




You can help make

FAMILIES COUNT IN DELAWARE



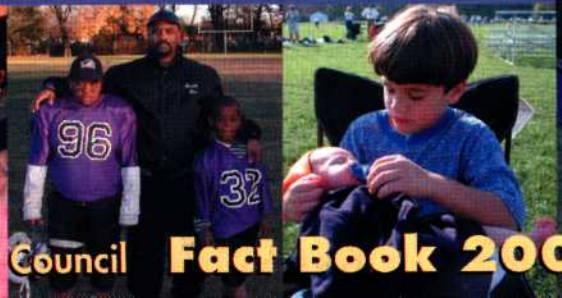
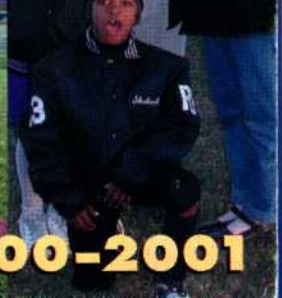






Model responsible behavior • Take a parenting class • Write a letter to a legislator on a family or children's issue • Offer to babysit free for a mom that needs a break • Use only language you would like to hear children use • Eat meals as a family • Make yourself available • Use positive discipline rather than physical punishment • Register and vote • Pay child support, if you owe it • Create opportunities to laugh and have fun with children • Set consistent limits • Practice the Golden Rule • Educate your children about their sexuality • Hire a teen • Get to know your child's friends and their parents • Volunteer at schools or programs in your community • Sponsor an Adopt-a-Family or Angel Tree participant • Work for family-friendly policies in your workplace



Family Services Cabinet Council **Fact Book 2000-2001**

STATE OF DELAWARE
OFFICE OF THE GOVERNOR

THOMAS R. CARPER
GOVERNOR

Dear Friends:

One of the very first things on my agenda when I became Governor in 1993 was to create the Family Services Cabinet Council (FSCC), made up of Cabinet Secretaries from the seven state departments having significant impact on children and families in Delaware. Over the past eight years, the FSCC has acted as a catalyst for public/private partnerships and to provide school- and community-based family services in ways that are convenient for Delaware families. As a group which has labored closely together for more than eight years, we are pleased to present this third publication of ***Families Count in Delaware***.

To serve Delaware's families best we must have information on their special needs and everyday challenges. The Families Count book tells us—all of us—what we are doing right and what we can do better. As Governor and as Senator-Elect, I look to this report and our many partners to lead us in the 21st Century with stronger, smarter, healthier families.

If we are to achieve the mission of strengthening and supporting Delaware families and children it will be due to a commitment on the part of the whole community, not just government, but our partners in the non-profit community, faith-based organizations, families and other caring adults. I hope you enjoy the report and find it useful as we continue our shared goal of supporting and strengthening families here in The First State.

Sincerely,

Tom Carper

Thomas R. Carper
Governor

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FAMILIES COUNT in Delaware Fact Book 2000-2001

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The photographs in this book do not necessarily represent the situations described.

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- Delaware Health Statistics Center
- Delaware Population Consortium
- Delaware State Housing Authority
- Domestic Violence Coordinating Council
- Statistical Analysis Center

And a special thank you to the Delaware families featured on the cover and throughout this book.

Table of Contents

Families Count in Delaware

Family Services Cabinet Council Mission Statement:

To strengthen and support Delaware families and help children achieve their full potential within safe and caring communities.

Welcome to the third edition of *FAMILIES COUNT in Delaware*, a collaborative project of the Family Services Cabinet Council and KIDS COUNT in Delaware which is housed in the Center for Community Development and Family Policy at the University of Delaware. Since 1998 the Family Services Cabinet Council has been monitoring the conditions of families, children and individuals in the community by focusing on outcomes. Outcome measures are defined as measures of the results that occur, at least in part, because of services provided, for example, "percent of low birth weight babies." The focus on outcomes carries important implications:

- It allows us to communicate goals that the state and the public value for the well being of our families, children, and individuals.
- In communicating outcomes, we introduce accountability for improved conditions.
- An outcome focus will also allow for improved decision-making in service delivery, internal management, and allocation of resources.

Integral to the success of this program is public involvement in identifying needs and working toward improved conditions. Assembled in this third report are the indicators which quantify the outcomes. These indicators were developed by Governor Carper's Family Services Cabinet Council in a process that started with a statement of the Council's mission and goals and the publication of the first FAMILIES COUNT in Delaware in the fall of 1998. The indicators are organized into the categories of

1) healthy children,
2) successful learners,
3) resourceful families,
4) nurturing families, and
5) strong and supportive communities.

FAMILIES COUNT continues to evolve as stakeholders and interested Delaware citizens review the indicators to determine if measures need to be reassessed or refined. Having high quality information to measure the status and chart the progress toward improving the lives of Delaware families is a result of the growing public demand for accountable and cost-effective services and the need for and the use of information to guide decision-making in all aspects of our state's efforts to solve our basic problems. Ultimately, this framework of indicators will help state and local policymakers gauge whether services and programs are making a difference in the outcomes for children and families.

Data are presented in a variety of displays. When possible, we compare Delaware to mid-Atlantic states and the nation. These comparisons help to determine where Delaware rates in comparison to the rest of the nation, and if progress is being made over time. In addition, we present the data by counties in order to gain better understanding of the needs in particular segments of the state. Though these data may be used to monitor change or progress, sometimes it is not easy to infer whether the trend is getting better or worse from the indicator, and the same information may be interpreted in different ways. In small states like Delaware, rates tend to vary significantly from year to year. Ranks sometimes mask very small differences among states. Positive trends and high ranks do not necessarily indicate that issues no longer need attention. Finally, we recognize that there are indicators that are not included here and should be. Some of these have been included in the report as "under construction."

Ultimately, the purpose of this book is to stimulate debate, not to end debate by providing definite answers. The best solutions to social problems will emerge from the debate, not from the data. We hope this type of information will add to the knowledge base of our social well being; guide and advance informed discussions; help us concentrate on issues that need attention; and focus on a better future for our children and families.

Families Count Indicators

Healthy Children

Goal: Children are born healthy. Children will remain free of preventable diseases and disabilities, and will have social, emotional, and physical health promoting behaviors. Children born with or who develop disabilities, health, social, or emotional problems reach their full potential.

	Delaware Compared to U.S. Average	Recent Trend in Delaware
Prenatal care Percent of mothers receiving prenatal care in the first trimester of pregnancy	BETTER	ABOUT THE SAME
Low birth weight babies Percent of low birth weight babies	WORSE	GETTING WORSE
Infant mortality Infant mortality rate per 1,000 live births	SIMILAR	ABOUT THE SAME
Lead poisoning* Percent of children age 6 and under with blood lead levels at or over 15 mcg/dl		GETTING BETTER
Child immunizations Percent of children fully immunized by age 2	SIMILAR	ABOUT THE SAME
Child deaths Rate of child deaths per 100,000 children ages 1–14	BETTER	ABOUT THE SAME
Children with health care coverage Percent of children to age 18 with health care coverage	BETTER	GETTING BETTER
Substance abuse, 8th graders* Percent of participants in Delaware survey of public school eighth graders using substances (cigarettes, alcohol, marijuana) in the last 30 days		GETTING BETTER
Substance abuse, 11th graders* Percent of participants in Delaware survey of public school eighth graders using substances (cigarettes, alcohol, marijuana) in the last 30 days		GETTING BETTER
Sexually transmitted diseases* Percent of teens ages 15–19 with gonorrhea or primary/secondary syphilis		ABOUT THE SAME
Teen deaths Rate of teen deaths by injury, homicide, and suicide (per 100,000 teens 15–19)	BETTER	GETTING WORSE

* Data not available to indicate trend and/or U.S. comparison.

Successful Learners

Goal: Children are prepared to enter school, progress to high school graduation and make successful transitions to adulthood. Increasing percentages go on to post-secondary education. Children with developmental disabilities or specific needs reach their full potential.

Early childhood disability intervention*
Percent of children ages birth to 3 receiving early intervention services

Head Start, Early Childhood Assistance Program*
Rate of participation for eligible 4 year olds in early childhood assistance programs

Student achievement: 3rd grade reading*
Percent of third graders meeting or exceeding the reading standard

Student achievement: 5th grade reading*
Percent of third graders meeting or exceeding the reading standard

Student achievement: 8th grode reading*
Percent of third graders meeting or exceeding the reading standard

Student achievement: 10th grade reading*
Percent of third graders meeting or exceeding the reading standard

Student achievement: 3rd grade math*
Percent of third graders meeting or exceeding the math standard

Student achievement: 5th grade math*
Percent of third graders meeting or exceeding the math standard

Student achievement: 8th grade math*
Percent of third graders meeting or exceeding the math standard

Student achievement: 10th grade moth*
Percent of third graders meeting or exceeding the math standard

Teens not in school, not warking
Percent of teens 16–19 not attending school and not working

High school dropouts*
Percent of high school dropouts

Resourceful Families

Goal: Families have educational, housing, health care, employment, and economic resources to be self-sustaining and self-sufficient at all stages in their family life cycle.

Children in poverty
Percent of children living in poverty

One-parent households
Percent of children ages 0–17 in one-parent households

Teen births
Teen birth rate for 1,000 females age 15–17

* Data not available to indicate trend and/or U.S. comparison.

Female headed households in poverty*
Percent of families in poverty with female single head of household and children

Child support collected
Percent of amount owed child support that is paid

Risk of homelessness/Families in substandard housing*
Percent of families living in substandard housing, or at risk of becoming homeless

Lack of health care coverage
Percent of persons under age 65 who do not have health care coverage

Nurturing Families

Goal: Families will provide a nurturing environment for all members free of violence, neglect, and abuse.

Abused/neglected children*
Children with substantiated reports of abuse or neglect per 1,000 children

Children in out-of-home care*
Children in out-of-home care per 1,000 children

Juvenile delinquents in out-of-home care*
Juvenile delinquents in out-of-home care per 1,000 youth ages 10–17

Domestic violence*
Number of domestic violence reports

Strong and Supportive Communities

Goal: Communities have child care, educational systems, physical infrastructure, and employment opportunities to support a high quality of life for all community members. Communities are drug, crime, and violence free. Residents are actively involved in achieving community self-sufficiency.

Unemployment rate
Unemployment rate by race and gender

Depending on neighbors*
Percent of households at 200 percent of poverty level or below that indicate they would seek help from a neighbor

Juvenile violent crime
Juvenile violent crime arrest rate (per 1,000 youths ages 10–17)

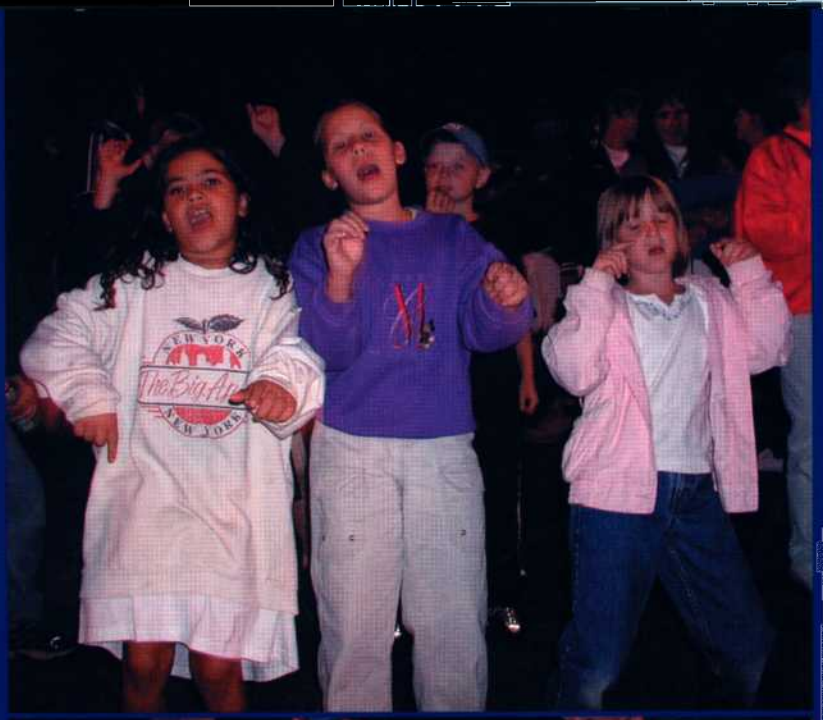
Adult violent crime arrests*
Adult violent crime arrest rate per 1,000 adults

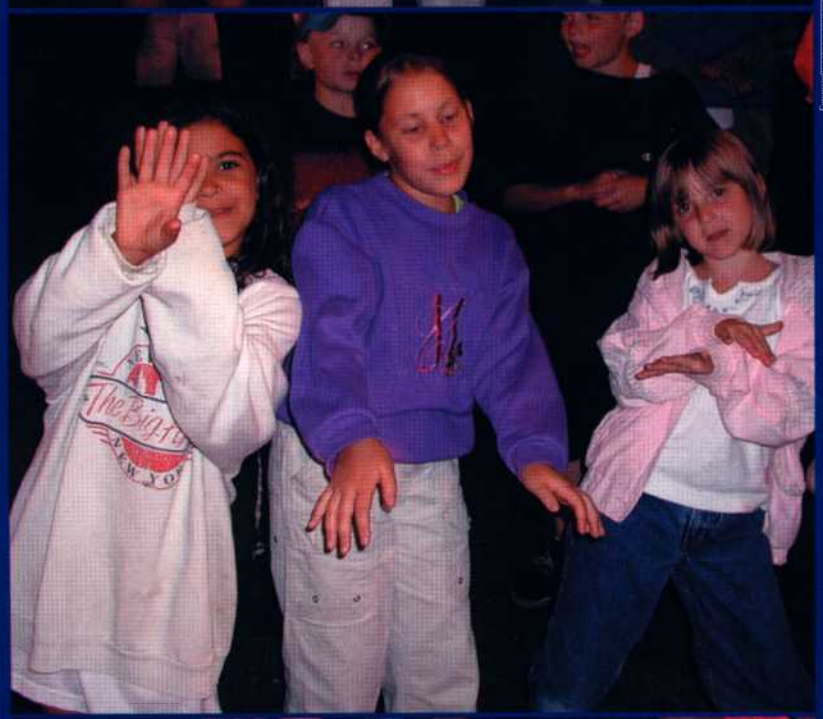
Adults on probation or parole*
Adults on probation or parole per 1,000 adults

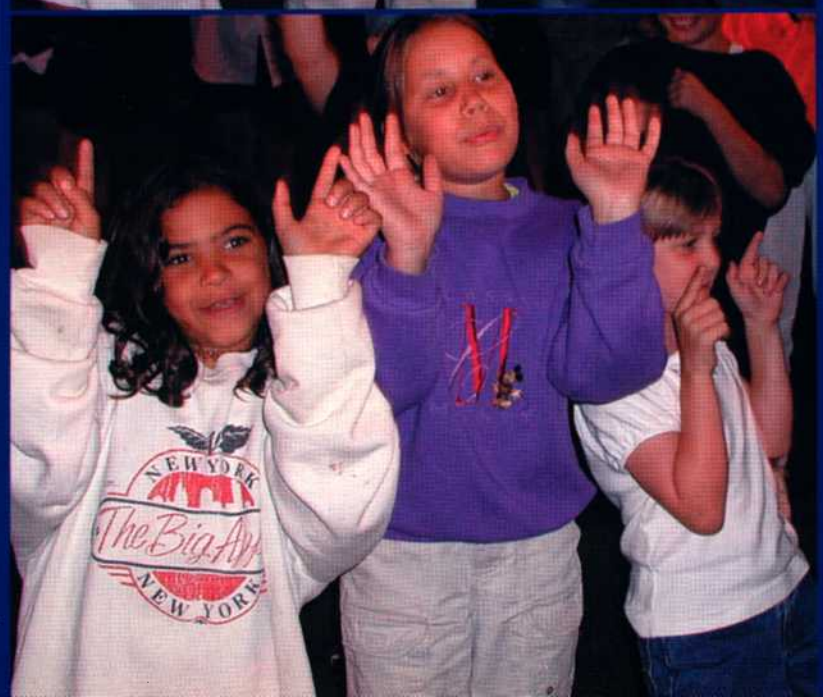
Substandard housing units*
Percent of substandard housing units

Home ownership
Percent of home ownership

* Data not available to indicate trend and/or U.S. comparison.







Healthy Children

Goal: Children are born healthy. Children will remain free of preventable diseases and disabilities, and will have social, emotional, and physical health promoting behaviors. Children born with or who develop disabilities, health, social, or emotional problems reach their full potential.

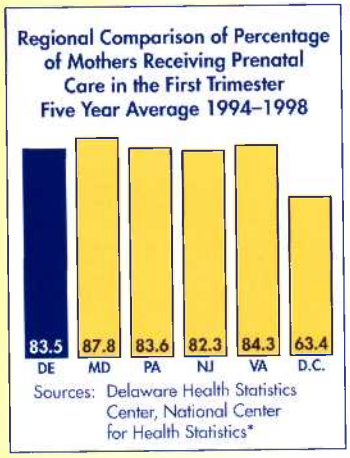
Prenatal Care

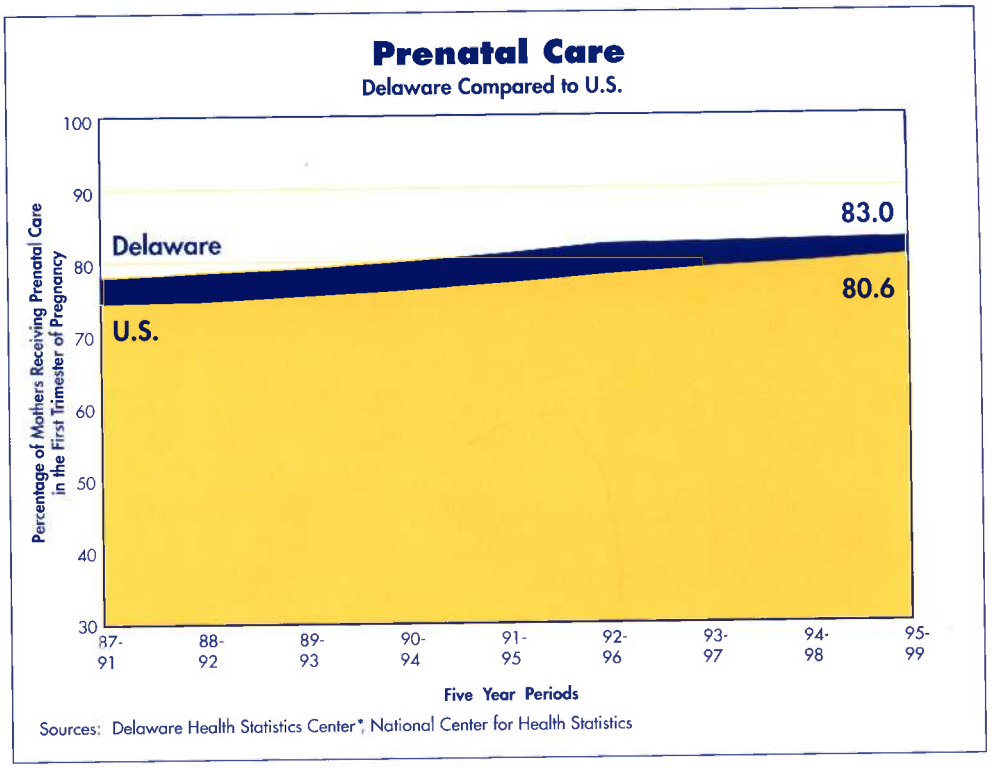
Indicator: ***Percent of mothers receiving prenatal care in the first trimester of pregnancy***

Infants born to women who do not receive prenatal care are four times more likely to die before their 1st birthday. Although it is generally accepted that prenatal care is the best preventive measure against low-birth weight, infant death and premature delivery, twenty-five percent of women in the United States still do not receive prenatal care within the first trimester.[1] Adequate prenatal care can prevent the occurrence of low-birth weight, chronic illnesses, extended neonatal care, and lifetime medical care for developmental problems caused by low birth weight.[2]

Visiting a physician during pregnancy can help to reduce the risk of a low-birth weight baby by 300 percent.[3] However many women avoid seeking prenatal care because of social, environmental and psychological barriers such as depression, wanting to keep the pregnancy a secret, crowded waiting rooms at clinics, lack of evening/weekend hours at the doctor's offices, and lack of education.[4] Prenatal care provides screening for and treatment of disease conditions as well as intervention with non-medical conditions such as smoking, substance abuse, physical abuse and/or nutritional deficiencies.[5] Also women who receive adequate prenatal care are more likely to receive proper care for their infants once they are born.

1 Oh Baby Women Receive More Prenatal Care Today Than A Decade Ago (1998). Available from www.ama-assn.org
2 KIDS COUNT in Michigan 1999 Data Book.
3 www.plannedparenthood.org
4 KIDS COUNT in Michigan 1999 Data Book.
5 2000 Rhode Island KIDS COUNT Fact Book.



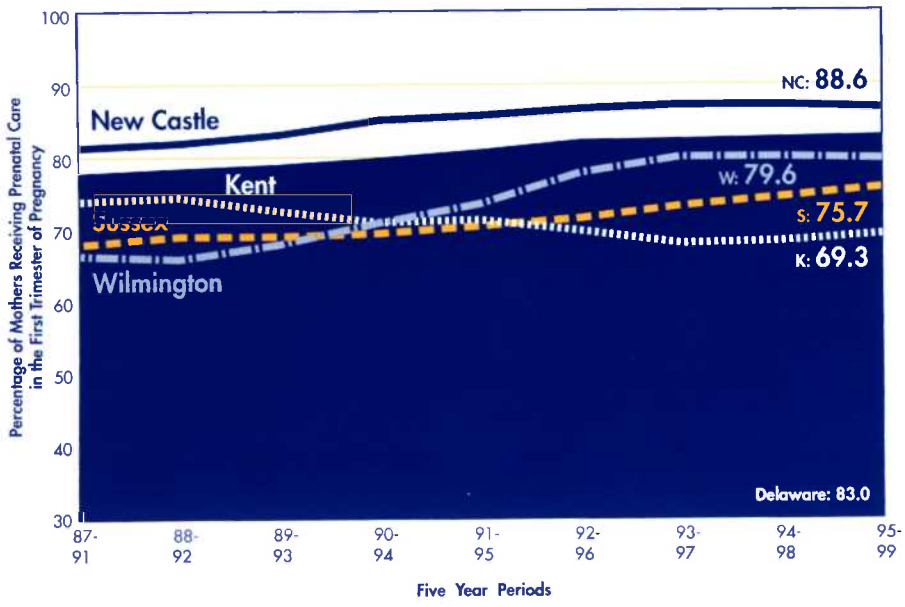


Program Statement: Delaware has expanded Medicaid to more pregnant women than ever before, now including low-income working women with income up to twice the poverty level. An eligible pregnant woman can be immediately enrolled in Medicaid enabling her to begin prenatal care without the usual waiting period.

* Percentages vary due to different estimating procedures being used by different sources.

Prenatal Care

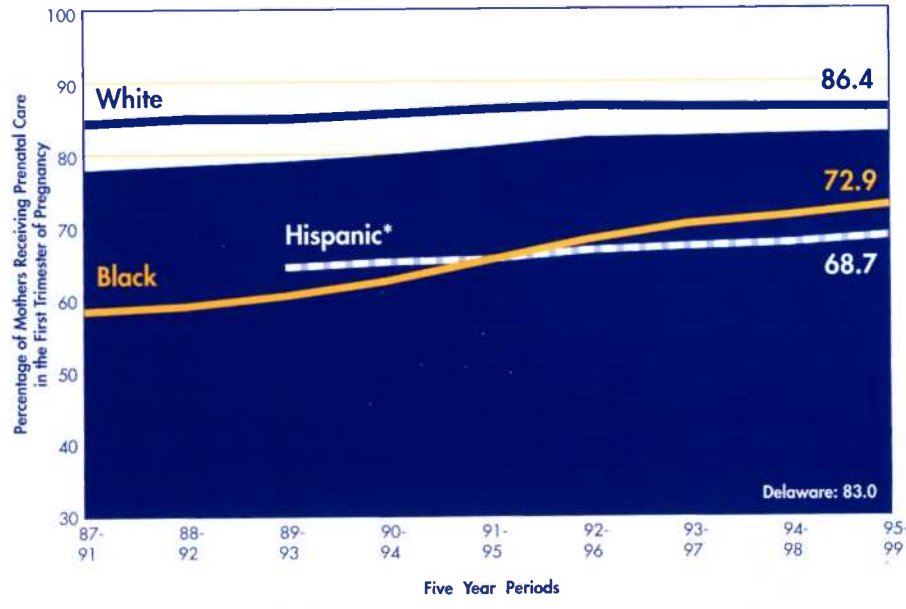
Delaware, Counties and Wilmington



Source: Delaware Health Statistics Center

Prenatal Care

Delaware by Race and Hispanic Origin



* Hispanic data was not available before the 1989-93 time period

Source: Delaware Health Statistics Center

For more information see

Low Birth Weight Babies p. F-12

In the KIDS COUNT Section:

Low Birth Weight Babies p. K-20

Infant Deaths by Adequacy of Prenatal Care p. K-23

Tables 15-18 p. K-67-70

Low Birth Weight Babies

Indicator: *Percent of low birth weight babies*

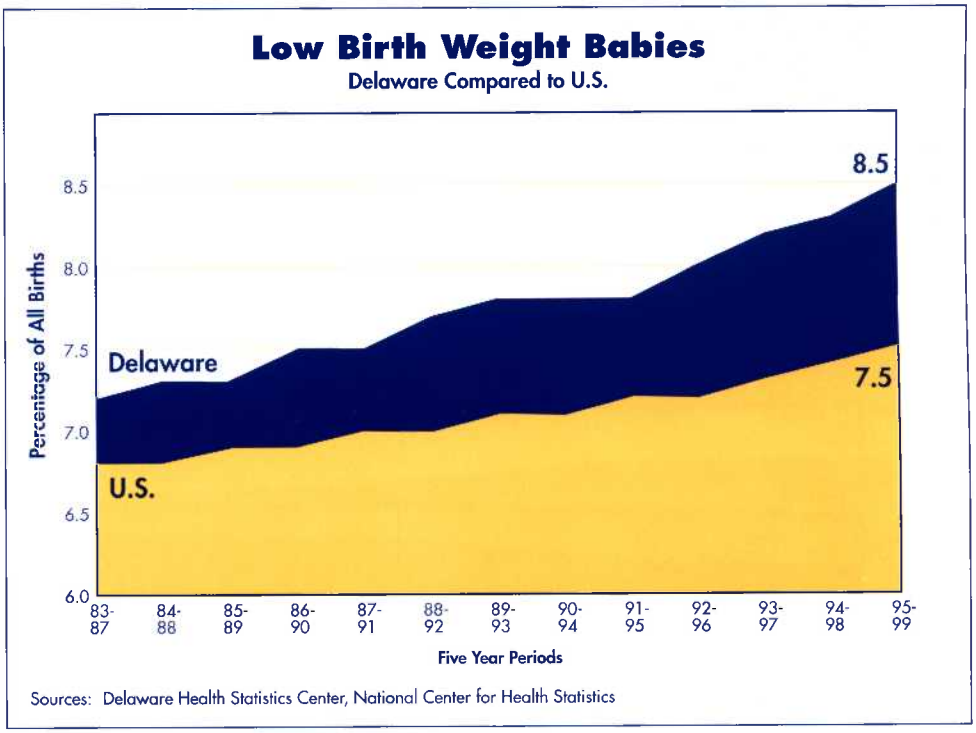
Low birth weight is defined as an infant being born at or below 2,500 grams (about 5.5 pounds). Babies weighing less than 5.5 pounds at birth are more likely to experience both physical and developmental problems than babies weighing more than 5.5 pounds at birth. Low birth weight babies may experience long-term physical problems such as an increased risk of adult-onset diabetes and coronary heart disease.[1] Developmental delays and problems causing the child to be placed in special education classes may also occur. At highest risk are babies weighing less than 3.3 pounds.[2] Risk factors associated with low birth weight include poor prenatal habits, in particular tobacco or alcohol use during pregnancy, low maternal weight gain, low maternal weight before pregnancy, and multiple births.[3] African-American women, teenage mothers, and mothers living in poverty are at a greater risk of experiencing low weight births. Despite being a small fraction of all births, low weight infants account for more than one-third of all dollars spent on health care for infants.[4]

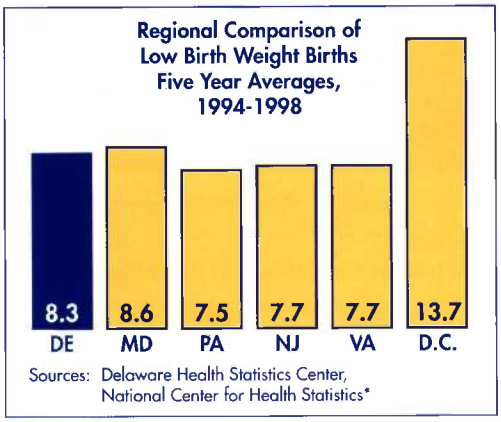
1 Maianu, L. et al., (1999). Low Birth Weight is Associated with Reduced Expression of GLUT4 and Carnitiane Palmitoyltransferase-1 in Adult skeletal Muscle. *Diabetes.* V48, pSA274.

2 Low Birth Weight Babies. (1998). *Nevada Kids Count Data Book*

3 Daltveit, A. K. et al (1999). Impact of multiple births and elective deliveries on the trends in low birth weight in Norway. American Journal of Epidemiology. V149, p1128.

4 Low Birth Weight Babies. (1999). *Alabama Kids Count 1999 Report*



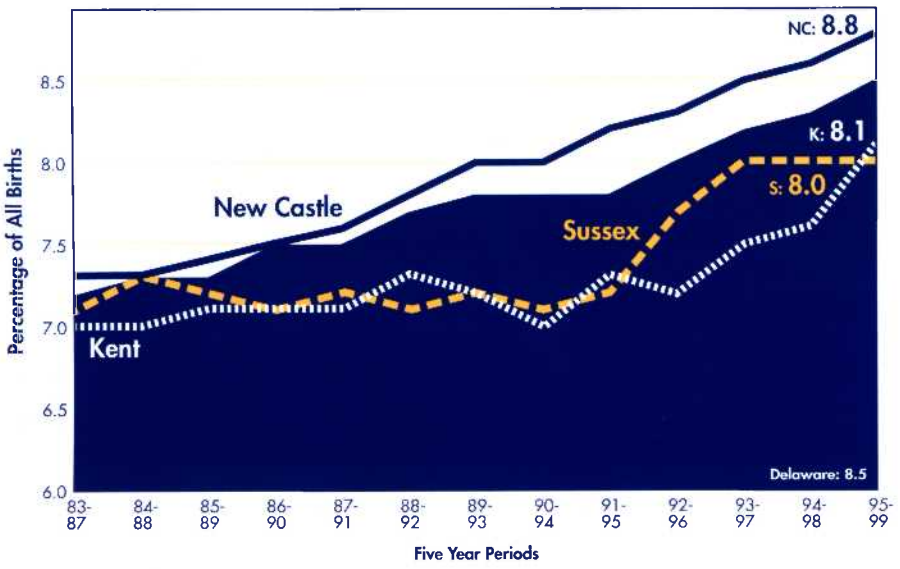


Program Statement: Having a healthy baby requires more than medical care. Medicaid provides Delaware women with high-risk pregnancies access to comprehensive services tailored to their needs. These services include medical care, nutritional services, housing, counseling, or other needed services.

* Percentages vary due to different estimating procedures being used by different sources.

Low Birth Weight Babies

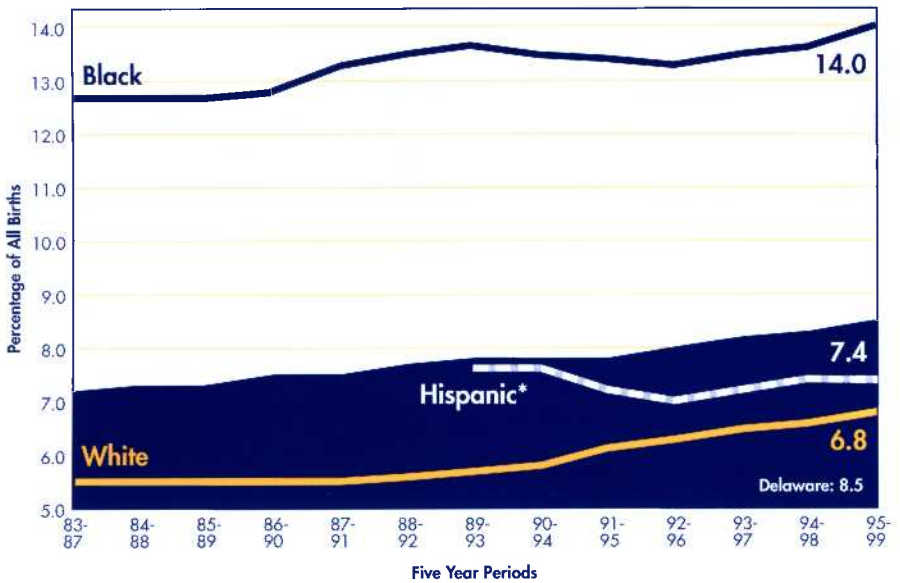
Delaware and Counties



Source: Delaware Health Statistics Center

Low Birth Weight Babies

Delaware by Race and Hispanic Origin



Source: Delaware Health Statistics Center

For more information see

Prenatal Care p. F-10

In the KIDS COUNT Section:

Low Birth Weight Babies p. K-20

Infant Deaths by Birth Weight of Infant p. K-23

Tables 11-18 p. K-64-70

Tables 21-22 p. K-72-73

Infant Mortality

Indicator: ***Infant mortality rate per 1,000 births***

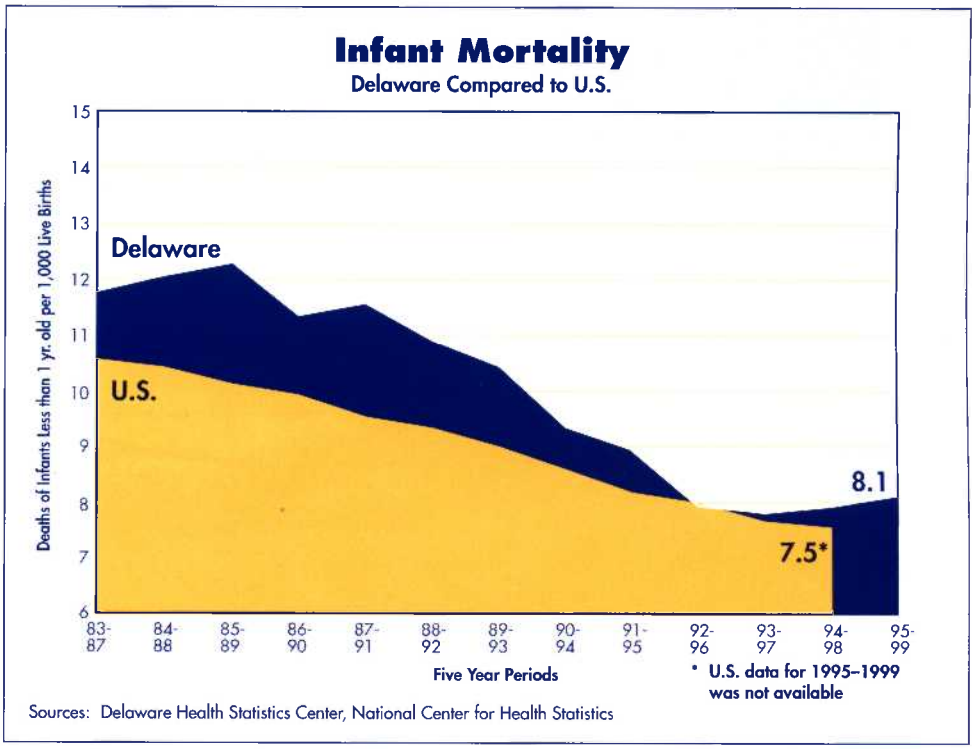
The infant mortality rate represents the number of deaths of children under one year old per 1,000 live births. This rate is important because it is associated with a variety of factors, such as maternal health, quality of and access to medical care, socioeconomic conditions, and public health practices.[1] Certain conditions increase the risk of infant mortality. These risks include maternal age (less than 19 or over 40), timing of pregnancy (leaving less than 18 months between births), poor maternal health or nutrition, and inadequate prenatal care.[2]

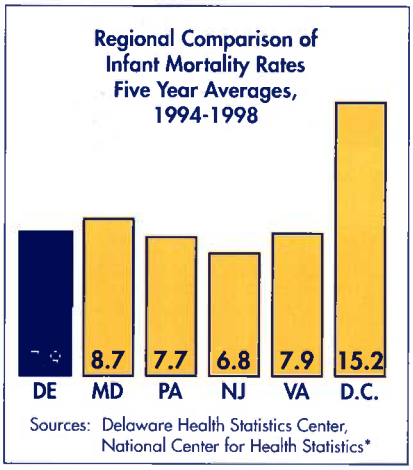
According to a national study, poverty is a key factor that affects the life expectancy of a child. The mortality rate for children born into families in poverty is 50 percent higher than that of children born into families with incomes above the poverty line.[3]

1 America's Children: Key National Indicators of Well-being, 1999

2 Infant Mortality. (1996). *Kids Count Data Book on Louisiana's Children.*

3 1998 Kids Count Databook: *State Profiles of Child Well-Being.* Annie E. Casey Foundation.



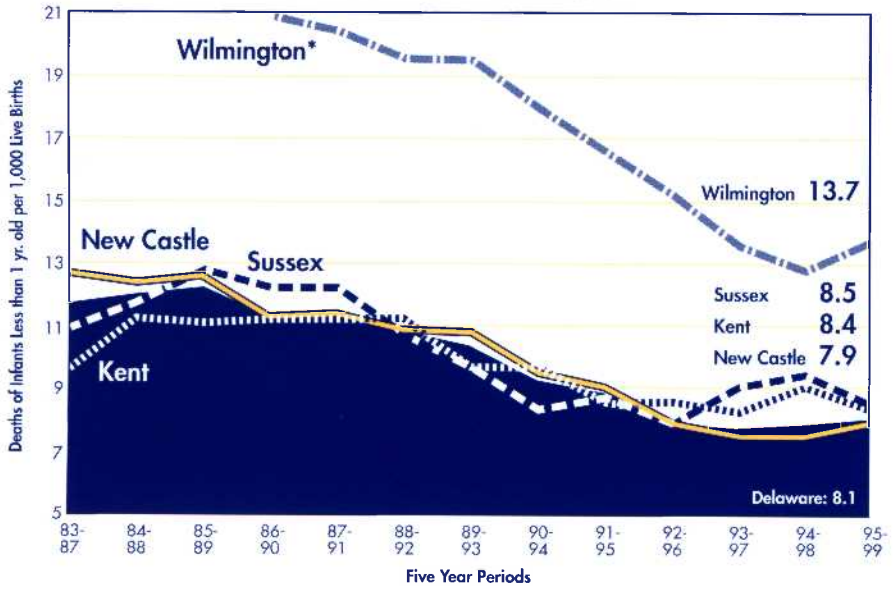


Program Statement: By providing medical and social services during pregnancy and after a baby is born, Delaware strives to prevent infant deaths. Through the Home Visiting Program, all first time parents are offered in-home support and referrals for needed services. In addition, the Perinatal Board has assumed statewide leadership to save babies' lives by examining the causes of infant mortality and providing information that promotes healthy family behavior through community outreach projects. In concert with these efforts, the Division of Public Health works to prevent Sudden Infant Death Syndrome (SIDS) through the "Back to Sleep" campaign, which promotes healthy sleeping positions for infants.

* Percentages vary due to different estimating procedures being used by different sources.

Infant Mortality

Delaware, Counties and Wilmington

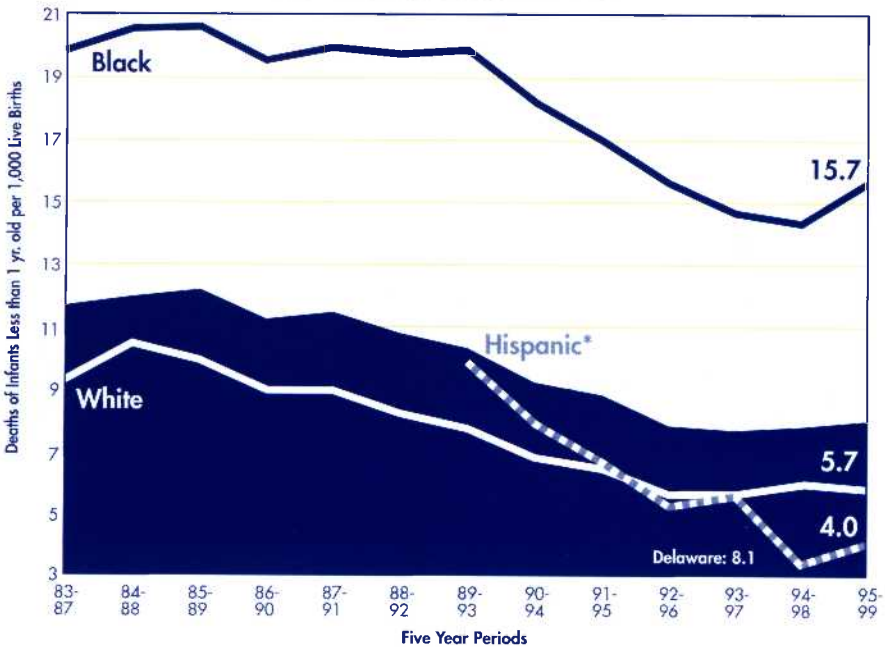


* Wilmington data not available before the 1986–1990 period.

Source: Delaware Health Statistics Center

Infant Mortality

Delaware by Race and Hispanic Origin



* Hispanic data not available before the 1990–1994 period.

Note: All rates for Hispanics are based on fewer than 20 deaths during the period and should be interpreted with caution.

Source: Delaware Health Statistics Center

For more information see

Prenatal Care	p. F-10
Low Birth Weight Babies	p. F-12
In the KIDS COUNT Section:	
Low Birth Weight Babies	p. K-20
Infant Mortality	p. K-22
Child Abuse and Neglect	p. K-54
Tables 9-17	p. K-58-63
Tables 19-22	p. K-70-73
Table 24	p. K-74
Table 74	p. K-96

Lead Poisoning

HEALTHY CHILDREN

Indicator: ***Percent of children age 6 and under with blood lead levels at or exceeding 15 mcg/dl***

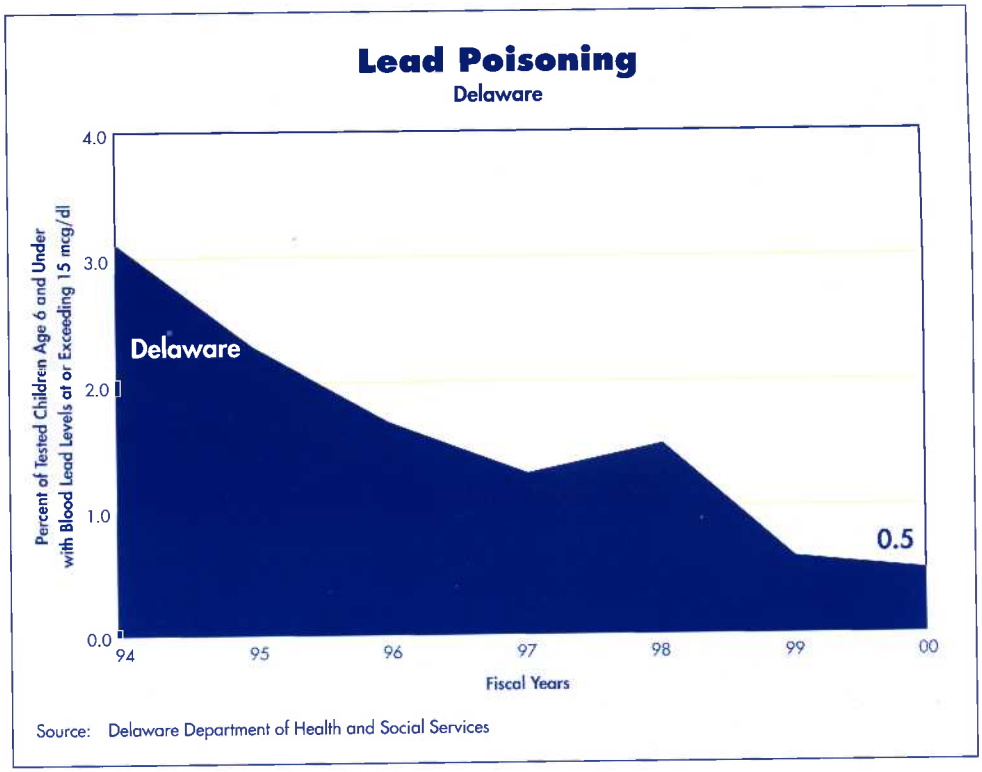
Lead exposure can come from breathing or swallowing lead dust or by eating soil and/or paint chips with lead in them. Lead is more dangerous to babies and young children than adults because their bodies absorb more lead and their developing brains and nervous systems are more sensitive to the damaging effects of lead. 890,000 preschoolers are still affected by lead poisoning today.[1] The definition of lead poisoning in Delaware has been 15 micrograms (this will soon change to 10 micrograms) of lead per deciliter of blood. Unfortunately low-income families are still eight times more likely to be affected by lead poisoning.

One thousand children in the Delaware area have tested positive for lead poisoning over the last six years.[2] According to Delaware's Department of Health and Social Services, lead poisoning is the number one environmental health threat to young children.[3] Although many believe lead poisoning to be a problem that had disappeared, it still plagues many urban areas. Delaware children are required to be tested for lead poisoning by their first birthday. Delaware officials have raised millions of dollars to clean up the lead and educate people about the dangers of lead.

1 Available from www.Aeclp org/2/index.html

2 Douglass, Kim. "Paint Risk in Delaware Is Pinpointed" The News Journal. Wilmington, DE Mon. Sept., 25, 2000. A1

3 ibid.



Program Statement: Increasing awareness of childhood lead poisoning is a priority in Delaware. The Division of Public Health sends letters to doctors and nurses to remind them that Delaware law requires **all** children to be screened at or around twelve months of age. The Division also works with community agencies to reduce lead-based hazards from homes where young children reside.

For more information see
In the KIDS COUNT Section
Table 72 p. K-95

Child Immunizations

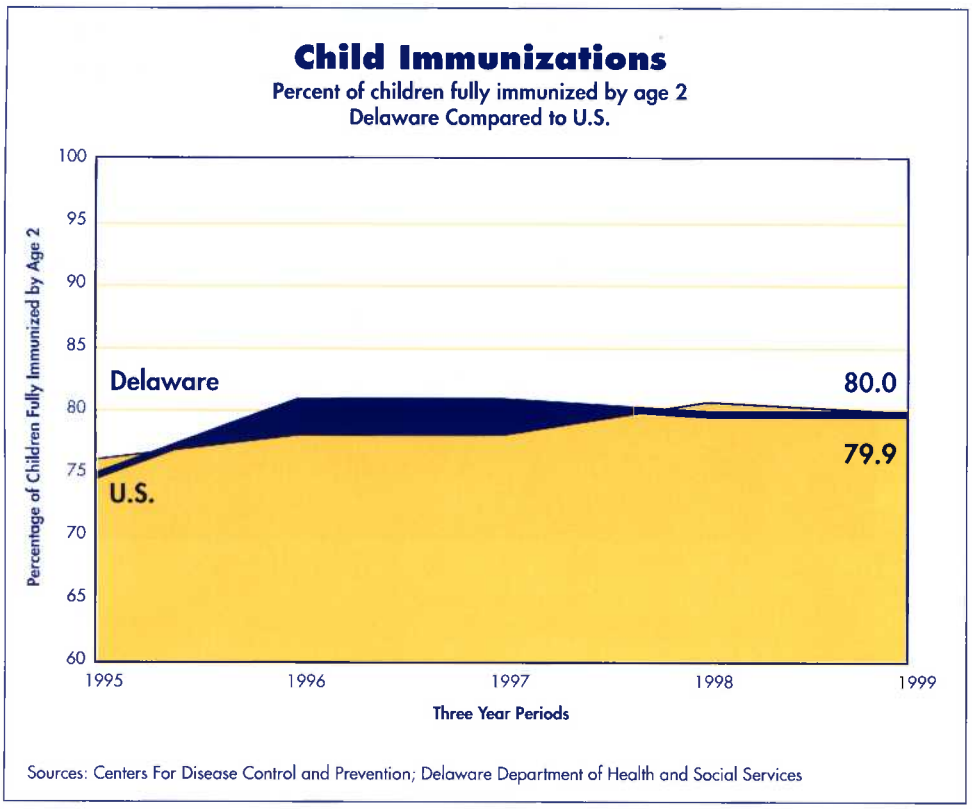
Indicator: **Percent of children fully immunized by age 2**

Immunizations are critical to protecting children from the dangers of deadly, yet preventable diseases. By the age of 2, a child should have gone through a series of sixteen shots for the following diseases: measles, mumps, polio, rubella, Hib, diphtheria, tetanus, pertussis, hepatitis B, and varicella.[1] The immune systems of children are far more susceptible to disease because they are not fully developed.

Delaware state law requires children to be immunized before they can enter school. Unfortunately many parents wait until the age of five to have their children immunized. Many childhood illnesses can develop between birth and age five that immunizations would prevent. Approximately ten dollars are saved on medical costs for every one dollar spent towards immunizations.[2]

1 Center for Disease Control. Available from www.cdc.gov/nip/publications/fs/gen/shouldknow.htm

2 2000 Rhode Island KIDS COUNT Factbook.



Sources: Centers For Disease Control and Prevention; Delaware Department of Health and Social Services

Program Statement: Delaware works toward immunizing all children. Through the Vaccines for Children program, eligible children receive free immunizations through their own medical providers. Children must also be fully immunized for families to receive full welfare benefits.

HEALTHY CHILDREN

For more information see

Health Care Coverage (children)	p. F-19
Health Care Coverage (families)	p. F-41

In the KIDS COUNT Section:

Child without Health Insurance	p. K-46
Table 71	p. K-94

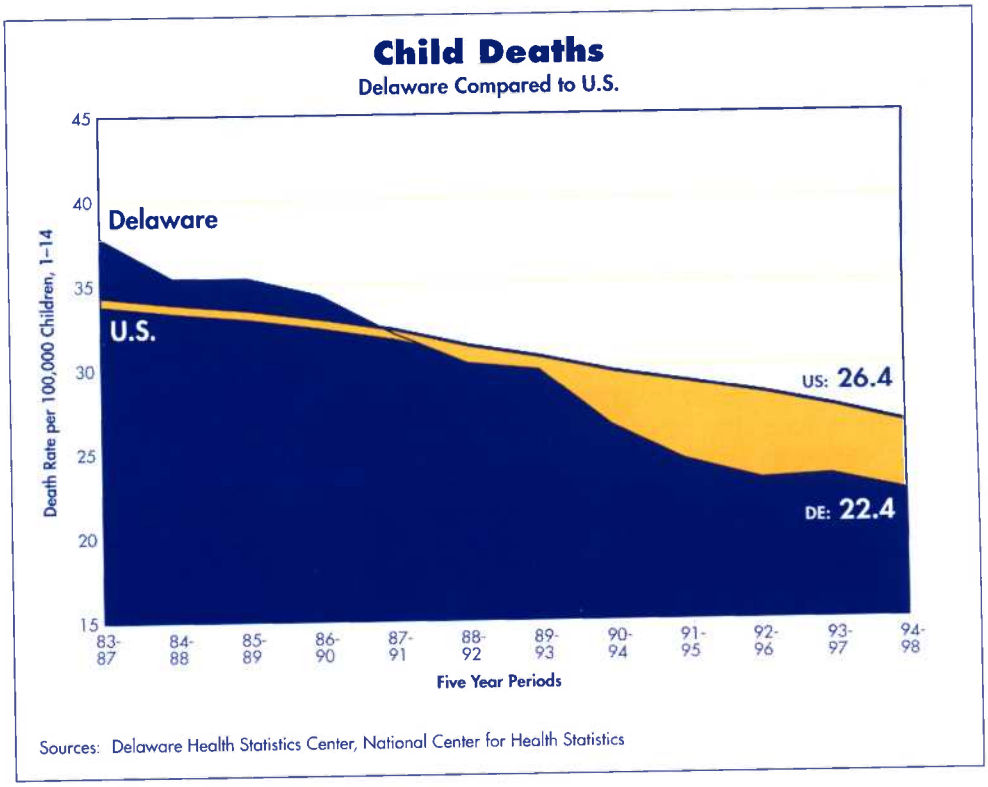
Child Deaths

HEALTHY CHILDREN

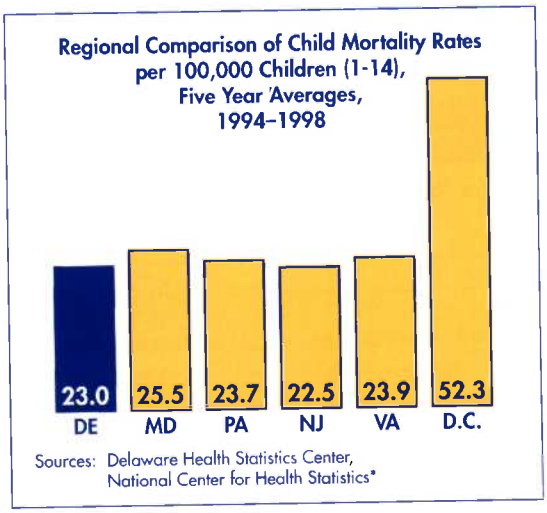
Indicator: ***Rate of child deaths per 100,000 ages 1–14***

The child death rate is based on the numbers of deaths per 100,000 children. Poverty is the foremost predictor of injury to children. Overall, lack of parental education, inadequate or lack of health insurance, low birth weight, premature birth, substandard living conditions, substance abuse, child maltreatment, single parent households, and lack of adult supervision are additional risk factors that influence and are associated with child deaths.[1] As a result of technological advances in medical treatment and procedures, the child death rate in the United States has decreased during the past several years. Unintentional injuries remain the leading causes of death for children ages 1 to 4, and most of the injuries are preventable.[2]

1 Child Death Rate. (1998). *Nevada Kids Count Data Book*
2 Lewit, E.M. and Baker, L. S. (1995, Spring) Unintentional Injuries. The Future of Children, 5(1).



Sources: Delaware Health Statistics Center, National Center for Health Statistics



Sources: Delaware Health Statistics Center, National Center for Health Statistics*

Program Statement: The Child Death Review Commission reviews all child deaths that occur in Delaware to look for ways to prevent similar deaths. Based on their review, the Commission has recommended actions to reduce child deaths by reducing traumatic injuries, increasing the use of child car seats, improving seat belt use by children, and enacting tougher sentencing laws for felonies resulting in death or serious injury to a child.

* Percentages vary due to different estimating procedures being used by different sources.

For more information see

Infant Mortality	p. F-14
Teen Deaths	p. F-23
In the KIDS COUNT Section:	
Child Deaths	p. K-24
Asthma	p. K-48
Child Abuse and Neglect	p. K-54
Tables 23-24	p. K-74
Table 74	p. K-96

Health Care Coverage

Indicator: Percent of children to age 18 with health care coverage

Between 1987 and 1996 the number of children without health insurance rose from 8.6 million to 10.6 million.[1] This increase was significant within the African-American population, which rose from 15.3% to 18.8% uninsured children (this was from 1995-1996). The two largest groups of uninsured children are adolescents and children whose parents average less than $50,000 a year.[2] In 1997, 16.7% of 12-17 year olds were uninsured.[3]

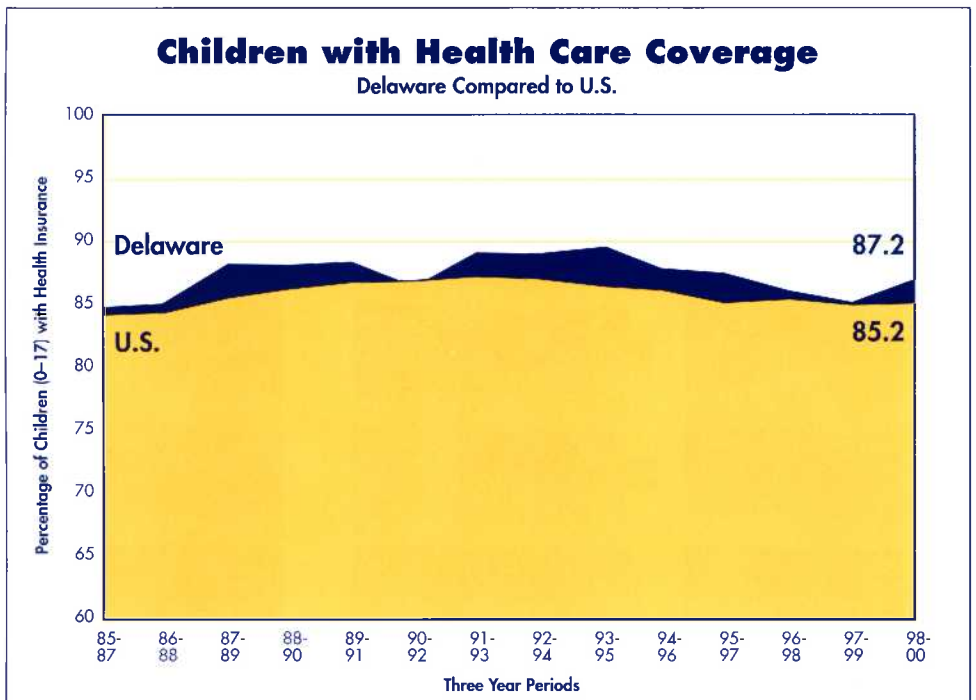
Many health risks can be monitored and controlled with adequate health care. It is more cost efficient to pay for prevention than it is to pay for curative measures. Children without insurance are 30% less likely to receive medical treatment for injuries than are children with insurance.[4]

1 "Children without health insurance" (1998). Census Brief March 1998

2 Health Insurance Coverage: 1999 Current Population Reports Robert J. Mills US Census Bureau

3 Creating access to care for children and youth: school based health centers 1998-99 (2000). National Assembly on School Based Health Care.

4 Hoffman, Catherine and Alan Schlobohm (2000) Uninsured in America: A Chart Book., 2ed



Source: Center for Applied Demography and Survey Research, University of Delaware

Delaware is experiencing an increase in children with health insurance due to the advent of the Delaware Healthy Children Program. In fact, preliminary data from 2000 indicates that the one-year percentage for children *without* health insurance is 6.7, or 93.3% of children insured.

Program Statement: With the advent of the Delaware Healthy Children Program in 1999, Delaware embarked on an aggressive campaign to enroll eligible children in public insurance programs. Uninsured children in families with incomes up to twice the poverty level have access to health insurance at minimal cost. Since the outreach campaign began, Delaware has enrolled 6,480 children in Medicaid and 7,455 children in the Delaware Healthy Children program.

HEALTHY CHILDREN

For more information see

Health Care Coverage (Families) p. F-41

In the KIDS COUNT Section:

Asthma p. K-48

Children without Health Insurance p. K-46

Tables 54-55 p. K-87-88

Substance Abuse

Indicator: ***Percent of participants in Delaware surveys of public school 8th graders using substances (cigarettes, alcohol, marijuana) in the last 30 days***

Research shows that alcohol is the drug most frequently used by 12–17 year olds and that alcohol-related car crashes are the number one killer of teens. Its use is associated not only with motor vehicle crashes but also with other injuries, deaths, problems in school, fighting, crime, and other serious consequences. [1]

Smoking has serious long-term consequences, including the risk of smoking related diseases, increased health care costs associated with treating these illnesses and the risk of premature death. [2] *Many adults who are addicted to tobacco today began smoking as adolescents, and it's estimated that more than 5 million of today's underage smokers will die of tobacco-related illnesses.* [3]

(continued on next page)

Substance Abuse

Percent of participants in Delaware surveys of public school 8th graders using substances (cigarettes, alcohol, marijuana) in the last 30 days
Delaware, 1999

Cigarette Use	Alcohol Use	Marijuana Use
Delaware – 20	Delaware – 26	Delaware – 16
Males – 19	Males – 25	Males – 18
Females – 21	Females – 25	Females – 14
NC Co. – 20	NC Co. – 26	NC Co. – 18
Males – 19	Males – 25	Males – 19
Females – 22	Females – 26	Females – 15
Kent Co. – 16	Kent Co. – 23	Kent C – 11
Males – 14	Males – 22	Males – 11
Females – 17	Females – 24	Females – 10
Sussex Co. – 24	Sussex Co. – 28	Sussex Co. – 17
Males – 24	Males – 30	Males – 21
Females – 23	Females – 25	Females – 13
1997 Rate: 22	1997 Rate: 28	1997 Rate: 15
1998 Rate: 24	1998 Rate: 29	1998 Rate: 19
1999 Rate: 20	1999 Rate: 26	1999 Rate: 16

Sources: The Center for Drug and Alcohol Studies, University of Delaware and the Office of Prevention, Department of Services for Children, Youth and Their Families

Program Statement: The Department of Education has primary responsibility for funds received under the Safe and Drug Free Schools and Communities Act. Grants to school districts support a range of skill-based programs and intervention strategies such as conflict resolution training and substance awareness. DOE also works collaboratively with the Office of Prevention at the Department of Services for Children, Youth and Their Families – Family Services Division, and the University of Delaware on substance abuse issues.

For more information see

Substance Abuse – 11th Grade	p. F-21
Student Achievement	p. F-28
In the KIDS COUNT Section:	
Student Violence and Possession	p. K-8
Alcohol, Tobacco, and Other Drugs	p. K-50
Healthy Lifestyles	p. K-52
Tables 31-37	p. K-77-80

Substance Abuse

Indicator: *Percent of participants in Delaware surveys of public school 11th graders using substances (cigarettes, alcohol, marijuana) in the last 30 days*

(continued from previous page)

Drug use by adolescents can have immediate as well as long-term health and social consequences. Marijuana use poses both health and cognitive risks while cocaine is linked with health problems such as eating disorders and death from heart attacks and strokes. Possession and/or use of drugs is illegal and can lead to a variety of penalties and a permanent criminal record. [1]

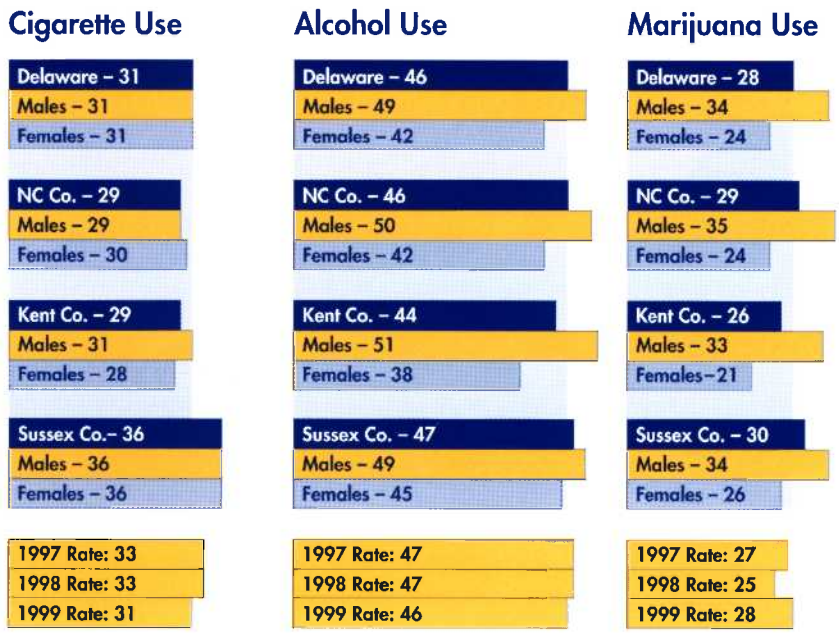
1 America's Children: Key National Indicators of Well-Being, 1999

2 Kessler, D.A. et al. (1996). The Food and Drug Administration's regulation of tobacco products. New England Journal of Medicine, 335 (13), 988-994.

3 Centers for Disease Control and Prevention. (1996). Projected smoking-related deaths among youth-United States. Morbidity and Mortality Weekly Report, 45 (44), 971-974.

Substance Abuse

Percent of participants in Delaware surveys of public school 11th graders using substances (cigarettes, alcohol, marijuana) in the last 30 days Delaware, 1999



Sources: The Center for Drug and Alcohol Studies, University of Delaware and the Office of Prevention, Department of Services for Children, Youth and Their Families

For more information see

Substance Abuse – 8th Grade p. F-20

Student Achievement p. F-28

In the KIDS COUNT Section:

Student Violence and Possession p. K-8

Alcohol, Tobacco, and Other Drugs p. K-50

Healthy Lifestyles p. K-52

Tables 31-37 p. K-77-80

Teen Deaths

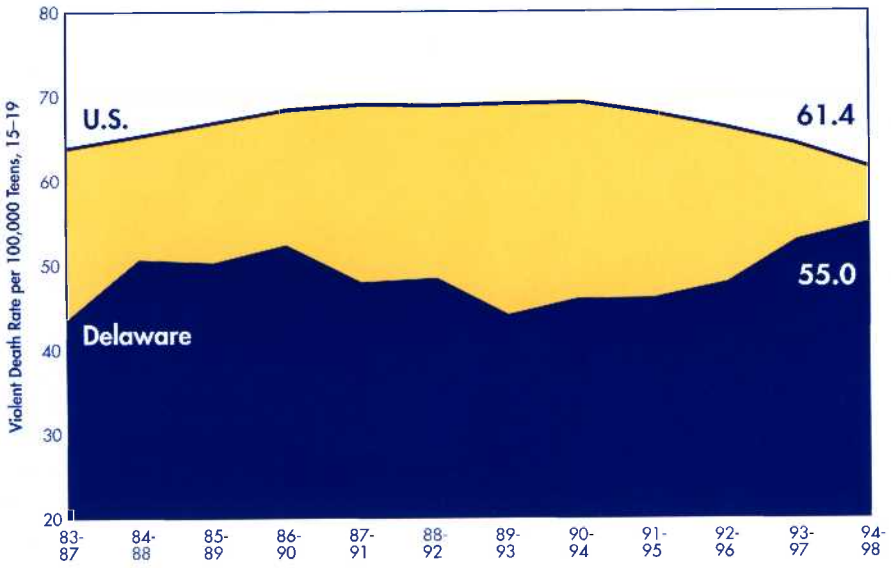
Indicator: *Rate of teen deaths by injury, homicide, and suicide (per 100,000 teens age 15–19)*

With teen violence on the rise, this indicator is frequently highlighted in the media. However, it is important to note that accidents continue to account for far more teen deaths that either homicide or suicide.[1]

Late adolescence poses serious peril to young people. Youth in this age group are almost three times as likely to die as their younger counterparts. With increasing freedom from adult supervision, some youths make choices that put themselves and others in mortal danger.[2] *Teenagers as a group are more willing to take risks, less likely to use safety belts and are more susceptible to the effects of alcohol. Teens with a history of psychiatric disorders, exposure to suicide, disruption of the family, and exposure to violence are at greatest risk for suicide.*[3]

1 Teen Deaths. (1998). *Indiana Kids Count 1998 Databook.*
2 Teen Deaths (1999). *Kids Count in Michigan, 1999 Databook.*
3 Teen Deaths. (1998). *Alabama Kids Count 1998 Report.*

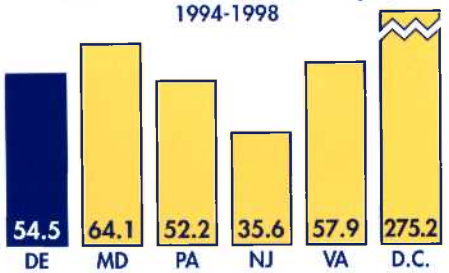
Teen Deaths by Accident, Homicide, and Suicide
Delaware Compared to U.S.



Sources: Delaware Health Statistics Center, National Center for Health Statistics

Program Statement: Prevention activities are offered to teens where they are-in schools and communities. School-based health center programs targeted to prevent deaths among teens include suicide prevention, alcohol and drug abuse prevention, violence prevention and conflict resolution, and counseling. Delaware's Family Service Cabinet Council coordinates many community-based prevention programs, including Family Service Partnerships, Strong Communities projects, and Prevention Networks.

Regional Comparison of Teen Death Rates per 100,000 teens (15-19) by Accidents, Suicides, and Homicides, Five Year Averages, 1994-1998



Sources: Delaware Health Statistics Center, National Center for Health Statistics*

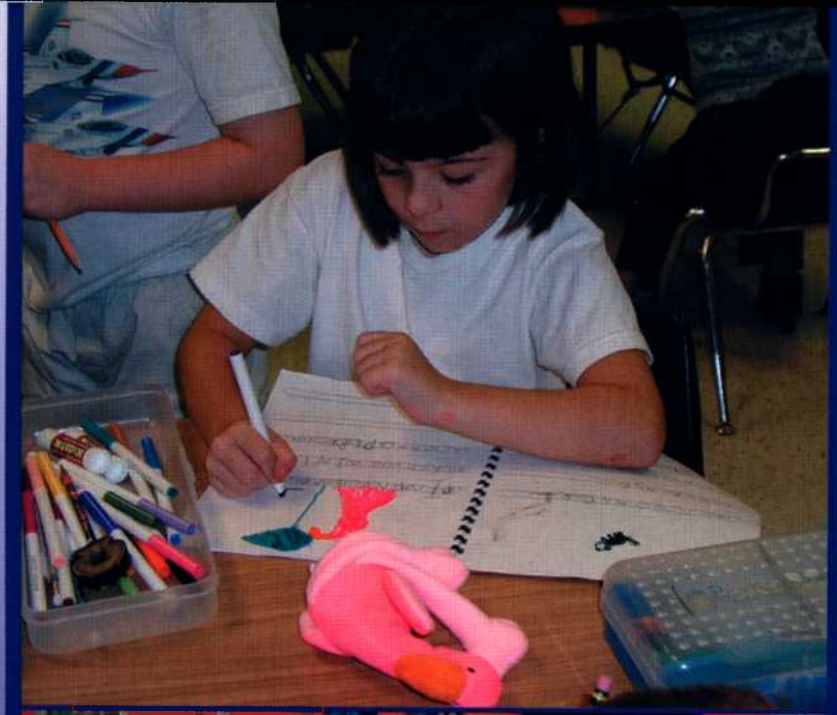
* Percentages vary due to different estimating procedures being used by different sources.

For more information see

Substance Abuse p. F-20-21

In the KIDS COUNT Section:

Teen Deaths p. K-26
Alcohol, Tobacco, and Other Drugs p. K-50
Healthy Lifestyles p. K-52
Table 25-26 p. K-75
Table 31-37 p. K-77-80



Successful Learners

Goal: Children are prepared to enter school, progress to high school graduation and make successful transitions to adulthood. Increasing percentages go on to post-secondary education. Children with developmental disabilities or specific needs reach their full potentials.

Early Intervention

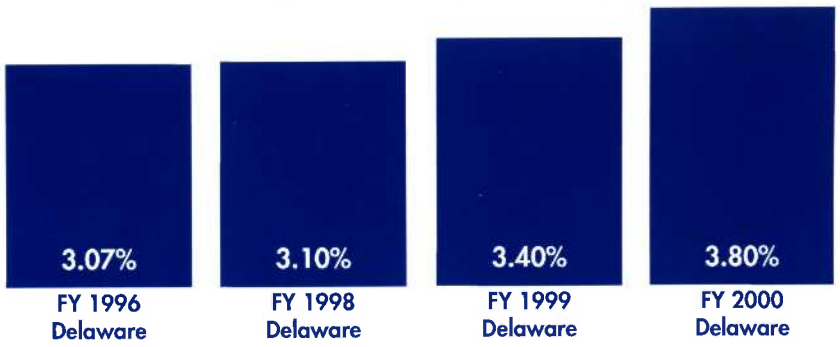
Indicator: Percent of children ages birth to three receiving early intervention developmental delay/disability services

Developmental delays/disabilities can seriously impact a person's ability to participate fully in life's activities. Developmental delays/disabilities can include: autism, deafness, deaf-blindness, hearing impairment, mental retardation, multiple disabilities, orthopedic impairment, emotional disturbance, learning disability, speech/language impairment, traumatic brain injury and/or visual impairment.[1] With the implementation of IDEA's Early Intervention Program, infants and youth are entitled to state service programs to help address the needs of these children.

1 Disabilities that qualify children and youth for special education services under IDEA (1997). National Information Center for Children and Youth with Disabilities.

Early Intervention

Percent of Children Aged 0–3 in the Early Intervention System, Delaware

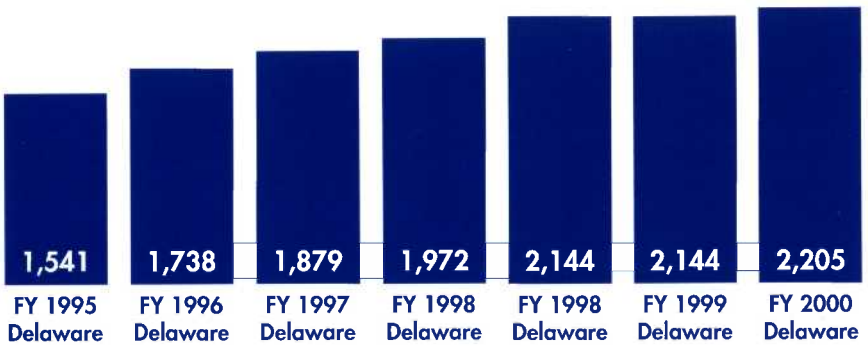


Source: Delaware Department of Health and Social Services

Note concerning comparison data: There are no comparable U.S. statistics since the eligibility criteria for early intervention varies from state to state, and the U.S. Office of Special Education has recently begun to report on Infants and Toddlers served under the Individuals with Disabilities Education Act. Please note that an April 1994 U.S. Department of Education report estimated that 2.2% of all infants and toddlers had limitations due to a physical, learning or mental health condition, but this may not include children with developmental delays and children with low birth weight who are also eligible in Delaware.

Child Development Watch

Total Children Served per Year, Delaware



Source: Early Intervention System

Program Statement: Delaware provides extra help to infants and toddlers who need it. Child Development Watch (CDW) partners with families to serve children ages birth to three with disabilities and developmental delays. Through individualized service plans, CDW provides access to needed services, such as physical, occupational, and speech-language therapy, family training and counseling, and transportation.

For more information see

Head Start and Early Childhood Assistance Program p. F-27

In the KIDS COUNT Section:

Early Care and Education p. K-40

Head Start and Early Childhood Assistance Program

Indicator: ***Rate of participation for eligible 4 year olds in Head Start and Early Childhood Assistance Program***

Common sense has always told us that babies benefit from an environment of love, nurturing, and stimulation. Now, new medical research confirms the notion that the experiences of children in the first three years of life determines, to a large degree, the brightness of their future.[1] Children's brains show almost twice the activity of an adult brain until the age of ten. Therefore, high quality early education opportunities for young children are essential and need to be available to children in all of their environments, including child care outside of the home. Further studies indicate that the quality of child care is important because it is closely linked with children's social, cognitive, and language development. Children in high quality early childhood programs are more likely to be emotionally secure and self-confident, proficient in language use, able to regulate impulsive and aggressive inclinations, and advanced in cognitive development.[2]

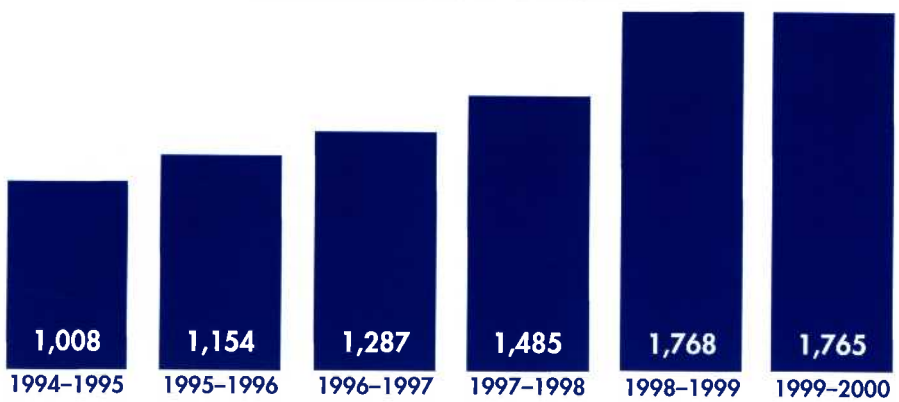
An ever increasing number of parents juggle work schedules and child care needs with availability of family financial and human resources to meet the demands of parental and employment responsibilities.[3] One obstacle that many working parents encounter is the limited availability of affordable child care. Even when cost is not an insurmountable barrier, many families find that child care is simply not available at the times and places it is needed.

1 Colorado's Children's Campaign, (1998) *Kids Count in Colorado.*
2 Tennessee Kids Count, (1999). *The State of the Child in Tennessee.*
3 Michigan Kids Count. (1999). *Michigan Kids Count Databook 1999.*

SUCCESSFUL LEARNERS

Head Start/ECAP

4-Year-Old Children Served in Delaware



	94–95	95–96	96–97	97–98	98–99	99-00
Estimated number of 4-yr.-olds in Head Start	855	865	886	931	925	922
Number of children in ECAP	153	289	401	554	843	843
Estimated number of 4-yr.-olds eligible	N/A	N/A	N/A	1,938	1,938	1,935
Percentage of 4-yr.-olds served	N/A	N/A	N/A	77%	91%	91%

Source: Delaware Department of Education

Program Statement: Delaware provides funding for comprehensive early childhood services for 4 year old children whose families are at or below 100% of poverty to complement existing Head Start programs that ensures opportunities for preschool education for all eligible children. Working collaboratively with federally-funded Head Start centers and other early care and education programs throughout the state, these Department of Education programs provide a full range of preschool, health, developmental, and other family support services.

For more information see
Early Intervention p. F-26
In the KIDS COUNT Section:
Early Care and Education p. K-40

Student Achievement

Indicator: *Percent of third, fifth, eighth, and tenth graders at or above the standard for reading*

Indicator: *Percent of third, fifth, eighth, and tenth graders at or above the standard for math*

The extent and content of students' knowledge, as well as their ability to think, learn, and communicate, affect their ability to succeed in the labor market well beyond their earning of a degree or attending school for a given number of years. On average, students with high test scores will earn more and will be unemployed less often than students with lower test scores.[1] Math and reading achievement test scores are important measures of students' skills in these subject areas, as well as good indicators of achievement overall in school.[2]

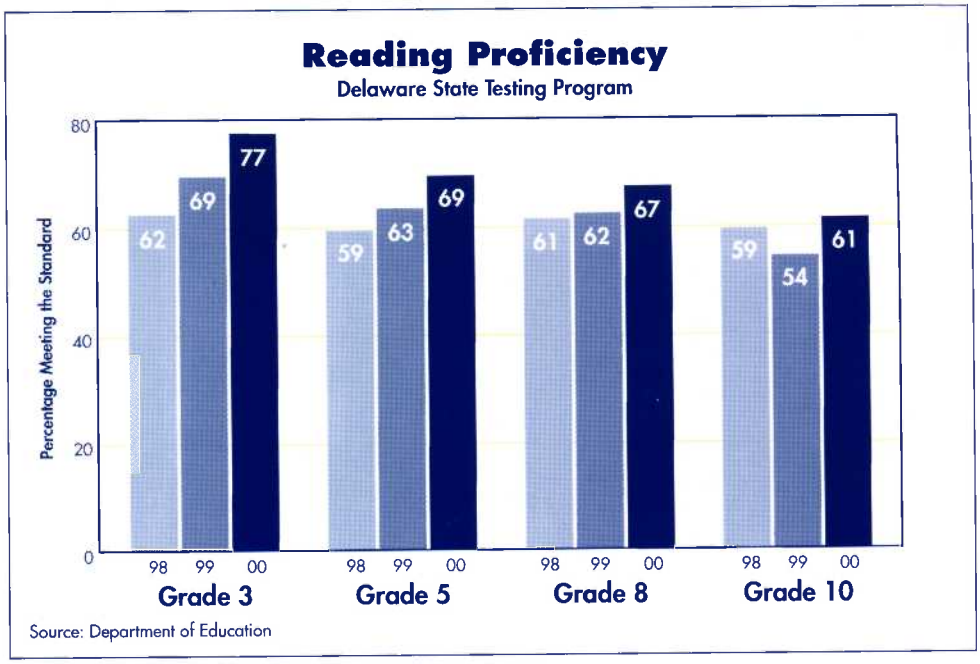
1 Decker, P.T., Rice, J K., Moore, M.T., and Rollefson, M. (1997). *Education and the economy: An indicators report.* Washington, D.C: National Center for Education Statistics.

2 Federal Interagency Forum on Child and Family Statistics. *America's Children: Key National Indicators of Well-Being, 1999.* Washington, D.C .

SUCCESSFUL LEARNERS

Delaware State Testing Program

The Delaware State Testing Program (DSTP), designed by Delaware educators, measures how well students are progressing toward the state content standards. The program is one part of a much larger and richer effort by the educational community to ensure a high quality education for each and every student in Delaware. The DSTP will assist Delaware educators in determining the degree to which we are achieving the goal. The score reports from this second year of the DSTP will give each school a sense of where they stand in their efforts to help all students meet the standards.



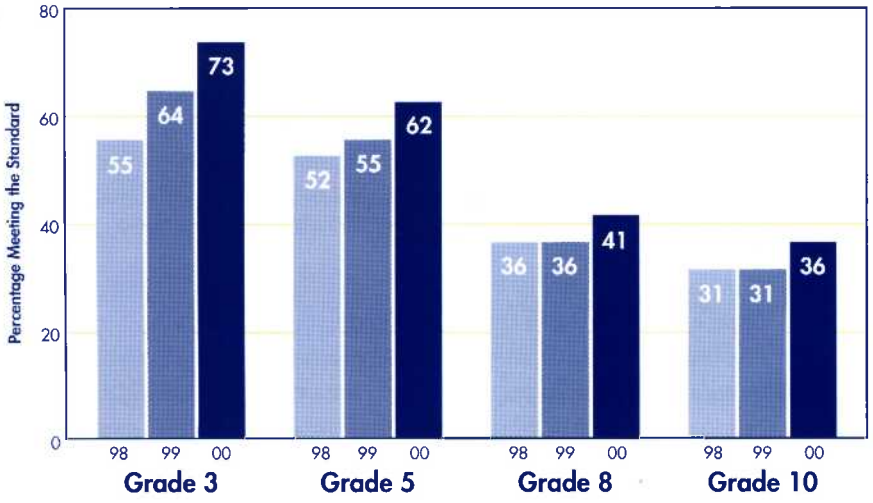
DSTP Proficiency Levels – Delaware State Testing Program

Students receive scores indicated by the following levels:

Level	Category	Description
5	Distinguished	Excellent performance
4	Exceeds the standard	Very good performance
3	Meets the standard	Good performance
2	Below the standard	Needs improvement
1	Well below the standard	Needs lots of improvement

Math Proficiency

Delaware State Testing Program



Source: Department of Education

The Building Blocks of Delaware's Education Plan

1. Ensuring children enter school ready to learn
2. Requiring accountability
   - Setting high standards in core academic subjects
   - Measuring performance of schools and school districts
   - Setting standard and providing incentives for teachers to excel
3. Guaranteeing safe, disciplined schools
4. Empowering parents through school choice, charter schools, and school-based decision making
5. Equipping schools with technology to support excellence in instruction
6. Providing education and training for work and life

Guiding Principles of Delaware's Accountability Plan

The most important function of the Delaware public school system is to produce graduates with outstanding skills and knowledge in the core academic subjects – English/language arts, math, science and social studies.

- Reading is the most important learning skill. The second most important learning skill is math.
- The social promotion of students deficient in reading and math is wrong and must end.
- Students who perform well should receive recognition for high achievement.
- Delaware should provide rewards for high-performing schools and consequences for holding poorly performing schools accountable.
- New teachers should meet pre-service standards, and the performance of all teachers should be evaluated at the local level.
- Local school districts should remain primarily responsible for professional and staff development.

SUCCESSFUL LEARNERS

For more information see

High School Dropouts p. F-31

In the KIDS COUNT Section:

High School Dropouts p. K-30

Tables 40-45 p. K-81-83

Teens Not in School and Not Working

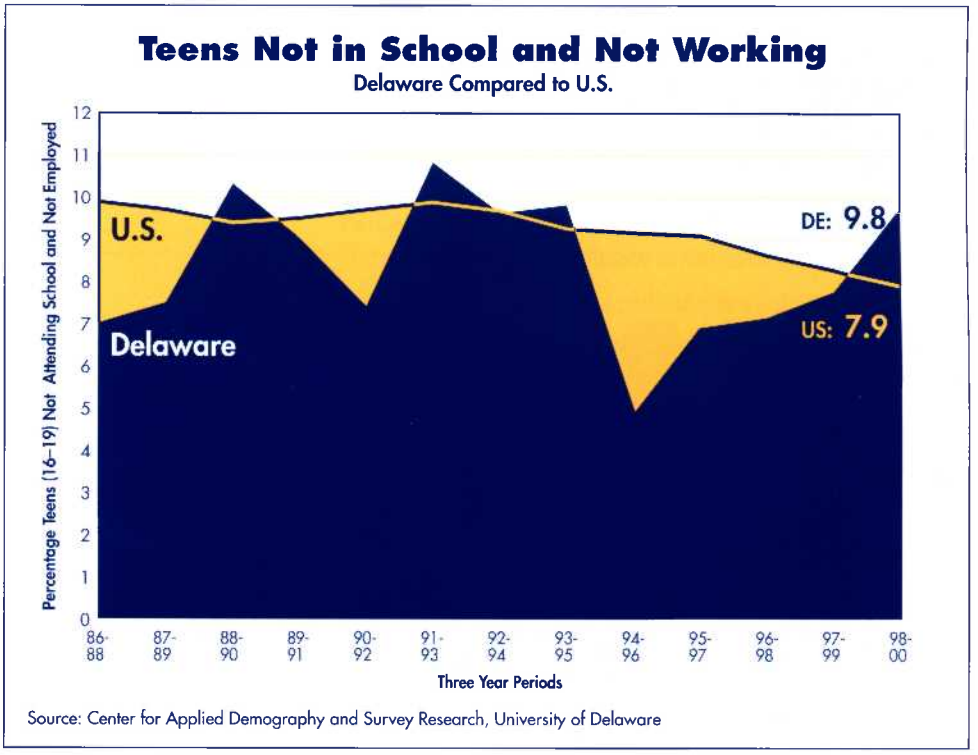
Indicator: ***Percent of teens age 16–19 not attending school and not working***

The indicator "teens not in school and not working" is defined as youths ages 16-19 who are not enrolled in school and are unemployed. This indicator includes recent high school graduates who are unemployed and teens who have dropped out of high school who are jobless. Work experience at this point in life is critical. People who spend a large share of their young adult years unemployed have a hard time finding and keeping a job later in life. [1]

Teens who are not in school and are not working are at increased risk of juvenile delinquency, substance abuse, juvenile crime, teen pregnancy, and lifelong poverty. Teens who have dropped out of high school are most vulnerable and at greatest risk. Gaps in schooling and lack of general preparation for the workforce also place teens at considerable risk as they make the difficult transition from adolescence to adulthood. [2]

1 Teens not in school and not working. (1999). *National Kids Count Data Book.*

2 Teens not in school and not working. (1998). *Nevada Kids Count Databook.*



Source: Center for Applied Demography and Survey Research, University of Delaware

For more information see

Student Achievement	p. F-28
High School Dropouts	p. F-31
Unemployment	p. F-50
In the KIDS COUNT Section:	
High School Dropouts	p. K- 30
Teens Not in School and Not Working	p. K-32
Tables 46-47	p. K-84
Table 65	p. K-92

Program Statement: In partnership with the Department of Education, the Division of Vocational Rehabilitation (DVR) operates a program to reduce the number of dropouts from secondary school and to assist students with disabilities transition from school to work. Two DVR counselors work with a team in each of the nineteen districts to develop individualized educational plans for students with disabilities. Through this effort, the Division intends to increase by 10% annually, the number of students who transition from education to employment over the next three years. In addition, The Department's overall School to Work efforts include partnerships with the Delaware Technical and Community College and local school districts to develop career pathways leading to successful work experiences.

High School Dropouts

Indicator: Percent of high school dropouts

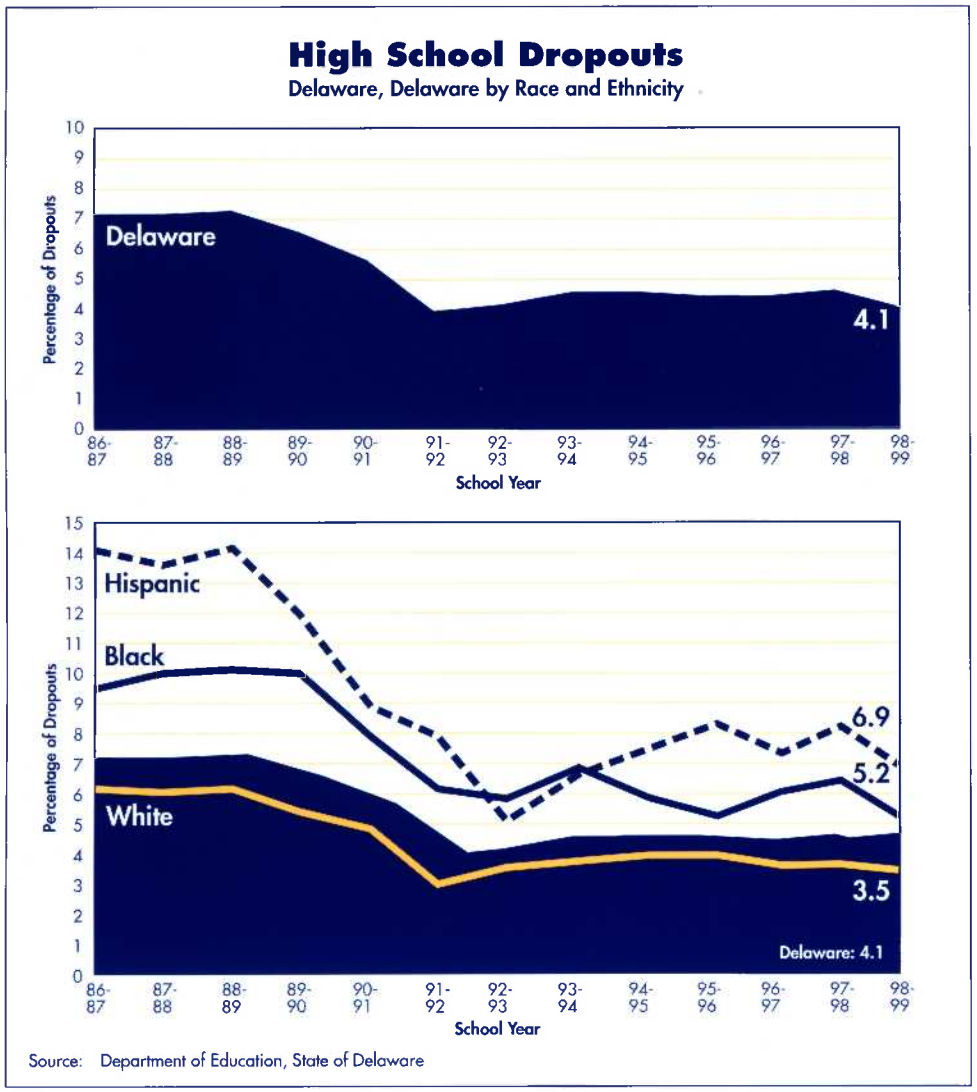
Students who drop out of high school face staggering odds in achieving economic success in the modern world. High school graduation is a minimum prerequisite to compete effectively in today's labor market.[1] Education is one of the most important factors that determines annual earnings that, in turn, are a direct link to one's socioeconomic status.[2] Students are more likely to drop out of school when they are poor, when they live in poor communities, or when they come from single-parent homes.[3] Potential warning signs that a child may drop out of high school include the inability to read at grade level, poor grades, truancy, substance abuse, and teen pregnancy.[4]

1 High school dropouts. (1998). *Nevada Kids Count Data Book.*

2 U.S. Department of Education, National Center for Education Stats. (1998, November 3). Education indicators: an international perspective.

3 Annie E. Casey Foundation. (1998). Kids Count Data Book.

4 Children's Defense Fund. (1995). The State of America's Children Yearbook.



Source: Department of Education, State of Delaware

SUCCESSFUL LEARNERS

For more information see

Student Achievement	p. F-28
Teens Not in School and Not Working	p. F-30
Unemployment	p. F-50

In the KIDS COUNT Section:

Infant Deaths by Education of Mother	p. K-23
High School Dropouts	p. K-30
Teens Not in School and Not Working	p. K-32
Suspension and Expulsions	p. K-33
Tables 40-45	p. K-81-83

Program Statement: The reduction of Delaware's high school dropout rate is a strong objective of several programs supported through the Department of Education. For example, Groves Adult High School is a statewide program designed for adults and out-of-school youth that have not received a high school diploma. The state has also funded alternative programs for students who have been or are close to being expelled.

Resourceful Families

Goal: Families have the educational, housing, health care, employment, and economic resources to be self-sustaining and self-sufficient at all stages in their family life cycle.

Children in Poverty

Indicator: Percent of children living in poverty

Poverty is related to all of the Families Count indicators. It is defined as the condition of not having enough income to meet basic needs for food, clothing, and shelter.[1] The 1999 poverty threshold for a family of four was $16,895 per year. Poverty has been found to be linked to a number of undesirable outcomes for children, including health, education, child abuse and neglect, delinquency, and emotional well-being.[2] Children who live in single-parent families with poorly educated, relatively young, minority race, or disabled adults are more likely to be poor and to experience longer poverty spells than children who do not live in such families.[3]

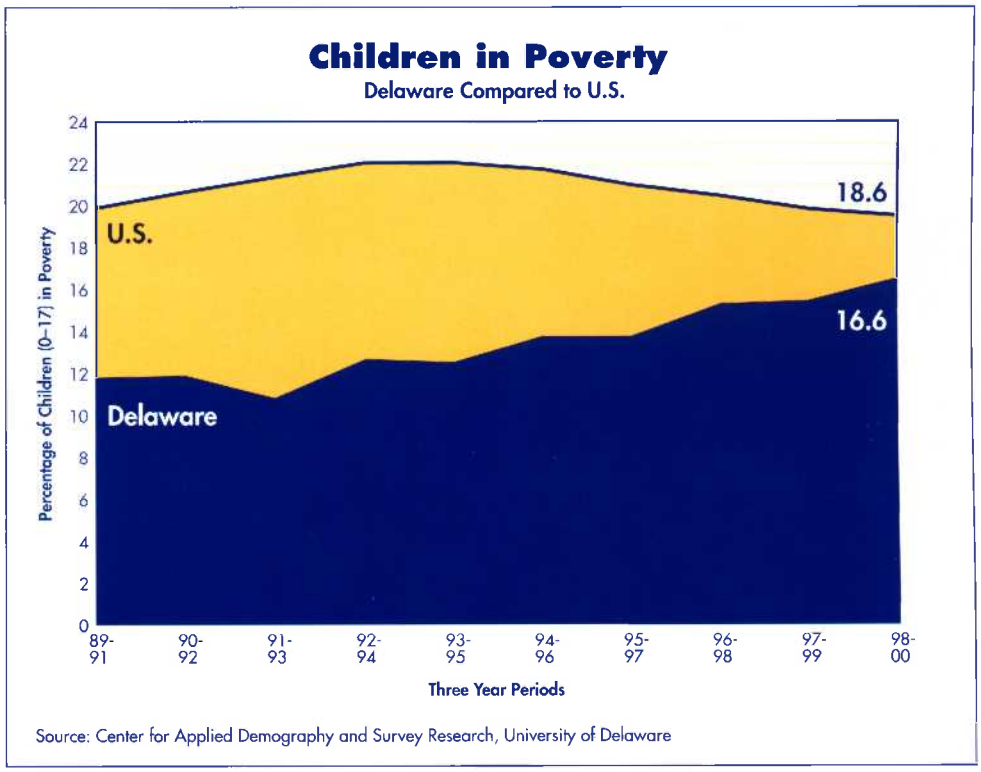
1 Future of children: the effects of poverty on children. (1997, Summer-Fall). *The Center of the Future on Children*, 7(2).

2 Children in poverty. (1999). *Kansas Kids Count Databook.*

3 Center for the Future of Children. The D
avid and Lucille Packard Foundation. (1997). The Future of Children: Children and Poverty. 7 (2).

For more information see

Health Care Coverage (Children)	p. F-19
Female Headed Household in Poverty	p. F-38
Child Support	p. F-39
Risk of Homelessness	p. F-40
Health Care Coverage (Families)	p. F-41
Unemployment	p. F-50
Substandard Housing	p. F-56
Home Ownership	p. F-57
In the KIDS COUNT Section:	
Children in Poverty	p. K-34
Median Income of Families by Family Type	p. K-36
Subsidized Child Care	p. K-41
Women and Children Receiving WIC	p. K-44
Children Receiving Free and Reduced Price School Meals	p. K-45
Children without Health Insurance	p. K-46
Tables 48-62	p. K-85-90



Source: Center for Applied Demography and Survey Research, University of Delaware

Program Statement: Delaware provides a safety net for the poor and is constantly striving to lift families out of poverty. Through Delaware's A Better Chance Welfare Reform Program, Delaware helps the parents of children in the poorest families get and keep jobs. The state also helps pay for child care and provides health coverage for families with incomes up to twice the poverty level, and requires parents to make timely child support payments.

One-Parent Households

Indicator: **Percent of children ages 0–17 in one-parent households**

Children living in single-parent families do not have the same resources and opportunities as those living in two-parent families.[1] When the single parent is a woman, the risk of sinking into poverty is significantly greater due to the wide earnings gap between men and women in the United States. Many single mothers also receive insufficient child support, which puts their children at greater risk for all the adverse outcomes linked to poverty.[2]

High divorce rates and high non-marital birth rates indicate that a record number of children are growing up without fathers in their lives. For the first time in history, the average child can expect to live a significant portion of his or her life in a home without a father.[3]

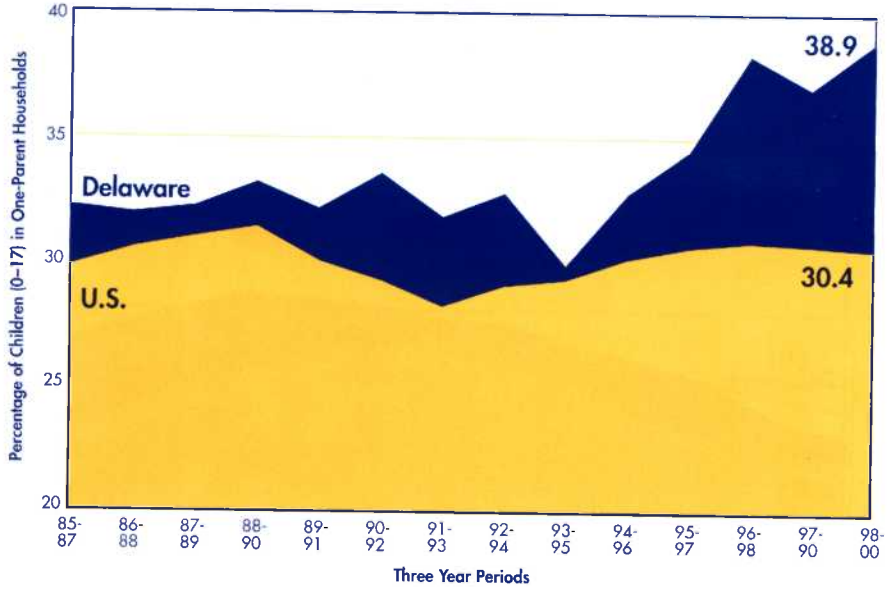
1 U.S. Bureau of Census (1997). *Census Brief:* Children with single parents - how they fare, U.S. Department of Commerce, Bureau of the Census, Washington, D.C.

2 Corocan, Mary E. and Ajay Chaudry (1997). The dynamics of childhood poverty. *The Future of Children: Children and Poverty*, The David and Lucille Packard Foundation, Los Altos, CA, Vol. 7, No. 2, Summer/Fall

3 Tennessee Kids Count. 1999. *The State of the Child in Tennessee.*

Children in One-Parent Households

Delaware Compared to U.S.



Source: Center for Applied Demography and Survey Research, University of Delaware

Program Statement: Delaware supports single-parent families through programs that

- enforce child support payments,
- offer subsidized child care,
- provide health insurance coverage through Medicaid and the Delaware Healthy Children Program,
- discourage teen pregnancy, and
- provide a wide variety of employment supports that include
  - assistance with finding and maintaining employment,
  - accessing transportation services,
  - increasing earnings, and
  - obtaining benefits.

For more information see

Female Headed Households in Poverty	p. F-38
Child Support	p. F-39
In the KIDS COUNT Section:	
Birth to Unmarried Teens	p. K-19
Infant Mortality by Martial Status of Mother	p. K-23
Children in Poverty by Household Structure	p. K-36
Children in One-Parent Households	p. K-38
Table 9	p. K-62
Table 18	p. K-70
Tables 58-64	p. K-89-91

Teen Births

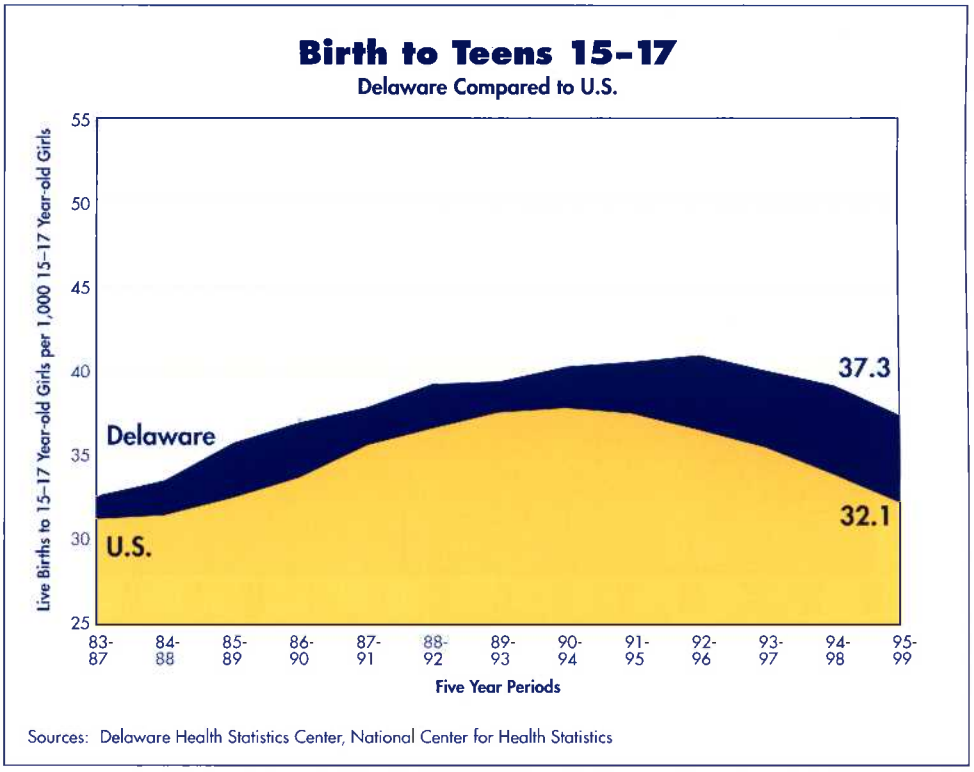
Indicator: Teen birth rate per 1,000 females age 15–17

When teens have children, both mothers and babies suffer negative consequences. Teen mothers often lack the appropriate parenting skills and find it difficult to cope with the stresses of parenthood, particularly if they lack support of either the fathers of their children or of their families[1].

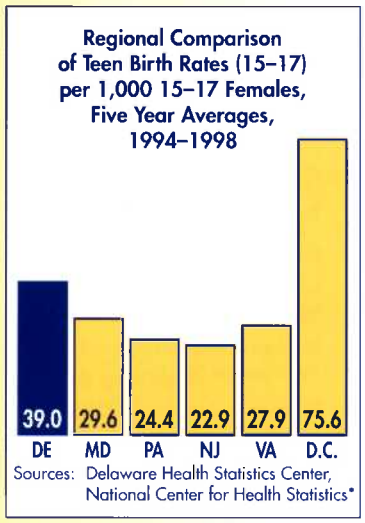
Often, the demands of fulfilling a parental role interferes with the teen mother's opportunity for peer relationships as well as the opportunity to develop her own sense of self-identity, a crucial development process for many individuals during their adolescent years[2].

Infants born to teenage mothers tend to have lower birth weights and experience higher rates of premature delivery and infant mortality. As they grow older, these children are more likely to be injured or become ill, have academic and behavioral problems in school and become teenage parents themselves[3].

1 Births to teens (1998). Kentucky Kids Count, *1998 Data Book*
2 Births to teens (1999). Kansas Kids Count, *1999 Data Book*
3 Births to teens. (1998). *Alabama Kids Count Report, 1999*



Sources: Delaware Health Statistics Center, National Center for Health Statistics

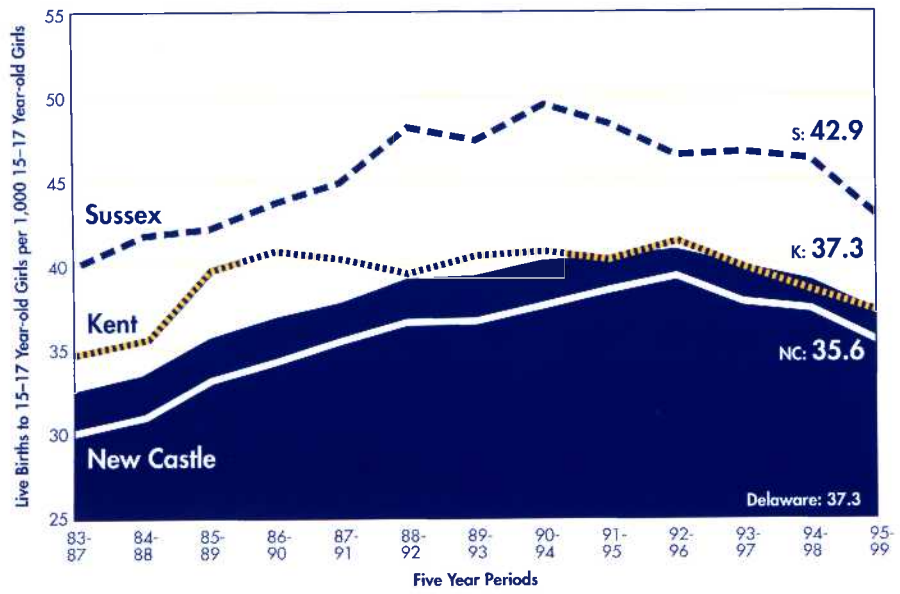


Program Statement: Through the Teen HOPE program, Delaware provides one-on-one and group counseling in seven School-Based Health Centers and seven community sites. At-risk teens are identified through negative pregnancy tests, positive STD tests, a history of substance abuse, and other risk factors. In Northeast Wilmington, BRIDGES, a fully coordinated youth program, combines academic and entrepreneurial development components with intensive counseling. The goal is to improve educational and economic opportunities while decreasing risky behaviors.

* Percentages vary due to different estimating procedures being used by different sources.

Birth to Teens 15-17

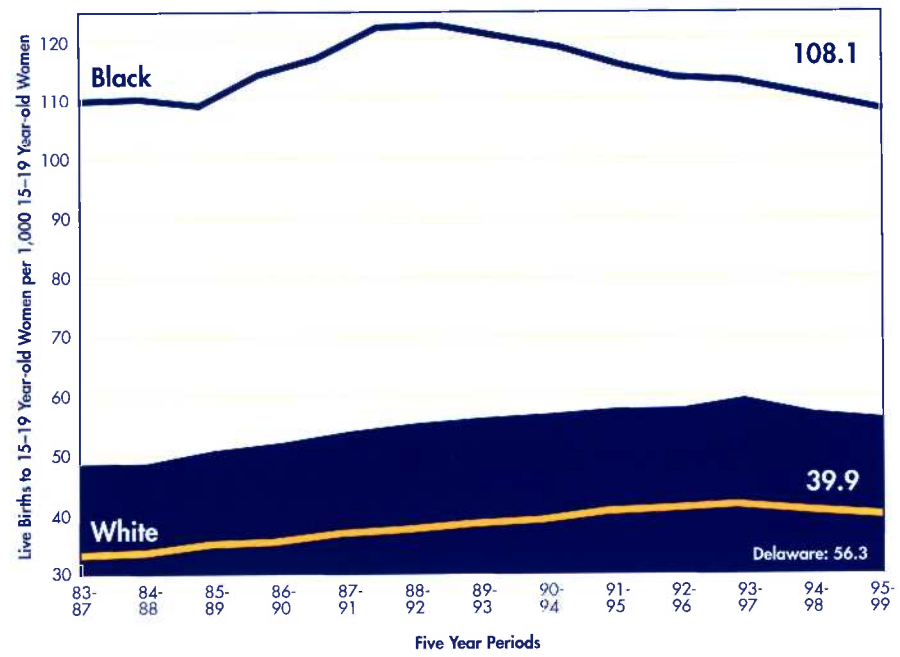
Delaware and Counties



Sources: Delaware Health Statistics Center

Births to Teens 15-19*

Delaware by Race



* 15–17 year old population data by race is currently unavailable

Sources: Delaware Health Statistics Center

RESOURCEFUL FAMILIES

For more information see

Sexually Transmitted Diseases	p. F-22
One-Parent Households	p. F-35
In the KIDS COUNT Section:	
Birth to Teens 15-17	p. K-18
Birth to Unmarried Teens	p. K-19
Low Birth Weight by Age and Race of Mother	p. K-21
Infant Mortality by Age of Mother	p. K-23
Children in Poverty by Household Structure	p. K-35
Children in One-Parent Households	p. K-38
Tables 6-10	p. K-60-63
Tables 13-14	p. K-65-66
Table 21	p. K-72

Female-Headed Households in Poverty

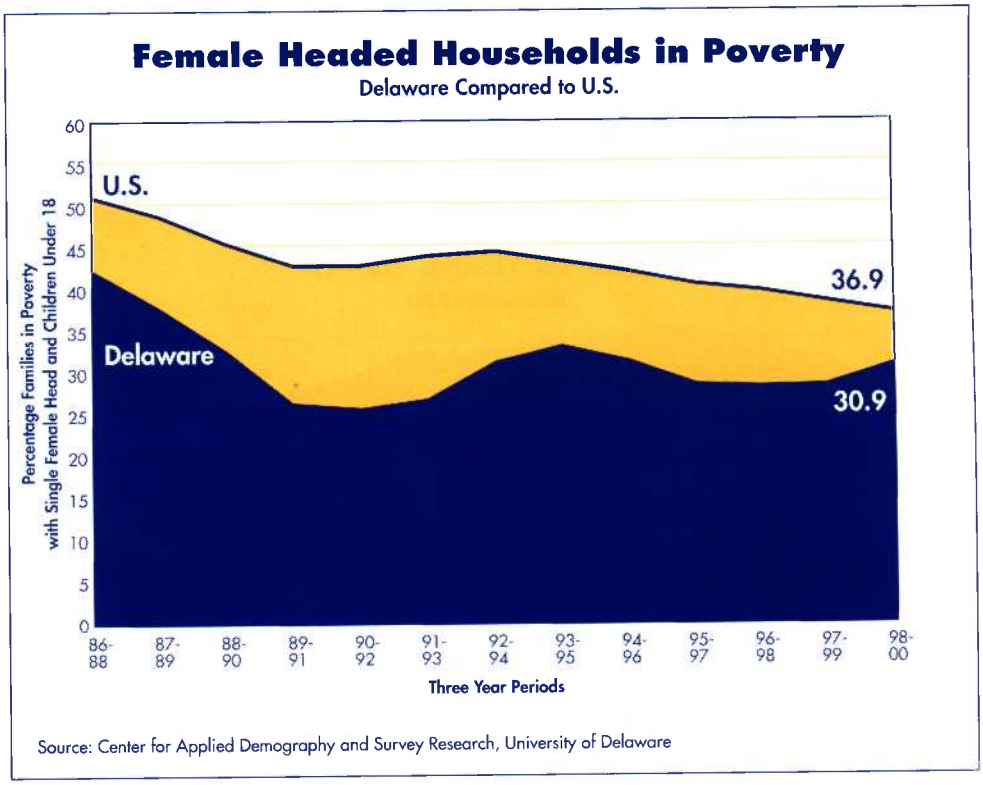
Indicator: ***Percent of families in poverty with female single head of household and children under 18***

Many children today are living with only one parent, and the majority of those single-parents are female. According to a recent Census Brief, seven million children live with unemployed single mothers.[1] Children born to single mothers out of wedlock, are 1.7 times more likely to be poor than those born to married parents. Several indicators play a role in the likelihood of a child living in poverty: the mother's education, work status, and/or the presence of other adults in the household.[2] The income of the poorest twenty percent of female-headed families with children fell an average of $580 per family between the years of 1995 and 1997. This amount includes the use of food stamps, housing subsidies, the Earned Income Tax Credit, and other benefits.[3]

1 Children with single parents: How they fare (1997). Census Brief US Dept. of Commerce

2 Assessing the New Federalism: Poverty among Children Born Outside of Marriage Preliminary Findings from the National Survey of America's Families Urban Institute Dec 1999

3 The Initial Impacts of Welfare Reform on the incomes of Single-Mother Families. Center on Budget and Policy Priorities 1999.



Source: Center for Applied Demography and Survey Research, University of Delaware

Program Statement: Although Delaware's child poverty rate is lower than the national average, we strive to eliminate poverty for families, especially those with single parents. Through programs that enforce child support payments, offer subsidized childcare and other employment supports, and discourage teen pregnancy, we hope to provide a stable environment for children to thrive.

For more information see

One Parent Households	p. F-35
Child Support	p. F-39
In the KIDS COUNT Section:	
Children in Poverty by Households Structure	p. K-36
Children in One-Parent Households	p. K-38
Table 9	p. K-62
Table 50	p. K-85
Tables 58-63	p. K-89-90

Child Support

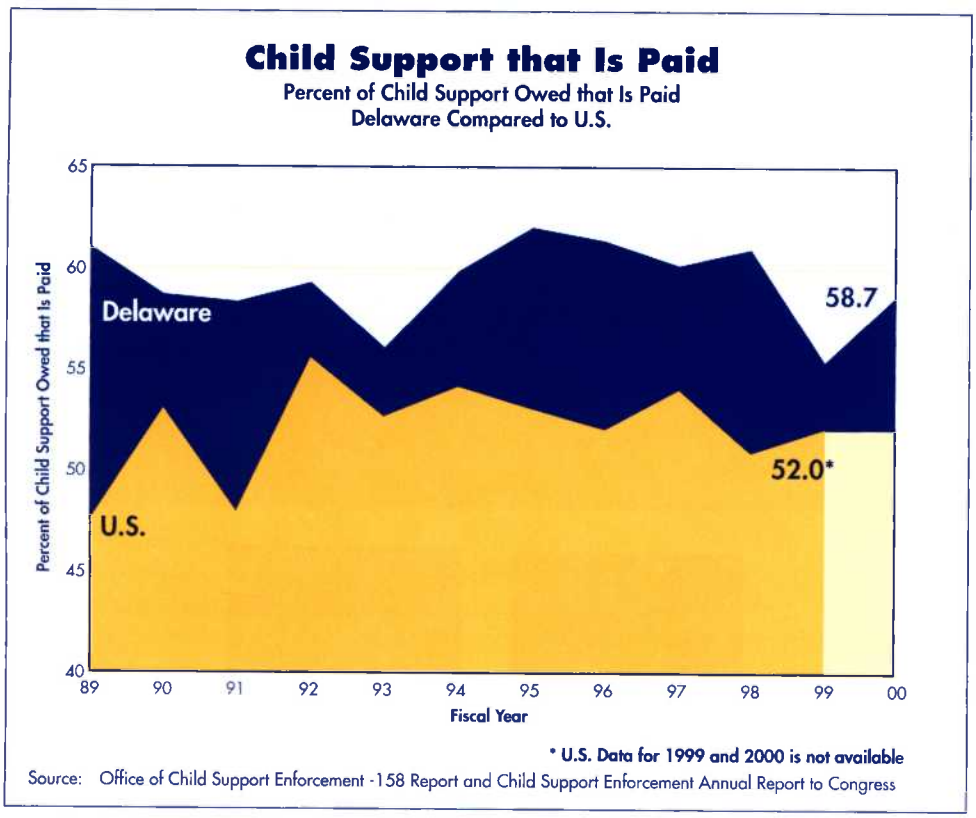
Indicator: *Percent of child support that is paid*

According to the most recent current population report, nearly three out of every ten children live in a single-parent household.[1] Often these parents need added financial support in the form of child support to provide for their children. Eighty-five percent of these custodial parents are women, who typically earn less than their male counterparts in the workforce.[2] Unfortunately being awarded child support payments via the court does not guarantee that the custodial parent will actually receive their payments, thus creating the need for child support enforcement agencies. Of the $17.7 billion due in child support in 1991, only $11.9 billion was actually paid to custodial parents.[3]

1 *Child Support for Custodial Mothers and Fathers: 1995* Current Population Reports US Dept of Commerce Mar 1999

2 ibid

3 Who Receives Child Support? (1995). Bureau of the Census Statistical Brief



Source: Office of Child Support Enforcement -158 Report and Child Support Enforcement Annual Report to Congress

RESOURCEFUL FAMILIES

Program Statement: In Delaware, the financial responsibility for children belongs to both parents. The Division of Child Support Enforcement enforces court orders that require the absent parent to provide payment to the custodial parent. The Division assists in establishing paternity and support orders and enforces collections through wage withholding and a variety of federally approved or mandated methods.

For more information see
In the KIDS COUNT Section:
Table 63 p. K-90

Risk of Homelessness

Indicator: ***Percent of families at risk of becoming homeless or living in substandard housing units***

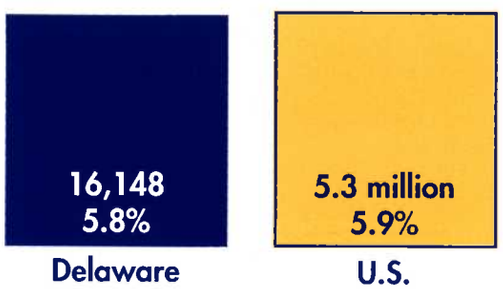
On any given night an estimated 750,000 Americans experience homelessness.[1] Although stereotypes suggest that most homeless people are elderly men, the fastest growing group of homeless people is families with young children. Several factors increase a person's risk of homelessness: lack of affordable housing, extremely low income, lack of social services, psychiatric disability, substance abuse, domestic violence, chronic illness, history of confinement in prisons and/or psychiatric hospitals, weak and overdrawn support networks of family and friends.[2] Today there are twice as many low-income families as there are affordable housing units. This increases the risk of homelessness for families with young children.

Homelessness poses an even greater danger to young children. The McKinney Education of Homeless Children and Youth Act was established in Congress in 1987.[3] This has helped states to ease the burden of enrolling homeless children into schools. Being homeless makes it very difficult to register for school, pay school fees, buy clothing for school, participate in afterschool activities or to access before and after school care programs.[4] Once enrolled in school, children face the insurmountable task of trying to catch up to their fellow students. They lack a safe, quiet environment to study and complete their homework. Often homeless children change schools frequently, making it difficult for schools to obtain transcripts and immunization records.

1 Facts about homelessness. National Alliance to End Homelessness 1998. Available from www.endhomelessness org
2 Priority home!: the federal plan to break the cycle of homelessness. March 1994
3 Education of homeless children and youth. National Coalition for the Homeless June 1999
4 Education of homeless children and youth. National Coalition for the Homeless June 1999

Risk of Homelessness

Number and percent of families living in substandard housing units or at risk of becoming homeless, 1995



Source: Delaware State Housing Authority

Program Statement: Delaware knows that families need more than just a temporary roof over their heads when they are facing homelessness. They need security along with hand-in-hand assistance in picking up the pieces that stabilize their lives and help them get back on the road to independence. Where possible, Delaware State Housing Authority makes every attempt to rescue not just the family, but also the substandard homes, by providing funds that repair the health and safety hazards pushing families toward homelessness. Delaware State Housing Authority also helps to bridge the gap between that state's network of homeless providers to jointly create one seamless, holistic continuum of care on which homeless families can rely to take care of their immediate needs, while helping them rebuild their lives. By pooling resources, and preventing or solving the problems behind homelessness, Delaware makes full recovery realistic for families facing the scariest of times.

For more information see

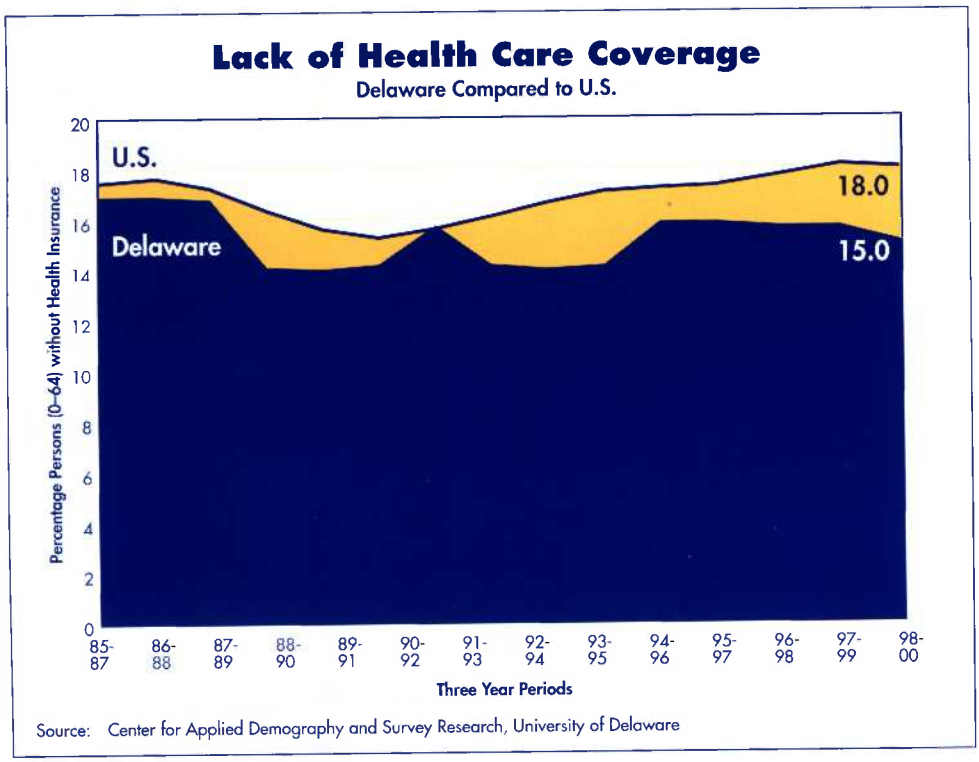
Substandard Housing	p. F-56
Home Ownership	p. F-57
In the KIDS COUNT Section:	
Table 57	p. K-88

Health Care Coverage

Indicator: ***Percent of persons under age 65 who do not have health care coverage***

According to the Kaiser Commission on Medicaid and the Uninsured many Americans determine the extent of their health care coverage based on the availability of insurance. Uninsured Americans often opt to self-medicate and self-diagnose symptoms rather than visit a doctor because the costs are too high. Children without insurance are 30% less likely to receive medical treatment for injuries than those with insurance.[1] Often more serious health problems can be avoided by visiting a doctor.

1 Hoffman, Catherine and Alan Schlobohm (2000). Uninsured in America. A chart Book., 2nd ed.



Source: Center for Applied Demography and Survey Research, University of Delaware

Program Statement: In Delaware all citizens living below the poverty level have access to health insurance. The Diamond State Health Plan insures low-income adults and children, giving them access to needed medical prevention and treatment services. The Delaware Healthy Children Program provides low-cost coverage to children in families with income up to twice the poverty level, extending coverage to more children of the working poor.

For more information see

Health Care Coverage (Children) p. F-19

In the KIDS COUNT Section:

Asthma p. K-48

Children without Health Insurance p. K-46

Table 54-55 p. K-87-88

Nurturing Families

Goal: Families will provide a nurturing environment for all members free of violence, neglect, and abuse.

Child Abuse

Indicator: *Children with substantiated reports of abuse or neglect per 1,000 children ages birth through 17*

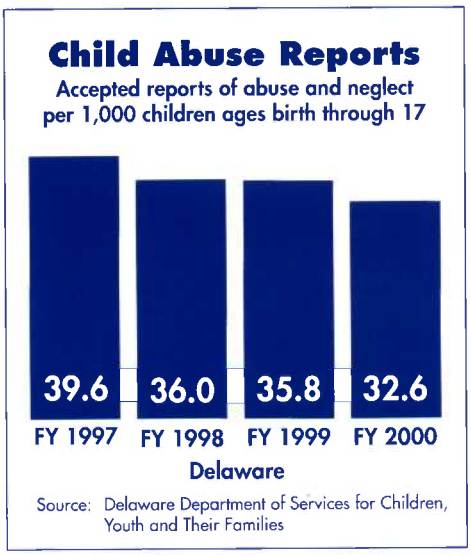
Accepted reports of abuse and neglect per 1,000 children ages birth through 17

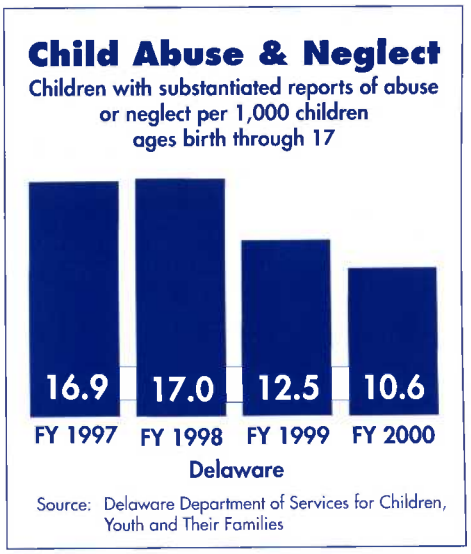
According to the 1998 National Child Abuse and Neglect Reporting System an estimated 903,000 children suffered from maltreatment.[1] More than half of these cases were instances of neglect, while 22.7% suffered physical abuse.[2] The highest victimization rates were for children ages 0-3 years old. There are several forms of abuse: physical, emotional, sexual, and/or neglect. Abuse and neglect can lead to short and long-term psychological and physical impacts such as violence, incarceration and mental illness.[3]

1 "Child Abuse and Neglect National Statistics" US Department of Health and Human Services

2 ibid

3 Trends in the Well-being of America's Children and Youth. US Department of Health and Human Services





Program Statement: The state has several programs to intervene early to help prevent child behavior or family problems from escalating to the point where abuse or neglect would become more probable.

K-3 Early Intervention Program – This early intervention program is for children in kindergarten through third grades who are having behavioral or family problems that are interfering with their success in school. School-based Family Crisis Therapists work with the children and their families through one-on-one and group counseling, parent training programs, and other services to address and resolve the sources of the behavior or family issues.

Families and Schools Together (FAST) – This prevention program aims at reducing the risks of school failure, juvenile delinquency, and substance abuse in adolescents for children in grade schools and their families. The program includes parent education and family activity components aimed at enhancing family functioning and decreasing problematic child behaviors.

Families and Centers Empowered Together (FACET) – FACET is a prevention program for parents of pre-schoolers in licensed child care centers in neighborhoods with high rates of teenage parenthood, substance abuse, economic disadvantage, stress and crime. Parents participate in alcohol/drug awareness activities, parent education/support groups, life skills, health and education workshops, and family activities.

(Continued on next page)

For more information see

Child Deaths	p. F-18
Children in Out-of-Home Care	p. F-45

In the KIDS COUNT Section:

Child Deaths	p. K-24
Child Abuse	p. K-54
Table 24	p. K-74
Table 74	p. K-96

Out-of-Home Care

Indicator: *Children in out-of-home care per 1,000 children*

Nearly half a million children are currently enrolled in out-of-home care. Out-of-home placements include non-relative foster homes, relative foster homes, specialized foster homes, group homes, shelter care, residential treatment centers, and medical facilities. The fastest growing groups of foster care children are those under the age of four who have medical complications and/or physical and mental limitations.[1] Many of these children enter the system because of abuse or neglect. Caring for these children places a great strain on the system. Many foster care parents do not want to care for children with special needs and those who are willing to take them in do not have adequate training to handle the complications that may arise with a child who has special needs.[2]

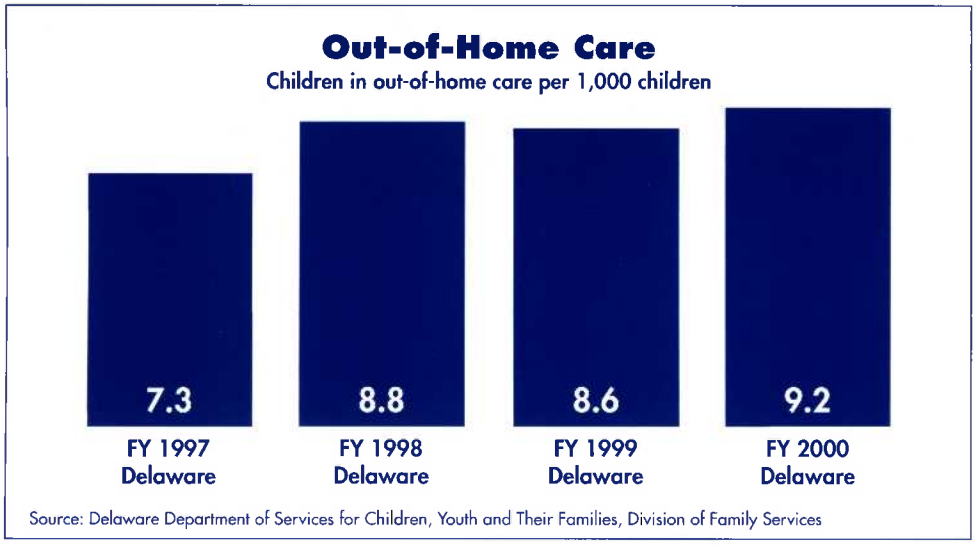
Recently Congress created the Foster Care Independence Act of 1999 to address another crucial issue in the foster care system-aging out. An average of 25,000 foster care children "age out" (turn 18) of the system and are removed from their foster care homes. Many of these youth lack access to job training programs, health care, and/or support networks upon leaving the out-of-home care system.[3] The Foster Care Independence Act of 1999 offers help during this transition period.[4] It allows states to provide Medicaid coverage up until the age of 21, for youth that were still in foster care on their 18th birthday. It also increases the amount of funding states have for adoption incentives to help them find more permanent homes for youth. It increases funding for training of foster care parents and social workers so that they are more adequately prepared to deal with the growing population of special needs children.

1 What you may not know about foster care? Available from www.connectforkids.org

2 ibid

3 ibid

4 *Frequently Asked Questions About the Foster Care Independence Act of 1999 and the John H. Chafee Foster Care Independence Program* National Foster Care Awareness Project Feb 2000



Program Statement: *(Continued from previous page)*

Promoting Safe and Stable Families – This program is aimed at strengthening community services infrastructure by providing family preservation and support services at seven community and school-based sites across the state. Family Resource Coordinators at each site assist families with service referrals, parent education, child care and recreational programs, and job search assistance.

For more information see

Child Abuse	p. F-44
Juvenile Delinquents in Out-of-Home Care	p. F-46

In the KIDS COUNT Section:

Child Abuse and Neglect	p. K-54
Table 75	p. K-96

Juvenile Delinquents in Out-of-Home Care

Indicator: ***Juvenile delinquents in out-of-home care per 1,000 youth ages 10 through 17***

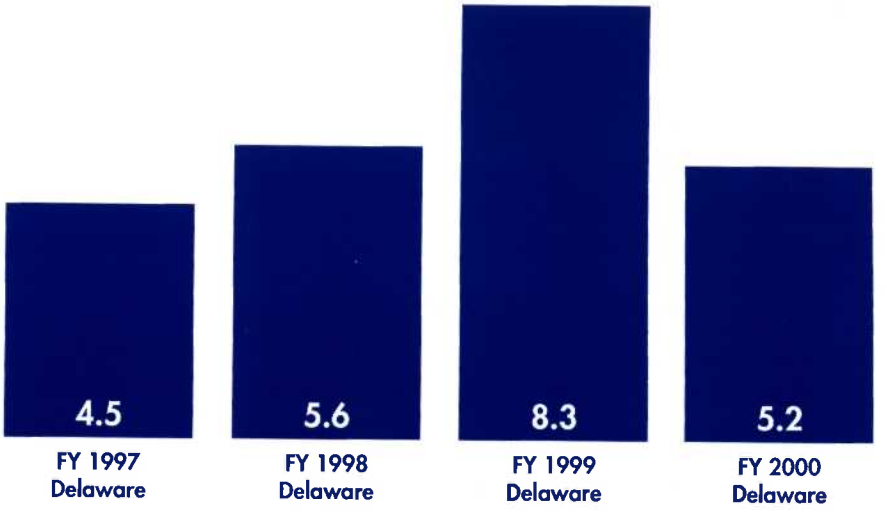
Risk factors for juvenile crime and delinquency include a lack of educational and job training opportunities, poverty, family violence, and inadequate supervision. Serious violent juvenile offenders seem to begin showing criminal tendencies at a young age and continue on until their late teens or adulthood.[1] Some of those tendencies are acts of aggression, dishonesty, property offenses and conflict with authority figures. In 1997, Delaware had a total of 223 youth living in out-of-home care as a result of delinquent behavior.[2] Research suggests that the current juvenile justice system does not hold youths publicly accountable for their behaviors which can lead to increased delinquency.[3]

1 Foote (1997). Expert panel issues report on serious and violent juvenile offenders. Office of Juvenile Justice and Delinquency Prevention

2 Sickmund and Wan (1999). Census of Juveniles in Residential Placement: 1997 Databook

3 Foote (1997). Expert panel issues report on serious and violent juvenile offenders. Office of Juvenile Justice and Delinquency Prevention

Juvenile Delinquents in Out-of-Home Care
per 1,000 youth ages 10–17



Source: Delaware Department of Services for Children, Youth and Their Families; Statistical Analysis Center

Program Statement: Some examples of programs used by the state to prevent continuing delinquency by youth on probation or community supervision in lieu of or on return to the community from an out-of-home placement are:

Project Stay Free – The Kingswood Community Center Project Stay Free is an intensive supervision program for youth on probation at high risk of re-offending. The program provides 24-hour, 7-day per week monitoring for 48 youth with electric monitoring for up to 10 youth.

Back on Track – This contracted prevention program through the YMCA Resource Center is for probation youth at low risk of re-offending and consists of five educational program components and supervised community service projects.

Multi-Systematic Therapy Program (MST) – This intensive home-based intervention program focuses on a youth's family, peer, and school relationships to reduce the environmental risks for juveniles at high risk of re-offending.

For more information see

Out-of-Home Care	p. F-45
Juvenile Violent Crime	p. F-53
In the KIDS COUNT Section:	
Juvenile Violent Crime Arrests	p. K-28
Table 27-37	p. K-76-80

Domestic Violence

Indicator: *Number of domestic violence reports*

In a survey of both men and women, the National Institute of Justice and the Center for Disease Control and Prevention found that nearly 25% of women and 7.6% of men reported that they had been raped and/or physically assaulted during their lifetime.[1] This shows that domestic violence remains a major concern for women and *men. Approximately 4.8 million women and 2.9 million men are victims of domestic violence annually.[2] Physical domestic violence is often prevalent in relationships where verbal abuse is also a factor. Women are more likely to be assaulted by their husbands; similarly men are more likely to be assaulted by a male partner.*

Within the last 30 years batterer intervention programs have become more prevalent within the criminal justice system. However more basic information is needed for criminal justice officials to prosecute domestic violence cases. A 1998 report by the National Institute of Justice, suggests that comprehensive training program for police officers and specialization of judges, lawyers and probation officers in the area of domestic violence would strengthen their ability to prosecute against and prevent further violence.

1 Tjaden and Thoennes (2000) Extent, nature and consequences of intimate partner violence, National Institute of Justice and the Center for Disease Control and Prevention

2 ibid

Definition:

Domestic Violence – The defendant or victim in a family violence case may be male or female, child or adult, or may be of the same sex. Family violence is any criminal offense or violation involving the threat of physical injury or harm; act of physical injury; homicide; sexual contact, penetration or intercourse; property damage; intimidation; endangerment, and unlawful restraint.

Child Present – A child is present at the time of the incident, as reported by the police.

Active PFA Order – Incidents in which there are any active court orders such as Custody, Protection from Abuse orders, No Contact orders, or other court orders.

Domestic Incident Reports

Delaware, 1999

Criminal Only	16,480 reports
Combined Criminal and Non-criminal	28,128 reports
Percent of Reports with a Child Present	31.4%
Percent of Reports with an Active Protection from Abuse Court Order	3.8%

Source: Dept. of Public Safety, Division of State Police

Deaths as a Result of Domestic Violence

Delaware, 1996–1999

Of the persons who died in this period **64%** died as the result of the use of a firearm.

Source: Dept. of Public Safety, Division of State Police

Program Statement: Domestic violence is a pattern of controlling and assaultive behavior that occurs within the context of adult, familial or intimate relationships. There are five central characteristics of domestic violence:

1. It is a learned behavior
2. It typically involves repetitive behavior encompassing different types of abuse such as coercion and threats, intimidation, emotional abuse, isolating the victim, minimizing, denying and blaming, economic abuse and using children.
3. The batterer, not substance abuse, the victim, or the relationship, causes domestic violence.
4. Danger to the victim and children is likely to increase at the time of separation
5. The victim's behavior is often a way of ensuring survival

There is cycle of domestic violence that begins with increased tension and anger, a battering incident in which the victim is slapped, kicked, choked, or assaulted with a weapon, sexually abused, or verbally threatened or abused. This is followed by a calm state during which the perpetrator may deny the violence and promise that it will never happen again. Unless professional assistance is sought, the process will repeat itself in most cases and in general, intensifies.

For the first time, Delaware in 1998 compiled statewide statistics on the incidents of domestic violence. This report includes much information, which will be an invaluable baseline as we move into the next millennium and continue our efforts to reduce the incidents of domestic violence. Family Court tracks the number and disposition of Protection from Abuse orders that are filed in court which also tell a story.

For more information see

Child Abuse p. F-44

In the KIDS COUNT Section:

Child Abuse and Neglect p. K-54

Table 74 p. K-96

Strong and Supportive Communities

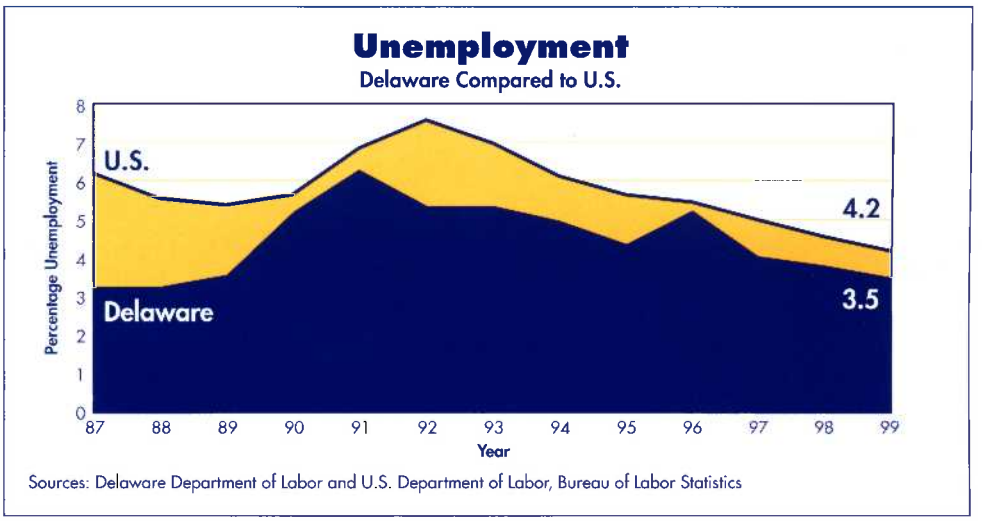
Goal: Communities have child care, educational systems, social service systems, physical infrastructure, and employment opportunities to support a high quality of life for all community members. Communities are drug, crime, and violence free. Residents are actively involved in achieving community self-sufficiency.

Unemployment

Indicator: *Unemployment rates by race and gender*

Delaware's unemployment rate was 3.5% in 1999, placing the state at 18th in the nation (with number one being the lowest rate)[1]. Suggestions as to why America has been successful in reducing unemployment include: excellent management by the Federal Reserve Board which has kept interest rates down without an increase in inflation, the deregulation of industries, and the opening up of global markets.[2] The rate does vary regionally. Several factors lead to the dispersion such as: crime, education, amenities, residency patterns, home ownership, international migration, and industry composition.[3]

1 *Delaware Snapshot* Office of Occupational and Labor Market Information 1999
2 Glasman, J.K. "Lonely unemployment line" *US News and World Report* Dec 1997 123(24), 36.
3 Partridge, M.D. and Rickman, D.S. The dispersion of US state unemployment rates: the role of market and non-market equilibrium factors Regional Studies. 31 (6). 593-606.



Sources: Delaware Department of Labor and U.S. Department of Labor, Bureau of Labor Statistics

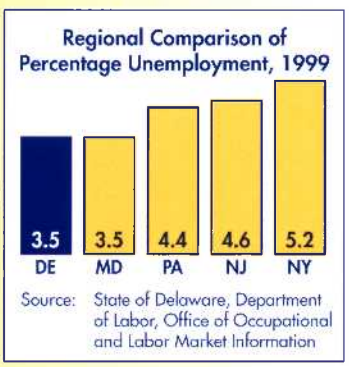
Program Statement: The Department of Labor's primary purposes are to:

- assist people in transitioning to work and assist employers in finding qualified applicants;
- provide partial income assistance to people who are laid off through no fault of their own or are injured on the job;
- protect workers from unfair and/or unsafe working conditions through the enforcement of labor laws and by identifying workplace hazards.

The department is comprised of the following divisions and offices:

The **Division of Employment and Training** (DET) provides services enabling employers and job seekers to make informed employment and training choices leading to employment. It operates a statewide labor exchange system in four full service delivery locations and administers major federal, state and employer funded training programs. The division also assists specific populations such as veterans, migrant and seasonal farm workers, welfare clients, dislocated workers and ex-offenders in transitioning to work.

The Virtual Career Network (VCNet.net), Delaware's automated Internet One-Stop system, offers employers and job seekers easy and open access to an electronic data base containing jobs from across the country, a talent bank of electronic resumes, and links to a wealth of related occupational, training, education and support services information. The website also links to *Career Directions,* the department's Internet-based, interactive system that shows the location of employers, child care centers, training sites, universities and colleges, and bus stops/routes. Users can produce customized maps from their home to work, with all these services in between at a radius of 1/4 mile to 10 miles.



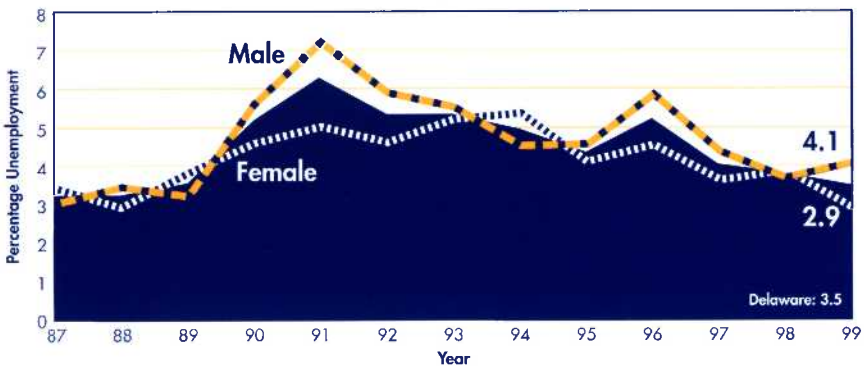
The **Division of Vocational Rehabilitation** provides information, opportunities and resources to individuals with disabilities leading to success in employment and independent living. The division has two major components:

- Vocational Rehabilitation Services (VRS), a state/federal employment program for eligible individuals with physical and mental disabilities. Services are offered in five locations across the state with school to work transition services available in every public high school.
- Disability Determination Services which adjudicates Social Security disability claims filed in Delaware and evaluates all applicants and refers appropriate individuals to VRS.

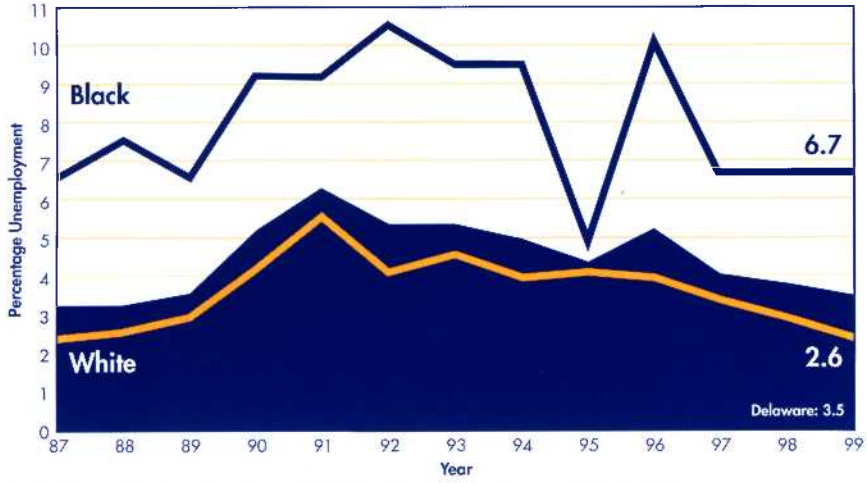
(Continued on next page)

Unemployment

Delaware by Gender



Delaware by Race



Sources: Delaware Department of Labor and U.S. Department of Labor, Bureau of Labor Statistics

Program Statement: *(Continued from previous page)*

The **Division of Unemployment Insurance** provides temporary, partial income maintenance to workers who have become unemployed through no fault of their own and makes referrals to re-employment services. The division collects employer taxes for the payment of unemployment benefits and collects a statewide training tax from employers to provide funds for the training of dislocated workers, school-to-work transition, industrial training and other training initiatives. Local offices are co-located with the Division of Employment and Training and the Division of Vocational Rehabilitation in the three counties.

The **Division of Industrial Affairs** is made up of four sections and has offices in Wilmington and Milford.

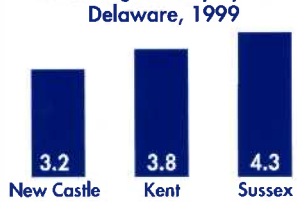
- The Office of Workers Compensation and the Industrial Accident Board administer and enforce the State's workers' compensation law that provides compensation to eligible workers who suffer work-related injuries or illnesses.
- The Office of Labor Law Enforcement enforces Delaware's 24 labor standards laws and civil rights laws. It establishes prevailing wage rates for public works projects and helps ensure compliance with the rates. The office also provides technical assistance to employers and employees by providing information about these laws.
- The Office of Occupational Safety and Health Consultation provides small and medium sized private employers with assistance in identifying and guidance in abating safety and health hazards in the workplace.
- An Office of Occupational Health and Safety Statistics collects, analyzes and disseminates statistics on work-related injuries, illnesses and fatalities.

The **Office of Occupational and Labor Market Information (OOLMI)** serves as a source of information about labor market conditions throughout the state. It translates raw labor market data into concise analyses and reports that advise policy makers about the labor force, employment, economic and demographic changes, and assists job seekers in making informed career choices.

The **Office of the Commission for Women** serves as a centralized resource for information, referral and assistance on matters of particular concern to women. The office creates and disseminates publications and organizes educational conferences, conducts public forums and facilitates collaboration among agencies, organizations and individuals in support of issues involving women and their families.

For more information, search on the web at www.delawareworks.com.

County Comparison of Percentage Unemployment Delaware, 1999



Source: State of Delaware, Department of Labor, Office of Occupational and Labor Market Information

For more information see

In the KIDS COUNT Section:

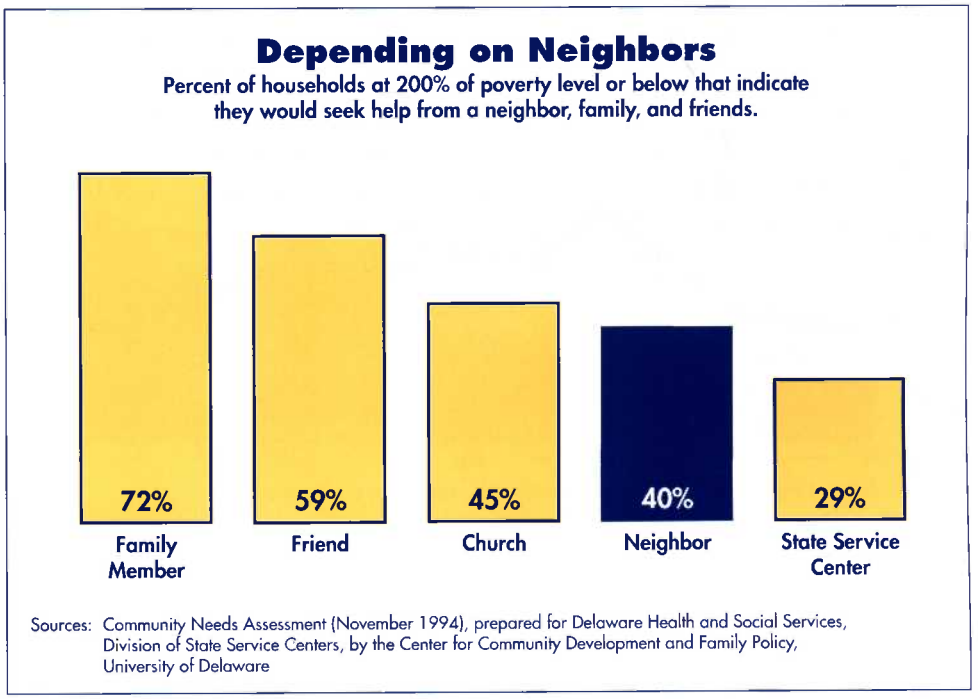
Table 65 p. K-92

Depending on Neighbors

Indicator: ***Percent of households at 200% of poverty level or below that indicate they would seek help from a neighbor, family, and friends.***

People sometimes experience alienation within their neighborhoods. It is important for community members to develop social relationships in order to share resources, services, and information[1]. When households are 200% poverty or below, they are at greater risk for alienation and may not have access to many resources or information. When a household would seek help from a neighbor, it is an indication that the community is strong and supportive of its members.

1 Egeberg, O. (1995, Fall). An exchange directory for every neighborhood. Whole Earth Review. 86 p. 26-27.



Program Statement: In supportive communities, residents feel they can turn to neighbors for help. In high-risk areas, the need for easily-obtainable information is particularly important since residents may find it difficult to access the system. Since 1995, several initiatives have been implemented to empower high-risk communities and disseminate information to them. For example, Family Services Partnerships have been established in eight high risk areas. Training, technology, and technical assistance have been provided regularly to the Partnerships to help them support their communities.

Juvenile Violent Crime

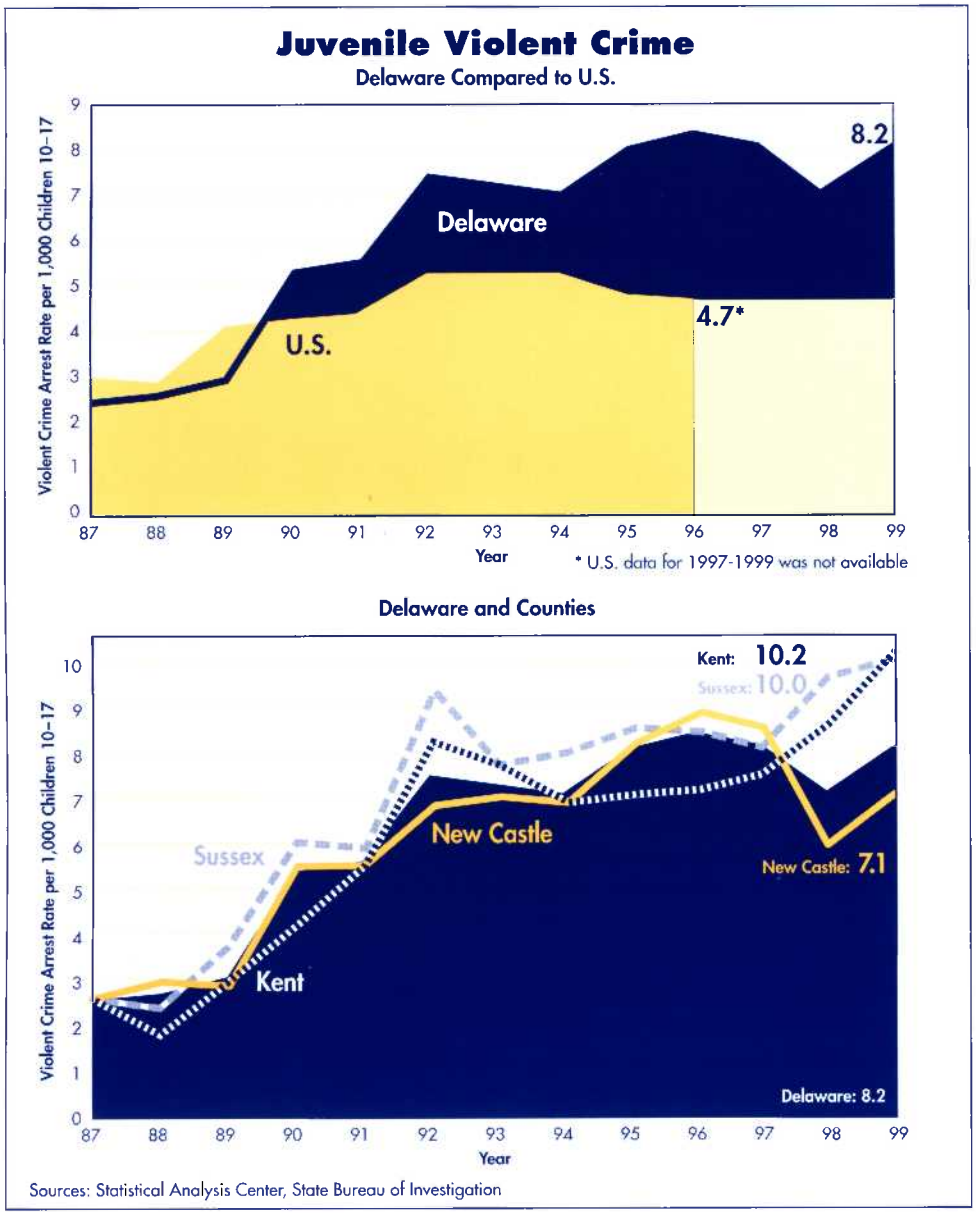
Indicator: *Juvenile violent crime arrest rate*

This rate tracks arrests of juveniles, ages 10 through 17, for the crimes of homicide, forcible rape, robbery, and aggravated assault per 100,000 youths. The continuing problem of drug abuse, the increasing availability of weapons, and the growth of gangs have contributed to rising juvenile violence.[1] However, it should be noted that children in this age group are more likely to be victims of violent crime rather than perpetrators of such crime.[2] Risk factors for violent crime arrests include poverty, family violence, inadequate supervision, limited education or job skills, and poor performance in school.[3]

1 Juvenile violent crime arrests (1998). *Alabama Kids Count 1998 Report.*

2 Juvenile violent crime arrests. ( ). *Nevada Kids Count Databook.*

3 Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice (1995). *Juvenile Offenders and Victims, A National Report.*



Program Statement: The Delaware Prevention Network (DPN) is one of Delaware's prevention programs for juveniles. DPN employs program components that are focused on youth, family, and community support networks. Another program is the Stormin' Norman's Classic Basketball League. About 1,400 youth ages 9 to 18 play on 114 teams in Wilmington. In addition to the basketball games, the program has components that deal with education, health, public safety, and community volunteer work.

For more information see

Teen Deaths	p. F-23
Juvenile Delinquents in Out-of-Home Care	p. F-46
Adult Violent Crime	p. F-54
Adults on Probation or Parole	p. F-55

In the KIDS COUNT Section:

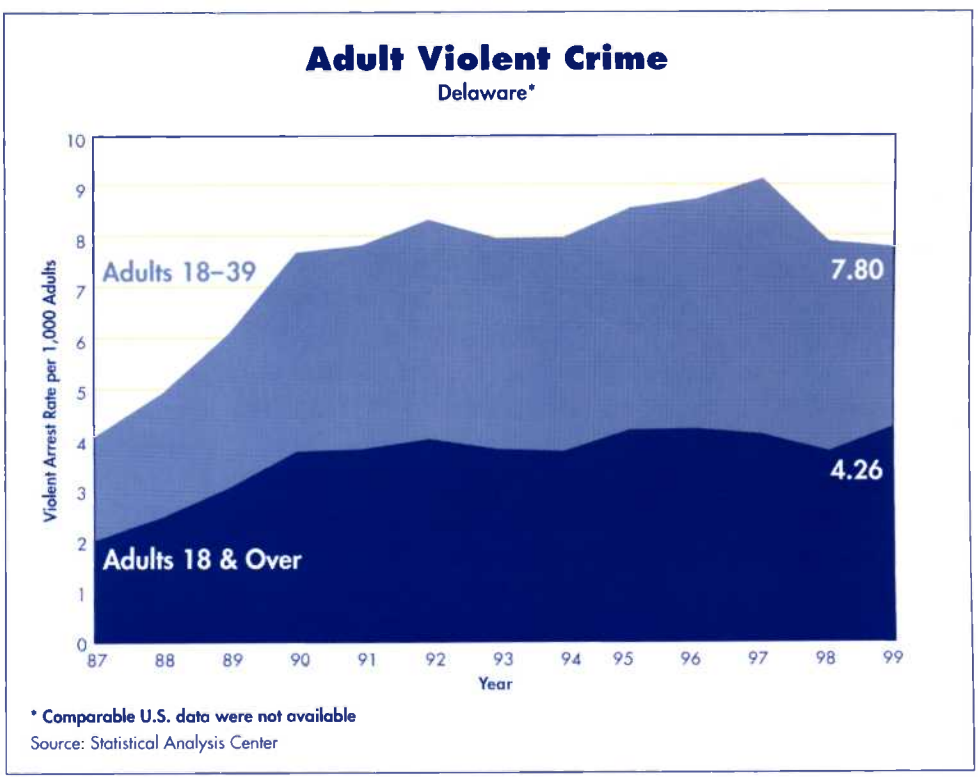
Juvenile Violent Crime Arrests	p. K-28
Teen Deaths	p. K-26
Table 24	p. K-68
Tables 27-37	p. K-76-80

Adult Violent Crime

Indicator: *Adult violent crime arrest rate per 1,000*

Among the steps being taken to combat crime is the dramatic increase in incarcerations. Additionally, tougher sentencing laws are ensuring that criminals across the nation are staying in jail for longer periods of time. However, imprisonment is costly business; increasingly, states will have to make tough spending decisions about whether to construct additional prisons or to invest in area schools, roads, tax cuts, etc. [1]

1 Fischer, K. (1998, January-February). Is locking them up the answer? For violent criminals probably—for the rest, it's not so clear. Washington Monthly. 30 (1), 32-34.



*** Comparable U.S. data were not available**

Source: Statistical Analysis Center

Program Statement: In order to meet the demands of an increasingly complex society, the Delaware State Police has aggressively pursued innovative programs to address violent crime. The use of the new DICAT (Division Wide Crime Analysis Tracking) system provides "real time" data to allow deployment of officers to address increases in criminal activity in specific geographic locations. The Community Services section addresses crime prevention issues that have an impact on the quality of life in Delaware's communities. Officers provide seminars on topics such as robbery and burglary prevention, neighborhood watch programs, safe traveling tips, self protection, and domestic violence. The Citizen's Police Academy provides participants a greater understanding of police practices, and the tools to form objective opinions regarding police action and to address community concerns regarding these actions. Participants are provided with knowledge that empowers them to participate in activities that reduce criminal activity in their communities.

For more information see

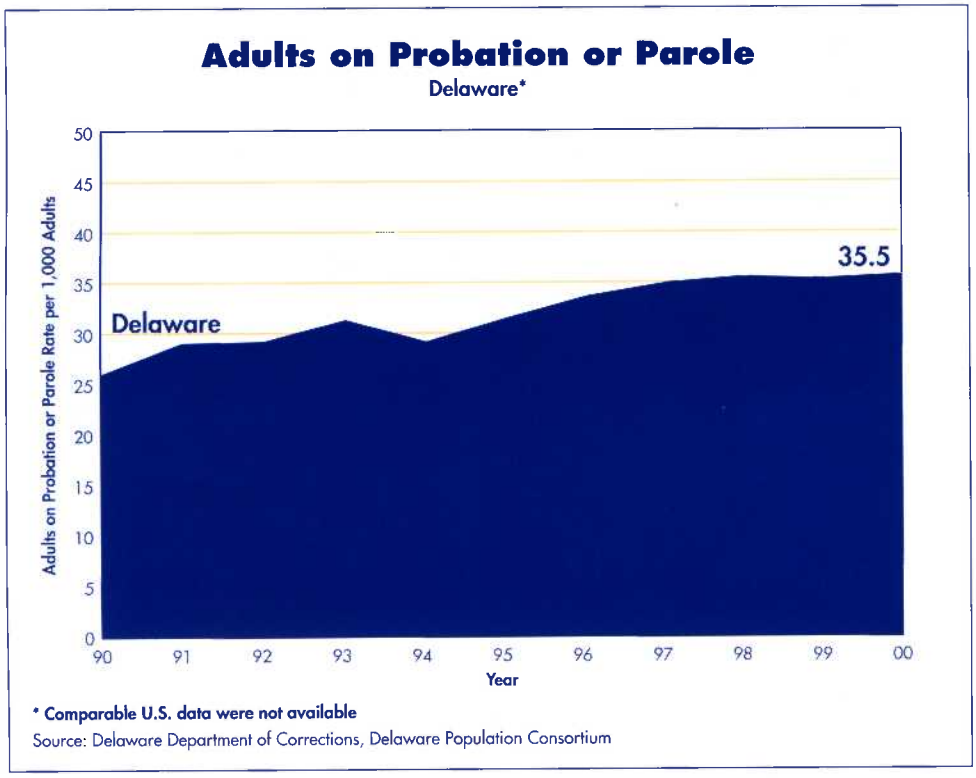
Juvenile Violent Crime	p. F-53
Juvenile Delinquents in Out-of-Home Care	p. F-46
Adults on Probation or Parole	p. F-55
In the KIDS COUNT Section:	
Juvenile Violent Crime Arrests	p. K-28
Tables 38-39	p. K-81

Adults on Probation or Parole

Indicator: *Adults on probation or parole under supervision per 1,000 adults*

Intermediate sanctions such as probation and parole are needed to help control inmate populations. Most probation or parole programs incorporate a wide variety of activities that emphasize close monitoring, participation in community service programs, tight curfews, steady employment, and drug testing[1].

1 Bennett, L. A. (1995, February). Current findings on intermediate sanctions and community corrections. Corrections Today, 57 (1), 86-89.



* Comparable U.S. data were not available

Source: Delaware Department of Corrections, Delaware Population Consortium

Program Statement: The Delaware Department of Correction is committed to public safety. The Bureau of Community Correction, Probation and Parole has teamed up with law enforcement agencies to increase community contacts and enhance visibility. The Safe Streets project initially focused on select neighborhoods within the city of Wilmington. In recent months, this initiative has expanded into New Castle County. In the coming year, efforts will be expanded statewide. Through Safe Streets we have identified those offenders in the community who are perhaps at higher risk for noncompliance with the conditions of supervision. The increased visibility and contacts in the community are impacting offender behavior and providing a greater sense of public safety in the community.

For more information see

Juvenile Violent Crime	p. F-53
Juvenile Delinquents in Out-of-Home Care	p. F-46
Adult Violent Crime	p. F-54

In the KIDS COUNT Section:

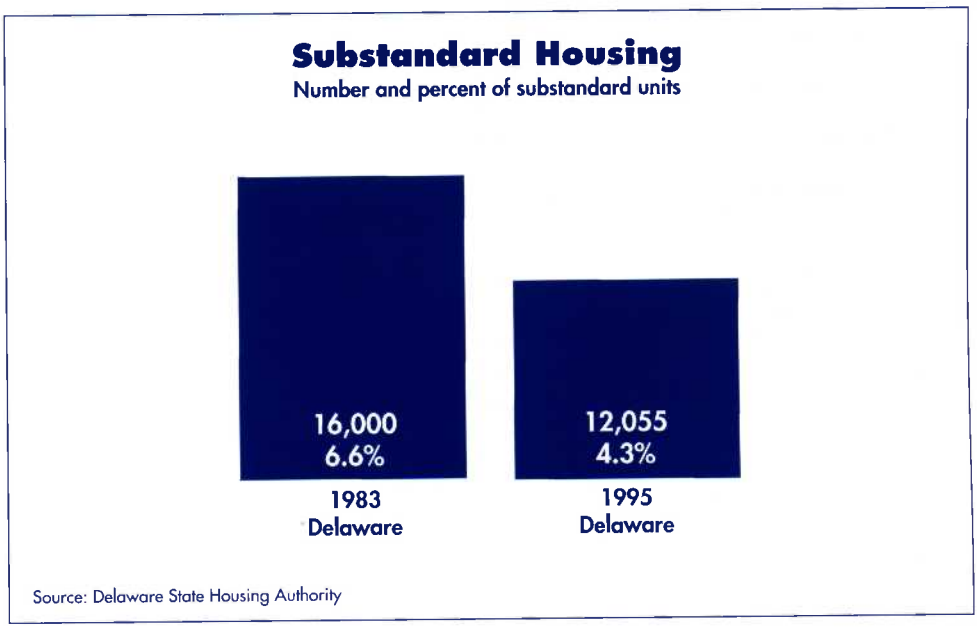
Juvenile Violent Crime Arrests	p. K-28
Tables 38-39	p. K-81

Substandard Housing

Indicator: *Percent of substandard housing units*

According to the Statewide Needs Assessment, more than 12,055 of Delaware's households are living in substantially substandard housing. This number reflects truly dilapidated living conditions as substantial rehabilitation is required in order to make these households structurally sound, safe, and habitable. Such rehabilitation is qualified as at least $30,000 per unit ($20,000 for a mobile home) in non-cosmetic repairs typically including at least two structural systems. It also includes units which may be otherwise structurally sound, but which have failing septic systems. At this time, there is no nationally comparable data available as Delaware's definition refers to a much more severe condition than national data.[1].

1 Delaware State Housing Authority (August 1996) *Statewide Housing Needs Assessment.* Prepared by Legg Mason Realty Group, Inc.



Program Statement: Realizing that substandard housing is more than a misfortune to the community—it is detrimental to the safety and overall well-being of "the family"—Delaware fights back against time's toll on our state's homes by rescuing financially-strapped families with low-interest rate, deferred loan packages, or grants that enable the owners of these homes to make the necessary housing repairs. Just as each home is different and has different needs, so do families; therefore, we go one step further in repairing homes by making it affordable for families to modify homes for handicapped-accessibility when necessary. Also, grants are provided to communities to demolish vacant severely-substandard homes that might otherwise be environmentally and physically dangerous. Delaware State Housing Authority rounds out this rescue plan by empowering entire communities to repair infrastructure deteriorations, or in some cases build infrastructure they lack, to become safe for this generation, and the next.

For more information see

Risk of Homelessness p. F-40

Home Ownership p. F-57

In the KIDS COUNT Section:

Table 57 p. K-88

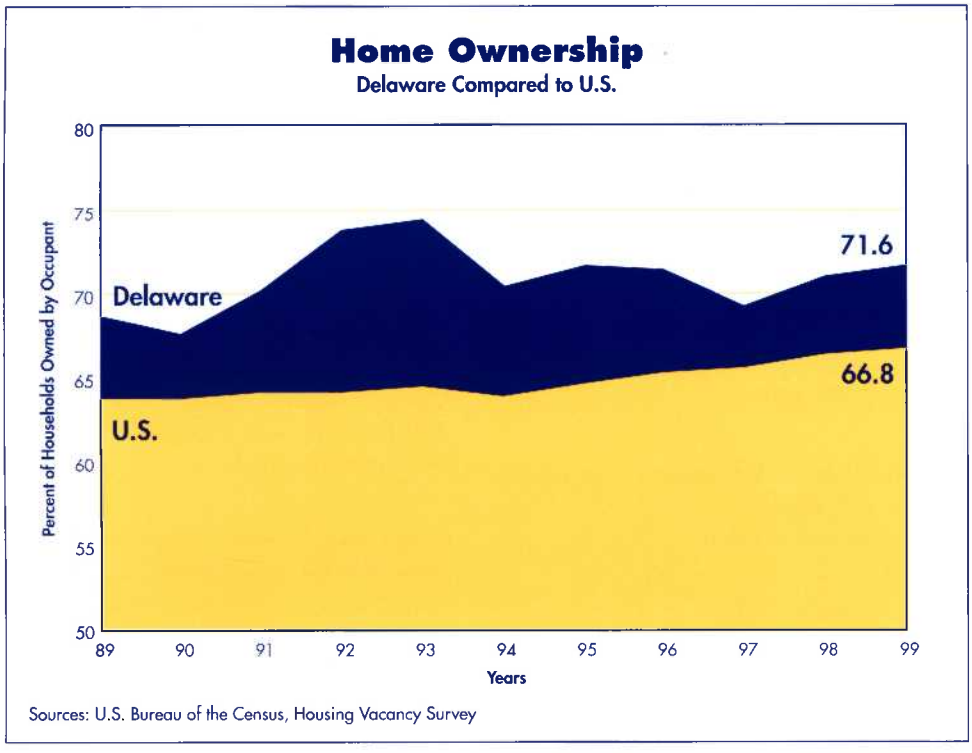
Home Ownership

Indicator: *Percent of home ownership*

Home ownership is an integral part of the American Dream. For many families, the home is their greatest asset. Recently states were given more flexibility to create and modify social public policy initiatives to help with housing affordability issues. Delaware has an average of 71.6% home ownership rates, which is significantly higher than the national average.[1] There still remains a significant portion of families that cannot afford this part of the American dream. Nationally 16% of low-income families reported housing hardship (not being able to pay rent, mortgage or utility bills within the last 12 months).[2] Home ownership for these families could lead to greater financial freedom, higher self-esteem, and greater stability within the familial setting. Thus it is crucial that we create programs to help increase the affordability of housing for all families.

1 "Housing Vacancies and Homeownership Annual Statistics: 1999" US Census Bureau. Available from www.census.gov/hhes/www/housing

2 Wigton and D'Orio (1999). Snapshots of America's families. The Urban Institute.



Sources: U.S. Bureau of the Census, Housing Vacancy Survey

Program Statement: Delaware makes home ownership affordable to those who often think this American Dream is out of their reach. While working with many financial institutions, builders, and real estate companies across the state, Delaware State Housing Authority (DSHA) unlocks the doors to home ownership for low- and moderate-income families every day by providing low-interest rate mortgage financing, along with down payment and closing cost assistance. DSHA also supports housing counseling, and helps families map out their own realistic paths to home ownership. Furthermore, the sprouting-up of economically-integrated communities, and affordably-priced neighborhoods are important to the state as DSHA focuses on making home ownership a more attainable goal for working families.

For more information see

Risk of Homelessness p. F-40

Substandard Housing p. F-56

In the KIDS COUNT Section:

Table 57 p. K-88

Where to Get More Information

For more information about the programs described within FAMILIES COUNT in Delaware, contact the state agencies listed below:

Delaware Information Helplines
1-800-464-4357 (in state)
1-800-273-9500 (out of state)

State of Delaware Web Site
www.state.de.us

Office of the Governor,
Advisor on Family Policy
302-577-3210

Delaware State Housing Authority
302-739-4263 (Dover)

302-577-5001 (Wilmington)
www.state.de.us/dsha

Department of Corrections
302-739-5601

Department of Education
302-739-4601
www.doe.state.de.us

Department of Labor
302-761-8000

Department of Health
and Social Services
www.state.de.us/dhss

Division of Public Health
302-739-4700

Division of Social Services
302-577-4400

Division of Alcoholism, Drug
Abuse and Mental Health
302-577-4460

Department of Public Safety
302-739-4311

Department of Services for
Children, Youth and Their Families
302-633-2500
www.state.de.us/kids

Drug Free Delaware
www.state.de.us/drugfree