1998 Rhode Island Kids Count Factbook

Rhode Island KIDS COUNT is a children's policy organization that provides information on child well-being, stimulates dialogue on children's issues, and promotes accountability and action to improve the economic security, health, safety and education of Rhode Island's children.

Primary funding for Rhode Island KIDS COUNT is provided by The Rhode Island Foundation and The Annie E. Casey Foundation. Additional funding is provided by the United Way of Southeastern New England, Prince Charitable Trusts, the Northeast and Islands Regional Educational LAB at Brown University, and other corporate and foundation sponsors.

The annual *Rhode Island KIDS COUNT Factbook* is one of fifty state-level projects designed to provide a detailed community-by-community picture of the condition of children. A national *KIDS COUNT Data Book* with comparable data for the United States is produced annually by The Annie E. Casey Foundation.

Additional copies of the *1998 Rhode Island KIDS COUNT Factbook* are available for $15.00 per copy. Reduced rates are available for bulk orders. To receive copies of the *1998 Factbook*, please contact:

Rhode Island KIDS COUNT
70 Elm Street
Providence, RI 02903
Phone: 401-351-9400
Fax: 401-351-1758
E-Mail: HN3170@handsnet.org
rikids@rikidscount.org

Visit our Web Site at www.rikidscount.org

1998 Rhode Island KIDS COUNT Factbook

P A R T N E R S

The Rhode Island Foundation

Ronald V. Gallo, President
Ronald D. Thorpe, Jr., Vice President for Program
Rick Schwartz, Director of Communications

Brown University
A. Alfred Taubman Center for Public Policy and American Institutions

Thomas J. Anton, Director
Jack D. Combs, Research Administrator

Rhode Island College
School of Social Work

Nancy Gewirtz, Professor,
Master of Social Work Program
George Metrey, Dean
School of Social Work

Rhode Island KIDS-COUNT

Elizabeth Burke Bryant, Executive Director
Ann-Marie Harrington, Research Analyst
Elizabeth Melendez, Administrative Assistant
Catherine Boisvert Walsh, Program Director

Table of Contents

Overview

Dream Variation

To fling my arms wide
In some place of the sun,
To whirl and to dance
Till the white day is done.
Then rest at cool evening
Beneath a tall tree
While night comes on gently,
Dark like me —
That is my dream!

To fling my arms wide
In the face of the sun,
Dance! Whirl! Whirl!
Till the quick day is done.
Rest at pale evening...
A tall, slim tree...
Night coming tenderly
Black like me.

– LANGSTON HUGHES

The *1998 Rhode Island KIDS COUNT Factbook* is the fourth annual profile of the well-being of children in Rhode Island. The annual Factbook is an important tool for planning and action by community leaders, policy makers, advocates, and others working toward changes that will improve the quality of life for all of Rhode Island's children.

The annual Factbook tracks progress across five areas of child well-being. All areas of child well-being are interrelated and critical throughout a child's development. A child's safety in his family and community affects his school performance; a child's economic security affects her health and education. The *1998 Rhode Island KIDS COUNT Factbook* reflects these interrelationships and builds a framework to guide children's policy, programs for children and families, and individual service on behalf of children.

The *1998 Rhode Island KIDS COUNT Factbook* provides a statistical portrait of the status of Rhode Island's children. Information is presented for the state of Rhode Island, each city and town, and an aggregate of the five cities in which more than 15% of the children live in poverty. These cities, referred to as "core cities" in the Factbook, are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

By examining the best available data statewide and in Rhode Island's 39 cities and towns, Rhode Island KIDS COUNT provides an information base that can result in more effective policy and community action on behalf of children. The *1998 Rhode Island KIDS COUNT Factbook* examines twenty-eight indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education. The most current, reliable data available is presented for each indicator.

Results for Children

Tracking changes in selected indicators enables state policy makers and community leaders to set priorities, apply knowledge of "what works" to reverse negative trends, and monitor progress. The Rhode Island KIDS COUNT indicators can be used as tools to measure Rhode Island's progress in achieving results for children.

Early Investments

Improving outcomes for children of all ages requires investments in young children and their families. Many of the difficult and costly problems faced by adolescents can be prevented with a better start in life. Yet, most resources are directed toward crisis intervention after children, families, and neighborhoods are already in trouble.

A Common Purpose

The actions of community leaders, parents, individuals, and organizations greatly influence children's chances for success and the challenges they will face. One person working with one child can make a dramatic difference for that child and that family. Conditions for large numbers of children will change when all sectors join together to improve child well-being by using our extensive knowledge of "what works".

Family and Community

Little

I am the sister of him
And he is my brother.
He is too little for us
To talk to each other.

So every morning I show him
My doll and my book;
But every morning he still is
Too little to look.

– DOROTHY ALDIS

Child Population

DEFINITION

Child population is the percentage of the total population that is under the age of 18.

SIGNIFICANCE

In 1995, there were 222,138 Rhode Island children under age 18.[1] Twenty-three percent of the Rhode Island population was under age 18 in 1995.[2] Only one household in four has a school-age child, reflecting a major shift toward the aging of America.[3] Many families are responsible for the care of children as well as elderly family members. At the turn of the century there were about nine dependent children for each dependent older adult. Today this ratio is close to two to one, and early in the next century there will be one dependent child for every dependent elderly person.[4]

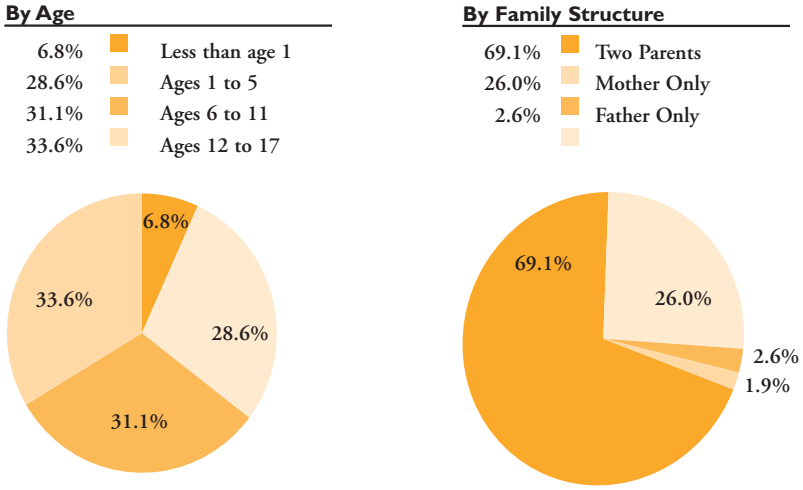
Rhode Island's children are diverse in race, ethnic background, language, and country of origin. Children under age 18 are significantly more diverse in racial and ethnic backgrounds than the adult population. In 1995, 91.1% of Rhode Island children were white, 5.4% were Black, 1.7% were Asian, and less than 1% were American Indian. Of Rhode Island's 222,138 children, 11.4% were Hispanic.[5]

According to the 1990 Census, 13,500 of Rhode Island's children were born outside the U.S., including 5,400 Hispanic children and 3,300 Asian children.[6] Many immigrant children and children of recent immigrants face language barriers. In 1990, more than 25,000 Rhode Island children age 5 to 17 spoke a language other than English at home.[7]

Rhode Island's Growing Diversity

- Between 1980 and 1990, the number of African-American children under age five increased by nearly 50%, the number of Hispanic children increased nearly three-fold, and the number of Asian children nearly doubled.[8]
- The growing diversity of Rhode Island's children will continue into the next century.
- Between 1995 and 2005 the number of white, non-Hispanic children is projected to decrease by 7 percent and the number of Black, Hispanic, Asian, and Native American children will increase by 43 percent.[9]

Rhode Island's Children, 1995



Source: U.S. Bureau of the Census, Current Population Survey, 1993 to 1997 average.

Race/Ethnicity of Children, 1995 and 2005

	1995	2005	% Change
White, Non-Hispanic	192,400	179,700	-7%
Black	13,600	16,000	+18%
Hispanic	22,800	34,400	+51%
Asian and Pacific Islander	7,500	12,100	+61%
Native American	1,300	2,100	+62%

Source: *1997 KIDS COUNT Data Book: State Profiles of Child Well-Being* (1997). Baltimore, MD: The Annie E. Casey Foundation. The 1995 figure represents Census Bureau projections as of July 1, 1995, while the 2005 figure represents the Census Bureau's projections as of July 1, 2005.

Table 1.

Child Population, Rhode Island, 1990

CITY/TOWN	TOTAL POPULATION	CHILDREN UNDER AGE 18 N	CHILDREN UNDER AGE 18 %	% MINORITY CHILDREN UNDER AGE 18
Barrington	15,849	3,912	24.7%	2.4%
Bristol	21,625	4,380	20.3%	4.4%
Burrillville	16,230	4,479	27.6%	0.8%
Central Falls	17,637	4,810	27.3%	49.3%
Charlestown	6,478	1,575	24.3%	5.3%
Coventry	31,083	7,626	24.5%	2.4%
Cranston	76,060	14,673	19.3%	8.1%
Cumberland	29,038	6,427	22.1%	3.4%
East Greenwich	11,865	2,913	24.6%	5.1%
East Providence	50,380	10,657	21.2%	12.1%
Exeter	5,461	1,521	27.9%	2.6%
Foster	4,316	1,185	27.5%	2.0%
Glocester	9,227	2,526	27.4%	1.6%
Hopkinton	6,873	1,839	26.8%	3.4%
Jamestown	4,999	1,123	22.5%	2.8%
Johnston	26,542	5,332	20.1%	3.9%
Lincoln	18,045	3,890	21.6%	3.6%
Little Compton	3,339	750	22.5%	2.7%
Middletown	19,460	4,676	24.0%	11.2%
Narragansett	14,985	2,869	19.1%	4.4%
Newport	28,227	5,756	20.4%	19.2%
New Shoreham	836	163	19.5%	3.1%
North Kingstown	23,786	6,076	25.5%	5.2%
North Providence	32,090	5,655	17.6%	5.9%
North Smithfield	10,497	2,332	22.2%	2.4%
Pawtucket	72,644	16,719	23.0%	21.2%
Portsmouth	16,857	4,175	24.8%	4.3%
Providence	160,728	37,972	23.6%	55.5%
Richmond	5,351	1,565	29.2%	3.6%
Scituate	9,796	2,426	24.8%	1.4%
Smithfield	19,163	3,898	20.3%	2.6%
South Kingstown	24,631	4,770	19.4%	7.8%
Tiverton	14,312	3,166	22.1%	1.7%
Warren	11,385	2,452	21.5%	2.7%
Warwick	85,427	18,322	21.4%	3.4%
Westerly	21,605	4,988	23.1%	3.0%
West Greenwich	3,492	915	26.2%	1.6%
West Warwick	29,268	6,560	22.4%	4.8%
Woonsocket	43,877	10,617	24.2%	14.5%
Core Cities	*323,113*	*75,874*	*23.5%*	*39.1%*
Remainder of State	*680,351*	*149,816*	*22.0%*	*4.9%*
Rhode Island	*1,003,464*	*225,690*	*22.5%*	*16.4%*

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

Minority is defined here by the race and ethnicity groups used in the 1990 Census of Population and includes children under age 18 identified by 1990 Census data as Black, Asian, Native American, and/or Hispanic. The denominator is the total number of children under age 18 according to the 1990 Census of Population.

References for Indicator

[1,2,5] U.S. Bureau of the Census, Current Population Survey, 1993 to 1997 average.

[3,8] U.S. Bureau of the Census, Census of Population, 1980 and 1990.

[4] Hodgkinson, H. L. (1996). *Bringing Tomorrow into Focus: Demographic Insights into the Future.* Washington, DC: Institute for Educational Leadership, Center for Demographic Policy.

[6] U.S. Bureau of the Census, 1990 Census of Population, Five-Percent Public Use Microdata Sample (PUMS).

[7] *1995 KIDS COUNT Data Book: State Profiles of Child Well-Being* (1995). Baltimore, MD: The Annie E. Casey Foundation.

[9] *1997 KIDS COUNT Data Book: State Profiles of Child Well-Being* (1997). Baltimore, MD: The Annie E. Casey Foundation.

Children in Single Parent Families

DEFINITION

Children in single parent families is the percentage of children under age 18 who live in families headed by a person, male or female, without a spouse present in the home. These numbers include "own children" defined as never-married children under 18 who are related to the family head by birth, marriage, or adoption.

SIGNIFICANCE

Children in single parent families are at increased risk of living in poverty when compared to children in two-parent families.[1] In 1995, just under half of Rhode Island's single parent families with children were living below the poverty line.[2] When the single parent is a woman, the risk of falling into poverty is greater, due to factors such as the wage gap between men and women, limited education and training for higher-wage jobs, and inadequate child support.[3] In 1994, only one in four female-headed families with children received child support.[4]

Although most Rhode Island children live with two parents, more than one in four lived in a single parent family in 1995.[5] According to the Center for Demographic Policy in Washington D.C., sixty percent of all children in the United States will spend some time in a single parent family before reaching age 18.[6] In 1996 in Rhode Island, 36.5 percent of all births were to unmarried women.[7]

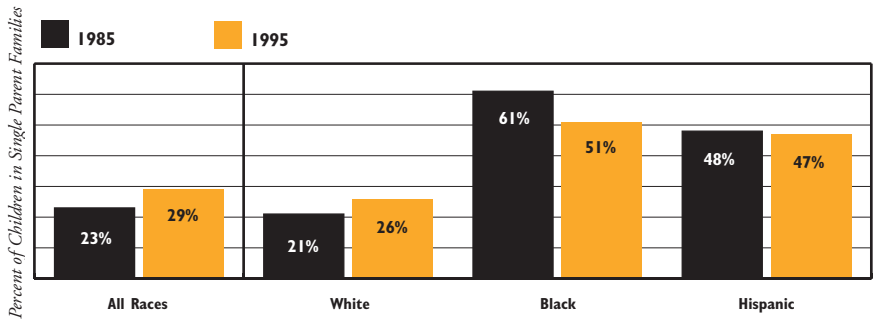
◆ Over the past three decades, births to unmarried women and a continuing high divorce rate have resulted in an increase in single parent families.[8]

◆ In 1995, the average household income in Rhode Island for two-parent families with children was $54,280 compared to $31,560 for single-parent families headed by a man and $21,743 for single-parent families headed by a woman.[9]

◆ Children born into single parent homes are more likely to grow up in a family with fewer financial resources than children who start-off in two-parent homes and end up in one-parent homes via separation or divorce. Never-married parents are significantly younger than divorced parents and on average have fewer years of school completed and lower levels of income.[10,11]

CHANGE SINCE THE 1980s

Children in Single Parent Families, by Race/Ethnicity,



Note: Percentages are calculated within each race and ethnic group.

◆ Since 1985, the percent of Rhode Island children living in a single parent household has increased from 23 percent to 29 percent.

Source: U.S. Bureau of the Census, Current Population Surveys, 1983 to 1987 average and 1993 to 1997 average.

Table 2.

Children's Living Arrangements, Rhode Island, 1990

CITY/TOWN	TOTAL FAMILY HOUSEHOLDS WITH CHILDREN UNDER 18	NUMBER OF CHILDREN UNDER 18 YEARS: TWO-PARENT FAMILY N	TWO-PARENT FAMILY %	SINGLE PARENT FAMILY N	SINGLE PARENT FAMILY %
Barrington	2,035	3,514	94.4%	207	5.6%
Bristol	2,300	3,660	88.9%	457	11.1%
Burrillville	2,314	3,824	87.2%	560	12.8%
Central Falls	2,373	2,859	61.7%	1,778	38.3%
Charlestown	833	1,244	83.0%	254	17.0%
Coventry	3,979	6,290	87.2%	920	12.8%
Cranston	7,911	11,360	81.2%	2,622	18.8%
Cumberland	3,491	5,551	90.2%	604	9.8%
East Greenwich	1,609	2,521	88.3%	335	11.7%
East Providence	5,766	7,950	81.7%	1,776	18.3%
Exeter	768	1,278	90.6%	132	9.4%
Foster	591	988	88.2%	132	11.8%
Glocester	1,320	2,036	88.6%	261	11.4%
Hopkinton	930	1,557	90.2%	170	9.8%
Jamestown	623	907	83.4%	181	16.6%
Johnston	2,851	4,229	81.7%	945	18.3%
Lincoln	2,181	3,210	86.1%	518	13.9%
Little Compton	420	612	89.7%	70	10.3%
Middletown	2,429	3,774	85.1%	659	14.9%
Narragansett	1,551	2,227	85.2%	387	14.8%
Newport	3,086	3,569	65.0%	1,920	35.0%
New Shoreham	97	149	88.7%	19	11.3%
North Kingstown	3,299	4,943	85.1%	864	14.9%
North Providence	3,115	4,563	86.6%	706	13.4%
North Smithfield	1,284	1,935	91.1%	188	8.9%
Pawtucket	8,957	11,266	73.9%	3,976	26.1%
Portsmouth	2,429	3,749	91.7%	339	8.3%
Providence	17,948	19,292	56.2%	15,054	43.8%
Richmond	791	1,344	94.9%	72	5.1%
Scituate	1,275	2,079	90.1%	228	9.9%
Smithfield	2,095	3,324	91.0%	330	9.0%
South Kingstown	2,603	3,681	81.8%	819	18.2%
Tiverton	1,727	2,477	84.0%	472	16.0%
Warren	1,356	1,880	83.8%	364	16.2%
Warwick	9,505	14,477	83.6%	2,835	16.4%
Westerly	2,746	4,071	85.7%	680	14.3%
West Greenwich	464	715	86.0%	116	14.0%
West Warwick	3,529	4,711	77.3%	1,386	22.7%
Woonsocket	5,650	6,850	68.6%	3,140	31.4%
Core Cities	***38,014***	***43,836***	***62.8%***	***25,868***	***37.1%***
Remainder of State	***80,217***	***120,830***	***85.4%***	***20,608***	***14.6%***
Rhode Island	***118,231***	***164,666***	***78.0%***	***46,476***	***22.0%***

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the number of children under age 18 according to the 1990 Census of Population.

References for Indicator

1 U.S. Bureau of the Census, 1990 Census of Population and Current Population Surveys, 1993 to 1997 average.

2,5,9 U.S. Bureau of the Census, Current Population Survey, 1993 to 1997 average.

3,10 Corcoran, M.E. & Chaudry, A. (1997). "The Dynamics of Childhood Poverty" in *The Future of Children, Children and Poverty*, Vol. 7, No. 2. (Summer/Fall 1997). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

4 *1997 KIDS COUNT Data Book: State Profiles of Child Well-Being* (1997). Baltimore, MD: Annie E. Casey Foundation.

6 Hodgkinson, Harold L., *A Demographic Look a Tomorrow* (1992). Washington, DC: Institute for Educational Leadership, Center for Demographic Policy.

7 Rhode Island Department of Health, Division of Family Health, Universal Newborn Screening Database, 1996.

8 U.S. Bureau of the Census, Census of Population, 1970, 1980, 1990.

11 U.S. Bureau of the Census (1997). *Census Brief: Children with Single Parent Families - How They Fare* (September 1997). Washington, DC: U.S. Department of Commerce, Bureau of the Census.

Economic Well-being

Afternoon On A Hill

I will be the gladdest thing
Under the sun!
I will touch a hundred flowers
And not pick one.

I will look at cliffs and clouds
With quiet eyes,
Watch the wind bow down the grass,
And the grass rise.

And when lights begin to show
Up from the town,
I will mark which must be mine,
And then start down.

– EDNA ST. VINCENT MILLAY

Median Household Income

DEFINITION

Median household income is the median annual income for Rhode Island households. The median income is the dollar amount which divides the income distribution into two equal groups – half with income above the median and half with income below the median.

SIGNIFICANCE

The median household income provides one measure of the ability of Rhode Island's families to meet the costs of food, clothing, housing, health care, transportation, child care, and higher education. In 1995, one-half of all Rhode Island families with children earned less than $39,226 and one-half earned more.[1]

Wages and earnings at the lowest end of the labor market – primarily low-skilled workers – have collapsed over the past two decades. The hourly wage rate for a person with a high school degree has fallen in real dollars by about 30% since the early 1970s.[2] There is still a disparity in earnings between women and men. Women's earnings are below those for men in every occupational category for full-time, year-round workers.[3]

Several fundamental changes in the U.S. economy have led to stagnating wages among low and middle-income workers. The manufacturing sector, which once provided relative prosperity for a broad middle class of unskilled and semi-skilled workers, is being replaced by low-paying service sector jobs. Technological innovations are increasing the demand for skilled workers.[4] As the economy shifts to low-paying jobs without benefits or higher-paying jobs that demand advanced education and skills, it is increasingly difficult for many families with children to make ends meet. In Rhode Island in 1995, nearly one in three households with children had a household income less than $25,000.[5]

CHANGE SINCE THE 1980s

Income Trends among Families with Children, Rhode Island, 1986 and 1995

INCOME GROUP	AVERAGE INCOME IN 1986	AVERAGE INCOME IN 1995	PERCENT CHANGE IN INCOME (ADJUSTED FOR INFLATION)
HIGHEST FIFTH OF FAMILIES	$98,470	$111,020	+13%
MIDDLE FIFTH OF FAMILIES	$46,260	$42,590	-8%
LOWEST FIFTH OF FAMILIES	$11,290	$9,910	-12%

◆ Rhode Island is one of 23 states in which high-income families had income gains over the past decade while low-income and middle-income families had income losses.

◆ The average incomes of Rhode Island families in the bottom fifth of the income distribution fell by $1,380, a decline of 12 percent. Over the same period, the richest fifth of families saw their incomes rise by more than $12,000, an increase of 13 percent. (The Census data used for this calculation excludes capital gains income.)

◆ Despite strong economic growth and low unemployment rates, the average incomes of the bottom three-fifths of the income distribution in the U.S. population are lower now than a decade ago. Only the top two-fifths of families have average incomes above the levels of the mid-1980s.

Source: Larin, K. & McNichol, E. (1997). *Pulling Apart: A State-By-State Analysis of Income Trends.* Washington, DC: Center on Budget and Policy Priorities. The 1986 figures represent 1985-1987 data from the U.S. Bureau of the Census, Current Population Survey; the 1995 figures represents 1994-1996 data from the U.S. Bureau of the Census, Current Population Survey.

Child Support Affects Family Income

- The failure of an absent parent to pay child support has significant economic consequences for a parent raising a child or children alone.

- 85,937 Rhode Island children are currently in the State's Child Support Enforcement System. Of these, 23% Rhode Island children have not yet had paternity established and therefore receive no child support. Court orders for child support require the establishment of paternity.

- Even when there is a child support agreement in place, child support payments tend to be low and unreliable. Of absent parents under court order, only 40% make child support payments on time and in full.

- As of December 31, 1997, the amount past due on court ordered child support totaled $214 million.

Source: RI Department of Administration, Division of Taxation-Child Support Enforcement, December 1997.

Table 3.

Median Household Income, Rhode Island, 1990

CITY/TOWN	MEDIAN INCOME
Barrington	$53,058
Bristol	$34,165
Burrillville	$37,156
Central Falls	$18,617
Charlestown	$36,040
Coventry	$37,230
Cranston	$34,528
Cumberland	$40,683
East Greenwich	$50,896
East Providence	$31,007
Exeter	$38,179
Foster	$40,795
Glocester	$40,000
Hopkinton	$36,737
Jamestown	$41,518
Johnston	$32,596
Lincoln	$37,082
Little Compton	$41,187
Middletown	$35,228
Narragansett	$35,545
Newport	$30,534
New Shoreham	$31,471
North Kingstown	$40,419
North Providence	$32,321
North Smithfield	$41,449
Pawtucket	$26,541
Portsmouth	$42,474
Providence	$22,147
Richmond	$40,975
Scituate	$45,170
Smithfield	$42,523
South Kingstown	$36,481
Tiverton	$36,170
Warren	$31,637
Warwick	$35,786
Westerly	$34,844
West Greenwich	$41,250
West Warwick	$31,625
Woonsocket	$25,363
Core Cities	***N/A***
Remainder of State	***N/A***
Rhode Island	***$32,181***

Note to Table

In Rhode Island in 1995, the median household income for all households was $41,390 (U.S. Bureau of the Census, Current Population Survey, 1993-1997 average).

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population, 1989 dollars. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References for Indicator

[1,5] U.S. Bureau of the Census, Current Population Survey, 1993 to 1997 average.

[2] Children's Defense Fund and Northeastern University's Center for Labor Market Studies (1992). *Vanishing Dreams: The Economic Plight of America's Young Families.* Washington, DC: The Children's Defense Fund.

[3] *The Status of Women in the States: Politics-Economics-Health-Demographics* (1996). Washington, DC: Institute for Women's Policy Research.

[4] Larin, K. & McNichol, E. (1997). *Pulling Apart: A State-By-State Analysis of Income Trends.* Washington, DC: Center on Budget and Policy Priorities.

Cost of Rent

DEFINITION

Cost of rent is the percentage of income needed by a low-income renter to cover the average cost of rent, including heat, in a community. Rent burdens over 30% are considered unaffordable.[1] A low-income renter is defined as income 30% below the 1997 median renter income.[2]

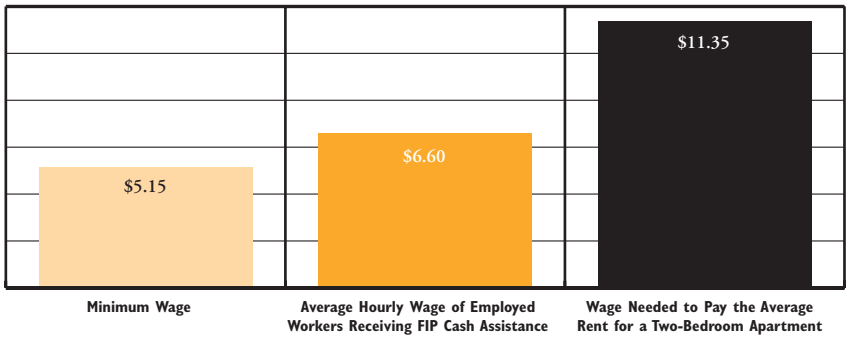
SIGNIFICANCE

Housing that costs more than one-third of a family's income is considered to be unaffordable. Families paying higher percentages of their income for housing are likely to go without other basic necessities such as food and clothing in order to pay their rent (or mortgage) and utilities. Much of the state's rental housing stock is more than fifty years old. Many of the units that might be affordable to a low-income family are in need of repair. Housing and building code violations — including roach and rodent infestation, lead exposure, faulty wiring, inadequate heating systems, and unsanitary plumbing problems — disproportionately affect low-income households. Inadequate, costly, or crowded housing has a negative impact on children's health, safety, education, and emotional well-being.[3,4]

While substandard housing is a problem in some neighborhoods, affordability is increasingly the primary problem faced by low-income families.[5] In Rhode Island, there are nearly two low-income renters for every low-rent unit.[6] Data from the 1993 American Housing Survey indicate that the shortage of affordable housing for low-income renters is wider than ever before. Since the late 1980s, the number of low-cost units has fallen and the number of low-income families has increased.[7]

Sixty-nine percent of Rhode Island's low-income renter households spend 30% or more of their income on housing, and 49% of low-income renters spend more than half of their income on rent.[8] Families that have to pay so much for rent are particularly vulnerable when their income is reduced for any reason. Any interruption in income or unexpected expense can place families at risk of eviction, doubling-up with family members, or homelessness.[9]

Wages and Rents, Rhode Island, 1996



◆ The average monthly rent for a two-bedroom apartment in Rhode Island in 1996 was $590. This rent would be affordable to a full-time year-round worker earning at least $11.35 per hour.

Federal Housing Assistance

◆ The Urban Institute estimates that housing assistance programs serve only one-quarter of eligible U.S. households. Housing assistance is not an entitlement; the number of families that receive assistance depends on how much funding Congress has made available.[10]

◆ The need for housing assistance among low-income families has increased while the availability of subsidies has fallen. The lowest-income families have less access to housing assistance than before, as federal guidelines eliminate preferences for the most vulnerable and open eligibility to higher-income families.[11]

◆ As of December 1997 in Rhode Island, 30% of households enrolled in the Family Independence Program were receiving housing assistance. Of the 5,707 FIP households receiving housing assistance, 33% lived in public housing, 60% had Section 8 certificates, and 7% were in other subsidized housing.[12]

Table 4.

Cost of Rental Housing for Low-Income Families, RI, 1997

CITY/TOWN	1996 AVERAGE RENT 2-BEDROOM	*1997 LOW-INCOME RENTER INCOME	% INCOME NEEDED FOR RENT LOW-INCOME RENTER	1997 POVERTY LEVEL FAMILY OF THREE	% INCOME NEEDED FOR RENT POVERTY LEVEL FAMILY OF THREE
Barrington	$810	$20,504	47%	$13,330	73%
Bristol	$569	$20,504	33%	$13,330	51%
Burrillville	$790	$20,504	46%	$13,330	71%
Central Falls	$475	$20,504	28%	$13,330	43%
Charlestown	$615	$20,504	36%	$13,330	55%
Coventry	$621	$20,504	36%	$13,330	56%
Cranston	$596	$20,504	35%	$13,330	54%
Cumberland	$626	$20,504	37%	$13,330	56%
East Greenwich	$631	$20,504	37%	$13,330	57%
East Providence	$569	$20,504	33%	$13,330	51%
Exeter	NA	$20,504	NA	$13,330	NA
Foster	NA	$20,504	NA	$13,330	NA
Glocester	NA	$20,504	NA	$13,330	NA
Hopkinton	$648	$20,504	38%	$13,330	58%
Jamestown	$715	$20,504	42%	$13,330	64%
Johnston	$592	$20,504	35%	$13,330	53%
Lincoln	$540	$20,504	32%	$13,330	49%
Little Compton	$732	$20,504	43%	$13,330	66%
Middletown	$654	$20,504	38%	$13,330	59%
Narragansett	$760	$20,504	44%	$13,330	68%
Newport	$680	$20,504	40%	$13,330	61%
New Shoreham	NA	$20,504	NA	$13,330	NA
North Kingstown	$638	$20,504	37%	$13,330	57%
North Providence	$584	$20,504	34%	$13,330	53%
North Smithfield	$620	$20,504	36%	$13,330	56%
Pawtucket	$503	$20,504	29%	$13,330	45%
Portsmouth	$705	$20,504	41%	$13,330	63%
Providence	$554	$20,504	32%	$13,330	50%
Richmond	$648	$20,504	38%	$13,330	58%
Scituate	$745	$20,504	44%	$13,330	67%
Smithfield	$701	$20,504	41%	$13,330	63%
South Kingstown	$635	$20,504	37%	$13,330	57%
Tiverton	$715	$20,504	42%	$13,330	64%
Warren	$559	$20,504	33%	$13,330	50%
Warwick	$674	$20,504	39%	$13,330	61%
Westerly	$637	$20,504	37%	$13,330	57%
West Greenwich	NA	$20,504	NA	$13,330	NA
West Warwick	$607	$20,504	36%	$13,330	55%
Woonsocket	$495	$20,504	29%	$13,330	45%
Core Cities	*$554*	*$20,504*	*NA*	*$13,330*	*NA*
Remainder of State	*$618*	*$20,504*	*NA*	*$13,330*	*NA*
Rhode Island	*$590*	*$20,504*	*35%*	*$13,330*	*53%*

** Median renter income is a statewide figure, because 1997 city/town data is not available.*

Source of Data for Table/Methodology

Rhode Island Housing and Mortgage Finance Corporation, January 1996. A low-income renter is defined as 30% below 1997 median renter income. Rent burdens over 30% are considered unaffordable. Average rents are based on a sample of 1,177 units available in Rhode Island during 1996.

Rents include the HUD allowance for heat, if heat was not included in the advertised rent.

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

References for Indicator

[1] *The State of Rhode Island Consolidated Plan, Fiscal Year 1995-1998* (1994). Providence, RI: Rhode Island Housing and Mortgage Finance Corporation.

[2,6,8] *In Short Supply: The Growing Affordable Housing Gap* (1995). Washington, DC: Center on Budget and Policy Priorities.

[3] *America's Children at Risk: A National Agenda for Legal Action* (1993). Washington, DC: American Bar Association.

[4,5] *America's Children: Key National Indicators of Well-Being* (1997). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[7] *Rental Housing Assistance at a Crossroads: A Report to Congress on Worst Case Housing Needs* (March 1996). Washington, DC: U.S. Department of Housing and Urban Development, Office of Policy Development and Research.

[9] *Children and Their Housing Needs: A Report to KIDS COUNT* (1993). Washington DC: Center on Budget and Policy Priorities.

[10] Kingsley, G.T. (December 1997). *New Federalism, Issues and Options for States,* Series A, No. A-19. "Federal Housing Assistance and Welfare Reform: Uncharted Territory." Washington DC: The Urban Institute.

[11] Kingsley, G.T. (December 1997). *New Federalism, Issues and Options for States,* Series A, No. A-19. "Federal Housing Assistance and Welfare Reform: Uncharted Territory." Washington DC: The Urban Institute; and "Housing Bills Would Reduce Assistance Available to Poor Families" (November 5, 1997). Washington, DC: Center on Budget and Policy Priorities.

[12] Rhode Island Department of Human Services, INRHODES Database, December 1, 1997.

Children in Poverty

DEFINITION

Children in poverty is the percentage of related children under age 18 who live in families below the poverty threshold, as defined by the U.S. Office of Management and Budget. "Related children" include the family head's children by birth, marriage, and adoption, as well as other persons under age 18 who are related to the family head, such as nieces and nephews.

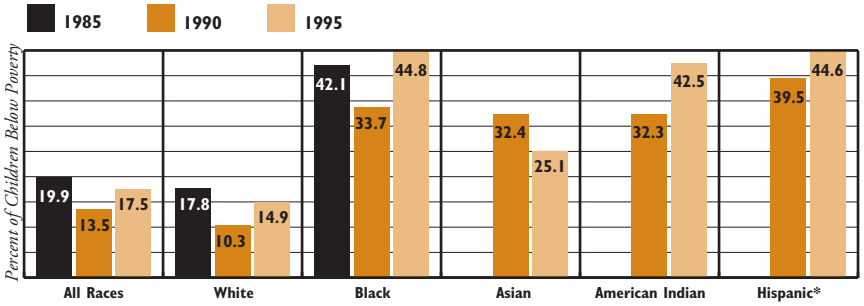
SIGNIFICANCE

Children most at risk of not achieving their full potential are children in poverty, regardless of race.[1] Poverty has an impact on every KIDS COUNT indicator. Children who grow up in poor families are more likely to go without necessary food and clothing, lack basic health care, live in substandard housing, and have unequal access to educational opportunities.[2] Investments in the economic well-being, health, education, and safety of families with children have been shown to improve child outcomes and reduce costs to society.[3] Efforts that improve the quality of a child's environment and social interactions, especially in the first three years of life, can produce lifelong impacts on learning, social skills, and mental health.[4]

In 1997, the official poverty level for a family of four was $16,050. This is less than half the median family income of $39,226 for Rhode Island families with children. Half of all poor children in Rhode Island in 1995 lived in families in which one or both parents worked full or part-time.[5] Over time, many more people are poor than the official poverty line suggests. There is considerable movement into and out of poverty each year.[6] Those living with incomes close to the poverty line are vulnerable to falling into poverty due to changes in employment, housing and utility costs, and life changes such as the birth of a child, changes in marital status, and illness or disability.[7]

CHANGE SINCE THE 1980s

Children in Poverty, by Race/Ethnicity, Rhode Island, 1985, 1990, 1995



Note: Percentages are calculated within each race or ethnic group.
**Hispanic children may also be included in other race categories.*
NA: Information for Asian, Native American and Hispanic children are not available for 1985.

◆ In 1995, there were 38,971 poor children in Rhode Island, 17.5% of all Rhode Island children. This is a decrease from almost 20% in 1985 and an increase since the 1990 Census figure when 13.5% of children lived in poverty.

◆ In 1995, more than three-quarters of Rhode Island's poor children were white; yet, Black, Hispanic, and Native American children were three times more likely to be living in poverty.

◆ According to the 1990 Census, 68% of Rhode Island's poor children lived in the core cities of Providence, Pawtucket, Woonsocket, Newport, and Central Falls. In 1990, these were the only five Rhode Island communities in which more than 15% of children lived in poverty. In 1997, almost three-quarters of children in the Family Independence Program lived in these five cities.

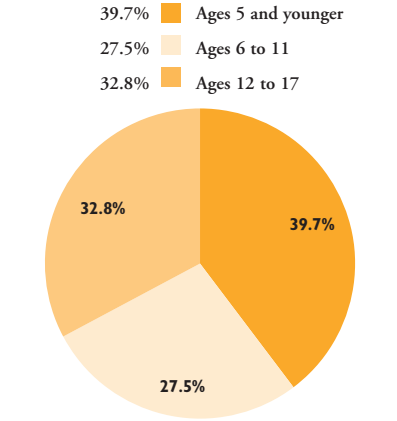
◆ In 1985, 60% of all poor children lived in single parent families; in 1995, 77% of all poor children lived in single parent families. Half of all single parent families lived in poverty in 1995.

Source: 1990 data are from the U.S. Bureau of the Census, 1990 Census of Population. 1985 and 1995 data are from the U.S. Bureau of the Census, Current Population Survey, 1983-1987 average and 1993-1997 average.

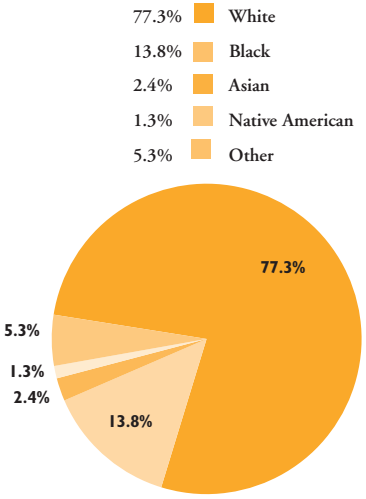
Children in Poverty

Rhode Island's Poor Children, 1995

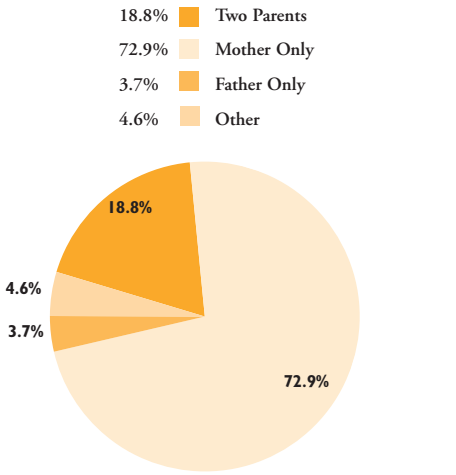
By Age



By Race*



By Family Structure



** Hispanic children may be included in any race category. 29% of Rhode Island's 38,971 poor children are Hispanic.*

◆ In 1995, there were 38,971 children living in families with incomes below the federal poverty line of $13,330 for a family of three. Almost one-third of all Rhode Island families with children earn less than $25,000 a year.

Source: U.S. Bureau of the Census, Current Population Survey, 1993-1997 average.

Young Children in Poverty, Rhode Island, 1995

◆In 1995 in Rhode Island, 40% of all poor children were under age 6. One in five Rhode Island children under the age of six was living in poverty.[8]

◆ As of December 1, 1997, there were 15,043 young children under age 6 in families receiving cash assistance from the Rhode Island Family Independence Program (which replaced Aid to Families with Dependent Children). Of all children in the Family Independence Program, 42% are under age 6.[9]

◆ Research shows that the quality of a child's environment and social interactions in the early years affect brain development, producing lifelong impacts on learning, social skills, and mental health.[10]

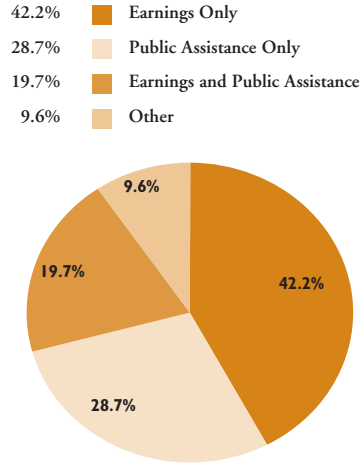
◆ The experience of poverty has particularly damaging effects in early childhood. Young children in poverty are more likely to experience delays in their physical, cognitive, language, and emotional development, which in turn affects their readiness for school.[11]

◆ Young children born into poverty are more likely to…[12]

be born low birthweight;
die in infancy or early childhood;
be hospitalized during childhood;
receive lower quality medical care;
experience hunger and malnutrition;
be victims of or witnesses to violence;
be exposed to environmental toxins.

Children in Poverty

Poor Children Under Age 6 in the U.S., by Source of Family Income, 1994



Total number of young children in poverty is 6.1 million

Source: National Center for Children in Poverty, *One in Four* (1996). New York: Columbia University, School of Public Health, National Center for Children in Poverty.

Working Poor Families

◆ In 1995, 51% of poor families worked full or part-time, up from 41% in 1993.[13] Factors related to poverty among working families include the predominance of service and retail jobs that pay lower wages, the declining value of the minimum wage, and the inability to find full-time, year-round work.[14]

◆ Sustainable employment requires jobs and supports that provide adequate resources for child care, health insurance, and transportation. Part-time, temporary or seasonal work, and non-traditional work shifts make child care arrangements fragile.[15]

◆ In the 1960s and 1970s, the earnings of a full-time year-round minimum wage earner lifted a family of three above the poverty line. Now the same effort leaves a family of three 20% below the poverty line. In 1997, a person working 40 hours per week at the Rhode Island minimum wage of $5.15 per hour will earn $10,712 annually.

◆ The Earned Income Tax Credit is a credit on the federal income tax, available since 1975, to low-income and moderate-income working families with children. The EITC increases the income available to working poor families and helps to bring minimum wage earners up to the poverty threshold (when combined with Food Stamps).[16]

Table 5.

Child Poverty, Rhode Island, 1990

	FAMILIES WITH CHILDREN BELOW POVERTY		CHILDREN UNDER 18 BELOW POVERTY		CHILDREN UNDER 6 BELOW POVERTY	
CITY/TOWN	N	%	N	%	N	%
Barrington	27	1.3%	52	1.3%	33	2.6%
Bristol	108	4.5%	253	5.9%	128	8.3%
Burrillville	148	6.3%	276	6.1%	119	8.5%
Central Falls	710	28.5%	1,576	32.5%	749	38.0%
Charlestown	68	7.8%	145	9.4%	39	6.4%
Coventry	199	4.7%	402	5.3%	180	7.3%
Cranston	735	8.9%	1,378	9.5%	562	10.9%
Cumberland	145	4.0%	302	4.7%	151	7.4%
East Greenwich	75	4.6%	153	5.3%	112	13.0%
East Providence	499	8.0%	904	8.7%	355	9.9%
Exeter	26	3.3%	52	3.6%	5	1.0%
Foster	34	5.5%	88	7.6%	0	0.0%
Glocester	99	7.2%	156	6.5%	77	10.0%
Hopkinton	40	4.1%	75	4.1%	9	1.4%
Jamestown	59	8.9%	92	8.1%	45	11.9%
Johnston	266	9.0%	452	8.4%	187	10.6%
Lincoln	164	7.2%	272	7.0%	98	7.2%
Little Compton	12	2.6%	20	2.7%	15	5.1%
Middletown	129	5.1%	275	6.0%	158	9.1%
Narragansett	71	4.4%	122	4.5%	36	3.6%
Newport	559	17.7%	1,143	20.3%	575	27.0%
New Shoreham	12	12.4%	17	10.1%	6	10.0%
North Kingstown	185	5.4%	281	4.7%	121	6.1%
North Providence	182	5.6%	298	5.4%	78	4.3%
North Smithfield	23	1.7%	37	1.6%	19	3.1%
Pawtucket	1,255	13.4%	2,525	15.5%	1,096	17.3%
Portsmouth	95	3.8%	182	4.4%	70	5.2%
Providence	5,621	29.2%	12,946	34.5%	5,531	36.8%
Richmond	9	1.1%	30	2.0%	0	0.0%
Scituate	45	3.3%	91	3.7%	19	2.3%
Smithfield	75	3.4%	155	4.1%	61	4.9%
South Kingstown	134	4.9%	350	7.5%	133	8.7%
Tiverton	109	6.0%	200	6.4%	81	7.9%
Warren	132	9.3%	199	8.5%	56	6.2%
Warwick	519	5.1%	1,084	5.9%	448	7.2%
Westerly	210	7.3%	432	8.7%	224	12.9%
West Greenwich	14	2.9%	26	2.9%	11	4.2%
West Warwick	395	10.7%	746	11.8%	291	13.0%
Woonsocket	1,183	20.0%	2,235	21.4%	1,034	26.9%
Core Cities	***9,328***	***23.2%***	***20,425***	***27.3%***	***8,985***	***30.7%***
Remainder of State	***5,043***	***6.0%***	***9,597***	***6.5%***	***3,927***	***7.9%***
Rhode Island	***14,371***	***11.6%***	***30,022***	***13.5%***	***12,912***	***16.3%***

Note to Table

Data used for this table are from 1990 because the most recent city/town data available are from the 1990 Census of Population.

In 1995 there were 38,971 poor children in Rhode Island, according to the U.S. Bureau of the Census, Current Population Survey, 1993-1997 average.

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls. The denominator is all children under age 18 according to the 1990 Census of Population.

References for Indicator

[1,2,3] *Children and Poverty*, Vol. 7, Number 2 (Summer/Fall 1997). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation; and, Children's Defense Fund (1994). *Wasting America's Future: The Children's Defense Fund Report on the Costs of Child Poverty.* Boston: Beacon Press.

[4,10] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation; and Shore, R. (1997). *Rethinking the Brain.* New York, NY: Families and Work Institute.

[5,8,13] U.S. Bureau of the Census, Current Population Survey, 1993 to 1997 average.

[6,7] O'Hare, W.P., "A New Look at Poverty in America," *Population Bulletin* (Vol. 51, No. 2, September 1996). Washington, DC: Population Reference Bureau, Inc.

[9] Rhode Island Department of Human Services, INRHODES Database, December 1, 1997.

[11, 12] National Center for Children in Poverty, *One in Four* (1996). New York: Columbia University, School of Public Health, National Center for Children in Poverty.

[14,15,16] Seavey, D.K.(1995). *Back to Basics: Women's Poverty and Welfare Reform.* Wellesley, MA: Center for Research on Women, Wellesley College; and Scholz, J. K. (1995). "Alternatives to Welfare Income: The EITC" in *Strategies for Self-Sufficiency: Jobs, Earnings, Child Support, and the Earned Income Tax Credit* (May 1995). Madison, WI: University of Wisconsin-Madison, Institute for Research on Poverty.

Children in the Family Independence Program

DEFINITION

Children in the Family Independence Program is the percentage of children less than age 18 who were living in families receiving cash assistance from the Family Independence Program (FIP) on December 1, 1997. These data measure the number of children and families receiving cash assistance from FIP at one point in time. They do not count the additional children and families who qualified for the program at other points in the year but were not enrolled on December 1, 1997.

SIGNIFICANCE

Rhode Island's Family Independence Program seeks to help low-income families work by providing the supports, including health insurance and subsidized child care, that families need to obtain and keep a job. The Family Independence Program allows two-parent and single-parent families to obtain assistance. The program helps increase family income by allowing working recipients to keep more of their earnings before cash assistance is decreased or terminated. Recipients who are not currently employed may be enrolled in work-readiness activities, including training and education, after a comprehensive work-readiness assessment is completed. Health insurance for children and subsidized child care are available to all Rhode Island families who meet the income criteria, whether or not they have ever received cash assistance through AFDC or FIP.

Through the FIP, children in families that are income-eligible are entitled to cash assistance without time limits. A five-year life-time limit for cash benefits is placed on adults in the family unless exempt. Cash assistance has a significant impact on the ability of poor families to provide food, shelter, and clothing for their children. If a family has no income, the monthly FIP benefit for a Rhode Island family of three is $554 per month for families that do not live in public housing.[1] With an additional average of $270 per month in Food Stamps, the average monthly combined benefit is $824. This amount is one-third below the federal poverty level. When combined with earned income and the earned income tax credit, cash assistance can move a family above the poverty line of $13,330 for a family of three. As of December 31, 1997, twenty percent of the 16,375 adults receiving FIP cash assistance were employed.[2]

As of December 1, 1997, there were 35,735 Rhode Island children receiving cash assistance through the Family Independence Program. More than 80% of all children receiving cash assistance through FIP are ages 12 and under.[3]

Under the federal welfare reform law that replaced AFDC with the Temporary Assistance for Needy Families program (TANF), states are allowed to develop their own support programs for needy families. The Family Independence Program is Rhode Island's welfare reform program as set forth in the Rhode Island Family Independence Act of 1996.

Elements of Effective Welfare Reform

Assists families in obtaining sustainable jobs that move them out of poverty.

◆ Low-income families require adequate income and benefits to meet their needs for housing, food, clothing, health insurance, child care, and transportation. Entry into sustainable jobs at a sufficient wage requires assistance with job placement, job training, English-language programs, literacy programs, vocational education, high school and GED, and post-secondary education.[4]

Supports the healthy development of children.

◆ Programs that increase family income, improve access to health care for children and families, and connect families to high-quality child care that is affordable are likely to have positive impacts on child well-being.[5,6] The Rhode Island Family Independence Program provides cash assistance to all eligible children without time limits. Full or partial child care subsidies are available for low-income working families up to 185% of poverty and for families enrolled in FIP who are employed or are in work-readiness programs. Health care coverage through RIte Care is available for children up to age 18 up to 250% of poverty.

Provides access to a range of supports needed by low-income families.

◆ It is the combination of benefits and support systems that is most likely to lift families out of poverty and enhance the well-being of children.[7] Children's well-being can be enhanced by access to the variety of social services and benefit programs that are available to them and their families (including cash assistance, Earned Income Tax Credits, Food Stamps, WIC, School Lunch and School Breakfast, RIte Care, and subsidized child care).[8]

Table 6.

Children Enrolled in the Family Independence Program (FIP), Rhode Island, December 1, 1997

CITY/TOWN	ESTIMATED 1997 CHILDREN UNDER 18	NUMBER RECEIVING FIP CASH ASSISTANCE FAMILIES	NUMBER RECEIVING FIP CASH ASSISTANCE CHILDREN	FIP CHILDREN AS % OF ALL CHILDREN UNDER 18
Barrington	3,613	28	50	1.4%
Bristol	4,618	137	216	4.7%
Burrillville	4,113	91	158	3.8%
Central Falls	5,785	868	1,718	29.7%
Charlestown	1,735	43	75	4.3%
Coventry	7,421	249	390	5.3%
Cranston	15,502	979	1,629	10.5%
Cumberland	6,508	166	254	3.9%
East Greenwich	2,539	74	121	4.8%
East Providence	10,804	669	1,082	10.0%
Exeter	1,504	18	29	1.9%
Foster	1,108	23	34	3.1%
Glocester	2,280	38	65	2.9%
Hopkinton	1,877	67	105	5.6%
Jamestown	1,104	12	17	1.5%
Johnston	5,771	315	517	9.0%
Lincoln	3,888	127	218	5.6%
Little Compton	696	8	12	1.7%
Middletown	5,049	112	202	4.0%
Narragansett	2,968	99	154	5.2%
Newport	6,424	609	1,160	18.1%
New Shoreham	211	4	5	2.4%
North Kingstown	5,871	216	340	5.8%
North Providence	6,118	360	578	9.4%
North Smithfield	1,976	26	46	2.3%
Pawtucket	18,836	2,036	3,824	20.3%
Portsmouth	4,005	63	102	2.5%
Providence	46,126	7,832	16,368	35.5%
Richmond	1,660	39	65	3.9%
Scituate	2,238	39	66	2.9%
Smithfield	3,718	65	93	2.5%
South Kingstown	4,863	137	267	5.5%
Tiverton	2,954	72	118	4.0%
Warren	2,561	126	242	9.4%
Warwick	18,457	841	1,364	7.4%
Westerly	5,516	274	486	8.8%
West Greenwich	953	23	39	4.1%
West Warwick	7,319	483	823	11.2%
Woonsocket	11,589	1,382	2,703	23.3%
Core Cities	*88,761*	*12,727*	*25,773*	*29.0%*
Remainder of State	*151,516*	*6,023*	*9,962*	*6.6%*
Rhode Island	*240,277*	*18,750*	*35,735*	*14.9%*

Source of Data for Tables/Methodology

Rhode Island Department of Human Services, INRHODES Data Tapes, December 1, 1997. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The denominator is an estimated number, and calculated by adding the number of children ages one to ten according to the 1990 Census of Population, plus seven times the average number of births for the years 1991 to 1995.

References for Indicator

[1,3] Rhode Island Department of Human Services, INRHODES Database, December 1, 1997. Families that live in public housing receive $504 per month.

[2] Rhode Island Department of Human Services, December 31, 1997.

[4] *Welfare That Works: The Working Lives of AFDC Recipients, A Report to the Ford Foundation* (1995). Washington, DC: Institute for Women's Policy Research.

[5] Collins, A., Jones, S., Bloom, H. (1996). *Children and Welfare Reform: Highlights from Recent Research.* New York: National Center for Children in Poverty, Columbia University School of Public Health.

[6] Bogenschneider, K. and T. Corbett (1995). *Welfare Reform: Can Government Promote Parental Self-Sufficiency While Ensuring the Well-Being of Children?* Madison, WI: University of Wisconsin-Madison Institute for Research on Poverty.

[7,8] *The Safety Net Delivers: The Effects of Government Benefits Programs in Reducing Poverty* (1996). Washington, DC: Center on Budget and Policy Priorities.

Children Receiving Food Stamps

DEFINITION

Children receiving food stamps is the percentage of income-eligible children under age 18 who participate in the Food Stamp program.

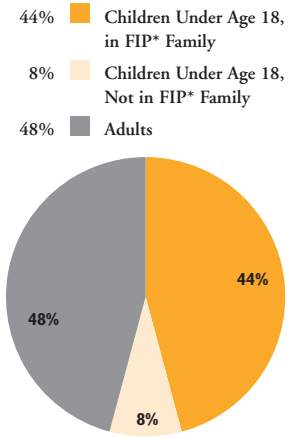
SIGNIFICANCE

The Food Stamp program provides coupons which can be used for the purchase of food at retail stores. Research shows that participation in the Food Stamp program increases a family's ability to purchase an adequate low-cost diet and helps low-income households achieve better nutritional intake.[1,2] The maximum monthly Food Stamp benefit for a family of three is $270. To qualify for Food Stamps, a household's gross income must be less than 130% of the poverty level for that family size and meet requirements which limit the value of assets (such as cash and automobiles).

The Food Stamp program is an entitlement, meaning that federal funding is provided to all applicants who meet the eligibility requirements. One of the documented strengths of the Food Stamp program is its ability to respond to economic changes in order to provide a basic level of food resources to low-income families and individuals.

More than half of all food stamp recipients in Rhode Island are children under age 18. There are 41,942 children in Rhode Island who receive benefits from the Food Stamp program, as of December 1, 1997.[3] There are an additional 35,000 children who live in families that meet the gross income requirement for Food Stamps but do not participate in the program.[4] Potential factors involved in non-participation of these families include assets that make them ineligible, lack of information about their eligibility for the program, difficulties with transportation to local offices, language barriers, complicated application procedures, and the stigma that is sometimes associated with using food stamps.[5,6]

Food Stamp Participation by Age, Rhode Island, December 1997



Total Served is 80,499
**FIP is the Family Independence Program.*

Source: RI Department of Human Services, INRHODES Database, December 1, 1997.

Food Stamps and the Federal Welfare Law

◆ The 1996 federal welfare reform law decreased federal funding for Food Stamps by an estimated $164 million in Rhode Island over the next six years.7 By 1998, families with children are expected to lose an average of $435 annually in food stamp benefits.[8]

◆ Under the 1996 federal welfare law, 18 to 50 year-old unemployed individuals who are not disabled and do not have a child in the household are restricted to three months of food stamp receipt in a 36-month period. Rhode Island has applied for and received waivers to exempt areas with high unemployment or insufficient jobs from the three-month cut-off.

◆ Research shows that families eligible for food stamps that do not receive cash assistance are less likely to access the Food Stamp program.[9]

◆ Rhode Island is one of 12 states that has state-funded food stamps for some legal immigrants who are no longer eligible for federally-funded food stamps under the 1996 federal welfare law.[10] Continued outreach and information is needed to ensure that legal immigrants who were residents of Rhode Island before 8/22/96 are enrolled in the Food Stamp program if they meet the eligibility requirements.

Food Insecurity

◆ According to the USDA's Food Security Measurement Study, 12.8% of Rhode Island's households experience "food insecurity." Members of food-insecure households experience anxiety about the availability of food and money and adjust the quality of food by purchasing low-cost foods of poorer nutritional value. In one-quarter of Rhode Island households experiencing food insecurity, the quantity of food is reduced for adults and/or children in the household.[11]

◆ Rhode Island's "food insecurity rate" of 12.8% is the sixteenth highest in the country. Rhode Island exceeds the national rate of 11.9% and has the highest percentage of food insecurity in the New England region.[12]

Table 7. **Children Under 18 Receiving Food Stamps, Rhode Island, December 1, 1997**

CITY/TOWN	ESTIMATED NUMBER ELIGIBLE	NUMBER OF ELIGIBLE PARTICIPATING	% OF ELIGIBLE PARTICIPATING
Barrington	83	67	80%
Bristol	NA	312	NA
Burrillville	541	245	45%
Central Falls	5,298	2,153	41%
Charlestown	NA	108	NA
Coventry	946	451	48%
Cranston	2,962	1,895	64%
Cumberland	625	331	53%
East Greenwich	138	139	100%
East Providence	2,816	1,274	45%
Exeter	NA	34	NA
Foster	118	35	30%
Glocester	298	105	35%
Hopkinton	NA	121	NA
Jamestown	47	15	32%
Johnston	760	617	81%
Lincoln	383	288	75%
Little Compton	57	27	47%
Middletown	668	250	37%
Narragansett	285	169	59%
Newport	2,648	1,357	51%
New Shoreham	8	8	100%
North Kingstown	579	368	64%
North Providence	1,191	680	57%
North Smithfield	157	59	38%
Pawtucket	9,973	4,575	46%
Portsmouth	201	119	59%
Providence	34,338	18,699	54%
Richmond	NA	81	NA
Scituate	146	90	62%
Smithfield	245	138	56%
South Kingstown	493	280	57%
Tiverton	358	135	38%
Warren	NA	303	NA
Warwick	2,681	1,571	59%
Westerly	861	581	67%
West Greenwich	NA	44	NA
West Warwick	1,837	973	53%
Woonsocket	6,096	3,245	53%
Core Cities	*58,885*	*30,029*	*51%*
Remainder of State	*20,784*	*11,913*	*57%*
Rhode Island	*77,019*	*41,942*	*54%*

Source of Data for Tables/Methodology

Estimated number eligible is based on the total number of children ages birth to 18 (projections from the 1990 Census) multiplied by the % of students eligible for free School Lunch in each community. Families with incomes less than 130% of poverty are income-eligible for free School Lunch and for Food Stamps (the Food Stamp program also has an assets limitation as part of eligibility determination). Free lunch percentages are from the Rhode Island Department of Education, October 1997.

Food Stamp program participation data are from the Rhode Island Department of Human Services, INRHODES Database, December 1, 1997.

NA: Numbers are not available as community has a regional school district.

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

References for Indicator

[1] *Statement on the Link Between Nutrition and Cognitive Development in Children* (1995). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

[2,6] Devaney, B.L. and M.R. Ellwood, J.M. Love, "Programs that Mitigate the Effects of Poverty on Children" in *The Future of Children: Children and Poverty,* Vol. 7, No. 2 (Summer/Fall 1997). Los Altos, CA: The David and Lucille Packard Foundation.

[3] Rhode Island Department of Human Services, INRHODES Database, December 1, 1997.

[4] Data from Rhode Island Department of Human Services, INRHODES Database, December 1, 1997 and Rhode Island Department of Education, October 1997. Calculations by Rhode Island KIDS COUNT.

[5] Kaufman, M. (Ed.), *Nutrition in Public Health: A Handbook for Delivering Services* (1990). Denver, CO: Aspen Institute.

[7] *State-Level Projections of Food Loss Due to Reductions in Funding for the Food Stamp Program Under Welfare Reform: Projections for the Six-Year Period FY1997-FY2002* (August 4, 1997). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

[8] *The Depth of the Food Stamp Cuts in the Final Welfare Bill* (1996). Washington, DC: Center on Budget and Policy Priorities.

[9] Spalter-Roth, R. and E. Soto, (April 1996). *Food Stamps and AFDC: A Double Life-Line for Low-Income Working Single Mothers.* Washington, DC: Institute for Women's Policy Research.

[10] *State-Funded Food Stamps for Legal Immigrants* (December 4, 1997). Washington, DC: Center on Budget and Policy Priorities.

[11,12] *State-Level Food Security Prevalence Estimates* (October, 1997). Medford, MA: Tufts Center on Hunger, Poverty, and Nutrition Policy.

Children Receiving School Breakfast

DEFINITION

Children receiving school breakfast is the percentage of low-income public school children who attend schools offering the School Breakfast Program. Half-day kindergarten, private schools, and residential child care facilities are not included in the calculations. Children are counted as low-income if they are eligible for and enrolled in free or reduced price lunch.

SIGNIFICANCE

Undernutrition during any period of childhood can have a detrimental impact on a child's cognitive development. The longer a child's nutritional needs go unmet, the greater the risk of cognitive impairment.[1] Low-income students are more likely than other students to arrive at school without an adequate breakfast.[2] The School Breakfast Program offers nutritious meals to children at participating schools, providing children with one-fourth or more of their Recommended Daily Allowance for key nutrients.

Federal and state funds are available to support the costs of the School Breakfast Program. At the 134 schools in Rhode Island that offer the School Breakfast Program, all students are offered the program and eligible students receive breakfast free or at a reduced price. To receive a reduced-price meal, household income must be below 185% of the federal poverty level. For free meals, household income must fall below 130% of poverty. Children in Food Stamp and Family Independence Program households are automatically eligible for free meals.

Children who participate in the School Breakfast Program have better school attendance, are more likely to arrive at school on time, and have higher standardized test scores than non-participants.[3] Schools can maximize student participation in the School Breakfast Program by providing information to parents and students even before the program is initiated; reducing stigma by promoting the program to all children; direct marketing to students through attractive posters, leaflets, and announcements; and encouraging community, parent and student involvement in all aspects of the program.[4,5]

Access to School Breakfast, Rhode Island, 1997

◆ 43% (134 out of 309) of Rhode Island schools offer the School Breakfast Program, compared to 72% of schools across the nation.[6] 68% of Rhode Island's low-income public school students attend schools offering breakfast.[7]

◆ In the communities of Burrillville, Central Falls, Providence, and West Warwick, 100% of low-income students attend schools offering the School Breakfast Program. In Cumberland, East Greenwich, Westerly, and Woonsocket, more than 75% of low-income students attend schools offering the School Breakfast Program, above the statewide average of 68%.[8]

◆ There are 15,901 eligible low-income students who are not receiving school breakfast because they attend the 175 Rhode Island public schools that do not participate in the School Breakfast Program.[9]

◆ 22 states have legislation mandating the provision of the School Breakfast Program in schools serving large numbers of low-income children. In Rhode Island, a mandate requiring School Breakfast for all schools in which 20% or more of the students are low-income would add 66 schools in 18 school districts; a mandate at 30% or more would add 37 schools in 12 school districts.[10]

Feeding Children When School is Out

◆ The Summer Food Service Program provides nutritious meals to low-income children during the summer months. Like School Breakfast, this program is an entitlement program funded by federal funds.

◆ In 1997, only 9 communities in Rhode Island offered the Summer Food Service Program. The Summer Food Program is often provided in conjunction with educational, developmental, and recreational activities. Eligible sponsors include playground programs, Housing Authorities, Boys and Girls Clubs, churches, recreation centers, schools, and other community organizations.

Table 8. **Low-Income Children Receiving School Breakfast, Rhode Island, Fall 1997**

SCHOOL DISTRICT	NUMBER OF LOW-INCOME STUDENTS IN DISTRICT	NUMBER OF LOW-INCOME STUDENTS ATTENDING SCHOOLS WITH BREAKFAST	PERCENT OF LOW-INCOME STUDENTS ATTENDING SCHOOLS WITH BREAKFAST	TOTAL NUMBER OF SCHOOLS IN DISTRICT	NUMBER OF SCHOOLS >20% FREE/REDUCED PRICE LUNCH	NUMBER OF SCHOOLS >30% FREE/REDUCED PRICE LUNCH
Barrington	100	0	0%	6	0	0
Bristol-Warren	1,043	675	65%	11	10	6
Burrillville	531	531	100%	5	4	0
Central Falls	2,658	2,658	100%	6	6	6
Chariho	484	176	36%	6	1	0
Coventry	929	274	29%	9	5	1
Cranston	2,314	1,578	68%	23	13	12
Cumberland	546	454	83%	9	3	1
East Greenwich	137	104	76%	6	0	0
East Providence	2,067	1,305	63%	14	11	9
Exeter-W. Greenwich	242	93	38%	4	0	0
Foster	53	0	0%	1	0	0
Foster-Glocester	116	0	0%	2	0	0
Glocester	132	0	0%	2	1	0
Jamestown	44	0	0%	2	0	0
Johnston	477	188	39%	8	4	2
Lincoln	359	38	11%	7	1	0
Little Compton	35	0	0%	1	0	0
Middletown	591	0	0%	6	4	3
Narragansett	235	0	0%	3	0	0
Newport	1,278	240	19%	10	9	8
New Shoreham	5	0	0%	1	0	0
North Kingstown	553	0	0%	10	2	1
North Providence	670	0	0%	9	6	3
North Smithfield	180	0	0%	3	0	0
Pawtucket	5,572	1,107	20%	16	16	15
Portsmouth	191	0	0%	6	1	1
Providence	18,873	18,873	100%	46	46	46
Scituate	147	0	0%	5	0	0
Smithfield	213	63	30%	6	1	0
South Kingstown	494	0	0%	7	1	0
Tiverton	379	0	0%	6	3	0
Warwick	2,142	244	11%	26	13	5
Westerly	651	582	89%	7	5	2
West Warwick	1,026	1,026	100%	6	5	3
Woonsocket	3,642	2,999	82%	14	14	14
Core Cities	*29,896*	*23,750*	*79%*	*91*	*89*	*83*
Remainder of State	*19,213*	*9,458*	*49%*	*218*	*96*	*55*
Rhode Island	*49,109*	*33,208*	*68%*	*309*	*185*	*138*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, Fall 1997. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

Number of low-income students is the number of students eligible for and enrolled in free or reduced price lunches in the Fall of 1997. Low-income students receiving breakfast is the percent of students enrolled in free or reduced priced lunches who attend schools serving breakfast in the Fall of 1997. Half-day kindergarten, private schools and residential child care facilities may offer the School Breakfast Program, but are not included in these calculations.

The denominator is the number of children enrolled in the public school who are eligible for and enrolled in free or reduced price lunches in the Fall of 1997, not including half-day kindergarten.

References for Indicator

[1,2,3] *Statement on the Link Between Nutrition and Cognitive Development in Children* (1995). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

[4] *School Breakfast Scorecard: A Status Report on the School Breakfast Program 1996-1997* (1997). Washington, DC: Food Research and Action Center.

[5] *What's for Breakfast* (1995). Providence, RI: Nutrition Council of Rhode Island in cooperation with the RI Department of Health.

[6] Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, 1997 and *School Breakfast Scorecard: A Status Report on the School Breakfast Program* 1996-1997 (1997). Washington, DC: Food Research and Action Center.

[7,8,9,10] Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, 1997. Calculations by Rhode Island KIDS COUNT.

Health

To Any Reader

As from the house your mother sees
You playing round the garden trees,
So you may see, if you will look
Through the windows of this book,
Another child, far, far away,
And in another garden, play.
But do not think you can at all,
By knocking on the window, call
That child to hear you. He intent
Is all on his play-business bent.
He does not hear; he will not look,
Nor yet be lured out of his book.
For, long ago, the truth to say,
He has grown up and gone away,
And it is but a child of air
That lingers in the garden there.

– ROBERT LOUIS STEVENSON

Children's Health Insurance

DEFINITION

Children's health insurance is the percentage of children under age 18 who were covered by any kind of public or private health insurance, including Medicaid, during the previous calendar year. These data reflect only those who were insured through the entire year and do not include those who were insured for only part of the year.

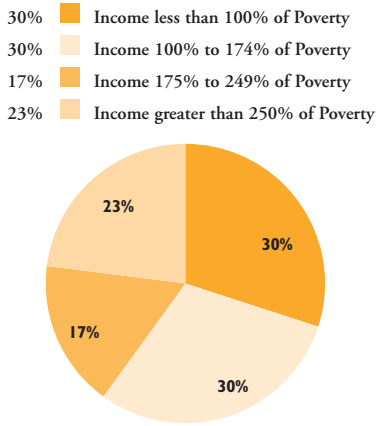
SIGNIFICANCE

Health care is vital to every child's healthy growth and development. Lack of insurance coverage makes it difficult to obtain primary and specialty care – including preventive health care, comprehensive treatment for acute and chronic illness, mental health services, dental care, and prescriptions.[1] Undiagnosed and untreated medical conditions can result in long-term health problems and interfere with learning and development.[2]

Insured children are more likely to have a relationship with a primary care physician, to receive required preventative services, and to receive a physician's care for health problems, such as asthma or ear infections.[3] Regular doctor visits are especially critical during early childhood to receive immunizations and to be screened and treated for any developmental problems.[4]

Uninsured children in fair or poor health are almost five times as likely as their insured counterparts to go without needed dental care, and one and one-half times as likely to be missing all or part of their current immunizations.[5] Low-income children and uninsured children are more likely to be hospitalized for conditions that could have been managed with appropriate outpatient care.[6]

Children Under Age 18 without Health Insurance, by Poverty Level, Rhode Island, 1992 to 1996



n = 20,500

Source: U.S. Bureau of the Census, Current Population Survey, 1992-1996 average. Compiled by The Annie E. Casey Foundation KIDS-COUNT.

Children's Health Insurance in Rhode Island

◆ RIte Care is Rhode Island's Medicaid managed care program. Families with incomes up to 250% of poverty can receive health insurance coverage for their children up to age 18. RIte Care insurance coverage is also available to pregnant women up to 350% of poverty, families enrolled in the Family Independence Program, and eligible family child care providers who serve low-income children.

◆ While the availability of health insurance coverage for children considerably increases access, it does not guarantee entry into the health care system.[7] Low family income and educational levels, lack of transportation, and language differences are among the barriers to obtaining health insurance and appropriately using health care services.[8]

◆ One in ten (20,500) Rhode Island children under 18 are without health insurance. Nearly one in five children who live in families earning less than 175% of the federal poverty line remain uninsured.

◆ Three-quarters of the uninsured children in Rhode Island live in families who have incomes under 250% of the federal poverty line and are therefore eligible to enroll in RIte Care.

◆ 4,800 Rhode Island children who live in families that do not meet the income requirement for RIte Care (250% of poverty) are uninsured. These children may be uninsured either because the parent's employer does not offer family coverage or because the family can not afford monthly payments for family coverage.[9]

Note: Data on uninsured children are from the U.S. Bureau of the Census, Current Population Survey, 1992-1996 average. Compiled by The Annie E. Casey Foundation KIDS-COUNT.

Facts About SSI

◆ Supplemental Security Income is a federal program that provides eligible children with disabilities up to $558 per month in cash assistance and enrolls them in Medicaid. The assistance helps families pay for food, clothing, shelter, and the extra costs of caring for a child with a disability.[11]

◆ The 1996 federal welfare reform law changed the definition of disability for children under the SSI program. The law requires the Social Security Administration to review the cases of certain children enrolled in SSI to see if they are disabled under the new definition.

◆ Federal law requires that there be no break in Medicaid coverage for children who lost SSI as a result of the new disability definition. Children who were receiving SSI payments on August 22, 1996, continue to be eligible for Medicaid.[12]

◆ More than 500 Rhode Island children were terminated from SSI in 1997 due to the new disability definition. If families are terminated from SSI because of the new disability definition, they have the right to appeal. Children who appeal have a good chance of success. They have won restoration of benefits in more than half of the appeals decided to date.[13]

◆ Social Security officials have found evidence that, across the country, children are being improperly terminated from the SSI program. Parents are being given a second opportunity to challenge the loss of cash benefits, even if they originally missed the deadline for appeal.[14]

Table 9.

Children Under 18 Receiving Medical Assistance,

CITY/TOWN	RITE-CARE	SSI	TOTAL
Barrington	127	11	138
Bristol	462	28	490
Burrillville	339	25	364
Central Falls	2,559	130	2,689
Charlestown	179	14	193
Coventry	803	38	841
Cranston	2,570	132	2,702
Cumberland	469	28	497
East Greenwich	211	15	226
East Providence	1,767	92	1,859
Exeter	90	2	92
Foster	77	3	80
Glocester	155	13	168
Hopkinton	207	5	212
Jamestown	38	3	41
Johnston	892	34	926
Lincoln	396	33	429
Little Compton	40	4	44
Middletown	356	28	384
Narragansett	286	8	294
Newport	1,663	74	1,737
New Shoreham	15	0	15
North Kingstown	609	30	639
North Providence	927	51	978
North Smithfield	97	9	106
Pawtucket	5,550	312	5,862
Portsmouth	236	14	250
Providence	24,501	1,245	25,746
Richmond	133	24	157
Scituate	121	8	129
Smithfield	205	15	220
South Kingstown	498	23	521
Tiverton	265	15	280
Warren	381	14	395
Warwick	2,273	135	2,408
Westerly	833	24	857
West Greenwich	81	6	87
West Warwick	1,427	69	1,496
Woonsocket	3,752	227	3,979
Out-of-State	*33*	*29*	*62*
Unknown	*5*	*8*	*13*
Core Cities	*38,025*	*1,988*	*40,013*
Remainder of State	*17,603*	*990*	*18,593*
Rhode Island	*55,628*	*2,978*	*58,606*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, INRHODES Database, December 1, 1997. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

RIte Care is the number of children enrolled in RIte Care as of December 1, 1997, including children who are income eligible, children enrolled in FIP, foster children and non-SSI children with disabilities. The Providence numbers for "other" include foster children who may live in other towns, because the DHS database lists foster children as Providence residents for administrative purposes.

References for Indicator

[1] "Health Insurance Coverage" in *The Future of Children*, Vol. 5, No. 3 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

[2] *Caring Prescriptions: Comprehensive Health Care Strategies for Children in Poverty* (1993). New York: Columbia University, National Center for Children in Poverty.

[3, 5, 6, 7, 8, 10] *Health Insurance Coverage Leads to Increased Health Care Access for Children* (1997). Washington DC, Government Accounting Office.

[4] *Unmet Needs: The Large Differences in Health Care Between Insured and Uninsured Children.* (1997). Washington, DC: Families USA.

[9] Scheils, J. and L. Alecxih, *Recent Trends in Employer Health Insurance Coverage and Benefits* (September, 1996). Washington, DC: American Hospital Association.

[11] *New Federalism: Issues and Options for States* (1997). "Supplemental Security Income for Children with Disabilities: Part of the Federal Safety Net" (July 1997). Washington, DC: The Urban Institute.

[12] *Alert – SSI Kids and Medicaid* (1997). Washington, DC: National Health Law Program.

[13, 14] "Disabled Youth Wrongly Lost Benefits" (November 16, 1997). *The Providence Journal.*

Women and Children Receiving WIC

DEFINITION

Women and children receiving WIC is the percentage of eligible women, infants and children served by the Special Supplemental Food Program for Women, Infants and Children (WIC).

SIGNIFICANCE

The Special Supplemental Food Program for Women, Infants and Children is a preventive program providing nutritious food, nutrition education, and improved access to health care.[1] This federally-funded program serves pregnant, postpartum and breastfeeding women; infants; and children less than five years of age. Household income must be below 185% of the poverty level. Participants must have a specified health or nutritional risk, such as abnormal weight gain during pregnancy or iron deficiency anemia.

WIC links the distribution of food to other health services, including prenatal and pediatric care. All participants receive food vouchers for cereal, milk, infant formula, and high protein foods (beans, peanut butter) that can be redeemed at retail stores. The WIC Farmer's Market Nutrition Program improves the intake of fresh fruits and vegetables by providing coupons to almost half of WIC participants to help them to purchase fresh produce at local farmers' markets.[2] In Rhode Island in 1997, six farmers' markets provided fresh fruits and vegetables to 9,946 recipients.

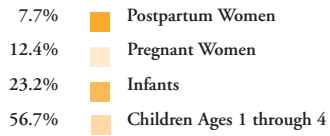
Access to WIC in Rhode Island

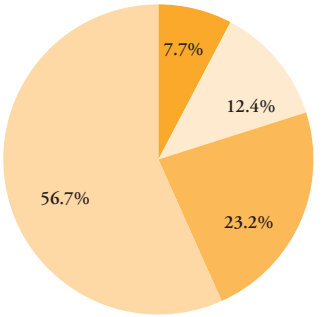
- The WIC program is closely connected to the health care delivery system. Participation in WIC increases the likelihood that women will receive early, regular prenatal care and that their children will get regular pediatric care and immunizations. Mothers and children who are poor, minority, or poorly educated benefit most.[3]

- WIC is not an entitlement program and is not funded at a level that is sufficient to serve all eligible women, infants, and children. In December 1997, 71% of eligible women, infants and children were served across the state.

- Four of the five cities with the highest child poverty rates – Providence, Pawtucket, Woonsocket, and Central Falls – have WIC participation rates that exceed the statewide average of 71%. In Newport, only 52% of women, infants, and children eligible for WIC are served.

Women, Infants and Children Served by WIC,





Total Served is 23,190

Source: Rhode Island Department of Health, Division of Family Health, WIC Program, December 1997.

WIC Protects Child Health and Development

- Participation in WIC during pregnancy reduces fetal deaths, infant mortality, and low birthweight and reduces Medicaid costs.[4] Low-income mothers participating in WIC have 25% fewer low birthweight babies (less than 5.5 pounds) and 44% fewer very low birthweight babies (less than 3.3 pounds) than mothers with similar incomes who were not participating in the WIC program.[5]

- WIC protects infants and children from iron-deficiency anemia and other nutrition related health problems.[6] By protecting a child's cognitive development, WIC results in savings for special education that may have otherwise been incurred due to malnutrition in infancy and early childhood.[7]

Table 10. **Women, Infants and Children Receiving WIC, Rhode Island, December 1997**

CITY/TOWN	ESTIMATED NUMBER ELIGIBLE	NUMBER PARTICIPATING	% OF ELIGIBLE PARTICIPATING
Barrington	211	37	18%
Bristol	403	214	53%
Burrillville	427	288	67%
Central Falls	1,642	1,365	83%
Charlestown	105	67	64%
Coventry	592	297	50%
Cranston	1,753	1,035	59%
Cumberland	554	259	47%
East Greenwich	241	56	23%
East Providence	1,205	846	70%
Exeter	13	44	100%*
Foster	10	42	100%*
Glocester	293	82	28%
Hopkinton	33	99	100%*
Jamestown	96	8	8%
Johnston	598	280	47%
Lincoln	360	175	49%
Little Compton	63	18	29%
Middletown	694	336	48%
Narragansett	71	131	100%*
Newport	1,332	687	52%
New Shoreham	39	2	5%
North Kingstown	370	221	60%
North Providence	262	419	100%*
North Smithfield	59	85	100%*
Pawtucket	3,198	2,759	86%
Portsmouth	249	117	47%
Providence	11,280	8,672	77%
Richmond	24	90	100%*
Scituate	75	54	72%
Smithfield	174	109	63%
South Kingstown	402	235	58%
Tiverton	260	151	58%
Warren	156	137	88%
Warwick	1,613	902	56%
Westerly	648	367	57%
West Greenwich	38	20	53%
West Warwick	777	617	79%
Woonsocket	2,566	1,867	73%
Core Cities	*20,018*	*15,350*	*77%*
Remainder of State	*12,868*	*7,840*	*61%*
Rhode Island	*32,886*	*23,190*	*71%*

Estimates are based on 1990 Census, and do not reflect recent increases in eligible population.

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, WIC Program, December 1997. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the number of children under age 5 who live in families with an income less than 185% of poverty, according to the 1990 Census of Population. This is an estimate of the eligible population and does not take into account increases in the number of women and children who became income eligible between 1990 and 1997.

References for Indicator

[1,4,6] Devaney, B.L., Ellwood, M.R., & Love, J.M. (1997). "Programs that Mitigate the Effects of Poverty on Children" in *The Future of Children: Children and Poverty,* Vol. 7, No. 2 (Summer/Fall 1997). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

[2] *Strengthening WIC Farmer's Markets: A Summary of State Strategies* (1996). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

[3] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[5] *Beyond Rhetoric: A New American Agenda for Children and Families, Final Report of the National Commission on Children* (1991). Washington, DC: U.S. Government Printing Office.

[7] *Statement on the Link Between Nutrition and Cognitive Development in Children* (1995). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

Women with Delayed Prenatal Care

DEFINITION

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

SIGNIFICANCE

Timely and comprehensive prenatal care, focused on the whole family and the living environment, increases the likelihood of delivering a healthy infant of normal birthweight. Women receiving late or no prenatal care are at increased risk of having infants who are low birthweight, who are stillborn, or who die within the first year of life. Women who receive adequate prenatal care are more likely to get preventive care for their infants.1 Delaying the start of prenatal care to the second trimester increases health risks for both mother and baby.[2]

Increasing the number of women who receive early prenatal care results in fewer complications at birth and reduces health care costs.[3] Prenatal care offers the opportunity to screen for and treat disease conditions that increase the risk for poor birth outcomes. Effective prenatal care also screens for and intervenes with non-medical conditions including smoking, substance use, physical abuse, nutritional deficiencies, needs for food, clothing and shelter, and information needs related to infant and child development.[4]

Early prenatal care is especially important for women at increased medical and social risk.[5] Delayed prenatal care is linked to maternal educational levels. In the U.S. in 1993, 90% of mothers 20 years of age and over with more than 12 years of education received early prenatal care, compared with 63% of mothers with fewer than 12 years of education.[6]

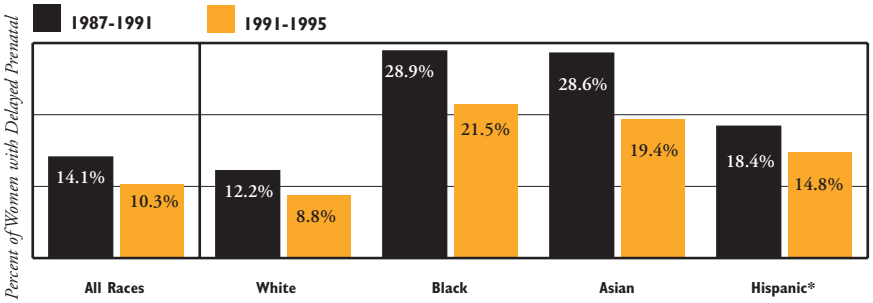
Risk Factors for Delayed Prenatal Care

◆ Women who live in the core cities of Providence, Pawtucket, Woonsocket, Newport, and Central Falls are less likely to begin prenatal care in the first trimester than women who live in other communities. In Woonsocket and Central Falls, more than 20% of women receive late or no prenatal care, twice the state rate for delayed care.[7]

◆ Adolescents, regardless of race, are less likely to receive early prenatal care than older mothers. In Rhode Island between 1991 and 1995, nearly 30% of young women ages 12 to 17 years old did not receive prenatal care until after the first

CHANGE SINCE THE 1980s

Delayed Prenatal Care by Race/Ethnicity, Rhode Island, 1987-1991 and 1991-1995



◆ Over the past decade, access to prenatal care has improved. The percentage of Rhode Island women who did not receive prenatal care in the first trimester decreased from 14.1% to 10.3%.

◆ While more women of all ethnic groups are entering prenatal care during the first trimester of pregnancy, African-American, Asian, and Hispanic women continue to be considerably less likely to receive prenatal care in the first trimester.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1987-1991 and 1991-1995. Data for 1994 and 1995 are provisional. *Hispanic data are not available for 1987 and 1988.

Table 11.

Delayed Prenatal Care, Rhode Island, 1991-1995

CITY/TOWN	# BIRTHS	# DELAYED CARE	% DELAYED CARE
Barrington	854	18	2.1%
Bristol	1,329	117	8.8%
Burrillville	966	64	6.6%
Central Falls	1,813	376	20.7%
Charlestown	471	34	NA
Coventry	2,035	94	4.6%
Cranston	4,443	317	7.1%
Cumberland	1,825	110	6.0%
East Greenwich	594	32	5.4%
East Providence	2,957	234	7.9%
Exeter	397	20	NA
Foster	264	13	NA
Glocester	527	32	6.1%
Hopkinton	519	31	6.0%
Jamestown	278	14	NA
Johnston	1,744	96	5.5%
Lincoln	1,044	63	6.0%
Little Compton	162	13	NA
Middletown	1,409	166	11.8%
Narragansett	786	31	3.9%
Newport	1,952	321	16.4%
New Shoreham	62	3	NA
North Kingstown	1,523	95	6.2%
North Providence	1,893	137	7.2%
North Smithfield	505	30	5.9%
Pawtucket	5,675	810	14.3%
Portsmouth	1,048	67	6.4%
Providence	14,958	2,172	14.5%
Richmond	474	26	NA
Scituate	545	26	4.8%
Smithfield	907	36	4.0%
South Kingstown	1,312	63	4.8%
Tiverton	754	65	8.6%
Warren	708	60	8.5%
Warwick	5,176	306	5.9%
Westerly	1,628	138	8.5%
West Greenwich	281	15	NA
West Warwick	2,264	202	8.9%
Woonsocket	3,358	705	21.0%
Core Cities	*27,756*	*4,384*	*15.8%*
Remainder of State	*41,684*	*2,768*	*6.6%*
Rhode Island	*69,440*	*7,152*	*10.3%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1991-1995. Data for 1994 and 1995 are provisional.

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

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

The denominator is the total number of live births to Rhode Island residents from 1991-1995.

References for Indicator

[1] Klerman, L.V. (1991). *Alive and Well?: A Research and Policy Review of Health Programs for Poor Children.* New York: Columbia University, National Center for Children in Poverty.

[2] *Prenatal Care in the United States: A State and County Inventory - Volume 1* (1989). New York: The Alan Guttmacher Institute.

[3,5] Child Trends, Inc. and the U.S. Bureau of the Census (1996). *Trends in the Well-Being of America's Children and Youth: 1996.* Washington, DC: U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation.

[4] Alexander, G.R. & Korenbrot, C.C. (1995). "The Role of Prenatal Care in Preventing Low Birth Weight" in *The Future of Children: Low Birth Weight,* Vol. 5, No. 1 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

[6] National Center for Health Statistics (1996). *Health, United States*, 1995. Hyattsville, MD: U.S. Public Health Service.

[7,8] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1991-1995. Data for 1994 and 1995 are provisional.

Low Birthweight Infants

DEFINITION

Low birthweight infants is the percentage of infants born weighing under 2,500 grams (5.5 pounds). The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

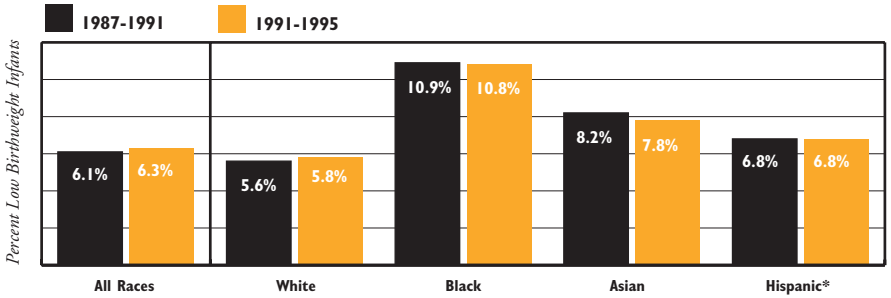
A baby's birthweight is a key indicator of newborn health and is directly related to infant survival, health and development. A baby is small at birth either because it was born too soon, because it grew too slowly, or some combination of the two. Babies born weighing less than 5.5 pounds are at greater risk for physical and developmental problems. Low birthweight babies are 20 times more likely than babies of normal weight to die within the first year of life.[1]

The incidence of low birthweight is strongly associated with poverty.[2] Prevention of low birthweight focuses on early and comprehensive prenatal care, adequate nutrition and weight gain, and smoking cessation. Smoking during pregnancy has been linked to 20% to 30% of low birthweight births and to long-term effects such as physical, mental, and cognitive impairments.[3]

Low birthweight rates for black infants in Rhode Island are almost twice those for white infants, and are higher than those for other racial groups.[4] Underlying the high rate of low birthweight among African-Americans in the U.S. is the higher rate of preterm delivery (babies born before 37 weeks gestation). The causes of preterm delivery are not well understood; the higher rates are not completely explained by differences in socio-economic status, health status, or use of tobacco or other drugs.[5]

CHANGE SINCE THE 1980s

Low Birthweight Infants by Race/Ethnicity, Rhode Island, 1987-1991 and 1991-1995



◆ Over the past decade, the rate of low birthweight babies in Rhode Island has remained stable for all race and ethnic groups.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1987-1991 and 1991-1995. Data for 1994 and 1995 are provisional. *Hispanic data are not available for 1987 and 1988.

Trends in the Survival of Low Birthweight Infants

◆ The decline in infant mortality without a parallel decline in low birthweight is attributable to the increased survival rates of low birthweight infants due to changes in medical technology, improvements in neonatal intensive care, and new drug therapies for very small infants.[6]

◆ Babies born weighing less than 1,500 grams (3.3 pounds) are at especially high risk for chronic lung and respiratory problems, visual and hearing impairments, mental retardation, and developmental and learning disabilities.[7]

◆ Low birthweight infants who survive are at greater risk for physical and developmental problems. Children who are now 6 to 15 years old, who were born low birthweight, are 50% more likely than children born of normal weight to be enrolled in a special education program.[8]

Table 12.

Low Birthweight Infants, Rhode Island, 1991-1995

CITY/TOWN	# BIRTHS	# LOW BIRTHWEIGHT	% LOW BIRTHWEIGHT
Barrington	854	46	5.4%
Bristol	1,329	81	6.1%
Burrillville	966	43	4.5%
Central Falls	1,813	143	7.9%
Charlestown	471	24	NA
Coventry	2,035	124	6.1%
Cranston	4,443	281	6.3%
Cumberland	1,825	76	4.2%
East Greenwich	594	28	4.7%
East Providence	2,957	195	6.6%
Exeter	397	21	NA
Foster	264	17	NA
Glocester	527	36	6.8%
Hopkinton	519	29	5.6%
Jamestown	278	11	NA
Johnston	1,744	111	6.4%
Lincoln	1,044	52	5.0%
Little Compton	162	10	NA
Middletown	1,409	58	4.1%
Narragansett	786	32	4.1%
Newport	1,952	116	5.9%
New Shoreham	62	2	NA
North Kingstown	1,523	79	5.2%
North Providence	1,893	120	6.3%
North Smithfield	505	27	5.3%
Pawtucket	5,675	411	7.2%
Portsmouth	1,048	46	4.4%
Providence	14,958	1,188	7.9%
Richmond	474	11	NA
Scituate	545	39	7.2%
Smithfield	907	40	4.4%
South Kingstown	1,312	59	4.5%
Tiverton	754	42	5.6%
Warren	708	40	5.6%
Warwick	5,176	251	4.8%
Westerly	1,628	97	6.0%
West Greenwich	281	15	NA
West Warwick	2,264	162	7.2%
Woonsocket	3,358	240	7.1%
Core Cities	*27,756*	*2,098*	*7.6%*
Remainder of State	*41,684*	*2,305*	*5.5%*
Rhode Island	*69,440*	*4,403*	*6.3%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1991-1995. Data for 1995 are provisional.

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

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

The denominator is the total number of live births to Rhode Island residents from 1991-1995.

References for Indicator

[1] Children's Defense Fund (1996)."Infant Health Improving" in *CDF Reports*, Vol. 17, No. 12 (November 1996). Washington, DC: Children's Defense Fund.

[2,5] Paneth, N.S. (1995). "The Problem of Low Birthweight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucille Packard Foundation.

[3] Chomitz, V.R., Cheung, L.W.Y., Lieberman, E., "The Role of Lifestyle in Preventing Low Birth Weight" in The Future of Children: Low Birthweight, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children.

[4] Healthy People 2000 - Rhode Island: The Health of Minorities in Rhode Island (1993). Providence, RI: Rhode Island Department of Health, Office of Health Statistics; and Rhode Island Department of Health, Maternal and Child Health Database, 1987-1991 and 1991-1995.

[6] Lewit, E., Schuurmann Baker, L., Corman, H., & Shiono, P.H. (1995). "The Direct Cost of Low Birth Weight" in The Future of Children: Low Birthweight, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children; and Shiono, P.H., & Behrman, R.E. (1995). "Low Birth Weight: Analysis and Recommendations" in The Future of Children: Low Birthweight, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children.

[7] Vohr, B.R. & Msall, M.E. (1997). "Neuropsychological and Functional Outcomes of Very Low Birthweight Infants" in Seminars in Perinatology, Vol. 21, No. 3 (June 1997); andPaneth, N.S. (1995). "The Problem of Low Birthweight" in The Future of Children: Low Birthweight, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucille Packard Foundation.

[8] Lewit, E., Schuurmann Baker, L., Corman, H., Shiono, P.H. (1995). "The Direct Cost of Low Birth Weight" in The Future of Children: Low Birthweight, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucille Packard Foundation.

Infant Mortality

DEFINITION

Infant mortality is the number of deaths occurring to infants under one year of age per 1,000 live births. The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

The infant mortality rate is an important measure of the well-being of infants, children, and pregnant women. Infant mortality is associated with a variety of factors, including women's health status, quality and access to medical care, socioeconomic conditions, and public health practices. In the United States, about two-thirds of infant deaths are closely linked to low birthweight, preterm delivery, and events surrounding the prenatal period and delivery; about one-third are associated with conditions or events that arise after the delivery, which often reflect social or environmental factors.[1,2]

Communities with multiple problems such as poverty, poor housing conditions, and unemployment tend to have higher infant mortality rates than more advantaged communities.[3] Risk factors contributing to infant deaths include a lack of preventive health and prenatal care, inadequate nutrition, and poor living conditions. Some of the health factors associated with infant deaths include congenital birth defects, complications resulting from early delivery and low birthweight, and respiratory problems.[4]

Infant mortality has two components: neonatal mortality, which is the number of deaths of infants younger than 28 days, and postneonatal mortality, the number of deaths of infants between 28 days and one year old. In 1996 in Rhode Island, 77 infants died before their first birthday; of these, 60 were younger than 28 days old. Twenty-two were live births less than 500 grams (1.1 pounds), 21 of whom died within the first day.[5]

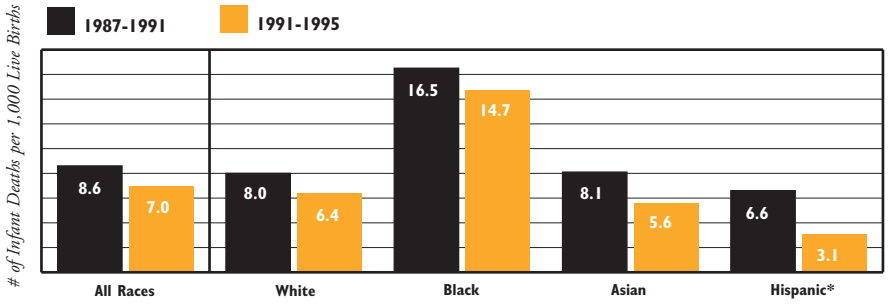
U.S. Infant Mortality Rate Ranks Behind Other Countries

◆ In 1996, the overall United States infant mortality rate ranked twenty-eighth worldwide. The U.S. infant mortality rate for black infants ranked forty-ninth when compared with other countries' overall rates.[6]

◆ Provisional data for 1996 show that the infant mortality rate for Rhode Island dropped to 5.5 infant deaths, a record low for Rhode Island and the lowest rate in the nation.[7,8]

CHANGE SINCE THE 1980s

Infant Mortality by Race/Ethnicity, Rhode Island, 1987-1991 and 1991-1995



◆ Over the past decade, Rhode Island's infant mortality rate has improved from 8.6 infant deaths per 1,000 births to 7.0 infant deaths per 1,000 births.

◆ Over the past ten years, infant mortality rates for all racial groups in Rhode Island have declined. Despite this progress, the black infant mortality rate continues to be twice that for white infants.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1987-1991 and 1991-1995. Data for 1994 and 1995 are provisional. *Hispanic figures are not available for 1987 and 1988.

Table 13.

Number of Infant Deaths, Rhode Island, 1991-1995

CITY/TOWN	# BIRTHS	# INFANT DEATHS	RATE/1000 BIRTHS
Barrington	854	3	3.5
Bristol	1,329	5	3.8
Burrillville	966	6	6.2
Central Falls	1,813	14	7.7
Charlestown	471	6	NA
Coventry	2,035	12	5.9
Cranston	4,443	23	5.2
Cumberland	1,825	12	6.6
East Greenwich	594	6	10.1
East Providence	2,957	28	9.5
Exeter	397	0	NA
Foster	264	2	NA
Glocester	527	3	5.7
Hopkinton	519	4	7.7
Jamestown	278	0	NA
Johnston	1,744	6	3.4
Lincoln	1,044	7	6.7
Little Compton	162	1	NA
Middletown	1,409	11	7.8
Narragansett	786	5	6.4
Newport	1,952	14	7.2
New Shoreham	62	0	NA
North Kingstown	1,523	14	9.2
North Providence	1,893	12	6.3
North Smithfield	505	5	9.9
Pawtucket	5,675	33	5.8
Portsmouth	1,048	6	5.7
Providence	14,958	139	9.3
Richmond	474	4	NA
Scituate	545	4	7.3
Smithfield	907	4	4.4
South Kingstown	1,312	9	6.9
Tiverton	754	7	9.3
Warren	708	2	2.8
Warwick	5,176	26	5.0
Westerly	1,628	12	7.4
West Greenwich	281	0	NA
West Warwick	2,264	20	8.8
Woonsocket	3,358	21	6.3
Core Cities	*27,756*	*221*	*8.0*
Remainder of State	*41,684*	*265*	*6.4*
Rhode Island	*69,440*	*486*	*7.0*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1991-1995. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

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

The denominator is the total number of live births to Rhode Island residents from 1991-1995.

References for Indicator

[1] *America's Children: Key National Indicators of Well-Being* (1997). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[2] Paneth, N.S. (1995). "The Problem of Low Birth Weight" in *The Future of Children: Low Birth Weight,* Vol.5, No.1 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

[3,6] *The State of the World's Children: 1997* (1997). New York: United Nations Children's Fund (UNICEF).

[4] Klerman, L.V., (1991) *Alive and Well?: A Research and Policy Review of Health Programs for Poor Children.* New York: Columbia University, National Center for Children in Poverty.

[5] Provisional 1996 data on 13,788 births, Rhode Island Department of Health, Office of Vital Statistics, January 1998.

[7] Monthly Vital Statistics Report (1997). *Births and Deaths: United States, 1996, Preliminary Data from the CDC.* Washington DC: National Center for Health Statistics.

[8] Provisional 1996 data on 13,788 births, Rhode Island Department of Health, Office of Vital Statistics, January 1998; and *1997 KIDS COUNT Data Book* (1997). Baltimore, MD: The Annie E. Casey Foundation.

Children with Lead Poisoning

DEFINITION

Children with lead poisoning is the percentage of three-year-old children screened for lead poisoning who had elevated blood lead levels (10 ug/dL) at any time prior to November 30, 1997. These data are for children eligible to enter kindergarten in the fall of 1999 (i.e. born between September 1, 1993 and August 31, 1994).

SIGNIFICANCE

Childhood lead poisoning is one of the most common pediatric health problems and is entirely preventable. Infants and young children are most susceptible to the toxic effects of lead. Lead's effects on the developing central nervous system may be irreversible. While the overall rate of lead poisoning is declining, the rate of lead poisoning for children living in homes with substantial lead contamination remains high. While all children are at risk for lead poisoning, low-income children and minority children are particularly likely to be affected. Inadequate nutrition and anemia, more common in low-income children, further increase a child's susceptibility to lead poisoning.[1]

Learning disabilities, hyperactivity, antisocial behavior, attention deficit disorder, hearing and speech impediments, and loss of intelligence can be attributed to lead levels equal to or greater than 10 ug/dL. Higher levels of lead exposure can result in serious health problems and can lead to coma, convulsions, and death.[2,3]

In Rhode Island there are 3,010 children eligible to enter kindergarten in the fall of 1999 who have been screened with lead levels over 10 ug/dL.[4] In 1997, eighteen Rhode Island children were hospitalized with seriously high lead levels greater than 40 ug/dL. Of these, 13 were from Providence, 2 were from Pawtucket, 1 was from North Providence, 1 was from West Warwick, and 1 was from Woonsocket. Two children were admitted to the hospital more than once.[5]

Some progress has been made in reducing the numbers of children in Rhode Island with lead exposure. In the fall of 1997, 28% of children entering kindergarten had a blood lead level over 10 ug/dL compared to 20% of children eligible to enter kindergarten in the fall of 1999.[6]

Lead Exposure in Rhode Island's Cities
Children under Age 6,
Screened between July 1, 1996 and June 30, 1997

	Number Screened	Number with Elevated Lead Levels	Percent with Elevated Lead Levels (greater than or equal to 10ug/dL)
Providence	8,830	2,428	28%
Central Falls	1,059	283	27%
Woonsocket	2,132	389	18%
Pawtucket	3,034	494	16%
Newport	914	132	14%
Rhode Island	*35,046*	*5,324*	*15%*

Source: Rhode Island Department Health, Division of Family Health. Data are for all children screened between July 1, 1996 and June 30, 1997 (n=35,046). Communities may vary in the percentage of children under age 6 who are screened.

◆ The core cities continue to have lead exposure rates equal to or higher than the state average. These communities also have the highest child poverty rates in the state. More than one in four children screened in Providence and Central Falls in 1997 had high lead levels. [7]

◆ Deteriorating lead-based paint and lead-contaminated dust, especially from pre-1950 housing, are the main causes of childhood lead poisoning. Almost half of Rhode Island's 414,572 housing units were built before 1950.[8]

◆ The lack of affordable housing in many communities means that many low-income families live in older dwellings with deteriorating lead paint, placing children at risk for lead poisoning.[9]

◆ Strategies that reduce lead hazards in housing and educates the public on the risks of lead poisoning to young children can prevent lead poisoning before it occurs.[10]

◆ A comprehensive approach that addresses housing, family and community education, health, nutrition, and child development can reduce the harmful effects of lead once exposure has occurred.[11]

Table 14.

Lead Poisoning in Children Entering Kindergarten in the Fall of 1999

CITY/TOWN	NUMBER TESTED FOR LEAD POISONING	# SCREENED POSITIVE >=10 UG/DL	% CHILDREN >=10 UG/DL
Barrington	263	18	6.8%
Bristol	272	24	8.8%
Burrillville	208	30	14.4%
Central Falls	442	127	28.7%
Charlestown	96	10	10.4%
Coventry	344	22	6.4%
Cranston	881	124	14.1%
Cumberland	412	22	5.3%
East Greenwich	125	8	6.4%
East Providence	623	90	14.4%
Exeter	74	7	9.5%
Foster	52	5	9.6%
Glocester	95	7	7.4%
Hopkinton	71	11	15.5%
Jamestown	87	13	14.9%
Johnston	301	24	8.0%
Lincoln	251	27	10.8%
Little Compton	46	2	4.3%
Middletown	186	24	12.9%
Narragansett	206	26	12.6%
Newport	387	100	25.8%
New Shoreham	13	6	46.2%
North Kingstown	363	34	9.4%
North Providence	337	36	10.7%
North Smithfield	95	6	6.3%
Pawtucket	1,318	273	20.7%
Portsmouth	209	30	14.4%
Providence	3,622	1,211	33.4%
Richmond	124	10	8.1%
Scituate	107	10	9.3%
Smithfield	197	9	4.6%
South Kingstown	385	59	15.3%
Tiverton	187	25	13.4%
Warren	154	19	12.3%
Warwick	914	85	9.3%
Westerly	161	24	14.9%
West Greenwich	56	9	16.1%
West Warwick	415	55	13.3%
Woonsocket	857	185	21.6%
Unknown Residence	*486*	*203*	*NA*
Core Cities	*6,626*	*1,896*	*28.6%*
Remainder of State	*8,310*	*911*	*11.0%*
Rhode Island	*15,422*	*3,010*	*19.5%*

Source of Data for Table/Methodology

Source: Rhode Island Department Health, Division of Family Health, November 1997.

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

Data for children entering kindergarten in the fall of 1999 reflects the number of RI children eligible to enter school in the fall of 1999 (i.e. born between 9/1/93 and 8/31/94).who screened positive for lead poisoning at anytime prior to November 30, 1997. Rhode Island law requires universal lead screening for children under six. Lead screening results for close to 100% of Rhode Island children in this age cohort are included in this indicator.

The denominator is the number of children entering school in the fall of 1999 who were screened for lead poisoning.

References for Indicator

[1] *Preventing Lead Poisoning in Young Children: A Statement by the Centers for Disease Control* (1991). Washington DC: U.S. Department of Health and Human Services, Centers for Disease Control.

[2] Pueschel, S.M., Linakis, J.G., and Anderson, A.C. (1996). Lead Poisoning in Childhood. Baltimore: Paul H. Brookes Publishing Co.

[3,8,11] Centers for Disease Control and Prevention (1997). *Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials (November 1997).* Atlanta: Centers for Disease Control and Prevention.

[4] Rhode Island Department of Health, Office of Health Risk Assessment and Division of Family Health, September 1,1993-November 30,1997.

[5] Rhode Island Department of Health, Division of Family Health, January 1997 - December 1997.

[6,7] Rhode Island Department of Health, Office of Health Risk Assessment and Division of Family Health, July 1, 1996 - June 30, 1997.

[9,10] Lead-Based Paint Hazard Reduction and Financing Task Force (1995). *Putting the Pieces Together: Controlling Lead Hazards in the Nation's Housing* (Summary, June 1995). Washington, DC: U.S. Department of Housing and Urban Development; and National Center for Lead-Safe Housing, (1992). Childhood lead poisoning and affordable housing: an overview. September 1992 [newsletter].

Births to Teens

DEFINITION

Births to teens is the number of births to teen girls ages 15 to 17 per 1,000 teen girls. Data are reported by the mother's place of residence, not the place of the infant's birth.

SIGNIFICANCE

Teen pregnancy and parenting threatens the development of teen parents as well as their children. Teen mothers are less likely to obtain adequate prenatal care and are less likely to have financial resources and social supports needed for healthy child development.[1] Children born to teen parents are more likely to suffer poor health, experience learning and behavior problems, live in poverty, go to prison, and become teen parents themselves.[2]

Being a teen parent seriously limits subsequent education and employment prospects.[3] Nationally, three out of five teen mothers drop out of school. Lifetime earnings are less than half of those of women who wait until age twenty before bearing their first child.[4] One-quarter of teen mothers have a second child within two years of their first.[5]

The male partners of teenage mothers tend not to be teens themselves. Nationally, 51% of births to girls ages 15 to 17 were fathered by men aged 20 or older.6 Only a small proportion of unwed fathers of children born to teen mothers provide ongoing economic support to their children.[7]

Between 1991 and 1995, there were 7,025 births to Rhode Island teens age 12 to 19. Of these, 148 babies were born to girls age 12 to 14 and 2,619 babies were born to girls age 15 to 17. Two out of three births to teens age 15 to 17 were to girls in the cities of Providence, Pawtucket, Woonsocket, Newport and Central Falls.[8]

CHANGE SINCE THE 1980s

Birth to Teens, Ages 15-17, Rhode Island, 1981-1985 and 1991-1995

Teen Birth Rate per 1,000 Teens Ages 15 to 17

◆ The teen birth rate for Rhode Island girls ages 15 to 17 increased from 22.3 births per 1,000 teens in the early 1980s to 30.3 births per 1,000 teens in the early 1990s.

Source: Rhode Island Department of Health, Maternal and Child Health Database, Birth Files, 1981-1985 and 1991-1995. Data for 1994 and 1995 are provisional.

Teen Pregnancy

◆ Between 1991 and 1995 in Rhode Island, there were 7,946 pregnancies to teens age 14 to 18. 58% resulted in a live birth, 39% of the pregnancies resulted in induced abortions, and 3% were spontaneous abortions.[9]

◆ In the U.S., 83% of teens who give birth and 61% of teens who have abortions are from poor or low-income families.[10]

◆ Risk factors for teen pregnancy develop during childhood and include early school failure, early behavioral problems, poverty, and family dysfunction. Both male and female teens are less likely to become teen parents when they have a range of positive life options and economic opportunities.[11]

Table 15. **Births to Teens, Age 15-17, Rhode Island, 1991-1995**

CITY/TOWN	# OF TEEN GIRLS AGES 15-17	# OF BIRTHS TO TEENS AGES 15-17	RATE PER 1,000 TEENS
Barrington	1,410	7	5.0
Bristol	1,845	30	16.3
Burrillville	1,605	21	13.1
Central Falls	1,545	120	77.7
Charlestown	485	7	NA
Coventry	3,065	42	13.7
Cranston	5,685	96	16.9
Cumberland	2,740	37	13.5
East Greenwich	1,360	4	2.9
East Providence	4,320	83	19.2
Exeter	585	9	15.4
Foster	450	0	NA
Glocester	1,030	10	9.7
Hopkinton	670	12	17.9
Jamestown	400	5	NA
Johnston	2,225	30	13.5
Lincoln	1,610	20	12.4
Little Compton	255	3	NA
Middletown	1,470	26	17.7
Narragansett	1,020	6	5.9
Newport	1,950	108	55.4
New Shoreham	25	0	NA
North Kingstown	2,385	37	15.5
North Providence	2,575	39	15.1
North Smithfield	1,165	8	6.9
Pawtucket	6,430	261	40.6
Portsmouth	1,710	12	7.0
Providence	13,395	1,033	77.1
Richmond	510	14	27.5
Scituate	1,080	5	4.6
Smithfield	1,430	7	4.9
South Kingstown	1,830	31	16.9
Tiverton	1,405	21	14.9
Warren	910	15	16.5
Warwick	7,275	131	18.0
Westerly	1,785	30	16.8
West Greenwich	365	3	NA
West Warwick	2,400	74	30.8
Woonsocket	3,995	222	55.6
Core Cities	*27,315*	*1,744*	*63.8*
Remainder of State	*59,080*	*875*	*14.8*
Rhode Island	*86,395*	*2,619*	*30.3*

Source of Data for Table/Methodology

Rhode Island Department of Health, Maternal and Child Health Database, Birth Files, 1991-1995. Data for 1994 and 1995 are provisional.

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

NA: Rates were not calculated for cities and towns with less than 500 teen girls ages 15-17, as rates for small denominators are statistically unreliable.

The denominator is the number of girls ages 15 through 17 according to the 1990 Census of Population, multiplied by five to compute a rate over five years, 1991-1995.

References for Indicator

[1] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[2,4] *The State of America's Children Yearbook 1995* (1995). Washington, DC: Children's Defense Fund.

[3,11] Child Trends, Inc. and the U.S. Census Bureau (1996). *Trends in the Well-Being of America's Children and Youth: 1996*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[5] *Sex and America's Teenagers* (1994). New York: Alan Guttmacher Institute.

[6,10] *Facts in Brief: Teen Sex and Pregnancy* (1997). New York: Alan Guttmacher Institute.

[7] *Kids Having Kids: A Robin Hood Foundation Special Report on the Costs of Adolescent Childbearing* (1996). Rebecca A. Maynard (Ed.). New York: The Robin Hood Foundation.

[8,9] Rhode Island Department of Health, Maternal and Child Health Database, Birth Files, 1991-1995. Data for 1994 and 1995 are provisional.

Alcohol, Drug, and Cigarette Use by Teens

DEFINITION

Alcohol, drug, and cigarette use by teens is the percentage of seventh-grade, ninth-grade, and twelfth-grade students who have used alcohol or marijuana in the past month or are current smokers, based on the 1995 Rhode Island Adolescent Substance Abuse Survey.

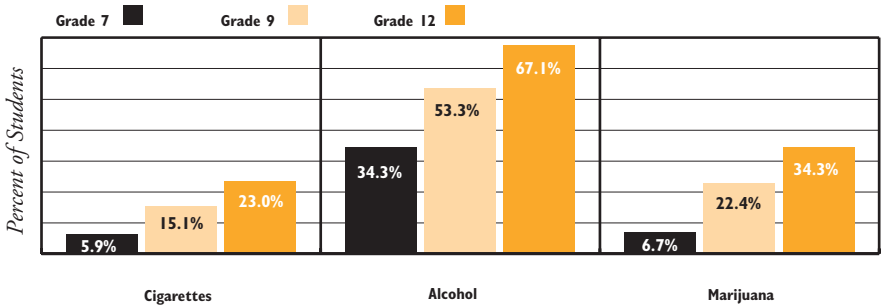
SIGNIFICANCE

The use of substances threatens the health and safety of children, families, and communities. Children and teens are negatively affected by the emotional and financial hardships caused by parents with substance abuse problems.[1] Abuse of alcohol and drugs is implicated in unemployment, worker absenteeism, accidents, vandalism, fires, damaged and destroyed playgrounds and housing, violent crimes, poverty, and homelessness.[2]

Young people who abuse alcohol and drugs are more likely to drop out of school, become teen parents, engage in high-risk sexual behavior, experience injuries, and become involved with the criminal justice system.[3] Substance use has been shown to cause dependency, mood changes, impaired judgment, memory loss, and prolonged aimlessness.[4] Suicide, homicides, and unintentional injuries account for approximately 80% of U.S. adolescent deaths. Many of these deaths involve alcohol and drugs.[5] Studies show that about 30% of drivers ages 15 to 20 who were involved in fatal crashes were under the influence of alcohol.[6]

The younger people start smoking cigarettes, the more likely they are to become strongly addicted to nicotine. 89% of adult daily smokers tried their first cigarette by age 18.[7] Smoking has serious long-term consequences, including the risk of smoking-related diseases, increased health care costs associated with treating these illnesses, and the risk of premature death. It is estimated that more than five million of today's underage smokers will die of tobacco-related illneses.[8]

Use* of Cigarettes, Alcohol, and Marijuana, by Student Grade Level, Rhode Island, 1995



**Student is a current cigarette smoker, or has used alcohol or marijuana in the past month. Based on a survey of 6,060 students in seventh grade; 4,629 students in ninth grade; and 2,627 students in twelfth grade.*

Source: *The 1995 Rhode Island Adolescent Substance Abuse Survey: Report of Statewide Results* (1996). Providence: Rhode Island Department of Health.

Alcohol Use and Youth

- Alcohol is the leading substance of abuse at all grade levels in Rhode Island. The prevalence of alcohol use among Rhode Island students is higher than national rates.[9]
- One-third of Rhode Island seventh-grade students reported using alcohol in the past month. More than half of ninth graders and more than two-thirds of twelfth graders reported using alcohol in the past month.
- In Rhode Island, 18% of eighth graders reported having been drunk in the past month, and 44% of twelfth graders reported being drunk in the last month.
- 21% of the seventh to twelfth graders surveyed reported that the drinking of one or both of their parents caused problems.

Source: *The 1995 Rhode Island Adolescent Substance Abuse Survey: Report of Statewide Results* (1996). Providence: Rhode Island Department of Health.

Drugs, Alcohol, and Crime

◆ The number of Rhode Island juvenile arrests for drug abuse violations in 1997 was the highest recorded total since 1977.[10]

◆ Drug and alcohol offenses referred to Family Court increased 54% between 1994 and 1997, from 691 offenses in 1994 to 1,061 offenses in 1997.[11]

◆ Minors in possession of alcohol increased 31% between 1996 and 1997.[12]

◆ Ninety percent of the incarcerated population at the Training School had been regular abusers of illicit substances and alcohol.[13]

Youth Cigarette Use

◆ The 1995 Rhode Island Department of Health Substance Abuse Survey reports that 15% of ninth graders and 23% of twelfth graders were current smokers at the time of the survey. Almost half of all students reported that one or both their parents smoked.[14]

◆ Teens who smoke are three times more likely than nonsmokers to use alcohol, eight times more likely to use marijuana, and 22 times more likely to use cocaine. Smoking is associated with a host of other risky behaviors, such as fighting and engaging in unprotected sex.[15]

Preventing Substance Abuse

Preventing substance abuse, violence, teen pregnancy, and other adolescent problems requires an approach that starts before the teen years and helps children and young adolescents develop critical life skills and supportive relationships. According to a 1995 Carnegie Corporation report, *Great Transitions: Preparing Adolescents for a New Century:*[16]

◆ Good schools, caring families, and supportive community institutions help young people make the transition into adulthood – well-educated, committed to family and friends, and prepared to be productive workers and citizens.

◆ Adolescents need critical life skills such as problem-solving, decision-making, resolving conflict non-violently, and coping with stress.

◆ Adolescents need environments that foster healthy social development, academic and vocational skills, and offer opportunities for recreation and community service.

◆ Adolescents need close, ongoing contact with caring and competent adults whose judgment they trust.

References for Indicator

[1] *America's Children at Risk: A National Agenda for Legal Action* (1993). Chicago: American Bar Association.

[2] *1996 National Survey of American Attitudes and Substance Abuse II* (1996). National Center on Addiction and Substance Abuse: Columbia University.

[3] *Sex and America's Teenagers* (1994). New York: Alan Guttmacher Institute.

[4] Perry, C.L. (1996). "Models for Effective Prevention" in *The Prevention Researcher,* Vol.3, No.1 (Winter, 1996).

[5,6] Child Trends, Inc. and the U.S. Census Bureau (1996). *Trends in the Well-Being of America's Children and Youth: 1996.* Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[7,15] *Preventing Tobacco Use Among Young People: A Report of the Surgeon General* (1994). Atlanta: The Centers for Disease Control and Prevention.

[8] *America's Children: Key National Indicators of Well-Being* (1997). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[9] *National Survey Results on Drug Use from the Monitoring the Future Study, 1975-1996* (1997). Washington, DC: U.S. Department of Health and Human Services.

[10] Governor's Justice Commission (October 1995). *Current Rhode Island Juvenile Arrest Analysis and Statistics;* and Rhode Island Family Court, RIJISS Intake Statistics, Year End Reports, 1994-1997.

[11,12] Rhode Island Family Court, RIJISS Intake Statistics, Year End Reports, 1994 -1997.

[13] *Strategic Plan 1995-2000 for Substance Abuse Prevention, Intervention, and Treatment* (1996). Rhode Island: The Rhode Island Department of Substance Abuse and the Governor's Council on Substance Abuse.

[14] *The 1995 Rhode Island Adolescent Substance Abuse Survey: Report of Statewide Results* (1996). Providence: Rhode Island Department of Health.

[16] *Great Transitions: Preparing Adolescents for a New Century* (1995). New York: Carnegie Council on Adolescent Development.

Additional Children's Health Issues

Rhode Island KIDS COUNT is dedicated to providing a comprehensive profile of the well-being of children in Rhode Island. However, there are some important issues affecting children for which there is a lack of available city and town data. Some of these critical health issues are as follows:

Access to Dental Care

◆ Children's unmet needs for dental care are substantial. Children who receive an inadequate level of dental care or no dental care at all can develop long-term oral health problems and are more likely to experience dental conditions that require emergency treatment. Chronic dental problems can lead to a poor self-image, a lack of concentration, absenteeism, and reduced school performance.[1]

◆ Access to dental care is a major obstacle confronting children from poor, working poor, and uninsured families. Minorities have the greatest extent of untreated dental problems for all age groups.[2] Low-income children are at greater risk for tooth decay and other symptoms of poor nutrition.[3]

◆ Five community health centers in the state provide dental care, and all have waiting lists for new patients. Dental screenings and services are available through Head Start, Donated Dental Services of Rhode Island (for children with disabilities), Traveler's Aid program for homeless teens. In Providence, expansions of the targeted school-based sealant program and the dental clinic at St. Joseph's Hospital have increased access for low-income and immigrant children.

References

[1, 3] *Health Care* (Summer/Fall 1993). Los Altos: The Center for the Future of Children.

[2] Zimmerman, H. (1996). *Dental Care and Unmet Needs for Dental Care Among the Uninsured and Medicaid Populations of Rhode Island*. Rhode Island: Rhode Island Health Care Association.

Child Immunizations

◆ Children need to be immunized on schedule to guard against a variety of preventable illnesses. It is estimated that every dollar spent on immunization saves ten dollars in later medical costs. [1] Routine childhood vaccines are provided free of charge in Rhode Island and exist to protect children from ten infectious diseases: measles, mumps, and rubella (MMR), diphtheria, tetanus, and pertussis (DPT), polio, Hemophilus influenza type B, and chicken pox.

◆ In order to most effectively protect children and communities from preventable diseases, it is important to ensure that all infants and children receive their vaccinations in accordance with the recommended childhood immunization schedule. According to the National Immunization Survey conducted in 1996 by the Centers for Disease Control, Rhode Island's immunization rate for 19 to 35 months-olds is 85%. This exceeds the United States average of 78%, yet is fifth among New England states.[2] Rhode Island is now reaching 90% of this age group with Hepatitis B vaccine, compared to 71% a year earlier. This exceeds the national average of 82%.[3]

◆ The estimated 15% of Rhode Island children who have not appropriately completed their immunization series remain at risk for developing disease that potentially can result in serious complications including pneumonia, brain damage, blindness, physical handicaps, and even death.[4] Retrospective surveys conducted by the Rhode Island Department of Health reveal significant discrepancies in the completeness of immunizations between children in low-income communities and the rest of the state. These discrepancies appear as early as three months of age, widen by seven months, and persist throughout the first two years of life.[5]

◆ Efforts to raise immunization rates include collaboration with WIC sites, health centers, free immunization walk-in clinics, and the development of KIDS NET, which includes a statewide immunization tracking system to remind parents and health care providers that innoculations are due.[6]

References

[1] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[2,3] *National Immunization Survey*, (1996). Atlanta: Centers for Disease Control and Prevention.

[4,5,6] Rhode Island Department of Health, Immunization Program, 1997.

Children's Mental Health

◆ Children's emotional well-being is essential to their growth and development. An estimated 12 to 15 percent of American children suffer from mental disorders. While the most frequent disorders treated include hyperactivity, attention deficit disorder and other conduct disorders, more than five percent of school-age children and adolescents suffer from depression and anxiety problems.[1] By age 14, girls are twice as likely as boys to suffer from depression, a gender difference that persists through adulthood. Seventy percent of children with disorders do not access mental health services.[2]

◆ In Rhode Island, the eight Community Mental Health Centers provided services to a total of 7,156 children and youth during the 1997 fiscal year.[3] Bradley Hospital, Rhode Island's largest psychiatric center for children and adolescents, admitted 753 children and youth to its hospital programs for the treatment of emotional disorders in fiscal year 1997.[4] Butler Hospital admitted 627 children and youth.[5]

◆ Mental health professionals emphasize early intervention in order to keep children's emotional problems from intensifying. Children with mental health problems are found in all areas of children's services, including education, health, child welfare, and juvenile justice. Multi-agency planning for coordinated care is critical. The Rhode Island Child and Adolescent Services System Program (CASSP) promotes local systems of care that are family-focused, multi-disciplinary, and tailor individual support services to meet the needs of the child and family.

◆ RIte Care, Rhode Island's Medicaid managed care program, includes coverage for some mental health services. There are significant numbers of children who do not qualify for RIte Care, or who qualify but are not enrolled, whose families are unable to pay for mental health services in the private market.

References

[1] *Critical Issues for Children and Youths* (1995). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

[2] *Great Transitions: Preparing Adolescents for a New Century* (1995). New York: Carnegie Council on Adolescent Development.

[3] Rhode Island Community Mental Health Centers, 1997.

[4] Bradley Hospital, June 1996 through July 1997.

[5] Butler Hospital, June 1996 through July 1997.

Children with Asthma

Asthma is one of the most common chronic health problem among children.[1] Many asthma attacks occur when children get respiratory infections, including those caused by common cold viruses. Asthma can be triggered by: exposure to cigarette smoke, dust in the home, stress, strenuous exercise, allergies, roach infestation, indoor and outdoor air pollutants, and weather conditions.[2]

Asthma is more common in families living in poverty or in crowded housing.[3] Managing asthma requires a long-term, multifaceted approach, including patient education, behavior changes, avoidance of asthma triggers, medicines to minimize and prevent symptoms, prompt treatment, and frequent medical follow-up.[4]

Children with asthma that is not managed well are more likely to miss school and to be hospitalized for symptoms that could have been prevented. Parents are more likely to miss work and to incur additional medical expenses associated with recurring medical visits and follow-up care.[5] National studies indicate that most of the potentially avoidable hospitalizations of children younger than age 15 are for pneumonia or asthma.[6]

Uninsured children are about twice as likely to receive no care from a physician for asthma.[7] Low-income and uninsured children are more likely to be hospitalized for conditions that could have been managed with appropriate outpatient care.[8] Compared with privately insured children, uninsured children have higher rates of hospitalization and Medicaid patients have even higher rates.[9]

Nationally, approximately 10% of children have symptoms consistent with asthma and nearly 5 million children under age 18 have asthma. The death rate from asthma for children 19 years and younger increased by 78% between 1980 and 1993.[10] In 1996 in Rhode Island, more than twenty-percent (2,085) of all child hospitalizations were for respiratory-related reasons. Of these, almost one-third (657) were for asthma.[11]

References

[1,2] *Childhood Asthma* (1997). Milwaukee: American Academy of Allergy, Asthma, and Immunology.

[3] Klerman, L. V. (1991). *Alive and Well? A Research and Policy Review of Health Programs for Poor Children.* New York, NY: Columbia University, National Center for Children in Poverty.

[4,10] *CDC's Asthma Prevention Program* (1997). Atlanta: Centers for Disease Control and Prevention, National Center for Environmental Health.

[5] Child Trends, Inc. (1996). *Trends in the Well-Being of America's Children and Youth: 1996.* Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation.

[6,7,8,9] *Health Insurance Coverage Leads to Increased Health Care Access for Children* (1997). Washington, DC: Government Accounting Office.

[11] Rhode Island Department of Health, Hospital Discharge Database, 1996.

Safety

Daisies

The stars are everywhere to-night,
Above, beneath me and around;
They fill the sky with powdery light
And glimmer from the night-strewn ground;
For where the folded daisies are
In every one I see a star.

And so I know that when I pass
Where no sun's shadow counts the hours
And where the sky was there is grass
And where the stars were there are flowers,
Through the long night in which I lie
Stars will be shining in my sky.

– ANDREW YOUNG

Child Deaths

DEFINITION

Child deaths are the number of deaths from all causes to children ages 1 to 14, per 100,000 children. The data are reported by place of residence, not place of death.

SIGNIFICANCE

The child death rate is a reflection of the physical health of children, the dangers to which children are exposed at home and in the community, and the level of adult supervision children receive.1 Despite medical advances in prevention and treatment, the leading cause of death among Rhode Island children is illness. Of the 204 child deaths in Rhode Island between 1991 and 1995, two-thirds were due to illness.2

Unintentional injuries are the second leading cause of death for Rhode Island children from age 1 to age 14. It is estimated that 90% of unintentional injuries can be prevented.3 Unintentional injuries disproportionately affect poor children, young children, males, and minorities. Poverty is the prime predictor of injury. Related factors that may increase a child's risk of injury include single-parent households, lack of education, young maternal age, multiple siblings, dilapidated housing, and unsafe play areas. The vast majority of unintentional injury-related deaths among children occur in the afternoon and evening hours when children are most likely to be out of school and unsupervised.4

The number of injury deaths is only a small part of the whole injury picture. For every death due to injuries, there are many more injuries that are untreated or require emergency room treatment or hospitalization.5 In 1992, the Rhode Island Department of Health compiled injury data for children from birth to age 14; there were 11 deaths, 882 hospitalizations, and 27,400 emergency room visits—all due to injuries.6 Many of the injuries that do not result in death leave children temporarily or permanently disabled, result in time lost from school, and decrease the child's ability to participate in everyday activities.7

CHANGE SINCE THE 1980s

Child Deaths by All Causes, Children Ages 1 to 14, Rhode Island, 1981-1985 and 1991-1995

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

- For the periods 1981 to 1985 and 1991 to 1995, the Rhode Island child death rate from all causes remained stable at 23 deaths per 100,000 children ages 1 to 14. There were 208 child deaths from 1981 to 1985 and 204 child deaths from 1991 to 1995.

- Between 1991 and 1995, the leading causes of death for children ages 1 to 14 were illnesses (136 deaths), fire (11 deaths), motor vehicle accidents (9 deaths), homicide (9 deaths), and suicide (7 deaths).

Source: Rhode Island Department of Health, Office of Health Statistics, 1981-1985 and 1991-1995.

Table 16.

Child Deaths, Rhode Island, 1991-1995

CITY/TOWN	NUMBER OF CHILDREN AGES 1-14	NUMBER OF CHILD DEATHS	RATE PER 100,000
Barrington	15,695	2	NA
Bristol	17,025	3	NA
Burrillville	17,930	4	NA
Central Falls	19,300	5	NA
Charlestown	6,455	1	NA
Coventry	30,045	6	NA
Cranston	57,505	8	NA
Cumberland	25,320	1	NA
East Greenwich	11,450	0	NA
East Providence	42,160	10	NA
Exeter	6,045	1	NA
Foster	4,745	1	NA
Glocester	10,145	0	NA
Hopkinton	7,445	3	NA
Jamestown	4,485	1	NA
Johnston	20,835	6	NA
Lincoln	15,265	1	NA
Little Compton	2,930	0	NA
Middletown	19,030	7	NA
Narragansett	11,390	2	NA
Newport	22,730	4	NA
New Shoreham	675	0	NA
North Kingstown	24,270	7	NA
North Providence	21,615	4	NA
North Smithfield	8,920	0	NA
Pawtucket	65,495	19	NA
Portsmouth	16,315	3	NA
Providence	151,095	48	NA
Richmond	6,345	3	NA
Scituate	9,390	1	NA
Smithfield	15,515	1	NA
South Kingstown	19,180	1	NA
Tiverton	12,140	1	NA
Warren	9,610	4	NA
Warwick	71,880	17	NA
Westerly	20,030	5	NA
West Greenwich	3,635	1	NA
West Warwick	25,840	8	NA
Woonsocket	42,310	15	NA
Core Cities	*300,930*	*91*	*30.2*
Remainder of State	*591,260*	*113*	*19.1*
Rhode Island	*892,190*	*204*	*22.9*

Source of Data for Table/Methodology

Rhode Island Department of Health, Office of Health Statistics, 1991-1995. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

NA: Because nearly all cities have a low number of deaths, the death rates are highly variable, and therefore the rates are not provided for cities and towns.

The denominator is the number of children ages 1 to 14 according to the 1990 Census of Population, multiplied by five to compute a rate over five years, 1991-1995.

References for Indicator

[1] *A Data Book of Child and Adolescent Injury* (1991). Washington, DC: Children's Safety Network.

[2] Rhode Island Department of Health, Office of Health Statistics, 1991-1995.

[3,4] *National Safe Kids Campaign* (1996). Childhood Injury Fact Sheet. Washington, DC: National Safe Kids Campaign.

[5,7] Lewit, Eugene M. and Linda Schuurman Baker, "Unintentional Injuries" in *The Future of Children*, Vol. 5, Number 1 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

[6] Rhode Island Department of Health (1992). Data from the Rhode Island Injury Hospitalizations Database, 1990.

Teen Deaths

DEFINITION

Teen deaths are the number of deaths from all causes to teens ages 15 to 19, per 100,000 teens. The data are reported by place of residence, not place of death.

SIGNIFICANCE

The transition to adulthood confronts teens of all ages with health and safety risks. Teens are more likely than any other age group to take risks that can cause injury to themselves or others. Factors contributing to teen deaths include risk-taking behavior, the use of alcohol and drugs, and violence.[1]

One-third of the deaths among Rhode Island teens are due to intentional injuries (i.e. suicide or homicide). Suicide and homicide claimed the lives of 45 teens between 1991 and 1995.[2] Twelve percent of the 27,202 students surveyed in the 1995 Rhode Island Adolescent Substance Abuse Survey reported that they often feel that life is not worth living.[3] A 1995 Massachusetts survey of students in grades 9 to 12 found that, in comparison with their peers, students who identified with one of the following groups were four times more likely to have attempted suicide: students who report unwanted sexual contact; students who identify as gay, lesbian, or bisexual; students who have had same sex sexual contact; and/or students who are involved with gangs.[4]

One-third of Rhode Island teen deaths are due to unintentional injuries. Of the 48 teen deaths due to unintentional injuries between 1991 and 1995, almost two-thirds were due to motor vehicle collisions.[5] The RI Department of Health's 1995 Youth Risk Behavior Study of 1,215 students in grades 9 to 12 found that only 20% of the teens always used safety-belts when riding in a car; 34% had driven with a someone in the previous month who had drank alcohol.[6] Nationally, motor vehicle accidents are the leading cause of death for young people ages 15 to 20 years old.[7]

Gun Deaths
Teens Ages 15 to 19, Rhode Island, 1990-1995

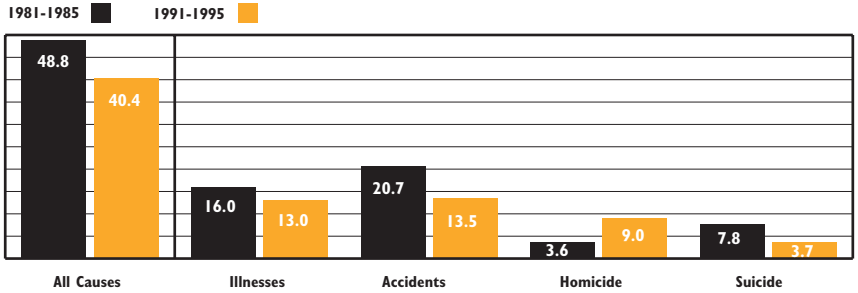
YEAR	NUMBER OF DEATHS
1990	4
1991	9
1992	3
1993	8
1994	5
1995	6

There were 5 gun deaths to children ages 5 to 14 during this time period.

Source: National Center for Health Statistics, Vital Statistics (1998). *Rhode Island Mortality Statistics, 1989-1994.* Atlanta, GA: Centers for Disease Control, and Rhode Island Department of Health, Office of Health Statistics, 1995.

CHANGE SINCE THE 1980s

Teen Deaths by Cause, Teens Ages 15-19, Rhode Island, 1981-1985 and 1991-1995



◆ In Rhode Island, the teen death rate has dropped from 48.8 deaths per 100,000 teens in the early 1980s to 40.4 deaths per 100,000 teens in the early 1990s. There were 219 teen deaths from 1981 to 1985 and 143 teen deaths from 1991-1995.

◆ In 1996 the national teen death rate of 83.5 deaths per 100,000 teens was nearly twice that of Rhode Island.

◆ Rhode Island has the lowest teen death rate in the country.[8]

◆ Since the early 1980s, the teen death rates for accidents (unintentional injuries) and illnesses and suicides have decreased; the teen death rate due to homicide has more than doubled.

◆ Between 1991 and 1995, the leading causes of death for teens ages 15 to 19 were illnesses (46 deaths), homicide (32 deaths), motor vehicle accidents (30 deaths), and suicide (13 deaths).

Table 17.

Teen Deaths, Rhode Island, 1991-1995

CITY/TOWN	NUMBER OF TEENS AGES 15-19	NUMBER OF TEEN DEATHS	RATE PER 100,000
Barrington	5,020	1	NA
Bristol	9,705	4	NA
Burrillville	5,660	2	NA
Central Falls	5,740	0	NA
Charlestown	1,640	1	NA
Coventry	10,695	6	NA
Cranston	21,325	8	NA
Cumberland	9,070	4	NA
East Greenwich	4,040	5	NA
East Providence	14,630	1	NA
Exeter	1,750	0	NA
Foster	1,445	2	NA
Glocester	3,535	3	NA
Hopkinton	2,290	0	NA
Jamestown	1,420	1	NA
Johnston	7,660	0	NA
Lincoln	5,540	1	NA
Little Compton	1,010	1	NA
Middletown	5,650	0	NA
Narragansett	3,910	5	NA
Newport	11,140	5	NA
New Shoreham	125	0	NA
North Kingstown	7,970	6	NA
North Providence	8,705	4	NA
North Smithfield	3,610	0	NA
Pawtucket	22,435	6	NA
Portsmouth	5,310	1	NA
Providence	72,915	44	NA
Richmond	1,815	1	NA
Scituate	3,430	1	NA
Smithfield	9,240	1	NA
South Kingstown	20,300	3	NA
Tiverton	5,020	1	NA
Warren	3,120	2	NA
Warwick	26,290	13	NA
Westerly	6,150	6	NA
West Greenwich	1,295	0	NA
West Warwick	8,990	2	NA
Woonsocket	14,710	2	NA
Core Cities	*126,940*	*57*	*44.9*
Remainder of State	*227,365*	*86*	*37.8*
Rhode Island	*354,305*	*143*	*40.4*

Source of Data for Table/Methodology

Rhode Island Department of Health, Office of Health Statistics, 1991-1995. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

Because nearly all cities have a low number of deaths, the death rates are highly variable, and therefore the rates are not provided for cities and towns.

The denominator is the number of teens ages 15 to 19 according to the 1990 Census of Population, multiplied by five to calculate a rate over five years, 1991-1995.

References for Indicator

[1] *Losing Generations: Adolescents in High Risk Settings* (1993). Washington, DC: National Academy Press.

[2,5] Rhode Island Department of Health, Office of Health Statistics, 1991-1995.

[3] *The 1995 Rhode Island Adolescent Substance Abuse Survey: Report of Statewide Results* (1995). Providence, RI: Rhode Island Department of Health.

[4] *1995 Massachusetts Youth Risk Behavior Survey* (1995). Quincy, MA: Massachusetts Department of Education.

[6] *1995 Rhode Island Youth Risk Behavior Survey* (March 1996). The Rhode Island Department of Health, Office of Health Statistics.

[7] U.S. Department of Transportation (1996). *Traffic Safety Facts 1996*. Washington, DC: National Highway Traffic Safety Administration.

[8] *Monthly Vital Statistics Report* (1997). Vol. 45, No. 11(S)2, June 12, 1997. Atlanta, GA: Centers for Disease Control and Prevention.

Homeless Children and Youth

DEFINITION

Homeless children and youth is the number of Rhode Island children under 13 years old who received emergency housing services at emergency homeless shelters and domestic violence shelters between July 1, 1996 and June 30, 1997. The numbers do not include homeless or runaway youth over age 13 because there are no accurate data available on this age group.

SIGNIFICANCE

Poverty and lack of affordable housing are the principal causes of family homelessness.[1] The shortage of affordable apartments and the dwindling number of housing subsidies have caused many Rhode Island families to "double-up", resulting in overcrowded, unstable living conditions. With a large percentage of family income going toward rent, any interruption in income or unexpected expense can place families at risk of homelessness.[2]

Homelessness severely affects the health and well-being of all family members. Stable housing is a basic necessity if a person is going to be productive at work or school. Transience makes it difficult or impossible to obtain and keep a job. Compared to housed poor children, homeless children experience poorer health, more developmental delays, and more anxiety, depression and behavioral problems.[3] The more children move, the more likely they are to drop out of school, regardless of family income, ethnicity, or parents' marital status.[4]

In Rhode Island, children under 13 years old represented 22% of the population receiving shelter at emergency shelters and domestic violence shelters in 1997.[5] Homelessness frequently separates children from their families due to shelter policies that may not allow older boys and fathers to stay in the shelter and parents deciding to have children stay with friends or relatives.

Housing Problems Affect Children's Health and Education

◆ Deprived of the protection and stability a home provides, homeless children often suffer from illness and serious emotional distress, exhibiting short attention spans, withdrawal, aggression, speech delays, and sleep disorders. They are more at risk for lead poisoning, asthma, and malnutrition and are at greater risk for educational underachievement.[6]

◆ Periods of homelessness, or a rapid succession of moves due to an unstable living situation, have a negative impact on a child's education.[7] Children find it difficult to concentrate in school and develop supportive relationships with adults or peers when their lives are disrupted by temporary moves.

◆ Rhode Island educators, particularly in the core cities, report a rise in the number of students moving in and out of their school communities during the course of an academic year. Children who miss school frequently fall behind quickly and are less likely to acquire the skills they need to escape poverty as adults.[8]

Homeless Children in Rhode Island, 1996-1997

◆ 899 children under age thirteen received shelter through Rhode Island's Emergency Shelter network (emergency and domestic violence shelters). Of these, 21 children received shelter through the voucher program that shelters homeless families in a local motel for one or more nights. These numbers do not include families who were turned away from shelters or those who sought shelter with family members or friends.

◆ Almost three-quarters of the families seeking shelter had incomes below $15,000 annually and almost one-quarter had no source of income at all. Within the six months prior to their shelter stay, half of the families had experienced domestic violence and one-quarter had experienced a loss of income.

Source: *Rhode Island Emergency Shelter Information Project Annual Report*, July 1, 1996 - June 30, 1997 (1997). Providence, RI: The Rhode Island Emergency Food and Shelter Board.

Homeless and Runaway Youth

◆ Many runaway and homeless youth are fleeing disruptive and abusive family conditions.[9] Some runaway youth are considered to be "throw-aways" who were told to leave a household, were abandoned or deserted, or tried to return home and were denied access.[10]

◆ Homeless youth are at risk of being physically and or sexually victimized, abusing drugs and alcohol, attempting suicide, becoming victims or perpetrators of crime, receiving money for sex to meet their basic survival needs, and contracting HIV/AIDS.[11]

◆ Adolescents who are connected to their parents, to their families, and to their school community are healthier and less likely to be involved in high risk situations than those who lack such supportive relationships. "Connectedness" is a protective factor in the lives of teens regardless of their race, ethnicity, family structure, or poverty status.[12]

Homeless Youth in Rhode Island

◆ There were 85 youth between the ages of 13 and 17 who received shelter through the emergency shelter system in Rhode Island between July 1996 and June 1997.[13] This is an underestimate of the number of youth in need of shelter, as many of the emergency and domestic violence shelters do not accept males over the age of twelve.

◆ While there are no accurate data on the total number of homeless and runaway youth in Rhode Island, there has been a steady increase in the number of homeless youth served by Travelers Aid's Runaway Youth Program, and an increasing demand for host home placement through the Runaway and Homeless Youth Network.[14]

◆ Rhode Island does not have an overnight emergency shelter for runaway youth. A total of 563 runaway or throwaway youth under age 18 accessed services through Travelers Aid from January through December 1997. Almost half of these youth had dropped out of school. The majority of these youth were from families with income below the poverty line.[15]

◆ In August 1997, 138 youth in DCYF care were classified as unauthorized absence/ runaways.[16]

References for Indicator

[1,3] National Coalition for the Homeless (1997). "Homeless Families With Children" *NCH Fact Sheet #7* (October 1997). Washington, DC: National Coalition for the Homeless.

[2,7] *Children and Their Housing Needs: A Report to KIDS COUNT* (1993). Washington, DC: Center on Budget and Policy Priorities.

[4] Weissbourd, R., *The Vulnerable Child* (1996). New York: Addison-Wesley Publishing Company.

[5,13] *Rhode Island Emergency Shelter Information Project Annual Report, July 1, 1996-June 30, 1997* (1997). Providence, RI: The Rhode Island Emergency Food and Shelter Board.

[6] *America's Children At Risk: A National Agenda for Legal Action* (1993). Chicago, IL: American Bar Association.

[8] National Coalition for the Homeless (1997). "Education of Homeless Children and Youth" *NCH Fact Sheet #10* (February 1997). Washington, DC: National Coalition for the Homeless

[9,11] *Youth with Runaway, Throwaway, and Homeless Experiences: Prevalence, Drug Use, and Other At-Risk Behaviors* (1995). FYSB Update. Washington, D.C.: Family and Youth Service Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

[10] Schneider, D. (1995). *American Childhood: Risks and Realities.* New Jersey: Rutgers University Press.

[12] Blum, R.W., & Rinehart, P.M. (1997). *Reducing the Risk: Connections that Make a Difference in the Lives of Youth.* Minneapolis, MN: University of Minnesota, Division of General Pediatrics and Adolescent Health.

[14,15] Travelers Aid, Providence, RI, Year-End Reports, 1995, 1996, and 1997.

[16] Department of Children, Youth and Families. August 1, 1997.

Juveniles Referred to Family Court

DEFINITION

Juveniles referred to Family Court is the percentage of youth ages 10 to 17 referred to Rhode Island Family Court for all wayward and delinquent offenses.

SIGNIFICANCE

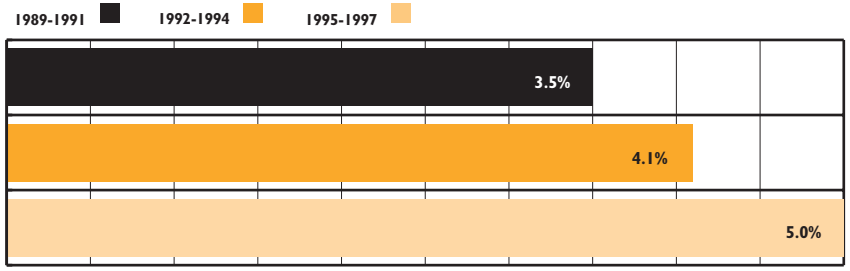
Poor school performance, including chronic truancy and falling behind one or more grade levels, increases the likelihood of involvement with the juvenile justice system. Other risk factors for juvenile crime and delinquency include poverty, family violence, inadequate supervision, and limited education and job skills.[1,2] Prevention and early intervention are the most cost-effective approaches to reducing delinquency.[3] To be most effective, strategies need to be community based, culturally appropriate and initiated early in a child's development, even before the first sign of trouble.[4] The best prevention for most adolescent risk behaviors (including crime and substance abuse) enables youth to develop caring, supportive relationships within their families, schools, peer groups, and community.[5] Well-designed programs can reduce truancy, provide support to parents, build mentoring relationships with adults, and help students learn how to problem-solve and resolve conflict peacefully. Success in school and in life can be promoted with after-school tutoring, vocational training, recreation, community service, and leadership development.[6]

The Rhode Island Family Court has jurisdiction over all juvenile offenders referred for wayward and delinquent offenses. All referrals to Family Court are from state and local law enforcement agencies, except for truancy cases which are referred by local school departments. Approximately one-third of all cases referred to Family Court are diverted instead of proceeding to a formal court hearing. In 24 communities, a Juvenile Hearing Board allows juvenile offenders to bypass the formal court process when they are willing to admit their offense.[7]

Juvenile diversion options include community service, restitution, mental health or substance abuse counseling, and/or a community-based program. According to Rhode Island Family Court, community-based diversion programs, rehabilitation options, and community-based placements are not available to all youth who need them.

CHANGE SINCE THE LATE-1980s

Juveniles Referred to Family Court*, Rhode Island, 1989 to 1997



Juveniles Referred to Family Court as a Percentage of All Youth Ages 10 to17

◆ Between 1989 and 1997, the percent of Rhode Island youths ages 10 to 17 who were referred to Family Court increased from 3.5% to 5.0%.

◆ There were 3,231 juveniles referred to Family Court for 7,969 offenses in 1989. There were 4,975 juveniles referred to Family Court for 10,066 offenses in 1997.

Juvenile Violent Crime in Rhode Island

◆ Over the past nine years, the juvenile violent crime rate in Rhode Island has more than doubled, increasing from 2.9 to 6.2 violent offenses (per 1,000 youth ages 10 to 17). There were 272 violent crime offenses in 1988 compared with 613 violent crime offenses in 1997.[8]

◆ In 1997, each of the five core cities had juvenile violent crime rates above the state rate of 6.2 violent offenses per 1,000 youth ages 10 to 17: Central Falls (12.5); Woonsocket (11.7); Providence (10.8); Pawtucket (9.2); and Newport (8.5).[9]

◆ Research has shown that the social context in which people live can promote violence. Factors such as poverty, unemployment, discrimination, exposure to violence, access to firearms, gang involvement, and alcohol and drug use are major determinants of youth violence.[10]

◆ Abused and neglected children are twice as likely to be arrested for a violent crime.[11] Child abuse prevention is needed to interrupt the cycle of violence and should focus on creating nurturing communities for children before they begin to get in trouble.[12]

Juvenile Wayward/Delinquent Offenses Referred to Family Court, Rhode Island, 1997

35%	Property Offenses	11%	Drugs and Alcohol
14%	Simple Assaults	6%	Violent Crime Offenses
13%	Status Offenses*	3%	Traffic Offenses
11%	Disorderly Conduct	3%	Weapons Offenses

n = 10,066

**Status Offenses are age-related acts that would not be punishable if the offender were an adult, such as truancy and disobedient conduct.*

***Other includes offenses such as false fire alarms, conspiracy, aiding and abetting, crank/obscene phone calls, and sex offenses other than rape.*

◆ In 1997 there were 4,975 youth referred to Family Court for a total of 10,066 offenses. These numbers do not include instances in which local law enforcement agencies refer a juvenile to a youth diversionary program or a city or town juvenile hearing board.[13]

◆ In 1997, each of the five core cities had juvenile offense rates (for all wayward/delinquent offenses) above the state rate of 101.9 offenses per 1,000 youth ages 10 to 17: Newport (156.1); Providence (141.2); Pawtucket (130.4); Central Falls (129.0); and Woonsocket (124.9). Half of all juvenile offenses referred to Family Court were by youth residing in the five core cities.[14]

◆ Between 1996 and 1997, drug and alcohol offenses increased 2.7%, from 1,033 to 1,061; minors in possession of alcohol increased 31%, from 181 to 237; weapons offenses decreased 18%, from 307 to 253; and carrying a pistol without a license decreased 50%, from 52 to 26.[15]

◆ In 1997, the Attorney General's Office filed 48 motions for waiver of jurisdiction to try juveniles as adults. Thirty-five of these motions were granted; 5 waivers were withdrawn, and 8 are pending.[16]

Source: Rhode Island Family Court, RIJISS Intake Statistics, Year End Reports, 1997

The Rhode Island Training School for Youth

◆ The Department of Children, Youth, and Families operates the Rhode Island Training School for Youth, the state's 174-bed residential detention facility for adjudicated youths and those awaiting trial.

◆ As of December 1997, there were 254 youths at the Training School, which is 46% over capacity. Approximately 1,252 youth passed through the Training School during 1997.[17]

◆ The Training School population ranges in age from 12 to 20; the average age is seventeen years; over 90% of the residents are male. Over 70% of the youth at the Training School are ethnic or racial minorities. Eighty percent of the youth at the Training School are residents of Providence, Pawtucket, Central Falls, or Woonsocket.[18]

◆ The mean reading level of the total Training School population is seventh grade, first month; and the mean mathematics level is fifth grade, fourth month. A survey of educational records of Training School youth confirms significant academic difficulty in local schools. Based on 55 records reviewed, in the year prior to incarceration, nine youths had passing grades and the remainder had all failing grades or no grades at all.[19]

References for Indicator

[1] *Juvenile Offenders and Victims, A National Report* (1995). Washington, DC: Office of Juvenile Justice and Delinquency Prevention, US Department of Justice.

[2] *Great Transitions: Preparing Adolescents for a New Century* (1995). New York: Carnegie Council on Adolescent Development.

[3,6] *Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders* (1995). Washington, DC: Office of Juvenile Justice and Delinquency Prevention, US Department of Justice.

[4, 5, 6, 12] *Combating Violence and Delinquency: the National Juvenile Justice Action Plan* (1996). Washington, DC: Coordinating Council on Juvenile Justice and Delinquency Prevention.

[7] Furtado, G. E. (1996). *Juvenile Hearing Boards: Communities Respond to Juvenile Crime* (May 1996). Rhode Island: Rhode Island Bar Journal.

[8, 9, 13, 14, 15] Rhode Island Family Court, RIJISS Intake Statistics, Year End Reports, 1997 and Rhode Island KIDS-COUNT-calculations.

[10] American Psychological Association (1993). *Violence and Youth: Psychology's Response, Summary Report of the American Psychological Association Commission on Violence and Youth.* New York: American Psychological Association.

[11, 12] *The Future of Children: The Juvenile Court* (1996). Los Altos, CA: The Center for The Future of Children, The David and Lucille Packard Foundation.

[16] Rhode Island Office of the Attorney General, 1997.

[17, 18, 19] Superintendent's Office, RI Training School for Youth, January 1998.

Child Abuse and Neglect

DEFINITION

Child abuse and neglect is the total number of indicated cases of child abuse and neglect per 1,000 children. "Indicated case" means that credible evidence exists that child abuse and/or neglect occurred following an investigation of an abuse report. An indicated case can involve more than one child. Child abuse included physical, sexual, and emotional abuse. Child neglect included physical, emotional, and medical neglect.

SIGNIFICANCE

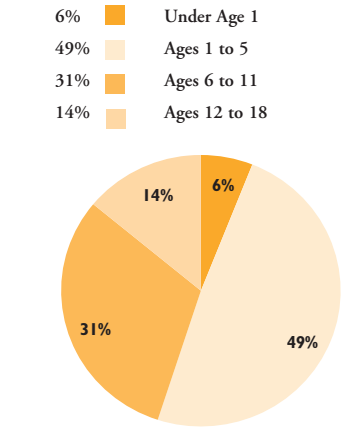
Preventing child abuse and neglect is critical to helping children grow into strong, healthy, productive adults and good parents. Children ate at increased risk for maltreatment if their parents or caregivers are overwhelmed by multiple problems such as inadequate income, lack of a job or a decent place to live, emotional stress, isolation from extended family or friends, drug and/or alcohol abuse, mental illness, or domestic violence.[1] Recent studies confirm that child abuse is linked to increases in dropout rates, juvenile delinquency, running away, substance abuse, suicide, criminal behavior, emotional disturbances, promiscuity, and teenage preganancy.[2]

Children can be victims of child maltreatment regardless of their racial or ethnic background or socio-economic status. Many abusive parents lack essential parenting skills and are struggling with a combination of social and economic issues. Resources dedicated to prevention services that assist families before parents abuse their children are extremely limited. Preventing child abuse and neglect requires help with housing, food, and child care as well as parenting education and counseling for substance abuse, domestic violence, and other problems. Families benefit from access to comprehensive services that are able to flexibly respond to their needs.[3]

- In Rhode Island in 1996, there were 2,541 indicated cases of child abuse and neglect, a rate of 9.1 per 1,000 children.
- For each of the past three years, seven communities have consistently had child abuse and neglect rates that exceeded the state average: Woonsocket, Central Falls, Providence, West Warwick, Newport, Pawtucket, and Westerly.
- These seven communities accounted for nearly two-thirds of the indicated cases of child abuse and neglect in 1994, 1995, and 1996.

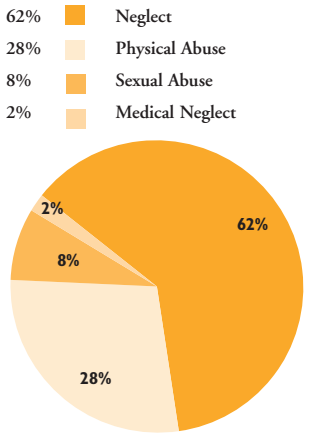
Indicated Cases of Child Abuse and Neglect, Rhode Island, 1996

By Age of Victim



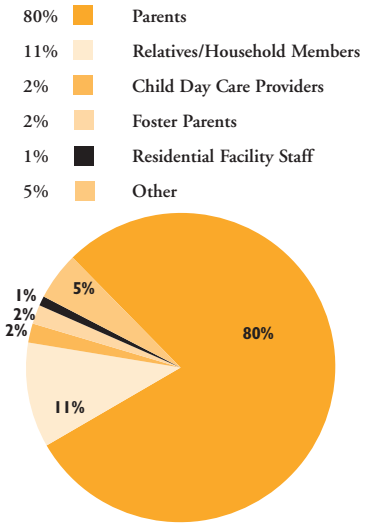
*(n = 2,984)**

By Type of Abuse



*(n = 4,645)***

By Relationship of Victim to Perpetrator



*(n = 4,953)****

Note on Pie Charts

All data are form the Rhode Island Department of Children Youth and Families, NCANDS database. Numbers may not add to 100 due to rounding.

**The number of victims is higher than the number of indicated cases. One indicated case can involve more than one child victim. Data reflect an unduplicated count of child victims.*

***This number reflects maltreatment events, not children. Children often experience more than one type of abuse. For example, if a child were physically and sexually abused, two maltreatment events would be counted.*

****Perpetrators can abuse more that one child and can abuse a child more than once.*

Facts About Child Abuse in Rhode Island, 1996

◆ 2,984 children were determined by DCYF to be victims of child abuse and neglect.

◆ 55% of child abuse and neglect victims were under age 6. There were 895 children under the age of three who were abuse and neglect victims; of these, 187 were infants under the age of one.

◆ Parents, relatives, or household members were the perpetrators in 91% of all maltreatment incidents.

◆ Between 1990 and 1997, thirty-four children died as a result of injuries due to abuse by a parent or caretaker.

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

YEAR	NUMBER OF DEATHS
1990	4
1991	7
1992	4
1993	3
1994	5
1995	5
1996	4
1997	2

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

DCYF (CANTS)* Hotline Calls for Reports of Abuse and/or Neglect, Investigations, and Indicated Cases, Rhode Island, 1994-1996

YEAR	HOTLINE CALLS REPORTING ABUSE/NEGLECT	NUMBER OF COMPLETED INVESTIGATIONS**	NUMBER INDICATED CASES
1994	13,968	8,478	2,732
1995	13,841	8,553	2,781
1996	13,098	8,398	2,541

** Child Abuse and Neglect Tracking System*
*** One CANTS investigation can be generated by multiple hotline calls.*

Source: All data are from the Rhode Island Department of Children, Youth and Families.

Children in Violent Homes

◆ Over 80% of abusive spouses or partners had themselves either been victims of child abuse, or had witnessed their mother's being abused.[4]

◆ Almost all children in homes with domestic violence witness the violence. Children from violent families can provide clinicians with detailed accounts of abusive incidents their parent never realized they had witnessed.[5]

◆ Children in violent homes fear for their mothers' safety and their own, often experiencing self-blame. Studies have shown that more than half of men who abuse their female partners abuse their children.[6]

◆ The range of problems among children who witness violence include anxiety, fear, sleep disruption, and school problems.[7] Exposure to violence in the home can limit cognitive development and the ability to form close attachments.[8]

◆ Despite the violence, women often stay in abusive homes, fearing the loss of necessary financial support or because their abusive partner threatens to harm their children if they leave.[9]

◆ 958 women and children in Rhode Island sought relief from abuse in one of Rhode Island's six domestic violence emergency shelters in 1996.[10]

Child Abuse and Neglect

DCYF Caseload:

On August 1, 1997 the total active caseload of the Rhode Island Department of Children, Youth and Families was 8,111 children. This does not count the 2,294 children in pending child abuse and neglect investigations or the 1,317 children enrolled in DCYF community-based programs.

Children in Out-of-Home Placements

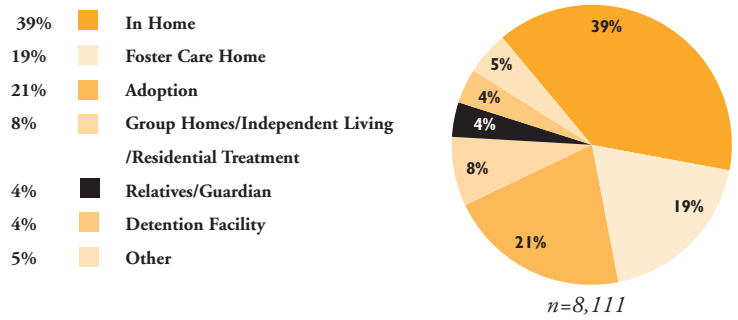
◆ Nationally, the number of children in out-of-home placements rose 72% in the last decade.[11] The most frequent reasons children are removed from their homes are neglect, lack of supervision, and sexual and physical abuse. Parent abuse of alcohol and illegal drugs are often contributing factors leading up to the need for substitute care.[12]

◆ Out-of-home placements include foster homes (relative, non-relative and specialized), placement with a relative or guardian, group home, shelter care, residential treatment, and medical facilities. As of August 1, 1997, there were 2,572 Rhode Island children under the care of DCYF in out-of-home placements. 138 were classified as unauthorized absence/runaways.

◆ As of August 1, 1997, 373 young people in DCYF care were in residential treatment, 157 were in group homes, and 124 were in independent living situations.

◆ Night-to-night placements refer to the temporary nightly placement of youths under the care of DCYF who are awaiting foster care placement or a group home/ treatment placement or who have run away from their current placement. Between January and September, 1997 an average of 94 youths per month were in night-to-night placements. This was reduced to only 2 in December 1997 due to state appropriation that increased placement options.

Children in DCYF Care by Living Arrangement



Foster Homes

◆ In Rhode Island as of August 1, 1997, there were 1,544 children living in foster homes: 56% in non-relative foster homes, 35% in relative foster homes, and 9% in specialized foster homes (which provide specialized care to children with special medical needs). The average length of stay for a child in foster care is more than two and one-half years.[13]

◆ Many children lag in out-of-home placements for years without any sense of permanency. With the passage of the federal Adoption and Safe Families Act of 1997, a permanency hearing must take place within twelve months of a child's entrance into foster care. Additionally, the federal law requires a termination of parental rights petition to be filed for children who have been in state custody for 15 of the most recent 22 months after reasonable efforts have been made to unify the family.[14] In 1997, 358 petitions for termination of parental rights were filed in Rhode Island Family Court.[15]

◆ Child abuse and neglect happens to children of all races, in all kinds of communities, in all economic classes. But national data indicate that poor families and families of color are more likely to be identified by the child welfare system and are more likely to have their children removed and placed in foster care; once in foster care, children of color are more likely to remain there for long periods of time, and to experience multiple placements in different homes before they are returned to their parents.[16]

Table 18.

Number of Indicated Cases of Child Abuse & Neglect per 1,000 Children, Rhode Island 1996

CITY/TOWN	TOTAL POPULATION OF CHILDREN UNDER 21	NUMBER OF INDICATED CASES OF CHILD ABUSE/NEGLECT	1996 RATE OF CASES OF CHILD ABUSE/NEGLECT PER 1,000 CHILDREN
Barrington	4,487	13	2.9
Bristol	6,186	24	3.9
Burrillville	5,109	31	6.1
Central Falls	5,579	99	17.7
Charlestown	1,783	21	11.8
Coventry	8,880	72	8.1
Cranston	17,558	129	7.3
Cumberland	7,523	24	3.2
East Greenwich	3,346	12	3.6
East Providence	12,520	91	7.3
Exeter	1,710	9	5.3
Foster	1,358	2	1.5
Glocester	2,944	18	6.1
Hopkinton	2,123	13	6.1
Jamestown	1,282	2	1.6
Johnston	6,309	27	4.3
Lincoln	4,543	29	6.4
Little Compton	867	4	4.6
Middletown	5,598	32	5.7
Narragansett	3,757	17	4.5
Newport	7,858	95	12.1
New Shoreham	184	0	0.0
North Kingstown	6,993	47	6.7
North Providence	6,846	55	8.0
North Smithfield	2,724	8	2.9
Pawtucket	19,655	227	11.5
Portsmouth	4,716	20	4.2
Providence	52,674	742	14.1
Richmond	1,766	8	4.5
Scituate	2,809	8	2.8
Smithfield	5,955	9	1.5
South Kingstown	9,612	31	3.2
Tiverton	3,752	19	5.1
Warren	2,851	45	15.8
Warwick	21,596	147	6.8
Westerly	5,771	65	11.3
West Greenwich	1,067	4	3.7
West Warwick	7,818	104	13.3
Woonsocket	12,511	238	19.0
Out of State	*NA*	*50*	*NA*
Missing/Unknown	*NA*	*58*	*NA*
Core Cities	*98,277*	*1,401*	*14.3*
Remainder of State	*182,343*	*1,140*	*6.3*
Rhode Island	*280,620*	*2,541*	*9.1*

Source of Data for Table/Methodology

Data are from the State of RI Department of Children, Youth and Families, Child Abuse and Neglect Tracking System, number of reports (indicated cases) for the period January 1, 1996 to December 31, 1996. Population data are from US Bureau of the Census, 1990 Census of Population.

An indicated case is an investigated report of child abuse and neglect for which credible evidence exists that child abuse and/or neglect occurred. An indicated case can involve more than one child.

The denominator is the number of children under the age of 21 according to the 1990 Census of Population.

References for Indicator

[1] American Bar Association (1993). *America's Children At Risk: A National Agenda for Legal Action.* Chicago: American Bar Association, Working Group on the Unmet Legal Needs of Children and Their Families; and Wolfner, G. and R. Gelles, *A Profile of Violence Toward Children: A National Study,* (1993). Kingston, RI: Family Violence Research Program, University of Rhode Island.

[2] *Hidden Casualties: The Relationship Between Violence and Learning* (1995). Washington, DC: The National Health and Education Consortium; and American Bar Association (1993). *America's Children At Risk: A National Agenda for Legal Action.* Chicago: American Bar Association, Working Group on the Unmet Legal Needs of Children and Their Families.

[3,16] American Bar Association (1993). *America's Children At Risk: A National Agenda for Legal Action.* Chicago: American Bar Association, Working Group on the Unmet Legal Needs of Children and Their Families.

[4,5,6] *Children and Domestic Violence: Know the Facts.* (1997). Providence, RI: Rhode Island Coalition Against Domestic Violence.

[7] *Children in Violent Homes* (1993). Courts and Communities: Confronting Violence in the Family, State Justice Institute Conference, San Francisco, CA: March 25-28, 1993.

[8,9] *The Impact of Domestic Violence on Children, A Report to the President of the American Bar Association* (1994). Chicago: American Bar Association Center on Children and the Law.

[10] Rhode Island Coalition Against Domestic Violence, 1997 data.

[11] *Children '97: Facts and Figures* (1997). Washington, DC: Child Welfare League of America.

[12] *Child Welfare: Complex Needs Strain Capacity to Provide Services* (1995). Washington, DC: US General Accounting Office.

[13] Department of Children, Youth, and Families, January 1998.

[14] *Child Welfare Update* (November, 1997). Washington, DC: National Association of Child Advocates.

[15] Rhode Island Family Court, January 1998.

Education

La Plaza y los Naranjos Encendidos...

La plaza y los naranjos encendidos
con sus frutas redondas y risueñas.

Tumulto de pequeños colegiales
que, al salir en desorden de la escuela,
llenan el aire de la plaza en sombra
con la algazara de sus voces nuevas.

¡Alegría infantil en los rincones
de las ciudades muertas!...
¡Y algo nuestro de ayer, que todavía
vemos vagar por estas calles viejas!

– ANTONIO MACHADO

The Plaza and the Flaming Orange Trees...

The plaza and the flaming orange trees
with their round and smiling fruit.

Clamor of small schoolchildren
scampering wildly out of school,
filling the air of the somber plaza
with the tumult of their new voices.

Childish cheer on the corners
of the dead towns!...
And something out of our yesterday, still
lingering in these old streets!

Child Care

DEFINITION

Child care is the number of regulated child care slots per 100 children under age 6 in need of regulated child care. Regulated child care slots include full-time licensed child care center slots and certified family child care home slots.

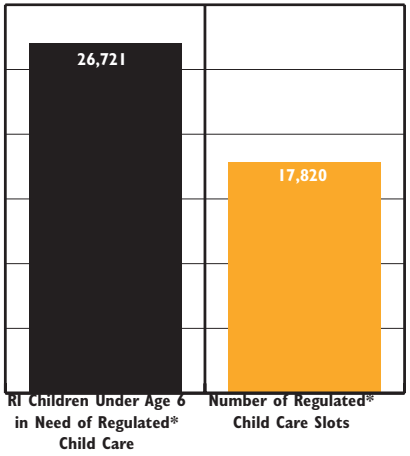
SIGNIFICANCE

Child care has become a fundamental need for Rhode Island families over the past two decades. In Rhode Island in 1995, 63% of mothers with children under the age of six are in the labor force.[1] More than 45,000 Rhode Island infants and pre-school children are in need of some form of child care because the mother is in the labor force.[2] Nationally, 47% of all employed mothers use either center-based child care or family child care homes for their young children.[3] Recent changes in welfare laws linking cash assistance to work or participation in work-readiness programs will mean additional children in need of quality child care.

Quality child care can promote school readiness by supporting children's physical health, self-confidence, and social competence. Early care has long-lasting effects on how children learn and develop, cope with stress, and handle their emotions.[4]

In Rhode Island, there are an estimated 67 regulated child care slots for every 100 children under age six in need of a licensed child care center or certified family child care home.[5] The supply of licensed and certified child care is even lower for infants and children under age 3, children with disabilities and special health care needs, and parents with unconventional or shifting work hours.

Licensed and Certified Child Care for Children Under Age 6, Rhode Island 1997



**Includes licensed child care centers and certified family child care homes.*

Source: Calculations by Rhode Island KIDS COUNT based on data from the Rhode Island Department of Human Services, the U.S. Bureau of the Census, and Options for Working Parents. See page 80 for methodology

Quality Child Care is Linked to...

Wages and Benefits

◆ Annual turnover for child care providers is nearly three times the rate reported for U.S. companies as a whole and nearly five times the rate reported for public school teachers.[6]

◆ Experienced child care providers frequently leave their jobs because of low salaries and inadequate benefits. Child care providers are among the lowest paid workers in the labor market.[7]

Licensing

◆ The safety and healthy development of children require quality standards for the licensing and regulation of child care providers, including family child care homes.[8]

◆ Licensing standards focus on maintaining children's health and safety, setting staff-child ratios and group sizes that support child development, and setting minimum staff training requirements.

Accreditation

◆ The National Association for the Education of Young Children accreditation standards are based on research showing that children benefit emotionally, socially, and cognitively when centers demonstrate: developmentally-appropriate curriculum; low staff-to-child ratios; small group sizes; higher levels of staff education and training; low staff turnover; and higher levels of staff compensation.[9]

Professional Development

◆ A staff with more formal education and specialized early childhood training provides better quality services for children and families.[10]

◆ Professional training is most effective when providers learn about child and family development, management, and child care policies; gain credentials that are linked to compensation or transfer to other career pathways; and form networks of support, engage in continuous learning from their peers and become mentors to others.[11]

Child Care Costs

◆ Families with incomes below $25,000 spend between 13% and 33% of their income on child care. The cost of full-time care is often the largest expense, after housing, for working parents who need full-time care for their children.[12]

◆ One of the primary mechanisms for subsidizing child care comes through the income tax codes. The federal Child and Dependent Care Tax Credit and the federal Dependent Care Assistance Plan (also called the flexible spending account) provide tax credits and pre-tax benefits for early child care. These benefits go disproportionately to higher-income families.[13]

◆ Rhode Island is one of three states that provide access to subsidized child care for all income-eligible working families. Even as child care subsidies become available, there is a structural shortage of quality licensed child care centers and certified family child care homes necessary to meet the increased demand for child care.

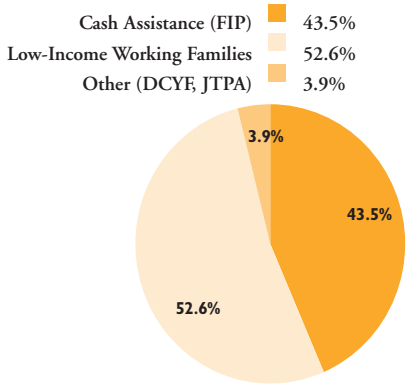
Rhode Island's Child Care Subsidy System

◆ Rhode Island working families with incomes up to 185% of poverty ($24,660 for a family of three) are eligible for a child care subsidy in which the parent pays a portion of the child care costs. Families participating in the Rhode Island Family Independence Program who are enrolled in education, training or work-related activities are eligible for child care at no cost to the family.

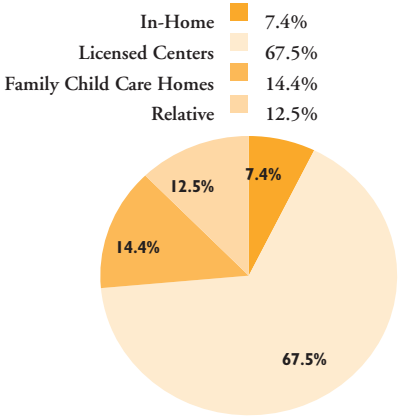
◆ Reimbursement rates for licensed child care centers and certified family child care providers paid by DHS will be incrementally increased to the 75th percentile of weekly market rates by the year 2000.

◆ Rhode Island is now offering paid health insurance to certified family child care home providers who care for children who receive state child care subsidies. These providers can enroll in the state's RIte Care health insurance program. Rhode Island is one of the only states offering health and dental insurance to certified home-based providers.

Child Care Subsidies by Family Type, Rhode Island, December 1997



Child Care Subsidies by Provider Type, Rhode Island, December 1997



Total Number of Subsidies is 7,159 as of December 1997.

Numbers may not add to 100 due to rounding

Source: Rhode Island Department of Human Services, December 1997

Child Care

Insufficient Supply of Child Care and Head Start

◆ As of December 1, 1997 there were 12,710 children ages 1 to 5 in families receiving cash benefits through the Family Independence Plan (FIP).14 Due to federal work requirements for recipients of cash assistance, it is anticipated that at least 50% of these children will eventually need some form of child care.

◆ Table 19 shows the significant shortage of child care center slots, family child care home slots, and Head Start slots needed to meet the needs of children enrolled in FIP whose parents move into the labor force. More than 75% of Rhode Island families receiving child care subsidies choose licensed child care centers or certified family child care homes for their child care arrangements.[15]

◆ Low-income families are often unable to access the highest quality child care programs, due to a combination of factors including insufficient income to pay higher fees, lack of transportation, and/or reliance on subsidies which do not meet the cost of providing the service.[16]

Table 19. **Children Under Age 6 in Family Independence Program (FIP), RI, 1997 and Number of Licensed Child Care and Head Start Slots for Children Under Age 6, RI, 1997**

	INFANT/TODDLERS			PRESCHOOL		
CITY/TOWN	# 1 & 2 YEAR OLDS ENROLLED IN FIP	# CHILD CARE CENTER SLOTS < AGE 3	# CERTIFIED FAMILY CHILD CARE HOME SLOTS	#3 TO 5 YEAR OLDS ENROLLED IN FIP	HEAD START SLOTS AGES 3 TO 5	CHILD CARE CENTER SLOTS AGES 3 TO 5
Barrington	4	89	55	5	0	192
Bristol	34	49	74	49	29	104
Burrillville	22	0	72	34	29	69
Central Falls	253	0	55	392	43	90
Charlestown	9	14	20	16	9	18
Coventry	63	48	187	89	41	161
Cranston	230	243	437	304	194	683
Cumberland	36	54	160	68	8	86
East Greenwich	17	167	33	17	4	360
East Providence	155	176	168	232	75	503
Exeter	4	15	12	8	3	47
Foster	6	19	12	6	2	42
Glocester	10	16	43	15	17	20
Hopkinton	21	0	35	21	9	0
Jamestown	2	9	33	4	1	20
Johnston	79	65	137	100	29	277
Lincoln	37	88	92	51	8	229
Little Compton	1	0	0	1	4	0
Middletown	26	110	26	45	39	378
Narragansett	23	37	31	34	19	103
Newport	174	85	40	274	145	215
New Shoreham	2	0	0	2	0	0
North Kingstown	48	113	118	78	39	361
North Providence	67	45	135	135	45	143
North Smithfield	8	0	66	9	5	0
Pawtucket	539	176	338	872	98	364
Portsmouth	7	71	44	19	16	88
Providence	2,171	781	1,122	3,540	897	2,061
Richmond	9	3	46	14	5	17
Scituate	7	47	20	15	4	81
Smithfield	10	117	47	21	10	268
South Kingstown	18	140	86	44	28	294
Tiverton	13	25	55	24	24	125
Warren	32	10	41	53	26	96
Warwick	176	440	367	309	122	1,140
Westerly	67	72	28	93	47	275
West Greenwich	2	57	5	6	2	87
West Warwick	144	147	92	211	109	365
Woonsocket	397	90	162	577	184	346
Core Cities	*3,534*	*1,132*	*1,717*	*5,655*	*1,367*	*3,076*
Remainder of State	*1,389*	*2,486*	*2,777*	*2,132*	*1,002*	*6,632*
Rhode Island	*4,923*	*3,618*	*4,494*	*7,787*	*2,369*	*9,708*

Table 20.

Child Care for Children Under Age 6, Rhode Island 1997

CITY/TOWN	POTENTIAL CHILDREN < AGE 6 IN NEED OF REGULATED CHILD CARE	REGULATED CHILD CARE SLOTS FOR CHILDREN UNDER AGE 6	SLOTS PER 100 CHILDREN <6 IN NEED OF REGULATED CHILD CARE
Barrington	314	336	107
Bristol	592	227	38
Burrillville	480	141	29
Central Falls	714	145	20
Charlestown	166	52	31
Coventry	785	396	50
Cranston	1,550	1,363	88
Cumberland	670	300	45
East Greenwich	183	560	305
East Providence	1,305	847	65
Exeter	166	74	45
Foster	109	73	67
Glocester	269	79	29
Hopkinton	192	35	18
Jamestown	98	62	63
Johnston	533	479	90
Lincoln	428	409	96
Little Compton	86	0	0
Middletown	483	514	106
Narragansett	330	171	52
Newport	672	340	51
New Shoreham	25	0	0
North Kingstown	603	592	98
North Providence	620	323	52
North Smithfield	186	66	35
Pawtucket	2,509	878	35
Portsmouth	393	203	52
Providence	5,775	3,964	69
Richmond	174	66	38
Scituate	263	148	56
Smithfield	370	432	117
South Kingstown	477	520	109
Tiverton	298	205	69
Warren	338	147	43
Warwick	1,772	1,947	110
Westerly	581	375	65
West Greenwich	93	149	160
West Warwick	725	604	83
Woonsocket	1,393	598	43
Core Cities	*11,063*	*5,925*	*54*
Remainder of State	*15,658*	*11,895*	*76*
Rhode Island	*26,721*	*17,820*	*67*

Source of Data for Table/Methodology

Child care center and family child care home data are from Options for Working Parents, Greater Providence Chamber of Commerce, December 1997.

The denominator is the potential number of children in need of regulated care, see methodology on page 80. The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots as of December, 1997. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

References for Indicator

[1] U.S. Bureau of the Census, Current Population Survey, 1993 to 1997 average.

[2] U. S. Bureau of the Census, 1990 Census of Population.

[3] Casper, L. (1995)."What Does it Cost to Mind Our Pre-Schoolers?" In *Current Population Reports.* P70-52. Washington, DC: US Bureau of the Census.

[4] Shore, R. (1997). *Rethinking the Brain.* New York: Families and Work Institute; and, *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[5] Calculations by Rhode Island KIDS COUNT based on data from the Rhode Island Department of Human Services (December 1997), the U.S. Bureau of the Census (1990), and Options for Working Parents (December 1997).

[6, 7, 8, 9] *Early Childhood Care and Education: An Investment That Works* (1995). Washington, DC: National Conference of State Legislatures.

[10, 11] Lopez, E.M. (1997). *Quality in Family and Child Care Partnerships*. Cambridge, MA: Harvard Family Research Project.

[13, 16] *Years of Promise: A Comprehensive Learning Strategy for America's Children.* (September 1996). New York: Carnegie Corporation of New York.

[12] Deborah Phillips and Anne Bridgman (eds.). *New Findings on Children, Families, and Economic Self-Sufficiency* (1995). Washington, DC: Board on Children and Families, National Research Council, Institute of Medicine.

[14,15] Rhode Island Department of Health and Human Services, INRHODES Database, December 1997.

Children Enrolled in Head Start

DEFINITION

Children enrolled in Head Start is the percentage of eligible 3 and 4 year old children enrolled in the Head Start preschool program as of October 1, 1997.

SIGNIFICANCE

Head Start is a comprehensive early childhood development program for low-income preschool children, primarily ages three to five, and their families. Most children in the program attend for one year and are four years old.[1] Children living in families with incomes below 100% of the federal poverty line are eligible for Head Start. Up to 10% of enrolled children can have a family income above the poverty line with priority given to children with special needs.

The Head Start program is designed to provide low-income children with the socialization and school-readiness skills they need to enter public schools on an equal footing with more economically advantaged children.[2] Children most at risk of school failure are those most likely to benefit from quality pre-school programs. Research indicates that low-income children who attend high-quality early childhood education programs score higher on achievement tests, earn higher grade-point averages, and are more likely to complete high school.[3] The Committee for Economic Development reported in 1991 that for every dollar spent on a comprehensive and intensive pre-school program for the disadvantaged, society saves up to $6 in the long-term costs of welfare, remedial education, teen pregnancy and crime.[4]

Head Start provides education, parent involvement, social services, health and nutrition, and mental health services that promote child development. The program seeks to not only assist children in low-income families, but also to help their parents achieve self-sufficiency. In Rhode Island, 2,369 children are enrolled in Head Start, 41% of eligible 3 and 4 year olds. Of the core cities, only Newport and Woonsocket have more than the state average of 41% of eligible children enrolled. Providence has 35% of eligible children enrolled; Pawtucket and Central Falls have less than 16% of eligible children enrolled.[5]

Early Care and Education for Low-Income Children

◆ High-quality early care and education services are least available to those whose children would derive the greatest benefit from them — low-income families. In 1995, only 45% of 3 to 5-year-olds from low-income families were enrolled in early care and education programs in the U.S. compared with 71% of 3 to 5-year-olds from high-income families.[6]

◆ Children in poor families have a greater need for more comprehensive and high quality child care and early education services. Studies show that children in poor families are nearly one-third more likely to suffer either from delays in growth and development, a learning disability, or a significant emotional or behavioral problem.[7]

◆ Implementation of welfare laws that require parents to work in order to receive cash benefits will increase the demand for full-day, full-year programs. Four of the eight Head Start programs in Rhode Island provide a 12-month program; five of the eight programs have a full-day program (at least nine hours of care) available to some or all of the families enrolled in Head Start.

◆ Recent reauthorizations of Head Start at the federal level place high priority on increasing quality, expanding to serve a greater percentage of eligible children, and strengthening collaborative efforts between Head Start and providers of child care and early education services.[8]

◆ In response to research indicating that the period from birth to age three is critical to healthy growth and development and later school success, Head Start now offers a program for pregnant women and their infants and children up to age three.[9] Four of the eight Rhode Island Head Start programs offer Early Head Start services to 204 families.

Table 21. **Percent of Eligible Children Ages 3 and 4 Enrolled in Head Start, Rhode Island, 1997**

CITY/TOWN	ESTIMATED ELIGIBLE CHILDREN AGED 3&4	NUMBER OF CHILDREN ENROLLED IN HEAD START	% OF ELIGIBLE 3&4 YEAR OLDS ENROLLED
Barrington	6	0	0%
Bristol	42	29	69%
Burrillville	27	29	100%
Central Falls	309	43	14%
Charlestown	11	9	79%
Coventry	72	41	57%
Cranston	222	194	87%
Cumberland	48	8	17%
East Greenwich	15	4	26%
East Providence	176	75	43%
Exeter	7	3	43%
Foster	3	2	67%
Glocester	10	17	100%
Hopkinton	16	9	55%
Jamestown	2	1	43%
Johnston	70	29	42%
Lincoln	32	8	25%
Little Compton	2	4	100%
Middletown	31	39	100%
Narragansett	28	19	68%
Newport	213	145	68%
New Shoreham	2	0	0%
North Kingstown	64	39	61%
North Providence	90	45	50%
North Smithfield	5	5	94%
Pawtucket	635	98	15%
Portsmouth	12	16	100%
Providence	2,621	897	34%
Richmond	11	5	47%
Scituate	11	4	36%
Smithfield	15	10	65%
South Kingstown	33	28	84%
Tiverton	24	24	100%
Warren	35	26	75%
Warwick	218	122	56%
Westerly	73	47	64%
West Greenwich	6	2	35%
West Warwick	148	109	73%
Woonsocket	423	184	43%
Core Cities	*4,200*	*1,367*	*33%*
Remainder of State	*1,569*	*1,002*	*64%*
Rhode Island	*5,769*	*2,369*	*41%*

Source of Data for Table/Methodology

Rhode Island Head Start Programs, children enrolled on October 1, 1997; U.S. Department of Health and Human Services, Region 1, Administration on Children, Youth and Families; and Rhode Island Department of Human Services INRHODES Data Tapes, December 1, 1995-1997. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the estimated number of eligible children based on a three year average of the number of 3 and 4-year-old children in families receiving AFDC or FIP at a single point in time during each of the following three years: 1995, 1996, and 1997. This is an underestimate of children eligible, because it does not include children eligible for Head Start who live in non-AFDC/non-FIP families living below the poverty line. Therefore, the actual percentage of eligible served is likely to be lower than shown here.

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

References for Indicator

[1] *The Future of Children: Long-Term Outcomes of Early Childhood Programs.* (1995). "Head Start" (Vol.5, No. 3). Los Altos, CA: Center for the Future of Children, The David Lucile Packard Foundation.

[2] The State of America's Children Yearbook: 1995 (1995). Washington, DC: Children's Defense Fund.

[3] Smith, S., Fairchild, M. & Groginsky, S. (1997). *Early Childhood Care and Education: An Investment that Works, 2nd Edition*. Washington, DC: National Conference of State Legislatures.

[4,7] Smith, S., Fairchild, M. & Groginsky, S. (1995). *Early Childhood Care and Education: An Investment that Works.* Washington, DC: National Conference of State Legislatures.

[5] Calculations by Rhode Island KIDS COUNT based on data from the Rhode Island Department of Human Services and the Rhode Island Head Start programs.

[6] *Years of Promise: A Comprehensive Learning Strategy for America's Children.* (1996). New York: Carnegie Corporation of New York.

[8] U.S. Department of Health and Human Services, Region 1, Administration for Children, Youth, and Families; and Smith, S., Fairchild, M. & Groginsky, S. (1997). *Early Childhood Care and Education: An Investment that Works, 2nd Edition.* Washington, DC: National Conference of State Legislatures.

[9] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

Children with Disabilities

DEFINITION

Children with disabilities is defined here as the number of children who are enrolled in special education in Rhode Island elementary and secondary schools. Children and youth ages 3 to 22 with disabilities are eligible for special education services through the local school system.

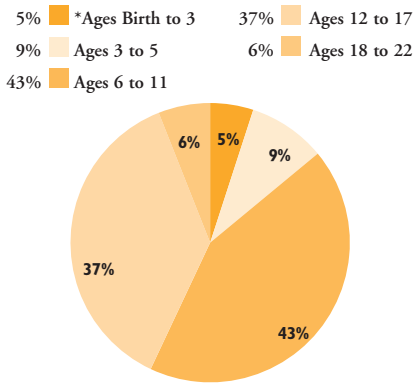
SIGNIFICANCE

Children with disabilities are an extremely heterogeneous group, varying by type of disability and age of the child, as well as by the many differences in the population at large – such as family income and demographics. While there are wide variations in the specific needs of each child, there are some issues of common concern to families of children with disabilities.[1] Whether disabilities are mild or severe, they have the potential to create special needs related to physical health, mental health, education, parent support, child care, recreation, and career preparation.[2]

Some children with disabilities may require costly therapeutic and health care services, as well as wheelchairs, communication devices, home-based therapy, respite care, and home modifications.[3] Because many of these services are not fully covered by insurance, families from all income levels can incur serious financial burdens. Children who meet certain disability criteria are eligible for Medicaid and/or cash assistance through the Supplemental Security Income program.[4]

Children with the same disability, in roughly the same degree of severity may vary tremendously in personality, motivation, social and family support systems, and compensating strengths. Children with disabilities need access to health care and education that is appropriate to their special needs.[5]

Children Enrolled in Early Intervention* and Special Education, By Age, Rhode Island, School Year 1996-1997



n = 29,124

Source: Special Education data are from the Rhode Island Department of Elementary and Secondary Education, Office of Special Education, June 30, 1997. *Early Intervention data for children birth to 3 are from the Rhode Island Department of Health, Division of Family Health, Early Intervention Database, June 30, 1997.

Early Intervention for Children Birth to Three

◆ Five regional Early Intervention programs, serving every Rhode Island community, provide services to infants and toddlers from birth to age 3 who are developmentally-delayed and at-risk . Early Intervention programs provide assessment and evaluation; health, medical, and social work services; physical, occupational, psychological, and speech/language therapy; and service coordination for 1,540 young Rhode Island children and their families.6 The specific kinds of services provided are tailored to the individual needs of each child and family.

◆ Under Part H of the Individuals with Disabilities Education Act, states are required to provide appropriate early intervention services to all children who meet either of the following criteria: (1) the child is experiencing a developmental delay in cognitive, physical, communication, social/emotional, or adaptive development; or (2) the child has been diagnosed with a physical or mental condition that has a high probability of resulting in a developmental delay. Members of the family are entitled to services to enable them to assist in the development of their child.7

Special Education for Pre-School and School-Age Children with Disabilities

◆ The Individuals with Disabilities Education Act mandates that all children have available to them a free and appropriate education designed to meet their unique needs.[8] Children with disabilities or suspected disabilities become eligible for special education services from their school district at age 3.

◆ In Rhode Island, there were 27,584 children (18% of the student population) who received special education services during the 1996-1997 school year.[9] Students enrolled in special education are categorized by their primary disability, although students must receive services based on their individual needs, not on their disability category.[10]

◆ In the 1996-1997 school year, of all Rhode Island children receiving special education services 55% were classified as learning disabled; 21% speech disorders; 7% behavioral disorders; 5% health-impaired; 4% developmentally delayed; 4% mentally retarded; and 3% other disabilities, including orthopedically impaired, deaf and blind, visually impaired or blind, multi-handicapped, autistic, and traumatic brain injury.[11]

Children and Youth in Special Education, by Primary Disability, Ages 3-22, Rhode Island 1996-1997

SCHOOL DISTRICT	#STUDENTS ENROLLED	BEHAVIORALLY DISORDERED	MENTALLY RETARDED	HEALTH IMPAIRED	LEARNING DISABLED	SPEECH DISORDER	DEVELOP-MENTALLY DELAYED	OTHER	TOTAL DISABILITIES	% STUDENT IN SPECIAL EDUCATION
Barrington	2,879	13	4	6	393	124	1	27	568	19.7%
Bristol-Warren	4,006	49	52	13	451	158	26	25	774	19.3%
Burrillville	2,966	66	23	30	323	135	25	9	611	20.6%
Central Falls	3,013	93	44	25	434	63	37	23	719	23.9%
Chariho	3,801	27	19	34	278	179	15	35	587	15.4%
Coventry	5,478	63	49	30	595	108	34	22	901	16.4%
Cranston	10,364	79	37	56	1,445	388	63	47	2,115	20.4%
Cumberland	4,750	95	38	156	290	252	36	40	907	19.1%
East Greenwich	2,244	20	5	29	165	82	9	19	329	14.7%
East Providence	6,822	82	70	138	440	352	29	27	1,138	16.7%
Exeter-W. Greenwich	1,963	37	7	80	101	129	7	9	370	18.8%
Foster	391	2	2	4	24	27	4	1	64	16.4%
Foster-Glocester	1,411	13	5	5	134	34	0	6	197	14.0%
Glocester	892	4	6	6	67	82	10	5	180	20.2%
Jamestown	635	6	3	10	70	31	2	8	130	20.5%
Johnston	3,352	28	17	47	469	196	28	14	799	23.8%
Lincoln	3,331	32	16	59	258	82	17	28	492	14.8%
Little Compton	384	3	3	2	49	25	1	1	84	21.9%
Middletown	2,740	38	11	30	233	145	8	13	478	17.4%
Narragansett	1,910	31	4	40	236	68	12	9	400	20.9%
Newport	3,115	33	12	15	422	110	52	20	664	21.3%
New Shoreham	126	2	0	0	6	21	0	0	29	23.0%
North Kingstown	4,441	16	6	10	494	190	21	13	750	16.9%
North Providence	3,571	37	17	57	300	186	25	15	637	17.8%
North Smithfield	1,664	22	4	35	131	55	4	13	264	15.9%
Pawtucket	9,550	217	134	60	802	384	126	60	1,783	18.7%
Portsmouth	2,730	28	11	27	203	193	9	17	488	17.9%
Providence	24,069	221	277	14	2,349	473	278	80	3,692	15.3%
Scituate	1,712	6	4	28	111	124	6	10	289	16.9%
Smithfield	2,702	11	9	18	204	145	14	13	414	15.3%
South Kingstown	3,968	61	20	30	442	227	14	25	819	20.6%
Tiverton	2,134	16	4	17	206	126	5	10	384	18.0%
Warwick	11,931	201	75	114	1,343	366	162	86	2,347	19.7%
Westerly	3,431	53	11	47	384	185	19	22	721	21.0%
West Warwick	3,906	73	20	13	419	162	22	13	722	18.5%
Woonsocket	6,595	140	109	138	724	229	43	56	1,439	21.8%
Davies Vocational	693	18	7	5	134	4	0	7	175	25.3%
RI School for Deaf	124	0	0	0	0	0	0	124	124	100.0%
Core Cities	*46,342*	*704*	*576*	*252*	*4,731*	*1,259*	*536*	*239*	*8,297*	*17.9%*
Remainder of State	*103,452*	*1,232*	*559*	*1,176*	*10,398*	*4,581*	*628*	*713*	*19,287*	*18.6%*
Rhode Island	*149,794*	*1,936*	*1,135*	*1,428*	*15,129*	*5,840*	*1,164*	*952*	*27,584*	*18.4%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 1996-1997 school year. Office of Special Education, June 30, 1997.

Other includes orthopedically impaired, deaf and blind, deaf, visually impaired or blind, multi-handicapped, autistic, and traumatic brain injury.

Total disabilities is an undercount of children with disabilities because it does not count children with disabilities who are not enrolled in special education.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls. The denominator is the number of students enrolled in the school district.

References for Indicator

[1,5,7,8,10] "Special Education for Students with Disabilities" (1996) in *Special Education for Students with Disabilities* (Spring 1996). Los Altos, CA: Center for the Future of Children, David and Lucille Packard Foundation.

[2] Martin, E. W., Martin, R. & Terman, D.L. (1996). "The Legislative and Litigation History of Special Education" in *Special Education for Students with Disabilities* (Spring 1996). Los Altos, CA: Center for the Future of Children, David and Lucille Packard Foundation.

[3] *A Lifeline: Medicaid and Rhode Islanders with Disabilities* (Spring 1996). Cranston, RI: Rhode Island Developmental Disabilities Council.

[4] Loprest, P. (1997) "Supplemental Security Income for Children with Disabilities: Part of the Federal Safety Net." *New Federalism: Issues and Options for States* (July 1997). Washington, DC: The Urban Institute.

[6] Rhode Island Department of Health, Division of Family Health, Early Intervention Database, June 30, 1997.

[9,11] Rhode Island Department of Elementary and Secondary Education, Office of Special Education, June 30, 1997.

Fourth-Grade Reading Skills

DEFINITION

Fourth-grade reading skills is the percentage of fourth-grade students who scored at the 40th percentile or higher on the Metropolitan Achievement Test (MAT) in 1996, considered a "basic" standard in terms of national norms. Scores are from the Reading Comprehension subtest and are based on the 1992 national norms.

SIGNIFICANCE

Reading skills are critical to a student's success in school and in the workforce. Students who cannot read are more likely to be absent from school and to exhibit behavior problems and low self-esteem.[1] Demographic variables, such as parent education, language proficiency, family structure, and the community's socioeconomic status are strong predictors of student achievement in reading.[2]

A home environment that encourages learning and parents that are involved in their children's education are important factors in school achievement.[3] According to the National Education Goals Panel, children who report that they regularly read for fun on their own time consistently outperform students who read only what is required of them at school. Children who regularly discuss their reading with family and friends score significantly higher in reading than students who report that they rarely or never do so.[4]

Achievement test scores are only one measure of a child's reading ability. These standardized tests need to be supplemented with a broader range of measures that are less subject to culture and gender bias. [5] Even by the broader standard of the 1994 National Assessment of Educational Progress, only 28% of fourth graders in the U.S. could meet the criteria for proficiency in reading, regardless of their socioeconomic status.[6] In Rhode Island, 32% of fourth-grade students scored at the proficient level or above, higher than the U.S. but still lagging behind the rest of the New England region.[7]

Reading Skill Development Begins at Birth

The long-term success of a child's learning and development depends on their health, safety, relationships, and experiences from birth through the early childhood years.

Birth to Three

◆ Babies raised in safe and stimulating environments are better learners later in life than those raised in less stimulating environments.8 In order to develop pre-reading skills, children need to have caring relationships with adults who listen and talk to them, tell stories, share books and music, and play with toys, crayons, and writing materials.[9]

Pre-School

◆ Young children who attend Head Start, pre-kindergarten, or other center-based preschool programs have higher emerging literacy scores than other 4-year-olds. The benefit of pre-school attendance accrues to children from both high-risk and low-risk family backgrounds.[10]

Elementary School

◆ Elementary schools that set high standards in learning and are committed to meeting those standards give children a better chance of leaving the fourth grade proficient in

Community and Family Factors Influence Reading Skills

◆ Children's academic achievement is higher when they live in communities that provide supportive environments for parenting and have a variety of out-of-school learning opportunities for both adults and children.[12]

◆ Parents of all educational backgrounds and income levels can play a significant role in shaping students' reading abilities by the reading practices and attitudes that they convey at home.[13]

◆ Student reading proficiency declines as television viewing increases. Nationally, one out of every five fourth graders watches six or more hours of television daily.[14]

Table 23.

Fourth-Grade Reading Scores, Rhode Island, 1996

	COMMUNITY-CONTEXT					% OF 4TH GRADE STUDENTS AT OR ABOVE THE 40TH PERCENTILE IN READING (MAT 1996)
	% CHILDREN IN POVERTY	% ADULTS COMPLETING HIGH SCHOOL	NUMBER OF STUDENTS ENROLLED	% LIMITED ENGLISH PROFICIENCY	% MINORITY ENROLLMENT	
Barrington	1.3%	88.9%	2,879	0.0%	2%	86%
Bristol-Warren	6.6%	NA	4,006	4.1%	2%	71%
Burrillville	6.1%	70.6%	2,966	0.2%	1%	72%
Central Falls	32.5%	46.9%	3,013	28.1%	61%	35%
Chariho	5.0%	82.2%	3,801	0.3%	4%	76%
Coventry	5.3%	74.4%	5,478	0.3%	3%	74%
Cranston	9.5%	74.0%	10,364	4.8%	12%	74%
Cumberland	4.7%	74.7%	4,750	2.4%	3%	79%
East Greenwich	5.3%	89.8%	2,244	0.7%	4%	92%
East Providence	8.7%	66.9%	6,822	5.9%	14%	65%
Exeter-W. Greenwich	3.2%	78.0%	1,963	0.0%	4%	66%
Foster	7.6%	81.9%	391	0.0%	1%	78%
Foster-Glocester	6.8%	82.5%	1,411	0.0%	1%	NA
Glocester	6.5%	82.8%	892	0.0%	2%	88%
Jamestown	8.1%	89.0%	635	0.3%	3%	82%
Johnston	8.4%	66.8%	3,352	1.1%	5%	69%
Lincoln	7.0%	76.1%	3,331	0.9%	4%	77%
Little Compton	2.7%	86.0%	384	0.0%	0%	83%
Middletown	6.0%	85.0%	2,740	0.9%	13%	69%
Narragansett	4.5%	87.2%	1,910	1.2%	4%	87%
Newport	20.3%	84.1%	3,115	1.6%	27%	62%
New Shoreham	10.1%	94.0%	126	0.0%	4%	75%
North Kingstown	4.7%	86.2%	4,441	1.2%	5%	80%
North Providence	5.4%	70.8%	3,571	3.2%	10%	62%
North Smithfield	1.6%	71.5%	1,664	0.0%	2%	80%
Pawtucket	15.5%	61.6%	9,550	11.0%	33%	49%
Portsmouth	4.4%	86.3%	2,730	0.0%	4%	82%
Providence	34.5%	62.8%	24,069	20.4%	75%	29%
Scituate	3.7%	83.8%	1,712	0.0%	2%	73%
Smithfield	4.1%	80.8%	2,702	0.1%	2%	83%
South Kingstown	7.5%	85.5%	3,968	0.7%	90%	76%
Tiverton	6.4%	70.5%	2,134	0.0%	1%	80%
Warwick	5.9%	77.8%	11,931	0.8%	4%	70%
Westerly	8.7%	75.6%	3,431	1.7%	4%	74%
West Warwick	11.8%	70.3%	3,906	3.6%	7%	64%
Woonsocket	21.4%	56.2%	6,595	4.3%	26%	45%
Core Cities	*27.3%*	*NA*	*46,342*	*15.4%*	*55%*	*NA*
Remainder of State	*6.5%*	*NA*	*102,635*	*1.8%*	*6%*	*NA*
Rhode Island	*13.5%*	*72.0%*	*148,977*	*6.0%*	*21%*	*64%*

Source of Data for Table/Methodology

Percent of children living in poverty and percent of adults completing high school are based on U.S. Bureau of the Census, 1990 Census of Population. Percent of 4th grade students meeting a basic standard in reading according to the 1996 Metropolitan Achievement Tests, Rhode Island School Districts, 1996. Core cities are Providence, Pawtucket, Central Falls, Woonsocket and Newport.

NA: Community has a regional high school.

All other data are from the Department of Elementary and Secondary Education, *Reaching for High Standards: Student Performance in Rhode Island, 1996.*

References

[1] *Wasting America's Future* (1994). Washington, DC: The Children's Defense Fund.

[2] *The National Education Goals Report: Building a Nation of Learners* (1995). Washington, DC: U.S. Government Printing Office; and, Zill, N., Collins, M., West, J., & Hausken, E.G. (1995). "Approaching Kindergarten: A Look at Preschoolers in the United States". *Young Children.*

[3,6,11,12] *Years of Promise: A Comprehensive Learning Strategy for America's Children.* (1996). New York: Carnegie Corporation of New York.

[4,13,14] *The National Education Goals Report: Building a Nation of Learners* (1995). Washington, DC: U.S. Government Printing Office

[5] *Reaching for High Standards: Student Performance in Rhode Island, 1995* (February 1996). Providence, RI: RI Department of Elementary and Secondary Education.

[7] *Quality Counts: A Report Card on the Condition of Public Education in the 50 States* (1997). Washington, DC: Education Week/Pew Charitable Trusts.

[8] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[9] Shore, R. (1997). *Rethinking the Brain: New Insights into Early Development.* New York: Families and Work Institute.

[10] Zill, N., Collins, M., West, J., & Hausken, E.G. (1995). "Approaching Kindergarten: A Look at Preschoolers in the United States". *Young Children.*

Out-of-School Time

DEFINITION

Out-of-school time is the availability of organized programs with adult supervision that are geared to the developmental needs of either younger children (ages 5 to 10) or middle school children (ages 10 to14) during the hours before and after school, during school vacations, and in the summer.

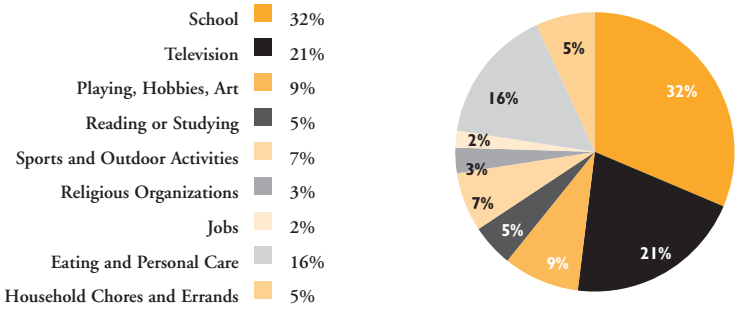
SIGNIFICANCE

Many parents need care for their school-age children during work hours. Children spend fewer than one-third of their waking hours in school.[1] Schools are typically open less than half the days of the year and in many cases are open only until mid-afternoon. Many children are alone during the hours before and after school. Older children are much more likely than younger children to spend time on their own.[2] Children who are without adult supervision when school is out are more likely to engage in risky behaviors. They are at significantly greater risk of truancy from school, emotional stress, receiving poor grades, substance use, sexual activity, and crime.[3] Children who spend more hours on their own and those who began self-care at younger ages are at increased risk.[4]

Children's activities outside school have a critical impact on school achievement and long-term success. Whether or not their mother is employed, the activities children engage in and the quality of adult supervision they receive are as important as family income and parents' education in determining academic success.[5] Self-care can be harmful compared with participation in qualified organized programs. Children in well-designed after-school programs have better peer relations, emotional adjustment, grades, and conduct in school than their peers in other care arrangements.[6]

In Rhode Island, there is a relatively low supply of before and after-school care for children ages 5 to 14. In 1993, only 10% of Rhode Island schools offered after-school care, a lower percentage than 46 other states.[7] Many families — of all income levels — are unable to find safe, affordable, good quality programs for their school-age children. Parents find it particularly difficult to locate suitable after-school programs for middle school-age children who are not ready to be left unsupervised but who are not happy with child care settings designed for younger children.[8]

How Children Ages 9 to 14 Spend Their Waking Hours



Source: *A Matter of Time: Risk and Opportunity in the Nonschool Hours* (1992). New York: Carnegie Corporation, Carnegie Council on Adolescent Development.

◆ Children spend more of their out-of-school hours watching television than any other single activity. Television viewing reduces the amount of time children and young adolescents spend in physical activity, creative play, social situations, and reading.[9]

◆ For children and youth without adult supervision, the out-of-school hours constitute high-risk time for high-risk behavior. Young people left on their own in the afternoon and evening hours stand a significantly greater chance of becoming involved in substance abuse, sexual activity, crime, and violence than their peers who are engaged in constructive activities.[10]

◆ Exact figures on the number of school-age children who spend time without adult supervision during a typical week are not available due to parents' reluctance to report leaving children alone. It is estimated that less than 5 percent of children under age 8 are regularly in self-care compared to nearly 35 percent of 12-year-olds.[11]

Programs for Out-of-School Time

◆ When school is out, children and young adolescents need a safe place that does not simply duplicate the school day. They need access to a wide variety of enriching activities — homework and reading help, sports, music, theater, art — and the opportunity to build meaningful relationships with their peers and caring adults.[12]

◆ Children in organized programs before and after school and during the summer have more learning opportunities, academic and enrichment activities, and spend less time watching television.[13]

◆ Many programs for school-age children could be improved through partnerships that link programs with school curricula, school building resources, community cultural and recreational opportunities, universities, libraries, museums, recreation centers, parks, and playgrounds.[14]

◆ The beneficial effects of organized school-age programs include more highly developed social skills, better likelihood of forming friendships, better homework quality, better conflict management, and improved reading and math scores.[15]

◆ Access to enriching opportunities during out-of-school time depends largely on a family's ability to pay.[16] Higher-income families have greater access to programs that require fees and transportation that lower-income families can not afford. Generally there is more availability and a wider variety of programs in wealthier communities.[17]

Programs for Middle School Students

◆ According to the Carnegie Council on Adolescent Development report, *A Matter of Time: Risk and Opportunity in the Nonschool Hours*, programs for 10 to 14-year-olds are most effective when they are specifically designed to meet the developmental needs of young adolescents. The report identifies the following elements needed by young teens:[18]

◆ Young adolescents require opportunities to form secure and stable relationships with caring adults who have time to talk, to listen, and to provide mature guidance.

◆ Young adolescents want safe and attractive places to play, practice their athletic skills, and be with their friends.

◆ Young adolescents benefit from learning critical skills such as goal-setting, problem-solving, and resisting negative peer influences.

◆ Young adolescents want to learn about and serve their communities.

◆ Young adolescents seek to be competent individuals, to be members of valuable groups, and to be recognized for their accomplishments.

References for Indicator

[1,3,9,10,17,18] *A Matter of Time: Risk and Opportunity in the Nonschool Hours* (1992). New York: Carnegie Corporation, Carnegie Council on Adolescent Development.

[2,4,5,6,11,13] *Fact Sheet on School-Age Children* (November 1997). Wellesley, MA: National Institute on Out-of-School Time, Center for Research on Women, Wellesley College.

[7] Annie E. Casey Foundation using data from the National Center for Educational Statistics 1993 - 1994, School and Staffing Survey.

[8] *CDF Reports* (November 1997). "After-School Time" (Special Report).Washington, DC: Children's Defense Fund

[12] Seligson, M. (1997). *School-Age Child Care Comes of Age*. Wellesley, MA: National Institute on Out-of-School Time, Center for Research on Women, Wellesley College.

[14,16] *Years of Promise: A Comprehensive Learning Strategy for America's Children* (1996). New York: Carnegie Corporation of New York.

[15] *Early Childhood Care and Education: An Investment That Works*, 2nd Edition (1997). Washington, DC: National Conference of State Legislatures.

High School Graduation Rate

DEFINITION

High school graduation rate is the percentage of the ninth-grade class that is expected to graduate, based on the existing drop-out incidence among 9th, 10th, 11th, and 12th grade students. The rate is computed using fall enrollment data and the number of students who drop out between October 2, 1995 and October 1, 1996. It is a four-year cumulative rate, and represents the probability of an individual student graduating from high school.

SIGNIFICANCE

Children who receive a quality education are more likely to grow into capable, self-sufficient adults who contribute to their communities. Early warning signs for a student likely to drop out of school include inability to read at grade level, poor grades, frequent truancy, behavior problems, substance abuse, and teen pregnancy.[1] Students can benefit from access to a broad range of community supports that address academic issues, language barriers, health problems, inadequate nutrition, neighborhood and family violence, and other factors that can disrupt school performance.

School completion can increase children's ability to escape poverty, form strong families, and raise successful children of their own.[2] The poverty rate for high school dropouts is ten times that of college graduates.[3] With the decline in manufacturing and the increased reliance on an information-based economy, education has become critical to a young person's success in the labor market. In 1996, U.S. students who dropped out of high school earned less than $10,000 annually.[4]

Student achievement can be improved when schools have high expectations for all students; effective curricula and teaching methods; prepared and sufficiently supported teachers; strong home/school linkages; adequate accountability systems; and effective and equitable allocation of resources.[5] Schools in low-income communities often have more limited access to up-to-date instructional materials, adequate classroom space, well-equipped libraries, laboratories, computers, and after-school sports and cultural activities.[6] Many children of color not only attend schools with fewer resources, but may also be confronted with low expectations.[7] Research shows minority students are disproportionately assigned to special education classes and steered toward vocational education.[8]

1996 High School Graduation Rates, by Median Income of Rhode Island Communities*

HIGHEST INCOME COMMUNITIES	GRADUATION RATE	LOWEST INCOME COMMUNITIES	GRADUATION RATE
Barrington	95.2%	Central Falls	70.1%
East Greenwich	92.3%	Providence	75.2%
Scituate	94.8%	Woonsocket	68.0%
Smithfield	91.8%	Pawtucket	64.1%
Portsmouth	92.6%	Newport	88.1%
Jamestown	NA	East Providence	77.7%
North Smithfield	93.6%	West Warwick	70.3%
Rhode Island	*82.7%*		

**Rhode Island median household incomes in 1990 ranged from a high of $53,058 in Barrington to a low of $18,617 in Central Falls. Rhode Island Median Income: $32,181*

◆ Achievement differences among school districts, and among schools within a district, are correlated with the socio-economic status of the community or neighborhood.[9]

Source: *Reaching for High Standards: Student Performance in Rhode Island, 1996* (February, 1997). Providence: RI Department of Elementary and Secondary Education; U.S. Bureau of the Census, 1990 Census of Population.

Student Mobility, School Attendance, and Suspensions

◆ Low-income families move more frequently than higher-income families. Students in low-income families are more likely to change schools two or more times after entering the first grade and before the middle of the eighth grade. Those who make frequent school changes can experience inappropriate placement in a new school, lack of continuity of lessons, disruptions in social ties, and feelings of alienation.[10]

◆ Nationally, absentee rates of elementary and middle schools increase with rates of student poverty. When students are absent from school, arrive late, or cut class, they miss opportunities to learn and can disrupt the lessons in progress.[11]

◆ Students who have been suspended from school are at higher risk for other poor school outcomes—including dropping out of school. Children who experience behavioral or academic problems early in their school career may be more likely to experience similar problems later on.[12]

Table 24.

High School Graduation Rate, Rhode Island, 1996

	COMMUNITY CONTEXT					% OF SENIORS TAKING THE SAT	1996 HIGH SCHOOL GRADUATION RATE
	% CHILDREN IN POVERTY	% ADULTS COMPLETING HIGH SCHOOL	NUMBER OF STUDENTS ENROLLED	% LIMITED ENGLISH PROFICIENCY	% MINORITY ENROLLMENT		
Barrington	1.3%	88.9	2,879	0.0%	2%	97%	95.2%
Bristol-Warren	6.6%	NA	4,006	4.1%	2%	62%	69.9%
Burrillville	6.1%	70.6	2,966	0.2%	1%	54%	89.7%
Central Falls	32.5%	46.9	3,013	28.1%	61%	43%	70.1%
Chariho	5.0%	82.2	3,801	0.3%	4%	53%	90.5%
Coventry	5.3%	74.4	5,478	0.3%	3%	54%	91.1%
Cranston	9.5%	74.0	10,364	4.8%	12%	59%	81.7%
Cumberland	4.7%	74.7	4,750	2.4%	3%	74%	95.3%
East Greenwich	5.3%	89.8	2,244	0.7%	4%	96%	92.3%
East Providence	8.7%	66.9	6,822	5.9%	14%	59%	77.7%
Exeter-W. Greenwich	3.2%	78.0	1,963	0.0%	4%	55%	91.2%
Foster	7.6%	81.9	391	0.0%	1%	NA	NA
Foster-Glocester	6.8%	82.5	1,411	0.0%	1%	63%	91.0%
Glocester	6.5%	82.8	892	0.0%	2%	NA	NA
Jamestown	8.1%	89.0	635	0.3%	3%	NA	NA
Johnston	8.4%	66.8	3,352	1.1%	5%	56%	91.9%
Lincoln	7.0%	76.1	3,331	0.9%	4%	66%	94.7%
Little Compton	2.7%	86.0	384	0.0%	0%	NA	NA
Middletown	6.0%	85.0	2,740	0.9%	13%	63%	84.0%
Narragansett	4.5%	87.2	1,910	1.2%	4%	76%	98.3%
Newport	20.3%	84.1	3,115	1.6%	27%	63%	88.1%
New Shoreham	10.1%	94.0	126	0.0%	4%	75%	62.5%
North Kingstown	4.7%	86.2	4,441	1.2%	5%	78%	92.3%
North Providence	5.4%	70.8	3,571	3.2%	10%	44%	90.9%
North Smithfield	1.6%	71.5	1,664	0.0%	2%	75%	93.6%
Pawtucket	15.5%	61.6	9,550	11.0%	33%	51%	64.1%
Portsmouth	4.4%	86.3	2,730	0.0%	4%	83%	92.6%
Providence	34.5%	62.8	24,069	20.4%	75%	64%	75.2%
Scituate	3.7%	83.8	1,712	0.0%	2%	72%	94.8%
Smithfield	4.1%	80.8	2,702	0.1%	2%	79%	91.8%
South Kingstown	7.5%	85.5	3,968	0.7%	90%	84%	84.9%
Tiverton	6.4%	70.5	2,134	0.0%	1%	70%	86.2%
Warwick	5.9%	77.8	11,931	0.8%	4%	63%	86.4%
Westerly	8.7%	75.6	3,431	1.7%	4%	74%	83.3%
West Warwick	11.8%	70.3	3,906	3.6%	7%	72%	70.3%
Woonsocket	21.4%	56.2	6,595	4.3%	26%	48%	68.0%
Core Cities	*27.3%*	*NA*	*46,342*	*15.4%*	*55%*	*NA*	*NA*
Remainder of State	*6.5%*	*NA*	*102,635*	*1.8%*	*6%*	*NA*	*NA*
Rhode Island	*13.5%*	*72.0*	*148,977*	*6.0%*	*21%*	*64%*	*82.7%*

Source of Data for Table/Methodology

Percent of children in poverty, percent adults completing high school are from the 1990 Census of Population. All other data are from the Rhode Island Department of Elementary and Secondary Education, Rhode Island Public Schools: 1996 District Profiles.

NA: Community has a regional high school.

The denominator is the number of children enrolled in 9th, 10th, 11th and 12th grades in the fall of 1996.

References

[1] *KIDS COUNT Data Book 1995: State Profiles of Child Well-Being* (1995). Baltimore, MD: Annie E. Casey Foundation; and *The State of America's Children Yearbook 1995* (1995). Washington, DC: The Children's Defense Fund.

[2,3] *Success in School: Education Ideas that Count* (1997). Supplement to *KIDS COUNT Data Book 1997; State Profiles of Child Well-Being*. Baltimore, MD: Annie E. Casey Foundation.

[4] *Current Population Reports*, (August 1996). "Educational Attainment in the United States: March 1995". Washington, DC: U.S. Census Bureau.

[5] *Years of Promise: A Comprehensive Learning Strategy for America's Children*. (1996). New York: Carnegie Corporation of New York.

[6,7,8] *America's Children at Risk: A National Agenda for Legal Action* (1993). Washington, DC: American Bar Association.

[9] *Reaching for High Standards: Student Performance in Rhode Island, 1995* (February 1996). Providence: RI Department of Elementary and Secondary Education.

[10] *The Condition of Education 1997* (1997). Washington, DC: National Center for Educational Statistics; and, Weissbourd, R. (1996). *The Vulnerable Child.* New York: Addison-Wesley Publishing Company.

[11, 12] *The Condition of Education 1997* (1997). Washington, DC: National Center for Educational Statistics.

Teens Not in School and Not Working

DEFINITION

Teens not in school and not working is the percentage of teens ages 16 to 19 who are not enrolled in school, not in the Armed Forces, and not employed. This indicator includes recent high school graduates who are unemployed, and teens who have dropped out of high school who are jobless.

SIGNIFICANCE

Dropping out of school and not becoming part of the workforce places teens at a significant disadvantage as they transition from adolescence to adulthood. These adolescents have a difficult time getting connected to the job market as young adults and are at significant risk for teen parenting and criminal activity.[1] They are likely to lack credible references, have little confidence in their abilities, and lack knowledge about job opportunities. Teens are most likely to drop out when they do not succeed in school activities and see little connection between academic success and the challenges in their daily life.[2]

For those likely to drop out of school with no connection to the job market, school-linked part-time jobs can be an important resource to prevent dropping-out, reinforce learning in school, and develop positive work attitudes and habits.[3]

Many school-to-work efforts do not adequately address the needs of students on the verge of dropping out of school and out-of-school youth.[4] All youth need opportunities to develop basic skills, such as math, reading and writing, as well as to develop other qualities that will help them to find a job, including problem-solving, creativity, self-motivation, and responsibility.[5] Ongoing relationships with caring adults and connections within the family and community are powerful factors in protecting young people from negative behaviors, encouraging good social skills, responsible values, and positive identity.[6] The most effective of the current generation of school-to-work programs have positive effects on students attitudes toward work, school attendance, and drop-out rates.[7]

CHANGE SINCE THE 1980s

Teens Ages 16-19 Not in School and Not Working, 1985 and 1995, Rhode Island

Percentage of Teens Not in School and Not Working

◆ Between 1985 and 1995 the percentage of teens not attending school and not working increased from 6.1% to 7.8%.

◆ In 1990, there were three Rhode Island communities in which close to 15% of teens ages 16 to 19 were not in school and not working: Woonsocket (16.4%); Central Falls (14.5%); and Hopkinton (14.3%).

Source: U.S. Bureau of the Census, Current Population Survey, 1983-1987 average (1985) and 1993-1997 average

Connecting Youth to School and Work

◆ Safe places in the community that offer productive activities for teens can connect youth to caring adults, strengthen teens' commitment to school, and provide opportunities for young people to contribute to their community and society. [8]

◆ Work experiences connected with school can be an important mechanism for building on the interests of at-risk students and engaging them in school-related activities. [9]

◆ At risk teens often do not have supportive relationships with adults who can help them connect with the job market and help them access employers and places of employment. Effective school-to-work programs develop these connections between at-risk youth and supportive adults.[10]

Table 25.

% Teens Not in School and Not Working, Ages 16-19, Rhode Island, 1990

CITY/TOWN	TOTAL NUMBER OF TEENS AGES 16-19	JOBLESS HIGH SCHOOL GRADUATES	JOBLESS NON-HIGH SCHOOL GRADUATES	TOTAL NUMBER OF JOBLESS TEENS	% OF TEENS WHO ARE JOBLESS
Barrington	800	8	17	25	3.1%
Bristol	1,703	43	34	77	4.5%
Burrillville	886	33	31	64	7.2%
Central Falls	931	35	100	135	14.5%
Charlestown	261	0	0	0	0.0%
Coventry	1,689	59	52	111	6.6%
Cranston	3,500	119	304	423	12.1%
Cumberland	1,474	59	128	187	12.7%
East Greenwich	627	0	7	7	1.1%
East Providence	2,408	72	180	252	10.5%
Exeter	279	16	17	33	11.8%
Foster	232	16	3	19	8.2%
Glocester	565	27	27	54	9.6%
Hopkinton	377	10	44	54	14.3%
Jamestown	226	0	10	10	4.4%
Johnston	1,235	13	30	43	3.5%
Lincoln	874	32	17	49	5.6%
Little Compton	167	0	4	4	2.4%
Middletown	922	20	27	47	5.1%
Narragansett	653	15	16	31	4.7%
Newport	1,978	56	46	102	5.2%
New Shoreham	20	0	0	0	0.0%
North Kingstown	1,269	12	30	42	3.3%
North Providence	1,444	29	78	107	7.4%
North Smithfield	578	30	0	30	5.2%
Pawtucket	3,632	81	303	384	10.6%
Portsmouth	851	10	13	23	2.7%
Providence	12,841	254	1,042	1,296	10.1%
Richmond	284	18	16	34	12.0%
Scituate	555	24	10	34	6.1%
Smithfield	1,625	21	16	37	2.3%
South Kingstown	3,818	15	7	22	0.6%
Tiverton	812	34	24	58	7.1%
Warren	505	0	37	37	7.3%
Warwick	4,231	151	198	349	8.2%
Westerly	992	10	108	118	11.9%
West Greenwich	211	15	0	15	7.1%
West Warwick	1,478	46	89	135	9.1%
Woonsocket	2,357	101	285	386	16.4%
Core Cities	***21,739***	***527***	***1,776***	***2,303***	***10.6%***
Remainder of State	***37,551***	***957***	***1,574***	***2,531***	***6.7%***
Rhode Island	***59,290***	***1,484***	***3,350***	***4,834***	***8.1%***

Sources of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the number of teens ages 16 to 19 according to the 1990 Census of Population.

References

[1,3,9] Lerman, R. I., "Helping Disconnected Youth by Improving Linkages Between High Schools and Careers" (May 16, 1996). Presentation at the American Enterprise Institute Forum, America's Disconnected Youth: Toward a Preventative Strategy.

[2] *A Matter of Time: Risk and Opportunity in the Non-School Hours* (1992). New York: Carnegie Corporation; and Rossi, Robert and Alesia Montgomery, Eds., Educational Reforms and Students At Risk: A Review of the Current State of the Art (January 1994). Washington, D.C.: U.S. Department of Education.

[4] *Skills, Standards and Entry Level Work: Elements of a Strategy for Youth Employability Development* (1995). Washington, D.C.: U.S. Department of Labor, Employment and Training Administration.

[5,6,8] America's Promise-The Alliance for Youth (1997). *Five Resources All American Youth Need: How Are We Doing As a Nation.* Minneapolis, MN: The Search Institute.

[7,10] *Job Opportunity Initiatives: Toward a Better Future for Low-Income Children and Youth* (1994). Minneapolis, MN: Rainbow Research, Inc.

Methodology and Acknowledgements

Methodology

The 1998 Rhode Island KIDS COUNT Factbook examines twenty-eight indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education.

How Each Indicator is Organized

- ***Definition:*** A description of the indicator and what it measures.
- ***Significance:*** The relationship of the indicator to child and family well-being.
- ***Sidebars:*** Current state and national data and information related to the indicator.
- ***City/Town Tables:*** Data for each indicator presented for each of Rhode Island's cities and towns, the state as a whole, and the core cities.
- ***Core Cities Data:*** Five core cities are identified based on high child poverty rates: Providence, Pawtucket, Woonsocket, Newport, and Central Falls. These are the only Rhode Island communities in which more than 15% of the children live below the poverty level, according to the 1990 Census.
- ***Most Recent Available Data:*** The *1998 Factbook* uses the most current, reliable data available for each indicator.

What's New

- ***Trend Data:*** Current data are compared to historical data, when possible. Health-outcome related indicators compare one five-year period in the 1980s to the five-year period from 1991 through 1995. Other outcome indicators, including: median household income, children in poverty, children with health insurance, and teens not in school and not working compare the 1983 through 1987 (1985 average) to 1993 through 1997 (1995 average), using the U.S. Census Bureau Current Population Survey. Other indicators examine trends in varying time frames, depending on the historical data available.
- ***New Indicators:*** Two new indicators have been added to the twenty-six indicators included in the *1997 Rhode Island KIDS COUNT Factbook*. Children with Disabilities and Out-of-School Time have been added to the Education section of the Factbook.
- ***Modifications to Indicators:*** Children Receiving AFDC has been changed to Children in the Family Independence Program. Children without Health Insurance has been changed to Children's Health Insurance. Asthma has been added to Additional Children's Health Issues.

Source of Data/Methodology for Calculations

For each indicator, the source of information for the actual number of events of interest (the numerator) are identified within the Source of Data/Methodology section next to the table for that indicator.

The *1998 Rhode Island KIDS COUNT Factbook* presents the data for each indicator using numbers, rates, and/or percentages. Numbers are important in assessing the scope of the problem and in estimating the resources required to address a problem. Numbers are not useful to compare the severity of the problem from one geographic area to another or to compare the extent of the problem in your state with national standards. For example, a community with more children might have more low birthweight infants due to the larger number of total births, not due to an increased likelihood of being born low birthweight.

A rate is a measure of the probability of an event – e.g. out of every 1,000 live births, how many infants will die before their first birthday? A percentage is another measure of the probability of an event – e.g. out of every 100 births, how many will be born low birthweight? Rates and percentages take into account the total population of children eligible for an event. They are useful in comparing the severity of the problem from one geographic area to another, to compare with state or national standards, or to look at trends over time.

For each indicator that uses a rate or a percent, the methodology used to estimate the total number of children eligible for the indicator of interest (i.e. the denominator) is noted within the Source of Data/Methodology section next to the table for the indicator.

Rates and percentages were not calculated for cities and towns with small denominators (less than 500 for delayed prenatal care, low birthweight infants, infant mortality rates, and births to teens). Rates and percentages for small denominators are statistically unreliable. NA is noted in the indicator table when this occurs. In the indicator for child deaths and teen deaths, the indicator events are rare; in these instances, city and town rates are not calculated, as small numbers make these rates statistically unreliable.

Limitations of the Data

In any data collection process there are always concerns about the accuracy and completeness of the data being collected. All data used in the 28 indicators were collected through the U.S. Bureau of the Census and through routine data collection systems operated by different agencies of the state of Rhode Island. We do not have estimates of the completeness of reporting to these systems.

In all cases, the most reliable data currently available is used. For census-based indicators, statewide numbers have been updated to 1995 using the Current Population Survey, 1993-1997 average. The Current Population Survey does not provide data at the level of city and town. City/town tables, therefore, use information from the 1990 Census of Population.

Over time the data used to assess child well-being in Rhode Island is likely to become more timely and will contain more complete information on the state's racial and ethnic communities than is currently available.

Methodology for Child Care Indicator

The denominator is the potential number of children in need of regulated care and is computed by: a.) multiplying the 1990 Census number of children under age 6 with mothers in the workforce by 47% (the percentage of U.S. women with children under age 6 who use center-based care or family child care homes as their child care arrangement), and adding it to b.) the number of 1 to 5 year olds living in families enrolled in the Family Independence Program as of December, 1997 that has been multiplied by 50% (assuming half of FIP mothers will work), and then multiplied by 75% (the percent of families receiving child care subsidies in Rhode Island who choose center-based care or families child care homes as their child care arrangement).

The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots as of December, 1997. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

Rhode Island KIDS COUNT Committees

Rhode Island KIDS COUNT Board of Directors

CHAIRPERSON

Trina Barnes
Executive Director
East Providence Community Center

VICE CHAIRPERSON

Michael Msall, MD
Director, Child Development Center
Hasbro Children's Hospital

TREASURER

Barbara Cottam
Senior Vice President
Citizens Bank

SECRETARY

Nancy Smith Greer
Director, Rhode Island Office
US Department of Housing
and Development

Lenette Azzi-Lessing
Executive Director
Children's Friend & Service

Carolyn Benedict-Drew
Executive Director
Family Service, Inc.

Laureen D'Ambra
Child Advocate
State Of Rhode Island

Rabbi Leslie Gutterman
Senior Rabbi
Temple Beth El

Alan Litwin
Managing Director
Kahn, Litwin & Co., Ltd.

Joan McPhee
Partner
Ropes & Gray

Tomas Ramirez
Zone Administrator
Providence School Department

Beverly Scott
General Manager
Rhode Island Public Transit Authority

Rhode Island KIDS COUNT State Agency Liaisons

Grace Beiser
Department of Administration

Samara Viner-Brown
Department of Health

Sherry Campanelli
Paul McLaughlin
Department of Human Services

Norman Dakake
Governor's Justice Commission

Carolyn Friedman
Department of Children Youth and Families

David Heden
Family Court

George McDonough
Karen Cooper
Department of Education

Daniel Thompson
Department of Mental Health, Retardation
and Hospitals

Barbara Weaver
Office of Library and Information Services
Department of Administration

Rhode Island KIDS COUNT Factbook Advisory Committee

Thomas Anton
Director
A. Alfred Taubman Center,
Brown University

Representative Nancy Benoit
Rhode Island General Assembly

Fredericka Bettinger

Jean Burritt Robertson
Coordinator of Research
Rhode Island Housing

Jack Combs
Research Administrator
A. Alfred Taubman Center
Brown University

Nancy Gewirtz
Professor
Rhode Island College
School of Social Work

Myra J. Edens
Director of Pediatric Patient Services
Hasbro Children's Hospital

David Gagnon
Executive Director
National Perinatal Information Center

Richard Gelles
Director
Family Violence Research Program
University of Rhode Island

William H. Hollinshead, MD
Medical Director
Division of Family Health
Rhode Island Department of Health

Senator Thomas Izzo
Rhode Island State Senate

Patricia Jaehnig
Assistant Coordinator, Public
Information and Education
Diocese of Providence

Jeremiah S. Jeremiah, Jr.
Chief Judge
Rhode Island Family Court

Linda Katz
Health Policy Director
Rhode Island Health Center Association

Patricia Martinez
Executive Director
Progreso Latino

Eleanor M. McMahon
A. Alfred Taubman Center for Public Policy
and American Institutions
Brown University

Jane Nugent
Vice President for Research and Information
United Way of Southeastern New England

Lenore Olsen
Rhode Island College
School of Social Work

Hillary Salmons
Project Manager
Health and Education Leadership for Providence

Gary Sasse
Executive Director
Rhode Island Public Expenditure Council

Rick Schwartz
Director of Communications
The Rhode Island Foundation

Allan W. Stein
Senior Vice President for Public Policy
United Way of Southeastern New England

Maria Luisa Vallejo
Board Member
Center for Hispanic Policy and Advocacy

Rhode Island KIDS COUNT Community Leadership Council

Roberta Hazen Aaronson
Childhood Lead Action Project

Christina Abuelo
Center for Hispanic Policy and Advocacy

Raymond Arsenault
Spurwink School

Marion Avarista
Travelers Aid Society of Rhode Island

Robert Barge
RI Legal Services

Bernard Beaudreau
Rhode Island Community Food Bank

Adeline Becker
Education Alliance, Brown University

Stanley Block, MD
Providence Ambulatory Health Care Foundation

Matt Brown
City Year

Barbara Cavallaro
Child Care Director's Association

Dan Challener
Providence Blueprint for Education

Christine Chiacu-Forsythe
Project REACH-Newport

Michael Cerullo
Ocean State Free-Net

Ruth Clegg
Junior League of Rhode Island

Brenda Clement
Rhode Island Housing Network

Barbara Colt
Rhode Island Health Center Association

Kate Coyne-McCoy
Rhode Island Chapter
National Association of Social Workers

Terese Curtin
Connecting for Children and Families

Deborah DeBare
Rhode Island Coalition Against Domestic Violence

Robert DeBlois
Urban Collaborative Accelerated Program

Lynda Dickinson
Head Start Directors Association

Elizabeth Earls
Rhode Island Council of Community Mental Health Centers

John E. Farley, Jr., MD
Bradley Hospital

Paul Fitzgerald
FACTS House

Patricia Flanagan, MD
Brown University School of Medicine

William Flynn
RI Campaign to Eliminate Childhood Poverty

James Gannaway
Casey Family Services

Ruth Glassman
Office of the Mental Health Advocate

Elsie Goodrum
Martin Luther King Center

Mary Silvia Harrison
Rhode Island Children's Crusade

Bernard Heath, Jr.
Family Resources, Inc.

Margaret Holland
RICORP

Nondas Hurst Voll
Fund for Community Progress

Judy Jones
Rhode Island Housing

Susan Adler Kaplan

David Karoff
The Rhode Island Commission for National and Community Service

Jeff Katz
Adoption Rhode Island

May Keirnan
Women & Infants Hospital

Sister Anne Keefe
City Arts!

Tanja Kubas-Meyer
Rhode Island Coalition for the Homeless

Sydavong Kue
Hmong United Associates of Rhode Island

Shannah Kurland
Direct Action for Rights and Equality

Sister Marlene Laliberte
The Genesis Center

Peg Langhammer
Rhode Island Rape Crisis Center

Peter Marshall
StopOver Services, Inc.

Sister Barbara McMichael
Providence Head Start

Martha McVicker
RI Disability Law Center

Reverend James C. Miller
Rhode Island State Council of Churches

Alexandra Moser
RI Public Policy Coalition for Child Care

Joseph Newsome
RI Committee for Non-Violence Initiatives

Roger Nolan
Aquidneck Management Associates, Ltd.

William Oh, MD
Hasbro Children's Hospital

Howard Phengxophone
Southeast Asian Youth and Family Development Project

Robert Power
Newport Partnership for Families

Senator Mary Parella
Rhode Island State Senate

Vidal Perez
LAB at Brown University

Sally Powers
March of Dimes

Harvey Press
Rhode Island Chapter, National Education Association

Sister Mary Reilly
Dorcas Place

Brother Michael Reis
Tides Family Services

Rosemary Santos
United Black and Brown Fund

Monica Schaberg, MD
Rhode Island Chapter, American Academy of Pediatrics

Reverend William Shaw
Coalition for Immigrants and Refugees

Henry Shelton
George Wiley Center

John Symynkywicz
DAWN for Children

Dan Wall
Hasbro Children's Hospital

Sheldon Whitehouse
U.S. Attorney

Ted Whiteside
RI Chapter, National Committee to Prevent Child Abuse

Thomas Whitten
John Hope Settlement House

Robert Wooler
Interagency Collaborative of Blackstone Valley

Acknowledgements

The *1998 Rhode Island KIDS COUNT Factbook* was made possible by the efforts of many dedicated individuals. Rhode Island KIDS COUNT gratefully acknowledges their assistance.

William O'Hare and Jennifer Baratz of the Annie E. Casey Foundation for their encouragement and technical assistance.

Jack D. Combs, Research Administrator at the A. Alfred Taubman Center for Public Policy and American Institutions, Brown University, for database management and analyses.

Samara Viner-Brown, Division of Family Health, RI Department of Health, for coordination and analyses of data from the RI Department of Health.

Elizabeth Melendez, RI KIDS COUNT Administrative Assistant for her assistance.

Betsy Greenwood and Bill Mott of Greenwood Associates for the design and layout of the Factbook, Bill Mott for the illustration, and E.A. Johnson Co. for the printing of the Factbook.

Katherine Eckstein, Rhode Island KIDS COUNT intern from the A. Alfred Taubman Center at Brown University.

Ron Gallo, Ron Thorpe, Rick Schwartz, and Karen Voci of The Rhode Island Foundation for their ongoing support and assistance.

Members of the Rhode Island KIDS COUNT Factbook Advisory Committee for their assistance in shaping the format and content of the Factbook.

Members of the Rhode Island KIDS COUNT Board of Directors for their support.

The State Agency Directors of the Rhode Island Children's Cabinet for their ongoing support of Rhode Island KIDS COUNT.

Thomas Anton, Brown University; Nancy Gewirtz, Rhode Island College; Trina Barnes, East Providence Community Center; William Hollinshead, Samara Viner-Brown, RI Department of Health for their review of the Factbook in draft form.

Margie Davis of the East Greenwich Free Library for her assistance with children's poetry.

For their technical assistance with the following sections of the Factbook:

Child Population, Children in Single Parent Families: Nancy Gewirtz, Lenore Olsen; Rhode Island College School of Social Work; Thomas Anton, Jack Combs, Brown University.

Median Household Income: Jack Murphy, RI Department of Administration; Jean Burritt Robertson, Rhode Island Housing; Jack Combs, Brown University.

Children in Poverty: Nancy Gewirtz, Lenore Olsen, Rhode Island College; Patricia Jaehnig, Diocese of Providence; Jean Burritt Robertson, Rhode Island Housing; Debbie Weinstein, Children's Defense Fund.

Children in Family Independence Program: Sherry Campanelli, Kevin McCarthy, Donalda Carlson, Randy Rosati, RI Department of Human Services; Linda Katz, RI Community Health Center Association; Thomas Anton, Brown University; Nancy Gewirtz, RI College School of Social Work.

Children Receiving Food Stamps: Sherry Campanelli, Robert McDonough, Nancy Tikkanen, RI Department of Human Services; John Cook, Gayle Kelly, Tufts Center on Hunger, Poverty and Nutrition Policy; Bernie Beaudreau, RI Community Food Bank; Nancy Gewirtz, RI College; Linda Katz, RI Community Health Center Association; Ann Morse, State and Local Coalition on Immigration, Immigrant Policy Project.

Children Receiving School Breakfast: Robert Kaveny, Adrienne DiMeo, RI Department of Education; Bernie Beaudreau, RI Community Food Bank; Henry Shelton, Bill Flynn George Wiley Center; Gayle Kelly, John Cook, Tufts Center on Hunger, Poverty and Nutrition Policy; Christin Driscoll, Ellen Vollinger, Food Research and Action Center.

Cost of Rent: Jean Burritt Robertson, Erin Reedy, Judy Jones, RI Housing; Eric Hirsch, Providence College; David McCreadie, Janet Peters, RI Food and Shelter Board; Tanya Kubas-Meyer, RI Coalition for the Homeless; Nancy Gewirtz, RI College, School of Social Work; Frederick Trappassi, Jr, Travelers Aid; Barbara Fields, RI LISC; Nancy Smith Greer, RI HUD Office.

Children's Health Insurance: Sharon Kernan, John A.Y. Andrews, Sherri Campanelli, John Young, Tricia Leddy, Frank Spinelli, Ron Ek, RI Department of Human Services; Barbara Colt, Linda Katz, RI Health Center Association; Stanley Block, MD, Providence Ambulatory Health Care Foundation; Larry Culpepper, MD, Memorial Hospital; Carolyn Benedict-Drew, Family Service, Inc.; Samara Viner-Brown, Jay Buchner, RI Department of Health; John Farley, MD, Bradley Hospital; Melvin Bell, Karen Voci, The Rhode Island Foundation; William O'Hare, Annie E. Casey Foundation; Jack Combs, Brown University.

Women and Children Receiving WIC: Myra Edens, Hasbro Children's Hospital; Charles White, Barbara Spencer, John Smith, Bethany Algiers, RI Department of Health.

Women with Delayed Prenatal Care, Low Birthweight Infants, Infant Mortality: William Hollinshead, MD, Samara Viner-Brown, RI Department of Health; Michael Msall, MD, RI Hospital Child Development Center; Myra Edens, Hasbro Children's Hospital; David Gagnon, National Perinatal Information Center; Brett Brown, Child Trends, Inc.

Children with Lead Poisoning: Peter Simon, MD, Bill Dundulis, Susan Feeley, Robert Vanderslice, Lynn Bibeault, William Hollinshead, MD, Veary Heng, RI Department of Health; Roberta Hazen Aaronson, Childhood Lead Action Project; Jeff Brown, MD, June Tourangeau, St. Joseph's Lead Clinic; Myra Edens, Hasbro Children's Hospital; Hillary Salmons, HELP Coalition.

Births to Teens: Samara Viner-Brown, RI Department of Health; Myra Edens, Hasbro Children's Hospital.

Alcohol, Drug, and Cigarette Use by Teens: Norman Dakake, Governor's Justice Commission; Noreen Mattis, Project Link; Samara Viner-Brown, William Hollinshead, MD, Jana Hessler, Sherri Knapp, Helen Drew, Rhode Island Department of Health; Myra Edens, Hasbro Children's Hospital.

Childhood Immunizations: Kim Salisbury-Keith, William Hollinshead, MD, RI Department of Health; Myra Edens, Hasbro Children's Hospital; David Gagnon, National Perinatal Information Center.

Children's Mental Health: Fredericka Bettinger; Elizabeth Earls, RI Council of Community Mental Health Centers; John E. Farley, Jr., MD; Sandi Silva, Bradley Hospital; Jim Hallman, Butler Hospital; Myra Edens, Hasbro Children's Hospital; Bruce Fickett, Department of Children Youth and Families.

Asthma: Michael Msall, MD, RI Hospital Child Development

continued, next page

Acknowledgements

Center; Myra Edens, Hasbro Children's Hospital; William Hollinshead, MD, Samara Viner-Brown, RI Department of Health; David Gagnon, National Perinatal Information Center; Hillary Salmons, HELP Coalition; Tony Mansell, MD, Kathy Mansell MD, Hasbro Children's Hospital.

Access to Dental Care: Maureen Ross, RI Department of Health; Robert Persson, St. Joseph Hospital Dental Clinic; Cornelia Anderson, DDS, Thundermist Health Center; Myra Edens, Hasbro Children's Hospital; Karen Voci, The Rhode Island Foundation.

Child Deaths and Teen Deaths: Samara Viner-Brown, Nancy Libby-Fisher, Liz Arouth, RI Department of Health; David Pugatch, MD, Hasbro Children's Hospital; Wendy Becker, Youth Pride, Inc.; Colleen Sands, Providence Safe Communities Partnership.

Homeless Children and Youth: Marian Avarista, Frederick Trappassi, Jr, Travelers Aid; Eric Hirsch, Providence College; Jean Burritt Robertson, Judy Jones, RI Housing; David McCreadie, RI Food and Shelter Board; Tanja Kubas-Meyer, RI Coalition for the Homeless; Nancy Gewirtz, Rhode Island College School of Social Work; Virginia Bilotti, RI Department of Education; Rev. Robert Carter, Urban League; Andy Smith, StopOver Services of Newport County; Brother Michael Reis, Tides Family Services.

Juveniles Referred to Family Court: David Heden, Marguerite DiPalma, Mark Camara, Julie Adoptante, RI Family Court; Katherine Eckstein, Brown University; Laureen D'Ambra, Office of the Child Advocate; Susan Bowler, RI Department Children, Youth, and Families; Warren Hurlbut, Arlene J. Chorney, RI Training School; Angela Bucci, Attorney General's Office; Sheldon Whitehouse, U.S. Attorney; Brother Michael Reis, Tides Family Services; Marion Avarista, Travelers Aid; Norman Dakake, Elizabeth Gilheeny, Governor's Justice Commission; Robert Fellner, University of Rhode Island.

Child Abuse and Neglect: Carolyn Friedman, Tom Dwyer, David Allenson, Barbara Dobbin, Department of Children, Youth and Families; Katherine Eckstein, Brown University; Richard Gelles, Jody Brown, Family Violence Research Center, URI; Laureen D'Ambra, Noreen Shawcross, Office of the Child Advocate; Deborah DeBare, Francie Mantak, RI Coalition Against Domestic Violence; Lenette Azzi-Lessing, Children's Friend and Service; Lenore Olsen, Rhode Island College; Christine DeFarias, RI Foster Parents Association; Carolyn Benedict-Drew, Family Service, Inc.; Peg Langhammer, RI Rape Crisis Center; Jeff Katz, Adoption RI; James Gannaway, Casey Family Services.

Child Care and Out-of-School Time: Patricia Nolan, Options for Working Parents; Barbara Burgess, Rhode Island Department of Education; Alexandra Moser, Office of Child Care, Diocese of Providence; Mary Ann Shallcross, Child Care Connection; George Neubauer, Providence Boys and Girls Club; Maryellen O'Mahony Henry, YMCA of Greater Providence; Barbara Gianola, Larry Pucciarelli, Sherri Campanelli, Paul Goulet, Randy Rosati, Rhode Island Department of Human Services; Representative Nancy Benoit; Nancy Gewirtz, Rhode Island College School of Social Work; Barbara Cavallaro, Rhode Island Child Care Director's Association; Joyce Butler, Maryann Finamore-Allmark, Rhode Island Public Policy Coalition for Child Care; Sue Connor, Rhode Island Association for the Education of Young Children; Lennette Azzi-Lessing, Teri DeBoise, Children's Friend and Service; Patricia Martinez, Progreso Latino; Eleanor McMahon, Jack Combs, A. Alfred Taubman Center, Brown University.

Children Enrolled in Head Start: Andrea Dodge, U.S. Department of Health and Human Services, Region I; Larry Pucciarelli, RI Department of Human Services; Mary Legacy, Cranston Child Development Program; Pamela Caldwell, Lynda Dickinson, Child, Inc.; Sister Barbara McMichael, Providence Head Start; Lorie Spencer, South County Head Start; Mary Nugent, East Bay Head Start; Cindy Larson, New Visions Head Start; Susan Connaughton, Tritown Head Start; Karen Bouchard, Woonsocket Head Start; Teri DeBoise, Children's Friend and Service; Eleanor McMahon, A. Alfred Taubman Center, Brown University; Robert Wooler, RI Youth Guidance Center; Karen Pucciarelli, New England Resource Center.

Children with Disabilities: Michael Msall, MD, RI Hospital Child Development Center; Fredericka Bettinger; Charlene Gilman, Robert Pryhoda, Barbara Burgess, RI Department of Education; William Hollinshead, MD, Samara Viner-Brown, Peter Simon, MD, RI Department of Health; Myra Edens, Hasbro Children's Hospital; John A.Y. Andrews, Rhode Island Department of Human Services; Martha McVicker, RI Disability Law Center; Dawn Wardyga, Family Voices.

Fourth-Grade Reading Skills: Dan Challener, Providence Blueprint for Education; Karen Voci, The Rhode Island Foundation; Karen Cooper, Virginia da Mota, Cynthia Corbridge, Pat DeVito, Marisa Quinn, Paula Rossi, Jane Correia, Mary Ellen Sacco, RI Department of Education.

High School Graduation Rate: Dan Challener, Providence Blueprint for Education; Eleanor McMahon, A. Alfred Taubman Center, Brown University; Jane Nugent, United Way of Southeastern New England; Robert Wooler, RI Youth Guidance Center; Lenette Azzi-Lessing, Children's Friend and Service; George McDonough, Karen Cooper, Virginia da Mota, Cynthia Corbridge, Pat DeVito, Marisa Quinn, Paula Rossi, Jane Correia, Mary Ellen Sacco, Terry Bergner, RI Department of Education; Karen Voci, The Rhode Island Foundation.

Teens Not in School and Not Working: Judy Marmaras, RI Department of Employment and Training; Jack Combs, Brown University; John Cronin, Greater RI Regional Training Board.

Poetry Credits

"Dream Variation" by Langston Hughes, reprinted from *The Dream Keeper and Other Poems* (1932). New York: Alfred A. Knopf.

"To Any Reader" by Robert Louis Stevenson, reprinted from *Favorite Poems Old & New* (1957). Garden City, NY: Doubleday & Co., Inc.

"Little" by Dorothy Aldis, reprinted from *Favorite Poems Old & New* (1957). Garden City, NY: Doubleday & Co., Inc.

"Daisies" by Andrew Young, reprinted from *The Golden Journey, Poems for Young People* (1965). Chicago: Reilly & Lee Company.

"Afternoon on a Hill" by Edna St. Vincent Millay, reprinted from *Favorite Poems Old & New* (1957). Garden City, NY: Doubleday & Co., Inc.

"La Plaza Y Los Naranjos Encendidos..." by Antonio Machado, reprinted *from Still Waters in the Air: Poems by Three Modern Spanish Poets* (1969). New York: The Dial Press.

Rhode Island KIDS COUNT
70 Elm Street
Providence, RI 02903

Phone: 401-351-9400
Fax: 401-351-1758
E-Mail: HN3170@handsnet.org
rikids@rikidscount.org
Web Site: www.rikidscount.org