2019 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, Nellie Mae Education Foundation, ZERO TO THREE, DentaQuest Foundation, van Beuren Charitable Foundation, Partnership for America's Children, 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, 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 *2019 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.

Any portion of this report may be reproduced without prior permission, provided the source is cited as:

2019 Rhode Island Kids Count Factbook
Providence, RI: Rhode Island KIDS COUNT

©2019 Rhode Island KIDS COUNT

2019 Rhode Island Kids Count Factbook

PARTNERS

Rhode Island Foundation

Neil Steinberg, President & CEO
Jessica David, Executive Vice President of Strategy & Community Investments
Jennifer Pereira, Vice President of Grant Programs

United Way of Rhode Island

Cortney Nicolato, President & CEO
Angela Ankoma, Executive Vice President, Director of Community Investment

The Annie E. Casey Foundation

Lisa Hamilton, President & Chief Executive Officer
Leslie Boissiere, Vice President, External Affairs
Noah Berger, Director, Policy Reform and Advocacy

Rhode Island KIDS COUNT

STAFF

Elizabeth Burke Bryant, Executive Director
Leanne Barrett, Senior Policy Analyst
Dorene Bloomer, Finance Director
Jennifer Waring Capaldo, Program Assistant
Katherine Linwood Chu, Communications Manager
Paige Clausius-Parks, Senior Policy Analyst
Jessy Donaldson, Fund Development/Research Analyst
Kara Foley, Policy Analyst
W. Galarza, Executive Assistant/Office Manager
Stephanie Geller, Deputy Director
Devan Quinn, Policy Analyst
Valerie Womer, Research Analyst
Pamela Stolz, Intern, Rhode Island College

Rhode Island KIDS COUNT Board of Directors

CHAIRPERSON

Marisa Albanese
Manager, Community and Customer Management
National Grid

VICE CHAIRPERSON

Barbara Silvis

TREASURER

Raymond Celona

SECRETARY

Elizabeth Lange, MD
Pediatrician
Waterman Pediatrics/Coastal Medical, Inc.

Karen Davis

Robert DeBlois
Director
The UCAP School

Amy P. Goldberg, MD
Pediatrician
The Aubin Center
Hasbro Children's Hospital

Jael Lopes
Director of Strategic Community Partnerships
Providence Public Schools

Reverend Nikita McCalister, MBA, MDiv
Associate Executive Minister for Administration
American Baptist Churches of RI

Tanitia Sello
Independent Consultant

Rhode Island State Agency Directors and Data Liaisons to Rhode Island KIDS COUNT

Kevin Gallagher
Office of the Governor

Michael DiBiase
Department of Administration

Lisa Vura-Weis (Acting Secretary)
Rebecca Lebeau
Executive Office of Health and Human Services

Rebecca Boss
Gabriela Arredondo-Santisteban
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Trista Piccola
Colleen Caron
Leon Saunders
Department of Children, Youth and Families

Nicole Alexander-Scott, MD
Samara Viner-Brown
Department of Health

Courtney Hawkins
J. James Butler
Department of Human Services

Honorable Michael Forte
Ronald Pagliarini
Family Court

Ken Wagner
Kenneth Gu
Department of Education

Michael Hogan
Gina Tocco
Department of Public Safety

Scott Jensen
Department of Labor and Training

Peter Alviti Jr.
Department of Transportation

Table of Contents

OVERVIEW 5

FAMILY AND COMMUNITY
- Child Population 8-9
- Children in Single-Parent Families 10-11
- Grandparents Caring for Grandchildren 12-13
- Mother's Education Level 14-15
- Racial and Ethnic Diversity 16-17
- Racial and Ethnic Disparities 18-21

ECONOMIC WELL–BEING
- Median Family Income 24-25
- Cost of Housing 26-27
- Homeless Children 28-29
- Secure Parental Employment 30-31
- Paid Family Leave 32-33
- Children Receiving Child Support 34-35
- Children in Poverty 36-39
- Children in Families Receiving Cash Assistance 40-43
- Children Receiving SNAP Benefits 44-45
- Women and Children Participating in WIC 46-47
- Children Participating in School Breakfast 48-49

HEALTH
- Children's Health Insurance 52-53
- Childhood Immunizations 54-55
- Access to Dental Care 56-57
- Children's Mental Health 58-59
- Children with Special Needs 60-61
- Infants Born at Risk 62-63
- Evidence-Based Family Home Visiting 64-65
- Women with Delayed Prenatal Care 66-67
- Preterm Births 68-69
- Low Birthweight Infants 70-71
- Infant Mortality 72-73
- Breastfeeding 74-75
- Children with Lead Poisoning 76-77
- Children with Asthma 78-79
- Housing and Health 80-81
- Childhood Overweight and Obesity 82-83
- Births to Teens 84-85
- Alcohol, Drug, and Tobacco Use 86-87

SAFETY
- Child Deaths and Teen Deaths 90-91
- Youth Violence 92-93
- Gun Violence 94
- Homeless and Runaway Youth 95
- Youth Referred to Family Court 96-97
- Youth at the Training School 98-101
- Children of Incarcerated Parents 102-103
- Children Witnessing Domestic Violence 104-105
- Child Abuse and Neglect 106-109
- Children in Out-of-Home Placement 110-111
- Permanency for Children in DCYF Care 112-113

EDUCATION
- Children Enrolled in Early Intervention 116-117
- Children Enrolled in Early Head Start 118-119
- Licensed Capacity of Early Learning Programs 120-121
- Children Receiving Child Care Subsidies 122-123
- High-Quality Early Learning Programs 124-127
- Children Enrolled in Head Start or State Pre-K 128-131
- Children Receiving Preschool Special Education Services 132-133
- Public School Enrollment and Demographics 134-135
- Children Enrolled in Kindergarten 136-137
- Out-of-School Time 138-139
- English Learners 140-141
- K-12 Students Receiving Special Education Services 142-143
- Student Mobility 144-145
- Third-Grade Reading Skills 146-147
- Eighth-Grade Reading Skills 148-149
- Math Skills 150-151
- Schools Identified for Intervention 152-153
- Chronic Early Absence 154-155
- Chronic Absence, Middle School and High School 156-157
- Suspensions 158-159
- High School Graduation Rate 160-161
- College Preparation and Access 162-163
- College Enrollment and Completion 164-165
- Teens Not in School and Not Working 166-167

METHODOLOGY AND REFERENCES 170-189

COMMITTEES AND ACKNOWLEDGEMENTS 190-195

Overview

Me x 2
by Jane Medina

I read times two.
I write times two.
I think, I dream,
I cry times two.

I laugh times two.
I'm right times two.
I sing, I ask
I try times two.

I do twice as much
As most people do,
'Cause most speak one,
But I speak two!

Yo x 2

Leo por dos.
Escribo por dos
Pienso y sueño
Y lloro por dos.

Yo río por dos
Grito por dos
Canto, pregunto
Intento por dos.

Hago mucho más
Que hacen todos ellos,
Porque you hablo dos:
Lo doble que aquéllos.

The *2019 Rhode Island Kids Count Factbook* is the twenty-fifth 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 *2019 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 *2019 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 *2019 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 in poverty are most at risk of not achieving their full potential. Rhode Island's child poverty rate was 18.9% between 2013 and 2017, during which time 39,229 children were 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 2013 and 2017, almost 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 Success for All Children

Improving student achievement, high school graduation, and postsecondary attainment rates in Rhode Island will require that schools and community leaders 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. This work must include a strong focus on equity and ensuring that all students, including low-income students, students of color, English learners, and students with disabilities, receive the support they need to succeed.

Family and Community

grandmother

by Ray A. Young Bear

if i were to see
her shape from a mile away
i'd know so quickly
that it would be her.
the purple scarf
and the plastic
shopping bag.
if i felt
hands on my head
i'd know that those
were her hands
warm and damp
with the smell
of roots.
if i heard
a voice
coming from
a rock
i'd know
and her words
would flow inside me
like the light
of someone
stirring ashes
from a sleeping fire

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 1,059,639 Rhode Island residents in 2017. Children under age 18 make up 20% of the population. Rhode Island's child population decreased from 247,822 in 2000 to 223,956 in 2010 and then further to an estimated 206,972 in 2017 (a 16% decrease from 2000 to 2017).[1,2,3] Between 2013 and 2017, there were 119,488 households with children under age 18 in Rhode Island, representing 29% of all households.[4] 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.[5] Fifty-one percent were male, and 49% were female.

In Rhode Island, between 2013 and 2017, 124,034 (59%) children under age 18 lived in married-couple households, 65,566 (31%) children lived in single-parent households, and 17,355 (8%) children lived with relatives, including grandparents. A total of 2,887 (1%) children lived with foster families or other non-relative heads of household. There were 714 (<1%) children and youth under age 18 who lived in group quarters and 26 (<1%) youth who were householders or spouses.[6,7,8]

Rhode Island's children are diverse in race, ethnicity, language, and country of origin. Mirroring the national trend, the Hispanic child population in Rhode Island has grown since 2000, both in numbers and as a percentage of the child population. Hispanics make up 25% of children under age 18 in the United States and 24% of children under age 18 in Rhode Island.[9,10,11]

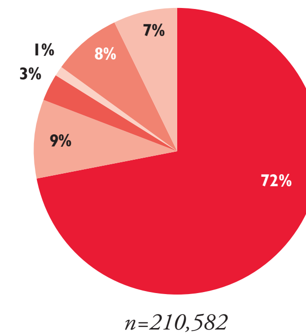
Between 2013 and 2017, there were 8,981 foreign-born children under the age of 18 living in Rhode Island, representing approximately 4% of the child population.[12] Of Rhode Island children ages five to 17, 77% speak only English at home, 17% speak Spanish, 4% speak other Indo-European languages, 2% speak Asian or Pacific Island languages, and 1% speak other languages at home.[13]

Sexual orientation is another important facet of diversity among youth. According to the *2017 Youth Risk Behavior Survey*, 11% 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, 2013-2017

By Race/Ethnicity*

%	
72%	White
9%	Black
3%	Asian
1%	American Indian and Alaska Native
8%	Some Other Race
7%	Two or More Races



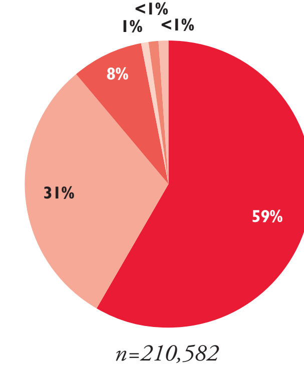
n=210,582

**Hispanic children may be included in any race category. Of Rhode Island's 210,582 children, 50,369 (24%) were Hispanic.*

Source: U.S. Census Bureau, American Community Survey, 2013-2017. Tables B01001A, B01001B, B01001C, B01001D, B01001E, B01001F, B01001G, and B01001I.

By Family Structure

%	
59%	Married-Couple**
31%	Single-Parent**
8%	Other Relatives
1%	Foster Family or Other Unrelated Household
<1%	Group Quarters
<1%	Child is Head of Household



n=210,582

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

Source: U.S. Census Bureau, American Community Survey, 2013-2017. Table B09001, Table B09002, and B09018.

Decennial Census 2020

◆ **The decennial Census count is used to apportion the 435 members of the U.S. House of Representatives and to allocate federal program funding to each state for the following decade. These federal funds support a wide array of programs that improve outcomes for children and families in Rhode Island.[15]**

◆ **Certain populations have been historically undercounted in the decennial Census, including young children under age five, immigrants, low-income populations, people of color, people experiencing homelessness, and people in non-traditional households.[16]**

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] U.S. Census Bureau, American Community Survey, 2017. Table S0201.

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

[3] U.S. Census Bureau, Census 2010 Summary File 1. Table DP-1.

[4] U.S. Census Bureau, American Community Survey, 2013-2017. Table S1101.

[5] U.S. Census Bureau, American Community Survey, 2013-2017. Table B01001.

[6] U.S. Census Bureau, American Community Survey, 2013-2017. Table B09002.

[7] U.S. Census Bureau, American Community Survey, 2013-2017. Table B09018.

[8] U.S. Census Bureau, American Community Survey, 2013-2017. Table B09001.

[9] 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, 2013-2017. Table B01001I.

[12] U.S. Census Bureau, American Community Survey, 2013-2017. Table B05003.

[13] U.S. Census Bureau, American Community Survey, 2013-2017. Table B16007.

[14] *2017 Youth Risk Behavior Survey*, Rhode Island Department of Health.

[15] U.S. Census Bureau. (2017). *Uses of Census Bureau data in federal funds distribution.* Retrieved December 28, 2018, from www.census.gov/library/working-papers/.

[16] Chapin, M. M. (2018). *2020 Census: Counting everyone once, only once, and in the right place.* Retrieved March 20, 2019, from www2.census.gov

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 – of any gender – who is unmarried, regardless of whether both parents live in the home but are unmarried or if only one parent lives in the home. These numbers include "own children" defined as never-married, under age 18, and related to the family head by birth, marriage, or adoption.

SIGNIFICANCE

According to the U.S. Census Bureau's American Community Survey, there were 189,600 children living with one or more parents in Rhode Island between 2013 and 2017. Of these, 35% (65,566) were living with an unmarried parent, remaining steady since the period between 2008 and 2012.[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 2013 and 2017, 75% of children living in poverty in Rhode Island were living in single-parent families. Children in single-parent families in Rhode Island were five times more likely to be living in poverty than those in married-couple families. Between 2013 and 2017 in Rhode Island, 38% of children in single-parent families lived in poverty, compared to 7% of children in married-couple families.[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 more likely than their peers to have 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]

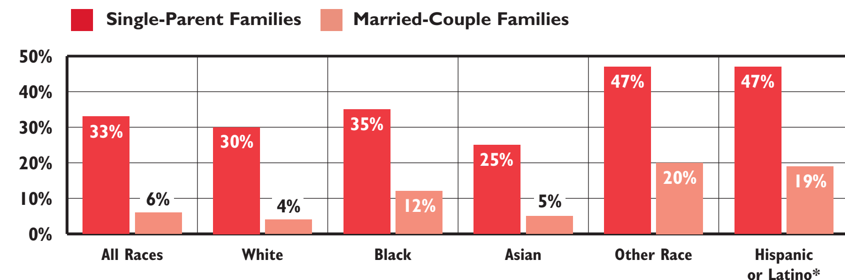
Single-Parent Families

	2007	2017
RI	33%	35%
US	32%	34%
National Rank*		*29th*
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, 2013-2017



Source: U.S. Census Bureau, American Community Survey, 2013-2017. Tables B17010, B17010A, B17010B, B17010C, B17010D, B17010F, B17010I. *Hispanic or Latino 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 and Black married-couple families and married-couple families of "some other race" are more likely than White and Asian married-couple families in Rhode Island to live in poverty.[13]**

Family Structure and Child Well-Being

◆ **Family structure influences children's social, emotional, and cognitive development. Children born to and raised in married-parent families have higher rates of economic, social, and psychological stability compared to children in single-parent families and families with different-sex cohabitating couples. 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.[14,15]**

◆ **Children in the U.S. live in a variety of family structures. Among those who live with at least one of their biological parents, 59% live in 'simple families' with only biological parent(s) and full sibling(s), and 41% live in 'complex families' with single parents, stepparents, stepsiblings, and/or half siblings. Family structure varies by education, with one in two children whose parents have a high school diploma or less education and about one in five children with a college-educated parent living in 'complex' families.[16]**

◆ **After increasing for several decades, the proportion of births to unmarried families in the U.S. has leveled off and has been just over 40% since 2009.[17] Babies born to cohabiting couples comprise 25% of all births and 60% of nonmarital births in the U.S., and they account for nearly the entire increase in nonmarital births.[18]**

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, 2013-2017. Table B09002.

[2] U.S. Census Bureau, American Community Survey, 2008-2012. 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] *Family structure.* (2015). Washington, DC: Child Trends

[5] U.S. Census Bureau, American Community Survey, 2013-2017. Table B17006.

[8,10] 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.

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

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

[13] U.S. Census Bureau, American Community Survey, 2013-2017. Tables B17010, B17010A, B17010B, B17010D, B17010F, B17010I.

[14] The National Conference on State Legislators. (2012). *Child poverty rates and family structure.* Retrieved December 16, 2016, from www.ncsl.org

(continued on page 174)

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

The number of grandparents raising grandchildren is on the rise. Eight million grandchildren live in households headed primarily by grandparents and 2.7 million of these grandparents serve as the primary caregiver. Black and American Indian and Alaskan Native children are more likely to be cared for by grandparents than other groups.[1]

Grandparents can provide continuity and family support for children in vulnerable families. Children may be in grandparent care because of child abuse or neglect, parental divorce or economic challenges or because they have a parent who is unemployed, incarcerated, ill, struggling with substance abuse, or coping with other problems.[2,3]

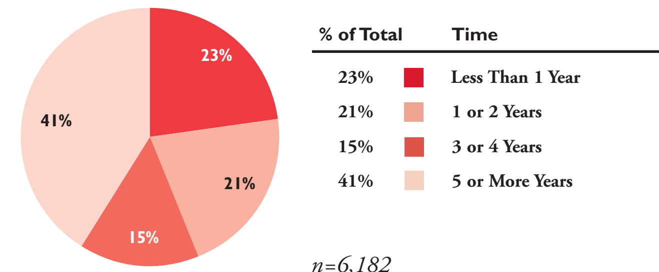
Twice as many grandmothers are involved in raising grandchildren than grandfathers. Forty percent of grandmother-only caregivers live below the poverty line and 76% receive public assistance. Nearly one in five of all grandparent caregivers live in poverty.[4,5]

Many grandparents have informal custody arrangements and are not involved with child welfare agencies, often receiving fewer services than traditional foster parents.[6] 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.[7]

Grandparents and other relative caregivers can lack information about the support services (such as training, respite, and peer support), resources, programs, and policies available to them. 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 legal process required for permanent status in order to avoid strain on family relationships and due to cost.[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, 2013-2017



% of Total	Time
23%	Less Than 1 Year
21%	1 or 2 Years
15%	3 or 4 Years
41%	5 or More Years

n=6,182

Source: U.S. Census Bureau, American Community Survey, 2013-2017. Table B10050.

◆ **Between 2013 and 2017, there were a total of 13,499 children in Rhode Island living in households headed by grandparents.[13] During this time period, there were 6,182 grandparents who were financially responsible for their grandchildren, 55% 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 the child welfare system have more adverse childhood experiences which contribute to negative health outcomes in adulthood. Children in foster care with relatives have better health outcomes, more stability, and are more likely to have a permanent home.[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, 2018, there were 901 children under age 19 in DCYF care who were in out-of-home placements with a grandparent or other relative. These children made up 43% of all children in out-of-home placements in Rhode Island.[18]**

◆ **The federal *Fostering Connections to Success and Increasing Adoptions Act* helps keep families together and improve outcomes by allowing federal dollars to support children exiting foster care to permanent homes with relative guardians.[19] Rhode Island is one of 35 states with a Guardianship Assistance Program that provides financial assistance payments to grandparents and other relative caregivers who assume legal guardianship.[20]**

Grandparents Caring for Grandchildren

Table 3.

Children's Living Arrangements, Rhode Island, 2010

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

Source of Data for Table/Methodology

U.S. Census Bureau, Census 2010.

The denominator is the number of children under age 18 living in family households according to Census 2010. A family household is defined by the U.S. Census Bureau as consisting of a householder and one or more people living together in the same household who are related to the householder by birth, marriage or adoption – it may include others not related to the householder.

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

References

[1,3,4] Peterson, T.L. (2018). *Grandparents raising grandchildren in the African American community.* Generations, 42(3), 30-36.

[2,5,12] Peterson Lent, J. Otto, A. (2018). *Grandparents, grandchildren, and caregiving: The impacts of America's substance use crisis.* Generations 42(3), 15-22.

[6,11,16] In loving arms: The protective role of grandparents and other relatives in raising children exposed to trauma. (2017). *Generations United.* Washington, DC

[7,8,9] KIDS COUNT. (2012). *Stepping up for kids: What government and communities should do to support kinship families.* Baltimore, MD: The Annie E. Casey Foundation.

[10] Walsh, W.A. (2014). *Related foster parents less likely to receive support services compared with nonrelative foster parents.* Durham, NH: Carsey Institute, University of New Hampshire

[13] U.S. Census Bureau, American Community Survey, 2013-2017. Table B09018.

[14] U.S. Census Bureau, American Community Survey, 2013-2017. 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 January 18, 2019, from www.dcyf.ri.gov

(continued on page 174)

Mother's Education Level

DEFINITION

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

SIGNIFICANCE

Parental educational attainment can have an impact on many aspects of child well-being, including children's health and health-related behaviors, school readiness, and involvement in pro-social activities.[1] Children of parents without high school degrees are more likely to struggle in school, including receiving lower achievement scores, repeating grades, and failing to graduate from high school.[2]

Infant mortality rates increase as mother's education levels decrease.[3] For example, in Rhode Island between 2013-2017, babies born to mothers with a high school degree or less had a higher infant mortality rate (5.7 per 1,000) than babies born to mothers with more advanced education (3.5 per 1,000 births).[4]

Children of more highly educated parents participate in early learning programs and home literacy activities more frequently, and enter school with higher levels of academic skills. Increasing maternal education can improve children's school readiness, language and academic skills, health, employment opportunities, and earnings.[5,6,7] Higher levels of parental education can decrease the likelihood that a child will live in poverty.[8] Between 2013-2017, women with bachelor's degrees in Rhode Island earned more than twice as much as those with less than a high school diploma and almost twice as much as women with a high school diploma.[9]

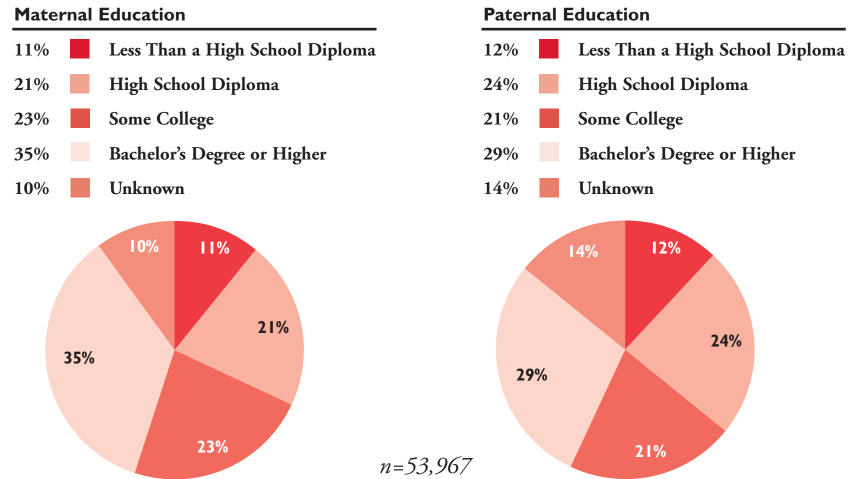
Between 2013-2017, 11% of Rhode Island births were to mothers with less than a high school diploma and 58% were to mothers with at least some college education.[10] Nationally in 2013, 12% of children lived with mothers with less than a high school diploma, and 63% had mothers with at least some college education.[11]

Births to Mothers With Less Than a High School Diploma, Rhode Island, 2013-2017

CITY/TOWN	% OF BIRTHS
Central Falls	33%
Pawtucket	16%
Providence	21%
Woonsocket	18%
Four Core Cities	*20%*
Remainder of State	*5%*
Rhode Island	*11%*

Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal Child Health Database, 2013-2017.

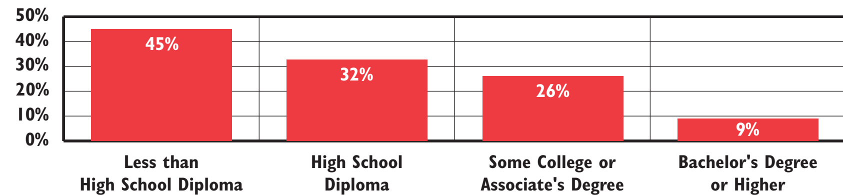
Births by Parental Education Levels, Rhode Island, 2013-2017



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal Child Health Database, 2013-2017.

◆ **In Rhode Island between 2013 and 2017, 32% of all infants were born to mothers with a high school diploma or less, and 36% were born to fathers with a high school diploma or less.[12]**

Poverty Rates for Families Headed by Single Women, by Educational Attainment, Rhode Island, 2013-2017



Source: U.S. Census Bureau, American Community Survey, 2013-2017. Table S1702.

◆ **In Rhode Island between 2013 and 2017, 45% of families headed by single females with less than a high school diploma lived in poverty, compared with 9% of those with a bachelor's degree or higher.[13]**

Mother's Education Level

Table 4.

Births by Education Level of Mother, Rhode Island, 2013-2017

CITY/TOWN	TOTAL # OF BIRTHS	BACHELOR'S DEGREE OR ABOVE		SOME COLLEGE		HIGH SCHOOL DIPLOMA		LESS THAN A HIGH SCHOOL DIPLOMA	
		N	%	N	%	N	%	N	%
Barrington	**537**	**406**	**76%**	**47**	**9%**	**30**	**6%**	**10**	*****
Bristol	**713**	**340**	**48%**	**177**	**25%**	**135**	**19%**	**27**	**4%**
Burrillville	**660**	**234**	**35%**	**184**	**28%**	**155**	**23%**	**38**	**6%**
Central Falls	**1,606**	**109**	**7%**	**285**	**18%**	**472**	**29%**	**532**	**33%**
Charlestown	**239**	**92**	**38%**	**62**	**26%**	**51**	**21%**	**11**	**5%^**
Coventry	**1,469**	**597**	**41%**	**436**	**30%**	**273**	**19%**	**75**	**5%**
Cranston	**3,912**	**1,650**	**42%**	**961**	**25%**	**722**	**18%**	**257**	**7%**
Cumberland	**1,717**	**954**	**56%**	**367**	**21%**	**203**	**12%**	**57**	**3%**
East Greenwich	**558**	**405**	**73%**	**67**	**12%**	**32**	**6%**	**11**	**2%^**
East Providence	**2,331**	**946**	**41%**	**543**	**23%**	**474**	**20%**	**166**	**7%**
Exeter	**238**	**121**	**51%**	**48**	**20%**	**36**	**15%**	**17**	**7%^**
Foster	**169**	**61**	**36%**	**54**	**32%**	**32**	**19%**	**6**	*****
Glocester	**333**	**142**	**43%**	**105**	**32%**	**49**	**15%**	**8**	*****
Hopkinton	**308**	**133**	**43%**	**79**	**26%**	**59**	**19%**	**12**	**4%^**
Jamestown	**116**	**80**	**69%**	**20**	**17%^**	**4**	*****	**1**	*****
Johnston	**1,328**	**511**	**38%**	**376**	**28%**	**256**	**19%**	**70**	**5%**
Lincoln	**997**	**491**	**49%**	**250**	**25%**	**138**	**14%**	**48**	**5%**
Little Compton	**83**	**40**	**48%**	**27**	**33%**	**6**	*****	**1**	*****
Middletown	**844**	**425**	**50%**	**185**	**22%**	**134**	**16%**	**29**	**3%**
Narragansett	**316**	**182**	**58%**	**64**	**20%**	**34**	**11%**	**7**	*****
New Shoreham	**57**	**23**	**40%**	**18**	**32%**	**7**	*****	**2**	*****
Newport	**1,303**	**591**	**45%**	**186**	**14%**	**227**	**17%**	**159**	**12%**
North Kingstown	**1,097**	**604**	**55%**	**196**	**18%**	**161**	**15%**	**50**	**5%**
North Providence	**1,627**	**623**	**38%**	**449**	**28%**	**327**	**20%**	**88**	**5%**
North Smithfield	**407**	**202**	**50%**	**102**	**25%**	**57**	**14%**	**15**	**4%^**
Pawtucket	**4,848**	**996**	**21%**	**1,217**	**25%**	**1,268**	**26%**	**761**	**16%**
Portsmouth	**618**	**351**	**57%**	**132**	**21%**	**67**	**11%**	**12**	**2%^**
Providence	**12,453**	**2,534**	**20%**	**2,542**	**20%**	**3,073**	**25%**	**2,605**	**21%**
Richmond	**280**	**142**	**51%**	**49**	**18%**	**57**	**20%**	**10**	*****
Scituate	**394**	**196**	**50%**	**101**	**26%**	**56**	**14%**	**8**	*****
Smithfield	**673**	**375**	**56%**	**160**	**24%**	**88**	**13%**	**11**	**2%^**
South Kingstown	**817**	**467**	**57%**	**131**	**16%**	**113**	**14%**	**35**	**4%**
Tiverton	**597**	**254**	**43%**	**165**	**28%**	**95**	**16%**	**27**	**5%^**
Warren	**455**	**175**	**38%**	**136**	**30%**	**83**	**18%**	**25**	**5%**
Warwick	**3,862**	**1,721**	**45%**	**1,021**	**26%**	**685**	**18%**	**179**	**5%**
West Greenwich	**230**	**116**	**50%**	**43**	**19%**	**42**	**18%**	**9**	*****
West Warwick	**1,720**	**456**	**27%**	**518**	**30%**	**454**	**26%**	**185**	**11%**
Westerly	**913**	**353**	**39%**	**214**	**23%**	**209**	**23%**	**58**	**6%**
Woonsocket	**2,925**	**432**	**15%**	**654**	**22%**	**972**	**33%**	**519**	**18%**
Unknown**	***217***	***104***	***49%***	***48***	***22%***	***37***	***17%***	***5***	*******
Four Core Cities	***21,832***	***4,071***	***19%***	***4,698***	***22%***	***5,785***	***26%***	***4,417***	***20%***
Remainder of State	***31,918***	***14,459***	***45%***	***7,673***	***24%***	***5,551***	***17%***	***1,724***	***5%***
Rhode Island	***53,967***	***18,633***	***35%***	***12,419***	***23%***	***11,373***	***21%***	***6,146***	***11%***

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal Child Health Database, 2013-2017. 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 2013 and 2017, maternal education levels were unknown for 5,395 births (10%).

*The data are statistically unreliable, and rates are not reported and should not be calculated.

** Unknown births include three births with missing maternal residence data.

^The data are statistically unstable, and rates or percentages should be interpreted with caution.

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

References

[1] *Parental education.* (2015). Washington, DC: Child Trends Data Bank.

[2] U.S. Department of Education, Institute for Education Sciences, National Center for Education Statistics. (2018). *The condition of education 2018.* Retrieved February 11, 2019, from nces.ed.gov/pubs2018/2018144.pdf

[3] 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. *The Lancet, 376*(9745), p. 959-974.

[4,10,12] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal Child Health Database, 2013-2017.

[5] Executive Office of the President of the United States. (2015). *The economics of early childhood investments.* Retrieved February 11, 2019, from obamawhitehouse.archives.gov/sites/default/files/docs/early_childhood_report_update_final_non-embargo.pdf

[6] *Early school readiness.* (2015). Washington, DC: Child Trends.

(continued on page 174)

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 2017, 51% of all U.S. children were non-Hispanic White.[3] By 2023, more than half of all children in the U.S. will be children of color.[4] In Rhode Island, the non-Hispanic White child population declined by 21% between 2000 and 2010, while the Hispanic child population grew by 31%.[5]

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

Including Hispanics in each race category, 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% identified as Some other race, and 7% identified as Two or more races. In 2010, 21% of children living in Rhode Island were Hispanic.[7]

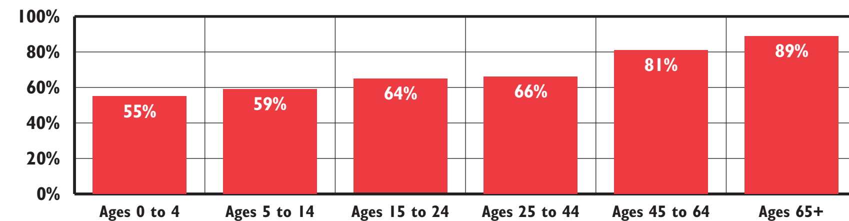
In 2010, more than two-thirds (67%) of all children of color in Rhode Island lived in the four core cities of Central Falls, Pawtucket, Providence, and Woonsocket. Almost three-quarters (74%) of children living in the four core cities were children of color.[8]

Between 2013 and 2017, there were 8,981 foreign-born children living in Rhode Island, 30% of whom were naturalized U.S. citizens.[9] Of Rhode Island's immigrant children, 29% were born in Asia, 25% were born in the Caribbean, 20% were born in Central or South America, 13% were born in Africa, 10% were born in Europe, and 1% were born in North America (Canada, Bermuda, or Mexico).[10]

Between 2013 and 2017, 23% of children between the ages of five and 17 living in Rhode Island spoke a language other than English at home, 96% of whom spoke English well or very well.[11]

Diversity presents both opportunities and challenges to 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. Many providers are focusing on a shift toward culturally competent services to serve increasingly diverse populations.[12]

Percent of Population Identified as Non-Hispanic White, by Age, Rhode Island, 2017



Source: U.S. Census Bureau, Population Estimates, 2017.

◆ **Young children in Rhode Island are less likely to be identified as non-Hispanic White than any other age group. Fifty-five percent of Rhode Island children under age five identify as non-Hispanic White, compared with 66% of adults ages 25 to 44 and 89% of people age 65 or over.[13]**

◆ **The median age of Hispanic Rhode Islanders in 2017 was 28 years, compared with 46 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 of 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), slightly above the US rate of 25%.[16] Nearly all (97%) children in Rhode Island immigrant families have parents who arrived in this country more than five years ago.[17]**

◆ **Sixteen percent of Rhode Island children in non-immigrant families are poor, compared with 20% of children in immigrant families.[18] Sixty-seven percent 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] Sixteen percent of Rhode Island children in immigrant families live in linguistically-isolated households, meaning no one 14 years or older speaks only English and no one over 14 speaks English "very well."[21]**

Table 5.

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

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

Source of Data for Table/Methodology

U.S. Census Bureau, Census 2010 Redistricting File. All categories are mutually exclusive. If Hispanic was selected as ethnicity, individuals are not included in other racial categories. Likewise, if more than one race was selected, individuals are included in Two or more races and not in their individual race categories.

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

References

[1] Federal Interagency Forum on Child and Family Statistics. (2017). *America's children: Key national indicators of well-being, 2017.* 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] The Annie E. Casey Foundation KIDS COUNT Data Center. (2018). *Child population by race–2012 - 2016.* Retrieved January 10, 2019, from www.datacenter.kidscount.org

[4] 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.

[5,6,7,8] U.S. Census Bureau, 2000 and 2010 Census.

[9] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017. Table B05003.

[10] Population Reference Bureau analysis of 2012-2015 American Community Survey PUMS data.

[11] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017. Table B16004.

[12] The Office of Planning, Research & Evaluation. (2014). *Enhancing cultural competence in social service agencies: A promising approach to serving diverse children and families.* Retrieved January 11, 2019, from https://www.acf.hhs.gov

[13,14] U.S. Census Bureau, Population Estimates, 2017.

[15] The Annie E. Casey Foundation KIDS COUNT Data Center. (2018). *Child population by nativity–2017.* Retrieved January 10, 2019, from datacenter.kidscount.org

(continued on page 174)

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 2013 and 2017, 19% of all Rhode Island children lived in poverty, 70% of whom were children of color.[4]

Black, Hispanic, and Native American children are more likely than White and Asian children to live in neighborhoods of concentrated poverty.[5] In 2010, two-thirds (67%) of Rhode Island's children of color 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 children of color.[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]

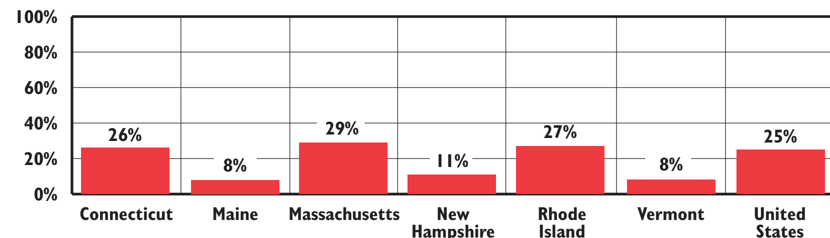
Black and Hispanic families were disproportionately impacted by the economic recession. In the U.S. between 2010 and 2013, White families' net worth rose by 2% while the net worth of Black and Hispanic families fell by 15% and 34% respectively. The median net worth of White households is more than 10 times greater than Black or Hispanic families.[10] In Rhode Island, Black and Hispanic families have higher rates of unemployment and earn lower wages 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 students of color and high-poverty.[13]**

◆ **Students in schools with high concentrations of low-income students and students of color 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, 2016-2017



Source: The Urban Institute Children of Immigrants Data Tool, Data from 2016-2017, www.urban.org
*Percentage reported represents children living in a family with at least one foreign-born parent.

◆ **Children in immigrant families are defined as children under age 18 living in a family with at least one foreign-born parent. In 2016-2017, 27% (55,000) of Rhode Island children were living in immigrant families.[16]**

◆ **More than half (54%) of Rhode Island's Hispanic children live in an immigrant family.[17]**

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

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Children in Poverty	14%	38%	29%	9%	64%	19%
Births to Mothers with <12 Years Education	6%	25%	13%	7%	23%	11%
Unemployment Rate	3.7%	7.2%	6.3%	NA	NA	4.1%
Median Family Income	$85,409	$37,585	$46,968	$80,024	$29,009	$79,043
Homeownership	65%	28%	31%	49%	19%	60%

Sources: *Children in Poverty* data are from the U.S. Census Bureau, American Community Survey, 2013-2017. Tables B17020, 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, 2013-2017 (race data is non-Hispanic). *Unemployment Rate* data are from the Bureau of Labor Statistics, Local Area Unemployment Statistics, 2018. *Median Family Income* data are from the U.S. Census Bureau, American Community Survey, 2013-2017, Tables B19113, B19113A, B19113B, B19113C, B19113D & B19113I. *Homeownership* data are from the U.S. Census Bureau, American Community Survey, 2013-2017, Tables B25003, B25003A, B25003B, B25003C, B25003D & B25003I. For U.S. Census Bureau data, Hispanics 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 2013 and 2017 in Rhode Island, 19% of all children, 64% of Native American children, 38% of Hispanic children, 29% of Black children, 14% of White children, and 9% of Asian children in Rhode Island lived in families with incomes below the federal poverty threshold.[18]**

◆ **Between 2013 and 2017 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.[19]**

◆ **In 2018 in Rhode Island, the unemployment rate among White workers was 3.7%, compared to 6.3% for Black workers and 7.2% for Hispanic workers. Nationally, the unemployment rate for White workers in 2018 was 3.5%, compared to 6.5% for Black workers and 4.7% for Hispanic workers.[20]**

◆ **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.[21] Hispanic, Native American, and Black 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.[22]**

Health Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Children Without Health Insurance	2.0%	3.9%	2.0%	4.4%	NA	2.1%
Women With Delayed or No Prenatal Care	12.2%	17.1%	21.8%	15.5%	15.3%	14.7%
Preterm Births	8.0%	9.3%	11.3%	7.7%	13.2%	8.7%
Low Birthweight Infants	6.4%	8.0%	11.2%	7.3%	12.3	7.4%
Infant Mortality (per 1,000 live births)	3.5	5.5	12.2	4.9^	*	5.5
Births to Teens Ages 15-19 (per 1,000 teens)	7.9	35.2	16.4	4.0	27.1	14.4

Sources: All data are from the Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017 unless otherwise specified. Race data is non-Hispanic. Information is based on self-reported race and ethnicity. *Children without Health Insurance* data are from the U.S. Census Bureau, American Community Survey, 2017, Tables B27001, B27001A, B27001B, B27001D & B27001I. 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 U.S. Census Bureau data, Hispanic also may be included in any of the race categories.

*The data are statistically unreliable and rates are not reported and should not be calculated.

^The data are statistically unstable and rates or percentages should be interpreted with caution.

◆ **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. Women of color are more likely than White women to receive delayed or no prenatal care and to have infants with low birth weight. Native American, Black, and Hispanic women are also more likely to have preterm births than White and Asian women. Black children are more likely to die in infancy than White, Hispanic, or Asian children. Hispanic, Native American, and Black youth are more likely than White and Asian youth to give birth as teenagers.[23]**

◆ **Black and Hispanic children in Rhode Island are more likely to go to the Emergency Department as a result of asthma than White children.[24] Nationally, children of Two or more races and Black children are the most likely of all racial and ethnic groups to have asthma.[25]**

◆ **In 2017, 95% of U.S. children had health insurance coverage. Hispanic (92%) and Native American (87%) children had the lowest rates of coverage.[26]**

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)	1.4	6.6	13.1	1.1	14.9	3.3
Children of Incarcerated Parents (per 1,000 children)	8.3	15.6	49.9	3.1	37.7	13.8
Children in Out-of-Home Placement (per 1,000 children)	6.2	13.4	16.6	1.7	10.1	7.1

Sources: *Youth at the Training School* data are from the Rhode Island Department of Children, Youth and Families, Rhode Island Training School, Calendar Year 2018. *Children of Incarcerated Parents* data are from the Rhode Island Department of Corrections, September 30, 2018 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, 2018. 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.

◆ **Youth of color continue to be disproportionately represented in the U.S. juvenile justice system. Youth of color (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.[27] Rhode Island's juvenile justice system continues to have a higher rate of disparity between White and youth of color than the nation.[28]**

◆ **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.[29] Nationally, children of color 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 have lower reunification rates.[30]**

◆ **Racial and ethnic disproportionality in child welfare and juvenile justice systems is in part a reflection of differential poverty rates between communities of color and White communities. However, while addressing poverty through policies would reduce out-of-home placement rates and juvenile incarceration rates, policies that work directly to reduce racial and ethnic disparities are necessary as well.[31]**

Education Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Third Grade Students Meeting Expectations in Reading	50%	25%	26%	44%	24%	40%
Third Grade Students Meeting Expectations in Math	45%	22%	21%	49%	15%	35%
Four-Year High School Graduation Rates	87%	77%	83%	92%	69%	84%
Immediate College Enrollment Rates	68%	46%	52%	65%	47%	61%
% of Adults Over Age 25 With a Bachelor's Degree or Higher	35%	14%	20%	49%	15%	33%

Sources: *Third Grade Students Meeting Expectations in Reading and Math* data are from the Rhode Island Department of Education, *Rhode Island Comprehensive Assessment System (RICAS)*, 2018. *Four Year High School Graduation Rates* data are from the Rhode Island Department of Education, Class of 2018. *Immediate College Enrollment Rates* data are from the Rhode Island Department of Education, Class of 2017. *Adult Educational Attainment* data are from the U.S. Census Bureau, American Community Survey, 2013-2017, 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, Black, and Hispanic children are less likely to meet expectations in reading and mathematics in third grade than White or Asian children.[32]**

◆ **Nationally and in Rhode Island, Native American, Hispanic, and Black students are less likely to graduate from high school within four years and are less likely to immediately enroll in college than White or Asian students. Gaps in college enrollment are particularly large for four-year college enrollment.[33,34]**

◆ **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.[35,36] In Rhode Island during the 2017-2018 school year, students of color received 54% of all disciplinary actions, although they made up only 42% of the student population.[37]**

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.[38]**

◆ **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.[39]**

◆ **Rhode Island's Latino children are ranked lowest in the nation on the Race for Results Opportunity Index that measures indicators of child opportunity, including health, education, and economic well-being.[40]**

Economics

◆ **Between 2013 and 2017, 37% percent of Rhode Island's Hispanic children were living in poverty, compared to 29% of Hispanic children nationally. The median family income for Hispanics in Rhode Island was $34,514, compared to $79,043 overall in Rhode Island.[41]**

Health

◆ **In Rhode Island between 2013 and 2017, 17.1% percent of Hispanic babies were born to women who received delayed or no prenatal care, compared with 14.7% of all babies in the state.[42]**

◆ **Between 2013 and 2017, Hispanic teens between the ages of 15 and 19 in Rhode Island had a birth rate that was more than twice as high as the overall teen birth rate in Rhode Island (35.2 per 1,000 Hispanic teens ages 15 to 19 compared to 14.4 per 1,000 for all teens).[43]**

Education

◆ **The four-year high school graduation rate among Hispanic youth in the class of 2018 was 77%, compared to Rhode Island's four-year high school graduation rate for all races of 84%.[44]**

◆ **The achievement gap between White and Latino students in Rhode Island is among the largest in the U.S.[45]**

References

[1,6,38,39] 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), 1-28.

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

[4,18,19,26,33,41] U.S. Census Bureau, American Community Survey, 2013-2017. Tables B17001, B17020A, B17020B, B17020C, B17020D, B17020H, B17020I, B27001A, B27001B, B27001C, B27001D, B27001I, B25003, B25003A, B25003B, B25003C, B25003D, B25003I, B15003, C15002A, C15002B, C15002C, C15002D, C15002I, B19013I, B19113, B01001I & B17001I.

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

[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.* (2016). Baltimore, MD: The Annie E. Casey Foundation.

[11] *State of working Rhode Island 2017: Paving the way to good jobs.* (2017). 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).

[16,17] The Urban Institute, Children of Immigrants Data Tool Data From 2016-2017, www.urban.org

[20] *Employment status of the civilian noninstitutional population by sex, race, Hispanic or Latino ethnicity, and detailed age, 2018 annual averages - Rhode Island and United States.* (2019). U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics.

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

[22,23,42,43] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017.

[24] Rhode Island Department of Health, Hospital Discharge Database, 2013-2017.

[25] National Health Interview Survey. (2017). Table C-1a. *Age adjusted percentages (with standard errors) of ever having asthma and still having asthma for children under 18 years, by selected characteristics: United States, 2017.* Retrieved March 18, 2019, from www.cdc.gov

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

[28] The W. Haywood Burns Institute. (n.d.) *Unbalanced justice.* Retrieved March 11, 2018, from data.burnsinstitute.org

[29] Rhode Island Department of Children, Youth and Families, RICHIST, December 31, 2018.

[30] *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.

(continued on page 174)

Economic Well-Being

A Father s Hands
by Rebecca Kai Dotlich

Gently shake
you awake.
Brush.
Braid.
Break eggs.
Write letters.
Patch tires.
Put out fires.
A father's hands
stack books.
Stir soup.
Pull weeds.
Lead.
Pound nails.
Steer sails.
A father's hands
lift.
Hold.
Build. Fold.
Swing bats.
Feed cats.
Paint. Sweep.
Peel.
Heal.

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 2017, the median family income for Rhode Island families with their own children was $79,967.[1] Rhode Island had the 12th highest median family income nationally and the 4th highest in New England.[2]

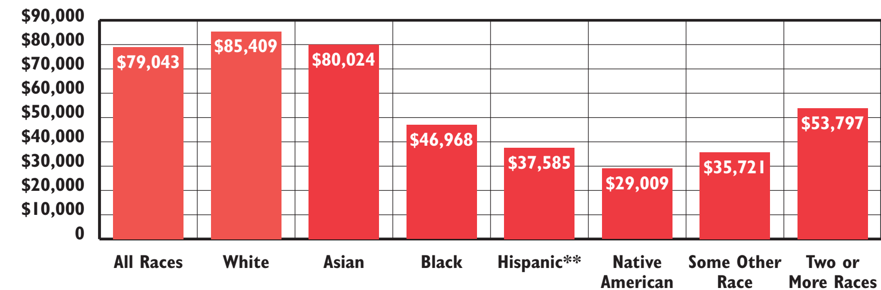
Between 2013 and 2017, Rhode Island's median income for families with their own children differed significantly by family type. The median family income for married two-parent families ($102,759) was almost two and a half times that of male-headed single-parent families ($42,018) and more than three and a half times that of female-headed single-parent families ($27,380).[3]

Rhode Island had the nation's highest unemployment rate in 2010 (11.3%), but by 2017 the state's unemployment rate had decreased to 4.2%, the same as the national unemployment rate, and only slightly higher than the overall New England rate (3.9%). Despite declines in unemployment, Rhode Island continues to have gaps in unemployment rates by race and ethnicity. In 2018, Rhode Island's unemployment rate for White workers was 3.7%, while it was 6.3% for Black workers and 7.2% for Hispanic workers.[4,5]

While Rhode Island's unemployment rate has declined, many workers remain unable to find full-time employment and struggle to make ends meet with inadequate and unpredictable income.[6] Almost 24 million people in the U.S. work in low-wage jobs where they are paid $11.50 per hour or less.[7] 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.[8]

In Rhode Island over the past few decades, income inequality has grown. In 2015, the top 1% of Rhode Island households had average incomes ($928,204) that were 18 times more than the bottom 99% ($50,963) of households. Rhode Island is ranked 32nd of the 50 states in income inequality based on the ratio of top 1% to bottom 99% income.[9]

Median Family Income by Race and Ethnicity, Rhode Island, 2013-2017*



Source: U.S. Census Bureau, American Community Survey, 2013-2017. Tables B19113, B19113A, B19113B, B19113C, B19113D, B19113F, B19113G, and B19113I. *Median Family Income by race and ethnicity includes all families because data for families with "own children" are not available by race and ethnicity. **Hispanics may be in any race category.

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

◆ **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 compared to residents who have only completed high school. More than one in three Hispanic and more than one in five Black adults in Rhode Island lack a high school diploma, compared to one in ten White adults.[11]**

◆ **According to the *2018 Rhode Island Standard of Need*, it costs a single-parent family with two young children $55,115 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 $62,844 to meet this budget without government subsidies.[12]**

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

Table 6. **Median Family Income, Rhode Island, 2013-2017**

CITY/TOWN	1999 MEDIAN FAMILY INCOME FOR FAMILIES WITH CHILDREN UNDER AGE 18 (ADJUSTED TO 2017 DOLLARS*)	2013-2017 MEDIAN FAMILY INCOME FOR FAMILIES WITH CHILDREN UNDER AGE 18: ESTIMATES WITH HIGH MARGINS OF ERROR**	2013-2017 MEDIAN FAMILY INCOME FOR FAMILIES WITH CHILDREN UNDER AGE 18: ESTIMATES WITH LOWER, ACCEPTABLE MARGINS OF ERROR
Barrington	$131,049		$153,318
Bristol	$78,706		$82,067
Burrillville	$81,299		$80,025
Central Falls	$32,481		$29,935
Charlestown	$81,291		$88,520
Coventry	$90,553		$100,471
Cranston	$83,983		$78,750
Cumberland	$100,789		$104,167
East Greenwich	$160,214		$158,889
East Providence	$72,134		$67,991
Exeter	$108,092	$109,957	
Foster	$93,549		$101,250
Glocester	$89,937		$111,902
Hopkinton	$87,179		$101,837
Jamestown	$117,442	$151,836	
Johnston	$83,595	$81,357	
Lincoln	$95,150	$79,694	
Little Compton	$83,651	$96,250	
Middletown	$81,618		$74,836
Narragansett	$100,729		$134,706
New Shoreham	$80,943	$64,375	
Newport	$63,647		$81,597
North Kingstown	$98,567		$107,455
North Providence	$74,522		$75,154
North Smithfield	$104,885		$106,047
Pawtucket	$49,533		$42,969
Portsmouth	$99,437		$115,101
Providence	$36,227		$37,183
Richmond	$93,677		$105,400
Scituate	$102,035		$93,929
Smithfield	$98,958		$121,579
South Kingstown	$100,751		$117,059
Tiverton	$94,191		$80,727
Warren	$79,022	$61,250	
Warwick	$84,181		$85,346
West Greenwich	$103,533		$111,908
West Warwick	$61,736		$60,641
Westerly	$76,707	$72,143	
Woonsocket	$50,866		$31,883
Four Core Cities	*NA*		*NA*
Remainder of State	*NA*		*NA*
Rhode Island	*$74,616*		*$72,430*

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 2017 constant dollars by multiplying 1999 dollar values by 1.47587899 as recommended by the U.S. Census Bureau.

The 2013-2017 data come from a Population Reference Bureau analysis of 2013-2017 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, 2017. Table B19125.

[2] U.S. Census Bureau, American Community Survey, 2017. Table R1902.

[3] U.S. Census Bureau, American Community Survey, 2013-2017. Table B19126.

[4,6,11] *State of working Rhode Island 2017: Paving the way to good jobs.* (2017). Providence, RI: The Economic Progress Institute.

[5] *Employment status of the civilian noninstitutional population by sex, race, Hispanic or Latino ethnicity, and detailed age, 2017 annual averages – Rhode Island and United States.* (2017). U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics.

[7] Patrick, K., Berlan, M., & Harwood, M. (2018). *Low-wage jobs held primarily by women will grow the most over the next decade.* Washington, DC: National Women's Law Center.

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

[9] Sommeiller, E. & Price, M. (2018). *The new gilded age: Income inequality in the U.S. by state, metropolitan area, and county.* Washington, DC: Economic Policy Institute.

[10] U.S. Census Bureau, American Community Survey, 2013-2017. Tables B19113, B19113A, B19113B, B19113C, B19113D, B19113F, B19113G, & B19113I.

[12,13] *The 2018 Rhode Island standard of need.* (2018). 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

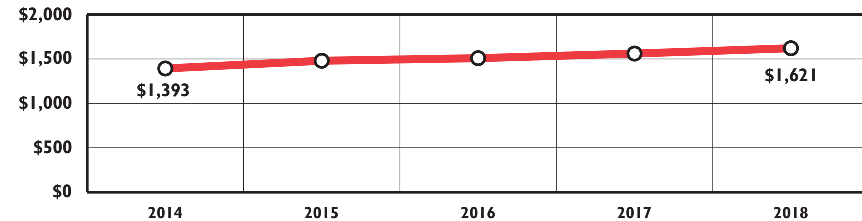
Poor quality, unaffordable, or crowded housing has a negative impact on children's physical health, development, and emotional well-being and on a family's ability to meet a child's basic needs. Children who live in families with cost burdens may live in low-quality and overcrowded housing and move frequently, all of which have been linked to lower educational achievement and increased risk of homelessness.[2,3]

In 2018, a worker would have to earn $31.17 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 three times the 2018 minimum wage of $10.10 per hour.[4] In 2017, Rhode Island required the 18th highest hourly wage to afford the rent for a two-bedroom home of any state.[5]

In 2018, the Area Median Income for families in Rhode Island was $81,384.[6] Families with this income can afford to purchase a median-priced, single-family home in 16 of the 39 communities in the state. In 2017, the median cost of a single-family home in Rhode Island was $255,000, 25% higher than in 2012, but still 22% lower than in 2007.[7]

Federally-funded Section 8 Housing Choice rental vouchers can help low-income individuals and families afford the cost of housing; however, there are not enough vouchers to meet the need. Long waiting periods are common and housing authorities may close waiting lists when there are more families on the list than can be helped in the near future.[8] Rhode Island's FY 2015 budget increased the real estate conveyance tax and created a dedicated funding stream for housing subsidies as well as homelessness prevention, housing retention, and lead abatement.[9] Rhode Island invests $5.21 per capita in affordable homes, compared to neighboring Massachusetts which invests $100.12 per capita, 20 times as much. Rhode Island State Law establishes a goal that 10% of every community's housing stock qualify as Low- and Moderate-Income Housing. Currently, only six of Rhode Island's 39 cities and towns meet that goal.[10]

Average Rent, Two-Bedroom Apartment, Rhode Island, 2014-2018



Source: Rhode Island Housing, Rhode Island Rent Surveys, 2014-2018. 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.

- **In 2018, the average cost of rent in Rhode Island rose by almost $60 from $1,561 in 2017 to $1,621, increasing 16% since 2014.[11]**

- **The percentage of renters in Rhode Island who spent 30% or more of their household income on rent was 46% in 2017, down from 49% in 2008. The percentage of homeowners who had a cost burden due to their mortgages decreased from 42% in 2008 to 32% in 2017.[12,13]**

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 are also at risk of food insecurity, poor health, and developmental delays.[14]**

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

- **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.[16] Rhode Island's FFY 2018 allocation for LIHEAP was $26.9 million.[17] In 2016, Rhode Island created a LIHEAP Enhancement Plan that established per-payment forgiveness of utility debt and allowed previously homeless families to obtain a crisis grant to cover the down payment required to participate in this program.[18]**

Table 7.

Cost of Housing for Very Low-Income Families, Rhode Island, 2018

	FAMILY INCOME		HOMEOWNERSHIP COSTS		RENTAL COSTS		
CITY/TOWN	2018 POVERTY LEVEL FAMILY OF THREE	2018 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	$20,780	$36,150	$3,113	103%	$1,293	75%	43%
Bristol	$20,780	$36,150	$2,212	73%	$1,346	78%	45%
Burrillville	$20,780	$36,150	$1,773	59%	$914	53%	30%
Central Falls	$20,780	$36,150	$1,069	35%	$1,410	81%	47%
Charlestown*	$20,780	$36,150	$2,348	78%	$1,014	59%	34%
Coventry	$20,780	$36,150	$1,756	58%	$1,626	94%	54%
Cranston	$20,780	$36,150	$1,764	59%	$1,606	93%	53%
Cumberland	$20,780	$36,150	$1,935	64%	$1,846	107%	61%
East Greenwich	$20,780	$36,150	$3,478	115%	$1,653	95%	55%
East Providence	$20,780	$36,150	$1,712	57%	$1,630	94%	54%
Exeter	$20,780	$36,150	$2,198	73%	$1,123	65%	37%
Foster*	$20,780	$36,150	$2,240	74%	$1,014	59%	34%
Glocester*	$20,780	$36,150	$2,066	69%	$1,014	59%	34%
Hopkinton*	$20,780	$36,000	$1,843	61%	$1,161	67%	39%
Jamestown*	$20,780	$36,150	$4,060	135%	$1,014	59%	34%
Johnston	$20,780	$36,150	$1,822	60%	$1,759	102%	58%
Lincoln	$20,780	$36,150	$2,454	81%	$1,647	95%	55%
Little Compton*	$20,780	$36,150	$3,500	116%	$1,014	59%	34%
Middletown	$20,780	$42,350	$2,646	75%	$1,579	91%	45%
Narragansett	$20,780	$36,150	$2,713	90%	$1,550	90%	51%
New Shoreham*	$20,780	$36,000	$5,787	193%	$1,161	67%	39%
Newport	$20,780	$42,350	$2,966	84%	$1,572	91%	45%
North Kingstown	$20,780	$36,150	$2,395	80%	$1,522	88%	51%
North Providence	$20,780	$36,150	$1,756	58%	$1,501	87%	50%
North Smithfield	$20,780	$36,150	$2,004	67%	$1,349	78%	45%
Pawtucket	$20,780	$36,150	$1,492	50%	$1,374	79%	46%
Portsmouth	$20,780	$42,350	$2,658	75%	$1,782	103%	50%
Providence**	$20,780	$36,150	$1,257	42%	$1,760	102%	58%
Richmond*	$20,780	$36,150	$2,131	71%	$1,014	59%	34%
Scituate*	$20,780	$36,150	$2,055	68%	$1,014	59%	34%
Smithfield	$20,780	$36,150	$2,107	70%	$1,156	67%	38%
South Kingstown*	$20,780	$36,150	$2,426	81%	$1,014	59%	34%
Tiverton	$20,780	$36,150	$2,065	69%	$1,532	88%	51%
Warren	$20,780	$36,150	$2,028	67%	$1,653	95%	55%
Warwick	$20,780	$36,150	$1,611	53%	$1,601	92%	53%
West Greenwich	$20,780	$36,150	$2,664	88%	$1,933	112%	64%
West Warwick	$20,780	$36,150	$1,597	53%	$1,548	89%	51%
Westerly	$20,780	$36,000	$2,106	70%	$1,463	84%	49%
Woonsocket	$20,780	$36,150	$1,497	50%	$1,177	68%	39%
Four Core Cities	*$20,780*	*$36,150*	*$1,329*	*44%*	*$1,637*	*95%*	*54%*
Remainder of State	*$20,780*	*$36,669*	*$2,400*	*79%*	*$1,614*	*93%*	*53%*
Rhode Island	*$20,780*	*$36,350*	*$1,851*	*61%*	*$1,621*	*94%*	*54%*

Source of Data for Table/Methodology

2018 poverty level for a family of three as reported in: *Federal Register, 82*(19), January 31, 2018, pages 8831-8832.

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 defined separately for each of the three metropolitan areas comprising Rhode Island and for the state as a whole. Core city and remainder of state are calculated by Rhode Island KIDS COUNT using unweighted community data. Reported by Rhode Island Housing. (2018). *2018 Rhode Island income limits for low- and moderate-income households.* Retrieved January 29, 2019, from www.rhodeislandhousing.org

Data on typical monthly housing payments are from HousingWorks RI's *2018 Housing Fact Book.* They are based on the median selling price of a single-family home using year-end 2017 data and calculated based on a 30-year mortgage at a 3.65% 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 by Rhode Island KIDS COUNT using unweighted community data.

Rhode Island Housing, *Rhode Island Rent Survey*, 2018. Estimates include rent and utility costs. Starting with the *2019 Factbook* average rent is calculated using the CoStar database for two-bedroom units. Average utility costs from the U.S. Census American Community Survey's annual one-year sample, which includes gas, fuel, water, and electricity for two-bedroom units. All values are in unadjusted dollars. Statewide average based on all units in state. Data cannot be compared to prior Factbooks.

*Rhode Island Housing 2018 *Rhode Island Rent Survey* data are not available. Average rent used for these communities is the HUD 2018 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 *Rhode Island 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 Rhode Island Housing.

(Sources continued with References on page 175)

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]

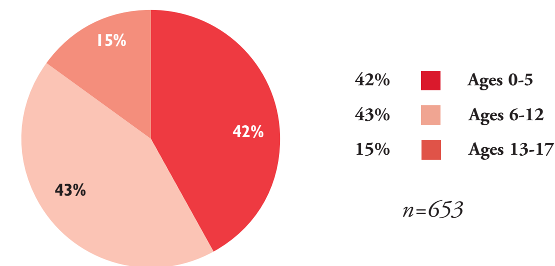
Homeless children are at a higher risk of abuse and exposure to violence. This trauma can lead to an increase in developmental delays and emotional distress and a decrease in academic achievement.[6,7] When homeless children are exposed to multiple traumatic events, they may have increased levels of 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 2018, 403 families with 653 children stayed at an emergency homeless shelter, domestic violence shelter, or transitional housing facility in Rhode Island. Children made up 17% of the people who used emergency homeless shelters, domestic violence shelters, and transitional housing in 2018. Forty-two percent of these children were under age six, not yet school age. As of December 12, 2018, there were 152 families on the state's wait list awaiting shelter.[11]

In 2018, United Way 211 received 95,406 calls from individuals and families seeking housing or shelter and 2,980 related to foreclosure prevention.[12]

Children in Emergency Shelters, Domestic Violence Shelters, and Transitional Housing Facilities by Age, 2018



Source: Rhode Island Emergency Shelter Information Project, 2018.

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 chronically absent from school, and have lower academic achievement than children who have housing.[13] In Rhode Island, just 60.7% of homeless students graduate high school on-time compared to 84.1% of all students.[14]**

◆ **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 including health, dental, and mental health services, tutoring, etc., needed to help them succeed in school.[15]**

◆ **The *McKinney-Vento Act* defines a child as homeless if he or she does not have a "fixed, regular and adequate night-time residence."[16] During the 2017-2018 school year, Rhode Island public school personnel identified 1,579 children as homeless. Of these children, 72% lived with other families ("doubled up"), 19% lived in shelters, 7% lived in hotels or motels, and 2% were unsheltered.[17]**

◆ **The federal *Every Student Succeeds Act (ESSA)*, which re-authorized *McKinney-Vento* in 2015, strengthens existing provisions for homeless students, guarantees school stability for students starting in preschool, and requires schools to report on student achievement and graduation rates for homeless students.[18]**

Supporting Young Children Experiencing Homelessness

◆ Many homeless families are comprised of single mothers with children. There are significant barriers to employment for these mothers experiencing homelessness, including low levels of education, lack of employment histories, and unreliable childcare. To secure stable employment, homeless parents need education, job skills, and safe, dependable care for their children.[19]

◆ The Child Care and Development Fund (CCDF) is a federal and state partnership program authorized under the Child Care and Development Block Grant Act (CCDBG). CCDF provides financial assistance to low-income families for child care, so parents can attend work, job training, or educational programs.[20]

◆ Despite the fact that early care and education can help mitigate the impacts of homelessness on children, homeless parents are less likely to receive child care assistance than other families.[21]

◆ New CCDBG regulations were issued in 2016. Under the new regulations, homeless children are considered a priority category. Offering priority to families experiencing homelessness can include prioritizing enrollment and waiving copayments for child care.[22]

Table 8. **Homeless Children Identified by Public Schools, Rhode Island, 2017-2018 School Year**

SCHOOL DISTRICT	TOTAL ENROLLMENT	# OF CHILDREN IDENTIFIED AS HOMELESS BY PUBLIC SCHOOL PERSONNEL
Barrington	3,362	*
Bristol Warren	3,226	24
Burrillville	2,273	52
Central Falls	2,518	113
Chariho	3,211	33
Coventry	4,746	96
Cranston	10,364	46
Cumberland	4,647	11
East Greenwich	2,498	0
East Providence	5,267	41
Exeter-West Greenwich	1,680	*
Foster	295	*
Foster-Glocester	1,257	16
Glocester	540	*
Jamestown	494	*
Johnston	3,265	*
Lincoln	3,083	20
Little Compton	248	0
Middletown	2,181	107
Narragansett	1,323	*
New Shoreham	2,237	0
Newport	120	96
North Kingstown	3,955	42
North Providence	3,631	46
North Smithfield	1,734	*
Pawtucket	8,738	68
Portsmouth	2,442	*
Providence	24,075	261
Scituate	1,269	0
Smithfield	2,395	54
South Kingstown	3,069	34
Tiverton	1,835	0
Warwick	8,953	84
West Warwick	2,790	10
Westerly	3,588	64
Woonsocket	5,982	129
Charter Schools	*7,909*	*48*
State-Operated Schools	*1,749*	*10*
UCAP	*136*	*0*
Four Core Cities	*41,313*	*571*
Remainder of State	*91,842*	*968*
Rhode Island	*142,949*	*1,539*

Source of Data for Table/Methodology

Rhode Island Department of Education, Public School Enrollment in grades preschool to 12 on October 1, 2017.

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 include Achievement First Rhode Island, Beacon Charter School, Blackstone Academy, Blackstone Valley Prep Mayoral Academy, Charette Charter, The Compass School, The Greene School, Highlander, International Charter, Kingston Hill Academy, Learning Community, Paul Cuffee Charter School, Rhode Island Nurses Institute, RISE Prep Mayoral Academy, Segue Institute for Learning, Sheila C. "Skip" Nowell Leadership Academy, Southside Charter School, Trinity Academy for the Performing Arts, and Village Green Virtual. State-operated schools reporting include the Metropolitan Regional Career & Technical Center and the Rhode Island School for the Deaf.

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 state, and state totals.

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

References

[1,4,19] Bassuk, E.L., DeCandia, C.J., Beach, C.A., & Berman, F. (2014). *America's youngest outcasts: A report card on child homelessness.* Needham, MA: The National Center on Family Homelessness.

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

(continued on page 175)

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. 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.[1,2]

Rhode Island's unemployment rate decreased from 4.5% in December 2017 to 3.9% in December 2018 and is now at the same level as the U.S. unemployment rate. During the recession in December 2009, Rhode Island's unemployment rate was 11.1%.[3,4]

In 2017, 6% of children in Rhode Island and 5% of children in the U.S. had at least one unemployed parent.[5] Children with unemployed parents are at increased risk for homelessness, child abuse or neglect, and failure to finish high school or college.[6]

Even when families have adults with secure parental employment, low wages cause many families to remain in poverty. Nationally, 30% of working families are low income (9.9 million). While the number of low-income working families fell slightly between 2015 and 2016, there are more low-income working families than at the onset of the recession in 2007 (9.5 million). Additionally, people of color are overrepresented among low-income working families. In 2016, families headed by people of color represented 41% of all working families, while accounting for 60% of low-income working families. In the workforce, low-income individuals tend to have few opportunities for advancement, limited benefits, and an overall lack of economic security.[7]

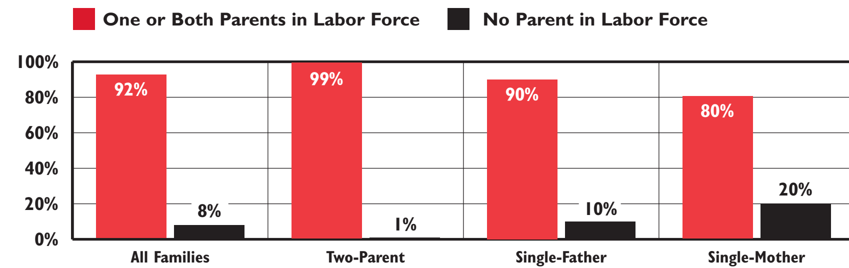
Children Living in Families Where No Parent Has Full-Time, Year-Round Employment

	2010	2016
RI	34%	31%
US	33%	28%
National Rank*		*38th*
New England Rank**		*6th*

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

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

Employment Status of Parents by Family Type, Rhode Island, 2013-2017



Source: U.S. Census Bureau, American Community Survey, 2013-2017. Table B23008.

◆ **The majority of children living in Rhode Island between 2013 and 2017 had one or both parents in the labor force. Children living with a single parent were 12 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, 71% had both parents in the labor force.[8]**

◆ **Between 2013 and 2017, there were 15,497 Rhode Island children living in families with no parent in the labor force. Children living in families with a single parent represented 88% (13,623) of families with no employed parents.[9]**

◆ **Between 2013 and 2017, 16% (3,923) of Rhode Island families with incomes below the federal poverty threshold had at least one adult with full-time, year-round employment, and 41% of Rhode Island families living in poverty had at least one adult working part-time.[10]**

◆ **According to the *2018 Rhode Island Standard of Need*, 67% of Rhode Island single-parent families and 28% 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.[11]**

◆ **Between 2013 and 2017, 72% of children under age six and 76% 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.[12]**

Barriers to Secure Employment for Low-Income Families

◆ **Families leaving cash assistance can face many barriers to employment. Research shows that families who leave welfare due to time limits or sanctions often have barriers such as mental and physical impairments, a child with a disability, or learning disabilities that can impede their ability to secure or sustain employment.[13]**

◆ **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.[14] 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.[15] In 2013, Rhode Island passed legislation that created the Temporary Caregivers Insurance (TCI) Program, 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.[16] Rhode Island is one of six states that offer paid family leave.[17]**

◆ **Limited education also can be a barrier to sustained employment. Between 2013 and 2017 in Rhode Island, adults without a high school diploma were nearly four times as likely to be unemployed as those with a bachelor's degree.[18]**

◆ **Having access to work supports, such as tax credits, SNAP/food stamps, child care, and health insurance, can facilitate steady employment over time. Researchers have found links between these programs and positive employment outcomes for parents, such as work stability and earnings.[19]**

References

[1] Federal Interagency Forum on Child and Family Statistics. (2017). *America's children: Key national indicators of well-being, 2017.* Washington, DC: U.S. Government Printing Office.

[2] Isaacs, J. (2013). *Unemployment from a child's perspective.* Washington, DC: Urban Institute and First Focus.

[3] Rhode Island Department of Labor and Training. (n.d.). *Rhode Island labor force statistics, seasonally adjusted 1976-present.* Retrieved January 17, 2019, from www.dlt.ri.gov

[4] Rhode Island Department of Labor and Training. (n.d.). *United States labor force statistics seasonally adjusted (in thousands) 1978-present.* Retrieved January 7, 2019, from www.dlt.ri.gov

[5] The Annie E. Casey Foundation KIDS COUNT Data Center. (2018). *Children with at least one unemployed parent - 2017.* Retrieved March 14, 2019, from www.datacenter.kidscount.org

[6] Lovell, P. & Isaacs, J. B. (2010). *Families of the recession: Unemployed parents and their children.* Washington, DC: First Focus.

[7] Jarosz, B. & Mather, M. (2018). *Low-income working families: Rising inequality despite economic recovery.* Retrieved January 7, 2019, from www.workingpoorfamilies.org

[8,9] U.S. Census Bureau, American Community Survey, 2013-2017. Table B23008.

(continued on page 175)

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 affordable child care arrangements affected their ability to remain employed.[20]**

◆ **In 2017 in Rhode Island, a single mother earning the state median income for a single-parent family ($26,809) would have to spend half (49.9%) of her income to pay for child care for an infant in center-based care.[21]**

◆ **In Rhode Island, child care assistance is available to all income-eligible working families with incomes at or below 180% of the federal poverty level ($38,394 for a family of three in 2019). Families may continue to receive their child care subsidy until their income reaches 225% of the federal poverty level ($47,993 for a family of three).[22,23,24]**

Earned Income Tax Credit (EITC) and Child Tax Credit (CTC)

◆ **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 serve as an incentive to work for families struggling to make ends meet. The federal EITC is the nation's most effective antipoverty program for working families. It lifted 5.8 million people, including about 3 million children, out of poverty in 2016.[25,26]**

◆ **Benefits of the EITC 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.[27]**

◆ **State EITCs can supplement the federal EITC to further support working families. In 2016, the Rhode Island General Assembly increased the state's EITC from 12.5% to 15% of the federal EITC. In 2017, approximately 81,000 Rhode Island working families and individuals received a total of $185 million in federal EITC tax credits.[28,29]**

◆ **The Child Tax Credit (CTC) helps working families offset the cost of raising children. The CTC lifted 2.7 million people out of poverty in 2016, including 1.5 million children. Boosting a family's income can expand opportunities for children and improve their immediate well-being, as well as improve outcomes into adulthood.[30]**

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 Program (TCI).

SIGNIFICANCE

Rhode Island's Temporary Caregiver Insurance (TCI) program, established in 2014, provides up to four weeks of partial 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]

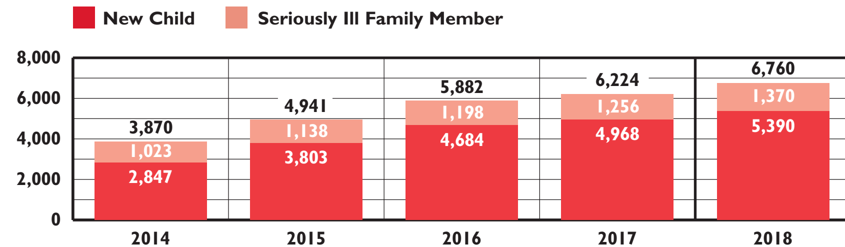
Almost all advanced, industrialized nations guarantee paid leave for new mothers and many include new fathers. In many European countries, families receive at least six months of paid leave to care for a new baby.[2] The U.S. requires employers with 50 or more workers to offer 12 weeks of leave for workers 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. 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 from 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. Providing time off from work for new parents gives babies time to form secure attachments, which form the foundation for healthy relationships and development.[6,7,8,9]

Rhode Island's Temporary Disability Insurance Program (TDI) provides partial-wage replacement for participating workers who are temporarily unable to work because of a physical or mental condition, including pregnancy complications and recovery from childbirth.[10,11] TCI supplements TDI; women who give birth are eligible for both.

Approved Temporary Caregiver Insurance Claims by Type, Rhode Island, 2014-2018



Source: Rhode Island Department of Labor and Training, TCI Program, 2014-2018

◆ **There were 6,760 approved claims for TCI during 2018 (up from 6,224 in 2017); 80% were to bond with a new child and 20% were to care for a seriously ill family member. Forty-four percent of individuals contributing to TDI/TCI earn less than $20,000, yet only 16% of all approved TCI claims were for an individual with wages in this category.[12]**

◆ **Of the 5,390 approved claims to bond with a new child, 98% (5,256) were for a newborn child and 2% were for a newly adopted (27), foster (64), or other child (43). Forty-one percent of claims to bond with a new child were filed by men and 59% were filed by women.[13]**

◆ **Of the 1,370 approved claims to care for a seriously ill family member, 55% were to care for a spouse or domestic partner, 30% were to care for a parent or parent-in-law, 14% were to care for a child, and 1% were to care for a grandparent. Thirty-one percent of claims to care for a seriously ill family member were filed by men and 69% were filed by women.[14]**

Temporary Disability Insurance for Pregnancy Complications & Childbirth

◆ **In 2018, there were 1,532 approved TDI claims for disabling pregnancy complications and 1,798 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 Claims for Paid Family Leave, Rhode Island, 2018**

	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	13	24	37	54	15	69
Bristol	15	20	35	71	21	92
Burrillville	19	24	43	59	20	79
Central Falls	28	30	58	58	14	72
Charlestown	6	18	24	20	12	32
Coventry	46	66	112	211	65	276
Cranston	111	128	239	431	108	539
Cumberland	44	56	100	158	38	196
East Greenwich	12	35	47	64	12	76
East Providence	71	65	136	226	68	294
Exeter	11	5	16	30	11	41
Foster	*	9	13	33	*	36
Glocester	11	14	25	47	12	59
Hopkinton	8	5	13	31	14	45
Jamestown	0	5	5	23	*	27
Johnston	38	48	86	177	50	227
Lincoln	22	18	40	66	25	91
Little Compton	0	0	0	6	*	8
Middletown	21	26	47	34	17	51
Narragansett	*	9	13	25	9	34
New Shoreham	0	0	0	0	0	0
Newport	32	24	56	58	8	66
North Kingstown	25	42	67	128	25	153
North Providence	42	44	86	160	52	212
North Smithfield	14	12	26	35	18	53
Pawtucket	114	114	228	385	84	469
Portsmouth	17	21	38	67	12	79
Providence	307	328	635	874	177	1,051
Richmond	5	8	13	19	9	28
Scituate	11	33	44	46	21	67
Smithfield	29	15	44	110	26	136
South Kingstown	21	26	47	81	24	105
Tiverton	12	17	29	46	13	59
Warren	9	20	29	39	12	51
Warwick	123	131	254	482	134	616
West Greenwich	12	9	21	26	8	34
West Warwick	60	53	113	228	38	266
Westerly	25	26	51	78	20	98
Woonsocket	39	65	104	158	34	192
Out-of-State	*151*	*205*	*356*	*546*	*135*	*681*
Four Core Cities	*488*	*537*	*1,025*	*1,475*	*309*	*1,784*
Remainder of State	*893*	*1,056*	*1,949*	*3,369*	*917*	*4,295*
Rhode Island	*1,381*	*1,593*	*2,974*	*4,844*	*1,226*	*6,079*
Total Program Claims	*1,532*	*1,798*	*3,330*	*5,390*	*1,370*	*6,760*

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, 2018. Approved TDI claims for pregnancy complications include cesarean births. TDI claims approved for pregnancy complications retain that code regardless of when the birth happens so they are not counted in the childbirth column.

In 2018 in Rhode Island, the average length of approved TDI claims for pregnancy complications was 9.6 weeks. The average length of approved TCI claims to bond with a new child was 3.2 weeks while the average number of weeks approved to care for a seriously ill family member was 2.8 weeks.

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. Employees of certain governmental entities do not contribute to and cannot claim TDI or TCI.

*Data for any town with less than 5 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] The child development case for a national paid family and medical leave program. (2018). Washington, DC: Zero to Three and the National Partnership for Women & Families.

(continued on page 176)

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.

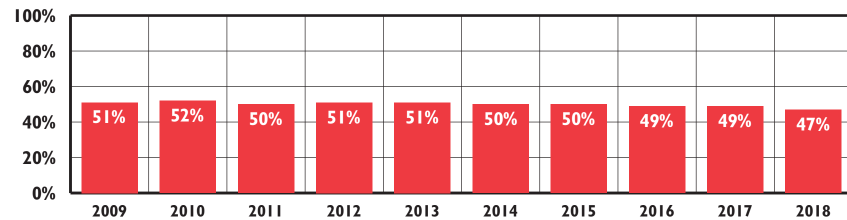
SIGNIFICANCE

Child support is a major part of the safety net for children and families. In 2017, one in five U.S. children (15.1 million) received public child support services.[1,2] 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 encourage responsible co-parenting and increase the reliability of child support paid by helping custodial parents locate the non-custodial parent, establishing paternity and support orders, and monitoring and enforcing child support obligations.[3]

Child support is a critical tool to provide resources for children living in poverty. 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 2015, child support kept 790,000 U.S. children out of poverty, and for poor custodial parents that received full child support, these payments represented more than half (58%) of their mean personal income. Custodial parents who receive steady child support payments are less likely to rely on public assistance programs and more likely to find work than those who do not.[4,5,6]

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] Incarcerated parents with active child support orders are unable to pay while in prison, and may face legal and financial burdens upon release.[8] Child support systems that encourage relationship building with the co-parent, positive parenting, and can strengthen parent-child relationships and increase child support payments. Non-custodial parents who pay regular child support are more involved with their children, providing them with critical emotional support and care. Child support reduces the risk of chilld maltreatment, and has a positive effect on children's academics and behavior.[9,10]

Non-Custodial Parents With Court Orders Who Pay Child Support on Time and in Full, Rhode Island, 2009-2018



Source: Rhode Island Department of Human Services, Office of Child Support Services, 2009-2018.

◆ **As of December 1, 2018, there were 71,628 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-five percent of the children in the Child Support system with a known Rhode Island residence lived in the four core cities. Nearly half (47%) of non-custodial parents under court order in Rhode Island were making child support payments on time and in full.[11]**

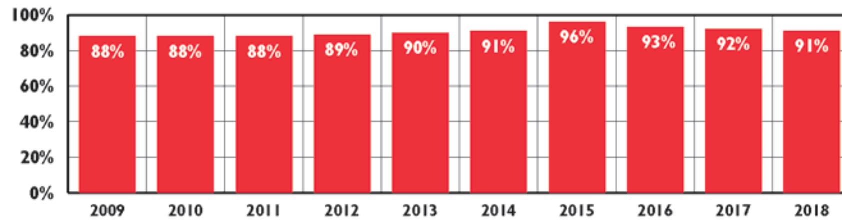
◆ **In 2018, the Rhode Island Office of Child Support Services collected $94.7 million in child support, an increase of about $273,000 over the previous year. Eighty-seven percent ($82.7 million) of the funds collected were distributed directly to families and the remainder was retained by the state and federal governments as reimbursement for RI Works (cash assistance), RIte Care health coverage, and other expenses.[12]**

◆ **In Federal Fiscal Year (FFY) 2017, the Rhode Island Office of Child Support Services collected $5.85 for every $1.00 Rhode Island spent on administering the program.[13]**

◆ **During FFY 2018, there were 16,313 court orders for non-custodial parents to provide medical insurance and 9,650 orders for non-custodial parents to contribute funds toward medical coverage. More than $4.3 million in payments was retained by the state to offset the cost of RIte Care, while approximately $3.1 million was disbursed directly to families to offset the cost of private health insurance coverage or other medical expenses.[14]**

◆ **In 2017, the Rhode Island General Assembly passed a law that allows the Office of Child Support Services to automatically file a motion to modify or a motion for relief when a noncustodial parent is or will be incarcerated for 180 days or more. This law also clarifies that incarceration may not be considered by the court as "voluntary unemployment."[15]**

Rhode Island Children in the Office of Child Support Services System With Paternity Established, 2009-2018



Source: Rhode Island Department of Human Services, Office of Child Support Services, 2009-2018. 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 88% of children in 2009 to 91% of children in 2018.[16]**

◆ **When applying for cash assistance, child care assistance, or RIte Care, parents are asked to provide information on the other parent to the Office of Child Support Services. This information is used to establish paternity (if not already established), and to seek child support payments and/or medical support. Victims of domestic violence can apply for a waiver of this requirement if providing this information could endanger themselves or their children.[17,18]**

◆ **In FFY 2017, Rhode Island had the lowest rate of court orders established for child support in New England (Maine – 95%; Connecticut – 93%; Vermont – 89%; Massachusetts – 89%; New Hampshire – 82%; Rhode Island – 77%). The national average for cases with child support orders established is 87%.[19]**

◆ **In FFY 2017, Rhode Island had the highest case/staff ratio in New England at 704 cases per person, nearly five times that of the lowest state, Vermont (141 cases per person).[20] 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

[1,13,19,20] U.S. Office of Child Support Enforcement, Administration for Children & Families. (2018). *FY 2017 preliminary report.* Retrieved January 29, 2019, from www.acf.hhs.gov

[2] Federal Interagency Forum on Child and Family Statistics. (2016). *Table POP-1: Child population: Number of children (in millions) ages 0-17 in the United States by age, 1950-2017 and projected 2018-2050.* Retrieved January 29, 2019, from www.childstats.gov

(continued on page 176)

Child Support and Rhode Island Works

◆ **As of December 1, 2018, Rhode Island's Office of Child Support Services system included 4,883 children enrolled in the cash assistance program (Rhode Island Works [RI Works]).[21]**

◆ **In December 2018, the average child support obligation for children enrolled in RI Works was $295 per month, compared to an average child support obligation of $407 per month for children in non-RI Works families.[22] (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.[23]**

◆ **An average of 413 families received at least one "pass-through" payment each month, for a total of $239,512 paid to families enrolled in RI Works in FFY 2018.[24]**

◆ **States have the option to increase the amount of money passed through to children. Pass through money is not included in calculating eligibility for cash assistance, which means it does not reduce the amount of the family's cash assistance. Under this federal policy, a number of states have increased the amount they pass through to children. Some states pass through up to $100 per month for one child (and up to $200 per month for two or more children). Rhode Island is one of eight states with a pass-through policy that limits the pass-through amount to $50, regardless of the number of children in the household.[25,26]**

◆ **More generous child support pass-through policies for families receiving cash assistance provide a greater incentive for custodial parents to seek child support and for noncustodial parents to make regular payments, because more of the child support payment goes to the child. Increased pass-throughs could therefore increase total child support collections, increase custodial family income, and potentially encourage constructive coparenting.[27,28]**

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, children of color 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 2018, the federal poverty threshold was $20,231 for a family of three with two children and $25,465 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 an additional way to evaluate the effects of anti-poverty policies.[10]

According to the *2018 Rhode Island Standard of Need*, it costs a single-parent family with two young children $55,115 a year to pay basic living expenses, more than two and half times the federal poverty level for a family of three. This family would need an annual pre-tax income of $62,844 to meet this budget without government subsidies. Work supports can help families with incomes below the federal poverty level meet their basic needs.[11]

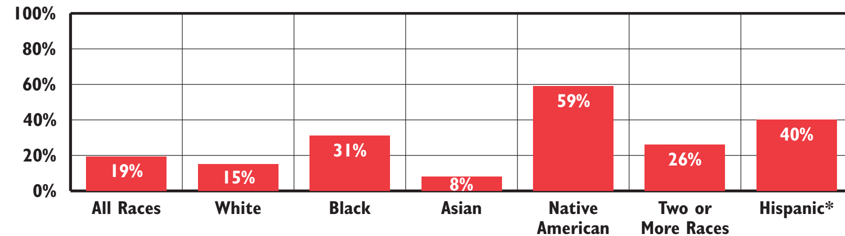
Children in Poverty

	2014	2015	2016	2017
RI	19.8%	19.4%	17.0%	16.6%
US	21.7%	20.7%	19.5%	18.4%
National Rank*				*24th*
New England Rank**				*6th*

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

Source: U.S. Census Bureau, American Community Survey, 2014-2017. Table R1704.

Children in Poverty, by Race and Ethnicity, Rhode Island, 2013-2017



Source: U.S. Census Bureau, American Community Survey, 2013-2017. Tables S1701, B17020A, B17020B, B17020C, B17020D, B17020G and B17020I. *Hispanic children may be included in any race category.

◆ **Between 2013 and 2017, 19% (39,229) of Rhode Island's 207,838 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.[13,14]**

◆ **Between 2013 and 2017, over half (55%) of all children living in poverty in Rhode Island were White, 14% were Black, 2% were Asian, 2% were Native American, 18% were Some other race, and 9% were Two or more races. During this same time period, 64% of Native American, 38% of Hispanic, and 29% of Black children in Rhode Island lived in poverty, compared to 9% of Asian children and 14% of White children.[15]**

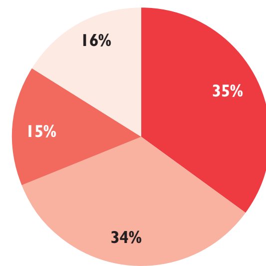
◆ **Between 2013 and 2017, 48% of Rhode Island's poor children were Hispanic. Hispanic children may be included in any race category. The Census Bureau asks about race separately from ethnicity, and the majority of families who identify as Some other race also identify as Hispanic.[16]**

◆ **In 2017, about one in six (17%) children in Rhode Island (a total of 33,858 children) lived in poverty.[17]**

Rhode Island's Poor Children, 2013-2017

By Age

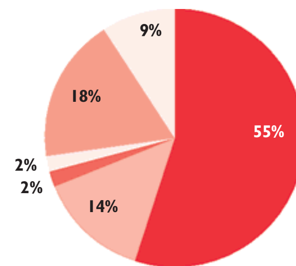
35%		Ages 5 and Younger
34%		Ages 6 to 11
15%		Ages 12 to 14
16%		Ages 15 to 17



n=39,229

By Race*

55%		White
14%		Black
2%		Asian
2%		Native American
18%		Some Other Race
9%		Two or More Races

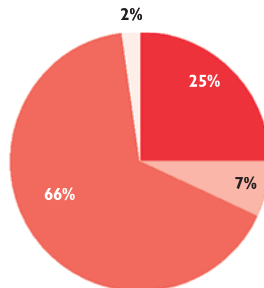


n=39,229

**Hispanic children may be included in any race category. Between 2013 and 2017, 19,356 (48%) of Rhode Island's 40,699 poor children were Hispanic.*

By Family Structure

25%		Married Couple Family
7%		Unmarried Male Householder
66%		Unmarried Female Householder
2%		Not in Related-Family Household



n=39,229

Source: U.S. Census Bureau, American Community Survey, 2013-2017. Tables S1701, B17001, B17006, B17020A, B17020B, B17020C, B17020D, B17020E, B17020F, B17020G, & B17020I. Population includes children for whom poverty status was determined.

Child Poverty Concentrated in Four Core Cities, Rhode Island, 2013-2017

CITY/TOWN	NUMBER IN POVERTY	PERCENTAGE IN POVERTY	NUMBER IN EXTREME POVERTY	PERCENTAGE IN EXTREME POVERTY
Central Falls	2,297	41.5%	809	14.6%
Pawtucket	4,913	30.9%	1,735	10.9%
Providence	14,520	36.0%	6,309	15.7%
Woonsocket	3,357	38.5%	1,661	19.0%
Rhode Island	*39,229*	*18.9%*	*16,523*	*7.9%*

Source: Population Reference Bureau analysis of 2013-2017 American Community Survey data.

◆ **Between 2013 and 2017, 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 in which more than one in four children live below poverty (36% between 2013-2017). 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 threshold, or $10,116 for a family of three with two children and $12,733 for a family of four with two children in 2018.[18,19]**

Young Children Under Age Six in Poverty, Four Core Cities and Rhode Island, 2013-2017

CITY/TOWN	NUMBER <AGE 6 IN POVERTY	PERCENTAGE <AGE 6 IN POVERTY
Central Falls	938	45.1%
Pawtucket	1,766	31.8%
Providence	4,776	34.7%
Woonsocket	1,328	43.6%
Rhode Island	*13,560*	*20.9%*

Source: Population Reference Bureau analysis of 2013-2017 American Community Survey data.

◆ **Between 2013 and 2017, 20.9% (13,560) of Rhode Island children under age six lived in poverty.[20] Children under age six are at higher risk of living in poverty than any other age group.[21] 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.[22,23]**

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, and plan for their future.[24,25]

◆ 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, and rent-to-own stores. 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.[26,27]

◆ In Rhode Island in 2017, 6.5% of households did not have a checking or savings account, the same as the U.S. rate. Nationally, households with lower income, disabled working-age adults, or adults with less than a high school education, as well as Black and Hispanic households, are less likely to have a checking or savings account.[28]

◆ 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.[29]

◆ States can protect consumers from high-cost payday lending by prohibiting these loans outright or enacting measures that make the loans more affordable, such as an annual rate cap or limiting the amount of monthly payments as a percent of a borrower's monthly income. Rhode Island is the only New England state that does not currently protect against payday lending.[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 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 do not have access to coverage through their employers, and others cannot afford the cost.[36] Children with health insurance (public or private) 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 2018, the average annual cost of center-based child care for one infant was $13,093.[38] Child care subsidies can help poor families afford the cost of high-quality child care, which can help parents maintain employment and support children's development.[39]

Educational Attainment

◆ By 2020, 71% of all jobs in Rhode Island will require postsecondary training beyond high school.[40] Forty-seven percent of Rhode Islanders had a postsecondary degree or certificate in 2016.[41]

Affordable Housing

◆ In 2018, the average rent for a two-bedroom apartment in Rhode Island was $1,621.[42] In Rhode Island, a family of three with an income at the federal poverty level would need to spend 94% of its income on rent to pay this amount, well above the recommended 30%. Nationally, only one in four eligible low-income families receive rental assistance to help them afford the high cost of housing.[43,44]

Child Support

◆ As of December 1, 2018, there were 71,628 children in Rhode Island's Office of Child Support Services system.[45] 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 be employed than those who do not.[46] Among poor custodial parents that received full child support in 2015 in the U.S., these payments represented 58% of their mean personal income.[47]

Table 10. **Children Living Below the Federal Poverty Threshold, Rhode Island, 2000 and 2013-2017**

CITY/TOWN	CHILDREN UNDER AGE 18 LIVING BELOW POVERTY, 2000		CHILDREN UNDER AGE 18 LIVING BELOW POVERTY 2013-2017: ESTIMATES WITH HIGH MARGINS OF ERROR*		CHILDREN UNDER AGE 18 LIVING BELOW POVERTY 2013-2017: ESTIMATES WITH LOWER, ACCEPTABLE MARGINS OF ERROR	
	N	%	N	%	N	%
Barrington	127	2.7%			70	1.6%
Bristol	436	10.0%			229	7.2%
Burrillville	236	6.0%	456	14.1%		
Central Falls	2,210	40.9%	2,297	41.5%		
Charlestown	78	4.7%	132	10.4%		
Coventry	481	5.9%			722	10.7%
Cranston	1,496	9.1%			2,296	14.4%
Cumberland	237	3.1%			774	11.0%
East Greenwich	147	4.1%			101	2.9%
East Providence	1,126	10.8%			919	11.1%
Exeter	112	7.5%	40	3.5%		
Foster	32	2.9%	39	5.3%		
Glocester	178	6.7%	153	7.7%		
Hopkinton	115	5.9%	111	7.9%		
Jamestown	17	1.4%	73	6.9%		
Johnston	527	9.0%	692	13.6%		
Lincoln	329	6.5%			648	13.3%
Little Compton	8	1.0%	41	7.2%		
Middletown	264	6.2%			423	12.5%
Narragansett	235	8.6%			18	0.9%
New Shoreham	19	10.2%	28	30.8%		
Newport	1,267	24.4%	743	21.2%		
North Kingstown	663	9.7%			661	11.6%
North Providence	579	10.1%			482	9.0%
North Smithfield	72	3.0%			138	5.5%
Pawtucket	4,542	25.3%			4,913	30.9%
Portsmouth	118	2.8%			200	5.7%
Providence	18,045	40.5%			14,520	36.0%
Richmond	82	4.2%	68	4.2%		
Scituate	113	4.3%	203	10.2%		
Smithfield	153	3.9%			41	1.2%
South Kingstown	324	5.3%			388	8.4%
Tiverton	92	2.8%			218	8.0%
Warren	205	8.4%	324	19.1%		
Warwick	1,243	6.7%			899	6.4%
West Greenwich	40	2.7%			1	0.1%
West Warwick	1,186	18.1%	1,040	19.8%		
Westerly	534	10.0%	771	18.8%		
Woonsocket	3,494	31.8%			3,357	38.5%
Four Core Cities	*28,291*	*35.9%*			*25,087*	*35.6%*
Remainder of State	*12,871*	*7.8%*			*14,142*	*10.3%*
Rhode Island	*41,162*	*16.9%*			*39,229*	*18.9%*

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 2013-2017 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. (2015). *Child poverty and adult success.* Washington, DC: Urban Institute.

[2,4,22] 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.* (2016). 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] Knop, B., & Siebens, J. (2018). *A child's day: Parental interaction, school engagement, and extracurricular activities: 2014.* Washington, DC: U.S. Census Bureau.

(continued on page 176)

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 during the month of December. Children and families who participated in the program at other points in the year but who were not enrolled in that month are not included.

SIGNIFICANCE

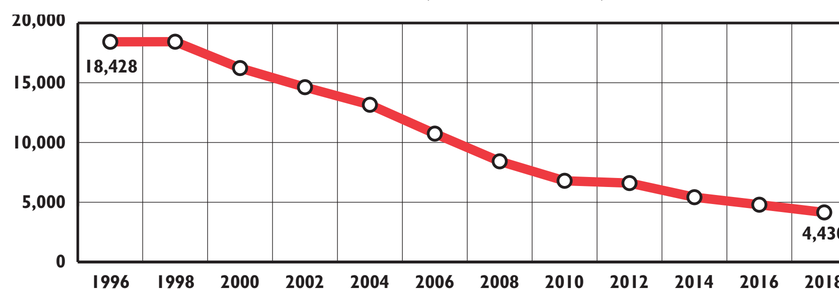
The goal of RI Works is to help very low-income families meet their basic needs by providing cash assistance and work supports, including employment services, SNAP benefits, health insurance, and subsidized child care. Children and families qualify for cash assistance based on their income, resources, 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 place of residence 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 2018, the average hourly wage of working parents enrolled in RI Works was $11.17 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 kept 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]



Source: Rhode Island Department of Human Services, InRhodes Database, December 1, 1996-2015 and RI Bridges Database, December 2016-2018. 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 2010-2018 caseload data. Comparisons to earlier years should be made with caution. Starting in 2016, caseload data are for the month of December and not for a point in time, December 1.

- **Since 1996, when the program began, the Rhode Island cash assistance caseload has declined steadily. Between 1996 and 2018, the Rhode Island cash assistance caseload decreased by 77% from 18,428 cases to 4,149 families.[10]**

- **The RI Works caseload 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 the entire family's case when parents reach their time limit, and limiting eligibility for legal permanent residents to those who have had that status for five years.[11]**

- **In December 2018, there were 2,781 adults and 7,195 children under age 18 enrolled in RI Works. Almost three-quarters (72%) of RI Works beneficiaries were children, and 43% of the children enrolled in RI Works were under the age of six.[12]**

- **In December 2018, 58% of RI Works cases were single-parent families, 39% were child-only cases, and 3% were two-parent families.[13]**

- **High unemployment rates 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 2017, 10,761 children in Rhode Island lived in extreme poverty, yet only 7,593 received cash assistance in December 2017.[14,15]**

Children in Families Receiving Cash Assistance

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. Rhode Island is one of only 13 states that has a lifetime limit less than the federal 60-month time limit, and one of only eight states that imposes a periodic time limit on its entire caseload.[17,18]

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 (for six-month periods), there is no limit on the total time a family can receive a hardship extension.[19,20]

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.[21]

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.[22]

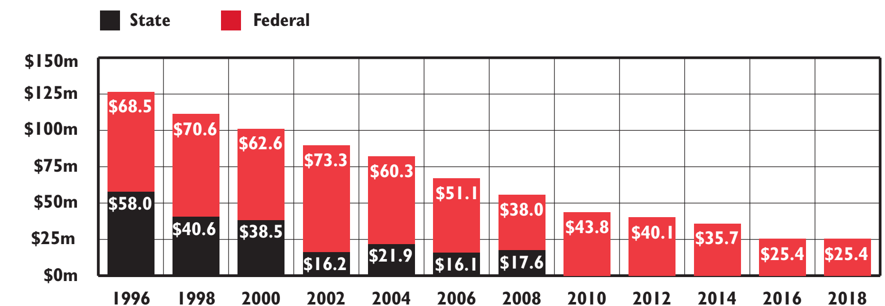
RI Works by Case Type, December 2018

	NUMBER	PERCENTAGE
Child-only cases	1,629	39%
Cases with adults with a work activity	1,647	40%
Cases with adults exempt from a work activity*	356	9%
Unknown status	517	12%
Total RI Works Caseload	*4,149*	

Source: Rhode Island Department of Human Services, RI Bridges Database, December 2018.

**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 (197), in third trimester of pregnancy (70), caring for a disabled spouse or child (1), being a victim of domestic violence (15), illness or incapacity (19), or second parent is a non-participant (54).*

Rhode Island Cash Assistance Expenditures, State Fiscal Years 1996-2018



Sources: Rhode Island Department of Human Services, *Family Independence Program 2007 annual report.* (FY 1996-2001); House Fiscal Advisory Staff. (2004-2018). *Budget as enacted: Fiscal Years 2005-2019.* (FY 2001-2018). Fiscal years 1996-2017 are funds spent and FY 2018 is final budget.

◆ In State Fiscal Year 2018, for the ninth year in a row, no state general revenue was allocated for cash assistance. State general revenue spending for cash assistance decreased steadily from 1996 through 2010. 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 80% between 1996 (when the program began) and 2018, from $126.5 million to $25.4 million.[23,24]

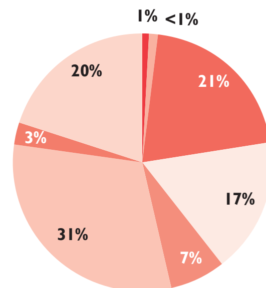
Children in Families Receiving Cash Assistance

Activities of Families Enrolled in the RI Works Program, December 2018*

By Type of Activity

1% (23)	Employed
<1% (1)	Work Experience
21% (353)	Education/Training
17% (286)	Job Search
7% (126)	Job/Work Readiness
31% (534)	Supportive Services
3% (43)	Teen and Family Development
20% (349)	Multiple Activities

n=1,715



Source: Rhode Island Department of Human Services, RI Bridges Database, December 2018. *Some cases may have a work activity and a work exemption during the same month. Percentages may not sum to 100% due to rounding.

◆ As of December 2018, 1% of families with work activities were employed. Less than 1% were in unpaid work experience.[25] Work experience can help parents gain new skills, knowledge, and work habits to improve their employability.[26]

◆ Parents with limited training and 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 2018, 21% of families were participating in education or training programs, up from 15% in December 2017.[28]

◆ Seventeen percent of families with a work activity were participating in job search activities, including job search and job skills development programs delivered in partnership with the Rhode Island Department of Labor and Training, and 7% were participating in other job readiness activities. Another 31% were receiving supportive services, including mental health and substance abuse treatment, and housing and homelessness services needed to address barriers to employment.[29,30]

◆ An additional 3% of families were in the Teen and Family Development Program, a program for young parents, and 20% of families were in multiple activities.[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 are required to receive 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.[33]

◆ In December 2018, there were 77 parents under the age of 20 enrolled in RI Works. Some are parent heads of household, and others may be parts of multi-generational households.[34]

Support for Individuals with Disabilities and Their Families

◆ Nationally, 10% of adult cash assistance recipients have a severe disability and require help with self-care or routine activities, and a much larger percentage (about 40%) have an emotional, cognitive, sensory, or cognitive disability that may be a barrier to employment.[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, or to substance abuse or mental health treatment, as appropriate.[36]

◆ As of December 2018, 651 families (16% of the total RI Works caseload) had hardship extensions, two for a physical or mental disability, two who were unable to work due to a domestic violence situation, one due to homelessness, and 646 because of economic hardship or 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

Table 11. **Children in Families Receiving Cash Assistance (RI Works), Rhode Island, December 2018**

CITY/TOWN	# OF CHILDREN UNDER AGE 18	NUMBER RECEIVING CASH ASSISTANCE FAMILIES	CHILDREN	% OF CHILDREN RECEIVING CASH ASSISTANCE
Barrington	4,597	4	4	<1%
Bristol	3,623	30	50	1%
Burrillville	3,576	31	44	1%
Central Falls	5,644	197	351	6%
Charlestown	1,506	2	2	<1%
Coventry	7,770	43	60	1%
Cranston	16,414	193	286	2%
Cumberland	7,535	37	59	1%
East Greenwich	3,436	17	25	1%
East Providence	9,177	119	189	2%
Exeter	1,334	4	6	<1%
Foster	986	3	4	<1%
Glocester	2,098	7	9	<1%
Hopkinton	1,845	5	8	<1%
Jamestown	1,043	4	6	1%
Johnston	5,480	67	120	2%
Lincoln	4,751	32	56	1%
Little Compton	654	2	5	1%
Middletown	3,652	35	62	2%
Narragansett	2,269	7	11	<1%
New Shoreham	163	0	0	0%
Newport	4,083	134	235	6%
North Kingstown	6,322	38	70	1%
North Providence	5,514	76	105	2%
North Smithfield	2,456	7	8	<1%
Pawtucket	16,575	440	783	5%
Portsmouth	3,996	16	21	1%
Providence	41,634	1,816	3,329	8%
Richmond	1,849	2	2	<1%
Scituate	2,272	10	18	1%
Smithfield	3,625	8	13	<1%
South Kingstown	5,416	22	48	1%
Tiverton	2,998	30	48	2%
Warren	1,940	20	30	2%
Warwick	15,825	163	236	1%
West Greenwich	1,477	0	0	0%
West Warwick	5,746	114	183	3%
Westerly	4,787	22	34	1%
Woonsocket	9,888	385	667	7%
Other/Unknown	*NA*	*7*	*8*	*NA*
Four Core Cities	*73,741*	*2,838*	*5,130*	*7%*
Remainder of State	*150,215*	*1,304*	*2,057*	*1%*
Rhode Island	*223,956*	*4,149*	*7,195*	*3%*

Education and Training Supporting Employment

◆ An estimated 75,000 working-age adults (ages 18 to 65) in Rhode Island do not have a high school diploma. Of the 5,500 adults in adult education programs in Rhode Island, 94% entered these programs with a reading or math level lower than the ninth grade.[39]

◆ By 2020, 71% of jobs in Rhode Island will require post-secondary education beyond high school.[40] Between 2013 and 2017, the unemployment rate for Rhode Islanders without high school diplomas was 10.6%, compared to 8.7% for those with high school degrees and 2.9% 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-one percent of parents enrolled in RI Works report not finishing high school. 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 almost two-thirds (66%) 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.[42]

◆ 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.[43] States should explore how to meet their work participation rate while offering beneficiaries a chance to improve job skills and long-term work preparedeness.[44]

Source of Data for Table/Methodology

Rhode Island Department of Human Services, RI Bridges Database, December 2018. 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

[1,2,3,5,8,16,17,19,21,22,26,27,30,33,36] Rhode Island Secretary of State. (2019). *Rhode Island Works Program rules and regulations* 218-RICR-20-00-2. Retrieved January 30, 2019, from sos.ri.gov

(continued on page 177)

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 October 2018.

SIGNIFICANCE

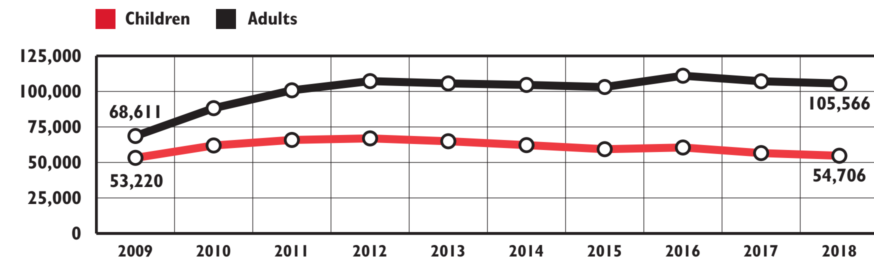
Hunger and lack of regular access to sufficient food are linked to serious physical, psychological, emotional, and academic problems in children and can interfere with their growth and development.[1,2] The Supplemental Nutrition Assistance Program (SNAP), formerly the Food Stamp Program, helps low-income individuals and families obtain better nutrition through monthly benefits they can use to purchase food at retail stores and some farmers' markets.[3] Child food insecurity has been shown to decrease by almost one-third after their families have received SNAP benefits for six months.[4]

Nationally, SNAP is available to households with gross monthly incomes below 130% of the federal poverty level, net monthly incomes below 100% of the federal poverty level, and no more than $2,250 in resources.[5] Rhode Island is one of 40 states that have implemented broad-based categorical eligibility, which allowed Rhode Island to increase the gross income limit and remove the resource limit for most applicants.[6] The gross monthly income limit for Rhode Island is 185% of the federal poverty level ($38,443 per year for a family of three in 2018).[7,8] Households must still meet the net monthly income limit of 100% of the federal poverty level after allowable deductions, which include deductions for housing costs and child care.[9]

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.[10] In Rhode Island during October 2018, 76% of SNAP recipients had gross incomes below the federal poverty level ($20,780 for a family of three in 2018).[11,12] In October 2018, the average monthly SNAP benefit for a family of three in Rhode Island was $377.[13]

Participation in SNAP has been associated with improvement in both current and long-term health outcomes among low-income or food insecure children.[14] SNAP also is effective in reducing poverty. Nationally in 2015, SNAP reduced poverty 20.9% for non-Hispanic Blacks, 17.6% for Hispanics, 15.5% for non-Hispanic Whites, and 21.3% for individuals in working families.[15] In addition, SNAP 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, 2009-2018



Source: Rhode Island Department of Human Services, InRhodes Database, 2009–2015 and RI Bridges Database, 2016-2018. Data represent children under age 18 and adults who participated in SNAP during the month of October.

◆ **Of the 160,272 Rhode Islanders enrolled in SNAP in October 2018, 66% were adults and 34% were children. Of the children enrolled in SNAP, 34% were under the age of six.[17]**

◆ **The number of children and adults receiving SNAP benefits decreased slowly between 2012 and 2015, then increased in 2016. It is possible that the 2016 increase was due to efforts to avoid denying eligible SNAP recipients during the difficult transition to the RI Bridges/UHIP computer system. Between 2016 and 2018, the number of adults and children receiving SNAP benefits again decreased.[18,19]**

Food Insecurity in Rhode Island

◆ **The USDA defines food insecurity as not always having access to enough food for an active, healthy life. Between 2015 and 2017, 12.4% of Rhode Island households and 12.3% of U.S. households were food insecure. In 2017, 15.7% of all U.S. households with children were food insecure, while 43.4% of U.S. households with children with incomes below the poverty level experienced food insecurity.[20]**

◆ **Several 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, the Summer Food Service Program, and the Child and Adult Care Food Program.[21] In 2018, food pantries and soup kitchens provided emergency food assistance to 53,000 Rhode Islanders each month who needed additional help to meet their nutritional needs.[22]**

Increasing Access to SNAP Benefits

◆ The decisions that states make about their enrollment and renewal processes for public benefits such as SNAP can help eligible families successfully access benefits and remain enrolled in the program. 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, and requiring less frequent certification.[23,24,25]

◆ Rhode Island could increase access to SNAP benefits for children and families by using a more flexible interview process that accommodates households' schedules and has different options for conducting interviews and completing renewals. Rhode Island could also consider the use of mobile technology in the enrollment process to increase access to SNAP benefits. Low-income individuals are more likely to be dependent on their cell phones as a means of going online. Mobile technologies would allow the state to more easily reach families that lack access to a personal computer.[26,27]

Table 12. **Children Under Age 18 Receiving SNAP Benefits, Rhode Island, October 2018**

CITY/TOWN	NUMBER PARTICIPATING
Barrington	91
Bristol	406
Burrillville	427
Central Falls	2,867
Charlestown	143
Coventry	828
Cranston	3,009
Cumberland	720
East Greenwich	168
East Providence	1,647
Exeter	73
Foster	90
Glocester	124
Hopkinton	162
Jamestown	41
Johnston	960
Lincoln	601
Little Compton	37
Middletown	466
Narragansett	176
New Shoreham	5
Newport	1,329
North Kingstown	726
North Providence	1,091
North Smithfield	164
Pawtucket	6,235
Portsmouth	222
Providence	20,730
Richmond	119
Scituate	144
Smithfield	192
South Kingstown	474
Tiverton	351
Warren	338
Warwick	2,166
West Greenwich	51
West Warwick	1,706
Westerly	687
Woonsocket	4,806
Unknown	*134*
Four Core Cities	*34,638*
Remainder of State	*19,934*
Rhode Island	*54,706*

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, RI Bridges Database, October 2018.

Due to changes in the availability of data, we report participation for the entire month of October, rather than October 1 in this Factbook. Due to this change in methodology, *Children Receiving SNAP Benefits* cannot be compared with Factbooks prior to 2016.

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

References

[1] *Food insecurity: Indicators of child and youth well-being.* (2016). Washington, DC: Child Trends.

[2,4,14] Carlson, S. & Keith-Jennings, B. (2018). *SNAP is linked with improved nutritional outcomes and lower health care costs.* Washington, DC: Center on Budget and Policy Priorities.

[3] Food Research and Action Center. (2017). *FRAC facts: SNAP strengths.* Retrieved January 28, 2019, from www.frac.org

[5,9] U.S. Department of Agriculture, Food and Nutrition Service. (2018). *Supplemental Nutrition Assistance Program (SNAP): Am I eligible for SNAP?* Retrieved January 25, 2019, from www.fns.usda.gov

[6] U.S. Department of Agriculture, Food and Nutrition Service. (2018). *Broad-based categorical eligibility.* Retrieved January 28, 2019, from www.fns.usda.gov

[7] Rhode Island Department of Human Services. (n.d.). *SNAP eligibility.* Retrieved January 25, 2019, from www.dhs.ri.gov

[8,12] U.S. Department of Health and Human Services. (2018). Annual update of the HHS poverty guidelines. *Federal Register, 83*(12), 2642-2644.

[10,16] *Policy basics: The Supplemental Nutrition Assistance Program (SNAP).* (2018). Washington, DC: Center on Budget and Policy Priorities.

(continued on page 177)

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

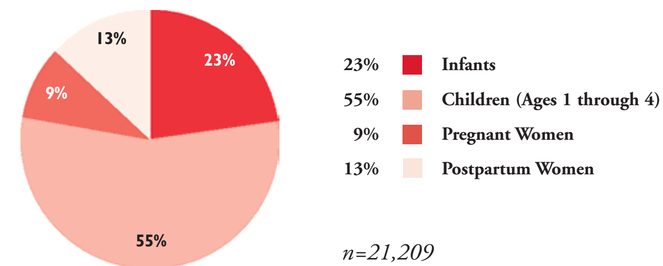
The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a federally-funded preventive program that provides participants with nutritious food, nutrition education, and referrals to health care and social services. WIC serves pregnant, postpartum, and breastfeeding women, infants, and children under five years of age living in low-income households. Any individual who participates in SNAP (formerly the Food Stamp Program), RIte Care, Medicaid, or Rhode Island Works is automatically income-eligible for WIC. Participants also must have a specified nutritional risk to qualify. This includes medically-based risks such as anemia or high-risk pregnancy, or dietary risks such as inadequate nutrition.[1,2,3]

WIC improves the quality of participants' diets and promotes healthy eating habits. Studies have shown that WIC participants access more nutritious foods, including more produce, whole grains, and low-fat dairy. WIC participation also may decrease household food insecurity (families that do not have regular access to food for an active healthy life).[4] Food insecurity in early childhood can lead to impaired cognitive, behavioral, and psychosocial development, and can limit academic achievement.[5] Pregnant women also have special nutritional needs that influence pregnancy outcomes and the health of their children.[6]

WIC participation has been shown to reduce infant mortality, improve birth outcomes (including reducing the likelihood of low birthweight and prematurity), improve cognitive development, reduce risk of child abuse and neglect, increase child immunization rates, boost cognitive development, and increase access to preventive medical care.[7,8]

Revisions made in 2014 to the WIC food package increased access to a wider variety of nutritious foods and strengthened breastfeeding support.[9] WIC consistently promotes breastfeeding as the optimal method of infant feeding.[10] In Rhode Island in Federal Fiscal Year (FFY) 2018, 79% of mothers participating in WIC initiated breastfeeding. Sixteen percent of infants participating in WIC were breastfed at three months of age, and 13% were breastfed at six months of age.[11]

Women, Infants, and Children Enrolled in WIC, Rhode Island, September 2018



Source: Rhode Island Department of Health, WIC Program, September 2018. Percentages may not sum to 100% due to rounding.

◆ **Infants and children ages one through four comprised more than three-quarters (78%) of the population being served by WIC in September 2018 in Rhode Island. Women accounted for over one-fifth (9% pregnant and 13% postpartum) of the population being served.[12]**

◆ **In September 2018, 68% of WIC participants in Rhode Island were White, 17% were Black, 3% were Asian, and 12% identified as other races or more than one race. Fifty-two percent of WIC participants identified as Hispanic. Hispanics are included in the racial groups above.[13]**

◆ **All four core cities had participation rates exceeding the statewide enrollment rate of 46% in 2018 – Central Falls (54%), Pawtucket (47%), Providence (56%), and Woonsocket (53%).[14]**

◆ **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 and children.[15] Rhode Island received $21.7 million in federal WIC funding during FFY 2018, which was less than the $22.9 million in funding for FFY 2017.[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, 31 farmers' markets provided fresh produce to 12,235 WIC participants through the FMNP in FFY 2018.[18]**

Table 13. **Women, Infants, and Children Enrolled in WIC, September 2018**

CITY/TOWN	ESTIMATED NUMBER ELIGIBLE	NUMBER ENROLLED	% OF ELIGIBLE ENROLLED
Barrington	154	34	22%
Bristol	429	153	36%
Burrillville	489	169	35%
Central Falls	2194	1182	54%
Charlestown	157	41	26%
Coventry	824	305	37%
Cranston	2953	1374	47%
Cumberland	719	208	29%
East Greenwich	178	47	26%
East Providence	1733	691	40%
Exeter	121	34	28%
Foster	105	24	23%
Glocester	180	38	21%
Hopkinton	224	122	54%
Jamestown	34	5	15%
Johnston	1043	421	40%
Lincoln	553	160	29%
Little Compton	54	11	20%
Middletown	440	206	47%
Narragansett	169	47	28%
New Shoreham	32	2	6%
Newport	905	450	50%
North Kingstown	588	183	31%
North Providence	1145	495	43%
North Smithfield	248	81	33%
Pawtucket	5243	2439	47%
Portsmouth	247	75	30%
Providence	15016	8423	56%
Richmond	131	25	19%
Scituate	216	67	31%
Smithfield	330	102	31%
South Kingstown	522	113	22%
Tiverton	360	105	29%
Warren	340	119	35%
Warwick	2334	774	33%
West Greenwich	101	28	28%
West Warwick	1469	528	36%
Westerly	753	207	27%
Woonsocket	3260	1721	53%
Four Core Cities	*25,713*	*13,765*	*54%*
Remainder of State	*20,280*	*7,444*	*37%*
Rhode Island	*45,993*	*21,209*	*46%*

Source of Data for Table/Methodology

Rhode Island Department of Health, WIC Program, September 2018.

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] U.S. Department of Agriculture. (2018). *Women, Infants, and Children (WIC program).* Retrieved January 8, 2019, from www.fns.usda.gov

[2] U.S. Department of Agriculture. (n.d.). *The Special Supplemental Nutrition Program for Women, Infants and Children (WIC program).* Retrieved January 8, 2019, from www.fns.usda.gov

[3,4,7,10] Carlson, Steven and Neuberger, Zoë. (2017). *WIC Works: Addressing the nutrition and health needs of low-Income families for 40 years.* Washington, DC: Center on Budget and Policy Priorities.

[5] *Food insecurity.* (2016). Washington, DC: Child Trends.

[6] U.S. Department of Health and Human Services, Office on Women's Health. (2018). *Pregnancy: Staying healthy and safe.* Retrieved January 8, 2019, from www.womenshealth.gov

[8] Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). *Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

(continued on page 177)

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

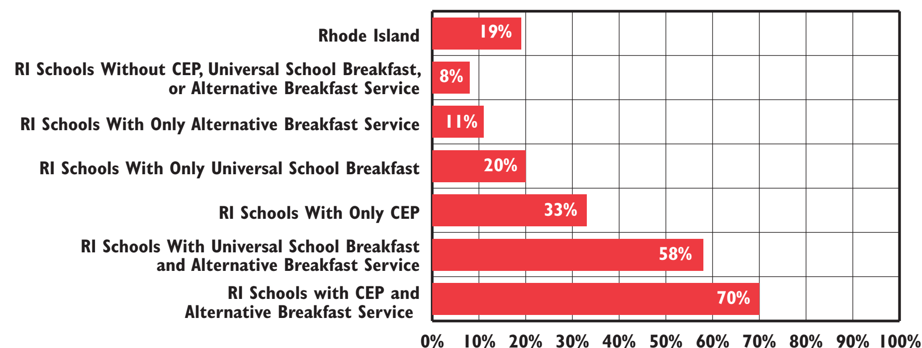
The School Breakfast Program helps ensure that the nation's most vulnerable children start their day off with a healthy meal. During the 2017-2018 school year,12.5 million low-income children in the U.S. participating in the School Breakfast Program ate breakfast at school each day, continuing a pattern 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 2017-2018 school year in Rhode Island, 53 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 33rd in the U.S. for participation in the School Breakfast Program, down from 31st last year. If Rhode Island increased low-income student participation in the School Breakfast Program to 70% of School Lunch Program participation, the state would receive $2.6 million in additional federal funds to support the School Breakfast Program.[9]

Children Participating in the School Breakfast Program, Rhode Island, October 2018



Source: Rhode Island Department of Education, Child Nutrition Programs, Office of Statewide Efficiencies, October 2018.

◆ **The federal Community Eligibility Provision (CEP) allows schools and districts with 40% or more students identified as low-income (e.g., enrolled in the Supplemental Nutrition Assistance Program) or at-risk (i.e., homeless or in foster care) to provide free breakfast and lunch to all students and offers higher reimbursements.[10] During the 2016-2017 school year, 20,721 schools (55% of all eligible schools nationally) participated in CEP. Rhode Island's participation rate was among the lowest with 19% of eligible schools participating.[11]**

◆ **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 the administrative burden for schools.[12,13] During the 2018-2019 school year, all schools in Cranston and Woonsocket, selected schools in five other districts, and three charter schools offered universal school breakfast.[14]**

◆ **Making breakfast part of the school day is another proven strategy for increasing breakfast participation, reducing stigma, and increasing convenience. In fact, some states are adopting legislation requiring schools to offer alternative breakfast service.[15,16] During the 2018-2019 school year, several Rhode Island school districts offered alternative breakfast service, including breakfast in the classroom, "grab and go" breakfasts, bagged breakfasts, or breakfast on a cart in all or some of their schools.[17]**

Table 14. **Children Participating in School Breakfast, Rhode Island, October 2018**

SCHOOL DISTRICT	OCTOBER 2018 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	3,357	44	1%	157	13	8%
Bristol Warren	3,383	354	10%	1,161	214	18%
Burrillville	2,368	156	7%	814	116	14%
Central Falls	2,774	1,318	48%	NA	NA	NA
Chariho	3,364	176	5%	704	116	16%
Coventry	9,462	390	4%	2,970	286	10%
Cranston	11,224	2,469	22%	4,590	1,420	31%
Cumberland	4,837	428	9%	1,029	250	24%
East Greenwich	2,544	69	3%	170	34	20%
East Providence	5,890	1,055	18%	2,975	734	25%
Exeter-West Greenwich	1,628	87	5%	285	49	17%
Foster	270	31	11%	64	26	40%
Foster-Glocester	1,344	98	7%	244	51	21%
Glocester	556	64	11%	74	27	37%
Jamestown	486	14	3%	44	*	17%
Johnston	3,409	370	11%	1,458	272	19%
Lincoln	3,214	224	7%	853	159	19%
Little Compton	253	*	1%	41	*	3%
Middletown	2,487	128	5%	732	99	13%
Narragansett	1,332	75	6%	284	42	15%
New Shoreham	136	11	8%	23	*	31%
Newport	2,338	516	22%	1,442	436	30%
North Kingstown	4,264	273	6%	1,031	218	21%
North Providence	4,027	624	15%	1,569	392	25%
North Smithfield	1,730	62	4%	320	40	12%
Pawtucket	10,325	2,470	24%	NA	NA	NA
Portsmouth	2,500	93	4%	398	55	14%
Providence	27,141	11,065	41%	NA	NA	NA
Scituate	1,245	29	2%	221	19	8%
Smithfield	2,699	130	5%	414	73	18%
South Kingstown	3,050	209	7%	568	154	27%
Tiverton	3,550	112	3%	864	74	9%
Warwick	9,334	657	7%	3,187	456	14%
West Warwick	3,993	579	15%	2,120	465	22%
Westerly	2,740	278	10%	970	234	24%
Woonsocket	6,734	2,257	34%	4,674	1,859	40%
Charter Schools	*8,892*	*3,006*	*34%*	*NA*	*NA*	*NA*
State-Operated Schools	*1,842*	*507*	*28%*	*NA*	*NA*	*NA*
UCAP	*137*	*23*	*17%*	*125*	*23*	*18%*
Four Core Cities	*46,974*	*17,110*	*36%*	*NA*	*NA*	*NA*
Remainder of State	*103,014*	*9,808*	*10%*	*31,776*	*6,541*	*21%*
Rhode Island	*160,859*	*30,454*	*19%*	*NA*	*NA*	*NA*

Source of Data for Table/Methodology

Rhode Island Department of Education, Child Nutrition Programs, Office of Statewide Efficiencies, October 2018.

NA indicates that data on low-income students and their participation in school breakfast was not available because some or all schools in this district were using the Community Eligibility Provision (CEP) and therefore not collecting data on the incomes of students' families. During the 2018-2019 school year, Central Falls, all elementary schools in Providence, some schools in Pawtucket, Highlander Charter School, Rhode Island Nurses Institute Middle College Charter School, and the Metropolitan Regional Career and Technical Center were using CEP.

*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 state, and state totals.

Charter schools include: Achievement First Rhode Island, Beacon Charter High School for the Arts, Blackstone Academy, Blackstone Valley Prep, Charette Charter School, 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 School for the Deaf, and Metropolitan Regional Career and Technical Center. UCAP is the Urban Collaborative Accelerated Program.

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

The October 2018 enrollment and number of low-income students are for the full month of October and are not comparable with the October 1, 2018 enrollment numbers reported elsewhere in the Factbook.

(Sources and References are continued on page 177)

Health

My Brother

by Benjamin L. Wiley

My Brother
My brother is Strong, when I am Weak
Courageous when I am scared
Funny when I am sad
My Brother

My Brother
He is there when I need him
He is there when I don't
He is the one that needs no introduction
My Brother

My Brother
He is the one that is Priceless
The one that is Sincere
My brother is the coolest
My Brother

If I ever needed him, you know whom I am going to call
My Brother

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 than those who are uninsured.[1] Medicaid and the Children's Health Insurance Program (CHIP) provide health insurance and access to health care for low-income children.[2] Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit entitles children to all age-specific pediatrician-recommended services to grow and thrive.[3] Children insured through Medicaid and CHIP are more likely to receive primary and preventive medical and dental care, have access to specialists, and have fewer unmet health needs than uninsured children. Evidence indicates that CHIP has reduced racial/ethnic disparities in access and utilization, improved educational outcomes, and shielded children from poverty.[4,5,6]

Children are more likely to be insured if their parents also have health insurance (especially continuous coverage).[7] RIte Care, 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. RIte Share is Rhode Island's premium assistance program that helps income-qualifying families afford an employer's health insurance plan.[8]

On December 31, 2018, 73% of RIte Care members who qualified based on family income and 72% of RIte Share enrollees were children under age 19.[9]

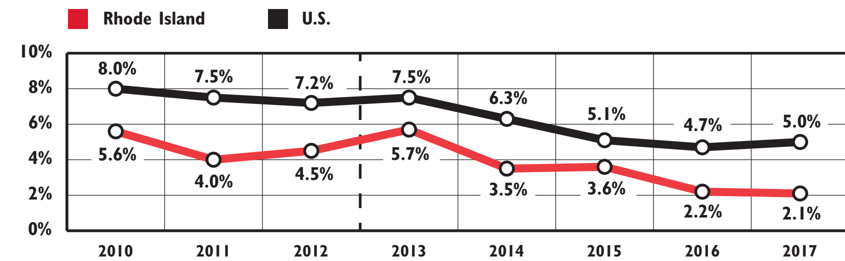
Rhode Island children who are older than age five, living in urban communities, or are Native American, Asian, or Hispanic are the most likely to be uninsured. In 2017, an estimated 2.1% of Rhode Island children were uninsured.[10,11,12,13]

Children Without Health Insurance	2013	2017
RI	5.7%	2.1%
US	7.5%	5.0%
National Rank*		*3rd*
New England Rank**		*3rd*

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

Source: For 2017: U.S. Census Bureau, American Community Survey, 2017. Table R2702. For 2013: U.S Census Bureau, American Community Survey, 2013. Table CP03.

Children Without Health Insurance, Rhode Island and U.S. , 2010-2017



Source: U.S. Census Bureau, American Community Survey, 2012 & 2017. Table CP03. Data from 2010 to 2012 are for children under 18 years of age and data from 2013 to 2017 are for children under 19 years of age due to a change in the 2017 American Community Survey. Prior Factbooks are not comparable.

◆ **In 2017, 2.1% of Rhode Island's children under age 19 were uninsured. Rhode Island ranks third best state in the U.S., with 97.9% of children covered. In 2017, 59% of Rhode Island children under age 19 are covered by private health insurance, most of which is obtained through their parents' employers.[14,15]**

◆ **Younger children are more likely to live in low-income families compared to older children and therefore are more likely to meet the income-eligibility threshold for RIte Care, which is 261% of the federal poverty level. Approximately 60% of children under the age of three were enrolled in RIte Care/medical assistance in 2017.[16,17,18]**

◆ **Approximately 70% (4,713) of the estimated 6,725 uninsured children under age 18 in Rhode Island between 2013 and 2017 were eligible for RIte Care coverage based on their family incomes but were not enrolled. An estimated 2,012 uninsured children lived in families with incomes above the income limit for RIte Care eligibility and 64% (1,279) of them may have been eligible for financial assistance through HealthSource RI based on income.[19]**

◆ **As of December 31, 2018, 3,826 children and 1,504 adults (5,330 total) were enrolled in RIte Share, a 26% decrease since 2017.[20]**

◆ **Families can enroll in health coverage though HealthSource RI, Rhode Island's health insurance marketplace under the federal *Affordable Care Act*. As of October 2018, 1,749 children were enrolled in private health coverage through HealthSource RI, 52% of whom received financial assistance through a premium tax credit or a cost sharing reduction.[21]**

Table 15.

Children Under Age 19 Receiving Medical Assistance, Rhode Island, December 31, 2018

CITY/TOWN	RITE CARE	SSI	KATIE BECKETT PROVISION	ADOPTION SUBSIDY	FOSTER CARE	TOTAL
Barrington	536	11	36	27	11	621
Bristol	1053	30	18	44	22	1,167
Burrillville	1216	35	21	86	22	1,380
Central Falls	5355	274	4	46	56	5,735
Charlestown	418	13	8	15	15	469
Coventry	2263	81	48	149	74	2,615
Cranston	6793	197	75	204	139	7,408
Cumberland	1907	85	48	75	28	2,143
East Greenwich	546	18	33	35	16	648
East Providence	4066	157	35	114	92	4,464
Exeter	289	6	5	22	6	328
Foster	323	4	7	16	7	357
Glocester	468	18	6	56	30	578
Hopkinton	411	9	5	25	10	460
Jamestown	131	8	9	4	6	158
Johnston	2536	87	43	69	44	2,779
Lincoln	1503	52	24	58	39	1,676
Little Compton	164	1	3	2	2	172
Middletown	1086	36	16	35	15	1,188
Narragansett	460	14	8	24	21	527
New Shoreham	67	0	2		0	69
Newport	2206	111	4	45	57	2,423
North Kingstown	1600	49	30	65	47	1,791
North Providence	1435	56	10	35	42	1,578
North Smithfield	604	20	13	47	20	704
Pawtucket	12287	499	30	172	175	13,163
Portsmouth	752	24	17	48	27	868
Providence	38152	1766	78	488	845	41,329
Richmond	413	11	12	27	13	476
Scituate	322	5	11	22	11	371
Smithfield	753	19	27	50	21	870
South Kingstown	1388	50	34	61	30	1,563
Tiverton	978	25	13	25	23	1,064
Warren	865	32	10	36	33	976
Warwick	5474	196	91	237	144	6,142
West Greenwich	248	3	12	18	9	290
West Warwick	3349	150	18	96	62	3,675
Westerly	1920	63	24	54	41	2,102
Woonsocket	7745	514	27	143	159	8,588
Four Core Cities	*5,355*	*3053*	*139*	*849*	*1,235*	*68,815*
Remainder of State	*106,727*	*1676*	*776*	*1926*	*1,179*	*54,100*
Rhode Island	*112,082*	*4729*	*915*	*2775*	*2,414*	*122,915*

Source of Data for Table/Methodology

Rhode Island Executive Office of Health and Human Services, MMIS Database, December 31, 2018.

The table includes children enrolled in RIte Care managed care as of December 31, 2018. 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 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.

References

[1] Murphey, David. (2017). *Health insurance coverage improves child well-being.* Washington, DC: Child Trends.

[2] *Medicaid's role for children.* (2017). Washington, DC: Georgetown University Health Policy Institute Center for Children and Families.

[3] *EPSDT: A primer on Medicaid's pediatric benefit.* (2017). Washington, DC: Georgetown University Health Policy Institute Center for Children and Families.

[4] Paradise, J. (2014). *The impact of the Children Health Insurance Program (CHIP): What does the research tell us?* Washington, DC: The Henry J. Kaiser Family Foundation.

[5] American Academy of Pediatrics. (2014). Policy statement: Children's Health Insurance Program (CHIP): Accomplishments, Challenges, and Policy Recommendations. *Pediatrics, 122*(3), 784-793.

[6] Wagnerman, K., Chester, A., & Alker, J. (2017). *Medicaid is a smart investment in children.* Washington, DC. Georgetown University Health Policy Institute Center for Children and Families.

(continued on page 178)

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 2017, 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 (Hep B); 1 dose of varicella (chickenpox); and 4 doses of pneumococcal conjugate vaccine (PCV).

SIGNIFICANCE

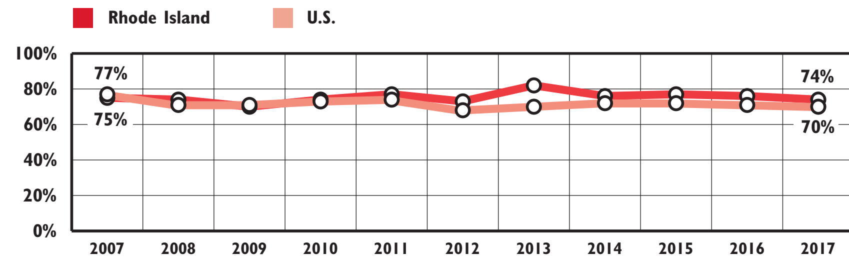
Timely and complete immunization protects children against a number of infectious diseases that were once common and resulted in death or disability. Vaccines interact with the immune system to produce antibodies that protect the body if it is later exposed to disease. The benefits of immunization include 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, and those who cannot be vaccinated for medical reasons are less likely to be exposed. 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 eradicated.[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]

The Rhode Island Department of Health obtains and distributes vaccines and works in partnership with local health care providers to maintain and share KIDSNET immunization data for children from birth through 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 conjugate; polio; rotavirus; and varicella (chickenpox). Kindergarten entry requires all of these and additional doses of DTAP, MMR, polio, and varicella.[7,8]

Fully Immunized Children*, Ages 19 Months to 35 Months, Rhode Island and United States, 2007-2017



**Fully immunized children received the 4:3:1:0:3:1:4 series in 2008 to 2010; and the 4:3:1:3:3:1:4 series from 2011-2017.*

Source: Centers for Disease Control and Prevention, National Immunization Survey, 2007-2017.

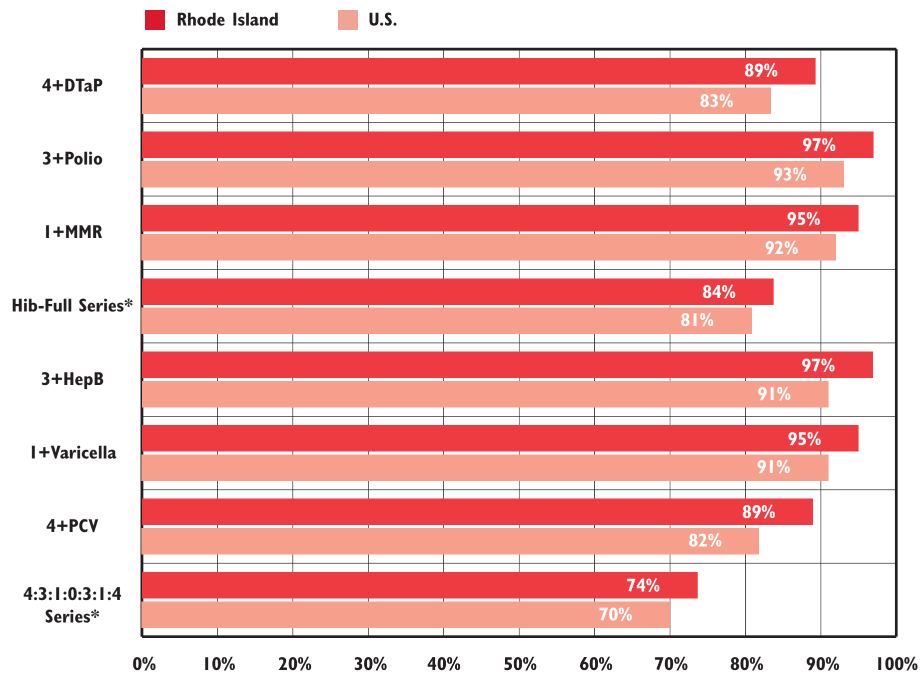
◆ **In 2017, 74% of Rhode Island's children ages 19 months to 35 months were fully immunized, above the national average of 70% and 14th best in U.S.[9]**

◆ **In 2017, the U.S. rate for fully immunized children ages 19 months to 35 months ranged from 63% for children living below the federal poverty level to 74% for children living at or above the federal poverty level. The 2017 U.S. rate was 72% for Asian, non-Hispanic children, 72% for White, non-Hispanic children, 70% for Hispanic children, and 67% for Black, non-Hispanic children.[10]**

◆ **Vaccine concerns have led some parents to request alternative vaccination schedules or to refuse some or all immunizations, which contribute to under-immunization.[11,12] Federal law requires that families be provided with information about each vaccine, including risks and benefits about the vaccine.[13]**

◆ **In Rhode Island, children may be exempt from receiving one or more vaccines for medical or religious reasons.[14] In the 2017-2018 school year, 1.1% (120) of kindergarten students had exemptions from vaccination requirements. Of these exemptions, 92% were for religious reasons and 8% were for medical reasons.[15] In the 2017-2018 school year, 4.4% (533) of 7th grade students had exemptions from vaccination requirements. Of these exemptions, 92% were for religious reasons and 8% were for medical reasons.[16]**

Vaccination Coverage Among Children, Ages 19 Months to 35 Months, Rhode Island and United States, 2017



Source: Rhode Island Department of Health analysis of data from the *National Immunization Survey-Children*, 2017.
*Depending on the product type received, 3+ or 4+ doses of Hib vaccine is a full dose.

◆ In 2017, Rhode Island ranked first in the U.S. for children receiving the rotavirus vaccines; second for 3+Polio and 3+HepB vaccines; fourth for 1+ MMR; fifth for the 4+DTaP, 1+Varicella, 4+PCV vaccines; and eleventh for the 3+HepB vaccine.[17]

◆ In 2017, Rhode Island's rate of completion for the 4:3:1:3:3:1:4 (74.4%) 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, and varicella had coverage rates that met or surpassed the Healthy People 2020 targets (90%) set for each type of vaccine for children ages 19 months to 35 months.[18]

References

[1] Centers for Disease Control and Prevention. (2017). *Why are childhood vaccines so important?* Retrieved January 21, 2019, from www.cdc.gov

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

(continued on page 178)

Immunizations for Elementary and Middle School Students

◆ The *2017-2018 Rhode Island Department of Health Immunization Survey* analyzed student immunization status reports through a web-based survey of all kindergarten and 7th grade school nurse teachers. The immunization statuses of 98% of kindergarten students and more than 95% of 7th grade students were assessed. Of the immunizations needed for school entry, entering kindergarteners had coverage rates between 96% and 98%, while entering 7th grade students had rates between 74% and 99%.[19,20]

Adolescent Immunization

◆ All Rhode Island seventh grade students are required to receive the human papillomavirus (HPV), tetanus, diphtheria, pertussis (Tdap), and meningococcal conjugate (MCV4) vaccines, as well as any needed catch-up doses, for entry into school.[21]

◆ According to the 2017 *National Immunization Survey–Teen*, Rhode Island adolescents ranked first in the U.S. for the 3+HPV vaccine for males (with 78% of adolescents vaccinated), second in the nation for the 3+HPV vaccine for females (77% vaccinated), third in the nation for the 1+MenACWY vaccine (94% vaccinated), and fifth in the nation for the 1+Tdap vaccine (95% vaccinated).[22]

◆ 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.[23,24]

◆ During the 2017-2018 school year, 103 schools participated in VBYG. In total, 4,942 vaccine doses were administered to 2,245 students. Vaccines administered included influenza, HPV, MCV4, hepatitis A, hepatitis B, measles, mumps, and rubella, polio, tetanus, diphtheria, tetanus, diphtheria, pertussis, and varicella (chicken pox).[25]

◆ The School Located Vaccination (SLV) program administered 28,200 doses of the influenza vaccine to both children and adults at school-based clinics throughout Rhode Island from October to December 2018. The goal of SLV is to ensure all Rhode Island children receive their annual flu vaccination at no out-of-pocket cost.[26]

Access to Dental Care

DEFINITION

Access to dental care is the percentage of children under age 21 who were enrolled in RIte Smiles or Medicaid fee-for-service on June 30, 2018 and who had received dental services at any point during the previous State Fiscal Year.

SIGNIFICANCE

Dental caries (tooth decay) is the most 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. Twenty-one percent of 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 Rhode Island, pediatric dental coverage is embedded in most private health insurance coverage, and RIte Smiles is Rhode Island's dental insurance for Medicaid-eligible children born after May 1, 2000.[4,5]

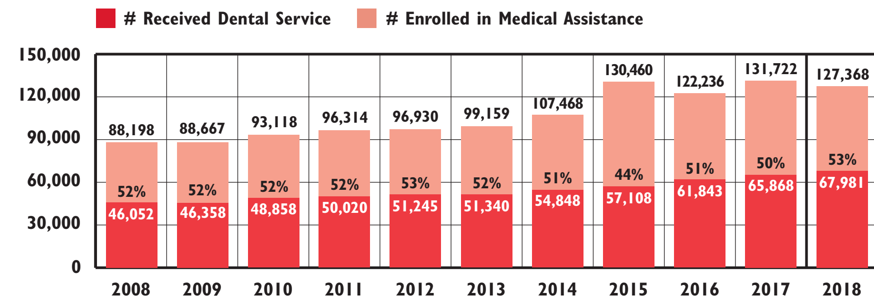
Children living in poverty are more likely to have untreated tooth decay than higher-income children. For children in low-income families, the efficacy and continuity of public dental insurance is a critical factor in access to dental care. In the U.S. and in Rhode Island, children who have public health insurance coverage have greater access to dental and medical care than children who have no insurance.[6,7,8]

Children of color 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]

Some evidence suggests that poor oral health during pregnancy is a potential risk factor for some pregnancy complications and poor birth outcomes, including preterm birth and low birthweight infants.[12] Although oral health care can be safely provided during pregnancy, less than two-thirds (59%) of Rhode Island women report having a dental visit during their pregnancy. In Rhode Island, uninsured women and low-income women are less likely to see a dentist. Fifty percent of women who participated in WIC received preventive dental care during their pregnancy.[13,14]

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, including those with special needs.[15,16]

Children Under 21 Enrolled in Medical Assistance* Programs Who Received Any Dental Service, Rhode Island, SFY 2008-2018



Source: Rhode Island Executive Office of Health and Human Services, State Fiscal Years (SFY) 2008-2018. *Medical Assistance includes RIte Care, RIte Share, and Medicaid fee-for-service.

◆ **Fifty-three percent (67,981) of the children who were enrolled in RIte Care, RIte Share, or Medicaid fee-for-service on June 30, 2018 received a dental service during State Fiscal Year (SFY) 2018. The number of children receiving dental services has increased by 57% since 2006, when RIte Smiles launched.[17]**

◆ **The federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard requires that states provide comprehensive dental benefits to children with Medicaid coverage, including preventive dental services.[18] In Rhode Island, 45% of children with Medicaid in Rhode Island received a preventive dental visit in FFY 2017.[19]**

◆ **RIte Smiles, Rhode Island's managed care oral health program for children has been credited with improving access to dental care for children. RIte Smiles is for low-income children born on or after May 1, 2000, and the cohort expands through an eligibility age-in process.[20,21,22] As of December 31, 2018, there were 113,462 children enrolled in RIte Smiles.[23,24]**

◆ **The federal *Affordable Care Act* made pediatric dental benefits mandatory offerings in individual and small employer plans.[25] In Rhode Island, most commercial coverage in the individual market of HealthSource RI (Rhode Island's state-based insurance marketplace) includes pediatric dental benefits as part of health coverage.[26]**

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, cumbersome 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, lack of child care, and issues with paperwork. Family education, case management, and streamlining administrative procedures can encourage provider enrollment and patient utilization.[27,28]

◆ Since RIte Smiles started in 2006, reimbursement rates have been raised for participating dental providers.[29] The number of dentists accepting qualifying children increased from 27 before RIte Smiles began to 90 at the launch of RIte Smiles.[30] In FY 2018, there were 309 unduplicated dentists in 195 practice locations participating in RIte Smiles.[31]

◆ General dentists and dental specialists who provide dental care to youth who do not qualify for the RIte Smiles program (currently between the ages of 18 and 21) continue to be reimbursed at the Medicaid fee-for-service reimbursement rate.[32] 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. Rhode Island had the fifth lowest Medicaid fee-for-service reimbursement rate for pediatric dental services in the nation in 2016.[33]

Consequences of Untreated Dental Disease

◆ Between 2013 and 2017, an average of 557 children under age 21 were treated for a primary dental-related condition in Rhode Island emergency departments annually. Of these children and youth, 23% were ages five and under, 18% were ages six to 11, 17% were ages 12 to 17, and 42% were age 18-20.[34]

◆ Each year between 2013 and 2017 in Rhode Island, an average of 67 children under age 19 were hospitalized with a diagnosis that included an oral health condition. During this time period, an average of 16 children per year under age 19 were hospitalized with an oral health condition as the primary reason for the hospitalization.[35]

Note: Effective October 1, 2015, the International Classification of Disease (ICD) Codes changes from the 9th classification to the 10th classification, which may impact comparability across the years.

Importance of Early Dental Visits for Very Young Children

◆ Clinical recommendations are that children first visit the dentist before age one.[36] However, nearly three-quarters (74%) of babies in the U.S. have not seen the dentist by their first birthday.[37]

◆ There are too few dentists specially trained to treat very young children, and too few who accept RIte Smiles. Pediatric dentists are dentists with specialized training who work with infants and children through adolescence, including those with special health needs.[38,39]

◆ In 2017, 39% of Rhode Island children under age five with Medicaid coverage received any dental service, and 36% received a preventive dental service.[40]

◆ 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, including for young children.[41]

◆ Primary care providers can conduct oral health risk assessment, refer for dental care, and provide preventive services, all of which can improve oral health outcomes.[42]

◆ All 50 state Medicaid programs reimburse primary care medical providers for preventive oral health services for very young children, including risk assessment, anticipatory guidance, and fluoride varnish application.[43]

References

[1,6,9,15,25,27,36,37,39] *The state of little teeth: Second edition.* (2019). 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. (2017). *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 States, 2017.* Retrieved February 17, 2019, from http://www.cdc.gov/nchs/nhis/shs/tables.htm

[4,26] HealthSource RI. (n.d.). *HealthSource RI dental coverage.* Retrieved February 20, 2019, from www.healthsourceri.com

[5] Rhode Island Executive Office of Health and Human Services (2019). *Dental services for children and young adults.* Retrieved February 20, 2019, from www.eohhs.ri.gov

[7] Wilkniss, S. & Tripoli, S. (2015). *Health investments that pay off: Strategies to improve oral health.* Washington, DC: National Governors Association.

(continued on page 178)

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 concerns 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 influences children's health and behavior at home, in school, and in the community. Mental health conditions can impair daily functioning, prevent or affect 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]

Mental health problems affect children of all backgrounds. Nationally, 10% of children under age five experience a significant mental health issue.[5] 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.[6]

Risk factors for childhood mental disorders include prenatal exposure to alcohol, physical and sexual abuse, adverse childhood experiences, toxic stress, genes or a family history of mental health issues, involvement with juvenile justice and child welfare systems, and living in poverty.[7,8,9]

Mental health treatment systems tend to be fragmented and crisis-driven with disproportionate spending on high-end care and often lack adequate investments in prevention and community-based services.[10,11,12] In Rhode Island, an estimated 36% of children ages three to 17 who needed mental health treatment or counseling had a problem obtaining needed care.[13] In Federal Fiscal Year (FFY) 2018, there were 465 children and youth awaiting psychiatric inpatient admission, similar to FFY 2017 when there were 462 boarders. The average wait time for FFY 2018 was 1.4 days, down from 3.6 days in FFY 2017. In FFY 2018, an average of seven children per day were ready to leave the psychiatric hospital (down from the FFY 2017 average of eight kids per day), but were unable due to a lack of step-down availability or there being no other safe placement (including at home).[14,15]

Infant and Early Childhood Mental Health

◆ **Infant mental health is the growing capacity of infants and toddlers to experience, regulate, and express emotions, form close and secure relationships with caregivers, and explore their environment to learn and thrive. Infant mental health is synonymous with healthy social and emotional development.[16]**

◆ **Infants need to form secure attachment with at least one caregiver. Infants who do not develop secure attachment are at risk for learning delays, relationship dysfunction, difficulty expressing emotions, and future mental health disorders.[17]**

◆ **Infants and toddlers can have specific mental health disorders related to development stage like Excessive Crying Disorder, or general disorders that manifest in certain ways among infants and toddlers like Social Phobia and Autism Spectrum Disorder.[18]**

Children with Medicaid and RIte Care with a Mental Health Diagnosis

◆ **In State Fiscal Year (SFY) 2018, 27% (33,407) of children under age 19 enrolled in Medicaid/RIte Care had a mental health diagnosis. Of those children with a mental health diagnosis, 21% were ages 6 and under, 37% were ages seven to 12, and 42% were ages 13 to 18. In addition, 42% were females and 58% were males.[19]**

◆ **In SFY 2018, 1,486 children under age 19 enrolled in Medicaid/RIte Care were hospitalized due to a mental health related condition (up from 983 in SFY 2016), and 2,649 children had a mental health related emergency department visit (up from 1,690 in SFY 2016, a 57% increase). Eighty-seven percent of those mental health-related emergency department visits did not result in a hospitalization.[20]**

◆ **Sixty-three percent of all emergency department visits for children with a mental health primary diagnosis were enrolled in RIte Care/Medicaid and 32% had commercial insurance.[21]**

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.[22] During 2018, 4,520 children under age 18 were treated at CMHOs, and 4,099 children were receiving treatment as of December 31, 2018.[23]

Psychiatric Hospitals

Children Under Age 19 Treated at Rhode Island Psychiatric Hospitals, October 1, 2017 – September 30, 2018 (FFY 2018)

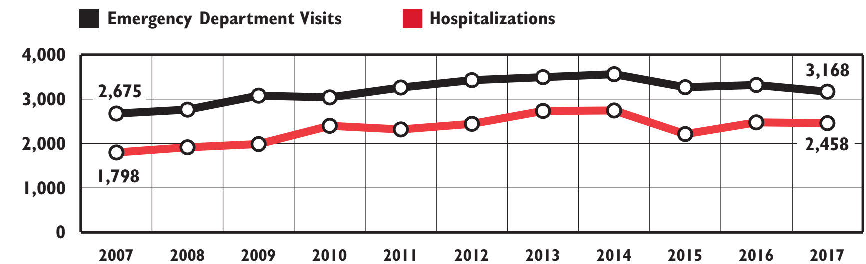
	BRADLEY HOSPITAL GENERAL PSYCHIATRIC SERVICES		BRADLEY HOSPITAL DEVELOPMENTAL DISABILITIES PROGRAM		BUTLER HOSPITAL ADOLESCENT PSYCHIATRIC SERVICES	
	# TREATED	AVERAGE LENGTH OF STAY	# TREATED	AVERAGE LENGTH OF STAY	# TREATED	AVERAGE LENGTH OF STAY
Inpatient	773	23 days	141	42 days	456*	9 days
Residential	188	48 days**	35	69 days**	--	--
Partial Hospitalization	727	22 visits	106	22 visits	175	6 visits
Home-Based	0	NA	20	26 visits	--	--
Outpatient	1,363	***	63	***	99	NA

Source: Lifespan, 2017-2018 and Butler Hospital, 2017-2018. 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 2018). The average length of stay is based on discharges. *An additional 61 youth were treated in adult programs. **Residential average length of stay has dropped significantly compared to last year's 235 day average due to a new residential short-term stay facility. *** Only total number treated with outpatient services by the Lifespan Physician Group is available

-- = 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 mental health care. The most common diagnoses for youth treated at Butler or Bradley Hospitals in FFY 2018 in an inpatient setting were depressive disorders, anxiety disorders, adjustment disorders, schizophrenia, and bipolar disorders.[24,25]

Emergency Care for Primary Diagnosis of Mental Disorder, Children Under Age 18, Rhode Island, 2007-2017*



Source: Rhode Island Department of Health, Hospital Discharge Database, 2007-2017. *Data are for emergency department visits and hospitalizations, not children. Children may visit emergency department or be hospitalized more than once. Trend line is comparable to Factbooks since 2012. *Note: Effective October 1, 2015, the International Classification of Disease (ICD) codes changed from the 9th classification to the 10th classification, which may impact comparability across the years.*

◆ In 2017, there were 3,168 emergency department visits and 2,458 hospitalizations of Rhode Island children with a primary diagnosis of mental disorder. Between 2007 and 2017, emergency department visits increased 18% and hospitalizations increased 37%.[26]

Suicide Among Rhode Island Children and Youth

◆ Children and youth with mental health conditions are at increased risk for suicide.[27] In 2017, 16% of Rhode Island high school students reported that they seriously considered attempting suicide, and 11% reported attempting suicide one or more times during the past year.[28] In Rhode Island between 2013 and 2017, there were 965 emergency department visits and 649 hospitalizations of youth ages 13-19 due to suicide attempts. Six children under age 20 died due to suicide in Rhode Island between 2013-2017.[29]

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.

[2,7,27] Murphey, D., Barry, M., & Vaughn, B. (2013). Adolescent health highlight: Mental health disorders. (Publication No. 2013-1). Washington, DC: Child Trends.

(continued on page 179)

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, and/or emotional. This indicator measures the number of children with special health care needs enrolled in Early Intervention, special education, Supplemental Security Income (SSI), and Medical Assistance.

SIGNIFICANCE

An estimated 19% of children in the U.S. and 21% of children in Rhode Island had 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] Thirty percent of parents with young children in Rhode Island and 31% of parents nationally reported completing a developmental screening.[3] In Rhode Island, 66% of CSHCN have two or more health conditions, compared to 68% of CSHCN in the U.S. Nationally, commonly reported health conditions among CSHCN include allergies, Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder, behavioral problems, asthma, learning disabilities, anxiety, developmental delays, and other mental health conditions.[4]

In Rhode Island in 2017, high school students with disabilities reported being bullied at school and cyber bullied more than their peers. They were also twice as likely to feel sad or hopeless and four times as likely to have attempted suicide as their non-disabled peers. They also reported higher rates of sexual activity, drinking, and use of cigarettes, electronic vapor products, and marijuana.[5,6]

CSHCN may require physical health, mental health, and education services, special equipment, or assistive technology. Health-related needs are best met via a comprehensive, coordinated, and family-centered medical home. Families may also need help with transportation, child care, family support, and home modifications. Having children with special needs can significantly upset parents' finances, employment, and family lives.[7,8,9]

In 2014, Congress passed the *Achieving a Better Life Experience Act (ABLE)*, which created tax-exempt saving accounts for people who become disabled before age 26. *ABLE* accounts cover a range of expenses related to living a life with disabilities, including health care, education, housing, transportation, and employment training.[10,11] In 2015, the Rhode Island General Assembly established *ABLE* savings accounts for Rhode Islanders with special health care needs.[12]

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 (EI) 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.[13]**

◆ **As of June 30, 2018, nine certified EI provider agencies served 2,219 children in Rhode Island. Nearly two-thirds (63%) of those children receiving EI services were male and just over one-third (37%) were female. Of these children, 57% were White, 30% were Hispanic, 7% were Black, 4% were Mixed Race, 2% were Asian, and <1% were American Indian or Alaska Native.[14]**

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.[15]**

◆ **As of June 30, 2018 in Rhode Island, there were 3,121 children ages three to five who received preschool special education services.[16]**

◆ **In Rhode Island as of June 30, 2018, 21,488 students in public schools ages six to 21 received special education services (15% of all students). Thirty-six percent of students receiving special education services in Rhode Island had a learning disability.[17]**

◆ **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 2018, 62% of the 1,224 children who reached age three while in EI were determined to be eligible for preschool special education, 19% were found not eligible, and 13% did not have eligibility determined when exiting EI. The remainder completed their service plan prior to reaching the maximum age for EI, moved out of state, withdrew, or were otherwise unreachable for follow-up.[18]**

Medical Assistance for Children With Special Health Care Needs

◆ As of December 31, 2018, there were 4,740 Rhode Island children and youth under age 19 receiving Medical Assistance benefits through their enrollment in the federal SSI program.[19,20]

◆ 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.[21] As of December 31, 2018, there were 911 Rhode Island children enrolled through the Katie Beckett provision, a decline of 49% from the peak enrollment of 1,770 in 2007.[22,23]

◆ Children with special health care needs have a variety of coverage options under Medicaid. Medicaid coverage also provides access to the Early and Periodic Screening, Diagnostic, and Treatment benefit, which requires that children receive all the services they need, either as a direct benefit or wrap-around benefit to commercial coverage they might have.[24,25]

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. They often enter the child welfare system in poor health and face difficulties accessing services while in care.[26,27]

◆ As of December 31, 2018, 2,421 children in Rhode Island were enrolled in Medical Assistance through the child welfare system.[28] Per provisions of the federal *Affordable Care Act*, 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.[29] In Rhode Island, estimates show that 71% of all eligible former foster youth were enrolled in Medicaid coverage as of December 31, 2018, up from 66% in 2017.[30]

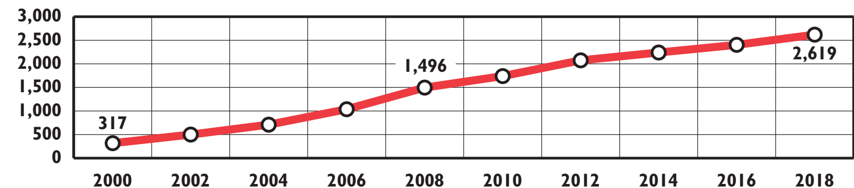
◆ Children who are adopted through the Rhode Island Department of Children, Youth and Families and have special needs may qualify for Medical Assistance coverage.[31] As of December 31, 2018, 2,771 children were enrolled in Medical Assistance because of special needs adoptions.[32]

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.[33]

◆ The national ASD prevalence among children age eight is estimated to be 16.8 per 1,000 children. ASD prevalence is significantly higher among boys (26.6 per 1,000 boys) than girls (6.6 per 1,000 girls). ASD prevalence is higher among non-Hispanic White children than non-Hispanic Black children and Hispanic children (17.2 per 1,000 children, compared to 16.0 and 14.0 per 1,000).[34]

Children Ages Three to 21 With Autism Spectrum Disorder (ASD), Rhode Island, June 2000 – June 2018



Source: Rhode Island Department of Education, June 2000 – June 2018. Numbers include parentally placed students.

◆ In June 2018, there were 2,619 Rhode Island children ages three to 21 with ASD who received special education services.[35] 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.[36] 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.[37,38]

References

[1] Data Resource Center for Child and Adolescent Health. (n.d.). *2016-2017 National Survey of Children's Health: Children with special health care needs.* Retrieved February 19, 2019, from www.childhealthdata.org

[2] Maternal and Child Health Bureau. (2018). *Children with special health care needs.* Retrieved February 19, 2019, from https://mchb.hrsa.gov

(continued on page 179)

Infants Born at Risk

DEFINITION

Infants born at risk is the number of babies born in Rhode Island to Rhode Island women who were low-income, single, did not have a high school diploma, and/or were under age 20.

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 80% 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 early childhood experiences and stable, loving relationships with parents and other caregivers have a sturdy foundation to achieve healthy growth and development, while babies who go without often encounter educational, social-emotional, health, and developmental challenges.[1,2,3]

Infancy is a time of great opportunity and vulnerability. A child's development can be compromised by "toxic stress" caused by a variety of adverse childhood experiences and risk factors, including poverty, maternal depression, family chaos, exposure to violence, child maltreatment, parental substance abuse, and/or parental incarceration. These negative experiences in early childhood place a child at increased risk for developmental delays, health problems, cognitive impairment, lowered rates of school success, and unhealthy behaviors throughout life.[4,5,6]

Economic hardship in early childhood is associated with poor educational and health outcomes. Differences in development are evident by age two, with children born into low-income families lagging behind children born into higher income families. When economic insecurity is combined with other risk factors such as having a single parent, a parent with low education levels, and/or a teen parent, children are at markedly increased risk for poor outcomes.[7] In the U.S., 44% of all infants and toddlers live in low-income families (below 200% of the federal poverty line) and 21% live in poverty, a significantly higher proportion than older children and adults. Children under age three are more than twice as likely to live in poverty than adults age 65 or older.[8]

Family planning programs help individuals avoid unintended pregnancies which are associated with negative educational, health, and economic outcomes for women and children.[9,10] In addition, evidence-based home visiting programs for vulnerable families help parents develop critical nurturing skills and improve outcomes for children and families.[11]

Births by Key Risk Factors, Four Core Cities and Rhode Island 2018

CITY/TOWN	BIRTHS	# TO LOW-INCOME MOTHERS	# TO SINGLE MOTHERS	# TO MOTHERS WITHOUT A HIGH SCHOOL DIPLOMA	# TO MOTHERS YOUNGER THAN 20
Central Falls	303	263	213	97	20
Pawtucket	852	596	481	110	38
Providence	2,352	1,760	1,355	466	147
Woonsocket	465	343	315	95	40
Rhode Island	*9,952*	*5,069*	*4,441*	*1,069*	*395*

Source: Rhode Island Department of Health, KIDSNET Database, 2018.

◆ The U.S. birth rate has been declining since 2007, reaching an historic low in 2017. The U.S. teen birth rate also reached a record low in 2017. Rhode Island had the fifth lowest overall birth rate and the sixth lowest teen birth rate in the U.S. in 2017, with 10.0 births per 1,000 women ages 15 to 44 and 11.4 births per 1,000 teens ages 15 to 19.[12]

◆ The total number of babies born in Rhode Island to Rhode Island women declined 17% between 2008 and 2018. The proportion of Rhode Island births that were to mothers without a high school diploma fell from 17% to 11% and the proportion of all births that were to teen mothers fell from 10% to 4% of all births during the same time period.[13]

◆ All babies born in Rhode Island are screened through the Rhode Island Department of Health's Newborn Risk Assessment Program. In 2018, there were 6,333 newborns (64%) who "screened positive," indicating the presence of one or more risk factors associated with poor developmental outcomes.[14]

◆ Of the 9,952 babies born in Rhode Island to Rhode Island women in 2018, nearly one-third (3,189) had a mother with a documented history of treatment for mental health conditions. Also, 627 (6%) had a mother with a documented history of substance abuse problems, and 225 (2%) had a mother with documented involvement in the child welfare system (either as an adult or as a child).[15]

Table 16.

Infants Born at Risk, Rhode Island, 2018

CITY/TOWN	TOTAL # OF BIRTHS	# OF BIRTHS TO LOW-INCOME MOTHERS	# OF BIRTHS TO SINGLE MOTHERS	BIRTHS TO MOTHERS WITHOUT A HIGH SCHOOL DIPLOMA	# OF BIRTHS TO MOTHERS YOUNGER THAN AGE 20
Barrington	107	14	8	0	0
Bristol	103	35	31	6	*
Burrillville	121	44	50	5	6
Central Falls	303	263	213	97	20
Charlestown	54	22	20	4	*
Coventry	280	84	84	9	*
Cranston	756	314	298	48	28
Cumberland	346	96	87	13	6
East Greenwich	109	17	18	0	0
East Providence	447	197	199	37	11
Exeter	52	11	12	3	0
Foster	41	11	10	2	*
Glocester	69	17	21	1	*
Hopkinton	30	11	7	1	0
Jamestown	22	4	2	0	0
Johnston	270	107	107	20	5
Lincoln	160	43	48	4	*
Little Compton	6	2	-	0	0
Middletown	156	51	39	8	*
Narragansett	42	19	15	2	*
New Shoreham	2	1	1	0	0
Newport	207	104	100	30	14
North Kingstown	235	55	61	7	7
North Providence	311	159	134	19	15
North Smithfield	83	35	28	2	*
Pawtucket	852	596	481	110	38
Portsmouth	135	23	33	2	*
Providence	2,352	1,760	1,355	466	147
Richmond	79	18	20	3	*
Scituate	89	24	26	3	*
Smithfield	132	31	35	2	*
South Kingstown	155	50	40	8	*
Tiverton	73	22	26	6	*
Warren	80	29	29	1	*
Warwick	712	233	265	24	12
West Greenwich	49	7	9	0	0
West Warwick	326	158	159	26	9
Westerly	140	48	54	5	*
Woonsocket	465	343	315	95	40
Unknown	*1*	*1*	*1*	*0*	*0*
Four Core Cities	*3,972*	*2,962*	*2,364*	*768*	*245*
Remainder of State	*5,979*	*2,096*	*2,076*	*301*	*150*
Rhode Island	*9,952*	*5,059*	*4,441*	*1,069*	*395*

Source of Data for Table/Methodology

Rhode Island Department of Health, KIDSNET Database, 2018. Birth data from 2018 are provisional. Data include only births that occurred in Rhode Island to Rhode Island residents. This table shows the number of births with key risk factors that place a child at high risk for poor developmental outcomes. Births to low-income women are births to women with public health insurance (Medicaid/RIteCare) or no insurance. Of the 5,059 births to low-income families in 2017, 5,023 had Medicaid/RIte Care coverage and 36 had no insurance.

* Fewer than 5 births to mothers younger than age 20 are suppressed by the RI Department of Health due to the policy regarding sensitive reproductive health information of a potentially socially-stigmatizing age group. These births are still counted in the four core cities, remainder of state, and state totals.

The definition for this indicator changed in 2016. The percentage of births with specific risk factors (births to women under age 20, single, and without a high school diploma) and the number and percentage of all births with all three risk factors is no longer being reported.

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

References

[1] *The basics of infant and early childhood mental health: A briefing paper.* (2017). Washington, DC: Zero to Three.

[2] First Things First. (n.d.). *Brain development.* Retrieved February 22, 2019, from www.firstthingsfirst.org/early-childhood-matters/brain-development

[3] Zero to Three. (2019). *Share the Think Babies message.* Retrieved February 22, 2019, from www.thinkbabies.org

[4] *Toxic stress.* (2017.) Cambridge, MA: Harvard Center on the Developing Child.

[5] Robert Wood Johnson Foundation. (2001-2018). *Adverse childhood experiences.* Retrieved February 22, 2019 from www.rwjf.org

[6] *Traumatic experiences widespread among U.S. youth, new data show.* (2017). Washington, DC: Robert Wood Johnson Foundation.

(continued on page 180)

Evidence-Based Family Home Visiting

DEFINITION

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

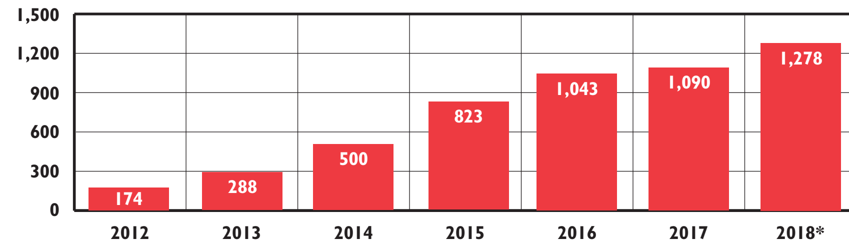
SIGNIFICANCE

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 face obstacles that impact their ability to meet the needs of their babies, the child's health, development, and learning trajectory are 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. This funding must be spent by states on approved models that meet rigorous evidentiary standards.[6] In 2018, there were 20 home visiting models 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 implement three of these evidence-based models: Healthy Families America, Nurse-Family Partnership, and Parents as Teachers; the federal government directly funds the Early Head Start home-based option.[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 Coordinated by the Rhode Island Department of Health, Rhode Island, 2012-2018



Source: Rhode Island Department of Health, Family Home Visiting, Family Visiting Database, October 2012-2018. *Beginning in 2018, enrolled families includes all families participating in Parents as Teachers programs, including those without MIECHV funding.

- **As of October 2018, of the 1,278 parents/caregivers participating in evidence-based home visiting programs 12% were under age 20, 17% were ages 20 to 24, and 71% were age 25 or older at enrollment. Twenty-three percent of the parents/caregivers had less education than a high school diploma or GED, 29% had a high school diploma or GED, 21% had some college or vocational training, 10% had a four-year college degree, and 17% had an unknown amount of education. At the time of enrollment, 36% of the parents/caregivers were single, 46% were married or had a domestic partner, 4% were divorced or separated, less than 1% were widowed, and 13% had an unknown marital status. Among the enrolled children, 8% were not born yet, 30% were under age one, 23% were age one, 21% were age two, 14% were age three, 4% were age four, and 1% were age five.[10]**

- **Home-based Early Head Start is also recognized as an evidence-based home visiting program that improves child outcomes.[11] As of October 2018 in Rhode Island, there were 656 pregnant women and children enrolled in home-based Early Head Start.[12]**

- **Early Intervention (EI) programs serve infants and toddlers with developmental delays and disabilities in Rhode Island and deliver nearly all (97%) services through home visits. As of June 2018, there were 2,219 children enrolled in EI in Rhode Island.[13]**

- **Rhode Island also operates First Connections, a statewide, short-term home visiting program designed to help families get connected to needed resources.[14] In 2018, 2,657 children received at least one First Connections home visit (49% lived in one of the four core cities and 51% in the remainder of the state).[15]**

Table 17.

Evidence Based Family Home Visiting, Rhode Island, 2018

	COMMUNITY CONTEXT, 2018				# FAMILIES ENROLLED IN EVIDENCE-BASED HOME VISITING PROGRAMS, OCTOBER 1, 2018			
CITY/TOWN	TOTAL # OF BIRTHS	# OF BIRTHS WITH 1 OR MORE RISK FACTORS	# OF BIRTHS TO LOW-INCOME FAMILIES	# RECEIVED FIRST CONNECTIONS VISIT IN 2018	HEALTHY FAMILIES AMERICA	NURSE-FAMILY PARTNERSHIP	PARENTS AS TEACHERS*	TOTAL
Barrington	107	32	14	14	1	0	1	2
Bristol	103	56	35	20	3	0	21	24
Burrillville	121	66	44	17	1	1	2	4
Central Falls	303	263	263	125	41	13	32	86
Charlestown	54	32	22	15	6	0	1	7
Coventry	280	144	84	73	14	0	10	24
Cranston	756	431	314	173	45	4	26	75
Cumberland	346	153	96	59	3	3	2	8
East Greenwich	109	41	17	20	1	1	3	5
East Providence	447	280	197	65	17	1	13	31
Exeter	52	30	11	21	0	0	0	0
Foster	41	20	11	9	0	1	0	1
Glocester	69	37	17	12	1	0	0	1
Hopkinton	30	12	11	15	3	0	3	6
Jamestown	22	7	4	6	0	0	0	0
Johnston	270	156	107	45	6	2	1	9
Lincoln	160	71	43	27	4	1	2	7
Little Compton	6	4	2	3	0	0	0	0
Middletown	156	76	51	26	5	0	8	13
Narragansett	42	28	19	16	1	0	1	2
New Shoreham	2	1	1	0	0	0	0	0
Newport	207	127	104	52	14	1	12	27
North Kingstown	235	99	55	59	4	1	17	22
North Providence	311	205	159	57	4	2	5	11
North Smithfield	83	48	35	11	1	0	0	1
Pawtucket	852	653	596	273	87	16	51	154
Portsmouth	135	59	23	26	6	0	4	10
Providence	2,352	1,835	1,760	758	285	78	100	463
Richmond	79	42	18	19	1	0	0	1
Scituate	89	36	24	4	0	0	0	0
Smithfield	132	62	31	21	0	0	0	0
South Kingstown	155	71	50	45	14	1	6	21
Tiverton	73	41	22	12	6	0	3	9
Warren	80	45	29	8	3	1	9	13
Warwick	712	390	233	203	22	0	40	62
West Greenwich	49	19	7	9	2	0	1	3
West Warwick	326	217	158	108	23	1	8	32
Westerly	140	76	48	77	10	0	40	50
Woonsocket	465	367	343	154	47	6	41	94
Unknown	*1*	*1*	*1*	*0*	*0*	*0*	*0*	*0*
Four Core Cities	*3,972*	*3,118*	*2,962*	*1,310*	*460*	*113*	*224*	*797*
Remainder of State	*5,979*	*3,214*	*2,096*	*1,347*	*221*	*21*	*239*	*481*
Rhode Island	*9,952*	*6,333*	*5,059*	*2,657*	*681*	*134*	*463*	*1,278*

Source of Data for Table/Methodology

Home visiting data are from the Rhode Island Department of Health, Family Home Visiting, Family Visiting Database. Birth data are from Rhode Island Department of Health, Center for Health and Data Analysis, KIDSNET. Number of births with one or more risk factor is the "risk positive" definition from the Developmental Risk Assessment. Births to low-income families are births to families with public health insurance (Medicaid/RIteCare) or no insurance.

*Beginning in 2018, enrolled families includes all families participating in Parents as Teachers programs, including those without MIECHV funding.

Unknown: Specific city/town information is unavailable.

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.* Retrieved February 28, 2019, from www.zerotothree.org

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

[4,7,11] Sama-Miller, E., et al. (2018). *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] *Home visiting family support programs: Benefits of the Maternal, Infant, and Early Childhood Home Visiting Program.* (2015). Washington, DC: The Pew Charitable Trusts.

[8,10,15] Rhode Island Department of Health, 2018.

[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.

[12] Rhode Island Early Head Start program reports to Rhode Island KIDS COUNT, October 2018.

[13] Rhode Island Executive Office of Health and Human Services, Center for Child and Family Health, June 30, 2018.

[14] Rhode Island Department of Health. (n.d.). *First Connections.* Retrieved March 1, 2019, from http://health.ri.gov

Women with Delayed Prenatal Care

DEFINITION

Women with delayed prenatal care is the percentage of women receiving prenatal care beginning in the second or third trimester of pregnancy. 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 affect 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.[1,2]

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. A prenatal visit is the first step in establishing an infant's medical home and can provide valuable links to other services.[3,4]

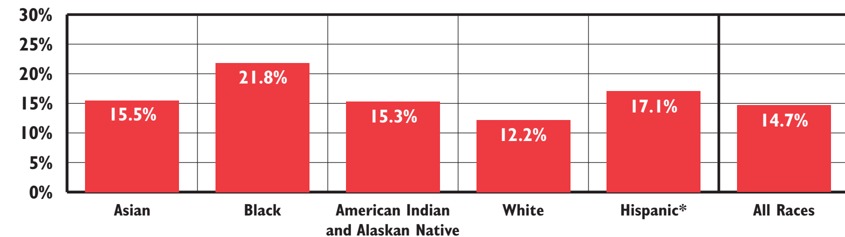
Early prenatal care is especially important for women who face multiple risks for poor birth outcomes, as is ensuring access to preconception health care services before pregnancy. Effective monitoring and treatment of chronic disease, education on preventive health practices, implementing and enhancing Medicaid policies to improve health insurance coverage, and ensuring access to culturally and linguistically competent health providers can improve prenatal care for women of childbearing age.[5,6]

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.[7]

Rhode Island women with delayed or no prenatal care are more likely to report their pregnancy was unintended than women who initiated care in the first trimester. Between 2012 and 2015 in Rhode Island, 66% of women whose prenatal care was delayed had unintentional pregnancies.[8]

In Rhode Island between 2013 and 2017, 14.6% of women who gave birth did not begin care until the second or third trimester. Adolescent and teen mothers were more likely to receive delayed prenatal care than older mothers in Rhode Island.[9]

Women With Delayed Prenatal Care by Race/Ethnicity, Rhode Island, 2013-2017



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Database, 2013-2017. * Race categories are non-Hispanic.

◆ **Between 2013 and 2017 in Rhode Island, Black women (21.8%), Hispanic women (17.1%), American Indian and Alaskan Native (15.5%), and Asian women (15.5%) were more likely to receive delayed prenatal care than White women (12.6%).[10]**

◆ **Between 2013 and 2017 in Rhode Island, women who did not graduate from high school were more likely to receive delayed prenatal care than women with more than a high school education (23% compared to 11.7%). Nineteen percent of pregnant women in the four core cities received delayed prenatal care.[11]**

Insurance Coverage Improves Access to Prenatal Care

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

◆ **Between 2013 and 2017, pregnant women with health coverage through RIte Care (Rhode Island's Medicaid managed care health program) were much less likely (19.0%) to receive delayed prenatal care than women who were uninsured (27.4%). Pregnant women with private insurance coverage were the least likely to receive delayed prenatal care (10.3%) during this time period.[14]**

◆ **RIte Care ranks in the top quartile in first trimester prenatal care, compared to other Medicaid health plans in the nation.[15]**

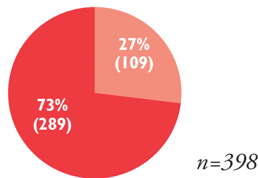
Women with Delayed Prenatal Care

Delayed Prenatal Care by Mother's Insurance Type, Rhode Island, 2013-2017

Delayed Prenatal Care (2nd or 3rd Trimester)

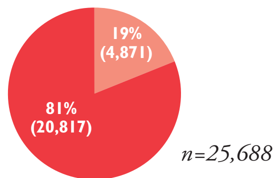
Prenatal Care in 1st Trimester

Uninsured



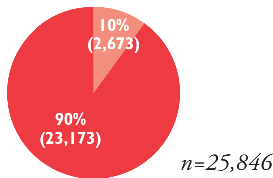
n=398

Public Insurance (RIte Care)



n=25,688

Private Insurance



n=25,846

Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017.

Table 18. **Delayed Prenatal Care, Rhode Island, 2013-2017**

CITY/TOWN	# BIRTHS	# DELAYED CARE	% DELAYED CARE
Barrington	537	60	11.2%
Bristol	713	91	12.8%
Burrillville	660	80	12.1%
Central Falls	1,606	298	18.6%
Charlestown	239	17	7.1%^
Coventry	1,469	167	11.4%
Cranston	3,912	519	13.3%
Cumberland	1,717	204	11.9%
East Greenwich	558	57	10.2%
East Providence	2,331	310	13.3%
Exeter	238	26	10.9%
Foster	169	22	13.0%
Glocester	333	41	12.3%
Hopkinton	308	27	8.8%
Jamestown	116	11	9.5%^
Johnston	1,328	151	11.4%
Lincoln	997	125	12.5%
Little Compton	83	14	16.9%
Middletown	844	106	12.6%
Narragansett	316	34	10.8%
New Shoreham	57	11	19.3%^
Newport	1,303	186	14.3%
North Kingstown	1,097	117	10.7%
North Providence	1,627	211	13.0%
North Smithfield	407	49	12.0%
Pawtucket	4,848	910	18.8%
Portsmouth	618	62	10.0%
Providence	12,453	2,275	18.3%
Richmond	280	23	8.2%
Scituate	394	53	13.5%
Smithfield	673	72	10.7%
South Kingstown	817	79	9.7%
Tiverton	597	81	13.6%
Warren	455	58	12.7%
Warwick	3,862	452	11.7%
West Greenwich	230	25	10.9%
West Warwick	1,720	249	14.5%
Westerly	913	69	7.6%
Woonsocket	2,925	562	19.2%
*Unknown***	*217*	*29*	*13.6%*
Four Core Cities	*21,832*	*4,045*	*18.5%*
Remainder of State	*31,918*	*3,859*	*12.1%*
Rhode Island	*53,967*	*7,933*	*14.7%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017. Data for births in 2014 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 2013-2017.

*The data are statistically unreliable and rates are not reported and should not be calculated.

^The data are statistically unstable and rates or percentages should be interpreted with caution.

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

** Unknown births include three births with missing maternal residence data.

Due to birth certificate changes that began in 2015 (the last three years in the 2013-2017 five-year average), comparisons with previous years should be made with caution. Delayed prenatal care is now a calculated variable that is based on the number of visits over 90 days (3 months). "No prenatal care" is not broken out.

References

[1,4] Yogman, M., Lavin, A., & Cohen, G. (2018). The prenatal visit. *Pediatrics 142*(1): e20181218.

[2,6] U.S. Department of Health & Human Services, Office on Women's Health. (n.d.). *Prenatal care.* Retrieved March 6, 2019, from www.womenshealth.gov

[3] Hagan, J. F., Shaw, J. S., & Duncan, P. M. (Eds.). (2017). *Bright futures: Guidelines for health supervision of infants, children and adolescents (4th ed.).* Elk Grove Village, IL: American Academy of Pediatrics.

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

[7] 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.

(continued on page 180)

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 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, pregnancy with multiples, and uterine and/or cervical abnormalities. Other risk factors include some health conditions, delayed or no prenatal care, stress, domestic violence, having pregnancies close together, 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, 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]

The U.S. preterm birth rate rose between 2016 and 2017, from 9.85% to 9.93%, the third year of an increase after steady declines from 2007 to 2014. The preterm birth rate varies by race/ethnicity, with non-Hispanic Black women (13.9%) continuing to have the highest preterm birth rate in the U.S. in 2017. Hispanic women had a preterm birth rate of 9.6% in 2017 and non-Hispanic White women had a rate of 9.0%. The rate increased for each group between 2016 and 2017.[10,11] Nationally, racial and ethnic disparities continue in the outcomes for preterm infants, with the preterm-related infant mortality rate for Black infants about three times the rate for White infants.[12]

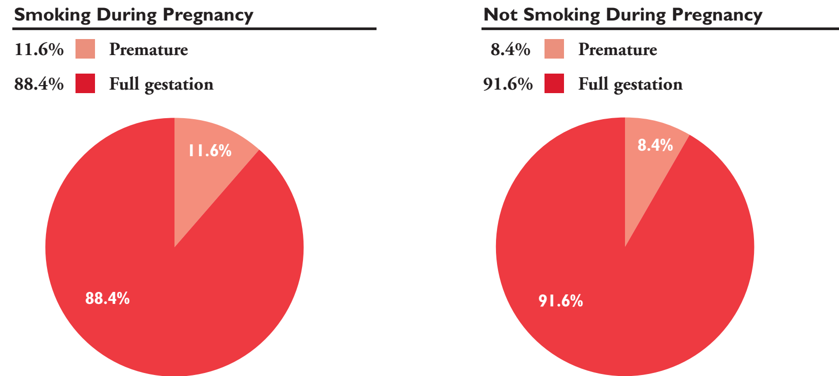
Preterm Births

	2007	2017
RI	10.8%	8.3%
US	10.4%	9.9%
National Rank*		*2nd*
New England Rank**		*2nd*

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

Sources: 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. For 2017: Martin, J. A., et al. (2018). Births: Final data for 2017. NVSR, 67(8), 1-49.

Preterm Births by Smoking Status, Rhode Island, 2013-2017



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017. *See note regarding new methodology for calculating preterm births, starting with the 2016 Factbook.

◆ **Between 2013 and 2017, 70.5% of all preterm births in Rhode Island were late preterm births (34-36 weeks gestation) and 17.6% of all preterm births were very preterm (<32 weeks gestation).[13]**

◆ **Multiple births are more likely to be born preterm. In Rhode Island between 2013 and 2017, 55.9% of multiple births were preterm, compared with 6.9% of singleton births.[14]**

◆ **Between 2013 and 2017, 13.2% of births of Non-Hispanic Native American infants and 11.3% of births of Non-Hispanic Black infants in Rhode Island were preterm, compared with 7.7% of Non-Hispanic Asian and 8.0% of Non-Hispanic White infants. During this same time period, 9.3% of births to Hispanic women in Rhode Island were preterm.[15]**

◆ **In Rhode Island between 2013 and 2017, 9.3% of births to women with a high school degree or less were preterm, compared with 7.9% of those with higher education levels.[16]**

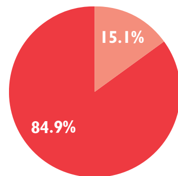
◆ **Social determinants of health, including poverty, racism, and access to care are important factors in the disparities in preterm births.[17]**

◆ **"17P", a weekly injection for mothers with singleton pregnancies between 16 and 36 weeks gestation and a prior preterm birth, can reduce the chance of future preterm birth by 33%.[18]**

Preterm Births by Mother's Insurance Type, Rhode Island, 2013-2017

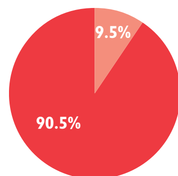
Uninsured

15.1% Preterm Births
84.9% Full-term Births



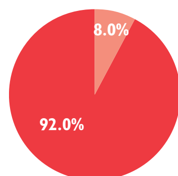
Public Insurance (RIte Care)

9.5% Preterm Births
90.5% Full-term Births



Private Insurance

8.0% Preterm Births
92.0% Full-term Births



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017.

Table 19. **Preterm Births, Rhode Island, 2013-2017**

CITY/TOWN	# BIRTHS	# PRETERM BIRTHS	% PRETERM BIRTHS
Barrington	537	33	6.1%
Bristol	713	52	7.3%
Burrillville	660	60	9.1%
Central Falls	1,606	144	9.0%
Charlestown	239	24	10.0%
Coventry	1,469	96	6.5%
Cranston	3,912	345	8.8%
Cumberland	1,717	133	7.7%
East Greenwich	558	47	8.4%
East Providence	2,331	188	8.1%
Exeter	238	20	8.4%^
Foster	169	13	7.7%^
Glocester	333	33	9.9%
Hopkinton	308	21	6.8%^
Jamestown	116	4	*
Johnston	1,328	108	8.1%
Lincoln	997	82	8.2%
Little Compton	83	11	13.3%
Middletown	844	66	7.8%
Narragansett	316	22	7%^
New Shoreham	57	7	*
Newport	1,303	115	8.8%
North Kingstown	1,097	88	8.0%
North Providence	1,627	162	10.0%
North Smithfield	407	29	7.1%
Pawtucket	4,848	477	9.8%
Portsmouth	618	32	5.2%
Providence	12,453	1,223	9.8%
Richmond	280	26	9.3%
Scituate	394	34	8.6%
Smithfield	673	37	5.5%
South Kingstown	817	63	7.7%
Tiverton	597	53	8.9%
Warren	455	38	8.4%
Warwick	3,862	316	8.2%
West Greenwich	230	13	5.7%^
West Warwick	1,720	142	8.3%
Westerly	913	57	6.2%
Woonsocket	2,925	248	8.5%
Unknown	*217*	*19*	*8.8%^*
Four Core Cities	*21,832*	*2,092*	*9.6%*
Remainder of State	*32,135*	*2,589*	*8.1%*
Rhode Island	*53,967*	*4,681*	*8.7%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017. Data for births in 2014 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 2013-2017.

*The data are statistically unreliable and rates are not reported and should not be calculated.

^The data are statistically unstable and rates or percentages should be interpreted with caution.

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 2013-2017 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 Unknown births include three births with missing maternal residence data.

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

References

[1] Centers for Disease Control and Prevention. (2018). *Preterm birth.* Retrieved March 12, 2019, from www.cdc.gov

[2,5,6] Mayo Clinic. (n.d.). *Premature birth.* Retrieved March 12, 2019, from www.mayoclinic.org

[3] Beauregard, J.L., et. al. (2018). Pretern birth, poverty, and cognitive development. *Pediatrics, 141*(1): e20170509.

[4] March of Dimes. (2018). *Preterm labor and premature birth: Are you at risk?* Retrieved March 12, 2019, 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.

(continued on page 180)

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, level of educational attainment, infections, 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. Fetal growth restriction results in low birthweight babies, and may be caused by infection, birth defects, or simply because the baby's parents are small.[4]

Cigarette smoking during pregnancy is a leading cause of low birthweight.[5,6] In Rhode Island, 6.8% of births between 2013 and 2017 were to mothers who smoked during their pregnancy. During that time, Rhode Island smokers (13.0%) 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 are at a greater risk of physical and developmental problems and death than those born at a normal birthweight. Children born at very low birthweight (less than 1,500 grams or 3.3 pounds) 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 higher risk of long-term health issues, including heart disease, diabetes, obesity, and intellectual and developmental disabilities. Low birthweight babies are also at greater risk for long-term learning difficulties and mental health problems than their peers.[8,9,10]

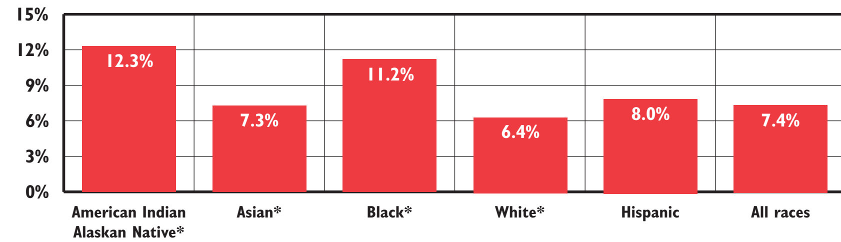
In the U.S. in 2017, 8.3% of infants were born at low birthweight, which was a 10.7% increase from 7.5% in 1997. In Rhode Island in 2017, 7.5% of Rhode Island's infants were born at low birthweight, which was a slight increase from 7.4% in 1997.[11,12] The Healthy People 2020 national target is 7.8%.[13]

Low Birthweight Infants	2007	2017
RI	8.0%	7.5%
US	8.2%	8.3%
National Rank*		*15th*
New England Rank**		*4th*

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

Source: For 2007: Martin, J. A., et al. (2010). Births: Final data for 2007. *National Vital Statistics Reports, 58*(24), 1-88. For 2017: Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Driscoll, A. K., & Drake, P. (2018). Births: Final data for 2017. National Vital Statistics Reports, 67(8), 1-49.

Low Birthweight Infants by Race/Ethnicity, Rhode Island, 2013-2017



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017. * Race categories are non-Hispanic. Data for births in 2017 are provisional.

◆ **There are racial and ethnic disparities in rates of low birthweight.[14] In Rhode Island between 2013 and 2017, 12.3% of American Indian Alaskan Native infants, 11.2% of Black infants, 7.3% of Asian infants, and 8.0% of Hispanic infants were born at low birthweight, compared to 6.4% of White infants.[15]**

◆ **Factors that persist throughout a woman's life, such as increased stress, income inequality, insufficient health care, toxic environmental exposures, lack of safe and affordable housing, and/or discrimination, 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 2013 and 2017 in Rhode Island, 9.5% of births among women under age 20 were low birthweight compared to 7.3% 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 8.5% of infants born to women with a high school degree or less were low birthweight, compared to 6.4% of those born to women with higher education levels.[18]**

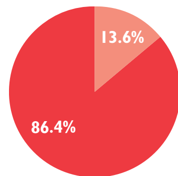
◆ **Rhode Island women who deliver a low birthweight infant are more likely to report smoking while pregnant, feeling unsafe in their neighborhood, delayed or no prenatal care, a depression diagnosis, and intimate partner violence than those with a normal weight baby, as well as health issues during their pregnancy such as high blood pressure or hypertension.[19]**

◆ **Between 2013 and 2017 in Rhode Island, 1.5% of all live births were born at very low birthweight (less than 1,500 grams or 3.3 pounds).[20]**

Low Birthweight by Mother's Insurance Type, Rhode Island, 2013-2017

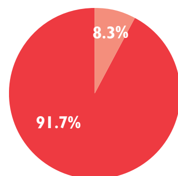
Uninsured

13.6% Low Birthweight
86.4% Normal Birthweight



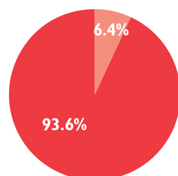
Public Insurance (RIte Care)

8.3% Low Birthweight
91.7% Normal Birthweight



Private Insurance

6.4% Low Birthweight
93.6% Normal Birthweight



Source: Rhode Island Department of Health, Center for Health Data and Analysis. Maternal and Child Health Database, 2013-2017. Data for births in 2017 are provisional.

Table 20. **Low Birthweight Infants, Rhode Island, 2013-2017**

CITY/TOWN	# BIRTHS	# LOW BIRTHWEIGHT	% LOW BIRTHWEIGHT
Barrington	537	25	4.7%
Bristol	713	33	4.6%
Burrillville	660	41	6.2%
Central Falls	1,606	131	8.2%
Charlestown	239	14	5.9%^
Coventry	1,469	91	6.2%
Cranston	3,912	274	7.0%
Cumberland	1,717	112	6.5%
East Greenwich	558	37	6.6%
East Providence	2,331	168	7.2%
Exeter	238	15	6.3%^
Foster	169	11	6.5%^
Glocester	333	20	6.0%^
Hopkinton	308	18	5.8%^
Jamestown	116	2	*
Johnston	1,328	93	7.0%
Lincoln	997	62	6.2%
Little Compton	83	4	*
Middletown	844	51	6.0%
Narragansett	316	22	7.0%^
New Shoreham	57	5	*
Newport	1,303	108	8.3%
North Kingstown	1,097	78	7.1%
North Providence	1,627	143	8.8%
North Smithfield	407	30	7.4%
Pawtucket	4,848	428	8.8%
Portsmouth	618	32	5.2%
Providence	12,453	1,095	8.8%
Richmond	280	18	6.4%^
Scituate	394	21	5.3%^
Smithfield	673	31	4.6%
South Kingstown	817	48	5.9%
Tiverton	597	45	7.5%
Warren	455	28	6.2%
Warwick	3,862	248	6.4%
West Greenwich	230	12	5.2%^
West Warwick	1,720	114	6.6%
Westerly	913	55	6.0%
Woonsocket	2,925	242	8.3%
Unknown	*217*	*13*	*6.0%^*
Four Core Cities	*21,832*	*1,896*	*8.7%*
Remainder of State	*32,135*	*2,122*	*6.6%*
Rhode Island	*53,967*	*4,018*	*7.4%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017. Data for births in 2017 are provisional. 2014 birth data 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 2013 and 2017.

*The data are statistically unreliable and rates are not reported and should not be calculated.

^The data are statistically unstable and rates or percentages should be interpreted with caution.

Unknown: Births were to Rhode Island residents, but specific city/town information was unavailable.

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

References

[1,5] *2018 KIDS COUNT data book: State trends in child well-being.* (2018). Baltimore, MD: The Annie E. Casey Foundation.

[2,4,10] March of Dimes. (2018). *Low birthweight.* Retrieved March 14, 2019, from www.marchofdimes.org

[3] Gage, T.B., Fang, F., O'Neill, E., & DiRienzo, G. (2013). Maternal education, birth weight, and infant mortality in the United States. *Demography 50*(2), 615-635.

[6] Centers for Disease Control and Prevention. (2017). *Tobacco use and pregnancy.* Retrieved March 14, 2019, from www.cdc.gov

[7,15,18,19,20] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017.

[8] American Psychological Association. (2017). *Low birth weight babies at higher risk for mental health problems later in life.* [Press release]. Retrieved from https://www.apa.org/news/press/releases/2017/02/low-birth-weight

[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.

(continued on page 180)

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, sudden infant death syndrome (SIDS), maternal complications, and unintentional injuries — account for 56% of all infant deaths with congenital malformations as the leading cause of infant deaths.[3] While infant mortality has declined nationally across all racial and ethnic groups, disparities remain. Nationally in 2016, the non-Hispanic Black infant mortality rate was 11.4 deaths per 1,000 births, the American Indian/Alaska Native rate was 7.4, the Hispanic rate was 5.0, the non-Hispanic White rate was 4.9, and the Asian rate was 3.6.[4]

The U.S. infant mortality rate declined from 26.0 deaths per 1,000 live births in 1960 to 5.9 deaths per 1,000 live births in 2016 due to improvements in healthier behaviors, medical advances, improved access to care, and economic growth.[5,6,7,8] Relative to other industrialized countries, the U.S. has higher rates of infant mortality due in part to a relatively high number of preterm births that result in infant mortality.[9,10]

The overall infant mortality rate in Rhode Island between 2013 and 2017 was 5.5 deaths per 1,000 live births. The infant mortality rate was 7.2 per 1,000 live births in the four core cities, compared with 4.4 per 1,000 live births in the remainder of the state. Mothers with a high school degree or less had a higher infant mortality rate (5.7 per 1,000 live births) than mothers with higher educational attainment (3.5 per 1,000 live births) between 2013 and 2017.[11]

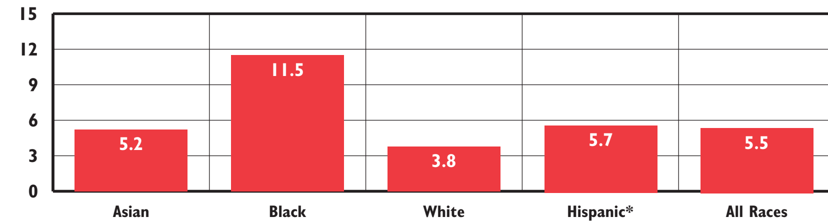
Infant Mortality Rate
(rate per 1,000 live births)

	2006	2016
RI	6.1	5.7
US	6.7	5.9
National Rank*		***16th***
New England Rank**		***4th***

**1st is best; 49th is worst*
***1st is best; 5th is worst*
(Vermont did not meet NCHS reporting standards in 2016)

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

Infant Mortality Rate per 1,000 Live Births by Race/Ethnicity, Rhode Island, 2013-2017



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017. *Hispanic infants can be of any race.

◆ **In Rhode Island between 2013 and 2017, the Black infant mortality rate was 11.5 deaths per 1,000 live births, up from 9.9 deaths per 1,000 births between 2012 and 2016.[12]**

◆ **The Black infant mortality rate is the highest of any racial or ethnic group even after controlling for risk factors such as socioeconomic status and educational attainment.[13]**

◆ **Between 2013 and 2017, 297 infants died in Rhode Island before their first birthday, a rate of 5.5 per 1,000 live births. This is a slight improvement from the 2012-2016 infant mortality rate of 5.6 per 1,000 live births (when there were 302 infant deaths). Between 2013 and 2017, 76% of infants who died were low birthweight (less than 2,500 grams) and 22% were born at normal weights.[14]**

◆ **Preterm birth is the leading cause of infant death in Rhode Island.15 Between 2013 and 2017, 75% (222) of all infant deaths were preterm (born before the 37th week of pregnancy).[16]**

◆ **Of the 297 infant deaths between 2013 and 2017 in Rhode Island, 76% (225) occurred in the neonatal period (during the first 27 days of life). 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.[17,18]**

◆ **Between 2013 and 2017, 24% (72) of the 297 infant deaths in Rhode Island occurred in the post-neonatal period (between 28 days and one year after delivery).[19]**

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.[20]

◆ Infant mortality is a result of a variety of factors and interventions to prevent infant mortality should occur at multiple levels, including individual health education and counseling, ongoing evidence-based clinical interventions, long-lasting health protecting actions, creating health-promoting environments, and socioeconomic interventions to eliminate disparities.[21]

◆ 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.[22] As of October 2018, there were 1,278 families enrolled in one of the evidence-based family home visiting programs coordinated by the Rhode Island Department of Health.[23]

Table 21. **Infant Mortality by City/Town, Rhode Island, 2013-2017**

CITY/TOWN	# OF BIRTHS	# OF INFANT DEATHS	RATE PER 1,000 LIVE BIRTHS
Barrington	537	0	0.0
Bristol	713	0	0.0
Burrillville	660	1	*
Central Falls	1,606	8	*
Charlestown	239	2	*
Coventry	1,469	3	*
Cranston	3,912	17	4.3^
Cumberland	1,717	9	*
East Greenwich	558	4	*
East Providence	2,331	14	6.0^
Exeter	238	1	*
Foster	169	0	0.0
Glocester	333	0	0.0
Hopkinton	308	5	*
Jamestown	116	0	0.0
Johnston	1,328	8	*
Lincoln	997	6	*
Little Compton	83	0	0.0
Middletown	844	5	*
Narragansett	316	0	0.0
New Shoreham	57	6	*
Newport	1,303	0	0.0
North Kingstown	1,097	2	*
North Providence	1,627	8	*
North Smithfield	407	3	*
Pawtucket	4,848	39	8.0
Portsmouth	618	2	*
Providence	12,453	96	7.7
Richmond	280	4	*
Scituate	394	3	*
Smithfield	673	0	0.0
South Kingstown	817	1	*
Tiverton	597	0	0.0
Warren	455	0	0.0
Warwick	3,862	10	*
West Greenwich	230	3	*
West Warwick	1,720	0	0.0
Westerly	913	8	*
Woonsocket	2,925	14	4.8^
Unknown	*214*	*15*	*
Four Core Cities	*21,832*	*157*	*7.2*
Remainder of State	*32,132*	*140*	*4.4*
Total	*53,964*	*297*	*5.5*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017.

The denominator is the total number of live births to residents between 2013 and 2017.

^ The data are statistically unstable and rates or percentages should be interpreted with caution.

* The data are statistically unreliable and rates are not reported and should not be calculated

Unknown: Deaths were to Rhode Island residents, but specific city/town information was unavailable.

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

References

[1] Federal Interagency Forum on Child and Family Statistics. (2017). *America's children: Key national indicators of well-being, 2017.* Washington, DC: U.S. Government Printing Office.

[2] Centers for Disease Control and Prevention. (2013). Infant deaths – United States, 2005-2008. *Morbidity and Mortality Weekly Report, 62*(Suppl 3), 171-174.

[3,7] Kochanek, K.D., Murphy, S.L., Xu, J., & Arias, E. (2017). Mortality in the United States, 2016. *NCHS Data Brief, 293,* 1-7.

[4] Centers for Disease Control and Prevention. (2018). *Infant mortality.* Retrieved March 18, 2019, from www.cdc.gov

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

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

[9] *Health at a glance 2017: OECD indicators.* (2018). Paris, FR: OECD Publishing.

(continued on page 180)

Breastfeeding

DEFINITION

Breastfeeding is the number and percentage of newborn infants who are 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 and continuous breastfeeding for at least 12 months after birth or longer as mutually desired by mother and child.[3]

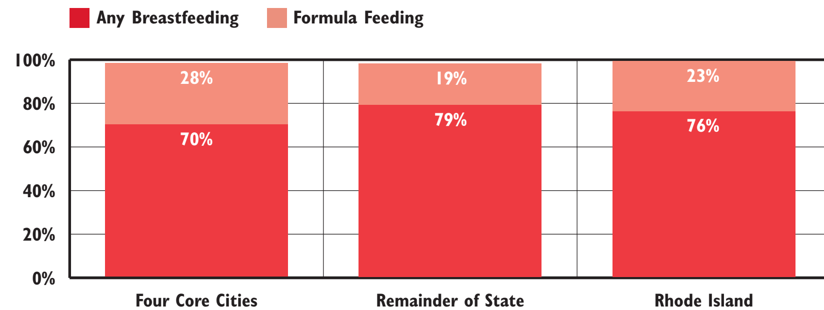
Breastfeeding decreases infant mortality and morbidity. Infant benefits include optimal nutrition and reduced risk for Sudden Infant Death Syndrome, infectious disease, and chronic conditions such as childhood obesity, type 1 and 2 diabetes, and otitis media. Breastfeeding benefits mothers by creating a strong bond with infants and decreasing risk for postpartum depression, type 2 diabetes, and hypertension. Breastfeeding provides significant social and economic benefits, including reduced cost to the family, reduced health care costs, and reduced employee absenteeism.[4,5,6]

Breastfeeding can be effectively promoted by hospital and other birth facility policies and practices that take place before, during, and after labor and delivery, including access to professional lactation consultants and involvement in community breastfeeding support networks.[7] In 2015, Women & Infants Hospital became the second-largest hospital in the U.S. to achieve the "Baby-Friendly" designation, which recognizes breastfeeding support and promotion by birth facilities.[8] Rhode Island ranks second best in the U.S. with 86% of babies born at Baby-Friendly hospitals.[9]

Breastfeeding rates generally increase with maternal age, higher educational attainment, and higher income levels.[10] Whether the pregnancy was intentional or not also affects rate of breastfeeding. In Rhode Island between 2016-2017, 10% of babies from intended pregnancies were not breastfed at all, compared with 15% of babies from unintended pregnancies.[11]

Healthy People 2020 sets target breastfeeding rates of 82% of infants ever having been breastfed and 34% at one year of age.[12] Among babies born in the U.S. in 2015, 83% were ever breastfed, 58% were breastfed at six months, and 36% were breastfed at 12 months. In 2015, Rhode Island reported rates of 81% of infants ever having been breastfed, 50% at six months, and 31% at one year of age; all decreases since 2013 and lower than the national averages.[13]

Breastfeeding and Formula Feeding at Birth, Rhode Island, 2013-2017*

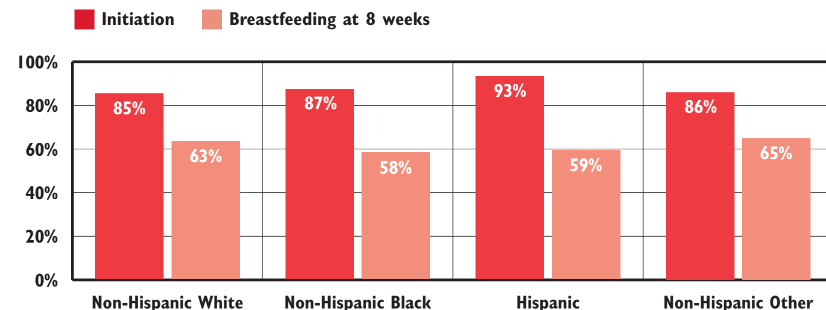


Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017. Breastfeeding and formula feeding are defined as intended feeding method at hospital discharge. Totals may not sum to 100% because data on feeding methods were not available for all births.

**Note: The data collection process at the Rhode Island Department of Health was changed in 2015. Prior to 2015, breastfeeding was recorded as "Breast," "Bottle," or "Both." Since 2015, a "Yes" or "No" question on the birth certificate worksheet "Is the infant being breastfed at discharge?" has been used. Data from and prior to 2015 for "Exclusive breastfeeding" and "Both breast and formula" have been combined into the "Any breastfeeding" category to align with current data collection practices.*

◆ **Between 2013 and 2017, 76% of new mothers in Rhode Island indicated that they intended to breastfeed when discharged from the hospital, 23% intended to formula feed.[14] Nearly nine out of ten (87%) new mothers in Rhode Island who were surveyed about three months after giving birth between 2012-2015 reported ever having breastfed. Forty-six percent reported continued breastfeeding at the time of the survey.[15]**

Breastfeeding Initiation and at Eight Weeks, Rhode Island, 2014



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Pregnancy Risk Assessment Monitoring System (PRAMS), 2014.

Rhode Island Supports for Breastfeeding

◆ All 50 states have passed legislation that provides mothers with the explicit right to breastfeed in public places.[16] Since 2015, Rhode Island law has prohibited job discrimination based on pregnancy, childbirth, and related medical conditions and requires employers to make reasonable accommodations for workers for conditions related to pregnancy and childbirth, including breastfeeding.[17]

◆ In 2014, Rhode Island became the first state in the U.S. to establish licensure for International Board Certified Lactation Consultants (IBCLCs). State-certified and trained lactation consultants provide comprehensive lactation support and counseling for pregnant and postpartum women. In January 2019, Rhode Island had 57 licensed IBCLCs.[18,19]

◆ Rhode Island is one of six states, in addition to Washington, D.C., that have enacted paid family leave programs, which can support breastfeeding initiation and duration.[20] U.S. mothers who have 12 or more weeks of paid maternity leave are nearly three times more likely to initiate breastfeeding and twice as likely to breastfeed for six or more months, compared to mothers with no paid leave.[21]

Table 22. **Breastfeeding at Time of Birth, Rhode Island, 2013-2017**

CITY/TOWN	NUMBER OF BIRTHS SCREENED	NUMBER ANY BREASTFEEDING	PERCENT ANY BREASTFEEDING
Barrington	527	483	92%
Bristol	664	521	78%
Burrillville	601	458	76%
Central Falls	1,572	1,080	69%
Charlestown	221	181	82%
Coventry	1,438	1,140	79%
Cranston	3,860	2,990	77%
Cumberland	1,582	1,293	82%
East Greenwich	589	512	87%
East Providence	2,265	1,699	75%
Exeter	233	195	84%
Foster	167	145	87%
Glocester	302	236	78%
Hopkinton	251	213	85%
Jamestown	111	108	97%
Johnston	1,309	970	74%
Lincoln	951	749	79%
Little Compton	55	46	84%
Middletown	760	638	84%
Narragansett	297	256	86%
New Shoreham	54	45	83%
Newport	1,154	920	80%
North Kingstown	1,084	926	85%
North Providence	1,598	1,196	75%
North Smithfield	394	320	81%
Pawtucket	4,610	3,330	72%
Portsmouth	526	454	86%
Providence	12,090	8,517	70%
Richmond	311	266	86%
Scituate	407	336	83%
Smithfield	643	530	82%
South Kingstown	889	778	88%
Tiverton	356	294	83%
Warren	415	317	76%
Warwick	3,757	2,926	78%
West Greenwich	221	179	81%
West Warwick	1,680	1,173	70%
Westerly	730	605	83%
Woonsocket	2,663	1,771	67%
Four Core Cities	*20,935*	*14,698*	*70%*
Remainder Of State	*30,402*	*24,098*	*79%*
Rhode Island	*51,337*	*38,796*	*76%*

Sources of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017.

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.

*Note: The data collection process at the Rhode Island Department of Health was changed in 2015. Prior to 2015, breastfeeding was recorded as "Breast," "Bottle," or "Both." Since 2015, a "Yes" or "No" question on the birth certificate worksheet "Is the infant being breastfed at discharge?" has been used. Data from and prior to 2015 for "Exclusive breastfeeding" and "Both breast and formula" have been combined into the "Any breastfeeding" category to align with current data collection practices.

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.

[2,18] *Breastfeeding: 2015-2020 Rhode Island strategic plan.* (2015). Providence, RI: Rhode Island Department of Health.

[4] Kavanaugh, K. & Lessen, R. (2015). Position of the Academy of Nutrition and Dietetics: Promoting and supporting breastfeeding. *Journal of the American Dietetic Association, 115*, 444-449.

[5] *Breastfeeding.* (2016). Washington, DC: Child Trends.

[6,21] The Center for Law and Social Policy. (2016). *Public policies to support breastfeeding: Paid family leave and workplace lactation accommodations.* Retrieved January 7, 2019, from www.clasp.org

(continued on page 180)

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, 2018.[1,2] These data are for children eligible to enter kindergarten in the fall of 2020 (i.e., children born between September 1, 2014 and August 31, 2015).

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 slowed growth and development, learning disabilities, behavioral problems, and neurological damage. 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 intelligence, and increased medical, special education, and juvenile justice costs.[6,7] Children can be exposed to lead in the places they spend the most time. Homes, schools, and child care settings can be contaminated with lead from paint or paint dust if built before 1978.

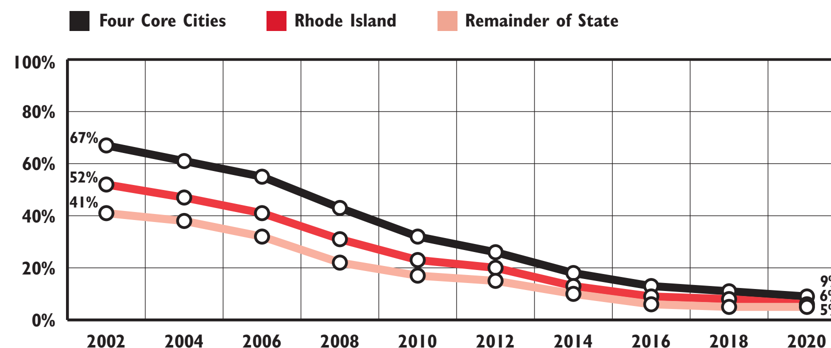
Children can also be exposed to lead poising through corrosion of lead service lines where a house or building's water pipe connects to the public water main.[8]

There is no safe lead level in children. In an effort to better alert health officials and families 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 allows parents and health officials to take corrective actions sooner.[9,10,11]

Although the percentage of children with elevated blood lead levels is declining nationally and in Rhode Island, low-income children are at higher risk of lead exposure.[12,13] In Rhode Island, children living in the four core cities are at increased risk for lead exposure because the housing stock tends to be older.[14]

In 2018, 635 (3%) of the 23,031 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 (4%) were four times as likely as children in the remainder of the state (1%) to have confirmed elevated blood lead levels ≥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, 2002-2020



Source: Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program, Children entering kindergarten between 2002 and 2020. *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, the core cities have nearly twice the rate of children with elevated blood levels.[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 lead levels 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]**

◆ **A 2016 Department of Health initiative tested schools for lead in drinking water. The results and recommendations for action are available by school on the Department of Health website.[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 μg/dL. The number of children under age six who were significantly lead poisoned has decreased by 81% over the past 13 years, from 349 in 2005 to 68 in 2018.[22]

◆ Starting in 2015, an environmental inspection of a child's home is offered when a single venous test 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 2018, 116 environmental inspections were offered, of which 67 were performed, 18 were refused, 18 were pending, and 13 the child had moved.[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 screening through age six. Lead screening is a mandated covered health insurance benefit in Rhode Island. By the end of 2018, 79% of Rhode Island three-year-olds had received at least one blood test, 51% had received at least two blood tests, and 21% were never tested.[24,25,26]

Table 23. **Lead Poisoning in Children Entering Kindergarten in the Fall of 2020, Rhode Island**

CITY/TOWN	NUMBER TESTED FOR LEAD POISONING	CONFIRMED WITH BLOOD LEAD LEVEL ≥5 μg/dL	
		NUMBER	PERCENT
Barrington	181	4	*
Bristol	145	11	7.6% ^
Burrillville	155	2	*
Central Falls	307	28	9.1%
Charlestown	36	2	*
Coventry	309	7	*
Cranston	768	52	6.8%
Cumberland	337	8	*
East Greenwich	158	5	*
East Providence	448	31	6.9%
Exeter	56	2	*
Foster	38	2	*
Glocester	57	2	*
Hopkinton	55	4	*
Jamestown	28	0	0.0%
Johnston	286	8	*
Lincoln	217	7	*
Little Compton	25	5	*
Middletown	201	8	*
Narragansett	61	3	*
New Shoreham	7	2	*
Newport	285	15	5.3% ^
North Kingstown	244	11	4.5% ^
North Providence	308	11	3.6% ^
North Smithfield	78	4	*
Pawtucket	872	51	5.8%
Portsmouth	130	2	1.5%
Providence	2,600	265	10.2%
Richmond	48	4	*
Scituate	101	1	*
Smithfield	122	0	0.0%
South Kingstown	179	7	*
Tiverton	127	7	*
Warren	107	11	10.3 ^
Warwick	741	30	4.0%
West Greenwich	47	0	0.0%
West Warwick	302	20	6.6%
Westerly	177	4	*
Woonsocket	589	26	4.4%
Unknown Residence	*2*	*NA*	*NA*
Four Core Cities	*4,368*	*370*	*8.5%*
Remainder of State	*6,564*	*292*	*4.4%*
Rhode Island	*10,934*	*662*	*6.1%*

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 2020 reflect the number of Rhode Island children eligible to enter school in the fall of 2020 (i.e., born between 9/1/14 and 8/31/15).

Children confirmed positive for lead poisoning (blood lead level ≥5 g/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 2018. 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 g/dL receive a confirmatory venous test.

The denominator for percent confirmed is the number of children entering kindergarten in the fall of 2020 who were tested for lead poisoning. Data include both venous and confirmed capillary tests.

Of the 727 children entering kindergarten in 2020 who had an initial blood lead screen of ≥5 g/dL, six did not receive a confirmatory second test. Their lead poisoning status is unknown.

Unknown: Children were Rhode Island residents, but specific city/town information was unavailable.

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

See Methodology Section for more information.

References

[1,10] Centers for Disease Control and Prevention. (n.d.). *Blood lead levels in children.* Retrieved February 20, 2019, from www.cdc.gov

[2,25] Rhode Island Department of Health. (2018). *Childhood lead poisoning prevention program referral intervention process.* Retrieved February 22, 2019, from www.health.ri.gov

(continued on page 180)

Children with Asthma

DEFINITION

Children with asthma is the rate of emergency department visits 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 the emergency department visit.

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 is unknown, various genetic, environmental, birth, and health factors have been linked to an increased risk for asthma.[1,2,3]

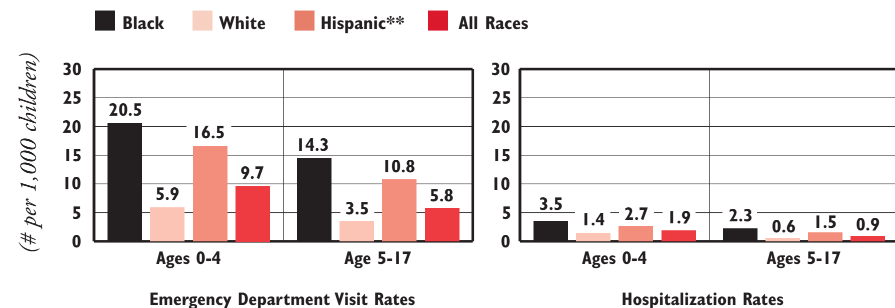
Nationally, asthma is one of the most common chronic conditions among children.[4] After peaking at 9.6% in 2009, asthma prevalence among U.S. children fell to 8.4% in 2017.[5,6] The highest rates of asthma are among males, children of Two or more races, and children living in poverty.[7] Racial and ethnic differences in asthma prevalence are believed to be correlated with poverty, exposure to indoor and outdoor air pollution, stress, acute exposure to violence, access to healthcare, and genetic factors.[8,9]

Compared with adults, children have higher rates of primary care and emergency department visits for asthma, similar hospitalization rates, and lower death rates.[10] Asthma remains the third leading 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 can improve health outcomes and reduce costly asthma hospitalizations if adhered to and supported by enhanced care and community-based interventions.[12,13,14,15,16]

Rhode Island middle and high school staff provide information and referrals about asthma. In 2016, 73% of middle and high schools reported providing health care referrals for students diagnosed with or suspected of having asthma, 53% percent of schools reported providing asthma education to students, 31% percent reported using an assessment tool to evaluate school policies, activities, and programs related to asthma, and 18% provided families with information on asthma.[17]

Asthma* Emergency Department and Hospitalization Rates, by Age and Race/Ethnicity, Rhode Island Children, 2013-2017



Source: Rhode Island Department of Health, Hospital Discharge Database, 2013-2017; U.S. Census Bureau, Census 2010.
*Rates are for primary diagnosis of asthma. **Hispanic children can be of any race.

◆ **In Rhode Island between 2013 and 2017, Black children, Hispanic children, and children ages five to twelve 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.[18]**

◆ **In Rhode Island between 2013 and 2017, boys under age 18 had higher asthma emergency department visits (8.7 per 1,000 boys) and hospitalization (1.4 per 1,000 boys) rates than girls under age 18 (5.8 and 1.0 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 2013 and 2017, 68% had RIte Care/Medicaid coverage, 26% had private health insurance, 4% were self-pay (which could mean they were uninsured or that their insurance did not cover the cost of care), and 2% were unknown/other. Among hospital admissions during that time, 57% had RIte Care/Medicaid coverage, 38% had private health insurance, 4% were self-pay, and 1% were unknown/other.[20]**

Child Hospitalization Rates for Asthma

◆ **In 2015, Rhode Island parents reported higher rates of current asthma prevalence of their children (9.8%) than the national average (8.5%). Rhode Island has the ninth highest self-reported child asthma prevalence among ranked states.[21]**

◆ **In Rhode Island between 2013 and 2017, there were 1,295 hospitalizations with primary asthma diagnosis of children under age 18, a rate of 1.2 per 1,000 children. The rate of primary asthma hospitalizations was more than twice as high in the four core cities (1.8 per 1,000 children) than in the remainder of the state (0.8 per 1,000 children).[22]**

◆ **Primary asthma hospitalization rates for children were highest in Providence (2.1 per 1,000 children), Central Falls (1.8), Pawtucket (1.7), Middletown (1.5), Barrington (1.5), East Providence (1.4), and Newport (1.3) between 2013 and 2017.[23]**

Table 24. **Asthma Emergency Department Visits for Children Under Age 18, Rhode Island, 2013-2017**

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
Barrington	4,597	105	4.6
Bristol	3,623	54	3.0
Burrillville	3,576	49	2.7
Central Falls	5,644	346	12.3
Charlestown	1,506	19	2.5^
Coventry	7,770	176	4.5
Cranston	16,414	402	4.9
Cumberland	7,535	97	2.6
East Greenwich	3,436	40	2.3
East Providence	9,177	240	5.2
Exeter	1,334	23	3.4^
Foster	986	6	*
Glocester	2,098	24	2.3^
Hopkinton	1,845	23	2.5^
Jamestown	1,043	12	2.3^
Johnston	5,480	140	5.1
Lincoln	4,751	76	3.2
Little Compton	654	7	*
Middletown	3,652	115	6.3
Narragansett	2,269	41	3.6
New Shoreham	163	0	0.0
Newport	4,083	205	10.0
North Kingstown	6,322	89	2.8
North Providence	5,514	210	7.6
North Smithfield	2,456	37	3.0
Pawtucket	16,575	774	9.3
Portsmouth	3,996	55	2.8
Providence	41,634	2,779	13.3
Richmond	1,849	20	2.2^
Scituate	2,272	20	1.8^
Smithfield	3,625	36	2.0
South Kingstown	5,416	87	3.2
Tiverton	2,998	18	1.2
Warren	1,940	54	5.6
Warwick	15,825	367	4.6
West Greenwich	1,477	27	3.7^
West Warwick	5,746	209	7.3
Westerly	4,787	117	4.9
Woonsocket	9,888	539	10.9
Four Core Cities	*73,741*	*4,438*	*12.0*
Remainder State	*150,215*	*3,205*	*4.3*
Rhode Island	*223,956*	*7,643*	*6.8*

Source of Data for Table/Methodology

Rhode Island Department of Health, Hospital Discharge Database, 2013-2017.

The Rhode Island Department of Health defines emergency department visits with primary asthma diagnosis as those resulting in a home discharge or another facility, but not admitted to the hospital as an inpatient. As such, data are not comparable to *Factbooks* prior to 2017.

The denominator used to compute the 2013-2017 rate of emergency department visits is the number of children according to the 2010 U.S. Census, multiplied by five.

^ The data are statistically unstable and rates or percentages should be interpreted with caution.

* The data are statistically unreliable and rates are not reported and should not be calculated.

Unknown: Children were Rhode Island residents, but specific city/town information was unavailable.

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

References

[1,4] *Asthma.* (2016). Washington, DC: Child Trends.

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

[3,8] 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. (2017). *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, 2017.* Retrieved January 7, 2019, 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.

(continued on page 181)

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]

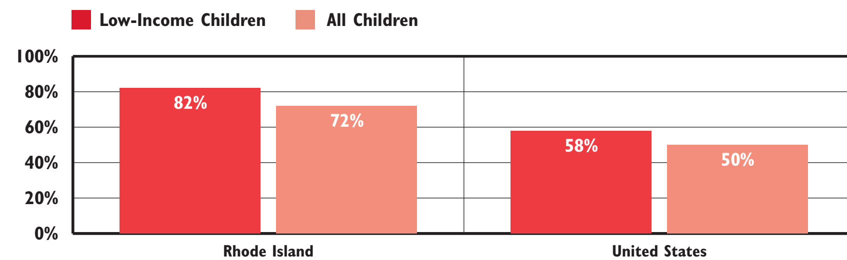
Unhealthy housing can cause or intensify many health conditions. Studies have connected poor quality construction, utility deficiencies, water intrusion, lead paint, radon, and pests to respiratory illnesses, asthma, unintentional injuries, lead poisoning, and cancer. Children under age 14, low-income children, and children of color 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*, 2013-2017, Rhode Island and the United States



Source: Population Reference Bureau analysis of 2013-2017 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.

◆ **Between 2013 and 2017, Rhode Island had the highest percentage of low-income children (82%) and the second highest percentage of children of all incomes (72%) living in older housing in the U.S., after New York.[11]**

◆ **Lead Poisoning: Children living in homes built before 1978 are at risk for lead poisoning. Even at low levels, lead exposure can negatively affect a child's health, development, and brain.[12] In 2018, 635 (3%) of Rhode Island children under age six had a confirmed blood lead level of ≥5 μg/dL.[13]**

◆ **Asthma: Asthma is a common chronic condition in children and is a leading cause of school absences and hospitalization for children under age 15 in the U.S.[14] Between 2013 and 2017, there were 4,029 emergency department visits of Rhode Island children ages six and under (9.9 per 1,000) for which asthma was the primary diagnosis.[15]**

◆ **Unintentional Injuries: Falls are the leading cause of non-fatal unintentional injuries among children in the U.S.[16] In 2017, housing-related falls resulted in 1,370 emergency room visits by Rhode Island children age six and under.[17]**

◆ **Weatherization Assistance Program: The program helps income eligible households reduce heating bills by providing whole-house energy efficiency and safety services. In 2018, 1,743 Rhode Island children under age 18 benefited from 1,694 completed weatherization projects administered by seven Community Action Program agencies.[18,19]**

Table 25.

Housing and Health, Rhode Island

CITY/TOWN	# OF CHILDREN AGES 6 AND UNDER 2010	CHILDREN WITH LEAD POISONING 2018			PRIMARY ASTHMA ED VISITS 2013-2017		HOUSING RELATED FALLS 2017	WEATHER-IZATION PROJECTS 2018	% HOUSING STOCK PRE-1980
		#	TESTED	%	#	RATE PER 1,000			
Barrington	1,213	1	463	*	55	9.1	21	7	84%
Bristol	1,316	6	342	*	35	5.3	18	24	67%
Burrillville	1,186	3	244	*	21	3.5^	14	23	65%
Central Falls	2,374	31	751	4.1%	189	15.9	48	17	88%
Charlestown	493	0	75	0.0%	10	*	7	23	51%
Coventry	2,508	6	585	*	105	8.4	39	42	65%
Cranston	5,814	34	1,628	2.1%	195	6.7	98	212	78%
Cumberland	2,603	6	701	*	33	2.5	36	22	63%
East Greenwich	930	2	257	*	19	4.1^	4	7	67%
East Providence	3,545	23	1,143	2.0%	129	7.3	60	118	85%
Exeter	390	0	66	0.0%	8	*	2	9	45%
Foster	315	1	55	*	4	*	6	7	66%
Glocester	633	2	105	*	8	*	5	19	65%
Hopkinton	618	5	125	*	11	*	7	12	63%
Jamestown	287	0	45	0.0%	8	*	3	4	58%
Johnston	1,930	2	466	*	58	6.0	33	71	64%
Lincoln	1,490	5	400	*	35	4.7	20	11	72%
Little Compton	188	1	31	*	3	*	3	5	70%
Middletown	1,331	3	302	*	58	8.7	30	15	67%
Narragansett	739	1	76	*	18	4.9^	13	17	57%
New Shoreham	57	0	22	0.0%^	0	0.0	0	0	56%
Newport	1,792	24	418	5.7%	120	13.4	37	12	82%
North Kingstown	1,965	5	430	*	46	4.7	25	20	64%
North Providence	2,040	11	626	1.8%^	121	11.9	44	62	72%
North Smithfield	752	4	175	*	11	*	10	11	67%
Pawtucket	6,835	58	1,920	3.0%	413	12.1	136	141	88%
Portsmouth	1,206	0	274	0.0%	28	4.6	16	14	62%
Providence	16,934	316	6,361	5.0%	1,543	18.2	350	385	84%
Richmond	635	1	82	*	12	3.8^	7	17	47%
Scituate	608	3	169	*	7	*	7	27	68%
Smithfield	1,076	1	292	*	18	3.3^	15	26	62%
South Kingstown	1,707	1	336	*	39	4.6	16	25	57%
Tiverton	1,006	5	337	*	5	*	8	42	61%
Warren	727	6	214	*	28	7.7	7	20	78%
Warwick	5,561	13	1,393	0.9%^	176	6.3	91	105	80%
West Greenwich	446	0	84	0.0%	9	*	0	6	31%
West Warwick	2,351	8	604	*	113	9.6	39	33	74%
Westerly	1,735	3	287	*	55	6.3	18	46	62%
Woonsocket	4,212	44	1,147	3.8%	283	13.4	77	37	89%
Four Core Cities	*30,355*	*449*	*10,179*	*4.4%*	*2,428*	*16.0*	*611*	*580*	*86%*
Remainder of State	*51,193*	*186*	*12,852*	*1.4%*	*1,601*	*6.3*	*759*	*1,114*	*70%*
Rhode Island	*81,548*	*635*	*23,031*	*2.8%*	*4,029*	*9.9*	*1,370*	*1,694*	*74%*

Source of Data for Table/Methodology

Source of Data for Table/Methodology Children Age Six and Under: U.S. Census Bureau, Census 2010. Table PCT12.

Children with Lead Poisoning: Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program, 2018. The numerator is the number of Rhode Island children with a confirmed blood lead level ≥5 g/dL in calendar year 2018. The denominator is the number of children who were tested in calendar year 2018. Data are for children under age six.

Children with Asthma: Rhode Island Department of Health, Hospital Discharge Database, 2013-2017. The Rhode Island Department of Health defines emergency department (ED) visits for children with a primary asthma diagnosis as those resulting in a home discharge or another facility, but not admitted to the hospital as an inpatient. For details, see Children with Asthma indicator. Data are for children age six and under.

Housing Related Falls: Rhode Island Department of Health, Center for Health Data and Analysis, 2017. Data are for children age six and under who are residents of Rhode Island.

Weatherization Projects: Rhode Island Department of Human Services, Weatherization Assistance Program data, 2018. Weatherization projects are defined as those receiving a final inspection by end of calendar year 2018.

Housing Stock Pre-1980: Population Reference Bureau analysis of 2013-2017 American Community Survey (ACS) Public Use Microsample (PUMS) data. Table B25034. 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.

* The data are statistically unreliable and rates are not reported and should not be calculated.

^ The data are statistically unstable and rates or percentages should be interpreted with caution.

Effective October 1, 2015, the International Classification of Disease (ICD) codes changed from the 9th classification to the 10th classification, which may impact comparability across the years for *Housing Related Falls.*

(Sources continued with References on page 181)

Childhood Overweight and Obesity

DEFINITION

Childhood overweight and obesity is the percentage of children whose body mass index (BMI) meets the definition for overweight or obese. Children with a BMI at or above the 95th percentile for gender and age are considered to be obese, and children 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 problems, 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]

Nationally, there is a continued upward trend in obesity.[5] In 2015-2016 in the U.S., the prevalence of obesity in children ages two to 19 was 19% with a significant increase in severe obesity for children ages two to five years.[6,7]

Prior to 2018, Rhode Island did not have adequate clinical childhood BMI data. A recent study of 41,394 de-identified records with clinical and related billing code data from 2016 found that 15% of Rhode Island children ages two to 17 are overweight and 20% are obese.[8]

The increased prevalence of childhood obesity is the result of complex interactions among many factors, including excess calorie consumption, genes, metabolism, behavior, environment, and culture.[9] Low consumption of healthy foods, high consumption of sugar-sweetened beverages and energy dense foods, low levels of physical activity, and high levels of screen time are all associated with obesity.[10]

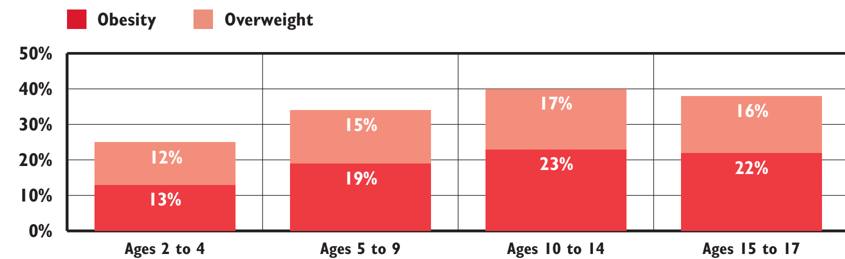
Prevention and intervention for at-risk, overweight, and obese children should occur early and at all ages.[11] Reducing overweight and obesity will require a comprehensive, multi-system approach.

Overweight and Obesity Among Children Age 10-17 (Combined Overweight and Obesity)	2017
RI	31%
US	31%
National Rank*	*31st*
New England Rank**	*5th*

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

Source: Data Resource Center for Child and Adolescent Health, *2017 National Survey of Children's Health*, childhealthdata.org

Rhode Island Childhood Overweight and Obesity by Age, 2016



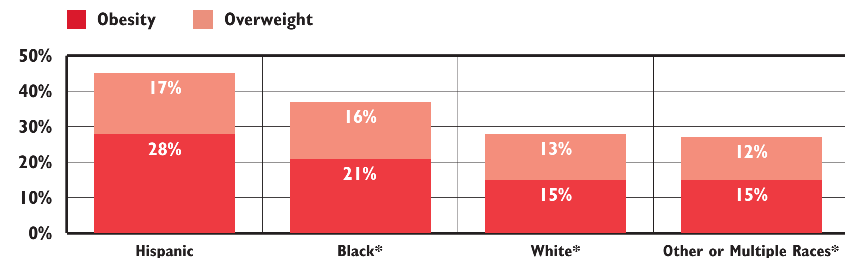
Source: Hassenfeld Child Health Innovation Institute analysis of BMI clinical and billing records of children ages two to 17 in Rhode Island from KIDSNET, Current Care, Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, and United Healthcare collected by the Department of Health, 2016.

◆ **Fifteen percent of Rhode Island children age two to 17 are overweight and 20% are obese.[12]**

◆ **Older children are more likely to be overweight or obese. Twenty-three percent of children ages 10 to 14 and 22% of children ages 15 to 17 are obese.[13]**

◆ **Twenty-six percent of children covered by public insurance are obese compared to 14% of children with private health insurance.[14]**

Rhode Island Childhood Overweight and Obesity by Race/Ethnicity, 2016



Source: Hassenfeld Child Health Innovation Institute analysis of BMI clinical and billing records of children ages two to 17 in Rhode Island from KIDSNET, Current Care, Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, and United Healthcare collected by the Department of Health, 2016. **Non-Hispanic.*

◆ **Hispanic children have the highest rates of overweight and obesity at 17% overweight and 28% obese.[15]**

Nutrition and Physical Activity

◆ Nutrition and physical activity are important components of supporting a healthy weight. Many children and adolescents consume diets with too many calories and not enough nutrients.[16,17] In 2017, 88% of Rhode Island high school students reported eating less than three servings of vegetables a day, the recommended amount. Eleven percent of Rhode Island high school students reported drinking soda at least once a day.[18]

◆ Regular physical activity, including school-based physical education and recess, has been shown to have physical, social, emotional, cognitive, academic, and health benefits.[19,20] In 2017, 54% of Rhode Island middle school students and 59% of high school students reported less than five days of physical activity in a week.[21]

◆ 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.[22]

Table 26. **Prevalence of Overweight and Obesity in Rhode Island Children Ages 2 to 17, 2016**

CITY/TOWN	% OVERWEIGHT	% OBESE	% OVERWEIGHT AND OBESE COMBINED
Barrington	13%	7%	20%
Bristol	18%	15%	33%
Burrillville	16%	16%	32%
Central Falls	19%	29%	48%
Charlestown	17%	19%	36%
Coventry	12%	15%	27%
Cranston	14%	19%	33%
Cumberland	15%	16%	31%
East Greenwich	13%	9%	22%
East Providence	15%	21%	36%
Exeter	10%	12%	22%
Foster	15%	13%	28%
Glocester	14%	11%	25%
Hopkinton	14%	14%	28%
Jamestown	*	17%^	NA
Johnston	16%	19%	35%
Lincoln	16%	17%	33%
Little Compton	24%^	32%^	NA
Middletown	12%	25%	37%
Narragansett	16%	19%	35%
New Shoreham	*	*	NA
Newport	15%	21%	36%
North Kingstown	9%	12%	21%
North Providence	17%	18%	35%
North Smithfield	16%	13%	29%
Pawtucket	17%	26%	43%
Portsmouth	10%^	23%	NA
Providence	17%	26%	43%
Richmond	13%	16%	29%
Scituate	14%	12%	26%
Smithfield	12%	12%	24%
South Kingstown	18%	16%	34%
Tiverton	13%	20%	34%
Warren	18%	17%	35%
Warwick	15%	15%	30%
West Greenwich	12%	16%	28%
West Warwick	14%	20%	34%
Westerly	12%	16%	28%
Woonsocket	14%	25%	39%
Four Core Cities	*17%*	*26%*	*43%*
Remainder of State	*14%*	*16%*	*30%*
Rhode Island	*15%*	*20%*	*35%*

Source of Data for Table/Methodology

Hassenfeld Child Health Innovation Institute analysis of BMI clinical and billing records of children ages 2 to 17 in Rhode Island from KIDSNET, Current Care, Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, and United Healthcare collected by the Department of Health, 2016.

^ The data are statistically unstable and rates or percentages should be interpreted with caution.

* The data are statistically unreliable and rates are not reported and should not be calculated.

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

References

[1] Centers for Disease Control and Prevention. (2015). *About child and teen BMI.* Retrieved January 23, 2019, from www.cdc.gov

[2] Centers for Disease Control and Prevention. (2016). *Childhood obesity causes and consequences.* Retrieved January 23, 2019, from www.cdc.gov

[3,22] Glickman, D., Parker, L., Sim, L., Del Valle Cook, H., & Miller, E. A. (2012). *Accelerating progress in obesity prevention: Solving the weight of the nation.* Washington, DC: Institute of Medicine of the National Academies.

[4] 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.

[5,7] Skinner, A.C., Ravanbakht, S.N., Skelton, J.A., et al. (2018) Prevalence of obesity and severe obesity in US children, 1999-2016. *Pediatrics. 141*(3):e20173459.

[6] Hales, C.M., Carroll, M.D., Fryar, C.D., & Ogden, C.L. (2017). *Prevalence of obesity among adults and youth: United States, 2015-2016.* Retrieved January 23, 2019, from www.cdc.gov/nchs

[8,12,13,14,15] Hassenfeld Child Health Innovation Institute analysis of BMI clinical and billing records of children ages two to 17 in Rhode Island from KIDSNET, Current Care, Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, and United Healthcare collected by the Department of Health, 2016.

(continued on page 181)

Births to Teens

DEFINITION

Births to teens is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

SIGNIFICANCE

Teen pregnancy and parenting threaten the development of teen parents as well as their children. Children of teen parents have higher rates of infant mortality, premature birth, and low birth weight. Children of teens have lower test scores, academic outcomes, and are more likely to have a teen birth themselves compared with children of older mothers.[1] There are strong intergenerational links between maternal education among teen mothers, and educational attainment, income, and well-being in the next generation.[2]

Teen mothers are less likely to graduate from high school or go to college.[3] Teen girls in foster care are more than twice as likely as their peers to become pregnant by age 19.[4]

Nationally, one in six births to teens are repeat births (two or more children born before the mother is 20 years old). Repeat teen births are more likely to be preterm or low birthweight than first teen births.[5] Teens mothers who have repeat births are more likely to experience additional negative outcomes, including increased health issues, lower educational attainment, and less economic independence.[6]

Despite downward national trends of teen births, including among all racial and ethnic groups, disparities in teen births persist. In 2017 in the U.S., the rate of teen birth for Hispanic teens (28.9 births per 1,000) and to non-Hispanic Black teens (27.56 per 1,000), were both more than twice the rate of non-Hispanic white teens (13.2 per 1,000).[7]

After peaking in 1991, the U.S. teen birth rate steadily declined, reaching a historic low in 2017. Despite these declines, the U.S. teen birth rate remains higher than other developed countries.[8,9,10]

Rhode Island's teen birth rate mirrors national trends, peaking in 1993 at a rate of 47.6 per 1,000, and reaching a historic low in 2017 at a rate of 11.4 per 1,000.[11,12] In 2018 in Rhode Island, 4% (395) of all babies were born to teen mothers.[13] Nationally and in Rhode Island, fewer teens are having sex and those that are sexually active are more likely to use contraception.[14,15]

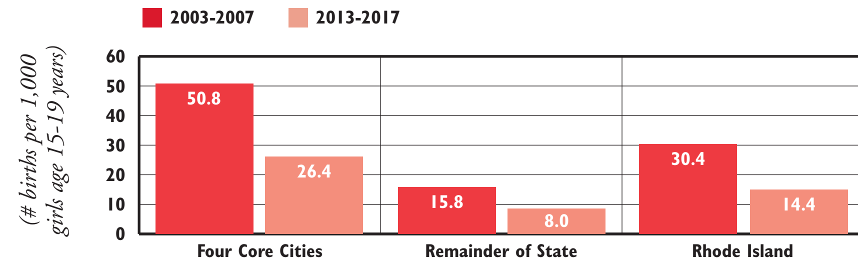
Teen Birth Rates
(rate per 1,000 girls ages 15-19)

	1991	2017
RI	44.7	11.4
US	61.8	18.8
National Rank*		*6th*
New England Rank**		*5th*

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

Source: For 1991: Ventura, S. J., et al. (2014). National and state patterns of teen births in the United States, 1940-2013. *NVSR, 63*(4), 1-33. For 2017: Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Driscoll, A. K., & Drake, P. (2018). Births: Final data for 2017. *National Vital Statistics Reports, 67*(8), 1-49.

Teen Birth Rates, Rhode Island, Five-Year Average Comparisons: 2003-2007, 2013-2017



Source: Rhode Island Department of Health, Center for Health Data and Analysis, 2003-2017.

◆ **In 2017, the birth rate for U.S. teens (18.8 births per 1,000 teen girls) and Rhode Island teens (11.4 births per 1,000 teen girls) were the lowest ever recorded.[16]**

◆ **The statewide five-year average teen birth rate declined 53% between 2003-2007 and 2013-2017, from 30.4 births per 1,000 teen girls to 14.4. The teen birth rate in the four core cities declined by 54% during that time but remains more than three times higher than the rest of the state.[17]**

◆ **Despite declines among all racial and ethnic groups, disparities still exist in teen birth rates.[18] In Rhode Island between 2013 and 2017, the teen birth rates for Hispanic (35.2 per 1,000), Native American (27.1 per 1,000), and Black (16.4 per 1,000) teens were higher than the rates of their White (7.9 per 1,000) and Asian (4.0 per 1,000) peers.[19]**

Repeat Births to Teens, Rhode Island, 2013-2017

AGE	TOTAL NUMBER OF BIRTHS	NUMBER OF REPEAT BIRTHS	PERCENT REPEAT BIRTHS
15-17	664	34	5%
18-19	1,995	350	18%
TOTAL 15-19	*2,659*	*384*	*14%*

Source: Rhode Island Department of Health, Center for Health Data and Analysis, 2013-2017.

◆ **Nationally, 17% of all births to teens ages 15-19 in 2016 were repeat births.[20] To continue to reduce repeat teen births, pregnant and parenting teens should be connected to patient-centered primary care that address a variety of needs and integrate a range of tailored services for young mothers and families.[21]**

Teen Birth Rates by Location

◆ In Rhode Island between 2013 and 2017, the rate of births to teens ages 15-19 in the core cities (26.4 per 1,000) was more than three times higher than the remainder of the state (8.0 per 1,000).[22]

◆ Fifteen percent of teen births in the core cities were repeat births, while 14% of teen births in the rest of the state were repeat births.[23]

◆ Healthcare providers play a key role in reducing teen births, by integrating comprehensive reproductive health counseling to all women and men of reproductive age, to help reduce unintended pregnancies.[24]

◆ In 2017, 19% of Rhode Island high school students who reported ever having sexual intercourse used no method (or were not sure) to prevent pregnancy, and 40% percent did not use a condom, the last time they had sexual intercourse.[25]

◆ Among 15 to 19-year-olds in Rhode Island between 2008 and 2017, the rates of chlamydia have increased by 36% (1,388 to 1,880 per 100,000) and the rates of gonorrhea have increased by 147% (89 to 219 per 100,000).[26]

Table 27. **Births to Teens, Ages 15-19, Rhode Island, 2013-2017**

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	3	4	*
Bristol	4	13	17	2.8^
Burrillville	7	18	25	9.2
Central Falls	53	139	192	47.4
Charlestown	3	17	20	17.3^
Coventry	6	29	35	6.5
Cranston	27	87	114	9.0
Cumberland	7	19	26	5.2
East Greenwich	0	7	7	*
East Providence	22	54	76	18.1
Exeter	4	9	13	15.9^
Foster	2	3	5	*
Glocester	0	9	9	*
Hopkinton	1	7	8	*
Jamestown	0	1	1	*
Johnston	5	34	39	10.6
Lincoln	3	24	27	11.4
Little Compton	0	0	0	0
Middletown	7	11	18	12.9^
Narragansett	2	2	4	*
New Shoreham	0	1	1	*
Newport	16	38	54	8.9
North Kingstown	9	23	32	7.2
North Providence	16	49	65	17.2
North Smithfield	3	5	8	*
Pawtucket	62	197	259	26.6
Portsmouth	4	7	11	*
Providence	268	715	983	22.1
Richmond	1	9	10	*
Scituate	1	7	8	*
Smithfield	1	4	5	*
South Kingstown	2	18	20	1.3^
Tiverton	4	10	14	13.3^
Warren	2	18	20	18.4^
Warwick	30	90	120	12.6
West Greenwich	1	8	9	*
West Warwick	24	79	103	34.2
Westerly	7	26	33	10.7
Woonsocket	59	199	258	44.6
Unknown	*0*	*6*	*6*	
Four Core Cities	*442*	*1,250*	*1,692*	*26.4*
Remainder of State	*222*	*739*	*961*	*8.0*
Rhode Island	*664*	*1,995*	*2,659*	*14.4*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017.

* The data are statistically unreliable and rates are not reported and should not be calculated.

^ The data are statistically unstable and rates or percentages should be interpreted with caution.

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

In the 2012 Factbook, the denominators for the city/town table were updated with population data from Census 2010. *Factbooks* prior to 2012 used population data from Census 2000. Changes in rates are affected by the updated population data.

Factbooks published before 2007 reported only births to girls ages 15 to 17. The definition of teen childbearing was expanded to include teens ages 15-19 to align with reports from the U.S. Centers for Disease Control and Prevention's National Center for Health Statistics.

Births to teens ages 14 and younger are collected by the Rhode Island Department of Health but are not reported in the *Factbook.*

Unknown births include three births with missing maternal residence data.

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

References

[1,14] *Teen births: Indicator of child and youth well-being.* (2016). Washington, DC: Child Trends.

[2,10,20] U.S. Department of Health & Human Services Office of Adolescent Health. (2016). *Trends in teen pregnancy and childbearing.* Retrieved March 1, 2019, from www.hhs.gov

[3] Centers for Disease Control and Prevention. (2019). *About teen pregnancy.* Retrieved March 1, 2019, from cdc.gov

[4] Brooks, K. (2019). *Teen pregnancy and foster care.* Washington, DC: National Center for Health Research.

(continued on page 182)

Alcohol, Drug, and Tobacco Use

DEFINITION

Alcohol, drug, and tobacco use is the percentage of middle school and high school students who report using alcohol, tobacco products (including e-cigarettes), and illicit substances.

SIGNIFICANCE

The use and/or abuse of substances such as alcohol, tobacco, and other substances by youth impact the health and safety of themselves, their families, their schools, and their communities.[1,2] Rhode Island ranks among the states with the highest percentages of adolescents reporting use of alcohol and many types of illicit drugs.[3]

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. 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.[4,5]

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 attachment to their communities.[6,7] 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.[8,9]

Prevention and reduction in teen substance abuse can be achieved by enacting policies that support prevention, screening, early intervention, treatment, and recovery. Policy examples include preventing underage substance use and sales to minors, improving school climate and academic achievement, enacting sentencing reform, and adequate funding for multi-sector youth development, treatment, and recovery services.[10]

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 sixth highest percentage among all states on this measure.[11]

Tobacco Use Among Rhode Island Youth

◆ In 2017, 26% of Rhode Island high school students reported currently smoking cigarettes or cigars or using smokeless tobacco or e-cigarettes (i.e. e-cigars, e-pipes, vaping pipes/pens, e-hookahs/pens). Current use is defined as use on at least one day during the 30 days before the survey.[12]

◆ E-Cigarettes: E-cigarettes are harmful to youth. They contain, among other chemicals, nicotine which is highly addictive and can harm brain development. Some e-cigarette pods have as much or more nicotine as a pack of cigarettes.[13]

◆ E-Cigarettes: Nationally in 2018, current e-cigarette use among high school students reached 21%, higher than use of traditional tobacco cigarettes or any other tobacco product.[14] In Rhode Island in 2017, 20% of high school students reported current use of e-cigarettes and 40% reported ever using e-cigarettes.[15] Effective January 1, 2018, the General Assembly passed legislation prohibiting the use of e-cigarettes in schools.[16]

◆ Cigarettes: Cigarette use has reached record low levels among U.S. middle and high school students.[17] In 2017, 6% of Rhode Island high school students reported currently smoking cigarettes. Fifty-nine percent of Rhode Island high school students who reported current cigarette use in 2017 also reported trying to quit smoking in the past year.[18]

◆ Hookah, cigars, and smokeless tobacco: The prevalence of youth hookah, cigar, and smokeless tobacco use has declined nationally and in Rhode Island.[19] In 2017, 5% of Rhode Island high school students reported currently smoking tobacco in a hookah, 7% reported currently smoking cigars, and 5% reported current use of smokeless tobacco.[20]

Tobacco to 21

◆ The Centers for Disease Control and Prevention, the Institute of Medicine, and the American Academy of Pediatrics suggest that raising the minimum legal sale age for tobacco products to 21 may prevent or delay initiation of tobacco use by adolescents.[21,22,23] Nationally, 88% of adult cigarette users who smoke daily report starting by age 18.[24] Rhode Island's minimum sale age is 18 years. As of January 2018, seven states have set the age to 21 (HI, CA, NJ, OR, ME, MA, VA).[25,26]

Current Substance Use, Rhode Island High School Students by Select Subgroups, 2017

	ALCOHOL USE*	E-CIGARETTE USE*	CIGARETTE USE*	MARIJUANA USE*	PRESCRIPTION DRUG MISUSE**
Female	26%	17%	5%	23%	3%
Male	20%	22%	7%	23%	4%
Black, Non-Hispanic	19%	12%	1%	27%	4%
White, Non-Hispanic	25%	23%	7%	22%	3%
All other races, Non-Hispanic	NA	16%	1%	19%	2%
Multiple races, Non-Hispanic	29%	20%	6%	38%	1%
Hispanic	20%	16%	6%	23%	4%
9th Grade	16%	17%	6%	15%	4%
10th Grade	20%	21%	5%	20%	5%
11th Grade	26%	22%	4%	26%	3%
12th Grade	33%	21%	9%	33%	2%
All Students	*23%*	*20%*	*6%*	*23%*	*4%*

Source: *2017 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. **Prescription drug misuse is defined as those without a doctor's prescription. NA is not available due to small sample size.

◆ Among Rhode Island high school students in 2017, 23% reported current alcohol consumption, 23% reported current marijuana use, 20% reported current use of e-cigarettes, 11% reported current binge drinking, 6% reported current cigarette use, 5% reported currently using over the counter drugs to get high, and 4% reported currently misusing prescription drugs.[27]

◆ In 2017, a majority of Rhode Island high school students reported that they have never smoked a cigarette (81%) or used an e-cigarette product (60%).[28]

◆ Cigarette excise taxes are a potential funding stream for state tobacco control programs.[29] Between SFY 2002-2018, Rhode Island cigarette tax revenue increased from $79.4 million to $143.1 million and state tobacco control funding decreased from $3 million to $388,000. Only .27% of the cigarette tax in SFY 2018 went toward tobacco control and smoking cessation programs.[30,31,32,33]

Family and Community Exposure

◆ Having parents or friends who use tobacco, alcohol, and other drugs, as well as living in communities where there is drug use, are risk factors for teen substance use.[34] In Rhode Island in 2017, 35% of middle school students and 33% of high school students reported living with someone who smokes cigarettes. One in six (17%) Rhode Island high school students under age 18 who used an e-cigarette during the past 30 days reported buying it in a store, despite laws prohibiting sales to minors. One in seven (14%) high school students who had ever taken a prescription drug without a doctor's prescription reported taking it from a friend or relative without their knowledge.[35]

Exposure to Substances at Birth

◆ Neonatal abstinence syndrome (NAS) refers to the objective and subjective signs and symptoms attributed to the cessation of prenatal exposure of substances. Neonatal opioid withdrawal syndrome, more specifically, refers to the withdrawal symptoms related to opioid exposure. Not all substance exposed newborns are diagnosed with NAS.[36]

◆ In Rhode Island in 2017, 113 newborns were diagnosed with NAS, at a rate of 106 per 10,000 births; almost as high as the highest rate in 2015 at 114 per 10,000 births, and double the rate of 37.2 in 2006.[37]

◆ Eighty-three percent of babies born with NAS in 2017 were born to white mothers, 94% were born to mothers who were covered by Medicaid, and 52% lived in the four core cities.[38]

◆ NAS rates will not decrease until Opiate Use Disorder rates decreases in the general population. Adequate treatment options and services for those struggling with Opiate Use Disorder are needed before and during pregnancy, at birth, and throughout parenting for the whole family.[39]

References

[1,4,6] *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health.* (2016). Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.

[2] *Substance-free youth.* (2015). Washington, DC: Child Trends.

(continued on page 182)

Safety

The Secret Place
by Dennis Lee

There's a place I go, inside myself,
Where nobody else can be,
And none of my friends can tell it's there—
Nobody knows but me.

It's hard to explain the way it feels,
Or even where I go.
It isn't a place in time or space,
But once I'm there, I know .

It's tiny, it's shiny, it can't be seen,
But it's big as the sky at night . . .
I try to explain and it hurts my brain,
But once I'm there, it's right.

There's a place I know inside myself,
And it's neither big nor small,
And whenever I go, it feels as though
I never left at all.

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 access to health care, children's mental and physical health, 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 steadily since 1980, but disparities still exist by age, gender, and 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 boys than girls. The child death rate is also higher for Black children than for children of all other racial and ethnic groups.[3,4]

In Rhode Island between 2013 and 2017, there were 81 deaths of children ages one to 14 (a rate of 10.04 per 100,000 children).[5] Of these children, 31 (38%) lived in the four core cities and 50 (62%) lived in the remainder of the state. Of the 81 deaths, 57 (70%) were due to disease, 16 (20%) were due to unintentional injuries, and 8 (10%) were due to intentional injuries (six suicides and two homicides).[6,7]

Children are particularly vulnerable to injury deaths due to their size, development, inexperience, and natural curiosity.[8] Unintentional injuries are the second highest cause of death for children ages one to 14 in Rhode Island and the leading cause in the U.S.[9,10]

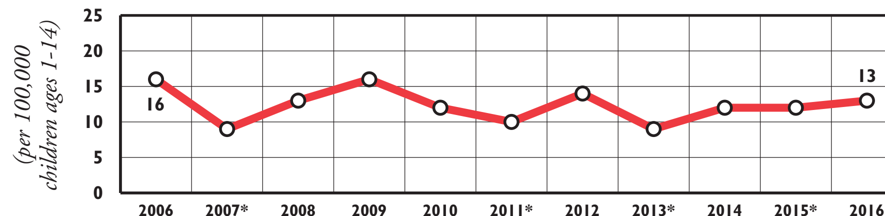
Nationally, the leading causes of child injury deaths are motor vehicle crashes and drowning.[11] Child injury deaths can be reduced by educating families about injury prevention strategies and the importance of using safety products (such as seat belts and fencing around pools), enforcing laws that promote safety (such as speed limits and the mandatory use of child passenger restraints), and through continued environmental and product design improvements (such as safely engineered toys and safety surfacing on playgrounds).[12]

Child Death Rate (per 100,000 Children Ages 1-14)		
	2006	2016
RI	16	13
US	19	17
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

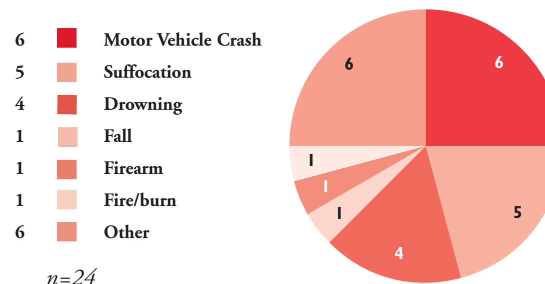
Child Death Rate per 100,000 Children Ages One to 14, Rhode Island, 2006-2016



Source: Centers for Disease Control and Prevention, CDC WONDER, wonder.cdc.gov
*Caution should be used with small numbers in numerators and denominators.

◆ **In 2016, Rhode Island's child death rate for children ages one to 14 was 13 per 100,000 children, which was a small increase from 2015. Rhode Island's New England rank improved from fourth in 2015 to third in 2016, and its U.S. rank remained the same at fourth lowest.[13]**

Child Deaths Due to Injury, by Cause, Rhode Island, 2013-2017



Source: Rhode Island Department of Health, Center for Health Data and Analysis, 2013-2017.

◆ **Between 2013 and 2017, 24 Rhode Island children ages one to 14 died as a result of injury. Motor vehicle crashes, suffocation, and drowning were the leading causes of these child deaths in Rhode Island during this time period.[14]**

References

[1] *2018 KIDS COUNT data book.* (2018). Baltimore, MD: The Annie E. Casey Foundation.

[2,3,10] *Infant, child, and teen mortality.* (2016). Washington, DC: Child Trends.

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

(continued on page 182)

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.[1] Teens' mental health, including mood disorders and depression, further impacts their safety.[2] Nationally in 2016, 75% of teen deaths were accidents, homicides, and suicides, all of which are preventable.[3,4]

Factors that protect against teen deaths include parent and family involvement, access to mental health services, state regulated teen driving programs, as well as violence and substance abuse prevention programs. Individual and group therapeutic programs in family, school, and community settings can support positive behavior changes and increase mental health awareness.[5,6,7]

Between 2013 and 2017, there were 94 deaths of teens ages 15 to 19 in Rhode Island, a rate of 25.5 per 100,000 teens. Of these teens, 36 (38%) lived in the four core cities and 58 (62%) lived in the remainder of the state.[8,9] Of these 94 teen deaths, 36 (38%) were due to unintentional injuries, 26 (28%) were due to intentional injuries (18 suicides and eight homicides), 21 (22%) were due to disease, and 11 (1%) were due to overdose.[10]

According to the *2017 Rhode Island Youth Risk Behavior Survey*, 11% of Rhode Island high school students reported attempting suicide one or more times in the 12 months before the survey was administered, which was the same as in 2015.[11] Of the 18 youth ages 15 to 19 who died from suicide between 2013 and 2017, 16 were male and two were female.[12] Nationally, depression and suicide among adolescents have increased in recent years, with more females reporting symptoms of depression and committing suicide nationally than males.[13] Mental health problems, depression, attempting suicide, substance abuse, experiencing partner violence, and having a family member or friend attempt suicide are associated with an increased risk of suicide or attempted suicide among youth.[14]

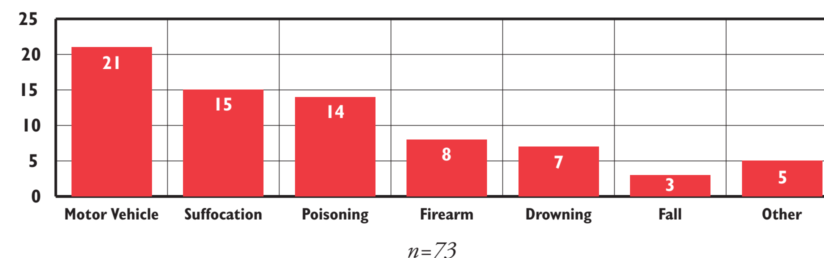
Teen Death Rate
(per 100,000 Children Ages 15-19)

	2006	2016
RI	34	22
US	63	51
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, 2013-2017



n=73

Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017. 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. Effective October 1, 2015, the International Classification of Disease (ICD) codes changed from the 9th classification to the 10th classification, which may impact comparability across the years.

◆ **Between 2013 and 2017 in Rhode Island, 58% of the 73 teen deaths caused by injury were unintentional. Twenty-nine percent of all injury deaths involved motor vehicles.[15]**

◆ **Among the 26 teens ages 15 to 19 killed in Rhode Island motor vehicle crashes between 2013 and 2017, 12 were driving, eight were passengers in vehicles driven by others, four were pedestrians, and two were bicyclists.[16]**

◆ **Two (17%) of the teen drivers who died in motor vehicle crashes in Rhode Island between 2013 and 2017 had been drinking, and two teen fatalities occurred with adult drivers who had been drinking.[17]**

◆ **Ten (59%) of teen drivers and passengers killed in automobile accidents in Rhode Island between 2013 and 2017 were not wearing a seatbelt.[18]**

◆ **In 2017, 37% of Rhode Island high school students reported texting or e-mailing while driving on at least one day in the month prior to taking the *Rhode Island Youth Risk Behavior Survey*. Fourteen percent reported riding in a vehicle driven by someone who had been drinking in the prior month, and 7% reported that they never or rarely wear a seatbelt while riding in a car driven by someone else.[19]**

References

[1,5] Office of Disease Prevention and Health Promotion. (2019). *Healthy People 2020: Adolescent health.* Retrieved February 21, 2019, from www.healthypeople.gov

[2] *Teen homicide, suicide, and firearm deaths.* (2015). Washington, DC: Child Trends.

(continued on page 182)

Youth Violence

DEFINITION

Youth violence is the number of arrests of youth 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, physical 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 stop youth violence from happening in the first place and requires an understanding of the factors that influence violence.[3] Efforts to prevent youth violence should begin in early childhood and address a wide range of individual, family, and community factors. Effective violence prevention strategies include strengthening youth 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. 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] Youth who are victims of violence are at increased risk for physical and mental health problems, academic difficulties, smoking, high-risk sexual behavior, and suicide.[8]

Nationally in 2017, 24% of students in grades nine through 12 reported being in a physical fight during the previous year, 19% reported being bullied on school property during the previous year, and 16% reported carrying a weapon during the previous month.[9]

The number of youth arrested for violent crimes in the U.S. reached a 33-year low in 2012, with youth making up 12% of all serious violent crime arrests. The Rhode Island juvenile arrest rate for serious violent crimes in 2012 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 2017 in Rhode Island, there were 535 juvenile arrests for assault offenses and 106 juvenile arrests for weapons offenses.[11] In 2018, violent crimes made up 5% (234) of the 4,403 juvenile offenses referred to Rhode Island Family Court.[12]

Bully Status, by Gender and Grade Level, Rhode Island, 2017

	MIDDLE SCHOOL		HIGH SCHOOL	
	MALE	FEMALES	MALES	FEMALE
Bullied on School Property	27%	40%	15%	19%
Bullied Electronically	13%	31%	11%	17%
Been in a Physical Fight	21%	10%	13%	8%

Source: *Youth Risk Behavior Survey*, 2017, 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 2017, 7% of high school students (6% of males and 7% of females) reported not going to school due to safety concerns.[14]**

◆ **Victims of bullying are at risk of emotional, behavioral, and mental health problems. Both victims and perpetrators of bullying are more likely to contemplate or attempt suicide.[15]**

◆ **Cyberbullying is bullying that takes place online or by digital communication through text messages, instant messengers, social media, and/or other digital applications.[16] In 2017 in Rhode Island, 21% of middle school students (31% of females and 13% of males) and 14% of high school students (17% of females and 11% of males) reported being electronically bullied.[17]**

Youth Witnessing Violence and Youth Gun Violence

◆ **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.[18]**

◆ **Guns are the leading cause of fatal violence to teens and are used in 88% of teen homicides and 41% of teen suicides in the U.S.[19] In Rhode Island between 2013 and 2017, there were 105 emergency department visits, 40 hospitalizations, and eight deaths of children and youth ages 15 to 19 attributed to firearms.[20]**

Table 28.

Youth Violence, Rhode Island

CITY/TOWN	COMMUNITY CONTEXT: VIOLENT CRIME OFFENSES (ALL AGES) 2017	COMMUNITY CONTEXT: TOTAL POPULATION AGES 11-17 2010	VIOLENCE IN HIGH SCHOOLS, 2017: % OF STUDENTS WHO WORRY ABOUT VIOLENCE IN SCHOOL	VIOLENCE IN HIGH SCHOOLS, 2017: % OF STUDENTS WHO REPORT PHYSICAL FIGHTS IN SCHOOL	JUVENILE ARRESTS FOR VIOLENCE, 2018: # FOR ASSAULT OFFENSES	JUVENILE ARRESTS FOR VIOLENCE, 2018: # FOR WEAPONS OFFENSES	JUVENILE ARRESTS FOR VIOLENCE, 2018: TOTAL # FOR ASSAULT AND WEAPONS OFFENSES
Barrington	10	2,186	9%	4%	4	1	5
Bristol	15	1,545	26%	45%	3	0	3
Burrillville	16	1,526	24%	7%	2	0	2
Central Falls	97	2,089	29%	49%	12	4	16
Charlestown	9	659	10%	12%	0	0	0
Coventry	35	3,509	20%	39%	10	1	11
Cranston	111	6,984	20%	43%	8	1	9
Cumberland	15	3,271	8%	15%	5	1	6
East Greenwich	6	1,671	2%	1%	0	0	0
East Providence	69	3,730	22%	54%	23	3	26
Exeter	NA	673	16%	2%	NA	NA	NA
Foster	7	467	11%	2%	1	0	1
Glocester	3	1,000	11%	2%	1	0	1
Hopkinton	4	826	10%	12%	2	0	2
Jamestown	8	528	14%	21%	0	0	0
Johnston	45	2,376	13%	31%	8	2	10
Lincoln	28	2,189	7%	7%	11	2	13
Little Compton	0	284	27%	21%	0	0	0
Middletown	16	1,504	11%	16%	7	1	8
Narragansett	10	1,052	8%	6%	3	1	4
New Shoreham	0	64	8%	3%	0	0	0
Newport	60	1,484	26%	31%	17	3	20
North Kingstown	18	2,917	14%	14%	15	2	17
North Providence	43	2,303	14%	29%	14	2	16
North Smithfield	8	1,132	5%	1%	2	0	2
Pawtucket	311	6,268	17%	25%	77	15	92
Portsmouth	11	1,881	27%	21%	6	0	6
Providence	960	16,024	19%	15%	184	46	230
Richmond	3	759	10%	12%	5	1	6
Scituate	5	1,143	12%	2%	1	0	1
Smithfield	10	1,729	7%	3%	8	0	8
South Kingstown	14	2,498	9%	5%	9	0	9
Tiverton	21	1,318	6%	10%	2	1	3
Warren	15	777	26%	45%	3	0	3
Warwick	97	6,781	24%	34%	24	2	26
West Greenwich	2	678	16%	2%	0	0	0
West Warwick	66	2,139	12%	7%	11	2	13
Westerly	17	2,003	36%	56%	15	0	15
Woonsocket	221	3,649	23%	42%	41	15	56
State Police/Other	*NA*	*NA*	*NA*	*NA*	*1*	*0*	*1*
Four Core Cities	*1,589*	*28,030*	*20%*	*23%*	*314*	*80*	*394*
Remainder of State	*797*	*65,586*	*15%*	*22%*	*221*	*26*	*247*
Rhode Island	*2,386*	*93,616*	*16%*	*22%*	*535*	*106*	*641*

Sources of Data for Table/Methodology

Total violent crime offense data are from U.S. Department of Justice, Federal Bureau of Investigation. (2017). *Crime in the United States 2017: Rhode Island offenses known to law enforcement.* Retrieved March 12, 2019, from ucr.fbi.gov

Total population ages 11–17 data are from U.S. Census Bureau, Census 2010.

Data on high school students experiencing violence at school are from the 2017-2018 administration of *SurveyWorks!*, Rhode Island Department of Education. Percentages reflect students answering frequently or almost always to the question of "how often do you worry about violence at your school" and "how often do students get into physical fights in your school." *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 can choose to attend high school in North Kingstown or Narragansett. Rhode Island total and remainder of state include charter schools, state operated schools, and UCAP.

Juvenile arrests for assault and weapons offenses data are from Mongeau, T. & Tocco, G. (2018). *2017 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 for Youth Violence

[1,6] Centers for Disease Control and Prevention. (2015). *Understanding youth violence: Fact sheet.* Retrieved March 6, 2019, from www.cdc.gov

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

[3] Centers for Disease Control and Prevention. (2019). *The social-ecological model: A framework for prevention.* Retrieved March 8, 2019, from www.cdc.gov

(continued on page 183)

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 including post-traumatic stress disorder, substance abuse, depression, anxiety, and suicidal ideation as well as cognitive and attention difficulties, and involvement in the child welfare and juvenile justice systems.[2,3]

In the U.S. during 2017, 56% (1,927) of the 3,443 firearm deaths of children and youth under age 20 were the result of homicide, 38% (1,296) were the result of suicide, 3% (115) were the result of unintentional injuries, 2% (72) was the result of shootings with an undetermined intent, and 1% (33) was the result of a legal intervention (e.g., law enforcement shooting).[4]

Firearms are the third leading cause of death in the U.S. overall among children ages one to 17.[5] Of the 3,443 U.S. children and youth under age 20 killed by firearms during 2017, 85% (2,912) were ages 15 to 19.[6] In the U.S., 2016 marked the highest number of child and teen gun related deaths since 2006. Although Black children made up only 14% of all children and teens in the nation in 2016, 43% of all gun deaths were among Black children and teens.[7] Nationally, in 2016, males ages 15 to 19 are six times more likely to die from a firearm-related incident than females of the same age. Among teens 15-19 years old in the U.S., the rate of firearm deaths for Black males (61 per 100,000) was more than four times the rate of both Hispanic males (15 per 100,000) and White males (13 per 100,000) in 2016.[8,9]

Preventing access to guns is an important measure in preventing 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 unintentionally and in an assault or suicide. Keeping guns unloaded and locked, as well as storing and locking ammunition separately, reduces the risk of gun-related injury and death by suicide or homicide.[10,11,12]

Gun-Related Emergency Department (ED) Visits, Hospitalizations, and Deaths Among Children and Youth, Rhode Island, 2013-2017

AGE	# OF ED VISITS	# OF HOSPITALIZATIONS	# OF DEATHS
1 to 14	57	7	1
15 to 17	49	14	4
18 to 19	56	23	4
TOTAL	*162*	*44*	*9*

Source: Rhode Island Department of Health, Center for Health Data and Analysis, 2013-2017.

Note: Effective October 1, 2015, the International Classification of Disease (ICD) codes changed from the 9th classification to the 10th classification, which may impact comparability across the years.

◆ **Between 2013 and 2017 in Rhode Island, nine (11%) of the 81 injury deaths of children and youth under age 20 were the result of firearms, up from eight deaths between 2012 and 2016. Of these, four were among youth ages 18 to 19, four were among youth ages 15 to 17, and one was a child age 14 or younger. Between 2013 and 2017 in Rhode Island, there were three youth under age 20 who committed suicide using a firearm.[13]**

◆ **In Rhode Island between 2013 and 2017, there were 162 emergency department visits and 44 hospitalizations of children and youth for gun-related injuries, down from 170 and 47 respectively, between 2012 and 2016.[14]**

Weapon Carrying Among Rhode Island Public Middle and High School Students, 2017

	FEMALES	MALES	TOTAL
High School students who carried a weapon on school property at least once in the past 30 days	3%	7%	5%
Middle School students who ever carried a weapon	11%	33%	22%

Source: *2017 Rhode Island Youth Risk Behavior Survey*, Rhode Island Department of Health, Center for health Data and Analysis.

◆ **Nationally and in Rhode Island, male students report higher rates of weapon carrying on school property and gun carrying than females.[15,16]**

References

[1] Xu, J., Murphy, S. L., Xu, J., Kochanek, K. D., Bastian, B., & Arias, E. (2018). Deaths: Final data for 2016. *National Vital Statistics Reports, 67*(5).

(continued on page 183)

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 abuse, strained family relationships, substance abuse by a family member, and/or parental neglect. While there are estimated to be more than four million homeless youth in the U.S., there is no standardized definition and standard methodology for measuring homeless youth.[1,2]

Youth may become homeless when they run away from or are discharged from the foster care system. Youth with foster care histories often become homeless at an earlier age and remain homeless longer than their peers. Youth who "age out" of foster care without permanent families are more likely to experience homelessness.[3,4]

Youth who identify as lesbian, gay, bisexual, transgender, or questioning (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. LGBTQ homeless youth experience greater levels of violence and physical and sexual exploitation while on the streets and in shelters than their heterosexual peers.[5,6]

It can be difficult for homeless youth to obtain needed food, clothing, and shelter. To meet these basic needs, many turn to prostitution, theft, and/or selling drugs which risks exploitation, arrest, assault, and/or contracting sexually transmitted infections.[7,8]

Homelessness often has a negative impact on education, employment, and health outcomes for youth. Homeless youth are more likely than their peers to be chronically absent, face disciplinary actions, be held back, and drop out.[9] They experience higher rates of physical and mental health problems, substance abuse, chronic physical conditions, and death than youth with stable housing.[10,11] Homeless youth often have trouble accessing health services because they may lack health insurance, information about their coverage, and/or parental consent for treatment.[12] They may also face difficulties attending school due to a lack of required enrollment records, as well as lack of transportation to school.[13]

Homeless Youth in Rhode Island

◆ **In 2018, Rhode Island conducted the second annual *Youth Point in Time Count* to assess the number and characteristics of Rhode Islanders ages 14 to 24 with experiences of current, former, or potential housing instability or homelessness. The *2018 Youth Point in Time Count* identified 173 young adults ages 14 to 24 experiencing current, former, or potential housing instability, 67 of whom were currently homeless. Information was also collected on age, gender, race/ethnicity, education level, sexual orientation, unsafe conditions, pregnancy and parenting, and barriers to services.[14]**

◆ **During the 2017-2018 school year, Rhode Island public school personnel identified 25 unaccompanied homeless youth.[15]**

◆ **In 2018, 256 single youth ages 18 to 24 (69 ages 18 to 20 and 187 ages 21 to 24) received emergency shelter services though the adult emergency shelter system in Rhode Island, compared to 188 18 to 24-year-olds in 2017.[16,17]**

◆ **In 2017, the National Runaway Safeline handled 64 crisis phone calls and online crisis chats regarding youth ages 21 and under who were homeless, runaways, or at risk of homelessness in Rhode Island, down from 75 in 2016. Nationally, 73% of callers to the Safeline were youth and the remainder were friends, family, and other adults.[18]**

◆ **On December 31, 2018, there were 35 youth in the care of the Rhode Island Department of Children, Youth and Families between the ages of 13 and 20 who were classified as AWOL, 15 females and 20 males. These youth were AWOL from either foster care or juvenile justice placements.[19]**

◆ **There were an additional 100 youth ages 13 to 17 who received emergency shelter services with their families in Rhode Island in 2018.[20] These youth are vulnerable to being separated from their families due to child welfare policies that result in child removal, or shelter policies that do not allow males and females to stay together or otherwise accommodate families.[21]**

References

[1,7,9] Ingram, E. S., Bridgeland, J. M., Reed, B., & Atwell, M. (2016). *Hidden in plain sight: Homeless students in America's public schools.* Washington, DC: Civic Enterprises & Hart Research Associates.

[2,4] Fernandes-Alcantara, A. L. (2018). *Runaway and homeless youth: Demographics and programs.* Washington, DC: Congressional Research Service.

(continued on page 183)

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]

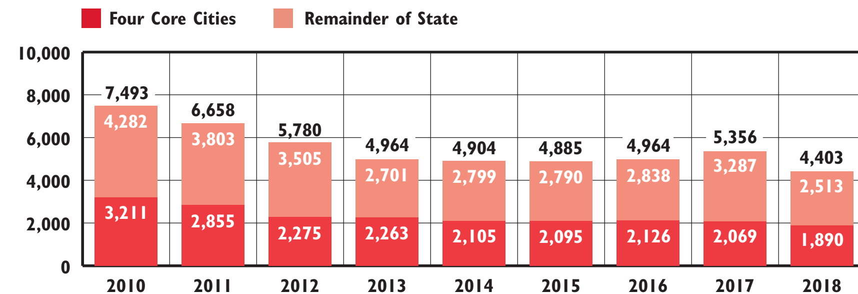
The Rhode Island Family Court has jurisdiction over children and youth under age 18 referred for wayward and delinquent offenses. When a police officer or school department refers a youth to Family Court, a petition is submitted, accompanied by an incident report, detailing the alleged violation of law.[2] During 2018 in Rhode Island, 2,565 youth (2% of Rhode Island youth between the ages of 10 and 17) were referred to Family Court, down from 2,704 youth during 2017. The number of offenses referred during 2018 (4,403) decreased from 2017, when 5,356 offenses were referred. Of the juvenile offenses in 2018, 234 (5%) involved violent offenses (55% of which occurred in the four core cities).[3,4,5]

In 2018 in Rhode Island, 20% of juvenile offenses referred to Family Court were committed by youth from Providence, 22% were committed by youth from the other three core cities, and 57% were committed by youth living in the remainder of the state.[6]

Using validated assessment tools to determine the risk of re-arrest, prioritizing and addressing the behavior and learning needs of each individual youth, and focusing efforts on youth most likely to reoffend can help prevent recidivism.[7,8] Sixty-five percent of youth referred to the Rhode Island Family Court in 2018 were referred for the first time, 16% had been referred once before, and 19% 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] Community-based programs that improve 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, 2010- 2018

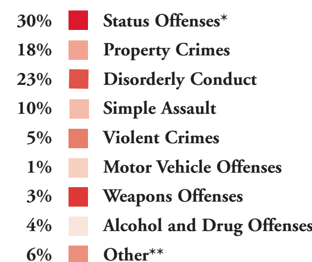


◆ **The number of juvenile offenses fell by 41% since 2010, from 7,493 to a low of 4,403 in 2018. The number of children and youth referred to Family Court for wayward and delinquent offenses declined 40% between 2010 and 2018, from 4,288 to 2,565.**

◆ **In 2018, 66% of offenses referred to the Family Court involved males and 34% females. Forty-one percent of offenses involved White youth, 25% Black youth, 15% Hispanic youth, 1% Asian youth, and 18% of offenses involved youth of Some other race or an unknown race.**

◆ **In 2018, 10% of offenses referred to Family Court involved youth ages 12 or younger, 43% youth ages 13 to 15, 46% youth ages 16 to 17, and 1% of unknown age.**

BY TYPE OF OFFENSE



n=4,403

**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, *2010-2018 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 2018 in Rhode Island, 43% of all cases referred to Family Court were diverted instead of proceeding to a formal court hearing, down from 45% in 2017.[13]

◆ The Rhode Island Family Court administers several alternatives to traditional court hearings, including the Truancy Court and the Juvenile Drug Court. In 2018, 1,729 juveniles were referred to the Truancy Court by schools, up from 1,264 in 2017. In 2018, 72 juveniles who committed drug offenses or had highlighted drug issues were diverted to the Juvenile Drug Court pre-adjudication, down from 110 in 2017.[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 2017, there were 34 Juvenile Hearing Boards in Rhode Island. Three communities did not have Juvenile Hearing Boards (Little Compton, Richmond, and South Kingstown), one had no activity (New Shoreham), one had been inactive for two years (North Kingstown), and two were in the process of preparing to receive referrals (Central Falls and Providence). 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 362 cases in 2017 (the most recent year for which data are available).[16]

LGBT Youth in the Juvenile Justice System

◆ 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 safety-related truancy. LGBT youth are more likely to be subjected to profiling, detained for low-level offenses, and victims of assault while in custody. Instituting protective policies and training for adults working in the juvenile justice system about the social, familial, and developmental challenges faced by LGBT youth could help keep them safe and support positive outcomes while they are in the community, in detention, or in correctional settings.[17,18]

Juveniles Tried as Adults

◆ Youth tried and punished in the adult court system are more likely to re-offend and to commit future crimes than youth who commit similar crimes but who are in juvenile systems. Adolescents in the adult criminal justice system are at risk for sexual and physical victimization, and disruptions in their development, including identity formation, learning, and relationship skills.[19]

◆ 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 are not fully developed during adolescence due to biological immaturity of the brain.[20,21]

◆ 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 conduct a waiver hearing so that the juvenile may be tried as an adult in Superior Court.[22]

◆ In 2018, the Attorney General's Office filed 21 (all of which were discretionary) motions to waive jurisdiction to try juveniles as adults. Of 21 discretionary waiver motions, one waived voluntarily and six remain pending before the Family Court at the end of 2018.[23]

◆ A juvenile in Rhode Island also may be "certified," allowing the Family Court to sentence the juvenile beyond age 19 if there is otherwise an insufficient period of time in which to accomplish rehabilitation. There were four certification motions filed in 2018 (all of 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.[24,25]

References

[1] Development Services Group, Inc. (2015). *Risk factors for delinquency-Literature review.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention. Retrieved March 11, 2019, from www.ojjdp.gov

[2] Rhode Island Family Court. (n.d.). *About the Family Court.* Retrieved March 11, 2019, from www.courts.ri.gov

(continued on page 183)

Youth at the Training School

DEFINITION

Youth at the Training School is the number of youth age 18 or under who were in the care or custody of the Rhode Island Training School at any time during the calendar year, including youth in community placements while in the care or custody of the Training School.

SIGNIFICANCE

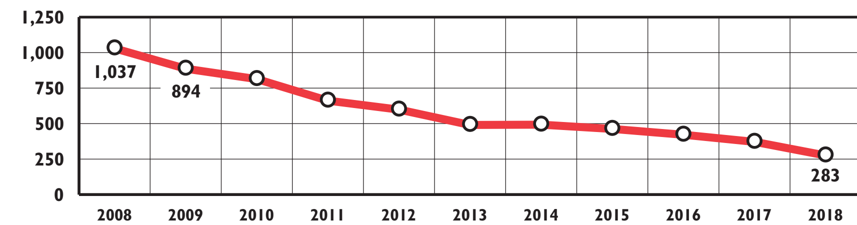
The juvenile justice system is responsible for ensuring community safety by promoting the positive development of youth in its care while recognizing that children have different developmental needs than adults.[1]

During adolescence, the brain's executive functions (including the ability to regulate emotions, control impulses, and weigh benefits and risk) have not fully developed. 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 lawbreaking 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, and Multi-Dimensional Treatment Foster Care. Alternatives to incarceration have been shown to be 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]

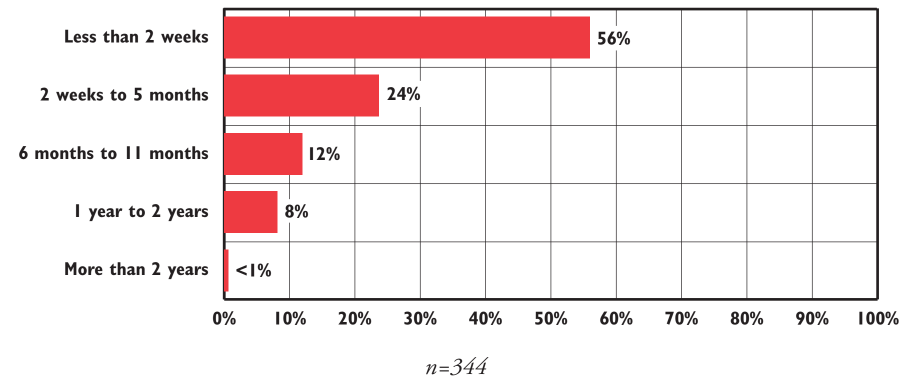
The Rhode Island Department of Children, Youth and Families (DCYF) operates the Rhode Island Training School, the state's secure facility for adjudicated youth and youth in detention awaiting trial. A total of 283 youth (80% male and 20% female) were in the care or custody of the Training School at some point during 2018, down from 383 during 2017. Between 2017 and 2018, the number of females at the Training School decreased by 17% and the number of males decreased by 28%. On December 31, 2018, there were 95 youth in the care or custody of the Training School, 51 of whom were physically at the Training School.[7]

Youth in the Care and Custody of the Rhode Island Training School, Calendar Years 2008-2018



◆ **Between 2009 and 2018, the annual total number of youth in the care and custody of the Training School at any point during the year declined from 894 to 283. 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 68% between 2009 and 2018.**

Discharges From the Rhode Island Training School, by Length of Time in Custody, Calendar Year 2018



n=344

Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2008-2018. Total discharges (344) are higher than the total number of youth who passed through the Training School (283) due to some youth being discharged from the Training School more than once in 2018.

Youth at the Training School by Age

◆ During 2018, there were no children age 11 or under, four children age 12, 36 youth ages 13-14, 136 youth ages 15-16, and 128 youth ages 17-18 held at the Training School. The average age for youth at the Training School was 16 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 283 youth who were in the care or custody of the Training School at some point during 2018, 17% (48) were admitted at least twice in 2018, and 5% (13) 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.[18] The Juvenile Probation division at DCYF serves youth placed in a residential treatment program (temporary community placement) 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 2, 2019, there were 494 youth on the DCYF probation caseload (418 males and 76 females). Four percent of youth on probation were ages 12-13, 20% were ages 14-15, 55% were ages 16-17, and 20% were age 18 or older.[20]

◆ More than half (59%) of youth on probation on January 2, 2019 were White, 24% were Black, 1% were American Indian, <1% were Asian, 7% were multiracial, and 9% were of undetermined race. Thirty-two percent of youth 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 the negative outcomes associated with incarceration.

◆ Since 2009, Rhode Island juvenile justice stakeholders have partnered 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, and receive harsher treatment than White youth.[23] The federal *Juvenile Justice and Delinquency Prevention Act (JJDPA)* requires states to collect data disaggregated by race 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, 2018
White	64%	56%
Hispanic	21%	36%
Black	6%	28%
Asian	3%	1%
Multi-Racial	5%	8%
American Indian	<1%	2%
Unknown	NA	5%
TOTAL	*223,956*	*283*

◆ Youth of color are disproportionately more likely than White youth to be in the care and custody of the Training School. During 2018, Black youth made up 28% of youth at the Training School, while making up 6% of the child population.

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

◆ In 2018, 8% (22) of the 283 youth in the care or custody of the Training School 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 2018, 148 youth (112 males and 36 females) received mental health services at the Training School for psychiatric diagnoses other than conduct disorders and substance abuse disorders. During 2018, 82 residents (60 males and 22 females) received substance abuse treatment services. Of these, 56 (all males) received residential substance abuse treatment.[28]

Educational Attainment

◆ While the average age of youth at the Training School in 2018 was 16 years, students' math skills were on average at the fifth-grade level and their reading levels were on average at the fifth-grade level at entry to the Training School.

◆ Of the 205 youth in ninth through twelfth grades who received educational services at the Training School during the 2018 academic year, 42% (87) received special education services based on Individualized Education Programs (IEPs).

◆ During 2018, 10 youth graduated from high school while serving a sentence at the Training School (7 earned a GED, and three graduated with a high school diploma). An additional 33 youth received post-secondary education services at the Training School during the 2018 academic year.[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 teen males and 9% teen females) is much higher than the general teen population (2% and 6% respectively).[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 344 discharges from the Training School during 2018, 24% resulted in stays of two days or less, 31% resulted in stays of three days to two weeks, and 45% resulted in stays of more than two weeks.[33]

Table 29. **Youth in the Care or Custody of the Rhode Island Island Training School, 2018**

CITY/TOWN	TOTAL POPULATION AGES 13-18	# OF ADJUDICATED YOUTH AT THE RITS	TOTAL # OF YOUTH AT THE RITS
Barrington	1,802	0	0
Bristol	1,780	0	2
Burrillville	1,319	3	3
Central Falls	1,859	9	17
Charlestown	554	0	1
Coventry	3,010	6	12
Cranston	6,184	5	16
Cumberland	2,746	4	3
East Greenwich	1,362	2	1
East Providence	3,243	2	10
Exeter	642	0	0
Foster	430	0	0
Glocester	878	0	1
Hopkinton	693	0	2
Jamestown	436	0	0
Johnston	2,025	3	5
Lincoln	1,851	2	3
Little Compton	228	0	0
Middletown	1,229	0	1
Narragansett	948	0	2
New Shoreham	50	0	0
Newport	1,604	3	6
North Kingstown	2,407	4	7
North Providence	2,027	1	1
North Smithfield	970	1	0
Pawtucket	5,514	21	39
Portsmouth	1,596	0	0
Providence	16,515	59	98
Richmond	637	0	1
Scituate	963	0	0
Smithfield	1,856	0	0
South Kingstown	3,540	1	3
Tiverton	1,115	0	1
Warren	675	0	1
Warwick	5,883	3	8
West Greenwich	568	0	0
West Warwick	1,891	0	7
Westerly	1,705	3	4
Woonsocket	3,112	11	17
Out-of-State	*NA*	*6*	*11*
Four Core Cities	*27,000*	*100*	*171*
Remainder of State	*58,847*	*37*	*90*
Rhode Island	*85,847*	*143*	*272*

Source of Data for Table/Methodology

Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2018; and the U.S. Census Bureau, Census 2010.

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

Youth included in the adjudicated column may or may not have been in detention at the Training School prior to adjudication.

Total number of youth includes adjudicated and detained youth who were in the care or custody of the Rhode Island Training School during calendar year 2018 (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 youth who live in other states but have committed crimes in Rhode Island and have been sentenced to serve time at the Training School. They are not included in the Rhode Island total.

References

[1,3,5,14,23] National Research Council. (2013). *Reforming juvenile justice: A developmental approach.* Committee on Assessing Juvenile Justice Reform. Bonnie, R.J., Johnson, R.J., Chemers, B.M., Schuck, J. A., Eds. Committee on Law and Justice, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

[2] Gottesman, D. & Schwarz, S. W. (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 22, 2019, from www.jjie.org

[6,13] *No place for kids: The case for reducing juvenile incarceration.* (2011). Baltimore, MD: The Annie E. Casey Foundation.

(continued on page 184)

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. have had a parent incarcerated in jail or state or federal prison at some point in their lives.[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, obesity, and depression) and educational challenges (including grade retention, placement in special education, and suspension). 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 1,693 parents incarcerated in Rhode Island on September 30, 2018 (including those awaiting trial), 93% (1,568) were fathers and 7% (125) 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., 40% of children in foster care had experienced parental incarceration at some point in their lives.[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. 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.[11,12]

The criminal justice system disproportionately affects people of color, and in the U.S. 24% of Black children and 11% of Hispanic children will experience parental incarceration compared to 4% of White children.[13] Of the 1,693 parents incarcerated in Rhode Island on September 30, 2018 (including those awaiting trial), 44% were White, 27% were Black, 25% were Hispanic, and 4% were of another race.[14]

Parents at the Rhode Island Adult Correctional Institutions (ACI), September 30, 2018

	INMATES SURVEYED*	# REPORTING CHILDREN	% REPORTING CHILDREN	# OF CHILDREN REPORTED
Awaiting Trial	664	432	65%	990
Serving a Sentence	2,104	1,261	60%	3,087
TOTAL	*2,768*	*1,693*	*61%*	*4,077*

Source: Rhode Island Department of Corrections, September 30, 2018. **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 2,768 inmates awaiting trial or serving a sentence at the ACI on September 30, 2018 who answered the question on number of children, 1,693 inmates reported having 4,077 children. Forty percent of sentenced mothers and 16% of sentenced fathers had sentences that were six months or less.[15]**

◆ **Of the 83 sentenced mothers on September 30, 2018, 55% were serving a sentence for a nonviolent offense, 30% for a violent offense, 7% for a drug-related offense, 6% for breaking and entering, and 1% for a sex-related offense. Of the 1,178 sentenced fathers, 50% were serving sentences for a violent offense, 19% for a nonviolent offense,13% for a sex-related offense,12% for a drug-related offense, and 6% for breaking and entering.[16]**

◆ **Thirty-seven percent of incarcerated parents awaiting trial or serving a sentence on September 30, 2018 had less than a high school diploma, 47% had a high school diploma or a GED, and 15% had at least some college education.[17]**

◆ **A supportive family, safe and secure housing, assistance obtaining employment, medical and mental health services, and substance abuse treatment are critical to parents' successful transition to the community after incarceration and to support the well-being of their children.[18,19]**

◆ **Families with parents with a criminal record can experience significant challenges even if the parent has never been incarcerated. A parent's criminal record is often a barrier to housing eligibility, employment opportunities, and access to public benefits. For immigrants, a conviction can lead to deportation.[20]**

Table 30. **Children of Incarcerated Parents, Rhode Island, September 30, 2018**

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	4	9	3,623	2.5
Burrillville	10	24	3,576	6.7
Central Falls	46	113	5,644	20.0
Charlestown	2	2	1,506	1.3
Coventry	22	44	7,770	5.7
Cranston	73	142	16,414	8.7
Cumberland	11	38	7,535	5.0
East Greenwich	5	16	3,436	4.7
East Providence	21	45	9,177	4.9
Exeter	5	12	1,334	9.0
Foster	2	7	986	7.1
Glocester	2	4	2,098	1.9
Hopkinton	5	8	1,845	4.3
Jamestown	2	4	1,043	3.8
Johnston	14	32	5,480	5.8
Lincoln	6	12	4,751	2.5
Little Compton	0	0	654	0.0
Middletown	6	10	3,652	2.7
Narragansett	6	12	2,269	5.3
New Shoreham	0	0	163	0.0
Newport	20	52	4,083	12.7
North Kingstown	13	41	6,322	6.5
North Providence	24	51	5,514	9.2
North Smithfield	4	6	2,456	2.4
Pawtucket	116	269	16,575	16.2
Portsmouth	5	14	3,996	3.5
Providence	403	932	41,634	22.4
Richmond	3	7	1,849	3.8
Scituate	1	2	2,272	0.9
Smithfield	6	8	3,625	2.2
South Kingstown	11	21	5,416	3.9
Tiverton	7	18	2,998	6.0
Warren	8	17	1,940	8.8
Warwick	54	106	15,825	6.7
West Greenwich	1	1	1,477	0.7
West Warwick	48	307	5,746	53.4
Westerly	18	33	4,787	6.9
Woonsocket	95	217	9,888	21.9
Unknown Residence	*111*	*275*	*NA*	*NA*
*Out-of-State Residence***	*69*	*173*	*NA*	*NA*
Four Core Cities	*660*	*1,531*	*73,741*	*20.8*
Remainder of State	*421*	*1,108*	*150,215*	*7.4*
Rhode Island	*1,081*	*2,639*	*223,956*	*11.8*

Source of Data for Table/Methodology

Rhode Island Department of Corrections, September 30, 2018. Offenders who were on Home Confinement and the awaiting trial population are excluded from this table.

U.S. Census Bureau, Census 2010.

Since the *2007 Factbook*, data are reported as of September 30, with the exception of the *2015 Factbook*, in which 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

[1,4,9] Laub, J. H. & Haskins, R. (2018). *Helping children with parents in prison and children in foster care.* Retrieved January 11, 2019, from https://futureofchildren.princeton.edu/

[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

[3,13] Turney, K. & Goodsell, R. (2018). *Parental incarceration and children's wellbeing.* Retrieved January 11, 2019, from www.futureofchildren.org

[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.

[6,8,10] Child Welfare Information Gateway. (2015). *Child welfare practice with families affected by parental incarceration.* Retrieved January 11, 2019, from www.childwelfare.gov

[7,14,15,16,17] Rhode Island Department of Corrections, September 30, 2018.

(continued on page 184)

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 2016 (the most recent year for which complete data are available), police reports indicate that children were present at 27% of domestic violence incidents resulting in arrests.[3]

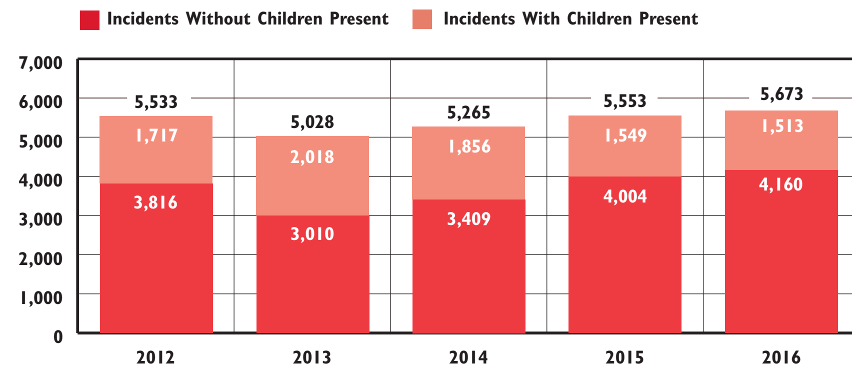
Children can be exposed to domestic violence in a number of ways. They may witness it directly (by seeing and/or hearing violent incidents), have their lives disrupted by moving or being separated from a parent, and/or may be used by the abusive parent to manipulate or gain control over the victim. Children who are exposed to domestic violence are also more likely to be victims of child abuse and neglect than those who are not.[4,5] Children may also lose a parent to domestic homicide.[6,7]

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. Children who witness domestic violence are more likely to experience physical, emotional, health, and learning challenges throughout their childhood and adulthood. They are more likely to have concentration and memory problems, and to have difficulty with school performance than children who have not witnessed domestic violence.[8,9,10]

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. There is a strong association between witnessing domestic violence as a child and becoming a perpetrator of domestic violence as an adult.[11,12]

Children are also sometimes injured or killed in domestic violence especially when their parent is planning to leave an abusive relationship. This includes biological children as well as step- and adopted children who live in the household because they are the children of the victimized partner.[13] It is, therefore, important to put supports in place to ensure the safety of all children living in households experiencing domestic violence.

Domestic Violence Incidents Resulting in Arrest, Rhode Island, 2012-2016



Source: Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit, 2012-2016. Includes domestic violence reports resulting in an arrest by local police and Rhode Island State Police.

◆ **In Rhode Island in 2016, there were 5,673 domestic violence incidents that resulted in arrests, up 2% from 5,553 incidents in 2015. Children were reported present in 27% (1,513) of incidents in 2016.[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]**

◆ **In Rhode Island in 2016, police reported that children saw the domestic violence incident in 1,125 arrests and children heard the incident in 1,254 arrests. These incidents were not mutually exclusive, and more than one child may have witnessed each incident.[16]**

◆ **Rhode Island's statewide network of five domestic violence shelters and advocacy programs provides emergency and support services to victims of domestic violence, dating violence, sexual violence, and stalking.[17] During 2018, the network provided services to 8,514 individuals, including 556 children (down from 8,758 and 604, respectively, in 2017). In 2018, 151 children and 235 adults spent a total of 21,376 nights in domestic violence shelters. During 2018, 71 children and 62 adults lived in domestic violence transitional housing (longer-term private apartments for victims of domestic violence) for a total of 29,679 nights.[18]**

Table 31. **Children Present During Domestic Violence Incidents Resulting in Arrests, Rhode Island, 2016**

CITY/TOWN	TOTAL # OF REPORTS	TOTAL # OF INCIDENTS WITH CHILDREN PRESENT	% WITH CHILDREN PRESENT
Barrington	25	9	36%
Bristol	92	21	23%
Burrillville	51	12	24%
Central Falls	195	50	26%
Charlestown	30	8	27%
Coventry	174	51	29%
Cranston	372	105	28%
Cumberland	101	24	24%
East Greenwich	43	11	26%
East Providence	258	59	23%
Exeter*	NA	NA	NA
Foster	24	9	38%
Glocester	19	3	16%
Hopkinton	49	15	31%
Jamestown	8	2	25%
Johnston	108	28	26%
Lincoln	65	25	38%
Little Compton	5	2	40%
Middletown	101	28	28%
Narragansett	65	18	28%
New Shoreham	3	1	33%
Newport	195	34	17%
North Kingstown	87	30	34%
North Providence	164	38	23%
North Smithfield	50	11	22%
Pawtucket	861	267	31%
Portsmouth	122	21	17%
Providence	878	258	29%
Richmond	23	6	26%
Scituate	12	4	33%
Smithfield	50	12	24%
South Kingstown	89	28	31%
Tiverton	69	16	23%
Warren	68	17	25%
Warwick	252	57	23%
West Greenwich	22	5	23%
West Warwick	248	69	28%
Westerly	145	38	26%
Woonsocket	461	106	23%
Rhode Island State Police	*89*	*15*	*17%*
Four Core Cities	*2,395*	*681*	*28%*
Remainder of State	*3,189*	*817*	*26%*
Rhode Island	*5,673*	*1,513*	*27%*

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]

Domestic Homicide and Guns

◆ When firearms are present in a domestic violence situation, women are five times more likely to die.[20] Between 2006-2015, forty-two percent of Rhode Island women killed by intimate partners were shot to death.[21]

◆ In 2018, "red flag" legislation passed that authorizes the Supreme Court to issue "extreme risk protection orders" requiring the surrender of all firearms from persons determined to be capable of causing personal injury.[22]

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, 2016 and December 31, 2016.

The data are only the incidents during which an arrest was made in which children were present, and do not represent the total number of children who experienced domestic violence in their homes. More than one child may have been present at an incident.

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

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

References

[1] Gilbert, A. L., Bauer, N. S., Carroll, A. E., & Downs, S. M. (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.

[3,14,16] Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit. Based on data from Domestic Violence and Sexual Assault/Child Molestation Reporting Forms, 2012-2016.

[4] Stop Violence Against Women. (2010). *Effects of domestic violence on children.* Retrieved March 8, 2019, 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.

[6,8] Wathen, C. N. & MacMillan, H. L. (2013). Children's exposure to intimate partner violence: Impacts and interventions. *Pediatrics & Child Health, 18*(8), 419-422.

(continued on page 184)

Child Abuse and Neglect

DEFINITION

Child abuse and neglect is the total unduplicated number of victims of child abuse and neglect per 1,000 children. Child abuse includes physical, sexual, and emotional abuse. Child neglect includes emotional, educational, physical, and medical neglect, as well as a failure to provide for basic needs.

SIGNIFICANCE

Children need love, affection, and nurturing from their parents or caregivers for healthy physical and emotional development. Experiencing child abuse or neglect can have lifelong consequences for a child's health, well-being, and relationships with others. Parents or caregivers are at increased risk for 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, substance abuse, mental health problems, teen pregnancy, impaired cognition, and low academic achievement.[2,3]

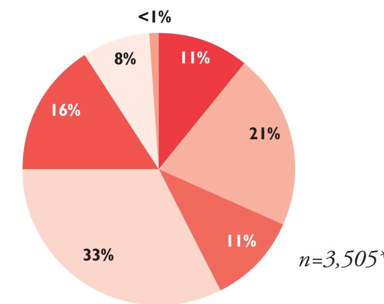
Responding to reports of child abuse and neglect and ensuring child safety are important functions of child protection systems. Maintaining the capacity to focus on prevention is equally critical and more cost-effective. In Rhode Island, if an investigation does not reveal maltreatment but family stressors 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 2018 in Rhode Island, there were 2,430 indicated investigations of child abuse and neglect involving 3,505 children. The rate of child abuse and neglect per 1,000 children under age 18 was almost two times higher in the four core cities (21.5 victims per 1,000 children) than in the remainder of the state (11.2 victims per 1,000 children). About half (49%) of the victims of child abuse and neglect in 2018 were young children under age six and almost one-third (32%) were ages three and younger.[5]

Child Abuse and Neglect, Rhode Island, 2018

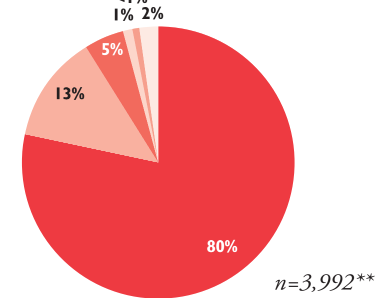
By Age of Victim*

11% (372)	Under Age 1
21% (742)	Ages 1 to 3
11% (395)	Ages 4 to 5
33% (1,148)	Ages 6 to 11
16% (550)	Ages 12 to 15
8% (297)	Ages 16 and Older
<1% (1)	Unknown



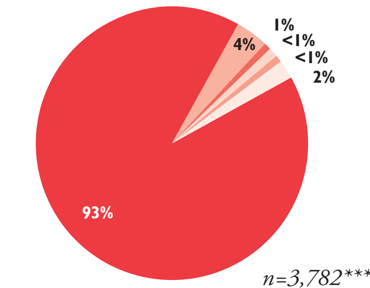
By Type of Neglect/Abuse**

80% (3,186)	Neglect
13% (501)	Physical Abuse
5% (185)	Sexual Abuse
1% (42)	Medical Neglect
<1% (14)	Emotional Abuse
2% (64)	Other



By Relationship of Perpetrator to Victims***

93% (3,506)	Parents
4% (140)	Relatives/Household Members
1% (51)	Foster Parents
<1% (13)	Child Care Providers
<1% (7)	Residential Facility Staff
2% (65)	Other or Unknown



Source: Rhode Island DCYF, Rhode Island Children's Information System (RICHIST), 2018. 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, 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, 2008-2018

YEAR	TOTAL # UNDUPLICATED CHILD MALTREATMENT REPORTS	% AND # OF REPORTS WITH COMPLETED INVESTIGATIONS	# OF INDICATED INVESTIGATIONS
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
2016	14,942	40% (5,935)	2,074
2017	15,945	42% (6,628)	2,404
2018	21,837	38% (8,296)	2,430

Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2008-2018.

**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).*

◆ **From 2017 to 2018 in Rhode Island, the number of unduplicated child maltreatment reports increased by 37%, and the number of completed investigations increased by 25%. The number of indicated investigations stayed about the same. In 2018, 29% (2,430) of the 8,296 completed investigations of child maltreatment were indicated, cases in which there is a "preponderance of evidence that a child has been abused and/or neglected".[6,7]**

◆ **Of the 21,837 maltreatment reports in 2018, 52% (11,300) were classified as "information/ referrals" (formerly "early warnings").[8] Information/referrals are reports made to the CPS Hotline concerning the well-being of a child that do not meet the criteria for an investigation. Criteria for investigation include that the victim is a minor, the alleged perpetrator is responsible for the child's welfare, there is reasonable cause to believe that abuse or neglect exists, and there is a specific incident or pattern of incidents suggesting that harm can be identified. In February of 2019, the Department began implementation of the Family Functioning Assessment model to conduct the Family Assessment Response (FAR) by CPS Caseworkers. When essential criteria for investigation are not present, the (FAR) may lead to a referral to the development of a safety plan with the family, including voluntary referral and delivery of other services in the community.[9]**

Emergency Department Visits, Hospitalizations, and Deaths Due to Child Abuse and/or Neglect, Rhode Island, 2013-2017

YEAR	# OF EMERGENCY DEPARTMENT VISITS*	# OF HOSPITALIZATIONS*	# OF DEATHS**
2013	133	34	3
2014	102	44	1
2015	92	28	0
2016	79	8	1
2017	107	18	2
TOTAL	*515*	*132*	*7*

Source: Rhode Island Department of Health, 2013-2017.

Note: Effective October 1, 2015, the International Classification of Disease (ICD) codes changed from the 9th classification to the 10th classification, which may impact comparability across the years.

**The number of Emergency Department visits and the number of hospitalizations include both suspected and confirmed assessments of child abuse and neglect.*

***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 2013 and 2017, there were 515 emergency department visits, 132 hospitalizations, and 7 deaths of Rhode Island children under age 18 due to child abuse and/or neglect.[10] Nationally, 75% of child maltreatment deaths involved neglect and 42% involved physical abuse (because a victim may have suffered more than one type of maltreatment, these categories are not mutually exclusive).[11]**

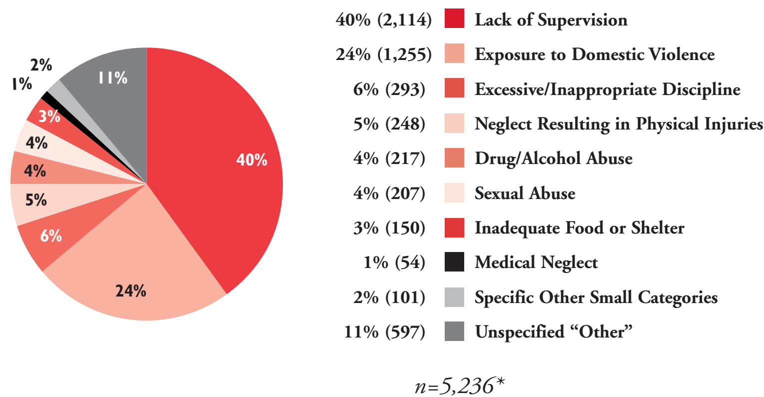
Child Abuse and Neglect in Rhode Island Communities

◆ **Many parents at risk of child abuse and neglect lack essential parenting skills and are struggling with a combination of social and economic issues. These families can benefit from programs that enhance social supports, parental resilience, and knowledge of parenting and child development.[12] In addition, providing access to child care, early childhood learning programs, and evidence-based home visiting programs (such as the Nurse-Family Partnership) to families with multiple risk factors can prevent the occurrence and recurrence of child abuse and neglect.[13,14]**

◆ **In 2018, Rhode Island had 14.6 child victims of abuse and neglect per 1,000 children, the same rate as in 2017. Woonsocket (35.7 victims per 1,000 children) 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 Central Falls (23.4), Newport (22.8), North Providence (22.7), Pawtucket (24.7), and West Warwick (23.1).[15]**

Child Abuse and Neglect

Indicated Allegations of Child Neglect, by Nature of Neglect, Rhode Island, 2018



Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2018.

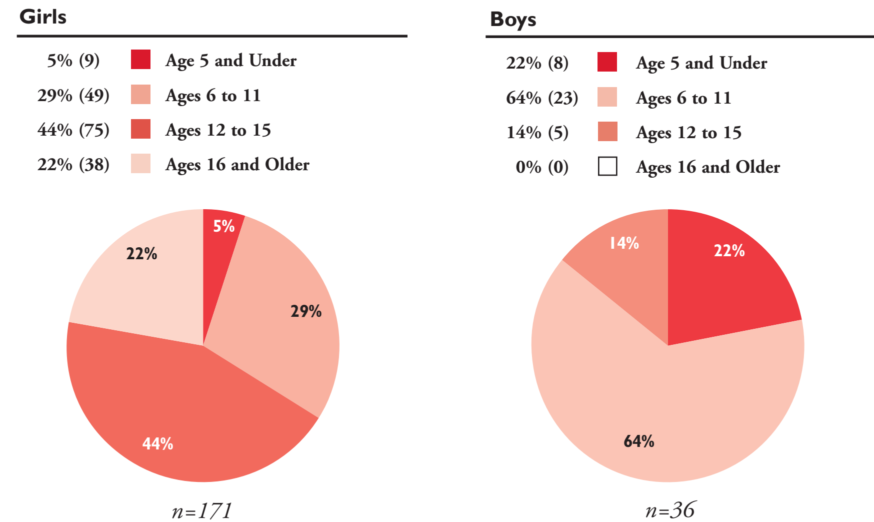
**The total refers to indicated allegations of neglect. Some children were victims of neglect more than once. Multiple allegations may be involved in each indicated investigation.*

◆ **Of the 5,236 indicated allegations (confirmed claims) of neglect to children under age 18 in Rhode Island in 2018, 40% involved lack of supervision. This highlights the importance of access to high-quality, affordable child care, preschool, and after-school programs.[16]**

◆ **The second largest category of neglect (24%) is "exposure to domestic violence." These are instances where the neglect is related to the child witnessing domestic violence in the home.[17]**

◆ **The "specific other small categories" include: educational neglect (34), tying/close confinement (16), abandonment (14), emotional neglect (11), corporal punishment (8), failure to thrive (8), emotional abuse (6), inappropriate restraint (3), and poisoning/noxious substances (1).[18]**

Child Sexual Abuse, by Gender and Age of Victim, Rhode Island, 2018



Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2018.

◆ **In Rhode Island in 2018, there were 207 indicated allegations (confirmed claims) of child sexual abuse. Some children were victims of sexual abuse more than once. The victim was a female in 83% (171) of the 207 indicated allegations of sexual abuse. Thirty-four percent of the female victims were under age 12 while 86% of the male victims were under age 12.[19]**

◆ **In the majority of sexual abuse cases, the perpetrator is a relative or person known to the victim, and sexual abuse by a stranger is less likely.[20]**

Table 32. **Indicated Investigations of Child Abuse and Neglect, Rhode Island, 2018**

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	7	1.5	7	1.5
Bristol	3,623	32	8.8	39	10.8
Burrillville	3,576	28	7.8	31	8.7
Central Falls	5,644	101	17.9	132	23.4
Charlestown	1,506	22	14.6	29	19.3
Coventry	7,770	58	7.5	90	11.6
Cranston	16,414	125	7.6	151	9.2
Cumberland	7,535	46	6.1	66	8.8
East Greenwich	3,436	7	2.0	15	4.4
East Providence	9,177	98	10.7	128	13.9
Exeter	1,334	7	5.2	6	4.5
Foster	986	5	5.1	11	11.2
Glocester	2,098	12	5.7	15	7.1
Hopkinton	1,845	15	8.1	23	12.5
Jamestown	1,043	2	1.9	5	4.8
Johnston	5,480	46	8.4	72	13.1
Lincoln	4,751	37	7.8	42	8.8
Little Compton	654	3	4.6	6	9.2
Middletown	3,652	33	9.0	55	15.1
Narragansett	2,269	21	9.3	16	7.1
New Shoreham	163	0	0.0	0	0.0
Newport	4,083	65	15.9	93	22.8
North Kingstown	6,322	33	5.2	52	8.2
North Providence	5,514	85	15.4	125	22.7
North Smithfield	2,456	8	3.3	14	5.7
Pawtucket	16,575	283	17.1	410	24.7
Portsmouth	3,996	31	7.8	32	8.0
Providence	41,634	521	12.5	687	16.5
Richmond	1,849	6	3.2	13	7.0
Scituate	2,272	8	3.5	14	6.2
Smithfield	3,625	11	3.0	28	7.7
South Kingstown	5,416	29	5.4	45	8.3
Tiverton	2,998	24	8.0	31	10.3
Warren	1,940	27	13.9	30	15.5
Warwick	15,825	123	7.8	168	10.6
West Greenwich	1,477	9	6.1	12	8.1
West Warwick	5,746	109	19.0	133	23.1
Westerly	4,787	57	11.9	85	17.8
Woonsocket	9,888	227	23.0	353	35.7
Four Core Cities	*73,741*	*1,132*	*15.4*	*1,582*	*21.5*
Remainder of State	*150,215*	*1,229*	*8.2*	*1,682*	*11.2*
Rhode Island	*223,956*	*2,361*	*10.5*	*3,264*	*14.6*

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 2018.

Victims of child abuse/neglect are unduplicated counts of victims with substantiated allegations of child abuse and/or neglect. More than one victim can be involved in an investigation.

An indicated investigation is an investigated report of child abuse and/or neglect for which a preponderance of evidence exists that child abuse and/or neglect occurred. An indicated investigation can involve more than one child and multiple allegations. City/town reports of indicated investigations omit certain investigations, particularly those where there are data entry errors affecting location. For this reason, the city/town table includes fewer indicated investigations than the chart with reports/investigations and indicated cases.

Data cannot be compared to Factbooks prior to 2009. The denominator is the number of children under age 18 according to the U.S. Census 2010 and the numerator is an unduplicated count of child victims. Previous Factbooks used children under age 21 as the denominator and the indicated investigations as the numerator to calculate the rate of indicated investigations per 1,000 children.

In 2018, Rhode Island increased the eligibility for voluntary extended DCYF services to under age 21.

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

References

[1,12,13] U.S. Department of Health and Human Services, Administration for Children and Families. (2018). *Keeping children safe and families strong in supportive communities: 2018 prevention resource guide.* Washington, DC: U.S. Government Printing Office.

[2] Child Welfare Information Gateway. *Long-term consequences of child abuse and neglect.* (2013). Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

(continued on page 184)

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, assessment and stabilization centers, residential facilities, and medical facilities. Permanency can be achieved through reunification with the family, adoption, or guardianship.

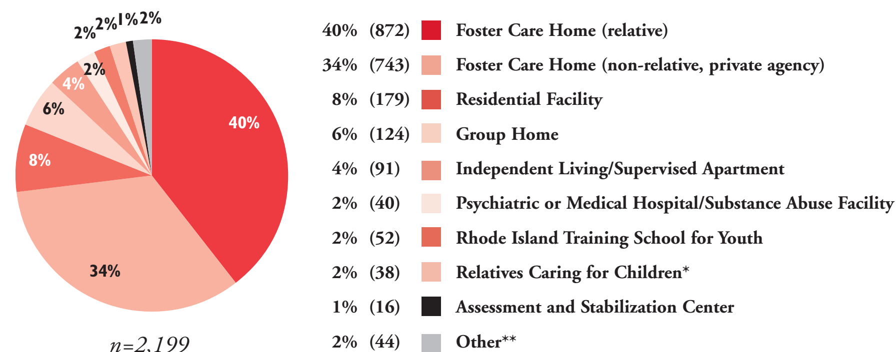
SIGNIFICANCE

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 secured as quickly as possible.[2] The federal *Fostering Connections to Success and Increasing Adoptions Act (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, screening, investigation, assessment, recruiting and retaining resource families, and permanency.[10] Children of color 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 reunited with their families or adopted, 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.[11]

Children in Out-of-Home Placement, Rhode Island, December 31, 2018



**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 (6), and minors with their mother in shelter/group home/residential facility (3).*

◆ **As of December 31, 2018, there were 2,199 children under age 21 in the care of DCYF who were in out-of-home placements.**

◆ **The total DCYF caseload on December 31, 2018 was 6,907, including 2,008 children living in their homes under DCYF supervision and 2,642 children living in adoption settings.**

◆ **The total DCYF caseload also includes 51 children in out-of-state placements/other agency custody, one child receiving respite care services, three youth in Job Corps and three children in other placements.**

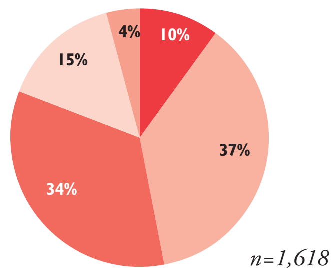
◆ **On December 31, 2018, 303 children were living in a residential facility or group home, an increase from 293 children on December 31, 2017. The percentage of children in out-of-home placement who were in a relative foster care home (40%) remained the same on December 31, 2018 as it was on December 31, 2017.**

Source: RI Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2017-2019. Percentages may not sum to 100% due to rounding.

Children and Youth in Out-of-Home Placement, by Type of Setting and Age, Rhode Island*

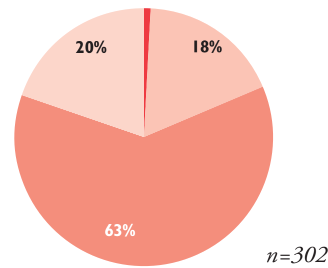
In Foster Care Homes

%	(n)	Age
10%	(167)	Under Age 1
37%	(595)	Ages 1 to 5
34%	(549)	Ages 6 to 13
15%	(243)	Ages 14 to 17
4%	(64)	Ages 18 and Over



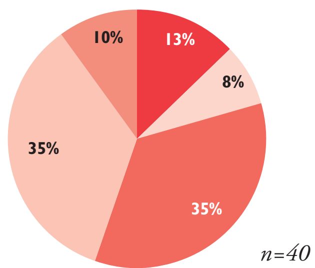
In Group Homes and Residential Facilities**

%	(n)	Age
0%	(0)	Under Age 1
<1%	(1)	Ages 1 to 5
18%	(53)	Ages 6 to 13
63%	(189)	Ages 14 to 17
20%	(59)	Ages 18 and Over



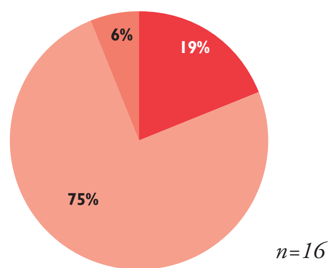
In Medical Facilities***

%	(n)	Age
13%	(5)	Under Age 1
8%	(3)	Ages 1 to 5
35%	(14)	Ages 6 to 13
35%	(14)	Ages 14 to 17
10%	(4)	Ages 18 and Over



In Assessment and Stabilization Centers****

%	(n)	Age
0%	(0)	Under Age 1
0%	(0)	Ages 1 to 5
19%	(3)	Ages 6 to 13
75%	(12)	Ages 14 to 17
6%	(1)	Ages 18 and Over



**Pie charts show data for a single point-in-time (Foster Care Homes-January 2, 2019; Group Homes and Residential Facilities, Medical Facilities, and Assessment and Stabilization Centers - December 31, 2018.)*

***Residential facilities data do not include psychiatric hospitals, medical hospitals, or the Rhode Island Training School.*

****Medical facilities data includes medical hospitals (26), psychiatric hospitals (39), and substance abuse treatment facilities (0).*

*****Assessment and Stabilization Centers are described as an emergency placement.*

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), January 2019. 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.[12] 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.[13]

Family First Prevention Services Act

◆ The *Family First Prevention Services Act (FFPSA) of 2018* enables states to use funds from the entitlement of Title IV-E of the Social Security Act that pays for child welfare, for "time-limited" services aimed at preventing the use of foster care in cases of maltreatment. States can spend money on services to address mental health issues, in-home parent skill-based programs, and substance abuse treatment. Parents or relatives caring for children who are at risk of entering foster care and youth in foster care who are pregnant or parenting are eligible for services through FFPSA.[14]

Pivot to Prevention

◆ In April of 2018, DCYF launched Pivot to Prevention, the Department's new operational direction to focus on child safety as a public health issue. DCYF will work with state partners to address poverty, substance abuse and serious mental health issues, and family violence in the community, whether or not families become involved with the Department.[15]

Congregate Care

◆ Older youth are more likely to be placed in congregate care settings (e.g., group homes, residential facilities) than young children. In Rhode Island during 2018, 302 of the children and youth in out-of-home placement were in group homes or residential facilities. Of those, 82% (248) were age 14 and older.[16]

Racial and Ethnic Disparities

◆ In Rhode Island in FY 2017, Black, Multiracial, and Hispanic youth ages 10 to 17 were overrepresented in entering into an out-of-home placement compared to their Rhode Island census population. Black Non-Hispanic children (45.2%) and Hispanic children (39.7%) who experienced out-of-home placement were placed in congregate care as their first placement more often compared to their White peers (27.8%).[17]

(References are on page 185)

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 under age 18 who entered out-of-home placement with the Rhode Island Department of Children, Youth and Families (DCYF) during a 12-month period.

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, children of color, 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]

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.[13] Youth who age out of foster care experience high rates of economic hardship (inability to pay rent, utilities, etc.), low educational attainment, homelessness, unemployment, and poor physical and mental health. They are more likely to enter the criminal justice system, become young parents, and enroll in public assistance programs.[14]

The federal *Fostering Connections Act of 2008* and *Strengthening Families Act of 2014* provide a wide range of incentives and strategies for states to support children and youth while in foster care as well as permanency.[15] The *Family First Prevention Services Act*, enacted February 2018, will provide federal funds for prevention services for children at risk of entering foster care and their families.[16]

Children Achieving Permanency, by Discharge Reason, Rhode Island, Entry Cohort FY 2017*

DISCHARGE REASON	NUMBER	PERCENTAGE	MEDIAN DAYS IN PLACEMENT
Reunification with Parents	366	91%	179.5
Guardianship	20	5%	259
Adoption – Direct Consent	9	2.2%	228
Living with Relative(s)	6	1.5%	171
Adoption	1	.3%	338
Total Number	*402*	*100%*	*187*

Source: *Permanency Report: Children in Foster Care FY16 - FY18. (n.d.)* Rhode Island Department of Children, Youth and Families. *Data cannot be compared to Factbooks prior to 2018. The data are now reported by entry cohort and represent children who achieved permanency within 12 months of entering out-of-home placement, excluding children who entered care at age 18 or older. Permanency includes reunification, guardianship, living with relative, adoption, and reunification.

◆ **Of the 1,156 Rhode Island children in entry cohort FY 2017, 35% (402) children in out-of-home placement in Rhode Island exited foster care to permanency (reunification, guardianship, living with other relatives, or adoption) within 12 months of entering out-of-home placement. Children who were over age 12 when they were removed were more likely to exit care without achieving permanency.[17]**

◆ **Among Rhode Island children in entry cohort FY 2017 who achieved permanency, 38.3% entered congregate care as a first placement. Children who were over age 12 when they entered out-of-home placement were more likely to enter congregate care as a first placement.[18]**

Reunification, Entry Cohort FY 2017

◆ **Of children in entry cohort FY 2017, 91% of children under age 18 achieved permanency through reunification with their family of origin within 12 months of entering out-of-home placement.[19]**

◆ **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.[20]**

Subsidized Guardianship, Entry Cohort FY 2017

◆ 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.[21] The number of children who achieved permanency through guardianship in Rhode Island decreased from 6.8% in entry cohort FY 2016 to 5% in entry cohort FY 2017.[22]

Adoptions of Children in DCYF Care, 2018

◆ During Calendar Year 2018, 255 children in the care of DCYF were adopted in Rhode Island, similar to the 261 children adopted in 2017. Of these children, 67% were White, 22% were multiracial, 11% were Black, and 1% were of Unknown race. Thirty-three percent of children adopted in 2018 were Hispanic (belonging to any race category).[23]

◆ Of the 255 children adopted in 2018, 70% were under age six, 25% were ages six to 13, and 5% were age 14 or older.[24]

Rhode Island Children Waiting to be Adopted, March 25, 2019

◆ On March 25, 2019, there were 252 Rhode Island children in the care of DCYF who were waiting to be adopted. Of these, 39% of children were ages zero to five, 30% were ages six to 10, 22% were ages 11 to 15, and 8% were ages 16 and over.[25,26]

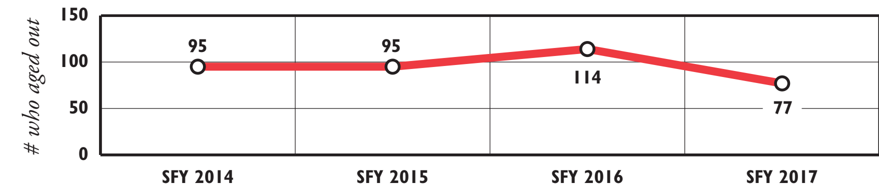
◆ Of all waiting children, 46% were White Non-Hispanic, 28% were Hispanic (any race), 11% were Black Non-Hispanic, and 14% were Multiracial or other Non-Hispanic.[27]

◆ Of the 252 children waiting to be adopted, 19% (49) were children of parents whose parental rights had been legally terminated.[28]

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. The *Voluntary Extension of Care Act (VEC)* passed in Rhode Island in 2018, provides a legal entitlement to voluntary extended foster care services until age 21. 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. DCYF began the implementation process for VEC program in July 2018. As a result, data reporting the number of Rhode Island youth aging out of foster care is in transition while the program is implemented and SFY 2018 data were not yet provided.[29,30]

Rhode Island Youth Aging Out of Foster Care, SFY 2014-2017



Source: Rhode Island Department of Children, Youth and Families, RICHIST 2014-2017.

◆ The number of Rhode Island youth who exited foster care never having gained permanency through reunification, adoption, or guardianship increased from 95 during SFY 2015 to 114 during SFY 2016, and then decreased to 77 in SFY 2017.[31]

◆ 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.[32]

◆ States that extend foster care to age 21, an option encouraged in the *Fostering Connections Act*, will more than offset the costs for the potential benefits in terms of increased educational attainment, reduced reliance on public assistance, and increased earnings.[33]

References

[1] Wedeles, J. (n.d.). *Placement stability in child welfare.* Retrieved March 14, 2019, from www.oacas.org

[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 185)

Education

As the Crow Flies

by Leslea Newman

As the crow flies
As the river flows
As the sea gull cries
As the wind blows

As the eagle soars
As the frog leaps
As the lion roars
As the lamb sleeps

As the rabbit hops
As the owl calls
As the leaf drops
As the rain falls

As the turtle suns
As the snake slides
As the horse runs
As the swan glides

As the flower grows
As the willow sways
As the moon glows
As the wolf bays

As the rainbow arcs
As the sun burns
As the dog barks
As the earth turns

As the stars gleam
As the doves coo
As the child dreams
So I love you.

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]

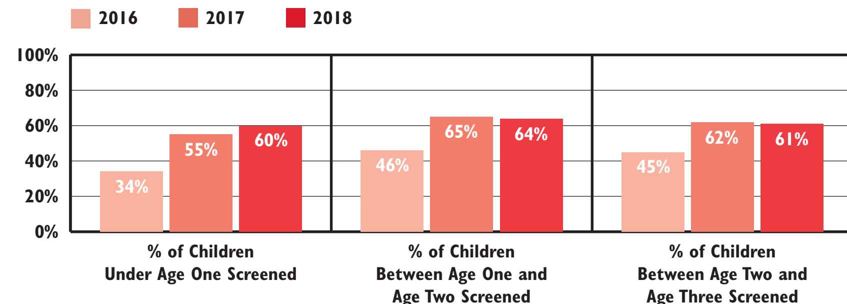
In 1986, Congress established Early Intervention (EI) services for infants and toddlers under the *Individuals with Disabilities Education Act (IDEA).* Part C of IDEA requires states to identify and provide appropriate EI services to children under age three who are developmentally delayed or have a 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 in order 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]

Developmental Screenings Completed, RIte Care Members Under Age 3, 2016-2018



Source: Rhode Island Executive Office of Health and Human Services, Performance Years 2016-2018.

◆ **As of June 30, 2018, there were 2,219 infants and toddlers receiving Early Intervention (EI) services, 7% of the population under age three. Of these, 52% percent were eligible due to a measured significant developmental delay, 25% due to significant circumstances impacting child or family functioning, 22% due to a single established condition category (such as Down Syndrome), and 1% were undetermined. Of the 2,219 children receiving EI services on June 30, 2018, 43% began receiving services before age one, 36% began at age one, and 21% began at age two.[7]**

◆ **In Calendar Year 2018 in Rhode Island, 4,389 children received EI services, up from 4,140 in 2017. In 2018, 1,224 children were discharged from EI upon reaching age three. Of these, 62% were found eligible and 19% were found not eligible for preschool special education. Thirteen percent were in the process of eligibility determination, and 6% left the program for other reasons.[8,9]**

◆ **Because maltreated infants and toddlers are more likely to have a developmental delay, federal legislation requires states to have procedures in place to refer children under age three who were victims of child abuse or neglect to EI. States may choose to refer these children for developmental screening to determine whether an EI referral is needed.[10,11] In 2018 in Rhode Island, there were 980 infants and toddlers under age three who were involved in indicated cases of abuse or neglect. Of these, 229 (23%) were referred to EI for an eligibility assessment, 645 (66%) were referred to First Connections for screening, 43 (4%) were already enrolled in EI or had otherwise been screened, and 63 (6%) moved out of state or were not referred. Of the 980 children, 171 (17%) had been found eligible for EI as of February 2019.[12,13]**

Table 33. **Infants and Toddlers Enrolled in Early Intervention (EI) by Eligibility Type, Rhode Island, 2018**

		CALENDAR YEAR 2018 ENROLLMENT		JUNE 30, 2018 ENROLLMENT BY ELIGIBILITY					
CITY/TOWN	# OF CHILDREN UNDER AGE 3	# OF CHILDREN ENROLLED IN EI	% OF CHILDREN UNDER AGE 3 ENROLLED IN EI	SINGLE ESTAB-LISHED CONDITION	MEASURED DEVELOP-MENTAL DELAY	CIRCUM-STANCES SIGNIFICANTLY IMPACTING CHILD/FAMILY FUNCTION*	DEVELOP-MENTAL DELAY NO SPECIFIC INFOR-MATION	# OF CHILDREN UNDER AGE 3 ENROLLED IN EI	% OF CHILDREN UNDER AGE 3 ENROLLED IN EI
Barrington	366	52	14%	10	12	7	0	29	8%
Bristol	507	50	10%	9	11	9	0	29	6%
Burrillville	460	79	17%	5	25	14	2	46	10%
Central Falls	1,028	135	13%	7	44	10	2	63	6%
Charlestown	186	17	9%	3	2	3	0	8	4%
Coventry	940	97	10%	14	21	17	0	52	6%
Cranston	2,318	295	13%	26	75	47	1	149	6%
Cumberland	970	160	16%	21	53	17	1	92	9%
East Greenwich	299	44	15%	7	6	5	0	18	6%
East Providence	1,560	152	10%	14	32	17	0	63	4%
Exeter	166	14	8%	3	3	1	0	7	4%
Foster	113	8	7%	2	4	1	0	7	6%
Glocester	247	19	8%	3	5	4	0	12	5%
Hopkinton	258	34	13%	5	4	5	1	15	6%
Jamestown	85	12	14%	1	2	3	0	6	7%
Johnston	816	122	15%	15	30	9	0	54	7%
Lincoln	587	86	15%	5	30	10	0	45	8%
Little Compton	68	5	7%	0	0	3	0	3	4%
Middletown	502	66	13%	4	12	8	0	24	5%
Narragansett	271	21	8%	2	1	5	0	8	3%
New Shoreham	21	0	0%	0	0	0	0	0	0%
Newport	820	79	10%	8	20	9	0	37	5%
North Kingstown	728	92	13%	13	20	19	1	53	7%
North Providence	851	122	14%	21	39	9	0	69	8%
North Smithfield	290	49	17%	3	17	3	0	23	8%
Pawtucket	2,959	349	12%	47	93	29	1	170	6%
Portsmouth	429	59	14%	7	15	8	1	31	7%
Providence	7,609	1,047	14%	126	282	106	8	522	7%
Richmond	235	12	5%	1	2	1	0	4	2%
Scituate	193	37	19%	2	13	7	0	22	11%
Smithfield	402	63	16%	5	14	11	0	30	7%
South Kingstown	640	73	11%	4	12	13	1	30	5%
Tiverton	398	57	14%	9	17	8	0	34	9%
Warren	296	39	13%	8	7	4	0	19	6%
Warwick	2,322	303	13%	33	65	46	2	146	6%
West Greenwich	178	20	11%	2	3	7	0	12	7%
West Warwick	1,044	102	10%	9	30	21	1	61	6%
Westerly	726	86	12%	12	14	14	0	40	6%
Woonsocket	1,900	332	17%	24	125	36	1	186	10%
Four Core Cities	*13,496*	*1,863*	*14%*	*204*	*544*	*181*	*12*	*941*	*7%*
Remainder of State	*20,292*	*2,526*	*12%*	*286*	*616*	*365*	*11*	*1,278*	*6%*
Rhode Island	*33,788*	*4,389*	*13%*	*490*	*1,160*	*546*	*23*	*2,219*	*7%*

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 2018 and June 30, 2018 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.

*See Early Intervention Policy Manual for list of circumstances.

References

[1] Lurie-Hurvitz, E. (2009). *Early experiences matter: Making the case for a comprehensive infant and toddler policy agenda.* Retrieved February 27, 2019, from www.zerotothree.org

[2] Jones, Lynn. (2009). *Making hope a reality: Early Intervention for infants and toddlers with disabilities.* Retrieved February 27, 2019, from www.zerotothree.org

[3] *Rhode Island Early Intervention certification standards policies and procedures: IV. Eligibility determination.* (2018). 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 February 27, 2019, from www.medicaid.gov

[7,8,13] Rhode Island Executive Office of Health and Human Services, 2018.

[9] Rhode Island Executive Office of Health and Human Services, 2017.

(continued on page 185)

Children Enrolled in Early Head Start

DEFINITION

Children enrolled in Early Head Start is the number and percentage of low-income infants and toddlers enrolled in a Rhode Island Early Head Start program.

SIGNIFICANCE

Established in 1995, 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 ($21,330 for a family of three in 2019).[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]

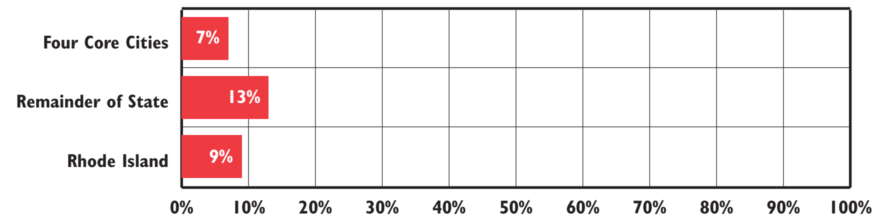
Pregnant women enrolled in Early Head Start are assessed for risks to a successful pregnancy. Individualized plans are developed to support prenatal health, promote healthy behaviors, and prepare for the baby's arrival.[5] After the baby is born, families participate by enrolling in either a center-based 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]

As of October 2018, of the 656 children and pregnant women enrolled in Early Head Start, 393 (60%) were enrolled in home-based services and 263 (40%) were in center-based programs.[7] An Early Head Start-Child Care Partnership grant awarded in 2015 created 100 new center-based Early Head Start slots in Rhode Island through partnerships with child care programs to increase the number of 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 at home and are more likely to be involved in preschool. Early Head Start parents are less likely to experience depression and more likely to be self-sufficient (higher incomes). Children who enroll in high-quality preschool after Early Head Start have better outcomes at kindergarten entry.[10,11]

As of October 2018, 644 infants and toddlers and 12 pregnant women were receiving Early Head Start services in Rhode Island, and there were 160 eligible pregnant women or children on the waiting list.[12]

Estimated Percentage of Eligible Infants and Toddlers Enrolled in Early Head Start, 2018



Source: Rhode Island Kid Count calculations using Early Head Start program enrollment October 2018 as the numerator and number of children under age three from Census 2010, Summary File 1 multiplied by the percentage of children under age six living in families with incomes below the federal poverty level according to the Population Reference Bureau's (PRB) analysis of 2013-2017 American Community Survey data as the denominator.

◆ **As of October 2018 in Rhode Island, there were 656 children and pregnant women enrolled in Early Head Start, 9% of the population in poverty and 5% of the population in low-income families. There were 337 children and pregnant women from the four core cities (7% of the population in poverty and 5% of the population in low-income families). In the remainder of the state, 319 children and pregnant women were enrolled in Early Head Start (13% of the population in poverty and 6% of the population in low-income families).[13,14]**

◆ **As of October 2018, 2% of Early Head Start clients were pregnant women, 15% were infants under age one, 31% were age one, 46% were toddlers age two, and 7% were age three.[15]**

◆ **Rhode Island Head Start programs serve significant numbers of children with high needs including: 105 infants and toddlers with developmental delays or disabilities (16% of all children enrolled), 40 children who were in foster care, and nine children who were homeless.[16] Early Head Start programs are required to prioritize enrollment for children with special needs and to screen all enrolled children to identify developmental delays and disabilities.[17]**

◆ **As of October 2018, 30% of the children enrolled in Early Head Start were also participating in the Child Care Assistance Program (CCAP).[18] Center-based Early Head Start programs do not cover the entire day for many working parents. CCAP is used to provide additional coverage for working parents.[19]**

Table 34.

Children Ages Birth to Three and Pregnant Women Enrolled in Early Head Start, Rhode Island, 2018

SCHOOL DISTRICT	ESTIMATED # OF CHILDREN <AGE 3	% LOW-INCOME CHILDREN IN DISTRICT	ESTIMATED # LOW-INCOME CHILDREN <AGE 3	# ENROLLED IN HOME-BASED EARLY HEAD START	# ENROLLED IN CENTER-BASED EARLY HEAD START	# ENROLLED IN EARLY HEAD START	ESTIMATED % OF LOW-INCOME INFANTS AND TODDLERS ENROLLED IN EARLY HEAD START
Barrington	618	4%	25	0	0	0	0%
Bristol Warren	642	30%	193	5	3	8	4%
Burrillville	441	30%	132	6	8	14	11%
Central Falls	579	91%	527	36	18	54	10%
Chariho	570	20%	114	3	2	5	4%
Coventry	963	31%	299	8	8	16	5%
Cranston	2,220	43%	955	0	21	21	2%
Cumberland	939	19%	178	0	4	4	2%
East Greenwich	468	5%	23	2	0	2	9%
East Providence	1,068	48%	513	14	15	29	6%
Exeter-West Greenwich	324	16%	52	1	0	1	2%
Foster	102	24%	24	0	0	0	0%
Glocester	240	12%	29	0	0	0	0%
Jamestown	162	8%	13	0	0	0	0%
Johnston	708	45%	319	8	7	15	5%
Lincoln	606	27%	164	0	4	4	2%
Little Compton	48	12%	6	0	0	0	0%
Middletown	417	30%	125	2	9	11	9%
Narragansett	186	21%	39	0	2	2	5%
New Shoreham	36	16%	6	0	0	0	0%
Newport	462	66%	305	19	35	54	18%
North Kingstown	783	22%	172	8	2	10	6%
North Providence	642	38%	244	12	9	21	9%
North Smithfield	348	16%	56	1	0	1	2%
Pawtucket	1,995	76%	1,516	40	35	75	5%
Portsmouth	444	14%	62	2	0	2	3%
Providence	5,028	84%	4,224	178	15	193	5%
Scituate	447	18%	80	0	1	1	1%
Smithfield	471	14%	66	7	2	9	14%
South Kingstown	603	17%	103	5	2	7	7%
Tiverton	351	24%	84	2	0	2	2%
Warwick	1,920	29%	557	10	29	39	7%
West Warwick	843	50%	422	18	17	35	8%
Westerly	519	36%	187	6	0	6	3%
Woonsocket	1,422	79%	1,123	0	15	15	1%
Charter Schools	*2,382*	*67%*	*1,596*	*NA*	*NA*	*NA*	*NA*
RI School for the Deaf	*15*	*66%*	*10*	*NA*	*NA*	*NA*	*NA*
Four Core Cities	*9,024*	*82%*	*7,400*	*254*	*83*	*337*	*5%*
Remainder of State	*18,591*	*29%*	*5,391*	*139*	*180*	*319*	*6%*
Rhode Island	*30,012*	*47%*	*14,106*	*393*	*263*	*656*	*5%*

Source of Data for Table/Methodology

Rhode Island Early Head Start Programs, children enrolled as of October 2018. Children enrolled are listed by residence of child, not location of the Head Start program.

The estimated number of low-income children under age three in each school district is based on October 2018 kindergarten enrollment (3x kindergarten enrollment) multiplied by the percentage of students who qualified for free or reduced-price lunch (at or below 185% of the federal poverty level).

Due to changes in methodology, the percentage of children enrolled in Early Head Start should not be compared with Factbooks prior to 2018.

Charter Schools with kindergarten 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, RISE Prep Mayoral Academy, and South Side Elementary Charter School.

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

References

[1,6] Vogel, C. A., et al. (2015). *Toddlers in Early Head Start: A portrait of 2-year-olds, their families, and the programs serving them.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation.

[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. (2019). Annual update of the HHS poverty guidelines. *Federal Register, 84*(22), 1167-1168.

[4] Cosse, R. (2017). *Early Head Start participants, programs, families, and staff in 2016.* Washington, DC: Center for Law and Social Policy.

[5] U.S. Department of Health and Human Services, Administration for Children and Families, Early Childhood Learning & Knowledge Center. (n.d.). *Services to pregnant women participating in Early Head Start.* Retrieved March 11, 2019, from https://eclkc.ohs.acf.hhs.gov

(continued on page 185)

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

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]

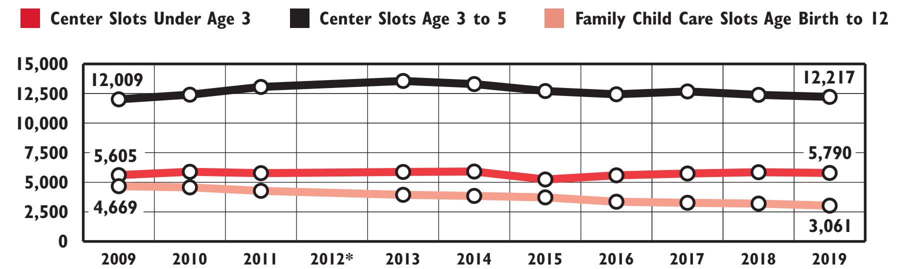
Early and ongoing enrollment in child care and early learning programs is common in the United States. Across the U.S., 42% of infants under the age of one and 73% of preschoolers between ages three and five regularly participate in a non-parental early care and education arrangement. Participation in 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 2013 and 2017, 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 high turnover and low compensation levels that do not reward education or training of staff. Early care and education teachers are among the lowest-paid U.S. workers, with almost half relying on public income supports to make ends meet (e.g., the Earned Income Tax Credit, Medicaid, TANF, and SNAP).[5]

The availability of well-designed and maintained buildings that meet the needs of young children is also essential to the supply of quality early learning programs.[6]

Early Learning Program Capacity, Rhode Island, 2009-2019



Source: Rhode Island Department of Children, Youth and Families, slots in licensed child care centers and family child care homes, 2009-2015. Rhode Island Department of Children, Youth and Families, number of licensed child care center slots and number of licensed family child care homes and slots, from RI Early Care and Education Data System (ECEDS), 2016-2019. *In the 2013 Factbook, data was collected as of January 2013, instead of December 2012.

◆ **In January 2019, there were 61 fewer slots for infants and toddlers (children under age three) and 169 fewer slots for preschoolers (children ages three to five) in licensed centers than in 2018.[7]**

◆ **In January 2019, there were 138 fewer slots in licensed family child care homes than in the previous year. The number of family child care slots is down 34% since 2009.[8]**

◆ **In Rhode Island, family child care providers (88%) are more likely than centers (74%) to accept children participating in the Child Care Assistance Program (CCAP), which covers all or part of the cost of child care for low-income working families.[9]**

◆ **In addition to licensed programs operated by community-based agencies 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 have preschool classrooms.[10]**

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.[11]**

Licensed Capacity of Early Learning Programs

Table 35. **Capacity of Licensed Early Learning Programs, Rhode Island, January 2019**

CITY/TOWN	# OF LICENSED CENTERS	# OF CENTER SLOTS FOR CHILDREN <AGE 3	# OF CENTER SLOTS FOR CHILDREN AGES 3-5	# OF LICENSED FAMILY CHILD CARE HOMES	# OF LICENSED FAMILY CHILD CARE HOME SLOTS*	TOTAL LICENSED EARLY LEARNING PROGRAM SLOTS
Barrington	9	140	328	4	24	492
Bristol	5	67	108	5	32	207
Burrillville	3	38	54	1	6	98
Central Falls	3	96	166	16	101	363
Charlestown	4	14	92	3	20	126
Coventry	7	131	233	4	28	392
Cranston	31	534	1,060	47	324	1,918
Cumberland	7	112	332	7	57	501
East Greenwich	11	225	428	0	0	653
East Providence	15	170	459	2	14	643
Exeter	2	24	52	1	8	84
Foster	1	19	18	0	0	37
Glocester	2	40	59	1	11	110
Hopkinton	3	12	60	2	14	86
Jamestown	1	30	34	1	8	72
Johnston	20	392	447	10	74	913
Lincoln	6	148	275	5	30	453
Little Compton	1	0	20	0	0	20
Middletown	10	185	410	0	0	595
Narragansett	2	12	20	0	0	32
New Shoreham	1	12	26	0	0	38
Newport	4	64	183	1	8	255
North Kingstown	7	103	316	3	17	436
North Providence	9	122	238	7	49	409
North Smithfield	1	77	91	4	36	204
Pawtucket	18	309	855	33	215	1,379
Portsmouth	5	104	163	0	0	267
Providence	46	714	1,921	272	1,777	4,412
Richmond	0	0	0	2	20	20
Scituate	1	11	36	1	6	53
Smithfield	9	298	501	0	0	799
South Kingstown	12	235	402	6	40	677
Tiverton	3	24	124	1	8	156
Warren	5	80	190	0	0	270
Warwick	26	831	1,303	7	56	2,190
West Greenwich	3	34	60	0	0	94
West Warwick	5	169	318	3	20	507
Westerly	8	88	296	2	12	396
Woonsocket	9	126	539	6	46	711
Four Core Cities	*76*	*1,245*	*3,481*	*327*	*2,139*	*6,865*
Remainder of State	*239*	*4,545*	*8,736*	*130*	*922*	*14,203*
Rhode Island	*315*	*5,790*	*12,217*	*457*	*3,061*	*21,068*

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 2019.

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, 2017, from: www.americanprogress.org

[4] U.S. Census Bureau, American Community Survey, 2013-2017. Table DP03.

[5] Phillips, D., Austin, L. J. E., & Whitebook, M. (2016). The early care and education workforce. *The Future of Children, 26*(2),139-158.

[6] *Early childhood initiative: Early learning facilities policy framework.* (2018). Washington, DC: Bipartisan Policy Center.

(continued on page 186)

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 licensed child care center, a licensed family child care home, or by a license-exempt provider (family, friend, or neighbor).

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 families access child care.[1]

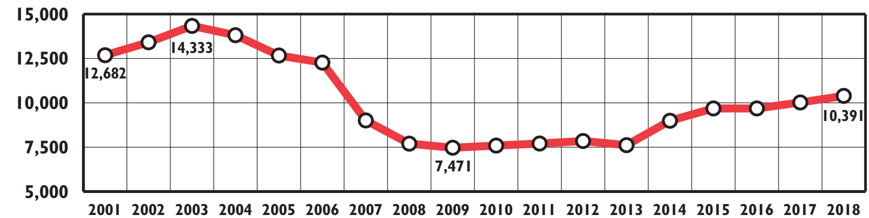
In Rhode Island, the average cost of full-time child care for an infant in a child care center consumes 50% of the median single-parent income and is more than the average tuition at public colleges. For families with two children (an infant and a preschooler) center-based child care costs exceed the average mortgage payment.[2] Using the federal affordability guideline that families should spend no more than 7% of their income on child care, a Rhode Island family would need to earn at least $155,757 annually to afford the average yearly cost for a three-year-old at a licensed center ($10,903).[3,4]

Subsidy rates for child care providers should meet or exceed the federal benchmark established to ensure low-income families have equal access to high-quality child care that supports children's development and learning. In 2018, Rhode Island joined 41 other states in the U.S. by establishing a tiered child care rate system to provide access to higher quality care. As of July 2018, the rates paid for infants and toddlers in centers with a five-star quality rating meet the federal benchmark enabling equal access, but rates for preschool and school-age children in centers and for children in family child care remain below the benchmark.[5,6,7,8]

Child care teachers make very low wages yet are responsible for the safety, health, and development of our youngest children. In Rhode Island in 2017, the median wage for a child care teacher was $11.82/hour. At least 11 states fund efforts to improve qualifications and retention of child care teachers through targeted wage supplements.[9,10]

As of December 2018, 10% of children participating in the Rhode Island Child Care Assistance Program were enrolled in programs with high-quality BrightStars ratings (four or five stars). Preschool-age children were more likely to be enrolled in a high-quality program (12%) than infants and toddlers (8%) or school-age children (9%).[11]

Child Care Subsidies, Rhode Island, 2001-2018



Source: Rhode Island Department of Human Services, December 2001-December 2015, September 2016, December 2017-December 2018. Data for December 2016 was not available.

◆ **In December 2018, there were 10,391 child care subsidies in Rhode Island, up 4% from December 2017, but down 28% from the 2003 peak. In December 2018 in Rhode Island, 77% of child care subsidies were for care in a licensed child care center, 22% were for care by a licensed family child care home or group family child care home, and 1% were for care by a non-licensed relative, friend, or neighbor.[12]**

◆ **Rhode Island families with incomes at or below 180% federal poverty level (FPL) ($37,404 for a family of three in 2018) who work a minimum of 20 hours per week are eligible to receive CCAP. Families may continue to receive a child care subsidy until their income reaches 225% FPL ($46,755 for a family of three in 2018). Families in Rhode Island Works (cash assistance) may also be eligible for CCAP to support education and employment activities.[13]**

◆ **In December 2018, 82% of all children receiving child care subsidies were in low-income working families not receiving cash assistance and 10% were in low-income families receiving cash assistance. Another 8% of child care subsidies were used for children in the care of the Rhode Island Department of Children, Youth and Families.[14]**

Average Annual Cost for Full-Time Child Care, Rhode Island, 2018

PROGRAM TYPE	COST PER CHILD
Child Care Center (infant care)	$13,093
Child Care Center (preschool care)	$10,903
Family Child Care Home (preschool care)	$8,811
School-Age Center-Based Program (child age 6-12)	$7,664

Source: Rhode Island KIDS COUNT analysis of average weekly rates from Silver, B. E. (2018). *Statewide survey of childcare rates in Rhode Island.* Kingston, RI: University of Rhode Island.

Children Receiving Child Care Subsidies

Table 36. **Child Care Subsidies, Rhode Island, December 2018**

CITY/TOWN	SUBSIDY USE BY CHILD RESIDENCE: UNDER AGE 3	AGES 3-5	AGES 6+	TOTAL CHILD CARE SUBSIDIES	SUBSIDY USE BY PROGRAM LOCATION: CENTER	FAMILY CHILD CARE	LICENSE EXEMPT	TOTAL CHILD CARE SUBSIDIES
Barrington	6	10	13	29	45	0	0	45
Bristol	10	23	20	53	44	0	0	44
Burrillville	18	23	27	68	56	0	0	56
Central Falls	94	135	176	405	257	86	3	346
Charlestown	4	4	2	10	5	0	0	5
Coventry	37	56	60	153	184	1	0	185
Cranston	127	211	230	568	729	185	2	916
Cumberland	20	36	75	131	139	4	1	144
East Greenwich	11	10	14	35	78	0	0	78
East Providence	58	86	150	294	348	5	3	356
Exeter	3	11	3	17	19	4	0	23
Foster	0	4	2	6	8	0	0	8
Glocester	1	7	3	11	43	0	0	43
Hopkinton	0	6	1	7	7	5	0	12
Jamestown	0	5	0	5	11	0	0	11
Johnston	35	69	58	162	361	47	3	411
Lincoln	16	41	45	102	177	13	0	190
Little Compton	2	0	1	3	0	0	0	0
Middletown	7	24	32	63	86	0	0	86
Narragansett	5	16	11	32	13	0	0	13
New Shoreham	0	0	0	0	0	0	0	0
Newport	38	55	99	192	164	0	0	164
North Kingstown	37	45	53	135	122	0	0	122
North Providence	44	70	80	194	163	19	0	182
North Smithfield	9	8	11	28	43	1	0	44
Pawtucket	263	392	507	1,162	1,008	128	7	1,143
Portsmouth	4	6	0	10	2	0	0	2
Providence	879	1,197	1,606	3,682	1,837	1,760	46	3,643
Richmond	4	10	2	16	6	7	0	13
Scituate	4	8	8	20	1	0	0	1
Smithfield	10	12	14	36	115	0	0	115
South Kingstown	22	33	22	77	126	2	0	128
Tiverton	4	16	5	25	21	8	0	29
Warren	14	25	21	60	86	0	0	86
Warwick	95	161	140	396	670	1	4	675
West Greenwich	2	3	2	7	8	0	2	10
West Warwick	90	118	135	343	280	0	0	280
Westerly	21	32	33	86	94	2	3	99
Woonsocket	142	261	330	733	609	45	4	658
DCYF	*295*	*333*	*176*	*804*	*NA*	*NA*	*NA*	*NA*
Undetermined Address	*2*	*1*	*8*	*11*				
Out-Of-State	*NA*	*NA*	*NA*	*NA*	*25*	*0*	*0*	*25*
Four Core Cities	*1,378*	*1,985*	*2,619*	*5,982*	*3,711*	*2,019*	*60*	*5,790*
Remainder of State	*758*	*1,244*	*1,372*	*3,374*	*4,254*	*304*	*18*	*4,576*
Rhode Island	*2,433*	*3,563*	*4,175*	*10,171*	*7,990*	*2,323*	*78*	*10,391*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, December 2018. Data for 2016 should not be compared with previous years since the month differs.

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 subsidies used by 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 child's residence. Subsidy use by program type is reported by location of the program. Total subsidies by program location exceeds subsidies by child residence because children may attend more than one program.

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 13 weeks of average school vacation/summer camp tuition.

References

[1,5] Schulman, K. (2018). *Overdue for investment: State child care assistance policies 2018.* Washington, DC: National Women's Law Center.

[2] *The U.S. and the high cost of child care: A review of prices and proposed solutions for a broken system.* (2018). Arlington, VA: Child Care Aware of America.

[3,6] U.S. Department of Health and Human Services. (2016). Child Care and Development Fund Program: Final rule. *Federal Register, 81*(190), 67438-67595.

[4] Rhode Island KIDS COUNT calculations based on average weekly rates from Silver, B. E. (2018). *Statewide survey of child care rates in Rhode Island.* Kingston, RI: University of Rhode Island, Charles T. Schmidt, Jr. Labor Research Center.

(continued on page 186)

High-Quality Early Learning Programs

DEFINITION

High-quality early learning programs is the percentage of licensed early learning centers, family child care homes, and public schools with preschool classrooms that have a high-quality rating of four or five stars from BrightStars, Rhode Island's Quality Rating and Improvement System for child care and early learning programs.

SIGNIFICANCE

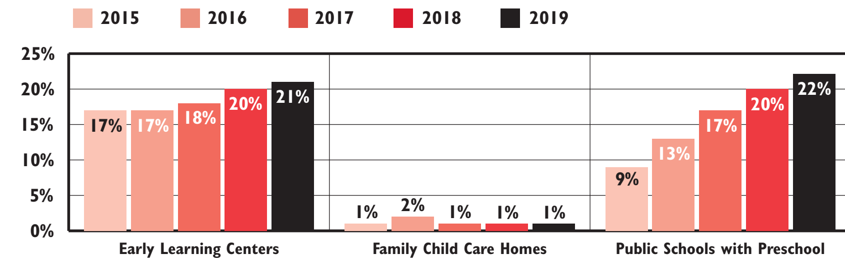
Decades of research show that high-quality early care and education programs can improve children's cognitive and social-emotional development, enabling them to perform better in school. Programs across the U.S. and in Rhode Island vary markedly in quality and can range from rich learning experiences to mediocre, custodial care.[1,2,3,4]

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.[5] The development and retention of highly qualified and appropriately compensated early childhood teachers is critical for improving program quality.[6]

Almost all states use Quality Rating and Improvement Systems (QRIS) to document and improve the quality of early learning and child care programs. QRIS measure a variety of program quality indicators (such as staff qualifications, learning environment, and staff-child interactions) and then create a composite index rating. QRIS ratings are shared with parents and they are often connected to financial incentives and supports, such as enhanced reimbursement rates or quality bonuses for higher quality child care programs.[7,8,9,10] Studies have shown that, over time, state QRIS can improve the quality of care available.[11]

BrightStars is Rhode Island's QRIS and conducts program quality assessments for early care and education centers, family child care homes, and public schools. Programs participating in BrightStars receive a star rating and support to set and achieve quality improvement goals. All programs serving children participating in the Child Care Assistance Program or the State Pre-K program are required to have a BrightStars rating. Star ratings are posted on a public website to inform family decision making when selecting a program.[12,13] Research suggests that parents have a strong preference for quality, particularly teachers' educational achievement. However, they are extremely sensitive to the cost of tuition, and may enroll their children in lower quality programs because they cannot afford the cost of higher quality programs.[14]

Percentage of Early Learning Centers, Family Child Care Programs, and Public Schools with a High-Quality BrightStars Rating (4 or 5 Stars), Rhode Island, 2015-2019



Source: RI Association for the Education of Young Children and RI Early Care and Education Data System (ECEDS), January 2015-January 2019.

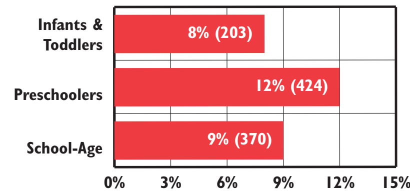
◆ **As of January 2019, there were 642 early learning programs with a BrightStars quality rating (78% of all early learning programs) – 78% of licensed child care centers, 80% of licensed family child care homes, and 55% of public schools with preschool classrooms. Sixty-five (21%) licensed early learning centers, five (1%) licensed family child care homes, and 12 (22%) public schools had met the benchmarks for a high-quality rating of four or five stars.[15]**

◆ **Since 2015, the percentage of early learning centers with a high-quality rating has grown from 17% to 21% and the percentage of public schools serving preschoolers that have a high-quality rating has increased from 9% to 22%.[16]**

◆ **Early learning centers and public schools in the core cities are more likely to have a high-quality BrightStars rating than those in the remainder of the state (26% vs. 19% for early learning centers and 25% vs. 20% for public schools). Family child care providers in the core cities are less likely to have a high-quality BrightStars rating than those in the remainder of the state (1% vs. 2%).[17]**

◆ **A 2016 evaluation of BrightStars found that the star levels effectively differentiate quality and five of the ten standards are linked to improved child outcomes, specifically improved social competence and math skills. The study also found that 70% of child care center and preschool directors had a positive or extremely positive impression of BrightStars.[18]**

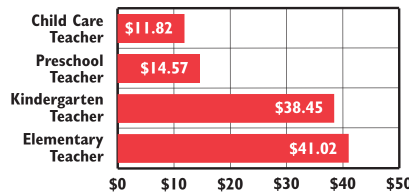
CCAP Children Enrolled in High-Quality Programs (4 or 5 Stars) by Age, December 2018



Source: Rhode Island Rhode Island Department of Human Services, December 2018.

◆ Preschool-age children enrolled in the Child Care Assistance Program (CCAP) are more likely to be enrolled in a high-quality program (12%) than infants and toddlers (8%) or school-age children (9%).[19]

Teacher Median Hourly Wages, Rhode Island, 2017



Source: Whitebook, M., McLean, C., Austin, L. J. E., & Edwards, B. (2018). *Early childhood workforce index 2018.* Berkeley, CA: Center for the Study of Child Care Employment.

◆ Early childhood teachers in Rhode Island earn less than the overall state median wage ($19.45) and have significantly lower wages than kindergarten and elementary school teachers.[20]

Table 37. **Licensed Child Care Centers and Preschools Participating in the BrightStars Quality Rating and Improvement System, Rhode Island, January 2019**

CITY/TOWN	LICENSED PROGRAMS	DCYF PROBATION	NO RATING	1 STAR	2 STARS	3 STARS	4 STARS	5 STARS	% IN BRIGHTSTARS	% WITH HIGH-QUALITY RATING
Barrington	9	1	5	2	1	0	1	0	44%	11%
Bristol	5	0	1	3	0	0	1	0	80%	20%
Burrillville	3	0	0	2	0	0	1	0	100%	33%
Central Falls	3	0	0	0	0	3	0	0	100%	0%
Charlestown	4	1	0	1	0	0	1	2	100%	75%
Coventry	7	0	0	3	1	2	1	0	100%	14%
Cranston	31	0	9	12	4	3	2	1	71%	10%
Cumberland	7	0	2	2	1	0	2	0	71%	29%
East Greenwich	11	0	4	2	3	0	2	0	64%	18%
East Providence	15	0	5	3	4	0	3	0	67%	20%
Exeter	2	0	0	0	1	0	1	0	100%	50%
Foster	1	0	0	0	1	0	0	0	100%	0%
Glocester	2	0	0	0	1	0	1	0	100%	50%
Hopkinton	3	1	0	2	1	0	0	0	100%	0%
Jamestown	1	0	0	0	0	1	0	0	100%	0%
Johnston	20	0	3	6	8	0	3	0	85%	15%
Lincoln	6	0	0	2	2	0	1	1	100%	33%
Little Compton	1	0	1	0	0	0	0	0	0%	0%
Middletown	10	1	5	1	0	2	2	0	50%	20%
Narragansett	2	0	1	1	0	0	0	0	50%	0%
New Shoreham	1	0	1	0	0	0	0	0	0%	0%
Newport	4	0	0	0	2	1	1	0	100%	25%
North Kingstown	7	0	2	0	2	1	2	0	71%	29%
North Providence	9	0	1	3	2	1	2	0	89%	22%
North Smithfield	1	0	0	1	0	0	0	0	100%	0%
Pawtucket	18	2	2	7	5	1	2	1	89%	17%
Portsmouth	5	0	4	1	0	0	0	0	20%	0%
Providence	46	2	11	6	11	5	9	4	76%	28%
Richmond	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Scituate	1	0	0	0	1	0	0	0	100%	0%
Smithfield	9	0	2	2	2	1	2	0	78%	22%
South Kingstown	12	0	3	2	3	1	2	1	75%	25%
Tiverton	3	0	0	1	1	0	1	0	100%	33%
Warren	5	1	2	1	0	1	1	0	60%	20%
Warwick	26	0	2	6	12	4	1	1	92%	8%
West Greenwich	3	0	0	1	2	0	0	0	100%	0%
West Warwick	5	0	0	2	1	1	1	0	100%	20%
Westerly	8	0	2	0	2	0	4	0	75%	50%
Woonsocket	9	0	0	2	0	3	2	2	100%	44%
Four Core Cities	*76*	*4*	*13*	*15*	*16*	*12*	*13*	*7*	*83%*	*26%*
Remainder of State	*239*	*5*	*55*	*62*	*58*	*19*	*39*	*6*	*77%*	*19%*
Rhode Island	*315*	*9*	*68*	*77*	*74*	*31*	*52*	*13*	*78%*	*21%*

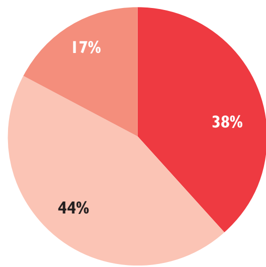
High-Quality Early Learning Programs

Licensed Family Child Care Programs by Language Spoken, Rhode Island 2014

38% English Only

44% Spanish Only

17% Bilingual in English and Spanish



n=188

Source: Oldham, E. & Hawes, S. (2014). *Rhode Island early learning workforce study: Licensed centers and family child care homes.* Retrieved March 6, 2019, from http://exceed.ri.gov

◆ In 2014, 44% of family child care providers in Rhode Island reported speaking Spanish only, 38% English only, and 17% were bilingual in English and Spanish. More than two-thirds worked more than 40 hours per week and 84% reported earning less than $40,000 annually.[21]

◆ In Rhode Island, Hispanic children in the CCAP program are more likely to be enrolled in family child care (40%) than non-Hispanic children (8%).[22]

Table 38. **Licensed Family Child Care Homes Participating in the BrightStars Quality Rating and Improvement System, Rhode Island, January 2019**

CITY/TOWN	LICENSED PROGRAMS	DCYF PROBATION	NO RATING	1 STAR	2 STARS	3 STARS	4 STARS	5 STARS	% IN BRIGHTSTARS	% WITH HIGH-QUALITY RATING
Barrington	4	0	1	3	0	0	0	0	75%	0%
Bristol	5	0	4	1	0	0	0	0	20%	0%
Burrillville	1	0	0	1	0	0	0	0	100%	0%
Central Falls	16	1	2	11	3	0	0	0	88%	0%
Charlestown	3	0	2	1	0	0	0	0	33%	0%
Coventry	4	0	2	2	0	0	0	0	50%	0%
Cranston	47	1	8	21	18	0	0	0	83%	0%
Cumberland	7	0	6	1	0	0	0	0	14%	0%
East Greenwich	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
East Providence	2	0	1	1	0	0	0	0	50%	0%
Exeter	1	0	0	0	0	0	1	0	100%	100%
Foster	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Glocester	1	0	1	0	0	0	0	0	0%	0%
Hopkinton	2	0	0	2	0	0	0	0	100%	0%
Jamestown	1	0	1	0	0	0	0	0	0%	0%
Johnston	10	0	2	5	3	0	0	0	80%	0%
Lincoln	5	0	4	1	0	0	0	0	20%	0%
Little Compton	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Middletown	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Narragansett	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
New Shoreham	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Newport	1	0	1	0	0	0	0	0	0%	0%
North Kingstown	3	0	1	2	0	0	0	0	67%	0%
North Providence	7	1	1	6	0	0	0	0	86%	0%
North Smithfield	4	0	2	1	0	0	1	0	50%	25%
Pawtucket	33	0	2	16	14	1	0	0	94%	0%
Portsmouth	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Providence	272	0	35	150	84	0	3	0	87%	1%
Richmond	2	0	2	0	0	0	0	0	0%	0%
Scituate	1	0	0	1	0	0	0	0	100%	0%
Smithfield	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
South Kingstown	6	0	3	2	1	0	0	0	50%	0%
Tiverton	1	0	0	1	0	0	0	0	100%	0%
Warren	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Warwick	7	0	6	1	0	0	0	0	14%	0%
West Greenwich	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
West Warwick	3	0	3	0	0	0	0	0	0%	0%
Westerly	2	0	1	1	0	0	0	0	50%	0%
Woonsocket	6	0	0	5	1	0	0	0	100%	0%
Four Core Cities	*327*	*1*	*39*	*182*	*102*	*1*	*3*	*0*	*88%*	*1%*
Remainder of State	*130*	*2*	*52*	*54*	*22*	*0*	*2*	*0*	*60%*	*2%*
Rhode Island	*457*	*3*	*91*	*236*	*124*	*1*	*5*	*0*	*80%*	*1%*

Table 39. **Public Schools with Preschool Classrooms Participating in the BrightStars Quality Rating and Improvement System, Rhode Island, January 2019**

DISTRICT	SCHOOLS WITH PRESCHOOL CLASSROOMS	NO RATING	1 STAR	2 STARS	3 STARS	4 STARS	5 STARS	% IN BRIGHTSTARS	% WITH HIGH-QUALITY RATING
Barrington	1	1	0	0	0	0	0	0%	0%
Bristol Warren	1	1	0	0	0	0	0	0%	0%
Burrillville	1	1	0	0	0	0	0	0%	0%
Central Falls	2	1	0	0	0	1	0	50%	50%
Chariho	1	0	0	0	0	0	1	100%	100%
Coventry	1	0	0	0	0	1	0	100%	100%
Cranston	7	3	1	0	3	0	0	57%	0%
Cumberland	1	1	0	0	0	0	0	0%	0%
East Greenwich	1	0	0	0	1	0	0	100%	0%
East Providence	3	1	0	1	0	0	1	67%	33%
Exeter-West Greenwich	1	0	0	0	0	1	0	100%	100%
Foster	0	NA	NA	NA	NA	NA	NA	NA	NA
Glocester	1	1	0	0	0	0	0	0%	0%
Jamestown	1	0	0	0	0	1	0	100%	100%
Johnston	1	0	0	0	1	0	0	100%	0%
Lincoln	1	0	0	0	1	0	0	100%	0%
Little Compton	0	NA	NA	NA	NA	NA	NA	NA	NA
Middletown	1	1	0	0	0	0	0	0%	0%
Narragansett	1	1	0	0	0	0	0	0%	0%
New Shoreham	0	NA	NA	NA	NA	NA	NA	NA	NA
Newport	1	0	1	0	0	0	0	100%	0%
North Kingstown	1	0	0	0	0	1	0	100%	100%
North Providence	2	0	0	2	0	0	0	100%	0%
North Smithfield	1	1	0	0	0	0	0	0%	0%
Pawtucket	3	1	1	0	0	1	0	67%	33%
Portsmouth	1	1	0	0	0	0	0	0%	0%
Providence	6	2	1	2	0	1	0	67%	17%
Scituate	1	1	0	0	0	0	0	0%	0%
Smithfield	1	0	0	0	0	1	0	100%	100%
South Kingstown	2	2	0	0	0	0	0	0%	0%
Tiverton	2	2	0	0	0	0	0	0%	0%
Warwick	2	1	1	0	0	0	0	50%	0%
West Warwick	2	0	0	2	0	0	0	100%	0%
Westerly	1	0	0	0	0	0	1	100%	100%
Woonsocket	1	1	0	0	0	0	0	0%	0%
Charter Schools	*1*	*1*	*0*	*0*	*0*	*0*	*0*	*0%*	*0%*
RI School for the Deaf	*1*	*0*	*0*	*0*	*0*	*1*	*0*	*100%*	*100%*
Four Core Cities	*12*	*5*	*2*	*2*	*0*	*3*	*0*	*58%*	*25%*
Remainder of State	*41*	*19*	*3*	*5*	*6*	*5*	*3*	*54%*	*20%*
Rhode Island	*55*	*25*	*5*	*7*	*6*	*9*	*3*	*55%*	*22%*

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 2019. Data on public schools are from the Rhode Island Department of Education, January 2019. Data on BrightStars quality ratings are from the Rhode Island Association for the Education of Young Children, January 2019. Data matched through the RI Early Care and Education Data System (ECEDS).

High-quality rating means a BrightStars rating of four or five stars.

NA=Not applicable.

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.* (pp. 11-31). Baltimore, MD: Paul H. Brookes Publishing Co.

[2] 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.

[3,14] Gordon, J., Herbst, C. M., & Tekin, E. (2018). *Who's minding the kids?: Experimental evidence on the demand for child care quality.* Cambridge, MA: National Bureau of Economic Research.

[4,5] 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.

[6] Phillips, D., Austin, L. J. E., & Whitebook, M. (2016). The early care and education workforce. *The Future of Children, 26*(2), 139-158.

(continued on page 186)

Children Enrolled in Head Start or State Pre-K

DEFINITION

Children enrolled in Head Start or State Pre-K is the percentage of low-income children and all children enrolled in a Rhode Island Head Start or State Pre-K preschool program the year before kindergarten. Head Start is managed by the federal government and State Pre-K is managed by the Rhode Island Department of Education. Both can be operated by community-based agencies or by public schools.

SIGNIFICANCE

Children begin learning at birth and brain development proceeds rapidly in early childhood. Learning disparities appear early and grow over time without access to enriching early learning experiences. Participation in high-quality early learning programs from birth through kindergarten entry helps to ensure children enter school with the skills needed to succeed. Without government funding, access to high-quality preschool is limited to higher-income families.[1,2,3]

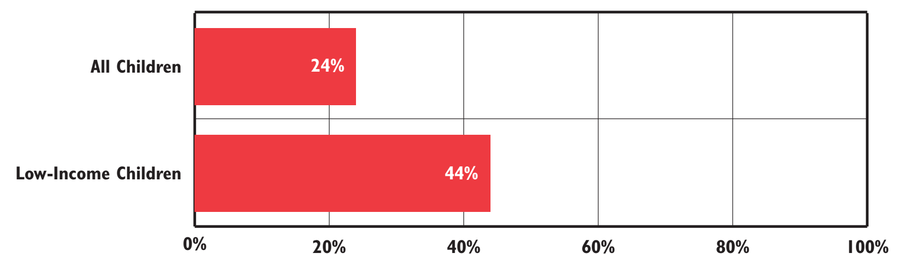
Decades of research have shown that high-quality preschool programs help children gain skills and knowledge prior to school entry and produce positive outcomes that last well into the school years including improved classroom and interpersonal behavior, reduced need for special education services, and improved high school graduation rates.[4]

Head Start is a federally-funded comprehensive early childhood program for the lowest income preschool children and is available to children during the two years before kindergarten. It is designed to address a wide variety of needs so that low-income children can begin school on a more equal footing with their economically advantaged peers. 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.[5,6]

State-funded Pre-K programs are growing across the U.S. As of 2017, 43 states and the District of Columbia operated State Pre-K programs, serving 33% of four-year-olds and 5% of three-year olds across the U.S. Rhode Island launched a State Pre-K program in 2009 serving four-year-olds in mixed-income classrooms, with classrooms located in communities with high poverty levels.[7] *The Rhode Island Prekindergarten Education Act* establishes a state goal to provide access to publicly-funded, high-quality Pre-K that builds on the existing early childhood education infrastructure.[8]

Head Start and State Pre-K are an important part of a strong state early learning system that starts at birth and continues through third grade, including high-quality child care and nurturing and language-rich early elementary classrooms.[9]

Percentage of Children Enrolled in Head Start or State Pre-K the Year before Kindergarten, Rhode Island 2018-2019



Source: Rhode Island KIDS COUNT calculations using October 2018 enrollment in Head Start and State Pre-K as numerator and October 2018 enrollment in public kindergarten as denominator with low-income population estimated using the % of children receiving free or reduced-price lunch.

◆ **As of the 2018-2019 school year, there were 2,359 children enrolled in either Head Start or State Pre-K during the year before kindergarten, approximately 24% of all children and 44% of low-income children. Fifty-four percent of these children were enrolled in Head Start and 46% were enrolled in State Pre-K.[10,11]**

◆ **Low-income children in the four core cities were more likely to be enrolled in Head Start or State Pre-K (52%) than low-income children in the remainder of the state (42%).[12,13]**

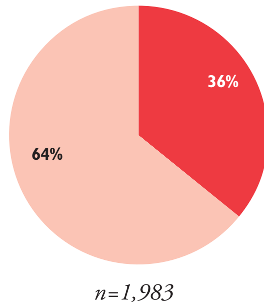
◆ **Also, in 2018, there were 1,291 four-year-olds enrolled in a child care program with a subsidy through the Child Care Assistance Program (CCAP) managed by the Rhode Island Department of Human Services. Children in State Pre-K or Head Start may also participate in CCAP because Head Start and State Pre-K do not cover the entire work day or work year for many families. In 2018, 20% of Head Start children were also enrolled in CCAP to cover hours and days when the Head Start program is not open but parents are at work.[14,15]**

◆ **In 2018 there were 1,062 four-year-olds with an Individualized Education Program (IEP) receiving early childhood special education services through a local school district. These services are delivered in Head Start, State Pre-K, child care, or district operated special education classrooms, or through walk-in appointments (e.g. speech therapy).[16]**

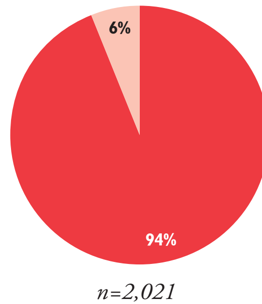
◆ **As of 2017, Rhode Island ranked 1st in the U.S. and DC (tied with Alabama and Michigan) for meeting research-based Pre-K quality benchmarks, but 33rd in the U.S. and DC for enrollment of four-year-olds.[17]**

Children Enrolled in Head Start or State Pre-K

Children Enrolled in Head Start by Age Cohort, Rhode Island, 2018



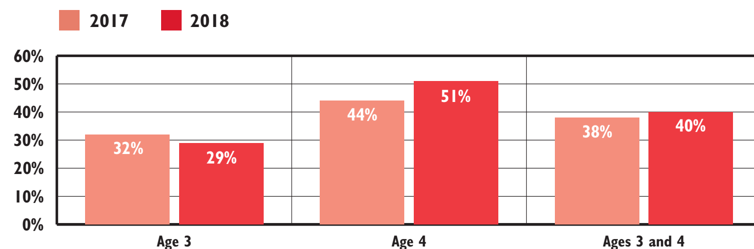
Head Start Slots by Funding Source, Rhode Island, 2018



Source: Rhode Island Head Start program data compiled by Rhode Island KIDS COUNT, October 2018.

◆ In October 2018 in Rhode Island, there were 1,983 children enrolled in Head Start. Most children (64%) were scheduled to enter kindergarten in the 2019-2020 school year. As of the 2018-2019 school year, there were 1,891 federally-funded Head Start slots in Rhode Island and 130 state-funded Head Start slots.[18]

Estimated Percentage of Eligible Children Enrolled in Head Start by Age, Rhode Island, 2017-2018



Source: Rhode Island KIDS COUNT calculations. The numerator is Rhode Island Head Start program enrollment data, October 2017 and 2018. The denominator is the estimated number of children ages three and four from Census 2010 multiplied by the % of children under age six living in families with incomes below the federal poverty line (FPL) from the 2012-2016 and 2013-2017 American Community Surveys.

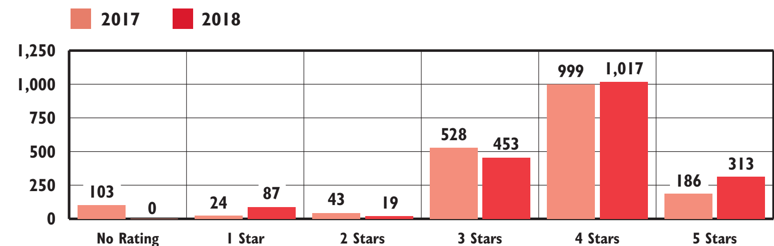
◆ As of 2018, approximately 40% of Rhode Island preschool-age children living in poverty were enrolled in Head Start (29% of the three-year-olds and 51% of the four-year-olds).[19]

Head Start Quality & Effectiveness

◆ Across the U.S., Head Start centers are typically higher quality than many other early care and education programs available. Rhode Island Head Start programs score above the national benchmark and are among the highest quality Head Start programs in the U.S. based on classroom observations of teacher-child interactions.[20]

◆ Head Start improves children's academic, cognitive, language, and social-emotional skills. Children who attend Head Start also show improved health outcomes including reduced childhood obesity and improved immunization rates. Head Start children are more likely to graduate from high school and attend college and are less likely to be charged with criminal activity as an adult.[21,22]

Children Enrolled in Head Start by BrightStars Rating of Site, Rhode Island, 2017-2018



Source: Rhode Island Head Start data compiled by Rhode Island KIDS COUNT, October 2017-2018.

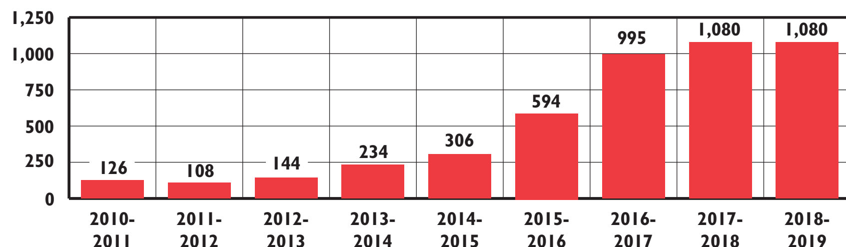
◆ As of October 2018, 70% of children enrolled in Head Start were in a program that had achieved a high-quality BrightStars rating of four or five stars. In comparison, only 12% of preschoolers in the CCAP were enrolled in a program that had achieved a high-quality BrightStars rating.[23,24]

Head Start and Children with High Needs

◆ Rhode Island Head Start programs serve significant numbers of children with high needs. As of 2018, 11% (224) of all children enrolled in Head Start had developmental delays or disabilities and received special education services through their local school districts. Also, in 2018, 3% (53) of Head Start children were in foster care, and 3% (53) were homeless.[25]

Children Enrolled in Head Start or State Pre-K

Rhode Island State Pre-K Enrollment, 2010-2011 through 2018-2019



Sources: National Institute for Early Education Research, *The State of Preschool 2010, 2011, 2012, 2013, 2014, 2015.* Rhode Island Department of Education, State Pre-K programs 2015-2016 through 2018-2019.

◆ Rhode Island began offering State Pre-K for four-year-olds in the 2009-2010 school year through public schools, Head Start agencies, and child care programs.[26]

◆ As of the 2018-2019 school year, there were 60 state Pre-K classrooms in Rhode Island with a total of 1,080 children enrolled, which is approximately 11% of all children estimated to enter kindergarten in 2019-2020. As of the 2018-2019 school year, 37% of the classrooms were operated by Head Start agencies, 33% were operated by child care programs, and 30% were operated by public schools.[27]

◆ The Rhode Island State Pre-K program is funded through the Rhode Island Education Funding Formula. In 2014, Rhode Island received a federal Preschool Development Grant to accelerate expansion and to improve program monitoring, evaluation, and technical assistance.[28]

State Pre-K Enrollment and Family Income

◆ 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.[29]

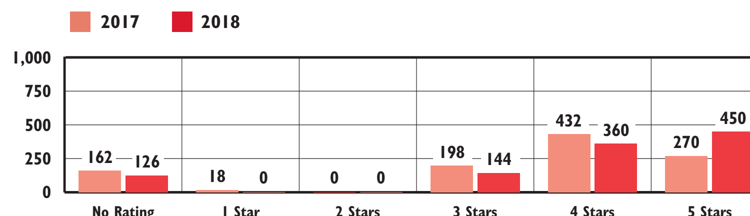
◆ As of the 2018-2019 school year, 71% (768) of the children enrolled in State Pre-K were low-income and 29% (312) were higher-income.[30]

State Pre-K Quality and Effectiveness

◆ In 2017 the Rhode Island State Pre-K program was recognized as one of only three State Pre-K programs in the U.S. to meet all 10 recommended quality benchmarks, including requiring teachers to have a bachelor's degree with specialized training in early childhood education and conducting annual classroom observations.[31]

◆ An evaluation of the Rhode Island State Pre-K program found that it improves children's language and math skills and closes the achievement gap between low-income children and their more affluent peers by three-quarters.[32]

Children Enrolled in State Pre-K by BrightStars Rating of Site, Rhode Island, 2017-2018



Source: Rhode Island Department of Education, 2017-2018.

◆ As of 2018, 75% of children enrolled in State Pre-K were in program sites with high-quality BrightStars ratings (four or five stars). In comparison, only 12% of preschoolers in CCAP were enrolled in programs with high-quality BrightStars ratings.[33,34]

State Pre-K and Children with High Needs

◆ Rhode Island State Pre-K classrooms serve significant numbers of children with high needs. As of 2018, 12% (126) of children in State Pre-K had developmental delays or disabilities, 2% (26) were in foster care, and 1% (10) were homeless.[35]

◆ As of 2018, 37% of the children enrolled in State Pre-K in Rhode Island were Hispanic and 25% spoke Spanish as a home language.[36]

Table 40. **Children Age Four Enrolled in Head Start or State Pre-K, Rhode Island, 2018**

SCHOOL DISTRICT	ESTIMATED # OF CHILDREN AGE 4	% LOW-INCOME CHILDREN IN DISTRICT	ESTIMATED # LOW-INCOME CHILDREN AGE 4	# CHILDREN AGE 4 IN HEAD START (ALL LOW-INCOME)	# LOW-INCOME CHILDREN IN STATE PRE-K	# HIGHER-INCOME CHILDREN IN STATE PRE-K	# CHILDREN AGE 4 IN HEAD START OR STATE PRE-K	ESTIMATED % OF ALL CHILDREN AGE 4 IN HEAD START OR STATE PRE-K	ESTIMATED % OF LOW-INCOME CHILDREN AGE 4 IN HEAD START OR STATE PRE-K
Barrington	206	4%	8	1	0	0	1	<1%	12%
Bristol Warren	214	30%	64	44	0	0	44	21%	69%
Burrillville	147	30%	44	6	0	0	6	4%	14%
Central Falls	193	91%	176	57	80	10	147	76%	78%
Chariho	190	20%	38	9	0	0	9	5%	24%
Coventry	321	31%	100	22	0	0	22	7%	22%
Cranston	740	43%	318	101	33	39	173	23%	42%
Cumberland	313	19%	59	6	0	0	6	2%	10%
East Greenwich	156	5%	8	0	0	0	0	0%	0%
East Providence	356	48%	171	54	78	66	198	56%	77%
Exeter-West Greenwich	108	16%	17	1	0	0	1	1%	6%
Foster	34	24%	8	1	0	0	1	3%	12%
Glocester	80	12%	10	3	0	0	3	4%	31%
Jamestown	54	8%	4	0	0	0	0	0%	0%
Johnston	236	45%	106	18	8	10	36	15%	24%
Lincoln	202	27%	55	0	0	0	0	0%	0%
Little Compton	16	12%	2	0	0	0	0	0%	0%
Middletown	139	30%	42	23	0	0	23	17%	55%
Narragansett	62	21%	13	2	0	0	2	3%	15%
New Shoreham	12	16%	2	0	0	0	0	0%	0%
Newport	154	66%	102	46	26	10	82	53%	71%
North Kingstown	261	22%	57	12	0	0	12	5%	21%
North Providence	214	38%	81	35	8	10	53	25%	53%
North Smithfield	116	16%	19	5	0	0	5	4%	27%
Pawtucket	665	76%	505	134	86	22	242	36%	44%
Portsmouth	148	14%	21	4	0	0	4	3%	19%
Providence	1,676	84%	1,408	420	302	58	780	47%	51%
Scituate	149	18%	27	0	0	0	0	0%	0%
Smithfield	157	14%	22	3	0	0	3	2%	14%
South Kingstown	201	17%	34	7	0	0	7	3%	20%
Tiverton	117	24%	28	6	0	0	6	5%	21%
Warwick	640	29%	186	70	18	36	124	19%	47%
West Warwick	281	50%	141	51	30	24	105	37%	58%
Westerly	173	36%	62	23	0	0	23	13%	37%
Woonsocket	474	79%	374	115	99	27	241	51%	57%
Charter Schools	*794*	*67%*	*532*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*
RI School for the Deaf	*5*	*66%*	*3*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*
Four Core Cities	*3,008*	*82%*	*2,467*	*726*	*567*	*117*	*1,410*	*47%*	*52%*
Remainder of State	*6,197*	*29%*	*1,797*	*553*	*201*	*195*	*949*	*15%*	*42%*
Rhode Island	*10,004*	*47%*	*4,702*	*1,279*	*768*	*312*	*2,359*	*24%*	*44%*

Source of Data for Table/Methodology

Rhode Island Head Start Programs, children enrolled as of October 2018 who were one year away from kindergarten enrollment. Children enrolled are listed by residence of child, not location of the Head Start program. Rhode Island Department of Education, children enrolled in State Pre-K as of October 2018.

The estimated number of low-income children age four in each school district is based on October 2018 kindergarten enrollment multiplied by the percentage of students who qualified for free or reduced-price lunch (at or below 185% of the federal poverty level).

The city/town table was redesigned in 2018 to include data on four-year-olds in either Head Start or State Pre-K. Data are tracked by school district community and use kindergarten enrollment as the denominator (estimated # of four-year-olds in the community served by the school district). Percentages should not be compared with prior Factbooks.

Charter Schools with kindergarten 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, RISE Prep Mayoral Academy, and South Side Elementary Charter School.

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

NA is not applicable.

References

[1] 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.

[2] Meloy, B., Gardner, M., & Darling-Hammond, L. (2019). *Untangling the evidence on preschool effectiveness: Insights for policymakers.* Washington, DC: Learning Policy Institute.

[3] *Early childhood program enrollment.* (2014). Washington, DC: Child Trends.

(continued on page 186)

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.

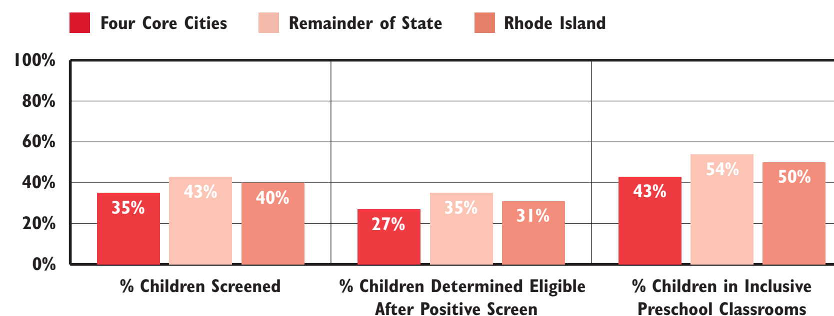
SIGNIFICANCE

Preschool special education is an important component of the early care and education system, providing specially-designed instruction so each child can meet learning standards. The federal *Individuals with Disabilities Education Act (IDEA)* specifies that children ages three to five with developmental delays and disabilities have the same right to a free and appropriate public education in the least restrictive environment as school-age children with disabilities.[1]

Developmental delays and disabilities 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 provided with high-quality educational opportunities, therapies, or interventions.[2,3] Routine developmental screening during the early stages of life, followed by evaluation and diagnostic assessment, helps children gain early access to needed services in order to prevent the occurrence of more severe problems.[4]

In Rhode Island, school districts work to screen every child age three through five every year through the Child Outreach screening program.[5] During the 2017-2018 school year in Rhode Island, districts completed developmental screenings for 40% of children ages three to five. Preschool-age children in the core cities are still less likely to receive a developmental screening (34%) than children in the remainder of the state (43%). Of those children who were referred based on positive screens, 32% were determined eligible for preschool special education. Children in the core cities were less likely to be determined eligible after referral (26%) than children in the remainder of the state (37%).[6]

Approximately 15% of U.S. children ages three to 17 have a developmental disability, with boys and children in low-income families more likely to have a disability than girls and children in higher-income families.[7] Under *IDEA*, each state sets its own criteria to determine eligibility for special education services, deciding where to draw the line along a continuum of functioning to identify children who are sufficiently delayed to need special education services.[8] In 2016, Rhode Island ranked in the top ten states for providing preschool special education services by serving 9.1% of children ages three to five compared with a U.S. average of 6.4%.[9]



Source: Rhode Island Department of Education, 2017-2018 Child Outreach Screening and Referral Rates and June 2018 Special Education Census. % children determined eligible is of those children referred from Child Outreach screening.

◆ **In June 2018, there were 3,121 children ages three to five receiving preschool special education services, 8% of all preschool-age children in Rhode Island. Children in the four core cities are slightly less likely to receive preschool special education services (8%) than children in the remainder of the state (9%).[10]**

◆ **Preschool children with disabilities who attend high-quality preschool with typically developing children and receive special education services in inclusive settings have improved outcomes.[11] In June 2018 in Rhode Island, 49% of preschool-age children received special education services within an inclusive early childhood classroom. Children in the four core cities were less likely to receive preschool special education services in an inclusive early childhood setting (42%) than children in the remainder of the state (53%).[12]**

◆ **About half of the children receiving preschool special education services in Rhode Island receive services outside of inclusive preschool programs, with 13% enrolled in a separate special education preschool class or school, 22% receiving services through "walk-in" visits to a service provider, 16% enrolled in a preschool setting but receiving special education services in another location, and less than 1% in a home or hospital.[13]**

◆ **In June 2018, 44% (1,374) of the 3,121 children receiving preschool special education services in Rhode Island qualified under the developmental delay category, 46% (1,432) had an identified speech/language disability, 7% (210) were diagnosed with autism, and 3% (105) had another diagnosed disability.[14]**

Children Receiving Preschool Special Education Services

Table 41. **Children Ages 3 to 5 Receiving Special Education Services, Rhode Island, 2018**

		DEVELOPMENTAL SCREENING RATES				PRESCHOOL SPECIAL EDUCATION BY SETTING				
SCHOOL DISTRICT	# OF CHILDREN AGES 3-5	% SCREENED 3 YEARS BEFORE K	% SCREENED 2 YEARS BEFORE K	% SCREENED 1 YEAR BEFORE K	% SCREENED AGES 3 TO 5	INCLUSIVE EARLY CHILDHOOD CLASS	% IN INCLUSIVE EARLY CHILDHOOD CLASS	OTHER SETTING	TOTAL # RECEIVING SERVICES	% RECEIVING SERVICES
Barrington	586	32%	71%	88%	66%	22	40%	33	55	9%
Bristol Warren	805	16%	47%	47%	37%	24	38%	40	64	8%
Burrillville	455	18%	46%	64%	42%	23	42%	32	55	12%
Central Falls	1,070	33%	58%	71%	54%	61	51%	59	120	11%
Chariho	641	23%	61%	55%	48%	32	51%	31	63	10%
Coventry	1,023	23%	52%	64%	46%	67	67%	33	100	10%
Cranston	2,697	13%	47%	57%	39%	86	44%	109	195	7%
Cumberland	1,236	10%	48%	59%	39%	45	54%	39	84	7%
East Greenwich	466	13%	58%	61%	42%	38	90%	*	42	9%
East Providence	1,494	10%	43%	61%	39%	34	28%	87	121	8%
Exeter-West Greenwich	363	34%	66%	73%	57%	14	47%	16	30	8%
Foster	111	25%	57%	65%	48%	*	50%	*	*	5%
Glocester	284	25%	57%	65%	48%	10	31%	22	32	11%
Jamestown	119	30%	75%	85%	66%	*	67%	*	12	10%
Johnston	850	16%	51%	78%	48%	55	67%	27	82	10%
Lincoln	708	13%	53%	61%	42%	56	72%	22	78	11%
Little Compton	58	19%	20%	71%	37%	*	67%	*	*	10%
Middletown	875	9%	27%	33%	24%	34	69%	15	49	6%
Narragansett	221	46%	85%	87%	71%	21	75%	*	28	13%
New Shoreham	30	100%	67%	100%	89%	0	0%	*	*	3%
Newport	1,104	18%	43%	49%	37%	40	73%	15	55	5%
North Kingstown	818	33%	67%	76%	59%	54	74%	19	73	9%
North Providence	1,037	20%	40%	62%	40%	39	46%	46	85	8%
North Smithfield	351	18%	55%	71%	49%	18	42%	25	43	12%
Pawtucket	2,989	10%	34%	56%	32%	127	49%	131	258	9%
Portsmouth	503	23%	60%	84%	57%	15	43%	20	35	7%
Providence	8,121	14%	41%	42%	32%	259	51%	251	510	6%
Scituate	286	25%	57%	65%	48%	*	27%	16	22	8%
Smithfield	458	39%	71%	76%	62%	25	49%	26	51	11%
South Kingstown	682	28%	76%	78%	62%	23	40%	35	58	9%
Tiverton	447	10%	32%	61%	36%	21	50%	21	42	9%
Warwick	2,670	9%	37%	55%	34%	110	53%	98	208	8%
West Warwick	1,086	17%	41%	61%	40%	68	52%	62	130	12%
Westerly	650	37%	71%	88%	64%	57	79%	15	72	11%
Woonsocket	1,958	9%	36%	61%	34%	26	11%	207	233	12%
Charter Schools	*NA*	*NA*	*NA*	*NA*	*NA*	*13*	*87%*	*	*15*	*NA*
RI School for the Deaf	*NA*	*NA*	*NA*	*NA*	*NA*	*0*	*0%*	*	*	*NA*
Four Core Cities	*14,138*	*14%*	*40%*	*49%*	*34%*	*473*	*42%*	*648*	*1,121*	*8%*
Remainder of State	*23,114*	*18%*	*50%*	*63%*	*43%*	*1,052*	*53%*	*925*	*1,977*	*9%*
Rhode Island	*37,252*	*16%*	*46%*	*58%*	*40%*	*1,538*	*49%*	*1,583*	*3,121*	*8%*

Sources of Data for Table/Methodology

Rhode Island Department of Education (RIDE), June 2018 Special Education Census.

2017-2018 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.

*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 2017-2018 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 Factbooks published before 2016.

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, a Head Start program, or a community-based child care program or preschool. Data include children who are district-placed and who are parentally-placed.

NA=Not applicable

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

References

[1,3,8,11] Hebbeler, K. & Spiker, D. (2016). Supporting young children with disabilities. *The Future of Children, 26*(2), 185-205.

[2] Centers for Disease Control and Prevention. (n.d.). *Developmental screening fact sheet.* Retrieved January 18, 2016, from www.cdc.gov

[4] 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.

(continued on page 187)

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, 2018, there were 143,247 students enrolled in Rhode Island public schools in preschool through grade 12, a decrease of 1% from 145,342 on October 1, 2008.[2]

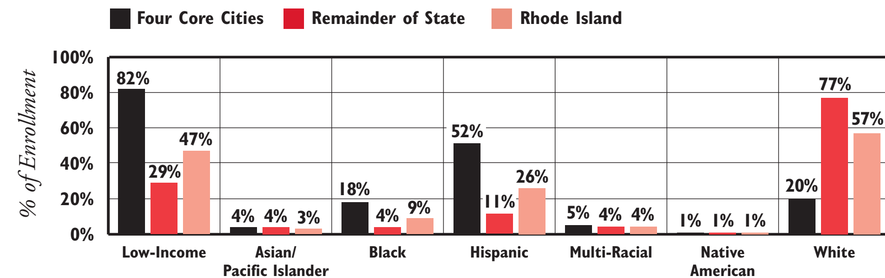
Of these 143,247 Rhode Island public school students, 29% (41,461) were attending schools in the four core cities (communities with the highest child poverty rates), 64% (91,441) were attending schools in the remaining districts, and the remaining 7% (10,345) attended charter schools, state-operated schools, or the Urban Collaborative Accelerated Project (UCAP). There were an additional 16,153 Rhode Island students attending private and parochial schools (including out-of-state schools) and 1,648 students were home-schooled.[3]

In October 2018, there were 62,499 students in grades K-5; 33,057 in grades 6-8; and 44,975 in grades 9-12. There were 2,716 children enrolled in preschool classrooms in Rhode Island public schools.[4] During the 2018-2019 school year, 1,080 children received services from State Pre-K programs in 18 public school classrooms and 42 community-based center classrooms.[5]

In October 2018, 57% of Rhode Island public school students were non-Hispanic White, 26% were Hispanic, 9% were Black, 3% were Asian/Pacific Islander, 4% were Multi-Racial, and 1% were Native American. In October 2018, 47% of public school students in Rhode Island were low-income (students who were eligible for the free or reduced-price lunch program).[6]

Rhode Island schools are also diverse in terms of students with disabilities and students who are English Language Learners. During the 2018-2019 school year, 15% of Rhode Island public school students were receiving special education services and 9% were English Language Learners (ELLs).[7]

Rhode Island Public School Enrollment by Low-Income Status, Race and Ethnicity, October 1, 2018



Source: Rhode Island Department of Education, October 1, 2018.

◆ **In October 2018, 20% of students enrolled in the four core cities were White, compared with 77% in the remainder of the state, and 82% of students enrolled in the four core cities were low-income compared with 29% in the remainder of the state.[8]**

The Condition of Public School Buildings

◆ **The condition of school facilities impacts the learning and behavior of students and teachers and is also an important indicator of equity.[9] A year-long assessment commissioned by RIDE found that only 12.4% of school buildings were judged to be in good to average condition and forecasted $627.6 million in high-priority construction and repairs needed to address building safety and code compliance issues. The statewide cost to bring all school buildings into ideal condition was estimated at $2.2 billion.[10]**

◆ **The average age of school buildings in the United States is 42 years old. In Rhode Island, the average age of school buildings is 56 years old. After 30 years, a school facility's systems are past their useful life. The cost for renewing schools in Rhode Island over the next five years is estimated to be $793.5 million.[11]**

◆ **In Rhode Island, elementary schools have the majority of building deficiencies. The estimated cost to address all deficiencies is nearly $880 million for elementary schools and nearly $760 million for high schools.[12]**

◆ **On November 6, 2018, Rhode Island voters approved a $250 million state bond for school renovation and new construction over the next five years.[13,14]**

Public School Enrollment and Demographics

Table 42. **Rhode Island Public School Enrollment by Grade and Demographic Groups, October 1, 2018**

	ENROLLMENT BY GRADE LEVEL*				ENROLLMENT BY DEMOGRAPHIC GROUPS							
SCHOOL DISTRICT	% PRE-SCHOOL	ELEMEN-TARY	MIDDLE	HIGH	% LOW-INCOME	% ASIAN PACIFIC ISLANDER	% BLACK	% HISPANIC**	% NATIVE AMERICAN	% MULTI-RACIAL	% WHITE	TOTAL ENROLL-MENT
Barrington	24	1,368	836	1,115	4%	7%	1%	3%	<1%	4%	84%	3,343
Bristol Warren	43	1,449	775	965	30%	2%	2%	6%	<1%	5%	86%	3,232
Burrillville	42	925	527	783	30%	1%	1%	4%	<1%	3%	91%	2,277
Central Falls	161	1,244	563	727	91%	1%	15%	60%	6%	3%	15%	2,695
Chariho	102	1,270	698	1,148	20%	1%	1%	3%	2%	3%	91%	3,218
Coventry	137	1,960	1,135	1,491	31%	2%	2%	4%	<1%	1%	90%	4,723
Cranston	86	4,472	2,470	3,451	43%	9%	5%	28%	1%	5%	52%	10,479
Cumberland	87	2,012	1,096	1,480	19%	4%	3%	11%	<1%	3%	79%	4,675
East Greenwich	61	1,061	645	768	5%	6%	<1%	7%	<1%	4%	82%	2,535
East Providence	75	2,320	1,216	1,525	48%	2%	11%	9%	1%	9%	67%	5,136
Exeter-West Greenwich	64	709	366	502	16%	2%	2%	5%	<1%	1%	91%	1,641
Foster	29	243	0	0	24%	0%	0%	4%	0%	1%	95%	272
Foster-Glocester	0	0	502	804	15%	1%	1%	2%	<1%	2%	94%	1,306
Glocester	3	520	0	0	12%	<1%	2%	2%	<1%	2%	94%	523
Jamestown	22	308	174	3	8%	2%	1%	<1%	0%	2%	95%	507
Johnston	106	1,444	799	916	45%	3%	5%	22%	<1%	1%	69%	3,265
Lincoln	94	1,359	748	928	27%	3%	4%	7%	<1%	2%	83%	3,129
Little Compton	23	139	82	0	12%	<1%	0%	1%	0%	5%	94%	244
Middletown	18	984	521	630	30%	4%	6%	12%	<1%	8%	69%	2,153
Narragansett	73	451	307	459	21%	2%	1%	3%	1%	4%	89%	1,290
New Shoreham	0	60	21	52	16%	2%	2%	17%	0%	2%	79%	133
Newport	53	990	453	660	66%	2%	12%	30%	2%	13%	40%	2,156
North Kingstown	113	1,499	921	1,474	22%	2%	2%	7%	<1%	4%	86%	4,007
North Providence	81	1,470	886	1,128	38%	3%	12%	22%	<1%	5%	58%	3,565
North Smithfield	39	713	403	522	16%	2%	1%	9%	0%	4%	84%	1,677
Pawtucket	171	4,244	2,331	2,026	76%	1%	29%	26%	1%	7%	37%	8,772
Portsmouth	20	932	552	935	14%	2%	2%	5%	<1%	3%	88%	2,439
Providence	341	10,724	5,444	7,435	84%	4%	16%	66%	1%	4%	9%	23,944
Scituate	16	509	323	383	18%	1%	<1%	3%	0%	1%	94%	1,231
Smithfield	49	1,023	621	720	14%	2%	1%	7%	<1%	3%	87%	2,413
South Kingstown	50	1,249	728	951	17%	2%	2%	5%	3%	5%	83%	2,978
Tiverton	32	784	426	535	24%	2%	2%	2%	<1%	3%	91%	1,777
Warwick	232	3,881	1,972	2,715	29%	4%	3%	11%	<1%	4%	78%	8,800
West Warwick	67	1,682	828	1,002	50%	3%	5%	15%	1%	3%	73%	3,579
Westerly	109	1,138	639	852	36%	3%	1%	8%	2%	7%	80%	2,738
Woonsocket	58	2,891	1,422	1,679	79%	5%	11%	34%	1%	6%	43%	6,050
Charter Schools	*24*	*4,447*	*1,490*	*2,466*	*68%*	*2%*	*16%*	*55%*	*1%*	*4%*	*23%*	*8,427*
State-Operated Schools	*11*	*25*	*13*	*1,734*	*63%*	*1%*	*15%*	*45%*	*<1%*	*5%*	*34%*	*1,783*
UCAP	*0*	*0*	*124*	*11*	*80%*	*2%*	*16%*	*66%*	*2%*	*1%*	*13%*	*135*
Four Core Cities	*731*	*19,103*	*9,760*	*11,867*	*82%*	*4%*	*18%*	*52%*	*1%*	*5%*	*20%*	*41,461*
Remainder of State	*1,950*	*38,924*	*21,670*	*28,897*	*29%*	*4%*	*4%*	*11%*	*1%*	*4%*	*77%*	*91,441*
Rhode Island	*2,716*	*62,499*	*33,057*	*44,975*	*47%*	*3%*	*9%*	*26%*	*1%*	*4%*	*57%*	*143,247*

Source of Data for Table/Methodology

Rhode Island Department of Education, Public School Enrollment in preschool through grade 12 as of October 1, 2018.

*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 served 1,080 children in 18 public school classrooms and 42 community-based center classrooms in 2018-2019. Elementary includes students in kindergarten through 5th grade, middle includes 6th through 8th grades, and high includes 9th through 12th grades.

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, Charette High School, 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 from Little Compton attend high school in Portsmouth. Jamestown students can choose to attend high school in Narragansett or North Kingstown.

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 187)

Children Enrolled in Kindergarten

DEFINITION

Children enrolled in kindergarten compiles selected data about children enrolled in public kindergarten in Rhode Island.

SIGNIFICANCE

As of 2016-2017, every public school district in Rhode Island is required to offer full-day kindergarten.[1] Children benefit academically from participating in full-day kindergarten.[2]

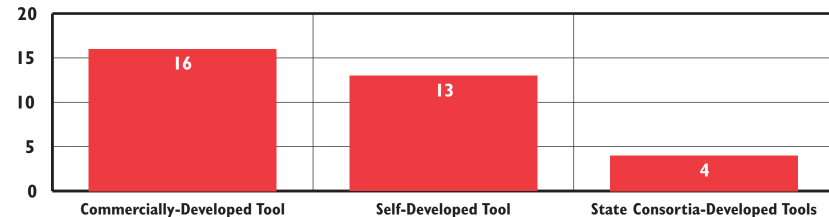
The transition to kindergarten is an important point in a child's educational experience, marking either the start of their formal education or the transition between preschool, which is not universally available or guaranteed as part of most states' public education systems, to the early elementary grades. During kindergarten and the early elementary grades, families establish patterns of engagement with their child's school and children learn important social-emotional, literacy, and math skills that establish a foundation for future learning.[3,4]

As of October 2017, approximately 68% of four-year-olds and 40% of three-year-olds in the U.S. participated in private or public preschool before kindergarten.[5] Children from higher-income families are more likely to be enrolled in preschool than children from lower-income families. There is strong evidence that high-quality preschool immediately improves children's language, literacy, and math skills. Preschool participation is also associated with longer-term positive outcomes such as reduced grade retention and need for special education, improved high school graduation rates, and reduced criminal activity.[6]

High-quality and developmentally-appropriate instruction in kindergarten and the early elementary grades helps sustain the positive impacts of preschool and addresses knowledge and skill deficits among children who have not had high-quality early learning opportunities.[7]

Kindergarten and early elementary grade teachers need specialized training in child development, reading instruction, the foundations of math, social-emotional skill building, how to incorporate play and hands-on learning into classroom instruction, and working with diverse groups of children and families. Strategies that support high-quality early grade instruction include requiring pre-K-Grade 3 teaching certificates, incorporating early childhood education training into elementary principal certification, and aligning quality improvement efforts from early childhood through third grade.[8]

States Using Kindergarten Entry Assessments by Type of Tool, January 2017



Source: Weisenfeld, G. G. (2017). *Assessment tools used in Kindergarten Entry Assessments (KEAs): State scan.* New Brunswick, NJ: Center on Enhancing Early Learning Outcomes.

◆ **Kindergarten entry assessments are an organized way to learn what children know and are able to do across all domains of development when they enter kindergarten. The information is used to improve the transition to kindergarten, guide instruction for individual children, and inform policymakers about early learning needs. These assessments should not be used for high-stakes decisions, such as delaying children's entry into kindergarten.[9,10]**

◆ **As of January 2017, 33 states were using an assessment tool to track skills and knowledge at kindergarten entry. Rhode Island has not yet implemented a statewide tool.[11]**

◆ **Kindergarten teachers can share information about children's strengths and challenges gathered through kindergarten entry assessments to engage parents as partners in the education process.[12]**

Public School Kindergarten Enrollment

◆ **On October 1, 2018, 100% of the 10,004 children enrolled in public kindergarten in Rhode Island were in full-day kindergarten classrooms. There were 9,205 kindergarteners in traditional public schools, 794 in public charter schools, and five in a state-operated school (The Rhode Island School for the Deaf).[13]**

Young English Learners

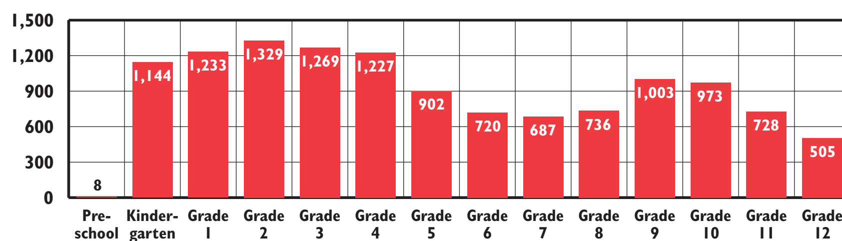
◆ Language learning is most effective and efficient during the early childhood years, between birth and age eight. Infants and young children learn new languages faster and with more competence than older children and adults.[14]

◆ Being bilingual has several advantages, including expanded economic and social opportunities and higher level executive function skills (cognitive flexibility and inhibitory control) that contribute to academic success. Being bilingual also may help delay or prevent the onset of cognitive problems associated with aging.[15]

◆ Both bilingual education and English immersion programs can effectively promote English language acquisition and proficiency. Bilingual education has the added advantage of supporting the development of a child's native language, encouraging fluency in both languages.[16]

◆ In Rhode Island, students in kindergarten through third grades are more likely to be identified as an English Language Learner than older students. In 2017-2018, 12% of all children in grades K-3 in Rhode Island (4,975) were English Learners compared to 9% of students in grades 4-6, 7% in grades 7-9, and 7% in grades 10-12. Less than 1% of the 1,664 children enrolled in public school preschool classrooms were identified as an English Learner. Of the 1,144 kindergarteners who were English Learners, 45% were enrolled in the Providence Public Schools, 17% were in one of the other three core city public school districts, and 15% were in a public charter school.[17]

English Learners by Grade Level, Rhode Island, 2016-2017 School Year



Source: Rhode Island Department of Education, 2017-2018.

References

[1] Rhode Island General Law 16-99-3. Enacted by the General Assembly as Article 6 of H-5900Aaa in 2015.

(continued on page 187)

Kindergartners and School Suspensions

◆ Children who are suspended early in their school years are more likely to be suspended again in future years. Students who are suspended are almost ten times more likely to experience academic failure, have negative attitudes toward school, drop out of high school, and become incarcerated.[18]

◆ Early suspensions are more likely when teachers believe the resources and supports available to them are inadequate to meet the needs of children with challenging behaviors. Large class sizes, inadequate child-teacher ratios, and lack of school resources to help teachers manage challenging behaviors are associated with increased suspensions. Early childhood mental health consultation is an intervention that works with teachers and families to reduce children's challenging behaviors, improve child-adult relationships, and prevent early suspensions.[19]

School Suspensions in Kindergarten, Rhode Island, 2017-2018

DISTRICT	NUMBER OF KINDERGARTNERS SUSPENDED	NUMBER OF SUSPENSIONS FOR KINDERGARTNERS	NUMBER OF DAYS KINDERGARTNERS WERE SUSPENDED
Central Falls	0	0	0
Pawtucket	0	0	0
Providence	37	80	125
Woonsocket	22	34	41
Charter Schools	*20*	*49*	*66*
Remainder of State	*59*	*121*	*139*
Rhode Island	*138*	*284*	*371*

Source: Rhode Island Department of Education, 2017-2018

◆ In 2017-2018 in Rhode Island, there were 138 kindergartners who were suspended at least one day, 49% of whom had a developmental delay or disability. Kindergartners experienced 284 disciplinary actions, with 249 out-of-school suspensions and 35 in-school suspensions. These students were suspended for a total of 371 days.[20]

◆ Compared to the 2016-2017 school year, the number of kindergartners who were suspended increased by 59%, and the number of suspensions increased by 68% in 2017-2018. The number of days kindergartners were suspended increased by 47% in the 2017-2018 school year.[21,22]

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 improve the supervision and safety of youth, promote positive social skills, and, with sufficient dosage, improve student achievement. Quality out-of-school time programs provide engaging activities that are intentionally designed to promote youth development and are taught by trained, dedicated instructors who work effectively with youth. Youth who participate consistently can show improved competence, caring, and connections.[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 Afterschool Network (a United Way of Rhode Island program) 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 2013 and 2017, 76% 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, 14% are in a child care center or in home-based child care, and 14% regularly stay at home by themselves.[7]

Students Served by 21st Century Community Learning Centers by Grade Span, Rhode Island, 2017-2018 School Year

SCHOOL DISTRICT	GRADES PK-3	GRADES 4-5	GRADES 6-8	GRADES 9-12	TOTAL
Central Falls	252	216	141	205	814
Cranston	72	47	73	0	192
East Providence	109	52	0	0	161
Newport	508	289	383	387	1,567
Pawtucket	515	305	12	0	832
Providence	368	224	1,178	2,375	4,145
Woonsocket	260	219	297	763	1,539
Charter, State-Operated and Other Schools	*205*	*141*	*600*	*257*	*1,203*
Rhode Island	*2,289*	*1,493*	*2,684*	*3,987*	*10,453*

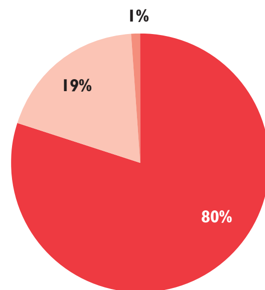
Source: RI Department of Education, Office of Student, Community and Academic Supports, 2017-2018 school year. Data are not unduplicated as students can be served by more than one grantee.

Summer Learning Loss

◆ **Low-income elementary school students lose reading and math skills over the summer while their higher-income peers make slight gains. Over time, this summer learning loss widens the achievement gaps that were already present between low-income and higher-income students at kindergarten entry so that low-income students fall further behind.[8,9]**

◆ **During the summer of 2017, 2,694 Rhode Island children entering grades Pre-K through 12 participated in 21st Century Community Learning Center programs; 855 (32%) entering grades PK-3, 616 (23%) entering grades 4-5, 625 (23%) entering grades 6-8, and 598 (22%) entering grades 9-12.[10] In addition, 1,131 Rhode Island children in kindergarten through grade 12 participated in Hasbro Summer Learning programs funded by United Way of Rhode Island.[11]**

School-Age Child Care Subsidies by Type of Setting, Rhode Island, 2018



n=4,270

Source: Rhode Island Department of Human Services, December 2018.

◆ **In January 2019 in Rhode Island, there were 12,298 school-age child care slots in 198 licensed early childhood or school-age centers. Seventy-two percent of the slots were in an independently licensed program serving only school-age children and 28% were in a licensed early childhood center.[12]**

◆ **In January 2019 in Rhode Island, there were 79 independent school-age child care programs participating in BrightStars, Rhode Island's Quality Rating and Improvement System (75% of licensed independent school-age child care programs). Ten programs (10% of all licensed programs) had a high-quality rating of four or five stars.[13]**

Table 43. **Licensed School-Age Child Care for Children Ages Six to 12 Rhode Island, January 2019**

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	5	346
Bristol	1,421	0	3	150
Burrillville	1,456	0	2	175
Central Falls	2,045	2	0	191
Charlestown	616	0	1	60
Coventry	3,142	4	1	172
Cranston	6,331	10	6	794
Cumberland	2,976	0	10	829
East Greenwich	1,482	3	1	141
East Providence	3,395	5	8	1,003
Exeter	480	0	1	100
Foster	369	1	0	26
Glocester	809	1	0	38
Hopkinton	741	0	1	52
Jamestown	429	0	1	50
Johnston	2,119	8	1	260
Lincoln	1,900	1	6	565
Little Compton	299	0	1	26
Middletown	1,442	0	3	132
Narragansett	856	0	2	97
New Shoreham	73	0	0	0
Newport	1,399	2	2	285
North Kingstown	2,581	4	2	209
North Providence	2,073	2	2	221
North Smithfield	1,002	1	2	188
Pawtucket	6,015	6	5	896
Portsmouth	1,622	1	2	159
Providence	15,342	16	14	2,743
Richmond	777	0	2	88
Scituate	935	1	0	26
Smithfield	1,445	4	2	211
South Kingstown	2,199	1	1	119
Tiverton	1,201	1	1	111
Warren	770	1	1	99
Warwick	6,195	7	6	725
West Greenwich	624	1	0	15
West Warwick	2,155	2	3	293
Westerly	1,850	3	0	151
Woonsocket	3,653	2	7	552
Four Core Cities	*27,055*	*26*	*26*	*4,382*
Remainder of State	*59,202*	*67*	*79*	*7,916*
Rhode Island	*86,257*	*93*	*105*	*12,298*

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 child care center slots and programs for children over age five, from RI Early Care and Education Data System (ECEDS), January 2019. These numbers do not include licensed family child care home slots 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] McCombs, J., Whitaker, A., & Yoo, P. (2017). *The value of out-of-school time programs.* Santa Monica, CA: RAND Corporation.

[3] Smith, E. P., Witherspoon, D. P., & Osgood, D. W. (2017). Positive youth development among diverse racial-ethnic children: Quality afterschool contexts as developmental assets. *Child Development, 88*(4), 1063-1078.

[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, 2013-2017. 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.

(continued on page 187)

English Learners

DEFINITION

English learners is the percentage of all public school children (preschool through grade 12) who are receiving English Learner services in Rhode Island public schools.

SIGNIFICANCE

The population of English Learner (EL) students in the U.S. has been growing over the last two decades. English Learners must acquire English language proficiency while also learning academic content at the appropriate level.[1,2] Nationally, and in Rhode Island, there are large achievement gaps between EL and non-EL students, with EL students having lower rates of math and reading achievement than non-EL students.[3,4]

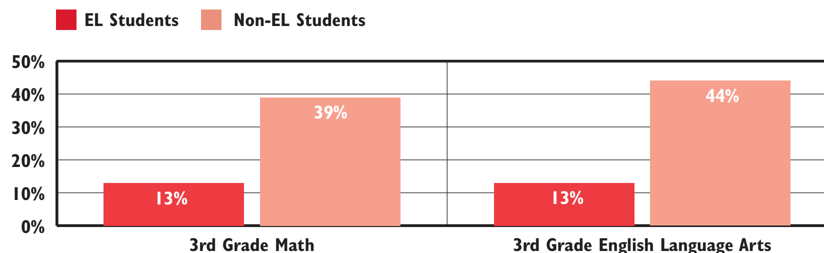
Children in immigrant families and the children of parents with limited English proficiency are much more likely to live in low-income households.[5] EL students are more likely to attend high-poverty schools that have low-test scores, have larger proportions of EL students, and are more racially and geographically isolated.[6,7] They may also experience discrimination, stigma, and stress related to different cultural expectations and English language proficiency status.[8,9] Students in families with limited English proficiency also have a harder time accessing health care, mental health care, and other social services.[10]

In the 2017-2018 school year in Rhode Island, EL students were 9% (12,464) of total students, and 34% of all EL students in Rhode Island were in grades preschool to grade three. Of all EL students, 84% were enrolled in free or reduced-price lunch programs, and 72% lived in the four core cities.[11,12] In the 2017-2018 school year, EL students in Rhode Island public schools spoke 94 different languages. The majority (79%) spoke Spanish, 5% spoke a creole language, 2% spoke Portuguese, 2% spoke Arabic, 2% spoke Chinese, and 10% spoke other or multiple languages.[13]

Bilingual education in the early grades can significantly improve English reading proficiency and bilingualism can support long-term academic and economic outcomes.[14,15] During the 2017-2018 school year, bilingual and two-way/dual language programs were offered in the Bristol Warren, Central Falls, Newport, Pawtucket, and Providence school districts, and at the International Charter School.[16] Younger EL students benefit from high-quality early learning opportunities.[17]

Successful EL programs have highly qualified and culturally competent teachers.[18] Schools that foster relationships with students, parents, and the community and offer dynamic, personalized instruction guided by ongoing assessments by effective teachers can help EL students succeed.[19,20]

Current English Learners Meeting Expectations in Math and English Language Arts, Rhode Island, 2018



Source: Rhode Island Department of Education, *Rhode Island Comprehensive Assessment System (RICAS)*, October 2018.

◆ **In 2018, 13% of third-grade EL students met or exceeded expectations in the *Rhode Island Common Assessment System (RICAS)* math assessment, compared to 39% of non-EL students.[21]**

◆ **In 2018, 13% of third-grade EL students met or exceeded expectations on the *Rhode Island Common Assessment System (RICAS)* English language arts assessment, compared to 44% of non-EL students.[22]**

Funding to Support English Learners

◆ **In 2016, the Rhode Island General Assembly established a pilot categorical program to provide additional support for the costs associated with educating English Learners.[23] In 2017, the Rhode Island General Assembly made this categorical fund permanent. This fund is designed to support high-quality, research-based services.[24]**

Early English Language Learning

◆ **As of September 1, 2018, there were 5,908 (12%) Rhode Island children under age five who were born to a mother who did not speak English.[25] 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 EL students.[26]**

Table 44.

English Learner Students, Rhode Island, 2017-2018

SCHOOL DISTRICT	TOTAL # OF STUDENTS	NUMBER OF ENGLISH LEARNER STUDENTS: ELEMENTARY (GRADES PRE-K-5)	MIDDLE (GRADES 6-8)	HIGH (GRADES 9-12)	TOTAL # OF EL STUDENTS	% OF TOTAL DISTRICT
Barrington	3,359	59	13	*	80	2%
Bristol Warren	3,195	67	*	*	81	3%
Burrillville	2,250	*	*	*	*	<1%
Central Falls	2,705	454	170	271	895	33%
Chariho	3,159	*	*	*	13	<1%
Coventry	4,686	15	*	10	27	1%
Cranston	10,362	394	99	115	608	6%
Cumberland	4,613	95	17	24	136	3%
East Greenwich	2,462	76	0	*	79	3%
East Providence	5,255	125	30	46	201	4%
Exeter-West Greenwich	1,634	*	*	*	14	1%
Foster	277	0	NA	NA	0	0%
Foster-Glocester	1,255	NA	0	0	0	0%
Glocester	535	0	NA	NA	0	0%
Jamestown	483	0	0	NA	0	0%
Johnston	3,251	125	25	36	186	6%
Lincoln	3,064	27	*	*	35	1%
Little Compton	243	0	*	NA	*	<1%
Middletown	2,169	47	17	19	83	4%
Narragansett	1,296	*	*	0	*	1%
New Shoreham	119	*	*	10	18	1%
Newport	2,194	141	42	51	234	11%
North Kingstown	3,891	51	17	*	74	2%
North Providence	3,587	69	14	13	96	3%
North Smithfield	1,705	*	*	*	17	1%
Pawtucket	8,814	688	229	281	1,198	14%
Portsmouth	2,407	12	*	*	20	1%
Providence	24,201	3,307	1,173	1,871	6,351	26%
Scituate	1,275	0	0	0	0	0%
Smithfield	2,380	10	*	*	13	1%
South Kingstown	3,042	47	*	*	59	2%
Tiverton	1,820	*	0	*	10	1%
Warwick	8,879	83	17	24	124	1%
West Warwick	3,562	56	*	14	76	3%
Westerly	2,740	36	*	12	54	2%
Woonsocket	5,956	312	128	113	553	9%
Charter Schools	*7,776*	*825*	*89*	*188*	*887*	*14%*
State-Operated Schools	*1,733*	*	*	*53*	*59*	*3%*
UCAP	*134*	*NA*	*8*	*2*	*10*	*7%*
Four Core Cities	*41,676*	*4,761*	*1,700*	*2,536*	*8,997*	*22%*
Remainder of State	*91,149*	*1,580*	*345*	*430*	*2,355*	*3%*
Rhode Island	*142,469*	*7,171*	*2,143*	*3,209*	*12,523*	*9%*

Sources of Data for Table/Methodology

Rhode Island Department Education, 2017-2018 school year. Total number of English Learner students is the number of students in each district who were actively enrolled in English Learner programs in the 2017-2018 school year. Students who are not yet fully English proficient but have exited ESL or bilingual education programs to regular education are not included in these numbers.

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

NA indicates that the school district does not serve students at that grade level.

Due to a change in methodology, the percentage of English 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 Learners divided by the "Total # of Students," which is the average daily membership in the districts of instruction.

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, Rhode Island Nurses Institute Middle College Charter School, RISE Prep Mayoral Academy, 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.

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

References

[1] McFarland, J., et al. (2018). *The condition of education 2018 (NCES 2018-144).* Washington, DC: National Center for Education Statistics, U.S. Department of Education. Retrieved February 6, 2019, from https://nces.ed.gov/programs/coe/ indicator_cgf.asp

(continued on page 187)

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 U.S. children ages three to 17 have a developmental delay or disability. Boys and children in low-income families are more likely to have a delay or disability than girls or children in higher-income families.[2]

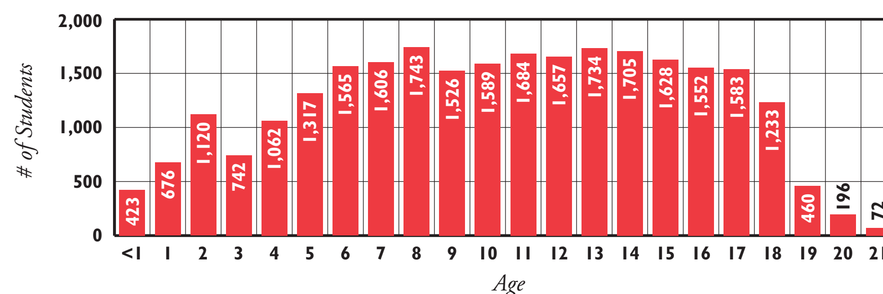
The federal *Individuals with Disabilities Education Act (IDEA)* guarantees a free appropriate public education to every child with a disability. Prior to passage of the original 1975 federal law, many children with disabilities were excluded from public school. Since passage, outcomes for children with 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] Concerns remain that not all children who could benefit from services are identified, that children of color are less likely to receive special education services than their white peers, and special education funding is not adequate.[4]

Although much progress has been made in improving high school graduation rates and post-secondary school enrollment, students with disabilities are still less likely to graduate from high school and more likely to be suspended than students without disabilities.[5,6]

The federal *Every Student Succeeds Act (ESSA)* requires states to continue annually reporting the performance of students with disabilities on standardized assessments to inform accountability and action plans.[7]

In 2018 in Rhode Island, 9% of third-grade students receiving special education services met expectations in the English Language Arts (ELA) and math sections of the *Rhode Island Comprehensive Assessment System (RICAS)*, compared with 46% in ELA and 40% in math of third graders without special education needs.[8]

In Rhode Island, the four-year graduation rate for the class of 2018 was 62% for students receiving special education services, compared to 88% for students not receiving these services. Some students enrolled in special education students may take additional time to graduate.[9]



Source: Rhode Island Executive Office of Health and Human Services, Center for Child and Family Health, Early Intervention enrollment, June 30, 2018. Rhode Island Department of Education, Office of Diverse Learners, Special Education Census, June 30, 2018. Includes parentally-placed students.

◆ **As of June 2018, there were 21,488 students ages six to 21 (15% of all kindergarten through grade 12 students) receiving special education services through Rhode Island public schools. Thirty-six percent of these students had a learning disability, 18% had a health impairment, 12% had a speech/language disorder, 11% had an autism spectrum disorder, 8% had an emotional disturbance, 7% had a developmental delay, 4% had an intellectual disability, and 3% had other disabilities.[10]**

◆ **As of June 2018, 70% of students ages six to 21 receiving special education services in Rhode Island were in their regular classroom for 80% of the day or more, 24% were in their regular classroom for less than 80% of the day, 4% were in a separate school, and 1% were in a residential facility, a correctional facility, were home-bound, or were hospitalized.[11] Since 2000, the percentage of students ages six to 21 receiving special education services in the U.S. who spent most of the day (80% or more of time) in general education classrooms has increased 34%.[12]**

◆ **Of Rhode Island students receiving special education services in 2017-2018, 67% were boys and 33% were girls; 53% were low-income (receiving free or reduced-price lunch) and 47% were not low-income; 56% were White, 27% were Hispanic, 9% were Black, 4% were Two or more races, 2% were Asian/Pacific Islander, and 1% were Native American, and 9% were English Learners.[13]**

K-12 Students Receiving Special Education Services

Table 45.

Students Ages 6 through 21 Receiving Special Education Services by Primary Disability, Rhode Island, 2018

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	3,359	65	15	36	75	101	14	68	19	393	12%
Bristol Warren	3,195	59	14	13	47	137	17	100	*	395	12%
Burrillville	2,250	44	17	19	46	137	13	38	*	322	14%
Central Falls	2,705	34	65	32	83	238	27	54	19	552	20%
Chariho	3,159	57	29	*	79	134	14	36	11	367	12%
Coventry	4,686	78	43	64	117	252	30	77	20	681	15%
Cranston	10,362	194	73	121	385	522	50	89	37	1,471	14%
Cumberland	4,613	97	46	49	81	188	32	107	25	625	14%
East Greenwich	2,462	53	28	19	60	70	15	27	*	279	11%
East Providence	5,255	98	74	82	155	300	40	79	26	854	16%
Exeter-West Greenwich	1,634	37	11	*	38	42	*	37	*	186	11%
Foster	277	*	*	*	*	*	0	23	*	38	14%
Foster-Glocester	1,255	22	0	*	25	38	14	*	*	117	9%
Glocester	535	*	*	*	*	12	*	28	*	52	10%
Jamestown	483	13	*	*	20	27	*	12	*	86	18%
Johnston	3,251	55	43	29	120	221	16	42	21	547	17%
Lincoln	3,064	53	39	36	89	172	10	61	15	475	16%
Little Compton	243	*	0	*	10	12	*	*	*	33	14%
Middletown	2,169	38	24	37	74	121	21	46	10	371	17%
Narragansett	1,296	17	15	16	39	94	*	29	13	227	18%
New Shoreham	119	*	*	0	10	*	0	*	0	22	18%
Newport	2,194	40	25	45	44	178	21	36	13	402	18%
North Kingstown	3,933	67	23	45	68	151	16	91	19	480	12%
North Providence	3,587	64	44	48	96	246	27	82	17	624	17%
North Smithfield	1,705	23	15	16	36	85	11	33	*	225	13%
Pawtucket	8,814	121	100	89	200	572	54	172	24	1,332	15%
Portsmouth	2,407	37	14	22	81	77	*	40	12	289	12%
Providence	24,201	242	291	300	537	1,484	176	528	107	3,665	15%
Scituate	1,275	19	*	*	22	61	*	32	*	150	12%
Smithfield	2,380	54	13	16	41	144	11	25	*	312	13%
South Kingstown	3,042	62	*	24	80	95	14	54	18	356	12%
Tiverton	1,820	45	16	26	45	86	11	26	*	263	14%
Warwick	8,879	213	133	118	285	443	55	106	44	1,397	16%
West Warwick	3,562	91	53	99	116	227	31	55	10	682	19%
Westerly	2,740	46	27	32	92	116	17	43	26	399	15%
Woonsocket	5,956	168	111	148	328	415	79	219	33	1,501	25%
Charter Schools	*7,777*	*80*	*58*	*54*	*177*	*450*	*23*	*167*	*11*	*1,020*	*13%*
State-Operated Schools	*1,733*	*14*	*0*	*28*	*48*	*86*	*	*	*63*	*243*	*14%*
UCAP	*134*	*0*	*0*	*0*	*	*16*	*0*	*0*	*0*	*18*	*13%*
Department of Corrections	*NA*	*0*	*0*	*19*	*15*	*	*0*	*0*	*0*	*37*	*NA*
Four Core Cities	*41,676*	*565*	*567*	*569*	*1,148*	*2,709*	*336*	*973*	*183*	*7,050*	*17%*
Remainder of State	*91,191*	*1,750*	*854*	*1,048*	*2,482*	*4,499*	*529*	*1,537*	*421*	*13,120*	*14%*
Rhode Island	*142,511*	*2,409*	*1,479*	*1,718*	*3,872*	*7,763*	*889*	*2,680*	*678*	*21,488*	*15%*

Source of Data for Table/Methodology

Rhode Island Department of Education (RIDE), Office for Diverse Learners, Special Education Census June 30, 2018. 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 2017-2018 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/or have traumatic brain injury.

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

Charter schools include Achievement First Providence Mayoral Academy, 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, The Hope Academy, Kingston Hill Academy, The Learning Community, Rhode Island Nurses Institute Middle College Charter School, RISE Prep Mayoral Academy, Segue Institute for Learning, Sheila "Skip" Nowell Leadership Academy, Southside Elementary Charter School, Trinity Academy for the Performing Arts, and Village Green Virtual Charter School.

State-operated schools 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 187)

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, behavior difficulties, lower levels of school engagement, and increased risk of dropping out of high school. Changing schools can disrupt learning, can negatively impact a student's achievement, and can cause social upheaval for children. Student mobility also can lead to less active parent involvement in their children's schools.[1,2]

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.[3,4]

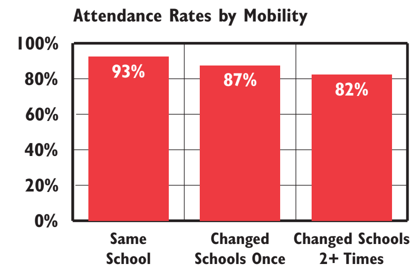
Regardless of income status and ethnicity, mobility can negatively affect student achievement. However, low-income and children of color are more likely to be mobile and experience greater negative impacts on their academic achievement, than higher-income and White students. Students receiving special education services also are likely to be negatively impacted by changing schools.[5,6]

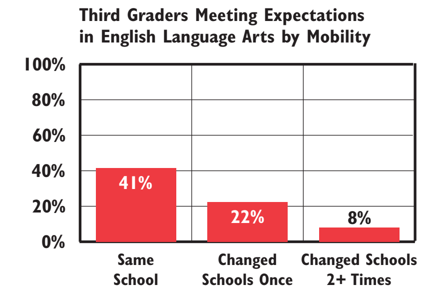
High mobility rates in schools can negatively impact all students because teachers must slow curriculum progress, repeat lessons, and adjust to changing classroom dynamics and student needs. Within-year moves are particularly disruptive for students, teachers and schools.[7,8]

Families may move their children to a different school because they are dissatisfied with the school, concerned about their child's safety, or because they are moving due to changes in family circumstances.[9] Changes in family circumstances can be either positive or negative factors, including eviction or foreclosure, divorce or marriage, job loss or job changes, death in the family, or a desire to improve quality of life. Mobile students in low-income and Black families are more likely to change schools due to family reasons than mobile students in higher-income and White families.[10,11]

Between 2013 and 2017 in Rhode Island, 11% of children ages five to 17 changed residence at least once during the previous year, 79% of whom moved within Rhode Island and 21% 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 2013 and 2017, 23% of Rhode Islanders living below the poverty line moved, compared with 10% of higher-income residents.[13]

School Mobility and Education Outcomes in Rhode Island, 2017-2018





Source: Rhode Island Department of Education, 2017-2018 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 93% attendance rate, compared with 87% for those who changed schools once and 82% for those who changed schools two or more times during the 2017-2018 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 2017-2018 school year in Rhode Island, 41% of third-grade children who did not experience mobility met expectations in reading/writing on the *Rhode Island Comprehensive Assessment System (RICAS)* state assessment, compared with 22% of students who moved once and 8% 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 other districts where students most frequently transfer to and from and align their curricula, programs, and policies to reduce learning disruption.[16]**

◆ **One-third of children in foster care will experience five or more school changes before they turn age 18, and such changes often result in lost academic progress. The federal *Every Student Succeeds Act* includes provisions to give children in foster care more educational stability by allowing students to stay in their school of origin if it is in their best interest and providing transportation to that school.[17]**

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.[18]

◆ Stability rates measure the number of children who attended the same school the entire school year in a school district. The stability rate is calculated by dividing the number of children enrolled the whole year at the same school in the school district by total enrollment for that school district. The stability rate for the four core cities was 80% in the 2017-2018 school year, compared with a stability rate of 91% in the remainder of the state.[19]

◆ Total enrollment for each district is cumulative over the course of the school year.[20]

◆ The overall Rhode Island student mobility rate was 13% in the 2017-2018 school year. The four core cities had a higher mobility rate (22%) than districts in the remainder of the state (9%).[21]

◆ During the 2017-2018 school year, Rhode Island high schools had higher mobility rates (16%) than elementary schools (13%) and middle schools (11%).[22]

Table 46. **Student Mobility and Stability Rates by District, Rhode Island, 2017-2018 School Year**

SCHOOL DISTRICT	CUMULATIVE ENROLLMENT FOR 2017-2018	# ENROLLED THE WHOLE YEAR	# ENROLLED AFTER SEPT. 30	# EXITED BEFORE JUNE 1	STABILITY RATE	MOBILITY RATE
Barrington	3,440	3,305	80	57	96%	4%
Bristol Warren	3,408	3,063	112	255	90%	11%
Burrillville	2,321	2,166	77	84	93%	7%
Central Falls	3,009	2,215	457	408	74%	29%
Chariho	3,252	3,016	96	153	93%	8%
Coventry	4,819	4,470	158	201	93%	7%
Cranston	11,007	9,792	567	726	89%	12%
Cumberland	4,849	4,374	226	279	90%	10%
East Greenwich	2,497	2,394	43	65	96%	4%
East Providence	5,488	4,995	187	337	91%	10%
Exeter-West Greenwich	1,667	1,568	40	67	94%	6%
Foster	270	256	*	*	95%	5%
Foster-Glocester	1,287	1,231	23	34	96%	4%
Glocester	544	518	16	11	95%	5%
Jamestown	488	454	15	21	93%	7%
Johnston	3,347	3,044	151	163	91%	9%
Lincoln	3,163	2,911	114	145	92%	8%
Little Compton	245	230	*	*	94%	6%
Middletown	2,318	2,023	135	180	87%	14%
Narragansett	1,313	1,224	37	57	93%	7%
New Shoreham	129	114	*	*	88%	12%
Newport	2,386	1,990	180	245	83%	18%
North Kingstown	4,006	3,698	147	180	92%	8%
North Providence	3,743	3,375	177	218	90%	11%
North Smithfield	1,759	1,629	54	81	93%	8%
Pawtucket	9,530	8,003	798	834	84%	17%
Portsmouth	2,504	2,317	73	119	93%	8%
Providence	27,497	21,779	2,841	3,490	79%	23%
Scituate	1,315	1,240	40	38	94%	6%
Smithfield	2,423	2,311	51	66	95%	5%
South Kingstown	3,125	2,901	107	137	93%	8%
Tiverton	1,886	1,736	61	95	92%	8%
Warwick	9,191	8,377	363	489	91%	9%
West Warwick	3,921	3,261	299	411	83%	18%
Westerly	2,842	2,556	123	186	90%	11%
Woonsocket	6,729	5,362	662	849	80%	22%
Charter Schools	*8,184*	*7,459*	*313*	*434*	*91%*	*9%*
State-Operated Schools	*2,015*	*1,628*	*226*	*260*	*81%*	*24%*
UCAP	*156*	*115*	*16*	*26*	*74%*	*27%*
Four Core Cities	*46,765*	*37,359*	*4,758*	*5,581*	*80%*	*22%*
Remainder of State	*94,953*	*86,539*	*3,773*	*5,123*	*91%*	*9%*
Rhode Island	*152,073*	*133,100*	*9,086*	*11,424*	*88%*	*13%*

Source of Data for Table/Methodology

Rhode Island Department of Education, 2017-2018 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, RISE Prep Mayoral Academy, Rhode Island Nurses Institute Middle College Charter School, 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

[1,3] Herbers, J. E., Reynolds, A. J., & Chen, C. (2013). School mobility and developmental outcomes in young adulthood. *Development and Psychopathology, 25*(2), 501–515.

[2,4,5,8] Scherrer, J. (2013). The negative effects of student mobility: Mobility as a predictor, mobility as a mediator. *International Journal of Education Policy & Leadership, 8*(1), 1-14.

[7] 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.

(continued on page 188)

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 *Rhode Island Comprehensive Assessment System (RICAS)* 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 successfully reach this milestone struggle in the later grades and are four times more likely to drop out of high school than their proficient peers.[1]

Interventions for students who struggle with reading are more successful when implemented before third grade than after third grade. When intervention is delayed until after third grade, most children never catch up to their grade-level peers.[2,3]

Literacy begins long before children encounter school instruction in writing and reading. Physical and social-emotional health, family supports, literacy-rich home environments (including telling stories) and parents who provide early cognitive development activities contribute to literacy development, reading achievement, and success in school.[4,5]

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.[6] Programs targeting the development of social-emotional and behavioral skills improve children's school readiness and academic achievement. Children who participate in high-quality early childhood education 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.[7,8]

Policymakers can increase third-grade reading proficiency by increasing access to high-quality child care, Pre-K, and Head Start; providing parents with supports to create enriched language and literacy opportunities beginning at birth; expanding access to high-quality summer learning programs; and addressing chronic early absence.[9,10]

4th-Grade *NAEP* Reading Proficiency

	2007	2017
RI	31%	39%
US	32%	35%
National Rank*		*14th*
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 *RICAS* English Language Arts Assessment, Rhode Island, 2018

SUBGROUP	
Male Students	36%
Female Students	45%
English Learners	13%
Non-English Learners	44%
Students with Disabilities	9%
Students without Disabilities	46%
Low-Income Students	26%
Higher-Income Students	56%
White Students	50%
Asian Students	44%
Black Students	26%
Hispanic Students	25%
Native American Students	24%
ALL STUDENTS	*40%*

Source: Rhode Island Department of Education, *Rhode Island Comprehensive Assessment System (RICAS), 2018.* Low-income status is determined by eligibility for the free or reduced-price lunch program.

◆ **In 2018, 40% of Rhode Island third graders met expectations on the *Rhode Island Comprehensive Assessment System (RICAS)*, English language arts assessment.[11]**

◆ **In Rhode Island in 2018, 26% of low-income third graders met expectations, compared with 56% of higher-income third graders. There were also large achievement gaps by race and ethnicity as well as by English learner and disability status.[12]**

◆ **2018 was the first year of the new *Rhode Island Comprehensive Assessment System (RICAS)* in grades three through eight in English language arts and mathematics. The *RICAS* assessments are aligned to the Common Core State Standards and are comparable to the *Massachusetts Comprehensive Assessment System.*[13]**

Table 47.

Third-Grade Reading Skills, Rhode Island, 2018

SCHOOL DISTRICT	# OF THIRD GRADERS TESTED	# MEETING EXPECTATIONS	% MEETING EXPECTATIONS
Barrington	242	177	73%
Bristol Warren	225	136	60%
Burrillville	153	49	32%
Central Falls	200	24	12%
Chariho	210	123	59%
Coventry	331	173	52%
Cranston	732	330	45%
Cumberland	338	172	51%
East Greenwich	190	128	67%
East Providence	388	164	42%
Exeter-West Greenwich	114	74	65%
Foster	37	13	35%
Glocester	94	58	62%
Jamestown	40	25	63%
Johnston	258	102	40%
Lincoln	227	125	55%
Little Compton	28	18	64%
Middletown	180	66	37%
Narragansett	72	46	64%
Newport	155	40	26%
North Kingstown	234	132	56%
North Providence	249	82	33%
North Smithfield	131	93	71%
Pawtucket	750	227	30%
Portsmouth	145	89	61%
Providence	1,738	323	19%
Scituate	80	38	48%
Smithfield	148	88	59%
South Kingstown	227	108	48%
Tiverton	129	69	53%
Warwick	622	255	41%
West Warwick	272	83	31%
Westerly	204	109	53%
Woonsocket	481	84	17%
Charter Schools	*670*	*319*	*48%*
Four Core Cities	*3,169*	*658*	*21%*
Remainder of State	*6,462*	*3,171*	*49%*
Rhode Island	*10,305*	*4,148*	*40%*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Education (RIDE), *Rhode Island Comprehensive Assessment System (RICAS)*, 2018.

Due to the adoption of a new assessment tool by RIDE in 2018, Third-Grade Reading Skills cannot be compared with Factbooks prior to 2018.

% meeting expectations are the third-grade students who met or exceeded expectations for their grade on the English language arts section of the *RICAS*. 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.

In Rhode Island, 98% of students were tested. Response rates vary by district.

2018 *RICAS* data for independent charter schools include Achievement First Rhode Island, Blackstone Valley Prep, The Compass School, Paul Cuffee Charter School, Highlander Charter School, The Hope Academy, International Charter School, Kingston Hill Academy, The Learning Community, and SouthSide Charter School. 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.

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

Data is not reported for New Shoreham or The Rhode Island School for the Deaf because the number of students tested was less than 10.

See Methodology Section for more information.

References

[1,2] Hernandez, D. J. (2012). *Double jeopardy: How third-grade reading skills and poverty influence high school graduation.* Baltimore, MD: The Annie E. Casey Foundation.

(continued on page 188)

Eighth-Grade Reading Skills

DEFINITION

Eighth-grade reading skills is the percentage of eighth-grade students who met expectations for reading in English language arts on the *Rhode Island Common Assessment System (RICAS)* 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 learners and low-income students, who are more likely to have low literacy skills.[5]

Nationally, there has been limited progress in improving literacy skills among secondary students.[6] Students who are struggling with reading may have distinct difficulties and require different interventions to address them.[7] Many 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 ongoing teacher support and training in the literacy strategy, incorporating literacy instruction in content area classes, explicit reading instruction in reading comprehension, collaborative learning and using student assessments effectively.[10,11]

8th-Grade *NAEP* Reading Proficiency

	2007	2017
RI	27%	37%
US	29%	35%
National Rank*	*31st*	*19th*
New England Rank**	*6th*	*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 four and eight.

Eighth Graders Meeting Expectations on the *RICAS* English Language Arts Assessment, Rhode Island, 2018

SUBGROUP	2018
Male Students	22%
Female Students	35%
*English Learners	<5%
Non-English Learners	30%
*Students With Disabilities	<5%
Students Without Disabilities	32%
Low-Income Students	13%
Higher-Income Students	41%
White Students	38%
Asian Students	37%
Black Students	11%
Hispanic Students	12%
Native American Students	9%
ALL STUDENTS	*28%*

Source: Rhode Island Department of Education, *Rhode Island Common Assessment System (RICAS), 2018.* Low-income status is determined by eligibility for the free or reduced-price lunch program. *Data is reported as <5% when more than 95% of students did not meet expectations.

◆ **In Rhode Island in 2018, 28% of all eighth-grade students met expectations in English language arts on the *Rhode Island Comprehensive Assessment System (RICAS)*. Thirteen percent of low-income eighth graders met expectations, compared with 41% of higher-income eighth graders. There were also large achievement gaps by race and ethnicity.[12]**

◆ **Less than 5% of English learners and students with disabilities met expectations.[13]**

◆ **Starting in the 2017-2018 school year, Rhode Island adopted the *Rhode Island Comprehensive Assessment System (RICAS)* for assessments in grades three through eight. The *RICAS* assessments are aligned to the Common Core Standards and are comparable to the *Massachusetts Comprehensive Assessment System.*[14]**

Table 48.

Eighth-Grade Reading Skills, Rhode Island, 2018

SCHOOL DISTRICT	# EIGHTH GRADERS TESTED	# MEETING EXPECTATIONS	% MEETING EXPECTATIONS
Barrington	245	172	70%
Bristol Warren	201	78	39%
Burrillville	178	40	22%
Central Falls	169	*	<5%
Chariho	262	130	50%
Coventry	371	151	41%
Cranston	841	230	27%
Cumberland	378	199	53%
East Greenwich	206	127	62%
East Providence	367	88	24%
Exeter-West Greenwich	130	51	39%
Foster-Glocester	165	89	54%
Jamestown	52	33	63%
Johnston	252	43	17%
Lincoln	274	71	26%
Little Compton	31	17	55%
Middletown	174	49	28%
Narragansett	117	54	46%
Newport	145	32	22%
North Kingstown	317	189	60%
North Providence	294	59	20%
North Smithfield	146	81	55%
Pawtucket	688	68	10%
Portsmouth	183	83	45%
Providence	1,703	144	8%
Scituate	118	22	19%
Smithfield	178	90	51%
South Kingstown	265	119	45%
Tiverton	155	38	25%
Warwick	706	178	25%
West Warwick	223	64	29%
Westerly	229	65	28%
Woonsocket	401	41	10%
Charter Schools	*437*	*99*	*23%*
Urban Collaborative	*80*	***	*5%*
Four Core Cities	*2,623*	*257*	*10%*
Remainder of State	*7,555*	*2,650*	*35%*
Rhode Island	*10,695*	*3,010*	*28%*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Education (RIDE), *Rhode Island Common Assessment System (RICAS)*, 2018.

Due to the adoption of a new assessment tool by RIDE in 2018, Eighth-Grade Reading Skills cannot be compared with prior Factbooks.

% meeting expectations are the eighth-grade students who met or exceeded expectations for their grade on the English language arts section of the *RICAS*. 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 students who first enrolled in a U.S. school after April 1, 2018 are not required to take the English language arts assessment.

* Indicates 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 the state, and state totals. Data is reported as <5% when more than 95% of students did not meet expectations.

2018 *RICAS* data for independent charter schools include: Beacon Charter School for the Arts, 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.

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

Data is not reported for New Shoreham or The Rhode Island School for the Deaf because the number of students tested was less than 10.

See Methodology Section for more information.

References

[1,6,10] Hervey, S. (2013). *Adolescent readers in middle school.* New York, NY: Generation Ready.

(continued on page 188)

Math Skills

DEFINITION

Math skills is the percentage of third- and eighth-grade students who met expectations for math on the *Rhode Island Comprehensive Assessment System (RICAS)* 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 with straight-forward computational procedures but tend to have a limited understanding of basic mathematical concepts, resulting in recent federal actions to increase the level of rigor, depth, and coherency of the mathematics content taught nationwide.[4,5] After two decades of improvement, performance in math in the U.S. has begun to level off.[6,7]

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.[8] Opportunities for advanced math instruction are especially important for low-income children. Low-income children are exposed to less complex math concepts, contributing to lower performance on assessments.[9]

Achieving math proficiency for all students requires that improvements be made in curriculum, instructional materials, assessments, classroom practice, teacher preparation, and professional development. These are particularly important as Rhode Island continues to implement new, more rigorous math standards.[10,11] Teachers should expose all students to challenging math concepts and provide additional support to struggling students.[12]

The *National Assessment of Educational Progress (NAEP)* measures proficiency in math and other subjects nationally and across states every other year.13 In 2017, 39% of Rhode Island fourth graders and 40% of U.S. fourth graders performed at or above the Proficient level in math on the *NAEP*, and 30% of Rhode Island eighth graders and 33% of U.S. eighth graders performed at or above the Proficient level in math on the *NAEP*.[14,15] Between 2011 and 2017, Rhode Island saw decreases in both fourth- and eighth-grade math achievement as measured by the *NAEP* math tests.[16]

Third- & Eighth- Grade Students Meeting Expectations on the *RICAS* Math Assessment, Rhode Island, 2018

SUBGROUP	THIRD GRADE	EIGHTH GRADE
Male Students	37%	22%
Female Students	34%	24%
*English Learners	13%	<5%
Non-English Learners	39%	25%
*Students With Disabilities	9%	<5%
Students Without Disabilities	40%	26%
Low-Income Students	22%	9%
Higher-Income Students	50%	35%
White Students	45%	31%
Asian Students	49%	35%
Black Students	21%	8%
Hispanic Students	22%	8%
Native American Students	15%	7%
ALL STUDENTS	*35%*	*23%*

Source: Rhode Island Department of Education, *Rhode Island Comprehensive Assessment System (RICAS)*, 2018. Low-income status is determined by eligibility for the free or reduced-price lunch program. *Data is reported as <5% when more than 95% of students did not meet expectations.

◆ **In Rhode Island in 2018, 22% of low-income third graders met expectations in math, on the Rhode Island Comprehensive Assessment System (RICAS) compared with 50% of higher-income third graders. There also were large achievement gaps by race and ethnicity, with 49% of Asian and 45% of White third graders meeting expectations, compared with 21% of Black, 22% of Hispanic, and 15% of Native American students. This large achievement gap is also seen in eighth-grade results, with 35% of Asian and 31% of White eighth graders meeting expectations, compared with 8% of Black and Hispanic students, and 7% of Native American students.[17]**

◆ **Starting in the 2017-2018 school year, Rhode Island adopted the *Rhode Island Comprehensive Assessment System (RICAS)* for assessments in grades three through eight. The *RICAS* assessments are aligned to the Common Core State Standards and are comparable to the *Massachusetts Comprehensive Assessment System.*[18]**

Table 49.

Third & Eighth Grade Students Meeting Expectations in Math, Rhode Island, 2018

SCHOOL DISTRICT	# OF THIRD GRADERS TESTED	% OF THIRD GRADERS MEETING EXPECTATIONS	# OF EIGHTH GRADERS TESTED	% OF EIGHTH GRADERS MEETING EXPECTATIONS
Barrington	241	60%	246	66%
Bristol Warren	228	59%	213	26%
Burrillville	154	25%	178	20%
Central Falls	219	13%	180	1%
Chariho	210	48%	262	45%
Coventry	332	39%	369	25%
Cranston	737	33%	845	16%
Cumberland	342	53%	379	45%
East Greenwich	191	66%	204	56%
East Providence	391	40%	372	12%
Exeter-West Greenwich	114	70%	132	33%
Foster	37	24%	NA	NA
Foster-Glocester	NA	NA	165	28%
Glocester	94	51%	NA	NA
Jamestown	40	63%	52	58%
Johnston	260	34%	252	15%
Lincoln	228	54%	274	37%
Little Compton	30	57%	31	61%
Middletown	180	40%	177	55%
Narragansett	72	64%	115	43%
Newport	160	26%	146	15%
North Kingstown	235	54%	318	49%
North Providence	252	28%	300	13%
North Smithfield	132	52%	146	38%
Pawtucket	767	29%	702	7%
Portsmouth	147	52%	183	46%
Providence	1,793	17%	1,775	6%
Scituate	80	44%	118	19%
Smithfield	149	39%	178	48%
South Kingstown	230	50%	264	41%
Tiverton	129	54%	155	25%
Warwick	632	31%	706	16%
West Warwick	275	18%	225	24%
Westerly	203	49%	229	26%
Woonsocket	484	16%	407	7%
Charter Schools	*672*	*41%*	*440*	*21%*
UCAP	*NA*	*NA*	*75*	*0%*
Four Core Cities	*3,263*	*20%*	*3,064*	*6%*
Remainder of State	*6,513*	*43%*	*7,242*	*30%*
Rhode Island	*10,452*	*35%*	*10,827*	*23%*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Education (RIDE), *Rhode Island Comprehensive Assessment System (RICAS)*, 2018.

Due to the adoption of a new assessment tool by RIDE in 2018, *Math Skills* cannot be compared with Factbooks prior to 2019.

% meeting expectations are students who met or exceeded expectations on the math section of the *RICAS*. Only students who actually took the test are counted in the denominator for the district and school proficiency rates. All students, including students with disabilities and English learners, are expected to participate in the *RICAS* assessment.

RICAS data for independent charter schools include Achievement First, Beacon Charter School, Blackstone Valley Prep Mayoral Academy, The Compass School, Paul Cuffee Charter School, Highlander Charter School, The Hope Academy, International Charter School, Kingston Hill Academy, The Learning Community, Segue Institute for Learning, Southside Charter School, and Trinity Academy for the Performing Arts.

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

Charter schools and the Urban Collaborative Accelerated Program (UCAP) are not included in the four core cities and the remainder of state calculations.

NA indicates that the school district does not serve students at that grade level.

New Shoreham and Rhode Island School for the Deaf serve fewer than 10 students at this grade level. Data is not shown to protect student confidentiality. These students are still counted in remainder of state and state totals.

References

[1,7,8] Child Trends. (2015). *Mathematics proficiency.* Retrieved March 5, 2019, from www.childtrends.org

[2] RI DataHub. (n.d.). *Data story: Math preparation and postsecondary success.* Retrieved March 5, 2019, from ridatahub.org

(continued on page 188)

Schools Identified for Intervention

DEFINITION

Schools identified for intervention is the percentage of Rhode Island public schools that are identified as in need of "Comprehensive Support and Improvement" by the Rhode Island Department of Education.

SIGNIFICANCE

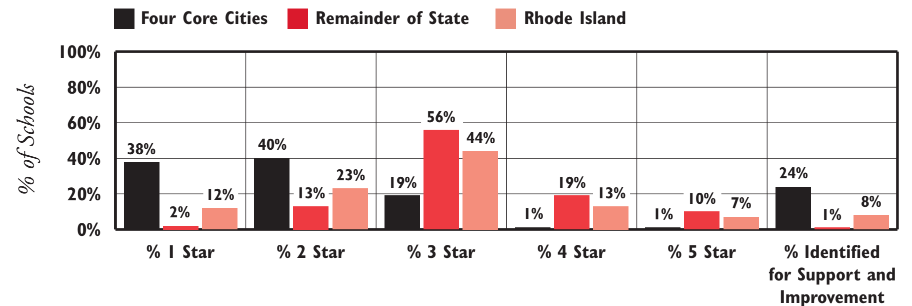
Research on school improvement efforts shows that schools can be improved through comprehensive, whole-school reforms. Critical elements of successful school improvement efforts include targeting resources to support the lowest performing schools, giving building leaders more autonomy around spending and hiring, using data-based decision making, developing ways to spread best practices, and engaging the whole community in improvement efforts.[1]

The U.S. Department of Education approved Rhode Island's new accountability system under the *Every Student Succeeds Act (ESSA)* in 2018.[2] The new system is structured to promote collective responsibility for continuous improvement at all levels of education through the use of measurements to differentiate school performance, a school classification system, and state, district and school report cards.[3]

The new system uses a five-star rating system to summarize overall school performance determined by a broad range of performance indicators.[4] These indicators include achievement in English language arts and math, student growth, graduation rate, English language proficiency, percentage of students exceeding expectations, student and teacher chronic absenteeism, and suspensions.[5] In future years, Rhode Island will include additional indicators including proficiency in science, high school graduates' proficiency in English language arts and math, and the percentage of graduating high school students who have earned college credits or industry credentials.[6]

Schools with five-star ratings have strong performance in all the indicators and no low-performing student subgroups. Schools with one-star ratings are low performing schools in multiple indicators.[7] The lowest performing 5% of all schools receiving Title I funds, high schools that do not graduate at least two-thirds of their students and schools with the lowest scores on academic indicators are identified as in need of "Comprehensive Support and Improvement."[8] These schools will receive additional support and oversight from the state. Schools identified as in need of additional targeted support and improvement have one or more student subgroups performing at the lowest levels in the state.[9]

Rhode Island School Performance Classifications, 2017-2018 School Year



Source: Rhode Island Department of Education, School and District Report Cards, 2017-2018 school year.

◆ **In Rhode Island in the 2017-2018 school year, 36 schools (12%) were given a one-star rating, 68 schools (23%) were given a two-star rating, 132 schools (44%) were given a three-star rating, 40 schools (13%) were given a four-star rating, and 21 schools (7%) were given a five-star rating.[10]**

◆ **Eight percent of schools in Rhode Island are identified as in need of Comprehensive Support and Improvement, and 17 of these 24 schools were located in the four core cities.[11]**

◆ **An additional 131 schools were identified as being in need of additional targeted support and improvement because they have one or more student subgroups who performed at the lowest levels in the state. Of these schools, 89% were identified because of the need for improvement for students with disabilities.[12]**

Every Student Succeeds Act (ESSA) School Accountability Plans

◆ ***ESSA* replaced *No Child Left Behind* as the nation's leading education law in 2015. The law requires states to include a measure of "school quality or student success," such as student engagement, chronic absence, school climate and safety, access to advanced coursework, or college and career readiness in their new accountability systems.[13,14]**

◆ **Strong *ESSA* accountability frameworks have an easy-to-understand rating system, incorporate student growth as well as proficiency, include academic measures inclusive of more than reading and math, incorporate the performance of student subgroups, include measures of college and career readiness, and include a measure of year-over-year growth.[15,16]**

Table 50.

Schools Identified for Intervention, 2017-2018 School Year

SCHOOL DISTRICT	TOTAL # OF SCHOOLS	# OF 5-STAR RATED SCHOOLS	# OF 4-STAR RATED SCHOOLS	# OF 3-STAR RATED SCHOOLS	# OF 2-STAR RATED SCHOOLS	# OF 1-STAR RATED SCHOOLS	# IDENTIFIED FOR COMPREHENSIVE SUPPORT AND IMPROVEMENT	% IDENTIFIED FOR COMPREHENSIVE SUPPORT AND IMPROVEMENT
Barrington	6	5	1	0	0	0	0	0%
Bristol Warren	6	2	1	3	0	0	0	0%
Burrillville	5	0	0	4	1	0	0	0%
Central Falls	5	0	0	0	3	2	0	0%
Chariho	7	2	1	3	0	1	1	14%
Coventry	7	0	1	6	0	0	0	0%
Cranston	23	0	5	11	5	2	1	4%
Cumberland	8	2	2	4	0	0	0	0%
East Greenwich	6	3	1	2	0	0	0	0%
East Providence	11	0	0	9	2	0	0	0%
Exeter-West Greenwich	4	1	1	2	0	0	0	0%
Foster	1	0	0	1	0	0	0	0%
Foster-Glocester	2	0	0	2	0	0	0	0%
Glocester	2	0	2	0	0	0	0	0%
Jamestown	2	1	1	0	0	0	0	0%
Johnston	7	0	1	2	3	1	0	0%
Lincoln	6	0	2	4	0	0	0	0%
Little Compton	1	0	0	1	0	0	0	0%
Middletown	5	0	0	5	0	0	0	0%
Narragansett	3	1	1	1	0	0	0	0%
New Shoreham	1	0	0	1	0	0	0	0%
Newport	3	0	0	0	3	0	0	0%
North Kingstown	8	2	3	3	0	0	0	0%
North Providence	9	0	0	4	5	0	0	0%
North Smithfield	4	0	4	0	0	0	0	0%
Pawtucket	16	0	1	7	4	4	3	19%
Portsmouth	4	0	3	1	0	0	0	0%
Providence	41	1	0	6	16	18	13	32%
Scituate	5	0	1	4	0	0	0	0%
Smithfield	6	0	2	4	0	0	0	0%
South Kingstown	7	0	1	4	2	0	0	0%
Tiverton	5	0	0	5	0	0	0	0%
Warwick	20	0	0	18	2	0	0	0%
West Warwick	5	0	0	3	2	0	0	0%
Westerly	5	0	2	2	1	0	0	0%
Woonsocket	10	0	0	1	6	3	1	10%
Charter Schools	*26*	*1*	*3*	*8*	*11*	*3*	*3*	*12%*
State-Operated Schools	*4*	*0*	*0*	*1*	*1*	*2*	*2*	*50%*
UCAP	*1*	*0*	*0*	*0*	*1*	*0*	*0*	*0%*
Four Core Cities	*72*	*1*	*1*	*14*	*29*	*27*	*17*	*24%*
Remainder of State	*194*	*19*	*36*	*109*	*26*	*4*	*2*	*1%*
Rhode Island	*297*	*21*	*40*	*132*	*68*	*36*	*24*	*8%*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Education, 2017-2018 school year.

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

Charter schools that are classified include Achievement First, Beacon Charter High School for the Arts, Blackstone Academy Charter, Blackstone Valley Prep, The Compass School, Paul Cuffee Charter School, The Greene School, Highlander Charter School, The Hope Academy, International Charter School, Kingston Hill Academy, The Learning Community Charter School, Rhode Island Nurses Institute Middle College Charter School, Segue Institute for Learning, Sheila "Skip" Nowell Leadership Academy, SouthSide Elementary School, Trinity Academy for the Performing Arts, and Village Green Virtual Charter School.

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.

Early Learning Centers, Pre-K programs and preschools are not rated and therefore not included in this table.

See the Methodology Section for more information.

References

[1] Strauss, C. & Miller, T. (2016). *Strategies to improve low-performing schools under the Every Student Succeeds Act: How 3 districts found success using evidence-based practices.* Washington, DC: Center for American Progress.

[2] U.S. Department of Education, Press Office. (2018). *Secretary DeVos approves Idaho, Mississippi and Rhode Island's ESSA state plans* [Press Release]. Retrieved from www.ed.gov

[3,5,7,8] Rhode Island Department of Education. (2018). *Rhode Island's Every Student Succeeds Act* state plan, from www.ride.ri.gov

[4,6,9,12] Rhode Island Department of Education. (2018) *Rhode Island launches new school report card platform* [Press Release]. Retrieved from www.ride.ri.gov

(continued on page 188)

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

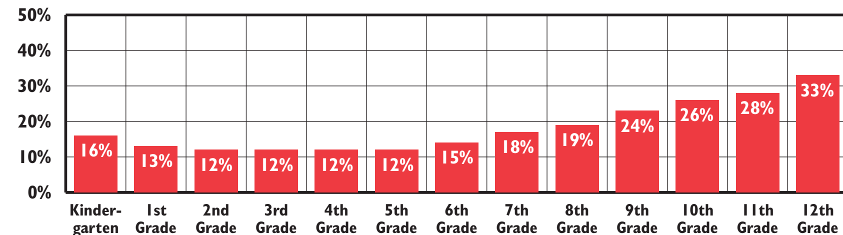
Students who are absent from school miss opportunities to learn and develop the important academic and social-emotional skills and approaches to learning that are part of the K-3 experience and critical for ongoing school success.[1,2] Children who are chronically absent in kindergarten show lower levels 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]

More than 3.1 million elementary school students nationwide or 14% of all elementary school students are chronically absent.[5] In the early grades, children from poor families are much more likely to be chronically absent 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] The rate of chronic absence is twice as high for students experiencing homelessness as it is for the general student population.[7] Chronic absenteeism can affect the reading and math outcomes of all students in a class, not just those who are absent, because teachers may backtrack or slow the learning pace to review lessons for students who have missed school.[8]

Young children are chronically absent from school for a variety of reasons. Asthma is one of the leading causes of school absenteeism, accounting for one-third of all absences, but other physical and behavioral health issues, including poor dental health, vision problems, diabetes, obesity, anxiety, and/or depression can also result in chronic absence.[9,10]

While illness is a leading factor in chronic early absence, 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 or absenteeism, disruptive classrooms, and/or bullying. 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 other factors that can lead to chronic absence.[11,12,13]

Chronic Absence Rates in Rhode Island by Grade, 2017-2018 School Year



Source: Rhode Island Department of Education, 2017-2018 school year.

◆ **Chronic absence rates are high in kindergarten and then decline before increasing again in middle and high school. During the 2017-2018 school year, 16% of Rhode Island kindergarten students, 13% of first graders, 12% of second graders, and 12% of third graders were chronically absent (i.e., absent 18 days or more), showing little change from the 2016-2017 school year when 16% of kindergarten students, 14% of first graders, 12% of second graders, and 12% of third graders were chronically absent.[14,15]**

◆ **During the 2017-2018 school year, 13% of all Rhode Island children in grades K-3 were chronically absent, and an additional 16% missed 12 to 17 days of school.[16]**

◆ **Averages for school-wide attendance can mask significant numbers of chronically absent individual students.[17] During the 2017-2018 school year, the average daily attendance rate for K-3 students in Rhode Island's four core cities was 92%, but 24% of students were chronically absent.[18]**

◆ **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, and creating attendance teams that regularly review data on student absenteeism and identify and intervene with students with troubling absenteeism patterns.[19,20]**

◆ **Thirty-seven states are prioritizing reducing chronic absence by making chronic absence rates a key part of their accountability systems.[21] Rhode Island is including both student and teacher chronic absence rates in its accountability system.[22]**

Table 51. **Chronic Early Absence Rates, Grades K-3, Rhode Island, 2017-2018 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	30	886	96%	51%	36%	10%	3%
Bristol Warren	93	954	95%	43%	32%	16%	10%
Burrillville	28	566	95%	40%	38%	14%	8%
Central Falls	154	851	92%	25%	28%	22%	24%
Chariho	32	801	96%	51%	37%	8%	4%
Coventry	69	1,299	95%	41%	35%	15%	9%
Cranston	176	2,904	95%	43%	32%	15%	10%
Cumberland	82	1,353	96%	48%	37%	11%	4%
East Greenwich	10	671	96%	48%	36%	12%	4%
East Providence	99	1,615	95%	39%	33%	16%	12%
Exeter-West Greenwich	20	478	96%	48%	37%	11%	4%
Foster	*	147	97%	63%	24%	9%	5%
Glocester	*	340	96%	54%	31%	11%	5%
Jamestown	*	191	95%	35%	47%	14%	5%
Johnston	52	957	94%	33%	34%	18%	15%
Lincoln	43	896	96%	45%	35%	12%	8%
Little Compton	*	99	96%	53%	31%	10%	6%
Middletown	60	690	95%	39%	38%	13%	9%
Narragansett	14	299	96%	43%	38%	15%	3%
New Shoreham	*	34	94%	18%	53%	12%	18%
Newport	75	712	94%	31%	33%	20%	16%
North Kingstown	57	933	96%	45%	36%	12%	7%
North Providence	73	1,007	95%	41%	33%	16%	10%
North Smithfield	13	487	96%	44%	35%	15%	6%
Pawtucket	312	2,827	94%	33%	32%	17%	17%
Portsmouth	40	607	96%	48%	35%	13%	5%
Providence	1,113	6,994	92%	24%	29%	21%	27%
Scituate	13	342	95%	39%	36%	18%	7%
Smithfield	23	658	96%	53%	34%	9%	4%
South Kingstown	55	845	96%	42%	41%	10%	6%
Tiverton	31	556	95%	38%	37%	17%	9%
Warwick	142	2,605	95%	39%	36%	15%	11%
West Warwick	105	1,142	94%	33%	34%	18%	15%
Westerly	54	755	95%	38%	37%	17%	7%
Woonsocket	345	1,934	92%	25%	31%	19%	24%
Charter Schools	*90*	*3,062*	*96%*	*46%*	*31%*	*14%*	*9%*
RI School for the Deaf	*0*	*18*	*91%*	*28%*	*17%*	*22%*	*33%*
Four Core Cities	*1,924*	*12,606*	*92%*	*26%*	*30%*	*20%*	*24%*
Remainder of State	*1,517*	*25,829*	*95%*	*42%*	*35%*	*14%*	*9%*
Rhode Island	*3,531*	*41,515*	*94%*	*38%*	*33%*	*16%*	*13%*

Source of Data for Table/Methodology

Rhode Island Department of Education, 2017-2018 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 3,531 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, RISE Prep Mayoral Academy, and SouthSide 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.

[2,3,12,19] 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 March 7, 2019, from http://ridatahub.org

(continued on page 189)

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]

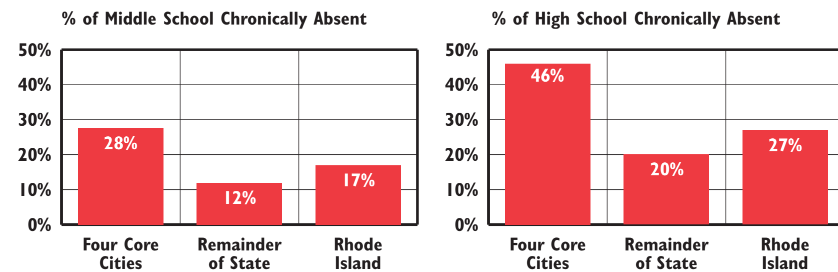
Students miss school for a variety of reasons, including physical and mental health problems, substance abuse, lack of access to health care, unstable housing, child welfare or juvenile justice involvement, work or family responsibilities, and lack of affordable or reliable transportation. Students may also stay away from school to avoid bullying, harassment, disciplinary actions due to tardiness, or embarrassment associated with lack of clean or appropriate clothing or literacy or other academic problems.[4,5,6]

A national survey of students found that the most common reasons students report being chronically absent are health-related reasons, transportation barriers, personal stress, preferring activities outside of school, and perceiving that school has little value (i.e., is boring, their parents do not care if they miss school, or a belief that school will not help them reach future goals).[7]

The Rhode Island Department of Education (RIDE) defines truancy as ten or more unexcused absences in a school year.[8] During the 2017-2018 school year in Rhode Island, 25% of middle school students and 35% of high school students were considered truant by RIDE.[9] Truant students in Rhode Island may be referred to the Family Court's Truancy Calendar, a community and school-based intervention program.[10]

One-third (33%) of Rhode Island's low-income middle and high school students were chronically absent in 2017-2018, compared with 14% of higher-income students. Middle and high school students receiving special education services (31%) were more likely than their peers not receiving these services (21%) to be chronically absent. Almost three-quarters (72%) of absences by middle and high school students were unexcused absences.[11]

Chronic Absence Rate by District Type, Middle and High School, 2017-2018 School Year



Source: Rhode Island Department of Education, 2017-2018 school year.

◆ **The chronic absence rate among middle (28%) and high (46%) school students in the four core cities is more than twice as high as the rates among middle (12%) and high (20%) school students in the remainder of the state.[12]**

◆ **One of the most effective strategies for increasing student achievement, high school graduation rates, and college access and completion, and for closing achievement gaps between higher income and lower income students, would be to increase the number of low-income students who attend school regularly.[13]**

Reducing Chronic Absence

◆ **Schools, districts, and 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.[14,15] Studies also show that high school attendance rates improve when school start times are later.[16]**

◆ **States can reduce chronic absence by increasing public awareness about the problem, sharing best practices, requiring school and district-level attendance teams, incorporating chronic absence measures into early warning and accountability systems and school improvement efforts, and allocating resources to address barriers to attendance.[17,18,19,20]**

Chronic Absence, Middle School and High School

Table 52.

Chronic Absence and Attendance Rates, Middle and High School, Rhode Island, 2017-2018 School Year

	MIDDLE SCHOOL (GRADES 6-8)					HIGH SCHOOL (GRADES 9-12)				
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	12	789	96%	12%	7%	20	1,164	96%	8%	5%
Bristol Warren	41	759	94%	15%	19%	80	941	92%	16%	25%
Burrillville	17	540	95%	13%	9%	35	780	94%	14%	13%
Central Falls	61	553	93%	18%	21%	178	662	89%	15%	32%
Chariho	29	727	96%	11%	6%	64	1,099	93%	16%	14%
Coventry	44	1,120	95%	15%	11%	73	1,490	94%	13%	17%
Cranston	133	2,479	94%	16%	15%	334	3,286	90%	17%	33%
Cumberland	53	1,107	95%	13%	8%	102	1,412	94%	16%	14%
East Greenwich	17	635	97%	7%	3%	19	756	98%	5%	1%
East Providence	57	1,218	93%	17%	20%	110	1,528	91%	16%	29%
Exeter-West Greenwich	15	387	95%	13%	9%	20	525	96%	9%	8%
Foster-Glocester	12	510	96%	9%	7%	19	746	93%	14%	20%
Jamestown	*	160	96%	19%	6%	NA	NA	NA	NA	NA
Johnston	23	799	93%	19%	21%	61	932	92%	17%	26%
Lincoln	40	785	95%	14%	11%	49	868	90%	20%	31%
Little Compton	0	89	96%	15%	7%	NA	NA	NA	NA	NA
Middletown	28	534	95%	16%	9%	55	607	94%	10%	14%
Narragansett	11	341	95%	18%	7%	21	442	94%	14%	17%
New Shoreham	0	24	93%	33%	13%	*	49	94%	24%	16%
Newport	30	446	93%	19%	21%	94	660	88%	18%	38%
North Kingstown	24	926	96%	12%	8%	69	1,421	94%	9%	12%
North Providence	40	898	95%	15%	13%	64	1,068	94%	14%	19%
North Smithfield	16	408	95%	18%	7%	34	505	95%	11%	11%
Pawtucket	201	2,242	93%	17%	20%	239	1,956	89%	15%	35%
Portsmouth	19	553	95%	17%	8%	34	894	94%	13%	13%
Providence	823	5,487	91%	20%	30%	1,401	7,262	85%	16%	50%
Scituate	*	332	94%	17%	14%	21	412	94%	19%	12%
Smithfield	16	587	96%	10%	6%	16	711	95%	14%	11%
South Kingstown	15	775	96%	11%	8%	36	937	94%	11%	12%
Tiverton	18	437	94%	16%	12%	16	534	90%	19%	29%
Warwick	92	2,094	94%	16%	15%	177	2,709	91%	15%	29%
West Warwick	59	764	92%	16%	19%	184	1,021	91%	13%	25%
Westerly	30	661	95%	16%	13%	63	834	93%	20%	21%
Woonsocket	159	1,321	91%	19%	33%	214	1,577	85%	14%	47%
Charter Schools	*51*	*1,354*	*95%*	*13%*	*11%*	*226*	*2,310*	*91%*	*14%*	*24%*
State-Operated Schools	*	*13*	*94%*	*8%*	*38%*	*290*	*1,675*	*93%*	*20%*	*20%*
UCAP	*19*	*123*	*87%*	*17%*	*49%*	*	*13*	*84%*	*15%*	*62%*
Four Core Cities	*1,244*	*9,603*	*92%*	*19%*	*28%*	*2,032*	*11,457*	*86%*	*16%*	*46%*
Remainder of State	*899*	*21,884*	*95%*	*15%*	*12%*	*1,874*	*28,334*	*93%*	*14%*	*20%*
Rhode Island	*2,219*	*32,977*	*94%*	*16%*	*17%*	*4,423*	*43,789*	*91%*	*15%*	*27%*

Source of Data for Table/Methodology

Rhode Island Department of Education, 2017-2018 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 2,219 Rhode Island middle school students and 4,423 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 can choose to attend high school in Narragansett or North Kingstown.

Charter middle schools include Beacon Charter School for the Arts, 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, Paul Cuffee Charter School, The Greene School, Highlander Charter School, Rhode Island Nurses Institute Middle College Charter School, Sheila C. "Skip" Nowell Leadership Academy, Trinity Academy for the Performing Arts, and the Village Green Virtual Public Charter School.

State-operated schools include William M. Davies Jr. Career & Technical High School, Rhode Island Training School operated by DCYF, Metropolitan Regional Career & Technical Center, and Rhode Island School for the Deaf. UCAP is the Urban Collaborative Accelerated Program.

NA indicates that the school district does not serve students at that grade level. *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 189)

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 and out-of-school suspensions.

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, 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. Being suspended even once in ninth grade is associated with a twofold increase in the likelihood of dropping out.[5,6] Suspended students are also at greater risk of criminal victimization, criminal activity, and incarceration as adults.[7]

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.[8]

In Rhode Island and nationally, Black, Hispanic, and Native American 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. In Rhode Island and nationally, students with disabilities also are more likely to be suspended than their peers.[9,10,11]

Of all disciplinary actions during the 2017-2018 school year, 14% (2,954) involved elementary school students (kindergarten-5th grade), 33% (7,108) involved middle school students (6th-8th grades), and 53% (11,297) involved high school students (9th-12th grades). For elementary school students, 76% of disciplinary actions were out-of-school suspensions. Kindergarteners received 284 disciplinary actions, including 249 out-of-school suspensions.[12]

Out-of-School Suspensions by Infraction, Rhode Island, 2017-2018

TYPE OF INFRACTION*	#	%	TYPE OF INFRACTION	#	%
Insubordination/Disrespect	2,633	22%	Obscene/Abusive Language	723	6%
Fighting	2,390	20%	Arson/Larceny/Robbery/Vandalism	278	2%
Harassment/Intimidation/Threat	1,559	13%	Weapon Possession	205	2%
Disorderly Conduct	1,530	13%	Electronic Devices/Technology	140	1%
Assault of Student or Teacher	1,374	12%	Attendance Offenses	0	0%
Alcohol/Drug/Tobacco Offenses	948	8%	Other Offenses	142	1%
			Total	*11,922*	

Source: Rhode Island Department of Education, 2017-2018 school year.

**Harassment offenses include hazing and hate crimes. Assault offenses include sexual assault.*

◆ **In 2016, the Rhode Island General Assembly passed a law that restricts the use of out-of-school suspensions to situations when a child's behavior poses a demonstrable threat that cannot be dealt with by other means.[13] From the 2016-2017 school year to the 2017-2018 school year, the number of out-of-school suspensions increased by 19%. More than half of out-of-school suspensions were for non-violent offenses, such as insubordination/disrespect, disorderly conduct, obscene/abusive language, alcohol/drug/tobacco offenses, and electronic devices/technology offenses.[14,15]**

Disparities in School Discipline by Special Education Status and Race/Ethnicity, Rhode Island, 2017-2018

	% OF STUDENTS ENROLLED	% OF SUSPENSIONS
Students With Disabilities	15%	32%
White Students	58%	46%
Hispanic Students	25%	32%
Black Students	9%	13%
Asian Students	5%	1%
Native American Students	1%	2%

Source: Rhode Island Department of Education, 2017-2018 school year. % suspensions includes in-school and out-of-school suspensions. Detailed data by district is available at www.ride.ri.gov

◆ **During the 2017-2018 school year, Rhode Island students with disabilities were suspended disproportionately. Students with disabilities represent 15% of the student population but represented 32% of suspensions.[16] In 2016, the Rhode Island General Assembly passed a law that requires school districts to identify any racial, ethnic, or special education disparities in suspension rates and to develop a plan to reduce such disparities.[17]**

Table 53.

Disciplinary Actions, Rhode Island School Districts, 2017-2018

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	3,359	10	54	2	64	2
Bristol Warren	3,195	452	496	16	948	30
Burrillville	2,250	26	195	9	221	10
Central Falls	2,705	246	185	7	431	16
Chariho	3,159	227	124	4	351	11
Coventry	4,686	719	110	2	829	18
Cranston	10,362	2,770	732	7	3,502	34
Cumberland	4,613	469	160	3	629	14
East Greenwich	2,462	*	*	<1	13	1
East Providence	5,255	29	953	18	982	19
Exeter-West Greenwich	1,634	34	30	2	64	4
Foster	277	*	*	1	*	3
Foster-Glocester	1,255	76	88	7	164	13
Glocester	535	*	0	0	*	<1
Jamestown	483	*	*	1	*	1
Johnston	3,251	167	143	4	310	10
Lincoln	3,064	0	243	8	243	8
Little Compton	243	0	*	<1	*	<1
Middletown	2,169	350	119	5	469	22
Narragansett	1,296	116	107	8	223	17
New Shoreham	119	*	*	1	*	2
Newport	2,194	16	290	13	306	14
North Kingstown	3,891	278	106	3	384	10
North Providence	3,587	759	261	7	1,020	28
North Smithfield	1,705	24	41	2	65	4
Pawtucket	8,814	38	735	8	773	9
Portsmouth	2,407	330	50	2	380	16
Providence	24,201	690	3,200	13	3,890	16
Scituate	1,275	42	14	1	56	4
Smithfield	2,380	81	45	2	126	5
South Kingstown	3,042	285	75	2	360	12
Tiverton	1,820	27	191	10	218	12
Warwick	8,879	212	814	9	1,026	12
West Warwick	3,562	557	329	9	886	25
Westerly	2,740	27	260	9	287	10
Woonsocket	5,956	0	919	15	919	15
Charter Schools	*7,776*	*362*	*633*	*8*	*995*	*13*
State-Operated Schools	*1,733*	*	*162*	*9*	*166*	*10*
UCAP	*134*	*	*42*	*31*	*43*	*32*
Four Core Cities	*41,676*	*974*	*5,039*	*12*	*6,013*	*14*
Remainder of State	*91,149*	*8,098*	*6,046*	*7*	*14,144*	*16*
Rhode Island	*142,469*	*9,439*	*11,922*	*8*	*21,361*	*15*

Source of Data for Table/Methodology

Rhode Island Department of Education, 2017-2018 school year.

The out-of-school suspension 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.

*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.

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, Hope Academy, International Charter School, Kingston Hill Academy, The Learning Community, Rhode Island Nurses Institute Middle College Charter School, RISE Prep Mayoral Academy, 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 189)

High School Graduation Rate

DEFINITION

High school graduation rate is the percentage of students who graduate from high school within four years of entering, calculated by dividing the number of students who graduate in four years or fewer by the total number of first-time entering ninth graders (adjusted for transfers in and transfers out during the four years).

SIGNIFICANCE

High school graduation is the minimum requisite for college and most employment. In Rhode Island, adults without high school diplomas are more likely to be unemployed and have lower median incomes than adults with high school degrees.[1,2] In 2016, 10% 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]

Adopting student-centered learning practices at the high school level can increase achievement and engagement for all students. These practices encourage deeper engagement by personalizing learning, allowing students to take ownership over their work, and pacing learning to match the student's mastery of the content.[6] Providing students with high-quality postsecondary and workforce engagement opportunities can also increase high school graduation rates and college and career readiness.[7]

In order to graduate, Rhode Island students up through the Class of 2020 must demonstrate proficiency in English language arts, math, science, social studies, the arts, and technology and complete at least 20 courses and two performance-based assessments.[8] Students in the class of 2021 and later must complete one performance-based assessment and can earn Council designations, including a Seal of Biliteracy, Commissioner's Seal, and Pathway Endorsements.[9,10]

High School Graduation Rates

	2016-2017
RI	84%
US	85%
National Rank*	*29th*
New England Rank**	*6th*

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

Source: National Center for Education Statistics. (2018). *Table 1*. Retrieved March 18, 2019, from www.nces.ed.gov

Rhode Island Four-Year High School Graduation and Dropout Rates, by Student Subgroup, Class of 2018

	COHORT SIZE	DROPOUT RATE	% COMPLETED GED	% OF STUDENTS STILL IN SCHOOL	FOUR-YEAR GRADUATION RATE
Female Students	5,037	7%	2%	4%	88%
Male Students	5,497	10%	2%	7%	81%
English Learners	968	20%	1%	7%	72%
Students With Disabilities	1,672	16%	2%	20%	62%
Students Without Disabilities	8,862	7%	2%	3%	88%
Low-Income Students	5,891	13%	2%	8%	77%
Higher-Income Students	4,643	3%	1%	3%	93%
White Students	6,270	6%	2%	4%	87%
Asian Students	308	4%	2%	3%	92%
Black Students	915	9%	1%	8%	83%
Hispanic Students	2,638	13%	2%	8%	77%
Native American	78	22%	0%	9%	69%
ALL STUDENTS	*10,534*	*9%*	*2%*	*6%*	*84%*

Source: Rhode Island Department of Education, Class of 2018. Percentages may not sum to 100% due to rounding.

◆ **The Rhode Island four-year graduation rate for the Class of 2018 was 84%, up from 70% for the Class of 2008.[11,12]**

◆ **The highest dropout rates and lowest high school graduation rates were among English Learners, students with disabilities, low-income students, and Hispanic and Native American students.[13]**

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 11,053 Rhode Island students who enrolled in ninth grade in 2012, 9,227 (83%) graduated in four years in 2016, 352 (3%) graduated in five years in 2017, and 59 (1%) graduated in six years in 2018.[14]**

◆ **Of the 352 students who graduated in five years in 2017, 141 (40%) were students with disabilities and 45 (13%) were English learners. Of the 59 students who graduated in six years in 2018, 43 (73%) were students with disabilities and 2 (3%) were English learners.[15]**

Table 54. **High School Graduation Rates, Rhode Island, Class of 2018**

SCHOOL DISTRICT	FOUR-YEAR COHORT RATES				
	# OF STUDENTS IN COHORT	DROPOUT RATE	% COMPLETED GED	% STILL IN SCHOOL	FOUR-YEAR GRADUATION RATE
Barrington	294	1%	0%	2%	97%
Bristol Warren	221	5%	1%	7%	86%
Burrillville	183	11%	3%	3%	83%
Central Falls	184	16%	1%	8%	75%
Chariho	251	6%	2%	4%	88%
Coventry	367	4%	1%	2%	92%
Cranston	794	6%	3%	5%	86%
Cumberland	291	6%	4%	8%	82%
East Greenwich	185	1%	0%	2%	97%
East Providence	372	7%	2%	5%	86%
Exeter-West Greenwich	131	2%	1%	3%	95%
Foster-Glocester	175	5%	1%	2%	92%
Johnston	197	4%	2%	3%	92%
Lincoln	192	4%	5%	3%	88%
Middletown	140	6%	1%	6%	86%
Narragansett	120	6%	3%	5%	86%
Newport	178	13%	0%	3%	84%
North Kingstown	345	4%	3%	4%	89%
North Providence	246	6%	4%	5%	86%
North Smithfield	112	8%	0%	8%	84%
Pawtucket	480	14%	1%	6%	79%
Portsmouth	199	3%	2%	0%	96%
Providence	1,786	16%	1%	8%	75%
Scituate	112	4%	3%	3%	91%
Smithfield	161	3%	2%	2%	93%
South Kingstown	217	3%	<1%	2%	94%
Tiverton	137	5%	2%	4%	89%
Warwick	669	9%	3%	6%	83%
West Warwick	261	7%	3%	4%	85%
Westerly	191	8%	2%	7%	83%
Woonsocket	351	20%	<1%	8%	72%
Beacon Charter High School for the Arts	*57*	*0%*	*0%*	*4%*	*96%*
Blackstone Academy	*74*	*5%*	*0%*	*4%*	*91%*
Blackstone Valley Prep Mayoral Academy	*64*	*3%*	*0%*	*8%*	*89%*
Paul Cuffee Charter School	*64*	*0%*	*0%*	*8%*	*92%*
The Greene School	*51*	*4%*	*0%*	*4%*	*92%*
Highlander Charter School	*39*	*8%*	*3%*	*10%*	*79%*
RI Nurses Institute Middle College	*33*	*9%*	*0%*	*9%*	*82%*
Sheila "Skip" Nowell Leadership Academy	*76*	*42%*	*1%*	*42%*	*14%*
Trinity Academy for the Performing Arts	*25*	*0%*	*0%*	*0%*	*100%*
Village Green Virtual Public Charter School	*49*	*4%*	*2%*	*0%*	*94%*
William M. Davies Jr. Career & Technical High School	*171*	*3%*	*0%*	*4%*	*93%*
DCYF Schools	*42*	*71%*	*14%*	*10%*	*5%*
Metropolitan Regional Career and Technical Center	*229*	*4%*	*1%*	*3%*	*92%*
Four Core Cities	*2,801*	*16%*	*1%*	*8%*	*75%*
Remainder of State	*6,752*	*6%*	*2%*	*4%*	*88%*
Rhode Island	*10,534*	*9%*	*2%*	*6%*	*84%*

Source of Data for Table/Methodology

Rhode Island Department of Education, Class of 2018.

The 2018 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 2014-2015 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 Jamestown students can choose to attend high school in Narragansett or North Kingstown. DCYF includes students attending DCYF alternative schools.

New Shoreham and Rhode Island School for the Deaf are not reported because there are fewer than 10 students in these cohorts. These students are included in the state total.

References

[1] U.S. Census Bureau, American Community Survey, 2013-2017. Table S2301.

[2] U.S. Census Bureau, American Community Survey, 2013-2017. Table B20004.

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

[4] Fiester, L. (2013). *Early warning confirmed: a research update on third-grade reading.* Baltimore, MD: The Annie E. Casey Foundation.

[5-7] DePaoli, J. L., Balfanz, R., Bridgeland, J., Atwell, M., & Ingram, E.S. (2017). *Building a grad nation: Progress and challenge in raising high school graduation rates.* Retrieved March 14, 2019, from www.americaspromise.org

(continued on page 189)

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.[1] Between 2013 and 2017 in Rhode Island, adults with high school diplomas were 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 $32,734, compared to $53,036 for adults with bachelor's degrees.[3]

Many students, especially low-income students, 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 Advanced Placement (AP) courses and dual and concurrent enrollment; 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 target financial aid strategically to students with the greatest needs.[4]

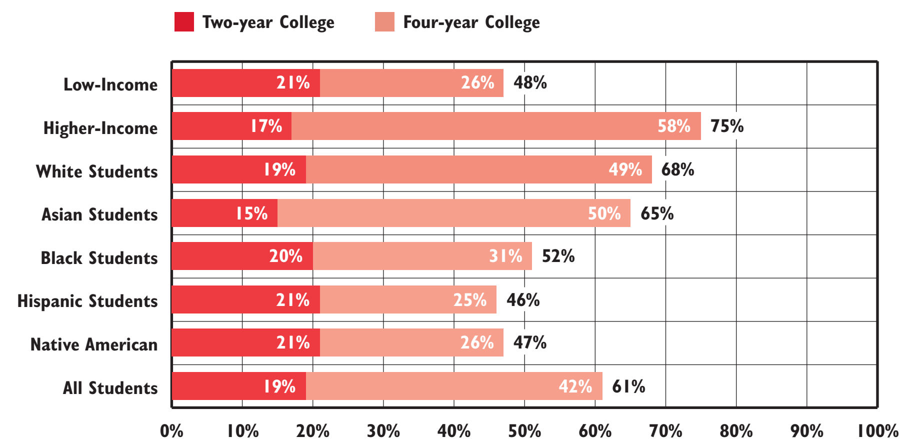
Students who participate in AP courses are likely to attend and succeed in college.[5] In 2018, 6,341 Rhode Island public school students took an AP course, 45% more than in 2015.[6,7]

Rhode Island covers the cost for all public high school students to take the SAT during the day in eleventh grade as a key strategy to increase college access.[8] In 2018, 95% of 11th graders completed the SAT. Statewide, 50% of 11th graders met expectations in English language arts and 30% met expectations in math on the SAT.[9]

Seniors who have completed a 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.[10] During the 2018-2019 cycle, Rhode Island ranked eighth in the U.S. for the number of high school seniors completing the FAFSA.[11]

Rhode Island's state Every Student Succeeds Act (ESSA) plan includes a proposed Post-Secondary Success Indicator that will initially measure the percentage of students that graduate with a career and technical education industry-approved credential, college credits through dual or concurrent enrollment, and/or successful completion of AP tests. Starting with the Class of 2021, this indicator will be further expanded to include the Seal of Biliteracy and the Pathway Endorsement.[12]

Immediate College Enrollment by Family Income, Race, Ethnicity, and Type of College, Class of 2017, Rhode Island



Source: Rhode Island Department of Education, Class of 2017. Percentages may not sum exactly due to rounding.

◆ **Sixty-one percent of Rhode Island students who graduated from high school in the Class of 2017 immediately enrolled in college. However, there are large gaps in college access, particularly four-year college enrollment, between low- and higher-income students as well as by race and ethnicity. Compared to the prior year, before the Rhode Island Promise Scholarship was available, the overall college enrollment rate has increased from 59% to 61%, the two-year college enrollment rate has increased from 16% to 19%, and the four-year college enrollment rate has decreased from 43% to 42%.[13]**

◆ **School counselors have an important role to play in setting students on a path to postsecondary success. In particular, Black students identify their school counselor as the person who had the most influence on their thinking about college.[14] Rhode Island has 424 students for every school counselor, far above the recommended ratio of 250 to one.[15]**

◆ **For states, improving college access 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, improving the quality of the K-12 education system, and aligning it with college and career expectations, simplifying the college admission process, and making college affordable.[16]**

Table 55.

College Preparation and Access, Rhode Island

SCHOOL DISTRICT	TOTAL GRADE 12 ENROLLMENT OCT. 2017	% OF GRADE 12 STUDENTS PLANNING TO ATTEND COLLEGE, 2018	% OF STUDENTS WHO FILLED OUT THE FAFSA, 2018	% OF GRADE 11 STUDENTS TAKING THE SAT DURING THE SCHOOL DAY, 2018	% OF SAT TAKERS PROFICIENT IN ELA , 2018	% OF SAT TAKERS PROFICIENT IN MATH, 2018
Barrington	305	95%	67%	97%	85%	80%
Bristol Warren	226	91%	64%	96%	61%	35%
Burrillville	192	88%	53%	100%	60%	42%
Central Falls	169	82%	51%	97%	14%	<5%
Chariho	242	85%	62%	97%	67%	47%
Coventry	367	89%	68%	96%	51%	27%
Cranston	806	89%	56%	97%	49%	27%
Cumberland	267	91%	64%	99%	66%	42%
East Greenwich	190	97%	72%	99%	85%	76%
East Providence	353	88%	52%	90%	43%	18%
Exeter-West Greenwich	136	NA	68%	99%	68%	50%
Foster-Glocester	175	88%	57%	96%	60%	37%
Johnston	236	91%	51%	97%	43%	22%
Lincoln	189	92%	66%	95%	72%	49%
Middletown	136	98%	65%	98%	60%	38%
Narragansett	124	96%	61%	89%	73%	55%
Newport	157	84%	73%	94%	34%	20%
North Kingstown	363	92%	63%	98%	81%	60%
North Providence	247	93%	57%	96%	44%	21%
North Smithfield	102	90%	65%	99%	70%	54%
Pawtucket	499	89%	46%	93%	23%	10%
Portsmouth	201	94%	66%	98%	75%	52%
Providence	1,512	86%	69%	90%	28%	15%
Scituate	113	95%	64%	99%	72%	37%
Smithfield	163	95%	80%	97%	70%	35%
South Kingstown	234	95%	65%	95%	69%	55%
Tiverton	149	90%	58%	96%	50%	32%
Warwick	677	85%	46%	95%	51%	25%
West Warwick	240	86%	58%	94%	50%	27%
Westerly	217	94%	52%	99%	67%	38%
Woonsocket	350	84%	51%	91%	33%	14%
Beacon Charter High School for the Arts	*58*	*74%*	*62%*	*96%*	*49%*	*20%*
Blackstone Academy	*75*	*93%*	*67%*	*99%*	*42%*	*16%*
Blackstone Valley Prep Mayoral Academy	*63*	*88%*	*84%*	*95%*	*64%*	*53%*
Paul Cuffee Charter School	*60*	*92%*	*78%*	*95%*	*31%*	*19%*
The Greene School	*48*	*94%*	*90%*	*98%*	*45%*	*19%*
Highlander Charter School	*40*	*86%*	*55%*	*100%*	*24%*	*14%*
RI Nurses Institute Middle College	*64*	*98%*	*61%*	*98%*	*13%*	*2%*
Sheila "Skip" Nowell Leadership Academy	*41*	*74%*	*24%*	*35%*	*<5%*	*<5%*
Trinity Academy for the Performing Arts	*26*	*85%*	*81%*	*100%*	*19%*	*<5%*
Village Green Virtual Public Charter School	*49*	*90%*	*73%*	*98%*	*14%*	*5%*
William M. Davies Jr. Career & Technical High School	*184*	*81%*	*56%*	*100%*	*42%*	*15%*
Metropolitan Regional Career and Technical Center	*229*	*87%*	*61%*	*98%*	*36%*	*12%*
Four Core Cities	*2,530*	*86%*	*61%*	*91%*	*27%*	*14%*
Remainder of State	*6,817*	*90%*	*60%*	*96%*	*60%*	*38%*
Rhode Island	*10,295*	*89%*	*60%*	*95%*	*50%*	*30%*

Source of Data for Table/Methodology

Total 12th grade enrollment is from the Rhode Island Department of Education as of October 1, 2017.

% of 12th grade students planning to attend college is from the 2017-2018 administration of Survey Works!, based on responses to the question, "What do you think you will do after you finish high school?" and includes students who responded that they planned to go to a community college, two-year college, or four-year college. Data are from the Rhode Island Department of Education.

The number of 12th graders completing the FAFSA is from U.S. Department of Education, Federal Student Aid, Rhode Island school-level data from the 2018-2019 cycle through June 2018, Retrieved March 17, 2019, from studentaid.ed.gov. The percentage of 12th graders completing the FAFSA is calculated by dividing the number of students completing applications into the number of 12th graders enrolled on October 1, 2017.

% of SAT takers proficient in ELA and math and % of 11th graders taking the SAT is from the Rhode Island Department of Education.

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. DCYF, New Shoreham and Rhode Island School for the Deaf are not reported because data reported would reflect fewer than 10 students. These students are included in the remainder of state and state totals as appropriate.

Little Compton students attend high school in Portsmouth, and Jamestown students can choose to attend high school in Narragansett or North Kingstown.

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

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, 2013-2017. Table S2301.

[3] U.S. Census Bureau, American Community Survey, 2014-2017. Table B20004.

(continued on page 189)

College Enrollment and Completion

DEFINITION

College enrollment and completion is the percentage of Rhode Island public high school students who enroll in a two- or four-year college and earn a college diploma (an associate's degree or bachelor's degree) within six years of enrollment.[1]

SIGNIFICANCE

By 2020, 71% of jobs in Rhode Island will require post-secondary education beyond high school, and yet only 35% of Rhode Island adults between the ages of 25 and 64 have a bachelor's degree or higher, and an additional 28% have some college or an associate's degree.[2,3] Between 2013 and 2017 in Rhode Island, 8.7% of adults with a high school diploma were unemployed, compared to 5.6% of those with some college or an associate's degree and 2.9% of those with a bachelor's degree or higher.[4] During that same period, the median annual income for adults with a high school diploma was $32,734, compared to $38,016 for adults with some college or an associate's degree and $53,036 for adults with a bachelor's degree.[5]

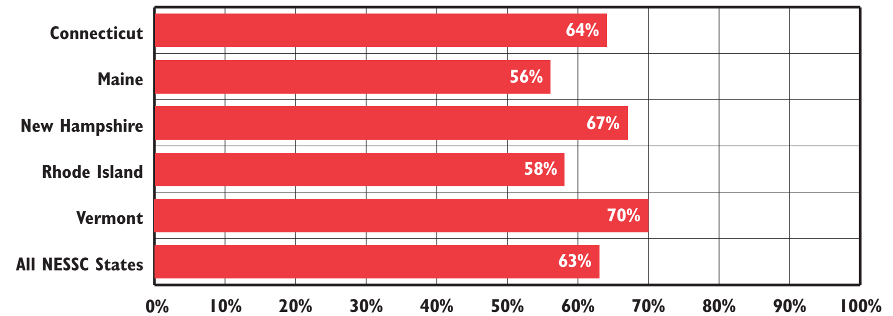
Students must complete college degrees to increase their income and reduce the risk of unemployment. While college enrollment rates have doubled in recent decades, there are still large gaps in the percentage of students who enroll in college, the types of colleges students enroll in, and the percentage who attain college degrees across different income groups.[6]

In the U.S., two-thirds of low-income students attend community colleges and for-profit institutions, many of which have low completion rates. Low-income students are also more likely to delay going to college and to have breaks in enrollment, both of which lower their chances of completing their college degrees.[7] There are also barriers to attainment for students of color. Addressing racial disparities can improve college completion outcomes and fulfill workforce needs.[8,9]

Low-income and first-generation college students often arrive at college less academically prepared than other students. They can benefit from a wide range of academic and social supports, including comprehensive assessment and placement, summer transition programs, peer-mentored and peer-facilitated programs that offer tutoring and other academic support, learning communities that allow a group of students to enroll in two or more classes together so they can establish peer relationships that support their success, personal and career counseling, mentoring, and/or referrals to social services.[10,11,12]

State policies that transform remediation practices, encourage full-time college attendance, and help students balance work and school, could further increase college completion rates.[13]

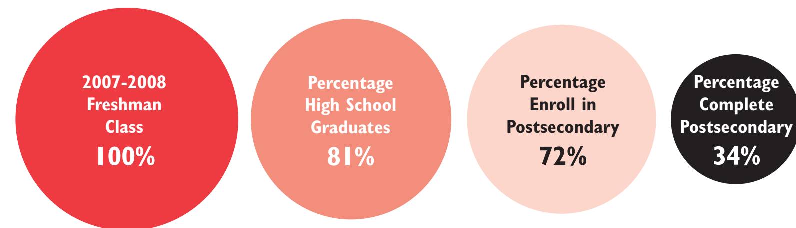
College Completion, New England Secondary School Consortium States (NESSC), 2011 Cohort



Source: *Common Data Project: 2018 annual report, school year 2016-2017.* (2018). Retrieved March 15, 2019, from www.newenglandssc.org

◆ **Fifty-eight percent of Rhode Island public high school graduates who enrolled in a two- or four-year college in 2011 earned a college diploma within six years, an increase of five percentage points from the 2010 cohort. In Rhode Island, there are large gaps in college completion between low-income and higher-income students, with 38% of low-income students completing college within six years, compared to 69% of higher-income students.**[14]

Pipeline to College Completion, Rhode Island, 2007-2008 High School Freshman Class



Source: Rhode Island Department of Education. (February 13, 2019). PrepareRI college readiness project: A system-wide effort to prepare all students for college success. Retrieved March 18, 2019, from www.ride.ri.gov

◆ **Of the students who were freshman in high school during the 2007-2008 school year, 81% had graduated from high school, 72% had enrolled in college, and 34% had completed college 10 years later.**[15]

Table 56.

College Enrollment and Completion, Rhode Island

SCHOOL DISTRICT	# OF STUDENTS WHO GRADUATED FROM HIGH SCHOOL IN 2017	# OF 2017 HS GRADUATES WHO ENROLLED IN COLLEGE WITHIN 6 MONTHS	% OF 2017 HS GRADUATES WHO ENROLLED IN COLLEGE WITHIN 6 MONTHS	# OF STUDENTS WHO ENROLLED IN COLLEGE IN 2016	# OF 2016 COLLEGE ENROLLEES WHO PERSISTED (ENROLLED FOR A THIRD SEMESTER)	% OF 2016 COLLEGE ENROLLEES WHO PERSISTED (ENROLLED FOR A THIRD SEMESTER)
Barrington	238	196	82%	253	244	96%
Bristol Warren	199	124	62%	185	160	86%
Burrillville	146	101	69%	117	98	84%
Central Falls	151	58	38%	91	57	63%
Chariho	300	183	61%	204	176	86%
Coventry	320	216	68%	291	237	81%
Cranston	678	429	63%	593	476	80%
Cumberland	284	202	71%	285	247	87%
East Greenwich	141	112	79%	171	163	95%
East Providence	293	167	57%	271	206	76%
Exeter-West Greenwich	123	81	66%	95	87	92%
Foster-Glocester	140	80	57%	109	94	86%
Johnston	169	108	64%	132	111	84%
Lincoln	178	136	76%	201	180	90%
Middletown	140	104	74%	124	107	86%
Narragansett	91	68	75%	100	87	87%
Newport	113	57	50%	77	61	79%
North Kingstown	299	233	78%	277	263	95%
North Providence	203	147	72%	197	164	83%
North Smithfield	108	87	81%	114	105	92%
Pawtucket	472	203	43%	283	205	72%
Portsmouth	239	191	80%	188	167	89%
Providence	1,212	596	49%	918	612	67%
Scituate	105	83	79%	95	92	97%
Smithfield	174	130	75%	142	126	89%
South Kingstown	231	172	74%	191	178	93%
Tiverton	112	73	65%	94	79	84%
Warwick	564	362	64%	482	400	83%
West Warwick	183	105	57%	133	108	81%
Westerly	188	123	65%	158	140	89%
Woonsocket	288	127	44%	201	139	69%
Beacon Charter High School for the Arts	*54*	*33*	*61%*	*42*	*30*	*71%*
Blackstone Academy	*39*	*20*	*51%*	*26*	*23*	*88%*
Paul Cuffee Charter School	*61*	*32*	*52%*	*43*	*30*	*70%*
The Greene School	*46*	*22*	*48%*	*24*	*20*	*83%*
Highlander Charter School	*16*	*0*	*0%*	*NA*	*NA*	*NA*
RI Nurses Institute Middle College	*52*	*28*	*54%*	*37*	*31*	*84%*
Sheila "Skip" Nowell Leadership Academy	*28*	*	*18%*	*11*	*	*45%*
Trinity Academy for the Performing Arts	*29*	*11*	*38%*	*28*	*23*	*82%*
Village Green Virtual Public Charter School	*75*	*37*	*49%*	*NA*	*NA*	*NA*
William M. Davies Jr. Career & Technical High School	*139*	*74*	*53%*	*145*	*106*	*73%*
Metropolitan Regional Career and Technical Center	*195*	*106*	*54%*	*132*	*93*	*70%*
Four Core Cities	*2,123*	*984*	*46%*	*1,493*	*1,013*	*68%*
Remainder of State	*5,979*	*4,078*	*68%*	*5,291*	*4,567*	*86%*
Rhode Island	*8,834*	*5,425*	*61%*	*7,244*	*5,918*	*82%*

Source of Data for Table/Methodology

of students who graduated from high school in 2017, # of 2017 high school graduates who enrolled in college within six months, # of students who enrolled in college in 2016, and # of 2016 college enrollees who persisted (were enrolled for a third semester) are all from Rhode Island Department of Education. The # of 2016 college enrollees who persisted may include students enrolled directly after high school or afterwards. Percentages may not sum exactly due to rounding.

Four core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Students from Little Compton attend high school in Portsmouth, and Jamestown students can choose to attend high school in Narragansett or North Kingstown.

New Shoreham, DCYF, and Rhode Island School for the Deaf are not reported because there are fewer than 10 students in these cohorts.

Data for Trinity Academy for the Performing Arts are from the National Student Clearinghouse report.

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

NA Schools did not have students graduating in this year.

References

[1] *Common Data Project: 2018 procedural guidebook.* (2018). Retrieved March 18, 2019, from http://newenglandssc.org

[2] 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.

[3] U.S. Census Bureau, American Community Survey, 2013-2017. Table B23006.

[4] U.S. Census Bureau, American Community Survey, 2013-2017. Table S2301.

[5] U.S. Census Bureau, American Community Survey, 2013-2017. Table B20004.

[6,7] 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.

(continued on page 190)

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 unemployed are included.

SIGNIFICANCE

School and work help teens acquire the skills, knowledge, experience, and supports they need to become productive adults. Youth 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, young mothers, and youth with disabilities have high rates of disconnection from both school and work.[1,2] Disconnected youth are more likely to live in poverty, experience poor physical and mental health, have a disability, be involved with the child welfare system, experience difficulties finding and maintaining employment, earn low wages, and need public benefits to make ends meet. Young people disconnected from both work and school are disproportionately people of color.[3,4,5]

Programs that offer post-secondary education or job training; provide high-quality early work experiences, adult mentoring, and youth development opportunities; and address root causes of inequity all decrease the likelihood of youth disconnection.[6,7,8] There is a real cost to youth disconnection. If we were to connect all youth, the federal government would gain an estimated $55 billion in annual tax revenue.[9]

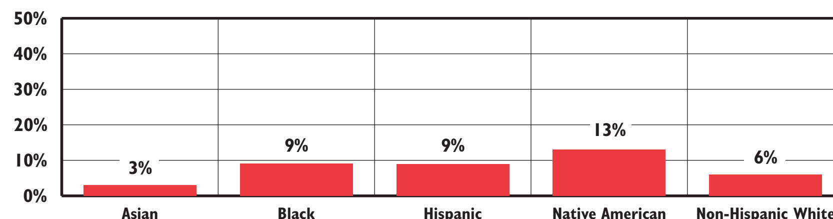
Between 2013 and 2017, an estimated 3,479 (5.7%) youth ages 16 to 19 in Rhode Island were not in school and not working. Of the youth who were not in school and not working, 54% were males, and 46% were females. Fifty-eight percent of these youth were high school graduates, and 42% had not graduated from high school.[10]

Teens Not in School and Not Working

	2017
RI	6%
US	7%
National Rank*	*16th*
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



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

◆ In the U.S., youth of color (with the exception of Asian youth) are more likely to be disconnected from school and work than White youth.[11] In 2016 among U.S. youth ages 16 to 19, 13% of Native American youth, 9% of Black youth, and 9% of Hispanic youth were not in school and not working, compared to 6% of White youth and 3% of Asian youth.[12]

◆ While Rhode Island has a low overall youth disconnection rate, there are striking racial and ethnic disparities. In 2015, 18.5% of Latino young adults ages 16 to 24 in Rhode Island were not in school and not working, which is nearly triple the White rate of 6.7%.[13]

◆ Youth disconnection has declined in recent years. In the U.S. in 2017, 7% of youth ages 16 to 19 reported being disconnected; compared to 10% in 2014. Older youth are more likely to be out of work and school than younger teens. In 2017, 11% of 18 to 19-year-olds were disconnected, compared to 4% of 16 to 17-year-olds.[14]

Compulsory School Attendance

◆ Rhode Island requires school attendance until age 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 2017, one state has compulsory attendance to age 19, 24 states (including Rhode Island) have compulsory attendance to age 18, 10 states to age 17, and 15 states to age 16.[16]

Connecting Youth to School and Work

◆ Education has a positive impact on the likelihood of finding and maintaining employment. Between 2013 and 2017, the unemployment rate for Rhode Island adults ages 25 to 64 with a bachelor's degree or higher was 2.9%, compared with 8.7% for high school graduates and 10.6% for those with less than a high school diploma.[17]

◆ Successful strategies to prevent youth disconnection must be comprehensive, including adequately funded K-12 public schooling, restorative discipline, a focus on healthy youth development and support services, multiple pathways to employment, and targeted post-secondary education and workforce development programs.[18,19,20]

◆ Programs and alternative schools that enable students to earn college credits while working toward their high school degrees can improve high school graduation rates and better prepare students for college completion and high-skill careers.[21]

Youth Work Experience

◆ Work experience during the teen years increases academic achievement, employability, and wages into early adulthood.[22]

◆ Public and private investment in summer work programs helps keep adolescents attached to constructive youth development activities, increases employment rates, and helps reduce youth violence.[23,24]

◆ Expanding work-based learning opportunities can help more youth in Rhode Island successfully transition into college and careers. These types of programs can help to motivate students, teach them critical skills, connect them with mentors and positive adult role models, and help them to make informed decisions about their future. Many work-based learning internship programs allow youth to receive school credit and/or earn money while gaining important workplace experience.[25]

References

[1,4,6,20] Lewis, K. & Burd-Sharps, S. (2018). *More than a million reasons for hope: Youth disconnection in America today.* Brooklyn, NY: Measure of America.

[2,5] Fernandes-Alcantara, A. L. (2018). *Vulnerable youth: Background and policies.* Washington, DC: Congressional Research Service.

[3,11,13,19] Burd-Sharps, S. & Lewis, K. (2017). *Promising gains, persistent gaps: Youth disconnection in America.* Brooklyn, NY: Measure of America.

[7] *Youth employment matters! Strengthening the youth-to-work pipeline through high-quality youth employment opportunities – Policy brief.* (2014). Washington, DC: Urban Alliance.

[8,18] Ross, M. & Kazis, R. (2016, May 24). *Employment and disconnection among teens and young adults: The role of place, race, and education.* Washington, DC: The Brookings Institution

[9] Lewis, K. & Gluskin, R. (2018). *Two futures: The economic case for keeping youth on track.* Brooklyn, NY: Measure of America.

[10] U.S. Census Bureau, American Community Survey, 2013-2017. Table B14005.

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

[14] *Disconnected youth.* (2018). Bethesda, MD: Child Trends

[15] Rhode Island General Law 16-19-1.

[16] National Center for Education Statistics. (2017). *Table 5.1. Compulsory school attendance laws, minimum and maximum age limits for required free education, by state: 2017.* Retrieved January 7, 2019, from nces.ed.gov

[17] U.S. Census Bureau, American Community Survey, 2013-2017. Table S2301.

[21] Early College Designs. (n.d.). *Reinventing high schools for postsecondary success.* Retrieved January 7, 2019, from www.jff.org

[22] *The Meaningful Youth Employment Initiative: A philanthropic campaign to increase community based jobs: 2016 investment guide.* (2016). Boston, MA: Youth Violence Prevention Funder Learning Collaborative.

[23] Ross, M. & Kazis, R. (2016). *Youth summer jobs programs: Aligning ends and means.* Washington, DC: Metropolitan Policy Program at Brookings.

[24] *Biennial employment and training plan FY18-19.* (2017). Cranston, RI: Governor's Workforce Board Rhode Island.

[25] *Workforce guidance.* (2018). Cranston, RI: Governor's Workforce Board.

Methodology

References

Committees

Acknowledgements

Methodology

The *2019 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 2013-2017 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 Factbooks prior to 2012, which were identified based on the child poverty rates reported in Census 2000. In Factbooks prior to 2012, 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 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 2013 and 2017. 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. Rates and percentages based on 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.

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 three-year estimates of the American Community Survey. Beginning with the *2016 Rhode Island Kids Count Factbook*, five-year estimates are used in all indicators that had used three-year estimates in prior Factbooks.

Margins of Error for Median Family Income and Children in Poverty

The 2013-2017 Median Family Income and Child Poverty data are estimates based on the American Community Survey, a sample survey. The reliability of estimates varies by community. In general, estimates for small communities are not as reliable as estimates for larger communities. The Margin of Error is a measure of the reliability of the estimate and is provided by the U.S. Census Bureau. The Margin of Error means that there is a 90% chance that the true value is no less than the estimate minus the Margin of Error and no more than the estimate plus the Margin of Error. Margins of Error are provided for all communities in the tables in this section.

Margins of Error, Median Family Income, Rhode Island, 2013-2017

CITY/TOWN	2013-2017 MEDIAN FAMILY INCOME FOR FAMILIES WITH CHILDREN UNDER AGE 18	MARGIN OF ERROR
Barrington	$153,318	$9,773
Bristol	$82,067	$16,450
Burrillville	$80,025	$11,027
Central Falls	$29,935	$2,501
Charlestown	$88,520	$7,427
Coventry	$100,471	$9,931
Cranston	$78,750	$6,812
Cumberland	$104,167	$11,031
East Greenwich	$158,889	$18,921
East Providence	$67,991	$8,918
Exeter	$109,957	$54,186
Foster	$101,250	$16,996
Glocester	$111,902	$11,218
Hopkinton	$101,837	$18,430
Jamestown	$151,836	$53,856
Johnston	$81,357	$20,651
Lincoln	$79,694	$25,444
Little Compton	$96,250	$28,679
Middletown	$74,836	$9,506
Narragansett	$134,706	$19,576
New Shoreham	$64,375	$32,325
Newport	$81,597	$18,398
North Kingstown	$107,455	$8,555
North Providence	$75,154	$6,632
North Smithfield	$106,047	$14,783
Pawtucket	$42,969	$3,022
Portsmouth	$115,101	$4,352
Providence	$37,183	$2,216
Richmond	$105,400	$19,272
Scituate	$93,929	$18,044
Smithfield	$121,579	$22,355
South Kingstown	$117,059	$10,339
Tiverton	$80,727	$9,442
Warren	$61,250	$16,352
Warwick	$85,346	$4,866
West Greenwich	$111,908	$10,787
West Warwick	$60,641	$7,192
Westerly	$72,143	$23,970
Woonsocket	$31,883	$5,605
Four Core Cities	*NA*	*NA*
Remainder of State	*NA*	*NA*
Rhode Island	*$72,430*	*$1,544*

Margins of Error, Children Living Below the Federal Poverty Threshold, Rhode Island, 2013-2017

CITY/TOWN	CHILDREN UNDER AGE 18 LIVING BELOW POVERTY, 2013-2017 #	MARGIN OF ERROR	%	MARGIN OF ERROR
Barrington	70	58	1.6%	1.29%
Bristol	229	128	7.2%	3.93%
Burrillville	456	197	14.1%	5.83%
Central Falls	2,297	399	41.5%	6.20%
Charlestown	132	95	10.4%	7.29%
Coventry	722	258	10.7%	3.73%
Cranston	2,296	517	14.4%	3.12%
Cumberland	774	259	11.0%	3.58%
East Greenwich	101	90	2.9%	2.59%
East Providence	919	275	11.1%	3.20%
Exeter	40	75	3.5%	6.56%
Foster	39	55	5.3%	7.35%
Glocester	153	105	7.7%	5.23%
Hopkinton	111	89	7.9%	6.20%
Jamestown	73	86	6.9%	7.98%
Johnston	692	279	13.6%	5.19%
Lincoln	648	213	13.3%	4.22%
Little Compton	41	51	7.2%	8.91%
Middletown	423	160	12.5%	4.58%
Narragansett	18	55	0.9%	2.73%
New Shoreham	28	41	30.8%	40.42%
Newport	743	198	21.2%	5.25%
North Kingstown	661	201	11.6%	3.42%
North Providence	482	184	9.0%	3.33%
North Smithfield	138	84	5.5%	3.25%
Pawtucket	4,913	596	30.9%	3.41%
Portsmouth	200	135	5.7%	3.83%
Providence	14,520	1,225	36.0%	2.81%
Richmond	68	83	4.2%	5.02%
Scituate	203	155	10.2%	7.66%
Smithfield	41	67	1.2%	2.01%
South Kingstown	388	154	8.4%	3.25%
Tiverton	218	108	8.0%	3.86%
Warren	324	144	19.1%	8.06%
Warwick	899	273	6.4%	1.92%
West Greenwich	1	48	0.1%	3.25%
West Warwick	1,040	312	19.8%	5.68%
Westerly	771	288	18.8%	6.77%
Woonsocket	3,357	500	38.5%	4.76%
Four Core Cities	25,087	915	35.6%	1.18%
Remainder of State	14,142	675	10.3%	0.48%
Rhode Island	39,229	1,878	18.9%	0.89%

For source information see page 25.

Methodology

Methodology for Homeless Children

The number of homeless children identified by public schools is based on the federal *McKinney-Vento Act* definition of homelessness and includes children living in emergency and transitional shelters, as well as children doubling up in homes with relatives and friends and living in hotels and motels, cars, campsites, parks, and other public places. Schools report the number of children by grade and the child's primary nighttime residence (i.e., sheltered, doubled-up, unsheltered, or in a hotel/motel). The total number of students identified by school districts may be higher than the total for Rhode Island if students were identified as homeless by multiple school districts in which they were enrolled.

Methodology for Children with Lead Poisoning

In 2012, the Centers for Disease Control and Prevention (CDC) lowered the threshold for which a child is considered to have an elevated blood lead level from ≤10 µg/dL to ≤5 µg/dL.

This new threshold, also called a reference value, is based on the U.S. population of children age one through five who are in the highest 2.5% of children when tested for lead in their blood. The CDC will update the reference value every four years using the two most recent National Health and Nutrition Examination Surveys (NHANES). Because no safe blood lead level in children has been identified, the CDC also will no longer use the term "level of concern" when talking about those children whose blood lead level exceed the reference value and require case management. Instead, they will replace that term with the reference value and the date of the NHANES that was used to calculate the reference value. For more information on this policy change, see www.cdc.gov.

Rhode Island law requires providers to conduct at least two blood lead screening tests on all children between the ages of nine and 36 months and to continue screening annually through age six.

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 youth 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, kidnapping, fighting, intimidating witness, stalking, cyber-stalking, 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 Four Core Cities and Remainder of State calculations.

Rhode Island Common Assessment Program (RICAS)

Starting in the 2017-2018 school year, Rhode Island began using a new statewide assessment, the *Rhode Island Common Assessment Program (RICAS).* The *RICAS* is aligned to the Common Core State Standards. The English language arts *RICAS* assesses students' ability to read and comprehend complex texts, use different sources to compare and synthesize ideas, and write effectively. The math *RICAS* 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 *RICAS* assessment, divided by the number of students who took that assessment.

RICAS 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 *RICAS* replaced the *Partnership for Assessment of Readiness for College and Careers (PARCC)*, which was administered in Rhode Island between 2014 and 2017. Results from the *RICAS* are not comparable with *PARCC* assessment tests.

Rhode Island totals may not be the same as the sum of the districts because results for districts with fewer than 10 students are not reported by RIDE. An asterisk is used when there are fewer than 10 students in a category to protect student confidentiality. These students are still counted in district totals and in the four core cities, remainder of the state, and state totals.

Methodology for Schools Identified for Intervention

The Rhode Island Department of Education (RIDE) classifies schools based on a Star Rating System that is comprised of a broad range of indicators including: proficiency levels on the *RICAS* English language arts and math assessments, student growth, graduation rate, English language proficiency, percentage of students exceeding expectations, student and teacher chronic absenteeism, and suspensions.

RIDE uses a one- to five-star rating. Schools with one-star ratings are low performing in multiple indicators. Schools identified for comprehensive support and improvement are designated one-star and are the lowest performing 5% of all schools. Schools with five-star ratings have strong performance in all indicators.

Early Learning Centers, Pre-K programs, and preschools are not rated and therefore not included in the classifications.

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 2018 federal poverty threshold was $20,231 for a family of three with two children and $25,465 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 poverty 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 2019 Federal Poverty Guidelines

FEDERAL POVERTY GUIDELINES	ANNUAL INCOME FAMILY OF THREE	ANNUAL INCOME FAMILY OF FOUR
50% FPL	$10,665	$12,875
100% FPL	$21,330	$25,750
130% FPL	$27,729	$33,475
150% FPL	$31,995	$38,625
180% FPL	$38,394	$46,350
185% FPL	$39,461	$47,638
200% FPL	$42,660	$51,500
225% FPL	$47,993	$57,938
250% FPL	$53,325	$64,375

(continued from page 11)

References for Children in Single Parent Families

[15,16,18] VanOrman, A. G. & Scommegna, P. (2016). Understanding the dynamics of family change in the United States. *Population Bulletin, 71*(1).

[17] *Births to unmarried women.* (2016). Washington, DC: Child Trends

(continued from page 13)

References for Grandparents Caring for Grandchildren

[18] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), December 31, 2018.

[19] Children's Defense Fund. (2015) *The Title IV-E Guardianship Assistance Program (GAP): An update on implementation and moving GAP forward.* Retrieved January 18, 2019 from www.grandfamilies.org.

[20] Children's Bureau. (2013). *Title IV-E Guardianship Assistance.* Retrieved January 18, 2019, from www.acf.hhs.gov

(continued from page 15)

References for Mother's Education Level

[7] 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 February 11, 2019, www.rwjf.org/en/library/research/2011/05/education-matters-for-health.html

[8] Jiang, Y., Ekono, M., & Skinner, C. (2016). *Basic facts about low-income children: Children under 18 years, 2014.* New York, NY: Columbia University, National Center for Children in Poverty.

[9] U.S. Census Bureau, American Community, 2013-2017. Table B20004.

[11] 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.

[13] U.S. Census Bureau, American Community Survey, 2013-2017. Table S1702.

(continued from page 17)

References for Racial and Ethnic Diversity

[16] The Annie E. Casey Foundation KIDS COUNT Data Center. (2018). *Children in immigrant families–2016.* Retrieved January 10, 2019, from datacenter.kidscount.org

[17] The Annie E. Casey Foundation KIDS COUNT Data Center. (2018), *Children in immigrant families whose resident parents have been in the country five years or less–2016.* Retrieved January 10, 2019, from datacenter.kidscount.org

[18] The Annie E. Casey Foundation KIDS COUNT Data Center. (2016). *Children living below the poverty threshold by family nativity–2016.* Retrieved February 5, 2018, from datacenter.kidscount.org

[19] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2012-2016. 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. (2016). *Children living in linguistically isolated households by family nativity–2016.* Retrieved February 5, 2018, from datacenter.kidscount.org

(continued from page 21)

References for Racial and Ethnic Disparities

[31] *Racial and ethnic disparity and disproportionality in child welfare and juvenile justice: A compendium.* (2009). Washington, DC: Center for Juvenile Justice Reform.

[32] Rhode Island Department of Education, *Rhode Island Comprehensive Assessment System (RICAS)*, 2018.

[34,44] Rhode Island Department of Education, Class of 2017 for immediate college enrollment and Class of 2018 for four-year high school graduation rate.

[35] Losen, D. J. (2011). *Discipline policies, successful schools, and racial justice.* Boulder, CO: National Education Policy Center.

[36] *2013-2014 Civil Rights Data Collection a first look: Key data highlights on equity and opportunity gaps in our nation's public schools.* (2016). Washington, DC: U.S Department of Education, Office for Civil Rights.

[37] Rhode Island Department of Education, 2017-2018 school year.

[40] KIDS COUNT. (2017). *2017 race for results policy report.* Baltimore, MD: The Annie E. Casey Foundation.

[45] 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)

**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 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] Federal Interagency Forum on Child and Family Statistics. (2017). *America's children: Key national indicators of well-being, 2017.* 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] Rhode Island KIDS COUNT calculations using data from Rhode Island Housing, 2018.

[5,6] Aurand, A., Emmanuel, D., Yentel, D., Errico, E., & Pang, M. (2018). *Out of reach 2018: The high cost of housing.* Washington, DC: National Low Income Housing Coalition.

[7,10] HousingWorks RI. (2018). *2018 housing fact book.* Providence, RI: HousingWorks RI at Roger Williams University.

[8] U.S. Department of Housing and Urban Development. (n.d.). *Housing choice vouchers fact sheet.* Retrieved January 29, 2019, from www.hud.gov

[9] Budget at a Glance (2015). *FY 2015 budget at a glance.* Retrieved February 1, 2019, from www.rilegislature.gov

[11] Rhode Island Housing, Rhode Island Rent Survey, 2014-2018.

[12] U.S. Census Bureau, American Community Survey, 2008. Table DP04.

[13] U.S. Census Bureau, American Community Survey, 2017. Table DP04.

[14] Children's Health Watch. (n.d.) Energy insecurity. Retrieved January 29, 2019, from www.childrenshealthwatch.org

[15] *Rules and regulations governing the termination of residential electric, gas and water utility service.* (2008). Providence, RI: State of Rhode Island and Providence Plantations Public Utilities Commission.

[16] Rhode Island Department of Human Services. (n.d.). *HEAP program information.* Retrieved February 1, 2019, from www.dhs.ri.gov

[17] LIHEAP Clearinghouse. (2018). *LIHEAP and WAP funding: LIHEAP 2018 State, tribe and territory regular block grant allocations, second release.* Retrieved January 29, 2019, from liheapch.acf.hhs.gov

[18] Rhode Island General Law 37-1-27.12. Enacted by the General Assembly as H-8163 SubA in 2016.

(continued from page 29)

References for Homeless Children

[3] National Alliance to End Homelessness. (2018). *What causes homelessness?* Retrieved February 20, 2019, from endhomelessness.org

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

[7,9] National Child Traumatic Stress Network. (2014). *Complex trauma: Facts for shelter staff working with homeless children and families.* Retrieved February 20, 2019, 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 20, 2019, from www.nctsn.org

[11] Rhode Island Emergency Shelter Information Project, 2018.

[12] *Help starts here. Solving problems and changing lives since 2007.* (2017). Providence, RI: United Way 211 Rhode Island. Retrieved February 20, 2019, from www.uwri.org

[13,15] U.S. Department of Education. (2016). *Supporting the success of homeless children and youths.* Retried February 25, 2019, from www2.ed.gov

[14,16] Education Leads Home. (n.d.). *State snapshot on student homelessness: Rhode Island.* Retrieved February 19, 2019, from www.americaspromise.org

[17] Rhode Island Department of Education, 2016-2017 school year.

[18] U.S. Department of Education (2016). *Education for Homeless Children and Youth Program Non-Regulatory Guidance.*

[20,22] U.S. Department of Health & Human Services Office of Child Care. (2016). *Child Care and Development Fund final rule frequently asked questions.* Retrieved February 19, 2019, from www.acf.hhs.gov

[21] National Association for the Education of Homeless Children and Youth. *Supporting Children and Families Experiencing Homelessness: A Child Care Development Fund State Guide.* Retrieved February 19, 2019, from www.naehcy.org

(continued from page 31)

References for Secure Parental Employment

[10] U.S. Census Bureau, American Community Survey, 2013-2017. Table B17016.

[11] *The 2018 Rhode Island Standard of Need.* (2018). Providence, RI: The Economic Progress Institute.

[12] U.S. Census Bureau, American Community Survey, 2013-2017. Table DP03.

[13] *Policy basics: Temporary Assistance for Needy Families.* (2018). Washington, DC: Center for Budget and Policy Priorities.

[14] Glynn, S. J., Boushey, H., & Berg, P. (2016). *Who gets time off? Predicting access to paid leave and workplace flexibility.* Washington, DC: Center for American Progress.

[15] Sole-Smith, V. (2016). *The high cost of unpaid leave.* Retrieved January 10, 2019, from www.theinvesitgativefund.org

[16] Rhode Island Department of Labor and Training. (2014). *Temporary Caregiver Insurance [Brochure].*

[17] National Conference of State Legislatures. (2018). *Paid family leave resources.* Retrieved January 8, 2019, from www.ncsl.org

[18] U.S. Census Bureau, American Community Survey, 2013-2017. Table S2301.

[19] Sherman, A., Trisi, D., & Parrott, S. (2013). *Various supports for low-income families reduce poverty and have long-term positive effects on families and children.* Washington, DC: Center on Budget and Policy Priorities.

[20] Glynn, S. J. (2014). *Breadwinning mothers, then and now.* Washington, DC: Center for American Progress.

[21] *The U.S. and the high cost of child care, appendices.* (2018). Arlington, VA: Child Care Aware of America.

[22] Rhode Island Senate Fiscal Office *Child Care Assistance Program.* (2015). Providence, RI: Rhode Island Senate Fiscal Office.

[23] U.S. Department of Health and Human Services. (2019). *Poverty guidelines.* Retrieved January 16, 2019, from https://aspe.hhs.gov

[24] Rhode Island General Law 40-5.2-20. Enacted by the General Assembly as Article 9 of H-5175 Aaa in 2017.

[25] Williams, E. & Waxman, S. (2018). *States can adopt or expand Earned Income Tax Credits to build a stronger future economy.* Washington, DC: Center on Budget and Policy Priorities.

[26] *Policy basics: The Earned Income Tax Credit.* (2018). Washington, DC: Center on Budget and Policy Priorities.

[27] Marr, C., Huang, C., Sherman, A., & DeBot, B. (2015). *EITC and Child Tax Credit promote work, reduce poverty, and support children's development, research finds.* Washington, DC: Center on Budget and Policy Priorities.

[28] National Conference of State Legislatures. (2018). *Tax credits for working families: Earned Income Tax Credit (EITC).* Retrieved January 8, 2019, from www.ncsl.org

References

[29] Internal Revenue Service. (2018) *Statistics for 2017 tax returns with EITC.* Retrieved January 8, 2019, from www.eitc.irs.gov

[30] *Policy basics: The Child Tax Credit.* (2018). Washington, DC: Center on Budget and Policy Priorities.

(continued from page 33)

References for Paid Family Leave

[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. (2015). Paid family leave's effect on hospital admissions for pediatric abusive head trauma. *Injury Prevention,* 1-4.

[9] Plotka, R. & Busch-Rossnagle, N. A. (2018). The role of length of maternity leave in supporting mother-child interactions and attachment security among American mothers and their infants. *International Journal of Child Care and Education Policy, 12*(2), 1-18.

[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.

[12,13,14,15] Rhode Island Department of Labor and Training, 2018.

(continued from page 35)

References for Children Receiving Child Support

[3] U.S. Office of Child Support Enforcement, Administration for Children & Families. (n.d.). *OCSE fact sheet.* Retrieved January 29, 2019, from www.acf.hhs.gov

[4,7,10] Sorensen, E. (2016). *The Child Support Program is a good investment.* Washington, DC: U.S. Office of Child Support Enforcement, Administration for Children & Families.

[5] Grall, T. (2018). Custodial mothers and fathers and their child support: 2015. *Current Population Reports, Series P60-262.* Washington, DC: U.S. Census Bureau.

[6,9,27] Hahn, H., Edin, K., & Abrahams, L. (2018). *Transforming child support into a family-building system.* Washington, DC: U.S. Partnership on Mobility from Poverty.

[8] Center for Family Policy and Practice. (2016). *Policy briefing, 16*(3), 2-3.

[11,12,14,16,21,22,24] Rhode Island Department of Human Services, Office of Child Support Services, 2009-2018.

[15] Rhode Island General Law Section 15-5-16.2. Enacted by the General Assembly as H-5553 SubA in 2017.

[17] Rhode Island Office of Child Support Services. (n.d.). *Medical support.* Retrieved January 30, 2019, from www.cse.ri.gov

[18] Rhode Island Coalition Against Domestic Violence, Women's Resource Center, and Rhode Island Department of Human Services. (n.d.). *The Family Violence Option Advocacy Program (FVOAP).* Retrieved January 30, 2019, from www.dhs.ri.gov

[23] Rhode Island Department of Human Services. (2010). Child Support Program, Section 0700, Rules and Regulations.

[25] National Conference of State Legislatures. (2017). *Child support pass-through and disregard policies for public assistance recipients.* Retrieved January 31, 2019, from www.ncsl.org

[26,28] Center for Law and Social Policy. (2016, September 16). *Child support pass-through amounts must be increased.* Retrieved January 31, 2019, from www.clasp.org

(continued from page 39)

References for Children in Poverty

[7,13,21] Koball, H., & Jiang, Y. (2018). *Basic facts about low-income children: Children under 18 years, 2016.* New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.

[8] National Center for Children in Poverty. (2018). *Rhode Island demographics of poor children.* Retrieved January 14, 2019, from www.nccp.org

[9,19] U.S Census Bureau. (n.d.). *Poverty thresholds for 2018 by size of family and number of related children under 18 years.* Retrieved February 5, 2019, from www.census.gov

[10] Fox, L. (2018). *The Supplemental Poverty Measure: 2017.* Washington, DC: U.S. Census Bureau.

[11] *The 2018 Rhode Island standard of need.* (2018). Providence, RI: The Economic Progress Institute.

[12] U.S. Census Bureau, American Community Survey, 2013-2017. Tables S1701.

[14,15,16] U.S. Census Bureau, American Community Survey, 2013-2017. Tables B17020A, B17020B, B17020C, B17020D, B17020E, B17020F, B17020G, & B17020I

[17] U.S. Census Bureau, American Community Survey, 2017. Table C17024.

[18,20] Population Reference Bureau analysis of 2013-2017 American Community Survey data.

[23] Frank, D. A., et al. (2010). Cumulative hardship and wellness of low-income, young children: Multisite surveillance study. *Pediatrics, 125*(5), e1115-e1123.

[24] Prosperity Now. (n.d.). *Prosperity Now scorecard financial assets and income: Unbanked households.* Retrieved January 18, 2019, from http://scorecard.prosperitynow.org

[25] Federal Deposit Insurance Corporation. (n.d.). *What is economic inclusion?* Retrieved January 18, 2019, from https://economicinclusion.gov

[26] Yun, A. (2017). *Financial exclusion: Why it is more expensive to be poor.* Retrieved January 24, 2019, from https://publicpolicy.wharton.upenn.edu

[27] *Payday lending in America: Policy solutions.* (2013). Philadelphia, PA: Pew Charitable Trusts

[28] *2017 FDIC National Survey of Unbanked and Underbanked Households.* (2018). Washington, DC: Federal Deposit Insurance Corporation.

[29] *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.

[30] Bourke, N., Karpekina, O., & Kravitz, G. (2018). *As payday loan market changes, states need to respond.* Retrieved January 22, 2019, from www.pewtrusts.org

[31] Prosperity Now. (n.d.). *Prosperity Now scorecard financial assets and income: Predatory small-dollar lending protections.* Retrieved January 24, 2019, from http://scorecard.prosperitynow.org

[32] Gehr, J. (2018). *Eliminating asset limits: Creating savings for families and state governments.* Washington, DC: Center for Law and Social Policy.

[33] Rhode Island Secretary of State. (2019). *Rhode Island Works Program rules and regulations* 218-RICR-20-00-2. Retrieved January 24, 2019, from sos.ri.gov

[34] Heffernan, C., Goehring, B., Hecker, I., Giannarelli, L., & Minton, S. (2018). *Welfare rules databook: State TANF policies as of July 2017,* OPRE Report 2018-109. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

[35] Trisi, D. (2018). *Economic security programs cut poverty nearly in half over last 50 years, new data show.* Washington, DC: Center on Budget and Policy Priorities.

[36] *Key facts about the uninsured population.* (2018). Washington, DC: The Henry J. Kaiser Family Foundation.

[37] Federal Interagency Forum on Child and Family Statistics. (2018) *America's children in brief: Key national indicators of well-being, 2018.* Washington, DC: U.S. Government Printing Office.

[38] Rhode Island KIDS COUNT analysis of average weekly rates from Silver, B. E. (2018). *Statewide survey of childcare rates in Rhode Island.* Kingston, RI: University of Rhode Island.

[39] Schmit, S., Ullrich, R., Cole, P., Gebhard, B., & Matthews, H. (2017). *Child care assistance: A critical support for infant, toddlers, and families.* Washington, DC: ZERO to THREE and Center for Law and Social Policy.

[40] 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.

[41] *A stronger nation: Learning beyond high school builds American talent, Rhode Island's report 2018.* (2018). Indianapolis, IN: Lumina Foundation.

[42] Rhode Island Housing, Rhode Island Annual Rent Survey, 2018.

[43] Rhode Island KIDS COUNT analysis of data from Rhode Island Housing, Rhode Island Rent Survey, 2018.

[44] Fischer, W., & Sard, B. (2017). *Chart book: Federal housing spending is poorly matched to need: Tilt toward well-off homeowners leaves struggling low-income renters without help.* Washington, DC: Center for Budget and Policy Priorities.

[45] Rhode Island Department of Human Services, Office of Child Support Services, 2018.

[46] Sorenson, E. (2016). *The Child Support Program is a good investment.* Washington, DC: Office of Child Support Enforcement, U.S. Department of Health and Human Services.

[47] Grall, T. (2018). Custodial mothers and fathers and their child support: 2015. *Current Population Reports, Series P60-262.* Washington, DC: U.S. Census Bureau.

(continued from page 43)

References for Children in Families Receiving Cash Assistance

[4,10,12,13,15,25,28,29,31,34,37,42] Rhode Island Department of Human Services, InRhodes Database and RI Bridges Database, December 1996-2018.

[6] Rhode Island Secretary of State. (2018). *Child Support Program rules and regulations* 218-RICR-30-00-1. Retrieved January 30, 2019, from sos.ri.gov

[7] Rhode Island Department of Human Services, Office of Child Support Services, 2019.

[9] Burnside, A. & Floyd, I. (2019). *TANF benefits remain low despite recent increases in some states.* Washington, DC: Center on Budget and Policy Priorities.

[11] Rhode Island Department of Human Services. Testimony given at October 2012 Caseload Estimating Conference, Providence, RI.

[14] U.S. Census Bureau, American Community Survey, 2017. Table C17024.

[18] Heffernan, C., Goehring, B., Hecker, I., Giannarelli, L., & Minton, S. (2018). *Welfare rules databook: State TANF policies as of July 2017.* OPRE report 2018-109. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

[20] Elizabeth Houghton and Maria D. Mendez v. Gary Alexander, Director of the RI Department of Human Services, P.C. 10-5625 (Superior Court 2010).

[23] *Family Independence Program: Ten years in review: 2007 annual report.* (2007). Cranston, RI: Rhode Island Department of Human Services.

[24] House Fiscal Advisory Staff. (2018). *Budget as enacted, Fiscal Year 2019.* Providence, RI: Rhode Island House of Representatives.

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

[35] Barden, B. (2013). *Assessing and serving TANF recipients with disabilities.* OPRE report 2013-56. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

[38] *Policy basics: Temporary Assistance to Needy Families.* (2018). Washington, DC: Center on Budget and Policy Priorities.

[39] *Request for proposals: Adult education funding for July 1, 2018 – June 30, 2021.* (2018). Providence, RI: Rhode Island Department of Elementary and Secondary Education.

[40] 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.

[41] U.S. Census Bureau, American Community Survey, 2013-2017. Table S2301.

[43] Hamilton, G. (2012). *Improving employment and earnings for TANF recipients.* Washington, DC: Urban Institute.

[44] Lower-Basch, E. (2018). *Work participation rate: Temporary Assistance for Needy Families.* Washington, DC: Center for Law and Social Policy.

(continued from page 45)

References for Children Receiving SNAP Benefits

[11,13,17,18] Rhode Island Department of Human Services, InRhodes Database, 2009-2015 and RI Bridges Database, 2016-2018.

[15] Wheaton, L. & Tran, V. (2018). *The antipoverty effects of SNAP.* Washington, DC: Urban Institute.

[19] Beane, E. J. (2017). *An assessment of the Unified Health Infrastructure Project: A report to Governor Gina M. Raimondo.* Retrieved March 7, 2017, from www.transparency.ri.gov

[20] Coleman-Jensen, A., Rabbitt, M. P., Gregory, C. A., & Singh, A. (2018). *Household food security in the United States in 2017, ERR-256.* Washington, DC: U.S. Department of Agriculture, Economic Research Service.

[21] U.S. Department of Agriculture, Food and Nutrition Service. (2018) *Programs and services.* Retrieved January 28, 2019, from www.fns.usda.gov

[22] *2018 status report on hunger in Rhode Island.* (2018). Providence, RI: Rhode Island Community Food Bank.

[23,26] *Improving SNAP and Medicaid access: SNAP interviews.* (2018). Washington, DC: Center on Budget and Policy Priorities and Center for Law and Social Policy.

[24] *Improving SNAP and Medicaid access: SNAP renewals.* (2018). Washington, DC: Center on Budget and Policy Priorities and Center for Law and Social Policy.

[25,27] U.S. Department of Agriculture, Food and Nutrition Service. (2018). *State options report: Supplemental Nutrition Assistance Program.* Retrieved January 29, 2019, from www.fns.usda.gov

(continued from page 47)

References for Women and Children Participating in WIC

[9] U.S. Department of Agriculture, Food and Nutrition Service. (2014). *USDA finalizes changes to the WIC Program, expanding access to healthy fruits and vegetables, whole grains, and low-fat dairy for women, infants, and children* [Press release]. Retrieved from www.fns.usda.gov

[11,12,13,14,16,18] Rhode Island Department of Health, WIC Program, 2018.

[15] U.S. Department of Agriculture, Food and Nutrition Service. (2015). *WIC at a glance.* Retrieved January 11, 2019, from www.fns.usda.gov

[17] U.S. Department of Agriculture, Food and Nutrition Service. (2017). *WIC Farmers' Market Nutrition Program (FMNP).* Retrieved January 11, 2019, from www.fns.usda.gov

(continued from page 49)

Source of Data for Table/Methodology for Children Participating in School Breakfast

Children are counted as low-income if they are eligible for the 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 for Children Participating in School Breakfast

[1,9,13,16] Girouard, D., FitzSimons, C., & Rosso, R. (2019). *School breakfast scorecard: School year 2017-2018.* Washington, DC: Food Research and Action Center.

[2] Cullen, K. W., & Chen, T. (2017). The contribution of the USDA school breakfast and lunch program meals to student daily dietary intake. *Preventive Medicine Reports 5*(2017), 82-85.

[3] Food Research and Action Center. (2016). *Research brief: Breakfast for learning.* Retrieved February 21, 2019, from www.frac.org

[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.

[5] Food Research and Action Center. (2016). *Research brief: Breakfast for health.* Retrieved February 21, 2019, from www.frac.org

References

[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] Rhode Island Department of Education. (n.d.). *RIDE's child nutrition programs: School Breakfast Program.* Retrieved February 22, 2019, from www.ride.ri.gov

[8,12,15] Maurice, A., & Rosso, R. (2019). *School breakfast: Making it work in large school districts.* Washington, DC: Food Research and Action Center.

[10,11] Hewins, J., Rosso, R., & Maurice, A. (2017). *Community Eligibility continues to grow in the 2016-2017 school year.* Washington, DC: Food Research and Action Center.

[14,17] Rhode Island Department of Education, Child Nutrition Programs, Office of Statewide Efficiencies, October 2018.

(continued from page 53)

References for Children's Health Insurance

[7] *Health coverage for parents and caregivers helps children.* (2017). Washington, DC: Georgetown University Health Policy Institute Center for Children and Families.

[8,18] Rhode Island Executive Office of Health & Human Services. (2019). *Healthcare programs.* Retrieved February 12, 2019, from www.eohhs.ri.gov

[9,16,20] Rhode Island Executive Office of Health and Human Services, MMIS Database, December 31, 2018 and June 30, 2017.

[10] U.S. Census Bureau, American Community Survey, 2013-2017. Table S2702.

[11] U.S. Census Bureau, American Community Survey, 2017. Table GCT2702.

[12] U.S. Census Bureau, American Community Survey, 2011-2013 & 2017. Tables B27001A, B27001B, B27001C, B27001D, B27001H, & B27001I.

[13,14] U.S. Census Bureau, American Community Survey, 2017. Table R2702.

[15] U.S. Census Bureau, American Community Survey, 2017. Table B27010.

[17] U.S. Census Bureau, American Community Survey, 2017. Table B09001.

[19] Population Reference Bureau analysis of U.S. Census Bureau, American Community Survey data, 2013-2017.

[21] HealthSource RI, Enrollment Report, Calendar Year 2018.

(continued from page 55)

References for Childhood Immunizations

[3] Centers for Disease Control and Prevention. (2018). *Why immunize?* Retrieved January 21, 2019, from www.cdc.gov

[4] Centers for Disease Control and Prevention. (2018). *About VFC.* Retrieved January 21, 2019, from www.cdc.gov

[5] U.S. Department of Health & Human Services. (2017). *Will the Affordable Care Act cover my flu shot?* Retrieved January 21, 2019, from www.cdc.gov

[6] Rhode Island Department of Health. (n.d.). *Childhood Immunization Program.* Retrieved January 21, 2019, from www.health.ri.gov

[7,14] State of Rhode Island and Providence Plantations. (2014). *Rules and regulations pertaining to immunization and testing for communicable diseases.* (Department of Health Publication R23-1-IMM). Providence, RI: Rhode Island Department of Health.

[8,21] Rhode Island Department of Health. (n.d.). *Immunization Information for Schools and Child Care Workers.* Retrieved January 21, 2019, from www.health.ri.gov

[9,17,18] Rhode Island Department of Health analysis of data from the *National Immunization Survey-Children*, 2017.

[10] Hill, H.A>, Elam-Evans, L.D., Yankey, D., Dingleton, J., Kamg, Y. Vaccination coverage among children aged 19-35 months – United States, 2017. *Morbidity and Mortality Weekly Report, 67*(40), 1123-1128.

[11] Hough-Telford, C., et al. (2016). Vaccine delays, refusals, and patient dismissals: A survey of pediatricians. *Pediatrics, 138*(3), 1-9.

[12] Edwards, K. M. & Hackell, J. M. (2016). Countering vaccine hesitancy. *Pediatrics, 138*(3), e1-e11.

[13] Centers for Disease Control and Prevention. (2015). *Vaccine safety.* Retrieved January 25, 2019, from www.cdc.gov

[15,19] Rhode Island Department of Health, *2017-2018 Kindergarten Immunization Assessments.*

[16,20] Rhode Island Department of Health, 2017-2018 *7th Grade Immunization Assessments.*

[22] Rhode Island Department of Health analysis of data from the *National Immunization Survey—Teen,* 2017.

[23] Rhode Island Department of Health. (n.d.). *About vaccine funding and selection.* Retrieved February 5, 2019, from www.health.ri.gov

[24,25] Rhode Island Immunization Program. (2018). *Vaccinate Before You Graduate: 2017-2018 Rhode Island annual report.* Providence, RI: Rhode Island Department of Health.

[26] School Located Vaccinations Influenza Program. (2018). *Rhode Island Annual Report: 2018-2019 School Year.* Providence, RI: Rhode Island Department of Health.

(continued from page 57)

References for Access to Dental Care

[8,11,38] *Rhode Island Oral Health Plan, 2017-2021.* (2017). Providence, RI: Rhode Island Oral Health Commission and the Rhode Island Department of Health.

[12] *Oral health during pregnancy: Oral health's unanswered questions.* (2018). Washington, DC: Children's Dental Health Project.

[13] *Oral health care during pregnancy and through the lifespan.* (2017). Washington, DC: The American College of Obstetricians and Gynecologists.

[14] Chenwi, H. (2018). *Preventive dental care during pregnancy, 2012-2015, Rhode Island PRAMS.* Providence, RI: Rhode Island Department of Health.

[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.

[17,23,31] Rhode Island Executive Office of Health and Human Services, 2006-2018.

[18] Centers for Medicare & Medicaid Services. (n.d.). *Dental care.* Retrieved February 19, 2019, from www.medicaid.gov

[19,40] Centers for Medicare & Medicaid Services. (n.d.). *Annual EPSDT participation report form CMS-416 Fiscal Year 2016-2017, Rhode Island and U.S.* Retrieved February 20, 2019, from www.medicaid.gov

[20] Centers for Medicare & Medicaid Services. (2010). *State of Rhode Island Medicaid dental review.* Retrieved March 13, 2017, from www.mchoralhealth.org

[21,29] *An Assessment of the Rhode Island Medicaid adult dental program.* (2014). Providence, RI: Rhode Island Executive Office of Health and Human Services.

[22,24] 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.

[28,33] Gupta, N., Nasseh, K.,Yarbrough, C.,Vujicic, M., Blatz, A. & Harrison, B. (2017). *Medicaid fee-for-service reimbursement rates for child and adult dental care for all states, 2016.* Chicago, IL: American Dental Association, Health Policy Institute.

[30,32] Rhode Island Department of Human Services, 2007-2008.

[34,35] Rhode Island Department of Health, Center for Health Data and Analysis, Hospital Discharge Database, 2013-2017.

[41] 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.

[42] *U.S. Department of Health and Human Services Strategic Framework, 2014-2017.* (2016). Washington, D.C.: U.S. Department of Health and Human Services Oral Health Coordinating Committee.

[43] The Pew Charitable Trusts. (2017). *Reimbursing physicians for fluoride varnish.* Retrieved February 20, 2019, from www.pewtrusts.org

(continued from page 59)

References for Children's Mental Health

[3,9] 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] Gleason, M. M., Goldson, E., Yogman, M. W., & Council on Early Childhood. (2016). Addressing early childhood emotional and behavioral problems. *Pediatrics, 138*(6), e1-e13.

[6] 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.

[8] 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.

[10] Wissow, L., van Ginneken, N., Chandna, J., and Rahman, A. (2016). *Integrating children's mental health into primary care.* Baltimore, MD: Center for Mental Health in Pediatric Care, Johns Hopkins School of Public Health.

[11] *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.

[12] *Mental health hearings: Findings and recommendations.* (2017). Providence, RI: Rhode Island Senate Health and Human Services Committee.

[13] Data Resource Center for Child & Adolescent Health. (2017). *2017 National Survey of Children's Health Problems obtaining mental health care, age 3-17 years.* Retrieved March 15, 2019, from childhealthdata.org

[14,24] Lifespan, 2017-2018.

[15] 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.

[16,17] Onunaku, N. (2005). *Improving maternal and infant mental health: Focus on maternal depression.* Los Angeles, CA: National Center for Infant and Early Childhood Health Policy, UCLA.

[18] Zero to Three. (2017). DC:0-5TM: *Diagnostic classification of mental health and developmental disorders of infancy and early childhood: A briefing paper.* Retrieved March 15, 2019, from www.zerotothree.org/resources

[19,20] Rhode Island Executive Office of Health and Human Services, MMIS Database, 2017-2018.

[21,26,29] Rhode Island Department of Health, Hospital Discharge Database, 2007-2017.

[22] Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. (2018). *Take charge of your behavioral health: A guide for young adults in Rhode Island's behavioral health system.* Retrieved March 12, 2019, from www.bhddh.ri.gov

[23] Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals, Division of Behavioral Healthcare, 2018.

[25] Butler Hospital, 2016-2018.

[28] 2017 Rhode Island Youth Risk Behavior Survey. (2017). Providence, RI: Rhode Island Department of Health.

(continued from page 61)

References for Children with Special Needs

[3] Data Resource Center for Child and Adolescent Health. (n.d.). *2016-2017 National Survey of Children's Health: Developmental screening, age 9-35 months.* Retrieved February 19, 2019, from www.childhealthdata.org

[4] Data Resource Center for Child and Adolescent Health. (n.d.). *2016-2017 National Survey of Children's Health: One or more health conditions.* Retrieved February 20, 2019, from www.childhealthdata.org

[5] *Key findings: 2017 Rhode Island Youth Risk Behavior Survey.* (2018). Providence, RI: Rhode Island Department of Health.

[6] Rhode Island Department of Health. (2017). *Adolescent health: Rhode Island data.* Retrieved February 21, 2019, from www.health.ri.gov

[7] The Catalyst Center. (2017). *Breaking the link between special health care needs and financial hardship.* Boston, MA: Boston University School of Public Health, Center for Advancing Healthy Policy and Practice.

[8] 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-e1460.

[9] Stabile, M. & Allin, S. (2012). The economic costs of childhood disability. *The Future of Children, 22*(1), 65-96.

[10] ABLE National Resource Center. (n.d.). *ABLE accounts: 10 things you should know.* Retrieved February 19, 2019, from http://ablenrc.org

[11] Public Law No. 113-295. Enacted by the U.S. Congress as H.R. 5771 in 2014.

[12] Rhode Island General Law 42-7.2-20.1. ABLE Accounts. Enacted by the General Assembly as H-5564 Substitute A in 2015.

[13] Adams, R.C., Tapia, C. & Council on Children with Disabilities. (2013). Early Intervention, IDEA Part C services, and the medical home: Collaboration for best practice and best outcomes. *Pediatrics, 132*(4), e1073-e1088

[14,18] Rhode Island Executive Office of Health and Human Services, Center for Child and Family Health, 2018.

[15] U.S. Department of Education. (n.d.). *About IDEA: Individuals with Disabilities Act.* Retrieved February 19, 2019, from https://sites.ed.gov

[16,17,35] Rhode Island Department of Education, Office of Diverse Learners, Special Education Census, June 30, 2018.

[19,22,28,30,32] Rhode Island Executive Office of Health and Human Services, MMIS Database, 2017 and 2018.

[20] U.S. Social Security Administration. (n.d.). *Understanding Supplemental Security Income SSI for children - 2018 edition.* Retrieved February 19, 2019, from www.ssa.gov

[21] Rhode Island Executive Office of Health and Human Services. (2018). *Katie Beckett program description.* Retrieved February 19, 2019, from www.eohhs.ri.gov

[23] Rhode Island Department of Human Services, Center for Child and Family Health, January 2008.

[24] Musumeci, M., & Foutz, J. (2018). *Medicaid's role for children with special health care needs: A look at eligibility, services, and spending.* Menlo Park, CA: Henry J. Kaiser Family Foundation.

[25] Centers for Medicare and Medicaid Services. (n.d.). *Early and Periodic Screening, Diagnostic, and Treatment.* Retrieved February 20, 2019, from www.medicaid.gov

[26] American Academy of Pediatrics, Council on Foster Care, Adoption, and Kinship Care, Committee on Adolescence, and Council on Early Childhood. (2015). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics 136*(4), e1131-e1140.

[27,29] Child Welfare Information Gateway. (2015). *Healthcare coverage for youth in foster care—and after.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration for Children, Youth and Families, Children's Bureau.

[31] Rhode Island Secretary of State. (2018). *Department of Children, Youth and Families: Case Management* 214-RICR-30-00-1. Retrieved February 20, 2019, from sos.ri.gov

[33,37] National Institute of Mental Health. (2018). *Autism Spectrum Disorder.* Retrieved February 20, 2019, from www.nimh.nih.gov

[34] Baio, J., et al. (2018). Prevalence of Autism Spectrum Disorder among children aged 8 years: Autism and Developmental Disabilities Monitoring Network, 11 sites, United States, 2014. *Surveillance Summaries, 67*(6), 1-23.

[36] Centers for Disease Control and Prevention. (n.d.). *Research: Autism Spectrum Disorder (ASD).* Retrieved February 20, 2019, from www.cdc.gov

[38] Mayo Clinic. (n.d.). *Autism spectrum disorder.* Retrieved February 20, 2019, from www.mayoclinic.org

References

(continued from page 63)

References for Infants Born at Risk

[7] Robbins, T., Stagman, S., & Smith, S. (2012). *Young children at risk: National and state prevalence of risk factors.* New York, NY: National Center for Children in Poverty.

[8] Koball, H. & Jiang, Y. (2018). *Basic facts about low-income children: Children under 18 years, 2016.* New York, NY: National Center for Children in Poverty.

[9] *Healthy People 2020: Family planning.* Retrieved February 22, 2019, from www.healthypeople.gov

[10] *Unintended pregnancy in the United States.* (2019). New York, NY: Guttmacher Institute.

[11] Supplee, L. (2016). *5 things to know about early childhood home visiting.* Washington, DC: Child Trends.

[12] Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Driscoll, A. K., & Drake, P. (2018). Births: Final data for 2017. *National Vital Statistics Reports, 67*(8). Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

[13,14,15] Rhode Island Department of Health, KIDSNET Database, 2008-2018.

(continued from page 67)

References for Women with Delayed Prenatal Care

[8] Kim, H., Monteiro, K., Cooper, T., Viner-Brown, S., & Weber, A. (2018). *2018 Rhode Island Pregnancy Risk Assessment Monitoring System data book: 3rd edition.* Providence, RI: Rhode Island Department of Health.

[9,10,11,13,14] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017.

[12] *Access in brief: Pregnant women and Medicaid.* (2018). Washington, DC: Medicaid and CHIP Payment and Access Commission.

[15] *Child health care quality measures.* (2017). Baltimore, MD: Centers for Medicare & Medicaid Services.

(continued from page 69)

References for Preterm Births

[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] Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Driscoll, A. K., & Drake, P. (2018). Births: Final data for 2017. *National Vital Statistics Reports, 67*(8), 1-49.

[11] Martin, J. A., et al. (2018). Births: Final data for 2016. *National Vital Statistics Reports, 67*(1), 1-55.

[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] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017.

[17] *Rhode Island community profile.* (2018). Arlington, VA: March of Dimes.

[18] *17-Hydroxyprogesterone (17P) toolkit for health care providers in Rhode Island.* (2018). Providence, RI: Rhode Island Task Force on Premature Births.

(continued from page 71)

References for Low Birthweight Infants

[11,14] Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Driscoll, A. K., & Drake, P. (2018). Births: Final data for 2017. *National Vital Statistics Reports, 67*(8), 1-49.

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

[13] U.S. Department of Health and Human Services. (2019). *Healthy People 2020.* Retrieved March 14, 2019, from www.healthypeople.gov

[16] Burris, H. & Hacker, M. (2017). Birth outcome racial disparities: a result of intersecting social and environmental factors. *Semin Perinatol 41*(6): 360–366.

[17] Robert Wood Johnson Foundation. (2018). *New county rankings show differences in health and opportunity by place and race.* [Press release]. Retrieved from https://www.rwjf.org/en/library/ articles-and-news/2018/03/county-health-rankings-show-differences-in-health-by-place-and-race.html

[19] Kim, H., Monteiro, K., Cooper, T., Viner-Brown, S., & Weber, A. (2018). *2018 Rhode Island Pregnancy Risk Assessment Monitoring System data book: 3rd edition.* Providence, RI: Rhode Island Department of Health, Center for Health Data and Analysis.

(continued from page 73)

References for Infant Mortality

[11,12,14,16,17,19,23] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2012-2017.

[13] Smith, I., Bentley-Edwards, K., El-Amin, S. and Darity, W. (2018) *Fighting at birth: Eradicating the black-white infant mortality gap.* Oakland, CA: Duke University's Samuel DuBois Cook Center on Social Equity and Insight for Community Economic Development.

[15] *Rhode Island birth defects data book 2018.* (2018). Providence, RI: Rhode Island Department of Health, Birth Defects Program.

[18] Heron, M. (2018). Deaths: Leading causes for 2016. *National Vital Statistics Report, 67*(6), 1-17.

[20,21] *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.

[22] 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

[7] U.S. Department of Health and Human Services. (2011). *Executive Summary: The Surgeon General's Call to Action to Support Breastfeeding.* Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.

[8] Women & Infants Hospital. (2015). *Women & Infants achieves baby-friendly designation* [Press release]. Retrieved January 7, 2019, from www.womenandinfants.org

[9,13] *Breastfeeding report card – United States, 2018.* (2018). Atlanta, GA: Centers for Disease Control and Prevention.

[10] Child Trends. (n.d.). *Breastfeeding.* Retrieved January 7, 2019, from www.childtrends.org/indicators/ breastfeeding

[11] Rhode Island Department of Health, Pregnancy Risk Assessment Monitoring System (PRAMS), 2018.

[12] Healthy People 2020. (2019). *Maternal, infant, and child health data details, MICH-21-Breastfeeding.* Retrieved January 7, 2019, from www.healthypeople.gov

[14] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017.

[15] Rhode Island Department of Health, Pregnancy Risk Assessment Monitoring System (PRAMS), 2013-2017.

[16] National conference of state legislatures. (n.d.). *Breastfeeding state laws.* Retrieved January 7, 2019, from www.ncsl.org/research/health/breastfeeding-state-laws

[17] Rhode Island General Law 28-5-7.4. Enacted by the General Assembly as H-5674 Sub A in 2015.

[19] Rhode Island Department of Health. (2019). License lists: List of licensed lactation consultants in Rhode Island, search of active licenses. Retrieved January 7, 2019, from www.health.ri.gov/lists/licensees/

[20] *State paid family and medical leave insurance laws.* (2018). Washington, DC: National partnership for women and families.

(continued from page 77)

References for Children with Lead Poisoning

[3] Rhode Island Department of Health. (2012). *Healthy housing data book.* Retrieved February 13, 2019, from www.health.ri.gov

[4] Whitehead, L.S., Buchanan, S. D. (2019). Childhood lead poisoning: A perpetual environmental justice issue? *Journal of Public Health Management and Practice, 25, S115-S120.*

[5] *Lead poisoning.* (2017). Washington, DC: Child Trends.

[6] World Health Organization. (2010). *Childhood lead poisoning.* Retrieved February 13, 2019, from www.who.int

[7] American Academy of Pediatrics Council on Environmental Health. (2016). Prevention of childhood lead toxicity. *Pediatrics, 138*(1), 1-15.

[8] Sacks, V; Balding, S. (2018). The United States can and should eliminate childhood lead exposure. *Child Trends,* Retrieved February 22, 2019, from www.childtrends.org/publications/united-states-can-eliminate-childhood-lead-exposure/

[9,13] Ettinger, A.S., Ruckart, P. Z., & Dignam, T. (2019) Lead poisoning prevention: The unfinished agenda. *Journal of Public Health Management and Practice, 25, S1-S2.*

[11,12] Rhode Island Department of Health. (n.d.). *Childhood lead poisoning.* Retrieved February 13, 2019, from www.health.ri.gov/data/childhoodleadpoisoning/.

[14] Aizer, A., Currie, J., Simon, P., & Vivier, P. (2016). *Do low levels of blood reduce children's future test scores? Working paper 22558.* Cambridge, MA: National Bureau of Economic Research.

[15,16,22] Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program, 2001-2018.

[17] Educational interventions 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.

[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 Department of Health. (n.d.). *Data Story: The educational cost of unhealthy housing.* Retrieved February 15, 2019, from http://ridatahub.org

[20] Rhode Island Department of Health. (n.d.). *Lead poisoning publications.* Retrieved February 15, 2019, from www.health.ri.gov

[21] Rhode Island Department of Health. (n.d.). *Immunizations and lead poisoning: A report on the students in public schools in the town of Barrington.* Retrieved February 15, 2019, from www.health.ri.gov

[23] Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program, Environmental Inspection Table, 2018.

[24] Rhode Island Public Law Sections 23-24.6-7 and 23-24.6-9.

[26] Rhode Island Department of Health, KIDSNET, 2019.

(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 8, 2019, 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.* 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 8, 2019, 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] Rhode Island Department of Education. (2016). *School health profiles report.* Retrieved January 8, 2019, from www.thriveri.org

[18,19,20,22,23] Rhode Island Department of Health, Center for Health Data and Analysis, Hospital Discharge Database, 2013-2017.

[21] Centers for Disease Control and Prevention. (2017). *2015 child asthma data: Prevalence tables.* Retrieved January 8, 2019, from www.cdc.gov

(continued from page 81)

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

References for Housing and Health

[1,4,9] The Federal Healthy Homes Work Group. (2013). *Advancing healthy housing: A strategy for action.* Retrieved March 5, 2019, from www.healthyhomes.hud.gov

[2] 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.

[11] Population Reference Bureau analysis of the 2013-2017 American Community Survey (ACS) Public Use Microsample (PUMS) data.

[12] *Lead poisoning.* (2017). Washington, DC: Child Trends.

[13] Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program, 2018.

[14] *Asthma.* (2016). Washington, DC: Child Trends.

[15,17] Rhode Island Department of Health, Hospital Discharge Database, 2013-2017.

[16] *Unintentional injuries.* (2014). Washington, DC: Child Trends.

[18] Rhode Island Department of Human Services. (n.d.). *Weatherization Assistance Program.* Retrieved March 5, 2019, from www.dhs.ri.gov

[19] Rhode Island Department of Human Services, Weatherization Assistance Program data, 2018.

(continued from page 83)

References for Childhood Overweight and Obesity

[9,16] *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.

[10] *Eat smart, move more: Rhode Island: A plan for action 2010-2015.* (2010). Providence, RI: Rhode Island Department of Health.

[11] Spear, B. A., et al. (2007). Recommendations for treatment of child and adolescent overweight and obesity. *Pediatrics, 120*(4), s254-s288.

[17] *Dietary guidelines for Americans 2015-2020.* (2015). Washington, DC: U.S. Department of Agriculture and U.S. Department of Health and Human Services.

[18,21] *Rhode Island Youth Risk Behavior Survey*, Rhode Island Department of Health, 2007-2017.

[19] Council on School Health. (2013). The crucial role of recess in school. *Pediatrics, 131*(1), 183-188.

[20] *The association between school-based physical activity, including physical education, and academic performance.* (2010). Atlanta, GA: U.S. Department of Health and Human Services.

References

(continued from page 85)

References for Births to Teens

[5] Dee, D., et al. (2017). Trends in repeat births and use of postpartum contraception among teens – United States, 2004-2015. *Morbidity and Mortality Weekly Report, 66*(16), 422-426.

[6,9,21] Lewin, A., et al. (2019). A primary care intervention to prevent repeat pregnancy among teen mothers. *American Journal of Preventive Medicine, 56*(3), 404-410.

[7,8,12,16,18] Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Driscoll, A. K., & Drake, P. (2018). Births: Final data for 2017. *National Vital Statistics Reports, 67*(8), 1-49.

[11] Ventura, S.J., Hamilton, B.E. & Mathews, T.J. (2014). National and state patterns of teen births in the United States, 1940-2013. *National Vital Statistics Reports, 63*(4), 1-33.

[13,17,19,22,23] Rhode Island Department of Health, Center for Health Data and Analysis, 2013-2017.

[15,25] Rhode Island Department of Health, Center for Health Data and Analysis, Youth Risk Behavior Survey, 2017.

[24] *Issue brief: Unintended pregnancy among women in Rhode Island, 2009-2011.* (2015). Providence, RI: Rhode Island Department of Health, Pregnancy Risk Assessment Monitoring System Program.

[26] *Sexually transmitted disease rates in youth, by year, Rhode Island, 2008-2017.* (2018). Providence, RI: Rhode Island Department of Health, Division of Preparedness, Response, Infection Diseases & Emergency Medical Services; Center for HIV, Hepatitis, STDs, and TB Epidemiology.

(continued from page 87)

References for Alcohol, Drug, and Tobacco Use

[3] Substance Abuse and Mental Health Services Administration. (2017). *National survey on drug use and health: Comparison of 2014-2015 and 2015-2016 population percentages (50 states and the District of Columbia).* Retrieved March 13, 2019, from www.samhsa.gov

[5,7,10,34] 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.

[8,17,19] Johnston, L. D., Miech, R. A., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2018). *Monitoring the future national survey results on drug use: 1975-2017: Overview, key findings on adolescent drug use.* Ann Arbor, MI: Institute for Social Research, The University of Michigan.

[9] Johnston, L. D., O'Malley, P. M., Miech, R. A., Bachman, J. G., & Schulenberg, J. E. (2017). *Demographic subgroup trends among adolescents in the use of various licit and illicit drugs, 1975-2016* [Monitoring the Future Occasional Paper Series No. 86]. Ann Arbor, MI: The University of Michigan, Institute for Social Research.

[11] 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 March 13, 2019, from www.samhsa.gov

[12,15,18,20,27,28,35] *2017 Rhode Island Youth Risk Behavior Survey,* Rhode Island Department of Health, Center for Health Data and Analysis.

[13] Centers for Disease Control and Prevention. (2018). *Quick facts on the risks of e-cigarettes for kids, teens, and young adults.* Retrieved March 13, 2019, from www.cdc.gov

[14] Cullen, K. A., et al. (2018). *Notes from the field: Use of Electronic cigarettes and any tobacco product among middle and high school students – United States, 2011-2018.* MMWR Morbidity Mortality Weekly Report, 67(45):1276-1277.

[16] Rhode Island General Law 23-20.9-5. Enacted by the General Assembly as H-5876 & S-402 SubA in 2017.

[21] Centers for Disease Control and Prevention. (2015). *Three out of four American adults favor making 21 the minimum age of sale for tobacco products.* Retrieved March 13, 2019, from www.cdc.gov

[22] *Public health implications of raising the minimum age of legal access to tobacco products.* (2015). Washington, D.C: Institute of Medicine of the National Academies.

[23] American Academy of Pediatrics. (n.d.). *Tobacco to 21: An easy way to save young lives.* Retrieved March 13, 2019, from www.aap.org

[24] *Preventing tobacco use among youth and young adults: A report of the Surgeon General.* (2012). Rockville, MD; U.S. Department of Health and Human Services. Office of the Surgeon General.

[25] *Tobacco Free Rhode Island.* (2017). RI local tobacco control ordinances and policies. Retrieved March 13, 2019, from http://tobaccofree-ri.org

[26] Campaign for Tobacco-Free Kids. (n.d.). *States and localities that have raised the minimum legal sale age for tobacco products to 21.* Retrieved March 13, 2019, from www.tobaccofreekids.org

[29] *Ending the tobacco problem: A blueprint for the nation.* (2007). Washington, D.C: Institute of Medicine of the National Academies.

[30] *Single audit report: Fiscal year ended June 30, 2002.* (2003). Providence, RI: Office of the Auditor General, General Assembly.

[31] *Budget as enacted: Fiscal year 2019.* (2018). Providence, RI: House Fiscal Advisory Staff, General Assembly.

[32] Rhode Island Department of Health, Correspondence. 2017.

[33] *Rhode Island Proposed Budget, Fiscal Year 2020: Technical Appendix.* (2019). Providence, RI: Office of the Governor.

[36] Coyle, M., et al. (2018). Neonatal abstinence syndrome. *Nature Reviews Journal: Disease Primers, 4*(47), 1-17.

[37,38] Rhode Island Department of Health, Center for Health Data Analysis, 2006-2017.

[39] Normile, B., Hanlon, C., Eichner, H. (2018). *State strategies to meet the needs of young children and families affected by the opioid crisis.* National Academy for State Health Policy.

(continued from page 90)

References for Child Deaths

[5] U.S. Census Bureau, Population Estimates, 2013-2017.

[6,7,9,14] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2012-2016.

[8,12] National Center for Injury Prevention and Control. (2012). *National action plan for child injury prevention.* Atlanta, GA: Centers for Disease Control and Prevention.

[10] Centers for Disease Control and Prevention. (n.d.). *10 leading causes of death by age group, United States – 2015.* Retrieved February 21, 2019, from www.cdc.gov

[11] Centers for Disease Control and Prevention. (n.d.). *10 leading causes of injury deaths by age group highlighting unintentional injury deaths, United States – 2015.* Retrieved February 21, 2019, from www.cdc.gov

[13] Centers for Disease Control and Prevention, CDC WONDER, wonder.cdc.gov

(continued from page 91)

References for Teen Deaths

[3] *2018 KIDS COUNT data book.* (2018). Baltimore, MD: The Annie E. Casey Foundation.

[4] Centers for Disease Control and Prevention. (n.d.). *10 leading causes of injury deaths by age group highlighting unintentional injury deaths, United States – 2016.* Retrieved February 22, 2019, from www.cdc.gov

[6] Salam, R.A., Das, J.K., Lassi Z.S., & Bhutta, Z.A. (2016). Adolescent health interventions: conclusions, evidence gaps, and research priorities. *Journal of Adolescent Health, 59*, S88-S92.

[7] 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.

[8,10,12,15] Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2013-2017.

[9] U.S. Census Bureau, Population Estimates, 2017.

[11,19] *2017 Rhode Island Youth Risk Behavior Survey.* (2017). Providence, RI: Rhode Island Department of Health, Center for Health Data and Analysis.

[13] Mojtabai, R., Olfson, M., & Han, B. (2016). National trends in the prevalence and treatment of depression in adolescents and young adults. *Pediatrics, 138*(6), 1-10.

[14] Thompson, M.P. & Swartout, K. (2018). Epidemiology of suicide attempts among youth transitioning to adulthood. *Journal of Youth Adolescence, 47*: 807-817.

[16,17,18] National Highway Traffic Safety Administration, Fatality Analysis Reporting System (FARS), 2013-2017. Analysis by the Rhode Island Department of Transportation, 2019

(continued from page 93)

References for Youth Violence

[7] *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.

[8] David-Ferdon, C., et al. (2015). *CDC grand rounds: Preventing youth violence.* Retrieved March 8, 2019, from www.cdc.gov

[9] *Trends in the prevalence of behaviors that contribute to violence-National YRBS: 1991-2017.* (n.d.). Retrieved March 8, 2019, 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] Hogan, M. & Tocco, G. (2018). *2017 Juvenile detention data.* Providence, RI: Rhode Island Department of Public Safety, Public Safety Grant Administration Office.

[12] Rhode Island Family Court. (2019). *2018 Juvenile offense report.* Providence, RI: Rhode Island Family Court.

[13] Musu-Gillette, L., Zhang, A., Wang, K., Zhang, J., Kemp, J., Diliberti, M., & Oudekerk, B. A. (2018). *Indicators of school crime and safety: 2017* (NCES 2017-064/NCJ 250650). 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] *2017 Rhode Island Youth Risk Behavior Survey,* Rhode Island Department of Health, Center for Health Data and Analysis.

[15] National Academies of Sciences, Engineering, and Medicine. (2016). *Preventing bullying through science, policy, and practice.* Washington, DC: The National Academies Press.

[16] Stop bullying. (2018). *What is Cyber bullying.* Retrieved March 8, 2019, from stopbullying.gov

[18] *Children's exposure to violence: Indicators on children and youth.* (2016). Washington, DC: Child Trends.

[19] *Teen homicide, suicide, and firearm deaths: Indicators on children and youth.* (2015). Washington, DC: Child Trends.

[20] Rhode Island Department of Health, Center for Health Data and Analysis, 2013-2017.

(continued from page 94)

References for Gun Violence

[2] Swaner, S., Ayoub, L.H., Jensen, E. Rempel, M. *Protect, heal, thrive: Lessons learned from the Defending Childhood Demonstration Program* (2015). New York, NY: Center for Court Innovation.

[3] *Children's exposure to violence.* (2016). Washington DC: Child Trends.

[4,6] 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 February 28, 2019, from www.cdc.gov

[5,10] Fowler, K.A., Dahlberg, L.L., Haileyesus, T., Gutierrez, C., & Bacon, S. (2017). Childhood firearm injuries in the United States. *Pediatrics, 140*(1).

[7] Children's Defense Fund. (2018). *Protect children not guns factsheet: 2016 Child Gun Deaths.* Retrieved February 26, 2019, from www.childrensdefense.org

[8,9] *Teen homicide, suicide, and firearm deaths.* (n.d.). Washington DC: Child Trends. Retrieved February 28, 2019, from www.childtrends.org

[11] Xuan, Z. & Hemenway, D. (2015). State gun law environment and youth gun carrying in the United States. *JAMA Pediatrics, 169*(11), 1024-1031.

[12] Law Center to Prevent Gun Violence. (2015). *Statistics on the dangers of gun use for self-defense.* Retrieved February 26, 2019, from www.smartgunlaws.org

[13,14] Rhode Island Department of Health, Center for Health Data and Analysis, 2013-2017.

[15] *2017 Rhode Island Youth Risk Behavior Survey,* Rhode Island Department of Health, Center for Health Data and Analysis.

[16] Kann, L. et al. (2018). Youth risk behavior surveillance-United States, 2017. *Morbidity and Mortality Weekly Report, 67*(8), 1-117.

(continued from page 95)

References for Homeless and Runaway Youth

[3,8,10,13,21] National Conference of State Legislatures. (2016). *Homeless and runaway youth.* Retrieved February 22, 2019, from www.ncsl.org

[5,11] United States Interagency Council on Homelessness (2015). *Opening Doors: Federal strategic plan to prevent and end homelessness.* Retrieved February 26, 2019, from www.usich.gov

[6] *LGBTQ youth national policy statement-LGBTQ youth homelessness.* (2012). Washington, DC: National Alliance to End Homelessness.

[12] *Alone without a home: A state-by-state review of laws affecting unaccompanied youth.* (2012). Washington, DC: National Law Center on Homelessness & Poverty and The National Network for Youth.

[14] *Home to Hope: 2018 Rhode Island Youth Count report.* (2018).

[15] Rhode Island Department of Education, 2017-2018 school year.

[16,17,20] Rhode Island Emergency Shelter Information Project, 2017 and 2018.

[18] National Runaway Switchboard. (2018). *NRS call statistics, 2017.* Retrieved February 26, 2019, from www.1800runaway.org

[19] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), December 31, 2018.

(continued from page 97)

References for Youth Referred to Family Court

[3,6,9] Rhode Island Family Court. (2019). *2018 Juvenile offense report.* Providence, RI: Rhode Island Family Court.

[4] U.S. Census Bureau, Census 2010 Summary File 1.

[5] Rhode Island Family Court. (2018). *2017 Juvenile offense report.* Providence, RI: Rhode Island Family Court.

[7,20] National Research Council. (2013). *Reforming juvenile justice: A developmental approach.* Washington, DC: The National Academies Press.

[8] Seigle, E., Walsh, N., & Weber, J. (2014). *Core principles for reducing recidivism and improving other outcomes for youth in the juvenile justice system.* New York, NY: Council of State Governments Justice Center.

[10] *Beyond bars: Keeping young people safe at home and out of youth prisons.* (2017). Washington, DC: The National Collaboration for Youth.

[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, 2016 and 2017. Waiting on numbers from Richard Scarpellino

[15] Rhode Island Family Court. (n.d.). *Juvenile drug court.* Retrieved February 8, 2011, from www.courts.ri.gov/family/drugcourt.htm

[16] 2017 *Juvenile hearing board totals.* (2018). Providence, RI: Rhode Island Department of Public Safety, Grant Administration Office.

[17] Development Services Group, Inc. (2014). *LGBTQ youths in the juvenile justice system-Literature review.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention. Retrieved March 11, 2019, from www.ojjdp.gov

[18] Annie E. Casey Foundation Juvenile Detention Alternatives Initiative. (2015). *Practice Guide 11: Lesbian, gay, bisexual, and transgender youth in the juvenile justice system.* Retrieved March 11, 2019, from www.aecf.org

[19] 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.

References

[21] 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.

[22,24] Rhode Island General Laws, Sections 14-1-5, 14-1-7, 14-1-7.1, 14-1-7.2, 14-1-7.3.

[23,25] Rhode Island Office of the Attorney General, January 2019.

(continued from page 101)

References for Youth at the Training School

[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, January 2016, January 2017, January 2018, and January 2019.

[9] Szymanski, L. A. (2004). Minimum and maximum age of juvenile correctional custody. *NCJJ Snapshot, 9*(5), Pittsburgh, PA: National Center for Juvenile Justice.

[10] National Juvenile Defender Center. (2016). *Minimum age for delinquency adjudication—Multi-jurisdiction survey.* Retrieved February 26, 2019, from www.njdc.info

[11] Puzzanchera, C. & Kang, W. (2017). *Easy access to FBI arrest statistics 1994-2014.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

[12] The Annie E. Casey Foundation. (2013). *KIDS COUNT 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.

[16,31] 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 program mission.* (n.d.). Retrieved February 26, 2019, from www.dcyf.ri.gov

[22] Rhode Island KIDS COUNT. (n.d.). *Juvenile Detention Alternatives Initiative.* Retrieved February 22, 2019, 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.T. & Balck, A. (2015). *Gender injustice: System-level juvenile justice reforms for girls.* Portland, OR: The National Crittenton Foundation.

[27] *Child abuse and neglect: Consequences.* (2018). Retrieved February 26, 2019, from www.cdc.gov

[28] Rhode Island Department of Children, Youth and Families, Rhode Island Training School, 2018.

[29] Rhode Island Department of Children, Youth and Families, Rhode Island Training School, Alternative Education Program, 2018.

[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 14-1-27.

[32] Coalition for Juvenile Justice. (n.d.). *Alternatives to detention in the juvenile justice system.* Retrieved January 31, 2018, from www.juvjustice.org

(continued from page 103)

References for Children of Incarcerated Parents

[11,18] Swavola, E., Riley, K., & Subramanian, R. (2016). *Overlooked: Women and jails in an era of reform.* New York, NY: Vera Institute of Justice

[12] *A shared sentence: The devastating toll of parental incarceration on kids, families and communities.* (2016). Baltimore, MD: The Annie E. Casey Foundation.

[19] LeBel, T. P. (2017). *Housing as the tip of the iceberg in successfully navigating prisoner reentry.* Retrieved January 11, 2019, from www.onlinelibrary-wiley-com.ric.idm.oclc.org

[20] Californians for safety and justice. (2018). *Repairing the road to redemption in California.* Retrieved January 11, 2019, from https://safeandjust.org

(continued from page 105)

References for Children Witnessing Domestic Violence

[7,13] Zeoli, A. (2018). *Children, domestic violence, and guns.* Minneapolis, MN: The National Resource Center on Domestic Violence and Firearms.

[9] 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.

[10] 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.

[11] 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.

[12] 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.

[15] Domestic Violence and Sexual Assault/Child Molestation Reporting Form, Rhode Island Domestic Violence Training and Monitoring Unit, 2017.

[17] *2017 annual report.* (2017). Warwick, RI: Rhode Island Coalition Against Domestic Violence.

[18] Rhode Island Coalition Against Domestic Violence. Data are from January 1, 2018 to December 31, 2018.

[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 8, 2019, from promising.futureswithoutviolence.org

[20] Campbell, J.C. et al. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health 93*(7), 1089-1097.

[21] *Domestic Homicides in Rhode Island, 2006-2015.* (2016). Warwick, RI: Rhode Island Coalition Against Domestic Violence.

[22] Rhode Island General Law 8-8.3-6. Enacted by the General Assembly as H-7688 Sub A in 2018.

(continued from page 109)

References for Child Abuse and Neglect

[3] Vasileva, M., & Petermann, F. (2016). Attachment, development, and mental health in abused and neglected preschool children in foster care: A meta-analysis. *Trauma, Violence & Abuse, 1*(16), 1-16.

[4] Rhode Island Department of Children, Youth and Families, Child Protective Services, 2017.

[5,6,8,15,16,17,18,19] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2009-2018.

[7] Rhode Island Department of Children, Youth and Families. (n.d.). *Program: Field investigations.* Retrieved February 8, 2019, from www.dcyf.ri.gov

[9] Rhode Island Secretary of State. (2018). *Child Protective Services* 214-RICR-20-00-1. Retrieved February 8, 2019, from sos.ri.gov

[10] Rhode Island Department of Health, 2013-2017. 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.

[11] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2019). *Child maltreatment 2017.* Retrieved February 8, 2019, from www.acf.hhs.gov

[14] Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). *Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[20] National Children's Advocacy Center. (2018). *Child sexual abuse: perpetrators-manipulation-disclosure-prevention.* Retrieved February 13, 2019, from www.natioanlcac.org

(continued from page 111)

References for Children in Out-of-Home Placement

[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 March 11, 2019, from www.acf.hhs.gov

[3,12] Children's Defense Fund. (2010). *The Fostering Connections to Success and Increasing Adoptions Act of 2008 offers help to children raised by relatives.* Retrieved March 11, 2019, from www.childrensdefense.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] Turney, K. & Wildeman, C. (2016). Mental and physical health of children in foster care. *American Academy of Pediatrics, 138*(5), 1-11.

[6] Healthy Foster Care America. (n.d.). *10 things every pediatrician should know about children in foster care.* Retrieved March 11, 2019, from www2.aap.org

[7] *Foster care.* (2015). Washington, DC: Child Trends.

[8] *Educating children in foster care: State legislation, 2008-2015.* (2016). Washington, DC: National Conference of State Legislatures.

[9] Williams-Mbengue, N., & McCann, M. (2015). *The adolescent brain- Key to success in adulthood. Extending foster care policy toolkit: Paper 5 of 5.* Washington, D.C: National Conference of State Legislatures.

[10] Child Welfare Information Gateway. (2016). *Racial disproportionality and disparity in child welfare.* Washington, DC: Department of Health and Human Services, Children's Bureau.

[11] *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.

[13] Rhode Island Department of Children, Youth and Families. (2012). *Legal guardianship and kinship guardianship assistance (Policy 700.0245).*

[14] National Conference on State Legislators. (2018). *Family First Prevention Services Act (FFPSA).* Retrieved March 11, 2019, from www.ncsl.org

[15] Rhode Island Department of Children, Youth and Families. (2018). *Pivot to Prevention.* Retrieved March 8, 2019, from www.dcyf.ri.gov

[16] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), December 31, 2018.

[17] *Permanency Report: Entry cohort of children in foster care FY13-FY17 (July 1, 2012 – June 30, 2017).* (2017). Providence, RI: Rhode Island Department of Children, Youth and Families.

(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 24-month outcome report.* (2012). 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] Child Welfare Information Gateway. (n.d.). *Working with the courts for permanency.* Retrieved March 14, 2019, 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] Child Welfare Information Gateway. (n.d.). *Achieving and maintaining permanency: Overview.* Retrieved March 14, 2019, from www.childwelfare.gov

[11] Children's Defense Fund. (2010). *Fostering Connections to Success and Increasing Adoptions Act summary.* Retrieved March 14, 2019, from www.childrensdefense.org

[12] 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.

[13] Shatzkin, K. (2015). *Every kid needs a family: Giving children in the child welfare system the best chance for success.* Baltimore, MD: The Annie E. Casey Foundation.

[14] 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.

[15] *Strengthening Families Act Signed into Law.* (n.d.) Retrieved March 15, 2019, from www.nacac.org

[16] Children's Defense Fund. (2018). *The Family First Prevention Services Act: Historic reforms to the child welfare system will improve outcomes for vulnerable children.* Retrieved March 14, 2019, from www.childrensdefense.org

[17,18,19,22] *Permanency Report: FY 2015 – FY 2017* (n.d.) Rhode Island Department of Children, Youth and Families.

[20] Walsh, W. A. (2010). *Hard times made harder: Struggling caregivers and child neglect.* Durham, NH: University of New Hampshire, The Carsey Institute.

[21] Rhode Island Department of Children, Youth and Families. (2012). *Legal guardianship and kinship guardianship assistance (Policy 700.0245).* Retrieved March 14, 2019, from www.sos.ri.gov

[23,24,25,26,27,28] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2016-2017.

[29] Rhode Island Department of Children, Youth and Families. (n.d.). *Voluntary extension of care (VEC) program youth/young adult fact sheet.* Retrieved March 14, 2019, from www.sos.ri.gov

[30] Rhode Island Department of Children, Youth and Families. (2008). *Services to youth ages 18-21 (policy: 700.0240)* Retrieved March 14, 2019, from www.sos.ri.gov

[32] ChildFocus, Inc. (2013). *Medicaid to 26 for youth in foster care: Key steps for advocates.* Washington, DC: State Policy Advocacy and Reform Center.

[33] *Foster care to 21: Doing it right.* (2011). St. Louis, MO: Jim Casey Youth Opportunities Initiative.

(continued from page 117)

References for Children Enrolled in Early Intervention

[10] Cohen, J., & Herrick, K. (2013). *Securing a bright future: Maltreated infants and toddlers.* Retrieved February 27, 2019, from www.zerotothree.org

[11] Child Welfare Information Gateway. (2018). *Addressing the needs of young children in child welfare: Part C Early Intervention services.* Washington, DC: U.S. Department of Health and Human Services.

[12] Rhode Island Department of Children, Youth and Families, Calendar Year 2018

(continued from page 119)

References for Children Enrolled in Early Head Start

[7,12,14,15,16,18] Rhode Island Early Head Start program reports to Rhode Island KIDS COUNT, October 2018.

[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.

[10] Zero to Three. (2017). *Early Head Start works.* Retrieved March 6, 2019, from www.zerotothree.org

[11] 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.

References

[13] Rhode Island Kid Count calculations using Early Head Start program enrollment October 2018 as the numerator and number of children under age 3 from Census 2010, Summary File 1 multiplied by the percentage of children under age 6 living in families with incomes below the federal poverty level according to the Population Reference Bureau's (PRB) analysis of 2013-2017 American Community Survey data as the denominator.

[17] U.S. Department of Health and Human Services, Administration for Children and Families, Early Childhood Learning & Knowledge Center. (2018). *Infographic: Young children with special needs.* Retrieved February 14, 2018, from https://eclkc.ohs.acf.hhs.gov

[19] *Early Head Start tip sheet No. 4: 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.

(continued from page 121)

References for Licensed Capacity of Early Learning Programs

[7,8] 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), 2016-2019. Rhode Island Department of Children, Youth and Families, slots in licensed child care centers and family child care homes, 2010-2015.

[9] Rhode Island Department of Human Services, licensed programs accepting Child Care Assistance Program subsidy, from RI Early Care and Education Data System (ECEDS), 2019.

[10] Rhode Island Department of Education, public schools operating preschool classrooms, from RI Early Care and Education Data System (ECEDS), 2019.

[11] 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.[9]

(continued from page 123)

References for Children Receiving Child Care Subsidies

[7] Rhode Island Department of Human Services. (2018). *DHS Child Care Assistance Program (CCAP) licensed child care center weekly rates and licensed family child care weekly rates, effective July 2018.*

[8] Silver, B. E. (2018). *Statewide survey of child care rates in Rhode Island.* Kingston, RI: University of Rhode Island, Charles T. Schmidt, Jr. Labor Research Center.

[9] Whitebook, M., McLean, C., Austin, L. J. E., & Edwards, B. (2018). *Early childhood workforce index 2018.* Berkeley, CA: Center for the Study of Child Care Employment, University of California, Berkeley.

[10] Hilty, R. & Shaw, S. (2019). *Most early care and education staff retention programs share common elements.* Bethesda, MD: Child Trends. Retrieved January 18, 2019, from www.childtrends.org

[11,12,14] Rhode Island Department of Human Services, Child Care Assistance Program enrollment, 2001-2018.

[13] *Rhode Island Department of Human Services. Child Care Assistance (CCAP) eligibility information.* Retrieved January 18, 2019, from www.dhs.ri.gov

(continued from page 127)

References for High-Quality Early Learning Programs

[7] Pianta, R., Downer, J., & Hamre, B. (2016). Quality in early education classrooms: Definitions, gaps, and systems. *The Future of Children, 26*(2), 119-137.

[8] *History of QRIS growth over time.* (2017). Fairfax, VA: Administration for Children and Families, National Center on Early Childhood Quality Assurance.

[9] *Indicators of quality for ratings.* (2017). Fairfax, VA: Administration for Children and Families, National Center on Early Childhood Quality Assurance.

[10] *Funding and financial incentives.* (2017). Fairfax, VA: Administration for Children and Families, National Center on Early Childhood Quality Assurance.

[11] Tout, K., et al. (2010). *Compendium of quality rating systems and evaluations.* Washington, DC: Child Trends and Mathematica Policy Research.

[12] Rhode Island Association for the Education of Young Children. (n.d.). *Frequently asked questions about BrightStars Quality Rating & Improvement System.* Retrieved March 3, 2019, from www.brightstars.org

[13] Rhode Island Department of Elementary and Secondary Education. (2019). *Request for proposals: Rhode Island Universal Pre-K Program.* Retrieved March 3, 2019, from www.ride.ri.gov

[15,16,17] Rhode Island Association for the Education of Young Children and RI Early Care and Education Data System, BrightStars ratings, January 2015 – January 2019.

[18] Maxwell, K. L., Blasberg, A., Early, D. M., Li, W., & Orfali, N. (2016). *Executive summary: Evaluation of Rhode Island's BrightStars Child Care Center and Preschool Quality Framework.* Chapel Hill, NC: Child Trends.

[19,22] Rhode Island Department of Human Services, Children Enrolled in the Child Care Assistance Program, December 2018.

[20] Whitebook, M., McLean, C., Austin, L. J. E., & Edwards, B. (2018). *Early childhood workforce index 2018.* Berkeley, CA: Center for the Study of Child Care Employment.

[21] Oldham, E. & Hawes, S. (2014). *Rhode Island early learning workforce study: Licensed centers and family child care homes.* Retrieved March 6, 2019, from http://exceed.ri.gov

(continued from page 131)

References for Children enrolled in Head Start or State Pre-K

[4] 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.

[5,20,21] Barnett, W. S.. & Friedman-Krauss, A. H. (2016). *State(s) of Head Start.* New Brunswick, NJ: National Institute for Early Education Research.

[6] Cosse, R. (2017). *Head Start preschool participants, programs, families and staff in 2016.* Washington, DC: Center for Law and Social Policy.

[7,17,26,28,31] Friedman-Kraus, A. H., et al. (2018). *The state of preschool 2017: State preschool yearbook.* New Brunswick, NJ: National Institute for Early Education Research, Rutgers Graduate School of Education.

[8] Rhode Island Prekindergarten Education Act, Rhode Island General Laws, § 16-87 (2008).

[9] Guernsey, L., Bornfreund, L., McCann, C., & Williams, C. (2014). *Subprime learning: Early education in America since the Great Recession.* Washington, DC: New America Foundation.

[10,12,15,18,23,25] Rhode Island Head Start Program reports to Rhode Island KIDS COUNT, October 2018.

[11,13,27,30,33,35,36] Rhode Island Department of Education, children enrolled in State Pre-K, October 2018

[14] Rhode Island Department of Human Services, children participating in the Child Care Assistance Program, December 2018.

[16] Rhode Island Department of Education, children receiving preschool special education services as of June 30, 2018.

[19] Rhode Island KIDS COUNT calculations using Rhode Island Head Start program enrollment data, October 2018 as the numerator and the estimated number of children ages three and four from Census 2010 multiplied by the % of children under age six living in families with incomes below the federal poverty line (FPL) from the 2013-2017 American Community Survey.

[22] 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.*

[24,34] Rhode Island Department of Human Services, Child Care Assistance Program enrollment by BrightStars program quality rating, December 2018.

[29] *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.

[32] Barnett, W. S. (2012, February 14). Rhode Island State Pre-K Demonstration Program evaluation. Presentation to the Rhode Island General Assembly.

(continued from page 133)

References for Children Receiving Preschool Special Education Services

[5] *Rhode Island's guidelines for implementing Child Outreach screening.* (2018). Providence, RI: Rhode Island Department of Education.

[6] Rhode Island Department of Education, 2017-2018 Child Outreach Screening Rates and Referral Rates.

[7] Boyle, C. A., et al. (2011). Trends in the prevalence of developmental disabilities in U.S. children, 1997-2008. *Pediatrics, 127*(6), 1034-1042.

[9] *40th annual report to Congress on the implementation of the Individuals with Disabilities Education Act, 2018* (2018). Washington, DC: U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs.

[10,12,13,14] Rhode Island Department of Education, June 2018 Special Education Census.

(continued from page 135)

References for Public School Enrollment and Demographics

[2,3,4,6,7,8] Rhode Island Department of Education, October 1, 2008 and October 1, 2018.

[5] Rhode Island Department of Education, State Pre-K enrollment 2018-2019.

[9] Fillardo, M. (2016). *State of our schools: America's K-12 facilities.* Washington, DC: 21st Century School Fund.

[10,11,12] *State of Rhode Island schoolhouses.* (2017). Providence, RI: Rhode Island Department of Education.

[13] State of Rhode Island Election Results. (2018). *2018 general election: Statewide summary.* Retrieved February 5, 2019, from https://www.ri.gov/election/results/2018/general_election/

[14] Rhode Island Secretary of State. (2018). *Voter information handbook: A guide to state referenda and voting procedures in Rhode Island.* Retrieved February 5, 2019, from https://vote.sos.ri.gov/assets/pdfs/voter_handbook_2018.pdf

(continued from page 137)

References for Children Enrolled in Kindergarten

[2,3] Auck, A., & Atchison, B. (2016). *50-state comparison: K-3 quality.* Denver, CO: Education Commission of the States.

[4,8] Atchison, B., Diffey, L., & Workman, E. (2016). *K-3 policymakers' guide to action: Making the early years count.* Denver, CO: Education Commission of the States.

[5] U.S. Census Bureau, Current Population Survey, Single grade enrollment and high school graduation status for people 3 years and over, by sex, age (single years for 3 to 24 years), race and Hispanic origin: October 2017.

[6,7] Yoshikawa, H., Weiland, C., & Brooks-Gunn, J. (2016). When does preschool matter? *The Future of Children, 26*(2), 21-35.

[9,12] *Case studies of the early implementation of Kindergarten Entry Assessments final report.* (2016). Washington, DC: U.S. Department of Education, Office of Planning, Evaluation and Policy Development, Policy and Program Studies Service.

[10] Little, M. H., Cohen-Vogel, L., & Curran, F.C. (2016). Facilitating the transition to kindergarten: What ECLS-K data tell us about school practices then and now. *AERA Open, 2*(3), 1-18.

[11] Weisenfeld, G. G. (2017). *Assessment tools used in Kindergarten Entry Assessments (KEAs): State scan.* New Brunswick, NJ: Center on Enhancing Early Learning Outcomes.

[13] Rhode Island Department of Education, October 2018.

[14] Kuhl, P. K. (2011). Early language learning and literacy: Neuroscience implications for education. *Mind Brain Education, 5*(3), 128-142.

[15,16] Barrow, L., & Markman-Pithers, L. (2016). Supporting young English Learners in the United States. *The Future of Children, 26*(2), 159-183.

[17,20,21] Rhode Island Department of Education, 2017-2018.

[18,19] Gilliam, W. S. (2016). *Early childhood expulsions and suspensions undermine our nation's most promising agent of opportunity and social justice.* Princeton, NJ: Robert Wood Johnson Foundation.

[22] Rhode Island Department of Education, 2016-2017.

(continued from page 139)

References for Out-of-School Time

[8] Quinn, D. M. & Polikoff, M. (2017). *Summer learning loss: What is it, and what can we do about it?* Washington, DC: Brookings Institution. Retrieved February 13, 2018, from www.brookings.edu

[9] Alexander, K. L., Entwisle, D. R., & Olson, L. S. (2007). Lasting consequences of the summer learning gap. *American Sociological Review, 72*, 167-180.

[10] Rhode Island Department of Education, Office of Student, Community and Academic Supports, Summer 2017. Data are not unduplicated as students can be served by more than one grantee.

[11] United Way of Rhode Island, Summer 2017.

[12,13] Rhode Island Early Care and Education Data System (ECEDS), January 2019.

(continued from page 141)

References for English Learners

[2,6,19] Ross,T. (2015). *The case for a two-generation approach for educating English language learners.* Washington, DC: Center for American Progress.

[3,17] Park, M., O'Toole, A., & Katsiaficas, C. (2017). *Dual language learners: A national demographic and policy profile.* Washington, DC: Migration Policy Institute.

[4,20] 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.

[5,7,9,10] *Dual language learners: Indicators of child and youth well-being* (2014). Washington, DC: Child Trends.

[8,18,20] Adair, J.K. (2015). *The impact of discrimination on the early schooling experiences of children from immigrant families.* Washington, DC: Migration Policy Institute.

[11,12,13,16] Rhode Island Department of Education, 2017-2018 school year.

[14] Gándara, P. (2015). *Is there really a labor market advantage to being bilingual in the U.S.?* Princeton, NJ: Educational Testing Service.

[15] *Dual-language immersion programs raise student achievement in English.* (2017). Santa Monica, CA: RAND Corporation.

[21,22] Rhode Island Department of Education, *Rhode Island Comprehensive Assessment System (RICAS)*, 2018.

[23] Rhode Island General Law 16-7-2-6. Enacted by the General Assembly as H-7454-A in 2016.

[24] Rhode Island General Law 16-7.2-6. Enacted by the General Assembly as H-5175 SubA in 2017.

[25] Rhode Island Department of Health, KIDSNET, 2018.

[26] Espinosa, L.M. (2013). *Early education for dual language learners: Promoting school readiness and early school success.* Washington, DC: Migration Policy Institute.

(continued from page 143)

References for K-12 Students Receiving Special Education Services

[1] *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.

[4] Samuels, C. A. (2019). Special education's future. *Education Week, 38*(17), 10-12.

[5] *Students with disabilities graduating from high school and entering postsecondary education: In brief.* (2017). Washington, DC: Congressional Research Service.

[6] Losen, D., Hodson, C., Keith, M. A. II, Morrison, K., & Belway, S. (2015). *Are we closing the school discipline gap?* Los Angeles, CA: The Civil Rights Project, University of California, Los Angeles.

[7] *ESSA: Key provisions and implications for students with disabilities.* (2016). Washington, DC: Council of Chief State School Officers.

References

[8] Rhode Island Department of Education, *Rhode Island Comprehensive Assessment System (RICAS)*, 2018.

[9] Rhode Island Department of Education, Class of 2018 four-year graduation rates.

[10,11,13] Rhode Island Department of Education, Office for Diverse Learners, Special Education Census, June 30, 2018.

[12] McFarland, J., et al. (2018). *The condition of education 2018.* (NCES 2018-144). Washington, DC: U.S. Department of Education, National Center for Education Statistics.

(continued from page 145)

References for Student Mobility

[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.

[11] Turner, M. A. & Berube, A. (2009). *Vibrant neighborhoods, successful schools: What the federal government can do to foster both.* Washington, DC: Urban Institute.

[12] U.S. Census Bureau, American Community Survey, 2013-2017. Table B07001.

[13] U.S. Census Bureau, American Community Survey, 2013-2017. Table B07012.

[14,15,18,19,20,21,22] Rhode Island Department of Education, 2017-2018 school year.

[16] *A revolving door: Challenges and solutions to educating mobile students.* (2011). Cambridge, MA: Rennie Center for Education Research & Policy.

[17] Heimpel, D. (2018). *Analysis: Rhode Island ESSA case could mean an end to repeated school transfers for youth in foster care.* Retrieved February 12, 2018, from www.the74million.org

(continued from page 147)

References for Third-Grade Reading Skills

[3] 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.

[4] Gruendel, J. M. (2017). Who says elephants can't dance? Linking the human services and third-grade reading for transformative change. *APHSA Policy and Practice*, Dec. 2017, 19-21.

[5] The Annie E. Casey Foundation. (2011). *The 30 million word gap: The role of parent-child verbal interaction in language and literacy development.* Retrieved February 27, 2019, from www.aecf.org

[6] Yoshikawa, H., et al. (2013). *Investing in our future: The evidence base on preschool education.* Ann Arbor, MI: Society for Research in Child Development.

[7] The Pew Center on the States. (2011). *Transforming public education: Pathway to a Pre-K-12 future.* Washington, DC: Pre-K Now.

[8] Fiester, L. (2013). *Early warning confirmed: A research update on third-grade reading.* Baltimore, MD: The Annie E. Casey Foundation.

[9] Alliance for Early Success. (2015). *Birth through eight: State policy framework.* Retrieved March 1, 2019, from https://earlysuccess.org

[10] McCombs, J., Whitaker, A., & Yoo, P. (2017). *The value of out-of-school time programs.* Santa Monica, CA: RAND Corporation.

[11,12] Rhode Island Department of Education, *Rhode Island Comprehensive Assessment System (RICAS)*, 2018.

[13] Rhode Island Department of Education. (n.d.). *RICAS assessments.* Retrieved February 27, 2019, from www.ride.ri.gov

(continued from page 149)

References for Eighth-Grade Reading Skills

[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.

[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] Haynes, M. (2015). *The next chapter: Supporting literacy within ESEA.* 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] Herrera, S., Truckenmiller, A. J., and Foorman, B. R. (2016). *Summary of 20 years of research on the effectiveness of adolescent literacy programs and practices* (REL 2016–178). Washington, DC: U.S. Department of Education, Institute of Education Sciences, National Center for Education Evaluation and Regional Assistance, Regional Educational Laboratory Southeast.

[12,13] Rhode Island Department of Education, *Rhode Island Common Assessment System (RICAS)*, 2017-2018.

[14] Rhode Island Department of Education. (n.d.). *RICAS assessment.* Retrieved February 28, 2019, from www.ride.ri.gov

(continued from page 151)

References for Math Skills

[3] Federal Coordination in STEM Education Task Force. (2012). *Coordinating federal science, technology, engineering, and mathematics (STEM) education investments: Progress report.* Retrieved March 12, 2019, from obamawhitehouse.archive.gov

[4] National Research Council. (2005). *Adding it up: Helping children learn mathematics.* Washington, DC: National Academy Press. Retrieved March 4, 2019, from www.nap.edu

[5,11] Dossey, J. A., McCrone, S. S., & Halvorsen, K. T. (2016). *Mathematics education in the United States 2016: A capsule summary fact book: Written for the Thirteenth International Congress on Mathematical Education (ICME-13)*, Hamburg, Germany, July 2016. Reston, VA: The National Council of Teachers of Mathematics.

[6,13] The Nation's Report Card. (2017). *2017 Mathematics & reading assessments.* Retrieved March 4, 2019, from www.nationsreportcard.gov

[9,12] OECD (2016). *Ten questions for mathematics teachers… and how PISA can help answer them.* Retrieved March 4, 2019, from www.oecd-ilibrary.org

[10] National Research Council. (2011). *Successful K-12 STEM education: Identifying effective approaches in science, technology, engineering, and mathematics.* Washington, DC: The National Academies Press.

[14,15,16] The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org

[17] Rhode Island Department of Education, *Rhode Island Common Assessment System (RICAS)*, 2017-2018.

[18] Rhode Island Department of Education. (2018). *RICAS assessment.* Retrieved March 1, 2019, from www.ride.ri.gov

(continued from page 153)

References for Schools Identified for Intervention

[10,11] Rhode Island Department of Education, 2017-2018 school year.

[13] U.S. Department of Education. (n.d.) *Every Student Succeeds Act (ESSA).* Retrieved March 11, 2019, from www.ed.gov

[14] 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.

[15] Bellwether Education Partners. (2017). *An independent review of ESSA state plans: Executive summary.* Retrieved March 12, 2019, from https://bellwethereducation.org

[16] Wright, B. L., & Petrilli, M. J. (2017). *Rating the ratings: An analysis of the 51 ESSA accountability plans.* Washington DC: Thomas B. Fordham Institute.

(continued from page 155)

References for Chronic Early Absence

[5] U.S. Department of Education. (2019). *Chronic absenteeism in the nation's schools.* Retrieved March 7, 2019, from www2.ed.gov

[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] National Center for Homeless Education. (2017). *In school every day: Addressing chronic absenteeism among students experiencing homelessness.* Retrieved March 7, 2019, from http://nche.ed.gov

[8] Gottfried, M. A. (2015). Chronic absenteeism in the classroom context: Effects on achievement. *Urban Education,* 1-32.

[9] Healthy Schools Campaign. (n.d.). *Addressing the health-related causes of chronic absenteeism: A toolkit for action.* Retrieved March 7, 2019, from http://healthyschoolscampaign.org

[10,11] Robert Wood Johnson Foundation. (2016). *The relationship between school attendance and health: Health policy snapshot.* Retrieved March 7, 2019, from www.rwjf.org

[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.

[14,16,18] Rhode Island Department of Education, 2017-2018 school year.

[15] Rhode Island Department of Education, 2016-2017 school year.

[17,20] Attendance Works. (2014). *How states can advance achievement by reducing chronic absence.* Retrieved March 7, 2019, from www.attendanceworks.org

[21] Phenicie, C. (2017). *37 states are using their ESSA plans to crack down on chronic student absences. So how will they do it?* Retrieved March 7, 2019, from www.the74million.org

[22] Rhode Island Department of Education. (2018). *Rhode Island's Every Student Succeeds Act state plan.* Retrieved March 7, 2019, from www.ride.ri.gov

(continued from page 157)

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.

[2,6,13,14] 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.

[3,17] Attendance Works. (2014). *The attendance imperative: How states can advance achievement by reducing chronic absence.* Retrieved March 11, 2019, from www.attendanceworks.org

[4] Robert Wood Johnson Foundation. (2016). *The relationship between school attendance and health: Health policy snapshot.* Retrieved March 11, 2019, from www.rwjf.org

[7] Brundage, A. H., Castillo, J. M. & Batsche, G. M. (2017). *Reasons for chronic absenteeism among secondary students.* Retrieved March 11, 2019, from www.floridarti.usf.edu

[8,9,11,12] Rhode Island Department of Education, 2017-2018 school year.

[10] Rhode Island Judiciary. (n.d.). *About the Family Court.* Retrieved March 13, 2019, from www.courts.ri.gov

[15,18] Attendance Works and the Everyone Graduates Center. (2016). *Preventing missed opportunity: Taking collective action to confront chronic absence.* Retrieved March 11, 2019, from www.attendanceworks.org

[16] McKeever, P. M. & Clark, L. (2017). Delayed high school start times later than 8:30am and impact on graduation rates and attendance rates. *Sleep Health, 3*(2), 119-125.

[19] Rafa, A. (2017). *Chronic absenteeism: A key indicator of student success.* Denver, CO: Education Commission of the States.

[20] Bauer, L., Liu, P., Schanzenbach, D. W., & Shambaugh, J. (2018). *Reducing chronic absenteeism under the Every Student Succeeds Act.* Washington, DC: The Hamilton Project at Brookings.

(continued from page 159)

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.

[2,10] Losen, D. J. (2011). *Discipline policies, successful schools, and racial justice.* Boulder, CO: National Education Policy Center.

[4,11,12,15,16] Rhode Island Department of Education, 2017-2018 school year.

[6] 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] Wolf, K. C., & Kupchik, A. (2017). School suspension and adverse experiences in adulthood. *Justice Quartely, 34*(3), 407-430.

[8] *Guiding principles: A resource guide for improving school climate and discipline.* (2014). Washington, DC: U.S. Department of Education.

[9] *K-12 education: Discipline disparities for black students, boys, and students with disabilities GAO-18-258.* (2018). Washington, DC: U.S. Government Accountability Office.

[13,17] Rhode Island General Law 16-2-17. Enacted by the General Assembly as H-7056 Sub A in 2016.

[14] Rhode Island Department of Education, 2016-2017 school year.

(continued from page 161)

References for High School Graduation Rate

[6] *Centered on results: Assessing the impact of student-centered learning.* (2015). Quincy, MA: Nellie Mae Education Foundation.

[8] Rhode Island Department of Education. (2015). *Regulations of the Council on Elementary and Secondary Education: K-12 literacy, restructuring of the learning environment at the middle and high school levels, and proficiency-based graduation requirements (PBGR) at high schools.* Retrieved March 14, 2019, from www.ride.ri.gov

[9] Rhode Island Department of Education. (2016). *Regulations of the Council on Elementary and Secondary Education: Secondary design: Middle and high school learning environments and the Rhode Island diploma system.* Retrieved March 14, 2019, from www.ride.ri.gov

[10] Rhode Island Department of Education. (n.d.). *Council designations.* Retrieved March 15, 2019, from www.ride.ri.gov

[11,13] Rhode Island Department of Education, Class of 2018 four-year cohort graduation rates.

[12] Rhode Island Department of Education, Class of 2008 four-year cohort graduation rates.

[14,15] Rhode Island Department of Education, 2012-2013 cohort five- and six-year cohort graduation rates.

(continued from page 163)

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] Zinth, J. (2016). *Advanced Placement: Model policy components.* Denver, CO: Education Commission of the States.

[6,9,13] Rhode Island Department of Education, 2018 and 2019.

[7] The College Board, State and district integrated report: Rhode Island – public schools, 2017.

[8] House Fiscal Advisory Staff. (2018). *Budget as enacted: Fiscal Year 2019.* Providence, RI: Rhode Island House of Representatives.

[10] 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.

[11] Rhode Island Office of the Postsecondary Commissioner. (2019). *RI FAFSA completion dashboard.* Retrieved March 17, 2019, from www.riopc.edu

[12] Rhode Island Department of Education. (2018). *Rhode Island's Every Student Succeeds Act state plan.* Retrieved March 15, 2019, from www.ride.ri.gov

[14] Education Trust. (2019). *School counselors matter.* Retrieved March 15, 2019, from www.edtrust.org

References and Rhode Island KIDS COUNT Committees

[15] American School Counselor Association. (n.d.). *Student-to-school-counselor ratio 2015-2016.* Retrieved March 15, 2019, from www.schoolcounselor.org

[16] The College Board. (2010). *The college completion agenda: State policy guide.* Retrieved March 15, 2019, from www.ncsl.org

(continued from page 165)

References for College Enrollment and Completion

[8] Shapiro, D., et al. (2017). *A national view of student attainment rates by race and ethnicity – fall 2010 cohort (Signature report no. 12b).* Herndon, VA: National Student Clearinghouse Research Center.

[9] Jones, T. & Berger, K. (2019). *Aiming for equity: a guide to statewide attainment goals for racial equity advocates.* Retrieved March 15, 2019, from www.edtrust.org

[10] Ganga, E., Mazzariello, A., & Edgecombe, N. (2018). *Developmental education: An introduction for policymakers.* Denver, CO: Education Commission of the States.

[11] *The role of social supports and self-efficacy in college success.* (2010). Washington, DC: Institute for Higher Education Policy.

[12] Engle, J. & Tinto, V. (2008). *Moving beyond access: College success for low-income and first-generation students.* Washington, DC: The Pell Institute for the Study of Opportunity in Higher Education.

[13] *The game changers: Are states implementing the best reforms to get more college graduates?* (2013). Washington, DC: Complete College America.

[14] *Common Data Project: 2018 annual report, school year 2016-2017.* (2018). Retrieved March 15, 2019, from www.newenglandssc.org

[15] Rhode Island Department of Education. (February 13, 2019). PrepareRI college readiness project:: A system-wide effort to prepare all students for college success. Retrieved March 18, 2019, from www.ride.ri.gov

[16] The College Board. (2010). *The college completion agenda: State policy guide.* Retrieved March 19, 2019, from www.ncsl.org

Rhode Island KIDS COUNT Factbook Advisory Committee

Cristina Amedeo
United Way 2-1-1 in RI & The POINT

Donnie Anderson
The Rhode Island State Council of Churches

Tom Bertrand
Rhode Island Department of Health

Annette Bourne
HousingWorks RI

Sarah Bowman
Rhode Island Department of Health

Kate Bramson
Rhode Island Senate Policy Office

Kristina Brown
HousingWorks RI

Tara Cooper
Rhode Island Department of Health

Sadie DeCourcy
Rhode Island Department of Health

Caitlin Divver
Foster Forward

Patricia Flanagan, MD
Hasbro Children's Hospital

Leslie Gell
Ready to Learn Providence

Kathleen Gorman
University of Rhode Island
Feinstein Center for a Hunger Free America

Jennifer Griffith
Office of the Child Advocate

Tonya Harris
Rhode Island Coalition Against Domestic Violence

Lisa Hildebrand
Rhode Island Association for the Education of Young Children

Keith Ivone
Rhode Island Department of Corrections

Ana Karantonis
Rhode Island Department of Education

Linda Katz
The Economic Progress Institute

Nishi Kumar
Rhode Island Housing

Cindy Larson
LISC Rhode Island

Teddy Marak
Rhode Island Department of Health

Paula McFarland
Rhode Island Community Action Association

Robin McGill
Office of the Postsecondary Commissioner

Joanne McGunagle
Comprehensive Community Action Program

Jan Mermin
Rhode Island Department of Education

Susan Orban
Washington County Coalition for Children

Jessica Patrolia
Rhode Island Department of Education

Candace Powell
Newport Partnership for Families

Donna Ramos Razza
East Bay Community Action Program

Rosemary Reilly-Chammat
Rhode Island Department of Education

Julian Rodriguez-Drix
Rhode Island Department of Health

Cynthia Roberts
Rhode Island Coalition Against Domestic Violence

Kayla Rosen
Rhode Island Executive Office of Health and Human Services

Samuel Salganik
Rhode Island Parent Information Network

Mike Simoli
Rhode Island Department of Education

Patrick Vivier, MD
Hassenfeld Child Health Innovation Institute

John Wesley
Rhode Island Coalition Against Domestic Violence

Amy Zimmerman
Rhode Island Executive Office of Health and Human Services

Rhode Island KIDS COUNT Community Leadership Council

Darlene Allen
Adoption Rhode Island

Reverend Dr. Donnie Anderson
Rhode Island State Council of Churches

Angela Ankoma
United Way of Rhode Island

Raymond Arsenault
Spurwink School

Lenette Azzi-Lessing
Boston University, School of Social Work

Robert Barge
Rhode Island Legal Services

Carolyn Belisle
Blue Cross & Blue Shield of Rhode Island

Marcela Betancur
Latino Policy Institute at Roger Williams University

Beth Bixby
Tides Family Services

Stanley Block, MD
Providence Community Health Centers

Rebecca Boxx
Providence Children & Youth Cabinet

Rhode Island KIDS COUNT Committees

Andrew Bramson
College Crusade of Rhode Island

Laura Brion
Childhood Lead Action Project

Mario Bueno
Progreso Latino

Stephen Buka
Brown University

David Caprio
Children's Friend

Michael Cerullo
Licensed Mental Health Counselor

Channavy Chhay
Center for Southeast Asians

Jeanne Cola
LISC 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

Phyllis Dennery, MD
Hasbro Children's Hospital

Lynda Dickinson
CHILD, Inc.

Susan Dickstein
Rhode Island Association for Infant Mental Health

Karen Feldman
Young Voices

Nick Figueroa
College Visions

Patricia Flanagan, MD
Hasbro Children's Hospital

Rachel Flum
The Economic Progress Institute

Shirley Spater Freedman, DMD

Caitlin Frumerie
Rhode Island Coalition for the Homeless

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

Jennifer Griffith
Office of the Child Advocate

Lisa Guillette
Foster Forward

Rabbi Leslie Y. Gutterman
Temple Beth El

Tonya Harris
Rhode Island Coalition Against Domestic Violence

Jane Hayward
Rhode Island Community Health Center Association

Lisa Hildebrand
Rhode Island Association for the Education of Young Children

Jennie Johnson
City Year Providence

Susan Kaplan

Linda Katz
The Economic Progress Institute

H. John Keimig
Healthcentric Advisors

John M. Kelly
Meeting Street

Khadija Lewis Khan
Beautiful Beginnings Child Care Center

Tanja Kubas-Meyer
Rhode Island Coalition for Children and Families

Peg Langhammer
Day One

Benedict F. Lessing, Jr.
Community Care Alliance

Lisa Conlan Lewis
Parent Support Network of Rhode Island

Margaret Holland McDuff
Family Service of Rhode Island

Kim Maine
Sunshine Child Development Center

Jennifer Mann
Rhode Island Chapter American Academy of Pediatrics

Anna Cano Morales
Rhode Island College

Barbara Mullen
Center for Leadership and Educational Equity (CLEE)

Anne Mulready
Rhode Island Disability Law Center

Patricia Nolin
Rhode Island College

Susan Orban
Washington County Coalition for Children

Jill Pfitzenmayer
Rhode Island Foundation

Candace Powell
Newport Partnership for Families

Elliott Rivera
Youth in Action

Sister Mary Reilly
Sophia Academy

Brother Michael Reis
Tides Family Services

Maxine Richman
Rhode Island Interfaith Coalition

Samuel Salganik
Rhode Island Parent Information Network

Hillary Salmons
Providence After School Alliance

Karen Santilli
Crossroads Rhode Island

Ramona Santos, Stephanie Gonzalez, and Janie Segui
Parents Leading for Educational Equity (PLEE)

Susan Schenck
Newport Partnership for Families

Andrew Schiff
Rhode Island Community Food Bank

Ronald Seifer
Bradley/Hasbro Children's Research Center

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

Karla Vigil and Carlon Howard
EduLeaders of Color RI

James Vincent
NAACP, Providence Chapter

Chanda Womack
ARISE

Brenda Whittle
Neighborhood Health Plan of Rhode Island

Acknowledgements

The *2019 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 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.

Rebecca Lebeau, RI Executive Office of Health and Human Services; Samara Viner-Brown, Center for Health Data and Analysis, RI Department of Health; James Butler, RI Department of Human Services; Leon Saunders, RI Department of Children, Youth and Families; and Kenneth Gu, RI Department of Education for coordination and analysis of data from their respective departments.

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: Jean D'Amico, Alicia VanOrman, Population Reference Bureau.

Grandparents Caring for Grandchildren: Leon Saunders, Brian Renzi, RI Department of Children, Youth and Families; Darlene Allen, Adoption RI; Lisa Guillette, Foster Forward; Jennifer Miller, Child Focus.

Mother's Education Level: Ellen Amore, Richard Lupino, Will Arias, Samara Viner-Brown, RI Department of Health.

Economic Well-Being

Median Family Income: Linda Katz, The Economic Progress Institute; Jean D'Amico, Alicia VanOrman, Population Reference Bureau.

Cost of Housing: Amy Rainone, Nishi Kumar, Rhode Island Housing; Eric Hirsch, Providence College and RI Emergency Food and Shelter Board; Brenda Clement, Annette Bourne, HousingWorks RI.

Homeless Children: Eric Hirsch, Providence College and RI Emergency Food and Shelter Board; Kenneth Gu, Eileen Botelho, RI Department of Education; Caitlin Frumerie, Amy Ferguson, RI Coalition for the Homeless, Cristina Amedeo, United Way of Rhode Island, Michael Tondra, RI Department of Administration.

Secure Parental Employment: Linda Katz, The Economic Progress Institute; Sharon Santilli, Office of Child Support Services; Vincent Rossi, RI Department of Labor and Training.

Paid Family Leave: Donna Murray, Kate Greenwell, Ray Pepin, Fern Casimiro, Matt Weldon, RI Department of Labor and Training; Senator Gayle Goldin, RI General Assembly; Marie Ganim, formerly at the RI Senate Policy Office, Rachel Flum, Economic Progress Institute.

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; Laura Speer, The Annie E. Casey Foundation; Amy Rainone, Nishi Kumar, Rhode Island Housing; Sharon Santilli, Office of Child Support Services; Arloc Sherman, Center on Budget and Policy Priorities; Jean D'Amico, Alicia VanOrman, Population Reference Bureau.

Children in Families Receiving Cash Assistance: Courtney Hawkins, Yvette Mendez, Alisha Pina, James Butler, Kimberly Rauch, Maria Cimini, Mary Tramonti, 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: Courtney Hawkins, Yvette Mendez, Alisha Pina, James Butler, Bethany Caputo, 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, United Way of RI.

Women and Children Participating in WIC: Ann Barone, Preet Kaur, RI Department of Health.

Children Participating in School Breakfast: Stephen Carey, Jennifer Goodwin, Kenneth Gu, RI Department of Education; Kathleen Gorman, University of RI Feinstein Center for a Hunger Free America; Andrew Schiff, RI Community Food Bank.

Health

Children's Health Insurance: Kim Paull, Rebecca Lebeau, RI Executive Office of Health and Human Services; Sandeep Janyavula, HealthSource RI; Linda Katz, The Economic Progress Institute; Jean D'Amico, Alicia VanOrman, Population Reference Bureau.

Childhood Immunizations: Hanna Kim, Kathy Marceau, Patricia Raymond, Samara Viner-Brown, Tricia Washburn, RI Department of Health.

Access to Dental Care: Kim Paull, Rebecca Lebeau, RI Executive Office of Health and Human Services; Kathy Taylor, Samara Viner-Brown, Sam Zwetchkenbaum, Sadie DeCourcy, Jim Beasley, RI Department of Health; Sandeep Janyavula, HealthSource RI; Eva Marie Stahl, Community Catalyst; Colin Reusch, Children's Dental Health Project.

Children's Mental Health: John Peterson, Henry Sachs, Daniel Wall, Susan Thompson, Mike Montella, Jessica Gelinas, Lifespan; Charles Alexandre, Mark Gloria, Butler Hospital; Tara Cooper, Kathy Taylor, Samara Viner-Brown, RI Department of Health; Gregory Fritz; Kim Paull, Rebecca Lebeau, RI Executive Office of Health and Human Services; Gabby Arrendondo, RI Department of Behavioral Health, Developmental Disabilities and Hospitals.

Children with Special Needs: Ruth Gallucci, Kenneth Gu, Beth Pinto, David Sienko, Jaime Viti, RI Department of Education; Jennifer Kaufman, Christine Robin Payne, Kim Paull, Rebecca Lebeau, RI Executive Office of Health and Human Services; Deborah Garneau, RI Department of Health.

Infants Born at Risk: Ellen Amore, Blythe Berger, Kristine Campagna, Richard Lupino, Samara Viner-Brown, RI Department of Health; Patricia Flanagan, Hasbro Children's Hospital.

Evidence-Based Family Home Visiting: Kristine Campagna, Blythe Berger, Sara Remington, Sidra Scharff, Sarah Bowman, Ellen Amore, Samara Viner-Brown, RI Department of Health.

Women with Delayed Prenatal Care, Low Birthweight Infants, Infant Mortality: Ellen Amore, William Arias, Richard Lupino, Ana Novais, Alvaro Tinajero, Samara Viner-Brown, RI Department of Health; Jean D'Amico, Alicia VanOrman, Population Reference Bureau.

Preterm Births: Ellen Amore, Richard Lupino, Will Arias, Ana Novais, Alvaro Tinajero, Samara Viner-Brown, RI Department of Health; James Padbury, Maureen Phipps, Betty Vohr, Women & Infants Hospital.

Breastfeeding: Hanna Kim, Karine Monteiro, Samara Viner-Brown, RI Department of Health, Kim Gans, Brown University.

Children with Lead Poisoning: Anne Cardoza, Ana Novais, Anne Primeau-Faubert, Michelle Kollett Almeida, RI Department of Health; Laura Brion, Childhood Lead Action Project.

Children with Asthma: Julian Rodriguez-Drix, Deborah Pearlman, Alvaro Tinajero, RI Department of Health.

Housing and Health: Sherry Dixon, National Center for Healthy Housing; Jean D'Amico, Alicia VanOrman, Population Reference Bureau; Anne Cardoza, Anne Primeau-Faubert, Michelle Kollett Almeida, Julian Rodriguez-Drix, Ana Novais, Deborah Pearlman, Kathy Taylor, Alvaro Tinajero, Samara Viner-Brown, RI Department of Health; Amy Rainone, Rhode Island Housing; Ruth Ann Norton, Green and Healthy Homes Initiative; James Butler, RI Department of Human Services; Jean D'Amico, Alicia VanOrman, Population Reference Bureau; Betsy Stubblefield Loucks

Childhood Overweight and Obesity: Midge Sabatini, RI Department of Education; Dora Dumont, Amore, Tara Cooper, RI Department of Health; Patrick Vivier, Michelle Rogers, Hassenfeld Child Health Innovation Institute; Marti Rosenberg, Libby Bunzli, Melissa Lauer, Executive Office of Health and Human Services; Melissa Oliver, Child, Inc.; 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, Will Arias, Richard Lupino, Tara Cooper, Ana Novais, Alvaro Tinajero, Samara Viner-Brown, Karine Monteiro, Tom Bertrand, Teddy Marak, RI Department of Health; Patricia Flanagan, Hasbro Children's Hospital; Deborah Perry, YWCA of Northern RI.

Substance Use: Sarah Bowman, Tara Cooper, Kathy Taylor, Ellen Amore, Will Arias, Samara Viner-Brown, RI Department of Health.

Safety

Child Deaths and Teen Deaths: Tara Cooper, Kathy Taylor, Samara Viner-Brown, RI Department of Health; Nancy Ricci, Jamie Overton, RI Department of Transportation; Jean D'Amico, Alicia VanOrman, Population Reference Bureau.

Youth Violence: Gina Tocco, RI Department of Public Safety; Brother Michael Reis, Tides Family Services; Tara Cooper, Kathy Taylor, Samara Viner-Brown, RI Department of Health; Peg Votta, RI Department of Education.

Gun Violence: Tara Cooper, Kathy Taylor, Samara Viner-Brown, RI Department of Health.

Homeless and Runaway Youth: Leon Saunders, Colleen Caron, Brian Renzi, Michael Burk RI Department of Children, Youth and Families; Eric Hirsch, Providence College and RI Emergency Food and Shelter Board; Ken Gu, RI Department of Education; Amy Ferguson, RI Coalition for the Homeless; Katheryn Tavares, Adoption Rhode Island; Michelle Duso, Power4Good; Susan Walker.

Youth Referred to Family Court: Michael Forte, Ron Pirolli, Kevin Richard, Richard Scarpellino, Sharon O'Keefe, RI Family Court; Gina Tocco, RI Department of Public Safety; Timothy Healy, Meghan McDonough, Michele Dupuis-Clarke, RI Office of the Attorney General; Brother Michael Reis, Tides Family Services.

Youth at the Training School: Trista Piccola, Larome Myrick, Leon Saunders, Colleen Caron, Kevin Aucoin, Brian Renzi, April Seppala, Mary Clair-Michaud, Elizabeth Lowenhaupt, Timothy Owens, RI Department of Children, Youth and Families; Brother Michael Reis, Tides Family Services; Timothy Healey, Meghan McDonough, Michele Dupuis-Clarke, RI Office of the Attorney General; Gina Tocco, RI Department of Public Safety.

Children of Incarcerated Parents: Patricia Coyne-Fague, Keith Ivone, Erin Boyar, Caitlin O'Connor, RI Department of Corrections.

Children Witnessing Domestic Violence: Elaine Dorazio, Veronica Hobbs, RI Supreme Court Domestic Violence Training and Monitoring Unit; Tonya Harris, John Wesley, RI Coalition Against Domestic Violence; Eric Hirsch, Providence College and RI Emergency Food and Shelter Board.

Child Abuse and Neglect: Trista Piccola, Leon Saunders, Brian Renzi, Colleen Caron, Michael Burk, RI Department of Children, Youth and Families; Tonya Harris, John Wesley, RI Coalition Against Domestic Violence; Kathy Taylor, Samara Viner-Brown, RI Department of Health.

Children in Out-of-Home Placement: Trista Piccola, Leon Saunders, Brian Renzi, Colleen Caron, Michael Burk, RI Department of Children, Youth and Families; Darlene Allen, Adoption RI; Lisa Guillette, Foster Forward.

Permanency for Children in DCYF Care: Trista Piccola, Leon Saunders, Brian Renzi, Colleen Caron, Michael Burk, RI Department of Children, Youth and Families; Darlene Allen, Adoption RI; Lisa Guillette, Foster Forward.

Education

Children Enrolled in Early Intervention: Jennifer Kaufman, Donna Novak, Christine Robin Payne, Chantele Rotolo, Rebekah

Acknowledgements

LaFontant, RI Executive Office of Health and Human Services; John Kelly, Casey Ferrara, Meeting Street; Ben Lessing, Darlene Magaw, Family Resources Community Action; Fran Rittner, Joseph Carr, RI Department of Children, Youth and Families; Kristine Campagna, RI Department of Health; Pamela High, Hasbro Children's Hospital; Leslie Bobrowski, Patricia Maris, 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; Linda Laliberte, Tara Lacoursiere East Bay Community Action Program; Evangeline Brennan, Meeting Street; Rhonda Farrell, Tri- County Community Action Agency; Mary Varr, Woonsocket Head Start Child Development Association; Susan Dickstein, RI Association for Infant Mental Health.

Licensed Capacity of Early Learning Programs, High-Quality Early Learning Programs: Veronica Davis, RI Department of Children, Youth and Families; Caitlin Molina, Larry Pucciarelli, RI Department of Human Services; Phyllis Lynch, Lisa Nugent, Zoe McGrath, Ruth Gallucci, RI Department of Education; Lisa Hildebrand, RIAEYC/ BrightStars; Leslie Gell, Ready to Learn Providence; Sue Washburn, 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.

Children Receiving Child Care Subsidies: Caitlin Molina, James Butler, Alisha Pina, Yvette Mendez, RI Department of Human Services; Rachel Flum, The Economic Progress Institute; Karen Schulman, Helen Blank, National Women's Law Center; Lisa Hildebrand, RIAEYC/BrightStars; 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: Phyllis Lynch, Zoe McGrath, Lisa Nugent, RI Department of Education.

Children Receiving Preschool Special Education Services: Ruth Gallucci, Beth Pinto, Jaime Viti, RI Department of Education.

Public School Enrollment and Demographics: Mario Goncalves, Kenneth Gu, RI Department of Education.

Children Enrolled in Kindergarten: Phyllis Lynch, David Sienko, Kenneth Gu, RI Department of Education.

Out-of-School Time: Veronica Davis, RI Department of Children, Youth and Families; Jan Mermin, RI Department of Education; Caitlin Molina, James Butler, RI Department of Human Services; Hillary Salmons, Providence After School Alliance; Charlotte Boudreau, RI School Age Child Care Association; Mavis Nimoh, Travis Escobar; United Way of RI, Lisa Hildebrand, RIAEYC/BrightStars.

English Learners: Kenneth Gu, Emily Klein, Flavia Molea Baker, RI Department of Education; Julie Nora, International Charter School.

K-12 Students Receiving Special Education Services: Beth Pinto, Ruth Gallucci, Jaime Viti, David Sienko, Kenneth Gu, RI Department of Education.

Student Mobility: Terese Curtin, Connecting for Children and Families, Inc.; Christine Arouth, East Bay Community Action Program; Samara Viner-Brown, RI Department of Health; Mario Goncalves, Kenneth Gu, Peg Votta, RI Department of Education.

Third- and Eighth-Grade Reading Skills: Kenneth Gu, Phyllis Lynch, Mary Ann Snider, Kirtley Fisher, RI Department of Education; Julia Steiny.

Math Skills: Kenneth Gu, Phyllis Lynch, Mary Ann Snider, RI Department of Education; Julia Steiny.

Schools Identified for Intervention: Kenneth Gu, Phyllis Lynch, Mary Ann Snider, RI Department of Education.

Chronic Early Absence: Kim Chouinard, Kenneth Gu, RI Department of Education; Christine Arouth, East Bay Community Action Program; Ralph Smith, Laura Speer, The Annie E. Casey Foundation.

Chronic Absence, Middle School and High School: Kenneth Gu, RI Department of Education.

Suspensions: Kenneth Gu, RI Department of Education; 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, Angela Teixeira, RI Department of Education.

College Preparation & Access and College Enrollment & Completion: Deborah Grossman-Garber, Robin McGill, Abby Godino, RI Office of the Postsecondary Commissioner; Robert Oberg, The College Crusade of RI; Kirtley Fisher, Kenneth Gu, Phyllis Lynch, Mary Ann Snider, Spencer Sherman, Peg Votta, RI Department of Education; Solanchi Fernandez, College Planning Center; Paul Harrington, Drexel University; Sarah Linet, Great Schools Partnership.

Teens Not in School and Not Working: Jean D'Amico, Alicia VanOrman, Population Reference Bureau.

Poetry Credits

Andrews, J., Hamilton, E. (2012). *Julie Andrews' Treasury for all Seasons Poems and Songs to Celebrate the Year.* " grandmother" by Ray A. Young Bear. New York, NY: Little, Brown and Company.

Hopkins, L. (2005) Day to Celebrate: A Full Year of Poetry, People, Holidays, History, Fascinating Facts, and More. "A Father's Hands" by Rebecca Kai Dotlich. New York, NY. HarperCollins Children's Books, a division of HarperCollins Publishers.

Medina, J. (1999). *My Name is Jorge: On Both Sides of the River.* "Me X 2" by Jane Medina. Honesdale, PA: Boyds Mills Press.

Prelutsky, J. (1999). *The 20th Century Children's Poetry Treasury.* "The Secret Place" by Dennis Lee. New York, NY: Alfred A. Knopf, Inc.

Wiley, B. (2006). "My Brother" retrieved March 20, 2019, from www.familyfriendpoems.com/poem/brother

Yolen, J. & Peters, A. (2007). *Here's a Little Poem A Very First Book of Poetry.* "As the Crow Flies" by Lesléa Newman. Cambridge, MA: Candlewick Press.

Rhode Island KIDS COUNT
One Union Station
Providence, RI 02903

(401) 351-9400
rikids@rikidscount.org
www.rikidscount.org
twitter.com/RIKidsCount
www.facebook.com/RhodeIslandKIDSCOUNT