THE STATE OF AMERICA'S CHILDREN®
2005

Children's Defense Fund

The Mission of the Children's Defense Fund

The Children's Defense Fund's Leave No Child Behind® mission is to ensure every child a *Healthy Start*, a *Head Start*, a *Fair Start*, a *Safe Start*, and a *Moral Start* in life and successful passage to adulthood with the help of caring families and communities.

CDF provides a strong, effective voice for *all* the children of America who cannot vote, lobby, or speak for themselves. We pay particular attention to the needs of poor and minority children and those with disabilities. CDF educates the nation about the needs of children and encourages preventive investment before they get sick or into trouble, drop out of school, or suffer family breakdown.

CDF began in 1973 and is a private, nonprofit organization supported by foundation and corporate grants and individual donations. We have never taken government funds.

© 2005 by the Children's Defense Fund
All rights reserved. Printed in the United States of America.
© Photography by Steve Liss (pages x, 30, 58, 86, 112, 144, 146)
© All remaining photography by Alison Wright Photography
© Poem excerpted with permission (page iii) from "Let America Be America Again" by Langston Hughes

One Day in the Life of America's Children

1	mother dies in childbirth.
4	children are killed by abuse or neglect.
5	children or teens commit suicide.
8	children or teens are killed by firearms.
77	babies die before their first birthdays.
177	children are arrested for violent crimes.
375	children are arrested for drug abuse.
390	babies are born to mothers who received late or no prenatal care.
860	babies are born at low birthweight.
1,186	babies are born to teen mothers.
1,900	public school students are corporally punished.
2,076	babies are born without health insurance.
2,341	babies are born to mothers who are not high school graduates.
2,385	babies are born into poverty.
2,482	children are confirmed abused or neglected.
2,756	high school students drop out.
3,742	babies are born to unmarried mothers.
4,262	children are arrested.
16,964	public school students are suspended.

Dedication

Dedicated to the children and families

still suffering from Hurricane Katrina

and the 37 million people

including 13 million children

who live in poverty in the richest nation on earth

Let America Be America Again

Let America be the dream the dreamers dreamed…

Say who are you that mumble in the dark?
I am the poor white, fooled and pushed apart,
I am the Negro bearing slavery's scars.
I am the red man driven from the land,
I am the immigrant clutching the hope I seek.

Langston Hughes

Foreword

On Poverty and the Aftermath of Hurricane Katrina

One of the unexpected side effects of Hurricane Katrina is that the storm opened up a national conversation on a piece of the tragedy that wasn't caused by the wind or water: poverty. Katrina ripped the blinders of denial off the chronic quiet invisible tsunami of poverty that afflicts 37 million Americans, including 13 million children. People were forced to see what poverty looked like on the clear pictures on their television screens: families who didn't have enough money to own a car or have a credit card or enough cash to pay for another way out of the hurricane's path, families left stranded without food, water, or shelter when the storm came.

The pictures of Hurricane Katrina's poor victims were hard to ignore. They put a vivid and desperate face on what is really a constant, daily crisis for millions of people in our rich nation. All over the country, poor families and children are being left behind as the benefits of our economy fail to trickle down.

The day after Hurricane Katrina hit, the U.S. Census Bureau released the latest data on American poverty showing that in 2004, poverty increased in our rich country for the fourth year in a row. The number of American children living in poverty has grown by 12.8 percent over the last four years, and is now over 13 million. This means 1.5 million more children were poor in 2004 than in 2000.

As these numbers were being released, was our government responding by announcing a federal emergency management plan to deal with child and family poverty? Just the opposite: The Bush Administration and Congress were proposing additional tax cuts for the wealthiest and budget cuts in programs that serve low-income children and families. The persistent and growing high level of child poverty reflects conscious, misguided and unjust choices. How can the Bush Administration and Congress give enormous tax breaks to the wealthiest Americans who have benefited most from the economic recovery while seeking to undermine the guarantees and cut the budgets for Medicaid, food stamps, and other programs that assist poor children who continue to be left behind?

More than seven out of every ten poor children in 2004 had at least one employed parent. Working hard and playing by the rules is not enough to lift families out of poverty. Even if a parent with one child works full time at the federal minimum wage, which hasn't been raised since 1997, the family still lives in poverty. Poverty affects all kinds of families and child poverty has risen significantly among all racial groups. Extreme child poverty, defined as living with an annual income below $7,610 for a family of three, increased by a terrible 20 percent between 2000 and 2004 and now affects almost 5.6 million children.

Far less wealthy industrialized countries have committed to end child poverty, while the United States is sliding backwards. We can do better. We must demand that our leaders do better.

In an address to the nation from New Orleans seventeen days after the storm hit, President Bush said, "Within the Gulf region are some of the most beautiful and historic places in America. As all of us saw on television, there is also some deep, persistent poverty in this region as well. And that poverty has roots in a history of racial discrimination, which cut off generations from the opportunity of America. We have a duty to confront this poverty with bold action. So let us restore all that we have cherished from yesterday, and let us rise above the legacy of inequality."

This is the exact same "deep, persistent poverty" the President spoke about in his first inaugural address, in January 2001, when he said, "In the quiet of American conscience, we know that deep, persistent poverty is unworthy of our nation's promise. And whatever our views of its cause, we can agree that children at risk are not at fault." As we have seen, this poverty has only grown deeper and more persistent since the President took office. But it is not too late for the administration to rise above its own current legacy of inequality. President Bush is still correct to say that poverty is wrong and unworthy of America's promise. Now is his opportunity to translate that assertion into action.

Our nation would be making a terrible mistake if we rebuilt the destroyed buildings and repaired the damaged levees caused by Hurricane Katrina without addressing the underlying foundation of poverty that made so much of the suffering worse and unfair to those at the bottom. Dr. Martin Luther King, Jr. foresaw these kinds of choices when he said, "Ultimately a great nation is a compassionate nation . . . One day we will have to stand before the God of history and we will talk in terms of things we've done. Yes, we will be able to say we built gargantuan bridges to span the seas, we built gigantic buildings to kiss the skies…It seems that I can hear the God of history saying, 'That was not enough! But I was hungry, and ye fed me not. I was naked, and ye clothed me not. I was devoid of a decent sanitary house to live in, and ye provided no shelter for me. And consequently, you cannot enter the kingdom of greatness. If ye do it unto the least of these, my brethren, ye do it unto me.'"

The God of history is watching our nation right now. How will we answer?

Marian Wright Edelman

Table of Contents

Mission
One Day in the Life of America's Children
Dedication

Foreword . . . . **iv**

Chapter 1 Family Income and Jobs: Raising Children *Out* of Poverty **1**
- The Poor Get Poorer-and More Numerous
- Relative Losses: Families Face Declining Incomes and Rising Costs
  - Inequality is Intensifying
  - Family Incomes Are Declining and Wage Growth is Weak
- Wages and Benefits: Missed Opportunities to Support Working Families
  - Families Struggle to Pay the Bills
  - Anemic Jobs Recovery Leaves Many Families Behind
  - Jobs Don't Always Lift Families Out of Poverty and Provide Economic Security
  - Low-Wage Jobs Lack What a Family Needs to Succeed
- Education and Training: A Path Out of Poverty
  - Eligibility for Unemployment Assistance is Limited
- Safeguarding Families: The Role of Government Benefits in Family Well-Being
- Welfare Reform: A Path to Employment or Increased Poverty?
- Has TANF Helped People Find Jobs?
- Food Insecurity is Rising
  - TANF Needs a New Focus
  - Federal Housing Policy Compounds the Problem
- Earned Income Tax Credits: A Powerful Anti-Poverty Program
- Affordable Housing Is Basic to Families' Well-Being
- Recommendations for Moving Forward

Chapter 2 Child Health: Fighting Poverty and Poor Health **31**
- The Poor Health Burden on Low-Income and Minority Children
  - Poverty and Health
  - Race/Ethnicity and Health
- Disparities in Prenatal Care, Infant Health, and Immunizations
  - Prenatal Care
  - Infant Mortality and Birthweight
  - Smoking and Substance Abuse
  - Immunization
- Disparities in Childhood Lead Poisoning
- Disparities in Prevalence and Severity of Childhood Asthma
- Disparities in Access to Dental Care
- Disparities in Obesity
- Disparities in Health Insurance Coverage

Trends in Children's Coverage
Demographics of Uninsured Children
Connecting the Dots: Children's Health Needs and Public Policy
The Positive Role of Government in Improving Children's Health
Investing in Child Health
Cost-Effectiveness of Health Coverage
Children's Health and the Nation's Economic Well-Being
Recommendations for Moving Forward

Chapter 3 Early Childhood: Critical Years, Critical Investments 59
Sensationalism Overlooks the Real Story: Unmet Need
Early Childhood Lays the Foundation
Head Start Works by Focusing on the "Whole Child"
Assessing the National Reporting System (NRS)
Head Start Funding and Teacher Credentials
America's Primary, Yet Dwindling, Source of Child Care Funding: The Child Care and Development Block Grant (CCDBG)
Tight State Budgets Have a Negative Impact on Child Care Policies
The Quality of Child Care Varies Greatly
Research Shows That High Quality Child Care Helps Children
School-Age, After-School, and Out-of-School Care
21st Century Community Learning Centers (CCLC)
Sustainability
Research Shows That Quality After-School Programs Help Children
Prekindergarten: Patchwork of Programs, Not Universal
Inadequate Resources
Quality Matters in School-Age Care
Lack of Affordable Care
Costs Versus Benefits of Child Care and Early Education
Recommendations for Moving Forward

Chapter 4 Education: The Path Out of Poverty 87
No Child Left Behind: High Schools at the Forefront
Education's Role in Lifting Children Out of Poverty
Dropping Out of School and Into Poverty
Education as an Economic Imperative
Education and Earnings
Disparities: Educational Disadvantage Disproportionately Affects Low-Income and Minority Students
The Achievement Gap Persists
Segregation and Inequities
Access to Quality Teaching
Access to Advanced Curricula
School Facilities
The Digital Divide
Access to School Counseling

Funding Gaps
Federal Funding
State/Local Budget Cuts
Policies That Negatively Impact Students of Color
High Stakes Tests
Automatic Grade Retention
School Discipline
Zero Tolerance
Criminalization of School Behavior
Recommendations for Moving Forward

Chapter 5 Child Welfare: Poverty and Families in Crisis 113
A Look at the Past Year
Who are the Children in Families in Crisis?
Children and Families Victimized by Violence
Children Who Are Abused and Neglected
Children Who Are Exposed to Domestic Violence
Children Separated or at Risk of Separation from Their Families
Children in Foster Care
Children Whose Parents Are Incarcerated
Children Raised by Relatives
Youth Leaving Foster Care
Children and Families with Special Needs
Children with Unmet Mental Health Needs
Children with Parents with Mental Health and Substance Abuse Problems
Homeless Families
Promoting Effective Strategies for Children and Families in Crisis
Supporting Families and Preventing Crises
Home Visiting
Early Care and Education
Homelessness Prevention
Engaging Families Early
Family Group Decision Making
Family to Family
Contact with Incarcerated Parents
Meeting the Special Needs of Children in Foster Care and Their Families
Comprehensive Family Treatment
Mental Health Treatment for Parents and Children
Providing Permanent Families for Children
Reunification
Adoption
Subsidized Guardianship
Kinship Navigator Program
Other Post-Permanency Supports and Connections
Recommendations for Moving Forward

Chapter 6 Youth Development: Poverty and the Pipeline to Prison 145
A Look at the Past Year
Poor Children and Delinquency
Risk Factors Accumulate Over Time
The Juvenile Justice System
Children are Abandoned to the System
Children are Abandoned Within the System
The Failure to Prioritize Prevention
Failures in Funding Priorities
Failures in Policy Priorities
Facts—Not Hype—Should Inform Response to Violence
The Benefits of Prevention and Intervention
Evidence-Based Approaches That Work
Programs Proven Successful
Effectively Reducing and Preventing Community Violence: The "Boston Miracle"
Successful Juvenile Justice System Reforms
Providing a National Model
Pursuing Detention Alternatives
Reducing Disproportionate Minority Confinement
Addressing the Unique Needs of Girls in the Juvenile Justice System
Recommendations for Moving Forward

CDF Regional, State and Local Offices

Chapter One

Family Income & Jobs

Raising Children *Out* of Poverty

Almost 37 million people living in America were poor in 2004, 13 million of them children. Real incomes are falling and poverty in the United States is more prevalent now than in the late 1960s and early 1970s, having escalated rapidly since 2000.

For every five children who have fallen into poverty since 2000, more than three fell into "extreme poverty," a term describing families living at less than one-half of the poverty level. This means that these families had to get by on less than $7,412 a year, or $20 a day.

More than seven out of every ten poor children in 2004 lived in a family with at least one employed relative. Working hard and playing by the rules is not enough to lift families out of poverty. For example, even if a parent with one child works full-time at the federal minimum wage, which has not been raised since 1997, the family still lives in poverty.

"The future promise of any nation can be directly measured by the present prospects of its youth."

—President John F. Kennedy, February 14, 1963

"We haven't reduced economic risks. We've simply redistributed them from the economy as a whole to individual households."[1]

—Harvard economist Martin L. Weitzman

Poverty kills. It also maims and stunts the growth and eclipses the dreams of hundreds of millions of children around the world. Yet the fact that more than 20,000 people worldwide will die in extreme poverty today will not make tomorrow's headlines.[2] Similarly disregarded is the irony that America's poorest residents continue to be worse off than those of almost any other country in the developed world.[3]

Poverty in America is a political problem, caused less by a lack of resources than by a failure to come to terms with reality. It is universally understood that food, shelter, health care, and other basics are crucial to the well-being of children and families. What is largely ignored by our leaders, the news media, and the public, however, is the fact that millions of families do not have adequate incomes to provide these basic necessities.

A childhood spent in poverty can have negative impacts on an individual's entire life. Children living in families that are poor are more likely than children living in other families to be exposed to inadequate education, inadequate or absent healthcare, hazardous housing, and poor nutrition. These multiple barriers associated with poverty build upon one another and unjustly deprive children of the opportunity to reach their full potential as parents, employees, and citizens. Children who grow up in poverty are more likely to become teen parents and, as adults, to earn less, to be unemployed more frequently, and to raise their own children in poverty.

Parents with low levels of education and skills continue to lag behind in employment and wages. Many government benefits for low-income families have dwindled, and current federal and state budget shortfalls will likely make even fewer resources available in the future. The typical household's income has fallen or remained stagnant for five consecutive years, and certain groups—most notably minorities, young and single parents, and people with disabilities—face particular difficulties trying to earn enough to support their families.

Poverty Affects All Americans

A majority of Americans will experience poverty at some point during their adult lifetime.

- At age 20, more than one in 10 Americans live in poverty.
- By age 40, more than one in three Americans have experienced at least one year of poverty during their early adulthood.
- By the time Americans have reached age 75, almost three in five have passed a year in poverty.
- One in three will experience a year of extreme poverty (below 50 percent of poverty) by the time they are 75 years of age, and more than three out of four will experience a year below 150 percent of poverty by the time they're 75.
- Between age 20 and age 65, more than two out of three Americans participate in some public assistance program and two in five receive some type of public assistance for a total of five years or more.

Source: Mark Robert Rank, *One Nation, Underprivileged* (Oxford University Press, 2004).

The Poor Get Poorer—and More Numerous

The failure to implement sound economic policies and maintain an adequate safety net at a time when the market has failed to provide enough job opportunities is evident in the poverty data released by the U.S. Census Bureau.

After falling for seven consecutive years during the 1990s, child poverty rose for four years in a row to 13 million in 2004; in all, 37 million Americans live below the poverty line.[4] Child poverty has increased by over 1.4 million children since 2000, accounting for more than a quarter of the 5.4 million people overall who have fallen into poverty. More than one out of every six American children were poor in 2004. By race and ethnicity, one in three Black children, almost three out of 10 Latino children, one in 10 Asian children, and more than one in 10 White, non-Latino children were poor.[5]

Even more disturbing than the continued rise in child poverty and the growing portion of the poor who are children is the striking increase in the number of children living in extreme poverty. Extreme poverty means families are living below one-half of the poverty level. That translates into a family of three having to support itself on less than $7,610 a year, or about $20 a day. From 2000 to 2004, the number of children in extreme poverty grew almost twice as fast as the number of children in poverty overall, 20 percent compared to 12.4 percent.[6] For every five children who have fallen into poverty since 2000, more than three fell into extreme poverty.

Poverty rates for children in female-headed households continue to be alarmingly high. More than two in five children in female-headed households are poor; more than half of those live in extreme poverty. Black and Latino children in single female households face particularly high rates

Family Income – Table 1

In the first four years of this century, the number of children living in extreme poverty increased by 20 percent.

Poverty and Extreme Poverty Among Children, 2000-2004 (Numbers in thousands)

	2000	2004	Percent Increase
Children in Poverty			
All Children	11,587	13,027	12.4%
Black Children	3,581	3,780	5.6
Latino Children*	3,522	4,102	16.5
White, Non-Hispanic Children	4,018	4,507	12.2
Children in Extreme Poverty			
All Children	4,634	5,561	20.0
Black Children	1,581	1,908	20.7
Latino Children*	1,168	1,459	24.9
White, Non-Hispanic Children	1,650	1,923	16.5

* The total number of Latino children in poverty grew very rapidly between 2000 and 2004; the number of Black children increased less dramatically. The growth in poverty among Black children was entirely due to the increase in poverty and extreme poverty rates, whereas the increase in the number of poor Latino children was due primarily to the growth in the size of the total group, while their poverty rates stayed the same.

Source: U.S. Department of Commerce, Bureau of the Census, March 2001 and March 2005 Current Population Survey. Poverty figures come from Historical Poverty Tables - People, Table 3, at <http://www.census.gov/hhes/www/poverty/histpov/hstpov3.html>. Extreme poverty figures come from Detailed Poverty Table POV01 for 2004 <http://pubdb3.census.gov/macro/032005/pov/new01_050.htm> and Table 2 for 2000 <http://pubdb3.census.gov/macro/032001/pov/new02_000.htm>. Calculations by Children's Defense Fund.

Note: The Census Bureau revised the weights used for its 2000 estimates, but has not revised its Detailed Poverty tables that are the source of the 2000 extreme poverty estimates. Estimates contained in the Historical Poverty Tables have been revised with the new weights.

of poverty; over half of Latino children and nearly half of Black children, compared to the still high rate of more than three in 10 White children, are poor.

This worsening reality not only hurts children and families; it dims our prospects as a nation. Impressive progress was made between 1992 and 2000, when close to 4 million children were lifted out of poverty. Since 2000 this positive trend has sharply reversed, and more than 1.4 million additional children have fallen into poverty.[7] If poverty had continued to decline between 2000 and 2004 at the same annual rate as it did between 1992 and 2000, the likelihood of a child being poor in America would have been reduced by an additional 13.7 percent. That means that, instead of seeing nearly one and a half million children fall into poverty over four years, 1.9 million more children would have escaped it.

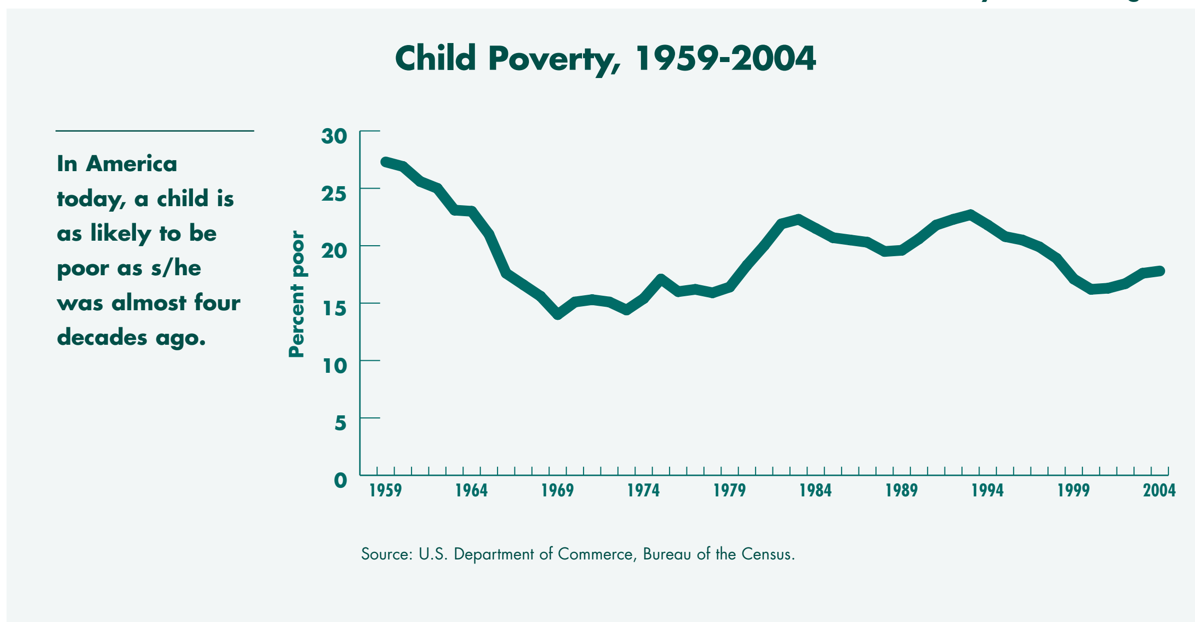
Relative Losses: Families Face Declining Incomes and Rising Costs

Inequality Is Intensifying

There are more children living in poverty today than there were 38 years ago even though the current value of the national wealth available per person is more than twice what it was at that time.[8] The continued growth of our society's material resources has provided a tremendous opportunity to alleviate childhood poverty, promote economic justice, and ensure that the basic needs of all Americans are met. Sadly, our nation's growing bounty is not being justly shared by all. America has failed to take full advantage of its growing wealth by making the necessary public investments to protect low-income families and children from economic insecurity and material deprivation.

Over the past three decades, inequality in the United States has intensified dramatically. Much of the nation's new wealth has gone to those with the highest incomes, erasing the equity gains of the post-World War II years.[9] The richest 5 percent of households received more than $1 out of every $5 in total income in 2004.[10] On average, the income of the top 20 percent of households was about 15 times greater than that of the households in the bottom 20 percent—the widest gap on record based on an analysis of U.S. Census Bureau figures.[11] What is more, the average after-tax income of the richest 1 percent of households was 50 times that of the bottom 20 percent of households.[12] These wealthy households have seen their after-tax income increase by 140 percent since 1979—65 times more than the gains seen by the typical household and 370 times the average income gain for the 22.2 million American households with the lowest incomes.[13]

Family Income – Figure 1



Family Income – Table 2

Black and Hispanic children are about three times as likely to be poor as non-Hispanic White children.

Poor Children in America, 2004, 2003, and 1973
Persons Younger than 18

	Number Poor (in thousands) 2004	Percent Poor 2004	Percent Poor 2003	Percent Poor 1973
All persons younger than 18	13,027	17.8%	17.6%	14.4%
White[1]	8,685	14.9	14.4	n/a
Black[1]	4,049	33.2	33.6	n/a
Asian and Pacific Islander[1]	334	9.8	12.7	n/a
Hispanic (may be any race)[2]	4,102	28.9	29.7	n/a
Non-Hispanic White[2]	4,507	10.5	9.8	n/a
South	5,202	19.6	20.3	19.7
All other regions	7,825	16.8	16.1	11.6
Central city[3]	n/a	n/a	26.1	20.4
Suburb[3]	n/a	n/a	12.3	7.8
Rural (nonmetropolitan)[3]	n/a	n/a	20.1	16.6
Related to head of household	12,504	17.3	17.2	14.2
White[1]	8,254	14.4	14.0	9.7
Black[1]	3,959	32.9	33.2	40.6
Asian and Pacific Islander[1]	329	9.7	12.4	n/a
Hispanic (may be any race)[2]	4,000	28.6	29.4	27.8
Non-Hispanic White[2]	4,193	9.9	9.3	n/a
In female-headed family	7,146	41.8	41.7	52.1
All other family types	5,358	9.7	9.6	7.6
Any family member works	8,907	13.1	12.8	n/a
Full-time year-round	4,289	7.5	6.8	n/a
Head of family works	7,027	11.9	12.1	8.7
Full-time year-round	3,008	7.0	6.6	4.1
Under age 6	4,737	19.9	19.8	15.7
Ages 6-17	7,723	16.0	15.9	13.6
Comparison: Adults 18-64	20,514	11.3	10.8	8.3
Seniors 65+	3,457	9.8	10.2	16.3

[1] Starting with poverty data for 2002, the Census Bureau permits persons to choose more than one race; racial groups shown here may overlap.
[2] Persons of Hispanic origin may be of any race. White non-Hispanic means White alone (no other race) and not of Hispanic origin.
[3] Data by metropolitan area status are not available for 2004.

n/a — Not available.

Source: U.S. Department of Commerce, Bureau of the Census, *Current Population Reports,* Series P-60, Nos. 98, 226, and 229, and Historical Poverty Tables – People, Table 20 <http://www.census.gov/hhes/www/poverty/histpov/hstpov20.html>. Calculations by Children's Defense Fund.

The trend in inequality is further exemplified by the explosion in the average compensation of chief executive officers (CEOs). The Economic Policy Institute (EPI) reports that the average CEO compensation in 2003 was 185 times that of the typical worker, compared to 24 times as much in 1965.[14] According to a study by Pearl Meyer & Partners, in 2004, the CEOs of major companies received an average of $9.97 million in total compensation, or more than $38,000 for each day of work.[15]

In addition to this growing income inequality, an increasing share of total national income has been going to corporate profits while a shrinking portion is going to incomes and wages. This means

that workers at the bottom of the income distribution are receiving a smaller share of the shrinking portion of national income that goes to employees' wages. The share of national income going to the wages and salaries of employees is lower than it has been in any year since the data started being collected in 1929. At the same time, the share of income going to after-tax corporate profits is now higher than it has been for the past 75 years.[16] This trend has intensified recently as corporate profits have seen a strong rebound following the 2001 recession. By the end of 2004, the *Financial Times* reports, profits of U.S. companies had soared to a record $1.27 trillion, or 10.6 percent of GDP—a level only surpassed once since 1968.[17]

Family Incomes Are Declining and Wage Growth Is Weak

It is not only the *share* of national income that goes to those at the middle and bottom of the income ladder that is declining, but also its real value. After peaking in 1999, median household incomes fell for five years in a row. Incomes have been falling or stagnant among all groups, and minority households are seeing the equity gains of the 1990s slip away. Median incomes have fallen to about $34,000 for Latino families and $30,000 for Black families—70 and 62 percent of White family income, respectively.[18] The median earnings of those who worked full-time, year-round also lost ground across the board over the last year. The slight gain in earnings equity for women since 2003 that the data reveal is entirely attributable to the fact that the earnings of men declined more rapidly than those of women, hardly a sign of progress. A typical woman who works full-time, year round still makes less than 77 cents for every dollar earned by a man with similar work effort.[19] For households in the bottom 20 percent, average incomes have fallen for five years in a row while those in the top 20 percent have seen their incomes rise for the past two years. Since 2000, incomes fell by 10 percent for younger households headed by someone 15 to 24 years old and by 7 percent among households headed by someone aged 25 to 34.[20]

These persistently negative trends in incomes, particularly for the households that already have the least, only tell one part of the story. According to an analysis by the Joint Economic Committee, in 2000 there was a notable shift in the distribution of total earnings growth for those workers fortunate enough to retain full-time, year-round employment. From 1994 to 2000, the bottom 10 percent of workers saw their real earnings grow at an average annual rate of 1.6 percent.[21] This rate was higher than that of the typical workers' earnings at 1.2 percent and only somewhat slower than the rate of increase for the richest 10 percent of workers, whose earnings grew at an average annual rate of 1.9 percent. By contrast, from 2000 to 2004, the bottom 10 percent of workers saw their wages shrink at an annual rate of 0.3 percent a year, while the wages of the highest earning individuals increased at an annual rate of 0.9 percent.

In the meantime, prices for goods and services have continued to increase at an accelerated pace since 2003.[22] The general effect is that families cannot afford the same living standard as before on their current wages. A close look reveals a decline in wages in 2004 that was more severe among those at the bottom of the earnings scale, falling by 1.3 percent for the bottom 10 percent of workers and actually increasing by 1 percent for the richest 5 percent.[23] By education level, all workers except those with advanced degrees saw their hourly wages fall in 2004. A bulk of the loss was concentrated among women with a high school education, or less than a high school education; a decrease of 1.1 percent and 1.4 percent, respectively.[24]

Wages and Benefits: Missed Opportunities to Support Working Families

Eight years have passed with no action by Congress to raise the minimum wage and help low-wage workers better support themselves and their families. As a result of the stagnating minimum wage, a full-time minimum wage paycheck—which would have kept a family of three above the poverty threshold until the mid 1980s—provides an annual income that is not even three-quarters of the poverty line in 2004. If the minimum wage had increased as quickly as CEO pay since 1990, today it would be $23.03 per hour, more than four times

Family Income – Table 3

State Median Income for a Four-Person Family, FY 2006

State	Income	State	Income
Alabama	$ 55,448	Montana	$ 49,124
Alaska	72,110	Nebraska	63,625
Arizona	58,206	Nevada	63,005
Arkansas	48,353	New Hampshire	79,339
California	67,814	New Jersey	87,412
Colorado	71,559	New Mexico	45,867
Connecticut	86,001	New York	69,354
Delaware	72,680	North Carolina	56,712
District of Columbia	56,067	North Dakota	57,092
Florida	58,605	Ohio	66,066
Georgia	62,294	Oklahoma	50,216
Hawaii	71,320	Oregon	61,570
Idaho	53,376	Pennsylvania	68,578
Illinois	72,368	Rhode Island	71,098
Indiana	65,009	South Carolina	56,433
Iowa	64,341	South Dakota	59,272
Kansas	64,215	Tennessee	55,401
Kentucky	53,198	Texas	54,554
Louisiana	50,529	Utah	62,032
Maine	59,596	Vermont	65,876
Maryland	82,363	Virginia	71,697
Massachusetts	82,561	Washington	69,130
Michigan	68,602	West Virginia	46,169
Minnesota	76,733	Wisconsin	69,010
Mississippi	46,570	Wyoming	56,065
Missouri	64,128		

Source: U.S. Department of Health and Human Services, Administration for Children and Families, "State Median Income Estimate for a Four-Person Family (FFY 2006)," *Federal Register*, Vol. 70, No. 32 (Thursday, February 17, 2005), pp. 8102-8104.

STORIES FROM THE STATES

Two Incomes and Still Too Little

Tabitha and her husband are raising three sons, ages 8, 6, and 20 months, near Columbus, Ohio. They are both employed; Tabitha works at check-out at Value City, while her husband works at Subway. Both earn the federal minimum wage, $5.15 an hour, for monthly earnings of $1,785. Still, their annual earnings of $21,424 leave them below the poverty line of $22,543 for a family with two parents and three children.

the current minimum wage of $5.15 an hour.[25] The annual income of an individual working full-time, with two children, at the $5.15 an hour minimum wage leaves them $4,500 below the 2004 poverty threshold.

Some 9.7 million children live in a household where at least one worker earns between the current minimum wage and $7.25 per hour, the minimum wage advocated by some Members of Congress in 2005.[26] Furthermore, 1.2 million of these children live in households where two or more workers earned less than the proposed minimum wage.[27] Many of the 13 million American children living below the poverty line would benefit from such an increase.

The current earnings of a single parent working full-time at minimum wage covers only 40 percent of the estimated cost of raising two children. This is down from 48 percent in 1997 when the minimum wage was last raised. If the minimum wage were raised to $7.25 per hour, it would cover 56 percent of the costs of raising two children, a significant improvement for working families. One out of three minimum wage earners is the sole income earner in families with children that would be affected by such a change.[28] This increase would help our neediest citizens most, as the lowest paid 40 percent of households would receive 60 percent of the increase in earnings.[29]

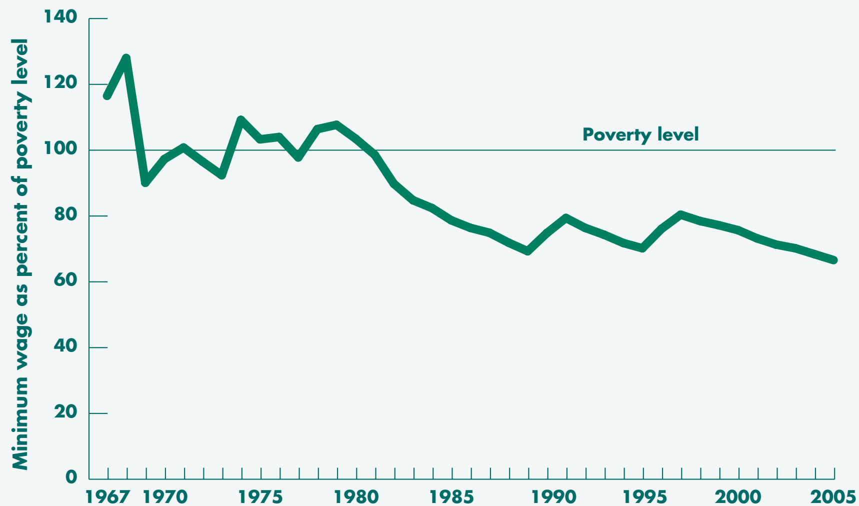
Families Struggle to Pay the Bills

Adequate incomes are necessary to cover the rising costs of raising a family. When incomes fail to keep pace with rising health care, housing, transportation, and energy costs, parents are forced to make impossible choices that can be detrimental to children and weaken families. For example, research has shown that families who cannot pay their home energy bills not only struggle to keep family members warm, but also have agonizing problems keeping them fed and healthy.[30] The

Family Income – Figure 2

Minimum Wage[1] vs. Poverty Level[2], 1967-2005

A parent of two children who works full-time, year-round at the federal minimum wage does not earn enough to lift his/her family out of poverty.



[1] Minimum wage is calculated for full-time, year-round employment (2080 hours per year). The federal minimum wage ($5.15 per hour) is used; some states have a higher minimum wage.

[2] Poverty level for a three-person family

Source: U.S. Department of Labor and U.S. Department of Health and Human Services. Calculations by Children's Defense Fund.

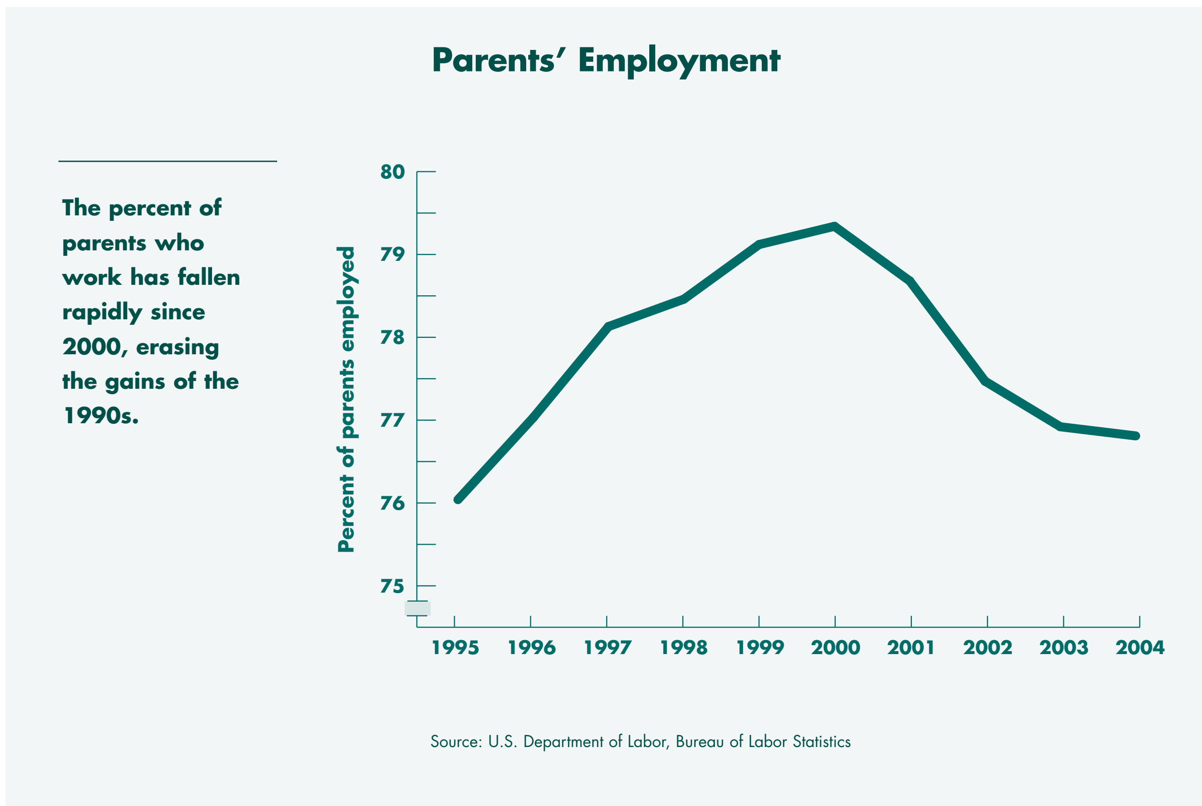
National Energy Assistance Directors' Association reported that the unaffordability of energy bills has a serious long-term impact on families: 22 percent of Low-Income Home Energy Assistance Program recipients[31] went without food for at least one day, 38 percent went without medical or dental care, 30 percent went without filling a prescription or taking the full dose of a prescription medicine, and 21 percent became sick because their home was too hot.[32] As energy prices continue to climb, low-income families are seeing their home energy and transportation costs take up a larger share of their budgets, limiting expenditures on other necessities.

When earnings fail to keep pace, families become more and more indebted as they struggle to meet these rising costs. According to a recent study, between 1989 and 2001, the credit card debt of very low-income families (earning less than $10,000 per year) increased at a staggering rate of 184 percent.[33] The study attributes this dramatic rise in debt to structural economic factors, including stagnant growth in real income among low- and moderate-income families in the face of escalating housing and health care costs.[34]

Anemic Jobs Recovery Leaves Many Families Behind

In addition to falling wages and salaries, a fundamental and related cause of the decline in family incomes and the growth in poverty since 2000 is joblessness. Unemployed workers and their families are the most directly impacted when the economy loses jobs or fails to generate sufficient new jobs for an expanding population. The portion of unemployed parents with children younger than 18 who were out of work for six months or longer almost doubled from 2000 to 2004—rising from 11.9 percent to 21.6 percent.[35] The more than half a million parents who are currently experiencing long-term unemployment—those who have been unemployed for more than six months—care for about one million children.[36]

Family Income – Figure 3



Much of the recent fall in the unemployment rate can be attributed to a falling percentage of the working aged population that is participating in the labor force, as opposed to expanding job opportunities. As a result, even though the unemployment rate is relatively low by historical standards, the portion of the working aged population that is employed has consistently declined since 2000.[37] Also, the unusually long period of job losses and weak employment gains characterized by the three years following the 2001 recession saw an unprecedented number of workers who stopped actively looking for jobs and, hence, are not accounted for in the unemployment rate.[38] The Bureau of Labor Statistics (BLS) reports that in 2004, 22.9 percent of parents with children under 18 did not work, significantly up from the most recent trough in 2000 of 20.6 percent.[39] A 2005 study shows that there are up to 5.1 million jobless men and women who would work if a job were available, but that are not counted as officially unemployed."[40]

In addition to the high number of workers who have dropped out of the labor force due to the lack of adequate employment opportunities, many workers are compelled to work fewer hours per week or fewer weeks per year than they would if there were sufficient opportunities. Rates of underemployment are higher than they have been in nearly a decade.[41] Twenty-eight percent of children in low-income families have a parent who either works full-time for part of the year or part-time. Over 40 percent of these low-income working parents reported that they could not find full-time and/or full-year work.[42] Hence, despite the overall recovery of the U.S. economy, and steady employment growth throughout 2004, many families continue to struggle to find work with the hours, stability, and wage rates necessary to adequately support their families.

Jobs Don't Always Lift Families Out of Poverty and Provide Economic Security

Low-wage work erodes our basic values of personal responsibility, hard work, and perseverance and sends the message that work does not pay.[43] About one in every four workers in the U.S. earned poverty-level hourly wages in 2004.[44] The result of so many low-paying jobs is that nearly 39 million Americans, including 20 million children, are members of low-income working families—with barely enough money to cover basic needs like housing, groceries, and child care.[45]

In an economic downturn, low-skilled, low-wage workers who are new to the labor force are particularly vulnerable to layoffs, reduced work hours, and periods of unemployment. Workers are much more likely to be classified as working poor if they have not achieved higher levels of education. According to the BLS, a worker with less than a high school education is more than eight times more likely to be classified as working poor than a worker with a college education.[46] Furthermore, it is projected that job growth between 2000 and 2010 will continue to be fastest for occupations that require a postsecondary credential (a vocational certificate or an associate's degree or higher), and the income gap is expected to continue to grow between those who have postsecondary education and those who do not. This means that low-skilled workers will likely continue to struggle to make ends meet in the future.[47]

Weekly earnings for full-time working women continue to lag behind those of men.[48] While employed women work only an hour less on average than men, according to the BLS, they spend an hour more per day doing household activities and caring for household members, and spend twice as much time providing child care than do their male counterparts. To best fight poverty, we must recognize that the majority of our nation's poor—including the working poor—are women, and adapt solutions to fit their needs. According to the BLS, women who maintain families were more than twice as likely to be among the ranks of the working poor as their male counterparts.[49] If women had higher paying jobs and equal pay for equal work, they could lift their children out of poverty and bring economic stability to their families. The broad and persistent disparities between Blacks and Latinos and their White counterparts hold true where working poverty is concerned as well. Although about seven in 10 workers in poverty were White in 2003, Black and Latino workers remained more than two times as likely to be counted as working poor.[50]

Low-Wage Jobs Lack What a Family Needs to Succeed

Low earners are most likely to advance in the labor market when they have access to higher-wage employers who also provide on-the-job training and career ladders. Unfortunately, low-income and especially minority workers living in poor neighborhoods often have limited access to such firms in their local labor markets due to few transportation options and limited information about or contacts in that market. Many parents who leave welfare for work do so for jobs that pay low wages and do not offer health and other benefits. Nor do they tend to move up the job ladder much over time. Thus, most former welfare recipients continue to be poor or near poor, even after entering the labor market, and their prospects for escaping poverty or near-poverty in the foreseeable future seem low.[51] Furthermore, a recent Brookings Institution report found that Black workers were more likely to be isolated from potential employment opportunities than their White counterparts in metropolitan areas with greater decentralization of employment or job sprawl.[52]

In order to remain competitive or secure higher profits, many employers have chosen the low road of freezing wages, reducing benefits, downsizing, using temporary workers, or outsourcing jobs to another part of the country or abroad. Individuals with jobs that provide few benefits such as health insurance and paid leave are more apt to miss work and to have reduced earnings or to lose their job due to family emergencies, disruptions in child care, and transportation problems. Workers in jobs with benefits such as health care and paid vacation are more likely to stay employed. One report found that workers in full-time jobs that provide health insurance have an 80 percent chance of working 18 consecutive months; workers without insurance have a 52 percent chance of staying employed that long.[53]

Data from the BLS show that almost half (47 percent) of private sector workers do not have paid sick leave. A study by the Institute for Women's Policy Research showed that 59 million workers lack paid sick leave.[54] Inadequate paid sick leave has consequences: Workers show up at work when they are not healthy, spreading illness to other workers, extending their own period of illness, and impairing their productivity on the job. Parents who must stay home when they are sick or to care for a sick child lose essential earnings and are at risk of being fired; children take longer to recover from illness and medical emergencies if their parents cannot spend time helping them recuperate. When paid and authorized sick leave is not available, working parents are placed at greater risk of losing earnings or even their jobs. Some of these workers will inevitably have to rely on unemployment, welfare, or other forms of public assistance.[55]

Eighty-nine million workers in the U.S. currently have fewer than seven days paid sick leave. In addition, a very large share of the workforce (70 percent, or more than 85 million workers) lack paid sick leave to take time off to care for sick family members including young children.[56] While many families cannot reliably count on paid sick leave, working poor families are at highest risk. A study found that 74 percent of working poor parents *did not* consistently have paid sick leave over a five-year period compared to 43 percent of those above 200 percent of the poverty line.[57]

Often, those who are lucky enough to have paid sick leave are not allowed to use it to care for a sick family member. Studies show that about half of working mothers reported they did not get paid when they stayed home to care for their sick children. Yet parental availability is critical for children's physical and mental health. Fifty-eight percent of young parents said they continued to go to work when their children were sick, and of the 42 percent who were able to stay at home with their sick children, more than half said they could do so because they received some type of paid leave. Thirty-four percent of parents reported that caring for their sick children led to difficulties at work, 12 percent said it led to lost pay, and 13 percent to loss of promotions or jobs.[58]

Education and Training: A Path Out of Poverty

"Quality education and training are critical to the success of our students, communities, and the economy."

The U.S. Chamber of Commerce[59]

Education and earnings are inextricably linked. Millions of Americans who work full-time find they cannot pay for their basic living expenses let alone afford to make investments in their future. The likelihood of being classified as working poor greatly diminishes as workers achieve higher levels of education. Children with full-time employed parents are increasingly likely to be low-income if their parents have not obtained a high degree of educational attainment. Eighty-two percent of children whose parents never finished high school are low-income, compared to 54 percent of children whose parents had a high school degree and only 22 percent of children whose parents had some college.[60] These percentages decrease only slightly when the number of hours worked is taken into account. Seventy-three percent of children whose parents worked full-time year-round but who did not finish high school were low-income, compared to two out of five (43 percent) children whose parents had a high school degree and just over one in seven children (15 percent) whose parents had some college.[61]

An adult aged 25 and older who worked full-time, year-round, typically earned $37,542 in 2004. When working adults' earnings are disaggregated by education, gaps become evident. Workers with a high school degree had earnings of about $31,000, compared to median earnings of more than $50,000 for those with a bachelor's degree.[62] Workers with low educational attainment are not only less likely to earn a livable wage, they are also less likely to find a job.

- In 2000, 87.8 percent of workers with a college degree were employed; this is 12 percent higher than the employment rate of persons whose highest degree was a high school diploma, and 40 percent higher than the employment rate of persons with less than a high school education.[63]
- Among women, the differences were even greater—82 percent of those with a college degree were working, an increase of 15 percent compared to those with a high school education and an increase of about 67 percent from those with less than a high school education.[64]
- A national study of unemployment spells between 1996 and 1999 found that those with less than a high school education were unemployed 47 percent longer than college-educated workers. Those whose highest degree was a high school diploma were unemployed 23.5 percent longer than those with at least some college.[65]

Having an advanced education has become more important over the last 30 years, as earnings gaps between workers with and without a college education have grown wider. In 1975, the average male high school graduate earned 66 cents for every dollar earned by someone with a bachelor's degree.[66] In 2003, male high school graduates earned only 53 cents for every dollar made by a male with a bachelor's degree.[67]

Nationally, almost 28 million adults do not have a high school degree.[68] Employers are reporting a shortage of highly qualified applicants with post high school training. From a business perspective, America's economic success depends on the business community's ability to recognize and use diverse human resources and the talents of workers. Sixty-five percent of non-college jobs require or prefer specific previous experience, 40 percent require training or skill certification, and 50 percent require the applicant complete a skills test.[69] A recent National Association of Manufacturers survey found that, even at the onset of the recent recession, over 80 percent of manufacturers reported a shortage of highly qualified applicants with specific educational backgrounds and skills.[70] Job training and education have been proven to decrease the shortage and assist low-income working families in increasing their wages. According to the National League of Cities, 87 percent of municipalities using job training to assist low-income working families find it an effective strategy.[71]

Income and race greatly influence one's chances of going to college. The rapid increase in college tuition costs, which have risen faster than both inflation and family income, deny many young adults the opportunity to reap the social and economic benefits of higher education. Financial barriers prevent 48 percent of college-qualified

high school graduates from low-income families from attending a four-year college; 22 percent of such graduates will not attend any college at all.[72] The racial gap regarding who goes to college has also widened in the last 30 years.[73] Graduation rates also vary by race, with nearly double the number of White students graduating with a bachelor's degree compared to Black and Hispanic students.[74]

In spite of the evidence that education and training lead to economic advancement, recent federal policies make it harder for low-income Americans to obtain the education and training they need to move forward in today's economy. In 2003, the average adult in a Workforce Investment Act funded program increased his or her total earnings by $3,260 over the first six months after graduating from the program.[75] Unfortunately, the federal government's investments in workforce development programs over the past two decades have failed to keep pace with the increasing demand for skilled workers. The range of workforce training programs—particularly those targeting low-income adults and youth—that have seen significant cuts in recent years have translated into significant lost opportunities both for workers and for the businesses that want to hire them.[76]

Eligibility for Unemployment Assistance Is Limited

Workers whose incomes fall below the poverty threshold typically experience one or more of the three main labor market problems: unemployment, low earnings, and involuntary part-time employment.[77] Unemployment Insurance (UI) provides an essential support to workers who lose their jobs and is particularly important during times of economic downturn. It helps to prevent poverty by providing a cash payment to eligible workers almost immediately after they become unemployed, helping them to continue to make ends meet in the absence of their lost income. By providing workers the income they need to keep their homes while they find a new job, UI offers workers, their families, communities, and the econ-

WIA One-Stop Centers Do Work

Established by the Workforce Investment Act (WIA), first passed in 1998, One-Stop centers deliver employment-related training and services. One-Stop centers are an essential community institution serving families and youth throughout the country, especially those in areas suffering from high poverty and high unemployment. At Arapahoe/Douglas Works! in Aurora, Colorado, job seekers gain the skills necessary for employment in local industries, such as the healthcare industry. The organization works with local Chambers of Commerce and economic development entities to engage and serve employers, ensuring that job training and placements are relevant and appropriate for the local job market. This leads to a successful job-training program for workers while meeting the employment needs of local industry.

The commitment of Arapahoe/Douglas Works! to continuous community partnerships is a key element of its success. The center goes beyond basic job training services by raising additional funding and collaborating with other organizations to expand services. Arapahoe/Douglas Works! connects clients to basic needs and support services, including child support, food, health care, and housing. This is essential to the success of the job training and workforce development program; job seekers need to be secure in their health and human needs to be successful employees. Additional funding also provides for workforce development services specifically for at-risk students within the Youth Works! program. Youth Works! provides services to youth through academic support, work experience, the national Job Corps, mentoring, and leadership development. The program enables youth to be engaged in their local community and prepares them to become more productive adults.

omy important stability. Research shows that during previous recessions, unemployment benefits have saved an average of 131,000 jobs.

Despite the well-documented positive effects of unemployment insurance, the program suffers from structural problems that unnecessarily limit eligibility, especially among low-income workers and women. Reform of the unemployment insurance system to expand eligibility could extend greatly needed benefits to millions of unemployed workers and their children struggling to make ends meet, while providing effective stimulus to the economy. The workers most likely to be left behind by the UI system are those who are already the most economically vulnerable and in need of the most assistance in staying attached to the labor market.

- Workers with lower earnings and less stable employment are less likely to receive benefits, as they need to work more hours than higher-income workers to meet minimum earnings requirements. Low-wage workers employed at least 35 hours a week are 44 percent less likely than higher wage workers to collect unemployment insurance and women are 15 percent less likely than men to receive benefits when they become unemployed.
- Many states do not cover unemployed workers not seeking full-time work, even if they had worked part-time before becoming unemployed and meet all other eligibility requirements. Only 24 states use the same standards to determine part-time eligibility as they do with full-time workers. More than one in six workers are part-time; and this group is disproportionately low-income and female.[78]
- Most states exclude unemployed workers from eligibility if they became unemployed for "personal" reasons. Some states allow good cause for specific reasons, such as lack of day care, medical causes, or domestic violence. A worker- and family-friendly unemployment system would not deny benefits to people who had become unemployed or were unable to search for work because of compelling domestic circumstances such as caring for sick children or parents, conflicts with work schedules and child care responsibilities or domestic violence.

Safeguarding Families: The Role of Government Benefits in Family Well-Being

Millions of low-income families are one crisis away from economic catastrophe. In the 1990s, significant progress was made towards ensuring families were better able to make it into the middle class. Many factors contributed to the employment growth of the 1990s, including a strong economy, state and federal welfare reforms, the large expansion of the Earned Income Tax Credit (EITC) in 1993, increased child care spending, increases in the minimum wage in 1996 and 1997, and broadened access to health care outside of welfare. However, the economy went into recession in 2001 and the recovery was very slow. States entered into a period of large budget deficits placing strains on Temporary Assistance for Needy Families (TANF) funds, forcing cutbacks in child care and other services. The pressures from the economy and state budget crises had an impact on employment, child poverty, child care, and welfare participation.[79]

These factors made the role of federal government benefits increasingly important. Research has shown that they are effective in bolstering the ability of low-income workers to meet their basic needs. One study showed that those leaving TANF with housing subsidies were more likely to stay off welfare than were those without benefits.[80] An Urban Institute report clearly demonstrates that former TANF recipients who receive other forms of assistance are less likely to return to TANF than those who do not receive assistance. For example, 27.7 percent of those leaving TANF without child care help returned within three months, compared to only 19.5 percent of families who did receive child care assistance. Similarly, 21.7 percent of families with government health insurance subsequently returned to TANF, compared to 32.8 percent of families without such insurance.[81]

Low-wage workers account for a surprisingly large segment of the nation's workforce. In 2003, one-quarter of the labor force earned $9.08 per hour or less. For many of these workers, publicly provided income supplements and work supports such as child care subsidies, food stamps, Medicaid/SCHIP, the Earned Income Tax Credit, and Child

STORIES FROM THE STATES
Crucial Assistance Is Only Temporary

Dreama Mollet lives in Columbus, Ohio, and is a single mother with four children. She had to quit a full-time job at the grocery store to care for her sick aunt. In order to remain eligible for the Ohio cash assistance program, she needed to stay employed at least part-time. She now works at a settlement house 30 hours per week and receives both cash and food assistance through the "Ohio Works First" work experience program. The cash assistance is limited to only three months, and Dreama worries that she will not be able to work enough hours to provide for her family once it expires. She does not have a car and can work only in locations served by public transportation.

Tax Credit help to increase job retention, reduce job turnover, and improve child and family well-being.

U.S. Census data show that government programs successfully lift millions of Americans out of poverty. In 2003, due to receipt of government benefits, poverty was reduced by almost half and child poverty was reduced by more than one-third.[82] Moreover, research has shown that if people were able to fully access all of the benefits for which they are eligible, poverty could be reduced by 20 percent and extreme poverty would fall by 70 percent.[83]

As extreme poverty is growing faster than poverty, the weakening of the social safety net for children at the bottom of the economic scale becomes a critical policy issue to address. It is important to maintain and provide even more assistance to families through TANF, nutrition programs, housing, the Earned Income Tax Credit, and other critical safety net programs to avoid leaving parents with even fewer resources to meet their children's needs.

Welfare Reform: A Path to Employment or Increased Poverty?

The Temporary Assistance for Needy Families (TANF) law passed in 1996 called for a strict five-year time limit on benefits and little opportunity for training and education that leads to better jobs. It is difficult to sort out the effects of the strong economy of the late 1990s, though those who tout the success of welfare reform claim that it is directly responsible for the caseload drop and that the need for TANF is decreasing. While the 1990s saw a decrease in welfare rolls and some families improved their circumstances, today we know that many families have moved much farther below the poverty line as a result of benefit reductions and restrictions. The increase in child poverty, poverty in female-headed households, and the striking increase in extreme child poverty in recent years indicate an increased need for TANF funding and a need to make poverty reduction the primary program goal.

Children younger than six, already the most likely to be extremely poor, were less likely than older children to be covered by TANF in 2000. Among older children in extreme poverty, coverage fell by two-fifths (from 57 percent to 33 percent) while coverage for extremely poor young children dropped by nearly three-fifths (from 61 percent to 26 percent). Prior to welfare reform, children younger than six were more likely to receive cash assistance than their school-aged counterparts. Cash assistance receipt declined by nearly one-third for poor children in single parent families, from 42 percent in 1996 to 29 percent in 2000, while during this period the proportion of children under eighteen who were quite poor and lived with single parents dropped only 8 percent.[84]

Has TANF Helped People Find Jobs?

TANF imposed time limits on recipients, and in 2001 families began reaching their five-year lifetime limit for receipt of benefits. Others in states that opted for time limits of fewer than 60 months were already struggling with those limits. A study

Who Remains on Welfare?

As welfare policy has changed, so too has the welfare population. A decade ago, Whites represented the largest proportion of cases, accounting for almost 4 million recipients. However, Whites have exited the welfare rolls faster than Blacks or Latinos, and now Blacks dominate the ranks. Less than one-third of Blacks leaving welfare found a job, compared to over half of Whites.[85] In 2002, according to the Department of Health and Human Services (HHS), 38.3 percent of recipients were Black and 24.9 percent were Latino, while Whites accounted for 31.6 percent.[86]

Studies predict that this trend will persist as minority populations spend longer periods on welfare than their White counterparts and as they continue to fair far worse in the job market and wage earnings.[87] Crafting of the welfare policies assumed all groups were on a level playing field, but given the persistent racial divide, minority families face significant challenges as they navigate the welfare system and the job market and remain overrepresented in low-wage jobs.

by MDRC found that nationally, as of December 2001, about 231,000 families reached either a federal or state time limit; at least 93,000 had their welfare case closed due to a time limit and another 38,000 had their benefits reduced.[88] Since the MDRC study, it is almost certain that many more families have reached their time limit, as federal time limits were only starting to kick in when this study was conducted.

Recent research shows that time limits account for one-third of those who leave TANF.[89] Further, the Department of Health and Human Services (HHS) data show that fewer than 2 percent of families are receiving assistance past 60 months—far fewer than the 20 percent allowable exceptions under the TANF law.

As welfare caseloads declined by more than half, states used the savings from the reduction in the number of families receiving assistance to provide important work support services like child care and transportation. But, as the value of the block grant declines, states are finding it necessary to eliminate many work incentives.[90] The Government Accountability Office reported that the TANF caseworkers and service providers they visited pointed to transportation difficulties, job shortages, low wages, and lack of services—especially child care—that challenged their efforts to help clients become employed and move toward self-sufficiency.[91]

A major study by the Public Health Institute (PHI) examining TANF welfare barriers to work found that full-time work is three to four times more likely when a family has secure child care arrangements.[92] According to the latest data, 550,000 children are on waiting lists for child care. This number significantly underestimates the need for care, as only one in three states actually keeps a waiting list. The others simply inform people there is no slot available for them. If all states kept a waitlist, the reported waitlist would be significantly larger.[93] Yet efforts to increase child care funding have been thwarted by the Administration, which has stated that it "would strongly oppose any amendment that increases funding for the Child Care and Development Fund."[94]

Forty-one percent of TANF recipients have not yet completed high school and 76 percent have low levels of literacy.[95] Even a single year of post-secondary education can have a major effect on earning capacity.[96] However, under TANF, states may count higher education as a work activity for only 20 percent of their caseload, so 80 percent of the recipients must either abandon hope of getting more education or squeeze it in on top of their other work activities and family life. As a result, colleges are seeing major declines in enrollment of welfare recipients.[97]

TANF Needs a New Focus

A family can expect an average TANF benefit of $412 per month, or an average of $164 per per-

When Families Lose Their Benefits

In West Virginia, only one of every four former recipients whose benefits ran out because of the five-year time limit has been able to get a job, and more than half of those who are working have only been able to find part-time work. The average ex-welfare family earned $6,120 in 2003—only one-third of the poverty level for a family of four. They were twice as likely to have been evicted from their homes, to have run out of food, or have had their utilities cut off since they were kicked out of West Virginia Works, the state's cash assistance program. They also pawned possessions, moved in with someone else, or borrowed money twice as often as before. More than half said they couldn't buy their children a birthday gift or clothes or let them participate in after-school activities because they did not have enough money.

Source: *The Associated Press*, "Former Welfare Recipients Struggling, Study Says," *The Herald Dispatch* (September 21, 2004).

son.[98] For two million families on welfare, TANF is often their last resort to sustain themselves. Yet many families eligible for assistance are not receiving it, and those attempting to leave TANF face increasing barriers.

In 2003, the proportion of welfare recipients entering jobs was 34 percent, two percentage points lower than in 2002 and a continuation of the downward trend in workforce participation rates evident over the last four years.[99] At the same time, poverty rates among families that leave TANF are very high, and half of the very poor families with children who are eligible for TANF assistance do not receive it—a number that is increasing.[100] Some of these families are intimidated by the complex application process or eligibility requirements, and others have health problems that limit their ability to apply for benefits.

Despite these trends, from 2001 through 2005 the TANF debate remained focused on work requirements, participation rates, and arbitrary successes such as the drop in caseloads, rather than on programs that promote work with adequate education and training that have proven to be successful in moving many families toward greater self-sufficiency. In addition, work supports such as child care, food stamps, the Earned Income Tax Credit, and health insurance are essential to successfully getting and keeping parents in jobs. TANF policies must incorporate strategies that ultimately lead to families having the resources available to meet their needs.

Education Pays

A Portland, Oregon, welfare-to-work program incorporating job training, education, job search assistance and more, outperformed other welfare-to-work programs, producing long-term significant increases in employment, earnings, job quality, and employment stability, according to a recent evaluation by the National Evaluation of Welfare-to-Work Strategies (NEWWS).[101] In three NEWWS sites, those who participated in basic education and then went on to post-secondary education or training had an additional $1,542, or 47 percent increase, in earnings in the third year of follow-up compared to those who participated only in basic education.[102] A 2002 study of the Maine Parents as Scholars program that supports welfare participants while they complete a two- or four-year college degree found that graduates increased their hourly median wages by 46 percent.[103]

STORIES FROM THE STATES
A Long Haul

Cars line up for free food in Ohio.

Faye Carter is married and raising three children, ages 4, 3 and 1 in Logan, Ohio. Her husband makes the long drive to Columbus for work while Faye cares for their children. (If she were to work full-time, at a minimum wage job, her monthly earnings of $893 would not even cover the estimated average monthly child care costs of $1,194 for a family such as hers—not to mention transportation and other work-related costs). Despite his long hours and hard work, her husband's income of an estimated $25,500 puts the family just slightly above the poverty line.

The Carter family has a little more money to feed the children, thanks to $126 in food stamps each month and Faye regularly visits the food pantry. She says, "They'll give you food if you need it, even at times that aren't scheduled. The pantry always has milk and formula for the kids." Lisa, Faye's mother, notes that "Last year the food pantry wasn't so packed." This year, "People are hungry. They don't have ways to support their families. Jobs are hard to find in Ohio." Lisa complains that you can't go to school and still qualify for child care assistance, yet you need a high school diploma to do cleaning or custodial work. She cites the difficulties of paying for gas and transportation in a rural area and says that doctors are leaving Logan, making it more difficult to take her children to see a pediatrician.

Food Insecurity Is Rising

The story of the Carter family provides a small window into the lives of food insecure families that must rely on services such as food pantries just to get by. A household is defined as food secure if all of its members consistently have access to enough food to allow for active and healthy living. There are 36.3 million food insecure Americans, including more than 13 million children.[104] Of these children, 420,000 experienced food insecurity with hunger in 2003. Moreover, in 3.9 million families, someone had to skip a meal because they were unable to purchase food.[105] These are the highest levels of food insecurity (both with and without hunger) since 1998. The majority of food insecure households have incomes that are near or below the poverty line.

Steadily rising rates of food insecurity among very young patients' families has pediatricians across the country alarmed. Food insecurity leads to many short-term health problems such as higher rates of infection and hospitalization, as well as lifelong developmental consequences for children. Compared to 1999, food insecurity was 77 percent more likely to be found in low-income households with children up to three years old, according to data through June 2004 from the Children's Sentinel Nutrition Assessment Program (C-SNAP). Infants and toddlers were found to be 95 percent more likely to experience poor diet or hunger compared to 1999.[106]

The Food Stamp program is central to alleviating hunger and poverty in the U.S. Food stamp participation closely follows the economic cycle. The number of people receiving food stamps fell by over 40 percent in the late 1990s, largely because of the strong economy. When the economy again weakened, the Food Stamp program was there to serve those in need.

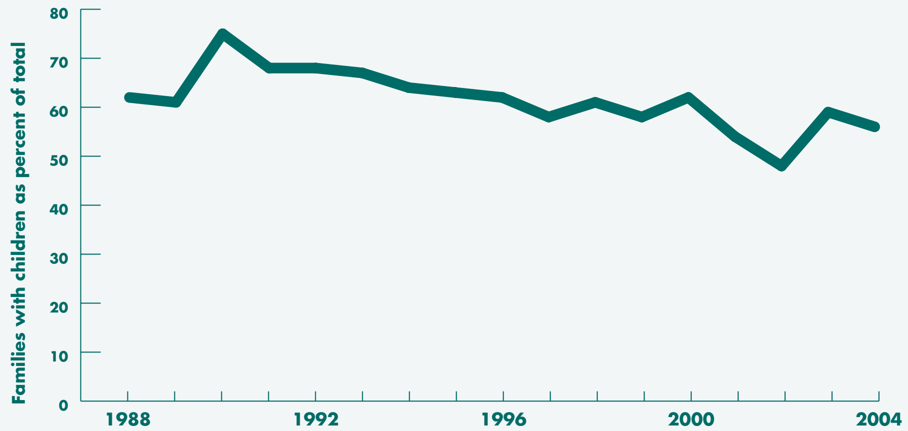
Since 2000, food stamp participation has increased by over 20 percent, reaching 10.6 million children. Some of the increase can be attributed to states improving access to the Food Stamp program, but this increase also was due to continuing high rates of joblessness. Still, the program is not reaching all those who are eligible. Only about

Family Income – Figure 5

Hunger in America

Proportion of those requesting food assistance in America's cities who are families with children

Families with children represent over half of those requesting food assistance in U.S. cities.

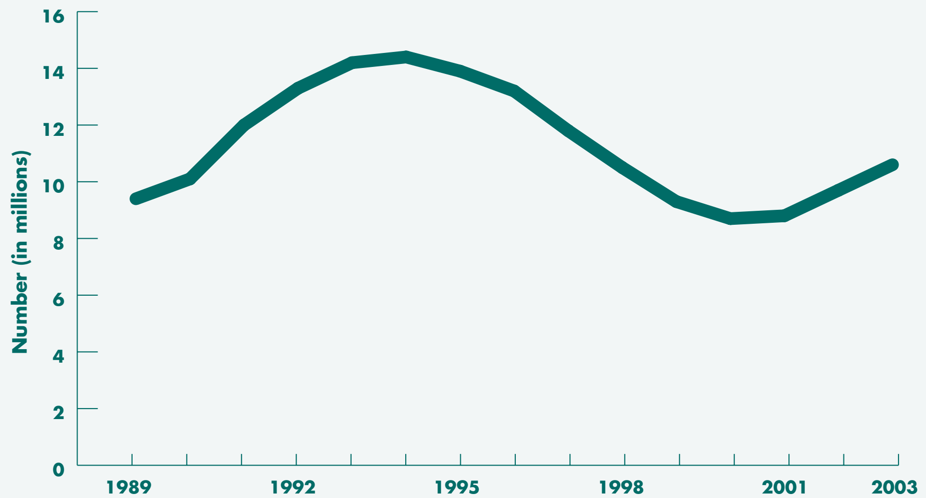


Source: U.S. Conference of Mayors - Sodexho, *Hunger and Homelessness Survey 2004* (December 2004), Appendix Chart, "Hunger and Homelessness in America's Cities: A Sixteen-Year Comparison of Data."

Family Income – Figure 6

Children Receiving Food Stamps, 1989-2003

10.6 million children receive food stamps—an increase of more than 20 percent since 2000.



Source: U.S. Department of Agriculture, Food and Nutrition Service, unpublished tabulations.

STORIES FROM THE STATES
Caring for Her Children and Parents

Rosetta Jones of Jonestown, Mississippi, works two jobs in order to provide for her four sons. They live together in a trailer with her aunt who is sick with Alzheimer's. Mrs. Jones also cares for both of her parents who live next door. She works as a room attendant in a casino during the day, earning $7.00 per hour, and at an oil mill for four hours during the evenings. However, she does not have a car and depends on friends for rides to and from work. She receives Section 8 housing right now, but dreams of owning a home for the whole family one day.

54 percent of eligible people received benefits in 2002.[107]

Affordable Housing Is Basic to Families' Well-Being

In addition to the increase in hunger, food insecurity, and food stamp participation, there has been a continued rise in the number of families that lack adequate housing or are homeless. Housing is the largest single expense for many working families, and more and more families in our nation cannot afford housing. While median incomes have been declining since 2000, housing costs have continued to rise significantly. Due to the combination of these two factors housing has become much less affordable. This is clearly illustrated by the fact that the proportion of renter households living in unaffordable housing has increased from 41 percent in 2000 to 48 percent in 2004.[108]

The hourly wage that a worker supporting a family needs to earn to afford a modest two-bedroom home at fair market rent is increasing.[109] One report shows that in 2003 the national median housing wage was $15.37, a 38 percent increase since 1999. In 48 states and the District of Columbia the combined earnings from two full-time minimum wage workers is not enough to afford fair market rent.[110] High housing costs make it difficult for working poor families to retain employment by leaving them with little income to pay work-related expenses such as transportation and child care.

Women, children, and the elderly are over-represented among those with housing problems, and single-parent households are more likely to experience housing difficulties. Children are present in 37 percent of all renter and homeowner households across income levels, but are present in 93 percent of over-crowded households and in 56 percent of households with multiple housing problems such as malfunctioning heating or plumbing systems, overcrowding, and health hazards. Housing-related health hazards include lead poisoning, asthma, asbestos, radon, and mold. Almost one-quarter of households with children are in older housing units with high risks of lead dangers.[111] The high cost of housing-related health dangers includes lost learning for children, lost work days for parents caring for ill children, medical expenses, and special education costs.

Lack of affordable housing was the leading cause of homelessness. In 2004 the request for emergency shelter assistance increased by 7 percent, sometimes forcing families to separate to obtain emergency shelter. Forty percent of the homeless are families with children. Unaccompanied youth, those 18 years of age and younger who are not with a family, comprised 5 percent of the homeless in a 27-city survey.[112]

Homeless children face hardships that include frequent changes in schools because their families must search for cheaper places to live, and they

often struggle to catch up with school work or have difficulty forming lasting friendships. They also suffer from anxiety because their families are forced each day to choose between spending money on housing, health care, or other basic needs. Children experiencing homelessness are diagnosed with learning disabilities at twice the rate of other children; they suffer from emotional or behavioral problems that interfere with learning at almost three times the rate of other children; and 21 percent of homeless children repeat a grade because of frequent absences from school, compared to 5 percent of other children.[113]

Federal Housing Policy Compounds the Problem

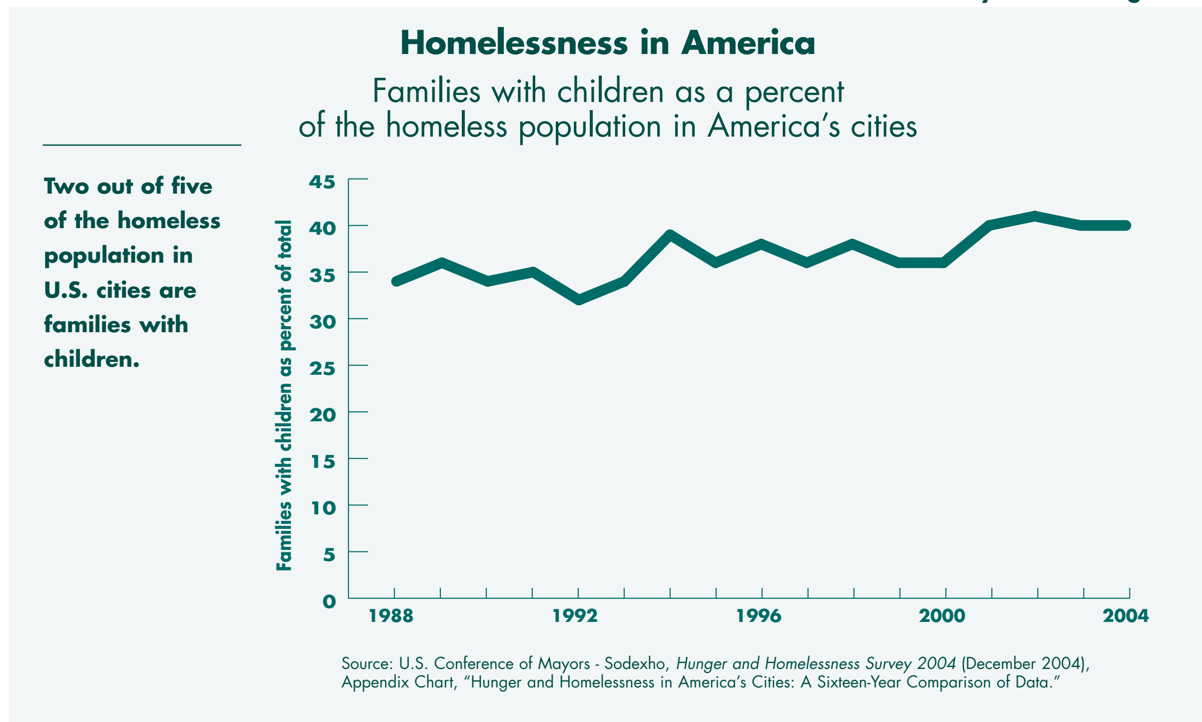
Federal housing policy is gradually shifting away from targeted rental assistance for low-income families toward homeownership. This change in emphasis runs counter to what may be in the best economic self-interest of these families. A recent study concludes that unlike middle- and upper-income homeowners, low-income families receive no tax benefit from homeownership, are likely to live in a home they buy for a relatively short time, are unlikely to earn a capital gain on any home they buy, and could end up losing the equivalent of one year's rent as a result of their decision to buy rather than rent.[114]

Homeownership may be a desirable and achievable goal for some low-income families, but the priority given to it by the Administration has resulted in a lack of support for the Department of Housing and Urban Development's (HUD) largest and most successful rental assistance program. The Section 8 voucher system provides rental assistance to approximately two million households, 60 percent of whom are families with children. Without a reversal in this policy direction, the burden for families challenged by simply keeping a roof over their heads and meeting basic needs will continue to escalate.

Earned Income Tax Credits: A Powerful Anti-Poverty Program

Created in 1975, the Earned Income Tax Credit (EITC) has become the nation's largest anti-

Family Income – Figure 7



Source: U.S. Conference of Mayors - Sodexho, *Hunger and Homelessness Survey 2004* (December 2004), Appendix Chart, "Hunger and Homelessness in America's Cities: A Sixteen-Year Comparison of Data."

poverty program, exceeding spending on other programs such as food stamps and TANF. In 2003, more than 4.4 million people and 2.4 million children were lifted out of poverty due to receipt of the EITC.[115] The EITC is a fully refundable federal tax benefit that can be applied to a person's tax liability to reduce or eliminate the amount of taxes owed and provide a refund if the credit exceeds taxes owed. The amount of the credit varies depending on the amount of income the taxpayer earned, whether he or she is married, and how many children are claimed. In 2005, low-income working families with two or more children can receive as much as $4,400 as their credit.

EITC refunds can help families meet current needs as well as provide money to invest in savings. One study found that 83 percent of families said that paying bills such as utilities and rent was one of the top three priorities for their EITC money, and 74 percent of families said that purchasing basic household commodities and clothing was a priority. Fifty percent of the families said they were going to save at least part of their EITC money, and 16 percent were going to pay tuition.[116] The EITC

Place-Based Services Can Boost Earnings

The Jobs-Plus Community Revitalization Initiative for Public Housing Families (Jobs-Plus) program was a demonstration program carried out between 1998 and 2003. This initiative was fully implemented in public housing developments in Dayton, Ohio; Los Angeles; and St. Paul, Minnesota. It had three main components: employment-related services, rent-based work incentives that allowed residents to keep more of their earnings, and activities to promote neighbor-to-neighbor support for work. The program offered employment services, job search assistance, vocational training, education programs, child care, and transportation assistance in conjunction with financial incentives such as rent breaks, so that an increase in earnings was not automatically offset by an increase in rent. The program allowed for a stabilized rent for up to 36 months.

Residents' earnings were significantly boosted by combining job training, rent incentives, and word-of-mouth promotion. Working-age residents participating in the program at the three sites increased their earnings by an average of 14 percent, or $1,141, annually over what they would have been without the program during the last four years of the study.

Source: Howard S. Bloom, James A. Riccia and Nandita Verma, "Promoting Work in Public Housing: The Effectiveness of Jobs-Plus" Final Report, MDRC, March 2005.

Free Tax Preparation Brings Results

The Children's Defense Fund Tax and Benefits Outreach effort seeks to ensure that children and working families receive tax assistance, like the Earned Income Tax Credit and the Child Tax Credit, as well as other benefits for which they are eligible. Many non-profits, like Children's Defense Fund, have stepped up efforts to help taxpayers with free tax preparation services. These services, provided at Volunteer Income Tax Assistance (VITA) sites, are helping working families obtain the full value of their tax returns to purchase necessary household items, pay off debt, buy new clothes, or put money in a savings account.

In 2005, Children's Defense Fund's national office coordinated work at six local faith- and community-based organization's VITA sites in Washington, D.C. From January through April of 2005, these VITA sites assisted more than 750 low-income taxpayers in claiming $990,000 in tax refunds and credits. Over $437,000 in benefits were obtained through the federal and state EITC. Nationally, more than $105 million in tax refunds resulted from CDF's direct and indirect coalition work.

Refund Anticipation Loans: A Deceptive Practice Aimed at Low-Income Taxpayers

Two-thirds of low-income taxpayers who claim the EITC pay commercial tax preparers to complete their taxes, and many pay huge fees to receive their refund one to two weeks earlier. These low-income taxpayers lost over $690 million in loan charges in 2003 and a total of $2.3 billion if the cost of commercial tax preparation is included.[117] The costs can include tax preparation, documentation preparation or application handling fees, electronic filing fees, and exorbitant charges related to Refund Anticipation Loan (RALs).

RALs are loans secured by the taxpayer's tax refund, including the EITC. Approximately 12.7 million RALs were taken out during the 2002 tax season at an average cost of $90 per taxpayer with average annual percentage rates (APR) ranging from 70 percent to 700 percent.[118] The most recent Internal Revenue Service figures indicate that 79 percent of RAL recipients in 2003 had adjusted gross incomes of $35,000 or less.[119] Minority consumers are the most frequent RAL users; 28 percent of African Americans and 21 percent of Latino taxpayers told surveyors they received RALs compared with 17 percent of White consumers.[120]

Many low-income families may feel they have little choice but to take out a RAL. The main reason is that RALs enable families to immediately access the amount of money they expect from their tax refunds, rather than waiting one to two weeks for the IRS to process their returns electronically. Because many of these families are unlikely to have the money on hand to pay for all the fees associated with the loan, the commercial tax preparers make it seem easy by deducting these fees first, relieving the families from having to find alternative resources. But because the RAL is a loan, it can actually leave a family in greater financial crisis. Usually, a RAL is paid off once the IRS processes the tax return and transfers the funds. However, if the IRS denies part of the refund for any reason or even withholds it temporarily for audit purposes, interest continues to accrue and the family is responsible. Given their real financial needs, it is unlikely that EITC families budget for this possibility. There is also ample anecdotal evidence that some families, especially those with limited English proficiency, do not fully comprehend that they are taking out a loan.

In middle- and upper-income communities, consumers have access to loans and credit cards at competitive rates, and branch offices of mainstream banks and savings and loans offer a full array of banking services. By contrast, in many low-income minority communities the absence of capital can deter entrepreneurs and limit the expansion of neighborhood businesses. Low-income consumers are forced to patronize fringe financial service providers that charge exorbitant rates for personal loans and limited banking services.[121] According to the Federal Reserve, one out of four families with incomes less than $25,000 does not have either a checking or savings account.[122] A broader population of low- to middle-income families have bank accounts but still rely on high-cost non-bank providers to conduct much of their financial business such as check cashing.

plays an important role in helping low- to moderate-income families meet their basic immediate needs and make ends meet while investing in the local economy.

A total of fifteen states and the District of Columbia currently have a state Earned Income Tax Credit (EITC) program. Families eligible for the federal EITC are eligible for their state program as well and receive the state benefit in addition to the federal credit.

Recommendations for Moving Forward

No child should be doomed to a life of poverty and reduced opportunities and cut off from the mainstream. Our goal must be to reduce and eliminate child poverty. To do so, we must increase the income of parents raising children. Child advocates, government officials, policy makers, and service providers working together can make progress toward achieving that goal. Government must do its part by making investments in education and training that lead to good jobs and by providing the supports necessary to meet the basic needs of families as they attempt to raise their children out of poverty.

Support policies that make work pay and ensure family friendly workplaces.

- Raise the minimum wage to at least $7.25 an hour to help ensure that workers at the bottom of the earnings scale are not left behind.
- Quality education and training are critical to the success of our communities and the economy and can be an effective tool in reducing poverty. The range of federal workforce training programs—especially those targeting low-income adults and youth—needs to be expanded to keep pace with the growing need for a skilled labor force.
- Ensure that all full-time workers have at least seven paid days off annually to take care of their own and family members' health needs, and that part-time workers have a pro-rated amount of paid leave.

Reform the Unemployment Insurance system so that it treats low-income workers and newer entrants to the labor market more fairly.

- Because of technological advances in records processing, there is no justifiable reason why the earnings from an unemployed worker's most recent three months on a job should not be counted in determining eligibility for UI. States should be required to count all of a worker's earnings up to the time when s/he became unemployed—not doing so is unfair to workers who have less stable employment and lower incomes.
- Parents who become unemployed because of a lack of child care or to protect themselves and their children from domestic violence should not lose their eligibility for benefits.
- Unemployed workers who seek part-time employment should not lose their eligibility for benefits if they otherwise qualify.

TANF can be a potent force for enhancing child well-being in the lives of the millions of children currently living in poverty if it focuses on poverty, not caseload, reduction.

- Increase funding for child care so that all eligible families receive the child care for which they are eligible.
- Set work requirements to allow maximum flexibility to achieve the job skills and training necessary to find and maintain well-paying jobs, and differentiate work hours for families with children under six years of age.
- Allow states to use TANF funds to assist all legal immigrant families regardless of when they came into the state.
- Require states to uniformly screen for barriers to work and assess child well-being, and provide flexibility for families to address the barriers in the context of work requirements.
- Adopt sanctioning policies that acknowledge families' good faith efforts to meet requirements.
- Use the funds in the TANF block grant to meet the employment, child care, and educational needs of families, rather than for unproven family formation and marriage promotion programs.

The Food Stamp program provides assistance to vulnerable families who need help buying groceries that meet their basic nutrition needs.

- Maintain the basic structure of the program, which provides a guaranteed benefit to those who are eligible.
- Extend the Food Stamp program to include all documented adult immigrants, regardless of how long they have been in the country.
- Expand education and outreach efforts so that all who are eligible for Food Stamps are informed of their eligibility and are encouraged to apply.
- Make benefit allotments more adequate to meeting the nutrition needs of families.

Having a place to call home is not only a human right but integrally connected to children's health, safety, and ability to learn.

- Increase the overall federal investment in affordable housing and reject further cuts to housing programs vital to families.
- Add 100,000 new Section 8 housing vouchers each year and maintain the structure of the program, which targets resources to the neediest families.
- Create a National Housing Trust Fund to expand the supply of affordable housing for families with children.

EITC is the largest anti-poverty program for families.

- Expand EITC so that families with more than two children receive a greater EITC benefit.
- Avoid creating barriers to accessing EITC through mechanisms such as IRS requiring certification prior to receiving the benefit. This can cause lengthy delays in receiving a refund.
- Prohibit usurious refund anticipation loans (RALs) so that working families are safeguarded from exploitative practices that keep them from retaining all of the EITC they have earned.
- Maintain low-income taxpayer assistance centers so that help is available to taxpayers who need it.

Expand the benefit provided to low-income families by the Child Tax Credit.

- Make the $1,000 per child credit fully refundable to ensure that the credit benefits low-income working families who have lower income tax liabilities.
- Or at least set the minimum income threshold at which families begin to qualify for the refundable portion of the CTC at $10,000—the level at which it was originally set in 2001—and de-index it from inflation. This would prevent 9.2 million children from losing the credit because their parents' incomes failed to keep pace with inflation.

Endnotes

[1] Peter G. Gosselin, "If America Is Richer, Why Are Its Families So Much Less Secure?" *Los Angeles Times* (October 10, 2004). Retrieved from the Internet at http://www.latimes.com/business/la-fi-riskshift 10oct10,1,3999173,print.story on July 28, 2005.

[2] Jeffery Sachs, *The End of Poverty: Economic Possibilities for Our Time* (New York: Penguin Press, 2005): 1.

[3] David R. Francis, "It's Better to be Poor in Norway than in the U.S.," *Christian Science Monitor* (April 14, 2005). Retrieved from the Internet at http://www.csmonitor.com/2005/0414/p17s02-cogn.html on July 28, 2005.

[4] In 2004 the poverty threshold for a family of four with two parents was $19,157 a year, $1,596 a month, or $52 a day.

[5] U.S. Department of Commerce, Bureau of the Census, "Table POV01. Age and Sex of All Peoples, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race," *Detailed Poverty Tables for 2004.* Retrieved from the Internet at http://pubdb3.census.gov/macro/032004/pov/new01_100.htm on September 14, 2005. Calculations by CDF.

[6] U.S. Department of Commerce, Bureau of the Census, March 2001 and March 2005 *Current Population Survey*. Poverty figures come from Historical Poverty Tables – People, Table 3, at http://www.census.gov/hhes/www/poverty/histpov/hstpov3.html. Extreme Poverty figures come from Detailed Poverty Table POV01 for 2004, http://pubdb3.census.gov/macro/032005/pov/new01_050.htm and Table 2 for 2000, http://pubdb3.census.gov/macro/032001/pov/new02_000.htm. Calculations by CDF.

[7] U.S. Department of Commerce, Bureau of the Census, "Table 3. Poverty Status of People, by Age, Race, and Hispanic Origin: 1959 to 2004," *Historical Poverty Tables.* Retrieved from the Internet at http://www.census.gov/hhes/www/poverty/histpov/hstpov3.html on September 16, 2005. Calculations by CDF.

[8] U.S. Department of Commerce, Bureau of Economic Accounts, National Income and Product Accounts Table 7.1. "Selected Per Capita Product and Income Series in Current and Chained Dollars." Retrieved from the Internet at http://www.bea.gov/bea/dn/nipaweb/SelectTable.asp? Selected=3#Top on July 28, 2005.

[9] U.S. Department of Commerce, Bureau of the Census, "The Changing Shape of the Nation's Income Distribution, 1947-1998," *Current Population Reports, Series P60-204,* June 2000. Retrieved from the Internet at http://www.census.gov/prod/2000pubs/p60-204.pdf on July 28, 2005.

[10] U.S. Department of Commerce, Bureau of the Census, "Table H-2. Share of Aggregate Income Received by Each Fifth and Top 5 Percent of Households," *Historical Income Tables-Households.* Retrieved from the Internet at http://www.census.gov/hhes/www/income/histinc/h02ar.html on September 26, 2005. Calculations by CDF.

[11] U.S. Department of Commerce, Bureau of the Census, *Income, Poverty, and Health Insurance Coverage in the United States: 2004, Current Population Reports,* No. P60-229 (Washington, DC: U.S. Government Printing Office): Table A-3. Calculations by CDF.

[12] Congressional Budget Office, *Effective Federal Tax Rates 1979-2001* (Washington, DC: April 2004): Table 1-C. Calculations by CDF.

[13] *Ibid.*

[14] Lawrence Mishel, Jared Bernstein and Sylvia Allegretto, *State of Working America 2004/2005* (Ithaca, New York: Cornell University Press, 2005): 214.

[15] Adam Geller, "CEO pay rises even as questions linger about overcompensation," *The Detroit News, Business* (April 16, 2005). Retrieved from the Internet at http://www.detnews.com/2005/business/0504/18/index.htm on July 28, 2005. The daily income amount is based on a 260-day work year of 5 days a week for 52 weeks.

[16] U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts Table 1.12. "National Income by Type of Income." Retrieved from the Internet at http://www.bea.gov/bea/dn/nipaweb/TableView.asp?SelectedTable=53&FirstYear=2002&LastYear=2004&Freq=Qtr on July 28, 2005. Calculations by CDF.

[17] "Strong demand propels profits at U.S. companies 13.5% to a record $1,268 bn," *Financial Times* (March 31, 2005): 1.

[18] U.S. Department of Commerce, Bureau of the Census, *Income, Poverty, and Health Insurance Coverage in the United States: 2004, Current Population Reports,* No. P60-229 (Washington, DC: U.S. Government Printing Office): Table A-1. Calculations by CDF.

[19] *Ibid.,* Table A-2.

[20] U.S. Department of Commerce, Bureau of the Census, "Table H-10. Age of Head of Household: All Races by Median and Mean Income: 1967 to 2004 ," *Historical Income Tables-Households.* Retrieved from the Internet at http://www.census.gov/hhes/income/histinc/h10ar.html on September 27, 2005. Calculations by CDF.

[21] "Real Earnings Growth Has Slowed and Become More Unequal Under President Bush," Economic-Points-of-Interest-Charts (E-PICS) (Washington, DC: Joint Economic Committee, April 5, 2005). Retrieved from the Internet at http://jec.senate.gov/democrats/epics/2005_earnings.htm on July 28, 2005.

[22] U.S. Department of Labor, Bureau of Labor Statistics, *Consumer Price Index—All Urban Consumers,* Series Id: CUUR0000SA0. Retrieved from the Internet at http://www.bls.gov/cpi/ on October 6, 2005.

[23] Sylvia Allegretto, Jared Bernstein and Isaac Shapiro, *"The Lukewarm 2004 Labor Market: Despite Some Signs of Improvement, Wages Fell, Job Growth Lagged, and Unemployment Spells Remained Long"* (Washington, DC: Economic Policy Institute and Center on Budget and Policy Priorities, February 2005). Retrieved from the Internet at http://www.epinet.org/issuebriefs/20050216_epi_cbpp.pdf on July 29, 2005.

[24] *Ibid.*

[25] Sarah Anderson, John Cavanagh, Scott Klinger and Liz Stanton, *Executive Excess 2005: Defense Contractors Get More Bucks for the Bang* (Washington, DC: Institute for Policy Studies and United for a Fair Economy, 12th Annual CEO Compensation Survey, August 30, 2005): 15. Retrieved from the Internet at http://www.faireconomy.org/press/2005/EE2005.pdf on October 4, 2005.

[26] CDF analysis of 2004 *Current Population Survey* data. This number and others in this report are based on CDF analysis and come from a simple count of workers with estimated earnings between $5.15 and $7.25 per hour in 2004, the most recent year for which data are available.

[27] *Ibid.*

[28] Economic Policy Institute analysis of 2004 *Current Population Survey* data. Retrieved from the Internet at http://www.epinet.org/content.cfm/issueguides_minwage on July 29, 2005.

[29] *Ibid.*

[30] National Energy Assistance Director's Association, *National Energy Assistance Survey Report* (April 2004). Retrieved from the Internet at http://www.neada.org/comm/surveys/NEADA_Survey_2004.pdf on July 29, 2005.

[31] The Low Income Home Energy Assistance Program (LIHEAP) began in 1982 and is a federally funded program to help eligible low-income households meet their home heating and/or cooling needs. To find out more, visit the official LIHEAP Web page at http://www.acf.dhhs.gov/programs/liheap/liheap.htm.

[32] National Energy Assistance Director's Association, *National Energy Assistance Survey Report* (April 2004). Retrieved from the Internet at http://www.neada.org/comm/surveys/NEADA_Survey_2004.pdf on July 29, 2005.

[33] Tamara Draut and Silva Javier, "Borrowing to Make Ends Meet: The Growth of Credit Card Debt in the '90s," (Demos, A Network for Ideas and Action, September, 2003).

[34] *Ibid*.

[35] CDF analysis of *Current Population Survey* data; annual averages of monthly data from 2000 through 2004.

[36] *Ibid*. The number of children that long-term unemployed parents care for is not the same as the number of children with at least one long-term unemployed parent, as some children might have two long-term unemployed parents.

[37] U.S. Department of Labor, Bureau of Labor Statistics, "Employment of the civilian noninstitutional population, 1940 to date," Household Data Annual Averages, Table 1. Retrieved from the Internet at http://www.bls.gov/cps/cpsaat1.pdf on July 29, 2005.

[38] Lee Price and Yulia Fungard, "Understanding the Severity of the Current Labor Slump," Economic Policy Institute Briefing Paper (Updated February 19, 2004. Originally published in November 2003).

[39] U.S. Department of Labor, Bureau of Labor Statistics, "Employment Characteristics of Families in 2004," Table 5. Retrieved from the Internet at http://www.bls.gov/news.release/pdf/famee.pdf on July 29, 2005.

[40] Katherine Bradbury, "Additional Slack in the Economy: The Poor Recovery in Labor Force Participation During This Business Cycle, Public Policy Brief No. 05-2" (Boston, MA: Federal Reserve Bank of Boston, April 2005). Retrieved from the Internet at http://www.bos.frb.org/economic/ppb/index.htm on July 22, 2005.

[41] National Center for Children in Poverty fact sheet: "Parental Employment in Low-Income Families" (Columbia University Mailman School of Public Health, January 2004).

[42] *Ibid.*

[43] Beth Shulman, *The Betrayal of Work: How Low-Wage Jobs Fail 30 Million Americans and Their Families* (The New Press, 2003).

[44] Unpublished Economic Policy Institute analysis of *2004 Current Population Survey* data.

[45] Tom Waldron, Brandon Roberts and Andrew Reamer, *Working Hard, Falling Short: America's Working Families and Pursuit of Economic Security* (Annie E. Casey Foundation, October 2004). Families are defined as low-income if their incomes are below 200% of the poverty line. Retrieved from the Internet at http://www.aecf.org/publications/data/working_hard_new.pdf on July 29, 2005.

[46] U.S. Department of Labor, Bureau of Labor Statistics, Report 983, "A Profile of the Working Poor, 2003." Retrieved from the Internet at http://www.bls.gov/cps/cpswp2003.pdf on July 29, 2005. According to the Bureau of Labor Statistics, "The working poor are those who spent at least 27 weeks in the labor force (working or looking for work)."

[47] Jennifer Miller, Frieda Molina, Lisa Grossman, et al., "Building Bridges to Self-Sufficiency: Improving Services for Low-Income Families" (Report from Manpower Demonstration Research Corporation and National Governor's Association for Best Practices, March 2004). Retrieved from the Internet at http://www.mdrc.org/publications/ 385/full.pdf April 11, 2005.

[48] Institute for Women's Policy Research Fact Sheet: "The Gender Wage Ratio: Women's and Men's Earnings," IWPR #C-350 (Washington, DC: Institute for Women's Policy Research, August 2005). Retrieved from the Internet at http://www.iwpr.org/pdf/C350.pdf on September 28, 2005.

[49] U.S. Department of Labor, Bureau of Labor Statistics, *Report 983, A Profile of the Working Poor, 2003* (Washington, DC: Bureau of Labor Statistics, 2005). Retrieved from the Internet at http://www.bls.gov/cps/cpswp2003.pdf on July 29, 2005.

[50] *Ibid.*

[51] Harry J. Holzer, "Encouraging Job Advancement Among Low-Wage Workers: A New Approach" (Washington, DC: Brookings Institution, May 2004). Retrieved from the Internet at http://www.brookings. edu/dybdocroot/es/wrb/publications/pb/pb30.pdf on July 29, 2005.

[52] Michael A. Stoll, *Job Sprawl and the Spatial Mismatch between Blacks and Jobs* (Washington, DC: Brookings Institution, February, 2005). Retrieved from the Internet at http://www.brookings.edu/dybdocroot/metro/pubs/20050214_jobsprawl.pdf on July 29, 2005.

[53] Julie Strawn and Karin Martinson, "Steady Work and Better Jobs: How to Help Low-Income Parents Sustain Employment and Advance in the Workforce" (New York, NY: Manpower Demonstration Research Corporation, 2002). Retrieved from the Internet at http://www.mdrc.org/publications/17/full.pdf on July 29, 2005.

[54] Vicky Lovell, "No Time to Be Sick: Why Everyone Suffers When Workers Don't Have Paid Sick Leave" (Washington, DC: Institute for Women's Policy Research, 2004). Retrieved from the Internet at http://www.iwpr.org/pdf/B242.pdf on July 29, 2005.

[55] Vicky Lovell, Barbara Gault and Heidi Hartmann, "Expanded Sick Leave Would Yield Substantial Benefits to Business, Employers and Families" (Washington, DC: Institute for Women's Policy Research, June 15, 2004). Retrieved from the Internet at http://www.iwpr.org/ pdf/B243.pdf on July 29, 2005.

[56] *Ibid.*

[57] Jody Heymann, *The Widening Gap: Why America's Working Families Are in Jeopardy and What Can Be Done About It* (New York, NY: Basic Books, 2000).

[58] *Ibid.*

[59] U.S. Chamber of Commerce, *Business Competitiveness Platform,* (Washington, DC: U.S. Chamber of Commerce, July 2004). Retrieved from the Internet at http://www.uschamber.com/publications/reports/0407_bizplatform.htm on July 29, 2005.

[60] National Center on Children in Poverty, "The Effects of Parental Education on Income" (Washington, DC: National Center for Children in Poverty, September 2004). Retrieved from the Internet at http://www.nccp.org/media/pei04-text.pdf on July 29, 2005. In this study, "low-income" is defined as twice the federal poverty level of income.

[61] *Ibid.*

[62] U.S. Department of Commerce, Bureau of the Census, *Detailed Income Tabulations from CPS*, "Table PINC-03. Educational Attainment – People 25 Years Old and Over, by Total Money Earnings in 2004, Work Experience in 2004, Age, Race, Hispanic Origin and Sex." Retrieved from the Internet at http://pubdb3.census.gov/macro/032005/perinc/new03_010.htm on September 28, 2005.

[63] Julie Strawn, *Why Congress Should Expand, Not Cut, Access to Long-Term Training in TANF* (Washington DC: Center for Law and Social Policy, February 2004). Retrieved from the Internet at http://www.clasp.org/publications/TANF_Postsec.pdf on July 29, 2005.

[64] *Ibid.*

[65] *Ibid.*

[66] U.S. Department of Commerce, Bureau of the Census, Educational Attainment, Historical Tables, "Table A-3. Mean Earnings of Workers 18 Years and Over, by Educational Attainment, Race, Hispanic Origin, and Sex: 1975 to 2003." Retrieved from the Internet at http://www.census.gov/population/www/socdemo/educ-attn.html on October 4, 2005. Calculations by CDF.

[67] This trend is similar among women, for whom the same ratio applies, dropping from 69 cents to the dollar in 1975 to 56 cents to the dollar in 2003.

[68] U.S. Department of Commerce, Bureau of the Census, *Educational Attainment, Detailed Tables*, "Table 1. Educational Attainment of the Population 15 Years and Over, by Age, Sex, Race, and Hispanic Origin 2004." Retrieved from the Internet at http://www.census.gov/population/www/socdemo/education/cps2004.html on October 4, 2005.

[69] Harry J.Holzer, "The Low-Wage Labor Market: Challenges and Opportunities for Economic Self-Sufficiency" (Washington, DC: Urban Institute; Prepared for U.S. Department of Health and Human Services, 1999). Retrieved from the Internet at http://aspe.hhs.gov/hsp/lwlm99/holzer.htm#Employer on July 29, 2005.

[70] Nisha Patel, "Why funding for job training matters" (Washington, DC: Center for Law and Social Policy, 2004). Retrieved from the Internet at http://www.clasp.org/publications/training_1pager.pdf on July 29, 2005.

[71] *Ibid.*

[72] Shane Hollett, Executive Director of the Ohio College Access Network, spoken in witness testimony to the U.S. Senate Committee on Health, Education, Labor and Pensions. "Promoting Access to Postsecondary Education: Issues for the Reauthorization of the Higher Education Act" (October 16, 2003). A summary of the testimony can be retrieved from the Internet at http://www.collegeaccess.org/NCAN/ItemPage.aspx?groupid=12&id=254&txtsearch=hollett%20testimony.

[73] David Callahan, Tamara Draut and Javier Silva, *Millions to the Middle: Three Strategies to Expand the Middle Class* (New York, NY: Demos: A Network for Ideas and Actions, 2004): 17-18. Retrieved from the Internet at http://www.demos-usa.org/pubs/millions_ web.pdf on July 29, 2005.

[74] Association of American Colleges and Universities, "Achievement Gap Continues to Challenge Ideal of Equal Educational Opportunity," *AAC&U News* (Washington, DC: AAC&U, March 2004). Retrieved from the Internet at http://www.aacu-edu.org/aacu_news/AACUNews04/March04/facts_figures.cfm on July 29, 2005.

[75] Employment and Training Reporter, "Earnings gains showed largest increase among WIA outcomes," *Employment and Training Reporter 36, No. 11* (Washington, DC: MII Publications, November 8, 2004): 163.

[76] Robin Spence and Brendan Kiel, "Skilling the American Workforce 'On the Cheap': Ongoing Shortfalls in Federal Funding for Workforce Development" (Washington, DC: The Workforce Alliance Report, September 2003): 1. Retrieved from the Internet at http://www.work forcealliance.org/twa-funding-analysis-09.pdf on July 29, 2005.

[77] U.S. Department of Labor, Bureau of Labor Statistics, *A Profile of the Working Poor, 2003* (Washington, DC: U.S. Department of Labor, March 2005, Report 983): 3.

[78] National Employment Law Project, *Part Time Workers and Unemployment Insurance* (New York, NY: National Employment Law Project, March 2004).

[79] Testimony of Mark Greenberg of CLASP to Subcommittee on 21st Century Competitiveness Committee on Education and the Workforce, U.S. House of Representatives, March 15, 2005.

[80] Geri Scott, *Private Employers and Public Benefits* (Boston, MA: Jobs for the Future, Prepared for Workforce Innovation Networks, February 2004).

[81] Pamela Loprest, "Use of Government Benefits Increases among Families Leaving Welfare," *Snapshots of American Families*, No. 7 (Washington, DC: Urban Institute, August 2003). Retrieved from the Internet at http://www.urban.org/UploadedPDF/310838_snapshots3_no6.pdf on July 29, 2005.

[82] Arloc Sherman, *Public Benefits: Easing Poverty and Ensuring Medical Coverage* (Washington, DC: Center on Budget and Policy Priorities, revised August 17, 2005). Retrieved from the Internet at http://www.cbpp.org/ 7-19-05acc.htm on October 4, 2005.

[83] Sheila R. Zedlewski, Linda Giannarelli, Joyce Morton and Laura Wheaton, *Extreme Poverty Rising, Existing Government Programs Could Do More* (Washington, DC: Urban Institute, Series B, No. B-45, April 2002). Retrieved from the Internet at http://www.urban.org/UploadedPDF/ 310455.pdf on July 29, 2005.

[84] Avis Jones-DeWeever, "The Children Left Behind: Deeper Poverty, Fewer Supports" (Washington, DC: Institute for Women's Policy Research, Fact Sheet D457a, November 2003). Retrieved from the Internet at http://www.iwpr.org/pdf/D457a.pdf on July 29, 2005. Quite poor children have family incomes that are less than 100 percent and equal to or greater than 50 percent of the poverty line.

[85] Leslie L. Clarke, Brenda Jarmon and Merlin R. Langley, *People Who Have Left WAGES* (Qualitative Study of WAGES, Fall 1999).

[86] U.S. Department of Health and Human Services, Administration for Children and Families, "Characteristics and Financial Circumstances of TANF Recipients," *TANF Sixth Annual Report to Congress* (Washington, DC: Department of Health and Human Services, November 2004): 2. Retrieved from the Internet at http://www.acf.hhs.gov/programs/ofa/annualreport6/chapter10/chap10.pdf on July 29, 2005.

[87] W.K. Kellogg Foundation, "Racial and Ethnic Disparities in the Era of Devolution: A Persistent Challenge to Welfare Reform" (W.K. Kellogg Foundation, A report of research findings from the Scholar Practitioner Program of the Devolution Initiative, December 2001).

[88] Dan Bloom, Mary Farrell, Barbara Fink, with Diana Adams-Ciardullo, "Welfare Time Limits: State Policies, Implementation, and Effects on Families" (Washington, DC: MDRC, July 2002). Retrieved from the Internet at http://www.mdrc.org/publications/51/full.pdf on July 28, 2005.

[89] Caroline Danielson and Jacob Alex Klerman, "Why Did Welfare Caseloads Decline?" (Welfare Policy Research Project of University of California and RAND, working paper, revised June 2004).

[90] Margy Waller, "Refresher Course in Welfare Reform," *The Cincinnati Post* (June 21, 2004). Retrieved from the Internet at www.cincypost.com/2004/06/21/margy062104.html on April 13, 2005.

[91] U.S. Government Accountability Office, *Welfare Reform: Rural TANF Programs Have Developed Many Strategies to Address Rural Challenges,* GAO-04-921 (Washington, DC: Government Accountability Office, October 12, 2004).

[92] Richard Speigelman and Jean C. Norris, "Child Care Essential Ingredient for Sustained, Full-Time Work for Welfare Recipients" (Alameda Country CalWORKs Needs Assessment and Outcomes Study, September 22, 2004).

[93] Heather Boushey and Joseph Wright, "Working Moms and Child Care, Data Brief No. 3" (Washington, DC: Center for Economic and Policy Research, May 5 2004). Retrieved from the Internet at

http:// www.cepr.net/publications/Childcare2004.htm on April 13, 2005.

94 Executive Office of the President, Office of Management and Budget, *Statement of Administration Policy: H.R. 4 Personal Responsibility and Individual Development for Everyone (PRIDE) Act* (Washington, DC: Office of Management and Budget, March 29, 2004).

95 M.K. Tally, *Job Training and Education Fight Poverty* (Washington, DC: Institute for Women's Policy Research, Fact Sheet D444, revised April 2002). Retrieved from the Internet at: http://www.iwpr.org/pdf/d444.pdf on April 15, 2005.

96 R.J. LaLonde, "The Promise of Public Sector-Sponsored Training Programs," *Journal of Economic Perspectives* 9, No. 2 (1995): 149-168.

97 Rebecca Gordon, *Cruel and Usual: How Welfare 'Reform' Punishes Poor People* (Oakland, CA: Applied Research Center, February 2001). Retrieved from the Internet at: http://www.arc.org/downloads/arc 010201.pdf on April 15, 2005.

98 Average number per month in fiscal year 2001.

99 Employment and Training Reporter, "Earnings gains showed largest increase among WIA outcomes" (Washington, DC: MII Publications, November 8, 2004), Employment and Training Reporter 36, No. 11 (Nov 2004): 163.

100 Shawn Fremstad, "Recent Welfare Reform Research Findings: Implications for TANF Reauthorization and State TANF Policies" (Washington, DC: Center on Budget and Policy Priorities, January 30, 2004). Retrieved from the Internet at http://www.cbpp.org/1-30-04wel.htm on April 13, 2005.

101 Susan Scrivener, Gayle Hamilton, Mary Farrel, et al., "National Evaluation of Welfare-to-Work Strategies: Implementation, Participation Patterns, Costs and Two-Year Impacts of the Portland (Oregon) Welfare-to-Work Program" (New York, NY: Manpower Demonstration Research Corporation, Prepared for the U.S. Department of Health and Human Services, May 1998). Retrieved from the Internet at: http://aspe.hhs.gov/hsp/isp/Portland/xsportld.htm#Notes on April 15, 2005.

102 Julie Strawn, "Why Congress Should Expand, Not Cut, Access to Long-Term Training in TANF" (Washington, DC: Center for Law and Social Policy, February 2004). Retrieved from the Internet at http://www. clasp.org/publications/TANF_Postsec.pdf on April 20, 2005.

103 *Ibid*.

104 Mark Nord, Margaret Andrews, and Steven Carlson, *Household Food Security in the United States, 2003*, Table 3, Food Assistance and Nutrition Research Report, No. (FANRR42) (Washington, DC: Economic Research Service, U.S. Department of Agriculture, October 2004). Retrieved from the Internet at http://www.ers.usda.gov/publications/fanrr42/fanrr42b.pdf.

105 Mark Nord, Margaret Andrews and Steven Carlson, *Household Food Security in the United States, 2002.* Food Assistance and Nutrition Report, Number 35 (Washington, DC: Economic Research Service, U.S. Department of Agriculture, 2003). Retrieved from the Internet at http://www.ers.usda.gov/publications/fanrr35/ on April 18, 2005.

106 Mariana Chilton and Angelo Giardino, "Who's Looking Out for the Little Ones?" *Philadelphia Daily News* (November 2, 2004). Retrieved from the Internet at http://www.philly.com/mld/dailynews/news/opinion/10075461.htm on April 20, 2005.

107 Laura A. Castner and Allen L. Schrim, *Reaching Those in Need: State Food Stamp Participation Rates in 2002"* (Mathematica Policy Research, Inc., March 2005). Retrieved from the Internet at http://www.mathematica-mpr.com/publications/pdfs/fns02rates.pdf.

108 U.S. Department of Commerce, Bureau of the Census, *Gross Rent as a Percentage of Household Income in the Past 12 Months, Table B25070, 2004 American Community Survey.* Calculations by CDF. The Department of Housing and Urban Development considers housing to be unaffordable if the rental cost is greater than 30 percent of household income.

109 The Fair Market Rent (FMR) is the amount in a given geographical area that is sufficient to cover rental charges for the lowest-cost 40 percent of the housing units. Every year HUD sets the FMRs for each area and at different levels for units depending on the number of bedrooms. FMRs include utility costs (except for telephones).

110 National Low Income Housing Coalition, "Out of Reach 2004: America's Housing Wage Climbs" (Washington, DC: National Low Income Housing Coalition report, December 2004). Retrieved from the Internet at http://www.nlihc.org/oor2004/ on June 22, 2005.

111 Joint Center for Housing Studies of Harvard University, *State of the Nation's Housing, 2003* (Cambridge, MA: Joint Center for Housing Studies of Harvard University, June 2003). Retrieved from the Internet at www.jchs.harvard.edu on April 18, 2005.

112 The United States Conference of Mayors, *U.S. Conference of Mayors- Sodexho Hunger and Homelessness Survey 2003* (The United States Conference of Mayors, December 2003). Retrieved from the Internet at www.usmayors.org on April 18, 2005.

113 The Better Homes Fund, "America's Homeless Children: New Outcasts," *A Public Policy Report from The Better Homes Fund* (Newton, MA: Better Homes Fund, 1999).

114 Dean Baker, *Who's Dreaming? Homeownership among Low Income Families* (Washington, DC: Center for Economic and Policy Research, January, 2005). Retrieved from the Internet at http://www.cepr.net/publications/housing_2005_01.pdf on April 20, 2005.

115 Robert Greenstein, "The Earned Income Tax Credit: Boosting Employment, Aiding the Working Poor" (Center on Budget and Policy Priorities, updated August 17, 2005). Retrieved from the Internet at http://www.cbpp.org/7-19-05eic.htm on October 4, 2005.

116 Timothy M. Smeeding, Katherin Ross Phillips and Michael O'Connor, "The EITC: Expectation, Knowledge, Use, and Economic and Social Mobility," *National Tax Journal* 53 (December 2000): 1187-1210.

117 CDF calculations based on IRS SPEC Return Data Base, Tax Year 2002 Return Information (July 2004). The $2.3 billion figure includes tax prep costs for 67 percent of EITC recipients and RAL costs for 34.6 percent of EITC recipients.

118 Chi Chi Wu and Jean Ann Fox, "All Drain, No Gain: Refund Anticipation Loans Continue to Sap the Hard-Earned Tax Dollars of Low-Income Americans: 2004 Refund Anticipation Loan Report" (Washington, DC: National Consumer Law Center and Consumer Federation of America, January 2004). Retrieved from the Internet at http://www.consumerlaw.org/initiatives/refund_anticipation/content/2004RALReportFinal.pdf on July 29, 2005.

119 *Ibid.*

120 *Ibid.*

121 The Enterprise Foundation, *Building Individual Assets; Individual Development Accounts (IDA) and Community Development Financial Institutions* (CDFI) (Columbia, MD: Enterprise Foundation, October 1999). Retrieved from the Internet at http://www.enterprise-foundation.org/model%20documents/1108.pdf on July 29, 2005.

122 Arthur B. Kennickell, Martha Starr-McCluer and Brian J. Surette, "Recent Changes in U.S. Family Finances: Results from the 1998 Survey of Consumer Finances," *Federal Reserve Bulletin* (January 2000). Retrieved from the Internet at http://www.federalreserve.gov/pubs/bulletin/2000/0100lead.pdf on July 29, 2005.

CHAPTER TWO

Child Health

Fighting Poverty and Poor Health

For the first time in our nation's history, the projected life expectancy for children may be *less* than that of their parents. More than nine million children in the United States remain uninsured and child health programs responsible for so much progress over the past few decades are threatened by budget cuts and policies that undermine our national safety net. States have been cutting back on Medicaid coverage for children, and enrollment in the State Children's Health Insurance Program (SCHIP) decreased in the last quarter of 2003.

Children who are not healthy bear a disproportionate burden of illness. This burden falls most heavily on children from lower-income families and children from ethnic and minority backgrounds. The result: Many of the forward strides in children's health have stalled. In 2002, the infant mortality rate rose for the first time in more than 40 years, from 6.8 deaths per 1,000 births to 7.0 per 1,000 births. The United States now ranks 25th in the world among industrialized nations in preventing infant mortality, and the percent of children born at low birthweight has increased.

Ensuring access to quality health care and reducing health disparities among children are keys to breaking the cycle of poverty and ensuring that all children live healthy and successful lives.

"Housing costs contribute to malnutrition, and malnutrition affects school performance and cognitive capacity… weakens immune systems and makes children susceptible to illness…. If you spend a day in a malnutrition clinic, you will see a dismal parade of babies and toddlers who look much younger than they are. Underweight and developmentally delayed, they cannot perform normally for their ages… doctors describe these conditions as 'failure to thrive'…"

—David K. Shipler, "Children Going Hungry," *The Washington Post*, February 27, 2005

Health is a critical component in the cognitive and social development of children. Children in poor health are more likely to have poor social and economic outcomes and even shorter life expectancies. They cannot fully participate in the learning process, due to greater school absenteeism and behavioral problems resulting from certain health conditions.[1] Children in poor health start out at a disadvantage and, in many cases, maintain that disadvantage throughout their adult lives. However, the life-long impact of poor health in early childhood can be prevented.

During the last half century, public policies have not only enhanced the economic and social environment for a large portion of the U.S. population, they have also increased access to quality health care and achieved tremendous progress in improving children's health. Through such public health programs as Vaccines for Children and public health insurance expansion through Medicaid and the State Children's Health Insurance Program (SCHIP), more children than ever before have access to preventive health care. The infant mortality rate has dropped by more than 70 percent, falling rapidly after the inception of Medicaid in 1965 and again after the Medicaid expansions in the early 1990s. A higher percentage of babies are born to women receiving early prenatal care, and a lower percentage to women receiving late or none. Higher immunization rates have yielded dramatic decreases in the incidence of many childhood diseases, such as disability due to polio or *Haemophilus influenzae* type b (Hib) and deaths due to incidences of diphtheria and tetanus.

Despite the overwhelming evidence demonstrating the importance of these programs in ensuring children's health, there is a growing disconnect between children's health needs and public policy. In fact, the initiatives responsible for most of the improvements in children's health status over the past few decades are being threatened by budget cuts and policies that undermine these safety net programs. States have been cutting back on Medicaid coverage for children and, for the first time since the program's inception, SCHIP enrollment actually decreased in the last quarter of 2003.[2] In 2002, the infant mortality rate rose for the first time in over 40 years, from 6.8 deaths per 1,000 births to 7.0 per 1,000 births.[3] This alarming statistic means the United States now ranks 25th in the world among industrialized nations in preventing infant mortality.[4] The percentage of children born at low birthweight has increased, and more than nine million children in the United States remain uninsured.[5]

Furthermore, those children who are not healthy bear a disproportionate burden of illness. This burden falls most heavily on children from lower-income families and children from ethnic and minority backgrounds. Differences in health outcomes for poor and minority children continue to persist for most major health problems affecting children, including lack of prenatal care, lead poisoning, inadequate dental care, asthma, obesity, and lack of health coverage. These inequalities in health access and outcomes constitute a major challenge to our nation's ability to thrive because the consequences of many conditions that afflict children continue through adulthood.

Recently, new challenges have begun to emerge in children's health, highlighting the need for continued attention to providing all children, especially children living in poverty, with the quality care they need. *A recent study in the New England Journal of Medicine revealed that for the first time in the nation's history, the projected life expectancy for children may drop.* Children today may live as many as two to five years less than their parents as a result of the negative health effects of obesity and obesity-related illnesses.[6] Reducing health disparities among children is key to breaking the cycle of poverty and ensuring the social and academic success of all children.

This chapter describes the current state of child health across several important indicators. Differences in health outcomes for income and race are examined for each indicator, highlighting the disproportionate number of minority and poor children with poor health outcomes. It goes on to describe the ongoing disconnect between children's health needs and policy. Programs influential in ensuring good health outcomes have been cut or altogether eliminated, even when their cost effectiveness is demonstrated by research. The chapter concludes with suggestions of ways to address and improve children's health outcomes.

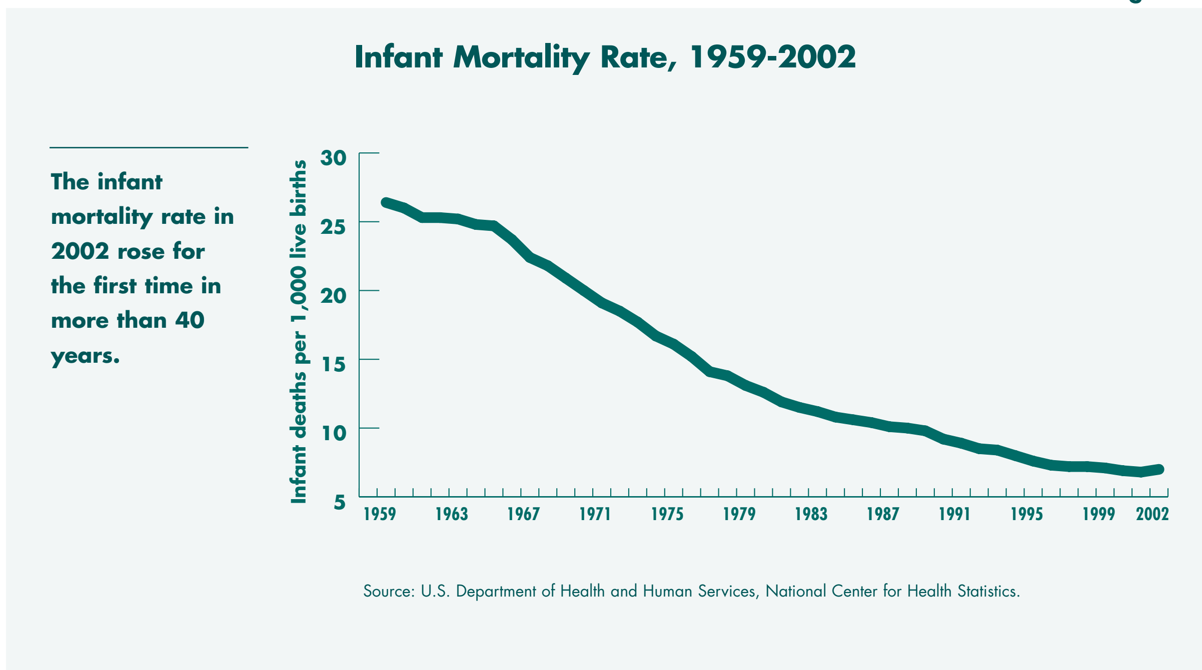
The Poor Health Burden on Low-Income and Minority Children

Most children born today in the United States experience few lasting or significant illnesses. They tend to be in excellent or very good health and suffer no serious abnormalities. Those who are not healthy, however, bear a disproportionate burden of illness, and this burden falls most heavily on children from lower income families and children from ethnic and minority backgrounds. Despite the dramatic progress in children's health, we enter the 21st century no closer to closing the gaps in health outcomes for many children than we were in the last.

Poverty and Health

Health is strongly correlated with income. Poor people are less healthy than those who are better off, whether the benchmark is mortality, the prevalence of acute or chronic diseases, or mental health. The association of poverty and health could be due to many factors. Families in poverty have higher stress levels as they struggle to meet their basic needs. They live in dangerous neighborhoods

Child Health – Figure 1



Source: U.S. Department of Health and Human Services, National Center for Health Statistics.

The Health Burden on Poor Children

Compared to higher-income children, low-income children are:*

- Almost five times as likely to be in only fair or poor health.
- Three times as likely to have an unmet medical need.
- Almost three times as likely to be uninsured and have no regular place for health care.
- More than twice as likely to not have seen a doctor for two years or delayed medical care due to cost.
- More than one and a half times as likely to miss 10 or more days of school due to illness or injury.

* Low-income is defined as family income below 200 percent of the Federal Poverty Level (FPL).

Sources:
1. National Center for Health Statistics, 2002 National Health Interview Survey. Calculations by Children's Defense Fund, January 2005.
2. National Health and Nutrition Examination Survey, 1999-2000. Calculations by the Children's Defense Fund, October 2004.

where they are exposed to more environmental hazards, and they endure greater hardships in their everyday lives.[7]

A family's well-being is strongly tied to the physical health of its members. When illness strikes one member, the entire family shares the burden. Income dwindles when parents cannot work. Opportunity is lost when children cannot attend school. Yet at the same time, poor people—who lack consistent access to nutritious food, clean water, preventive health measures, or a healthy, sustainable environment—are extremely vulnerable to illness, disability, and even death.[8]

Numerous studies have shown that poverty is associated with higher rates of poor health and chronic health conditions in children. Low-income children have greater exposure to lead, decreased management of asthma, a higher number of dental caries, and higher rates of obesity. Children in poor physical or mental health cannot fully participate in the learning process. All of these factors may contribute to why children who live in poverty experience negative health outcomes.

Race/Ethnicity and Health

Health is also associated with race and ethnicity. Indeed, the gaps in health status between Whites and minorities have persisted and, for some indicators, widened further. For example, while age-adjusted death rates from all causes declined for both Whites and Blacks, Blacks are still at a 30 percent higher risk of death than Whites, a disparity greater than in 1960.[9] Major disparities exist in coronary heart disease (CHD) with a disproportionate burden of death and disability among minority and low-income populations. With almost 700,000 deaths a year, CHD is the leading cause of death in the United States, accounting for 29 percent of all deaths. In 2001, premature deaths (occurring in persons under age 64) from CHD were higher among American Indian/Alaskan Native (36 percent), Black (31.5 percent), and Latino (23.5 percent) populations than among Whites (14.7 percent).[10] Similarly, when looking at all cancers combined, Black men are 26 percent and Latino men are 16 percent more likely than White men to die of a malignancy. Black women are 52 percent, and Latino women are 20 percent, more likely than White women to die of cancer.[11]

Racial disparities in health exist not only for adults; minority children—especially Black and Latino children—continue to lag behind White and affluent children in almost every health indicator. The disproportionate burden of illness and death experienced by low-income and minority children remains a major obstacle to improving children's well-being. Disparities persist in the rates of infant mortality and prenatal care, immunizations, asthma, dental care, lead poisoning, and obesity, to name just a few such indicators. These conditions impact many aspects of children's development and

functioning. Their effects occur before birth, continue through adolescence, and often last a lifetime.

Disparities in Prenatal Care, Infant Health, and Immunizations

The foundation for children's physical, mental, and emotional health begins before birth during the formation of the brain and body, and is linked to maternal health. For example, recent research has studied the far-reaching effects of prenatal brain development on later functioning.[12] These studies suggest that there are certain stages of development, both before birth and after birth, when environmental influences can have a potentially permanent effect on a child.[13] Early prenatal and infant care and regular health monitoring can help to counterbalance certain negative biological and environmental factors, creating healthier children and most likely healthier adults as well.

Prenatal care, birthweight, and immunizations are all strong contributors to a child's chances (or lack thereof) for healthy physical and mental development, and by extension, success in school and their adult life. For example, a low birthweight child is twice as likely as a normal weight child to have clinically significant behavior problems, such as hyperactivity.[14, 15] Children born with low birthweight are also about 50 percent more likely to score below average on measures of reading and mathematics.[16] These risks have been measured in young children as well as teens, indicating that the impact of early childhood conditions can affect learning throughout childhood.[17]

These risks are also greater if compounded with other physical, ethnic, or socioeconomic factors. For example, one birthweight study found that maternal smoking during pregnancy and Hispanic origin were two predictors of whether low birthweight children would develop behavior problems.[18] Socioeconomic disadvantage is also a risk factor for low birthweight and premature birth.[19]

Prenatal Care

Prenatal care for pregnant women, important in reducing the incidence of infant mortality and low birthweight, is consequently a critical component in ensuring the healthy development of infants and children. The level and timing of prenatal care is often used as a proxy for access to care and birth outcomes. During the 1990s, the proportion of women starting prenatal care in the first three months of pregnancy improved slowly but steadily. This improvement coincides with a law passed in 1989 that requires Medicaid coverage for pregnant women with incomes below 133 percent of the federal poverty guideline (many states provide coverage to pregnant women at higher-income levels).[20]

In 2002, 83.7 percent of mothers began prenatal care during the first three months of their pregnancy, a slight increase from the previous year. In that same year, 3.6 percent of all mothers had late or no prenatal care, which is defined as care never initiated or only initiated during the last three months of the pregnancy. However, racial and ethnic differences continue in the timeliness of prenatal care. In 2002, 75.2 percent of non-Latino Black and 76.7 percent of Latino women received prenatal care in the first trimester, compared to 85.4 percent of non-Latino White women.[21] Further, non-Latino Black and Latino women were more than two times as likely as non-Latino White women to have late or no prenatal care (6.2 percent and 5.5 percent, respectively, vs. 3.1 percent).[22]

Infant Mortality and Birthweight

Racial and ethnic differences also exist in the rates of infant mortality and low birthweight. Although the overall infant mortality rate dropped steadily until the increase in 2002, the difference between White and Black infant mortality rates did not. In 2002, there were more than 28,000 infant deaths (children under age one), more than all deaths combined among children ages one through 19. Infants born to Black mothers were more than twice as likely as infants born to White mothers to die before their first birthday (14.4 vs. 5.8 deaths per 1,000 live births). Almost one-third of all infants who died in 2002 were infants born to Black mothers.[23]

Infant mortality and birthweight remain critical indicators of children's health and illustrate the

persistence of health disparities among children. While low birthweight is one of the leading causes of infant mortality among all races, it is by far the greatest cause of death for infants born to Black mothers. In 2002, 7.8 percent of infants were born weighing less than 2,500 grams or 5.5 pounds, which is similar to previous years. Non-Latino Black infants were almost twice as likely to be born at low birthweight as non-Latino White infants (13.4 percent vs. 6.9 percent).[24]

Smoking and Substance Abuse

Prenatal care is also important because it presents opportunities to address behavioral issues during pregnancy, such as smoking or substance abuse, that also have significant impacts on infant and child health. Women who smoke during pregnancy are at greater risk for having a premature birth, pregnancy complications, low birthweight infants, a stillbirth, as well as a higher rate of infant mortality. Smoking during pregnancy also is associated with Sudden Infant Death Syndrome (SIDS), poor lung development, asthma, and other negative consequences for child health and development.

The percentage of women who smoke during pregnancy has declined during the last decade. In 2002, 11.4 percent of women giving birth reported smoking during pregnancy. There were, however, racial differences, with Black women less likely than White women to smoke during pregnancy (8.7 percent vs. 12.3 percent, respectively).[25] This difference is unexpected given the higher rates of infant mortality and low birthweight among infants

Child Health – Table 1

Selected Maternal and Infant Health Indicators, by Race and Hispanic Origin of Mother, 2002

Characteristic	All Races	White		Black		Native American	Asian, Pacific Islander	Hispanic*
		Total	Non-Hispanic	Total	Non-Hispanic			
Percent								
Early prenatal care[1]	83.7%	85.4%	88.6%	75.2%	75.2%	69.8%	84.8%	76.7%
Late or no prenatal care[2]	3.6	3.1	2.2	6.2	6.2	8.0	3.1	5.5
Low birthweight[3]	7.8	6.8	6.9	13.3	13.4	7.2	7.8	6.5
Very low birthweight[4]	1.5	1.2	1.2	3.1	3.1	1.3	1.1	1.2
Births to teens	10.8	9.8	7.9	18.0	18.1	18.5	3.8	14.9
Births to unmarried	34.0	28.5	23.0	68.2	68.4	59.7	14.9	43.5
Births to mothers who have not completed high school	21.5	21.6	11.7	24.4	24.3	30.8	10.3	48.1
Per 1,000								
Infant mortality rate[5]	7.0	5.8	5.8	13.8	13.9	8.6	4.8	5.6
Per 100,000								
Maternal mortality rate[6]	8.9	6.0	5.6	24.9	24.9	na	na	7.1

*Persons of Hispanic origin can be of any race; includes races other than White and Black.

na — data not available

[1]Care begun in the first three months of pregnancy.

[2]Care begun in the last three months of pregnancy, or not at all.

[3]Less than 2,500 grams (5 lbs., 8 oz.).

[4]Less than 1,500 grams (3 lbs., 4 oz.).

[5]Infant deaths per 1,000 live births. These rates are from the linked birth-death files for 2001, and differ somewhat from other infant mortality rates published by the National Center for Health Statistics.

[6]Maternal deaths per 100,000 live births.

Source: National Center for Health Statistics.

born to Black women, illustrating that a variety of factors can influence outcomes of infant development.

Consistent prenatal monitoring and care are key to the health of both mother and baby, as even small amounts of harmful substances can have devastating effects on infant health. There is no safe threshold for alcohol consumption, demonstrated by findings that negative outcomes have been found in children who were prenatally exposed to the equivalent of just half a drink per day.[26] Children born with Fetal Alcohol Syndrome have neurological abnormalities and generally are academically behind their peers. Moderate exposure (measured as 2.2 drinks/day) is associated with learning and psychiatric problems, distractibility, and hyperactivity.[27] Even low levels of exposure (measured as .03 oz. of alcohol/day) have been associated with behavior problems in school-aged children.[28]

Immunization

Prenatal care also allows providers to convey the importance of immunizations and future health visits. Immunization is one of the most effective ways to protect a child from serious, preventable infectious diseases, enabling children to enter school in good health, ready to learn. Vaccination programs in the United States have resulted in the elimination of smallpox and rendered diseases such as rubella, diphtheria, polio, and tetanus exceedingly uncommon. In addition, cases of Hib (*Haemophilus influenzae* type b)—the leading cause of childhood bacterial meningitis and postnatal mental retardation—and cases of measles were reduced significantly as a result of a broad improvement in childhood vaccination levels during the last decade.

Child Health – Table 2

Due in part to increased access to immunizations, more than three-fourths of all poor children are fully immunized, but still lag behind higher-income children.

Immunization of Two-Year-Olds* in 1995 and 2004, by Race/Ethnicity and Poverty Status

	Percent fully immunized 4:3:1:3 series**		Percent fully immunized 4:3:1:3:3 series***	
	1995	2004	1995	2004
All income levels				
All races	73.7%	82.5%	55.1%	80.9%
White non-Hispanic	76.4	85.1	55.6	83.3
Black non-Hispanic	69.8	76.0	53.3	74.5
Hispanic	68.2	81.2	53.0	79.7
Below poverty				
All races	67.3	78.0	51.0	76.8
White non-Hispanic	68.9	77.6	45.6	76.5
Black non-Hispanic	69.6	73.8	53.1	72.0
Hispanic	62.9	79.8	53.4	78.9

*Children 19–35 months of age

**Four or more doses of diphtheria, tetanus, pertussis vaccine (DTP or DTaP or DT); three or more doses of poliovirus vaccine; one or more doses of any measles-containing vaccine (MCV); and three or more doses of *Haemophilus influenzae* type b vaccine (Hib).

***Four or more doses of diphtheria, tetanus, pertussis vaccine (DTP or DTaP or DT); three or more doses of poliovirus vaccine; one or more doses of any measles-containing vaccine (MCV); three or more doses of *Haemophilus influenzae* type b vaccine (Hib); and three or more doses of hepatitis B vaccine (HepB). The hepatitis B vaccine was a relatively new recommendation for children in 1995, so rates of immunization were somewhat low. The percentage of children fully immunized was therefore also lower.

Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1995 and 2004 National Immunization Survey, Table 32, at <http://www.cdc.gov/nip/coverage/NIS/04/toc-04.htm>.

This improvement is, in part, attributable to the Vaccines for Children (VFC) program. Established in 1993 as part of the Childhood Immunization Initiative, the VFC program provides free vaccines to doctors for Native American children and children who are uninsured or receiving Medicaid, so they can be immunized in their own private doctor's office. Prior to VFC's implementation in 1993, about two-thirds of two-year-olds had been fully immunized. By 2004, 80.9 percent of two-year-olds were immunized, meeting the *Healthy People 2010* goal. New vaccines that have become available to prevent hepatitis B, chickenpox, and pneumococcal pneumonia are now included in the immunization schedule for children.

While incredible progress has been made in increasing U.S. immunization rates for children, sustained policy, outreach, and educational efforts are necessary to not only maintain current rates, but to improve upon them. The percentage of two-year-olds receiving the full 4:3:1:3:3[29] complement of vaccines for diphtheria/tetanus/pertussis, polio, measles, Hib, and hepatitis B reached a high of 80.9 percent in 2004. Yet the immunization rate for children in families below the poverty level was only 76.8 percent.[30] According to data from the Centers for Disease Control and Prevention's National Immunization Survey, 74.5 percent of non-Hispanic Black and 79.7 percent of Latino 2-year-olds received the 4:3:1:3:3 complement, compared with 83.3 percent of non-Hispanic Whites.[31] These immunization differences indicate a need for renewed immunization outreach and education efforts, particularly to poor and minority children. Disparities such as these leave millions of children at risk for often debilitating and potentially life-threatening infectious diseases.

Disparities in Childhood Lead Poisoning

The leading source of lead exposure in America's children is deteriorating lead paint in older housing. Lead poisoning continues to be a threat to children's health despite the 1978 nationwide ban on lead paint. Nearly one million children are affected by lead poisoning, exhibiting elevated blood lead levels.[32] It is estimated that one out of every 20 children in the United States has some lead poisoning but is not exhibiting visible signs or symptoms.[33]

The threat of lead exposure is even greater for low-income and minority children. For example, low-income children (below 200 percent of poverty) are more than five times as likely to have elevated blood lead levels of at least five micrograms per deciliter (mg/dL) than higher-income

STORIES FROM THE STATES

Unsafe Living Conditions and Lead Poisoning

Troccora Nicholson lives in Duncan, Mississippi, with her five children. Their home is a dilapidated trailer that should be condemned. Parts of the wall are falling down; a section of plywood from the wall fell and hit her son in the head. The sky can be seen through a hole in the ceiling. Rain gets into the trailer, which is now filled with mold. In the bathroom, there is a gap in the floor covered with plywood because it is wide enough for snakes to enter. Troccora's unsafe home is the reason one of her younger sons has lead poisoning and RSV (Respiratory Syncytial Virus). She receives Medicaid and other public assistance for her children, but she cannot move out of the trailer because she is currently unemployed and has no way of traveling to a job.

Child Health – Table 3

Young Black children are more than twice as likely as White children to have elevated blood lead levels.

Lead Exposure

	Percent of children* with lead levels over 5 µg/dL	
	All Children	Ages 1 to 5
All**	3.2%	8.2%
Race/ethnicity		
Non-Hispanic White	2.5	7.0
Non-Hispanic Black	7.0	17.4
Hispanic	2.8	6.3
Family income		
200% of poverty or more	0.9	***
Under 200% poverty	5.2	***
Insurance status		
Insured	2.9	7.7
Uninsured	5.2	11.3

* Children are ages 1 through 18.

** Includes all children measured, regardless of race, income, or insurance status.

*** Sample size too small to produce a reliable estimate.

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, 1999-2000 and 2001-2002 National Health and Nutrition Examination Survey (NHANES).

Calculations by Children's Defense Fund.

children.[34] These children are more likely to occupy housing and schools that contain lead-based paint. For example, 16 percent of lower-income children living in older housing have lead poisoning, compared with 4 percent of all children.[35] Children receiving Medicaid constituted about one-third of the U.S. population of children ages one to five, but represented about 60 percent of children with elevated blood lead levels.[36] According to the Alliance to End Childhood Lead Poisoning, Black children are at five times greater risk of exposure than White children.[37]

Consistent lead screening is essential to the identification of children in need of treatment. As part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit, the Centers for Medicaid and Medicare Services (CMS) requires that Medicaid children be screened for lead poisoning, at a minimum, at ages 12 months and 24 months. Therefore, at least one blood test for lead is supposed to occur by the age of 2.[38] In three states—New Jersey, Massachusetts, and Rhode Island—the law mandates screening of all children younger than age six, regardless of Medicaid status.[39]

However, a National Conference of State Legislatures survey reported many barriers to consistent application of lead screening, including provider noncompliance, lack of access to laboratories, lack of funding, transient population, and problems with parental follow-through.[40] Although most states (37) claim that blood lead screenings of children in Medicaid occur regularly as part of EPSDT requirements, a General Accountability Office (GAO) report found that more than 80 percent of Medicaid children have not been screened for blood lead levels despite this requirement.[41] This is particularly disconcerting given that children in the Medicaid program are three times more likely than other children to suffer from lead poisoning.[42]

All children are potentially vulnerable to lead poisoning because they engage in more hand-to-

mouth activity and, thus, are easily poisoned from chronic ingestion of lead paint chips and house dust or soil that may have lead particles in it.[43] In addition, a child's growing body can absorb more lead than adults, and their developing brains and nervous systems are more sensitive to the damaging effects of lead. High levels of lead can cause behavior and learning problems, stunted growth, hearing problems, and headaches.[44] A variety of studies have tracked the effect of elevated blood lead levels in children, and have found that there is anywhere between a one- and five-point drop in IQ with each increase of 10 µg/dL in blood lead level.[45,46,47]

Smaller concentrations of blood lead levels also have been associated with decreased IQ scores and cognitive impairment in exposed children. Children with lead levels at half the known danger threshold or lower have demonstrated decreases in IQ and intellectual function.[48,49,50] This evidence supports what the Centers for Disease Control and Prevention has acknowledged: There is no safe level for lead exposure in children.[51] Children with lead exposure at a variety of levels can suffer from cognitive impairments that hinder their ability to learn.

Disparities in Prevalence and Severity of Childhood Asthma

Asthma is one of the few chronic illnesses that affects children more frequently than adults. While asthma rates have increased among all age groups in the United States, young children have experienced the largest increase in prevalence. Children from birth to age 17 are more likely to suffer from asthma than adults 18 and older.[52] From 1980 to 1994, the prevalence of asthma in children under the age of five more than doubled. Older children ages five to 14 also experienced substantial increases, with asthma rates nearly doubling between 1980 and 1994.[53] Today asthma affects almost five million children and their families.

Race, poverty, and environmental factors are all contributors to the high number of asthma cases. The problem is most severe for low-income, inner-city youths. Funded by the National Institutes of Health, the National Cooperative Inner-City Asthma Study identified a number of asthma risk factors for Black, Latino, and White children in urban families including: high levels of indoor allergens, especially the cockroach allergen; high levels of tobacco smoking among family members and caretakers; and high indoor levels of nitrogen dioxide, a respiratory irritant produced by inadequately vented stoves and heating appliances.[54]

Although the prevalence of asthma is increasing for all children, low-income and Black children are disproportionately affected. Children from poor families and Black children are not only more likely to have asthma than children from higher income families and White or Latino children, they also are more likely to have suffered asthma attacks.[55] Children with disabling asthma have almost twice as many restricted activity days and lost school days as children with impairments due to other types of chronic conditions.[56] Disabling asthma was 66 percent higher among Black children, 46 percent higher among low-income

STORIES FROM THE STATES

Volunteer Medical Care at the Hope Clinic

The Hope Clinic, in Rio Grande Valley, Texas, is a clinic for patients who have no options in health care, no insurance, and do not qualify for government assistance. It is run solely on donations and has an entirely volunteer staff; only the executive director is paid. Jacquelin Bocanegra is an eight-year-old who goes to the Hope Clinic for treatment of her asthma. At the clinic, a volunteer pharmacy student works as a translator to give Jacquelin and her mother instructions on how to use her inhaler.

children, and 37 percent higher among children in single-parent families.[57]

Poorly controlled asthma can result in costly emergency care and hospitalization. Each incidence of emergency room treatment can easily translate into many missed days of school. Children under 18 years of age made up 36 percent of all asthma-related outpatient visits and 38 percent of emergency department visits in 2002.[58] In one study of acute emergency room asthma treatment, 45 percent of the children studied missed more than two days of school, and 24 percent missed more than five days of school as a result of their acute asthma episode.[59]

Racial differences also exist in the number of hospital visits, emergency room visits, and deaths attributed to asthma. Black children under the age of five are almost three times as likely to be hospitalized for asthma as young White children. In addition, hospital emergency department visits are four times higher for Black children under the age of five than for White children. Although the overall death rate in children with asthma is low, Black children five to 14 years of age are five times as likely to die from asthma as are White children of the same age.[60] The rate of hospitalization for Black children increased by 25 percent from 1980-1999 compared with the 11 percent increase seen in White children.[61] In fact, Black and Latino caregivers were more likely than White caregivers to report that the emergency department was their primary source for asthma treatment and medications for their children.[62]

The lack of health insurance is a powerful barrier to proper asthma management, which is particularly important for severe cases of asthma. Compared to similar children with health insurance, uninsured children with disabilities or chronic illness are seven times as likely to lack a regular source of health care and almost five times as likely to lack needed medical care.[63] Access to comprehensive health care will give children the preventive treatment they need to control their asthma.[64] Other barriers to care also need to be addressed because Black and Latino children are less likely to see a specialist for a follow-up visit, even when they are enrolled in their state's Medicaid program.[65]

Disparities in Access to Dental Care

Tooth decay (dental cavities and caries) is one of the most common chronic diseases affecting children in the United States. This preventable health problem begins early and progressively worsens with age. Seventeen percent of children ages two to four years have decay. By age eight, approximately 52 percent of children have experienced decay. By age 17, dental decay affects 78 percent of the youth population.[66]

Eighty percent of all dental caries occur in only 25 percent of children.[67] The burden of untreated

Community Success Stories: Community-Based Childhood Asthma Management Project

Waianae, Hawaii, has among the highest prevalence of asthma in the state, especially in its Native Hawaiian pediatric population. By providing a community-based asthma management program, the program's staff sought to reduce inappropriate medical utilization and improve the quality of life for their pediatric asthma population. They also aimed to decrease the Waianae Coast Comprehensive Health Center's (WCCHC) emergency department pediatric asthma utilization rates.

Program staff implemented a comprehensive asthma management system that included an automated asthma tracking system and a standard system of care adapted for cultural sensitivity and based on the National Asthma Education and Prevention Program Asthma Guidelines. This coordinated team care approach is responsible for the significant decrease in both per capita expenditures (from $735 to $181), asthma-related emergency department visits (from 60 to 10), and overall asthma-related visits (from 1.5 to 0.25) in individuals served by the program over a three-year period.

Child Health – Table 4

Black, Hispanic, low-income, and uninsured children have greater dental problems and less access to care than other children.

Children's Dental Health and Access to Dental Care

	Percent of children who had:		
	Two or more years since last dental contact*	Unmet dental need*	Mouth and teeth in fair or poor condition**
Race/ethnicity			
White, non-Hispanic	14.9%	5.5%	10.6%
Black, non-Hispanic	20.0	6.4	21.3
Hispanic	25.9	7.3	22.0
Family income			
200% of poverty or more	14.3	4.0	9.9
Under 200% of poverty	24.1	10.2	19.5
Insurance status			
Insured	15.8	4.8	13.7
Uninsured	35.9	15.2	22.8

* Children ages 2 through 17

** Children ages 2 through 18

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, 2002 National Health Interview Survey; and U.S. Department of Health and Human Services, National Center for Health Statistics, 1999–2000 National Health and Nutrition Examination Survey (NHANES). Calculations by Children's Defense Fund.

dental caries is concentrated among low-income and minority children. The level of untreated dental caries among Black children (36 percent) and Latino children (43 percent) ages six to eight years is greater than for White children (26 percent) of the same age.[68] Children in low-income families are more than twice as likely as children in higher-income families to have untreated dental cavities and 20 percent more likely not to have had a dental visit in the past year.[69] They also are twice as likely to have mouths and teeth in fair or poor condition.[70]

A nationally drawn sample of children's well child and dental visit prevalence revealed that being low-income, uninsured, Black, or Latino is associated with a lack of recommended dental care.[71] Black and Latino children are significantly less likely than White children to have the recommended amount of dental visits as set forth by the American Academy of Pediatric Dentistry.[72] This is consistent with other data on Medicaid-enrolled patients and their limited amount of dental care. Past reports show that less than 20 percent of Medicaid-enrolled children receive any preventive dental visits.[73] Also, when the U.S. General Accounting Office asked states for the percentage of their dentists that saw 100 or more Medicaid patients (adults and children combined) in a year, not a single state reported a number that exceeded 50 percent.[74]

A major factor contributing to infrequent use of dental services among low-income children with Medicaid coverage is the shortage of dentists who will treat them. In some cases, particularly in rural areas of the country, there are a limited number of dental providers. In other areas, few dentists are willing to treat Medicaid beneficiaries due to low provider payment rates and burdensome paperwork.[75] Nationally, only about 10 percent of all

STORIES FROM THE STATES

Lack of Medicaid Dentists and Delayed Care

Beth Lovett lives in Jackson, Ohio, and has two daughters, ages five and nine, who are covered under Healthy Start/Healthy Families (Ohio's Medicaid/SCHIP programs). Beth's younger daughter, Makayla, needs fillings for her teeth. A summer preschool dental exam revealed the problem, but she will have to wait more than six months to get her daughter in to see a dentist in her area that takes Medicaid. Beth would like to be able to take her daughter in sooner for a dental visit, but she said it could cost $150 just for a simple cleaning if you are uninsured.

dentists accept Medicaid patients.[76] Less than one in five Medicaid-covered children visited a dentist during a year-long survey by the U.S. Inspector General.[77]

Other barriers to receiving dental care include obtaining reliable transportation to dental clinics, and overcoming scheduling difficulties and a perceived bias against Medicaid patients.[78] The result is often a missed school day for a child and a long wait at the dentist's office. Caregivers faced with these and other barriers to care will sometimes postpone their children's dental care, which can lead to more acute symptoms and additional dental caries.[79]

Untreated caries can progress into infections and abscesses, leading to facial swelling, pain, and discomfort. Children with serious dental problems can get to the point where their mouths hurt too much for them to eat, leading to malnourishment and stunted growth. School absenteeism due to both decay and other dental problems is estimated at 52 million hours each year.[80]

Childhood tooth decay is preventable when a combination of policies, including national, professional, community, and individual measures, are put into practice. In addition to water fluoridation and dental sealant programs, community programs also must address issues at the root of disparities in oral health care: health illiteracy and lack of awareness, apathy about preventive services, infant feeding practices, diet, language and cultural differences with providers, and lack of access and transportation to dental care.[81]

There are a number of means that communities can employ to address systemic issues associated with a lack of dentists, their poor geographic distribution, and the limited number of minority dental professionals. Partnerships with dental schools can help introduce volunteer providers into the community, mobile clinics can service rural areas without access, and scholarship programs and loan forgiveness initiatives can help increase the minority presence in the dental profession. Communities also have overcome barriers to access by integrating dental services into primary medical care or other child health and education programs, including Head Start and the Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Disparities in Obesity

Obesity has not only reached epidemic proportions for adults in the United States, but has also become a health crisis facing children. The number of overweight children has more than tripled since 1980. It is estimated that 15.3 percent of children and 15.5 percent of children and teens ages six to 19—almost nine million young people—are overweight.[82] Another 15 percent are considered at risk of becoming overweight.[83] Even among preschool children between ages two and five, more than 10 percent are overweight.[84]

While the prevalence of excessive weight and obesity has increased for both genders and across

all racial, ethnic, and age groups, the increases have not been even. Children in lower income families generally experience a greater prevalence than do those from higher-income families.[85] There has been a significant increase in the prevalence of very young (birth to five years) low-income children who are overweight. Between 1983 and 1995, there was an overall 16 percent increase for overweight and obese low-income children. The greatest increase in age groups was seen by four- to five-year-olds, with a 23.3 percent increase from 1983-1995.[86]

From 1988 to 2000, the percentages of Black and Latino children who were overweight more than doubled while the number of overweight White children climbed by 50 percent.[87] From 1999-2000, non-Latino Black and Mexican-American adolescents ages 12 to 19 were more likely to be overweight (24 percent) than non-Latino White adolescents (13 percent).[88] Mexican-American children ages six to 11 were more likely to be overweight (24 percent) than non-Latino Black children (20 percent) and non-Latino White children (12 percent).[89] Non-Latino Black girls and Mexican-American boys are at particularly high risk of being overweight.

On an individual basis, the main causes of overweight and obese children are the same as those for adults—eating too much of the wrong foods and moving around too little. According to the Centers for Disease Control and Prevention, only one-fifth (22 percent) of all U.S. children in grades nine to 12 eat the recommended five or more servings of fruits and vegetables per day.[90] Children at younger and younger ages are being exposed to foods high in calories, fats, and sugars and low in nutritional value, setting the stage for possible poor health and the negative outcomes that come with it. In one survey of infant and toddler diets, 23 percent of 19- to 24-month-olds had consumed soda or another sweetened beverage on the day of the interview.[91]

Compounding the problem of generally poor diets is the decline in physical activity among children and teens. Exercise can reduce the rates of excessive weight and obesity by offsetting the amount of calories consumed. However, less than half of all high school students are vigorously active on a regular basis, and 11.5 percent report no recent physical activity at all.[92] Activity levels for students are lower among minorities, with Black students in grades nine through 12 less likely (54.8 percent) to participate in vigorous physical activity than Latino (59.3 percent) or White students (65.2 percent).[93] This is illustrated by a recent study that followed Black and White girls from ages nine to 19 years of age. The drop in their activity levels continued through adolescence, and by the age of 16 or 17, 56 percent of the Black girls and 31 percent

STORIES FROM THE STATES

The Battle Between Nutrition and Making Ends Meet

Martha Estella Luevanos is a single mother with seven children, ranging from ages three to 13. She receives a disability check because her eight-year-old daughter, Elvira, was injured in a car accident. Her other income is through food stamps, Social Security, and Medicaid. Martha used to be the woman other neighborhood mothers would send their children to while they worked nights at the local bars. The children would show up skinny and sickly, and Martha would give them healthy foods like soup and beans. The other mothers would wonder how she was able to get their children looking so well. She would say it was food and love. But Martha's husband recently left and she is no longer able to take in the neighborhood children. In order to make a living, she has begun selling candy bars to the same children she used to provide with healthy foods.

Child Health – Table 5

Three out of ten children of all ages are overweight or at risk of becoming overweight.

Overweight Children*

	Percent of					
	All children ages 2 to 18			Children ages 6 to 18		
	At risk	Overweight	At risk or overweight	At risk	Overweight	At risk or overweight
All**	14.6%	14.7%	29.3%	15.4%	15.9%	31.3%
Race/ethnicity						
White, Non-Hispanic	13.8	12.3	26.1	14.5	13.3	27.8
Black, Non-Hispanic	14.8	18.2	33.0	14.9	20.7	35.6
Hispanic	16.9	19.5	36.4	17.7	20.6	38.3
Family income						
200% of poverty or more	13.4	13.3	26.7	13.9	14.7	28.6
Under 200% of poverty	15.5	16.4	31.9	16.4	17.5	33.9
Insurance status						
Insured	14.2	14.6	28.8	14.8	15.8	30.6
Uninsured	17.3	15.3	32.6	18.6	16.1	34.7

* "At risk" of overweight are those children with a body mass for age (BMI) from the 85th percentile to less than the 95th percentile. "Overweight" designates those children with a BMI for age at the 95th percentile and above.

** Includes all children measured, regardless of race, income, or insurance status.

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, 1999-2000 and 2001-2002 National Health and Nutrition Examination Survey. Calculations by Children's Defense Fund.

of the White girls did not engage in any consistent leisure time activity. Higher body mass index (BMI) levels also were associated with declines in leisure activity.[94]

While eating habits and physical activity are the two direct actions that yield the positive energy balance that leads to weight gain, there are an infinite number of social, economic, cultural, psychological, biological, and political factors that shape and affect those two simple activities. The differences in obesity rates are partially due to variations in access to physical education classes, school sports, and safe recreation areas in neighborhoods and school districts—factors that are often impossible to change on the individual level. For example, while it may be appropriate to encourage children to increase their activity levels by walking to school, this is problematic for children living in unsafe neighborhoods.

A report by the Secretary of Health and Human Services and the Secretary of Education highlights the many aspects of American culture that discourage physical activity, including an emphasis on cars rather than walking; unsafe community areas and playgrounds; and the appeal of television and video and computer games.[95] The report recommends that more school-based and after-school programs, community programs, and health education programs be implemented. These can help to improve children's health status, self-esteem, and social skills and contribute to the reduction in the number of children who suffer from obesity.

To date, very few programs have been successful in alleviating and treating obesity. This means that efforts must be concentrated on primary prevention. Moreover, because obesity is a condition attributed to learned behaviors, it is essential that children become the focus of interventions. By assessing all

Community Success Stories: SPARK

SPARK's (Sports, Play, and Active Recreation for Kids) mission is to "Create, Implement and Evaluate," with a goal of teaching physical education from a public health approach instead of a sports-oriented approach. Making physical activity a lifetime activity alongside behavior change is an important core component of the program.

SPARK has been implemented in Head Start programs, supplemental nutrition programs for Women, Infants and Children (WIC), preschool, elementary, middle and high schools, as well as after-school programs, nationwide. SPARK trainers travel to schools and community organizations to instruct teachers and educators on how to set up the program. Their comprehensive approach includes an assessment, age-appropriate curricula, staff development, equipment, and a follow-up consultation. Components of the program involve training on how to instruct effectively, how to incorporate physical activity into their lesson plans, and how to "disguise" physical activity as fun.

Among SPARK's many successes is the academic achievement experienced by its participants. Despite spending between 200 and 300 percent more time out of the classroom, SPARK students performed either as well or better than other students on standardized tests.

of the factors that affect obesity, including culture and the built environment, successful interdisciplinary programs, policies, and cultural adaptations may help curb this growing problem.

Disparities in Health Insurance Coverage

Health insurance coverage is fundamental to ensuring children's access to necessary and appropriate health services, including primary and preventive care. Health coverage makes a positive impact on children's overall health and quality of care. Uninsured children are more likely to lack a usual source of care, go without needed care, and experience worse health outcomes than children with health coverage. For example, uninsured children are almost nine times more likely than insured children to have no regular source of care and over five times more likely to have not had contact with a health professional for two or more years.[96] Uninsured children are also more than one and a half times more likely than insured children to have mouth and teeth in fair or poor condition.[97]

Over the past decade, public health coverage expansions through Medicaid and the creation of the State Children's Health Insurance Program (SCHIP) have provided critical health care for the nation's poorest children, many of whom could not afford coverage otherwise. Children with health insurance have more regular sources for their medical care, report fewer unmet medical needs, and see a reduction in preventable hospitalizations.[98,99] Compared to uninsured children, publicly-insured children are more likely to obtain preventive and primary medical care, more likely to receive dental care, and less likely to miss out on necessary medical or dental care because of their families' inability to afford the care.[100]

Because of the availability of public health programs, children's health coverage improved slightly in the last couple of years despite the recent weak economy and the erosion of private health insurance coverage. However, progress in children's coverage has drastically slowed and is currently being threatened by continued state budget shortfalls that have led to increasing cuts in public health insurance programs, such as Medicaid and SCHIP.

Trends in Children's Coverage

In the midst of an anemic economy and escalating health insurance premiums, employer-based coverage has declined by 3.8 million people. This decline contributed to the addition of 5.2 million uninsured adults to a record 45 million people, an increase of 1.4 percent for the period from 2000 to 2003.[101]

Child Health – Table 6

Uninsured children are more than five times as likely as insured children to lack access to medical care.

Children's* Health Status and Access to Care, 2002

	Percent of children who:				
	Were in only fair or poor health	Had no usual place of care	Had two or more years since contact with health provider	Had delayed medical care due to cost	Had unmet medical need
Race/ethnicity					
White, non-Hispanic	1.5%	3.2%	2.5%	3.1%	1.8%
Black, non-Hispanic	3.5	5.8	3.6	3.9	2.9
Hispanic	3.1	11.6	9.3	4.4	2.8
Family income					
200% of poverty or more	0.8	3.0	2.5	2.3	1.3
Under 200% of poverty	3.9	8.4	5.9	5.6	4.0
Insurance status					
Insured	2.0	3.0	2.7	2.3	1.3
Uninsured	2.3	26.4	14.4	13.4	9.4

* Ages 0 through 17

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, 2002 National Health Interview Survey. Calculations by Children's Defense Fund.

STORIES FROM THE STATES

Medicaid/SCHIP as Acute Care Providers

Misty Smith, a Jackson, Ohio, Head Start worker, has two sons, ages four and six. She works 28 hours a week for $6.50 an hour, bringing home less than $500 a month. She receives Healthy Start/Healthy Families health care coverage for her children, as well as food stamps and child care assistance. She is a very committed mother and attributes her ability to provide for her children to the assistance she receives, especially Healthy Start/Healthy Families. "If I never had assistance, I would not make it. My youngest had [a serious food allergic reaction]. He ended up being hospitalized for a week because of it. My oldest had his tonsils removed and was hospitalized for two days because of a stomach virus." Healthy Start/Healthy Families paid for all of this care so that Misty did not have to worry about the medical bills.

In contrast to adults, children's coverage has remained stable due to coverage expansions under Medicaid and SCHIP. From the years 2000 to 2003, the number of uninsured children declined from 9.4 million to 9.1 million.[102] According to the Urban Institute, coverage under Medicaid, SCHIP, and other state programs increased by 4.8 percent between 2000 and 2003.[103]

However, 11.8 percent, or 9.1 million, of the nation's children ages from birth through 18 still have inadequate access to health care because they lack health insurance coverage.[104] About six million of these uninsured children are eligible for Medicaid or SCHIP under current law.[105] Enrolling these eligible children is key not only to shrinking the number of uninsured children, but also to decreasing the entire uninsured population, since children make up a significant portion of the uninsured.

Demographics of Uninsured Children

The progress in increasing the number of insured children has not been successful in closing the gap in access to health coverage for some children. Disparities in health coverage continue to persist among minority, poor, immigrant, and older children.

The establishment of SCHIP has led to significant progress in reducing the number of uninsured near-poor children. However, similar progress has not been achieved concerning the poorest children. Poor children (under 100 percent of poverty) are nearly four times more likely than their most affluent counterparts (above 300 percent of poverty) to be uninsured. About one in five children living in families under 200 percent of poverty are uninsured, compared to one in nine children in families between 200-300 percent of poverty. Children in families with incomes exceeding 300 percent of poverty had a one in 19 chance of being uninsured.[106]

In addition to poor children, children of color are also less likely to be insured. Although non-Latino White children make up the largest single group (38.7 percent) of uninsured children ages zero to 18, Black and Latino children combined represent over 50 percent of all uninsured children.[107] Also, when comparing all children regardless of insurance status, 14.9 percent of Black children and 21.9 percent of Latino children are uninsured compared to 7.7 percent of White children.[108] That means that Black children are almost twice as likely and Latino children almost three times more likely to be uninsured than non-Latino White children.

Efforts to decrease the number of uninsured children also must focus on children in older age groups. Adolescents constitute a somewhat larger share of the uninsured than other children.[109] About 13.6 percent of children ages 12 to 18 are uninsured, compared to 11 percent of children ages six to 11 and 10.3 percent of children under age six. Adolescents make up more than 44 percent

Child Health – Table 7

Almost two-thirds of all uninsured children have at least one parent who works full-time throughout the year.

Who Are the Uninsured Children?*

Race and Ethnicity

38.7%	are White
34.8%	are Latino
18.9%	are Black
4.2%	are Asian or Pacific Islander
2.3%	are of more than one race
1.1%	are American Indian or Alaskan Native

Family

52.2%	live in a two-parent household
85.5%	have at least one working parent
65.1%	have a least one parent who works full-time throughout the year
69.1%	live in families with incomes above poverty
86.6%	are citizens of the United States

*Ages 0 through 18

Source: U.S. Department of Commerce, Bureau of the Census, 2004 Annual Social and Economic Supplement to the Current Population Survey. Calculations by Children's Defense Fund.

of all uninsured children.[110] Rates of employer-sponsored coverage are higher for older children, but coverage under public programs is significantly lower, partially due to age-based eligibility criteria.[111]

Connecting the Dots: Children's Health Needs and Public Policy

Despite overwhelming evidence that public health policies have greatly improved children's health through programs that have increased children's access to quality health care, there is a disconnect between children's health needs and current public policy. Programs that spurred most of the improvements in children's health outcomes over the past half century are not expanding in line with needs. Recent efforts to freeze, cut, and even eliminate certain health programs critical to children's health are undermining the framework of safety net programs of public insurance, despite their cost-effectiveness in ensuring that children grow up healthy. Underlying issues that impact health disparities, such as children's poverty, are not being adequately addressed.

The Positive Role of Government in Improving Children's Health

Government can play a positive role in promoting policies that improve children's health. During the last half-century, we have witnessed tremendous progress brought about by public policies that have improved the health of the U.S. population. Access to public health programs, such as Vaccines for Children and public insurance through Medicaid and SCHIP, has increased the primary and preventive health care that children receive, dramatically improving children's health. The many achievements of public policies include the eradication of devastating diseases such as smallpox, the virtual elimination of disabilities from diseases such as polio, the drastic decline in infant mortality, and the extension of life expectancy by more than a decade.

Government can continue the progress in children's health care by further investing in these pro-

Child Health – Table 8

Lower-income children are more likely to be uninsured than higher-income children.

Uninsured Children*, by Income, 2003

Total number of uninsured children	9.1 million
Percent of children who are uninsured	11.8%
Percent uninsured in families with incomes of:	
under 100% of poverty	20.1
100-199% of poverty	18.4
200-299% of poverty	10.6
300% of poverty or more	5.4

*Ages 0 through 18

Source: U.S. Department of Commerce, Bureau of the Census, 2004 Annual Social and Economic Supplement to the Current Population Survey. Calculations by Children's Defense Fund.

STORIES FROM THE STATES

Insured and Uninsured in the Same Family

Rachel Blevins is married with four children and lives in Jackson, Ohio. Rachel and her husband, who owns and drives a semi truck, make above the income limits for Healthy Start/Healthy Families, Ohio's Medicaid/SCHIP programs, but they qualify for Head Start for their four-year-old daughter, Paige. Paige also has medical coverage because she was a premature infant, born at 34 weeks and weighing only three pounds. However, the Blevins must pay out-of-pocket for medical care for their 12-year-old son.

STORIES FROM THE STATES

Preventive Health Education in the Rio Grande Valley

Lourdes Flores is a "promotora" with Migrant Health Promotion in Texas. Promotoras are usually members of a community who take the initiative to educate themselves and their community members about the importance of healthy lifestyles. In the Rio Grande Valley community, diabetes is particularly prevalent due to genetic predisposition and an unhealthy diet. Lourdes holds a health class, oftentimes in the poorest areas of the Valley, to educate residents (usually women) on basic health care for themselves and their children. The promotoras develop the curriculum, prepare the classes, and recruit people from the neighborhood to attend. Lourdes and other promotoras play a vital role in education and preventive health in the Rio Grande Valley community.

grams to improve health care access and reduce health disparities. This investment is not only a moral commitment that must exist for our children, it is imperative for the economic well-being of our nation.

Investing in Child Health

Studies have shown that preventive health care, such as newborn hearing screenings and immunizations, not only save lives and improve health, but also save money. The Universal Newborn Hearing Screening Program (UNHS) is able to diagnose hearing loss in infants as young as six months of age, compared with 12 to 18 months of age when other selective processes are used. There is a large potential cost savings in early diagnosis, since early therapy and treatment can prevent both the loss of language development as well as more expensive reactive treatments for a hearing-impaired child. One model in particular has predicted a potential cost savings of $44,000 per child when diagnosed early for hearing loss. Even though this was a model and not a formal study of infants, a cost savings of that amount warrants further research and the continuation of the UNHS program.[112]

Diseases like measles and hepatitis B have not been eradicated, and vaccination is the only method we have of preventing children from suffering the permanent and sometimes debilitating effects of these diseases. For every $1 spent vaccinating children against measles, mumps, and rubella, $16 is saved in medical costs to treat those illnesses.[113] Influenza vaccination of school-age children has been shown to yield a net savings from a societal perspective and have health benefits within the community.[114] The risks involved in not vaccinating youth have been seen as recently as the 1970s, when both the United Kingdom and Japan saw epidemics of pertussis due to a drop in immunization rates.[115,116]

Regarding obesity, overweight kids tend to become overweight adults, continuing to put them at greater risk for heart disease, high blood pressure, and stroke. The probability of childhood obesity persisting into adulthood is estimated to increase from about 20 percent at four years of age to roughly 80 percent by adolescence.[117] Approximately 112,000 U.S. deaths each year are associated with obesity.[118] The total direct and indirect costs attributed to excessive weight and obesity amounted to $117 billion in the year 2000.[119]

Cost-Effectiveness of Health Coverage

Whether or not a person has health coverage often governs how soon that person will be able to get health care and whether it is the best available. Conversely, individuals who are uninsured or underinsured are less likely to receive appropriate and timely health care, if they receive any care at all.

STORIES FROM THE STATES

The Cost of Being Uninsured

Toni Callis is a single mother with three daughters living in Plattsburgh, New York. She works as a waitress and does not receive health benefits. She is studying to become an RN, building on her experience in a hospital unit in the Army. In July, Toni applied for Medicaid for herself and her daughters, but all were denied. It wasn't until September that she learned about Child Health Plus and Family Health Plus (New York's SCHIP and Parental Medicaid expansion programs) and then only through word of mouth. Before getting public health insurance, she couldn't afford to purchase glasses for one of her daughters, and Toni herself could not get preventive treatment for an infection. Her subsequent visit to an emergency room resulted in a $400 medical bill.

Every parent knows that children do not stop getting sick simply because they lack health coverage. As children's medical needs remain untreated, the costs to treat the more serious conditions that develop often are passed onto communities through uncompensated hospital stays and clinic visits, contributing to higher premiums for the insured. Access to health coverage is also a strong determinant of health outcomes and has been cited often as a key issue in reducing disparities. These conditions especially affect racial and ethnic minorities, with Blacks almost twice as likely and Latinos almost three times as likely as Whites to be uninsured.

For decades Medicaid has provided critical health care, including primary and preventive care, for the poorest children in America. Providing preventive care for children is cost-effective, especially in comparison to older populations. This care includes immunizations and newborn hearing screenings. Per-capita costs for children ($1,850) are the lowest of all groups eligible for Medicaid, compared to $10,700 per elderly enrollee in fiscal year (FY) 2002. At a cost of about $47 billion, children account for less than a quarter of total program spending.[120]

STORIES FROM THE STATES

Medicaid as a Safety Net for Children in Need

Maria Morales lives with her husband and two daughters, Saida and Maricela, in Mercedes, Texas. Their neighborhood (colonia La Mesa) has no sewer, only septic tanks that cause a sewage hazard when it rains. Maria's daughter Maricela suffers from Attention Deficit Hyperactivity Disorder (ADHD) and depression. Recently, the family protested the loss of their Children's Health Insurance Program funding at the Hispanic Chamber of Commerce. At present, Maria and her husband's combined income is low enough to qualify for Children's Medicaid, which has been a blessing for them because Medicaid covers mental health and dental care, which were cut from the SCHIP program. This means that Maricela can still receive treatment for her ADHD and depression.

Children's Health and the Nation's Economic Well-being

Child health is not only important for physical well-being, but healthy children are more likely to become healthy adults and more productive members of society. Current health disparities among children will have a significant impact on the entire workforce. The Department of Labor predicts that the youth labor force (ages 16 to 24) will grow more rapidly between 2000 and 2010 than the overall labor force for the first time in 25 years.[121] Leading employers are recognizing that developing strategies to eliminate health disparities makes good business sense as minorities comprise 41.5 percent of those entering the workforce between 1998 and 2008. By 2030 nearly 50 percent of the labor force will be Black or Latino, while 74 percent of retirees will be White.[122]

Given the escalating impact of medical costs on businesses' bottom line as well as state budget deficits, reducing these risk factors and providing access to quality health care—including primary and preventive care—can result in significant cost savings to society. Addressing health disparities for minority children is not only a moral imperative, it is an economic investment in the nation's future.

Recommendations for Moving Forward:

Every child deserves a healthy start with access to affordable health insurance and quality health care. Public policies have contributed to the progress that has been made in children's health over the past few decades through expanded public health insurance coverage, increased public health services programs, and continued federal funds supporting research on children's health issues.

As we look to improve children's health, special attention should be focused on those populations of children who are disadvantaged from the beginning of their lives. Steps must be taken by child health advocates, government officials, policy makers, and service providers to help ensure public policies that support continued progress toward giving every child a healthy start in life, rather than seeing the improvements of the last half century stall or even disappear.

Expand health coverage by broadening eligibility for children and parents.

- Provide options and appropriate financial support to states to expand coverage to parents and additional groups of children, such as increasing SCHIP coverage of children in families with incomes between 200 to 300 percent of the poverty level. States also should first be required to streamline enrollment and retention processes.
- Support expansion in coverage for immigrant children and children with disabilities, such as those in the Immigrant Children's Health Improvement Act and the Family Opportunity Act.
- Support enhancement of transitional Medicaid for families moving from welfare to work.

Improve Medicaid and SCHIP enrollment and retention.

- Promote state policies that further simplify Medicaid and SCHIP enrollment and retention processes and expand outreach.
- Participate as a teacher, health provider, or member of a congregation in outreach efforts to enroll more eligible children in Medicaid and SCHIP.
- Advocate for the establishment of incentives at the federal level that encourage states to elect enrollment and retention improvements.

Support appropriate funding for Medicaid and SCHIP.

- Advocate at the state and federal levels for higher Medicaid reimbursement rates and for other efforts to increase provider participation in Medicaid.
- Monitor state applications for waivers of Medicaid and SCHIP requirements, including reductions of the EPSDT benefit, and respond as appropriate.

Raise awareness about the impact of children's health conditions.

- Highlight the causes of childhood lead poisoning and urge appropriate precautions: check for peeling paint and water damage, wash window sills and floors often to keep them free of lead dust, keep children from playing in bare soil, and have them tested.
- Educate parents and others caregivers, community leaders, and health providers about the impact of lead poisoning, asthma, obesity, dental decay, and low birthweight on children's physical, cognitive, and emotional development since these factors impact the ability of children to succeed in school and in life.
- Collaborate with federal, state, and local governments, public and private organizations, congregations, and other community-based groups to work in supporting community programs that address children's health issues.

Work towards understanding and eliminating children's health disparities.

- Understand and identify sources of unequal access and health care in your community and their impact on children's health outcomes. Partner with stakeholders in the community to find and implement solutions to reduce income, race and ethnicity-based health disparities.
- Take steps to address racial and ethnic disparities in children's health and mental health. These include expansions in health coverage for immi-

grant children and others and retention of children in Medicaid and SCHIP; improvements in health care delivery with attention to overcoming cultural and linguistic barriers; and special efforts to train health care professionals about disparities in the delivery of care and to expand outreach to underserved communities.

- Increase individual knowledge within communities about how to best access care, ask the appropriate questions during clinical encounters, and participate in treatment decisions for children.
- Promote the collection of data by governments at all levels, providers, and research institutions that look at health outcomes for children based on income, race, and ethnicity to better measure health disparities; support increased funding for research and health programs that are working to reduce racial disparities in health; and insist on programs and policies that increase cultural competency training for providers and workforce diversity in health care.

Endnotes

[1] Nicholas Zill, *Child Health and School Readiness: Background paper on a National Education Goal*, Publication No. 1190-06 (Washington, DC: Child Trends, 1990).

[2] Vernon K. Smith, David M. Rousseau and Molly O'Malley, *SCHIP Program Enrollment: December 2003 Update* (Washington, DC: Kaiser Family Foundation, July 2004).

[3] Marian F. MacDorman, et al., "Explaining the 2001-02 Infant Mortality Increase: Data from the Linked Birth/Infant Death Data Set," *Centers for Disease Control and Prevention, National Vital Statistics Reports* 53, No. 12 (2005): 1-24.

[4] The United Nation's Children's Fund, *The State of the World's Children 2005* (New York, NY: The United Nations Children's Fund (UNICEF), 2004): Table 1: Basic Indicators. Calculations by the Children's Defense Fund, March 2005.

[5] Children's Defense Fund calculations based on the U.S. Census Bureau's 2004 *Current Population Survey*, Annual Social and Economic Supplement (ASEC).

[6] S. Jay Olshansky, et al., "A Potential Decline in Life Expectancy in the United States in the 21st Century," *New England Journal of Medicine* 352, No. 11 (2005): 1138-1145.

[7] Stephen Isaacs and Steven Schroeder, "Class – The Ignored Determinant of the Nation's Health," *The New England Journal of Medicine* 351, No. 11 (2004): 1137-1142.

[8] Nicholas Zill, *Child Health and School Readiness: Background paper on a National Education Goal,* Publication No. 1190-06 (Washington, DC: Child Trends, 1990).

[9] Kenneth D. Kochanek, et al., "Deaths: Final Data for 2002," *National Vital Statistics Reports* 53, No. 5 (2004).

[10] Centers for Disease Control and Prevention, "Disparities in Premature Deaths from Heart Disease – 50 States and the District of Columbia, 2001," *Morbidity and Mortality Weekly Report* 53, No. 6 (2004): 121-125.

[11] A. Jemal, at al., "Annual Report to the Nation on the Status of Cancer, 1975-2001, with a special feature regarding survival," *Cancer* 101, No.1 (2004): 3-27.

[12] Neal Halfon and Miles Hochstein, "Life Course Health Development: An Integrated Framework for Developing Health, Policy, and Research," *Milbank Quarterly* 80, No.3 (2002): 433-479. Retrieved from the Internet at http://www.milbank.org/quarterly/8003feat.html on November 2, 2004.

[13] *Ibid.*

[14] Ronald F. Gray, Alka Indurkhya and Marie C. McCormick, "Prevalence, Stability, and Predictors of Clinically Significant Behavior Problems in Low Birth Weight Children at 3, 5, and 8 Years of Age," *Pediatrics* 114, No. 3 (2004): 736-743.

[15] Cecelia McCarton, "Behavioral Outcomes in Low Birth Weight Infants," *Pediatrics* 102, No. 5 (1998): 1293-1297.

[16] Naomi Breslau, Nigel S. Paneth and Victoria C. Lucia, "The Lingering Academic Effects of Low Birth Weight Children," *Pediatrics* 114, No.4 (2004): 1035-1040.

[17] Maureen Hack, et al., "Outcomes in Young Adulthood for Very-Low-Birth-Weight Infants," *The New England Journal of Medicine* 346, No. 3 (2002): 149-157.

[18] Note on the "full complement of vaccines": The '4:3:1:3' full complement of vaccinations recommended in 1994 for 2-year-olds by the Centers for Disease Control's Advisory Committee on Immunization. Practices include the following vaccines: four or more does of diphtheria/tetanus/pertussis vaccine (DTP); three or more doses of poliovirus vaccine; one or more dose of any measles-containing vaccine (MCV); and three or more doses of *Haemophilus influenzae* type b vaccine (Hib).

[19] Centers for Disease Control and Prevention, *Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series among Children 19-35 Months of Age by Poverty Level and Race/Ethnicity – United States,* National Immunization Survey, Q1/2000-Q4/2000. Retrieved from the Internet at www.cdc.gov/nip/coverage/NIS/00,table32x1 on March 11, 2002.

[20] Renee Schwalberg, et al., *Medicaid Coverage of Perinatal Services: Results of a National Survey* (Washington, DC: Kaiser Family Foundation, 2001). Retrieved from the Internet at http://www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13738 on August 2, 2004.

[21] Joyce A. Martin, et al., "Births: Final Data for 2002," *National Vital Statistics Reports* 52, No. 10 (2003): 1-116.

[22] *Ibid.*

[23] Kenneth D. Kockanek, Sherry L. Murphy and Robert N. Anderson, "Deaths: Final Data for 2002," *National Vital Statistics Reports* 53, No. 5 (2004): 1-116.

[24] Joyce A. Martin, et al., "Births: Final Data for 2002," *National Vital Statistics Reports* 52, No. 10 (2003): 1-116.

[25] *Ibid.*

[26] Robert J. Sokol, Virginia Delaney-Black and Beth Nordstrom, "Fetal Alcohol Spectrum Disorder," *Journal of the American Medical Association* 290, No. 22 (2003): 2996-2999.

[27] *Ibid.*

[28] Beena Sood, et al., "Prenatal Alcohol Exposure and Childhood Behavior Effect at Age 6 to 7 Years: Dose-Response Effect," *Pediatrics* 108, No. 2 (2001): 34-43.

[29] Note on the "full complement of vaccines": For the purpose of comparison over time, we use the '4:3:1:3:3' full complement of vaccinations recommended in 1994 for 2-year-olds by the Centers for Disease Control's Advisory Committee on Immunization Practices. It includes the following vaccines: four or more does of diphtheria/tetanus/pertussis vaccine (DTP); three or more doses of poliovirus vaccine; one or more dose of any measles-containing vaccine (MCV); three or more doses of *Haemophilus influenzae* type b vaccine (Hib); and three or more doses of hepatitis B vaccine (Hep B).

[30] Centers for Disease Control and Prevention, National Immunization Program: 1995 and 2004 National Immunization Survey, Table 32. Available at http://www.cdc.gov/nip/coverage/NIS/04/toc-04.htm.

[31] Centers for Disease Control and Prevention, National Immunization Program: 2004 National Immunization Survey, Table 30. Retrieved from the Internet at http://www.cdc.gov/nip/coverage/NIS/ 04/toc-04.htm.

[32] Centers for Disease Control and Prevention, "Recommendations for Blood Lead Screening of Young Children Enrolled in Medicaid: Targeting a Group at High Risk," *Morbidity and Mortality Weekly Report* 49 RR14 (2000): 1-13.

[33] *Ibid.*

[34] National Health and Nutrition Examination Survey; 1999-2000 and 2001-2002. Calculations by the Children's Defense Fund, October 2004.

[35] Centers for Disease Control and Prevention, "Recommendations for Blood Lead Screening of Young Children Enrolled in Medicaid: Targeting a Group at High Risk," *Morbidity and Mortality Weekly Report* 49 RR14 (2000): 1-13.

[36] U.S. General Accounting Office, *Medicaid: Elevated Blood Lead Levels in Children,* GAO/HEHS-98-78 (Washington, DC: U.S. General Accounting Office, 1998).

[37] Alliance for Healthy Homes (formerly the Alliance to End Childhood Lead Poisoning), "Disparities in Risk." Retrieved from the Internet at http://www.aeclp.org/chil_ar/chil_ar_disparities.htm on December 10, 2004.

[38] U.S. General Accounting Office, *Medicaid: Elevated Blood Lead Levels in Children,* GAO/HEHS-98-78 (Washington, DC: U.S. General Accounting Office, 1998).

[39] *Ibid.*

[40] National Conference of State Legislators, Forum for State Health Policy Leadership, *Lead Screening for Children Enrolled in Medicaid: State Approaches* (Washington, DC: National Conference of State Legislators, 2001).

[41] U.S. General Accounting Office, *Medicaid: Elevated Blood Lead Levels in Children,* GAO/HEHS-98-78 (Washington, DC: U.S. General Accounting Office, 1998).

[42] U.S. General Accounting Office, *Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children,* HEHS-99-18 (Washington, DC: U.S. General Accounting Office, January 15, 1999).

[43] President's Task Force on Environmental Health Risks and Safety Risks to Children, *Eliminating Childhood Lead Poisoning: A Federal Strategy Targeting Lead Paint Hazards* (Washington, DC: February 2000). Retrieved from the Internet at http://www.hud.gov/offices/lead/reports/fedstrategy2000.pdf on October 22, 2004.

[44] U.S. Environmental Protection Agency and U.S. Consumer Product Safety Commission, *Protect Your Family from Lead in Your Home EPA747-K-94-001* (Washington, DC: U.S. Environmental Protection Agency, May 1995). Retrieved from the Internet at http://www.leadsafe.org/National_information/EPA_Publications/Protect_your_family.html on October 21, 2004.

[45] Richard L. Canfield, et al., "Intellectual Impairment in Children with Blood Lead Concentrations Below 10mg per Deciliter," *The New England Journal of Medicine* 348, No. 16 (2003): 1517-1526.

[46] David C. Bellinger, "Lead," *Pediatrics* 113, No.4 (2004): 1016-1022.

[47] President's Task Force on Environmental Health Risks and Safety Risks to Children, *Eliminating Childhood Lead Poisoning: A Federal Strategy Targeting Lead Paint Hazards* (Washington, DC: February 2000). Retrieved from the Internet at http://www.hud.gov/offices/lead/reports/fedstrategy2000.pdf on October 22, 2004.

[48] Richard L. Canfield, et al., "Intellectual Impairment in Children with Blood Lead Concentrations Below 10mg per Deciliter," *The New England Journal of Medicine* 348, No. 16 (2003): 1517-1526.

[49] "Even Low Lead in Kids Has a High IQ Cost," *Science News* (May 7, 2001): 277.

[50] David C. Bellinger, "Lead," *Pediatrics* 113, No.4 (2004): 1016-1022.

[51] Centers for Disease Control and Prevention, Childhood Lead Poisoning Prevention Program, "Why not change the blood lead level of concern at this time?" (Atlanta, GA: Centers for Disease Control and Prevention, Childhood Lead Poisoning Program, 2004). Retrieved from the Internet at http://www.cdc.gov/nceh/lead/spot Lights/changeBLL.htm on November 9, 2004.

[52] National Center for Health Statistics, *Asthma Prevalence, Health Care Use, and Mortality, 2002* (Hyattsville, MD: National Center for Health Statistics, February 2005). Retrieved from the Internet at www.cdc.gov/nchs/products/pubs/pubd/hestats/asthma/asthma.htm on April 20, 2005.

[53] Centers for Disease Control and Prevention, *CDC Surveillance Summaries*, April 24, 1998 (MMWR 1998): 47 (No. SS-1).

[54] U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Allergy and Infectious Diseases, "Asthma: A Concern for Minority Populations" Fact Sheet. Retrieved from the Internet at http://www.niaid.nih.gov/factsheets/asthma.htm on March 15, 2005.

[55] Achinta N. Dey, et al., "Summary Health Statistics for U.S. Children: National Health Interview Survey, 2002," *Vital and Health Statistics,* Series 10, No.221 (2004): 1-77.

[56] Centers for Disease Control and Prevention, *Healthy People 2010*, Chapter 24, Respiratory Diseases. Retrieved from the Internet at www.health.gov/healthypeople/Document/HTML/Volume2/24 Respiratory.htm on March 15, 2002.

[57] Paul W. Newacheck and Neal Halfon, "Prevalence, Impact, and Trends in Childhood Disability Due to Asthma," *Archives of Pediatric and Adolescent Medicine* 154, No. 3 (2000): 287-93.

[58] National Center for Health Statistics, *Asthma Prevalence, Health Care Use, and Mortality, 2002* (Hyattsville, MD: National Center for Health Statistics, February 2005). Retrieved from the Internet at www.cdc.gov/nchs/products/pubs/pubd/hestats/asthma/asthma.htm on April 20, 2005.

[59] Martha W. Stevens and Marc H. Gorelick, "Short-Term Outcomes After Acute Treatment of Pediatric Asthma," *Pediatrics* 107, No.6 (2001): 1357-1362.

[60] Centers for Disease Control and Prevention, *Healthy People 2010*, Chapter 24, Respiratory Diseases. Retrieved from the Internet at www.health.gov/healthypeople/Document/HTML/Volume2/24Respiratory.htm on March 15, 2002.

[61] Lara J. Akinbami and Kenneth C. Schoendorf, "Trends in Childhood Asthma: Prevalence, Health Care Utilization, and Mortality," *Pediatrics* 110, No.2 (2002): 315-322.

[62] Edwin D. Boudreaux, et al., "Race/Ethnicity and Asthma among Children Presenting to the Emergency Department: Differences in Disease Severity and Management," *Pediatrics* 111, No. 5 (2003): 615-621.

[63] Paul W. Newacheck, et al., "Access to Health Care for Children with Special Health Care Needs," *Pediatrics* 105, No. 4 (2000): 760-766.

[64] Timothy G. Ferris, et al., "Insurance and Quality of Care for Children with Acute Asthma," *Ambulatory Pediatrics* 1, No.5 (2001): 267-74. Retrieved from the Internet at http://199.245.200.232/ampeonline/?request=index-html on November 28, 2001.

[65] Alexandra E. Shields, Catherine Comstock and Kevin B. Weiss, "Variations in Asthma Care by Race/Ethnicity among Children Enrolled in a State Medicaid Program," *Pediatrics* 113, No.3 (2004): 496-504.

[66] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health, "Children's Oral Health." Retrieved from the Internet at http://www.cdc.gov/OralHealth/topics/child.htm on July 30, 2004.

[67] Charlotte W. Lewis, et al., "The Role of the Pediatrician in the Oral Health of Children: A National Survey," *Pediatrics* 106, No. 6 (2000): 84-90.

[68] U.S. Department of Health and Human Services, *Healthy People 2010: Understanding and Improving Health, 2nd ed.* (Washington, DC: U.S. Government Printing Office, November 2000): Chapter 21. Retrieved from the Internet at http://www.health.gov/healthypeople/document/pdf/Volume2/21Oral.pdf on June 15, 2004.

[69] Agency for Healthcare Research and Quality, *Improving the Design of Medicaid Dental Programs May Lead to Better Oral Health for Poor Children ,No. 254* (Washington, DC: Agency for Healthcare Research and Quality, October 2001).

[70] National Health and Nutrition Examination Survey (NHANES), 1999-2004. Calculations by the Children's Defense Fund, October 2004.

[71] *Ibid.*

[72] Stella M. Yu, et al., "Factors That Influence Receipt of Recommended Preventive Pediatric Health and Dental Care," *Pediatrics* 110, No. 6 (2002): 73-80.

[73] Wendy E. Mouradian, Elizabeth Wehr and James J. Crall, "Disparities in Children's Oral Health and Access to Dental Care," *JAMA* 284, No. 20 (2000): 2625-2631.

[74] U.S. General Accounting Office, Report to Congressional Requestors, *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations,* GAO/HEHS-00-149 (Washington, DC: U.S. General Accounting Office, September 2000).

[75] *Ibid.*

[76] Wendy E. Mouradian, Elizabeth Wehr and James J. Crall, "Disparities in Children's Oral Health and Access to Dental Care," *JAMA* 284, No. 20 (2000): 2625-2631.

[77] U.S. Department of Health and Human Services, *Oral Health in America: A Report of the Surgeon General* (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000). Retrieved from the Internet at http://silk.nih.gov/public/hck1ocv.@www.surgeon.fullrpt.pdf.

[78] Mahyar Modifi, Gary Rozier and Rebecca King, "Problems with Access to Dental Care for Medicaid-Insured Children: What Caregivers Think," *American Journal of Public Health* 92, No. 1 (2002): 53-58.

[79] *Ibid.*

[80] Genevieve M. Kenney, Grace Ko and Barbara A. Ormond, *Gaps in Prevention and Treatment: Dental Care for Low-Income Children*, New Federalism Series: National Survey of American Families, No. B-4 (Washington, DC: Urban Institute, April 2000).

[81] U.S. Department of Health and Human Services, *Healthy People 2010: Understanding and Improving Health, 2nd ed.* (Washington, DC: U.S. Government Printing Office, November 2000): Chapter 21. Retrieved from the Internet at http://www.health.gov/healthypeople/document/pdf/Volume2/21Oral.pdf on June 15, 2004.

[82] U.S. Department of Health and Human Services news release, "Obesity Still on the Rise, New Data Show" (Washington, DC: U.S. Department of Health and Human Services, October 2002). Retrieved at http://www.cdc.gov/nchs/pressroom/02news/obesityonrise.htm on December 2, 2003.

[83] *Ibid.*

[84] *Ibid.*

[85] U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* (Rockville, MD: U.S. Department of Health and Human Services, 2001).

[86] Zuguo Mei, et al., "Increasing Prevalence of Overweight among U.S. Low-Income Preschool Children: The Centers for Disease Control and Prevention Pediatric Nutrition Surveillance, 1983 to 1995," *Pediatrics* 101, No.1 (1998): e12.

[87] Cynthia L. Ogden, et al., "Prevalence and Trends in Overweight among U.S. Children and Adolescents, 1999-2000," *JAMA* 288, No.14 (2002):1728-32.

[88] National Center for Health Statistics, *Health, United States, 2002,* with Chartbook on Trends in the Health of Americans (Hyattsville, MD: U.S. Department of Health and Human Services, 2002).

[89] *Ibid.*

90 Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, division of Adolescent and School Health, "Poor Nutrition." Retrieved from the Internet at www.cdc.gov/nccdphp/dash/nutrition.htm on November 12, 2004.

91 Sally Ann Lederman, et al., "Summary of the Presentations at the Conference on Preventing Childhood Obesity, December 8, 2003," *Pediatrics* 114, No. 4 (2004): 1146-1173.

92 Jo Ann Grumbaum, et al., "Youth Risk Behavior Surveillance – United States 2003," *Morbidity and Mortality Weekly Report* 53, No.SS-2 (2004): 1-29.

93 *Ibid.*

94 Sue Y.S. Kimm, et al., "Decline in Physical Activity in Black Girls and White Girls during Adolescence," *New England Journal of Medicine* 347, No. 10 (2002): 709-715.

95 U.S. Department of Health and Human Services and U.S. Department of Education, *Promoting Better Health for Young People Through Physical Activity and Sports: A report to the President from the Secretary of Health and Human Services and the Secretary of Education* (Washington, DC: U.S. Department of Health and Human Services and U.S. Department of Education, December 2000).

96 National Center for Health Statistics, 2002 National Health Interview Survey. Calculations by the Children's Defense Fund, January 2005.

97 National Health and Nutrition Examination Survey, 1999-2000. Calculations by the Children's Defense Fund, October 2004.

98 Judith R. Lave, et al., "Impact of a Children's Health Insurance Program on Newly Enrolled Children," *Journal of the American Medical Association* 279, No. 22 (1998): 1820-1825.

99 Kaiser Commission on Medicaid and the Uninsured, *Children's Health – Why Health Insurance Matters* (Washington, DC: The Henry J. Kaiser Family Foundation, 2002). Retrieved from the Internet at http://www.kff.org/uninsured/4055-index.cfm on December 6, 2004.

100 Leighton Ku and Sashi Nemalendran, *Improving Children's Health: A Chartbook About the Roles of Medicaid and SCHIP* (Washington, DC: Center on Budget and Policy Priorities, January 2004).

101 Carmen DeNavas-Walt, Bernadette D. Proctor and Robert J. Mills, "Income, Poverty, and Health Insurance Coverage in the United States: 2003," U.S. Census Bureau, *Current Population Reports*, 60-226 (Washington, DC: U.S. Government Printing Office, 2004).

102 Children's Defense Fund calculations based on the U.S. Census Bureau's *March 2001 Current Population Survey*, Annual Demographic Supplement, and the *2003 Current Population Survey*, Annual Social and Economic Supplement (ASEC).

103 John Holahan and Arunabh Ghosh, *The Economic Downturn and Changes in Health Coverage, 2000-2003* (Washington, DC: Urban Institute for the Kaiser Family Foundation, September 2004).

104 Children's Defense Fund calculations based on the U.S. Census Bureau's *March 2004 Current Population Survey*, Annual Social and Economic Supplement (ASEC).

105 Children's Defense Fund calculations based on the U.S. Census Bureau's *2003 Current Population Survey*, Annual Social and Economic Supplement (ASEC).

106 U.S. Census Bureau, *2004 Current Population Survey*, Annual Social and Economic Supplement (ASEC). Calculations by the Children's Defense Fund, January 2005.

107 *Ibid.*

108 U.S. Census Bureau, *2004 Current Population Survey*, Annual Social and Economic Supplement (ASEC).

109 John Holahan, Lisa Dubay and Genevieve Kenney, "Which Children Are Still Uninsured and Why?" *Future of Children* 13, No. 1 (2003): 55-79.

110 CDF calculation based on *Current Population Survey*, March 2003 Annual Demographic Survey.

111 Claire D. Brindis, Madlyn C. Morreale and Abigail English, "The Unique Health Care Needs of Adolescents," *Future of Children* 13, No. 1 (2003): 117-135.

112 Ron Keren, et al., "Projected Cost-Effectiveness of Statewide Universal Newborn Hearing Screening," *Pediatrics* 110, No.5 (2002): 855-864.

113 E.J. Hatziandreu, R.E. Brown and M.T. Halpern, *A Cost-Benefit Analysis of the Measles-Mumps-Rubella (MMR) Vaccine.* Final report prepared for National Immunization Program, Centers for Disease Control and Prevention (Arlington, VA: Center for Public Health Research and Evaluation, Battelle Memorial Institute, 1994).

114 Terry White, Suzanne Lavoie and Mary D. Nettleman, "Potential Cost Savings Attributable to Influenza Vaccination of School-aged Children," *Pediatrics* 103, No. 6 (1999): 73-77.

115 Centers for Disease Control and Prevention, National Vaccine Program Office, Vaccine Fact Sheets, *What Would Happen If We Stopped Vaccinations* (Atlanta, GA: Centers for Disease Control and Prevention, National Vaccine Program Office, 2001). Retrieved from the Internet at http://www.hhs.gov/nvpo/factsheets/fs_tableI_doc3.htm on November 15, 2004.

116 Centers for Disease Control and Prevention, National Immunization Program, Fact Sheet, "Why Immunize?" (Atlanta, GA: Centers for Disease Control and Prevention, National Immunization Program, 2003). Retrieved from the Internet at http://www.cdc.gov/ nip/publications/fs/gen/Why.htm on November 15, 2004.

117 *Ibid.*

118 Katherine M. Flegal, et al., "Excess Deaths Associated with Underweight, Overweight, and Obesity," *Journal of the American Medical Association* 293, No. 15 (2005): 1861-1867.

119 U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* (Rockville, MD: U.S. Department of Health and Human Services, 2001).

120 Centers for Medicare and Medicaid Services, FY 2002 Medicaid Statistical Information System (MSIS) data. Calculations by the Children's Defense Fund.

121 U.S. Department of Labor, *Strategic Plan for Fiscal Years 2003-2008* (Washington, DC: U.S. Department of Labor, 2003).

122 *Ibid.*

CHAPTER THREE

Early Childhood

Critical Years, Critical Investments

Nearly three out of four mothers with children under 18 participate in the U.S. labor force today, compared with just under half in 1975.[1] Low-income working families whose children would benefit the most from quality child care are those least able to afford it. Full-day child care for one child can easily cost between $4,000 and $10,000 a year—at least as much as public college tuition in most states.[2] One-quarter of America's families with young children earn less than $25,000 a year; a family with both parents working full-time at minimum wage earns just $21,400 a year.[3]

We know that a child's experiences in the first years of life help lay the groundwork for future growth and progress. Yet there is a disconnect between the demand for affordable, quality child care and early education programs and our government's commitment to ensuring that these programs are available and affordable to those who need them most. In 2004, just one in seven of the 15 million children eligible for federal child care assistance actually received it. More than three million children eligible for Head Start and Early Head Start were not served.

STORIES FROM THE STATES

Reaching for the Dream

In an attempt to live the American Dream, Shasta Murphy, a single mom with three children, has worked her way up to a managerial position paying $360/week ($18,720/year) at the Wendy's in Jackson, Ohio. Shasta's family lost their public health coverage in 2004 and, ever since, their lives have been a budgeting nightmare. She receives no public benefits other than child care assistance, which allows her to take her children to a home-based child care provider who she likes and trusts. If Shasta were to lose her child care assistance—a very real concern for her—she would not be able to keep her job and would have to turn to cash assistance. Shasta is actively involved in her children's lives and pays close attention to how well they are doing in school. A higher paying job would enable Shasta to afford child care even if she were to lose her child care assistance. Gaining financial security is important for Shasta and her family, prompting her to enroll in a home study program with a Professional Career Design Institute to become certified as a home designer/decorator and earn a higher wage. Despite all of her hard work and dedication to her children, she still lives in fear of having to choose between work and making sure that her children are in a safe child care situation.

Our country risks taking a giant step backwards on early childhood policies due to stagnant federal funding and state budget crises. Parents should never have to choose between working to put food on the table and making sure their children are well cared for while they work. Yet too many families face this dilemma daily. As the number of working mothers has increased dramatically over the past three decades, so has the need for reliable, affordable, quality child care. In the past year, states dealing with increasing budget deficits have made drastic cuts to child care services. Nearly half of the states, lacking sufficient funds to serve all who qualify for child care assistance, place families on waiting lists and, in some cases, turn them away without even taking their names.[4]

There is a fundamental disconnect between the need for affordable, quality child care and early education programs and our government's commitment to ensuring that these programs are available and affordable to those who need them most:

- About 59 percent of women were in the labor force in 2004. In 1970, this percentage was much smaller, with only 43 percent in the work force. For mothers with children under the age of 18, participation in the labor force rose to 71 percent in 2004, compared to 47 percent in 1975.[5]
- The contribution of married women's earnings to family income has increased substantially. In 1970, married women contributed about 27 percent of family income, compared to just over 35 percent in 2003.[6]
- Child care remains unaffordable for many families. Full-day child care for one child can easily cost between $4,000 and $10,000 a year.[7]
- Low-income working families whose children would benefit the most from quality child care are those who are least able to afford it. One-quarter of America's families with young children earn less than $25,000 a year, and a family with both parents working full-time at minimum wage earns just $21,400 a year.[8]
- More than 15 million children are eligible for child care assistance, yet most do not receive any.

America's wavering commitment to nurturing and protecting our youngest children stands in stark contrast to our growing recognition of the importance of the early years in preparing them for

Early Childhood – Table 1

Waiting Lists for Child Care Assistance in Selected States – 2005

	Number of Children on the Waiting List
Alabama	13,260
California	280,000*
Florida	39,677
Georgia	17,600
Maryland	19,674
Massachusetts	13,563
New Jersey	6,994
North Carolina	15,871
Texas	22,045

* In early 2005, there was no statewide waiting list in California; instead, counties maintained waiting lists. This figure is an estimate.

Source: Karen Schulman and Helen Blank, *Child Care Assistance Policies 2005: States Fail to Make Up Lost Ground, Families Continue to Lack Critical Supports* (Washington, DC: National Women's Law Center, 2005).

school and life. Research on early brain development confirms that children's experiences in their first years of life lay the groundwork for future growth and progress. If our nation continues to give tax breaks to millionaires and billionaires while slashing essential services to low-income Americans, more and more families will be making trade-offs between child care and work—and more and more children will arrive at school already at a disadvantage because they have not been given the opportunity to become emotionally, socially, and cognitively prepared.

Sensationalism Overlooks the Real Story: Unmet Need

Several news stories captured the headlines during the past year, among them a North Carolina woman who locked her eight-year-old son in the trunk of her car for more than 16 hours while she worked and a Florida kindergartener who was handcuffed and taken away by police after throwing a temper tantrum at school. Both of these stories are troubling; they speak of struggling parents and children. Yet they are extreme situations on the margins of the real, unreported story: the unmet need of literally millions of families and children for high quality, affordable child care and early childhood programs.

Only one out of seven children eligible for the Child Care and Development Block Grant (CCDBG), the federal child care assistance program, receives assistance. In about one-third of the states, a family of three earning $25,000 a year would not qualify for child care assistance. Twenty states had either waiting lists or frozen intake in 2005, with well over 450,000 children on these lists.[9] Furthermore, other states facing their own budget crises have had to restrict the availability of child care subsidies, resulting in a further decrease in the number of children receiving child care services.

More than three million children eligible for Head Start and Early Head Start were not served in 2004. Head Start funding has not kept pace with the number of eligible children in recent years; in 2003 about half of all eligible preschool-age children were served by Head Start, compared to about 60 percent in 2001. In 2003, less than 3 percent of eligible infants and toddlers were served by Early Head Start.

The time after school also presents a problem for many families. Yet the 21st Century Learning Centers Program, which provides after-school opportunities for academic enrichment, serves only

about 1.3 million children. School days between the hours of 3 and 6 p.m. are the peak time for children to commit crimes or become crime victims, for 16- and 17-year-olds to be in or cause a car crash or have sex, and for children to smoke, drink, or use drugs. Ignoring the danger of leaving children unsupervised, the Administration's fiscal year 2006 budget underfunded 21st Century Community Learning Centers by $1.3 billion below the authorized level for 2006, leaving 1.7 million children without after-school services.

Early childhood programs are critical to giving children the support and help they need in preparing them for success in school and life. Unfortunately, the children who most need these programs are the most likely to be expelled. A recent report published by the Yale University Child Study Center, "Prekindergartners Left Behind: Expulsion Rates in State Prekindergarten Systems," noted that the prekindergarten expulsion rate for state public prekindergarten programs was over three times higher than the rate for K-12 students. The study found that the rates were highest for older preschoolers, African Americans, and boys. Rather than expelling these children, we should be doing more to make sure they have nurturing, supportive environments that will help them succeed in school.

Poor quality care can result in:

- Substantial amounts of unoccupied time spent tuned out and unengaged in social interactions.
- Delays in cognitive and language development, pre-reading skills, and other age-appropriate behaviors.
- Insecure attachment to caregivers.
- More frequent displays of aggression towards other children and adults.[10]

Early Childhood – Table 2

Labor Force Participation of Women with Children Under Age Six, Selected Years

	All Women		Married Women	
	Number	Percent	Number	Percent
1950	–	–	1,399,000	11.9%
1955	–	–	2,012,000	16.2
1960	–	–	2,474,000	18.6
1965	–	–	3,117,000	23.2
1970	–	–	3,914,000	30.3
1975	–	–	4,518,000	36.7
1980	6,538,000	46.8%	5,227,000	45.1
1985	8,215,000	53.5	6,406,000	53.4
1990	9,397,000	58.2	7,247,000	58.9
1999	10,322,000	64.4	7,246,000	61.8
2000	10,316,000	65.3	7,341,000	62.8
2001	10,199,000	64.9	7,317,000	62.5
2002	9,474,000	64.3	7,057,000	61.1
2003	9,460,000	63.0	7,051,000	60.0
2004	9,375,000	62.5	6,980,000	59.6

– Data not available

Source: U.S. Department of Labor, Bureau of Labor Statistics.

Early Childhood – Table 3

If families can't afford a preschool experience, will their children ever get to college?

States Where the Average Annual Cost of Child Care for a Four-Year-Old in an Urban Area Center Is at Least Twice the Average Annual Cost of Public College Tuition

State	Urban area	Average annual cost of child care for a four-year-old in a center	Average annual cost of public college tuition	Ratio of child care costs to public college tuition
Alaska	Anchorage	$ 6,019	$ 2,855	2.11
Iowa	Urban areas statewide	6,198	2,998	2.07
Kansas	Wichita	4,889	2,439	2.00
Nevada	Reno	4,862	2,034	2.39
New Mexico	Albuquerque	4,801	2,340	2.05
New York	Rockland County	8,060	3,983	2.02
North Carolina	Durham	5,876	2,054	2.86
Utah	Salt Lake City	4,550	2,147	2.12

Source: Karen Schulman, *The High Cost of Child Care Puts Quality Care Out of Reach for Many Families* (Washington, D.C.: Children's Defense Fund, 2000), Table A-1; and U.S. Department of Education, National Center for Education Statistics, *Digest of Education Statistics 2000* (2001), Table 314. Calculations by Children's Defense Fund.

Early Childhood Lays the Foundation

All children need experiences during their earliest years, both in and out of the home, that promote their healthy development. Low-income children, in particular, benefit from high quality child care, early education, and after-school experiences that provide them with opportunities to develop academic, social, and emotional skills. These children often also need access to improved nutrition and health care.

Infants and toddlers (birth to age two) need nurturing, quality care in order to develop the intellectual, behavioral, social, and emotional abilities that form the critical foundation for later success in school and in life. There are about 12 million children under age three living in the United States and one in five lives in poverty.[11] About half of all women in the labor force have at least one child under the age of three;[12] seven million infants and toddlers had some type of child care arrangement in 1999, according to the most recent data.[13] A 1994 Carnegie Corporation study noted that "the quality of young children's environment and social experience has a decisive, long-lasting impact on their well-being and ability to learn." The study emphasizes that the first three years of life are critical in a child's brain development, which is far more susceptible to adverse influences than had been realized.[14] A subsequent report stated, "Evidence amassed by neuroscientists and child development experts over the last decade points to the wisdom and efficacy of prevention and early intervention."[15]

Conclusive evidence warns us that without proper care and nurturing, infants and toddlers are at risk of long-term developmental delays:

- The first three years of life play a decisive role in children's early learning. Research on children's brain development has shown that how children grow and develop depends on the interplay between nature (the children's genetic endowment) and nurture (including their nutrition, surroundings, care, and stimulation).[16]
- Studies show that young children's positive social experiences impact their future well-being and ability to learn. Their early experiences also affect how they cope with stress and how they regulate their own emotions. [17]
- Research shows that children's brain development is far more susceptible to adverse influences than had been realized. This means that children's environments (such as their homes

Early Childhood – Table 4

Low-income children are much less likely than their higher-income peers to have access to early childhood programs.

Preschool Enrollment Rates for 3- and 4-Year-Olds*

Year	All children	Family income less than $20,000	Family income $75,000+
1994	45.2%	37.3%	68.0%
1995	46.7	35.9	70.1
1996	46.3	37.5	70.1
1997	50.4	44.5	69.3
1998	50.2	40.4	72.1
1999	52.1	43.3	70.4
2000	49.9	43.8	69.4
2001	50.2	40.3	68.3
2002	51.8	39.4	74.1
2003	52.8	43.6	70.9

*Rates are calculated for 3- and 4-year-olds not yet in kindergarten.

Source: U.S. Department of Commerce, Bureau of the Census, October Current Population Survey, various years. Calculations by Children's Defense Fund.

and child care settings) play a significant role in influencing how they develop. Environmental influences not only affect a child's general development, but actually affect how the intricate circuitry of the brain is "wired."[18]

A study bringing together the current science of early childhood development, *From Neurons to Neighborhoods*, reported that "from the time of conception to the first day of kindergarten, development proceeds at a pace exceeding that of any subsequent stage of life. Efforts to understand this process have revealed the myriad and remarkable accomplishments of the early childhood period, as well as the serious problems that confront some young children and their families long before school entry. Although there have been long-standing debates about how much the early years really matter in the larger scheme of lifelong development, our conclusion is unequivocal: What happens during the first months and years of life matters a lot, not because this period of development provides an indelible blueprint for adult well-being, but because it sets either a sturdy or fragile foundation for what follows."[19]

To make the most of classroom instruction, children must come to first grade with strong language and cognitive skills and the motivation to learn to read. The 1998 report, *Preventing Reading Difficulties in Young Children*, makes clear that "preschool children need high-quality language and literacy environments in their homes and in out-of-home settings."[20] Children who recognize their letters, are read to at least three times a week, recognize their basic numbers and shapes, and understand the mathematical concept of relative size as they enter kindergarten demonstrate significantly higher overall reading and mathematics knowledge and skills in kindergarten and first grade than children who do not have these resources and skills. Children also are much more likely to perform better in reading and mathematics if they frequently display a positive approach to learning and are in very good to excellent health as they enter kindergarten.[21]

A 2002 report sponsored by the Ewing Marion Kauffman Foundation highlights the social and emotional development of young children as fundamental to early learning. One paper included in the report examines the research and concludes

that "advances in the child's understanding of other people, self-understanding, emotional growth, self-control, conscience, and peer relationships provide an essential bedrock of skills necessary for learning in the classroom."[22]

High quality early childhood programs are particularly beneficial for children who live in low-income families:

- A study that followed children over a three-year period found that at age three, children from families receiving welfare had less than half the number of words in their vocabulary as children from other families. This gap grew over time, and by first grade the children from families receiving welfare knew only one-quarter as many words as children from other families.[23]
- In 2001, only 48 percent of children ages three to five and not yet in kindergarten who were living below the poverty level were read to every day by a family member, compared to 61 percent of children who were living at or above the poverty level, according to the U.S. Department of Education.[24]
- Nearly one out of four low-income children ages 1 to 5 (family incomes below 200 percent of the poverty level) were read to or told stories fewer than three times a week, according to the 1999 National Survey of America's Families. This was about half as often as the proportion of children in families with higher incomes.[25]
- A report issued by the Economic Policy Institute found substantial differences by race and ethnicity in children's test scores as they begin kindergarten. Before starting kindergarten, the average cognitive score of children in the highest socioeconomic status (SES) group was 60 percent above the lowest SES group. The report also found that the average math achievement was 21 percent lower for Black children than for White children and 19 percent lower for Hispanic children.[26]

If children from low-income families are not offered the opportunity to catch up to their peers by kindergarten or first grade, they are more likely to remain trapped in the cycle of poverty rather than breaking free of it. A report on literacy development in children from low-income homes states that the "emergent literacy knowledge and skills that children bring to first grade from prior experiences in their homes, preschool centers, and kindergartens is a critical determinant of how well

STORIES FROM THE STATES

A Head Start for Every Child

Rachel Blevins of Ohio has four children: four-year-old Paige, an eleven-year-old son, and two stepchildren. Paige was born at 34 weeks and weighed only 3 lbs. Rachel enrolled Paige in Head Start because she wanted her shy daughter to have social interaction with other children. Now she appears to have blossomed and enjoys reading and singing.

Beth Lovett, mom to Makayla, 5, and Beth, 9, enrolled Makayla in Head Start because she wanted Makayla to be ready for kindergarten. She thinks that her kids will have an advantage on the proficiency tests (for elementary school children) because of their experience in Head Start.

What these children have in common are caring mothers who recognize the need for early childhood programs in order for their children to succeed in school. One of the strengths of Head Start is its comprehensive approach to early child development, focusing on children's cognitive, physical, social, and emotional development. Head Start's comprehensive services met both children's developmental needs.

they will learn to read in elementary school. In turn, how well they learn to read in elementary school is a critical determinant of their lifelong career and economic prospects."[22]

Head Start Works by Focusing on the "Whole Child"

Head Start is the only national, high quality early education program that provides comprehensive education, health, nutrition, and social services to the country's neediest children and their families. Since its establishment in 1965, Head Start has served more than 22 million of America's poorest children.

Congress funded Head Start at $6.78 billion in FY 2004, allowing the program to serve 905,851 children ages zero to five.[23] Head Start is administered at the local level, enabling it to respond to the needs of diverse communities within the context of extensive federal quality and performance standards. Indian Tribes, faith-based organizations, local governments, nonprofits and for-profits, and public school districts were among the 1,604 grantees operating 20,050 Head Start centers across the country in 2004.[29]

At least 90 percent of Head Start families must be at or below the federal poverty line to qualify for enrollment in the program. In 2005, this means that a three-person family earning less than $16,090 (the federal poverty level in 2005) would be eligible for enrollment in Head Start.[30] Programs also are required to reserve at least 10 percent of their slots for children with disabilities.[31] Head Start also provides specific programs for migrant and Native American children and serves infants, toddlers, and pregnant women through the Early Head Start program.

One of the program's strengths is its focus on the whole child—not simply his or her cognitive development. Head Start acknowledges that children from low-income families have *many needs* critical to their ability to learn, including health services, social services, and parental involvement in their development.

According to a long-term evaluation, Head Start helps reduce the gap in school readiness skills between children in poverty and their more advantaged peers. Children entering Head Start exhibit skills substantially below national norms but make gains toward these norms during their time in Head Start, especially in vocabulary and early writing skills. Once in kindergarten, Head Start graduates continue to make progress, advancing toward national norms in vocabulary, early writing, and letter identification. Children also show growth in social skills and a reduction in hyperactive behavior while attending Head Start.[32]

Results from the U.S. Department of Health and Human Services' June 2005 *Head Start Impact Study: First Year Findings* confirmed that Head

Every Head Start program offers:

- **Health Services –** Head Start coordinates with community resources to ensure children's medical, dental nutrition, and mental health needs are met. Head Start also ensures that children are immunized and receive hot meals.
- **Social Services –** Complimentary to its education and health services, Head Start provides social services to its families. Support services that are frequently used include parenting education, health education, emergency or crisis intervention, adult education, housing assistance, and transportation assistance.
- **Parent Involvement –** Head Start programs acknowledge parents' critical role in their child's education. Programs work to engage parents both in the classroom as volunteers and at home through home visits. Parents also can serve on policy councils, which give them direct input into how their child's program is administered. Through Head Start, parents gain access to job training, literacy, language classes, and other supports that help them attain economic stability.

Start is a high quality comprehensive program that helps America's poorest children overcome the disadvantages of growing up in poverty while engaging their parents in the process. The study found positive impacts in each domain (cognitive, social-emotional, health, and parenting) and reported that at the end of just one year, Head Start was able to cut the achievement gap in children's pre-reading skills nearly in half in comparison to the general population.[33]

An evaluation of Early Head Start found that the program produced sustained positive impacts on children's cognitive and language development at age 3. Early Head Start children were significantly less likely than children who did not participate to score in the at-risk range of developmental functioning in these areas. Early Head Start also had positive impacts on children's social-emotional development; they were more engaged with their parents and more attentive during play while displaying less negative behavior. In addition, Early Head Start parents provided more support for language and learning at home, were more likely to read daily to their child, and were less likely to engage in negative parenting behaviors.

Assessing the National Reporting System (NRS)

In 2003, after only 18 months of development, the Administration implemented the National Reporting System (NRS), which tests the early literacy, language, and math skills of all 4- and 5-year-old children enrolled in Head Start at the beginning and end of the school year. The NRS test has been administered to more than 400,000 4- and 5-year-olds to date at a cost of more than $22 million. Controversial from its onset, the test was adamantly opposed by the early childhood community on grounds that the only useful assessments of preschoolers are based on on-going teacher observation rather than a single focused test performed on a given day. NRS testing practices run counter to a wide body of research on young children's development and assessment, as well as the Administration's own stated policy in the No Child Left Behind Act "*not to test students before third grade.*" The National Research Council warns: "Assessments must be used carefully and appropriately if they are to resolve, and not create, educational problems" for both children and programs. This high stakes test, cobbled together from a number of existing assessment tools, fails to consider children's progress in the emotional, behavioral, or physical domains. It also disregards the needs of children with disabilities and limited facility with English, who represent a significant number of children enrolled in Head Start.

In May 2005, the General Accountability Office (GAO) confirmed what the Children's Defense Fund and other early childhood experts have maintained for the past two years: that the NRS is neither a reliable nor valid method for assessing the progress of young children. CDF has called on Congress to remedy this misallocation of resources by suspending NRS testing until the National

Reliability: If the test is repeated, the results are the same.
Validity: The test accurately measures what it is supposed to measure.

"…results from the first year of the NRS currently cannot be used to hold grantees accountable or to target training and technical assistance because the Head Start Bureau (HSB) analyses have not yet shown that the NRS provides the scope and quality of assessment information needed for these purposes. The usefulness of educational tests is dependent on their consistency of measurement (their reliability), along with whether they measure what they are designed to measure (their validity). HSB has asserted that the NRS meets these criteria because it borrows certain material from existing tests that have met them, but the agency has not shown the NRS itself to be valid and reliable over time." [34]

Average Annual Teacher Salary by Level of Education

Head Start Teacher[37]	
Child Development Associate Credential	$20,306
Associate Degree in ECE or Related Field	$22,249
Baccalaureate Degree in ECE or Related Field	$26,241
Graduate Degree in ECE or Related Field	$32,478
K-12 Public School Teacher[38]	$45,822

Academy of Sciences completes a review of appropriate assessments for preschoolers enrolled in Head Start and deems NRS testing to be valid and reliable.

Head Start Funding and Teacher Credentials

Questions raised in early 2005 concerning financial mismanagement and improprieties at a relative handful of Head Start programs have cast a shadow over the oversight of Head Start program finances. Early childhood experts agree, however, that the program as a whole should not be held hostage due to the inappropriate behavior of a small number of individuals. The vast majority of Head Start centers manage their finances well and have a very low rate of fraud or negligence.

In 2003, the Administration proposed, without success, to hand over control of Head Start to the states. In 2004, the Administration tried once again to convert the Head Start program, this time proposing a "demonstration project" to implement block grants in a handful of states. Early childhood advocates turned back these efforts, and Head Start re-authorization bills introduced in early 2005 maintain the integrity of the program as well as its performance standards.

Head Start classrooms are consistently rated high in quality.[35] Head Start programs are also more likely to meet national accreditation standards for good quality early childhood development programs and tend to have lower turnover rates than many other early childhood and child care settings.[36] Congress is considering several proposals that would increase the Head Start teacher requirements. While the House and the Senate's proposals differ, they both mandate increased teacher requirements without providing any additional funding. These provisions would require all new Head Start teachers to have at least an associate's degree by 2008 and 50 percent of all Head Start teachers to have at least a bachelor's degree by 2011. While it is important to ensure that Head Start teachers are highly qualified, it is also important to address the need for scholarships and other means to compensate Head Start teachers for these costly educational requirements.

America's Primary, Yet Dwindling, Source of Child Care Funding: The Child Care and Development Block Grant (CCDBG)

Created in 1990, the Child Care Development Block Grant (CCDBG) is the main source of child care funding available to the states from the federal government. The Department of Health and Human Services administers CCDBG grants through the Child Care Bureau of the Administration for Children and Families. The CCDBG provides the primary support for child care assistance for low-income working families, families receiving public assistance, and those enrolled in training or continuing education. The CCDBG helps these families afford the child care that is critical to their finding and maintaining employment and preparing their children for success in school. States can use these funds to lift families out of poverty by allowing them to find affordable, quality care for their children while they work.

CCDBG is funded by money from both federal and state governments. The three primary sources of funding for CCDBG are:

- Mandatory funds: All federal funds, requiring no state match, and determined based on historical federal share of expenditures in the State IV-A child care programs;
- Matching funds: Comprised of federal and state funds, the remaining amount appropriated under section 418(a)(3) of the Social Security Act after the mandatory funds are allotted; available to states contingent on their contributing a matching amount at a specified rate (the Federal Medicaid Assistance Percentage rate, or FMAP); and
- Discretionary funds: Appropriated by Congress each year and requiring no state match.

Additional funding comes from the following sources:

- MOE (Maintenance of Effort) funds: A state is eligible for these funds if they continue to spend the same amount on child care services that they spent on the repealed Title IV-A child care programs in FY 1994 or FY 1995 (whichever was greater).
- TANF funds: States can transfer up to 30 percent of TANF funds to CCDBG or spend TANF funds directly for child care.
- SSBG (Social Services Block Grant) funds: States can transfer SSBG funds.

In 2000, the average number of families served per month by CCDBG was 1,040,600.[39] In 2004, this number stood at 1,001,600 families per month—a decrease of 39,000 families over five years.[40] At the same time, the number of families with children under 18 years of age living below the poverty line increased from 4,866,000 in 2000 to 5,847,000 in 2004, an increase of more than 980,000 families with children living below poverty.[41] While CCDBG has never been sufficiently funded to serve all eligible children, the federal government's response has been and continues to be inadequate in the wake of the declining numbers.

The federal government estimates that 2.5 million children received child care assistance from the various funding sources in 2003. However, the Administration itself projects that the number of children receiving help declined by 200,000 million in 2004 and will decline by 500,000 by 2010. The federal government provided $4.8 billion for CCDBG in 2004—the same level of funding since 2002. The Administration's proposed budget did not account for inflation and did not ask for one more dime for child care funding for 2005 or 2006.

Our nation can do more; currently only one in seven children eligible for child care assistance actually receives it. Investing in child care and after-school care is a smart choice that we can and must make—we can't afford not to. Child care helps our economy today by making it possible for parents to work and helps the economy of tomorrow by preparing our future workforce.

Tight State Budgets Have a Negative Impact on Child Care Policies

Over the past year, states have made drastic cuts to child care services because of state budget crises that have been exacerbated by recent federal tax cuts. The National Conference of State Legislatures

The need for child care has become a daily fact of life for many parents:

- 65 percent of mothers with children under age six and 79 percent of mothers with children ages six to 13 are in the labor force.[42]
- In 2001, only one-quarter of all families with children younger than six—and only one-third of married-couple families with young children—had one parent working and one parent who stayed at home.[43] Working women earn about half or more of their families' earnings in the majority of U.S. households.[44]
- The proportion of single mothers with jobs, after remaining steady at around 58 percent from 1986 to 1993, increased sharply to 71.5 percent in 1999.[45]

confirms the detrimental effects of revenue shortfalls and shrinking budgets, stating that "improving the quality of child care has been a challenge in recent years, particularly when states have been unable to make significant investments due to revenue shortfalls and uncertainty about reauthorization of the federal welfare law, which includes the Child Care and Development Block Grant."[46]

What does this mean for our nation's children? It means that well over 550,000 children across the country will remain on waiting lists for child care assistance. This number vastly underestimates the true number turned away because many states do not even maintain waiting lists; countless families are discouraged from applying for assistance because of long lists; and many families are unaware that they are eligible for assistance in the first place.

States' income eligibility limits have continued to become more restrictive as a result of stagnant federal funding and tightening state budgets. Current federal law allows states to set their income eligibility threshold (or limit) as high as 85 percent of the State Median Income (SMI[1]). However, in 2004, only one state, Maine, set its threshold that high.[47] The trends for income eligibility limits are troubling:

- Between 2001 and 2004, the cutoff for a family to qualify for child care assistance declined as a percentage of the poverty level in about three-fifths of the states.
- Between 2001 and 2004, the income eligibility cutoff for child care assistance declined in almost one-quarter of the states.
- In 2004, a family of three earning $17,800 per year would not even qualify for child care assistance.[48]

States also set their own copayments for child care assistance so that families cover part of the costs of child care. States structure their copayment system based on a family's income, the type of care, and the cost of care. Copayments are structured so that as a family's income rises, they increasingly shoulder a greater share of the costs of child care.

Unfortunately, as states look at ways to make their dollars go further, they look at increasing copayments as a way of reducing costs. Between 2001 and 2004, families in about half of the states with an income at 100 percent of poverty had their copayments increase.[49]

Reasonable state payment rates for publicly funded care are critical in ensuring access to decent child care. Low reimbursement rates make providers reluctant to serve children receiving child care assistance and deprive providers who do accept the rates of the resources they need to maintain a high level of program quality. As a result, such policies leave low-income parents with few good child care options. About half of the states set their market rates based on outdated market prices or below current market prices. A number of states reimburse providers at rates that are at least $100 per month lower than what providers typically charge.[50]

State policies that determine how much parents receiving assistance contribute to the cost of child care also affect access. Requiring high parent copayments may prohibit parents from participating in the child care assistance program at all. In addition, policies that base copayments on the cost of care make it difficult for parents with very low incomes to choose good quality care without suffering financially. Low-income families should not be expected to pay a higher percentage of their income than the national average (7 percent), and families with very low incomes should be exempt from any fees.[51]

The Quality of Child Care Varies Greatly

Children need high quality early experiences that promote all aspects of their development, including their social, emotional, physical, and cognitive development—all of which are essential in preparing them to succeed in school and in life. While many child care and early education programs are subject to federal, state, and/or local licensing or quality standards that provide basic health and safety protections, these programs usually cost more money or are already filled to capacity. There are no uniform quality standards that govern all

[1] State Median Income (SMI) is the income level below which half of the families in the state fall and half have incomes exceed.

child care and early education programs nationwide.

Strong state licensing requirements can have a major impact when it comes to ensuring children's well-being. The staff who care for and educate children on a daily basis play a critical role in children's development, yet many states do not require providers to have basic child development training, acceptable child-to-staff ratios, or quality standards. Cosmetologists must attend as much as 2,000 hours of training before they can get a license,[52] yet 37 states allow teachers in child care centers to begin working with children without receiving any training in early childhood development.[53]

Low salaries also negatively affect the quality of child care, fueling high turnover rates that make it difficult for children to form meaningful, trusting relationships with their caregivers. It's not surprising that professional, qualified child care workers are difficult to find and retain in a job market where they earn, on average, only $17,610 per year[54] and tend to receive no health or dental benefits or paid leave.[55]

High quality child care and early education programs invest more in personnel by paying higher staff salaries, providing greater funding for training and education and hiring additional teachers to increase the child-to-staff ratio. The result is the attraction of highly qualified staff, reduced turnover rates, appropriate curricula, comprehensive services for children and families, and children who are better prepared to succeed in school.

Ajay Chaudry's investigation of low-income working mothers' child care struggles poignantly illustrates the paradox of high quality child care—critical yet unaffordable: "Unstable and low-quality child care has an enormous impact on children's well-being. While mothers are well aware of this, they also know that within the existing child care markets and subsidy system, quality is a luxury that they cannot afford or even properly consider…"[56]

A 2002 MDRC study of findings on the child care decision of roughly 20,000 low-income parents revealed differences between employment programs that provided expanded child care assistance to parents and others that provided standard assistance:

- Welfare reform and employment programs increased parents' employment and use of paid child care.

STORIES FROM THE STATES

Two Jobs, No Child Care

Natoya grew up in an abusive foster care family and got pregnant at 14. She is now 28 and has five children ages 2, 5, 6, 10 and 13. Despite the absence of role models during her youth, Natoya is struggling to earn enough money to care for her children. She works two jobs: full-time at a Wal-Mart in St. Paul, Minnesota, and part-time caring for Janet, a quadriplegic. She is behind on her rent and will be moving out of her apartment because she can no longer afford it. Her children are in Memphis in the care of her relatives. "They took away my child care, now it's a sliding fee. I was making $1,800 a month working full-time. I had to take a one month leave because I was having a nervous breakdown after I lost child care. I took my kids to Memphis. I needed to situate my kids; I was worried about their safety."

The dilemma Natoya faces is common for low-income families with children—she took on two jobs and still couldn't afford quality child care for her children. The dilemma is that families are never able to get ahead; the safety net is failing them and their children. The lack of affordable child care is a predicament for too many American families.

- Programs that offered expanded assistance increased child care subsidy use, lowered parents' personal costs, and reduced the percentage of parents reporting child care problems with finding and keeping jobs.
- Parents reported difficulties remaining eligible for child care assistance due to unclear or inflexible rules to accommodate their ever-changing employment situations.[57]

Research Shows That High Quality Child Care Helps Children

The importance of accessible, affordable child care cannot be overstated. Child care helps low-income families find and keep work, helps shape their children's futures, and is key to school readiness. The research is clear that the quality of child care has a lasting impact on children's well-being and ability to learn.

- Children in poor quality child care have been found to be delayed in language and reading skills, and display more aggression toward other children and adults.[58]
- A study released in 1999 found that children in high quality child care demonstrated greater mathematical ability, greater thinking and attention skills, and fewer behavioral problems than children in lower quality care. These differences held true for children from a range of family backgrounds, with particularly significant effects for children at risk.[59]
- School-age children's academic performance is enhanced by attending formal child care programs of at least adequate quality, according to several studies. Children attending such programs have been found to have better work habits and relationships with peers and to be better adjusted and less anti-social than children who spend their out-of-school hours alone, in front of the television or informally supervised by other adults.[60]

School-Age, After-School, and Out-of-School Care

According to the Federal Poverty Guidelines issued by the Department of Health and Human Services (DHHS), Natoya's income of $1,800 per month (or $21,600 a year) places her well below the federal poverty line of $25,870 per year (for a family of six). Natoya's experience is not unique—there are millions of eligible families who need and qualify for child care assistance, yet don't receive it because there is just not enough money to go around. Instead, families and their children are turned away or placed on waiting lists for child care assistance in their state. These families turn, more often than not, to unregulated child care, also known as informal care. Natoya was lucky enough to have family members who were willing to care for her children. Many families turn to relatives and friends to care for their children because it is the most affordable option for them. Others might set up an informal care network and rotate taking turns caring for their children. Some families might have the child who is the oldest care for the other children, often referred to as sibling care. Having a 12-year-old care for a five-year-old might be an inexpensive care option, but clearly it is not the preferred choice for any parent. Lastly, unregulated care, or care that children are receiving for which there are no formal requirements or processes for assessment, inspection, or quality control, is the only alternative for many parents, simply because it is less expensive than regulated care.

Currently, there are more than 73 million children living in the 50 states and the District of Columbia, with almost 24 million preschoolers and more than 49 million children of school-age.[61] Each day, an estimated 12 million children under six—including children with mothers who work outside the home and those who do not—spend some or all of their day being cared for by someone other than their parents on a regular basis.[62] In fact, all but two states, Illinois and Maryland, do not have regulations or laws that clarify when a child is considered old enough to care for himself/herself or to care for other children.[63]

Because school days between the hours of 3 to 6 p.m. are a peak time for children and teens to get into trouble,[64] after-school programs play an important role in keeping them safe while their parents work. Studies have found that children who attend quality after-school programs have better peer relations, emotional adjustment, grades, and

conduct in school than their peers who are not in programs. They have more learning opportunities and academic or enrichment activities, and they spend less time watching television. It's clear that school-age children also need quality out-of-school care.

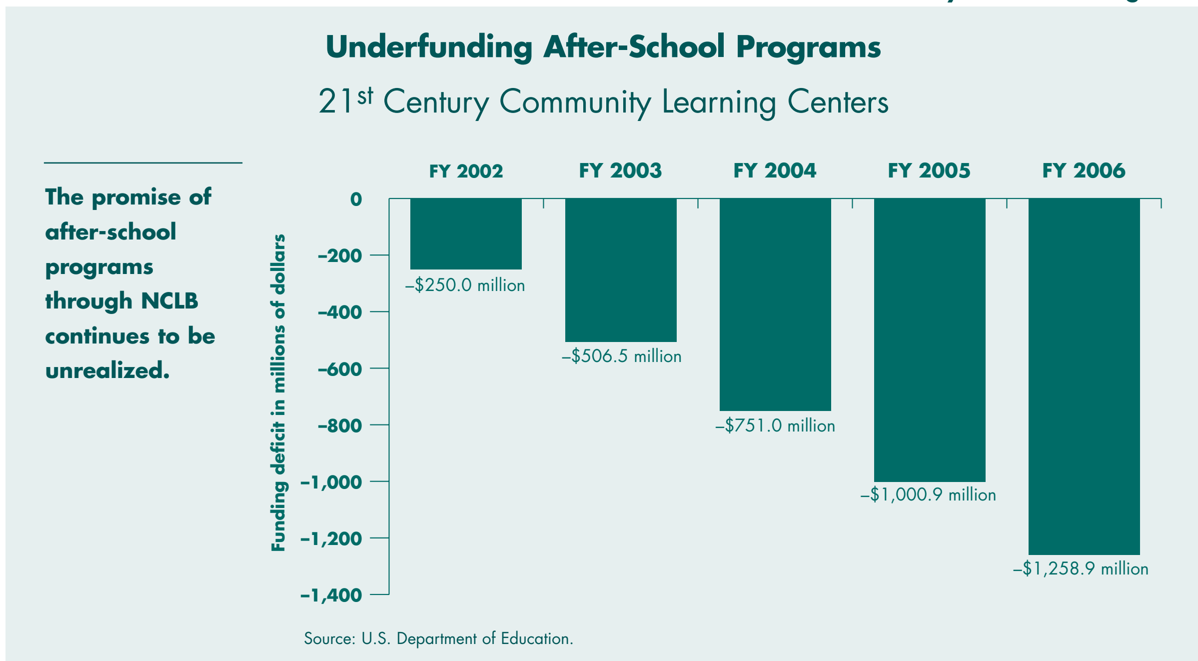
After-school programs are a cost-effective federal investment that meets the needs of children and their parents. Quality programs for school-age children during their out-of-school hours can support their learning and successful development while keeping them out of trouble. More than six million "latchkey children" go home to an empty house on any given afternoon.[65] When the school day ends, working parents worry about whether their children are safe or are being tempted to engage in dangerous activities. We would be shortchanging our children if we gave them the support and resources necessary to arrive at school ready to learn and then did not continue to support them during their school years.

21st Century Community Learning Centers (CCLC)

In 2001, the Administration's No Child Left Behind legislation reauthorized the 21st Century Community Learning Centers (21st CCLC) Program that was created in 1995. This after-school program provides opportunities for academic enrichment through a wide array of activities in order to help students in low-performing schools meet state and local student academic achievement standards in reading, math, and science. These services are provided during non-school hours (before and after school, during the summer, and on Saturdays). The program also provides help to children and their families through youth development programs like drug and violence prevention; character education programs; counseling programs; and art, music, literacy, technology, and recreation programs that are designed to reinforce and complement the regular school day activities.

Congress chose to increase the program's funding each year until 2003, when it was cut by $6.5 million. Even though the President's own No Child Left Behind (NCLB) legislation called for 21st CCLC to be funded at $2 billion in FY 2005, the Administration requested just under $1 billion. The Children's Defense Fund estimates that just over 1.3 million children were served by the program in 2004 (the Department of Education's most recent estimate is that 1.2 million children were served in 2001). This falls far short of the

Early Childhood – Figure 1



Source: U.S. Department of Education.

well-documented need for after-school programming and care for our nation's children.

The Administration's fiscal year 2006 budget proposed to "level fund" this important after-school program at $991 million, underfunding the program by 1.3 billion dollars of the authorized level of NCLB for 2006—leaving 1.7 million children without after-school services.

Sustainability

Sustainability is a major problem for after-school programs. Many programs receive a substantial grant that provides funding for the first several years, but once the initial grant runs out, programs are forced to turn to a different source for continued funding. Considering that the hours after school lets out and before parents return home are a dangerous time for children to be unsupervised, ensuring these programs are able to continue to serve children should be of the highest priority for our nation.

Research Shows That Quality After-School Programs Help Children

Evaluations and studies of after-school programs have consistently shown that these programs have a positive effect on children as well as their families. The U.S. Department of Education reports that children and youth who participate in quality after-school programs achieve better academically, are better behaved in school, have stronger peer relationships, and are less likely to be involved in drugs and violence.[66] Studies indicate that school-age children who are left alone after-school are more likely to engage in risk-taking behavior, smoke cigarettes, drink alcohol, and experience stress.[67] Students involved in quality after-school programs have more learning opportunities and academic or enrichment activities, and they spend less time watching television.[68] Further research also has demonstrated that children who are under adult supervision, in programs or at home, have better social skills and higher self-esteem than their peers who are unsupervised after school.[69]

Working parents with school-age children do not need full-time care, but they do need part-time quality care in the hours after school. Low-income working families especially need affordable school-age care that will enable them to maintain their full-time jobs while ensuring that their children are in a safe, supervised, and structured atmosphere. Even part-time care for school-age children can total $3,500 or more per year.[70]

What is especially troubling about the availability and affordability of after-school programs is the extent to which families living in poverty are able to utilize or even afford these programs. School-age children living in families below the poverty line are one-third as likely as children living in families at or above 200 percent of the poverty line to participate in at least one enrichment activity after school.[71] Despite the growth of after-school programs like 21st CCLC, school-age children in low-income families still face limited opportunities to participate in after-school activities; yet these are often the children who could benefit most from these programs.

Prekindergarten: Patchwork of Programs, Not Universal

In 1989, the nation's governors and the first President Bush signed the National Education Goals. The first of these goals stated that, by the year 2000, every child would enter school ready to learn and that access to a high quality early childhood program was key to meeting this goal. Though this goal has not yet been achieved, efforts to help all children become better prepared for school continue. These efforts include prekindergarten initiatives, which are supported through a variety of private and public sources at the federal, state, and local levels.

Prekindergarten in the United States is not universal; instead, a patchwork of public and private programs throughout the states exists. As a country, we have come a long way in providing preschool to the children who need it the most—children who live in poverty. The number of children attending state-funded preschool programs rose from 693,000 in 2001-2002 to 738,000 in 2002-2003.[76] In 2002-2003, however, only 38 states had recognized the importance of investing in our young children from the outset and had

After-School Program Benefits

- Research shows that children who spend 20 to 35 hours per week engaged in constructive learning activities are significantly more likely to succeed in school. Children's out-of-school hours represent a substantial, ongoing opportunity for them to learn through play, to learn how to get along with other children, and to form enduring and supportive relationships with adults.[72]
- A 2001 study found that teenagers who participate in after-school, extracurricular activities, such as bands, sports teams, clubs, and community groups, are more likely to graduate from high school than those who spend their afternoon hours without adult supervision. The study found that 90 percent of those who were involved in an organized program after school graduated from high school.[73]
- A U.S. Department of Education study of the 21st CCLC Program found wide-ranging positive effects of after-school programs on student behavior and academic performance. Various programs reported reductions in local violence and juvenile crime, lower incidence of student retention in school, and higher school-attendance rates.[74]
- An evaluation of the Extended-Service Schools Initiative found that after-school programs help youth avoid risk-taking behaviors, improve their attitude towards school, and increase their self-confidence, according to an evaluation of the initiative. Sixty-five percent of youths reported that the program helped them stay out of trouble and helped them do better in school. Nearly three-quarters of youth said they saw choices and possibilities in life that they had not realized they had. The benefits of the program were not limited just to the children; parents also benefited from the program. Eighty-two percent of the parents said the program helped their children try harder in school. Knowing their children had a good place to go after school also reduced parents' stress levels and enabled them to better balance their responsibilities for work and family.[75]

funded public prekindergarten programs.[77] While states **must** provide education for children in grades K-12, they are not universally mandated by law to provide prekindergarten for all children.

Other prekindergarten programs, both public and private, exist throughout the United States to serve children of all socio-economic backgrounds. The difference between states' and even among states' prekindergarten programs can be quite dramatic, with each state determining its own eligibility criteria, guidelines for access, curriculum, teacher standards, class size, and funding level. Some states, including California, Delaware, Arizona, and Massachusetts, set income eligibility criteria for participation in prekindergarten programs, with most focusing their efforts on children living in low-income families as well as children who have other risk factors.

Access to prekindergarten is a significant problem even in states that offer it. In late 2004, the GAO studied five states that expanded their prekindergarten programs to serve more children. It found that none of the states required providers to transport children to and from their prekindergarten program and that many children were enrolled in half-day programs. The GAO report discussed the implications of these two findings, "which officials believed might have limited the participation of children from low-income and working families."

Inadequate Resources

Only with a sufficient amount of funding per child can prekindergarten programs offer a high level of quality. The average cost per child in the

federal Head Start program offers a benchmark for the cost of providing a comprehensive, quality part-year program. In 2004, the average expenditure per child in Head Start was $7,222.[78] This level of funding should allow programs to hire well-trained staff, maintain safe facilities, purchase materials and equipment, and invest in other important resources. Comparing the expenditure per child in Head Start to state-funded prekindergarten programs illustrates how we are shortchanging our children. In 2002-2003, state spending per child enrolled in state-funded prekindergarten averaged about $3,500.[79]

In 2004, 12 states did not provide any prekindergarten programs: Alaska, Florida, Idaho, Indiana, Mississippi, Montana, New Hampshire, North Dakota, Rhode Island, South Dakota, Utah, and Wyoming.[80] But other states are making inroads in meeting the needs of their children. The Trust for Early Education reported that 15 states increased their prekindergarten funding in fiscal year 2005: Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Illinois, Maine, New Jersey, North Carolina, Oklahoma, Pennsylvania, Virginia, and Wisconsin.[81]

Even when states do make an effort to provide prekindergarten, many state initiatives are typically structured to provide part-day and/or part-year programs. This is problematic for parents who work full-time year-round. They are forced to find additional child care arrangements for their children for the remainder of their workday, as well as during the summer when school is out. Transportation becomes a major stumbling block as well, as the children usually have to be moved from one location to another. States have increasingly been paying more attention to these issues and are focusing on improving the coordination among different providers and child care arrangements.

Quality Matters in School-Age Care

Quality programs for school-age children during their out-of-school hours can support children's learning and successful development and keep them out of trouble.

President Bush's tax cuts allowed wine, whisky, and beer manufacturers to benefit from a tax write-off with a revenue loss of $66 million in 2005. This is enough revenue to pay for more than 85,000 children to receive quality after-school care.

- 46 percent of kindergarten teachers report that half of their class or more have specific problems, including difficulty following directions, lack of academic skills, problems in their situations at home, and/or difficulty working independently when entering kindergarten.
- In its long-term study of child care, the National Institute of Child Health and Human Development found that children in higher quality care for their first four-and-a-half years of life scored higher on tests of cognitive skills, language ability, vocabulary, and short-term memory and attention than children in lower quality care. Children in higher quality care also were better able to get along with their peers, according to their caregivers.
- A four-state study has been following a group of children to compare high quality child care with lower quality child care. The most recent findings reveal that children in high quality care demonstrate greater mathematic ability, greater thinking and attention skills, and fewer behavioral problems. These differences hold true for children from a variety of family backgrounds, with particularly significant effects for children at risk.
- A report by the National Research Council, "*Eager to Learn: Educating Our Preschoolers,*" states that "Cognitive, social-emotional, and motor development are complementary, mutually supportive areas of growth all requiring active attention in the preschool years… All are therefore related to early learning and later academic achievement…" A high quality program must address each of these critical developmental areas in order to ensure children are ready to learn.[82]

Other gaps in state policies and investments for child care assistance and state prekindergarten

Sample Costs to Support a Family of Three (per month)

Basic Needs	Monthly Costs 2005[1]
Housing[2]	-$805
Food[3]	-$427
Child Care[4]	-$620
Health Care[5]	-$63
Clothing[6]	-$58
Transportation[7]	-$416
Miscellaneous[8]	-$98
Total	**-$2,487**
Full-time minimum wage income[9]	**$893**
Income gap per month	**-$1,594**

Which basic needs would you tell this family to give up?

NOTE: This example is based on a single parent earning a minimum wage, working full-time, and raising two children ages four and seven.

1 The above table reflects minimal national average costs for families raising children, using the most recent data available. Housing and food costs are estimated for a three-person family. The estimate only counts the cost of clothing and miscellaneous expenditures for the children, and counts the out-of-pocket average costs for children's health care not covered by Medicaid or private insurance. Full family costs, of course, really include expenditures for the parent for these necessities as well.

2 Fair market rent for a two-bedroom apartment in FY 2005. Estimate by the Center on Budget and Policy Priorities, based on data from the U.S. Department of Housing and Urban Development.

3 Assumes a mother and two children, ages 4 and 7, using the USDA's low-cost food plan. Source: U.S. Department of Agriculture, March 2005.

4 Karen Schulman, *The High Cost of Child Care Puts Quality Care Out of Reach for Many Families* (Washington, DC: Children's Defense Fund, 2000). This cost estimate is for family child care in the state of Ohio.

5 USDA's 2003 Annual Report: Expenditures on Children by Families. Includes medical and dental services not covered by insurance, prescription drugs and medical supplies not covered by insurance, and health insurance premiums not paid by employer or other organization. Does not include parent's health care costs (single-parent family estimates).

6 USDA's 2003 Annual Report: Expenditures on Children by Families. Does not include costs of clothing for the parent (single-parent family estimates).

7 USDL Bureau of Labor Statistics Consumer Expenditures in 2001-02. Includes gas, oil, other vehicle expenses, vehicle purchases (net outlay), and public transportation for average three-person household making $10,000-$14,999 in 2001-02.

8 USDA's 2003 Annual Report: Expenditures on Children by Families. Includes personal care items, entertainment, and reading materials. Does not include these for the parent (single-parent family estimates).

9 $5.15 an hour, 40 hours a week, 52 weeks a year divided by 12. These figures do not take into account payroll taxes or the value of the Earned Income Tax Credit.

programs deprive low-income families of access to quality child care and early education.

Lack of Affordable Care

The problem of locating affordable, licensed, and quality child care is especially difficult for infants and toddlers, school-aged children, children with disabilities and special needs, and parents who need odd hour care for their children. Contributing to this problem are welfare rules that require a single parent with a child under age six to work 20 hours a week and other single parents to work 30 hours a week and second and third shift hours. Another factor is the continual rise of mothers in the workforce, with almost three out of every four women working often at odd hours to accommodate child care needs.[83] States are making some progress towards offering odd hour care, care for children with special needs, and increasing the number of facilities serving infants and toddlers.

Children with special needs require quality child care, especially children with severe disabilities or those who require medical services. The term "special needs" can refer to physical, emotional, mental, or behavioral needs. The latest data show that 6.5 million children from infancy to 18 years of age have disabilities and received services under the Individuals with Disabilities Act (IDEA) in 2000-2001.[84] These children with disabilities and special needs are more likely to be from low-income families. In 2003, nine states reported new programs or policies regarding special needs care for children: Illinois, Kansas, Maryland, Massachusetts, Ohio, Rhode Island, South Dakota, Virginia, and West Virginia.

School-age and after-school care are the least available types of care for children. Each day, more than six million "latchkey children" go home to an empty house and are unsupervised.[85] In 2003, four states reported cuts in funding for school-age care initiatives: Maryland, Oklahoma, South Carolina, and the District of Columbia. Three states, South Dakota, Virginia, and Wyoming, all implemented various grants for the use of school-age care.

The need for additional odd hour care stems from the increase of mothers in the work force and two-parent working families. The Families and Work Institute reports that:

- One in four Americans work either Saturday or Sunday once a week.
- The traditional 40-hour work week is disappearing at a rapid pace.
- Men on average work 48.2 hours per week and women work 41.4 hours per week.[86]

In families where both parents work, the Families and Work Institute found that among parents of children under age 6, 41 percent use full- or part-day child care for their children, and 64 percent of parents say they coordinate work schedules to be able to access established child care hours.[87] In 2003, there were only two reported efforts to make odd hour care available. The District of Columbia encouraged child care providers to increase operation hours, and Massachusetts piloted an odd hour care program in family and center-based child care facilities that are contracted with the Office of Child Care Services (OCCS). California currently has some odd hour care initiatives but due to the reduction in reimbursement rates, the availability of odd hour care could be impacted.

Costs Versus the Benefits of Child Care and Early Education

Investing in our children during their early development pays off not only in the short run, but in the long run as well. High quality child care and early childhood programs can reduce criminal and violent behavior. Fight Crime: Invest in Kids, an anti-crime group of more than 2,000 police chiefs, sheriffs, prosecutors, victims of violence, and youth violence experts, have found that a lack of access to quality early childhood programs increases the probability that children will become involved in crime and violence.[88] One study indicates that "the national cost of failing to provide at least two years of quality early care and education is extremely high, on the order of $100,000 for each child born into poverty, or $400 billion for all poor children under five today."[89] For example, one study found that early childhood programs combining a focus on early education and family support have result-

ed in long-term decreases in the incidence and seriousness of juvenile offenses.[90]

Studies have revealed that Head Start and similar prekindergarten programs cut crime. Children left out of Head Start are more likely to commit crimes when they grow up compared to children who did attend the program. [92]

Research shows that Head Start helps kids learn to get along with others and follow directions, and reduces problem behavior that can lead to youth and adult crime. Head Start has also shown strong results for children in improving language and math skills, reducing grade retention, and increasing graduation rates. These school successes have led to Head Start graduates having higher rates of employment and earnings. Head Start has given a literal "head start" to more than 22 million of the country's neediest children, helping them to become contributing, responsible adults.

High-Return Investments

- The High/Scope Perry Preschool Study of the long-term impact of a good early childhood program for low-income children found that after 40 years, each $1 invested had a return of over $17 by increasing the likelihood that children would be literate, employed, and enrolled in post-secondary education, and making them less likely to be school dropouts, dependent on welfare, or arrested for criminal activity or delinquency.[93]
- A study of the long-term benefits of the Abecedarian early intervention project found a return of $4 for each $1 invested. Children who participated in the program were less likely to require special or remedial education, had higher earnings as adults, and were less likely to smoke and incur related health care costs. Their parents also had greater earnings.[94]
- A study of the short-term impact of the Colorado prekindergarten program found that it saved $4.7 million over just three years in reduced special education costs.[95]

The benefits of high quality early childhood programs result in significant cost savings in *both* the short and long term. The Committee for Economic Development found that "early environments play a large role in shaping later outcomes. Skill begets skill and learning begets more learning. Early advantages cumulate; so do early disadvantages. Later remediation of early deficits is costly, and often prohibitively so."[96] As a result, the economic impact of the child care and early education industry is substantial:

- In Massachusetts, the child care and early education industry provides nearly 30,000 jobs and generates $1.5 billion in gross receipts.[97]
- In North Carolina, the child care and early education industry was found to provide more than 46,000 jobs and contributed $1.5 billion in annual gross receipts.[98]
- In Ohio, an expansion of the state public prekindergarten that would require an investment of $410 million would generate estimated returns of $782 million. The benefits of the investment would be 1.91 times greater than the costs.[99]
- By decreasing the number of students who had to repeat a grade in elementary school, the Michigan School Readiness Program saved the state $11 million annually.[100]

A longitudinal study of a comprehensive, publicly funded preschool program in Chicago for 15 years has followed a group of children who participated in the program. The study has found that relative to a comparison group, participants in the program had a 29 percent higher rate of high school completion, a 33 percent lower rate of juvenile arrest, a 41 percent reduction in special education placement, a 40 percent reduction in the rate of grade retention, and a 51 percent reduction in child maltreatment.[101]

Children living in high-crime neighborhoods and attending after-school programs had fewer school absences, better conflict-management strategies, and better work habits at school than did their school classmates not attending the programs who lived in the same neighborhoods, according to a three-year study of four programs.[102]

While it may seem like the cost of ensuring that our children receive high quality care and education is high, the cost of **not** providing these critical services and programs is much higher. According to the Institute for Educational Leadership, "The cost to the nation in terms of talent unfulfilled and lives of promise wasted is enormous. Certainly, efforts to even the playing field from kindergarten onward are useful, but they have to begin by dealing with the deficits created in many children from birth to age five."[103] Investing in our children would be one of the wisest possible choices we could make. As other researchers have noted: "Compared with the billions of dollars spent each year on economic development schemes, [Early Childhood Development] is a much better economic development tool."[104]

Recommendations for Moving Forward

We call on all who support CDF's mission to ensure every child a *Healthy Start*, a *Head Start*, a *Fair Start*, a *Safe Start,* and a *Moral Start* in life and successful passage to adulthood with the help of caring families and communities—including child advocates, policy makers, government officials, researchers, and service providers—to work together to achieve:

- a solid foundation for young children that allows them to enter school with the skills necessary to become strong readers and good students;
- access to after-school activities for school-aged children that not only offer a safe haven, but also provide the academic enrichment they need to stay and succeed in school;
- reliable, affordable child care options that enable parents to work outside the home or give children extra learning experiences if their parents stay at home; and
- opportunities for parents to stay at home during their child's critical first months or when a child is sick.

In addition, CDF supports the following policies and programs that, in addition to helping parents work and ensuring that children arrive at school ready to succeed, have been shown to have far greater benefits to society than the costs. It is critical to hold national, state, and local elected officials accountable for their support of and commitment to policies and programs that provide the least well-off children with the opportunities they need to succeed in life and parents with the supports that will enable them to properly provide and care for their children.

Head Start

- Urge members of Congress to fully fund both Head Start and Early Head Start so that all eligible children, whose families want them to participate, receive the important early childhood education experiences they deserve.
- Support higher staff qualifications policies that link heightened standards to appropriate funding and incentives.
- Oppose allowing faith-based organizations to conduct discriminatory hiring practices that violate civil rights protections.
- Encourage the suspension of the National Reporting System until the test has been fully evaluated and appropriate steps are taken to ensure its validity, reliability, and purpose.
- Support increased flexibility for Head Start programs to serve more families whose incomes may be above the federal poverty line.
- Investments in the quality of the program also should be continued to ensure that it maintains its comprehensive approach to addressing children's cognitive, physical, emotional, and social development as well as to strengthen the early learning components.
- Preserve Head Start's focus on comprehensive services.
- Support further improvements in the quality of Head Start.

Child Care

- Urge your Members of Congress to support an increase in the CCDBG to provide child care help to guarantee child care assistance to all low-

income working families and to help families participating in activities that lead to a job or a better-paying job, such as searching for work, receiving job training, or attending college.

- Significantly boost funds set aside to bolster the quality of child care.
- Offer new incentives to states to support initiatives to recruit and retain child care providers.
- Make resource and referral services more accessible to families.
- Ensure that reimbursement rates paid to providers serving children receiving child care assistance are, at a minimum, based on current market rates.
- Ensure that providers have appropriate training in child development before working with children and receiving public funds.
- Ensure that providers receiving public funds are inspected at least annually to ensure children are in safe settings.
- Provide additional funding for campus-based child care centers to help parents pursue higher education.
- Invest in efforts to improve and expand child care facilities to ensure children are in healthy, safe, and appropriate environments.

Improving Availability and Access of Child Care

- Ensure that child care is available for children with disabilities and other special needs by setting higher reimbursement rates for this type of care and using other incentives to ensure access.
- Make it easier for eligible families to get and keep child care assistance.
- States should streamline their application process so families receiving TANF or working for low wages can more easily access child care assistance.
- States should provide parents with counseling and support in choosing reliable, quality child care options.
- Ensure a real choice of child care providers for families receiving child care assistance by setting reasonable parent co-payments and establishing provider reimbursement rates that are, at a minimum, based on current market rates.
- Expand child care opportunities for parents who work nontraditional hours by establishing higher reimbursement rates and special contracts for providers who offer care during early morning hours, evenings, and weekends.
- End the practice (employed by some states) of requiring child support payments and/or paternity tests as a condition for receiving child care assistance.

Out-of-School Care

- Expand funding for the 21st Century Community Learning Centers program to provide more children with safe, supportive, and academically enriching after-school activities.
- Increase the availability of before- and after-school as well as summer programs that offer academic, recreational, and creative enrichment activities for elementary, middle, and high school students.

Prekindergarten

- Create a program to provide funds to states for quality prekindergarten for children ages three to five.
- Provide additional avenues for states to coordinate their prekindergarten and Head Start programs.

Infants and Toddlers

- Ensure that new funds are available to expand and improve infant and toddler care. Expand and improve infant care by creating family child care networks, setting infant care reimbursement rates high enough to ensure access to services, offering specialized training for infant caregivers, and creating strong licensing standards related to infant and toddler care.
- Give parents the option of staying home with their very young children through policies such as paid family leave.
- Offer refundable state dependent care tax credits to help parents afford child care.

Endnotes

[1] U.S. Department of Labor, Bureau of Labor Statistics, *Women in the Labor Force: A Databook* (Washington, DC: U.S Department of Labor, 2005).

[2] Karen Schulman, *The High Cost of Child Care Puts Quality Care Out of Reach for Many Families* (Washington, DC: Children's Defense Fund, 2000).

[3] Children's Defense Fund calculations based on data from the U.S. Census Bureau, *Current Population Survey* Annual Demographic Supplement, Detailed Income Tables, "Table FINC-03. Presence of Related Children Under 18 Years Old – All Families, by Total Money Income in 2001, Type of Family Work Experience in 2001, Race and Hispanic Origin of Reference Person." Retrieved from the Internet at http://ferret.bls.census.gov/macro/032002/faminc/toc.htm.

[4] Karen Schulman and Helen Blank, *Child Care Assistance Policies 2005: States Fail to Make Up Lost Ground, Families Continue to Lack Critical Supports* (Washington, DC: National Women's Law Center, 2005).

[5] U.S. Department of Labor, Bureau of Labor Statistics, *Women in the Labor Force: A Databook* (Washington, DC: U.S. Department of Labor, 2005).

[6] *Ibid.*

[7] Karen Schulman, *The High Cost of Child Care Puts Quality Care Out of Reach for Many Families* (Washington, DC: Children's Defense Fund, 2000).

[8] Children's Defense Fund calculations based on data from the U.S. Census Bureau, *Current Population Survey* Annual Demographic Supplement, Detailed Income Tables, "Table FINC-03. Presence of Related Children Under 18 Years Old – All Families, by Total Money Income in 2001, Type of Family Work Experience in 2001, Race and Hispanic Origin of Reference Person." Retrieved from the Internet at http://ferret.bls.census.gov/macro/032002/faminc/toc.htm on May 3, 2005.

[9] Karen Schulman and Helen Blank, *Child Care Assistance Policies 2005: States Fail to Make Up Lost Ground, Families Continue to Lack Critical Supports* (Washington, DC: National Women's Law Center, 2005).

[10] Testimony by Deborah Phillips before the U. S. Senate Committee on Labor and Human Resources, March 1, 1995.

[11] Children's Defense Fund calculations.

[12] U.S. Department of Labor, Bureau of Labor Statistics, *Women in the Labor Force: A Databook* (Washington, DC: U.S Department of Labor, 2005).

[13] U.S. Census Bureau, *Who's Minding the Kids? Child Care Arrangements: Spring 1999* (Washington, DC: U.S. Census Bureau, 1999).

[14] Carnegie Corporation of New York, *Starting Points: Meeting the Needs of Our Youngest Children, Executive Summary* (New York, NY: Carnegie Corporation, 1994).

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

[16] *Ibid.*

[17] Carnegie Corporation of New York, *Starting Points: Meeting the Needs of Our Youngest Children, Executive Summary* (New York, NY: Carnegie Corporation, 1994).

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

[19] J.P. Shonkoff and D. A. Phillips, Eds., National Research Council and Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Washington, DC: National Academy Press, 2000).

[20] C.E. Snow, M.S. Burns and P. Griffin, Eds., National Research Council, *Preventing Reading Difficulties in Young Children* (Washington, DC: National Academy Press, 1998).

[21] K. Denton and J. West, *Children's Reading and Mathematics Achievement in Kindergarten and First Grade* (Washington, DC: U.S. Department of Education, National Center for Education Statistics, 2002).

[22] R.A. Thompson, "The Roots of School Readiness in Social and Emotional Development," The Kauffman Early Education Exchange (2002), Set for Success: Building a Strong Foundation for School Readiness Based on the Social-Emotional Development of Young Children (Kansas City, MO: The Ewing Marion Kauffman Foundation, 2002).

[23] B. Hart and T.R. Risley, *Meaningful Differences in the Everyday Experience of Young American Children* (Baltimore, MD: Paul H. Brookes Publishing Co., 1995).

[24] U.S. Department of Health and Human Services, Federal Interagency Forum on Child and Family Statistics, *America's Children: Key National Indicators of Well-Being, 2002* (Washington, DC: U.S. Government Printing Office, 2002). Retrieved from the Internet at http://www.childstats.gov/americaschildren on July 25, 2005.

[25] S. Vandivere, K.A. Moore and M. Zaslow, *Children's Family Environment: Findings from the National Survey of America's Families: Snapshots of America's Families II* (Washington, DC: Urban Institute and Child Trends, 2000).

[26] Valerie E. Lee and David T. Burkam, *Inequality at the Starting Gate: Social Background Differences in Achievement as Children Begin School* (Washington, DC: Economic Policy Institute, 2002).

[27] P.R. Britto and J. Brooks-Gunn, Eds., *The Role of Family Literacy Environments in Promoting Young Children's Emerging Literacy Skills: New Directions for Child and Adolescent Development, No. 92* (San Francisco, CA: Jossey-Bass, 2001).

[28] U.S. Department of Health and Human Services, Head Start Bureau, *Head Start Regulations, 45 CFR 1305.6 (c)* (Washington, DC: U.S. Department of Health and Human Services, 2005). Retrieved from the Internet at http://www.acf.hhs.gov/programs/hsb/pdf/1305_ALL.pdf on March 2, 2005.

[29] *Ibid.*

[30] U.S. Department of Health and Human Services, *The 2005 HHS Poverty Guidelines* (Washington, DC: U.S. Department of Health and Human Services, 2005). Retrieved from the Internet at http://aspe.hhs.gov/poverty/05poverty.shtml on March 2, 2005.

[31] U.S. Department of Health and Human Services, Head Start Bureau, *Head Start Regulations, 45 CFR 1305.6 (c)* (Washington, DC: U.S. Department of Health and Human Services, 2005). Retrieved from the Internet at http://www.acf.hhs.gov/programs/hsb/pdf/1305_ALL.pdf on March 2, 2005.

[32] N. Zill, "Improving Head Start: What We Have Learned from the Family and Child Experiences Survey," A Presentation at a Science and Public Policy Briefing sponsored by the Federation of Behavioral, Psychological, and Cognitive Sciences and the Foundation for Child Development, in Washington, DC (September 13, 2002).

[33] U.S. Department of Health and Human Services, Administration for Children and Families, *Head Start Impact Study: First Year Findings* (Washington, DC: U.S. Department of Health and Human Services, 2005).

[34] U.S. General Accountability Office, *Head Start: Further Development Could Allow Results of New Test to Be Used for Decision Making* (Washington, DC: U.S. General Accountability Office, 2005). Retrieved from the Internet at www.gao.gov/cgi-bin/getrpt?GAO-05-343 on May 25, 2005.

[35] N. Zill, "Improving Head Start: What We Have Learned from the Family and Child Experiences Survey," Presentation at a Science and Public Policy Briefing sponsored by the Federation of Behavioral, Psychological, and Cognitive Sciences and the Foundation for Child Development, in Washington, DC (September 13, 2002).

[36] E. Kisker, S. Hofferth, D. Phillips, and E. Farquhar, *Profile of Child Care Settings: Early Education and Care in 1990* (Princeton, N.J.: Mathematica Policy Research, Inc., 1991).

[37] U.S. Department of Health and Human Services, Administration for Children and Families, Head Start Bureau, *Head Start 2003-2004 Program Information Report* (Washington, DC: U.S. Department of Education, 2004).

[38] U.S Department of Education, National Center for Education Statistics, *Digest of Education Statistics, 2003 Table 77* (Washington, DC: Department of Education 2003). Retrieved from the Internet at http://nces.ed.gov/programs/digest/d03/tables/dt077.asp on June 18, 2005.

[39] U.S. Department of Health and Human Services, Administration for Children and Families, *FFY 2000 CCDF Data Tables and Charts* (Washington, DC: U.S. Department of Health and Human Relations, 2000). Retrieved from the Internet at http://www.acf.hhs.gov/programs/ccb/research/00acf800/chldser1.htm on June 18, 2005.

[40] U.S. Department of Health and Human Services, Administration for Children and Families, *FFY 2004 CCDF Data Tables and Charts* (Washington, DC: U.S. Department of Health and Human Relations, 2004). Retrieved from the Internet at http://www.acf.hhs.gov/programs/ccb/research/04acf800/table1.htm on August 18, 2005.

[41] U.S. Census Bureau, Housing and Household Economic Statistics Division, *Historical Poverty Tables* (Washington, DC: U.S. Census Bureau, 2003). Retrieved from the Internet at http://www.census.gov/hhes/www/poverty/histpov/hstpov4.html on September 22, 2005.

[42] In the labor force includes mothers who are employed as well as mothers who are looking for work. Unpublished data from the Bureau of Labor Statistics on marital and family characteristics from the March 2001 *Current Population Survey.*

[43] Children's Defense Fund calculations based on data from the U.S. Census Bureau, *Current Population Survey* Annual Demographic Supplement, Detailed Income Tables, "Table FINC-03. Presence of Related Children Under 18 Years Old – All Families, by Total Money Income in 2001, Type of Family Work Experience in 2001, Race and Hispanic Origin of Reference Person" and "Table FINC-04. Presence of Related Children Under 18 Years Old –Married Couple Families, by Total Money Income in 2001, Work Experience in 2001, Race and Hispanic Origin of Reference Person."

Retrieved from the Internet at http://ferret.bls.census.gov/macro/032002/faminc/toc.htm on April 19, 2005.

[44] AFL-CIO, *Ask a Working Woman Survey Report* (Washington, DC: AFL-CIO, 2004).

[45] Robert Pear, "Far More Single Mothers Are Taking Jobs," *The New York Times* (November 5, 2000).

[46] Beth Clemens, Julie Poppe and Steffanie Clothier, "Incentives for Quality: Tiered Strategies in Child Care" (Denver, CO: National Conference of State Legislatures, 2004).

[47] Karen Schulman and Helen Blank, *Child Care Assistance Policies 2005: States Fail to Make Up Lost Ground, Families Continue to Lack Critical Supports* (Washington, DC: National Women's Law Center, 2005).

[48] *Ibid.*

[49] *Ibid.*

[50] K. Schulman, H. Blank and D. Ewen, *A Fragile Foundation: State Child Care Assistance Policies* (Washington, DC: Children's Defense Fund, 2001).

[51] U.S. Census Bureau, *Who's Minding the Kids? Child Care Arrangements: Spring 1997* (Washington, DC: U.S. Census Bureau, 2002).

[52] Conversation with Norma Lee, Executive Director, Cosmetology Advancement Foundation, December 18, 2001.

[53] Children's Defense Fund analysis of data compiled by Sarah LeMoine of the National Child Care Information Center, Center Child Care Licensing Requirements: Minimum Early Childhood Education (ECE), Preservice Qualifications and Annual Ongoing Training Hours for Teachers and Master Teachers (August 2004). Retrieved from the Internet at http://nccic.org/pubs/cclicensingreq/cclr-teachers.html on April 2, 2005.

[54] U.S. Department of Labor, Bureau of Labor Statistics, "November 2003 National Occupational Employment and Wage Estimates" (Washington, DC: U.S. Department of Labor, 2003). Retrieved from the Internet at http://www.bls.gov/news.release/ocwage.t01.htm on March 28, 2005.

[55] Marcy Whitebook, Carollee Howes and Deborah Phillips, "Worthy Work, Unlivable Wages: The National Child Care Staffing Study," 1988-1997 (Washington, DC: Center for the Child Care Workforce, 1998); and Suzanne Helburn, et al., "Cost, Quality, and Child Outcomes Study" (Denver, CO: University of Colorado, 1995).

[56] Chaudry, Ajay, *Putting Children First* (Washington, DC: Russell Sage Foundation, 2004).

[57] Gennetian, Lisa A., et al., *Making Child Care Choices: How Welfare and Work Policies Influence Parents' Decisions* (New York, NY: MDRC, 2002).

[58] Testimony by Deborah Phillips before the Senate Committee on Labor and Human Resources, March 1, 1995.

[59] E.S. Peisner-Feinberg, et al., *The Children of the Cost, Quality, and Outcomes Study Go to School: Executive Summary* (Chapel Hill, NC: University of North Carolina, 1999).

[60] B.M. Miller, S.O'Connor, S.W. Sirignano and P. Joshi, *I Wish the Kids Didn't Watch So Much TV: Out-of-School Time in Three Low Income Communities* (Wellesley, MA: Wellesley College, Center for Research on Women, School-Age Child Care Project, 1996).

[61] U.S. Department of Commerce, Bureau of the Census, *Table 2: Annual estimates of the population by selected age groups and sex for the United States: April 1, 2000 to July 1, 2004* (Washington, DC: U.S. Department of Commerce, 2004). Retrieved from the Internet at http://www.census.gov/popest/estimates.php on July 14, 2005.

[62] U.S. Department of Health and Human Services, Federal Interagency Forum on Child and Family Statistics, *America's Children: Key National Indicators of Well-Being, 2005* (Washington, DC: U.S. Government Printing Office, 2005).

[63] National Child Care Information Center, *Children Home Alone and Babysitter Age Guidelines* (Fairfax, VA: National Child Care Information Center, 2005). Retrieved from the Internet at http://nccic.org/poptopics/homealone.pdf on June 25, 2005.

[64] Sanford A. Newman, et al., *America's After-School Choice: The Prime Time for Juvenile Crime or Youth Enrichment and Achievement* (Washington, DC: Fight Crime: Invest in Kids, 2000).

[65] U.S. Census Bureau, *Who's Minding the Kids? Child Care Arrangements: Spring 1997* (Washington, DC: U.S. Census Bureau, 2002).

[66] U.S. Department of Education, *21st Century Community Learning Centers: Providing Quality After School Learning Opportunities for America's Families, September 2000* (Washington, DC: U.S. Department of Education, 2000). Retrieved from the Internet at http://www.ed.gov/pubs/Providing_Quality_Afterschool_Learning/report2000.pdf on July 25, 2005.

[67] K.M. Dwyer, et al., "Characteristics of Eighth-Grade Students Who Initiate Self-Care in Elementary and Junior High School," *Pediatrics*, Vol. 86, No. 3 (1990): 448-454.

[68] J.K. Posner and D.L. Vandell (1994), "Low-Income Children's After-School Care: Are There Beneficial Effects of After-School Programs?" *Child Development*, Vol. 65; and D. Baker and P.A. Witt (1996), "Evaluation of the Impact of Two After-School Recreation Programs," *Journal of Park and Recreation Administration*, Vol. 14, No. 3.

[69] P.A. Witt, "Evaluation of the Impact of Three After-School Recreation Programs Sponsored by the Dallas Park and Recreation Department, *Journal of Park and Recreation Administration* (Mahomet, IL: American Academy for Park and Recreation Administration, 1997). Retrieved from the Internet at http://rptsweb.tamu.edu/faculty/witt/wittpub3.htm on July 25, 2005.

[70] Karen Schulman, *The High Cost of Child Care Puts Quality Care Out of Reach for Many Families* (Washington, DC: Children's Defense Fund, 2000).

[71] U.S. Census Bureau, *Who's Minding the Kids? Child Care Arrangements: Spring 1997* (Washington, DC: U.S. Census Bureau, 2002).

[72] B.M. Miller, S.O'Connor, S.W. Sirignano and P. Joshi, *I Wish the Kids Didn't Watch So Much TV: Out-of-School Time in Three Low Income Communities* (Wellesley, MA: Wellesley College, Center for Research on Women, School-Age Child Care Project, 1996).

[73] E. Hunter, *UF Researcher: After-School Activities Help Kids Stay in School; Study Suggests Even Good Students May Be At Risk Without Adult Supervision* (Gainesville, FL: University of Florida, 2005). Retrieved from the Internet at http://www.napa.ufl.edu/2001news/afterschool.htm on June 28, 2005.

[74] U.S. Department of Education, *21st Century Community Learning Centers: Providing Quality After School Learning Opportunities for America's Families, September 2000* (Washington, DC: U.S. Department of Education, 2000).

[75] J.B. Grossman, et al., *Multiple Choices After School: Findings from the Extended-Service Schools Initiative* (Philadelphia, PA: Public/Private Ventures and New York, NY: MDRC, 2002).

[76] National Institute for Early Education Research, *The State of Preschool: 2004 State Preschool Yearbook* (Washington, DC: National Institute for Early Education Research, 2004).

[77] *Ibid.*

[78] U.S. Department of Health and Human Services, Administration for Children and Families, Head Start Bureau, *Head Start Fact Sheet* (Washington, DC: U.S. Department of Health and Human Services, 2004). Retrieved from the Internet at http://www2.acf.dhhs.gov/programs/hsb/research/2005.htm on July 21, 2005.

[79] National Institute for Early Education Research, *The State of Preschool: 2004 State Preschool Yearbook* (Washington, DC: National Institute for Early Education Research, 2004).

[80] *Ibid.*

[81] The Trust for Early Education, *Quality Pre-Kindergarten for All: State Legislative Report* (Washington, DC: The Trust for Early Education, 2004).

[82] B. Bowman, M.S. Donovan, and M.S. Burns, Eds., *Eager to Learn: Educating Our Preschoolers* (Washington, DC: National Research Council, 2000).

[83] U.S. Department of Labor, Office of the Secretary, *Futurework: Work and Family* (Washington, DC: U.S. Department of Labor, 1999). Retrieved from the Internet at http://www.dol.gov/asp/programs/history/herman/reports/futurework/report/chapter3/main.htm on June 20, 2005.

[84] U.S. Department of Education, *To Assure the Free Appropriate Public Education of All Children with Disabilities: Twenty-fifth Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act.* (Washington, DC: U.S. Department of Education, 2005).

[85] U.S. Census Bureau, *Who's Minding the Kids? Child Care Arrangements: Spring 1997* (Washington, DC: U.S. Census Bureau, 2002).

[86] James T. Bond, Ellen Galinsky and Jeffery Hill, *When Work Works: A Summary of Families and Work Institute Research Findings* (New York, NY: The Families and Work Institute, 2004). Retrieved from the Internet at http://familiesandwork.org/3w/research/3wes.html on July 19, 2005.

[87] *Ibid.*

[88] Fight Crime: Invest in Kids, "America's Early Education Crisis: A Crime Prevention Tragedy" (Washington, DC: Fight Crime: Invest in Kids, 2004).

[89] W. Steven Barnett, "Long-Term Effects of Early Childhood Programs on Cognitive and School Outcomes," *Child Development* Vol.4, No. 3 (1994): 25-45.

[90] H. Yoshikawa, "Long-Term Effects of Early Childhood Programs on Social Outcomes and Delinquency," *The Future of Children*, Vol. 5, No. 3. (1995): 76-93.

[91] Fight Crime: Invest in Kids, "America's Early Education Crisis: A Crime Prevention Tragedy" (Washington, DC: Fight Crime: Invest in Kids, 2004).

[92] W. Steven Barnett, "Long-Term Effects of Early Childhood Programs on Cognitive and School Outcomes," *Child Development* Vol.4, No. 3 (1994): 25-45.

[93] L.J. Schweinhart, J. Montie, Z. Xiang, W.S. Barnett, C.R. Belfield and M. Nores (2005), "Lifetime Effects: The High/Scope Perry Preschool Study Through Age 40" (Ypsilanti, MI: High/Scope Press, 2005).

[94] L.N. Masse and W.S. Barnett, *A Benefit Cost Analysis of the Abecedarian Early Childhood Intervention* (New Brunswick, NJ: National Institute for Early Education Research, 2002).

[95] Colorado Department of Education, *Colorado Preschool Program Child Progress in Years 1-3: Summer 1989 through Summer 1992* (Denver, CO: Colorado Department of Education, 1993).

[96] James J. Heckman and Dimitriy V. Masterov, *The Productivity Argument for Investing in Young Children* (Washington, DC: Committee for Economic Development, 2004).

[97] Saskia Traill and Jen Wohl, *The Economic Impact of the Child Care and Early Education Industry in Massachusetts* (Oakland, CA: National Economic Development and Law Center, 2004).

[98] *Ibid.*

[99] Clive Belfield, *Investing in Early Childhood Education in Ohio: An Economic Appraisal* (New York, NY: Columbia University, 2004).

[100] Michigan Department of Education, *State Funded Preschool Program Works for Children At Risk* (Lansing, MI: Michigan Department of Education, 2002). Retrieved from the Internet at http://www.state.mi.us/mde/off/board/news/news012302.pdf on January 23, 2002.

[101] A.J. Reynolds, J.A. Temple, D.L. Robertson, and E.A. Mann (June 1, 2001), "Age 21 Cost-Benefit Analysis of the Title I Chicago Child-Parent Center Program, Executive Summary, June 2001." Report presented at the Annual Meeting of the Society for Prevention Research in Washington, D.C.

[102] D.L. Vandell and K.M. Pierce (April 1999), "Can After-School Programs Benefit Children Who Live in High-Crime Neighborhoods?" Presentation at the Poster Symposium, Children's Out-of-School Time: The Next Generation of Research, Biennial Meeting of the Society for Research in Child Development, in Albuquerque, New Mexico.

[103] Harold L. Hodgkinson, *Leaving Too Many Children Behind: A Demographer's View on the Neglect of America's Youngest Children* (Washington, DC: Institute for Educational Leadership, 2003).

[104] Rob Grunewald and Art Rolnick, *A Proposal for Achieving High Returns on Early Childhood Development* (Minneapolis, MN: Federal Reserve Bank of Minneapolis, 2004).

[105] Brooks-Gunn, "Do You Believe in Magic? What We Can Expect from Early Childhood Intervention Programs," *Social Policy Report*, Vol. 27, No. 1 (2003).

CHAPTER FOUR

Education

The Path Out of Poverty

Educational opportunity shapes employment status, wages, and general well-being to a greater extent than ever before, while lack of opportunity too often precludes success and contributes to school failure, dropping out, and poverty.

Americans with less than a high school diploma saw their mean family income decline by 14 percent between 1979 and 1995, while college graduates' mean income rose 14 percent. Americans with a college degree will earn nearly twice as much over their lifetimes as those with a high school degree; professional degree holders earn almost four times as much.

High school dropouts are three times as likely to receive welfare benefits as are those who complete high school but do not go on to college. Students from low-income families drop out at six times the rate of those from wealthy families.

Poor children consistently achieve at lower levels than their more affluent peers. In writing, only 15 percent of those fourth graders eligible for free and reduced-price lunch write at grade level compared to 42 percent of those who are not eligible.

If the misery of the poor be caused not by the laws of nature, but by our institutions, great is our sin.

—Charles Darwin

Forty years after President Johnson declared a War on Poverty and the Civil Rights Act was signed into law, too many poor and minority children still lack a fair chance to live, learn, thrive, and contribute in America. Nearly 13 million American children live below the poverty line[1] and one-third of all children will be poor at some point in their childhood.[2] For these children, public schools represent one of the greatest hopes to escape a life of poverty. As Chief Justice Earl Warren wrote for the unanimous Supreme Court in *Brown v. Board of Education*, "In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education."[3] More than 50 years later, it is clear that to a greater extent than ever before, educational opportunity shapes individuals' employment status, wages, and general well-being, while lack of opportunity too often precludes success and contributes to school failure, dropping out, and poverty.

- Those with less than a high school diploma saw their mean family income *decline* by 14 percent between 1979 and 1995, but college graduates' mean income *rose* 14 percent.[4]
- Those with a college degree will earn nearly twice as much over their lifetimes as those with a high school degree; people with professional degrees earn almost four times as much.[5]
- People with bachelor's degrees were twice as likely as those without high school diplomas to report being in excellent or very good health [6]
- Unequal educational opportunities are linked to social problems, such as drug abuse, crime, and lack of access to medical care.[7]
- High school dropouts are three times as likely to be welfare recipients as are high school completers who do not go to college.[8]
- High school dropouts make up 30 percent of federal and 40 percent of state prison inmates.[9]

No Child Left Behind: High Schools at the Forefront

At a time when news coverage often focuses on security, terrorism, and the national economy, Americans still rank education as an issue of great importance.[10] Issues related to the implementation and funding of the three-year-old No Child Left Behind Act (NCLB) continue to dominate the education policy landscape, with many states and districts escalating their opposition to the law. A bipartisan report from the National Council of State Legislatures (NCSL) examining NCLB summarized state legislators' concerns. It included 43 specific recommendations to change the law and its implementation,[11] including full federal funding for its provisions, increased flexibility for states and districts, and more sophisticated and accurate assessments that recognize student achievement cannot be measured by a single, high stakes test.

The NCSL report echoed the views of a growing number of state and local leaders that many of the law's provisions amount to one-size-fits-all, unfunded federal mandates. Utah Governor Jon Huntsman signed a controversial law stating that the state's education laws trumped NCLB when there was a conflict between the two.[12] In Connecticut, Attorney General Richard Blumenthal announced his intention to sue the U.S. Department of Education over extra cost burdens the law's testing mandates place on his state.[13] In April of this year, the National Education Association (NEA), the nation's largest teacher's union, along with nine school districts in Michigan, Texas, and Vermont, filed suit against the Department of Education

seeking relief from the mandates of the Act because, the plaintiffs allege, the federal government has provided $27 billion less than is necessary to carry out the provisions of the Act, as required by the law.[14]

In response to state complaints over the costs and rigidity of NCLB, Margaret Spellings, Secretary of the Department of Education, signaled a willingness to introduce more flexibility into the law. In May 2005, Spellings announced new guidelines allowing states to use modified standards and assessments for a greater number of students in special education—a change that will make it easier for some states to make "adequate yearly progress" (AYP) and avoid federal sanctions.[15] On a more general note, Spellings announced that the department would approach implementation of NCLB in a more flexible way, as long as the basic requirements of the Act are met by states. At the time of publication, 37 states had requested changes to their state accountability plans that would affect calculation of AYP,[16] but Florida was the first state to benefit from such flexibility. Citing the state's commitment to the principles and goals of the Act, Secretary Spellings granted two of the three requests for rule changes—and both will increase the number of districts meeting proficiency targets. Last year, only about 23 percent of Florida's public schools made AYP. With the changes, Florida education officials estimate that an additional 4 percent of schools would reach proficiency targets without an increase in test scores.[17]

Reactions to Spelling's flexibility policy have been mixed. Some education and civil rights advocacy groups expressed disappointment, arguing that the Act's accountability provisions must be rigidly enforced if they are to be effective. A spokesperson for the National Council of La Raza, a non-profit organization dedicated to improving life opportunities for Hispanic Americans, critiqued Spellings' new policy: "None of this added flexibility will improve instruction and improve outcomes" but will only allow states to appear to be doing better.[18] In fact, a recent study by the Civil Rights Project at Harvard found that the Department of Education had allowed California to reduce the number of districts in need of improvement by 60 percent by exempting up to two grade spans (i.e. high school and middle school) from needing to make AYP at all. Nineteen states received such flexibility.[19] Disability rights groups have echoed that sentiment, believing increased flexibility amounts to a retreat from accountability standards meant to ensure students with disabilities a fair and equal education.[20]

Numerous state education officials, many of whom have been sharply critical of NCLB, hailed Spelling's announcement as a long overdue step in changing a law they view as deeply flawed. Thomas Houlihan of the Council of Chief State School Officers (CCSSO), a national organization of public officials who head state departments of education, applauded the new rules calling them "a positive step forward."[21]

Another approach to the law came from a coalition of more than 61 national education, civil rights, disability, children's, and citizens' groups, including the Children's Defense Fund, who have expressed a commitment to the Act's objectives of strong academic achievement for all children, including children of color, from low-income families, with disabilities, and of limited English proficiency. The group endorses the use of an accountability system that helps close the achievement gap but believes changes are necessary to make the Act fair and effective. The group's recommendations are based on concerns that the Act puts too much weight on standardized testing, fails to provide adequate funding to support key reforms, and emphasizes sanctions over promoting long-term, systemic reforms that will truly improve student achievement and understanding.

Recent months also have seen an increased focus on high school and reform. President Bush used his 2005 State of the Union address to announce a new $1.5 billion "High School Initiative," the centerpiece of which is an expansion of the NCLB testing regime to two additional years of high school. The President's initiative also incorporates several new programs, among them a proposal to fund individual graduation plans for struggling students, merit rewards for teachers who increase achievement in low-income schools, and a "State Scholars" program to encourage stu-

dents to take more rigorous classes.[22] Critics of these proposals argue that funding for these new programs is generated by eliminating other important high school programs such as TRIO and GEAR-UP, which help low-income students access and succeed in higher education. In addition, the $1.5 billion the President sought for his initiative is part of his FY 2006 budget request that sought an overall 1 percent cut to education funding—the first cut to education funding in a decade. The President's plan was received coolly on Capitol Hill, largely due to these budgetary concerns and to concerns about further expanding the No Child Left Behind Act. Representative Michael N. Castle (R-DE), Chairman of the House Education Reform subcommittee, expressed serious misgivings about the future of the reform package and asserted that it would be highly unlikely to pass the Congress this year.[23]

State leaders and the business community have also focused on high school reform. The National Governors Association convened a two-day summit on this issue, where more than a dozen states committed to providing college preparatory courses to secondary students and increasing graduation rates. Microsoft Chairman Bill Gates began the conference with the unsettling warning that American high schools were nearing obsolescence. Gates reminded his audience that "only one-third of our students graduate from high school ready for college, work, and citizenship… [those] who graduate from high school, but never go on to college, will earn, on average, about $25,000 a year. For a family of five, that's close to the poverty line." If you're Black or Hispanic you earn even less.[24]

Gates' message echoed similar sentiments from other business leaders who have joined education advocates in calling on policy makers to bring about significant and immediate improvements in our schools so that all children—not only those from the wealthiest families—benefit from a quality education.[25] Their message is that providing low-income and minority children an adequate education is no longer only the just course of action, it is an economic imperative. Improving our education system is essential if we are to provide children with the tools they need to escape a life of poverty and give our businesses a highly skilled workforce, strengthen our families, and prepare our citizenry for effective participation in democracy. As this chapter will show, education plays a central and indispensable role in providing children the knowledge and skills they need to complete a successful passage to adulthood.

STORIES FROM THE STATES

Access to Adult Education

Leta Jackson, of Brooklyn Center, Minnesota, with her children, Kayla, Naturelle, Jacquinn, and Emari at her kitchen table: "My mom was addicted to drugs. I dropped out of school my sophomore year. I ran away from my dad's. My grandma took care of us and encouraged me to get my GED. At age 18, I had Kayla. I moved to Minneapolis because there were more opportunities here. I worked at Hennepin County Medical Center as a nursing assistant for two years and supported two kids and made my rent, but got pregnant and lost my job. I first went to Crisis Nursery when Kayla was three years old and she is eight years old now. I've been unemployed for two years. I'm going to school and have work study at Hennepin Technical College to become a leasing agent for residential properties. Transportation is a problem. I rely on the bus and I ride it for three hours to school."

Education's Role in Lifting Children Out of Poverty

Comparing the opportunities of a well-educated child versus a child denied a high quality education casts in stark relief the critical role public schools play in preventing poverty. Research shows a strong relationship between education attainment and economic well-being. Children who are provided a comprehensive, high quality education are less likely to be poor and more likely to find employment and receive higher wages than their less educated peers. In addition, we find that children from low-income families are constantly outperformed by their wealthier peers across a broad range of academic measures. Poor children, therefore, often find themselves in a Catch-22 with their economic circumstances denying them access to the escape valve out of a life of poverty—a quality education.

Poor children consistently achieve at lower levels than their more affluent peers. In writing, only 15 percent of those fourth graders eligible for free and reduced-price lunch could write at grade level compared to 42 percent of those who are not eligible.[27] In math, only 46 percent of eligible fourth graders performed at grade level compared to 79 percent of those who are not eligible.[27]

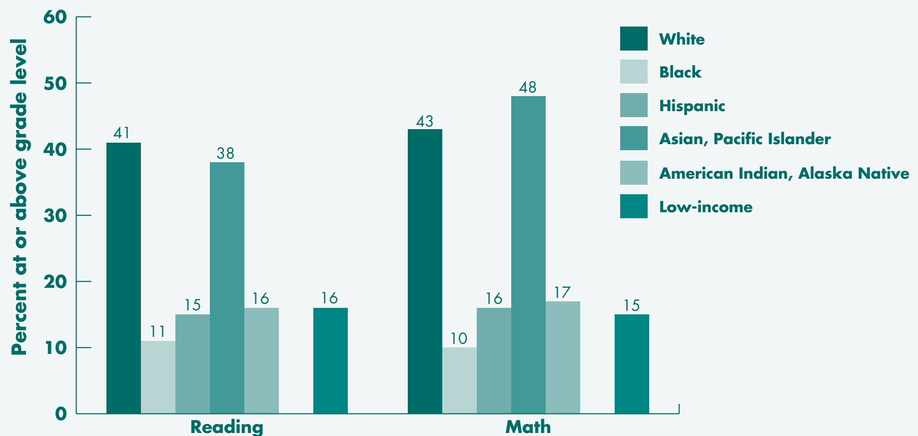
Dropping Out of School and into Poverty

Poor and minority children comprise a disproportionate number of high school dropouts. Students from low-income families drop out at six times the rate of those from wealthy families.[28] In addition, students from low-income, single-parent, less educated families drop out at a much higher rate than other students.[29] A growing body of evidence shows that dropouts are far more likely than graduates to be unemployed, incarcerated, and living in poverty.[30] A 2003 study of employment rates in Chicago, for example, shows that the jobless rate for young, adult Black male dropouts is more than 50 percent.[31] A 2002 U.S. Census Bureau report showed that Latinos who finished high school earn 43 percent more than Latinos who dropped out.[32] Staying in school is also the best way to stay out of prison. High school dropouts are almost three times as likely to be incarcerated as youths who have graduated from high school.[32]

Education – Figure 1

Fourth Graders at or Above Grade Level in Reading and Math

The majority of fourth graders cannot read or do math at grade level.



Sources: U.S. Department of Education, National Center for Education Statistics, *The Nation's Report Card: Reading Highlights 2003* (NCES2004-452, November 2003), pp. 14-15; and U.S. Department of Education, National Center for Education Statistics, *The Nation's Report Card: Mathematics Highlights 2003* (NCES2004-451, November 2003), pp. 14-15. Calculations by Children's Defense Fund.

Education as an Economic Imperative

Given today's global economy, our nation's economic strength has never depended more on the educational attainment of its citizens. As Federal Reserve Chairman Alan Greenspan stated recently, "We need to increase our efforts to ensure that as many of our citizens as possible have the opportunity to capture the benefits of the [changing economy]. One critical element in creating that opportunity is the provision of rigorous education and ongoing training for all members of our society." Our government's commitment to public education determines an individual's employment status, wages, and health as well as the country's economic growth to a greater extent than ever before.

An estimated 14 percent of our nation's economic growth between 1929 and 1982 is attributable to improvements in education.[34] A 1 percent increase in spending on education relative to income was associated with a 0.72 percent increase in total employment in 48 states from 1973 to 1980.[35] A state's economic performance correlates to previous investments in such areas as education, according to a state report card assessment by the Corporation for Enterprise Development. Eight out of 11 states with the highest grades for local investment received an "A" or "B" in overall economic performance.[36]

Education and Earnings

On average, each year of education increases a worker's hourly wages by 10 percent.[37] According to the U.S. Census Bureau, workers 18 and over with a bachelor's degree earn an average of $51,206 a year, while those with a high school diploma earn $27,915. Workers with an advanced degree make an average annual salary of $74,602, and those without a high school diploma average $18,734.[38]

Disparities: Educational Disadvantage Disproportionately Affects Low-Income and Minority Students

Despite the positive role education can play in shaping the lives of our young people, for children of color, in particular, schools also play a significant

Education – Table 1

Whites earn more than minorities with the same level of education.

Median Annual Earnings by Education, Race, and Gender, 2003 year-round, full-time workers Ages 18 and older

	Not a high school graduate	High school graduate	Bachelor's degree or higher
White, non-hispanic			
Male	$ 28,320	$ 35,882	$ 63,253
Female	20,343	26,344	44,180
Black			
Male	20,978	28,996	49,338
Female	18,001	22,792	40,861
Hispanic			
Male	20,796	26,378	47,772
Female	15,975	21,505	40,444

Source: U.S. Department of Commerce, Bureau of the Census, "Educational Attainment in the United States: 2004," Tables 9 and 9a, at <http://www.census.gov/population/www/socdemo/education/cps2004.html>.

role in perpetuating inequality on the path to poverty. The dual school system *Brown* intended to abolish continues to this day. Over the last half-century, the educational needs of children of color remained largely unmet and the result has been too many children of color unprepared for the demands of today's global economy and unable to rise out of the poverty of their youth.

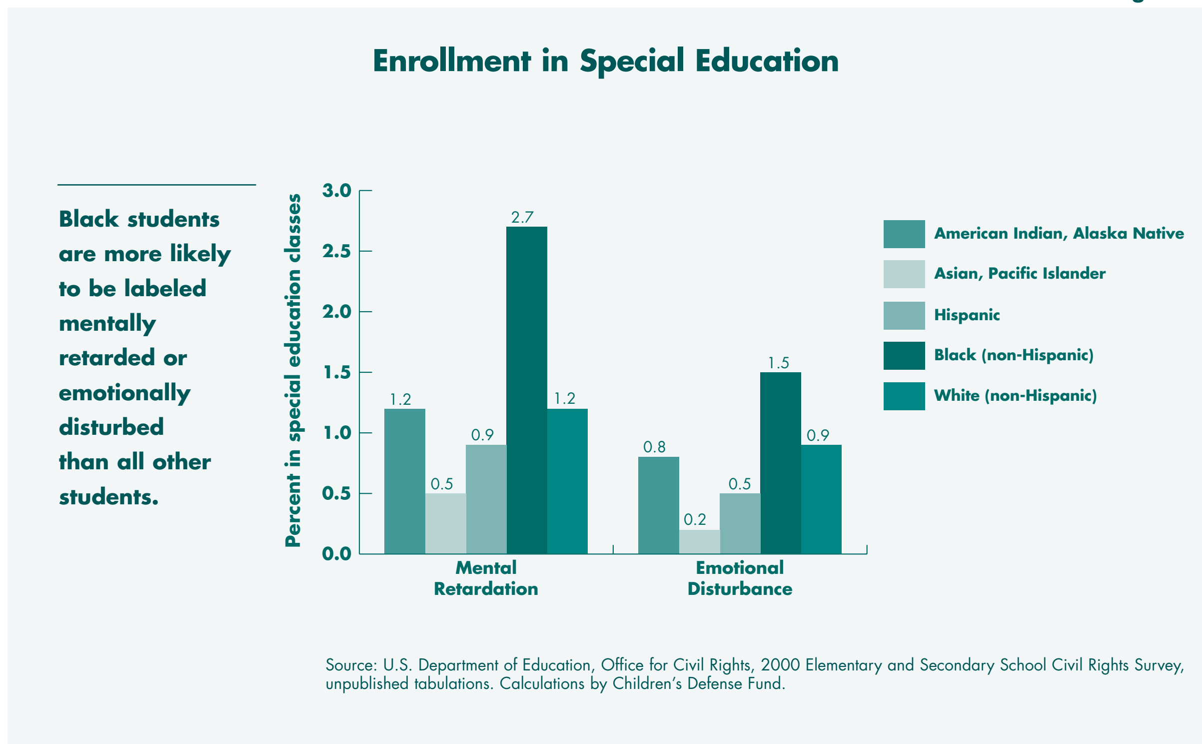
The Achievement Gap Persists

Student Achievement Gap data based on the National Association of Educational Progress (NAEP) show:

- Of all the nation's fourth graders, 41 percent of Whites are reading at grade level compared to 15 percent of Hispanic and 13 percent of Black students.[39]
- Black and Hispanic 12th graders perform at the same level in reading and math as White eighth graders.[40]
- A Black child is more than twice as likely as a While child to be behind grade level, and the longer a Black child is in school, the further behind he falls. A Hispanic child is significantly more likely than a White child to be behind a grade level.[41]
- In math, 37 percent of White eighth graders perform at grade level compared to 12 percent of Latinos and 7 percent of Blacks.[42]
- Black and Hispanic children are more likely than White children to be absent from school.[43]
- Black and Hispanic children are less likely than White children to be in programs for the gifted and talented.[44] Black children are much more likely than White children to be in programs for children with mental retardation or emotional or behavior disturbances.[45]
- Children of color and low-income children are less likely to graduate from college.

In 2003, 34.2 percent of non-Hispanic White adults, aged 25-29, had earned a bachelor's degree or more, compared to 17.2 percent of Blacks, 10 percent of Latinos, and 61.6 percent of Asians in the same age range.[46] At the age of 24, nearly half of young adults raised in affluent families have

Education – Figure 2

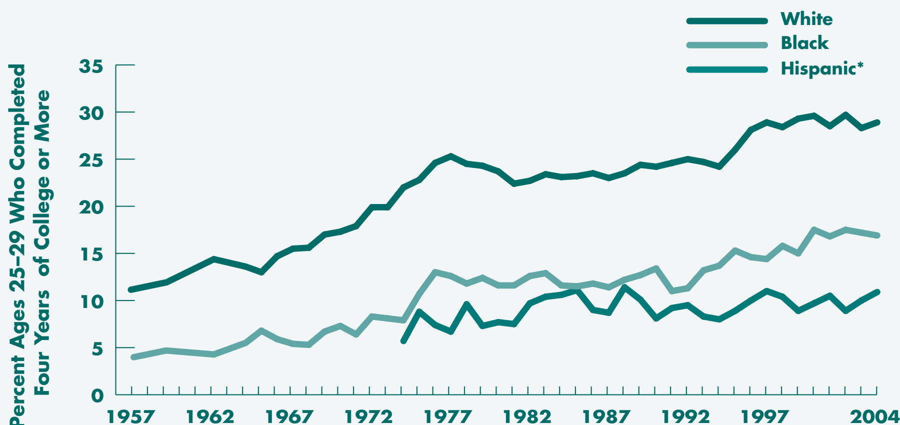


Source: U.S. Department of Education, Office for Civil Rights, 2000 Elementary and Secondary School Civil Rights Survey, unpublished tabulations. Calculations by Children's Defense Fund.

Education – Figure 3

College Graduation Rates Among Young Adults, 1957–2004

Young Blacks and Hispanics are less likely to graduate from college than Whites.



*Persons of Hispanic origin can be of any race.

Source: U.S. Department of Commerce, Bureau of the Census, Table A-2, Percent of People 25 Years Old and Over Who Have Completed High School or College, by Race, Hispanic Origin and Sex: Selected Years 1940 to 2004, at <http://www.census.gov/population/socdemo/education/tabA-2.pdf>.

graduated from college compared with only 7 percent of young adults raised in low-income families.[47] Even when low-income children do reach post-secondary education, they are less likely to graduate on time. In 2001, over 70 percent of financially secure post-secondary students had received college degrees compared to only 47 percent of students from moderately to highly disadvantaged backgrounds.[48] This significantly impacts children because parental education is a key predictor of children's academic success.[49]

Segregation and Inequities

Much of this disadvantage is rooted in the segregation and inequity that continue to drag down the quality of public education. One of every three Black children attends a school that has 90 percent or more minority enrollment.[50] Forty-seven percent of Black students and 51 percent of Latino students (compared with 5 percent of White students) are in schools where 75 percent or more of the students are poor.[51] Schools with large populations of Black and Hispanic students are more likely to suffer from teacher shortages and to lack high quality teachers.[52] The "instant academies," all White private schools that sprung up in the 1950s in reaction to *Brown*, are alive and well today. For example, in the Lee County School District in South Carolina, White students are almost 900 times more likely to attend private schools than Black students. In some districts, Black children are still offered only what Bob Moses, founder of the Algebra Project and a leader of the Student Nonviolent Coordinating Committee during the Civil Rights Movement, calls "share cropper education"—education designed to prepare them for manual labor.[53] It is no surprise that with this prevalence of segregation, inequality plagues Black school children.

Access to Quality Teaching

Research demonstrates that access to quality teaching is one of the most significant factors in improving student achievement and closing the achievement gap.[54] Yet for poor and minority children, quality teaching is often not available.[55]

- Schools with the highest percentages of minority, limited English proficient, and low-income students are more likely to employ beginning

teachers than those with the lowest percentage of minority, limited English proficient and low-income students.[56] For example, 20 percent of teachers in high-poverty schools have three or fewer years of teaching experience, compared with 11 percent of teachers in low poverty schools.[57]

- Classes in high-poverty schools are 77 percent more likely to be assigned to teachers who did not major in the field in which they are teaching than are classes in low poverty schools.[58] Classes in majority non-White schools are over 40 percent more likely to be assigned to an out-of-field teacher than those in mostly White schools.[59]
- Teachers with master's degrees are less likely to teach in high-minority, low-income schools than they are to teach in high-income, low-minority schools.[60]
- Teacher attrition is the main reason there is a shortage of high quality teachers.[61] Teachers are significantly more likely to leave a school because of poor working conditions, and teachers in high-minority, low-income schools report significantly worse working conditions, including inadequate facilities, fewer textbooks and supplies, less administrative support, and larger class sizes.[62] As a result, the turnover rate for teachers in high-poverty schools is almost one-third higher than the rate for all teachers in all schools.[63] Contributing to a vicious cycle, high turnover becomes a burdensome cost to school districts and represents a loss of resources to the education system, which then means fewer textbooks, larger classes, etc.[64] A study conducted in Texas estimates the cost of teacher turnover to be between $216 and $329 million each year.[65]

Lower student to teacher ratio has not only been correlated with higher academic performance,[66] but also with lower levels of school violence.[67] Yet small class sizes are not available to minority and non-minority students on an equal basis.

- In classes with more than 75 percent minority students, 31 percent of teachers have 25 or more students.
- In classes with less than 10 percent minority students, only 22 percent of teachers have 25 or more students.
- In classes that are 10-25 percent minority, 25 percent of teachers have classes with 25 or more students.[68]

Access to Advanced Curricula

According to a study by the U.S. Department of Education, the rigor of courses taken reflects the quality of education schools deliver.[69] Yet advanced curricula and high quality college preparation is not available equally to all. In analyzing data from the Department of Education's Office of Civil Rights, the National Research Council found that Black and Latino students are half as likely as Whites to be placed in gifted and talented classes. Asian/Pacific Islanders are one-third more likely than Whites to be placed in these advanced classes.[70] The number of Advanced Placement exams taken by Black students has increased 600 percent since 1984, and the number taken by Latino students increased 460 percent. Yet gaps in exam taking persist between Blacks and Latinos and their White peers. There were 184.7 White test-takers per 100,000 White 12th graders in 2000, compared to only 53.4 Black test-takers per 100,000 Black 12th graders and 111.3 Latino test-takers per 100,000 Latino 12th graders.[71]

There also are significant gaps in access to advanced math and science courses. Where 45.1 percent of White and 55 percent of Asian/Pacific Islander high school graduates have taken precalculus, calculus, trigonometry and other advanced math courses, only 30.4 percent of Black, 26.2 percent of Latino and 26.9 percent of Native American high school students graduate having taken these courses.[72] Trends are the same in the sciences. Whereas 15.9 percent of White and 29.5 percent of Asian/Pacific Islander students graduate having taken advanced physics, chemistry, or biology, only 10.3 percent of Black, 10.7 percent of Latino, and 5.1 percent of Native American students graduate having completed such courses.[73]

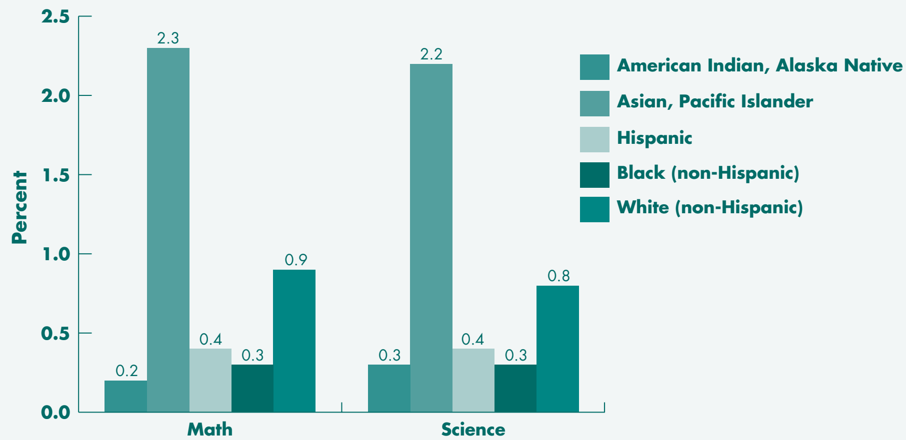
School Facilities

Overcrowding of public schools has become a significant problem—especially as public school enrollment has reached historic levels and is

Education – Figure 1

Enrollment in Advanced Placement Math and Science Courses

Access to advanced placement math and science is not available to all students.



Source: U.S. Department of Education, Office for Civil Rights, 2000 Elementary and Secondary School Civil Rights Survey, unpublished tabulations. Calculations by Children's Defense Fund.

expected to continue to grow well into the future.[74] The problem is particularly acute for high-minority, low-income schools. Schools whose students are 50 percent or more minority are nearly twice as likely as schools whose students are less than 20 percent minority to be overcrowded.[75]

Schools whose students are 70 percent or more low-income are more than twice as likely as those whose students are less than 20 percent low-income to be overcrowded.[76]

The problem of overcrowding has grown worse in recent years, and media reports have demonstrated a link between overcrowding and school violence. One example came in June of 2005 when Thomas Jefferson High School in Los Angeles was the scene of several brawls involving hundreds of students. The school was built to hold 1,500. Its current enrollment is 3,800.[77]

The Digital Divide

To compete in the "Information Age," all students require access to modern computers with hi-speed Internet access. More than a decade after the Internet first appeared in classrooms, poor and minority children have significantly fewer opportunities to use this technology. Research shows that children from disadvantaged backgrounds rely more heavily on schools to provide them with computers and Internet access. In fact, computer use at school exceeds use at home by 30 percentage points or more for Blacks and Hispanics, with many disadvantaged students unable to get online anywhere but school. Of students who access the Internet at only one location, 52 percent come from poor families.[78] Yet children from disadvantaged backgrounds are less likely to attend schools with adequate technology.

The subsequent divide between White and poor and minority students is staggering: The difference in Internet use between White and Black students is 21 percent. The comparison between Whites and Hispanics is larger still—with a 30 percentage point gap.[79]

The digital divide is especially significant because greater access to technology correlates with greater educational attainment and income. Of those children having no parent who has graduated from high school, only 32 percent use the Internet. Eighty percent of poor students use computers compared to 93 percent of non-poor students.[80]

Access to School Counseling

Given the significant academic and non-academic challenges facing students today, the need for school counselors is greater than ever. Counselors help students navigate often complex academic requirements, prepare for college, and develop important, personal relationships with students. School counselors also provide support to a student population increasingly plagued by untreated mental health problems. There is significant research showing the link between mental health problems and dropping out of school.[81] Estimates have shown that nearly two-thirds of the country's dropouts have some kind of behavioral or emotional problem.[82] One national study finds that 14.2 percent of high school dropouts have a history of some kind of psychiatric disorder compared to only 5 percent of high school graduates who do not go on to college.[83]

Students at high-minority, high-poverty schools have significantly reduced access to school or community-based counseling services.[84] Schools with a minority population of 10 percent or less have well over 2.5 times as many school counselors and guidance staff as schools with 75 percent or more minority students. High-minority schools also have far fewer certified counselors.[84]

Funding Gaps

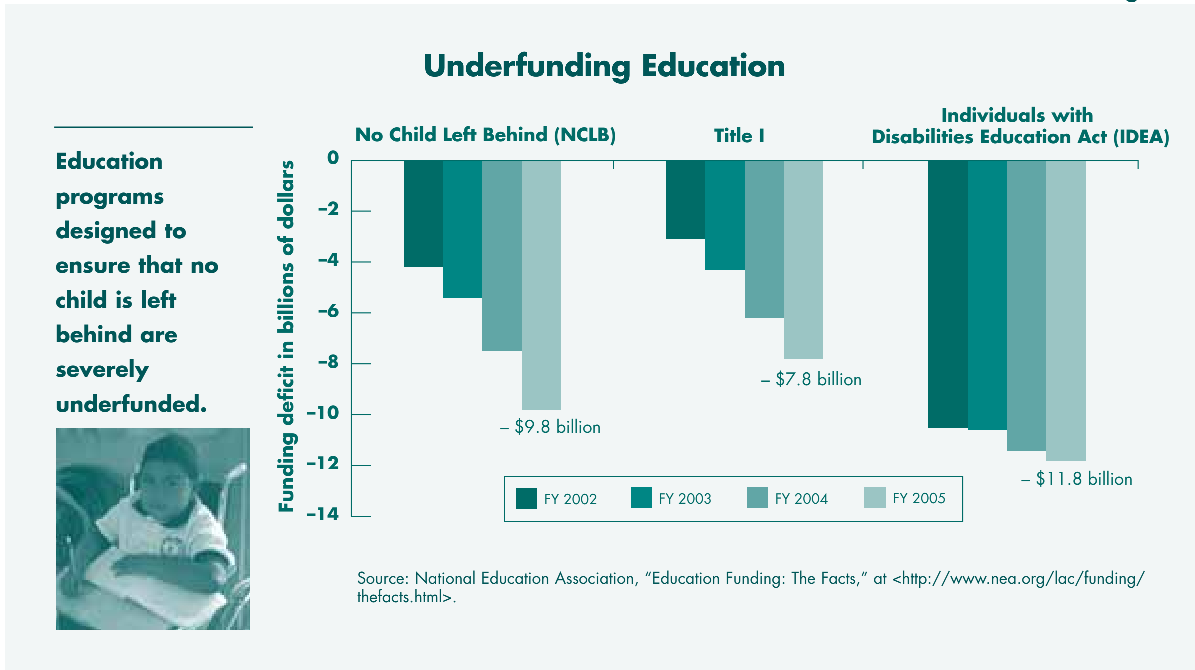
Many of the disparities in resources are due to insufficient financial support for high-minority, low-income schools. Without this support, schools cannot repair and modernize their facilities; attract and retain high quality teachers; reduce class size; hire adequate numbers of school counselors; provide basic materials like textbooks, pens, and paper; or provide access to advanced curricula. Unlike other industrialized nations, a large percentage of U.S. schools are funded from local property taxes. As a result, schools often reflect the relative wealth of the communities surrounding them, and wide gaps in funding exist between high- and low-income areas. In Illinois, for example, districts spend almost $2,500 more, on average, per pupil in the wealthiest areas compared to the high-poverty ones.[86] The gap between rich and poor districts is even more significant when one considers that students from disadvantaged backgrounds are more expensive to educate than those from wealthier areas.[87] A recent analysis found that in 31 of 49 states, school districts with high-minority populations received fewer resources.[88] Indeed, the gap in funding between poor and non-poor schools has been widening in recent years, growing from $1,208 in 1997 to $1,348 in 2002. That's a difference of $33,700 in each classroom of 25 students.[89] Funding disparities also exist between states. In 2003, state per student spending ranged from $5,175 to $12,046, a difference of $171,775 spent per classroom[90]

Federal Funding

The President's fiscal year 2006 budget sought to cut education funding for the first time in a decade. While schools are struggling to meet the requirements of the No Child Left Behind Act (NCLB), the Administration's budget underfunds those programs by $12 billion this year, bringing the total underfunding since NCLB became law to almost $40 billion. Within this shortfall, the President's plan leaves behind nearly three million disadvantaged students who cannot be fully served by Title I because the budget provides only $13.3 billion of the $22.75 billion promised in NCLB—a deficit of more than $9 billion for only one year.[91]

The Administration's budget also failed to provide adequate or promised resources for special education. Despite having signed into law the Individuals with Disabilities Education Improvement Act of 2004 (IDEA), the President moved away from the bipartisan funding agreement reached in the Act and funded special education at $3.6 billion below the authorized level.[92] As a result, funding for IDEA Part B State Grants would provide just 18.6 percent of the national average per-pupil expenditure toward meeting the excess cost of educating students with disabilities—still less than half of the 40 percent "full funding" level that Congress committed to paying when IDEA was first adopted 30 years ago.

Education – Figure 5



Source: National Education Association, "Education Funding: The Facts," at <http://www.nea.org/lac/funding/thefacts.html>.

State/Local Budget Cuts

According to the National Council of State Legislatures, most states are facing serious budget shortfalls in fiscal year 2006.[93] To make up for lost tax revenue, many have made, or intend to make, significant cuts in education. Lawmakers in Colorado, for example, are considering amending their state constitution to allow them to spend less on schools.[94] Struggling to trim 5 percent off its budget, Maine is debating a plan that would cut almost $100 million from schools. Large protests have erupted across California as its governor, Arnold Schwarzenegger, pursues a budget that would leave schools with billions less in needed funding.[95]

The federal and state budget cuts of the past five years have fueled what is now a widespread effort to achieve school funding adequacy through litigation. Forty-five states have litigated, or are in the process of litigating, some kind of funding adequacy or equity court battle. The cases trace their legal origin to 1973 when *Rodiquez v. San Antonio Independent School District* was brought before the U.S. Supreme Court. Plaintiffs petitioned the Court to declare the state's school funding formula unconstitutional based on large disparities among districts. The Court ruled for the defendants, saying education was a state not a federal matter, turning future litigants toward the state court system.[96] Plaintiffs have had some preliminary success, winning cases in Arizona, Kansas, Massachusetts, Montana, North Carolina, New Jersey, New York, and Wyoming. New cases have been filed in Alaska, Georgia, and Nebraska. However, the process of change has been slow. Courts have tended to delegate the task for devising adequate funding systems to state legislatures where the plans have met resistance. Lawmakers in New York, for example, are in defiance of a court order to make their education funding system more adequate.[97]

Meanwhile, funding shortfalls trickle down to the local level. Most cities, ranging from the most disadvantaged to the most affluent, have been forced to cut important academic services. The Piedmont School District in California, one of the wealthiest in the nation, is but one example of the local effects of state and federal revenue shortfalls. Having enjoyed a quarter of a century of fiscal adequacy, Piedmont was forced to cut $1.3 million over three years from their schools. In Philadelphia, literacy programs, up to half of paraprofessional jobs, hundreds of teaching jobs, and potentially the entire Comprehensive Early Learning Centers

Program are on the chopping block.[98] At the Gill-Montague Regional School District in Massachusetts, 19 teachers were let go, and the district was forced to combine grades in the elementary schools. For example, first and second grade is held in one classroom with one teacher, and the same is true for third and fourth grades. Some students now spend free periods running errands for teachers.[99] Across the state, about 1,400 teachers have lost their jobs, class sizes have grown so large that they're hard to control, and some students are paying high fees for sports, activities, and transportation.

Walking the Path: Parent Involvement in Education

Positive cooperative relationships between schools and parents can be a key to student and school success. Students with involved parents, regardless of their background, are more likely to earn higher grades and test scores, take advanced courses, be promoted, have better attendance rates, be better behaved, graduate and go on to college. Teachers with students whose parents are highly involved are more attentive to those students. With that in mind, the New Song Academy in Baltimore has made parent involvement a pillar of its success. New Song serves low-income children, the majority with learning disabilities and/or emotional and behavioral disorders. The charter school actively reaches out to parents and involves them in ways that are comfortable, constructive, and build upon individual parents' strengths. The school solicits parent volunteers to work with children and hires parents for full- and part-time positions. According to the school, parents do not just drop their children off at school, they are considered colleagues, neighbors, and friends working hand-in-hand to educate the children of their community.[100]

Policies That Negatively Impact Students of Color

While financial and resource-based inequalities pervade our school system, politicians, policy makers, and educators often have advanced "one size fits all" education policies that also have had the effect of discriminating against poor and minority students and have proven to play a significant role in promoting school failure, high school dropout, and subsequent poverty.

High Stakes Tests

Accountability and assessment are essential to ensure that children who have been traditionally neglected by schools are not forgotten. But they are only a piece of what needs to be done. It is not enough to impose a system of high stakes tests on schools and children and call it, in and of itself, education reform. Without significant investments in educational resources so that all children have the opportunity to learn and to succeed on assessments, what could be substantive education reform will be reduced merely to a system of measurement and punishment, leaving America's most vulnerable children on the margins, decreasing their motivation to learn, and increasing their risk of dropping out—perpetuating the cycle of poverty.

Significant concerns have been raised that under high stakes-low budget accountability systems, an overemphasis on, and in some cases abuse of, testing has characterized reform in many high-minority, low-income schools. For example, a study in New Jersey found that teachers from high-poverty schools "reported substantially more time devoted explicitly to test preparation activities than those in wealthy districts."[101] These non-substantive educational practices have reduced student learning, motivation, and engagement,[102] putting poor children and children of color at even greater risk of failure and dropping out.

Another negative consequence of the over-reliance on a single test has been the elimination or reduction of important academic subjects that are not covered by state tests. According to a survey of public school principals conducted by the Council

for Basic Education, increases in instructional time for reading, math, and science are leading to decreases in arts, foreign language, social studies, civics, and geography. The most significant decreases are in high-minority schools. For example, high-minority schools have experienced a 36 percent decrease in instructional time for the arts and 23 percent decrease in instructional time and professional development for teachers of foreign languages.[103]

In no case have schools betrayed the hopes and potential of students more cynically than when they disguise school failure at the expense of low-performing, at-risk students. Media outlets recently reported that Orlando school officials have been pushing low-performing students out of high schools and into GED programs as a way to artificially inflate the schools' overall test scores. These schools also are not counting these students as official dropouts. Instead, they simply drop the GED-bound students from their rolls, deceptively concealing their low graduation rates. Last year, one school referred 271 failing students into GED programs. The school's graduation rate subsequently rose from 61 percent to 66 percent, while the actual number of diplomas handed out fell from 412 to 354.[104] Another recent study showed that a large increase in children retained in ninth grade corresponds with the rapid growth in high stakes accountability systems in the 1990s. These results have been interpreted by some to indicate that children are unfairly retained to avoid their scores being included in high schools' overall scores.[105]

Another recent study, sponsored by the U.S. Department of Education, showed that high stakes policies can also harshly impact students with disabilities. In states where teachers, schools, and students are rewarded for performance, discipline rates for students with disabilities are more than 50 percent higher than in states that do not provide these rewards. For example, in states that give bonuses to schools for good performance, the discipline rate for students with disabilities is 17.35 per 1,000 students. In states without such rewards, the rate is 10.88 per 1,000 students with disabilities.[106]

The unfairness of one-size-fits-all testing is most evident when a single, standardized test is used to make life-defining decisions about individual students, such as graduation, grade promotion, or ability tracking. Graduation from high school is the foundation for future success in college and the workplace. Therefore, decisions about whether or not a student will graduate should be made in the most thoughtful way. While, historically, states and districts have made individualized decisions to graduate students, by 2009, half of all states will use a single standardized test as the sole means to determine whether a student will graduate.[107]

Studies have shown that standardized testing has led to negative academic outcomes for students and schools, particularly for those from low-

STORIES FROM THE STATES

Building a Foundation Early in Life

At the Early Childhood class in Colonia South Tower in Rancho Blanco Alamo, Texas, teacher Dolores leads a class of six young children (Jesus Alberto, Cristian, Reyna, Omar, Paola, and Arlene) in lessons involving fine motor skills, fitting shapes into holes, fitting keys into locks, and playing with blocks. The class prepares children for prekindergarten and to leave their mother for the first time. The children practice singing, dancing, and table manners.

income and minority communities. A National Research Council report found that high stakes tests may help to motivate those students who are "just getting by, but know they can do better." However, they likely will harm the lowest performing students who will "not exert effort when they do not expect their efforts to lead to success."[108] A recent report by the Center on Education Policy found that exit exam scores were significantly lower among Blacks, Hispanics, low-income students, children with disabilities, and those with limited English proficiency. Gaps in pass rates between these groups and non-Hispanic White students climb as high as 40 percent, depending on the subject.[109] In Massachusetts, for example, the dropout rate increased from 2.9 percent to 3.5 percent among seniors graduating in 2003, the first year that students were required to pass an exit exam to graduate.[110] An earlier study found that nine of the 10 states with the highest dropout rates used high stakes exit exams, while none of the states with the lowest dropout rates used these tests.[111] By 2009, eight out of 10 minority public school students (compared to seven out of 10 public school students, in general) will be denied high school diplomas if they do not pass a standardized exit exam.[112]

Research shows why such testing is neither fair nor the most accurate way of evaluating students and emphasizes the importance of using multiple indicators of achievement before making important decisions about individual students. The Joint Standards for Educational and Psychological Testing explicitly state that "in educational settings a decision or characterization that will have a major impact on a student should not be made on the basis of a single test score."[113] The Association of American Publishers, which represents the companies that publish standardized tests, asserts, "It is important both legally and technically not to put all the weight on a single test when making important decisions about students and schools. Rather, there must be multiple measures or indicators of performance to support important decisions."[114]

Sound education policy cannot demand the same academic results on the same assessments from all students while ignoring the gross educational disparities that confront poor and minority students and students with disabilities and limited English proficiency. It cannot rely on punishing students because they did not succeed when they are competing on a vastly unequal playing field. Given the inequalities we know exist, it is no surprise that Black students are passing exit exams at significantly lower rates than their non-Hispanic White peers.[115]

Lest this analysis lead to the conclusion that the answer is to eliminate standards, assessment, and accountability—to do so would harm student learning and widen the achievement gap. We would do well to remember that before the high stakes

Walking the Path: The Developmental Approach to Learning

Helping children learn by first meeting their individual, developmental needs is key to school success. The Yale School Development Program, also known as the Comer School Development Program (SDP), pioneered by Dr. James Comer, is a comprehensive school reform model centered on children's development along six developmental pathways—cognitive, physical, psychological, ethical, social, and linguistic. SDP brings together school personnel, parents, and students to take responsibility for children's individual development and, consequently, their readiness to learn. Relationships are key to students' success. By not focusing exclusively on cognitive development, but on all developmental pathways, and by ensuring inter-staff collaboration and parental involvement, school districts fully adopting SDP have been able to significantly increase student academic performance in districts across the country. The program is now in place in more than 50 school districts nationwide.[116]

testing emphasis during the past decade, low-income and minority students were also ill-served. It is not the testing or testing itself that is the culprit. What is necessary is systemic change that begins with the belief that all children can learn to high standards; a sound system of standards, accountability and assessments; small classes in small schools; high quality teachers; high quality comprehensive early childhood programs; attention to non-cognitive factors like health; up-to-date technology, facilities and instructional materials; public engagement; and sufficient funds to provide these resources.

Automatic Grade Retention

While "ending social promotion" has become a popular slogan, the automatic grade retention policy that generally accompanies it has further disadvantaged struggling students and has disproportionately affected Black and Hispanic students. In fact, the National Research Council found that simply repeating a grade does not improve achievement over the long term and can actually result in negative outcomes for those retained compared to those with similar academic problems who are not retained. Among those negative outcomes is a significantly increased dropout rate.[117]

While certainly there are some circumstances when grade retention is an appropriate way to help some students, the negative effects of the policy are profoundly illustrated in a longitudinal study of the Baltimore Public Schools. The study found that:

- 71 percent of students retained once dropped out;
- 80 percent of students retained more than once dropped out; and,
- 94 percent of those retained both in elementary and in middle school dropped out.[118]

Most recent data show that twice as many Black students as non-Hispanic White students have been retained at least once.[119] Data on Black and Hispanic students ages 10 and 16 show that they are more likely than their White and Asian peers to be two or more grades behind.[120] While there are certain circumstances when grade retention is appropriate, those decisions are complex and should be made on a case-by-case basis, in the best interests of the child. Yet because of high stakes testing policies, many students are retained based solely on the results of a single test, increasing the risk that children will be incorrectly placed and their school paths will be jeopardized. Most at risk are Black children. Black eighth grade students are almost 2.5 times more likely than non-Hispanic White students to be subjected to high stakes tests to determine promotion.[121]

Schools should only retain a student after a careful evaluation of the student's social, emotional, and cognitive needs. In general, academically failing students should be provided high quality extra support as needed as they move from grade to grade.

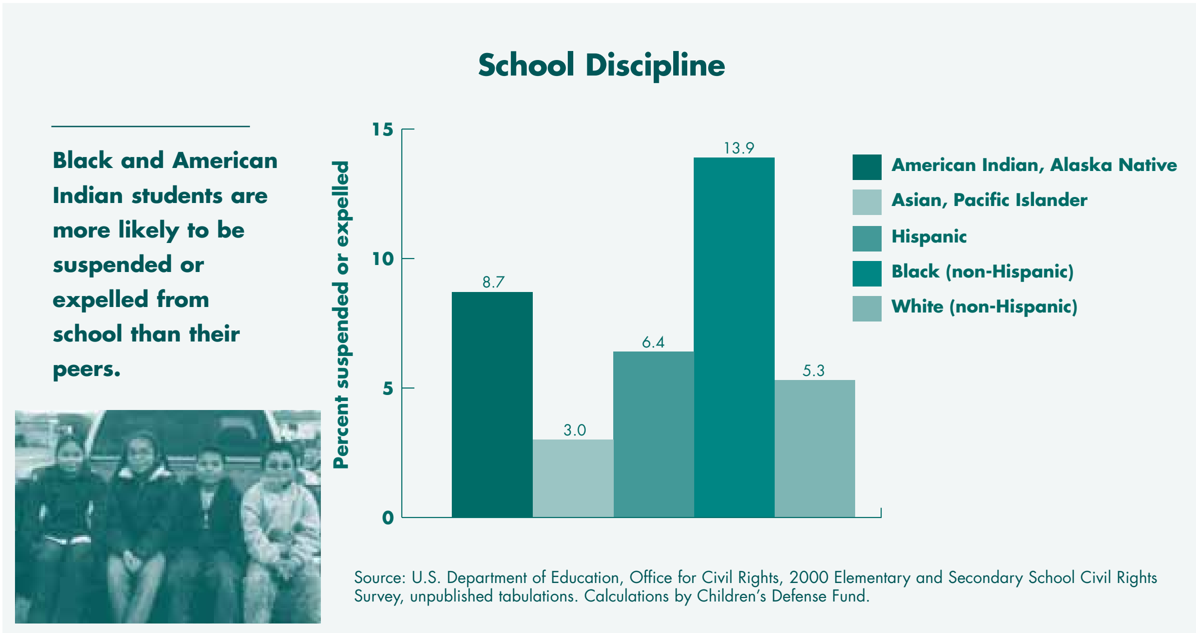
School Discipline

Despite the fact that schools remain the safest place for children to be, many schools have started to crack down on misbehavior in increasingly inappropriate ways. According to a recent report by the U.S. Department of Education, a larger number of serious violent victimizations occur away from school than occur at school.[122] The percentage of students who report being victimized at school has also declined—from 10 percent in 1995 to 6 percent in 2001.[123] Yet many school districts have initiated overly punitive discipline polices that have the effect of pushing children out of school and off the pathway to success.

Zero Tolerance

Minority youth also have been disproportionately affected by the use of zero tolerance discipline policies, which require automatic and often disproportionate punishment for a variety of school code of conduct violations. Nationally, Black youth are more than twice as likely as non-Hispanic White youth to be suspended or expelled from school. Hispanic youth are also significantly more likely than Whites to be suspended or expelled.[124] While such punishments are appropriate in many contexts, it is clear that too often they are used thoughtlessly, in response to minor offenses, and to the detri-

Education – Figure 6



Source: U.S. Department of Education, Office for Civil Rights, 2000 Elementary and Secondary School Civil Rights Survey, unpublished tabulations. Calculations by Children's Defense Fund.

ment of minority children. Disproportionate and arbitrary punishment impairs children's development by disrupting their trusting relationships with adults and by distorting their sense of fairness and justice. Such policies accelerate the path to the juvenile and criminal justice systems by giving children more unsupervised time and more time with peers who are engaged in delinquency.[125] Numerous studies demonstrate that students who are suspended or expelled are more likely than their peers to drop out of school altogether.[126] One study found that being suspended or expelled is one of the top three school-related reasons for dropping out.[127]

The Safe and Responsive Schools Project, housed at the Indiana Education Policy Center, has had tremendous success in providing alternatives to out-of-school suspension. Lobbying by this organization, along with local education advocates and concerned parents, convinced the Indiana legislature to do away with their ineffective zero tolerance policies and adopt a preventive model. If low-income students and families are to pull themselves out of poverty, they are going to require that more states move toward prevention and away from zero tolerance.

Decisions about suspension and expulsion should be made individually, after careful consideration of their efficacy for school safety and for each child. Rather than focusing on school-wide systems of punishment that wait for children to fail,

Walking the Path: School-Wide Positive Behavioral Support

The 2001 Surgeon General's Report on Youth Violence identified "commitment to school" as key to averting youth violence. Recent research has shown that if schools move from control and punishment to positive behavioral support, they can significantly reduce misbehavior among even the most challenging students. In this model, endorsed by the U.S. Department of Education, school staff come together as a team to agree on a plan where behavioral expectations are defined and taught. Good behavior is reinforced, and inappropriate behavior is corrected, in consistent, predictable, and constructive ways. The result: fewer disciplinary infractions, less youth violence, improved academic achievement, and increased academic and social engagement.[128]

schools should focus on school-wide systems of prevention and individual student support.

Criminalization of School Misbehavior

Along with the implementation of zero tolerance policies, schools also have dramatically broadened the scope of juvenile offenses to include what used to be considered obnoxious but normal acting out. Childish misconduct like talking in class, talking back to a teacher, or juvenile speech can now result in the arrest of children as young as four. This "criminalization" of school misbehavior has resulted in a number of controversial overreactions on the part of school staff and local law enforcement that disproportionately impacts minority children. A few recent examples include:

- In Virginia, an eight-year-old boy was arrested when he allegedly threw a violent temper tantrum. The four-foot tall child was taken away in handcuffs from his elementary school and charged with disorderly conduct and assault and battery. The boy was upset because his teacher wouldn't let him go outside to play.[129]
- In Palm Beach County, Florida, a six year-old student was arrested for trespassing on school property. The student was walking through the school yard, after school hours, on his way home.[130]
- In Irvington, New Jersey, two elementary school boys were arrested and charged with making terrorist threats for playing cops and robbers with a paper gun.[131]

While the aforementioned anecdotes may seem comical in their absurdity, punishing non-criminal student behavior is common and has harmful effects. The Advancement Project released a report this year entitled, "Education on Lockdown: The Schoolhouse to Jailhouse Track," that examined the negative consequences of zero tolerance, the expanding role of law enforcement in our nation's schools, and the criminalization of school misbehavior. The report finds that increasingly students are being suspended, expelled, or arrested for non-violent "offenses." The facts highlighted in the report tell a grim tale:

- The number of students given out-of-school suspensions increased from 1.7 million to 3.1 million from 1974 to 2000. An analysis of this trend shows that suspensions are being used increasingly for "trivial conduct, much of which is subjectively labeled 'disrespect,' 'disobedience,' and 'disruption.'"
- There is also a growing trend toward arrests in a number of school districts across the country. As reported in "Education on Lockdown," Denver, Colorado, students referred to law enforcement by school officials, either through tickets and/or arrests, increased by 71 percent between 2000 and 2004, and minority students were referred at much higher rates than their White counterparts. During the 2003-2004 school year, Black students were twice as likely and Latino students were seven times as likely as White students to receive a ticket at school.
- In 2003, 8,539 students were arrested in Chicago public schools. Almost 10 percent of those students arrested were 12 years old or younger, and four of the arrests were of seven-year-old children. Though Black students made up roughly 50 percent of student enrollment, they constituted more than 77 percent of arrests made in Chicago schools that year. Palm Beach County, Florida, exhibited similar racial disparities. In 2003-2004, Black students made up less than 29 percent of enrollment, yet almost 64 percent of school-based arrests.[132]

Recommendations for Moving Forward

There is a tremendous need to proactively keep students in school and out of trouble and to help them academically, emotionally, and socially. Ensuring a quality education for all children is not only a moral imperative, but a wise investment. A recent study by researchers at the Maxwell School of Public Policy at Syracuse University found that an extra $1,000 spent on education is associated with a 10 percent reduction in the number of low math and reading scores, a 15 percent reduction in high school dropout rates, and a 10 percent reduction in teen birth rates.[133]

With this in mind, schools must do far more to ensure that all children have the resources they need for success. Schools must provide:

- Advanced, relevant, and diverse curricula that includes service and other experiential learning;
- Higher quality teachers and school leaders who better represent the population of students in public schools;
- Personalized, more responsive learning environments, including smaller class size, where students feel challenged, respected and receive more support and individual attention;
- Increased parent involvement so parents can reinforce student learning at home, and schools can better understand students' individual needs;
- Expanded partnerships with business, cultural institutions, preschools, universities, and other community-based organizations to open opportunities and support for children in school;
- Collaborations with other service providers so students' health, mental health, housing, and child welfare needs do not overwhelm their ability to learn and stay in school;
- High quality mental health services for students; and
- Safe and modern school facilities.

A strong accountability system is necessary if we are to raise achievement for all children, including children of color, children from low-income families, those with disabilities, and children of limited English proficiency. However, to be effective, accountability systems must:

- Hold the federal government, states, and districts accountable to ensure equity and adequacy of educational resources for all children.
- Never use a single test to make high stakes decisions about schools and students. Instead, examine success in the most comprehensive, fair way by considering a variety of collateral academic indicators of student performance in addition to tests.
- Use only high quality assessments that employ multiple measures of student achievement that assess higher order thinking skills and understanding, not just rote memorization and test taking skills.
- Ensure there is an accurate measure of and accountability for dropout rates, disaggregated by race, ethnicity, income, disability, and limited English proficiency status.
- Require more substantial improvement in dropout rates as a condition for making Adequate Yearly Progress under NCLB.
- Investigate and punish schools and districts for unfairly and inappropriately placing students at risk of failure outside the accountability system in low-track programs and classes.
- Base any effort to allow states and districts to waive requirements of NCLB on solid evidence that those waivers will be educationally beneficial for children and will not arbitrarily leave some children behind. Rather than simply allowing states to use creative accounting to get schools out of "needs improvement" status, such as by exempting entire grade spans from district accountability, the Education Department should ensure that waivers are rooted in solid educational practice that will lead to a more valid assessment of how schools and districts are really doing in educating their students and advancing education reform.

- Allow time for improvement plans to take hold. Sanctions under NCLB should have a proven record of success and should not be applied if those sanctions are going to undermine existing, effective reform efforts.
- Permit states, in determining Adequate Yearly Progress, to consider individual student improvement over time in addition to the percentage of students that achieve a certain level of proficiency.
- Develop and implement an accountability system based on disaggregated data with consequences for state officials that is parallel to the accountability system that applies to schools and districts.

A comprehensive national policy vision that moves all children's needs, ranging from health and nutrition to early care and education, to the top of our national agenda is urgently needed. As stated in chapter Chapter Three, if children are to succeed in K-12 they need a *Head Start*.

- Provide a solid foundation for young children that allows them to enter school with the skills necessary to become strong readers and good students.
- Offer access to after-school activities for school-aged children that not only offer a safe haven, but also provide the academic enrichment they need to stay and succeed in school.
- Provide reliable, affordable child care options that enable parents to work outside the home or give children extra learning experiences if their parents stay at home.
- Give parents the opportunity to stay at home during their child's critical first months or when their child is sick.

If we want children to come to school ready to learn, if we want children to be engaged while in school, and if we want children to leave school on a successful passage to adulthood, it is essential that they not come to school hungry or sick or victimized by violence. Policy makers need to recognize that children do not come in pieces. They live in families and communities who need the capacity to support them. Legislation, such as the comprehensive Act to Leave No Child Behind, which addresses children's multiple needs, is essential for successful education reform.

Endnotes

[1] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2003," *Current Population Reports*, No. P60-226 (Washington, DC: U.S. Government Printing Office).

[2] "Key Facts About American Children." Retrieved from the Internet at http://www.childrensdefense.org/data/keyfacts.aspx.

[3] Chief Justice Earl Warren, *Brown v. Board of Education*, 347 U.S. 483 (1954).

[4] Lisa M. Lynch, "What Can We Do? Remedies for Reducing Inequality," in Albert Fishlow and Karen Parker, eds., *Growing Apart: The Causes and Consequences of Global Wage Inequality* (New York, NY: Council on Foreign Relations, 1999). As cited in W. Schweke, *Smart Money: Education and Economic Development* (Washington, DC: Economic Policy Institute, 2004).

[5] U.S. Census Bureau, *The Big Payoff: Educational Attainment and Synthetic Estimates of Work-Life Earnings* (Washington, DC: U.S. Census Bureau, July 2002). Retrieved from the Internet at www.census.gov/prod/2002pubs/p23-210.pdf on July 14, 2005.

[6] National Center for Education Statistics, *2002 Condition of Education* (Washington, DC: Department of Education, 2002).

[7] Gary Orfield, ed., *Dropouts in America: Confronting the Graduate Rate Crisis* (Cambridge, MA: Harvard Education Press, 2004): 1-2.

[8] U.S. General Accounting Office, *School Dropouts: Education Could Play a Stronger Role in Identifying and Disseminating Promising Prevention Strategies*, GAO-02-240 (Washington, DC: U.S. General Accounting Office, February 2002): 4.

[9] *Ibid.*

[10] Public Agenda, "Education: People's Chief Concerns" (New York, NY: Public Agenda, 2005). Retrieved from the Internet at http://www. publicagenda.org/issues/pcc_detail.cfm?issue_type=education&list=1 on August 23, 2005.

[11] National Conference of State Legislatures, Task Force on No Child Left Behind (Washington, DC: February 2005). Retrieved from the Internet at http://www.ncsl.org/programs/educ/nclb_report.htm on October 3, 2005.

[12] Michelle R. Davis and Jeff Archer, "Complaint Targets Utah NCLB Law," *Education Week* (May 11, 2005). Retrieved from the Internet at http://www.edweek.org/ew/articles/2005/05/11/36nclb.h24.html on July 14, 2005.

[13] Jeff Archer, "Connecticut Pledges First State Legal Challenge to NCLB Law," *Education Week* (April 13, 2005). Retrieved from the Internet at http://www.edweek.org/ew/articles/2005/04/13/31conn.h24.html on July 14, 2005.

[14] National Education Association, *Pontiac v. Spellings* (Washington, DC: National Education Association, April 20, 2005). Retrieved from the Internet at http://www.nea.org/lawsuit/images/nclb complaint.pdf on July 14, 2005.

[15] Christina A. Samuels, "Officials Detail NCLB Test Flexibility for Students with Disabilities," *Education Week* (May 10, 2005). Retrieved from the Internet at http://www.edweek.org/ew/articles/2005/05/10/37spellings_web.h24.html on July 14, 2005.

[16] Lynn Olson, "Florida Gains Flexibility on NCLB Provisions," *Education Week* (May 25, 2005). Retrieved from the Internet at http://www.edweek.org/ew/articles/2005/05/25/38nclb.h24.html on July 14, 2005.

[17] Leslie Postal and John Kennedy, "Florida Receives New Flexibility for Schools Law," *Orlando Sentinel* (May 17, 2005).

[18] Ron Matus, "Will Rule Change Leave Kids Behind?" *St. Petersburg Times* (May 21, 2005). Retrieved from the Internet at http://www.sptimes.com/2005/05/21/State/Will_rule_change_leav.shtml on July 14, 2005.

[19] Christopher Tracey, Gail Sunderman and Gary Orfield, *Changing District Accountability Standards: Implications for Racial Equity*, The Civil Rights Project at Harvard University (June 2005): 23.

[20] Council for Exceptional Children. Retrieved from the Internet at http://www.cec.sped.org/pp/CECresponse.pdf.

[21] Council of Chief State School Officers, "CCSSO Executive Director Responds to U.S. Department of Education's New Flexibility" (Washington, DC: Council of Chief State School Officers, May 10, 2005). Retrieved from the Internet at http://www.ccsso.org/Whats_New/Press_Releases/6297.cfm.

[22] The White House, *Strengthening Higher Education for a Successful Workforce* (Washington, DC: The White House, 2005). Retrieved from the Internet at http://www.whitehouse.gov/infocus/education/.

[23] Erik W. Robelen, "Bush's High School Plan Off to Rocky Start," *Education Week* (February 16, 2005). Retrieved from the Internet at http://www.edweek.org/ew/articles/2005/02/16/23brt.h24.html?querystring=castle on July 14, 2004.

[24] Bill Gates, "National Education Summit on High Schools" (Seattle, WA: Bill and Melinda Gates Foundation, February 26, 2005). Retrieved from the Internet at: http://www.gatesfoundation.org/MediaCenter/Speeches/BillgSpeeches/BGSpeechNGA-050226.htm on July 14, 2005.

[25] Business Roundtable Press Release, "No Child Left Behind Receives High Marks at Business Roundtable Forum" (Washington, DC, February 2005). Retrieved from the Internet at http://www.businessroundtable.org/newsroom/document.aspx?qs=5906BF807822B0F1AD7438F22FB51711FCF50C8.

[26] National Center for Education Statistics, *2003 National Assessment of Educational Progress* (Washington, DC: U.S. Department of Education, 2003). Retrieved from the Internet at: http://nces.ed.gov/nationsreportcard/ on August 30, 2005.

[27] *Ibid.*

[28] National Center for Education Statistics, *Condition of Education 2005* (Washington, DC: Department of Education, 2005): Table 16-1. Retrieved from the Internet at: http://nces.ed.gov/programs/coe/2004/ section3/indicator16.asp#info on August 30, 2005.

[29] U.S. General Accounting Office, *School Dropouts: Education Could Play a Stronger Role in Identifying and Disseminating Promising Prevention Strategies*, GAO-02-240 (Washington, DC: U.S. General Accounting Office, February 2002): 3.

[30] Center on Labor Market Studies, as cited in Gary Orfield, ed., *Dropouts in America: Confronting the Graduate Rate Crisis* (Cambridge, MA: Harvard Education Press, 2004): 1.

[31] *Ibid.*

[32] U.S. Census Education Attainment 2002 as cited in Gary Orfield, ed., *Dropouts in America: Confronting the Graduate Rate Crisis* (Cambridge, MA: Harvard Education Press, 2004).

[33] Caroline Wolf Harlow, *Educational and Correctional Populations* (Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, 2002). Calculations by the Children's Defense Fund.

[34] E. Denison, *Trends in American Economic Growth 1929-1982* (Washington, DC: Brookings Institution, 1985) as cited in W. Schweke, *Smart Money: Education and Economic Development* (Washington, DC: Economic Policy Institute, 2004).

[35] M. Wasylenko (1986), "The Effect of Business Employment on Employment Growth: Final Report of the Minnesota Tax Study Commission, Vol. 2," Staff Papers. As cited in W. Schweke, *Smart Money: Education and Economic Development* (Washington, DC: Economic Policy Institute, 2004).

[36] Corporation for Enterprise Development, "The Development Report Card for the States" (Washington, DC: CFED, 1986-2003). As cited in W. Schweke, *Smart Money: Education and Economic Development* (Washington, DC: Economic Policy Institute, 2004).

[37] Arloc Sherman, *Wasting America's Future: The Children's Defense Fund Report on the Costs of Child Poverty* (Boston, MA: Beacon Press, 1994). As cited in W. Schweke, *Smart Money: Education and Economic Development* (Washington, DC: Economic Policy Institute, 2004).

[38] U.S. Census Bureau News, "College Degree Nearly Doubles Annual Earnings, Census Bureau Reports" (Washington, DC: U.S. Census Bureau, March 28, 2005). Retrieved from the Internet at http://www.census.gov/Press-Release/www/releases/archives/education/004214.html on August 23, 2005.

[39] National Center for Education Statistics, *2003 National Assessment of Educational Progress* (Washington, DC: U.S. Department of Education, 2003). Retrieved from the Internet at http://nces.ed.gov/nationsreportcard/ on August 24, 2005.

[40] Jay R. Campbell, Catherine M. Hombo and John Mazzeo, *National Assessment of Educational Progress 1999: Trends in Academic Progress*, NCES 2000-469 (Washington, DC: National Center for Education Statistics, 2000). Retrieved from the Internet at http://nces.ed.gov/nationsreportcard/pdf/main1999/2000469.pdf on August 23, 2005. As quoted in "Qualified Teachers for At-Risk Schools: A National Imperative." Retrieved from the Internet at http://www.ncrel.org/quality/partnership.pdf.

[41] National Center for Education Statistics, "Grade Retention, Suspension, and Expulsion," *Status and Trends in the Education of Hispanics* (Washington, DC: U.S. Department of Education, 2003). Retrieved from the Internet at: http://nces.ed.gov/pubs2003/hispanics/Section2.asp#1 on August 23, 2005.

[42] National Center for Education Statistics, *National Assessment of Educational Progress 2003* (Washington, DC: U.S. Department of Education, 2003). Retrieved from the Internet at: http://nces.ed.gov/nationsreportcard/ on August 23, 2005.

[43] National Center for Education Statistics, "Grade Retention, Suspension, and Expulsion," *Status and Trends in the Education of Hispanics* (Washington, DC: U.S. Department of Education, 2003). Retrieved from the Internet at: http://nces.ed.gov/pubs2003/hispanics/Section2.asp#1 on August 23, 2005. Calculations by the Children's Defense Fund based on data from the U.S. Department of Education.

[44] National Center for Education Statistics, *Status and Trends in the Education of Blacks* (Washington, DC: U.S. Department of Education, September 2003); National Center for Education Statistics, "Grade Retention, Suspension, and Expulsion," *Status and Trends in the Education of Hispanics* (Washington, DC: U.S. Department of Education, 2003). Retrieved from the Internet at: http://nces.ed.gov/pubs2003/hispanics/Section2.asp#1 on July 14, 2005.

[45] U.S. Department of Education, Office for Civil Rights, 2000. Elementary and Secondary School Civil Rights Survey, unpublished tabulations. Calculations by the Children's Defense Fund.

[46] U.S. Census Bureau, *Educational Attainment in the United States: 2003* (Washington, DC: U.S. Census Bureau, June 2004).

[47] Steven J. Ingels, Thomas R. Curtin, Philip Kaufman, Martha Naomi Alt and Xianglei Chen, "Coming of Age in the 1990s: The Eighth Grade Class of 1988 – 12 Years Later," *Education Statistics Quarterly* 4, No. 2 (September 2002). Retrieved from the Internet at http://nces.ed.gov/programs/quarterly/vol_4/4_2/2-1.asp on July 14, 2005. Quoted in "Qualified Teachers for At-Risk Schools."

[48] National Center for Education Statistics, *Digest of Education Statistics, 2003* (Washington, DC: U.S. Department of Education, 2003): Table 313. Retrieved from the Internet at http://nces.ed.gov/programs/digest/d03/tables/dt313.asp on July 14, 2005.

[49] Nicholas Zill, "School Readiness and Children's Developmental Status," *ERIC Digest* (Washington, DC: Young Children, December 1995). Retrieved from the Internet at http://www.kidsource.com/kidsource/content3/School.Readiness.p.k12.2.html.

[50] Children's Defense Fund analysis of unpublished tabulations from the U.S. Department of Education, Office of Civil Rights.

[51] National Center for Education Statistics, *Condition of Education 2004* (Washington, DC: U.S. Department of Education, 2004).

[52] Hamilton Lankford, Susanna Loeb and James Wyckoff, "Teacher Sorting and the Plight of Urban Schools: A Descriptive Analysis," *Educational Evaluation and Policy Analysis* 24, No. 1 (2001): 37-62. As quoted in "Qualified Teachers for At-Risk Schools."

[53] Julia Cass, *Dismantling the Cradle to Prison Pipeline* Draft (Washington, DC: Children's Defense Fund, April 2005): xv.

[54] Kati Haycock, "Good Teaching Matters," *Thinking K-16*, 3, No. 2 (Summer 1998).

[55] National Research Council, *Minority Students in Special and Gifted Education* (Washington, DC: National Academy Press, 2002): 174.

[56] National Center on Education Statistics, *Condition of Education 2003* (Washington, DC: U.S. Department of Education, 2003).

[57] Daniel P. Mayer, John E. Mullens and Mary T. Moore, "Monitoring School Quality: An Indicators Report," NCES 2001-030 (Washington, DC: National Center for Education Statistics, December 2000), as quoted in "Qualified Teachers for At-Risk Schools." Retrieved from the Internet at http://nces.ed.gov/pubs2001/2001030.pdf on July 14, 2005.

[58] Craig D. Jerald, *All Talk, No Action: Putting an End to Out-of-Field Teaching* (Washington, DC: The Education Trust, August 2002). Calculations from Department of Education data. Retrieved from the Internet at http://nces.ed.gov/programs/coe/2004/section4/indicator24.asp#info.

[59] *Ibid.*

[60] National Center for Education Statistics, *Condition of Education 2002* (Washington, DC: U.S. Department of Education, 2002).

[61] National Commission on Teaching and America's Future, *No Dream Denied: A Pledge to America's Children, 6* (Washington, DC: National Commission on Teaching and America's Future, January 2003).

[62] *Ibid.*

[63] *Ibid.*

[64] Texas Center for Educational Research, *The Cost of Teacher Turnover* (Austin, TX: Texas Center for Educational Research, November 2000).

[65] *Ibid.*

[66] American Federation of Teachers, *Benefits of Small Class Size* (Washington, DC: American Federation of Teachers). Retrieved from the Internet at http://www.aft.org/topics/classsize on August 24, 2005.

[67] Delbert S. Elliott, Beatrix A. Hamburg and Kirk R. Williams, "Violence in American Schools: An Overview" in *Violence in American Schools* (New York, NY: Cambridge University Press, 1998): 3-28.

[68] National Center for Education Statistics, *School and Staffing Survey (SASS), 1999-2000* (Washington, DC: U.S. Department of Education) as cited in Paul E. Barton, *Parsing the Achievement Gap: Baselines for Tracking Progress* (Princeton, NJ: Educational Testing Service, October 2003).

[69] National Center for Education Statistics, *Condition of Education 2002* (Washington, DC: U.S. Department of Education, 2002).

[70] Committee on Minority Representation in Special Education, M. Suzanne Donovan and Christopher T. Cross, eds., *Minority Students in Special and Gifted Education* (Washington, DC: National Academy Press, 2002): 51.

[71] National Center for Education Statistics, *Status and Trends in the Education of Blacks* (Washington, DC: U.S. Department of Education, September 2003): Supplemental Table 4.7.

[72] National Center for Education Statistics, *Status and Trends in the Education of Blacks* (Washington, DC: U.S. Department of Education, September 2003).

[73] *Ibid.*

[74] National Center for Education Statistics, *Condition of Education 2001* (Washington, DC: U.S. Department of Education, 2001).

[75] *Ibid.*

[76] *Ibid.*

[77] Mandalit del Barco, "Racial Tensions Overheat at L.A. High School" (Washington, DC: National Public Radio, June 3, 2005). Retrieved from the Internet at http://www.npr.org/templates/story/story.php?storyId=4678680 on August 23, 2005.

[78] National Center for Education Statistics, "Computer and Internet Use by Children and Adolescents in 2001" (Washington, DC: U.S. Department of Education, 2003). Retrieved from the Internet at http://nces.ed.gov/pubs2004/2004014.pdf.

[79] *Ibid.*

[80] *Ibid.*

[81] Committee on Increasing High Schools Students' Engagement and Motivation to Learn; Board on Children, Youth and Families Division of Behavioral and Social Sciences and Education; National Research Council Institute of Medicine, *Engaging Schools: Fostering High School Students' Motivation to Learn* (Washington, DC: The National Academies Press, 2004).

[82] J. Knitzer, Z. Steinberg and B. Fleisch, *At the Schoolhouse Door: An examination of programs and policies for children with behavioral and emotional problems* (New York, NY: Bank Street College of Education Press, 1990).

[83] R.C. Kessler, J.C. Anthony, D.G Blazer, et al., "The U.S. National Co-Morbidity Survey: Overview and Future Directions."

[84] National Center for Education Statistics, *Condition of Education 2005* (Washington, DC: U.S. Department of Education, 2005).

[85] National Center for Education Statistics, *Condition of Education 2005* (Washington, DC: U.S. Department of Education, 2005). Retrieved from the Internet at: http://nces.ed.gov//programs/coe/2004/pdf/27_2004.pdf on August 23, 2005.

[86] Kevin Carey, "The Funding Gap 2004: Many States Still Shortchange Low-Income and Minority Students" (Washington, DC: The Education Trust, Fall 2004). Retrieved from the Internet at: http://www2.edtrust.org/NR/rdonlyres/30B3C1B3-3DA6-4809-AFB9-2DAACF11CF88/0/funding2004.pdf.

[87] *Ibid.*

[88] *Ibid.*

[89] *Ibid.*

[90] National Center for Education Statistics, *Digest of Education Statistics: 2003* (Washington, DC: U.S. Department of Education, November 2004): Table 168.

[91] U.S. Department of Education, *President's FY 2006 Budget Request for the U.S. Department of Education* (Washington, DC: U.S. Department of Education, 2005). Retrieved from the Internet at http://www.ed.gov/about/overview/budget/budget06/index.html on April 14, 2005.

[92] 108th Congress, House of Representatives, *Individuals with Disabilities Education Improvement Act of 2004* (Washington, DC: House of Representatives, November 17, 2004). Retrieved from the Internet at http://thomas.loc.gov/cgi-bin/cpquery/T?report=hr779&dbname=cp108& on July 14, 2005.

[93] National Council of State Legislatures, "States Still Struggling to Keep Budgets Balanced," *NCSL News* (Washington, DC: National Council of State Legislatures, April 14, 2005). Retrieved from the Internet at http://www.ncsl.org/programs/press/2005/pr050412.htm.

[94] Tim Tankersley, "Statewide Ballot Gains Elbow Room," *Rocky Mountain News* (June 2, 2005).

[95] News10.net, "Thousands Protest Governor's Budget, Reform Proposals" (Sacramento, CA: KXTV News 10, May 25, 2005). Retrieved from the Internet at http://www.news10.net/storyfull1.asp?id=11111.

[96] ACCESS, "Litigation: Texas" (New York, NY: Campaign for Fiscal Equity). Retrieved from the Internet at http://www.schoolfunding.info/states/tx/lit_tx.php3.

[97] Campaign for Fiscal Equality Statement. Retrieved from the Internet at www.cfequity.org on August 23, 2005.

[98] The PFT Reporter: Official Publication of the Philadelphia Federation of Teachers*, PFT Protests Layoffs, Program Cuts: School Budget Eliminates Jobs and Programs* (Philadelphia, PA: Philadelphia Federation of Teachers, 2005). Retrieved from the Internet at http://www.pft.org/archrept/rep0605/p_01.html.

[99] Megan Tench, "Reductions Hurt Across State, Say Union and Administrators," *Boston Globe* (February 19, 2005). Retrieved from the Internet at http://www.schlichtman.org/cuts021904.html on April 14, 2005.

100 P. Brown and L. Fiester, "New Song Academy: Linking Education and Community Development to Build Stronger Families and Neighborhoods" (Baltimore, MD: Annie E. Casey Foundation, 2003). Retrieved from the Internet at http://www.aecf.org/publications/data/ns-final.pdf.

101 Joan Herman, *Instructional Effects in Elementary Schools* (Los Angeles, CA: The Regents of the University of California, 2002): 9.

102 National Research Council Institute of Medicine, *Engaging Schools* (Washington, DC: National Academies Press, 2004): 216.

103 Council on Basic Education, *Academic Atrophy: The Condition of Liberal Arts in America's Public Schools* (Washington, DC: Council on Basic Education, 2004).

104 John Merrow, "Disappearing Dropouts," *NewsHour with Jim Lehrer* (New York, NY: MacNeil/Lehrer Productions, November 30, 2004). Retrieved from the Internet at http://www.pbs.org/newshour/bb/education/july-dec04/dropouts_11-30.html#.

105 Walt Haney, et al., *The Education Pipeline in the United States 1970-2000* (Boston, MA: The National Board on Educational Testing and Public Policy, January 2004).

106 John Herner, *Issue Brief: Discipline and Students with Disabilities* (Dayton, OH: University of Dayton, May, 2004). Retrieved from the Internet at: www.ssco.org/saas/ on August 24, 2005.

107 Center on Education Policy, *State High School Exit Exams: A Maturing Reform* (Washington, DC: Center on Education Policy, 2004): 5.

108 National Research Council, *Engaging Schools: Fostering High School Students' Motivation to Learn* (Washington, DC: National Academies Press. 2004): 57.

109 Center on Education Policy, *State High School Exit Exams: A Maturing Reform* (Washington, DC: Center on Education Policy, 2004): 7.

110 *Ibid.* at 47.

111 A.E. Kreitzer, F. Madaus and W. Haney, "Competency Testing and Dropouts," *Dropouts from School: Issues, Dilemmas and Solutions*, L. Weis, E. Farrar and H.G. Petrie, eds. (Albany, NY: State University of New York Press, 1989) as cited in National Research Council, *High Stakes: Testing for Tracking, Promotion and Graduation,* J.P. Heubert and R. Hauser, eds. (Washington, DC: National Academies Press, 1999): 174.

112 Center on Education Policy, *State High School Exit Exams: A Maturing Reform* (Washington, DC: Center on Education Policy, 2004): 5.

113 American Education Research Association, American Psychological Association, and National Council on Measurement in Education, *Standards for Educational and Psychological Testing* (Washington, DC: AERA Publications, 1999): Standard 13.7.

114 Association of American Publishers, *Standardized Assessment: A Primer (Revised Edition)* (Washington, DC: Association of American Publishers). Retrieved from the Internet at http://www.publishers.org/school/pdf/Testing%20Primer%20Revised.pdf on July 14, 2005.

115 Center on Education Policy, *State High School Exit Exams: A Maturing Reform* (Washington, DC: Center on Education Policy, 2004): 37.

116 Retrieved from the Internet at http://info.med.yale.edu/comer.

117 U.S. General Accounting Office, *School Dropouts: Education Could Play a Stronger Role in Identifying and Disseminating Promising Prevention Strategies,* GAO-02-240 (Washington, DC: U.S. General Accounting Office, February 2002): 3.

118 Karl Alexander, Doris Entwisle and Nader Kabbani, "The Dropout Process in Life Course Perspective: Early Risk Factors at Home and at School," *Teacher's College Record* 103, No. 5 (October 2001): 775.

119 U.S. Department of Education, National Center for Education Statistics, and National Household Education Survey, "Parent Interview Component" (Washington, DC: U.S. Department of Education, 1999).

120 Bureau of the Census, *Current Population Survey* (Washington, DC: U.S. Department of Commerce, October 2002): Table 2. Calculations by the Children's Defense Fund.

121 S. Reardon, "Eighth Grade Minimum Competency Testing and Early High School Dropout Patterns," presented at the annual meeting of the American Educational Research Association (New York, NY: American Educational Research Association, April 1996) as cited in Jay P. Heubert and Robert M. Hauser, eds., *High Stakes: Testing for Tracking, Promotion and Graduation* (Washington, DC: National Academies Press, 1999): 130.

122 National Center for Education Statistics, *Violence in U.S. Public Schools: 2000 School Survey on Crime and Safety* (Washington, DC: U.S. Department of Education, October 2003).

123 National Center for Education Statistics and Bureau of Justice Statistics, *Indicators of School Crime and Safety: 2003* (Washington, DC: U.S. Department of Education, October 2003).

124 National Center for Education Statistics, National Household Education Survey, *Highlights from the Status and Trends in the Education of Hispanics* (Washington, DC: U.S. Department of Education, 2003). Retrieved from the Internet at http://nces.ed.gov/Pubs2003/Hispanics/figures.asp?FigureNumber=3_2.

125 Advancement Project and the Civil Rights Project, *Opportunities Suspended: The Devastating Consequences of Zero Tolerance and School Discipline Policies* (Boston, MA: Harvard University, June 2000).

126 Terry Keleher, "Racial Disparities Related to School Zone Tolerance Policies," in testimony to the U.S. Commission on Civil Rights (Washington, DC: Applied Research Center, February 18, 2000). Retrieved from the Internet at http://www.arc.org.

127 Advancement Project and the Civil Rights Project, *Opportunities Suspended: The Devastating Consequences of Zero Tolerance and School Discipline Policies* (Boston, MA: Harvard University, June 2000).

128 Positive Behavioral Interventions and Supports. Retrieved from the Internet at http://www.pbis.org.

129 "8-Year-Old Arrested After Alleged Tantrum," *Associated Press* (March, 4 2005). Retrieved from the Internet at http://www.pbis.org.

130 "8-Year-Old Arrested After Alleged Tantrum," *Associated Press* (March, 4 2005). Retrieved from the Internet at http://www.newsreview.info/article/20050304/BLOG/50304029/-1/BLOG07.

131 Interview with Gail Davis, Legal Aid of Palm Beach County, April, 2002.

132 Christine Haughney (2001), "2 Boys, a Paper Gun and a Heap of Trouble," *Washington Post* (June 20, 2005).

133 Advancement Project, *Education on Lockdown: The Schoolhouse to Jailhouse Track* (Washington, DC: Advancement Project, March 2005).

134 Kristen Harknett, Irwin Garfinkel, Jay Bainbridge, Timothy Smeeding, Nancy Folbre and Sara McLanahan, *Do Public Expenditures Improve Child Outcomes in the U.S.? A Comparison Across 50 States* (Syracuse, NY: Center for Policy Research, Syracuse University, March 2003).

135 National Research Council Institute of Medicine, *Engaging Schools* (Washington, DC: National Academies Press, 2004): 211.

CHAPTER FIVE

Child Welfare

Poverty and Families in Crisis

Poverty is the single best predictor of child abuse and neglect. Children who live in families with annual incomes of less than $15,000 are 22 times more likely to be abused or neglected than those with annual incomes of $30,000 or more. Sadly, some of our public child welfare systems also are perpetuating the cycle of poverty for those in its charge. Despite promising efforts in a number of states to protect children and strengthen families, too many children in crisis still go without the services and supports they need and *now even risk losing some of the basic supports they have had, as* Congress and state legislatures debate cuts in health care, education, specialized treatment services and, in some cases, even foster care and adoption assistance services.

I've been through verbal abuse, physical abuse, sexual abuse, all the abuse that you can think of.... I ended up in three different foster homes.... I had one good foster family, one that taught me about morals and values. It was a pretty good family; it taught me about life.

—Lou Della Casey, St. Paul, Minnesota

More than 900,000 children, one every 35 seconds, were abused and neglected in 2003. Four out of ten received no services whatsoever from America's child welfare system, despite the fact that problems left unaddressed often have long-term consequences for children. For example, it is not surprising to learn from a new study of foster care alumnae that one-third of those who had been in foster care were living below the poverty level, one-third had no health insurance, half had one or more mental health problems, and the rate of post traumatic stress disorder among a group of youth formerly in foster care was twice as high as that for war veterans.

This chapter begins with a quick look at the past year and an overview of children and families in crisis and the problems they face. It describes efforts to engage and support families and to address particular needs such as substance abuse treatment, mental health treatment, and help for families victimized by domestic violence. The chapter also highlights examples of systemic efforts to provide a full continuum of services that meet the needs of vulnerable children and families and empower families to care for their children. It closes with a set of recommendations for moving forward to help more children and families benefit from positive reform efforts.

A Look at the Past Year

Recent events in child welfare unfortunately mimic those of the last several years. Newspapers and television stations report horrific child abuse cases from around the country. In some instances, children have been seriously harmed by parents and, in others, by foster parents or adoptive parents. As is too often the case, these tragic situations garner a lot of attention, but seldom enough to gain system improvements that can be sustained over time and help the hundreds of thousands of children in crisis whose family situations are very different from those reported. Too many of these children still go without the services and supports they need and now even risk losing what they had, as Congress and state legislatures debate cuts in health care, education, specialized treatment services and, in some cases, even foster care and adoption assistance payments.

The latest child maltreatment and foster care figures for the nation show no significant increases or decreases. However, in a number of states, child welfare agencies are beginning to see the impact of escalating numbers of methamphetamine cases. The U.S. Department of Justice reports that children residing in homes in which methamphetamines were being produced increased nearly ten-fold during the period 2000-2002.[1]

At the same time, there is also good news from states. Some states are working to implement "alternative response systems" so they can get help to families earlier, when signs of problems first arise. Others have approved the hiring of hundreds of new child protection staff. The 2004 extension of the Individuals with Disabilities Education Act and several major reports remind us of the need to better respond to the education and special education needs of children in foster care. Other jurisdictions report significant decreases in their foster care caseloads as intensive efforts are made to keep children out of care and to return them more quickly to their own families or new permanent families. Some cities and states are giving special attention to youths in group homes and other congregate care settings who often are most at risk of leaving foster care with no permanent family connections. Attention to youths who age out of foster care at 18, 19 or older continues to grow. And grandparents

and other relatives who are raising children, often without the necessary supports, are coming together to get the help their children need.

There has been increased attention to making federal dollars better respond to the needs of vulnerable children and youth and to improving the functioning of the courts, which play a key role in deciding the futures of abused and neglected children. Unfortunately, the debate is still stuck on whether or not we can do more with the same dollars. At the same time, several national level reports have reminded us that even the best reforms will mean little for children without improvements in the quality of the child welfare workforce.

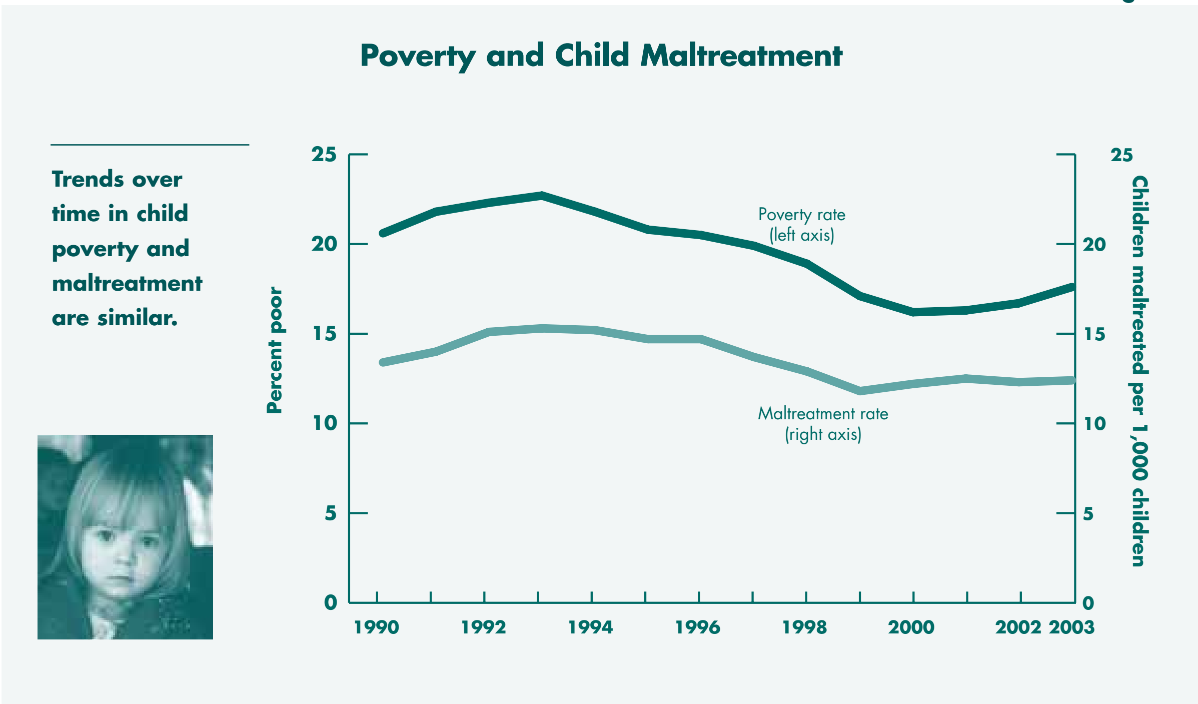
The U.S. Supreme Court's decision in *Roper v. Simmons*, 2005 WL 46 4890 (U.S. 2005), banning the death penalty for crimes committed by juveniles under the age of 18 was good news, but it also underscored how many children who are abused or neglected or face other problems are at risk of entering the juvenile justice system and moving on to adult prisons.

So the struggle must continue. In addition to eliminating child poverty and getting every child the health care, early childhood experiences, housing, and income supports and education they need, we know that we must not forget the children who require not only these basic supports, but more specialized help as well.

Who Are the Children in Families in Crisis?

Poverty is the single best predictor of child abuse and neglect. Changes in poverty rates and maltreatment rates have similar patterns over time (see CW – Figure 1). Research demonstrates that children who live in families with annual incomes less than $15,000 are 22 times more likely to be abused or neglected than children living in families with annual incomes of $30,000 or more.[2] This does not mean, however, that most poor parents abuse or neglect their children. Indeed, in 2003, there were 12.9 million children living in poverty in this country and fewer than one million were confirmed to have been abused or neglected—and not all of these children were poor. Nor does the strong connection between poverty and child abuse and neglect suggest a causal link. Yet poverty and child abuse or neglect can interact in several

Child Welfare – Figure 1



ways. Understanding the connections between poverty and child maltreatment can help us develop appropriate responses that address the needs of children and families. Rather than using poverty to blame or excuse parents for child abuse or neglect, understanding the links helps tailor responses to the particular needs of individual families. Pretending that poverty is not a component that needs to be addressed leaves child welfare workers, policy makers, advocates and, most importantly, families struggling with one hand tied behind their backs.

Neglect is the form of child maltreatment where the link to poverty is most obvious, since it often can be directly tied to a family's lack of resources. Neglect constitutes the majority of child maltreatment. While most states' laws are written with the goal of distinguishing neglect and poverty, the reality is that the lines between the two often become blurred. For example, a young, single mother of a four-year-old and a six-year-old can only find work on the night shift and is unable to afford child care during those hours. She tucks the children into bed each night, locks the door and heads to work praying nothing will go wrong. Under many state laws, this mother has failed to properly supervise, and thus has neglected her children. Similar situations may arise when a family with children is homeless.

Poverty also may contribute to child abuse and neglect by adding stress to a family's life. The daily struggle to put food on the table and keep a roof overhead may be the proverbial straw that breaks the camel's back. Poverty also may create (or be associated with) a strong sense of social isolation.[3] A parent, who would otherwise have the patience to deal with a demanding toddler or a challenging teenager, may lose his or her patience after being laid off or being evicted, especially if that parent feels they have no one to whom they can turn for assistance. Poverty also may be associated with increased reports of child abuse and neglect because poor families are more likely to receive services from and be under the scrutiny of public social service and health agencies.

Poverty and child maltreatment can also co-occur when parents face challenges such as substance abuse, untreated mental health problems, and domestic violence. These challenges make it difficult to sustain employment, particularly employment that lifts the family out of poverty. These same challenges also may interfere with a parent's ability to adequately care for his or her children, particularly children with special needs, and to access the appropriate resources that are needed.

Children and Families Victimized by Violence

Children Who Are Abused and Neglected

Child abuse/neglect is the leading reason children come to the attention of public child welfare agencies. An estimated three million children were reported to these agencies as abused and neglected and referred for investigation or assessment in 2003.[4] Over 900,000 of the children were determined to be abused or neglected after investigations were conducted; 60.9 percent of these children were neglected, 18.9 percent physically abused, 9.9 percent sexually abused, and 4.9 percent emotionally abused.[5] Young children (ages zero to four) accounted for the largest percentage of the victims. Pacific Islander, American Indian, Alaska Native, and Black children had the highest rates of victimization.[6]

The increased rates of victimization among children who are members of minority groups is likely related to the increased incidence of abuse and neglect among poor families and the racial disparities that exist in poorer families. As mentioned above, cases of neglect, especially, are concentrated in poor families. Dorothy Roberts, a Professor of Law at Northwestern University, explains that *because of America's high rate of child poverty, the United States has a rate of child abuse and neglect two to three times higher than other industrialized countries.* The greatest disparity is seen in child neglect: nine in every 1,000 children are neglected in the United States, compared to only two per 1,000 in Canada.[7]

Just as poverty is a risk factor for child abuse and neglect, child maltreatment is correlated to a number of other negative child outcomes. For example, research indicates that there are strong connections between child abuse and neglect and

subsequent juvenile delinquency or criminal activity. While the majority of children who are abused or neglected do not subsequently engage in delinquent or criminal behavior, children who are abused or neglected are more likely to become involved with the juvenile justice and adult criminal justice systems. Abused and neglected children are 1-1/2 to six times as likely to be delinquent and 1-1/4 to three times as likely to be arrested as an adult.[8]

In addition to the detrimental impact that child maltreatment has on children, families, and communities, child abuse also comes at a serious fiscal cost to society. The non-profit organization, Fight Crime, Invest in Kids, reports that child abuse and neglect costs Americans between $83 billion and $94 billion dollars a year in direct and indirect costs, and two-thirds of this amount are costs related to crime.[9] Direct costs to the child welfare system alone in 2002 were estimated at $22 billion.[10] The indirect costs of child abuse and neglect reflect the long-term consequences of child maltreatment in special education, mental health, substance abuse, teen pregnancy, welfare receipt, domestic violence, homelessness, juvenile delinquency, and adult criminality.[11]

Children Who Are Exposed to Domestic Violence

Some children come to the attention of the child welfare system because they themselves have been abused or exposed to domestic violence in other ways. An estimated 3.3 to 10 million children witness the abuse of a parent or adult caregiver each year. Children who are exposed to domestic violence are at a greater risk of being abused or neglected themselves. Studies indicate that in 30 to 60 percent of families experiencing family violence there are both adult and child victims.[12] Although in most states exposure to domestic violence, without actual abuse, does not require a report to child protective services, sometimes a police officer or children's services provider who is aware of domestic violence will refer a child to the child welfare system out of concern for the child's safety, even without evidence of actual harm to the child.

The actual impact of domestic violence on children varies depending on the presence of a range of protective factors. Therefore, a core component of the response to domestic violence should be deciding what is the appropriate response in each case. For example, exposure to family violence has different effects on children depending on the age and gender of the child, a child's relationship with his or her parents and other adults, a child's school performance, and the frequency of and type of violence exhibited. Without protective factors, exposure to domestic violence can cause a child to experience behavioral, social, and emotional problems. Many children who witness violence exhibit violent and aggressive behavior themselves, and many suffer from depression and poor self-esteem. Exposure to domestic violence also has been correlated to poor school performance, low cognitive skills, difficulty with conflict resolution, and trouble with positive social peer relations.[13]

Poverty, domestic violence, and involvement in the child welfare system often are inextricably linked. The National Institute of Justice in the U.S. Department of Justice reports that women living in disadvantaged neighborhoods are more than twice as likely to be victims of intimate violence and also more likely to be injured and experience severe violence than women in advantaged neighborhoods. The Institute reports that job instability, low income, and financial stress are often related to incidence of partner abuse. [14] A mother's economic instability may keep her in an abusive relationship to the detriment of her and her child's safety. On the other hand, low-income women who decide to leave their abusive partners may risk losing their children if they cannot adequately provide for their well-being.

Children Separated or at Risk of Separation from Their Families

Children in Foster Care

Nationally, 15 percent of the children who are victimized by abuse and neglect are removed from their homes.[15] An estimated 800,000 children are in foster care at some point during a year. As of the end of fiscal year 2003, 523,000 children were in family foster homes, group homes, or residential treatment centers. On average, a child in care was

Child Welfare – Table 1

Who's in Foster Care?

	Percent in foster care	Percent in U.S. child population
Race and ethnicity		
White, non-Hispanic	39%	60%
Black	35	16
Latino	17	18
American Indian, Alaska Native	2	1
Asian	1	4
Other and unknown	6	3
Age		
Under age 1	5	
1-5 years	25	
6-10 years	21	
11-15 years	30	
16-18 years	18	
19 + years	2	
Type of placement		
Non-relative foster home	46	
Relative foster home	23	
Institution	10	
Group home	9	
Pre-adoptive home	5	
Trial home visit	4	
Runaway	2	
Supervised independent living	1	
Exit from foster care during year		
Reunification	55	
Living with relative	11	
Adoption	18	
Emancipation	8	
Guardianship	4	
Transfer to another agency	2	
Runaway	2	

Note: Race/ethnicity, age, and placement are estimates of children in foster care on September 30, 2002; exit data reflect outcomes for children exiting foster care during FY 2002.

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "The AFCARS Report: Preliminary FY 2003 Estimates as of April 2005," at <http://www.acf.hhs.gov/programs/cb/publications/afcars/report10.pdf>.

10 years old, living with a non-relative foster family, and had been in foster care for almost three years.[16] Children in foster care face enormous challenges to getting the health care and education as well as special services they need to help them make a successful transition to adulthood.

Children of color are significantly over-represented in foster care. Although Black children make up 16 percent of the nation's children, they make up 35 percent of children in foster care. Children of color enter foster care at higher rates, even when their families have the same characteristics as comparable non-Hispanic White children and families.[17] On average, children of color also remain in foster care for a longer time than non-Hispanic White children and are less likely than non-Hispanic White children to be reunited with their parents; and the process of adoption for Black children takes longer than it does for White children. The over-representation of children of color is in part due to the economic inequities that persist in our society and the conscious or unconscious racial bias within the foster care system. As was discussed earlier, poverty can lead to child abuse and neglect and reduced resources to attend to parental substance abuse, and mental health and domestic violence problems, all of which bring many children to the attention of the child welfare system. In addition to addressing poverty, we must examine racial bias at different decision-making points in the child welfare system to craft appropriate responses.[18]

Too many children in foster care wait for permanent families after reunification has been ruled out. Approximately 119,000 children in foster care are waiting to be adopted.[19] A 2004 state-by-state analysis of adoptions of children in foster care found numerous barriers to providing these children with permanent families. They included: court and agency reluctance to terminate parental rights without an identified adoptive home; the absence of adoptive homes; inadequate child welfare case management, due in large part to large caseloads, high staff turnover rates, and incomplete case records; and the lack of court resources, most commonly including judges, attorneys, and administrative staff.[20]

Children Whose Parents Are Incarcerated

The incarceration of a parent, particularly a mother, also may bring children to the attention of the child welfare system. Today, women are the fastest growing segment of the U.S. prison population. Since 1995, the total number of female prisoners has grown by 48 percent.[21] The U.S. Bureau of Justice Statistics reports that 84 percent of women in federal prison and 64 percent of women in state prison reported living with their minor children before entering prison. Ten percent of children with mothers incarcerated in state prisons are in foster care; 80 percent are being cared for by relatives.[22]

The Bureau of Justice Statistics estimates that there are 1.5 million children who have parents incarcerated in state or federal prison or in jails.[23] Fifty-eight percent of these children are younger than 10 years old. Many of them are from poor or low-income families. The Urban Institute reports that 42 percent of incarcerated mothers in state prisons relied on public assistance prior to incarceration. More than half of incarcerated mothers had incomes below $600 in the month prior to arrest.[24] The loss of the incarcerated parent's income, however small, places an additional burden on grandparents and other family members who step in to care for children when the parents are incarcerated and who often face special challenges. Studies have documented that children with incarcerated parents, especially those already exposed to certain risk factors, are at a greater risk for emotional and behavioral difficulties, poor academic performance, juvenile delinquency, and substance abuse. They are five times more likely than other children to end up in prison themselves, and one in 10 will have been incarcerated before reaching adulthood.[25]

Poverty also frequently threatens the ability of parents who have been incarcerated to reunite with their children. Not only are the parents incarcerated for long periods (on average between 49 and 66 months), but once released they may have difficulty finding employment and housing, and penalties related to incarceration, such as denial of public assistance, may make it very difficult for a parent to secure necessary resources to care for a child.[26]

Children Raised by Relatives

When children's parents are unable to care for them, relatives often step in as caregivers. Substance abuse, untreated mental and emotional disorders, domestic violence, and incarceration are often the factors that interfere, at least temporarily, with parents' ability to raise their children. Many of the children being raised by grandparents and other relatives have special needs—often due to their parents' substance abuse, mental health, or domestic violence problems.

About six million children live in households headed by grandparents or other relatives and approximately 2.5 million of these children live in such households with neither parent present, essentially making these relatives responsible for raising the children.[27] About one in five of these children lives in poverty.[28] Even those families who are not living in poverty may need financial and other assistance to meet the needs of the children. Sometimes a grandparent who takes on the caregiving role is retired and living on a fixed income. Sometimes he or she is working, but needs help finding and paying for quality child care. Whatever the situation, relative caregivers almost never anticipated that they would be raising the children in their care.

Most relative caregivers do not receive financial help in raising the children in their care. For those who do, the two most likely sources of financial support are "child only" grants through the Temporary Assistance for Needy Families (TANF) program and foster care payments. About 450,000 children living with relatives rather than their parents get TANF child-only grants.[29] As many as 200,000 children living with relative caregivers are in foster care and may receive higher foster care payments (see Child Welfare – Table 1).

Youth Leaving Foster Care

Youth who leave foster care at various ages face special challenges. A 2005 report by Casey Family Programs and Harvard Medical School found that former foster youth who participated in the Northwest Alumni Study continued to face major challenges in the areas of mental health, education,

STORIES FROM THE STATES

Mary Conn

Mary Conn is a grandmother raising seven children and caring for her bedridden mother in Columbus, Mississippi. Mrs. Conn raised three children on her own and was not planning on taking care of seven more, but when all three of her children ended up in prison, she was the only one left to take care of the grandchildren. She recently suffered a heart attack and is scheduled for heart surgery to remove blockage. Despite her health condition and only receiving a disability check for her heart condition and $199 a month in food stamps for the children, Mrs. Conn draws strength from her faith and has managed to keep all of her grandchildren out of the foster care system and on the honor roll at school, while also taking care of her ailing mother. Grandparents like Mrs. Conn are doing their best against seemingly insurmountable odds, but they need more services and supports to provide a safe, stable, and permanent home for their grandchildren.

and employment.[30] The study, which examined the outcomes for 659 foster care alumni between the ages of 20 and 33, found that within the previous 12 months, more than half had at least one mental health problem, one in five had three or more mental health problems, and one in four alumni experienced post-traumatic stress disorder. One-third of the former foster youths had household incomes at or below poverty level, and one third had no health insurance.[31]

Research reveals that youths who age out of foster care at 18, 19, or 20, without families to return to and without being adopted, are especially poorly prepared to be self-sufficient. A national study of former foster youths interviewed 2.5 to 4 years after they left care found that nearly half of these youth left care without a high school diploma or GED.[32] A more recent study by the University of Chicago's Chapin Hall Center for Children of 600 youths aging out of care in Illinois, Iowa, and Wisconsin found that just over a third of the youth had a high school diploma or GED at age 19.[33] With findings of low educational achievement, poor mental health, and the absence of community supports, it is not surprising that youths exiting from foster care with no family find it challenging to find employment and maintain stable housing. According to the Kids Count 2004 Data Book, only half of the youths who aged out of the foster care system were regularly employed two to four years later.[34] Even when they do find employment, many youths do not earn enough to be self-sufficient. Another study by Chapin Hall on employment outcomes for youths aging out of care in three states (California, Illinois, and South Carolina) found that these youths have mean earnings below the poverty level and progress more slowly in the labor market than other youth.[35] Frequently youths who age out of care also are left without permanent family connections or a connection with a caring adult, making all the challenges they face greater because they have no one to turn to for moral and financial support when crises arise.

In 1999, Congress enacted the Foster Care Independence Act (FCIA), which established the John H. Chafee Foster Care Independence Program. It provides funds to states for supportive services to youth, including limited housing assistance, job training, education, and other independent living services. The Government Accountability Office (GAO) examined the impact the Chafee Program had on states' ability to provide independent living services and supports for youths in care who were expected to age out at 18 or older.[36] The GAO found that fewer than half of all eligible youths in foster care are being served by the Chafee program, with some states serving a greater proportion of

eligible youths than others. It reported that gaps in mental health, employment, and mentoring services, particularly in rural areas, have contributed to the low numbers of eligible youths being served. The lack of transportation and housing options and limited efforts to engage foster youths and foster parents were cited as additional barriers.

Children and Families with Special Needs

Children with Unmet Mental Health Needs

Nationally, one in five children and adolescents has a mental illness severe enough to cause some level of impairment. Yet only about one in three of them receives mental health services in any given year.[37] Poor children and children of color are overrepresented in the number of children with unmet mental health needs.[38] Studies also have shown that Black children in foster care are less likely than other children in care to receive specialty mental health services.[39]

In *Children in Foster Homes: How Are They Faring?* Child Trends reported that children in foster care are almost four times more likely to have special needs than children not in foster care, regardless of age.[40] Another national study of children ages two to 14 who are involved in the child welfare system, either at home or in foster care, found that nearly half had clinically significant emotional or behavioral problems but only about one-quarter received mental health treatment.[41] The lack of mental health treatment most often refers not only to the absence of services, but also to the lack of mental health assessments, appropriate referrals, and parent-focused interventions, and the lack of understanding by professionals of the unique mental health needs of these children.

Too frequently, children end up in the child welfare system or the juvenile justice system because parents cannot afford or cannot access the mental health services and treatment their children need. The Virginia legislature, for example, recently undertook an investigation of the reasons parents end up with no choice but to relinquish custody of their children to obtain necessary and appropriate mental health services. The study found that the problem is a direct result of inadequate access to and availability of prevention, early intervention, and intensive mental health and substance abuse treatment services for children and adolescents. The state's own analysis of the problem found that 23 percent of the 8,702 children in the state's child welfare system were placed in care solely to obtain medical treatment. Barriers to appropriate mental health services included the family's financial status, a fragmented system of care, lack of clear authority for providing children's mental health services, educational restrictions, and the simple lack of services.[42] These findings were similar to those identified by the GAO in a 2003 report that conservatively reported that nearly 13,000 children were placed by their parents in the child welfare or juvenile justice systems so they could get treatment.[43] The President's New Freedom Commission on Mental Health also called for the elimination of this problem.[44]

Children with Parents with Mental Health and Substance Abuse Problems

The lack of services and treatment for parents' mental health and substance abuse problems can create family crises and bring children to the attention of the child welfare system. It is estimated that nine percent of the children in the U.S live with at least one parent who abuses alcohol or other drugs.[45] An estimated 40 to 80 percent of the families who come to the attention of the child welfare system have substance abuse problems.[46]

Research indicates that the risk of women's drug use is heightened by negative experiences or stressors such as poverty, racial bias, sexual and/or physical abuse, domestic violence, and mental illness.[47] In the case of mothers who abuse substances, the effects of the cycles of poverty and violence are strikingly clear. The National Women's Study found a correlation between the number of violent assaults a woman sustains in her lifetime and the severity of her drug or alcohol dependency. In addition to violence and poverty, untreated mental illness can often lead to substance abuse. At least half of women in drug treatment will be diagnosed with a mental disorder such as depression, and for

many of these women, mental illness predates drug use and is the result of violence in their lives.[48]

Research also indicates that women living in low-income families are more likely than other women to be exposed to high-stress living conditions that can contribute to depression. Recent research has found that changes in women's income and poverty status were associated with changes in women's depressive symptoms in the first three years after a child's birth.[49] Studies indicate that maternal depression is associated with a host of adverse outcomes in infancy, such as language and cognitive problems, insecure attachment, social interactive difficulties, and behavioral problems.

Studies that consider the links between maternal depression, poverty, and child development have shown that when maternal depression is present, the adverse effects of a mother's depressive symptoms can be buffered by greater resources—social, educational, and material.[50] However, a lack of parental resources is a major barrier to parents seeking treatment for mental illness and substance abuse. A recent Substance Abuse and Mental Health Services Administration (SAMHSA) study shows that 51.4 percent of adults with mental health problems reported not receiving treatment because the costs of such treatment were too high; 33.2 percent of adults who reported having substance abuse problems did not seek treatment because of barriers related to cost.[51]

Homeless Families

Families are the fastest growing segment of the homeless population, now accounting for 40 percent of the nation's homeless.[52] Homelessness and entry into the foster care system relate to similar challenges: domestic violence, substance abuse, and unmet mental health needs. Factors leading to homelessness are further exacerbated by poverty and the absence of adequate housing options. Homelessness puts children at a particularly high risk for being in foster care. A 2003 study in Philadelphia found that a group of homeless mothers was about seven

New Special Education Help for Children in Foster Care

A large number of children in foster care have special needs and 30 to 40 percent of them are receiving special education services. Although federal law protects the rights of children with disabilities, including children in foster care, to receive a free and appropriate education, there are many characteristics of foster care that make it challenging for these children to access special education services. Many children in foster care move frequently and often with little notice. As children move from home to home and school to school, too frequently their records don't follow them and their special needs go unnoticed. The cost of failing to address such challenges for these vulnerable children is high. Children who lack the special services they need often drop out of school or fall behind in a way that makes dropping out more likely.

Congress addressed the needs of these children in its reauthorization of the Individuals with Disabilities Education Act (IDEA) in December 2004. The revised Act includes several changes intended to address the special needs of children who are homeless or who are wards of the state. In particular, it recognizes that children who are homeless or are in foster care are a highly mobile population and provides protections to ensure the timely transfer of information as children in care move from home to home and school to school. It also emphasizes the importance of timely appointments of surrogate parents for children in care who do not have parents to advocate on their behalf, and adds that the judge overseeing the child welfare case may appoint the surrogate.

times more likely to be involved in the child welfare system than mothers without housing problems.[53] The study also found that homeless mothers had an increased risk of child welfare involvement compared to low-income mothers who were not homeless.[54] A 2004 analysis of homeless children in New York City found that 24 percent had some involvement in the child welfare system[55]; 40 percent of those children who stayed in shelter care for more than 90 days entered the child welfare system.[56]

Once they enter foster care, children from families with housing problems are more likely to stay in care for longer periods of time.[57] Lack of adequate housing can be a barrier to timely reunification. It is a sad irony that foster care also can increase a young person's risk of homelessness in adulthood. A recent study of foster care alumni found that 22 percent were homeless for one or more nights within a year of being discharged from care.[58] The Chapin Hall Study referred to earlier also found that of the youth who were 19 and no longer in care, 14 percent had been homeless at least once after being discharged from care.[59]

Promoting Effective Strategies for Children and Families in Crisis

Whatever the connection between poverty and child abuse and neglect or related risks to children, the way to help children most often involves helping their parents address a set of challenges. There are some cases of severe abuse where immediate termination of parental rights may be the only safe alternative for a child, and sometimes children must be removed from their homes and placed in foster care while problems are addressed in order to ensure their safety. However, in many cases, as described in the following paragraphs, children can be kept safely at home *if* the services the family needs are available, and the child's basic needs can be met. Sometimes this means linking families to services to help address their need for child care, food, health care, and housing, as well as their physical, emotional, social, educational, and developmental needs.

To address the needs of the whole child, not just physical safety, the child welfare system needs to engage families early. It must be able to help each family connect with the continuum of resources and supports that a family needs to care for its children. The special challenges of substance abuse, mental health, and domestic violence problems must be addressed. The point is not to excuse the parent's behavior, but to respond in a way that addresses the underlying problems so that the child's need for a safe, nurturing home can be met. When children cannot be kept safely with their families, there must be attention to providing quality temporary care in the most family-like setting appropriate for the child and to ensuring that children are moved to permanent families in a timely fashion, either returning home to their parents or to live permanently with adoptive parents or their legal guardians, who often are grandparents or other relatives.

Numerous efforts are underway across the country to prevent child abuse and neglect and to keep children in safe, permanent families. A few of these efforts being conducted by public agencies are highlighted below. Some of these are targeted to low-income families, but even when they are not, many of the children served are often from low-income families. This sometimes creates special challenges, especially for treatment programs, because they must address basic subsistence needs for families before they can turn to their specific need for treatment.

Promoting service approaches like those described below, on the scale that they are needed, is extremely challenging, especially given the lack of resources available to address even families' basic needs, much less their need for intensive specialized treatment. Our ability to help children and families in crisis depends in large part on our willingness as a nation to invest in the income supports, health care, early childhood education, education, and youth development activities identified in the other chapters in this report. Such investments could go far in reducing child maltreatment, but they are not sufficient.

There also is a need for expanded capacity to invest in prevention, specialized treatment, new permanency options for children, and a quality child welfare workforce. Unfortunately, however,

federal, state, and local investments for children in foster care exceed investment in prevention by a ratio of three to one (see Figure Child Welfare – 2).[60] While the country professes to value its children, four out of 10 children who are abused and neglected get no treatment at all, and many others get far less than they need.[61] Yet to give each of these children just a basic service such as home visiting would cost only $1.1 billion a year, less than one day of military costs in the President's fiscal year 2006 budget. As struggles to make better policy choices for children continue, there are positive efforts for children being undertaken across the country.

Supporting Families and Preventing Crises

In seeking out ways to support families early on, it is important to look at the range of activities that can help promote protective factors for children. All of these approaches involve engaging and supporting families, where possible, in ways that build on their strengths and increase their competence to nurture and protect their own children and keep them out of the child welfare system.

Home Visiting

The Task Force on Community Preventive Services of the federal Centers for Disease Control and Prevention identifies home visiting programs as highly effective in preventing child abuse and neglect in families at risk for maltreatment, including disadvantaged populations and families with low-birthweight infants.[62] There are several different models of home visiting programs that offer a variety of supports to families with differing needs, but they all seek to get help to families when children are first born. In a number of communities and states, different programs are used for different groups of children and families, depending on the best match between families' needs and programs' strengths.

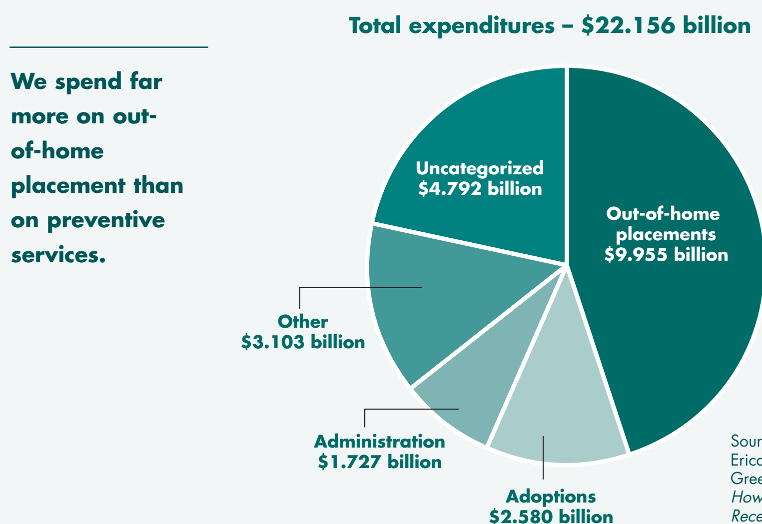
The Nurse-Family Partnership (NFP) is the home visiting program with the longest track record and most extensive evaluations.[63] It is designed to serve low-income, at-risk pregnant women bearing their first child to improve pregnancy outcomes, to promote children's health and development, and to strengthen families' economic self-sufficiency. The program consists of intensive and comprehensive home visitation by

Child Welfare – Figure 2

State Child Welfare Expenditures, FY 2002

Total expenditures – $22.156 billion

We spend far more on out-of-home placement than on preventive services.



Source: Cynthia Andrews Scarcella, Roseana Bess, Erica Hecht Zielewski, Lindsay Warner, and Rob Green, *The Cost of Protecting Vulnerable Children IV: How Child Welfare Funding Fared During the Recession* (Washington, DC: The Urban Institute, 2004), Table 2. "Other" includes preventive and other services.

bachelor degree-level nurses throughout a woman's pregnancy and continuing through the child's second birthday. The nurse works with a mother on health-related behaviors during pregnancy, including cigarette smoking, drinking, and drug use, provides a comprehensive educational program about the physical and emotional needs of her child, and helps the mother develop and clarify life choices with respect to family planning, educational achievement, and workforce participation. NFP programs have been replicated in more than 263 counties in 20 states, with statewide implementation in Colorado, Louisiana, Pennsylvania, and Oklahoma.[64]

Some states have used home visiting programs to target low-income families. Minnesota, for example, offers home visiting services to families eligible for Temporary Assistance for Needy Families (TANF). Operated by the Department of Health, a public health nurse and trained home visitor offer families health promotion, screening, and assessment services as well as links to community resources.[66] In Ohio, Early Start provides home visiting at the county-level for families with children under age three who are in the TANF program or are at risk of child abuse, neglect, or developmental delay. This voluntary program consists not only of home visits, but also includes service coordination and case management, individualized family service plans, family support services, child health and developmental screenings, and referrals to other service providers, including a primary health care provider. Visits are conducted by professional or paraprofessional nurses on a weekly basis following the birth of the child and are gradually reduced to monthly visits until the child turns three. Parents also may attend groups or classes on child development, health and safety, effective parenting, and nutrition.[67]

Nurse-Family Partnership Yields Positive Outcomes

A 15-year follow-up study of Nurse-Family Partnership use in Elmira, New York, showed that low-income and unmarried women and their children who were provided a nurse home visitor had 79 percent fewer verified reports of child abuse or neglect; 31 percent fewer subsequent births; an average of over two years' greater interval between the birth of their first and second child; 30 months less receipt of Aid to Families with Dependent Children; and 44 percent fewer maternal behavioral problems due to alcohol and drug abuse. In addition, the cost of the program was recovered by the first child's fourth birthday, and substantial savings to government and society were calculated over a child's lifetime. Although the actual cost of the program varies in each community, the average annual cost to implement the Nurse-Family Partnership is roughly $3,000 per family, with higher costs during the initial two years of the program.[65]

Early Care and Education

Quality early care and education programs also can play an important role in strengthening families and preventing child abuse and neglect. The Center for the Study of Social Policy (CSSP) has compiled a compendium of effective early childhood programs and identified the essential components of the programs that promote child protection. CSSP makes a strong case that early care and education programs are in a unique position to identify and provide low-income families with the concrete resources they need to prevent the ultimate occurrence of child abuse and neglect.[68] It notes that family poverty is the strongest factor known to be correlated with child abuse and neglect and a family's access to necessary material resources is among the strongest protective factors to prevent child maltreatment.[69]

There are a number of early care and education programs throughout the country helping to prevent child abuse and promote healthy child development. Programs such as Albuquerque's Child Development Program, San Francisco's Early Childhood Mental Health Program, and the Dorchester (Massachusetts) Haitian Center Early Care and Education Program creatively blend early childhood education, child care, mental health,

family support, and education services to provide for the comprehensive needs of low-income families early on, before crises begin or escalate.[70]

The Family and Children's Educational Services (FACES) program in Brunswick, Georgia, is another quality comprehensive early childhood program. FACES offers families in an urban low-income community access to a range of prevention and support services to advance the educational and personal achievement of their children. The program collaborates with Healthy Families, United Way/Family Connection, Child Care Resource and Referral, Zero to Three, Head Start, government agencies, and private partners to focus on early childhood as an entry point for addressing a host of social issues. It uses resource coordinators in each of its early childhood classrooms to identify child and family challenges, such as poverty, and quickly connect families with appropriate services. It has a flexible discretionary fund of about $2,000 that allows it to pay for small but significant resources that can often mitigate some of the stresses of poverty that increase the likelihood of child neglect. Resource coordinators and classroom staff also conduct numerous home visits throughout the year to build relationships with parents, observe the home environment, and support families in crisis. A cornerstone of the FACES home visiting program is its flexibility. Staff work to provide whatever the families need.[71] Local research shows that 64 percent of children who participated in FACES were above average in kindergarten readiness and 68 percent were above average in first grade readiness. The FACES program won the Doris Duke Charitable Foundation "Exemplary Program Award" in 2003.[72]

Homelessness Prevention

Efforts to prevent family homelessness are critical to breaking the cycle of poverty, homelessness, and family involvement in the child welfare system. Providing early supports for youth aging out of foster care also helps prevent them from ending up on the street without a place to live. Homelessness prevention activities can help prevent foster care placements and also help reunify children already in foster care with their families. Housing for these families is a good investment. The cost of keeping children in an average size family in foster care is $47,608 annually.[73] The average cost of permanent housing and supportive services for a family of the same size is only $13,412.[74] Efforts to prevent homelessness often involve partnerships between multiple child- and family-serving agencies.

The Connection Inc. is a collaborative effort of the Connecticut Human Service and Community Development Agency and the Connecticut Department of Children and Families (DCF). It provides supportive housing for families who have come to the attention of the child welfare system or are in the system and are seeking help to stay together or to have their children returned from foster care. Parents are provided scattered site housing, employment services, a little cash assistance to get started, and intensive home-based case management and "wrap around services" to help them achieve a permanent, safe, stable, and nurturing family environment for their children. On average, a case remains open for a period of one year after the family is housed. A family graduates from the program when a parent has complied with the goals and objectives of his/her treatment and care plans, has a subsidy or income adequate for housing payments, has achieved family preservation/reunification, and has demonstrated an ability to manage their household independently.[75]

In Mesa County, Colorado, the Department of Human Services and the Grand Junction Housing Authority have a Housing Advocate Program. It provides case management and advocacy to low-income families for whom inadequate housing is a significant factor in the possible placement of the child in foster care or in the delay of reunifying a child in care with his or her family. Mesa County Human Services initiates referrals to the Family Unification Program, which provides Section 8 housing certificates to these families. The Housing Advocate provides a range of services, based on the families' individual needs, that include home visits, referrals to services within the community, mediation and negotiation services for disputes with landlords, as well as education programs on a variety of topics such as budgeting and credit. Colorado's

Family Unification Program also provides 18-month Section 8 housing vouchers to assist youth aging out of foster care who do not have adequate housing.[76]

Engaging Families Early

Efforts to engage families and the broader community early when children first come to the attention of the child welfare system help to maintain family connections and maximize opportunities for prompt permanency decisions for the children. These family connections are especially important given that the vast majority of these children end up remaining with or eventually returning to their parents. For example, of children exiting care in 2003, 55 percent were reunited with their parents or other relatives. Children who remain in care until age 18 or older and then leave care without being adopted also often reconnect at some point with family members. Given the expedited timetables for permanency planning in federal law, early engagement of families helps to ensure that parents understand their responsibilities and opportunities to reunite with their children. It also provides the chance for staff to assess parent-child interaction and the likelihood of reunification.

Family Group Decision Making

Family Group Decision Making (FGDM) is one approach used to engage families (parents as well as other relatives) early in decision making about the child. Family Group Decision Making views families from a strengths-based perspective and gives them the opportunity to create their own solutions for permanence and safety for their children. This approach recognizes that parents are often the best experts as to their children's needs and should be engaged in the planning for them. FGDM allows for cultural sensitivity by calling on families to identify issues and plan a response within their own familial, cultural, and community context. FGDM is also helpful for families in poverty. Poor families can request the various services they need to support their children and also help in accessing those services and sustaining family functioning.[77]

Training on FGDM in the United States started nearly 10 years ago, and the model has since been adapted and implemented in numerous states, counties, and agencies from Arizona to Pennsylvania to Rochester, Minnesota. The District of Columbia's child and family services agency recently began using a hybrid of FGDM/ Family Team Meetings that it believes will be useful to low-income families and families of color. The Family Team Meetings are initiated in the first 72 hours after a child is removed from his/her home and before a court hearing. The plan for the family is made by the parents, the child (if the child is determined to be developmentally and emotionally ready to participate), relatives, the caseworker, social service providers who have worked with the child, and any other adult who is identified as being connected to the child. The individualized plan that the family team comes up with and agrees upon is then presented to the Court for approval.

The District of Columbia aims to use Family Team Meetings to engage more families early in the decision making process around critical issues such as a child's placement and to empower families with resources so that crises and/or potential crises may be identified, treated, or averted. Preliminary data show that in 42 percent of the 120 team meetings held in the District of Columbia between January and April 2005, kin stepped forward as willing to care for the child when a child was at risk of being removed from the home.[78]

Family to Family

Other approaches used to engage families and communities also build on family strengths and seek to find ways to increase the understanding of the broader community about the problems facing children and families in crisis. The Family to Family initiative, designed in 1992 by the Annie E. Casey Foundation, offers the opportunity for child welfare systems to reconceptualize, redesign, and reconstruct their foster care systems to achieve a set of goals that will better support children and families. Family to Family sites strive to establish high quality services and supports to help families stay together, develop a network of family foster care

that is neighborhood-based, involve kinship families, foster families, and birth parents as team members, and create community partnerships to increase the capacity of the community to address the needs of families involved in the child welfare system.[79] There are approximately 40 Family to Family sites in 16 states. Each site's approach varies with community needs; however, all employ four core strategies: recruiting, training, and supporting families who can care for children and families in their own neighborhoods; building community partnerships; making decisions as a team; and using evaluation results and data to inform practice.[80]

Family to Family in Wayne County, Michigan, first got the community engaged by documenting the large numbers of children who were being removed from their homes by the public child welfare agency and sent to suburban communities. The high-poverty neighborhood in which Family to Family began understood the impact on the local school system when 100 children were sent out-of-county and more than half a million dollars in resources were lost to the community. There was a recognition that the children belong to the community. Now the county makes no removals without team decision making sessions, at which the family tells of their crises and children 10 and older also are at the table. Eighteen full-time facilitators, hired with funds previously used for foster care, guide this process. More than 70 percent of the children referred for removal from their homes to date have remained at home or with relatives.

Special efforts are made to find foster care placements for children in the community. Once located foster parents must meet with birth parents within a week after children are removed from their home, and support groups are offered for all parents. A parent advocate program is beginning so that parents whose children previously have been involved with the child welfare system can help parents whose children are currently involved navigate the multiple systems, including the courts, to assist in reunification efforts. Teen advocates are trained and available to help when older youth are at the table and need peer support. Two hundred community representatives also have been trained to advocate for the community and its families through the placement process. Family to Family has now been implemented in 27 counties in Michigan and will go statewide in 2007.[81]

Engaging Black Churches

In 2002, in Wake County, N.C., Black children accounted for less than 25 percent of all children in the county, yet they comprised 79 percent of children in foster care in the county. Because Wake County did not have enough foster homes, 20 percent of children entering foster care were placed out-of-county.[82]

Wake County's Family to Family initiative focuses on keeping children safely in their neighborhoods and close to their birth families and communities. The county has formed a partnership with 33 local churches to help recruit and support foster families. Churches help reach out to potential foster families, support foster families and children, provide space for foster parent training, and work with the child welfare agency to support families at risk so their children will not come into care. Each church, through a liaison, submits a plan of how it will contribute to the larger partnership.[83] The number of churches involved in the partnership and the depth of their involvement has increased each year and communities have noted that different denominations and communities of faith have been united in this common goal of improving outcomes for children.[84] Initial results are very positive. The percentage of foster children who are Black has decreased from 79 percent to 65 percent , and the percentage of children entering foster care who are placed outside the county has decreased from 20 percent to 7 percent.[85]

Contact with Incarcerated Parents

Incarcerated parents raise special challenges for the child welfare system when it is trying to expedite permanency decisions for children in foster care.

The Annie E. Casey Foundation, in collaboration with the Women's Prison Association & Home, Inc., conducted a needs analysis in Maryland, New York, and Alabama to assess supports given to children in out-of-home placement whose parents were incarcerated. Their findings revealed the need for better coordination between the child welfare and criminal justice systems, more sufficient support for incarcerated parents, regular child visits, and enhanced efforts to reunify formerly incarcerated parents with their children.[86]

New York City's Administration for Children's Services Division of Family Permanency, in collaboration with its Department of Corrections, established the Children of Incarcerated Parents Program (CHIPP).[87] CHIPP is designed to provide services, training, and technical assistance to the courts, advocates, and child welfare professionals as well as children and families when a child welfare case involves incarcerated parents. The hallmark of the CHIPP program is its coordination of weekly (to Rikers Island in New York City) or monthly (to prisons in upstate New York) child-parent or sibling visits. CHIPP also provides training and technical assistance to caseworkers and other service providers on case-specific and criminal justice-related issues as well as on the needs of children with incarcerated parents.[88]

Meeting the Special Needs of Children in Foster Care and Their Families

For children who must be placed in foster care, there must be continuing attention to their needs and the needs of their families so timely decisions can be made about reunification or alternative permanency plans. Families struggling with substance abuse and mental health problems pose special challenges for the child welfare system. The most effective services for these families often involve cross-system partnerships and are family-centered, strength-based and comprehensive.

Comprehensive Family Treatment

As many as two-thirds of parents whose children are in foster care require substance abuse treatment, but only about one-third of these parents receive the services they need.[95] Comprehensive family treatment can help prevent child abuse and neglect and often allows for children and families to stay together or to be reunited. Positive outcomes are dependent in large part on getting substance abuse treatment and child welfare agencies, and often mental health agencies as well, working together to assist families in obtaining the help they need.

Such efforts have been undertaken in several states. The Arizona Families F.I.R.S.T. (AFF) program is administered by the Department of Economic Security in partnership with the Department of Health Services to promote permanency for children and stability in families, protect the health and safety of abused and/or neglected children, and promote economic security for families. This is accomplished through the provision of family-centered substance abuse and recovery support services to parents whose substance abuse is a significant barrier to maintaining or reunifying the family.

Arizona Families F.I.R.S.T. provides an array of structured interventions to reduce or eliminate abuse of and dependence on alcohol and other drugs, and to address other adverse conditions related to substance abuse. Interventions are provided through contracted community providers in outpatient, intensive outpatient, and residential settings. AFF includes an emphasis on face-to-face outreach within 24 hours; ongoing strategies to keep clients engaged in treatment; concrete supportive services such as child care, transportation, and housing; and an after-care phase to manage relapse occurrences. Some residential providers also allow children to remain with their parent during treatment. Essential elements, based on family and community needs, are incorporated into the service delivery, such as culturally responsive services, gender specific treatment, services for children, and motivational interviewing to assist the entire family in its recovery. More than 80 percent of the families served are poor enough to qualify for the state's Medicaid program and often require comprehensive services to address the multitude of stressors in their lives.[96]

Evaluations of the AFF programs have shown positive results. Nearly half of the referrals made to

Pulling It All Together to End Poverty and Family Violence

El Paso County, Colorado, has implemented a particularly comprehensive vision for providing families the continuum of services they need to care for their children. However, El Paso County is not alone. A number of counties in California are trying to implement similar models tailored to their specific populations and resources. North Carolina, Arizona, and Alabama also are trying similar approaches on a statewide basis, although some efforts are still in their infancy.

In El Paso County, the Department of Human Services integrated its cash assistance and child welfare programs in order to end both poverty and family violence. County leaders, administrators, front line workers, private providers, and families came to understand that the two problems were inextricably linked and set out to design supports and services that would tackle both problems simultaneously.

No matter what door the family knocked on and no matter how the department learned about the family, services would be provided that met the particular needs of that family. The department's philosophy rested on the premise that families have many strengths, in addition to needs, and that often they know best what is needed to make things work.

Together, county officials, private providers and families developed a comprehensive assessment of families and their needs. Based on this assessment, the county offers information to families about cash assistance, Medicaid, Food Stamps, the Low-Income Child Care Program and other services to help *each family* design a plan to meet its specific needs. Staff work with families to continually reassess the plan and adjust it to meet their changing needs; they are accessible to families in schools and community centers.

El Paso County recognized early on that having a dedicated and talented work force was critical to implementing its plan of action. It uses creative training techniques to help staff better understand the challenges families face. For example, in one exercise new workers are given a set of instructions (e.g., pay a phone bill, get utilities restored, visit a food bank, locate affordable housing) and a 20-pound bag of flour (to simulate a small child) that they must carry with them as they visit various agencies to try to get help.

El Paso County also developed a new way to respond to reports of child abuse and neglect. Rather than "investigate" and determine whether the report could be proven, the department uses

its family assessment process in less serious cases to identify families' needs and then to respond appropriately with the services needed for them to care for their children. In 2003, about half the cases were formally investigated and about half used the less adversarial assessment process.[89]

"Direct Link" is another resource developed by El Paso County. It focuses on parents with substance abuse problems whose children are at risk of abuse and neglect and entry into foster care. The program seeks to provide intensive treatment to parents in their own homes and in the community. A team comprised of child welfare, mental health, substance abuse treatment, and cash assistance staff meets with each family in the program to develop and continually revise, *with that family*, a plan that addresses the family's needs. Often the plan includes providing child care for the children during the day while parents participate in treatment, attend job training or school, or receive parenting education or counseling. The plan may involve home visits in the evening and random drug screens. The plan also is likely to include enrolling the family in Medicaid or SCHIP, Food Stamps, or programs needed to help the parents get back on their feet. The local court has partnered with Direct Link to create a Family Treatment Drug Court. Workers report that families are more engaged in and compliant with treatment objectives, and parents report feeling respected and understood.[90]

The department early on also designed a set of flexible services and financial supports for relative caregivers who stepped in to care for children before the child welfare agency became involved. The goal is to keep these children out of foster care when possible. To help achieve this, the county offers financial assistance up to the level of assistance a caregiver could receive in the foster care program, on an individualized basis, according to the particular needs of the family. For example, a grandmother approached the department after her daughter dropped four grandchildren on her doorstep. The grandmother needed help finding a bigger apartment, getting some bunk beds, school clothes and supplies, and basically getting started caring for her grandchildren. The total amount of money she sought was $3,500—a huge sum compared to a typical cash assistance payment, but a miniscule amount in terms of what it would cost to put four children in foster care for a year. The department also provides other supports such as child care subsidies, respite care, support groups, and legal assistance to help the relatives care for their children. It offers this same help to relatives who have become legal guardians of children and are willing to care for them permanently when they exit foster care.

Pulling it all together is helping the children of El Paso County. Between 1998 and 2003, the number of children in out-of-home placements decreased by 22 percent, while the national number of children in foster care stayed about the same.[91] The number of children in more costly residential placements, instead of family foster homes, decreased by approximately 25 percent during this period.[92] In 2003, 82 percent of children involved with the child welfare agency were able to remain in their homes. El Paso County also exceeded the national standard for reunification—reuniting 81 percent of the children who return home within 12 months.[93] Yet the county continues to have a very low rate of re-occurrence of maltreatment after the department becomes involved. In 2003, the re-occurrence rate was 2.9 percent, less than half the national average of 7.6 percent.[94]

STORIES FROM THE STATES

Lou Della Casey

Research shows that when mothers enter quality, comprehensive family treatment programs for substance abuse they are better equipped to keep their families together. Mrs. Casey grew up in foster care herself and later lost parental rights to two of her children due to emotional and psychological neglect associated with her substance abuse problems. When Mrs. Casey realized she was pregnant with a third child, she says she thought, "Not this time…I was going to fight…I want to be a parent." When Mrs. Casey tested positive for drugs and alcohol during this pregnancy, she was referred to a program that enabled her to get the family treatment she needed so that she could be a good parent to her daughter. With the help of the program, Mrs. Casey is raising her young daughter and attending college part-time. She explains the difference this treatment has made in her life: "I have tools and resources now: a treatment program and Healthy Start…. They went above and beyond."

the agencies resulted in the client receiving treatment and the agencies were successful in keeping clients in treatment for the time allotted by the AFF. AFF program directors noted that families involved with child protective services where treatment was court mandated were motivated to stay in treatment to keep their children or to reunify with them. Among the 2,180 families participating in AFF who were referred by Child Protective Services (CPS) during fiscal year 2004, 96 percent had not experienced a subsequent substantiated report of abuse or neglect when their status was reviewed after six months of treatment.[97]

The Women's Treatment Center (TWTC) in Chicago, Illinois, is a public-private collaboration that provides a range of substance abuse treatment services to families. It includes comprehensive residential family treatment for mothers with children under five years of age, a special outpatient program for women referred by the Illinois Department of Children and Family Services who are in danger of losing custody of their children because of substance abuse, and a department of corrections program that offers parenting skills, case management, and recovery home services for inmates with less than two years to serve for nonviolent offenses. The comprehensive residential program offers recovering mothers a continuum of care, beginning with medically supervised detoxification and recovery. Mothers and their young children are then given housing and continued supports as they make the transition from residential treatment to outpatient care and beyond. This multi-level step- down program includes supervised housing for women as they continue outpatient treatment and education; and help finding employment and transitional housing for women who have completed treatment and are working or attending school. In 2003, TWTC directly served 1,200 women and 400 children.[98]

Mental Health Treatment for Parents and Children

The President's New Freedom Commission on Mental Health report emphasized the importance of expanding community-based treatment options for children and youths with serious emotional disorders. The commission supports programs that promote broad system improvements, a reduction in mental health problems, and heightened school performance and residential stability that can help reduce the number of children who must turn to the child welfare or juvenile justice systems for help when other services are not available. [99]

There are several states taking important steps to expand and improve treatment options for adults and children with mental health treatment needs. In New Mexico, for example, state agencies are working together to address the gap in mental health and substance abuse services. The New Mexico Behavioral Health Purchasing Collaborative has a legislative mandate to implement an integrated behavioral health service delivery system. This system will blend numerous funding streams and is expected to not only greatly improve the delivery and quality of services, but also to be cost-effective.[100]

Improvements in the child welfare system must address the mental health needs of parents as well as children. It is recognized in many jurisdictions, for example, that maternal depression brings some families to the child welfare system because mothers who are depressed and without appropriate treatment may not be able to ensure their children's needs are met. The Invisible Children's Project (ICP) is a nationally recognized program for parents with mental illness. ICP is run by the National Mental Health Association (NMHA) and funded by the Center for Mental Health Services (CMHS) in the Department of Health and Human Services.[101] In 2000, five pilot sites in New York, New Jersey, Virginia, and Tennessee were selected to survey the mental health needs in their communities, and a few states began ICP implementation. The majority of referrals to ICP come from child welfare authorities and sometimes ICP is mandated as part of a Department of Social Services state plan. ICP services are family-centered, strengths-based, and comprehensive. ICP offers 24-hour family case management services: referrals and links to community resources, crisis services and advocacy, and support services including respite child care, parenting education, access to financial assistance, and supported education and employment as well as supported housing services.[102] Case studies of the program in New York, conducted in 2002, found significant improvements in outcomes for families involved with ICP. At the time of the study, all children had returned home from state child welfare custody or remained home despite having been considered at-risk for removal.[103]

Providing Permanent Families for Children

Central to providing permanent families for children are processes and strategies designed to expedite the permanency decision making process in a thoughtful way. In some jurisdictions this is done with extra effort by the court, whereas in others the additional pressure comes from the agency or from advocates for children and families.

Reunification

A number of states have implemented programs that focus on the need for family reunification services from the time children enter care until after they return home. Low-income families face special barriers to achieving reunification because often they lack the services and supports necessary to reunify with their children even after the crises have subsided. The Allegheny County, Pennsylvania, Office of Children, Youth and Families has had success in keeping children out of foster care and safe with their families or returning them home quickly when it is safe to do so. From January 1997 to January 2004, Allegheny County decreased the number of children in out-of-home placement by 24 percent. The county reports a total of 902 children were returned home from foster care in 2003 and that their focus on reunification helped reduce the average length of time that children spend in an out-of-home placement by 30 percent between January 1997 and January 2004.[104]

Allegheny County's approach to reunification is integral to its anti-poverty initiative and commitment to achieving permanency for children. The county invests resources in prevention and in-home services, which include family support centers, crisis intervention services, treatment programs, and family group decision making. If children do need to enter care, the agency works hard to reunify them with their parents and/or with a relative. The county offers housing and transportation assistance, among other services, and contracts with agencies such as the Center for Family Excellence, which provides social services and legal counsel and facilitates family visits. Over 60 percent of the chil-

dren maintain some sort of family connection by being placed with a relative. Marc Cherna, director of the Allegheny County Office of Children, Youth and Families, explains they have been successful in keeping children with their families in safe and stable homes because they understand that "so many people come to our attention because of poverty." Allegheny County recognizes that family breakdown can be prevented or family reunification can be achieved if families are given the services and supports to meet their basic needs.[105]

Santa Clara County, California, has implemented an approach to achieving reunification that is focused solely on children who have been placed or are at risk of being placed in a residential facility because of their severe mental health and behavioral health disorders. This population of high-needs children usually has the most difficulty attaining reunification. The county, through its "wrap around" approach, seeks to help families and communities build a system of comprehensive services and supports upon which they and their children can depend in the future. A facilitator from the program works with a "family team" to develop a service plan and an emergency plan for emotional, psychological, and medical crises. The program also establishes a community team that includes representatives from the child welfare, mental health, juvenile probation, and education agencies to ensure that the wrap around services are administered properly. Although the services are only temporary, families are followed for some time after children have returned home. The cornerstone of the wrap around services' success is that they help families and communities build and enhance a system of care and support so that reunification is successful and children do not re-enter care. Of the 274 children discharged from the service programs, 82 percent were living with parents or other relatives, a high rate of reunification for this population of children who have many serious needs.[106]

Adoption

The focus nationally and in states on finding adoptive families in a more timely manner for children waiting in foster care also continues. Particular emphasis has been placed on increasing adoptions of older children in foster care. The Adoption Promotion Act of 2003, for example, seeks to increase the number of older children adoptions, as well as other adoptions. States receive an adoption incentive payment for an increase in the number of children adopted from foster care and the number of special needs children adopted from care. States then receive an additional bonus for an increase in the number of children over the age of nine adopted from foster care. In October 2004, close to $18 million was awarded to 31 states and Puerto Rico for their success in increasing the number of older children adopted from foster care.[107] The Administration for Children and Family Services also launched a Web site, www.adoptuskids.com, to help recruit and retain adoptive families and is now highlighting older children in its outreach efforts.

These older youth who are among the most difficult to place in adoptive families are also at a very high risk for living in poverty and becoming homeless upon leaving foster care if they aren't placed with families. You Gotta Believe!, The Older Child Adoption and Permanency Movement, Inc., is a program that seeks to prevent homelessness by finding permanent foster families or legal adoptive homes for teens and preteen children in foster care. It places youth ages 10 and older, who are free for adoption, with parents who are willing to adopt, and those youth who may not be free for adoption but upon discharge will have no home to which they can return with foster parents who are willing to offer the youth a life-long family. Recruitment is conducted through television and radio programs and community-based education sessions. Case workers have found, however, that the youth themselves are often best equipped to identify adults with whom they have had positive relationships. Case workers reach out to these individuals, be they former teachers, case workers, or relatives. Training is offered in six metro areas and is conducted on a rolling basis so that interested parties can begin the certification process immediately. It consists of a 10-week program that emphasizes the importance of permanency for older youth. You Gotta Believe! expects to place between 40 to 50

youth in New York this year. Its influence extends beyond New York as staff speak across the country about the importance of permanency for older children and its effectiveness in preventing homelessness and other negative outcomes for youth.[108]

Subsidized Guardianship

For children for whom returning home or adoption is not possible, permanent placement with grandparents or other relatives who are legal guardians is another extremely viable permanency option. In fact, a number of states have developed subsidized guardianship, programs that offer subsidies and ongoing services to children exiting foster care into legal guardianship and a few states have used these subsidized guardianships to prevent children from entering foster care unnecessarily in the first place. Thirty-five states and the District of Columbia now have subsidized guardianship programs.[109] Most of these programs are funded totally by state and/or local dollars. Even though legal guardianship was recognized as a permanency option in the federal Adoption and Safe Families Act, it was not accompanied by federal financial assistance as adoptions are. There are, however, nine states that have received waivers from HHS to use federal foster care funds under Title IV-E of the Social Security Act to provide subsidies to some legal guardians.

California's Kin-GAP Program provides kinship caregivers who are unable to adopt the children in their care with another financially supported option for permanency. In order to be eligible, the child must be an adjudicated dependent and have been in foster care with the relative for at least 12 months, and reunification and adoption must have been ruled out. Subsidies are equal to foster care payments minus the cost of services. Although the child welfare system maintains minimum contact through annual visits, this option provides many children a more permanent placement. An evaluation of the program 18 months after it had been implemented found that 6,701 children had exited foster care to Kin-GAP. More than 60 percent of these children had been in care for more than three years and for almost three-quarters of them the kin placement was their first or second placement in foster care.[110] Building on the experience of California and other states, a bipartisan group of Senators introduced the Kinship Caregiver Support Act, which would allow all states to use federal foster care dollars for subsidized guardianship programs.[111]

Kinship Navigator Program

Another key to preserving placements with kin is getting the relative caregivers information about essential services and supports that exist for which the children are often eligible. For example, about 20 percent of relative-headed households live in poverty, and many of the children in these families are eligible for federal and state benefits such as TANF, the State Children's Health Insurance Program (SCHIP), Medicaid, and food stamps. Many caregivers, however, are not aware of the resources available to the children and sometimes themselves. At least two states, Ohio and New Jersey, and several others on a pilot basis, have made special efforts through Kinship Navigator programs to ensure that kin, at a minimum, receive the services, supports, and benefits for which they are eligible. Ohio's Kinship Navigator Program helps relative caregivers "navigate" their way through government systems and find local supports and resources. The program works to educate kinship caregivers about a wide variety of available community services and assist them in getting access. It also offers a minimum of core services, including information and referral and access to legal services, child care services, respite care, training, and financial services. In 2002, the Kinship Navigator Program served at least 4,000 kinship families with 6,000 children.[112] The Kinship Caregiver Support Act previously mentioned would authorize federal funds to expand navigator programs.

Other Post-Permanency Supports and Connections

Children who have been returned home, adopted or placed in a guardianship arrangement

without access to a navigator program sometimes experience instability because families do not continue to get the supports they need. Post-adoption and other post-permanency services help to assure support for families and also can help families connect with available treatment. They are particularly important for children who have a history of child abuse and neglect, are older when they leave care, have experienced multiple foster care placements, and/or have special needs and who require more costly services and supports. Casey Family Services, which serves about 4,000 children on the East Coast, has found that the availability of post-adoption services may actually help decrease the number of children waiting in foster care for adoption as access to these services is a determining factor in prospective parents' decision to adopt.[113]

To promote post-permanency services, Oregon's Department of Human Services helped establish the Oregon Post-Adoption Resource Center, which provides free-of-charge information, referrals, and technical assistance to families across the state who have adopted a child from foster care. Welcome packages are sent to parents who have adopted children, describing services available through the center. Other services include training for eligible families, a lending library and resource center, a comprehensive Web site with references and announcements, assistance in securing support for adoptive parents, a newsletter, and referrals to community services for children.[114]

Illinois' Adoption Project and Guardianship Preservation Services offer a range of services to support a child's placement in either adoption or guardianship as soon as the adoption or guardianship is finalized. The state assesses the level of care necessary for each family and takes into consideration the special education needs of children. Services to families statewide include 24-hour crisis intervention; comprehensive assessments; intensive therapeutic interventions focusing on the dynamics of adoption and the impact of past loss and trauma on present circumstances. They also include support groups; cash assistance to help families purchase needed items or services, such as transportation to support group meetings, and fees for specialized camp; and advocacy and referral, including education advocates to support the families.[115]

Ongoing support for children who are reunified with their families has not been as forthcoming, but is very much needed. Some programs such as, Connection Inc., described on page 126, that provide housing assistance to help parents reunite with their children, do continue to provide supportive housing after the child welfare agency's involvement with the family ends. There are also states, like Michigan and North Carolina, that have defined their efforts at family preservation to include ongoing supports for families after children are returned home. In Michigan, the Family Reunification Program provides intensive services that are designed to improve child safety, reduce length of out-of-home stay, and reduce re-entry into care. The agency conducts an assessment of the family's needs and provides strengths-based services, including individualized therapy, parenting skills classes and family workshops. The agency also provides case management, and is available 24 hours a day to children and their families.[116]

Recently, there has been more attention at the federal, state and local levels to provide ongoing supports for youth who age out of foster care without being reunited with their families. Since 2003, the Chafee Education and Training Voucher (ETV) Program has offered tuition assistance payments of up to $5,000 a year to help with the costs of higher education. HHS distributed $42 million to states in FY 2003 and $44 million in FY 2004. The funds are available for young people who age out of foster care or were adopted from foster care after their 16th birthday. Funds may be used for tuition, school supplies, computers, and approved living expenses including rent, health care, and child care. Several states, including Alabama, Arkansas, Colorado, Indiana, New York, North Carolina and Ohio, have partnered with the Orphan Foundation of America (OFA), a private non-profit that offers scholarships, financial aid assistance, and mentoring programs for youth aging out to administer their ETV programs and ensure a comprehensive approach to getting youth the help they need. OFA looks at every applicant individually, assessing their tuition needs and the cost of daily living, and each student gets the ETV disbursement that best suits these needs. The OFA also provides three gift boxes a year through the

Care Package Program and offers group and individualized online mentoring.

In order to successfully transition into self-supporting adulthood, youths need not only systemic supports, but also permanent connections with caring adults. Several jurisdictions have programs underway to enhance such connections. In Roxbury, Massachusetts, the Department of Social Services, in collaboration with Children's Services of Roxbury's Massachusetts Families for Kids program, is working to help adolescents in the foster care system develop lifelong family relationships before aging out of care.[117] The youth-driven, strengths-based, and culturally competent program identifies, locates, and consults with individuals willing and able to make a commitment to a teen. Specialized adolescent recruitment develops potential permanent placement and/or lifelong family ties for youth who do not have permanent connections.

New York City's Administration for Children's Services also has developed a policy aimed at facilitating permanency options for older youth who end up aging out of foster care. The policy seeks to connect every youth on an independent living track with a caring adult willing to serve in a parental capacity. Child welfare workers are trained to identify and reconstruct relationships that adolescents may have had with a caring adult in the past. New York City's policy also restricts the use of independent living as a permanency goal and emphasizes that every child needs permanent family connections.[118]

Recommendations for Moving Forward

The goal for 2006 must be to keep all children safe in nurturing, permanent families and communities. We must build on what we know about the strengths and needs of children and families in crisis and how to prevent and treat the child abuse and neglect, domestic violence, substance abuse, and mental health problems that threaten children's safety and well-being. Partnerships are needed that link multiple child serving systems, agencies, both formal and informal, and parents, grandparents and other relatives, youth, foster and adoptive families, community and business leaders, faith-based organizations, and advocates for children and families—they all have a role to play. Public child protection agencies, courts and other service providers also must be willing to do business differently. Policy, practice and program activities should be focused on the following:

Promoting community child protection strategies that keep children safe and support families.

Keeping children safe must be everybody's business. Child protection agencies should partner with families and communities and use new strategies that protect children and build on family strengths.

- Provide incentives to states and communities to encourage the use of family and community engagement strategies, such as family support programs, family group decision making, family-to-family and others that recognize the importance of asking parents what they need to protect their children.
- Encourage faith-based organizations to open their facilities to services for children and their parents, pairing members of their congregations with children and families in need of assistance; sponsoring scholarships for children to participate in colleges, universities and special recreation activities; and surveying their members about ways they can offer help to children and their families in the community.

Expanding opportunities for addressing the challenges associated with substance abuse, mental health problems, and domestic violence that bring families and their children to the attention of the child welfare system.

Prevention and specialized treatment can help to keep children in families struggling with substance abuse, mental health problems, and domestic violence out of the system or to get them out more quickly when placement is necessary.

- Make available comprehensive individualized family treatment services that address the needs of parents with alcohol and drug problems and the needs of their children, including offering the after-care services that are central to meaningful recovery.
- Expand opportunities for addressing the mental health needs of young children, youths with serious emotional disturbances, and parents whose mental health problems bring their children to the attention of the child welfare system.
- Take steps to expand community-based treatment services so parents will not be required to relinquish custody of their children to the child welfare system in order to get them the treatment they need.
- Educate children's services and domestic violence service providers, the courts, and law enforcement about the impact of domestic violence on children and the need for appropriate individualized responses and steps to prevent it and minimize its harmful effects.

Moving children in foster care to permanent families through reunification, adoption, subsidized guardianship or other permanent adult connections.

Permanency should be a goal for children throughout their time in care.

- Promote permanency for children when they first come to the attention of the child welfare system, by seeking out extended family when children cannot remain safely with their parents.
- Provide services quickly to ensure timely permanency decisions for children in care.

- Promote a range of post-permanency services for children who return home, are adopted, or placed permanently with kin to help ensure they do not return to foster care. Include investments to provide mental health and other specialized services for children in permanent placements.
- Assist youth to live independently when they leave care, regardless of their permanency plans. Help expand new supports for young people to address their unmet needs for health care, housing, education, employment, and personal support and permanent adult connections when they leave care.
- Ensure that every state takes advantage of the new federal option to extend Medicaid to youths up to age 21 who were in foster care on their 18th birthday.

Supporting grandparents and other relatives who are caring for children whose parents are unable to do so.

Supports to relative caregivers and their children will help keep families together and prevent children from entering foster care unnecessarily.

- Establish, expand, and support state kinship care navigator programs to provide comprehensive information and support to kinship care families who are struggling to find appropriate resources and to educate service providers about the unique needs of these families.
- Increase state and federal support for subsidized guardianship programs that provide an important permanent alternative for children who exit the child welfare system into the legal guardianship or custody of caring relatives. Ensure that these families are provided both cash assistance and post-permanency supports when necessary.
- Offer information and technical assistance to community and faith-based organizations, which are often the only providers that relative caregivers are willing to approach for help.

Promoting a quality work force for vulnerable children and families in the child welfare system.

Significant reforms in child welfare require new attention to practice and increased investments in training, supervision, recruitment, retention, and work load reduction, so children can get the individualized services and treatment that are essential to improved outcomes for children.

- Promote training and ongoing professional development for caseworkers and supervisors that will build the competencies necessary to help staff respond appropriately to the needs of children.
- Implement caseload and workload standards that are consistent with national standards established by the Child Welfare League of America and allow staff to respond to the individual needs of children and families.
- Improve the quality of care children receive by offering training to staff from other child serving agencies and programs working with children in the child welfare system, including those addressing substance abuse, mental health, and domestic violence.
- Ensure that child welfare practice is oriented toward a vision of child welfare that promotes the engagement of families and communities and builds on their strengths.

Endnotes

[1] Homes in which methamphetamines are produced are often referred to as "Meth Labs." Karen Swetlow, *OVC Bulletin: Children at Clandestine Methamphetamine Labs: Helping Meth's Youngest Victims.* (Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Victims of Crime, June 2003): 3.

[2] U.S. Department of Health and Human Services, Administration for Children, National Center on Child Abuse and Neglect, *Third National Incidence Study of Child Abuse and Neglect (NIS-3)* (Washington, DC: U.S. Department of Health and Human Services, September 1996).

[3] David Shipler notes that people living in poverty often experience "paralyzing depression, feel resigned, helpless, and defeated." David Shipler, *The Working Poor: Invisible in America* (New York: Aldred A. Knopf, 2004).

[4] U.S. Department of Health and Human Services, Administration on Children, Youth and Families, *Child Maltreatment 2003* (Washington, DC: U.S. Department of Health and Human Services, 2005): xiii.

[5] 16.9% of cases were classified as "Other" types of abuse. *Ibid.*, Table 3-4.

[6] *Ibid.*, 23.

[7] The current rate for child abuse and neglect in the United States is 7.5 per 1,000 and comes from *Child Maltreatment 2003*. Dorothy Roberts, *Shattered Bonds: The Color of Child Welfare* (New York: Civitas Books, 2002): 29.

[8] M.G. Maxfield and C.S. Widom (1996), "The Cycle of Violence: Revisited Six Years Later," *Archives of Pediatric and Adolescent Medicine, 150*: 390-95; C. Smith, C. and T.P. Thornberry (1995), "The Relationship Between Childhood Maltreatment and Adolescent Involvement in Delinquency," *Criminology,* 33(4): 451-81; M.T. Zingraff, J. Leiter, K.A. Myers, M.C. Johnsen (1993), "Child Maltreatment and Youthful Problem Behavior," *Criminology*, 31(2): 173-202; Diana J. English, Cathy Spatz Widom and C. Brandford, *Childhood Victimization and Delinquency, Adult Criminality and Violent Criminal Behaviors*, final report presented to the National Institute of Justice, February 1, 2002.

[9] Fight Crime: Invest in Kids, *New Hope For Preventing Child Abuse and Neglect* (Washington, DC: Fight Crime, Invest in Kids, 2003): 19.

[10] Cynthia Andrews Scarcella, Roseana Bess, Erica Hecht Zieleweski, Lindsay Warner and Rob Geen, "The Cost of Protecting Vulnerable Children IV: How Child Welfare Funding Fared during the Recession," (Washington D.C.; The Urban Institute, 2004)

[11] National Clearinghouse on Child Abuse and Neglect Information, *Cost of Injury Analysis: Safe Children and Healthy Families Are a Shared Responsibility* (Washington, DC: Department of Health and Human Services, Administration for Children and Families, Children's Bureau, January 2005). Retrieved from the Internet at: http://nccanch.acf.hhs.gov/topics/prevention/develop/making/injury.cfm on May 4, 2005.

[12] National Institute of Justice: Violence Against Women & Family Violence, *NIJ's Violence Against Women Research and Evaluation Program: Selected Results* (Washington, DC: U.S. Department of Justice). Retrieved from the Internet at http://www.ojp.usdoj.gov/nij/vawprog/selected_results.html. on March 24, 2005.

[13] National Clearinghouse on Child Abuse and Neglect Information, *Children and Domestic Violence: A Bulletin for Professionals* (Washington, DC: Department of Health and Human Services, Administration for Children and Families, Children's Bureau, 2005).

[14] Michael Benson, *When Violence Hits Home: How Economics and Neighborhood Play a Role* (U.S. Department of Justice: National Institute of Justice, 2004).

[15] U.S. Department of Health and Human Services, Administration on Children, Youth and Families, *Child Maltreatment 2003* (Washington, DC: U.S. Department of Health and Human Services, 2005): Table 6-4.

[16] U.S. Department of Health and Human Services, Administration on Children and Families, the AFCARS Report, Preliminary FY 2002 estimates as of April 2005. Retrieved from the Internet at http://www.acf.hhs.gov/programs/cb/publications/afcars/report9.htm on February 1, 2005.

[17] Robert Hill, *The Role of Race in Foster Care Placement*. Paper presented at Race Matters Forum sponsored by the University of Illinois at Urbana-Champaign, January 9-10, 2001.

[18] Robert B. Hill, *Disproportionality of Minorities in Child Welfare: Synthesis of Research Findings* (Illinois: Race Matters Consortium). Retrieved from the Internet at http://www.racemattersconsortium.org/docs/whopaper4.pdf on March 24, 2005.

[19] U.S. Department of Health and Human Services, Administration on Children and Families, the AFCARS Report, Preliminary FY 2002 estimates as of August 2004. Retrieved from the Internet at http://www.acf.hhs.gov/programs/cb/publications/afcars/report9.htm on February 1, 2005.

[20] The Urban Institute Child Welfare Research Program: Jennifer Ehrle Macomber, Cynthia Andrews Scarcella, Erica H. Zielewski and Rob Geen, *Foster Care Adoption in the United States: A State by State Analysis of Barriers and Promising Approaches* (Washington, DC: Urban Institute, 2004).

[21] Paige M. Harrison and Allen J. Beck, *Prisoners in 2003* (Washington, DC: U.S. Department of Justice, Office of Justice Programs, November 2004).

[22] Christopher J. Mumola, *Incarcerated Parents and Their Children* (Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, August 2000): 4.

[23] Christopher J. Mumola, *Incarcerated Parents and Their Children* (Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, August 2000): 1.

[24] *Ibid.*

[25] Annie E. Casey Foundation, *Family to Family:Tools for Rebuilding Foster Care, Partnerships between Corrections and Child Welfare* (Baltimore, MD: Annie E. Casey Foundation, March 2002): 8.

[26] Lenora Lapidus, Namita Luthra, et al., *Caught in the Net: The Impact of Drug Policies on Women and Families* (New York: The American Civil Liberties Union, Break the Chains, the Brennan Center, 2005): 55.

[27] Terry Lugaila and Julia Overturf, *Children and the Households They Live In: 2000 – Census 2000 Special Reports* (Washington, DC: United States Census Bureau, February 2004).

[28] *Ibid.*

[29] U.S. Department of Health and Human Services, Administration for Children and Families, "Temporary Assistance for Needy Families (TANF): Sixth Annual Report to Congress" (Washington, DC: U.S. Government Printing Office, November 2004). Retrieved from http://www.acf.hhs.gov/programs/ofa/annualreport6/ar6index.htm.

[30] P.J. Pecora, et al., *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study* (Seattle, WA: Casey Family Programs, 2005). Retrieved from the Internet at http://www.casey.org.

[31] *Ibid.*

[32] Westat, Inc., *A National Evaluation of Title IV-E Foster Care Independent Living Programs for Youth* (Washington, DC: U.S. Department of Health and Human Services, 1991).

[33] Mark E. Courtney, et al., "Midwest Evaluation of the Adult Functioning of Former Foster Youth" (Chicago, IL: University of Chicago, Chapin Hall Center for Children, 2005). Retrieved from the Internet at http://www.chapinhall.org/article_abstract.aspx?ar=1355&L2=61&L3=130.

[34] Annie E. Casey Foundation, "Moving Youth from Risk to Opportunity," *Kids Count Databook* 2004, (Baltimore, MD: Annie E. Casey Foundation, 2004). Retrieved from the Internet at http://www.aecf.org/kidscount/databook/essay/essay3.htm on May 11, 2005.

[35] Robert M. Goerge, et al., *Employment Outcomes for Youth Aging out of Foster Care* (Chicago, IL: University of Chicago, Chapin Hall Center for Children, 2002). Retrieved from the Internet at http://www.chapinhall.org/PDFDownload_new.asp?tk=1017266&ar=1353&L2=61&L3=130

[36] The Government Accountability Office (GAO) report, "Foster Youth – HHS Actions Could Improve Coordination of Services and Monitoring of States' Independent Living Programs," GAO-05-25, prepared November 2004.

[37] U.S. Department of Health and Human Services, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* (Washington, DC: U.S. Public Health Service, 2000).

[38] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999).

[39] M.S. Hurlburt, L.K. Leslie, J. Landsverk, R.P. Barth, B.J. Burns, R.D. Gibbons, D.J. Slymen and J. Zhang, "Contextual Predictors of Mental Health Service Use among Children Open to Child Welfare," *Archives of General Psychiatry* (61) 2004: 1217-1224.

[40] Sharon Vandivere, Rosemary Chalk and Kristin Anderson Moore, "Children in Foster Homes: How Are They Faring," *Child Trends Research Brief* (Washington, DC: Child Trends, December 2003): 8.

[41] Barbara Burn, Susan Phillips, et al., "Mental Health Needs and Access to Mental Health Services by Youth Involved with Child Welfare: A National Survey," *Journal of the American Academy of Child and Adolescent Psychiatry.*

[42] State Executive Council Workgroup on "The Relinquishment of Custody for the Purpose of Accessing Behavioral Health Treatment, Final Draft Report," (Richmond, VA, October 5, 2004).

[43] U.S. General Accounting Office, "Child Welfare and Juvenile Justice: Several Factors Influence the Placement of Children Solely to Obtain Mental Health Services," (Washington, DC: Government Accounting Office, 2003, GAO-03-865T).

[44] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America: Final Report*, DHHS Pub. No. SMA-03-3832 (Rockville, MD: DHHS, 2003).

[45] Office of Applied Studies, "Children living with substance-abusing or substance dependent parents," (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2003). Retrieved from the Internet at www.DrugAbuseStatistics.samhsa.gov on April 11, 2005.

[46] Nancy K. Young, Sidney L. Gardner and K. Dennis, *Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy* (Washington, DC: Child Welfare League of America Press, 1998)

[47] Lenora Lapidus, Namita Luthra, et al., *Caught in the Net: The Impact of Drug Policies on Women and Families* (New York: The American Civil Liberties Union, Break the Chains, the Brennan Center, 2005): 8.

[48] *Ibid.,* 10.

[49] Eric Dearing, Beck Taylor and Kathleen McCartney, "Implications of Family Income Dynamics for Women's Depressive Symptoms during the First Three Years After Childbirth," *American Journal of Public Health* (August 2004, Vol. 94, No. 8): 1372-1377. Some research has found that 28% of poor mothers reported maternal depression as compared with 17% of nonpoor mothers. (Stephen M. Petterson and Alison Burke Albers, "Effects of Poverty and Maternal Depression on Early Child Development," *Child Development,* November/December 2001, Vol. 72, No. 6).

[50] Stephen M. Petterson and Alison Burke Albers, "Effects of Poverty and Maternal Depression on Early Child Development," *Child Development* (November/December 2001, Vol. 72, No. 6): 1796-1797.

[51] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *2003 National Survey on Drug Use and Health: Results* (Washington DC: Department of Health and Human Services, 2004). Retrieved from the Internet at http://www.oas.samhsa.gov/nhsda/2k3nsduh/2k3Results.htm#8.2

[52] The National Center on Family Homelessness, *Homeless Children: America's New Outcasts*, (Newton Centre, MA: National Center on Family Homelessness, 2005). Retrieved from the Internet at www.familyhomelessness.org/fact_outcasts.pdf. on April 25, 2005.

[53] J.F. Culhane, et al. (2003), Prevalence of child welfare services involvement among homeless and low income mothers: A five-year birth cohort study, as cited in Mark Courtney, Steven L. McMurtry and Andrew Zinn, "Housing Problems Experienced by Recipients of Child Welfare Services," Child Welfare Special Issue: Housing and Homelessness (Edited by Ruth Anne White and Debra Rog), CWLA (2004).

[54] *Ibid.*

[55] Jung Min Park, et al., "Child Welfare Involvement among Children in Homeless Families," *Child Welfare Special Issue: Housing and Homelessness* (Washington, D.C. Child Welfare League of America, 2004).

[56] *Ibid.*

[57] U.S. Department of Health and Human Services, Children's Bureau, *National Study of Protective, Preventive, and Reunification Services to Children and Their Families Final Report* (Washington, DC: U.S. Department of Health and Human Services, Administration on Children and Families, Children's Bureau, 1997). Retrieved from the Internet at http://www.acf.hhs.gov/programs/cb/publications/97natstudy/factors.htm April 25, 2005.

[58] Peter J. Pecora, et al., *Assessing The Effects of Foster Care: Early Results from the Casey National Alumni Study* (Connecticut: Casey Family Services, 2005) Retrieved from the Internet at http:// www.casey. org/ Resources/Publications/NationalAlumniStudy.htm. on April 25, 2005.

[59] Mark E. Courtney et al., Chapin Hall Center for Children, University of Chicago, "Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19" (Chicago, IL: Chapin Hall Center for Children, 2005). Retrieved from the Internet at http://www.chapinhall.org/article_abstract. aspx?ar=1355&L2=61&L3=130.

[60] Based on CDF estimates from Cynthia Andrews Scarcella. Roseana Bess, Erica Hecht Zieleweski, Lindsay Warner and Rob Geen, "The Cost of Protecting Vulnerable Children IV: How Child Welfare Funding Fared during the Recession" (Washington DC; The Urban Institute, 2004).

[61] U.S. Department of Health and Human Services, Administration on Children, Youth and Families, *Child Maltreatment 2003* (Washington, DC: 2005).

[62] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, "First Reports Evaluating the Effectiveness of Strategies for Preventing Violence: Early Childhood Home Visitation and Firearm Laws," Findings from the Task Force on Community Preventive Services, Vol. 52, No. RR-14 (October 2003).

[63] D. Olds, P. Hill, S. Mihalic and R. O'Brien, *Blueprints for Violence Prevention, Book Seven: Prenatal and Infancy Home Visitation by Nurses* (Boulder, CO: Center for the Study and Prevention of Violence, 1998).

[64] For more information, visit the Nurse Family Partnership Web site at www.nursefamilypartnership.org. Additional data obtained from Marie Roda, consultant with the Nurse Family Partnership (May 20, 2005).

[65] Research findings highlighted on the Nurse Family Partnership Web site at: http://www.nursefamilypartnership.org/resources/ files/PDF/NFP%20Overview.pdf. Findings from the follow-up of children in Memphis at age six, four years following the end of the Memphis study, and the follow-up of children in Denver at age four were published in the December 2004 issue of *Pediatrics*. See also http://www.nccfc.org/faq.cfm#q5.

[66] Data comes from the Minnesota Department of Health's Web site on Family Home Visiting, http://www.health.state.mn.us/divs/fh/ mch/fhv/, and a telephone conversation with Nancy Reed, Family Home Visiting consultant of the Maternal and Child Health Section of the Minnesota Dept. of Health on April 20, 2005.

[67] The Ohio Early Start Program is part of the Help Me Grow Program. For more information, visit their Web site at http:// www.odh.state.oh.us/ODHPrograms/WELHOME/welhome1.htm

[68] Center for the Study of Social Policy, *Strengthening Families Through Early Care and Education: Protective Factors Literature Review: Early Care and Education Programs and the Prevention of Child Abuse and Neglect* (Washington: DC: Doris Duke Charitable Foundation/Center for the Study of Social Policy, 2004).

[69] *Ibid.*

[70] Center for the Study of Social Policy, *Strengthening Families Through Early Care and Education: Learning Network of Exemplary Program* (Washington: DC, Doris Duke Charitable Foundation/Center for the Study of Social Policy, 2004).

[71] Family and Children Educational Services Web site http://www.glynn.k12.ga.us/FACES/ (March 2005).

[72] *Ibid.*

[73] D.S. Harburger with R.A. White, "Reunifying Families, Cutting Costs: Housing-child Welfare Partnerships for Permanent Supportive Housing," *Child Welfare*, 83 (5), 389-392 (2004).

[74] *Ibid.*

[75] Phone interview with Betsy Cronin, The Connection at (203) 789-4427, ext. 104; E-mail: bcronin@TheConnectionInc.org and Supportive Housing for Families Practice Standards on April 15, 2003.

[76] Phone interview with Mary Gregory, Administrative Director, Grand Junction Housing Authority at (970) 245-0388 (maryg@gjha.org).

[77] Mike Doolan, *The Family Group Conference: A Mainstream Approach in Child Welfare Decision-Making* (Denver,CO: American Humane: National Center on Family Group Decision Making, 2004).

[78] Description of DC's Family Team Meetings and the preliminary evaluation data was obtained in a phone interview conducted by CDF staff with DC Family Team Meeting staff members: Nicole Wright Gurdon, FTM Project Manager and Erin McDonald, FTM Evaluation Team Lead, on April 20, 2005.

[79] Annie E. Casey Foundation, *Family to Family: Tools for Rebuilding Foster Care: Outcomes, Goals and Strategies* (Baltimore, MD: The Annie E. Casey Foundation, 2005). Retrieved from the Internet at <http://www.aecf.org/initiatives/familytofamily/tools/outcomes_goals. pdf> on April 29, 2005.

[80] *Ibid.*

[81] Personal communication with Susan Kelly, Center for the Study of Social Policy, who is providing technical assistance to the Wayne County Family to Family Program, April, 2005.

[82] Personal communication with Dr. Warren Ludwig, Ph.D.,Director of Child Welfare, Wake County Human Services, on April 29, 2005. Wake County Child Welfare, Wake County Human Services, "Linking Self-Evaluation and Community Partnerships, Wake County Child Welfare" (unpublished PowerPoint presentation).

[83] Personal communication with Dr. Warren Ludwig, Ph.D., Director of Child Welfare, Wake County Human Services, on April 29, 2005.

[84] Alma Shelton, Regina Petteway and Warren Ludwig, Ph.D., Wake County Human Services, "Application for Outstanding County Program Awards," January 28, 2005 (unpublished).

[85] Wake County Child Welfare, Wake County Human Services, "Linking Self-Evaluation and Community Partnerships, Wake County Child Welfare" (unpublished PowerPoint presentation).

[86] Annie E. Casey Foundation, *Family to Family: Tools for Rebuilding Foster Care: Partnerships between Corrections and Child Welfare* (Baltimore, MD: Annie E. Casey Foundation, March 2002): 8.

[87] Personal communication with Paula Fendall, Director, Children of Incarcerated Parents Program and Visiting Improvement Project, May 10, 2005.

[88] *Ibid.*

[89] El Paso County Department of Human Services: 2003 Annual Summary. Retrieved from the Internet at http://dhs.elpasoco.com/ humansvc/pdf/AnnualSum2003.pdf.

[90] Rutledge Q. Hutson, *A Vision for Eliminating Poverty and Family Violence: Transforming Child Welfare and TANF in El Paso County, Colorado* (Washington, DC: Center for Law and Social Policy, January 2003).

[91] El Paso County Department of Human Services: 2003 Community Report. Retrieved from the Internet at http://dhs.elpasoco.com/humansvc/pdf/LastW2003ANRPT.pdf on April 26, 2005. National foster care caseload data is available only through 2002 but the number of children in care in 1998 is similar to the number of children in care in 2002. See U.S. Department of Health and Human Services, Children's Bureau Web site at http://www.acf.hhs.gov/programs/cb/dis/afcars/publications/afcars.htm for the most current estimates available through the national Adoption and Foster Care Reporting and Analysis System.

[92] El Paso County Department of Human Services: 2003 Community Report. Retrieved from the Internet at http://dhs.elpasoco. com/humansvc/pdf/LastW2003ANRPT.pdf on April 26, 2005.

[93] *Ibid.* The national standard that states are required to meet is 76.2% of children returned home within 12 months. Thirty-seven states met the standard in 2001, the most recent year for which national data are available, and the national average was 68.7%. U.S. Department of Health & Human Services, Child Welfare Outcomes 2001: Annual Report (Washington, DC. U.S. Department of Health and Human Services 2004).

[94] El Paso County Department of Human Services: 2003 Annual Summary. Retrieved from the Internet at http://dhs.elpasoco.com/humansvc/pdf/AnnualSum2003.pdf. The national standard is 6.1%, and only 13 states met the standard in 2001, the most recent year for which national data are available. U.S. Department of Health and Human Services, Child Welfare Outcomes 2001: Annual Report (Washington, DC. U.S. Department of Health & Human Services, 2004).

[95] U.S. Department of Health and Human Services, Administration for Children, Office of Planning, Research and Evaluation, National Survey of Child and Adolescent Well-Being: One Year in Foster Care Report (Washington, DC: U.S. Department of Health and Human Services, November 2003).

[96] James Bell Associates, *Evaluation of Arizona Families F.I.R.S.T. Annual Evaluation Report* (Phoenix, AZ: Department of Economic Security, Division of Children, Youth and Families, 2005): 7.

[97] *Ibid.*, 32-33.

[98] The Women's Treatment Center, fact sheet provided by Executive Director Jewell Oates at the AOD briefing. Available at http://www.womenstreatmentcenter.org/.

[99] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in Americ: Final Report* (Rockville, MD: DHHS Pub. No. SMA-03-3832, 2003).

[100] Retrieved from the Internet at http://www.state.nm.us/hsd/bhdwg/.

[101] National Mental Health Association, *The Invisible Children's Project.* Retrieved from the Internet at http://www.nmha.org/children/invisible.cfm on May 26, 2005.

[102] Beth Hinden, Kathleen Biebel, Joanne Nicholson and Liz Mehnert, *The Invisible Children's Project: A Family-Centered Intervention for Parents with Mental Illness* (Orange County, New York: Mental Health Association, Center for Mental Health Services Research Department of Psychiatry, University of Massachusetts, Substance Abuse and Mental Health Services Administration, April 15, 2002): 1.

[103] *Ibid.*, iv.

[104] Marc Cherna and Marcia Sturdivant, *A Profile of Children, Youth and Families* (Pittsburgh, PA: Allegheny County Department of Human Services, Office of Children, Youth and Families). Retrieved from the Internet at http://www.county.allegheny.pa.us/dhs/About DHS/profiles-current/snap-textCYFcurrent.pdf on April 25, 2005.

[105] Personal communication with Marc Cherna, Director of Allegheny County Office of Children, Youth and Families.

[106] Office of the Assistant Secretary for Planning and Evaluation, *Assessing the Context of Permanency and Reunification in the Foster Care System* (Washington, DC: U.S. DHHS, 2001). Retrieved from the Internet at http://aspe.os.dhhs.gov/hsp/fostercare-reunif01/.

[107] Children's Bureau Express, "HHS Awards Adoption Bonuses to States" (Washington, DC: United States Department of Health and Human Services, Administration for Children and Families, Children's Bureau, November 2004). Retrieved from the Internet at http://cbexpress.acf.hhs.gov/articles.cfm?issue_id=2004-11&article_id=894.

[108] Personal Communication with Pat O'Brien, Founder and Executive Director, You Gotta Believe! On April 19, 2005.

[109] Children's Defense Fund, *States' Subsidized Guardianship Laws at a Glance* (Washington, DC: Children's Defense Fund, October 2004).

[110] California Department of Social Services. *Report to the Legislature on the Kinship Guardianship Assistance Payment (Kin-Gap) Program* (Sacramento, CA: California Department of Social Services, 2001).

[111] The Kinship Caregiver Support Act (S. 985) was introduced in the 109th Congress. For more information, visit the Children's Defense Fund bill summary at http://www.childrensdefense.org/childwelfare/legislative/kcsa_2005_one_pager.pdf.

[112] Personal communication with Barbara Turpin, Statewide Kinship Coordinator with the Ohio Department of Jobs and Family Services, Office for Children and Families, February 2005.

[113] Casey Report, 7.

[114] More information about the Oregon Post-Adoption Resource Center can be found at http://www.orparc.org/.

[115] North American Council on Adoptable Children (NACAC). See http://www.nacac.org/postadoptionarticles/IL.html.

[116] Statement of James E. Beougher, Director, Child and Family Services Administration, Michigan Family Independence Agency. Testimony before the Subcommittee on Human Resources of the House Committee on Ways and Means, Hearing on the Promoting Safe and Stable Families Program, May 10, 2001. Retrieved from the Internet at, http://waysandmeans.house.gov/legacy/humres/107cong/5-10-01/5-10beou.htm.

[117] Children's Services of Roxbury, Inc., Massachusetts Families for Kids, Lifelong Family Connections for Adolescents program brochure. Retrieved from the Internet at http://www.csrox.org/pdffiles/2004LFC.pdf.

[118] Sania Metzger, "Permanency for Teens: New York City's Emerging Policy," *Voice Magazine,* Vol. 5, Issue 2 (Spring 2004): 18-19.

BACK

CHAPTER SIX

Youth Development

Poverty and the Pipeline to Prison

While opportunities for getting into trouble abound for all children, growing up in poverty contributes to a greater likelihood of involvement in crime and violence. Studies show that children living in extreme, persistent poverty are more likely to engage in delinquency, especially serious delinquency.

In communities with concentrated poverty and high levels of chaos and disorganization, residents are often unwilling to intervene when children engage in antisocial or unlawful acts. Unemployment in high-poverty urban areas gives way to a proliferation of drug trafficking, firearms, and gang violence among youths and young adults.

By the time they reach adolescence, many poor minority youths already are on a path to delinquency that began many years prior. Children with needs or problems that go unaddressed because of unjust economic policies and priorities, as well as failures in the healthcare, early childhood, education, and child welfare systems, find that there is one child-serving system that always remains open to them: the juvenile justice system.

The benefits of prevention and intervention are clear. For every child diverted from a lifetime of crime, we not only save a child, we save between $1.3 and $1.5 million.

"Poverty is the worst form of violence."

—Mahatma Gandhi

There has never been a more dangerous time for poor children and families. Funding for Head Start, health care, foster care, and food stamps are threatened. There is a critical shortage of affordable housing. Preschoolers are expelled. Five-year-olds are handcuffed and removed from school for temper tantrums. High stakes accountability testing and zero tolerance discipline policies are driving many poor and minority students out of school. High school graduation rates for Black and Latino students hover around 50 percent. Children who are pushed out or drop out end up on the streets, in trouble, or involved in the juvenile justice system. Incarcerated children suffer horrendous abuses and atrocities while in the custody of juvenile facilities.

The pressures and risks of today's world are difficult enough for children in stable families, communities, and schools with sufficient income and services to meet all their needs. For hundreds of thousands of underserved, poor, and minority children and families, these pressures and risks can be insurmountable.

To stay on the path to successful adulthood, children need significant support and protection, including: strong families; early development and education; quality health and mental health care; good schools; healthy communities; constructive peer relationships; after-school and summer programs; and positive role models. Parents, community and faith leaders, service providers, policy makers and others must meet our children's needs for support and guide them in navigating the risks of childhood. It is our job to protect our children.

But far too many poor minority children are without protection. Single mothers struggle with two and three jobs just to provide the basics of clothing, food, and shelter for their children. Parents face enormous odds in affording or providing the measures that will protect their children from delinquency, while cash-strapped schools, communities, and states are unable to provide adequate funding for quality after-school, mentoring, prevention, and other youth programs. Unemployment in high-poverty urban areas gives way to a proliferation of drug trafficking, firearms, and gang violence among youths and young adults. Children desperate for a sense of belonging will find it wherever it is available. When the doors to churches and community programs are all too often closed, they find it on the streets. With little or no protection against the risks, children are left to fend for themselves.

The result? An accumulation of disadvantages, from birth onward, that puts these children at great risk of entering the juvenile justice system or adult criminal justice system. They are pulled into a "cradle to prison pipeline" that diminishes their chances for college and meaningful work and makes it much more likely that they will follow a trajectory to prison or even premature death. Children with needs or problems that go unaddressed because of unjust economic policies and priorities, as well as failures in the healthcare, early childhood, education, and child welfare systems, find that there is one child-serving system that always remains open to them: the juvenile justice system. Here in the richest nation on earth, we ignore and neglect the needs of our most vulnerable children until they have done something that lands them in trouble with the law. Then we snap to attention, readily handing children over to a penal system that all too often makes matters even worse.

Neglecting the needs of our children until it is too late is not only immoral, it is utterly unnecessary. We know what works. We can change the lives and futures of our at-risk children.

This chapter examines the factors that contribute to youth delinquency and incarceration and

how these factors are exacerbated by poverty, the many ways we fail to protect at-risk children, the value and cost effectiveness of prevention, and what we can and must do differently to guide our children to productive futures. In a society that increasingly insists that children be accountable on multiple fronts, we are denying them the resources they need to live up to that accountability. Demanding accountability from our children while refusing to be accountable to them is tantamount to criminal neglect.[1]

A Look at the Past Year

The past year produced mixed results for at-risk youth and threats posed by the pipeline to prison. Early in the year, the U.S. Senate turned its attention to the gun industry and a proposal to provide it unprecedented legal immunity from civil lawsuits by victims of gun violence. The deliberations produced three major victories in the passage of amendments that would have: (1) renewed the 10-year-old Assault Weapons Ban, due to expire in September 2004; (2) closed the "gun show loophole" in federal law that allows guns to be sold at private gun shows without federally required background checks; and (3) required child trigger locks on handguns sold in the United States. These three common sense measures, however, were enough for the gun lobby to kill the underlying bill. The immunity bill made a comeback in 2005 and passed the Senate, this time with a child safety lock amendment in place, but attempts to pass other common sense measures were unsuccessful. The bill passed the House in October 2005 and is fully expected to be signed into law.

Several other federal policy initiatives had important ramifications for the "cradle to prison pipeline." Both the House and Senate have drafted legislation that purports to address gang violence. Unfortunately neither house has proposed solutions that would actually reduce and prevent gang violence in communities. The emphasis has been upon punitive measures and a "lock-em-up" mentality, which the data show simply does not work to reduce crime. Child advocacy and juvenile justice groups nationwide have opposed these measures because of provisions that would make it more likely that children would be prosecuted as adults in the federal system. A large coalition of organizations oppose these bills because of their harmful impact on youth, juvenile justice policy, immigration rights, mandatory minimum sentencing, the imposition of the death penalty, and civil rights.

The landmark U.S. Supreme Court decision in *Roper v. Simmons*, handed down on March 1, 2005, abolished the death penalty for individuals whose crimes were committed when they were juveniles. The decision created a critical distinction between the way we treat juveniles who commit crimes and the way we treat adults. Christopher Simmons was sentenced to death for a murder he had committed at the age of 17. The Court cites three differences that set juveniles apart from adults: (1) juveniles' susceptibility to immature and irresponsible behavior; (2) their own vulnerability and comparative lack of control over their immediate surroundings; and (3) the reality that juveniles are still struggling to define their identity. The Court defines all three as mitigating factors proving that children who committed crimes while under the age of 18 should not be punished in the same way that we punish adults.

Testimony presented before the House in July 2004 detailed more than 15,000 children, some as young as seven, who had been improperly incarcerated because there were no mental health services available in their communities. Congress responded by passing, and the President signed, the Mentally Ill Offenders Treatment and Crime Reduction Act. This new law stipulates that resources for mental illness assessment and treatment, including community-based resources, be made available to both adult and juvenile offenders.

This year, as in previous years, advocates worked hard to convince Congress of the continual and critical need for funding juvenile prevention and intervention programs that help keep youth out of trouble and engaged in their schools and communities. Since 2002, these programs have been cut nearly 40 percent, including programs such as mentoring, substance abuse prevention and treatment, mental health assessment and treatment, gang prevention and intervention, community service, and intensive family-based interventions

STORIES FROM THE STATES

Jeremiah Program Offers Hope

Dynese Martin was two months pregnant with her second child when she sought help from the Jeremiah Program, a Minneapolis-based non-profit that provides transitional housing and support services to single mothers and their children. The program sets high standards for success. Clients are expected to have completed their education goals, be employed in a full-time career job, and have acquired life skills to be self-sufficient. Clients' children are prepared for school success and can take pride in their mother's accomplishments. "I had to jump through hurdles to get into this program," said Dynese. "I get a lot of help. I'm creating lasting childhood memories for my kids."

for both at-risk youth and system-involved youth. Funding for juvenile justice programs continued to decline at both the federal and state levels over the last four years, threatening many critical programs for America's youth.

The past year also has seen the continuation of an alarming trend in schools across the country: the increased criminalization of misbehavior once handled within the community or in the principal's office. Younger and younger children are referred directly from school into the juvenile justice system, raising critical questions about the role of education professionals as well as law enforcement and juvenile justice system officials. Authorities in St. Petersburg, Florida, shackled *both the wrists and ankles of one five-year-old child* and removed her from school after she had quieted down from a 30-minute temper tantrum. The line between schools and the juvenile justice system is becoming increasingly blurred, pushing more children into the pipeline to prison.

Poor Children and Delinquency

While opportunities for getting into trouble abound for all children, growing up in poverty contributes to a greater likelihood of involvement in crime and violence.[2] Studies show that children living in extreme, persistent poverty are more involved in delinquency, especially serious delinquency.[3] In communities with concentrated poverty and high levels of chaos and disorganization, residents are often unwilling to intervene when children are engaging in antisocial or unlawful acts.[4]

Risk Factors Accumulate Over Time

By the time they reach adolescence, many poor minority youths already are on a trajectory to delinquency that began many years earlier. Poverty magnifies risks and disadvantages that intersect, overlap, and accumulate over time. Moreover, this accumulation of risk factors makes it even more likely that children will become involved in delinquency and crime. One study showed that a 10-year-old exposed to six or more risk factors is 10 times as likely to commit a violent act by age 18 as a 10-year-old exposed to only one risk factor.[5]

Health Care: Poor and minority children experience profound disadvantages in prenatal and childhood health care. Having a teenage mother is a strong predictor of later delinquency,[14] and a Black child is almost twice as likely as a non-Hispanic White child to be born to a teenage mother.[15] The percentage of Black babies born with a low birth- weight, putting them at risk for a range of postnatal complications, is twice that of White babies.[16] A low birthweight child is more likely to experience educational disadvantages that can persist into early adulthood.[17] Lead poisoning presents a heightened risk for poor and minority children. Black and Latino children living in older housing (pre-1946) are more likely to have elevated blood lead levels than White children living in comparable

housing—22 and 13 percent compared to 6 percent.[18] And adolescents with childhood elevated blood lead levels report higher levels of delinquency and anti-social behavior.[19]

Early Childhood Development: As children grow, early development and education are critical to their continuing success and protection against future delinquency. One long-term study shows that at-risk toddlers not enrolled in a quality childcare and development program were five times more likely to become chronic law-breakers as adults.[20] Yet Head Start serves only about half of all eligible children. Only 25 percent of Latino and 35 percent of Black three- to five-year-olds are able to perform three out of four basic reading and math skills.[21]

Juvenile Delinquency and Detention: A Snapshot of Contributing Risks

- Being born to a teenage mother is a strong predictor of later delinquency.[6]
- At-risk toddlers not enrolled in a quality childcare and development program were five times more likely to become chronic law breakers as adults.[7]
- A lack of parental involvement and interaction with children may increase children's future risk of violence.[8]
- Abused and neglected children are 1-1/2 to six times as likely to be delinquent and 1-1/4 to three times as likely to be arrested as an adult.[9]
- Adolescents with childhood elevated blood lead levels report higher levels of delinquency and anti-social behavior.[10]
- High school dropouts are almost three times as likely to be incarcerated as youths who have graduated from high school.[11]
- The likelihood that children of incarcerated parents will someday become incarcerated themselves is five to six times higher than for their peers.[12]
- In 2003, two-thirds of the detention facilities in 47 states held youth who did not need to be in detention as they waited for mental health services.[13]

Education: High school dropouts are almost three times as likely to be incarcerated as youths who have graduated from high school.[22] Research shows that students who are suspended or expelled are more likely than their peers to drop out of school altogether.[23] Yet, despite a decrease in school violence, zero tolerance discipline policies continue to increase the number of suspensions and school-based arrests. Poor and minority students are much more likely to experience lower quality teaching that can contribute to poor academic performance and suspension. Under the Bush Administration's No Child Left Behind Act, schools in poor communities without the resources to comply with its unfunded mandates are penalized when their children do not meet annual goals. Rather than addressing the achievement gap for poor and minority children, these policies increase their risk of dropping out and subsequent delinquency.

Family Stabililty: The crushing weight of poverty destroys families and communities. Economic hardship and stressful life events are associated with a lack of parent-child involvement and attachment.[24] This in turn increases children's future risk of violence.[25] Single mothers struggling to hold their households together economically have little time or emotional stamina for nurturing and guiding their children. Generational cycles of abuse, neglect, and substance abuse continue unchecked without funding or resources for community-based mental health and substance abuse programs. Children with parents in prison are five to six times more likely than their peers to be incarcerated themselves.

Child Welfare: Poverty is the single best predictor of child abuse and neglect. Children who live in families with annual incomes less than $15,000 are 22 times more likely to be abused or neglected than children living in families with annual incomes of $30,000 or more.[26] Abused and neglected children are 1-1/2 to six times as likely to be delinquent and 1-1/4 to three times as likely to be arrested as an adult.[27] Poverty and child abuse or neglect interact in different ways. Cases of neglect, which represent the majority of maltreatment cases, are most likely to be linked to poverty since neglect is often tied to a family's lack of resources. Poverty also may add stress to a family's

life and create a strong sense of social isolation. The poverty rate for Black and Hispanic children is far higher than it is for non-Hispanic White children. Thirty-four percent of Black children were living in poverty in 2004, as were 29 percent of Hispanic children, and 11 percent of non-Hispanic White children.[28]

Mental Health: Frequently children end up in the juvenile justice system because their parents cannot afford or cannot access the mental health services and treatment their children need. The U.S. General Accounting Office reported thousands of families relinquishing custody of their children to the juvenile justice system so they could receive treatment.[29] Studies have reported that as many as three-fourths of the youth who are incarcerated have a mental health disorder and about one in five has a severe disorder.[30]

Substance Abuse: Research shows that poverty increases the risk that youths will engage in substance abuse and crime.[31] According to Columbia University's National Center on Addiction and Substance Abuse, four out of five juveniles arrested in 2000 were substance-involved, meaning they were under the influence of alcohol or drugs when they committed their crime, tested positive for drugs at the time of their arrest, were arrested for committing a drug or alcohol offense, reported substance abuse problems, or shared some combination of these characteristics.[32] In 2000, an estimated 1.3 of the 1.6 million juvenile cases referred to juvenile court were substance-involved.[33]

The Juvenile Justice System

Without adequate protections, children can become involved in the juvenile justice system. Poor children are at a distinct disadvantage since their families cannot afford the quality legal representation that their more privileged peers retain to stay out of the system. Whether their contact with the system is limited or protracted, it can have far-reaching and, all too often, extremely negative effects. In many states, detained and incarcerated children are warehoused in large facilities and receive a bare minimum of education and other services. Exacerbating this is the fact that poor children committed to the juvenile justice system lose Medicaid eligibility, and thus medications or other treatments are often discontinued. This can have devastating effects for children with mental health problems.

The juvenile justice system evolved more than a century ago in an attempt to avoid the very abuses

STORIES FROM THE STATES

The Van Curen Family

Mark and Cheryl Van Curen live in Zaleski, Ohio (pop. 500), and are raising five children—Brandy (17), Jessica (14), Brandon (13), Diedra (10), and Whitney (7). The two youngest girls are the children of Mark's deceased sister who, along with her boyfriend, died of carbon monoxide poisoning after passing out from heavy drinking in a van left running in a closed garage. The girls were toddlers at the time.

Mark works from 3:00 a.m. until 4:00 p.m. Monday through Friday for a refuse-hauling company. He then works on Friday and Saturday from 10:00 p.m. until 6:00 a.m. for the local police department.

Because of the way his sister died, Mark does not tolerate alcohol use in their family. But he says that young people in the area are very prone to drinking and drugs because there is nothing else for them to do.

Mental Health Care for At-risk Children: A National Crisis

At the request of Rep. Henry A. Waxman and Sen. Susan Collins, the Special Investigations Division of the House Government Report Committee surveyed every juvenile detention facility in the United States to assess what happens to youth when community mental health services are not readily available. (*In 1998, Rep. Waxman formed the Special Investigations Division of the minority staff to conduct investigations into issues that are important to the minority members of the Government Reform Committee and other members of Congress.*)

This report, the first national study of its kind, presents the results of the survey. It covers the period from January 1 to June 30, 2003.

- **Two-thirds of juvenile detention facilities hold youth who are waiting for community mental health treatment.** These facilities are located in 47 states. In 33 states, youth with mental illness are held in detention centers without any charges against them. Youth incarcerated unnecessarily while waiting for treatment are as young as seven years old.
- **Over a six month period, nearly 15,000 incarcerated youth waited for community mental health services.** Each night, nearly 2,000 youth wait in detention for community mental health services, representing 7 percent of all youth held in juvenile detention.
- **Two-thirds of juvenile detention facilities that hold youth waiting for community mental health services report that some of these youth have attempted suicide or attacked others.** Yet one-quarter of these facilities provide no or poor quality mental health services, and over half report inadequate levels of training.
- **Juvenile detention facilities spend an estimated $100 million each year to house youth who are waiting for community mental health services**. This estimate does not include any of the additional expense in service provision and staff time associated with holding youth in urgent need of mental health services.

taking place in many juvenile facilities today. The creation of a separate justice system for children not only acknowledged that we should hold children accountable for wrongdoing differently than we do adults, it also represented the belief that we should never give up on children, and the hope that even the most wayward youths can be rehabilitated to become productive citizens. During the late 1800s and early 1900s, each state and the District of Columbia established its own juvenile court so that now there are 51 different juvenile justice systems in place. The federal government contracts with the states and the District of Columbia to house juveniles who are committed under federal law.

Children Are Abandoned to the System

Today, state juvenile justice systems are immensely overburdened and enormously underfunded. Ongoing budget cuts at both the federal and state levels have closed programs vital to impoverished communities and schools. These programs keep children out of trouble and out of the juvenile justice system, providing mentoring, after-school opportunities, substance abuse prevention and treatment, mental health screening and treatment, gang prevention and intervention, and more. At the same time, an alarming increase in the prevalence and severity of zero tolerance discipline policies is reducing children to case numbers and disproportionately penalizing minority children. News headlines are filled with stories of elementary school children carted off to the local juvenile facility for misbehavior. Notably, these stories occur most often in high-poverty, high-minority schools. These children need individualized services, not handcuffs and jail. But services are not available.

The result is a disturbing reality. The only thing our nation guarantees any child is a detention or prison cell *after* they get into trouble. Research has conclusively shown that prevention

and intervention work, yet policy makers are still fixated on increasing funding for incarceration—the most expensive and least effective option available for at-risk youths—and decreasing funding for effective prevention. Yet only 25 percent of the youths incarcerated have committed a violent offense.[34] (Moreover, as Figure 2 shows, juvenile arrests for violent crime have steadily decreased over the past decade.) A recent report showed that two-thirds of the detention facilities in 47 states hold youth who do not need to be in detention as they wait for mental health services. Over a six-month period in 2003, nearly 15,000 incarcerated youth, some as young as seven, were held in hundreds of juvenile facilities across the country because mental health services were not available in their communities.[35]

While only a small percentage of children have committed violent offenses, we are incarcerating children because we literally do not have effective alternatives in place—hardly in keeping with the original intent of the juvenile justice system. According to a report from the American Bar Association: "[I]ncreasingly, it is not so much the criminality of the behavior but the lack of alternatives for children with severe emotional and behavior problems, children who have been expelled from school, and children whose families cannot provide adequate care that brings them into the juvenile justice system."[36]

Clearly, the lack of available services for poor children who need them creates an enormous disadvantage and makes it much more likely that they will be incarcerated than children from families with resources. Statistics also demonstrate the racially disparate application of many laws, particularly drug laws. For those charged with drug offenses, Black youths are 48 times more likely to be incarcerated than non-Hispanic White youths. For violent offenses, Black youths are nine times more likely to be incarcerated than are non-Hispanic White youths.[37] Among youth with no prior admissions, Latinos are 13 times more likely to be incarcerated than non-Hispanic Whites for drug offenses. For violent offenses, Latinos are five times more likely to be incarcerated.[38]

Children may receive a more punitive disposition than they might otherwise if their parents are not involved or are unable to leave work to accompany them to court, since there is no advocate to assure the court that they will monitor the child's progress and conditions of release. In addition, sentencing patterns have been shown to have a racially disparate impact due to many factors. Studies show that, given the same behavioral symptoms, more Black youths than non-Hispanic White youths are incarcerated, and more non-Hispanic White youths than Black youths are placed in mental health institutions.[39] As Ed Latessa, a criminologist at the University of Cincinnati notes, "[I]f your family has money, you get psychiatric intervention…if they don't, you get the prison psychologist."[40]

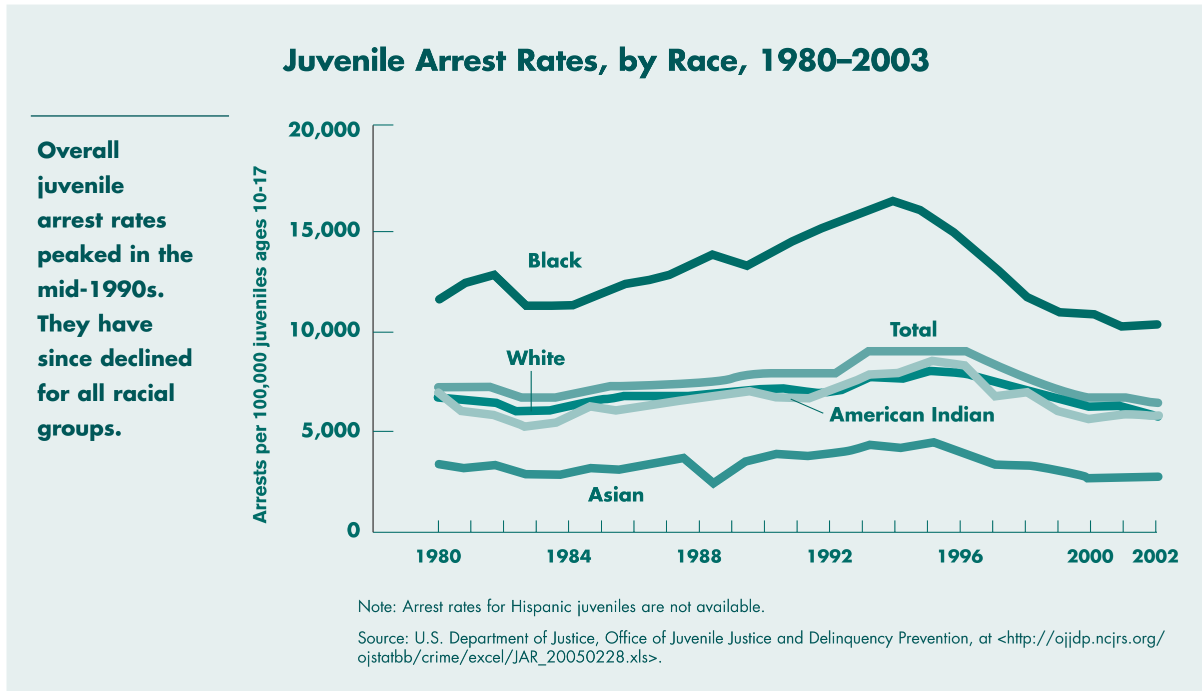
Children Are Abandoned Within the System

Abuse within the walls of juvenile facilities is horrifyingly rampant. The 1974 Juvenile Justice and Delinquency Protection Act (JJDPA) provides most of the federal funds for the improvement of state juvenile justice systems. In order to receive funding, states must comply with four core protections:

- *Deinstitutionalization of Status Offenders.* States may not hold in secure detention those youths who have committed status offenses, such as truancy or running away. These are offenses that may only be committed by juveniles. *Delinquent* offenses, by contrast, are those offenses that would be crimes if committed by an adult.
- *Adult jail and Lock-up Removal.* Juveniles may not be detained in adult jails except for very limited exceptions just before or after court hearings, or in the event of travel emergencies.
- *"Sight and Sound" Separation.* If children are placed in an adult jail, there must be both a sight and a sound separation between them and adults, to prevent any physical assault or psychological abuse.
- *Disproportionate Minority Confinement (DMC).* States are required to assess and have a plan for addressing the disproportionate confinement of minority youth in all secure facilities.

Many states have made dramatic improvements in their juvenile justice systems, but lawsuits claim-

Youth Development – Figure 1



ing abuses abound. In May 2005, the state of Mississippi entered into a consent decree with the U.S. Department of Justice for failure to comply with three of the four core protections. Despite numerous lawsuits and sanctions over the years, Mississippi continues to violate the JJDPA. Children are incarcerated for status offenses like running away. Documented abuses include spraying children with chemicals, leaving children hog-tied, and forcing them to eat their own vomit.[41] Tragically, Mississippi is not the only state where such horrors have occurred; numerous states have been documented for abuse of juveniles, including California, Connecticut, Florida, Maryland, Nevada, and New York.

America is failing at-risk children in two very significant ways. First, we are pushing poor and minority children into a pipeline to prison by ignoring their critical needs until it is too late. The increasing criminalization of childhood offenses unnecessarily clogs the juvenile justice system; many programs and services for poor children and families that would keep children out of the juvenile justice system are underfunded or simply not present in the impoverished communities that most urgently need them.

Second, far too many incarcerated children are subjected to horrors and abuse within the very juvenile justice system designed to care for and rehabilitate children and return them safely to their families, communities, and society. Young people are not rehabilitated in detention; they are learning to be better criminals and, in some cases, horribly mistreated and even abused. Upon returning to their communities, their chances for success are often worse than when they went in.

The safe return of incarcerated children is far from guaranteed, and too many states fail to provide effective re-entry services so that youths can successfully integrate back into their schools and communities. The need for re-entry services for youthful offenders is just beginning to get much needed attention at the state and federal levels. Without re-entry services, youths are at greater risk for dropping out of school, failing to find jobs, and ending up back in the juvenile justice or even criminal justice system, caught up in a vicious cycle of economic disparities and delinquency.

The Failure to Prioritize Prevention

Prevention saves lives and money. It pulls poor and minority children out of the "cradle to prison pipeline." It saves enormous amounts in the long run, yet can generate higher costs in the short run.

Thus, garnering the political will among elected officials on two-, four-, and six-year electoral cycles to invest in prevention for at-risk youths is an ongoing and difficult challenge.

Failures in Funding Priorities

Funding for prevention and intervention programs targeted to at-risk youth has come under severe attack in recent years. The Administration's 2006 federal budget request reflected a one-year cut of nearly 50 percent to juvenile justice funding, comprised of cuts to several funding streams. This drastic reduction would further undermine the ability of states to fund programs that keep children out of trouble and out of the juvenile justice system. Since 2002, funding for federal juvenile justice prevention and intervention programs has been reduced by nearly 40 percent.

Federal funding streams support a host of prevention and intervention strategies. Title V, the Community Prevention Grants Program, funds collaborative, community-based delinquency prevention efforts to reach youth in high risk situations before they make poor choices. Title V is the only federal juvenile justice funding stream that is used purely for prevention. Funding under Title V can be used for many preventive services, ranging from pre/postnatal strategies (such as home visitation by nurses and preschool/parent training programs) to youth development initiatives involving the use of mentoring, after-school activities, tutoring, truancy, and drop-out reduction. All have been shown to reduce delinquency.[42]

The Administration proposed for 2006, the third year in a row, to eliminate the Juvenile Accountability Block Grant (JABG), a program that enjoys wide and bipartisan support in Congress and emphasizes accountability and services for youth in the juvenile justice system. JABG programs include counseling, restitution, community service, substance abuse treatment, mental health assessment and treatment, and school-based violence prevention. JABG funds highly regarded research-based programs such as Multi-Systemic Therapy, a comprehensive and proven effective program in reducing delinquency and recidivism among at-risk youth.

Effective law enforcement, such as the Community Oriented Policing Services Program (COPS), complements and supports prevention and intervention efforts for at-risk youth. The cornerstone of community policing is building relationships with community members so that an effective collaboration between law enforcement and community members takes root and increasingly contributes to community stability and safety. The active involvement and concern of community members, sometimes referred to as "collective efficacy," is critical to sustained crime prevention, particularly in low-income communities.[43] All of these programs strengthen the core capabilities of law enforcement agencies and have greatly improved their ability to fight and prevent crime. Yet budget cuts are forcing layoffs of state and local officers. While massive increases were proposed for homeland security and defense spending, the Administration asked state law enforcement to take on more and more responsibility with less and less funding.

The combination of devastating cuts to critical prevention and intervention programs as well as community law enforcement is a recipe for disaster for poor children, families, and communities. We spend on average three times as much per prisoner as per pupil. But we don't spend money when and where it can actually make a difference in the lives of poor children and families.

Failures in Policy Priorities

Despite what we know about the value of prevention, and in addition to the funding cuts that are diminishing the reach of programs we know work, many of our policies simply do not substantively support violence prevention. Child and youth deaths from gun and gang or group violence is a crisis nationwide. Yet common sense gun safety legislation is considered political suicide by a majority of policy makers. And far too many policy makers promote "tough on crime" policies that provide convenient sound bites but do little if anything to actually deter and reduce community violence. Since crime and community violence occur at higher levels in poor and minority urban areas, it is poor children and families who are most

Youth Development – Table 1

Homicide has become the dominant manner of gun deaths among children and teens. In 1979, 45 percent of firearm deaths were homicides; by 2002, this had risen to 64 percent.

Firearm deaths, by manner and by race, persons under age 20, 1979–2002 (excludes legal intervention)

	Manner					Race				
	Total	Homicide	Suicide	Accident	Unknown	Black	White	American Indian, Alaska Native[1]	Asian, Pacific Islander[1]	Hispanic[2]
1979	3,710	1,651	1,220	726	113	929	2,700	—	—	—
1980	3,749	1,743	1,214	689	103	944	2,739	—	—	—
1981	3,589	1,660	1,213	604	112	944	2,569	49	27	
1982	3,332	1,498	1,207	550	77	811	2,450	55	23	—
1983	2,962	1,238	1,150	504	70	739	2,155	42	25	—
1984	3,030	1,289	1,114	552	75	716	2,238	44	32	—
1985	3,169	1,322	1,256	519	72	850	2,241	42	36	—
1986	3,349	1,513	1,293	472	71	938	2,337	43	31	—
1987	3,400	1,573	1,281	467	79	1,117	2,199	28	54	—
1988	3,974	1,953	1,387	543	91	1,458	2,405	76	53	—
1989	4,384	2,367	1,380	567	70	1,694	2,563	50	76	—
1990	4,935	2,852	1,476	541	66	2,047	2,753	47	87	748
1991	5,329	3,247	1,436	551	95	2,297	2,878	60	91	883
1992	5,353	3,336	1,426	501	90	2,359	2,834	55	105	924
1993	5,715	3,625	1,460	526	104	2,600	2,925	51	139	977
1994	5,793	3,579	1,565	512	137	2,559	3,024	75	135	993
1995	5,254	3,249	1,450	440	115	2,153	2,898	73	130	1,005
1996	4,613	2,836	1,309	376	92	1,976	2,475	64	98	817
1997	4,205	2,562	1,262	306	75	1,687	2,357	59	102	748
1998	3,761	2,184	1,241	262	74	1,416	2,197	60	88	661
1999	3,365	1,990	1,078	214	83	1,301	1,934	57	73	605
2000	3,012	1,776	1,007	193	36	1,149	1,762	44	57	568
2001	2,911	1,771	928	182	30	1,128	1,695	49	39	518
2002	2,867	1,830	828	167	42	1,112	1,639	52	64	581
Total	95,761	52,644	30,181	10,964	1,972	34,924	57,967	1,175	1,565	10,028

[1] Data for American Indian/Alaska Native and Asian/Pacific Islander not available for 1979-1980.

[2] Persons of Hispanic origin can be of any race. Hispanic data not available prior to 1990. From 1990 to 1996, a small number of states with small Hispanic populations did not include Hispanic identifiers in their reporting to the federal government.

Sources: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, CDC WONDER, at <http://wonder.cdc.gov/mortSQL.html>, accessed December 2004; and U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, WISQARS, at <http://www.cdc.gov/ncipc/wisqars/>, accessed December 2004. Calculations by Children's Defense Fund.

harmed by these policy failures.

On September 13, 2004, the Administration and Congress allowed the 10-year-old federal Assault Weapons Ban to expire, returning semi-automatic military style machine guns to the streets of our cities and communities. Semi-automatic assault weapons are the guns of choice for criminals. They are designed for one reason and one reason only: to kill the maximum number of human beings as quickly and as efficiently as possible.

Gun deaths have declined since the ban went into effect in 1994. From 1983 through 1994,

child and teen deaths from firearms increased *every single year*—while from 1994 to 2002 (the latest year for which data are available), there was a decrease *every single year* in firearm deaths among children and teens. Since 1994, child and teen firearm deaths have decreased 50 percent. Renewing the assault weapons ban will do nothing to infringe upon legitimate hunting and self-protection purposes of the citizenry. More than two-thirds of citizens, virtually every major law enforcement organization, and more than 900 police chiefs supported renewing the ban. Yet even with that level of support, our political leaders allowed it to expire, bowing to the enormous power of the gun lobby.

Though child gun deaths continue to decline, they are still unacceptably high. Firearms are the second leading cause of death among 10- to 19-year-olds. From 1979 to 2003, approximately 100,000 children and teens were killed by firearms. Children are twice as likely to be victims of violence as adults and more likely to be killed by adults than by other children. The firearm death rate for Black males ages 15 to 19 is almost four times that of non-Hispanic White males in the same age group.

Common sense gun safety legislation—banning assault weapons, requiring child safety locks, and requiring criminal background checks of *all* purchasers of guns—saves lives and does not impinge upon lawful gun rights.

There is a link between gun violence and the easy access to firearms that exists in the United States. One study found that regardless of storage practice, type, or number of firearms in the home, the presence of firearms is associated with an increased risk of homicide and suicide in the home.[44] The rate of firearm deaths among children under 15 is far higher in the United States than in 25 other industrialized countries *combined*. This is the result of public policies that must change if comprehensive crime prevention efforts are to succeed.

Facts—Not Hype—Should Inform Response to Violence

Responding effectively to group and gang violence is a similarly challenging issue for policy makers. Since public safety is arguably the number one concern of most citizens, the majority of elected officials promise that they will "crack down" on crime and criminals. This is effective, yet empty, rhetoric. The reality is that "tough on crime" policies like harsher prosecution and sentencing laws have proven ineffective in reducing crime. State crime comparisons show there is no positive relationship between the severity of a state's laws and decreases in violent crime.[45] The prevalence of crime in any given community is more closely related to economic indicators such as employment, housing, and residential stability. Nevertheless, "smart on crime" policies that emphasize prevention, treatment, and services are a tough sell. As Jeffrey Fagan, a national criminal justice expert and professor at Columbia University, notes, "It's counterintuitive to say that punishment backfires. It's hard to get the public to understand."[46]

One of the biggest challenges in selling "smart on crime" policies noted by Fagan is the prevalence of hype and misinformation about actual levels of violent crime across the country. Because of the media coverage surrounding the details of more heinous yet isolated crimes, the actual frequency of crime is either lost or overlooked. As stated in a report by the Justice Policy Institute:

> While most experts readily advance the need to reduce high levels of violent crime, including serious gang crime that exists in some communities and neighborhoods, the current phenomenon of presenting gang-related crime or violence as a growing "national crisis" requiring federal legislation, new mandatory minimums... misrepresents the national crime picture.[47]

Policy makers who propose highly punitive, yet ineffective, responses to gang crime often make sweeping statements about purported and dramatic increases in gang crime in recent years. These statements may reassure fearful constituents that "something" is being done about violence, but they do not reflect the reality of crime rates and trends. Consequently, such extreme positions confound an objective analysis of what we can do to *genuinely and comprehensively* reduce and prevent group and gang violence.

In fact, both of the measurements utilized by the U.S. Department of Justice in measuring crime on an annual basis, the Uniform Crime Reports (UCR) and the National Crime Victimization Survey (NCVS), show that violent crime is steadily decreasing. According to the UCR, violent crime decreased 32 percent between 1995 and 2004.[48]

The Bureau of Justice Statistics (BJS) produces the NCVS, a highly detailed analysis of crime incidents reported by a nationally representative segment of the U.S. population. The most recent analysis by BJS of the NCVS echoes the findings of the UCR, showing that violence by perceived gang members declined 73 percent between 1993 and 2004.[49]

The House passed a highly punitive gang bill in 2005 that is a prime example of the difficulties involving public perception and crime prevention. One of the bill's provisions makes it easier to prosecute juveniles as adults in the federal system. Yet established research shows that prosecuting young people as adults does not reduce youth crime. Instead, it increases youth crime. Jails and prisons are crime schools. Young people prosecuted as adults are more likely to re-offend, and to re-offend more quickly and more seriously, than youths who remain in the juvenile justice system.[50]

Moreover, research shows that, in comparison to youth held in juvenile facilities, young people incarcerated with adults are five times as likely to be sexually assaulted by other inmates, twice as likely to be beaten by staff, 50 percent more likely to be assaulted with a weapon, and eight times more likely to commit suicide. A similar gang bill is under consideration in the Senate. Child advocacy and juvenile justice groups around the country have uniformly condemned these two bills as harmful to children and ineffective public policy for reducing group and gang violence.

In response to the passage of the House bill, H.R. 1279, the Federal Advisory Council on Juvenile Justice urged Congress to reject the transfer of juveniles to adult court, citing the large body of contradictory research, the critical need for judges to have discretion when sentencing juveniles, and the disparate impact of transfer on minorities, particularly Native Americans.[51]

The Benefits of Prevention and Intervention

We do know what works to prevent youth delinquency and reduce violence. Collaborative and comprehensive approaches to community violence that create working partnerships between law enforcement and prevention/intervention groups work. Prevention and intervention programs keep children from getting into trouble and pull children out of trouble. These programs also save lives and enormous taxpayer costs. For every child diverted from a lifetime of crime, we save between $1.3 and $1.5 million, a conservative estimate since potential cost benefits such as better salaries and reduced public service costs outside the justice system are difficult to measure.[52] To put these savings in another context, this means that a program that costs $10,000 per child, and has a success rate of only one in 100, still saves us more by serving 100 children and saving *only one* child than it would cost to lose that child to a lifetime of crime. Our public policies must be responsive to research and evaluation findings on the value of prevention and intervention.

Evidence-Based Approaches That Work

Research and evaluation demonstrates the effectiveness of many treatment-oriented, research-based, and focused family interventions for at-risk youth, such as:

- *Multi-Systemic Therapy (MST)* – Multi-Systemic Therapy is an intensive home-based intervention for chronic, violent, or substance abusing juvenile offenders, ages 12 to 17. Trained therapists work with the youth and his or her family. The program emphasizes addressing the causes of delinquency. Services are delivered in the youth's home, school, and community settings. There is an average of 60 hours of contact over a four-month period. Chronic juvenile offenders who graduated from intensive family MST therapy were one-third as likely to be rearrested within four years (22 percent) as the graduates of indi-

Youth Development – Table 2

In 2002, the number of children and teens killed by firearms – 2,867 – would fill 114 public elementary school classrooms.

Firearm deaths of children and teens, by age, manner, and race/Hispanic origin, 2002

	Under age 1	Ages 1-4	Ages 5-9	Ages 10-14	Ages 15-19	Total under age 20
All races	**10**	**61**	**71**	**274**	**2,451**	**2,867**
Accident	1	11	14	34	107	167
Suicide	0	0	0	86	742	828
Homicide	9	49	55	150	1,567	1,830
Undetermined intent	0	1	2	4	35	42
White	**4**	**42**	**45**	**174**	**1,374**	**1,639**
Accident	1	9	10	26	69	115
Suicide	0	0	0	73	632	705
Homicide	3	33	35	71	649	791
Undetermined intent	0	0	0	4	24	28
Black	**6**	**17**	**18**	**83**	**988**	**1,112**
Accident	0	2	3	6	36	47
Suicide	0	0	0	9	78	87
Homicide	6	14	13	68	865	966
Undetermined intent	0	1	2	0	9	12
American Indian, Alaska Native	**0**	**1**	**3**	**7**	**41**	**52**
Accident	0	0	1	1	2	4
Suicide	0	0	0	1	17	18
Homicide	0	1	2	5	20	28
Undetermined intent	0	0	0	0	2	2
Asian, Pacific Islander	**0**	**1**	**5**	**10**	**48**	**64**
Accident	0	0	0	1	0	1
Suicide	0	0	0	3	15	18
Homicide	0	1	5	6	33	45
Undetermined intent	0	0	0	0	0	0
Hispanic*	**0**	**17**	**17**	**38**	**509**	**581**
Accident	0	3	3	2	13	21
Suicide	0	0	0	10	88	98
Homicide	0	14	14	26	402	456
Undetermined intent	0	0	0	0	6	6

*Persons of Hispanic origin can be of any race.

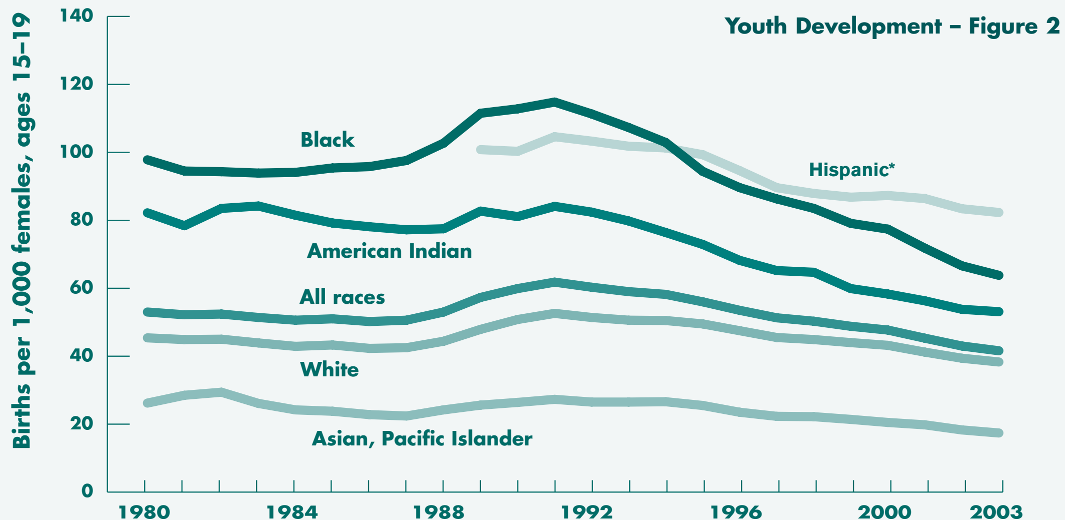
Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Control and Prevention, WISQARS, at <http://www.cdc.gov/ncipc/wisqars>, accessed December 2004. Calculations by Children's Defense Fund.

vidual therapy (71 percent). MST saves $28.33 for every dollar spent.[53]

- *Functional Family Therapy (FFT)* – Functional Family Therapy is a prevention/intervention program targeting youth ages 11 to 18 at risk for or engaged in delinquency, violence, substance use, or conduct disorders. Services generally require anywhere from 8 to 26 hours of direct service time per youth and can be conducted on an outpatient basis or as a home-based model. The program has an average of 12 home visits per family. Rates of offending and foster care or institutional placement have been reduced at least 25 percent and as much as 60 percent. Youths whose families received FFT were half as likely to be re-arrested as the youths whose families did not receive FFT (26 percent vs. 50 percent). FFT saves $28.81 for every dollar spent.[54]
- *Multidimensional Treatment Foster Care (MTFC)* – Multidimensional Treatment Foster Care is an alternative to group residential placement for high-risk and chronic juvenile offenders. Youth are placed with two trained and supervised foster parents for six to 12 months, and the youth's parents participate in family therapy. Boys randomly assigned to treatment foster care averaged half as many new arrests as the boys placed in group homes (2.6 arrests vs. 5.4 arrests). MTFC saves $43.70 for every dollar spent.[55]

Trends in Teen Birth Rates, 1980–2003

Despite the fact that teen birth rates are at their lowest since the 1970s, the United States still has the highest rates of teen pregnancy and births in the western industrialized world. According to the National Campaign to Prevent Teen Pregnancy, the concerns about these numbers are manifold. Teen mothers are less likely than other teens to complete high school and go on to college and are more likely to require public assistance. The children of these young mothers also suffer. Children of teenage mothers have lower birth weights than babies born to older mothers, are more likely to perform poorly in school, and are at greater risk of abuse and neglect. The sons of teen mothers are more likely to end up incarcerated, and daughters are more likely to become teen mothers themselves.



*Persons of Hispanic origin can be of any race. Hispanic data prior to 1989 not available.

Sources: U.S. Department of Health and Human Services, National Center for Health Statistics, *National Vital Statistics Report*, Vol. 54, No. 2, "Births: Final Data for 2003" (September 8, 2005), Tables 4 and 9; and National Campaign to Prevent Teen Pregnancy, "General Facts and Stats," at <http://www.teenpregnancy.org/resources/data/genlfact.asp>.

Programs Proven Successful

Additional successful interventions include early childhood, prevention, and school-based programs such as:

- *Nurse Home Visitation* – Nurse Home Visitation provides intensive visitation by nurses during a woman's pregnancy and the first two years after birth. Nurses support the development of the child as well as the parenting skills of the parents. In a 15-year follow-up, both the mothers and their children who had received home visitation had lower criminal outcomes than those not participating in the program. Nurse Home Visitation saves $3.06 for every dollar spent.[56]
- *Mentoring* – Mentoring evaluations have focused largely on the Big Brothers Big Sisters of America Program (BBBSA). Mentoring programs are invaluable community-based efforts, linking at-risk youths with adults who serve as role models and are trained to know when to refer youths to other community resources for needs they cannot address. The length of participation can last from several months to several years. Mentoring programs save an average of $5.29 for every dollar spent.[57]

The Washington State Institute for Public Policy analyzed the "bottom line" cost benefits of prevention and early intervention programs for youth and made general findings that are highly instructive for public policy choices with scarce resources:

- Investments in effective programs for juvenile offenders have the highest net benefit, saving $1,900 to $31,200 per youth.
- Home visiting programs that target high-risk and low-income mothers and children can return from $6,000 to $17,200 per youth.
- While net benefits are low, many substance abuse prevention programs are cost-effective because they are relatively inexpensive.
- Few programs are effective at reducing teenage pregnancy.
- Some programs are *neither beneficial nor cost-effective*. These include juvenile boot camps, and juvenile parole and "scared straight" programs that take juvenile offenders to visit adult prisons.[58]

Effectively Reducing and Preventing Community Violence: The "Boston Miracle"

The proliferation of guns and deadly group and gang violence among youths and young adults, particularly in poor inner city neighborhoods, is unacceptable. The human toll this violence exacts upon children, families, and communities simply cannot be overstated. In communities all across this country, children have witnessed friends and neighbors shot intentionally, accidentally, in schools, sitting in their cars, and even through the walls of their own living rooms. Parents, children, community and faith leaders, and elected officials are overcome with grief at each new tragedy. Yet, as detailed above, many policy makers seem more intent on approaches that sound tough and effective but in reality will do little or nothing to stop the violence that plagues communities, most of which is concentrated in impoverished neighborhoods in large cities.[59] Communities, families, and children deserve better.

One approach has been proven to work. Operation Ceasefire, which originated in Boston in 1996, is considered a national model for effective and dramatic youth and gang violence reduction. In one year, after record high levels of youth homicides, the youth homicide rate in Boston (for ages 15 to 24) dropped by two-thirds. This happened because a broad coalition of federal, state, and local governmental agencies, nonprofit community service organizations, businesses, religious leaders, parents, and resident stakeholders came together and agreed on one thing—the killing of young people by young people must stop.

Through nearly two years of comprehensive discussions and strategic planning, the working group developed and implemented the three main components of "Operation Ceasefire," a coordinated city-wide strategy to deter youth and gang firearm violence:

1. Law enforcement identified violent groups (such as drug crews) and gangs and held meetings with them. Research had shown that these groups and gangs, a very small percentage of youth, were

responsible for the clear majority of violent crime. Law enforcement communicated to group and gang members that the violence had to stop and that the consequences for violence would be swift, sure, and applicable to an entire gang. They promised that they would offer protection and help to everyone and would target any group committing an act of violence. Little enforcement was actually necessary; it was focused on the most violent groups and was repeatedly marketed to other groups as evidence that violence would not be tolerated. *This element reversed the street pressure in which groups egged on their members to commit violent acts.*

2. Community and faith leaders sent a loud, clear, and consistent moral message to gangs, as fellow community members, that the killing was wrong and must stop. Participants and evaluators reported that the message was effective even with the most hardened offenders. *This element made the position of the community clear, validated the position of law enforcement, and made it impossible for violent offenders to believe that they had community support for violence.*

3. Working with community partners, the city built a network of extensive services, targeted first at the core group of members of violent groups and gangs. These youths and young adults, in effect, "moved to the front of the line" for services. *This element focused help on violent offenders who would take it.*

The results of this transformational initiative have been called the "Boston miracle." They occurred without substantial new funding and within a few months of the first face-to-face meetings with violent groups and gangs. A similar program in Indianapolis, evaluated by academics from the University of Michigan, produced nearly identical results. The same kind of impact has been seen in Minneapolis; Stockton, California; High Point and Winston-Salem, North Carolina; Portland, Oregon; and Rochester, New York. Rochester adopted the model in 2003 and experienced a 70 percent drop in the homicide rate among Black males ages 15 to 30 by the end of 2004. Based on the Rochester success, New York is moving Operation Ceasefire to Buffalo, Syracuse, Albany, Newburgh, and Nassau County.

Jurisdictions across the country are paying close attention to this model as the only comprehensive violence prevention strategy that has shown such significant results in reducing gang and gun violence, allowing poor families and children to feel safe in their neighborhoods.

Successful Juvenile Justice System Reforms

Comprehensive juvenile detention reform is underway in many state and local jurisdictions

STORIES FROM THE STATES

Dreaming of Success

Jackie Chipilinski, wearing a t-shirt bearing the message "fearless," displays a common theme of adolescence as she contemplates her future dream of studying physical therapy at a local college. Tiffany Russell, attends an alternative high school for children who receive services for anger and other behavioral issues and wants to study cosmetology at Hocking College when she graduates. Robby Swaro, plans to join the army when he graduates from Trimble High School in 2006. All three live in Glouster, Ohio.

around the country. These reforms affirm the original intent of the juvenile justice system: to provide care, services, and rehabilitation for young offenders. It is clear that at-risk youths have much better outcomes when their needs are assessed and treated in the least restrictive environment possible. When incarceration is necessary for public safety reasons, smaller facilities near youths' homes and communities are highly preferrable to large facilities hundreds of miles away.

It is equally clear that youths need to know that someone cares about what happens to them and is invested in helping them to change. So many poor children end up in the juvenile justice system because they lack supports at every level. What happens to them there is critical. For far too many, it is the last stop before the adult criminal justice system. As Mark Steward, Director of the Missouri Department of Youth Services and its exemplary juvenile programs, explained, "[W]e put [the kids] in a safe and stable and supportive environment, some for the first time in their lives… With us they have an opportunity. Send them to a typical training school, where staff intimidate them and they have to fight to survive, and they've got no shot."

Providing a National Model

The state of Missouri is widely considered to have the best juvenile correctional system in the nation. Missouri closed its youth prisons in 1983 and divided the state into five regions so that confined juveniles would remain within driving distance of their homes. Each region has two facilities, housing no more than 40 youths each. One serves as a day treatment clinic to prevent the escalation of criminal behavior. The other is a lockup for more serious offenders. Instead of punishment, the state focuses on intensive individual and family counseling, academic and vocational education, and behavior modification.

While many states are adding mental health treatment as an occasional service, Missouri infuses mental health into every aspect of its correctional programs. Comprehensive treatment services include case management, family therapy, residential care, juvenile court diversion, intensive case supervision, school-based day treatment, and follow-up services to ensure a successful transition back to their communities.

From the first day they enter a juvenile facility, Missouri youth spend virtually every moment with a team of about 10 other teens. They eat together, study together, and live together, all under the supervision of two trained youth specialists. Any time a youth is troubled about anything, he or she can call a meeting of the team to discuss the problem and work out solutions.

Missouri is also remarkable for the way that it handles restraint of youths who become violent. They do not use "hog ties" or handcuffs. Youth are almost never held in isolation. Instead, they rely on their team framework. Only a staff member may authorize a restraint and once they do, the youth is physically restrained by members of his team until he regains his composure. This unorthodox method has shown remarkable results in the 15 years since its implementation by Director Mark Steward. There have been neither serious injuries from restraints nor lawsuits or complaints by parents. Serious fighting among youths is almost non-existent.

Missouri's success has not come at the expense of the budget. In 2002, the Missouri Department of Youth Services (DYS) spent $103 per youth, while Louisiana spent $270 per youth, Maryland spent $192, and Florida spent $271. All three states have youth recidivism rates dramatically higher than Missouri. Recidivism rates are measured differently in different states so comparisons are difficult, but Missouri arguably has the lowest recidivism rate in the nation. Seventy percent of youth released in 1999 avoided re-offending within three years. Missouri has disproved traditional concerns that public safety will be compromised if services and treatment are emphasized over incarceration.

Pursuing Detention Alternatives

In early 1998, the juvenile detention center in San Bernalillo County, New Mexico, reached an unmanageable high of 143 teens. Stackable bunk beds were added to the center to accommodate the overflow. Tensions rose for youth and staff alike.

Director Tom Swisstack established a steering committee of top officials from probation, prose-

cution, the public defender's office, and juvenile court to tackle the question of how to reduce the number of youths in detention. An extensive review of existing procedures revealed several problems. First, probation agreements contained so many conditions it was extremely difficult for youths to stay free of violations. This led to a frequency of probation revocations that landed youths back in detention. Moreover, youths picked up on "bench warrants" for not showing up for court dates would then be held over until the rescheduled court date.

San Bernalillo County implemented a series of reforms, including assessment and redesign of probation agreements to increase positive incentives and make violations less likely; institution of a system of established and graduated sanctions to decrease the frequency of probation violations; a new system for assisting youths in attending court dates and providing second chances for reasonable excuses; and the creation of an out-patient mental health clinic that provides counseling and medication for court-involved youth. In four years, the population of the San Bernalillo County Detention Center dropped from 143 to 63, a decrease of 56 percent. With a positive and systematic approach to change, the county has proven that alternatives to detention work and benefit all parties involved, especially youths.

Reducing Disproportionate Minority Confinement

One of the four core protections under the JJDPA requires states to create a strategy to address disproportionate minority representation in the juvenile justice system. Between 1983 and 1997, the youth detention population in the U.S. increased 47 percent, but youth of color accounted for 80 percent of this increase. Although they represent just 34 percent of the U.S. adolescent population, minority youths represent 62 percent of the youth in detention.[60]

Multnomah County, Oregon, has focused on reducing racial disparities in its juvenile court system, and the county has proven remarkably successful. In 1990, Latino youth were more than twice as likely to be detained as non-Hispanic White youth and Asians. Blacks and Native Americans were detained at rates that were 47 to 60 percent higher than non-Hispanic White youth. The county instituted several reforms including a new risk assessment tool to help in determining which youths should be detained, the hiring of more minority staff in probation, and additional staff to assist public defenders in effectively advocating for their low-income clients, many of whom were minorities.

Between 1995 and 2000, Multnomah County reduced the likelihood that an arrested youth would be detained to 12 percent for Blacks and 11 percent for Latinos, versus 9 percent for non-Hispanic Whites.[61] During the same period, the number of juveniles arrested for violent crimes dropped 24 percent, and the number of juveniles arrested for property crimes dropped 40 percent. The total crime rate for youth dropped 26 percent during this period, proving that jurisdictions can reduce racial disparities, make more modest use of detention, and still not compromise public safety.

Addressing the Unique Needs of Girls in the Juvenile Justice System

Girls are the fastest growing population in the juvenile justice system and their treatment must be gender-specific. The Pace Center for Girls, Inc. (Practical Academic Cultural Education) is a school-based program that serves as an alternative to incarceration. The success of the PACE Program is based on two key factors: a focus on understanding the relationship between victimization and female juvenile crime, and a strength-based approach that focuses on the unique potential of each girl, not the mistakes or poor choices she may have made. Components of the PACE program include academic education, individualized attention, gender-specific life management skills, mental health treatment, parental involvement, community volunteer opportunities, and a three-year comprehensive follow-up program.

For more than 15 years, PACE has advocated for fundamental changes in how we address the needs of girls in the juvenile justice system. PACE offers training and technical assistance that helps providers develop and implement gender-responsive programs or systems designed to assist girls at risk

or involved in the juvenile justice system. The mission of PACE is to provide girls and young women an opportunity for a better future through education, counseling, training, and advocacy.

Meaningful juvenile justice system reform is at work in various jurisdictions. These initiatives prove that the vast majority of at-risk youth do much better when they are referred to effective detention alternatives within their communities, and their multiple needs are assessed and comprehensively treated. Detention alternatives have been implemented without increases in either costs or crime rates, and in fact, many jurisdictions have seen decreases in both. Youths, families, and communities are well served when alternatives to detention are developed and implemented to address the multiple and comprehensive needs of system-involved youth and their families.

Recommendations for Moving Forward

Acknowledging and understanding the many dangers that young people face today as they make the journey to adulthood are key steps in creating a society where every young person has the love, support, and resources he or she needs to become a productive adult. We must address the various risk factors that contribute to youth delinquency, particularly within the exacerbating context of poverty, and we must look for the least restrictive way to provide help and assistance to at-risk youth within the context of public safety. Most importantly, we must realize the effectiveness and value of prevention and intervention.

At the same time, we cannot ignore that there is a small percentage of youths who commit violent offenses. These youths must be held accountable and receive the services and treatment they need for successful rehabilitation. But we must maintain perspective about what works to address root causes of delinquency and crime in the face of the fear that is generated anew whenever a newsworthy incident of violence involving youths or young adults occurs. It is critical to bear in mind that both violent youth crime and school violence have been steadily decreasing for the last decade.

The Children's Defense Fund believes our nation has the resources and knowledge to prevent every at-risk youth from embarking upon a lifetime of crime and that we also have the capacity to divert all youths who have engaged in delinquency. To do so will require a comprehensive commitment to the values of prevention and rehabilitation at all levels of decision-making. Key recommendations include:

All key players, including policy makers and government, judges, law enforcement, probation officers, youth services, educators, child-serving systems, community and faith leaders, parents, and all concerned citizens, must:

- Understand the myriad risk factors that contribute to and cause juvenile delinquency from birth on, including disadvantages in prenatal and health care, early childhood education, child welfare, education, mental health, and income and job opportunities.
- Acknowledge that these factors have a disparate impact on poor and minority youth.

All key players in youth policy and programmatic decision-making must:

- Commit to reducing the risk factors in a systematic and comprehensive way. This is clearly an enormous and highly complex task but youth delinquency will not be reduced in a vacuum.
- Change the contributing risk factors if we are to truly promote positive youth development for all young Americans.

Research shows that prevention and intervention work and save money. We must:

- Commit to and adequately fund prevention and intervention programs.
- Incorporate an underlying emphasis upon prevention into our public policies that affect at-risk and court-involved youth.

Research must drive policy, not the other way around. We must:

- Demand that our elected officials provide solutions to public safety problems that address the

root causes of crime and violence and that take into account the plethora of research that addresses these root causes.
- Have the courage to speak the truth, however politically unpopular, and realistically pursue policy supports for violence prevention and common sense gun safety.

We must learn from and replicate systemic reform efforts at the state and local levels, such as those occurring in Missouri, Bernalillo County, and Multnomah County.
- Pursue meaningful comprehensive juvenile justice system reform.
- Use incarceration only when necessary for public safety.
- Aggressively stamp out the abuse of juveniles within detention facilities.
- Ensure youths entering the system have their needs comprehensively assessed so that they receive appropriate and quality educational services as well as mental health and substance abuse treatment. Also provide them with re-entry support and planning as they reintegrate into their families, communities, and schools.

Preventing youth delinquency and promoting positive youth development requires the cooperation and collaboration of all child-serving systems and programs. CDF has begun an initiative that will focus on this goal. To do this, we must:
- Identify successful child-serving systems across the country and articulate commonalities in their strategies for success. Also identify jurisdictions that have created successful integrative services and collaborations between systems.
- Generate recommendations for building a seamless network of child-serving systems so that we can truly leave no child behind. This will lead to policy recommendations with grassroots foundations, and our policy recommendations will support ongoing systemic and programmatic reform.

Youth of today face enormous challenges. For poor and minority youth, the challenges are exacerbated and so is their need for comprehensive prevention and intervention programs. While the root causes of juvenile delinquency are extremely diverse and complex, the approach we must take is straightforward. Prevention works and research on established programs and child outcomes proves this. What we need is the political will to provide the support and resources for preventing delinquency and rehabilitating delinquent youths. Prison is not a foregone conclusion for any child. We must not give up on any child.

Endnotes

[1] National Center on Addiction and Substance Abuse at Columbia University (CASA), *Criminal Neglect: Substance Abuse, Juvenile Justice and the Children Left Behind* (2004).

[2] R. Sampson and J. Lauritsen, "Violent Victimization and Offending: Individual-, Situational-, and Community-Level Risk Factors," *Understanding and Preventing Violence*: Vol. 3, *Social Influences*, A.J. Reiss and J.A. Roth, eds. (Washington, DC: National Academy Press): 1-114.

[3] Katharine Browning, Terence P. Thornberry and Pamela K. Porter, "Highlights of Findings from the Rochester Youth Development Study," *OJJDP Fact Sheet #103*, FS-99103 (Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, April 1999).

[4] Robert J. Sampson, Steven W. Raudenbush and Felton Earls, "Neighborhoods and Violent Crime: A Multilevel Study of Collective Efficacy, *Science* 277 (August 1997). Retrieved from the Internet at http://www.wjh.harvard.edu/soc/faculty/sampson/1997.4.pdf on June 27, 2005.

[5] Todd I. Herrenkohl, et al., "Developmental Risk Factors for Youth Violence, *Journal of Adolescent Health* 26, No.7 (2000): 176-186.

[6] Amy Conseur, et al., "Maternal and Perinatal Risk Factors for Later Delinquency," *Pediatrics* 99, No. 6 (June 1997): 785-790.

[7] Lawrence J. Schweinhart, Helen V. Barnes and David P. Weikart, *Significant benefits: The High/Scope Perry Preschool study through age* 27 (Monographs of the High/Scope Educational Research Foundation, 10) (Ypsilanti, MI: High/Scope Press, 1993).

[8] David P. Farrington, "Early Predictors of Adolescent Aggression and Adult Violence," *Violence and Victims* 4, No. 2 (1989): 79-100.

[9] U.S. Department of Health and Human Services, Administration for Children, National Center on Child Abuse and Neglect, *Third National Incidence Study of Child Abuse and Neglect (NIS-3)* (Washington, DC: U.S. Department of Health and Human Services, September 1996).

[10] David C. Bellinger, "Lead," *Pediatrics* 113, No. 4 (2004): 1016-1022.

[11] Caroline Wolf Harlow, *Educational and Correctional Populations* (Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, 2002). Calculations by the Children's Defense Fund.

[12] Denise Johnston, "Effects of Parental Incarceration," in Katherine Gabel and Denise Johnston, eds., *Children of Incarcerated Parents* (New York, NY: Lexington Books, 1995): 59-88.

[13] U.S. House of Representatives, Committee on Government Reform, Minority Staff Special Investigations Division, *Incarceration of Youth Who Are Waiting for Community Mental Health Services in the United States* (Washington, DC: U.S. House of Representatives, July 2004). Retrieved from the Internet at http://www.house.gov/reform/min/pdfs_108_2/pdfs_inves/pdf_health_mental_health_youth_incarceration_july_2004_rep.pdf on June 27, 2005.

[14] Amy Conseur, et al., "Maternal and Perinatal Risk Factors for Later Delinquency," *Pediatrics* 99, No. 6 (June 1997): 788.

[15] Children's Defense Fund, *The State of America's Children 2004* (Washington, DC: Children's Defense Fund, 2004): xii.

[16] T.J. Matthews, Fay Menacker and Marian F. MacDorman, "Infant Mortality Statistics from the 2001 Period Linked Birth/Infant Death Data Set," *National Vital Statistics Reports* 52, No. 2 (2003): 1-28.

[17] Maureen Hack, et al., "Outcomes in Young Adulthood for Very-Low-Birth-Weight Infants," *New England Journal of Medicine* 346, No. 3 (2002); Naomi Breslau, Nigel S. Paneth and Victoria C. Lucia, "The Lingering Effects of Low Birth Weight Children," *Pediatrics* 114, No. 4 (2004): 1035-1040.

[18] Pamela A. Meyer, et al., "Surveillance for Elevated Blood Levels Among Children – 1997-2001," *Morbidity and Mortality Weekly Report* 52, No. SS10 (2003): 1-21. Retrieved from the Internet at http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5210a1.htm on June 27, 2005.

[19] David C. Bellinger, "Lead," *Pediatrics* 113, No. 4 (2004): 1016.

[20] Lawrence J. Schweinhart, Helen V. Barnes and David P. Weikart, *Significant benefits: The High/Scope Perry Preschool study through age* 27 (Monographs of the High/Scope Educational Research Foundation, 10) (Ypsilanti, MI: High/Scope Press, 1993).

[21] Child Trends Databank, *Early School Readiness* (Washington, DC: Child Trends). Retrieved from the Internet at http://www.childtrends databank.org/pdf/7_PDF.pdf on June 27, 2005.

[22] Caroline Wolf Harlow, *Educational and Correctional Populations* (Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, 2002). Calculations by the Children's Defense Fund.

[23] Terry Keleher, "Racial Disparities Related to School Zone Tolerance Policies." Testimony to the U.S. Commission on Civil Rights, February 18, 2000, Applied Research Center. Retrieved from the Internet at http://www.arc.org on June 27, 2005.

[24] Katharine Browning, Terence P. Thornberry and Pamela K. Porter, "Highlights of Findings from the Rochester Youth Development Study," OJJDP Fact Sheet #103, FS-99103 (Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, April 1999): 2.

[25] David P. Farrington, "Early Predictors of Adolescent Aggression and Adult Violence," *Violence and Victims* 4, No. 2 (1989): 79-100.

[26] Michael G. Maxfield and Cathy Spatz Widom, "The Cycle of Violence: Revisited Six Years Later," *Archives of Pediatric and Adolescent Medicine* 150 (April 1996): 390-95; Caroline Smith and Terence P. Thornberry, "The Relationship Between Childhood Maltreatment and Adolescent Involvement in Delinquency," *Criminology* 33, No. 4 (1995): 451-481; Matthew T. Zingraff, Jeremy Leiter, Kristen A. Myers and Matthew C. Johnson, "Child Maltreatment and Youthful Problem Behavior," *Criminology*, 31 No. 2 (1993): 173-202; Diana J. English, Cathy Spatz Widom and Carol Brandford, "Childhood Victimization and Delinquency, Adult Criminality and Violent Criminal Behaviors," final report presented to the National Institute of Justice on February 1, 2002.

[27] U.S. Department of Health and Human Services, Administration for Children, National Center on Child Abuse and Neglect, *Third National Incidence Study of Child Abuse and Neglect (NIS-3)* (Washington, DC: U.S. Department of Health and Human Services, September 1996).

[28] U.S. Census Bureau, "Table POV01. Age and Sex of All Peoples, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race," *Detailed Poverty Tables for 2003* (Washington, DC: U.S. Census Bureau, 2004). Retrieved from the Internet at http://pubdb3.census.gov/macro/032004/pov/new01_100.htm on June 27, 2005.

[29] General Accounting Office, *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services* (Washington, DC: General Accounting Office, April 2003).

[30] Joseph J. Cocozza, ed., *Responding to Youth with Mental Disorders in the Juvenile Justice System* (Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System, 1992).

[31] David P. Farrington, "Explaining and Preventing Crime: The Globalization of Knowledge – The American Society of Criminology 1999 Presidential Address," *Criminology* 38, No. 1 (2000): 1-24; Jeanne Brooks-Gunn, Greg J. Duncan and J. Lawrence Aber, eds., *Neighborhood Poverty* (New York, NY: Russell Sage Foundation, 1997).

[32] The National Center on Addiction and Substance Abuse (CASA) at Columbia University, *CASA Analysis of the Arrestee Drug Abuse Monitoring Program (ADAM) 2000* [Data file] (Washington, DC: U.S. Department of Justice, National Institute of Justice); Charles Puzzanchera, Anne L. Stahl, Terrence A. Finnegan, Nancy Tierney and Howard N. Snyder, *Juvenile Court Statistics 2000* (Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention).

[33] *Ibid.*

[34] Melissa Sickmund, "Juveniles in Corrections," *Juvenile Offenders and Victims National Report Series Bulletin* (Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, June 2004). Retrieved from the Internet at http://www.ncjrs.org/pdffiles1/ojjdp/202885.pdf on July 8, 2005.

[35] U.S. House of Representatives, Committee on Government Reform, Minority Staff Special Investigations Division, *Incarceration of Youth Who Are Waiting for Community Mental Health Services in the United States* (Washington, DC: U.S. House of Representatives, July 2004): 4. Retrieved from the Internet at http://www.house.gov/reform/min/pdfs_108_2/pdfs_inves/pdf_health_mental_health_youth_incarceration_july_2004_rep.pdf on June 27, 2005.

[36] American Bar Association, et al., *Justice Cut Short: An Assessment of Access to Counsel and Quality of Representation in Delinquency Proceedings in Ohio* (Columbus, OH: Ohio State Bar Foundation, March 2003).

[37] Building Blocks for Youth, Fact Sheet: "Punitive Policies Hit Youth of Color the Hardest." Retrieved from the Internet at http://www.building blocksforyouth.org/issues/dmc/facts_yoc.html on June 27, 2005.

[38] Building Blocks for Youth, *Donde Esta La Justicia? A Call to Action on Behalf of Latino and Latina Youth in the Juvenile Justice System.* Retrieved from the Internet at http://www.buildingblocksforyouth.org/latino_rpt/exec_eng.html on June 27, 2005.

[39] R. Cohen, "To Prisons or Hospitals: Race and Referrals in Juvenile Justice," *Journal of Health Care for the Poor and Underserved* 2, No. 2 (1991): 248-250; Sheldon L. Kaplan and J. Busner, "A Note on Racial Bias in the Admission of Children and Adolescents to State Mental Health Facilities Versus Correctional Facilities in New York," *American Journal of Psychiatry* 149, No. 6 (1992): 768-772.

[40] Julia Cass, *Dismantling the Cradle to Prison Pipeline* (Washington, DC: Children's Defense Fund, 2005): xv.

[41] Ralph F. Boyd, Jr., in a letter to The Honorable Ronnie Musgrove, Governor of Mississippi, "Re: CRIPA Investigation of Oakley and Columbia Training Schools in Raymond and Columbia, Mississippi" (June 19, 2003).

[42] Steve Aos, Polly Phipps, Robert Barnoski and Roxanne Lieb, *The Comparative Costs and Benefits of Programs to Reduce Crime* (Olympia, WA: Washington State Institute for Public Policy, May 2001). Retrieved from the Internet at http://nicic.org/Library/020074 on July 7, 2005.

[43] Dan Hurley, "Scientist at Work – Felton Earls: On Crime as Science (A Neighbor at a Time)," *The New York Times* (January 6, 2004): F1.

[44] Linda L. Dahlberg, Robin M. Ikeda and Marcie-jo Kresnow, "Guns in the Home and Risk of a Violent Death in the Home: Findings from a National Study," *The American Journal of Epidemiology* 160, No. 10 (November 2004): 929-936.

[45] Elliott Currie, *Crime and Punishment in America* (New York: Metropolitan Books, 1998).

[46] Coalition for Juvenile Justice, *Childhood on Trial: The Failure of Trying and Sentencing Youth in Adult Criminal Court* (Washington, DC: Coalition for Juvenile Justice, 2005) citing Barbara White Stack, "Is This Justice? Punishment Backfires Under 'Adult Time,'" *Pittsburgh Post-Gazette* (March 20, 2001).

[47] Jason Ziedenberg, "Ganging Up On Communities: Putting Gang Crime in Context" (Washington, DC: Justice Policy Institute, July 15, 2005). Retrieved from the Internet at http://www.justicepolicy.org/downloads/JPIGangreport705.pdf on August 8, 2005.

[48] Federal Bureau of Investigation, *Crime in the United States 2004: Uniform Crime Report* (Washington, DC: Department of Justice, October 2005). Retrieved from the Internet at http://www.fbi.gov/ucr/cius_04/.

[49] Erika Harrell, Bureau of Justice Statistics, "Violence by Gang Members, 1993-2003" (Washington, DC: U.S. Department of Justice, June 2005). Retrieved from the Internet at http://www.ojp.usdoj.gov/bjs/pub/pdf/vgm03.pdf on July 7, 2005.

[50] U.S. House of Representatives, *H.R. 1279 Gang Deterrence and Community Protection Act of 2005* (Washington, DC: U.S. House of Representatives, 2005).

[51] Federal Advisory Committee on Juvenile Justice, "Recommendation on Federal Gang Legislation" (May 17, 2005).

[52] Barbara J. Burns, et al., *Treatment, Services and Intervention Programs for Child Delinquents* (Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 2003) citing Mark A. Cohen, "The monetary value of saving a high-risk youth," *Journal of Quantitative Criminology* 14, No. 1 (March 1998): 5-33.

[53] Steve Aos, Polly Phipps, Robert Barnoski and Roxanne Lieb, *The Comparative Costs and Benefits of Programs to Reduce Crime* (Olympia, WA: Washington State Institute for Public Policy, May 2001): 18. Retrieved from the Internet at http://nicic.org/Library/020074 on July 7, 2005.

Steve Aos, Roxanne Lieb, Jim Mayfield, Marna Miller and Annie Pennucci, *Benefits and Costs of Prevention and Early Intervention Programs for Youth* (Olympia, WA: Washington State Institute for Public Policy, September 2004).

[54] *Ibid.*

[55] *Ibid.*

[56] *Ibid.*

[57] *Ibid.*

[58] Steve Aos, Roxanne Lieb, Jim Mayfield, Marna Miller and Annie Pennucci, *Benefits and Costs of Prevention and Early Intervention Programs for Youth* (Olympia, WA: Washington State Institute for Public Policy, September 2004): 7.

[59] "Highlights of the 2002-2003 National Youth Gang Surveys," U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, June 2005.

[60] Eileen Poe-Yamagata and Michael A. Jones, *And Justice for Some: Differential Treatment of Minority Youth in the Justice System* (Washington, DC: Youth Law Center – Building Blocks for Youth, April 2000).

[61] Justice Policy Institute, "Reducing Disproportionate Minority Confinement: The Multnomah County, Oregon Success Story and Its Implications" (Washington, DC: Justice Policy Institute, 2002).

Table A-1

National Trends

Poverty among Children

Year	Number of Children under 18 Who Are Poor	Child Poverty Rate	Number of Children[1] under 6 Who Are Poor	Poverty Rate for Children[1] under 6
1959	17,552,000	27.3%	n/a	n/a
1960	17,634,000	26.9	n/a	n/a
1961	16,909,000	25.6	n/a	n/a
1962	16,963,000	25.0	n/a	n/a
1963	16,005,000	23.1	n/a	n/a
1964	16,051,000	23.0	n/a	n/a
1965	14,676,000	21.0	n/a	n/a
1966	12,389,000	17.6	n/a	n/a
1967	11,656,000	16.6	n/a	n/a
1968	10,954,000	15.6	n/a	n/a
1969	9,691,000	14.0	3,298,000	15.3%
1970	10,440,000	15.1	3,561,000	16.6
1971	10,551,000	15.3	3,499,000	16.9
1972	10,284,000	15.1	3,276,000	16.1
1973	9,642,000	14.4	3,097,000	15.7
1974	10,156,000	15.4	3,294,000	16.9
1975	11,104,000	17.1	3,460,000	18.2
1976	10,273,000	16.0	3,270,000	17.7
1977	10,288,000	16.2	3,326,000	18.1
1978	9,931,000	15.9	3,184,000	17.2
1979	10,377,000	16.4	3,415,000	17.8
1980	11,543,000	18.3	4,030,000	20.5
1981	12,505,000	20.0	4,422,000	22.0
1982	13,647,000	21.9	4,821,000	23.3
1983	13,911,000	22.3	5,122,000	24.6
1984	13,420,000	21.5	4,938,000	23.4
1985	13,010,000	20.7	4,832,000	22.6
1986	12,876,000	20.5	4,619,000	21.6
1987	12,843,000	20.3	4,852,000	22.4
1988	12,455,000	19.5	5,032,000	22.6
1989	12,590,000	19.6	5,071,000	22.5
1990	13,431,000	20.6	5,198,000	23.0
1991	14,341,000	21.8	5,483,000	24.0
1992	15,294,000	22.3	5,781,000	25.0
1993	15,727,000	22.7	6,097,000	25.6
1994	15,289,000	21.8	5,878,000	24.5
1995	14,665,000	20.8	5,670,000	23.7
1996	14,463,000	20.5	5,333,000	22.7
1997	14,113,000	19.9	5,049,000	21.6
1998	13,467,000	18.9	4,775,000	20.6
1999	12,280,000	17.1	4,162,000	18.4
2000	11,587,000	16.2	4,066,000	17.8
2001	11,733,000	16.3	4,188,000	18.2
2002	12,133,000	16.7	4,296,000	18.5
2003	12,866,000	17.6	4,654,000	19.8
2004	13,027,000	17.8	4,737,000	19.9

[1]Related children in families

Source: U.S. Department of Commerce, Bureau of the Census.

Table A-2

Maternal and Infant Health

Year	Infant Mortality Rates[1] Total	White	Black	Black-White Ratio	Low Birth-weight[2]	Percent of Babies Born to Mothers Who Received Late[3] or No Prenatal Care Total	White	Black
1940	47.0	43.2	72.9	1.69	n/a	n/a	n/a	n/a
1950	29.2	26.8	43.9	1.64	n/a	n/a	n/a	n/a
1959	26.4	23.2	44.8	1.93	n/a	n/a	n/a	n/a
1960	26.0	22.9	44.3	1.93	7.7%	n/a	n/a	n/a
1961	25.3	22.4	41.8	1.87	7.8	n/a	n/a	n/a
1962	25.3	22.3	42.6	1.91	8.0	n/a	n/a	n/a
1963	25.2	22.2	42.8	1.93	8.2	n/a	n/a	n/a
1964	24.8	21.6	42.3	1.96	8.2	n/a	n/a	n/a
1965	24.7	21.5	41.7	1.94	8.3	n/a	n/a	n/a
1966	23.7	20.6	40.2	1.95	8.3	n/a	n/a	n/a
1967	22.4	19.7	37.5	1.90	8.2	n/a	n/a	n/a
1968	21.8	19.2	36.2	1.89	8.2	n/a	n/a	n/a
1969	20.9	18.4	34.8	1.89	8.1	8.1%	6.3%	18.2%
1970	20.0	17.8	32.6	1.83	7.9	7.9	6.2	16.6
1971	19.1	17.1	30.3	1.77	7.7	7.2	5.8	14.6
1972	18.5	16.4	29.6	1.80	7.7	7.0	5.5	13.2
1973	17.7	15.8	28.1	1.78	7.6	6.7	5.4	12.4
1974	16.7	14.8	26.8	1.81	7.4	6.2	5.0	11.4
1975	16.1	14.2	26.2	1.85	7.4	6.0	5.0	10.5
1976	15.2	13.3	25.5	1.92	7.3	5.7	4.8	9.9
1977	14.1	12.3	23.6	1.92	7.1	5.6	4.7	9.6
1978	13.8	12.0	23.1	1.93	7.1	5.4	4.5	9.3
1979	13.1	11.4	21.8	1.91	6.9	5.1	4.3	8.9
1980	12.6	10.9	22.2	2.04	6.8	5.1	4.3	8.8
1981	11.9	10.3	20.8	2.02	6.8	5.2	4.3	9.1
1982	11.5	9.9	20.5	2.07	6.8	5.5	4.5	9.6
1983	11.2	9.6	20.0	2.08	6.8	5.6	4.6	9.7
1984	10.8	9.3	19.2	2.06	6.7	5.6	4.7	9.6
1985	10.6	9.2	19.0	2.07	6.8	5.7	4.7	10.0
1986	10.4	8.8	18.9	2.15	6.8	6.0	5.0	10.6
1987	10.1	8.5	18.8	2.21	6.9	6.1	5.0	11.1
1988	10.0	8.4	18.5	2.20	6.9	6.1	5.0	10.9
1989	9.8	8.1	18.6	2.30	7.0	6.4	5.2	11.9
1990	9.2	7.6	18.0	2.37	7.0	6.1	4.9	11.3
1991	8.9	7.3	17.6	2.41	7.1	5.8	4.7	10.7
1992	8.5	6.9	16.8	2.43	7.1	5.2	4.2	9.9
1993	8.4	6.8	16.5	2.43	7.2	4.8	3.9	9.0
1994	8.0	6.6	15.8	2.39	7.3	4.4	3.6	8.2
1995	7.6	6.3	15.1	2.40	7.3	4.2	3.5	7.6
1996	7.3	6.1	14.7	2.41	7.4	4.0	3.3	7.3
1997	7.2	6.0	14.2	2.37	7.5	3.9	3.2	7.3
1998	7.2	6.0	14.3	2.38	7.6	3.9	3.3	7.0
1999	7.1	5.8	14.6	2.52	7.6	3.8	3.2	6.6
2000	6.9	5.7	14.1	2.47	7.6	3.9	3.3	6.7
2001	6.8	5.7	14.0	2.46	7.7	3.2	2.4	6.4
2002	7.0	5.8	14.4	2.48	7.8	3.6	3.1	6.2
2003	n/a	n/a	n/a	n/a	7.9	3.5	3.0	6.0

[1]Infant deaths before the first birthday per 1,000 live births

[2]Birthweight less than 2,500 grams (5 lbs., 8 oz.)

[3]Prenatal care begun in the last three months of pregnancy

n/a — data not available

Source: U.S. Department of Health and Human Services, National Center for Health Statistics.
Calculations by Children's Defense Fund.

Table A-3

Adolescent Childbearing

Year	Overall Fertility Rate[1]	Overall Unmarried Birth Rate[2]	Teen Fertility Rate[3]	Teen Unmarried Birth Rate[4]
1959	118.8	21.9	89.1	15.5
1960	118.0	21.6	89.1	15.3
1961	117.1	22.7	88.6	16.0
1962	112.0	21.9	81.4	14.8
1963	108.3	22.5	76.7	15.3
1964	104.7	23.0	73.1	15.9
1965	96.3	23.5	70.5	16.7
1966	90.8	23.4	70.3	17.5
1967	87.2	23.9	67.5	18.5
1968	85.2	24.4	65.6	19.7
1969	86.1	25.0	65.5	20.4
1970	87.9	26.4	68.3	22.4
1971	81.6	25.5	64.5	22.3
1972	73.1	24.8	61.7	22.8
1973	68.8	24.3	59.3	22.7
1974	67.8	23.9	57.5	23.0
1975	66.0	24.5	55.6	23.9
1976	65.0	24.3	52.8	23.7
1977	66.8	25.6	52.8	25.1
1978	65.5	25.7	51.5	24.9
1979	67.2	27.2	52.3	26.4
1980	68.4	29.4	53.0	27.6
1981	67.4	29.5	52.2	27.9
1982	67.3	30.0	52.4	28.7
1983	65.8	30.3	51.4	29.5
1984	65.4	31.0	50.6	30.0
1985	66.2	32.8	51.0	31.4
1986	65.4	34.2	50.2	32.3
1987	65.7	36.0	50.6	33.8
1988	67.2	38.5	53.0	36.4
1989	69.2	41.6	57.3	40.1
1990	70.9	43.8	59.9	42.5
1991	69.3	45.0	61.8	44.6
1992	68.4	44.9	60.3	44.2
1993	67.0	44.8	59.0	44.0
1994	65.9	46.2	58.2	45.8
1995	64.6	44.3	56.0	43.8
1996	64.1	43.8	53.5	42.2
1997	63.6	42.9	51.3	41.4
1998	64.3	43.3	50.3	40.9
1999	64.4	43.3	48.8	39.7
2000	65.9	44.0	47.7	39.0
2001	65.3	43.8	45.3	37.0
2002	64.8	43.7	43.0	35.4
2003	66.1	44.9	41.6	34.8

[1] Births per 1,000 females ages 15-44
[2] Births per 1,000 unmarried females ages 15-44
[3] Births per 1,000 females ages 15-19
[4] Births per 1,000 unmarried females ages 15-19

Source: U.S. Department of Health and Human Services, National Center for Health Statistics.

Table A-4

Youth Unemployment and Joblessness

	Total Unemployment Rates[1]			Youth Jobless Rate[2] for July
	All Ages	Age 16-19	Age 20-24	Age 16-19
1959	5.5%	14.6%	8.5%	49.2%
1960	5.5	14.7	8.7	47.4
1961	6.7	16.8	10.4	49.5
1962	5.5	14.7	9.0	48.0
1963	5.7	17.2	8.8	51.9
1964	5.2	16.2	8.3	50.8
1965	4.5	14.8	6.7	47.9
1966	3.8	12.8	5.3	44.0
1967	3.8	12.9	5.7	44.1
1968	3.6	12.7	5.8	44.7
1969	3.5	12.2	5.7	43.4
1970	4.9	15.3	8.2	45.5
1971	5.9	16.9	10.0	46.4
1972	5.6	16.2	9.3	44.8
1973	4.9	14.5	7.8	42.7
1974	5.6	16.0	9.1	43.0
1975	8.5	19.9	13.6	45.4
1976	7.7	19.0	12.0	43.4
1977	7.1	17.8	11.0	42.4
1978	6.1	16.4	9.6	39.9
1979	5.8	16.1	9.1	40.1
1980	7.1	17.8	11.5	42.2
1981	7.6	19.6	12.3	44.3
1982	9.7	23.2	14.9	47.9
1983	9.6	22.4	14.5	46.5
1984	7.5	18.9	11.5	43.3
1985	7.2	18.6	11.1	43.4
1986	7.0	18.3	10.7	43.3
1987	6.2	16.9	9.7	42.7
1988	5.5	15.3	8.7	40.4
1989	5.3	15.0	8.6	40.4
1990	5.5	15.5	8.8	43.6
1991	6.7	18.6	10.8	47.7
1992	7.4	20.0	11.3	48.0
1993	6.8	19.0	10.5	46.7
1994	6.1	17.6	9.7	46.0
1995	5.6	17.3	9.1	45.2
1996	5.4	16.7	9.3	46.0
1997	4.9	16.0	8.5	47.0
1998	4.5	14.6	7.9	45.3
1999	4.2	13.9	7.5	45.5
2000	4.0	13.1	7.1	46.5
2001	4.7	14.7	8.3	48.5
2002	5.8	16.5	9.7	52.3
2003	6.0	17.5	10.0	56.3
2004	5.5	17.0	9.4	56.1

[1] Percent of the labor force unemployed

[2] Percent of the youth population ages 16-19 without a job

Source: U.S. Department of Labor, Bureau of Labor Statistics. Calculations by Children's Defense Fund.

Table B1-1

Children in the States

Population and Poverty

	All Children, 2004		Poor Children 2003–2004		Poor Children 1999	
	Number	Percent of total population	Number	Percent of children in the state	County with highest child poverty rate	Percent of children in the county
Alabama	1,094,533	24.2%	249,443	23.3%	Perry County	49.2%
Alaska	188,229	28.7	20,602	11.2	Wade Hampton Census Area	29.6
Arizona	1,547,260	26.9	307,425	20.3	Apache County	43.0
Arkansas	676,550	24.6	168,876	25.9	Phillips County	45.6
California	9,596,463	26.7	1,776,733	18.9	Tulare County	33.0
Colorado	1,178,889	25.6	166,972	14.5	Costilla County	32.4
Connecticut	838,788	23.9	86,736	10.5	New Haven County	13.3
Delaware	193,506	23.3	26,296	13.8	Sussex County	15.3
District of Columbia	109,547	19.8	35,876	33.9	District of Columbia	31.7
Florida	4,003,290	23.0	688,812	17.7	Hamilton County	36.0
Georgia	2,332,567	26.4	483,807	21.3	Hancock County	45.4
Hawaii	298,693	23.7	42,370	14.4	Hawaii County	21.7
Idaho	372,411	26.7	70,901	19.6	Butte County	28.5
Illinois	3,238,150	25.5	535,347	16.8	Alexander County	39.1
Indiana	1,600,295	25.7	233,548	14.8	Crawford County	25.7
Iowa	680,437	23.0	83,160	12.4	Page County	22.3
Kansas	683,491	25.0	83,972	12.5	Sheridan County	27.9
Kentucky	980,187	23.6	240,258	25.0	Owsley County	56.4
Louisiana	1,164,961	25.8	343,256	30.0	East Carroll Parish	56.8
Maine	282,129	21.4	47,072	17.1	Washington County	23.0
Maryland	1,394,808	25.1	154,847	11.4	Baltimore City	31.0
Massachusetts	1,464,189	22.8	180,161	12.5	Suffolk County	25.2
Michigan	2,533,439	25.1	439,390	17.6	Lake County	29.2
Minnesota	1,240,280	24.3	130,105	10.7	Beltrami County	22.4
Mississippi	749,569	25.8	227,656	31.0	Holmes County	52.4
Missouri	1,384,542	24.1	219,816	16.2	Pemiscot County	43.6
Montana	208,093	22.5	39,341	19.2	Roosevelt County	41.8
Nebraska	434,566	24.9	55,616	13.1	Rock County	36.6
Nevada	603,596	25.9	111,478	18.8	Mineral County	21.9
New Hampshire	304,994	23.5	28,848	9.7	Coos County	11.9
New Jersey	2,156,059	24.8	251,387	11.8	Hudson County	22.4
New Mexico	492,287	25.9	133,560	27.7	Luna County	47.1
New York	4,572,363	23.8	925,501	20.7	Bronx County	41.7
North Carolina	2,118,492	24.8	455,439	21.9	Halifax County	33.3
North Dakota	138,955	21.9	20,969	15.5	Sioux County	45.2
Ohio	2,779,212	24.3	497,574	18.3	Vinton County	28.3
Oklahoma	859,870	24.4	173,181	20.7	Harmon County	38.2
Oregon	852,357	23.7	159,768	19.1	Malheur County	26.0
Pennsylvania	2,837,009	22.9	466,274	16.8	Philadelphia County	31.6
Rhode Island	243,813	22.6	50,390	21.0	Providence County	22.7
South Carolina	1,024,700	24.4	228,903	22.8	Allendale County	48.1
South Dakota	190,874	24.8	27,377	14.8	Buffalo County	61.8
Tennessee	1,391,289	23.6	285,832	21.1	Hancock County	37.7
Texas	6,266,779	27.9	1,411,655	22.9	Starr County	59.5
Utah	740,114	31.0	97,273	13.3	San Juan County	34.9
Vermont	134,894	21.7	15,411	11.7	Orleans County	19.0
Virginia	1,804,900	24.2	227,332	12.9	Clifton Forge City	39.8
Washington	1,486,020	24.0	251,702	17.2	Okanogan County	29.0
West Virginia	384,641	21.2	92,502	24.4	McDowell County	53.0
Wisconsin	1,307,986	23.7	178,511	14.0	Menominee County	39.9
Wyoming	116,932	23.1	15,941	14.0	Fremont County	24.4
United States	73,277,998	25.0	13,245,202	18.4	Buffalo County, South Dakota	61.8

Source: U.S. Department of Commerce, Bureau of the Census, "Annual Estimates of the Resident Population by Selected Age Groups for the United States and States: July 1, 2004 and April 1, 2000" (2005); U.S. Department of Commerce, Bureau of the Census, American Community Survey 2004, Table B17001; and U.S. Department of Commerce, Bureau of the Census, 2000 Census of Population and Housing, SF3. Calculations by Children's Defense Fund.

Table B1-2

Number and Percent of Children under 18 Who Are Poor, Based on 1999 Income

	One Race Only									
	All races		White		Black		American Indian, Alaska Native		Asian	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Alabama	237,881	21.5%	85,685	12.0%	142,772	40.5%	1,332	21.0%	973	14.0%
Alaska	22,041	11.8	8,866	7.8	958	12.7	8,164	22.7	1,055	15.8
Arizona	257,710	19.3	122,031	13.8	11,807	25.7	40,929	42.7	2,212	10.8
Arkansas	146,321	21.8	76,001	15.4	59,328	43.1	1,461	26.4	613	13.4
California	1,757,100	19.5	654,930	14.1	196,084	30.4	26,131	28.1	141,125	16.4
Colorado	121,614	11.3	71,058	8.5	10,301	22.1	2,909	24.3	2,458	10.9
Connecticut	85,908	10.4	36,005	5.8	23,268	24.5	445	17.6	1,383	6.5
Delaware	23,405	12.3	8,823	6.8	11,257	25.0	130	16.5	285	7.8
District of Columbia	35,367	31.7	1,504	9.0	31,427	37.6	97	22.9	380	23.6
Florida	627,997	17.6	295,099	12.0	253,733	33.9	3,253	25.5	7,653	12.8
Georgia	365,406	17.1	113,382	9.1	221,332	30.4	1,297	23.0	4,114	9.6
Hawaii	40,542	14.1	4,776	10.0	487	9.4	174	26.3	6,726	7.8
Idaho	51,868	14.3	41,155	12.9	366	19.8	1,738	29.4	257	10.2
Illinois	456,901	14.3	171,707	8.0	202,966	34.8	1,983	23.0	8,477	8.6
Indiana	187,801	12.2	120,413	9.3	50,754	32.3	795	17.9	1,450	11.3
Iowa	79,247	11.0	61,426	9.4	8,018	40.0	847	28.8	1,087	11.4
Kansas	83,957	12.0	52,636	9.2	14,081	29.7	1,409	19.1	1,461	13.0
Kentucky	203,547	20.8	160,848	18.8	33,399	38.8	632	32.2	717	10.5
Louisiana	319,670	26.6	82,339	12.2	224,551	47.3	2,165	26.6	3,519	23.5
Maine	40,171	13.7	36,469	13.0	695	34.3	889	39.0	559	21.7
Maryland	141,877	10.7	44,182	5.7	83,450	19.8	648	18.0	3,519	7.2
Massachusetts	177,383	12.0	93,438	8.0	28,136	27.3	1,119	27.1	10,287	17.6
Michigan	352,935	13.9	165,127	8.7	148,352	33.9	3,642	19.8	4,721	10.1
Minnesota	121,691	9.6	66,437	6.2	20,797	34.2	6,631	35.0	12,695	24.4
Mississippi	206,450	27.0	49,749	12.4	151,217	44.1	1,330	34.5	927	20.8
Missouri	220,556	15.7	135,328	12.0	69,031	34.9	1,811	27.2	1,663	12.3
Montana	42,912	19.0	30,856	15.9	188	24.8	9,327	44.7	195	15.8
Nebraska	54,477	12.3	36,103	9.5	8,702	38.3	2,167	38.9	556	10.1
Nevada	69,777	14.0	37,713	11.1	11,509	29.0	1,788	23.3	1,432	7.9
New Hampshire	23,635	7.8	20,698	7.2	682	25.6	110	18.7	380	9.3
New Jersey	227,754	11.1	89,085	6.5	81,003	24.8	1,021	21.0	8,119	6.5
New Mexico	125,218	25.0	56,661	19.7	3,222	32.7	26,003	41.0	634	14.6
New York	915,710	20.0	357,773	12.6	281,550	32.9	8,607	35.5	45,952	19.6
North Carolina	311,053	16.1	118,931	9.4	153,338	30.2	7,564	25.4	3,142	10.6
North Dakota	22,163	14.0	14,818	10.6	351	26.5	5,699	45.8	106	12.4
Ohio	408,685	14.4	228,720	10.0	146,909	36.7	1,651	24.9	3,400	11.1
Oklahoma	171,929	19.6	87,911	14.8	32,211	39.4	24,763	26.6	1,269	12.3
Oregon	121,460	14.7	84,473	12.6	4,744	29.9	3,348	26.8	2,584	10.8
Pennsylvania	421,745	14.7	234,932	10.2	129,204	35.8	1,559	30.5	9,115	16.8
Rhode Island	41,162	16.9	20,560	10.8	5,480	38.2	962	51.8	1,706	26.1
South Carolina	187,275	18.8	56,181	9.5	121,942	33.7	899	24.1	1,059	12.2
South Dakota	33,965	17.2	17,741	10.9	426	30.3	13,939	54.3	98	6.9
Tennessee	247,397	18.0	133,758	13.1	99,541	34.4	743	20.3	1,564	11.8
Texas	1,189,935	20.5	631,209	16.6	218,071	30.0	7,863	24.6	16,497	11.9
Utah	71,765	10.1	52,658	8.5	1,264	23.9	3,821	37.6	1,179	13.1
Vermont	16,595	11.4	15,318	11.1	237	21.6	176	26.3	235	15.1
Virginia	209,532	12.3	84,834	7.4	103,309	26.2	836	16.8	5,661	9.6
Washington	202,891	13.7	120,259	10.7	13,846	25.3	8,219	28.4	10,932	14.5
West Virginia	96,096	24.3	87,006	23.5	6,177	44.8	158	19.7	186	8.8
Wisconsin	150,166	11.2	77,633	6.9	45,299	41.7	4,665	27.0	7,347	23.0
Wyoming	18,215	14.5	14,315	12.7	128	17.2	1,712	42.4	61	8.8
United States	11,746,858	16.6	5,469,560	11.2	3,467,900	33.1	249,561	31.6	343,725	14.3

[1]People of Hispanic origin can be of any race.
—Too few poor children to calculate a reliable poverty rate.

Source: U.S. Department of Commerce, Bureau of the Census, 2000 Census of Population and Housing, SF3 tabulations.
Calculations by Children's Defense Fund.

Table B1-2

Number and Percent of Children under 18 Who Are Poor, Based on 1999 Income (continued)

	One Race Only									
	Native Hawaiian, Pacific Islander		Other		Two or More Races		Hispanic[1]		Non-Hispanic White	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Alabama	103	33.1%	3,117	31.1%	3,899	21.8%	6,910	29.1%	83,043	11.8%
Alaska	292	22.3	431	13.8	2,275	12.7	1,347	13.6	8,452	7.7
Arizona	386	19.5	67,071	30.3	13,274	18.9	141,543	29.3	58,992	8.9
Arkansas	182	33.0	4,791	32.1	3,945	27.6	10,104	32.7	71,940	15.0
California	7,414	20.3	612,382	29.6	119,034	17.7	1,074,580	27.2	280,593	8.9
Colorado	225	19.3	26,753	24.9	7,910	14.0	56,586	22.5	46,752	6.5
Connecticut	102	28.9	19,082	35.8	5,623	18.4	34,571	30.9	24,609	4.2
Delaware	0	—	1,692	29.4	1,218	18.3	3,521	26.9	7,579	6.1
District of Columbia	51	—	1,330	23.3	578	17.9	2,786	25.6	496	3.7
Florida	398	25.0	39,019	26.1	28,842	21.4	151,007	22.2	197,154	9.9
Georgia	194	21.6	15,949	26.7	9,138	19.0	31,984	24.6	100,326	8.4
Hawaii	10,375	28.3	644	18.4	17,360	16.0	7,079	21.1	3,917	9.0
Idaho	83	22.5	6,119	28.1	2,150	18.3	11,703	28.0	36,687	12.1
Illinois	134	13.8	54,895	21.5	16,739	16.6	107,087	19.8	128,577	6.8
Indiana	79	16.3	7,073	21.1	7,237	18.9	14,640	20.2	114,214	9.0
Iowa	49	—	3,718	26.7	4,102	24.3	7,338	24.0	58,578	9.1
Kansas	67	20.8	8,409	24.7	5,894	19.5	16,142	22.6	46,710	8.6
Kentucky	31	—	2,265	30.2	5,655	28.0	4,734	27.4	158,600	18.7
Louisiana	106	29.5	2,075	22.2	4,915	25.3	7,276	24.3	79,166	12.0
Maine	3	—	279	30.7	1,277	24.2	876	26.2	35,972	12.9
Maryland	14	3.1	4,613	15.2	5,451	11.6	9,266	13.3	40,651	5.4
Massachusetts	115	—	31,948	38.0	12,340	22.4	56,209	37.2	75,715	6.8
Michigan	100	18.8	11,171	24.8	19,822	22.0	25,221	21.7	155,146	8.4
Minnesota	55	13.9	5,735	24.8	9,341	21.2	12,259	23.0	62,016	5.9
Mississippi	16	—	1,216	31.7	1,995	23.9	3,348	29.6	48,635	12.3
Missouri	150	16.7	4,125	26.0	8,448	22.7	10,164	24.8	130,900	11.8
Montana	10	—	488	29.5	1,848	25.3	2,075	27.7	29,995	15.8
Nebraska	25	—	4,289	25.1	2,635	21.1	8,496	23.8	32,758	9.0
Nevada	226	10.2	12,026	21.2	5,083	15.1	29,233	20.5	23,170	8.6
New Hampshire	0	—	916	35.3	849	15.6	1,895	26.8	19,835	7.0
New Jersey	105	16.5	35,058	25.1	13,363	16.7	73,953	22.5	60,225	4.9
New Mexico	44	—	32,461	30.8	6,193	21.2	75,278	29.6	20,286	12.4
New York	759	34.5	163,995	38.9	57,074	28.5	308,765	35.9	263,623	10.4
North Carolina	187	18.4	17,977	31.4	9,914	21.1	33,335	29.2	107,161	8.8
North Dakota	0	—	251	31.3	938	26.7	814	28.1	14,479	10.5
Ohio	170	21.5	8,696	26.9	19,139	24.4	18,666	24.4	221,404	9.8
Oklahoma	132	25.0	10,045	32.5	15,598	23.7	21,034	30.9	80,853	14.2
Oregon	479	22.6	16,737	31.7	9,095	19.1	30,156	29.1	74,637	11.8
Pennsylvania	263	23.5	30,094	42.5	16,578	24.9	54,030	37.7	219,155	9.7
Rhode Island	85	—	8,982	45.6	3,387	29.7	16,013	46.9	15,272	8.6
South Carolina	28	—	3,617	31.7	3,549	20.4	7,692	28.5	53,341	9.2
South Dakota	30	—	260	23.1	1,471	28.4	1,118	27.6	17,382	10.8
Tennessee	75	16.2	4,962	29.6	6,754	24.5	9,734	26.9	130,105	12.9
Texas	759	21.3	271,541	30.7	43,995	21.1	734,288	31.2	205,667	8.3
Utah	1,073	18.3	7,914	23.5	3,856	15.1	16,603	22.2	46,022	7.8
Vermont	2	—	108	25.4	519	16.9	346	21.1	15,144	11.0
Virginia	92	10.3	6,321	15.1	8,479	13.1	14,469	14.7	78,671	7.2
Washington	1,342	19.1	29,878	34.0	18,415	17.7	51,733	30.3	104,147	9.8
West Virginia	33	—	362	31.0	2,174	31.3	1,025	29.0	86,369	23.5
Wisconsin	51	10.1	8,050	26.7	7,121	20.2	17,695	24.6	70,992	6.5
Wyoming	2	—	1,149	28.8	848	22.0	2,443	22.7	13,471	12.5
United States	26,696	22.7	1,612,079	29.8	577,337	19.9	3,339,170	27.8	4,059,584	9.3

Table B1-3

AFDC/TANF Benefit Levels and Participation

	Maximum monthly benefit for a three-person family[1]						Number of welfare (AFDC/TANF) recipients		
	July 1970		January 2003						
	Actual dollars	Inflation-adjusted value in 2003[2]	Actual dollars	As percent of 2003 poverty guideline	Rank	Percent change 1970-2003	August 1996	March 2005	Percent change[3]
Alabama	$ 65	$ 303	$ 215	16.9%	46	-29.0%	100,662	48,117	-52.2%
Alaska	328	1,528	923	58.1	1	-39.6	35,544	13,342	-62.5
Arizona	138	643	347	27.3	34	-46.0	169,442	98,165	-42.1
Arkansas	89	415	204	16.0	48	-50.8	56,343	18,845	-66.6
California	186	867	679	53.4	3	-21.6	2,581,948	1,092,422	-57.7
Colorado	193	899	356	28.0	32	-60.4	95,788	38,060	-60.3
Connecticut	283	1,318	636	50.0	5	-51.8	159,246	39,812	-75.0
Delaware	160	745	338	26.6	36	-54.7	23,654	12,296	-48.0
District of Columbia	195	909	379	29.8	29	-58.3	69,292	41,916	-39.5
Florida	114	531	303	23.8	38	-43.0	533,801	104,503	-80.4
Georgia	107	499	280	22.0	42	-43.8	330,302	87,979	-73.4
Hawaii	226	1,053	570	39.0	13	-45.9	66,482	20,713	-68.8
Idaho	211	983	309	24.3	37	-68.6	21,780	3,446	-84.2
Illinois	232	1,081	396	31.1	26	-63.4	642,644	97,736	-84.8
Indiana	120	559	288	22.6	41	-48.5	142,604	124,007	-13.0
Iowa	201	936	426	33.5	23	-54.5	86,146	42,942	-50.2
Kansas	222	1,034	429	33.7	22	-58.5	63,783	45,269	-29.0
Kentucky	147	685	262	20.6	44	-61.7	172,193	75,375	-56.2
Louisiana	88	410	240	18.9	45	-41.5	228,115	37,009	-83.8
Maine	135	629	485	38.1	14	-22.9	53,873	25,876	-52.0
Maryland	162	755	473	37.2	18	-37.3	194,127	54,658	-71.8
Massachusetts	268	1,249	618	48.6	7	-50.5	226,030	103,921	-54.0
Michigan	219	1,020	459	36.1	20	-55.0	502,354	216,726	-56.9
Minnesota	256	1,193	532	41.8	11	-55.4	169,744	73,880	-56.5
Mississippi	56	261	170	13.4	51	-34.8	123,828	33,795	-72.7
Missouri	104	485	292	23.0	39	-39.7	222,820	97,352	-56.3
Montana	202	941	507	39.9	12	-46.1	29,130	12,894	-55.7
Nebraska	171	797	364	28.6	31	-54.3	38,592	23,300	-39.6
Nevada	121	564	348	27.4	33	-38.3	34,261	15,531	-54.7
New Hampshire	262	1,221	625	49.1	6	-48.8	22,937	14,333	-37.5
New Jersey	302	1,407	424	33.3	24	-69.9	275,637	105,044	-61.9
New Mexico	149	694	389	30.6	27	-44.0	99,661	44,476	-55.4
New York	279	1,300	577	45.4	8	-55.6	1,143,962	322,681	-71.8
North Carolina	145	676	272	21.4	43	-59.7	267,326	65,919	-75.3
North Dakota	213	992	477	37.5	16	-51.9	13,146	7,242	-44.9
Ohio	161	750	373	29.3	30	-50.3	549,312	180,165	-67.2
Oklahoma	152	708	292	23.0	39	-58.8	96,201	26,448	-72.5
Oregon	184	857	460	36.2	19	-46.3	78,419	46,354	-40.9
Pennsylvania	265	1,235	421	33.1	25	-65.9	531,059	253,763	-52.2
Rhode Island	229	1,067	554	43.6	9	-48.1	56,560	27,157	-52.0
South Carolina	85	396	205	16.1	47	-48.2	114,273	34,955	-69.4
South Dakota	264	1,230	483	38.0	15	-60.7	15,896	5,871	-63.1
Tennessee	112	522	185	14.5	50	-64.5	254,818	185,246	-27.3
Texas	148	690	201	15.8	49	-70.8	649,018	195,944	-69.8
Utah	175	815	474	37.3	17	-41.9	39,073	23,016	-41.1
Vermont	267	1,244	709	55.8	2	-43.0	24,331	11,459	-52.9
Virginia	225	1,048	389	30.6	27	-62.9	152,845	28,126	-81.6
Washington	258	1,202	546	42.9	10	-54.6	268,927	140,461	-47.8
West Virginia	114	531	453	35.6	21	-14.7	89,039	27,219	-69.4
Wisconsin	184	857	673	52.9	4	-21.5	148,888	46,749	-68.6
Wyoming	213	992	340	26.7	35	-65.7	11,398	545	-95.2
United States[4]	184	857	396	31.1	—	-53.8	12,077,254	4,547,143	-62.3

[1]Where benefits vary by program status, benefits shown are for families required to work. Benefits in Wisconsin are for families in community service. Where benefits vary by place within a state, the highest benefit is generally shown.
[2]The Consumer Price Index for All Urban Consumers (CPI-U) inflation adjustment for converting July 1970 dollars to January 2003 dollars was 4.659.
[3]Some states changed the definition of their caseload. California removed two-parent families; Texas added families enrolled during a month; Wisconsin added child-only cases.
[4]Benefit levels are medians; enrollment figures are totals for 50 states and the District of Columbia.

Sources: U.S. Congress, House of Representatives, Committee on Ways and Means, 2004 Green Book, WMCP 108-6, Table 7-13, at <http://waysandmeans.house.gov/Documents.asp?section=813>; and U.S. Department of Health and Human Services, Office of Family Assistance, at <http://www.acf.hhs.gov/programs/ofa/caseload/caseloadindex.htm>. Calculations by Children's Defense Fund.

Table B1-4

Child Support Enforcement, 2002

	Cases	Court order	Percent with court order	Collection	Percent with collection
Alabama	259,413	171,787	66.2%	113,717	43.8%
Alaska	46,385	38,452	82.9	29,733	64.1
Arizona	237,710	149,328	62.8	92,218	38.8
Arkansas	131,109	102,961	78.5	70,910	54.1
California	1,906,364	1,434,766	75.3	793,194	41.6
Colorado	134,387	112,136	83.4	62,653	46.6
Connecticut	206,731	132,409	64.0	84,369	40.8
Delaware	54,132	38,078	70.3	27,550	50.9
District of Columbia	107,951	32,014	29.7	16,910	15.7
Florida	669,165	435,620	65.1	353,708	52.9
Georgia	476,456	324,380	68.1	195,174	41.0
Hawaii	94,787	56,088	59.2	30,583	32.3
Idaho	79,772	62,280	78.1	45,410	56.9
Illinois	865,936	353,188	40.8	205,219	23.7
Indiana	311,058	219,561	70.6	143,180	46.0
Iowa	170,885	150,027	87.8	128,522	75.2
Kansas	141,158	90,210	63.9	65,341	46.3
Kentucky	312,494	218,822	70.0	132,399	42.4
Louisiana	265,642	178,942	67.4	123,955	46.7
Maine	65,084	56,732	87.2	41,201	63.3
Maryland	309,645	212,566	68.6	152,033	49.1
Massachusetts	245,921	174,559	71.0	110,235	44.8
Michigan	977,654	745,135	76.2	453,993	46.4
Minnesota	240,371	187,587	78.0	153,346	63.8
Mississippi	290,044	144,546	49.8	104,618	36.1
Missouri	390,552	308,247	78.9	172,333	44.1
Montana	40,104	30,896	77.0	24,148	60.2
Nebraska	98,137	74,628	76.0	57,606	58.7
Nevada	94,417	56,983	60.4	39,079	41.4
New Hampshire	37,391	30,669	82.0	26,961	72.1
New Jersey	340,875	268,389	78.7	227,583	66.8
New Mexico	70,294	31,140	44.3	23,890	34.0
New York	899,276	656,700	73.0	445,833	49.6
North Carolina	426,096	311,702	73.2	245,796	57.7
North Dakota	31,113	23,386	75.2	21,223	68.2
Ohio	901,429	643,410	71.4	490,479	54.4
Oklahoma	140,798	98,122	69.7	70,905	50.4
Oregon	246,669	165,046	66.9	115,226	46.7
Pennsylvania	589,847	489,368	83.0	421,739	71.5
Rhode Island	70,085	35,876	51.2	21,198	30.2
South Carolina	224,971	150,078	66.7	101,586	45.2
South Dakota	42,724	26,734	62.6	23,170	54.2
Tennessee	350,470	198,178	56.5	142,947	40.8
Texas	951,631	656,579	69.0	497,260	52.3
Utah	74,795	63,617	85.1	57,731	77.2
Vermont	24,344	20,853	85.7	15,753	64.7
Virginia	361,504	289,918	80.2	199,862	55.3
Washington	302,812	275,559	91.0	236,592	78.1
West Virginia	115,766	86,703	74.9	59,173	51.1
Wisconsin	339,882	268,455	79.0	220,246	64.8
Wyoming	39,299	30,813	78.4	22,384	57.0
United States	15,805,535	11,114,223	70.3	7,710,874	48.8

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Support Enforcement, "FY 2002 Annual Statistical Report," Tables 43, 44, and 53, at <http://www.acf.hhs.gov/programs/cse/pubs/2003/reports/annual_statistical_report/>. Calculations by Children's Defense Fund.

Table B1-5

Housing Costs

	Fair Market Rent[1] 2005	Minimum Wage[2] 2005	Fair Market Rent as a Percent of Minimum Wage[3] 2005	Persons in households paying 30 percent or more of income for housing,[4] 2000					
				Under age 18				Ages 18-64	Ages 65+
				All incomes		Poor		All incomes	All incomes
				Number	Percent	Number	Percent	Percent	Percent
Alabama	$ 435	$ 5.15	48.7%	283,882	26.9%	145,775	71.6%	21.2%	21.6%
Alaska	916	7.15	73.9	53,258	30.7	14,751	74.4	24.3	26.0
Arizona	650	5.15	72.8	412,163	31.9	164,114	71.6	25.8	24.4
Arkansas	473	5.15	53.0	172,480	27.1	95,606	74.2	20.6	20.9
California	587	6.75	50.2	3,735,942	42.4	1,351,629	83.2	33.7	31.9
Colorado	563	5.15	63.1	342,340	32.4	86,770	79.0	26.4	24.9
Connecticut	755	7.10	61.3	260,205	32.0	62,384	80.3	24.3	30.1
Delaware	616	6.15	57.8	49,444	26.7	15,011	72.9	20.9	22.3
District of Columbia	1,187	6.60	103.8	38,020	36.3	22,366	72.6	27.6	29.8
Florida	555	6.15	52.1	1,216,746	35.1	451,585	80.4	27.6	25.9
Georgia	527	5.15	59.0	608,653	29.5	241,713	74.2	23.1	25.0
Hawaii	955	6.25	88.2	106,594	40.8	28,598	79.5	32.6	24.8
Idaho	512	5.15	57.4	98,321	28.2	34,840	75.4	23.6	21.2
Illinois	523	6.50	46.4	958,183	30.8	324,143	78.8	23.6	25.2
Indiana	522	5.15	58.5	340,522	22.6	127,381	74.7	17.9	20.7
Iowa	515	5.15	57.7	143,615	20.5	53,466	73.9	17.3	17.8
Kansas	561	5.15	62.8	144,088	21.3	55,512	73.3	18.0	18.6
Kentucky	483	5.15	54.1	242,631	26.0	125,524	69.6	20.5	20.2
Louisiana	471	5.15	52.8	321,319	28.3	195,287	70.5	22.0	22.2
Maine	542	6.35	49.2	80,264	28.0	27,909	74.7	22.4	24.8
Maryland	439	5.15	49.2	390,101	30.1	97,774	77.4	23.4	25.3
Massachusetts	654	6.75	55.9	456,014	31.5	124,938	77.8	24.4	30.0
Michigan	555	5.15	62.2	639,000	25.6	254,236	78.1	19.3	21.4
Minnesota	524	5.15	58.7	294,977	23.6	83,947	73.8	18.3	21.8
Mississippi	515	5.15	57.7	213,993	29.7	125,718	69.9	22.8	23.9
Missouri	494	5.15	55.3	331,517	24.4	147,403	74.1	18.9	19.9
Montana	514	5.15	57.6	63,984	29.9	26,201	69.1	25.8	22.5
Nebraska	585	5.15	65.5	94,001	22.1	34,609	71.2	18.3	19.9
Nevada	852	5.15	95.4	171,528	35.3	49,672	80.1	28.3	31.1
New Hampshire	930	5.15	104.2	83,888	28.0	17,058	78.4	22.2	29.5
New Jersey	814	5.15	91.2	734,553	36.5	169,535	83.8	27.7	34.8
New Mexico	487	5.15	54.6	148,992	31.3	72,084	63.9	26.0	22.7
New York	513	6.00	49.3	1,760,226	39.7	690,076	84.2	30.1	33.8
North Carolina	508	5.15	56.9	539,201	29.0	207,133	75.4	22.6	23.9
North Dakota	509	5.15	57.0	28,156	18.8	12,298	63.4	17.0	20.0
Ohio	460	5.15	51.5	741,264	26.7	284,485	76.6	20.3	22.6
Oklahoma	457	5.15	51.2	209,550	25.1	105,351	69.5	20.2	19.1
Oregon	616	7.25	49.0	289,135	35.8	89,752	80.2	28.4	27.7
Pennsylvania	428	5.15	47.9	796,057	28.5	286,938	75.7	21.6	25.0
Rhode Island	774	6.75	66.2	80,847	34.0	29,297	77.7	25.4	31.6
South Carolina	484	5.15	54.2	274,117	28.8	120,723	74.2	22.5	23.2
South Dakota	607	5.15	68.0	42,284	22.8	18,472	66.5	19.0	21.5
Tennessee	476	5.15	53.3	375,687	28.3	162,843	74.3	21.9	21.9
Texas	479	5.15	53.7	1,535,480	27.5	737,580	69.6	21.8	22.8
Utah	572	5.15	64.1	220,767	31.8	52,707	81.4	25.3	18.8
Vermont	810	7.00	66.8	43,306	30.5	11,906	77.5	25.1	28.6
Virginia	476	5.15	53.3	471,815	28.5	139,218	74.6	22.2	22.3
Washington	605	7.35	47.5	515,349	35.7	146,328	78.8	28.7	27.0
West Virginia	439	5.15	49.2	99,525	26.6	57,441	68.2	20.6	17.1
Wisconsin	529	5.15	59.3	331,323	25.1	107,303	77.9	19.5	23.5
Wyoming	470	5.15	52.7	26,650	22.2	11,250	68.9	19.5	18.4
United States		5.15		21,611,957	31.4	8,098,640	76.7	24.6	25.6

[1] See *Federal Register*, Vol. 69, No. 190 (October 1, 2004), pp. 59004-59010 for a detailed explanation of fair market rent. FMR is used to determine the amount of housing assistance vouchers or subsidies. The FMRs reported here are the monthly rents for a two-bedroom apartment in the lowest-cost metropolitan area in the state.

[2] The national minimum wage is $5.15 per hour; some states have their own, higher, minimum wage.

[3] Before-tax income based on full-time, year-round work.

[4] Percent calculations limited to households with income and housing costs greater than zero and for whom poverty status and housing cost data are available.

Sources: U.S. Department of Housing and Urban Development, "Fair Market Rents... Fiscal Year 2005," *Federal Register*, Vol. 69, No. 190 (October 1, 2004), pp. 59003-59070; U.S. Department of Labor, Employment Standards Administration, Minimum Wage and Overtime Premium Pay Standards Applicable to Nonsupervisory NONFARM Private Sector Employment Under State and Federal Laws, January 1, 2005, at <http://www.dol.gov/esa/minwage/america.htm>; and U.S. Department of Commerce, Bureau of the Census, 2000 Census of Population and Housing, unpublished tabulations extracted by the Children's Defense Fund. Calculations by Children's Defense Fund.

Number of Children Receiving Food Stamps, FY 1989, FY 1994, FY 1999 – FY 2003

	FY 1989	FY 1994	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
Alabama	203,627	280,653	216,200	201,592	215,029	212,394	225,258
Alaska	13,852	24,710	20,743	20,495	19,073	23,678	25,382
Arizona	142,460	280,587	150,380	153,290	173,284	226,840	250,572
Arkansas	103,406	134,327	130,021	119,945	135,647	139,107	156,173
California	1,130,068	2,206,228	1,336,701	1,254,677	1,131,254	1,161,171	1,150,598
Colorado	108,030	142,831	84,579	74,918	73,850	87,090	103,070
Connecticut	62,617	123,647	86,894	82,366	69,479	72,891	83,694
Delaware	15,639	28,661	19,432	16,501	16,956	20,930	24,000
District of Columbia	29,772	52,408	42,400	44,274	32,894	32,621	33,938
Florida	319,164	748,014	425,329	405,698	413,195	435,201	472,407
Georgia	247,169	415,623	328,559	292,312	282,110	334,649	378,116
Hawaii	39,780	56,673	61,446	52,062	50,093	47,816	40,569
Idaho	29,783	43,834	29,799	29,016	31,830	36,100	38,829
Illinois	480,701	546,825	397,268	379,611	416,832	409,122	470,729
Indiana	139,258	254,607	159,095	153,820	176,501	204,165	230,740
Iowa	80,704	96,003	60,457	59,176	58,884	66,004	71,171
Kansas	60,856	89,723	56,731	52,349	57,791	69,799	72,654
Kentucky	190,408	228,424	167,608	177,774	187,176	198,531	215,517
Louisiana	356,575	403,454	280,474	267,902	272,622	315,290	318,987
Maine	38,077	59,146	41,572	33,833	44,651	42,104	44,862
Maryland	127,879	206,048	142,036	104,334	97,221	103,912	124,138
Massachusetts	153,172	240,069	131,011	128,532	118,607	123,195	149,588
Michigan	445,279	539,922	343,440	314,814	323,391	385,787	413,122
Minnesota	120,559	175,763	95,861	102,834	105,419	107,834	112,063
Mississippi	224,555	252,405	152,968	143,083	153,755	172,154	176,279
Missouri	192,188	295,224	197,603	199,391	208,570	248,665	266,920
Montana	26,322	35,654	28,819	28,151	25,724	29,929	31,398
Nebraska	45,161	62,558	45,471	37,438	41,562	43,737	46,043
Nevada	19,408	45,887	28,936	32,967	34,714	51,139	54,293
New Hampshire	9,273	30,016	19,239	17,739	17,374	18,278	21,307
New Jersey	191,648	290,707	193,346	160,218	148,468	151,550	168,677
New Mexico	75,537	126,461	92,563	89,952	88,564	87,847	103,200
New York	722,389	1,094,408	718,290	627,158	656,101	623,170	639,008
North Carolina	177,509	313,632	258,261	233,276	233,795	288,035	312,225
North Dakota	18,890	22,968	16,147	14,663	16,907	18,766	19,026
Ohio	492,247	598,321	305,001	302,998	290,359	336,660	413,507
Oklahoma	123,659	190,671	131,670	128,232	128,776	160,108	189,250
Oregon	90,838	134,838	103,126	103,061	122,147	162,130	169,892
Pennsylvania	441,560	544,571	395,157	354,724	345,540	345,011	361,935
Rhode Island	29,370	51,496	41,458	41,871	40,117	40,434	37,511
South Carolina	137,577	205,812	157,901	146,533	160,349	191,374	226,053
South Dakota	25,213	24,734	22,140	23,886	21,571	25,910	24,095
Tennessee	230,158	347,335	217,141	231,108	229,189	279,527	314,756
Texas	846,306	1,406,259	800,811	753,763	792,354	910,531	1,123,744
Utah	52,402	68,105	53,059	41,425	41,757	47,657	58,796
Vermont	14,362	29,579	18,208	18,728	14,404	16,288	15,679
Virginia	148,798	275,223	168,992	148,798	150,121	169,836	181,150
Washington	153,771	231,318	152,780	134,342	142,430	155,815	170,739
West Virginia	111,043	135,908	96,025	92,058	89,288	91,317	100,044
Wisconsin	175,538	181,645	96,597	102,242	110,460	154,405	161,366
Wyoming	14,572	16,868	12,554	12,640	10,818	11,423	12,448
United States	9,429,127	14,390,783	9,332,299	8,742,570	8,819,003	9,687,927	10,605,518

Source: U.S. Department of Agriculture, Food and Nutrition Service, unpublished tabulations from Fiscal Year QC database.

Table B1-7

Participation in Child Nutrition Programs, FY 2004

	School Lunch	School Breakfast	Summer Food	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)				Child and Adult Care Food Program (children only)[1]
				Women	Infants	Children	Total	
Alabama	557,539	175,582	39,297	28,794	33,555	57,961	120,310	41,578
Alaska	50,517	12,080	1,490	6,225	6,329	13,986	26,541	9,407
Arizona	544,948	178,678	4,773	42,555	45,838	87,591	175,984	59,327
Arkansas	322,284	133,161	11,902	24,345	24,390	40,425	89,159	29,146
California	2,788,900	934,280	106,962	313,985	290,618	688,094	1,292,697	304,431
Colorado	332,848	72,679	5,321	21,177	22,697	39,535	83,409	33,464
Connecticut	291,020	52,334	6,575	10,692	14,485	26,951	52,128	16,547
Delaware	78,017	22,546	8,648	3,886	5,242	9,173	18,301	10,684
District of Columbia	46,022	21,947	33,099	4,093	4,405	7,596	16,093	5,678
Florida	1,442,874	528,540	104,998	93,870	99,464	179,695	373,030	138,211
Georgia	1,169,724	443,342	77,877	68,736	70,166	120,926	259,828	114,705
Hawaii	125,346	38,987	5,645	8,077	8,149	16,976	33,202	8,898
Idaho	152,884	41,931	13,417	8,651	8,861	18,766	36,279	6,279
Illinois	1,057,321	213,311	63,035	67,717	81,426	126,690	275,833	116,176
Indiana	672,818	140,072	45,060	34,619	38,589	58,114	131,321	53,226
Iowa	384,626	72,587	6,769	15,533	15,316	35,339	66,188	29,567
Kansas	321,806	77,953	11,118	15,189	16,186	32,613	63,987	53,431
Kentucky	528,305	206,623	54,103	27,719	29,947	59,508	117,175	41,803
Louisiana	632,806	246,865	37,391	35,867	41,746	64,006	141,619	61,140
Maine	106,077	29,210	6,012	5,450	5,557	11,909	22,916	13,472
Maryland	426,105	118,690	36,964	27,245	30,226	50,072	107,542	45,889
Massachusetts	541,556	114,725	28,250	28,206	27,316	60,242	115,764	51,601
Michigan	849,905	218,083	38,740	52,155	53,788	115,838	221,781	68,701
Minnesota	581,317	113,869	26,961	27,793	28,058	60,826	116,677	103,277
Mississippi	401,044	181,526	23,836	23,987	31,361	47,390	102,738	31,691
Missouri	610,530	183,540	35,869	35,176	36,165	61,423	132,763	49,693
Montana	78,644	19,400	10,203	4,894	4,349	12,053	21,296	13,101
Nebraska	225,281	42,131	5,298	9,616	10,090	19,962	39,668	34,948
Nevada	146,033	44,797	3,805	11,850	13,464	20,981	46,295	9,246
New Hampshire	111,572	19,603	3,902	3,828	4,189	8,705	16,722	6,185
New Jersey	617,340	101,350	54,927	36,072	37,001	70,178	143,251	56,666
New Mexico	207,893	99,330	40,324	14,648	15,908	32,974	63,530	41,024
New York	1,799,770	493,958	405,393	118,701	122,055	232,128	472,883	229,447
North Carolina	884,746	319,174	34,181	54,881	57,288	106,749	218,918	114,755
North Dakota	77,677	15,085	3,055	3,310	3,284	7,523	14,117	16,758
Ohio	1,050,068	237,463	39,534	63,016	81,371	122,882	267,269	96,195
Oklahoma	389,194	166,830	11,214	28,699	29,946	57,491	116,136	56,635
Oregon	280,585	122,433	9,739	24,744	20,380	55,012	100,135	31,053
Pennsylvania	1,085,104	225,595	118,210	54,650	62,611	123,442	240,702	96,729
Rhode Island	85,235	22,735	7,942	5,268	5,789	11,722	22,779	9,622
South Carolina	473,091	187,995	67,067	28,298	30,086	48,400	106,784	31,224
South Dakota	103,208	20,450	3,701	4,962	5,410	11,238	21,610	11,381
Tennessee	647,082	219,971	40,188	40,303	43,015	72,076	155,394	54,307
Texas	2,770,515	1,234,653	80,136	211,771	216,730	439,085	867,586	198,711
Utah	289,404	43,808	21,986	17,494	17,761	31,534	66,788	27,863
Vermont	54,555	17,724	3,103	3,390	3,280	9,620	16,290	6,635
Virginia	700,805	178,083	45,782	33,768	34,250	63,814	131,832	47,310
Washington	506,141	137,334	23,071	37,186	36,722	85,329	159,237	72,123
West Virginia	200,588	87,625	13,898	11,898	12,017	26,417	50,332	17,112
Wisconsin	567,829	73,827	27,811	26,179	27,031	56,985	110,194	63,401
Wyoming	49,475	10,609	1,585	3,186	2,864	6,329	12,379	8,328
United States	28,418,977	8,715,103	1,910,167	1,884,351	1,966,767	3,824,271	7,675,389	2,848,773

[1]Approximately 93,000 adults in day programs participated in CACFP in FY 2004.

Source: U.S. Department of Agriculture, Food and Nutrition Service.

Table B2-1

Children's Health Insurance Coverage

	Uninsured Children under Age 19 2002-2004[1]		Medicaid[2]						Number of Children Ever Enrolled in SCHIP
			Children Enrolled in Medicaid				Children as a Percent of 2003 Medicaid:		
	Number	Percent	FY 2000	FY 2001	FY 2002	FY 2003	Enrollees	Expenditures	2004
Alabama	107,000	9.2%	369,234	393,885	426,858	446,910	50.0%	29.7%	79,407
Alaska	25,000	12.6	69,527	74,955	78,862	82,133	64.9	41.0	21,966
Arizona	248,000	15.3	416,475	464,422	538,685	621,160	48.6	38.7	87,681
Arkansas	70,000	9.8	267,858	301,362	340,577	378,602	56.0	34.9	NR
California	1,368,000	13.5	3,439,897	3,442,868	3,736,900	4,027,113	40.1	23.6	1,035,752
Colorado	184,000	14.9	210,332	230,852	249,941	272,855	57.6	24.3	57,244
Connecticut	75,000	8.5	216,378	225,175	244,460	250,457	49.9	14.4	21,438
Delaware	22,000	10.6	61,911	65,146	70,159	73,422	46.8	27.3	10,250
District of Columbia	11,000	9.3	77,884	78,499	78,580	80,605	51.3	25.4	6,093
Florida	664,000	15.7	1,183,121	1,306,465	1,446,388	1,536,407	54.1	24.8	419,707
Georgia	316,000	12.9	741,564	772,837	906,024	985,745	60.1	30.8	280,083
Hawaii	22,000	6.9	88,629	89,256	93,135	197,695	47.0	23.3	19,237
Idaho	49,000	12.5	96,543	113,696	130,588	138,934	66.6	28.3	19,054
Illinois	386,000	11.3	990,260	1,056,389	1,114,447	1,132,901	52.0	21.9	234,027
Indiana	162,000	9.6	454,780	499,851	536,410	565,861	59.9	23.5	80,698
Iowa	52,000	7.2	161,301	171,031	189,130	201,890	53.3	22.4	40,776
Kansas	52,000	7.2	154,951	165,490	180,449	192,292	59.1	23.2	44,350
Kentucky	111,000	10.7	367,857	392,452	403,649	421,365	52.0	28.0	94,500
Louisiana	148,000	12.0	487,484	538,733	622,989	664,460	63.0	25.0	105,580
Maine	21,000	6.8	92,383	97,040	110,827	119,776	31.7	27.3	29,171
Maryland	140,000	9.5	402,773	407,061	435,318	455,377	55.2	25.5	111,488
Massachusetts	110,000	7.1	465,540	465,870	495,235	493,808	41.4	15.8	166,508
Michigan	185,000	6.9	768,290	813,664	865,593	912,318	58.0	21.8	NR
Minnesota	84,000	6.4	303,800	318,868	337,822	363,855	49.8	23.9	4,784
Mississippi	100,000	12.6	333,366	393,963	405,954	416,038	56.9	24.4	82,900
Missouri	107,000	7.3	542,409	560,082	587,202	619,268	53.5	23.3	176,014
Montana	36,000	16.4	50,882	54,142	56,703	59,438	53.8	27.0	15,281
Nebraska	30,000	6.5	138,643	148,193	159,458	163,218	61.9	28.3	33,314
Nevada	115,000	18.1	90,796	92,201	110,054	135,505	57.4	30.2	38,519
New Hampshire	20,000	6.0	64,579	64,115	69,084	76,997	59.4	23.5	10,951
New Jersey	252,000	11.1	469,207	473,499	506,813	504,357	51.8	18.9	127,244
New Mexico	78,000	14.9	257,745	272,490	295,769	304,673	61.8	35.6	20,804
New York	469,000	9.7	1,398,471	1,528,477	1,686,999	1,868,944	41.9	14.8	826,611
North Carolina	275,000	12.3	650,470	709,945	735,862	771,801	53.2	25.5	174,259
North Dakota	12,000	8.4	31,378	31,597	33,718	36,723	47.9	15.7	5,133
Ohio	242,000	8.2	775,213	907,943	958,481	1,042,983	53.8	17.6	220,190
Oklahoma	148,000	16.2	368,715	408,766	442,139	426,537	64.0	30.3	100,761
Oregon	110,000	12.2	244,614	255,652	269,380	269,972	43.1	24.8	46,720
Pennsylvania	300,000	10.0	804,000	825,596	858,134	891,917	49.9	25.0	177,415
Rhode Island	16,000	6.2	88,535	94,096	98,926	100,864	47.8	22.7	25,573
South Carolina	91,000	8.4	420,617	475,319	493,385	516,608	52.1	29.9	75,597
South Dakota	17,000	8.4	59,752	65,400	70,673	74,456	62.2	29.4	13,397
Tennessee	141,000	9.6	654,063	681,853	720,954	700,895	42.4	17.3	
Texas	1,431,000	21.7	1,632,816	1,724,049	1,984,630	2,331,846	63.7	33.9	650,856
Utah	76,000	9.8	125,618	131,143	142,584	157,294	56.5	33.5	38,693
Vermont	8,000	5.5	65,668	67,420	68,887	69,067	43.2	29.4	6,693
Virginia	193,000	10.1	380,438	391,842	409,973	420,037	57.0	23.2	99,569
Washington	142,000	9.0	538,431	589,824	632,458	648,794	55.9	25.2	17,002
West Virginia	39,000	9.5	186,253	183,800	192,028	188,197	51.3	22.0	36,906
Wisconsin	89,000	6.4	313,634	339,853	374,294	413,568	45.8	16.7	67,893
Wyoming	15,000	12.1	30,594	35,012	42,625	47,543	61.9	27.0	5,525
United States	9.0 million	11.6	22,605,679	23,992,139	26,040,193	27,873,481	50.5	23.0	6,063,614

[1] The U.S. percentage and number of uninsured are from the 2005 Current Population Survey, Annual Social and Economic Supplement. The estimated percentage of uninsured children in each state is the average of the percentages of children uninsured during the years 2002–2004. Three-year averages are used because of small sample sizes in some states. The estimated number of uninsured children in each state is calculated by applying that average percentage to the most recent estimates of the number of children younger than 19 in each state.

[2] Children are ages 0 through 18. Numbers include those children enrolled in Medicaid through SCHIP/Medicaid expansions, but do not include those children enrolled in separate SCHIP programs.

NR — data not reported

Sources: U.S. Department of Commerce, Bureau of the Census, 2003, 2004, and 2005 Annual Social and Economic Supplement to the Current Population Survey; U.S. Department of Commerce, Bureau of the Census, July 1, 2004 state population estimates by single year of age, at <http://www.census.gov/popest/estimates.php>; U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicaid Statistical Information System, FFY 2000, 2001, 2002, and 2003, at <http://msis.cms.hhs.gov/cognos/cgi-bin/ppdscgi.exe>, accessed April 20, 2005 and November 2, 2005; and U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "FY 2004 Number of Children Ever Enrolled in SCHIP by Program Type," at <http://www.cms.hhs.gov/schip/enrollment/schip04.pdf>. Calculations by Children's Defense Fund.

Table B2-2

Early Prenatal Care[1], 2003

	Total All Races		White Total		White Non-Hispanic		Black Total		Black Non-Hispanic		Hispanic[2]	
	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
Alabama	83.8%	28	87.3%	22	90.0%	19	75.7%	26	75.7%	26	52.0%	49
Alaska	79.8	41	83.7	35	82.9	47	81.8	9	81.0	10	79.6	14
Arizona	76.6	46	76.9	47	88.0	31	76.0	25	79.5	16	66.7	40
Arkansas	81.3	36	83.2	37	84.6	40	73.5	33	73.4	34	71.5	26
California	87.3	11	87.4	21	90.8	8	84.1	7	84.1	7	85.2	2
Colorado	79.3	42	79.8	45	86.1	38	70.9	41	70.7	41	67.0	39
Connecticut	88.7	6	89.8	7	92.7	3	81.0	11	81.4	9	78.2	18
Delaware	84.4	24	86.2	28	88.8	25	78.8	16	79.6	15	71.9	25
District of Columbia	76.1	47	86.4	27	89.6	23	71.1	40	71.0	40	69.6	33
Florida	85.8	17	88.1	16	90.1	18	77.9	19	77.8	19	84.2	4
Georgia	84.0	27	86.2	28	90.5	12	79.1	15	79.1	17	69.1	36
Hawaii	82.4	32	85.5	32	86.3	37	89.3	2	89.1	2	80.8	9
Idaho	81.4	35	81.6	40	83.9	43	87.8	3	87.4	4	68.3	38
Illinois	85.4	19	87.7	19	91.0	5	74.2	30	74.1	30	80.0	13
Indiana	81.5	34	83.0	38	84.7	39	69.3	45	69.3	45	66.0	42
Iowa	88.9	5	89.5	10	90.6	11	76.8	23	76.8	24	74.8	23
Kansas	87.8	8	88.5	15	90.5	12	80.1	14	80.2	14	77.2	20
Kentucky	87.0	13	87.7	19	88.2	29	80.7	13	80.7	12	74.0	24
Louisiana	84.1	26	90.0	6	90.3	16	75.5	27	75.5	28	83.3	6
Maine	87.5	10	87.9	17	87.9	32	74.9	28	75.6	27	80.7	10
Maryland	83.7	29	88.7	14	91.0	5	74.6	29	75.3	29	70.1	30
Massachusetts	90.0	4	91.4	3	92.4	4	81.5	10	80.3	13	83.9	5
Michigan	86.1	16	89.0	12	89.8	21	72.8	37	72.7	38	77.6	19
Minnesota	86.5	14	88.8	13	90.5	12	72.3	39	72.3	39	71.0	28
Mississippi	84.9	21	90.7	5	91.0	5	77.8	20	77.8	19	79.6	14
Missouri	88.4	7	89.7	8	90.2	17	81.0	11	80.9	11	81.0	8
Montana	84.4	24	86.9	24	87.4	34	86.0	4	87.8	3	80.6	11
Nebraska	83.4	30	84.4	34	86.9	35	72.7	38	72.8	36	69.8	32
Nevada	75.8	48	75.8	48	84.6	40	70.7	42	70.6	42	64.1	45
New Hampshire	92.8	1	93.0	1	93.4	2	85.1	6	85.5	5	84.4	3
New Jersey	80.2	40	83.4	36	89.2	24	64.4	48	63.5	48	68.6	37
New Mexico	68.9	49	70.2	49	77.0	49	68.7	46	69.1	46	66.2	41
New York	82.4	32	85.2	33	88.6	26	73.1	35	72.8	36	76.2	21
North Carolina	84.5	23	86.9	24	90.8	8	76.8	23	76.8	24	69.6	33
North Dakota	87.3	11	89.7	8	90.0	19	85.2	5	84.8	6	79.5	16
Ohio	87.7	9	89.3	11	89.8	21	78.8	16	78.8	18	79.0	17
Oklahoma	77.8	44	79.6	46	82.0	48	69.8	44	69.8	44	65.5	43
Oregon	81.2	37	81.5	41	84.5	42	78.0	18	77.6	21	70.0	31
Pennsylvania	76.0	—	79.2	—	80.4	—	57.2	—	57.4	—	61.2	—
Rhode Island	90.9	2	92.2	2	93.5	1	82.8	8	82.1	8	86.9	1
South Carolina	77.5	45	81.0	44	83.6	45	70.5	43	70.6	42	56.9	48
South Dakota	78.4	43	82.8	39	83.4	46	64.8	47	65.5	47	64.0	46
Tennessee	83.4	30	86.2	28	88.1	30	73.0	36	73.0	35	63.7	47
Texas	80.9	38	81.1	43	88.4	28	77.0	21	77.0	23	75.5	22
Utah	80.3	39	81.2	42	83.9	43	63.2	49	61.8	49	65.1	44
Vermont	90.6	3	90.8	4	90.8	8	74.0	31	73.5	32	81.5	7
Virginia	85.3	20	87.9	17	90.4	15	76.9	22	77.3	22	71.2	27
Washington	74.0	—	75.0	—	77.6	—	67.9	—	68.9	—	63.1	—
West Virginia	85.8	17	86.2	28	86.4	36	73.5	33	73.5	32	69.3	35
Wisconsin	84.9	21	86.9	24	88.5	27	73.6	32	73.7	31	70.7	29
Wyoming	86.4	15	87.0	23	87.9	32	96.2	1	96.2	1	80.1	12
United States	84.1		85.7		89.0		75.9		75.9		77.5	

[1] Care begun in the first trimester (first three months) of pregnancy

[2] Persons of Hispanic origin can be of any race.

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, *National Vital Statistics Report*, Vol. 54, No. 2 (September 8, 2005), "Births: Final Data for 2003," Table 34. Ranks calculated by Children's Defense Fund.

Table B2-3

Low Birthweight,[1] 2003

	Total all races[2]		White				Black				Hispanic[3]	
			Total		Non-Hispanic		Total		Non-Hispanic			
	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
Alabama	10.0%	47	8.0%	43	8.1%	44	14.4%	34	14.5%	35	6.7%	24
Alaska	6.0	1	5.7	1	5.2	1	9.7	1	9.1	1	5.1	1
Arizona	7.1	17	6.9	20	6.9	20	11.3	5	12.1	7	6.9	25
Arkansas	8.9	39	7.6	39	7.7	38	14.6	36	14.6	36	6.3	18
California	6.6	10	6.1	6	6.1	5	12.3	13	12.4	11	6.0	8
Colorado	9.0	41	8.6	49	8.8	50	15.6	42	15.7	42	8.3	38
Connecticut	7.5	19	6.9	20	6.4	10	11.9	8	12.5	12	8.6	41
Delaware	9.4	45	7.8	42	7.8	41	14.2	32	14.3	33	7.7	36
District of Columbia	10.9	50	6.5	10	6.1	5	12.9	18	13.7	27	7.6	35
Florida	8.5	33	7.1	27	7.2	30	13.1	20	13.2	17	6.9	25
Georgia	9.0	41	7.1	27	7.4	34	13.0	19	13.0	14	5.7	5
Hawaii	8.6	36	6.7	17	6.5	14	12.2	12	13.3	18	8.4	40
Idaho	6.5	6	6.5	10	6.5	14	—	—	—	—	6.5	22
Illinois	8.3	31	6.9	20	7.1	26	14.4	34	14.4	34	6.4	20
Indiana	7.9	22	7.2	33	7.3	32	13.3	23	13.3	18	5.9	6
Iowa	6.6	10	6.3	8	6.3	9	13.1	20	13.3	18	6.2	14
Kansas	7.4	18	6.9	20	7.1	26	12.8	16	12.8	13	6.1	9
Kentucky	8.7	38	8.2	46	8.3	47	13.6	26	13.7	27	6.2	14
Louisiana	10.7	49	7.7	41	7.7	38	14.9	38	14.9	38	7.9	37
Maine	6.5	6	6.5	10	6.6	17	—	—	—	—	—	—
Maryland	9.1	44	7.0	25	7.1	26	12.7	15	13.0	14	7.0	27
Massachusetts	7.6	20	7.2	33	7.0	24	10.5	4	11.8	6	8.3	38
Michigan	8.2	29	6.9	20	6.9	20	14.1	31	14.1	31	6.6	23
Minnesota	6.2	4	5.8	3	5.8	3	10.3	3	10.3	2	5.1	1
Mississippi	11.4	51	8.6	49	8.6	49	15.2	40	15.2	40	7.2	31
Missouri	8.0	25	7.1	27	7.2	30	13.4	24	13.4	23	6.1	9
Montana	6.8	13	6.6	15	6.5	14	—	—	—	—	9.2	46
Nebraska	6.9	15	6.6	15	6.8	19	11.5	6	11.5	4	6.1	9
Nevada	8.1	26	7.4	37	7.7	38	13.1	20	13.3	18	7.0	27
New Hampshire	6.2	4	6.1	6	6.1	5	—	—	—	—	5.9	6
New Jersey	8.1	26	7.1	27	7.0	24	12.6	14	13.3	18	7.3	33
New Mexico	8.5	33	8.5	47	8.2	46	15.6	42	16.0	43	8.7	42
New York	7.9	22	6.8	18	6.6	17	12.0	10	12.2	9	7.5	34
North Carolina	9.0	41	7.3	35	7.6	37	14.2	32	14.2	32	6.2	14
North Dakota	6.5	6	6.3	8	6.4	10	—	—	—	—	—	—
Ohio	8.3	31	7.4	37	7.4	34	13.5	25	13.6	24	7.2	31
Oklahoma	7.8	21	7.3	35	7.5	36	13.7	29	13.6	24	6.1	9
Oregon	6.1	3	5.9	4	6.1	5	11.7	7	11.6	5	5.3	3
Pennsylvania	8.1	26	7.0	25	6.9	20	13.7	29	14.0	30	8.9	44
Rhode Island	8.5	33	8.0	43	7.8	41	11.9	8	12.3	10	8.9	44
South Carolina	10.1	48	7.6	39	7.8	41	15.0	39	15.0	39	6.4	20
South Dakota	6.6	10	6.5	10	6.4	10	—	—	—	—	9.4	47
Tennessee	9.4	45	8.0	43	8.1	44	14.8	37	14.8	37	6.1	9
Texas	7.9	22	7.1	27	7.3	32	13.6	26	13.7	27	7.0	27
Utah	6.5	6	6.5	10	6.4	10	15.2	40	15.3	41	7.0	27
Vermont	7.0	16	7.1	27	7.1	26	—	—	—	—	—	—
Virginia	8.2	29	6.8	18	6.9	20	12.8	16	13.0	14	6.3	18
Washington	6.0	1	5.7	1	5.6	2	10.1	2	11.1	3	5.6	4
West Virginia	8.6	36	8.5	47	8.5	48	12.0	10	12.1	7	—	—
Wisconsin	6.8	13	6.0	5	6.0	4	13.6	26	13.6	24	6.2	14
Wyoming	8.9	39	8.9	51	8.9	51	—	—	—	—	8.7	42
United States	7.9		6.9		7.0		13.4		13.6		6.7	

[1]Birthweight less than 2,500 grams (5 lbs. 8 oz.)

[2]Includes races other than White and Black

[3]Persons of Hispanic origin can be of any race.

—Number of low birthweight births too small to calculate a reliable rate.

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, *National Vital Statistics Report*, Vol. 54, No. 2 (September 8, 2005), "Births: Final Data for 2003," Table 46. Ranks calculated by Children's Defense Fund.

Table B2-4

Infant Mortality, 2002

	All races			White			Black		
	Number	Rate[1]	Rank	Number	Rate[1]	Rank	Number	Rate[1]	Rank
Alabama	539	9.1	44	283	7.1	42	255	13.9	13
Alaska	55	5.5	6	27	—	—	6	—	—
Arizona	559	6.4	18	475	6.2	29	36	13.0	9
Arkansas	312	8.3	40	201	6.9	38	103	13.9	13
California	2,889	5.5	6	2,212	5.2	8	420	12.9	7
Colorado	415	6.1	14	342	5.5	12	62	21.1	35
Connecticut	274	6.5	20	191	5.5	12	74	14.2	15
Delaware	96	8.7	42	58	7.3	46	35	12.9	7
District of Columbia	85	11.3	50	16	—	—	67	14.5	17
Florida	1,548	7.5	31	893	5.8	23	629	13.6	11
Georgia	1,192	8.9	43	569	6.6	33	588	13.7	12
Hawaii	127	7.3	28	18	—	—	7	—	—
Idaho	128	6.1	14	123	6.1	27	1	—	—
Illinois	1,339	7.4	29	780	5.6	17	519	16.3	26
Indiana	657	7.7	35	503	6.8	36	143	15.3	23
Iowa	199	5.3	4	179	5.1	6	17	—	—
Kansas	281	7.1	26	228	6.5	32	44	15.2	22
Kentucky	392	7.2	27	318	6.6	33	70	14.2	15
Louisiana	665	10.3	48	253	6.9	38	401	15.0	20
Maine	59	4.4	1	56	4.3	1	1	—	—
Maryland	551	7.5	31	240	5.3	9	298	12.3	4
Massachusetts	395	4.9	2	302	4.5	2	76	9.1	1
Michigan	1,057	8.1	37	619	6.0	25	416	18.5	32
Minnesota	364	5.4	5	290	5.0	5	50	10.3	3
Mississippi	428	10.3	48	155	6.9	38	269	14.8	19
Missouri	637	8.5	41	443	7.1	42	189	17.1	27
Montana	83	7.5	31	68	7.1	42	3	—	—
Nebraska	178	7.0	24	141	6.1	27	30	20.8	34
Nevada	197	6.0	12	138	5.1	6	48	18.4	31
New Hampshire	72	5.0	3	72	5.3	9	0	—	—
New Jersey	655	5.7	9	382	4.5	2	255	12.8	6
New Mexico	174	6.3	16	132	5.7	22	11	—	—
New York	1,519	6.0	12	977	5.4	11	493	9.9	2
North Carolina	959	8.2	39	505	5.9	24	430	15.6	24
North Dakota	49	6.3	16	38	5.6	17	2	—	—
Ohio	1,180	7.9	36	761	6.2	29	400	17.7	29
Oklahoma	410	8.1	37	279	7.1	42	81	17.2	28
Oregon	260	5.8	10	229	5.6	17	13	—	—
Pennsylvania	1,091	7.6	34	772	6.6	33	305	15.1	21
Rhode Island	90	7.0	24	71	6.4	31	15	—	—
South Carolina	507	9.3	46	213	6.0	25	287	15.8	25
South Dakota	70	6.5	20	42	4.9	4	3	—	—
Tennessee	727	9.4	47	419	7.0	41	299	18.3	30
Texas	2,368	6.4	18	1,773	5.6	17	561	13.5	10
Utah	273	5.6	8	255	5.5	12	6	—	—
Vermont	28	—	—	28	—	—	0	—	—
Virginia	741	7.4	29	394	5.5	12	323	14.6	18
Washington	456	5.8	10	366	5.5	12	43	12.7	5
West Virginia	188	9.1	44	169	8.5	47	19	—	—
Wisconsin	472	6.9	23	329	5.6	17	121	18.9	33
Wyoming	44	6.7	22	42	6.8	36	0	—	—
United States	28,034	7.0		18,369	5.8		8,524	14.4	

[1]Infant deaths (before the first birthday) per 1,000 live births

—Number of infant deaths too small to calculate a stable rate

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, *National Vital Statistics Report*, Vol. 53, No. 5, "Deaths: Final Data for 2002" (October 12, 2004), Table 32. Ranks calculated by Children's Defense Fund.

Table B2-5

Immunization Status of Two-year-olds[1] in 2003 and 2004
Percent of two-year-olds who received all recommended immunizations in the series

	4:3:1:3 series[2]			4:3:1:3:3 series[3]		
	1995	2003	2004	1995	2003	2004
Alabama	73.1%	82.2%	83.0%	45.8%	80.4%	82.3%
Alaska	74.0	81.4	76.1	54.3	79.7	75.3
Arizona	68.7	78.8	81.0	51.2	76.9	78.6
Arkansas	73.4	79.5	84.9	53.6	76.5	82.4
California	70.3	79.6	83.1	57.7	77.4	81.3
Colorado	74.9	68.6	80.1	51.4	67.5	77.1
Connecticut	85.9	94.6	88.7	63.9	94.0	87.8
Delaware	67.5	79.6	86.4	54.7	76.3	86.0
District of Columbia	68.6	77.2	86.0	49.8	76.2	82.5
Florida	74.0	82.7	89.7	53.4	81.0	88.5
Georgia	76.8	76.6	85.5	61.7	76.6	84.7
Hawaii	75.2	82.8	82.6	66.2	82.0	81.2
Idaho	66.0	81.6	82.6	40.7	78.1	80.6
Illinois	77.8	84.6	83.7	57.2	82.9	82.7
Indiana	73.9	81.7	81.3	41.8	79.0	79.0
Iowa	82.7	82.6	86.1	47.7	81.1	86.1
Kansas	69.8	77.7	79.5	35.7	75.7	77.5
Kentucky	81.4	81.2	80.4	59.6	81.0	79.1
Louisiana	76.6	72.4	76.3	61.8	69.9	74.9
Maine	88.1	81.8	85.0	46.6	78.6	82.1
Maryland	76.6	84.3	81.3	59.2	81.3	80.0
Massachusetts	81.4	91.7	90.9	70.7	90.7	89.1
Michigan	67.9	82.9	81.3	46.7	81.5	81.2
Minnesota	75.0	84.4	85.7	41.2	83.9	85.2
Mississippi	79.4	84.0	85.8	38.1	83.6	84.0
Missouri	74.5	84.2	86.0	50.5	83.3	81.6
Montana	70.7	84.6	81.6	44.7	80.0	78.2
Nebraska	71.0	82.0	83.0	49.2	80.4	82.3
Nevada	66.8	78.1	70.6	55.9	75.7	68.4
New Hampshire	88.7	88.4	89.0	72.7	86.5	86.3
New Jersey	70.4	75.8	83.3	60.5	75.0	82.7
New Mexico	74.0	77.0	84.8	43.8	75.2	83.5
New York	74.0	81.9	82.8	62.6	78.6	82.2
North Carolina	80.0	88.6	82.3	62.5	86.7	81.6
North Dakota	78.6	82.5	84.0	65.7	80.4	82.0
Ohio	71.3	84.2	82.2	47.7	82.3	79.5
Oklahoma	73.8	72.3	72.6	42.3	70.5	72.1
Oregon	71.3	79.3	81.1	56.6	76.5	78.9
Pennsylvania	76.5	86.9	87.1	62.2	86.2	85.7
Rhode Island	82.5	87.3	88.2	58.5	85.2	86.7
South Carolina	78.2	84.6	82.2	72.2	84.3	79.8
South Dakota	78.7	83.4	88.0	27.5	80.9	86.1
Tennessee	74.0	80.5	83.2	57.8	78.8	82.4
Texas	70.5	77.2	74.4	52.4	74.8	72.5
Utah	65.0	80.2	75.2	43.7	78.8	71.3
Vermont	86.5	89.5	88.8	55.8	83.6	85.0
Virginia	69.1	84.8	83.4	52.8	84.0	81.0
Washington	76.4	79.7	81.2	57.0	75.3	77.7
West Virginia	73.0	77.4	87.7	28.9	74.6	86.6
Wisconsin	75.3	82.7	85.1	53.1	81.2	82.9
Wyoming	75.2	77.2	84.1	18.9	75.8	83.3
United States	73.7	81.3	82.5	55.1	79.4	80.9

[1]Children are between 19 and 35 months of age.

[2]4:3:1:3 series includes four or more doses of diphtheria, tetanus, and pertussis vaccine (DTP,DTaP,or DT); three or more doses of poliovirus vaccine; one or more doses of measles-containing vaccine; and three or more doses of *Haemophilus influenzae* type b (Hib) vaccine.

[3]4:3:1:3:3 series includes all of the vaccines in the 4:3:1:3 series and three or more doses of hepatitis B (HepB) vaccine. The addition of hepatitis B to the recommended series was more recent (late in 1991) and therefore the 1995 rates that include HepB are far lower than the rates that do not include HepB.

Sources: "Hepatitis B Virus: A Comprehensive Strategy for Eliminating Transmission in the United States Through Universal Childhood Vaccination: Recommendations of the Immunization Practices Advisory Committee (ACIP)," *Morbidity and Mortality Weekly Report*, 40(RR-13) (November 22, 1991); and Centers for Disease Control and Prevention, National Immunization Surveys, 1995, 2003, and 2004, Tables 28 and 29, at <http://www.cdc.gov/nip/coverage/NIS/95/toc-95.htm>, <http://www.cdc.gov/nip/coverage/NIS/03/toc-03.htm>, and <http://www.cdc.gov/nip/coverage/NIS/04/toc-04.htm>.

Table B3-1

Parents in the Labor Force, 2003

	Mothers in the labor force by age of youngest child (percent)		Children with mothers in the labor force (percent)		Children with all parents in the labor force (percent)	
	Under age 6	Ages 6-17	Under age 6	Ages 6-17	Under age 6	Ages 6-17
Alabama	63.8%	73.5%	59.6%	70.9%	58.3%	68.7%
Alaska	65.9	80.1	66.7	78.4	65.7	77.1
Arizona	57.3	76.0	55.2	70.2	56.2	68.9
Arkansas	64.4	79.5	61.6	72.3	60.7	71.3
California	56.1	71.0	54.1	65.3	54.2	64.7
Colorado	61.5	77.5	61.1	68.9	61.1	68.3
Connecticut	61.7	80.1	60.4	75.1	60.5	73.3
Delaware	67.6	82.7	63.9	78.4	63.9	77.5
District of Columbia	64.9	80.9	63.1	76.4	64.4	76.1
Florida	66.7	75.2	64.8	71.4	64.5	70.9
Georgia	63.1	77.1	60.5	72.7	60.1	71.6
Hawaii	66.5	79.2	66.1	75.8	65.8	72.9
Idaho	61.7	78.7	59.0	68.2	58.3	67.5
Illinois	61.9	75.3	60.4	69.4	59.8	68.5
Indiana	64.3	77.6	61.8	71.2	61.3	69.7
Iowa	74.1	83.6	71.3	80.4	69.8	79.7
Kansas	69.5	81.5	67.2	76.8	68.4	76.5
Kentucky	59.5	71.9	56.3	67.7	55.1	65.0
Louisiana	66.7	72.5	64.5	69.2	62.9	69.0
Maine	68.0	82.2	61.6	77.8	62.2	73.8
Maryland	68.3	79.7	66.5	74.8	67.5	74.6
Massachusetts	62.9	77.4	60.9	72.7	59.5	71.6
Michigan	62.6	75.8	60.6	70.3	60.0	68.8
Minnesota	71.2	83.1	69.4	78.3	67.8	76.5
Mississippi	71.7	77.8	68.2	73.6	67.3	72.7
Missouri	67.0	78.4	64.4	72.0	63.0	70.8
Montana	73.0	79.5	71.3	74.7	68.5	74.1
Nebraska	77.5	81.9	74.4	79.1	72.6	77.4
Nevada	59.0	74.9	57.0	68.7	57.8	69.0
New Hampshire	65.7	81.3	61.6	75.9	61.0	75.0
New Jersey	61.0	75.5	58.7	71.1	57.5	70.2
New Mexico	63.0	71.2	64.9	69.1	64.9	69.3
New York	58.8	74.0	56.2	68.6	56.2	67.7
North Carolina	64.7	77.6	62.0	73.8	61.3	72.6
North Dakota	77.4	82.1	77.8	80.6	74.5	78.8
Ohio	65.9	78.4	64.3	73.2	63.3	72.2
Oklahoma	56.1	70.3	53.6	64.9	51.7	63.2
Oregon	61.8	75.3	60.3	70.2	59.1	69.4
Pennsylvania	64.5	74.2	62.3	69.8	62.4	68.4
Rhode Island	66.9	77.8	67.0	72.7	66.6	71.7
South Carolina	64.0	77.1	63.1	73.4	63.7	72.1
South Dakota	73.5	85.1	72.3	80.9	72.2	79.2
Tennessee	63.5	74.9	61.2	69.8	61.2	68.4
Texas	57.5	72.0	55.7	66.8	55.8	65.9
Utah	52.3	72.7	48.3	63.4	49.4	62.9
Vermont	71.1	85.1	68.5	82.1	69.6	81.1
Virginia	65.7	77.6	62.8	72.9	61.9	71.5
Washington	60.5	76.4	58.7	69.7	59.1	68.6
West Virginia	58.4	68.3	58.5	65.7	56.1	61.5
Wisconsin	71.2	81.0	69.5	77.4	67.9	75.9
Wyoming	65.6	81.4	63.3	76.5	64.3	76.1
United States	62.4	75.5	60.2	70.4	59.8	69.4

Source: U.S. Department of Commerce, Bureau of the Census, American Community Survey, 2003, Tables P062 and P063, downloaded from American Fact Finder at <http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_lang=en&_ts= 149166631549> , October and November 2004, and Table R18, at <http://factfinder.census.gov/servlet/GRTTable?_bm=y&-_box_head_ nbr=R18& ds_name=ACS_2003_EST_G00_&-format=US-30&-CONTEXT=grt>. Calculations by Children's Defense Fund.

Table B3-2

Child Care Assistance

	Income Cutoff for Child Care Assistance,[1] 2004			Number of Children Served by the Child Care and Development Block Grant (CCDBG): Average Monthly Enrollment		
	Annual Income Cutoff	Percent of State Median Income	Percent of Federal Poverty Guidelines	2001	2002	2003
Alabama	$ 19,836	43%	127%	34,000	32,300	30,400
Alaska	46,248	77	295	6,300	6,200	5,300
Arizona	25,188	53	161	28,100	26,600	29,100
Arkansas	25,311	63	162	9,300	10,400	12,900
California[2]	35,100	66	224	202,000	163,300	153,600
Colorado	19,838 - 34,344	35 - 60	127 - 219	24,500	25,100	22,800
Connecticut	34,735	50	222	13,700	15,300	11,700
Delaware	30,528	50	195	7,500	6,300	6,800
District of Columbia	34,700	67	221	13,500	9,200	8,500
Florida	23,505	49	150	80,500	96,000	121,200
Georgia	24,416	49	156	57,800	63,800	61,900
Hawaii	44,136	80	282	8,900	11,400	11,200
Idaho	20,742	48	132	9,700	7,600	7,800
Illinois	27,936	50	178	103,000	88,900	85,700
Indiana	19,080	36	122	38,100	41,400	34,300
Iowa	21,936	42	140	15,300	15,400	14,100
Kansas	28,236	54	180	14,900	15,500	16,000
Kentucky	22,890	50	146	37,700	39,100	39,900
Louisiana	31,152	72	199	38,700	45,700	54,600
Maine	41,715	85	266	2,100	3,600	4,500
Maryland	29,990	43	191	21,200	28,100	30,000
Massachusetts	28,968	43	185	32,700	32,500	32,200
Michigan	23,880	42	152	50,100	38,400	61,200
Minnesota	26,705	44	170	26,400	26,600	25,700
Mississippi	30,999	79	198	8,400	19,900	23,300
Missouri	17,784	35	113	35,900	34,500	37,900
Montana	22,536	56	144	7,200	6,800	5,200
Nebraska	18,312	36	117	12,800	12,300	12,000
Nevada	37,344	75	238	7,000	8,400	6,100
New Hampshire	29,004	48	185	6,600	7,000	7,300
New Jersey	30,520	45	195	44,200	43,300	37,500
New Mexico	23,508	60	150	22,800	22,700	22,100
New York[3]	31,340	56	200	180,800	138,100	142,700
North Carolina	35,352	74	226	81,700	77,300	88,300
North Dakota	29,556	64	189	4,700	4,600	4,700
Ohio	23,505	44	150	84,000	86,800	52,100
Oklahoma	35,655	79	228	38,700	34,500	21,300
Oregon	23,505	48	150	25,600	24,200	22,100
Pennsylvania	30,420	55	194	65,100	51,400	60,700
Rhode Island	34,335	58	219	4,300	4,900	5,800
South Carolina	26,705	54	170	20,300	22,300	23,000
South Dakota	31,344	62	200	3,400	3,700	4,300
Tennessee	28,260	60	180	59,600	49,900	52,100
Texas	22,896 - 40,416	48 - 85	146 - 260	105,500	116,200	117,300
Utah	27,768	56	177	9,900	9,100	8,900
Vermont	31,032	59	198	3,500	3,300	3,700
Virginia	22,896 - 38,160	39 - 65	146 - 244	15,900	24,000	25,800
Washington	30,528	55	195	51,200	52,500	52,900
West Virginia	21,228	51	135	7,800	9,600	9,200
Wisconsin	28,990	53	185	26,300	22,600	18,200
Wyoming	29,004	59	185	3,200	3,600	4,100
United States						

[1]The annual income cutoffs shown in the table represent the maximum income a family can have when they apply for child care assistance. Some states allow families, once receiving assistance, to continue receiving assistance up to a higher income level than that initial cutoff.

[2]California serves a significant number of families and children through State funds, which resulted in the state's revising its estimate of the number of children served by the Child Care and Development Block Grant (CCDBG) in FY 2002. The state recognized and corrected their reporting to show that only 86% of families and children are being served (as opposed to 100%). The other 14% are actually being served by non-CCDBG funds.

[3]Prior to FY 2002, New York reported children based on a payment system that allowed a child to be counted more than once. Beginning with FY 2002, the state revised their reporting system, which eliminated double-counting.

Sources: *Federal Register*, Vol. 68, No. 72 (April 15, 2003), pp. 18230-18232; *Federal Register*, Vol. 69, No. 30 (February 13, 2004), pp. 7336-7338; Karen Schulman and Helen Blank "Child Care Assistance Policies 2001-2004: Families Struggling to Move Forward, States Going Backward" (National Women's Law Center, September 2004); and U.S. Department of Health and Human Services, Child Care and Development Fund Statistics, at <http://www.acf.hhs.gov/programs/ccb/research/index.htm>.

Table B3-3

Head Start Enrollment, 2003–2004

	Total Enrollment[1]	Race, ethnicity of enrollees (percentage distribution)[2]								
		American Indian, Alaska Native	Asian	Black	Hispanic, Latino	Native Hawaiian, Pacific Islander	White	Bi-racial, multi-racial	Other	Unknown
Alabama	16,374	0.3%	0.1%	73.5%	3.0%	0.0%	21.4%	1.4%	0.0%	0.3%
Alaska	1,634	45.2	5.5	7.5	5.9	1.4	23.9	9.9	0.0	0.7
Arizona	13,215	4.4	0.4	5.0	68.6	0.1	16.2	4.6	0.1	0.4
Arkansas	10,879	0.5	0.4	43.6	7.3	0.3	45.1	2.5	0.0	0.3
California	98,933	0.5	5.2	11.8	65.7	0.8	10.8	4.0	0.3	0.8
Colorado	9,820	1.4	1.0	8.4	56.9	0.5	24.2	4.3	0.0	3.2
Connecticut	7,148	0.2	1.9	35.6	36.8	0.3	17.9	5.7	0.5	1.1
Delaware	2,197	0.3	1.0	57.1	22.2	0.0	12.8	5.2	0.3	1.2
District of Columbia	3,403	0.0	1.0	79.3	18.2	0.0	0.1	0.3	0.3	0.7
Florida	35,574	0.3	0.7	55.6	23.0	0.1	16.1	2.8	0.2	1.3
Georgia	23,450	0.1	0.5	69.4	10.0	0.4	16.7	2.2	0.0	0.5
Hawaii	3,063	0.5	19.6	3.9	5.6	48.8	11.5	9.3	0.0	0.8
Idaho	2,957	1.7	0.4	1.2	24.2	0.3	65.3	5.3	0.0	1.7
Illinois	39,672	0.2	1.3	50.3	25.5	0.1	18.8	3.3	0.0	0.5
Indiana	14,234	0.2	0.5	27.3	10.2	0.1	55.7	5.7	0.0	0.5
Iowa	7,775	0.5	0.9	12.9	12.4	0.1	64.2	8.3	0.1	0.4
Kansas	7,949	0.9	0.8	17.0	24.1	0.1	47.9	8.7	0.1	0.4
Kentucky	16,071	0.1	0.5	18.9	3.3	0.0	72.3	4.5	0.2	0.2
Louisiana	21,982	0.3	0.6	81.8	1.7	0.0	14.2	1.1	0.1	0.2
Maine	3,979	1.1	1.4	3.4	1.9	0.1	86.5	3.1	0.0	2.5
Maryland	10,344	0.1	1.1	65.2	10.0	0.1	18.5	4.2	0.2	0.6
Massachusetts	13,011	0.5	4.6	18.5	36.2	0.2	32.2	5.2	1.9	0.6
Michigan	35,124	1.0	1.1	37.9	8.6	0.1	45.1	5.4	0.1	0.7
Minnesota	10,339	3.5	5.3	22.9	16.8	0.0	45.3	4.3	0.2	1.8
Mississippi	26,754	0.1	0.4	83.6	1.0	0.0	13.8	0.9	0.0	0.3
Missouri	17,473	0.2	1.4	36.5	5.3	1.1	50.8	4.2	0.0	0.4
Montana	2,945	9.8	0.5	1.1	3.0	0.1	75.9	8.2	0.1	1.2
Nebraska	5,080	2.2	1.0	15.8	23.9	0.2	50.5	6.0	0.0	0.5
Nevada	2,754	1.4	1.4	22.1	53.1	0.9	16.7	4.1	0.4	0.0
New Hampshire	1,632	0.4	1.4	4.3	7.3	0.1	79.4	5.9	0.4	0.8
New Jersey	15,130	0.4	2.0	43.4	36.0	0.1	10.8	3.7	1.0	2.8
New Mexico	7,451	7.5	0.6	2.9	69.7	3.4	10.4	4.1	0.1	1.3
New York	49,300	0.4	3.5	28.5	32.9	0.5	28.6	4.6	0.5	0.5
North Carolina	19,098	1.7	0.7	59.5	14.2	0.0	19.9	3.6	0.3	0.3
North Dakota	2,353	11.4	0.7	2.6	2.7	0.1	68.1	6.5	0.0	7.9
Ohio	38,029	1.7	0.7	39.8	4.8	0.0	46.2	5.5	0.2	1.0
Oklahoma	13,474	15.1	0.5	21.7	14.0	0.3	42.6	5.3	0.0	0.6
Oregon	8,716	1.9	1.8	7.3	30.3	0.4	48.2	6.7	0.2	3.0
Pennsylvania	30,868	0.1	1.7	35.8	11.3	0.1	44.3	5.3	0.1	1.2
Puerto Rico	37,498	0.0	0.0	0.0	99.6	0.0	0.0	0.0	0.0	0.2
Rhode Island	3,150	1.2	2.9	13.7	32.1	0.2	40.3	8.0	0.2	1.4
South Carolina	12,248	0.5	0.1	87.0	2.7	0.0	7.3	2.3	0.0	0.0
South Dakota	2,827	19.7	0.9	3.7	4.2	0.1	68.0	2.8	0.0	0.5
Tennessee	16,437	0.1	0.4	43.2	4.4	0.1	48.6	3.1	0.0	0.1
Texas	67,785	0.2	0.7	20.3	62.1	0.2	11.5	2.1	0.0	2.8
Utah	5,518	3.9	1.1	1.5	31.6	1.4	49.8	10.4	0.1	0.2
Vermont	1,569	0.5	1.0	2.2	1.3	0.0	87.1	4.9	0.0	2.9
Virginia	13,768	0.2	2.3	50.8	11.4	0.4	30.0	3.9	0.0	1.0
Washington	11,118	2.3	5.7	10.3	27.3	1.0	40.4	10.7	0.1	2.2
West Virginia	7,650	0.2	0.2	8.4	0.6	0.1	85.5	4.3	0.0	0.7
Wisconsin	13,532	1.3	3.5	24.9	17.9	0.2	42.9	6.8	0.0	2.5
Wyoming	1,793	1.7	0.4	2.5	22.1	0.8	67.9	4.3	0.0	0.1
United States[3]	845,077	1.2	1.9	34.3	27.2	0.5	29.5	4.1	0.2	1.0

[1]Total enrollment refers to "funded" enrollment slots rather than "actual" enrollment slots.

[2]The percentage distribution of race/ethnicity was obtained by using "actual" enrollment data from the 2003–2004 Program Information Report Database.

[3]The United States total excludes the Virgin Islands, Outer Pacific grantees, American Indian programs, and Migrant and Seasonal Worker programs. These programs have a combined enrollment of 60,893 children.

Sources: U.S. Department of Health and Human Services, Head Start Bureau, Head Start Program Fact Sheet Fiscal Year 2004, at <http://www2.acf.dhhs.gov/programs/hsb/research/2005.htm>, accessed April 28, 2005, and the Head Start 2003–2004 Program Information Report (PIR). Calculations by Children's Defense Fund.

Table B3-4

State Prekindergarten Initiatives

	State Investment		Enrollment in prekindergarten programs, 2002-2003 percent enrolled			
			State prekindergarten program		State prekindergarten program, Head Start, or IDEA preschool program	
	State program	State funded Head Start	3-year-olds	4-year-olds	3-year-olds	4-year-olds
Alabama	✓		0.0%	2.2%	11.9%	23.8%
Alaska		✓	0.0	0.0	16.9	22.3
Arizona	✓		0.0	5.1	9.9	23.7
Arkansas	✓		2.4	6.1	19.9	35.3
California	✓		2.2	8.7	11.2	25.0
Colorado	✓		1.5	13.8	10.3	28.7
Connecticut	✓	✓	3.4	10.4	12.7	24.2
Delaware	✓	✓	0.0	8.5	10.1	24.6
District of Columbia	✓		n/a	n/a	n/a	n/a
Florida			0.0	0.0	9.3	16.2
Georgia	✓		0.0	54.3	11.6	68.1
Hawaii	✓		0.0	6.2	10.8	21.1
Idaho	✓		0.0	0.0	8.1	19.4
Illinois	✓		8.0	24.4	19.9	41.5
Indiana			0.0	0.0	9.6	15.3
Iowa	✓		1.3	4.5	12.1	20.5
Kansas	✓		0.0	14.7	13.1	32.6
Kentucky	✓		10.5	27.7	29.5	60.8
Louisiana	✓		0.0	20.9	17.1	43.2
Maine	✓	✓	0.0	10.8	17.6	39.4
Maryland	✓	✓	2.0	26.3	11.5	39.9
Massachusetts	✓	✓	10.6	10.5	20.9	25.5
Michigan	✓		0.0	19.2	13.6	39.2
Minnesota	✓	✓	1.3	2.1	12.1	18.0
Mississippi			0.0	0.0	28.7	43.2
Missouri	✓		2.4	4.3	16.1	22.2
Montana			0.0	0.0	17.0	27.1
Nebraska	✓		1.5	2.5	14.2	20.2
Nevada	✓		0.7	1.5	6.3	11.1
New Hampshire			0.0	0.0	7.7	10.9
New Jersey	✓		14.6	24.1	23.2	35.4
New Mexico	✓		0.8	2.5	14.3	28.3
New York	✓		0.6	29.7	14.1	56.2
North Carolina	✓		0.0	5.6	8.9	21.9
North Dakota			0.0	0.0	17.8	31.0
Ohio	✓	✓	6.2	9.5	19.1	26.6
Oklahoma	✓	✓	0.0	59.4	16.4	82.4
Oregon	✓	✓	3.0	5.8	13.4	22.7
Pennsylvania	✓		0.0	1.8	11.7	18.9
Rhode Island	✓	✓	0.0	0.0	11.6	23.3
South Carolina	✓		1.9	32.3	16.4	51.1
South Dakota			0.0	0.0	19.9	26.9
Tennessee	✓		1.1	3.2	10.1	22.0
Texas	✓		4.1	43.0	14.7	57.6
Utah			0.0	0.0	7.2	14.9
Vermont	✓		7.0	9.8	19.9	26.6
Virginia	✓		0.0	6.3	8.0	20.1
Washington	✓		1.8	6.9	10.0	21.8
West Virginia	✓		9.5	28.9	27.4	57.9
Wisconsin	✓	✓	1.0	24.8	14.8	43.0
Wyoming			0.0	0.0	19.8	30.5
United States	40 states	13 states	2.5	16.1	13.8	34.0

n/a — data not available

Source: National Institute for Early Education Research (NIEER), *The State of Preschool: 2004 State Preschool Yearbook* (2004), Table 3 and State Profiles pages.

Table B3-5

State Minimum Training for Early Childhood Education Providers[1]
Pre-service and In-service Requirements, as of August 2004

	Is training required for providers in:			
	Small Family Child Care Homes		Large Family Child Care Homes	
	Pre-service	In-service during Orientation or Initial Licensure	Pre-service	In-service during Orientation or Initial Licensure
Alabama	✓		✓	
Alaska				
Arizona			✓	
Arkansas				
California	✓		✓	
Colorado		✓		✓
Connecticut				
Delaware	✓	✓	✓	
District of Columbia			NC	NC
Florida	✓		✓	✓
Georgia				
Hawaii	✓		✓	
Idaho				
Illinois			✓	✓
Indiana		✓		✓
Iowa				
Kansas				
Kentucky		✓		✓
Louisiana			NC	NC
Maine			NC	NC
Maryland	✓		NC	NC
Massachusetts	✓		✓	
Michigan				✓
Minnesota		✓		✓
Mississippi			✓	
Missouri			✓	
Montana		✓		✓
Nebraska				
Nevada		✓		✓
New Hampshire				
New Jersey			NC	NC
New Mexico				
New York		✓		✓
North Carolina			NC	NC
North Dakota		✓		✓
Ohio				
Oklahoma				
Oregon	✓			
Pennsylvania				
Rhode Island			✓	
South Carolina				✓
South Dakota				
Tennessee		✓		✓
Texas	✓		✓	
Utah				
Vermont			✓	
Virginia				
Washington	✓		NC	NC
West Virginia				
Wisconsin		✓	NC	NC
Wyoming			✓	
Total	10	11	14	13

✓ — training required

Blank — no training required

NC — No Category. "No Category" means that a state does not delineate the specified category in the types of care it licenses. For example, Maine has one category for family child care; it does not delineate large family child care homes. In this state, the care of less than three children is exempt from licensing, and family child care homes may serve 3-12 children. Care of 13 or more children, whether in a residential setting or another facility, is regulated by center licensing rules.

[1]Several states have county or city licensing regulations that may supercede the state requirement; these regulations are not included in this table. If a state's training requirements can be fulfilled by training that is not specific to early childhood care and education (such as first aid/CPR), it is reported as "no training required."

Sources: Child Care Licensing Requirements (August 2004): Minimum Early Childhood Education (ECE) Preservice Qualifications, Orientation/Initial Licensure, and Annual Ongoing Training Hours for Family Child Care Providers, by Sarah LeMoine of the National Child Care Information Center at <http://nccic.org>.

Table B3-6

Annual Wages of Child Care Workers and Early Childhood Teachers, 2004

	Head Start teachers (mean)	Child care workers (median)	Preschool teachers (median)	Kindergarten teachers (median)	Elementary teachers (median)
Alabama	$ 19,355	$ 13,560	$ 19,890	$ 40,330	$ 39,310
Alaska	22,370	18,860	26,580	47,110	48,660
Arizona	23,597	16,130	18,520	36,780	34,040
Arkansas	20,895	13,420	16,490	35,440	35,920
California	28,326	19,380	22,470	51,390	51,090
Colorado	23,816	18,030	21,390	38,850	40,620
Connecticut	28,237	19,480	22,490	55,600	55,380
Delaware	28,792	16,600	21,200	45,960	49,060
District of Columbia	30,093	17,910	26,460	34,890	42,790
Florida	22,480	15,200	19,250	40,530	38,780
Georgia	22,886	15,280	19,260	43,440	44,660
Hawaii	28,422	15,580	24,660	38,290	39,370
Idaho	18,699	15,610	17,330	25,420	42,700
Illinois	25,054	17,920	21,380	33,420	41,370
Indiana	21,644	16,890	19,180	40,550	45,200
Iowa	23,264	14,750	18,430	34,830	33,540
Kansas	22,799	16,460	21,530	35,400	35,920
Kentucky	22,256	15,180	17,450	39,410	38,940
Louisiana	21,368	13,330	18,460	36,810	35,940
Maine	22,588	17,910	21,100	39,060	40,200
Maryland	27,523	19,720	20,980	37,200	44,670
Massachusetts	23,673	20,820	25,520	52,040	53,020
Michigan	28,762	19,100	23,430	45,630	53,000
Minnesota	23,902	17,060	25,420	42,580	43,290
Mississippi	18,127	13,630	21,430	31,580	32,630
Missouri	20,603	15,950	19,390	33,590	34,480
Montana	17,002	16,320	20,250	33,330	35,630
Nebraska	21,413	15,210	18,750	38,860	37,900
Nevada	20,995	16,630	18,120	34,830	40,530
New Hampshire	22,507	18,400	22,060	35,360	43,270
New Jersey	30,304	17,130	25,850	45,370	48,050
New Mexico	21,952	15,400	16,980	36,560	36,090
New York	30,389	21,920	—	—	61,500
North Carolina	22,204	16,760	17,030	35,670	36,850
North Dakota	22,976	14,420	17,430	30,930	34,380
Ohio	21,573	16,480	18,760	45,030	45,270
Oklahoma	22,700	13,940	16,820	30,890	33,480
Oregon	24,142	17,000	21,960	38,920	43,780
Pennsylvania	22,571	16,460	21,170	41,980	49,450
Rhode Island	24,542	19,160	28,620	50,580	57,790
South Carolina	18,163	14,740	16,180	39,270	38,650
South Dakota	24,105	14,770	24,190	30,600	32,140
Tennessee	22,273	14,750	15,620	36,330	37,900
Texas	25,736	14,010	18,610	40,110	41,240
Utah	18,954	15,360	17,500	37,720	39,520
Vermont	22,201	17,360	22,280	43,660	41,970
Virginia	27,078	15,910	19,630	42,240	47,200
Washington	24,757	17,300	22,940	41,340	44,430
West Virginia	22,740	14,180	15,750	39,390	39,850
Wisconsin	26,416	17,720	20,570	38,490	42,780
Wyoming	16,820	14,790	20,020	38,060	40,700
United States	24,211	16,760	20,980	41,400	43,160

— Data not reported

Sources: U.S. Department of Health and Human Services, Head Start Bureau, 2003–2004 Program Information Report (PIR); and U.S. Department of Labor, Bureau of Labor Statistics, at <http://data.bls.gov/oes/search.jsp?data_tool=OES>.

Table B3-7

Maximum Number of Children Allowed Per Caretaker and Maximum Group Size in Child Care Centers[1] Selected Ages, 2004

	Children Per Caretaker			Maximum Group Size		
	9 Months	27 Months	4 Years	9 Months	27 Months	4 Years
Alabama	4:1	7:1	16:1	NR	NR	NR
Alaska	5:1	6:1	10:1	10	12	20
Arizona	5:1 or 11:2	8:1	15:1	NR	NR	NR
Arkansas	6:1	9:1	15:1	12	18	30
California	4:1	6:1	12:1	NR	12	NR
Colorado	5:1	7:1	12:1	10	14	24
Connecticut	4:1	4:1	10:1	8	8	20
Delaware	4:1	10:1	15:1	NR	NR	NR
District of Columbia	4:1	4:1	10:1	8	8	20
Florida	4:1	11:1	20:1	NR	NR	NR
Georgia	6:1	10:1	18:1	12	20	36
Hawaii	4:1	8:1	16:1	8	NR	NR
Idaho	6:1	12:1	12:1	NR	NR	NR
Illinois	4:1	8:1	10:1	12	16	20
Indiana	4:1	5:1	12:1	8	10	24
Iowa	4:1	6:1	12:1	NR	NR	NR
Kansas	3:1	7:1	12:1	9	14	24
Kentucky	5:1	10:1	14:1	10	20	28
Louisiana	5:1	11:1	15:1	NR	NR	NR
Maine	4:1	5:1	10:1	8	10	30
Maryland	3:1	6:1	10:1	6	12	20
Massachusetts	3:1 or 7:2	4:1 or 9:2	10:1	7	9	20
Michigan	4:1	8:1	12:1	NR	NR	NR
Minnesota	4:1	7:1	10:1	8	14	20
Mississippi	5:1	12:1	16:1	10	14	20
Missouri	4:1	8:1	10:1	8	16	NR
Montana	4:1	8:1	10:1	NR	NR	NR
Nebraska	4:1	6:1	12:1	12	NR	NR
Nevada	6:1	10:1	13:1	NR	NR	NR
New Hampshire	4:1	6:1	12:1	12	18	24
New Jersey	4:1	10:1	12:1	20	20	20
New Mexico	6:1	10:1	12:1	NR	NR	NR
New York	4:1	5:1	8:1	8	12	21
North Carolina	5:1	10:1	20:1	10	20	25
North Dakota	4:1	5:1	10:1	8	10	20
Ohio	5:1 or 2:12	7:1	14:1	12	14	28
Oklahoma	4:1	8:1	15:1	8	16	30
Oregon	4:1	5:1	10:1	8	10	20
Pennsylvania	4:1	6:1	10:1	8	12	20
Rhode Island	4:1	6:1	10:1	8	12	20
South Carolina	6:1	10:1	18:1	NR	NR	NR
South Dakota	5:1	5:1	10:1	20	20	20
Tennessee	4:1	7:1	13:1	8	14	20
Texas	4:1	11:1	18:1	10	22	35
Utah	4:1	7:1	15:1	8	14	30
Vermont	4:1	5:1	10:1	8	10	20
Virginia	4:1	10:1	12:1	NR	NR	NR
Washington	4:1	7:1	10:1	8	14	20
West Virginia	4:1	8:1	12:1	8	16	24
Wisconsin	4:1	6:1	13:1	8	12	24
Wyoming	4:1	8:1	12:1	10	18	30
Maximum Recommended Level[2]	3:1 to 4:1	4:1 to 6:1	8:1 to 10:1	6 to 8	8 to 10	16 to 20

NR — not regulated

[1] There may be some exceptions to these ratio and group size requirements in some states under certain circumstances. For example, some states have different requirements for small centers, classes with mixed-age groups, or different levels of licensing. See original source for details.

[2] Maximum Recommended Level: As recommended in the accreditation guidelines developed by the National Association for the Education of Young Children and in the National Health and Safety Performance Standards developed by the American Public Health Association and the American Academy of Pediatrics.

Sources: State data compiled and posted by the National Child Care Information Center at <http://nccic.org> from licensing regulations posted on the National Resource Center for Health and Safety in Child Care at <http://nrc.uchsc.edu>: "Child Care Licensing Requirements: Child:Staff Ratios and Maximum Group Size Requirements" (August 2003). Maximum recommended levels obtained from the accreditation guidelines developed by the National Association for the Education of Young Children (NAEYC) and "Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care."

Table B3-8

Child Care Costs vs. College Tuition Costs, 2000

	Child care costs for a 4-year-old[1]	Tuition at a 4-year public college[2]	College tuition as a percent of child care costs
Alabama	$ 3,672	$ 2,833	77.2%
Alaska	6,019	2,855	47.4
Arizona	4,352	2,252	51.7
Arkansas	3,640	2,785	76.5
California	4,858	2,559	52.7
Colorado	5,096	2,775	54.5
Connecticut	6,405	4,435	69.2
Delaware	5,510	4,642	84.2
District of Columbia	—	2,070	—
Florida	4,255	2,244	52.7
Georgia	4,992	2,524	50.6
Hawaii	5,505	2,965	53.9
Idaho	4,814	2,458	51.1
Illinois	5,304	4,038	76.1
Indiana	4,732	3,646	77.0
Iowa	6,198	2,998	48.4
Kansas	4,889	2,439	49.9
Kentucky	4,368	2,723	62.3
Louisiana	4,160	2,430	58.4
Maine	5,790	4,122	71.2
Maryland	4,774	4,552	95.3
Massachusetts	8,121	4,105	50.5
Michigan	4,830	4,538	94.0
Minnesota	7,436	3,800	51.1
Mississippi	3,380	2,872	85.0
Missouri	4,784	3,701	77.4
Montana	4,680	3,011	64.3
Nebraska	4,680	2,930	62.6
Nevada	4,862	2,034	41.8
New Hampshire	6,520	6,083	93.3
New Jersey	5,252	5,255	100.1
New Mexico	4,801	2,340	48.7
New York	8,060	3,983	49.4
North Carolina	5,876	2,054	35.0
North Dakota	4,627	2,990	64.6
Ohio	5,672	4,495	79.2
Oklahoma	4,108	2,183	53.1
Oregon	5,580	3,582	64.2
Pennsylvania	6,188	5,610	90.7
Rhode Island	6,365	4,318	67.8
South Carolina	3,900	3,638	93.3
South Dakota	4,243	3,210	75.7
Tennessee	4,420	2,698	61.0
Texas	4,160	2,644	63.6
Utah	4,550	2,147	47.2
Vermont	5,980	6,913	115.6
Virginia	4,857	3,733	76.9
Washington	6,604	3,357	50.8
West Virginia	4,238	2,549	60.1
Wisconsin	6,104	3,313	54.3
Wyoming	4,056	2,416	59.6
United States		3,351	

[1]Average annual cost in a child care center in an urban area; see source for specific urban area in each state.

[2]Annual tuition at a four-year public college or university in the state

Sources: Karen Schulman, *The High Cost of Child Care Puts Quality Care Out of Reach for Many Families* (Children's Defense Fund, 2000), Table A-1; and U.S. Department of Education, National Center for Education Statistics, *Digest of Education Statistics 2000* (2001), Table 314. Calculations by Children's Defense Fund.

Table B4-1

Participants in Federal Education and Disability Programs

	Title I 2000-2001	Individuals with Disabilities Education Act (IDEA), 2003, ages:							Supplemental Security Income (SSI) Child Recipients December 2003
		3-5	6-11	12-17	6-17	14-21	18-21	Total 3-21	
Alabama	294,838	7,843	36,845	43,203	80,048	32,686	5,165	93,056	27,318
Alaska	25,009	1,968	7,941	7,400	15,341	5,099	650	17,959	1,054
Arizona	362,960	11,952	47,524	47,736	95,260	34,327	4,913	112,125	15,527
Arkansas	161,888	10,670	24,402	28,840	53,242	21,759	2,881	66,793	15,356
California	2,622,815	61,950	285,774	302,394	588,168	215,682	25,645	675,763	92,830
Colorado	107,713	9,673	33,871	34,943	68,814	25,747	3,960	82,447	6,580
Connecticut	79,496	8,135	27,799	34,304	62,103	25,886	3,714	73,952	6,277
Delaware	22,059	2,031	7,586	8,013	15,599	5,835	787	18,417	2,970
District of Columbia	65,442	301	4,199	7,092	11,291	6,214	1,650	13,242	3,923
Florida	870,114	35,258	168,163	175,871	344,034	128,187	18,466	397,758	77,253
Georgia	499,009	20,260	86,021	78,829	164,850	53,988	5,838	190,948	30,768
Hawaii	68,868	2,284	8,489	11,731	20,220	8,520	762	23,266	1,378
Idaho	45,186	3,807	12,290	11,914	24,204	8,491	1,081	29,092	3,537
Illinois	469,040	32,718	132,360	138,588	270,948	101,859	14,445	318,111	42,616
Indiana	115,095	18,439	75,518	70,132	145,650	52,066	7,807	171,896	19,019
Iowa	59,854	5,985	28,224	35,861	64,085	26,750	3,647	73,717	6,283
Kansas	89,862	9,190	26,241	26,878	53,119	20,207	2,830	65,139	6,618
Kentucky	302,295	20,219	44,126	36,128	80,254	25,828	3,310	103,783	25,203
Louisiana	351,870	11,386	42,385	42,771	85,156	32,814	5,391	101,933	29,477
Maine	26,702	4,647	14,999	16,585	31,584	12,050	1,553	37,784	3,196
Maryland	149,387	12,105	45,728	51,973	97,701	36,644	4,059	113,865	14,039
Massachusetts	237,176	14,822	62,926	73,611	136,537	54,786	7,683	159,042	16,646
Michigan	520,844	23,465	98,826	104,280	203,106	76,684	11,721	238,292	35,563
Minnesota	155,466	12,987	45,653	50,699	96,352	37,695	4,854	114,193	9,595
Mississippi	273,129	7,994	29,596	26,353	55,949	19,619	2,905	66,848	21,261
Missouri	207,754	15,140	59,025	62,433	121,458	46,594	6,995	143,593	18,075
Montana	38,695	1,798	8,038	8,748	16,786	6,357	851	19,435	1,803
Nebraska	48,157	4,445	19,675	18,398	38,073	13,410	2,043	44,561	3,401
Nevada	58,038	4,933	19,188	19,590	38,778	13,634	1,490	45,201	5,234
New Hampshire	17,980	2,586	11,785	15,476	27,261	11,501	1,464	31,311	1,714
New Jersey	252,512	18,545	104,761	107,504	212,265	79,424	10,462	241,272	20,901
New Mexico	118,610	5,656	19,846	23,754	43,600	17,903	2,558	51,814	6,261
New York	828,609	55,588	162,610	201,677	364,287	152,531	22,790	442,665	68,062
North Carolina	320,919	21,018	84,088	81,822	165,910	57,890	7,028	193,956	33,416
North Dakota	19,837	1,501	5,748	6,047	11,795	4,592	748	14,044	940
Ohio	448,333	19,659	100,019	119,279	219,298	91,121	14,921	253,878	41,422
Oklahoma	247,536	7,769	38,336	42,083	80,419	31,598	4,857	93,045	11,594
Oregon	107,960	7,453	32,161	33,230	65,391	23,974	3,239	76,083	7,505
Pennsylvania	458,549	24,459	106,963	128,266	235,229	95,930	13,571	273,259	50,909
Rhode Island	20,233	2,930	13,402	14,616	28,018	10,590	1,275	32,223	3,757
South Carolina	227,275	11,818	48,331	46,469	94,800	33,865	4,459	111,077	17,718
South Dakota	21,385	2,540	8,094	6,323	14,417	4,751	803	17,760	1,879
Tennessee	288,487	11,121	50,688	54,957	105,645	41,386	5,861	122,627	21,915
Texas	2,072,206	40,607	206,319	235,211	441,530	174,426	24,634	506,771	65,233
Utah	64,371	6,733	25,976	22,598	48,574	16,483	2,438	57,745	3,839
Vermont	24,051	1,378	4,893	6,667	11,560	5,113	732	13,670	1,496
Virginia	145,194	16,422	69,686	78,452	148,138	58,870	8,228	172,788	20,290
Washington	206,382	13,010	53,297	51,786	105,083	37,882	5,580	123,673	13,097
West Virginia	130,808	5,604	21,542	21,351	42,893	16,128	2,275	50,772	8,219
Wisconsin	173,690	15,393	47,714	57,866	105,580	45,018	6,855	127,828	15,429
Wyoming	13,977	2,211	5,321	5,315	10,636	3,923	583	13,430	817
United States	14,537,665	670,406	2,724,992	2,936,047	5,661,039	2,164,317	302,457	6,633,902	959,213

Sources: U.S. Department of Education, Office of Elementary and Secondary Education, *State ESEA Title I Participation Information for 2000-2001: Final Summary Report* (2004), Table 8; U.S. Department of Education, Office of Special Education and Rehabilitative Services, 27th Annual Report, Data Tables for OSEP State Reported Data, Table AA1, at <http://www.ideadata.org/tables27th ar_aa1.htm>; and Social Security Administration, SSI Annual Statistical Report, Table 9, at <http://www.socialsecurity.gov/policy/docs/statcomps/ssi_asr/2003>. Calculations by Children's Defense Fund.

Table B4-2

Public School Education

	Pupil/teacher ratio Fall 2001	High school completion rate 1999-2001	Expenditures per pupil 2000-2001	
			Dollars	Rank
Alabama	15.8	82.0%	$ 5,885	44
Alaska	16.7	90.9	9,216	7
Arizona	20.0	77.6	5,278	49
Arkansas	13.6	86.7	5,568	48
California	20.5	85.1	6,987	25
Colorado	16.8	82.4	6,567	34
Connecticut	13.7	93.6	10,127	4
Delaware	15.3	90.8	8,958	9
District of Columbia	13.9	88.2	12,046	1
Florida	18.6	83.8	6,170	39
Georgia	15.9	84.7	6,929	27
Hawaii	16.8	91.3	6,596	33
Idaho	17.8	88.3	5,725	46
Illinois	16.0	88.4	7,643	17
Indiana	16.7	89.4	7,630	18
Iowa	13.9	92.4	6,930	26
Kansas	14.2	88.2	6,925	28
Kentucky	16.2	87.4	6,079	41
Louisiana	16.6	82.6	6,037	42
Maine	12.3	93.6	8,232	13
Maryland	16.0	84.9	8,256	11
Massachusetts	14.1	91.4	9,509	5
Michigan	17.5	88.1	8,278	10
Minnesota	16.0	93.1	7,645	16
Mississippi	15.8	84.3	5,175	50
Missouri	13.9	90.4	6,657	31
Montana	14.6	92.4	6,726	30
Nebraska	13.5	90.8	7,223	24
Nevada	18.5	79.6	5,807	45
New Hampshire	14.1	86.6	7,286	22
New Jersey	12.9	89.3	11,248	2
New Mexico	14.7	85.0	6,313	37
New York	13.7	86.8	10,716	3
North Carolina	15.4	84.7	6,346	36
North Dakota	13.2	96.8	6,125	40
Ohio	15.0	87.0	7,571	19
Oklahoma	14.9	86.0	6,019	43
Oregon	19.4	86.3	7,528	21
Pennsylvania	15.4	89.8	8,210	14
Rhode Island	14.2	85.5	9,315	6
South Carolina	14.8	84.5	6,631	32
South Dakota	13.6	91.6	6,191	38
Tennessee	15.9	86.6	5,687	47
Texas	14.7	79.9	6,539	35
Utah	21.8	88.9	4,674	51
Vermont	11.8	86.6	9,153	8
Virginia	13.0	88.2	7,281	23
Washington	19.2	88.3	6,750	29
West Virginia	14.0	88.5	7,534	20
Wisconsin	14.4	90.3	8,243	12
Wyoming	12.5	87.3	7,835	15
United States	15.9	86.3	7,376	

Sources: U.S. Department of Education, National Center for Education Statistics, *Digest of Education Statistics* 2003 (2004), Tables 66 and 170; and U.S. Department of Education, National Center for Education Statistics, *Dropout Rates in the United States*: 2001 (2004), Table A8.
Calculations by Children's Defense Fund.

Table B4-3

Reading and Math Achievement of 4th Graders
Percent of fourth grade public school students performing below grade level, 2005

	Reading						Math					
	Total	White	Black	Hispanic	Asian, Pacific Islander	American Indian, Alaska Native	Total	White	Black	Hispanic	Asian, Pacific Islander	American Indian, Alaska Native
Alabama	78%	68%	92%	—	—	—	79%	70%	93%	—	—	—
Alaska	74	64	76	81%	81%	91%	66	56	80	77%	64%	85%
Arizona	76	63	88	89	64	—	72	57	87	86	57	—
Arkansas	71	63	90	79	—	—	66	58	90	75	—	—
California	78	63	89	90	65	77	72	54	88	86	49	73
Colorado	64	54	82	83	58	—	61	51	82	82	58	—
Connecticut	61	53	88	85	51	—	57	47	89	85	43	—
Delaware	65	54	85	78	45	—	64	50	85	82	30	—
District of Columbia	89	30	92	88	—	—	91	22	95	89	—	—
Florida	70	61	87	75	57	—	64	51	84	72	34	—
Georgia	74	63	88	86	43	—	70	57	88	78	43	—
Hawaii	77	63	79	73	81	—	73	58	84	79	75	—
Idaho	67	63	—	89	—	—	59	56	—	83	—	—
Illinois	70	58	91	86	56	—	68	56	91	86	34	—
Indiana	70	65	88	89	—	—	62	55	87	79	—	—
Iowa	67	64	88	85	60	—	63	60	85	83	—	—
Kansas	67	63	90	86	45	—	53	48	76	70	29	—
Kentucky	70	67	85	—	—	—	73	71	91	—	—	—
Louisiana	80	68	91	—	—	—	76	62	91	—	—	—
Maine	64	65	—	—	—	—	61	61	—	—	—	—
Maryland	68	55	88	79	45	—	62	47	86	74	41	—
Massachusetts	56	49	80	89	53	—	51	43	82	86	36	—
Michigan	69	62	90	—	—	—	63	54	92	—	—	—
Minnesota	62	57	90	82	72	—	53	46	85	85	60	—
Mississippi	82	69	93	—	—	—	81	68	93	—	—	—
Missouri	68	62	86	79	—	—	69	63	91	90	—	—
Montana	64	61	—	64	—	87	61	59	—	70	—	83
Nebraska	67	60	90	88	—	—	64	56	93	90	—	—
Nevada	79	72	90	88	76	—	74	62	90	87	58	—
New Hampshire	61	61	—	—	—	—	53	52	—	83	—	—
New Jersey	62	54	85	81	43	—	54	45	83	75	26	—
New Mexico	79	64	76	86	—	92	81	66	94	87	—	91
New York	66	57	83	83	50	—	64	51	87	83	39	—
North Carolina	70	61	87	83	69	—	60	48	83	74	37	—
North Dakota	65	62	—	—	—	91	59	57	—	—	—	87
Ohio	65	59	90	76	—	—	57	49	84	79	—	—
Oklahoma	74	70	90	83	—	78	72	64	89	84	—	79
Oregon	70	66	85	90	65	—	63	58	88	86	46	—
Pennsylvania	64	58	85	81	53	—	59	50	87	84	—	—
Rhode Island	70	64	85	89	71	—	69	63	91	91	61	—
South Carolina	74	64	89	71	—	—	64	47	87	70	—	—
South Dakota	67	63	—	—	—	86	60	55	—	—	—	87
Tennessee	73	67	89	87	—	—	72	65	91	74	—	—
Texas	71	56	85	81	53	—	60	40	82	72	28	—
Utah	65	62	—	86	70	—	63	59	—	87	67	—
Vermont	62	62	—	—	—	—	57	56	—	—	—	—
Virginia	63	55	85	74	47	—	60	50	86	78	36	—
Washington	65	60	80	86	60	—	58	52	74	83	54	—
West Virginia	74	74	85	—	—	—	74	75	83	—	—	—
Wisconsin	67	62	90	80	66	—	60	52	93	84	71	—
Wyoming	66	62	—	84	—	—	58	55	—	69	—	—
United States	70	61	88	85	60	81	65	53	87	81	46	78

—Data not reported; number of students too small to calculate a reliable rate

Sources: U.S. Department of Education, National Assessment of Education Progress, *The Nation's Report Card: Reading 2005* (2005), Figure 11 and Table A-4; and U.S. Department of Education, National Assessment of Education Progress, *The Nation's Report Card: Mathematics 2005* (2005), Figure 11 and Table A-4. Calculations by Children's Defense Fund.

Table B5-1

Child Abuse and Neglect, 2003

	Child victims of abuse and neglect		Type of abuse or neglect (percentage distribution)[2]						
	Number	Rate[1]	Neglect	Medical neglect	Physical abuse	Sexual abuse	Psychological maltreatment	Other	Unknown or missing
Alabama	9,290	8.4	39.6%	—	38.6%	24.7%	1.3%	—	—
Alaska	7,996	42.2	59.8	—	21.8	7.2	11.3	—	—
Arizona	4,838	3.2	74.4	—	22.2	6.0	0.9	—	—
Arkansas	7,232	10.6	54.5	3.0%	18.9	29.2	1.1	0.3%	—
California	—	—	—	—	—	—	—	—	—
Colorado	8,137	7.1	46.6	1.4	21.5	11.5	5.0	—	18.0%
Connecticut	12,256	14.7	68.1	3.1	11.5	4.5	33.6	0.9	2.2
Delaware	1,236	6.2	36.5	4.0	25.1	12.4	22.6	6.6	
District of Columbia	2,518	23.2	82.3	—	19.5	4.9	—	—	—
Florida	138,499	35.3	30.2	1.9	13.9	4.5	2.4	67.3	—
Georgia	43,923	19.1	79.6	4.5	9.9	5.0	3.5	4.3	—
Hawaii	4,046	13.6	16.9	1.6	11.9	5.7	2.5	88.2	—
Idaho	1,527	4.1	70.1	2.0	16.9	7.7	0.5	9.4	—
Illinois	28,344	8.8	58.3	3.4	34.8	19.2	0.2	0.0	—
Indiana	21,205	13.2	66.9	2.9	17.6	20.3	—	—	—
Iowa	13,303	19.2	74.0	1.5	15.5	6.7	1.3	9.4	—
Kansas	5,682	8.2	26.5	2.5	25.7	15.2	18.2	22.2	0.8
Kentucky	18,178	18.3	79.2	—	17.5	5.9	1.1	—	—
Louisiana	11,432	9.7	76.9	—	22.0	7.4	3.9	0.4	—
Maine	4,719	16.5	71.9	—	27.2	14.3	58.0	—	—
Maryland	16,688	12.1	57.5	—	32.0	12.5	0.3	—	—
Massachusetts	36,558	24.6	89.8	—	16.2	3.1	0.3	0.0	—
Michigan	28,690	11.3	70.5	2.2	20.1	5.5	4.1	3.2	—
Minnesota	9,230	7.4	72.8	1.4	19.7	10.3	0.8	—	—
Mississippi	5,940	7.8	55.0	3.1	22.8	15.1	9.3	0.3	—
Missouri	10,183	7.2	50.4	3.2	27.9	27.9	6.1	2.6	—
Montana	1,951	9.0	38.7	1.6	59.1	8.7	15.5	0.3	—
Nebraska	3,875	8.8	72.7	0.1	21.2	10.0	8.0	—	—
Nevada	4,578	7.9	82.1	1.2	16.0	3.8	6.8	—	—
New Hampshire	1,043	3.4	62.9	2.2	19.4	20.8	1.5	—	—
New Jersey	8,123	3.8	51.9	12.5	25.6	9.3	4.2	—	0.2
New Mexico	6,238	12.4	67.6	2.4	32.2	6.2	5.5	0.0	—
New York	75,784	16.7	90.4	3.6	12.8	4.0	0.9	25.1	—
North Carolina	32,847	15.7	90.3	2.1	3.1	3.6	0.4	0.5	—
North Dakota	1,494	10.2	88.2	—	22.1	11.8	53.0	—	—
Ohio	47,444	16.9	53.6	0.0	22.9	15.5	13.9	—	—
Oklahoma	12,529	14.3	86.5	3.6	18.8	7.4	4.4	—	0.0
Oregon	10,368	12.2	25.6	4.5	11.1	10.7	3.9	57.7	—
Pennsylvania	4,571	1.6	3.9	2.6	36.6	57.2	1.4	—	—
Rhode Island	3,290	13.5	78.5	2.2	17.9	6.8	0.2	2.3	—
South Carolina	11,143	10.9	64.8	4.1	34.7	7.8	1.3	0.2	—
South Dakota	4,346	22.2	73.1	—	20.8	4.2	17.7	—	0.1
Tennessee	9,421	6.8	49.3	2.1	32.7	24.6	0.6	0.3	—
Texas	50,522	8.1	63.8	4.8	26.9	14.6	2.1	—	—
Utah	12,366	16.6	20.9	0.5	14.2	19.6	44.0	15.8	—
Vermont	1,233	9.0	4.8	3.2	52.8	42.1	1.2	—	—
Virginia	6,485	3.6	59.9	2.9	24.5	16.7	1.7	—	—
Washington	6,020	4.0	78.2	0.7	19.8	7.6	1.1	0.1	—
West Virginia	8,875	22.7	53.7	1.1	32.0	6.6	21.0	5.3	—
Wisconsin	10,174	7.6	25.0	0.7	13.8	41.4	0.3	23.1	—
Wyoming	786	6.5	65.0	1.1	14.8	11.3	10.3	5.6	—
United States[3]	906,000	12.4	60.9	2.3	18.9	9.9	4.9	16.9	0.2

[1] Number of child victims per 1,000 children

[2] Totals may be greater than 100 percent because some victims were subject to multiple types of maltreatment.

[3] The United States total is an estimate by the Children's Bureau; a more accurate figure is not possible because California did not report data for 2003.

— no data reported by state

Note: Because of differences in definitions and reporting requirements, data may not be comparable from state to state.

Source: U.S. Department of Health and Human Services, Children's Bureau, *Child Maltreatment 2003* (2005), Tables 3-2, 3-3, and 3-4.

Table B5-2

Foster Care, FY 1999 – FY 2003

	Number of children in care on last day of year					Children in care, FY 2001, by race/ethnicity			
	FY1999	FY2000	FY2001	FY2002	FY2003	Black Non-Hispanic	Hispanic	White Non-Hispanic	Other Non-Hispanic
Alabama	5,511	5,621	5,859	5,883	6,079	51%	1%	47%	1%
Alaska	2,248	2,193	1,993	2,072	2,040	9	1	28	62
Arizona	7,034	6,475	6,050	6,173	7,469	11	33	48	9
Arkansas	2,919	3,045	2,959	2,971	3,000	35	2	58	5
California	117,937	112,807	107,168	100,451	97,261	31	36	27	6
Colorado	7,639	7,533	7,138	9,209	8,754	15	29	51	5
Connecticut	7,487	6,996	7,440	6,007	6,742	36	26	34	4
Delaware	1,193	1,098	1,023	886	814	61	7	32	0
District of Columbia	3,466	3,054	3,339	3,321	3,092	91	1	0	7
Florida	34,292	36,608	32,477	31,963	30,677	44	8	45	3
Georgia	11,991	11,204	13,175	13,149	13,578	56	3	37	3
Hawaii	2,205	2,401	2,584	2,762	2,967	2	2	11	85
Idaho	959	1,015	1,114	1,246	1,401	2	12	77	8
Illinois	34,327	29,565	28,202	24,344	21,608	72	5	20	2
Indiana	8,933	7,482	8,383	8,640	8,899	38	5	54	3
Iowa	4,854	5,068	5,202	5,238	5,011	12	5	70	13
Kansas	6,774	6,569	6,409	6,190	5,781	21	5	68	6
Kentucky	5,942	6,017	6,165	6,814	6,895	19	1	73	7
Louisiana	5,581	5,406	5,024	4,829	4,541	61	1	36	2
Maine	3,154	3,191	3,226	3,084	2,999	2	2	75	21
Maryland	13,455	13,113	12,564	12,026	11,521	78	1	19	2
Massachusetts	11,169	11,619	11,568	12,510	12,608	19	22	52	7
Michigan	20,300	20,034	20,896	21,251	21,376	47	4	45	5
Minnesota	8,996	8,530	8,167	8,052	7,338	21	6	52	21
Mississippi	3,196	3,292	3,443	2,686	2,812	54	1	42	3
Missouri	12,577	13,181	13,394	13,029	11,900	37	1	60	1
Montana	2,156	2,180	2,008	1,912	1,866	1	4	57	38
Nebraska	5,146	5,674	6,254	6,377	6,091	17	8	66	9
Nevada	N/A	1,615	2,959	3,291	3,599	22	12	52	14
New Hampshire	1,385	1,311	1,288	1,291	1,217	3	5	86	6
New Jersey	9,494	9,794	10,666	11,442	12,801	62	7	23	8
New Mexico	1,941	1,912	1,757	1,885	2,100	7	55	27	12
New York	51,159	47,118	43,365	40,753	37,067	46	17	17	21
North Carolina	11,339	10,847	10,130	9,527	9,534	47	6	43	4
North Dakota	1,131	1,129	1,167	1,197	1,238	3	3	59	35
Ohio	20,078	20,365	21,584	21,038	19,323	47	3	44	6
Oklahoma	8,173	8,406	8,674	8,812	9,194	19	6	49	26
Oregon	9,278	9,193	8,966	9,101	9,381	9	8	61	21
Pennsylvania	22,690	21,631	21,319	21,410	21,768	51	9	39	1
Rhode Island	2,621	2,302	2,414	2,383	2,334	20	16	58	6
South Carolina	4,545	4,525	4,774	4,818	4,894	60	2	38	1
South Dakota	1,101	1,215	1,367	1,396	1,580	2	4	29	65
Tennessee	10,796	10,144	9,679	9,359	9,487	36	2	59	3
Texas	16,326	18,190	19,739	21,353	22,191	28	35	33	4
Utah	2,273	1,805	1,957	2,025	2,033	4	18	55	24
Vermont	1,445	1,389	1,382	1,526	1,409	2	1	97	1
Virginia	6,778	6,789	6,866	7,109	7,046	50	4	43	4
Washington	8,688	8,945	9,101	9,669	9,213	12	12	59	18
West Virginia	3,169	3,388	3,298	3,220	4,069	8	1	84	7
Wisconsin	10,868	10,504	9,497	8,744	7,824	60	5	32	3
Wyoming	774	815	965	929	1,055	3	7	86	4
United States	557,493	544,303	536,138	525,353	515,477	38	17	38	8

Sources: U.S. Department of Health and Human Services, Administration for Children and Families, Adoption and Foster Care Analysis and Reporting System (AFCARS), as of April 2005, at <http://www.acf.hhs.gov/programs/cb/dis/tables/entryexit2002.htm>; and U.S. Congress, House of Representatives, Committee on Ways and Means, WMCP 108-6 (2004), Table 11-30, at <http://waysandmeans.house.gov/Documents.asp?section=813 .

Table B5-3

Kinship Care

	Children living in relative-headed households, 2000: Not child of householder, household headed by: Any relative	Not child of householder, household headed by: Grandparent	No parents present, household headed by: Any relative	No parents present, household headed by: Grandparent	Grandparents responsible for own grandchildren, 2004: Total number	Number responsible for one year or more	Number in labor force	Poor: Number	Poor: Percent
Alabama	108,137	89,126	51,486	38,164	58,215	45,160	29,321	13,435	23.1%
Alaska	9,963	7,415	5,110	3,222	5,532	3,955	3,447	692	12.5
Arizona	128,829	93,146	54,833	31,254	59,180	48,007	38,299	10,929	18.5
Arkansas	60,414	49,040	30,111	21,927	38,964	30,031	23,918	8,756	22.5
California	940,397	618,927	389,631	195,269	248,355	193,385	143,605	39,253	15.8
Colorado	65,826	47,430	28,185	16,329	35,061	24,497	19,083	4,703	13.4
Connecticut	49,307	37,604	21,123	12,825	12,365	10,895	8,080	1,295	10.5
Delaware	17,388	13,593	7,803	4,858	9,026	7,629	5,553	2,476	27.4
District of Columbia	22,458	17,216	10,702	7,148	5,733	4,742	2,990	1,535	26.8
Florida	336,313	253,936	151,492	94,477	125,456	92,795	74,918	25,957	20.7
Georgia	214,593	162,628	98,773	62,874	99,149	76,861	56,630	21,629	21.8
Hawaii	47,677	37,638	13,814	8,341	14,225	11,543	8,147	1,650	11.6
Idaho	15,596	11,938	7,087	4,642	8,741	6,972	4,468	1,313	15.0
Illinois	284,268	210,046	119,676	72,416	101,960	78,669	64,343	19,006	18.6
Indiana	92,856	75,496	39,180	27,395	56,026	44,604	39,610	9,893	17.7
Iowa	26,683	20,820	11,230	7,203	11,732	8,846	7,184	1,095	9.3
Kansas	34,813	26,532	16,184	10,171	18,481	13,933	12,623	2,456	13.3
Kentucky	64,352	53,049	30,241	22,004	37,732	28,947	18,538	10,000	26.5
Louisiana	142,066	115,446	64,866	46,094	50,230	39,958	26,159	13,734	27.3
Maine	10,882	8,931	4,326	2,910	7,029	5,700	3,441	1,553	22.1
Maryland	126,100	97,312	54,323	34,503	49,490	36,762	29,163	9,855	19.9
Massachusetts	82,879	64,230	30,615	18,366	26,669	24,456	19,368	2,787	10.5
Michigan	174,773	136,950	71,200	45,805	68,962	54,055	39,321	12,721	18.4
Minnesota	43,731	31,704	19,053	10,882	17,852	11,353	13,644	1,363	7.6
Mississippi	99,370	81,613	46,693	33,929	49,977	37,645	26,705	15,179	30.4
Missouri	90,911	73,805	39,188	27,454	42,299	29,905	25,927	6,699	15.8
Montana	11,200	9,077	5,161	3,539	7,384	4,540	3,904	1,894	25.7
Nebraska	17,482	12,901	8,321	5,120	12,983	9,598	9,816	1,726	13.3
Nevada	42,722	29,650	19,278	11,105	16,970	13,313	9,639	1,730	10.2
New Hampshire	11,007	9,035	3,869	2,585	3,992	3,494	2,903	604	15.1
New Jersey	165,351	124,046	63,514	36,633	51,163	44,047	30,187	5,926	11.6
New Mexico	49,959	40,068	21,279	14,630	23,502	19,484	11,503	6,834	29.1
New York	401,228	294,137	165,493	95,352	123,315	92,978	66,965	29,756	24.1
North Carolina	166,356	129,180	80,126	53,366	91,837	73,830	56,844	21,995	24.0
North Dakota	4,807	3,692	2,414	1,533	2,774	1,727	1,631	312	11.2
Ohio	180,287	146,615	76,794	53,208	84,196	67,219	51,909	16,855	20.0
Oklahoma	69,419	55,032	34,185	23,815	41,021	29,615	22,374	5,578	13.6
Oregon	47,903	34,848	20,735	12,499	22,955	16,942	14,948	2,877	12.5
Pennsylvania	194,659	158,607	76,356	51,929	77,514	57,400	40,824	12,826	16.5
Rhode Island	13,621	10,745	5,170	3,305	5,503	4,553	3,080	1,519	27.6
South Carolina	107,140	87,261	49,894	36,042	53,881	45,905	32,796	15,954	29.6
South Dakota	10,051	7,934	5,146	3,514	5,463	4,217	3,126	1,487	27.2
Tennessee	122,414	98,495	56,682	39,444	66,178	51,286	41,450	12,731	19.2
Texas	579,486	438,768	244,100	152,951	256,204	200,245	154,687	58,388	22.8
Utah	39,030	29,446	13,756	7,988	18,734	13,177	11,394	1,213	6.5
Vermont	4,636	3,757	1,838	1,231	1,939	1,689	1,490	152	—
Virginia	130,792	101,025	56,663	37,041	59,408	49,946	28,765	8,738	14.7
Washington	78,283	56,010	35,761	20,495	36,302	25,795	20,708	3,294	9.1
West Virginia	26,536	22,655	10,809	8,146	19,999	15,675	10,786	3,884	19.4
Wisconsin	56,808	42,865	25,373	15,445	29,010	21,830	19,578	6,456	22.3
Wyoming	6,013	4,777	2,738	1,880	4,026	2,900	2,808	433	10.8
United States	5,827,772	4,386,197	2,502,380	1,553,258	2,374,694	1,842,710	1,398,600	463,126	19.5

— Number in sample too small to calculate a reliable rate

Sources: U.S. Department of Commerce, Bureau of the Census, 2000 Census of Population and Housing; and U.S. Department of Commerce, Bureau of the Census, 2004 American Community Survey, Tables B10050, B10058, and B10059. Calculations by Children's Defense Fund.

Table B5-4

Adoptions from Foster Care, FY 1995 – FY 2003

	FY1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
Alabama	128	153	136	115	153	202	238	249	329
Alaska	103	112	109	95	137	202	278	230	208
Arizona	215	383	474	—	761	853	938	793	839
Arkansas	84	185	146	258	318	325	362	297	385
California	3,094	3,153	3,614	4,418	6,416	8,818	9,156	8,840	7,433
Colorado	338	454	458	581	719	711	749	992	1,024
Connecticut	198	146	278	314	403	499	444	617	342
Delaware	38	46	33	62	33	103	117	133	101
District of Columbia	86	113	132	140	166	319	231	253	240
Florida	904	1,064	992	1,549	1,355	1,629	1,508	2,309	2,786
Georgia	383	537	558	727	1,143	1,091	1,001	1,135	1,091
Hawaii	42	64	150	301	281	280	260	366	318
Idaho	46	40	47	57	107	140	132	118	138
Illinois	1,759	2,146	2,695	4,656	7,028	5,664	4,106	3,634	2,701
Indiana	520	373	592	800	764	1,160	901	923	761
Iowa	227	383	440	525	764	729	661	886	1,130
Kansas	333	292	421	419	566	468	428	475	546
Kentucky	197	214	222	211	360	398	548	559	612
Louisiana	292	321	310	311	356	476	470	487	497
Maine	85	144	96	125	202	379	367	317	404
Maryland	324	413	290	480	594	552	815	949	734
Massachusetts	1,073	1,113	1,161	1,100	922	861	778	808	733
Michigan	1,717	1,950	2,047	2,257	2,446	2,804	2,980	2,848	2,622
Minnesota	232	239	302	429	633	614	567	626	644
Mississippi	109	101	131	170	237	288	266	227	182
Missouri	538	600	533	640	849	1,265	1,101	1,542	1,403
Montana	104	98	143	152	187	238	275	247	224
Nebraska	208	168	180	—	279	293	310	315	274
Nevada	155	145	148	—	123	231	244	254	296
New Hampshire	51	59	24	51	62	97	95	114	131
New Jersey	616	678	570	815	732	832	1,030	1,385	935
New Mexico	141	148	152	197	258	347	369	275	220
New York	4,579	4,590	4,979	4,819	4,864	4,234	3,935	3,791	3,862
North Carolina	289	417	694	882	949	1,337	1,327	1,324	1,296
North Dakota	42	41	57	111	143	108	145	137	120
Ohio	1,202	1,258	1,400	1,015	1,868	2,044	2,230	2,396	2,420
Oklahoma	226	371	418	505	830	1,096	959	1,014	1,152
Oregon	427	468	441	665	765	831	1,071	1,115	849
Pennsylvania	1,018	1,127	1,526	1,516	1,454	1,712	1,564	2,020	1,946
Rhode Island	216	341	226	222	292	260	267	256	264
South Carolina	231	220	318	465	456	378	384	345	280
South Dakota	42	72	55	55	84	94	97	145	144
Tennessee	458	330	195	337	382	431	646	922	954
Texas	804	746	1,091	1,602	2,056	2,045	2,325	2,299	2,504
Utah	283	124	268	334	369	303	349	346	311
Vermont	62	83	80	118	139	117	116	153	167
Virginia	320	298	276	235	326	448	495	424	487
Washington	645	521	656	878	1,047	1,141	1,204	1,077	1,315
West Virginia	139	188	220	211	312	352	362	361	322
Wisconsin	360	511	530	643	642	736	754	1,028	1,187
Wyoming	10	20	16	32	45	61	46	52	56
United States	25,693	27,761	31,030	36,600	46,377	50,596	50,001	52,408	49,919

— Data not available

Source: U.S. Department of Health and Human Services, Children's Bureau, "Adoptions of Children with Public Welfare Agency Involvement by State FY 1995 - FY 2003," at <http://www.acf.hhs.gov/programs/cb/dis/adoptchild03b.pdf>. Calculations by Children's Defense Fund.

Table B6-1

Youth at Risk

	Dropouts, 2000[1]		Youth unemployment rate 2004[2]	Number of juvenile arrests 2004[3]	Juveniles in juvenile and adult corrections facilities, 2000			Cost per pupil 2000-2001	Cost per prisoner FY 2001	Ratio, per prisoner to per pupil
	Number	Percent			Juvenile facilities	Adult facilities	Total			
Alabama	30,593	12.0%	15.7%	13,596	1,731	236	1,967	$ 5,885	$ 8,128	1.4
Alaska	3,342	8.9	22.5	4,520	357	37	394	9,216	36,730	4.0
Arizona	42,567	14.8	21.1	52,893	1,872	898	2,770	5,278	22,476	4.3
Arkansas	14,903	9.6	24.1	9,358	898	353	1,251	5,568	15,619	2.8
California	194,720	10.2	20.8	204,602	14,644	1,604	16,248	6,987	25,053	3.6
Colorado	29,530	12.2	20.6	43,373	2,013	159	2,172	6,567	25,408	3.9
Connecticut	12,509	7.4	16.4	19,671	894	452	1,346	10,127	26,856	2.7
Delaware	4,568	10.4	9.9	6,767	91	14	105	8,958	22,802	2.5
District of Columbia	3,265	10.2	30.4	338	46	39	85	12,046	26,670	2.2
Florida	94,312	12.0	15.4	121,143	6,320	1,455	7,775	6,170	20,190	3.3
Georgia	63,906	13.8	16.3	24,054	4,125	910	5,035	6,929	19,860	2.9
Hawaii	3,757	6.1	15.0	9,542	193	10	203	6,596	21,637	3.3
Idaho	7,193	8.2	16.9	15,567	597	72	669	5,725	16,319	2.9
Illinois	69,581	10.0	18.0	36,581	3,903	868	4,771	7,643	21,844	2.9
Indiana	35,469	9.8	14.4	34,024	2,895	571	3,466	7,630	21,841	2.9
Iowa	10,413	5.8	12.2	18,872	1,215	74	1,289	6,930	22,997	3.3
Kansas	13,302	8.1	15.2	12,426	1,159	111	1,270	6,925	21,381	3.1
Kentucky	26,345	11.6	21.7	7,829	1,531	186	1,717	6,079	17,818	2.9
Louisiana	33,820	11.7	21.2	35,055	2,396	632	3,028	6,037	12,951	2.1
Maine	4,295	6.2	13.9	8,580	389	4	393	8,232	44,379	5.4
Maryland	23,314	8.4	14.6	52,191	1,782	295	2,077	8,256	26,398	3.2
Massachusetts	21,968	6.6	13.4	14,460	2,250	195	2,445	9,509	37,718	4.0
Michigan	49,358	8.7	18.9	39,224	4,364	778	5,142	8,278	32,525	3.9
Minnesota	17,383	5.9	12.4	30,905	1,819	112	1,931	7,645	36,836	4.8
Mississippi	22,502	12.4	20.7	12,514	1,431	369	1,800	5,175	12,795	2.5
Missouri	32,898	10.2	17.4	36,935	2,434	372	2,806	6,657	12,867	1.9
Montana	4,398	8.0	11.0	—	365	69	434	6,726	21,898	3.3
Nebraska	7,522	7.0	12.6	14,577	1,405	49	1,454	7,223	25,321	3.5
Nevada	15,713	16.0	13.0	17,722	889	218	1,107	5,807	17,572	3.0
New Hampshire	4,951	7.3	12.3	7,812	417	27	444	7,286	25,949	3.6
New Jersey	29,378	7.2	13.8	60,443	2,189	110	2,299	11,248	27,347	2.4
New Mexico	13,649	12.1	18.9	10,994	553	312	865	6,313	28,035	4.4
New York	88,982	8.8	16.3	47,820	6,896	1,739	8,635	10,716	36,835	3.4
North Carolina	53,754	12.8	19.2	37,870	2,172	743	2,915	6,346	26,984	4.3
North Dakota	2,065	4.8	10.9	6,396	285	6	291	6,125	22,425	3.7
Ohio	52,892	8.3	16.3	47,954	3,954	606	4,560	7,571	26,295	3.5
Oklahoma	21,173	10.0	12.2	23,128	1,480	89	1,569	6,019	16,309	2.7
Oregon	19,893	10.4	22.3	30,109	1,497	207	1,704	7,528	36,060	4.8
Pennsylvania	47,958	7.1	18.4	104,140	6,219	440	6,659	8,210	31,900	3.9
Rhode Island	5,047	8.2	14.5	7,195	365	6	371	9,315	38,503	4.1
South Carolina	26,150	11.4	16.8	2,866	1,705	527	2,232	6,631	16,762	2.5
South Dakota	3,916	8.0	10.3	4,734	965	126	1,091	6,191	13,853	2.2
Tennessee	30,639	9.8	14.4	34,434	2,548	142	2,690	5,687	18,206	3.2
Texas	160,699	12.6	18.5	194,033	7,811	3,420	11,231	6,539	13,808	2.1
Utah	15,185	8.8	17.0	21,687	1,202	168	1,370	4,674	24,574	5.3
Vermont	2,157	5.9	11.8	1,401	120	18	138	9,153	25,178	2.8
Virginia	29,320	7.8	10.9	33,881	3,107	405	3,512	7,281	22,942	3.2
Washington	29,099	8.8	21.9	35,285	2,280	198	2,478	6,750	30,168	4.5
West Virginia	8,942	9.0	16.0	1,940	477	25	502	7,534	14,817	2.0
Wisconsin	20,476	6.4	11.9	101,245	1,837	618	2,455	8,243	28,622	3.5
Wyoming	2,413	7.6	11.2	6,704	392	56	448	7,835	28,845	3.7
United States	1,562,184	9.9	17.0	1,598,247	112,479	21,130	133,609	7,376	22,650	3.1

[1] Youth ages 16-19 not enrolled in school and not high school graduates

[2] Youths ages 16-19

[3] Data incomplete for the District of Columbia, Illinois, Kentucky, Nevada, New York, and South Carolina; no data available for Montana

Sources: U.S. Department of Commerce, Bureau of the Census, 2000 Census of Population and Housing, SF1 and SF3; U.S. Department of Labor, Bureau of Labor Statistics, "Employment status of the civilian noninstitutional population by sex, race, Hispanic or Latino ethnicity, marital status, and detailed age, 2004 annual averages," at <http://stats.bls.gov/gps/home.htm>; U.S. Department of Labor, Bureau of Labor Statistics, 2004 Annual Averages, Table 3, "Employment status of the civilian noninstitutional population by age, sex, and race," *Employment and Earnings*, January 2005; U.S. Department of Justice, Federal Bureau of Investigation, *Crime in the United States* 2004 (October 2005), Tables 41 and 69; U.S. Department of Education, National Center for Education Statistics, *Digest of Education Statistics: 2003* (November 2004), Table 168; and U.S. Department of Justice, Bureau of Justice Statistics, *State Prison Expenditures, 2001* (June 2004), Table 2. Calculations by Children's Defense Fund.

Table B6-2

Teen Birth Rates,[1] 1990–2003

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Alabama	71.0	73.6	72.0	69.2	70.6	68.5	67.1	64.5	63.9	60.9	60.7	56.5	54.5	52.4
Alaska	65.3	66.0	65.2	59.7	59.5	54.5	50.8	49.3	47.5	47.7	49.0	41.0	39.5	38.6
Arizona	75.5	79.7	80.2	78.1	76.8	73.5	71.5	68.7	68.8	68.0	67.9	64.3	61.2	61.1
Arkansas	80.1	79.5	74.8	72.8	74.8	71.9	73.5	70.8	68.7	66.1	66.2	62.3	59.9	59.0
California	70.6	73.8	72.8	71.8	70.2	66.8	61.0	55.7	52.0	49.1	47.0	44.1	41.1	40.1
Colorado	54.5	58.3	58.4	55.8	55.2	52.3	50.7	49.3	50.2	50.0	51.3	47.3	47.0	43.9
Connecticut	38.8	40.1	39.0	38.8	39.7	38.6	36.6	35.1	34.9	32.7	31.1	28.2	25.8	24.8
Delaware	54.5	60.4	58.7	58.0	57.8	54.6	53.8	52.3	50.6	50.7	48.0	47.4	46.3	44.9
District of Columbia	93.1	109.6	106.7	112.8	97.0	85.2	79.2	67.1	62.0	56.0	53.2	63.6	69.1	60.3
Florida	69.1	67.9	65.2	63.7	63.0	60.2	57.2	55.8	53.9	51.7	51.1	47.7	44.5	42.5
Georgia	75.5	76.0	74.2	72.0	70.6	69.8	66.8	65.6	64.0	63.5	62.8	60.0	55.7	53.5
Hawaii	61.2	59.2	54.2	53.7	54.4	48.8	48.9	44.4	47.0	45.0	46.1	42.1	38.2	37.3
Idaho	50.6	53.9	51.5	50.3	46.1	48.7	46.9	43.0	44.6	43.5	42.9	41.0	39.1	39.3
Illinois	62.9	64.5	63.0	62.0	61.5	58.4	55.3	52.7	51.8	49.7	48.0	45.8	42.2	40.4
Indiana	58.6	60.4	58.5	57.9	57.0	56.6	55.1	52.8	52.2	50.5	49.1	46.8	44.6	43.5
Iowa	40.5	42.5	40.5	40.7	39.3	38.3	37.4	35.3	34.9	35.4	34.2	33.5	32.5	31.9
Kansas	56.1	55.4	55.6	55.5	53.3	52.0	49.4	48.4	47.5	48.1	46.1	44.3	43.0	41.2
Kentucky	67.6	68.8	64.8	63.7	64.2	62.3	61.2	59.0	57.2	56.4	55.1	51.9	51.0	49.6
Louisiana	74.2	76.0	76.1	75.9	74.5	69.9	66.8	65.9	65.6	63.0	62.1	58.6	58.1	56.0
Maine	43.0	43.5	40.0	37.1	35.6	33.9	31.7	32.3	30.7	30.2	29.2	27.3	25.4	24.9
Maryland	53.2	54.1	50.6	49.7	49.3	47.2	45.7	43.1	42.6	42.2	41.3	37.5	35.4	33.3
Massachusetts	35.1	37.5	37.5	37.2	36.4	33.3	31.1	30.4	29.5	27.4	25.9	24.9	23.3	23.0
Michigan	59.0	58.9	56.6	53.1	52.0	49.1	46.4	44.3	43.5	41.4	40.2	38.3	34.8	34.4
Minnesota	36.3	37.3	35.9	35.0	34.4	32.5	32.3	32.1	30.9	30.3	30.1	28.4	27.5	26.6
Mississippi	81.0	85.3	83.6	82.2	81.7	79.2	74.0	71.8	71.4	70.9	70.1	66.8	64.7	62.5
Missouri	62.8	64.4	63.1	59.4	58.6	55.1	53.2	51.1	51.0	49.4	48.7	46.4	44.1	43.2
Montana	48.4	46.8	46.0	46.1	41.6	42.4	39.3	38.2	38.0	36.0	36.7	36.0	36.4	35.0
Nebraska	42.3	42.4	41.1	40.5	42.9	37.8	38.9	37.4	37.5	37.5	37.7	36.8	37.0	36.0
Nevada	73.3	74.5	70.6	73.2	73.4	73.4	69.5	67.4	65.6	63.9	63.0	56.4	53.9	53.0
New Hampshire	33.0	33.1	31.3	30.5	29.9	30.3	28.2	28.2	26.8	23.8	23.3	21.1	20.0	18.2
New Jersey	40.5	41.3	38.9	37.9	39.0	37.7	35.2	34.8	34.7	32.8	31.8	28.9	26.8	25.5
New Mexico	78.2	79.5	79.7	80.6	77.0	74.0	70.5	67.8	68.7	66.8	65.6	63.2	62.4	62.7
New York	43.6	45.5	44.5	44.6	44.3	42.2	39.9	36.7	36.4	34.7	33.2	32.2	29.5	28.2
North Carolina	67.6	70.0	69.2	66.1	65.3	63.0	62.3	59.9	59.8	58.0	58.6	55.0	52.2	49.0
North Dakota	35.4	35.5	36.9	36.3	33.9	32.9	31.6	29.2	29.7	27.0	27.3	27.2	27.2	26.8
Ohio	57.9	60.5	58.0	56.7	54.9	53.4	50.4	49.8	48.5	46.5	46.0	42.8	39.5	39.4
Oklahoma	66.8	72.1	69.8	68.3	65.6	63.7	63.1	63.7	61.4	60.1	59.7	58.3	58.0	55.9
Oregon	54.6	54.8	53.0	50.8	50.2	50.1	50.5	46.2	47.1	46.1	42.8	40.3	36.8	34.4
Pennsylvania	44.9	46.7	44.8	43.7	42.9	40.9	38.4	36.1	35.9	35.1	34.0	33.0	31.6	31.2
Rhode Island	43.9	44.7	46.2	47.6	45.0	39.8	38.9	38.3	36.5	33.5	33.6	36.0	35.6	31.3
South Carolina	71.3	72.5	69.7	64.7	64.7	62.8	60.2	58.8	58.3	58.5	58.0	56.5	53.0	51.5
South Dakota	46.8	47.6	48.3	44.4	43.0	40.9	40.1	40.6	39.8	38.5	38.1	38.2	38.0	34.7
Tennessee	72.3	74.8	70.9	69.2	69.7	66.6	64.5	62.4	62.5	60.8	59.5	57.1	54.3	53.5
Texas	75.3	78.4	78.2	77.7	77.2	75.6	73.1	71.2	70.5	69.6	68.9	66.0	64.4	62.9
Utah	48.5	48.0	45.7	43.4	41.4	40.9	41.2	41.0	39.6	38.8	38.3	38.3	36.8	34.6
Vermont	34.0	39.2	35.6	34.8	32.4	28.1	29.5	26.3	23.8	25.0	23.4	23.9	24.2	18.9
Virginia	52.9	53.4	51.7	49.6	50.5	48.4	45.4	44.0	43.4	42.6	40.9	39.8	37.6	36.1
Washington	53.1	53.7	51.0	50.5	48.6	48.0	45.6	43.0	42.4	41.0	39.2	35.6	33.0	31.5
West Virginia	57.3	58.0	56.3	55.6	54.3	52.7	50.5	49.1	49.6	48.5	46.5	45.6	45.5	44.8
Wisconsin	42.6	43.7	42.0	41.0	38.8	37.9	36.9	35.8	35.2	36.3	35.2	34.1	32.3	31.3
Wyoming	56.3	54.3	49.8	49.9	48.7	47.9	44.7	43.9	48.9	41.4	41.7	39.0	39.9	40.8
United States	59.9	61.8	60.3	59.0	58.2	56.0	53.5	51.3	50.3	48.8	47.7	45.3	43.0	41.6

[1]Number of births to teens ages 15-19 per 1,000 females ages 15-19

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, *National Vital Statistics Report*, Vol. 52, No. 12 (August 4, 2003), "Revised Birth and Fertility Rates for the 1990s and New Rates for Hispanic Populations, 2000 and 2001: United States," Table 10; U.S. Department of Health and Human Services, National Center for Health Statistics, *National Vital Statistics Report*, Vol. 52, No. 10 (December 17, 2003), "Births: Final Data for 2002," Table 10; and U.S. Department of Health and Human Services, National Center for Health Statistics, *National Vital Statistics Report*, Vol. 54, No. 2 (September 8, 2005), "Births: Final Data for 2003," Table 10.

Table B6-3

Firearm Deaths of Children and Teens Ages 0–19, by Manner, 2000–2002

	Total*			Homicide*			Suicide			Accident			Undetermined Intent		
	2000	2001	2002	2000	2001	2002	2000	2001	2002	2000	2001	2002	2000	2001	2002
Alabama	52	64	68	31	34	36	17	20	22	3	8	10	1	2	0
Alaska	24	19	18	2	6	7	20	11	10	2	1	1	0	1	0
Arizona	81	81	101	46	49	58	29	25	30	2	6	8	4	1	5
Arkansas	43	30	39	21	13	18	14	12	12	8	5	6	0	0	3
California	402	379	406	319	316	337	66	47	54	16	15	13	1	1	2
Colorado	38	53	53	17	23	20	19	26	30	2	3	1	0	1	2
Connecticut	14	16	15	8	12	10	6	4	4	0	0	1	0	0	0
Delaware	2	4	10	1	3	4	1	1	3	0	0	3	0	0	0
District of Columbia	28	32	36	28	29	34	0	1	1	0	2	1	0	0	0
Florida	100	111	120	58	65	81	35	38	33	7	5	5	0	3	1
Georgia	106	110	104	67	69	65	28	34	28	8	7	9	3	0	2
Hawaii	1	5	1	1	2	1	0	3	0	0	0	0	0	0	0
Idaho	13	25	19	0	3	3	11	17	12	2	5	4	0	0	0
Illinois	186	175	146	157	139	127	23	28	15	5	6	3	1	2	1
Indiana	82	59	69	43	30	31	31	23	28	5	5	9	3	1	1
Iowa	21	27	17	1	3	6	18	22	9	2	2	2	0	0	0
Kansas	31	36	17	16	15	6	13	18	9	2	3	2	0	0	0
Kentucky	35	34	33	11	12	12	17	15	13	7	7	6	0	0	2
Louisiana	94	95	100	63	62	70	22	27	19	9	6	10	0	0	1
Maine	8	5	3	1	1	0	7	4	3	0	0	0	0	0	0
Maryland	79	81	92	59	66	77	18	12	14	1	2	1	1	1	0
Massachusetts	11	24	25	9	18	22	2	5	1	0	1	2	0	0	0
Michigan	100	105	100	66	61	60	26	39	36	5	4	4	3	1	0
Minnesota	36	37	29	11	12	9	23	24	18	2	0	1	0	1	1
Mississippi	67	34	58	31	14	28	23	13	21	13	5	7	0	2	2
Missouri	81	92	72	47	55	45	27	29	25	7	4	2	0	4	0
Montana	18	13	15	3	3	2	11	9	10	3	1	1	1	0	2
Nebraska	23	18	11	12	3	5	10	14	6	0	1	0	1	0	0
Nevada	31	28	25	19	20	19	12	7	6	0	0	0	0	1	0
New Hampshire	7	8	4	2	1	1	5	7	3	0	0	0	0	0	0
New Jersey	39	25	32	23	19	24	13	5	5	2	1	3	1	0	0
New Mexico	55	27	32	31	14	15	19	11	16	5	2	1	0	0	0
New York	123	135	91	90	102	74	28	27	14	3	6	3	2	0	0
North Carolina	95	86	71	60	48	47	29	31	21	5	7	1	1	0	2
North Dakota	7	2	5	1	1	0	5	1	4	0	0	1	1	0	0
Ohio	75	85	83	40	50	52	30	26	22	4	6	6	1	3	3
Oklahoma	33	41	38	10	18	13	15	16	22	7	7	3	1	0	0
Oregon	27	17	36	3	7	14	22	9	17	2	1	2	0	0	3
Pennsylvania	110	103	113	69	63	73	37	33	35	4	6	4	0	1	1
Rhode Island	10	6	10	8	6	8	2	0	2	0	0	0	0	0	0
South Carolina	41	42	40	23	20	26	13	15	9	5	6	4	0	1	1
South Dakota	8	8	7	0	1	0	4	7	4	4	0	2	0	0	1
Tennessee	87	65	79	48	34	47	33	24	22	6	7	8	0	0	2
Texas	252	241	220	117	140	140	108	84	72	21	15	7	6	2	1
Utah	16	27	17	2	7	3	14	20	14	0	0	0	0	0	0
Vermont	4	3	2	0	2	1	4	1	1	0	0	0	0	0	0
Virginia	72	77	72	41	50	50	26	23	17	3	3	4	2	1	1
Washington	49	38	40	23	17	17	22	20	21	2	1	1	2	0	1
West Virginia	24	13	20	9	5	7	13	5	10	2	3	3	0	0	0
Wisconsin	67	61	49	28	28	24	34	26	23	5	7	2	0	0	0
Wyoming	4	9	4	0	0	1	2	9	2	2	0	0	0	0	1
United States	3,012	2,911	2,867	1,776	1,771	1,830	1,007	928	828	193	182	167	36	30	42

*Total firearm deaths and homicide firearm deaths exclude firearm deaths by legal (police or corrections) intervention and deaths by air rifles.

Sources: U.S. Department of Health and Human Services, National Center for Health Statistics, Table III: Deaths from 358 selected causes [2000]; and U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, WISQARS, at <http://www.cdc.gov/ncipc/wisqars/> [2001, 2002]. Calculations by Children's Defense Fund.

CDF Regional, State and Local Offices

California (Los Angeles)
3655 South Grand Avenue
Suite 270
Los Angeles, CA 90007
Tel: (213) 749-8787
Fax: (213) 749-4119
www.cdfca.org

California (Oakland)
2201 Broadway
Suite 705
Oakland, CA 94610
Tel: (510) 663-3224
Fax: (510) 663-1783
www.cdfca.org

Minnesota
200 University Avenue West
Suite 210
St. Paul, MN 55103
Tel: (651) 227-6121
Fax: (651) 227-2553
www.cdf-mn.org

New York (New York City)
420 Lexington Avenue
Suite 655
New York, NY 10170
Tel: (212) 697-2323
Fax: (212) 697-0566
www.cdfny.org

New York (Albany)
119 Washington Avenue
3rd Floor
Albany, NY 12210
Tel: (518) 449-2830
Fax: (518) 449-2846
www.cdfny.org

Ohio (Columbus)
52 East Lynn Street
Suite 400
Columbus, OH 43215
Tel: (614) 221-2244
Fax: (614) 221-2247
www.cdfohio.org

Ohio (Cleveland)
Tel: (216) 952-7846

South Carolina
117 Cheraw Street
Bennettsville, SC 29512
Tel: (843) 479-5310
Fax : (843) 479-0605

Southern Regional Office
(Mississippi, Alabama, Arkansas,
Florida, Georgia, Louisiana)
P. O. Box 11437
Jackson, MS 39283
Tel: (601) 321-1966
Fax: (601) 321-8736
www.cdf-sro.org

Tennessee
CDF Haley Farm Spiritual Renewal and
Leadership Development Center
P.O. Box 840
Clinton, TN 37717
Tel: (865) 457-6466
Fax: (865) 457-6464

Texas (Austin)
316 West 12th Street
Suite 105
Austin, TX 78701
Tel: (512) 480-0990
Fax: (512) 480-0995
www.cdftexas.org

Texas (Houston)
4500 Bissonnet
Suite 260
Bellaire, TX 77401
Tel: (713) 664-4080
Fax: (713) 664-1975
www.cdftexas.org

Texas (Rio Grande Valley)
944 A West Nolana Loop
Pharr, TX 78577
Tel: (956) 782-4000
Fax: (956) 283-7975
www.cdftexas.org

ISBN: 1-881985-34-2
ISSN: 1084-3191

Children's Defense Fund

25 E Street, NW
Washington, DC 20001
(202) 628-8787
www.childrensdefense.org