

**Results and Indicators for Children:
An Analysis to Inform Discussions About Promise Neighborhoods**

Produced by



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Introduction

President Obama has proposed creation of up to 20 “Promise Neighborhoods” in communities experiencing poverty, crime, and low student achievement. Promise Neighborhoods would engage children and parents within a defined geographic area in a multi-faceted strategy to meet several goals: good physical and mental health for every child, enrollment in and graduation from college by every child, and good jobs for parents so that families are economically self-sufficient.

Measuring the effectiveness of Promise Neighborhoods will be critical. Are children healthier, and are they prepared for college? Are parents better able to nurture and support their children? Are communities stronger and more supportive of families? The extent to which these questions can be answered well will tell us much about the potential of ambitious, community-based efforts to change the odds for poor children in disadvantaged communities. So how well can we answer these questions?

The news is mixed. On the one hand, significant progress has been made at both the national and state levels on using information to assess child well-being. On the other hand, when it comes to smaller geographic levels, our capability to track important well-being indicators is weaker. While some information is routinely available at the city level, and several cities have built rich, albeit unique data resources for their own jurisdictions, there are few indicators comparable *across* cities. The Promise Neighborhoods initiative underscores the importance of taking this work to a new stage. This report explores the feasibility of producing a set of core indicators for Promise Neighborhoods that assess child well-being at the city or neighborhood level. The information in this report can inform efforts by the policy community to identify appropriate city/neighborhood-level data that may figure in the design and evaluation of the Promise Neighborhoods initiative.

The President has identified as a model for this initiative the Harlem Children’s Zone (HCZ) in New York City. HCZ provides a system of supports and services within a 97-block neighborhood to combat the negative effects of concentrated poverty and high crime. The results of these efforts are impressive. A “pipeline” of coordinated services and supports has worked to boost children’s academic achievement in elementary and middle school, prepare youth for college, and assist families in buying homes and getting more involved in school activities. Indicators (population-based measures of well-being) provided the tangible evidence of progress toward these goals.

HCZ has intentionally adopted a model that focuses on important results. These core goals have been variously described, but can be summarized as follows:

- Children Are Healthy and Prepared for School Entry,
- Children Are Healthy and Succeed in School,
- Youth Graduate from High School and College, and
- Families and Neighborhoods Support the Healthy Development, Academic Success, and Well-Being of Their Children.

Having a core set of results (goals) for children and families rallies the broadest possible cross-section of community members around goals that no single organization can achieve by itself. Results explicitly promote common purpose, support collaboration, and provide a guide for decision-making. When linked with a set of indicators that objectively measure progress toward these shared goals, a results-based system provides a powerful strategy for community change. Like HCZ, Promise Neighborhoods could be well served by indicator data currently available at the city level, as well as city-level data that may become available through new efforts. Of course, data at the census tract/neighborhood level would be even more useful for this initiative, where sites are likely to be less-than-whole-city geographies.

There are special challenges, however, in linking a comprehensive, system-wide approach, exemplified by the Promise Neighborhoods idea, to progress on broad social goals. The first is that attributing cause-and-effect under these circumstances is complex, since multiple factors-- many outside of the control of any initiative—influence condition. It is arguable, for example, that a goal as broad as reducing poverty is beyond the scope of what Promise Neighborhoods can accomplish. Nevertheless, there are a number of factors (for example, poor nutrition and low-quality child care) which mediate between poverty and poor outcomes. These *are* areas where it is reasonable to assume this work could have an impact.

A second major challenge, though, is the dearth of reliable indicator data at a community/neighborhood, or even city level. It is only in the past two decades, with the lead of the Kids Count project and similar efforts, that useful *state*-level indicator data have been regularly available. Data systems to regularly report on well-being at a city (let alone neighborhood) level are in their infancy. Efforts such as the National Neighborhood Indicators Project,¹⁸¹ and Making Connections⁶ have aimed to develop the capacity of *particular* communities to assemble data that paint a reasonably comprehensive picture of conditions for their residents, but there are very few publicly-sponsored, ongoing data collection systems reporting widely at a city level.

Table 1 lists those national surveys that report data for all cities, or for some large cities. All of these sources also provide information at the state level; others, as indicated in the table, provide *only* state-level data. More data sources provide information at the state level, and it might be possible to expand their sampling frames to provide city-level data for selected communities. For example, the National Survey of Children's Health (which currently provides state-level data) represents a promising template for collection of new city-level data. At the least, these existing surveys provide items that could be readily imported into a city or neighborhood data collection effort.

In sum, the landscape for indicators of child and family well-being, available broadly and uniformly for potential Promise Neighborhood sites, is sparse. Such sites of course could supplement these data with indicators developed locally. Most communities have access, at least in theory, to a wealth of administrative data from schools, municipal services, and health and social service agencies. Many communities have undertaken special-purpose surveys of residents or service-providers. However, securing the appropriate data-sharing agreements, organizing and managing the data, and undertaking the collection of new data are all tasks requiring significant resources. And, because of the lack of standard measures and definitions

(e.g., for what constitutes child abuse or neglect, what crimes are reported, or how to assess readiness for school), what supplemental indicators communities are able to assemble could not easily be used for cross-site comparisons.

Table 1: National Surveys Providing State- or City-level Data or Both			
National Surveys	State-level Data	City-level Data	Number of Cities
Demographic			
American Housing Survey	x	x	13 large cities
American Community Survey	x	x	All larger cities
Decennial Census	x	x	All cities
National Vital Statistics System	x	x	All cities
Census Small Area Income and Poverty Estimates	x		
Current Population Survey	x		
Health and Safety			
Youth Risk Behavior Surveillance System	x	x	22 large cities
National Survey of Children's Health	x		
Children with Special Health Care Needs survey	x		
Education			
National Assessment of Educational Progress	x	x	11 large urban school districts
Schools and Staffing Survey	x		
Common Core of Data	x		
Crime			
Uniform Crime Reports	x	x	All cities
National Crime Victimization Survey	x	x	12 large cities
Child Welfare			
Adoption and Foster Care Analysis Reporting System	x		

Our Criteria for Selection of Suggested Indicators

In the following pages, we suggest an initial set of 21 results and accompanying indicators. At the outset, we want to emphasize that for some of the results there simply are not good existing indicators. However, in making our selection we applied several criteria. *First*, we sought indicators that were strongly related to the over-arching goals of the Promise Neighborhoods initiative:

- Children are Healthy and Prepared for School Entry,
- Children and Youth are Healthy and Succeed in School,
- Youth Graduate From High School and College, and
- Families and Neighborhoods Support the Healthy Development, Academic Success, and Well-Being of Their Children.

Second, we sought indicators where data at a city level are either currently available (sometimes for only some, not all, cities), or could foreseeably be gathered, using as a template items from existing surveys. *Third*, we prioritized indicators where measures permit (or would permit) comparable data *across* communities. This last criterion may or may not prove to be of prime importance to Promise Neighborhoods; however, reviewing the whole range of measures used in various localities was a task well beyond the scope of this effort. Instead, we point out those areas where local, generally non-comparable, data likely exist.

For each indicator, we briefly summarize research on its importance for children and families, and we provide information about potential sources. As is clear from the discussion above, in many cases it is not currently possible to assess a number of important indicators at the neighborhood, or even city, level. Thus, in many cases, the source listed (for example, the National Survey of Children's Health) for a recommended indicator is one that provides a framework for data collection. Actual availability of data for Promise Neighborhood sites would depend either on a significant expansion of the original survey's sampling frame, or on items' inclusion in a locally administered survey.

We have grouped the indicators under HCZ's four core goals referenced above. For each indicator we have also highlighted some key features:

- our judgment (according to the research literature) of the strength of the indicator's relationship to one or more of the core results;
- our judgment as to the face validity (i.e., "communication power") of the indicator;
- an assessment of the *current* availability of the data at a *neighborhood* level;
- our judgment of the likely burden for Promise Neighborhoods sites to collect the data;
- suggestions for indicators that could monitor progress in the interim preceding any notable change in the primary indicator.

Information about the 21 suggested results is summarized in Table 2. We hope that the information provided here will contribute to a rich discussion of both what can be accomplished with available data, and what could be accomplished if additional data were available.

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Table 2: Summary of Results, Data Sources, and Suggested Indicators

OVERARCHING RESULT: CHILDREN ARE HEALTHY AND PREPARED FOR SCHOOL ENTRY			
Results	Source(s)	Geographic Availability	Suggested Indicators
<p><i>1. Births are healthy and well-timed.</i> Significant because health at birth is correlated with infant mortality and later health, and mother’s age and marital status are signals of financial and social disadvantage for the child.</p>	National Vital Statistics System (city, state, nation); comparable across cities and states. Reports readily available online.	City level	Percent of births not low birth weight, not very preterm, and the mother is married and at least 20 years old.
<p><i>2. Children have no untreated health conditions or avoidable developmental delays at time of school entry.</i> Significant because children with these concerns do less well in school. Also, with untreated conditions there is risk of medical complications.</p>	National Survey of Children with Special Health Care Needs (state, national); National Survey of Children’s Health (state, nation) (city level data collection is a possibility); both comparable across states. Reports and tables are readily available online for both. The NSCSHCN Disability Screener could be combined with a question on whether the child has been treated for any conditions.	Un available at the city level	Percent of children with selected preventable chronic health conditions or avoidable developmental delays at school entry.
<p><i>3. Children live through infancy and adolescence.</i> Significant because death affects not only the child, but parents and family.</p>	National Vital Statistics System (city, state, nation). Comparable across all these.	City level	Rates of infant and child mortality.
<p><i>4. Children are ready for school learning (socially, cognitively, emotionally) at the time of school entry.</i> Significant because children behind at school entry tend not to catch up with their peers in school.</p>	Schools and Staffing Survey (state, nation); National Survey of Children's Health (state, nation) (City-level data collection is a possibility); both comparable across states. Both have tables readily available online.	Un available at the city level	Percent of young children read to frequently by family members. OR Percent of young children deemed “ready” according to local measures of school readiness.

Table 2: Summary of Results, Data Sources, and Suggested Indicators, Continued

OVERARCHING RESULT: CHILDREN AND YOUTH ARE HEALTHY AND SUCCEED IN SCHOOL			
Results	Source(s)	Geographic Availability	Suggested Indicators
<p>5. <i>Children demonstrate achievement of grade-level proficiency in major subjects, including reading and arithmetic, at third grade and subsequently.</i> Significant because competence in these subjects is strongly related to overall school success.</p>	<p>National Assessment of Education Progress (11 school districts, state, nation); comparable across 11 cities and across states; reports on fourth- and eighth-grade achievement. Reports readily available online.</p>	<p>Available for some cities</p>	<p>Percent of students achieving proficiency according to NAEP Assessments at fourth and eighth grades. OR Percent of students proficient in reading and math at third or fourth grade, and eighth grade, according to local assessments.</p>
<p>6. <i>Children are in schools where income- and race-based reading gaps are eliminated by third grade.</i> Significant because disparities according to income and race persist if unaddressed, foreclosing opportunities for many children.</p>	<p>National Assessment of Education Progress (11 school districts, state, national); comparable across 11 school districts and all states; reports on fourth- and eighth-grade achievement. Reports and tables readily available online.</p>	<p>Available for some cities</p>	<p>Percent of schools making progress in eliminating gaps associated with income and race in NAEP reading proficiency at fourth grade. OR Percent of schools making progress in eliminating gaps associated with income and race in local assessments of reading proficiency at third grade.</p>
<p>7. <i>Children are not chronically absent from school.</i> Significant because children need to be in school to gain the benefits associated with it, and chronic absence may lead to dropping out.</p>	<p>National Assessment of Education Progress (“3 or more days in the past month”) (11 school districts, state, nation); comparable across 11 cities and across states. Reports readily available online. Other sources (e.g., NCES) use “10 or more days in the year.”</p>	<p>Available for some cities</p>	<p>Percent of children missing 3 or more days of school in the past month. OR Percent of children missing 10 or more days in the school year.</p>

Table 2: Summary of Results, Data Sources, and Suggested Indicators, Continued

OVERARCHING RESULTS: CHILDREN AND YOUTH ARE HEALTHY AND SUCCEED IN SCHOOL			
Results	Source(s)	Geographic Availability	Suggested Indicators
<p>8. <i>Children and youth are physically, mentally, and emotionally healthy.</i> Significant because well-being is multi-dimensional.</p>	<p>Youth Risk Behavior Surveillance System (comparable across 22 cities and 39 states, nation). Reports readily available online.</p>	<p>Available for some cities</p>	<p>Percent of students in grades 9-12 who:</p> <ul style="list-style-type: none"> • “Felt sad and hopeless for more than two weeks” in the past 12 months • Seriously considered suicide in the past 12 months • Smoked cigarettes in the past 30 days • Drank alcohol in the past 30 days • Are obese • Ate fruits and vegetables less than 5 times a day in the past 7 days • Drink soda at least once a day in the past 7 days
<p>9. <i>Youth are active participants in civic life.</i> Significant because youth involvement builds social skills and is associated with civic involvement in adulthood.</p>	<p>National Survey of Children's Health (comparable across states, nation) (City-level data collection is a possibility); Current Population Survey (nation). Reports and tables readily available online.</p>	<p>Unavailable at the city level</p>	<p>Percent of youth volunteering in the community.</p>
<p>10. <i>Children and youth avoid violent mortality.</i> Significant because collectively violence is a leading cause of death for children and youth. Also, this is an indirect measure of community safety.</p>	<p>National Vital Statistics System. Rate of violent death (suicides, homicides, and unintentional injuries) per population (city, state, nation).</p>	<p>City level</p>	<p>Rate of child and youth violent death.</p>

Table 2: Summary of Results, Data Sources, and Suggested Indicators, Continued

OVERARCHING RESULT: YOUTH GRADUATE FROM HIGH SCHOOL AND COLLEGE			
Results	Source(s)	Geographic Availability	Suggested Indicators
11. <i>Youth graduate from high school.</i> Significant because youth who graduate from high school with excellent academic and social-emotional skills are more likely to experience later success.	The National Center for Education Statistics' Common Core of Data (school districts, state, nation); American Community Survey (comparable across census tracts, cities, states, nation). Both have tables readily available online.	Soon to be available at the Census tract level	Percent of 9th-grade class who earned high school diplomas.
12. <i>Youth graduate from college (or achieve a rigorous post-secondary credential).</i> Significant because a college education is increasingly a threshold criterion for employment at a living wage or better.	American Community Survey (comparable across census tracts, cities, and states, nation).	Soon to be available at the Census tract level	Percent of youth aged 25-29 who have obtained a 2-year or 4-year post-secondary degree.
13. <i>Youth are prepared for or engaged in productive careers.</i> Significant because “disconnected youth”—i.e., those not attending school and without employment—are likely to struggle financially.	Decennial Census (census tract, city, state, nation); American Community Survey (census tract, city, state, nation); both comparable across census tracts, cities, and states. Tables are readily available online.	Soon to be available at the Census tract level	Percent of youth ages 25-29 who are enrolled in school or employed.
14. <i>Youth are prepared for parenting before they become parents.</i> Significant because children of prepared parents tend to have more positive social, psychological, health, and educational outcomes, and their parents face fewer challenges.	Decennial Census (census tract, city, state, nation); American Community Survey (census tract, city, state, nation); both comparable across census tracts, cities, and states. Tables are readily available online.	Soon to be available at the Census tract level	Percent of parents who are age 20 or older, have at least a high school education, are married, and one or both parents are employed.

Table 2: Summary of Results, Data Sources, and Suggested Indicators, Continued

OVERARCHING RESULT: FAMILIES AND NEIGHBORHOODS SUPPORT THE HEALTHY DEVELOPMENT, ACADEMIC SUCCESS, AND WELL-BEING OF THEIR CHILDREN			
Results	Source(s)	Geographic Availability	Suggested Indicators
<p>15. <i>Children and youth are free of abuse and neglect.</i> Significant because abuse in childhood causes immediate harm and is linked to many emotional and behavioral problems in childhood, adolescence, and adulthood.</p>	<p>The Adoption and Foster Care Analysis Reporting System (state, nation); National Child Abuse and Neglect Data System (state, nation).</p>	<p>Unavailable at the city level</p>	<p>Rate of child abuse and neglect (substantiated victims).</p>
<p>16. <i>Fewer children and youth live apart from their families.</i> Significant because children living apart from their parents are at risk for a number of behavioral and emotional problems.</p>	<p>American Community Survey (some cities, some states, nation); Adoption and Foster Care Analysis Reporting System (nation). Both have tables readily available online. The AFCARS data provide more detailed information than the American Community Survey but are inconsistently reported across states.</p>	<p>Unavailable at the city level</p>	<p>Percent of children in foster care, or otherwise living apart from their biological/adoptive parents.</p>
<p>17. <i>Families are connected to supportive networks and needed services.</i> Significant because supportive services and communities help meet essential family needs.</p>	<p>Decennial Census (comparable across census tracts, cities, and states, nation); American Community Survey (comparable across census tracts, cities, and states, nation); National Survey of Children's Health (comparable across states, nation); Survey of Income and Program Participation (nation). All have tables readily available online.</p>	<p>Soon to be available at the Census tract level</p>	<p>Percent of children living neighborhoods that provide social support.</p> <p>Percent of children participating in organized out-of-school activities.</p> <p>Percent of low-income families receiving food stamps.</p>
<p>18. <i>Families are connected to education, training, and income supplements aimed at living above the poverty level.</i> Significant because poverty (especially deep, persistent, and early poverty) affects children negatively at all stages of life.</p>	<p>American Housing Survey (comparable across cities, state, nation); American Community Survey (comparable across census tracts and cities, state, nation); Census Small Area Income and Poverty Estimates (state, nation). All of these are comparable across states and have tables available online.</p>	<p>Soon to be available at the Census tract level</p>	<p>Percent of families above the federal poverty threshold.</p>

Table 2: Summary of Results, Data Sources, and Suggested Indicators, Continued

OVERARCHING RESULT: FAMILIES AND NEIGHBORHOODS SUPPORT THE HEALTHY DEVELOPMENT, ACADEMIC SUCCESS, AND WELL-BEING OF THEIR CHILDREN

Results	Source(s)	Geographic Availability	Suggested Indicators
19. <i>Children live in families that provide structure, nurturance and high expectations.</i> Significant because these characteristics support positive child development.	National Survey of Children's Health (comparable across states, nation) (city-level data collection is a possibility); The NSCH has tables readily available online.	Unavailable at the city level	Percent of families who eat meals together, who have rules regarding television watching, where parents read to the child, and where there is good parent-child communication.
20. <i>Neighborhoods are safe and free of violence or crime.</i> Significant because crime contributes to psychological stress, social isolation, and reduced physical activity, as well as causing bodily harm and loss of property.	Uniform Crime Reports (agency, city, state, national); National Crime Victimization Survey (12 large cities, state, nation). Reports readily available online. A drawback is that cities and states may define crimes in different ways, and reporting rates vary by locale.	Available for some cities	Rates of violent and property crimes.
21. <i>Families live in safe and decent housing.</i> Significant because safe and decent housing provides children a healthy and stable place to grow and develop.	American Housing Survey (city, state, nation); American Community Survey (census tract, city, state, nation); National Survey of Children's Health (state, nation). Tables readily available online.	City level	Percent of families with children living in unsafe, unstable, or overcrowded housing.

RESULT

1. Births are healthy and well-timed.

SIGNIFICANCE

Birth outcomes are important indicators of a healthy and well-timed pregnancy. Low birth weight and prematurity are closely associated with the risk of infant mortality and later child health problems. Indeed, factors associated with low birth weight and short gestation are the second leading cause of infant mortality in the United States after birth defects, and the infant mortality rate for low birth weight infants is over 20 times that of normal-weight infants.^{111,118}

Infants with a low birth weight (less than 2,500 grams, or about 5.5 pounds) are at elevated risk for developing debilitating medical conditions, such as cerebral palsy.⁷⁵ Studies also find that low birth weight is negatively associated with cognitive development, perhaps extending into and beyond adolescence.^{14,75}

Another important indicator of healthy and well-timed births is gestational age. Births at less than 37 weeks are preterm; births at less than 32 weeks of pregnancy are considered very preterm.¹¹⁵ Research finds that children born preterm have greater difficulty with reading, spelling, and math than their peers who were born at term.¹⁷ In addition, children born prematurely tend to have language difficulties related to grammar and abstraction.⁹ Preterm children also tend to be more inattentive, aggressive, hyperactive, and less able to handle leadership roles than their full-term peers.¹⁵

Other serious health conditions associated with adverse birth outcomes include mental retardation, respiratory distress syndrome, bronchopulmonary dysplasia, retinopathy of prematurity, and deafness. Any of these can impair a child's ability to learn and may have lasting effects into adulthood.

A mother's characteristics also play a role in whether is birth is healthy and well-timed. These include her age at the time of her first birth, her marital status, and whether her pregnancy was intended. Many teen mothers are at a disadvantage because they are unprepared for the financial responsibilities and the emotional and psychological challenges of early parenting.⁴² In comparison with older mothers, teen mothers are more likely to be high school dropouts, limiting the financial support they can provide for their children and increasing the likelihood that they

Suggested indicator: *Percent of births that are not low birth weight, not very pre-term, and not born to a teen or unmarried mother.*

Strength of connection with PN Goals: HIGH with healthy development, school success, and overall well-being.

Face validity/Communication power: HIGH.

Current availability of data at neighborhood level: NOT routinely available.

Likely comparability of data across PNs: HIGH, if able to obtain official birth statistics.

Likely burden of collection for PNs: HIGH, requiring cooperation of local health officials

Suggested interim-progress indicators: Focus could be on one or more of the four risk factors (low birthweight, pre-term, teen birth, unmarried mother).

will rely on public assistance. Children born to teen mothers generally have less stimulating home environments and poorer academic and behavioral outcomes than do children born to older mothers.^{124,107} Teen mothers are also less likely to be married at the time of their child's birth, and to be single mothers later in adulthood, so they often face the responsibility of raising a child alone.³⁷

Women who give birth outside of marriage tend to be more disadvantaged. In general, unmarried mothers have lower incomes, lower education levels, and greater dependence on public assistance than married mothers.¹⁷⁴ Furthermore, children born to unmarried mothers are more likely to grow up in single-parent households, experience unstable living arrangements, live in poverty, and have socioemotional difficulties.^{7,82,54,122} During adolescence, these children are more likely to have low educational attainment, engage in sex at younger ages, and have premarital births themselves.^{7,122}

Unintended pregnancies are defined as pregnancies that, at the time of conception, are either mistimed or unwanted.¹⁶³ Women whose pregnancies are unintended initiate prenatal care later than those whose pregnancies were intended.^{51,93,97,96,99,151} Unintended births also have implications for the child that last from early childhood through adolescence and even into adulthood, including heightened risk of poor physical health,^{49,52,88,165} poor mental health,^{8,52} a less close mother-child relationship,^{11,90,193} and poorer educational outcomes.^{52,128}

MEASURES AND DATA AVAILABILITY

The National Vital Statistics System, with the collaboration of the individual states, collects data on registered live births in the United States. Data include information on the child's health status, family demographic information, and maternal health and behavior during pregnancy and birth.

SUGGESTED INDICATORS

- Percent of births that are not low birth weight, not very pre-term, and not born to a teen or unmarried mother.

Source: National Vital Statistics System (city, state, nation).

Notes: This data system does not include women's pregnancy intentions.

RESULT

2. Children have no untreated health conditions or avoidable developmental delays at time of school entry.

SIGNIFICANCE

It is estimated that 12 to 16 percent of U.S. children have developmental or behavioral disorders.¹⁹ The majority are not identified before school entrance.^{18,47,53,104,143,145,147,158} It is critical to the well-being of children and families that children's adverse health conditions or developmental delays receive attention prior to starting school. Delayed or disordered development can lead to increased risk of other medical complications or behavior disorders.⁴

The American Academy of Pediatrics recommends routine screening, from birth to age five, to identify children with delays in language, motor, or cognitive development, or with autism spectrum disorders.^{4,5} Children who are identified with developmental delays can be referred for early intervention services.¹⁵⁰ These may include multidisciplinary evaluation, case management, medical treatment, and family training and counseling. In addition to improving the child's quality of life at the time of the intervention, such services can have positive effects later in life—on high school drop-out, employment, early child bearing, and criminal behavior.^{12,70}

It is important to recognize delays in language skills early, not only because these are foundational for school success, but also because early intervention may improve outcomes, especially for children with hearing loss, and may enable early diagnosis of children with mental retardation and pervasive developmental disorders.^{72,189} In addition, the importance of early intervention for young children with autism spectrum disorder has been well documented.^{89,141,155,156,167,188}

MEASURES AND DATA AVAILABILITY

The National Survey of Children with Special Health Care Needs collects information at the state and national levels on the prevalence of special health care needs of children and their families, and the effects of those needs on their lives. The survey covers child health status, access to medical care, health insurance coverage, coordination of care, and impact and involvement of the family in the child's health care. The survey's disability screener combined with a question on whether the child has been treated for any conditions could yield data on

Suggested indicator: *Percent of children with selected preventable chronic health conditions or avoidable developmental delays at school entry.*

Strength of connection with PN Goals: HIGH with healthy development and school success.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: NOT routinely available.

Likely comparability of data across PNs: LOW, unless sites are able to adopt a common measure (e.g., from NSCSHCN).

Likely burden of collection for PNs: HIGH.

Suggested interim-progress indicators: Percent of two-year-olds with all recommended immunizations.

untreated health conditions. Questions to identify children with disabilities are also included in the National Survey of Children's Health, which provides data at the national and state level.

Individual cities or counties may also screen preschool children for special health care needs, and be able to share data.

SUGGESTED INDICATORS

- Percent of children with selected preventable chronic health conditions or avoidable developmental delays at school entry.
Source: National Survey of Children with Special Health Care Needs (state, nation).
Notes: It would be possible to use the National Survey of Children's Health, or the National Survey of Children with Special Health Care Needs in an expanded sampling frame in order to yield city-level data.

An alternative, less comprehensive indicator would be

- Percent of two-year-olds with all recommended immunizations.
Source: National Immunization Survey.
Notes: Currently provides estimates for some cities, all states, and the nation.

RESULT

3. Children live through infancy, childhood, and adolescence.

SIGNIFICANCE

Child deaths are tragic events deeply affecting parents and other family members. Infant mortality is considered an important marker of a country's health care system, and is commonly used in international comparisons as an indicator of the health and well-being of populations.³² Child and adolescent deaths are a less common phenomenon than infant mortality, but in developed countries like the U.S. can reflect levels of safety within communities, as well as risk-taking behaviors.

Causes of death do not differ greatly across racial/ethnic groups, with some notable exceptions. For infants, the leading cause of death overall is congenital anomalies ("birth defects"); for black infants, premature birth is the leading cause. The leading cause overall of adolescent mortality is unintentional injuries (primarily motor vehicle crashes); for black male adolescents and young adults (ages 15-24) the leading cause of death is homicide.

A word of caution in regard to mortality data is that, because numbers at a city/neighborhood level are generally small, even a few events can have a marked impact on rates. Thus, in assessing trends communities should examine absolute numbers as well as rates.

MEASURES AND DATA AVAILABILITY

The National Vital Statistics System provides information on mortality rates at the city, state, and national levels.

SUGGESTED INDICATORS

- Rates of infant and child mortality,
Source: National Vital Statistics System) (city, state, nation).
Notes: Because of variability in how addresses are coded, data may not be reliable at a city/neighborhood level.

Suggested indicator: *Rates of infant and child mortality.*

Strength of connection with PN Goals: HIGH with healthy development.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: LOW, unless sites can obtain cooperation of local public health officials.

Likely uniformity of data across PNs: LOW, unless sites can obtain cooperation of local public health officials.

Likely burden of collection for PNs: HIGH, unless sites can obtain cooperation of local public health officials.

Suggested interim-progress indicators: None.

RESULT

4. Children are ready for school learning (socially, cognitively, emotionally) at the time of school entry.

SIGNIFICANCE

Research on children's early development emphasizes that children's readiness for school is multifaceted. Early language and literacy skills are fundamental,^{168,185} but so are physical health and development, social-emotional development, and dispositions such as curiosity and attention.^{81,86,142,178,199} The National Education Goals Panel proposed five dimensions of development and skills that contribute to children's ability to participate in and learn from school. These are: (1) physical well-being and motor development; (2) social and emotional development; (3) approaches to learning; (4) language development; and (5) cognition and general knowledge.⁹⁴ According to research conducted by Child Trends, children who demonstrate competence across all five domains are more academically successful in first grade than are children who have competence in only one or two domains.⁷⁷

Much research shows that children's language and pre-reading skills at school entry predict later academic outcomes, and children who enter school behind in these skills often have difficulty catching up.^{76,100,101,153} Furthermore, children who fail to catch up early on often face additional challenges in their school careers.⁶² One study found that half of the racial gap in achievement scores of high school students was already evident at the time of school entry.¹⁶¹

Other research finds that being socially and emotionally ready for school is associated with positive social and emotional development, as well as with positive academic outcomes and later school success.^{100,101,153} For example, children who can regulate their emotions are better able to concentrate and focus on tasks, a critical ability in school.^{140,142} Other areas of development, such as health and enthusiasm, are also important to children's school readiness and early success in school.^{36,87,192}

It is now well established that high-quality early childhood education programs help children—especially those from low-income families—get ready for school.²⁵ Specifically, participation in prekindergarten education is associated with higher reading skills at school entry. According to some research, this preparation can fully close reading gaps, with advantages especially long-lasting for African American and Latino children from low-income families.¹¹²

Suggested indicator: *Percent of young children read to frequently by family members.*

Strength of connection with PN Goals: HIGH with school success.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: NOT routinely available.

Likely comparability of data across PNs: LOW, unless sites use a common survey.

Likely burden of collection for PNs: HIGH.

Suggested interim-progress indicators: None.

MEASURES AND DATA AVAILABILITY

Measurement of children’s readiness for school is still at an early stage of development. There is no single widely adopted measure. Rather, individual research studies, school districts, and (in a few cases) states have used a variety of assessments, some of which are more comprehensive and consistent with guidance from early childhood experts (but also more costly) than others.

The National Survey of Children’s Health includes two relevant questions, “How much time do children/youth spend reading for pleasure?” and “How often are young children read to by family members?” Children who are read to by family members experience a number of benefits directly related to school readiness, involving not only literacy but also social-emotional skills.¹⁷²

The Schools and Staffing Survey also contains questions relevant to school readiness. This national-level-only survey asks teachers, administrators, and school districts about the learning and social environments within their schools. Many questions are repeated in each survey cycle, allowing the investigation of trends over time.

Indicators of school readiness typically include such items as: child recognizes all letters; counts to 20 or higher; writes name; reads or pretends to read; is physically healthy; develops positive relationships with teachers and peers; and has a curiosity about new tasks. These questions could be included in the NSCH, and provide a template for potential city-level estimates.

Alternatively, communities may want to consider for this indicator locally used measures of school readiness, especially if those are consistent with recommended “best practice.”

SUGGESTED INDICATORS

- Percent of young children read to frequently by family members.
Source: National Survey of Children’s Health (state, nation).
- Percent of young children deemed “ready” according to local measures of school readiness that meet acceptable standards of validity and reliability.
Source: Local or state offices collecting this information.

Suggested indicator: *Percent of young children deemed “ready” according to local measures of school readiness.*

Strength of connection with PN Goals: VARIABLE connection with school success, depending on measure(s) used.

Face validity/Communication power: VARIABLE, depending on measure(s) used.

Availability of data at neighborhood level: VARIABLE.

Likely comparability of data across PNs: LOW.

Likely burden of collection for PNs: VARIABLE, depending on measure(s) used.

Suggested interim-progress indicators: None.

RESULT

5. Children demonstrate achievement of grade-level proficiency in major subjects, including reading and arithmetic, at third grade and subsequently.

SIGNIFICANCE

Reading is a fundamental skill that affects learning and performance in many school subjects.^{29,92} It also predicts the likelihood of graduating from high school and attending college.¹¹⁰ Additionally, proficiency in reading predicts career success; strong reading skills protect against unemployment in early adulthood,³⁰ and scores on adult literacy tests predict wages.¹⁶ Given these implications, it is important to promote and assess early success in reading.

Low family income is associated with lower reading scores for children. Further, there are significant differences in reading abilities across race and ethnicity groups, with white and Asian-American students consistently performing better than black and Hispanic students at all age levels; however, these differences could reflect any number of community variables.¹³¹

Math proficiency is also essential for daily life functioning and is becoming more important in an increasingly technological workplace. Students who take higher-level math courses are more likely to attend and complete college.¹ Mathematics competence is also related to higher levels of employability¹²⁷ as well as higher earnings in adulthood.¹²⁶

Though mathematics proficiency scores have risen recently for all race and ethnicity groups, white students continue to outscore their black, Hispanic, and American Indian counterparts. Asian-American students score above all other race and ethnicity groups.¹³⁵ Given these demographic disparities, it is important to examine community-level factors that are potential sources for differences.

MEASURES AND DATA AVAILABILITY

According to the National Center for Education Statistics,¹³² by spring of 3rd grade, most children can identify ending sounds, common words, and words in context. In mathematics, most children can recognize sequences, and add and subtract. These findings come from the Early Childhood Longitudinal Survey – Kindergarten Cohort, which is not readily adaptable to a survey yielding city-level indicators.

Suggested indicator: *Percent of children proficient in reading and mathematics at fourth and eighth grades.*

Strength of connection with PN Goals: HIGH with school success.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: NOT routinely available.

Likely uniformity of data across PNs: LOW, unless sites use a common assessment.

Likely burden of collection for PNs: HIGH.

Suggested interim-progress indicators: None.

The National Assessment of Education Progress has information on proficiency in reading and mathematics in fourth and eighth grades, at the school district level for the following large districts: Atlanta, Austin, Boston, Charlotte-Mecklenburg, Chicago, Cleveland, Houston, Los Angeles, New York City, San Diego, and the District of Columbia. Data for NAEP are collected every other year.

Alternatively, communities may want to consider locally used reading and math assessments.

SUGGESTED INDICATORS

- Percent of children proficient in reading and mathematics at fourth and eighth grades
Source: National Assessment of Education Progress (some school districts/cities, states, nation).
- Percent of children proficient in reading and mathematics at third/fourth and eighth grades, according to local measures that meet acceptable standards of validity and reliability.
Source: Local school districts.

Suggested indicator: *Percent of children achieving proficiency according local assessments at 3rd or 4th grade, and 8th grade..*

Strength of connection with PN Goals: HIGH with school success.

Face validity/Communication power: HIGH

Availability of data at neighborhood level: VARIABLE, depending on measure chosen.

Likely uniformity of data across PNs: LOW.

Likely burden of collection for PNs: LOW, if able to use existing data.

Suggested interim-progress indicators: None.

RESULT

6. Children are in schools where income- and race-based reading gaps are eliminated by third grade.

SIGNIFICANCE

National data show that disparities exist in children's literacy skills according to income and race. Contributing factors may be in place during the early years. Young children living in poverty are less likely to be read to every day by family members than are children living at or above the poverty line. Similarly, young non-Hispanic white and Asian children are more likely to be read to than either black or Hispanic children.⁶⁴ By fourth grade, national trends in reading gaps are apparent, where non-Hispanic white and Asian students score significantly higher on reading proficiency assessments than their black and Hispanic counterparts, and low income children score lower than children living in more economically advantaged situations.¹³¹

To overcome these income- and race-based reading gaps children need improved access to educational resources. More specifically, participation in prekindergarten education is associated with significantly higher reading skills at school entry. According to some researchers, this type of school preparation fully closes reading gaps, and the advantages are especially long-lasting for African American and Latino children from low income homes.¹¹²

MEASURES AND DATA AVAILABILITY

The National Assessment of Education Progress (NAEP) survey has information on reading proficiency in fourth and eighth grades by race and income-level at the school district level for the following large districts: Atlanta, Austin, Boston, Charlotte-Mecklenburg, Chicago, Cleveland, Houston, Los Angeles, New York City, San Diego, and the District of Columbia. Data for NAEP are collected other every year.

In addition, the No Child Left Behind legislation requires reporting, by school, on academic achievement disparities by race/ethnicity and income.

Suggested indicator: *Percent of schools making progress in eliminating gaps associated with income and race in reading proficiency at fourth grade.*

Strength of connection with PN Goals: HIGH with school success.

Face validity/Communication power: MEDIUM.

Availability of data at neighborhood level: HIGH, if communities can access school-level data.

Likely uniformity of data across PNs: HIGH.

Likely burden of collection for PNs: LOW.

Suggested interim-progress indicators: None.

SUGGESTED INDICATORS

- Percent of schools making progress in eliminating gaps associated with income and race in reading proficiency at fourth grade.

Source: National Assessment of Education Progress (some cities/school districts, states, nation).

RESULT

7. Children are not chronically absent from school.

SIGNIFICANCE

Chronic absence as early as kindergarten predicts truancy in subsequent school years.¹⁵⁷ Students who are not in class have fewer opportunities to learn the material necessary for academic and professional success.⁶³ Furthermore, chronic absence is predictive of other negative outcomes, including school dropout, substance abuse, and gang and criminal activity.^{10,119,120}

Chronic absenteeism is affected by various community- and school-level factors. For example, large schools have higher levels of absenteeism.⁶⁶ Additionally, communities with students who perceive their schools as chaotic, boring, staffed with apathetic teachers, and lacking discipline policies for truancy have higher rates of chronic absenteeism.^{59,154} Various school-wide interventions have been successful in reducing absenteeism, including those with the following elements: requiring schools to communicate with families about attendance, celebrating good attendance with students and families, connecting chronically absent students with community mentors, and conducting attendance-focused activities.¹⁶⁶

MEASURES AND DATA AVAILABILITY

The National Center for Education Statistics defines truancy (delinquent-level absenteeism) as missing ten or more days of school per year. The National Assessment of Education Progress (NAEP) survey has information on students missing three or more days in the past month, for these large school-districts: Atlanta, Austin, Boston, Charlotte-Mecklenburg, Chicago, Cleveland, Houston, Los Angeles, New York City, San Diego, and the District of Columbia. These data are collected biannually for 4th, 8th, and 12th grades.

SUGGESTED INDICATORS

- Percent of students not missing three or more days of school
Source: National Assessment of Education Progress (some cities/school districts, states, nation).
- Percent of students not missing ten or more days of school during the year
Source: School administrative records.

Suggested indicator: *Percent of children not missing three or more days of school in the past month, or 10 or more days in the school year.*

Strength of connection with PN Goals: HIGH with school success.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: VARIABLE, depending on measure chosen.

Likely uniformity of data across PNs: HIGH, if common measure used.

Likely burden of collection for PNs: LOW, if sites are able to use existing data; otherwise, HIGH.

Suggested interim-progress indicators: None.

RESULT

8. Children and youth are physically, mentally, and emotionally healthy.

SIGNIFICANCE

Health can be considered in both physical and emotional aspects, with both important for overall well-being. Physical health can be assessed by a global rating, or by the presence of specific limiting conditions. Among adolescents, poor overall physical health has been linked to a series of poor outcomes, including lower levels of academic achievement⁷⁴ and strained peer and parental relationships.¹⁰² Youth with health limitations, such as specific conditions and impairments or learning disabilities, often report emotional problems resulting in part from their inability to fully engage in home, school, community, or social activities.¹³⁷ Health-related behaviors in childhood and adolescence, such as exercise and eating habits, substance abuse, and unsafe sex, also pose serious risks to present and subsequent health.

Emotional health can be described in terms of the presence or absence of various psychological conditions (e.g., internalizing disorders such as depression, and externalizing disorders such as behavior problems) or positive and negative self-perceptions (e.g., self-concept). Both internalizing and externalizing disorders are important, because the symptoms that accompany these are potentially debilitating.^{138,139} Internalizing disorders have been linked to life stress, low levels of social support, maladaptive coping,¹⁶⁴ and peer¹⁷¹ and behavior problems.¹⁰³ Externalizing disorders in childhood have been linked to internalizing disorders and substance abuse in adolescence.⁸⁵ Positive self-perceptions, and specifically self-concept, also reflect emotional health. Self-concept is the sum of an individual's beliefs about his or her own attributes; having a negative self-concept in adolescence is associated with depression¹⁰⁸ and, in girls, with eating disorders.⁵⁰

Poor general health is also associated with community factors, including low family income and living in areas with high levels of environmental risk.^{79,80} Additionally, community violence has been associated with higher levels of post-traumatic stress and aggression in adolescents.¹²¹

Demographic disparities are apparent in physical and mental health indicators. Non-Hispanic black adolescent girls are more likely to be overweight than their non-Hispanic white and Mexican-American counterparts.¹⁴⁴ Hispanic and non-Hispanic white adolescents are more

Suggested indicator: *Percent of youth in grades 8-12 reporting various health risk behaviors.*

Strength of connection with PN Goals: HIGH with healthy development.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: NOT routinely available.

Likely uniformity of data across PNs: LOW, unless sites use a common survey.

Likely burden of collection for PNs: HIGH.

Suggested interim-progress indicators: None.

likely to give serious thought to attempting suicide than non-Hispanic black youth, and Hispanic students are more likely than members of other race and ethnic groups to attempt suicide.³¹ Additionally, young adults living in poverty are more likely than their affluent peers to suffer from depression.⁴⁰

MEASURES AND DATA AVAILABILITY

The Youth Risk Behavior Surveillance System (YRBSS) reports information biannually from students in 9th through 12th grades, at the national level, and for some states and cities. The survey is anonymous, and all items are self-reported. Students report on their current height and weight (which can be used to derive overweight or obese status), and on a number of behaviors associated with either good health or health risks. There are questions regarding nutrition and physical activity, use of alcohol and other drugs, and sexual behavior. In the area of mental health, three survey items (all referring to the past 12 months) are relevant: “felt sad and hopeless for two weeks or more,” “seriously considered attempting suicide,” and “attempted suicide one or more times.”

Large cities for which data are available in the YRBSS reports are Baltimore, Boston, Chicago, Charlotte-Mecklenburg, Chicago, Dallas, Detroit, the District of Columbia, Houston, Los Angeles, Memphis, Milwaukee, New York City, Philadelphia, San Bernardino, San Diego, and San Francisco. A drawback of the YRBSS is that data are obtained only for youth in school.

Measures of some of these constructs are included in the National Survey of Children’s Health and, with an expanded sampling frame, could be collected at the city level. Items include obesity (child’s height and weight), mental health (“does [the child] have any kind of emotional, developmental, or behavioral problem for which he/she needs treatment or counseling?”), and physical activity (“How often does [the child] engage in vigorous physical activity?”). Also, if adolescents were to be interviewed directly, questions on sexual activity, substance use, and depression could be asked.

Many local school districts screen children for physical, mental health, and developmental concerns. However, significant numbers of children with health-related issues may not be identified.

SUGGESTED INDICATORS

- Percent of students in grades 9-12 who “felt sad and hopeless” for more than two weeks in the past 12 months
- Percent of students in grades 9-12 who seriously considered suicide in the past 12 months
- Percent of students in grades 9-12 who smoked cigarettes in the past 30 days
- Percent of students in grades 9-12 who drank alcohol in the past 30 days
- Percent of students in grades 9-12 who are obese
- Percent of students in grades 9-12 who ate fruits and vegetables less than five times a day in the past seven days
- Percent of students in grades 9-12 who drank soda at least once a day in the past seven days

Source: Youth Risk Behavior Surveillance System (22 cities, most states, nation)

Notes: Data are limited to youth in school.

RESULT

9. Youth are active participants in civic life.

SIGNIFICANCE

Civic engagement refers to activities that involve children, youth, or adults around issues of community interest. It includes activities such as volunteer work, political involvement, voting, and activism on social, political, or other issues. Establishing a sense of civic responsibility in childhood promotes the development of a civic identity in later years,¹⁹¹ While being engaged in community activities may be important throughout childhood, young children's ability to be involved is limited. Accordingly, an indicator for this outcome should probably be focused on civic involvement in adolescence.

Civic engagement has been associated with a variety of child well-being outcomes, particularly positive social development, including positive parent-child⁶⁷ and peer relationships.⁷¹ Children with high levels of civic engagement are also more likely to participate in other positive networks—in particular, religious activities.¹⁹⁰ In addition, civic engagement has been associated with positive personal values, such as a belief in the advancement of the greater good in society.¹⁴⁹ Recent data reflect considerable disengagement among adolescents, with only 41% participating in volunteer activities on an occasional or regular basis,⁴⁶ and 60% reporting apathy regarding political and community life.⁹⁵ However, among high school seniors, data indicate an increase in volunteering over the past decade.⁴³ White youth are more likely to vote and to volunteer for community service than African-American and Hispanic youth.⁹¹

Suggested indicator: *Percent of youth volunteering in the community.*

Strength of connection with PN Goals: MEDIUM with healthy development and overall well-being.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: NOT routinely available.

Likely uniformity of data across PNs: LOW, unless sites use a common survey.

Likely burden of collection for PNs: HIGH.

Suggested interim-progress indicators: None.

MEASURES AND DATA AVAILABILITY

Data on adolescents' participation in civic life are not routinely available at the city level, aside from voting and voter registration for youth ages 18-24; these data are available through the Census Bureau.²⁶ The National Survey of Children's Health asks parents about whether the child (ages 12-17) participates in volunteer work or community service.

SUGGESTED INDICATORS

- Percent of children involved in volunteering or community service.

Source: National Survey of Children's Health (state, nation).

Notes: A city-level survey could include the volunteering question, as well as questions on whether the youth is registered to vote and voted in the last presidential election.

RESULT

10. Children and youth avoid violent mortality.

SIGNIFICANCE

Violent deaths carry impact beyond the child's friends and family, contributing to a breakdown of trust in a community.¹⁷³ Homicide is the third, and suicide the fourth leading cause of death for children ages 10-14. For adolescents and young adults ages 15-24 years old, homicide is the second leading cause of death, behind unintentional injury, and suicide is the third leading cause. Unintentional injury (primarily in motor vehicle crashes) is the leading cause of death for all racial groups ages 10-14 and 15-24, except blacks, for whom it is the second leading cause.

There are significant racial disparities in child and youth homicides. For black children, homicide is the second leading cause of death for age groups 1-4 and 10-14; it is the third leading cause of death for children 5-9 years old, and it is the leading cause of death for 15-24 year olds. Among whites, homicide is the fourth leading cause of death in the age groups 1-4, 5-9, and 10-14, but rises to the third leading cause of death among 15- to 24-year-olds.

Suicide data also show large racial disparities among youth, with blacks, American Indian/Alaska natives, and Asian/Pacific Islanders having higher rates than whites in one or more age groups.

A word of caution in regard to mortality data is that, because numbers at a city/neighborhood level are generally small, even a few events can have a marked impact on rates. Thus, in assessing trends communities should examine absolute numbers as well as rates.

MEASURES AND DATA AVAILABILITY

The Centers for Disease Control's Web-based Injury Statistics Query and Reporting System provides injury-related data (including violent deaths); the data are available at the state, regional, and national levels. The National Vital Statistics System reports on mortality at city, state, and national levels. The Uniform Crime Report provides information on homicides at city, state, and national levels, but crime at the city level is inconsistently reported.

SUGGESTED INDICATORS

- Rate of child and youth violent death.
Source: National Vital Statistics System (city, state, nation).

Suggested indicator: *Rate of child and youth violent death.*

Strength of connection with PN Goals: HIGH with healthy development.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: LOW, unless sites can obtain cooperation of local public health officials.

Likely uniformity of data across PNs: LOW, unless sites can obtain cooperation of local public health officials.

Likely burden of collection for PNs: HIGH, unless sites can obtain cooperation of local public health officials.

Suggested interim-progress indicators: None.

RESULT

11. Youth graduate from high school.

SIGNIFICANCE

There is no single consensus on what constitutes an “effective” education. However, the America’s Promise Alliance lists nine components:³

- a positive school climate,
- a school culture emphasizing academic achievement,
- knowing how to use technology effectively,
- reading for pleasure,
- having friends who value being a good student,
- a school perceived as relevant and motivating,
- having parents who are actively involved with their child’s education,
- having adult sources of guidance about schooling and careers, and
- having opportunities to learn social-emotional skills.

Short of having data on each of these components, however, high school graduation itself is a significant predictor of success. High school graduation is associated with higher likelihood of employment,⁶⁹ and higher income levels and occupational status³⁴ in adulthood. Having a high school diploma is a better measure of an effective education than a General Equivalency Diploma (GED). Relative to a high school diploma, having a GED is generally linked to poorer outcomes in the education, employment, and health realms. GED recipients are less likely to attend post-secondary school than high school graduates, and those who do attend are more likely to enroll in 2-year as opposed to 4-year institutions. GED recipients also have a lower likelihood of economic success in adulthood,²⁸ with some studies even indicating that there is no direct economic return from GED certification.⁸⁴

The “meaning” of a high school diploma, in terms of certifiable knowledge, skills, or dispositions, is of course highly variable across communities. Some states offer or require standards-based exit exams, which provide some degree of assurance of competence; however, like any high-stakes tests, these are controversial, with criticisms ranging from their focus on a too-narrow set of skills, to questions of fairness.

Suggested indicator: *Percent of ninth-grade class earning a high school diploma.*

Strength of connection with PN

Goals: HIGH with school success, and post-secondary education & success.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: HIGH, if sites are able to get cooperation from local schools.

Likely uniformity of data across PNs: HIGH, if a common measure is used.

Likely burden of collection for PNs: LOW, if sites are able to use existing data.

Suggested interim-progress indicator: Percent of youth ages 18-24 who have a high school diploma (ACS data; available for small geographies, but only as 5-yr. estimates).

MEASURES AND DATA AVAILABILITY

Data on the proportion of ninth graders who graduate four years later are included in the National Center for Education Statistics' Common Core of Data. These data are reported each year, by state. The American Community Survey has estimates for the percentage of the population with a high school diploma or equivalency, but does not distinguish between obtaining a GED and obtaining a high school diploma.

SUGGESTED INDICATORS

- Percent high school diplomas awarded as a proportion of ninth graders who entered high school

Source: Common Core of Data (states).

RESULT

12. Youth graduate from college (or achieve a rigorous post-secondary credential).

SIGNIFICANCE

Attainment of post-secondary education is associated with a range of positive outcomes. For example, young adults who have completed higher levels of education are more likely to achieve economic success as indicated by higher wages and income and lower unemployment.¹³³ Young adults who obtain a bachelor's degree or higher earn a median income that is more than double that of their peers with only a high school diploma.⁸³ Higher-level education attainment is also associated with positive socio-emotional outcomes. Specifically, adults with higher education levels report better health and higher levels of socio-emotional well-being, and they are less likely to divorce.^{160,175}

Of course, there are numerous settings, other than college, where young adults can acquire important vocational skills. These include various trade schools, the military, and job apprenticeships. However, there are few reliable data to indicate the success of such alternatives, in part because the quality of the educational experience in these settings varies greatly.

Rates of higher-education participation and degree attainment among young adults have shown significant increases in recent history, though overall rates remain low. The proportion of young adults between ages 25 and 29 holding a bachelor's degree increased from 17% in 1971 to 28% in 2006. There were especially large increases among those completing at least some college, where the rate went from 34% in 1971 to 58% in 2000.¹³⁰

Gains in higher educational attainment have been particularly great among blacks and Hispanics. However, large demographic gaps still exist. Specifically, among young adults ages 25 to 29, the proportion of non-Hispanic whites who attained at least a bachelor's degree in 2006 was more than three times that of Hispanics (34% compared with 10%) and slightly less than two times that of blacks (19%).¹³⁰

Suggested indicator: *Percent of youth ages 25-29 who have obtained a 2- or 4-year post-secondary degree.*

Strength of connection with PN Goals: HIGH with post-secondary-school success.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: HIGH.

Likely uniformity of data across PNs: HIGH.

Likely burden of collection for PNs: LOW.

Suggested interim-progress indicators: None.

MEASURES AND DATA AVAILABILITY

The American Community Survey has information on college graduation with a 2-year or 4-year post-secondary degree, and can be used for this indicator.

SUGGESTED INDICATORS

- Percent of youth aged 25-29 who have obtained a 2-year or 4-year post-secondary degree.
Source: American Community Survey (census tract, city, state, nation).

RESULT

13. Youth are prepared for or engaged in productive careers.

SIGNIFICANCE

One of the primary challenges for youth during the transition to adulthood is obtaining steady employment.¹⁵⁹ Securing a job is especially important for youth who are not enrolled in school. Among youth who are neither employed nor attending school—often referred to as “disconnected youth” – men are more likely to engage in delinquent behavior or illegal activities to earn money,⁶⁰ while women are more likely to become dependent on welfare.¹⁰⁵ Career type and employment position also matter for youth success. Employed youth who receive low wages are at risk for outcomes associated with poorer economic status, including chronic health conditions and poor mental health.²⁰ Youth and young adults in jobs providing fringe benefits often have access to helpful services, including health and dental care. Research shows it is important to secure well-paying jobs early in one’s career, as individuals with low paying jobs tend to remain poor for significant periods of time.³⁵

Between 1986 and 2005, the proportion of youth nationally who were neither enrolled in school nor employed fluctuated between seven and ten percent. Racial and ethnic disparities exist in these data, with 16- to 19-year-old Hispanic and black youth more likely to be out of school and work than their white and Asian/Pacific Islander counterparts.¹³⁴ The availability of jobs in communities is influenced by both local and macro-level economic conditions, including policy choices, as is access to post-secondary education.

MEASURES AND DATA AVAILABILITY

Being prepared for a productive career could be defined as: having a high school diploma, and being enrolled in post-secondary education or gainfully employed. It also might include holding a job that has benefits, such as sick leave, paid vacation, and health insurance. These data, along with wage information, are available through the Decennial Census and American Community Survey (ACS).

The Decennial Census and the ACS both have information at the census tract, city, state, and national levels on income, on whether the individual is employed or not, and on job classification and school enrollment.

Suggested indicator: *Percent of youth ages 25-29 who are enrolled in school or employed.*

Strength of connection with PN Goals: HIGH with post-secondary school success.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: HIGH

Likely uniformity of data across PNs: HIGH.

Likely burden of collection for PNs: LOW.

Suggested interim-progress indicators: None.

SUGGESTED INDICATORS

- Percent of youth ages 25-29 enrolled in school or employed.

Source: American Community Survey (census tract, city, state, nation).

RESULT

14. Youth are prepared for parenting before they become parents.

SIGNIFICANCE

We suggest defining “prepared” parents as those who are age 20 or older, are married, have graduated from high school, and have at least one spouse who is employed. Age is an important indicator of preparation for parenthood because it is associated with higher levels of cognitive and emotional maturity and responsibility, as well as with the financial stability necessary for raising children. Teen parents often are lagging in school achievement or have dropped out of high school, which decreases their employability and increases their reliance on public assistance.⁴² The children of teen parents also face substantial challenges and are at risk for a range of poor outcomes, including premature birth, low birth weight, higher likelihood of infant death,¹⁸³ less stimulating home environments, and poorer academic and behavioral outcomes.^{113,124}

Marriage is an important asset for parenting, because often it facilitates shared responsibility in childrearing. Furthermore, two-parent families tend to have higher incomes relative to single-parent families, making the cost of raising children more manageable. Numerous studies show that a low-conflict marriage between two biological or adoptive parents provides for the best child outcomes, with children growing up in step- and single parent families often at risk for poorer health, educational attainment, behavioral and socio-emotional outcomes.^{23,176} Children growing up in households with cohabiting parents are also at risk for these poor outcomes, because the majority of parents who cohabit never marry, and many of these relationships are unstable.²²

Attaining a high school diploma is important preparation for parenthood because graduation is associated with a greater likelihood of employment,⁶⁹ higher income levels, and higher occupational status.³⁴ Having access to these financial and career opportunities makes it more likely that parents can provide adequately for their children.

Preparation for parenthood, as the construct is proposed here, can be measured across communities, but only among those who already have children.

Suggested indicator: *Percent of parents who are age 20 or older, have at least a high school education, are married, and one or both are employed.*

Strength of connection with PN Goals: HIGH with post-secondary success.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: HIGH.

Likely uniformity of data across PNs: HIGH.

Likely burden of collection for PNs: LOW.

Suggested interim-progress indicators: Communities could focus on fewer than all four dimensions.

MEASURES AND DATA AVAILABILITY

A measure of preparation for parenthood is a composite of parents' ages, education level, marital status, and employment status. Subtracting the age of the oldest biological child in the household from the age of the parent(s) produces a measure of parents' ages at first birth; restricting the analysis to parents with young children (e.g., under age 10) would yield a more sensitive measure.

The Decennial Census and the American Community Survey collect all of these variables at the census tract, city, state, and national levels.

SUGGESTED INDICATORS

- Percent of parents who are age 20 or older, have at least a high school education, are married, and one or both are employed.

Source: American Community Survey (census tract, city, state, nation).

RESULT

15. Children and youth are free of abuse and neglect

SIGNIFICANCE

Abuse and neglect of children are related to increased likelihood of physical injury, delayed physical growth, and neurological damage.³⁹ Child maltreatment is also associated with psychological and emotional problems such as aggression, depression, and post-traumatic stress disorder.^{39,73} In addition, child abuse is linked to increased risk of substance abuse, eating disorders, obesity, depression, suicide, and sexual promiscuity later in life.^{33,39} Women who were victims of physical assault as children are twice as likely to be victims of physical assault as adults.^{39,178} Also, evidence suggests that victims of child maltreatment are more likely to engage in deviant or criminal behavior as juveniles and adults.^{39,177}

These consequences place a financial burden on taxpayers through the child welfare system, the juvenile justice system, the physical and mental health care systems, and the criminal justice system, and through lost productivity to society. However, good estimates of the costs associated with child maltreatment are elusive, because much abuse and neglect goes unrecognized or unreported, and because a number of adverse factors may contribute to the same bad outcomes.

An estimated 3.2 million referrals for abuse or neglect were made in 2007 to child protection agencies, or approximately one of every 25 children. Those referrals were for the alleged abuse or neglect of about 5.8 million children, which is nearly one of every 13 children in the United States.⁵⁵

MEASURES AND DATA AVAILABILITY

The number of children who have been determined to be abused or neglected as a proportion of all children is a commonly used measure of the level of abuse and neglect.

The National Child Abuse and Neglect Data System includes data on reports of maltreatment to state child protective services agencies. The data consist of all investigations and assessments of alleged child maltreatment that received a disposition in the reporting year. Reporting is at national and state levels only. There are serious limitations to these data, however—not only because much abuse and neglect goes unreported, but also because states differ in their criteria for what is accepted as a report of abuse/neglect, and for substantiation of reports.

Suggested indicator: *Rate of child abuse & neglect (substantiated victims).*

Strength of connection with PN Goals: HIGH with healthy development, school success, and overall well-being.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: LOW, unless sites can obtain cooperation of local child welfare officials.

Likely uniformity of data across PNs: LOW, due to differing reporting rates and different standards for substantiation.

Likely burden of collection for PNs: HIGH, unless sites can obtain cooperation of local child welfare officials.

Suggested interim-progress indicators: None.

SUGGESTED INDICATORS

- Rate of child abuse and neglect (substantiated victims)

Source: National Child Abuse and Neglect Data System (state, national).

Notes: Data are subject to under-reporting and inconsistent definitions of abuse.

RESULT

16. Fewer children and youth live apart from their families.

SIGNIFICANCE

Children may live apart from their families because they are living with more-distant relatives, in foster care, or in a group home or institution. In general, children living in households without a biological parent have been found to be at risk for negative outcomes, including behavioral and emotional problems. Specifically, children in the foster care system are more likely to be suspended or expelled from school, exhibit low levels of school engagement and involvement with extracurricular activities, have developmental delays or neurological impairments, to be in poor or fair health, and to have a limiting physical, learning, or mental health condition.^{98,182} Further, longer periods of time spent in foster care are associated with problems in adulthood, including unemployment, homelessness, incarceration, and experiencing early pregnancy.^{45,48}

Some factors that can vary by neighborhood (e.g., race/ethnicity and income) are related to the likelihood of a child's being placed in the foster care system. Nearly one-third of children in foster homes come from families living below the poverty threshold. Additionally, non-Hispanic blacks, and Hispanics are overrepresented in the foster care system. Though rates of foster care placement have declined in recent years,¹⁸⁰ there are still significant numbers of children in out-of-home placements.

MEASURES AND DATA AVAILABILITY

This indicator requires data on the number of children in foster care, and the number of children in group care. The American Community Survey (ACS) effort includes individuals in psychiatric hospitals, long-term hospital care, and juvenile detention. However, these data are not easily accessible and not reported online by age or by type of group quarters. At the state and national levels, the Adoption and Foster Care Analysis Reporting System (AFCARS) reports data on children in public child welfare systems. AFCARS provides information on health (including emotional health), demographics, and contextual family variables, but reporting is not consistent across states.

Suggested indicator: *Percent of children in foster care, or otherwise living apart from their biological/adoptive parents.*

Strength of connection with PN

Goals: HIGH-to-LOW with healthy development, school success, and post-secondary success, depending on particular circumstances.

Face validity/Communication power: MEDIUM.

Availability of data at

neighborhood level: LOW, unless communities can obtain local administrative data.

Likely uniformity of data across

PNs: LOW, unless data-collection standards are developed.

Likely burden of collection for

PNs: HIGH.

Suggested interim-progress

indicators: Percent of children living in "group quarters" (includes juvenile detention facilities, psychiatric hospitals, and long-term regular hospital care).

SUGGESTED INDICATORS

- Percent of children in foster care.

Source: AFCARS (data available for states, though not comparable across them, and the nation).

Note: Reporting is not consistent across states.

RESULT

17. Families are connected to supportive networks and needed services.

SIGNIFICANCE

Supportive networks and services are those that provide accessible, culturally appropriate material and social-emotional assistance, and are available in the communities where families reside. Supportive networks include provision of public benefits and services, including public safety, and informal help from relatives, friends, and neighbors. For example, supportive neighborhoods have people who look after and assist one another.¹⁸⁶ Neighborhood services include government cash-assistance programs, such as food stamps or Temporary Assistance for Needy Families, as well as local, often in-kind services, such as babysitting co-ops, food pantries, out-of-school-time programs, libraries, and community centers.

Research on supportive neighborhoods indicates that children coming from areas with higher levels of support report stronger connections to their families, peers, and communities.¹⁸⁷ Adolescents living in unsupportive neighborhoods are at risk for a range of negative outcomes, including having multiple sexual partners,²⁴ lower cognitive ability and school achievement, and more physical and mental health problems, compared with those living in resource-rich neighborhoods.¹⁰⁶

The number and types of available neighborhood resources are also linked to neighborhood safety. Families who report that their neighbors are more likely to help one another out tend to live in safer neighborhoods.⁴¹ Adolescents living in communities that provide fewer youth organizations are more likely to be exposed to neighborhood violence.⁶⁸

Demographic data indicate that Hispanic, and black children are more likely than their white counterparts to live in unsafe neighborhoods.³⁸

MEASURES AND DATA AVAILABILITY

The National Survey of Children's Health (NSCH) measures some neighborhood variables. In the NSCH, a composite measure of "supportive neighborhoods" includes parents' responses to the following items:

- "People in my neighborhood help each other out,"
- "We watch out for each other's children in this neighborhood,"
- "There are people I can count on in this neighborhood," and

Suggested indicator: *Percent of children living in neighborhoods that provide social support.*

Strength of connection with PN Goals: MEDIUM with healthy development, and school success.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: NOT routinely available.

Likely uniformity of data across PNs: LOW, unless sites can use a common survey.

Likely burden of collection for PNs: HIGH.

Suggested interim-progress indicators: None.

- “If my child were outside playing and got hurt or scared, there are adults nearby who I trust to help my child.”

Suggested indicator: *Percent of children participating in organized out-of-school activities.*

Strength of connection with PN
Goals: MEDIUM with family capacity to promote well-being, depending on program quality.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: NOT routinely available.

Likely uniformity of data across PNs: LOW, unless sites can use a common survey.

Likely burden of collection for PNs: HIGH.

Suggested interim-progress indicators: None.

Suggested indicator: *Percent of low-income families receiving food stamps.*

Strength of connection with PN
Goals: MEDIUM with family capacity to promote well-being.

Face validity/Communication power: MEDIUM

Availability of data at neighborhood level: HIGH.

Likely uniformity of data across PNs: HIGH

Likely burden of collection for PNs: LOW.

Suggested interim-progress indicators: None.

There are questions about vandalism, litter on the street or sidewalk, perceived child safety in the neighborhood and school, and questions about whether amenities such as parks, community centers, and libraries are available in the neighborhood.

The NSCH also includes a question on the child’s participation in “organized activities outside of school”; this or a similar item used in a neighborhood-level survey could provide important information on a community’s success in connecting children and youth with programs that have the potential to influence a number of positive outcomes.

The Decennial Census and American Community Survey (ACS) include information on the proportion of low-income families receiving food stamps in the past 12 months, which could

serve as a proxy for how readily families access government assistance. These surveys also include information on parental employment. However, they do not have information about neighborhood cohesiveness.

SUGGESTED INDICATORS

- Percent of children living in neighborhoods that provide social support.
- Percent of children participating in organized out-of-school activities.
Source: National Survey of Children's Health (state, nation).
Notes: City- or smaller-level data would require an expanded sample.
- Percent of low-income families receiving food stamps.
Source: American Community Survey (census tract, city, state, nation)

RESULT

18. Families are connected to education, training, and income supplements aimed at living above the poverty level.

SIGNIFICANCE

Family poverty is a major risk to child development, and children in situations of early, deep, and persistent poverty are especially unlikely to experience optimal well-being. Family poverty affects children in every stage of development and is correlated with lower achievement in school, lower intelligence test scores, grade retention, behavior problems, and poorer health.²¹ Many factors account for this association.¹²⁵ Some of these factors reflect the reasons that families are in poverty, such as low parent education and single parenthood. Other factors (for example, poor nutrition) represent pathways by which poverty undermines children's development.

Children in poverty are more likely to have lower academic achievement, because they may grow up in households that are less cognitively stimulating and attend less rigorous schools, and they are more likely to experience stress, which can negatively affect working memory.¹²⁵ Poor children are more likely to move frequently compared with those in more affluent households, adding to stress and interrupting schooling. In addition, poor children are more likely to be exposed to health threats, such as environmental toxins, poor nutrition, maternal depression, parental substance abuse, violence, and low-quality child care. Poor families are more likely to live in housing with lead paint and structural damage, and they are more likely to live in neighborhoods without access to a variety of healthy foods.

Poverty not only plays a major role in a multitude of "bad outcomes," but is itself the result of numerous factors. Thus, there are a number of potential avenues for reducing its harm, even short of seeing change in the poverty indicator. For example, the extent to which families access income assistance programs, such as food stamps, has near-term impact on economic security.

MEASURES AND DATA AVAILABILITY

There are many problems with the current official measure of poverty—the federal poverty threshold—and researchers and policy makers continue to debate how best to assess poverty. For the purpose of this report, we recommend use of the existing federal poverty threshold.

Suggested indicator: *Percent of families with incomes above the federal poverty threshold.*

Strength of connection with PN Goals: HIGH with healthy development, school success, and family capacity to promote well-being.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: HIGH.

Likely uniformity of data across PNs: HIGH.

Likely burden of collection for PNs: LOW.

Suggested interim-progress indicators: Percent of low-income families receiving food stamps; percent of low-income families receiving public assistance/welfare.

Many surveys include information on income that allows for the calculation of poverty rates at the national level. The American Community Survey (ACS) reports such data annually for *Public Use Microdata Areas* (those containing a minimum of 100,000 people). The American Housing Survey has some large cities in its public-use data file: Atlanta, GA, Cleveland, OH, Denver, CO, Hartford, CT, Indianapolis, IN, Memphis, TN-AR-MS, New Orleans, LA, Oklahoma City, OK, Pittsburgh, PA, Sacramento, CA, St. Louis, MO-IL, San Antonio, TX, and Seattle-Everett, WA. The Census Small Area Income and Poverty Estimates can provide state- and national-level estimates of poverty for years the census is not being conducted. These data sources all use the federal poverty threshold as the measure of poverty.

SUGGESTED INDICATORS

- Percent of families living below the poverty threshold.

Source: American Community Survey.

Notes: Annual poverty data are not available for geographies with less than 100,000 population. However, beginning in 2010, the American Community Survey will report five-year-average estimates (updated annually) for areas with at least 20,000 population.

RESULT

19. Children live in families that provide structure, nurturance, and high expectations.

SIGNIFICANCE

In families, structure is typically provided in the form of routines. Routines can be defined as patterned interactions which have meaning to the family, and can include activities such as eating meals and doing household chores together. A number of studies have linked family routines to various indicators of child and adolescent well-being. Specifically, the establishment of routines is related to fewer behavior problems in children;⁶⁵ to lower levels of adolescent drinking, smoking, drug use, delinquent behaviors, suicidal thoughts; and to later initiation of sexual activity.^{136,179}

Nurturing families provide close, caring and communicative relationships. A positive, nurturing parent-child relationship is one of the strongest predictors of well-being in children and adolescents,⁷⁸ and has been associated with better cognitive development,¹¹⁶ social competence, self-esteem, self-reliance,^{169,184} behavioral regulation,¹⁴⁸ lower levels of emotional distress and suicidality, later initiation of sexual activity, lower levels of substance abuse,¹⁵² and overall adjustment.¹⁰⁹

The majority of research on parents' expectations for their children is centered on the academic realm. High parental expectations are linked with better educational outcomes at all age levels, starting with first grade,⁶¹ and extending to upper elementary and middle school,¹¹⁴ high school,² and beyond.⁴⁴ Indeed, this factor has been found to be a better predictor of later academic success than actual school performance in early childhood.¹⁴⁶ Fewer studies have examined the impact of parental expectations on socio-emotional and risk-taking outcomes, but associations have been found between high parental academic expectations and lower levels of substance use.¹²⁹

A number of parenting education programs are available, and some have been shown in rigorous evaluations to be effective in increasing parents' knowledge. However, participants tend to be parents of children with exceptional problems, or parents with exceptionally poor parenting skills (e.g., those referred because of suspected abuse or neglect). Thus, it is unclear whether such programs could provide data of direct relevance to a community-wide change effort.

Suggested indicator: *Percent of families who eat meals together, have rules regarding television watching, where parents read to children, and where there is good parent-child communication.*

Strength of connection with PN Goals: HIGH with healthy development, school success, and family capacity to promote well-being.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: NOT routinely available.

Likely uniformity of data across PNs: LOW, unless sites use a common survey.

Likely burden of collection for PNs: HIGH.

Suggested interim-progress indicators: Communities could focus on fewer than all four dimensions.

MEASURES AND DATA AVAILABILITY

These constructs are not currently measured across all cities, although city-specific surveys have been developed (e.g., the Miami-Dade, FL, Children's Trust Survey and the Hennepin County, MN survey). One measure commonly used to assess home life is the Home Observation for Measurement of the Environment (HOME).²⁷ However, because of the cost of this data collection, it is unlikely to be feasible for obtaining city-level estimates. The National Survey of Children's Health includes measures of how often a family eats meals together, whether parents have rules regarding television watching, whether parents read to the child, and the quality of parent-child communication. These could be used to create a composite indicator at either the state or national level. With expanded sampling, city-level estimates could be produced.

SUGGESTED INDICATORS

- Percent of families who eat meals together, have rules regarding television watching, where parents read to children, and where there is good parent-child communication.
Source: National Survey of Children's Health (state, national).
Notes: City- or smaller-level data would require special sampling.

RESULT

20. Neighborhoods are safe and free of violence or crime.

SIGNIFICANCE

Neighborhood crime undermines children's development in a number of ways. Crime can result in direct harm or victimization. It can affect children emotionally (e.g., through diminished trust and safety) as well as physically (injury or death). Higher rates of neighborhood crime can lead to an increased likelihood of delinquency, crime, or arrest among resident youth. Such problems can affect schoolwork, friendships, and home-life. Reducing crime can help break what otherwise can be a negative, reinforcing cycle.¹⁸⁴

Density of population, concentration of poverty, mixed use (businesses and residences in the same area), transience of population, concentration of single-parent households, and presence of dilapidated buildings are all associated with higher crime rates.^{162,170} Areas with high crime also tend to lack legitimate economic opportunities, have lower quality services for residents, and have residents who are negative role models. Thus, while reducing overall rates of crime may not be a realistic goal of community-building efforts such as Promise Neighborhoods, there may be some positive effects in this area if there is success in moving other indicators.

MEASURES AND DATA AVAILABILITY

Crime is typically measured in two ways: official statistics and victim reports. Official statistics are gathered from reports made to law enforcement agencies. Victim surveys are also sometimes used to estimate crime, because they capture some crimes that otherwise go unreported.

Official crime report data have several drawbacks. Many crimes are not consistently reported—for example thefts and sexual assaults. In general, if multiple crimes occur in one incident, only the most serious crime is reported, and if there are multiple victims, the data record a single incident.

Victim-report data have problems as well. Sexual assault and domestic violence, for example, are under-reported, resulting in conservative estimates. Additionally data are limited to those crimes victims are asked about. The data also may not include offender race, age, and non-physical characteristics.

Suggested indicator: *Rates of violent and property crimes.*

Strength of connection with PN Goals: MEDIUM with healthy development and family capacity to promote well-being.

Face validity/Communication power: MEDIUM (includes only reported crimes).

Availability of data at neighborhood level: VARIABLE, depending on data submitted by local law enforcement agencies.

Likely uniformity of data across PNs: HIGH, if sites adhere to UCR definitions.

Likely burden of collection for PNs: LOW, if sites can gain cooperation from local law enforcement agencies.

Suggested interim-progress indicators: None.

One official-report dataset that provides information at the city level is the Uniform Crime Report (UCR), published by the Federal Bureau of Investigation. The UCR collects data at the state, metropolitan statistical area, city (with over 10,000 inhabitants), suburban/rural county, and college/university level, but reporting is not consistent across cities. The National Crime Victim Survey, based on victim reports, has data only at the national level. Although most experts believe crime is under-reported, if reporting patterns are consistent over time, declines in crime can be tracked with UCR data.

SUGGESTED INDICATORS

- Rates of violent and property crimes.
Source: Uniform Crime Report (city, state, nation).
Notes: Violent crime consists of murder, forcible rape, robbery, and aggravated assault. Property crimes are burglary, larceny-theft, motor vehicle theft, and arson.

RESULT

21. Families live in safe and decent housing.

SIGNIFICANCE

Decent and safe housing provides children a healthy and stable place to live. Unsafe housing can contribute to insecurity and expose children to other health, psychological, and safety risks. Exposure to lead paint, for example, can result in reduced cognitive functioning and behavioral problems.⁵⁶ Pest activity can cause health problems and aggravate existing ones.⁵⁸ Overcrowding can lead to health and safety risks, particularly if crowded conditions are combined with physical housing deficiencies.¹¹⁷

Children and youth in unstable housing or who are homeless experience a loss of community; interrupted routines; and loss of possessions, privacy, and security.¹³ They are vulnerable to physical and sexual assault, witnessing violence, or becoming separated from family members. Unstable housing may result in changing schools often during the school year, which can negatively affect social and academic development.¹²³

MEASURES AND DATA AVAILABILITY

Safe and decent housing can be measured by need for repair; presence of health hazards like lead, insects, and rodents; and crowding. It may also be indicated by homelessness and the prevalence of unstable housing. Safety of the housing structure itself is important; selected housing deficiencies are reported in the American Housing Survey (AHS). Presence of pests is measured by “signs of” rats, mice, or other rodents in the last 13 months.⁵⁷ Crowding is defined as more than one person per room.

In addition to those living “on the street,” homeless children may be in any of the following living situations: sharing the house of other persons because of economic hardship; living in motels, hotels, trailer parks, or camping grounds because of a lack of alternatives; living in shelters; temporarily in hospitals because of abandonment; or waiting for foster care placement. These arrangements are all considered unstable housing. Housing tenure (length of residence at one address) can also reflect unstable housing.

The American Housing Survey has information for thirteen large cities in its public-use data file. The American Community Survey’s (ACS) *Public Use Microdata Areas* include those with a minimum population of 100,000, and correspond with county, neighborhood, and city boundaries. Data for these areas are available annually. The ACS asks questions about housing

Suggested indicator: *Percent of families with children living in unsafe, unstable, or overcrowded housing.*

Strength of connection with PN Goals: MEDIUM with healthy development and family capacity to promote well-being.

Face validity/Communication power: HIGH.

Availability of data at neighborhood level: NOT routinely available.

Likely uniformity of data across PNs: LOW, unless sites adopt common measures.

Likely burden of collection for PNs: HIGH.

Suggested interim-progress indicators: None.

safety, crowding, sharing living quarters, and information to estimate an individual's housing cost burden.

Under terms of the McKinney-Vento Homeless Assistance Act, each school district has a liaison for homeless children, and is required to report on the number of homeless children assisted by the liaison to attend school.

The National Survey of Children's Health includes a question about safe neighborhoods, and the American Housing Survey includes a similar question.

SUGGESTED INDICATORS

- Percent of housing units with one or more of the following problems:
 - holes in the floors, open cracks or holes in the interior of the unit,
 - broken plaster or peeling paint in the interior,
 - no electrical wiring, exposed wiring, and rooms without electric outlets,
 - "signs of" rats, mice, or other rodents (three separate questions) in the last 13 months,
 - less than one room per person

Source: American Housing Survey (13 large cities, state, nation).

REFERENCES

- ¹ Adelman, C. (1999). *Answers in the tool box: Academic intensity, attendance patterns, and bachelor's degree attainment*. Washington, DC: Office of Education Research and Improvement, U.S. Department of Education.
- ² Ainley, J., Foreman, J., & Sheret, M. (1991). High school factors that influence students to remain in school. *Journal of Educational Research*, 85(2), 69-81.
- ³ America's Promise Alliance. (n.d.). Every Child, Every Promise: Turning failure into action [Electronic Version], 68. Retrieved October 7, 2009 from <http://www.americaspromise.org/Resources/Research-and-Reports/~media/Files/About/ECEP%20-%20Full%20Report.aspx>.
- ⁴ American Academy of Pediatrics. (2006). Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening. *Pediatrics*, 118(1), 405-420.
- ⁵ American Academy of Pediatrics Committee on Children with Disabilities. (2001). Developmental surveillance and screening of infants and young children. *Pediatrics*, 108(1), 192-196.
- ⁶ Annie E. Casey Foundation. (2009). Making Connections. Retrieved October, 7, 2009, from <http://www.aecf.org/MajorInitiatives/MakingConnections.aspx>
- ⁷ Aquilino, W. S. (1996). The life course of children born to unmarried mothers: Childhood living arrangements and young adult outcomes. *Journal of Marriage and the Family*, 58(2), 293-310.
- ⁸ Axinn, W. G., Barber, J. S., & Thornton, A. (1998). The long term impact of childbearing decisions on children's self-esteem. *Demography*, 35(4), 435-444.
- ⁹ Aylward, G. P. (2003). Cognitive Function in Preterm Infants: No Simple Answers. *Journal of the American Medical Association* 289(6), 752-753.
- ¹⁰ Baker, M. L., Sigmon, J.N., & Nugent, M.E. (2001). *Truancy reduction: Keeping students in school*. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.
- ¹¹ Barber, J. S., Axinn, W. G., & Thornton, A. (1999). Unwanted childbearing, health, and mother-child relationships. *Journal of Health and Social Behavior*, 40(3), 237-257.
- ¹² Barnett, W. S., & Escobar, C. M. (1990). Economic costs and benefits of early intervention. In S. J. Meisels & J. P. Shonkoff (Eds.), *Handbook of Early Childhood Intervention* (pp. 560-582). Cambridge Cambridge University Press.
- ¹³ Bassuk, E. L., & Friedman, S. M. (2005). *Facts on trauma and homeless children*. Los Angeles, CA: National Child Traumatic Stress Network Homelessness and Extreme Poverty Working Group.
- ¹⁴ Behrman, J. R., Rosenzweig, M. R., & Taubman, P. (1994). Endowments and the Allocation of Schooling in the Family and in the Marriage Market: The Twins Experiment. *Journal of Political Economy*, 102, 1131-1174.
- ¹⁵ Bhutta, A. T. (2002). Cognitive and Behavioral Outcomes of School-Aged Children Who Were Born Preterm: A Meta-Analysis. *Journal of the American Medical Association* 288(6), 728-737.
- ¹⁶ Blau, F., & Kahn, L. (2000). *Do cognitive scores explain US wage inequality?* : National Bureau of Economic Research, Inc.

- ¹⁷ Bowen, J. R., Gibson, F. L., & Hand, P. J. (2002). Educational Outcome at 8 Years of Children Who Were Born Prematurely: A Controlled Study. *Journal of Pediatrics and Child Health* 38(5), 438-444.
- ¹⁸ Bowie, D., & Parry, J. A. (1984). Court come true - for better or for worse. *British Medical Journal*, 299, 1322-1324.
- ¹⁹ Boyle, C. A., Decourle, P., & Yeargin-Allsoop, M. Y. (1994). Prevalence and health impact of developmental disabilities. *Pediatrics*, 93, 863-865.
- ²⁰ Bradley, R. H., & Corwyn, R. F. (2002). Socioeconomic status and child development. *Annual Review of Psychology*, 53, 371-399.
- ²¹ Brown, B., & Moore, K. A. (2009). *What gets measured gets done: High priority opportunities to improve our nation's capacity to monitor child and youth well-being, A white paper for the Annie E. Casey Foundation*. Washington, DC: Child Trends.
- ²² Brown, S. L. (2000). Union transitions among cohabitators: The significance of relationship assessments and expectations. *Journal of Marriage and the Family*, 62, 833-846.
- ²³ Brown, S. L. (2004). Family structure and child well-being: The significance of parental cohabitation. *Journal of Marriage and the Family*, 66(2), 351-367.
- ²⁴ Browning, C. R., Buntington, L.A., Leventhal, T., & Brooks-Gunn, J. (2008). Neighborhood structural inequality, collective efficacy, and sexual risk behavior among urban youth. *Journal of Health and Social Behavior*, 49(3), 269-285.
- ²⁵ Burchinal, P., Kainz, K., Cai, K., Tout, K., Zaslow, M., Martinez-Beck, I., et al. (2009). *Early care and education quality and child outcomes*. Washington, DC: Child Trends.
- ²⁶ Bureau, C. (2008). Voting and registration in the election of November 2006. Retrieved May 18, 2009, from <http://www.census.gov/population/www/socdemo/voting/cps2006.html>
- ²⁷ Caldwell, B., & Bradley, R. H. (1984). *Home Observation for Measurement of the Environment (HOME)*. Little Rock, AR: University of Arkansas.
- ²⁸ Cameron, S. V., & Heckman, J.J. (1993). The nonequivalence of high school equivalents. *Journal of Labor Economics*, 11(1), 1-47.
- ²⁹ Carnine, L., & Carnine, D. (2004). The interaction of reading skills and science content knowledge when teaching struggling secondary students. *Reading and Writing Quarterly*, 20, 203-218.
- ³⁰ Caspi, A., Wright, B.E., Moffit, T.E., & Silva, P.A. (1998). Childhood predictors of unemployment in early adulthood. *American Sociological Review*, 63(3), 424-451.
- ³¹ Center for Disease Control and Prevention. (2006). *Surveillance Summaries* (Vol. 55 (No. SS-5) Table 16).
- ³² Centers for Disease Control and Prevention. (2007). *Factsheets: Infant mortality*. Atlanta, GA: Office of Minority Health & Health Disparities.
- ³³ Centers for Disease Control and Prevention National Center for Injury Prevention and Control. (n.d.). Child Maltreatment; Fact Sheet. Retrieved April 11, 2005, from <http://www.cdc.gov/ncipc/factsheets/cmfacts.htm>
- ³⁴ Chen, Z., & Kaplan, H. (2003). School failure in early adolescence and status attainment in middle adulthood: A longitudinal study. *Sociology of Education*, 76(2), 110-127.
- ³⁵ Child Trends. *Children in working poor families*. Washington, DC: Child Trends.
- ³⁶ Child Trends. (2001). *School readiness: Helping communities get children ready for school and schools ready for children*. Washington, DC: Child Trends.
- ³⁷ Child Trends. (2002). *Ten Reasons to Keep the Focus on Teen Childbearing*. Washington, DC.

- ³⁸ Child Trends. (2008). *Percentage of children living in unsafe neighborhoods, by race and ethnicity, 2003. Analyses from the 2003 National Survey of Children's Health*. Washington, DC: Child Trends.
- ³⁹ Child Trends. (n.d.). Child Trends DataBank - Child Maltreatment. Retrieved May 27, 2009, from <http://www.childtrendsdatbank.org/indicators/40ChildMaltreatment.cfm>
- ⁴⁰ Child Trends Data Bank. (2006). *Depressive symptoms among young adults*. Washington, DC: Child Trends.
- ⁴¹ Child Trends Data Bank. (2008b). *Neighborhood safety*. Washington, DC: Child Trends.
- ⁴² Child Trends Data Bank. (2008c). *Teen births*. Washington, DC: Child Trends.
- ⁴³ Child Trends Data Bank. (2008d). *Volunteering*. Washington, DC: Child Trends.
- ⁴⁴ Conklin, M. E., & Dailey, A.R. (1981). Does consistency of parental educational encouragement matter for secondary school students? *Sociology of Education*, 54, 254-262.
- ⁴⁵ Cook, R. (1991). *A national evaluation of Title IV-E foster care independent living programs for youth: Phase 2 final report*. Rockville, MD: Westat.
- ⁴⁶ Corporation for National and Community Service. (2005). Building active citizens: The role of social institutions in teen volunteering, brief 1. In *The youth helping America series*. Washington, DC: CNCS.
- ⁴⁷ Corrigan, N., Stewart, M., Scott, M., & Fee, F. (1996). Predictive value of preschool surveillance in detecting learning difficulties. *Archives of Disease in Childhood*, 74(6), 517-512.
- ⁴⁸ Courtney, M. E., & Piliavin, I. (1998). *Foster youths transition to adulthood: Outcomes 12 to 18 months after leaving out-of-home care*. Madison, WI: School of Social Work, University of Wisconsin-Madison.
- ⁴⁹ Crissey, S. (2006). Effect of pregnancy intention on child well-being and development: Combining retrospective reports of attitude and contraceptive use. *Population Research and Policy Review*, 24(6), 594-615.
- ⁵⁰ Crowther, J. H., & Chernyk, B. (1986). Bulimia and binge eating in adolescent females: A comparison. *Clinical Psychology Review*, 22, 833-874.
- ⁵¹ D'Angelo, D. V., Gilbert, B. C., Rochat, R. W., Santelli, J. S., & Herold, J. M. (2002). Differences between mistimed and unwanted pregnancies among women who have live births. *Perspectives on Sexual and Reproductive Health*, 36(5), 192-197.
- ⁵² David, H. P. (2006). Born unwanted, 35 years later: The Prague study. *Health Matters*, 14(27), 181-190.
- ⁵³ Dearlove, J., & Kearney, D. (1990). How good is general practice developmental screening? *British Medical Journal*, 300, 117-1180.
- ⁵⁴ Demo, D., & Cox, M. (2000). Families with young children: A review of research in the 1990s. *Journal of Marriage and the Family*, 62(4), 876-895.
- ⁵⁵ Department of Health and Human Services Administration on Children Youth and Families. (2009). *Child Maltreatment 2007*. Washington, DC: U.S. Government Printing Office.
- ⁵⁶ Department of Housing and Urban Development. (2007). *HUD Sets New Requirements to Prevent Childhood Lead Poisoning in Housing Assisted or Being Sold by the Federal Government* (Fact Sheet). Washington, DC: Department of Housing and Urban Development.
- ⁵⁷ Department of Housing and Urban Development. (2008). *American Housing Survey for the United States: 2007*. Washington, DC: Department of Housing and Urban Development.
- ⁵⁸ Department of Housing and Urban Development. (2008, October 1). Integrated Pest Management. Retrieved May 8, 2009, from <http://www.hud.gov/offices/lead/healthyhomes/ipm.cfm>

- ⁵⁹ Duckworth, K., & DeJung, J. (1989). Inhibiting class cutting among high school students. *The High School Journal*, 72, 188-195.
- ⁶⁰ Ednam, P., Holzer, H.J., & Offner, P. (2006). Improving financial incentives for low-wage work. In *Reconnecting disadvantaged young men* (pp. 11-36). Washington, DC: Urban Institute Press.
- ⁶¹ Entwisle, D. R., & Alexander, K.L. (1990). Beginning school math competence: Minority and majority comparisons. *Child Development*, 61(2), 454-471.
- ⁶² Entwisle, D. R., & Alexander, K. L. (1993). Entry into School: The Beginning School Transition and Educational Stratification in the United States. *Annual Review of Sociology*, 19, 401-423.
- ⁶³ Epstein, J. L., & Sheldon, S.B. (2002). Present and accounted for: Improving student attendance through family and community involvement. *Journal of Educational Research*, 95(5), 308-318.
- ⁶⁴ Federal Interagency Forum on Child and Family Statistics. (2006). *America's children: Key national indicators of well-being*. Washington, DC: Government Printing Office.
- ⁶⁵ Fiese, B. H., Tomcho, T.J., Douglas, M., Josephs, K., Poltrock, S., & Baker, T. (2002). A review of 50 years of research on naturally occurring family routines and rituals: Causes for celebration? *Journal of Family Psychology*, 16(4), 381-390.
- ⁶⁶ Finn, J. D., & Voelkl, K.E. (1993). School characteristics related to student engagement. *Journal of Negro Education*, 62, 249-268.
- ⁶⁷ Fletcher, A., Elder, G., & Mekos, D. (2000). Parental influences on adolescent involvement in community activities. *Journal of Research on Adolescence*, 10(1), 29-48.
- ⁶⁸ Gardner, M., & Brooks-Gunn, J. (2009). Adolescents' exposure to community violence: Are neighborhood youth organizations protective? *Journal of Community Psychology*, 37(4), 505-525.
- ⁶⁹ Goldschmidt, P., & Wang, J. (1999). When can schools affect dropout behavior? A longitudinal multilevel analysis. *American Research Journal*, 36(4), 715-738.
- ⁷⁰ Gomby, D. S., Larner, M. B., Stevenson, C. S., Lewit, E. M., & Behrman, R. E. (1995). Long term outcomes of early childhood programs: Analysis and recommendations. *Futures of Children*, 5, 6-24.
- ⁷¹ Green, D. P., Gerber, A.S., & Nickerson, D.W. (2003). Getting out the vote in local elections: Results from six door-to-door canvassing experiments. *Journal of Politics*, 65, 1083-1096.
- ⁷² Guralnick, M. J. (1997). *The Effectiveness of Early Intervention*. Baltimore, MD: Paul H. Brookes Publishing Co.
- ⁷³ Guterman, N. B. (2001). *Stopping Child Maltreatment Before It Starts: Emerging Horizons in Early Home Visitation Services*. Thousand Oaks, CA: Sage Publications.
- ⁷⁴ Haas, S. A., & Fosse, N.E. (2008). Health and the educational attainment of adolescents: Evidence from the NLSY97. *Journal of Health and Social Behavior*, 49(2), 178-192.
- ⁷⁵ Hack, M., Klein, N. K., & Taylor, H. G. (1995). Long-Term Developmental Outcomes of Low Birth Weight Infants. *The Future of Children*, 5, 176-196.
- ⁷⁶ Hair, E. C., Halle, T., Terry-Humen, E., & Calkins, J. (2003). Children's school readiness in the ECLS-K: Predictions to academic, health, and social outcomes in first grade. *Early Childhood Research Quarterly*, 21, 431-454.
- ⁷⁷ Hair, E. C., Halle, T., Terry-Humen, E., & Calkins, J. (2003, April). *Naturally Occurring Patterns of School Readiness: How the Multiple Dimensions of School Readiness Fit Together*.

Paper presented at the 2003 Biennial Meeting for the Society for Research in Child Development; Tampa, FL.

⁷⁸ Hair, E. C., Jager, J., & Garrett, S. (2002). *Background for community-level work on social competency in adolescents: Reviewing the literature on contributing factors*. Washington, DC: Child Trends.

⁷⁹ Hair, E. C., Moore, K. A., Garrett, S. B., Kinukawa, A., Lippman, L., & Michelson, E. (2005). The Parent-Adolescent Relationship Scale. In K. A. Moore & L. Lippman (Eds.), *What do children need to flourish?: Conceptualizing and measuring indicators of positive development*. New York, NY: Springer.

⁸⁰ Hair, E. C., Moore, K.A., Hadley, A.M., Kaye, K., Day, R.D., & Orthner, D.K. (2009). Parent marital quality and the parent-adolescent relationship: Effects on adolescent and young adult health outcomes. *Marriage & Family Review, 45*(2/3), 218-248.

⁸¹ Halle, T., Zaff, J., Calkins, J., & Margie, N. G. (2000). *Background for community-level work on school readiness: A review of definitions, assessments, and investment strategies. Part II: Reviewing the literature on contributing factors to school readiness*: Paper prepared for the John S. and James L. Knight Foundation.

⁸² Haveman, R., Wolfe, B., & Pence, K. (2001). Intergenerational effects of nonmarital and early childbearing. In L. L. Wu & B. Wolfe (Eds.), *Out of wedlock: Causes and consequences of nonmarital fertility*. New York: Russell Sage Foundation.

⁸³ Havemen, R., & Smeeding, T. (2006). The role of higher education in social mobility. *The Future of Children, 16*(2), 125-150.

⁸⁴ Heckman, J. J., & LaFontaine, P.A. (2006). Bias-corrected estimates of GED returns. *Journal of Labor Economics, 24*(3), 661-700.

⁸⁵ Hinshaw, S. P., & Lee, S.S. (2003). Conduct and oppositional defiant disorders. In E. J. Marsh & R. A. Barkley (Eds.), *Child Psychopathology* (pp. 144-198). New York, NY: Guilford Press.

⁸⁶ Huffman, L. C., Mehlinger, S. L., & Kerivan, A. S. (2000). Risk factors for academic and behavioral problems at the beginning of school. In *Off to a good start: Risk factors for academic and behavioral problems at the beginning of school and selected federal policies affecting children's social and emotional development and their readiness for school* (pp. 1-94). Chapel Hill, NC: University of North Carolina; FPG Child Development Center.

⁸⁷ Huffman, L. C., Mehlinger, S. L., & Kerivan, A. S. (2000). Risk factors for academic and behavioral problems at the beginning of school. In *A Good Beginning: Sending America's Children to School with the Social and Emotional Competence They Need to Succeed*. Bethesda, MD: The Child Mental Health Foundations and Agencies Network.

⁸⁸ Hummer, R., Hack, K. A., & Raley, R. K. (2004). Retrospective reports of pregnancy wantedness and child well-being in the United States. *Journal of Family Issues, 25*(3), 404-428.

⁸⁹ Hurth, J., Shaw, E., Izeman, S., Whaley, K., & Rogers, S. (1999). Areas of agreement about effective practices serving young children with autism spectrum disorders. *Infants and Young Children, 12*, 17-26.

⁹⁰ Ispa, J. M., Sable, M. R., Porter, N., & Csizmadia, A. (2007). Pregnancy acceptance, parenting stress, and toddler attachment in low-income black families. *Journal of Marriage and the Family, 69*(1), 1-13.

⁹¹ Johnston, L. D., Bachman, J.G., & O'Malley, P.M. (1999). *Monitoring the future: Questionnaire responses from the nation's high school seniors*. Ann Arbor, MI: University of Michigan Institute for Social Research.

- ⁹² Jordan, W. J., & Nettles, S.M. (1999). *How students invest their time out of school: Effects on school engagement, perceptions of life chances, and achievement*. Washington, DC: Center for Research on the Education of Students Placed At Risk.
- ⁹³ Joyce, T. J., Kaestner, R., & Korenman, S. (2000). The effect of pregnancy intention on child development. *Demography*, 37(1), 83-94.
- ⁹⁴ Kagan, S. L., Moore, E., & Bredekamp, S. (1995). *Reconsidering Children's Early Development and Learning: Toward Common Views and Vocabulary*. Washington, DC: National Education Goals Panel Goal 1 Technical Planning Group.
- ⁹⁵ Keeter, S., Zukin, C., Adnolina, M., & Jenkins, K. (2002). *The civic and political health of the nation: A generational portrait*. Report prepared for the Center for Information and Research on Civic Learning and Engagement.
- ⁹⁶ Korenman, S., Kaestner, R., & Joyce, T. (2001). Unintended pregnancy and the consequences of non-marital childbearing. In L. L. Wu & B. Wolfe (Eds.), *Out of wedlock: Causes and consequences of non-marital fertility*. New York: Russell Sage Foundation.
- ⁹⁷ Korenman, S., Kaestner, R., & Joyce, T. (2002). Consequences for infants of parental disagreement in pregnancy intention. *Perspectives on Sexual and Reproductive Health*, 34(4), 198-205.
- ⁹⁸ Kortenkamp, K., & Ehrle, J. (2002). The well-being of children involved with the child welfare system: A national overview. In *New Federalism, Series B, No. B-43*. Washington, DC: The Urban Institute.
- ⁹⁹ Kost, K., Landry, D. J., & Darroch, J. E. (1998). Predicting maternal behaviors during pregnancy: Does intention status matter? *Family Planning Perspectives*, 30(2), 79-88.
- ¹⁰⁰ Kurdek, L. A., & Sinclair, R. J. (2000). Psychological, family, and peer predictors of academic outcomes in first through fifth-grade children. *Journal of Educational Psychology*, 92(3), 449-457.
- ¹⁰¹ La Paro, K. M., & Pianta, R. C. (2000). Predicting children's competence in the early school years: A meta-analytic review. *Review of Educational Research*, 70(4), 443-484.
- ¹⁰² Laftman, S. B., & Ostberg, V. (2006). The pros and cons of social relations: An analysis of adolescents' health complaints. *Social Science & Medicine*, 63(3), 611-623.
- ¹⁰³ Last, C. G., Hersen, M., Kazdin, A.E., Finkelstein, R., & Strauss, C.C. (1987). Comparison of DSM-III separation anxiety and overanxious disorders: Demographic characteristics and patterns of comorbidity. *Journal of the American Academy of Child Psychiatry*, 26(4), 527-531.
- ¹⁰⁴ Lavigne, J. V., Binns, J. H., Christoffel, K. K., Rosenbaum, D., Arend, R., Smith, K., et al. (1993). Behavioral and emotional problems among preschool children in pediatric primary care: Prevalence and pediatricians' recognition. *Pediatrics*, 91, 649-655.
- ¹⁰⁵ Leroy, S. (2004). *Welfare and poverty: Family matters*: The Fraser Institute.
- ¹⁰⁶ Leventhal, T., & Brooks-Gunn, J. (2003). Children and youth in neighborhood contexts. *Current Directions in Psychological Science*, 12(1), 27-31.
- ¹⁰⁷ Levine, J. A., Pollack, H., & Comfort, M. E. (2001). Academic and behavioral outcomes among the children of young mothers. *Journal of Marriage and the Family*, 63(2), 355-369.
- ¹⁰⁸ Lewinsohn, P. M., Gotlib, I.H., & Seeley, J.R. (1997). Depression-related psychosocial variables: Are they specific to depression in adolescents? *Journal of Abnormal Psychology*, 106(3), 365-375.
- ¹⁰⁹ Loeb, R. C., Horst, L., & Horton, P. J. (1980). Family interaction patterns associated with self-esteem in preadolescent girls and boys. *Merrill-Palmer Quarterly*, 26(3), 205-217.

- ¹¹⁰ Ludwig, J. (1999). Information and inner city educational attainment. *Economics of Education Review, 18*, 17-30.
- ¹¹¹ MacDorman, M. F., & Atkinson, J. O. (1999). Infant Mortality Statistics From the 1997 Period Linked Birth/Infant Death Data Set. In *National Vital Statistics Reports* (Vol. 47). Hyattsville, MD: National Center for Health Statistics.
- ¹¹² Magnuson, K. A., Ruhm, C., & Waldfogel, J. (2004). *Does prekindergarten improve school preparation and performance?* Cambridge, MA: National Bureau of Economic Research.
- ¹¹³ Manlove, J. S., Terry-Humen, E., Mincieli, L. A., & Moore, K. A. (2008). Outcomes for Children of Teen Mothers from Kindergarten through Adolescence. In S. D. Hoffman & R. A. Maynard (Eds.), *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy* (2nd ed., pp. 460). Washington, DC: Urban Institute Press.
- ¹¹⁴ Marjoribanks, K. (1987). Ability and attitude correlates of academic achievement: Family-group differences. *Journal of Educational Psychology, 79*(2), 171-178.
- ¹¹⁵ Martin, J. A. (2002). Births: Final Data for 2000. In *National Vital Statistics Reports* (Vol. 52). Hyattsville, MD: National Center for Health Statistics.
- ¹¹⁶ Matas, L., Arend, R., & Sroufe, L.A. (1978). Continuity of adaptation in the second year: The relationship between quality of attachment and later competent functioning. *Child Development, 49*, 547-556.
- ¹¹⁷ Mather, M., Rivers, K. L., & Jacobsen, L. A. (2005). The American Community Survey. *Population Bulletin, 60*(3), 3-20.
- ¹¹⁸ Matthews, T. J., Menacker, F., & MacDorman, M. F. (2003). Infant Mortality Statistics from the 2001 Period: Linked Birth/Infant Death Data Set. In *National Vital Statistics Reports* (Vol. 52). Hyattsville, MD: National Center for Health Statistics.
- ¹¹⁹ McCluskey, C. P., Bynum, T. S., & Patchin, J. W. (2004). Reducing chronic absenteeism: An assessment of an early truancy initiative. *Crime & Delinquency, 50*(2), 214-234.
- ¹²⁰ McCluskey, C. P., Bynum, T.S., & Patchin, J.W. (2004). Reducing chronic absenteeism: An assessment of an early truancy initiative. *Crime & Delinquency, 50*(2), 214-234.
- ¹²¹ McDonald, C. C. M., & Richmond, T.R. (2008). The relationship between community violence exposure and mental health symptoms in urban adolescents. *Journal of Psychiatric and Mental Health Nursing, 15*(10), 833-849.
- ¹²² McLanahan, S., & Sandefur, G. (1994). *Growing up with a single parent: What hurts, what helps*. Cambridge: Harvard University Press.
- ¹²³ Miko, R., & Thompson, S. (2004). Pay the rent or feed the kids? Tough choices. *Women and Environments International Journal, 62/63*, 3.
- ¹²⁴ Moore, K. A., Morrison, D.R., & Greene, A.D. (1997). Effects on the children born to adolescent mothers. In R. A. Maynard (Ed.), *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*. Washington, DC: The Urban Institute.
- ¹²⁵ Moore, K. A., Redd, Z., Burkhauser, M., Mbwana, K., & Collins, A. (2009). *Children in poverty: Trends, consequences, and policy options*. Washington, DC: Child Trends.
- ¹²⁶ Murnane, R. J., Willett, J.B., & Levy, F. (1995). The growing importance of cognitive skills in wage determination. *The Review of Economics and Statistics, 77*(2), 251-266.
- ¹²⁷ Murnane, R. J., Willett, J.B., Braatz, M.J., & Duhaldeborde, Y. (2001). Do different dimensions of male high school students' skills predict labor market success a decade later? Evidence from the NLSY. *Economics of Education Review, 20*, 311-320.

- ¹²⁸ Myrhmam, A., Olsen, P., Rantakallio, P., & Laara, E. (1995). Does the wantedness of a pregnancy predict a child's educational attainment? *Family Planning Perspectives*, 27(3), 116-119.
- ¹²⁹ Nash, S. G., McQueen, A., & Bray, J.H. (2005). Pathways to adolescent alcohol use: Family environment, peer influence, and parental expectations. *Journal of Adolescent Health*, 37(1), 19-28.
- ¹³⁰ National Center for Education Statistics. (2002). *The condition of education 2002*. Washington, DC: U.S. Department of Education.
- ¹³¹ National Center for Education Statistics. (2003). *The nation's report card: Reading 2002*. Washington, DC: U.S. Department of Education.
- ¹³² National Center for Education Statistics. (2005). *The condition of education 2005: Indicator 8 children's skills and proficiency in reading and mathematics through grade 3*. Washington, DC: National Center for Education Statistics.
- ¹³³ National Center for Education Statistics. (2006a). *Digest of education statistics, 2006*. Washington, DC: U.S. Department of Education.
- ¹³⁴ National Center for Education Statistics. (2006b). *The condition of education 2006*. Washington, DC: U.S. Department of Education.
- ¹³⁵ National Center for Education Statistics. (2007). *National assessment of educational progress mathematics assessments (NAEP), 2007, 2005, 2003, 2000, 1996, 1992, and 1990 mathematics assessments*. Washington, DC: U.S. Department of Education.
- ¹³⁶ National Center on Addiction and Substance Abuse at Columbia University. (2003). *The importance of family dinners*. New York, NY: CASA.
- ¹³⁷ National Health Interview Survey. (1997). *Healthy People 2010*. Washington, DC: U.S. Department of Health and Human Services.
- ¹³⁸ National Institute of Mental Health. (2006). Depression.
- ¹³⁹ National Mental Health Information Center. (2006). Children and adolescents with anxiety disorders.
- ¹⁴⁰ National Research Council. (2001). Eager to learn: Educating our preschoolers. In B. T. Bowman, M. S. Donovan & M. S. Burns (Eds.). Washington, DC: National Academy Press.
- ¹⁴¹ National Research Council. (2001). Educating children with autism. In C. Lord & J. P. McGee (Eds.), *Committee on Educational Interventions for Children with Autism*. Washington, DC: National Academy Press, Division of Behavioral and Social Sciences and Education.
- ¹⁴² National Research Council & Institute of Medicine. (2000). From neurons to neighborhoods: The science of early childhood development. In J. P. Shonkoff & D. A. Phillips (Eds.). Washington, DC: National Academy Press.
- ¹⁴³ Ni Bhrolchain, C. M. (1994). Will deprived areas still need community pediatricians? An unpopular hypothesis. *Public Health*, 108(5), 319-326.
- ¹⁴⁴ Ogden, C., Carroll, M., Curtin, L., McDowell, M., Tabak, C., & Flegal, K. (2006). Prevalence of overweight and obesity in the United States, 1999-2004. *Journal of the American Medical Association*, 295(13), 1549-1555.
- ¹⁴⁵ Palfrey, J. S., Singer, J. D., Walker, D. K., & Butler, J. A. (1994). Early identification of children's special needs: A study in five metropolitan communities. *Journal of Pediatrics*, 111, 651-655.
- ¹⁴⁶ Parsons, J. E., Adler, T.F., & Kaczala, C.M. (1982). Socialization of achievement attitudes and beliefs: Parental influences. *Child Development*, 53(2), 310-322.

- ¹⁴⁷ Parving, A., & Salomon, G. (1996). The effect of neonatal universal hearing screening in a health surveillance perspective: A controlled study of two health authority districts. *Audiology*, 35(3), 158-168.
- ¹⁴⁸ Patterson, G. R. (1982). *Coercive family processes*. Eugene, OR: Castalia Press.
- ¹⁴⁹ Perkins, D., Brown, B., & Taylor, R. (1996). The ecology of empowerment: Predicting participation in community organizations. *Journal of Social Issues*, 52(1), 85-110.
- ¹⁵⁰ Public Law 108-446. Individuals With Disabilities Education Improvement Act of 2004.
- ¹⁵¹ Pulley, L. V., Klerman, L. V., Tang, H., & Baker, B. A. (2002). The extent of pregnancy mistiming and its association with maternal characteristics and pregnancy outcomes. *Perspectives on Sexual and Reproductive Health*, 34(4), 206-211.
- ¹⁵² Resnick, M., Bearman, P., Blum, R., Bauman, K., Harris, K. Jones, J., Beuhring, T., Sieving, R. E., Shew, M., Ireland, M., Bearinger, L. H., & Udry, J. R. (1997). Protecting adolescents from harm: Findings from the national longitudinal study on adolescent health. *Journal of the American Medical Association*, 278, 823-832.
- ¹⁵³ Reynolds, A. J., & Bezruczko, N. (1993). School adjustment of children at risk through fourth grade. *Merrill-Palmer Quarterly*, 39(4), 457-480.
- ¹⁵⁴ Roderick, M., Arney, M., Axelman, M., DaCosta, K., Steiger, C., Stone, S., Villarreal-Sosa, L., & Waxman, E. (1997). *Habits hard to break: A new look at truancy in Chicago's public high schools*. Chicago: School of Social Service Administration, University of Chicago.
- ¹⁵⁵ Rogers, S. (1996). Brief report: Early intervention in autism. *Journal of Autism and Developmental Disorders*, 26, 243-246.
- ¹⁵⁶ Rogers, S. (1999). Intervention for young children with autism: From research to practice. *Infants and Young Children*, 12, 1-16.
- ¹⁵⁷ Romero, M., & Young-Sun, L. (2007). *A national portrait of chronic absenteeism in the early grades*. New York, NY: The National Center for Children in Poverty.
- ¹⁵⁸ Rona, R. J., Allsop, M., Morris, R., & Morgan, M. (1989). Referral patterns after school medical examinations. *Archives of Diseases of Childhood*, 64, 829-833.
- ¹⁵⁹ Rosenbaum, J. E., & Person, A.E. (2003). Beyond college for all: Policies and practices to improve transitions into college and jobs. *Professional School Counseling*, 6(4), 252-260.
- ¹⁶⁰ Ross, C. E., & Wu, C. (1995). The links between education and health. *American Sociology Review*, 60, 719-745.
- ¹⁶¹ Rouse, C., Brooks-Gunn, J., & McLanahan, S. (2005). Introducing the Issue. In *School Readiness: Closing Racial and Ethnic Gaps* (Vol. 15): Future of Children.
- ¹⁶² Sampson, R. J., & Groves, W. B. (1989). Community structure and crime: Testing social-disorganization theory. *American Journal of Sociology*, 94(4), 774-802.
- ¹⁶³ Santelli, J. S., Rochat, R., Hatfield-Timajchy, K., Gilbert, B., Curtis, K., Cabral, R., et al. (2003). The measurement and meaning of unintended pregnancy. *Perspectives on Sexual and Reproductive Health*, 35(2), 94-101.
- ¹⁶⁴ Schraedley, P. K., Gotlib, I.H., & Hayward, C. (1999). Gender differences in correlates of depressive symptoms in adolescents. *Journal of Adolescent Health*, 25(2), 98-108.
- ¹⁶⁵ Shapiro-Mendoza, C., Selwyn, B. J., Smith, D. P., & Sanderson, M. (2005). Parental pregnancy intention and early childhood stunting. *International Journal of Epidemiology*, 34(2), 387-396.
- ¹⁶⁶ Sheldon, S. B., & Epstein, J.L. (2004). Getting students to school: Using family and community involvement to reduce chronic absenteeism. *The School Community Journal*, 14(2), 39-56.

- ¹⁶⁷ Simpson, R. (1999). Early intervention with children with autism: The search for best practices. *The Journal of the Association for Persons with Severe Handicaps*, 24, 218-221.
- ¹⁶⁸ Snow, C. E., Burns, M. S., & Griffin, P. (Eds.). (1998). *Preventing reading difficulties in young children*. Washington, DC: National Academy Press.
- ¹⁶⁹ Sroufe, L. A., Fox, N., & Pancake, V. (1983). Attachment and dependency in developmental perspective. *Child Development*, 54(6), 1615-1627.
- ¹⁷⁰ Stark, R. (1987). Deviant places: a theory of the ecology of crime. *Criminology*, 25(4), 893-909.
- ¹⁷¹ Strauss, C. C. (1988). Social deficits of children with internalizing disorders. In B. B. L. A. E. Kazdin (Ed.), *Advances in Clinical Child Psychology (Vol. 11)*. New York, NY: Plenum Press.
- ¹⁷² Sulzby, E., & Teal, W. (1991). Emergent Literacy. In R. Barr, M. Kamil, P. Mosenthal & P. Pearson (Eds.), *Handbook of Reading Research (Vol. II, pp. 727-758)*. New York: NY: Longman.
- ¹⁷³ Sutherland, E. (1949). *White Collar Crime*. New York, NY: Dryden Press.
- ¹⁷⁴ Terry-Humen, E., Manlove, J. S., & Moore, K. A. (2001). Births outside of marriage: Perceptions vs. reality. In *Child Trends Research Brief*. Washington, DC: Child Trends.
- ¹⁷⁵ The National Marriage Project. (2004). *Ten important findings on marriage and choosing a marriage partner - helpful facts for young adults*.
- ¹⁷⁶ The Urban Institute. (2006). *Parents and children facing a world of risk: Next steps towards a working family agenda*. Washington, DC: The Urban Institute.
- ¹⁷⁷ Thomas, D., Leicht, C., Hughes, C., Madigan, A., & Dowell, K. (2003). Emerging Practice in the Prevention of Child Abuse and Neglect. National Clearinghouse on Child Abuse and Neglect Information. Retrieved May 27, 2009, from <http://www.childwelfare.gov/preventing/programs/whatworks/report/index.cfm>
- ¹⁷⁸ Tjaden, P., & Thoennes, N. (2000). Full report of the prevalence, incidence, and consequences of violence against women: findings from the National Violence Against Women Survey [Electronic Version] from <http://www.ojp.usdoj.gov/nij/pubs-sum/183781.htm>
- ¹⁷⁹ U.S. Council of Economic Advisors. (2000).
- ¹⁸⁰ U.S. Department of Health and Human Services. (2008). *Data for 1990-1997 for total foster children per 1,000 children ages 17 and under: Trends in the well-being of America's children and youth 1999*. Washington, DC: U.S. Department of Health and Human Services.
- ¹⁸¹ Urban Institute. (2009). National Neighborhood Indicators Partnership. Retrieved October, 7, 2009, from <http://www2.urban.org/nnip/>
- ¹⁸² Vandivere, S., Chalk, R., & Moore, K.A. (2003). Children in foster homes: How are they faring? In *Child Trends Research Brief*. Washington, DC: Child Trends.
- ¹⁸³ Ventura, S. J., Martin, J.A., Curtin, S.C., Menacker, F., & Hamilton, B.E. (1999). Births: Final data for 1999. In *National Vital Statistics Reports vol. 49(1)*. Hyattsville, MD: National Center for Health Statistics.
- ¹⁸⁴ Walters, E., Wippman, J., & Sroufe, L.A. (1979). Attachment, positive affect, and competence in the peer group: Two studies in construct validation. *Child Development*, 50(3), 821-829.
- ¹⁸⁵ Whitehurst, G. J., & Lonigan, C. J. (2002). Emergent literacy: Development from prereaders to readers. In S. B. Neuman & D. K. Dickinson (Eds.), *Handbook of early literacy research* (pp. 11-29). New York: Guilford.
- ¹⁸⁶ Wilkenfeld, B., Lippman, L., & Moore, K. A. (2007). *Neighborhood support index*. Washington, DC: Child Trends.

- ¹⁸⁷ Wilkenfeld, B., Moore, K. A., & Lippman, L. (2008). *Neighborhood support and children's connectedness*. Washington, DC: Child Trends.
- ¹⁸⁸ Woods, J., & Wetherby, A. (2003). Intervention for infants and toddlers who are at risk for autism spectrum disorders. *Language, Speech, and Hearing Services in Schools, 34*, 180-193.
- ¹⁸⁹ Yoshinaga-Itano, C., Sedey, A. L., Coulter, D. K., & Mehl, A. L. (1998). Language of early and later identified children with hearing loss. *Pediatrics, 102*, 1161-1171.
- ¹⁹⁰ Youniss, J., McLellan, J., Su, Y., & Yates, M. (1999). The role of community service in identity development. *Journal of Adolescent Research, 14*(2), 248-261.
- ¹⁹¹ Zaff, J. F., Malanchuk, O., & Eccles, J.S. (2008). Predicting positive citizenship from adolescence to young adulthood: The effects of a civic context. *Applied Developmental Science, 12*(1), 38-53.
- ¹⁹² Zaslow, M., Calkins, J., & Halle, T. (2000). *Background for Community-Level Work on School Readiness: A Review of Definitions, Assessments, and Investment Strategies. Part I: Defining and Assessing School Readiness - Building on the Foundation of NEGP Work*. Washington, DC: Child Trends.
- ¹⁹³ Zuravin, S. J. (1991). Unplanned childbearing and family size: Their relationship to child neglect and abuse. *Family Planning Perspectives, 23*(4), 155-161.

Appendix A: Individual Data Sources

Individual Data Sources: Summary Content

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Socio-Demographic Surveys and Administrative Data

American Community Survey (ACS)

Description: The ACS provides annual estimates of demographic, housing, social, and economic characteristics for all states, as well as for all cities, counties, metropolitan areas, and communities of 65,000 people or more. For communities with between 65,000 and 20,000 people, three-year-averaged data are reported; for communities with populations less than 20,000, five-year-averaged data will be available beginning in 2010.

Periodicity: Annual

Coverage: All 50 states, the District of Columbia, and Puerto Rico (Puerto Rico data available for 2005 only)

Sample Size: 2,000,000 households annually.

Age Groups: 0-17, 18 and above

Respondent: Householder

Sponsors: U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau

Web site: <http://www.census.gov/acs/www/>

Limitations: Provides few direct measures of well-being. For communities with less than 65,000 population, multi-year data only are available, providing estimates that are less responsive to short-term changes.

CHILD CHARACTERISTICS

Health

Long-lasting health conditions (ages 5 and older); difficulty functioning due to health conditions (ages 5 and older); births (female, age 15 and older).

Education/Intellectual Development

School enrollment; highest level of education completed; current grade in school; public/private school.

Social/Emotional/Civic Well-Being

Demographics

Age; sex; race; citizenship; Hispanic origin; receipt of Food Stamps; language spoken at home; employment; total income; wage/salary income.

CONTEXTUAL INFLUENCES

Family

Family structure; number of people in household; marital status; race; Hispanic origin; housing type and amenities; citizenship; highest level of education completed; English proficiency; military service; employment; commute time to work; on layoff; seeking employment; number of weeks worked; type of employment; total income; wage/salary income; Social Security income; Supplemental Social Security income; public assistance income.

Peers

School

Community

American Housing Survey (AHS)

Description: The American Housing Survey collects data every year on the quality of housing in the United States. It is comprised of two surveys. The national survey is collected on odd-numbered years and the metropolitan survey is collected as the budget allows, mostly every other year.

Periodicity: Every other year.

Coverage: All 50 states and the District of Columbia. For 2009, the metropolitan survey will include five metropolitan areas: Chicago, Detroit, New York, Northern New Jersey, and Philadelphia. Seattle and New Orleans will also be included.

Sample Size: The national survey collects data on 60,000 housing units every other year.

Age Groups: 0-17, 18 and older

Respondent: Household head

Sponsors: U.S. Census Bureau

Web site: <http://www.census.gov/hhes/www/housing/ahs/ahs.html>

Limitations: The metropolitan survey changes often, mostly in response to the Department of Housing and Urban Development's budget. Not all cities are included, only those with a population of at least 100,000 individuals. There is only one variable (age) directly about the child. Other variables are contextual.

CHILD CHARACTERISTICS

Health

Education/Intellectual Development

Social/Emotional/Civic Well-Being

Demographics

Age

CONTEXTUAL INFLUENCES

Family

Income, Age, Sex, Citizenship, Family Structure, Marital Status, Persons per Bedroom, Poverty Status, Race of Household Head, Square Feet Per Person, Worked at Home Last Week, Commute to Work

Peers

School

Community

Quality, Safety

Census Small Area Income and Poverty Estimates (SAIPE)

Description: The SAIPE program provides estimates of selected income and poverty statistics in years that the decennial census is not administered. Estimates encompass all states and counties, including the total number of people in poverty under age 18 and the number of “related children” ages 5 to 17 living in poor families. Poverty estimates are also available for related children ages 5 to 17 for all school districts.

Periodicity: State and county estimates, yearly since 1995; school district estimates, yearly since 1999

Coverage: All 50 states and the District of Columbia; counties; school districts

Sample Size: N/A

Age Groups: 0-17, 18 and above

Respondent: N/A

Sponsors: U.S. Census Bureau

Web site: <http://www.census.gov/hhes/www/saipe/index.html>

Limitations: Poverty estimates are useful but often not very precise at the county or district level, especially for sparsely populated areas. Estimates at the state level are considerably more precise.

CHILD CHARACTERISTICS

Health

Education/Intellectual Development

Social/Emotional/Civic Well-Being

Demographics

CONTEXTUAL INFLUENCES

Family

Peers

School

School enrollment numbers; grade ranges of schools; related children ages 5-17 in poverty.

Community

All people in poverty; children under age 18 in poverty; related children ages 5-17 in poverty; median household income.

Current Population Survey (CPS)

Description: The CPS is the primary source of information on the labor force characteristics of the U.S. population. The sample is scientifically selected to represent the civilian noninstitutional population. Respondents are interviewed to obtain information about the employment status of each member of the household 15 years of age and older. Estimates obtained from the CPS include employment, unemployment, earnings, hours of work, and other indicators. They are available by a variety of demographic characteristics including age, sex, race, marital status, and educational attainment. They are also available by occupation, industry, and class of worker. Supplemental questions to produce estimates on a variety of topics including school enrollment, income, previous work experience, health, employee benefits, and work schedules are also often added to the regular CPS questionnaire.

Periodicity: Annual

Coverage: All 50 states and the District of Columbia, but state-representative data are not available.

Sample Size: Approximately 72,000 households nationally

Age Groups: 0-17 (labor-related information on ages 15 and older)

Respondent: Household members

Sponsors: Bureau of Labor Statistics, U.S. Census Bureau

Web site: <http://www.bls.gov/cps/>

Limitations: Does not include many measures of child well-being.

Note: The list of measures below is based on the March annual demographic file.

CHILD CHARACTERISTICS

Health

Disability benefits; health insurance coverage, whether covered by state's CHIP.

Education/Intellectual Development

Current school enrollment; highest grade completed.

Social/Emotional/Civic Well-Being

Demographics

Age; race; Hispanic origin; nativity status; sex; paid child care.

CONTEXTUAL INFLUENCES

Family

Age; marital status; race; Hispanic origin; country of birth; citizenship; number of people in household; number of families in household; type of family; number of children under age 18; number of children under age 6; parents present in household; type of housing unit; public housing; telephone in household; child support payments; child support income; disability income; public assistance income/benefits; Social Security benefits; Supplemental Social Security benefits; unemployment compensation; total household income; receipt of Food Stamps; WIC benefits; free/reduced lunch; hot lunch in school; occupation; type of employment; fulltime employment; highest level of education attained; hours worked per week; high school/college enrollment; adjusted gross income; searching for employment.

Decennial Census

Description: The Decennial Census collects data every 10 years about households, income, education, homeownership, and more for the United States, Puerto Rico, and its territories. The data are used for a wide variety of purposes including: reapportionment of the seats in the House of Representatives; distribution of funds for government programs such as Medicaid; planning the right locations for schools, roads, and other public facilities; helping real estate agents and potential residents learn about a neighborhood; and identifying trends over time that can help predict future needs.

Periodicity: Every 10 years (last in 2000)

Coverage: All 50 states and the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Northern Marianas.

Sample Size: In 2000, population of 281,421,906 nationally. About 1 in 6 households are selected to answer the long form questionnaire, from which most of the data are collected.

Age Groups: 0-17, 18 and older

Respondent: Household head

Sponsors: U.S. Census Bureau

Web site: <http://www.census.gov>

Limitations: Only conducted every 10 years; few direct measures of well-being. In 2010, the long-form of the Census will be replaced by the American Community Survey and only the short-form will be administered to the population.

Note: Those measures that are included on the short-form are starred (*) below.

CHILD CHARACTERISTICS

Health

Long-lasting health conditions; difficulty functioning due to health conditions.

Education/Intellectual Development

School enrollment; public/private school; current grade level; highest level of education completed.

Social/Emotional/Civic Well-Being

Demographics

*Sex; *age; *Hispanic origin; *race; *relation to head of household; marital status; language spoken at home; English proficiency; citizenship; employment (age 16 and up); commute time (age 16 and up); type of employment (age 16 and up); hours/weeks worked (age 16 and up); total income (age 16 and up); wage/salary income (age 16 and up); public assistance income (age 16 and up).

CONTEXTUAL INFLUENCES

Family

* Sex; * age; * Hispanic origin; * race; *relation to head of household; marital status; language spoken at home; English proficiency; highest level of education completed; citizenship; long-lasting health conditions; difficulty functioning due to health conditions; grandchildren living at home; military service; employment; commute time to work; on layoff; seeking employment; type of employment; hours/weeks worked; wage/salary income; Social Security income; Supplemental Social Security income; public assistance income; retirement income; total income.

National Vital Statistics: Birth Data

Description: Federal law mandates that vital statistics be collected and made available at the state and national level. The National Vital Statistics System, with the collaboration of the individual States, is responsible for improving the quality, uniformity and availability of these vital statistics. Although multiple records are assessed, the birth data provide critical information based on registered live births in the United States. Data are based on the standard certificate of a live birth and include information on the child's health status, family demographic information, as well as maternal health and behavior during pregnancy and birth. Vital statistics help identify various health and social issues facing the U.S. population, allow trends to be tracked over time and permit comparisons among various populations.

Periodicity: Continuous, 1933*- Present

Coverage: All 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Northern Marianas

Sample Size: U.S. (excluding territories): Approximately 4.1 million reported births per year; 4.3 million were reported in 2007. State birth numbers range from approximately 6,200 (VT) to approximately 570,000 births (CA) in 2007 (data for 2007 are still preliminary).

Age Groups: Newborns

Respondent: Parent report; hospital staff report

Sponsors: National Center for Health Statistics and the Vital Statistics Cooperative Program, Centers for Disease Control and Prevention

Web site: <http://www.cdc.gov/nchs/births.htm>

Limitations: The U.S. Standard Certificate of Live Birth was revised in 2003. As of 2007, 24 states (CA, CO, DE, FL, GA, ID, IN, IA, KS, KY, MI, NE, ND, NH, NY, OH, PA, SC, SD, TN, TX, VT, WA, WY) have implemented the revised birth certificate. The remaining 37 states, New York City, and the District of Columbia collected and reported data based on the previous version of the Standard Certificate. As a result, not all measures are comparable across states. The Vital Statistics System also uses data from the U.S. Census Bureau, used for denominators, to calculate population estimates. Currently, states that have not yet implemented the revised Certificate of Live Birth collect racial birth certificate data that are incompatible with current U.S. Census data racial categories. As a result, some birth rate estimations by race are subject to error. This is particularly the case for smaller population groups.

Note: *Although data were collected previously, 1933 is considered the earliest year when accurate and complete registration of births and deaths are available for the U.S. (with the exception of AK, HI).

CHILD CHARACTERISTICS

Health

Premature birth; labor & delivery characteristics; birth weight; healthy at birth; abnormal conditions and congenital anomalies at birth; plurality of birth; infant death; breastfeeding.

Education/Intellectual Development

Social/Emotional/Civic Well-Being

Demographics

Age; gender; geographic location of birth.

CONTEXTUAL INFLUENCES

Family

Parental age; maternal geographic location (birth & current); paternal geographic location of birth; maternal urban/rural marker; marital status of mother; parental educational level; parental race and Hispanic origin; WIC receipt; maternal previous birth history/outcomes; parity; maternal prenatal care; maternal height and prenatal weight; maternal smoking; maternal prenatal risk factors and health status; maternal morbidity.

Peers

School

Community

Health and Safety Data Sources

Survey of Children with Special Health Care Needs (CSHCN)

Description: The CSHCN collects information of the prevalence of special health care needs of children and their families, and its effects on their lives. The survey covers child health status, access to medical care, health insurance coverage, coordination of care, and impact and involvement of the family in the child's health care.

Periodicity: 2000-2002, 2005-2006

Coverage: All 50 states and the District of Columbia

Sample Size: 850 children with special health care needs in each state; 5,000 without special health care needs nationally.

Age Groups: 0-17

Respondent: Parent or guardian knowledgeable about child's health care needs

Sponsors: Maternal and Child Health Bureau of the Health Resources and Services Administration and Office of the Assistant Secretary for Planning and Evaluation of the Department of the Department of Health and Human Services

Web site: <http://cshcndata.org/Content/Default.aspx>

Limitations: Rates of uninsurance in the CSHCH are lower than other national surveys, which may be due to question design differences.

Note: Measures in bold are those asked of all children (children with special health care needs and those without). Measures not in bold are asked only about children with special health care needs. The 2000-2002 version of this survey included over 2700 children without special health care needs in each state in order to estimate state-level health care coverage.

CHILD CHARACTERISTICS

Health

Immunizations; medications (currently need or use); condition requiring prescription medication; condition requiring medical care, or mental health or education services; limited or prevented from doing same things as peers; special therapy such as OT, PT, speech, treatment or counseling; condition expected to last 12 months or longer; need or use more medical care or services than peers. In past year... how often condition affects ability to do things like peers; extent condition affects ability to do things like peers; stability of health care needs; severity of difficulties caused by health problems.

Specific health difficulties: eyeglasses or contacts; hearing aids; respiratory problems; difficulty swallowing, digesting food, or metabolism; blood circulation; repeated or chronic physical pain; difficulty with self-care, coordination or moving around (using hands for newborns); asthma; diabetes (use insulin); heart problem; blood problems; cystic fibrosis; cerebral palsy; muscular dystrophy; epilepsy or other seizure disorder; migraine or frequent headaches; arthritis or joint problems; allergies. Use of health services: routine preventative care; care from specialty doctor; preventative dental care; prescription medications; physical, occupational, or speech therapy; mental health care or counseling; substance abuse treatment or counseling; home health care; eyeglasses or vision care; hearing aid or hearing care; mobility aids or devices; communication aids or devices; medical supplies; durable medical equipment; Early Intervention Services; Special Education Services; number of emergency room visits in past year; number of times hospitalized in last year; usual source of health care when sick or need health advice (specify

type); usual source of routine preventative care; has a personal doctor, nurse, etc (specify); ever have delay or not receive health care (list reason – no transportation, no insurance, language barrier, etc.); referrals (need one in past year, difficulty getting one); support/satisfaction with support for coordinating child’s care. How often doctors...spend enough time with child; listen to you; are sensitive to your family’s values and customs; give you specific info needed; feel like a partner in your child’s care. Doctor talks about transition to care as adult, would this be helpful; discusses healthcare of child as adult; encourages child to take responsibility for his or her health care needs. Difficulties in trying to use services (reasons, satisfaction); health insurance type/source of coverage; coverage status in past year; extent of coverage.

Education/Intellectual Development

Difficulty with learning, understanding, or paying attention; difficulty with speaking, communication or being understood; ADD; autism or ASD; Down Syndrome; mental retardation or developmental delay.

Social/Emotional/Civic Well-Being

Specific difficulties with: feeling anxious or depressed; behavior problems; making and keeping friends; depression or other emotional problems.

Demographics

Age; age of siblings; gender; race/ethnicity.

Family

Provide care at home for child (hrs/week); time spent coordinating care (hrs/wk); financial burden of child’s health problem; family member stopped working or cut down on work to care for child; additional income needed to pay for medical expenses; use of respite care, genetic counseling, or mental health care or counseling; use/availability of interpreter to speak with doctors or health care providers; how much paid out of pocket for child’s health care in past year; ; highest level of education of anyone in household; primary language spoken in household; respondent’s relationship to child; number of people in household; other parent living in household; adopted (U.S. or foreign, child in foster care first); household income; SSI receipt; cash assistance from state or county welfare agency

CONTEXTUAL CHARACTERISTICS

Peers

School

Community

National Survey of Children's Health (NSCH)

Description: The survey was designed to produce national and state-specific estimates for various physical, emotional, and behavioral health indicators for children. It includes measures of children's experiences in the health care system and questions about the family and respondent perceptions of the child's neighborhood. The telephone administered survey was conducted under the direction of the National Center for Health Statistics.

Periodicity: 2003, 2007; expected to be fielded every four years

Coverage: All 50 states and the District of Columbia

Sample Size: 102,353 interviews completed with approximately 2,000 completed interviews per state and the District of Columbia in 2003. In 2007, there were approximately 91,000 interviews, with about 1,800 per state.

Age Groups: 0-17 years

Respondent: Parent or guardian who lives in household and knows the most about the health and health care of the child

Sponsors: Primary funding provided by: the Maternal and Child Health Bureau, Health Resources and Services Administration, with additional support from the Center for Disease Control's National Center for Infectious Diseases using funds provided by the National Vaccine Program Office.

Web site: <http://www.cdc.gov/nchs/about/major/slaits/nsch.htm>

Limitations: The NSCH is based entirely on parent-reported data and data are limited by the amount of information a parent respondent can report. The phone interview format excludes families who do not live in homes with land lines (attempts are made to correct for this in the weighting process). Children living in institutional settings are not included. Educational measures are limited.

CHILD CHARACTERISTICS

Health

Overall child health status; functional limitations; height; weight; underweight/overweight; dental health; child injury; developmental delays; chronic illness/disability; frequent illness; health-related behaviors (physical activity/exercise, nutrition, adequate sleep); hearing/vision problems; asthma; breastfeeding; parental concerns about eating disorder and substance use.

Health care receipt and coverage:

Health care coverage (public or private) and consistency; S-CHIP coverage; preventive health care (medical and dental); childhood immunization (hepatitis A); hospitalization due to accident or injury; prescription medication; use of special health care services or equipment; medical home.

Education/Intellectual Development

Parental and health professional concerns about child's learning, development, and behavior; types of child care (e.g. child care center, family-based child care, nanny or relative care in home, nursery school, preschool or kindergarten, Head Start or Early Start program); child care burden on parents; school enrollment (public, private, or home school); problems (behavioral or academic) in school; grade repetition/behind for age; school engagement; reads for pleasure; television/video game/computer time.

Social/Emotional/Civic Well-Being

Problem behaviors; positive and negative social competence; internalizing behaviors (sad, unhappy or depressed); after-school/extracurricular activities (sports, clubs or organizations, volunteer, work for pay); religious attendance; emotional well-being.

Demographics

Race and Hispanic origin; age; gender; language spoken in home; family structure; immigrant status; parental employment status; highest household educational attainment; family income; poverty status; children in foster care; TANF receipt; food stamps receipt; free/reduced lunch receipt; WIC receipt; child care subsidy receipt; state or residence; residential turbulence.

Family

Family outings and activities; meals together; parent/guardian-child communication; parent/guardian-child relationship; parental/guardian concerns of raising child; conflict resolution; monitoring/limit-setting/supervision/rules (media); child is read stories.

Parental Health:

General parental health (physical and mental); parent physical activity; parent health care coverage (public or private); household tobacco use; parental aggravation; parental sense of social support.

Peers

Reported bullying.

School

Perceived school safety; school type.

Community

Neighborhood cohesion/trust; perceived safety of child in neighborhood; level of support in neighborhood; level of negative influences in neighborhood; perceived home safety.

Youth Risk Behavior Surveillance System (YRBSS)

Description: This survey is designed to monitor major health risk behaviors in six broad areas: tobacco use; dietary behaviors; physical activity; alcohol and other drug use; behaviors related to injury and violence; and sexual behaviors contributing to unintended pregnancy and STDs. It is used, among other purposes, to monitor progress towards meeting Healthy People goals in reducing negative youth health behaviors and their consequences.

Periodicity: Grades 9-12: Bi-annual, 1990-2009. Grades 6-8: 2005.

Coverage: In 2007, 44 states and 22 major cities and localities (including the District of Columbia), as well as Puerto Rico, the Virgin Islands, American Samoa, Guam, the Marshall Islands, the Northern Marianas, and Palau (territory data are available for selected years only). The following states did not participate in the state surveys: AL, CA, CO, LA, MN, PA, VA, WA

Sample Size: 13,953 national sample in grades 9-12 (2005). State samples vary.

Age Groups: Grades 9-12 and Grades 6-8 (2005 only)

Respondent: Youth report

Sponsors: Division of Adolescent and School Health, Centers for Disease Control and Prevention

Web site: <http://www.cdc.gov/HealthyYouth/yrbs/index.htm>

Limitations: YRBS does not cover all states, and not all states have achieved representative samples. It also does not include dropouts. Some states exclude certain measures that they deem inappropriate or too sensitive.

PERSONAL CHARACTERISTICS

Health and Safety

General health; overweight; safety equipment use (bicycle helmets, safety belts); binge drinking; marijuana; other illicit drugs (by type); tobacco use; steroid use; driving and drinking; weapons; felt unsafe; been threatened; fighting; dating violence; rape; sexual activity (ever had; current activity; use of birth control; drugs prior to sex); dietary behaviors; nutrition; vigorous physical activity; P.E. classes; sports teams; ever taught about HIV/AIDS in school; asthma.

Education/Intellectual Development

Social/Emotional/Civic Well-Being

Sad/hopeless; suicide ideation and attempts.

Demographics

Age; grade; race; gender.

Education

Common Core of Data (CCD)

Description: The CCD is the Department of Education's primary database on public elementary and secondary education in the United States. CCD is a comprehensive, annual, national statistical database of all public elementary and secondary schools and school districts, which contains data that are designed to be comparable across all states. The CCD survey collects data about all public elementary and secondary schools, all local education agencies, and all state education agencies throughout the United States. CCD contains three categories of information: general descriptive information on schools and school districts; data on students and staff; and fiscal data. The general descriptive information includes name, address, phone number, and type of locale; the data on students and staff include selected demographic characteristics; and the fiscal data cover revenues and current expenditures. CCD is made up of a set of five surveys sent to state education departments. Most of the data are obtained from administrative records maintained by the state education agencies (SEAs). The SEAs compile CCD requested data into prescribed formats and transmit the information to NCES.

Periodicity: Annually.

Coverage: Approximately 97,000 elementary and secondary schools, approximately 18,000 public school districts, all 50 states, the District of Columbia the Department of Defense Education Schools, and the outlying areas.

Sample Size: Universe.

Age Groups: Elementary and secondary schools

Respondent: Administrative records, submitted by state education departments.

Sponsors: National Center for Education Statistics, U.S. Department of Education

Web site: <http://nces.ed.gov/ccd/index.asp>

Limitations: Assessment does not include private- or home-schooled children.

CHILD CHARACTERISTICS

Health

Education/Intellectual Development

Number of high school graduates and completers in the previous year.

Social/Emotional/Civic Well-Being

Demographics

Race/ethnicity (for selected states; size of school district and region of the country).

CONTEXTUAL INFLUENCES

Family

Peers

School

Teacher:

School:

Pupil/teacher ratio; percent of free-lunch eligible students (selected states).

Community

National Assessment of Educational Progress (NAEP)

Description: The NAEP assessments test subject-area achievement of American students in the 4th and 8th grade in reading, mathematics, science, and writing at the state-level. NAEP also gathers background information on students, teachers, and schools in order to provide a context for student achievement and to meet federal reporting requirements. Demographic subgroup breaks such as race, gender, and parental education are also available.

Periodicity: Every two years for 4th and 8th grade students at the state level. State-level estimates were first collected in 1990.

Coverage: In 2005, all 50 states, the District of Columbia and the Department of Defense Education Activity (DoDEA) participated. Data were also collected for a third trial assessment of 10 urban school districts: Atlanta, Austin, Boston, Charlotte, Chicago, Cleveland, Houston, Los Angeles, New York City, and San Diego. Data by select years were available for Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Northern Marianas.

Sample Size: In 2005, 163,000 4th grade students and 152,800 8th grade students were assessed in mathematics. An average of 2,500 students is sampled from each state. In 2005, state samples for mathematics for 4th grade ranged from 1,800 in Wyoming to 10,700 in California.

Age Groups: 4th and 8th grade

Respondent: Student; teacher; principal or head of school

Sponsors: National Center for Education Statistics, U.S. Department of Education

Web site: <http://nces.ed.gov/nationsreportcard/>

Limitations: Assessment does not include home schooled children. The background questionnaire does not include questions on family structure or poverty. State assessments of mathematics and reading are mandated by federal law, but assessing other subjects is voluntary.

Notes: **This review is based largely on 2005 mathematics questionnaires.** The NAEP *national* assessment also includes 12th grade students, and additional subject areas, such as civics and U.S. history. State assessments are identical to those given nationally.

CHILD CHARACTERISTICS

Health

Education/Intellectual Development

Reading, mathematics, and science proficiency; type of math class currently taking/expected to take next year; pages read per day for school or homework; days absent in past month; how often uses computer for math at school (by specific activity); calculator use (how, type); difficulty/effort/importance of doing well on NAEP math assessment.

8th grade: Time spent on computer doing work for math class; how often use the specific computer programs for math homework; use of computer to learn math in after school programs (8th only), computer use when doing math work; play math computer games in math class (8th only)/outside of math class; use of calculators in class/outside of class (basic, scientific, graphing); use calculator to check work, calculate answers to homework, use for classwork during lesson, for quizzes and test.

Social/Emotional/Civic Well-Being

Demographics

Race/ethnicity; non-English language spoken in home; mother/father highest level of education.

CONTEXTUAL INFLUENCES

Family

Receives newspaper at least 4 times a week; receives magazines regularly; number of books in home; home computer, encyclopedia in home; talks about school with family.

Peers

School

Teacher:

Race/ethnicity; number of years teaching at elementary or secondary level; current certification from another state; highest academic degree; math-related subject or education (4th includes other subjects); computer available for teacher and student; how often students use computer for various activities; extent students are permitted to use calculators; kinds they usually use; who sets calculator policy at school; how often students use calculators for various activities.

School:

Grades taught; type of school; participation in National School Lunch Program; how NSLP eligibility is determined; percentage of students eligible; percentage of students who receive targeted Title I services; gifted and talented program; instruction provided in student's home language; ESL; special education.

4th grade: time each day required to spend on math; grouped by ability; placements evaluation; placement specialist. 8th grade: percentage of students who enroll in more than one math class a year for remediation/advancement; percentage of students enrolled in various math classes; are students assigned to classes by ability; percentage of students who transfer levels in 9th grade.

Community

Schools and Staffing Survey (SASS)

Description: SASS is a national survey of primary and secondary schools (both public and private) which asks teachers, administrators, and school districts about the environment within their schools. Many survey questions are repeated in each survey cycle, allowing the investigation of trends over time. SASS has four main components: the School Questionnaire, the Teacher Questionnaire, the Principal Questionnaire, and the School District Questionnaire. SASS emphasizes teacher demand and shortage; staffing patterns; teacher recruitment and hiring practices; types of programs and services offered; school-level student, teacher, and administrator characteristics; and general conditions in schools. SASS also collects data on many other topics, including principals' and teachers' perceptions of school climate and problems in their schools; teacher compensation; certification; workload, perceptions and attitudes about teaching; and basic characteristics of the student population.

Periodicity: Every three to four years (last in 2007)

Coverage: All 50 states plus the District of Columbia

Sample Size: 45,000 teachers; 9,000 schools; 4,700 school districts

Age Groups: School-age

Respondent: Administrator, teacher

Sponsors: Institute of Education Sciences, National Center for Education Statistics, U.S. Department of Education

Web site: <http://nces.ed.gov/surveys/sass/>

Limitations: Since the focus of SASS is on the school and teacher experiences, it does not provide much information on child well-being, such as health, achievement, and social involvement. While some questions relate to student characteristics, students are not interviewed. It does provide good information about the type of school environment that students are in. Also, the ability to produce state-level estimates is restricted to users who have a special license from the National Center for Education Statistics, as this information includes state identifiers which could link sampled schools, principals, or teachers to the districts in which they are associated.

CHILD CHARACTERISTICS

Health

Frequency of: alcohol use; illegal drug use; student pregnancy; poor student health.

Education/Intellectual Development

Frequency of: tardiness; absenteeism; class cutting; drop outs.

Social/Emotional/Civic Well-Being

Frequency of: physical conflicts among students; robbery; vandalism; weapons possession; physical abuse of teachers; racial tensions; bullying; verbal abuse of teachers; widespread disorder in classrooms; disrespect toward teachers; gang activities; student apathy; lack of parental involvement; poverty; students unprepared to learn.

Demographics

Number of students enrolled; number of migrant students; number of male students; race/Hispanic student distribution; National School Lunch Program; number enrolled in free/reduced lunch; number of students receiving Title 1 services.

CONTEXTUAL INFLUENCES

Family

Peers

School

Grade levels offered in school; number of teachers hired; total number of teachers; number of students in classroom; number of hours spent teaching English/Math/Social Studies/Science; teacher education (BA, MA, Ph.D., etc); teacher certification type; teacher working conditions; teachers coaching/sponsoring student groups; number of computers; internet access; lack of space for instruction; gifted/honors program; Advanced Placement classes; community service requirement; number of community service hours required.

Community

Child Welfare

Adoption and Foster Care Analysis Reporting System (AFCARS)

Description: AFCARS is funded by the federal government to provide case specific information on all adopted children who are placed by the state's child welfare agency or by private agencies under contract with the public welfare agency. In this federally mandated collection system, states are also required to collect data on all children in foster care, particularly those children for whom the state child welfare agency has responsibility for care, supervision, and placement.

Periodicity: Continuous. States submit data to AFCARS twice a year, first reporting period ends April 30 and the second September 30. The Children's Bureau combines submissions for the two reporting periods and removes duplicate records. 1995 to present.

Coverage: All 50 states, the District of Columbia, and Puerto Rico.

Sample Size: The number of children in foster care as of September 30, 2007 (the most current data available) is approximately 523,000. The number adoptions of children with Public Child Welfare Agency involvement is approximately 53,000 in 2007.

Age Groups: 0 and above

Respondent: State (public child welfare agency)

Sponsors: Funding for project was provided by the Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services.

The data are archived and made available by the National Data Archive on Child Abuse and Neglect at Cornell University, Ithaca, NY.

Web site: <http://www.acf.hhs.gov/programs/cb/systems/index.htm#afcars>

Limitations: Pre-1998 fiscal year datasets are not as reliable as subsequent datasets because fiscal penalties were not applicable. There is an inconsistent reporting of adopted and foster children across states.

CHILD CHARACTERISTICS

Health

Diagnosed disability; visually or hearing impairment; physical disability; other diagnosed conditions; reason for the removal from home and placed in foster care (child alcohol abuse, child drug abuse, child disability, child behavior problem).

Education/Intellectual Development

Mental retardation.

Social/Emotional/Civic Well-Being

Emotionally disturbed.

Demographics

State; child birth date; gender; race; Hispanic origin; foster care payments; adoption subsidy; public assistance.

CONTEXTUAL INFLUENCES

Family

Biological mother/father birth date; marital status of biological mother; date the court terminated the biological mother/father's parental rights; foster/adoptive family structure; foster/adoptive parent birth date; foster/adoptive parent race or Hispanic origin; preadoptive relationship to adoptive parent (step-parent, other relative, foster parent, nonrelative); reason for the removal from home and placed in foster care (physical abuse, sexual abuse, neglect, alcohol abuse parent, drug abuse parent, parent death, parent incarceration, caretaker inability to cope, abandonment, relinquishment, inadequate housing).

National Child Abuse and Neglect Data System (NCANDS)

Description: Child-specific data of investigated reports of maltreatment to state child protective services agencies are reported in the NCANDS Child File. It is a federally-sponsored annual national data collection effort for tracking the volume and nature of child maltreatment reporting. States submit their data after their administrative system is mapped to the NCANDS data structure. The data consists of all investigations and assessments of alleged child maltreatment that received a disposition in the reporting year.

Periodicity: Continuous, began 1990

Coverage: 50 states, the District of Columbia, and Puerto Rico

Sample Size: In 2005, an estimated 899,000 children were determined to be victims of child abuse and neglect by child protective services agencies

Age Groups: 0-17; limited information on those 18 and older

Respondent: State report

Sponsors: Original data collected under the authority of the Children's Bureau with funding provided by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. The data is archived and made available by the National Data Archive on Child Abuse and Neglect (NDACAN) at Cornell University, Ithaca, NY.

Web site: <http://www.acf.hhs.gov/programs/cb/systems/index.htm#ncands>

Limitations: NCANDS reports with data for all states are available from the U.S.

Department of Health and Human Services, Administration on Children, Youth and Families in *Child Maltreatment* publications, but only aggregate counts by state are available for 1990-2005 from (NDACAN).

There are also restricted usage files of case-level data, but only for certain states that are available for researchers. 44 states and the District of

Columbia in 2004 agreed to archive their NCANDS Child File data with

NDACAN: AK, AL, GA, ND, OR, and WI did not submit data. States vary considerably on how they define maltreatment and how they investigate and count cases, so comparability across states is problematic. If the child died due to maltreatment, certain demographic characteristics are suppressed for confidentiality reasons.

CHILD CHARACTERISTICS

Health

Prior victim of maltreatment; maltreatment type (physical abuse, neglect or deprivation of necessities, medical neglect) and disposition level (substantiated, indicated or reason to suspect, alternative response victim, alternative response nonvictim, unsubstantiated); alcohol abuse; drug abuse; visually or hearing impaired; physically disabled; other medical condition.

Education/Intellectual Development

Crime

The Uniform Crime Report (UCR)

Description: Law enforcement agencies voluntarily submit crime incidents reported to them to the Federal Bureau of Investigation. The FBI compiles the data into the Uniform Crime Report through the Bureau of Justice Statistics. These data allow the monitoring of crime trends over time.

Periodicity: Yearly, began in 1930 with a limited number of agencies and states

Coverage: Law enforcement agencies in cities in the 50 states and the District of Columbia.

Age Groups: 18 and older.

Respondent: All law enforcement agencies.

Web site: <http://www.fbi.gov/ucr/>

Limitations: The UCR does not record multiple crimes or multiple victims for any single incident. If multiple crimes occur in one incident, only the most serious crime is reported. If there are multiple victims for one offender in one incident, the data record a single offense. Also, many crimes are under-reported. These data do not collect information on police contact with a juvenile. Also, the definitions of crimes vary by cities and by states. Reporting varies by agency and by city as well.

CHILD CHARACTERISTICS

Health

Education/Intellectual Development

Social/Emotional/Civic Well-Being

Demographics

CONTEXTUAL INFLUENCES

Family

Peers

School

Community

Arrests, Crimes Reported.

National Crime Victimization Survey (NCVS)

Description: The National Crime Victimization Survey collects information on crime victimization, and especially is useful for reporting crime rates for under-reported crimes such as rape, sexual assault, robbery, assault, theft, household burglary, and motor vehicle theft.

Periodicity: Yearly, began in 1973.

Coverage: 50 states, and the District of Columbia. Cities participating in the city study were the following: Chicago, IL, Kansas City, MO, Knoxville, TN, Los Angeles, CA, Madison, WI, New York, NY, San Diego, CA, Savannah, GA, Spokane, WA, Springfield, MA, Tucson, AZ, and Washington, DC. The United States territories and outlying islands (Virgin Islands, Guam, etc.) are considered “outside the United States” in the NCVS.

Sample Size: The NCVS includes information on 76,000 households comprising about 135,300 individuals.

Age Groups: Individuals 12 years old and older.

Respondent: Household residents.

Web site: <http://www.ojp.usdoj.gov/bjs/cvict.htm>

Limitations: The NCVS does not record multiple crimes or multiple victims for any single incident. If multiple crimes occur in one incident, only the most serious crime is reported. If there are multiple victims for one offender in one incident, the data record a single offense. Also, many crimes are still under-reported even though the likelihood is less than for the Uniform Crime Report.

CHILD CHARACTERISTICS

Health

Crime Victimization.

Education/Intellectual Development

Social/Emotional/Civic Well-Being

Crime Victimization.

Demographics

Victim Age, Perceived Offender Age, Victim Gender, Perceived Offender Gender, Victim Race, Perceived Offender Race, Victim Income, Victim Marital Status.

CONTEXTUAL INFLUENCES

Family

Peers

School

Community

Place of Crime’s Occurrence, Time of Crime’s Occurrence.

Appendix B: Examples of Items that Could be Collected at the City Level Using the National Survey of Children's Health (NSCH)

- Depression (parent report or adolescent self-report if adolescents are interviewed)
- Adolescent self-report of delinquency, crime, substance use, sexual activity, fights/bullying, behavior problems
- Victim of crime/bullying
- Items from the Youth Risk Behavior Surveillance System that have to do with “5. Youth are physically, mentally, and emotionally healthy”:
 - In the past 12 months have/did you?:
 - “seriously considered attempting suicide”
 - “attempted suicide”
 - “ate fruits and vegetables less than five times a day”
 - “drank soda at least once a day”
 - “feeling sad and hopeless”
- Adequate sleep
- CSHCN Disability Screener questions:
 1. Does child currently need or use medicine prescribed by a doctor, other than vitamins?
 - Is [his/her] need for prescription medicine because of ANY medical, behavioral or other health condition?
 - Is this a condition that has lasted or is expected to last 12 months or longer?
 2. Does child need or use more medical care, mental health or educational services than is usual for most children of the same age?
 - Is [his/her] need for medical care, mental health, or educational services because of ANY medical, behavioral or other health condition?
 - Is this a condition that has lasted or is expected to last 12 months or longer?
 3. Is child limited or prevented in any way in [his/her] ability to do the things most children of the same age can do?
 - Is [his/her]'s limitation in abilities because of ANY medical, behavioral or other health condition?
 - Is this a condition that has lasted or is expected to last 12 months or longer?
 4. Does child need or get special therapy such as physical, occupational, or speech therapy?
 - Is [his/her] need for special therapy because of ANY medical, behavioral or other health condition?
 - Is this a condition that has lasted or is expected to last 12 months or longer?
 5. Does child have any kind of emotional, developmental or behavioral problem for which he/she needs treatment or counseling?
 - Has [his/her]'s emotional, developmental, or behavioral problem lasted or expected to last for 12 months or longer?
- Sample questions on school readiness:
 - Does the child recognize all letters?
 - Can the child count to 20 or higher?
 - Can the child write his or her name?
 - Does the child read or pretend to read?

- Items from the National Survey of Children’s Health:
 - “How much time do children/youth spend reading for pleasure?”
 - “How often are young children read to by family members?”
 - "During the past 12 months, did [he/she] participate in any clubs or organizations after school or on weekends?"
 - “Is [child’s name] involved in volunteer work or community service?”
 - “How often does [child’s name] and the family eat meals together?”
 - “Does the family have rules about what television programs [child’s name] is allowed to watch?”
 - “How much time does [child’s name] spend reading for pleasure?”
 - “How often is [child’s name] read to by family members?”
 - “How well can you and [child’s name] share ideas or talk about things that really matter?”
- “Is youth registered to vote?”
- “Did youth vote in the last presidential election?”