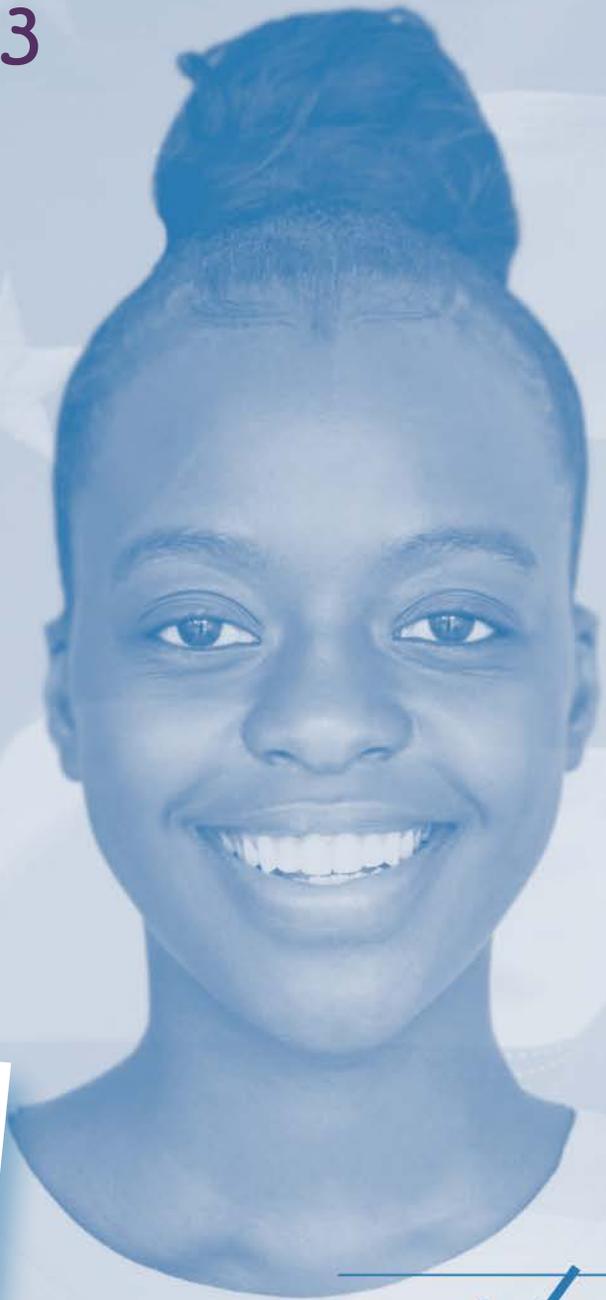
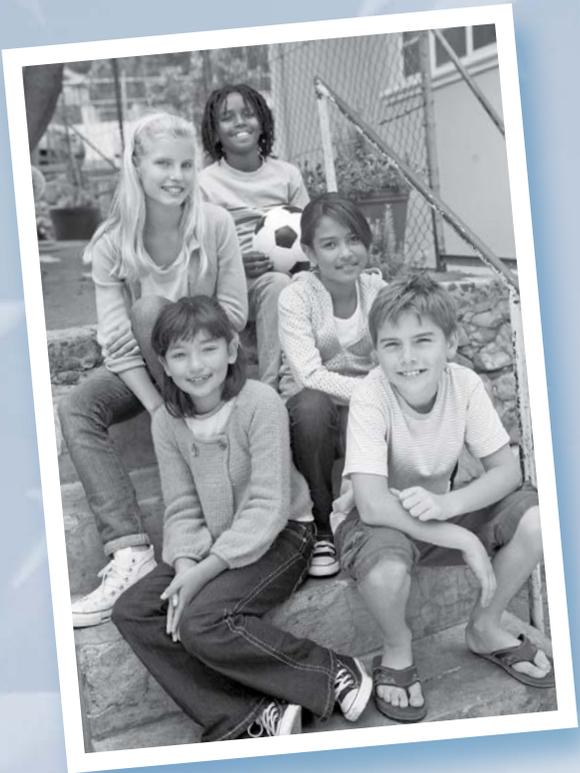


America's Children: Key National Indicators of Well-Being, 2023



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Federal Interagency Forum on Child and Family Statistics

The Federal Interagency Forum on Child and Family Statistics was founded in 1994. Executive Order No. 13045 formally established the Forum in April 1997 to foster coordination and collaboration in the collection and reporting of Federal data on children and families. Agencies that are members of the Forum as of spring 2023 are as follows:

Consumer Product Safety Commission

<https://www.cpsc.gov>

Department of Agriculture

Economic Research Service

<https://www.ers.usda.gov>

Department of Commerce

U.S. Census Bureau

<https://www.census.gov>

Department of Defense

Office of the Deputy Under Secretary of Defense Military Community and Family Policy

<https://prhome.defense.gov/M-RA/Inside-M-RA/MCFP>

Department of Education

National Center for Education Statistics

<https://nces.ed.gov>

Department of Health and Human Services

Administration for Children and Families

<https://www.acf.hhs.gov>

Agency for Healthcare Research and Quality

<https://www.ahrq.gov>

Eunice Kennedy Shriver National Institute of Child Health and Human Development

<https://www.nichd.nih.gov/Pages/index.aspx>

Maternal and Child Health Bureau

<https://www.mchb.hrsa.gov>

National Center for Health Statistics

<https://www.cdc.gov/nchs>

National Center for Immunization and Respiratory Diseases

<https://www.cdc.gov/ncird/index.html>

National Institute of Mental Health

<https://www.nimh.nih.gov/index.shtml>

National Institute on Drug Abuse

<https://nida.nih.gov/>

Office of the Assistant Secretary for Planning and Evaluation

<https://aspe.hhs.gov>

Office of Population Affairs

<https://www.hhs.gov/opa>

Substance Abuse and Mental Health Services Administration

<https://www.samhsa.gov>

Department of Housing and Urban Development

Office of Policy Development and Research

<https://www.huduser.gov/portal/home.html>

Department of Justice

Bureau of Justice Statistics

<https://bjs.ojp.gov/>

National Institute of Justice

<https://nij.ojp.gov/>

Office of Juvenile Justice and Delinquency Prevention

<https://ojjdp.ojp.gov>

Department of Labor

Bureau of Labor Statistics

<https://www.bls.gov>

Women's Bureau

<https://www.dol.gov/agencies/wb>

Department of Transportation

National Highway Traffic Safety Administration

<https://www.nhtsa.gov/>

Environmental Protection Agency

Office of Children's Health Protection

<https://www.epa.gov/children/>

Office of Management and Budget

Statistical and Science Policy Office

<https://www.whitehouse.gov/omb/information-regulatory-affairs/statistical-programs-standards/>

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Foreword

The Federal Interagency Forum on Child and Family Statistics (Forum) is a wonderful example of how Federal agencies can increase the effectiveness, efficiency, and accessibility of the government by working across agency boundaries to collaborate and innovate. The Forum was chartered in April 1997 through Executive Order No. 13045. It has since been successfully bringing together (from a very decentralized system) high-quality information that the public and policymakers can easily access and understand about our Nation's children and youth. Working together, Federal agencies are able to set priorities on what information to collect; develop new methods for collecting such information; improve the communication of information on the status of children to the policy community and the general public; and produce more complete data on children at the Federal, state, and local levels.

America's Children: Key National Indicators of Well-Being, 2023, is a compendium of indicators about our Nation's young people. The report, the 25th produced by the Forum, presents 41 key indicators on important aspects of children's lives. These indicators are drawn from our most reliable Federal statistics, are easily understood by broad audiences, are objectively based on substantial research, are balanced so that no single area of children's lives dominates the report, are measured often to show trends over time, and are representative of large segments of the population rather than one particular group.

The report continues to present key indicators in seven domains: family and social environment, economic circumstances, health care, physical environment and safety, behavior, education, and health. To ensure that the information stays relevant, the Forum periodically revises indicators, data sources, and features to maintain the relevance of the report.

Each volume of *America's Children* also spotlights critical data gaps identified by the Forum's Planning Committee and its Federal statistical agencies. Starting with the 2017 report, such data concerns, related to understanding the condition and progress of our Nation's children, were consolidated into a stand-alone Data Topics report section, rather than included as Indicators Needed at the end of each report domain.

The value of the *America's Children* series and the extraordinary cooperation that these reports represent reflect the Forum's determination to work together effectively to help our Nation better understand the well-being of our children today and what may bring them a better future. The Forum agencies should be congratulated once again for developing such a comprehensive set of indicators and ensuring that they are readily accessible in both content and format. The report is an excellent reflection of the dedication of the Forum agency staff members who assess data needs, strive to present relevant statistics in an easy-to-use format, and work together to produce this substantial and important publication. Of course, suggestions of ways we can enhance this volume are always welcome.

No work of this magnitude and quality would be possible without the continued cooperation of the millions of Americans who provide the data that are summarized and analyzed by Federal statistical agencies. This report is, first and foremost, for you and the entire American public. We thank you for your support and important contributions, and we hope the volume will continue to be useful to you.

*Office of the Chief Statistician
U.S. Office of Management and Budget*

Acknowledgments

The success of the Forum is driven by the commitment of the members of the Federal Interagency Forum on Child and Family Statistics.

This report was written by the staff of the Forum, including Traci Cook, Forum Staff Director; Laura Hales, Economic Research Service; Paul Hemez, U.S. Census Bureau; Josh DeLaRosa, National Center for Education Statistics; Brett Brown, Administration for Children and Families; Sheila Franco and Ashley Woodall, National Center for Health Statistics; Doug Richesson, Substance Abuse and Mental Health Services Administration; Thyria Alvarez and Barry Steffen, U.S. Department of Housing and Urban Development; Alexandra Thompson, Bureau of Justice Statistics; Connor Borkowski, Bureau of Labor Statistics; Laura Romano, Environmental Protection Agency; Cindi Knighton, Centers for Disease Control and Prevention; Hazel Hiza, Center for Nutrition Policy and Promotion; and Jessica Cotto, National Institute on Drug Abuse.

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Other staff members of the Forum agencies provided data, developed indicators, or wrote parts of the report. They include Kevin Barragan-Smith, Kalee Burns, Frances Chen, Brittany King, Emily Shrider, Timothy Smith, and David Waddington, U.S. Census Bureau; Emily Schmitt and Elaine Stedt, Administration for Children and Families; Hector Rodriguez and Shalom Williams, Bureau of Labor Statistics; Grace Robiou, Environmental Protection Agency; Mark Prell, Economic Research Service; Joseph Afful, Lara Akinbami, Yutaka Aoki, Shilpa Bengeri, Lindsey Black, Amy Branum, Debra Brody, Christopher Cairns, Anne Driscoll, Nazik Elgaddal, Cheryl Fryar, Matthew Garnett, Brady Hamilton, Joyce Martin, Arialdi Miniño, Cynthia Ogden, Jeannine Schiller, Merianne Spencer, Alan Simon, Anjel Vahratian, Xun Wang, and Julie Weeks, National Center for Health Statistics; Jennifer Tyson, National Institute of Justice; Jennifer Turnham, U.S. Department of Housing and Urban Development; and Laurie Elam-Evans, Holly Hill, Mike Underwood, and Cassandra Pingali, Centers for Disease Control and Prevention.

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About This Report

The Federal Interagency Forum on Child and Family Statistics (Forum) was chartered in 1997 by the authority of Executive Order No. 13045. The Forum fosters collaboration among 23 Federal agencies that (1) produce and/or use statistical data on children and (2) seek to improve Federal data on those children. This year's report, *America's Children: Key National Indicators of Well-Being, 2023*, provides the Nation with carefully selected key national indicators of our children's well-being and monitors changes in these indicators. The purposes of this report are to improve reporting of Federal data on children and families; make the most relevant data on the well-being of children and their families available in an easy-to-use, nontechnical format; stimulate discussions among policymakers, data providers, and the public; and cultivate relationships between the statistical and policy communities.

New to this year's report is an indicator modification highlighting the prevalence of disability among children ages 5–17. This indicator uses the Washington Group on Disability Statistics' (WG) Short Set Composite Disability Indicator from the National Center for Health Statistics' (NCHS) National Health Interview Survey (NHIS). It replaces the previous HEALTH5 (Activity Limitation) indicator, which was discontinued with the 2019 NHIS redesign.

A Special Feature on Enrollment Rates of Young Children is also new this year. This Special Feature is produced by the National Center for Education Statistics (NCES) and uses household-reported data from the 2010–2021 October School Enrollment supplement of the Current Population Survey (CPS). These data describe school enrollment rates of children ages 3 to 5 before and during the COVID-19 pandemic.

Conceptual Framework

There are many interrelated aspects of children's well-being. This report identifies seven major domains that characterize the well-being of a child and influence the likelihood that a child will grow to be a well-educated, economically secure, productive, and healthy adult. The seven domains are family and social environment, economic circumstances, health care, physical environment and safety, behavior, education, and health. These domains are interrelated and can have synergistic effects on well-being.

Each section of the report corresponds to one of the seven domains and includes a set of key national indicators. These indicators either characterize an aspect of well-being or an influence on well-being.

- *Family and Social Environment* includes indicators that characterize children's family lives and social settings.
- *Economic Circumstances* includes indicators related to children's basic material needs.

- *Health Care* includes indicators that characterize access to and the use of health services among children.
- *Physical Environment and Safety* includes indicators that characterize children's environmental conditions or are related to children's safety.
- *Behavior* includes indicators that characterize personal behaviors and their effects.
- *Education* includes indicators that characterize how children learn and progress in school.
- *Health* includes indicators that characterize the physical, mental, and social aspects of children's health.

Structure of the Report

America's Children presents a set of key national indicators that measure important aspects of children's lives and are collected regularly, reliably, and rigorously by Federal agencies. In determining this list of key national indicators, the Forum carefully examined the available data and sought input from the Federal policymaking community, foundations, academic researchers, and state and local children's service providers. These key national indicators were chosen because they meet the following criteria:

- *Easy to understand* by broad audiences;
- *Objectively* based on reliable data with substantial research connecting them to child well-being;
- *Balanced*, so that no single area of children's lives dominates the report;
- *Measured regularly*, so that they can be updated and show trends over time; and
- *Representative* of large segments of the population, rather than one particular group.

America's Children is designed as an overview of the concepts and broad findings that are presented in other, more technical or more comprehensive reports produced by various Forum agencies. This report provides not only the selected indicators of child well-being but also extensive supplementary information. Appendix A, Data Source Descriptions, describes the sources and surveys used to generate the data. In addition, detailed data tables for each indicator are available on the Forum's website (<https://www.childstats.gov>).

Changes to This Year's Report

Whenever possible, we have updated indicators with the latest available data and have included a note about when the data were last updated for each indicator.

Race and Ethnicity and Poverty Status

Most indicators in *America's Children* are tabulated by race and ethnicity. Unless otherwise noted, the data sources used in this report have implemented the standards for reporting race and ethnicity statistics issued in 1997 by the U.S. Office of Management and Budget (OMB; <https://www.gpo.gov/fdsys/pkg/FR-1997-10-30/pdf/97-28653.pdf>).

Many indicators in this report also include data tabulated by poverty status. All poverty-status calculations in this report are based on OMB's Statistical Policy Directive 14, the official poverty measurement standard for the United States. A family is living below the poverty level if its before-tax cash income is below a defined level called the poverty threshold. Poverty thresholds are updated annually and vary based on family size and composition.

Statistical Significance

Most data in this report are estimates based on a sample of the population and are therefore subject to sampling error. Differences between estimates are tested for statistical significance at either the 0.05 or 0.10 cutoff level, according to agency standards; all differences discussed in the report are statistically significant according to the standards of the agency responsible for the data. Agency details about statistical reporting standards for indicators included in the *America's Children* report and standard error tables for select indicators are available online at <https://www.childstats.gov>.

Data Topics

The Forum works with the Federal statistical agencies to identify data topics of interest. This process helps identify many important aspects of children's lives for which regular indicators have not been developed.

In some areas, Forum agencies have successfully fielded surveys incorporating new measures, but data are not yet available for monitoring purposes. In other areas, agencies are exploring ways to collect new measures and improve existing ones.

This year's report includes a new data topic on Environmental Justice. This topic addresses data needed to assess environmental impacts on children's well-being, such as climate change, access to clean water, and children living near sources of pollution.

For Further Information

There are several places to obtain more information on the indicators found in this report, including the data tables, the data source descriptions, the Forum's website (<https://www.childstats.gov>) and [@childstats](https://twitter.com/childstats) on Twitter. Several publications of the Federal statistical agencies provide additional details about indicators in this report and on other areas of child well-being. Two such reports are *The Condition of Education* (<https://nces.ed.gov/programs/coe/>), published annually by the National Center for Education Statistics, and *Health, United States* (<https://www.cdc.gov/nchs/hus.htm>), published annually by the National Center for Health Statistics.

Detailed Tables

When available, tables show data by the following categories: gender, age, race and Hispanic origin, poverty status, parental education, region of the country, and family structure. In addition, detailed data tables for each indicator are available on the Forum's website (<https://www.childstats.gov>).

Data Source Descriptions

Appendix A contains basic information on the data used to generate the indicators and how to contact the agency responsible for the data. These agencies can provide more detailed information about the concepts and methods used to produce their statistics.

Website

The Forum's website (<https://www.childstats.gov>) contains data tables, links to previous reports, information on statistical standards used for data reporting in the *America's Children* report, links for ordering reports, and additional information about the Forum.

Twitter

Follow the Forum on Twitter at [@childstats](https://twitter.com/childstats) for selected highlights from *America's Children*.

Highlights

America's Children: Key National Indicators of Well-Being, 2023 continues a series of annual reports to the Nation on conditions affecting children in the United States. Highlights from each section follow.

Demographic Background

- There were 72.5 million children ages 0–17 in the United States in 2022, a decrease of 0.4 million since 2021. The number of children is projected to increase to 78.2 million in 2050. (POP1)
- The percentage of the U.S. population under age 18 has declined in recent decades, from 26% in 2000 to 24% in 2010 and 22% in 2022. By 2050, 20% of the U.S. population is projected to be under age 18, with 22% age 65 and over. (POP2)
- Racial and ethnic diversity has grown dramatically in the United States in the last three decades. This growth was first evident among children. This population is projected to become even more diverse in the decades to come. In 1990, 69% of U.S. children were White, non-Hispanic. For 2022, the percentage of children that are White, non-Hispanic is estimated at 49%. By 2050, 39% of U.S. children are projected to be White, non-Hispanic and 31% are projected to be Hispanic (up from 26% in 2022). (POP3)

Family and Social Environment

- In 2022, 70% of all children ages 0–17 lived with two parents (65% with two married parents and 5% with two unmarried cohabiting parents), 22% lived with only their mothers, 5% lived with only their fathers, and 4% lived without a parent in the household. The percentage of children living with two unmarried parents is not statistically different from the percentage of children living with only their father. (FAM1.B)
- In 2021, the birth rate among unmarried women ages 15–44 was 38 births for every 1,000 women. From 2019 to 2020, birth rates among unmarried women ages 15–44 decreased for each age group. From 2020 to 2021, birth rates continued to decrease for those ages 15–17, 18–19, and 20–24, increased for those ages 25–29 and 35–39, and remained stable for those ages 30–34 and 40–44. (FAM2.A)

- In 2021, 41% of births were to unmarried women. Generally, the percentage of births to unmarried women decreased with age—mothers under age 15 were more likely to be unmarried, while mothers ages 35–39 were more likely to be married. (FAM2.B)
- In 2019, among children ages 3–5 who were not yet enrolled in kindergarten and who had employed mothers, 58% received center-based care as their primary care arrangement. This percentage was higher than the corresponding percentages whose primary care arrangement was relative care (17%), home-based nonrelative care (10%), multiple nonparental care arrangements for equal amounts of time (2%), or who only received parental care (14%). (FAM3.A)
- In 2019, among children ages 3–5 who were not yet in kindergarten and who had employed mothers, 69% were enrolled in center-based care for any amount of time. This percentage was higher than the corresponding percentage in 1995 (61%) but not measurably different from the percentage in 2016 (70%). (FAM3.B)
- In 2022, 22% of children were native-born children with at least one foreign-born parent, and 3% were foreign-born children with at least one foreign-born parent. (FAM4)
- In 2021, about 21% of school-age children spoke a language other than English at home, and 5% of school-age children spoke a language other than English at home and had difficulty speaking English. (FAM5)
- The adolescent birth rate among females ages 15–17 declined from 15 per 1,000 in 2011 to 6 per 1,000 in 2021, a record low for the country. (FAM6)
- In 2021, the rate of substantiated victims of child maltreatment was 8.1 per 1,000 children ages 0–17. Children younger than age 1 were at much higher risk for being victims of child maltreatment than were older children. In 2021, there were 25.3 maltreated children per 1,000 children under age 1. (FAM7.A)
- Neglect is by far the most common form of maltreatment, with 76% of child maltreatment victims being neglected and 16% physically abused in 2021. (FAM7.B)

Economic Circumstances

- In 2021, 15.3% of all children aged 0–17 (11.1 million) lived in poverty, 0.7 percentage points lower than in 2020. (ECON1.A)
- In 2021, 7.2% of children aged 0–17 lived below 50% of the poverty line. (ECON1.B)
- For all children, the 2021 Supplemental Poverty Measure (SPM) was 5.2%, 10.1 percentage points lower than the official poverty rate of 15.3%. (ECON1.C)
- The percentage of children who had at least one parent working year round, full time increased to 77% in 2021 as labor market conditions continued to recover from the COVID-19 pandemic and efforts to contain it. (ECON2)
- About 9.3 million children (13% of all children) lived in households that were classified as food insecure in 2021. (ECON3)

Health Care

- In 2021, the percentage of children ages 0–17 without health insurance at the time of interview was 4%. Hispanic children were more likely to be uninsured (8%) compared with Black, non-Hispanic (4%) and White, non-Hispanic (3%) children. (HC1)
- Uninsured children ages 0–17 with no usual source of health care increased from 13% in 2020 to 21% in 2021. In 2021, the percentage of uninsured children who had no usual source of health care was 20 percentage points higher than the percentage of children with private health insurance (1%) and 18 percentage points higher than the percentage of children with public health insurance (3%). (HC2)
- For children born in 2018, those in families with incomes below the poverty threshold were less likely to have completed the combined 7-vaccine series (60%) compared with those in families with incomes at or above the poverty level (75%). (HC3.A)
- In 2020, the percentage of children ages 5–17 years with a dental visit in the past year was 89%, down from 91% in 2019. Children who lacked health insurance coverage in 2020 were less likely to have a dental visit in the past year (63%) compared with children who had private (92%) or public (89%) health insurance coverage. (HC4.A)
- In 2017–March 2020, the percentage of children ages 5–17 with untreated dental caries (i.e., cavities) was 12%. Children in families with incomes below poverty were more than two times as likely to have untreated dental caries (19%) compared with children in families with incomes at or above 200% of the poverty level (8%). (HC4.B)

Physical Environment and Safety

- In 2021, about 59% of children lived in counties with measured pollutant concentrations above the levels of one or more of the EPA's National Ambient Air Quality Standards at least once during the year. Ozone is the pollutant most often measured above its current air pollution standard. (PHY1)
- Overall, the percentage of children ages 4–11 with detectable blood cotinine levels—a chemical marker of recent exposure to secondhand smoke—was 36% in 2017–March 2020. Approximately 58% of Black, non-Hispanic children ages 4–11 had detectable blood cotinine levels compared with 39% of White, non-Hispanic children and 20% of Mexican American children. (PHY2)
- In 2021, about 7% of children were served by community drinking water systems that did not meet all applicable health-based standards. (PHY3)
- In 2017–March 2020, the percentage of children with elevated blood lead levels (at or above 5 micrograms lead per deciliter of blood) was 0.4%, compared with 8.6% in 1999–2002 and 25.6% in 1988–1994. (PHY4)
- In 2021, 39% of U.S. households (both owners and renters) with children had one or more of three housing problems: physically inadequate housing, crowded housing, or housing cost burden greater than 30% of household income. This was not statistically significantly different from 2019. (PHY5)
- In 2021, the rate at which youth were victims of serious violent crimes was 4 per 1,000 youth ages 12–17. (PHY6)
- In 2019–2020, falls were the leading cause of injury-related emergency department visits among children ages 1–4 (54 visits per 1,000 children) and among children ages 5–14 (28 visits per 1,000 children). (PHY7.A)
- In 2021, the leading injury-related cause of death among children ages 1–4 was drowning (3 per 100,000), whereas motor-vehicle-traffic-related injuries (2 per 100,000) were the leading injury-related cause of death among children ages 5–14. (PHY7.B)
- In 2019–2020, being struck by or against an object or person (25 visits per 1,000), motor vehicle traffic-related injuries (21 visits per 1,000), and falls (20 visits per 1,000) were the leading causes of injury-related emergency department visits among adolescents ages 15–19. (PHY8.A)
- In 2021, unintentional injuries—the leading cause of injury-related death among adolescents ages 15–19—was 24 per 100,000, up from 22 per 100,000 in 2020. Among males, death rates for homicide (22 per 100,000) were higher than suicide (16 per 100,000). Among females, death rates for suicide (5 per 100,000) were higher than homicide (4 per 100,000). (PHY8.C)

Behavior

- In 2022, the percentages of students who reported smoking cigarettes daily in the past 30 days continued to be at historically low levels, with 0.3% of 8th-, 1% of 10th-, and 2% of 12th-grade students reporting use. (BEH1)
- Youth binge drinking rates remained steady among 8th, 10th, and 12th graders from 2021 to 2022. (BEH2)
- In 2022, illicit drug use in the past 30 days was reported by 7% of 8th graders, 13% of 10th graders, and 22% of 12th graders. The estimates did not significantly change from 2021. Marijuana continues to be the main driver of trends in illicit drug use. (BEH3.A)
- In 2022, marijuana use in the past 30 days was reported by 5% of 8th-, 12% of 10th-, and 20% of 12th-grade students. The percentages remained steady compared with those in 2021. (BEH3.B)
- The percentage of students reporting ever having had sexual intercourse declined from 54% in 1991 to 46% in 2001 and was relatively stable through 2013 (47%) before decreasing to 30% in 2021. (BEH4)
- In 2021, the serious violent crime offending rate was 5 crimes per 1,000 youth ages 12–17; there were 122,900 serious violent crimes involving youth. (BEH5)

Education

- Approximately 85% of children ages 3–5 who were not yet in kindergarten were read to three or more times per week by a family member in 2019. This rate was higher than the rate in 1993 (78%), although it fluctuated in the intervening years. (ED1)
- At both Grades 4 and 8, the average mathematics scores in 2022 were higher than in 1990, but the Grade 4 and Grade 8 2022 average mathematics scores in 2022 were lower than in 2019. (ED2.AB)
- At Grades 4 and 8, the average reading scores in 2022 were lower than the scores in 2019 and not measurably different from the scores in 1992. (ED2.C)
- In 2017–18, about 23% of public high school students were enrolled in geometry, 20% were enrolled in algebra II, 16% were enrolled in advanced mathematics, 5% were enrolled in calculus, and 5% were enrolled in Advanced Placement mathematics. (ED3)
- In 2017–18, about 30% of public high school students were enrolled in biology, 20% were enrolled in chemistry, 11% percent were enrolled in physics, and 6% percent were enrolled in Advanced Placement science. (ED3)

- In 2021, some 94% of young adults ages 18–24 had completed high school with a diploma or an alternative credential such as a General Educational Development (GED) certificate. The high school completion rate has increased since 2000, when it was 86%. (ED4)
- In 2022, 9% of youth ages 16–19 were neither enrolled in school nor working, little changed from the prior year. (ED5)
- During the 2021–22 school year, 20% of youth ages 16 to 19 were both enrolled in school and employed. Young women were more likely to be employed and enrolled in school (23%) than were young men (18%). The proportion of youth both enrolled in school and employed is about 2.0 percentage points higher than in 2010. (ED5)
- In the 2021–22 school year, 60% of youth ages 16 to 19 were enrolled in school and not employed, while 20% of youth were both enrolled in school and employed. (ED5)
- In 2021, some 62% of high school completers enrolled in a 2-year or 4-year college in the fall immediately following their graduation from high school. (ED6)

Health

- In 2021, 10.5% of infants were born preterm, slightly higher than the percentage in 2011 (9.8%). (HEALTH1.A)
- In 2021, 9% of infants were born with low birthweight. Infants of Black, non-Hispanic women were the most likely to have low birthweight (15%) compared with infants of Native Hawaiian or Other Pacific Islander, non-Hispanic (9%); Asian, non-Hispanic (9%); American Indian or Alaska Native, non-Hispanic (8%); Hispanic (8%); and White, non-Hispanic (7%) women. (HEALTH1.B)
- Despite the decline in infant mortality rates from 2010 (6 per 1,000) to 2020 (5 per 1,000), racial and ethnic disparities persist. In 2020, infant mortality rates were highest for infants born to Black, non-Hispanic mothers (10 per 1,000) and lowest for infants born to Asian, non-Hispanic mothers (3 per 1,000). (HEALTH2)
- In 2019, 6% of parents reported that their child ages 4–17 had serious emotional or behavioral difficulties. Parents were more likely to report serious emotional or behavioral difficulties for boys (7%) than for girls (4%). (HEALTH3)
- In 2019, 4 out of 10 children ages 4–17 with serious emotional or behavioral difficulties used special education services for an emotional or behavioral problem. (HEALTH3)
- In 2021, more than 1 in 5 adolescents experienced a major depressive episode (MDE) in the past year, including nearly 30% of adolescent girls. (HEALTH4)

-
- In 2020–2021, 12.7% of children ages 5–17 had disability. Children with family incomes below poverty (18%) and those with family incomes at 100%–199% of the poverty level (15%) were more likely to report disability than children with family incomes at or above 200% of the poverty level (11%). (HEALTH5)
 - During 2019–2020, overall the total diets of children and adolescents did not align with the 2015–2020 Dietary Guidelines for Americans. (HEALTH6)
 - In 2017–March 2020, 21% of children ages 6–11 and 22% of adolescents ages 12–17 had obesity. (HEALTH7)
 - In 2021, among children ages 0–17, 6% of children were reported to currently have asthma, and 3% of children had one or more asthma attacks in the past year. (HEALTH8)
 - In 2021, 13% of Black, non-Hispanic children were reported to currently have asthma compared with 5% of Hispanic; 6% of White, non-Hispanic; and 3% of Asian, non-Hispanic children. (HEALTH8)

America's Children at a Glance

	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
Demographic Background			
Child population^a			
Children ages 0–17 in the United States	72.8 million (2021)	72.5 million (2022)	↓
Children as a percentage of the population^a			
Children ages 0–17 in the United States	21.9% (2021)	21.7% (2022)	↓
Racial and ethnic composition^a			
Children ages 0–17 by race and Hispanic origin ^b			
White, non-Hispanic	49.3% (2021)	48.8% (2022)	↓
Black, non-Hispanic	13.8% (2021)	13.9% (2022)	↑
American Indian or Alaska Native, non-Hispanic	0.8% (2021)	0.8% (2022)	NS
Asian, non-Hispanic	5.5% (2021)	5.6% (2022)	↑
Native Hawaiian or Other Pacific Islander, non-Hispanic	0.2% (2021)	0.2% (2022)	NS
Two or more races, non-Hispanic	4.7% (2021)	4.8% (2022)	↑
Hispanic	25.7% (2021)	26.0% (2022)	↑
Family and Social Environment			
Family structure and children's living arrangements			
Children ages 0–17 living with two married parents	65% (2021)	65% (2022)	NS
Births to unmarried women			
Births to unmarried women ages 15–44	38.6 per 1,000 (2020)	37.8 per 1,000 (2021)	↓
Births to unmarried women among all births	41% (2020)	41% (2021)	NS
Child care			
Children ages 3–5, not yet enrolled in kindergarten with employed mothers, whose primary child care arrangement was nonparental care on a regular basis	85% (2016)	86% (2019)	NS
Children ages 3–5, not yet enrolled in kindergarten with employed mothers, who were in center-based care arrangements for any amount of time	70% (2016)	69% (2019)	NS
Children of at least one foreign-born parent			
Children ages 0–17 living with at least one foreign-born parent	25.4% (2020)	25.6% (2022)	NS
Language spoken at home and difficulty speaking English			
Children ages 5–17 who speak a language other than English at home	23% (2019)	21% (2021)	↓
Children ages 5–17 who speak a language other than English at home and who have difficulty speaking English	4% (2019)	5% (2021)	↑
Adolescent births			
Births to females ages 15–17	6.3 per 1,000 (2020)	5.7 per 1,000 (2021)	↓
Child maltreatment^a			
Substantiated reports of maltreatment of children ages 0–17	8.4 per 1,000 (2020)	8.1 per 1,000 (2021)	↓

See notes at end of table.

Legend:

NS = No statistically significant change

↑ = Statistically significant increase

↓ = Statistically significant decrease

	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
Economic Circumstances			
Child poverty and family income			
Children ages 0–17 in poverty	16.0% (2020)	15.3% (2021)	↓
Children living below 50% of the poverty threshold	7.6% (2020)	7.2% (2021)	NS
Secure parental employment			
Children ages 0–17 living with at least one parent employed year-round, full-time	71.7% (2020)	77.2% (2021)	↑
Food insecurity			
Children ages 0–17 in households classified by the USDA as “food insecure”	16% (2020)	13% (2021)	↓
Health Care			
Health insurance coverage			
Children ages 0–17 who were uninsured at the time of interview	5% (2020)	4% (2021)	NS
Usual source of health care			
Children ages 0–17 with no usual source of health care	2% (2020)	3% (2021)	NS
Immunization			
Children who completed the combined 7-vaccine series by age 24 months	70% (2017) ^c	70% (2018) ^c	NS
Oral health			
Children ages 5–17 with a dental visit in the past year	91% (2019)	89% (2020)	↓
Physical Environment and Safety			
Outdoor air quality			
Children ages 0–17 living in counties with pollutant concentrations above the levels of the current air quality standards	50% (2019)	59% (2021)	NS
Secondhand smoke			
Children ages 4–11 with any detectable blood cotinine level, a measure for recent exposure to secondhand smoke	37% (2015–2016)	36% (2017–March 2020)	NS
Drinking water quality			
Children served by community water systems that did not meet all applicable health-based drinking water standards	7% (2019)	7% (2021)	NS
Lead in the blood of children			
Children ages 1–5 with blood lead greater than or equal to 5 µg/dL	0.9% (2013–2016)	0.4% (2017–March 2020)	NS
Housing problems			
Households with children ages 0–17 reporting housing cost burden, crowding, and/or physically inadequate housing	38% (2019)	39% (2021)	NS
Youth victims of serious violent crimes^d			
Serious violent crime victimization of youth ages 12–17	4 per 1,000 (2020)	4 per 1,000 (2021)	NS

See notes at end of table.

Legend:	NS = No statistically significant change	↑ = Statistically significant increase	↓ = Statistically significant decrease
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	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
Physical Environment and Safety— cont.			
Child injury and mortality			
Injury deaths of children ages 1–4	10 per 100,000 (2020)	11 per 100,000 (2021)	↑
Injury deaths of children ages 5–14	6.6 per 100,000 (2020)	7 per 100,000 (2021)	↑
Adolescent injury and mortality			
Injury deaths of adolescents ages 15–19	46 per 100,000 (2020)	48 per 100,000 (2021)	↑
Behavior			
Regular cigarette smoking			
Students who reported smoking daily in the past 30 days			
8th grade	0.4% (2021)	0.3% (2022)	NS
10th grade	1% (2021)	1% (2022)	NS
12th grade	2% (2021)	2% (2022)	NS
Alcohol use			
Students who reported having 5 or more alcoholic beverages in a row in the past 2 weeks			
8th grade	3% (2021)	2% (2022)	NS
10th grade	6% (2021)	6% (2022)	NS
12th grade	12% (2021)	13% (2022)	NS
Illicit drug use			
Students who reported using illicit drugs in the past 30 days			
8th grade	6% (2021)	7% (2022)	NS
10th grade	11% (2021)	13% (2022)	NS
12th grade	21% (2021)	22% (2022)	NS
Sexual activity			
High school students who reported ever having had sexual intercourse	38% (2019)	30% (2021)	↓
Youth perpetrators of serious violent crimes^d			
Youth offenders ages 12–17 involved in serious violent crimes	4 per 1,000 (2020)	5 per 1,000 (2021)	NS
Education			
Family reading to young children			
Children ages 3–5 who were read to 3 or more times in the last week	81% (2016)	85% (2019)	↑

See notes at end of table.

Legend: NS = No statistically significant change

↑ = Statistically significant increase

↓ = Statistically significant decrease

	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
Education — cont.			
Mathematics and reading achievement			
Average mathematics scale score of			
4th graders (0–500 scale)	241 (2019)	236 (2022)	↓
8th graders (0–500 scale)	282 (2019)	274 (2022)	↓
12th graders (0–300 scale)	152 (2015)	150 (2019)	NS
Average reading scale score of			
4th graders (0–500 scale)	220 (2019)	217 (2022)	↓
8th graders (0–500 scale)	263 (2019)	260 (2022)	↓
12th graders (0–500 scale)	287 (2015)	285 (2019)	↓
High School Completion			
Young adults ages 18–24 who have completed high school	94% (2020)	94% (2021)	NS
Youth neither enrolled in school^e nor working			
Youth ages 16–19 who are neither enrolled in school nor working	9% (2021)	9% (2022)	NS
College enrollment			
Recent high school completers enrolled in college the October immediately after completing high school	63% (2020)	62% (2021)	NS
Health			
Preterm birth and low birthweight			
Infants less than 37 completed weeks of gestation at birth	10.1% (2020)	10.5% (2021)	↑
Infants weighing less than 5 lb 8 oz at birth	8% (2020)	9% (2021)	↑
Infant mortality			
Deaths before first birthday	6 per 1,000 (2019)	5 per 1,000 (2020)	↓
Emotional and behavioral difficulties			
Children ages 4–17 reported by a parent to have serious difficulties with emotions, concentration, behavior, or getting along with other people	6% (2018)	6%* (2019)	NS
Obesity			
Children ages 6–17 with obesity	20% (2011–2014)	21% (2017–March 2020)	NS
Asthma			
Children ages 0–17 who currently have asthma	7% (2019)	6% (2021)	NS

*Caution: Due to survey redesign, 2019 estimates should not be compared with data from earlier years.

^a These population estimates are not sample derived and thus not subject to statistical testing. Change between years identifies differences in the proportionate size of these estimates.

^b Percentages may not sum to 100 because of rounding.

^c Data years refer to birth years of children receiving vaccinations.

^d The 2020 National Crime Victimization Survey (NCVS) weights include an additional adjustment to address the impact of modified field operations due to COVID-19. For more information on the weighting adjustments applied in 2020, see the Source and Accuracy Statement for the 2020 NCVS in the NCVS 2020 Codebook (<https://www.icpsr.umich.edu/web/INACID/studies/38090/summary>) and *Criminal Victimization, 2020* (NCJ 301775, BJS, October 2021).

^e School refers to high school and college.

Legend: NS = No statistically significant change

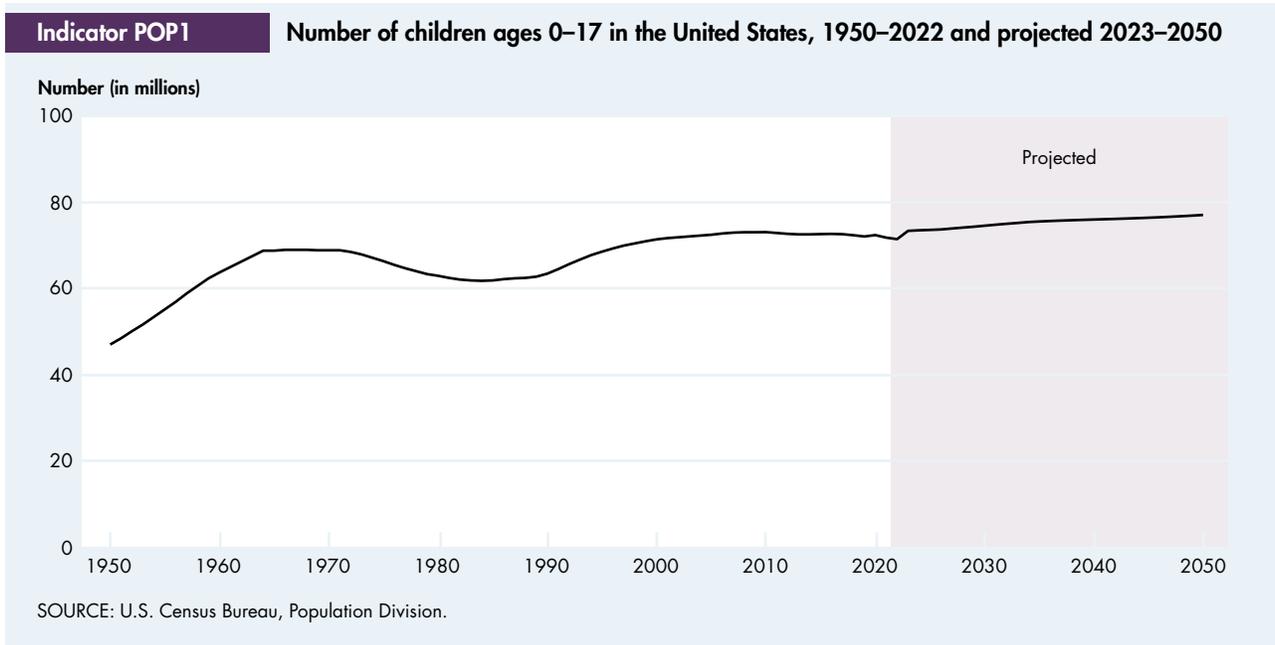
↑ = Statistically significant increase

↓ = Statistically significant decrease

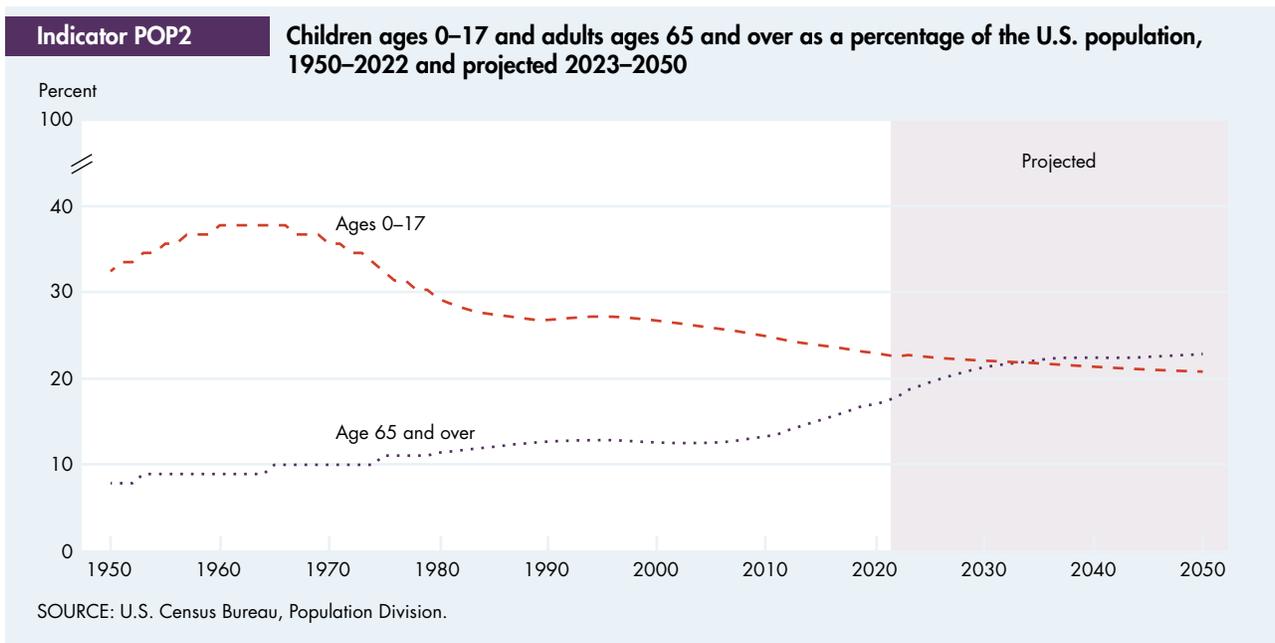
Demographic Background

Understanding the changing demographic characteristics of America’s children is critical for shaping social programs and policies. The number of children determines the demand for schools, health care, and other social services that are essential for meeting the daily needs of families. While the number of children living in the United States has grown, the ratio of children to adults has decreased. At the same time, the racial and ethnic composition of the Nation’s children continues to change. Demographic composition provides an important context for understanding the indicators presented in this report and provides a glimpse of future American families.

There were 72.5 million children in the United States in 2022, which was 0.4 million less than in 2021. The total number of children is projected to increase to 78.2 million in 2050. In 2022 (the latest year of data available at the time of publication), there were fewer children in the 0–5 age group (22.4 million) than in the 6–11 age group (24.2 million) or the 12–17 age group (25.8 million).

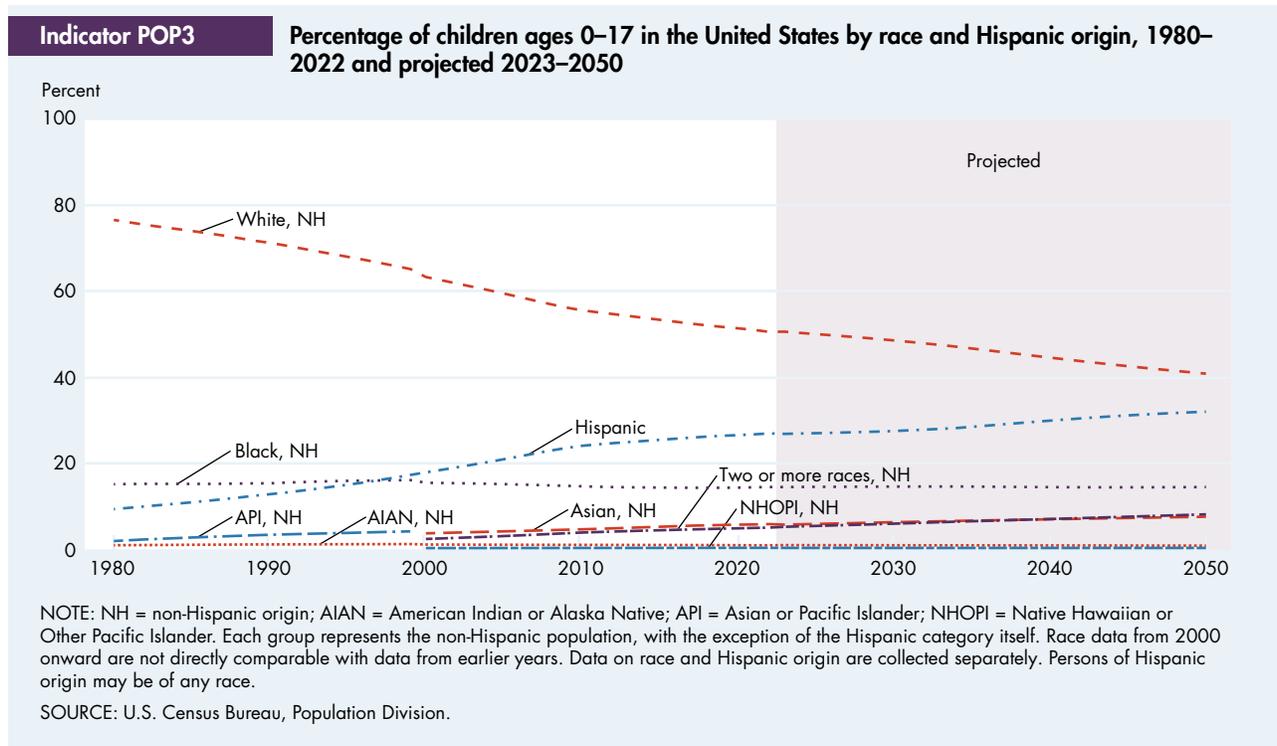


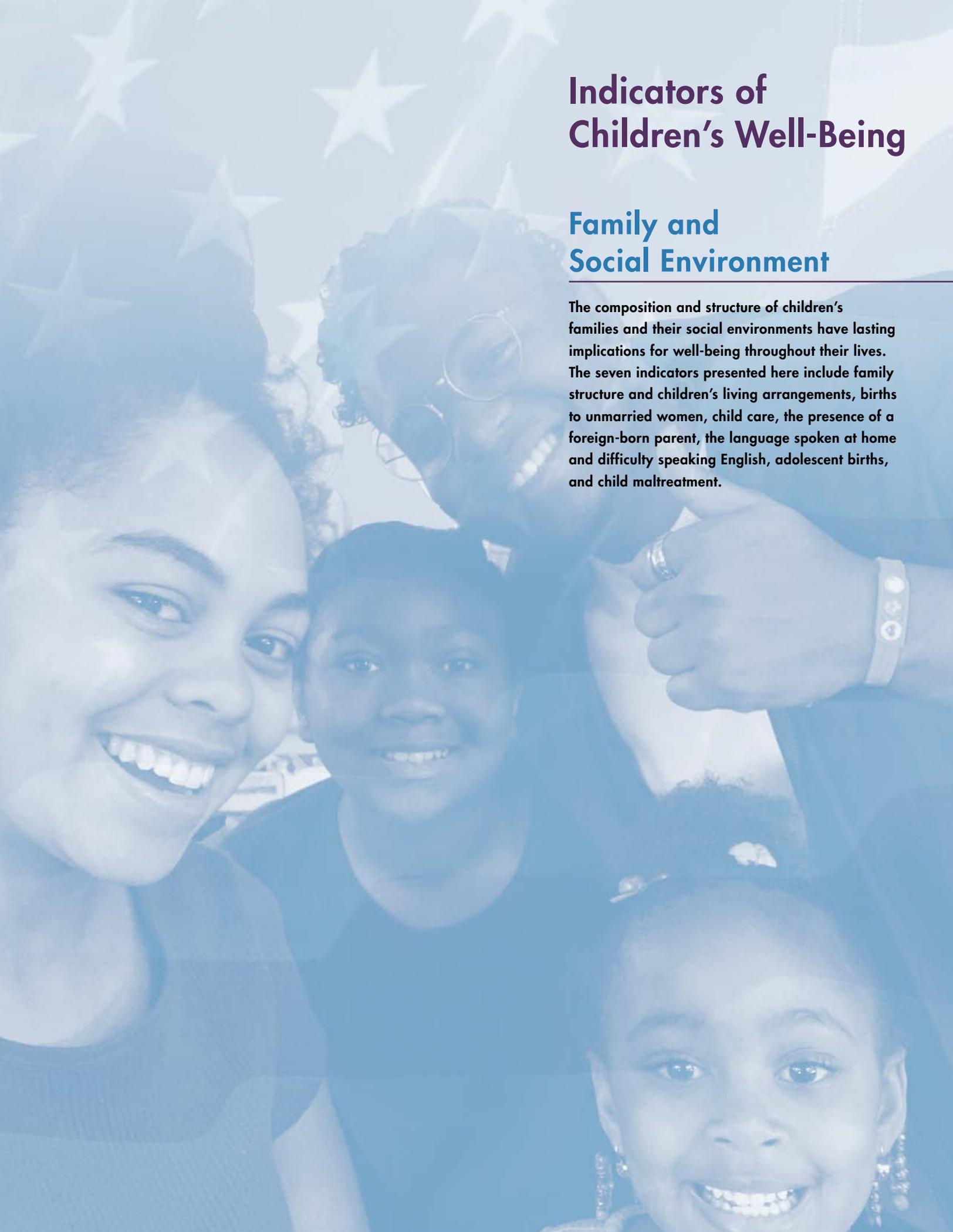
Since the mid-1960s, children have decreased as a proportion of the total U.S. population. In 2022, children made up 22% of the population, down from a peak of 36% at the end of the Baby Boom, in 1964. Children’s share of the population is projected to continue its slow decline through 2050, when children are projected to make up 20% of the population.



Racial and ethnic diversity has grown dramatically in the United States in the last 3 decades. This growth was first evident among children. In 2022, 49% of U.S. children were White, non-Hispanic; 26% were Hispanic; 14% were Black, non-Hispanic; 6% were Asian, non-Hispanic; and 6% were non-Hispanic “All other races.”

This population is projected to become even more diverse in the decades to come. Whereas the percentages of children in most of the other racial and ethnic origin groups have declined, the percentage of children who are Hispanic has grown substantially, increasing from 9% of the child population in 1980 to 26% in 2022. In 2030, less than half of all children are projected to be White, non-Hispanic. By 2050, it is projected that 39% of all children will be White, non-Hispanic; 31% will be Hispanic; 14% will be Black, non-Hispanic; 7% will be Asian, non-Hispanic; and 9% will be non-Hispanic “All other races.”





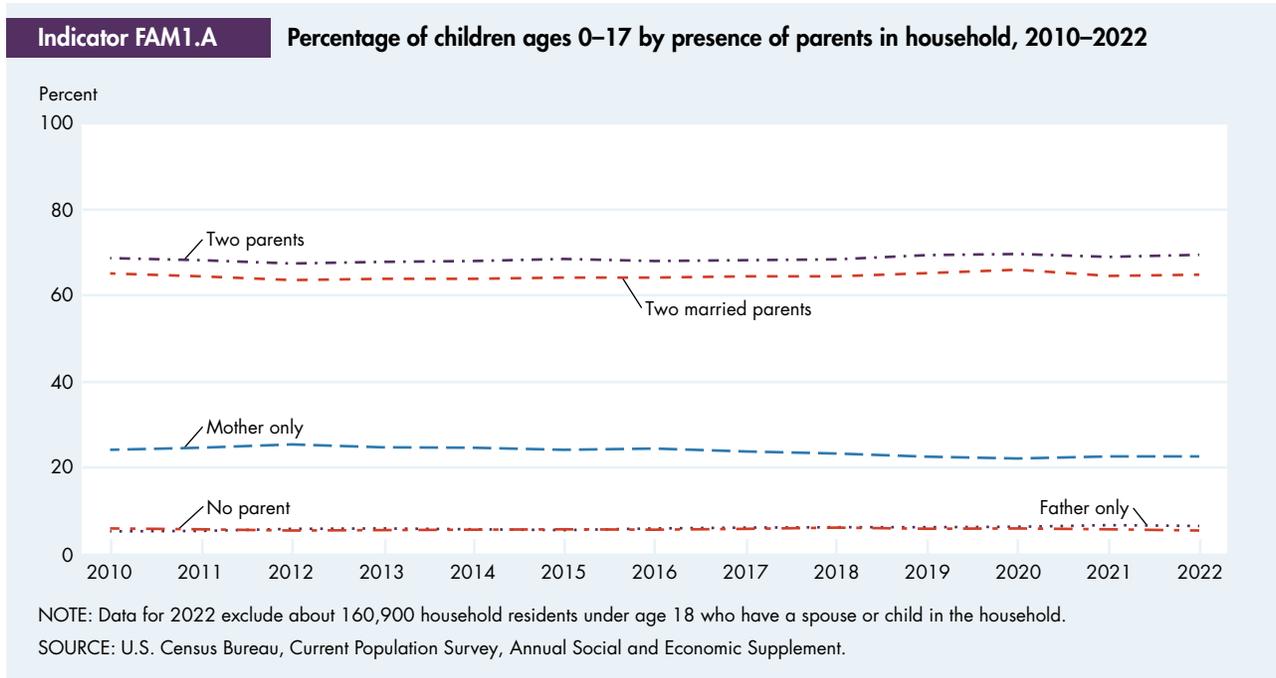
Indicators of Children's Well-Being

Family and Social Environment

The composition and structure of children's families and their social environments have lasting implications for well-being throughout their lives. The seven indicators presented here include family structure and children's living arrangements, births to unmarried women, child care, the presence of a foreign-born parent, the language spoken at home and difficulty speaking English, adolescent births, and child maltreatment.

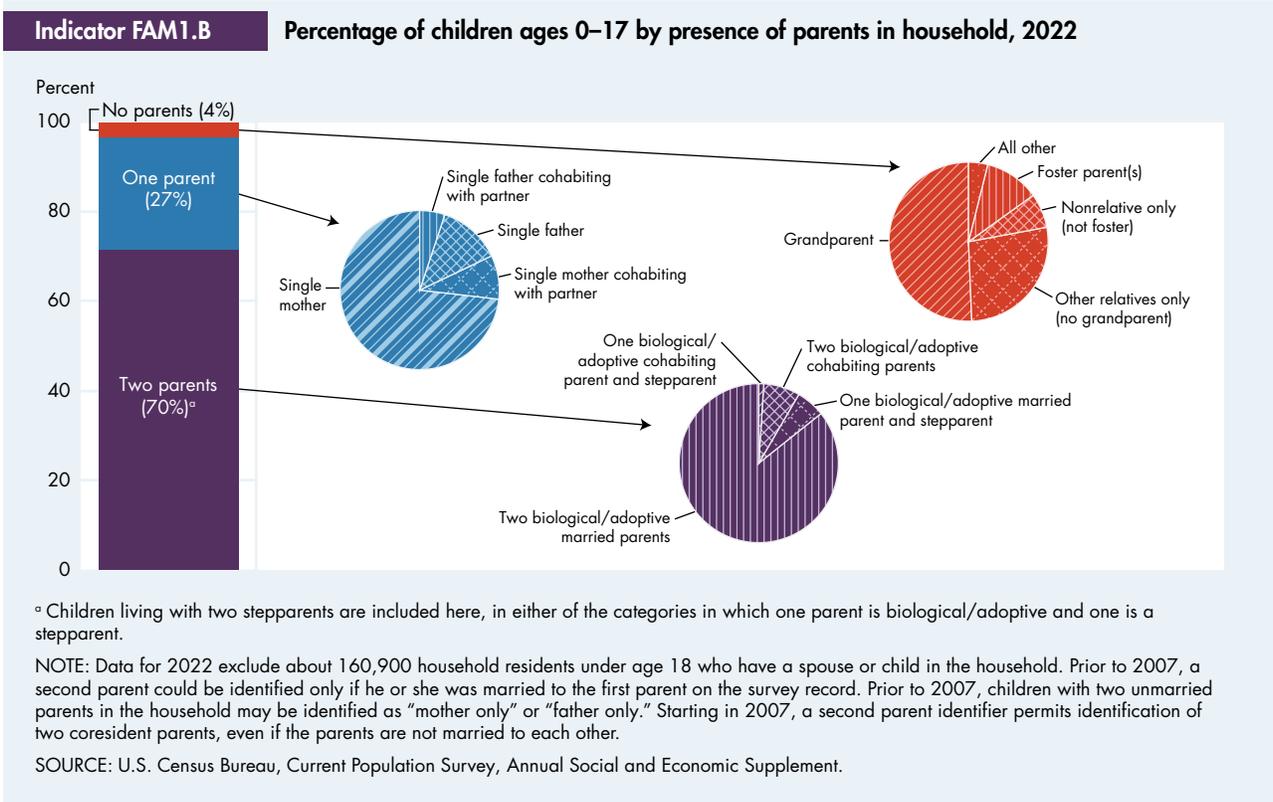
Family Structure and Children’s Living Arrangements

The composition of families is dynamic and has implications for critical parental and economic resources as well as a child’s health and overall well-being.¹ Family structure has changed over time, with more parents cohabiting and a growing share of children living with a parent who is unmarried.² Examining the ongoing complexities of family structures and living arrangements provides useful insight for assessing children’s well-being.



- Sixty-five percent of children ages 0–17 lived with two married parents in 2022.
- In 2022, 22% of children lived with their mothers only, 5% lived with their fathers only, and 4% lived with neither of their parents.
- Five percent of all children lived with two cohabiting parents in 2022.³
- Seventy-five percent of White-alone, non-Hispanic children lived with two married parents in 2022 compared with 60% of Hispanic and 38% of Black-alone children.⁴

While the majority of children live with two parents, many children have other living arrangements. Information about detailed parental relationships and the presence of other adults in the household, such as unmarried partners, grandparents, and other relatives, is important for understanding children’s social, economic, and developmental well-being.



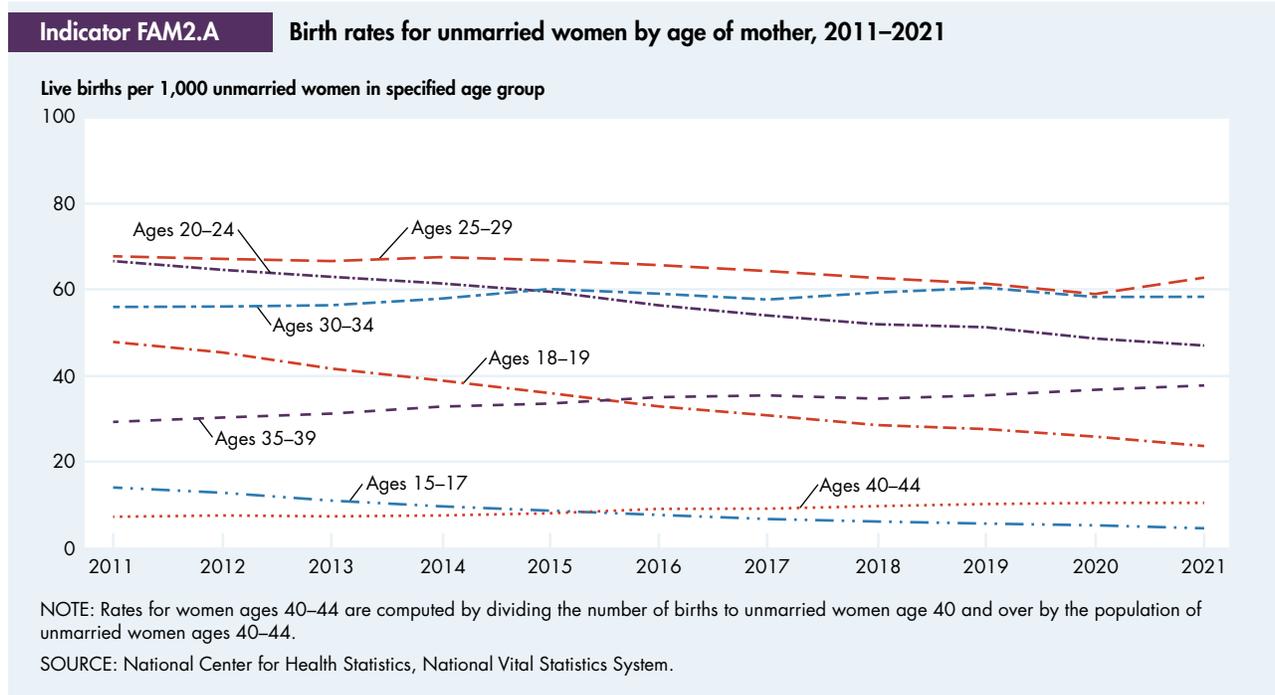
- In 2022, 70% of children ages 0–17 lived with two parents (65% with two married parents and 5% with two unmarried cohabiting parents), 22% lived with their mothers only, 5% lived with their fathers only, and 4% lived with no parent.⁵
- Among children living with two parents, 92% lived with both of their biological or adoptive parents, and 8% lived with a stepparent.⁶

- About 6% of children who lived with two biological or adoptive parents had parents who were not married.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

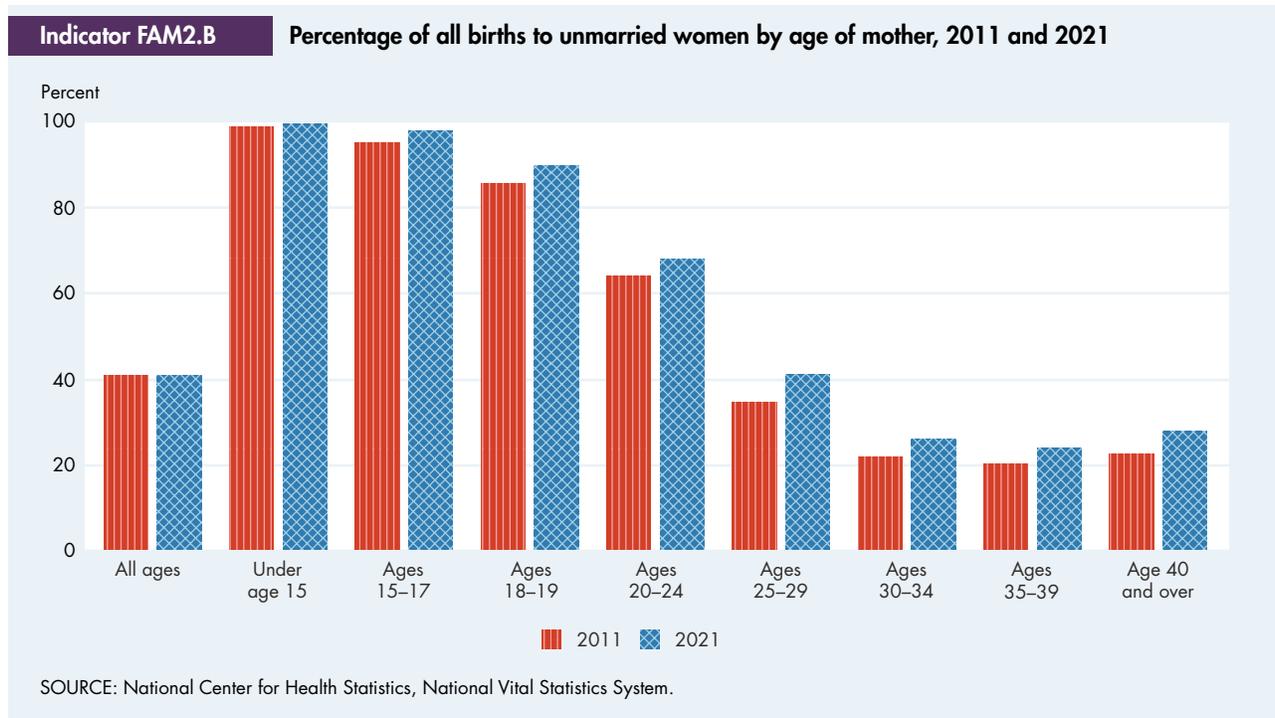
Births to Unmarried Women

The birth rate among unmarried women has increased since 1980; recent increases, however, are attributable primarily to increased births to cohabitating mothers rather than to single, unpartnered mothers.⁷ Moreover, the demography of unmarried births has changed over the past 40 years. Unmarried births to younger mothers, particularly teens, have declined, whereas births to older mothers, including first births, have increased.⁸ However, it is important to continue to track outcomes of unmarried births as differences in racial and ethnic, economic, and other key demographic factors between births to unmarried compared with married women persist. Historically, children of unmarried mothers are at a higher risk of adverse birth outcomes, such as low birthweight, preterm birth, and infant mortality, compared with children of married mothers.^{7,9}



- In 2021, the birth rate for unmarried women ages 15–44 was 38 births for every 1,000 unmarried women. The rate was highest for unmarried women ages 25–29 (63 per 1,000), followed by women ages 30–34 (59 per 1,000), 20–24 (47 per 1,000), 35–39 (38 per 1,000), 18–19 (24 per 1,000), 40–44 (11 per 1,000), and 15–17 (6 per 1,000).
- From 2011 to 2021, birth rates for unmarried women under age 30 decreased, whereas birth rates for unmarried women age 30 and over increased.

The proportion of births to unmarried women is useful for understanding the extent to which children born in a given year may be affected by any disadvantage—social, financial, or health—associated with being born outside of marriage. The change in the percentage of births to unmarried women reflects both changes in the birth rate for unmarried women relative to the birth rate for married women and changes in the percentage of women of childbearing age who are unmarried.¹⁰

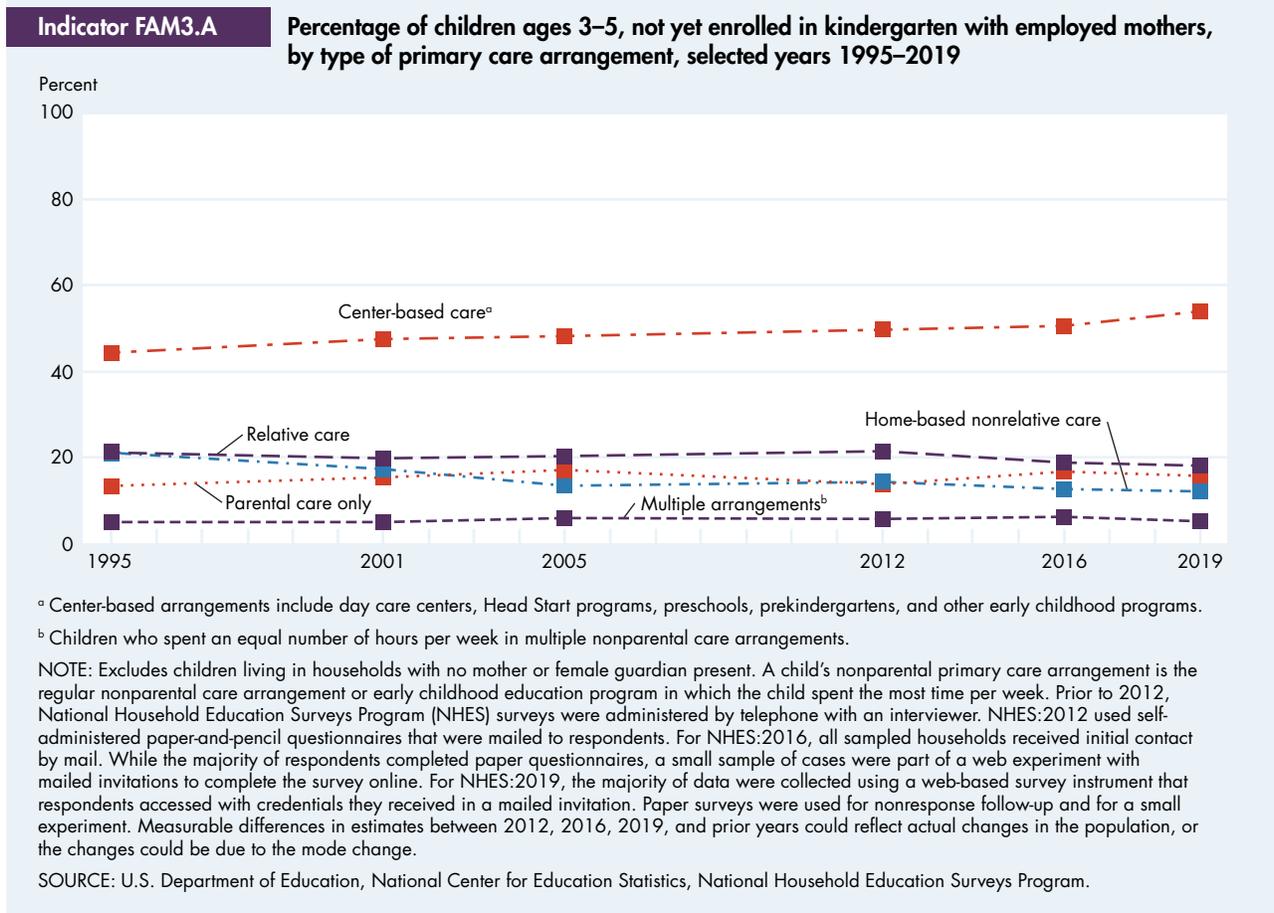


- The percentage of births to unmarried women of all ages decreased from 41% in 2011 to 40% in 2018 and then remained stable through 2021 at 41%.
- The percentage of births to unmarried women among adolescents ages 15–17 increased from 95% in 2011 to 98% in 2021; this percentage increased from 86% in 2011 to 90% in 2021 among women ages 18–19.
- Among women in their 20s, the percentage of births to unmarried women increased during the period. This percentage increased from 64% in 2011 to 68% in 2021 among women ages 20–24. For unmarried women ages 25–29, the percentage of births increased from 34% in 2011 to 41% in 2021.
- Among women age 30 and over, the percentage of births to unmarried women increased during the period. This percentage increased from 22% in 2011 to 26% in 2021 among women ages 30–34. For unmarried women ages 35–39, the percentage of births increased from 20% in 2011 to 24% in 2021. For unmarried women age 40 and over, the percentage of births increased from 22% in 2011 to 28% in 2021.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on [childstats.gov](https://www.childstats.gov).

Child Care

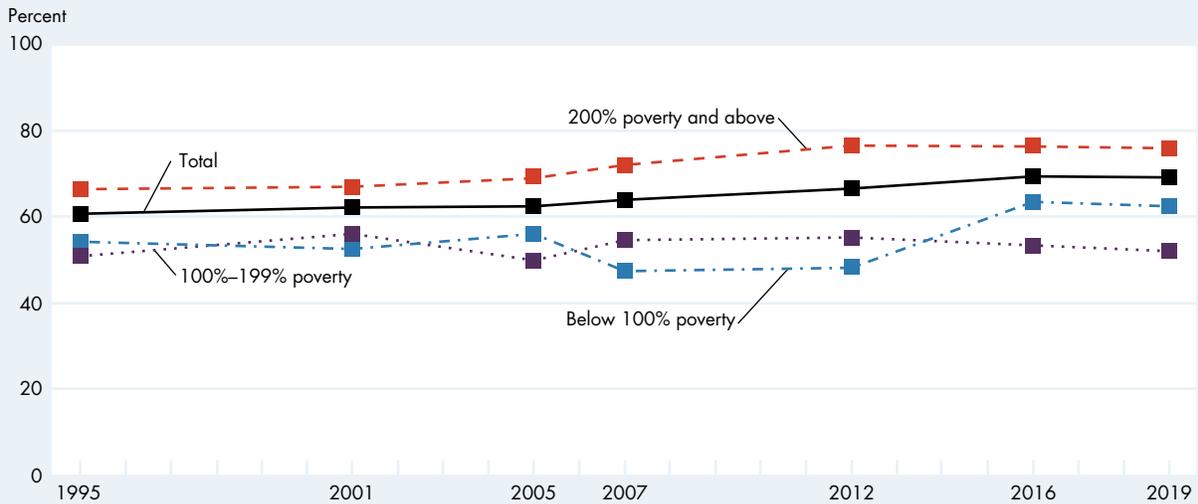
Many children spend time with a child care provider other than their parents. Alternative child care arrangements are particularly important for children ages 3–5 who are not yet enrolled in kindergarten and whose mothers are employed. Nonparental care can be provided in the home by relatives or nonrelatives or can be center-based care.



- In 2019, among children ages 3–5¹¹ who had employed mothers, 58% received center-based care¹² as their primary care arrangement.¹³ This percentage was higher than the corresponding percentages whose primary care arrangements were relative care (17%), home-based nonrelative care (10%), multiple nonparental care arrangements for equal amounts of time (2%), or only parental care (14%).
- For children ages 3–5 with employed mothers, a higher percentage in 2019 than in 1995 primarily received center-based care (58% versus 47%), while lower percentages in 2019 than in 1995 primarily received home-based nonrelative care (10% versus 20%) or relative care (17% versus 20%). There was no measurable difference between 1995 and 2019 in the percentages of children who had multiple nonparental care arrangements for equal amounts of time or only parental care as their primary care arrangement.

Indicator FAM3.B

Percentage of children ages 3–5, not yet enrolled in kindergarten with employed mothers, in center-based care arrangements for any amount of time by poverty status, selected years 1995–2019



NOTE: Excludes children living in households with no mother or female guardian present. Center-based programs included day care centers, prekindergartens, nursery schools, Head Start programs, and other early childhood education programs. Prior to 2012, National Household Education Surveys Program (NHES) surveys were administered via telephone with an interviewer. NHES:2012 used self-administered paper-and-pencil questionnaires that were mailed to respondents. For NHES:2016, all sampled households received initial contact by mail. While the majority of respondents completed paper questionnaires, a small sample of cases were part of a web experiment with mailed invitations to complete the survey online. For NHES:2019, the majority of data were collected using a web-based survey instrument that respondents accessed with credentials they received in a mailed invitation. Paper surveys were used for nonresponse follow-up and for a small experiment. Measurable differences in estimates between 2012, 2016, 2019, and prior years could reflect actual changes in the population, or the changes could be due to the mode change.

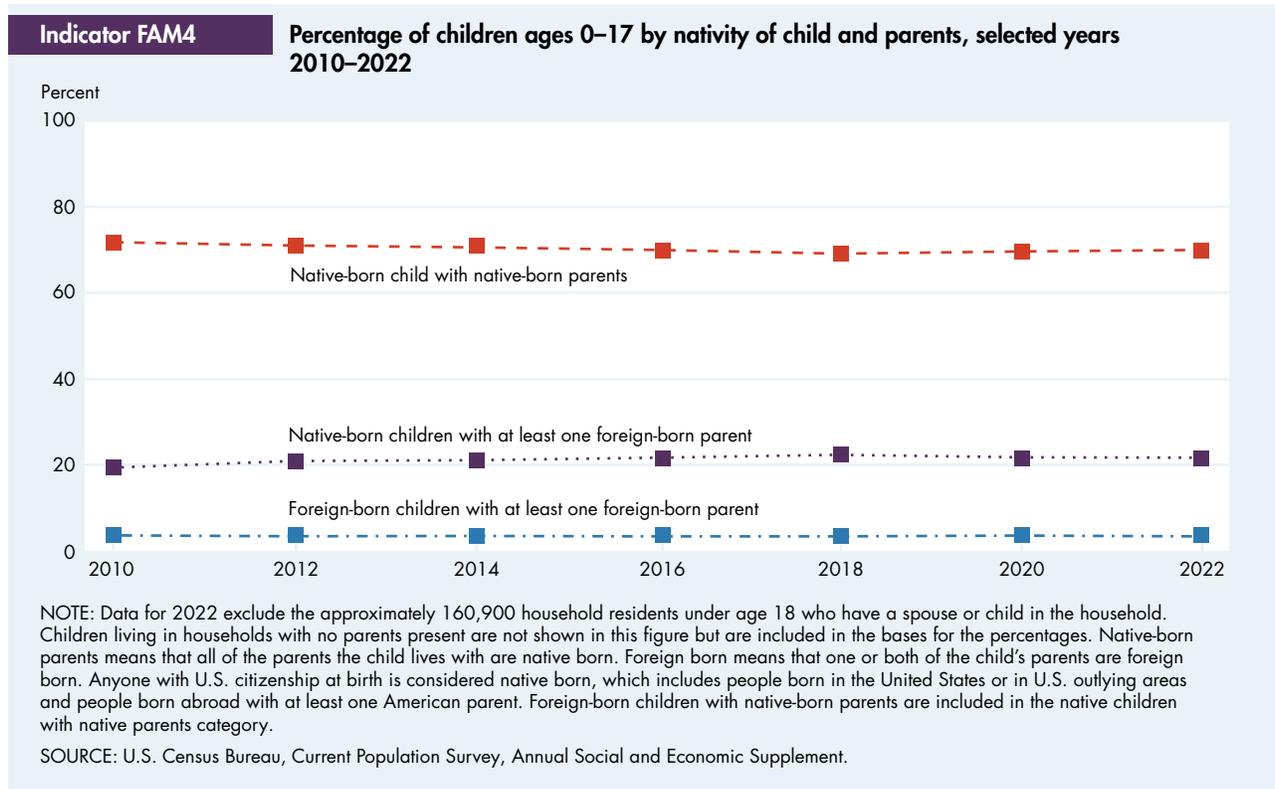
SOURCE: U.S. Department of Education, National Center for Education Statistics, National Household Education Surveys Program.

- In 2019, among children ages 3–5 with employed mothers, 69% were enrolled in center-based care for any amount of time. This percentage was higher than the corresponding percentage in 1995 (61%) but not measurably different from the percentage in 2016 (70%).
- In 2019, among children ages 3–5 with employed mothers, the percentage who were enrolled in center-based care was higher for those whose families had incomes at 200% or more of the poverty level (76%) than for those whose families had incomes below 100% of the poverty level (63%) and those whose families had incomes between 100% and 199% of the poverty level (52%).
- The percentage of children who were enrolled in center-based care was higher in 2019 than in 1995 for those whose families had incomes at 200% or more of the poverty level (76% versus 67%); for children whose families had incomes below 100% of the poverty level or between 100% and 199% of the poverty level, there was no measurable difference between 1995 and 2019 in the percentage who were enrolled in center-based care.
- Among children ages 3–5 with employed mothers, the percentage who were enrolled in center-based care in 2019 was higher for White, non-Hispanic children (75%) than for Hispanic children (64%). There were no measurable differences in the percentages of children enrolled in center-based care among other racial or ethnic groups.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Children of at Least One Foreign-Born Parent

The foreign-born population of the United States has grown since 1970.¹⁴ This increase in the past generation has largely been due to immigration from Latin America and Asia and has led to an expansion in the diversity of language and cultural backgrounds of children growing up in the United States.¹⁵ Potential language and cultural barriers confronting children and their foreign-born parents may make additional language resources at both school and home necessary for these children.¹⁶

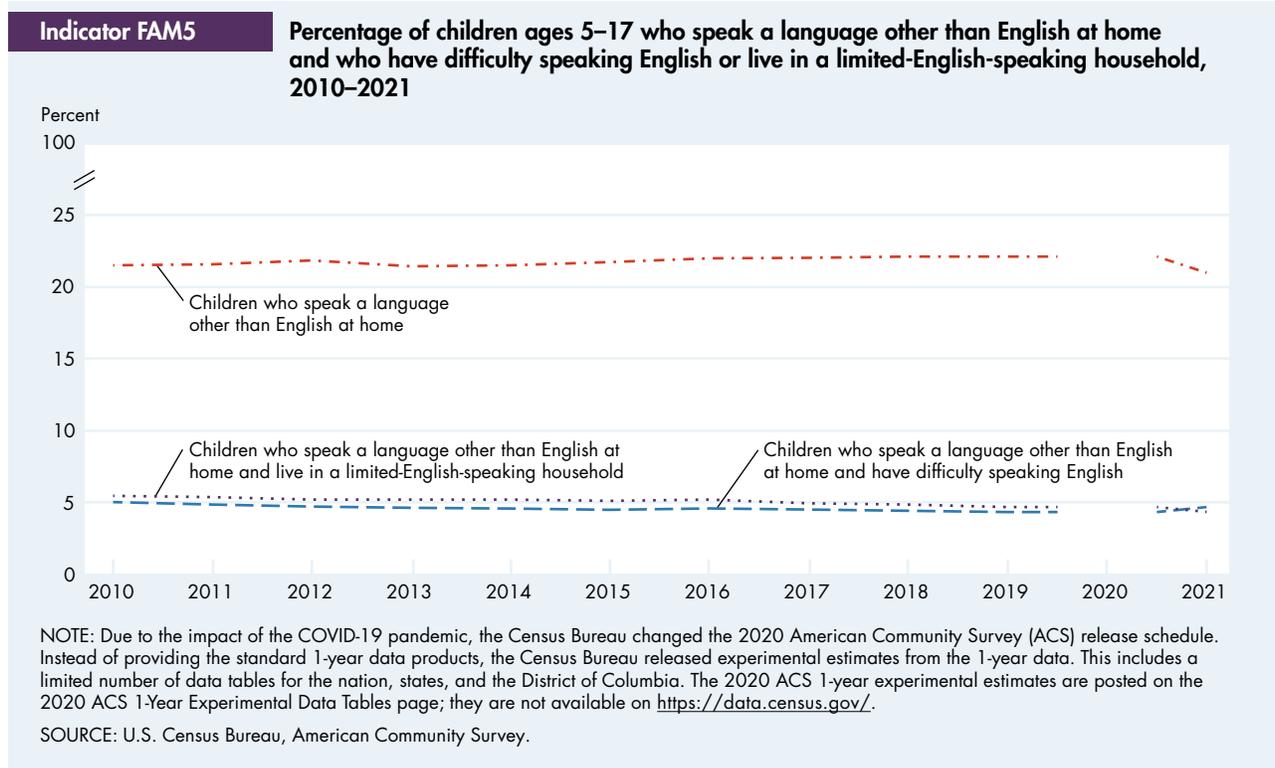


- In 2022, 22% of children were native born with at least one foreign-born parent, and 3% were foreign born with at least one foreign-born parent. Seventy-one percent of children were native born with native-born parents.
- The percentage of all children (native and foreign born) living in the United States with at least one foreign-born parent did not significantly change from 2020 (25.4%) to 2022 (25.6%).

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Language Spoken at Home and Difficulty Speaking English

Children who speak languages other than English at home and who also have difficulty speaking English¹⁷ may face greater challenges progressing in both school and the labor market. Once it is determined that a student speaks another language, school officials must, by law, evaluate the child’s facility with English and provide services such as special instruction to improve the child’s English, if needed. A limited-English-speaking household is a household in which no one age 14 or over speaks only English at home, and no one age 14 or over speaks a language other than English at home and speaks English “very well.”

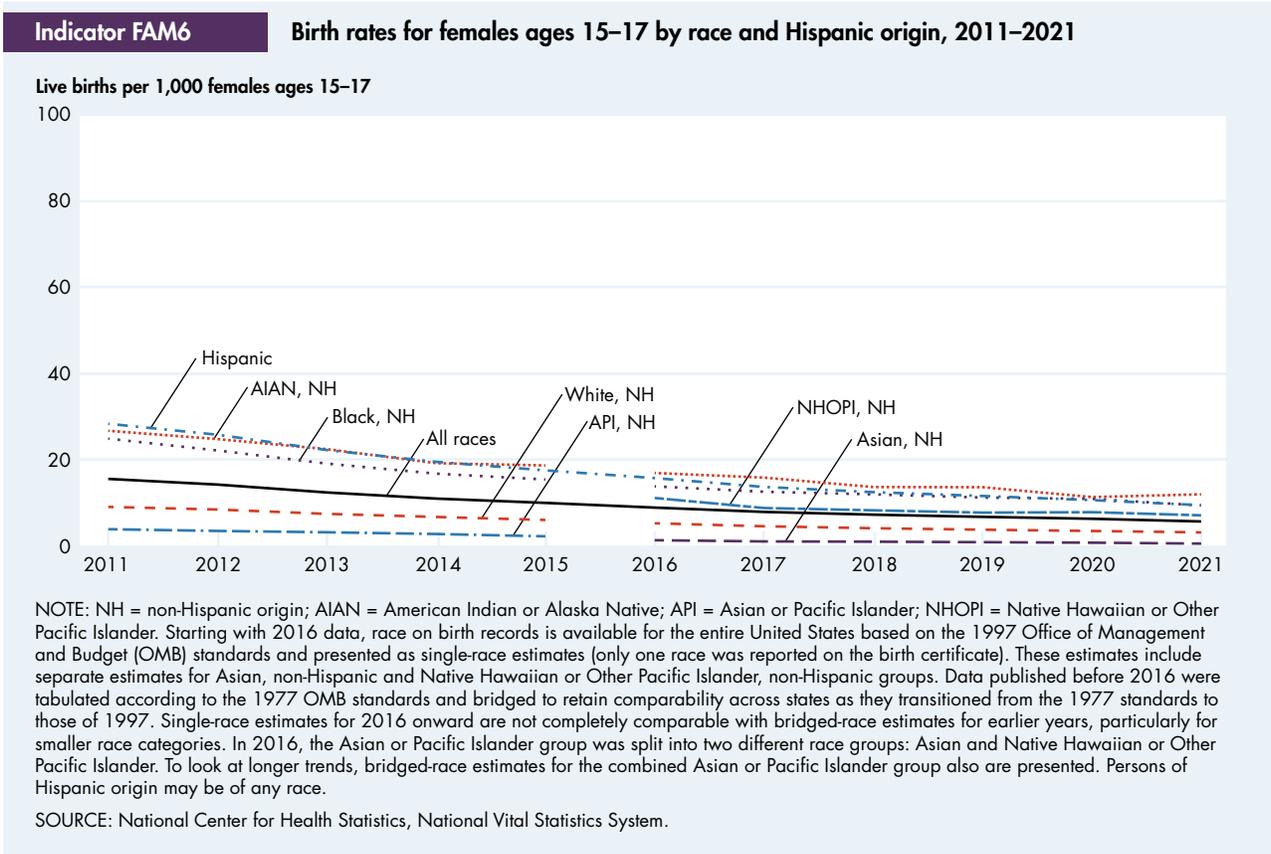


- In 2021, about 21% of school-age children spoke a language other than English at home, and 5% of school-age children both spoke a language other than English at home and had difficulty speaking English.
- The percentage of school-age children who spoke a language other than English at home decreased by 1 percentage point from 2010 to 2021, from about 22% to about 21%. At the same time, the number of school-age children who spoke a language other than English at home and had difficulty speaking English stayed roughly level, at about 5% in both 2010 and 2021.
- In 2010, about 6% of school-age children spoke a language other than English at home and lived in limited-English-speaking households. This percentage declined to about 5% in 2015 and declined again to about 4% in 2021.
- The percentage of school-age children who spoke a language other than English at home varied by region of the country in 2021, from a low of about 12% in the Midwest to a high of about 30% in the West.
- In 2021, the percentage of school-age children who had difficulty speaking English also varied by region, from a low of about 3% in the Midwest to a high of 6% in the West.
- Approximately 52% of school-age Asian-alone children and 56% of school-age Hispanic children spoke a language other than English at home in 2021 compared with about 6% of White-alone, non-Hispanic and about 7% of Black-alone, non-Hispanic school-age children.¹⁸
- In 2021, approximately 12% of school-age Asian-alone and 12% of school-age Hispanic children spoke another language at home and had difficulty speaking English compared with about 1% of White-alone, non-Hispanic and 1% of Black-alone, non-Hispanic school-age children.¹⁹

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Adolescent Births

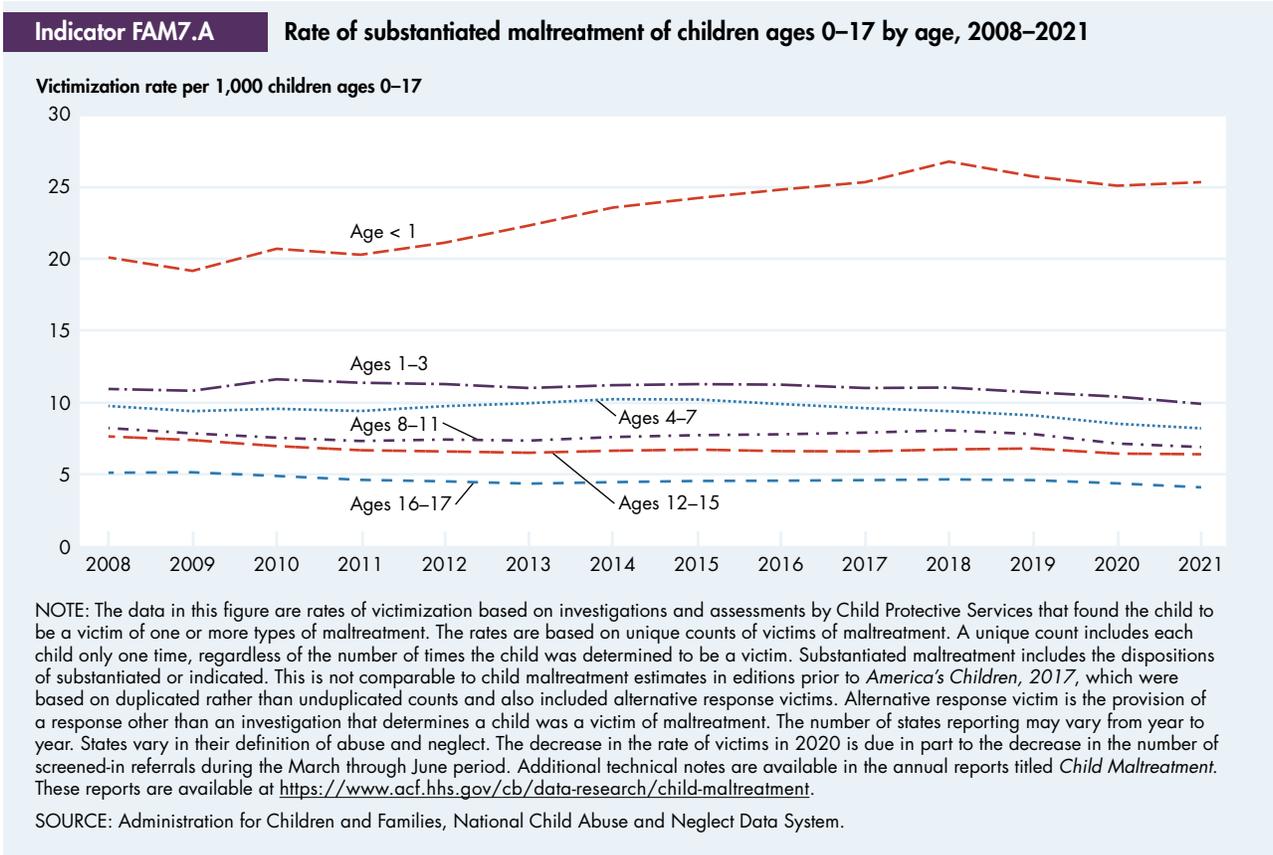
Childbirth during adolescence often is associated with long-term difficulties for both mother and child. Compared with babies born to older mothers, babies born to adolescent mothers, particularly younger adolescent mothers, are at higher risk for low birthweight and infant mortality.^{8,20,21} These babies 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.^{22,23} For the mothers, giving birth during adolescence is associated with limited educational attainment, which in turn can reduce employment prospects and earnings potential.^{22,23} Although adolescent birth rates for all racial and ethnic groups have been on a long-term decline since the late 1950s, birth rates historically have been higher for Hispanic and Black, non-Hispanic adolescents than for White, non-Hispanic adolescents.^{8,24}



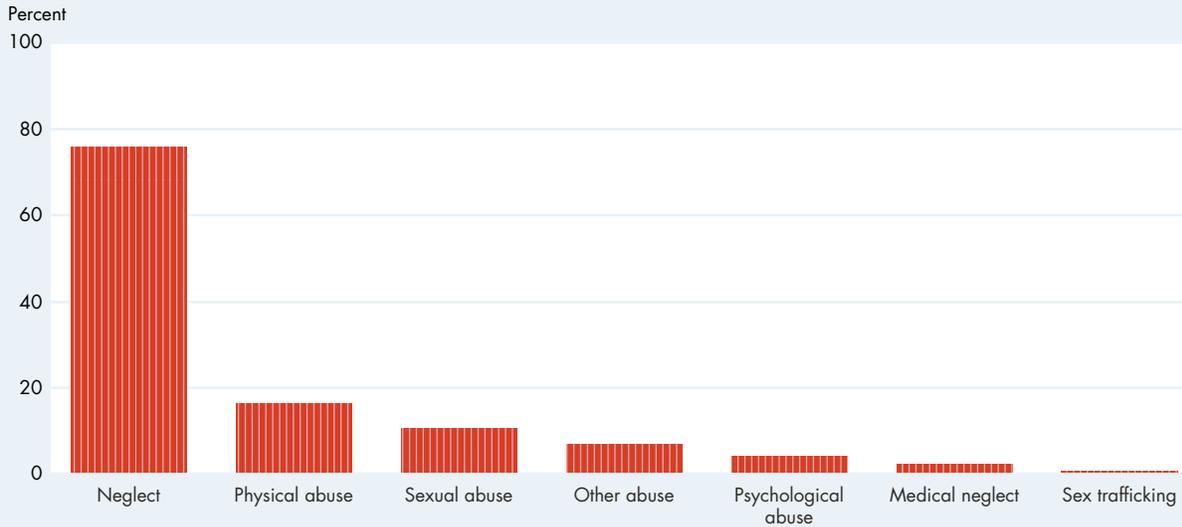
- The birth rate for females ages 15–17 declined from 15 per 1,000 in 2011 to 6 per 1,000 in 2021, a record low for the United States. This long-term downward trend was found for every race and Hispanic origin group during the period.
 - For White, non-Hispanic adolescents, the birth rate for females ages 15–17 decreased throughout the period, from 9 per 1,000 in 2011 to 3 per 1,000 in 2021.
 - For Black, non-Hispanic adolescents, the birth rate for females ages 15–17 decreased throughout the period, from 25 per 1,000 in 2011 to 9 per 1,000 in 2021.
 - For American Indian or Alaska Native, non-Hispanic adolescents, the birth rate for females ages 15–17 decreased throughout the period, from 26 per 1,000 in 2011 to 12 per 1,000 in 2019.
 - For Asian or Pacific Islander, non-Hispanic adolescents ages 15–17, the birth rate for females ages 15–17 decreased from 4 per 1,000 in 2011 to 2 per 1,000 in 2015. In 2021, the birth rates were 1 per 1,000 for Asian, non-Hispanic adolescents and 7 per 1,000 for Native Hawaiian or Other Pacific Islander, non-Hispanic adolescents.
 - For Hispanic adolescents ages 15–17, the birth rate for females ages 15–17 decreased throughout the period, from 28 per 1,000 in 2011 to 9 per 1,000 in 2021.
 - Despite the declines for each race and Hispanic origin group, substantial racial and ethnic disparities persisted. In 2021, American Indian or Alaska Native, non-Hispanic adolescents ages 15–17 had the highest birth rate (12 per 1,000); followed by Hispanic (9 per 1,000); Black, non-Hispanic (9 per 1,000); Native Hawaiian or Other Pacific Islander, non-Hispanic (7 per 1,000); White, non-Hispanic (3 per 1,000); and Asian, non-Hispanic (1 per 1,000) adolescents.
- Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on [childstats.gov](https://www.childstats.gov).*

Child Maltreatment

Child maltreatment includes physical, sexual, and psychological abuse, as well as neglect (including medical neglect). Maltreatment in general is associated with a number of negative outcomes for children, including developmental delay, lower school achievement, juvenile delinquency, substance abuse, and mental health problems. Many of these problems can follow maltreated children into adulthood.²⁵ Certain types of maltreatment can result in long-term physical, social, and emotional problems—even death. For example, abusive head trauma can result in visual, neurological, cognitive, behavioral, and sleep impairments, as well as special education needs.^{25,26} Please note that the calculation of child maltreatment was changed recently and is not comparable with data presented in editions prior to *America's Children, 2017*. Specifically, rates are now based on unduplicated counts, and alternative response victims are no longer included.



- The national rate of child maltreatment dropped from 9.1 to 8.1 per 1,000 children between 2017 and 2021.
- The risk of maltreatment is higher for younger children, particularly infants. In 2021, children under age 1 had a maltreatment rate of 25.3 per 1,000, which is more than twice the rate for any other age group.
- The maltreatment rate among children under age 1 increased from 20.1 per 1,000 to 26.7 per 1,000 between 2008 and 2018 before dropping to 25.3 in 2021.
- Maltreatment rates for children ages 0–17 varied substantially among race and Hispanic origin groups, from 1.4 per 1,000 children up to 15.2 per 1,000 children in 2021. Rates per 1,000 children were, in ascending order, as follows: 1.4 for Asian, non-Hispanic; 7.1 for White, non-Hispanic; 7.7 for Hispanic; 8.5 for Native Hawaiian or Other Pacific Islander, non-Hispanic; 10.3 for children of Two or more races, non-Hispanic; 13.1 for Black, non-Hispanic; and 15.2 for American Indian or Alaska Native, non-Hispanic.

Indicator FAM7.B**Percentage of substantiated maltreatment of children ages 0–17 by maltreatment type, 2021**

NOTE: Percentages for neglect do not include medical neglect. Medical neglect is reported separately. Bars total to more than 100% because a single child may be the victim of multiple kinds of maltreatment. Substantiated maltreatment includes the dispositions of substantiated or indicated. This is a change from estimates in editions prior to *America's Children, 2017* when substantiated maltreatment included dispositions of substantiated, indicated, and alternative response victim. Alternative response victim is the provision of a response other than an investigation that determines a child was a victim of maltreatment. Additional technical notes are available in the annual reports titled *Child Maltreatment*, which are available at <https://www.acf.hhs.gov/cb/data-research/child-maltreatment>.

SOURCE: Administration for Children and Families, National Child Abuse and Neglect Data System.

- Neglect is by far the most common form of maltreatment; three fourths of all maltreated children were found to have been neglected.
- Sixteen percent of maltreated children were found to have been physically abused, 10% were sexually abused, and 6% were psychologically abused.
- Differences by age are particularly notable for sexual abuse, increasing from 1% for those ages 0–3 to 23% for children ages 12–15 and 24% for ages 16–17.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

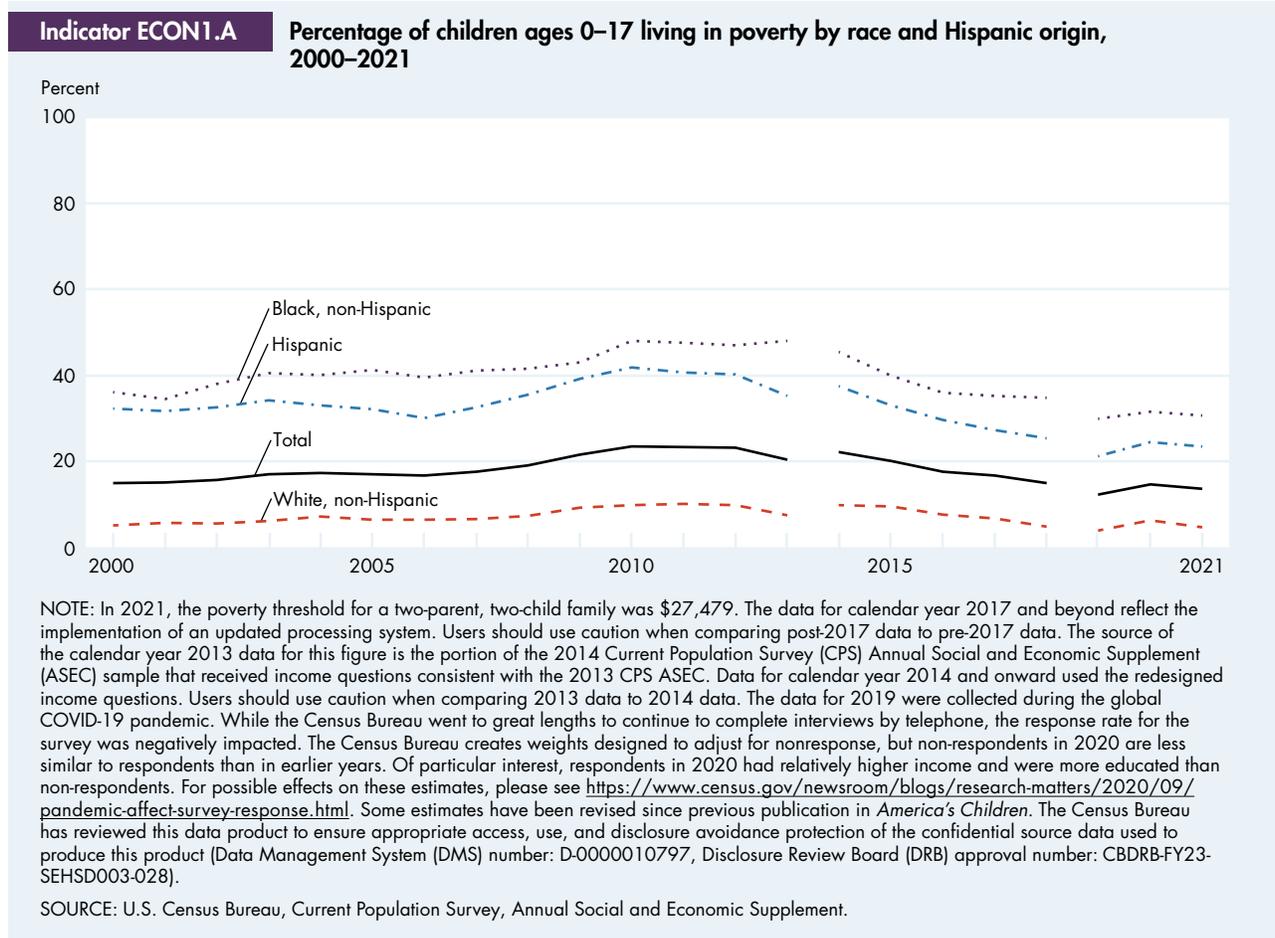


Economic Circumstances

The well-being of children depends greatly on the economic circumstances and material well-being of their families. Indicators of economic resources include the income and poverty status of children's families and the secure employment of children's parents. An indicator on food insecurity presents information on the difficulty of obtaining adequate food among households with children. These indicators provide a broad perspective on children's economic situations.

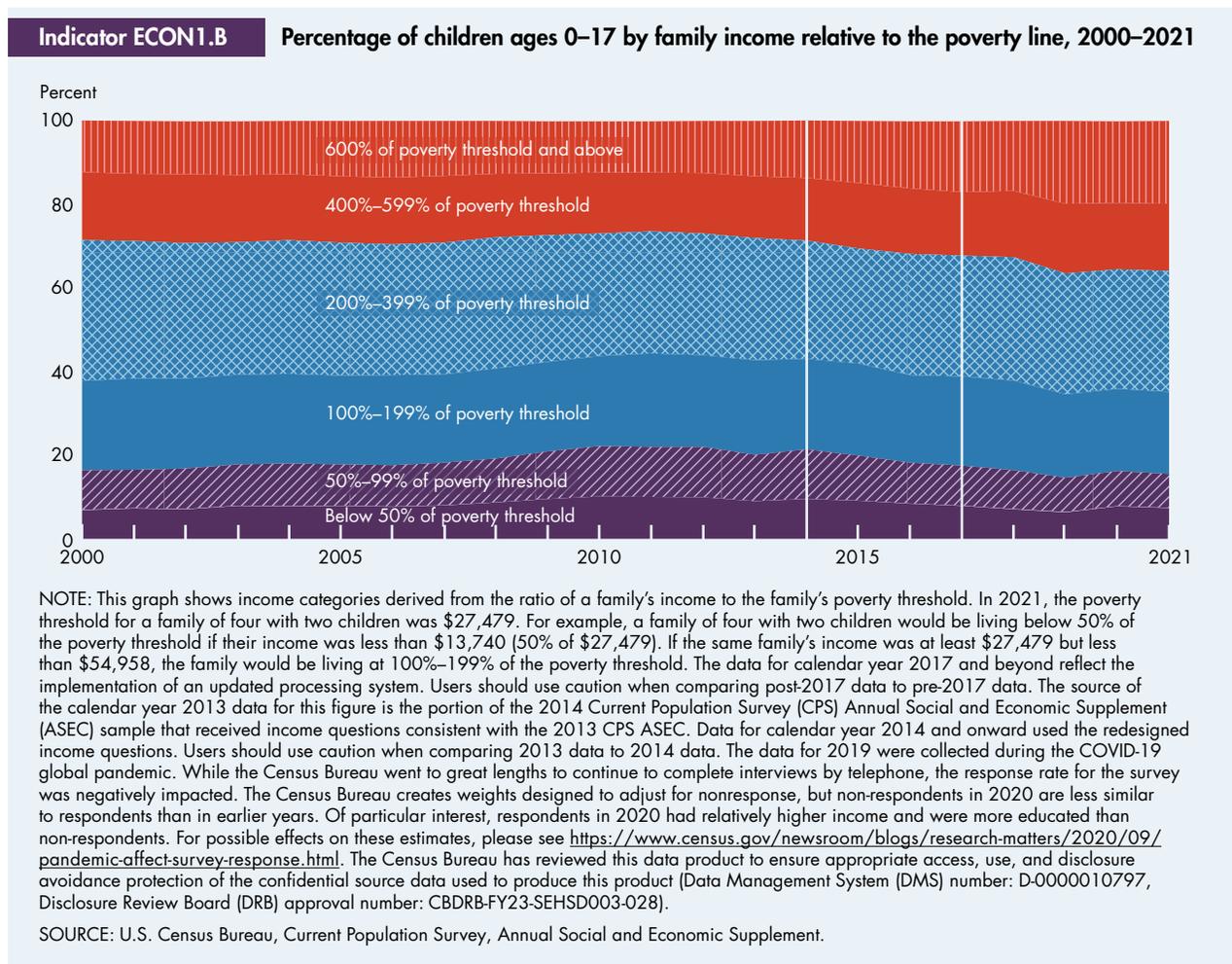
Child Poverty and Income Distribution

Children living in poverty are vulnerable to environmental, educational, health, and safety risks. Compared with their peers, children living in poverty, especially young children, are more likely to have cognitive, behavioral, and socioemotional difficulties. Throughout their lifetimes, they are more likely to complete fewer years of school and experience more years of unemployment.^{27,28,29,30} The data below are based on the official poverty measure for the United States as defined in U.S. Office of Management and Budget Statistical Policy Directive 14.³¹



- In 2021, 15.3% of all children ages 0–17 were in poverty, a 0.7 percentage point decrease from 2020.
- The 2021 poverty rate was higher for Black, non-Hispanic and Hispanic children than for White, non-Hispanic children.⁴ Some 8.8% of White, non-Hispanic children lived in poverty compared with 27.3% of Black, non-Hispanic children and 22.4% of Hispanic children.
- From 2010 to 2021, the poverty rate for all children decreased from 22.0% to 15.3%. The decrease in poverty was greater for Black, non-Hispanic and Hispanic children than for White, non-Hispanic children.³² Between 2010 and 2021, poverty rates decreased by 3.5 percentage points for White, non-Hispanic children, 11.8 percentage points for Black, non-Hispanic children, and 12.5 percentage points for Hispanic children.
- Children in married-couple families were less likely to be living in poverty than children living in female-householder families (no spouse present). In 2021, about 6.8% of children in married-couple families were living in poverty compared with 37.1% in female-householder families.
- In 2021, the poverty rate for White, non-Hispanic children in married-couple families was 3.8%, whereas the poverty rate for White, non-Hispanic children in female-householder families was 29.1%.
- For Black, non-Hispanic children, the poverty rates were 10.7% for those in married-couple families and 41.5% for those in female-householder families in 2021.
- In 2021, about 13.0% of Hispanic children in married-couple families were living in poverty compared with 42.3% in female-householder families.
- Children ages 0–5 were more likely to be living in families with incomes below the poverty threshold than those ages 6–17. In 2021, 16.3% of children ages 0–5 lived in poverty compared with 14.9% of older children.

Family income distribution provides a broader picture of children’s economic circumstances. Families with incomes below their assigned poverty thresholds are considered to be in poverty. However, the income-to-poverty ratio provides additional information on families’ economic security. A family with income that is less than half of their poverty threshold would have an income-to-poverty ratio of 50%, whereas a family that has income that surpasses their threshold would have a ratio greater than 100%. The further a family’s income-to-poverty ratio falls below 100%, the more severe their economic circumstances. As a family’s income-to-poverty ratio increases above 100%, they experience more economic security.



■ In 2021, 29.0% of children lived in families where incomes were 200–399% of the poverty threshold. Fewer children lived in families where incomes were 400–599% of the poverty threshold than in families where incomes were 100–199% of the poverty threshold. Some 16.1% of children lived in families where incomes were 400–599% of the poverty threshold, while 19.7% lived in families where incomes were 100–199% of the poverty threshold.

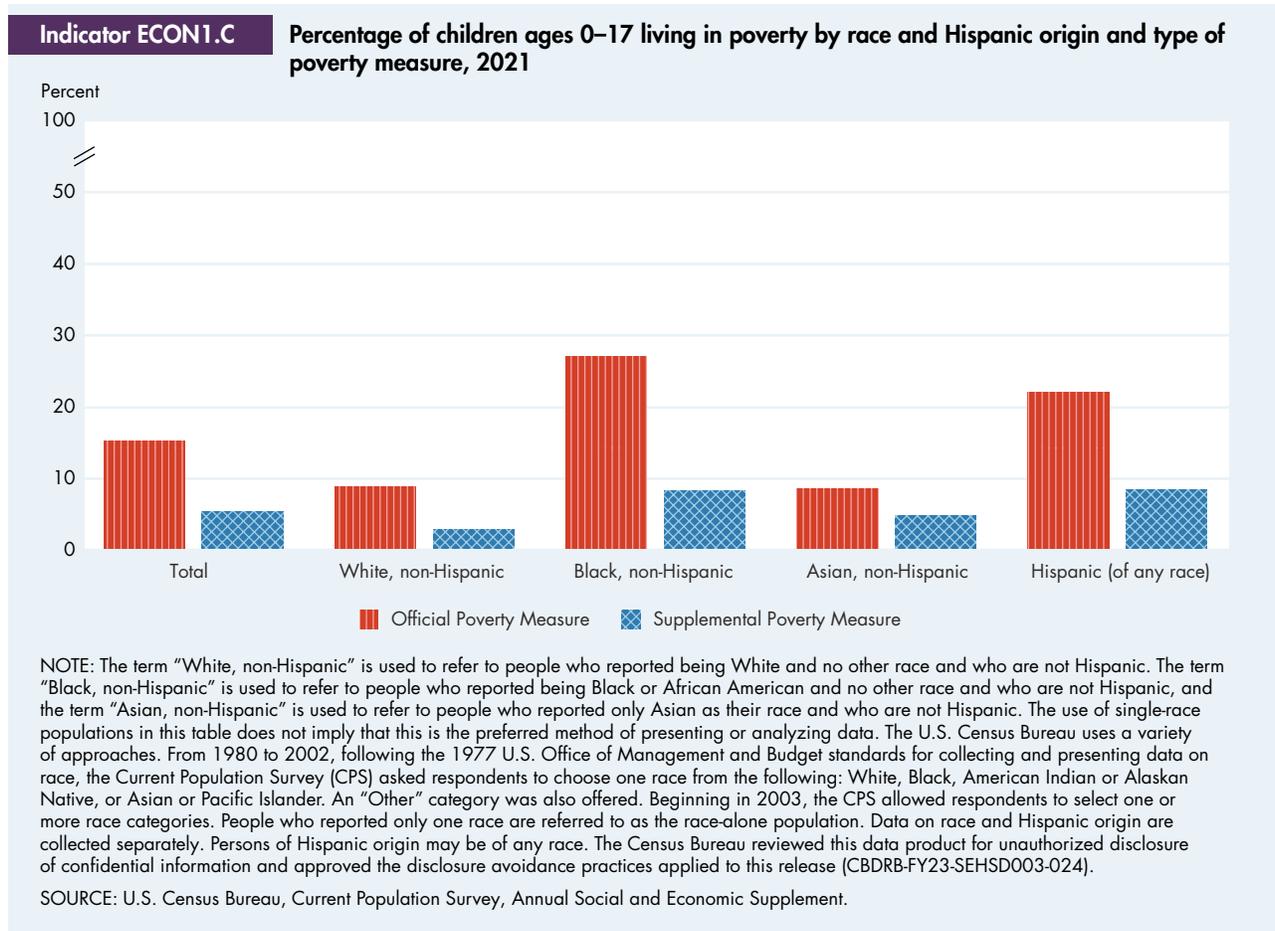
■ The percentage of children living in families with incomes below 50% of the poverty threshold was lower in 2021 (7.2%) than in 2010 (9.9%). The percentage of children living in families with incomes of 600% of the poverty threshold and above was higher in 2021 (19.9%) than in 2010 (12.3%).

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on [childstats.gov](https://www.childstats.gov).

Supplemental Poverty Measure

Since the publication of the first official poverty estimates in 1964, there has been continuing debate about the best approach for measuring poverty in the United States. Since 2011, the U.S. Census Bureau has published poverty estimates using the Supplemental Poverty Measure (SPM). The SPM does not replace the official poverty measure (OPM) but serves as an additional indicator of economic well-being and provides a deeper understanding of economic conditions and policy effects. The SPM is based on the suggestions of an interagency technical working group.³³

In contrast to the OPM, which compares pre-tax cash income to a set of thresholds first derived in the early 1960s, the SPM considers money income and non-cash benefits while subtracting necessary expenses such as taxes and work and medical expenses. SPM thresholds were derived by staff at the U.S. Bureau of Labor Statistics from Consumer Expenditure Survey data on basic necessities (food, shelter, clothing, and utilities) and are adjusted for geographic differences in the cost of housing.



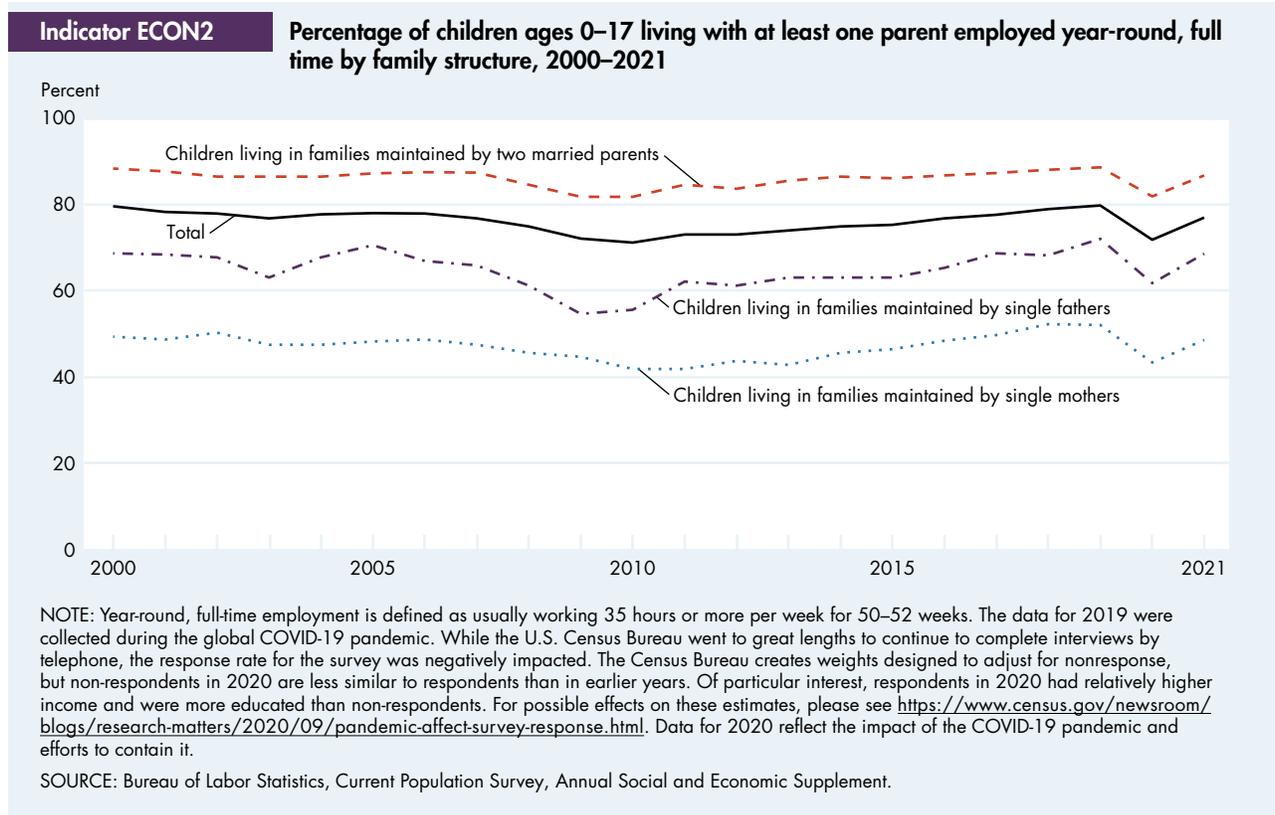
- The SPM child poverty rate fell to 5.2% in 2021. This was the lowest SPM child poverty rate on record.
- For all children, the 2021 SPM rate was 10.1 percentage points lower than the OPM rate of 15.3.^{34,35}

- In 2021, the SPM rate was lower than the OPM rate for children of all race and Hispanic-origin groups.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Secure Parental Employment

Secure parental employment is a major factor in the financial well-being of families.³¹ It is associated with higher family income and has been linked to a number of positive outcomes for children, including better health, education, and social and emotional development.³⁶ One measure of secure parental employment is the percentage of children whose resident parent or parents were employed full time throughout a given year.

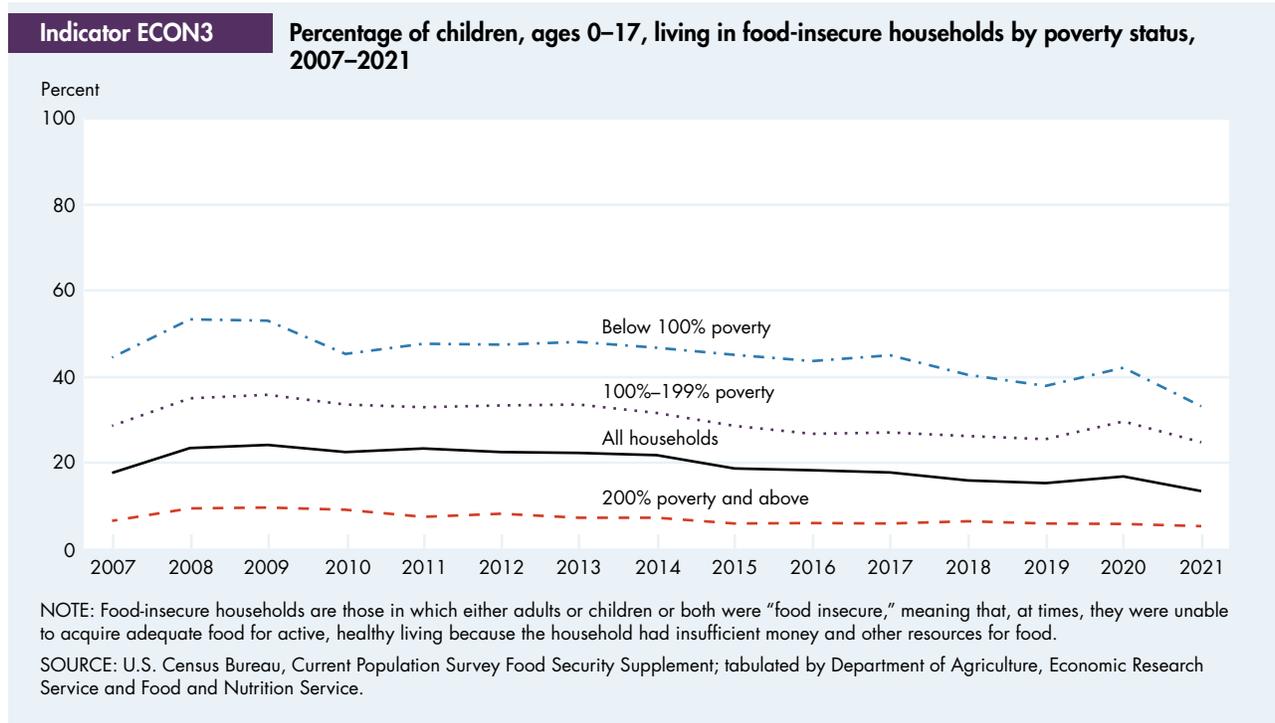


- The percentage of children who had at least one parent working year-round, full time increased from 72% in 2020 to 77% in 2021.
- In 2021, 88% of children living in families maintained by two married parents had at least one parent who worked year-round, full time. In contrast, about 69% of children living in families maintained by a single father and 48% of children living in families maintained by a single mother had a parent who worked year-round, full time.
- Since 2010, approximately 80%–90% of children living in families maintained by two married parents have had at least one parent employed. In contrast, approximately 60%–70% of children living in families maintained by a single father and approximately 40%–50% of children living in families maintained by a single mother had a least one parent employed. All these groups experienced significant increases in 2021 as labor market conditions improved from the prior year.
- In 2021, 78% of children ages 6–17 had at least one parent working year-round, full time. For children ages 0–5, this percentage was 75%. Both measures increased significantly from 2020 to 2021.
- In families maintained by two married parents who were living below the poverty threshold in 2021, about 42% of children had at least one parent working year-round, full time. In contrast, 92% of children in families maintained by two married parents who were living at or above the poverty threshold had at least one parent working year-round, full time.
- Black, non-Hispanic children and Hispanic children were less likely than White, non-Hispanic children to have a parent working year-round, full time. In 2021, 70% of Hispanic children and 64% of Black, non-Hispanic children lived in families with secure parental employment compared with 84% of White, non-Hispanic children.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Food Security

A family’s ability to provide for its children’s nutritional needs is linked to the family’s food security—that is, to its access at all times to adequate food for an active, healthy life for all household members.³⁷ The food security status of households is based on self-reported difficulty in obtaining enough food, reduced food intake, reduced diet quality, and anxiety about an adequate food supply. In some households classified as food insecure, only adults’ diets and food intakes were affected, but in a majority of such households, children’s eating patterns were also disrupted to some extent, and the quality and variety of their diets were adversely affected.³⁸ In a subset of food-insecure households—those classified as having very low food security among children—a parent or guardian reported that at some time during the year, one or more children were hungry, skipped a meal, or did not eat for a whole day because the household could not afford enough food.^{39,40}



- In 2021, 13% of all children (9.3 million children) lived in households classified as food insecure. This percentage of children living in food-insecure households was lower than the percentage in 2020 (16%) and was the lowest recorded level since the Great Recession (23% in 2009).
- The prevalence of food insecurity has consistently been highest for children living in households with annual incomes below the official poverty line, followed by households with incomes at 100%–199% of the poverty line, and lowest for households with incomes at or above 200% of the poverty line. In 2021, 32% of children in households with incomes below 100% of the poverty line were food insecure (substantially above the national average for all children), whereas 5% of children in households with incomes below 200% of the poverty line were food insecure (well below the national average).
- In 2021, the percentages of children living in food-insecure households were above the national average of 13% for those whose parents or guardians were Black, non-Hispanic (22%);

those whose parents or guardians were Hispanic (19%); those whose parents or guardians lacked a high school diploma or General Educational Development (GED) certificate (33%); those whose parents or guardians’ highest level of education is high school/GED (19%); those whose parents or guardians’ highest level of education is some college (18%); those living with a single mother (25%); and those living with a single father (16%).

- In 2021, the percentages of children living in food-insecure households were below the national average of 13% for those whose parents or guardians were White, non-Hispanic (8%); those whose parents or guardians’ highest level of education is a bachelor’s degree or higher (5%); those whose parents or guardians are married (8%); and those who live in the Northeast (10%).

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

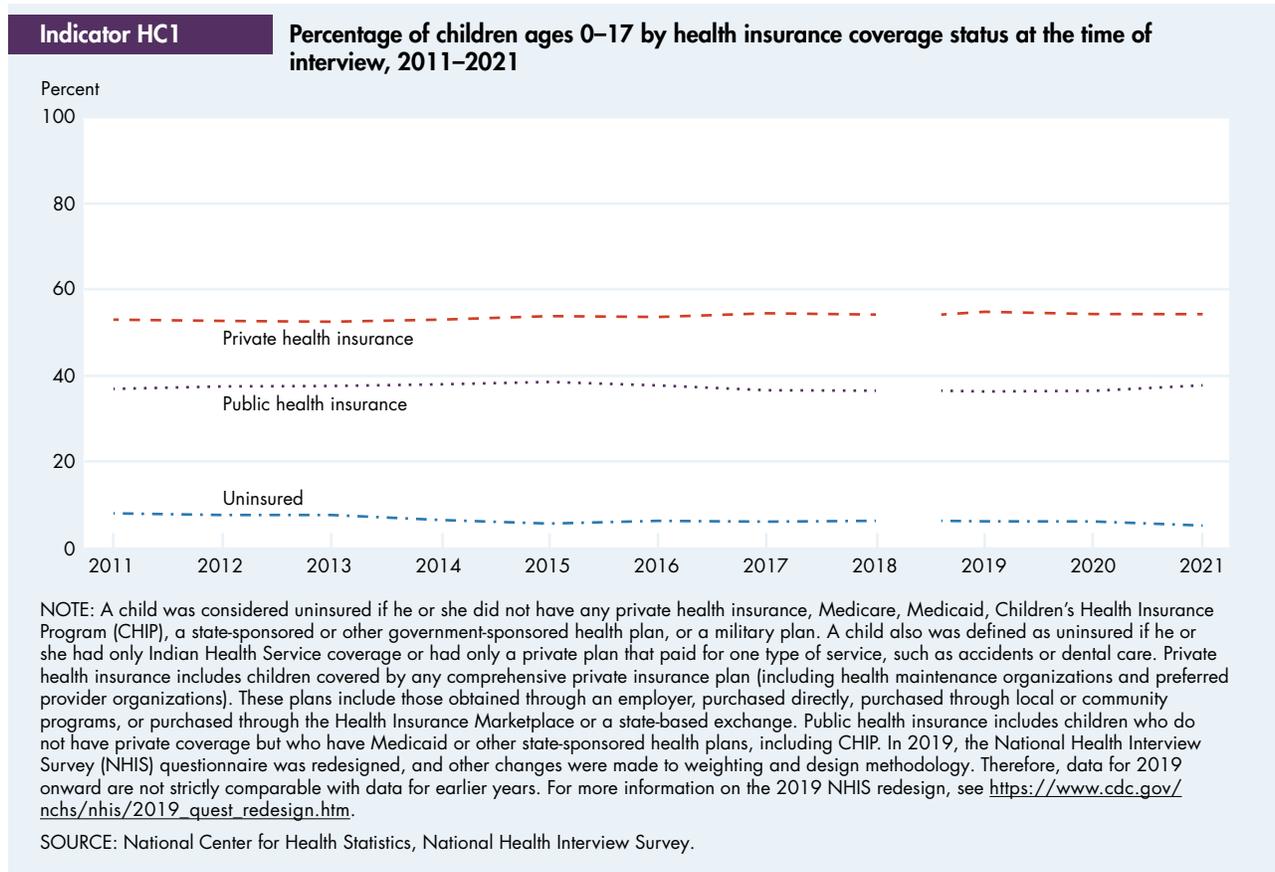


Health Care

Health care comprises the prevention, treatment, and management of illness and the preservation of mental and physical well-being through services offered by health professionals. Effective health care is an important aspect of promoting good health. This section presents information on selected determinants of health care utilization for children (having health insurance coverage and having a usual source of health care) and selected measures of health care utilization (immunization, children having a dental visit, and children with untreated dental caries [i.e., cavities]).

Health Insurance Coverage

Health insurance is a major determinant of access to healthcare.⁴¹ Children and adolescents need regular and ongoing health care to treat acute and chronic conditions and provide injury care and routine preventative care, including vaccinations.⁴² Children with health insurance, whether public or private, are more likely than children without insurance to have a regular and accessible source of healthcare (see HC2). Children may be eligible for health insurance through private coverage or public programs such as Medicaid, enacted in 1966, and the Children’s Health Insurance Program, started in 1997.^{43,44} The percentage of children who have health insurance is one indicator of the extent to which families can obtain preventive care or healthcare for a sick or injured child.⁴⁵

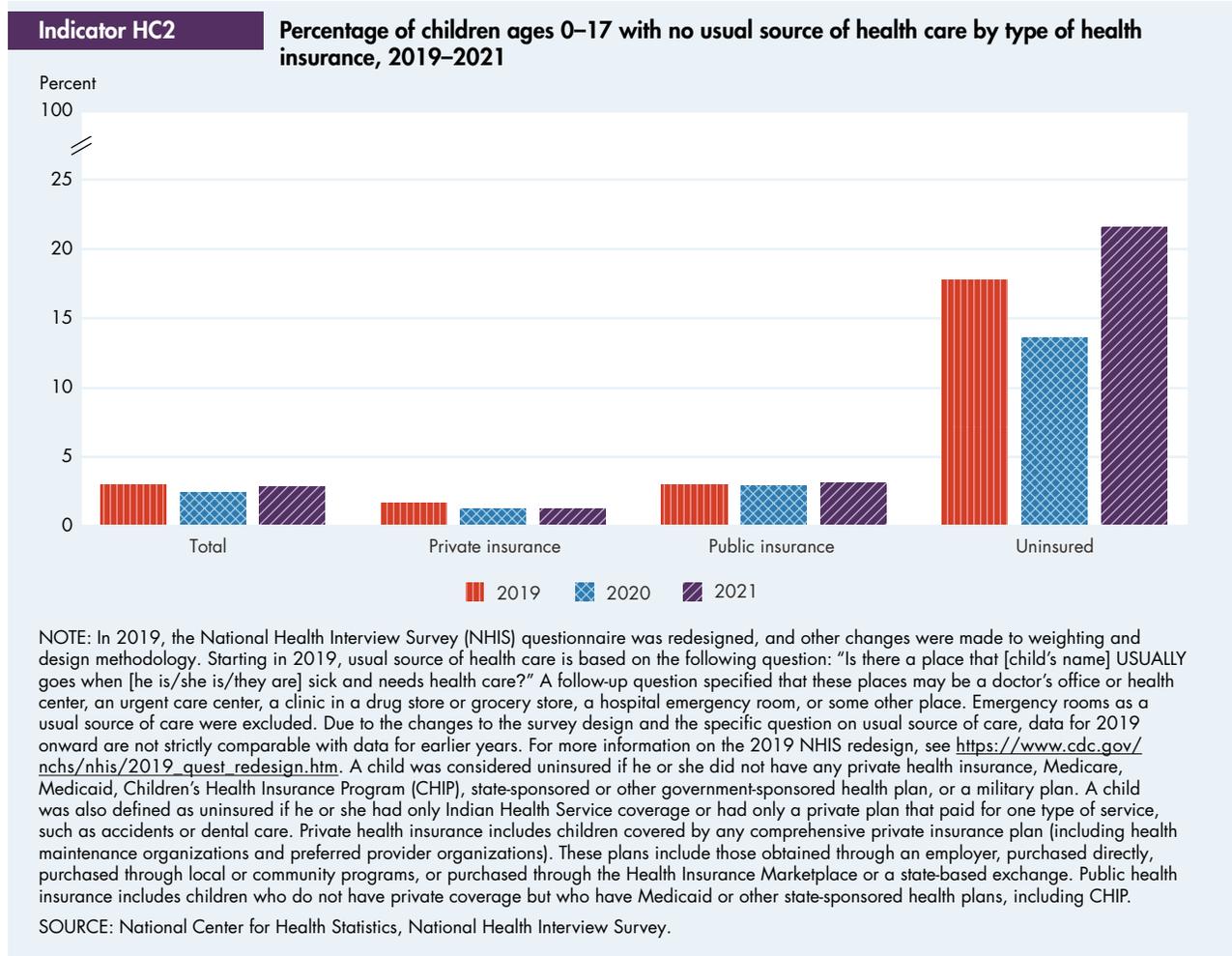


- The percentage of children ages 0–17 without health insurance at the time of interview decreased from 7% in 2011 to 5% in 2015 and then remained stable through 2018. From 2019 to 2021, the percentage of children who lacked health insurance continued to remain stable at 4%–5%.
- The percentage of children with private health insurance remained stable from 2011 to 2018 at 53%–55%. From 2019 to 2021, the percentage of children with private health insurance continued to remain stable at 55%–56%.
- The percentage of children with public health insurance increased from 37% in 2011 to 39% in 2015 and then decreased through 2018 to 37%. From 2019 to 2021, the percentage of children with public health insurance was stable at 36%–38%.
- In 2021, Hispanic children were more likely to be uninsured (8%) than Black, non-Hispanic (4%) and White, non-Hispanic (3%) children. White, non-Hispanic children were more likely to have private health insurance (70%) than Black, non-Hispanic (35%) and Hispanic (33%) children. Black, non-Hispanic (59%) and Hispanic (57%) children were more likely to have public health insurance than White, non-Hispanic children (24%).

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on [childstats.gov](https://www.childstats.gov).

Usual Source of Health Care

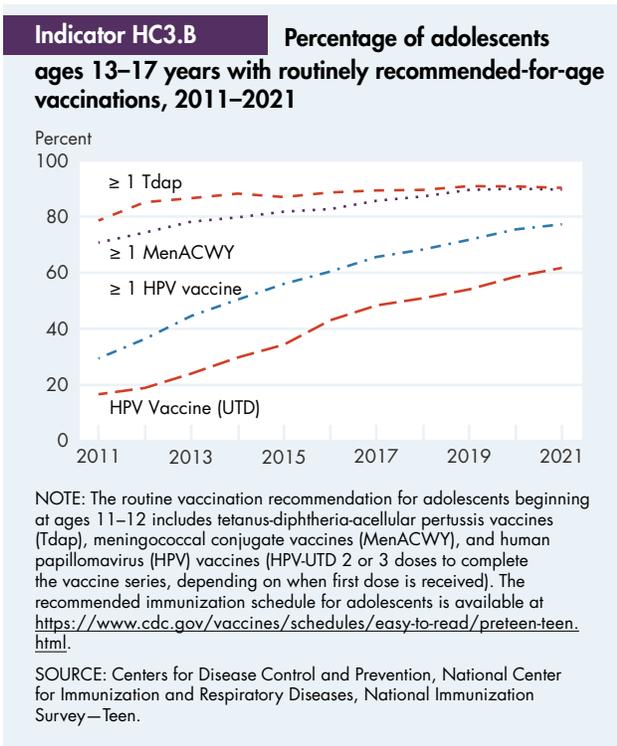
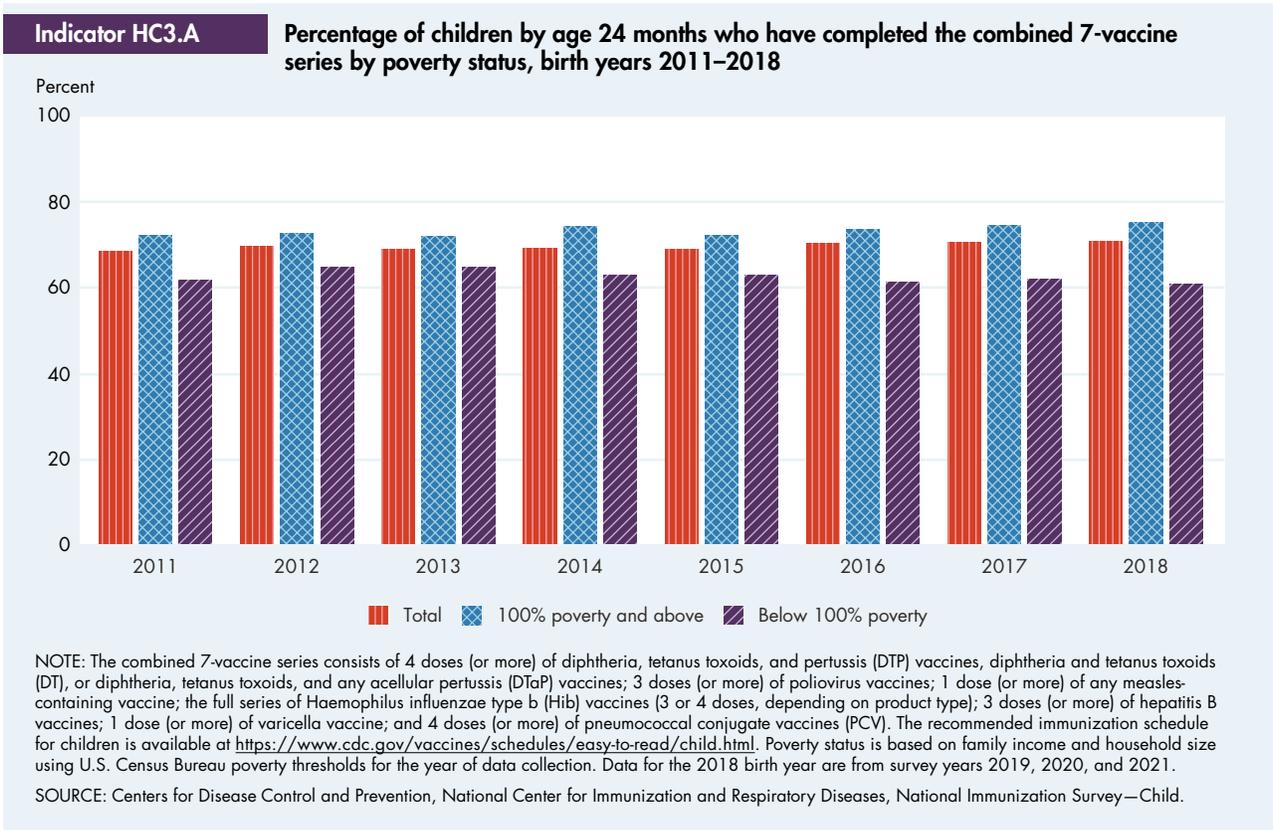
Children’s health depends at least partially on their access to health services. Health care for children includes physical examinations, preventive care, health education, observations, screening, immunizations, and sick care.⁴⁶ Having a usual source of health care—a particular person or place a child goes to for sick and preventive care—facilitates the timely and appropriate use of pediatric services.⁴⁷ Emergency rooms are excluded here as a usual source of care because their focus on emergency care generally excludes the continuity and types of health care mentioned earlier.⁴⁸



- The percentage of children ages 0–17 who had no usual source of health care was stable from 2019 to 2021. While estimates varied from 2%–3% during this period, differences were not significant.
 - Uninsured children are more likely to lack a usual source of health care compared with children who have health insurance. The percentage of uninsured children who had no usual source of health care was stable from 2019 to 2020, and then increased from 13% in 2020 to 21% in 2021.
 - In 2021, the percentage of uninsured children who had no usual source of health care was 20 percentage points higher than the percentage of children with private health insurance who had no usual source of health care (1%) and 18 percentage points higher than the percentage of children with public health insurance who had no usual source of health care (3%).
 - Children in families with incomes below poverty (4%) or at 100%–199% of the poverty level (5%) were more likely to lack a usual source of health care compared with children in families with incomes at 200% poverty and above (2%) in 2021.
- Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.*

Immunization

Childhood vaccination is essential to protect children from severe illness, disability, and death from vaccine-preventable diseases. Data on vaccination coverage are used to identify groups at risk of vaccine-preventable diseases, monitor trends in vaccination over time, and evaluate the effectiveness of interventions designed to increase coverage.

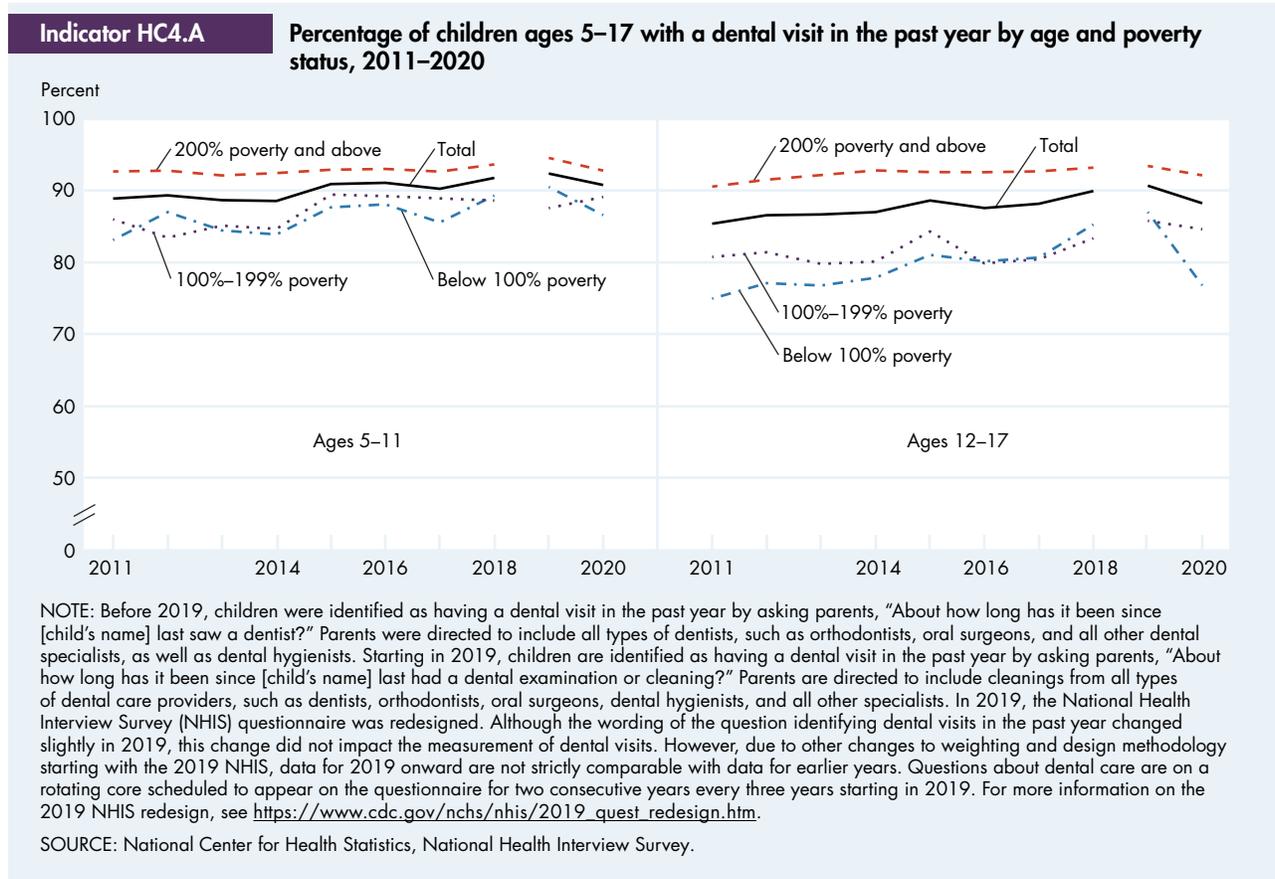


- For children born in 2018, those in families with incomes below the poverty threshold had lower coverage with the 7-vaccine series by age 24 months of 60% compared with 75% for those in families with incomes at or above the poverty level.
- Among children born since 2011, the total percentage who received the recommended combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months has remained steady. Disparity in coverage by poverty has persisted.
- Since 2011, human papillomavirus (HPV) vaccine coverage has steadily increased. In 2021, HPV vaccination coverage for adolescents ages 13–17 years for one dose (or more) of HPV vaccine was 77%, and up-to-date (UTD) HPV vaccine coverage was 62%. HPV vaccine coverage is lower than the other two vaccinations recommended for adolescents.
- Vaccination coverage for adolescents ages 13–17 for the two additional routinely recommended vaccinations for adolescents remains high. In 2021, vaccination coverage for one dose (or more) of tetanus, diphtheria, and acellular pertussis vaccine (Tdap) was 90% and vaccination coverage for one dose (or more) of meningococcal conjugate vaccine (MenACWY) was 89%.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Oral Health

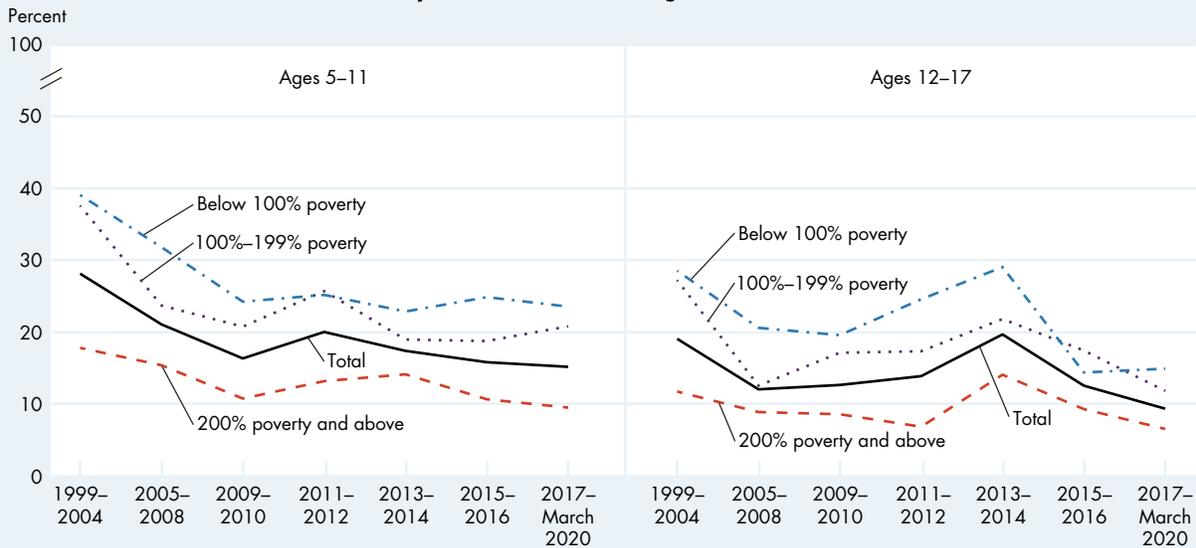
Oral health is an essential component of overall health.⁴⁹ Good oral health requires both self-care and professional care. Regular dental visits provide an opportunity for prevention, early diagnosis, and treatment of oral and craniofacial diseases and conditions. Routine dental visits are recommended beginning at 1 year of age.⁵⁰ However, dental caries (i.e., cavities) continue to be one of the most common diseases of childhood and remain a significant problem among children in some racial and ethnic groups and among children in poverty.^{51,52}



- In 2020, 89% of children ages 5–17 had a dental visit in the past year, down from 91% in 2019. Children ages 5–11 (91%) were more likely to have had a dental visit in the past year compared with adolescents ages 12–17 (88%).
- From 2011 to 2019, among both children ages 5–11 and adolescents ages 12–17, the percentage of children with a dental visit in the past year was higher among those with family incomes at or above 200% of the poverty level than those with family incomes below poverty or with family incomes at 100%–199% of the poverty level.
- Among children ages 5–11 in 2020, 92% of children with family incomes at or above 200% of the poverty level had a dental visit in the past year, which was 6 percentage points higher than those with family incomes at 100%–199% of the poverty level (86%). There was no significant difference between those with family incomes below poverty and those with family incomes at or above 200% of the poverty level.
- Among adolescents ages 12–17 in 2020, 91% of adolescents with family incomes at or above 200% of the poverty level had a dental visit in the past year, which was 14 percentage points higher than those with family incomes below poverty (77%) and 7 percentage points higher than those with family incomes at 100%–199% of the poverty level (85%). There was no significant difference between those with family incomes below poverty and those with family incomes at 100%–199% of the poverty level.

Indicator HC4.B

Percentage of children ages 5–17 with untreated dental caries (cavities) by age and poverty status, selected years 1999–2004 through 2017–March 2020



NOTE: The National Health and Nutrition Examination Survey (NHANES) program suspended field operations in March 2020 due to the COVID-19 pandemic. As a result, data collection for the 2019–2020 cycle was not completed. Therefore, data collected from 2019 to March 2020 were combined with data from the 2017–2018 cycle to create a 2017–March 2020 pre-pandemic file. This file covers 3.2 years of data collection. For more information, see: <https://www.cdc.gov/nchs/nhanes/continuousnhanes/overviewbrief.aspx?Cycle=2017-2020>.

SOURCE: National Center for Health Statistics, National Health Interview Survey.

- The percentage of children ages 5–11 with untreated dental caries (i.e., cavities) decreased from 27% in 1999–2004 to 16% in 2009–2010 and then did not significantly change through 2017–March 2020. In 2017–March 2020, 15% of children ages 5–11 had untreated dental caries.
- The percentage of children ages 12–17 with untreated dental caries did not significantly change from 1999–2004 to 2017–March 2020. In 2017–March 2020, 9% of children ages 12–17 had untreated dental caries.
- Among children ages 5–11 in 2017–March 2020, the percentage with untreated dental caries for children in

poverty was 23%—more than two times as high as the percentage for children with family incomes at or above 200% of the poverty level (9%).

- Among adolescents ages 12–17 in 2017–March 2020, the percentage with untreated dental caries for adolescents in poverty was 15%—more than two times as high as the percentage of adolescents with family incomes at or above 200% of the poverty level (6%).

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

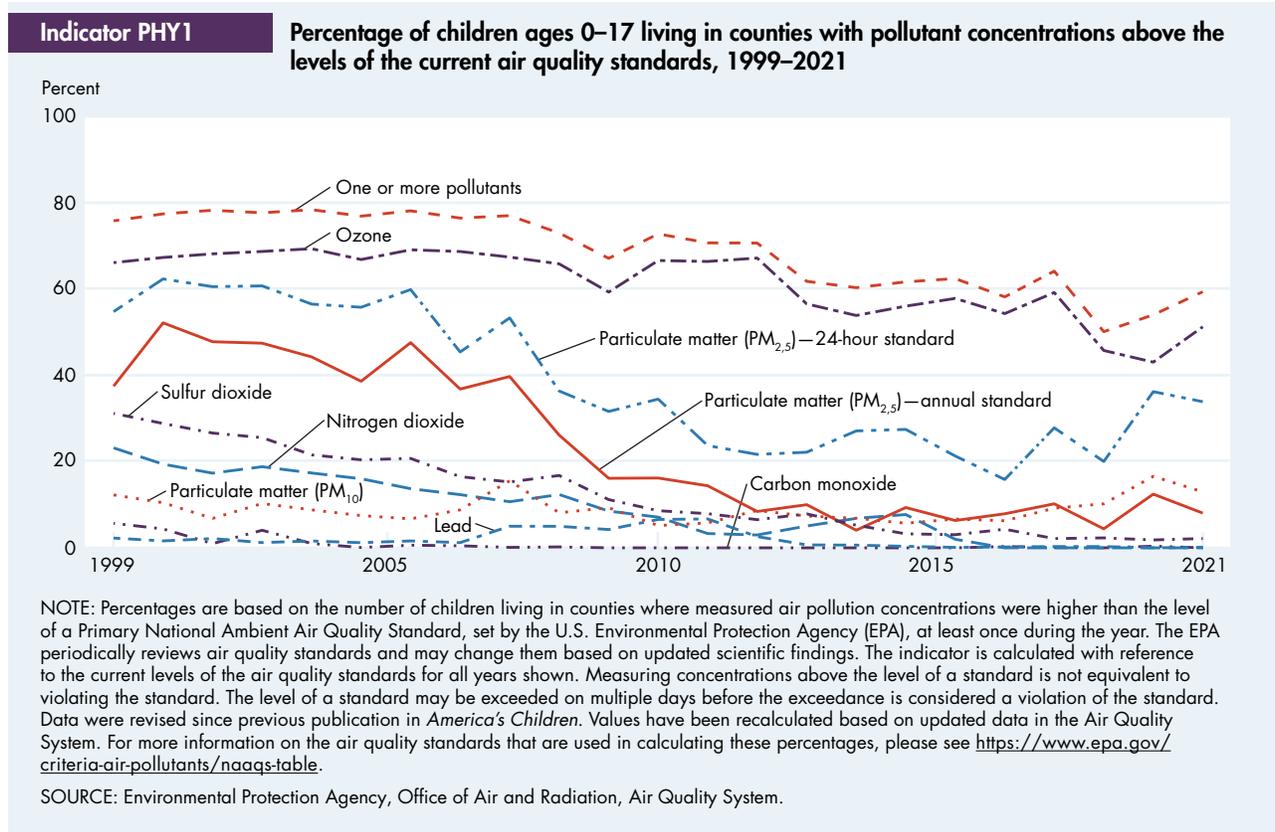
Physical Environment and Safety

The physical environment in which children live plays a role in their health, development, and safety. This section presents indicators on environmental conditions such as outdoor air quality, secondhand smoke, drinking water quality, and exposure to lead that may affect children. In addition, indicators of housing problems, youth victims of serious violent crimes, and child and adolescent injury and mortality are presented.



Outdoor Air Quality

The environment in which children live plays an important role in their health and development. Children may be more vulnerable than adults to the adverse effects of environmental contaminants in air, food, drinking water, and other sources because their bodies are still developing. In addition, children have increased potential for exposure to pollutants because they eat, drink, and breathe more, in proportion to the size of their bodies, than adults. One important measure of children’s environmental health is the percentage of children living in areas in which air pollution levels are higher than the allowable levels of the Primary National Ambient Air Quality Standards.⁵³ These standards, established by the U.S. Environmental Protection Agency under the Clean Air Act, are designed to protect public health, including the health of susceptible populations such as children. Ozone, particulate matter, sulfur dioxide, and nitrogen dioxide are air pollutants associated with increased asthma episodes and other respiratory illnesses in children. These problems can lead to increased emergency room visits and hospitalizations.^{54,55,56,57} Lead can affect the development of the central nervous system in young children,⁵⁸ and exposure to carbon monoxide can reduce the capacity of blood to carry oxygen.⁵⁹



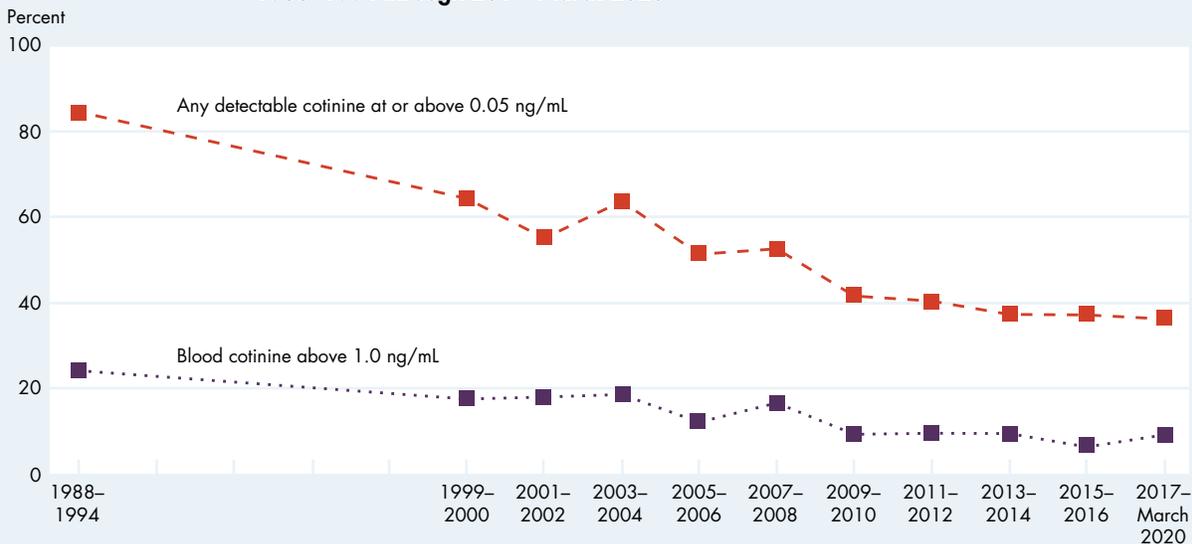
- From 1999 to 2021, the percentage of children living in counties with measured pollutant concentrations above the levels of one or more Primary National Ambient Air Quality Standards at least once during the year decreased from 76% to 59%.
 - From 1999 to 2021, the percentage of children living in counties with measured ozone concentrations above the level of the current ozone standard at least 1 day during the year decreased from 66% to 51%.
 - In 2021, approximately 34% of children lived in counties with measured concentrations of fine particulate matter (PM_{2.5}) above the level of the current 24-hour PM_{2.5} standard at least once during the year compared with 55% of children in 1999.
 - From 1999 to 2021, the percentage of children living in counties with measured sulfur dioxide concentrations above the level of the current standard for sulfur dioxide at least 1 day per year declined from 31% to 2%. During the same time frame, the percentage of children living in counties with measured concentrations above the level of the current standard for nitrogen dioxide at least 1 day per year decreased from 23% to 0%.
 - In 2021, the percentage of children living in counties with measured pollutant concentrations above the levels of one or more Primary National Ambient Air Quality Standards at least once during the year by race/ethnicity was 48% for American Indian or Alaska Native, non-Hispanic children; 51% for White, non-Hispanic children; 58% for Native Hawaiian and Other Pacific Islander, non-Hispanic children; 59% for Black, non-Hispanic children; 60% for children of two or more races; 75% for Asian, non-Hispanic children; and 73% for Hispanic children.
- Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.*

Secondhand Smoke

Children who are exposed to secondhand smoke have an increased probability of experiencing adverse health effects such as infections of the lower respiratory tract, bronchitis, pneumonia, middle ear disease, sudden infant death syndrome (SIDS), and respiratory symptoms.⁶⁰ Secondhand smoke also can play a role in the development and exacerbation of asthma.⁶⁰ The U.S. Surgeon General has determined that there is no risk-free level of exposure to secondhand smoke.⁶⁰ Cotinine, a breakdown product of nicotine, is a marker for recent (previous 1–2 days) exposure to secondhand smoke in nonsmokers.

Indicator PHY2.A

Percentage of children ages 4–11 with specified blood cotinine levels, selected years 1988–1994 through 2017–March 2020

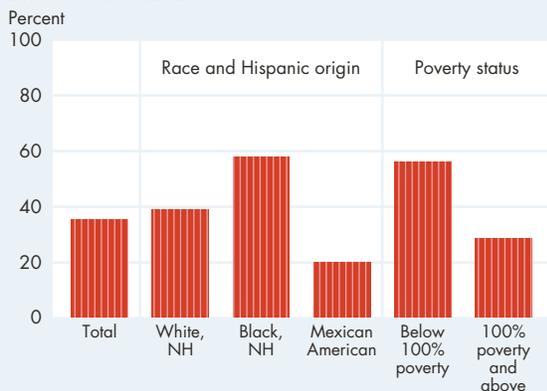


NOTE: Cotinine levels are reported for nonsmoking children only. “Any detectable cotinine” indicates blood cotinine levels at or above 0.05 nanograms per milliliter (ng/mL), the level of cotinine that could be detected in blood in 1988–1994. The average (geometric mean) blood cotinine level in children living in homes in which someone smoked was 1.0 ng/mL in 1988–1994.⁶¹ The National Health and Nutrition Examination Survey (NHANES) program suspended field operations in March 2020 due to the COVID-19 pandemic. As a result, data collection for the 2019–2020 cycle was not completed. Therefore, data collected from 2019 to March 2020 were combined with data from the 2017–2018 cycle to create a 2017–March 2020 pre-pandemic file. This file covers 3.2 years of data collection. For more information, see: <https://www.cdc.gov/nchs/nhanes/continuousnhanes/overviewbrief.aspx?Cycle=2017-2020>.

SOURCE: National Center for Health Statistics, National Health and Nutrition Examination Survey.

Indicator PHY2.B

Percentage of children ages 4–11 with any detectable blood cotinine level by race and Hispanic origin and poverty status, 2017–March 2020



NOTE: NH = non-Hispanic origin. Cotinine levels are reported for nonsmoking children only. “Any detectable blood cotinine” indicates blood cotinine levels at or above 0.05 nanograms per milliliter (ng/mL), the detectable level of cotinine in the blood in 1988–1994. Beginning in 2007, NHANES allows the reporting of both total Hispanics and Mexican Americans; however, estimates reported here are for Mexican Americans to be consistent with earlier years. Persons of Mexican American origin may be of any race.

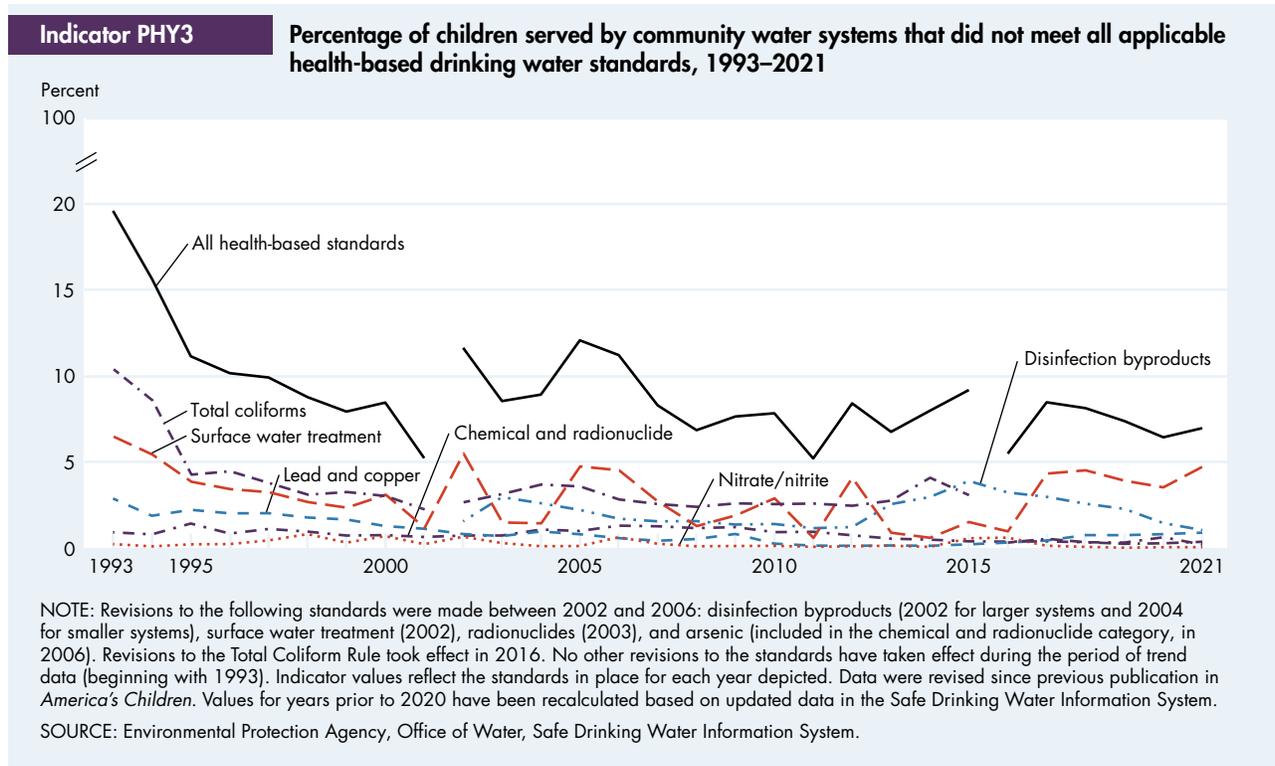
SOURCE: National Center for Health Statistics, National Health and Nutrition Examination Survey.

- In 2017–March 2020, 58% of Black, non-Hispanic children ages 4–11 had detectable blood cotinine levels compared with 39% of White, non-Hispanic children and 20% of Mexican American children.
- About 56% of children ages 4–11 living in poverty had detectable blood cotinine levels in 2017–March 2020 compared with 29% of children living above the poverty level.
- The percentage of children ages 4–11 with detectable blood cotinine levels [at or above 0.05 nanograms per milliliter (ng/mL)] was 85% in 1988–1994 and 36% in 2017–March 2020.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on [childstats.gov](https://www.childstats.gov).

Drinking Water Quality

Contaminants in surface and ground waters that serve as sources of drinking water may be quite varied and may cause a range of health effects in children, including acute diseases such as gastrointestinal illness, developmental effects such as learning disorders, and serious long-term illnesses such as cancer.⁶² The U.S. Environmental Protection Agency (EPA) sets drinking water standards designed to protect people against adverse health effects. These standards currently include Maximum Contaminant Levels (MCLs) and treatment technique requirements for more than 90 chemical, radiological, and microbiological contaminants.⁶³ One way to gain insight into children’s potential exposure to drinking water contaminants is to look at community water system compliance with these standards. The EPA’s drinking water regulations require public water systems, including community water systems, to monitor for compliance with Federal health-based standards and treat their water if needed to meet standards. About 13% of the population receives drinking water from private water systems that are not required to monitor and report the quality of drinking water.⁶⁴



- The percentage of children served by community drinking water systems that did not meet all applicable health-based standards declined from 20% in 1993 to about 5% in 2001. Since 2002, this percentage has fluctuated between 5% and 12% and was 7% in 2021.
- Drinking water is a source of lead and copper exposures for children. The percentage of children served by community drinking water systems that did not meet the health-based standard for lead and copper was about 3% in 1993 and less than 1% in 2021.
- Coliforms indicate the potential presence of harmful bacteria associated with infectious illnesses. The percentage of

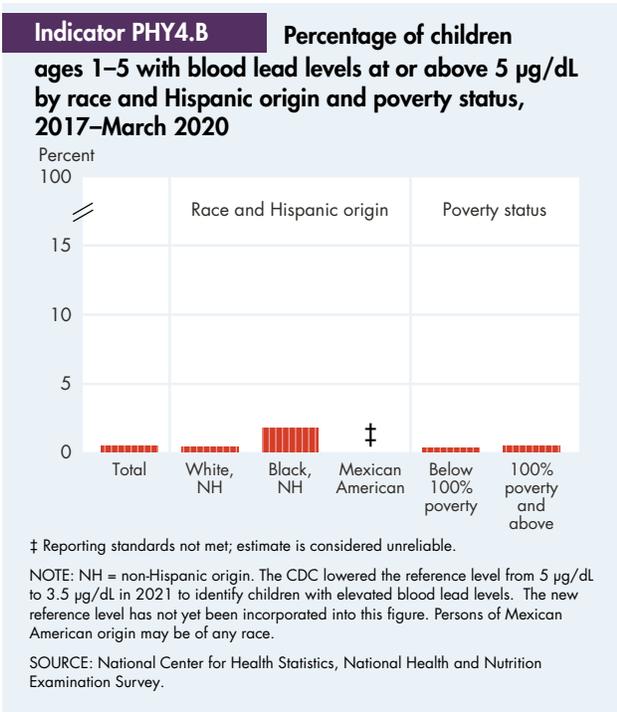
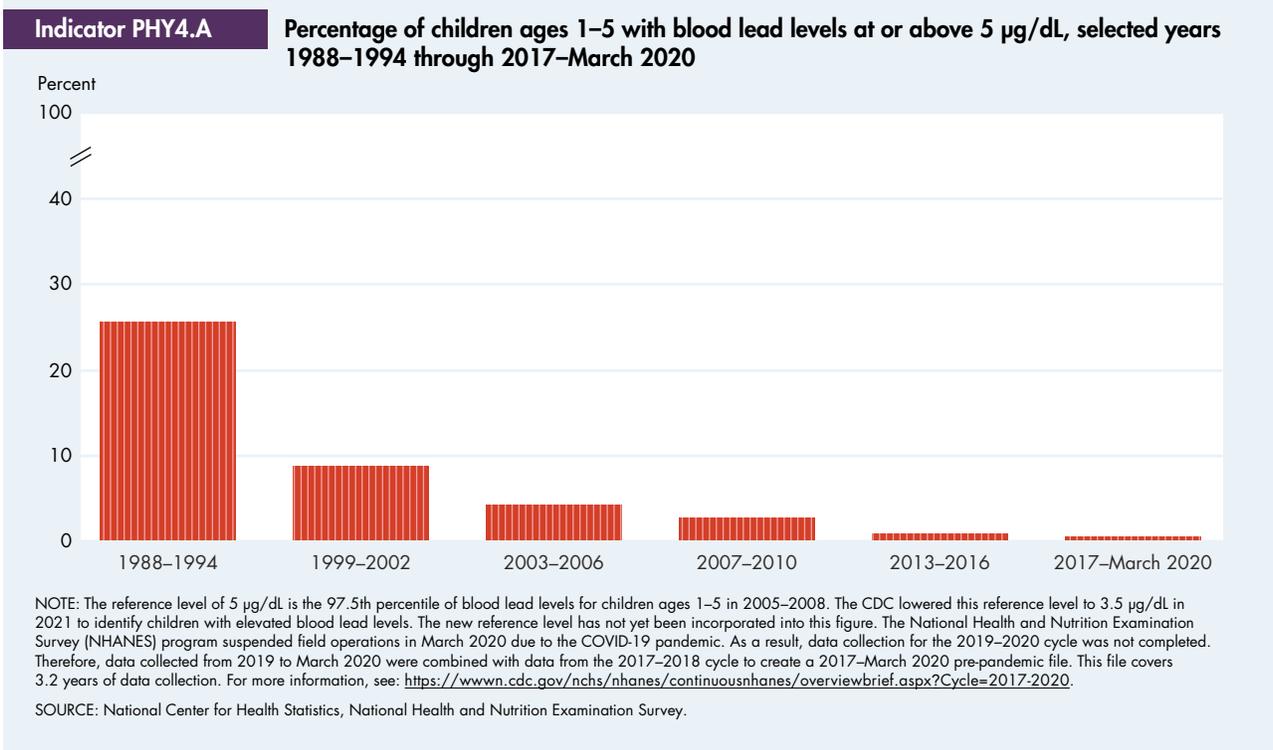
children served by community drinking water systems that did not meet the health-based standard for total coliforms was about 10% in 1993 and less than 1% in 2021.

- Disinfection byproducts are formed when drinking water disinfectants react with naturally occurring organic matter in water. In 2021, about 1% of all children served by community water systems were served by systems that had violations of the disinfection byproducts standard. Exposure to disinfection byproducts may lead to cancer or developmental effects.⁶⁵

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Lead in Blood of Children

Lead is a major environmental health hazard for young children. Childhood exposure to lead contributes to learning problems (including reduced intelligence quotient [IQ] and reduced academic achievement) and behavioral problems.⁶⁶ The blood lead reference value of 5 micrograms per deciliter (µg/dL) is used here, but the blood lead reference value the Centers for Disease Control and Prevention (CDC) revised in 2021 will be considered for the future.⁶⁷ A blood lead level above CDC’s reference value is defined as “elevated” for purposes of identifying children for follow-up activities, such as environmental investigations and ongoing monitoring,⁶⁸ but no level of childhood lead exposure can be considered safe,⁶⁹ and adverse health effects can occur at much lower concentrations.⁶⁶ Lead exposures have declined since the 1970s, due largely to the removal of lead from gasoline and paint. Children ages 1–5 are particularly vulnerable because they frequently engage in hand-to-mouth behavior.

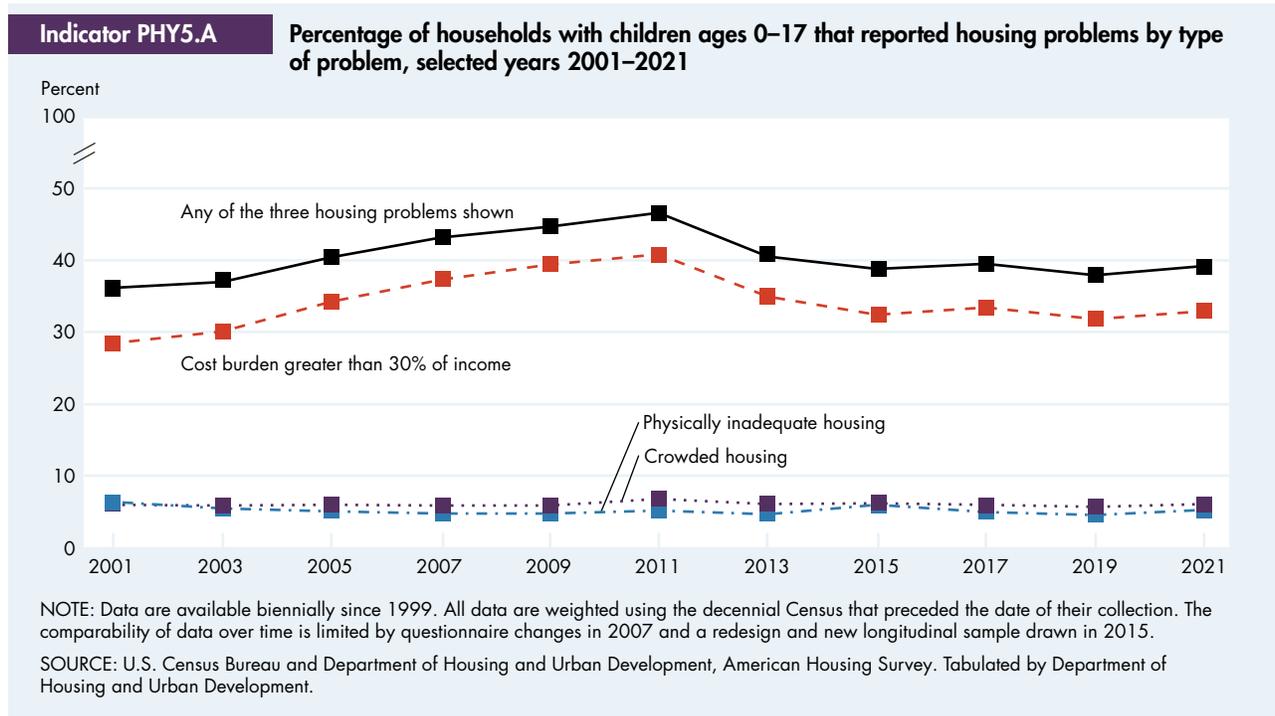


- In 2017–March 2020, the percentage of children with elevated blood lead levels (at or above 5 micrograms lead per deciliter of blood) was 0.4%. In 1999–2002, the percentage was 8.6%, and in 1988–1994, it was 25.6%.
- In 2017–March 2020, the percentage of Black, non-Hispanic children with blood lead levels at or above 5 µg/dL was greater than the percentage for White, non-Hispanic children with blood lead levels at or above 5 µg/dL (1.7% and 0.4%, respectively).
- In 2017–March 2020, 0.3% of children living in poverty had blood lead levels at or above 5 µg/dL compared with 12.9% in 1999–2004.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Housing Problems

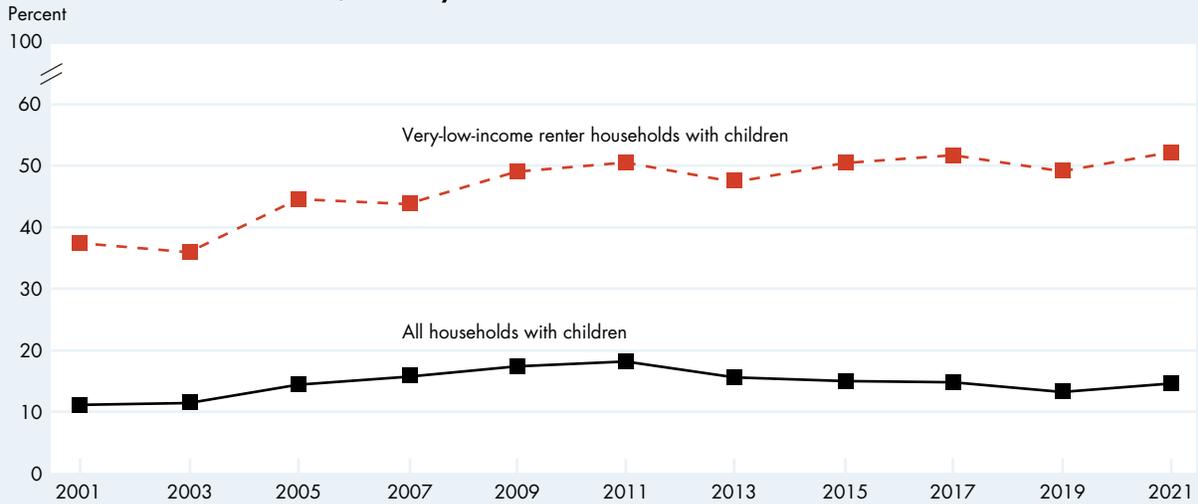
Housing that is inadequate, crowded, or too costly can pose serious problems to children’s physical, psychological, and material well-being.^{70,71} Housing cost burdens, especially at high levels, are a risk factor for negative outcomes for children and their caregivers, including eviction and homelessness, degraded physical and mental health, overcrowding, poor nutrition, frequent moving, lack of supervision while parents are at work, and low cognitive achievement.^{72,73,74,75,76} During 2022, an estimated 97,800 children were homeless at a single point in time, and 10% of these children were unsheltered.⁷⁷ The percentage of households with children that report that they are living in physically inadequate,⁷⁸ crowded, or costly housing provides insight into the impact of economic factors on housing choices and children’s well-being.



- In 2021, 39% of U.S. households with children had one or more of three housing problems: physically inadequate housing, crowded housing, or housing cost burden greater than 30% of household income.⁷⁹ This percentage increased from 2001 (36%) but was not significantly different from 2019⁸⁰ (38%).
- In 2021, about 6% of households with children had physically inadequate housing, defined as housing with severe or moderate physical problems. This increased from 5% in 2019.
- The prevalence of housing cost burdens among families with children was 33% in 2021, not significantly different than 32% in 2019, but 5 points above the prevalence of 28% in 2001.

Indicator PHY5.B

Percentage of households with children ages 0–17 that reported severe housing cost burdens, selected years 2001–2021



SOURCE: U.S. Census Bureau and Department of Housing and Urban Development, American Housing Survey. Tabulated by Department of Housing and Urban Development.

■ The percentage of families with children having severe housing cost burdens, defined as paying more than half of their income for housing, was 15% in 2021, a significant increase from 13% in 2019.

■ Among very-low-income renter households⁸¹ with children, 53% experienced severe housing cost burdens in 2021, which is not significantly different from 49% in 2019. The prevalence of severe cost burdens among this disadvantaged population has increased substantially from 38% in 2001.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

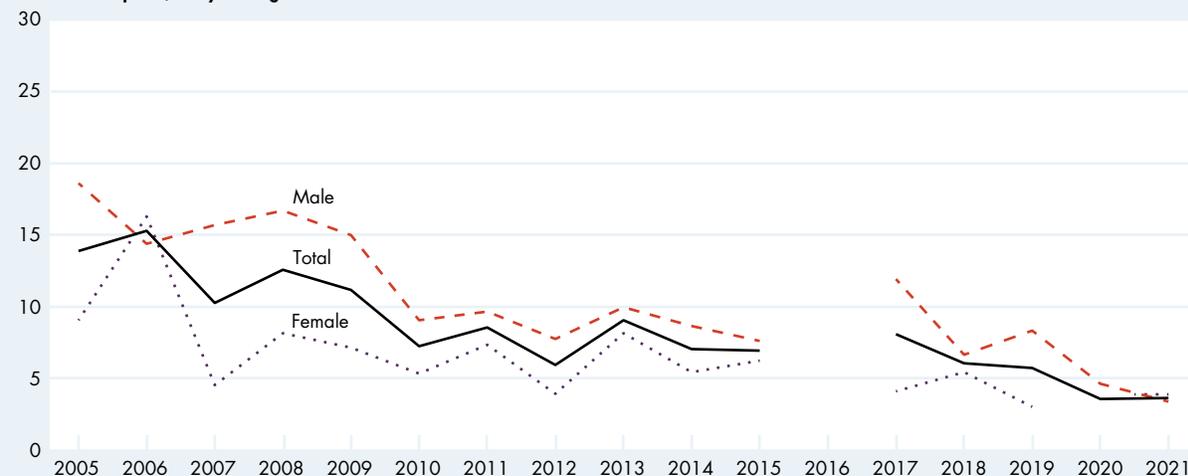
Youth Victims of Serious Violent Crimes

Violence frequently has dire and long-lasting impacts on young people who experience, witness, or feel threatened by it. In addition to causing direct physical harm to young victims, serious violence can adversely affect their mental health and development and increase the likelihood that they themselves will commit acts of serious violence.^{82,83}

Indicator PHY6

Rate of serious violent crime victimization of youth ages 12–17 by gender, 2005–2021

Victimizations per 1,000 youth ages 12–17



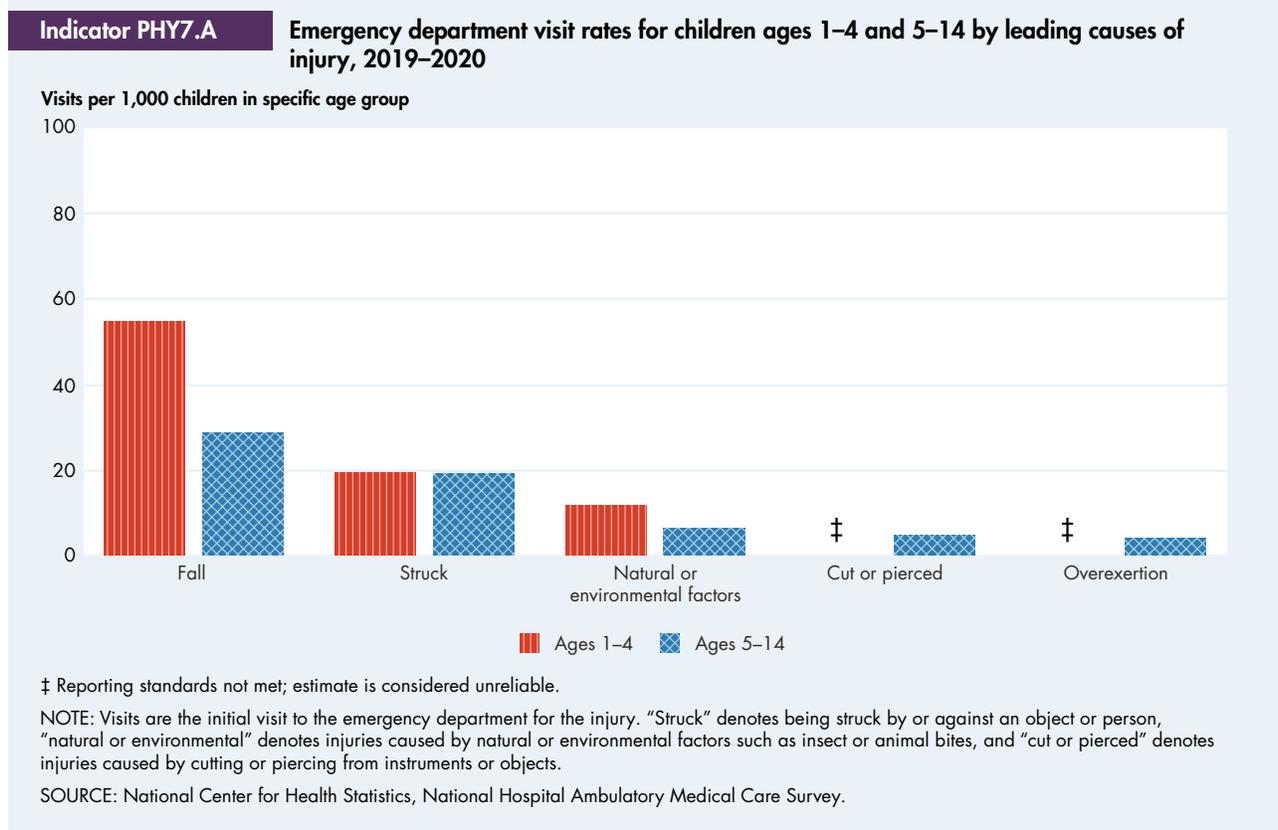
NOTE: Serious violent crimes include aggravated assault, rape, robbery (stealing by force or threat of violence), and homicide. In 2021, homicides represented 1.4% of serious violent crime, and the total number of homicides of juveniles has been relatively stable over the last decade. Beginning in 2021, the number of homicides was estimated using the FBI's National Incident-Based Reporting System. From 1993-2020, the number of homicides were estimated using the FBI's Supplementary Homicide Reports. See *Criminal Victimization, 2007*, <https://bjs.ojp.gov/content/pub/pdf/cv07.pdf>, for more information. In 2016, the National Crime Victimization Survey sample was redesigned, so 2016 estimates among youths are not comparable with estimates for other years. The 2020 NCVS weights include an additional adjustment to address the impact of modified field operations due to COVID-19. The 2020 estimate for female youth did not meet reporting standards due to insufficient unweighted sample cases and is excluded from the graphic. For more information on the weighting adjustments applied in 2020, see the Source and Accuracy Statement for the 2020 National Crime Victimization Survey in the NCVS 2020 Codebook (<https://www.icpsr.umich.edu/web/NACJD/studies/38090/summary>) and *Criminal Victimization, 2020* (NCJ 301775, BJS, October 2021).

SOURCE: Bureau of Justice Statistics, National Crime Victimization Survey and Federal Bureau of Investigation, Uniform Crime Reporting Program, National Incident-Based Reporting System.

- In 2021, the rate at which youth were victims of serious violent crimes was 4 crimes per 1,000 youth ages 12–17. A total of 89,800 such crimes occurred in 2021.
 - The rate of serious violent crimes involving youth victims was not significantly different from 2010 to 2021. However, the rate in 2021 was significantly lower than the rate in 2005 of 14 crimes per 1,000 youth.
 - Older youth (ages 15–17) were as likely to be victims of a serious violent crime as younger youth (ages 12–14) in 2021.
 - Male youth were as likely to be victims of a serious violent crime as female youth in 2021.
 - From 2005 to 2021, the rate at which male youth were victims of serious violent crime declined from 18 crimes per 1,000 male youth ages 12–17 to 3 per 1,000. The rate for female youth declined from 9 to 4 per 1,000 female youth ages 12–17 during the same time period.
- Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.*

Child Injury and Mortality

Although injury death rates have declined in the past 2 decades for children ages 1–14, unintentional injuries remain the leading cause of death for children ages 1–4 and ages 5–14. In addition, nonfatal injuries continue to be important causes of child morbidity, disability, and reduced quality of life.⁸⁴ The economic cost (medical expenses and productivity losses) of injuries among children under age 15 in 2019 was \$396 billion.⁸⁵ In 2020, there were 4,272 fatal injuries and nearly 3 million emergency department (ED) visits for non-fatal injuries among children ages 1–14.⁸⁶ The leading causes of injury differ for children and adolescents (see PHY8.A).



- Among children ages 1–4 and ages 5–14, falls were the leading cause of injury-related ED visits in 2019–2020.
- For children ages 5–14, being struck by or against an object or person was the second leading cause of injury-related ED visits in 2019–2020. For children ages 1–4, there was no significant difference between being struck by or against an object or person and being injured from natural or environmental factors.
- In 2019–2020, there were 54 ED visits for falls per 1,000 children ages 1–4 and 28 ED visits for falls per 1,000 children ages 5–14. Falls accounted for 39% of initial injury-related ED visits for children ages 1–4 and 29% of initial injury-related ED visits for children ages 5–14.
- The rates of injury-related ED visits resulting from being struck by or against an object or person were 19 visits per 1,000 for children ages 1–4 and ages 5–14.
- Injury-related ED visits for injuries caused by natural or environmental factors, including insect and animal bites, were 12 visits per 1,000 for children ages 1–4 and 6 visits per 1,000 for children ages 5–14.

Indicator PHY7.B

Death rates among children ages 1–14 by all causes, all injury causes, and age group, 2011–2021

Deaths per 100,000 children in specific age group

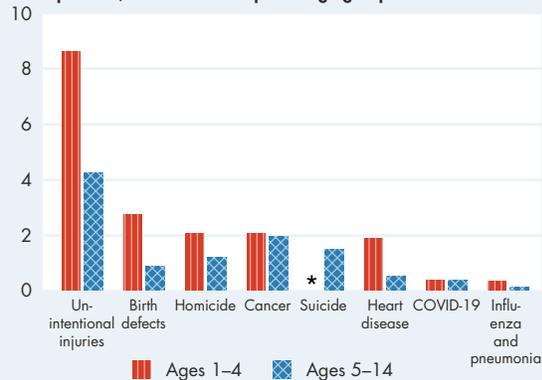


SOURCE: National Center for Health Statistics, National Vital Statistics System.

Indicator PHY7.C

Death rates among children ages 1–14 by cause of death and age group, 2021

Deaths per 100,000 children in specific age group



* Not a cause of death for children ages 1–4. Most suicides in the 5–14 age group are among those ages 10–14.

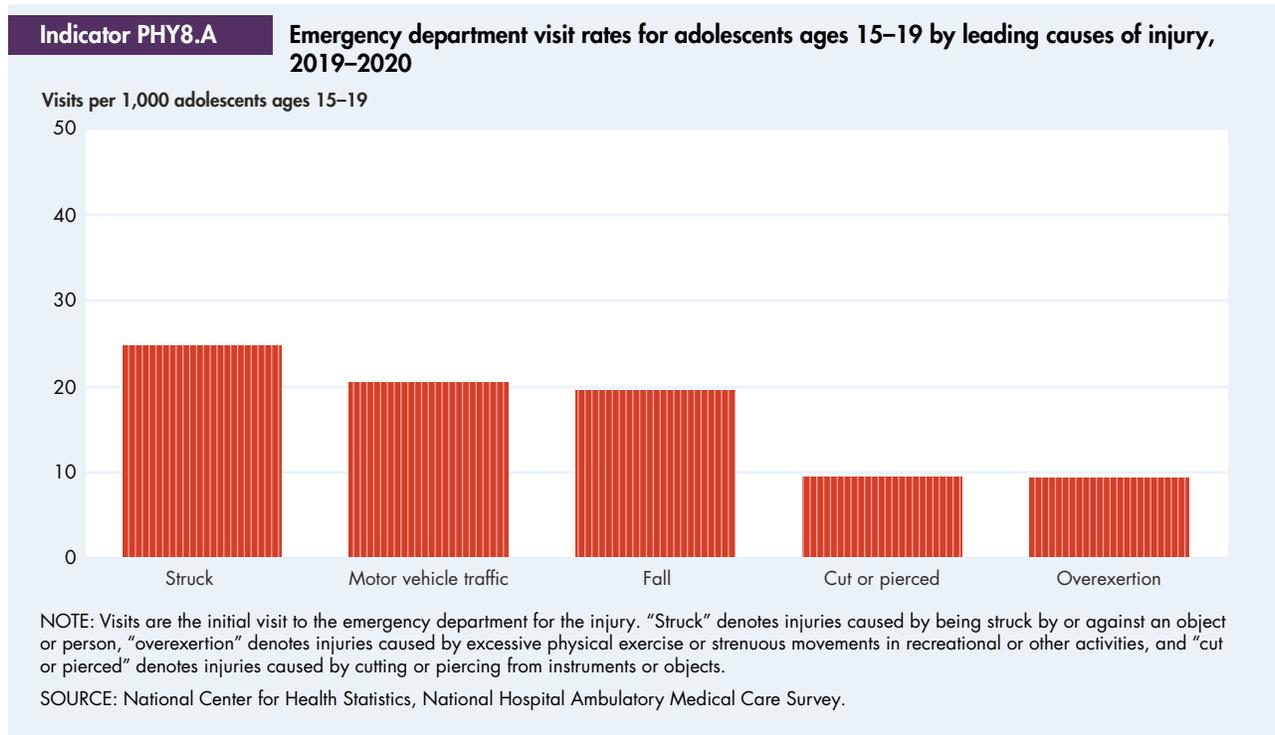
SOURCE: National Center for Health Statistics, National Vital Statistics System.

- From 2011 to 2021, the all-cause death rate among children ages 1–4 declined from 26.3 deaths per 100,000 to 25.0 deaths per 100,000. The injury-related death rate among children ages 1–4 decreased from 11.4 deaths per 100,000 in 2011 to 9.5 deaths per 100,000 in 2019 but did not change significantly through 2021 at 11.2 deaths per 100,000.
- The all-cause death rate among children ages 5–14 increased from 13.2 deaths per 100,000 in 2011 to 14.3 deaths per 100,000 in 2021. The injury-related death rate increased from 5.5 deaths per 100,000 in 2011 to 6.0 deaths per 100,000 in 2019 but did not change significantly through 2021 at 7.0 deaths per 100,000.
- In 2021, unintentional injuries (accidents) were the leading cause of death for children ages 1–4 (8.5 deaths per 100,000) and ages 5–14 (4.2 deaths per 100,000). The second leading cause of death was birth defects among children ages 1–4 (2.7 deaths per 100,000) and cancer among children ages 5–14 (1.9 deaths per 100,000).
- Among both younger and older children, males have higher death rates than females. In 2021, males ages 1–4 had a death rate of 27.0 per 100,000 compared with 22.9 deaths per 100,000 for females. Among children ages 5–14, males had a death rate of 16.4 deaths per 100,000 compared with 12.2 per 100,000 for females.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Adolescent Injury and Mortality

Injury accounts for about 77% of adolescent deaths. Compared with younger children, adolescents ages 15–19 have much higher death rates overall and from injuries. Adolescents are much more likely to die from injuries sustained from motor vehicle traffic crashes and firearms than younger children.⁸⁷ The leading causes of nonfatal injury resulting in an emergency department (ED) visit also differ between adolescents and younger children. For example, the leading cause of adolescent nonfatal injury ED visits is being struck by or against an object or person, whereas for younger children, the leading cause of nonfatal injury ED visits is falls (see PHY7.A). In addition, ED visits for nonfatal injuries for adolescents more often result from violence, sports-related activities, or motor vehicle traffic crashes. In 2020, there were 9,628 fatal injuries and more than 1.4 million ED visits for non-fatal injuries among adolescents.⁸⁶

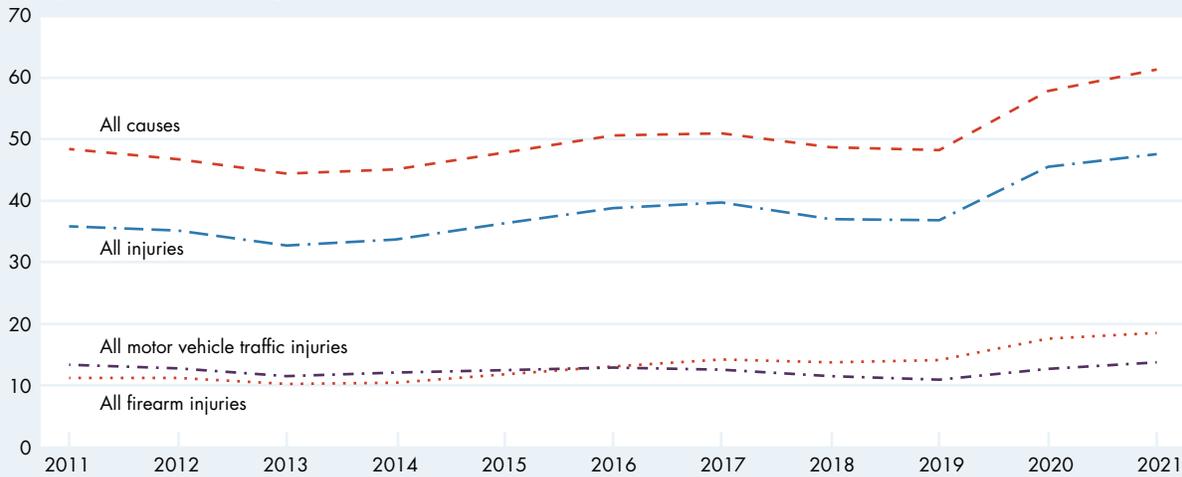


- In 2019–2020, the three leading causes of injury-related ED visits among adolescents ages 15–19 were being struck by or against an object or person (25 visits per 1,000), motor vehicle traffic crashes (21 visits per 1,000), and falls (20 visits per 1,000). These three leading causes accounted for 53% of the injury-related ED visits for this age group.
- The rates for injury-related ED visits resulting from overexertion and being cut or pierced from instruments or objects each resulted in 9 visits per 1,000 adolescents.

Indicator PHY8.B

Death rates among adolescents ages 15–19 by all causes and all injury causes and selected mechanisms of injury, 2011–2021

Deaths per 100,000 adolescents ages 15–19

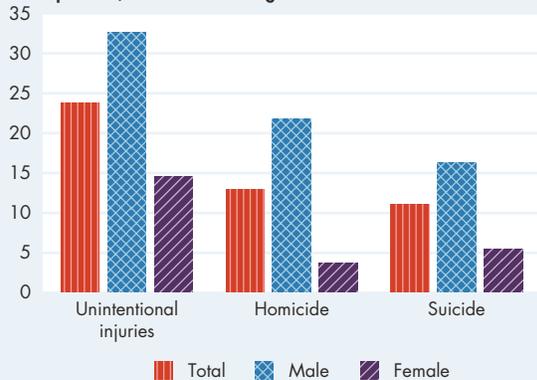


SOURCE: National Center for Health Statistics, National Vital Statistics System.

Indicator PHY8.C

Injury mortality rates among adolescents ages 15–19 by manner of intent and gender, 2021

Deaths per 100,000 adolescents ages 15–19



NOTE: The manner of intent involves whether the injury was purposefully inflicted (if it can be determined) or unintentional. If the injury is deemed intentional, it is further classified as self-inflicted (suicide) or inflicted on another person (homicide).

SOURCE: National Center for Health Statistics, National Vital Statistics System.

- In 2021, the death rate for adolescents ages 15–19 was 62 per 100,000, 13 points higher than the death rate in 2011 (49 deaths per 100,000).
- From 2011 to 2021, injuries were the leading cause of death for adolescents. In 2021, injuries accounted for more than three fourths of adolescent deaths.
- Before 2016, motor vehicle traffic injuries were the leading mechanism of injury deaths among adolescents ages 15–19. In 2016, there was no significant difference between deaths related to motor vehicle traffic injuries and firearm injuries. However, beginning in 2017, firearm-related injury deaths (18 deaths per 100,000 in 2021) became more common than motor vehicle traffic deaths (13 deaths per 100,000 in 2021).
- For motor vehicle traffic injuries, the death rate fluctuated from 2011 to 2019 but did not change significantly.
- For firearm injuries, the death rate was stable from 2011 to 2013 and then increased from 10 deaths per 100,000 in 2013 to 18 deaths per 100,000 in 2021.
- The unintentional injury (accident) death rate in 2021 was higher among male adolescents (32 deaths per 100,000) than among female adolescents (14 deaths per 100,000). The homicide rates also were higher among males than females (22 deaths per 100,000 and 4 deaths per 100,000, respectively), as were the suicide rates (16 deaths per 100,000 and 5 deaths per 100,000, respectively).

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

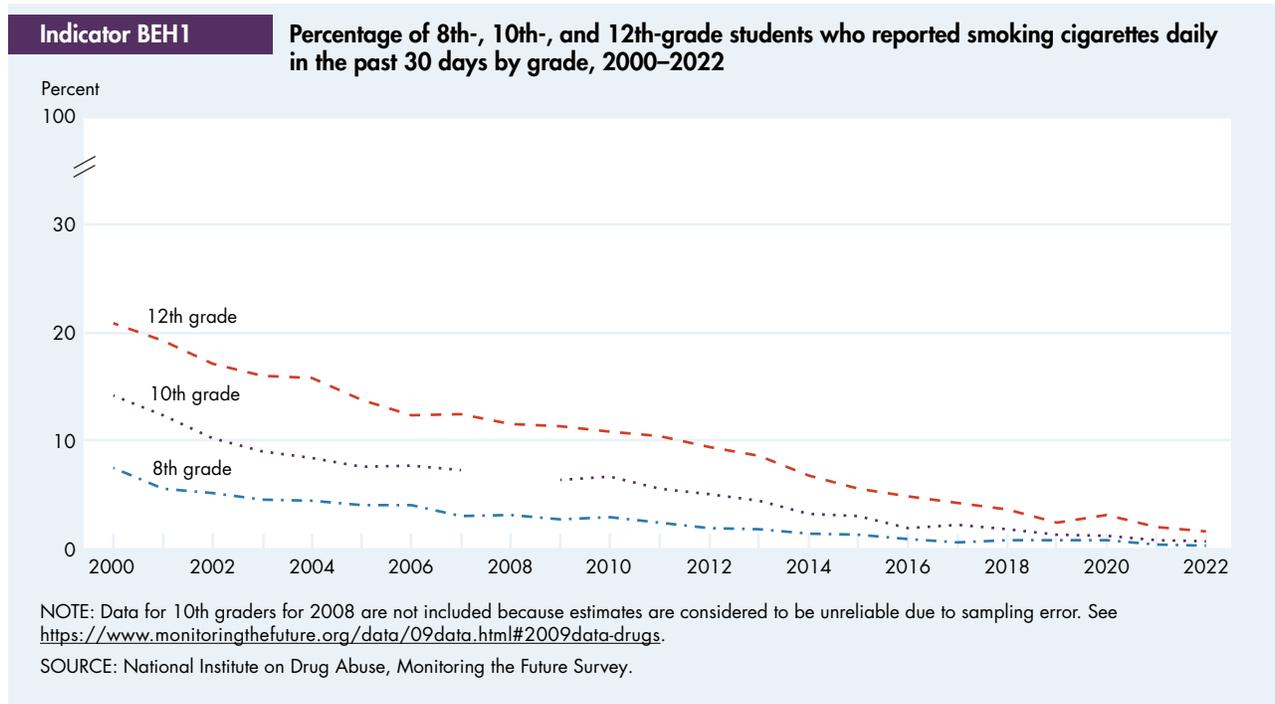


Behavior

The well-being of young people can be affected by aspects of their behavior and social environments. The indicators in this section focus on illegal and high-risk behaviors. Substance-use behaviors are shown for regular cigarette smoking, alcohol use, and illicit drug use. Other indicators in this section present data on behaviors such as sexual activity and the perpetration of serious violent crime.

Regular Cigarette Smoking

Smoking has serious long-term consequences, including the risk of smoking-related diseases and premature death, as well as the increased health care costs of treating associated illnesses.⁸⁸ More than 480,000 annual deaths are attributable to tobacco use, making tobacco more lethal than all other addictive drugs. Nearly 90% of smokers start smoking by age 18. Each day, nearly 991 youth, ages 12–17, smoke their first cigarette, and another more than 424 youth and young adults who are occasional smokers become daily smokers.⁸⁹ The high rate of incidence and the consequences of cigarette smoking underscore the importance of studying patterns of smoking among adolescents.

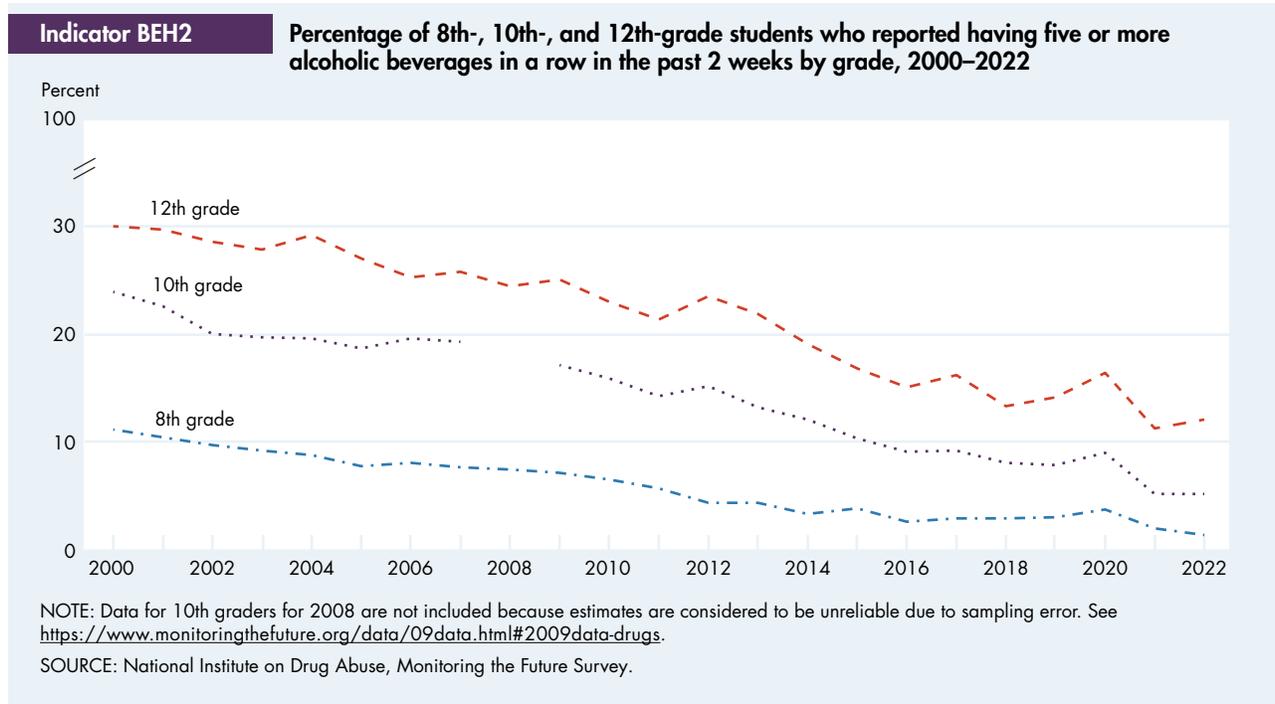


- In 2022, the percentages of 10th- and 12th-grade students who reported smoking cigarettes daily in the past 30 days continued to be the lowest in the history of the survey.
- In 2022, 0.3% of 8th-grade students, 0.7% of 10th-grade students, and 1.6% of 12th-grade students reported smoking cigarettes daily in the past 30 days compared with 7.4%, 14.0%, and 20.6%, respectively, in 2000.
- Daily cigarette use in the past 30 days was reported by 0.3% of male and 0.1% of female 8th graders, by 1% of male and 0.4% of female 10th graders, and by 2.1% of male and 0.8% of female 12th graders.
- Also, in 2022, 2.1% of White, non-Hispanic 12th-grade students reported smoking cigarettes daily in the past 30 days compared with 0.8% of Black, non-Hispanic students and 0.9% of Hispanic 12th-grade students.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on [childstats.gov](https://www.childstats.gov).

Alcohol Use

Alcohol is the most common psychoactive substance used during adolescence. Its use is associated with motor vehicle accidents, injuries, and deaths; problems in school and the workplace; and fighting, crime, and other serious consequences. Early onset of binge drinking, defined here as five or more alcoholic beverages in a row or during a single occasion in the previous 2 weeks, may be especially problematic, potentially increasing the likelihood of these negative outcomes.⁹⁰

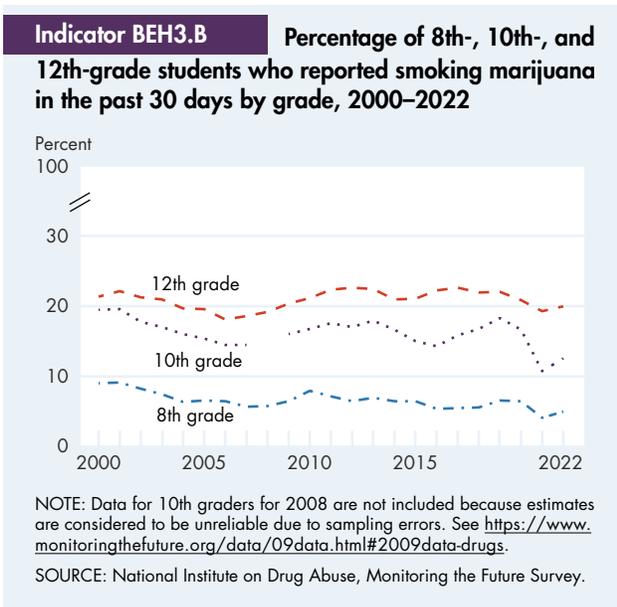
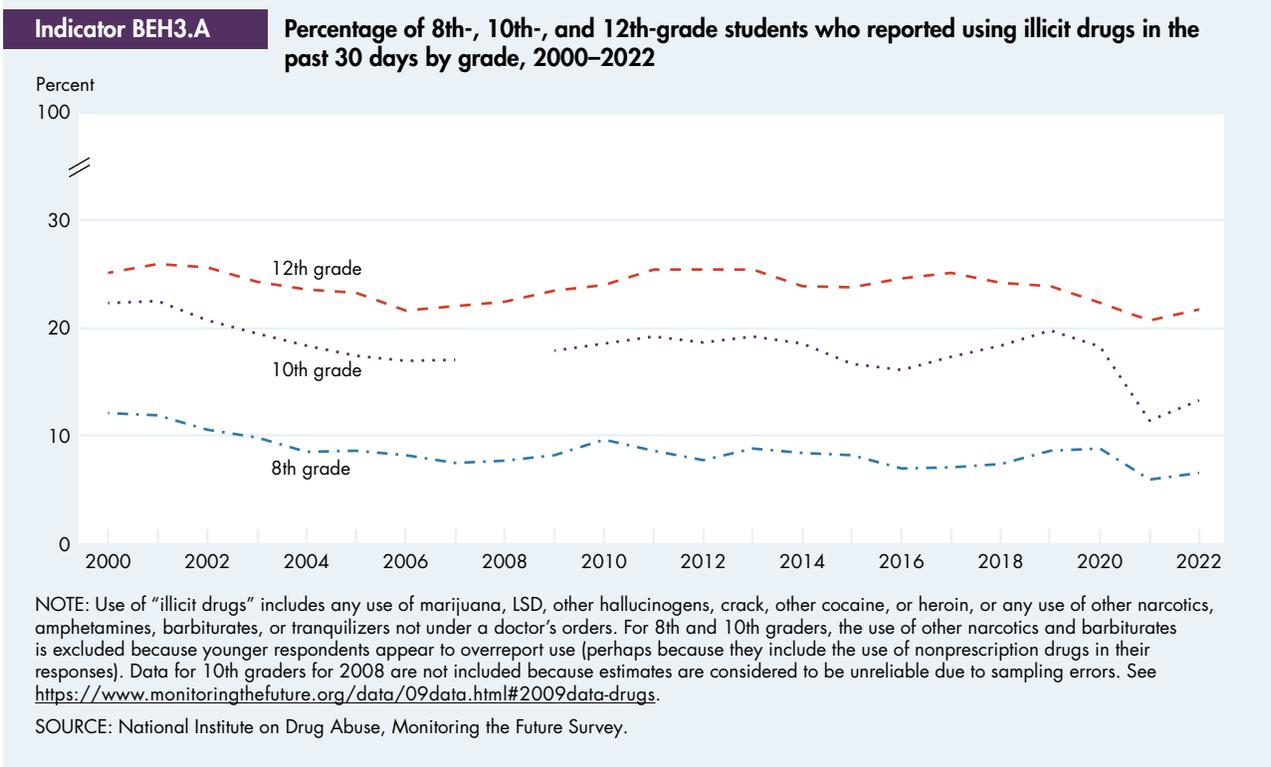


- In 2022, the percentages of 8th-, 10th-, and 12th-grade students who reported binge drinking was 2.2%, 5.9%, and 12.6%, respectively.
- Binge drinking declined from 4.5% in 2020 to 2.2% in 2022 for 8th-grade students, and from 9.6% in 2020 to 5.9% in 2022 for 10th-grade students.
- In 2022, about 2.1% of male and 1.7% of female 8th-grade students reported binge drinking; among 10th-grade students, the proportion was 5.4% for males and 6.1% for female students; and among 12th-grade students, 14.3% of male students and 11.2% of female students reported binge drinking.
- Among 8th-grade students, 2.6% of White, non-Hispanic; 2.1% of Hispanic; and 1.6% of Black, non-Hispanic students reported binge drinking. In the same year, 6.6% of White, non-Hispanic; 5.8% of Hispanic; and 3.8% of Black, non-Hispanic 10th-grade students reported binge drinking. Among 12th-grade students in 2022, 16.0% of White, non-Hispanic; 8.1% of Hispanic; and 4.5% of Black, non-Hispanic students reported binge drinking.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on [childstats.gov](https://www.childstats.gov).

Illicit Drug Use

Drug use by adolescents can have immediate as well as long-term health and social consequences. Marijuana use may have a wide range of effects, both physical and mental, including cognitive risks.^{91,92} It also is the main driver of illicit drug use among teens, with an estimated one in eight high school seniors reporting use in the past month. Other drug use, such as the misuse of prescription and over-the-counter drugs, can increase the risk of adverse health effects, including overdose—especially when taken in combination with other drugs or alcohol. Hallucinogens, such as MDMA, can affect brain chemistry and may result in problems with memory and learning new information.⁹³ Any illicit drug use during adolescence is a risk-taking behavior that has potentially serious negative consequences.

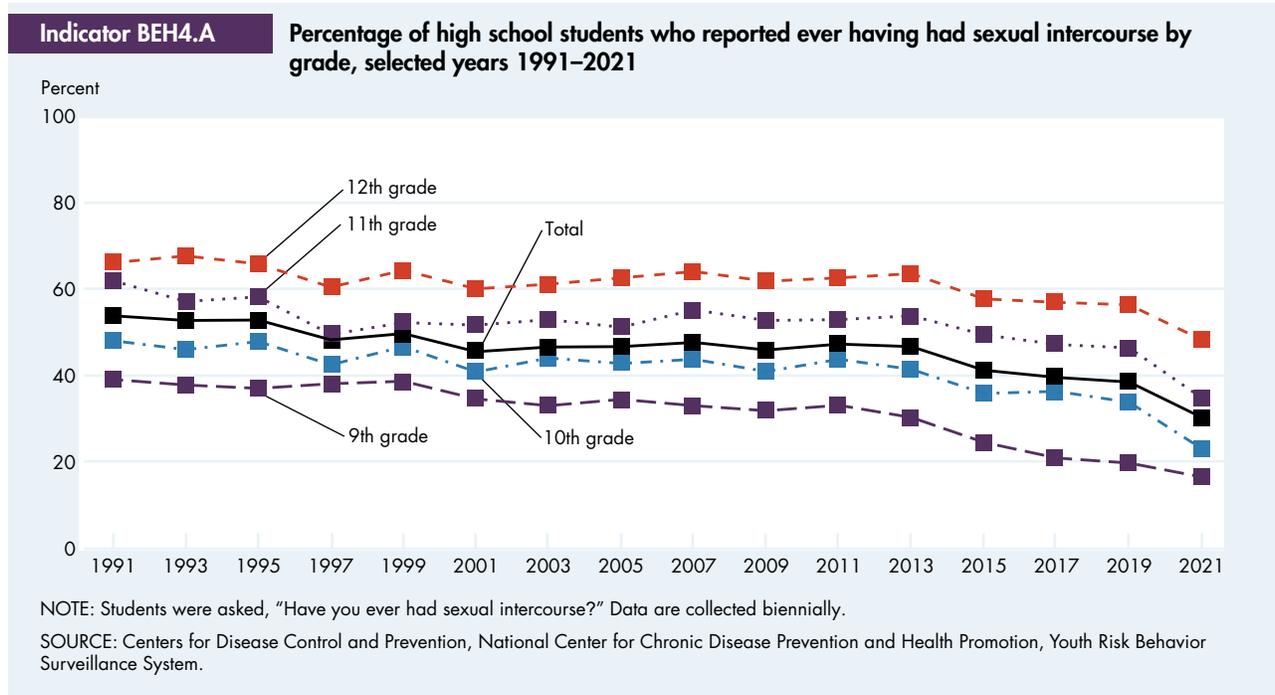


- In 2022, illicit drug use in the past 30 days was reported by 7% of 8th graders, 13% of 10th graders, and 22% of 12th graders. These estimates were not significantly different from 2021.
- In 2022, illicit drug use in the past 30 days was reported by 6% of male and 7% of female 8th graders, by 12% of male and 14% of female 10th graders, and by 21% of male and 22% of female 12th graders.
- Marijuana use in the past 30 days was reported by 5% of 8th graders, 12% of 10th graders, and 20% of 12th graders in 2022. Rates remained unchanged between 2021 and 2022.

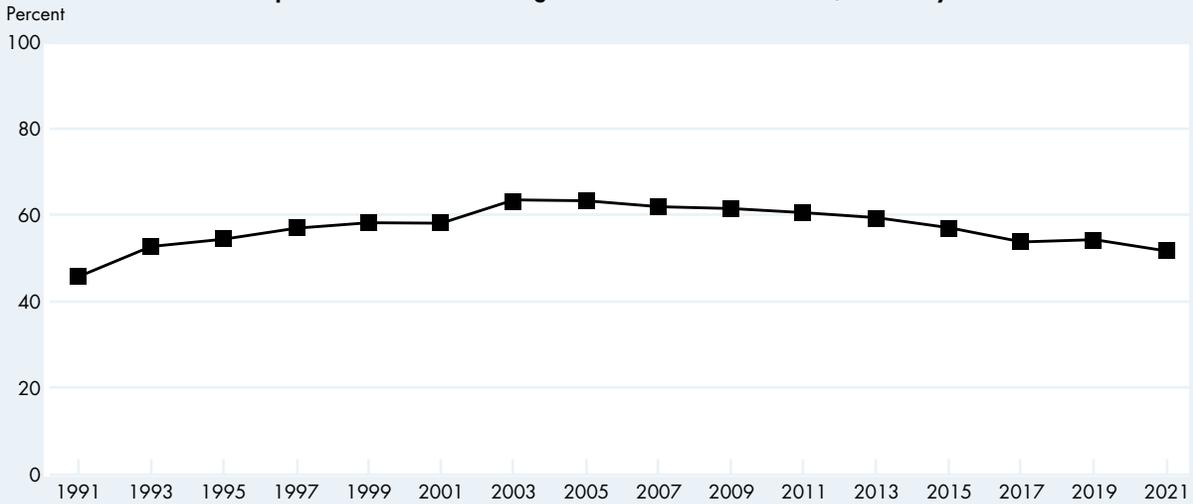
Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on [childstats.gov](https://www.childstats.gov).

Sexual Activity

Early sexual activity is associated with emotional⁹⁴ and physical health risks. Youth who engage in sexual activity are at risk of contracting sexually transmitted infections (STIs) and becoming pregnant. STIs, including HIV, can infect a person for a lifetime and have consequences, including disability and early death. Delaying sexual initiation is associated with a decrease in the number of lifetime sexual partners,⁹⁵ and having fewer lifetime partners is associated with a decrease in the rate of STIs.^{96,97} In addition, teen pregnancy is associated with a number of negative risk factors, for not only the mother but also for her child (see FAM6).

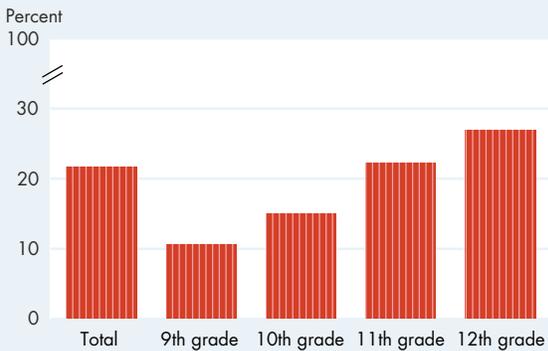


- The percentage of students reporting ever having had sexual intercourse declined from 54% in 1991 to 46% in 2001 and was relatively stable through 2013 (47%) before decreasing to 38% in 2019, and 30% in 2021.⁹⁸
- Between 1991 and 2021, the percentage of students reporting ever having had sexual intercourse declined among all four grades: 9th grade (39% to 16%), 10th grade (48% to 23%), 11th grade (62% to 35%), and 12th grade (67% to 48%).

Indicator BEH4.B**Among students who had sexual intercourse in the past 3 months, the percentage who reported condom use during their last sexual intercourse, selected years 1991–2021**

NOTE: Students were asked, “The last time you had sexual intercourse, did you or your partner use a condom?” Data are collected biennially.

SOURCE: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Youth Risk Behavior Surveillance System.

Indicator BEH4.C**Among high school students who reported having had sexual intercourse during the past 3 months, the percentage who reported use of birth control pills to prevent pregnancy before last sexual intercourse with opposite-sex partner by grade, 2021**

NOTE: Changes in question wording made this measure incompatible with similar data gathered in prior years, so estimates here are limited to 2021. Data for birth control pill use are based on the student’s response to the question, “The last time you had sexual intercourse with an opposite-sex partner, what one method did you or your partner use to prevent pregnancy?” “Birth control pills” was one option. Birth control pills to prevent pregnancy does not include emergency contraception such as Plan B or the “morning after” pill. Data are collected biennially.

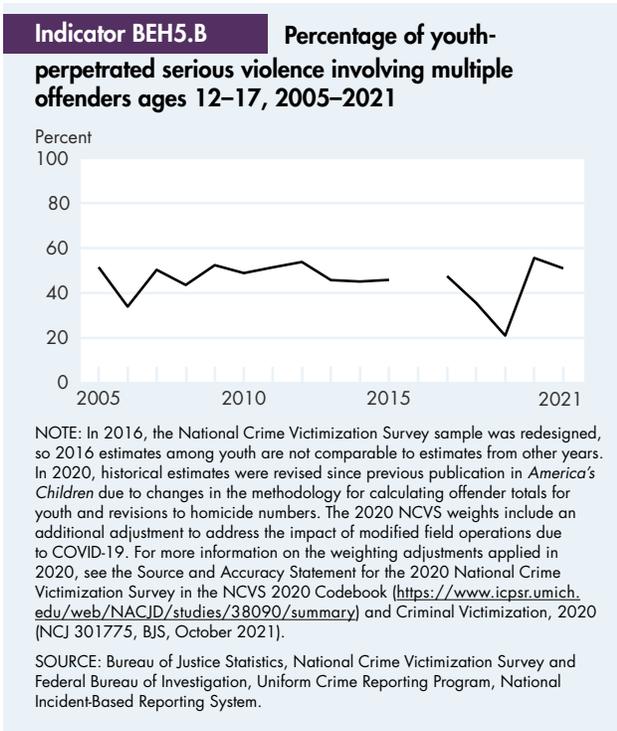
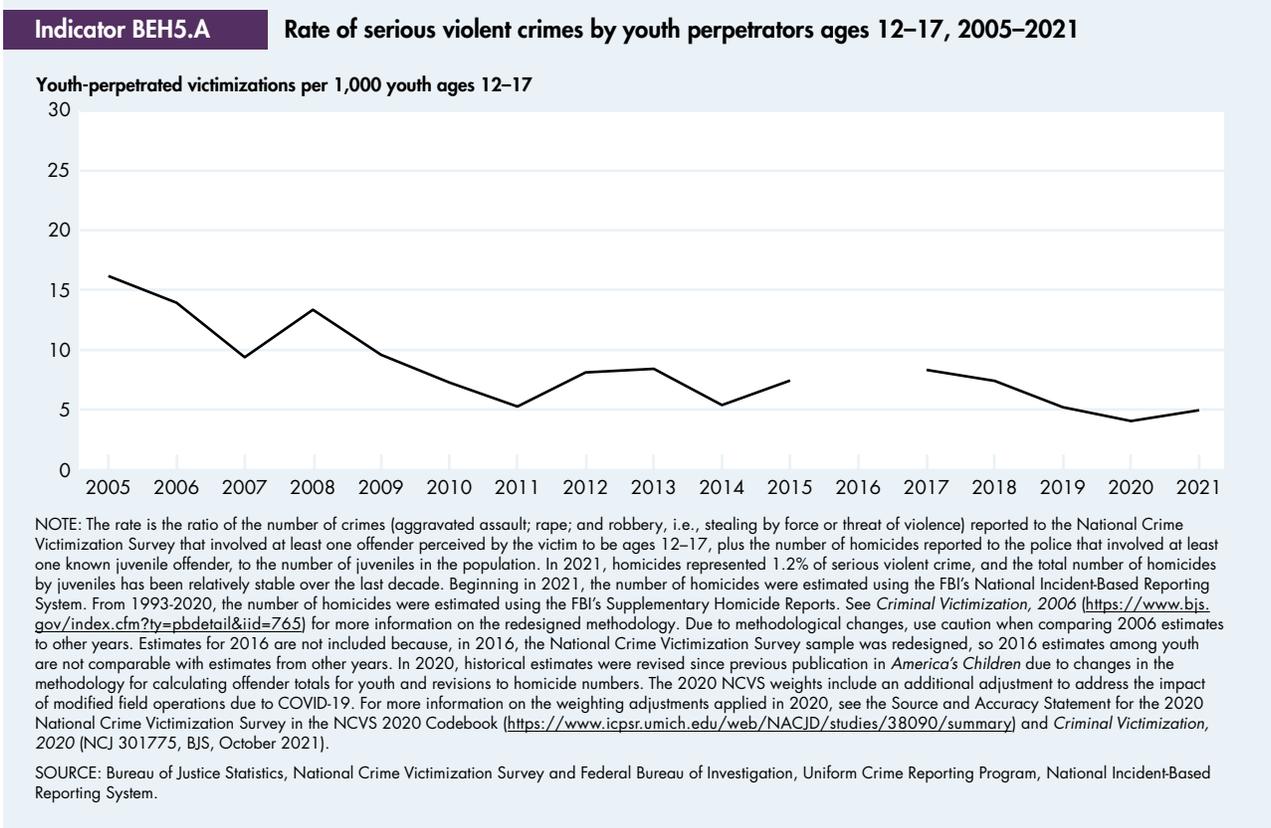
SOURCE: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Youth Risk Behavior Surveillance System.

- Among sexually active students, the percentage reporting they or their partner used a condom the last time they had intercourse increased between 1991 (46%) and 2005 (63%) and then decreased to 52% in 2021.
- The percentage of students who used birth control pills before last sexual intercourse with opposite-sex partner (to prevent pregnancy, not counting emergency contraception such as Plan B or the “morning after” pill, among students who were currently sexually active) was 21% in 2021, ranging from 10% in 9th grade to 26% in 12th grade.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Youth Perpetrators of Serious Violent Crimes

Youth who commit violent crimes tend to exhibit multiple problematic behaviors that affect their well-being, including drug use, risky sexual behaviors, and problems in school.⁹⁹ One measure of youth violence is the rate of serious violent crimes committed by juveniles. Because insufficient data exist to determine the ages of each individual offender when a crime is committed by more than one perpetrator, 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 rate of crimes perpetrated by a juvenile.



- In 2021, the serious violent crime offending rate was 5 crimes per 1,000 juveniles ages 12–17, with a total of 122,900 such crimes involving juveniles. This rate was not significantly different from the rate in 2020 or 2019.
- The violent crime offending rate declined 70% from 17 crimes per 1,000 juveniles ages 12–17 in 2005 to 5 crimes per 1,000 in 2021.
- In 49% of all youth-perpetrated serious violent crimes reported by victims in 2021, more than one offender was involved in the incident.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

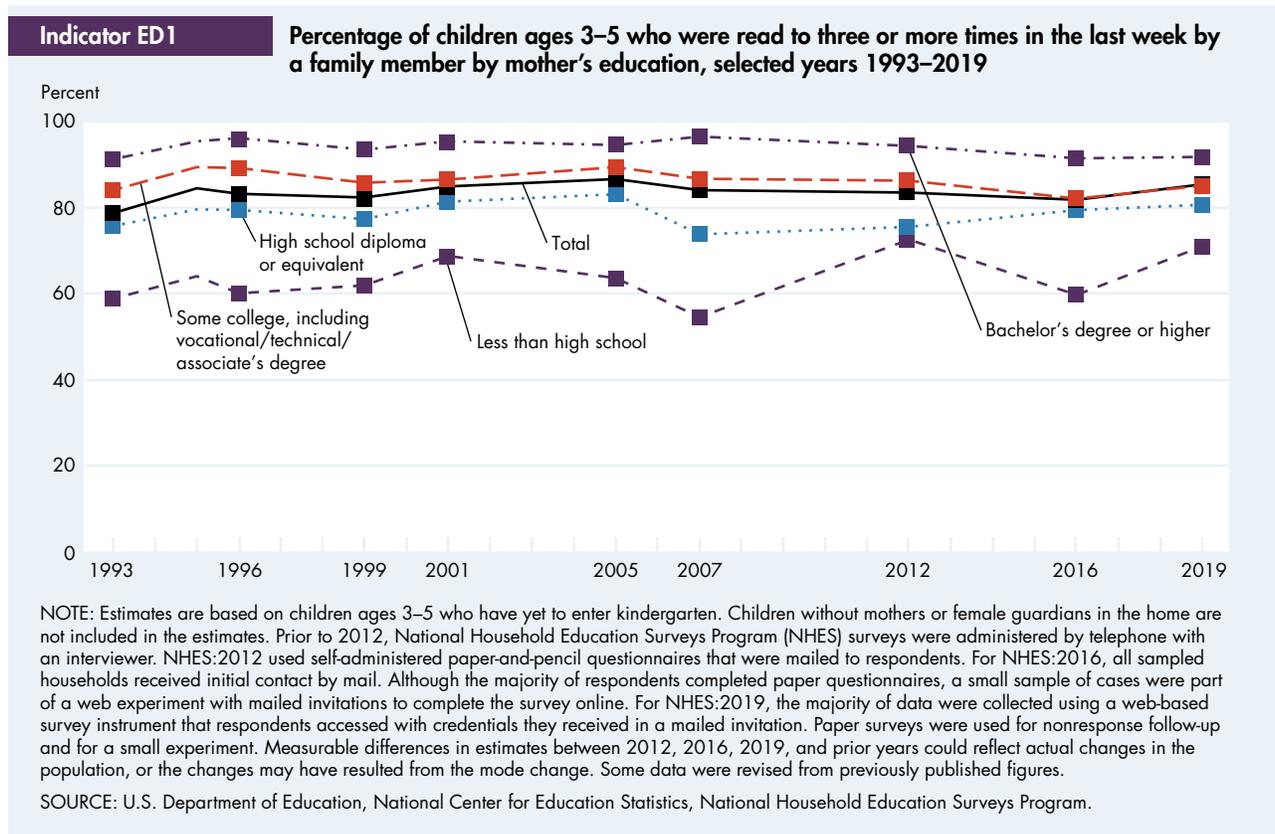


Education

This section presents key indicators of children's learning and progress from early childhood through postsecondary school entry, including family reading to young children, mathematics and reading achievement, and high school academic coursetaking. Indicators on high school completion, college enrollment, and youth neither enrolled in school nor working indicate the level to which youth are prepared for further education or the workforce (or the level to which youth are at risk of limiting their prospects).

Family Reading to Young Children

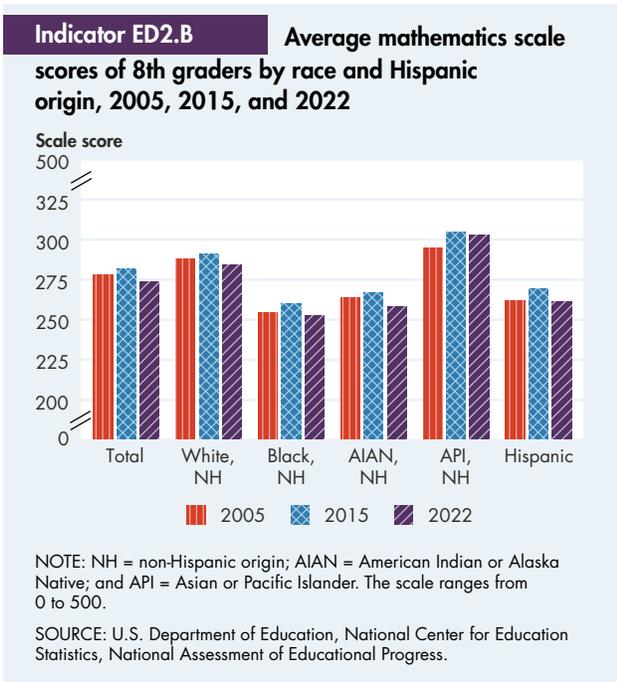
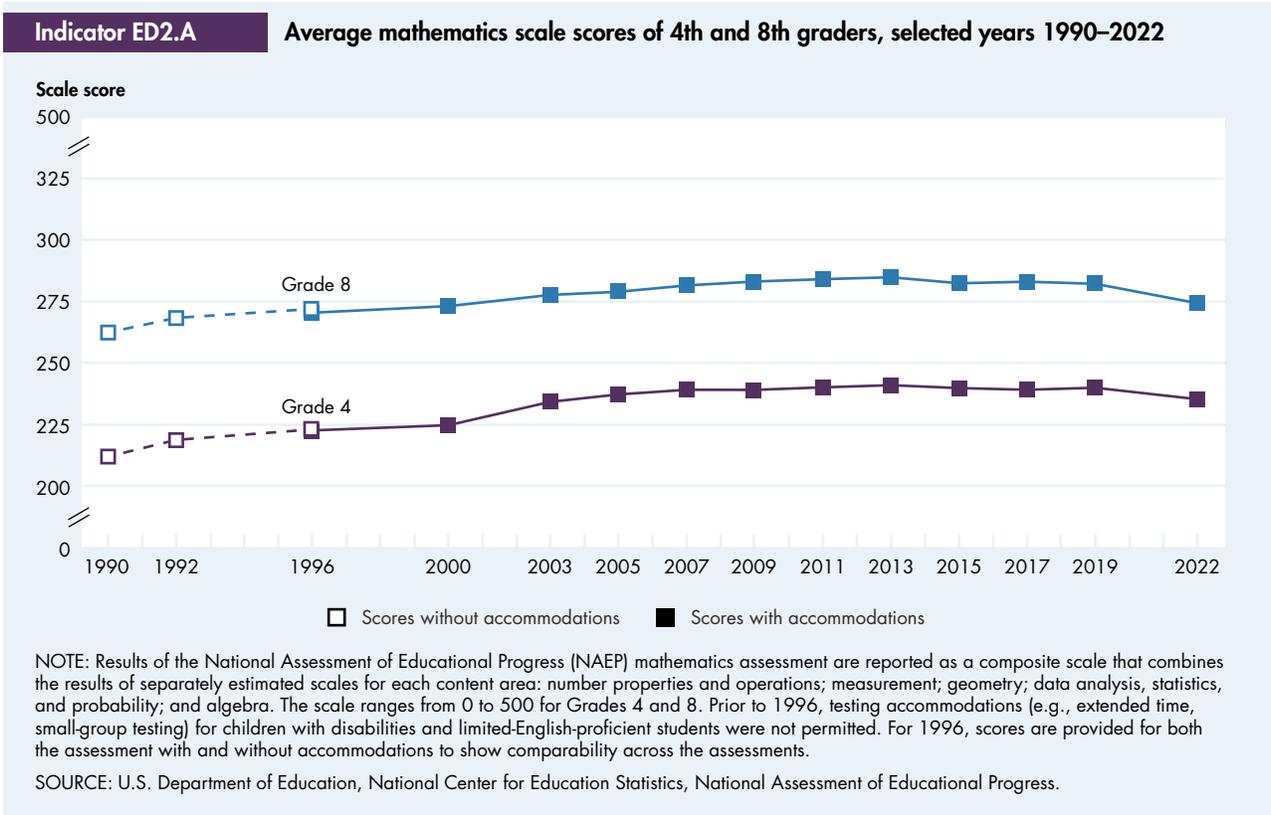
Reading to young children promotes language acquisition and is linked with literacy development and, in later years, with achievement in reading comprehension and overall success in school.¹⁰⁰ The percentage of young children read to three or more times per week by a family member is one indicator of how well young children are being prepared for school.



- In 2019, approximately 85% of children ages 3–5 who were not yet in kindergarten were read to three or more times per week by a family member. This percentage was higher than the percentage in 1993 (78%), although it fluctuated in the intervening years.
 - The percentage of children who were read to three or more times per week by a family member in 2019 was generally higher for those whose mothers had higher levels of educational attainment. For example, 91% of children whose mothers had at least a bachelor’s degree were read to three or more times per week, compared with 84% of children whose mothers had some college education, including a vocational, technical, or associate’s degree; 80% of children whose mothers had a high school diploma or equivalent; and 71% of children whose mothers had less than a high school diploma.
 - For children whose mothers had less than a high school diploma, the percentage of children who were read to three or more times per week by a family member was higher in 2019 (71%) than in 1993 (60%).
 - In 2019, the percentages of children who were read to three or more times per week by a family member were higher for non-Hispanic children who were White (91%) and of Two or more races (89%) than for their Black, non-Hispanic (75%); Asian, non-Hispanic (81%); and Hispanic (77%) peers. There were no statistically significant differences between the percentages of Asian, non-Hispanic; Black, non-Hispanic; and Hispanic children who were read to three or more times per week.
 - In 2019, the percentage of children who were read to three or more times per week by a family member was higher for children in families with incomes at above 200% of the poverty level (88%) than for those in families with incomes at 100%–199% of the poverty level (84%) and those in families with incomes below the poverty level (73%).
- Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.*

Mathematics and Reading Achievement

Factors such as the extent of children’s knowledge and children’s ability to think, learn, and communicate affect the likelihood of their becoming productive adults and active citizens. Mathematics and reading achievement test scores measure students’ skills in these subjects and can be good indicators of overall achievement in school. To assess progress in mathematics and reading, the National Assessment of Educational Progress (NAEP) measures trends in the academic performance of students in Grades 4, 8, and 12. The most recent NAEP mathematics and reading assessments for students in Grades 4 and 8 were conducted in 2022, and the most recent mathematics and reading assessments for students in Grade 12 were conducted in 2019.



- At both Grades 4 and 8, the average mathematics scores in 2022 were higher than in 1990 but were lower than average scores from 2019. At Grade 4, the score dropped 5 points on the score scale between 2019 and 2022, and at Grade 8 the drop was 8 points. At Grade 8, the average mathematics score in 2022 was lower than all previous assessment years going back to 2003.
- At Grade 12, the average mathematics score in 2019 was not measurably different from the score in 2015 or the score in 2005, the earliest year with comparable data.¹⁰¹
- In 2022, at Grade 4, the average mathematics score was 6 points higher for male students than for female students. At Grade 8, the average mathematics score was 2 points higher for male than for female students.
- In 2022, at both Grades 4 and 8, Asian, non-Hispanic students had the highest average mathematics scores. White, non-Hispanic students had the next highest average mathematics scores at each grade level in 2022. At both Grades 4 and 8, Black, non-Hispanic students had lower average mathematics scores in 2022 than did students in other racial/ethnic groups.¹⁰²

Indicator ED2.C

Average reading scale scores of 4th and 8th graders, selected years 1992–2022



NOTE: The National Assessment of Educational Progress (NAEP) reading assessment scale is a composite combining separately estimated scales for each type of reading (literacy and informational) specified by the reading framework. The scale ranges from 0 to 500. The 2000 assessment included data for only Grade 4. In 1992, 1994, and 1998, testing accommodations (e.g., extended time, small-group testing) for children with disabilities and limited-English-proficient students were not permitted. For 1998, scores are provided for both the assessment with and without accommodations to show comparability across the assessments.

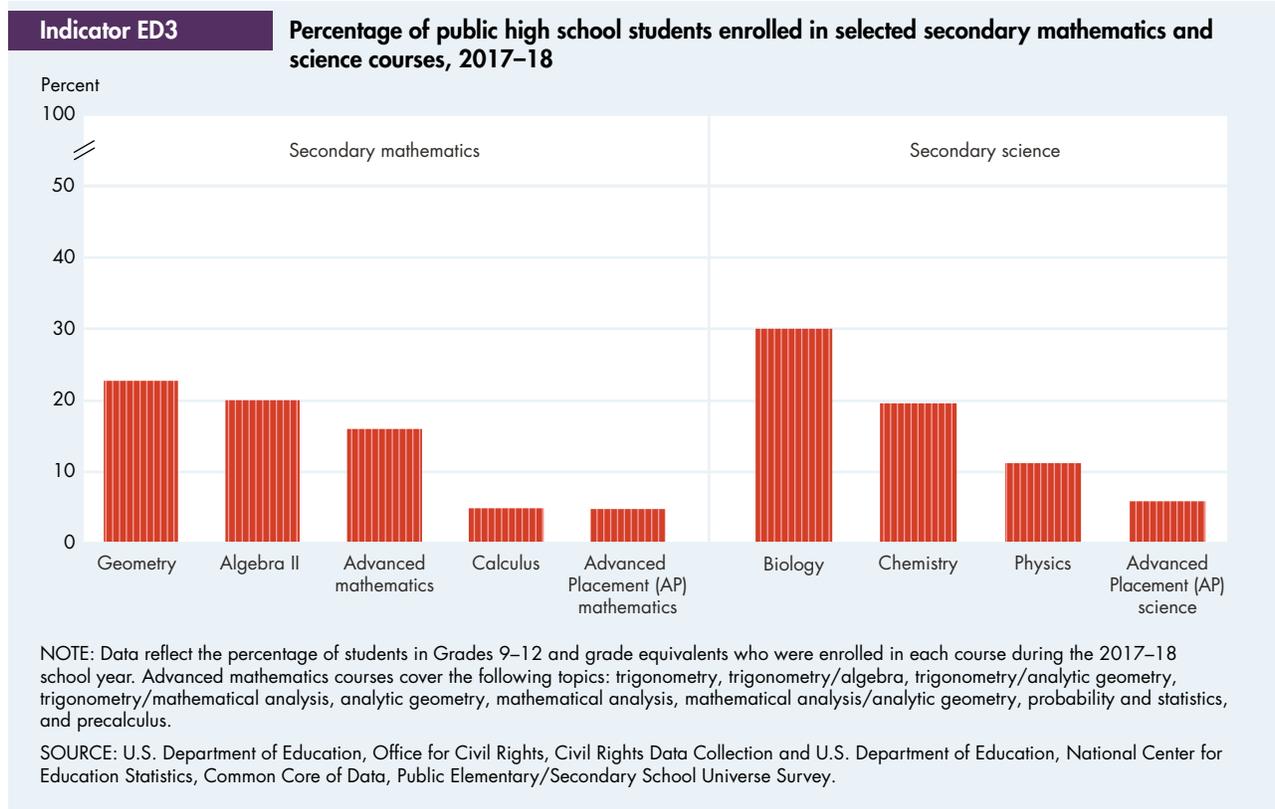
SOURCE: U.S. Department of Education, National Center for Education Statistics, National Assessment of Educational Progress.

- At Grades 4 and 8, the average reading scores in 2022 were lower than the scores in 2019 and not measurably different from the scores in 1992. At both Grades 4 and 8, the drops between 2019 and 2022 were 3 points on the score scale. At Grade 12, the average reading score in 2019 was lower than the score in 2015 and also lower than the score in 1992.
- Unlike the pattern observed on the NAEP mathematics assessment, at both Grades 4 and 8, average reading scores in 2022 were higher for female students than for male students.
- Similar to the NAEP mathematics assessment, at both Grades 4 and 8, Asian, non-Hispanic students had the highest average reading scores in 2022 followed by White, non-Hispanic students.¹⁰²
- Grade 8 students whose parents had higher levels of educational attainment generally had higher average reading scores than students whose parents had lower levels of educational attainment.¹⁰³

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

High School Academic Coursetaking

Since *A Nation at Risk* was published in 1983,¹⁰⁴ school reforms have emphasized increasing the number of academic courses students take in high school. More recent reforms have emphasized increasing the rigor of courses taken. Research suggests that student enrollment in rigorous mathematics and science courses is associated with increased interest in majoring in science, technology, engineering, and mathematics (STEM) fields.¹⁰⁵ Young adults who major in STEM fields tend to have more positive economic outcomes, such as higher median earnings, than those with degrees in non-STEM fields.¹⁰⁶

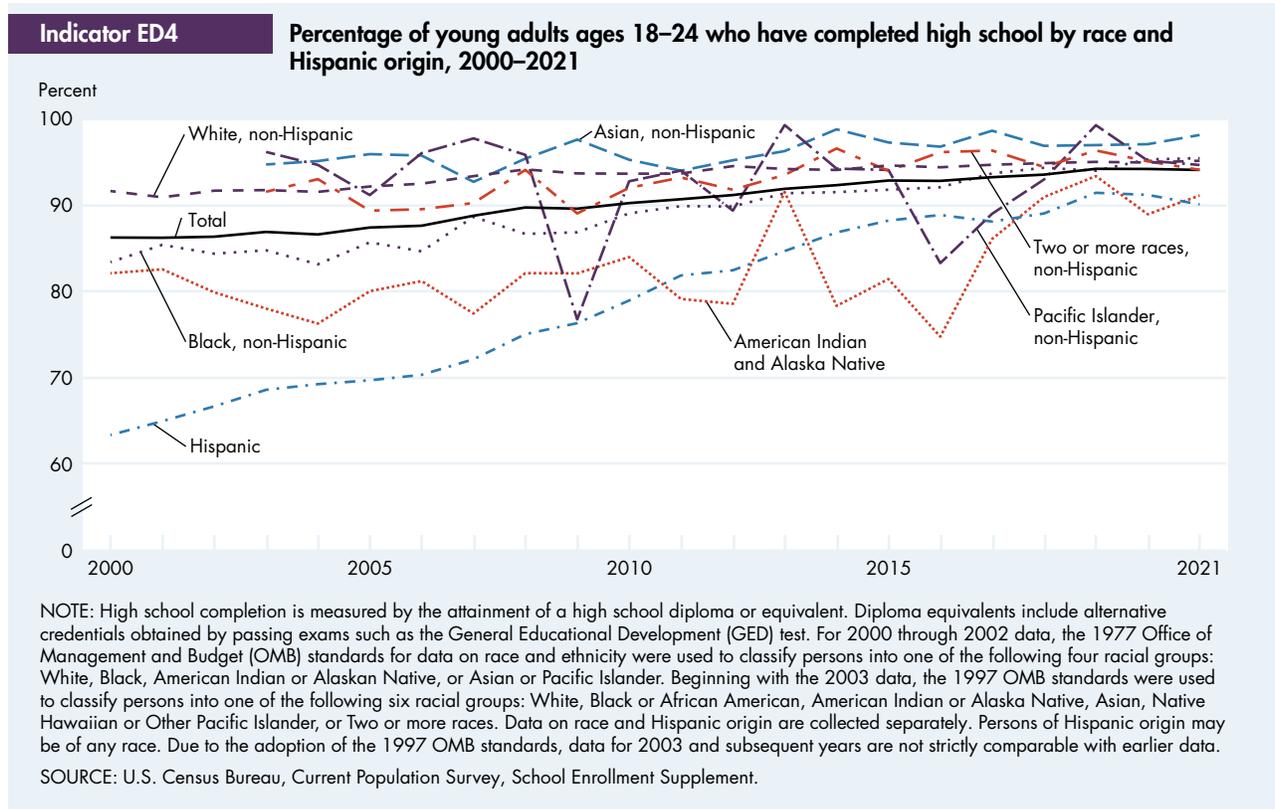


- During the 2017–18 school year, about 23% of public high school students in Grades 9–12¹⁰⁷ were enrolled in geometry classes, 20% were enrolled in algebra II, 16% were enrolled in advanced mathematics, 5% were enrolled in calculus, and 5% were enrolled in Advanced Placement (AP) mathematics. In terms of science classes, about 30% of public high school students were enrolled in biology, 20% were enrolled in chemistry, 11% were enrolled in physics, and 6% were enrolled in AP science.
- During the 2017–18 school year, a higher percentage of females than males in Grades 9–12 in public schools were enrolled in algebra II, advanced mathematics, biology, chemistry, and AP science. A higher percentage of males than females were enrolled in physics.
- Higher percentages of Asian, non-Hispanic students than of students of any other racial/ethnic group were enrolled in calculus and AP mathematics during the 2017–18 school year (13% and 14%, respectively). The percentages of students enrolled in calculus and AP mathematics were lowest for Black, non-Hispanic and American Indian or Alaska Native, non-Hispanic students (2% for both groups and subjects). Similarly, the percentage of students enrolled in AP science was highest for Asian, non-Hispanic students (17%) and lowest for American Indian or Alaska Native, non-Hispanic students (2%).
- For both males and females, a greater percentage of Asian, non-Hispanic students than students of other races/ethnicities enrolled in AP mathematics and AP science.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

High School Completion

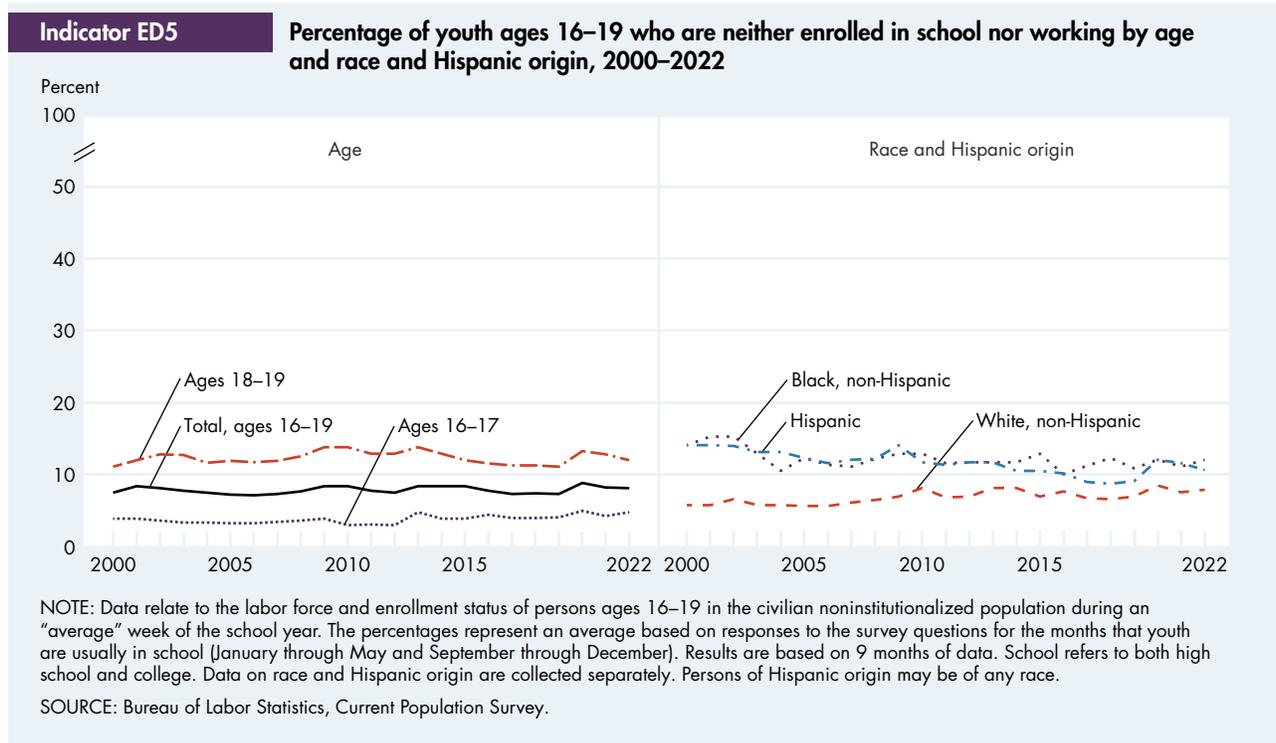
Attainment of a high school diploma or its equivalent is an indicator that a person has acquired the basic academic skills needed to function in today's society. The percentage of young adults ages 18–24 with a high school diploma or an equivalent credential is a measure of the extent to which young adults have completed a basic prerequisite for many entry-level jobs and higher education. Persons with higher levels of education tend to have better economic outcomes than their peers with lower levels of education.¹⁰⁸



- In 2021, about 94% of young adults ages 18–24 had completed high school with a diploma or an alternative credential, such as a General Educational Development (GED) certificate. The high school completion rate has increased since 2000, though there was no measurable difference between the rates in 2021 and 2019, the year immediately before the pandemic.
 - Between 2000 and 2021, the high school completion rate increased for Black, non-Hispanic young adults (from 84% to 96%) and for White, non-Hispanic young adults (from 92% to 95%).
 - During this period, the completion rate for Black, non-Hispanic young adults was lower than that for their White, non-Hispanic peers in every year between 2000 and 2016. In every year between 2017 and 2021, the rates were not measurably different between these two groups.
 - The completion rate for Hispanic young adults increased 26 percentage points¹⁰⁹ between 2000 and 2021, from 64% to 90%, although it was consistently lower than the rates for their White, non-Hispanic and Black, non-Hispanic peers during this period.
 - High school completion rates increased between 2003 (when separate data became available for all race groups) and 2021 for young adults who were Hispanic (from 69% to 90%); American Indian or Alaska Native, non-Hispanic (from 78% to 91%); Black, non-Hispanic (from 85% to 96%); White, non-Hispanic (from 92% to 95%); and Asian (from 95% to 98%). In contrast, the completion rates in 2021 for non-Hispanic young adults who were of Two or more races (94%) and Pacific Islander (95%) were not statistically different from the rates in 2003.
 - In 2021, the high school completion rate was lower for Hispanic young adults (90%) than for their peers of many other racial groups (specifically, 95% for White, non-Hispanic young adults, 96% for Black, non-Hispanic young adults, and 98% for Asian, non-Hispanic young adults). In addition, the completion rates for Black, non-Hispanic young adults (96%) and White, non-Hispanic young adults (95%) were lower than the rate for their Asian, non-Hispanic peers (98%).
- Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.*

Youth Neither Enrolled in School Nor Working

Youth ages 16–19 who are neither in school nor working are detached from core activities that play an important role in a person’s transition from adolescence to adulthood. A report shows that “a disconnected youth will suffer an earnings penalty of over \$30,000 per year in middle adulthood as compared to someone who came from a family with the same income but who was in school or working during those critical, transitional years to adulthood.”¹⁰⁸ 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 2022, 9% of youth ages 16–19 were neither enrolled in school nor working. This estimate is little different from the prior year.

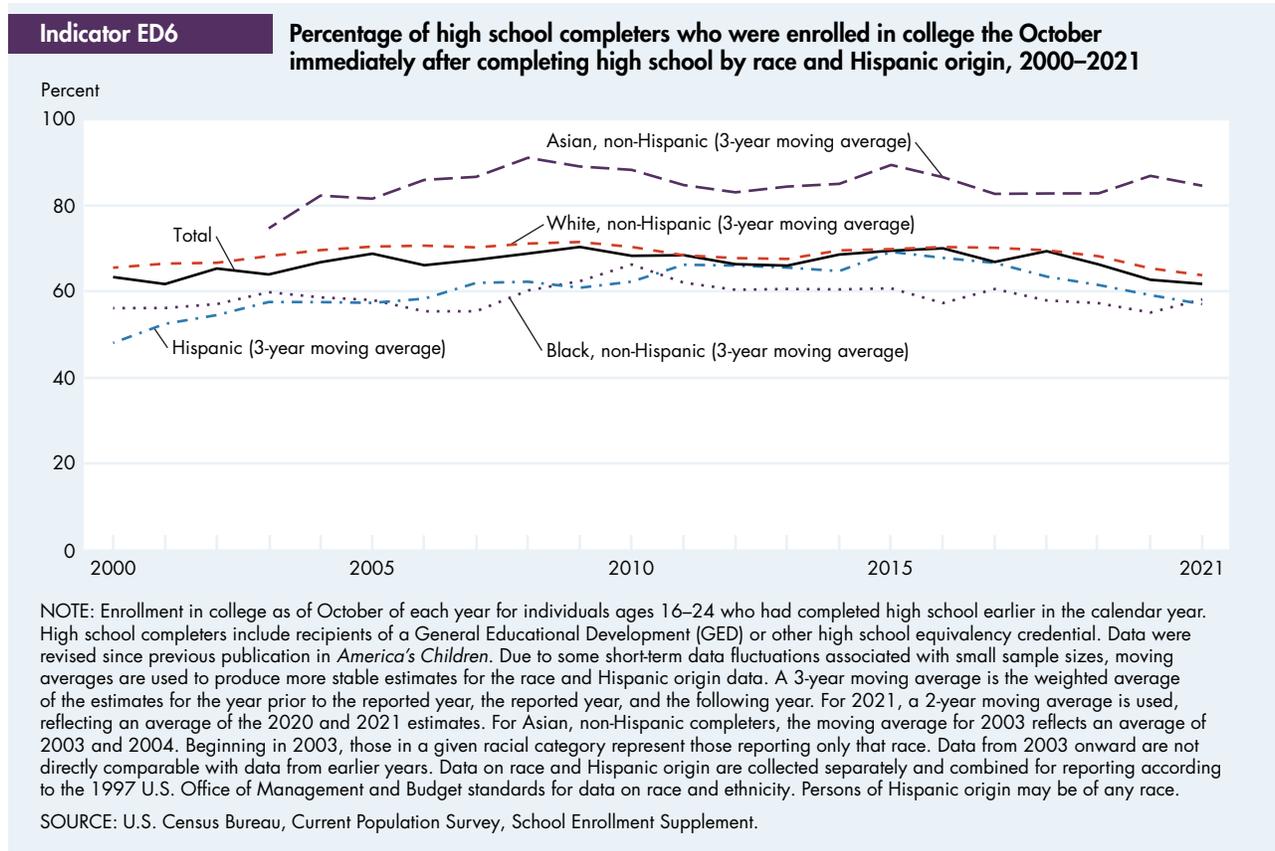


- In 2022, 9% of youth ages 16–19 were neither enrolled in school nor working. This is little different from the prior year (9%).
- Black, non-Hispanic youth and Hispanic youth had higher rates of detachment from work and school than White, non-Hispanic youth. In 2022, 11% of Black, non-Hispanic youth and 10% of Hispanic youth were neither enrolled in school nor working compared with 8% of White, non-Hispanic youth.
- The percentage of Black, non-Hispanic youth and Hispanic youth neither enrolled in school nor working has changed little since 2010.
- Older youth ages 18–19 are almost three times as likely to be detached from school and work activities as youth ages 16–17. In 2022, 13% of youth ages 18–19 were neither enrolled in school nor working compared with 5% of youth ages 16–17.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

College Enrollment

A college education generally enhances a person’s employment prospects and increases his or her earning potential.¹¹⁰ One measure of the accessibility and perceived value of a college education by high school completers is the percentage of these students who enroll in college in the fall immediately after high school. Research shows that high school completers who delay enrollment in postsecondary education are less likely to persist in their education and attain a postsecondary credential.¹¹¹



- In 2021, some 62% of high school completers enrolled in a 2-year or 4-year college in the fall immediately after graduating from high school. This percentage was not measurably different than the corresponding percentage in 2000 (63%).
- The immediate college enrollment rate for Hispanic high school completers increased from 49% in 2000 to 57% in 2021. Similar increases were not present for students in other groups.¹¹² Specifically, in 2000, some 65% of White, non-Hispanic high school completers immediately enrolled in college, which not measurably different from the reported 64% in 2021. Additionally, the immediate college enrollment rates for Black, non-Hispanic high school completers in 2000 (56%) and 2021 (58%) did not measurably differ. Similarly, the immediate college enrollment rates did not measurably differ between 2003 (the first year that separate data for Asian, non-Hispanic students became available) and 2021 for Asian, non-Hispanic high school completers.
- In 2021, the immediate college enrollment rate was higher for Asian, non-Hispanic high school completers (84%) than for their White, non-Hispanic (64%), Black, non-Hispanic (58%), and Hispanic (57%) peers. In 2021, the immediate college enrollment rate also was higher for White, non-Hispanic high school completers than for their Hispanic peers, but neither group’s rate was statistically different from that of their Black, non-Hispanic peers.
- In 2021, the immediate college enrollment rate for female high school completers (70%) was higher than that of their male peers (55%).

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

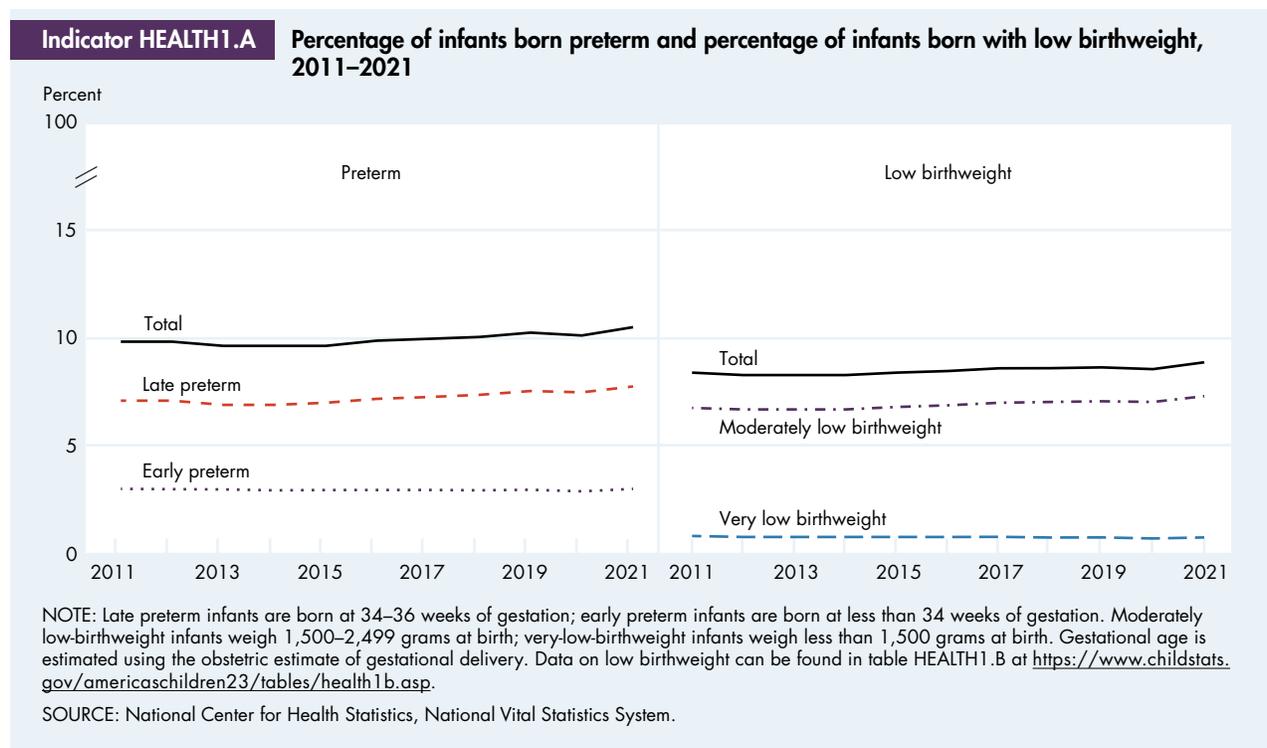
A young woman with dark hair tied back is running on a track. She is wearing a light-colored long-sleeved shirt, dark leggings, and dark sneakers. The background shows a large American flag with stars and stripes, and bleachers in the distance. The entire image has a blue tint.

Health

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 indicators of several aspects or determinants of child health. Some relate to birth outcomes, such as preterm birth, low birthweight, and infant mortality. Others describe key health conditions, including emotional or behavioral difficulties, adolescent depression, obesity, and asthma. An indicator on disability measures 13 core functioning domains and another compares children’s food intake with the *Dietary Guidelines for Americans*.

Preterm Birth and Low Birthweight

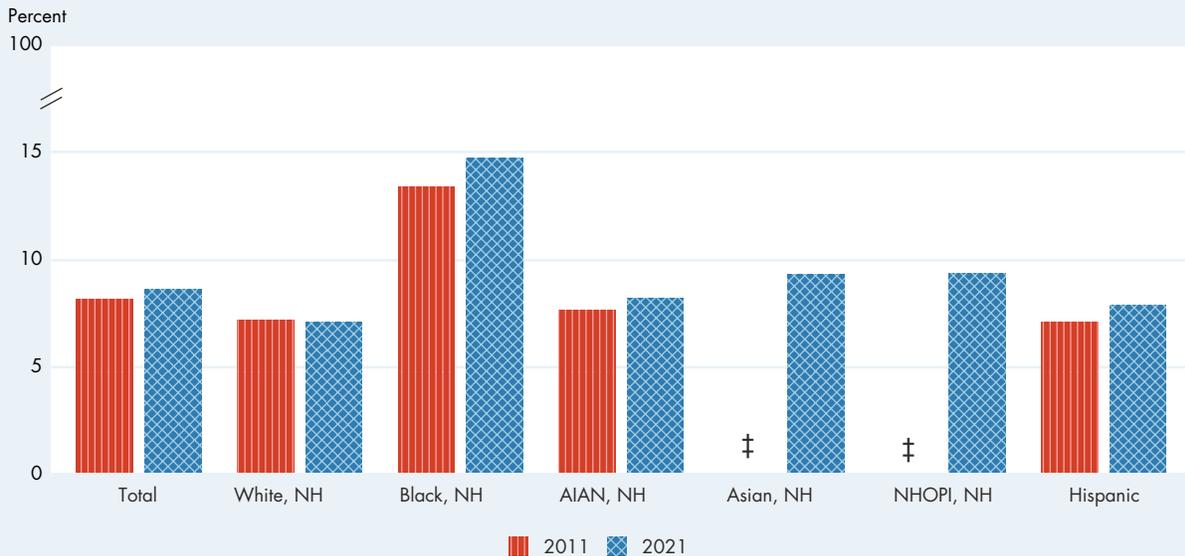
Infants born preterm (less than 37 completed weeks of gestation) or with low birthweight (less than 2,500 grams, or 5 lb 8 oz) are at higher risk of early death and long-term health and developmental issues than infants born later in pregnancy or at higher birthweights.^{20,113,114} Many but not all preterm infants also are low birthweight, and vice versa. Preterm infants born at less than 34 weeks (early preterm) are at high risk for poor outcomes, including chronic health conditions, long-term disability, and death.^{113,115} The majority of preterm births are infants born at 34–36 weeks (late preterm). Late preterm infants are at a lower risk of poor outcomes than infants born earlier but are at a higher risk than infants delivered at term or later.¹¹³ The increasing multiple birth rate was a contributing factor to the rise in preterm birth and low birthweight. However, preterm birth and low-birthweight levels also increased substantially among singleton births.⁸ Disorders related to preterm birth and low birth weight are the second leading cause of infant death in the United States.²⁰



- The percentage of infants born preterm (less than 37 weeks of gestation) was stable from 2011 to 2014 and then increased from 9.6% in 2014 to 10.5% in 2021.
- The percentage of infants born late preterm (34–36 completed weeks of gestation) in 2021 was 8%, slightly up from 7% in 2011.
- The percentage of infants born early preterm (less than 34 completed weeks of gestation) in 2021 was 2.8%, the same percentage as in 2011.
- The percentage of infants born with low birthweight (less than 2,500 grams, or 5 lb 8 oz) increased from 8% in 2011 to 9% in 2021.
- From 2011 to 2021, the percentage of infants born with moderately low birthweight increased (7.1% in 2021), while the percentage of infants born with very low birthweight decreased (1.4% in 2021).

Indicator HEALTH1.B

Percentage of infants born with low birthweight by race and Hispanic origin of mother, 2011 and 2021



‡ Data for Asian, NH and NHOPI, NH groups were not available in 2011.

NOTE: NH = non-Hispanic origin; AIAN = American Indian or Alaska Native; NHOPI = Native Hawaiian or Other Pacific Islander. Starting with 2016 data, race on birth records is available based on the 1997 Office of Management and Budget (OMB) standards and presented as single-race estimates (only one race was reported on the birth certificate). These estimates include separate estimates for Asian, NH and NHOPI, NH groups. Data before 2016 were tabulated according to the 1977 OMB standards and bridged to retain comparability across states as they transitioned from the 1977 standards to those of 1997. Single-race estimates for 2016 onward are not completely comparable with bridged-race estimates for earlier years, particularly for the smaller race categories. Persons of Hispanic origin may be of any race.

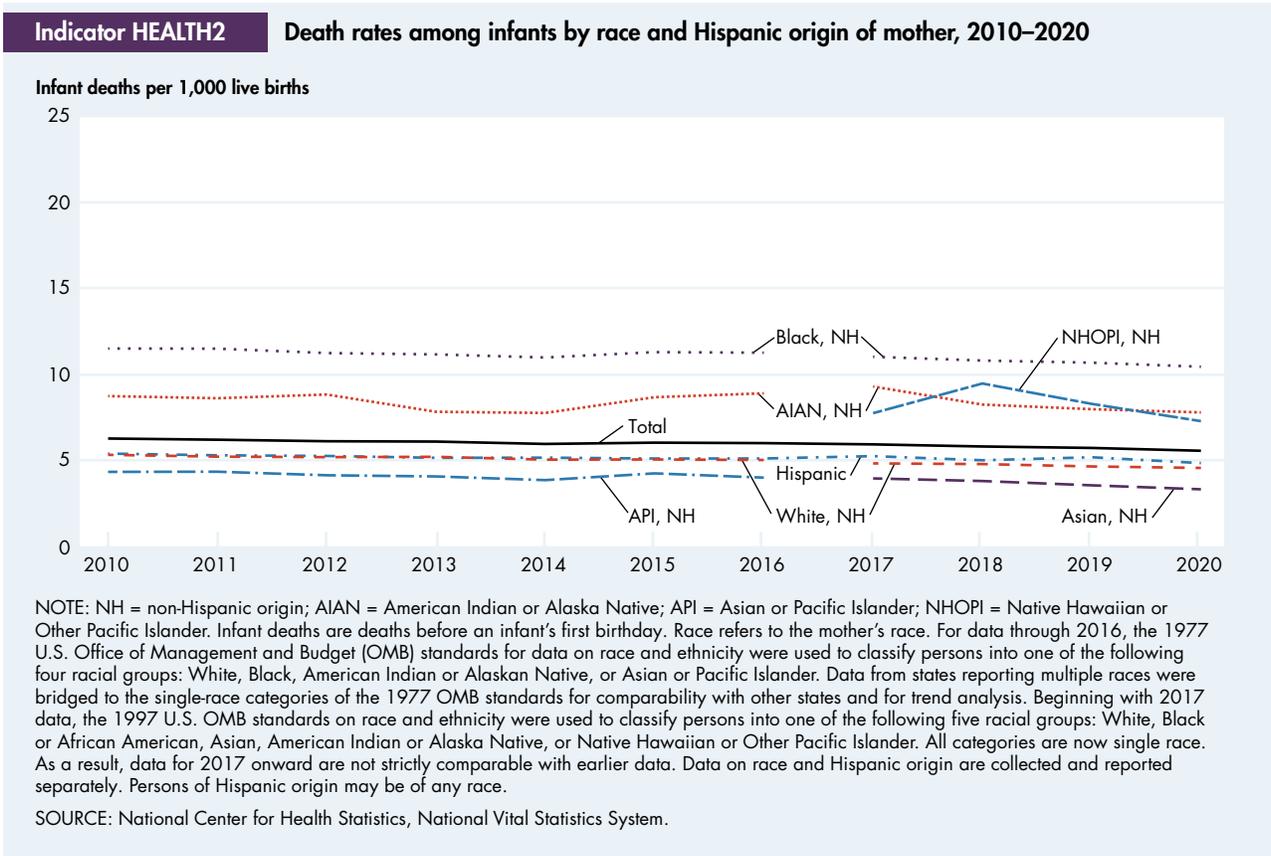
SOURCE: National Center for Health Statistics, National Vital Statistics System.

- In 2021, Black, non-Hispanic women were the most likely to have a low-birthweight infant (15%) compared with Native Hawaiian and Other Pacific Islander, non-Hispanic (9%); Asian, non-Hispanic (9%); American Indian or Alaska Native, non-Hispanic (8%); Hispanic (8%); and White, non-Hispanic (7%) women.
- From 2011 to 2021, the percentage of low-birthweight infants born to Black, non-Hispanic; American Indian or Alaska Native, non-Hispanic; and Hispanic women generally increased, whereas the percentage of low-birthweight infants born to White, non-Hispanic women decreased.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Infant Mortality

Infant mortality is defined as the death of an infant before his or her first birthday. Infant mortality is related to the underlying health of the mother, public health practices, socioeconomic conditions, and the availability and use of appropriate health care for infants and pregnant women.^{8,116} Despite medical advances and public health efforts, the mortality rates of Black, non-Hispanic and American Indian or Alaska Native, non-Hispanic infants have been consistently higher than the rates of other racial and ethnic groups.^{20,117} Higher rates of infants born preterm or at low birthweight account for most of the deaths among Black, non-Hispanic infants.²⁰ Higher rates of birth defects account for much of the deaths among American Indian or Alaska Native, non-Hispanic infants.⁸

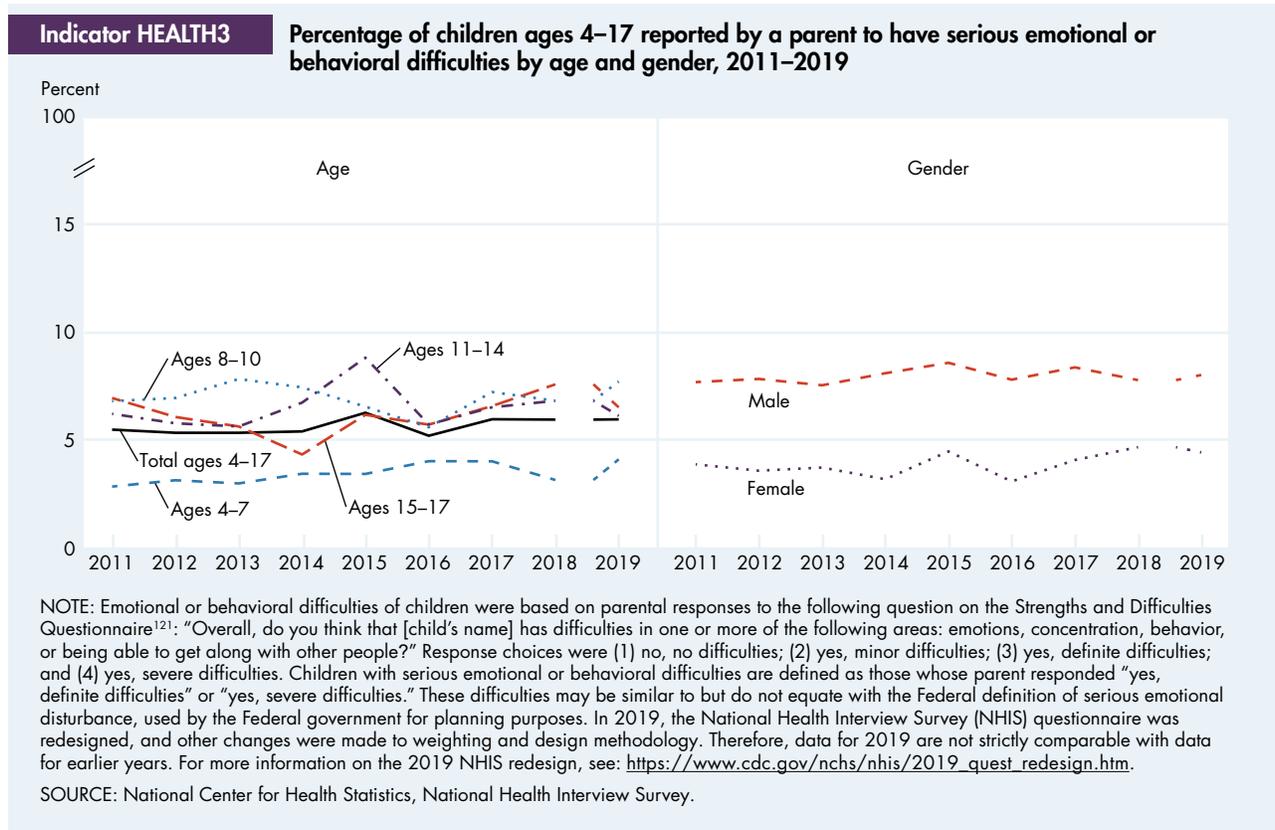


- The infant mortality rate decreased from 6 infant deaths per 1,000 live births in 2010 to 5 infant deaths per 1,000 live births in 2020.
- From 2010 to 2020, the mortality rate decreased for Black, non-Hispanic; Hispanic; and White, non-Hispanic infants. The mortality rate for American Indian or Alaska Native, non-Hispanic infants did not change significantly during the period.
- Although the mortality rate for Asian, non-Hispanic or Pacific Islander, non-Hispanic infants did not change significantly from 2010 to 2016 (4 infant deaths per 1,000 live births in 2016), trends differed for Asian, non-Hispanic and Native Hawaiian or Other Pacific Islander, non-Hispanic infants from 2017 to 2020. The mortality rate decreased from 4 infant deaths per 1,000 live births in 2017 to 3 infant deaths per 1,000 live births in 2020 for Asian, non-Hispanic infants, while the mortality rate did not change significantly for Native Hawaiian or Other Pacific Islander, non-Hispanic infants from 2017 to 2020 (7 infant deaths per 1,000 live births in 2020).
- In 2020, the mortality rate was highest for Black, non-Hispanic infants (10 infant deaths per 1,000 live births), followed by American Indian or Alaska Native, non-Hispanic (8 infant deaths per 1,000 live births); Native Hawaiian or Other Pacific Islander, non-Hispanic (7 infant deaths per 1,000 live births); Hispanic (5 infant deaths per 1,000 live births); White, non-Hispanic (4 infant deaths per 1,000 live births); and Asian, non-Hispanic (3 infant deaths per 1,000 live births) infants.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Emotional and Behavioral Difficulties

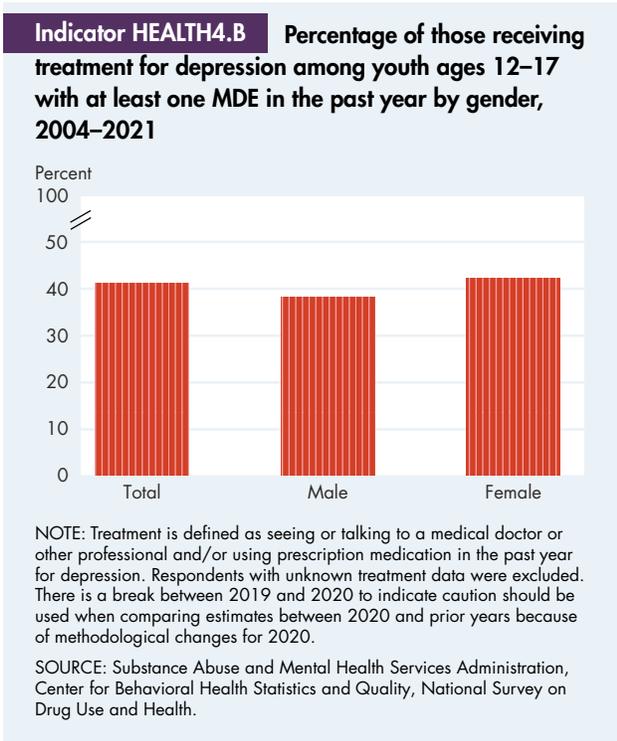
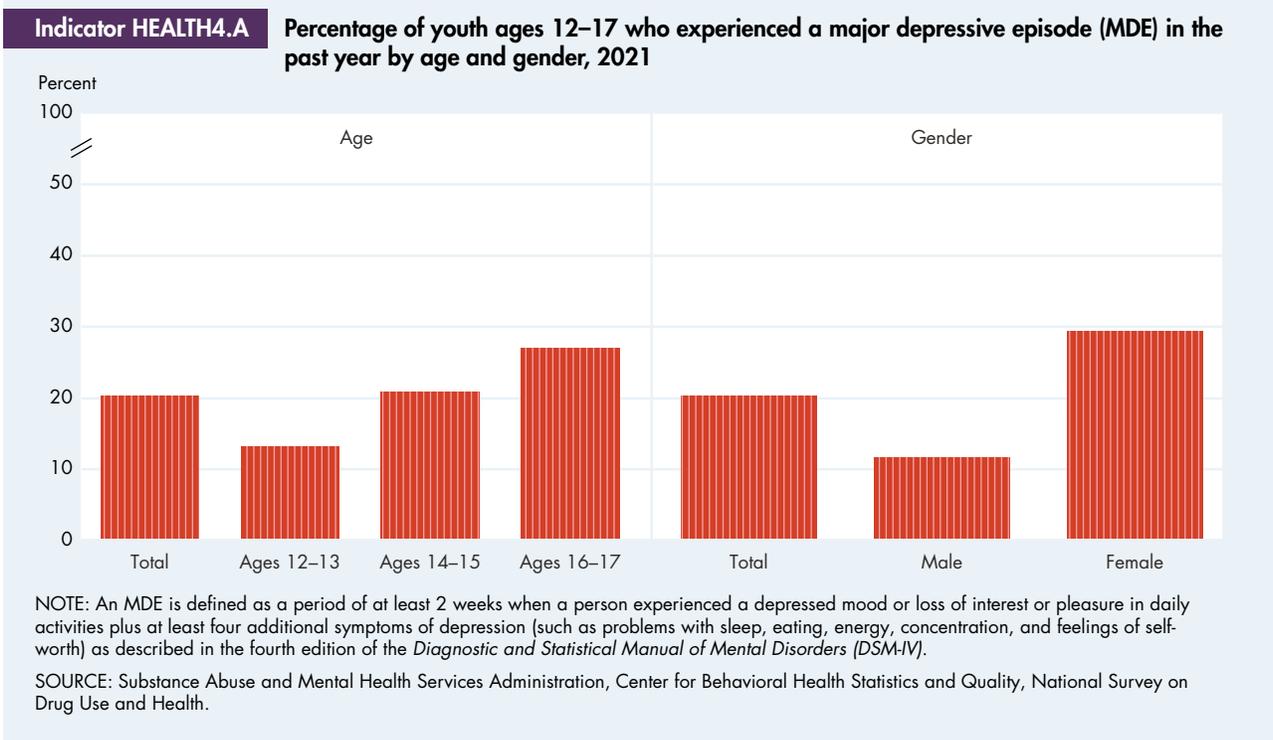
Positive emotional and behavioral health is an integral part of healthy development and enhances a child’s sense of well-being, supports rewarding social relationships with family and peers, and facilitates achievement of full academic potential.¹¹⁸ Children with emotional or behavioral difficulties may experience problems managing their emotions, focusing on tasks, interacting with family and peers, or controlling their behavior. These difficulties, which may persist throughout a child’s development, can lead to lifelong problems.¹¹⁹ Parents play a crucial role in informing health professionals about a child’s emotional and behavioral difficulties and obtaining mental health services.¹²⁰



- In 2019, 6% of children were reported as having serious emotional or behavioral difficulties. The percentage of parents reporting that their child ages 4–17 displayed serious difficulties with emotions, concentration, behavior, or getting along with other people was stable from 2011 to 2018. While estimates varied from 5%–6% during this period, differences were not significant.
 - In 2019, parents of children ages 8–10 (7%) and 15–17 (6%) were more likely to report serious emotional or behavioral difficulties compared with parents of children ages 4–7 (4%).
 - Among children ages 4–17 in 2019, parents were more likely to report serious emotional or behavioral difficulties for boys (7%) than for girls (4%). This pattern was reflected among children ages 4–7 (6% for boys and 2% for girls) and 11–14 (8% for boys and 4% for girls) but not among children ages 8–10 and 15–17 for which there was no significant difference.
 - In 2019, the percentage of children reported as having serious emotional or behavioral difficulties was higher among children living with a relative or guardian who was not a parent (9%) or with a single mother (8%) compared with children living with two parents (5%) or with a single father (4%).
- Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.*

Adolescent Depression

Depression has a significant impact on adolescent development and well-being.¹²² Adolescent depression can adversely affect school and work performance, impair peer and family relationships, and exacerbate the severity of other health conditions such as asthma and obesity.^{123,124,125} Depressive episodes often persist, recur, or continue into adulthood.¹²⁶ Youth who have had a major depressive episode (MDE) in the past year are at greater risk for suicide and are more likely than other youth to initiate alcohol and other drug use, experience concurrent substance use disorders, and smoke daily.^{127,128,129}

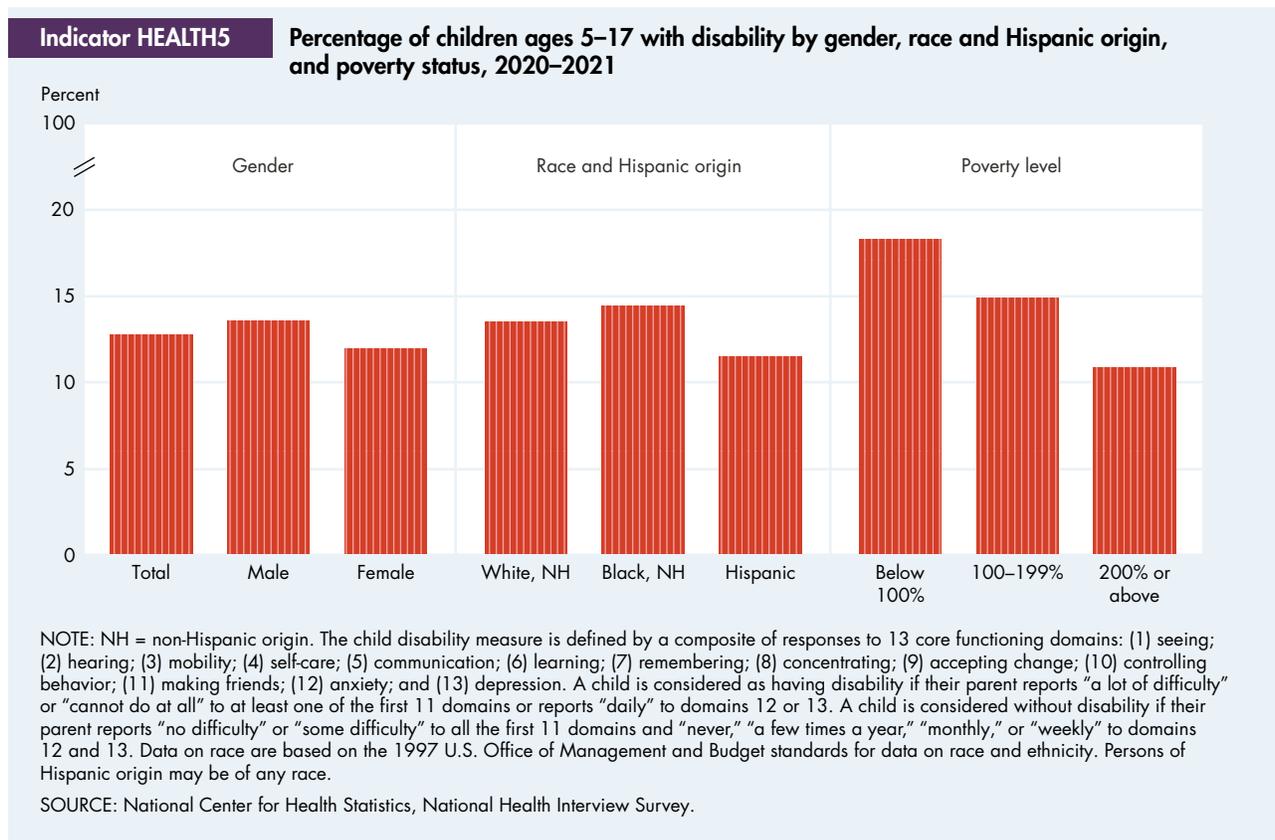


- In 2021, 20% of the population ages 12–17 had at least one MDE during the past year.
- Among youth ages 12–17, the prevalence of MDE was more than twice as high among females (29%) as among males (12%).
- The prevalence of MDE in 2021 was lowest among youth ages 12–13 (13%) compared with youth ages 14–15 (21%) and ages 16–17 (27%).
- In 2021, the prevalence of MDE with severe impairment was 15%. Nearly three times as many females (22%) experienced MDE with severe impairment compared with males (8%).
- Nearly 60% of youth with MDE in the past year did not receive treatment for depression in 2021.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Disability

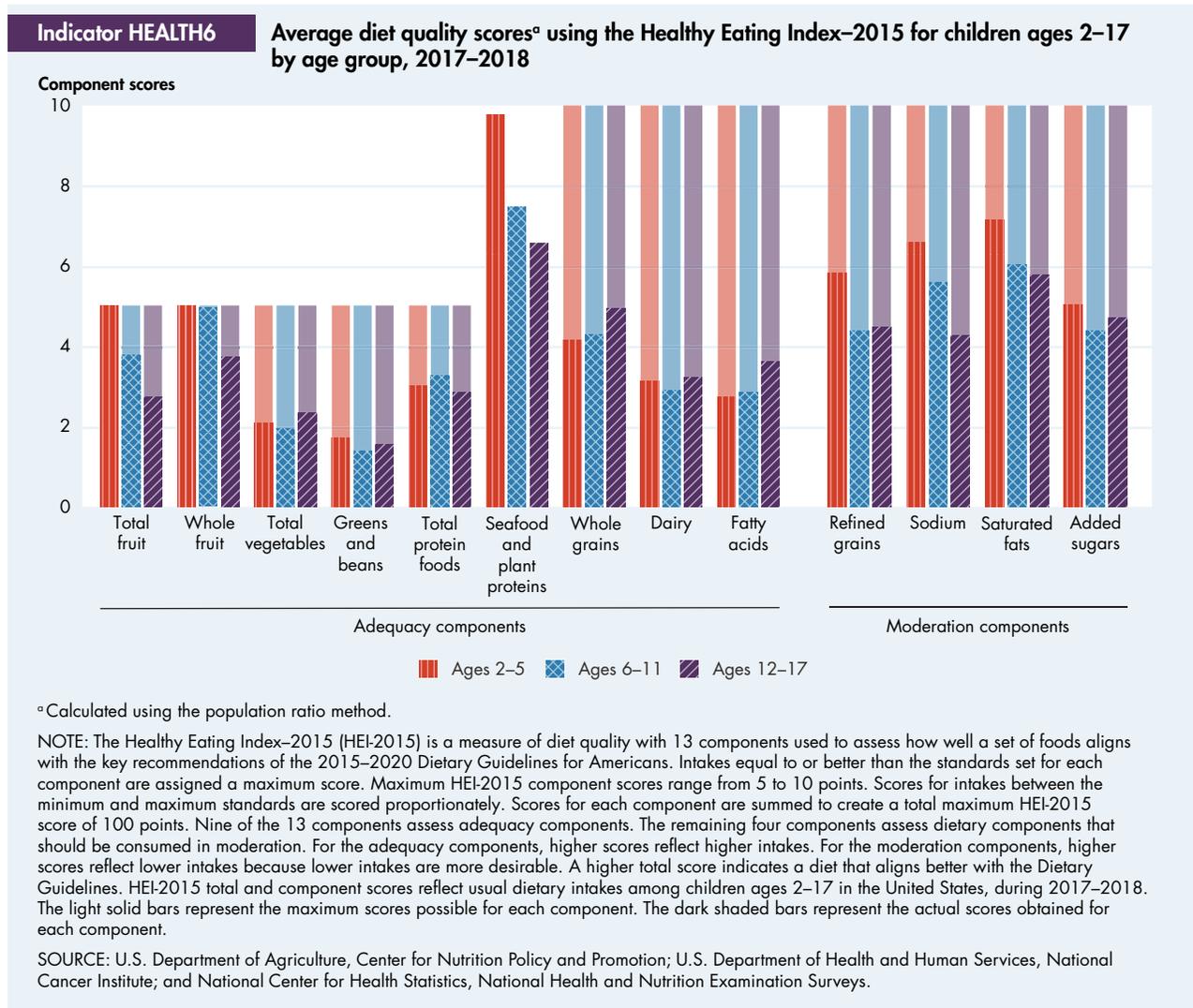
Disability affects all aspects of a child’s life, and the impacts of disability in childhood extend into adulthood.¹³⁰ Children with disabilities may be disproportionately exposed to risk factors that can affect their survival and development, such as poverty, stigma and discrimination, institutionalization, abuse and neglect, and limited access to services, programs, and educational opportunities.¹³¹



- In 2020–2021, 13% of children ages 5–17 were reported to have disability.
 - There was no significant difference in the percentage of reported disability for males (14%) and females (12%).
 - There was no significant difference in the percentage of reported disability for White, non-Hispanic (13%); Black, non-Hispanic (14%); and Hispanic (11%) children.
 - Children with family incomes below poverty (18%) and those with family incomes at 100%–199% of the poverty level (15%) were more likely to report disability than children with family incomes at or above 200% of the poverty level (11%).
- Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.*

Diet Quality

The Dietary Guidelines for Americans provide science-based advice on what to eat and drink to promote health, reduce risk of chronic disease, and meet nutrient needs.^{132,133} Poor eating patterns in childhood are associated with childhood obesity, risk of chronic diseases starting in childhood, such as type 2 diabetes^{134,135} and to diseases that emerge throughout the life cycle, such as cardiovascular disease and cancer.^{132,133,134} The Healthy Eating Index-2015 (HEI-2015) is a dietary assessment tool comprising 13 components designed to measure quality in terms of how well dietary intake aligns with the 2015–2020 Dietary Guidelines for Americans.¹³³ HEI scores among children show that from an early age, diets do not align with the Dietary Guidelines.



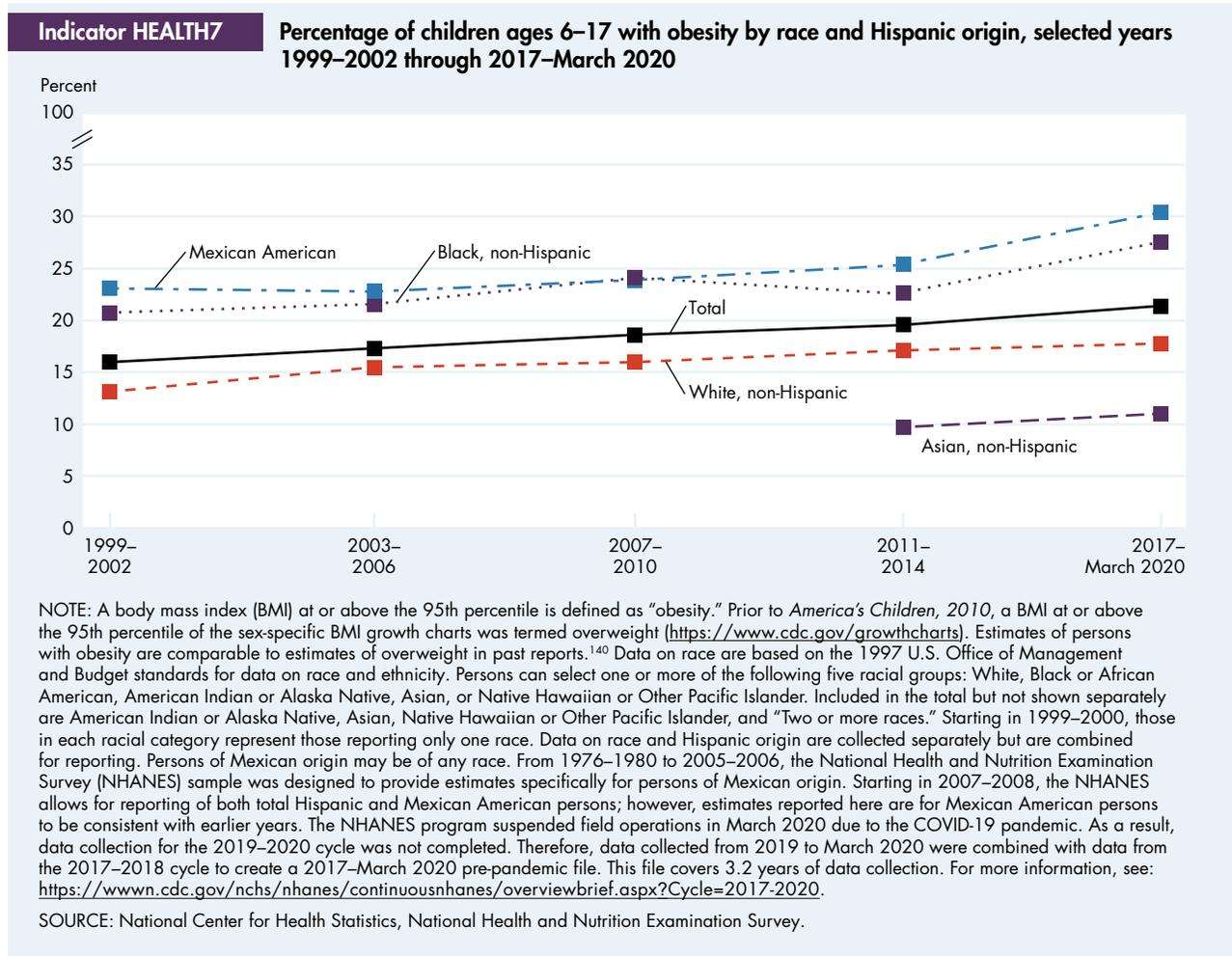
- During 2017–2018, the average Total HEI-2015 scores for ages 2–5, 6–11, and 12–17 were 61, 53, and 51, respectively, out of 100. Overall, the total diets of children and adolescents did not align with the 2015–2020 Dietary Guidelines for Americans.
- During 2017–2018, children ages 2–5 met the maximum HEI-2015 component scores for Total Fruit and Whole Fruit, and the average component score for Dairy was higher in this age group than in other age groups. The component score for Whole Fruit was 5 out of 5 for children ages 6–11.
- Component scores were furthest from the maximum for Greens and Beans, Whole Grains, Fatty Acids, Sodium, and Saturated Fats, among children ages 2–17.

- Children and adolescents can improve the quality of their diets by making nutrient-dense food choices as part of a healthy dietary pattern described in the Dietary Guidelines for Americans. Vegetables, fruits, whole grains, seafood, eggs, beans, peas, and lentils, unsalted nuts and seeds, fat-free and low-fat dairy products (including fortified soy beverages and yogurts), and lean meats and poultry—when prepared with no or little added sugars, saturated fat, and sodium—are nutrient-dense foods.

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on [childstats.gov](https://www.childstats.gov).

Obesity

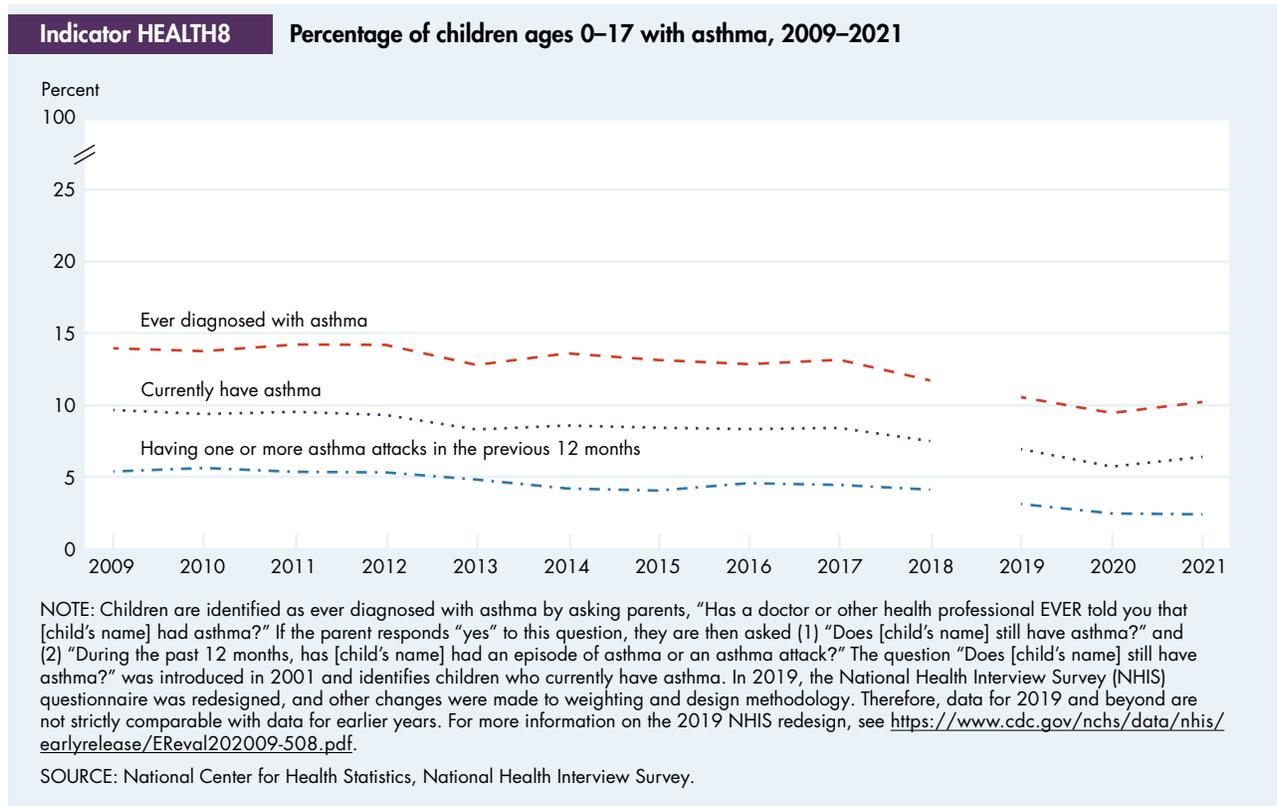
Children with obesity often become adults with obesity, with increased risks for a wide variety of poor health outcomes, including diabetes, stroke, heart disease, arthritis, and certain cancers.^{136,137} The consequences of obesity during childhood often are psychosocial but also include impaired mobility, early puberty, and asthma.¹³⁶ The prevalence of obesity among U.S. children changed relatively little from the early 1960s through 1980; however, after 1980 it increased sharply.¹³⁷ From 1999 through 2018, obesity among children and adolescents ages 6–11 and 12–19 continued to increase.¹³⁸ In addition to individual factors, such as diet and physical activity, social, economic, and environmental forces (such as family, school, or community factors that promote more eating out and less physical activity) may have contributed to the increased prevalence of obesity.¹³⁹



- From 1999–2002 through 2017–March 2020, the percentage of children ages 6–17 with obesity increased from 16% to 21%.
 - In 2017–March 2020, about 21% of children ages 6–11 and 22% of adolescents ages 12–17 had obesity; there was no significant difference between the percentages.
 - Among children ages 6–17 in 2017–March 2020, Black, non-Hispanic (27%) and Hispanic (28%) children were more likely to have obesity than White, non-Hispanic (18%) and Asian, non-Hispanic (11%) children.
 - There was no significant difference between the percentages of boys (23%) and girls (20%) ages 6–17 who had obesity in 2017–March 2020.
- Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.*

Asthma

Asthma is a disease of the lungs that can cause wheezing, difficulty in breathing, and chest pain. It is one of the most common chronic diseases among children. Asthma varies greatly in severity. Some children who have been diagnosed with asthma may not experience any serious respiratory effects. Other children may have mild symptoms or may respond well to the management of their asthma, typically through the use of medication. However, some children with asthma may suffer serious attacks that greatly limit their activities; result in visits to emergency rooms or hospitals; or, in rare cases, cause death. Environmental factors such as air pollution and secondhand tobacco smoke, along with infections, exercise, and allergens, can trigger asthma attacks in children who have the disease.^{56,57,60,141,142,143}



- The prevalence of children ages 0–17 ever diagnosed with asthma decreased from 14% in 2009 to 12% in 2018. In 2021, 10% of children had been diagnosed with asthma at some point in their lives compared to 11% in 2019.
- The prevalence of children reported to currently have asthma decreased from 10% in 2009 to 8% in 2018. In 2021, 6% of children were reported to currently have asthma compared to 7% in 2019.
- The percentage of children with an asthma attack in the past year decreased from 5% in 2009 to 4% in 2018. In 2021, 3% of children had one or more asthma attacks in the past year, which has remained steady since 2019.
- The prevalence of current asthma in 2021 was highest among Black, non-Hispanic children (13%) compared with Asian, non-Hispanic (3%); Hispanic (5%); and White, non-Hispanic (6%) children.
- In 2021, approximately 9% of children living below poverty had asthma compared with 6% of children with family incomes at 100%–199% of the poverty level and 6% of children with family incomes at or above 200% of the poverty level.

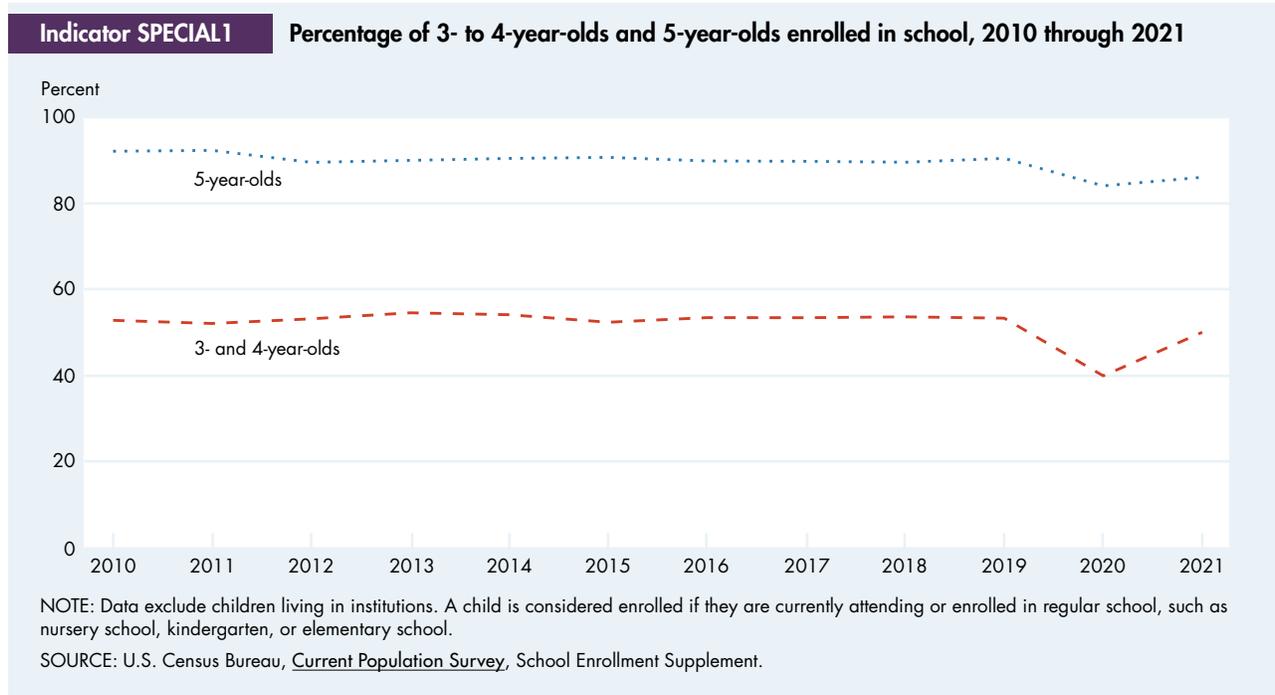
Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on [childstats.gov](https://www.childstats.gov).



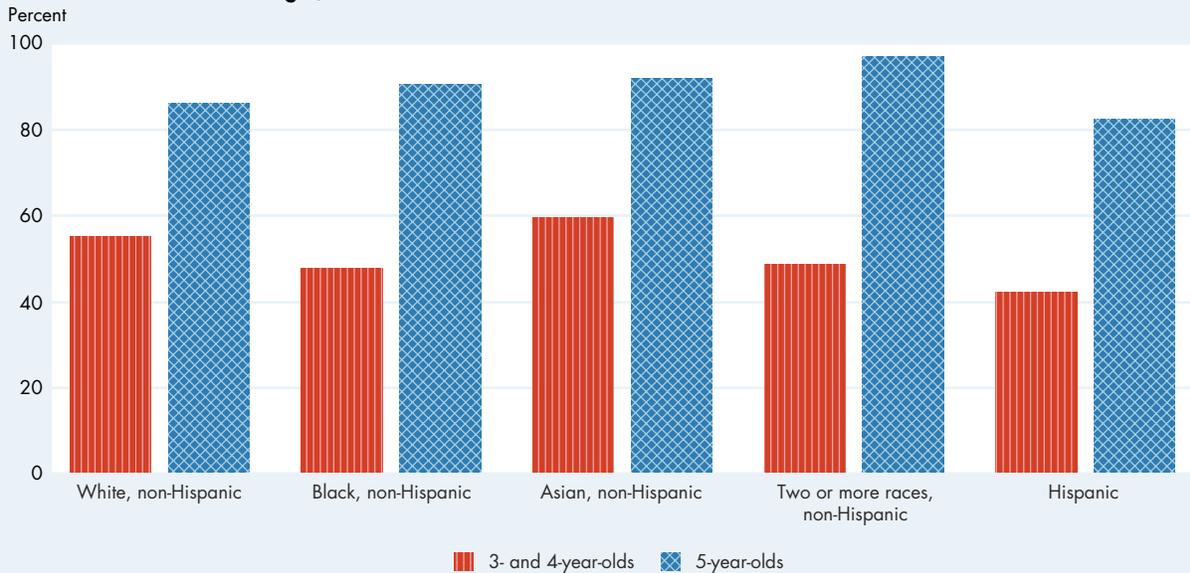
Special Feature

Percentages of Young Children Enrolled in Education

Early childhood education is related to children’s long-term educational, health, and economic outcomes.^{144,145} Many students have experienced interruptions in school enrollment since the emergence of the COVID-19 pandemic,¹⁴⁶ and children ages 3–5 are no exception.¹⁴⁷ The percentages of children enrolled in preschool, kindergarten, and other grades for this age group dropped after the onset of the pandemic. Please note that children living in institutions such as prisons or nursing facilities have been excluded from the data.



- In 2021, 86% of 5-year-olds were enrolled in school, compared with 50% of 3- to 4-year-olds.
- For both 3- to 4-year-olds and 5-year-olds, the percentages of children enrolled in 2019 were not measurably different than 2010.
- From 2019 to 2020, the first year of the COVID-19 pandemic, the percentage of 5-year-olds enrolled fell 6 percentage points (from 91% to 84%), while the percentage of 3- to 4-year-olds enrolled fell 13 percentage points (from 54% to 40%).
- During the COVID-19 pandemic between 2020 and 2021, the percentage of 5-year-olds enrolled was not measurably different, while the percentage of 3- to 4-year-olds enrolled increased by 10 percentage points (from 40% to 50%).
- Despite the recovery observed in the percentage of 3- to 4-year-olds enrolled between 2020 and 2021, this group’s percentage enrollment remained lower than before the COVID-19 pandemic (50% in 2021 vs. 54% in 2019). For 5-year-olds, the percentage of children enrolled was lower in 2021 (86%) compared with both 2019 (91%) and 2010 (92%).

Indicator SPECIAL2**Percentage of 3- to 4-year-olds and 5-year-olds enrolled in school, by race and Hispanic origin, 2021**

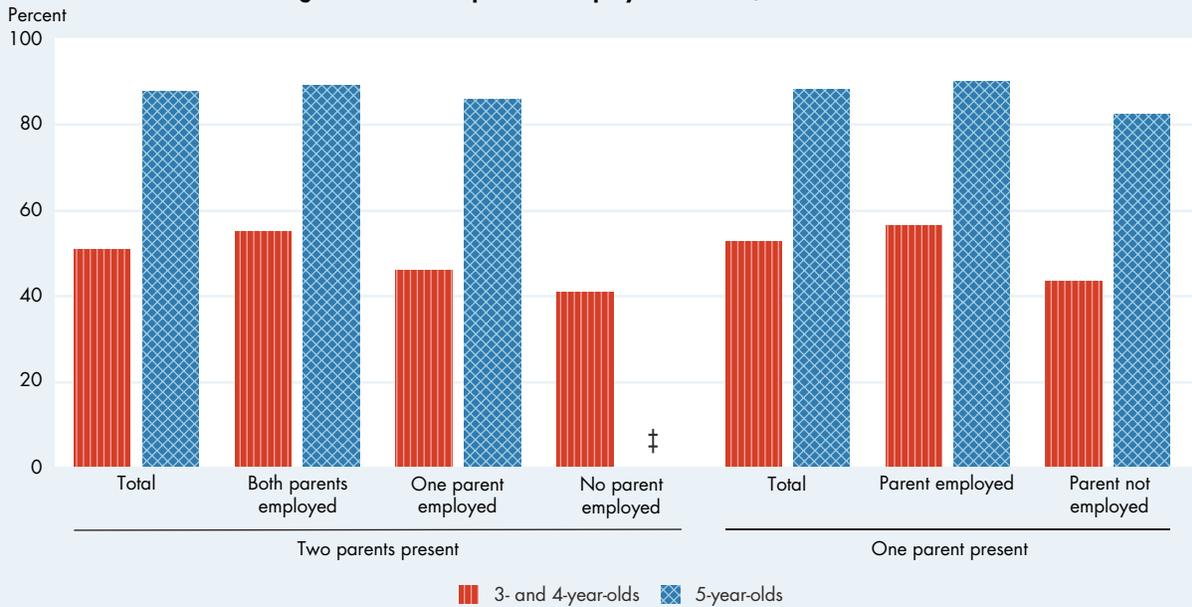
NOTE: Data exclude children living in institutions. A child is considered enrolled if they are currently attending or enrolled in regular school, such as nursery school, kindergarten, or elementary school. Included in the total but not shown separately are the categories American Indian or Alaska Native, non-Hispanic and Pacific Islander, non-Hispanic. Children categorized as White, non-Hispanic; Black, non-Hispanic; or Asian, non-Hispanic were of a single race. Persons of Hispanic origin may be of any race.

SOURCE: U.S. Census Bureau, *Current Population Survey*, School Enrollment Supplement.

- In 2021, the percentage of children enrolled was lower for 3- to 4-year-olds who were Hispanic (42%) than for those who were White, non-Hispanic (55%) or Asian, non-Hispanic (59%).¹⁴⁸
- The percentage of children enrolled was lower for 5-year-olds who were Hispanic (82%) than for those who were Black, non-Hispanic (90%), Asian, non-Hispanic (92%), or of Two or more races, non-Hispanic (97%).
- For 5-year-olds, the percentage enrolled was lower for those who were White, non-Hispanic (86%) than for those who were of Two or more races, non-Hispanic.
- In 2019, before the COVID-19 pandemic, the percentages of children enrolled in school were not measurably different when compared by race and Hispanic origin, for both 3- to 4-year-olds and for 5-year-olds.¹⁴⁹

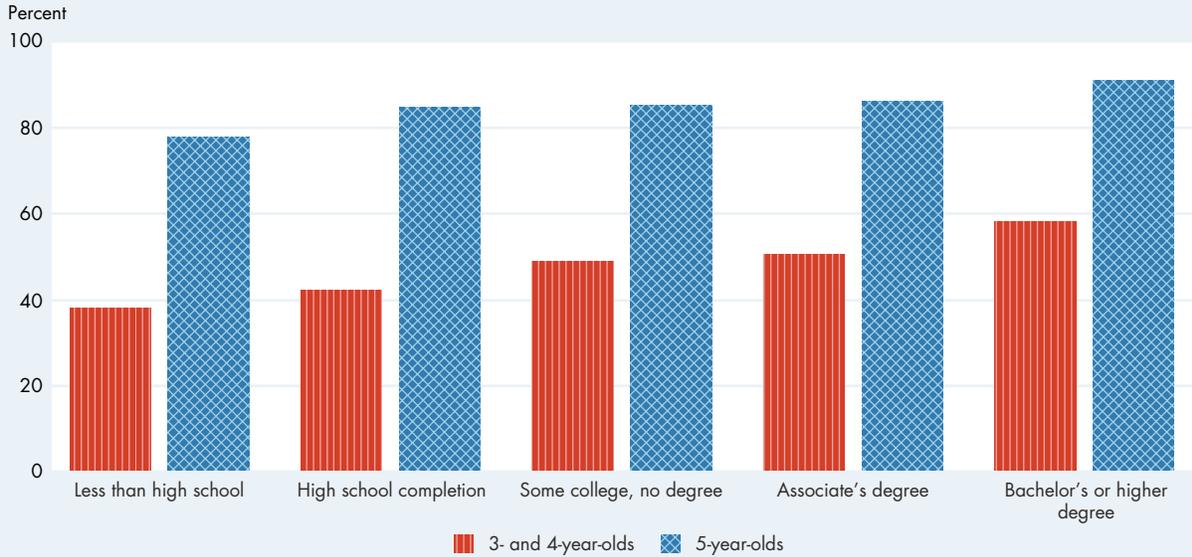
Indicator SPECIAL3

Percentage of 3- to 4-year-olds and 5-year-olds enrolled in school, by number of parents living with child and parents' employment status, 2021



‡ Reporting standards not met. Either there are too few cases for a reliable estimate or the coefficient of variation (CV) is 50 percent or greater.
 NOTE: Data exclude children living in institutions. A child is considered enrolled if they are currently attending or enrolled in regular school, such as nursery school, kindergarten, or elementary school.
 SOURCE: U.S. Census Bureau, *Current Population Survey, School Enrollment Supplement*.

- In 2021, the percentages of 3- to 4-year-olds enrolled in school differed by parents' employment status. In 2021, the percentage enrolled was 54% for 3- to 4-year-olds who lived with two employed parents, compared with 45% for 3- to 4-year-olds who lived with two parents and one parent was employed.
- In the same year, the percentage of children enrolled in school was higher for 3- to 4-year-olds who lived with one parent who was employed (56%) than it was for 3- to 4-year-olds who lived with one parent who was not employed (43%). In 2021, the percentage of 5-year-olds enrolled in school did not differ by parents' employment, among those who lived with two parents and among those who lived with one parent.

Indicator SPECIAL4**Percentage of 3- to 4-year-olds and 5-year-olds enrolled in school, by parents' highest level of educational attainment, 2021**

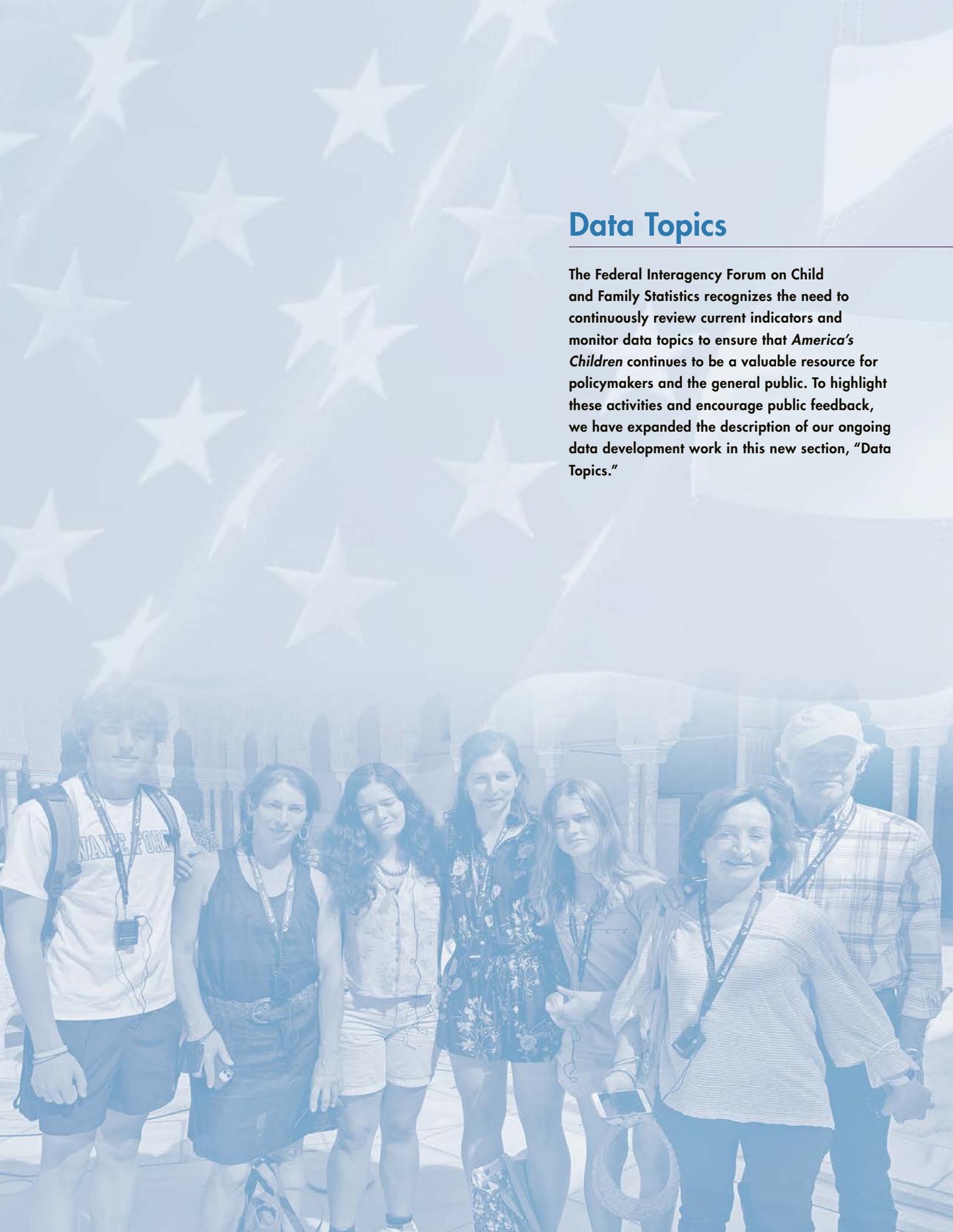
NOTE: Data exclude children living in institutions. A child is considered enrolled if they are currently attending or enrolled in regular school, such as nursery school, kindergarten, or elementary school. Parents' highest level of educational attainment is the highest education level of any parent residing with the child (including an adoptive or stepparent). High school completion includes parents who completed high school through equivalency programs, such as a GED program.

SOURCE: U.S. Census Bureau, *Current Population Survey*, School Enrollment Supplement.

- In 2021, the percentage of children enrolled in school was higher for 3- to 4-year-olds whose parents had a bachelor's or higher degree (57%) than for those whose parents had less than a high school credential (37%), completed high school (41%),¹⁵⁰ or had some college education but did not earn a degree (48%).
- Although the percentages of children enrolled had been higher for 3- to 4-year-olds whose parents had a bachelor's or higher degree than for those whose parents had an associate's degree in every year from 2010 to 2019, there was no measurable difference between these groups in 2020 or 2021.

- For 5-year-olds in 2021, the percentage enrolled was higher for those whose parents had a bachelor's or higher degree than for those whose parents had less than a high school credential (90% vs. 77%).

Endnotes begin on page 70. Bullets contain references to data that can be found in detailed tables on childstats.gov.



Data Topics

The Federal Interagency Forum on Child and Family Statistics recognizes the need to continuously review current indicators and monitor data topics to ensure that *America's Children* continues to be a valuable resource for policymakers and the general public. To highlight these activities and encourage public feedback, we have expanded the description of our ongoing data development work in this new section, "Data Topics."

Data Topics

This section follows the overall structure of the report and addresses data topics currently at some phase of assessment or development—either as an indicator, a special feature, or some other future Forum product.

Family and Social Environment

The continually changing nature of children’s lives creates many new variations and forms of family and living arrangements that may be challenging to describe in an indicator format using large national omnibus surveys. More data analysis and data presentation considerations are needed on the following topics:

- *Time use.* Currently, no regular Federal data source examines time spent on the whole spectrum of children’s activities. In 2003, the U.S. Bureau of Labor Statistics began the American Time Use Survey (ATUS), which measures the amount of time teens spend doing various activities, such as paid work, child care, volunteering, and socializing. The National Assessment of Educational Progress (NAEP) provides information about the time 4th-, 8th-, and 12th-grade students spend on homework and internet use. ATUS and NAEP are promising sources that can help us better understand aspects of youth time use.
- *Social connections and engagement.* The formation of close attachments to family, peers, school, and community has been linked to healthy youth development in numerous research studies. Although various Federal surveys, such as those sponsored by the National Center for Education Statistics (including the National Household Education Surveys [NHES]) and other longitudinal studies programs contain important research information on these domains, they lack the periodicity needed to support a permanent *America’s Children* indicator in this complex domain. More research is needed to either determine a more suitable indicator metric and data source or identify another indicator structure for data development.
- *Parental incarceration.* An increasing body of research shows that children’s overall health and well-being is adversely affected by parental incarceration. The Bureau of Justice Statistics (BJS) is currently addressing data on this topic.

Economic Circumstances

Economic security depends on the interaction of a range of financial measures; therefore, development of a composite measure is needed. Although this year’s report continues to provide information on poverty, income, and food security, additional measures are needed on the following:

- *Economic well-being.* Economic well-being over time should be anchored in a broader range of financial health measures, rather than just annual income. Multiple measures of family income or consumption, some of which might incorporate

estimates of family wealth and various assets, could produce more reliable estimates of changes in children’s economic well-being over time. An additional consideration would be to examine the effect of local economic conditions, which could jeopardize or build economic well-being over time. The U.S. Census Bureau expects that the Survey of Income and Program Participation (SIPP) will provide valuable information about economic well-being.

Health Care

This report provides information on a limited number of key indicators on health care. Information on more comprehensive aspects of health care is needed to better understand the effect of health care on children’s well-being. Additional measures are needed on the following:

- *Adequacy of health insurance coverage.* This report contains information on whether children had health insurance coverage at the time of interview. Information also is needed on patterns of insurance coverage and the characteristics of the child’s insurance plan to determine whether the plan is adequate to meet health care needs. The SIPP may be able to provide information about the source of insurance providers.

Physical Environment and Safety

More data than those presented in the current report are needed to better understand and monitor children’s physical environment and safety. Additional information is needed on the following:

- *Exposure to violence.* Research suggests that witnessing violence can have detrimental effects similar to the effects of being a direct victim of violence. BJS and the Office of Juvenile Justice and Delinquency Prevention are developing new survey topics. BJS continues to evaluate these new data as potential sources for future indicators relating to exposure to violence.
- *Homelessness.* The scope of information on unsheltered and sheltered homelessness among households with children has improved significantly through the use of homeless service providers’ administrative data found in the Annual Homeless Assessment Reports from the U.S. Department of Housing and Urban Development (HUD). Another HUD initiative seeks to develop survey methods to measure housing insecurity among those housed. These studies will offer new information about children lacking stable housing.
- *Environmental justice.* Research shows that overburdened communities, communities of color, and Tribal and indigenous communities are more likely to suffer from disproportionate adverse health and environmental impacts. Several indicators in this report currently contain information on structural and social determinants of health

such as age, race, ethnicity, income, gender, and geography. The Forum is exploring development of additional indicators and data sources to assess environmental justice concerns such as children living near sources of pollution, climate change, and access to clean water.

Behavior

Data that more adequately monitor the behaviors of youth are of interest to agencies. For example, agencies may explore the following topics further:

- *Activities promoting health and development.* Youth participation in a broad range of activities (e.g., volunteering, part-time employment, afterschool activities) has been associated with positive developmental outcomes. Additional research is needed to ascertain how such activities relate to success in later life. The Forum is currently considering the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System and the U.S. Environmental Protection Agency's *Exposure Factors Handbook* as potential sources for future indicators that can broaden our understanding of this topic.
- *Youth in the justice system.* The youth perpetrators of serious violent crime indicator has been updated in this year's *America's Children* report. BJS may explore additional data sources that contain data on the number and characteristics of youth arrestees and detainees prosecuted in both juvenile and adult courts and incarcerated in the Nation's jails, prisons, and juvenile facilities.

Education

It is vital to understand children's early development because what children experience at that stage has lasting implications for the rest of their lives. The Forum has specifically addressed the area of social-emotional development among young children through a contract awarded to Child Trends; deliverables for this project are posted on the Forum's website (<https://www.childstats.gov>).

- *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 track the cognitive, emotional, and social skills of preschoolers and young children over time. The 2016 and 2019 editions of the NHES include several measures of young children's learning and development. Because of the limited periodicity for the NHES, new survey questions may be more suitable for special features in the *America's Children* report.

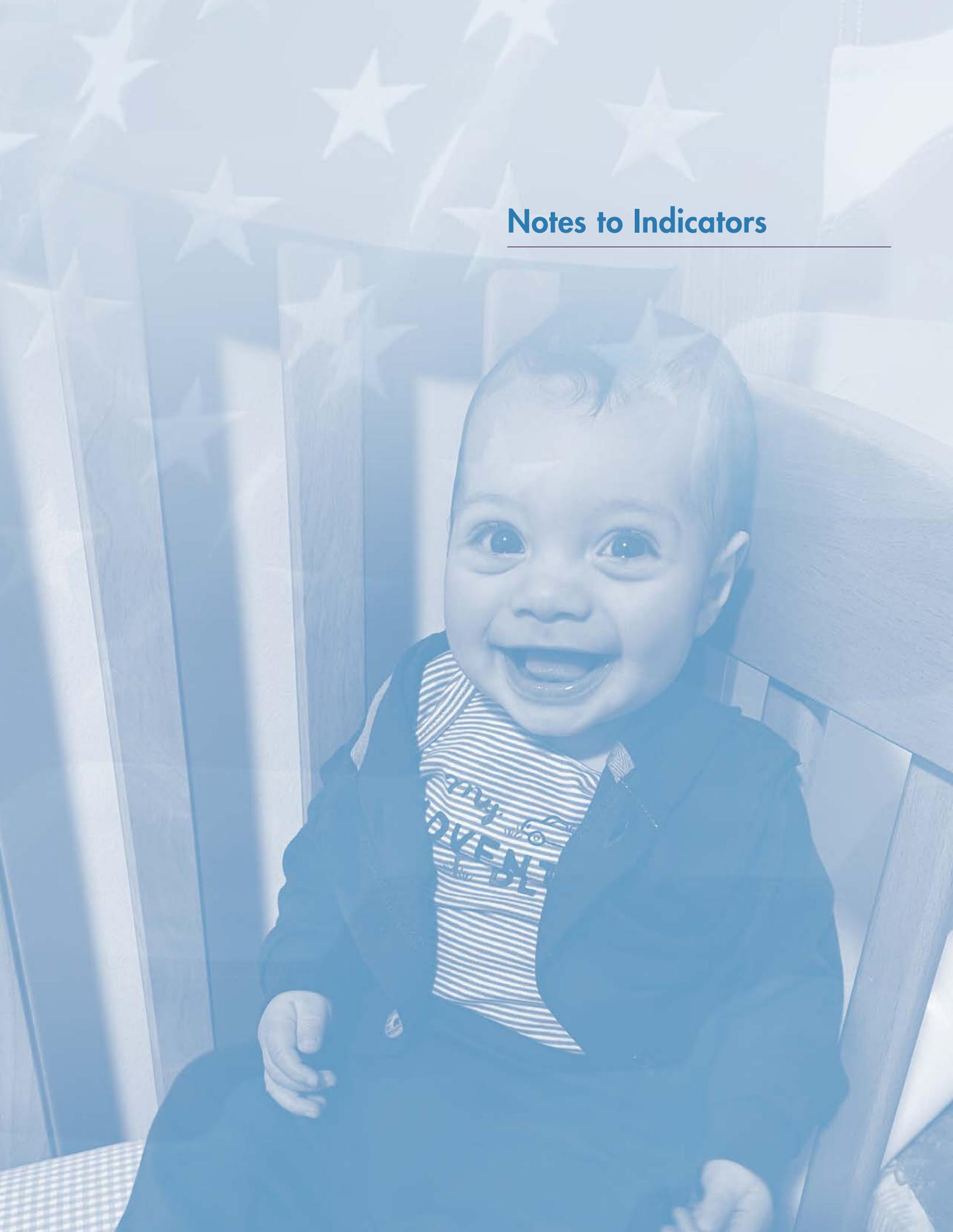
Health

Identifying key dimensions of health can be challenging because of difficulties in reaching consensus on relevant definitions and measurements.

- *Disability.* There is long-standing interest in developing an improved measure of child disability based on the functional difficulties experienced by children. In 2019, the National Health Interview Survey was redesigned, and other changes were made to weighting and design methodology. The redesign introduced a short set of questions from the Washington Group on Disability Statistics on child disability, which covers 13 core functioning domains—seeing, hearing, mobility, self-care, communication, learning, remembering, concentrating, accepting change, controlling behavior, making friends, anxiety, and depression. Reporting on child disability began in the *America's Children, 2023* report.

Taken together, these developmental efforts reflect both near-term objectives and long-term strategies in maintaining the value of *America's Children* reports. We welcome feedback in terms of these specific initiatives as well as on the value of the full *America's Children* report.

Notes to Indicators



Notes to Indicators

¹ Lee, D., & McLanahan, S. (2015). Family structure transitions and child development: Instability, selection, and population heterogeneity. *American Sociological Review*, 80(4), 738–763. <https://doi.org/10.1177/0003122415592129>.

² Thomas, D. (2020). As family structures change in U.S., a growing share of Americans say it makes no difference. *Pew Research Center*. Retrieved from <https://www.pewresearch.org/fact-tank/2020/04/10/as-family-structures-change-in-u-s-a-growing-share-of-americans-say-it-makes-no-difference>.

³ The number of children living with two unmarried parents is calculated by subtracting the number who live with two married parents from the total number who live with two parents.

⁴ Federal surveys now give respondents the option of reporting more than one race. Therefore, two basic ways of defining a race group are possible. A group such as Black may be defined as those who reported Black and no other race (the race-alone or single-race concept) or those who reported Black regardless of whether they also reported another race (the race-alone or in-combination concept). This indicator shows data using the first approach (race-alone). Use of the single-race population does not imply that it is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches. Data on race and Hispanic origin are collected separately. Persons of Hispanic origin may be of any race.

⁵ The percentage of children living with two unmarried parents is not statistically different from the percentage of children living with only their father.

⁶ For more information, refer to America's Families and Living Arrangements detailed tables, at <https://www.census.gov/topics/families/families-and-households.html>.

⁷ Smock, P. J., & Schwartz, C. R. (2020). The demography of families: A review of patterns and change. *Journal of Marriage and Family*, 82(1), 9–34. DOI: <https://dx.doi.org/10.1111/jomf.12612>.

⁸ Osterman, M. J. K., Hamilton, B. E., Martin, J. A., Driscoll, A. K., & Valenzuela, C.P. (2023). Births: Final data for 2021. *National Vital Statistics Reports*, 72(1). National Center for Health Statistics. DOI: <https://dx.doi.org/10.15620/cdc:122047>.

⁹ Livingston, G. (2015). For most highly educated women, motherhood doesn't start until the 30s. *Fact Tank: News in the numbers*. Pew Research Center.

¹⁰ The birth rate for unmarried women is the number of births per 1,000 unmarried women in a given age group (e.g., ages 20–24). The percentage of all births to unmarried women is the number of births occurring to unmarried women divided by the total number of births. The percentage of all births to unmarried women is affected by the birth rate for married women, the birth rate for unmarried women (who account for about 40% of all births), and the proportion of women of childbearing age who are unmarried.

¹¹ Throughout indicators FAM3.A and FAM3.B, “children ages 3–5” refers to children in the age group who were not yet enrolled in kindergarten.

¹² Center-based arrangements include day care centers, Head Start programs, preschools, prekindergartens, and other early childhood programs.

¹³ A child's primary care arrangement is classified into five groups based on the type of arrangement in which the child spent the most time per week: (1) center-based care, (2) relative care, (3) home-based nonrelative care, (4) multiple arrangements (i.e., children who spent an equal amount of time in each of two or more types of arrangements), and (5) parental care only (i.e., children who had no regularly scheduled care arrangement and received care only from their parent[s]).

¹⁴ Gibson, C., & Jung, K. (2006). *Historical census statistics on the foreign-born population of the United States: 1850 to 2000*. (U.S. Census Bureau: Population Division Working Paper Number 81). <http://www.census.gov/library/working-papers/2006/demo/POP-twps0081.html>.

¹⁵ Grieco, E. (2010). *Race and Hispanic origin of the foreign-born population in the United States: 2007*. (American Community Survey Reports) (ACS-11). <https://www.census.gov/library/publications/2010/acs/acs-11.html>.

¹⁶ Hernandez, D. J., Denton, N. A., & Macartney, S. E. (2008). Children in immigrant families: Looking to America's future. *Social Policy Report*, 22(3), 3–11. http://www.srcd.org/sites/default/files/documents/22_3_hernandez_final.pdf.

¹⁷ Adult respondents were asked if the children in the household spoke a language other than English at home and how well they could speak English. Categories used for reporting how well children could speak English were “Very well,” “Well,” “Not well,” and “Not at all.” All those who were reported to speak English less than “Very well” were considered to have difficulty speaking English based on an evaluation of the English-speaking ability of a sample of children in the 1980s.

¹⁸ Federal surveys now give respondents the option of reporting more than one race. Therefore, two basic ways of defining a race group are possible. A group such as Black may be defined as those who reported Black and no other race (the race-alone or single-race concept) or those who reported Black regardless of whether they also reported another race (the race-alone or in-combination concept). This indicator shows data using the first approach (race-alone). Use of the single-race population does not imply that it is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches. Data on race and Hispanic origin are collected separately. Persons of Hispanic origin may be of any race. The percentages of Asian-alone, non-Hispanic; White-alone, non-Hispanic; and Black-alone, non-Hispanic school children who spoke a language other than English at home were statistically different from each other.

¹⁹ The percentages of Asian-alone, non-Hispanic and Hispanic children ages 5–17 who spoke English less than “Very well” were statistically different from the percentages of White-alone, non-Hispanic and Black-alone, non-Hispanic children ages 5–17 who spoke English less than “Very well.” The percentages for the latter two groups were not statistically different from one another.

²⁰ Ely, D. M., & Driscoll, A. K. (2022). Infant mortality in the United States, 2020: Data from the period linked birth/infant death file. *National Vital Statistics Reports*, 71(5). National Center for Health Statistics. DOI: <https://dx.doi.org/10.15620/cdc:120700>.

²¹ Woodall, A. M., & Driscoll, A. K. (2020). *Racial and ethnic differences in mortality rate of infants born to teen mothers: United States, 2017–2018* (NCHS Data Brief No. 371). National Center for Health Statistics.

²² Maynard, R. A. (Ed.). (2008). *Kids having kids: Economic costs and social consequences of teen pregnancy*. Urban Institute Press.

²³ Driscoll, A. K. (2014). Adult outcomes of teen mothers across birth cohorts. *Demographic Research*, 30(44), 1277–1292.

²⁴ Ventura, S. J., Mathews, T. J., & Hamilton, B. E. (2001). Births to teenagers in the United States, 1940–2000. *National Vital Statistics Reports*, 49(10). National Center for Health Statistics.

²⁵ Child Welfare Information Gateway. (2019). *Long-term consequences of child abuse and neglect*. U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau. https://www.childwelfare.gov/pubPDFs/long_term_consequences.pdf.

²⁶ Christian, C. W., Block, R., & the Committee on Child Abuse and Neglect. (2009). Abusive head trauma in infants and children. *Pediatrics*, 123, 1409–1411.

²⁷ Strohschein, L. (2005). Household income histories and child mental health trajectories. *Journal of Health and Social Behavior*, 46(4), 357–359.

²⁸ Duncan, G., & Brooks-Gunn, J. (Eds.). (1997). *Consequences of growing up poor*. Russell Sage Press.

²⁹ Wagmiller, R. L., Jr., Lennon, M. C., Kuang, L., Alberti, P. M., & Aber, J. L. (2006). The dynamics of economic disadvantage and children’s life changes. *American Sociological Review*, 71(5), 847–866.

³⁰ Dahl, G., & Lochner, L. (2008). *The impact of family income on child achievement: Evidence from the earned income tax credit* (NBER Working Paper No. 14599). National Bureau of Economic Research. <https://www.nber.org/papers/w14599>.

³¹ Following U.S. Office of Management and Budget Statistical Policy Directive 14, poverty status is determined by comparing a family’s (or an unrelated individual’s) income to one of 48 dollar amounts called thresholds. The thresholds vary by the size of the family and the members’ ages. In 2021, the poverty threshold for a family with two adults and two children was \$27,479. For further details, see <http://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html>.

³² The change in poverty rate from 2010 to 2021 was not statistically different for Black, non-Hispanic children and Hispanic children.

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- ³³ For the latest report, see Creamer, J., Shrider, E., Burns, K., & Chen, F. (2022). *Poverty in the United States: 2021* (U.S. Census Bureau, Current Population Reports, P60-277). U.S. Government Publishing Office, Washington, DC. <https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-277.pdf>.
- ³⁴ Estimates include unrelated individuals under age 15.
- ³⁵ Statistical comparisons between SPM and OPM estimates are at the 90 percent confidence level.
- ³⁶ Cauthen, N. K. (2002). *Policies that improve family income matter for children* (Improving Children’s Economic Security: Research Findings About Increasing Family Income Through Employment, Policy Brief No. 1). National Center for Children in Poverty. https://academiccommons.columbia.edu/download/fedora_content/download/ac:127558/CONTENT/text_480.pdf.
- ³⁷ Anderson, S. A. (Ed.). (1990). Core indicators of nutritional state for difficult-to-sample populations. *Journal of Nutrition*, 120(11S), 1557–1600.
- ³⁸ Coleman-Jensen, A., McFall, W., & Nord, M. (2013). *Food insecurity in households with children: Prevalence, severity, and household characteristics, 2010–11* (Economic Information Bulletin No. 113). U.S. Department of Agriculture, Economic Research Service. <https://www.ers.usda.gov/publications/pub-details/?pubid=43765>.
- ³⁹ In reports prior to 2006, households with “very low food security among children” were described as “food insecure with hunger among children.” The methods used to assess children’s food security remained unchanged, so the statistics for 2005 and later years are directly comparable with those for 2004 and earlier years. For further information, see <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security>.
- ⁴⁰ Coleman-Jensen, A., Rabbitt, M. P., Gregory, C., & Singh, A. (2022). *Household food security in the United States in 2021* (Economic Research Report No. 309). U.S. Department of Agriculture, Economic Research Service. <https://www.ers.usda.gov/publications/pub-details/?pubid=104655>.
- ⁴¹ Sommers, B. D., Gunja, M. Z., Finegold, K., & Musco, T. (2015). Changes in self-reported insurance coverage, access to care, and health under the Affordable Care Act. *JAMA*, 314(4), 366–374. <https://doi.org/10.1001/jama.2015.8421>.
- ⁴² Committee on Practice and Ambulatory Medicine, Bright Futures Periodicity Schedule Workgroup. (2021). 2021 recommendations for preventive pediatric health care. *Pediatrics*, 147(3), Article e2020049776. <https://doi.org/10.1542/peds.2020-049776>.
- ⁴³ Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq.
- ⁴⁴ Title XXI of the Social Security Act, 42 U.S.C. 1397aa–1397mm.
- ⁴⁵ Larson, K., Cull, W. L., Racine, A. D., & Olson, L. M. (2016). Trends in access to health care services for US children: 2000–2014. *Pediatrics*, 138(6), Article e20162176. <https://doi.org/10.1542/peds.2016-2176>.
- ⁴⁶ Hagan, J. F., Jr., Shaw, J. S., & Duncan, P. M. (Eds.). (2017). *Bright futures: Guidelines for health supervision of infants, children, and adolescents* (4th ed.). American Academy of Pediatrics.
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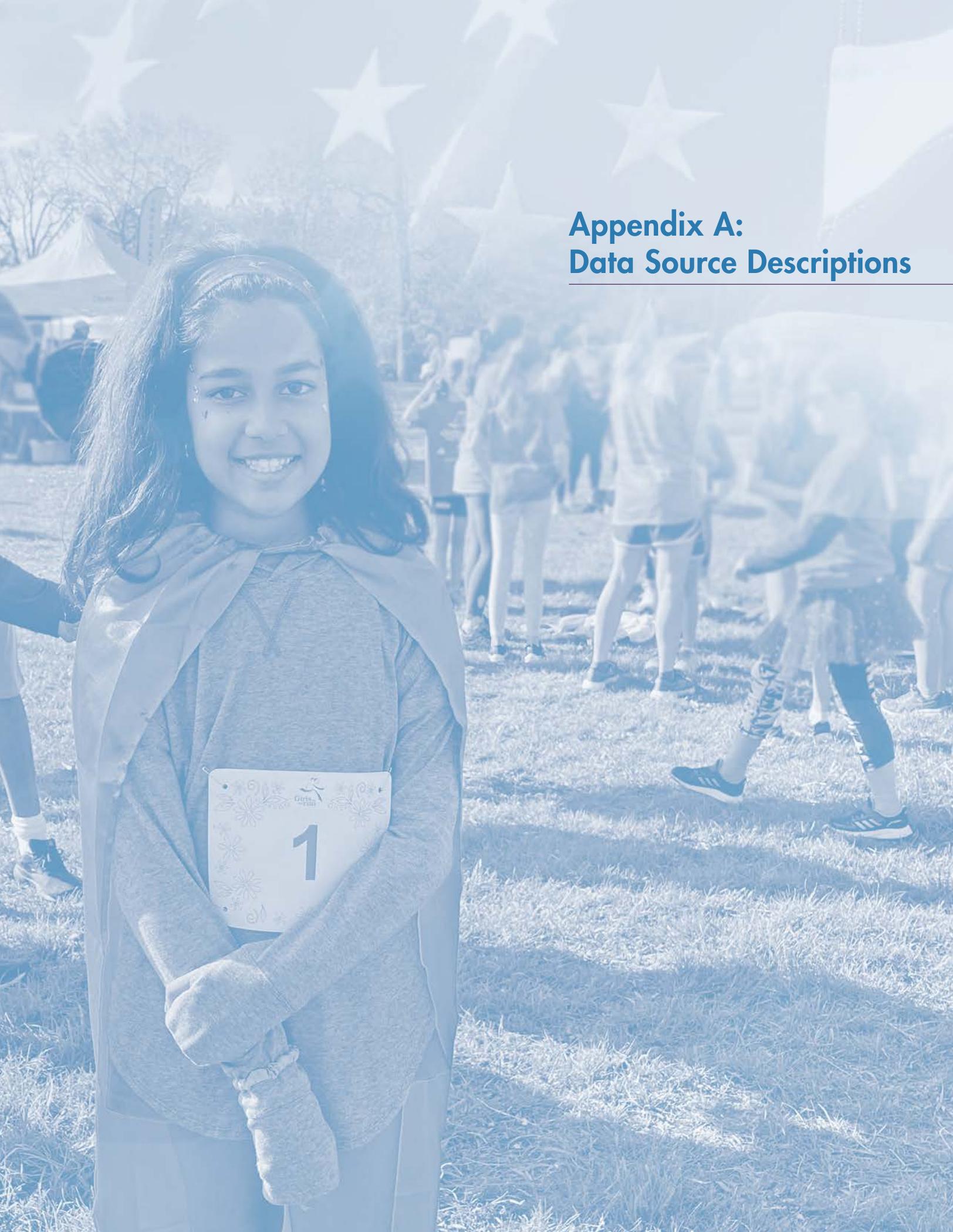
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- ¹⁴⁹ For 3- to 4-year-olds, the percentage of Pacific Islander children enrolled in school did not meet reporting standards in 2019. For 5-year-olds, the percentages of Pacific Islander and American Indian or Alaska Native children enrolled in school did not meet reporting standards in 2019. These percentages were thus excluded from the analyses.
- ¹⁵⁰ Includes parents who completed high school through equivalency programs, such as a GED program.



Appendix A: Data Source Descriptions

Data Source Descriptions

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Air Quality System

The Air Quality System (AQS) contains ambient air pollution data collected by the U.S. Environmental Protection Agency (EPA) and by state, local, and tribal air pollution control agencies. Data on criteria pollutants (particulate matter, ozone, carbon monoxide, nitrogen dioxide, sulfur dioxide, and lead) consist of air quality measurements collected by sensitive equipment at thousands of monitoring stations in all 50 states, plus the District of Columbia, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands. Each monitor measures the concentration of a particular pollutant in the air. Monitoring data indicate the average pollutant concentration during a specified time interval, usually 1 hour or 24 hours. The AQS also contains meteorological data, descriptive information about each monitoring station (including its geographic location and operator), and data quality assurance/quality control information. Data are available from AQS dating back to 1957. The system is administered by the EPA's Office of Air Quality Planning and Standards, Outreach and Information Division, in Research Triangle Park, North Carolina. For the Outdoor Air Quality indicator, a county is considered to have a pollutant concentration above the level of the current air quality standard if the measured pollutant level was greater than the level of the standard at any monitor within the county during the year. The indicator is calculated as the sum of children living in counties with pollutant concentrations above the level of a standard divided by the total number of children in the United States. This calculation differs from the method for identifying areas in violation of an air quality standard. See *America's Children and the Environment* at <https://www.epa.gov/ace> (Indicator E1) for further discussion.

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American Community Survey

The American Community Survey (ACS) is an annual nationwide survey that replaced the long form decennial censuses beginning in 2010. The objective of the ACS is to provide data users with timely housing, social, and economic data that are updated every year and can be compared across states, communities, and population groups.

The ACS was implemented in three parts: (1) Demonstration period, 1996–1998, beginning at four sites; (2) Comparison site period, 1999–2004, comparing 31 sites continuously over this period as well as adding other counties to the survey in preparation for full implementation; and (3) Full implementation nationwide in 2005. Sampling of group quarters was added in 2006. Starting in January 2005, the U.S. Census Bureau

implemented the ACS in every county of the United States, with an annual sample of 3 million housing units. Beginning in 2006, the survey data have been available every year for large geographic areas and population groups of 65,000 or more.

For small areas and population groups of 20,000 or less, a period of 5 years is necessary to accumulate a large enough sample to provide estimates with accuracy similar to the decennial census. Each month, a systematic sample of addresses is selected from the most current Master Address file (MAF). The sample represents the entire United States. Data are generally collected by mail or the internet; however, households that do not respond by mail or the internet may be contacted using computer-assisted telephone interviewing (CATI), computer-assisted personal interviewing (CAPI), or both.

Information about the ACS is available online at <https://www.census.gov/programs-surveys/acs/>.

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American Housing Survey

The American Housing Survey (AHS) is sponsored by the Office of Policy Development and Research of the U.S. Department of Housing and Urban Development and is conducted by the U.S. Census Bureau. The survey provides data necessary for evaluating progress toward “a decent home and a suitable living environment for every American family,” a goal affirmed in 1949 and 1968 legislation. The AHS began as an annual survey in 1973 and has been conducted biennially in odd-numbered years since 1985. A longitudinal, nationally representative sample of 60,000 housing units plus newly constructed units was surveyed during the period 1985 to 2013, and a new sample was drawn in 2015. Transient accommodations, military and worker housing, and institutional quarters are excluded. AHS data detail the types, size, conditions, characteristics, costs and values, equipment, utilities, and dynamics of the housing inventory, as well as some information about neighborhood conditions. Data include demographic, financial, and mobility characteristics of the occupants. Since 1997, the AHS has been conducted using computer-assisted personal interviewing.

Information about the AHS is available online at <https://www.census.gov/programs-surveys/ahs.html>.

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Civil Rights Data Collection

The U.S. Department of Education's Office for Civil Rights (OCR) has surveyed the Nation's public elementary and secondary schools since 1968. The survey was first known as the OCR Elementary and Secondary School Survey; in 2004, it was renamed the Civil Rights Data Collection (CRDC). The survey collects data on school discipline, access to and participation in high-level mathematics and science courses, teacher characteristics, school finances, and other school characteristics. These data are reported by race/ethnicity, sex, and disability.

Data in the survey are collected pursuant to 34 C.F.R. [Code of Federal Regulations] Section 100.6(b) of the U.S. Department of Education regulation implementing Title VI of the Civil Rights Act of 1964. The requirements also are incorporated by reference in Department regulations implementing Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. School, district, state, and national data are currently available. Data from individual public schools and districts are used to generate national and state data.

The CRDC has generally been conducted biennially in each of the 50 states plus the District of Columbia. (Puerto Rico was added to the collection for 2017–18.) The 2009–10 CRDC was collected from a sample of approximately 7,000 school districts and over 72,000 schools in those districts. It was made up of two parts: Part 1 contained beginning-of-year “snapshot” data and Part 2 contained cumulative, or end-of-year, data.

The 2011–12, 2013–14, 2015–16, and 2017–18 CRDC were surveys of all public schools and school districts in the Nation. The 2011–12 survey collected data from approximately 16,500 school districts and 97,000 schools, the 2013–14 survey collected data from approximately 16,800 school districts and 95,500 schools, the 2015–16 survey collected data from about 17,400 school districts and 96,400 schools, and the 2017–18 survey collected data from about 17,600 school districts and 97,600 schools.

The CRDC webpage (<https://www2.ed.gov/about/offices/list/ocr/data.html>) contains, among other information, survey forms, lists of data elements, and lists of questions and answers pertaining to the 2009–10 through 2017–18 CRDC surveys.

Further information on the CRDC may be obtained from

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<https://www2.ed.gov/about/offices/list/ocr/data.html>

Current Population Survey

Core Survey and Supplements. The Current Population Survey (CPS) is a nationwide survey of about 60,000 households conducted monthly for the U.S. Bureau of Labor Statistics by the U.S. Census Bureau. The survey is representative of the civilian noninstitutionalized population of the United States with a sample located in more than 2,000 counties and independent cities and coverage in every state and the District of Columbia.

The CPS core survey is the primary source of information on the employment characteristics of the civilian noninstitutionalized population, including estimates of unemployment released every month by the U.S. Bureau of Labor Statistics.

In addition to the core survey, monthly CPS supplements provide additional demographic and social data. The Annual Social and Economic Supplement (ASEC)—formerly called the March Supplement—and the October school enrollment supplement provide information used to estimate the status and well-being of children. The ASEC and school enrollment supplement have been administered every year since 1947. In this report, data on poverty status, health insurance, and the parents' highest level of school completed or degree attained are derived from the ASEC. The October supplement to the CPS asks questions on school enrollment by grade and other school characteristics about each member of the household age 3 or over. In this report, data on high school completion and college enrollment are derived from the October supplement. The food security supplement, introduced in April 1995 and administered in December since 2001, is described in detail below.

The CPS sample is selected from a complete address list of geographically delineated primary sampling units, which are based on census addresses and updated using recent construction and other data. It is administered through field representatives, either in person or by telephone using computer-assisted personal interviewing (CAPI). Some CPS data also are collected through a centralized telephone operation, computer-assisted telephone interviewing (CATI). For more information regarding the CPS, its sampling structure, and estimation methodology, see *Design and Methodology: Current Population Survey* (Technical Paper 77, October 2019) available online at <https://www.census.gov/programs-surveys/cps/technical-documentation/complete.html>.

The 2014 CPS ASEC (which refers to health insurance coverage estimates of the 2013 calendar year) is the first to use the improved measures of health insurance coverage. Following more than a decade of research, evaluation, and consultation with outside experts, the U.S. Census Bureau implemented an

approach shown to improve the accuracy of health insurance coverage measurement. For a list of references, please see the U.S. Census Bureau director's statement on the improved set of health insurance coverage questions at <https://census.gov/newsroom/press-releases/2014/cb14-67.html>. Due to these changes, data for the 2014 CPS ASEC are not comparable with data from earlier years.

The 2014 CPS ASEC included redesigned questions for income and health insurance coverage. All of the approximately 98,000 addresses were selected to receive the improved set of health insurance coverage items. The improved income questions were implemented using a split panel design. Approximately 68,000 addresses were selected to receive a set of income questions similar to those used in the 2013 CPS ASEC. The remaining 30,000 addresses were selected to receive the redesigned income questions. The source of data for tables in this volume is the CPS ASEC sample of 98,000 addresses.

There was an implementation of an updated processing system for the 2018 CPS ASEC. For more information, see technical documentation at <https://www2.census.gov/programs-surveys/demo/datasets/income-poverty/time-series/data-extracts/2018/cps-asec-bridge-file/2018-asec-bridge-file-documentation.pdf> and information on the updated processing system at <https://www.census.gov/data/datasets/time-series/demo/income-poverty/cps-asec-design.html>. Due to these changes, data for the 2018 CPS ASEC are not comparable with data from earlier years.

Food Security Supplement. The food security supplement contains a systematic set of questions validated as measures of the severity of food insecurity on a 12-month and a 30-day basis. Statistics presented in this report are based on 12-month data from the CPS food security supplements. The food security questions are based on material reported in prior research on hunger and food security and reflect the consensus of nearly 100 experts at the 1994 Food Security and Measurement Conference, convened jointly by the National Center for Health Statistics and the Food and Nutrition Service of the U.S. Department of Agriculture. The supplement was developed, tested, and refined further by the conferees, members of a Federal interagency working group, and survey methods specialists for the U.S. Census Bureau's Center for Survey Methods Research. All households interviewed in the CPS in December are eligible for the supplement. Special supplement sample weights were computed to adjust for the demographic characteristics of supplement noninterviews.

Information about food security is available online at the Economic Research Service at <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/>. Information about the CPS is available online at <https://www.census.gov/cps>.

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Decennial Census Data

The U.S. Census Bureau conducted decennial censuses in the United States in 2000, 2010, and 2020, as well as in previous decades back to 1790. Statistical data from the censuses of 2000 and 2010 are available through data.census.gov.

Date:

- April 1, 2000 (Census Day) is the reference date for Census 2000.
- April 1, 2010 (Census Day) is the reference date for the 2010 Census.
- April 1, 2020 (Census Day) is the reference date for the 2020 Census

Census 2000 and earlier decennial censuses gathered information on demographic, social, economic, and housing characteristics of the population. Census 2000 datasets include more subjects than those for later censuses because Census 2000 used both a short form (with a limited number of characteristics for every person and every housing unit) and a long form (with additional questions asked of a sample of persons and housing units). The short form provided information on age, sex, race, Hispanic or Latino origin, household relationship, tenure (whether a housing unit is owner- or renter-occupied), and occupancy status. The long form covered additional population characteristics, such as income, educational attainment, labor force status, place of birth, etc., and additional housing characteristics.

In the 2010 and 2020 Census of the United States, a limited number of questions were asked of every person and every housing unit. Population and housing characteristics not covered in the decennial Census can be found in data from the American Community Survey, also available on data.census.gov.

In any large-scale statistical operation such as the decennial Census, human- and computer-related errors occur. These errors are commonly referred to as nonsampling errors. Such errors include not enumerating every household or every person in the population, not obtaining all required information from the respondents, obtaining incorrect or inconsistent information, and recording information incorrectly.

Although it is impossible to completely eliminate nonsampling error from an operation as large and complex as the decennial census, the Census Bureau attempts to control the sources of such error during the collection and processing operations. Please see <https://www.census.gov/programs-surveys/decennial-census/decade/2020/planning-management/process/data-quality.html> or <https://www.census.gov/newsroom/press-releases/2021/quality-indicators-on-2020-census.html> for quality indicators on the 2020 Census.

For information on the computation and use of standard errors, contact

U.S. Census Bureau Customer Service Center
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Monitoring the Future

The Monitoring the Future (MTF) study is a continuing series of surveys intended to assess the changing lifestyles, values, and preferences of American youth. Each year since 1975, high school seniors from a representative sample of public and private high schools have participated in this study. The 2022 survey was the 31st survey to include comparable samples of 8th and 10th graders in addition to seniors. The study is conducted by the University of Michigan's Institute for Social Research (ISR) under a grant from the National Institute on Drug Abuse. The survey design consists of a multistage random sample, where the stages include selection of geographic areas, one or more schools in each area, and a sample of students within each school. Data are collected in the spring of each year using questionnaires administered in the classroom by representatives from ISR. The 2022 survey included a total of 31,438 students from 308 schools nationwide.

In 2020, data collection was halted earlier than usual due to the COVID-19 pandemic and subsequent stay-at-home orders. This resulted in smaller samples being obtained that year, but analyses show that these samples were nationally representative.

Adjustments in 10th-grade change scores in 2009. All figures and tables in this report omit the 10th-graders data point from the 2008 survey because the data for that year were believed to be inaccurate due to sampling error, a highly unusual occurrence. This was the first time there was a need to adjust the data from a survey in the 43 years of the study; fortunately, only a single grade was affected.

Several facts led to this decision. First, it was observed that in 2008, 10th grade was the only grade that showed a decline in marijuana use, as well as in the indexes of use that include marijuana. In 2009, it was the only grade to show an increase in some of those same measures. Although trends do sometimes differ from one grade to another, the fact that this happened in just a single year led to the conclusion that the 10th-grade sample from 2008 likely showed erroneously low levels of use of certain drugs—particularly marijuana and alcohol—most likely because of sampling error. Other findings also supported this interpretation.

An examination of the subgroup trend tables shows that in 2009, there were unusually large increases of marijuana use in two regions of the country, the West and the South, raising the possibility that relatively few schools accounted for the

increase in that year. Further, there was no evidence in the trend lines from the other two grades that such an increase was actually occurring in those two regions for either marijuana or alcohol use, as would be expected if the 10th-grade data accurately represented the population. Finally, an examination of data from 10th graders in the matched half sample of schools that participated in both the 2008 and 2009 surveys reveals considerably smaller 1-year increases in the use of these two drugs than does the full sample analysis. The changes in the matched half samples are routinely examined to help validate the results from the full samples. Normally, the two indicators of change replicate closely.

Therefore, it was judged unlikely that the apparent decline in 2008 and sharp increase in 2009 for 10th graders are accurate characterizations of the total populations. Thus, the 10th-grade data points from 2008 are omitted in the figures and tables. However, the 1-year change score was calculated using the matched half sample of schools participating in both 2008 and 2009, and it was noted that the change was not significant. Their results should be relatively unaffected by schools entering and leaving the sample each year. Importantly, these adjusted change scores bring the 10th-grade change data much more into line with what is observed to be occurring in the other two grades.

For more information, please see

Johnston, L. D., Miech, R. A., Patrick, M. E., O'Malley, P. M., Schulenberg, J. E., & Bachman, J. G. (2023). *Monitoring the Future national survey results on drug use 1975–2022: Overview, key findings on adolescent drug use*. Ann Arbor: Institute for Social Research, University of Michigan.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2010). *Monitoring the future: National survey results on drug use, 1975–2009: Volume I, Secondary school students* (NIH Publication No. 10-7584). National Institute on Drug Abuse.

Information about MTF is available online at <https://www.nida.nih.gov/DrugPages/MTF.html> and <https://monitoringthefuture.org>.

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National Assessment of Educational Progress

The National Assessment of Educational Progress (NAEP) is a series of cross-sectional studies initially implemented in 1969 to assess the educational achievement of U.S. students and monitor changes in those achievements.

In the main national NAEP, a nationally representative sample of students is assessed at Grades 4, 8, and 12 in various academic subjects. The assessment is based on frameworks developed by the National Assessment Governing Board (NAGB). It includes both multiple-choice items and constructed-response items (those requiring written answers). Results are reported in two ways: by average score and by achievement level. Average scores are reported for the Nation, participating states and jurisdictions, and subgroups of the population. Percentages of students performing at or above three achievement levels (*NAEP Basic*, *NAEP Proficient*, and *NAEP Advanced*) also are reported for these groups.

From 1990 until 2001, main NAEP was conducted for states and other jurisdictions that chose to participate. In 2002, under the provisions of the No Child Left Behind Act of 2001, all states began to participate in main NAEP, and an aggregate of all state samples replaced the separate national sample. (School district-level assessments—under the Trial Urban District Assessment program—also began in 2002.)

Results are available for the mathematics assessments administered in 2000, 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017, 2019, and 2022. In 2005, NAGB called for the development of a new mathematics framework. The revisions made to the mathematics framework for the 2005 assessment were intended to reflect recent curricular emphases and better assess the specific objectives for students at each grade level. The revised mathematics framework focuses on two dimensions: mathematical content and cognitive demand. By considering these two dimensions for each item in the assessment, the framework ensures that NAEP assesses an appropriate balance of content, as well as a variety of ways of knowing and doing mathematics. Since the 2005 changes to the mathematics framework were minimal for Grades 4 and 8, comparisons over time can be made between assessments conducted before and after the framework's implementation for these grades. The changes that the 2005 framework made to the Grade 12 assessment, however, were too drastic to allow Grade 12 results from before and after implementation to be directly

compared. These changes included adding more questions on algebra, data analysis, and probability to reflect changes in high school mathematics standards and coursework; merging the measurement and geometry content areas; and changing the reporting scale from 0–500 to 0–300. For more information regarding the 2005 mathematics framework revisions, see <https://nces.ed.gov/nationsreportcard/mathematics/frameworkcomparison.asp>.

Results are available for the reading assessments administered in 2000, 2002, 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017, 2019, and 2022. In 2009, a new framework was developed for the 4th-, 8th-, and 12th-grade NAEP reading assessments. Both a content alignment study and a reading trend or bridge study were conducted to determine if the new reading assessment was comparable with the prior assessment. Overall, the results of the special analyses suggested that the assessments were similar in terms of their item and scale characteristics and the results they produced for important demographic groups of students. Thus, it was determined that the results of the 2009 reading assessment could still be compared with those from earlier assessment years, thereby maintaining the trend lines first established in 1992. For more information regarding the 2009 reading framework revisions, see <https://nces.ed.gov/nationsreportcard/reading/whatmeasure.asp>.

NAEP Long-Term Trend Assessments. In addition to conducting the main assessments, NAEP also conducts long-term trend assessments. Long-term trend assessments provide an opportunity to observe the educational progress in reading and mathematics of 9-, 13-, and 17-year-olds since the early 1970s. The long-term trend reading assessment measures students' reading comprehension skills using an array of passages that vary by text types and length. The assessment was designed to measure students' ability to locate specific information in the text provided; make inferences across a passage to provide an explanation; and identify the main idea in the text. The NAEP long-term trend assessment in mathematics measures knowledge of mathematical facts; ability to carry out computations using paper and pencil; knowledge of basic formulas, such as those applied in geometric settings; and the ability to apply mathematics to skills of daily life, such as those involving time and money.

Information about NAEP is available online at <https://nces.ed.gov/nationsreportcard>.

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National Child Abuse and Neglect Data System

The National Child Abuse and Neglect Data System (NCANDS) annually collects case-level data on reports alleging child abuse and neglect, as well as the results of these reports, from state child protective services agencies. The mandate for NCANDS is based on the Child Abuse Prevention and Treatment Act (CAPTA), as amended in 1988, which directed the Secretary of the Department of Health and Human Services (HHS) to establish a national data collection and analysis program that would make available state child abuse and neglect reporting information. HHS responded by establishing NCANDS as a voluntary, national reporting system. In 1992, HHS produced its first NCANDS report based on data from 1990. The annual data report *Child maltreatment* evolved from that initial report.

During the early years of the system, states provided aggregated data on key indicators of reporting of alleged child maltreatment. Starting with the 1993 data year, states voluntarily began to submit case-level data. For a number of years, states provided both datasets, but starting with data year 2000, the case-level dataset became the primary source of data for the annual report. In 1996, CAPTA was amended to require that all states receiving funds from the Basic State Grant program work with the Secretary of HHS to provide specific data, to the extent practicable, on children who had been maltreated. The NCANDS data elements were revised to meet these requirements beginning with the submission of 1998 data.

Every year, NCANDS data are submitted voluntarily by the 50 states, the District of Columbia, and the Commonwealth of Puerto Rico. The NCANDS reporting year is based on the federal fiscal year calendar that spans October 1 to September 30. States submit case-level data, called a Child File, by constructing an electronic file of child-specific records for each report of alleged child abuse and neglect that received a Child Protective Services (CPS) response in the form of an investigation or alternative response. Case-level data include information about the characteristics of the reports of abuse and neglect, the children involved, the types of maltreatment, the CPS findings, the risk factors of the child and the caregivers, the services provided, and the perpetrators.

The Child File is supplemented by agency-level aggregate statistics in a separate data submission called the Agency File. The Agency File contains data that are not reportable at the child-specific level and often are gathered from agencies external to CPS. Information collected in the Agency File include receipt of prevention and postresponse services and caseload and workforce data. States are asked to submit both the Child File and the Agency File each year.

CAPTA (42 U.S.C. §5106a), as amended by the CAPTA Reauthorization Act of 2010 (P.L. 111–320), retained the existing definition of child abuse and neglect as, at a minimum:

Any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm.

Each state defines the types of child abuse and neglect in state statute and policy. CPS agencies determine the appropriate response for the alleged maltreatment based on those statutes and policies. The most common response is an investigation. The result of an investigation response is a determination (also known as a disposition) about the alleged child maltreatment.

In NCANDS, a victim is defined as a child for whom the state determined at least one maltreatment was substantiated or indicated and for whom a disposition of substantiated or indicated was assigned. It is important to note that a child may be a victim in one report and a nonvictim in another report. Substantiation is a case determination that concludes that the allegation of maltreatment or risk of maltreatment is supported by state law or policy. “Indicated” is a case determination that concludes that although maltreatment cannot be substantiated by state law or policy, there is reason to suspect that the child may have been maltreated or was at risk of maltreatment.

State statutes also establish the level of evidence needed to determine a disposition of substantiated or indicated. The local CPS agencies respond to the safety needs of the children who are the subjects of child maltreatment reports based on these state definitions and requirements for levels of evidence.

NCANDS data are a critical source of information for many publications, reports, child welfare personnel, researchers, and others. NCANDS data are used as a performance measure in several Federal programs.

NCANDS data also are used for the annual Child Maltreatment report series. Each report summarizes the major national and state-by-state findings for the given fiscal year and is a key resource for thousands of people and organizations across the world. The Children’s Bureau has published an annual Child Maltreatment report since 1992. Reports are available on the Children’s Bureau website at <https://www.acf.hhs.gov/cb/data-research/child-maltreatment>.

Rates are based on the number of states submitting data to NCANDS each year; states include the District of Columbia and the Commonwealth of Puerto Rico. Information about NCANDS is available online at <https://www.acf.hhs.gov/cb/data-research/ncands>.

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National Crime Victimization Survey

The National Crime Victimization Survey (NCVS) is the Nation’s primary source of information on criminal victimization. The NCVS is sponsored by the Bureau of Justice Statistics and data are collected by the U.S. Census Bureau. The NCVS collects information on nonfatal victimizations, reported and not reported to the police, against persons age 12 or over from a nationally representative sample of U.S. households. In 2021, there were 150,138 household interviews. Overall, 67% of eligible households completed an interview. Within participating households, 238,043 persons completed an interview in 2021, representing an 82% response rate among eligible persons from responding households. Sample households are chosen using a multistage stratified sample design. All household members age 12 and over in selected households are interviewed to obtain information on the frequency, characteristics, and consequences of criminal victimization in the United States. The survey measures the likelihood of victimization by rape, sexual assault, robbery, assault, theft, household burglary, and motor vehicle theft for the population as a whole, as well as for segments of the population such as adolescents and members of various racial and gender groups. Victims also are asked (either in person or by telephone) whether they reported the incident to the police. In instances of personal violent crimes, victims are asked about the characteristics of the perpetrator.

The NCVS is the largest national forum for allowing victims the opportunity to describe the impact of crime and to provide their characteristics and those of violent offenders. It has been ongoing since 1973 and was redesigned in 1992.

Due to changes in survey methodology in 2006, national-level estimates were not comparable with estimates based on NCVS data from previous years. See *Criminal Victimization, 2006*, <https://bjs.ojp.gov/library/publications/criminal-victimization-2006>, for more information on the redesigned methodology. In 2016, the NCVS sample was redesigned, and 2016 estimates among youth are not comparable with estimates from other years.

The 2020 NCVS weights include an additional adjustment to address the impact of modified Census Bureau field operations due to COVID-19. For more information on the weighting adjustments applied in 2020, see the Source and Accuracy Statement for the 2020 National Crime Victimization Survey in the NCVS 2020 Codebook (<https://www.icpsr.umich.edu/web/NACJD/studies/38090/summary>) and *Criminal Victimization, 2020* (NCJ 301775, BJS, October 2021).

Information about the NCVS is available online at <https://bjs.ojp.gov/programs/ncvs>.

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National Health and Nutrition Examination Survey

The National Health and Nutrition Examination Survey (NHANES) is a major program of the National Center for Health Statistics (NCHS). NHANES is designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews and health examinations. The NHANES interview includes demographic, socioeconomic, dietary, and health-related questions. The examination component consists of medical, dental, and physiological measurements, as well as laboratory tests administered by highly trained medical personnel. Findings from this survey are used to determine the prevalence of major diseases and risk factors for diseases among the civilian noninstitutionalized population of the United States and serve as the basis for national standards for such measurements as body mass index and blood pressure.

The NHANES program began in the early 1960s and has been conducted as a series of surveys focusing on different population groups or health topics. In 1999, the survey became a continuous program that, in addition to a core focus on major chronic health conditions and nutrition, has flexible content to meet emerging public health concerns. Each year, the survey examines a nationally representative sample of about 5,000 persons located in 15 counties across the country. Health interviews are conducted in respondents' homes. Health measurements are performed in specially designed and equipped mobile centers, which travel to the selected 15 counties during each survey year. The study team consists of medical and health technicians, and dietary and health interviewers.

Data collection is conducted with notebook computers. Survey information is available to NCHS staff within 24 hours of collection, which enhances quality assessment and increases the speed with which data are released to the public.

Since 1999, the sample design has consisted of multiyear, stratified, clustered four-stage samples, with public-use data released in 2-year cycles. In March 2020, the 2019–2020 data collection was interrupted due to the COVID-19 pandemic. As a result, data collection for the 2019–2020 cycle was not completed; the collected data for that period were not nationally representative. To create a nationally representative sample, the partial 2019–March 2020 data were combined with the full dataset from the previous cycle (2017–2018). The resulting files are referred to as the 2017–March 2020 pre-pandemic files. In 2017–March 2020, of the 9,003 children and adolescents ages 1–19 sampled, interviewers collected information for 5,754 children and adolescents, and completed 5,228 examinations. For children and adolescents, the unweighted response rates for interviews and examinations were 56.7% and 51.5%, respectively.

Starting with data updates for the *America's Children, 2017*, report, the reliability of survey percentage estimates is assessed using the Clopper-Pearson confidence interval, which was adapted for complex surveys by Korn-Graubard, to determine if the estimate is unreliable and should be suppressed. This method has been applied to all NHANES estimates. The reliability of prior estimates for other indicators are evaluated based on relative standard error.

For more information about the survey methodology, see:

National Center for Health Statistics. (2021, May 27). Brief Overview and Analytic Guidelines. <https://wwwn.cdc.gov/nchs/nhanes/continuousnhanes/overviewbrief.aspx?Cycle=2017-2020>.

Chen, T. C., Clark, J., Riddles, M. K., Mohadjer, L. K., & Fakhouri, T. H. I. (2020). National Health and Nutrition Examination Survey, 2015–2018: Sample design and estimation procedures. *Vital and Health Statistics*, 2(184). National Center for Health Statistics. https://www.cdc.gov/nchs/data/series/sr_02/sr02-184-508.pdf

Information about NHANES is available online at <https://www.cdc.gov/nhanes>.

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National Health Interview Survey

The National Health Interview Survey (NHIS) is conducted by the National Center for Health Statistics (NCHS). NHIS monitors the health of the U.S. population by collecting and analyzing data on a broad range of topics. NHIS is a continuing nationwide sample survey of the civilian noninstitutionalized population in the U.S., excluding patients in long-term care facilities, persons on active duty with the Armed Forces, prisoners, and U.S. nationals living in foreign countries. Data are collected through personal household interviews by trained interviewers. Before 1997, a paper-and-pencil questionnaire format was used. From 1997 onward, computer-assisted personal interviewing (CAPI) was used. Interviewers obtain information on personal and demographic characteristics, including race and ethnicity, through self-reports or reports by a member of the household. Interviewers also collect data on illnesses, injuries, impairments, chronic conditions, disability, utilization of health services, and other health topics. Each year, the survey is reviewed, and special topics are added or deleted. For most health topics, the survey collects data for an entire year.

The NHIS sample is designed to estimate the national prevalence of health conditions, health service utilization, and health behaviors of the civilian noninstitutionalized population

of the United States, and included an oversample of Black, Hispanic, and Asian persons (from 2006 to 2015). The NHIS core questionnaire items are revised about every 10 to 15 years. The sample for the NHIS is redesigned and redrawn about every 10 years to better measure the changing U.S. population and to meet new survey objectives. In 2019, the NHIS questionnaire was redesigned to better meet the needs of data users, the Centers for Disease Control and Prevention, and the Department of Health and Human Services. Starting with the 2019 survey, the NHIS annual data release only includes the Sample Adult, Sample Child, Imputed Income, and Paradata files. Household, family, and person data files are no longer released. Due to changes in weighting and design methodology, direct comparisons between estimates before 2019 and 2019 onward should be made with caution, as the impact of these changes has not been fully evaluated at this time. In 2019, 9,193 children under age 18 were sampled from 33,138 households with a response rate of 59%. (Starting with the 2019 survey, an interviewed household is defined as one where the household roster and a substantial portion of either the Sample Adult Interview or the Sample Child interview is completed. Previous survey cycles defined an interviewed household as one where at least one family in the household completed a substantial portion of the family interview.) In 2020, the COVID-19 pandemic created challenges conducting in-person interviews, resulting in a shift from in-person to all-telephone interviewing in late March 2020. This change caused the response rate to decline. In July 2020, interviews were attempted by telephone first, with follow-ups to complete interviews by personal visit. Due to concerns about possible loss of coverage and lower response rates, the original August–December 2020 sample was reduced to instead provide resources for reinterviewing adults who completed the 2019 NHIS. This resulted in a smaller-than-normal sample of 5,790 children under age 18 from 21,930 households with a response rate of 48% in 2020. Due to ongoing data collection difficulties resulting from the COVID-19 pandemic, interviews were attempted by telephone first from January to April 2021 and in-person visits were only used to follow-up on nonresponse, deliver recruitment materials, and conduct interviews when telephone numbers were unknown. Starting in May 2021, regular in-person survey interviews resumed, and interviewers were given the flexibility to follow up by telephone and contact respondents by telephone first based on local COVID-19 conditions. In 2021, 8,261 children under age 18 were sampled from 30,673 households with a response rate of 50%.

Starting with data updates for the *America's Children, 2017*, report, the reliability of survey percentage estimates is assessed using the Clopper-Pearson confidence interval, which was adapted for complex surveys by Korn-Graubard, to determine if the estimate is unreliable and should be suppressed. This method has been applied to all NHIS estimates. The reliability of prior estimates for other indicators are evaluated based on relative standard error.

For more information about the survey methodology, see

National Center for Health Statistics. (2022). *Survey Description, National Health Interview Survey, 2021*. https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2021/srvydesc-508.pdf.

National Center for Health Statistics. (2021, September 30). *What's different about the 2020 NHIS Data?* <https://www.cdc.gov/nchs/nhis/2020nhisdata.htm>.

National Center for Health Statistics. (2020). *Survey Description, National Health Interview Survey, 2019*. ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2019/srvydesc-508.pdf.

National Center for Health Statistics. (2020, October 6). *2019 Questionnaire Redesign. National Health Interview Survey*. https://www.cdc.gov/nchs/nhis/2019_quest_redesign.htm.

Information about NHIS is available online at <https://www.cdc.gov/nchs/nhis.htm>.

For health data for children, see:

NCHS. *Summary health statistics for U.S. children: National Health Interview Survey*. <https://www.cdc.gov/nchs/nhis/shs.htm>.

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National Hospital Ambulatory Medical Care Survey

The National Hospital Ambulatory Medical Care Survey (NHAMCS) Emergency Department (ED) Component is conducted by the National Center for Health Statistics. NHAMCS-ED collects data on ambulatory care visits to hospital emergency departments. Data are abstracted or electronically extracted from medical records by U.S. Census Bureau field representatives. Patient characteristics collected include age, sex, race, ethnicity, and expected source of payment. Visit characteristics collected include reasons for visit, diagnoses, tests and procedures, medications, providers seen, and disposition. Data are also collected on selected hospital characteristics, such as trauma level and electronic health record capabilities. Annual data collection began in 1992.

The survey is a nationally representative sample of in-person visits to EDs in non-Federal, short-stay, and general hospitals. NHAMCS uses a four-stage probability sample design, involving samples of geographic primary sampling units (PSUs); hospitals within PSUs; EDs; and patient visits to EDs.

The hospital sample consists of about 500 hospitals. In 2019, 19,481 ED patient record forms were completed, and the ED hospital response rate was 84.2%. In 2020, 14,860 ED patient record forms were completed, and the ED hospital response rate was 76.2%. For information on how data collection procedures were adapted during the COVID-19 pandemic, see <https://pubmed.ncbi.nlm.nih.gov/34878878/>.

For background information, see

McCaig, L. F., & McLemore, T. (1994). Plan and operation of the National Hospital Ambulatory Medical Care Survey. *Vital and Health Statistics 1*(34). National Center for Health Statistics. https://www.cdc.gov/nchs/data/series/sr_01/sr01_034acc.pdf.

Information about NHAMCS is available on the National Health Care Survey website at <https://www.cdc.gov/nchs/nhcs/index.htm> or the Ambulatory Health Care website at <https://www.cdc.gov/nchs/ahcd/index.htm>.

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National Household Education Survey

The National Household Education Surveys Program (NHES) is a data collection system designed to address a wide range of education-related issues. Surveys have been conducted in 1991, 1993, 1995, 1996, 1999, 2001, 2003, 2005, 2007, 2012, 2016, and 2019. NHES targets specific populations for detailed data collection. It is intended to provide more detailed data on the topics and populations of interest than are collected through supplements to other household surveys.

The 1991 NHES included a survey on early childhood program participation. Investigators screened approximately 60,000 households to identify a sample of about 14,000 children, ages 3–8. They interviewed parents to collect information about these children's educational activities and the role of the family in the children's learning. In 1993, the National Center for Education Statistics (NCES) fielded a school readiness survey in which parents of approximately 11,000 children ages 3–7 or in 2nd grade or below were asked about their children's experiences in early childhood programs, developmental level, school adjustment and related problems, early primary school experiences, general health and nutrition status, home activities, and family characteristics (including family stability and economic risk factors). In 1995, NCES also fielded a survey on early childhood program participation, similar to that of 1991. It entailed screening approximately 44,000 households and interviewing 14,000 parents of children from birth through 3rd grade. In 1996, NCES fielded a survey of parent and family involvement in education, interviewing nearly 21,000 parents of children in Grades 3–12. About 8,000 youth in Grades 6–12 were also interviewed about their community service and civic involvement. The 1999 NHES was designed to collect end-of-the-decade estimates of key indicators collected in previous NHES surveys and to collect data from children and their parents about plans for the child's education after high school. Approximately 60,000 households were screened for a total of about 31,000 interviews with parents of children from birth through Grade 12 (including about 6,900 infants, toddlers, and preschoolers) and adults age 16 or over not enrolled in Grade 12 or below.

Three surveys were fielded as part of the 2001 NHES. The Early Childhood Program Participation Survey was similar in content to the 1995 collection and collected data about the education of 7,000 prekindergarten children ranging in age from birth to age 6. The Before- and After-School Programs and Activities Survey collected data about nonparental care arrangements and educational activities in which children participate before and after school. Data were collected for approximately 10,000 children in kindergarten through Grade 8. The third survey fielded in 2001 was the Adult Education and Lifelong Learning Survey, which gathered data about the formal and informal educational activities of 11,000 adults.

The 2005 NHES included surveys that covered early childhood program participation and after-school programs and activities. Data were collected from parents of about 7,200 children for the Early Childhood Program Participation Survey and from parents of nearly 11,700 children for the After-School Programs and Activities Survey. These surveys were substantially similar to the surveys conducted in 2001, with the exceptions that the Early Childhood Program Participation Survey and the After-School Programs and Activities Survey did not collect information about before-school care for school-age children.

The 2007 NHES fielded the Parent and Family Involvement in Education Survey, which was similar in design and content to the Parent and Family Involvement in Education Survey fielded in 2003. New features added in 2007 were questions about supplemental education services provided by schools and school districts (including use of and satisfaction with such services), as well as questions to efficiently identify the school attended by the sampled students. For the 2007 Parent and Family Involvement Survey, interviews were completed with parents of 10,680 sampled children in kindergarten through Grade 12, including 10,370 students enrolled in public or private schools and 310 homeschooled children.

NHES:2012, NHES:2016, and NHES:2019 included the Parent and Family Involvement in Education Survey and the Early Childhood Program Participation Survey. The Parent and Family Involvement in Education Survey gathered data on students who were enrolled in kindergarten through Grade 12 or who were homeschooled at equivalent grade levels. Survey questions that pertained to students enrolled in kindergarten through Grade 12 requested information on various aspects of parent involvement in education (such as help with homework, family activities, and parent involvement at school), and survey questions pertaining to homeschooled students requested information on the student's homeschooling experiences, the sources of the curriculum, and the reasons for homeschooling. The Early Childhood Program Participation Survey focused on children age 6 or younger who were not yet enrolled in kindergarten. The survey questionnaire covered children's participation in early education and care arrangements provided by relatives or nonrelatives in private homes, center-based day care, or preschool programs (including Head Start). Additional topics included family learning activities, early literacy and numeracy skills, out-of-pocket expenses for nonparental care and education, factors related to parents' selection of providers, and parents' perceptions of care and education quality. Parents also were asked about child characteristics, including the child's health and disability status; characteristics of the child's parents or guardians who live in the household; and household characteristics.

Additional information about the NHES is available online at <https://nces.ed.gov/nhes/>.

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National Immunization Surveys

The National Immunization Surveys (NIS) are a family of telephone surveys used to monitor vaccination coverage among children ages 19–35 months (NIS-Child), adolescents ages 13–17 years (NIS-Teen), and for influenza vaccination, ages 6 months–17 years (NIS-Flu). Data collection for NIS-Child began in April 1994 to assess vaccination coverage after measles outbreaks in the early 1990s. Similar to the NIS-Child, the NIS-Teen was launched in 2006.

The NIS provide population-based, state, selected local area, and territorial estimates of vaccination coverage among children and adolescents using a standard survey methodology. The surveys collect data through telephone interviews with parents or guardians in all 50 states, the District of Columbia, and some cities or counties and U.S. territories. Cell phone numbers are randomly selected and called to identify one or more age-eligible children or adolescents from the household. The parents and guardians of eligible children for NIS-Child and adolescents for NIS-Teen are asked during the interview for the names of their children's or teen's vaccination providers and permission to contact them. With this permission, a questionnaire is mailed to each child's vaccination provider(s) to collect the information on the types of vaccinations, number of doses, dates of administration, and other administrative data about the health care facility. Estimates of vaccination coverage are determined for vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP). Children and adolescents are classified as being up to date based on the ACIP-recommended numbers of doses for each vaccine. All vaccination coverage estimates are based on provider-reported vaccination history.

Information about the NIS is available online at <https://www.cdc.gov/vaccines/imz-managers/nis/index.html>.

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National Survey on Drug Use and Health

The National Survey on Drug Use and Health (NSDUH) is sponsored by the Center for Behavioral Health Statistics and Quality of the Substance Abuse and Mental Health Services Administration (SAMHSA).

NSDUH has been conducted since 1971 and serves as the primary source of information on the prevalence and incidence of illicit drug, alcohol, and tobacco use in the civilian noninstitutionalized population ages 12 and over in the United States. Information about substance use and substance use disorders, mental health problems, and receipt of substance abuse and mental health treatment is also included.

The survey covers residents of households (living in houses/townhouses, apartments, condominiums, etc.), persons in noninstitutional group quarters (e.g., shelters, rooming/boarding houses, college dormitories, migratory workers' camps, and halfway houses), and civilians living on military bases. The survey excludes homeless people who do not use shelters, active military personnel, and residents of institutional group quarters. NSDUH data are not only representative of the population nationally but also representative of the population in each state and the District of Columbia. The survey design includes an independent, multistage area probability sample for each state and the District of Columbia to accommodate state estimates of substance use and mental health. The unit analysis is at the person level. Respondents are given a choice of mode of data collection, either through in-person interviews or via a web survey. Computer-assisted interviewing (CAI) methods, including audio computer-assisted self-interviewing (ACASI), are used to provide a private and confidential setting to complete in-person interviews. Over 67,500 interviews are conducted each year using these methods.

Information about NSDUH is available online at <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>. To access SAMHSA's public-use files, including an online data analysis tool, please visit <https://datafiles.samhsa.gov/>. NSDUH-restricted files, including state and other geographic identifiers, can be accessed through the Research Data Center (RDC) system of the National Center for Health Statistics. For RDC-related questions, please email rdca@cdc.gov.

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National Vital Statistics System—Linked Birth/Infant Death Data Set

The National Center for Health Statistics' (NCHS) National Vital Statistics System collects and publishes data on births and deaths in the United States. The period data set of the Linked Birth/Infant Death Data Set is used to produce the statistics presented in this report. In the period-linked data set, the numerator consists of all infant deaths occurring in a given year linked to their corresponding birth certificates from that calendar year or the previous year. The Linked file includes all the variables on the national natality file, as well as medical information reported for the same infant on the death record and the age of the infant at death. The infant's race and Hispanic origin are classified based on the race and Hispanic origin of the mother reported on the birth certificate. This is preferred over race and Hispanic origin on the death certificate because information on the birth certificate is usually provided by the parents, while information on the death certificate may be completed by a third party (like the coroner or physician). Linked files are available starting with the birth cohort of 1983. Linked files were not produced for the 1992–1994 data years.

Race Reporting. The 2003 revision of the U.S. Standard Certificate of Live Birth uses revised race and ethnicity sections conforming to the 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. The 2003 revision permits reporting of more than one race (multiple races). In 2003, states began adopting this new certificate on a rolling basis. Starting with the 2017 linked data set, single-race data are available for all 50 states and the District of Columbia. For data before 2017, bridged-race categories were presented to provide uniformity and comparability of data over time. Therefore, data for race groups for 2017 onwards are not comparable with earlier data. The bridged population estimates can be found online at <https://www.cdc.gov/nchs/nvss/bridged-race.htm>.

For more information, see:

Ely, D. M., & Driscoll, A. K. (2022). Infant mortality in the United States, 2020: Data from the period linked birth/infant death file. *National Vital Statistics Reports*, 71(5). National Center for Health Statistics. DOI: <https://dx.doi.org/10.15620/cdc:120700>.

Information about the Linked Birth/Infant Death file is available online at <https://www.cdc.gov/nchs/nvss/linked-birth.htm>.

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National Vital Statistics System—Mortality

The National Center for Health Statistics' (NCHS) National Vital Statistics System (NVSS) collects and publishes data on deaths in the United States. NCHS obtains information on deaths from the registration offices of all states, New York City, and the District of Columbia. Funeral directors and family members provide demographic information on death certificates. Medical certification of cause of death is provided by a physician, medical examiner, or coroner.

Cause of death. For 1980–1998, cause of death is classified according to the *International Classification of Diseases (ICD)*, 9th Revision. For 1999 onward, cause of death is classified according to the ICD, 10th Revision. The following ICD codes are used in the *America's Children* report:

Cause of Death	ICD-9	ICD-10
Birth defects	740–759	Q00–Q99
Cancer	140–208	C00–C97
COVID-19	...	U07.1
Heart disease	390–398, 402, 404–429	I00–I09, I11, I13, I20–I51
Homicide	E960–E969	*U01–*U02, X85–Y09, 87.1
Influenza and pneumonia	480–487	J09–J18
Injuries (intentional and unintentional)	E800–E869, E880–E929, E950–E999	*U01–*U03, V01–Y36, Y85–Y87, Y89
Drowning	E830.0–E830.9, E832.0–E832.9, E910.0–E910.9, E954, E964, E984	W65–74, X71, X92, Y21
Fall	E880.0–E886.9, E888, E957.0–E957.9, E968.1, E987.0–E987.9	W00–W19, X80, Y01, Y30
Fire and burns	E890–E899, E924.0–E924.9, E958.1, E958.2, E958.7, E961, E968.0, E968.3, E988.1, E988.2, E988.7	*U01.3, X00–X19, X76–77, X97–X98, Y26–Y27, Y36.3
Firearms	E922, E955.0–E955.4, E965.0–E965.4, E970, E985.0–E985.4	*U01.4, W32–W34, X72–X74, X93–X95, Y22–Y24, Y35.0
Firearm homicide	E965.0–E965.4	*U01.4, X93–X95
Firearm suicide	E955.0–E955.4	X72–X74
Motor vehicle traffic	E810–E825	V02–V04, V09.0, V09.2, V12–V14, V19.0–V19.2, V19.4–V19.6, V20–V79, V80.3–V80.5, V81.0–V81.1, V82.0–V82.1, V83–V86, V87.0–V87.8, V88.0–V88.8, V89.0, V89.2

Cause of Death	ICD-9	ICD-10
Pedestrian (nontraffic)	E800.2, E801.2, E802.2, E803.2, E804.2, E805.2, E806.2, E807.2, E820.7, E821.7, E822.7, E823.7, E824.7, E825.7, E826.0, E827.0, E828.0, E829.0	V01.0, V02.0, V03.0, V04.0, V05, V06, V09.0, V09.1, V09.3, V09.9
Suffocation	E911–E913.9, E953.0–E953.9, E963, E983.0–E983.9	W75–W84, X70, X91, Y20
Suicide	E950–E959	*U03, X60–X84, Y87.0
Unintentional injuries	E800–E869, E880–E929	V01–X59, Y85–Y86

... Category not applicable.

Population denominators. Population denominators are based on Census data. The 2003 revision of the U.S. Standard Certificate of Death uses revised race and ethnicity sections conforming to the 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. The 2003 revision permits reporting of more than one race (multiple races). In 2003, states began adopting this new certificate on a rolling basis. Starting with 2018 data, all 50 states and the District of Columbia have adopted the 2003 certificate. Prior to 2018 data, to provide uniformity and comparability of data for trend comparison, bridged race categories were presented. Therefore, data for race groups for 2018 and subsequent years are not comparable with earlier data. The bridged population estimates can be found online at https://www.cdc.gov/nchs/nvss/bridged_race.htm. Prior to *America's Children, 2003*, rates were based on populations estimated from the 1990 Census.

For more information about these methodologies, see:

Ingram, D. D., Weed, J. A., Parker, J. D., Hamilton, B. E., Schenker, N., Arias, E., & Madans, J. (2003). U.S. Census 2000 population with bridged race categories. *Vital Health Statistics, 2*(135). National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/bridged_race.htm.

Anderson, R. N., & Arias, E. (2003). The effect of revised populations on mortality statistics for the United States, 2000. *National Vital Statistics Reports, 51*(9). National Center for Health Statistics. https://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_09.pdf.

National Center for Health Statistics. (2015, November 6). *Comparability of cause-of-death between ICD revisions*. https://www.cdc.gov/nchs/nvss/mortality/comparability_icd.htm.

For more information on national mortality data, see:

Murphy, S. L., Kochanek, K. D., Xu, J., & Arias, E. (2022). *Mortality in the United States, 2021* (NCHS Data Brief, No. 456). National Center for Health Statistics. DOI: <https://dx.doi.org/10.15620/cdc:122516>.

Xu, J., Murphy, S. L., Kochanek, K. D., & Arias, E. (2021). Deaths: Final data for 2019. *National Vital Statistics Reports, 70*(8). National Center for Health Statistics. DOI: <https://dx.doi.org/10.15620/cdc:106058>.

National Center for Health Statistics. (2004). Technical appendix. *Vital statistics of the United States, 1999, vol. II, mortality, part A*. <https://www.cdc.gov/nchs/data/statab/techap99.pdf>.

Information about NVSS deaths data is available online at <https://www.cdc.gov/nchs/nvss/deaths.htm>.

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National Vital Statistics System—Natality

The National Center for Health Statistics' (NCHS) National Vital Statistics System (NVSS) collects and publishes data on births in the United States. NCHS obtains information from the registration offices of all states, New York City, and the District of Columbia. The birth certificate must be filed with the local registrar of the district in which the birth occurs. Each birth must be reported promptly; the reporting requirements vary from state to state, ranging from 24 hours to as much as 10 days after the birth. Demographic information on birth certificates, such as race and ethnicity, is provided by the mother at the time of birth. Hospital records provide the base for information on birthweight.

Population Denominators. Population denominators are based on Census data. The 2003 revision of the U.S. Standard Certificate of Live Birth uses revised race and ethnicity sections conforming to the 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. The 2003

revision permits reporting of more than one race (multiple races). In 2003, states began adopting this new certificate on a rolling basis. Starting with 2016 data, all 50 states and the District of Columbia have adopted the 2003 certificate. Prior to 2016 data, to provide uniformity and comparability of data for trend comparison, bridged-race categories were presented. Therefore, data for race groups for 2016 and subsequent years are not comparable with earlier data. The bridged population estimates can be found online at https://www.cdc.gov/nchs/nvss/bridged_race.htm. Prior to *America's Children, 2003*, rates were based on populations estimated from the 1990 Census.

Detailed information on the methodologies used to develop the revised populations, including the populations for birth rates for teenagers and birth rates for unmarried teenagers, is presented in several publications.

For more information about these methodologies, see:

Matthews, T. J., & Hamilton, B. E. (2019). Total fertility rates by state and race and Hispanic origin: United States, 2017. *National Vital Statistics Reports, 68*(1). National Center for Health Statistics. https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_01-508.pdf

Ventura, S. J., Hamilton, B. E., & Sutton, P. D. (2003). Revised birth and fertility rates for the United States, 2000 and 2001. *National Vital Statistics Reports, 51*(4). National Center for Health Statistics. https://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_04.pdf

Hamilton, B. E., Sutton, P. D., & Ventura, S. J. (2003). Revised birth and fertility rates for the 1990s and new rates for Hispanic Populations, 2000 and 2001: United States. *National Vital Statistics Reports, 51*(12). National Center for Health Statistics. https://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_12.pdf

Ingram, D. D., Weed, J. A., Parker, J. D., Hamilton, B. E., Schenker, N., Arias, E., & Madans, J. (2003). U.S. Census 2000 population with bridged race categories. *Vital and Health Statistics, 2*(135). National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/bridged_race.htm

For more information on national natality data, see

Osterman, M. J. K., Hamilton, B. E., Martin, J. A., Driscoll, A. K., & Valenzuela, C.P. (2023). Births: Final data for 2021. *National Vital Statistics Reports, 72*(1). National Center for Health Statistics. DOI: <https://dx.doi.org/10.15620/cdc:122047>.

National Center for Health Statistics. (2008). *Detailed technical notes. United States, 2005, natality*. https://wonder.cdc.gov/wonder/sci_data/natal/detail/type_txt/natal05/TechAppendix05.pdf

Information about NVSS births data is available online at <https://www.cdc.gov/nchs/nvss/births.htm>.

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Safe Drinking Water Information System

The Safe Drinking Water Information System (SDWIS) is the national regulatory compliance database for the drinking water program of the U.S. Environmental Protection Agency (EPA). SDWIS includes information on the Nation's 160,000 public water systems and data submitted by states and EPA regions in conformance with reporting requirements established by statute, regulation, and guidance.

The EPA sets national standards for drinking water. These requirements take three forms: maximum contaminant levels (MCLs, the maximum allowable level of a specific contaminant in drinking water), treatment techniques (specific methods that facilities must follow to remove certain contaminants), and monitoring and reporting requirements (schedules that utilities must follow to report testing results). States report any violations of these three types of standards to the EPA.

Water systems must monitor for contaminant levels on fixed schedules and report to the EPA when a maximum contaminant level has been exceeded. States also must report when systems fail to meet specified treatment techniques. More information about the maximum contaminant levels can be found online at <https://www.epa.gov/ground-water-and-drinking-water/table-regulated-drinking-water-contaminants>.

The EPA sets minimum monitoring schedules that drinking water systems must follow. These minimum monitoring schedules (states may require systems to monitor more frequently) vary by the type and size of the drinking water system, the source water (surface water or ground water), and contaminant. For example, at a minimum, all drinking water systems regularly monitor nitrate, community water systems that serve surface water monitor daily for turbidity, and ground water systems may monitor inorganic contaminants every 9 years.

SDWIS includes data on the total population served by each public water system and the state in which the public water system is located. However, SDWIS does not include the number of children served. The fractions of the population served by noncompliant public water systems in each state were estimated using the total population served by violating community water systems divided by the total population

served by all community water systems. The numbers of children served by violating public water systems in each state were estimated by multiplying the fraction of the population served by violating public water systems by the number of children (ages 0–17) in the state.

Information about SDWIS is available online at <https://www.epa.gov/enviro/sdwis-overview>.

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Youth Risk Behavior Surveillance System

The Youth Risk Behavior Surveillance System (YRBSS) was developed in 1990 to monitor health risk behaviors and experiences that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States.

The YRBSS includes national, state, and local school-based surveys of representative samples of 9th- through 12th-grade students. These surveys are conducted every 2 years, usually during the spring semester. The national Youth Risk Behavior Survey (YRBS), conducted by the Centers for Disease Control and Prevention, provides data representative of high school students in public and private schools in the United States. The state and local surveys, conducted by departments of health and education, typically provide data representative of public high school students in each state or local school district. Survey procedures for the national, state, and local surveys are designed to protect students' privacy by allowing for anonymous and voluntary participation. Before survey administration, local parental permission procedures are followed. Students complete the self-administered questionnaire during one class period and record their responses directly on an electronic device, computer-scannable booklet, or answer sheet.

For the 2021 national YRBS, the sampling frame consisted of all public and private schools with students in at least one of Grades 9–12 in the 50 states and the District of Columbia. A three-stage cluster sample design produced a nationally representative sample of students in Grades 9–12 who attend public and private schools. All students in selected classes were eligible to participate. Schools, classes, and students that refused to participate were not replaced. In 2021, 17,508 questionnaires were completed in 152 schools. The school response rate was 73%, and the student response rate was 79%. The overall response rate (school response rate multiplied by the student response rate) was 57%.

Information about the YRBSS, including the 2021 national YRBS, is available online at <https://www.cdc.gov/yrbs>.

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