

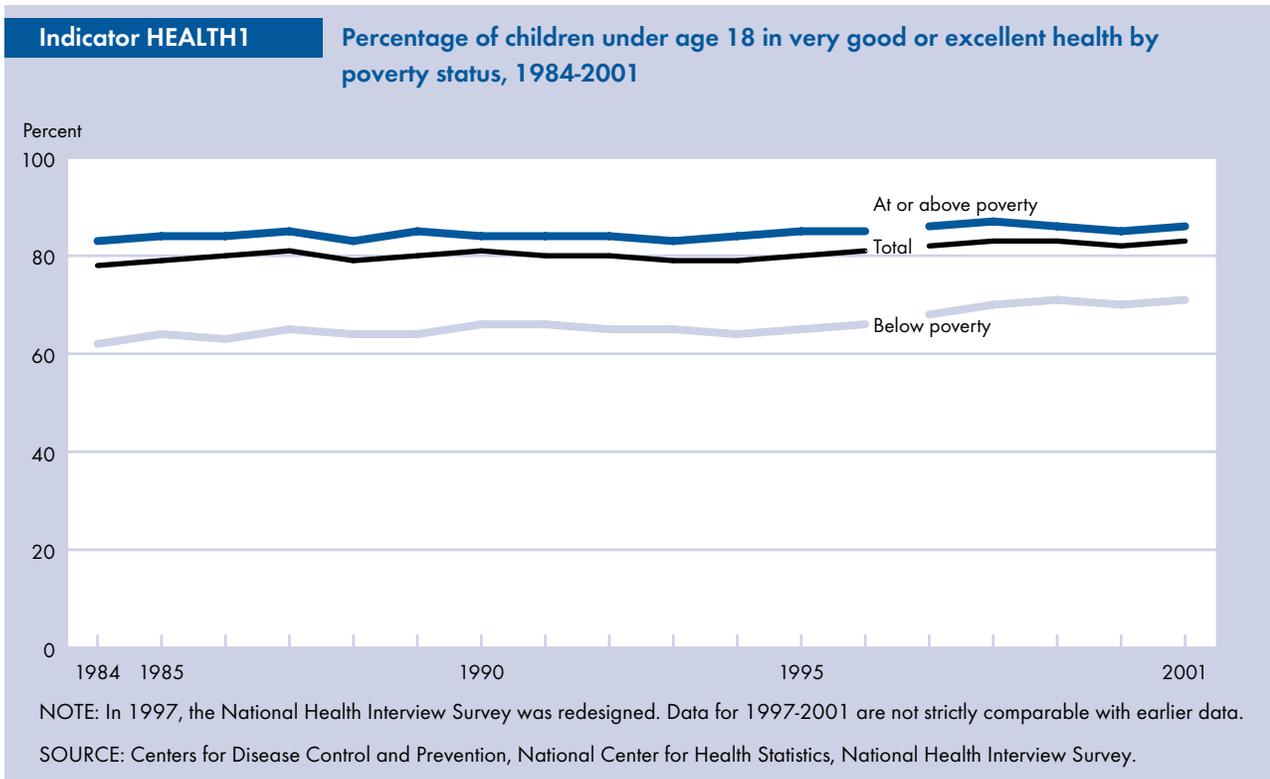
Indicators of Children's Well-Being

Health Indicators

The World Health Organization defines health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.” This section presents information on several important measures of child health. Data depicted include indicators of general health and chronic disease, a measure of birth outcomes (low birthweight), mortality rates, overweight, immunization rates, and rates of births to adolescents. Important measures for which data are not available include child abuse and neglect, mental health, and disability.

General Health Status

The health of children and youth is fundamental to their well-being and development. Parental reports of their children's health provide one indication of the overall health status of the Nation's children. This indicator measures the percentage of children whose parents report them to be in very good or excellent health.



- In 2001, about 83 percent of children were reported by their parents to be in very good or excellent health.
- Children under age 5 are slightly more likely to be in very good or excellent health than are children ages 5 to 17 (85 and 82 percent, respectively).
- White, non-Hispanic children were more likely than Black, non-Hispanic and Hispanic children to be in very good or excellent health. In 2001, 87 percent of White, non-Hispanic children were reported to be in very good or excellent health, compared with 74 percent of Black, non-Hispanic children and 77 percent of Hispanic children.
- Child health varies by family income. Children living below the poverty line are less likely than children in higher-income families to be in very good or excellent health. In 2001, about 71 percent of children in families below the poverty line were in very good or excellent health, compared with 86 percent of children in families living at or above the poverty line.
- Each year, children at or above the poverty line were substantially more likely to be in very good or excellent health than were children whose families were below the poverty line. However, the health gap between children below and those at or above the poverty line decreased slightly between 1984 and 2001.

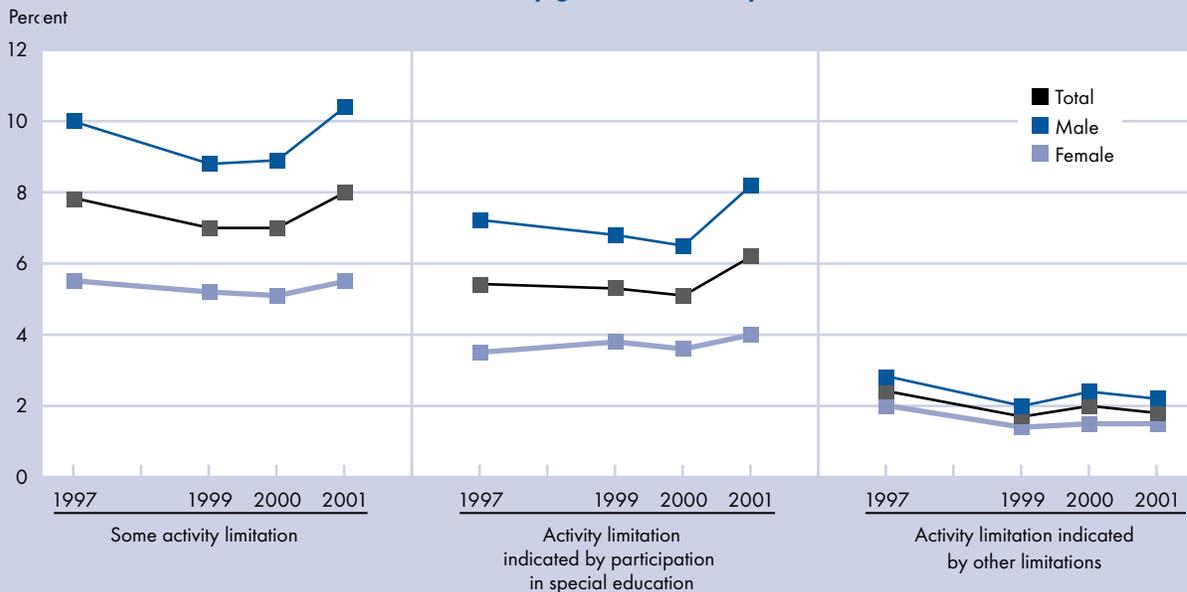
Bullets contain references to data that can be found in Table HEALTH1 on page 98. See indicator ECON1.A and ECON1.B on pages 16-17 for a description of child poverty.

Activity Limitation

Limitation of activity refers to a reduction in an individual’s usual age-appropriate activities that results from a physical, mental, or emotional problem. “Age-appropriate” refers to the activities in which the individual would normally engage in at his/her age, such as school for children 5 to 17 years of age. In children, activity limitation is a broad measure of health and functioning in areas such as understanding or accomplishing routine schoolwork, eating, bathing, dressing, playing, and walking. Chronic health conditions that limit children’s activities include, but are not restricted to: hearing, visual, and speech problems; learning disabilities; mental retardation and other developmental problems (such as cerebral palsy); mental and emotional problems; and a variety of chronic health problems (such as asthma). The long-term impact of activity limitation in children can often be ameliorated by use of health care and educational services.^{60,61}

Indicator HEALTH2

Percentage of children ages 5 to 17 with any limitation in activity resulting from chronic conditions by gender, selected years 1997-2001



NOTE: Data are available for 1997, 1999, 2000, and 2001. Children are identified as having activity limitations by asking parents whether children (1) are limited in their ability to walk, to care for themselves, or to participate in any other activities, and whether they (2) receive special education services. Positive responses to either indicate some activity limitation. Children with activity limitations are categorized as children with activity limitation indicated by participation solely in special education and children with activity limitations indicated by other limitations, which includes some children who also receive special education services.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

- In 2001, approximately 8 percent of children ages 5 to 17 were reported to have limitations of activity due to chronic conditions. Six percent were identified as having activity limitations solely by their participation in special education. Two percent had limitations affecting their ability to walk, care for themselves, or participate in other activities.
- Activity limitations, particularly those requiring special education services, are reported more often for males than for females. The reasons for this gender difference is unclear, however; maturational, behavioral, social, and diagnostic explanations have been proposed.⁶²
- Children in families of lower socioeconomic status (as measured by family income and parental education) have higher rates of activity limitations compared with children in higher socioeconomic status families. Among children ages 5 to 17, 12 percent of children living in families with incomes below the poverty line had activity limitations due to chronic conditions in 2001, compared with 8 percent of children living in families with incomes at or above the poverty line.

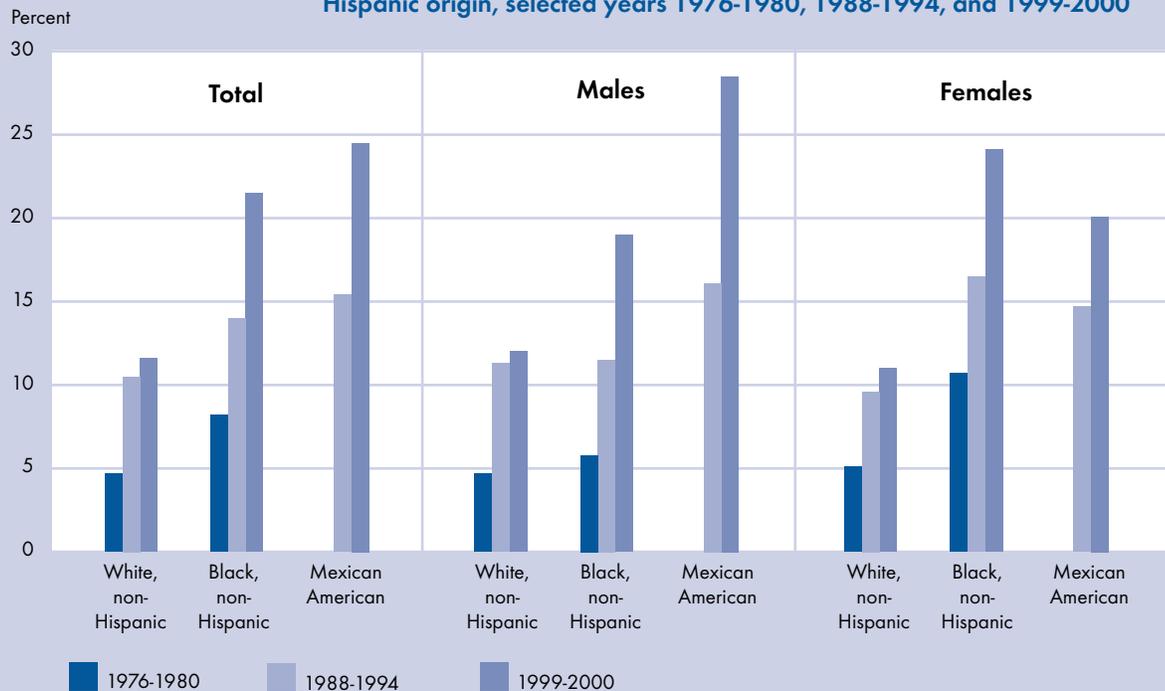
Bullets contain references to data that can be found in Table HEALTH2 on page 99. Endnotes begin on page 63.

Overweight

Overweight adolescents often become overweight adults, with an increased risk for a wide variety of poor health outcomes including diabetes, stroke, heart disease, arthritis and certain cancers.^{63,64} The immediate consequences of overweight in childhood are often psychosocial but also include cardiovascular risk factors such as high blood pressure, high cholesterol, and the precursors to diabetes.⁶⁵ The prevalence of overweight among U.S. children changed relatively little from the early 1960's through 1980; however, since 1980 it has increased sharply.⁶⁶ The reasons for the increase in children who are overweight are not entirely clear and little is known about the prevention and treatment of overweight on a population basis. Numerous factors (e.g. advances in technology and trends in eating out) have been suggested as causes; however, definitive data linking these factors to the recent trends are lacking. On an individual basis, it is clear that overweight is a result of an imbalance between energy intake and energy expenditure. Recent national estimates indicate that only half of U.S. children participate in vigorous physical activity⁶⁷ and less than a quarter eat the recommended 5 or more servings of fruits and vegetables per day,⁶⁸ both of which are likely to contribute to the current high rates of overweight. In addition to individual factors such as these, it is essential that we identify the social, economic, and cultural forces contributing to the increasing prevalence of overweight among U.S. children.

Indicator HEALTH3

Percentage of children ages 6 to 18 who are overweight, by gender, race, and Hispanic origin, selected years 1976-1980, 1988-1994, and 1999-2000



NOTE: Data for Mexican American children are not available from 1976-80 due to differences in reporting of race and Hispanic origin. Overweight is defined as body mass index (BMI) at or above the 95th percentile of the 2000 Centers for Disease Control and Prevention BMI-for-age growth charts. BMI is calculated as weight in kilograms divided by the square of height in meters.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey.

- Since the 1980s, there has been a steady increase in the proportion of children who are overweight. In 1976-1980, only 6 percent of children ages 6 to 18 were overweight. By 1988-1994 this proportion had risen to 11 percent, and continued to climb to 15 percent by 1999-2000.
- Data from 1999-2000 indicate that substantial racial and ethnic disparities exist such that larger percentages of Black, non-Hispanic, and Mexican American children are overweight compared with White, non-Hispanic children.
- Black, non-Hispanic girls and Mexican American boys are at particularly high risk of being

overweight. In 1999-2000, 24 percent of Black, non-Hispanic girls and 29 percent of Mexican American boys were overweight.

- Among adolescent males ages 12 to 18, virtually no differences existed between ethnic groups in 1988-94. By 1999-2000, there were large ethnic differences: 12 percent of White, non-Hispanic compared with 21 percent of Black, non-Hispanic compared with 30 percent of Mexican American males were overweight.

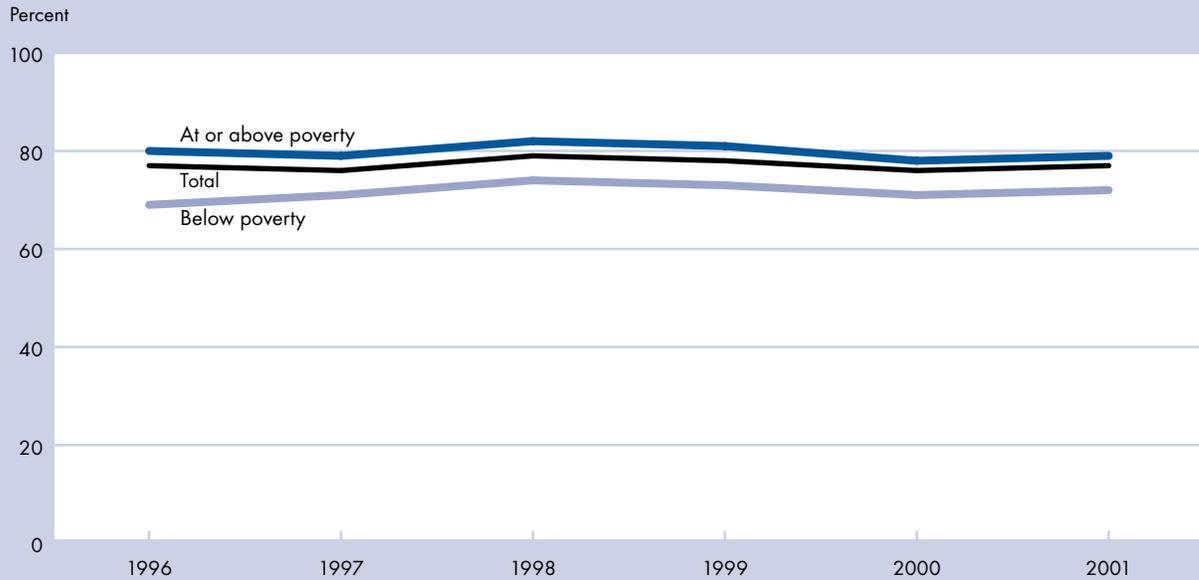
Bullets contain references to data that can be found in Table HEALTH3 on page 100. Endnotes begin on page 63.

Childhood Immunization

Adequate immunization protects children against several diseases that killed or disabled children in past decades. Rates of childhood immunization are one measure of the extent to which children are protected from serious vaccine-preventable illnesses. The combined immunization series (often referred to as the 4:3:1:3 combined series) rate measures the extent to which children have received the recommended doses of four key vaccinations.

Indicator HEALTH4

Percentage of children ages 19 to 35 months with the 4:3:1:3 combined series of vaccinations by poverty status, 1996-2001



NOTE: Vaccinations included in the combined series are 4 doses of a vaccine containing diphtheria and tetanus toxoids (either diphtheria, tetanus toxoids, and pertussis vaccine [DTP] or diphtheria and tetanus toxoids vaccine [DT]), 3 doses of polio vaccine, 1 dose of a measles-containing vaccine (MCV), and 3 doses of *Haemophilus influenzae* type b (Hib) vaccine. The recommended immunization schedule for children is available at <http://www.cdc.gov/nip/recs/child-schedule.pdf>.

SOURCE: Centers for Disease Control and Prevention, National Immunization Program and National Center for Health Statistics, National Immunization Survey.

- In 2001, 77 percent of children ages 19 to 35 months had received the recommended combined series of vaccines (often referred to as the 4:3:1:3 combined series).
- Children with family incomes below the poverty level had lower rates of coverage with the combined series than children with family incomes at or above the poverty line—72 percent of children below poverty compared with 79 percent of higher-income children.
- Rates of coverage with the full series of vaccines (4:3:1:3) were higher among White, non-Hispanic children than among Black, non-Hispanic or Hispanic children. Seventy-nine percent of White, non-Hispanic children ages 19 to 35 months received these immunizations compared with 71 percent of Black, non-Hispanic children and 77 percent of Hispanic children.
- Overall and for children living above and below the poverty level, coverage with the combined series remained relatively stable between 1999 and 2001, as did the gap in coverage between children in families living above and below the poverty level.
- Coverage with three or more doses of Hib vaccine among children ages 19 to 35 months remained relatively stable at 93 percent from 1996-2001.
- In addition to the combined series of vaccines, there are other important immunizations such as those for hepatitis B and varicella (chicken pox). Coverage with three or more doses of hepatitis B vaccine among children ages 19 to 35 months increased from 82 percent in 1996 to 89 percent in 2001.
- Coverage with varicella (chicken pox) vaccine among children ages 19 to 35 months continued to increase from 58 percent in 1999 to 76 percent in 2001. Gains in coverage for varicella vaccine were seen among all children regardless of race or ethnicity and poverty level; however, children living at or above the poverty line had higher coverage levels than children living below the poverty level.

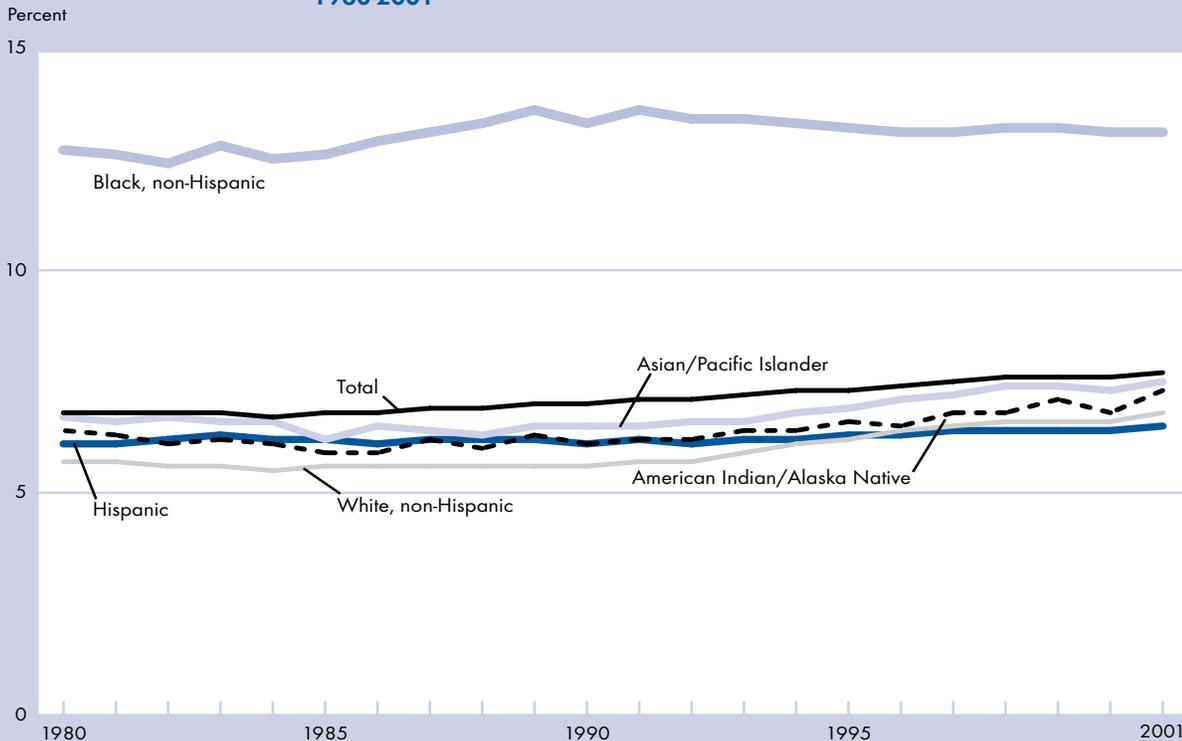
Bullets contain references to data that can be found in Table HEALTH4 on page 101.

Low Birthweight

Low-birthweight infants (infants born weighing less than 2,500 grams, or about 5.5 pounds) are at higher risk of death or long-term illness and disability than are infants of normal birthweight.^{69,70} Low birthweight results from an infant's being born preterm (before 37 weeks' gestation) or from being small for his or her gestational age.

Indicator HEALTH5

Percentage of infants born of low birthweight by mother's race and Hispanic origin, 1980-2001



SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

- The percentage of infants born of low birthweight was 7.7 in 2001, up slightly from 7.6 percent recorded in each year from 1998 to 2000. The low-birthweight rate has increased slowly but steadily since 1984, when it was 6.7 percent. The rate for 2001 was the highest since 1972.^{10,20}
- The low-birthweight rate for Black, non-Hispanic infants is significantly higher than that of any other racial or ethnic group. From 1990 to 2001 the low-birthweight rate among Black, non-Hispanic infants varied between 13.6 and 13.1 percent. Infants of other racial and ethnic groups experienced increases in low-birthweight rates between 1990 and 2001: among White, non-Hispanic infants the rate rose from 5.6 to 6.8, among Hispanic infants it rose from 6.1 to 6.5, among Asians/Pacific Islanders it rose from 6.5 to 7.5, and among American Indians/Alaska Natives it rose from 6.1 to 7.3, the highest it has been in three decades.
- The percentage of low-birthweight births varies widely within Hispanic and Asian/Pacific Islander subgroups. Data for 2001 indicate that among Hispanics, women of Mexican origin had the lowest percentage of low-birthweight infants (6.1 percent) and Puerto Ricans the highest (9.3 percent). Among Asian/Pacific Islander subgroups, low-birthweight rates were lowest among women of Chinese origin (5.3 percent) and highest among women of Filipino origin (8.7 percent).
- About 1.4 percent of infants were born with very low birthweight (less than 1,500 grams, or about 3.25 pounds) in each year from 1996 to 2001, up from 1.3 percent in each year from 1989 to 1995 and 1.2 percent in each year from 1981 to 1998.
- One reason for the recent increase in low birthweight over the past several years is that the number of twin, triplet, and higher-order multiple births has increased.^{10,70,71} Twins and other multiples are much more likely than singleton infants to be of low birthweight; 55 percent of twins and 94 percent of triplets, compared with 6 percent of singletons, were of low birthweight in 2001. However, even among singletons, there has been an increase in low birthweight.¹⁰

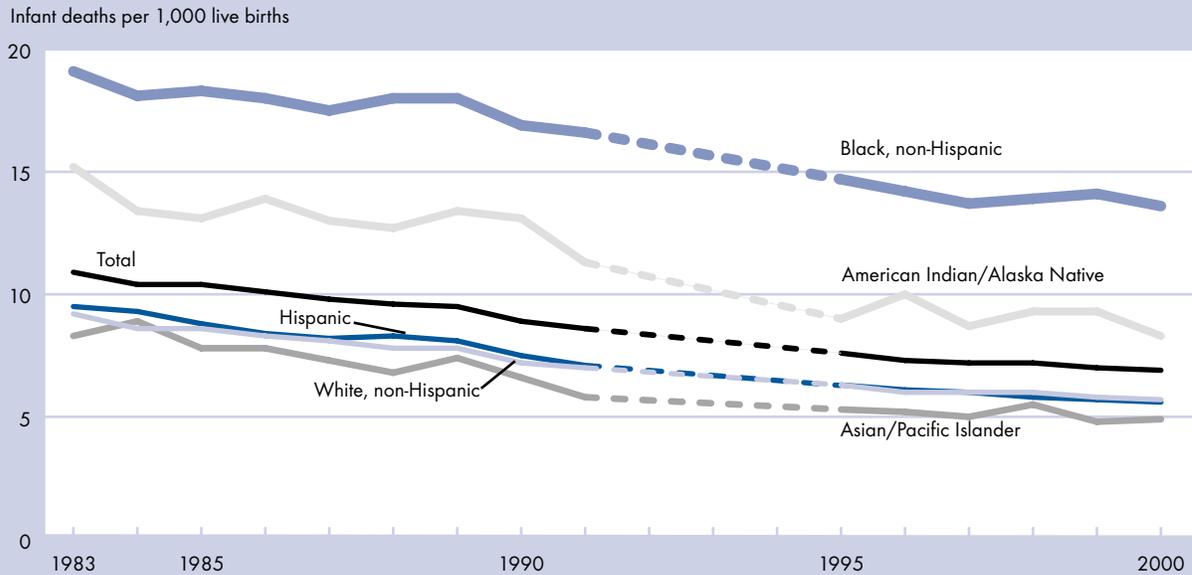
Bullets contain references to data that can be found in Table HEALTH5 on page 102. Endnotes begin on page 63.

Infant Mortality

Infant mortality is defined as the death of an infant before his or her first birthday. The infant mortality rate is an important measure of the well-being of infants, children, and pregnant women because it is associated with a variety of factors, such as maternal health, quality of and access to medical care, socioeconomic conditions, and public health practices.⁷² In the United States, about two-thirds of infant deaths occur in the first month after birth and are due mostly to health problems of the infant or the pregnancy, such as preterm delivery or birth defects. About one-third of infant deaths occur after the first month and may be influenced by social or environmental factors, such as exposure to cigarette smoke or inadequate access to health care.⁷³

Indicator HEALTH6

Infant mortality rates by race and Hispanic origin, selected years 1983-2000



NOTE: Data are available for 1983-91 and 1995-2000.⁷⁴ Infant deaths are deaths before a child's first birthday.

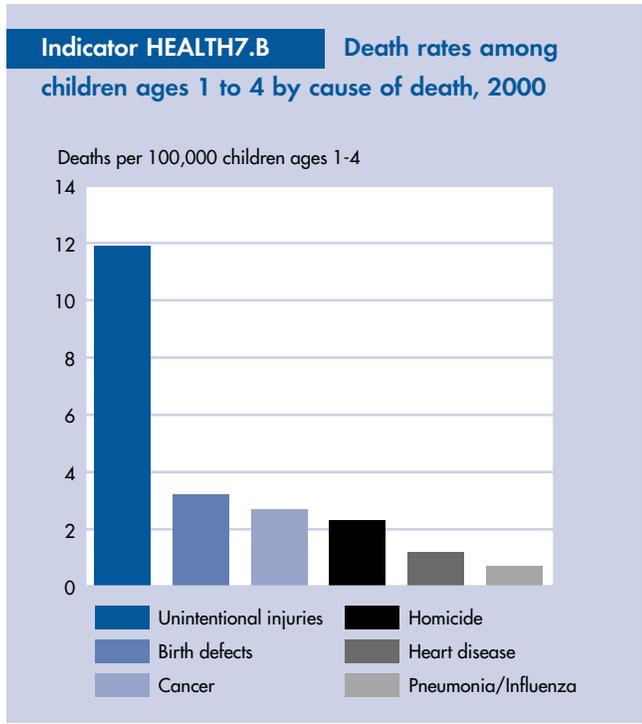
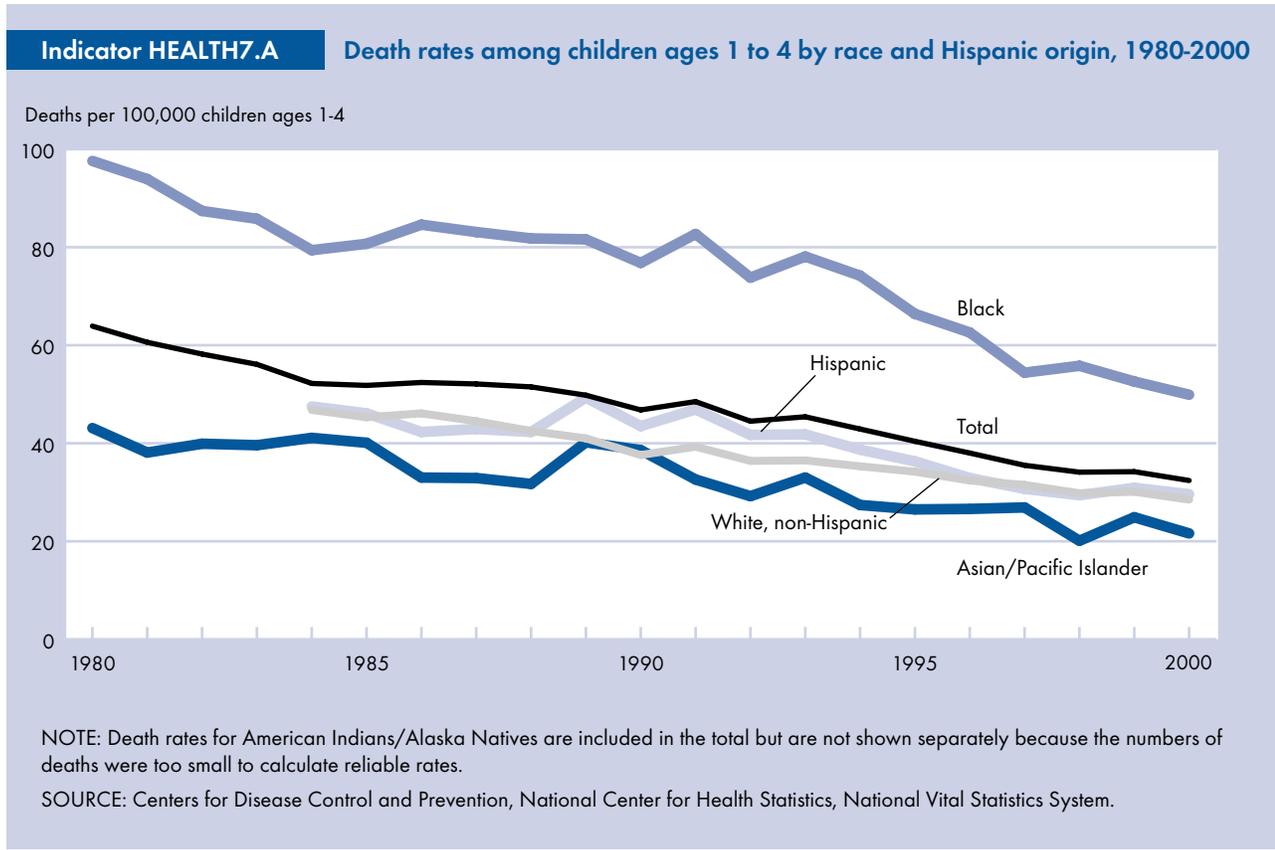
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Linked File of Live Births and Infant Deaths.

- The 2000 infant mortality rate for the United States was 6.9 deaths per 1,000 live births, a slight drop from the 1999 rate of 7.0.
- From 1999 to 2000, infant mortality decreased for White, non-Hispanic, Black, non-Hispanic, Hispanic, and American Indian/Alaska Native infants; however, the rate increased for Asian/Pacific Islander infants.
- Infant mortality has dropped for all racial and ethnic groups since 1983, but substantial racial and ethnic disparities remain. Black, non-Hispanic and American Indian/Alaska Native infants have consistently had a higher infant mortality rate than that of other racial or ethnic groups. For example, in 2000, the Black, non-Hispanic infant mortality rate was 13.6 infant deaths per 1,000 live births and the American Indian/Alaska Native rate was 8.3, both significantly higher than the rates among White, non-Hispanics (5.7), Hispanics (5.6), or Asians/Pacific Islanders (4.9).
- Infant mortality rates also vary within racial and ethnic populations. For example, among Hispanics in the United States, the infant mortality rate for 2000 ranged from 4.5 for infants of Cuban and Central/South American origins to a high of 8.2 for Puerto Ricans. Among Asians/Pacific Islanders, infant mortality rates ranged from 3.5 for infants of Chinese origin to 9.1 for Native Hawaiians.

Bullets contain references to data that can be found in Table HEALTH6 on page 103. Endnotes begin on page 63.

Child Mortality

Child death rates are the most severe measure of ill health in children. These rates have generally declined over the past two decades. Deaths to children ages 1 to 4 are calculated separately from those for children ages 5 to 14 because causes and death rates vary substantially by age.



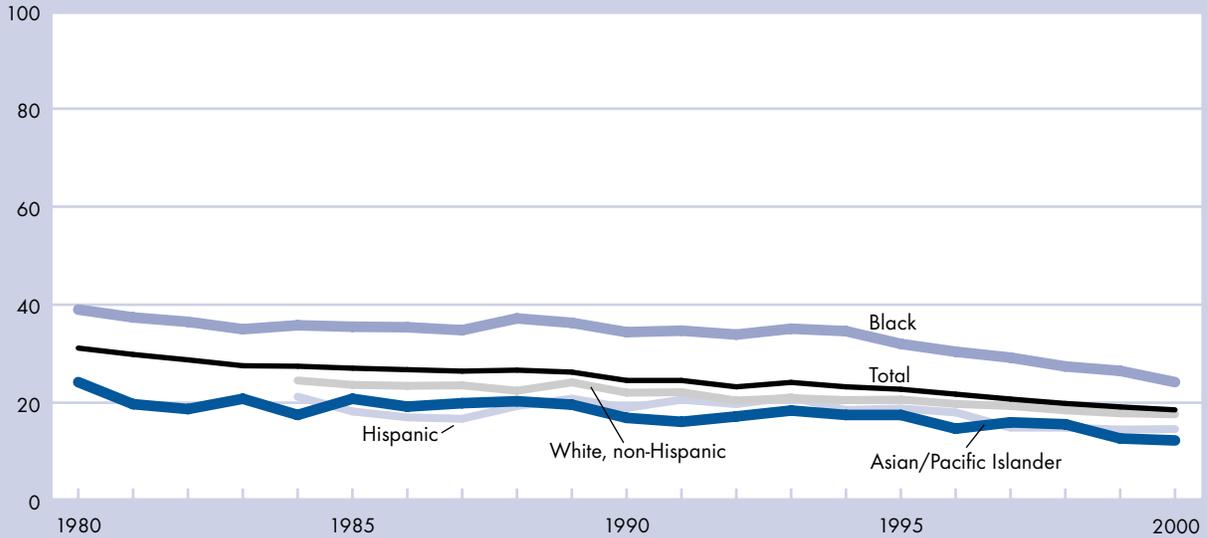
- In 2000, the death rate for children ages 1 to 4 was 32 per 100,000 children.
- Between 1980 and 2000, the death rate declined by almost half for children ages 1 to 4.
- Among children ages 1 to 4, Black children had the highest death rate in 2000, at 50 per 100,000 children. Asian/Pacific Islander children had the lowest death rate, at 22 per 100,000.
- Among children ages 1 to 4, unintentional injuries were the leading cause of death at 12 per 100,000, followed by birth defects and cancer at 3 per 100,000 children each.
- Motor vehicle traffic crashes are the most common type of injury among children. Use of child restraint systems, including safety seats, booster seats, and seat belts, can greatly reduce the number and severity of injuries to child occupants of motor vehicles. In 2000, 44 percent of child occupants ages 1 to 4 who died in crashes were unrestrained.⁷⁵

Death rates for children ages 5 to 14 are lower than those for children under age 5. The leading cause of death for children at this age remains unintentional injuries, but some other causes of death, such as birth defects, are less common among children ages 5 to 14 than among children ages 1 to 4.

Indicator HEALTH7.C

Death rates among children ages 5 to 14 by race and Hispanic origin, 1980-2000

Deaths per 100,000 children ages 5-14



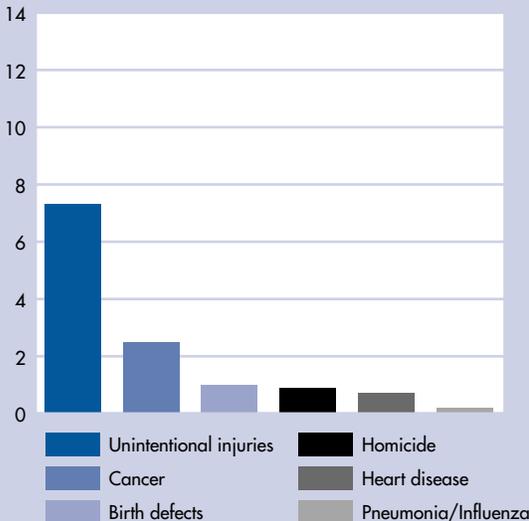
NOTE: Death rates for American Indians/Alaska Natives are included in the total but not shown separately because the numbers of deaths were too small to calculate reliable rates.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

Indicator HEALTH7.D

Death rates among children ages 5 to 14 by cause of death, 2000

Deaths per 100,000 children ages 5-14



- The death rate in 2000 for children ages 5 to 14 was 18 per 100,000 children.
- Between 1980 and 2000, the death rate declined by approximately 40 percent, from 31 to 18 deaths per 100,000 children ages 5 to 14.
- Similar to mortality patterns for children under the age of 5, among children ages 5 to 14, Black children had the highest death rates in 2000 at 24 deaths per 100,000, and Asians/Pacific Islanders had the lowest death rate at 12 per 100,000.
- Among children ages 5 to 14, unintentional injuries were the leading cause of death, followed by cancer, birth defects, and homicides.
- The majority of unintentional injury deaths among children ages 5 to 14 result from motor vehicle traffic crashes. More than 64 percent of children ages 5 to 14 who died as occupants in motor vehicle crashes in 2000 were not wearing a seatbelt or other restraint.⁷⁵

Bullets contain references to data that can be found in Tables HEALTH7.A and HEALTH7.B on pages 104-105. Endnotes begin on page 63.

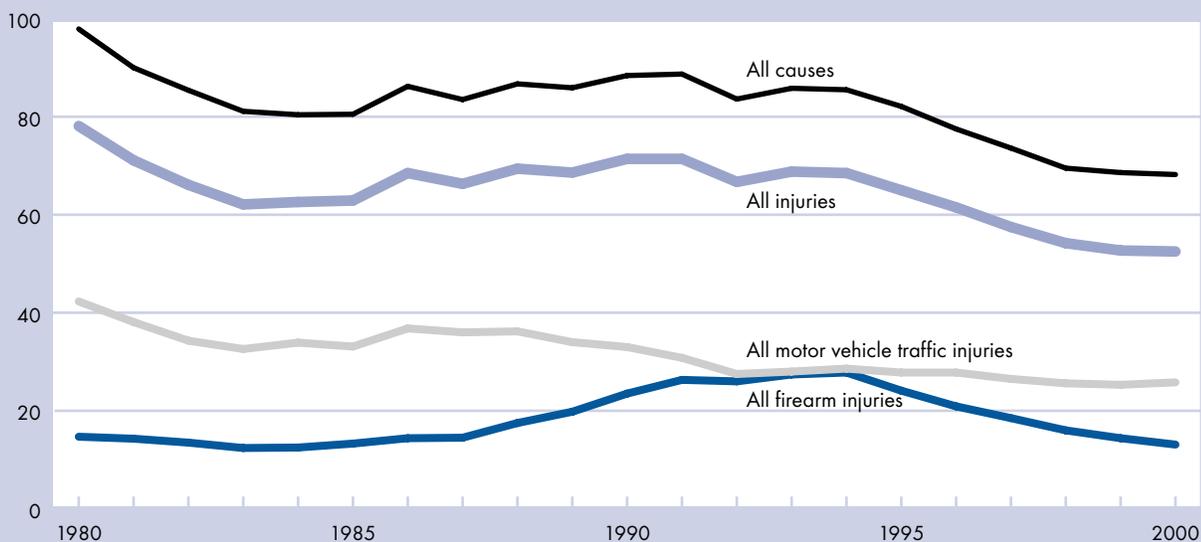
Adolescent Mortality

Compared with younger children, adolescents ages 15 to 19 have much higher mortality rates. Adolescents are much more likely to die from injuries sustained from motor vehicle traffic accidents or firearms.⁷⁶ This difference illustrates the importance of looking separately at mortality rates and causes of death among teenagers ages 15 to 19.

Indicator HEALTH8.A

Death rates among adolescents ages 15 to 19 by cause of death, 1980-2000

Deaths per 100,000 adolescents ages 15-19



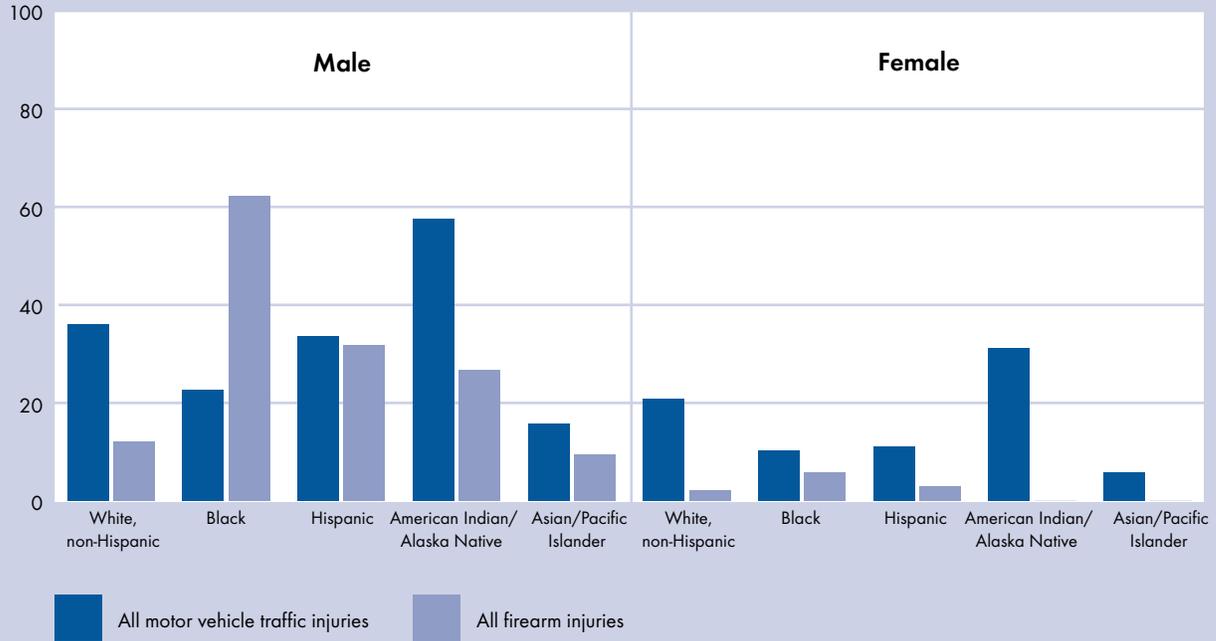
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

- In 2000, the death rate for adolescents ages 15 to 19 was 67 deaths per 100,000. Overall, the rate has declined substantially since 1980, despite a period of increase between 1986 and 1991. Injury, which includes homicide, suicide, and unintentional injuries, continues to account for more than 3 of 4 deaths among adolescents.²⁰
- Injuries from motor vehicles and firearms are the primary causes of death among adolescents. In 2000, motor vehicle traffic-related injuries accounted for 25 of the 67 deaths per 100,000 youth ages 15 to 19 (37 percent), while firearm injuries accounted for 13 of the 67 deaths per 100,000 youth ages 15 to 19 (19 percent).
- Motor vehicle injuries were the leading cause of death among adolescents for each year between 1980 and 2000, but the motor vehicle death rate declined by more than one-third during the time period.
- In 1980, motor vehicle traffic-related deaths among adolescents ages 15 to 19 occurred almost three times as often as firearm injuries (intentional and unintentional). By 2000, the rate of motor vehicle traffic-related deaths was less than double that of firearm injuries.
- Motor vehicle traffic-related and firearm death rates have followed different trends since 1980. From 1980 to 1985, both rates declined; in the following years, however, the motor vehicle traffic death rate continued to decline modestly while the firearm death rate increased markedly. During the years 1992 to 1994, the two rates differed only slightly. However, since 1994, the firearm death rate has decreased by more than half while the motor vehicle death rate has decreased only slightly.
- Most of the increase in firearm injury deaths between 1983 and 1993 resulted from an increase in homicides. The firearm homicide rate among youth ages 15 to 19 more than tripled from 5 to 18 per 100,000 between 1983 and 1993. At the same time, the firearm suicide rate rose from 5 to 7 per 100,000. From 1994 to 2000, the firearm homicide rate declined by over one-half and the firearm suicide rate declined by nearly one-third.
- After injuries, additional leading causes of death for adolescents include cancer, heart disease, and birth defects.²⁰

Indicator HEALTH8.B

Injury death rates among adolescents ages 15 to 19 by gender, race, Hispanic origin, and type of injury, 2000

Deaths per 100,000 adolescents ages 15-19



NOTE: There were too few firearm deaths to calculate a reliable rate for American Indian/Alaska Native females and Asian/Pacific Islander females.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

- Motor vehicle and firearm injury deaths are both more common among male than among female adolescents. In 2000, the motor vehicle traffic death rate for males was nearly twice the rate for females, and the firearm death rate among males was eight times that for females.
- Among adolescents in 2000, motor vehicle injuries were the most common cause of death among all females, as well as among White, non-Hispanic, Hispanic, American Indian/Alaska Native, and Asian/Pacific Islander males. Firearm injuries were the most common cause of death among Black males. Black males were more than twice as likely to die from a firearm injury as from a motor vehicle traffic injury.
- Deaths from firearm suicides were more common than deaths from firearm homicides among White, non-Hispanic adolescents, while the reverse is found for Black and Hispanic adolescent males.

- Deaths from firearm injuries among adolescents declined between 1994 and 2000, particularly among Black and Hispanic males. From 1994 to 2000, the firearm homicide rates for Black and Hispanic adolescent males declined substantially, from 126 to 52 per 100,000 for Black males, and from 49 to 22 per 100,000 for Hispanic males.

Bullets contain references to data that can be found in Table HEALTH8 on pages 106-107. Endnotes begin on page 63.

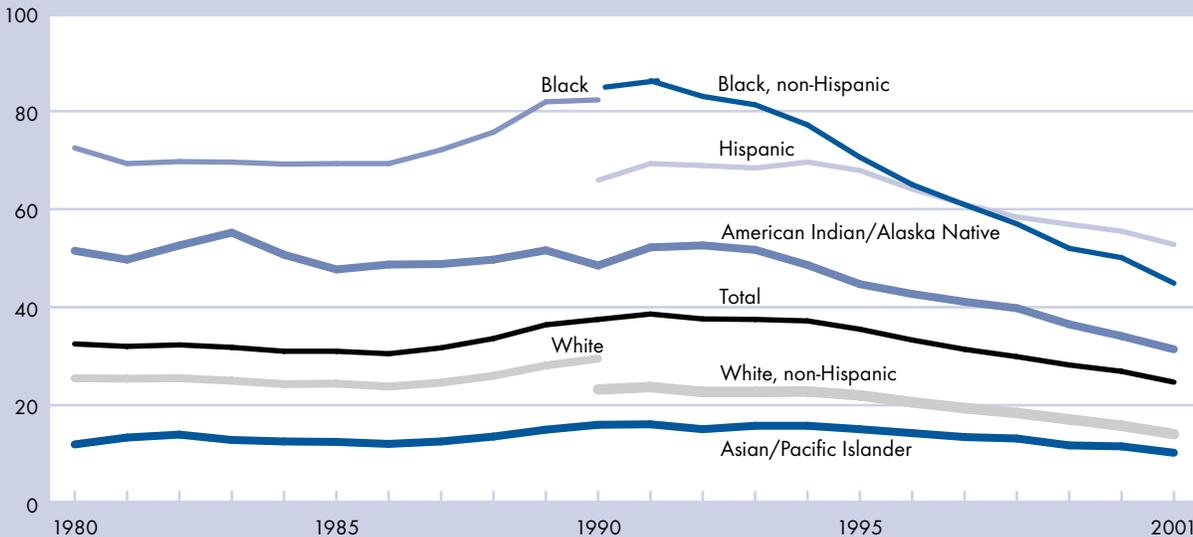
Adolescent Births

Bearing a child during adolescence is often associated with long-term difficulties for the mother and her child. These consequences are often attributable to poverty and the other adverse socioeconomic circumstances that frequently accompany early childbearing.⁷⁷ Compared with babies born to older mothers, babies born to adolescent mothers, particularly young adolescent mothers, are at higher risk of low birthweight and infant mortality.^{10,13,69} They are more likely to grow up in homes that offer lower levels of emotional support and cognitive stimulation, and they are less likely to earn high school diplomas. For the mothers, giving birth during adolescence is associated with limited educational attainment, which in turn can reduce future employment prospects and earnings potential.⁷⁸ The birth rate of adolescents under age 18 is a measure of particular interest because the mothers are still of school age.

Indicator HEALTH9

Birth rates for females ages 15 to 17 by race and Hispanic origin, 1980-2001

Live births per 1,000 females ages 15-17



NOTE: Rates for 1980-89 are calculated for all Whites and all Blacks. Rates for 1980-89 are not shown for Hispanics; White, non-Hispanics; or Black, non-Hispanics because information on the Hispanic origin of the mother was not reported on the birth certificates of most states.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

- In 2001, the adolescent birth rate was 25 per 1,000 young women ages 15 to 17. There were 145,324 births to these young women in 2001. The 2001 rate was a record low for the Nation.^{10,14,15}
- The birth rate among adolescents ages 15 to 17 declined more than one-third, from 39 to 25 births per 1,000, between 1991 and 2001. This decline follows a one-fourth increase between 1986 and 1991. The 2001 rate was a record low for young adolescents.^{14,15,79}
- There are substantial racial and ethnic disparities in birth rates among adolescents ages 15 to 17. In 2001, the birth rate for this age group was 10 per 1,000 for Asians/Pacific Islanders, 14 for White, non-Hispanics, 31 for American Indians/Alaska Natives, 45 for Black, non-Hispanics, and 53 for Hispanics.¹⁴
- The birth rate for Black, non-Hispanic females ages 15 to 17 dropped by nearly half between 1991 and 2001, completely reversing the increase between 1986 and 1991. The birth rate for White, non-Hispanic teens declined by two-fifths during 1991-2001.¹⁵
- The birth rate for Hispanics in this age group declined more modestly in the 1990s; the rate fell by about one-fourth between 1991 and 2001.¹⁵
- In 2001, 88 percent of births to females ages 15 to 17 were to unmarried mothers, compared with 62 percent in 1980 (See POP7.B).
- The birth rates for first and second births for ages 15 to 17 declined by one-third and one-half, respectively, between 1990 and 2001.
- The pregnancy rate (the sum of births, abortions, and fetal losses per 1,000 females) declined by nearly one-third for adolescents ages 15 to 17 during 1990 to 1999, reaching a record low of 56 per 1,000 in 1999. Rates for births, abortions, and fetal losses declined for young adolescents in the 1990s.^{15,80,81}

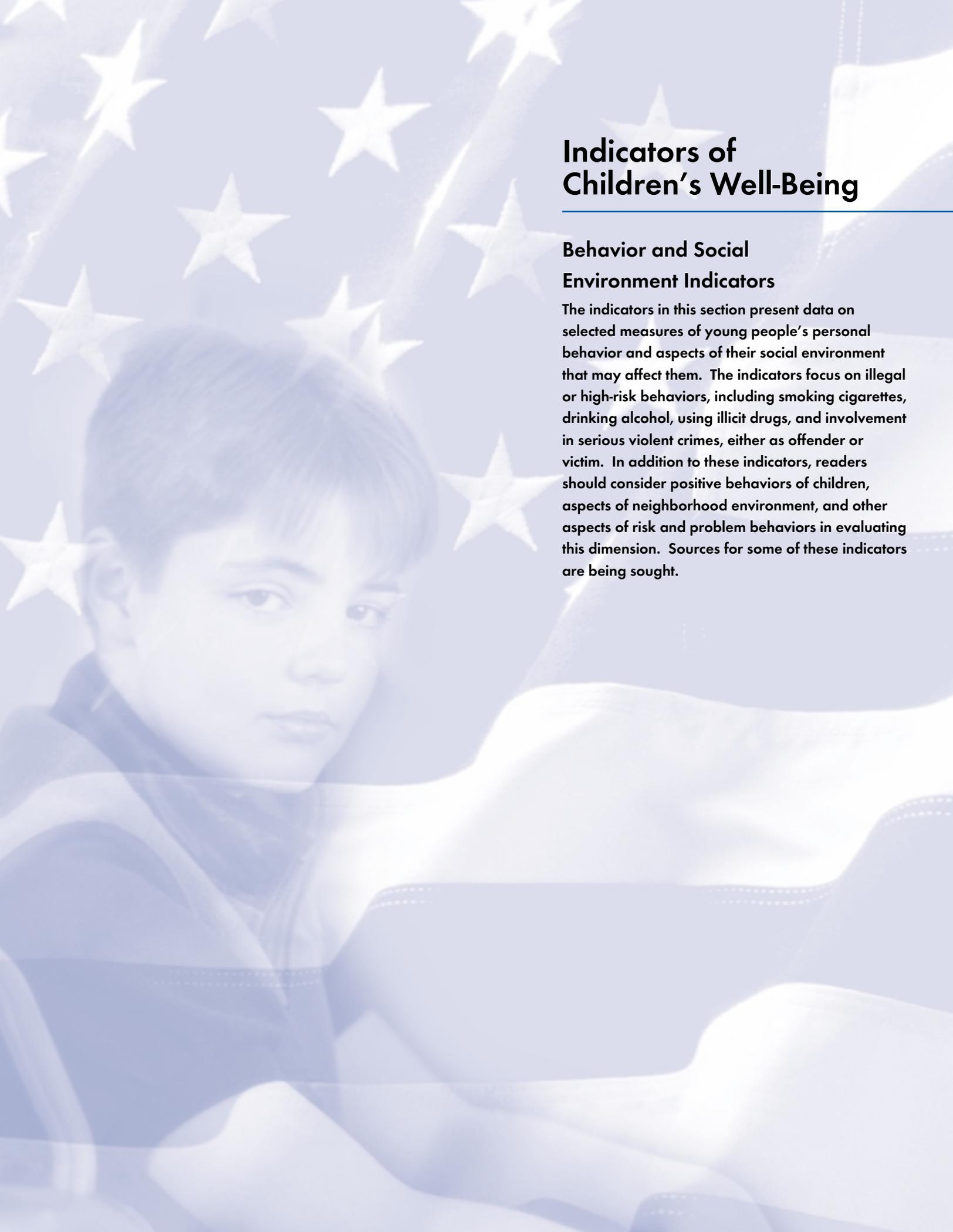
Bullets contain references to data that can be found in Table HEALTH9 on page 108 and Table POP7.B on page 82. Endnotes begin on page 63.

Indicators Needed

Health

National indicators in several key dimensions of health are not yet available because of difficulty in definitions and measurement, particularly using survey research. The following health-related areas have been identified as priorities for indicator development by the Federal Interagency Forum on Child and Family Statistics:

- *Disability.* The Forum is very interested in developing an improved measure of functioning that can be derived from regularly collected data. Such a measure is often referred to as a disability measure. The difficulties inherent in developing such a measure relate to the fact that disability is a complicated, multidimensional concept. Many definitions of disability are currently in use by policy-makers and researchers, but there is little agreement regarding which aspects of functioning should be included or how they should be measured. Disability is best thought of as an umbrella term that includes pathology, impairment, functional limitations, task limitations, and activity limitations as well as characteristics of the environment that can be either a barrier or a support to the activity of the individual. The measurement of functioning and disability in children is critically important, and the Forum is working on determining which aspects of disability should be reported in this volume, and on developing indicators that address these core aspects of health-related well-being.
- *Mental health.* An international panel of experts in the area of children's mental health has been working with staff at the National Institute of Mental Health, the Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration, and Forum agencies to determine data needs and develop better measures to obtain data on children's mental health. As a result of this collaborative effort, new questions were recently added to the National Center for Health Statistics' annual National Health Interview Survey. Some data have been collected, and plans are being made to evaluate the data and conduct a validity study.
- *Child abuse and neglect.* Also needed are regular, reliable estimates of the incidence of child abuse and neglect that are based on sample surveys rather than administrative records. One estimate of child abuse and neglect was presented as a special feature in *America's Children, 1997*. Since administrative data are based on cases reported to authorities, it is likely that these data underestimate the magnitude of the problem. Estimates based on sample survey data could potentially provide more accurate information; however, a number of issues still persist, including how to effectively elicit this sensitive information, how to identify the appropriate respondent for the questions, and whether there is a legal obligation for the surveyor to report abuse or neglect.

A young boy with dark hair and a serious expression is looking directly at the camera. He is wearing a dark jacket. The background is a faded American flag with stars and stripes. The overall tone is blue and white.

Indicators of Children's Well-Being

Behavior and Social Environment Indicators

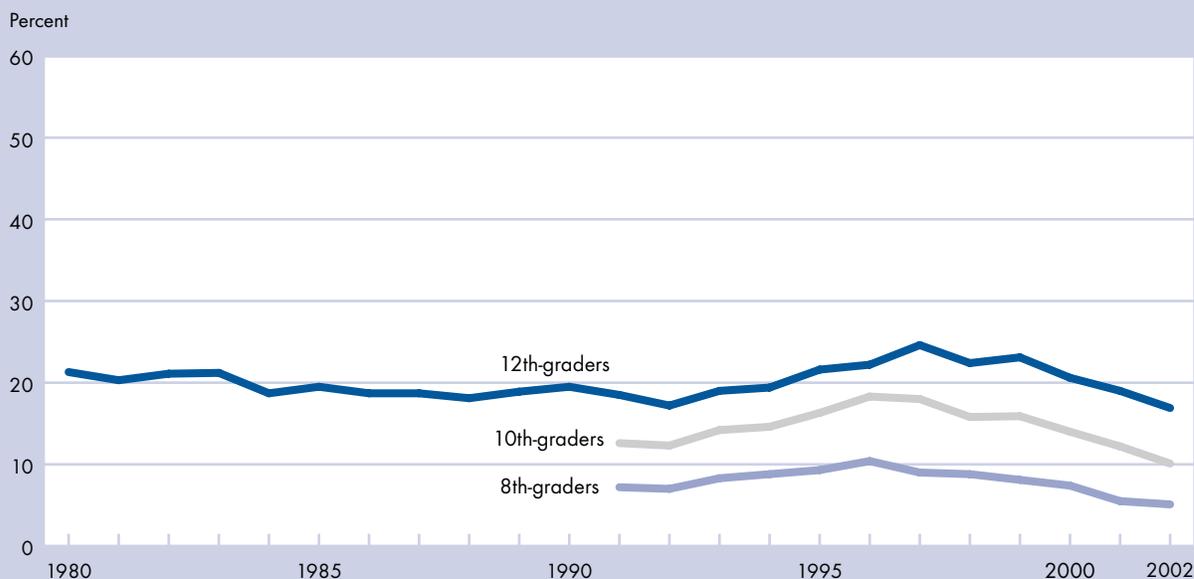
The indicators in this section present data on selected measures of young people's personal behavior and aspects of their social environment that may affect them. The indicators focus on illegal or high-risk behaviors, including smoking cigarettes, drinking alcohol, using illicit drugs, and involvement in serious violent crimes, either as offender or victim. In addition to these indicators, readers should consider positive behaviors of children, aspects of neighborhood environment, and other aspects of risk and problem behaviors in evaluating this dimension. Sources for some of these indicators are being sought.

Regular Cigarette Smoking

Smoking has serious long-term consequences, including the risk of smoking-related diseases and the risk of premature death, as well as causing increased health care costs associated with treating the illnesses.⁸² Many adults who are addicted to tobacco today began smoking as adolescents, and it is estimated that more than 5 million of today's underage smokers will die of tobacco-related illnesses.⁸³ These consequences underscore the importance of studying patterns of smoking among adolescents.

Indicator BEH1

Percentage of students who reported smoking cigarettes daily in the previous 30 days by school grade, 1980-2002



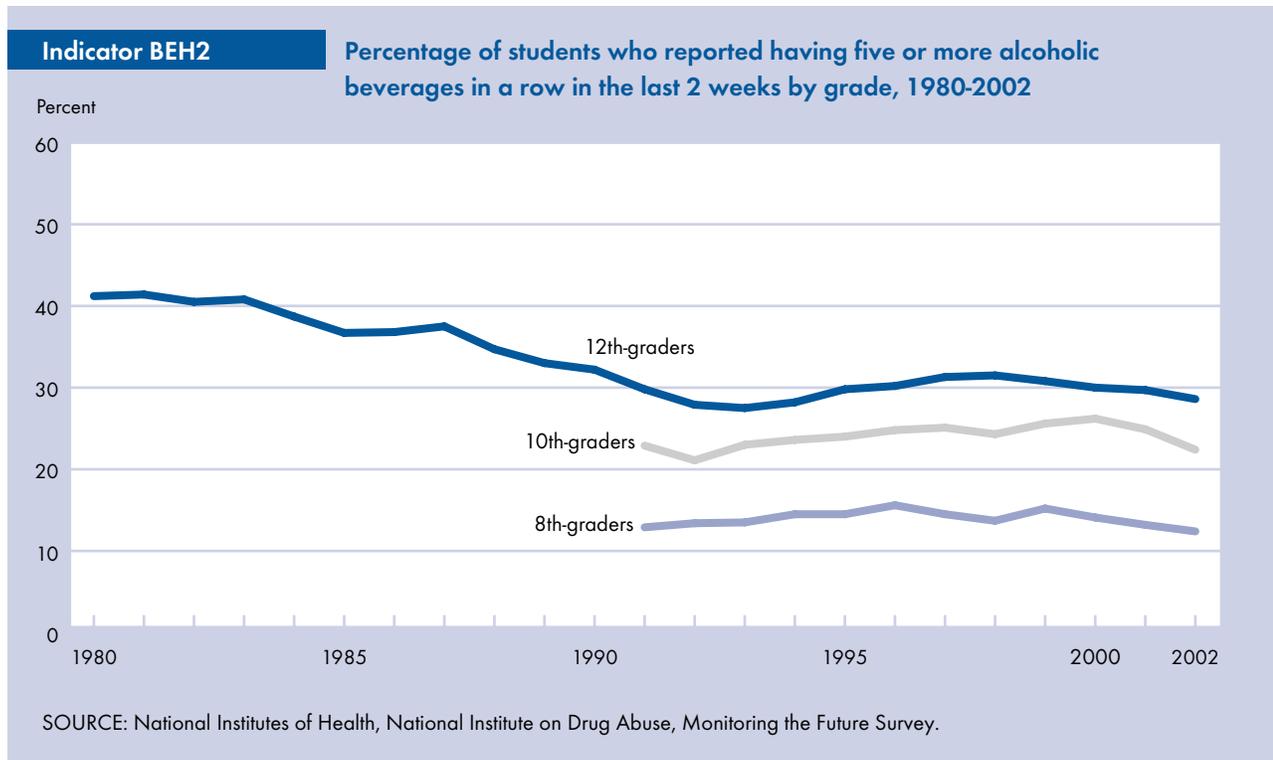
SOURCE: National Institutes of Health, National Institute on Drug Abuse, Monitoring the Future Survey.

- Between 2001 and 2002, the rate of daily smoking in the past month decreased from 12 percent to 10 percent among 10th-graders and from 19 percent to 17 percent among 12th-graders. These declines, and similar decreases for 8th-graders in other indicators of cigarette smoking, continue decreases seen since 1997 for 12th-graders and 1996 for 8th- and 10th-graders. Five percent of 8th-graders reported daily smoking in the past month in 2002, unchanged from 2001. For each grade, the rates of daily smoking in 2002 are the lowest in the history of the survey (since 1975 for 12th-graders and since 1991 for 8th- and 10th-graders).
- Long-term trends for high school seniors show that daily smoking declined from 21 percent in 1980 to just over 17 percent in 1992, increased to 25 percent in 1997, and declined to just under 17 percent in 2002.
- Males and females are generally similar in their rates of daily smoking. Among males, 5 percent of 8th-graders, 9 percent of 10th-graders, and 17 percent of 12th-graders reported daily smoking in the past 30 days in 2002; among females, the corresponding rates were 5 percent for 8th-graders, 11 percent for 10th-graders, and 16 percent for 12th-graders.
- Rates of smoking differ substantially between racial and ethnic groups. White students have the highest rate of smoking, followed by Hispanics and then Blacks. Among high school seniors in 2002, 22 percent of Whites reported daily smoking, compared with 9 percent of Hispanics and 6 percent of Blacks.

Bullets contain references to data that can be found in Table BEH1 on page 109. Endnotes begin on page 63.

Alcohol Use

Alcohol is the most commonly used psychoactive substance during adolescence. Its use is associated with motor vehicle accidents, injuries, and deaths; with problems in school and in the workplace; and with fighting, crime, and other serious consequences.⁸⁴ Early onset of heavy drinking may be especially problematic, potentially increasing the likelihood of negative outcomes.



- From 2001 to 2002, the proportion of 10th-graders reporting episodic heavy drinking (i.e., having at least five drinks in a row at least once in the previous 2 weeks) declined from 25 percent to 22 percent. Rates remained stable from 2001 to 2002 among 8th- and 12th-graders, with 12 and 29 percent, respectively, reporting this type of alcohol consumption in the past 2 weeks in 2002.
- Long-term trends for high school seniors indicate a peak in 1981, when 41 percent reported heavy drinking. Over the next 12 years, the percentage of high school seniors reporting heavy drinking declined gradually to a low of 28 percent in 1993. Since 1993, the prevalence of this behavior has held fairly steady.
- Among 12th-graders, males are more likely to drink heavily than are females. In 2002, 34 percent of 12th-grade males reported heavy drinking, compared with 23 percent of 12th-grade females. As adolescents get older, the differences between males and females in this drinking behavior appear to become more pronounced. Among 10th-graders, the gender difference in heavy drinking has been

found in earlier years (e.g., 29 percent for males versus 21 percent for females in 2001), but a sharp decline in drinking among males brought the rates closer in 2002 (24 percent for males versus 21 percent for females).

- Heavy drinking is much more likely among White and Hispanic secondary school students than among their Black counterparts. For example, among 12th-graders, 12 percent of Blacks reported heavy drinking in 2002, compared with 34 percent of Whites and 26 percent of Hispanics. Similarly, among 10th-graders, 12 percent of Blacks reported heavy drinking, compared with 26 percent of Whites and 27 percent of Hispanics.

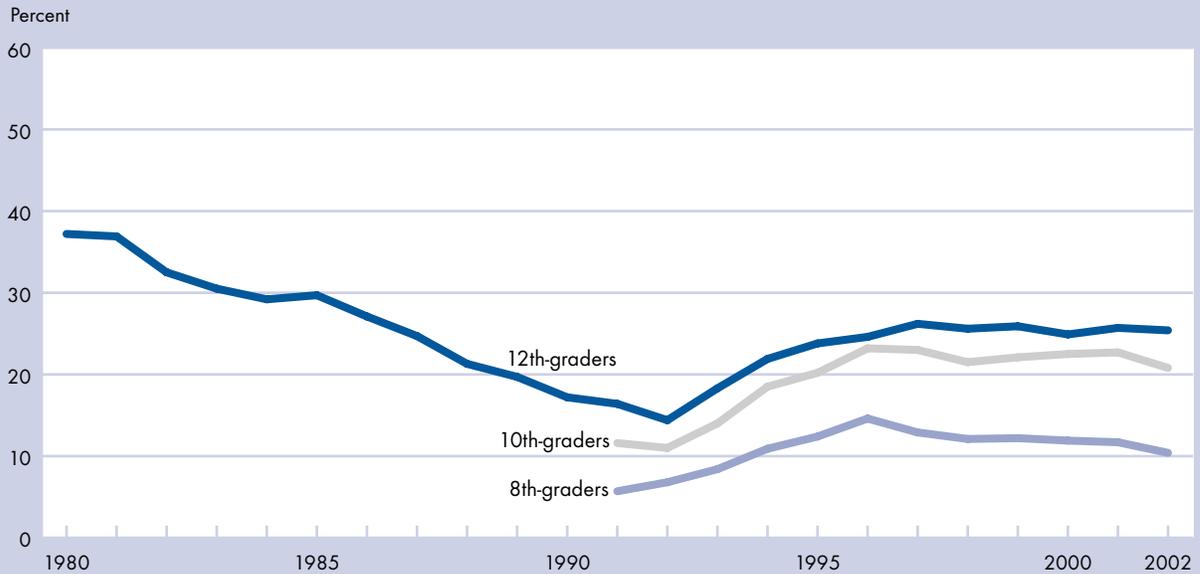
Bullets contain references to data that can be found in Table BEH2 on page 110. Endnotes begin on page 63.

Illicit Drug Use

Drug use by adolescents can have immediate as well as long-term health and social consequences. Cocaine use is linked with health problems that range from eating disorders to disability to death from heart attacks and strokes.⁸⁵ Marijuana use poses both health and cognitive risks, particularly for damage to pulmonary functions as a result of chronic use.^{86,87} Hallucinogens can affect brain chemistry and result in problems with learning new information and memory.⁸⁸ As is the case with alcohol use and smoking, drug use is a risk-taking behavior that has potentially serious negative consequences.

Indicator BEH3

Percentage of students who reported using illicit drugs in the previous 30 days by grade, 1980-2002



NOTE: Illicit drugs include marijuana, cocaine (including crack), heroin, hallucinogens (including LSD, PCP, and ecstasy [MDMA]), amphetamines (including methamphetamine), and nonmedical use of psychotherapeutics.

SOURCE: National Institutes of Health, National Institute on Drug Abuse, Monitoring the Future Survey.

- Between 2001 and 2002, illicit drug use in the past 30 days declined from 23 percent to 21 percent among 10th-graders. One-quarter of 12th-graders and one-tenth of 8th-graders reported past 30-day illicit drug use in 2002, unchanged from the previous year.
- Twelve-year trends for 8th- and 10th-graders show that past-30-day illicit drug use increased from the early to mid-1990s, peaking in 1996 at 15 percent and 23 percent in the respective grades. For 8th-graders, illicit drug use then declined gradually from 1996 to 2001 and decreased further in 2002; for 10th-graders, it remained stable until the decrease between 2001 and 2002.
- Longer-term trends for high school seniors show that past-30-day illicit drug use declined from 37 percent in 1980 to 14 percent in 1992. The rate then rose sharply, reaching 26 percent in 1997, and has remained around that level through 2002.
- Among 12th-graders, more males than females report illicit drug use (29 percent compared with 22 percent, respectively, in 2002). For younger students, gender differences are less dramatic but are in the same direction. Between 2001 and 2002, past-30-day illicit drug use by males declined from 13 to 11 percent among 8th-graders and from 25 to 22 percent among 10th-graders; illicit drug use by females in these grades remained stable over this period.
- White and Hispanic students generally have higher illicit drug use rates than do Black students. Among 10th-graders, for example, 23 percent of Whites and 21 percent of Hispanics reported past-30-day illicit drug use, compared with 16 percent of Blacks in 2002.

Bullets contain references to data that can be found in Table BEH3 on page 111. Endnotes begin on page 63.

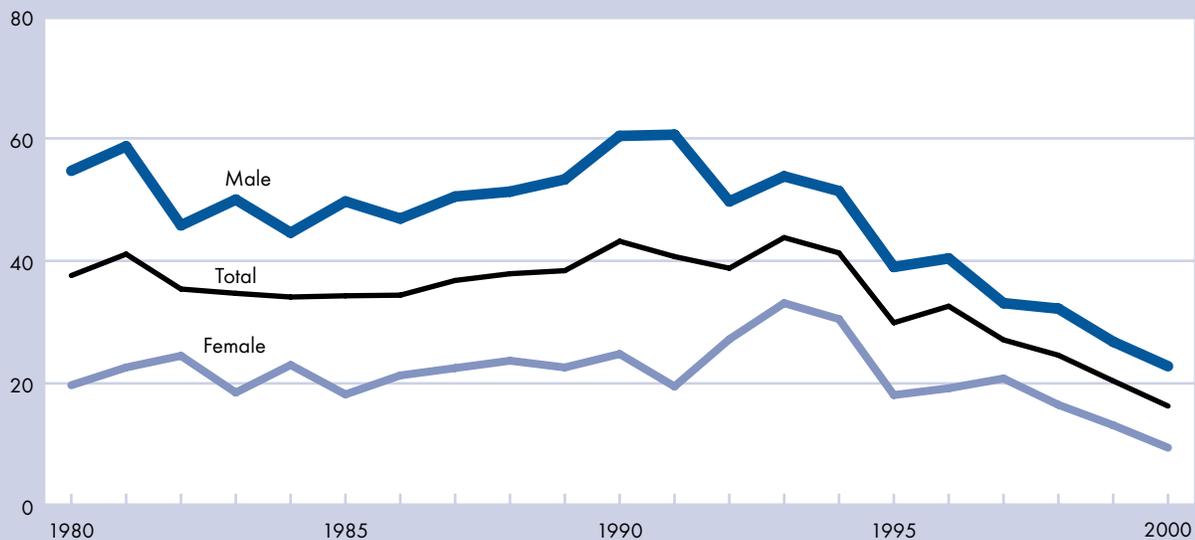
Youth Victims and Perpetrators of Serious Violent Crimes

Violence affects the quality of life of young people who experience, witness, or feel threatened by it. In addition to the direct physical harm suffered by young victims of serious violence, such violence can adversely affect victims' mental health and development and increase the likelihood that they themselves will commit acts of serious violence.^{89,90} Youth ages 12 to 17 are twice as likely as adults to be victims of serious violent crimes,⁹¹ which include aggravated assault, rape, robbery (stealing by force or threat of violence), and homicide.

Indicator BEH4.A

Rate of serious violent crime victimization of youth ages 12 to 17 by gender, 1980-2000

Youth victims per 1,000 juveniles ages 12-17



NOTE: Serious violent crimes include aggravated assault, rape, robbery (stealing by force or threat of violence), and homicide. Because of changes made in the victimization survey, data prior to 1992 are adjusted to make them comparable with data collected under the redesigned methodology. Numbers for 2000 are preliminary and do not contain final homicide estimates.

SOURCE: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey. Federal Bureau of Investigation, Uniform Crime Reporting Program, Supplementary Homicide Reports.

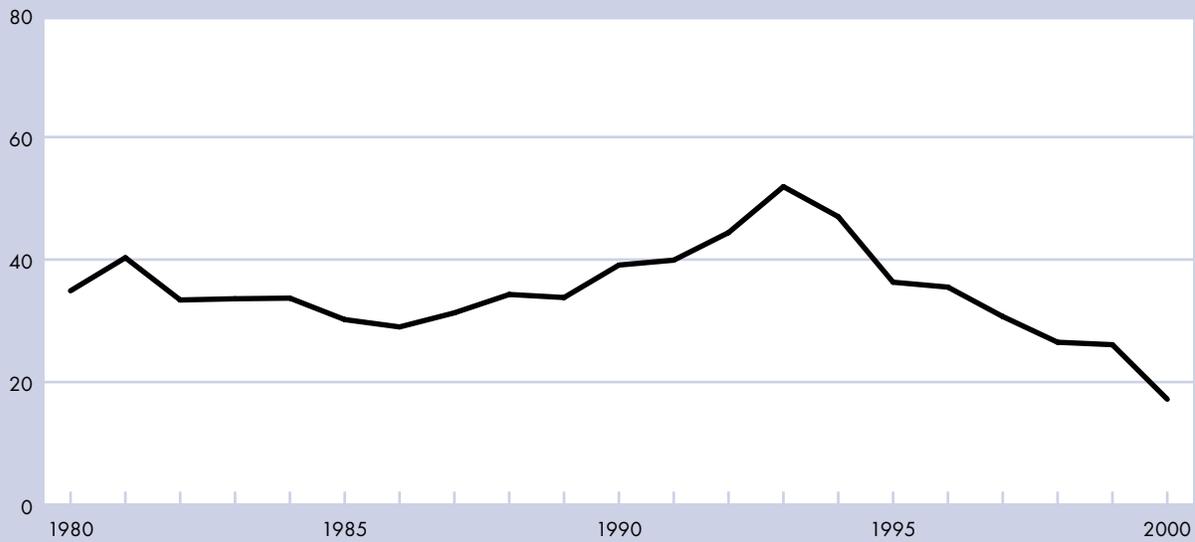
- In 2000, the rate at which youth were victims of serious violent crimes was 16 crimes per 1,000 juveniles ages 12 to 17, totaling about 390,000 such crimes.
- The serious violent crime victimization rate fluctuated between 34 and 43 per 1,000 from 1980 to 1990 and peaked at 44 per 1,000 in 1993. Since 1993, the rate of serious violent crime against youth has decreased by 63 percent, down to 16 per 1,000 in 2000.
- Males are more than twice as likely as females to be victims of serious violent crimes. In 2000, the serious violent crime victimization rate was 23 per 1,000 male youth, compared with 10 per 1,000 female youth.
- In 2000, the serious violent crime victimization rate for youth dropped more for younger teens (ages 12 to 14) than for older teens (ages 15 to 17). In 2000, the rate for older teens dropped to 19 per 1,000 and for younger teens dropped to 14 per 1,000.

The level of youth violence in society can be viewed as an indicator of youths' ability to control their behavior, as well as the adequacy of socializing agents such as families, peers, schools, and religious institutions to supervise or channel youth behavior to acceptable norms. One measure of the serious violent crime committed by juveniles is the incidence rate of serious violent juvenile crime.

Indicator BEH4.B

Serious violent crime offending rate by youth ages 12 to 17, 1980-2000

Crimes per 1,000 youth ages 12-17



NOTE: This rate is the ratio of the number of crimes (aggravated assault, rape, and robbery; i.e., stealing by force or threat of violence) reported to the National Crime Victimization Survey for which the age of the offenders was known, plus the number of homicides reported to police that involved at least one juvenile offender perceived by the victim (or by law enforcement in the case of homicide) to be 12 through 17 years of age, to the number of juveniles in the population. Because of changes made in the victimization survey, data prior to 1992 are adjusted to make them comparable with data collected under the redesigned methodology. Numbers for 2000 are preliminary and do not contain final homicide estimates.

SOURCE: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey. Federal Bureau of Investigation, Uniform Crime Reporting Program, Supplementary Homicide Reports.

- According to reports by victims, in 2000 the serious violent crime offending rate was 17 crimes per 1,000 juveniles ages 12 to 17, totaling 413,000 such crimes involving juveniles. This is a 67 percent drop from the 1993 high and the lowest rate recorded since the national victimization survey began in 1973.
- Reports by victims indicate that between 1980 and 1989, the serious violent juvenile crime offending rate fluctuated between 29 and 40 per 1,000, and then began to increase from 34 per 1,000 in 1989 to a high of 52 per 1,000 in 1993. Since then, the rate has steadily dropped, to 17 per 1,000 in 2000.
- Based on victims' reports, since 1980 the percentage of all serious violent crime involving juveniles has ranged from 19 percent in 1982 to 26 percent in 1993, the peak year for youth violence. In 2000, 19 percent of all such victimizations reportedly involved a juvenile offender.

- In more than half (59 percent) of all serious violent juvenile crimes reported by victims in 2000, more than one offender was involved in the incident. Because insufficient detail exists to determine the age of each individual offender when a crime is committed by more than one offender, the number of additional juvenile offenders cannot be determined. Therefore, this rate of serious violent crime offending does not represent the number of juvenile offenders in the population, but rather the number of crimes committed involving juveniles ages 12 to 17 in relation to the juvenile population.

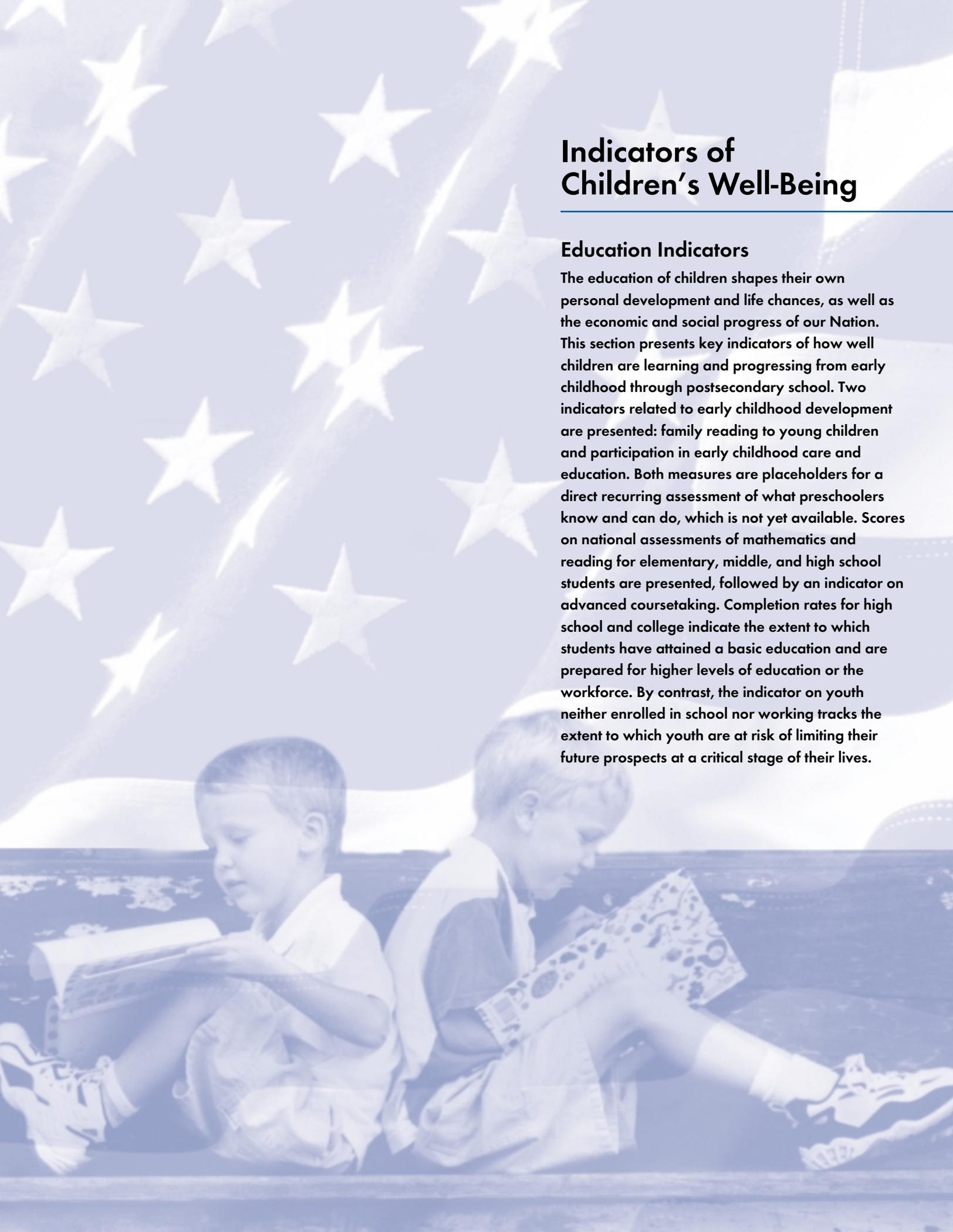
Bullets contain references to data that can be found in Tables BEH4.A and BEH4.B on pages 112-113. Endnotes begin on page 63.

Indicators Needed

Behavior and Social Environment

A broader set of indicators than those presented in this section is needed to adequately monitor the social environment and behaviors of youth. Other behavior and social environment measures are needed on:

- *Indicators of positive behaviors.* The participation of youth in positive activities and the formation of close attachments to family, school, and community have been linked to positive outcomes in research studies. Additional research needs to be conducted to strengthen our understanding of positive activities and the aspects of those activities that protect youth from risk. Then, regular sources of data that can be used to monitor trends in these important areas over time need to be developed. To that end, the Forum co-sponsored the Indicators of Positive Development conference to conceptualize, define, and measure positive youth development. The child care background measure shows participation rates in extracurricular activities such as organized sports, clubs, arts, religious activities, and other school or community activities. In addition, the youth participation in volunteer activities measure was presented as a special feature in the *America's Children, 2000* report. Forum agencies are also examining the measurement and influence of young people's feelings of closeness with their parents.
- *Neighborhood environment.* Research shows that growing up in distressed neighborhoods has an effect over and above that of individual or family background characteristics on child well-being. A survey is being implemented that would, for the first time, enable the monitoring of America's communities and neighborhoods over time and identify distressed neighborhoods in which children are living.
- *Youth violence.* According to victim reports, 19 percent of violent crimes in 2000 involved a youth offender between the ages of 12 and 17. Since crime data are reported by victims, not perpetrators, the indicator on serious violent crime offending by youth does not provide critical information on the number and characteristics of youthful offenders involved in serious crime. Additional work is needed to produce a more comprehensive and useful measure of the prevalence of violence among young people.



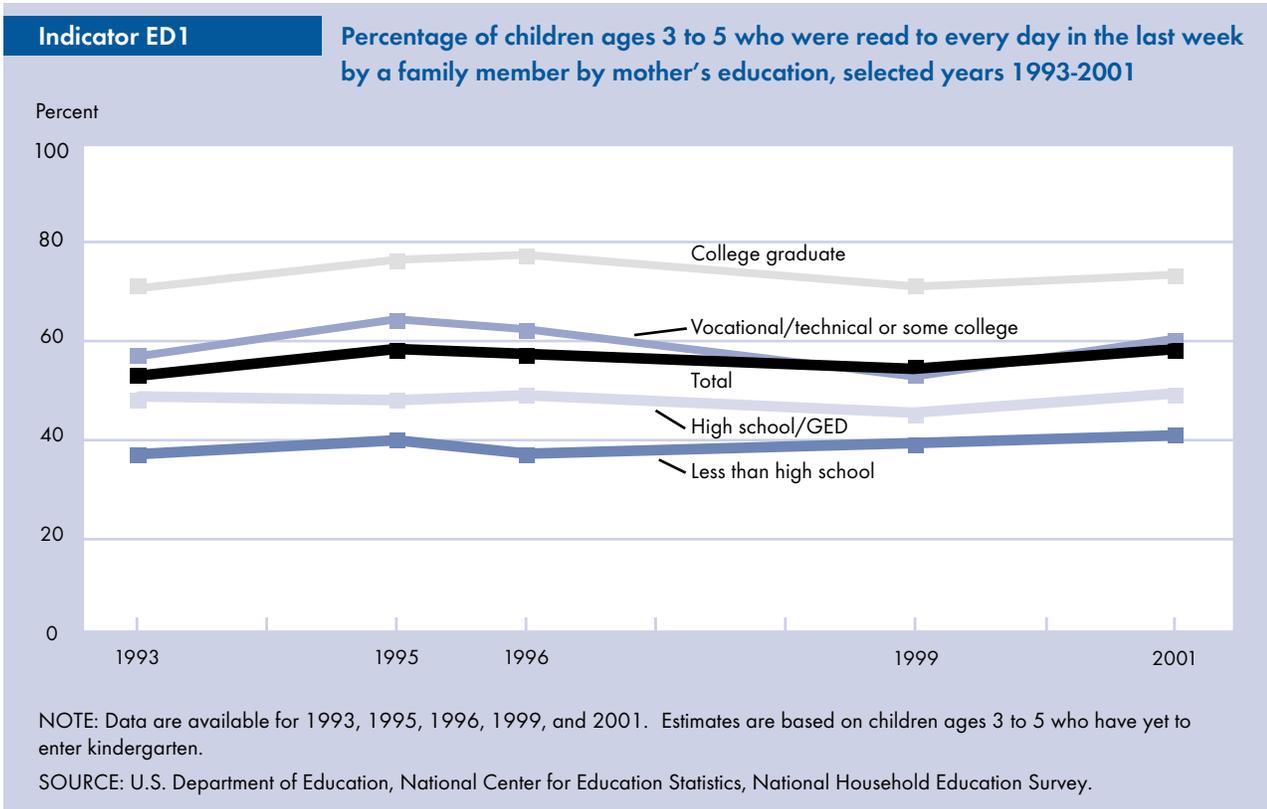
Indicators of Children's Well-Being

Education Indicators

The education of children shapes their own personal development and life chances, as well as the economic and social progress of our Nation. This section presents key indicators of how well children are learning and progressing from early childhood through postsecondary school. Two indicators related to early childhood development are presented: family reading to young children and participation in early childhood care and education. Both measures are placeholders for a direct recurring assessment of what preschoolers know and can do, which is not yet available. Scores on national assessments of mathematics and reading for elementary, middle, and high school students are presented, followed by an indicator on advanced coursetaking. Completion rates for high school and college indicate the extent to which students have attained a basic education and are prepared for higher levels of education or the workforce. By contrast, the indicator on youth neither enrolled in school nor working tracks the extent to which youth are at risk of limiting their future prospects at a critical stage of their lives.

Family Reading to Young Children

Reading to young children promotes language acquisition and correlates with literacy development and, later on, with achievement in reading comprehension and overall success in school.⁹² The percentage of young children read aloud to daily by a family member is one indicator of how well young children are being prepared for school. Mother's education is consistently related to whether children are read to by a family member.



- In 2001, 58 percent of children ages 3 to 5 were read to daily by a family member, a higher rate than in 1993. The percentage has fluctuated between 53 and 58 percent since 1993.
- In 2001, 73 percent of children whose mothers were college graduates were read to every day. In comparison, daily reading occurred for 60 percent of children whose mothers had some postsecondary education, 49 percent of children whose mothers had completed high school but had no further education, and 42 percent of children whose mothers had not finished high school.
- White, non-Hispanic children were more likely to be read to every day than either Black, non-Hispanic or Hispanic children. Sixty-four percent of White, non-Hispanic children, 48 percent of Black, non-Hispanic children, and 42 percent of Hispanic children were read to every day.
- Children in families with incomes below the poverty line were less likely to be read to every day than were children in families with incomes at or above the poverty line. Forty-eight percent of children in families in poverty were read to every day in 2001, compared with 61 percent of children in families at or above the poverty line.
- Children living with two parents were more likely to be read to every day than were children who live with one or no parent. Sixty-one percent of children in two-parent households were read to every day in 2001, compared with 48 percent of children living with one or no parent.

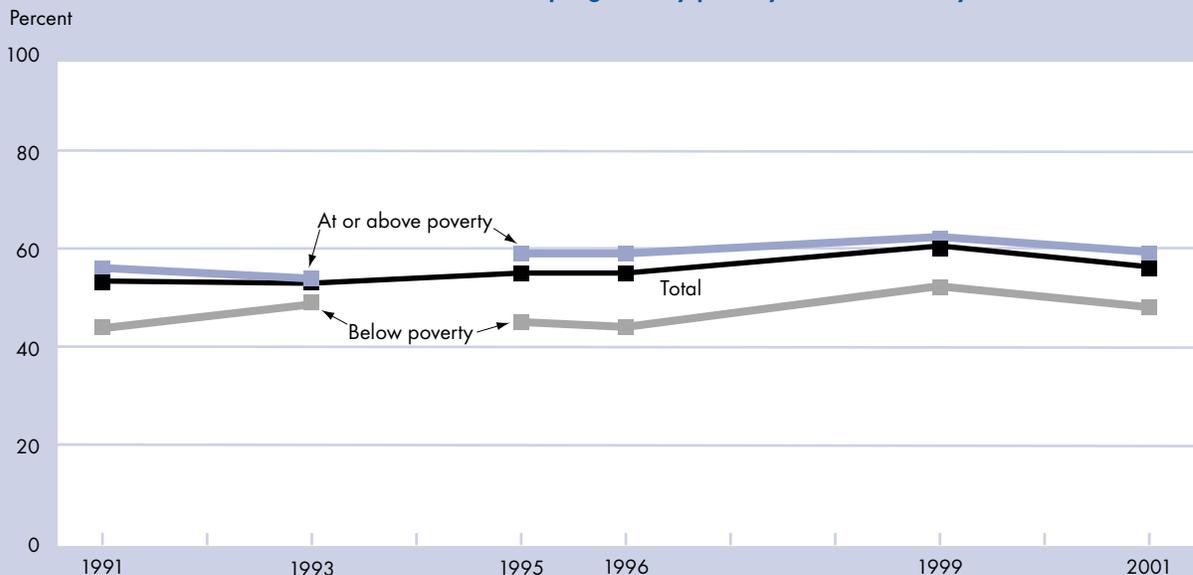
Bullets contain references to data that can be found in Table ED1 on page 114. Endnotes begin on page 63.

Early Childhood Care and Education

Like family reading, participation in an early childhood education program can provide preschoolers with skills and enrichment that can increase their chances of success in school. Studies have demonstrated that participation in high-quality early childhood education programs has short-term positive effects on IQ and achievement and long-term positive effects on low-income minority children's school completion.⁹³ Until an ongoing direct measure of preschoolers' cognitive, behavioral, and social skills is available for this monitoring report, this indirect indicator monitors the percentage of children who are exposed to a variety of early childhood education programs.

Indicator ED2

Percentage of children ages 3 to 5 who are enrolled in center-based early childhood care and education programs by poverty status, selected years 1991-2001



NOTE: Data are available for 1991, 1993, 1995, 1996, 1999, and 2001. Estimates are based on children who have yet to enter kindergarten. Poverty estimates for 1991 and 1993 are not comparable to those for later years.

SOURCE: U.S. Department of Education, National Center for Education Statistics, National Household Education Survey.

- In 2001, 56 percent of children ages 3 to 5 who had not yet entered kindergarten attended center-based early childhood care and education programs. These programs include day care centers, nursery schools, preschool programs, Head Start programs, and prekindergarten programs.
- Between 1991 and 2001, the percentage of children of this age attending early childhood programs varied between 53 and 60 percent.
- Children living in poverty were less likely to attend these programs than were those living in families at or above poverty in 2001 (47 percent compared with 59 percent).
- Children with more highly educated mothers are more likely to attend an early childhood program than other children. Seventy percent of children whose mothers had completed college attended such programs in 2001, compared with 38 percent whose mothers had less than a high school education.
- White, non-Hispanic and Black, non-Hispanic children are more likely than Hispanic children to attend an early childhood program. In 2001, 59 percent of White, non-Hispanic and 64 percent of Black, non-Hispanic children ages 3 to 5 attended such programs, compared with 40 percent of Hispanic children.
- Children with employed mothers are more likely to participate in early childhood care and education programs than children of mothers not in the labor force.

Bullets contain references to data that can be found in Table ED2 on page 115. Endnotes begin on page 63.

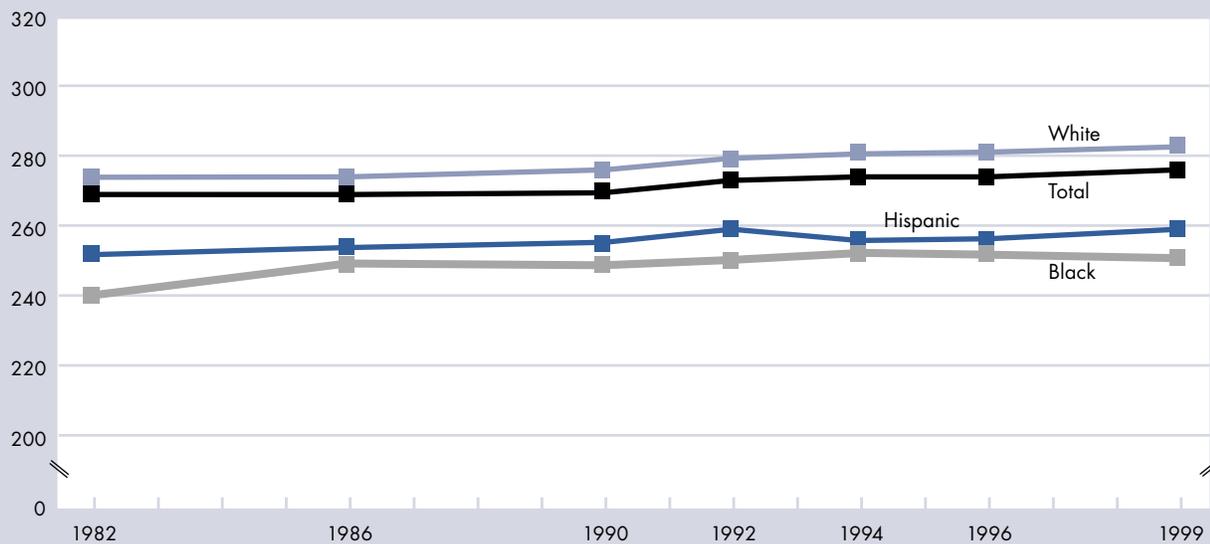
Mathematics and Reading Achievement

The extent and content of students' knowledge, as well as their ability to think, learn, and communicate, affect their ability to succeed in the labor market as adults. On average, students with higher test scores will earn more and will be unemployed less often than students with lower test scores.⁹⁴ Mathematics and reading achievement test scores are important measures of students' skills in these subject areas, as well as good indicators of achievement overall in school. To assess progress in mathematics and reading, the National Assessment of Educational Progress measures national trends in the academic performance of students at ages 9, 13, and 17.

Indicator ED3.A

Average mathematics scale scores for students age 13 by race and Hispanic origin, selected years 1982-99

Average score (on a scale from 0-500)



NOTE: Data are available for 1982, 1986, 1990, 1992, 1994, 1996, and 1999. The mathematics proficiency scale ranges from 0 to 500, with the following skill levels associated with the corresponding scale score:

- Level 150: Simple arithmetic facts
- Level 200: Beginning skills and understandings
- Level 250: Numerical operations and beginning problem solving
- Level 300: Moderately complex procedures and reasoning
- Level 350: Multi-step problem solving and algebra

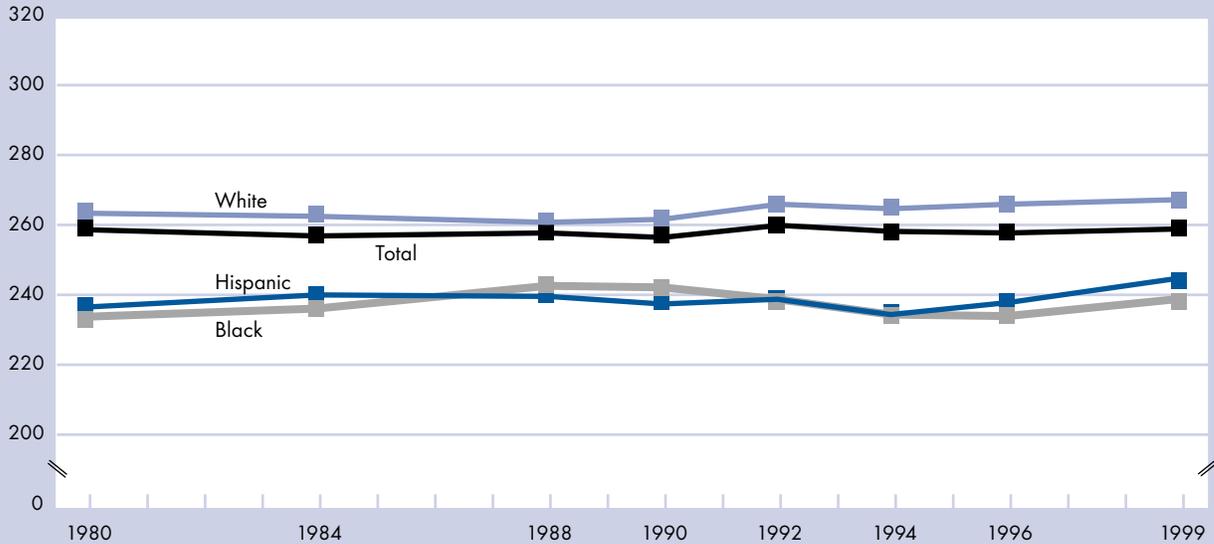
SOURCE: U.S. Department of Education, National Center for Education Statistics, National Assessment of Educational Progress.

- Average mathematics scores increased for all age groups between 1982 and 1999.
- Scores in 1999 did not improve significantly over the last assessment in 1996 in reading or mathematics in any of the three age groups tested—ages 9, 13, and 17.
- White, non-Hispanic students have had consistently higher reading and mathematics scores than either Black, non-Hispanic or Hispanic students at ages 9, 13, and 17. The gaps between non-Hispanic Whites and Blacks and between non-Hispanic Whites and Hispanics decreased in each subject in some age groups during the 1980s and 1990s, but widened for others. Larger reductions in these gaps occurred during the 1970s because of gains in the scores of Black, non-Hispanic and Hispanic students.

Indicator ED3.B

Average reading scale scores for students age 13 by race and Hispanic origin, selected years 1980-99

Average score (on a scale from 0-500)



NOTE: Data are available for 1980, 1984, 1988, 1990, 1992, 1994, 1996, and 1999. The reading proficiency scale ranges from 0 to 500, with the following skill levels associated with the corresponding scale score:

- Level 150: Simple, discrete reading tasks
- Level 200: Partial skills and understanding
- Level 250: Interrelates ideas and makes generalizations
- Level 300: Understands complicated information
- Level 350: Learns from specialized reading materials

SOURCE: U.S. Department of Education, National Center for Education Statistics, National Assessment of Educational Progress.

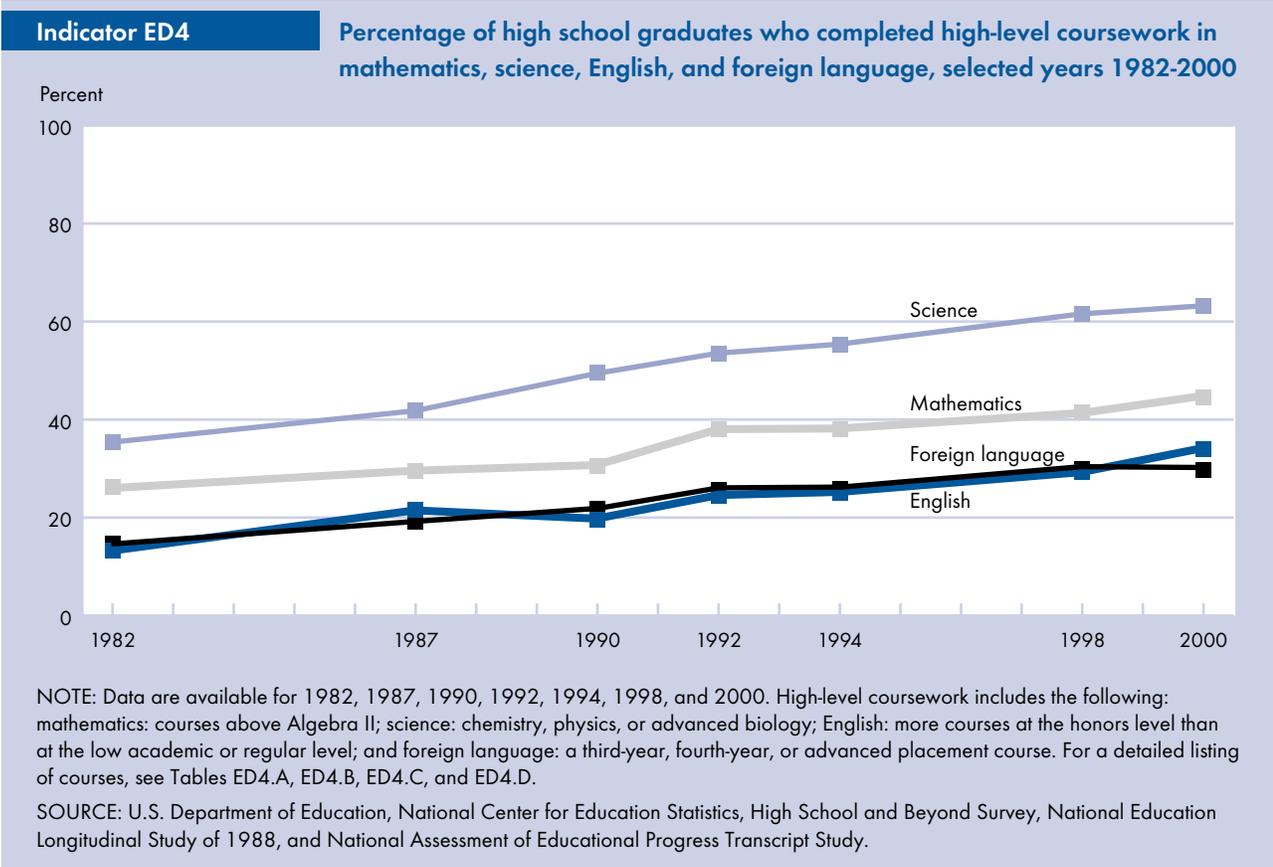
- Average reading scores have not improved among students ages 9, 13, or 17 since 1980.
- On average, students at ages 13 and 17 whose parents have completed more years of school have higher reading and mathematics scores than do their peers whose parents have had fewer years of education.⁹⁵

- Girls had higher reading scores than boys at all three ages in 1999. In 1996, boys outperformed girls in mathematics at all three ages, but that gap was no longer significant in 1999. At ages 9 and 13, the differences between boys and girls were not significant for most years between 1980 and 1996.

Bullets contain references to data that can be found in Tables ED3.A and ED3.B on pages 116 -117. Endnotes begin on page 63.

High School Academic Coursetaking

Since *A Nation at Risk* was published in 1983, school reforms have emphasized increasing the number of academic courses students take in high school. Research has shown a strong relationship between the level of difficulty of courses students take and their performance on assessments. For both college-bound and non-college-bound students, assessment scores increased more for students taking advanced courses than for students who did not take advanced courses.⁹⁶ Studies have also shown that students who take advanced coursework, such as Calculus, in high school are more likely to enroll in college and succeed beyond college.⁹⁷



- Forty-five percent of 2000 high school graduates had taken at least one advanced mathematics course (defined as a course above Algebra II), an increase from 26 percent of 1982 high school graduates. In addition, the percentage of 2000 high school graduates taking a nonacademic or low-level academic course as their most advanced course was 7 percent, compared with 24 percent for 1982 graduates.
- In science, more than half (63 percent) of all 2000 high school graduates had taken physics, chemistry, or advanced biology, more than the percentage of 1982 graduates who had taken these courses (35 percent). In addition, the percentage of students who had taken a physical science course lower than biology, chemistry, and physics as their most advanced course dropped from 27 percent of 1982 graduates to 9 percent of 2000 graduates.
- Thirty-four percent of all 2000 high school graduates took honors-level English courses, an increase from 13 percent of 1982 high school graduates. There was no detectable difference between the percentage of 1982 and 2000 graduates taking low academic level courses (10 and 11 percent, respectively).
- More high school students are taking foreign language courses. Thirty percent of 2000 high school graduates had taken a third- or fourth-year or advanced placement course, compared with 15 percent of 1982 graduates. Seventeen percent of 2000 high school graduates did not take any foreign language course, compared with 46 percent of 1982 high school graduates.

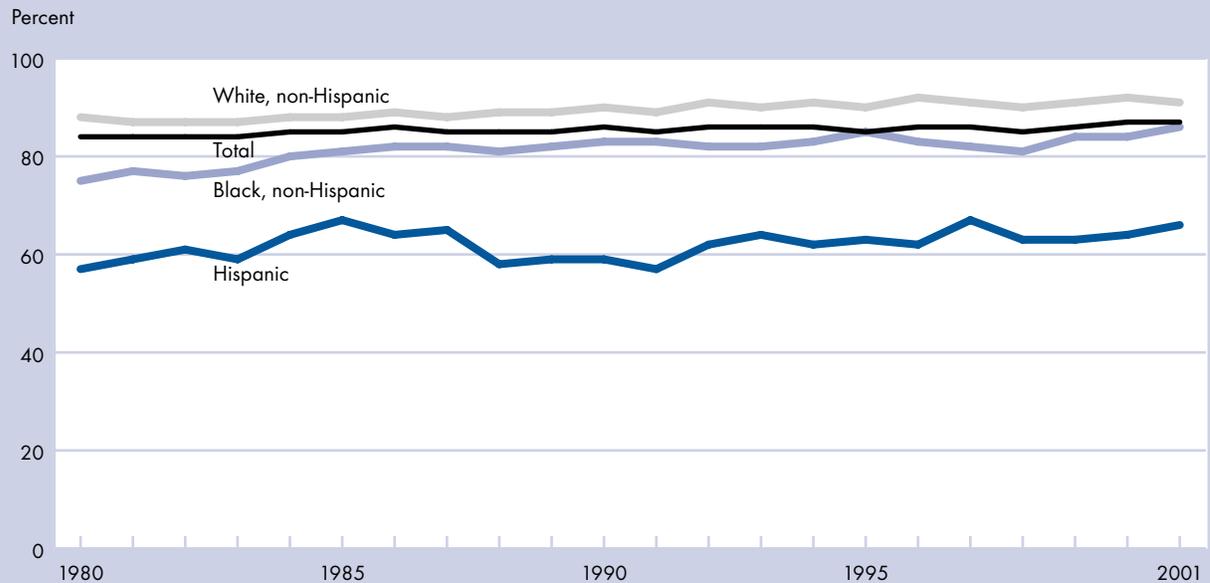
Bullets contain references to data that can be found in Tables ED4.A-ED4.D on pages 118-121. Endnotes begin on page 63.

High School Completion

A high school diploma or its equivalent represents acquisition of the basic reading, writing, and mathematics skills a person needs to function in modern society. The percentage of young adults ages 18 to 24 with a high school diploma or an equivalent credential is a measure of the extent to which young adults have completed a basic prerequisite for many entry-level jobs as well as higher education.

Indicator ED5

Percentage of adults ages 18 to 24 who have completed high school by race and Hispanic origin, 1980-2001



NOTE: Percentages are based only on those not currently enrolled in high school or below. Prior to 1992, this indicator was measured as completing 4 or more years of high school rather than the actual attainment of a high school diploma or equivalent.

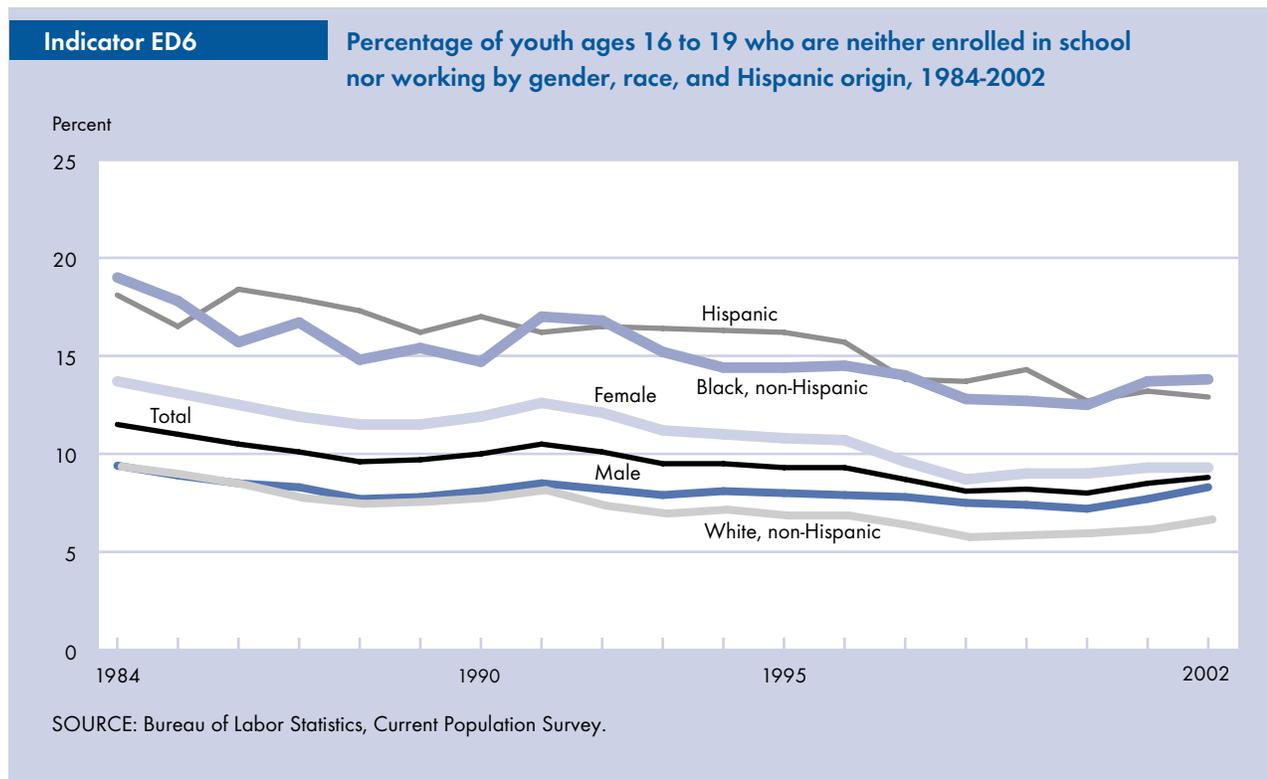
SOURCE: U.S. Census Bureau, October Current Population Survey. Tabulated by the U.S. Department of Education, National Center for Education Statistics.

- In 2001, 87 percent of young adults ages 18 to 24 had completed high school with a diploma or an alternative credential such as a General Education Development (GED) certificate. The high school completion rate has increased slightly since 1980, when it was 84 percent.
- The rate at which Black, non-Hispanic youth completed high school increased between 1980 and 1990, from 75 percent to 83 percent. It has fluctuated since then and was at 86 percent in 2001. Among White, non-Hispanics, the high school completion rate increased from 88 percent in 1980 to 91 percent in 2001.
- Hispanic youth have had a consistently lower high school completion rate than White, non-Hispanic and Black, non-Hispanic youth. Since 1980, the high school completion rate for Hispanic youth has fluctuated between 57 and 67 percent and was at 66 percent in 2001.
- Most young adults complete high school by earning a regular high school diploma. Others complete high school by earning an alternative credential, such as a GED. Between 1990 and 1999, the diploma rate declined by 4 percentage points, decreasing from 81 percent to 77 percent. In comparison, the alternative credential rate increased by 5 percentage points, from 4 to 9 percent.⁹⁸

Bullets contain references to data that can be found in Table ED5 on page 122. Endnotes begin on page 63.

Youth Neither Enrolled in School Nor Working

The transition from adolescence to adulthood is a critical period in each individual's life. Youth ages 16 to 19 who are neither in school nor working are detached from both of the core activities that usually occupy teenagers during this period. Detachment from school or the workforce, particularly if this situation lasts for several years, puts youth at increased risk of having lower earnings and a less stable employment history than their peers who stayed in school and/or secured jobs.⁹⁹ The percentage of youth who are not enrolled in school and not working is one measure of the proportion of young people who are at risk of limiting their future prospects.



- In an average week during the 2002 school year, about 9 percent of youth ages 16 to 19 were neither enrolled in school nor working.
- The proportion of youth neither enrolled nor working declined between 1991 and 1998, and has since stabilized. Most of the decline in the proportion of youth neither enrolled nor working occurred among young women. In 1991, 13 percent of young women were neither in school nor working. By 2002, this proportion had decreased to 9 percent. Nevertheless, young women continue to be slightly more likely to be detached from these activities than young men.
- Black, non-Hispanic and Hispanic youth are considerably more likely to be detached from these activities than White, non-Hispanic youth. In 2002, 13 percent of Hispanic youth and 14 percent of Black, non-Hispanic youth were neither in school nor working, compared with 7 percent of White, non-Hispanic youth.
- The proportion of Black, non-Hispanic youth who are neither enrolled in school nor working has decreased from 19 percent in 1984 to 14 percent in 2002. The proportion of Hispanic youth who are neither enrolled in school nor working has also decreased, from 18 percent in 1984 to 13 percent in 2002.
- Older youth, ages 18 to 19, are more than three times as likely to be detached from these activities as youth ages 16 to 17. In 2002, 14 percent of youth ages 18 to 19 were neither enrolled in school nor working compared with 4 percent of youth ages 16 to 17.
- In contrast to the unchanging percentage of youth who are neither enrolled in school nor working, the percentage of youth who are both enrolled and employed has decreased in recent years. Between 1999 and 2002, the percentage of youth ages 16 to 19 who are both enrolled and employed decreased from 31 to 27 percent, which is similar to the percentage in 1990.

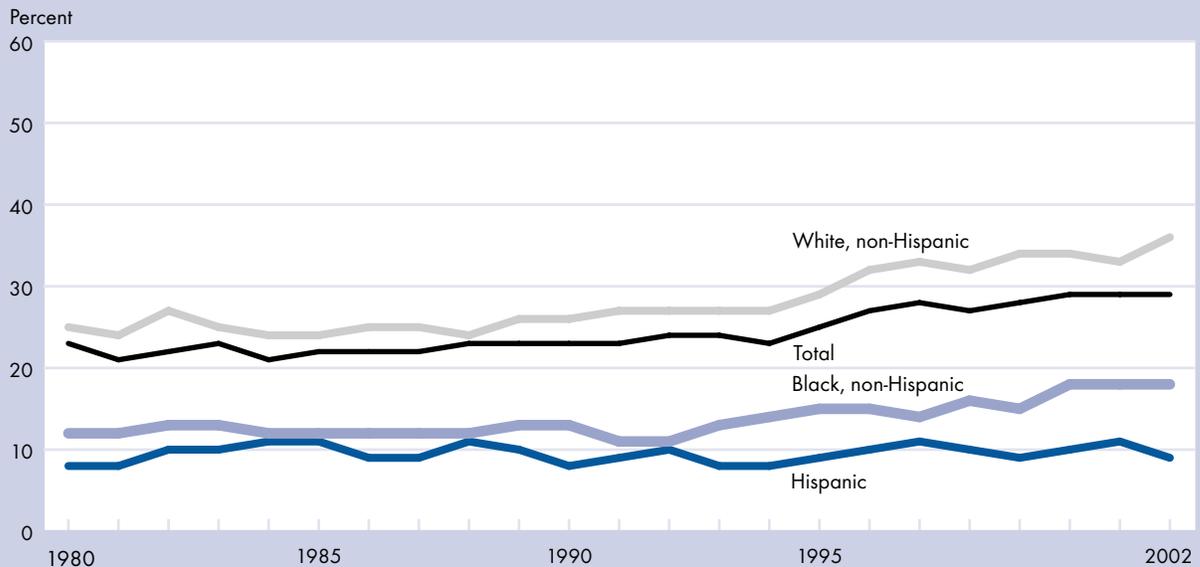
Bullets contain references to data that can be found in Tables ED6.A and ED6.B on pages 123-124. Endnotes begin on page 63.

Higher Education

Higher education, especially completion of a bachelor's or more advanced degree, generally enhances a person's employment prospects and increases his or her earning potential.¹⁰⁰ The percentage who have completed a bachelor's degree is one measure of the percentage of young people who have successfully applied for and persisted through a program of higher education.

Indicator ED7

Percentage of 25- to 29-year-olds who have completed a bachelor's or more advanced degree by race and Hispanic origin, 1980-2002



NOTE: Prior to 1992, this indicator was measured as completing 4 or more years of college rather than the actual attainment of a bachelor's degree.

SOURCE: U.S. Census Bureau, March Current Population Survey. Tabulated by the U.S. Department of Education, National Center for Education Statistics.

- In 2002, 29 percent of 25- to 29-year-olds had earned a bachelor's or higher degree.
- This percentage increased between 1980 and 2002, from 23 to 29 percent; since 1996, the percentage has fluctuated between 27 and 29 percent.
- White, non-Hispanic persons ages 25 to 29 were more likely than either Black, non-Hispanics or Hispanics in the same age group to have earned a bachelor's degree. In 2002, 36 percent of White, non-Hispanics, 18 percent of Black, non-Hispanics, and 9 percent of Hispanics in this age group had earned a bachelor's degree or higher.
- Since 1980, the percentage of Hispanic 25- to 29-year-olds who earned bachelor's degrees or higher has fluctuated between 8 and 11 percent and was at 9 percent in 2002.
- The percentage of Black, non-Hispanic 25- to 29-year-olds who earned a bachelor's degree increased from 12 percent in 1980 to 18 percent in 2002.
- In 2002, 8 percent of 25- to 29-year-olds had earned an associate's degree but had not subsequently earned a bachelor's degree.

Bullets contain references to data that can be found in Table ED7 on page 125. Endnotes begin on page 63.

Indicator Needed

Education

Regular, periodic data collections are needed to collect information on young children's cognitive, social, and emotional development.

- *Early childhood development.* Although this report offers indicators of young children's exposure to reading and early childhood education, a regular source of data is needed to monitor specific social, intellectual, and emotional skills of preschoolers over time. One assessment of kindergartners' skills and knowledge was presented as a special feature in *America's Children, 2000*.