

Family Services Cabinet Council
FAMILIES COUNT
in Delaware • 1998



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. Since its inception, I have personally chaired the Council, which is made up of Cabinet Secretaries from the seven state departments having significant impact on children and families in Delaware. As a group which has labored closely together for more than six years, we are pleased to present this first publication of *Families Count in Delaware*.

As we move into the 21st century, it becomes increasingly important for us to focus on the measurable outcomes of the substantial investments that we have made in addressing the health, education, and social issues facing Delawareans.

The indicators found in Families Count in Delaware will -- over time -- provide us with valuable data to allow for informed debate and public policy development focused on the mission of the Council: "To strengthen and support Delaware families and help children achieve their full potential within safe and caring communities."

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,

A handwritten signature in cursive script that reads "Tom Carper".

Thomas R. Carper
Governor

Family Services Cabinet Council
FAMILIES COUNT
in Delaware • 1998



FAMILIES COUNT in Delaware

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Thanks to the Birth to Three Program and
Delaware State Housing Authority for the
use of photographs, and a special thank
you to the Delaware children featured in
photographs on the cover and throughout
the book.

Thanks for the data: Delaware Departments of
Corrections, Education, Health and Social Services,
Labor, and Services for Children, Youth and Their
Families; Center for Applied Demography and Survey
Research, Center for Drug and Alcohol Studies,
Delaware Health Statistics Center, Delaware Population
Consortium, Delaware State Housing Authority,
Statistical Analysis Center

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Strong and Supportive Communities

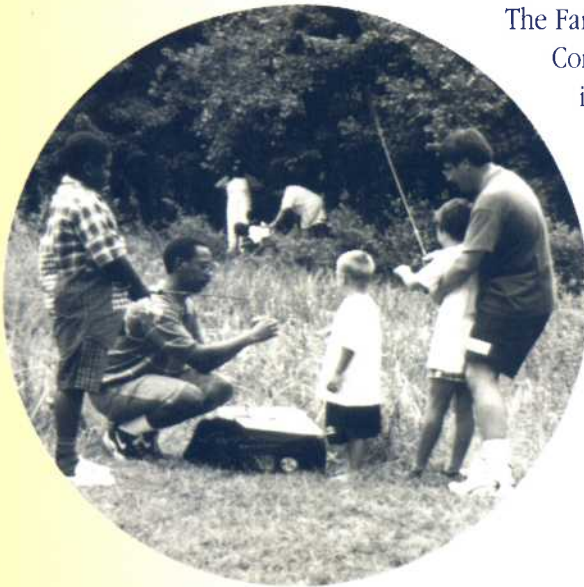
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FAMILIES COUNT in Delaware



The Family Services Cabinet Council, in conjunction with the Center for Community Development and Family Policy at the University of Delaware, is 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.
- 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 towards improved conditions. Quantifying the progress towards achieving the outcomes are the indicators assembled in this report. 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 is coming to fruition with the first publication of *FAMILIES COUNT in Delaware*. 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.





Plans for further development of the FAMILIES COUNT in Delaware indicators include involving stakeholders in a critical review of the indicators to determine if indicators need to be revised, added to, or deleted. 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.”

The fact that Delaware trends mirror national trends is an indication of underlying societal forces. For example, the increasing number of births to single parents has been attributed to among other factors: increased financial independence for women; changes in social norms regarding marriage and sexual behavior; and diminished economic opportunities, especially for young men. Other trends are predictable from the nation’s demographics: for example, the growing elderly population has serious implications for social services.

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 on our social well being; guide and advance informed discussions; and help us focus on issues that need attention.

The 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.

Prenatal care

Percent of mothers receiving prenatal care in the first trimester of pregnancy

Delaware Compared to U.S. Average Recent Trend in Delaware



Low birth weight babies

Percent of low birth weight babies



Infant mortality

Infant mortality rate per 1,000 live births



Lead poisoning

Percent of children age 6 and under with blood lead levels at or over 15 mcg/dl



Child immunizations

Percent of children fully immunized by age 2



Child deaths

Rate of child deaths per 100,000 children ages 1-14



Children with health care coverage

Percent of children to age 18 with health care coverage



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

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

Sexually transmitted diseases*

Percent of teens ages 15-19 with gonorrhea or primary/secondary syphilis



Teen deaths

Rate of teen deaths by injury, homicide, and suicide (per 100,000 teens 15-19)



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



Teens not in school, not working

Percent of teens 16-19 not attending school and not working



High school dropouts*

Percent of high school dropouts



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

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



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

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.

***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

Department of Corrections
302-739-560

Department of Education
302-739-4601

Delaware State Housing Authority
302-739-4263

Department of Health and Social Services
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 Labor
302-761-8000

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

A photograph of three young girls in a grassy field. In the background, a soccer net is visible. The girl in the back is standing and smiling. The girl in the middle is crouching and smiling. The girl in the front is lying on the grass, resting her chin on her hands and smiling. The text "Healthy Children" is in the top right corner, and a quote is to its left.

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*

Early prenatal care and regular prenatal visits increase the probability that babies will be born healthy, because medical problems can be detected earlier and high-risk health habits such as substance abuse and smoking may be curtailed¹. Delaying the start of prenatal care to the second trimester increases health risks for both mother and baby². A mother who receives no prenatal care is three times more likely to deliver a low birth weight baby than one who has received appropriate prenatal care³.

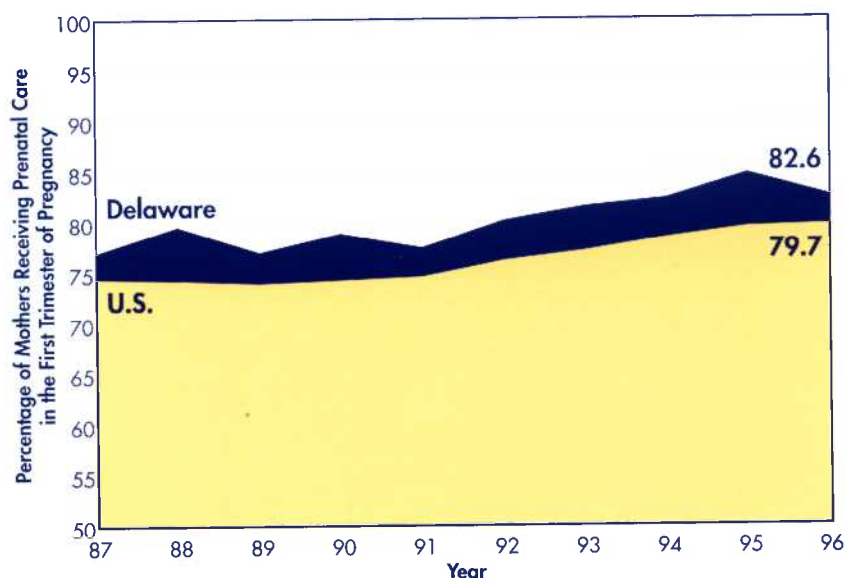
1 Voices for Children in Nebraska. (1997). *KIDS COUNT in Nebraska 1997 Report*.

2 The Alan Guttmacher Institute. (1989). *Prenatal Care in the U.S.: A State and Country Inventory*. 1.

3 The National Education Goals Panel. (1997, October). *Prenatal Care*. *Special Early Childhood Report*, 1997. 10-11

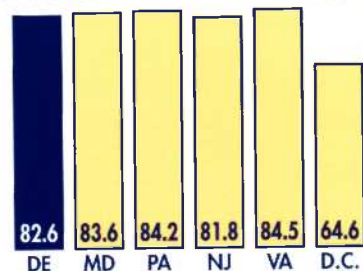
For more information see
 Low Birth Weight Babies p. F-12
In the KIDS COUNT Section:
 Low Birth Weight Babies p. K-20
 Infant Deaths by Adequacy
 of Prenatal Care p. K-23
 Tables 13-17 p. K-64-67

Prenatal Care
 Delaware Compared to U.S.



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

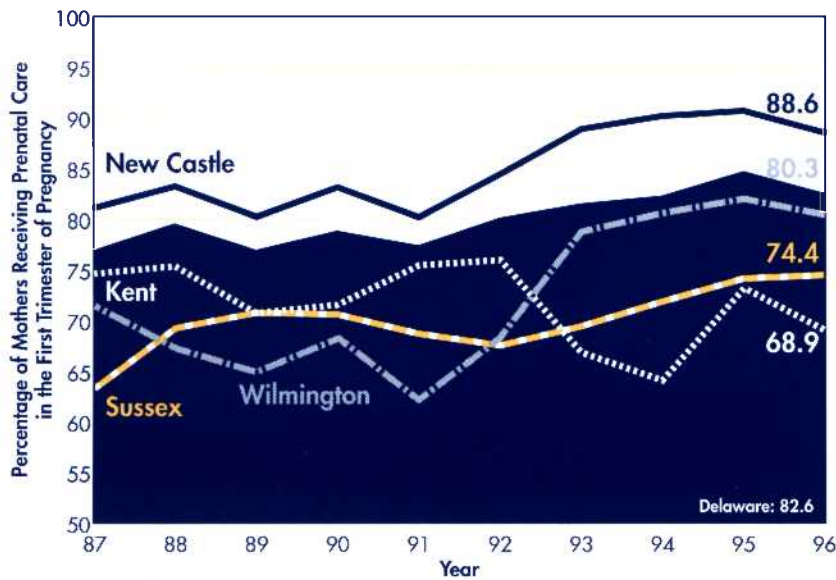
**Regional Comparison of
 Percentage of Mothers Receiving
 Prenatal Care in the First Trimester, 1996**



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

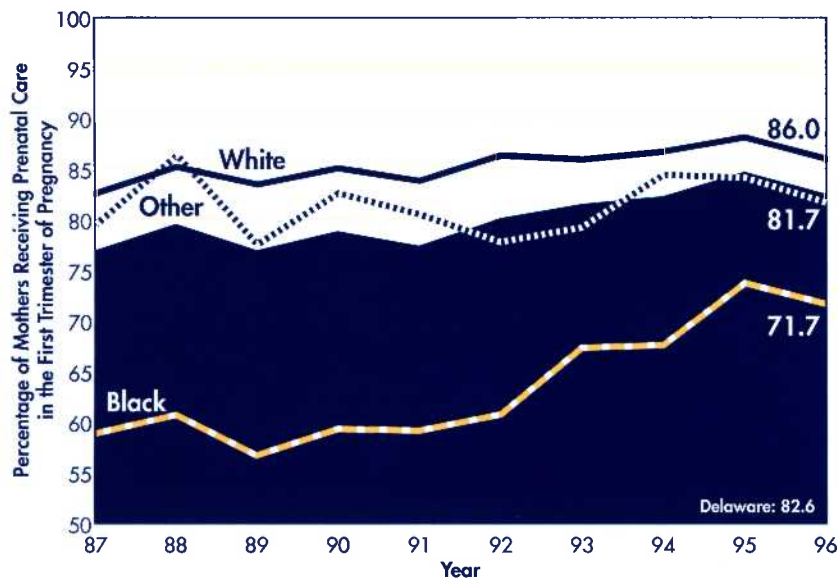
Program Statement: Delaware has expanded Medicaid to more pregnant women than ever before, including low-income working women. An eligible pregnant woman can be immediately enrolled in Medicaid, enabling her to begin prenatal care without the usual waiting period.

Prenatal Care Delaware, Counties and Wilmington



Source: Delaware Health Statistics Center

Prenatal Care Delaware by Race



Source: Delaware Health Statistics Center

Low Birth Weight Babies



Indicator: Percent of low birth weight babies

A baby's weight at birth is related to the baby's survival, health, and development. Low birth weight is a condition that may increase a child's risk of developing health, learning, and behavioral problems later in life¹. Babies who are born weighing less than 5.5 pounds are more likely to require special education. Nearly fifty percent of all low birth weight infants will, at some point in their lives, enter special education programs². Risk factors associated with low birth weight are cigarette smoking during pregnancy, poverty, lack of education, inadequate prenatal care, lack of health insurance, and premature birth³.

- 1 The National Education Goals Panel. (1997, October). Birth weight. *Special Early Childhood Report* 1997 12-13.
- 2 The David and Lucile Packard Foundation. (1995). The future of children: low birth weight. *Center for the Future of Children*, 5 (1), 7.
- 3 The David and Lucile Packard Foundation. (1995). The future of children: low birth weight. *Center for the Future of Children*, 5 (1), 4.

For more information see

Prenatal Care p. F-10

In the KIDS COUNT Section:

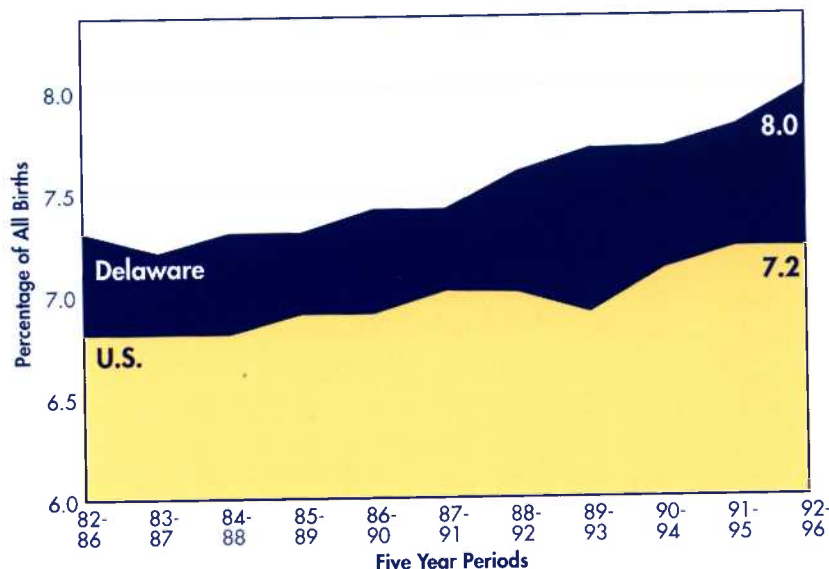
Infant Deaths
by Birth Weight of Infant p. K-23

Health problems
in low-income children p. K-35

Tables 9-17 p. K-62-67

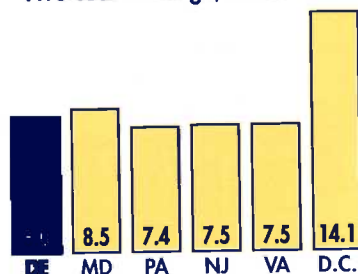
Tables 20-21 p. K-68-69

Low Birth Weight Babies Delaware Compared to U.S.



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

Regional Comparison of Low Birth Weight Births Five Year Average, 1992-1996

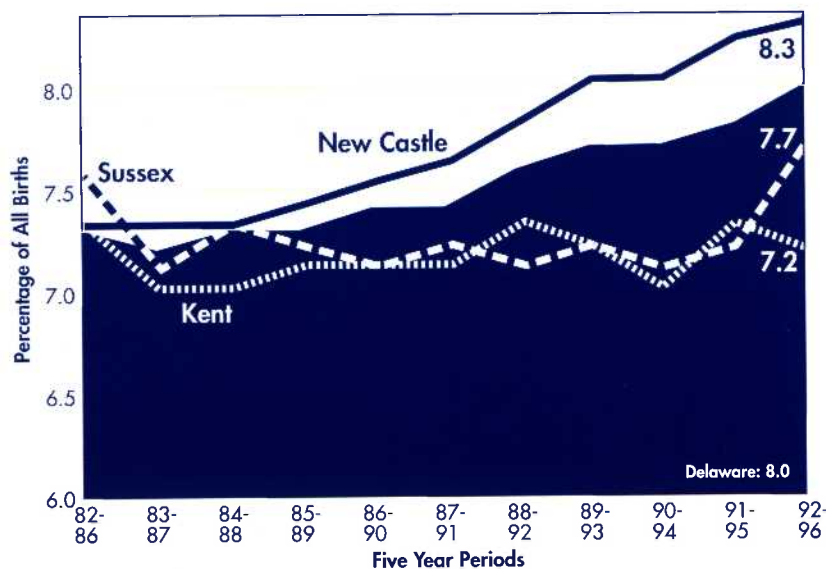


Sources: Delaware Health Statistics Center, National Center for Health Statistics

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.

Low Birth Weight Babies

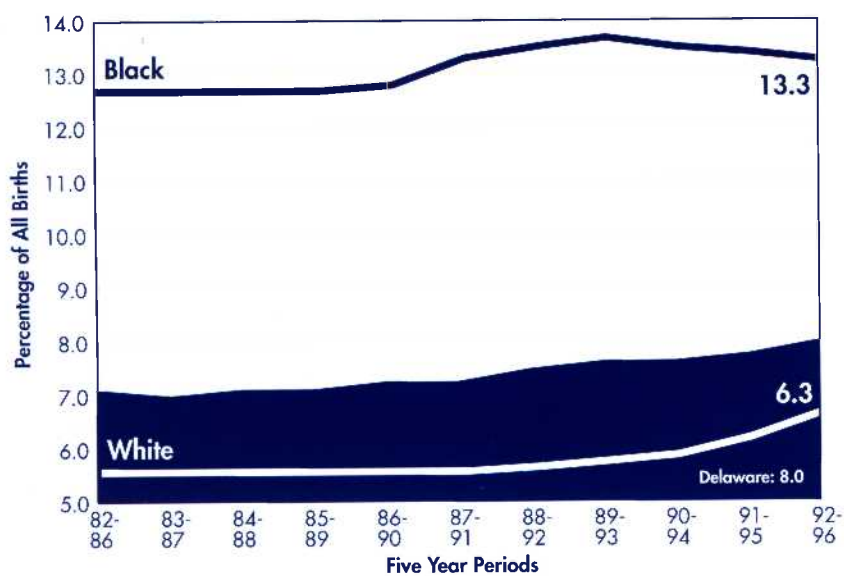
Delaware and Counties



Source: Delaware Health Statistics Center

Low Birth Weight Babies

Delaware by Race



Source: Delaware Health Statistics Center

Infant Mortality



Indicator: Infant mortality rate per 1,000 births

Although the overall infant mortality rate in the U.S. has been falling steadily over the past few decades, African-American babies still die at more than twice the rate of white babies in our country¹. In Delaware, the infant mortality rate for African-American babies is almost three times that of white babies. Low birth weight, lack of prenatal care, inadequate nutrition, lack of education, premature birth, child maltreatment, and poverty all increase the risk of infant mortality². Because infant mortality levels reflect the effectiveness of social and health care measures, improving infant mortality also requires improving the social, economic, environmental, and political disparity linked to poor outcomes for children¹.

¹ Annie E. Casey Foundation. (1997). *KIDS COUNT Fact Book: 1997*. 13

² The David and Lucile Packard Foundation. (1995). *The Future of children: low birth weight*. Center for the Future of Children.

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

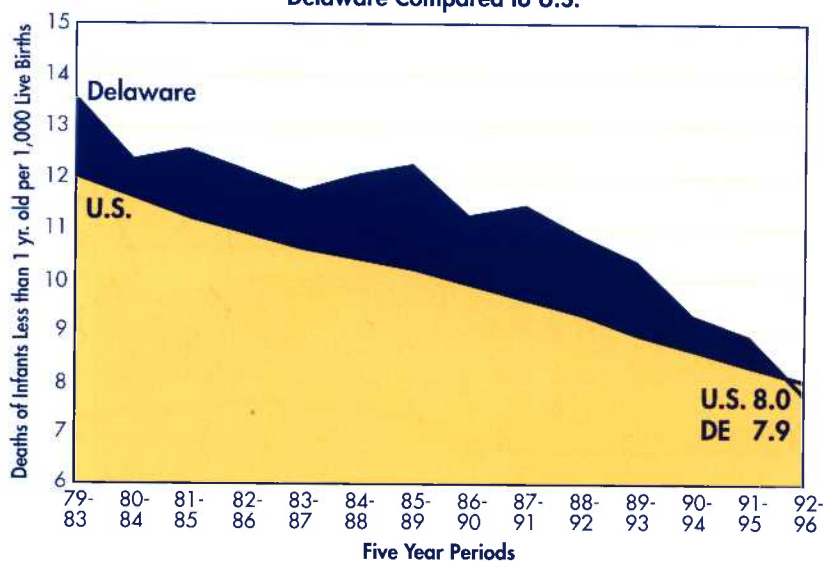
Infant Mortality p. K-22

Health problems
in low-income children p. K-35

Child Abuse and Neglect p. K-48

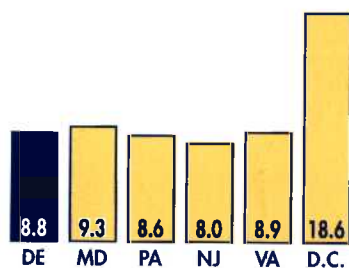
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Infant Mortality Delaware Compared to U.S.



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

Regional Comparison of Infant Mortality Rates Five Year Average, 1991-1995*



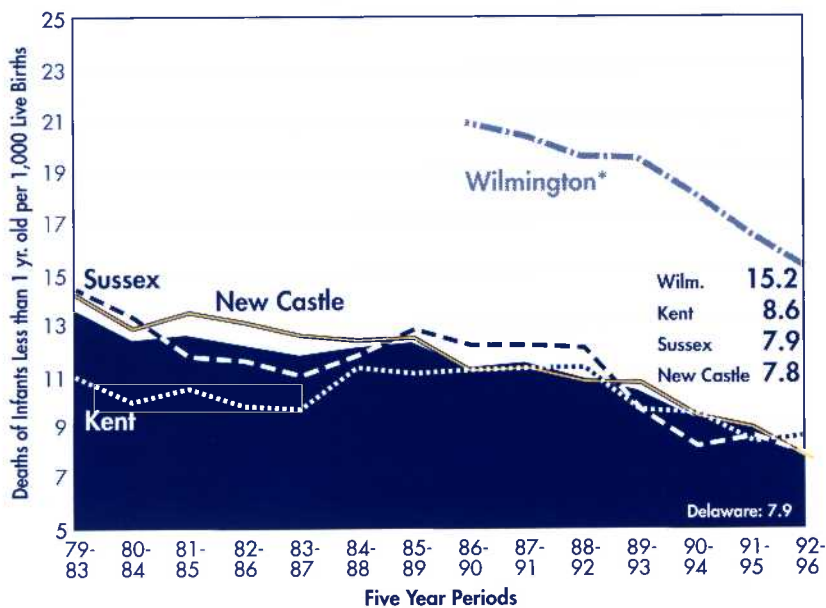
*All data were not available for 1992-96.

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

Program Statement: By providing medical and social services during pregnancy and after a baby is born, Delaware continues to reduce 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 providing information that promotes healthy family behavior. 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.

Infant Mortality

Delaware, Counties and Wilmington

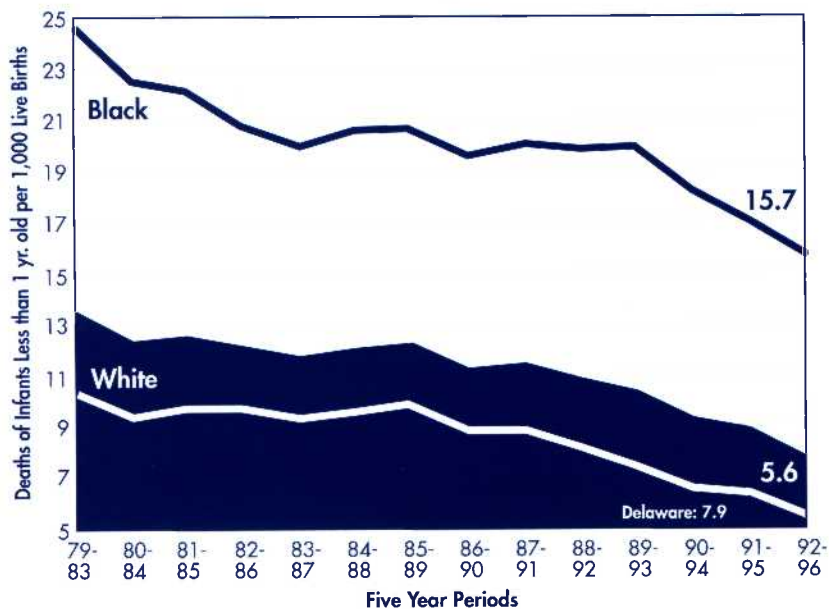


* Wilmington data not available before the 1986-1990 period.

Source: Delaware Health Statistics Center

Infant Mortality

Delaware by Race



Source: Delaware Health Statistics Center

Lead Poisoning



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

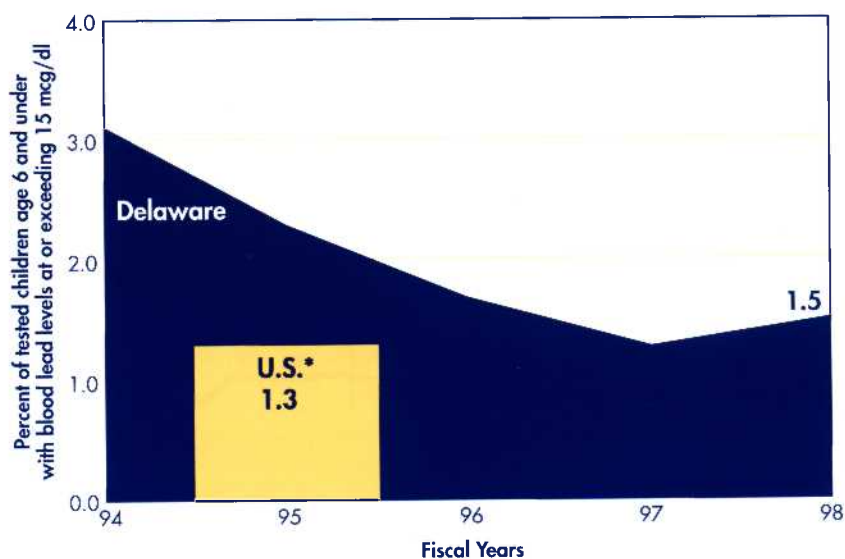
While blood lead levels have dropped considerably across the U.S. since the 1970's, today many children remain at risk for lead poisoning². Children absorb lead chips from paint or dust more readily than adults¹. Exposure can be especially dangerous to children because their nervous system is still developing². Lead poisoning causes neurological damage¹. Additionally, high levels of lead in the bones of growing children has been correlated with physical complaints, anxiety, depression, delinquency, and other social problems³.

- ¹ Males, M. (1997). Women's Health: Adolescents. *Lancet*, 349 (Supplement I, pp. 13-16). Bacharach, C. A. and Carve, K. (1992). *Outcomes of Early Childbearing: An appraisal of recent evidence*. Summary of a conference. Bethesda, MD: National Institute of Child Health and Human Development.
- ² Centers for Disease Control and Prevention. (1997, April 2). Update: Blood lead levels, United States 1991-1994. *Journal of the American Medical Association* 277(13) pp. 1031-1032.
- ³ Lead and Delinquency. (1996, June). *Harvard Mental Health Letter* 12 (12) p. 7. Adapted from the *Journal of the American Medical Association* (1996, February 7).

For more information see
In the KIDS COUNT Section:

Health problems
in low-income children p. K-35
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Lead Poisoning Delaware Compared to U.S.



* U.S. data only available for 1995 from the Third National Health and Nutrition Examination Survey (NHANES III) 1991-95

Source: Delaware Department of Health and Social Services

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 children be screened before entering child care or school. The Division also works with community agencies on eliminating lead-based paint from homes where young children reside.

Child Immunizations

Indicator: Percent of children fully immunized by age 2

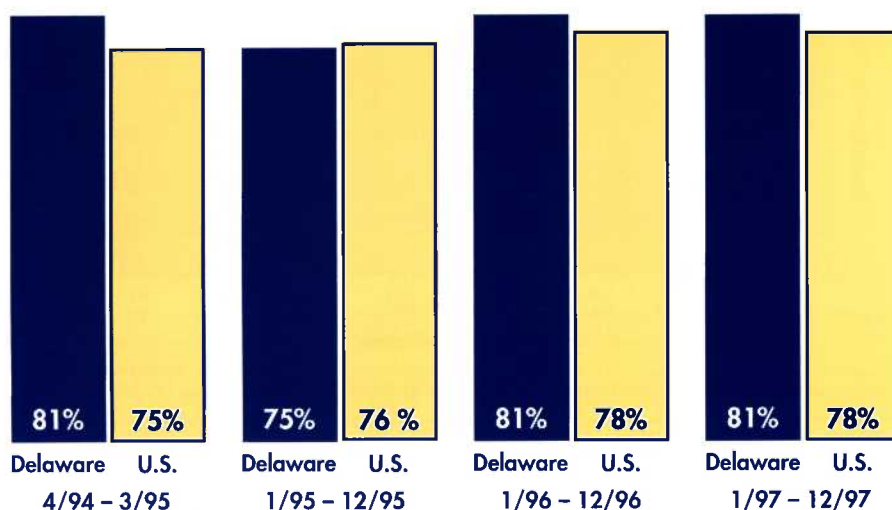
One of the most important measures parents can take to keep their children free of preventable diseases is to make certain that they are fully immunized. Childhood vaccines prevent ten infectious diseases: polio, measles, diphtheria, mumps, pertussis (whooping cough), rubella (German measles), tetanus, *Haemophilus influenza* type-b (a cause of spinal meningitis), varicella (chicken pox), and hepatitis-B¹. Because immunizations are required for school entry, by age five most U.S. children have been immunized². However, younger children (between 1.5 and 3) have an immunization rate much lower than the average rate. It is important that these children are vaccinated due to their likely exposure to infectious disease in day-care settings and elsewhere¹. By age two, between 12 and 16 vaccine doses are due, requiring about six visits to health care providers¹.



1 Center for Disease Control, Division of Media Relations. (1997, July 24). Facts about the childhood immunization initiative: fact sheet. Available <<http://www.cdc.gov>>

2 The National Education Goals Panel. (1997, October). Immunizations. *Special Early Childhood Report 1997*. 16-17.

Child Immunizations
Percent of children fully immunized by age 2



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

For more information see

Health Care Coverage (Children) p. F-19

Health Care Coverage (Families) p. F-39

In the KIDS COUNT Section:

Children without Health Insurance p. K-45

Health problems in low-income children p. K-35

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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.

Child Deaths



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

The child death rate reflects the physical health of children, dangers in their environment, their access to health care services, and the level of adult supervision that children receive¹. Older children are more likely (than infants birth to age 1) to die of accidental injuries and homicide, although some deaths in this age group also will occur due to medical conditions². The number of deaths due to injuries presents only part of the picture. For every death due to injuries, there are many more injuries that require emergency room services or hospitalization³.

1 Children's Safety Network. (1991). *A Data Book of Child and Adolescent Injury*.

2 Voices for Children in Nebraska. (1997). *KIDS COUNT in Nebraska 1997 Report*.

3 National Safe Kids Campaign. (1996). *Childhood Injury: fact sheet*.

For more information see

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Teen Deaths p. F-23

Child Abuse p. F-42

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Child Deaths p. K-24

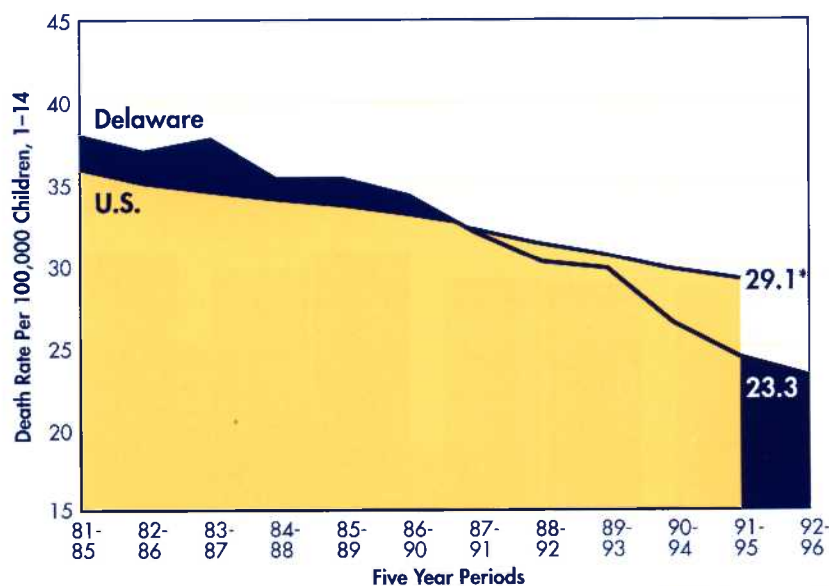
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in low-income children p. K-35

Asthma p. K-44

Child Abuse and Neglect p. K-48

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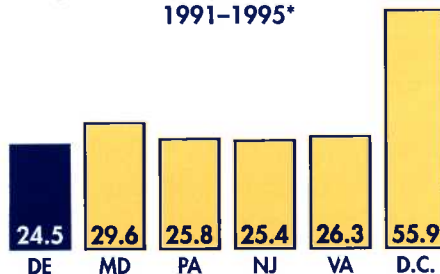
Child Deaths Delaware Compared to U.S.



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

* U.S. data not available for the 1992–1996 period.

Regional Comparison of Child Mortality Rates per 100,000 Children (1-14), Five Year Averages 1991–1995*



*All data were not available for 1992–96.

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, and improving seat belt use by children.

Health Care Coverage

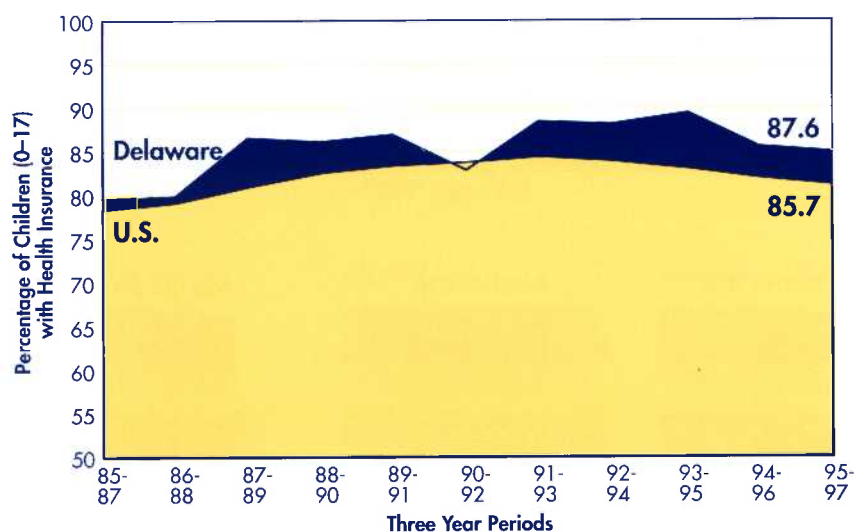
Indicator: Percent of children to age 18 with health care coverage

Access to health care is an important predictor of health outcomes for children. Insured children are more likely to have a relationship with a primary care physician, to receive required preventive services, and to receive a physician's care for health problems such as asthma or ear infections¹. Regular doctor visits are especially critical during early childhood to receive immunizations and to be screened and treated for any developmental problems².



- 1 General Accounting Office. (1997). *Health Insurance Coverage Leads to Increased Health Care Access for Children*. Washington, D. C.
- 2 Families USA. (1997). *Unmet Needs: The Large Differences in Health Care Between Insured and Uninsured Children*. Washington, D. C.

Children with Health Care Coverage
Delaware Compared to U.S.



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

For more information see

Health Care Coverage (Families) p. F-39

In the KIDS COUNT Section:

Asthma p. K-44

Children without Health Insurance p. K-45

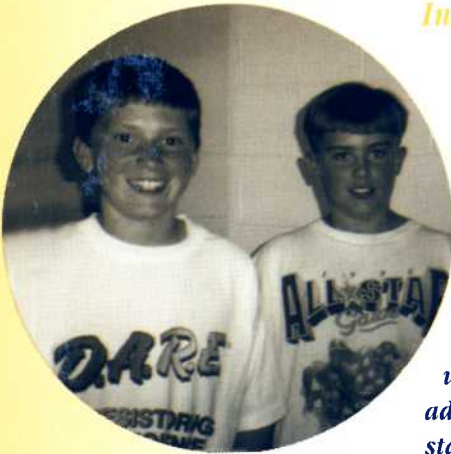
Table 50 p. K-83

Program Statement: Nationally, the Balanced Budget Act of 1997 created a new children's health insurance program focused on low income children. This legislation allows states to initiate or expand health insurance for uninsured children³. Delaware submitted its plan to the U.S. Department of Health and Human Services on June 30, 1998⁴. The plan was approved and with the advent of the Delaware Healthy Children Program 10,500 uninsured children in families with incomes up to twice the poverty level will have access to health insurance at minimal cost beginning in January '99. This will provide health care access for about 95% of Delaware's children.

3 Letter to state officials. (1997). *Children's Health Insurance Program*. Available <<http://www.hcfa.gov/init/schiplt3.htm>>

4 Available <<http://www.hcfa.gov>>

Substance Abuse



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

Youth who abuse drugs and alcohol are more likely to drop out of school, become teen parents, engage in high risk sexual behavior, experience injuries, and become involved with the criminal justice system¹. Over 90% of 8th graders report having had some drug education in school, yet only 24% of the 8th graders think there is a great risk from daily drinking². Regardless of age, gender, family income, and race or ethnicity, adolescents who do not live with two biological parents are 50-150% more likely than other adolescents to use illicit drugs, alcohol, or cigarettes, to be dependent on substances, or to report problems associated with use³. If parents or siblings smoke cigarettes, 8th grade students are likely to smoke cigarettes and use other drugs².

1 The Alan Guttmacher Institute. (1994). *Sex and America's Teenagers*. New York.

2 The Center for Drug and Alcohol Studies, University of Delaware and the Office of Prevention, Department of Services for Children, Youth and Their Families. (1997, December). *Alcohol, Tobacco, and Other Drug Abuse among Delaware students, 1997*.

3 Children's Defense Fund. (1995). *State of America's Children Yearbook 1995*. Washington, D. C.

For more information see

Substance Abuse
11th Graders p. F-21

In the KIDS COUNT Section:

Alcohol, Tobacco
and Other Drugs p. K-46

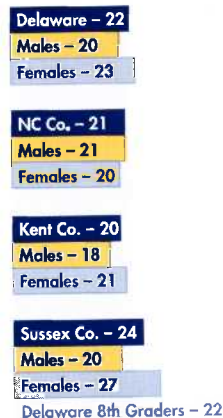
Student Violence
and Possession p. K-29

Tables 29-31 p. K-73-74

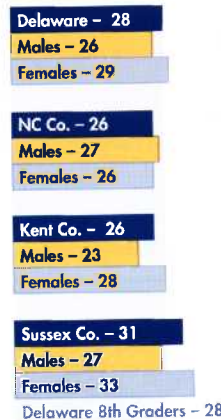
Substance Abuse

Percent of participants in Delaware surveys of public school 8th graders using substances (cigarettes, alcohol, marijuana) in the last 30 days
Delaware, 1997

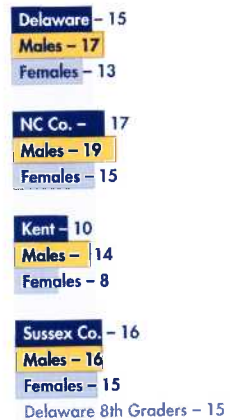
Cigarettes Use



Alcohol Use



Marijuana Use



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 responsibility for funds received under the Safe and Drug Free Schools and Communities Act. Grants to school districts support a range of prevention and intervention strategies such as conflict resolution training and mentoring. DOE also works collaboratively with the Delaware Prevention Coalition and the University of Delaware on substance abuse issues.

Substance Abuse

Indicator: Percent of participants in Delaware surveys of public school 11th 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.¹ Binge drinking (defined here as three or more drinks at a time in the past two weeks) is quite high among 11th graders. Most students who report having at least one drink in the past month also report binge drinking in the past two weeks. Thirty percent of all 11th graders report binge drinking.²



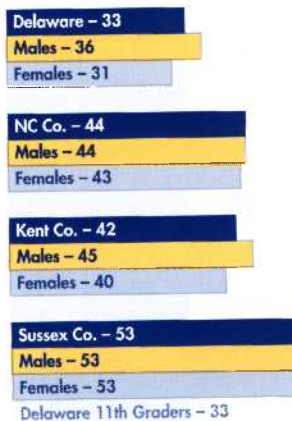
¹ Kansas Action for Children. (1997). *Kansas KIDS COUNT 1997 Data Book*.

² The Center for Drug and Alcohol Studies, University of Delaware and the Office of Prevention, Department of Services for Children, Youth and Their Families (1997, December). *Alcohol, Tobacco, and Other Drug Abuse among Delaware students, 1997*.

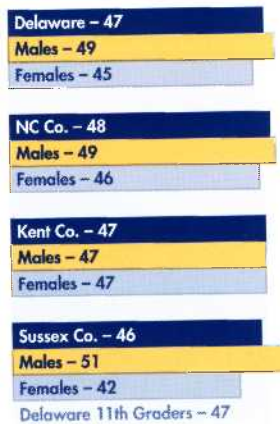
Substance Abuse

Percent of participants in Delaware surveys of public school 11th graders using substances (cigarettes, alcohol, marijuana) in the last 30 days
Delaware, 1997

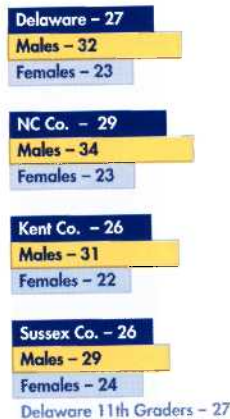
Cigarettes Use



Alcohol Use



Marijuana Use



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 Graders p. F-20

In the KIDS COUNT Section:

Alcohol, Tobacco
and Other Drugs p. K-46

Student Violence
and Possession p. K-29

Tables 29-31 p. K-73-74

Sexually Transmitted Diseases



For more information see
In the KIDS COUNT Section:

Table 68

p. K-90

Indicator: Percent of teens age 15-19 with gonorrhea or primary/secondary syphilis

According to the Centers for Disease Control and Prevention, the U.S. has one of the highest rates (of industrialized nations) for sexually transmitted diseases (STDs) with people under twenty-five accounting for nearly two-thirds of all reported cases. One out of every six teenagers (age 13-19) become infected each year¹. Ignorance about STDs is a growing problem among adolescents; in one American Social Health Association study, only 33% of teenagers could name a single STD².

Gonorrhea is spread through unprotected sexual intercourse. While the disease is treatable with antibiotics, if gone unnoticed, gonorrhea can result in pelvic inflammatory disease, infertility, ectopic or tubal pregnancies, or can spread to the blood or the joints. Gonorrhea also increases the risk of HIV infection³. Syphilis is also spread through unprotected sexual intercourse. Once recognized, syphilis is easily and completely curable with antibiotics. The open sores (chancres) which characterize the primary stage of syphilis increase one's risk of contracting the HIV virus⁴.

1 Sexually transmitted disease and adolescents. (1996, April). *State Legislature*, 22(4), 7.

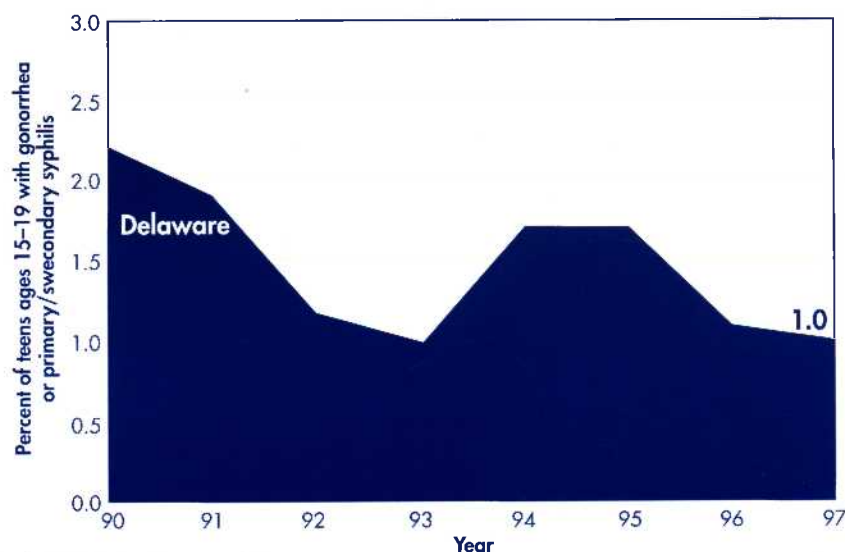
2 MacPherson, P. (1996, March). In the dark about safe sex. *Hospitals and Health Networks*, 70(5), 42.

3 Office of Communications, National Institute of Allergy and Infectious Diseases, National Institute of Health, U.S. Department of Health and Human Services. (1998, June). Gonorrhea fact sheet. Available <<http://www.niaid.nih.gov/factsheets/stdgon.htm>>

4 Syphilis. *The STD Homepage*. Available <<http://med-www.bu.edu/people/sycamore/std/syphilis.htm>>

Sexually Transmitted Diseases

Delaware*, 1990-1997



* Reliable U.S. data is not available

Source: Delaware Department of Health and Social Services

Program Statement: Delaware strives to prevent high risk behaviors that lead to teen pregnancy and sexually transmitted diseases (STDs). As part of broad-based strategies to reduce risky behavior, any teen can receive basic contraceptive and disease prevention counseling when seen in STD or family planning clinics statewide, where free condoms are also available.

Teen Deaths

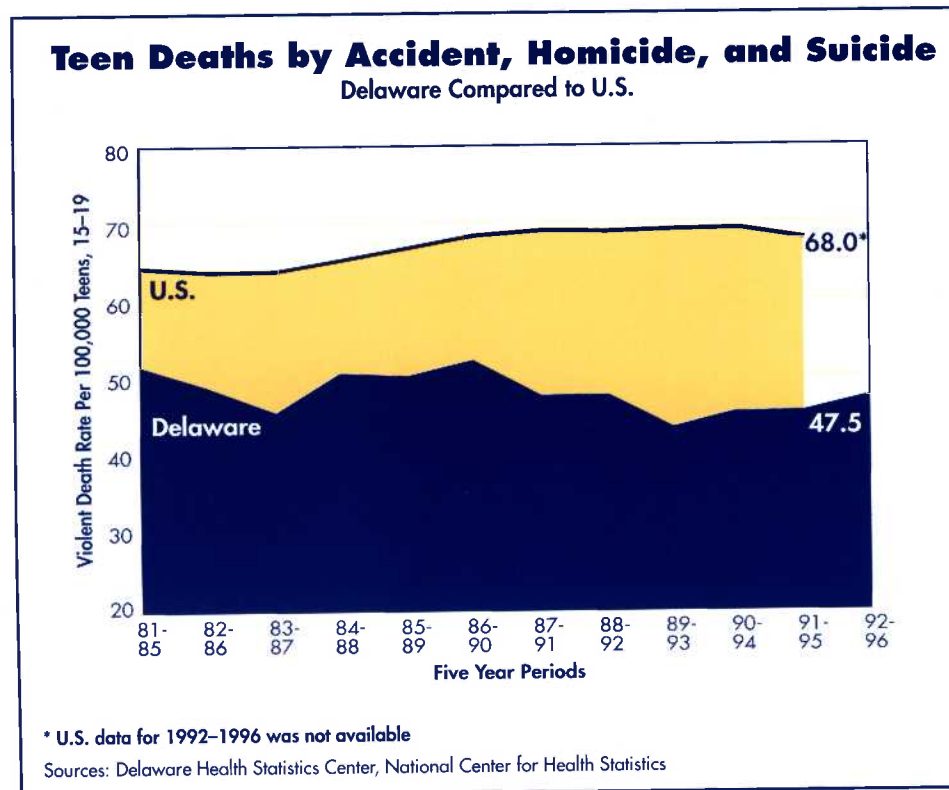
Indicator: Rate of teen deaths by injury, homicide, and suicide (per 100,000 teens age 15-19)

The transition to adulthood presents teens with increased health and safety risks. Factors contributing to teen deaths include risk-taking behavior, the use of alcohol and drugs, and violence¹. Although nationally there has been a steady decline in teen deaths due to motor vehicle accidents, this reduction has been offset by a marked increase in the number of teen deaths by homicide².

In the U.S., three out of four homicides and two out of three suicide victims under the age of twenty-five die from gunshot wounds³. Most youth who are shot, however, do not die. The average medical cost for treating a youth with a gunshot wound is estimated to be \$14,000. This does not include physician charges or rehabilitation charges⁴.



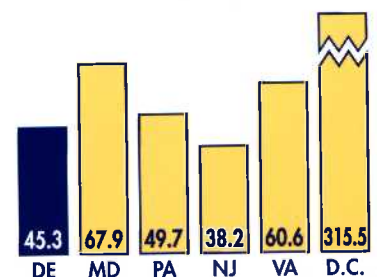
- 1 National Academy Press (1993) *Losing Generations: Adolescents in High Risk Settings*.
- 2 Annie E. Casey Foundation. (1997). *KIDS COUNT Data Book: 1997*, 14.
- 3 Maternal and Child Health Bureau, U.S. Department of Health and Human Services (1994). Children's safety network. *Childhood Injury: Cost and Prevention Facts*.
- 4 Maternal and Child Health Bureau, U.S. Department of Health and Human Services. (1994). Children's safety network *Firearm Facts: Information on Gun Violence and Its Prevention*.



For more information see

Substance Abuse	p. F-20
In the KIDS COUNT Section:	
Teen Deaths	p. K-26
Alcohol, Tobacco and Other Drugs	p. K-46
Juvenile Victims and Their Perpetrators	p. K-29
Tables 23-24	p. K-71
Tables 29-31	p. K-73-74

Regional Comparison of Teen Death Rates per 100,000 teens (15-19) by Accidents, Suicides, and Homicides Five Year Averages, 1991-1995*



All data were not available for 1992-96.
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 Services Cabinet Council coordinates many community-based prevention programs, including Family Services Partnerships, Strong Communities projects, and Prevention Networks.

Successful Learners

A young girl with dark hair, wearing a white shirt with a black floral pattern, is looking down at a book. A young boy with short dark hair, wearing a white t-shirt, is looking up at the book. They are both holding the book, which has a blue cover. The background is a red brick wall.

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 disability services

Children with disabilities are an extremely heterogeneous group, varying by type of disability and age of the child, as well as by the many differences in the population at large—such as family income and demographics. While there are wide variations in the specific needs of each child, there are some issues of common concern to families of children with disabilities¹. Whether disabilities are mild or severe, they have the potential to create special needs related to physical health, mental health, education, parent support, child care, recreation, and career preparation².

- ¹ The David and Lucile Packard Foundation. (1996). Special education for students with disabilities. *Special Education for Students with Disabilities*. Los Altos, CA: Center for the Future of Children.
- ² Martin, E. W., Martin, R. and Terman, D. L.; The David and Lucile Packard Foundation. (1996). The legislative and litigation history of special education. *Special Education for Students with Disabilities*. Los Altos, CA: Center for the Future of Children.

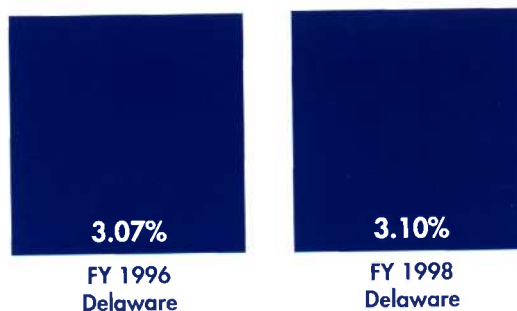
For more information see

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

In the KIDS COUNT Section:

Early Care
and Education p. K-38

Early Intervention Delaware

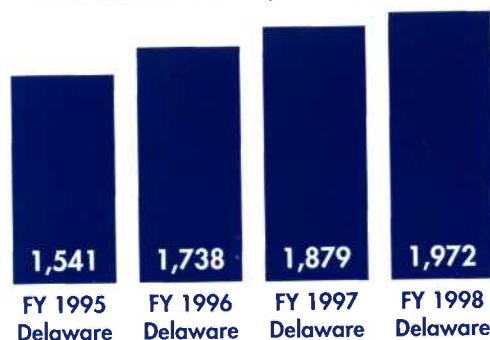


Source: Delaware Department of Health and Social Services

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 for 1995. 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.

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.

Child Development Watch Total Children Served per Year, Delaware



Source: Birth to 3 Program

Head Start and Early Childhood Assistance Program

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



Head Start and the Early Childhood Assistance Program provide comprehensive early childhood development program for low-income preschool children and their families; most children in the program attend for one year and are four years old¹. The Early Childhood Assistance Program (ECAP) in Delaware provides funding for four year olds who meet eligibility criteria for Head Start programs. Head Start and ECAP program components include education, parent involvement, social services, health and nutrition, and mental health. The programs are designed to provide low-income children with the socialization and school readiness skills they need to enter public schools on an equal footing with more economically advantaged children². Many factors contribute to a child's success in school. School readiness is based on children's physical growth, self-confidence, and social competence. Readiness is not determined solely by the innate abilities and capacities of young children. Readiness is shaped and developed by people and environments in the early childhood years³.

¹ David and Lucile Packard Foundation (1995). *Head Start. Future of Children: Long Term Outcomes of Early Care Programs*, 5 (3).

² Children's Defense Fund. (1995). *The State of America's Children Yearbook: 1995*

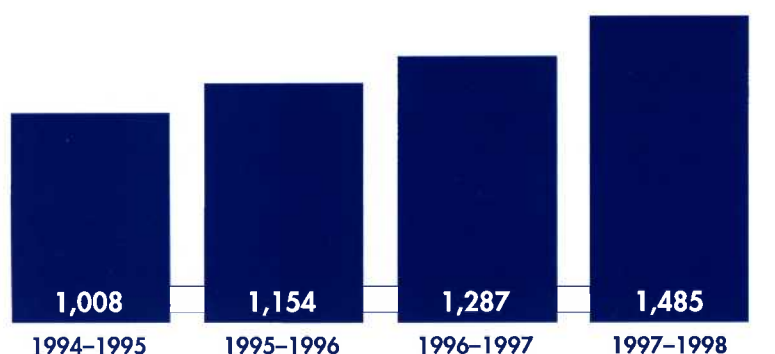
³ Carnegie Corporation. (1994). *Starting Points: Meeting the Needs of Our Youngest Children*.

For more information see
Head Start p. F-27

In the KIDS COUNT Section:

Early Care and Education p. K-38

Head Start/ECAP
4-Year-Old Children Served in Delaware



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

Source: Delaware Department of Education

Program Statement: Delaware has provides supplemental funding for comprehensive services for 4 year old children whose families are at or below 100% of poverty. Linking with the federally funded Head Start programs throughout the state, these Department of Education programs provide a full range of preschool, health, developmental, and other family support services.

Teens Not in School and Not Working



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

Dropping out of school and not becoming a part of the workforce places teens at a significant disadvantage as they make this transition from adolescence to adulthood. Research suggests that this detachment, particularly if it lasts several years, increases the risk that a young person, over time, will have lower earnings and a less stable employment history than his or her peers who stayed in school and/or secured jobs¹. Low-level skills and low-level wages make it extremely difficult for young men and women to support their families and have a standard of living that is above the poverty threshold².

1 Brown, B. (1996). *Who are America's Disconnected Youth?* Report prepared for the American Enterprise Institute, Washington, D. D : Child Trends, Inc.

2 Annie E. Casey Foundation. (1997). *KIDS COUNT Data Book*. 1997, 15-16

For more information see

High School Dropouts p. F-29

Unemployment p. K-46

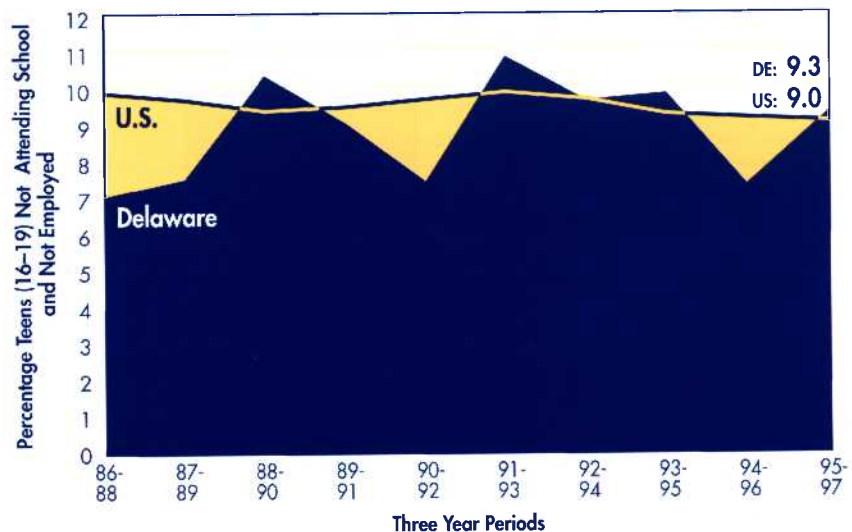
In the KIDS COUNT Section:

High School Dropouts p. K-30

Teens Not in School and Not Working p. K-32

Tables 38–45 p. K-78–81

Teens Not in School and Not Working Delaware Compared to U.S.



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

Program Statement: In partnership with the Department of Education, the Division of Vocational Rehabilitation operates a program to reduce the number of dropouts from secondary school and to assist students with disabilities transition from school to work. Two DRV counselors work with a team in each of the 19 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.

High School Dropouts

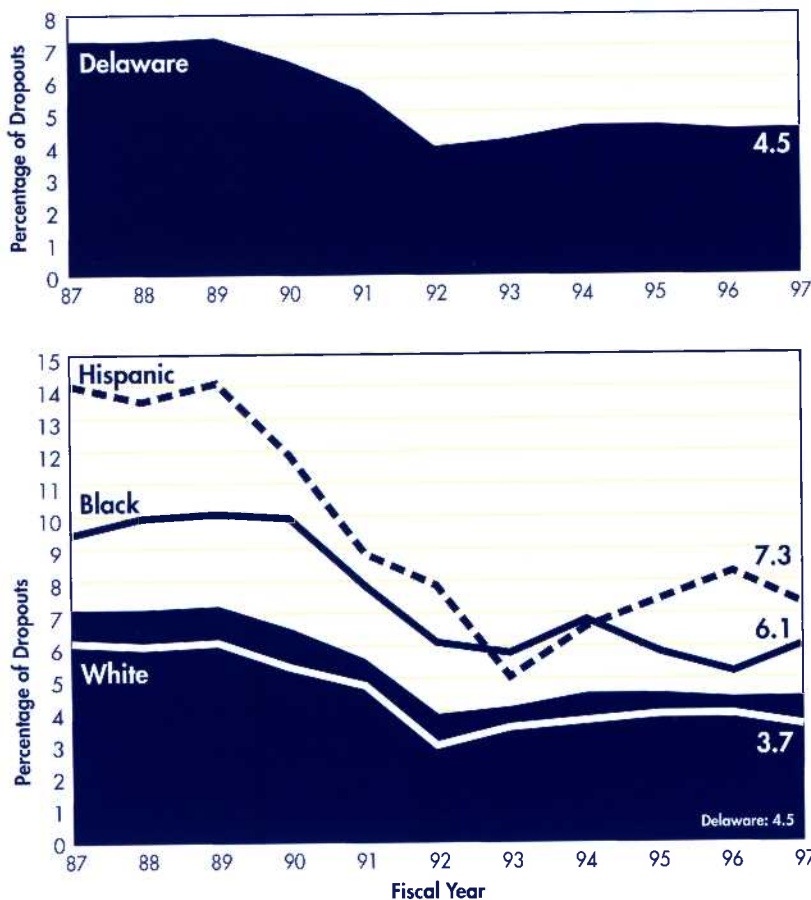
Indicator: Percent of high school dropouts

Students who drop out of high school face staggering odds in achieving economic success in the modern world. With each advancing year, the prospects for those who have not completed high school become more and more bleak. The probability of falling into poverty is three times higher for high school dropouts than for those who have finished high school¹. Students are more likely to drop out of school when they are poor, when they live in low-income communities, and when they come from single-parent families¹. Early warning signs that a student is at risk are the inability to read at grade level, poor grades, truancy, substance abuse, and teen pregnancy².



- 1 Annie E. Casey Foundation. (1997) *KIDS COUNT Data Book: 1997*, 15-16.
2 Children's Defense Fund. (1995). *The State of America's Children Yearbook: 1995*.

High School Dropouts
Delaware, Delaware by Race and Ethnicity



Source: Department of Education, State of Delaware

For more information see

Teens Not in School and Not Working p. F-28
Unemployment p. K-46

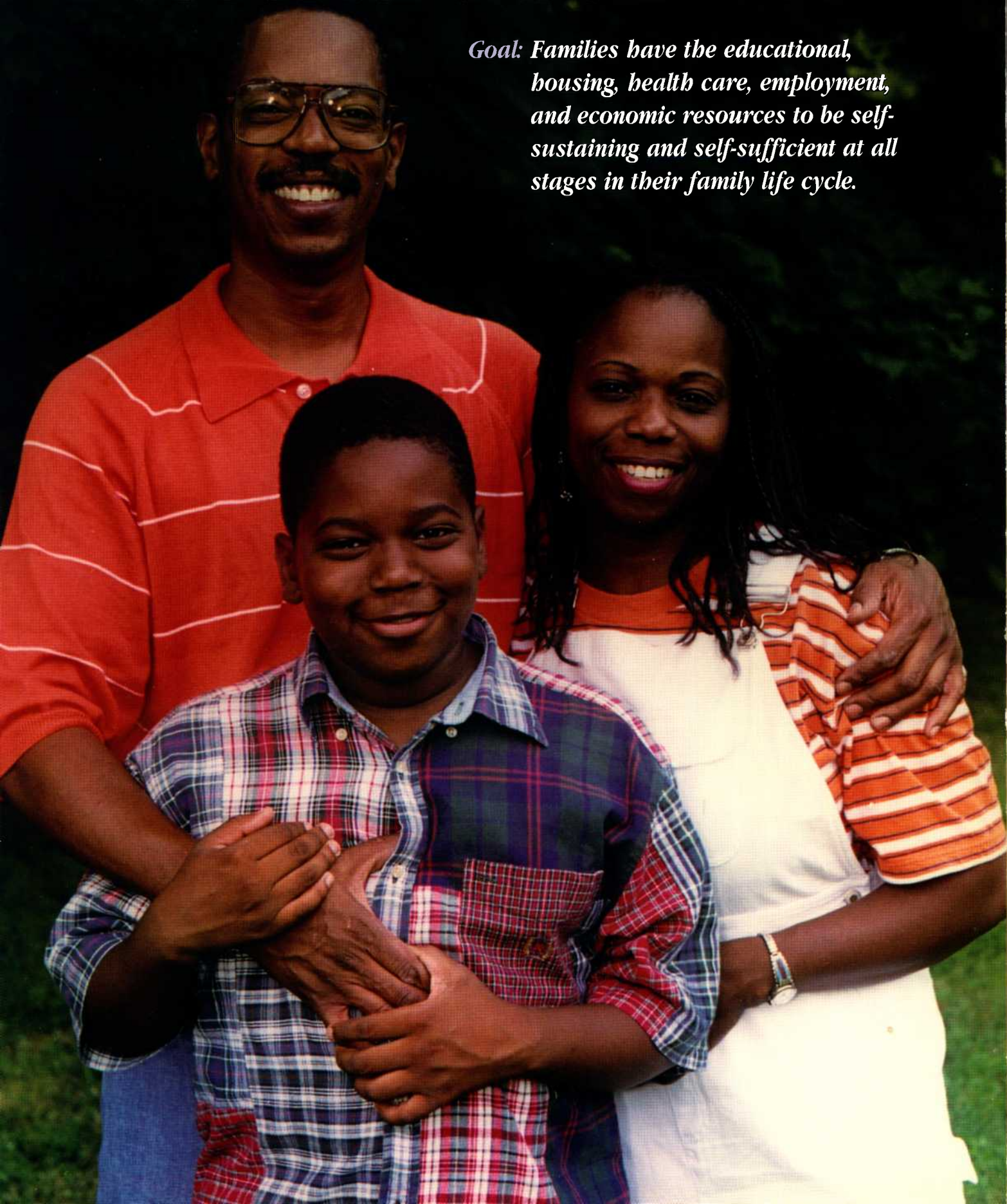
In the KIDS COUNT Section:

Infants Deaths by Education of the Mother p. K-23
High School Dropouts p. K-30
Teens Not in School and Not Working p. K-32
Suspensions and Expulsions p. K-33
Table 20 p. K-69
Tables 38-45 p. K-78-81

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

Children are more likely to be poor than adults and their disproportionate poverty is getting worse. According to the Census Bureau, in the U.S., one child out of five lives in poverty. Close to one in four children under the age of six is poor¹. The percentage of children in poverty is one of the most extensively used measures of child well-being. Child poverty is associated with many poor outcomes for children including illness, poor school performance, and delinquency². Poor children are also at greater risk for homelessness, child maltreatment, substandard housing, poor nutrition, and dying in infancy³.

1 Children's Defense Fund. (1998). *The State of America's Children: 1998*.

2 Annie E. Casey Foundation (1997). *KIDS COUNT Data Book: 1997*, 16.

3 Carnegie Corporation of New York. (1994). *Starting Points: Meeting the Needs of Young Children*, 17-19.

For more information see

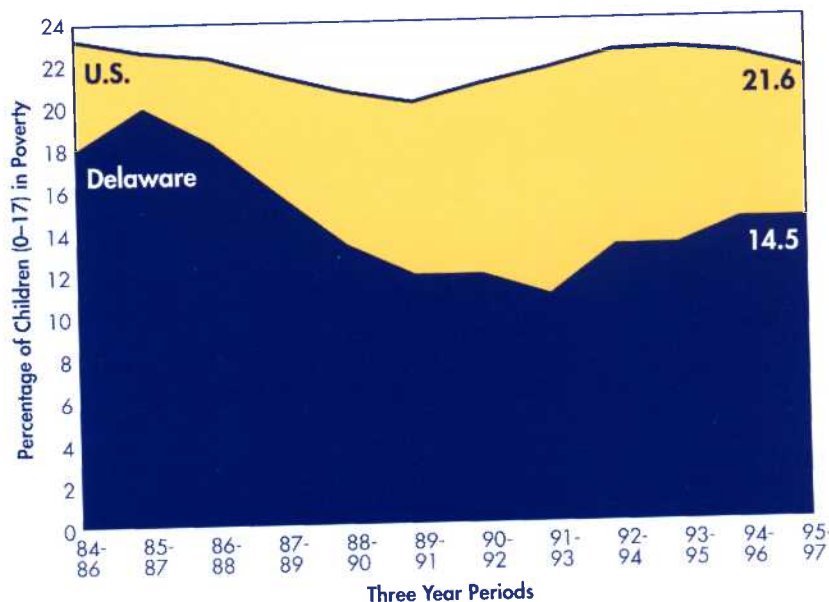
Health Care Coverage	p. F-19
Female Headed Households in Poverty	p. F-36
Child Support	p. F-37
Risk of Homelessness	p. F-38
Health Care Coverage	p. F-39
Unemployment	p. F-46
Substandard Housing	p. F-52
Home Ownership	p. F-53

In the KIDS COUNT Section:

Children in Poverty	p. F-34
Median Income of Families by Family Type	p. K-37
Child Care Costs	p. K-39
Subsidized Child Care	p. K-40
Children Receiving Free and Reduced Price School Meals	p. K-42
Women and Children Receiving WIC	p. K-43
Children without Health Insurance	p. K-45
Tables 46-57	p. K-81-85

Children in Poverty

Delaware Compared to U.S.



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

Program Statement: Delaware's child poverty rate is one of the lowest in the country. Delaware provides a safety net for the poor and is constantly striving to lift families out of poverty. Through our welfare reform program, A Better Chance, Delaware helps the parents of children in the poorest families get and keep a job. The state also helps pay for child care, provides access to affordable health care and encourages parents to make timely child support payments.

One-Parent Households

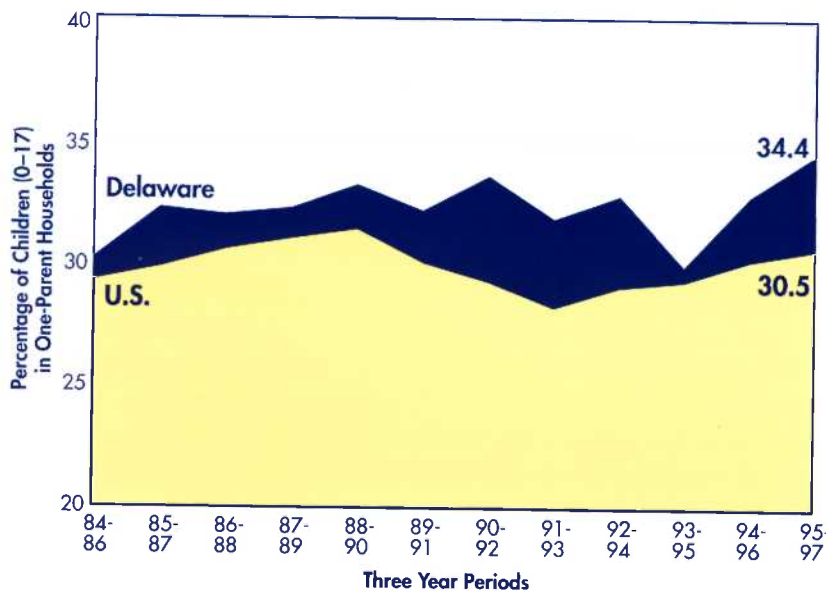
Indicator: Percent of children ages 0-17 in one-parent households

Children living with single-parent families do not have the same resources and opportunities as those living in two-parent families¹. Many single parents receive insufficient child support which puts their children at greater risk for adverse outcomes linked to poverty. Children growing up in single-parent families are at greater risk of homelessness, substandard housing, poor nutrition, and death². According to the Center for Demographic Policy in Washington, D. C., sixty percent of all U.S. children will spend some time in a single-parent family before reaching 18³.



- 1 The David and Lucile Packard Foundation. (1994). *The Future of Children: Children and Divorce*, 4 (1).
- 2 Garfinkel, I. And McLanahan, S. S. (1986). *Single Mothers and Their Children*. Washington, D. C.: The Urban Institute.
- 3 Hodgkinson, H. L. (1992). *A Demographic Look at Tomorrow*. Washington, D. C.: Institute for Educational Leadership, Center for Demographic Policy.

Children in One-Parent Households
Delaware Compared to U.S.



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

For more information see

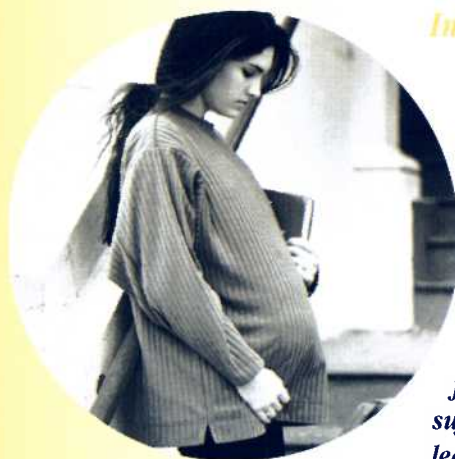
Female Headed Households in Poverty p. F-36
Child Support p. F-37

In the KIDS COUNT Section:

Birth to Unmarried Teens p. K-15
Infant Mortality by Marital Status of Mother p. K-23
Children in Poverty by Household Structure p. K-35
Children in One-Parent Households p. K-36
Table 7 p. K-60
Table 20 p. K-69
Table 46 p. K-81
Tables 54-59 p. 84-86

Resourceful Families

Teen Births



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

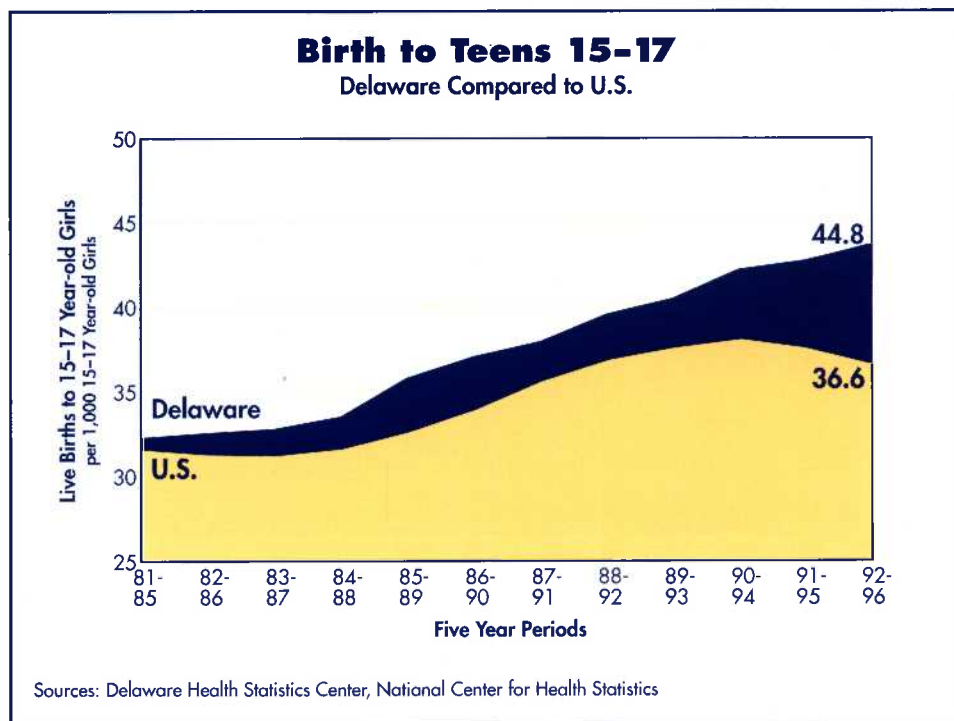
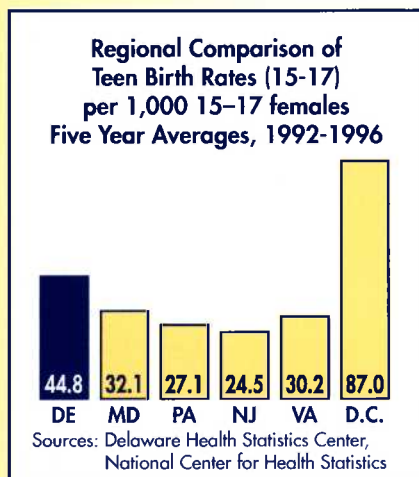
Teen parenthood reduces life opportunities for both teen mothers and their children. Becoming a parent while still a teenager is difficult because most teen mothers are not married, have not completed high school, and are unable to financially support their children¹. Unmarried teen mothers are much less likely to receive child support payments which makes it difficult for them to support their children financially. The lifetime earnings of teen mothers are less than half those of women who defer childbearing until age twenty².

Babies born to teen parents also face many risks. Because teen parents have fewer career and educational opportunities, their children are more likely to suffer the devastating effects of poverty including low birth weight, poor health, learning problems, maltreatment, and ultimately becoming teen parents themselves³.

1 Annie E. Casey Foundation (1997). *KIDS COUNT Fact Book: 1997*, 91.

2 Congress of the United States, Office of Technology Assessment. (1991). Background and effectiveness of selective prevention and treatment services. *Adolescent Health*, (II), 323-356.

3 Carnegie Corporation of New York. (1994). *Starting Points: Meeting the needs of our Youngest Children*, 15-20.

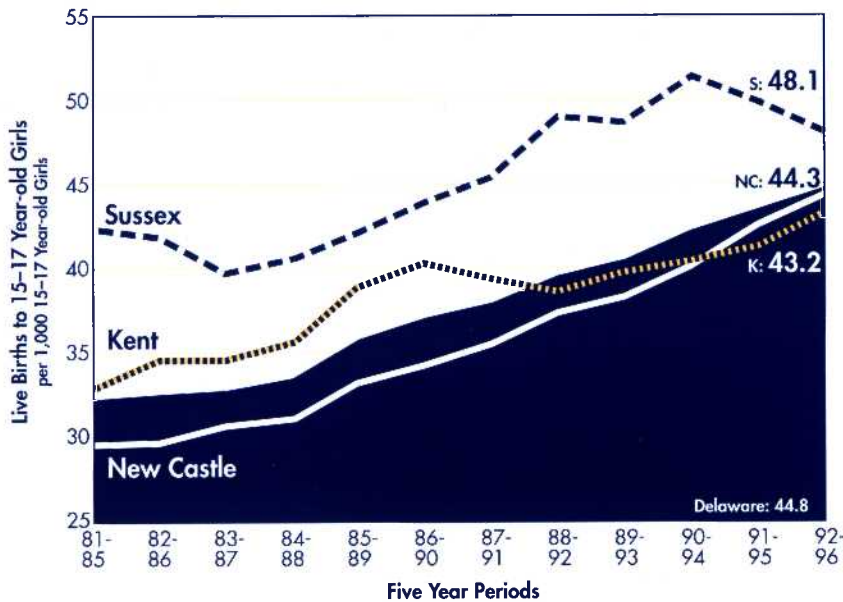


Program Statement: In Delaware, becoming a teen parent doesn't pay. Mothers under 18 who give birth after January 1, 1999 will receive no cash benefits for the baby, but instead will receive other forms of short-term assistance.

In addition, Delaware's Alliance for Adolescent Pregnancy Prevention works with the media to send a strong message to teens about making responsible choices. The Alliance and its members work to increase communication in families and to encourage teens to wait to become sexually active. For those teens at the highest risk, intensive counseling is available through several public health clinics and school-based wellness centers.

Birth to Teens 15-17

Delaware and Counties



Sources: Delaware Health Statistics Center

For more information see

Sexually Transmitted Diseases p. F-22

One-Parent Households p. F-33

In the KIDS COUNT Section:

Birth to Teens 15-19 p. K-14

Births to Unmarried Teens p. K-15

Teen Birth Rates by Census Tracts p. K-16

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

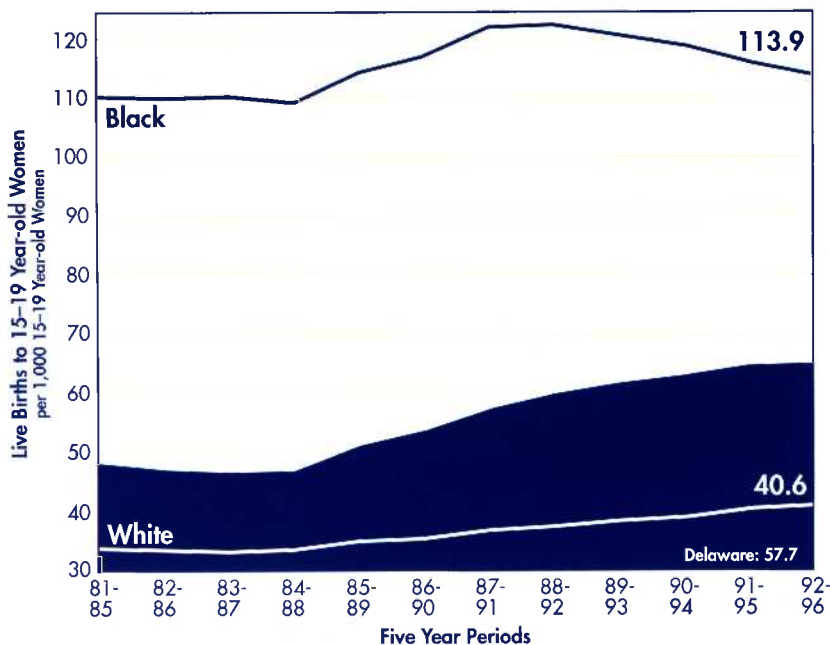
Children in One-Parent Households p. K-36

Tables 4-8 p. K-58-61

Table 20 p. K-69

Births to Teens 15-19*

Delaware by Race



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

Sources: Delaware Health Statistics Center

Female Headed Households in Poverty



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

Nationwide, slow growth in wages and growth in the proportion of children living in mother-only families account for much of the increase in child poverty in recent years¹. Poverty has particularly damaging effects in early childhood. Young children in poverty are more likely to experience delays in their physical, cognitive, language, and emotional development, which in turn affects their readiness for school².

1 The David and Lucile Packard Foundation. (1997, Summer/Fall) *Executive Summary: The Future of Children: Children and Poverty*, 7 (2). The Center for the Future of Children.

2 National Center for Children in Poverty. (1996). *One in Four*.

For more information see

One Parent Households p. F-33

Child Support p. F-37

In the KIDS COUNT Section:

Children in Poverty by Household Structure p. K-35

Children in One-Parent Households p. K-36

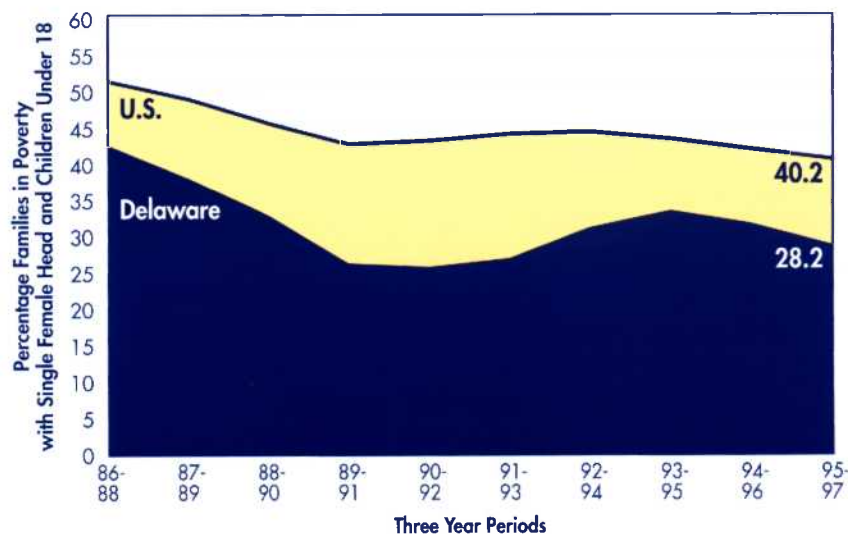
Table 7 p. K-60

Table 46 p. K-81

Tables 54-59 p. 84-86

Female Headed Households in Poverty

Delaware Compared to U.S.



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

Program Statement: Although Delaware's child poverty rate is one of the lowest in the country, we strive to eliminate poverty for families, especially those with single parents. Through programs that enforce child support payments, offer subsidized childcare, and discourage teen pregnancy, we hope to provide a stable environment for children to thrive.

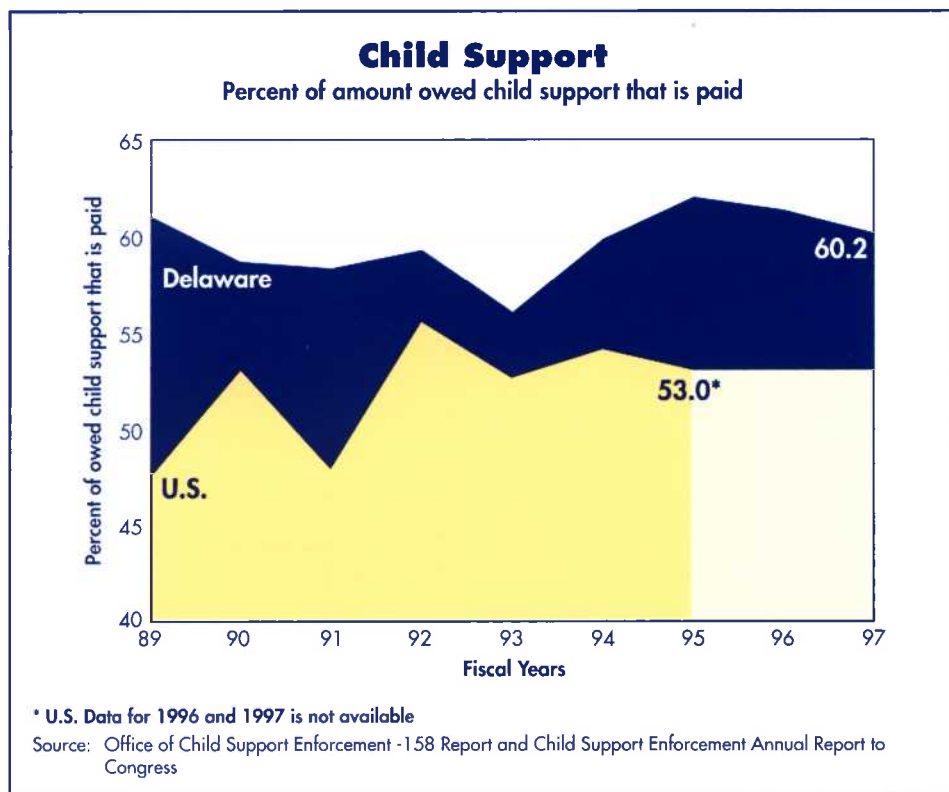
Child Support

Indicator: Percent of child support that is paid

The ability to meet the needs of children is, in many cases, out of the control of the parent who lives with and cares for those children. Many social and economic factors necessitate the need for services such as child support enforcement in order for some parents to fulfill their responsibilities to their families¹. The failure of an absent parent to pay child support has significant consequences for a parent raising a child/children alone. Even when there is a child support agreement in place, child support payments tend to be low and unreliable².

¹ Maine KIDS COUNT. (1997). Social and economic opportunity. *Maine KIDS COUNT 1997 Data Book*.

² Rhode Island Department of Administration, Division of Taxation, Child Support Enforcement. (1996, December). As cited in *1997 Rhode Island KIDS COUNT Factbook*.



For more information see
In the KIDS COUNT Section:

Table 58

p. K-85

Program Statement: In Delaware, the financial responsibility for children belongs to both parents. The Division of Child Support Enforcement helps parents collect money from absent parents to raise a child. The Division assists in establishing paternity and support orders and enforces collections through wage withholding and other means.

Risk of Homelessness



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

For too many families, adequate housing at any price is out of reach¹. With over half of a family's income going toward rent, any interruption in income or unexpected expense can place families at risk of homelessness². According to the U.S. Department of Housing and Urban Development (HUD) figures based on the Census Bureau's 1993 American Housing Survey data, more than 5.3 million renter households are experiencing worst case housing needs. These households have incomes below 50 percent of median family incomes in their area and pay more than half of their income for rent and utilities or live in severe substandard housing.³ In Delaware, the 1995 Statewide Housing Needs Assessment indicates that 16,148 renter households are experiencing similar circumstances.⁴

For more information see

Substandard Housing p. F-52

Home Ownership p. F-53

In the KIDS COUNT Section:

Table 53 p. K-84

1 Children's Defense Fund. (1998). Spotlight on housing and homelessness. *The State of America's Children Yearbook*: 1998.

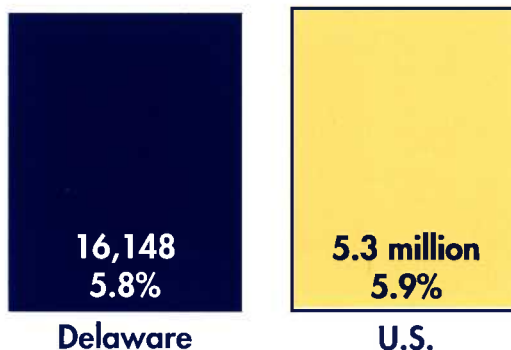
2 American Bar Association. (1993). *America's Children at Risk: A National Agenda for Legal Action*.

3 U.S. Department of Housing and Urban Development (March 1996) *Rental Housing Assistance at a Crossroads: A Report to Congress on Worst Case Housing Needs*

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

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. For families on the verge of homelessness due to a crisis causing them to fall behind on their housing costs, we provide emergency funds. Because the threat is imminent for many of these families, Delaware State Housing Authority bridges 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.

Health Care Coverage

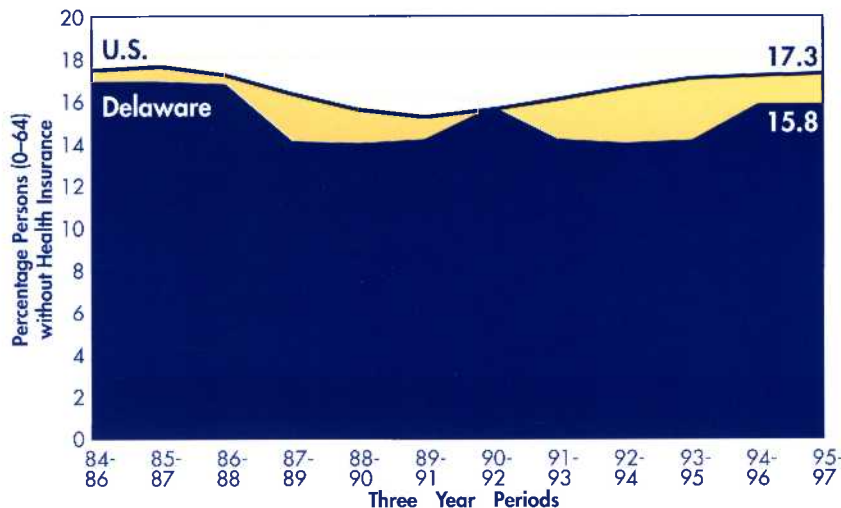
Indicator: Percent of persons under age 65 who do not have health care coverage

Presently, the U.S. is the only major industrialized nation that does not ensure universal access to health care for all of its citizens. Although the U.S. spends one out of every eight dollars on health care, over one-eighth of all Americans lack health insurance coverage. Another concern is health care cost inflation¹. It is unlikely that the federal government will impose cost-containment provisions on the total amount spent for health care by this country as a whole or on that expended by the private health care sector. Thus, employers and individuals in the private sector experiencing problems due to the growth of their health care costs can expect little help from Congress².



- 1 Wong, J. D. (1997, June). Health care finance in the U.S. past, present, and future. *International Journal of Public Administration*, 20 (6), 1297-1315.
- 2 Blendon, R. J., Brodie, M., and Benson, J. (1995, January). What should be done now that health system reform is dead? *The Journal of the American Medical Association*, 273 (3), 243-244.

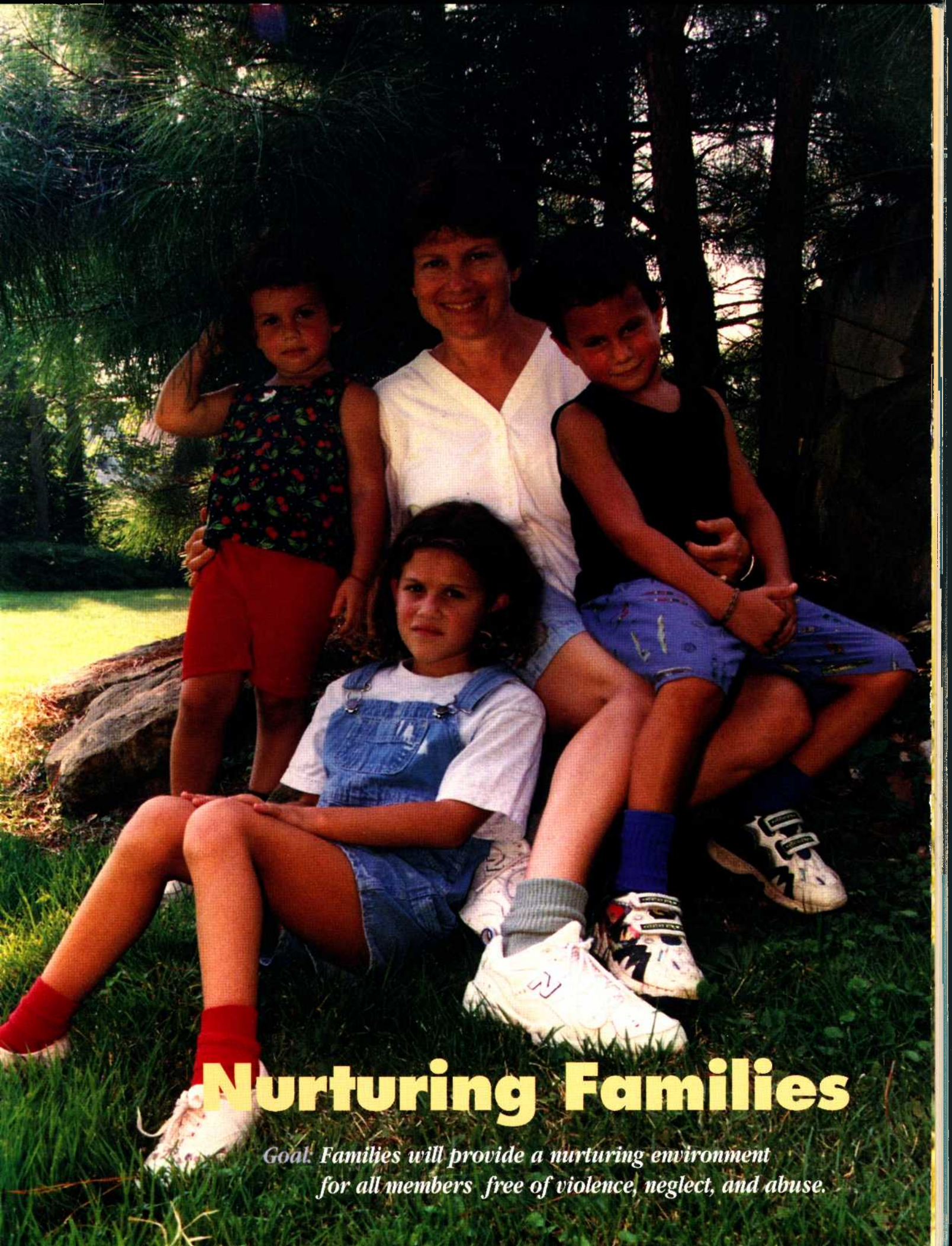
Lack of Health Care Coverage Delaware Compared to U.S.



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

Program Statement: Delaware assures that all citizens living below the poverty level have health insurance. The Diamond State Health Plan insures low-income adults and children, giving them access to needed medical prevention and treatment services. Low-cost coverage will be offered to children in families with incomes up to twice the poverty level beginning in 1999, extending coverage to more children of the working poor.

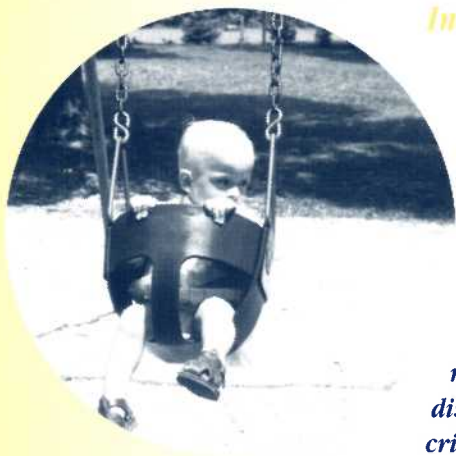
For more information see
 Health Care Coverage (Children) p. F-19
In the KIDS COUNT Section:
 Asthma p. K-44
 Children without Health Insurance p. K-45
 Table 50 p. K-83



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*

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

Every year, nearly three million children throughout the United States are reported to child protective services agencies as alleged victims of child maltreatment. Of these, more than one million children are found to be confirmed victims of abuse or neglect¹. The consequences of child abuse and neglect are overwhelming. Child maltreatment can result in death, permanent disability, delayed development, mental and behavioral problems, teen pregnancy, criminal behavior, depression, and suicide².

1 U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect. (1996). *Child Maltreatment 1994: Reports from the States to the National Center on Child Abuse and Neglect*. Washington, D. D.

2 Georgians for Children. (1996). *1996-97 Georgia KIDS COUNT Factbook*.

For more information see

Child Deaths p. F-18

Children in Out-of-Home Care p. F-43

In the KIDS COUNT Section:

Child Deaths p. K-24

Child Abuse p. K-48

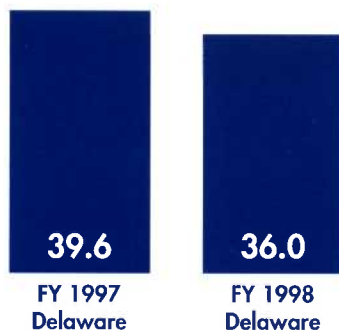
Table 21 p. K-70

Table 23 p. K-71

Table 63 p. K-88

Child Abuse Reports

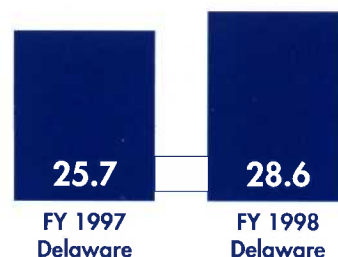
Accepted reports of abuse and neglect per 1,000 children ages birth through 17



Source: Delaware Department of Services for Children, Youth and Their Families

Child Abuse & Neglect

Children with substantiated reports of abuse or neglect per 1,000 children



Source: Delaware Department of Services for Children, Youth and Their Families

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 behavior 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.

(Continued on next page)

Out-of-Home Care

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

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 most frequent reasons children are removed from their homes are neglect, lack of supervision, sexual or physical abuse, and incapacity of the parent. Increasingly, parental abuse of alcohol and illegal drugs are contributing factors leading up to the need for substitute care. Some children are in out-of-home placements because they represent a danger to themselves, their families, or their communities¹.

¹ U.S. General Accounting Office (1995). *Child Welfare: Complex Needs Strain Capacity to Provide Services*. Washington, D. C.



For more information see

Child Abuse p. F-42

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

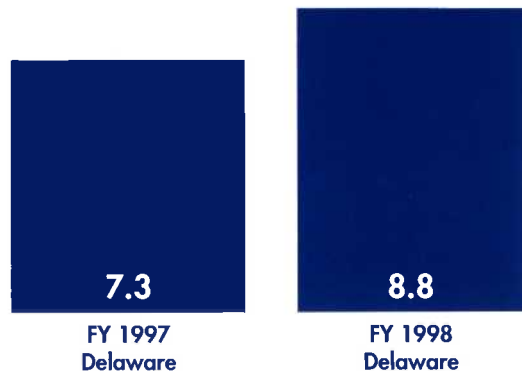
In the KIDS COUNT Section:

Child Abuse and Neglect K-48

Table 64 p. K-89

Out-of-Home Care

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



Source: Delaware Department of Services for Children, Youth and Their Families

Program Statement: (Continued from previous page)

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.

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.

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. Research consistently suggests that youth who become involved in juvenile crime frequently have mental health problems prior to being incarcerated and incarcerated youth demonstrate significantly higher levels of psychopathology than non-incarcerated youth¹.

1 The David and Lucile Packard Foundation. (1996) *The Future of Children: The Juvenile Court*. Center for the Future of Children.

For more information see

Out-of-Home-Care p. F-43

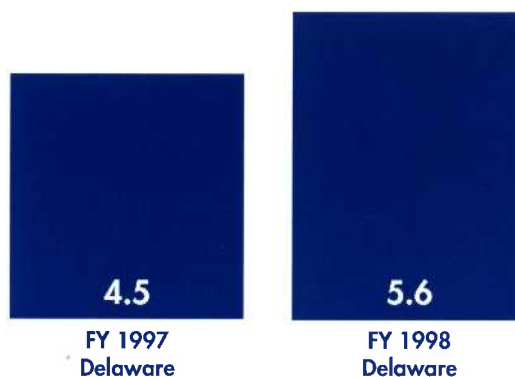
Juvenile Violent Crime p. F-49

In the KIDS COUNT Section:

Juvenile Violent Crime Arrests p. K-28

Table 64 p. K-89

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



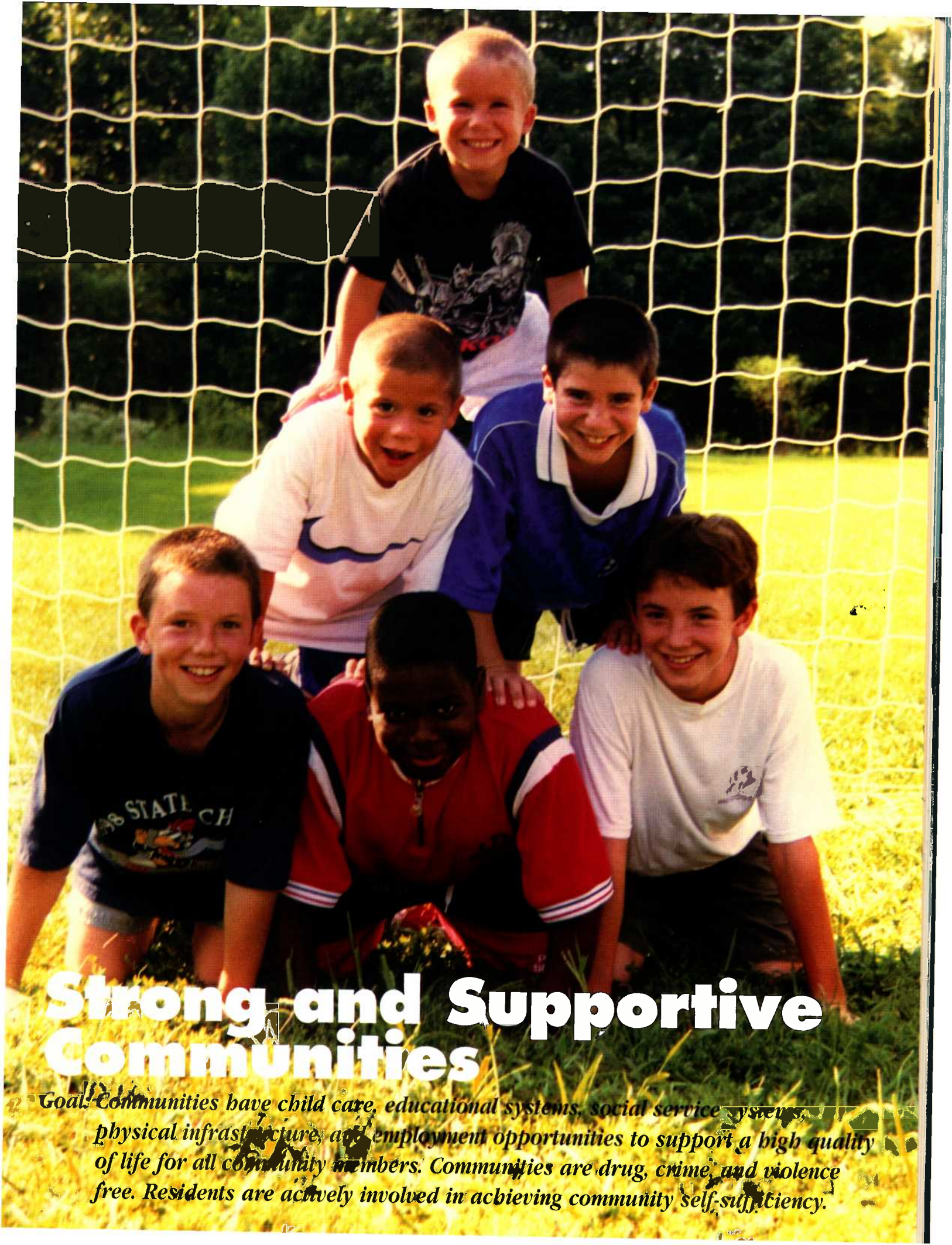
Source: Delaware Department of Services for Children, Youth and Their Families; Statistical Analysis Center

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 for probation youth at low risk of re-offending 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.



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

According to the U.S. Bureau of Labor Statistics, the unemployment rate is the lowest it has been since 1973. 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 markets¹. The rate does vary regionally. This dispersion is said to be due to several factors including crime, education, amenities, residency patterns, home ownership, international migration, and industry composition².

¹ Glassman, J. K. (1997, December). Lonely unemployment line. *U.S. News & World Report*, 123 (24), 36.

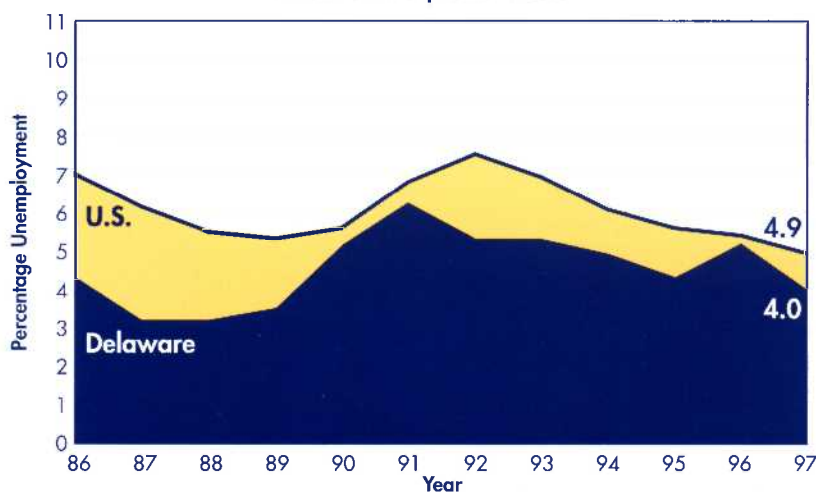
² Partridge, M. D. and Rickman, D. S. (1997, August). The dispersion of U.S. state unemployment rates: the role of market and non-market equilibrium factors. *Regional Studies*, 31 (6), 593-606.

For more information see
In the KIDS COUNT Section:

Table 60

p. K-87

Unemployment Delaware Compared to U.S.



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

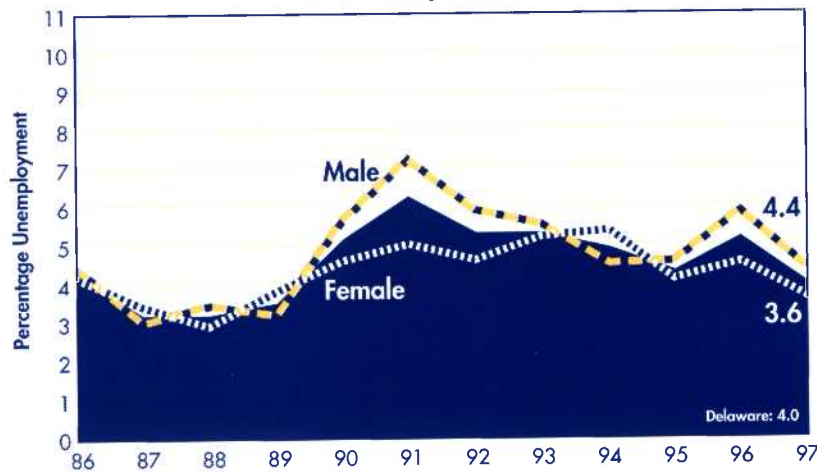
Program Statement: The Department of Labor is involved in numerous initiatives to enable people to become employed. The Division of Employment and Training provides a wide variety of one-stop integrated employment and training services to over 44,000 people annually through occupational skills training programs, school-to-work training programs, summer youth employment, and training programs, re-employment services, employer services, automated self-service and by matching job seekers with employment.

The Virtual Career Network (VCNet), Delaware's automated Internet One-Stop system developed by the Division of Employment and Training and the Office of Occupational and Labor Market Information (OOLMI) 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 supportive services information.

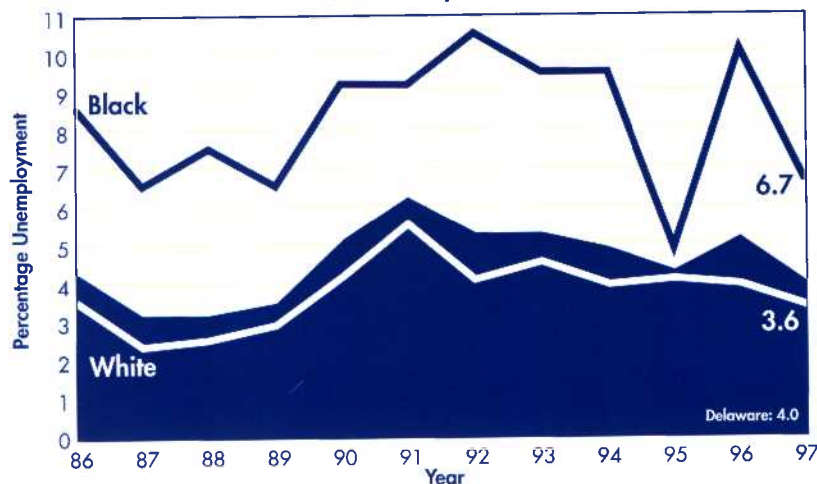
In conjunction with Department of Health and Social Services and the Delaware Economic Development Office, DET assists welfare recipients move from dependence to independence by obtaining and maintaining employment.

(Continued on next page)

Unemployment Delaware by Gender

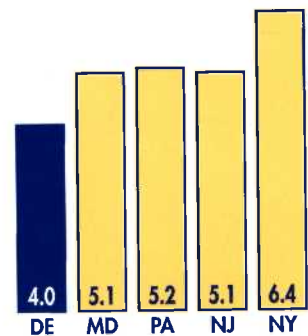


Delaware by Race



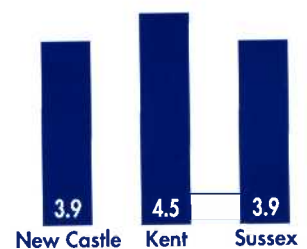
Sources: Delaware Department of Labor and U.S. Department of Labor, Bureau of Labor Statistics

Regional Comparison of Percentage Unemployment, 1996



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

County Comparison of Percentage Unemployment Delaware, 1996



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

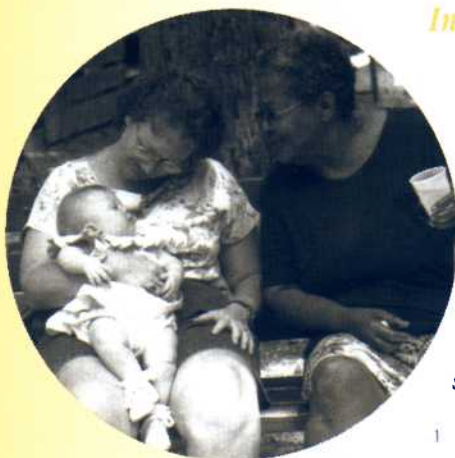
Program Statement: *(Continued from previous page)*

The mission of the Division of Vocational Rehabilitation is to provide opportunities and resources to eligible individuals with disabilities leading to success in employment and independent living. Approximately 700 people with disabilities will be successfully placed in jobs each year.

The Division of Vocational Rehabilitation is implementing two new initiatives to provide services for individuals with mental illness which will enable them to obtain or retain work in entry level jobs. Pathways to Employment will help people who work at the professional level keep or obtain a job. DRV, in conjunction with the Governor's Committee on the Employment of People with Disabilities has developed a Business Leadership Network aimed at promoting more employment opportunities for people with disabilities.

OOLMI produces several publications to assist people on preparing for careers. The new Stepping Stones labor market survival guide will help welfare clients acquire skills and attitudes necessary to survive in the labor market. The Delaware Career Compass has provided almost a decade worth of students and job seekers with critical information about job seeking skills, labor market information, and educational options.

Depending on Neighbors



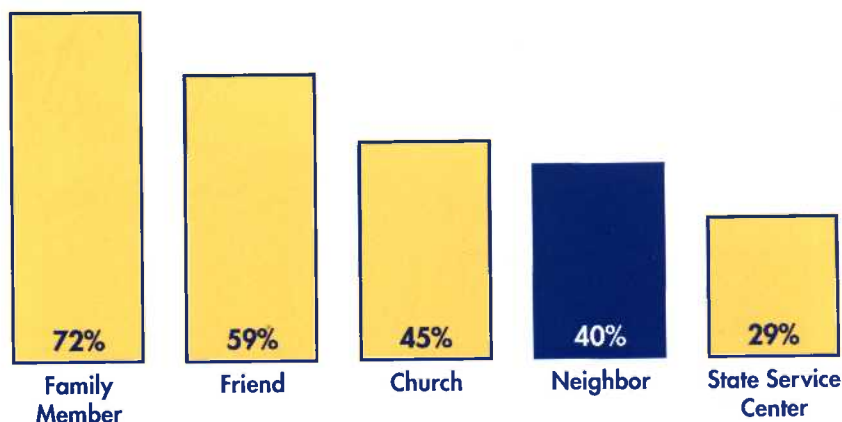
Indicator: *Percent of households at 200% of poverty level or below that indicate they would seek help from a neighbor, family, and friends.*

People sometimes experience alienation within their neighborhoods. It is important for community members to develop social relationships in order to share resources, services, and information¹. 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.

Depending on Neighbors

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



Sources: Community Needs Assessment (November 1994), prepared for Delaware Health and Social Services, Division of State Service Centers, by the Center for Community Development, College of Urban Affairs, University of Delaware

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 private or public service programs. 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. In addition, training, technology, and technical assistance have been provided regularly to the Partnerships.

Juvenile Violent Crime

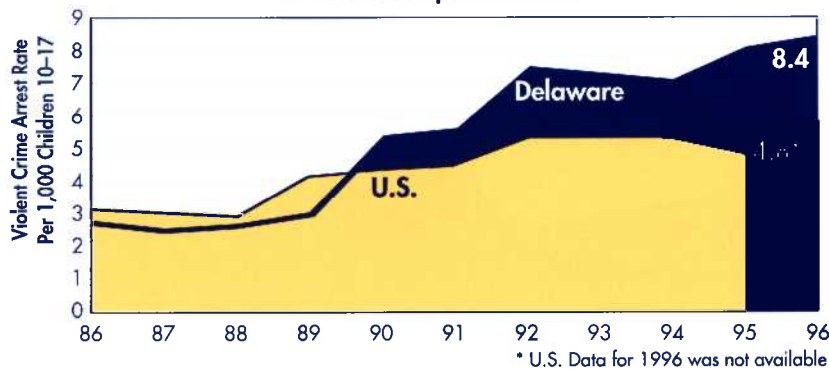
Indicator: Juvenile violent crime arrest rate

Risk factors for juvenile violent crime and delinquency include poverty, family violence, inadequate supervision, limited education or job skills, and poor school performance¹. Prevention and early education are the most cost-effective approaches to reducing delinquency². To be most effective, strategies should be community based, culturally appropriate, and initiated early in a child's development. Well designed programs can reduce truancy, provide support to parents, build mentoring relationships with adults, and help students learn how to problem-solve and resolve conflict peacefully³.

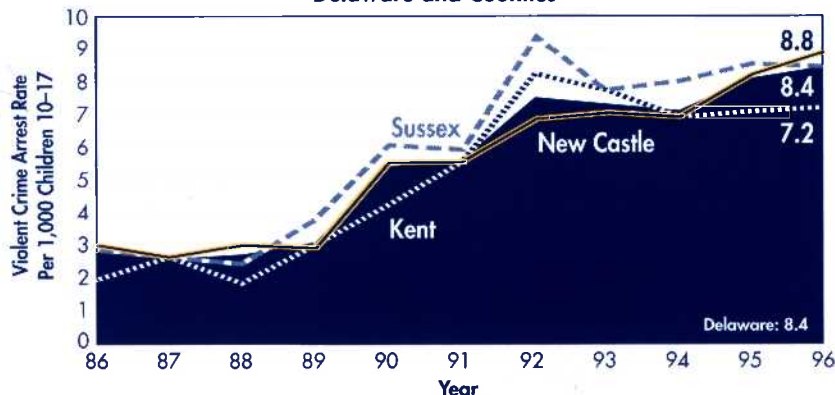
1. Office of Juvenile Justice and Delinquency Prevention, US Department of Justice. (1995). *Juvenile Offenders and Victims, A National Report*. Washington, D. C.
2. Office of Juvenile Justice and Delinquency Prevention. (1995). *Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders*. Washington, D. C.
3. Coordinating Council on Juvenile Justice and Delinquency Prevention. (1996). *Combating Violence and Delinquency: the National Juvenile Justice Action Plan*. Washington, D. C.



Juvenile Violent Crime
Delaware Compared to U.S.



Delaware and Counties



Sources: Statistical Analysis Center, State Bureau of Investigation

For more information see

Teen Deaths p. F-23

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

Adult Violent Crime p. F-50

Adults on Probation or Parole p. F-51

In the KIDS COUNT Section:

Juvenile Violent Crime Arrests p. K-28

Teen Deaths p. K-26

Tables 25-37 p. K-72-77

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 1,000 youth ages 9 to 18 play on 50 teams in Wilmington. In addition to the basketball games, the program has components that deal with education, health, public safety, and community volunteer work.

Adult Violent Crime



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

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.

For more information see

Juvenile Violent Crime p. F-49

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

Adults on Probation or Parole p. F-51

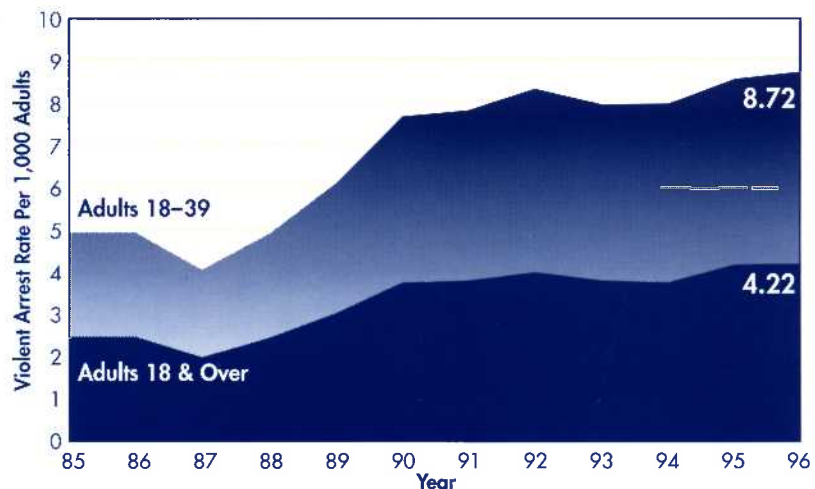
In the KIDS COUNT Section:

Juvenile Violent Crime Arrests p. K-28

Tables 25-37 p. K-72-77

Adult Violent Crime

Delaware*



* Comparable U.S. data was not available

Source: Statistical Analysis Center

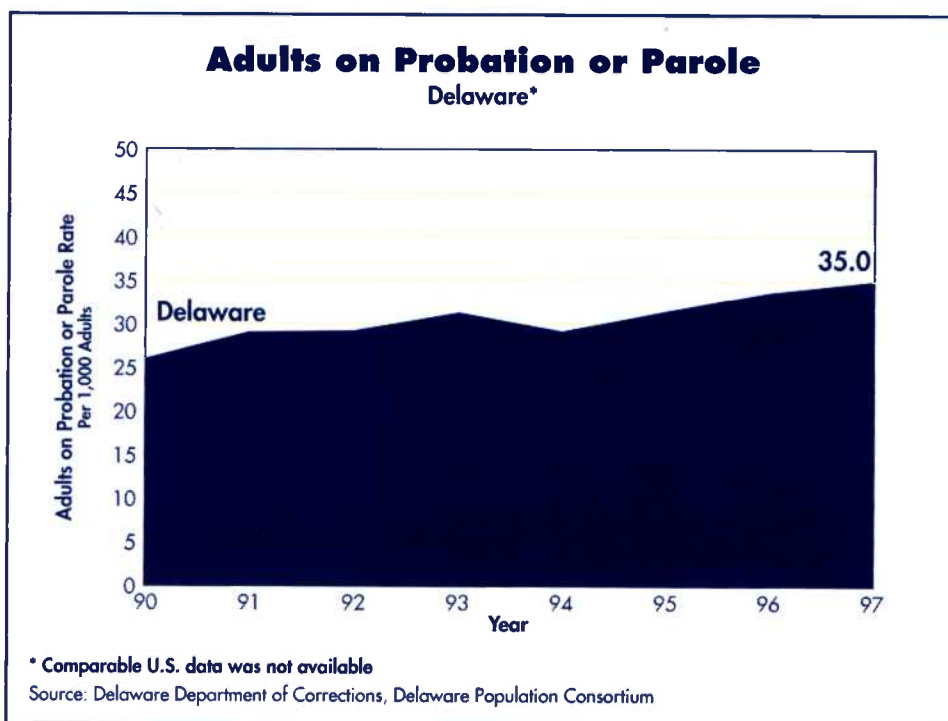
Program Statement: In order to meet the demands of an increasingly complex society, the Delaware State Police has aggressively pursued innovative programs to address violent crime. The use of the new DICAT (Division Wide Crime Analysis Tracking) system provides “real time” data to allow deployment of 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.

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 testing¹.

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



Definitions:

Probation – a period of community supervision for an adjudicated adult without incarceration.

Parole – a period of community supervision for an adjudicated adult following a period of incarceration.

For more information see

Juvenile Violent Crime p. F-49

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

Adult Violent Crime p. F-50

In the KIDS COUNT Section:

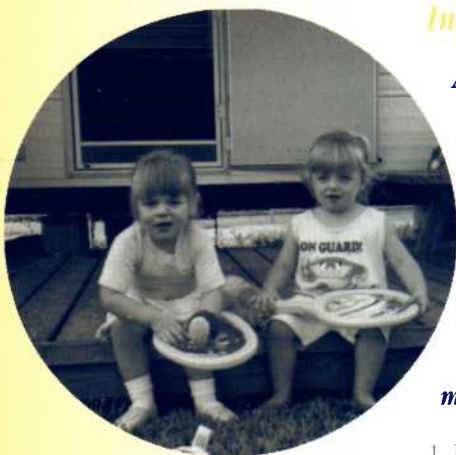
Juvenile Violent Crime Arrests p. K-28

Tables 25-37 p. K-72-77

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.

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

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.

For more information see

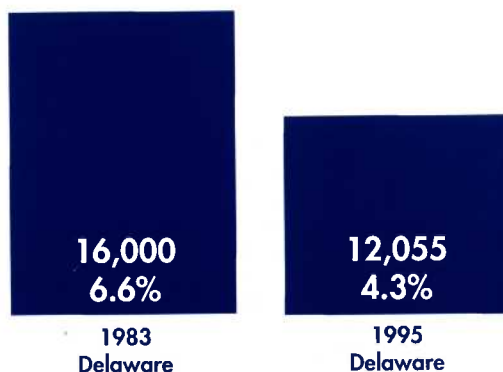
Risk of Homelessness p. 38

Home Ownership p. F-53

In the KIDS COUNT Section:

Table 53 p. K-84

Substandard Housing Number and percent of substandard units



Source: Delaware State Housing Authority

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 in some cases, 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.

Home Ownership

Indicator: Percent of home ownership

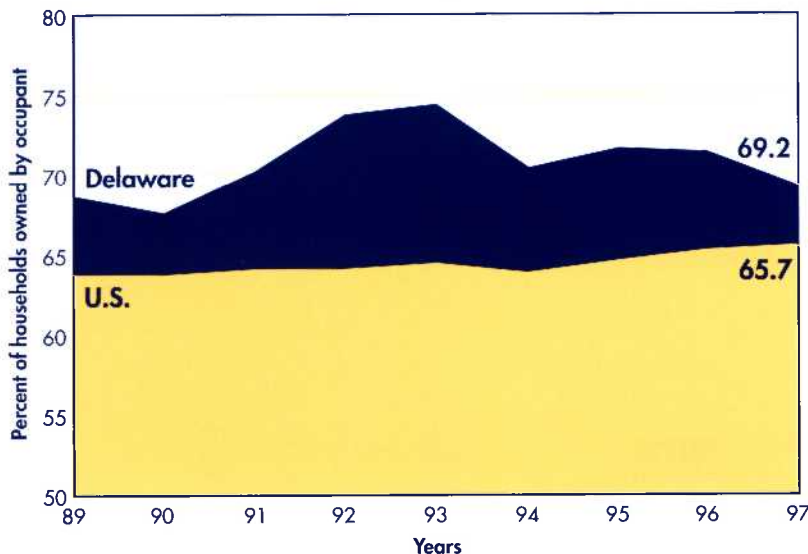
Home ownership has long been recognized as a key component of the "American Dream." Home Ownership proves tremendous benefits to our society. ¹ Owning a home gives families a stake in where they live. It strengthens our economy, builds communities and, to the individual family, represents a powerful tool for building stability and self-esteem. However, those who aspire to home ownership are finding it harder and harder to attain. In the past, many young parents earned enough income to save up for a down payment or were helped by programs such as the GI Bill. Today, with wages falling for young workers, too many families struggle simply to pay the rent. ²



¹ Susan A. Fank, DSHA Director, excerpt from July 5, 1998 Guest Opinion in the *Delaware State News*.

² Children's Defense Fund (1998). Spotlight on housing and homelessness. *The State of America's Children Yearbook: 1998*.

Home Ownership Delaware Compared to U.S.



Source: Delaware State Housing Authority

For more information see

Risk of Homelessness p. 38

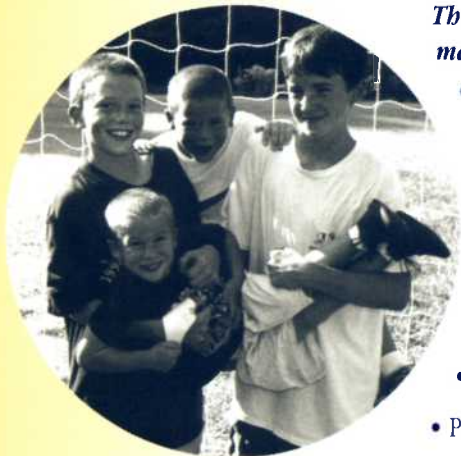
Substandard Housing p. F-52

In the KIDS COUNT Section:

Table 53 p. K-84

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 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 costs loans. We also support housing counseling, and offer education to rental communities—big and small—to help 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 we focus on making home ownership a more attainable goal for working families.

Indicators "Under Construction"



The Family Services Cabinet Council has identified additional indicators which may further help to measure the well-being of Delaware's families. However, at the present time these indicators are still "under construction". Processes are being developed to collect the data that is needed. For example, the indicators related to children as learners are linked to the Delaware State Testing Program for which results will be released in late 1998. As soon as these data collections processes are completed, the results will be published in FAMILIES COUNT in Delaware.

- Percent of third graders tested scoring at or above basic reading levels
- Percent of third graders tested scoring at or above basic math levels
- Percent of fifth graders tested scoring at or above basic reading levels
- Percent of fifth graders tested scoring at or above basic math levels
- Percent of eighth graders tested scoring at or above basic reading levels
- Percent of eighth graders tested scoring at or above basic math levels
- Percent of tenth graders tested scoring at or above basic math levels
- Percent of students going on to post-secondary enrollment
- School readiness measure
- Domestic violence rate