]

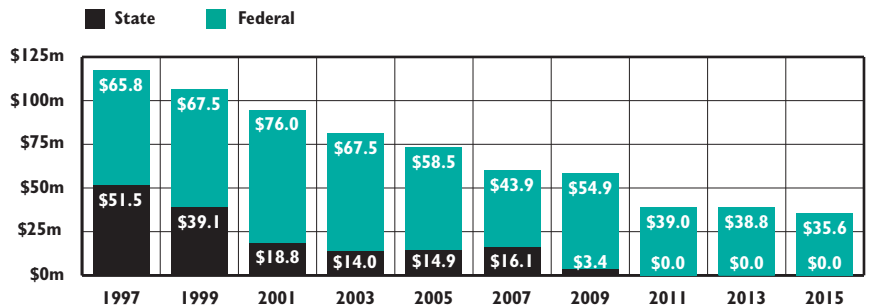
RI Works by Case Type, 2015

	NUMBER	PERCENTAGE
Child-only cases	1,757	39%
Cases with adults required to engage in a work activity	2,722	61%
Cases with adults exempt from a work activity*	397	9%
Total RI Works Caseload	*4,479*	

Source: Rhode Island Department of Human Services, InRhodes Database, 2015.

**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 (109), caring for a disabled spouse or child (22), being a victim of domestic violence (26), 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 1997-2015



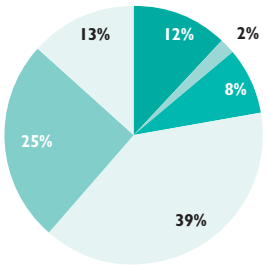
Sources: Rhode Island Department of Human Services, *Family Independence Program 2007 annual report.* (FY 1997-2001); House Fiscal Advisory Staff. (2004-2015). Budget as enacted: Fiscal Years 2005-2016. (FY 2003-2015). Fiscal years 1997-2013 are funds spent and FY 2015 is final budget.

◆ In State Fiscal Year 2015, for the sixth 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 2015, from $126.5 million to $35.6 million.[22,23]

Children in Families Receiving Cash Assistance

Activities of Families Enrolled in the RI Works Program, December 2015

By Type of Activity	
12% (333)	Employed
2% (63)	Work Experience
8% (220)	Education/Training
39% (1,066)	Job Search/Job Readiness
25% (673)	Assessment/Transition
13% (367)	Sanctioned



n=2,722

Source: Rhode Island Department of Human Services, InRhodes Database, December 2015. Percentages may not sum to 100% due to rounding.

◆ As of December 2015, 12% 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] Work experience can help parents gain new skills, knowledge, and work habits to improve their employability.[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 2015, 8% of families were participating in education or training programs.[28]

◆ Over one-third (39%) 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. Twenty-five 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]

◆ Thirteen percent of families 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 2015, there were 168 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, 2015, 776 families (17% of the total RI Works caseload) had hardship extensions, 197 for a physical or mental disability, 16 to care for a disabled family member, seven who were unable to work due to a domestic violence situation, seven due to homelessness, and 549 because of another critical condition or circumstance.[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 2010 and 2014, the unemployment rate for Rhode Islanders without high school diplomas was 15.8%, compared to 11.6% for those with high school degrees and 4.1% for those with a Bachelor's degree or higher.[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, more than one-third (37%) of those tested in English tested at or below the sixth-grade reading level, while two-thirds (67%) 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] States should explore how to meet their work participation rate while offering beneficiaries a chance to improve job skills and long-term work preparedeness.[45]

Source of Data for Table/Methodology

Rhode Island Department of Human Services, InRhodes Database, December 2015. 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

[1,2,3,5,8,16,17,18,20,21,26,30,33,36] Rhode Island Department of Human Services. (2016). *Rhode Island Department of Human Services Code of Rules: RI Works Program (Policy #1400).* Retrieved February 24, 2016, from www.policy.dhs.ri.gov

(continued on page 173)

Table 11. **Children in Families Receiving Cash Assistance (RI Works), Rhode Island, December 1, 2015**

CITY/TOWN	# OF CHILDREN UNDER AGE 18	NUMBER RECEIVING CASH ASSISTANCE		% OF CHILDREN RECEIVING CASH ASSISTANCE
		FAMILIES	CHILDREN	
Barrington	4,597	6	8	<1%
Bristol	3,623	25	34	1%
Burrillville	3,576	23	33	1%
Central Falls	5,644	236	414	7%
Charlestown	1,506	4	4	<1%
Coventry	7,770	56	98	1%
Cranston	16,414	230	369	2%
Cumberland	7,535	47	87	1%
East Greenwich	3,436	21	34	1%
East Providence	9,177	114	168	2%
Exeter	1,334	5	10	1%
Foster	986	5	6	1%
Glocester	2,098	4	5	<1%
Hopkinton	1,845	5	7	<1%
Jamestown	1,043	4	8	<1%
Johnston	5,480	56	83	2%
Lincoln	4,751	34	52	1%
Little Compton	654	3	4	1%
Middletown	3,652	38	56	2%
Narragansett	2,269	13	22	1%
New Shoreham	163	0	0	0%
Newport	4,083	142	248	6%
North Kingstown	6,322	33	54	1%
North Providence	5,514	81	127	2%
North Smithfield	2,456	16	29	1%
Pawtucket	16,575	471	761	5%
Portsmouth	3,996	19	26	1%
Providence	41,634	1,805	3,331	8%
Richmond	1,849	10	13	1%
Scituate	2,272	9	13	1%
Smithfield	3,625	4	5	<1%
South Kingstown	5,416	21	25	<1%
Tiverton	2,998	36	64	2%
Warren	1,940	18	28	1%
Warwick	15,825	239	336	2%
West Greenwich	1,477	3	4	<1%
West Warwick	5,746	146	236	4%
Westerly	4,787	38	57	1%
Woonsocket	9,888	443	790	8%
Other/Unknown	*NA*	*16*	*26*	*NA*
Four Core Cities	*73,741*	*2,955*	*5,296*	*7%*
Remainder of State	*150,215*	*1,508*	*2,353*	*2%*
Rhode Island	*223,956*	*4,479*	*7,675*	*3%*

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 2015 and the percentage change between 2010 and 2015 in the number of children under age 18 participating.

SIGNIFICANCE

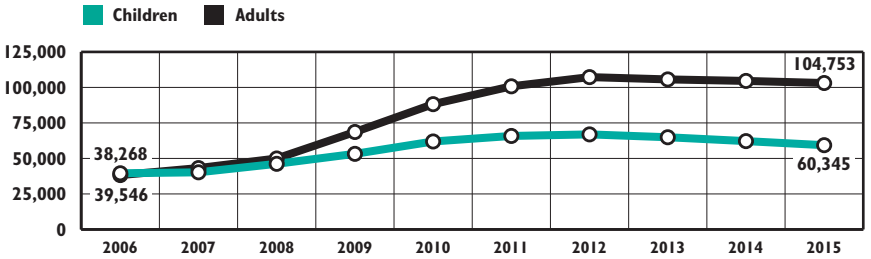
Hunger and lack of regular access to sufficient food are linked to serious physical, psychological, emotional, and academic problems in children and can interfere with their growth and development.[1,2] The Supplemental Nutrition Assistance Program (SNAP), formerly the Food Stamp Program, helps low-income 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]

Nationally, SNAP is available to households with gross incomes below 130% of the federal poverty level, net incomes below 100% of the federal poverty level, and no more than $2,250 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 ($37,167 per year for a family of three in 2015).[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, 2015, almost three-fourths (74%) of Rhode Island families receiving SNAP benefits had incomes below 100% of the federal poverty level ($20,090 for a family of three in 2015).[12,13] In 2015, the average monthly SNAP benefit for a family of three in Rhode Island was $361.[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, 2006-2015



Source: Rhode Island Department of Human Services, InRhodes Database, 2006–2015. Data represent children under age 18 and adults who participated in SNAP during the month of October.

◆ **Of the 165,098 Rhode Islanders enrolled in SNAP in October 2015, 63% were adults and 37% were children. More than one-third (34%) 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 2012 and 2014, 12.7% of Rhode Island households and 14.3% of U.S. households were food insecure. In 2014, 19.2% of all U.S. households with children were food insecure, while 44.8% 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 2015, food pantries and soup kitchens provided emergency food assistance to an average of 60,000 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, 2010 and October 1, 2015, the number of Rhode Island children receiving SNAP benefits decreased by 1%, from 59,652 to 59,325. SNAP participation rates among children decreased by 2% in the four core cities and increased by 1% 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., improving phone systems and simplifying and clarifying 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, 2010, 2014, and 2015**

CITY/TOWN	NUMBER PARTICIPATING IN 2010	NUMBER PARTICIPATING IN 2014	NUMBER PARTICIPATING IN 2015	% CHANGE IN NUMBER PARTICIPATING FROM 2010 TO 2015
Barrington	113	102	116	3%
Bristol	456	444	408	-11%
Burrillville	458	530	473	3%
Central Falls	3,270	3,368	3,349	2%
Charlestown	206	205	161	-22%
Coventry	1,006	1,048	967	-4%
Cranston	3,418	3,485	3,428	<1%
Cumberland	788	776	809	3%
East Greenwich	185	169	189	2%
East Providence	1,971	2,067	1,959	-1%
Exeter	106	88	91	-14%
Foster	79	104	99	25%
Glocester	159	122	117	-26%
Hopkinton	235	222	208	-11%
Jamestown	35	36	39	11%
Johnston	1,008	1,054	985	-2%
Lincoln	585	671	647	11%
Little Compton	42	48	43	2%
Middletown	436	418	472	8%
Narragansett	278	235	212	-24%
New Shoreham	7	10	5	-29%
Newport	1,386	1,277	1,341	-3%
North Kingstown	798	828	791	-1%
North Providence	1,169	1,315	1,273	9%
North Smithfield	187	303	290	55%
Pawtucket	6,396	7,250	7,091	11%
Portsmouth	277	253	263	-5%
Providence	22,933	22,226	21,681	-5%
Richmond	138	134	137	-1%
Scituate	162	155	155	-4%
Smithfield	229	252	235	3%
South Kingstown	498	572	497	<1%
Tiverton	373	350	381	2%
Warren	430	431	384	-11%
Warwick	2,367	2,642	2,540	7%
West Greenwich	74	77	62	-16%
West Warwick	1,699	1,787	1,699	0%
Westerly	848	934	919	8%
Woonsocket	4,847	4,913	4,746	-2%
Unknown	*NA*	*81*	*63*	*NA*
Four Core Cities	*37,446*	*37,757*	*36,867*	*-2%*
Remainder of State	*22,206*	*23,144*	*22,395*	*1%*
Rhode Island	*59,652*	*60,982*	*59,325*	*-1%*

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, 2010, 2014, and 2015.

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 2010 is presented as a baseline and data for 2014 and 2015 are presented for comparison. Due to this change in methodology, *Children Receiving SNAP Benefits* cannot be compared with Factbooks prior to 2014.

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. (2016). *Supplemental Nutrition Assistance Program (SNAP).* Retrieved February 2, 2016, from www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap

(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

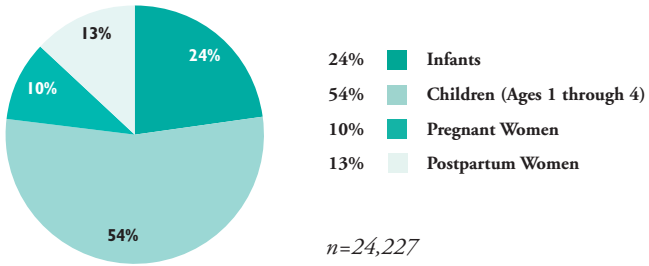
The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a federally-funded preventive program that provides participants with nutritious food, nutrition education, and access to health care and social services. WIC serves pregnant, postpartum, and breastfeeding women, infants, 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] Seventy-four percent of mothers participating in WIC in Rhode Island in Federal Fiscal Year 2015 initiated breastfeeding, 17% of infants were breastfed at three months of age, and 14% were breastfed at six months of age.[10]

Women, Infants, and Children Enrolled in WIC, Rhode Island, September 2015



Source: Rhode Island Department of Health, WIC Program, September 2015. Totals may not sum to 100% due to rounding.

◆ **Infants and children ages one through four comprised more than three-quarters (77%) of the population being served by WIC in September 2015 in Rhode Island. Women accounted for over one-fifth (10% pregnant and 13% postpartum) of the population being served.[11]**

◆ **In September 2015, 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-five percent of WIC participants identified as Hispanic or Latino. Hispanics are included in the racial groups above.[12]**

◆ **The four core cities - Central Falls (71%), Pawtucket (60%), Providence (65%), and Woonsocket (67%) - had WIC participation rates exceeding the statewide enrollment rate of 59% in 2015.[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 $23.4 million in federal funding for WIC during FFY 2015.[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, 32 farmers' markets provided fresh produce to 13,879 WIC participants during the FMNP in FFY 2015.[18]**

Table 13. **Women, Infants and Children Enrolled in WIC, Rhode Island, September 2015**

CITY/TOWN	ESTIMATED NUMBER ELIGIBLE	NUMBER PARTICIPATING	% OF ELIGIBLE PARTICIPATING
Barrington	105	38	36%
Bristol	406	232	57%
Burrillville	404	236	58%
Central Falls	1,986	1,408	71%
Charlestown	132	57	43%
Coventry	747	390	52%
Cranston	2,535	1,448	57%
Cumberland	585	276	47%
East Greenwich	158	64	41%
East Providence	1,482	788	53%
Exeter	115	62	54%
Foster	110	44	40%
Glocester	158	54	34%
Hopkinton	214	86	40%
Jamestown	29	17	59%
Johnston	827	468	57%
Lincoln	477	242	51%
Little Compton	52	12	23%
Middletown	383	236	62%
Narragansett	161	74	46%
New Shoreham	37	2	5%
Newport	882	619	70%
North Kingstown	579	246	42%
North Providence	1,029	542	53%
North Smithfield	221	97	44%
Pawtucket	4,563	2,736	60%
Portsmouth	262	261	100%
Providence	13,327	8,720	65%
Richmond	85	76	89%
Scituate	198	51	26%
Smithfield	287	115	40%
South Kingstown	539	218	40%
Tiverton	304	144	47%
Warren	294	143	49%
Warwick	1,977	941	48%
West Greenwich	81	35	43%
West Warwick	1,365	674	49%
Westerly	716	390	54%
Woonsocket	2,955	1,985	67%
Four Core Cities	*22,831*	*14,849*	*65%*
Remainder of State	*17,936*	*9,378*	*52%*
Rhode Island	*40,767*	*24,227*	*59%*

Source of Data for Table/Methodology

Rhode Island Department of Health, WIC Program, September 30, 2015.

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).

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

References

[1,14] *Child nutrition fact sheet: Women, Infants, and Children (WIC).* (n.d.). Washington, DC: Food Research & Action Center.

[2,15] *WIC: The special supplemental nutrition program for women, infants and children (nutrition program facts).* (2014). Retrieved February 15, 2016, 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.

[5] U.S. Department of Health and Human Services, Office on Women's Health. (2010). *Pregnancy: Staying healthy and safe.* Retrieved February 15, 2016, from www.womenshealth.gov

[6,9] U.S. Department of Agriculture, Food and Nutrition Service. (2013). *How WIC helps.* Retrieved February 15, 2016, 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

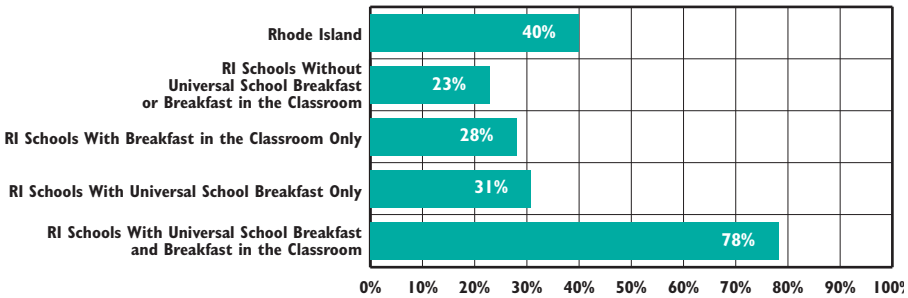
The School Breakfast Program helps ensure that the nation's most vulnerable children start their day off with a healthy meal. During the 2014-2015 school year, 11.7 million low-income children in the U.S. participating in the School Breakfast Program ate breakfast at school each day, continuing a pattern 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 2014-2015 school year in Rhode Island, 51 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 30th in the U.S. for participation in the School Breakfast Program, down from 28th 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 2015



Source: Rhode Island Department of Education, Office of School Food Services, Office of Statewide Efficiencies, October 2015.

◆ **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 2015-2016 school year, all schools in Central Falls, Cranston, Pawtucket, Providence, and Woonsocket, selected schools in three other districts, nine charter schools, and the Urban Collaborative Accelerated Program offered universal school breakfast.[12]**

◆ **Making breakfast part of the school day is another proven strategy for increasing breakfast participation, reducing stigma, and increasing convenience.[13,14] During the 2015-2016 school year, several districts offered breakfast in the classroom, "grab and go" breakfasts, bagged breakfasts, or breakfast on a cart in all or some of their schools.[15]**

◆ **The federal Community Eligibility Provision (CEP) allows schools and districts with high poverty rates to provide free breakfast and lunch to all students who have been identified as low-income by another program (e.g., SNAP) or are at risk of hunger (e.g., they are homeless). During the 2015-2016 school year, nine of the 98 eligible schools in Rhode Island were using CEP.[16]**

◆ **During the summer, many low-income children lose access to the free and reduced-price meals they rely on during the school year. In Rhode Island, 17% of the children who participated in the School Lunch Program during the 2013-2014 school year participated in the 2014 Summer Nutrition Programs. During July 2014, 164,867 lunches were served through Summer Nutrition Programs, a 22% increase over the previous year.[17]**

Children Participating in School Breakfast

Table 14.

Children Participating in School Breakfast, Rhode Island, October 2015

SCHOOL DISTRICT	OCTOBER 2015 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	3,328	29	1%	196	*	4%
Bristol Warren	3,328	162	5%	1,100	144	13%
Burrillville	2,383	200	8%	724	151	21%
Central Falls**	2,657	1,382	52%	2,144	1,217	57%
Chariho	3,237	228	7%	661	148	22%
Coventry	4,750	391	8%	1,558	331	21%
Cranston**	10,441	2,655	25%	4,673	1,510	32%
Cumberland	4,552	528	12%	1,105	382	35%
East Greenwich	2,455	63	3%	144	36	25%
East Providence	5,282	1,177	22%	2,861	874	31%
Exeter-West Greenwich	1,638	68	4%	212	39	18%
Foster	277	12	4%	61	*	10%
Foster-Glocester	1,155	47	4%	203	35	17%
Glocester	545	60	11%	73	47	64%
Jamestown	496	22	4%	47	12	26%
Johnston	3,217	358	11%	1,543	301	20%
Lincoln	3,012	187	6%	794	153	19%
Little Compton	243	*	1%	33	*	3%
Middletown	2,287	144	6%	642	117	18%
Narragansett	1,321	77	6%	247	57	23%
New Shoreham	113	12	11%	18	*	33%
Newport	2,173	424	20%	1,389	388	28%
North Kingstown	4,017	253	6%	899	193	21%
North Providence	3,562	488	14%	1,431	359	25%
North Smithfield	1,729	115	7%	314	77	25%
Pawtucket**	9,022	2,102	23%	6,855	1,794	26%
Portsmouth	2,480	124	5%	354	80	23%
Providence**	23,867	12,994	54%	18,848	11,811	63%
Scituate	1,366	41	3%	258	26	10%
Smithfield	2,390	105	4%	339	57	17%
South Kingstown	3,249	181	6%	715	154	22%
Tiverton	1,843	118	6%	571	89	16%
Warwick	9,140	691	8%	3,032	541	18%
West Warwick	3,485	564	16%	1,705	474	28%
Westerly	2,908	376	13%	1,018	335	33%
Woonsocket**	5,908	2,762	47%	4,231	2,035	48%
Charter Schools	*6,270*	*2,731*	*44%*	*4,554*	*2,232*	*49%*
State-Operated Schools	*1,747*	*341*	*20%*	*1,097*	*320*	*29%*
UCAP	*141*	*130*	*92%*	*114*	*95*	*83%*
Four Core Cities	*41,454*	*19,240*	*46%*	*32,078*	*16,857*	*53%*
Remainder of State	*92,402*	*9,903*	*11%*	*28,920*	*7,131*	*25%*
Rhode Island	*142,014*	*32,345*	*23%*	*66,763*	*26,635*	*40%*

Source of Data for Table/Methodology

Rhode Island Department of Education, October 2015.

*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, Hope Academy, International Charter School, Kingston Hill Academy, The Learning Community, RI Nurses Institute Middle College Charter School, RISE Prep Mayoral Academy, 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 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 2015 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 2015. "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 2015.

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

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 medical and dental care, be screened for the achievement of developmental milestones, obtain needed timely treatment, have access to prescription medications, and miss fewer days of school.[1,2] 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, which have been shown to increase access to primary and preventive care for children and improve long-term health, academic and economic outcomes.[5,6] 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, 2015, 71% of RIte Care members who qualified based on family income were children under age 19. There were also 49,844 low-income parents with RIte Care coverage on December 31, 2015.[7,8] RIte Care enrollment rose to a new high of 141,901 in December 2015 (up from 130,639 in December 2014).[9,10]

In 2014, an estimated 3.3% of children in Rhode Island were uninsured, with older children, Asian, Black, Native American, and Hispanic children, and those living in urban communities being most likely to be uninsured.[11,12,13,14]

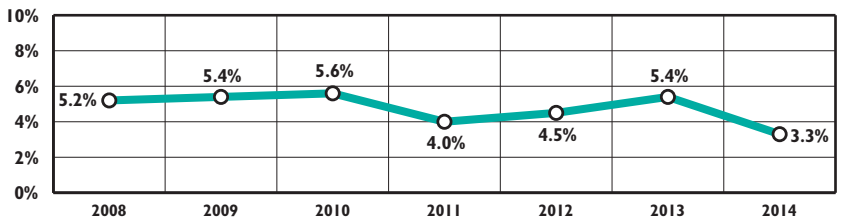
Children Without Health Insurance

	2008	2014
RI	5.2%	3.3%
US	9.3%	6.0%
National Rank*		*7th*
New England Rank**		*3rd*

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

Source: For 2014: U.S. Census Bureau, American Community Survey, 2014. Table R2702. For 2008: U.S Census Bureau, American Community Survey, 2012. Table CP03.

Children Without Health Insurance, Rhode Island, 2008-2014



Source: U.S. Census Bureau, American Community Survey, 2012 & 2014. Table CP03. Data are for children under 18 years of age and are not comparable to Factbooks prior to 2015.

◆ **In 2014, 3.3% of Rhode Island's children under age 18 were uninsured. Rhode Island ranks seventh best in the U.S., with 96.7% of children having health insurance. Just over half (57%) of Rhode Island children are covered by private health insurance, most of which is obtained through their parents' employers.[15,16]**

◆ **Approximately 72% (6,925) of the estimated 9,590 uninsured children under age 18 in Rhode Island between 2010 and 2014 were eligible for RIte Care coverage based on their family incomes, but were not enrolled. An estimated 2,665 uninsured children lived in families with incomes above 261% of the federal poverty level (the income limit for RIte Care eligibility) and 61% (1,625) of them may have been 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, 2015, 5,915 children and 2,249 parents (8,164 total) were enrolled in RIte Share.[19]**

◆ **Between 2013 and 2014, the percentage of children covered exclusively by their parents' employer-sponsored health plan increased from 50% to 51% and the percentage of children insured exclusively by Medicaid/RIte Care increased from 31% to 33%.[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*. As of October 2015, 1,651 children were enrolled in commercial coverage in the individual market of HealthSource RI, which is a 29% increase from 2014 (1,282).[21]**

Table 15. **Children Under Age 19 Receiving Medical Assistance, Rhode Island, December 31, 2015**

CITY/TOWN	RITE CARE	SSI	KATIE BECKETT PROVISION	ADOPTION SUBSIDY	FOSTER CARE	TOTAL
Barrington	443	13	41	20	8	525
Bristol	1,011	29	15	47	21	1,123
Burrillville	996	55	21	81	41	1,194
Central Falls	4,734	269	4	31	42	5,080
Charlestown	412	13	9	14	6	454
Coventry	1,911	77	48	113	68	2,217
Cranston	6,614	236	82	190	125	7,247
Cumberland	1,664	78	52	61	33	1,888
East Greenwich	446	27	35	30	16	554
East Providence	3,652	178	43	106	88	4,067
Exeter	253	9	6	18	7	293
Foster	276	14	7	15	13	325
Glocester	351	19	7	45	38	460
Hopkinton	550	9	8	31	11	609
Jamestown	106	4	7	3	11	131
Johnston	2,175	87	38	61	48	2,409
Lincoln	1,328	52	30	50	27	1,487
Little Compton	136	2	5	1	1	145
Middletown	971	38	21	31	31	1,092
Narragansett	428	27	11	24	37	527
New Shoreham	58	0	3	0	0	61
Newport	2,036	116	6	38	50	2,246
North Kingstown	1,532	55	35	41	52	1,715
North Providence	2,434	104	27	68	56	2,689
North Smithfield	469	24	16	39	17	565
Pawtucket	10,999	558	37	137	149	11,880
Portsmouth	629	22	19	23	49	742
Providence	32,289	1,860	58	373	490	35,070
Richmond	223	9	4	5	4	245
Scituate	534	19	20	32	10	615
Smithfield	704	19	26	48	43	840
South Kingstown	1,236	53	41	60	33	1,423
Tiverton	813	40	12	27	16	908
Warren	768	30	10	32	28	868
Warwick	4,792	184	109	211	125	5,421
West Greenwich	211	2	9	16	8	246
West Warwick	2,891	140	17	82	58	3,188
Westerly	1,855	82	25	37	27	2,026
Woonsocket	6,645	547	26	128	123	7,469
Unknown Residence	*318*	*60*	*0*	*43*	*79*	*500*
Four Core Cities	*54,667*	*3,234*	*125*	*669*	*804*	*59,499*
Remainder of State	*44,908*	*1,866*	*865*	*1,700*	*1,206*	*50,545*
Rhode Island	*99,893*	*5,160*	*990*	*2,412*	*2,089*	*110,544*

Source of Data for Table/Methodology

Rhode Island Executive Office of Health and Human Services, MMIS Database, December 31, 2015.

The table includes children enrolled in RIte Care managed care, fee-for-service, and RIte Share as of December 31, 2015. Children with special health care needs who are covered through RIte Care or Medical Assistance are also included because they receive SSI, adoption subsidies, or qualify for the Katie Beckett provision.

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 unavailable.

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.

[2] Majerol, M., Newkirk, V., & Garfield, R. (2015). *The uninsured: A primer. Key facts about health insurance and the uninsured in the era of health reform.* Washington, DC: The Henry J. Kaiser Family Foundation, Kaiser Commission on the Uninsured.

(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 2014, 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

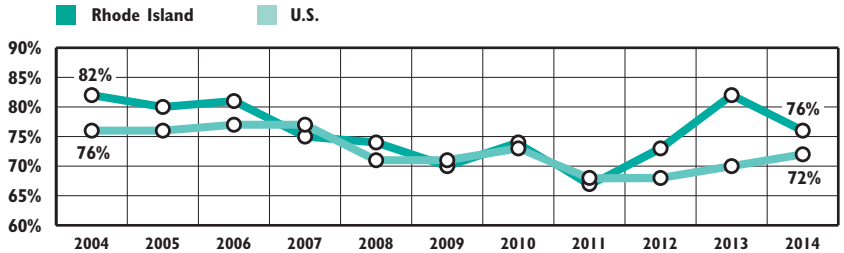
Timely and complete immunization protects children against a number of infectious diseases that were once common and resulted in death or disability. Vaccines interact with the immune system to produce antibodies that protect the body if it is later exposed to disease. The benefits of immunization include 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 and individuals 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. In order to ensure that vaccines reach all children, 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]

Rhode Island requires vaccination against the following diseases prior to entry into child care, preschool, Head Start, or Kindergarten: diphtheria, tetanus, and pertussis; Haemophilus influenza type b; hepatitis A; hepatitis B; influenza; measles, mumps, and rubella; pneumococcal; polio; rotavirus; and varicella (chickenpox). Kindergarten entry requires all of these except hepatitis A, Haemophilus influenzae type B, influenza, pneumococcal conjugate, and rotavirous.[7,8]

Fully Immunized Children*, Ages 19 Months to 35 Months, Rhode Island and United States, 2004-2014



*Fully immunized children received the 4:3:1:3:3:1 series from 2004 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 in 2011-2014.

Source: Centers for Disease Control and Prevention, *National Immunization Survey*, 2004-2014.

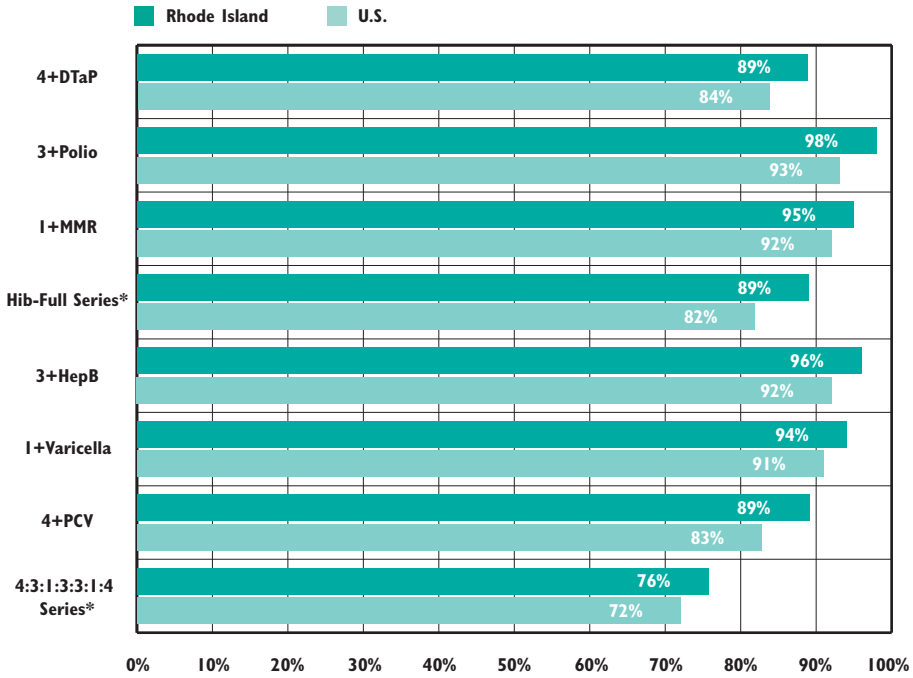
◆ **In 2014, Rhode Island's rate of children ages 19 months to 35 months that were fully immunized (76%) was above the national average of 72% and 11th best in U.S.[9]**

◆ **In 2014, the U.S. rate for fully immunized children ages 19 months to 35 months ranged from 66% for children living below the federal poverty level to 75% for children living at or above the federal poverty level. The 2014 U.S. rate was 74% for Hispanic children, 73% for White, non-Hispanic children, 70% for Asian, non-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.[11,12] 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.[13] In Rhode Island, children may be exempt from receiving one or more vaccines for medical or religious reasons.[14] In the 2014-2015 school year, 1% (127) of kindergarten students and 0.8% (95) of 7th grade students received exemptions from vaccination requirements. Of the 222 exemptions, 73% were for religious reasons and 28% were for medical reasons.[15]**

◆ **Since 2015, Rhode Island child care workers are 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.[16]**

Vaccination Coverage Among Children, Ages 19 Months to 35 Months, Rhode Island and United States, 2014



Source: Rhode Island Department of Health analysis of data from the *National Immunization Survey-Children*, 2014.
*Depending on the product type received, 3+ or 4+ doses of Hib vaccine is a full dose.

◆ In 2014, Rhode Island ranked first in the U.S. for the rotavirus vaccines; third for the 3+Polio vaccine; fourth for the 3+HepB, 4+PCV and 4+DTaP vaccines; eighth for 1+VAR vaccine; and ninth for the 1+MMR vaccine.

◆ In 2014, Rhode Island's rate of completion for the 4:3:1:3:3:1:4 series (76%) did not reach the national *Healthy People 2020* target (80%), but a number of individual vaccine coverage rates in Rhode Island did. Polio, MMR, HepB, varicella, and rotavirus had coverage rates that surpassed the *Healthy People 2020* targets (90%) set for each type of vaccine for children ages 19 months to 35 months.[17,18]

References

[1] Centers for Disease Control and Prevention. (2014). *Why are childhood vaccines so important?* Retrieved January 14, 2016, from www.cdc.gov

[2] *Immunization.* (2015). Washington, DC: Child Trends.

(continued on page 174)

Immunizations for Elementary and Middle School Students

◆ The 2014-2015 *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 98.9% of kindergarten students and 99.7% of 7th grade students were reported. Of the immunizations needed for school entry, entering kindergarteners had coverage rates between 95% and 98%, while entering 7th grade students had rates between 79% and 99%.[19]

Adolescent Immunization

◆ All Rhode Island adolescent students are required to receive the human papillomavirus (HPV), tetanus, diphtheria, pertussis (Tdap), and meningococcal conjugate (MCV) vaccines for entry into school as well as any needed catch-up doses.[20]

◆ According to the 2014 *National Immunization Survey-Teen*, Rhode Island adolescents ranked first in the U.S. for the 3+HPV vaccine for males, 2+MMR vaccine, and the 2+VAR vaccine, third for the 3+HPV vaccine for females, fourth for the 1+MCV vaccine, seventh for the 3+HepB vaccine, and eighth for the 1+Tdap vaccine. In 2014, 98% of Rhode Island adolescents had received the 2+MMR vaccine, 96% had received the 2+VAR vaccine, 95% had received the 3+HepB vaccine, 94% had received the 1+MCV vaccine, 92% had received the 1+Tdap vaccine, and 54% of females and 43% of males had received the 3+HPV vaccine.[21]

◆ 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.[22,23]

◆ During the 2014-2015 school year, 94 schools participated in VBYG. In total, 10,766 vaccine doses were administered to 8,875 students. The three most administered vaccines were influenza (7,667 doses), HPV (871 doses), and MCV4 (685 doses). Other vaccines administered included hepatitis A (HepA), hepatitis B (HepB), measles, mumps, and rubuella (MMR), polio (IPV), tetanus, diphtheria (TD), tetanus, diphtheria, pertussis (Tdap), and varicella (chicken pox).[24]

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 significant negative impacts on children's overall health, growth and development, school attendance, and academic achievement.[1,2]

Insurance is a strong predictor of access to health and dental care. Nearly one in five (17%) uninsured children in the U.S. have unmet dental needs, compared with 5% of those with Medicaid and 3% of those with private health insurance.[3] In 2014, 94% of children in Rhode Island had dental insurance that paid for routine dental care, up from 73% in 2001 and 62% in 1990.[4,5]

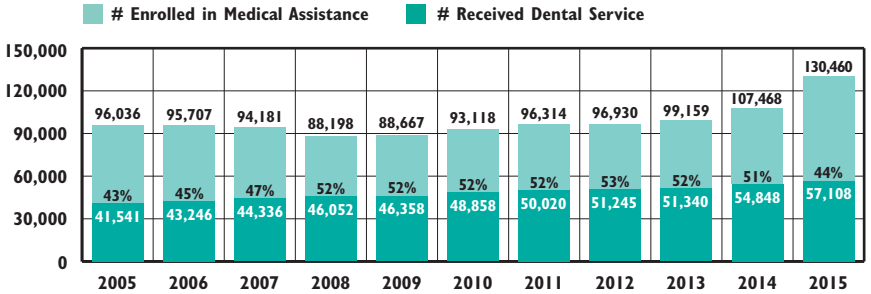
Children living in poverty are more likely to have untreated tooth decay than higher-income children. Medicaid-eligible children are more than three times as likely to have untreated tooth decay as higher-income children. For children in low-income families, the efficacy and continuity of public dental 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 about 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 dental 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 2005-2015



Source: Rhode Island Executive Office of Health and Human Services, State Fiscal Years (SFY) 2005-2015. *Medical Assistance includes RIte Care, RIte Share, and Medicaid fee-for-service and include children under age 21.

◆ **Forty-four percent (57,108) of the children and youth under age 21 who were enrolled in RIte Care, RIte Share, or Medicaid fee-for-service on June 30, 2015 received a dental service during State Fiscal Year (SFY) 2015. This is down from SFY 2014, but the number of children receiving dental services has increased by 37% since 2005.[17] Rhode Island ranked 32nd in the U.S. for children enrolled in Medicaid with a dental visit in 2014.[18]**

◆ **The federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate requires that states provide comprehensive dental benefits to children with Medicaid coverage.[19] States have been asked to increase preventive dental services by 10% between Federal Fiscal Year (FFY) 2010 and 2015. With a baseline of 43% and a goal of 53%, 44% of children with Medicaid in Rhode Island received a preventive dental visit in FFY 2014.[20,21]**

◆ **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, 2015, there were 88,504 children under age 15 enrolled in RIte Smiles. During SFY 2015, 76% of all Medicaid dental claims for children were for RIte Smiles members.[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 October 2015, 1,651 children under age 19 were enrolled in commercial health coverage in the individual market of HealthSource RI (Rhode Island's state-based insurance marketplace). One-third (36%) obtained commercial dental coverage through HealthSource RI; 64% did not.[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 2015, there were 359 unduplicated dentists in 195 practice 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 the RIte Smiles program 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 Disease

◆ Between 2010 and 2014, an average of 696 children under age 21 were treated for a primary dental-related condition in Rhode Island emergency departments annually. Of these children and youth, 20% were ages five and under, 16% were ages six to 11, 16% were ages 12 to 17, and 48% were age 18-21.[36]

◆ Each year between 2010 and 2014 in Rhode Island, an average of 69 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 Very 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] In Rhode Island, children under age six (63%) are less likely to have received a dental visit in the past 12 months than children over age six (97% of 6-11 year olds and 93% of 12-17 year olds).[40]

◆ 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.[41]

◆ As of FFY 2014, 41% of Rhode Island children under age five with Medicaid coverage received any dental service, and 37% received a preventive dental service.[42]

◆ In 2015, the Rhode Island General Assembly passed legislation to increase access to oral health care for children by allowing dental hygienists to perform approved services in public health settings.[43]

◆ Primary care providers can conduct oral health risk assessment, refer for dental care, and provide preventive services, all of which improve oral health outcomes and lead to a dental home.[44]

◆ In addition to covering dental visits for children before the age of one, Rhode Island is one of 49 state Medicaid programs that reimburse primary care medical providers for preventive oral health services for very young children, including risk assessment, anticipatory guidance, and fluoride varnish application.[45,46]

References

[1,6,9,15,29,38,41] *The state of little teeth.* (2014). Chicago, IL: American Academy of Pediatric Dentistry.

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

[3,10] National Health Interview Survey. (2014). *Table C-11a: Age-adjusted percent distributions (with standard errors) of unmet dental need due to cost in the past 12 months and of length of time since last visit with a dentist or other dental health care professional for children aged 2-17 years, by selected characteristics: United State, 2014.* Retrieved January 27, 2016, from www.cdc.gov/nchs/nhis/shs.htm

(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

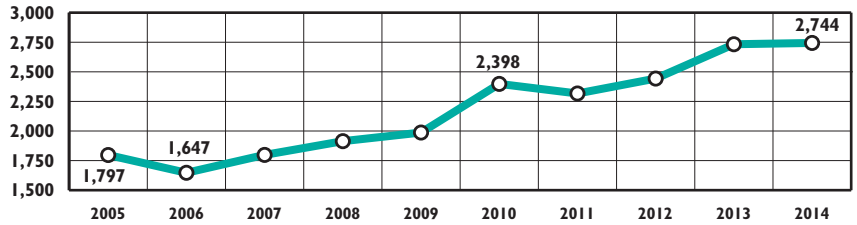
Mental health in childhood and adolescence is defined as the achievement of expected developmental, cognitive, social, and emotional milestones and the ability to use effective coping skills. Mental health status influences children's health and behavior at home, in child care or school, and in the community. 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] An estimated 34% of Rhode Island children who needed mental health treatment or counseling in the past 12 months 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 treatment system of care that is based in multiple settings including the home, schools, and community, but more progress is still needed.[17,18,19]

Hospitalizations with Primary Diagnosis of Mental Disorder, Children Under Age 18, Rhode Island, 2005-2014*



Source: RI Hospital Discharge Database (HDD), RI Department of Health, 2005-2014. *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, and anxiety, 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 2014, there were 2,744 hospitalizations of children with a primary diagnosis of mental disorder at Bradley, Butler, Hasbro Children's Hospital, Newport, and Memorial Hospitals, a 53% increase from 2005. Of the Rhode Island children hospitalized in 2014, 74% were ages 13 to 17, 50% had Medicaid/RIte Care coverage and 47% had commercial coverage, and 39% lived in one of the four core cities (where 33% of the child population lives).[20,21]**

◆ **When a young person needs inpatient behavioral health treatment, but there is no appropriate placement available, they may be "boarded" on medical floors at acute care hospitals or in emergency departments.[22] In Federal Fiscal Year (FFY) 2015, 251 children and youth under age 18 with a psychiatric diagnosis were boarded for an average of less than one day on medical floors at Hasbro Children's Hospital or Rhode Island Hospital, which is a decrease from FFY 2014 when 328 children were boarded for an average of two days. The expanded Medical/Psychiatric Program at Hasbro Children's Hospital provides both inpatient and partial hospitalization care to children with complex mental and medical health conditions who seek treatment through the emergency department or a medical provider.[23,24]**

◆ **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 due to insufficient capacity or type or there is no other safe placement (including at home), they are referred to as "stuck." Bradley Hospital reported having an average of eight "stuck kids" per day in FFY 2015, up from four "stuck kids" in FFY 2014.[25]**

Psychiatric Hospitals

Children Under Age 19 Treated at Rhode Island Psychiatric Hospitals, October 1, 2014 – September 30, 2015 (FFY 2015)

	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	941	15 days	143	38 days	489*	9 days
Residential	43	217 days	30	198 days	– –	– –
Partial Hospitalization	824	18 days	18	18 days	102	5 visits
Home-Based	0	0	24	23 visits	– –	– –
Outpatient	1,644	61 visits	86	61 visits	52	NA

Source: Lifespan, 2014-2015 and Butler Hospital, 2014-2015. 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 2015). The average length of stay is based on discharges. *An additional 51 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. 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 2015 in an inpatient setting were depressive disorders (48%), bipolar disorders (24%), anxiety disorders (14%), and adjustment disorders (4%).[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 and nine community-based classrooms/public school partnerships for children with behavioral health problems and developmental disabilities, which together had an average daily enrollment of 377 students in FFY 2015.[28]

Children with Medicaid and RIte Care with a Mental Health Diagnosis

◆ In State Fiscal Year (SFY) 2015, 22% (26,930) children under age 19 enrolled in Medicaid/RIte Care had a mental health diagnosis, including but not limited to anxiety, alcohol/drug dependence, psychoses as well as depressive, mood, and personality disorders. Of those children with a mental health diagnosis, 29% were ages 6 and under, 34% were ages seven to 12, and 37% were ages 13 to 18.

◆ In SFY 2015, 595 children under age 19 enrolled in Medicaid/RIte Care were hospitalized due a mental health related condition and 1,269 children had a mental health related emergency department visit. Ninety-one percent of those mental health related emergency department visits for children under age 19 in SFY 2015 did not result in a hospitalization.[29]

Suicide Among Rhode Island Children and Youth

◆ Children and youth with mental health conditions are at increased risk for suicide.[30] In 2015, 11% of Rhode Island high school students reported attempting suicide one or more times during the past year, down from 14% in 2013.[31] In Rhode Island between 2010 and 2014, there were 873 emergency department visits and 442 hospitalizations of youth ages 13-19 due to suicide attempts.[32] Twenty-four children and youth under age 20 died due to suicide in Rhode Island between 2010 and 2014.[33]

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 2015, 5,837 children under age 18 were treated at CMHOs, and 3,660 children were receiving treatment as of December 31, 2015.[34]

References

[1] Centers for Disease Control and Prevention. (2013). Mental health surveillance among children: United States, 2005-2011. *Morbidity and Mortality Weekly Report, 62*(Supp.2):1-35.

[2,10,30] Murphey, D., Barry, M., & Vaughn, B. (2013). *Adolescent health highlight: Mental health disorders.* (Publication No. 2013-1). Washington DC: Child Trends.

(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]

Rhode Island high school students with disabilities report experiencing physical fights, being electronically bullied and being bullied at school, and acute depression more frequently than their non-disabled peers. They also had 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 using marijuana.[7,8]

CSHCN may require medical services, equipment, assistive technology, or home modifications that may result in serious financial burdens on families.[9,10] Having children with special needs significantly impacts parents' finances, employment, and family lives.[11,12] In 2015, the Rhode Island General Assembly established Achieving a Better Life Experience (ABLE) tax-free saving accounts for people who become disabled before age 26, which cover a range of expenses, including health care, education, housing, transportation, and employment training.[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 2015, 11 certified Early Intervention (EI) provider agencies served 4,359 children. As of June 30, 2015, there were 2,195 children enrolled in EI (6% of all children under age three). Nearly two-thirds (62%) of those children receiving EI services were male and just over one-third (38%) were female. EI enrollment was not evenly distributed among children by age, with 19% less than one year old, 31% between ages one and two, and 50% 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, 2015 in Rhode Island, there were 2,927 children ages three to five who received preschool special education services.[19]**

◆ **In Rhode Island as of June 30, 2015, 20,800 students in public schools ages six to 21 received special education services (15% of all students). 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 services at age three. In 2015, 64% of the 1,041 children who reached age three while in EI were determined to be eligible for preschool special education, 21% were found not eligible, and 10% were still in the eligibility determination process 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, 2015, there were 5,160 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, 2015, there were 990 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, 2015, 2,089 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 59% of all eligible former foster youth were enrolled in Medicaid coverage as of December 31, 2015, up from 51% in 2014.[34]

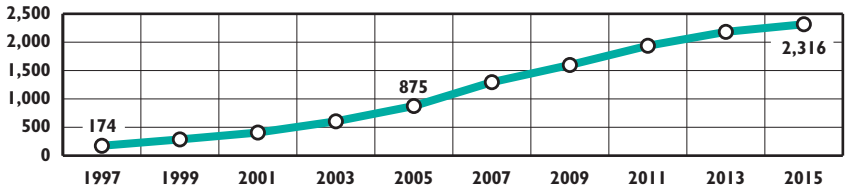
◆ Children who are adopted through the Rhode Island Department of Children, Youth and Families and have special needs may qualify for Medical Assistance coverage. As of December 31, 2015, 2,412 children were enrolled in Medical Assistance because of special needs adoptions.[35]

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]

◆ The national ASD prevalence among children age eight is estimated to be one out of every 68 children (one out of 42 boys and one out of 189 girls).[38]

Children Ages Three to 21 With Autism Spectrum Disorder (ASD), Rhode Island, December 1997-June 2015



Source: Rhode Island Department of Education, Office of Student, Community and Academic Supports, December 1997-June 2015. All data prior to 2000 is a December point in time run, and all data starting in 2000 and beyond is a June point in time run. Numbers include parentally placed students.

◆ In June 2015, there were 2,316 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 by skilled professionals can result in improvements in the levels of independent functioning of children and youth with ASD and long-term life outcomes.[43,44]

References

[1] Data Resource Center for Child and Adolescent Health. (n.d.). *2011/12 National Survey of Children's Health-Children with special health care needs (CSHCN).* Retrieved February 11, 2015, from www.childhealthdata.org

[2,4] Data Resource Center for Child and Adolescent Health. (2012). *Who are children with special health care needs?* Retrieved February 13, 2015, from www.childhealthdata.org

(continued on page 175)

Infants Born at Highest Risk

DEFINITION

Infants born at highest risk is the percentage of babies born in Rhode Island 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 from which 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 adverse childhood experiences and risk factors 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 2015 in Rhode Island, 240 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]

Births by Key Risk Factors, Four Core Cities and Rhode Island, 2015

CITY/TOWN	BIRTHS	% TO MOTHERS WITHOUT A HSD/GED	% TO SINGLE MOTHERS	% TO MOTHERS YOUNGER THAN 20	% TO MOTHERS WITH ALL 3 RISK FACTORS
Central Falls	300	35%	70%	12%	7%
Pawtucket	916	16%	60%	6%	3%
Providence	2,471	21%	59%	8%	4%
Woonsocket	500	17%	64%	8%	4%
Rhode Island	*10,418*	*11%*	*45%*	*5%*	*2%*

Source: Rhode Island Department of Health, KIDSNET Database, 2015.

◆ **The U.S. birth rate had been declining since 2007 and reached an historic low in 2013, but rose slightly in 2014. Rhode Island had the fifth lowest birth rate in the U.S. in 2014, with 10.3 births per 1,000 women ages 15 to 44.[11]**

◆ **The total number of babies born in Rhode Island to Rhode Island women declined 13% between 2007 and 2015, from 12,010 to 10,418 births.[12]**

◆ **Between 2007 and 2015 in Rhode Island, the number of infants born at highest risk (babies born to unmarried teen mothers without a high school diploma) fell 63%. The proportion of births to single mothers declined from 47% to 45% of births, while the proportion of births to mothers without a high school diploma fell from 18% to 11%, and the proportion of births to teen mothers fell from 10% to 5% of all births.[13]**

◆ **All babies born in Rhode Island are screened through the Rhode Island Department of Health's Newborn Risk Assessment Program. In 2015, there were 6,546 babies born (63% of all babies born) who "screened positive," indicating the presence of one or more risk factors associated with poor developmental outcomes.[14]**

◆ **Of the 10,418 babies born to Rhode Island women in 2015, nearly one-third (3,052) had a mother with a history of treatment for mental health conditions. Also, 482 had a mother with a documented history of substance abuse problems and 227 had a mother who was involved or had been involved with the child welfare system (either as an adult or as a child).[15]**

Table 16.

Infants Born at Highest Risk, Rhode Island, 2015

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	113	4	21	1	0	0%
Bristol	132	9	49	7	4	3%
Burrillville	125	2	48	4	1	<1%
Central Falls	300	106	209	37	21	7%
Charlestown	38	1	15	3	0	0%
Coventry	305	9	111	8	2	<1%
Cranston	802	53	305	24	13	2%
Cumberland	320	11	91	3	1	<1%
East Greenwich	119	2	21	1	1	<1%
East Providence	433	41	178	13	5	1%
Exeter	51	2	17	2	1	2%
Foster	29	1	10	1	1	3%
Glocester	64	1	15	0	0	0%
Hopkinton	41	2	9	0	0	0%
Jamestown	28	0	5	0	0	0%
Johnston	272	17	128	12	6	2%
Lincoln	209	7	61	5	2	1%
Little Compton	15	0	4	0	0	0%
Middletown	165	11	54	7	5	3%
Narragansett	49	0	18	0	0	0%
New Shoreham	11	0	4	0	0	0%
Newport	224	30	91	7	5	2%
North Kingstown	226	8	62	7	1	<1%
North Providence	338	24	148	20	5	1%
North Smithfield	72	2	17	0	0	0%
Pawtucket	916	144	549	52	25	3%
Portsmouth	106	0	18	0	0	0%
Providence	2,471	527	1,455	189	98	4%
Richmond	30	2	13	4	2	7%
Scituate	84	2	22	3	1	1%
Smithfield	135	2	37	1	1	<1%
South Kingstown	154	4	61	6	1	<1%
Tiverton	64	2	21	2	0	0%
Warren	81	2	22	1	1	1%
Warwick	796	33	264	21	6	<1%
West Greenwich	40	2	11	1	0	0%
West Warwick	329	34	167	26	9	3%
Westerly	130	3	41	3	2	2%
Woonsocket	500	84	319	42	20	4%
Unknown	*101*	*0*	*31*	*0*	*0*	*NA*
Four Core Cities	*4,187*	*861*	*2,532*	*320*	*164*	*4%*
Remainder of State	*6,130*	*323*	*2,159*	*193*	*76*	*1%*
Rhode Island	*10,418*	*1,184*	*4,722*	*513*	*240*	*2%*

Source of Data for Table/Methodology

Rhode Island Department of Health, KIDSNET Database, 2015. Birth data from 2015 are provisional. Data include only births that occurred in Rhode Island to Rhode Island residents. 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

[1] U.S. Department of Health and Human Services. (2011). *Supporting brain development in traumatized children and youth.* Washington, DC: Child Welfare Information Gateway.

[2] U.S. Department of Health and Human Services. (2009). *Understanding the effects of maltreatment on brain development.* Washington, DC: Child Welfare Information Gateway.

[3,4] *Early experiences matter: A guide to improved policies for infants and toddlers.* (2009). Washington, DC: Zero to Three National Center for Infants and Toddlers.

[5] Shonkoff, J. P., Garner, A. S., & the Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; and Section on Developmental and Behavioral Pediatrics. (2011). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics, 129*(1), e232-e246.

[6] *Teen pregnancy, poverty, and income disparity.* (2010). Washington, DC: The National Campaign to Prevent Teen Pregnancy.

[7,12,13,14,15] Rhode Island Department of Health, KIDSNET Database, 2007-2015.

[8] Clothier, S. & Tweedie, J. (2012). Bringing up baby. *State Legislatures, 38*(1), 24-26.

[9] *Expanding home visiting research: New measures of success.* (n.d.). Washington, DC: The Pew Charitable Trusts.

[10] *Home Visiting Program: Rhode Island.* (2015). Washington, DC: U.S. Department of Health and Human Services, Health Resources and Services Administration.

(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 visiting programs managed by the Rhode Island Department of Health.

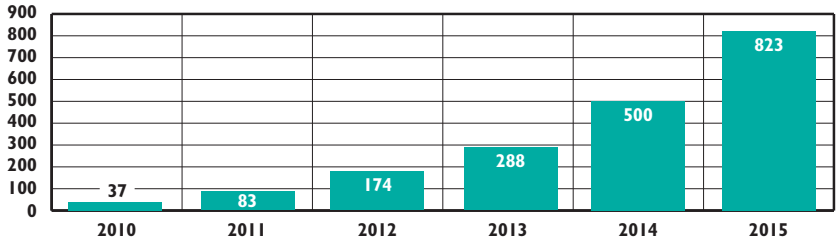
SIGNIFICANCE

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 baby, 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 2015, there are 19 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 (MIECHV-Funded), Rhode Island, 2010-2015



Source: Children's Friend and Service, Nurse-Family Partnership enrollment in October 2010 and October 2011. Rhode Island Department of Health, enrollment in MIECHV-funded evidence-based home visiting programs, October 2012-2015.

◆ **As of October 2015, of the children enrolled in MIECHV evidence-based home visiting programs 16% had mothers under age 20, 35% had mothers ages 20 to 24, and 49% had mothers age 25 or older at enrollment.[10] One-quarter (26%) of the mothers had less education than a high school diploma or GED, 21% had a high school diploma or GED, 17% had some college or vocational training, 3% had a four-year college degree, and 33% had an unknown amount of education at enrollment.[11]**

◆ **At the time of enrollment, 70% of the mothers were single (had never married), 22% were married or had a domestic partner, 3% were divorced or separated, and 5% had an unknown marital status.[12] Among the enrolled children, 13% were in utero, 47% were under age one, 33% were age one, 7% were age two, and <1% were age three.[13]**

◆ **Home-based Early Head Start is also recognized as an evidence-based home visiting program that improves child outcomes.[14] As of October 2015 in Rhode Island, there were 367 children enrolled in home-based Early Head Start.[15]**

◆ **Early Intervention (EI) programs serve infants and toddlers with developmental delays and disabilities in Rhode Island and deliver nearly all (95%) services through home visits. As of June 2015, there were 2,195 children enrolled in EI in Rhode Island.[16]**

◆ **Rhode Island also operates First Connections, a statewide, short-term home visiting program designed to help families get connected to needed resources. In 2015, 3,648 children received at least one First Connections home visit (58% lived in one of the four core cities and 42% in the remainder of the state).[17]**

Table 17.

Evidence-Based Family Home Visiting, Rhode Island, 2015

CITY/TOWN	COMMUNITY CONTEXT, 2015			# RECEIVED FIRST CONNECTIONS VISIT IN 2015	# FAMILIES ENROLLED IN EVIDENCE-BASED HOME VISITING PROGRAMS, OCTOBER 1, 2015			
	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	113	33%	0%	14	1	0	0	1
Bristol	132	59%	3%	38	1	1	0	2
Burrillville	125	49%	1%	25	0	0	0	0
Central Falls	300	86%	7%	208	50	7	7	64
Charlestown	38	58%	0%	13	1	0	0	1
Coventry	305	53%	1%	71	9	0	0	9
Cranston	802	55%	2%	227	24	4	3	31
Cumberland	320	47%	<1%	46	1	1	1	3
East Greenwich	119	38%	1%	24	1	0	0	1
East Providence	433	58%	1%	87	14	4	1	19
Exeter	51	49%	2%	14	0	0	0	0
Foster	29	38%	3%	0	0	0	0	0
Glocester	64	36%	0%	7	0	0	0	0
Hopkinton	41	32%	0%	6	2	0	0	2
Jamestown	28	36%	0%	2	0	0	0	0
Johnston	272	61%	2%	43	1	1	0	2
Lincoln	209	45%	1%	36	3	2	0	5
Little Compton	15	53%	0%	4	0	0	0	0
Middletown	165	50%	3%	43	6	1	0	7
Narragansett	49	39%	0%	10	0	0	0	0
New Shoreham	11	73%	0%	2	0	0	0	0
Newport	224	54%	2%	79	9	3	0	12
North Kingstown	226	46%	<1%	62	7	0	0	7
North Providence	338	61%	1%	79	2	1	1	4
North Smithfield	72	43%	0%	13	0	1	0	1
Pawtucket	916	75%	3%	410	73	31	27	131
Portsmouth	106	43%	0%	17	3	1	0	4
Providence	2,471	78%	4%	1,286	259	55	60	374
Richmond	30	83%	7%	33	2	0	0	2
Scituate	84	44%	1%	12	0	0	0	0
Smithfield	135	39%	1%	12	1	0	0	1
South Kingstown	154	55%	1%	54	4	0	0	4
Tiverton	64	61%	0%	23	4	3	0	7
Warren	81	47%	1%	18	5	0	0	5
Warwick	796	53%	1%	248	11	3	0	14
West Greenwich	40	45%	0%	9	1	0	0	1
West Warwick	329	67%	3%	130	18	1	0	19
Westerly	130	51%	2%	49	9	0	0	9
Woonsocket	500	82%	4%	194	50	17	14	81
Unknown Residence	*101*	*40%*	*0%*	*0*	*0*	*0*	*0*	*0*
Four Core Cities	*4,187*	*79%*	*4%*	*2,098*	*432*	*110*	*108*	*650*
Remainder of State	*6,130*	*52%*	*1%*	*1,550*	*140*	*27*	*6*	*173*
Rhode Island	*10,418*	*63%*	*2%*	*3,648*	*572*	*137*	*114*	*823*

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 family home visiting program are from the Rhode Island Department of Health. 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 includes only 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

References

[1,3] DiLauro, E. & Schreiber, L. (2012). *Reaching families where they live: Supporting parents and child development through home visiting.* Washington, DC: Zero to Three.

[2,6] *States and the new federal home visiting initiative: An assessment from the starting line.* (2011). Washington, DC: The Pew Charitable Trusts.

[4,7,14] Avellar, S., et al. (2015). *Home visiting evidence of effectiveness review: Executive summary.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation.

[5] *Medicaid financing of early childhood home visiting programs: Options, opportunities, and challenges.* (2012). Washington, DC: The Pew Charitable Trusts.

[8,10,11,12,13,17] Rhode Island Department of Health, 2015.

[9] Howard, K. S. & Brooks-Gunn, J. (2009). The role of home-visiting programs in preventing child abuse and neglect. *The Future of Children, 19*(2), 119-146.

[15] Rhode Island Early Head Start program reports to Rhode Island KIDS COUNT, October 2015.

[16] Rhode Island Executive Office of Health and Human Services, Center for Child and Family Health, June 30, 2015.

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]

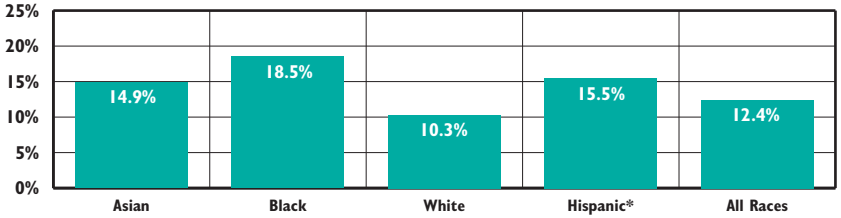
Effective prenatal care screens for and intervenes with a range of maternal needs including nutrition, social support, mental health, smoking cessation, substance use, domestic violence, and unmet needs for food and shelter.[2,3,4] A prenatal visit is the first step in establishing an infant's medical 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 2010 and 2014, 12.4% of women who gave birth either received no prenatal care or did not begin care until the second or third trimester, an improvement from 12.8% in 2009-2013. Pregnant adolescents in Rhode Island are the most likely to delay prenatal care.[9] Between 2009 and 2011, 22% of Rhode Island mothers who had an unintended pregnancy had delayed or no prenatal care, compared with 7.9% of mothers who had an intended pregnancy.[10]

Women With Delayed Prenatal Care by Race/Ethnicity, Rhode Island, 2010-2014



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Database, 2010-2014. *Hispanic may be included in any racial category. Data for births in 2014 are provisional.

◆ **Between 2010 and 2014 in Rhode Island, Black women (18.5%), Hispanic women (15.5%), and Asian women (14.9%) were more likely to receive delayed prenatal care than White women (10.3%).[11]**

◆ **Between 2010 and 2014 in Rhode Island, 17% of women with a high school degree or less were more likely to receive delayed prenatal care than their peers, and the rate of delayed prenatal care among pregnant women in the four core cities was 16.1%.[12,13]**

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 are most likely to initiate care in the first trimester are also older, married, and have higher levels of education.[14,15]**

◆ **Between 2010 and 2014, pregnant women with RIte Care coverage (Rhode Island's Medicaid managed care health insurance program) were much less likely (17.2%) to receive delayed prenatal care than women who were uninsured (33%). Pregnant women with private insurance coverage were the least likely to receive delayed prenatal care (7.6%) during this time period.[16]**

◆ **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 75th percentile in member access to timely prenatal care when compared to other Medicaid health plans in the nation.[17]**

Table 18. **Delayed Prenatal Care, Rhode Island, 2010-2014**

CITY/TOWN	# BIRTHS	# DELAYED CARE	% DELAYED CARE
Barrington	503	40	8.0%
Bristol	778	83	10.7%
Burrillville	632	71	11.2%
Central Falls	1,619	256	15.8%
Charlestown	260	12	NA
Coventry	1,417	150	10.6%
Cranston	3,887	424	10.9%
Cumberland	1,613	143	8.9%
East Greenwich	552	55	10.0%
East Providence	2,453	233	9.5%
Exeter	256	23	NA
Foster	163	22	NA
Glocester	342	42	NA
Hopkinton	357	30	NA
Jamestown	117	12	NA
Johnston	1,282	143	11.2%
Lincoln	901	79	8.8%
Little Compton	79	1	NA
Middletown	834	72	8.6%
Narragansett	373	28	NA
New Shoreham	56	5	NA
Newport	1,295	121	9.3%
North Kingstown	1,020	88	8.6%
North Providence	1,582	172	10.9%
North Smithfield	412	39	NA
Pawtucket	4,941	765	15.5%
Portsmouth	573	33	5.8%
Providence	12,890	2,118	16.4%
Richmond	348	18	NA
Scituate	331	42	NA
Smithfield	593	44	7.4%
South Kingstown	897	63	7.0%
Tiverton	528	37	7.0%
Warren	458	64	NA
Warwick	3,831	389	10.2%
West Greenwich	241	24	NA
West Warwick	1,789	251	14.0%
Westerly	959	66	6.9%
Woonsocket	2,946	469	15.9%
Unknown	*41*	*3*	*NA*
Four Core Cities	*22,396*	*3,608*	*16.1%*
Remainder of State	*31,712*	*3,119*	*9.8%*
Rhode Island	*54,149*	*6,730*	*12.4%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014. Data for births in 2014 are provisional and do not include births among Rhode Island residents that occurred out-of-state.

The denominator is the total number of live births to Rhode Island residents from 2010-2014.

NA: Rates should not be calculated due to small numbers and the lack of statistical reliability.

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

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.

References

[1] Child Trends. (2015). *Late or no prenatal care: Indicators on children and youth.* Retrieved January 25, 2016, from www.childtrendsdatabank.org

[2] Akkerman, D., et al. (2012). *Health care guideline: Routine prenatal care.* Retrieved January 25, 2016, from www.icsi.org

[3] Hagan, J. F., Shaw, J. S., & Duncan, P. M. (Eds.). (2008). *Bright futures: Guidelines for health supervision of infants, children and adolescents (3rd ed.).* Elk Grove Village, IL: American Academy of Pediatrics.

[4] Zolotor, Adam J. & Carlough, Martha C. (2014). Update on prenatal care. *American Family Physician, 89*(3),199-208.

[5] Cohen, G. & Committee on Psychosocial Aspects of Child and Family Health. (2009). The prenatal visit. *Pediatrics, 124*(4), 1227-1232.

[6,7] Shore, R. & Shore, B. (2009). *KIDS COUNT Indicator brief: Reducing infant mortality.* Baltimore, MD: The Annie E. Casey Foundation.

[8,15] Kim, H., Cain, R., & Viner-Brown, S. (2014). *2014 Rhode Island Pregnancy Risk Assessment Monitoring System data book.* Providence, RI: Rhode Island Department of Health.

[9,11,12,13,16] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014.

[10] *Unintended pregnancy among women in Rhode Island, 2009-2011.* (2015). Providence, RI: Rhode Island Department of Health.

[14] U.S. Department of Health and Human Services. (2013). *Women's health USA 2012.* Retrieved January 25, 2016, from www.mchb.hrsa.gov/whusa12/

[17] *Monitoring quality and access in RIte Care and Rhody Health Partners.* (2015). Cranston, RI: Rhode Island Executive Office of Health and Human Services.

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 health conditions, weight, maternal depression, 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 enduring health problems, 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 been in decline. In 2014, the U.S. preterm birth rate was 9.6%, a decrease of 8% from the peak of 10.4% in 2007. Preterm births also declined among White, non-Hispanic (down 10%), Black, non-Hispanic (down 10%), and Hispanic (down 3%) infants since 2007. Despite declines, Black, non-Hispanic women continue to have the highest preterm birth rate in the nation (13.2% in 2014).[10,11]

Preterm birth is a major contributor to infant mortality in the U.S., particularly among non-Hispanic Black, Cuban, American Indian/Alaska Native, and Puerto Rican infants.[12]

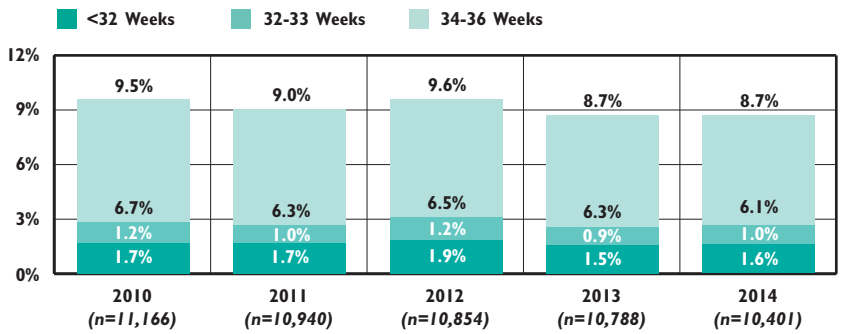
Preterm Births

	2007	2014
RI	10.8%	8.6%
US	10.4%	9.6%
National Rank*		*12th*
New England Rank**		*4th*

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

Sources: For 2014: Hamilton, B. E., et al. (2015). Births: Final data for 2014. *NVSR, 64*(12), 1-65. For 2007: Martin, J. A., et al. (2015). Measuring gestational age in vital statistics data: Transitioning to the obstetric estimate. *NVSR, 64*(5), 1-19.

Preterm Births by Gestational Age*, Rhode Island, 2010-2014



Source: RI Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014. Percentages by gestational age may not sum to total percentage of preterm births due to rounding. *See note regarding new methodology for calculating preterm births, starting with this Factbook. Data for births in 2014 are provisional.

◆ **The single-year preterm birth rate in Rhode Island remained the same from 2013 to 2014 (8.7%). Between 2010 and 2014, 70.1% of all preterm births in Rhode Island were late preterm births (34-36 weeks gestation) and 18.3% of all preterm births were very preterm (<32 weeks gestation).[13]**

◆ **Multiple births are more likely to be born preterm. In Rhode Island between 2010 and 2014, 56.3% of multiple births were preterm, compared with 7.3% of singleton births.[14]**

◆ **Between 2010 and 2014, 11.4% of births of Black infants in Rhode Island were preterm, compared with 9.1% of Asian and 8.5% of White infants. During this same time period, 9.6% of births to Hispanic women in Rhode Island were preterm.[15]**

◆ **The rate of preterm births varies by age. In Rhode Island between 2010 and 2014, 9.4% of births among teen girls under age 20, 8.6% of births among women ages 20 to 34, and 11.2% of births among women age 35 and older were preterm.[16]**

◆ **Among women with private health insurance coverage in Rhode Island between 2010 and 2014, 8.7% of births were preterm, compared with 9.4% of those with public insurance coverage and 17.2% of births to women with no health insurance.[17]**

◆ **In Rhode Island between 2010 and 2014, 9.4% of births to women with a high school degree or less were preterm, compared with 8.3% of those with higher education levels.[18]**

Table 19. **Preterm Births, Rhode Island, 2010-2014**

CITY/TOWN	# BIRTHS	# PRETERM BIRTHS	% PRETERM BIRTHS
Barrington	503	33	6.6%
Bristol	778	57	7.3%
Burrillville	632	56	8.9%
Central Falls	1,619	142	8.8%
Charlestown	260	23	NA
Coventry	1,417	134	9.5%
Cranston	3,887	383	9.9%
Cumberland	1,613	113	7.0%
East Greenwich	552	55	10.0%
East Providence	2,453	197	8.0%
Exeter	256	11	NA
Foster	163	13	NA
Glocester	342	36	NA
Hopkinton	357	31	NA
Jamestown	117	9	NA
Johnston	1,282	104	8.1%
Lincoln	901	89	9.9%
Little Compton	79	6	NA
Middletown	834	57	6.8%
Narragansett	373	23	NA
New Shoreham	56	2	NA
Newport	1,295	113	8.7%
North Kingstown	1,020	68	6.7%
North Providence	1,582	155	9.8%
North Smithfield	412	41	NA
Pawtucket	4,941	478	9.7%
Portsmouth	573	43	7.5%
Providence	12,890	1,335	10.4%
Richmond	348	30	NA
Scituate	331	26	NA
Smithfield	593	47	7.9%
South Kingstown	897	66	7.4%
Tiverton	528	46	8.7%
Warren	458	47	NA
Warwick	3,831	320	8.4%
West Greenwich	241	16	NA
West Warwick	1,789	157	8.8%
Westerly	959	72	7.5%
Woonsocket	2,946	294	10.0%
Unknown	*41*	*3*	*NA*
Four Core Cities	*22,396*	*2,249*	*10.0%*
Remainder Of State	*31,712*	*2,679*	*8.4%*
Rhode Island	*54,149*	*4,931*	*9.1%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014. Data for births in 2014 are provisional and do not include births among Rhode Island residents that occurred out-of-state.

The denominator is the total number of live births to Rhode Island residents from 2010-2014.

*Beginning in 2015, the federal Centers for Disease Control and Prevention and the Rhode Island Department of Health transitioned to a new standard for estimating the gestational age of the newborn. The new measure – the obstetric estimate of gestation at delivery (OE) – replaces the measure based on the date of the last normal menses (LMP).

The 2010-2014 five-year preterm birth percentage and the single year average are measured by OE. Because of this change, preterm birth data reported prior to the 2016 Factbook are not comparable. National preterm birth data use the OE measurement as of the 2007 data year at the time of publication of this Factbook.

NA: Rates should not be calculated due to small numbers and the lack of statistical reliability.

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

References

[1] Centers for Disease Control and Prevention. (2015). *Preterm birth.* Retrieved February 4, 2016, from www.cdc.gov

[2,4,6] *Preterm births.* (2015). Washington, DC: Child Trends.

[3] Mayo Clinic. (2014). *Premature birth.* Retrieved February 4, 2016, from www.mayoclinic.org

[5] March of Dimes. (2015). *Preterm labor and premature birth.* Retrieved February 4, 2016, from www.marchofdimes.org

[7] McCabe, E. R. B., Carrino, G. E., Russell, R. B., & Howse, J. L. (2014). Fighting for the next generation: U.S. prematurity in 2030. *Pediatrics, 134*(6), 1-7.

[8] Spittle, A. J., et al. (2010). Preventive care at home for very preterm infants improves infant and caregiver outcomes at 2 years. *Pediatrics, 126*(1), e171-e178.

[9] Spencer-Smith, M. M., et al. (2012). Long-term benefits of home-based preventive care for preterm infants: A randomized trial. *Pediatrics, 130*(6), 1094-1101.

[10] Hamilton, B. E., Martin, J. A., Osterman, M. J. K., Curtin, S. C., & Mathews, T. J. (2015). Births: Final data for 2014. *National Vital Statistics Reports, 64*(12), 1-65.

[11] Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Curtin, S. C., & Mathews, T. J. (2015). Births: Final data for 2013. *National Vital Statistics Reports, 64*(1), 1-65.

[12] Mathews, T. J., MacDorman, M. F., & Thoma, M. E. (2015). Infant mortality statistics from the 2013 period linked birth/infant death data set. *National Vital Statistics Reports, 64*(9), 1-29.

[13,14,15,16,17,18] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014.

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 2014 in the U.S., 57.9% of all preterm infants (under 37 weeks gestation) were born at low birthweight, while 2.7% 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.[5,6] In Rhode Island, 7.6% of babies born between 2010 and 2014 had mothers who smoked during their pregnancy. During that time, Rhode Island smokers (12.3%) were nearly twice as likely to deliver a low birthweight infant as women who did not smoke (6.9%).[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 also 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 2014, 8.0% of infants were born at low birthweight, which was a 14% increase from 7.0% in 1990. Rhode Island's low birthweight rate increased from 6.2% in 1990 to 7.1% in 2014, a 15% increase.[11,12] The *Healthy People 2020* national target is 7.8%.[13]

Low Birthweight Infants

	2004	2014
RI	8.0%	7.1%
US	8.1%	8.0%
National Rank*		*15th*
New England Rank**		*2nd*

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

Source: For 2014: Hamilton, B. E., et al. (2015). Births: Final data for 2014. *National Vital Statistics Reports, 64*(12), 1-63. For 2004: Martin, J. A., et al. (2006). Births: Final data for 2004. *National Vital Statistics Reports, 55*(1), 1-102.

Low Birthweight Infants by Race/Ethnicity, Rhode Island, 2010-2014

Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014. *Hispanic infants can be of any race. Data for births in 2014 are provisional.

◆ **There are racial and ethnic disparities in rates of low birthweight.[14] In Rhode Island between 2010 and 2014, 11.2% of Black infants, 9.0% of Asian infants, and 7.8% of Hispanic infants were born at low birthweight, compared to 6.6% 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]**

◆ **Between 2010 and 2014 in Rhode Island, 9.1% of births among women under age 20 were low birthweight compared to 7.4% of those over age 20; 8.7% of infants born to women living in the four core cities were low birthweight compared to 6.6% in the remainder of the state; and 8.2% of infants born to women with a high school degree or less were low birthweight, compared to 6.3% of those born to women with higher education levels.[18]**

◆ **Among women with private health insurance coverage in Rhode Island between 2010 and 2014, 6.6% of births were low birthweight, compared with 8.2% of those with public insurance (RIte Care or Medicaid) and 14.1% of births to women with no insurance.[19]**

◆ **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.[20]**

◆ **Between 2010 and 2014 in Rhode Island, 1.5% of all live births were born at very low birthweight (less than 1,500 grams).[21]**

Table 20. **Low Birthweight Infants, Rhode Island, 2010-2014**

CITY/TOWN	# BIRTHS	# LOW BIRTHWEIGHT	% LOW BIRTHWEIGHT
Barrington	503	23	4.6%
Bristol	778	46	5.9%
Burrillville	632	47	7.4%
Central Falls	1,619	124	7.7%
Charlestown	260	12	NA
Coventry	1,417	96	6.8%
Cranston	3,887	305	7.8%
Cumberland	1,613	91	5.6%
East Greenwich	552	44	8.0%
East Providence	2,453	149	6.1%
Exeter	256	11	NA
Foster	163	8	NA
Glocester	342	19	NA
Hopkinton	357	22	NA
Jamestown	117	7	NA
Johnston	1,282	84	6.6%
Lincoln	901	67	7.4%
Little Compton	79	3	NA
Middletown	834	51	6.1%
Narragansett	373	22	NA
New Shoreham	56	3	NA
Newport	1,295	88	6.8%
North Kingstown	1,020	57	5.6%
North Providence	1,582	123	7.8%
North Smithfield	412	38	NA
Pawtucket	4,941	420	8.5%
Portsmouth	573	31	5.4%
Providence	12,890	1160	9.0%
Richmond	348	18	NA
Scituate	331	16	NA
Smithfield	593	32	5.4%
South Kingstown	897	53	5.9%
Tiverton	528	31	5.9%
Warren	458	39	NA
Warwick	3,831	249	6.5%
West Greenwich	241	14	NA
West Warwick	1,789	141	7.9%
Westerly	959	54	5.6%
Woonsocket	2,946	254	8.6%
Unknown	*41*	*1*	*NA*
Four Core Cities	*22,396*	*1,958*	*8.7%*
Remainder of State	*31,712*	*2,094*	*6.6%*
Rhode Island	*54,149*	*4,053*	*7.5%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014. Data for births in 2014 are provisional and do not include births among Rhode Island residents that occurred out-of-state.

The denominator is the total number of live births to Rhode Island residents from 2010-2014.

NA: Rates should not be calculated due to small numbers and the lack of statistical reliability.

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

References

[1] *2015 KIDS COUNT data book: State trends in child well-being.* (2015). Baltimore, MD: The Annie E. Casey Foundation.

[2,5] Shore, R. & Shore, B. (2009). *KIDS COUNT indicator brief: Preventing low birthweight.* Baltimore, MD: The Annie E. Casey Foundation.

[3] Chambrone, L., Guglielmetti, M. R., Pannuti, C. M., & Chambrone, L. A. (2011). Evidence grade associating periodontitis to preterm birth and/or low birth weight: I. A systematic review of prospective cohort studies. *Journal of Clinical Periodontology, 38*(9), 795-808.

[4,11,14] Hamilton, B. E., Martin, J. A., Osterman, M. J. K., Curtin, S. C., & Mathews, T. J. (2015). Births: Final data for 2014. *National Vital Statistics Reports, 64*(12), 1-63.

[6,20] Kim, H., Cain, R., Viner-Brown, S., & Roach, C. (2014). *2014 Rhode Island Pregnancy Risk Assessment Monitoring System data book: 2009-2011 data to guide evidence-based decision making.* Providence, RI: Rhode Island Department of Health, Center for Health Data and Analysis.

[7,15,18,19,21] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014.

[8,13] Child Trends. (2015). *Low and very low birthweight infants.* Retrieved January 26, 2016, from www.childtrendsdatabank.org

[9] Matthews, T. J., MacDorman, M. F., & Thoma, M.E. (2015). Infant mortality statistics from the 2013 period linked birth/infant death data set. *National Vital Statistics Reports, 64*(9), 1-30.

[10] *Child health USA 2014.* (2015). Rockville, MD: U.S. Department of Health and Human Services, Maternal and Child Health Bureau.

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

[16] Lu, M. C., et al. (2010). Closing the black-white gap in birth outcomes: A life-course approach. *Ethnicity & Disease, 20*, 62-76.

[17] Janevic, T., et al. (2010). Neighborhood deprivation and adverse birth outcomes among diverse ethnic groups. *Annals of Epidemiology, 20*(6), 445-451.

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, socioeconomic conditions, and public health practices.[1] Communities with high poverty and disadvantaged social conditions tend to have higher infant mortality rates than more advantaged neighborhoods.[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, non-Hispanic Black women had 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 a record low of 5.8 deaths per 1,000 live births in 2014, due to improvements in health behaviors, medical advances, improved access to care, and economic growth.[5,6,7,8] Relative to other industrialized countries, the U.S. has made slower progress in reducing infant mortality due in part to a relatively high number of preterm births resulting in infant mortality.[9,10]

The overall infant mortality rate in Rhode Island between 2010 and 2014 was 6.2 deaths per 1,000 live births. The infant mortality rate was 8.0 per 1,000 live births in the four core cities, compared with 5.0 per 1,000 live 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 (6.1 per 1,000 live births) than mothers with more advanced educational degrees (4.8 per 1,000 1,000 live births).[11]

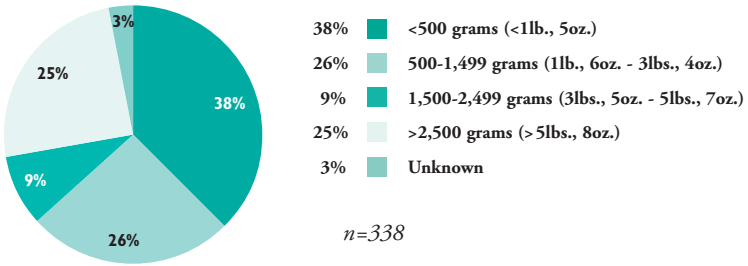
Infant Mortality Rate
(rate per 1,000 live births)

	2004	2014
RI	5.3	4.4
US	6.8	5.8
National Rank*		*3rd*
New England Rank**		*2nd*

**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, 2010-2014



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014. Data for births in 2014 are provisional. Totals may not sum to 100% due to rounding.

◆ **Between 2010 and 2014, 338 infants died in Rhode Island before their first birthday, a rate of 6.2 per 1,000 live births. This is an improvement from the 2009-2013 infant mortality rate of 6.6 per 1,000 live births (when there were 362 infant deaths). Between 2010 and 2014, 72% of infants who died were low birthweight, 25% were born at normal weights, and 3% had unknown birthweights.[12]**

◆ **Preterm birth is the leading cause of infant death in Rhode Island.[13] Between 2010 and 2014, 73% (242) of all infant deaths were preterm (occurring before the 37th week).[14]**

◆ **Of the 338 infant deaths between 2010 and 2014 in Rhode Island, 75% (253) occurred in the neonatal period (during the first 27 days of life).[15] 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.[16]**

◆ **Between 2010 and 2014, 25% (85) of the 338 infant deaths in Rhode Island occurred in the post-neonatal period (between 28 days and one year after delivery).[17]**

◆ **Racial and ethnic disparities exist in infant mortality. In Rhode Island between 2010 and 2014, the Black infant mortality rate was 10.8 deaths per 1,000 live births, the Asian infant mortality rate was 6.4 per 1,000 live births, and the White infant mortality rate was 4.8 per 1,000 live births. The Hispanic infant mortality rate was 6.1 per 1,000 live births, compared with 5.7 deaths per 1,000 live births among non-Hispanics in Rhode Island.[18]**

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.[19]

- 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.[20]

- Participation in enhanced prenatal and postnatal care programs, such as evidence-based family home visiting programs, have been shown to reduce the risk of infant death.[21] As of October 2015, there were 823 families enrolled in one of three MIECHV evidence-based home visiting programs in Rhode Island.[22]

Table 21. **Infant Mortality, Rhode Island, 2010-2014**

CITY/TOWN	# OF BIRTHS	# OF INFANT DEATHS	RATE PER 1,000 LIVE BIRTHS
Barrington	503	0	NA
Bristol	778	2	NA
Burrillville	632	2	NA
Central Falls	1,619	8	NA
Charlestown	260	2	NA
Coventry	1,417	6	NA
Cranston	3,887	17	4.4
Cumberland	1,613	10	NA
East Greenwich	552	7	NA
East Providence	2,453	13	5.3
Exeter	256	0	NA
Foster	163	1	NA
Glocester	342	3	NA
Hopkinton	357	0	NA
Jamestown	117	0	NA
Johnston	1,282	8	NA
Lincoln	901	6	NA
Little Compton	79	0	NA
Middletown	834	2	NA
Narragansett	373	2	NA
New Shoreham	56	0	NA
Newport	1,295	7	NA
North Kingstown	1,020	3	NA
North Providence	1,582	9	NA
North Smithfield	412	4	NA
Pawtucket	4,941	40	8.1
Portsmouth	573	4	NA
Providence	12,890	108	8.4
Richmond	348	5	NA
Scituate	331	2	NA
Smithfield	593	1	NA
South Kingstown	897	2	NA
Tiverton	528	1	NA
Warren	458	3	NA
Warwick	3,831	24	6.3
West Greenwich	241	0	NA
West Warwick	1,789	9	NA
Westerly	959	3	NA
Woonsocket	2,946	24	8.1
Unknown	*41*	*0*	*NA*
Four Core Cities	*22,396*	*180*	*8.0*
Remainder of State	*31,712*	*158*	*5.0*
Rhode Island	*54,149*	*338*	*6.2*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014. Data for births in 2014 are provisional and do not include births among Rhode Island residents that occurred out-of-state.

The denominator is the total number of live births to Rhode Island residents between 2010 and 2014.

NA: Rates should not be calculated due to small numbers and the lack of statistical reliability.

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

References

[1] Federal Interagency Forum on Child and Family Statistics. (2015). *America's children: Key national indicators of well-being, 2015.* Washington, DC: U.S. Government Printing Office.

[2] MacDorman, M. F. & Mathews, T. J. (2013). Infant deaths – United States, 2005-2008. *Morbidity and Mortality Weekly Report, 62*(3), 171-174.

[3,7] Murphy, S. L., Kochanek, K. D., Xu, J., & Arias, E. (2015). Mortality in the United States, 2014. *NCHS Data Brief, 229,* 1-7.

[4] Mathews, T. J., MacDorman, M. F., & Thoma, M. E. (2015). Infant mortality statistics from the 2013 period linked birth/infant death data set. *National Vital Statistics Reports, 64*(9), 1-29.

[5] MacDorman, M. F. & Rosenberg, H. M. (1993). Trends in infant mortality by cause of death and other characteristics, 1960-88. *National Vital Statistics Reports, 20*(20), 1-51.

[6] Population Reference Bureau calculations using CDC WONDER, wonder.cdc.gov, 2003-2014.

[8,10] *Child Health USA 2014.* (2015). Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration.

[9] Organization for Economic Cooperation and Development. (2015). *Infant mortality. Health at a glance 2015: OECD indicators.* Paris, FR: OECD publishing.

[11,12,14,15,17,18,22] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014.

(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]

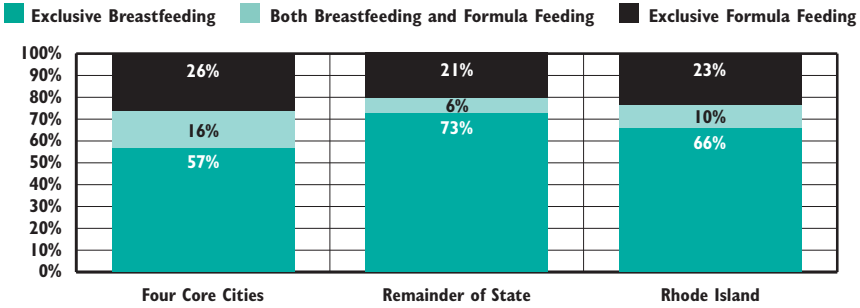
Breastfeeding decreases infant mortality and morbidity. Benefits for infants include optimal nutrition and reduced risk for sudden infant death syndrome, as well as reduced risk for chronic conditions such as childhood obesity, type 1 and 2 diabetes, and childhood leukemia. Additionally, breastfeeding 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 the 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 attainment, and higher income levels.[9] Whether or not the pregnancy was intentional or not also affects rate of breastfeeding. In Rhode Island between 2009-2011, 17% of babies from intended pregnancies were not breastfed at all, compared with 22% of babies from unintended pregnancies.[10]

Healthy People 2020 sets target breastfeeding rates of 81.9% of infants ever having been breastfed, 60.6% at six months of age, and 34.1% at one year of age.[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 12 months.[12]

Breastfeeding and Formula Feeding, Rhode Island, 2010-2014



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Newborn Developmental Risk Screening Program, 2010-2014. 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 2010 and 2014, 66% of new mothers in Rhode Island indicated that they intended to exclusively breastfeed when discharged from the hospital, 23% intended to exclusively formula feed, and 10% intended to use a combination of both.[13]**

◆ **More than three-quarters (86%) of new mothers in Rhode Island who were surveyed about three months after giving birth between 2012-2013 reported having ever breastfed. Fifty-three percent reported continued breastfeeding at the time of the survey.[14]**

◆ **Rhode Island is one of 45 states with legislation that provides mothers with the explicit right to breastfeed in public places.[15] In Rhode Island in 2015, legislation passed that prohibits job discrimination based on pregnancy, childbirth, and related medical conditions. It requires employers to make reasonable accommodations for workers for conditions related to pregnancy and childbirth, including breastfeeding.[16]**

◆ **In 2014, Rhode Island became the first state to establish licensure for International Board Certified Lactation Consultants. State-certified lactation consultants provide comprehensive lactation support and counseling for pregnant and postpartum women.[17]**

◆ **In 2015, Women & Infants Hospital became the second-largest hospital in the U.S. to achieve the "Baby-Friendly" designation, which recognizes facilities that support and promote breastfeeding. Rhode Island ranks number one in the country in the percentage of babies born at Baby-Friendly hospitals.[18]**

Table 22.

Breastfeeding, Rhode Island, 2010-2014

CITY/TOWN	NUMBER OF BIRTHS SCREENED	NUMBER BREAST AND FORMULA FEEDING	NUMBER EXCLUSIVELY BREASTFEEDING	PERCENT WITH ANY BREASTFEEDING	PERCENT EXCLUSIVELY BREASTFEEDING
Barrington	491	11	441	92%	90%
Bristol	741	44	542	79%	73%
Burrillville	590	18	434	77%	74%
Central Falls	1,593	360	841	75%	53%
Charlestown	252	8	206	85%	82%
Coventry	1,394	50	999	75%	72%
Cranston	3,839	340	2,632	77%	69%
Cumberland	1,484	79	1,115	80%	75%
East Greenwich	540	11	447	85%	83%
East Providence	2,395	168	1,638	75%	68%
Exeter	253	22	193	85%	76%
Foster	157	9	127	87%	81%
Glocester	329	13	251	80%	76%
Hopkinton	354	6	291	84%	82%
Jamestown	112	1	107	96%	96%
Johnston	1,267	79	833	72%	66%
Lincoln	872	39	638	78%	73%
Little Compton	61	1	49	82%	80%
Middletown	798	35	649	86%	81%
Narragansett	368	18	294	85%	80%
New Shoreham	54	6	46	96%	85%
Newport	1,236	93	886	79%	72%
North Kingstown	1,013	44	767	80%	76%
North Providence	1,554	99	1,072	75%	69%
North Smithfield	385	11	308	83%	80%
Pawtucket	4,739	699	2,816	74%	59%
Portsmouth	532	11	448	86%	84%
Providence	12,659	2,161	7,184	74%	57%
Richmond	331	11	280	88%	85%
Scituate	328	14	246	79%	75%
Smithfield	582	17	449	80%	77%
South Kingstown	916	57	717	84%	78%
Tiverton	364	13	284	82%	78%
Warren	440	17	324	78%	74%
Warwick	3,773	221	2,614	75%	69%
West Greenwich	238	12	177	79%	74%
West Warwick	1,757	105	1,115	69%	63%
Westerly	892	40	702	83%	79%
Woonsocket	2,780	267	1,563	66%	56%
Four Core Cities	*21,771*	*3,487*	*12,404*	*73%*	*57%*
Remainder of State	*30,692*	*1,723*	*22,321*	*78%*	*73%*
Rhode Island	*52,463*	*5,210*	*34,725*	*76%*	*66%*

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, 2010-2014.

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.

References

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

[2,15,17] *Breastfeeding: 2015-2020 Rhode Island strategic plan.* (2015). Providence, RI: Rhode Island Department of Health.

[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.

[5,9] *Breastfeeding.* (2014). Washington, DC: Child Trends.

[7,12] *Breastfeeding report card – United States, 2014.* (2014). Atlanta, GA: Centers for Disease Control and Prevention.

[8] *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.

[10] *Issue brief: Unintended pregnancy among women in Rhode Island, 2009-2011.* (2015). Providence, RI: Rhode Island Department of Health.

(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, 2015.[1,2] These data are for children eligible to enter kindergarten in the fall of 2017 (i.e., children born between September 1, 2011 and August 31, 2012).

SIGNIFICANCE

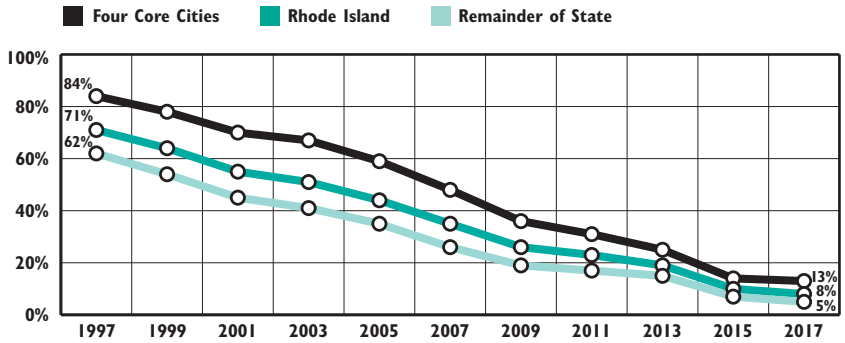
Lead poisoning is a preventable childhood disease. Infants, toddlers, and preschool-age children are most susceptible to the toxic effects of lead because they absorb lead more readily than adults and have inherent vulnerability due to developing central nervous systems.[3] Lead exposure, even at very low levels, can cause irreversible damage including reduced fetal and postnatal growth, decreased hearing, delayed puberty, kidney damage, increased risk for behavioral problems, decreased cognitive abilities, and lower academic performance. Though rare, severe poisoning can result in seizures, comas, and even death.[4,5] The societal costs of childhood lead poisoning include the loss of future earnings due to decreased cognition, and increased medical, special education, and juvenile justice costs.[6,7,8]

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.[9,10]

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.[11,12,13] 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.[14]

In 2015, 1,342 (5.3%) of the 25,399 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 (7.7%) were more than twice as likely as children in the remainder of the states (3.3%) to have confirmed EBLLs ≥5 µg/dL.[15]

Children Entering Kindergarten with History of Elevated* Blood Lead Level Screening (≥5 µg/dL), Rhode Island, Four Core Cities, and Remainder of State, 1997-2017



Source: Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program, Children entering kindergarten between 1997 and 2017. *Elevated blood lead level of ≥5 µg/dL.

◆ **The number of children with elevated blood lead levels has been steadily declining in all areas of Rhode Island over the past two decades. Compared to the remainder of the state, children living in the four core cities are at an increased risk for lead exposure.[16]**

Lead Exposure and Academic Performance

◆ **Exposure to lead has been shown to negatively impact academic performance in early childhood.[17] 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 risked for absenteeism, grade repetition, and special education services.[18,19]**

◆ **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 respective districts. Information regarding screenings, regulations, associated risks, and parent communication are also included.[20,21]**

Significantly Lead Poisoned Children Under Age Six

◆ Starting in 2015, a child is considered to be "significantly lead poisoned" if she or he has a single venous blood test result of ≥15 ug/dL. The number of children under age six who were significantly lead poisoned has decreased by 76% over the past ten years, from 349 in 2005 to 84 in 2015, but is up from 2014 (70).[22]

◆ Starting in 2015, an environmental inspection of a child's home is offered when a single venous test result is ≥15 µg/dL (versus ≥20 µg/dL previously). The Rhode Island Department of Health sends certified lead inspectors to determine whether lead hazards are present and works with owners to make the property lead-safe. In 2015, 68 inspections were offered, of which 41 were performed, 14 were refused, 11 the child moved, and two were pending.[23]

Lead Poisoning Screening for Children Age Three

◆ All Rhode Island children must have at least two blood lead screening tests by age three and annual screenings through age six. Lead screening is a mandated covered health insurance benefit in Rhode Island. In 2015, 84% of Rhode Island three-year-olds received a blood lead test.[24,25,26]

Table 23. **Lead Poisoning in Children Entering Kindergarten in the Fall of 2017, Rhode Island**

CITY/TOWN	NUMBER TESTED FOR LEAD POISONING	CONFIRMED WITH BLOOD LEAD LEVEL ≥5 µg/dL	
		NUMBER	PERCENT
Barrington	121	6	5.0%
Bristol	177	10	5.6%
Burrillville	108	10	9.3%
Central Falls	317	51	16.1%
Charlestown	56	6	10.7%
Coventry	288	18	6.3%
Cranston	743	35	4.7%
Cumberland	334	8	2.4%
East Greenwich	139	2	1.4%
East Providence	474	45	9.5%
Exeter	50	4	8.0%
Foster	33	0	0.0%
Glocester	51	1	2.0%
Hopkinton	60	1	1.7%
Jamestown	32	4	12.5%
Johnston	230	4	1.7%
Lincoln	156	12	7.7%
Little Compton	18	2	11.1%
Middletown	201	9	4.5%
Narragansett	63	3	4.8%
New Shoreham	12	1	8.3%
Newport	292	24	8.2%
North Kingstown	182	6	3.3%
North Providence	245	13	5.3%
North Smithfield	91	2	2.2%
Pawtucket	938	115	12.3%
Portsmouth	136	6	4.4%
Providence	2,706	366	13.5%
Richmond	48	4	8.3%
Scituate	86	2	2.3%
Smithfield	127	1	0.8%
South Kingstown	203	15	7.4%
Tiverton	137	9	6.6%
Warren	80	15	18.8%
Warwick	736	26	3.5%
West Greenwich	48	2	4.2%
West Warwick	314	13	4.1%
Westerly	176	7	4.0%
Woonsocket	597	36	6.0%
Four Core Cities	*4,558*	*568*	*12.5%*
Remainder of State	*6,247*	*326*	*5.2%*
Rhode Island	*10,805*	*894*	*8.3%*

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 2017 reflect the number of Rhode Island children eligible to enter school in the fall of 2017 (i.e., born between 9/1/11 and 8/31/12).

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 2015. 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 2017 who were tested for lead poisoning. Data include both venous and confirmed capillary tests.

Of the 912 children entering kindergarten in 2017 who had an initial blood lead screen of ≥5 µg/dL, one did not receive a confirmatory second test. Their lead poisoning status is unknown.

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

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

See Methodology Section for more information.

References

[1,9] Centers for Disease Control and Prevention. (n.d.). *Blood lead levels in children.* Retrieved February 22, 2016, from www.cdc.gov

[2,24] Rhode Island Department of Health. (2012). *Lead screening and referral guidelines: Universal blood lead screening.* Retrieved February 22, 2016, from www.health.ri.gov

(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 treatable episodes of coughing, wheezing, shortness of breath, and chest tightness, which can be life threatening. Asthma attacks can be triggered by respiratory infections, air pollutants, cigarette smoke, allergens, 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]

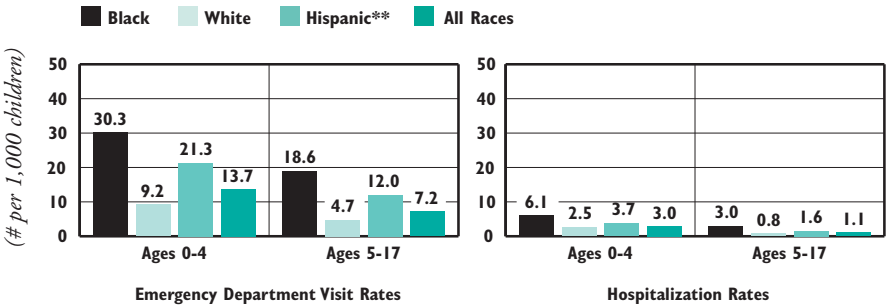
Nationally, asthma is the most common chronic condition among children.[4] After peaking at 9.6% in 2009, asthma prevalence among U.S. children fell to 8.6% in 2014.[5,6] The highest rates of asthma are among males, Black and American Indian/Alaska Native children, and children living in poverty.[7] 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.[8,9]

Compared with adults, children have higher rates for primary care and emergency department visits for asthma, 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 child and family to create an asthma action plan, which provides instruction on how to avoid asthma triggers and how to use medications properly. 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 2014, the average charge of an asthma emergency department visit for a child was $1,729 and $11,365 for a child hospitalization due to asthma.[17]

Asthma* Emergency Department and Hospitalization Rates, by Age and Race/Ethnicity, Rhode Island Children, 2010-2014



Source: Rhode Island Department of Health, Hospital Discharge Database, 2010-2014; U.S. Census Bureau, Census 2010.
*Rates are for primary diagnosis of asthma. **Hispanic children can be of any race.

◆ **In Rhode Island between 2010 and 2014, non-Hispanic Black children, Hispanic children, and children under age five were the most likely to visit the emergency department or be hospitalized as a result of asthma. Children of all ages were more likely to visit the emergency department than to be hospitalized for asthma; 13% (1,334) of all asthma emergency department visits for children under age 18 resulted in a hospitalization.[18]**

◆ **In Rhode Island between 2010 and 2014, boys under age 18 had higher asthma emergency department (10.8 per 1,000 boys) and hospitalization (2.0 per 1,000 boys) rates than girls under age 18 (6.9 and 1.3 per 1,000 girls respectively).[19]**

◆ **Among all children who had an emergency department visit for a primary diagnosis of asthma in Rhode Island between 2010 and 2014, 62% had RIte Care/Medicaid coverage, 32% had private health insurance, and 5% were self-pay (which could mean they were uninsured or that their insurance did not cover the cost of care). Among hospital admissions during that time, 50% had RIte Care/Medicaid coverage, 45% had private health insurance, and 5% were self-pay.[20]**

◆ **Between the 2009-10 and 2012-13 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, 2010-2014

CITY/TOWN	ESTIMATED # 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	94	4.1	28	1.2
Bristol	3,623	73	4.0	16	0.9
Burrillville	3,576	78	4.4	21	1.2
Central Falls	5,644	364	12.9	58	2.1
Charlestown	1,506	48	6.4	7	0.9
Coventry	7,770	169	4.4	37	1.0
Cranston	16,414	635	7.7	139	1.7
Cumberland	7,535	140	3.7	31	0.8
East Greenwich	3,436	51	3.0	11	0.6
East Providence	9,177	359	7.8	108	2.4
Exeter	1,334	27	4.0	7	1.0
Foster	986	15	3.0	6	1.2
Glocester	2,098	25	2.4	12	1.1
Hopkinton	1,845	55	6.0	12	1.3
Jamestown	1,043	22	4.2	4	NA
Johnston	5,480	212	7.7	58	2.1
Lincoln	4,751	136	5.7	30	1.3
Little Compton	654	8	2.4	0	0.0
Middletown	3,652	149	8.2	24	1.3
Narragansett	2,269	48	4.2	3	NA
New Shoreham	163	1	NA	0	0.0
Newport	4,083	241	11.8	21	1.0
North Kingstown	6,322	146	4.6	31	1.0
North Providence	5,514	211	7.7	42	1.5
North Smithfield	2,456	47	3.8	12	1.0
Pawtucket	16,575	930	11.2	167	2.0
Portsmouth	3,996	82	4.1	15	0.8
Providence	41,634	3,603	17.3	601	2.9
Richmond	1,849	30	3.2	8	0.9
Scituate	2,272	44	3.9	12	1.1
Smithfield	3,625	53	2.9	20	1.1
South Kingstown	5,416	116	4.3	15	0.6
Tiverton	2,998	31	2.1	16	1.1
Warren	1,940	55	5.7	11	1.1
Warwick	15,825	491	6.2	91	1.2
West Greenwich	1,477	25	3.4	2	NA
West Warwick	5,746	272	9.5	43	1.5
Westerly	4,787	192	8.0	26	1.1
Woonsocket	9,888	665	13.5	70	1.4
Four Core Cities	*73,741*	*5,562*	*15.1*	*896*	*2.4*
Remainder of State	*150,215*	*4,381*	*5.8*	*919*	*1.2*
Rhode Island	*223,956*	*9,943*	*8.9*	*1,815*	*1.6*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Hospital Discharge Database, 2010-2014.

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.

**The denominator used to compute the 2010-2014 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.

NA: Rates should not be calculated due to small numbers and the lack of statistical reliability.

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

References

[1,4] Child Trends. (2015). *Asthma.* Retrieved January 20, 2016, from www.childtrendsdatabank.org

[2] *The burden of asthma in Rhode Island.* (2014). Providence, RI: Rhode Island Department of Health, Asthma Control Program.

[3] Ekerholm, S., Pearlman, D. N., Robinson, D., Sutton, N., & Goldman, D. (2012). *Measuring up: A health surveillance update on Rhode Island children with asthma.* Providence, RI: Rhode Island Department of Health, Division of Community, Family Health and Equity, Asthma Control Program.

[5,7] National Health Interview Survey. (2014). *Table C-1a. Age-adjusted percentages (with standard errors) of ever having asthma and still having asthma for children under age 18 years, by selected characteristics: United States, 2014.* Retrieved January 27, 2016, from www.cdc.gov/nchs/nhis

[6] Centers for Disease Control and Prevention. (2012). National surveillance of asthma: United States, 2001-2010. *Vital and Health Statistics, 3*(35), 1-57.

[8] American Lung Association. (2010). *State of lung disease in diverse communities 2010.* Retrieved January 20, 2016, from www.lungusa.org

(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

Homes that are dry, clean, pest-free, safe, contaminant-free, well-ventilated, well-maintained, and thermally-controlled can provide a healthy environment for children and residents.[1] Safe, affordable, and stable housing maintains the health and well-being of families and children, supporting mental and emotional health as well as physical safety.[2] Healthy housing also protects families from weather, environmental hazards, and injury and provides a safe place for children to eat, sleep, play, and grow.[3]

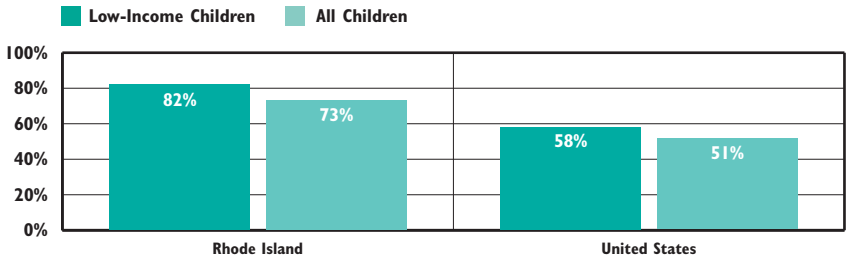
Unhealthy housing can cause or intensify many health conditions. Studies have connected poor quality construction, utility deficiencies, water intrusion, lead paint, radon, and pests to respiratory illnesses, asthma, unintentional injuries, lead poisoning, and cancer. Children under age 14, low-income children, and minority children under age five are at increased risk for fall injuries due to unsafe sleep and home environments, including aging and deteriorating housing.[4,5,6]

Poor quality housing is also a strong predictor of emotional and behavioral problems in low-income children and youth as well as academic achievement. Adolescents living in poorer quality homes have lower reading and math proficiency than their peers.[7]

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, health, 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, academic difficulties, and substance use.[8]

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.[9,10]

Children Living in Older Housing*, 2010-2014, Rhode Island and the United States



Source: Population Reference Bureau analysis of 2010-2014 American Community Survey (ACS) Public Use Microsample (PUMS) data. *Older housing is defined as built before 1980. The ACS reports housing year built by decade, so this is the best available approximation for housing built before 1978 when interior lead paint was banned. Factbooks prior to 2016 are not comparable due to the discontinuation of 3 year ACS data.

◆ **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 2010 and 2014, 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 has the highest percentage of low-income children living in older housing.[11]**

◆ **Rhode Island children (of all incomes) were more likely to live in older housing (73%) than U.S. children (51%) between 2010 and 2014. Rhode Island has the second highest percentage of children living in older housing in the U.S., after New York.[12]**

◆ **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 exposure than children living in the remainder of the state.[13,14]**

◆ **Because affordable housing is in short supply, many low-income families must pay more than 30% of their income for housing, which is a cost-burden. Low-income families who are forced to spend more than they can afford on housing can 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.[15,16]**

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.[17,18]

◆ One in twelve (8.3%) Rhode Island children due to start kindergarten in the fall of 2017 has had a confirmed blood lead level of ≥5 µg/dL, indicating exposure to an environmental lead hazard.[19] 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.[20] The prevalence of childhood lead poisoning has steadily decreased over the past decade.[21]

Asthma

◆ Inadequate ventilation, dust, cockroaches, mold, pet dander, and cigarette smoke can all trigger or exacerbate respiratory problems, including asthma. Asthma is a 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.[22,23]

◆ Between 2010 and 2014, there were 1,806 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.[24,25] In Rhode Island, low-income and minority children residing in the four core cities have higher rates of asthma.[26]

Unintentional Injuries

◆ Falls are the leading cause of non-fatal unintentional injuries among children under age 18 in the U.S.[27] 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.[28]

◆ In 2014, housing-related falls resulted in 4,449 emergency room visits by Rhode Island children. Half (51%) of these visits were for children under age six.[29]

Community Mitigation of Housing Hazards

Lead Screening and Abatement

◆ The state of Rhode Island has enacted many policies and programs to reduce the causes and prevalence of childhood lead poisoning. All Rhode Island children must have at least two blood lead screening tests by age three and annual screenings through age six.[30] In 2015, 84% of all Rhode Island three-year-olds received a blood lead test.[31]

◆ All lead poisoned children (≥5 µg/dL) are referred for non-medical case management and education and those with a blood lead level of ≥15 µg/dL are offered an environmental inspection. In 2015, 68 inspections were offered, of which 41 were performed, 14 were refused, 11 the child moved, and two were pending.[32,33] Funding and services through Rhode Island Housing are also available to make eligible homes lead safe.[34]

Weatherization Assistance Program

◆ Since its inception in 1976, the Weatherization Assistance Program has helped eligible households reduce heating bills by providing whole-house energy efficiency and safety services such as reducing drafts, providing proper ventilation, and installing smoke detectors, insulation, and carbon monoxide detectors. In 2015, 543 children benefited from 848 completed weatherization projects throughout Rhode Island that were administered by seven Community Action Program agencies.[35,36]

References

[1,4,9] The Federal Healthy Homes Work Group. (2013). *Advancing healthy housing: A strategy for action.* Retrieved March 4, 2016, from www.healthyhomes.hud.gov

[2,15] Economic Policy Program Housing Commission. (2013). *Housing America's future: New directions for national policy.* Washington, DC: Bipartisan Policy Center.

[3] Raymond, J., Wheeler, W., & Brown, M. J. (2011). Inadequate and unhealthy housing, 2007 and 2009. *Morbidity and Mortality Weekly Report, 60*, 21-27.

[5] *Home safety fact sheet.* (2015). Washington, DC: Safe Kids Worldwide.

[6] Safe Kids USA. (2011). *Safety from falls.* Retrieved March 1, 2013, from www.safekids.org

[7] Coley, R. L., Leventhal, T., Lynch, A. D., & Kull, M. (2013). *Poor quality housing is tied to children's emotional and behavioral problems: Parents' stress from living in poor quality and unstable housing takes a toll on children's well-being.* Chicago, IL: MacArthur Foundation.

[8] Cutts, D. B., et al. (2011). U.S. housing insecurity and the health of very young children. *American Journal of Public Health, 101*(8), 1508-1514.

[10] *The Surgeon General's call to action to promote healthy homes.* (2009). Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.

(continued on page 177)

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

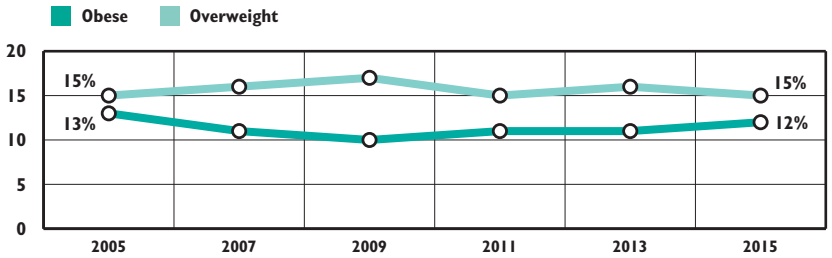
Children and adolescents who are overweight or obese are at immediate and/or long-term risk of many health problems, including type 2 diabetes, cardiovascular disease, asthma, joint pain, sleep apnea, and other acute and chronic health problems. Over time, these conditions may contribute to a shorter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

Over the past four decades, the prevalence of childhood obesity in America has more than tripled, and 17% of U.S. children ages 2-19 were obese in 2013-2014.[6,7] 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] 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.[9]

The health risks of being overweight and obese can be long-lasting.[10,11] Overweight kindergartners are four times as likely as their healthy-weight peers to become obese by eighth grade, two-thirds of obese fifth graders remain obese in tenth grade, and teenagers who are obese have a greater than 70% risk of being obese as adults.[12,13,14] Prevention and intervention for at risk, overweight, and obese children should occur early and at all ages.[15]

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 as well as in early learning programs, and improving access to safe and walkable neighborhoods and recreational areas.[16]

Obesity and Overweight
Among Rhode Island High School Students, 2005-2015



Source: *Youth Risk Behavior Survey*, Rhode Island, 2005-2015. BMI calculated using self-reported student response.

◆ **Rhode Island's overall high school obesity and overweight prevalence has not significantly improved or worsened since 2005. In Rhode Island in 2015, 12% of high school students self-reported as obese and 15% self-reported being overweight. Hispanic students (19%), males (16%), and Black students (15%) were more likely to report being obese compared to their White (10%) and female (8%) high school peers.[17]**

◆ **In October 2015, the BMI values of 14,025 electronic medical health records of children under age 18 residing in Providence who are active patients of a Providence Community Health Center site were examined. The analysis found 23% of Providence children were obese and 18% were overweight. Obesity varied by age: 20% of children ages two to five, 26% of children ages six to 11, and 22% of children ages 12 to 17 were obese. Among Hispanic children, who accounted for 73% of all patients served, 24% were obese.[18]**

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. Many children and adolescents consume diets with too many calories and not enough nutrients.[19]**

◆ **Among Rhode Island high school students in 2015, 13% reported consuming one or more cans of soda daily (down from 25% in 2007) and 83% reported eating less than the recommended five servings of fruits/vegetables daily.[20]**

Promoting Increased Physical Activity

◆ **Recess** is an important component in optimizing a child's social, emotional, physical, and cognitive development.[21] The Institute of Medicine recommends schools offer at least 20 minutes of recess per day for elementary and middle school students and prohibit withholding it.[22] In Rhode Island in 2015, 10 of 39 school districts required 20 minutes or more and 70% of surveyed elementary school principals reported withholding recess for discipline.[23,24]

◆ **Physical Education (PE)** curriculum and instruction are designed to develop age-appropriate motor skills, knowledge and behaviors of physical fitness, sportsmanship, emotional intelligence, self-efficacy, and active living.[25] In Rhode Island, students are required to receive an average of 20 minutes per day of health and PE instruction.[26] Nationally, the daily recommended amount of PE alone is 30 minutes in elementary school and 45 minutes in middle and high school.[27]

◆ **Regular physical activity**, including school-based, has been show to have physical, cognitive and academic benefits, including improved grades and standardized test sores.[28,29] In Rhode Island in 2015, 27% of middle school students and 20% of high school students reported being physically active every day for at least 60 minutes, which is the recommended amount to optimize health and development.[30,31]

Physical Activity and Sedentary Behavior, Rhode Island Middle School and High School Students by Gender, 2015

	MIDDLE SCHOOL			HIGH SCHOOL		
	MALE	FEMALE	ALL STUDENTS	MALE	FEMALE	ALL STUDENTS
2 or Fewer days of Physical Education Weekly	50%	51%	50%	42%	39%	41%
3 or Fewer Days of Physical Activity* Weekly	30%	39%	34%	40%	54%	47%
3 or More Hours of TV on School Days	29%	30%	30%	23%	22%	22%
3 or More Hours of Computer** Time/Video Games on School Days	46%	50%	48%	40%	40%	40%

Source: *2015 Rhode Island Youth Risk Behavior Survey*, Rhode Island Department of Health, Center for Health Data and Analysis. *Defined as at least 60 minutes per day. **Non-school related.

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.[32] In Rhode Island during the 2014-2015 school year, 2,742 children aged three to five were enrolled in a Head Start program. Of those enrolled, 20% were obese and 25% were overweight.[33] Comparable national data show that 16% of children enrolled in Head Start were obese and 13% were overweight during that time.[34]

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.[35] In Rhode Island in 2015, 12,871 children ages two to four were enrolled in WIC, 17% of whom were obese and 43% of whom were overweight.[36]

◆ Since 2011, there has been a 24% 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.[37]

◆ WIC also tracks the number of children under age five who have a biological parent who is obese (i.e., have a BMI over 30). In 2015, 23% of infants and 13% of children ages one to four had a biological parent who was obese.[38]

References

[1] Centers for Disease Control and Prevention. (2015). *About child and teen BMI.* Retrieved March 2, 2016, from www.cdc.gov

[2,10] *Overweight children and youth.* (2014). Washington, DC: Child Trends.

[3,11] Centers for Disease Control and Prevention. (2015). *Childhood obesity causes and consequences.* Retrieved March 2, 2016, from www.cdc.gov

[4,16] *Accelerating progress in obesity prevention: Solving the weight of the nation.* (2012). Washington, DC: Institute of Medicine of the National Academies.

[5] Halfon, N., Larson, K., & Slusser, W. (2013). Associations between obesity and comorbid mental health, developmental, and physical health conditions in a nationally representative sample of US children aged 10 to 17. *Academic Pediatrics, 13*(1), 6-13.

(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. Only 38% of mothers who give birth before age 18 have 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 more likely than their peers to get pregnant by age 19.[3]

Children of teen parents are at increased risk for low birthweight, preterm delivery, infant mortality, child maltreatment, and placement in 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 historic low in 2014, 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 2014.[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 2014 in Rhode Island, 579 babies were born to mothers under age 20, accounting for 6% of all babies born.[13]

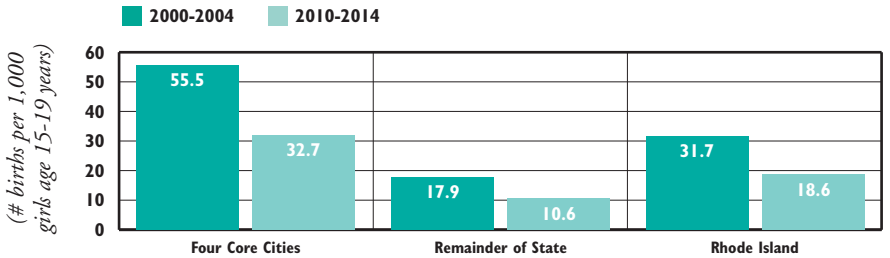
Teen Birth Rates
(rate per 1,000 girls ages 15-19)

	1991	2014
RI	44.7	15.8
US	61.8	24.2
National Rank*		*7th*
New England Rank**		*5th*

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

Sources: For 2014: Martin, J. A., et al. (2015). Births: Final data for 2014. *NVSR, 64*(13), 1-63. For 1991: Ventura, S. J., et al. (2014). National and state patterns of teen births in the United States. *NVSR, 63*(4), 1-33.

Teen Birth Rates, Rhode Island, Five-Year Averages Comparisons, 2000-2004 and 2010-2014



Source: Rhode Island Department of Health, Center for Health Data and Analysis, 2000-2014. Data for births in 2014 are provisional.

◆ **The statewide five year average teen birth rate declined 41% between 2000-2004 and 2010-2014, from 31.7 births per 1,000 teen girls to 18.6. The teen birth rate in the four core cities also declined by 41% during that time.[14]**

◆ **In 2014, the birth rate for U.S. teens (24.2 births per 1,000 teen girls) and Rhode Island teens (15.8 births per 1,000 teen girls) were the lowest ever recorded.[15,16]**

◆ **Despite declines among all racial and ethnic groups, disparities still exist in teen birth rates.[17] In Rhode Island between 2010 and 2014, the teen birth rates for Hispanic (45.9) and Black (33.2) teens were higher than the rates of their White (11.6) and Asian (11.5) peers.[18]**

Repeat Births to Teens, Rhode Island, 2010-2014

AGE	TOTAL NUMBER OF BIRTHS	NUMBER OF REPEAT BIRTHS	PERCENT REPEAT BIRTHS
15-17	1,061	69	6.5%
18-19	2,648	492	18.6%
TOTAL	*3,709*	*561*	*15.1%*

Source: Rhode Island Department of Health, Center for Health Data and Analysis, 2010-2014.

◆ **Nationally, 17% of all births to teens ages 15-19 in 2013 were repeat births. Since 1991, repeat teen births have declined 23% nationwide.[19] To continue to reduce repeat teen births, pregnant and parenting teens should be connected with evidence-based home visiting programs that address a broad range of needs and routinely offer effective postpartum contraception.[20]**

Teen Birth Rates by Age and Location

◆ In Rhode Island between 2010 and 2014, the rate of births to teens ages 15-17 in the core cities (22.8 per 1,000 teen girls) was more than four times higher than in the remainder of state (4.8 per 1,000 teen girls). The birth rate for teens ages 15-17 in Central Falls was 32.7, compared to Woonsocket at 26.8, Providence at 23.6, and Pawtucket at 15.7.[21]

◆ The rate of births to Rhode Island teens ages 18-19 was more than twice as high in the core cities (40.3 per 1,000 teen girls) than in the remainder of state (18.1 per 1,000 teen girls) between 2010 and 2014. The birth rate for teens ages 18-19 in Central Falls was 124.1, compared to Woonsocket at 101.2, Pawtucket at 59.0, and Providence at 29.3.[22]

Table 25. **Births to Teens, Ages 15-19, Rhode Island, 2010-2014**

CITY/TOWN	# OF BIRTHS TO GIRLS AGES 15-17	# OF BIRTHS TO GIRLS AGES 18-19	# OF BIRTHS TO GIRLS AGES 15-19	BIRTH RATE PER 1,000 GIRLS AGES 15-19
Barrington	1	6	7	2.3
Bristol	8	19	27	4.8
Burrillville	4	24	28	11.6
Central Falls	72	180	252	69.0
Charlestown	4	17	21	18.3
Coventry	8	46	54	9.4
Cranston	50	132	182	14.3
Cumberland	12	32	44	8.3
East Greenwich	0	13	13	5.4
East Providence	34	83	117	17.5
Exeter	7	12	19	13.5
Foster	2	5	7	9.1
Glocester	3	10	13	7.6
Hopkinton	6	8	14	11.5
Jamestown	0	2	2	2.8
Johnston	11	47	58	14.3
Lincoln	7	20	27	7.7
Little Compton	0	1	1	NA
Middletown	9	21	30	13.5
Narragansett	4	5	9	3.5
New Shoreham	0	1	1	NA
Newport	25	60	85	16.5
North Kingstown	8	29	37	8.4
North Providence	14	51	65	14.7
North Smithfield	7	8	15	8.1
Pawtucket	112	267	379	32.5
Portsmouth	7	9	16	5.3
Providence	430	946	1,376	27.2
Richmond	1	8	9	8.4
Scituate	1	7	8	4.6
Smithfield	3	12	15	2.9
South Kingstown	4	24	28	2.0
Tiverton	6	12	18	8.4
Warren	4	17	21	15.5
Warwick	42	94	136	12.2
West Greenwich	2	8	10	9.0
West Warwick	37	113	150	38.8
Westerly	14	44	58	18.9
Woonsocket	102	253	355	56.3
Unknown	*0*	*2*	*2*	*NA*
Four Core Cities	*716*	*1,646*	*2,362*	*32.7*
Remainder of State	*345*	*1,000*	*1,345*	*10.6*
Rhode Island	*1,061*	*2,648*	*3,709*	*18.6*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014. Data for births in 2014 are provisional and do not include births among Rhode Island residents that occurred out-of-state.

The denominators for girls ages 15-19 are from the Census 2010 Summary File 1, which are then multiplied by five.

NA: Rates should not be calculated due to small numbers and the lack of statistical reliability.

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 15-17. The definition of teen childbearing was expanded to include teens ages 15-19 to align with reports from the U.S. Centers for Disease Control and Prevention's National Center for Health Statistics.

NA: Rates should not be calculated due to small numbers and the lack of statistical reliability.

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

References

[1] *2016 public policy agenda.* (2016). Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.

[2] *Teen pregnancy, poverty and income disparity.* (2010). Washington, DC: The National Campaign to Prevent Teen Pregnancy.

[3,5] *Teen childbearing and child welfare.* (2013). Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.

[4,11] *Teen births.* (2015). Washington, DC: Child Trends.

[6] *Teen childbearing, education, and economic wellbeing.* (2012). Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.

(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 report having used alcohol, illegal drugs, or tobacco products.

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, poor school achievement, peer and parental substance abuse, chaotic home environment, and poverty. Protective factors lessen the risk of drug use, and include a strong parent-child bond, healthy school environment, academic competence, and neighborhood pride.[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, but recently these differences have narrowed due to an increased use of marijuana among Black students.[9,10]

Teen substance abuse can be prevented or reduced by enacting policies that support prevention, screening, early intervention, treatment, and recovery. Policy examples include preventing the sale of substances to minors, improving school climate and academic achievement, enacting sentencing reform, and sustaining adequate funding for multi-sector youth development, treatment, and recovery services.[11]

In Rhode Island in 2013-2014, 3% of youth ages 12-17 needed but did not receive specialty treatment for their alcohol use problem, which is the 15th highest rate among all states. Four percent of Rhode Island youth ages 12-17 needed but did not receive any specialty treatment for their illicit drug use. Rhode Island has the seventh highest state percentage on this measure.[12]

Tobacco Use Among Rhode Island Youth

◆ **Cigarettes: Cigarette use has reached record low levels among U.S. middle and high school students.[13] In 2015, 5% of Rhode Island high school students reported smoking cigarettes in the past 30 days, which is a statistically significant decrease from 2013, when 8% reported current cigarette smoking. Nearly half (46%) of Rhode Island high school students who reported current cigarette use in 2015 also reported trying to quit smoking in the past year.[14]**

◆ **Electronic Vapor Products: Among U.S. adolescents in 2015, e-cigarette use was higher than use of traditional tobacco cigarettes or any other tobacco product.[15] In Rhode Island in 2015, 41% of high school students reported ever using an electronic vapor product and 19% reported using an electronic vapor product in the past 30 days. Current use was highest among Rhode Island high school seniors (25%), White students (21%), and males (20%).[16] In 2014, Rhode Island became one of 48 states to prohibit the sale of electronic nicotine delivery systems to minors.[17]**

◆ **Hookah: The prevalence of smoking tobacco using a hookah has been rising among adolescents nationally since 2010, with most use being less than two occasions.[18] In 2015, 12% of Rhode Island high school students reported using a hookah to smoke tobacco in the past 30 days. Rates of current use were highest among Rhode Island Hispanic students (16%), seniors (15%), and females (13%).[19]**

◆ **Cigars: Use of small cigars (cigarillos) among U.S. adolescents has declined significantly since 2010.[20] In Rhode Island in 2015, 8% of high school students reported smoking cigars in the past 30 days. Current cigar use was highest among Rhode Island high school seniors (13%) and males (12%), as well as among Hispanic (9%), Black (8%), and White (8%) students.[21]**

◆ **Smokeless Tobacco: After rising in the mid-2000s, use of smokeless tobacco by U.S. adolescents has been in decline since 2010.[22] In 2015, 5% of Rhode Island high school students reported using smokeless tobacco, with males (8%), seniors (8%), and Black (7%) youth reporting the highest levels of use.[23]**

Current Substance Use, Rhode Island High School Students by Select Subgroups, 2015

	ALCOHOL USE	BINGE DRINKING*	TOBACCO USE**	MARIJUANA USE	PRESCRIPTION DRUG MISUSE***
Female Students	30%	14%	21%	23%	6%
Male Students	22%	12%	28%	24%	7%
Black Students	20%	11%	21%	24%	5%
White Students	28%	13%	26%	24%	5%
Multiple Race Students	28%	13%	28%	26%	12%
Hispanic Students	27%	14%	23%	23%	8%
9th Grade Students	15%	6%	20%	13%	6%
10th Grade Students	22%	10%	24%	19%	5%
11th Grade Students	30%	15%	21%	28%	5%
12th Grade Students	37%	21%	34%	33%	7%
ALL STUDENTS	*26%*	*13%*	*25%*	*24%*	*6%*

Source: *2015 Rhode Island Youth Risk Behavior Survey,* Rhode Island Department of Health, Center for Health Data and Analysis. Current use is defined as students who answered yes to using respective substances in the 30 days prior to the survey. *Binge drinking is defined as drinking five or more drinks within a couple of hours. **Tobacco includes cigarettes, smokeless tobacco, cigars, or electronic vapor products. ***Prescription drug misuse is defined as those without a doctor's prescription.

◆ Among Rhode Island high school students in 2015, 26% reported current (i.e., in the past 30 days) alcohol consumption, 25% reported current tobacco use, 24% reported current marijuana use, 13% reported current binge drinking, 6% reported current prescription drug misuse, and 5% reported using over-the-counter drugs to get high during the past 30 days.[24]

◆ In Rhode Island In 2015, 9% of high school students reported ever (i.e., in their lifetime) using synthetic marijuana, 6% reported ever using inhalants, 5% reported ever using ecstasy, 5% reported ever using cocaine, 4% reported ever using heroin, and 4% reported ever taking steroids without a doctor's prescription.[25]

◆ In 2015, a majority of Rhode Island high school students reported that they have never taken a prescription drug without a doctor's prescription (88%), tried cigarette smoking (78%), used marijuana (61%), nor used an electronic vapor product (59%). Nearly half (48%) of Rhode Island high school students also reported never having consumed alcohol.[26]

Family and Community Risk Factors

◆ Having parents or friends who use tobacco, alcohol, and other drugs, as well as living in communities in which there is drug dealing and use are risk factors for teen substance use.[27] In Rhode Island in 2015, 32% of Rhode Island high school students reported living with someone who smokes cigarettes. One in five (22%) Rhode Island high school students under age 18 who used an electronic vapor product during the past 30 days reported buying them in a store (despite laws prohibiting such purchases). One in ten (10%) high school students who had ever taken a prescription drug without a doctor's prescription reported buying it at school.[28]

Babies Born with Exposure to Substances

◆ Babies born with exposure to opioids (pain medication) face immediate and long-term negative outcomes. Neonatal Abstinence Syndrome (NAS) refers to the withdrawal and negative effects experienced by newborns born to mothers who use opioids and/or other drugs during pregnancy.[29]

◆ In Rhode Island in 2014, 97 babies were diagnosed with NAS, a rate of 92 per 10,000 births, up from 76 babies (for a rate of 72 per 10,000 births) in 2013 and more than double the rate of 37.2 in 2006. Eighty-eight percent of babies born with NAS between 2010 and 2014 in Rhode Island were born to White mothers, 85% had Medicaid coverage, and 34% lived in the four core cities and 66% lived in the remainder of the state.[30]

◆ Mothers' smoking during pregnancy is associated with adverse outcomes for children, including preterm births, low birthweight, and infant mortality.[31] Nationally, one in ten women who gave birth in 2014 smoked during the three months before they became pregnant and nearly one-quarter of those women quit smoking before pregnancy.[32]

◆ In Rhode Island between 2010 and 2014, 8% (4,130) of all births were to women who smoked during their pregnancy. During that time, Rhode Island mothers who smoked had higher percentages of low birthweight (12.3%) and preterm births (12.0%) compared to mothers who did not smoke (6.9% and 8.7% respectively).[33]

References

[1] *Binge drinking.* (2015). Washington, DC: Child Trends.

(continued on page 178)

Safety

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.[1,2]

The U.S. child death rate has declined over the past three decades but disparities still exist by age group, gender, as well as race and ethnicity. Children ages one to four are more likely to die than children ages five to 14 and the child death rate is higher for male children than female children. The child death rate is also higher for Black children than for children of other racial and ethnic groups.[3,4]

In Rhode Island between 2010 and 2014, there were 92 deaths of children ages one to 14 (a rate of 10.4 per 100,000 children in that age range). Thirty-five (38%) of these children lived in the four core cities and 57 (62%) lived in the remainder of the state. Of the 92 deaths, 59 (64%) were due to disease, 14 (15%) were due to unintentional injuries, 12 (13%) were due to intentional injuries (nine suicides and three homicides), and seven (8%) were due to other causes.[5,6]

Children are particularly vulnerable to injury due to their size, development, inexperience, and natural curiosity.[7] Unintentional injuries are the leading cause of death for children ages one to 14 in Rhode Island and in the U.S. and account for nearly one-third of all deaths among children ages one to 14 nationally.[8,9,10]

Nationally, the leading causes of child injury deaths are motor vehicle crashes and drowning.[11] Child injury deaths can be reduced by educating 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 safety seats), and through continued environmental and product design improvements (such as flame-resistant sleepwear and safety surfacing on playgrounds).[12]

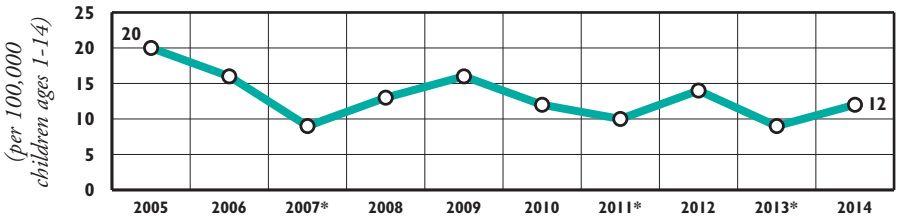
Child Death Rate
(per 100,000 Children Ages 1-14)

	2004	2014
RI	11	12
US	21	16
National Rank*		*4th*
New England Rank**		*3rd*

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

Source: Centers for Disease Control and Prevention, CDC WONDER, wonder.cdc.gov

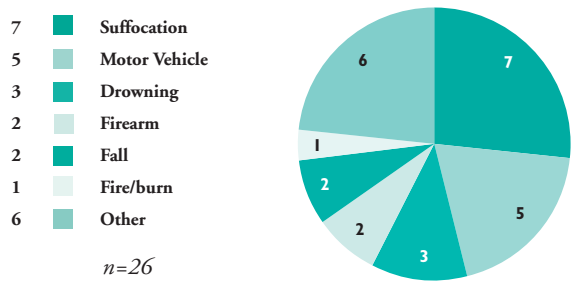
Child Death Rate per 100,000 Children Ages One to 14, Rhode Island, 2005-2014



Source: The Centers for Disease Control and Prevention, CDC WONDER, wonder.cdc.gov. *Caution should be used with small numbers in numerators and denominators (there were 20 deaths or fewer in 2007, 2011, and 2013).

◆ **In 2014, Rhode Island's child death rate for children ages one to 14 was 12 per 100,000 children. This was an increase from the rate of 9 deaths per 100,000 children in 2013 and resulted in Rhode Island's rank falling from best to 4th in the U.S.[13]**

Child Deaths Due to Injury, by Cause, Rhode Island, 2010-2014



Source: Rhode Island Department of Health, Center for Health Data and Analysis, 2010-2014.

◆ **Between 2010 and 2014, 26 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.[14]**

References

[1] *2015 KIDS COUNT data book.* (2015). Baltimore, MD: The Annie E. Casey Foundation.

[2,3,10] *Infant, child, and teen mortality.* (2015). Washington, DC: Child Trends.

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

(continued on page 178)

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 2010 and 2014, there were 100 deaths of teens ages 15 to 19 in Rhode Island, a rate of 26.0 per 100,000 teens.[9,10] Thirty-seven of these teens lived in the four core cities and 63 lived in the remainder of the state.[11]

Of the teen deaths between 2010 and 2014, 32 were due to unintentional injuries, 27 were due to intentional injuries, 27 were due to disease, eight were due to overdose, and six were of other or unknown causes. Of the intentional injury deaths, 15 were suicides and 12 were homicides.[12]

According to the *2015 Rhode Island Youth Risk Behavior Survey*, 11% of Rhode Island high school students reported attempting suicide one or more times during the past 12 months, a decrease from 14% in 2013.[13] Of the 15 youth ages 15 to 19 who died from suicide between 2010 and 2014 in Rhode Island, 12 were male and three were female.[14] Mental health problems, such as depression as well as substance abuse are associated with an increased risk of suicide among youth.[15]

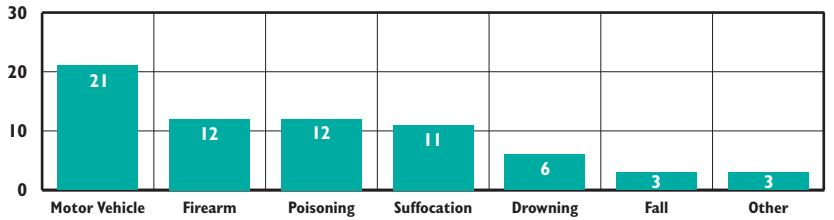
Teen Death Rate
(per 100,000 Youth Ages 15-19)

	2004	2014
RI	54	22
US	66	46
National Rank*		*1st*
New England Rank**		*1st*

**1st is best; 50th is worst*
***1st is best; 6th 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, 2010-2014



n=68

Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2010-2014. 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. Data for 2014 are provisional.

◆ **Between 2010 and 2014 in Rhode Island, 59% of the 68 teen deaths caused by injury were unintentional. Thirty-one percent of all injury deaths involved motor vehicles.[16]**

◆ **Among the 23 teens ages 15 to 19 killed in Rhode Island motor vehicle crashes between 2010 and 2014, 13 were driving, nine were passengers in vehicles driven by others, and one was a bicyclist.[17]**

◆ **Six (46%) of the teen drivers who died in motor vehicle crashes in Rhode Island between 2010 and 2014 had been drinking and two teen fatalities occurred with adult drivers who had been drinking.[18]**

◆ **Thirteen (65%) of teen drivers and passengers killed in automobile accidents in Rhode Island between 2010 and 2014 were not wearing a seatbelt.[19]**

◆ **Eighteen percent of Rhode Island high school students report riding in a vehicle driven by someone who had been drinking in the past month and 6% report that they never or rarely wear a seatbelt while riding in a car driven by someone else. Forty-six percent reported texting or e-mailing while driving on at least one day in the past month.[20]**

References

[1,6] Shore, R. & Shore, B. (2009). *KIDS COUNT indicator brief: Reducing the teen death rate.* Baltimore, MD: The Annie E. Casey Foundation.

(continued on page 178)

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]

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.[5,6,7] Youths who are victims of violence are at increased risk for developing physical and mental health problems, having academic difficulties, smoking, engaging in high-risk sexual behavior, and suicide.[8]

Nationally in 2013, 25% of students in grades nine through 12 reported being in a physical fight during the previous year, 20% reported being bullied at school during the previous year, and 18% reported carrying a weapon during the previous month.[9]

The number of juveniles arrested for violent crimes in the U.S. reached a 33-year low in 2012, with juveniles making up 12% of all serious violent crime arrests. The Rhode Island juvenile arrest rate for serious violent crimes was 128 per 100,000 youth ages 10 to 17, compared to the U.S. rate of 187 per 100,000 youth ages 10 to 17.[10] In 2014 in Rhode Island, there were 476 juvenile arrests for assault offenses and 110 juvenile arrests for weapons offenses.[11] In 2015, violent crimes made up 5% (234) of the 4,885 juvenile offenses referred to Rhode Island Family Court.[12]

Violent Behavior and Victimization, Rhode Island Public High School Students, 2015

	FEMALES	MALES	TOTAL
Been bullied on school property during the past 12 months	16%	15%	16%
Carried a weapon such as a gun, knife, or club on school property one or more of 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	5%	7%	6%
Were in a physical fight one or more times on school property during the past 12 months	7%	11%	9%
Experienced physical dating violence in the past 12 months (among those who have dated someone during the past 12 months)	10%	8%	9%
Were ever physically forced to have sexual intercourse when they did not want to	10%	6%	8%

Source: *2015 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 2015, 6% of high school students reported not going to school due to safety concerns and 16% had been bullied at school in the past year.[14]**

◆ **Witnessing violence can cause emotional, physical, and mental harm, even for children who are not the direct victims of violence. Early, chronic exposure to violence can damage a child's brain development and condition them to react with fear and anxiety to a range of circumstances.[15]**

◆ **Cyberbullying is bullying that takes place through computers, cell phones, and other electronic devices.[16] In 2015 in Rhode Island, 21% of middle school students (30% of females and 12% of males) and 12% of high school students (15% of females and 10% of males) reported being electronically bullied.[17]**

Gun Violence Among Youth

◆ **Guns are the leading instrument of fatal violence to teens and are used in 88% of teen homicides and 41% of teen suicides in the U.S.[18] In Rhode Island between 2010 and 2014, there were 136 emergency department visits for gunshot injuries, 53 hospitalizations, and 12 deaths of youth ages 15 to 19 attributed to firearms.[19]**

Table 26.

Youth Violence, Rhode Island

	COMMUNITY CONTEXT		VIOLENCE IN HIGH SCHOOLS, 2014		JUVENILE ARRESTS FOR VIOLENCE, 2014		
CITY/TOWN	VIOLENT CRIME OFFENSES (ALL AGES) 2014	TOTAL POPULATION AGES 11-17 2010	% OF STUDENTS SAW ANOTHER STUDENT BRING A WEAPON TO SCHOOL IN PAST YEAR	% OF STUDENTS IN A PHYSICAL FIGHT AT SCHOOL IN PAST YEAR	# FOR ASSAULT OFFENSES	# FOR WEAPONS OFFENSES	TOTAL # FOR ASSAULT AND WEAPONS OFFENSES
Barrington	4	2,186	14%	6%	1	1	2
Bristol	12	1,545	12%	11%	4	0	4
Burrillville	14	1,526	10%	8%	2	0	2
Central Falls	134	2,089	12%	11%	17	13	30
Charlestown	5	659	23%	9%	1	0	1
Coventry	25	3,509	23%	8%	15	0	15
Cranston	106	6,984	16%	10%	8	2	10
Cumberland	18	3,271	21%	8%	6	1	7
East Greenwich	4	1,671	13%	5%	0	0	0
East Providence	52	3,730	18%	8%	16	1	17
Exeter	NA	673	11%	7%	NA	NA	NA
Foster	11	467	20%	10%	1	0	1
Glocester	4	1,000	20%	10%	0	0	0
Hopkinton	4	826	23%	9%	0	0	0
Jamestown	2	528	14%	8%	2	0	2
Johnston	42	2,376	24%	11%	8	2	10
Lincoln	12	2,189	12%	7%	1	0	1
Little Compton	1	284	11%	7%	1	0	1
Middletown	19	1,504	12%	9%	10	3	13
Narragansett	5	1,052	21%	6%	7	0	7
New Shoreham	0	64	NA	NA	0	0	0
Newport	95	1,484	24%	10%	33	7	40
North Kingstown	29	2,917	14%	8%	4	2	6
North Providence	49	2,303	17%	7%	13	1	14
North Smithfield	3	1,132	10%	6%	2	0	2
Pawtucket	208	6,268	15%	10%	52	10	62
Portsmouth	13	1,881	11%	7%	6	3	9
Providence	927	16,024	18%	10%	162	48	210
Richmond	5	759	23%	9%	3	0	3
Scituate	3	1,143	13%	8%	0	0	0
Smithfield	6	1,729	10%	8%	12	1	13
South Kingstown	14	2,498	16%	9%	9	0	9
Tiverton	19	1,318	13%	12%	8	0	8
Warren	16	777	12%	11%	2	0	2
Warwick	84	6,781	14%	10%	21	2	23
West Greenwich	8	678	11%	7%	1	0	1
West Warwick	61	2,139	13%	9%	5	0	5
Westerly	25	2,003	13%	7%	7	3	10
Woonsocket	219	3,649	22%	12%	32	8	40
State Police/Other	*NA*	*NA*	*NA*	*NA*	*4*	*1*	*5*
Four Core Cities	*1,488*	*28,030*	*NA*	*NA*	*263*	*79*	*342*
Remainder of State	*770*	*65,586*	*NA*	*NA*	*209*	*30*	*239*
Rhode Island	*2,258*	*93,616*	*16%*	*9%*	*476*	*110*	*586*

Sources of Data for Table/Methodology

Total violent crime offense data are from U.S. Department of Justice, Federal Bureau of Investigation. (2015). *Crime in the United States 2014: Rhode Island offenses known to law enforcement.* Retrieved January 19, 2016, 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. Due to a change in the *SurveyWorks!* question format, the weapons data in *Violence in High Schools* cannot be compared to previous Factbooks. 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.

Juvenile arrests for assault and weapons offenses data are from Mongeau, T. & Tocco, G. (2015). *2014 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

[1,6] *Understanding youth violence: Fact sheet. (2015).* Retrieved January 19, 2016, from www.cdc.gov

[2,4,5,9] David-Ferdon, C. & Simon, T. R. (2014). *Preventing youth violence: Opportunities for action.* Atlanta, GA: Centers for Disease Control and Prevention.

(continued on page 178)

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]

In the U.S. during 2014, 57% of the 2,549 firearm deaths of children and youth under age 20 in the United States were the result of homicide, 36% 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).[4]

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.[5,6] Of the 2,549 U.S. children and youth under age 20 killed by firearms during 2014, 82% (2,089) were ages 15 to 19. Children under age 15 have the lowest rates of firearm-related deaths of any age group.[7]

Nationally, males ages 15 to 19 are 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 (47 per 100,000) was more than three times the rate of Hispanic males (13 per 100,000) and more than four times the rate of White males (11 per 100,000) in 2014.[8]

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.[9,10,11]

Gun-Related Emergency Department (ED) Visits, Hospitalizations, and Deaths Among Children and Youth, Rhode Island, 2010-2014

AGE	# OF ED VISITS	# OF HOSPITALIZATIONS	# OF DEATHS
1 to 14	53	6	2
15 to 17	62	20	3
18 to 19	74	33	9
TOTAL	*189*	*59*	*14*

Source: Rhode Island Department of Health, Center for Health Data and Analysis, 2010-2014. Data for 2014 are provisional.

◆ **Between 2010 and 2014 in Rhode Island, 14 (15%) of the 94 injury deaths of children and youth under age 20 were the result of firearms, down from 19 deaths between 2009-2013. Of these, 64% (9) were among youth ages 18 to 19, 21% (3) were among youth ages 15 to 17, and 14% (2) were among children ages 14 or younger. Between 2010 and 2014 in Rhode Island, there was one youth under age 20 who committed suicide using a firearm.[12]**

◆ **In Rhode Island between 2010 and 2014, there were 189 emergency department visits and 59 hospitalizations of children and youth for gun-related injuries. down from 198 and 73, respectively, in 2009-2003.[13]**

Weapon Carrying Among Rhode Island Public High School Students, 2015

	FEMALES	MALES	TOTAL
Carried a weapon on school property at least once in the past 30 days	2%	7%	5%

Source: *2015 Rhode Island Youth Risk Behavior Survey,* Rhode Island Department of Health, Center for Health Data and Analysis.

◆ **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., Kochanek, K. D., Xu, J., & Heron, M. (2015). Deaths: Final data for 2012. *NVSR, 63*(9). Retrieved January 12, 2016, from www.cdc.gov

[2] U.S. Department of Justice, Attorney General's National Task Force on Children Exposed to Violence. (2012). *Report of the U.S. Department of Justice National Task Force on Children Exposed to Violence.* Retrieved from www.justice.gov

[3] Child Trends. (2013). *Children's exposure to violence.* Retrieved January 12, 2016, from www.childtrendsdatabank.org

[4,7] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (n.d.). *Web-based Injury Statistics Query and Reporting System (WISQARS).* Retrieved January 13, 2016, from www.cdc.gov/ncipc/wisqars

(continued on page 179)

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. Homeless youth with foster care histories often become homeless at an earlier age and remain homeless longer than their peers.[3] When youth "age out" of foster care at age 18 without permanent families, they are more likely to experience homelessness.[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 needed food, clothing, and shelter, so many turn to prostitution, theft, and/or selling drugs to provide for their basic needs. Consequently, homeless youth face risk of arrest, pregnancy, and/or contracting sexually transmitted infections.[11,12]

Homeless youth often are disconnected from education, employment, medical, and mental health care.[13,14] They 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

◆ Blackstone Valley Community Action Program runs a Basic Center Program and two drop-in centers for unaccompanied and runaway homeless youth in Rhode Island. The drop-in centers are located at the Blackstone Valley Community Action Program's main site in Pawtucket and at the Institute for the Study and Practice of Nonviolence in Providence. They offer food, clothing, hygiene products, and preventive services and connect youth to host home opportunities. This site became a federal Family and Youth Services Bureau grantee on October 1, 2014.[22]

◆ During the 2014-2015 school year, Rhode Island public school personnel identified 37 unaccompanied homeless youth.[23]

◆ In 2015, 47 single youth ages 18 to 20 and 125 young adults ages 21 to 24 received emergency shelter services though the adult emergency shelter system in Rhode Island, compared to 97 18 to 20 year-olds and 266 21 to 24 year-olds in 2014.[24,25]

◆ In 2014, the National Runaway Switchboard handled 148 crisis-related calls regarding youth ages 21 and under who were homeless, runaways, or at risk of homelessness in Rhode Island, up from 104 in 2013. Nationally, 62% of callers to the Switchboard were youth and the remainder were friends, family, probation officers, and other adults.[26,27]

◆ On December 31, 2015, there were 36 youth in the care of the Rhode Island Department of Children, Youth and Families between the ages of 12 and 18 who were classified as unauthorized absences/runaways (AWOL), 23 females and 13 males, down from 52 last year. These youth were AWOL from either foster care or juvenile justice placements.[28]

◆ There were an additional 160 youth ages 13 to 17 who received emergency shelter services with their families in Rhode Island in 2014.[29] These youth are vulnerable to being separated from their families due to shelter or child welfare policies.[30]

References

[1,3,10,11,13,17,30] National Conference of State Legislatures. (2013). *Homeless and runaway youth.* Retrieved February 23, 2016, from www.ncsl.org

[2] Bardine, D. (2015). *What works to end youth homelessness.* Washington, DC: The National Network for Youth.

(continued on page 179)

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 parental supervision and attachment, child maltreatment, and community disorganization, poverty, and crime.[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 2015 in Rhode Island, 2,770 youth (3% of Rhode Island youth between the ages of 10 and 17) were referred to Family Court, up from 2,713 youth during 2014. Fewer offenses (4,885) were referred to Family Court in 2015 than during the previous year, when 4,904 offenses were referred. Of the juvenile offenses in 2015, 234 (5%) involved violent offenses (55% of which occurred in the four core cities). An additional 589 probation violations also came before the Family Court in 2015.[3,4,5]

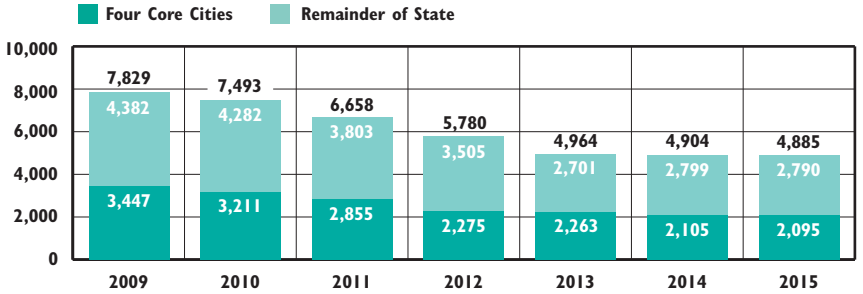
In 2015 in Rhode Island, 24% of juvenile offenses referred to Family Court were committed by youth from Providence, 19% were committed by youth from the other three core cities, and 57% were committed by youth living in the remainder of the state.[6,7]

Assessing the risk of re-arrest and intervention needs of each youth is necessary for providing appropriate supports to prevent recidivism.[8] Eighteen percent of youth referred to the Family Court in 2015 had been referred once before, and 20% had been referred at least twice before.[9]

Research shows that 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]

Programs that facilitate behavior change by improving a youth's skills, relationships, and insight are more effective at preventing recidivism than those that emphasize discipline and threat of consequences. Effective interventions include individual, group, and family counseling, mentoring programs, academic and vocational training, case management services, and restorative justice practices.[11]

Juvenile Wayward/Delinquent Offenses Referred to Rhode Island Family Court, 2009-2015



◆ **The number of children and youth referred to Family Court for wayward and delinquent offenses declined 43% between 2009 and 2015, from 4,825 to 2,770. During the same period, the number of juvenile offenses declined by 38%, from 7,829 to 4,885.**

◆ **In 2015, 68% of offenses referred to the Family Court involved males and 32% females. Forty-six percent of offenses involved White youth, 22% Black youth, 16% Hispanic youth, 1% Asian youth, and 16% of offenses involved youth of some other race or an unknown race.**

◆ **In 2015, 8% of offenses referred to Family Court involved youth ages 12 or younger, 43% youth ages 13 to 15, 48% youth ages 16 to 17, and 1% of unknown age.**

BY TYPE OF OFFENSE

25%	Status Offenses*	4%	Motor Vehicle Offenses
21%	Property Crimes	3%	Weapons Offenses
21%	Disorderly Conduct	2%	Alcohol and Drug Offenses
11%	Simple Assault	7%	Other**
5%	Violent Crimes		

n=4,885

**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, *2009-2015 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.[12] In 2015 in Rhode Island, 20% of all cases referred to Family Court were diverted instead of proceeding to a formal court hearing, the same as in 2014.[13]

◆ The Rhode Island Family Court administers several alternatives to traditional court hearings, including the Truancy Court and the Juvenile Drug Court. In 2015, 1,353 juveniles were referred to the Truancy Court by schools. In 2015, 53 juveniles who committed drug offenses or had highlighted drug issues were diverted to the Juvenile Drug Court pre-adjudication.[14] Juveniles referred to the Drug Court undergo a six- to twelve-month program that includes intensive court supervision, drug treatment, and educational and employment services.[15]

◆ In 2014, there were 35 Juvenile Hearing Boards in Rhode Island. Four communities did not have Juvenile Hearing Boards (Little Compton, North Providence, Richmond, and South Kingstown). Comprised of volunteer community members, these Boards permit the diversion of juveniles 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 374 cases in 2014 (the most recent year for which data are available).[16]

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 behavior (like engaging in commercial sexual activity), and truancy related to safety issues at school. 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.[17]

Juveniles Tried as Adults in Rhode Island

◆ 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 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, learning, and relationship skills.[18]

◆ 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 to resist peer pressure. Research also shows that judgment and decision-making skills do not fully develop until the mid-twenties.[19,20]

◆ 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.[21]

◆ In 2015, the Attorney General's Office filed 20 (19 discretionary and one mandatory) motions to waive jurisdiction to try juveniles as adults. Of the discretionary waiver motions, five youth were waived voluntarily, three were waived after a hearing, three waiver motions were amended to certification after the youth pled to an adult sentence, and eight were pending before the Family Court at the end of 2015.[22]

◆ 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 was one certification filed in 2015 (which resulted in certification). 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.[23,24]

References

[1] Development Services Group, Inc. (2015). *Risk factors for delinquency-Literature review.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

[2] Rhode Island Family Court. (n.d.). *About the Family Court.* Retrieved February 25, 2013, from www.courts.ri.gov

(continued on page 179)

Youth at the Training School

DEFINITION

Youth at the Training School is the number of juveniles 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

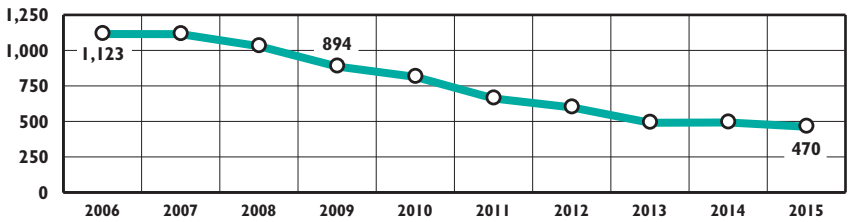
The juvenile justice system is responsible for ensuring community safety by promoting the positive development of youth in its care while recognizing that children have different developmental needs than adults.[1]

During adolescence, the brain's executive functions (including the ability to regulate emotions, control impulses, and weigh benefits and risk) have not fully developed. 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]

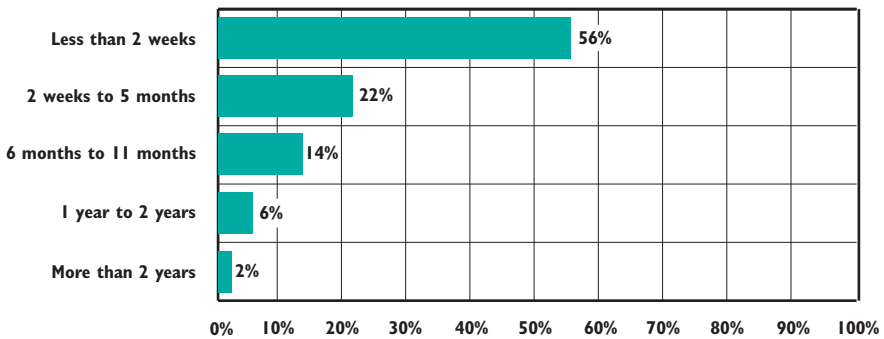
The Rhode Island Department of Children, Youth and Families (DCYF) operates the Rhode Island Training School, the state's secure facility for adjudicated youth and youth in detention awaiting trial. A total of 470 youth (76% male and 24% female) were in the care or custody of the Training School at some point during 2015, down from 500 during 2014. The number of females at the Training School increased by 54% between 2014 and 2015, while the number of males decreased by 16%. On December 31, 2015, there were 136 youth in the care or custody of the Training School, 84 of whom were physically at the Training School.[7]

Youth in the Care and Custody of the Rhode Island Training School, Calendar Years 2006-2015



◆ **Between 2006 and 2015, the annual total number of youth in the care and custody of the Training School any point during the year declined from 1,123 to 470. 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 47% between 2009 and 2015.**

Discharges From the Rhode Island Training School, by Length of Time in Custody, Calendar Year 2015



n=586

Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2006-2015. Total discharges (586) are higher than the total number of youth who passed through the Training School (470) due to some youth being discharged from the Training School more than once in 2015.

Youth at the Training School by Age

◆ During 2015, there were no children age 10 or under, eight children ages 11-12, 70 youth ages 13-14, 231 youth ages 15-16, and 206 youth ages 17-19 held at the Training School. The average age for youth at the Training School was 15.9 years.[8]

◆ Rhode Island is one of 12 states that has no statutory minimum age for holding children in secure confinement and no minimum age of delinquency jurisdiction.[9,10]

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 that mandates the use of a screening tool (called a Risk Assessment Instrument, RAI) for Rhode Island youth being considered for secure detention. The RAI has been piloted but has not yet been fully implemented.[15,16]

◆ Of the 470 youth who were in the care or custody of the Training School at some point during 2015, 21% (101) were admitted at least twice in 2015, and 6% (28) were admitted to the Training School three or more times.[17]

Probation for Rhode Island Youth

◆ The purpose of Juvenile Probation is to provide supervision and monitoring to youth who are under court jurisdiction to ensure that they comply with court orders and conditions of probation.[18] The Juvenile Probation division at DCYF serves youth placed in community-based residential settings as well as those living at home and in foster care. Youth on probation have access to an array of services to help support them in the community and reduce the likelihood that they will reoffend.[19]

◆ On January 4, 2016, there were 516 youth on the DCYF probation caseload (431 males and 85 females). Three percent of youth on probation were ages 11-13, 22% were ages 14-15, 54% were ages 16-17, and 20% were age 18 or older.[20]

◆ Almost half (44%) of youth on probation on January 4, 2016 were White, 24% were Black, 2% were American Indian, 1% was Asian, 8% were multiracial, and 21% were of undetermined race. Twenty-nine percent of youth were identified as Hispanic, who may be of any race.[21]

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.[22]

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, receive harsher treatment, and remain in the system than White youth.[23] 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.[24]

Disproportionate Minority Contact in Rhode Island

	% OF TOTAL CHILD POPULATION, 2010	% OF YOUTH IN THE CARE AND CUSTODY OF RHODE ISLAND TRAINING SCHOOL, 2015
White	64%	32%
Hispanic	21%	33%
Black	6%	23%
Asian	3%	2%
Multi-Racial	5%	7%
Other*	2%	1%
Unknown	NA	2%
n=	*223,956*	*470*

◆ Youth of color are disproportionately more likely than White youth to be detained or sentenced to the Training School. During 2015, Black youth made up 23% 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 make up a growing share of youth involved 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 use a developmental approach that addresses the social contexts that influence girls' behavior, including family, peers, and community.[25]

Risk Factors for Rhode Island Youth at the Training School

History of Child Abuse and Neglect

◆ Thirty-three (7%) of the 470 youth in the care or custody of the Training School during 2015 had at some point in their childhood been victims of documented child abuse or neglect.[26]

◆ Children who experience child abuse or neglect are at an increased risk for developing behavior problems and becoming involved in the juvenile justice system.[27]

Behavioral Health Needs

◆ In 2015, 173 youth (128 males and 45 females) received mental health services at the Training School for psychiatric diagnoses other than conduct disorders and substance abuse disorders. During 2015, 115 residents (91 males and 24 females) received substance abuse treatment services at the Training School. Of these, 60 (all males) received residential substance abuse treatment. Eighty-one youth sentenced to the Training School received psychopharmacologic treatment during 2015.[28]

Educational Attainment

◆ While the average age of youth at the Training School in 2015 was 15.9 years of age, 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 ninth through twelfth grade who received educational services at the Training School during 2015, 30% received special education services and had Individualized Education Plans (IEPs).

◆ During 2015, 33 youth graduated from high school while serving a sentence at the Training School (25 earned a GED and 8 graduated with a high school diploma). An additional 30 youth received post-secondary education services at the Training School in 2015.[29]

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).[30]

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 only two 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.[31,32]

- Some youth are detained for short periods of time and released at their first court appearance (usually the following business day). Of the 586 discharges from the Training School during 2015, 24% resulted in stays of two days or less, 32% resulted in stays of three days to two weeks, and 44% resulted in stays of more than two weeks.[33]

Table 27. **Youth in the Care or Custody of the Rhode Island Island Training School, 2015**

CITY/TOWN	TOTAL POPULATION AGES 13-18	# OF ADJUDICATED YOUTH AT THE RITS	TOTAL # OF YOUTH AT THE RITS
Barrington	1,802	0	3
Bristol	1,780	0	1
Burrillville	1,319	0	4
Central Falls	1,859	14	30
Charlestown	554	1	3
Coventry	3,010	9	10
Cranston	6,184	11	22
Cumberland	2,746	3	4
East Greenwich	1,362	1	1
East Providence	3,243	6	16
Exeter	642	1	3
Foster	430	0	0
Glocester	878	0	2
Hopkinton	693	1	1
Jamestown	436	0	0
Johnston	2,025	1	6
Lincoln	1,851	2	5
Little Compton	228	0	0
Middletown	1,229	3	4
Narragansett	948	0	2
New Shoreham	50	0	0
Newport	1,604	8	22
North Kingstown	2,407	2	3
North Providence	2,027	3	9
North Smithfield	970	0	0
Pawtucket	5,514	16	39
Portsmouth	1,596	0	0
Providence	16,515	84	172
Richmond	637	0	0
Scituate	963	1	1
Smithfield	1,856	2	1
South Kingstown	3,540	3	4
Tiverton	1,115	3	6
Warren	675	0	0
Warwick	5,883	7	16
West Greenwich	568	0	0
West Warwick	1,891	7	22
Westerly	1,705	3	7
Woonsocket	3,112	11	31
Out-of-State	*NA*	*11*	*20*
Four Core Cities	*27,000*	*125*	*272*
Remainder of State	*58,847*	*78*	*178*
Rhode Island	*85,847*	*203*	*450*

Source of Data for Table/Methodology

Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2015; and the U.S. Census Bureau, Census 2010.

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 2015 (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.

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

References

[1,3,5,14,23] National Research Council. (2013). *Reforming juvenile justice: A developmental approach.* Committee on Assessing Juvenile Justice Reform, R. J. Bonnie, R. L. Johnson, B. M. Chemers, & J. A. Schuck, Eds. Committee on Law and Justice, Division of Behavioral and Social Sciences and Education.Washington, DC: The National Academies Press.

[2] Gottesman, D. & Wile Schwarz, S. (2011). *Juvenile justice in the U.S.: Facts for policymakers.* New York,NY: Columbia University, National Center for Children in Poverty.

[4] Juvenile Justice Information Exchange. (n.d.). *What are community-based alternatives?* Retrieved February 9, 2016, from www.jjie.org

(continued on page 179)

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

More than five million children in the U.S. (7% of all U.S. children) have had a parent incarcerated in state or federal prison at one time or another.[1]

Parental incarceration can contribute to children's insecure attachment to their parent, which can lead to poor developmental outcomes. Children of incarcerated parents experience high rates of physical and mental health problems (including asthma, depression, and anxiety) and educational problems (including grade retention, absenteeism, and dropping out). Parental incarceration increases children's risk for learning disabilities, ADHD, conduct problems, developmental delays, and speech problems.[2,3,4,5]

Nationally, most children of incarcerated parents live with their other parent, a grandparent, or other relatives.[6] Of the 1,870 parents incarcerated in Rhode Island on September 30, 2015 (including those awaiting trial), 94% (1,756) were fathers and 6% (114) were mothers.[7] Nationally, nearly half (48%) of incarcerated parents lived with their children one month prior to incarceration.[8]

Children of incarcerated parents are more likely than other children to be involved with the child welfare system. In the U.S. in 2013, 8% (almost 20,000) of children who entered foster care did so at least in part due to the incarceration of a parent.[9] These children often represent complex cases for child welfare agencies, involving balancing parental rights with the safety and well-being of the child.[10]

Programs and policies targeted at the unique needs of incarcerated pregnant women and mothers can improve outcomes for them and their families.[11] 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 children and improve the family reunification process.[12]

Of the 1,870 parents incarcerated in Rhode Island on September 30, 2015 (including those awaiting trial), 43% were White, 32% were Black, 23% were Hispanic, and 2% were of another race. Sixty-four percent of incarcerated parents with a known in-state residence identified one of the four core cities as their last place of residence.[13]

Parents at the Rhode Island Adult Correctional Institutions (ACI), September 30, 2015

	INMATES SURVEYED*	# REPORTING CHILDREN	% REPORTING CHILDREN	# OF CHILDREN REPORTED
Awaiting Trial	620	394	64%	906
Serving a Sentence	2,548	1,476	58%	3,316
TOTAL	*3,168*	*1,870*	*59%*	*4,222*

Source: Rhode Island Department of Corrections, September 30, 2015. **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 3,168 inmates awaiting trial or serving a sentence at the ACI who were surveyed as of September 30, 2015 and answered the question on number of children, 1,870 inmates reported having 4,222 children. Forty-five percent of sentenced mothers and 14% of sentenced fathers had sentences that were six months or less.[14]**

◆ **Of the 78 sentenced mothers on September 30, 2015, 59% were serving a sentence for a nonviolent offense, 28% for a violent offense, 5% for a drug-related offense, 5% for breaking and entering, and 3% for a sex offense. Of the 1,398 sentenced fathers, 46% were serving sentences for a violent offense, 20% for a nonviolent offense, 13% for a sex-related offense, 13% for a drug-related offense, and 7% for breaking and entering.[15]**

◆ **Forty-one percent of incarcerated parents awaiting trial or serving a sentence at the ACI on September 30, 2015 had less than a high school degree education, 47% had a high school diploma or a GED, and 12% had at least some college education.[16]**

◆ **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 to support the well-being of their children.[17,18]**

◆ **Nationally, nearly half of all children (between 33 and 36.5 million) have at least one parent with some sort of a criminal record. These families can experience significant challenges even if the parent has never been incarcerated. A parent's criminal record is often an obstacle to securing employment, accessing housing supports, and obtaining public assistance.[19]**

Table 28.

Children of Incarcerated Parents, Rhode Island, September 30, 2015

CITY/TOWN	# OF INCARCERATED PARENTS	# OF CHILDREN REPORTED*	2010 TOTAL POPULATION UNDER AGE 18	RATE PER 1,000 CHILDREN
Barrington	2	3	4,597	0.7
Bristol	10	24	3,623	6.6
Burrillville	7	19	3,576	5.3
Central Falls	49	102	5,644	18.1
Charlestown	3	6	1,506	4.0
Coventry	28	52	7,770	6.7
Cranston	74	138	16,414	8.4
Cumberland	18	53	7,535	7.0
East Greenwich	5	15	3,436	4.4
East Providence	30	77	9,177	8.4
Exeter	2	3	1,334	2.2
Foster	2	4	986	4.1
Glocester	5	8	2,098	3.8
Hopkinton	3	7	1,845	3.8
Jamestown	1	2	1,043	1.9
Johnston	24	61	5,480	11.1
Lincoln	4	4	4,751	0.8
Little Compton	1	2	654	3.1
Middletown	11	30	3,652	8.2
Narragansett	8	14	2,269	6.2
New Shoreham	0	0	163	0.0
Newport	24	54	4,083	13.2
North Kingstown	10	33	6,322	5.2
North Providence	32	63	5,514	11.4
North Smithfield	2	2	2,456	0.8
Pawtucket	145	334	16,575	20.2
Portsmouth	2	3	3,996	0.8
Providence	521	1,188	41,634	28.5
Richmond	1	3	1,849	1.6
Scituate	1	2	2,272	0.9
Smithfield	6	9	3,625	2.5
South Kingstown	13	27	5,416	5.0
Tiverton	6	15	2,998	5.0
Warren	4	11	1,940	5.7
Warwick	53	95	15,825	6.0
West Greenwich	4	8	1,477	5.4
West Warwick	60	117	5,746	20.4
Westerly	7	17	4,787	3.6
Woonsocket	114	260	9,888	26.3
Unknown Residence	*109*	*260*	*NA*	*NA*
*Out-of-State Residence***	*75*	*191*	*NA*	*NA*
Four Core Cities	*829*	*1,884*	*73,741*	*25.5*
Remainder of State	*463*	*981*	*150,215*	*6.5*
Rhode Island	*1,292*	*2,865*	*223,956*	*12.8*

Source of Data for Table/Methodology

Rhode Island Department of Corrections, September 30, 2015. 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 30, while previous Factbooks reported data as of December 31. In the 2015 Factbook, data were reported as of October 10, 2014.

*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, nor are those with an unknown residence.

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

References

[1,4] Murphey, D. & Cooper, P. M. (2015). *Parents behind bars: What happens to their children?* Retrieved December 18, 2015, from www.childtrends.org

[2] Shlafer, R. J., Gerrity, E., Ruhland, E., & Wheeler, M. (2013). *Children with incarcerated parents-Considering children's outcomes in the context of family experiences.* Retrieved December 22, 2015, from www.cyfc.umn.edu

[3] Uggen, C. & McElrath, S. (2014). Parental incarceration: What we know and where we need to go. *Journal of Criminal Law and Criminology, 104*(3), 597-604.

[5] Turney, K. (2014). Stress proliferation across generations? Examining the relationship between parental incarceration and childhood health. *Journal of Health and Social Behavior, 55*(3), 302-319.

[6,8,9] Child Welfare Information Gateway. (2015). *Child welfare practice with families affected by parental incarceration.* Retrieved December 22, 2015, from www.childwelfare.gov

[7,13,14,15,16] Rhode Island Department of Corrections, September 30, 2015.

(continued on page 180)

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 2014, police reports indicate that children were present at 35% of domestic violence incidents resulting in arrests.[3]

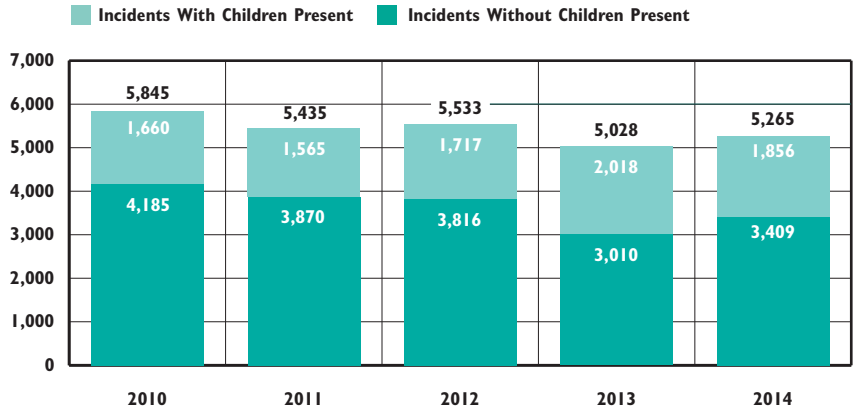
Children can be exposed to domestic violence in a number of ways. They may witness it directly (by seeing or hearing violent incidents in their homes or families), have their lives disrupted by moving or being separated from a parent, and/or may be used by the batterer to manipulate or gain control over 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] Children may also lose a parent to domestic homicide.[6]

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.[7] 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.[8,9]

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.[10] There is a strong association between witnessing domestic violence as a child and becoming a perpetrator of domestic violence as an adult.[11]

Incidents of domestic violence are historically under-reported. Nationally, it is estimated that 41% of family violence incidents are not reported to police.[12] 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.[13]

Domestic Violence Incidents Resulting in Arrest, Rhode Island, 2010-2014



Source: Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit, 2010-2014. Includes domestic violence reports resulting from an arrest by local police and Rhode Island State Police.

◆ **In Rhode Island in 2014, there were 5,265 domestic violence incidents that resulted in arrests, up 5% from 5,028 incidents in 2013. Children were reported present in 35% (1,856) of incidents in 2014.[14] 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.[15]**

◆ **Rhode Island police reported that children saw the domestic violence incident in 1,165 arrests and children heard the incident in 1,283 arrests during 2014. These incidents were not mutually exclusive and more than one child may have witnessed the incident.[16]**

◆ **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.[17] During 2015, the network provided services to 8,934 individuals, including 587 children. In 2015, 254 children and 250 adults spent a total of 18,776 nights in domestic violence shelters. Sixty-one children and 48 adults lived in domestic violence transitional housing (longer-term private apartments for victims of domestic violence) during 2015.[18]**

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.[19]

Table 29. **Children Present During Domestic Violence Incidents Resulting in Arrests, Rhode Island, 2014**

CITY/TOWN	TOTAL # OF REPORTS	TOTAL # OF INCIDENTS WITH CHILDREN PRESENT	% WITH CHILDREN PRESENT
Barrington	40	9	23%
Bristol	79	21	27%
Burrillville	53	18	34%
Central Falls	171	72	42%
Charlestown	32	11	34%
Coventry	133	50	38%
Cranston	318	136	43%
Cumberland	110	41	37%
East Greenwich	36	8	22%
East Providence	228	97	43%
Exeter**	NA	NA	NA
Foster	28	11	39%
Glocester	24	5	21%
Hopkinton	31	11	35%
Jamestown	5	2	40%
Johnston	161	53	33%
Lincoln	50	25	50%
Little Compton	9	0	0%
Middletown	100	35	35%
Narragansett	69	29	42%
New Shoreham	3	1	33%
Newport	230	67	29%
North Kingstown	88	35	40%
North Providence	227	60	26%
North Smithfield	50	24	48%
Pawtucket	678	242	36%
Portsmouth	75	19	25%
Providence	794	302	38%
Richmond	23	9	39%
Scituate	25	8	32%
Smithfield	57	16	28%
South Kingstown	88	38	43%
Tiverton	83	32	39%
Warren	74	35	47%
Warwick	284	93	33%
West Greenwich	21	5	24%
West Warwick	285	81	28%
Westerly	135	59	44%
Woonsocket*	295*	72*	24%*
Rhode Island State Police	*73*	*24*	*33%*
Four Core Cities	*1,938*	*688*	*36%*
Remainder of State	*3,254*	*1,144*	*35%*
Rhode Island	*5,265*	*1,856*	*35%*

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, 2014 and December 31, 2014.

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.

*Data for Woonsocket are provisional.

**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. (2012). *Relationship violence among young adult couples.* Washington, DC: Child Trends.

[3,13,14,16] Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit. Based on data from Domestic Violence and Sexual Assault/Child Molestation Reporting Forms, 2010-2014.

[4] Stop Violence Against Women. (2010). *Effects of domestic violence on children.* Retrieved March 2, 2016, 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] *Domestic violence homicides in Rhode Island, 2006-2015.* (2016). Providence, RI: Rhode Island Coalition Against Domestic Violence.

(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

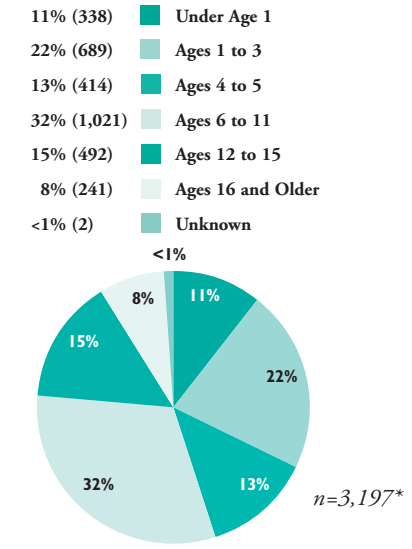
Children need love, affection, and nurturing from their parents and caregivers for healthy physical and emotional development. Experiencing child abuse or neglect can have lifelong consequences for health, well-being, and relationships with others. Parents or caregivers are at increased risk for maltreating children in their care if they are overwhelmed by multiple risk factors such as poverty, divorce, substance abuse, and/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, truancy, substance abuse, mental health problems, teen pregnancy, impaired cognition, and low academic achievement.[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]

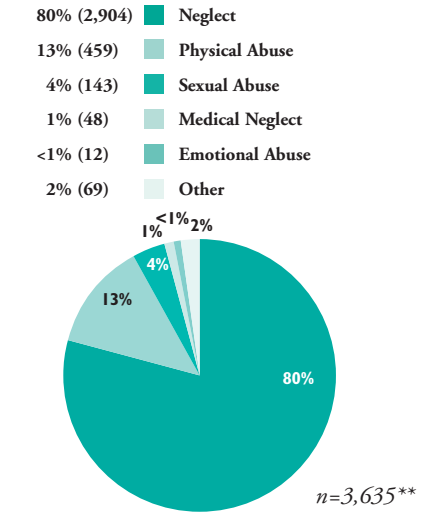
In 2015 in Rhode Island, there were 2,227 indicated investigations of child abuse and neglect involving 3,197 children. The child abuse and neglect rate per 1,000 children under age 18 was nearly two times higher in the four core cities (20.3 victims per 1,000 children) compared to the remainder of the state (10.6 victims per 1,000 children). Almost half (45%) of the victims of child abuse and neglect in 2015 were young children under age six and almost one-third (32%) were ages three and younger.[5]

Child Abuse and Neglect, Rhode Island, 2015

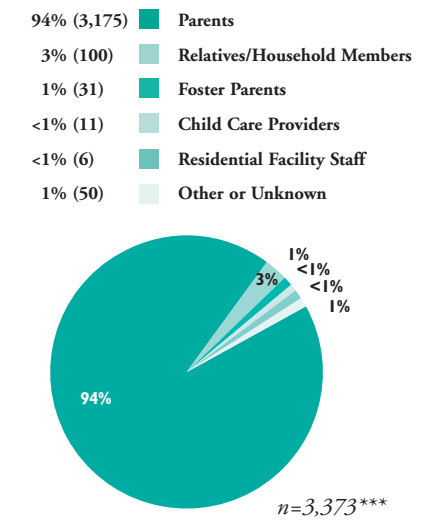
By Age of Victim*



By Type of Neglect/Abuse**



By Relationship of Perpetrator to Victims***



Source: Rhode Island DCYF, Rhode Island Children's Information System (RICHIST), 2015. 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 the number of abuse and neglect incidents. Under Rhode Island law, DCYF's 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, 2006-2015

YEAR	TOTAL # UNDUPLICATED CHILD MALTREATMENT REPORTS	% AND # OF REPORTS WITH COMPLETED INVESTIGATIONS	# OF INDICATED INVESTIGATIONS
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
2015	14,402	45% (6,470)	2,227

Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2006-2015.

**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).*

◆ **After increasing annually between 2011 and 2014, the number of child maltreatment reports, completed investigations, and indicated investigations declined between 2014 and 2015 in Rhode Island. Between 2014 and 2015, the numbers of unduplicated child maltreatment reports decreased by 2%, completed investigations decreased by 15%, and indicated investigations decreased by 8%. In 2015, 34% (2,227) of the 6,470 completed investigations of child maltreatment were indicated.[6] An indicated investigation is one in which there is a preponderance of evidence that child abuse and/or neglect occurred.[7]**

◆ **Of the 14,402 maltreatment reports in 2015, 47% (6,749) 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 caseworker (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, 2010-2014

YEAR	# OF EMERGENCY DEPARTMENT VISITS	# OF HOSPITALIZATIONS	# OF DEATHS**
2010	161	31	0
2011	159	38	2
2012	153	25	1
2013	133	34	3
2014	102	44	1
TOTAL	*708*	*172*	*7*

Source: Rhode Island Department of Health, 2010-2014. Data for 2013 and 2014 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 2010 and 2014, there were 708 emergency department visits, 172 hospitalizations, and seven deaths of children in Rhode Island under age 18 due to child abuse and/or neglect.[11] Nationally, 71% of child maltreatment deaths involved neglect and 47% involved physical abuse (because a victim may have suffered more than one type of maltreatment, these categories are not mutually exclusive).[12]**

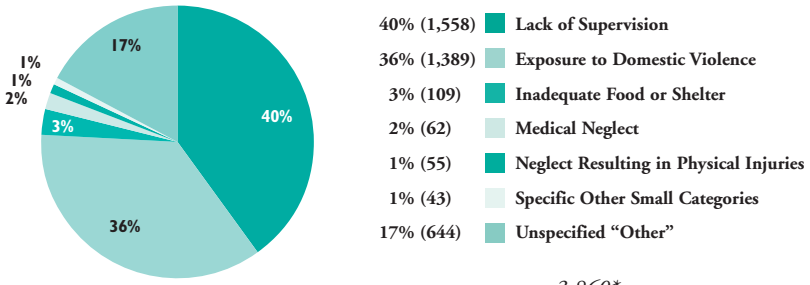
Child Abuse and Neglect in Rhode Island Communities

◆ **Many parents at risk of abusing and/or neglecting their child 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 basic needs, 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 Rhode Island in 2015, the child abuse and neglect rate was 13.8 per 1,000 children, down from a rate of 14.5 per 1,000 children in 2014. With a rate of 31.4 victims per 1,000 children, Woonsocket 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 Newport (26.9), Central Falls (26.8), West Warwick (25.9), Pawtucket (25.0), and Warren (21.1).[17]**

Child Abuse and Neglect

Indicated Allegations of Child Neglect, by Nature of Neglect, Rhode Island, 2015



*n=3,860**

◆ **The importance of adequate capacity, affordability, and quality of child care, preschool, other early childhood programs, and after-school opportunities is highlighted by the fact that of the 3,860 indicated allegations (confirmed claims) of neglect to children under age 18 in Rhode Island in 2015, 40% involved lack of supervision.**

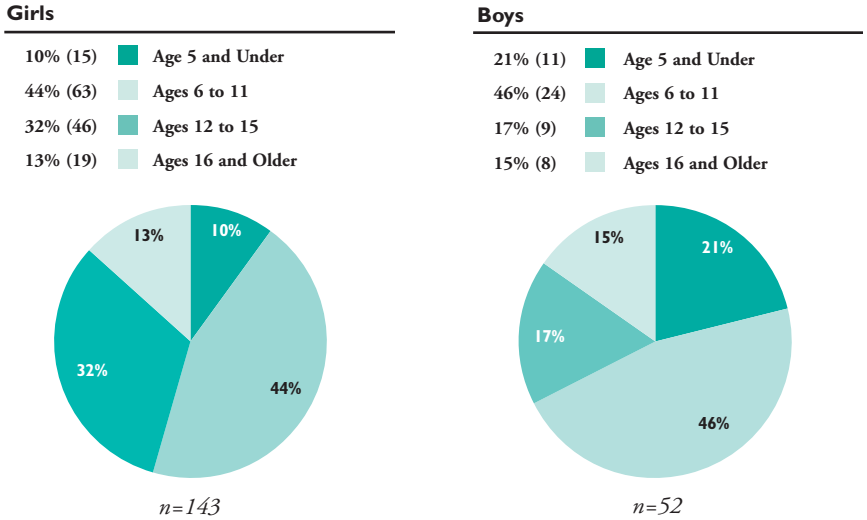
◆ **The second largest category of neglect (36%) is "exposure to domestic violence." These are instances where the neglect is related to the child witnessing domestic violence in the home.**

◆ **The "specific other small categories" include: drug and alcohol abuse (15), educational neglect (13), tying/close confinement (8), excessive/inappropriate discipline (5), emotional neglect (1), and failure to thrive (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, 2015.

Child Sexual Abuse, by Gender and Age of Victim, Rhode Island, 2015



Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2015. Percentages may not sum to 100% due to rounding.

◆ **In Rhode Island in 2015, there were 195 indicated allegations (confirmed claims) of child sexual abuse. Some children were victims of sexual abuse more than once. The victim was a female in 73% (143) of the 195 indicated allegations of sexual abuse. Fifty-five percent of the female victims were known to be under age 12 while 67% 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 30. **Indicated Investigations of Child Abuse and Neglect, Rhode Island, 2015**

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	CHILD ABUSE/NEGLECT VICTIMS PER 1,000 CHILDREN
Barrington	4,597	9	2.0	14	3.0
Bristol	3,62	18	5.0	23	6.3
Burrillville	3,576	35	9.8	35	9.8
Central Falls	5,644	90	15.9	151	26.8
Charlestown	1,506	11	7.3	13	8.6
Coventry	7,770	58	7.5	79	10.2
Cranston	16,414	92	5.6	130	7.9
Cumberland	7,535	59	7.8	83	11.0
East Greenwich	3,436	15	4.4	29	8.4
East Providence	9,177	108	11.8	146	15.9
Exeter	1,334	14	10.5	11	8.2
Foster	986	7	7.1	6	6.1
Glocester	2,098	13	6.2	17	8.1
Hopkinton	1,845	15	8.1	27	14.6
Jamestown	1,043	4	3.8	6	5.8
Johnston	5,480	24	4.4	52	9.5
Lincoln	4,751	37	7.8	43	9.1
Little Compton	654	2	3.1	3	4.6
Middletown	3,652	43	11.8	38	10.4
Narragansett	2,269	13	5.7	15	6.6
New Shoreham	163	2	12.3	2	12.3
Newport	4,083	72	17.6	110	26.9
North Kingstown	6,322	53	8.4	72	11.4
North Providence	5,514	55	10.0	84	15.2
North Smithfield	2,456	12	4.9	22	9.0
Pawtucket	16,575	271	16.3	415	25.0
Portsmouth	3,996	17	4.3	25	6.3
Providence	41,634	480	11.5	620	14.9
Richmond	1,849	8	4.3	15	8.1
Scituate	2,272	10	4.4	19	8.4
Smithfield	3,625	20	5.5	19	5.2
South Kingstown	5,416	32	5.9	47	8.7
Tiverton	2,998	23	7.7	40	13.3
Warren	1,940	22	11.3	41	21.1
Warwick	15,825	86	5.4	107	6.8
West Greenwich	1,477	3	2.0	7	4.7
West Warwick	5,746	113	19.7	149	25.9
Westerly	4,787	46	9.6	69	14.4
Woonsocket	9,888	237	24.0	310	31.4
Four Core Cities	*73,741*	*1,078*	*14.6*	*1,496*	*20.3*
Remainder of State	*150,215*	*1,151*	*7.7*	*1,598*	*10.6*
Rhode Island	*223,956*	*2,229*	*10.0*	*3,094*	*13.8*

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 2015.

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 totals of indicated investigations in the city/town table may differ from 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. (2015). *Making meaningful connections: 2015 prevention resource guide.* 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 180)

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.

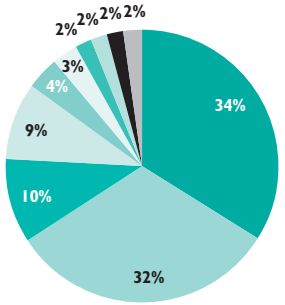
SIGNIFICANCE

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, 2015



n=2,084

34%	(711)	Foster Care Home (relative)
32%	(659)	Foster Care Home (non-relative, private agency)
10%	(207)	Residential Facility
9%	(193)	Group Home
4%	(85)	Rhode Island Training School for Youth
3%	(68)	Independent Living/Supervised Apartment
2%	(45)	Psychiatric or Medical Hospital/Substance Abuse Facility
2%	(38)	Relatives Caring for Children*
2%	(32)	DCYF Shelter Care
2%	(46)	Other**

**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 (35), pre-adoptive homes (8), and minors with a mother in shelter/group home/residential facility (3).*

◆ **As of December 31, 2015, there were 2,084 children under age 21 in the care of DCYF who were in out-of-home placements.**

◆ **The total caseload of DCYF on December 31, 2015 was 7,089, including 2,413 children living in their homes under DCYF supervision and 2,527 children living in adoption settings. This total caseload shows a third consecutive annual increase after years of decline, increasing from 7,078 in 2014.**

◆ **The total DCYF caseload also includes 54 children in out-of-state placements/other agency custody, six children receiving respite care services, one youth in Job Corps, and four children in other placements.**

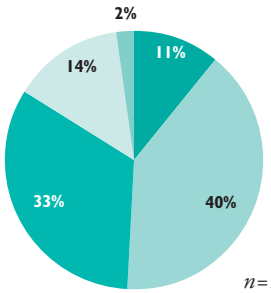
◆ **On December 31, 2015, 400 children living in a residential facility or group home, a decline of 11% from 449 children on December 31, 2014. The percentage of children in out-of-home placement who were in a relative foster care home increased from 31% on December 31, 2014 to 34% on December 31, 2015.**

Source: RI Department of Children, Youth and Families, RICHIST, 2006-2015.

Children and Youth in Out-of-Home Placement by Type of Setting and Age, Rhode Island*

In Foster Care Homes

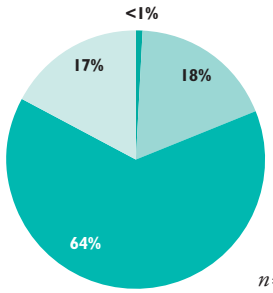
11% (157)	Under Age 1
40% (553)	Ages 1 to 5
33% (451)	Ages 6 to 13
14% (186)	Ages 14 to 17
2% (27)	Ages 18 and Over



n=1,374

In Group Homes and Residential Facilities**

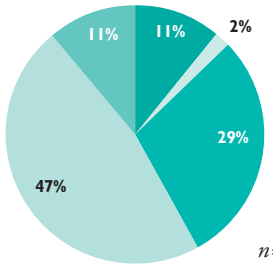
0% (0)	Under Age 1
<1% (1)	Ages 1 to 5
18% (73)	Ages 6 to 13
64% (257)	Ages 14 to 17
17% (69)	Ages 18 and Over



n=400

In Medical Facilities***

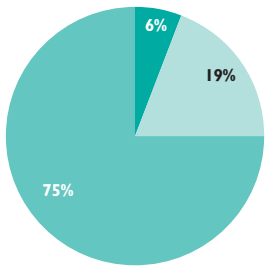
11% (5)	Under Age 1
2% (1)	Ages 1 to 5
29% (13)	Ages 6 to 13
47% (21)	Ages 14 to 17
11% (5)	Ages 18 and Over



n=45

In Shelter Care

0% (0)	Under Age 1
6% (2)	Ages 1 to 5
19% (6)	Ages 6 to 13
75% (24)	Ages 14 to 17
0% (0)	Ages 18 and Over



n=32

**Pie charts show data for a single point-in-time (Foster Care Homes-January 4, 2016; Group Homes and Residential Facilities, Medical Facilities, and Shelter Care-December 31, 2015.)*

***Residential facilities do not include psychiatric hospitals, medical hospitals, or the Rhode Island Training School.*

****Medical facilities data includes medical hospitals (10), psychiatric hospitals (33), and substance abuse treatment facilities (2).*

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), January 2016. 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) 2015, 10.9% of the 1,274 children who had been in out-of-home care for less than one year had experienced three or more placements, down from 12.4% in FFY 2014. Three or more placements were experienced by 24.7% of the 728 children who were in care between 12 and 24 months, down from 25.1% in FFY 2014. Fifty-five percent of the 582 children who had been in care for 24 months or more experienced three or more placements.[13]

Recurrence of Abuse and Neglect

◆ Of the 1,649 Rhode Island children who were victims of abuse or neglect during FFY 2015 (whether or not they were removed from the home), 9.3% experienced one or more recurrences of abuse or neglect within six months, up from 8.8% in FFY 2014. 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 40 on December 31, 2014 to 32 on December 31, 2015. Two of these Rhode Island children in shelter care were under age six, six were ages six to 13, and 24 were age 14 and older.[15]

References

[1] 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 February 11, 2016, 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]

Children and youth who live in families (kinship or non-kinship) while in the child welfare system are better prepared to thrive in permanent homes, whether through reunification, adoption, or guardianship.[14]

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 young parents, and enroll in public assistance programs.[15]

The federal *Fostering Connections Act of 2008* and *Strengthening Families Act of 2014* provide a range of incentives and strategies for states to support children and youth while in foser care as well as permanency.[16,17]

Exits from Foster Care*, Rhode Island, FFY 2015

	ALL EXITS	WITH DISABILITY	OVER AGE 12 AT ENTRY
Adoption	19%	22%	1%
Guardianship	11%	6%	5%
Reunification	54%	49%	57%
Aged Out	13%	NA**	29%
Other	4%	23%	8%
TOTAL NUMBER	*741*	*245*	*289*

Source: *Safety, permanency, and well-being in Rhode Island: Child welfare outcomes annual report for FY 2015.* (2016). 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) 2015, 741 children in out-of-home placement in Rhode Island exited foster care. Of the children who exited, 84% 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 2015, 13.4% 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 2015

◆ **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 72.8% in FFY 2014 to 68.0% in FFY 2015. The national standard is 76.2% of reunifications occurring within 12 months of the child's removal.[20]**

◆ **In 2015, 80% 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 2015

◆ 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 increased from 8.1% in FFY 2014 to 10.8% in FFY 2015.[24]

Adoptions of Children in DCYF Care, 2015

◆ During Calendar Year 2015, 231 children in the care of DCYF were adopted in Rhode Island, up from 212 in 2014. Of these children, 58% were White, 23% were multiracial, 16% were Black, <1% were American Indian, and 2% were of unknown race. Twenty-nine percent of children adopted in 2015 were Hispanic (belonging to any race category).[25]

◆ Of the 231 children adopted, 62% were under age six, 32% were ages six to 13, and 5% were age 14 or older.[26]

Rhode Island Children Waiting to be Adopted, September 30, 2015

◆ On September 30, 2015, there were 305 Rhode Island children in the care of DCYF who were waiting to be adopted. Of these, 1% of children were under age one, 35% were ages one to five, 31% were ages six to 10, 23% were ages 11 to 15, 10% were ages 16 and older, and <1% were of unknown age.[27]

◆ Of all waiting children, 42% were White, 28% were Hispanic (of any race), 17% were Black, 11% were Two or more races, 1% were Asian, <1% were Native American, and <1% were of unknown race/ethnicity.[28]

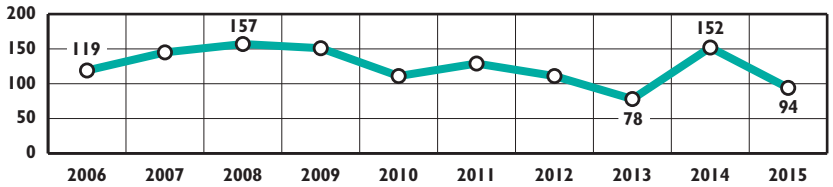
◆ Of the 305 children waiting to be adopted, 35% (106) were children of parents whose parental rights had been legally terminated.[29]

◆ In FFY 2015, 39% of children in the Rhode Island child welfare system were adopted within 24 months from the time of removal from their home, down from 42% in FFY 2014. Rhode Island exceeded the national standard of 32% of adoptions occurring within 24 months of the child's removal in FFY 2015.[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, FFY 2006-2015



Source: *Safety, permanency, and well-being in Rhode Island: Child welfare outcomes annual reports for FY 2006-2015.* 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.

◆ The number of Rhode Island youth who exited foster care never having gained permanency through reunification, adoption, or guardianship decreased from 152 during FFY 2014 to 94 during FFY 2015.[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 federal *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: The Carsey Institute.

(continued on page 181)

Education

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]

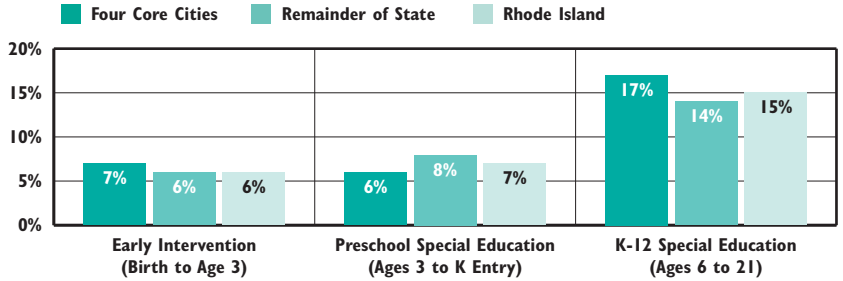
In 1986, Congress established Early Intervention (EI) services for infants and toddlers under the *Individuals with Disabilities Education Act (IDEA)*. Part C of *IDEA* requires states to identify and provide appropriate EI services to children under age three who are developmentally delayed or have 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). Current eligibility criteria allow children with significant circumstances (e.g., significant trauma/losses, history of abuse/neglect, family lacking basic resources, parental substance abuse, significant parental health/mental health issues, and intellectual disability of caretaker, among others) to qualify through informed clinical opinion if the circumstances impact child or family functioning.[3]

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.[4]

The American Academy of Pediatrics recommends that physicians use a standardized developmental screening tool during well-child visits to improve detection of developmental delays.[5] Early childhood developmental screenings are required and covered for all children with RIte Care coverage through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.[6]

Percentage of Children Receiving Special Education Services by Age, Rhode Island, June 2015



Source: Rhode Island KIDS COUNT calculations using Rhode Island Executive Office of Health and Human Services, June 30, 2015 Early Intervention enrollment, Census 2010, Summary File 1, Rhode Island Department of Education, June 30, 2015 Special Education Census, population of children ages 3-5 from KIDS NET, and Resident Average Daily Membership.

◆ **As of June 30, 2015, there were 2,195 infants and toddlers receiving Early Intervention (EI) services, 6% of the population under age three. Nineteen percent of infants and toddlers receiving EI services were under age one, 31% were age one, and 50% were age two. Eighty-two percent were eligible under the developmental delay category and 18% were eligible under the single established condition category.**[7]

◆ **In Calendar Year 2015 in Rhode Island, 4,359 children received EI services, up from 4,339 in 2014.**[8,9] **In 2015, 1,041 children were discharged from EI upon reaching age three. Of these, 64% were found eligible and 21% were found not eligible for preschool special education. Ten percent were in the process of eligibility determination and 5% left the program for other reasons.**[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 a victim of child abuse or neglect to EI for an eligibility assessment.**[11,12] **In 2015 in Rhode Island, there were 843 infants and toddlers under age three who were maltreated. Of these, 25% were referred to EI for an eligibility assessment, 34% were referred to First Connections for screening, 4% were already enrolled in EI, and 37% were not referred. Of the 445 DCYF-involved children referred to EI in 2015, 57% were found eligible, 13% were found not eligible, 20% were in the determination process, and 10% were not evaluated.**[13,14]

Table 31. **Infants and Toddlers Enrolled in Early Intervention (EI) by Eligibility Type, Rhode Island, 2015**

		CALENDAR YEAR 2015 ENROLLMENT		JUNE 30, 2015 ENROLLMENT BY AGE OF CHILD				
CITY/TOWN	# OF CHILDREN UNDER AGE 3	# OF CHILDREN ENROLLED IN EI	% OF CHILDREN UNDER AGE 3 ENROLLED IN EI	UNDER AGE 1	AGE 1	AGE 2	# OF CHILDREN UNDER AGE 3 ENROLLED IN EI	% OF CHILDREN UNDER AGE 3 ENROLLED IN EI
Barrington	366	36	10%	4	4	14	22	6%
Bristol	507	77	15%	6	16	18	40	8%
Burrillville	460	48	10%	4	12	15	31	7%
Central Falls	1,028	157	15%	20	19	57	96	9%
Charlestown	186	22	12%	2	2	5	9	5%
Coventry	940	119	13%	12	13	33	58	6%
Cranston	2,318	269	12%	24	38	67	129	6%
Cumberland	970	114	12%	8	26	30	64	7%
East Greenwich	299	52	17%	3	14	10	27	9%
East Providence	1,560	181	12%	23	37	42	102	7%
Exeter	166	23	14%	2	0	7	9	5%
Foster	113	17	15%	2	3	3	8	7%
Glocester	247	22	9%	0	3	9	12	5%
Hopkinton	258	28	11%	5	1	6	12	5%
Jamestown	85	13	15%	1	0	3	4	5%
Johnston	816	90	11%	5	11	20	36	4%
Lincoln	587	89	15%	6	17	19	42	7%
Little Compton	68	9	13%	2	2	1	5	7%
Middletown	502	80	16%	6	12	19	37	7%
Narragansett	271	24	9%	3	3	2	8	3%
New Shoreham	21	1	5%	0	0	0	0	0%
Newport	820	100	12%	15	14	21	50	6%
North Kingstown	728	118	16%	18	23	31	72	10%
North Providence	851	108	13%	13	12	33	58	7%
North Smithfield	290	52	18%	2	9	20	31	11%
Pawtucket	2,959	347	12%	25	58	85	168	6%
Portsmouth	429	45	10%	5	8	8	21	5%
Providence	7,609	1,074	14%	113	172	266	551	7%
Richmond	235	13	6%	1	1	3	5	2%
Scituate	193	35	18%	7	7	6	20	10%
Smithfield	402	46	11%	3	7	12	22	5%
South Kingstown	640	65	10%	5	7	22	34	5%
Tiverton	398	55	14%	7	8	19	34	9%
Warren	296	40	14%	4	9	10	23	8%
Warwick	2,322	315	14%	26	44	72	142	6%
West Greenwich	178	22	12%	2	0	4	6	3%
West Warwick	1,044	133	13%	11	13	21	45	4%
Westerly	726	63	9%	5	8	16	29	4%
Woonsocket	1,900	257	14%	24	45	64	133	7%
Four Core Cities	*13,496*	*1,835*	*14%*	*182*	*294*	*472*	*948*	*7%*
Remainder of State	*20,292*	*2,524*	*12%*	*242*	*384*	*621*	*1,247*	*6%*
Rhode Island	*33,788*	*4,359*	*13%*	*424*	*678*	*1,093*	*2,195*	*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 2015 and June 30, 2015 enrollment (point-in-time).

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] Jones, L. (2009). *Early experiences matter: A guide to improved policies for infants and toddlers.* Washington, DC: Zero to Three.

[3] *Rhode Island Early Intervention policies and procedures: Eligibility determination.* (2013). Cranston, RI: Rhode Island Executive Office of Health and Human Services.

[4] Boyle, C. A., et al. (2011). Trends in the prevalence of developmental disabilities in U.S. children, 1997-2008. *Pediatrics, 127*(6), 1034-1042.

[5] 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.

[6] *Birth to 5: Watch me thrive! CMS efforts to ensure children receive developmental and behavioral screening.* (n.d.). Retrieved March 15, 2016, from www.medicaid.gov

[7,8,10,14] Rhode Island Executive Office of Health and Human Services, 2015.

[9] Rhode Island Executive Office of Health and Human Services, 2014.

[12] Child Welfare Information Gateway. (2013). *Addressing the needs of young children in child welfare: Part C-Early Intervention services.* Washington, DC: Children's Bureau.

[13] Rhode Island Department of Children, Youth and Families, 2015. DCYF also refers siblings and other potentially eligible non-victims to EI for evaluation, but these children are not included in these figures.

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 the federal poverty level ($20,160 for a family of three in 2016).[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]

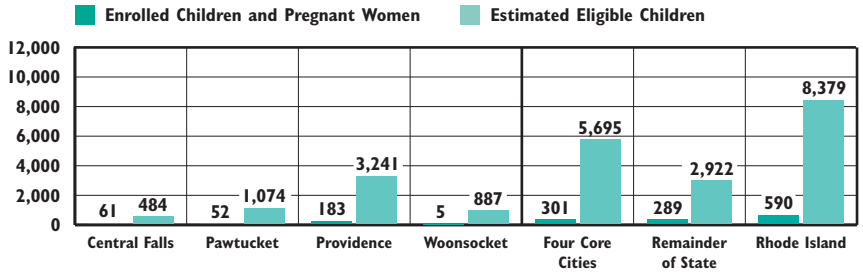
Pregnant women enrolled in Early Head Start are assessed for risks to a successful pregnancy. Individualized plans are developed to support prenatal health, promote healthy behaviors and prepare for the baby's arrival.[5] After the baby is born, families participate by enrolling in either a center-based 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 provide a combination of home-based and center-based services.[6]

In Rhode Island in 2015, there were 629 federally-funded Early Head Start slots, of which 58% were home-based and 42% were center-based.[7] An Early Head Start-Child Care Partnership grant awarded in 2015 created 100 new center-based Early Head Start slots in Rhode Island. The federal grant incentivizes partnerships between Early Head Start programs and child care programs to increase the number of very low-income infants and toddlers enrolled.[8,9]

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.[10,11] Children who enroll in preschool after Early Head Start have better outcomes in early reading skills.[12]

As of October 2015, 582 infants and toddlers and eight pregnant women were receiving Early Head Start services in Rhode Island and there were 257 eligible pregnant women or children on the waiting list.[13]

Access to Early Head Start for Low-Income Children and Pregnant Women, Rhode Island, 2015



Source: Rhode Island Early Head Start program enrollment data compiled by Rhode Island KIDS COUNT, October 2015. 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 the federal poverty line (FPL) according to the Population Reference Bureau's analysis of 2010-2014 American Community Survey data.

◆ **In 2015 in Rhode Island, federal funding enabled 590 children and pregnant women to participate in Early Head Start, 7% of the estimated eligible population. There were 301 children and pregnant women from the four core cities (5% of the estimated income-eligible population) and 289 children and pregnant women from the remainder of the state (10% 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 – 13%, Pawtucket – 5%, Providence – 6%, and Woonsocket – 1%.[14,15]**

◆ **As of October 2015, 1% of Early Head Start clients were pregnant women, 24% were infants under age one, 38% were age one, 35% were age two, and 2% were age three.[16]**

◆ **Rhode Island Head Start programs serve significant numbers of children with high needs including: 67 infants and toddlers with developmental delays or disabilities (12% of all children enrolled), 24 children who were in foster care, and 31 children who were homeless.[17] 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.[18]**

◆ **As of October 2015, 31% of the children enrolled in Early Head Start were also participating in the Child Care Assistance Program (CCAP).[19] Center-based Early Head Start programs are open six hours per day and do not cover the entire day.[20] CCAP is used to provide additional coverage for working parents.**

Children Enrolled in Early Head Start

Table 32. **Children Ages Birth to Three and Pregnant Women Enrolled in Early Head Start, Rhode Island, 2015**

CITY/TOWN	ALL CHILDREN <AGE 3	% CHILDREN <AGE 6 IN POVERTY	ESTIMATED ELIGIBLE POPULATION <AGE 3 IN POVERTY	# OF PREGNANT WOMEN ENROLLED IN EARLY HEAD START	# OF CHILDREN ENROLLED IN EARLY HEAD START	ESTIMATED % CHILDREN <AGE 3 ENROLLED IN EARLY HEAD START	ESTIMATED % ELIGIBLE POPULATION ENROLLED IN EARLY HEAD START
Barrington	366	1.3%	5	0	0	0%	0%
Bristol	507	5.6%	28	0	3	1%	11%
Burrillville	460	12.6%*	58	1	9	2%	17%
Central Falls	1,028	47.1%**	484	2	59	6%	13%
Charlestown	186	32.3%***	60	0	0	0%	0%
Coventry	940	25.9%**	243	0	14	1%	6%
Cranston	2,318	16.4%*	380	0	24	1%	6%
Cumberland	970	6.8%*	66	0	0	0%	0%
East Greenwich	299	13.4%**	40	0	1	0%	3%
East Providence	1,560	23.6%*	368	0	25	2%	7%
Exeter	166	NA	NA	0	0	0%	NA
Foster	113	13.8%***	16	0	1	1%	6%
Glocester	247	9.6%**	24	0	0	0%	0%
Hopkinton	258	14.5%***	37	0	0	0%	0%
Jamestown	85	7.9%***	7	0	0	0%	0%
Johnston	816	20.4%*	166	0	16	2%	10%
Lincoln	587	13.8%*	81	0	0	0%	0%
Little Compton	68	17.8%***	12	0	1	1%	8%
Middletown	502	13.3%*	67	0	10	2%	15%
Narragansett	271	9.7%*	26	0	0	0%	0%
New Shoreham	21	10.0%***	2	0	0	0%	0%
Newport	820	13.3%*	109	0	54	7%	50%
North Kingstown	728	20.0%**	146	0	0	0%	0%
North Providence	851	21.1%**	180	0	20	2%	11%
North Smithfield	290	3.6%*	10	0	4	1%	40%
Pawtucket	2,959	36.3%*	1,074	0	52	2%	5%
Portsmouth	429	4.0%*	17	0	0	0%	0%
Providence	7,609	42.6%*	3,241	4	179	2%	6%
Richmond	235	15.7%***	37	0	0	0%	0%
Scituate	193	9.4%**	18	0	0	0%	0%
Smithfield	402	NA	NA	0	4	1%	NA
South Kingstown	640	13.1%**	84	0	0	0%	0%
Tiverton	398	11.1%*	44	0	1	0%	2%
Warren	296	12.8%**	38	0	5	2%	13%
Warwick	2,322	8.7%	202	1	50	2%	25%
West Greenwich	178	NA	NA	0	2	1%	NA
West Warwick	1,044	24.1%**	252	0	43	4%	17%
Westerly	726	14.5%**	105	0	0	0%	0%
Woonsocket	1,900	46.7%*	887	0	5	0%	1%
Four Core Cities	*13,496*	*42.2%*	*5,695*	*6*	*295*	*2%*	*5%*
Remainder of State	*20,292*	*14.4%*	*2,922*	*2*	*287*	*1%*	*10%*
Rhode Island	*33,788*	*24.8%*	*8,379*	*8*	*582*	*2%*	*7%*

Source of Data for Table/Methodology

Rhode Island Early Head Start Programs, children enrolled as of October 2015. 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. 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 the federal poverty line (FPL) according to the Population Reference Bureau's (PRB) analysis of 2010-2014 American Community Survey data. Estimated eligible children for the four core cities, remainder of state, and Rhode Island is calculated using PRB estimates for those groupings and is not a sum of estimates by community.

The American Community Survey is a sample survey, and therefore the number and percentage of children living in poverty are estimates. The reliability of these estimates varies by community.

* The Margin of Error around the percentage is greater than 5 but less than 10 percentage points.

** The Margin of Error around the percentage is greater than 10 but less than 15 percentage points.

*** The Margin of Error around the percentage is greater than or equal to 15 percentage points.

NA: American Community Survey estimate of % of children under age six in poverty is not available for this community.

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

References

[1,6,10] Raikes, H. H., Chazan-Cohen, R., Love, J. M., & Brooks-Gunn, J. (2010). Early Head Start impacts at age 3 and a description of the age 5 follow-up study. In A. J. Reynolds, A. J. Rolnick, M. M. Englund & J. A. Temple (Eds.), *Childhood programs and practices in the first decade of life.* (pp.99-118). New York, NY: Cambridge University Press.

[2] *Improving Head Start for School Readiness Act of 2007*, § 42 U.S.C. 9801, § 645 (2007).

[3] U.S. Department of Health and Human Services. (2016). Annual update of the HHS poverty guidelines. *Federal Register, 81*(15), 4036-4037.

(continued on page 181)

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]

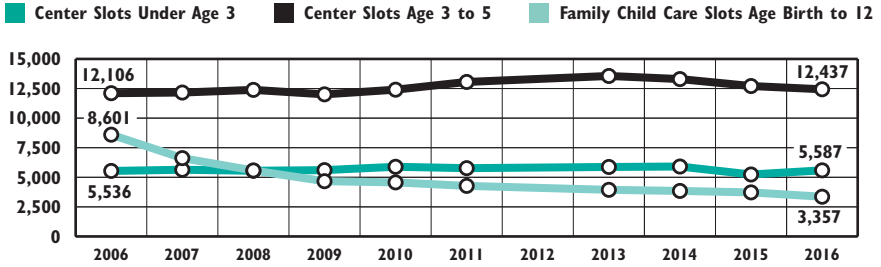
Early and on-going enrollment in child care and early learning programs is common in the United States. Across the U.S., 42% of infants under the age of one and 73% of preschoolers between ages three and five regularly participate in a non-parental early care and education arrangement. Participation in early care and education varies by family income, with 63% of children ages birth to five living in households with incomes above poverty enrolled in child care or early learning programs, compared with 49% of those below poverty. 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 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 2010 and 2014, 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 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, 2006-2016



Source: Options for Working Parents, slots in licensed child care centers and certified family child care homes, 2006. Rhode Island Department of Children, Youth and Families, slots in licensed child care centers and family child care homes, 2007-2016. 2016 data are from the RI Early Care and Education Data System (ECEDS). Starting with the 2013 Factbook, data are collected as of January, instead of December.

◆ **In January 2016, there were 351 more slots for infants and toddlers (children under age three) in licensed centers than in 2015, making up some of the loss in the previous year. There were 274 fewer slots for preschoolers (children ages three to five) in centers in 2016 than in 2015, continuing the downward trend since the 2013 peak.[8]**

◆ **In January 2016, there were 366 fewer slots in licensed family child care homes than in the previous year. The number of family child care slots is down 61% from a peak high of 8,601 in 2006 to 3,357 in 2016.[9]**

◆ **The majority of licensed child care programs in Rhode Island accept children participating in the Child Care Assistance Program (CCAP). Seventy-four percent of licensed centers and 85% of licensed family child care homes accept CCAP certificates, which cover all or part of the cost of child care for low-income working families.[10]**

◆ **In addition to licensed programs operated by community-based agencies, businesses, and family child care providers, there are 53 traditional public schools in Rhode Island, one public charter school (Highlander), and one state-operated school (the RI School for the Deaf) that offer early learning programs for preschoolers.[11]**

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.[12]**

Licensed Capacity of Early Learning Programs

Table 33.

Capacity of Licensed Early Learning Programs, Rhode Island, January 2016

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	8	129	296	5	34	459
Bristol	5	59	108	4	24	191
Burrillville	3	19	87	2	14	120
Central Falls	4	78	187	20	127	392
Charlestown	4	14	72	1	6	92
Coventry	7	156	179	2	16	351
Cranston	31	454	1,171	47	324	1,949
Cumberland	7	124	315	8	67	506
East Greenwich	12	344	652	0	0	996
East Providence	16	144	536	6	40	720
Exeter	2	34	38	1	8	80
Foster	1	17	25	0	0	42
Glocester	3	55	82	0	0	137
Hopkinton	2	0	44	3	24	68
Jamestown	1	31	33	1	8	72
Johnston	19	374	447	10	65	886
Lincoln	5	102	160	3	20	282
Little Compton	1	0	18	0	0	18
Middletown	9	143	389	3	18	550
Narragansett	2	12	20	0	0	32
New Shoreham	1	13	26	0	0	39
Newport	4	63	195	1	8	266
North Kingstown	7	107	307	3	28	442
North Providence	10	146	194	9	63	403
North Smithfield	1	67	91	4	36	194
Pawtucket	19	330	818	37	237	1,385
Portsmouth	5	93	134	1	6	233
Providence	48	762	1,944	291	1,917	4,587
Richmond	0	0	0	4	35	35
Scituate	1	11	36	5	40	87
Smithfield	9	291	563	0	0	854
South Kingstown	12	185	371	5	38	564
Tiverton	3	24	113	1	6	143
Warren	5	74	224	1	8	306
Warwick	27	740	1,360	10	75	2,175
West Greenwich	2	6	48	0	0	54
West Warwick	5	168	316	2	14	498
Westerly	7	124	329	1	5	458
Woonsocket	9	94	509	6	46	649
Four Core Cities	*80*	*1,264*	*3,458*	*354*	*2,327*	*7,013*
Remainder of State	*237*	*4,323*	*8,979*	*143*	*1,030*	*14,302*
Rhode Island	*317*	*5,587*	*12,437*	*497*	*3,357*	*21,315*

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, from RI Early Care and Education Data System (ECEDS), January 2016. 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

[1] Burchinal, M., Kainz, K., & Cai, Y. (2011). How well do our measures of quality predict child outcomes?: A meta-analysis and coordinated analysis of data from large-scale studies of early childhood settings. In Zaslow, M., Martinez-Beck, I., Tout, K., & Halle, T. (Eds.), *Quality measurement in early childhood settings* (pp. 11-31). Baltimore, MD: Paul H. Brookes Publishing.

[2] Halle, T., Martinez-Beck, I., Forry, N. D., & McSwiggan, M. (2011). Setting the context for a discussion of quality measures: The demographic landscape of early care and education. In Zaslow, M., Martinez-Beck, I., Tout, K. & Halle, T. (Eds.), *Quality measurement in early childhood settings* (pp. 3-10). Baltimore, MD: Paul H. Brookes Publishing.

[3] Glynn, S. J., Farrell, J., & Wu, N. (2013). *The importance of preschool and child care for working mothers.* Retrieved February 10, 2014, from www.americanprogress.org

[4] U.S. Census Bureau, American Community Survey, 2010-2014. Table DP03.

[5] Kagan, S. L., Kauerz, K,. & Tarrant, K. (2008). *The early care and education teaching workforce at the fulcrum: An agenda for reform.* New York: Teachers College Press.

[6] Sussman, C. & Gillman, A. (2007). *Building early childhood facilities: What states can do to create supply and promote quality.* New Brunswick, NJ: National Institute for Early Education Research.

(continued on page 182)

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 through the Rhode Island Department of Human Services' Child Care Assistance Program (CCAP). 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 access child care.[1]

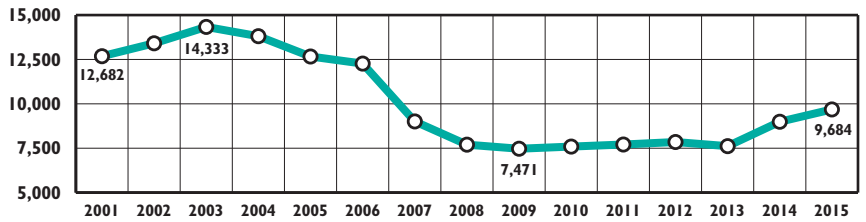
In Rhode Island, the average cost of full-time child care for an infant in a child care center consumes 49% of the median single-parent income and is more than the average tuition and fees at public colleges. The average annual cost of child care for two children (an infant and a preschooler) in Rhode Island is more than twice the state's median annual rent and is slightly higher than the average annualized mortgage.[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 $101,000 annually to afford the average yearly cost for a three-year-old at a licensed center ($10,172).[3,4]

Child care subsidies increase the likelihood that low-income parents are able to work, are employed full-time, and are able to maintain employment over longer periods of time. Parental employment improves the economic security of a family and is associated with improved social and emotional well-being of children.[5]

Child care subsidies increase the likelihood that families use licensed child care, and research has shown that licensed child care is generally higher quality than unlicensed care.[6] Subsidies can also help low-income families access higher-quality child care programs that support children's development and learning. Low provider reimbursement rates often restrict access to high-quality child care.[7]

As of January 2016, 10% of children participating in the Rhode Island Child Care Assistance Program (CCAP) ages birth through 12 were enrolled in a program with a high-quality BrightStars rating (four or five stars). Preschool-age children were more likely to be enrolled in a high-quality program than infants and toddlers.[8] The majority of states in the U.S. use a tiered provider reimbursement rate system with higher payments going to higher quality child care programs in order to incentivize and support quality.[9]

Child Care Subsidies, Rhode Island, 2001-2015



Source: Rhode Island Department of Human Services, December 2001–December 2015.

◆ **In December 2015, there were 9,684 child care subsidies in Rhode Island, an increase of 8% from 8,991 in December 2014, but down 32% from the 2003 peak.[10] In December 2015 in Rhode Island, 78% of child care subsidies were for care in a licensed child care center, 21% were for care by a licensed family child care home or group family child care home, and 1% were for care by a license-exempt relative, friend, or neighbor.[11]**

◆ **As of 2015, families with incomes under 180% FPL ($36,162 for a family of three) who work a minimum of 20 hours per week are eligible for CCAP. Families may continue to participate until their income reaches 225% FPL ($45,203 for a family of three) as part of a pilot set to expire on September 30, 2016 unless it is extended or made permanent. Families in Rhode Island Works and some other low-income families may also be eligible for CCAP to support education and employment activities.[12]**

◆ **In December 2015, 84% of all child care subsidies in Rhode Island were used by low-income working families not receiving cash assistance, 8% by families in the Rhode Island Works Program, and 8% for children in the care of the Rhode Island Department of Children, Youth and Families.[13]**

Average Annual Cost for Full-Time Child Care, Rhode Island, 2015

PROGRAM TYPE	COST PER CHILD
Child Care Center (infant care)	$12,091
Child Care Center (preschool care)	$10,172
Family Child Care Home (preschool care)	$8,655
School-Age Center-Based Program (child age 6-12)	$7,775

Source: Rhode Island KIDS COUNT analysis of average weekly rates from Bodah, M. M. (2015). *Statewide survey of childcare rates in Rhode Island.* Kingston, RI: University of Rhode Island.

Children Receiving Child Care Subsidies

Table 34.

Child Care Subsidies, Rhode Island, December 2015

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	4	15	19	10	11	13	34
Bristol	1	50	51	15	13	14	42
Burrillville	3	43	46	2	7	26	35
Central Falls	30	392	422	98	142	164	404
Charlestown	0	17	17	5	5	2	12
Coventry	9	129	138	41	54	64	159
Cranston	58	503	561	158	226	172	556
Cumberland	8	101	109	26	43	32	101
East Greenwich	4	13	17	20	30	13	63
East Providence	17	304	321	73	142	167	382
Exeter	0	23	23	5	6	6	17
Foster	2	14	16	5	2	0	7
Glocester	1	16	17	16	17	0	33
Hopkinton	0	16	16	2	1	2	5
Jamestown	0	3	3	3	6	1	10
Johnston	9	143	152	114	119	78	311
Lincoln	5	104	109	33	59	88	180
Little Compton	0	1	1	0	0	0	0
Middletown	6	69	75	19	42	15	76
Narragansett	0	34	34	0	3	9	12
New Shoreham	0	0	0	0	0	0	0
Newport	52	219	271	66	109	101	276
North Kingstown	2	141	143	70	64	48	182
North Providence	8	196	204	41	66	84	191
North Smithfield	2	34	36	18	28	13	59
Pawtucket	48	1,057	1,105	249	390	478	1,117
Portsmouth	1	22	23	12	16	5	33
Providence	405	3,013	3,418	794	1,142	1,457	3,393
Richmond	2	11	13	16	19	19	54
Scituate	0	13	13	2	3	3	8
Smithfield	1	43	44	1	2	0	3
South Kingstown	1	48	49	45	70	35	150
Tiverton	3	27	30	4	11	5	20
Warren	1	48	49	14	30	26	70
Warwick	35	368	403	191	252	210	653
West Greenwich	1	9	10	4	8	1	13
West Warwick	19	275	294	76	87	87	250
Westerly	1	94	95	37	44	35	116
Woonsocket	54	610	664	87	218	310	615
DCYF	*NA*	*NA*	*820*	*NA*	*NA*	*NA*	*NA*
Out-Of-State	*0*	*0*	*0*	*16*	*23*	*3*	*42*
Four Core Cities	*537*	*5,072*	*5,609*	*1,228*	*1,892*	*2,409*	*5,529*
Remainder of State	*256*	*3,146*	*3,402*	*1,144*	*1,595*	*1,374*	*4,113*
Rhode Island	*793*	*8,218*	*9,831*	*2,388*	*3,510*	*3,786*	*9,684*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, InRhodes Database, December 2015.

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

[1,9] Schulman, K. & Blank, H. (2015). *Building blocks: State child care assistance policies 2015.* Washington, DC: National Women's Law Center.

[2] *Parents and the high price of child care: 2015 report.* (2015). Arlington, VA: Child Care Aware of America.

[3] U.S. Department of Health and Human Services. (1998). Child Care and Development Fund: Final rule. *Federal Register, 63*(142). Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

(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]

BrightStars Quality Ratings for Licensed Early Learning Programs and Public Schools Serving Preschoolers, Rhode Island, January 2016

	CENTERS & PRESCHOOLS	PUBLIC SCHOOLS	FAMILY CHILD CARE
Unrated	18% (57)	40% (22)	13% (67)
1 Star	31% (99)	15% (8)	59% (293)
2 Stars	20% (64)	27% (15)	24% (121)
3 Stars	14% (43)	5% (3)	1% (7)
4 Stars	12% (39)	13% (7)	2% (8)
5 Stars	5% (15)	0% (0)	<1% (1)
TOTAL	*317*	*55*	*497*

Source: Rhode Island Association for the Education of Young Children and the RI Early Care and Education Data System (ECEDS), January 2016.

◆ **As of January 2016, there were 690 licensed early care and education programs with an active BrightStars quality rating, up from 669 in January 2015 and more than three times as many as were rated in January 2014. Fifty-four (17%) licensed early learning centers had met the benchmarks for a high-quality rating of four or five stars (one more center than in January 2015). Nine (2%) family child care homes had received a high-quality rating of four or five stars (one more home than in 2015).[14]**

◆ **As of January 2016, there were 33 public schools with a BrightStars quality rating (60% of the 55 public schools serving preschoolers in the state). Seven (13%) had a high-quality rating (two more schools than in 2015).[15]**

◆ **Of the 110 early learning programs that applied for a BrightStars rating increase or renewal in 2015, 59% received a star level increase of one or more levels, 35% maintained their star level, and 6% dropped one or more star levels.[16]**

◆ **The Rhode Island Department of Education awards Comprehensive Early Childhood Education approval to preschool classrooms that meet state-defined quality benchmarks. As of January 2016, there were 17 preschool classrooms in 12 licensed centers (seven fewer classrooms in 4 fewer centers than in 2015) and one public school classroom that met approval standards (one more than in 2015).[17]**

◆ **Rhode Island's $50 million federal Race to the Top-Early Learning Challenge grant, which will end in December 2016, is focused on increasing participation in BrightStars and providing intensive support to programs to meet high-quality benchmarks.[18]**

Early Learning Programs Participating in BrightStars

Table 35.

Licensed Early Learning Programs Participating in the BrightStars Quality Rating and Improvement System, Rhode Island, January 2016

	CHILD CARE CENTERS AND PRESCHOOLS					FAMILY CHILD CARE HOMES				
CITY/TOWN	LICENSED PROGRAMS	PROGRAMS WITH A BRIGHTSTARS QUALITY RATING	PROGRAMS WITH A HIGH-QUALITY RATING	% IN BRIGHTSTARS	% WITH HIGH-QUALITY RATING	LICENSED PROGRAMS	PROGRAMS WITH A BRIGHTSTARS QUALITY RATING	PROGRAMS WITH A HIGH-QUALITY RATING	% IN BRIGHTSTARS	% WITH HIGH-QUALITY RATING
Barrington	8	4	1	50%	13%	5	2	0	40%	0%
Bristol	5	4	0	80%	0%	4	1	0	25%	0%
Burrillville	3	3	1	100%	33%	2	1	0	50%	0%
Central Falls	4	3	1	75%	25%	20	20	0	100%	0%
Charlestown	4	4	2	100%	50%	1	1	0	100%	0%
Coventry	7	7	1	100%	14%	2	2	0	100%	0%
Cranston	31	21	2	68%	6%	47	41	0	87%	0%
Cumberland	7	5	2	71%	29%	8	2	0	25%	0%
East Greenwich	12	11	2	92%	17%	0	NA	NA	NA	NA
East Providence	16	12	3	75%	19%	6	4	0	67%	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	2	2	0	100%	0%	3	3	1	100%	33%
Jamestown	1	1	0	100%	0%	1	0	0	0%	0%
Johnston	19	18	2	95%	11%	10	8	0	80%	0%
Lincoln	5	4	1	80%	20%	3	1	0	33%	0%
Little Compton	1	0	0	0%	0%	0	NA	NA	NA	NA
Middletown	9	7	2	78%	22%	3	1	0	33%	0%
Narragansett	2	1	0	50%	0%	0	NA	NA	NA	NA
New Shoreham	1	1	1	100%	100%	0	NA	NA	NA	NA
Newport	4	4	1	100%	25%	1	0	0	0%	0%
North Kingstown	7	7	1	100%	14%	3	3	0	100%	0%
North Providence	10	7	1	70%	10%	9	5	0	56%	0%
North Smithfield	1	1	0	100%	0%	4	2	2	50%	50%
Pawtucket	19	17	2	89%	11%	37	34	0	92%	0%
Portsmouth	5	3	0	60%	0%	1	0	0	0%	0%
Providence	48	40	15	83%	31%	291	278	5	96%	2%
Richmond	0	NA	NA	NA	NA	4	0	0	0%	0%
Scituate	1	1	0	100%	0%	5	3	0	60%	0%
Smithfield	9	7	1	78%	11%	0	NA	NA	NA	NA
South Kingstown	12	8	3	67%	25%	5	4	0	80%	0%
Tiverton	3	2	0	67%	0%	1	1	0	100%	0%
Warren	5	3	0	60%	0%	1	1	0	100%	0%
Warwick	27	24	4	89%	15%	10	3	0	30%	0%
West Greenwich	2	2	0	100%	0%	0	NA	NA	NA	NA
West Warwick	5	5	0	100%	0%	2	1	0	50%	0%
Westerly	7	6	0	86%	0%	1	1	0	100%	0%
Woonsocket	9	9	5	100%	56%	6	6	0	100%	0%
Four Core Cities	*80*	*69*	*23*	*86%*	*29%*	*354*	*338*	*5*	*95%*	*1%*
Remainder of State	*237*	*191*	*31*	*81%*	*13%*	*143*	*92*	*4*	*64%*	*3%*
Rhode Island	*317*	*260*	*54*	*82%*	*17%*	*497*	*430*	*9*	*87%*	*2%*

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 2016. Data on BrightStars quality ratings are from the Rhode Island Association for the Education of Young Children, January 2016. Data matched through the RI Early Care and Education Data System (ECEDS).

High-quality rating means a BrightStars rating of four or five stars.

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

References

[1] Burchinal, M., Kainz, K., & Cai, Y. (2011). How well do our measures of quality predict child outcomes? In Zaslow, M., Martinez-Beck, I., Tout, K., & Halle, T. (Eds.), *Quality measurement in early childhood settings.* 11-31. Baltimore, MD: Paul H. Brookes Publishing Co.

[2] Demma, R. (2010). *Building ready states: A governor's guide to supporting a comprehensive, high-quality early childhood state system.* Washington, DC: National Governor's Association, NGA Center for Best Practices.

[3] Vandell, D. L., Belsky, J., Burchinal, M., Steinberg, L., & Vandergrift, N. (2010). Do effects of early child care extend to age 15 years? Results from the NICHD study of early child care and youth development. *Child Development, 81*(3), 737-756.

[4,7] Center on the Developing Child at Harvard University. (2007). *A science-based framework for early childhood policy: Using evidence to improve outcomes in learning, behavior, and health for vulnerable children.* Cambridge, MA: Harvard University.

[5] Maxwell, K. L. & Kraus, S. (2010). *Rhode Island's 2009 child care center and preschool quality study.* Chapel Hill, NC: University of North Carolina, FPG Child Development Institute.

[6] Maxwell, K. L. & Kraus, S. (2010). *Rhode Island's 2010 family child care quality study.* Chapel Hill, NC: University of North Carolina, FPG Child Development Institute.

(continued on page 182)

Children Enrolled in Head Start

DEFINITION

Children enrolled in Head Start is the percentage of eligible children enrolled in a Rhode Island Head Start preschool program.

SIGNIFICANCE

Head Start is a federally-funded comprehensive early childhood program for the lowest 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]

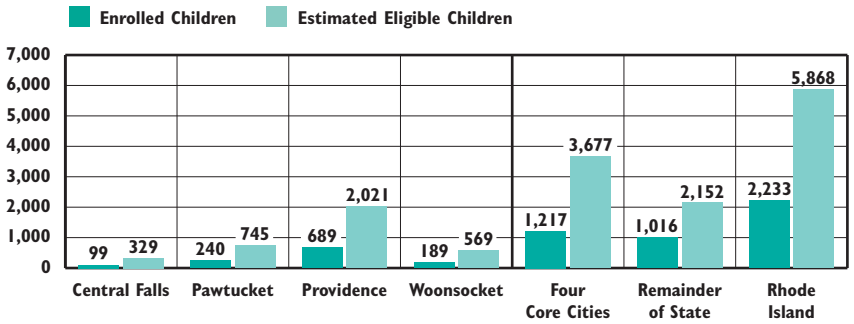
Family income is strongly correlated with children's cognitive, language, and literacy skills at school entry. Before kindergarten entry, children in the highest socio-economic group have cognitive test scores that are 60% higher than the average scores of children in the lowest socio-economic group. 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. However, those improvements may no longer be discernible at the end of third grade. Researchers suggest that early elementary "fade out" may be related to other low-income children "catching up" in the early grades or stagnation associated with attending low-quality elementary schools.[6,7,8,9]

Lasting impacts for children who were in Head Start have been found in reduced grade retention and special education placement and increased high school graduation and college enrollment. Head Start participation is also associated with reduced arrests, child mortality, and childhood obesity.[10]

As of October 2015, there were 2,233 children enrolled in Head Start and 368 eligible children on the waiting list.[11] Rhode Island Head Start programs served significant numbers of children with high needs including 240 preschool children with developmental delays or disabilities (11% of all children enrolled), 48 children who were in foster care, and 70 children who were homeless. Fifteen percent of children enrolled in Rhode Island Head Start programs were also participating in the Child Care Assistance Program.[12]

Access to Head Start for Children in Poverty, Rhode Island, 2015

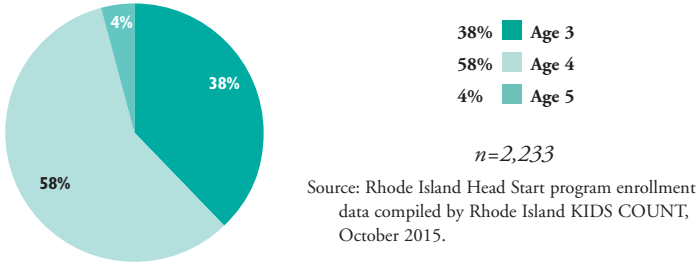


Source: Rhode Island Head Start program enrollment data compiled by Rhode Island KIDS COUNT, October 2015. Estimated eligible children is the number of children ages three and four according to Census 2010 multiplied by the % of children under age six living in families with incomes below the federal poverty line (FPL) according to the Population Reference Bureau's analysis of 2010-2014 American Community Survey data.

◆ **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 2015, Rhode Island Head Start programs served 2,233 children, 38% of the estimated 5,868 income-eligible three- and four-year old children and 9% of all children ages three and four.[13,14]**

◆ **In the four core cities, 33% of the estimated eligible children were enrolled in Head Start, compared with 47% in the remainder of the state. The estimated percentage of eligible children enrolled in Head Start for each core city is: Central Falls – 30%, Pawtucket – 32%, Providence – 34%, and Woonsocket – 33%.[15,16]**

Children Enrolled in Head Start by Age, Rhode Island, 2015



n=2,233

Source: Rhode Island Head Start program enrollment data compiled by Rhode Island KIDS COUNT, October 2015.

Table 36.

Children Enrolled in Head Start, Rhode Island, 2015

CITY/TOWN	ALL CHILDREN AGES 3 & 4	% CHILDREN <AGE 6 IN POVERTY	ESTIMATED ELIGIBLE CHILDREN AGES 3 & 4 IN POVERTY	# OF CHILDREN ENROLLED IN HEAD START	ESTIMATED % OF CHILDREN AGES 3 & 4 ENROLLED IN HEAD START	ESTIMATED % OF ELIGIBLE CHILDREN ENROLLED IN HEAD START
Barrington	369	1.3%	5	3	1%	60%
Bristol	401	5.6%	22	13	3%	59%
Burrillville	321	12.6%*	40	16	5%	40%
Central Falls	699	47.1%**	329	99	14%	30%
Charlestown	153	32.3%***	49	7	5%	14%
Coventry	734	25.9%**	190	55	7%	29%
Cranston	1,684	16.4%*	276	182	11%	66%
Cumberland	810	6.8%*	55	10	1%	18%
East Greenwich	277	13.4%**	37	1	0%	3%
East Providence	982	23.6%*	232	86	9%	37%
Exeter	105	NA	NA	3	3%	NA
Foster	99	13.8%***	14	0	0%	0%
Glocester	191	9.6%**	18	2	1%	11%
Hopkinton	167	14.5%***	24	5	3%	21%
Jamestown	102	7.9%***	8	0	0%	0%
Johnston	528	20.4%*	108	44	8%	41%
Lincoln	412	13.8%*	57	0	0%	0%
Little Compton	49	17.8%***	9	1	2%	11%
Middletown	431	13.3%*	57	34	8%	60%
Narragansett	210	9.7%*	20	7	3%	35%
New Shoreham	15	10.0%***	22	0	0%	0%
Newport	514	13.3%*	68	74	14%	109%
North Kingstown	593	20.0%**	119	33	6%	28%
North Providence	575	21.1%**	121	60	10%	50%
North Smithfield	218	3.6%*	8	5	2%	63%
Pawtucket	2,053	36.3%*	745	240	12%	32%
Portsmouth	359	4.0%*	14	8	2%	57%
Providence	4,743	42.6%*	2,021	689	15%	34%
Richmond	190	15.7%***	30	5	3%	17%
Scituate	197	9.4%**	19	4	2%	21%
Smithfield	343	NA	NA	4	1%	NA
South Kingstown	504	13.1%**	66	13	3%	20%
Tiverton	287	11.1%*	32	15	5%	47%
Warren	240	12.8%**	31	25	10%	81%
Warwick	1,579	8.7%	137	124	8%	91%
West Greenwich	115	NA	NA	0	0%	NA
West Warwick	703	24.1%**	169	108	15%	64%
Westerly	490	14.5%**	71	69	14%	97%
Woonsocket	1,218	46.7%*	569	189	16%	33%
Four Core Cities	*8,713*	*42.2%*	*3,677*	*1,217*	*14%*	*33%*
Remainder of State	*14,947*	*14.4%*	*2,152*	*1,016*	*7%*	*47%*
Rhode Island	*23,660*	*24.8%*	*5,868*	*2,233*	*9%*	*38%*

Source of Data for Table/Methodology

Rhode Island Head Start Programs, all children enrolled (ages three to five) as of October 2015. 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. 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 the federal poverty line (FPL) according to the Population Reference Bureau's (PRB) analysis of 2010-2014 American Community Survey data. Estimated eligible children for the four core cities, remainder of state, and Rhode Island is calculated using PRB estimates for those groupings and is not a sum of estimates by community.

The American Community Survey is a sample survey, and therefore the number and percentage of children living in poverty are estimates. The reliability of these estimates varies by community.

* The Margin of Error around the percentage is greater than 5 but less than 10 percentage points.

** The Margin of Error around the percentage is greater than 10 but less than 15 percentage points.

*** The Margin of Error around the percentage is greater than or equal to 15 percentage points.

NA: American Community Survey estimate of % of children under age six in poverty is not available for this community.

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

References

[1,4,6] Resnick, G. (2010). Project Head Start: Quality and links to child outcomes. In A. J. Reynolds, A. J. Rolnick, M. M. Englund, & J. A. Temple (Eds.), *Childhood programs and practices in the first decade of life: A human capital integration*. (121-153). New York, NY: Cambridge University Press.

[2] Schmit, S. (2013). *Head Start participants, programs, families and staff in 2012.* Washington, DC: Center for Law and Social Policy.

(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 29% 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 of high-income and highly educated families are much more likely to be enrolled in preschool than children from low- and moderate-income families.[5]

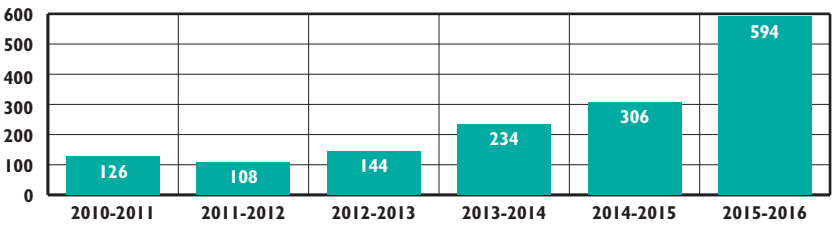
High-quality preschool programs show strong economic returns, with benefits to children and the public far exceeding the original investment. Small class sizes, low child-teacher ratios, and teachers who are well-educated, well-paid, emotionally supportive, and use curricula effectively produce the biggest gains for 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 five 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 math skills and close the achievement gap between low-income children and their more affluent peers by three-quarters.[11]

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.[12]

Rhode Island State Pre-K Funded Slots, 2010-2011 through 2015-2016



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 through 2015-2016.

◆ **As of the 2015-2016 school year, there are 33 State Pre-K classrooms in Rhode Island with a total of 594 children enrolled. Twenty-five percent of children enrolled in State Pre-K speak a language other than English at home and 12% have a developmental delay or disability.[13]**

◆ **Of the 33 State Pre-K classrooms, 52% (17) are operated by a Head Start agency, 39% (13) by a child care center/preschool, and 9% (3) by a public school district.[14]**

◆ **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. Children are selected to participate in State Pre-K through a lottery, with children from low-income families prioritized for enrollment based on the proportion of low-income children in the local school district.[15]**

◆ **In the 2015-2016 school year, 417 (70%) of the children enrolled in State Pre-K are low-income.[16] This is approximately 8% of the population of low-income four-year olds under 200% FPL statewide.[17] Including the 1,391 low-income four-year-olds enrolled in Head Start in Rhode Island, approximately 33% of the state's low-income four-year-olds are enrolled in a public preschool program (State Pre-K or Head Start).[18]**

State Pre-K Expansion

◆ **With 5% of all four-year-olds enrolled, Rhode Island ranks near the bottom of the 40 states for access to State Pre-K.[19,20] Expansion of the State Pre-K program is included in Rhode Island's education funding formula.[21] In 2014, Rhode Island was awarded a federal Preschool Development Grant that will accelerate expansion.[22]**

Table 37.

Children Enrolled in State Pre-K, Rhode Island, 2015-2016

CITY/TOWN	# OF CHILDREN AGE 4	% CHILDREN <AGE 6 IN LOW-INCOME FAMILIES	ESTIMATED # OF LOW-INCOME CHILDREN AGE 4	# LOW-INCOME CHILDREN ENROLLED IN STATE PRE-K	% LOW-INCOME CHILDREN AGE 4 ENROLLED IN STATE PRE-K	# CHILDREN ENROLLED IN STATE PRE-K	% CHILDREN AGE 4 ENROLLED IN STATE PRE-K
Barrington	199	5.2%*	10	0	0%	0	0%
Bristol	206	22.5%**	46	0	0%	0	0%
Burrillville	173	19.7%**	34	0	0%	0	0%
Central Falls	345	80.8%**	279	48	17%	54	16%
Charlestown	81	53.5%***	43	0	0%	0	0%
Coventry	366	33.9%**	124	0	0%	0	0%
Cranston	862	34.3%*	296	16	5%	36	4%
Cumberland	426	22.9%*	98	0	0%	0	0%
East Greenwich	158	22.6%**	36	0	0%	0	0%
East Providence	469	48.4%*	227	9	4%	18	4%
Exeter	55	NA	NA	0	0%	0	0%
Foster	53	27.2%***	14	0	0%	0	0%
Glocester	106	9.6%**	10	0	0%	0	0%
Hopkinton	87	31.6%***	27	0	0%	0	0%
Jamestown	50	7.9%***	4	0	0%	0	0%
Johnston	278	48.6%**	135	0	0%	0	0%
Lincoln	211	32.3%**	68	0	0%	0	0%
Little Compton	28	24.3%***	7	0	0%	0	0%
Middletown	226	30.3%*	68	0	0%	0	0%
Narragansett	117	16.1%**	19	0	0%	0	0%
New Shoreham	7	30%***	2	0	0%	0	0%
Newport	232	33.1%**	77	33	43%	54	23%
North Kingstown	318	28.2%**	90	0	0%	0	0%
North Providence	282	32.1%**	91	0	0%	0	0%
North Smithfield	108	20.7%***	22	0	0%	0	0%
Pawtucket	1,006	58.5%*	589	28	5%	36	4%
Portsmouth	196	24.4%***	48	0	0%	0	0%
Providence	2,382	70.0%*	1,667	165	10%	198	8%
Richmond	102	21.4%***	22	0	0%	0	0%
Scituate	94	15.6%***	15	0	0%	0	0%
Smithfield	169	10.4%*	18	0	0%	0	0%
South Kingstown	273	27.6%**	75	0	0%	0	0%
Tiverton	143	29.5%***	42	0	0%	0	0%
Warren	127	47.1%***	60	0	0%	0	0%
Warwick	850	24.4%*	207	21	10%	54	6%
West Greenwich	53	6.9%**	4	0	0%	0	0%
West Warwick	354	53.7%**	190	27	14%	54	15%
Westerly	244	34.1%***	83	0	0%	0	0%
Woonsocket	584	73.3%*	428	70	16%	90	15%
Four Core Cities	*4,317*	*68.9%*	*2,974*	*311*	*10%*	*378*	*9%*
Remainder of State	*7,703*	*31.0%*	*2,388*	*106*	*4%*	*216*	*3%*
Rhode Island	*12,020*	*45.2%*	*5,433*	*417*	*8%*	*594*	*5%*

Source of Data for Table/Methodology

The number children enrolled in State Pre-K is from the Rhode Island Department of Education, October 2015.

The number of children age four in each community is from Census 2010, Summary File 1.

Estimated number of low-income children age four is the number of children age four according to Census 2010 multiplied by the % of children under age six living in families with incomes below 200% of the federal poverty line (FPL) according to the Population Reference Bureau's analysis of 2010-2014 American Community Survey data. Estimated eligible children for the four core cities, remainder of state, and Rhode Island is calculated using PRB estimates for those groupings and is not a sum of estimates by community.

The American Community Survey is a sample survey, and therefore the number and percentage of children living in poverty are estimates. The reliability of these estimates varies by community.

* The Margin of Error around the percentage is greater than 5 but less than 10 percentage points.

** The Margin of Error around the percentage is greater than 10 but less than 15 percentage points.

*** The Margin of Error around the percentage is greater than or equal to 15 percentage points.

NA: American Community Survey estimate of % of children under age six in poverty is not available for this community.

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

References

[1,10,20,22] Barnett, W. S., Carolan, M. E., Squires, J. H., Brown, K. C., & Horowitz, M. (2015). *The state of preschool 2014: State preschool yearbook.* New Brunswick, NJ: National Institute for Early Education Research, Rutgers Graduate School of Education.

[2,6] Epstein, D. J. & Barnett, W. S. (2012). Early education in the United States: Programs and access. In R. C. Pianta, W. S. Barnett, L. M. Justice & S. M. Sheridan (Eds.), *Handbook of early childhood education.* (pp. 3-21). New York, NY: The Guilford Press.

(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

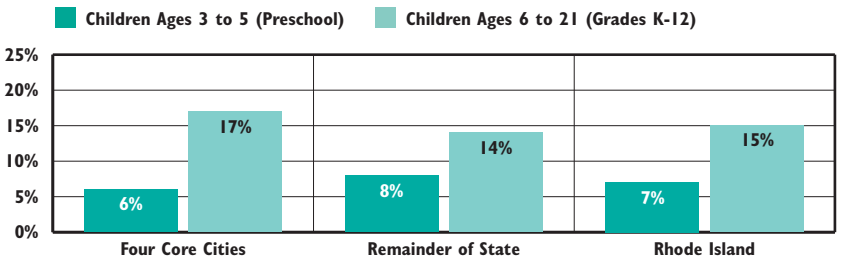
Preschool special education is an important component of the early care and education system, providing access to early learning opportunities for hundreds of thousands of preschool-age children across the U.S.[1] The federal *Individuals with Disabilities Education Act (IDEA)* specifies that, beginning 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 2015, 41% of children in preschool special education in Rhode Island qualified under the developmental delay category, 49% 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 2014-2015 school year in Rhode Island, districts completed developmental screenings for 14% of three-year-olds, 38% of four-year-olds, and 50% of five-year-olds.[11]

Special Education Participation Rate, Children Ages 3 to 5 and 6 to 21, Rhode Island, June 2015



Source: Rhode Island Department of Education, June 2015 Special Education Census. Denominator for children ages three to five is the number of children ages three to five residing in each district. Denominator for children ages six to 21 is the resident average daily membership (RADM) from RIDE. RADM only includes children receiving public education services so it is not comparable to the preschool special education denominator.

◆ **Approximately 15% of 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.[12]**

◆ **In June 2015 there were 2,972 children ages three to five receiving preschool special education services, 7% of all preschool-age children in the state. Children in the four core cities are less likely to be receiving preschool special education services (6%) than children in the remainder of the state (8%). Twenty-eight 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 2015 in Rhode Island, 47% of preschool-age children received special education services within an inclusive early childhood classroom along with their typically developing peers, while 17% were enrolled in a separate special education class, school, or residential facility. Other children were not enrolled in an early childhood classroom, receiving services through "walk-in" visits to a service provider (25%) or at home (1%). Another 10% were enrolled in a regular early childhood classroom but did not receive their special education services in that class.[14]**

◆ **In June 2015, children in the four core cities were less likely to receive preschool special education services in an inclusive early childhood setting (41%) than children in the remainder of the state (50%).[15] Inclusion in high-quality early learning programs benefits children with and without disabilities.[16]**

Children Receiving Preschool Special Education Services

Table 38. **Children Ages 3 to 5 Receiving Special Education Services, Rhode Island, 2015**

		DEVELOPMENTAL SCREENING RATES			PRESCHOOL SPECIAL EDUCATION BY SETTING				
SCHOOL DISTRICT	# OF CHILDREN AGES 3-5	% 3-YEAR-OLDS SCREENED	% 4-YEAR-OLDS SCREENED	% 5-YEAR-OLDS SCREENED	INCLUSIVE EARLY CHILDHOOD CLASS	% IN INCLUSIVE EARLY CHILDHOOD CLASS	OTHER SETTING	TOTAL # RECEIVING SERVICES	% RECEIVING SERVICES
Barrington	557	37%	65%	88%	10	21%	37	47	8%
Bristol Warren	897	18%	43%	49%	43	61%	27	70	8%
Burrillville	485	7%	43%	59%	39	66%	20	59	12%
Central Falls	1,164	33%	51%	72%	36	42%	49	85	7%
Chariho	682	23%	58%	64%	23	32%	49	72	11%
Coventry	1,000	14%	39%	56%	62	62%	38	100	10%
Cranston	2,673	11%	40%	63%	49	31%	110	159	6%
Cumberland	1,194	8%	41%	46%	50	56%	40	90	8%
East Greenwich	567	6%	38%	37%	*	19%	25	31	5%
East Providence	1,677	11%	35%	51%	40	30%	95	135	8%
Exeter-West Greenwich	368	24%	59%	74%	11	31%	24	35	10%
Foster	104	14%	39%	50%	*	55%	*	11	11%
Glocester	229	14%	39%	50%	11	44%	14	25	11%
Jamestown	146	36%	47%	58%	*	64%	*	11	8%
Johnston	935	23%	40%	62%	35	40%	52	87	9%
Lincoln	720	19%	53%	62%	74	80%	19	93	13%
Little Compton	89	13%	32%	59%	0	NA	0	0	0%
Middletown	847	12%	25%	36%	44	80%	11	55	6%
Narragansett	247	37%	63%	74%	25	86%	*	29	12%
New Shoreham	36	0%	40%	50%	*	100%	0	*	8%
Newport	1,145	12%	32%	31%	48	72%	19	67	6%
North Kingstown	851	27%	67%	78%	37	60%	25	62	7%
North Providence	1,080	14%	34%	58%	44	51%	43	87	8%
North Smithfield	343	25%	54%	62%	15	44%	19	34	10%
Pawtucket	3,457	10%	31%	50%	62	33%	126	188	5%
Portsmouth	577	11%	27%	50%	21	55%	17	38	7%
Providence	9,217	11%	32%	33%	227	48%	250	477	5%
Scituate	259	14%	39%	50%	13	46%	15	28	11%
Smithfield	479	29%	65%	69%	25	52%	23	48	10%
South Kingstown	787	25%	60%	77%	31	56%	24	55	7%
Tiverton	466	11%	27%	48%	21	58%	15	36	8%
Warwick	2,613	10%	28%	48%	83	44%	107	190	7%
West Warwick	1,195	12%	46%	65%	46	39%	73	119	10%
Westerly	765	36%	68%	68%	57	80%	14	71	9%
Woonsocket	2,020	12%	21%	43%	73	34%	143	216	11%
Charter Schools	*NA*	*NA*	*NA*	*NA*	*12*	*92%*	*	*13*	*NA*
RI School for the Deaf	*NA*	*NA*	*NA*	*NA*	*0*	*0%*	*	*	*NA*
Four Core Cities	*15,858*	*12%*	*31%*	*40%*	*398*	*41%*	*568*	*966*	*6%*
Remainder of State	*24,013*	*16%*	*42%*	*57%*	*979*	*50%*	*968*	*1,947*	*8%*
Rhode Island	*39,871*	*14%*	*38%*	*50%*	*1,389*	*47%*	*1,538*	*2,927*	*7%*

Sources of Data for Table/Methodology

Rhode Island Department of Education (RIDE), June 2015 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 2014-2015 school year from the Rhode Island Department of Health's KIDSNET database shared with RIDE.

Due to changes in the denominator, screening rates and percentage receiving preschool special education services should not be compared with data in previous Factbooks.

2014-2015 Child Outreach screening data is from the RIDE Office of Student, Community, and Academic Supports. 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

[1] Epstein, D. J. & Barnett, W. S. (2012). Early education in the United States: Programs and access. In R. C. Pianta, W. S. Barnett, L. M. Justice., & S. M. Sheridan, (Eds.), *Handbook of early childhood education* (pp. 3-21). New York, NY: The Guilford Press.

[2,4,6] Danaher, J. (2011). *NECTAC notes: Eligibility policies and practices for young children under Part B of IDEA.* Chapel Hill, NC: National Early Childhood Technical Assistance Center.

(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, 2015, there were 142,014 students enrolled in Rhode Island public schools in preschool through grade 12, a decrease of 6% from 151,619 on October 1, 2006.

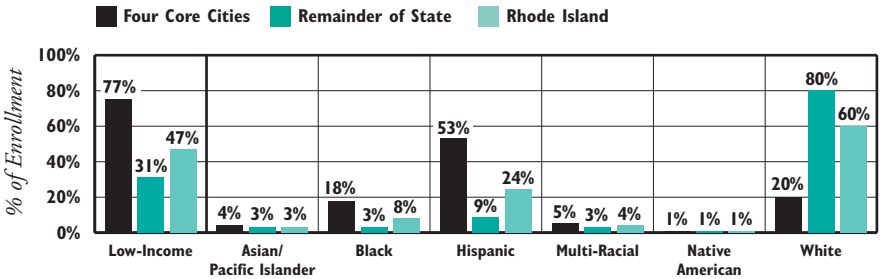
Of the 142,014 Rhode Island public school students in October 2015, 29% (41,454) were attending schools in the four core cities (communities with the highest child poverty rates), 65% (92,402) were attending schools in the remaining districts, and the remaining 8,158 attended charter schools, state-operated schools, or the Urban Collaborative Accelerated Project (UCAP). There were an additional 13,495 Rhode Island students attending private and parochial schools (including out-of-state schools) and 1,693 students were home-schooled.[2]

In October 2015, there were 63,884 students in grades K-5, 32,809 in grades 6-8, and 42,871 in grades 9-12. There were 2,450 children enrolled in preschool in Rhode Island public schools.[3] The Rhode Island State Pre-K program served 594 children in 2015-2016, including 54 in three public school classrooms and the remainder in community-based centers.[4]

In October 2015, 60% 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 2015, 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 2014-2015 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, 2015



Source: Rhode Island Department of Education, October 1, 2015.

◆ **In October 2015, 20% of students enrolled in the four core cities were White, compared with 80% 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]**

The Changing Makeup of Rhode Island Public Schools

◆ **On October 1, 2015, almost one-half (47%) of Rhode Island public school students were low-income (eligible for free or reduced price lunch), up from 33% in 2006.[8]**

◆ **Over the past decade, Rhode Island schools have become more diverse. On October 1, 2015, 60% of students enrolled in Rhode Island public schools were non-Hispanic White, a decrease from 69% on October 1, 2006. On October 1, 2015, 24% of students enrolled in Rhode Island public schools were Hispanic, an increase from 18% on October 1, 2006.[9] Hispanic students continue to be concentrated in minority schools. During the 2011-2012 school year, 40% of Latino students were enrolled in Rhode Island public schools with 90-100% minority students, while 24% of Latino students were enrolled in majority White (over 50%) schools.[10]**

◆ **On October 1, 2015, 7,316 (5%) Rhode Island public school students were enrolled in charter schools, including district charter schools, up from 2,812 (2%) on October 1, 2006.[11] Part of the increase in charter school enrollment is due to a moratorium on charter schools put in place by the 2004 General Assembly that was lifted in 2008.[12]**

Table 39. **Rhode Island Public School Enrollment by Grade and Demographic Groups, October 1, 2015**

	ENROLLMENT BY GRADE LEVEL*				ENROLLMENT BY DEMOGRAPHIC GROUPS							
SCHOOL DISTRICT	PRE-SCHOOL	ELEMENTARY	MIDDLE	HIGH	% LOW-INCOME	% ASIAN PACIFIC ISLANDER	% BLACK	% HISPANIC**	% NATIVE AMERICAN	% MULTI-RACIAL	% WHITE	TOTAL ENROLLMENT
Barrington	24	1,416	843	1,045	6%	6%	1%	3%	<1%	3%	87%	3,328
Bristol Warren	44	1,588	764	932	33%	2%	2%	1%	1%	4%	91%	3,328
Burrillville	44	990	596	753	30%	1%	1%	3%	<1%	2%	93%	2,383
Central Falls	165	1,368	457	667	81%	1%	12%	72%	1%	4%	10%	2,657
Chariho	83	1,258	752	1,144	20%	1%	1%	2%	2%	2%	92%	3,237
Coventry	136	1,957	1,143	1,514	33%	1%	1%	4%	<1%	2%	92%	4,750
Cranston	84	4,549	2,527	3,281	45%	8%	5%	25%	1%	4%	58%	10,441
Cumberland	90	1,989	1,141	1,332	24%	3%	3%	10%	<1%	2%	82%	4,552
East Greenwich	47	1,025	638	745	6%	5%	1%	5%	<1%	4%	85%	2,455
East Providence	90	2,475	1,167	1,550	54%	6%	9%	4%	1%	7%	73%	5,282
Exeter-West Greenwich	57	633	423	525	13%	1%	1%	3%	0%	<1%	94%	1,638
Foster	0	277	0	0	22%	0%	0%	1%	0%	1%	98%	277
Foster-Glocester	0	0	470	685	18%	1%	<1%	1%	<1%	1%	96%	1,155
Glocester	4	541	0	0	13%	1%	1%	<1%	<1%	1%	97%	545
Jamestown	23	306	162	5	9%	2%	1%	<1%	0%	3%	93%	496
Johnston	77	1,470	783	887	48%	3%	4%	17%	<1%	1%	75%	3,217
Lincoln	97	1,257	762	896	26%	2%	3%	6%	<1%	1%	88%	3,012
Little Compton	0	141	102	0	14%	1%	<1%	1%	0%	1%	97%	243
Middletown	20	1,059	544	664	28%	4%	6%	12%	<1%	7%	71%	2,287
Narragansett	51	550	300	420	19%	1%	1%	2%	1%	5%	89%	1,321
New Shoreham	0	44	33	36	16%	3%	0%	12%	0%	2%	84%	113
Newport	59	1,028	471	615	64%	2%	16%	25%	2%	12%	43%	2,173
North Kingstown	82	1,540	971	1,424	22%	2%	1%	4%	1%	3%	88%	4,017
North Providence	93	1,587	878	1,004	40%	3%	10%	20%	<1%	3%	63%	3,562
North Smithfield	37	721	459	512	18%	2%	1%	6%	<1%	2%	88%	1,729
Pawtucket	110	4,734	2,142	2,036	76%	1%	26%	31%	1%	6%	35%	9,022
Portsmouth	26	974	579	901	14%	2%	2%	4%	<1%	2%	90%	2,480
Providence	275	11,512	5,418	6,662	79%	5%	17%	64%	1%	4%	9%	23,867
Scituate	11	551	341	463	19%	1%	1%	1%	0%	<1%	97%	1,366
Smithfield	47	1,048	550	745	14%	2%	1%	5%	<1%	3%	89%	2,390
South Kingstown	110	1,331	796	1,012	22%	2%	2%	4%	3%	4%	84%	3,249
Tiverton	26	829	434	554	31%	1%	2%	1%	<1%	2%	94%	1,843
Warwick	193	3,965	2,146	2,836	33%	3%	2%	9%	<1%	3%	82%	9,140
West Warwick	62	1,662	742	1,019	49%	2%	5%	13%	1%	2%	77%	3,485
Westerly	92	1,282	662	872	35%	3%	1%	7%	2%	6%	81%	2,908
Woonsocket	64	2,992	1,312	1,540	72%	6%	10%	32%	<1%	5%	46%	5,908
Charter Schools	*23*	*3,215*	*1,164*	*1,868*	*73%*	*2%*	*14%*	*54%*	*1%*	*4%*	*25%*	*6,270*
State-Operated Schools	*4*	*20*	*18*	*1,705*	*63%*	*1%*	*14%*	*41%*	*1%*	*6%*	*37%*	*1,747*
UCAP	*0*	*0*	*119*	*22*	*81%*	*2%*	*16%*	*72%*	*1%*	*6%*	*3%*	*141*
Four Core Cities	*614*	*20,606*	*9,329*	*10,905*	*77%*	*4%*	*18%*	*53%*	*1%*	*5%*	*20%*	*41,454*
Remainder of State	*1,809*	*40,043*	*22,179*	*28,371*	*31%*	*3%*	*3%*	*9%*	*1%*	*3%*	*80%*	*92,402*
Rhode Island	*2,450*	*63,884*	*32,809*	*42,871*	*47%*	*3%*	*8%*	*24%*	*1%*	*4%*	*60%*	*142,014*

Source of Data for Table/Methodology

Rhode Island Department of Education, Public School Enrollment in preschool through grade 12 as of October 1, 2015.

*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 594 children in 2014-2015, including 54 in three public school classrooms 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, RISE Prep Mayoral Academy, 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

[1] Barton, P. E. & Coley, R. J. (2009). *Parsing the achievement gap II.* Princeton, NJ: Educational Testing Service.

(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

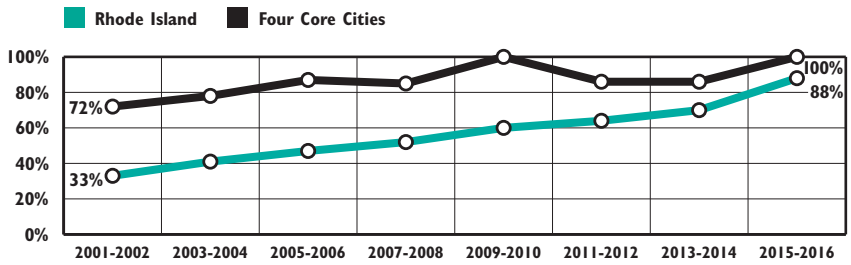
Children benefit academically from participating in full-day kindergarten. Children in full-day kindergarten make significant gains in early reading, math, and social skills when compared with children in half-day kindergarten. Full-day kindergarten can reduce grade retention and remediation rates. One 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] Also, teachers in full-day kindergarten programs have more time to provide meaningful learning opportunities that encourage cognitive, physical, and social-emotional development.[5,6]

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 81% in 2014.[7,8] 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.[9] High-quality kindergarten can also improve social and emotional skills. Kindergarteners with strong social and emotional skills are more likely to be successful as adults–including having better high school and college completion rates, improved employment stability, and reduced criminal activity.[10,11]

In the 2015-2016 school year, 88% 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 81% of students in the remainder of the state attending full-day kindergarten.[12]

Children in Full-Day Public Kindergarten Programs, Rhode Island, 2001-2002 through 2015-2016 School Years



Source: Rhode Island Department of Education, kindergarten enrollment October 1, 2001–October 1, 2015.

◆ **In the 2015-2016 school year, 88% of Rhode Island kindergartners statewide and 100% of kindergartners in the four core cities were in full-day kindergarten. As of the 2015-2016 school year, 31 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]**

◆ **Three school districts are operating universal full-day kindergarten for the first time in the 2015-2016 school year (Johnston, North Kingstown, and Tiverton).**

◆ **As of the 2015-2016 school year, there are only four districts in Rhode Island that do not offer full-day kindergarten for all students: Coventry, Cranston, East Greenwich, and Warwick. Cranston, East Greenwich, and Warwick expanded enrollment in full-day kindergarten classrooms, but do not yet have universal access.[14] State legislation enacted in 2015 requires all districts to implement full-day kindergarten by August 2016.[15]**

Kindergarten Entry Profile

◆ **Kindergarten Entry Assessments are an organized way to learn what children know and are able to do across all domains of development. The information is used to improve the transition to kindergarten, guide instruction for individual children, and inform policymakers.[16,17] Rhode Island is working with several other states and national experts to develop a new, comprehensive Kindergarten Entry Profile that incorporates best practices for young children. The new tool is being piloted in several districts in Rhode Island in the 2015-2016 school year.[18]**

Children Enrolled in Full-Day Kindergarten

Table 40. **Children Enrolled in Full-Day Kindergarten Programs, Rhode Island, 2014-2015 and 2015-2016**

SCHOOL DISTRICT	2014-2015 SCHOOL YEAR			2015-2016 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	170	170	100%	183	183	100%
Bristol Warren	253	253	100%	244	244	100%
Burrillville	145	145	100%	146	146	100%
Central Falls	222	222	100%	197	197	100%
Chariho	188	188	100%	173	173	100%
Coventry	292	1	<1%	256	0	0%
Cranston	598	3	<1%	623	93	15%
Cumberland	317	317	100%	285	285	100%
East Greenwich	140	34	24%	124	41	33%
East Providence	386	386	100%	411	411	100%
Exeter-West Greenwich	101	101	100%	112	112	100%
Foster	31	31	100%	39	39	100%
Glocester	82	82	100%	82	82	100%
Jamestown	46	46	100%	44	44	100%
Johnston	231	4	2%	220	220	100%
Lincoln	191	191	100%	199	199	100%
Little Compton	22	22	100%	17	17	100%
Middletown	174	174	100%	187	187	100%
Narragansett	75	75	100%	74	74	100%
New Shoreham	8	8	100%	9	9	100%
Newport	195	195	100%	181	181	100%
North Kingstown	205	64	31%	217	217	100%
North Providence	249	249	100%	245	245	100%
North Smithfield	112	112	100%	104	104	100%
Pawtucket	764	764	100%	719	719	100%
Portsmouth	148	148	100%	153	153	100%
Providence	1,838	1,838	100%	1,767	1,767	100%
Scituate	69	69	100%	73	73	100%
Smithfield	120	120	100%	157	157	100%
South Kingstown	203	203	100%	197	197	100%
Tiverton	108	0	0%	142	142	100%
Warwick	581	162	28%	607	322	53%
West Warwick	295	295	100%	273	273	100%
Westerly	217	217	100%	190	190	100%
Woonsocket	523	523	100%	476	476	100%
Charter Schools	*583*	*583*	*100%*	*769*	*769*	*100%*
State-Operated Schools	*3*	*3*	*100%*	*2*	*2*	*100%*
Four Core Cities	*3,347*	*3,347*	*100%*	*3,159*	*3,159*	*100%*
Remainder of State	*5,952*	*4,065*	*68%*	*5,967*	*4,813*	*81%*
Rhode Island	*9,885*	*7,998*	*81%*	*9,897*	*8,743*	*88%*

Source of Data for Table/Methodology

Rhode Island Department of Education, October 1, 2014 and October 1, 2015.

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, RISE Prep Mayoral Academy, 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] Kauerz, K. (2010). *PreK-3rd: Putting full-day kindergarten in the middle.* Washington, DC: Foundation for Child Development.

[2,6] Strategies for Children. (2013). *Investing in full-day kindergarten is essential.* Retrieved January 9, 2015, from www.strategiesforchildren.org

[3] Gibbs, C. R. (2014). *Experimental evidence on early intervention: The impact of full-day kindergarten.* University of Virginia Batten School of Leadership and Public Policy Faculty Working Paper. Retrieved December 15, 2014, from www.batten.virginia.edu

[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.

[7] Kauerz, K. (2005). *Full-day kindergarten: A study of state policies in the United States.* Denver, CO: Education Commission of the States.

[8] U.S. Census Bureau, Current Population Survey, 2014. 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 2014.

[9] Chetty, R., et al. (2010). $320,000 kindergarten teachers. *Phi Delta Kappan, 92*(3), 22-25.

(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. 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 extracurricular 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 2010 and 2014, 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% are in a child care center, 7% are 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, 2014-2015

SCHOOL DISTRICT	GRADES PK-5	GRADES 6-8	GRADES 9-12	TOTAL
Central Falls	285	250	303	838
Cranston	150	162	7	319
East Providence	159	0	0	159
Newport	725	226	252	1,203
North Kingstown	257	474	8	739
Pawtucket	1,516	426	340	2,282
Providence	926	1,704	1,329	3,959
West Warwick	87	172	2	261
Woonsocket	512	425	943	1,880
Charter Schools	*508*	*255*	*1*	*764*
The MET	*0*	*0*	*256*	*256*
UCAP	*0*	*199*	*24*	*223*
Four Core Cities	*3,239*	*2,805*	*2,915*	*8,959*
Remainder of the State	*1,378*	*1,034*	*269*	*2,681*
Rhode Island	*5,125*	*4,293*	*3,465*	*12,883*

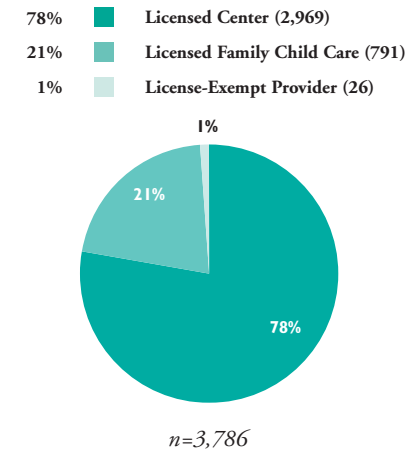
Source: RI Department of Education, Office of Student, Community and Academic Supports, Summer 2014 and 2014-2015 school year. Students participating in summer programs are reported in the grade level they are entering in the fall. Data are not unduplicated as students can be served by more than one grantee and in more than one community. Charter schools are: Highlander Charter School, Paul Cuffee Charter School, and The Learning Community. UCAP is the Urban Collaborative Accelerated Program.

Summer Learning Loss

◆ **Low-income elementary school students lose up to two months of reading skills over the summer while their higher-income peers make slight gains. Over time, this summer learning loss widens the reading achievement gap that was already present between low-income and higher-income students at kindergarten entry so that low-income students are almost three grade levels behind in reading skills by the end of fifth grade.[8,9]**

◆ **During the summer of 2014, 3,193 Rhode Island children entering grades Pre-K through 12 participated in 21st Century Community Learning Center programs in 45 schools, and over 1,600 Rhode Island children in kindergarten through grade 12 participated in 17 Hasbro Summer Learning Initiative programs.[10,11] Students who participated in these two summer learning programs had improved reading and math skills and fewer unexcused absences and disciplinary incidents.[12,13]**

School-Age Child Care Subsidies by Type of Setting, Rhode Island, 2015



n=3,786

Source: Rhode Island Department of Human Services, InRhodes Database, December 2015.

◆ **In January 2016 in Rhode Island, there were 11,823 school-age child care slots in 201 licensed centers. Seventy percent of the slots were in an independently licensed program serving only school-age children and 30% were in a licensed early childhood center.[14]**

◆ **In January 2016 in Rhode Island, there were 90 independent school-age child care programs participating in BrightStars, Rhode Island's Quality Rating and Improvement System (87% of licensed independent school-age child care programs). Nine programs had a high-quality rating of four or five stars.[15]**

Table 41. **Licensed School-Age Child Care for Children Ages Six to 12 Rhode Island, January 2016**

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	197
Bristol	1,421	1	3	156
Burrillville	1,456	0	2	175
Central Falls	2,045	2	0	191
Charlestown	616	0	1	60
Coventry	3,142	4	2	278
Cranston	6,331	14	5	698
Cumberland	2,976	0	8	659
East Greenwich	1,482	3	1	142
East Providence	3,395	4	6	573
Exeter	480	0	1	100
Foster	369	1	0	18
Glocester	809	1	0	24
Hopkinton	741	0	1	52
Jamestown	429	0	1	50
Johnston	2,119	8	0	183
Lincoln	1,900	1	6	441
Little Compton	299	0	1	26
Middletown	1,442	0	4	124
Narragansett	856	0	1	60
New Shoreham	73	0	0	0
Newport	1,399	2	2	303
North Kingstown	2,581	4	3	246
North Providence	2,073	1	4	359
North Smithfield	1,002	1	1	172
Pawtucket	6,015	7	3	723
Portsmouth	1,622	2	0	74
Providence	15,342	16	23	3,341
Richmond	777	0	2	88
Scituate	935	1	0	26
Smithfield	1,445	5	1	206
South Kingstown	2,199	1	1	119
Tiverton	1,201	1	1	111
Warren	770	1	1	102
Warwick	6,195	7	6	757
West Greenwich	624	0	0	0
West Warwick	2,155	2	3	283
Westerly	1,850	2	1	131
Woonsocket	3,653	3	7	575
Four Core Cities	*27,055*	*28*	*33*	*4,830*
Remainder of State	*59,202*	*70*	*70*	*6,993*
Rhode Island	*86,257*	*98*	*103*	*11,823*

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 2016. 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.

References

[1] Mahoney, J. L., Parente, M. E., & Zigler, E. F. (2009). Afterschool programs in America: Origins, growth, popularity, and politics. *Journal of Youth Development, 4*(3).

[2] *Taking a deeper dive into afterschool: Positive outcomes and promising practices.* (2014). Washington, DC: Afterschool Alliance.

[3,4] Mahoney, J. L., Parente, M. E., & Zigler, E. F. (2010). After-school program participation and children's development. In J. Meece & J. S. Eccles (Eds.), *Handbook of research on schools, schooling, and human development* (pp. 379-397). New York, NY: Routledge.

[5] Devaney, E., Smith, C., & Wong, K. (2012). Understanding the "how" of quality improvement: Lessons from the Rhode Island Program Quality Intervention. *Afterschool Matters, 16,* 1-10.

[6] U.S. Census Bureau, American Community Survey, 2010-2014. Table DP03.

[7] Laughlin, L. (2013). *Who's minding the kids? Child care arrangements: Spring 2011.* (Current Population Reports, P70-135.) Washington, DC: U.S. Census Bureau.

[8] *Early warning! Why reading by the end of third grade matters: A KIDS COUNT special report.* (2010). Baltimore, MD: The Annie E. Casey Foundation.

[9] Alexander, K. L., Entwisle, D. R., & Olson, L. S. (2007). Lasting consequences of the summer learning gap. *American Sociological Review, 72,* 167-180.

(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, which 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 use ongoing assessments of student progress, have highly qualified teachers trained to teach ELL students, and 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 are located in high-poverty communities.[9,10]

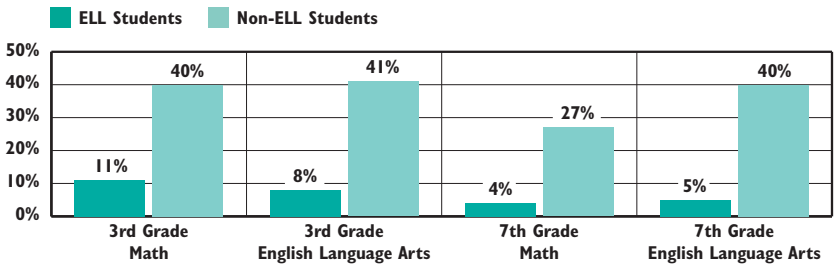
In the 2014-2015 school year in Rhode Island, ELL students were 7% of total students (10,281). Of these, 87% were enrolled in free or reduced-price lunch programs and 75% lived in the four core cities.[11]

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 2014-2015 school year, ELL students in Rhode Island public schools spoke 90 different languages. The majority (79%) spoke Spanish, 6% spoke Asian languages, 5% spoke Creole, 2% spoke Portuguese, 2% spoke Arabic, and 6% spoke other or multiple languages.[14]

Bilingual education in the early grades can significantly improve English reading proficiency and support long-term academic and economic outcomes.[15,16] During the 2014-2015 school year, 13% percent of ELL students were enrolled in a bilingual program, and 87% were enrolled in an English as a Second Language (ESL) program with bilingual programs offered in the Central Falls and Providence school districts and at the International Charter School.[17]

Current English Language Learners Meeting Expectations in Math and English Language Arts, Rhode Island, 2015



Source: Rhode Island Department of Education, *Partnership for the Assessment of Readiness for College and Careers (PARCC)*, October 2015.

◆ **In 2015, 8% of third-grade ELL students met or exceeded expectations on the *Partnership for the Assessment of Readiness for College and Careers (PARCC)* English language arts assessment, compared to 41% of non-ELL students.[18]**

◆ **In 2015, 4% of seventh-grade ELL students met or exceeded expectations on the *Partnership for the Assessment of Readiness for College and Careers (PARCC)* math assessment, compared to 27% of non-ELL students.[19]**

Early English Language Learning

◆ **As of September 1, 2015, there were 4,970 Rhode Island children under age five who were born to a mother who did not speak English.[20] In the 2014-2015 school year, 49% of all ELL students in Rhode Island were in grades preschool to grade three.[21]**

◆ **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.[22] 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.[23]**

◆ **In the 2015-2016 school year, kindergarten-immersion bilingual programs were added in the South Kingstown and Pawtucket school districts.[24]**

Table 42.

English Language Learner Students, Rhode Island, 2014-2015

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	3,271	31	*	*	37	1%
Bristol Warren	3,322	60	20	0	80	2%
Burrillville	2,350	*	*	*	*	<1%
Central Falls	2,720	336	113	154	603	22%
Chariho	3,283	*	0	*	*	<1%
Coventry	4,649	*	*	*	12	<1%
Cranston	10,067	378	97	84	559	6%
Cumberland	4,503	93	16	*	118	3%
East Greenwich	2,355	10	*	0	11	<1%
East Providence	5,217	132	33	21	186	4%
Exeter-West Greenwich	1,619	*	*	*	12	1%
Foster	282	0	0	0	0	0%
Foster-Glocester	1,110	0	0	0	0	0%
Glocester	524	0	0	0	0	0%
Jamestown	488	*	*	0	*	1%
Johnston	3,030	100	21	10	131	4%
Lincoln	3,019	17	*	*	25	1%
Little Compton	250	0	0	0	0	0%
Middletown	2,279	57	28	17	102	4%
Narragansett	1,316	*	*	*	*	<1%
New Shoreham	116	*	*	*	10	9%
Newport	2,052	61	15	30	106	5%
North Kingstown	3,957	39	*	10	57	1%
North Providence	3,516	45	14	*	66	2%
North Smithfield	1,750	*	*	*	*	<1%
Pawtucket	9,011	465	144	170	779	9%
Portsmouth	2,549	*	*	*	11	<1%
Providence	24,040	3,549	1,072	1,163	5,784	24%
Scituate	1,373	0	0	0	0	0%
Smithfield	2,368	*	0	*	10	<1%
South Kingstown	3,275	23	*	*	29	1%
Tiverton	1,765	*	0	*	*	<1%
Warwick	8,953	78	17	12	107	1%
West Warwick	3,395	51	12	12	75	2%
Westerly	3,018	44	*	*	53	2%
Woonsocket	5,996	333	106	119	558	9%
Charter Schools	*5,397*	*533*	*97*	*57*	*687*	*13%*
State-Operated Schools	*1,764*	*	*	*34*	*38*	*2%*
UCAP	*137*	*0*	*0*	*0*	*0*	*0%*
Four Core Cities	*41,767*	*4,683*	*1,435*	*1,606*	*7,724*	*18%*
Remainder of State	*91,021*	*1,275*	*309*	*248*	*1,832*	*2%*
Rhode Island	*140,086*	*6,494*	*1,842*	*1,945*	*10,281*	*7%*

Sources of Data for Table/Methodology

Rhode Island Department Education, 2014-2015 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 2014-2015 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.

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.

Charter schools with ELL students 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, 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. State-operated schools with ELL students are William M. Davies Career & Technical High School, DCYF Schools, and Rhode Island School for the Deaf. UCAP is the Urban Collaborative Accelerated Program.

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

References

[1] Calderón, M., Slavin, R., & Sánchez, M. (2011). Effective instruction for English learners. *The Future of Children, 21*(1), 103-119.

(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

Early and accurately targeted special education services help students with developmental delays and disabilities improve their academic achievement and prevent grade retention.[1] Approximately 15% of children ages three to 17 have a developmental delay or disability. Children in low-income families are more likely to have a delay or disability than children in higher-income families.[2]

The federal *Individuals with Disabilities Education Act (IDEA)* guarantees a free appropriate public education to every child with a disability. Prior to passage of the original 1975 federal law, many children with disabilities were excluded from public school. Since passage, outcomes for children with disabilities have steadily improved. More students with disabilities are being educated in neighborhood schools, included in general education classrooms, reaching proficiency standards, graduating from high school, enrolling in post-secondary education programs, and becoming employed as adults.[3] In recent years, more children are receiving special education services earlier (in grades K-3).[4]

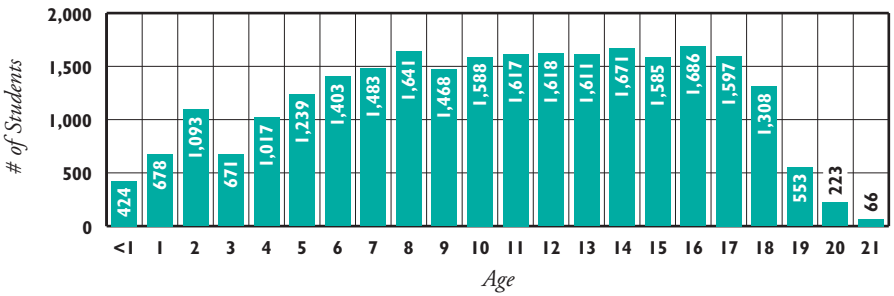
Despite this progress, children with developmental delays and disabilities (approximately 13% of the U.S. public school population) are still less likely to reach academic proficiency targets, graduate from high school, or attend college than students without disabilities. They are also more likely to be suspended from school.[5,6]

The federal *Every Student Succeeds Act (ESSA)* requires states to continue reporting the performance of students with disabilities on standardized assessments to inform accountability and action plans.[7]

In 2015 in Rhode Island, 10% of students receiving special education services met expectations on the third-grade English language arts section and 12% on the third grade math section of the *Partnership for Assessment for College and Careers (PARCC)* assessment, compared with 42% and 41% respectively of students without special education needs.[8]

In Rhode Island, the four-year graduation rate for the class of 2015 was 68% for students receiving special education services, compared to 88% for students not receiving these services. Some students enrolled in special education may take additional time to graduate.[9]

Students Ages Birth to 21 Receiving Early Intervention and Special Education Services, Rhode Island, June 2015



Source: Rhode Island Executive Office of Health and Human Services, Center for Child and Family Health, Early Intervention enrollment, June 30, 2015. Rhode Island Department of Education, Office of Diverse Learners, Special Education Census, June 30, 2015. Includes parentally-placed students.

◆ **As of June 2015, there were 20,800 students ages six to 21 (15% of all kindergarten through grade 12 students) receiving special education services through Rhode Island public schools. Thirty-eight percent of these students had a learning disability, 17% had a health impairment, 13% 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.[10]**

◆ **As of June 2015, 73% of students ages six to 21 receiving special education services in Rhode Island were in a regular class for 80% of the day or more, 21% were in a regular class for less than 80% of the day, 5% were in a separate school, and 1% were in a residential facility, a correctional facility, were home-bound, or were hospitalized.[11] Over the past two decades, the percentage of special education students ages six to 21 who spent most of the day (80% or more of time) in general education classrooms nearly doubled nationwide.[12]**

◆ **Of students receiving special education services in June 2015, 68% were boys, 59% were low-income (receiving free or reduced-price lunch), 42% identified as Hispanic or a racial/ethnic category other than White, and 8% were English Language Learners.[13]**

K-12 Students Receiving Special Education Services

Table 43.

Students Ages 6 through 21 Receiving Special Education Services by Primary Disability, Rhode Island, 2015

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	3,258	53	10	42	52	110	11	66	18	362	11%
Bristol Warren	3,296	58	22	18	39	109	18	81	*	353	11%
Burrillville	2,324	45	16	22	47	114	14	63	*	329	14%
Central Falls	2,622	27	19	35	81	269	25	63	16	535	20%
Chariho	3,256	48	29	13	55	124	12	27	13	321	10%
Coventry	4,588	54	39	51	108	305	25	36	26	644	14%
Cranston	10,032	177	66	102	318	497	37	77	30	1,304	13%
Cumberland	4,460	72	21	42	113	211	26	119	28	632	14%
East Greenwich	2,331	47	27	13	50	57	10	38	15	257	11%
East Providence	5,158	89	42	81	145	281	33	80	24	775	15%
Exeter-West Greenwich	1,596	30	*	*	26	43	*	55	*	187	12%
Foster	282	*	0	0	*	*	*	18	*	33	12%
Foster-Glocester	1,110	14	0	*	23	44	*	*	*	108	10%
Glocester	522	*	*	*	10	*	*	21	*	46	9%
Jamestown	475	11	*	*	16	17	*	*	*	62	13%
Johnston	2,973	65	37	31	129	279	14	45	15	615	21%
Lincoln	2,973	44	35	34	73	135	13	73	13	420	14%
Little Compton	250	*	*	0	*	17	*	*	*	35	14%
Middletown	2,266	36	*	40	63	118	22	53	12	351	15%
Narragansett	1,287	23	14	22	46	83	*	31	*	231	18%
New Shoreham	116	*	*	0	11	0	*	*	*	24	21%
Newport	2,024	28	15	28	39	144	24	49	11	338	17%
North Kingstown	3,898	52	52	42	56	148	17	93	13	473	12%
North Providence	3,470	56	63	48	102	208	14	81	22	594	17%
North Smithfield	1,731	24	*	18	43	85	11	45	*	238	14%
Pawtucket	8,937	131	106	90	184	558	57	189	30	1,345	15%
Portsmouth	2,529	44	*	47	98	126	*	25	13	367	15%
Providence	23,768	211	259	390	418	1,533	177	660	101	3,749	16%
Scituate	1,366	19	*	*	27	58	*	41	*	161	12%
Smithfield	2,336	36	17	13	30	103	12	25	*	242	10%
South Kingstown	3,205	55	28	33	84	85	18	67	21	391	12%
Tiverton	1,745	45	*	24	35	113	11	34	13	280	16%
Warwick	8,836	219	85	124	313	585	40	120	46	1,532	17%
West Warwick	3,356	80	49	79	68	189	26	43	12	546	16%
Westerly	2,918	46	33	39	99	123	15	53	23	431	15%
Woonsocket	5,973	125	103	102	288	388	74	187	36	1,303	22%
Charter Schools	*5,385*	*43*	*35*	*55*	*137*	*366*	*	*128*	*	*777*	*14%*
State-Operated Schools	*1,762*	*15*	*0*	*71*	*63*	*129*	*	*0*	*61*	*341*	*19%*
UCAP	*137*	*0*	*0*	*0*	*0*	*20*	*0*	*0*	*0*	*20*	*15%*
Department of Corrections	*NA*	*0*	*0*	*20*	*8*	*20*	*0*	*0*	*0*	*48*	*NA*
Four Core Cities	*41,300*	*494*	*487*	*617*	*971*	*2,748*	*333*	*1,099*	*183*	*6,932*	*17%*
Remainder of State	*89,967*	*1,582*	*750*	*1,029*	*2,329*	*4,523*	*458*	*1,577*	*434*	*12,632*	*14%*
Rhode Island	*138,551*	*2,134*	*1,272*	*1,792*	*3,508*	*7,806*	*799*	*2,804*	*685*	*20,800*	*15%*

Source of Data for Table/Methodology

Rhode Island Department of Education (RIDE), Office for Diverse Learners, Special Education Census June 30, 2015. Data do not include parentally placed students. The denominator (number of students) is the "resident average daily membership" (RADM) for grades K-12 in the 2014-2015 school year provided by RIDE.

Due to changes in methodology, *K-12 Students Receiving Special Education Services* in this Factbook cannot be compared with Factbooks prior to 2015. 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 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 those with traumatic brain injury.

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

Independent charter schools reported for this indicator are Achievement First Providence Mayoral Academy, Beacon Charter High School for the Arts, Blackstone Academy, Blackstone Valley Prep, The Compass School, The Greene School, Highlander Charter School, International Charter School, The Hope Academy, Kingston Hill Academy, The Learning Community, Rhode Island 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 The 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, more likely to repeat a grade, more likely to be suspended, and less likely to graduate from high school than their non-mobile peers.[4,5]

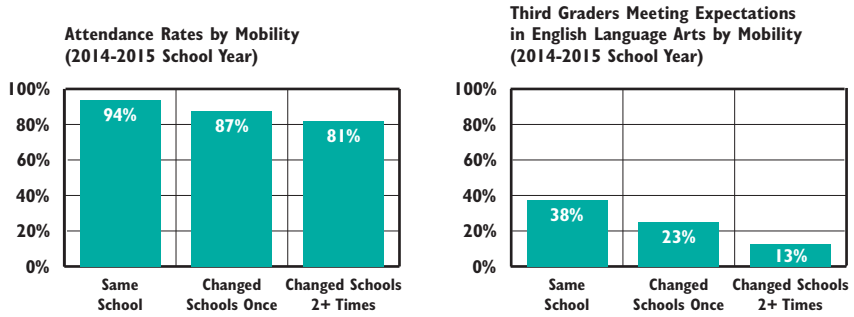
Low-income and minority children are more likely to be mobile than higher-income and White students. School mobility has a greater negative impact on the academic achievement of low-income students than it does on higher-income students. Students receiving special education services also are likely to be negatively impacted by changing schools.[6]

High mobility rates 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 2010 and 2014 in Rhode Island, 11% of children ages five to 17 changed residence at least once during the previous year, 82% of whom moved within Rhode Island and 18% 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 2010 and 2014, 24% of low-income Rhode Islanders moved, compared with 10% of higher-income residents.[13]

School Mobility and Education Outcomes in Rhode Island



Source: Rhode Island Department of Education, 2014-2015 school year.

◆ **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 87% for those who changed schools once and 81% for those who changed schools two or more times during the 2014-2015 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 2014-2015 school year in Rhode Island, 38% of third-grade children who did not experience mobility met expectations in reading/writing on the *Partnership for Assessment of Readiness for College and Careers (PARCC)* state assessment, compared with 23% of students who moved once and 13% of students who moved two or more times.[15]**

◆ **School districts with high mobility rates can reduce the negative effects of mobility on students by providing immediate and comprehensive screening of entering students to ensure that students are properly placed. 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.[16]**

◆ **Schools can help reduce the negative effects of mobility, but broader social policies may be needed to reduce student mobility. Increasing the availability of housing vouchers and access to public benefits, such as the Supplemental Nutrition Assistance Program (SNAP) and WIC, could help low-income families maintain their housing and reduce school mobility.[17,18]**

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 district. The stability rate for the four core cities was 79% in the 2014-2015 school year, compared with a stability rate of 91% in the remainder of the state.[20]

◆ Total enrollment for each district is cumulative over the course of the school year.[21]

◆ The overall Rhode Island student mobility rate was 14% in the 2014-2015 school year. The four core cities had a higher mobility rate (22%) than districts in the remainder of the state (10%).[22]

◆ During the 2014-2015 school year, Rhode Island high schools had higher mobility rates (16%) than elementary schools (14%) and middle schools (11%).[23]

Table 44. **Student Mobility and Stability Rates by District, Rhode Island, 2014-2015 School Year**

SCHOOL DISTRICT	CUMULATIVE ENROLLMENT FOR 2014-2015	# ENROLLED THE WHOLE YEAR	# ENROLLED AFTER SEPT. 30	# EXITED BEFORE JUNE 1	STABILITY RATE	MOBILITY RATE
Barrington	3,376	3,238	74	68	96%	4%
Bristol Warren	3,522	3,238	116	184	92%	9%
Burrillville	2,416	2,348	68	0	97%	3%
Central Falls	3,200	2,417	453	422	76%	27%
Chariho	3,531	3,150	190	219	89%	12%
Coventry	5,060	4,710	159	215	93%	7%
Cranston	11,111	9,943	551	673	89%	11%
Cumberland	4,769	4,408	180	196	92%	8%
East Greenwich	2,506	2,372	87	49	95%	5%
East Providence	5,637	5,055	255	348	90%	11%
Exeter-West Greenwich	1,721	1,591	67	77	92%	8%
Foster	288	276	*	*	96%	4%
Foster-Glocester	1,145	1,089	16	40	95%	5%
Glocester	544	512	*	27	94%	6%
Jamestown	525	483	22	21	92%	8%
Johnston	3,351	3,021	177	168	90%	10%
Lincoln	3,217	2,959	140	122	92%	8%
Little Compton	258	244	*	10	95%	5%
Middletown	2,471	2,124	162	212	86%	15%
Narragansett	1,401	1,300	57	48	93%	7%
New Shoreham	121	113	*	*	93%	7%
Newport	2,322	1,887	230	233	81%	20%
North Kingstown	4,300	3,965	158	196	92%	8%
North Providence	3,841	3,357	240	278	87%	13%
North Smithfield	1,882	1,703	97	113	90%	11%
Pawtucket	10,096	8,415	811	1,002	83%	18%
Portsmouth	2,691	2,452	114	135	91%	9%
Providence	28,086	22,088	2,802	3,778	79%	23%
Scituate	1,472	1,382	48	45	94%	6%
Smithfield	2,475	2,333	92	64	94%	6%
South Kingstown	3,486	3,205	136	171	92%	9%
Tiverton	1,942	1,784	68	99	92%	9%
Warwick	9,841	8,788	492	617	89%	11%
West Warwick	3,795	3,213	299	337	85%	17%
Westerly	3,174	2,899	137	158	91%	9%
Woonsocket	6,900	5,461	624	920	79%	22%
Charter Schools	*5,658*	*5,267*	*122*	*279*	*93%*	*7%*
State-Operated Schools	*2,109*	*1,627*	*272*	*331*	*77%*	*29%*
UCAP	*149*	*131*	*	*10*	*88%*	*13%*
Four Core Cities	*48,282*	*38,381*	*4,690*	*6,122*	*79%*	*22%*
Remainder of State	*98,191*	*89,142*	*4,449*	*5,135*	*91%*	*10%*
Rhode Island	*154,389*	*134,548*	*9,541*	*11,877*	*87%*	*14%*

Source of Data for Table/Methodology

Rhode Island Department of Education, 2014-2015 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 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. State-operated schools include DCYF Schools, Metropolitan Regional Career & Technical High School, 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

[1,5,9] Reynolds, A. J., Chen, C., & Herbers, J. E. (2009). *School mobility and educational success: A research synthesis and evidence on prevention.* Paper presented at the National Research Council Workshop on the Impact of Mobility and Change on the Lives of Young Children, Schools and Neighborhoods, Washington, DC.

[2,4,6,7,10] Burkam, D. T., Lee, V. E., & Dwyer, J. (2009). *School mobility in the early elementary grades: Frequency and impact from nationally-representative data.* Paper presented at the National Research Council Workshop on the Impact of Mobility and Change on the Lives of Young Children, Schools and Neighborhoods, Washington, DC.

[3,8,11] Turner, M. A. & Berube, A. (2009). *Vibrant neighborhoods, successful schools: What the federal government can do to foster both.* Washington, DC: Urban Institute.

(continued on page 184)

Third-Grade Reading Skills

DEFINITION

Third-grade reading skills is the percentage of third-grade students who met expectations in English language arts on the *Partnership for Assessment of Readiness for College and Careers (PARCC)* 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 the 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 provide early cognitive development activities contribute to advanced literacy development, reading achievement, and success in school.[2,3]

High-quality preschool and pre-kindergarten (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 the most 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 grade-level peers.[7,8]

Policymakers can increase third-grade reading proficiency by increasing access to high-quality early care and education programs (including Pre-K and full-day kindergarten), supporting programs that engage parents as partners in their children's early language and literacy development, and encouraging cross-agency partnerships.[9]

4th-Grade *NAEP* Reading Proficiency

	2005	2015
RI	30%	40%
US	30%	35%
National Rank*		*9th*
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 for grades 4 and 8.

Third Graders Meeting Expectations on the *PARCC* English Language Arts Assessment, by Student Subgroups, 2015

Male Students	33%
Female Students	43%
English Language Learners	8%
Non-English Language Learners	41%
Students With Disabilities	10%
Students Without Disabilities	42%
Low-Income Students	21%
Higher-Income Students	53%
White Students	48%
Asian Students	47%
Black Students	22%
Hispanic Students	18%
Native American Students	17%
ALL STUDENTS	*37%*

Source: Rhode Island Department of Education, *Partnership for the Assessment of Readiness for College and Careers (PARCC)*, 2015. Low-income status is determined by eligibility for the free or reduced-price lunch program.

◆ **In 2015, 37% of Rhode Island third graders met expectations on the *Partnership for the Assessment of Readiness for College and Careers (PARCC)* English language arts assessment.[10]**

◆ **In Rhode Island in 2015, 21% of low-income third graders met expectations, compared with 53% of higher-income third graders.[11]**

Statewide Assessments of Reading and English Language Arts

◆ **The *New England Common Assessment Program (NECAP)* was Rhode Island's statewide assessment system from 2005 to 2013. 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).*[12]**

◆ **The *PARCC* is aligned to the *Common Core State Standards* in English language arts/literacy and assesses students' ability to read and comprehend complex texts, use different sources to compare and synthesize ideas, and write effectively.[13,14]**

Table 45. **Third Graders Meeting Expectations in English Language Arts, Rhode Island, 2015**

SCHOOL DISTRICT	# OF THIRD GRADERS ENROLLED	# OF THIRD GRADERS TESTED	% OF THIRD GRADERS TESTED	# OF THIRD GRADERS MEETING EXPECTATIONS	% OF THIRD GRADERS MEETING EXPECTATIONS
Barrington	255	251	98%	158	63%
Bristol Warren	302	284	94%	123	43%
Burrillville	173	137	79%	44	32%
Central Falls	211	201	95%	26	13%
Chariho	232	224	97%	132	59%
Coventry	352	344	98%	158	46%
Cranston	811	776	96%	405	52%
Cumberland	328	317	97%	159	50%
East Greenwich	171	168	98%	96	57%
East Providence	407	387	95%	161	42%
Exeter-West Greenwich	110	93	85%	38	41%
Foster	43	42	98%	15	36%
Glocester	100	98	98%	46	47%
Jamestown	57	55	96%	33	60%
Johnston	245	238	97%	116	49%
Lincoln	214	206	96%	115	56%
Little Compton	25	22	88%	14	64%
Middletown	201	188	94%	87	46%
Narragansett	102	99	97%	60	61%
New Shoreham	6	4	67%	*	*
Newport	151	142	94%	52	37%
North Kingstown	285	270	95%	161	60%
North Providence	271	263	97%	72	27%
North Smithfield	116	107	92%	31	29%
Pawtucket	774	742	96%	166	22%
Portsmouth	162	150	93%	80	53%
Providence	1,977	1,888	95%	264	14%
Scituate	92	87	95%	43	49%
Smithfield	172	145	84%	64	44%
South Kingstown	241	233	97%	187	80%
Tiverton	145	118	81%	78	66%
Warwick	682	653	96%	243	37%
West Warwick	253	241	95%	55	23%
Westerly	224	210	94%	83	40%
Woonsocket	488	457	94%	109	24%
Charter Schools	*418*	*413*	*99%*	*165*	*40%*
Four Core Cities	*3,450*	*3,288*	*95%*	*565*	*17%*
Remainder of State	*6,946*	*6,557*	*94%*	*3,110*	*47%*
Rhode Island	*10,814*	*10,258*	*95%*	*3,840*	*37%*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Education (RIDE), *Partnership for Assessment of Readiness for College and Careers (PARCC)*, 2015.

Due to the adoption of a new assessment tool by RIDE in 2015, Third-Grade Reading Skills cannot be compared with prior Factbooks.

% meeting expectations are the third-grade students who met or exceeded expectations for their grade on the English language arts section of the *PARCC*. Only students who actually took the test are counted in the denominator for the district and school proficiency rates. Students with Individualized Education Programs (IEPs) may participate in alternate assessments instead. English Language Learners in the U.S. less than one year are exempt from the English language arts assessment.

2015 *PARCC* data for independent charter schools include Blackstone Valley Prep, 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 four core cities and remainder of state calculations.

* 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 four core cities, remainder of state, and state totals.

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.

(continued on page 184)

Seventh-Grade Reading Skills

DEFINITION

Seventh-grade reading skills is the percentage of seventh-grade students who met expectations in English language arts on the *Partnership for the Assessment of Readiness for College and Careers (PARCC)* 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

	2005	2015
RI	29%	35%
US	29%	33%
National Rank*		*25th*
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 for grades 4 and 8.

Seventh Graders Meeting Expectations on the *PARCC* English Language Arts Assessment, by Student Subgroups, 2015

Male Students	31%
Female Students	47%
English Language Learners	5%
Non-English Language Learners	40%
Students With Disabilities	6%
Students Without Disabilities	44%
Low-Income Students	22%
Higher-Income Students	53%
White Students	48%
Asian Students	46%
Black Students	18%
Hispanic Students	20%
Native American Students	25%
ALL STUDENTS	*39%*

Source: Rhode Island Department of Education, *Partnership for the Assessment of Readiness for College and Careers (PARCC), 2015.* Low-income status is determined by eligibility for the free or reduced-price lunch program.

◆ **In 2015, 39% of Rhode Island seventh graders met expectations on the *Partnership for the Assessment of Readiness for College and Careers (PARCC)* English language arts assessment.[12]**

◆ **In Rhode Island in 2015, 22% of low-income seventh graders met expectations in English language arts, compared with 53% of higher-income seventh graders.[13]**

Statewide Assessments of Reading and English Language Arts

◆ **The *NECAP* was Rhode Island's statewide assessment system from 2005 to 2013. 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).*[14]**

◆ **The *PARCC* is aligned to the *Common Core State Standards* in English language arts/literacy and assesses students' ability to read and comprehend complex texts, use different sources to compare and synthesize ideas, and write effectively.[15]**

Table 46. **Seventh Graders Meeting Expectations in English Language Arts, Rhode Island, 2015**

SCHOOL DISTRICT	# OF SEVENTH GRADERS ENROLLED	# OF SEVENTH GRADERS TESTED	% OF SEVENTH GRADERS TESTED	# OF SEVENTH GRADERS MEETING EXPECTATIONS	% OF SEVENTH GRADERS MEETING EXPECTATIONS
Barrington	293	287	98%	216	75%
Bristol Warren	234	215	92%	91	42%
Burrillville	213	65	31%	18	28%
Central Falls	152	133	88%	9	7%
Chariho	250	236	94%	163	69%
Coventry	396	377	95%	133	35%
Cranston	857	802	94%	395	49%
Cumberland	375	361	96%	160	44%
East Greenwich	188	185	98%	149	81%
East Providence	373	311	83%	92	30%
Exeter-West Greenwich	134	127	95%	73	57%
Foster-Glocester	144	137	95%	65	47%
Jamestown	53	49	92%	32	65%
Johnston	265	257	97%	130	51%
Lincoln	254	239	94%	123	51%
Little Compton	37	33	89%	20	61%
Middletown	171	154	90%	65	42%
Narragansett	85	81	95%	50	62%
New Shoreham	11	9	82%	*	*
Newport	154	144	94%	53	37%
North Kingstown	349	298	85%	200	67%
North Providence	281	244	87%	87	36%
North Smithfield	154	129	84%	66	51%
Pawtucket	657	628	96%	105	17%
Portsmouth	211	188	89%	101	54%
Providence	1,793	1,602	89%	297	19%
Scituate	115	53	46%	14	26%
Smithfield	202	188	93%	97	52%
South Kingstown	263	252	96%	146	58%
Tiverton	160	130	81%	62	48%
Warwick	703	619	88%	191	31%
West Warwick	238	215	90%	78	36%
Westerly	214	197	92%	64	32%
Woonsocket	432	383	89%	55	14%
Charter Schools	*372*	*370*	*99%*	*124*	*34%*
UCAP	*39*	*38*	*97%*	*2*	*5%*
Four Core Cities	*3,034*	*2,746*	*91%*	*466*	*17%*
Remainder of State	*7,398*	*6,588*	*89%*	*3,142*	*48%*
Rhode Island	*10,843*	*9,742*	*90%*	*3,734*	*38%*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Education (RIDE), *Partnership for Assessment of Readiness for College and Careers (PARCC)*, 2015.

Due to the adoption of a new assessment tool by RIDE in 2015, Seventh-Grade Reading Skills cannot be compared with prior Factbooks.

% meeting expectations are the seventh-grade students who met or exceeded expectations for their grade on the English language arts section of the *PARCC*. Only students who actually took the test are counted in the denominator for the district and school proficiency rates. Students with Individualized Education Programs (IEPs) may participate in alternate assessments. English Language Learners in the U.S. less than one year are exempt from the English language arts assessment.

2015 *PARCC* 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 total 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.

*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 four core cities, remainder of state, and state totals.

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

See Methodology Section for more information.

References

[1,6,10] Hervey. S. (2013). *Adolescent readers in middle school.* 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.

(continued on page 184)

Math Skills

DEFINITION

Math skills is the percentage of third-, fourth-, fifth-, sixth-, and seventh-grade students who met expectations for math on the *Partnership for Assessment of Readiness for College and Careers (PARCC)* test.

SIGNIFICANCE

Students must rely on math 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 the growing STEM industries.[3]

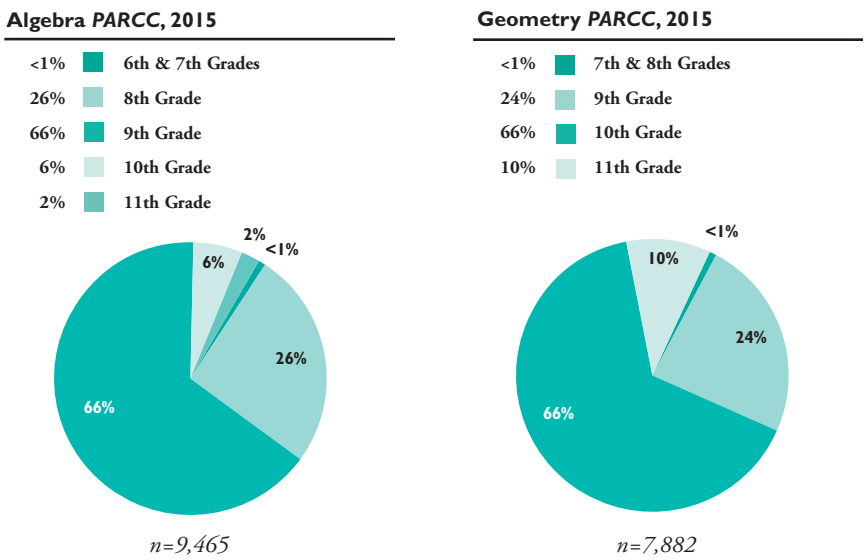
State, national, and international assessments show that U.S. students fare well when asked to perform straightforward computational procedures but they tend to have a limited understanding of basic mathematical concepts needed to solve simple problems. After two decades of improvement, performance in math in the U.S. has begun to level off.[4,5,6]

Family risk factors such as poverty and low parental education levels are associated with low student achievement in math. 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 2015, 80% of Rhode Island fourth graders and 81% of U.S. fourth graders performed at or above the Basic level in math on the *NAEP*, and 72% of Rhode Island eighth graders and 70% of U.S. eighth graders performed at or above the Basic level in math on the *NAEP*.[13,14] Rhode Island is one of only eight states that saw decreases in both fourth- and eighth-grade math achievement between 2013 and 2015 as measured by the *NAEP* math tests.[15]

Algebra and Geometry *PARCC* Test Takers by Grade, Rhode Island, 2015



Source: RIDE, *Rhode Island's PARCC Results for Students in Grade 3 through 8 and High School,* 2015.

◆ **Rhode Island administers the math *PARCC* to students annually in grades three through eight and gives course-based assessments to students who have completed algebra and geometry, in whichever grade those courses are completed.[16,17]**

◆ **More than one-quarter (26%) of eighth graders took the algebra assessment rather than the standard math assessment, so the eighth grade math results do not reflect the overall performance of Rhode Island's eighth graders.[18]**

Statewide Assessments of Math

◆ **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)*, which is aligned to the *Common Core State Standards* in math and assesses students' ability to demonstrate mathematical reasoning and apply mathematical concepts to solve complex, real-world problems.[19,20]**

Table 47.

Third- Fourth-, Fifth-, Sixth-, & Seventh-Grade Students Meeting Expectations in Math, Rhode Island, 2015

SCHOOL DISTRICT	% OF STUDENTS MEETING EXPECTATIONS				
	THIRD GRADE	FOURTH GRADE	FIFTH GRADE	SIXTH GRADE	SEVENTH GRADE
Barrington	67%	47%	65%	49%	60%
Bristol Warren	46%	35%	34%	40%	34%
Burrillville	28%	21%	18%	16%	24%
Central Falls	12%	7%	4%	6%	1%
Chariho	49%	56%	39%	37%	43%
Coventry	42%	29%	37%	24%	28%
Cranston	39%	24%	25%	29%	22%
Cumberland	62%	43%	53%	32%	34%
East Greenwich	58%	44%	49%	55%	70%
East Providence	39%	22%	29%	21%	16%
Exeter-West Greenwich	61%	38%	43%	43%	48%
Foster	43%	26%	32%	NA	NA
Glocester	55%	48%	61%	NA	NA
Foster-Glocester	NA	NA	NA	34%	37%
Jamestown	55%	52%	47%	55%	59%
Johnston	31%	39%	30%	20%	16%
Lincoln	54%	36%	41%	24%	30%
Little Compton	55%	40%	46%	36%	55%
Middletown	49%	34%	30%	48%	33%
Narragansett	58%	42%	41%	51%	50%
New Shoreham	*	*	*	25%	*
Newport	34%	22%	21%	27%	22%
North Kingstown	56%	44%	45%	47%	51%
North Providence	34%	29%	15%	12%	14%
North Smithfield	41%	48%	32%	26%	34%
Pawtucket	25%	14%	21%	14%	11%
Portsmouth	59%	39%	30%	40%	53%
Providence	14%	11%	9%	10%	8%
Scituate	45%	45%	47%	30%	32%
Smithfield	50%	36%	30%	24%	43%
South Kingstown	74%	70%	43%	58%	47%
Tiverton	55%	31%	28%	38%	48%
Warwick	35%	25%	26%	34%	21%
West Warwick	23%	14%	19%	22%	25%
Westerly	41%	32%	11%	27%	24%
Woonsocket	21%	11%	18%	10%	7%
Charter Schools	*46%*	*31%*	*27%*	*21%*	*20%*
State-Operated Schools	*NA*	*NA*	*NA*	*NA*	*NA*
UCAP	*NA*	*NA*	*NA*	*NA*	*0%*
Four Core Cities	*17%*	*12%*	*13%*	*11%*	*8%*
Remainder of State	*46%*	*34%*	*33%*	*33%*	*33%*
Rhode Island	*36%*	*27%*	*27%*	*26%*	*25%*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Education, *Partnership for Assessment of Readiness for College and Careers (PARCC),* Spring 2015.

Due to the adoption of a new assessment tool by the Rhode Island Department of Education in the 2014-2015 school year, Math Skills in this Factbook cannot be compared with previous Factbooks.

The number of students who met or exceeded expectations received a score of four or five on the math section of the *PARCC* assessment, respectively. Only students who actually took the test are counted in district or school denominators. 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.

2015 *PARCC* data for independent charter schools include Blackstone Valley Prep Mayoral Academy, Highlander Charter School, International Charter School, Kingston Hill Academy, The Learning Community, Paul Cuffee Charter School, The Compass School, Segue Institute for Learning, and Trinity Academy for the Performing Arts.

Charter 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 and * indicates that the number of students was too small to report.

References

[1,5,7] Child Trends. (2013). *Mathematics proficiency.* Retrieved February 23, 2015, from www.childtrendsdatabank.org

[2] RI DataHub. (n.d.). *Data story: Math preparation and postsecondary success.* Retrieved March 3, 2016, from ridatahub.org

[3] Federal Coordination in STEM Education Task Force. (2012). *Coordinating federal science, technology, engineering, and mathematics (STEM) education investments: Progress report.* Washington, DC: Committee on STEM Education, National Science and Technology Council. Retrieved March 3, 2016, from www.whitehouse.gov

(continued on page 184)

Schools Identified for Intervention

DEFINITION

Schools identified for intervention is the percentage of Rhode Island public schools that are classified as "Focus" or "Priority" and identified for intervention by the Rhode Island Department of Education.

SIGNIFICANCE

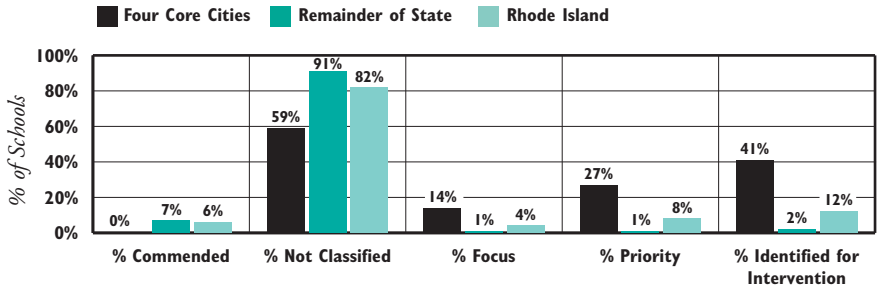
Since its passage in 2001, the federal *No Child Left Behind Act (NCLB)* has focused on closing achievement gaps and improving public schools. In 2012, Rhode Island replaced its former system of classifying schools with a new accountability system that identifies each school's strengths and weaknesses and focuses on outcomes for student subgroups so Rhode Island can provide the support and interventions schools need to improve student achievement and close achievement gaps.[1] This accountability system classifies schools based on proficiency in English language arts and math, success in closing the achievement gap, growth at the elementary and middle school levels, and graduation rates at the high school level.[2]

Because the 2014-2015 school year was the first year that the *Partnership for Assessment of Readiness for College and Careers (PARCC)* was administered, it is a transition year for the state's school classification system. Schools previously identified as "Focus" or "Priority," the two lowest classifications, retain that classification. Schools are classified as "Commended" if they have high levels of achievement, are narrowing achievement gaps within their schools, and have at least a 95% participation rate on both the English language arts and math *PARCC* assessments. All other schools received no classification for the 2014-2015 school year.[3]

The recent authorization of the *Every Student Succeeds Act (ESSA)* makes some changes to how states must design their school accountability systems going forward. States may now consider assessments other than standardized tests, such as portfolios or projects, when making school accountability decisions and must include a measure of "school quality or student success," such as student engagement, access to advanced coursework, or college and career readiness, in their accountability systems.[4,5,6]

Research on school improvement efforts shows that schools can be improved through comprehensive, whole-school reforms. Critical elements of successful school turnaround efforts include identifying and supporting strong teachers and building leaders, using data-based decision making, setting high expectations for all students, providing wrap-around services to support the social, emotional, and behavior needs of students, and creating a positive and collaborative school culture.[7]

Rhode Island School Performance Classifications, 2014-2015 School Year



Source: Rhode Island Department of Education, 2014-2015 school year. Percentages may not sum to 100% due to rounding.

◆ **In Rhode Island in the 2014-2015 school year, 17 schools (6%) were classified as "Commended," 11 schools (4%) were classified as "Focus," and 21 schools (8%) schools were classified as "Priority." Because the 2014-2015 school year was the first year for *PARCC* assessments, only "Commended," "Focus," and "Priority" schools are classified this year. All other schools receive no school classification this year. Schools designated as "Priority" or "Focus" schools (12% of schools in Rhode Island in 2014-2015) were identified for intervention, and 27 of these 32 schools were located in the four core cities.[8,9]**

Interventions Designed to Improve Schools

◆ **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.[10]**

◆ **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.[11]**

◆ **All public schools in Rhode Island, regardless of classification, are included in the accountability system and are expected to strive for continued improvement.[12,13]**

Table 48.

Schools Identified for Intervention, 2014-2015 School Year

SCHOOL DISTRICT	TOTAL # OF SCHOOLS	# COMMENDED	# NOT CLASSIFIED	# FOCUS	# PRIORITY	# SUBJECT TO STATE INTERVENTION	% SUBJECT TO STATE INTERVENTION
Barrington	6	2	4	0	0	0	0%
Bristol Warren	6	1	5	0	0	0	0%
Burrillville	4	0	4	0	0	0	0%
Central Falls	4	0	1	1	2	3	75%
Chariho	6	1	5	0	0	0	0%
Coventry	7	0	7	0	0	0	0%
Cranston	23	2	20	1	0	1	4%
Cumberland	8	0	8	0	0	0	0%
East Greenwich	6	1	5	0	0	0	0%
East Providence	11	0	9	0	2	2	18%
Exeter-West Greenwich	3	0	3	0	0	0	0%
Foster	1	0	1	0	0	0	0%
Foster-Glocester	2	0	2	0	0	0	0%
Glocester	2	0	2	0	0	0	0%
Jamestown	2	1	1	0	0	0	0%
Johnston	6	1	5	0	0	0	0%
Lincoln	6	1	5	0	0	0	0%
Little Compton	1	0	1	0	0	0	0%
Middletown	5	0	5	0	0	0	0%
Narragansett	3	0	3	0	0	0	0%
New Shoreham	1	0	1	0	0	0	0%
Newport	2	0	2	0	0	0	0%
North Kingstown	8	0	8	0	0	0	0%
North Providence	9	0	9	0	0	0	0%
North Smithfield	4	0	4	0	0	0	0%
Pawtucket	16	0	14	0	2	2	13%
Portsmouth	4	0	4	0	0	0	0%
Providence	37	0	15	8	14	22	59%
Scituate	5	0	5	0	0	0	0%
Smithfield	6	0	6	0	0	0	0%
South Kingstown	7	3	4	0	0	0	0%
Tiverton	5	1	4	0	0	0	0%
Warwick	22	0	22	0	0	0	0%
West Warwick	5	0	5	0	0	0	0%
Westerly	6	0	6	0	0	0	0%
Woonsocket	9	0	9	0	0	0	0%
Charter Schools	*14*	*3*	*10*	*1*	*0*	*1*	*7%*
State-Operated Schools	*4*	*0*	*3*	*0*	*1*	*1*	*25%*
UCAP	*1*	*0*	*1*	*0*	*0*	*0*	*0%*
Four Core Cities	*66*	*0*	*39*	*9*	*18*	*27*	*41%*
Remainder of State	*192*	*14*	*175*	*1*	*2*	*3*	*2%*
Rhode Island	*277*	*17*	*228*	*11*	*21*	*32*	*12%*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Education, 2014-2015 school year.

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.

The only newly classified schools this year are Commended Schools. Schools previously in the lowest two classifications – Focus and Priority Schools – retain that classification for this year. All other schools receive no school classification this year. Schools listed as "not classified" in this table were not Commended, Focus, or Priority schools or were not classified in 2013-2014 because they did not have sufficient years of data or had new school designations.

References

[1] *Rhode Island school and district accountability system ESEA flexibility under NCLB.* (2012). Providence, RI: Rhode Island Department of Education.

[2] *Rhode Island accountability process revisions for school years 2015 and 2016.* (2015). Providence, RI: Rhode Island Department of Education.

[3,9] Rhode Island Department of Education. (2016). *Seventeen schools honored as R.I. commended schools* [Press release.]. Retrieved February 16, 2016, from www.ride.ri.gov

[4] *Fact Sheet: Congress acts to fix No Child Left Behind.* (2015). Washington, DC: Office of the Press Secretary, The White House.

(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

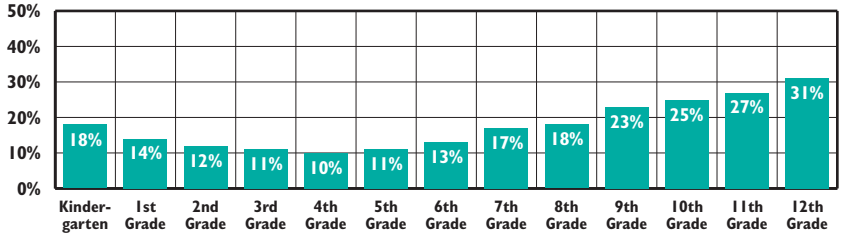
Students who are absent from school miss opportunities to learn and develop positive relationships within the school community. During the early elementary school years, children develop important skills and approaches to learning that are critical for ongoing school success. Through their experiences 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 ten 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 student absenteeism and mobility.[7] Unaddressed health and behavioral health issues, including 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, 2014-2015 School Year



Source: Rhode Island Department of Education, 2014-2015 school year.

◆ **Chronic absence rates are high in kindergarten and then decline before increasing again in middle and high school. During the 2014-2015 school year, 18% of Rhode Island kindergarten students, 14% of first graders, 12% of second graders, and 11% of third graders were chronically absent (i.e., absent 18 days or more).[14]**

◆ **During the 2014-2015 school year, 14% of Rhode Island children in grades K-3 were chronically absent, and an additional 16% missed 12 to 17 days of school.[15] Chronic absenteeism can affect the reading and math outcomes of 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 2014-2015 school year, the average daily attendance rate for K-3 students in Rhode Island's four core cities was 93%, but 23% 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 49. **Chronic Early Absence Rates, Grades K-3, Rhode Island, 2014-2015 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	20	877	96%	46%	40%	11%	3%
Bristol Warren	57	1,072	95%	38%	38%	14%	10%
Burrillville	14	640	95%	40%	37%	16%	8%
Central Falls	165	918	93%	33%	29%	20%	18%
Chariho	35	896	96%	48%	36%	11%	4%
Coventry	54	1,306	96%	45%	37%	12%	6%
Cranston	226	2,973	94%	33%	37%	17%	13%
Cumberland	73	1,302	96%	51%	37%	8%	4%
East Greenwich	20	634	96%	46%	41%	10%	4%
East Providence	116	1,674	95%	42%	32%	16%	11%
Exeter-West Greenwich	27	393	96%	40%	41%	15%	5%
Foster	*	171	96%	52%	33%	11%	4%
Glocester	13	341	98%	80%	15%	4%	1%
Jamestown	15	208	95%	41%	36%	15%	8%
Johnston	55	988	93%	26%	32%	22%	20%
Lincoln	45	819	96%	46%	33%	12%	8%
Little Compton	*	90	95%	36%	44%	14%	6%
Middletown	52	715	95%	38%	38%	16%	8%
Narragansett	12	352	96%	45%	37%	13%	6%
New Shoreham	*	24	92%	17%	21%	46%	17%
Newport	57	705	95%	35%	35%	19%	11%
North Kingstown	65	1,007	96%	45%	36%	13%	7%
North Providence	81	1,060	95%	41%	32%	15%	12%
North Smithfield	33	479	96%	46%	39%	11%	4%
Pawtucket	431	3,218	95%	39%	32%	16%	13%
Portsmouth	46	624	96%	45%	39%	11%	5%
Providence	1,347	7,913	92%	28%	27%	18%	26%
Scituate	21	333	94%	35%	34%	13%	18%
Smithfield	24	663	96%	50%	39%	9%	2%
South Kingstown	46	873	96%	45%	40%	11%	4%
Tiverton	36	519	96%	41%	35%	18%	6%
Warwick	186	2,573	95%	37%	35%	17%	11%
West Warwick	128	1,140	94%	36%	34%	19%	11%
Westerly	53	875	95%	41%	34%	15%	9%
Woonsocket	341	2,136	91%	23%	25%	20%	32%
Charter Schools	*44*	*2,033*	*96%*	*52%*	*30%*	*12%*	*6%*
Rhode Island School for the Deaf	*0*	*13*	*92%*	*31%*	*31%*	*8%*	*31%*
Four Core Cities	*2,284*	*14,185*	*93%*	*30%*	*28%*	*18%*	*23%*
Remainder of State	*1,619*	*26,326*	*95%*	*41%*	*36%*	*14%*	*9%*
Rhode Island	*3,947*	*42,557*	*94%*	*38%*	*33%*	*16%*	*14%*

Source of Data for Table/Methodology

Rhode Island Department of Education, 2014-2015 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 3,947 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 Mayoral Academy, The Compass School, Paul Cuffee Charter School, Highlander Charter School, Hope Academy, International Charter School, Kingston Hill Academy, The Learning Community, and South Side Elementary Charter School.

*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

[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 10, 2016, 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]

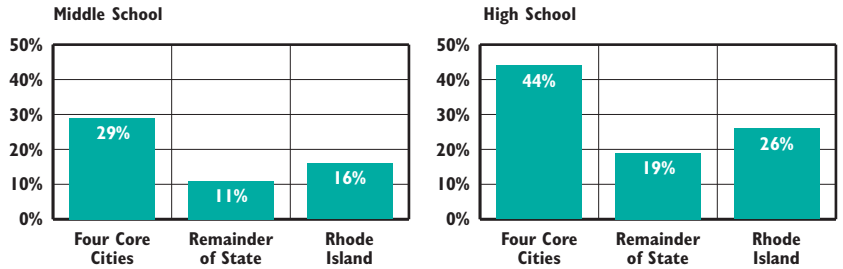
Family and economic factors connected to student absenteeism include poverty, lack of access to health care, unstable housing, child welfare or juvenile justice involvement, work or family responsibilities, and lack of affordable or reliable transportation. School factors contributing to chronic absence 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 Rhode Island Department of Education (RIDE) defines truancy as ten or more unexcused absences in a school year.[9] During the 2014-2015 school year in Rhode Island, 22% of middle school students and 31% of high school students were considered truant by RIDE.[10] Truant students in Rhode Island may be referred to the Family Court's Truancy Calendar, a community and school-based intervention program.[11]

One-third (33%) of Rhode Island's low-income middle and high school students were chronically absent in 2014-2015, compared with 12% of higher-income students. Middle and high school students receiving special education services (30%) were more likely than their peers not receiving these services (21%) to be chronically absent. Almost three-quarters (71%) of absences by middle and high school students were unexcused absences.[12]

Chronic Absence Rate by District Type, Middle and High School, 2014-2015 School Year



Source: Rhode Island Department of Education, 2014-2015 school year.

◆ **The chronic absence rate among middle (29%) and high (44%) school students in the four core cities is more than twice as high as the rates among middle (11%) and high (19%) school students in the remainder of the state.[13]**

◆ **One of the most effective strategies for increasing student achievement, high school graduation rates, 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.[14]**

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.[15]**

◆ **States can reduce chronic absence by raising awareness about the problem; producing chronic absence reports with data available by district, grade, and subgroup; making chronic absence rates and strategies for improving them a key part of accountability systems and district and school improvement plans; and allocating resources to address barriers to attendance.[16]**

Chronic Absence, Middle School and High School

Table 50.

Chronic Absence and Attendance Rates, Middle and High School, Rhode Island, 2014-2015 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	13	826	96%	10%	4%	32	1,062	96%	11%	5%
Bristol Warren	32	773	95%	17%	12%	74	937	92%	19%	20%
Burrillville	*	622	95%	16%	10%	*	716	94%	16%	14%
Central Falls	50	437	91%	20%	33%	182	728	85%	14%	48%
Chariho	42	756	96%	9%	4%	113	1,145	94%	14%	14%
Coventry	21	1,152	96%	14%	6%	91	1,540	94%	12%	14%
Cranston	116	2,560	93%	17%	19%	241	3,175	88%	15%	40%
Cumberland	35	1,128	96%	10%	6%	64	1,301	94%	14%	14%
East Greenwich	*	626	97%	10%	2%	26	726	98%	5%	2%
East Providence	49	1,165	93%	18%	19%	86	1,524	92%	16%	27%
Exeter-West Greenwich	*	421	96%	12%	7%	31	540	95%	14%	18%
Foster-Glocester	17	467	92%	23%	15%	17	644	93%	19%	17%
Jamestown	*	147	96%	13%	9%	NA	NA	NA	NA	NA
Johnston	25	755	93%	21%	23%	55	874	92%	17%	24%
Lincoln	24	768	95%	13%	11%	46	916	92%	15%	23%
Little Compton	*	102	94%	24%	8%	NA	NA	NA	NA	NA
Middletown	43	527	95%	14%	9%	57	669	95%	12%	11%
Narragansett	21	296	96%	13%	8%	20	425	94%	14%	16%
New Shoreham	*	37	95%	16%	14%	*	35	94%	23%	17%
Newport	34	445	94%	17%	13%	110	578	89%	18%	32%
North Kingstown	29	964	96%	13%	7%	80	1,429	95%	10%	10%
North Providence	55	837	96%	11%	10%	105	997	92%	18%	30%
North Smithfield	18	445	96%	13%	4%	48	535	95%	15%	10%
Pawtucket	171	2,028	94%	15%	18%	280	2,072	90%	14%	34%
Portsmouth	19	596	96%	14%	9%	47	935	95%	13%	11%
Providence	893	5,400	91%	17%	30%	1,354	6,446	86%	16%	45%
Scituate	12	352	95%	13%	12%	20	467	94%	16%	12%
Smithfield	13	585	96%	10%	5%	26	718	95%	12%	10%
South Kingstown	14	775	96%	10%	5%	68	1,035	94%	11%	11%
Tiverton	19	433	95%	10%	10%	34	558	93%	19%	19%
Warwick	98	2,188	95%	16%	12%	216	2,818	92%	16%	24%
West Warwick	55	765	94%	13%	15%	117	968	92%	12%	22%
Westerly	22	655	95%	16%	9%	60	931	94%	17%	15%
Woonsocket	208	1,328	89%	18%	38%	218	1,545	85%	14%	51%
Charter Schools	*33*	*1,085*	*96%*	*15%*	*7%*	*144*	*1,624*	*89%*	*14%*	*28%*
State-Operated Schools	*28*	*11*	*94%*	*18%*	*0%*	*325*	*1,717*	*91%*	*21%*	*32%*
UCAP	*11*	*125*	*89%*	*17%*	*38%*	*	*11*	*86%*	*36%*	*36%*
Four Core Cities	*1,322*	*9,193*	*91%*	*17%*	*29%*	*2,034*	*10,791*	*86%*	*15%*	*44%*
Remainder of State	*859*	*22,168*	*95%*	*14%*	*11%*	*1,888*	*28,203*	*93%*	*14%*	*19%*
Rhode Island	*2,253*	*32,582*	*94%*	*15%*	*16%*	*4,393*	*42,346*	*91%*	*15%*	*26%*

Source of Data for Table/Methodology

Rhode Island Department of Education, 2014-2015 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 2,253 Rhode Island middle school students and 4,393 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 separately 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 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 high schools include Beacon Charter High School for the Arts, Blackstone Academy, Blackstone Valley Prep Mayoral Academy, Highlander Charter School, Paul Cuffee Charter School, The Greene School, Rhode Island Nurses Institute Middle College, 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 numbers are still counted in district totals and in the four core cities, remainder of the state, and state total.

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 developing and enforcing disciplinary policies that set high expectations for student behavior, providing clear, appropriate, and consistent consequences for misbehavior, encouraging the use of alternative disciplinary approaches, such as restorative justice, and ensuring the equitable, appropriate, and limited use of suspensions.[7]

During the 2014-2015 school year in Rhode Island, 26,677 disciplinary actions were attributed to 10,449 students. In Rhode Island during the 2014-2015 school year, 7% of the student population was suspended at least once. The total number of disciplinary actions is about two and a half times the number of students disciplined because some students were disciplined multiple times.[8]

Of all disciplinary actions during the 2014-2015 school year, 9% (2,515) involved elementary school students (pre-kindergarten through 5th grade), 39% (10,506) involved middle school students (6th-8th grades), and 51% (13,656) involved high school students (9th-12th grades). Kindergartners received 203 disciplinary actions, including 187 out-of-school suspensions.[9]

Out-of-School Suspensions by Infraction, Rhode Island, 2014-2015

TYPE OF INFRACTION*	#	%	TYPE OF INFRACTION	#	%
Insubordination/Disrespect	3,758	29%	Alcohol/Drug/Tobacco Offenses	581	4%
Disorderly Conduct	3,038	23%	Arson/Larceny/Robbery/Vandalism	332	3%
Fighting	1,685	13%	Electronic Devices/Technology	297	2%
Assault of Student or Teacher	1,029	8%	Weapon Possession	156	1%
Obscene/Abusive Language	988	8%	Attendance Offenses	0	0%
Harassment/Intimidation/Threat	985	8%	Other Offenses	125	1%
			Total	*12,974*	

Source: Rhode Island Department of Education, 2014-2015 school year. Percentages may not sum to 100% due to rounding.
*Harassment offenses include hazing and hate crimes. Assault offenses include sexual assault.

◆ **Since the 2009-2010 school year, the number of out-of-school suspensions in Rhode Island has decreased by 47%. During the 2014-2015 school year, out-of-school suspensions accounted for just under one half (49%) of disciplinary actions. More than one-half of out-of-school suspensions were for non-violent offenses, such as insubordination or disrespect (29%) and disorderly conduct (23%).[10,11]**

Disparities in School Discipline by Special Education Status and Race/Ethnicity, Rhode Island, 2014-2015

	% OF STUDENTS ENROLLED	% OF SUSPENSIONS
Students With Disabilities	15%	30%
White Students	61%	44%
Asian Students	3%	1%
Black Students	8%	14%
Hispanic Students	24%	35%
Native American Students	1%	2%

Source: Rhode Island Department of Education, 2014-2015 school year. Detailed data by district is available at www.ride.ri.gov

◆ **In Rhode Island and nationally, Black and Hispanic students are more likely to be suspended than their White peers despite the fact that there is no evidence that these students have more serious patterns of rule breaking.[12,13,14]**

◆ **Schools must comply with special requirements about the discipline of students with disabilities that are included in state and federal laws, including the *Individuals with Disabilities Education Act (IDEA).*[15]**

Table 51.

Disciplinary Actions, Rhode Island School Districts, 2014-2015

SCHOOL DISTRICT	TOTAL # OF STUDENTS ENROLLED	TOTAL # OF STUDENTS SUSPENDED IN-SCHOOL	TOTAL # OF STUDENTS SUSPENDED OUT-OF-SCHOOL	OUT-OF-SCHOOL SUSPENSIONS PER 100 STUDENTS	TOTAL DISCIPLINARY ACTIONS	ACTIONS PER 100 STUDENTS
Barrington	3,271	14	49	1	63	2
Bristol Warren	3,322	578	475	14	1,053	32
Burrillville	2,350	29	155	7	184	8
Central Falls	2,720	384	89	3	473	17
Chariho	3,283	458	211	6	669	20
Coventry	4,649	651	150	3	801	17
Cranston	10,067	1,402	1,209	12	2,611	26
Cumberland	4,503	72	278	6	350	8
East Greenwich	2,355	21	21	1	42	2
East Providence	5,217	0	508	10	508	10
Exeter-West Greenwich	1,619	*	99	6	103	6
Foster	282	*	*	1	*	1
Foster-Glocester	1,110	256	112	10	368	33
Glocester	524	0	0	0	0	0
Jamestown	488	*	*	1	11	2
Johnston	3,030	84	70	2	154	5
Lincoln	3,019	*	209	7	210	7
Little Compton	250	*	0	0	*	1
Middletown	2,279	408	109	5	517	23
Narragansett	1,316	71	93	7	164	12
New Shoreham	116	*	*	1	*	3
Newport	2,052	23	342	17	365	18
North Kingstown	3,957	278	76	2	354	9
North Providence	3,516	872	730	21	1,602	46
North Smithfield	1,750	0	57	3	57	3
Pawtucket	9,011	131	905	10	1,036	11
Portsmouth	2,549	228	124	5	352	14
Providence	24,040	1,410	4,520	19	5,930	25
Scituate	1,373	35	*	0	36	3
Smithfield	2,368	89	94	4	183	8
South Kingstown	3,275	505	124	4	629	19
Tiverton	1,765	0	105	6	105	6
Warwick	8,953	600	534	6	1,134	13
West Warwick	3,395	189	241	7	431	13
Westerly	3,018	47	239	8	286	9
Woonsocket	5,996	4,396	764	13	5,160	86
Charter Schools	*5,397*	*166*	*248*	*5*	*414*	*8*
State-Operated Schools	*1,764*	*287*	*	*0*	*292*	*17*
UCAP	*137*	*0*	*20*	*15*	*20*	*15*
Four Core Cities	*41,767*	*6,321*	*6,278*	*15*	*12,599*	*30*
Remainder of State	*91,019*	*6,928*	*6,423*	*7*	*13,352*	*15*
Rhode Island	*140,084*	*13,702*	*12,974*	*9*	*26,677*	*19*

Source of Data for Table/Methodology

Rhode Island Department of Education, 2014-2015 school year.

The out-of-school suspensions rate per 100 students is the total number of out-of-school suspensions 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").

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 one removal to an Interim Alternative Education Setting (IAES) by school personnel was reported because new guidance from the Rhode Island Department of Education defined in-school suspensions more broadly than in the past. 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, SouthSide Charter School, 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 are 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 requirement for college and most employment. In Rhode Island, adults without high school diplomas are more likely to be unemployed and have lower median incomes than adults with high school degrees.[1,2] In 2014, 12% of Rhode Island children lived in households headed by a non-high school graduate, lower than the national average of 14%.[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 academic supports can be put in place to help students get "on track" for graduation.[5] Supports during the transition from middle to high school have been found to be particularly important to preventing dropping out.[6,7]

Adopting student-centered learning practices at the high school level can increase achievement and engagement for students from a variety of backgrounds. These practices encourage deeper engagement with school by personalizing learning to a student's interests, allowing students to take ownership over their work and continue learning outside of the classroom, and pacing learning to match the student's mastery of the content.[8]

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 2021, reach a minimum achievement level on the state assessment in content areas designated by the Board of Education. The Rhode Island Secondary School Regulations and high school graduation requirements are currently under revision.[9]

High School Graduation Rates

	2013-2014
RI	81%
US	82%
National Rank*	*34th*
New England Rank**	*6th*

**1st is best; 49th is worst*
***1st is best; 6th is worst*

Source: National Center for Education Statistics. (2015). *Table 1.* Retrieved February 26, 2016, from www.nces.ed.gov

Rhode Island Four-Year High School Graduation and Dropout Rates, by Student Subgroup, Class of 2015

	COHORT SIZE	DROPOUT RATE	% COMPLETED GED	% OF STUDENTS STILL IN SCHOOL	FOUR-YEAR GRADUATION RATE
Female Students	5,341	5%	1%	7%	86%
Male Students	5,564	8%	2%	10%	80%
English Language Learners	1,240	11%	<1%	12%	77%
Students With Disabilities	2,553	12%	2%	19%	68%
Students Without Disabilities	8,352	5%	1%	6%	88%
Low-Income Students	6,276	10%	2%	12%	76%
Higher-Income Students	4,629	2%	1%	4%	93%
White Students	6,889	5%	2%	7%	87%
Asian Students	366	6%	1%	5%	89%
Black Students	891	8%	2%	13%	77%
Hispanic Students	2,341	10%	1%	13%	76%
Native American	82	20%	1%	15%	65%
ALL STUDENTS	*10,905*	*7%*	*2%*	*9%*	*83%*

Source: Rhode Island Department of Education, Class of 2015. Percentages may not sum to 100% due to rounding.

◆ **The Rhode Island four-year graduation rate for the Class of 2015 was 83%, 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).[10]**

◆ **Poverty is associated with the likelihood of dropping out.[11] Almost one in eight students in Rhode Island's four core cities drop out of high school (12% drop out rate) compared to about one in 20 students in the remainder of the state (5% drop out rate).[12]**

Rhode Island Five- and Six-Year High School Graduation Rates

◆ **Rhode Island calculates five- and six-year graduation rates to recognize that graduation is an accomplishment regardless of the time it takes. Of the 11,425 Rhode Island students who enrolled in ninth grade in 2009, 9,150 (80.1%) graduated in four years in 2013, 435 (3.8%) graduated in five years in 2014, and 57 (<1%) graduated in six years in 2015.[13]**

◆ **Of the 435 students who graduated in five years in 2014, 45% were students with disabilities. Of the 57 students who graduated in six years in 2015, 65% were students with disabilities.[14]**

Table 52.

High School Graduation Rates, Rhode Island, Class of 2015

SCHOOL DISTRICT	FOUR-YEAR COHORT RATES # OF STUDENTS IN COHORT	DROPOUT RATE	% COMPLETED GED	% STILL IN SCHOOL	FOUR-YEAR GRADUATION RATE
Barrington	284	2%	<1%	2%	95%
Bristol Warren	248	4%	<1%	10%	86%
Burrillville	183	4%	4%	3%	89%
Central Falls	224	5%	3%	11%	81%
Chariho	317	3%	2%	4%	90%
Coventry	377	4%	<1%	5%	91%
Cranston	826	4%	2%	9%	85%
Cumberland	360	4%	0%	8%	88%
East Greenwich	195	2%	1%	4%	94%
East Providence	390	6%	2%	9%	82%
Exeter-West Greenwich	142	5%	4%	8%	83%
Foster-Glocester	161	2%	1%	6%	92%
Johnston	199	8%	1%	7%	84%
Lincoln	264	4%	<1%	3%	93%
Middletown	186	8%	4%	6%	82%
Narragansett	121	4%	1%	2%	93%
Newport	142	15%	1%	6%	79%
New Shoreham	13	0%	0%	15%	85%
North Kingstown	340	4%	3%	4%	89%
North Providence	244	<1%	1%	4%	95%
North Smithfield	148	3%	0%	9%	89%
Pawtucket	535	10%	2%	8%	81%
Portsmouth	221	2%	0%	2%	96%
Providence	1,649	11%	1%	13%	75%
Scituate	118	2%	0%	4%	94%
Smithfield	160	3%	0%	2%	96%
South Kingstown	243	5%	<1%	6%	88%
Tiverton	134	2%	2%	2%	93%
Warwick	738	8%	4%	8%	81%
West Warwick	239	7%	0%	8%	85%
Westerly	244	3%	1%	5%	91%
Woonsocket	456	20%	2%	16%	63%
Beacon Charter High School for the Arts	*56*	*2%*	*2%*	*5%*	*91%*
Blackstone Academy	*40*	*3%*	*0%*	*15%*	*83%*
The Greene School	*34*	*0%*	*0%*	*24%*	*76%*
William M. Davies Jr. Career & Technical High School	*205*	*4%*	*<1%*	*8%*	*87%*
Paul Cuffee Charter School	*63*	*2%*	*0%*	*5%*	*94%*
Rhode Island School for the Deaf	*16*	*19%*	*0%*	*81%*	*0%*
DCYF Schools	*59*	*17%*	*39%*	*34%*	*10%*
Metropolitan Regional Career and Technical Center	*216*	*3%*	*<1%*	*7%*	*90%*
Four Core Cities	*2,864*	*12%*	*1%*	*12%*	*75%*
Remainder of State	*7,237*	*5%*	*1%*	*6%*	*88%*
Rhode Island	*10,905*	*7%*	*2%*	*9%*	*83%*

Source of Data for Table/Methodology

Rhode Island Department of Education, Class of 2015.

The 2015 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 2011-2012 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.

Rhode Island Nurses Institute Middle College and the Sheila C. "Skip" Nowell Leadership Academy are not reported separately because these students generally complete their course of study in more than four years. These 115 students are, however, included in the state total.

References

[1] U.S. Census Bureau, American Community Survey, 2010-2014. Table S2301.

[2] U.S. Census Bureau, American Community Survey, 2010-2014. Table B20004.

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

[4,7,11] Shore, R. & Shore, B. (2009). *KIDS COUNT indicator brief: Reducing the high school dropout rate.* Baltimore, MD: The Annie E. Casey Foundation.

[5,6] Balfanz, R., et al. (2014). *Building a grad nation: Progress and challenge in ending the high school dropout epidemic.* Retrieved February 18, 2015, from www.americaspromise.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 2010 and 2014 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 $30,757, compared to $52,493 for adults with bachelor's degrees.[3]

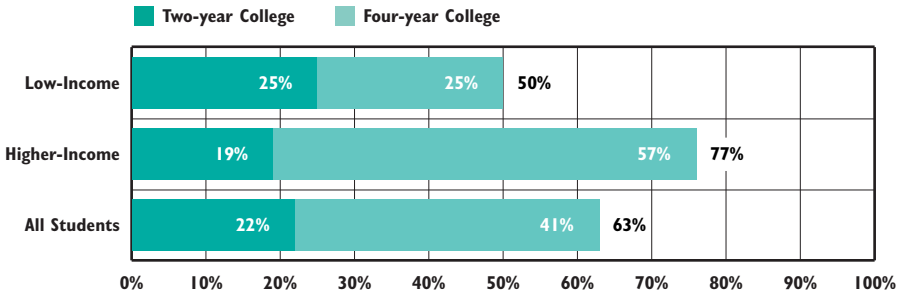
Many students, low-income students in particular, face barriers to college enrollment and success, such as insufficient academic preparation, difficulty navigating the application and financial aid processes, and the high cost of college. States can help address these barriers and improve college access by ensuring that all students have access to advanced coursework (including AP courses), take college entrance exams, complete the Free Application for Federal Student Aid (FAFSA), get adequate counseling to enroll in college and access financial aid, and that financial aid is targeted strategically to those students with the greatest needs.[4]

Students who participate in upper-level honors and Advanced Placement (AP) courses are likely to attend and succeed in college.[5] During the 2014-2015 school year, 4,675 Rhode Island public school students took an AP course exam, 7% more than the previous year.[6]

Among students in the Class of 2015, 59% took the SAT exam. Average SAT scores for Rhode Island public school students were 480 in critical reading, 481 in math, and 468 in writing.[7] Students with scores of 500 or better in each section are more likely to enroll in and succeed in college.[8]

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.[9] Among Rhode Island seniors due to graduate in 2015, 55% completed a FAFSA by June 2015.[10]

Immediate College Enrollment by District Type and Type of College, Class of 2014, Rhode Island



Source: Rhode Island Department of Education, Class of 2014. Percentages may not sum exactly due to rounding.

◆ **Sixty-three percent of Rhode Island students who graduated from high school in the Class of 2014 immediately enrolled in college. However, there are large gaps in college access, particularly four-year college enrollment, between low- and higher-income students. Among Rhode Island students who graduated from high school in 2014, 25% of low-income students immediately enrolled in a four-year college, compared to 57% of higher-income students.**[11]

◆ **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.**[12,13,14]

◆ **Many students who enroll in college do not complete their degree. 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, making college affordable, and providing student support programs that increase college completion rates.**[15] **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.**[16]

Table 53.

College Preparation and Access, Rhode Island

SCHOOL DISTRICT	TOTAL 12TH GRADE ENROLLMENT OCT. 2014	4-YEAR HIGH SCHOOL GRADUATION RATE, 2015	% OF 12TH GRADERS WHO FILLED OUT THE FAFSA, 2015	AVERAGE SAT SCORE IN CRITICAL READING, 2015	AVERAGE SAT SCORE IN MATH, 2015	AVERAGE SAT SCORE IN WRITING, 2015	% OF 12TH GRADERS TAKING THE SATs, 2015
Barrington	299	95%	62%	573	588	562	87%
Bristol Warren	226	86%	58%	537	527	542	48%
Burrillville	190	89%	49%	494	503	483	49%
Central Falls	226	81%	45%	365	398	357	46%
Chariho	298	90%	56%	514	499	501	57%
Coventry	399	91%	56%	473	481	459	59%
Cranston	838	85%	51%	477	475	466	50%
Cumberland	355	88%	61%	496	508	482	76%
East Greenwich	202	94%	50%	568	572	556	79%
East Providence	381	82%	56%	468	468	446	52%
Exeter-West Greenwich	140	83%	51%	525	512	509	64%
Foster-Glocester	161	92%	61%	499	493	483	64%
Johnston	206	84%	49%	460	450	449	55%
Lincoln	262	93%	63%	521	527	508	69%
Middletown	173	82%	53%	509	531	494	65%
Narragansett	125	93%	66%	527	543	522	74%
New Shoreham	13	85%	54%	517	492	489	77%
Newport	122	79%	58%	468	460	460	65%
North Kingstown	360	89%	59%	543	540	525	70%
North Providence	252	95%	55%	468	460	463	55%
North Smithfield	143	89%	62%	523	539	511	69%
Pawtucket	503	81%	47%	405	406	395	61%
Portsmouth	233	96%	65%	536	538	526	74%
Providence	1,435	75%	60%	407	406	394	68%
Scituate	116	94%	63%	540	534	522	74%
Smithfield	167	96%	65%	494	504	480	69%
South Kingstown	261	88%	56%	551	572	543	70%
Tiverton	133	93%	58%	467	464	450	48%
Warwick	718	81%	49%	502	484	487	46%
West Warwick	202	85%	52%	473	458	464	54%
Westerly	271	91%	51%	502	517	487	56%
Woonsocket	394	63%	45%	449	448	431	38%
Beacon Charter High School for the Arts	*53*	*91%*	*75%*	*459*	*426*	*454*	*66%*
Blackstone Academy	*39*	*83%*	*82%*	*408*	*430*	*409*	*97%*
Paul Cuffee Charter School	*61*	*94%*	*62%*	*380*	*394*	*375*	*84%*
Sheila "Skip" Nowell Leadership Academy	*32*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*
The Greene School	*30*	*76%*	*67%*	*550*	*478*	*515*	*77%*
RI Nurses Institute Middle College	*100*	*NA*	*11%*	*408*	*388*	*406*	*47%*
William M. Davies Jr. Career & Technical High School	*205*	*87%*	*52%*	*443*	*455*	*426*	*47%*
DCYF Schools	*17*	*10%*	*NA*	*NA*	*NA*	*NA*	*NA*
Metropolitan Regional Career and Technical Center	*222*	*90%*	*56%*	*463*	*443*	*435*	*5%*
RI School for the Deaf	*14*	*0%*	*NA*	*NA*	*NA*	*NA*	*7%*
Four Core Cities	*2,558*	*75%*	*54%*	*NA*	*NA*	*NA*	*60%*
Remainder of State	*7,247*	*88%*	*56%*	*NA*	*NA*	*NA*	*61%*
Rhode Island	*10,578*	*83%*	*55%*	*480*	*481*	*468*	*59%*

Source of Data for Table/Methodology

12th grade enrollment data (October 1, 2014) and high school graduation rates are from the Rhode Island Department of Education.

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 2011-2012, 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. (2015). *FAFSA completion by high school.* Retrieved March 6, 2016, from studentaid.ed.gov.

SAT scores and number of students taking the SAT are from the College Board. % of 12th graders taking the SAT is calculated using data from the College Board in combination with 12th grade enrollment data from the Rhode Island Department of Education.

High school graduation rate and % of 12th graders taking the SAT include all district students, including students who are placed out of district, so district high school graduation rate and SAT participation data may differ from data reported by high school even in districts with only one high school.

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

[1] Carnevale, A. P., Smith, N., & Strohl, J. (2013). *Recovery: Job growth and education requirements through 2020 (State report).* Washington, DC: Georgetown University, Center on Education and the Workforce.

[2] U.S. Census Bureau, American Community Survey, 2010-2014. Table S2301.

[3] U.S. Census Bureau, American Community Survey, 2010-2014. Table B20004.

(continued 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, experience, 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 mothers, and teens with disabilities have the highest rates of disconnection 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, 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 2010 and 2014, an estimated 3,879 (6%) youth ages 16 to 19 in Rhode Island were not in school and not working. Of the youth who were not in school and not working, 56% were males and 44% were females. Fifty-six percent of these youth were high school graduates and 44% had not graduated from high school.[10]

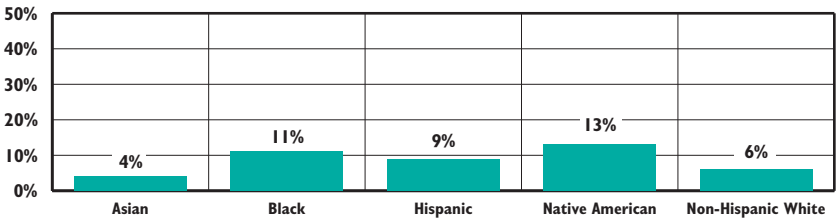
Teens Not in School and Not Working

	2014
RI	7%
US	7%
National Rank*	*20th*
New England Rank**	*6th*

**1st is best; 49th 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, 2014



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

◆ **Minority youth (with the exception of Asian youth) are more likely to be disconnected from school and work than White youth.[11] In 2014 among youth ages 16 to 19 in the U.S., 13% of Native American youth, 11% of Black youth, and 9% of Hispanic youth were not in school and not working, compared to 6% of White youth and 4% of Asian youth.[12]**

◆ **In the Providence-Warwick metro area in 2013, 27.2% of Latino youth ages 16 to 24 were disconnected, compared with 16.3% in the U.S.; 9.2% of White youth in this age group were disconnected, compared with 11.3% in the U.S.[13]**

◆ **The economic recession had a negative impact on the job market for youth and young adults. In 2015, there were almost 10.2 million youth ages 16-29 in the U.S. who were neither working nor enrolled in school.[14]**

Compulsory School Attendance

◆ **In 2011, Rhode Island raised its compulsory 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 2015, 24 states have set compulsory attendance to age 18, 11 states required attendance to age 17, and the remaining 15 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 2010 and 2014, the unemployment rate for Rhode Island adults ages 25 to 64 with a bachelor's degree or higher was 4%, compared with 16% 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]**

◆ **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.[20]**

Youth Work Experience

◆ **Work experience during the teen years increases academic performance, employability, and wages into early adulthood.[21]**

◆ **Public and private investment in summer work programs helps keep adolescents attached to constructive youth development activities and can help prevent youth violence.[22]**

◆ **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.[23,24]**

References

[1,2,4,11,13] Lewis, K. & Burd-Sharps, S. (2015). *Zeroing in on place and race: Youth disconnection in America's cities.* Brooklyn, NY: Measure of America.

[3,6] Hair, E. C., Moore, K. A., Ling, T. J., McPhee-Baker, C., & Brown, B. V. (2009). *Youth who are "disconnected" and those who then reconnect: Assessing the influence of family, programs, peers and communities.* Washington, DC: Child Trends.

[5] Federal Interagency Forum on Child and Family Statistics. (2014). *America's young adults: Special issue, 2014.* Washington, DC: U.S. Government Printing Office.

[7,21] *Youth employment matters! Strengthening the youth-to-work pipeline through high-quality youth employment opportunities – Policy brief.* (2014). Washington, DC: Urban Alliance.

[8,18] *Youth and work: Restoring teen and young adult connections to opportunity.* (2012). Baltimore, MD: The Annie E. Casey Foundation.

[9] Vericker, T., Pergamit, M., Macomber, J., & Kuehn, D. (2009). *Vulnerable youth and the transition to adulthood: Second-generation Latinos connecting to school and work.* U.S. Department of Health and Human Services, Office of Human Services Policy, Office of the Assistant Secretary of Planning and Evaluation. Washington, DC: Government Printing Office.

[10] U.S. Census Bureau, American Community Survey, 2010-2014. Table B14005.

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

[14] Desilver, D. (2016). *Millions of young people in the U.S. and EU are neither working nor learning.* Washington, DC: Pew Research Center.

[15] Rhode Island General Law 16-19-1. Enacted by the General Assembly as H-5061 and S-0046 Substitute A in 2011.

[16] National Center for Education Statistics. (n.d.). *Table 5.1. Compulsory school attendance laws, minimum and maximum age limits for required free education, by state: 2015.* Retrieved March 17, 2016, from nces.ed.gov

[17] U.S. Census Bureau, American Community Survey, 2010-2014. Table S2301.

[19] Shore, R. & Shore, B. (2009). *KIDS COUNT indicator brief: Reducing the number of disconnected youth.* Baltimore, MD: The Annie E. Casey Foundation.

[20] Early College High School Initiative. (n.d.). *Overview & FAQ: What are early college high schools?* Retrieved January 21, 2015, from www.earlycolleges.org

[22] *Meaningful youth employment investment guide.* (2013). Boston, MA: Youth Violence Prevention Funder Learning Collaborative and Youth Workforce Development and Education Working Group.

[23] *FY2016 and FY2017 biennial employment and training plan.* (2014). Cranston, RI: Governor's Workforce Board Rhode Island.

[24] Adams, C. J. (2013). *Internships help students prepare for workplace.* Retrieved February 16, 2016, from www.edweek.org

Methodology

The *2016 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 2010-2014 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 2016 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 2010 and 2014. 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-level 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.

In 2015, the U.S. Census Bureau discontinued publishing 3-year estimates of the American Community Survey. Beginning with the *2016 Rhode Island Kids Count Factbook*, 5-year estimates are used in all indicators that had used 3-year estimates in prior Factbooks.

Margins of Error for Median Family Income and Children in Poverty

The 2010-2014 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

Margins of Error, Median Family Income, Rhode Island, 2010-2014

CITY/TOWN	2010-2014 MEDIAN FAMILY INCOME FOR FAMILIES WITH CHILDREN UNDER AGE 18	MARGIN OF ERROR
Barrington	$143,469	$12,244
Bristol	$91,767	$13,711
Burrillville	$72,688	$18,865
Central Falls	$27,601	$6,268
Charlestown	$74,233	$9,034
Coventry	$94,078	$7,495
Cranston	$80,987	$3,427
Cumberland	$99,255	$12,511
East Greenwich	$166,944	$19,453
East Providence	$54,314	$6,307
Exeter	$109,099	$17,969
Foster	$86,375	$36,448
Glocester	$92,270	$10,072
Hopkinton	$90,921	$16,682
Jamestown	$158,950	$45,722
Johnston	$82,188	$11,245
Lincoln	$88,085	$18,766
Little Compton	$114,167	$39,361
Middletown	$85,244	$6,363
Narragansett	$105,313	$25,260
New Shoreham	$108,295	$47,482
Newport	$53,750	$14,448
North Kingstown	$107,697	$11,513
North Providence	$67,534	$5,734
North Smithfield	$107,026	$15,780
Pawtucket	$40,304	$3,042
Portsmouth	$115,201	$24,392
Providence	$32,558	$2,736
Richmond	$122,540	$17,982
Scituate	$98,269	$8,260
Smithfield	$96,339	$14,791
South Kingstown	$105,365	$5,703
Tiverton	$86,984	$6,324
Warren	$60,694	$13,171
Warwick	$77,375	$4,982
West Greenwich	$103,074	$15,593
West Warwick	$50,688	$5,706
Westerly	$67,885	$20,855
Woonsocket	$32,711	$4,684
Four Core Cities	*NA*	*NA*
Remainder of State	*NA*	*NA*
Rhode Island	*$67,119*	*$1,862*

Margins of Error, Children Living Below the Federal Poverty Threshold, Rhode Island, 2010-2014

CHILDREN UNDER AGE 18 LIVING BELOW POVERTY, 2010-2014			
#	MARGIN OF ERROR	%	MARGIN OF ERROR
68	65	1.5%	1.46%
183	101	5.5%	2.97%
354	183	10.8%	5.38%
2,361	410	41.9%	6.29%
326	221	22.5%	14.69%
873	291	12.4%	4.03%
2,380	475	15.4%	2.94%
586	228	7.9%	3.02%
228	171	7.1%	5.27%
1,670	438	17.3%	4.33%
84	80	7.4%	6.79%
88	70	11.0%	8.43%
79	78	4.4%	4.25%
70	77	5.2%	5.53%
122	117	13.7%	12.89%
683	211	12.7%	3.75%
438	194	9.2%	3.94%
47	58	7.4%	8.84%
357	116	9.3%	2.89%
105	79	4.7%	3.52%
9	33	8.9%	32.59%
582	210	16.4%	5.67%
753	269	12.2%	4.29%
734	254	14.5%	4.81%
132	101	5.6%	4.20%
5,120	647	32.1%	3.72%
238	148	6.6%	4.03%
15,894	1,211	39.7%	2.67%
119	110	6.5%	5.88%
175	125	8.4%	5.89%
79	83	2.2%	2.27%
396	196	8.1%	3.94%
259	117	8.9%	3.92%
240	117	12.0%	5.70%
1,319	272	8.9%	1.79%
72	78	4.3%	4.62%
1,219	342	21.3%	5.64%
666	266	14.3%	5.49%
4,036	547	42.0%	4.86%
27,411	*932*	*38.5%*	*1.16%*
15,733	*721*	*11.0%*	*0.49%*
43,114	*1,836*	*20.1%*	*0.84%*

Methodology

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.

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.

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.

Partnership for Assessment of Readiness for College and Careers (PARCC)

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)*. The *PARCC* is aligned to the Common Core State Standards. The English language arts *PARCC* assesses students' ability to read and comprehend complex texts, use different sources to compare and synthesize ideas, and write effectively. The math *PARCC* assesses students' ability to demonstrate mathematical reasoning and apply mathematical concepts to solve complex, real-world problems.

The percentage of students meeting expectations is the number of students who met or exceeded expectations for their grade on a specific *PARCC* assessment, divided by the number of students who took that assessment.

PARCC test results (including the number of students who opted-out of taking the test) are available for the state, district, and school levels on the Rhode Island Department of Education (RIDE) website.

The *PARCC* replaced the *New England Common Assessment Program (NECAP)*, which was administered in Rhode Island between 2005 and 2013. Results from the *PARCC* are not comparable with *NECAP* assessment tests.

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.

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 of age and over. The 2015 federal poverty threshold for a family of three with two children is $19,096 and $24,036 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

2016 FEDERAL POVERTY GUIDELINES	ANNUAL INCOME FAMILY OF THREE	ANNUAL INCOME FAMILY OF FOUR
50%	$10,080	$12,150
100%	$20,160	$24,300
130%	$26,208	$31,590
175%	$35,280	$42,525
180%	$36,288	$43,740
185%	$37,296	$44,955
200%	$40,320	$48,600
225%	$45,360	$54,675
250%	$50,400	$60,750

(continued from page 11)

References for Children in Single Parent Families

[14] The National Conference on State Legislators. (2012). *Child poverty rates and family structure.* Retrieved January 8, 2016, from www.ncsl.org

[15] *Fragile Families and Child Wellbeing Study: Fact sheet.* (n.d.). Retrieved January 8, 2016, from www.fragilefamilies.princeton.edu

[16] Child Trends Data Bank. (2015). *Births to unmarried women.* Retrieved January 8, 2016, from www.childtrendsdatabank.org

(continued from page 13)

References for Grandparents Caring for Grandchildren

[14] U.S. Census Bureau, American Community Survey, 2010-2014. Table B10050.

[15] U.S. Census Bureau, Census 2010.

[17] Rhode Island Department of Children, Youth and Families. (2009). *Kinship care. (Policy 900.0025).* Retrieved December 23, 2015, from www.dcyf.ri.gov

[18] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), December 31, 2015.

[20] Children's Bureau. (2013). *Title IV-E Guardianship Assistance.* Retrieved November 4, 2014, from www.acf.hhs.gov/programs/cb/resource/title-iv-e-guardianship-assistance

(continued from page 15)

References for Mother's Education Level

[9] Addy. S., Engelhardt, W., & Skinner, C. (2013). *Basic facts about low-income children: Children under 18 years, 2011.* New York, NY: Columbia University, National Center for Children in Poverty.

[10] U.S. Census Bureau, American Community Survey, 2010-2014. Table B20004.

[14] U.S. Census Bureau, American Community Survey, 2010-2014. Table S1702.

(continued from page 17)

References for Racial and Ethnic Diversity

[17] The Annie E. Casey Foundation KIDS COUNT Data Center. (2013). *Children in immigrant families whose resident parents have been in the country five years or less.* Retrieved January 11, 2016, from www.datacenter.kidscount.org

[18] The Annie E. Casey Foundation KIDS COUNT Data Center. (2012). *Children living below the poverty threshold by family nativity.* Retrieved January 11, 2016, from www.datacenter.kidscount.org

[19] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2010-2014. Table B05010.

[20] Skinner, C., Wight, V. R., Aratani, Y., Cooper, J. L., & Thampi, K. (2010). *English language proficiency, family economic security, and child development.* New York, NY: National Center for Children in Poverty.

[21] The Annie E. Casey Foundation KIDS COUNT Data Center. (2013). *Children living in linguistically isolated households by children in immigrant families.* Retrieved January 11, 2016, from www.datacenter.kidscount.org

(continued from page 21)

References for Racial and Ethnic Disparities

[29] *Policy actions to reduce racial disproportionality and disparities in child welfare: A scan of eleven states.* (2009). Washington, DC: Alliance for Racial Equity in Child Welfare.

[30] *Racial and ethnic disparity and disproportionality in child welfare and juvenile justice: A compendium.* (2009). Washington, DC: Center for Juvenile Justice Reform.

[31] Rhode Island Department of Education, *Partnership for Assessment of Readiness for College and Careers (PARCC) results,* 2015.

[32] U.S. Census Bureau, American Community Survey, 2010-2014, Tables B15003, C15002A, C15002B, C15002C, C15002D & C15002I.

[33,34,42] Rhode Island Department of Education, 2014-2015 school year.

[35] U.S. Census Bureau, Census 2010 Redistricting Data and Population Division.

References

[38] U.S. Census Bureau, American Community Survey, 2010-2014. Tables B19113 & B19113I.

[41] U.S. Census Bureau, Census 2010, Summary File 1 & Table P12H.

[43] Huguley, J. (2013). *Latino students in Rhode Island: A review of local and national performances.* Providence, RI: The Latino Policy Institute at Roger Williams University.

(continued from page 27)

References for Cost of Housing

[1] All rents have been adjusted using the HUD utility allowances to include heat, cooking fuel, electricity, and hot water.

[2] U.S. Federal Interagency Forum on Child and Family Statistics. (2015). *America's children: Key national indicators of well-being, 2015.* Washington, DC: U.S. Government Printing Office.

[3] Cunningham, M. & MacDonald, G. (2012). *Housing as a platform for improving education outcomes among low-income children.* Washington, DC: What Works Collaborative, Urban Institute.

[4] Affordable housing is nowhere to be found for millions. (2015). *National Low Income Housing Coalition Housing Spotlight, 5*(1), 1-8.

[5,10,11,12] *2015 Housing fact book.* (2015). Providence, RI: HousingWorks RI at Roger Williams University.

[6] Ault, M., Sturtevant, L., & Viveiros, J. (2015). *Housing landscape 2015: An annual look at the housing affordability challenges of America's working households.* Washington, DC: Center for Housing Policy.

[7] Rhode Island KIDS COUNT calculations using data from Rhode Island Housing, 2016.

[8,9] *Out of reach 2015: Low wages and high rents lock renters out.* (2015). Washington, DC: National Low Income Housing Coalition.

[13] U.S. Department of Housing and Urban Development. (n.d.). *Housing choice vouchers fact sheet.* Retrieved February 18, 2016, from www.hud.gov

[14] Rhode Island General Assembly. (2014). *Budget at a glance.* Retrieved July 3, 2014, from http://webserver.rilin.state.ri.us

[15] Rhode Island Housing, Rhode Island Rent Survey, 2006-2015.

[16] U.S. Census Bureau, American Community Survey, 2006. Selected housing characteristics. Table DP04.

[17] U.S. Census Bureau, American Community Survey, 2014. Selected housing characteristics, Table DP04.

[18] Cook, J. T., et al. (2008). A brief indicator of household energy security: Associations with food security, child health, and child development in U.S. infants and toddlers. *Pediatrics, 122*(4), e867-e875.

[19] *Rules and regulations governing the termination of residential electric, gas and water utility service.* (2015). Providence, RI: State of Rhode Island and Providence Plantations Public Utilities Commission.

[20] Rhode Island Office of Energy Resources. (n.d.). *Low Income Home Energy Assistance Program (LIHEAP).* Retrieved February 18, 2016, from www.energy.ri.gov

[21] LIHEAP Action Center. (2015). *Rhode Island Facts.* Retrieved February 18, 2016, from http://liheap.org/states/ri

(continued from page 29)

References for Homeless Children

[7,9] National Child Traumatic Stress Network. (2014). *Complex trauma: Facts for shelter staff working with homeless children and families.* Retrieved February 23, 2016, from www.nctsn.org

[8] National Child Traumatic Stress Network. (2014). *Complex trauma: Facts for service providers working with homeless youth and young adults.* Retrieved February 23, 2016, from www.nctsn.org

[11] Rhode Island Emergency Shelter Information Project, 2015.

[12] United Way 211 Rhode Island. (2016). *Help starts here, Rhode Island.* Retrieved February 22, 2016, from www.211ri.org

[13] Burchman, H., Elliott, J., & Wagner, S. (2012). *Opening Doors Rhode Island: Strategic plan to prevent and end homelessness.* Providence, RI: Rhode Island Housing Resources Commission, Rhode Island Interagency Council on Homelessness, and Rhode Island Housing.

[14] Rhode Island Coalition for the Homeless. (n.d.). *Zero: 2016.* Retrieved February 23, 2016, from www.rihomeless.org

[15] Community Solutions. (n.d.). *Zero: 2016.* Retrieved February 23, 2016, from www.cmtysolutions.org

[16] Rhode Island Coalition for the Homeless. (n.d.). *Zero: 2016 Aim statement.*

[17,18,21] Cunningham, M., Harwood, R., & Hall, S. (2010). *Residential instability and the McKinney-Vento Homeless Children and Education Program: What we know, plus gaps in research.* Washington, DC: Urban Institute.

[19] National Center for Homeless Education. (n.d.). *The McKinney-Vento definition of "homeless."* Retrieved February 22, 2016, from center.serve.org

[20] Rhode Island Department of Education, 2014-2015 school year.

(continued from page 31)

References for Secure Parental Employment

[2] Wertheimer, R., Moore, K. A., & Burkhauser, M. (2008). *The well-being of children in working poor and other families: 1997 and 2004.* Washington, DC: Child Trends.

[3] Rhode Island Department of Labor and Training. (n.d.). *Rhode Island labor force statistics, seasonally adjusted 1976-present.* Retrieved March 2, 2016, from www.dlt.ri.gov

[4] Rhdoe Island Department of Labor and Training. (n.d.). *State rank by unemployment rate, seasonally adjusted.* Retrieved March 15, 2016, from www.dlt.ri.gov

[5] The Annie E. Casey Foundation KIDS COUNT Data Center. (2015). *Children with at least one unemployed parent - 2014.* Retrieved February 23, 2016, from www.datacenter.kidscount.org

[6] Isaacs, J. (2013). *Unemployment from a child's perspective.* Washington, DC: Urban Institute and First Focus.

[7] Lovell, P. & Isaacs, J. B. (2010). *Families of the recession: Unemployed parents and their children.* Washington, DC: First Focus.

[8] U.S. Census Bureau, American Community Survey, 2010-2014. Table DP03.

[9] Roberts, B., Povich, D., & Mather, M. (Winter 2012-2013). *Low-income working families: The growing economic gap.* Retrieved February 23, 2016, from www.workingpoorfamilies.org

[10,17] Shore, R. & Shore, B. (2009). *Increasing the number of children whose parents have stable employment.* Baltimore, MD: The Annie E. Casey Foundation.

[11,12] U.S. Census Bureau, American Community Survey, 2010-2014. Table B23008.

[13] U.S. Census Bureau, American Community Survey, 2010-2014. Table B17016.

[14] *Low-income children in the United States: National and state trend data, 1998-2008.* (2009). New York, NY: Columbia University, Mailman School of Public Health, National Center for Children in Poverty.

[15] National Center for Children in Poverty. (n.d.). *Rhode Island demographics of low-income children.* Retrieved February 23, 2016, from www.nccp.org

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

[18] Lee, S. (2007). *Keeping moms on the job: The impacts of health insurance and child care on job retention and mobility among low-income mothers.* Washington, DC: Institute for Women's Policy Research.

[19] Farrell, J. & Venator, J. (2012). *Paid sick days work for U.S. employees and employers.* Washington, DC: Center for American Progress.

[20] Glynn, S. J. & Venator, J. (2012) *Workplace flexibility: Allowing employees some leeway is good for business and the economy.* Washington, DC: Center for American Progress.

[21] Ajinkya, J. (2013). *Who can afford unpaid leave?* Retrieved February 23, 2016, from www.centerforamericanprogress.org

[22] The State of Rhode Island and Providence Plantations, Department of Labor and Training. (2014). *Temporary Caregiver Insurance [Brochure].*

[23] National Conference of State Legislatures. (2014). *State family and medical leave laws.* Retrieved February 23, 2016, from www.ncsl.org

[24] U.S. Census Bureau, American Community Survey, 2010-2014. Table S2301.

References

[25] Mills, G., Compton, J. F., & Golden, O. (2011). *Assessing the evidence about work support benefits and low-income families: Rationale for a demonstration and evaluation.* Washington, D.C: The Urban Institute and Ford Foundation.

[26] Adams, G. & Rohacek, M. (2010). *Child care instability: Definitions, context, and policy implications.* Washington, DC: The Urban Institute.

[27] *Parents and the high cost of child care, 2015 report.* (2015). Arlington, VA: Child Care Aware of America.

[28] *Child Care Assistance Program.* (2015). Providence, RI: Rhode Island Senate Fiscal Office.

[29] U.S. Department of Health and Human Services. (2015). Annual update of the HHS poverty guidelines. *Federal Register, 81*(15), 4036-4037.

[30] *Policy basics: State Earned Income Tax Credits.* (2015). Washington, DC: The Center on Budget & Policy Priorities.

[31] *Policy basics: The Earned Income Tax Credit.* (2016). Washington, DC: The Center on Budget & Policy Priorities.

[32] Marr, C., Huang, C., Sherman, A., & DeBot, B. (2015). *Earned Income Tax Credit promote work, reduce poverty, and support children's development, research finds.* Washington, DC: Center on Budget and Policy Priorities.

[33] National Conference of State Legislatures. (2016). *Tax credits for working families: Earned Income Tax Credit (EITC).* Retrieved February 24, 2016, from ncsl.org

(continued from page 35)

References for Children Receiving Child Support

[3] Grall, T. (2013). Custodial mothers and fathers and their child support: 2011. *Current Population Reports, Series P60-246.* Washington, DC: U.S. Census Bureau.

[4] Entmacher, J. (2013). Child support is helping poor families in tough times. *Child Support Report, 35*(1), 11.

[5,7,9] Turetsky, V. (2005). *The Child Support Enforcement program: A sound investment in improving children's chances in life.* Washington, DC: Center for Law and Social Policy.

[6] Huang, C. & Han, K. (2012). Child support enforcement in the United States: Has policy made a difference? *Children and Youth Services Review, 34*, 622-627.

[8] Knox, V., Cowan, P. A., Cowan, C. P., & Bildner, E. (2011). Policies that strengthen fatherhood and family relationships: What do we know and what do we need to know? *The Annals of the American Academy of Political and Social Science, 635*(1), 216-239.

[10,11,13,14,19,20,21,22] Rhode Island Department of Human Services, Office of Child Support Services, 2006-2015.

[12] U.S. Office of Child Support Enforcement, Administration for Children & Families. (2015). *FY 2014 preliminary report.* Table P-36. Retrieved January 25, 2016, from www.acf.hhs.gov

[15] Rhode Island Office of Child Support Services. (n.d.). *Medical Support.* Retrieved January 19, 2016, from www.cse.ri.gov

[16] Rhode Island Coalition Against Domestic Violence and Women's Resource Center of Newport and Bristol Counties. (n.d.). *The Family Violence Option Advocacy Program (FVOAP).* Retrieved January 25, 2016, from www.cse.ri.gov

[17] U.S. Office of Child Support Enforcement, Administration for Children & Families. (2015). *FY 2014 preliminary report.* Table P-39. Retrieved January 25, 2016, from www.acf.hhs.gov

[18] U.S. Office of Child Support Enforcement, Administration for Children & Families. (2015). *FY 2014 preliminary report.* Tables P-52 & P-80. Retrieved January 25, 2016, from www.acf.hhs.gov

[21] Rhode Island Department of Human Services. (2010). Child Support Program, Section 0700, Rules and Regulations.

[23,25] Lippold, K., Nichols, A., & Sorensen, E. (2010). *Evaluation of the $150 child support pass-through and disregard policy in the District of Columbia.* Washington, DC: The Urban Institute.

[24] National Conference of State Legislatures. (2015). *Child support pass-through and disregard policies for public assistance recipients.* Retrieved January 25, 2016, from www.ncsl.org

(continued from page 39)

References for Children in Poverty

[7,13,20] Jiang, Y., Ekeno, M., & Skinner, C. (2015). *Basic facts about low-income children: Children under age 18 years, 2013.* New York, NY: National Center for Children in Poverty, Columbia University.

[8,40] National Center for Children in Poverty. (2014). *Rhode Island: Demographics of poor children.* Retrieved February 3, 2016, from www.nccp.org

[9,17] U.S Census Bureau. (n.d.). *Poverty thresholds for 2015 by size of family and number of related children under 18 years.* Retrieved February 5, 2016, from www.census.gov

[10] Short, K. (2011). *The research Supplemental Poverty Measure: 2010.* Washington, DC: U.S. Census Bureau.

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

[12] U.S. Census Bureau, American Community Survey, 2010-2014. Tables S1701.

[14,15] U.S. Census Bureau, American Community Survey, 2010-2014. Tables B170201, B17020A, B17020B, B17020C, B17020D, B17020F, B17020G, & Table B17020I.

[16] U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates. Table C17024.

[18,19] Population Reference Bureau analysis of 2010-2014 American Community Survey data.

[22] Frank, D. A., et al. (2010). Cumulative hardship and wellness of low-income, young children: Multisite surveillance study. *Pediatrics, 125*(5), e1115-e1123.

[23] Corporation for Enterprise Development. (n.d.). *CFED assets and opportunity scorecard: Unbanked households.* Retrieved February 9, 2016, from http://scorecard.assetsandopportunity.org

[24,28] *Taking the first step: Six ways to start building financial security and opportunity at the local level.* (2012). Washington, DC: National League of Cities and Corporation for Enterprise Development.

[25,27,29] *2013 FDIC National Survey of Unbanked and Underbanked Households.* (2014). Washington, DC: Federal Deposit Insurance Corporation.

[26,30] *Payday lending in America: Policy solutions.* (2013). Philadelphia, PA: Pew Charitable Trust.

[31] *Policy brief: Protections from predatory short-term loans.* (2012). Washington, DC: Corporation for Enterprise Development.

[32] Fass Hiatt, S. & Newcomer, A. (2010). *President Obama's asset limit proposal: Supporting families and promoting improved coordination.* Washington, DC and New York City, NY: Center for Law and Social Policy, Single Stop, and First Focus.

[33] Rhode Island Department of Human Services. (2015). *Rhode Island Department of Human Services code of rules: RI Works Program.* Retrieved February 3, 2016, from www.policy.dhs.ri.gov/1400.htm

[34] Huber, E., Cohen, E., Briggs, A., & Kassabian, D. (2015). *Welfare rules databook: State TANF policies as of July 2014,* OPRE Report 2014-52. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services and the Urban Institute.

[35] *Measuring access to opportunity in the United States.* (2015). Baltimore, MD: The Annie E. Casey Foundation.

[36] The Kaiser Commission on Medicaid and the Uninsured. (2015). *Key facts about the uninsured population.* Washington, DC: The Henry J. Kaiser Family Foundation.

[37] *America's children in brief: Key national indicators of well-being, 2015.* (2015). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[38] Rhode Island KIDS COUNT calculations based on average weekly rates from Bodah, M. M. (2015). *Statewide survey of childcare rates in Rhode Island.* Kingston, RI: University of Rhode Island, Charles T. Schmidt, Jr. Labor Research Center.

[39] Wight, V. R., Chau, M., & Aratani, Y. (2011). *Who are America's poor children? The official story.* New York, NY: National Center for Children in Poverty, Columbia University.

[41] Carnevale, A. P., Smith, N., & Strohl, J. (2013). *Recovery: Job growth and education requirements through 2020.* Washington, DC: Georgetown University Center on Education and the Workforce.

References

[42] Rhode Island Housing, Rhode Island Annual Rent Survey, 2015.

[43] Rhode Island KIDS COUNT analysis of data from Rhode Island Housing, Rhode Island Rent Survey, 2015.

[44,45] Sard, B. & Fischer, W. (2013). *Chart book: Federal housing spending is poorly matched to need: Tilt toward well-off homeowners leaves struggling low-income renters without help.* Retrieved January 8, 2015, from www.cbpp.org

[46] Rhode Island Department of Human Services, Office of Child Support Services, 2006-2015.

[47] Turetsky, V. (2005). *The Child Support Enforcement program: A sound investment in improving children's chances in life.* Washington, DC: Center for Law and Social Policy.

[48] Grall, T. (2013). Custodial mothers and fathers and their child support: 2011. *Current Population Reports, Series P60-246.* Washington, DC: U.S. Census Bureau.

(continued from page 43)

References for Children in Families Receiving Cash Assistance

[4,10,13,15,24,25,28,29,31,34,37,42] Rhode Island Department of Human Services, InRhodes Database, December 1996-2015.

[6] Rhode Island Department of Human Services. (2010). Child Support Program, Section 0700, Rules and Regulations.

[7] Rhode Island Department of Human Services, Office of Child Support Services, 2016.

[9] The Economic Progress Institute. (2012). *Facts about Rhode Island Works.* Retrieved February 25, 2016, from www.economicprogressri.org

[11] Rhode Island Department of Human Services. Testimony given at October 2012 Caseload Estimating Conference, Providence, RI.

[12] *Rhode Island: TANF caseload and TANF-to-poverty ratio fact sheet.* Retrieved February 25, 2016, from www.cbpp.org

[14] U.S. Census Bureau, American Community Survey, 2014. Table C17024.

[19] Elizabeth Houghton and Maria D. Mendez v. Gary Alexander, Director of the RI Department of Human Services, P.C. 10-5625 (Superior Court 2010).

[22] *Family Independence Program 2007 annual report.* (2007). Cranston, RI: Rhode Island Department of Human Services.

[23] House Fiscal Advisory Staff. (2015). *Budget as enacted, Fiscal Year 2016.* Providence, RI: Rhode Island House of Representatives.

[27] Rhode Island General Law 40-5.2-12. Enacted by the General Assembly as S-2476 in 2014.

[32] *Why it matters: Teen pregnancy, poverty, and income disparity.* (2010). Washington, DC: The National Campaign to Prevent Teen Pregnancy.

[35] Loprest, P. & Maag, E. (2009). *Disabilities among TANF recipients: Evidence from the NHIS, final report.* Washington, DC: The Urban Institute.

[38] *Policy basics: An introduction to TANF.* (2015). Washington, DC: Center on Budget and Policy Priorities.

[39] *Request for proposals: Adult education for college, work & career, family, and community.* (2010). Providence, RI: Rhode Island Department of Education.

[40] Carnevale, A. P., Smith, N., & Strohl, J. (2013). *Recovery: Job growth and education requirements through 2020 (Executive summary).* Washington, DC: Georgetown University Center on Education and the Workforce.

[41] U.S. Census Bureau, American Community Survey, 2010-2014. Table S2301.

[43] Literacy levels, CCRI-REACH TABE tested report on RI Works participants by the Community College of Rhode Island, October 1, 2014-September 30, 2015.

[44] Hamilton, G. (2012). *Improving employment and earnings for TANF recipients.* Washington, DC: The Urban Institute.

[45] Lower-Basch, E. (2015). *Work Participation Rate: Temporary Assistance for Needy Families.* Washington, DC: CLASP.

(continued from page 45)

References for Children Receiving SNAP Benefits

[4] Bailey, K., et al. (2011). *Too many hurdles: Barriers to receiving SNAP put children's health at risk: Children's HealthWatch policy action brief.* Boston, MA: Children's HealthWatch.

[5,10] United States Department of Agriculture, Food and Nutrition Service. (2015). *Supplemental Nutrition Assistance Program.* Retrieved February 2, 2016, from www.fns.usda.gov/snap/eligibility

[6,23] *Supplemental Nutrition Assistance Program (SNAP) 2009-2012 accomplishments.* (n.d.). Cranston, RI: Rhode Island Department of Human Services.

[7] United States Department of Agriculture, Food and Nutrition Service. (2009). *Improving access to SNAP through broad-based categorical eligibility. Memorandum to regional administrators.* Retrieved February 11, 2011, from www.fns.usda.gov/snap/rules/Memo/2009/09309.pdf

[8] Rhode Island Department of Human Services. (n.d.). *Supplemental Nutrition Assistance Program (SNAP) Income Guidelines.* Retrieved February 2, 2016, from www.dhs.ri.gov

[9,13] U.S. Department of Health and Human Services. (2015). Annual update of the HHS poverty guidelines. *Federal Register, 80*(14), 3236-3237.

[11,16,19] *Policy basics: Introduction to SNAP.* (2015). Washington, DC: Center on Budget and Policy Priorities.

[12,14,17,18,22] Rhode Island Department of Human Services, InRhodes Database, 2006-2015.

[15] *SNAP and public health: The role of the Supplemental Nutrition Assistance Program in improving the health and well-being of Americans.* (2013). Washington, DC: Food Research and Action Center.

[20] Coleman-Jensen, A., Rabbitt, M. P., Gregory, C., & Singh, A. (2015). *Household food security in the United States in 2014: Economic research report number 194.* Washington, DC: United States Department of Agriculture, Economic Research Service.

[21] *2015 status report on hunger in Rhode Island.* (2015). Providence, RI: Rhode Island Community Food Bank.

[24] *DHS past and present.* (2010). Retrieved January 30, 2011, from www.eohhs.ri.gov/modernization/steering

[25] Hahn, H. & Kassabian, D. (2013). *Early lessons from the Work Support Strategies Initiative: Rhode Island.* Washington, DC: Urban Institute.

[26] United States Department of Agriculture, Food, and Nutrition Service. (2012). *Supplemental Nutrition Assistance Program-State options report.* Washington, DC: United States Department of Agriculture, Program Development Division.

[27] Rosenbaum, D. & Dean, S. (2011). *Improving the delivery of key work supports: Policy and practice opportunities at a critical moment.* Washington, DC: Center on Budget and Policy Priorities.

(continued from page 47)

References for Women and Children Participating in WIC

[8] Cole, N., Jacobson, J., Nichols-Barrer, I., & Fox, M. (2011). *WIC food packages policy options study: Final report.* Alexandria, VA: U.S. Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis.

[10,11,12,13,16,18] Rhode Island Department of Health, WIC Program, 2010-2015.

[17] *WIC Farmers' Market Nutrition Program.* (2016). Retrieved February 15, 2016, from www.fns.usda.gov

(continued from page 49)

References for Children Participating in School Breakfast

[1,9,14] *School breakfast scorecard: School year 2014-2015.* (2016). Washington, DC: Food Research and Action Center.

[2] Potamites, E. & Gordon, A. (2010). *Children's food security and intakes from school meals.* Princeton, NJ: Mathematica Policy Research, Inc.

[3] Levin, M. (2014). *Breakfast for learning.* Washington, DC: Food Research and Action Center.

[4] Coleman-Jensen, A., McFall, W., & Nord, M. (2013). *Food insecurity in households with children: Prevalence, severity, and household characteristics, 2010-11.* Washington, DC: U.S. Department of Agriculture.

References

[5] Hartline-Grafton, H. (2014). *Breakfast for health.* Washington, DC: Food Research and Action Center.

[6] 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.

[7] Thrive, Rhode Island Island's Coordinated School Health Program. (n.d.). *Nutrition.* Retrieved February 9, 2016, from www.thriveri.org

[8,10,13] Hewins, J. (2015). *School breakfast: Making it work in large school districts.* Washington, DC: Food Research and Action Center.

[11] *School breakfast scorecard: School year 2013-2014.* (2016). Washington, DC: Food Research and Action Center.

[12,15] Rhode Island Department of Education, Office of School Food Services, Office of Statewide Efficiencies, October 2015.

[16] Center for Budget and Policy Priorities. (2015). *Community eligibility database: Schools that can adopt community eligibility for 2015-2016.* Retrieved February 9, 2016, from www.cbpp.org

[17] FitzSimons, C., Anderson, S., Hayes, C., & Burke, M. (2015). *Hunger doesn't take a vacation: Summer nutrition status report 2015.* Washington, DC: Food Research and Action Center.

(continued from page 53)

References for Children's Health Insurance

[3] Yamauchi, M., Carlson, M. J., Wright, B. J., Angier, H., & DeVoe, J. E. (2013). Does health insurance continuity among low-income adults impact their children's insurance coverage? *Maternal and Child Health Journal, 17*(2), 248-255.

[4] Alker, J. & Chester, A. (2015). *Children's health insurance rates in 2014: ACA results in significant improvements.* Washington, DC: Georgetown University Health Policy Institute Center for Children and Families.

[5] Paradise, J. (2014). *The impact of the Children's Health Insurance Program (CHIP): What does the research tell us?* Washington, DC: The Henry J. Kaiser Family Foundation, Kaiser Commission on the Uninsured.

[6] Chester, A. & Alker, J. (2015). *Medicaid at 50: A look at the long-term benefits of childhood Medicaid.* Washington, DC: Georgetown University Health Policy Institute Center for Children and Families.

[7,9,10] Rhode Island Executive Office of Health and Human Services, RIte Care and RIte Share Enrollment and Eligibility Recap Reports, December 2014 and December 2015.

[8,19] Rhode Island Executive Office of Health and Human Services, MMIS Database, December 31, 2015.

[11,15] U.S. Census Bureau, American Community Survey, 2014. Table R2702.

[12] U.S. Census Bureau, American Community Survey, 2014. Table S2702.

[13] U.S. Census Bureau, American Community Survey, 2011-2013 & 2014. Tables B27001A, B27001B, B27001C, B27001D, B27001H, & B27001I.

[14] U.S. Census Bureau, American Community Survey, 2014. Table GCT2702.

[16,20] U.S. Census Bureau, American Community Survey, 2013 & 2014. Table B27010.

[17] Population Reference Bureau analysis of U.S. Census Bureau, American Community Survey data, 2010-2014.

[18] Rhode Island Executive Office of Health and Human Services. (n.d.). *Healthcare for families with children.* Retrieved February 8, 2016, from www.eohhs.ri.gov

[21] HealthSource RI, Enrollment Report, Calendar Year 2014 & 2015.

(continued from page 55)

References for Childhood Immunizations

[3] Centers for Disease Control and Prevention. (2014). *Why immunize?* Retrieved January 14, 2016, from www.cdc.gov

[4] Centers for Disease Control and Prevention. (2014). *About Vaccines for Children Program.* Retrieved January 14, 2016, from www.cdc.gov

[5] Centers for Disease Control and Prevention. (2014). *How the Affordable Care Act increases access to influenza vaccination for health care personnel.* Retrieved January 14, 2016, from www.cdc.gov

[6,22] Rhode Island Department of Health. (n.d.). *Office of Immunization,* Retrieved January 14, 2016, from www.health.ri.gov

[7,14] State of Rhode Island and Providence Plantations. (2014). *Rules and regulations pertaining to immunization and communicable disease testing in preschool, school, colleges or universities.* (Department of Health Publication R23-1-IMM). Providence, RI: Rhode Island Department of Health.

[8,16,20] *Summary of immunization requirement changes for Rhode Island preschool (includes child care), school, and college/universities.* (2014). Providence, RI: Rhode Island Department of Health.

[9,17,18] Rhode Island Department of Health analysis of data from the *National Immunization Survey-Children,* 2014.

[10] National, state, and local area vaccination coverage among children aged 19-35 months – United States, 2014. (2015). *Morbidity and Mortality Weekly Report, 64*(33), 889-896.

[11] Dempsey, A. F., et al. (2011). Alternative vaccination schedule preferences among parents of young children. *Pediatrics, 128*(5), 848-856.

[12] Hough-Telford, C., Kimberlin, D., & O'Connor, K. G. (2015). *Vaccine refusals and requests for alternate vaccine schedules (AVS): National surveys of pediatricians.* Retrieved January 15, 2016, from www.aap.org

[13] General recommendations on immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP). (2011). *Morbidity and Mortality Weekly Report, 60*(2), 3-61.

[15,19] Rhode Island Department of Health, *2014-2015 Kindergarten and 7th Grade Immunization Assessments.*

[21] Rhode Island Department of Health analysis of data from the *National Immunization Survey-Teen,* 2014.

[23] Rhode Island Department of Health. (n.d.). *About vaccine funding and selection.* Retrieved January 14, 2016, from www.health.ri.gov

[24] Rhode Island Immunization Program. (2015). *Vaccinate Before You Graduate: 2014-2015 Rhode Island annual report.* Providence, RI: Rhode Island Department of Health.

(continued from page 57)

References for Access to Dental Care

[4,40] *Rhode Island data brief: Access to dental care among Rhode Island children and adults, 2014.* (2015). Providence, RI: Rhode Island Department of Health, Oral Health Program.

[5] *Rhode Island Health Interview Survey results.* (1990, 2001). Providence, RI: Rhode Island Department of Health, Rhode Island Medicaid Research and Evaluation Project, Health Indicator Project, Rhode Island Oral Health Access Project.

[7] Wilkniss, S. & Tripoli, S. (2015). *Health investments that pay off: Strategies to improve oral health.* Washington, DC: National Governors Association.

[8,11,13,23,31,46] *Rhode Island Oral Health Plan, 2011-2016.* (2011). Providence, RI: Rhode Island Oral Health Commission and the Rhode Island Department of Health.

[12,14] Oh, J., Leonard, L., Fuller, D., & Miller, K. (2011). Less than optimal oral health care during pregnancy in Rhode Island women: Oral health care as a part of prenatal care. *Health By Numbers, 94*(5), 141-143.

[16] Holt, K., Barzel, R., & Bertness, J. (2014). *Oral health for children and adolescents with special health care needs: Challenges and opportunities.* Washington, DC: National Maternal and Child Oral Health Resource Center.

[17,25,33] Rhode Island Executive Office of Health and Human Services, 2005-2015.

[18,21,42] Centers for Medicare & Medicaid Services. (n.d.). *Annual EPSDT participation report form CMS-416 Fiscal Year 2014, Rhode Island and U.S.* Retrieved January 26, 2016, from www.medicaid.gov

[19] Centers for Medicare & Medicaid Services. (n.d.). *Dental care.* Retrieved January 28, 2016, from www.medicaid.gov

[20] Mann, C. (2014). *CMCS informational bulletin: Update on CMS Oral Health Initiative and other oral health related items.* Baltimore, MD: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

[22] Centers for Medicare & Medicaid Services. (2010). *State of Rhode Island Medicaid dental review.* Retrieved January 28, 2016, from www.mchoralhealth.org

References

[24,26] McQuade, W., et al. (2011). Assessing the impact of RI's managed oral health program (RIte Smiles) on access and utilization of dental care among Medicaid children ages ten years and younger. *Health by Numbers, 94*(8), 247-249.

[27] Yarbrough, C., Nasseh, K., & Vujicic, M. (2014). *Key insights on dental insurance decisions following the rollout of the Affordable Care Act.* Chicago, IL: American Dental Association, Health Policy Institute.

[28] HealthSource RI, Enrollment Report, Calendar Year 2015.

[30,35] Nasseh, K., Vujicic, M., & Yarbrough, C. (2014). *A ten-year, state-by-state, analysis of Medicaid Fee-for-Service reimbursement rates for dental care services.* Chicago, IL: American Dental Association, Health Policy Institute.

[32,34] Rhode Island Department of Human Services, 2007-2008.

[36,37] Rhode Island Department of Health, Center for Health Data and Analysis, Hospital Discharge Database, 2010-2014.

[39] Association of State and Territorial Dental Directors. (2012). *First dental visit by age one.* Retrieved February 1, 2016, from www.astdd.org

[43] Rhode Island General Law 5.31.1-39. Enacted by the General Assembly as H-5953 Substitute A and S-0683 Substitute A in 2015.

[44] *Rhode Island oral health issue brief: Rhode Island young children's preventive dental visit: The need for primary care providers' engagement in children's oral health.* (2011). Providence, RI: Rhode Island Department of Health Oral Health Program.

[45] The Pew Charitable Trusts. (2015). *Reimbursing physicians for fluoride varnish.* Retrieved February 1, 2016, from www.pewtrusts.org

(continued from page 59)

References for Children's Mental Health

[3,8] Murphey, D., Vaughn, B., & Barry, M. (2013). *Adolescent health highlight: Access to mental health care.* (Publication No. 2013-2). Washington DC: Child Trends.

[4] Smith, J. P. & Smith, G. C. (2010). Long-term economic costs of psychological problems during childhood. *Social Science & Medicine, 71*, 110-115.

[5] Kim, H. K., Viner-Brown, S. I., & Garcia, J. (2007). Children's mental health and family functioning in Rhode Island. *Pediatrics, 119*(Supplement 1), S22-S28.

[6,9] *Mental health: A report of the Surgeon General.* (1999). Rockville, MD: U.S. Department of Health and Human Services.

[7] Murphey, D., et al. (2014). *Are the children well? A model and recommendations for promoting the mental wellness of the nation's young people.* Princeton, NJ: Robert Wood Johnson Foundation & Child Trends.

[11] Data Resource Center for Child & Adolescent Health. (2012). *2011/2012 National Survey of Children's Health-Received needed mental health care, age 2-17 years.* Retrieved March 11, 2015, from www.childhealthdata.org

[12] *Strategies to support the integration of mental health into pediatric primary care.* (2009). Washington, DC: The National Institute for Health Care Management Foundation.

[13] *A review of the Department of Children, Youth and Families.* (2001). Providence, RI: Rhode Island Public Expenditure Council, Commissioned by Rhode Island Children's Policy Coalition.

[14] *Toward an organized system of care for Rhode Island's children, youth and families: The report of the Rhode Island System of Care Task Force.* (2002). Providence, RI: Rhode Island System of Care Task Force.

[15] *Report to the Governor and General Assembly required by Section 42-72-5.2 of the General Laws of Rhode Island on development of a continuum of children's behavioral health programs.* (2006). Cranston, RI: Rhode Island Executive Office of Health and Human Services.

[16,19] Rhode Island Senate Health and Human Services Committee. (2013). *Oversight of the Department of Children, Youth and Families.* Retrieved March 11, 2015, from www.rilin.state.ri.us

[17] Stroul, B. A. & Friedman, R. M. (2011). *Effective strategies for expanding the system of care approach: A report on the study of strategies for expanding systems of care.* Atlanta, GA: ICF Macro.

[18] *Special Joint Commission to Study the Integration of Primary Care and Behavioral Health: Final Report.* (2014). Providence, RI: Rhode Island Senate and House of Representatives.

[20] Rhode Island Department of Health, Hospital Discharge Database, 2004-2014.

[21] U.S. Census Bureau, Census 2010 Summary File 1.

[22] Abid, Z., Meltzer, A., Lazar, D., & Pines, J. (2014). Psychiatric boarding in U.S. EDs: A multifactorial problem that requires multidisciplinary solutions. *Urgent Matters, 1*(2), 1-6.

[23,25,26,28] Lifespan, 2011-2015.

[24] Hasbro Children's Hospital. (n.d.). *Medical psychiatric program.* Retrieved March 16, 2016, from www.hasbrochildrenshospital.org

[27] Butler Hospital, 2014-2015.

[29] Rhode Island Executive Office of Health and Human Services, MMIS Database, 2014-2015.

[31] *2015 Youth Risk Behavior Survey*, Rhode Island Department of Health, Center for Health Data and Analysis.

[32] Rhode Island Department of Health, Hospital Discharge Database, 2010-2014.

[33] Rhode Island Department of Health, Center for Health Data and Analysis, 2010-2014.

[34] Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals, Division of Behavioral Healthcare, 2015.

(continued from page 61)

References for Children with Special Needs

[3] Data Resource Center for Child and Adolescent Health. (n.d.). *2007 and 2011/12 National Survey of Children's Health-Developmental screening during health care visit, age 10 months-5 years.* Retrieved February 11, 2015, from www.childhealthdata.org

[5,10] The Catalyst Center. (2009). *Breaking the link between special health care needs and financial hardship.* Boston, MA: Boston University, School of Public Health, Health & Disability Working Group.

[6] American Academy of Pediatrics, Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee. (2014). Policy statement: Patient- and family-centered care coordination: A framework for integrating care for children and youth across multiple systems. *Pediatrics, 133*(5), e1451-e1459.

[7] *2015 Rhode Island Youth Risk Behavior Survey,* Rhode Island Department of Health, Center for Health Data and Analysis.

[8] *Rhode Island data brief: Disability and health among high school students in 2013.* (2013). Providence, RI: Rhode Island Department of Health.

[9] Porterfield, S. L. & DeRigne, L. (2011). Medical home and out-of-pocket medical costs for children with special health care needs. *Pediatrics, 128*(5), 892-900.

[11] Data Resource Center for Child and Adolescent Health. (n.d.). *2009/10 National Survey of Children with Special Health Care Needs – MCHB core outcomes and key indicators, Impact on families.* Retrieved February 11, 2015, from www.childhealthdata.org

[12] Stabile, M. & Allin, S. (2012). The economic costs of childhood disability. *The Future of Children: Children with disabilities, 22*(1), 65-96.

[13] Rhode Island General Law 42-7.2-20.1. ABLE Accounts. Enacted by the General Assembly as H-5564 Substitute A in 2015.

[14] National Disability Institute. (2014). *Congress passes ABLE Act: Major victory for persons with disabilities and their families.* Retrieved March 3, 2016, from www.realeconomicimpact.org

[15] Public Law No. 113-295. Enacted by the U.S. Congress as H.R. 5771 in 2014.

[16] *The importance of Early Intervention for infants and toddlers with disabilities and their families.* (2011). Chapel Hill, NC: University of North Carolina, The National Early Childhood Technical Assistance Center.

[17,21,22,25,31,34,35] Rhode Island Executive Office of Health and Human Services, Center for Child and Family Health, January, June, & December 2015.

[18] U.S. Department of Education. (n.d.). *Building the legacy: IDEA 2004.* Retrieved March 2, 2016, from http://idea.ed.gov

[19,20] Rhode Island Department of Education, 2015.

[23] U.S. Social Security Administration. (n.d.). *Understanding Supplemental Security Income SSI for children - 2015 edition.* Retrieved March 2, 2016, from ww.socialsecurity.gov

References

[24] Rhode Island Executive Office of Health and Human Services. (2015). *Katie Beckett eligibility for children with disabilities and special needs.* Retrieved March 1, 2016, from www.eohhs.ri.gov

[26] Rhode Island Department of Human Services, Center for Child and Family Health, January 2008.

[27] *Access to health care has improved for children with special health care needs in Rhode Island.* (2009). Cranston, RI: Rhode Island Department of Human Services, Medicaid Research and Evaluation Project.

[28] *Neighborhood's program for children with special health care needs limits cost growth to 1.4 percent over the last three years by expanding access to care and building new service options.* (2009). Providence, RI: Neighborhood Health Plan of Rhode Island.

[29] Lewis, C., Beckwith, J., Fortin, K., & Goldberg, A. (2011). Fostering health: Health care for children and youth in foster care. *Medicine & Health/Rhode Island, 94*(7), 200-202.

[30] Grayson, J. (2012, Winter). Mental health needs of foster children and children at risk of removal. *CYF News,* pp. 2-5.

[32] Houshyar, S. (2014). *Medicaid to 26 for former foster youth: An updated on the state option and state efforts to ensure coverage for all young people irrespective of where they aged out of care.* Washington, DC: First Focus, State Policy Advocacy and Reform Center.

[33] *The new Medicaid coverage for youth who age out of foster care in Rhode Island to age 26.* (2013). Providence, RI: Rhode Island Department of Children, Youth and Families.

[36] *Autism Spectrum Disorders.* (2013). Washington, DC: Child Trends.

[37,40,43] Centers for Disease Control and Prevention. (2015). *Facts about ASD.* Retrieved March 2, 2016, from www.cdc.gov

[38] Centers for Disease Control and Prevention. (2014). Prevalence of Autism Spectrum Disorder among children aged 8 years - Autism and Developmental Disabilities Monitoring Network, 11 sites, United States, 2010. *Morbidity & Mortality Weekly Report, 63*(2), 1-22.

[39] Rhode Island Department of Education, Office of Student, Community and Academic Supports, 2015.

[41] Centers for Disease Control and Prevention. (2012). *Why are autism spectrum disorders increasing?* Retrieved January 28, 2014, from www.cdc.gov/features/autismprevalence/

[42,44] Mayo Clinic. (2014). *Autism spectrum disorder.* Retrieved March 1, 2016, from www.mayoclinic.com

(continued from page 63)

References for Infants Born at Highest Risk

[11] Hamilton, B. E., Martin, J. A., Osterman, M. J. K., Curtin, S. C., & Mathews, T. J. (2015). Births: Final data for 2014. *National Vital Statistics Reports, 64*(12). Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

(continued from page 73)

References for Infant Mortality

[13] *Rhode Island Birth Defects Program: Birth defects data book 2014.* (2015). Providence, RI: Rhode Island Department of Health, Birth Defects Program.

[16] Heron, M. (2016). Deaths: Leading causes for 2013. *National Vital Statistics Reports, 65*(2), 1-94.

[19,20] *AMCHP compendium on infant mortality. Forging a comprehensive initiative to improve birth outcomes and reduce infant mortality: Policy and program options for state planning.* (2012). Washington, DC: Association of Maternal and Child Health Programs.

[21] Meghea, C. I., You, Z., Raffo, J., Leach, R. E., & Roman, L. A. (2015). Statewide Medicaid enhanced prenatal care programs and infant mortality. *Pediatrics, 136*(2), 334-342.

(continued from page 75)

References for Breastfeeding

[11] Healthy People 2020. (2016). *Maternal, Infant, and Child Health Objectives, MICH-21-Breastfeeding.* Retrieved February 9, 2016, from www.healthypeople.gov

[13] Rhode Island Department of Health, Division of Family Health, Newborn Developmental Risk Screening Program and Maternal and Child Health Database, 2010-2014.

[14] Rhode Island Department of Health, Division of Family Health, Pregnancy Risk Assessment Monitoring System, 2012-2013.

[16] Rhode Island General Law 28-5-7.4. Enacted by the General Assembly as H-5674 SubA in 2015.

[18] Women & Infants Hospital. (2015). *Women & Infants achieves baby-friendly designation* [Press release]. Retrieved from www.womenandinfants.org

(continued from page 77)

References for Children with Lead Poisoning

[3] *Healthy housing data book: A report from the Healthy Housing Collaborative.* (2012). Providence, RI: Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program.

[4] *NTP monograph: Health effects of low-level lead.* (2012). Research Triangle Park, NC: U.S. Department of Health and Human Services, National Toxicology Program, Office of Health Assessment and Translation.

[5] *Lead poisoning.* (2015). Washington, DC: Child Trends.

[6] Gould, E. (2009). Childhood lead poisoning: Conservative estimates of the social and economic benefits of lead hazard control. *Environmental Health Perspectives, 117*(7), 1162-1167.

[7] Trasande, L. & Liu, Y. (2011). Reducing the staggering costs of environmental disease in children, estimated at $76.6 billion in 2008. *Health Affairs, 30*(5), 863-870.

[8,17] Educational Services for Children Affected by Lead Expert Panel. (2015). *Educational interventions for children affected by lead.* Atlanta, GA: U.S. Department of Health and Human Services.

[10] Centers for Disease Control and Prevention. (2012). *CDC response to Advisory Committee on Childhood Lead Poisoning Prevention recommendations in "Low level lead exposure harms children: A renewed call of primary prevention."* Retrieved February 22, 2016, from www.cdc.gov

[11] Centers for Disease Control and Prevention. (2016). *Lead: CDC's national surveillance data (1997-2014).* Retrieved February 22, 2016, from www.cdc.gov

[12] Rhode Island Department of Health. (2015). *Childhood lead poisoning.* Retrieved February 22, 2016, from www.health.ri.gov

[13] Raymond, J., Wheeler, W., & Brown, M. J. (2014). Lead screening and prevalence of blood lead levels in children aged 1-2 years – child blood lead surveillance system, United States, 2002-2010 and National Health and Nutrition Examination Survey, United States, 1999-2010. *Morbidity & Mortality Weekly Report, 63*(2), 36-42.

[14] *Core cities data: A supplement to childhood lead poisoning in Rhode Island: The numbers, 2011 edition.* (2011). Providence, RI: Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program.

[15,23] Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program, Children Under Age Six, 2005-2015.

[16] Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program, Children Entering Kindergarten in Fall, 1997-2017.

[18] McLaine, P., et. al. (2013). Elevated blood lead levels and reading readiness at the start of kindergarten. *Pediatrics. 131*(6), 1081-1089.

[19] Rhode Island DataHub. (n.d.). *The educational cost of unhealthy housing.* Retrieved February 22, 2016, from http://ridatahub.org

[20] Rhode Island Department of Health. (n.d.). *Lead poisoning publications.* Retrieved February 22, 2016, from www.health.ri.gov

[21] Rhode Island Department of Health. (n.d.). *Immunizations and lead poisoning: A report on the students in your Local Education Agency: Cranston.* Retrieved February 22, 2016, from www.health.ri.gov

[23] Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program, Environmental Inspection Table, 2015.

[25] Rhode Island Public Law Sections 23-24.6-7 and 23-24.6-9.

[26] Rhode Island Department of Health, KIDSNET, 2016.

References

(continued from page 79)

References for Children with Asthma

[9,15] President's Task Force on Environmental Health Risks and Safety Risks to Children. (2012). *Coordinated federal action plan to reduce racial and ethnic asthma disparities.* Retrieved January 20, 2016, from www.epa.gov/childrenstaskforce

[10] Akinbami, L. J., et al. (2012). Trends in asthma prevalence, health care use, and mortality in the United States, 2001-2010. *NCHS Data Brief* (94). Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics.

[11,16] Harty, M. & Horton, K. (2013). *Using Medicaid to advance community-based childhood asthma interventions: A review of innovative Medicaid programs in Massachusetts and opportunities for expansion under Medicaid nationwide.* Washington, DC: Childhood Asthma Leadership Coalition and The George Washington University, School of Public Health and Health Services, Department of Health Policy.

[12] National Institutes of Health. (2012). *Asthma care quick reference: Diagnosing and managing asthma.* Retrieved January 20, 2016, from www.nhlbi.nih.gov

[13] Sleath, B., et al. (2012). Communication during pediatric asthma visits and self-reported asthma medication adherence. *Pediatrics, 130*(4), 627-633.

[14] Woods, E. R., et al. (2012). Community asthma initiative: Evaluation of a quality improvement program for comprehensive asthma care. *Pediatrics, 129*(3), 465-472.

[17,18,19,20] Rhode Island Department of Health, Center for Health Data and Analysis, Hospital Discharge Database, 2010-2014.

[21] *Asthma claims data book.* (2014). Providence, RI: Rhode Island Department of Health, Asthma Control Program.

(continued from page 81)

References for Housing and Health

[11,12] Population Reference Bureau analysis of the 2010-2014 American Community Survey (ACS) Public Use Microsample (PUMS) data.

[13,21] Rhode Island Department of Health. (n.d.). *Childhood lead poisoning.* Retrieved March 4, 2016, from www.health.ri.gov

[14,17] *Lead poisoning.* (2015). Washington, DC: Child Trends.

[16] Maqbool, N., Viveiros, J., & Ault, M. (2015). *The impacts of affordable housing on health: A research summary.* Washington, DC: Center for Housing Policy and National Housing Conference.

[18] *NTP monograph: Health effects of low-level lead.* (2012). Research Triangle Park, NC: U.S. Department of Health and Human Services, National Toxicology Program, Office of Health Assessment and Translation.

[19] Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program, Children Entering Kindergarten in Fall 2017.

[20] *Core cities data: A supplement to childhood lead poisoning in Rhode Island: The numbers, 2011 edition.* (2011). Providence, RI: Rhode Island Department of Health.

[22] *Asthma.* (2015). Washington, DC: Child Trends.

[23] Harty, M. B. & Horton, K. (2013). *Using Medicaid to advance community-based childhood asthma interventions: A review of innovative Medicaid programs in Massachusetts and opportunities for expansion under Medicaid nationwide: Issue brief from the Childhood Asthma Leadership Coalition.* Washington, DC: Childhood Asthma Leadership Coalition and The George Washington University, School of Public Health and Health Services, Department of Health Policy.

[24,29] Rhode Island Department of Health, Division of Family Health, Hospital Discharge Database, 2010-2014.

[25] U.S. Census Bureau, Census 2010, Redistricting File.

[26] *Reducing the burden of asthma in Rhode Island: Asthma state plan 2014-2019.* (2014). Providence, RI: Rhode Island Department of Health.

[27] *Unintentional injuries.* (2014). Washington, DC: Child Trends.

[28] Jacobs, D. E. & Baeder, A. (2009). *Housing interventions and health: A review of the evidence.* Columbia, MD: National Center for Healthy Housing.

[30] Rhode Island Department of Health. (2012). *Lead screening and referral guidelines: Universal blood lead screening.* Retrieved March 4, 2016, from www.health.ri.gov

[31] Rhode Island Department of Health, KIDSNET, 2016.

[32] Rhode Island Department of Health. (n.d.). *Healthy homes and lead poisoning information for parents.* Retrieved March 4, 2016, from www.health.ri.gov

[33] Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program, Environmental Inspection Table, 2015.

[34] State of Rhode Island Division of Planning Office of Health Housing. (n.d.). *Lead – healthy housing.* Retrieved March 4, 2016, from www.planning.ri.gov

[35] Rhode Island Department of Human Services. (n.d.). *Weatherization Assistance Program.* Retrieved March 4, 2016, from www.dhs.ri.gov

[36] Rhode Island Department of Human Services, Weatherization Assistance Program data, 2015.

(continued from page 83)

References for Adolescent Obesity

[6] Fryar, C. D., Carroll, M. D., & Ogden, C. L. (2014). *Prevalence of overweight and obesity among children and adolescents: United States, 1963-1965 through 2011-2012.* Washington, DC: National Center for Health Statistics.

[7] Ogden, C. L., Carroll, M. D., Fryar, C. D., & Flegal, K. M. (2015). Prevalence of obesity among adults and youth: United States, 2011-2014. *NCHS Data Brief.* Washington, DC: National Center for Health Statistics.

[8,14] *The Surgeon General's vision for a healthy and fit nation.* (2010). Rockville, MD: U.S. Department of Health and Human Services, Office of the Surgeon General.

[9] *Eat smart, move more: Rhode Island: A plan for action 2010-2015.* (2010). Providence, RI: Rhode Island Department of Health.

[12] Cunningham, S. A., Kramer, M. R., & Venkat Narayan, K. M. (2014). Incidence of childhood obesity in the United States. *The New England Journal of Medicine, 370*(5), 403-411.

[13] Schuster, M. A., et al. (2014). Changes in obesity between fifth and tenth grades: A longitudinal study in three metropolitan areas. *Pediatrics, 134*(6), 1051-1058.

[15] Spear, B. A., et al. (2007). Recommendations for treatment of child and adolescent overweight and obesity. *Pediatrics, 120*(4), s254-s288.

[17,20,30] *Rhode Island Youth Risk Behavior Survey*, Rhode Island Department of Health, 2005-2015.

[18] Brown University Institute for Community Health Promotion analysis of BMI electronic medical records values of active children receiving care at Providence Community Health Centers, 2015.

[19] *Dietary Guidelines for Americans 2015-2020.* (2015). Washington, DC: U.S. Department of Agriculture and U.S. Department of Health and Human Services.

[21] Council on School Health. (2013). The crucial role of recess in school. *Pediatrics, 131*(1), 183-188.

[22,25,27,31] *Educating the student body: Taking physical activity and physical education to school.* (2013). Washington, DC: Institute of Medicine of the National Academies.

[23] Rhode Island KIDS COUNT analysis of Rhode Island school district wellness policies. Retrieved December 2015, from www.rihsc.org

[24] Recess for Rhode Island survey of elementary principals, 2015.

[26] Rhode Island Public Law 16-22-4.

[28] Centers for Disease Control and Prevention. (2015). *Physical activity facts.* Retrieved March 2, 2016, from www.cdc.gov

[29] *The association between school-based physical activity, including physical education, and academic performance.* (2010). Atlanta, GA: U.S. Department of Health and Human Services.

[32] U.S. Department of Health and Human Services. (2015). *Head Start services.* Retrieved March 3, 2016, from www.acf.hhhs.gov

References

[33] Rhode Island Head Start Program Information Report, Summary Report, 2015.

[34] National Head Start Program Information Report, Summary Report, 2015.

[35] U.S. Department of Agriculture. (2015). *About WIC – WIC at a glance.* Retrieved March 2, 2016, from www.fns.usda.gov

[36,37,38] Rhode Island Department of Health, WIC Program, FY 2011-2015.

(continued from page 85)

References for Births to Teens

[7] *Too young.* (2013). Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.

[8] Sedgh, G., Finer, L. B., Bankole, A., Eilers, M. A., & Singh, S. (2015). Adolescent pregnancy, birth, and abortion rates across countries: Levels and recent trends. *Journal of Adolescent Health, 56*(2015), 223-230.

[9,15] Hamilton, B. E., Martin, J. A., Osterman, M. J. K., Curtin, S. C., & Mathews, T. J. (2015). Births: Final data for 2014. *National Vital Statistics Reports, 64*(12), 1-63.

[10,16] The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org

[12] *2015 Youth Risk Behavior Survey,* Rhode Island Department of Health, Center for Health Data and Analysis.

[13,14,18,21,22,23] Rhode Island Department of Health, Center for Health Data and Analysis, 2000-2014.

[17,19] Ventura, S. J., Hamilton, B. E., & Mathews, M. S. (2014). National and state patterns of teen births in the United States. *National Vital Statistics Reports, 63*(4), 1-33.

[20] Gavin, L., et al. (2013). Vital signs: Repeat births among teens – United States, 2007-2010. *Morbidity and Mortality Weekly Report, 62*(13), 249-255.

(continued from page 87)

References for Alcohol, Drug, and Tobacco Use by Teens

[2] Murphey, D., Barry, M., Vaughn, B., & Terzian, M. (2012). *Tobacco use.* Washington DC: Child Trends.

[3] *Illicit drug use.* (2015). Washington, DC: Child Trends.

[4,12] Substance Abuse and Mental Health Services Administration. (2015). *National Survey on Drug Use and Health: Comparison of 2012-2013 and 2013-2014 population percentages (50 states and the District of Columbia).* Retrieved February 12, 2016, from www.samhsa.gov

[5,7,11,27] Levi, J., Segal, L. M., De Biasi, A., & Martin, A. (2015). *Reducing teen substance misuse: What really works.* Washington, DC: Trust for America's Health.

[6,8] *Principles of adolescent substance abuse disorder treatment: A research-based guide.* (2014). Bethesda, MD: National Institutes of Health, National Institute on Drug Abuse.

[9,13,15,18,20,22] Johnston, L. D., O'Malley, P. M., Miech, R. A., Bachman, J. G., & Schulenberg, J. E. (2016). *Monitoring the Future national survey results on drug use, 1975-2015: Overview, key findings on adolescent drug use.* Ann Arbor, MI: The University of Michigan, Institute for Social Research.

[10] Johnston, L. D., O'Malley, P. M., Miech, R. A., Bachman, J. G., & Schulenberg, J. E. (2015). *Demographic subgroup trends among adolescents in the use of various licit and illicit drugs, 1975-2014* [Monitoring the Future Occasional Paper Series No. 83]. Ann Arbor, MI: The University of Michigan, Institute for Social Research.

[14,16,19,21,23,24,25,26,28] *2015 Rhode Island Youth Risk Behavior Survey,* Rhode Island Department of Health, Center for Health Data and Analysis.

[17] National Conference of State Legislators. (2015). *Alternative nicotine products: Electronic cigarettes.* Retrieved February 12, 2016, from www.ncsl.org

[29] *Neonatal abstinence syndrome: How states can help advance the knowledge base for primary prevention and best practices of care.* (2014). Arlington, VA: Association of State and Territorial Health Officials.

[30,33] Rhode Island Department of Health, Center for Health Data Analysis, 2006-2014.

[31] *Mothers who smoke while pregnant.* (2015). Washington, DC: Child Trends.

[32] Curtin, S. C. & Mathews, T. J. (2016). Smoking prevalence and cessation before and during pregnancy: Data from the birth certificate, 2014. *National Vital Statistics Reports, 65*(1), 1-13.

(continued from page 90)

References for Child Deaths

[5,8,14] Rhode Island Department of Health, Maternal and Child Health Database, 2010-2014.

[6] U.S. Census Bureau, Population Estimates, 2010-2014.

[7,12] National Center for Injury Prevention and Control. (2012). *National action plan for child injury prevention.* Atlanta, GA: Centers for Disease Control and Prevention.

[9] Centers for Disease Control and Prevention. (n.d.). *10 leading causes death by age group, United States – 2013.* Retrieved February 1, 2016, from www.cdc.gov

[11] Centers for Disease Control and Prevention. (n.d.). *10 leading causes of injury death by age group highlighting unintentional injury deaths, United States – 2013.* Retrieved February 1, 2016, from www.cdc.gov

[13] Centers for Disease Control and Prevention, CDC WONDER, wonder.cdc.gov

(continued from page 91)

References for Teen Deaths

[2] Blum, R. W. & Qureshi, F. (2011). *Morbidity and mortality among adolescents and young adults in the United States, AstraZeneca fact sheet 2011.* Baltimore, MD: John Hopkins Bloomberg School of Public Health.

[3,7] Community Preventive Services Task Force. (2012). Improving adolescent health through interventions targeted to parents and other caregivers: A recommendation. *American Journal of Preventive Medicine, 42*(3), 327-328.

[4,8] Terzian, M., Hamilton, K., & Ericson, S. (2011). *What works to prevent or reduce internalizing problems or socio-emotional difficulties in adolescents: Lessons from experimental evaluations of social interventions.* Washington DC: Child Trends.

[5] *Teen homicide, suicide, and firearm deaths.* (2015). Washington, DC: Child Trends.

[9,11,12,16] Rhode Island Department of Health, Hospital Discharge Database, 2010-2014.

[10] U.S. Census Bureau, Population Estimates, 2010-2014.

[13,20] *2015 Rhode Island Youth Risk Behavior Survey results.* (2015). Providence, RI: Rhode Island Department of Health, Center for Health Data and Analysis.

[14] Rhode Island Department of Health, Center for Health Data Analysis, 2010-2014.

[15] *Rhode Island Child Death Data Review.* (2009-2012). (2014). Providence, RI: Rhode Island Department of Health.

[17,18,19] National Highway Traffic Safety Administration, Fatality Analysis Reporting System (FARS), 2010-2014. Analysis by the Rhode Island Department of Transportation, 2016.

(continued from page 93)

References for Youth Violence

[3] Centers for Disease Control and Prevention. (2015). *Youth violence: Prevention strategies.* Retrieved January 18, 2016, from www.cdc.gov

[7] U.S. Department of Justice, Office of Justice Programs. (2011). *Impact of child abuse and maltreatment on delinquency, arrest and victimization.* Retrieved February 21, 2014, from www.nij.gov

[8] David-Ferdon, C., et al. (2015). *CDC grand rounds: Preventing youth violence.* Retrieved January 19, 2016, from www.cdc.gov

[10] Puzzanchera, C. (2014). *Juvenile arrests 2012. National Report Series Bulletin* (NCJ 248513). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

[11] Mongeau, T. & Tocco, G. (2015). *2014 Juvenile detention data.* Providence, RI: Rhode Island Department of Public Safety, Public Safety Grant Administration Office.

[12] Rhode Island Family Court. *2015 Juvenile offense report.* (2016). Providence, RI: Rhode Island Family Court.

References

[13] Robers, S., Zhang, A., Morgan, R. E., & Musu-Gillette, L. (2015). *Indicators of school crime and safety: 2014* (NCES 2015-072/NCJ 248036). Washington, DC: U.S. Department of Education, National Center for Education Statistics & U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[14,17] *2015 Rhode Island Youth Risk Behavior Survey*, Rhode Island Department of Health, Center for Health Data and Analysis.

[15] *Children's exposure to violence.* (2013). Retrieved January 19, 2016, from www.childtrends.org

[16] U.S. Department of Health & Human Services. (n.d.). *What is cyberbullying?* Retrieved February 18, 2015, from www.stopbullying.gov

[18] *Teen homicide, suicide, and firearm deaths.* (2015). Retrieved January 19, 2016, from www.childtrends.org

[19] Rhode Island Department of Health, Center for Health Data and Analysis, 2010-2014.

(continued from page 94)

References for Gun Violence

[5] Children's Defense Fund. (2013). *Protect children not guns 2013.* Retrieved January 12, 2016, from www.childrensdefense.org

[6,9] American Academy of Pediatrics. (2012). *Firearm-related injuries affecting the pediatric population. Pediatrics, 130*(5), e1416-e1423.

[8] Child Trends. (2015). *Teen homicide, suicide, and firearm deaths.* Retrieved January 13, 2016, from www.childtrendsdatabank.org

[10] Xuan, Z. & Hemenway, D. (2015). State gun law environment and youth gun carrying in the United States. *JAMA Pediatrics, 169*(11), 1024-1031.

[11] Law Center to Prevent Gun Violence. (2015). *Statistics on the dangers of gun use for self-defense.* Retrieved January 13, 2016, from www.smartgunlaws.org

[12,13] Rhode Island Department of Health, Center for Health Data and Analysis, 2010-2014.

[14] *2015 Rhode Island Youth Risk Behavior Survey*, Rhode Island Department of Health, Center for Health Data and Analysis.

[15] Centers for Disease Control and Prevention. (2013). *Youth Risk Behavior Survey fact sheets.* Retrieved January 13, 2016, from www.cdc.gov

[16] Eaton, D. K., et al. (2014). Youth risk behavior surveillance-United States, 2013. *Morbidity and Mortality Weekly Report, 63*(4), 1-47.

(continued from page 95)

References for Homeless and Runaway Youth

[4] *Predictors of homelessness during the transition from foster care to adulthood.* (2016). Chicago, IL: Chapin Hall at the University of Chicago.

[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.

[7] Durso, L. E. & Gates, G. J. (2012). *Serving our youth: Findings from a national survey of services providers working with lesbian, gay, bisexual & transgender youth who are homeless or at risk of becoming homeless.* Los Angeles, CA: The Williams Institute with True Colors Fund and The Palette Fund.

[12,16,19] Aratani, Y. (2009). *Homeless children and youth: Causes and consequences.* New York, NY: Columbia University, Mailman School of Public Health, National Center for Children in Poverty.

[14,20] Hudson, A. L., et al. (2010). Health-seeking challenges among homeless youth. *Nursing Research, 59*(3), 212-218.

[15] *Homeless children and youth.* (2015). Washington, DC: Child Trends.

[18] Roy, E., Haley, N., Boudreau, J., Leclerc, P., & Boivin, J. (2009). The challenge of understanding mortality changes among street youth. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 87*(1), 95-101.

[21] *Alone without a home: A state-by-state review of laws affecting unaccompanied youth.* (2012). Washington, DC: National Law Center on Homelessness and Poverty & National Network for Youth.

[22] U.S. Department of Health and Human Services, Administration for Children and Families. (n.d.). *Rhode Island runaway and homeless youth grantees.* Retrieved February 24, 2016, from www.acf.hhs.gov

[23] Rhode Island Department of Education, 2014-2015 school year.

[24,25,29] Rhode Island Emergency Shelter Information Project, 2014 and 2015.

[26] National Runaway Switchboard. (2014). *NRS call statistics, 2014.* Retrieved February 24, 2016, from www.1800runaway.org

[27] National Runaway Switchboard. (2013). *NRS call statistics, 2013.* Retrieved March 5, 2015, from www.1800runaway.org

[28] Rhode Island Department of Children, Youth and Families, December 31, 2015.

(continued from page 97)

References for Youth Referred to Family Court

[3,6,9] Rhode Island Family Court. (2016). *2015 Juvenile offense report.* Providence, RI: Rhode Island Family Court.

[4,7] U.S. Census Bureau, Census 2010 Summary File 1.

[5] Rhode Island Family Court. (2015). *2014 Juvenile offense report.* Providence, RI: Rhode Island Family Court.

[8] National Research Council. (2012). *Reforming juvenile justice: A developmental approach.* Washington, DC: The National Academies Press.

[10] *No place for kids: The case for reducing juvenile incarceration.* (2011). Baltimore, MD: Annie E. Casey Foundation.

[11] Lipsey, M. W., Howell, J. C., Kelly, M. R., Chapman, G., & Carver, D. (2010). *Improving the effectiveness of juvenile justice programs: A new perspective on evidence-based practice.* Washington, DC: Center for Juvenile Justice Reform, Georgetown University.

[12] Rhode Island General Laws, Sections 14-1-32.1, 14-1-32.4, 14-1-33, 14-1-51, 14-1-67.

[13,14] Rhode Island Family Court, 2015.

[15] Rhode Island Family Court. (n.d.). *Juvenile drug court.* Retrieved February 8, 2011, from www.courts.ri.gov/family/drugcourt.htm

[16] *2014 juvenile hearing board totals.* (2015). Providence, RI: Rhode Island Department of Public Safety, Grant Administration Office.

[17] Development Services Group. (2014). *LGBTQ youths in the juvenile justice system-Literature review.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

[18] Mulvey, E. P. & Schubert, C. A. (2012). *Transfer of juveniles to adult court: Effects of a broad policy in one court.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

[19] Gottesman, D. & Wile Schwarz, S. (2011). *Juvenile justice in the U.S.: Facts for policymakers.* New York, NY: Columbia University, National Center for Children in Poverty.

[20] Mulvey, E. P. (2011). *Highlights from pathways to desistance: A longitudinal study of serious adolescent offenders.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

[21,31] Rhode Island General Laws, Sections 14-1-5, 14-1-7, 14-1-7.1, 14-1-7.2, & 14-1-7.3.

[22,24] Rhode Island Office of the Attorney General, January 2016.

(continued from page 101)

References for Youth at the Training School

[6,13] *No place for kids: The case for reducing juvenile incarceration.* (2011). Baltimore, MD: The Annie E.Casey Foundation.

[7,8,17,20,21,26,33] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), Calendar Years 2013 and 2014, January 2015, and January 2016.

[9] Szymanski, L. A. (2004). Minimum and maximum age of juvenile correctional custody. *NCJJ Snapshot, 9*(5), Pittsburgh, PA: National Center for Juvenile Justice.

References

[10] National Juvenile Defender Center. (2015). *Minimum age for delinquency adjudication—Multi-jurisdiction survey.* Retrieved February 11, 2016, from www.njdc.info

[11] Puzzanchera, C. & Kang, W. (2014). *Easy access to FBI arrest statistics 1994-2012.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

[12] KIDS COUNT. (2013). *Data snapshot: Reducing youth incarceration in the United States.* Baltimore, MD:The Annie E. Casey Foundation.

[15] Chappell, A. T., Maggard, S. R., & Higgins, J. L. (2013). Exceptions to the rule? Exploring the use of overrides in detention risk assessment. *Youth Violence and Juvenile Justice, 11*(4), 332-348.

[16] Rhode Island General Laws, Section 14-1-11.

[18] Jones, M. A., Clark, P. A., & Quiros, R. J. (2012). *Juvenile probation and mentoring: The referral stage.* Washington DC: Office of Juvenile Justice and Delinquency Prevention.

[19] *Juvenile correctional services.* (2015). Retrieved February 11, 2016, from www.dcyf.ri.gov

[22] Rhode Island KIDS COUNT. (n.d.). *Juvenile Detention Alternatives Initiative.* Retrieved February 12, 2016, from www.rikidscount.org

[24] Leiber, M., Bishop, D., & Chamlin, M. B. (2011). Juvenile justice decision-making before and after the implementation of the disproportionate minority contact (DMC) mandate. *Justice Quarterly, 28*(3), 460-492.

[25] Sherman, F. & Balck, A. (2015). *Gender injustice: System-level juvenile justice reforms for girls.* Portland, OR: The National Crittenton Foundation.

[27] *Child maltreatment: Consequences.* (2014). Retrieved February 16, 2016, from www.cdc.gov

[28] Rhode Island Department of Children, Youth and Families, Rhode Island Training School for Youth, 2015.

[29] Rhode Island Department of Children, Youth and Families, Rhode Island Training School, Alternative Education Program, 2015.

[30] Sedlack, A. J. & Bruce, C. (2010). *Youth's characteristics and backgrounds: Findings from the Survey of Youth in Residential Placement.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

[31] Rhode Island General Laws, Sections 14-1-11 and 14-1-27.

[32] Coalition for Juvenile Justice. (n.d.). *Alternatives to detention in the juvenile justice system.* Retrieved February 16, 2016, from www.juvjustice.org

(continued from page 103)

References for Children of Incarcerated Parents

[10] *When a parent is incarcerated: A primer for social workers.* (2011). Baltimore, MD: The Annie E. Casey Foundation.

[11] *Mothers behind bars: A state-by-state report card and analysis of federal policies on conditions of confinement for pregnant and parenting women and the effect on their children.* (2010). Washington, DC: The Rebecca Project for Human Rights & The National Women's Law Center.

[12] De Masi, M. E. & Teuten Bohn, C. (2010). *Children with incarcerated parents: A journey of children, caregivers and parents in New York state.* New York, NY: Council on Children and Families.

[17] Meade, E. & Mellgren, L. (2011). *Overview and inventory of HHS efforts to assist incarcerated and reentering individuals and their families.* Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[18] Fontaine, J. (2013). *Examining housing as a pathway to successful reentry: A demonstration design process.* Washington, DC: The Urban Institute.

[19] Vallas, R., Boteach, M., West, R., & Odum, J. (2015). *Removing barriers to opportunity for parents with criminal records and their children: A two-generation approach.* Washington, DC: Center for American Progress.

(continued from page 105)

References for Children Witnessing Domestic Violence

[7] 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.

[8] Cohen, E., McAlister Groves, B., & Kracke, K. (2009). *The Safe Start Center series on children exposed to violence: Understanding children's exposure to violence.* North Bethesda, MD: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, Safe Start Center.

[9] McAlister Groves, B. & Augustyn, M. (2009). *The Safe Start Center series on children exposed to violence: Pediatric care settings.* North Bethesda, MD: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, Safe Start Center.

[10] 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.

[11] Roberts, A. L., Gilman, S. E., Fitzmaurice, G., Decker, M. R., & Koenen, K. C. (2010). Witness of intimate partner violence in childhood and perpetration of intimate partner violence in adulthood. *Epidemiology, 21*(6), 809-818.

[12] *Family violence statistics including statistics on strangers and acquaintances.* (2005). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[15] Domestic Violence and Sexual Assault/Child Molestation Reporting Form, Rhode Island Domestic Violence Training and Monitoring Unit, 2014 revision.

[17] Rhode Island Coalition Against Domestic Violence. (2015). *2014 annual report.* Warwick, RI: Rhode Island Coalition Against Domestic Violence.

[18] Rhode Island Coalition Against Domestic Violence. Data are from January 1, 2015 to December 31, 2015.

[19] DeBoard-Lucas, R. Wasserman, K., McAlister Groves, B., & Bair-Merritt, M. (2013). *16 trauma-informed, evidence-based recommendations for advocates working with children exposed to intimate partner violence.* Retrieved March 3, 2016, from promising.futureswithoutviolence.org

(continued from page 109)

References for Child Abuse and Neglect

[3] Gould, F., et al. (2012). The effects of child abuse and neglect on cognitive functioning in adulthood. *Journal of Psychiatric Research, 46*(4), 500-506.

[4] Rhode Island Department of Children, Youth and Families, Child Protective Services, 2015.

[5,6,8,17,18] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2005-2015.

[7] Rhode Island Department of Children, Youth and Families. (n.d.). *Child welfare.* Retrieved February 3, 2016, from www.dcyf.ri.gov

[9] Rhode Island Department of Children, Youth and Families. (2015). *Information/Referral (I/R) reports (Policy 500.0040).* Retrieved February 3, 2016, from www.sos.ri.gov

[10] Rhode Island Department of Children, Youth and Families. (2014). *Criteria for a child protective services investigation (Policy 500.0040).* Retrieved February 3, 2016, from www.sos.ri.gov

[11] Rhode Island Department of Health, 2010-2014. Data on child deaths are from Vital Records and data on emergency department visits and hospitalizations are from the Center for Health Data and Analysis, Hospital Discharge Database.

[12] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2015). *Child maltreatment 2013.* Washington, DC: Government Printing Office.

[15] U.S. Department of Health and Human Services, Administration for Children and Families. (2010). *Information memorandum* (DHHS Publication No. ACF-IM-HS-10-04). Washington, DC: U.S. Government Printing Office.

References

[16] Centers for Disease Control and Prevention. (2015). *Children maltreatment: Prevention strategies.* Retrieved January 31, 2015, from www.cdc.gov

[19] American Psychological Association. (n.d.). *Understanding child sexual abuse: Education, prevention, and recovery.* Retrieved February 1, 2013, from www.apa.org

(continued from page 111)

References for Children in Out-of-Home Placement

[3,11] The Fostering Connections Resource Center. (n.d.). *Description of the law.* Retrieved January 11, 2013, from www.fosteringconnections.org

[4] *Final report: Rhode Island child and family services review.* (2010). Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

[5] Lewis, C., Beckwith, J., Fortin, K., & Goldberg, A. (2011). Fostering health: Health care for children and youth in foster care. *Medicine & Health/Rhode Island, 94*(7), 200-202.

[6] Healthy Foster Care America. (n.d.). *10 things every pediatrician should know about children in foster care.* Retrieved February 11, 2016, from www2.aap.org

[7] *Foster care.* (2015). Washington, DC: Child Trends.

[8] National Working Group on Foster Care and Education. (2011). *Education is the lifeline for youth in foster care.* Retrieved February 11, 2016, from www.casey.org

[9] Golonka, S. (2010). *The transition to adulthood: How states can support older youth in foster care.* Economic, Human Services and Workforce Division, NGA Center for Best Practices. Retrieved February 12, 2016, from www.nga.org

[10] *Policy actions to reduce racial disproportionality and disparities in child welfare: A scan of eleven states.* (2009). Washington, DC: Alliance for Racial Equity in Child Welfare.

[12] The Fostering Connections Resource Center. (n.d.). *Rhode Island's guardianship assistance program.* Retrieved January 11, 2013, from www.fosteringconnections.org

[13,14] *Safety, permanency, and well-being in Rhode Island: Child welfare outcomes annual report for FY 2015.* (2016). 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.

[15] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), December 31, 2014 and December 31, 2015.

(continued from page 113)

References for Permanency for Children in DCYF Care

[4,7] Avery, R. J. (2010). An examination of theory and promising practice for achieving permanency for teens before they age out of foster care. *Children and Youth Services Review, 32,* 399-408.

[5] *Permanency Roundtable Project: 12-month outcome report.* (2011). Seattle, WA: Casey Family Programs.

[6] *Never too old: Achieving permanency and sustaining connections for older youth in foster care.* (2011). New York, NY: Evan B. Donaldson Adoption Institute.

[8] U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Child Welfare Information Gateway. (n.d.). *Working with the courts for permanency.* Retrieved February 20, 2015 from www.childwelfare.gov

[9] Sciamanna, J. (2013). *Reunification of foster children with their families: The first permanency outcome.* Washington, DC: State Policy Advocacy and Reform Center.

[10] U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Child Welfare Information Gateway. (n.d.). *Achieving and maintaining permanency: Overview.* Retrieved February 23, 2015, from www.childwelfare.gov

[11,16] Fostering Connections Resource Center. (n.d.). *Description of the law.* Retrieved January 9, 2013, from www.fosteringconnections.org

[12,17] *Fostering Connections to Success and Increasing Adoptions Act (H.R.6893) Summary.* (2008). Washington, DC: Children's Defense Fund and Center for Law and Social Policy.

[13] Stoltzfus, E., Fernandes-Alcantara, A. L., & Solomon-Fears, C. (2014). *Child welfare and child support: The Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183).* Washington, DC: Congressional Research Service.

[14] KIDS COUNT. (2015). *Every Kid Needs a Family.* Baltimore, MD: The Annie E. Casey Foundation.

[15] Stern, I. R. & Nakamura, L. (2012). *Improving outcomes for youth transitioning out of foster care.* Honolulu, HI: University of Hawai'i, Center on the Family.

[18,19,20,24,27,28,29,30,32] *Safety, permanency, and well-being in Rhode Island: Child welfare outcomes annual report for FY 2015.* (2016). 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.

[21,25,26] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2015.

[22] Walsh, W. A. (2010). *Hard times made harder: Struggling caregivers and child neglect.* Durham, NH: University of New Hampshire, Carsey Institute.

[23] Fostering Connections Resource Center. (n.d.). *Rhode Island's guardianship assistance program: Rhode Island's state plan amendment for guardianship approved.* Retrieved January 10, 2013, from www.fosteringconnections.org

[31] *Services to youth ages 18-21: Q and A.* (2007). Providence, RI: Rhode Island Department of Children, Youth and Families.

[33] ChildFocus, Inc. (2013). *Medicaid to 26 for youth in foster care: Key steps for advocates.* Washington, DC: State Policy Advocacy and Reform Center.

[34] *Foster care to 21: Doing it right.* (2011). St. Louis, MO: Jim Casey Youth Opportunities Initiative.

(continued from page 119)

References for Children Enrolled in Early Head Start

[4] Schmit, S. (2013). *Early Head Start participants, programs, families and staff in 2012.* Washington, DC: Center for Law and Social Policy.

[5] Kanda, M. B. & Askew, G. L. (2004). The whole 9 months and beyond: Early Head Start services for pregnant women. In J. Lombardi & M. M. Bogle (Eds.), *Beacon of hope: The promise of Early Head Start for America's youngest children.* (pp. 63-76). Washington, DC: Zero to Three Press.

[7,13,14,16,17,19] Rhode Island Early Head Start program reports to Rhode Island KIDS COUNT, October 2015.

[8] *PARTNERS: Partnering across Rhode Island to nurture educational readiness statewide.* Children's Friend, February 2015

[9] *101: Early Head Start- Child Care Partnerships.* (2014). Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

[11] Early Head Start: Research Findings. (2010). *Child Trends: Early Childhood Highlights, 1*(2). Washington, DC: Child Trends.

[12] Love, J. M., Chazan-Cohen, R., Raikes, H., & Brooks-Gunn, J. (2013). What makes a difference: Early Head Start evaluation findings in a developmental context. *Monographs of the Society for Research in Child Development, 78*(1), vii-viii, 1-173.

[15] Rhode Island KIDS COUNT calculations of estimated eligible children using 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 the federal poverty line (FPL) according to the Population Reference Bureau's analysis of 2010-2014 American Community Survey data

[18] *Research to practice: Children with disabilities in Early Head Start.* (2006). Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

[20] *Early Head Start tip sheet: Full-day/full-year services & EHS/infants and toddlers.* (2014). Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start.

References

(continued from page 121)

References for Licensed Capacity of Early Learning Programs

[7] *Rhode Island Race to the Top – Early Learning Challenge Grant.* Retrieved January 29, 2013, from www.ride.ri.gov

[8,9] Rhode Island Department of Children, Youth and Families, slots in licensed child care centers and family child care homes, from RI Early Care and Education Data System (ECEDS), 2016. Rhode Island Department of Children, Youth and Families, slots in licensed child care centers and family child care homes, 2007-2015. Options for Working Parents, slots in licensed child care centers and certified family child care homes, 2006.

[10] Rhode Island Department of Human Services, licensed programs accepting Child Care Assistance Program subsidy, from RI Early Care and Education Data System (ECEDS), 2016.

[11] Rhode Island Department of Education, public schools operating preschool classrooms, from RI Early Care and Education Data System (ECEDS), 2016.

[12] Schmit, S. & Matthews, H. (2013). *Better for babies: A study of state infant and toddler child care policies.* Washington, DC: Center for Law and Social Policy.

(continued from page 123)

References for Children Receiving Child Care Subsidies

[4] Rhode Island KIDS COUNT calculations based on average weekly rates from Bodah, M. M. (2015). *Statewide survey of childcare rates in Rhode Island.* Kingston, RI: University of Rhode Island, Charles T. Schmidt, Jr. Labor Research Center.

[5,7] *Child care assistance: A vital support for working families.* (2015). Washington, DC: Center for Law and Social Policy.

[6] Forry, N. D., Daneri, P., & Howarth, G. (2013). *Child care subsidy literature review. OPRE Brief 2013-60.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Administration.

[8] Rhode Island Department of Human Services and the RI Early Care and Education Data System (ECEDS), Child Care Assistance Program enrollment by program quality rating, January 2016.

[10,11,13] Rhode Island Department of Human Services, InRhodes Database, 2001-2015.

[12] *Child Care Assistance Program.* (2015). Providence, RI: Senate Fiscal Office.

(continued from page 125)

References for Early Learning Programs Participating in BrightStars

[8] Center on the Developing Child at Harvard University. (n.d.). *In brief: Early childhood program effectiveness.* Retrieved January 28, 2016, from www.developingchild.harvard.edu

[9] Quality rating and improvement systems for early care and education. (2010). *Child Trends: Early Childhood Highlights, 1*(1), 1-4.

[10] Mitchell, A. (2009). *Quality Rating and Improvement Systems as the framework for early care and education system reform.* Retrieved January 29, 2016, from www.buildinitiative.org

[11] Mitchell, A. (2012). *Financial incentives in Quality Rating and Improvement Systems: Approaches and effects (for the QRIS National Learning Network).* Retrieved February 11, 2014, from www.qrisnetwork.org

[12] Rhode Island Association for the Education of Young Children. (2013). *Information and policies for the BrightStars Quality Rating and Improvement System.* Retrieved February 3, 2015, from www.brightstars.org

[13] Rhode Island Department of Human Services. (2014). Starting RIght Child Care Assistance Program (CCAP): Section 0850, Rules and Regulations.

[14,15] Rhode Island Association for the Education of Young Children from the RI Early Care and Education Data System, BrightStars ratings, January 2014-2016.

[16] Rhode Island Association for the Education of Young Children, programs applying for rating increase or renewal in 2015.

[17] Rhode Island Department of Education from the RI Early Care and Education Data System (ECEDS), classrooms with Comprehensive Early Childhood Education approval, January 2015-2016.

[18] *Race to the Top – Early Learning Challenge Grantee Abstract: Office of the Governor, State of Rhode Island.* Retrieved February 4, 2013, from www.ed.gov

(continued from page 127)

References for Children Enrolled in Head Start

[3] Klein, L. & Knitzer, J. (2007). *Promoting effective early learning: What every policymaker and educator should know.* New York, NY: Columbia University, Mailman School of Public Health, National Center for Children in Poverty.

[5] Barnett, S. & Frede, E. (2009). *Federal early childhood policy guide for the first 100 days.* New Brunswick, NJ: Rutgers University, National Institute for Early Education Research.

[7] Puma, M., et al. (2012). *Third grade follow-up to the Head Start Impact Study final report, Executive summary.* (OPRE Report #2012-45b). Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

[8] Barnett, W. S. & Carolan, M. E. (2014). *Facts about fadeout: The research base on long-term impacts of high-quality pre-K.* New Brunswick, NJ: Center on Enhancing Early Learning Outcomes.

[9] Bitler, M. P., Hoynes, H. W., & Domina, T. (2014). *Experimental evidence on distributional effects of Head Start.* Cambridge, MA: National Bureau of Economic Research.

[10] Ludwig, J. & Phillips, D. A. (2008). Long-term effects of Head Start on low-income children. *Annals of the New York Academy of Sciences, 1136,* 257-268.

[11,12,13,15] Rhode Island Head Start Program reports to Rhode Island KIDS COUNT, October 2015.

[14,16] Rhode Island KIDS COUNT calculations of estimated eligible children using 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 the federal poverty line (FPL) according to the Population Reference Bureau's analysis of 2010-2014 American Community Survey data.

(continued from page 129)

References for Children Enrolled in State Pre-K

[3] Lamy, C. (2012). Poverty is a knot, and preschool is an untangler. In R. C. Pianta, W. S. Barnett, L. M. Justice & S. M. Sheridan (Eds.), *Handbook of early childhood education.* (pp.158-174). New York, NY: The Guilford Press.

[4,8] Yoshikawa, H., et al. (2013). *Investing in our future: The evidence base on preschool education.* Ann Arbor, MI: Society for Research in Child Development and New York, NY: Foundation for Child Development.

[5] Barnett, W. S., Carolan, M. E., Fitzgerald, J., & Squires, J. H. (2012). *The state of preschool 2012: State preschool yearbook.* New Brunswick, NJ: National Institute for Early Education Research, Rutgers University.

[7] Galinsky, E. (2006). *The economic benefits of high-quality early childhood programs: What makes the difference?* Washington, DC: Committee for Economic Development.

[9] Rhode Island Prekindergarten Education Act, Rhode Island General Laws, § 16-87 (2008).

[11] Barnett, W. S. (2012, February 14). Rhode Island State Pre-K Demonstration Program evaluation. Presentation to the Rhode Island General Assembly.

[12] Guernsey, L., Bornfreund, L., McCann, C., & Williams, C. (2014). *Subprime learning: Early education in America since the Great Recession.* Washington, DC: New America Foundation.

[13,14,16] Rhode Island Department of Education, State Pre-K enrollment 2015-2016.

[15] *Request for proposal (RFP) – Bid# 7535368: Evaluate quality of Rhode Island Pre-Kindergarten Program.* (2013). Providence, RI: State of Rhode Island Department of Administration, Division of Purchases.

[17] Rhode Island KIDS COUNT calculation using the estimated number of low-income children age four according to Census 2010 multiplied by the % of children under age six living in families with incomes below 200% of the federal poverty line (FPL) according to the Population Reference Bureau's analysis of 2010-2014 American Community Survey data.

References

[18] Rhode Island KIDS COUNT calculation using the number of children ages four and five enrolled in Rhode Island Head Start programs as of October 2015 plus the number of children enrolled in Rhode Island State Pre-K programs as of October 2015 divided by the estimated population of four year olds in families with incomes below 200% of the federal poverty line.

[19] Rhode Island KIDS COUNT calculation using the number of children enrolled in State Pre-K as of October 2015 divided by the number of four-year-olds in Rhode Island from Census 2010, Summary File 1.

[21] The Education Adequacy Act, Rhode Island General Laws, § 16-7.2-6 (2010).

(continued from page 131)

References for Children Receiving Preschool Special Education Services

[3] National Dissemination Center for Children with Disabilities. (2012). *Overview of Early Intervention.* Retrieved February 21, 2013, from www.nichcy.org

[5] Centers for Disease Control and Prevention (n.d.). *Developmental screening fact sheet.* Retrieved January 9, 2014, from www.cdc.gov

[7,11,13,14,15] Rhode Island Department of Education, June 2015 Special Education Census.

[8] National Early Childhood Technical Assistance Center. 2015. *Early identification: Public awareness and primary referral sources.* Retrieved February 2, 2016, from www.ectacenter.org

[9] Meisels, S. J. & Atkins-Burnett, S. (2005). *Developmental screening in early childhood: A guide. (5th edition).* Washington, DC: National Association for the Education of Young Children.

[10] *Child Outreach screening guidelines.* (2009). Providence, RI: Rhode Island Department of Education.

[12] Boyle, C. A., et al. (2011). Trends in the prevalence of developmental disabilities in U.S. children, 1997-2008. *Pediatrics, 127*(6), 1034-1042.

[16] Buysse, V. (2012). Access, participation, and supports: A framework for improving inclusive early education opportunities for children with disabilities. In C. Pianta, W. S. Barnett, L. M. Justice, & S. M. Sheridan (Eds.), *Handbook of early childhood education* (pp. 480-506). New York, NY: The Guilford Press.

(continued from page 133)

References for Public School Enrollment and Demographics

[2,3,4,5,7,8,9,11] Rhode Island Department of Education, October 1, 2006 and October 1, 2015.

[6] Rhode Island Department of Education, 2014-2015 school year.

[10] Orfield, G., Frankenberg, E., Ee, J., & Kuscera, J. (2014). *Brown at 60: Great progress, a long retreat and an uncertain future.* Los Angeles, CA: The Civil Rights Project.

[12] *The state of Rhode Island's charter public schools.* (2014). Providence, RI: Rhode Island Department of Education.

(continued from page 135)

References for Children Enrolled in Full-Day Kindergarten

[10] Chetty, R., et al. (2011). How does your kindergarten classroom affect your earnings?: Evidence from Project STAR. *The Quarterly Journal of Economics, 126*, 1593-1660.

[11] Jones, D. E., Greenberg, M., & Crowley, M. (2015). Early social-emotional functioning and public health: The relationship between kindergarten social competence and future wellness. *American Journal of Public Health, 105*(11), 2283-2290.

[12,13,14] Rhode Island Department of Education, October 1, 2015.

[15] *Governor's FY 2016 budget at a glance summary and special reports.* (2015). Providence, RI: Rhode Island House of Representatives.

[16] Scott-Little, C. & Maxwell, K. L. (2015). *Improving systems of learning through the use of child standards and assessments.* Retrieved December 17, 2015, from www.buildinitiative.org

[17] *Kindergarten entry assessment –KEA.* Retrieved December 17, 2015, from www.buildinitiative.org

[18] *Rhode Island to participate in multi-state consortium to develop kindergarten entry assessment.* Retrieved December 17, 2015, from www.ride.ri.gov

(continued from page 137)

References for Out-of-School Time

[10] Rhode Island Department of Education, 21st Century Community Learning Center programs, 2014 summer and 2014-2015 school year.

[11,13] *Rethink summer: The Hasbro Summer Learning Initiative.* (n.d.). Providence, RI: Rhode Island Afterschool Plus Alliance.

[12] Vinson, M., Marchand, J., Sparr, M., & Moroney, D. (2013). *Rhode Island 21st Century Community Learning Center program evaluation: Evaluation report 2011-12.* Chicago, IL: American Institutes for Research.

[14] Rhode Island Department of Children, Youth and Families, licensed school-age child care programs and slots from the RI Early Care and Education Data System (ECEDS), January 2016.

[15] Rhode Island Association for the Education of Young Children, programs with a BrightStars rating from the RI Early Care and Education Data System (ECEDS), January 2016.

(continued from page 139)

References for English Language Learners

[2,13] Huguley, J. (2013). *Latino students in Rhode Island: A review of local and national performances.* Providence, RI: The Latino Policy Institute at Roger Williams University.

[3] Mather, M. (2009). *Reports on America: Children in immigrant families chart new path.* Washington, DC: Population Reference Bureau.

[4,8,9] *Educating English Language Learners.* (2013). Portland, OR: Grantmakers for Education.

[5,7,15] Russakoff, D. (2011). *Prek-3rd: Raising the educational performance of English language learners.* New York, NY: Foundation for Child Development.

[6] Horwitz, A. R., et al. (2009). *Succeeding with English language learners: Lessons learned from the Great City Schools.* Washington, DC: The Council of the Great City Schools.

[10,12] Suárez-Orozco, C., Suárez-Orozco, M. M., & Todorova, I. (2008). *Learning a new land: Immigrant students in American society.* Cambridge, MA: Harvard University Press.

[11,14,17,21,24] Rhode Island Department of Education, 2014-2015 school year.

[16] Gándara, P. (2015). *Is there really a labor market advantage to being bilingual in the U.S.?* Princeton, NJ: Educational Testing Service.

[18,19] Rhode Island Department of Education, *Partnership for Assessment of Readiness for College and Careers (PARCC),* October 2015.

[20] Rhode Island Department of Health, KIDSNET, 2015.

[22] Espinosa, L. M. (2013). *Early education for dual language learners: Promoting school readiness and early school success.* Washington, DC: Migration Policy Institute.

[23] Espinosa, L. M. (2013). *PreK-3rd: Challenging common myths about dual language learners: An update to the Seminal 2008 Report.* New York, NY: Foundation for Child Development.

(continued from page 141)

References for K-12 Students Receiving Special Education Services

[1,4] *Individualized Education Plans.* (2015). Washington, DC: Child Trends.

[2] Boyle, C. A. et al. (2011). Trends in the prevalence of developmental disabilities in U.S. children, 1997-2008. *Pediatrics, 127*(6), 1034-1042.

[3] *Thirty-five years of progress in educating children with disabilities through IDEA.* (2010). Washington, DC: U.S. Department of Education, Office of Special Education and Rehabilitative Services.

[5] Greene, M. (2015). Are students with disabilities being left behind? Washington, DC: America's Promise Alliance. Retrieved February 1, 2016, from www.americaspromise.org

[6] *Caught in the crisis: Students with disabilities in U.S. high schools.* (2011). Washington, DC: Alliance for Excellent Education.

[7] Samuels, C. (2015, December 10). *What does ESSA mean for special education?* Retrieved February 1, 2016, from www.edweek.org

[8] Rhode Island Department of Education, *Partnership for Assessment of Readiness for College and Careers (PARCC),* 2015.

References

[9] Rhode Island Department of Education, Class of 2015 four-year graduation rates.

[10,11,13] Rhode Island Department of Education, Office for Diverse Learners, June 30, 2015 Special Education Census.

[12] Kena, G., et al. (2015). *The Condition of Education 2015* (NCES 2015-144). Washington, DC: U.S. Department of Education, National Center for Education Statistics.

(continued from page 143)

References for Student Mobility

[12] U.S. Census Bureau, American Community Survey, 2010-2014. Table B07001.

[13] U.S. Census Bureau, American Community Survey, 2010-2014. Table B07012.

[14,15,19,20,21,22,23] Rhode Island Department of Education, 2014-2015 school year.

[16] *A revolving door: Challenges and solutions to educating mobile students.* (2011). Cambridge, MA: Rennie Center for Education Research & Policy.

[17] Scherrer, J. (2013). The negative effects of student mobility: Mobility as a predictor, mobility as a mediator. *International Journal of Education Policy and Leadership, 8*(1), 1-14.

[18] Ettman, L., Ettinger de Cuba, S., Sheward, R., Sandel, M., & Coleman, S. (2015). *When 2+2=5: How co-enrollment in public assistance leads to stable housing for America's young children.* Children's HealthWatch Policy Action Brief. Boston, MA: Boston Medical Center.

(continued from page 145)

References for Third-Grade Reading Skills

[3] Federal Interagency Forum on Child and Family Statistics. (2015). *America's children: Key national indicators of well-being, 2015.* Washington, DC: U.S. Government Printing Office.

[4] Yoshikawa, H., et al. (2013). *Investing in our future: The evidence base on preschool education.* Ann Arbor, MI: Society for Research in Child Development.

[5] The Pew Center on the States. (2011). *Transforming public education: Pathway to a Pre-K-12 future.* Washington, DC: Pre-K Now.

[7] Lesnick, J., Goerge, R. M., Smithgall, C., & Gwynne, J. (2010). *Reading on grade level in third grade: How is it related to high school performance and college enrollment?* Chicago, IL: Chapin Hall at the University of Chicago.

[9] *A Governor's guide to early literacy: Getting all students reading by third grade.* (2013). Washington, DC: National Governors Association.

[10,11] Rhode Island Department of Education, *Partnership for Assessment of Readiness for College and Careers (PARCC)* results, 2015.

[12,13] Rhode Island Department of Education. (n.d.). *Partnership for Assessment of Readiness for College and Careers (PARCC): Parent FAQs (frequently asked questions).* Retrieved February 17, 2016, from www.ride.ri.gov

[14] The Partnership for Assessment of Readiness for College and Careers. (n.d.). *ELA/literacy: Helping you to understand the summative assessments.* Retrieved February 17, 2016, from http://parcconline.org

(continued from page 147)

References for Seventh-Grade Reading Skills

[3] Carnegie Council on Advancing Adolescent Literacy. (2010). *Time to act: An agenda for advancing adolescent literacy for college and career success.* New York, NY: Carnegie Corporation of New York.

[5] *Adolescent literacy: Fact sheet.* (2013). Washington, DC: Alliance for Excellent Education.

[7] Ayers, J. & Miller, M. (2009). *Informing adolescent literacy policy and practice: Lessons learned from the Striving Readers Program.* Washington, DC: Alliance for Excellent Education.

[8,9] Haynes, M. (2009). *State actions to improve adolescent literacy: Results from NASBE's State Adolescent Literacy Network.* Arlington, VA: National Association of State Boards of Education.

[11] Lander, R. (2010). *Minority Student Achievement Network research brief: Key characteristics of effective adolescent literacy programs.* Madison, WI: Wisconsin Center for Education Research.

[12,13] Rhode Island Department of Education, *Partnership for Assessment of Readiness for College and Careers (PARCC)* results, 2015.

[14] Rhode Island Department of Education. (2015). *PARCC assessment.* Retrieved February 24, 2015, from www.ride.ri.gov

[15] The Partnership for Assessment of Readiness for College and Careers (2013). *PARCC frequently asked questions.* Retrieved February 10, 2015, from http://parcconline.org

(continued from page 149)

References for Math Skills

[4,9] National Research Council. (2005). *Adding it up: Helping children learn mathematics.* Washington, DC: National Academy Press.

[6,12,15] The Nation's Report Card. (2015). *2015 Mathematics and reading assessments.* Retrieved March 4, 2016, from www.nationsreportcard.gov

[8] National Research Council. (2009). *Mathematics learning in early childhood: Paths toward excellence and equity.* Washington, DC: National Academy Press.

[10] National Mathematics Advisory Panel. (2008). *Foundations for success: The final report of the National Mathematics Advisory Panel.* Washington, DC: U.S. Department of Education.

[11] Balfanz, R., Bridgeland, J. M., Bruce, M., & Fox, J. H. (2012). *Building a grad nation: Progress and challenge in ending the high school dropout epidemic.* Baltimore, MD: Civic Enterprises, Everyone Graduates Center at Johns Hopkins University, America's Promise Alliance, and the Alliance for Excellent Education.

[13,14] The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org

[16,18] *Rhode Island's PARCC results for students in grades 3 through 8 and high school, 2015: A look into teaching and learning.* (2015). Providence, RI: Rhode Island Department of Education.

[17] Rhode Island Department of Education. (2016). *Assessment schedule.* Retrieved March 7, 2015, from www.ride.ri.gov

[19] Rhode Island Department of Education. (2015). *PARCC assessment.* Retrieved February 26, 2015, from www.ride.ri.gov

[20] The Partnership for Assessment of Readiness for College and Careers. (n.d.). *A different kind of test.* Retrieved March 4, 2016, from parcconline.org

(continued from page 151)

References for Schools Identified for Intervention

[5] *Frequently asked questions regarding implementation of the Every Student Succeeds Act.* (2016). Washington, DC: Council of Chief State School Officers.

[6] Marion, S. (2016). *Considerations for state leaders in the design of school accountability systems under the Every Student Succeeds Act.* Dover, NH: National Center for the Improvement of Educational Assessment.

[7] Miller, T. D. & Brown, C. (2015). *Dramatic action, dramatic improvement: The research on school turnaround.* Washington, DC: Center for American Progress.

[8] Rhode Island Department of Education, 2013-2014 school year.

[10,13] *ESEA flexibility request, Rhode Island.* (2014). Washington, DC: U.S. Department of Education.

[11,12] Rhode Island Department of Education. (n.d.). *Accelerating schools toward greatness: The Rhode Island Accountability System.* Retrieved January 6, 2015, from www.ride.ri.gov

(continued from page 153)

References for Chronic Early Absence

[6] Romero, M. & Lee, Y. (2008). *Risk factors for chronic absenteeism: Facts for policymakers.* New York, NY: Columbia University, Mailman School of Public Health, National Center for Children in Poverty.

[7] Aratani, Y. (2009). *Homeless children and youth: Causes and consequences.* New York, NY: Columbia University, Mailman School of Public Health, National Center for Children in Poverty.

[8] Basch, C. E., Gracy, D., Johnson, D., & Fabian, A. (2015). *Health barriers to learning and the education opportunity gap.* Denver, CO: Education Commission of the States.

[10] Romero, M. & Lee, Y. (2008). *How maternal, family and cumulative risk affect absenteeism in early schooling: Facts for policymakers.* New York, NY: Columbia University, Mailman School of Public Health, National Center for Children in Poverty.

References

[13] Balfanz, R. & Byrnes, V. (2012). *The importance of being in school: A report on absenteeism in the nation's public schools.* Baltimore, MD: The Johns Hopkins University, Center for Social Organization of Schools.

[14,15,18] Rhode Island Department of Education, 2014-2015 school year.

[16] Gottfried, M. A. (in press). Chronic absenteeism in the classroom context: Effects on achievement. *Urban Education.*

[17,21] Attendance Works. (2014). *How states can advance achievement by reducing chronic absence.* Retrieved February 10, 2016, from www.attendanceworks.org

[19] Attendance Works. (2015). *Mapping the early attendance gap: Charting a course for school success.* Retrieved February 10, 2016, from www.attendanceworks.org

(continued from page 155)

References for Chronic Absence, Middle School and High School

[1,5] Sundius, J. & Farneth, M. (2008). *Missing school: The epidemic of school absence.* Baltimore, MD: Open Society Institute-Baltimore.

[2,6,14,15] Balfanz, R. & Byrnes, V. (2012). *The importance of being in school: A report on absenteeism in the Nation's public schools.* Baltimore, MD: The Johns Hopkins University, Center for Social Organization of Schools.

[3,16] Attendance Works. (2014). *The attendance imperative: How states can advance achievement by reducing chronic absence.* Retrieved February 15, 2016, from www.attendanceworks.org

[4] U.S. Department of Education. (n.d.). *Truancy: A serious problem for students, schools, and society.* Retrieved February 26, 2010, from www.ed.gov

[7] Railsback, J. (2004). *Increasing student attendance: Strategies from research and practice.* Portland, OR: Northwest Regional Educational Laboratory.

[8] Wilkins, J. (2008). *School characteristics that influence student attendance: Experiences of students in a school avoidance program.* Chapel Hill, NC: The University of North Carolina Press.

[9,10,12,13] Rhode Island Department of Education, 2014-2015 school year.

[11] Rhode Island Judiciary. (n.d.). *About the Family Court.* Retrieved February 15, 2016, from www.courts.ri.gov

(continued from page 157)

References for Suspensions

[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.

[2,14] Losen, D. J. (2011). *Discipline policies, successful schools, and racial justice.* Boulder, CO: National Education Policy Center.

[4,8,9,11,13] Rhode Island Department of Education, 2014-2015 school year.

[6,12] Losen, D. J. & Martinez, T. E. (2013). *Out of school & off track: The overuse of suspensions in American middle and high schools.* Los Angeles, CA: The Center for Civil Rights Remedies.

[7,15] *Guiding principles: A resource guide for improving school climate and discipline.* (2014). Washington, DC: U.S. Department of Education.

[10] Rhode Island Department of Education, 2009-2010 school year.

(continued from page 159)

References for High School Graduation Rate

[8] *Centered on results: Assessing the impact of student-centered learning.* (2015). Quincy, MA: Nellie Mae Education Foundation.

[9] RI Department of Education Secondary School Regulations. (2015). *Council on Elementary and Secondary Education Secondary School Regulations.* Retrieved February 27, 2016, from sos.ri.gov

[10,12] Rhode Island Department of Education, Class of 2015 four-year cohort graduation rates.

[13,14] Rhode Island Department of Education, 2009-2010 cohort five- and six-year cohort graduation rates.

(continued from page 161)

References for College Preparation and Access

[4] Miller, A., Valle, K., Engle, J., & Cooper, M. (2014). *Access to attainment: An access agenda for 21st Century college students.* Washington, DC: Institute for Higher Education Policy.

[5] Tierney, W. G., Bailey, T., Constantine, J., Finkelstein, N. & Hurd, N. F. (2009). *Helping students navigate the path to college: What high schools can do. (NCEE # 2009-4066).* Washington, DC: National Center for Education Evaluation and Regional Assistance, Institute of Education Sciences, U.S. Department of Education.

[6] Rhode Island Department of Education. (2015). *R.I. students increase participation, success rates on AP exams: SAT scores off slightly, though participation rises over 5 years* [Press release.]. Retrieved from www.ride.ri.gov

[7] *Rhode Island Public Schools overview 2014-2015.* (2015). New York, NY: The College Board.

[8] Wyatt, J., Kobrin, J., Wiley, A., Camara, W. J., & Proestler, N. (2011). *SAT benchmarks: Development of a college readiness benchmark and its relationship to secondary and postsecondary school performance.* New York, NY: The College Board.

[9,12] Roderick, M., et al. (2008). *From high school to the future: Potholes on the road to college.* Chicago, IL: Consortium on Chicago School Research, University of Chicago.

[10] U.S. Department of Education, FAFSA completion by high school, 2015.

[11] Rhode Island Department of Education, 2016.

[13] Haskins, R., Holzer, H. & Lerman, R. (2009). *Promoting economic mobility by increasing postsecondary education.* Washington, DC: Economic Mobility Project.

[14] *Using dual enrollment to improve the educational outcomes of high school students.* (2015). Iowa City, IA: ACT.

[15] The College Board. (2010). *The college completion agenda: State policy guide.* Retrieved March 6, 2015, from www.ncsl.org

[16] *The game changers: Are states implementing the best reforms to get more college graduates?* (2013). Washington, DC: Complete College America.

Rhode Island KIDS COUNT Committees

Rhode Island KIDS COUNT Factbook Advisory Committee

Cristina Amedeo
United Way of Rhode Island

Angela Ankoma
Rhode Island Department of Health

Deborah Anthes
Rhode Island Department of Human Services

Katherine Begin
Prevent Child Abuse Rhode Island

Carolyn Belisle
Blue Cross & Blue Shield of Rhode Island

James Berson
Greater Providence YMCA

Becky Bessette
Rhode Island Department of Education

Amy Black
HealthSource RI

Eileen Botelho
Rhode Island Department of Education

Rebecca Boxx
Annenberg Institute for School Reform

Andrew Bramson
DataSpark

Maria Carvalho
The College Crusade of Rhode Island

Ailis Clyne
Rhode Island Department of Health

Tara Cooper
Rhode Island Department of Health

Ellen Cynar
City of Providence Healthy Communities Office

Gail Davis
Lifespan

Caitlin Divver
Foster Forward

Marie Ganim
Rhode Island Senate Policy Office

Leslie Gell
Ready to Learn Providence

Kathleen Gorman
University of Rhode Island
Feinstein Center for a Hunger Free America

Courtney Hawkins
Providence Talks

Susan Jacobsen
Thundermist Health Center

Pamela Jennings
University of Rhode Island
Feinstein Center for a Hunger Free America

Linda Katz
The Economic Progress Institute

Laurie Leonard
Rhode Island Department of Health

Janet Limoges
Rhode Island Department of Health

Betsy Stubblefield Loucks
Green and Healthy Homes Initiatives

Gail Mance-Rios
Rhode Island Higher Education Assistance Authority

Jennifer Mann
American Academy of Pediatrics, Rhode Island Chapter

Paula McFarland
Rhode Island Community Action

Joanne McGunagle
Comprehensive Community Action Program

Ana Novais
Rhode Island Department of Health

Rachel Orsinger
Rhode Island Coalition Against Domestic Violence

Christine Payne
Rhode Island Executive Office of Health and Human Services

Joan Pillsbury
Rhode Island Executive Office of Health and Human Services

Candace Powell
Retired Maternal-Child Health Nurse

Karen Pucciarelli
Education Development Center

Lawrence Pucciarelli
Rhode Island Department of Human Services

Anne Reeder
Rhode Island Department of Health

Rosemary Reilly-Chammant
Rhode Island Department of Education

Sharon Santilli
Rhode Island Department of Human Services

Peter Squatrito
Rhode Island Department of Human Services

Alissa St. Jacques
Blue Cross & Blue Shield of Rhode Island

Meghan Towle
Rhode Island Department of Health

Margaret Votta
Rhode Island Department of Education

Tricia Washburn
Rhode Island Department of Health

Rhode Island KIDS COUNT Community Leadership Council

Roberta Hazen Aaronson
Childhood Lead Action Project

Denise Achin
Rhode Island Technical Assistance Project

Darlene Allen
Adoption Rhode Island

Reverend Dr. Donald C. Anderson
Rhode Island State Council of Churches

Raymond Arsenault
Spurwink School

Lenette Azzi-Lessing
Wheelock College

Robert Barge
Rhode Island Legal Services

Kate Begin
Prevent Child Abuse Rhode Island

Carolyn Belisle
Blue Cross & Blue Shield of Rhode Island

Kerrie Bennett
Delta Dental of Rhode Island

Stanley Block, MD
Providence Community Health Centers

Erin Boyar
Rhode Island Department of Corrections

Rebecca Boxx
Providence Children & Youth Cabinet

Stephen Brunero
Rhode Island Parent Information Network

Mario Bueno
Progreso Latino

Stephen Buka
Brown University

David Caprio
Children's Friend

Sharon K. Carter
Newport Partnership for Families

Rhode Island KIDS COUNT Committees

Michael Cerullo
Licensed Mental Health Counselor

Channavy Chhay
Center for Southeast Asians

Heidi Collins
Connecting for Children and Families

Lisa Conlan Lewis
Parent Support Network of Rhode Island

Lela Coons
Warwick Coalition to Prevent Child Abuse

Patrice Cooper
UnitedHealthcare Community Plan

Terese Curtin
Connecting for Children & Families

Laureen D'Ambra
Rhode Island Family Court

Deborah DeBare
Rhode Island Coalition Against Domestic Violence

Robert C. DeBlois
Urban Collaborative Accelerated Program

Phyllis Dennery, MD
Hasbro Children's Hospital

Lynda Dickinson
CHILD, Inc.

Susan Dickstein
Bradley/Hasbro Children's Research Center

John E. Farley, Jr., MD

Ruth Feder
Mental Health Association of Rhode Island

Karen Feldman
Young Voices

Patricia Flanagan, MD
Hasbro Children's Hospital

Rachel Flum
The Economic Progress Institute

Shirley Spater Freedman, DMD

Gregory Fritz, MD
Rhode Island Hospital

Marie Ganim
Rhode Island Senate Policy Office

Cynthia Garcia-Coll
Brown University

Reverend Betsy Aldrich Garland
Rhode Island Interfaith Coalition

Joseph Garlick
NeighborWorks Blackstone River Valley

Leslie Gell
Ready to Learn Providence

Kathleen S. Gorman
URI, Feinstein Center for a Hunger Free America

Adam Greenman
United Way of Rhode Island

Jennifer Griffith
Office of the Child Advocate

Lisa Guillette
Foster Forward

Rabbi Leslie Y. Gutterman
Temple Beth El

Jane Hayward
Rhode Island Community Health Center

Lisa Hildebrand
Rhode Island Association for the Education of Young Children

Kathleen Hittner, MD
Office of the Health Insurance Commissioner

Jennie Johnson
City Year Rhode Island

Chuck Jones
Thundermist Health Center

Susan Kaplan

Linda Katz
The Economic Progress Institute

H. John Keimig
Healthcentric Advisors

John M. Kelly
Meeting Street

Elizabeth Lange, MD
Rhode Island Chapter American Academy of Pediatrics

Peg Langhammer
Day One

Cindy Larson
Rhode Island LISC

Victor Lerish, MD
Barrington Pediatric Associates

Benedict F. Lessing, Jr.
Community Care Alliance

Khadija Lewis Khan
Beautiful Beginnings Child Care Center

Christine Lopes Metcalfe
RI-CAN

Kim Maine
Sunshine Child Development Center

Margaret Holland McDuff
Family Service of Rhode Island

Patrick McGuigan
The Providence Plan

Simon Moore
College Visions

Ann Mulready
Rhode Island Disability Law Center

Patricia Nolin
Rhode Island College

Susan Orban
Washington County Coalition for Children

Rahmanian Pegah
Youth in Action

Jill Pfitzenmayer
Initiative for Nonprofit Excellence
The Rhode Island Foundation

Candace Powell

Sister Mary Reilly
Sophia Academy

Brother Michael Reis
Tides Family Services

Maxine Richman
Rhode Island Interfaith Coalition

Angela Romans
Annenberg Institute at Brown University

James Ryczek
Rhode Island Coalition for the Homeless

Hillary Salmons
Providence After School Alliance

Karen Santilli
Crossroads Rhode Island

Andrew Schiff
Rhode Island Community Food Bank

Ronald Seifer
Bradley/Hasbro Children's Research Center

Nancy Serpa
Junior League of Rhode Island

Henry Shelton
The George Wiley Center

Toby Shepherd
The Rhode Island Foundation

John C. Simmons
Rhode Island Public Expenditure Council

Martin Sinnott
Child & Family

Susan Stevenson
Gateway Healthcare

The Honorable O. Rogeriee Thompson
U.S. 1st Circuit Court of Appeals

Lynne Urbani
Rhode Island House of Representatives Policy Office

James Vincent
NAACP, Providence Chapter

Brenda Whittle
Neighborhood Health Plan of Rhode Island

Acknowledgements

The *2016 Rhode Island Kids Count Factbook* was made possible by the efforts of many dedicated individuals. Rhode Island KIDS COUNT gratefully acknowledges their assistance. Special thanks to: Laura Beavers Speer, Dennis Campa, Jann Jackson, and Flo Gutierrez of The Annie E. Casey Foundation for their support and technical assistance.

The Rhode Island state agency directors for their ongoing support of Rhode Island KIDS COUNT and for the work of their data and policy staff as we produce the Factbook each year. Members of the Rhode Island Kids Count Factbook Advisory Committee and the State Agency Data Liaisons for their assistance in shaping the format and content of the Factbook.

John A. Y. Andrews, Information Systems Consultant, RI Executive Office of Health and Human Services; Samara Viner-Brown, Chief, Center for Health Data and Analysis, RI Department of Health; Zulma Garcia, Administrator for Planning and Training and Blair Lynch, Communications Coordinator, RI Department of Human Services; David Allenson, Systems Administrator, RI Department of Children, Youth and Families; and Kenneth Gu, Senior Data Systems Administrator, RI Department of Education for coordination and analysis of data from their respective departments.

Elizabeth Ochs for research, writing, editing, and fact checking.

Greenwood Associates for the design and layout, Gail Greenwood for the illustrations, and The Allied Group for the printing of the Factbook.

The Rhode Island KIDS COUNT Board of Directors for their support.

For their technical assistance with the following sections of the Factbook:

Family and Community

Child Population, Children in Single-Parent Families, Racial and Ethnic Diversity, Racial and Ethnic Disparities: Linda Katz, The Economic Progress Institute; Ellen Amore, Julian Drix, Richard Lupino, Meghan McCormick, Ana Novais, Kathy Taylor, Samara Viner-Brown, RI Department of Health; David Allenson, Brian Renzi, RI Department of Children, Youth and Families; Kenneth Gu, Emily Klein, RI Department of Education; Pablo Rodriguez, Women and Infants Hospital; Jean D'Amico, Mark Mather, Population Reference Bureau.

Grandparents Caring for Grandchildren: David Allenson, Brian Renzi, Kevin Savage, RI Department of Children, Youth and Families; Darlene Allen, Adoption RI; Lisa Guillette, Kat Keenan, Foster Forward; Jennifer Miller, Child Focus; Jaia Peterson Lent, Generations United.

Mother's Education Level: Ellen Amore, Richard Lupino, Kathy Taylor, Samara Viner-Brown, RI Department of Health; Laura Beavers Speer, The Annie E. Casey Foundation.

Economic Well-Being

Median Family Income: Laura Beavers Speer, The Annie E. Casey Foundation; Linda Katz, The Economic Progress Institute.

Cost of Housing: Amy Rainone, Rick Rollins, Rhode Island Housing; Jessica Cigna, HousingWorks RI; Eric Hirsch, Providence College and RI Emergency Food and Shelter Board.

Homeless Children: Eric Hirsch, Providence College and RI Emergency Food and Shelter Board; Kenneth Gu, Eileen Botelho, RI Department of Education; Amy Rainone, Rick Rollins, Rhode Island Housing; Maria Cimini, Karen Jeffreys, Jim Ryczek, RI Coalition for the Homeless; Michael Tondra, RI Department of Administration; Brother Michael Reis, Tides Family Services; Barbara Duffield, National Association for the Education of Homeless Children and Youth.

Secure Parental Employment: Laura Beavers Speer, The Annie E. Casey Foundation; Linda Katz, The Economic Progress Institute; Sharon Santilli, Office of Child Support Services; Vincent Rossi, RI Department of Labor and Training.

Paid Family Leave: Senator Gayle Goldin, RI General Assembly; Marie Ganim, RI Senate Policy Office; Donna Murray, Ray Pepin, Fern Casimiro, RI Department of Labor and Training; Jenn Steinfeld, Women's Fund of RI.

Children Receiving Child Support: Sharon Santilli, Office of Child Support Services; Rachel Flum, Linda Katz, The Economic Progress Institute; Vincent Rossi, RI Department of Labor and Training.

Children in Poverty: Linda Katz, The Economic Progress Institute; William O'Hare, Laura Beavers Speer, The Annie E. Casey Foundation; Amy Rainone, Rick Rollins, Rhode Island Housing; David Allenson, Colleen Caron, Brian Renzi, Leon Saunders, RI Department of Children, Youth and Families; Arloc Sherman, Center on Budget and Policy Priorities; Jean D'Amico, Mark Mather, Population Reference Bureau.

Children in Families Receiving Cash Assistance: Deborah Anthes, George Bowen, Zulma Garcia, Blair Lynch, Sally McGrath, Peter Squatrito, Joshua Morgan, Mary Tramonti, Maria Volpe, RI Department of Human Services; Rachel Flum, Linda Katz, The Economic Progress Institute; Denise Szymczuk, Community College of RI; Sharon Santilli, Office of Child Support Services; Kim Chouinard, RI Department of Education.

Children Receiving SNAP Benefits: George Bowen, Zulma Garcia, Blair Lynch, Sally McGrath, Peter Squatrito, Joshua Morgan, RI Department of Human Services; Kathleen Gorman, University of RI Feinstein Center for a Hunger Free America; Linda Katz, The Economic Progress Institute; Andrew Schiff, RI Community Food Bank; Cristina Amedeo, Anthony Maione, United Way of RI.

Women and Children Participating in WIC: Ann Barone, Michael Lauder, Samara Viner-Brown, Charles White, RI Department of Health.

Children Participating in School Breakfast: Becky Bessette, Kenneth Gu, RI Department of Education; Kathleen Gorman, University of RI Feinstein Center for a Hunger Free America; Henry Shelton, George Wiley Center; Andrew Schiff, RI Community Food Bank.

Acknowledgements

Health

Children's Health Insurance: John A.Y. Andrews, Deborah Florio, Grant Porter, Gloria Yu, RI Executive Office of Health and Human Services; Amy Black, HealthSource RI; Laura Beavers Speer, The Annie E. Casey Foundation; Linda Katz, The Economic Progress Institute; Jean D'Amico, Population Reference Bureau.

Childhood Immunizations: Hanna Kim, Kathy Marceau, Patricia Raymond, Samara Viner-Brown, Tricia Washburn, RI Department of Health.

Access to Dental Care: John A.Y. Andrews, Deborah Florio, Joan Pillsbury, Grant Porter, Gloria Yu RI Executive Office of Health and Human Services; Laurie Leonard, Junhie Oh, Kathy Taylor, Travis Vendetti, Samara Viner-Brown, RI Department of Health; Amy Black, HealthSource RI; Eva Stahl, Community Catalyst; Colin Reusch, Children's Dental Health Project.

Children's Mental Health: Kathleen Donise, Michele Gessman, Russell Gross, Emily Katz, Ornella Potter, John Peterson, Henry Sachs, Susan Thompson, Daniel Wall, Lifespan; Charles Alexandre, Mark Gloria, Butler Hospital; Tara Cooper, Kathy Taylor, Samara Viner-Brown, RI Department of Health; Gregory Fritz, Hasbro Children's Hospital; John A.Y. Andrews, Deborah Florio, Grant Porter, Gloria Yu, RI Executive Office of Health and Human Services; Marylin Gaudreau, Corinna Roy, RI Department of Behavioral Health, Developmental Disabilities and Hospitals.

Children With Special Needs: Ruth Gallucci, Kenneth Gu, Elliot Krieger, Beth Pinto, David Sienko, Patricia Strauss, RI Department of Education; John A.Y. Andrews, Brenda Duhamel, Deborah Florio, Grant Porter, Gloria Yu, RI Executive Office of Health and Human Services; Deborah Garneau, RI Department of Health; Jodi DiBernardo, Neighborhood Health Plan of Rhode Island.

Infants Born at Highest Risk: Ellen Amore, Blythe Berger, Kristine Campagna, Richard Lupino, Samara Viner-Brown, RI Department of Health; Patricia Flanagan, Hasbro Children's Hospital; Susan Dickstein, Ronald Seifer, Bradley/Hasbro Children's Research Center.

Evidence-Based Family Home Visiting: Kristine Campagna, Blythe Berger, Sara Remington, Sarah Bowman, Perry Gast, Samara Viner-Brown, RI Department of Health; Maria Chionchio, Children's Friend.

Women with Delayed Prenatal Care, Low Birthweight Infants, Infant Mortality: Ellen Amore, William Arias, Richard Lupino, Ana Novais, Kathy Taylor, Samara Viner-Brown, RI Department of Health; Jean D'Amico, Population Reference Bureau; Nichole Aguiar, March of Dimes; Laura Beavers Speer, The Annie E. Casey Foundation; Pamela High, Hasbro Children's Hospital.

Preterm Births: Ellen Amore, Richard Lupino, Ana Novais, Samara Viner-Brown, RI Department of Health; Nichole Aguiar, March of Dimes; Vani Bettegowda, Joann Petrini, National March of Dimes Foundation; James Padbury, Maureen Phipps, Betty Vohr, Women & Infants Hospital; Janet Muri, National Perinatal Information Center; Stephen Davis, Neighborhood Health Plan of RI.

Breastfeeding: Ellen Amore, Ann Barone, Michael Lauder, Richard Lupino, Samara Viner-Brown, Charles White, RI Department of Health.

Children with Lead Poisoning: Michelle Kollett Almeida, Ellen Amore, James Bruckshaw, Anne Cardoza, Ana Novais, Anne Primeau-Faubert, Samara Viner-Brown, RI Department of Health; Roberta Hazen Aaronson, Childhood Lead Action Project; Rachel Peterson, Joel Stewart, ProvPlan.

Children with Asthma: Julian Drix, Meghan McCormick, Samara Viner-Brown, RI Department of Health; Lillianne Lewis, Centers for Disease Control and Prevention; Chris Camillo, Providence Community Health Centers; Myra Edens, Hasbro Children's Hospital; Rachel Peterson, Joel Stewart, ProvPlan.

Housing and Health: Sherry Dixon, Rebecca Morley, National Center for Healthy Housing; Laura Beavers Speer, The Annie E. Casey Foundation; Jean D'Amico, Population Reference Bureau; Michelle Kollett Almeida, Ellen Amore, James Bruckshaw, Anne Cardoza, Julian Drix, Ana Novais, Anne Primeau-Faubert, Meghan McCormick, Kathy Taylor, Samara Viner-Brown, RI Department of Health; James Celenza, RI Committee on Occupational Safety and Health; Amy Rainone, Rhode Island Housing; Jessica Cigna, HousingWorks RI; Simon Kue, RI Housing Resources Commission; Julie A. Capobianco, RI Office of Energy Resources; Rachel Peterson, Joel Stewart, ProvPlan; Besty Stubblefield Loucks, Ruth Ann Norton, Green and Healthy Homes Initiative; Lewis Babbitt III, RI Department of Human Services; Paula McFarland, Rhode Island Community Action Association.

Childhood Obesity: Becky Bessette, Rosemary Rilly-Chammat, Midge Sabatini, RI Department of Education; Ann Barone, Tara Cooper, Dora Dumont, Eliza Lawson, Michael Lauder, Samara Viner-Brown, Charles White, RI Department of Health; Melissa Oliver, Child, Inc.; Akilah Dulin-Keita, Kim Gans, Gemma Gorham, Brown University; Bryan McCormick, Jill Vialet, Playworks; Rachel Peterson, Joel Stewart, ProvPlan; Karin Wetherill, RI Healthy Schools Coalition; Megan Tucker, American Heart Association/American Stroke Association; Janice O'Donnell, Recess for RI; Andrew Saal, Adriana Vargas, Providence Community Health Centers; Jane Hayward, RI Health Center Association.

Births to Teens: Ellen Amore, Kimberly Harris, Richard Lupino, Ana Novais, Samara Viner-Brown, RI Department of Health; Patricia Flanagan, Hasbro Children's Hospital; Deborah Perry, YWCA of Northern RI; Sarah Fox, Women & Infants Hospital; Beata Nelken, Thundermist Health Center.

Alcohol, Drug, and Tobacco Use by Teens: Tara Cooper, Samara Viner-Brown, RI Department of Health.

Acknowledgements

Safety

Child Deaths and Teen Deaths: Tara Cooper, Kathy Taylor, Samara Viner-Brown, RI Department of Health; Sharon Bazor, Siobhan Catala, Nancy Ricci, RI Department of Transportation; Jean D'Amico, Population Reference Bureau.

Youth Violence: Kate Reilly, Sojourner House; Kat Keenan, Foster Forward; Gina Tocco, RI Department of Public Safety; Cesar Perez, Michael Schmitt, Tides Family Services; Beatriz Perez, Kathy Taylor, Samara Viner-Brown, RI Department of Health; Michael Burk, Kevin McKenna, RI Department of Children, Youth and Families; Peg Votta, RI Department of Education.

Gun Violence: Tara Cooper, Kathy Taylor, Samara Viner-Brown, RI Department of Health.

Homeless and Runaway Youth: David Allenson, Michael Burk, Colleen Caron, Brian Renzi, RI Department of Children, Youth and Families; Eric Hirsch, Providence College and RI Emergency Food and Shelter Board; Karen Jeffreys, Jim Ryczek, RI Coalition for the Homeless; Ken Gu, RI Department of Education.

Youth Referred to Family Court: Michael Forte, Haiganush Bedrosian, Laureen D'Ambra, Ronald Pagliarini, Ron Pirolli, Kevin Richard, Richard Scarpellino, RI Family Court; Gina Tocco, RI Department of Public Safety; John Moreira, Michele Dupuis-Clarke, RI Office of the Attorney General; Brother Michael Reis, Tides Family Services.

Youth at the Training School: David Allenson, Susan Bowler, Colleen Caron, William Cauley, Charles Golembeske, Brian Renzi, RI Department of Children, Youth and Families; Brother Michael Reis, Tides Family Services; John Moreira, RI Office of the Attorney General; Laureen D'Ambra, RI Family Court; Gina Tocco, RI Department of Public Safety; A.T. Wall, RI Department of Corrections.

Children of Incarcerated Parents: Erin Boyar, Caitlin O'Connor, A. T. Wall, RI Department of Corrections.

Children Witnessing Domestic Violence: Elaine Dorazio, Veronica Hobbs, RI Supreme Court Domestic Violence Training and Monitoring Unit; Deborah DeBare, Rachel Orsinger, RI Coalition Against Domestic Violence; Eric Hirsch, Providence College and RI Emergency Food and Shelter Board.

Child Abuse and Neglect: David Allenson, Michael Burk, Colleen Caron, Brian Renzi, Leon Saunders, Kevin Savage, RI Department of Children, Youth and Families; Deborah DeBare, RI Coalition Against Domestic Violence; Margaret Holland McDuff, Family Service; Peg Langhammer, Day One; Ellen Amore, Kathy Taylor, Samara Viner-Brown, RI Department of Health; Kate Begin, Prevent Child Abuse RI.

Children in Out-of-Home Placement: David Allenson, Michael Burk, Colleen Caron, Brian Renzi, Leon Saunders, Diane Savage, Kevin Savage, RI Department of Children, Youth and Families; Laureen D'Ambra, RI Family Court; Regina Costa, Office of the Child Advocate; Darlene Allen, Adoption RI; Kate Begin, Prevent Child Abuse RI; Lisa Guillette, Kat Keenan, Foster Forward.

Permanency for Children in DCYF Care: David Allenson, Michael Burk, Colleen Caron, Brian Renzi, Kevin Savage, RI Department of Children, Youth and Families; Darlene Allen, Adoption RI; Lisa Guillette, Kat Keenan, Foster Forward.

Education

Children Enrolled in Early Intervention: Brenda Duhamel, Deborah Florio, Christine Robin Payne, RI Executive Office of Health and Human Services; John Kelly, Meeting Street; Ben Lessing, Darlene Magaw, Family Resources Community Action; Fran Rittner, Joseph Carr, Kayleigh Pratt, RI Department of Children, Youth and Families; Kristine Campagna, RI Department of Health; Pamela High, Hasbro Children's Hospital; Maureen Whelan, Leslie Bobrowski, Sherlock Center at Rhode Island College.

Children Enrolled in Early Head Start and Head Start: Larry Pucciarelli, RI Department of Human Services; Toni Enright, Cranston Child Development Center; Lynda Dickinson, Michelle Mathiesen, CHILD, Inc.; Aimee Mitchell, Dana Mullen, Children's Friend; Michael Carbone, East Bay Community Action Program; Evangeline Brennan, Meeting Street; Lori Ann Hiener, South County Community Action; Rhonda Farrell, Tri-Town Community Action Agency; Mary Varr, Dee Henry, Woonsocket Head Start Child Development Association; Susan Dickstein, RI Association for Infant Mental Health.

Licensed Capacity of Early Learning Programs, Early Learning Programs Participating in BrightStars: Brenda Kevin Savage, RI Department of Children, Youth and Families; Karen Beese, Deborah Anthes, Larry Pucciarelli, RI Department of Human Services; Michele Palermo, Melissa Emidy, Carla Swanson, RI Department of Education; Lisa Hildebrand, Kelly Brennan, RIAEYC/ BrightStars; Christine Chiacu-Forsythe, Leslie Gell, Ready to Learn Providence; Karen Pucciarelli, Center for Early Learning Professionals; Cindy Larson, LISC; Maryann Finamore-Allmark; Kim Maine, Sunshine Child Development Center; Khadija Lewis Khan, Beautiful Beginnings Child Care Center; Diana Perdomo, United Way of RI.

Children Receiving Child Care Subsidies: Karen Beese, Zulma Garcia, Blair Lynch, Peter Squatrito, Sally McGrath, George Bowen, RI Department of Human Services; Rachel Flum, The Economic Progress Institute; Helen Blank, National Women's Law Center; Lisa Hildebrand, RIAEYC/BrightStars; Christine Chiacu-Forsythe, Leslie Gell, Ready to Learn Providence; Maryann Finamore-Allmark; Kim Maine, Sunshine Child Development Center; Khadija Lewis Khan, Beautiful Beginnings Child Care Center.

Children Enrolled in State Pre-K: Kristen Greene, Michele Palermo, RI Department of Education.

Children Receiving Preschool Special Education Services: Ruth Gallucci, Beth Pinto, Patricia Strauss, RI Department of Education.

Acknowledgements

Public School Enrollment and Demographics: Mario Goncalves, Kenneth Gu, Elliot Krieger, RI Department of Education.

Children Enrolled in Full-Day Kindergarten: Kristen Greene, Michele Palermo, Kenneth Gu, Elliot Krieger, RI Department of Education.

Out-of-School Time: Kevin Savage, RI Department of Children, Youth and Families; Jan Mermin, Melissa Emidy, RI Department of Education; Karen Beese, RI Department of Human Services; Hillary Salmons, Providence After School Alliance; Charlotte Boudreau, Erica Saccoccio, Mary Ann Shallcross, RI School Age Child Care Association; Adam Greenman, Joseph Morra; United Way of RI.

English Language Learners: Jillian Belanger, Kenneth Gu, Emily Klein, Elliot Krieger, RI Department of Education; Julie Nora, International Charter School.

K-12 Students Receiving Special Education Services: Beth Pinto, Ruth Gallucci, Patricia Strauss, David Sienko, Emily Klein, Elizabeth Landry, Elliot Krieger, Kenneth Gu, RI Department of Education.

Student Mobility: Rachel Peterson, The Providence Plan; Terese Curtin, Connecting for Children and Families, Inc.; Christine Arouth, Newport School Department; Samara Viner-Brown, RI Department of Health; Mario Goncalves, Kenneth Gu, Elliot Krieger, Peg Votta, RI Department of Education.

Third-and Seventh-Grade Reading Skills: Kenneth Gu, Elliot Krieger, Phyllis Lynch, Mary Ann Snider, RI Department of Education; Julia Steiny; Steven Nardelli, RI League of Charter Schools.

Math Skills: Kenneth Gu, Elliot Krieger, Phyllis Lynch, Mary Ann Snider, RI Department of Education; Julia Steiny.

Schools Identified for Intervention: David Abbott, Kenneth Gu, Elliot Krieger, Phyllis Lynch, Mary Ann Snider, RI Department of Education.

Chronic Early Absence: Kim Chouinard, Kenneth Gu, Elliot Krieger, RI Department of Education; Christine Arouth, Ralph Smith, Laura Beavers Speer, The Annie E. Casey Foundation.

Chronic Absence, Middle School and High School: Kenneth Gu, Elliot Krieger, RI Department of Education; Patrick McGuigan, The Providence Plan.

Suspensions: Kenneth Gu, Elliot Krieger, Elizabeth Landry, RI Department of Education; Hillary Davis, American Civil Liberties Union; Karen Feldman, Young Voices; Zack Mezera, Providence Student Union; Dannie Ritchie, Brown University; Martha Yager, American Friends Service Committee – South East New England Program.

High School Graduation Rate: Cali Cornell, Kenneth Gu, Elliot Krieger, Elizabeth Landry, Angela Teixeira, RI Department of Education.

College Preparation and Access: Deborah Grossman-Garber, Michael Joyce, Gail Mance-Rios, RI Office of the Postsecondary Commissioner; Maria Carvalho, Robert Oberg, The College Crusade of RI; Simon Moore, College Visions; William LeBlanc, Community College of RI; Ronald DiOrio, University of Rhode Island; Kenneth Gu, Elliot Krieger, Phyllis Lynch, Mary Ann Snider, Peg Votta, RI Department of Education; Solanchi Fernandez, College Planning Center; Tom Mortensen, Postsecondary Opportunity; Paul Harrington, Drexel University.

Teens Not in School and Not Working: Laura Beavers Speer, The Annie E. Casey Foundation; Jean D'Amico, Population Reference Bureau.

Poetry Credits

Alarcón, F. (2005). *Poems to dream together / Poemas paras soñar juntos.* "Family Garden" / "Jardin Familiar" by Francisco X. Alarcón. New York, NY: Lee & Low Books, Inc.

Angelou, M. (1994). *The complete collected poems of Maya Angelou.* "On the Pulse of Morning" by Maya Angelou. New York, NY: Random House, Inc.

Blumhagen, V. "Adventures with Books." Retrieved March 10, 2016, from bookkidsblog.wordpress.com

Foster, J. (2000). *My first Oxford book of poems.* "Pond" by Sue Cowling. New York, NY: Oxford University Press.

Moore, L. (1982). *Something new begins: New and selected poems.* "Until I Saw the Sea" by Lilian Moore. New York, NY: Atheneum Books.

Prelutsky, J. (1983). *The Random House book of poetry for children.* "To Dark Eyes Dreaming" by Zilpha Keatley Snyder. New York, NY: Random House, Inc.

Notes

Rhode Island KIDS COUNT
One Union Station
Providence, RI 02903

(401) 351-9400
rikids@rikidscount.org
www.rikidscount.org