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ABSTRACT

Shifting to results-based accountability is a difficult stage in reforming family and children's services. Heretofore, these services have been more concerned with the number of clients seen or papers processed than in their clients' quality of life. This document should help communities find the data they need to measure qualitative outcomes. It provides a core list of conditions, for example, birthweight, immunizations, substance abuse, and teen suicide. Information on defining outcomes, finding the data to measure outcomes, and analyzing the data to assess local performance is listed. Also listed are various state and local data collection offices which may be able to help groups collect and appraise their data. Each definition for the outcome had to define the problem accurately, reflect data that were readily available, and be useable over time and across jurisdictions. This rigor in defining conditions will: (1) help communities determine the outcomes on which data are already being collected; (2) provide them a baseline to measure future progress; and (3) highlight areas where they should focus their work. Appendices list organizations, by state, that collect data on topics such as child welfare, juvenile justice, and other areas. Also appended are U.S. standard birth and death certificates. (Contains 25 references.) (RJM)

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Finding the Data: A Start-Up List of Outcome Measures with Annotations

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A Companion Document to "The Case for Shifting to Results-Based Accountability"

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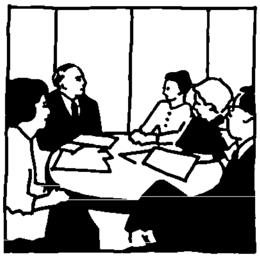

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This document is a product of the Improved Outcomes for Children Project, which the Center coordinates in conjunction with the Harvard Project on Effective Services (Lisbeth Schorr) and the National Center on Education and the Economy. We gratefully acknowledge the financial support of the Lilly Endowment, Carnegie Corporation, Danforth Foundation, New American Schools Development Corporation and Pew Charitable Trusts.

This document incorporates and builds on work conducted by Janet Levy through the Joining Forces project, sponsored by the Council of Chief State School Officers and the American Public Welfare Association, which in turn was assisted by the work of Nick Zill and Christine Nord (formerly of Child Trends and now of Westat).

In addition, we gratefully acknowledge the use of information from the following organizations in order to prepare the lists of state and local data offices:

- American Public Welfare Association (State Child Welfare Agency Directors)
- Council of Chief State School Officers (Directory of Chief State School Officers)
- Drugs and Crime Data Center and Clearinghouse (Statistical Analysis Centers and Uniform Crime Reports Contacts)
- National Association of State Alcohol and Drug Abuse Directors (Membership list)
- National Center on Child Abuse and Neglect (State Liaison Officers for Child Abuse and Neglect)
- U.S. Department of Commerce, Bureau of the Census (State Data Center Program Coordinating Organizations)
- The Annie E. Casey Foundation (KIDS COUNT Grantees)

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INTRODUCTION

One of the most fundamental, necessary, and difficult stages in reforming family and children's services is shifting to results-based accountability. This means moving from a system in which success is measured by the number of clients seen or papers processed, to one in which success is measured by whether the lives of children, youth and families are made better.

The companion paper to this document, "The Case for Shifting to Results-Based Accountability" by Lisbeth Schorr, explains the argument for, and cautions about, this shift. Results-based accountability helps provide communities and front-line workers the freedom, authority and responsibility to do "whatever it takes" to improve the lives of children and families. It can facilitate the cross-systems collaborations that are necessary to develop comprehensive approaches. It can greatly clarify which strategies are effective and which are not.

But results-based accountability also has risks. It requires significant new "infrastructure" in order to be used fairly. It can be misused and result in "creaming" or discrimination. It can emphasize quantifiable outcomes at the expense of outcomes that are more subtle but no less important. Ultimately, it should result in re-allocation of funds away from ineffective strategies to effective ones; communities will need to prepare for these changes.

Despite these cautions, there is widespread agreement that this shift is the right direction for communities to take. While building the necessary capacity for implementing new accountability systems is a long process, virtually every community can begin by taking two steps. First, states and communities need to agree on their own set of outcomes that reflects the results they want for their children, youth and families. Second, they can collect data on those outcomes, report those data to the public, and incorporate them in management feedback and accountability systems. Collecting and reporting initial data gives the community a baseline to measure its future progress; the reporting of subsequent data shows the community how it's doing. Data on outcomes also help the community determine the areas where they should focus their work.

"The Case for Shifting to Results-Based Accountability" provides a set of outcomes that communities can use as a starting point for developing their own "desired results." These outcomes reflect a "minimalist" set of readily quantifiable, well-known indicators of well-being. This document, "Finding the Data: A Start-up List of Outcome Measures with Annotations," was developed to help communities determine the outcomes on which data are already being collected, and find the data on their community. The aim was to do as much of the "legwork" as possible in order to make it easier for states and communities to determine how their families were doing.

For each of the outcomes in the core list contained in "The Case for Shifting to Results-Based Accountability" this document provides information about:

- how that outcome can be measured,
- what cautions should be heeded in collecting data, and
- where data can be found on a national, state and local level.

The appendices in the back list many organizations, by state, that collect data on topics such as child welfare, juvenile justice, educational scores, child health and other areas. These organizations should provide a wealth of information about the status of children, youth and families in your community.

We hope that this document helps facilitate your community's use of outcomes to improve the lives of its families, youth and children. We welcome your feedback.

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TECHNICAL NOTES

While many audiences may find this document useful, its primary purpose is to assist communities that are trying to measure outcomes to find the data they need to do so. For each outcome on the core list, this document provides information on defining the outcome, finding the data to measure the outcome, and analyzing the data to assess local performance. It includes lists of various state and local data collection offices that may be able to help state and local groups collect and analyze their data. It also includes copies of the standard certificate of birth and the standard certificate of death to show how and what data are routinely collected for these two events.

Each definition for the outcome was crafted to meet several criteria. The definition had to define the problem accurately, reflect data that were readily available, and be useable over time and across jurisdictions. Two particular issues warrant further explanation: the choice of age ranges and the use of rates, percents and numbers in the definitions.

Age-Breaks

Most indicators are focused on measuring the condition of children among specific age-groups. There are three reasons for these age breaks. First, in some cases, such as the number of untreated vision or hearing conditions of children entering school, the age-breaks were chosen to measure a condition at the time in a child's life when that condition will have a particularly significant impact on the child's development. Second, in other cases, such as teen homicides, ages 15-19, the age breaks were chosen to maximize ready access to published data. Third, in many cases, particularly among the teen indicators, the age-breaks were chosen to reflect the ages for which the condition is most prevalent. If the age range includes ages for which the condition is very rare, the overall rate will seem artificially low.

However, it also may be revealing to review data for other age groups, such as for instance, births to younger single teens as well as single teens ages 15-17, in order to fully understand trends and to inform preventive and early intervention strategies. It is important to bear in mind that selecting these age ranges does not imply that communities should not care about events in children and adolescents outside these age ranges. Communities may well decide to use different ranges depending on local priorities.

Numbers, Percents and Rates[1]

Each indicator is expressed as either a number (such as number of child abuse cases), a percent (number per 100) or rate (number per 1000 or other population size). Each is an important means of conveying information with data. Each of them tells us something slightly different, and should be used and interpreted with that in mind. For example, if the child population is on the rise in a particular area, the number of children experiencing some difficulty may be on the rise and require a policy response, even though the rate or percent of children with such problems stays constant or even drops. The number is also important in determining the level of resources that may be needed to address the problem. Alternatively, when the rates of problems increase, the appropriate policy response may differ somewhat depending on whether the actual number of children with such problems is rising or falling.

When reporting rates or percents, it is important that one furnish some means for the reader to gauge their precision. Reporting the raw numbers on which they are based can provide the reader some sense of the figure's precision. It can also provide the audience with a sense of the scope of the problem—sometimes, knowing that 10 children in a community have been arrested for a violent crime is more powerful than reading the rate and having to do one's own translation. While the definitions do not state this explicitly, it is also important that rates and percents omit from both the numerator and the denominator cases for which data are missing. For example, in calculating the rate of low birthweight births, one should not include in either the number of low birthweight births, or the number of total births, those cases for which the weight is not available.

In deciding whether to use a percent (per 100) or rate (per 1000 or other number), communities should choose the format that results in a number that is meaningful to the audience with which it is communicating. Percents are the more common format, but for rarer occurrences, it can be easier to visualize 5 children per 1000 experiencing a problem than 0.5 children per 100.

Our work on this issue continues to evolve, and the authors would welcome feedback from readers. We are especially interested in the experiences of communities that are trying to measure these outcomes for their own children and youth.

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[1] Some of this information is taken from Brett Brown and Nick Zill, A Review of the First Seven State Kids Count Annual Reports, 1992.

CHILD AND YOUTH OUTCOMES

A Core List to Serve as a Starting Point

Healthy Births

- Lower rates of low birthweight births
- Higher rates of early prenatal care
- Lower rates of births to single mothers under 18

Two-Year Olds Immunized

Children Ready for School

- Immunizations complete
- No untreated vision or hearing problems
- School-readiness traits as identified on sample basis[2]

Children Succeeding In Elementary School, Middle School, High School

- As indicated by lower rates of school drop-out, and by
- Academic achievement measures[3] demonstrating competency over challenging subject matter in grades 4, 8 and 12

Children and Youth Who Are Healthy, Safe, and Prepared for a Productive Adulthood

- Children not abused or neglected
- Children living in own family[4]
- Children living in families with incomes over the poverty line
- Youth Avoiding
  - Early unmarried childbearing
  - Substance abuse
  - Arrests for violent crime
  - Suicide
  - Homicide
  - Accidental death
  - Sexually transmitted diseases and HIV/AIDS
  - Idleness: not in school and not employed

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[2] "The Case for Shifting to Results-Based Accountability" includes a discussion of this measure.

[3] This assumes that communities will be utilizing separately developed indicators of school success.

[4] This is an imperfect but measurable proxy for children living in safe, nurturing, loving environments.

ANNOTATIONS

INDICATOR

LOW BIRTHWEIGHT: percent of babies born low birthweight

DEFINITION

Percent of births that are below 5.5 pounds (2500 grams).

The indicator is constructed by dividing the number of births below 5.5 pounds by the total number of births for a particular year, and multiplying by 100.[5]

((Low birthweight births/total births) x 100)

SIGNIFICANCE

The weight of a baby at birth is a key indicator of newborn health, and is directly related to infant survival, health and development. Low birthweight infants are more likely to die during the first year. In the U.S., such infants account for nearly two-thirds of all infant deaths through age 28 days. They are also more likely to experience disabilities and health problems such as mental retardation, developmental delays, visual and hearing defects, chronic respiratory ailments, autism, and learning difficulties, that interfere with normal development and progress in school.

FACTS

In 1990, 289,417 low birthweight babies were born in this country, representing 7 percent of all births. Rates were 5.7 percent for whites, 6.1 percent for Hispanics and American Indians, and 13.3 percent for African-Americans. The percent of babies born low birthweight has not fallen nationally since 1980.

A national goal of 5.0 percent low birthweight births by the year 2000 has been set by the Federal government as part of its *Healthy People 2000* effort. A target of 9 percent has been set for African-American births.

DATA SOURCES

Birthweight is reported on the standard certificate of birth in all states (see Appendix J). The data are reported by mother's residence, not the location of the hospital.

NATIONAL: National and state level data are available from the Federal government in printed form and as machine readable data. Data are published in a monthly "Monthly Vital Statistics Report", and an annual Vital Statistics of the United States, Volume I—Natality. For these publications, however, there is a three-year lag between the end of the calendar year and the publication date. In addition, machine (computer) readable data are available from the office listed below. These files contain the information from each individual birth record, and can be very useful for those wishing to do their own data analyses.

Natality Branch/Division of Vital Statistics
National Center for Health Statistics (NCHS)
6525 Belcrest Road, Room 840
Hyattsville, MD 20782
(301) 436-8954

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[5] As noted in the introduction, all rates include in the numerator and the denominator only those cases for which the data is known—for this outcome, both the number of births below 5.5 pounds and the total number of births would include only those cases for which the birthweight was known.

In addition, the Federal Public Health Service (in the U.S. Department of Health and Human Services) produces an annual publication titled *Child Health USA*, that reports national data on low birth weight and many other measures of child health. This publication can be ordered from the following source:

National Maternal and Child Health Clearinghouse
8201 Greensboro Drive
McLean, VA 22102
(703) 821-8955

STATE: State and local data are available from the bureau of vital statistics in each state, usually located within the state health department, which is responsible for collecting birth certificate data and reporting it to the National Center for Health Statistics (see Appendix H). Some state level data also appear in the NCHS publications listed above. Data from the state health department will generally be more recent than that available from NCHS.

LOCAL: Local data are available from state health departments. Local health departments may also keep track of birth data for the locality, and may have their own publications.

COMMENTS

Data are available for states and for civil divisions within states (e.g. by county, city, town and village). In some areas, data are available by census tract, though the absolute incidence of low birthweight is likely to be low and the rates unstable at this fine geographic level.

This measure can be produced separately by race, age, marital status and educational level of mother in all states [6]. As of 1991, 49 states and the District of Columbia separately identify Hispanic children, up from 30 states in 1986. For this reason, however, retrospective data on Hispanic children may not be available in some states.

Since 1989, race specific birth data from the birth certificate have been tabulated based on the race of the mother. Previous to that, such tabulations were based on the race of the non- white parent (if any) or, if both were nonwhite, on the race of the father.[7] One must therefore be cautious about interpreting race-specific trends involving years before and after 1989, as this change will have some small effect on the number of children identified with a particular race.

The most recent available data may be up to two years old in some states, and three years old from the National Center for Health Statistics.

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[6] In six states (California, Connecticut, Michigan, Nevada, New York and Texas), the marital status of the mother is not asked directly, but is inferred by comparing parent and child surnames. There are several conditions to analyze this proxy; for example, if both mother and father have the same surname, or if the father and child have the same surname, the assumption is that the parents are married. Texas began to collect data on marital status in 1994. For two states, New York and Washington, data on mother's education has been available through the federal data system only since 1992.

[7] In Hawaii, the child was identified as Hawaiian if either parent was Hawaiian.

States now link birth and death certificates, which makes it possible to tabulate infant mortality for specific birth weights.

RELATED MEASURES

In addition to measuring the portion of babies born low birthweight, it may be useful to identify very low birthweight babies, that is, babies weighing less than 3.5 pounds (1500 grams) at birth. Such babies are at the highest risk of dying, and of experiencing significant problems in health and development. The incidence of such births may be too small, however, to be useful for small jurisdictions.

INDICATOR

PRENATAL CARE: percent births to mothers receiving prenatal care in the first trimester.

DEFINITION

The percent of births to women receiving prenatal care in the first trimester.

The indicator is constructed by dividing the number of births where the mother received prenatal care in the first three months of pregnancy by the total number of births for a particular year, and multiplying by 100.

((Births with early care/total births) x 100)

SIGNIFICANCE

The receipt of early and ongoing prenatal care increases the chances of delivering healthy, full-term, normal weight babies. Early prenatal care can encourage good health habits during pregnancy, can lead to early detection of medical problems, and can become a gateway to parenting support and education and assistance with nutrition, housing and other needs. All of these are associated with improved birth outcomes. The benefits are greatest for women who are at the highest risk of poor birth outcomes such as teenage mothers, poor women and women of color. Early care can also reduce health care costs associated with neonatal intensive services for low birthweight babies.

FACTS

In 1991 76 percent of all mothers in the U.S. received prenatal care in first trimester. Nationwide, this rate has changed little since 1979. However, because of changes in policies and programs in some states and communities, rates of early prenatal care receipt have improved in these localities.

Seventy-nine percent of white mothers and 62 percent of black mothers received first trimester prenatal care in 1990. For mothers under the age of 18, rates in 1990 were 52 percent and 43 percent for whites and blacks, respectively.

As part of the *Healthy People 2000* effort, the Federal government has set as a goal that 90 percent of all pregnant women receive prenatal care in the first trimester by the year 2000.

Approximately six percent of all U.S. mothers received late (third trimester) or no prenatal care.

DATA SOURCES

The month at which prenatal care began is reported on the standard certificate of birth in all states. The data are reported by mother's residence, not the location of the hospital.

NATIONAL: National and state level data are available from the Federal government in printed form and as machine (computer) readable data. Data are published in a monthly "Monthly Vital Statistics Report", and an annual Vital Statistics of the United States, Volume I—Natality. For these publications, however, there is a three-year lag between the end of the calendar year and the publication date. Their Advanced Data series often presents health data with a 2 year lag, though it is a less complete source of information. In addition, machine (computer) readable data are available from the office listed below. These files contain the information from each individual birth record, and can be very useful for those wishing to do their own data analyses.

Natality Branch/Division of Vital Statistics
National Center for Health Statistics (NCHS)
6525 Belcrest Road, Room 840
Hyattsville, MD 20782
(301) 436-8954

STATE: State and local data are available from the bureau of vital statistics in each state, usually located within the state health department, which is responsible for collecting birth certificate data and reporting it to the National Center for Health Statistics (see Appendix H). Some state level data also appears in the NCHS publications listed above. Data from the state health department will generally be more recent than that available from NCHS.

LOCAL: Local health departments may also keep track of birth data for the locality, and may have their own publications.

COMMENTS

Data are available for states, and for civil divisions within states (e.g. by county, city, town and village). In some areas, data are available by census tract.

This measure can be produced separately by race, age, marital status and educational level of mother in all states.[8] As of 1991, 49 states and the District of Columbia separately identify Hispanic children, up from 30 states in 1986. For this reason, however, retrospective data on Hispanic children may not be available in some states.

Since 1989, race specific data taken from the birth certificate have been tabulated based on the race of the mother. Previous to that, such tabulations were based on the race of the non-white parent (if any) or, if both were nonwhite, on the race of the father.[9] One must therefore be cautious about interpreting race-specific trends involving years before and after 1989, as this change will have some small effect on the number of children identified with a particular race.

The most recent available data may be up to two years old in some states, and three years old from the National Center for Health Statistics.

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[8] In six states (California, Connecticut, Michigan, Nevada, New York and Texas), the marital status of the mother is not asked directly, but is inferred by comparing parent and child surnames. In two states, New York and Washington, information on mother's educational level has been available through the federal data system only since 1992.

[9] In Hawaii, the child was identified as Hawaiian if either parent was Hawaiian.

RELATED MEASURES Children whose mothers received late (third trimester) or no prenatal care face the highest levels of risk. For that reason, it may be useful also to track the percent of all births to mothers who receive late or no prenatal care. In 1990, 6 percent of all births fell into this category, though in some areas and among some groups the rate is considerably higher. The information necessary to produce this indicator is also recorded on the standard certificate of birth.

It is important both that prenatal care begin early, and that it be provided continuously throughout pregnancy. The outcome as described indicates only when care started, not whether it was provided regularly and with appropriate frequency throughout pregnancy. It is desirable, therefore, to measure not only the timing of initial care, but the frequency of care also. All of the necessary data are available on the standard certificate of birth.

INDICATOR **NONMARITAL TEEN BIRTHS:** Rate of nonmarital births to teen women ages 15-17

DEFINITION The annual rate per 1000 women ages 15-17 who have nonmarital births.

The indicator is constructed by dividing the number of live births to single women ages 15-17 by the total number of women ages 15-17 in a given year, and multiplying the result by 1000.

((Births to single teen women ages 15-17/all women ages 15-17) x 1000)

SIGNIFICANCE Single teen parenthood is a predictor of future economic hardship for both parent and child. Young mothers are less likely to finish high school, and are far more likely to be poor, unmarried, and welfare dependent than those giving birth at later ages. Children born to single teen mothers are more likely to be disadvantaged as children and as adults.

FACTS In 1991, 188,226 babies were born to mothers ages 15-17 in the U.S. Of that total, approximately 78 percent were nonmarital births. The percent of births that were nonmarital was about 67 percent for whites, and 96 percent for African-Americans of that age.

The annual nonmarital birth rate for females ages 15-17 was approximately 30 per 1000 in 1991. The rate for whites of that age was 21 per 1000, and 81 per 1000 for African-Americans.

DATA SOURCES Mother's age and marital status at birth are reported on the standard certificate of birth in all states. The data are reported by mother's residence, not the location of the hospital.

NATIONAL: National and state level data are available from the Federal government in printed form and as machine readable data. Data are published in a monthly "Monthly Vital Statistics Report", and an annual <u>Vital Statistics of the United States, Volume I—Natality</u>. For these publications, however, there is a three-year lag between the end of the calendar year and the publication date. In addition, machine (computer) readable data are available from the office listed below. These files contain the information from each individual birth record, and can be very useful for those wishing to do their own data analyses.

Natality Branch/Division of Vital Statistics
National Center for Health Statistics (NCHS)
6525 Belcrest Road, Room 840
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301) 436-8954

Estimates of the total number of teen females in a particular jurisdiction for a particular year are available for the nation and for states from the Population Estimates Branch, U.S. Bureau of the Census (301) 763-5002. These estimates are not routinely produced for sub-state jurisdictions such as cities and counties. Those interested in obtaining substate level estimates should contact their State Data Center (see Appendix E).

STATE: State and local data are available from the bureau of vital statistics in each state, usually located within the state health department, which is responsible for collecting birth certificate data and reporting it to the National Center for Health Statistics (see Appendix H). Some state level data also appears in the NCHS publications listed above. Data from the state health department will generally be more recent than that available from NCHS.

LOCAL: Data are available for states, and for civil divisions within states (e.g. by county, city, town and village) from the state health department. In some areas, data are available by census tract, though the absolute incidence is likely to be low and the rates unstable at this fine geographic level. Local health departments may also keep track of birth data for the locality, and may have their own publications.

COMMENTS

These data can be produced separately by race or hispanic origin, age, and educational level of mother in all states[10]. As of 1991, 49 states and the District of Columbia separately identify Hispanic children, up from 30 states in 1986. For this reason, however, retrospective data on Hispanic children may not be available in some states.

Since 1989, race-specific data from the birth certificate have been tabulated based on the race of the mother. Previous to that, such tabulations were based on the race of the nonwhite parent (if any) or, if both were nonwhite, on the race of the father.[11] One must therefore be cautious about interpreting race-specific

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[10] In six states (California, Connecticut, Michigan, Nevada, New York and Texas), the marital status of the mother is not asked directly, but is inferred by comparing parent and child surnames. In two states, New York and Washington, information on mother's education has only been available through the federal data system since 1992.

[11] In Hawaii, the child was previously identified as Hawaiian if either parent was Hawaiian.

trends involving years before and after 1989, as this change will have some small effect on the number of children identified with a particular race.

Most recent available data may be up to two years old in some states, and three years old from the National Center for Health Statistics.

The age range for this indicator has been limited to 15-17. Births before age 15 are rare, though they may be more significant in areas with very high teen birth rates. Therefore, including younger ages would make the overall rate seem artificially low.

RELATED MEASURES There are a number of alternative indicators of teen birth that are commonly used. One such indicator is the percentage of all births that are to single teens. However, changes in this indicator may result from a number of causes. A rise in the birth rate of 15-17 year olds would produce an increase in the proportion of all births to women under age 18, if the post-teen birth rate remained the same. However, a drop in the birth rate of women ages 18 and over could easily produce the same result. For this reason, interpretation of trends in this indicator should be done with caution.

For some purposes, it is useful to look at another indicator of teen birth that can be calculated from birth certificate data; the percent of all births to teens that are second or higher order births. Having a second birth while still a teen further increases the probability of school dropout, welfare receipt, and poor birth outcomes for children. The indicator is also a reasonable measure of the community's capacity to provide adequate family planning and other social supports for first time teen mothers.

Another related indicator is the percent of births to mothers with less than a high school education. Research shows a significant relationship between maternal education and child well-being, especially in school achievement. In families in which the mother has less than a high school education, there is a high likelihood of poverty, that children are more likely to experience difficulties in school, and that children will leave school early. The highest grade completed by the mother is reported on the standard certificate of birth for all states as of 1992.

To track the formation of new at-risk families, one could measure the percent of <u>first births</u> that are to mothers with less than a high school education or diploma. In 1990, approximately 22 percent of all first births were to mothers without a high school education. To track the total portion of the child population that is at-risk at any one time because of the educational status of the mothers, one could measure the percent of all <u>children</u> (rather than births) whose mother has less than a high school credential. This information comes from the Decennial Census, and for most states from the annual March Current Population Survey, by race, living arrangement, etc. Several years of CPS data would be needed to produce reliable estimates for all but the largest states.

It is also important to bear in mind that births to single teens are not a function of the mother alone. The vast majority of fathers to children born to single teen mothers do not live with the mother or child; many have limited or no long-term involvement with the child. With an increased public policy emphasis on encouraging and enforcing long term financial involvement of nonresident fathers, the percent of men fathering children with single teen mothers is also an important indicator. Unfortunately, the coverage of the data available on birth certificates regarding fathers is not good, as many single teen mothers fail to report any information on the father.

INDICATOR

IMMUNIZATIONS: percent of children who have been completely immunized by age two.

DEFINITION

The percent of all two-year olds who have received the full schedule of age-appropriate immunizations against diphtheria, tetanus, pertussis, measles, mumps, rubella, and polio.

This indicator is measured by dividing the number of fully immunized two-year olds by the total number of two-year-olds and multiplying by 100.

((Fully immunized two-year-olds/total two-year-olds) x 100)

SIGNIFICANCE

Proper and timely immunization effectively protects children from a host of debilitating and sometimes deadly childhood diseases. The Federal Public Health Service currently recommends that children receive nine different vaccines (all requiring multiple doses) given in five to seven visits between birth and school entry, most before age 2.

If immunization campaigns are related to an emphasis on connecting the family with an ongoing source of quality health care, measuring the immunization status of two-year olds may also be a proxy measure for the proportion of very young children getting access to at least minimal well-child care.

FACTS

Using a combination of survey and medical record data, the Centers for Disease Control estimates that immunization rates for 1-4 year olds in 1985 (the last year for which national estimates are available) were approximately 75 percent for measles, mumps, polio, rubella, and DPT. However, based on 1990 and 1991 data for 19 urban areas and one rural area, the Centers for Disease Control and Prevention estimates that only 44 percent of children had been fully vaccinated by their second birthday.

Rates of full immunization for children in kindergarten and first grade are close to 100 percent due to the nearly universal requirement that all children attending school be fully immunized.

As part of the *Healthy People 2000* effort, the Federal government has recommended that by the year 2000, at least 90 percent of children should have completed their basic immunization series by age two.

DATA SOURCES

NATIONAL: National estimates of immunization rates among preschool children have not been available since 1985. The Centers for Disease Control, Division of Immunization has resumed collecting data and producing these estimates, which will be available on an annual basis starting in 1994. Estimates for 2 year olds will be produced. For more information contact the Division of Immunization at (404) 639-8235.

STATE: The immunization status of two year old children is not routinely reported by state or local health departments. However, some state health departments have conducted surveys. These surveys are based on a retrospective review of school-entry immunization records. These data are available for some states through the Centers for Disease Control, Division of Immunization (see above). Alternatively, contact the State Data Center (See Appendix E).

LOCAL: Data on immunization of 2 year olds may be available from the local health department or, if such data are collected retrospectively at the time of entry into school, from the local school board.

COMMENTS Any immunization data gathered on the basis of parental report rather than medical records may underestimate the level of immunization by 25 percent or more. Parents often do not recall accurately, or are not aware that their child has been immunized. (This methodology may also overestimate immunization levels if parents erroneously assume or claim that their children have been immunized.) Whenever possible, immunization data should be based directly on medical records.

RELATED MEASURES While it is important to track the incidence of childhood infectious diseases, these data are not a good substitute for measuring the immunization status of children. They may substantially underestimate immunization status since a child may be inadequately immunized but will not show up in infectious disease counts unless there is an outbreak of that disease in his or her community.

One may also wish to track the percent of children entering kindergarten who are fully immunized. In most cases, however, these rates are close to 100 percent because full immunization is required prior to school entry in most localities.

INDICATOR

UNTREATED VISION OR HEARING PROBLEMS:

percent of children with untreated vision or hearing problems at school entry.

DEFINITION Number of children at initial school entry (usually kindergarten) who have an untreated vision or hearing problem divided by the total number of children entering school, and multiplied by 100.

((Number of children entering school with untreated vision or hearing problem/total number of children entering school) x 100)

SIGNIFICANCE Problems with vision and hearing can interfere with a child's ability to learn. These are problems for which screening is simple and inexpensive; most conditions requiring correction are fairly easy to treat.

Facts

In 1990, the U.S. DHHS estimated that about 1 million children (one to two percent) have hearing impairments. By age 16, nearly twenty percent have simple refractive errors (such as near-sightedness or far-sightedness) that impair vision.

Data Sources

NATIONAL: The latest National Health and Nutrition Examination Survey (NHANES III) is a large and comprehensive survey of the health of the U.S. population ages 2 months and older. The survey includes approximately 14,000 children under the age of 18, and was carried out over a six year period, from 1988-1994. All children were given hearing and vision examinations as part of the survey. As of March, 1994 no data on hearing and sight problems of children had been published, but there are plans to do so in the future. For information on publications containing data from NHANES III, contact:

Division of Health Examination Statistics/NCHS
6525 Belcrest Road, Room 1000
Hyattsville, MD 20782
(301) 436-7068

STATE: While there is no centralized state data system for reporting data on untreated vision and hearing problems, some data for specific populations may be available from state health or education departments. State policies regarding school entrance and periodic screening of school children for vision and hearing problems vary by state and by local school district.

Every state has an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for Medicaid-eligible children under age 21 which requires screening, diagnosis, and treatment of eligible children for vision and hearing problems. EPSDT is administered by the state agency designated to handle Medicaid. Responsibility for screening and follow-up treatment may be assigned to state agencies other than the agency administering Medicaid and the EPSDT program. EPSDT coordinators are within departments of health, welfare, social services, or umbrellas human resources and human services agencies.

LOCAL: Local school district offices, as well as individual schools, may have data on untreated vision and hearing problems.

Comments

In some communities these and other health data may be collected as part of a regular school entry screening program, but may not be tallied into school-wide or system-wide incidences and rates. If the data are gathered, however, it may be simple and relatively inexpensive to keep formal tallies.

Related measures

Untreated vision and hearing problems are among a number of conditions which can affect a child's ability to learn. A broader indicator might include data on the number or percent of children who have other untreated developmental disabilities or delays, or health conditions, such as high lead levels, poor nutritional status, learning disorders, or asthma.

Communities may also want to track untreated vision, hearing, or other health problems throughout childhood as some may show up after school entry.

INDICATOR

ABUSE AND NEGLECT: substantiated cases of child abuse or neglect.

DEFINITION

Number of cases in a given year in which abuse or neglect of children has been substantiated.

SIGNIFICANCE

For healthy development, children need a safe and nurturing family environment. This measure suggests the extent to which children's security is threatened rather than protected by the adults on whom they are most dependent.

Child abuse or neglect can result in physical harm, death, or profound developmental and behavioral problems. Abused and neglected children may be at greater risk of becoming delinquents and of mistreating their own children.

FACTS

In 1992, an estimated 1.2 million children were substantiated victims of abuse and neglect (in this context, substantiated means that the appropriate child protection agency investigated the accusation and found sufficient cause to open a case). In that year, more than 2.9 million children were reported abused or neglected, about triple the number in 1980. Nationwide, about 40 percent of reported cases are substantiated. This rate has remained constant since the mid-1980's.

Not all states report on the age of abused and neglected children. However, on average in 1991, an estimated 7.6 percent of the children who were substantiated as being abused were neglected were under one year of age, 31.8 percent between the ages of 1 and five, 38.3 percent between the ages of six and twelve, and 20.8 percent were thirteen and older.

Though the probability of abuse and neglect is higher among minority children, over half (54.7 percent) of abused and neglected children are white. Slightly over half are female (53.2 percent). Parents are the most common perpetrators of abuse and neglect. Neglect is more frequent than abuse.

A national goal of less than 25.2 reported (as opposed to substantiated) cases of child abuse and neglect per 1000 children by the year 2000 has been set by the Federal government as part of its *Healthy People 2000* effort. In 1991, the rate was approximately 45 per 1000, up from 30 per 1000 in 1985.

DATA SOURCES

NATIONAL: There are two regularly published sources of data on child abuse and neglect. The first is an occasionally updated "working paper" series published by the National Center on Child Abuse and Neglect (NCCAN—the data system is called the National Child Abuse and Neglect Data System (NCANDS)).

National rates of substantiated cases of child abuse and neglect are published on an annual basis, and are available from the sources listed below. These data, which are often available for states as well, are available by age, race, and sex of children; form of maltreatment; and relationship to perpetrator. These reports and papers from the NCANDS working paper series are available from the following source:

Clearinghouse on Child Abuse and Neglect
PO Box 1182
Washington, D.C. 20013
(703) 385-7565
(800) FYI-3366

In addition, the National Committee for the Prevention of Child Abuse, a private organization, has since 1986 conducted an annual survey of states, and publishes the following information: national estimates on child abuse and neglect reports and fatalities; state estimates of fatalities; nationally averaged substantiation rates for child abuse and neglect reports; and percentage change in child abuse and neglect reports and forms of maltreatment by state. The most recent report, titled "Current Trends in Child Abuse Reporting and Fatalities" is available from the following source:

National Committee for the Prevention of Child Abuse
332 South Michigan Avenue
Suite 1600
Chicago, Illinois 60604
(312) 663-3520

STATE: Reports of the number of substantiated cases of child abuse and neglect are available for most states in the NCANDS "working paper" publications cited above. Data for substantiated cases not available through the Clearinghouse may be available through state agencies.

All states have a central registry of reported cases of child abuse and neglect maintained by the division of child protective services usually within state departments of social or human services (see Appendix C).

LOCAL: Most city or county jurisdictions maintain a central registry of reported and substantiated child abuse and neglect cases in the division of child protective services within social services departments.

COMMENTS

Data on substantiated cases of child abuse and neglect may not be comparable across states, because states have different ways of recording the data. Some states keep them by incident, while others keep them according to family (where multiple incidents may have occurred). Users need to know how the data are kept in their state or locality.

Data on child abuse and neglect can be affected by jurisdictional variations in definitions of child abuse and neglect, counting procedures for reports, investigation procedures, methodologies for collecting statistics, and program policies and capacities. One should therefore use extreme caution in comparing rates across jurisdictions. In addition, one needs to be aware of significant changes in these factors within a jurisdiction, as they may affect the number of cases reported independently of the actual incidence of child abuse and neglect.

RELATED MEASURES

To compare jurisdictions or track changes over time, one should follow social trends, including abuse and neglect, using percentages or rates rather than absolute numbers. Unlike raw numbers, rates will tell you unambiguously whether the risk of a child's being abused or neglected is increasing or decreasing. Unfortunately, annual estimates of the child population (necessary to the production of percentages and rates) are not generally available below the state level except at the time of the decennial census. If such estimates are available for the community, then the rate may also be calculated. Such estimates may be available from the State Data Center (see Appendix E). Annual estimates are available at the national and state level from the Population Estimates Branch, U.S. Bureau of the Census (301) 763-5002.

Because of the relatively rare incidence of this problem, the child abuse or neglect rate is commonly expressed as a rate per 1000. It is measured by dividing the number of cases of indicated abuse or neglect by the total number of children under age 18 and multiplying by 1,000.

Although abuse and neglect cases are commonly reported together, they are distinct outcomes, the former involving actual physical or emotional attacks. For some purposes it may be fruitful to track them separately, identifying where one, the other, or both are present. For example, abuse is most effectively addressed by a different set of remedies than neglect. Communities will need to know the scope of each separate problem before they can make decisions on programs or services to address them.

Most communities track reported as well as substantiated cases of child abuse and neglect. In addition, the national goal refers to reported rather than substantiated cases (see above).

INDICATOR

CHILDREN IN OUT-OF-HOME CARE: **number of children under 18 in out-of-home care.**

DEFINITION

Number of children who were placed in temporary or permanent out-of-home care (or "substitute" care) through child welfare agencies for at least one day in the year, including placement in a foster family home, group home or shelter, non-finalized adoptive home[12], or other substitute care facility (e.g. maternity home, mental retardation or correctional facility).

SIGNIFICANCE

The number of children in foster or substitute care reflects on the well-being of children and the functioning of the child welfare system. It is a rough index of social conditions and the conditions within families which pose substantial risk to children. Family instability, poverty, crime, violence, homelessness, substance abuse, and serious illness may contribute to the need to find alternative care. Data on the number, condition, length of stay, and outcomes for children in foster care indicate in addition how well the child welfare system is functioning to protect and nurture children.

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[12] Non-finalized adoptive home here means a home in which the parents intend to adopt the child but have not yet completed the process.

As explained in the Comments section below, it is important to recognize that increases or decreases in the number of children in out-of-home care are not intrinsically good or bad. Numbers may increase or decrease for a variety of reasons, and any presentation of the data must be accompanied by analysis to indicate if changes indicate beneficial trends.

FACTS

In Fiscal Year 1992, a total of 659,000 children were served by the states' child welfare system. In June 1992, a one-day census found 442,000 in foster care of some kind, a 68 percent increase over the number a decade before.

In 1991, an annual "checkpoint" day found that 69,237 juveniles were being held for delinquent offenses in public or private juvenile detention, corrections, and shelter facilities.

A 1988 one-day census showed that there were 1,676 juveniles in county and municipal jails. A 1990 one-day census indicated there were 3,600 children under age 18 in state and Federal correctional facilities.

DATA SOURCES

NATIONAL: A voluntary survey of states has been conducted annually since 1982. While in 1991 all states responded, not all states report on all questions. And in previous years, not all states reported. Definitions and reporting periods vary among states. In 1986, Congress mandated an improved data reporting and tracking system. This new system is expected to be in place by the end of 1995. For more information, contact:

Voluntary Cooperative Information System (VCIS)
American Public Welfare Association
810 First Street, N.E., Suite 500
Washington, D.C. 20002-4267
(202) 682-0100

STATE: Every state has a child welfare agency which reports annual data on children under its custody (see Appendix D). These agencies are most often within departments of human services, human resources or social services.

LOCAL: Local data may be available from county or city child welfare agencies.

COMMENTS

Each state has its own legal, administrative and programmatic structure for its child welfare programs. It is important to identify changes in service capacity and policy changes in reviewing trend data. A new emphasis on preventive and rehabilitative service to keep families together rather than removing children from their homes may be reflected in a decrease in the child welfare population. Similarly, budget cuts decreasing child welfare service workers may also limit follow-up on reported cases of child abuse and neglect and therefore a decrease in the number of children placed in substitute care. Because this indicator is so important, and yet quantitative data on it are especially difficult to collect and interpret, communities may want to continually re-investigate means to measure performance on this outcome.

More than two-thirds of foster children are removed from their homes because of neglect, caretaker incapacity or absence. Parental use of illegal drugs and abuse of alcohol are important contributing factors to the decision to remove a child. Other reasons for removal include physical and sexual abuse, child delinquency, parental incapacity or unwillingness to care for a child's disability, and other reasons.

Most children are placed in foster family homes. There is a growing interest in kinship care, placement with family relatives. Group homes and special shelters are also used.

It is difficult to put together a coherent picture of all children in out-of-home care. Some data are collected by facility or program (e.g. number of children in county and city jails), and some collected by the agency (e.g. corrections, mental health, child welfare) that places children in a variety of facilities or programs. Cross-tabulating the two is difficult.

RELATED MEASURES The percent of placements of children in substitute care that are repeat placements reflects the capacity of the child welfare agency to marshal the family supports necessary to ensure children's safety and well-being once they are returned home.

Children need stability to thrive. Measuring the length of stay of children in foster care and the number of placements while in care assesses the capacity of the child welfare system to meet this need. On average, by the end of the 1980's children were spending less time in substitute care but experiencing an increase in the number of separate placements during their continuous stay.

Every ten years when the Decennial Census is taken, it is also possible to measure the number of children who live away from their families in group quarters (e.g. prisons, mental hospitals, juvenile facilities), rooming homes, and emergency shelters). These are not just children sponsored by the child welfare system but also those placed by other state agencies, including corrections and mental health. Data are available by state, county, city, and census track and by age, gender and race. Contact the state data center (see Appendix E). Census data will reflect the location of the placement site rather than the residence of the parents.

INDICATOR

CHILD POVERTY: the percent of children in poverty.

DEFINITION The percent of children living below the Federally established poverty line.

The indicator is constructed by dividing the number of poor children under the age of 18 by the total number of children under age 18, and multiplying the result by 100.

((Children under 18 in families under poverty line/total children under 18) x 100)

The Federal poverty definition takes into account both income and family size, with higher income cutoffs for larger families. The poverty line is a multiple (3 times) of the amount of money it takes on average to feed a family of a particular size an adequate diet for a year.

SIGNIFICANCE

Growing up in poor and low income families has been associated with a host of negative outcomes for children including less adequate prenatal care, low birthweight and higher infant mortality, slower cognitive development, lower levels of school readiness, and lower levels of educational and socioeconomic attainment as adults.

FACTS

In 1991, there were an estimated 13.7 million children living in poverty in the U.S. This represents a 7.4 percent increase over 1990. In 1990, 18.2 percent of all children were poor. Poverty rates for African-American and Hispanic children were much higher, at 39.7 percent and 32.2 percent, respectively.

There is a great deal of variation across states in the percent of children who are poor, ranging from a low of 7.4 percent in Connecticut to a high of 33.6 percent in Mississippi.

In 1992, the poverty line for a family of four was $13,950.

DATA SOURCES

NATIONAL: Annual national estimates of child poverty rates are produced by the Federal government based on data from the March Current Population Survey, and from the Survey of Income and Program Participation (SIPP). They are available in the following Census publication (there is a separate publication for each year):

> Poverty in the United States. U.S Bureau of the Census, Current Population Reports, Series P-60.

To order, call Census Customer Services at (301) 763-4100.

STATE: Annual estimates of the percent of children in poverty can be produced for specific states using data from the March Current Population Survey. Due to small state sample sizes in this data set, reliable estimates for most states can only be produced by combining up to five years worth of survey data. State estimates generated using this technique are published annually in the *Kids Count Data Book*, which can be ordered from the Annie E. Casey Foundation. These estimates may not be very reliable for states with the smallest populations.

Kids Count, Annie E. Casey Foundation
111 Market Place, Suite 420
Baltimore, MD 21202
(410) 234-2872

LOCAL: Child poverty rates at the substate level (e.g. counties, cities, metropolitan areas) are available every 10 years from the decennial census. Estimates for 1990 are published in the Census publication series titled *General Population Characteristics, 1990.* There is a separate report for each state. These reports are available in many libraries, and can be ordered from the Census Data User Services (301) 763-4100.

For years falling between decennial censuses, local estimates of child poverty are generally not available. Researchers in New York state have recently developed a technique for producing county level child poverty estimates using both decennial census data and annual administrative data for means-tested program participation (e.g. AFDC). This technique is explained in detail in the following publication, which can be requested from the authors:

Postcensal Estimates of Poverty for New York State Counties by Seth Leon
and Nancy Dunton
New York State Department of Social Services
40 N. Pearl St., 16D, Albany, NY 12243

This method is specific to New York state, and may not be applicable to other states without modification. Contact representatives of the State Data Center (see Appendix E) to see whether similar estimation procedures have been developed for specific counties in a given state.

COMMENTS

Because the cost of living can differ substantially from county to county and state to state, the Federal poverty level will represent greater hardship in those areas where the cost of living is higher.

Some may wish to use AFDC, Food Stamp recipiency or participation in the subsidized school lunch program to track child poverty, because such data are available for counties and states on an annual basis. However, the number of children living in families receiving AFDC or Food Stamps is quite sensitive to changes in program eligibility requirements, and in interpretation and local enforcement practices of existing eligibility rules. Variations across these dimensions over time and across jurisdictions make this an unreliable proxy measure for trends in the child poverty rate.

RELATED MEASURES

The official poverty rate measure defines a rather austere level of existence. Available research suggests that children who are "near poor" also suffer disadvantages compared to children who are better off materially. Some government means-tested programs allow participation of families that earn some percentage above the poverty line. One may wish to track the percent of children living at or below 133 percent, 150 percent, or 200 percent of the Federal poverty line.

INDICATOR

HIGH SCHOOL DROPOUT: The percent of students ages 15 and older who drop out of school during a 12-month period.[13]

DEFINITION

The percent of students ages 15 and older and enrolled in grades 10-12 who leave school without graduating during a 12-month period.

The indicator is constructed by identifying all secondary school students age 15 and older who are enrolled in grades 10-12 at the beginning of the school year, and who are not enrolled and have not graduated by the beginning of the

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[13] This age cut-off was chosen because most of the available data is segmented at this point. In addition, few states allow drop-out before age 15, and so the rate is much lower at younger ages. Including younger children would therefore artificially deflate the rate.

next school year.[14] This number is divided by the total number of students ages 15 and older enrolled in grades 10-12 at the beginning of the year, and multiplied by 100.

((Students enrolled at start of one year but not enrolled or graduated at start of next year/students enrolled at start of initial year) x 100)

SIGNIFICANCE

Dropping out of high school can have serious negative long term consequences for youth. Those who drop out are significantly less likely to be regularly employed well into their twenties. The jobs available to those who have dropped out generally do not pay well, are unstable, and have limited opportunities for upward mobility.

For young women, dropping out of school is associated with a higher probability of subsequently becoming a teen mother, further restricting the opportunities of the young mothers and increasing the risks their children face as they grow up.

FACTS

In 1990, the annual dropout rate for persons ages 15 and older and in grades 10-12 was approximately 4 percent. Rates were somewhat higher for African-American students at about 5 percent, but considerably higher for Hispanic students at 8 percent.

Since 1973, annual dropout rates have decreased by about one-third overall, and by over 40 percent for African-American students.

The percent of students who drop out permanently is of course considerably higher than the annual dropout rate. In 1990, 15.7 percent of all persons ages 20-24 had not completed high school.

The Department of Education has adopted as a goal for the year 2000 that at least 90 percent of all children will graduate from high school.

DATA SOURCES

NATIONAL: National estimates for this indicator are based on the October Current Population Survey and are published on an annual basis in "Dropout Rates in the United States", published by the U.S. Department of Education, National Center for Education Statistics. (202) 219-1651.

STATE: State level estimates based on October CPS data are not currently produced. By combining data for 3-5 years, it is possible, though statistically very complicated, to produce state level estimates. Such estimates can only be produced for the larger states (perhaps the 10 or 15 most populous), because only one-half the survey sample can be used to produce this particular indicator.

Some state departments of education may produce this or a similar indicator measuring annual high school dropout rates (see Appendix A).

LOCAL: Local school districts may keep this or a similar indicator. If they do not, such information can be produced based on student records. As a practical

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[14] A dropout is identified as one who is not graduated, not enrolled in the school system, and for whom there is no evidence (such as a request for records) of having transferred to another school system.

matter, however, this may prove difficult if student records are not computerized and very complete.

COMMENTS

The recommended indicator is subject to substantial yearly fluctuations, largely in response to changes in the economy. To minimize these fluctuations, it is advisable to compare three-year averages (e.g. 1990-92, 1991-93, 1992-94, etc.). This technique will minimize year-to-year changes, but will highlight longer term trends more accurately.

Some secondary schools are ungraded; they should use age ranges and enrollment in the school rather than grade levels to determine drop-out rates.

RELATED MEASURES

There are several useful indicators related to high school dropout that can be produced, each with its own strengths and limitations. This annual measure is recommended over a measure of permanent dropout (e.g. the percent of 20-24 year olds who never finish high school) for several reasons. First, as a practical matter, data of this sort are very expensive to collect at the local level, requiring a large, random sample survey of the local population of 20-24 year olds. Second, such data will be less sensitive to recent changes in high school completion trends since one is looking at an older age group.

However, those two conditions notwithstanding, the proportion of youth ages 20-24 who are not high school graduates is an excellent measure of permanent dropout at the national level, and over time. National estimates are available on an annual basis from the Digest of Education Statistics, published by the National Center for Education Statistics. To order, call (202) 219-1651.

In calculating high school dropout rates, there is some question as to whether those receiving their GED (general education development) certificate should be included with those who have received a high school diploma. Available research suggests that GEDs are worth considerably less in the labor market than actual degrees. For most purposes, we recommend that those receiving GED's be treated separately.

The Department of Education maintains and publishes several measures related to high school dropout. One looks at the proportion of ninth graders who graduate four years later. This is produced by taking the total number of high school graduates in a school system (or state) and dividing by the total number of ninth graders enrolled four years earlier. This is a very easily produced statistic, and can be reasonably useful so long as there is not a lot of migration into or out of the school district in the intervening years; this would artificially inflate or deflate the true graduation rate. Such an indicator, even if otherwise accurate, will underestimate the total percent of students who graduate from high school, since some will take longer than four years to graduate, while others will return and finish their degree at a later age.

INDICATOR

SUBSTANCE ABUSE: abuse of alcohol and use of illegal drugs by youth in grades 7-12.

DEFINITION

The percent of youth in grades 7-12 who have consumed five or more drinks of alcohol on a single occasion in the last 30 days.

The percent of youth in grades 7-12 who have taken illegal drugs (other than alcohol) within the last 30 days.

These indicators are constructed by dividing the number of youth in grades 7-12 who have consumed five or more drinks of alcohol on a single occasion (or taken illegal drugs) by the total number of youth in grades 7-12, and multiplying by 100.

((Youth in grades 7-12 who have abused alcohol (or taken illegal drugs)/all youth in grades 7-12) x 100)

SIGNIFICANCE

The consumption of alcohol and use of illicit drugs places adolescents at risk of health, education and social problems and physical danger. Drug use and alcoholic consumption are both a precursor and reflection of low self-expectations and poor performance, lack of parental and community supports and options. Illicit drug use is higher among those teens who have no post-high school plans. High-risk activity at an early age is often a predictor of later problem behavior.

FACTS

In 1991, a survey of students in grades 9-12 revealed that 51 percent had consumed alcohol in the previous 30 days, and 31 percent had consumed five or more drinks on one or more occasions in the last 30 days. Fifteen percent had smoked marijuana, and 2 percent had used cocaine within the last 30 days. Another 1991 study found that an estimated 1.2 million adolescents ages 12-17 had ever used at least one illicit drug, and an estimated 4.6 million had reported ever using alcohol. Overall the rates of alcohol and illicit drug use by adolescents were lower in 1991 than at any time since the late 1970's though it remains a problem.

In fiscal year 1991, 60,561 children under age 18 were admitted for alcohol treatment.[15] Most were males. Most were white. In fiscal year 1991, 75,784 children under age 18 were admitted for drug treatment. Most were male and white, though the differences were not as great between males and females and whites, blacks and Latinos as for alcohol treatment.

DATA SOURCES

NATIONAL: The National Institute on Drug Abuse, Division of Epidemiology and Preventive Research, conducts a "National Household Survey on Drug Abuse" which provides national data. Results from this survey are available in the following publication: U.S. Department of Health and Human Services (1990). National Household Survey on Drug Abuse: Main Findings 1988. DHHS Publication No. (ADM)90-1682). Washington, D.C.: GPO.

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[15] These children received treatment in facilities and programs that received funds administered by the state alcohol and drug abuse agencies.

If you wish to procure the survey for analysis, contact:

National Institute on Drug Abuse
Division of Epidemiology and Prevention Research
Rockwall II, Suite 615
5600 Fishers Lane
Rockville, MD 20857
(301) 443-7980

Similar data are gathered through the Youth Risk Behavior Surveillance System, an annual survey of students in grades 9-12. Results of this are published, and are available to the public through the following source:

Centers for Disease Control and Prevention
Division of Adolescent and School Health
4770 Buford Highway NE
Mail stop K33
Atlanta, GA 30341-3724
(404) 488-5330

The *Monitoring the Future* survey has been collecting information on drug and alcohol use by high school seniors on an annual basis since 1975. To order publications containing the results of this survey, including information on drug and alcohol use, contact:

Patrick O'Malley
Institute for Social Research
University of Michigan
Ann Arbor, MI 48106-1248
(313) 763-5043

Caution should be exercised in data from this study and the Youth Risk Behavior Surveillance Survey, however, since both they fail to cover high school dropouts, students who are arguably most at risk.

STATE: Every state has an agency that collects data on substance abuse (see Appendix B). These agencies are within state departments of health or mental health.

In addition, 43 states and 13 large cities now conduct their own semi-annual Youth Risk Behavior Survey, in coordination with the national Youth Risk Behavior Surveillance System run by the Centers for Disease Control. These surveys are expected to continue at least through the year 2000. For information on participating states and cities, please contact:

Centers for Disease Control and Prevention
Division of Adolescent and School Health
4770 Buford Highway NE
Mail stop K33
Atlanta, GA 30341-3724
(404) 488-5330

LOCAL: Local data may be available from health departments or from school systems. In addition, some large cities participate in the Youth Risk Behavior Surveillance System (see above).

COMMENTS Because drug use is a sensitive issue, surveys will tend to under-report the actual incidence of alcohol and drug use among youth.

Surveys that interview only students (such as the Youth Risk Surveillance Surveys) do not include dropouts, those most likely to have alcohol and drug problems. This becomes a significant problem for older teens, as youth begin to drop out of high school at around the tenth grade.

RELATED MEASURES Tobacco use is another major health hazard for the fetuses of pregnant teens, and is a precursor of future use and poor health outcomes into adulthood. The surveys reviewed above also collect data on tobacco use among youth, and communities may want to monitor these data as well.

INDICATOR **VIOLENT YOUTH CRIME: Number of arrests for violent crime among youths, ages 10-17.**

DEFINITION The number of arrests of youths ages 10-17 for homicide, forcible rape, robbery, or aggravated assault, including repeat arrests of the same youth within the given year.

SIGNIFICANCE Arrests of youthful offenders for violent crimes is a measure of anti-social and self-destructive behavior. It is an indicator of more severe dysfunction than arrests for any crime.

FACTS In 1991, it is estimated that 130,000 youth arrests were made for rape, robbery, homicide, or aggravated assault—42,000 more arrests than in 1986. The national juvenile violent crime arrest rate per 100,000 youths ages 10-17 was 466 in 1991, a 48 percent increase in the rate since 1986 when it was 314 arrests per 100,000 youths ages 10-17.

In 1991, black youths were five times more likely to be arrested for a violent crime than white youths. However, the white juvenile violent crime rate between 1986 and 1991 increased more rapidly than the black rate.

Male juveniles were seven times more likely than females to be arrested for a violent crime. However, between 1986 and 1991, the rate for females increased more rapidly than the rate for males.

While juvenile arrests for violent crimes represent a small portion of all juvenile arrests, they are a significant proportion of all arrests for violent crime.

DATA SOURCES NATIONAL: "Crime in the United States: Uniform Crime Reports" provides annual reports by state, age, and gender for 28 offenses. Offenses are reported according to the jurisdiction in which the arrest was made. These reports can be ordered from:

National Criminal Justice Reference Service
U.S. Department of Justice
Rockville, Maryland 20850
(800) 851-3420

Special runs for particular localities will be produced for a fee by the Law Enforcement and Support group within the Federal Bureau of Investigation, (202) 324-5015. The resulting data are available on hard copy or computer tape.

STATE: State data are available from the publication listed above. In forty-one states and the District of Columbia, there is a state Uniform Crime Reports contact from which state and local data can be obtained (see Appendix G).

State departments of public safety, state police departments or associations of police chiefs and sheriffs, or state bureaus of investigation may publish state and local annual crime statistics by sex, race, age and offense. Not all jurisdictions regularly report this information, however.

All fifty states have criminal justice statistical analysis centers that function as data and clearinghouse centers (see Appendix F).

LOCAL: City or county departments of public safety, local police departments of sheriffs' offices may be able to provide data not retrievable from the above state and Federal sources.

COMMENTS

Arrests are not a count of youthful offenders but of incidents. An offender may be reported more than once during the year.

The number of arrests can vary substantially from jurisdiction to jurisdiction and over time due to differences or changes in juvenile arrest policies. The tracking of violent crimes rather than all crimes has been recommended because they are less affected by variations in juvenile arrest policy. In addition, the relationship between arrests and conviction is tighter than for nonviolent crimes.

Juvenile arrest rates can also be affected by changes in the size of the juvenile population. For example, if a locality is experiencing a rapid increase in population size through in-migration, the absolute number of arrests will increase even though the arrest rate stays the same.

RELATED MEASURES

Ideally one should follow social trends, including violent crime, using percentages or rates rather than absolute numbers. Unlike raw numbers, rates indicate unambiguously whether the rate of youth arrests for violent crime is increasing or decreasing. (However, it is important to bear in mind that since the data are based on number of arrests, not number of people arrested, the rate does not reflect an individual's chance of being arrested.) Unfortunately, annual estimates of the child population ages 10-17 (necessary to the production of percentages and rates) are not generally available below the state level accept at the time of the decennial census. If such estimates are available for the community, then the rate may also be calculated. To see if such estimates are available, contact that State

Data Center for your state (see Appendix E). Annual estimates are available at the national and state level from the Population Estimates Branch, U.S. Bureau of the Census (301) 763-5002.

The juvenile violent crime arrest rate is the number of arrests of youths ages 10-17 for violent crimes divided by the number of youths of the same age, multiplied by 100,000. This rate is commonly reported as "per 100,000" because arrests are relatively rare events.

((Arrests of youth ages 10-17 for violent crimes/total youth ages 10-17) x 100,000)

For greatest accuracy, rates will need to be adjusted for under-reporting, since most states have fewer than 100 percent of all localities reporting crime statistics. For advice concerning such adjustments for a particular locality, contact the Law Enforcement and Support group within the Federal Bureau of Investigation, (202) 324-5015.

INDICATOR

TEEN SUICIDE: Number of teen suicides among youth ages 15-19.

DEFINITION

The number of youths per 100,000 ages 15-19 who die each year from suicide.

SIGNIFICANCE

The incidence of teen suicides is an indicator of teenage stress, mental health and community and family support. A high incidence of youth suicides reflects inadequacies in family and social supports, health and mental health services, and opportunities for success and a sense of well-being.

The risk of suicide is heightened among those youths with a history of mental illness or mental disorder, drug or alcohol abuse, recent behavioral changes such a depression or truancy, previous attempts at suicide or suicide by a family member. Also at greater risk are those teens in stressful situations, such as parental divorce or separation, an unwanted pregnancy, loss of a parent or close friend, sense of failure or humiliation.

Morbidity due to failed suicide attempts has important public health significance. Failed attempts can result in brain damage, internal injuries or permanent disability and continued emotional stress.

FACTS

Between 1985 and 1990 a total of almost 12,000 teens ages 15-19 committed suicide. The teen suicide rate for this age group was 11.1 per 100,000 teens in 1990.

Male teens are more likely than females to commit suicide. White teens are twice as likely as black teens to commit suicide. White male teens are at greatest risk.

Sixty-seven percent of youths ages 15-19 who commit suicide do so with firearms. A national goal to reduce suicides among youths ages 15 through 19 to no more than 8.2 per 100,000 youths of the same age by the year 2000 has been set by the Federal government as part of its *Healthy People 2000* effort. A target to reduce by 15 percent the incidence of injurious suicide attempts among adolescents is also included.

DATA SOURCES The cause of death is reported on the standard death certificate in all states. Data are reported by residence, not by the location of the suicide.

NATIONAL: National data on suicide is published in the following annual volume, which is available in most research libraries: Vital Statistics of the United States, Volume II—Mortality, published by the National Center for Health Statistics.

STATE: State and local data are available from the bureau of vital statistics in each state (see Appendix H), usually located within the state health department. Data may also be available from the state departments of public safety.

LOCAL: Data on the number of teen suicides in a locality may be available from state or local departments of health or public safety.

COMMENTS Because the number of suicides each year is small, this indicator may not be a useful benchmark in many communities and some states.

Data on suicides may be under-reported. Social stigma and guilt or cultural factors may contribute to an under-reporting of suicides by families, physicians and others. Some suspected cases may be reported as accidents.

RELATED MEASURES To compare jurisdictions or to track changes over time, one should follow social trends, including teen suicide, using percentages or rates rather than absolute numbers. Unlike raw numbers, rates will tell you unambiguously whether the risk of youth suicide is increasing or decreasing. Unfortunately, annual estimates of the youth population ages 15-19 (necessary to the production of percentages and rates) are not generally available below the state level accept at the time of the decennial census. If such estimates are available for the community, then the rate may also be calculated. To see if such estimates are available between censuses, contact that State Data Center for your state (see Appendix E). Annual estimates are available at the national and state level from the Population Estimates Branch, U.S. Bureau of the Census (301) 763-5002.

The rate is constructed by dividing the number of teenagers ages 15-19 who die each year from suicide by the total number of youths ages 15-19 and multiplying by 100,000. This rate is commonly reported as "per 100,000" because suicides are relatively rare events.

((Teens ages 15-19 who die by suicide/total teens ages 15-19) x 100,000)

INDICATOR

TEEN HOMICIDE: teen homicide rate among youth ages 15-19.

DEFINITION

The number of deaths due to homicide in any given year per 100,000 youths ages 15-19.

SIGNIFICANCE

The incidence of teen deaths by murder is an indicator of teen delinquent behavior, hostility and anger. It is also a reflection of access to firearms. Most teenage murder victims are killed by other teenagers.

It is also an indicator of community safety—the perception of risk which when heightened may diminishes lives and may lead to mental health and behavioral problems; the actual risk of harm or murder to others; and the availability or trafficking of destructive agents such as guns, alcohol, and drugs.

Most teen homicides involve the use of firearms. However, the use of drugs, the support of drug use or interactions related to drug use are also common factors associated with teen homicides.

FACTS

In 1990, there were 3,042 deaths from homicides among adolescents age 15-19 for a rate of 17.0 homicides per 100,000 teens.

Homicide is the second leading cause of death among fifteen-to-nineteen year olds. It is the leading cause for males in this age group and for both male and female African-American teenagers. In 1990, the death rate from homicide for black youths was eight times the rate for whites and has been increasing dramatically in recent years.

DATA SOURCES

The cause of death is reported on the standard death certificate in all states. Data are by residence, not the location of the homicide.

NATIONAL: National data on homicide are published in the following annual volume, which is available in most research libraries: Vital Statistics of the United States, Volume II—Mortality, published by the National Center for Health Statistics, Division of Vital Statistics.

STATE: State and local data are available from the bureau of vital statistics in each state (see Appendix H), usually located within the state health department. Data may also be available from the state departments of public safety.

LOCAL: Data on the number of teen homicides in a locality may be available from state or local departments of health or public safety.

COMMENTS

Because the number of teen homicides each year is small, this indicator may not be a useful benchmark in many communities and some states.

RELATED MEASURES

To compare jurisdictions or to track changes over time, one should follow social trends, including teen homicide, using percentages or rates rather than absolute numbers. Unlike raw numbers, rates will tell you unambiguously whether the risk of youth homicide is increasing or decreasing. Unfortunately, annual estimates of the youth population ages 15-19 (necessary to the production of percentages and rates) are not generally available below the state level accept at the time of the decennial census. If such estimates are available for the community, then the rate may also be calculated. To see if such estimates are available between censuses, contact that State Data Center for your state (see Appendix E). Annual estimates are available at the national and state level from the Population Estimates Branch, U.S. Bureau of the Census (301) 763-5002.

The rate is constructed by dividing the number of teenagers ages 15-19 who die each year from suicide by the total number of youths ages 15-19 and multiplying by 100,000. This rate is commonly reported as "per 100,000" because suicides are relatively rare events.

((Teens ages 15-19 who die by homicide/total teens ages 15-19) x 100,000)

Another child and community safety measure is the number of deaths by firearms among children of all, or specified ages. In 1991, 5,261 children birth through age 19 died as a result of a firearm injury from homicides, suicides, and accidents.

The prevalence of childhood injuries that do not result in death but are serious enough to require medical attention is another measure of child safety. Data, however, are scattered. National data are collected by a number of different agencies depending on the cause of the injury (e.g. burns, traffic injuries, suicide attempts, etc). No state currently has a childhood injury tracking system. Hospital emergency rooms are not required to maintain data on released patients or to code the cause of an injury. However, about a dozen states have passed legislation mandating that hospital collect with their patient data an "external cause of event code" on how and where an injury occurred.

INDICATOR

ACCIDENTAL DEATHS: number of accidental deaths per 100,000 among children and youths ages 1-19.

DEFINITION

Number of children ages 1-19 who die each year as a result of unintentional injuries (e.g. traffic fatalities, fires and burns, drownings, poisonings/choking, firearms, and falls).

SIGNIFICANCE

This measure is an indicator of risk to children's health, and of risk-taking behavior, especially among older adolescents. It is also a measure of the adequacy of a broad range of public health and accident prevention strategies, including public education, product development and use (e.g. bike helmets, safety belts, smoke detectors, etc.), and risk reduction and treatment resources (e.g. alcohol abuse prevention and treatment, poison control centers, recreation options). Fatalities from accidents are higher in lower-income areas because of many factors, including poorer emergency and medical care, and more hazardous environments (e.g older roads and cars, and housing).

FACTS

In 1990, 13,777 children aged 1-19 died of accidental injury. The age range broke out into 2,566 deaths for ages 1-4; 1,777 for ages 5-9; 1,879 for ages 10-14; and 7,561 for ages 15-19.

For all age groups, motor vehicle injuries are the leading cause of injury-related death. Other causes include fires and related burns, firearms, falls and drownings. The motor vehicle accident death rate for fifteen-to-nineteen year-olds is five times the rate of any other category of unintended injury. Male teens are more likely than females to die in a motor vehicle accident. White males are at greatest risk.

DATA SOURCES

The cause of death is reported on all standard certificates of death in every state (see Appendix K). The data are reported by residency, not by the location of the accidental death.

NATIONAL: National data on causes of death are published in the following annual volume, which is available in most research libraries: <u>Vital Statistics of the United States, Volume II—Mortality</u>, published by the National Center for Health Statistics, Division of Vital Statistics.

STATE: State and local data are available from the bureau of vital statistics in each state, usually located within the state health department. Data may also be available from the state departments of public safety.

LOCAL: Data on the number of deaths from accidents in a locality may be available from state or local departments of health or public safety.

COMMENTS

To compare jurisdictions or to track changes over time, this indicator should be expressed as a rate in order to control for the impact of demographic changes.

RELATED MEASURES

To compare jurisdictions or to track changes over time, one should follow social trends, including accidental death, using percentages or rates rather than absolute numbers. Unlike raw numbers, rates will tell you unambiguously whether the risk of accidental death is increasing or decreasing. Unfortunately, annual estimates of the population ages 1-19 (necessary to the production of percentages and rates) are not generally available below the state level accept at the time of the decennial census. If such estimates are available for the community, then the rate may also be calculated. To see if such estimates are available between censuses, contact that State Data Center for your state (see Appendix E). Annual estimates are available at the national and state level from the Population Estimates Branch, U.S. Bureau of the Census (301) 763-5002.

The rate is constructed by dividing the number of children ages 1-19 die each year from accidents by the total number of children ages 1-19 and multiplying by 100,000. This rate is commonly reported as "per 100,000" because accidental deaths are relatively rare events.

((Children ages 1-19 who die from accidents/total children ages 1-19) x 100,000)

Because motor vehicle fatalities make up such a large portion of accidental deaths, it may be advisable to track the incidence of motor vehicle fatalities. In addition to data compiled by offices of vital statistics, each state has an agency responsible for compiling data on fatal motor vehicle accidents based on death certificates. This agency varies from state to state but includes state departments of transportation, of motor vehicles or state police. The state and local data are fed into the Fatal Accident Reporting System. FARS data are collected continuously by local police departments and reported to the National Highway and Traffic Safety Agency by the state agency. NHTSA publishes monthly fact sheets and quarterly and annual reports. Data are reported by single-year ages, relationship of children to the vehicle, related causes. There is a two to three month lag between collection and publication of data. These publications can be ordered from the following source:

National Highway and Traffic Safety Administration
National Center for Statistics and Analysis
U.S. Department of Transportation
400 7th St., SW
Washington, D.C. 20590
(202) 366-4198

Jurisdictions may also want to track accidental injury rates in addition to death rates. Injuries cause their own stream of additional societal and personal costs. These would yield far greater numbers and therefore give a more detailed picture of the problems causing both injury and death. However, injury data are more difficult to find and to classify—communities may need to use hospital discharge data or other disparate sources to find this information.

INDICATOR

SEXUALLY TRANSMITTED DISEASE, AIDS AND HIV AMONG TEENS: Incidence of sexually-transmitted diseases, AIDS and HIV infection (tracked separately) among adolescents age 15 through 19.

DEFINITION

The number of new cases each year of each sexually-transmitted disease, AIDS and HIV infection among youth ages 15 through 19. The most common sexually-transmitted diseases include gonorrhea, syphilis, chlamydia, and genital herpes. Each of these diseases should be tracked separately.

SIGNIFICANCE

The incidences of sexually-transmitted diseases are indicators of adolescent risk-taking behavior (i.e. unprotected sexual activity) which can lead to poor health outcomes.

HIV/AIDS among teens and adults are transmitted primarily through the risk behaviors of unprotected sexual activity and drug use, though it is also transmitted through blood transfusions.

These indicators are also in part a measure of teens' access to health education and care and family planning services. Sexually-transmitted diseases are preventable and curable. HIV is preventable and while it is not presently curable, its impact can be managed through care.

FACTS

Since the 1970's, teen sexual activity among adolescents has increased and with it the spread of sexually-transmitted diseases and HIV infection among teens.

As of July, 1992, 3,898 cases of AIDS were reported among children under age 13 and 872 among young people ages 13 through 19.

As of July, 1992, 8,911 cases of AIDS were reported among the young adult population, ages 20-24. These cases represent one in five of all cases. Because the latency period between HIV infection and AIDS symptoms is up to nine years, many of these young adults were probably infected as teenagers. By the end of 1991, there were an estimated 10,000 to 20,000 symptomatic HIV-infected infants, children, and youths.

Although still outnumbered by males, females are more represented in adolescent HIV infection and AIDS than they are among adult cases. The majority of infected adolescent females are African-American or Latina. CDC estimates that the number of AIDS cases is increasing almost twice as fast among women as among men.

Of the 12 million cases of sexually-transmitted diseases estimated to occur annually, 3 million (25 percent) are among teenagers. Chlamydia is the most common sexually-transmitted disease among teens. In 1990, 183,865 cases of gonorrhea were reported among teenagers, ages 15-19, and 5,184 cases of syphilis. While the number of cases of gonorrhea has been on the decline since 1980, the number of cases of syphilis has been rising since 1985.

A national goal to reduce the incidence of gonorrhea to no more than 750 cases among adolescents aged 15-19 per 100,000 adolescents of the same age has been set by the Federal government as part of its *Healthy People 2000* effort. There are goals for perinatal HIV infection and other sexually-transmitted diseases. However, they are not specific to this population.

DATA SOURCES

NATIONAL: National data on rates of HIV/AIDS infection are published annually by the U.S. Department of Health and Human Services/Public Health Service/Centers for Disease Control and Prevention. The series is titled "HIV/AIDS Surveillance Reports". To order the report, contact:

National AIDS Clearinghouse
(800) 458-5231

The Centers for Disease Control and Prevention also publishes "Morbidity and Mortality Weekly Report," which has national data on trends in teen rates of sexually transmitted diseases.

STATE: The Centers for Disease Control and Prevention collects data on AIDS, gonorrhea, and syphilis from every state. However, reporting on HIV infection and other sexually-transmitted diseases is not required. Not all states collect data on all such diseases. As of April 1990, only 32 states reported HIV infections and 33 states reported chlamydial infections. See the publications listed above for available state data.

Every state health department has a communicable diseases surveillance system, located in an office of epidemiology or communicable (infectious) diseases.

Data are available by disease, age, race, gender, and county. Issues of confidentiality may preclude getting data by smaller civil divisions.

LOCAL: Local data are available from state health departments. Local health departments may also keep track of health data for the locality, and may have their own publications.

COMMENTS Data are reported by case, not individual. Since an individual can have more than one case of a disease, the data do not reflect accurately the number of people infected. Data are reported by each disease for which data are collected. If disease data are not already aggregated into a sexually-transmitted disease rate, it is important to consult with experts regarding the appropriate weighting of each disease in constructing an overall rate. No one disease, however, constitutes an accurate measure of overall disease rates since the incidence and trends of each vary.

Among reporting states, there are differences in reporting requirements, and in compliance with reporting requirements by public and private health providers which may affect the data and its consistency over time and among states.

RELATED MEASURES For the more common sexually transmitted diseases (e.g gonorrhea and chlamydia) it will be possible, and for many purposes preferable, to track the rate per 100,000 rather than the absolute number. The rate is shown as "per 100,000" because the incidence is still relatively rare. The production of these rates requires that one have estimates of the size of the total population age 15-19 for the geographic area of interest. Between censuses, such estimates are produced by the Federal government for states. Contact your state data center for additional information (see Appendix E).

INDICATOR

YOUTH IDLENESS: The percent of youth ages 16-24 who are not productively engaged.

DEFINITION The percent of youth ages 16-24 who are not working, not in the military, not in school, and not married to one so engaged.

The indicator is constructed by dividing the total number of idle youth ages 16-24 by the total number of persons ages 16-24, and multiplying by 100.

((Idle person ages 16-24/total person ages 16-24) x 100)

SIGNIFICANCE It is important that children make a smooth transition to becoming independent adults. A number of roles are commonly adopted, simultaneously or in succession, as part of that transition process including the roles of student, worker, spouse and homemaker. This indicator measures the percent of youth who are engaged in none of the roles associated with making a successful transition to becoming an independent adult.

FACTS

Using data from the March Current Population Survey, the Population Reference Bureau estimates that, in 1990, 5 percent of all youth ages 16-19 were idle during the week preceding the survey. In some areas, and among some groups, this rate is much higher.

DATA SOURCES

NATIONAL: National estimates can be produced using data from the March Current Population Survey, and are currently published in the annual *Kids Count Data Book* of the Annie E. Casey Foundation.

Kids Count, Annie E. Casey Foundation
111 Market Place, Suite 420
Baltimore, MD 21202
(410) 234-2872

In addition, the raw data are available on CD-Rom from Census Data User Services: (301) 763-4100

To identify idle youth using this data source, one must look at marital status, major activity during the week preceding the survey, and major activity of the spouse in the week preceding the survey. The production of such estimates requires that one have substantial computer programming capabilities. Those lacking such capabilities may wish to contact their state data center (see Appendix E).

STATE: State level estimates for this indicator can be produced using the data source described above, though for most states this requires combining 3-5 years of data. State estimates appearing in the *Kids Count Data Book* are produced using this technique. Estimates may not be reliable for states with very small populations (see Appendix I).

LOCAL: Estimates for substate localities can be produced every 10 years using data from the decennial census. Such estimates will be artificially high, however, in counties containing state and Federal detention facilities. It is therefore best to eliminate those in detention centers from the equation before estimating the percent of youth who are idle at the substate level.

COMMENTS

Available data allow only for estimates based on activities in the week preceding the survey. Ideally, one would prefer to identify those who are idle for substantial periods of time, perhaps half the year or more. Beginning in 1996, the Survey of Income and Program Participation, a survey fielded by the Bureau of the Census, will produce the data and sample sizes necessary to make reliable national estimates using this longer time span.

Some of those identified as "idle" are in fact productively employed in the informal economy doing off-the-books (but otherwise legitimate) work. Few of these jobs, however, supply the level of income and the regularity of employment associated with being an independent adult.

RELATED MEASURES

For young men, homemaking is still a rare role, though not so rare as in the past. For that reason, operational definitions of idleness that do not include homemaking will produce reasonably good estimates of idleness among males.

APPENDICES

APPENDIX A

Chief State School Officers

The authors wish to thank the Council of Chief State School Officers for permission to duplicate this list.

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The authors wish to thank the National Association of State Alcohol and Drug Abuse Directors, Inc. for permission to duplicate this list.

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APPENDIX C

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APPENDIX E

State Data Center Programs

The authors wish to thank the United States Department Bureau of the Census for permission to duplicate this list.

State Data Center Program Coordinating Organizations (Includes Business and Industry Data Center Initiative Components)

Since 1978, the State Data Center (SDC) Program has provided training and technical assistance in accessing and using Census data for research, administration, planning, and decisionmaking by the government, the business community, university researchers, and other interested data users. The Business and Industry Data Center (BIDC) Program, initiated in 1988, supports the business community by expanding SDC services to government, academic, and non-profit organizations that directly serve businesses.

The SDC/BIDC organizations also provide additional services denoted by various codes beneath their entry, and defined on the last page.

For more information on the SDC/BIDC programs, contact the Data User Services Division, Bureau of the Census, Washington, D.C. 20233-8300, (301) 763-1580.

March 30, 1994

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MS. NADENE ROENSPIES
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CHEYENNE, WY 82002-0060
MR. STEVE FURTNEY
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OTHER

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ALASKA
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BUREAU OF VITAL STATISTICS
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JUNEAU, AK 99811-0675
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STATE DEPARTMENT OF HEALTH
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APPENDIX I

Primary Contacts for State KIDS COUNT Projects

Funded by the Annie E. Casey Foundation, KIDS COUNT grantees collect and publish data on major indicators of children and family well-being. Each grantee publishes an annual report showing the status of children and families in the state; the Foundation publishes an annual compilation of state data. To obtain the Foundation's annual KIDS COUNT report, contact the Annie E. Casey Foundation, 701 St. Paul Street, Baltimore, MD 21202; telephone (410) 547-6600. The authors wish to thank the Annie E. Casey Foundation for permission to duplicate this list.

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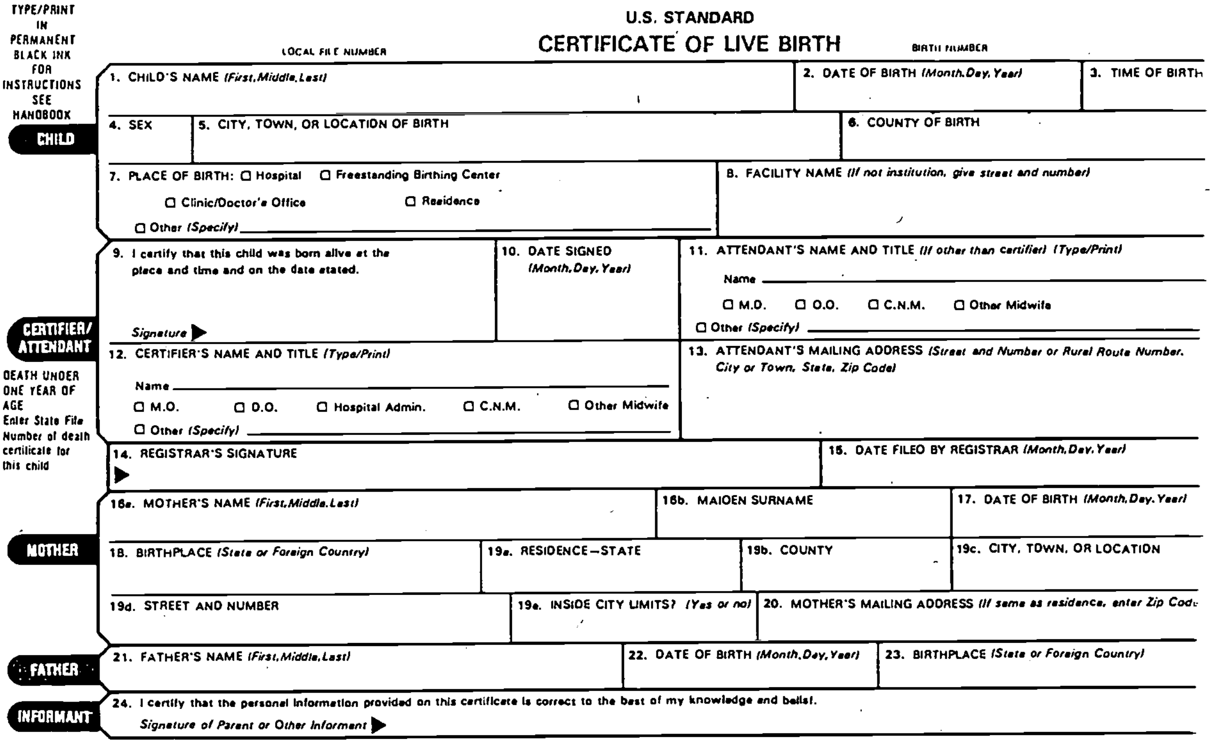
APPENDIX J

Standard Certificate of Birth



TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

U.S. STANDARD

CERTIFICATE OF LIVE BIRTH

LOCAL FILE NUMBER

BIRTH NUMBER

CHILD

1. CHILD'S NAME *(First, Middle, Last)*

2. DATE OF BIRTH *(Month, Day, Year)*

3. TIME OF BIRTH

4. SEX

5. CITY, TOWN, OR LOCATION OF BIRTH

6. COUNTY OF BIRTH

7. PLACE OF BIRTH: ☐ Hospital ☐ Freestanding Birthing Center ☐ Clinic/Doctor's Office ☐ Residence ☐ Other *(Specify)* ________

8. FACILITY NAME *(If not institution, give street and number)*

CERTIFIER/ ATTENDANT

9. I certify that this child was born alive at the place and time and on the date stated.

Signature ▶

10. DATE SIGNED *(Month, Day, Year)*

11. ATTENDANT'S NAME AND TITLE *(If other than certifier) (Type/Print)*

Name ________

☐ M.D. ☐ D.O. ☐ C.N.M. ☐ Other Midwife

☐ Other *(Specify)* ________

12. CERTIFIER'S NAME AND TITLE *(Type/Print)*

Name ________

☐ M.D. ☐ D.O. ☐ Hospital Admin. ☐ C.N.M. ☐ Other Midwife

☐ Other *(Specify)* ________

13. ATTENDANT'S MAILING ADDRESS *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*

DEATH UNDER ONE YEAR OF AGE

Enter State File Number of death certificate for this child

14. REGISTRAR'S SIGNATURE

▶

15. DATE FILED BY REGISTRAR *(Month, Day, Year)*

MOTHER

16a. MOTHER'S NAME *(First, Middle, Last)*

16b. MAIDEN SURNAME

17. DATE OF BIRTH *(Month, Day, Year)*

18. BIRTHPLACE *(State or Foreign Country)*

19a. RESIDENCE—STATE

19b. COUNTY

19c. CITY, TOWN, OR LOCATION

19d. STREET AND NUMBER

19e. INSIDE CITY LIMITS? *(Yes or no)*

20. MOTHER'S MAILING ADDRESS *(If same as residence, enter Zip Cod*

FATHER

21. FATHER'S NAME *(First, Middle, Last)*

22. DATE OF BIRTH *(Month, Day, Year)*

23. BIRTHPLACE *(State or Foreign Country)*

INFORMANT

24. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief.

Signature of Parent or Other Informant ▶

(Continued on next page)

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

	25. OF HISPANIC ORIGIN? *(Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.)*	26. RACE—American Indian, Black, White, etc. *(Specify below)*	27. EDUCATION *(Specify only highest grade completed)* Elementary/Secondary (0-12)	College (1-4 or 5+)
MOTHER	25a. ☐ No ☐ Yes Specify:	26a.	27a.	
FATHER	25b. ☐ No ☐ Yes Specify:	26b.	27b.	

28. PREGNANCY HISTORY *(Complete each section)*

LIVE BIRTHS *(Do not include this child)*		OTHER TERMINATIONS *(Spontaneous and induced at any time after conception)*
28a. Now Living Number ______ ☐ None	28b. Now Dead Number ______ ☐ None	28d. Number ______ ☐ None
28c. DATE OF LAST LIVE BIRTH *(Month, Year)*		28e. DATE OF LAST OTHER TERMINATION *(Month, Year)*

29. MOTHER MARRIED? (At birth, conception, or any time between) *(Yes or no)*

30. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*

31. MONTH OF PREGNANCY PRENATAL CARE BEGAN—First, Second, Third, etc. *(Specify)*

32. PRENATAL VISITS—Total Number *(If none, so state)*

33. BIRTH WEIGHT *(Specify unit)*

34. CLINICAL ESTIMATE OF GESTATION *(Weeks)*

35a. PLURALITY—Single, Twin, Triplet, etc. *(Specify)*

35b. IF NOT SINGLE BIRTH—Born First, Second, Third, etc. *(Specify)*

MULTIPLE BIRTHS
Enter State File Number for Mate(s)
LIVE BIRTH(S)

FETAL DEATH(S)

36. APGAR SCORE

36a. 1 Minute

36b. 5 Minutes

37a. MOTHER TRANSFERRED PRIOR TO DELIVERY? ☐ No ☐ Yes If Yes, enter name of facility transferred from:

37b. INFANT TRANSFERRED? ☐ No ☐ Yes If Yes, enter name of facility transferred to:

38a. MEDICAL RISK FACTORS FOR THIS PREGNANCY
(Check all that apply)

Anemia (Hct. <30/Hgb. <10)	01	☐
Cardiac disease	02	☐
Acute or chronic lung disease	03	☐
Diabetes	04	☐
Genital herpes	05	☐
Hydramnios/Oligohydramnios	06	☐
Hemoglobinopathy	07	☐
Hypertension, chronic	08	☐
Hypertension, pregnancy-associated	09	☐
Eclampsia	10	☐
Incompetent cervix	11	☐
Previous infant 4000+ grams	12	☐
Previous preterm or small-for-gestational-age infant	13	☐
Renal disease	14	☐
Rh sensitization	15	☐
Uterine bleeding	16	☐
None	00	☐
Other ______ *(Specify)*	17	☐

38b. OTHER RISK FACTORS FOR THIS PREGNANCY
(Complete all items)

Tobacco use during pregnancy .... Yes ☐ No ☐
Average number cigarettes per day ______
Alcohol use during pregnancy .... Yes ☐ No ☐
Average number drinks per week ______
Weight gained during pregnancy ______ lbs.

39. OBSTETRIC PROCEDURES
(Check all that apply)

Amniocentesis	01	☐
Electronic fetal monitoring	02	☐
Induction of labor	03	☐
Stimulation of labor	04	☐
Tocolysis	05	☐
Ultrasound	06	☐
None	00	☐
Other ______ *(Specify)*	07	☐

40. COMPLICATIONS OF LABOR AND/OR DELIVERY
(Check all that apply)

Febrile (>100°F. or 38°C.)	01	☐
Meconium, moderate/heavy	02	☐
Premature rupture of membrane (>12 hours)	03	☐
Abruptio placenta	04	☐
Placenta previa	05	☐
Other excessive bleeding	06	☐
Seizures during labor	07	☐
Precipitous labor (<3 hours)	08	☐
Prolonged labor (>20 hours)	09	☐
Dysfunctional labor	10	☐
Breech/Malpresentation	11	☐
Cephalopelvic disproportion	12	☐
Cord prolapse	13	☐
Anesthetic complications	14	☐
Fetal distress	15	☐
None	00	☐
Other ______ *(Specify)*	16	☐

41. METHOD OF DELIVERY *(Check all that apply)*

Vaginal	01	☐
Vaginal birth after previous C-section	02	☐
Primary C-section	03	☐
Repeat C-section	04	☐
Forceps	05	☐
Vacuum	06	☐

42. ABNORMAL CONDITIONS OF THE NEWBORN
(Check all that apply)

Anemia (Hct. <39/Hgb. <13)	01	☐
Birth injury	02	☐
Fetal alcohol syndrome	03	☐
Hyaline membrane disease/RDS	04	☐
Meconium aspiration syndrome	05	☐
Assisted ventilation <30 min	06	☐
Assisted ventilation ≥30 min	07	☐
Seizures	08	☐
None	00	☐
Other ______ *(Specify)*	09	☐

43. CONGENITAL ANOMALIES OF CHILD
(Check all that apply)

Anencephalus	01	☐
Spina bifida/Meningocele	02	☐
Hydrocephalus	03	☐
Microcephalus	04	☐
Other central nervous system anomalies *(Specify)* ______	05	☐
Heart malformations	06	☐
Other circulatory/respiratory anomalies *(Specify)* ______	07	☐
Rectal atresia/stenosis	08	☐
Tracheo-esophageal fistula/ Esophageal atresia	09	☐
Omphalocele/ Gastroschisis	10	☐
Other gastrointestinal anomalies *(Specify)* ______	11	☐
Malformed genitalia	12	☐
Renal agenesis	13	☐
Other urogenital anomalies *(Specify)* ______	14	☐
Cleft lip/palate	15	☐
Polydactyly/Syndactyly/Adactyly	16	☐
Club foot	17	☐
Diaphragmatic hernia	18	☐
Other musculoskeletal/integumental anomalies *(Specify)* ______	19	☐
Down's syndrome	20	☐
Other chromosomal anomalies *(Specify)* ______	21	☐
None	00	☐
Other ______ *(Specify)*	22	☐

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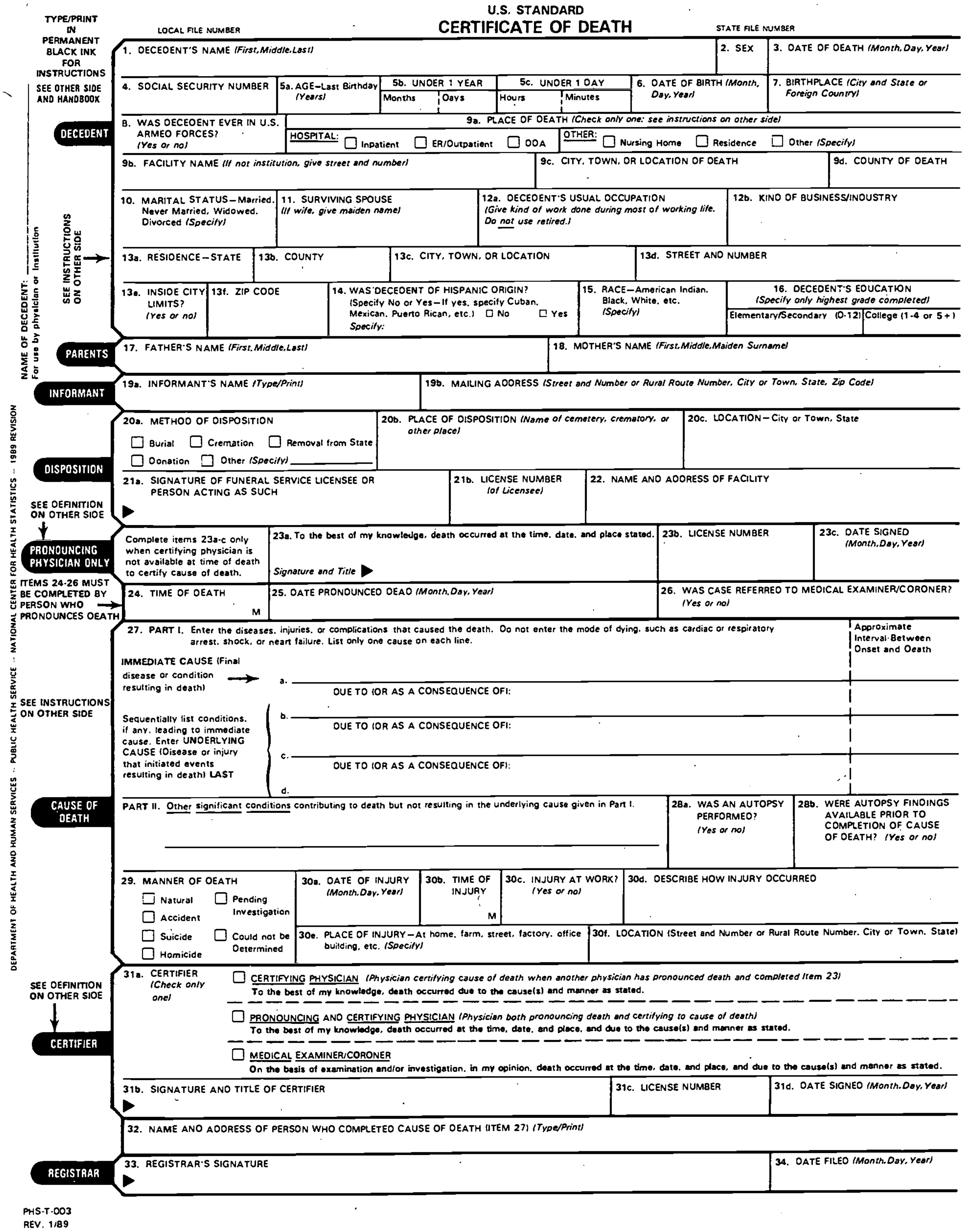
Appendix K

Standard Certificate of Death



TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE OTHER SIDE AND HANDBOOK

LOCAL FILE NUMBER

U.S. STANDARD
CERTIFICATE OF DEATH

STATE FILE NUMBER

DECEDENT

1. DECEDENT'S NAME *(First,Middle,Last)*
2. SEX
3. DATE OF DEATH *(Month,Day,Year)*
4. SOCIAL SECURITY NUMBER
5a. AGE—Last Birthday *(Years)*
5b. UNDER 1 YEAR — Months | Days
5c. UNDER 1 DAY — Hours | Minutes
6. DATE OF BIRTH *(Month, Day, Year)*
7. BIRTHPLACE *(City and State or Foreign Country)*
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? *(Yes or no)*
9a. PLACE OF DEATH *(Check only one: see instructions on other side)*
HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA
OTHER: ☐ Nursing Home ☐ Residence ☐ Other *(Specify)*
9b. FACILITY NAME *(If not institution, give street and number)*
9c. CITY, TOWN, OR LOCATION OF DEATH
9d. COUNTY OF DEATH
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced *(Specify)*
11. SURVIVING SPOUSE *(If wife, give maiden name)*
12a. DECEDENT'S USUAL OCCUPATION *(Give kind of work done during most of working life. Do not use retired.)*
12b. KIND OF BUSINESS/INDUSTRY

SEE INSTRUCTIONS ON OTHER SIDE →

13a. RESIDENCE—STATE
13b. COUNTY
13c. CITY, TOWN, OR LOCATION
13d. STREET AND NUMBER
13e. INSIDE CITY LIMITS? *(Yes or no)*
13f. ZIP CODE
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ No ☐ Yes
Specify:
15. RACE—American Indian, Black, White, etc. *(Specify)*
16. DECEDENT'S EDUCATION *(Specify only highest grade completed)*
Elementary/Secondary (0-12) | College (1-4 or 5+)

NAME OF DECEDENT: ______
For use by physician or institution

PARENTS

17. FATHER'S NAME *(First,Middle,Last)*
18. MOTHER'S NAME *(First,Middle,Maiden Surname)*

INFORMANT

19a. INFORMANT'S NAME *(Type/Print)*
19b. MAILING ADDRESS *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*

DISPOSITION

20a. METHOD OF DISPOSITION
☐ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other *(Specify)* ______
20b. PLACE OF DISPOSITION *(Name of cemetery, crematory, or other place)*
20c. LOCATION—City or Town, State
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ▶
21b. LICENSE NUMBER *(of Licensee)*
22. NAME AND ADDRESS OF FACILITY

SEE DEFINITION ON OTHER SIDE ↓

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.
23a. To the best of my knowledge, death occurred at the time, date, and place stated.
Signature and Title ▶
23b. LICENSE NUMBER
23c. DATE SIGNED *(Month,Day,Year)*

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH →

24. TIME OF DEATH M
25. DATE PRONOUNCED DEAD *(Month,Day,Year)*
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? *(Yes or no)*

CAUSE OF DEATH

SEE INSTRUCTIONS ON OTHER SIDE

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ______
DUE TO (OR AS A CONSEQUENCE OF):
b. ______
DUE TO (OR AS A CONSEQUENCE OF):
c. ______
DUE TO (OR AS A CONSEQUENCE OF):
d. ______

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
28a. WAS AN AUTOPSY PERFORMED? *(Yes or no)*
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? *(Yes or no)*

29. MANNER OF DEATH
☐ Natural ☐ Pending Investigation
☐ Accident
☐ Suicide ☐ Could not be Determined
☐ Homicide
30a. DATE OF INJURY *(Month,Day,Year)*
30b. TIME OF INJURY M
30c. INJURY AT WORK? *(Yes or no)*
30d. DESCRIBE HOW INJURY OCCURRED
30e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. *(Specify)*
30f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

SEE DEFINITION ON OTHER SIDE ↓

CERTIFIER

31a. CERTIFIER *(Check only one)*
☐ CERTIFYING PHYSICIAN *(Physician certifying cause of death when another physician has pronounced death and completed Item 23)*
To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN *(Physician both pronouncing death and certifying to cause of death)*
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER/CORONER
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
31b. SIGNATURE AND TITLE OF CERTIFIER ▶
31c. LICENSE NUMBER
31d. DATE SIGNED *(Month,Day,Year)*
32. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) *(Type/Print)*

REGISTRAR

33. REGISTRAR'S SIGNATURE ▶
34. DATE FILED *(Month,Day,Year)*

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Improved Outcomes for Children Project

This project works with states and local communities that are trying to reform both their educational and human services systems to ensure that children arrive at school, everyday, ready to learn. The project uses a five-part framework to help communities enact long-term reforms:

- identify outcomes and remain accountable for results,
- develop collaborative governance structures at the state and local level,
- provide effective services and supports,
- develop financing strategies that support long-term reform, and
- develop the capacity of professionals and lay people to work in a reformed system.

Products

	Basic Design/Systems Approach	How to's/Tools
OVERALL FRAMEWORK	○ A Framework for Improving Outcomes for Families and Children	○ Diagnostic Checklist for States, Schools and Communities ○ *Community Resource Guide to Improving Results for Children, Youth, and Families* ○ *Building Capacity for Community Partnerships*
OUTCOMES	○ The Case for Shifting to Results-Based Accountability	○ Finding the Data: A Start-Up List of Outcome Measures with Annotations ○ *Moving to Accountability*
GOVERNANCE	○ Collaborative Strategies in Five Communities of the National Alliance for Restructuring Education ○ Changing Governance to Achieve Better Results for Children and Families	○ First Steps: Beginning the Process of Community Governance
SERVICES AND SUPPORTS	○ Services and Supports to Improve Outcomes for Families and Children	○ Providing Services and Supports for Children, Youth and Families: What Schools Can Do ○ *Achieving the Goal of Every Young Child Ready for School: A Community Planning Guide*
FINANCING	○ Financing Reform of Family and Children's Services: An Approach to the Systematic Consideration of Financing Options ○ From Outcomes to Budgets: An Approach to Outcome-Based Budgeting for Family and Children's Services	○ A Strike for Independence: How a Missouri School District Generated Two Million Dollars to Improve the Lives of Children
PROFESSIONAL DEVELOPMENT	○ A Staff Development Framework	○ Draft Curriculum for Family-Centered Training ○ Needs and Resources Assessment for Family-Centered Training ○ *Lessons Learned*

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