America's Children in Brief: Key National Indicators of Well-Being, 2020

Forum on Child and Family Statistics

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 summer 2020 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 Assistant Secretary of Defense for 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/

Maternal and Child Health Bureau
https://www.mchb.hrsa.gov

National Center for Health Statistics
https://www.cdc.gov/nchs

National Institute of Mental Health
https://www.nimh.nih.gov/index.shtml

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://www.bjs.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/

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Federal Interagency Forum on Child and Family Statistics

America's Children in Brief: Key National Indicators of Well-Being, 2020

This year's America's Children in Brief: Key National Indicators of Well-Being *continues two decades of collaboration by agencies across the Federal Government to advance our understanding of our Nation's children and what may be needed to bring them a better tomorrow. Data used in this report were collected before the COVID-19 pandemic. While many of the data surveys reflected in this report have adapted to address data needs related to the pandemic, these data were not available for inclusion at the time of publication.*

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

Introduction

The Federal Interagency Forum on Child and Family Statistics (Forum) was chartered in 1997 by Executive Order No. 13045. The Forum fosters collaboration among 23 Federal agencies that produce and use statistics on children and families and seeks to improve these Federal data. Each year, the Forum publishes a report compiling measures of well-being drawn from the most reliable Federal statistics.

Conceptual Framework for Key National Indicators

The Forum has identified 41 indicators that describe the well-being of children. These indicators span seven domains: Family and Social Environment, Economic Circumstances, Health Care, Physical Environment and Safety, Behavior, Education, and Health. The indicators also must meet the following criteria:

- Easy to understand by broad audiences
- Objectively based on reliable data
- Balanced, so that no single area dominates the report
- Measured regularly so that they can be updated and show trends
- Representative of large segments of the population

Pending data availability, the Forum updates all 41 indicators annually on its website (https://www.childstats.gov/) and alternates publishing a detailed report, *America's Children: Key National Indicators of Well-Being,* with a summary version, *America's Children in Brief,* which highlights selected indicators.

America's Children in Brief, 2020

This year's *America's Children in Brief* highlights selected indicators by metropolitan status to give the reader a closer look at how well-being is influenced by the type of community in which children and their families live. The *Brief* also provides a snapshot of the overall well-being of America's children through the At-a-Glance summary table displaying the most recent data for all 41 indicators.

The focus on metropolitan status is motivated by the long-standing recognition that there are substantial differences across communities and such differences may influence child well-being in diverse ways. Underlying characteristics of communities that affect child well-being reported in this *Brief* include the following types of factors:[1–10]

- **Demographic characteristics of the population.** The age, race, and ethnic composition of communities differ by metropolitan status.
- **Physical characteristics of natural and built environments.** Living environments influence the health and well-being of children and families in many ways, and living environments vary substantially by metropolitan status. Differences in housing types, conditions, and costs in different communities affect the prevalence of housing problems among the children and families who live there.

- **Economic activity and conditions.** The level of economic vitality in a community affects the employment opportunities of parents. The concentration of firms, labor markets, and consumer markets varies by metropolitan status, providing different levels and types of advantages to the children and families who dwell in them.
- **Social and cultural factors.** Social and cultural factors that influence support networks, behavior, and perceived choices vary by geography. For instance, behavioral risk factors such as smoking prevalence or substance use often differ significantly by metropolitan status.
- **Community institutions, resources, and services.** Community institutions that can directly influence child well-being include the proximity of hospitals and clinics, the availability of good schools and public parks, and the presence of cultural and religious institutions that enrich children's lives and development. These community resources vary across the spectrum of metropolitan status.
- **Health and wellness.** Community conditions can influence a child's health, and health in childhood can affect other outcomes. For example, asthma is more prevalent in older and denser housing and areas with worse air quality, which vary by metropolitan status. Chronic conditions such as childhood asthma can impact school attendance, which can impact educational achievement.

Discussions of the geographic classifications, race and ethnicity measures, and statistical significance analyses used in this report follow.

Geographic Classifications

Classifying counties into "standard metropolitan areas" was introduced around 1950. The U.S. Office of Management and Budget (OMB) develops definitions for these areas to provide a nationally consistent set of delineations for collecting, tabulating, and publishing Federal statistics for geographic areas. Although some of the definitions and terminology have changed since they were first introduced, the OMB's *Standards for Delineating Metropolitan and Micropolitan Statistical Areas* have the same goals today as in the past.[11] The general concept of a metropolitan statistical area is an area containing a large population nucleus and adjacent communities that have a high degree of integration with that nucleus. The concept of a micropolitan statistical area closely parallels that of the metropolitan statistical area but contains a smaller nucleus.

- Metropolitan statistical areas contain a large (at least 50,000 residents) urbanized area and adjacent counties with a high degree of economic integration (as measured by commuting to work) with that core.
- Nonmetropolitan counties are those not classified as within a metropolitan statistical area. Nonmetropolitan areas include counties in micropolitan statistical areas and rural counties.
    - Micropolitan statistical areas as defined by the OMB contain an urban cluster with 10,000 to 49,999 residents. Adjacent counties with a high degree of economic integration (as measured by commuting to work) with that core are also classified as part of the micropolitan statistical area. Approximately 85% of micropolitan statistical areas comprise only one county.[12]
    - Counties that are not classified by the OMB as within a metropolitan or a micropolitan statistical area are classified as "rural counties" for this report. Rural counties may include small urban areas, as well as completely rural areas.

When possible, indicator data in this report are presented for three categories: metropolitan areas, micropolitan areas, and rural counties. In some cases, limited sample sizes or number of cases or issues with data reliability required that data be limited to two categories: metropolitan areas and nonmetropolitan areas comprising micropolitan areas and rural counties.

Race and Ethnicity

Every effort is made to include data breakouts by race and ethnicity for regular indicators in the full *America's Children* report and for selected indicators in this year's *Brief.* Unless otherwise noted, data by race and ethnicity in this report have implemented the *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity* (hereafter referred to as standards on race and ethnicity) issued in 1997 by the OMB (https://www.gpo.gov/fdsys/pkg/FR-1997-10-30/pdf/97-28653.pdf). The 1997 standards on race and ethnicity allow for observer or proxy identification of race but clearly state a preference for self-classification. Data on race and Hispanic origin are collected separately. Persons of Hispanic origin may be of any race. Data in this report are generally presented for the following six race and Hispanic origin groups: American Indian or Alaska Native, non-Hispanic; Asian, non-Hispanic; Black or African American, non-Hispanic; Native Hawaiian or Other Pacific Islander, non-Hispanic; White, non-Hispanic; and Hispanic or Latino. On the charts, shortened labels often are used because of limited space.

The 1997 standards on race and ethnicity also offer an opportunity for respondents to select more than one of the five race groups, leading to many possible multiple-race categories. These standards allow for two basic ways of defining a race group. 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). In this report, indicators present data using the first approach (single race). Use of the single-race population does not imply that it is the preferred method of presenting or analyzing data. Generally, a small percentage of people report two or more races. When possible, estimates for this group are shown separately. All groups not shown separately are included in the totals.

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.

For Further Information on the Forum

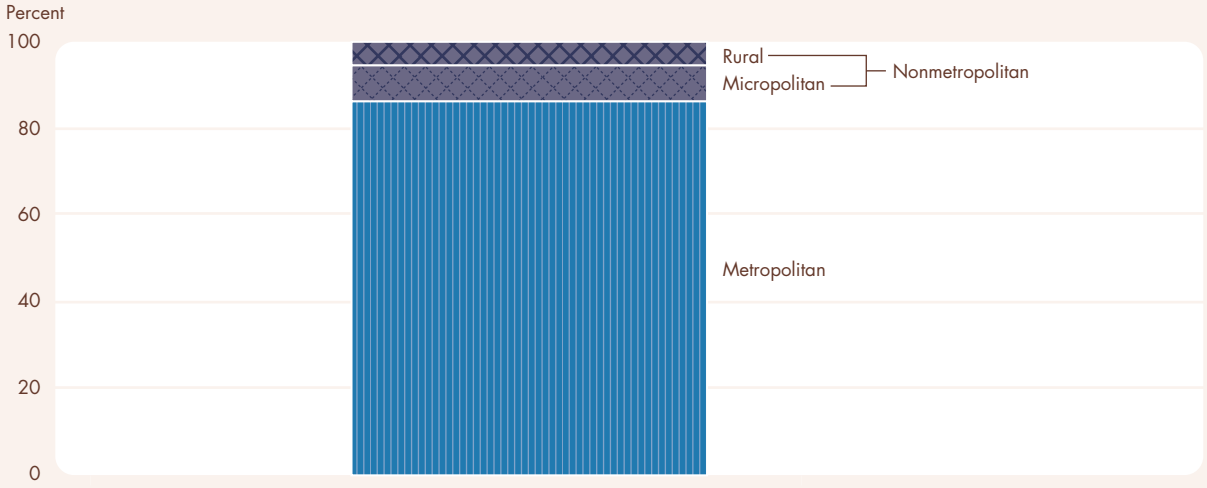
The Forum's website (https://www.childstats.gov) also includes this additional information:

- Detailed data for indicators discussed in this *Brief* as well as trend data and other *America's Children* indicators not discussed here.
- Data source descriptions and agency contact information.
- *America's Children* reports from 1997 to the present and other Forum reports.
- Links to Forum agencies, their online data tools, and various international data sources.
- Forum news and information on the Forum's overall structure and organization.

Demographic Background

Understanding the changing demographic characteristics of America's children is critical for shaping social programs and policies. Demographic composition provides an important context for understanding the indicators presented in this report and provides a glimpse of American families.

Figure 1 **Percentage of children ages 0–17 in the United States by metropolitan status, 2018**



NOTE: The U.S. Office of Management and Budget classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas. The U.S. Census Bureau reviewed this data product for unauthorized disclosure of confidential information and has approved the disclosure avoidance practices applied to this release. CBDRB-FY2020-POP001-0123.

SOURCE: U.S. Census Bureau, American Community Survey.

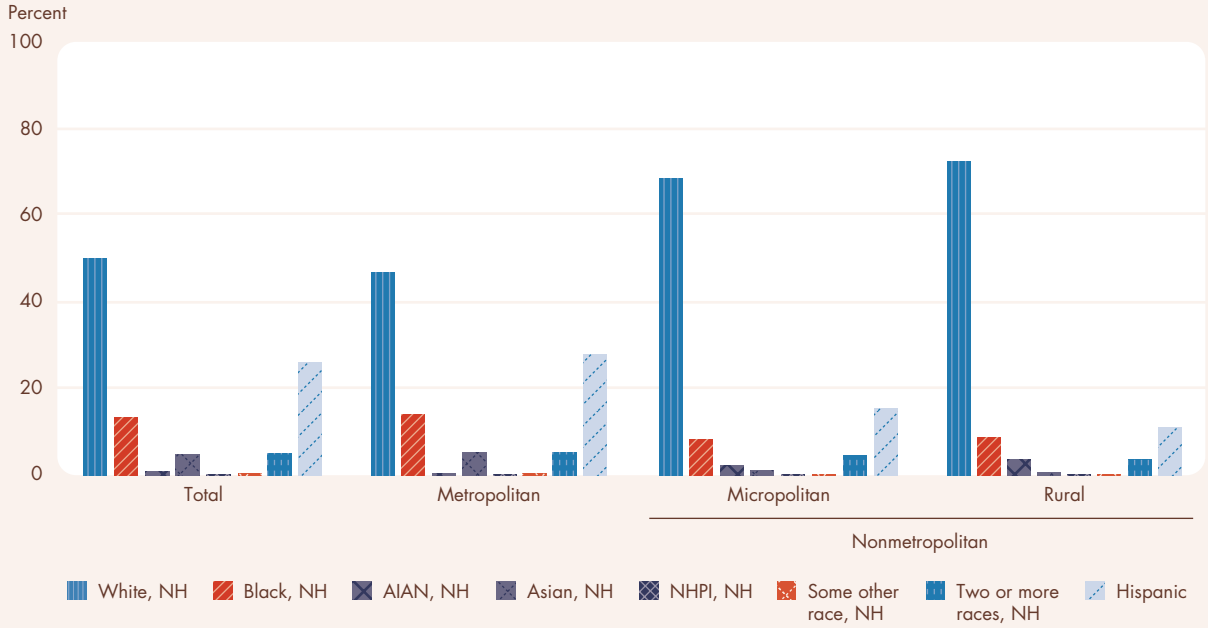
- In 2018, 86.3% of children lived in metropolitan areas, 8.3% of children lived in micropolitan areas, and 5.4% of children lived in rural areas.

Bullet contains references to data in Table BRIEF1 at childstats.gov. Endnotes begin on page 27.

Race and Hispanic Origin Composition

The United States is racially and ethnically diverse. Racial and ethnic composition also may vary by geographic area.

Figure 2 **Percentage of children ages 0–17 in the United States by race, Hispanic origin, and metropolitan status, 2018**



NOTE: NH = non-Hispanic origin; AIAN = American Indian or Alaska Native; and NHPI = Native Hawaiian or Other Pacific Islander. The 1997 U.S. Office of Management and Budget (OMB) standards on race and ethnicity are used to classify persons into one of the following five racial groups: White, Black or African American, Asian, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander. Each group is limited to the non-Hispanic population, with the exception of the Hispanic category itself. Federal surveys give respondents the option of reporting more than one race. Therefore, two ways of defining a race group are possible. A group such as Black may be defined as those who report Black and no other race or those who report Black regardless of whether they also report another race. This indicator shows data using the first approach. Those reporting more than one race were classified in the "Two or more races, NH" category. Data on race and Hispanic origin are collected separately. Persons of Hispanic origin may be of any race. The OMB classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas. The U.S. Census Bureau reviewed this data product for unauthorized disclosure of confidential information and has approved the disclosure avoidance practices applied to this release. CBDRB-FY2020-POP001-0123.

SOURCE: U.S. Census Bureau, American Community Survey.

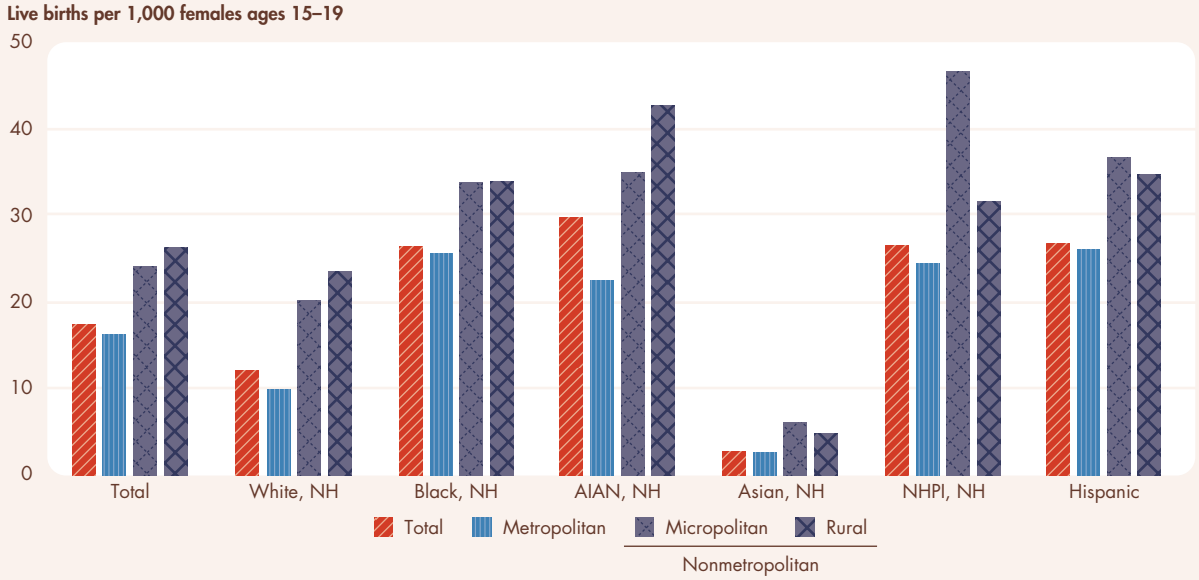
- In 2018, of all U.S. children: 50.0% were White, non-Hispanic; 25.9% were Hispanic; 13.3% were Black, non-Hispanic; 5.0% were Two or more races, non-Hispanic; 4.6% were Asian, non-Hispanic; 0.8% were American Indian or Alaska Native, non-Hispanic; 0.4% were some other race, non-Hispanic; and 0.2% were Native Hawaiian or Other Pacific Islander, non-Hispanic.
- In 2018, White, non-Hispanic children and American Indian or Alaska Native, non-Hispanic children accounted for a larger percentage of the population in nonmetropolitan (micropolitan and rural) areas than in metropolitan areas.
- In 2018, there were more Black, non-Hispanic children; Asian, non-Hispanic children; and Two or more race, non-Hispanic children in metropolitan areas than in micropolitan or rural areas. There were also more Hispanic children in metropolitan areas (27.3%) than in micropolitan areas (15.2%) or rural areas (10.9%).
- In 2018, no racial or Hispanic group accounted for more than 50% of children in metropolitan areas, whereas White, non-Hispanic children represented at least two-thirds of children in both micropolitan and rural areas (68.4% and 72.4%, respectively).

Bullets contain references to data in Table BRIEF1 at childstats.gov. Endnotes begin on page 27.

Adolescent Births

Childbirth during adolescence often is associated with long-term difficulties for the mother and her child. Compared with babies born to older mothers, babies born to adolescent mothers, particularly younger adolescent mothers, are at higher risk of low birthweight and infant mortality.[13,14] 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.[14,15] For the mothers, giving birth during adolescence is associated with limited educational attainment, which in turn can reduce employment prospects and earnings potential.[13]

Figure 3 **Birth rates for females ages 15–19 by race and Hispanic origin and metropolitan status, 2018**



NOTE: NH = non-Hispanic origin; AIAN = American Indian or Alaska Native; and NHPI = Native Hawaiian or Other Pacific Islander. Race refers to the mother's race. The 1997 U.S. Office of Management and Budget (OMB) standards on race and ethnicity are used to classify persons into one of the following five racial groups: White, Black or African American, Asian, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander. All categories are single race. Included in the total, but not shown separately, are people reporting two or more races. Data on race and Hispanic origin are collected and reported separately. Persons of Hispanic origin may be of any race. The OMB classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

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

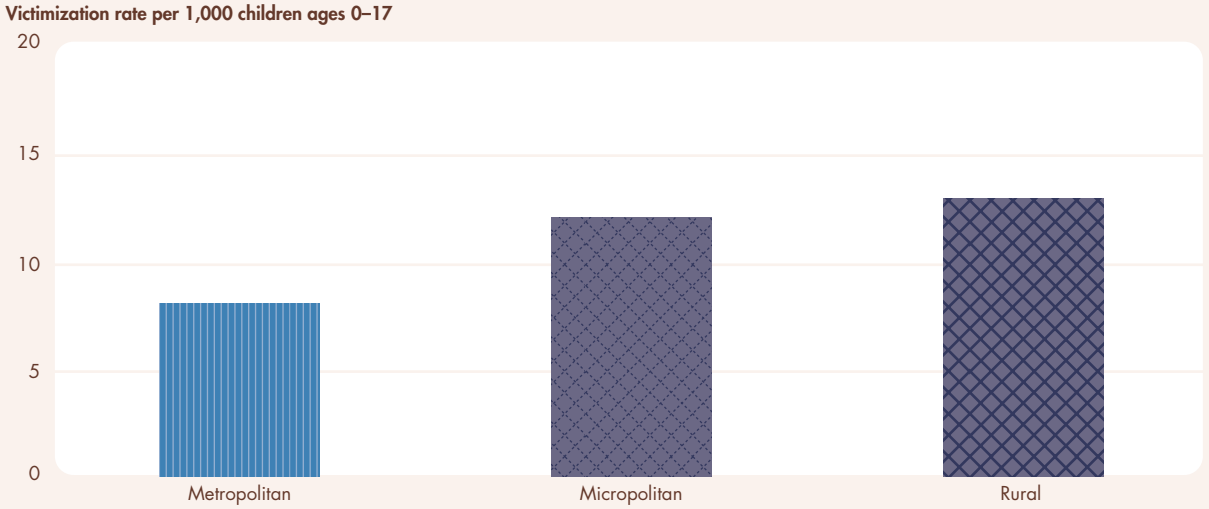
- The birth rate among females ages 15–19 was 17 per 1,000 in 2018. The birth rate was highest for adolescents living in rural counties (26 per 1,000), followed by those living in micropolitan counties (24 per 1,000) and metropolitan counties (16 per 1,000).
- In 2018, the birth rate among females ages 15–19 was 30 per 1,000 for American Indian or Alaska Native, non-Hispanic; 27 per 1,000 for Hispanic; 27 per 1,000 for Native Hawaiian or Other Pacific Islander, non-Hispanic; 26 per 1,000 for Black, non-Hispanic; 12 per 1,000 for White, non-Hispanic; and 3 per 1,000 for Asian, non-Hispanic adolescents.
- For White, non-Hispanic and American Indian or Alaska Native, non-Hispanic adolescents in 2018, the birth rate was highest for those living in rural counties and lowest for those living in metropolitan counties.
- For Black, non-Hispanic and Asian, non-Hispanic adolescents in 2018, the birth rate was highest for those living in micropolitan and rural counties and lowest for those living in metropolitan counties.
- For Hispanic and Native Hawaiian or Other Pacific Islander, non-Hispanic adolescents in 2018, the birth rate was higher for those living in micropolitan counties compared with those living in metropolitan counties.

Bullets contain references to data in Table BRIEF2 at childstats.gov. Endnotes begin on page 27.

Child Maltreatment

Child maltreatment includes physical, sexual, and psychological abuse, as well as neglect (including medical neglect). Maltreatment in general is associated with various 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.[16] Certain types of maltreatment can result in long-term physical, social, and emotional problems—even death. For example, abusive head trauma can result in mental retardation, cerebral palsy, or paralysis.[17] Please note that the calculation of child maltreatment 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.

Figure 4 **Rate of substantiated maltreatment of children ages 0–17 by metropolitan status, 2018**

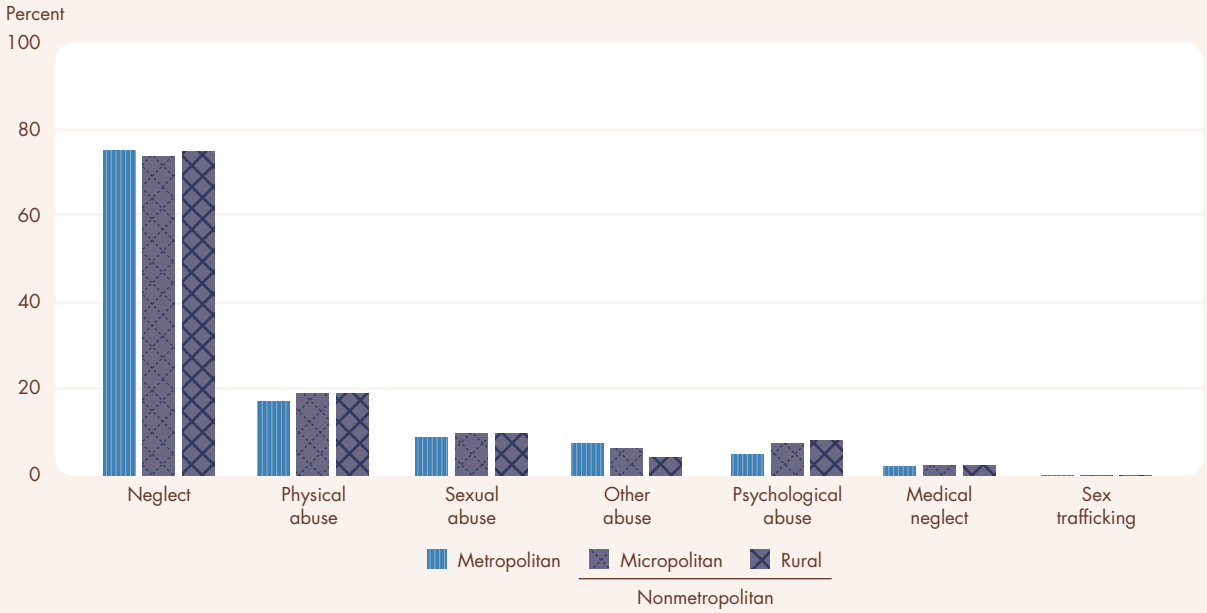


NOTE: The data in this figure are rates of maltreatment based on investigations and assessments by Child Protective Services (CPS) that found the child to be a victim of one or more types of maltreatment. The rates are based on unique counts of victims of maltreatment. A unique count includes each child only one time regardless of the number of times the child was determined to be a victim. Maltreatment includes the dispositions of substantiated or indicated. Data may include state resubmissions and may not match previously published data. Rates are based on the number of states submitting data to the National Child Abuse and Neglect Data System (NCANDS) each year; states include the District of Columbia and the Commonwealth of Puerto Rico. The number of states reporting may vary slightly from year to year: not all states report on all measures, and not all states report in all years. Additional technical notes are available in the annual reports titled *Child Maltreatment*. These reports are available at https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment. The Justice for Victims of Trafficking Act of 2015 included an amendment to the Child Abuse Prevention and Treatment Act under Title VIII—Better Response for Victims of Child Sex Trafficking by adding a requirement to collect and report sex trafficking data. States began reporting sex trafficking as a maltreatment type to NCANDS with their Federal fiscal year 2018 data submissions as required by a change in the law. For this first year of reporting, 27 states submitted data about victims of sex trafficking to NCANDS; as a result, sex trafficking rates underrepresent the true national rate, and rates for 2018 are not directly comparable with previous years. The U.S. Office of Management and Budget classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas. Metropolitan status calculations do not include Puerto Rico. Counties were classified based on the county of the child's residence at the time of the alleged abuse. If the child was in out-of-home care at the time of the report, the county of the facility or foster home should be used. This county may or may not be the county where the abuse occurred and may or may not be the county in which the CPS response occurred.

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

- Maltreatment rates were substantially lower in metropolitan areas (8.1 per 1,000 children) than in micropolitan areas (12.1 per 1,000 children) and rural areas (13.0 per 1,000 children) in 2018.

Figure 5 **Percentage of substantiated maltreatment of children ages 0–17 by maltreatment type and metropolitan status, 2018**



NOTE: This figure represents a duplicated count of maltreatments, based on a unique count of victims. Bars may 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. Additional technical notes are available in the annual reports titled *Child Maltreatment*. These reports are available at https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment. The Justice for Victims of Trafficking Act of 2015 included an amendment to the Child Abuse Prevention and Treatment Act under Title VIII—Better Response for Victims of Child Sex Trafficking by adding a requirement to collect and report sex trafficking data. States began reporting sex trafficking as a maltreatment type to NCANDS with their Federal fiscal year 2018 data submissions as required by a change in the law. For this first year of reporting, 27 states submitted data about victims of sex trafficking to NCANDS; as a result, sex trafficking rates underrepresent the true national rate, and rates for 2018 are not directly comparable with previous years. The U.S. Office of Management and Budget classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas. Metropolitan status calculations do not include Puerto Rico. Counties were classified based on the county of the child's residence at the time of the alleged abuse. If the child was in out-of-home care at the time of the report, the county of the facility or foster home should be used. This county may or may not be the county where the abuse occurred and may or may not be the county in which the Child Protective Services response occurred.

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

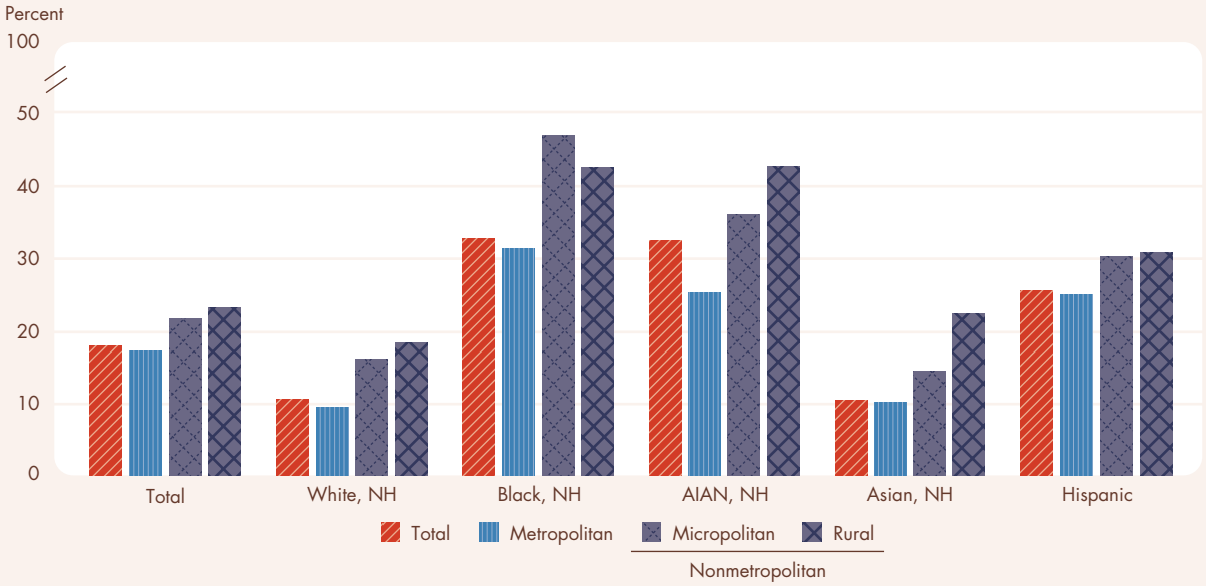
- Neglect is by far the most common form of maltreatment, with three-fourths of all maltreated children found to have been neglected and nearly identical percentages across metropolitan, micropolitan, and rural areas. The percentage of reports involving physical (18%) and sexual (9%) abuse also were similar across geographic areas, with only slightly lower percentages in metropolitan areas compared with micropolitan and rural areas. Rates of physical abuse were 17% in metropolitan areas and 19% in micropolitan and rural areas. Rates of sexual abuse were 9% in metropolitan areas and 10% in micropolitan and rural areas.

Bullets contain references to data in Tables BRIEF3 and BRIEF4 at childstats.gov. Endnotes begin on page 27.

Child Poverty

Children living in poverty are vulnerable to environmental, educational, health, and safety risks. Compared with their peers, children living in poverty 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.[18–21] These data 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.[22]

Figure 6 **Percentage of children ages 0–17 living in poverty by race, Hispanic origin, and metropolitan status, 2018**



NOTE: NH = non-Hispanic origin and AIAN = American Indian or Alaska Native. In 2018, the poverty threshold for a two-parent, two-child family was $25,465. The 1997 U.S. Office of Management and Budget (OMB) standards on race and ethnicity are used to classify persons into one of the following five racial groups: White, Black or African American, Asian, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander. Federal surveys give respondents the option of reporting more than one race. Therefore, two 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 or those who report Black regardless of whether they also report another race. This indicator shows data using the first approach. Included in the total, but not shown separately, are Native Hawaiian or Other Pacific Islander, people reporting some other race, or people reporting two or more races. Data on race and Hispanic origin are collected separately. Persons of Hispanic origin may be of any race. The OMB classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas. The U.S. Census Bureau reviewed this data product for unauthorized disclosure of confidential information and has approved the disclosure avoidance practices applied to this release. CBDRB-FY2020-POP001-0123.

SOURCE: U.S. Census Bureau, American Community Survey.

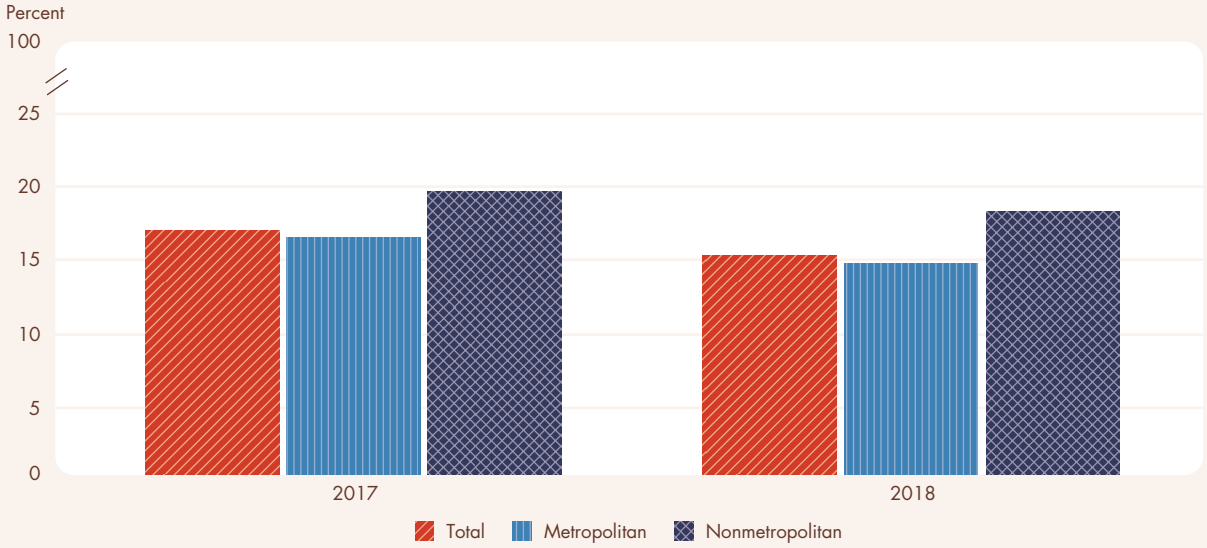
- In 2018, children ages 0–17 living in metropolitan areas had the lowest poverty rates. In 2018, 17% of children living in metropolitan areas lived in poverty, 22% of children living in micropolitan areas lived in poverty, and 23% of children living in rural areas lived in poverty.
- Among the racial and ethnic groups presented, Black, non-Hispanic children ages 0–17 had the highest poverty rates in metropolitan and micropolitan areas in 2018. In metropolitan areas, 31% of Black, non-Hispanic children lived in poverty. Nearly half (47%) of all Black, non-Hispanic children in micropolitan areas lived in poverty.
- Among the geographical areas, poverty rates for White, non-Hispanic; American Indian or Alaska Native, non-Hispanic; and Asian, non-Hispanic children ages 0–17 were highest in rural areas. Poverty rates for Black, non-Hispanic children were highest in micropolitan areas, and poverty rates for Hispanic children were highest in nonmetropolitan areas. The difference between micropolitan and rural areas was not statistically significant but both were higher than the poverty rate in metropolitan areas.

Bullets contain references to data in Table BRIEF5 at childstats.gov. Endnotes begin on page 27.

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.[23] 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 also were disrupted to some extent, and the quality and variety of their diets were adversely affected.[24]

Figure 7 **Percentage of children ages 0–17 in food-insecure households by metropolitan status, 2017–2018**



NOTE: Food-insecure households are those in which either adults or children or both were "food insecure," meaning that, at times, they were unable to acquire adequate food for active, healthy living because the household had insufficient money and other resources for food. The U.S. Office of Management and Budget classifies some counties as within a metropolitan statistical area. The remaining counties are considered nonmetropolitan. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

SOURCE: U.S. Census Bureau, Current Population Survey Food Security Supplement; tabulated by the U.S. Department of Agriculture, Economic Research Service and Food and Nutrition Service.

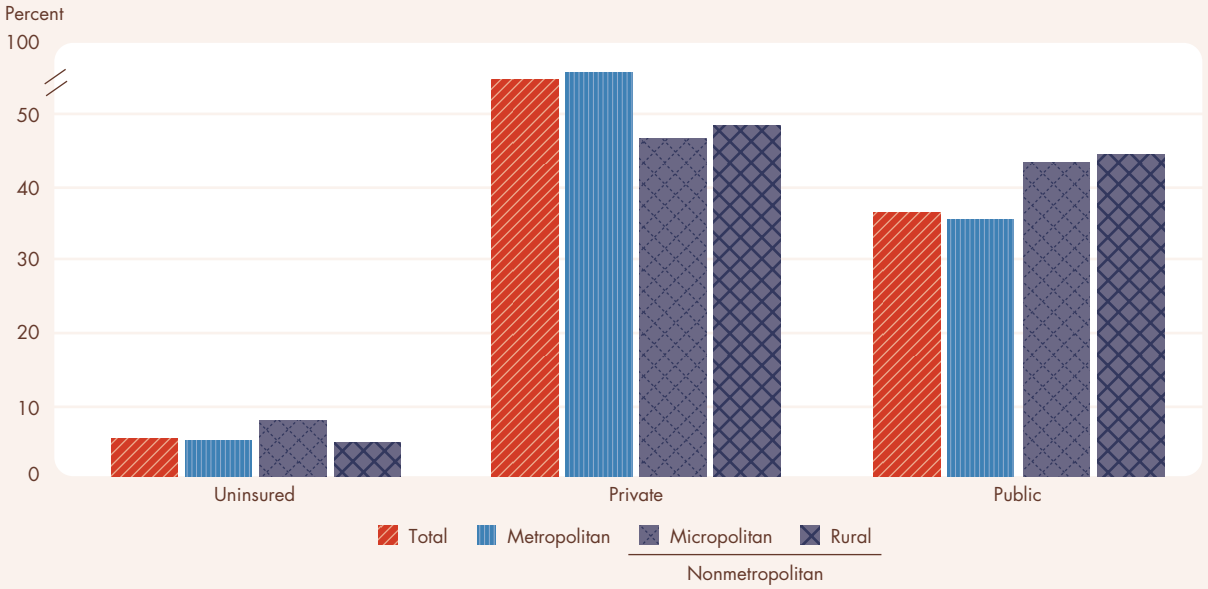
- In 2018, 11.2 million children (15% of all children) lived in households that were classified as food insecure.
- The percentage of children living in food-insecure households in 2018 (15%) was statistically different from the percentage in 2017 (17%).
- In 2018, the percentage of children in households that were food insecure was higher outside metropolitan areas (18%) than in metropolitan areas (15%). The percentage of children in food-insecure households in metropolitan areas decreased from 2017 (17%) to 2018 (15%).
- In 2018, the percentages of children living in food-insecure households were above the national average of 15% for Black, non-Hispanic (26%) and Hispanic (18%).

Bullets contain references to data in Table BRIEF6 at childstats.gov. Endnotes begin on page 27.

Health Insurance Coverage

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.[25] Health insurance is a major determinant of access to health care.[26] Children with health insurance are more likely than children without insurance to have a regular and accessible source of health care. The percentage of children who have health insurance is one indication of the extent to which families can obtain preventive care or health care for a sick or injured child.[27,28]

Figure 8 **Percentage of children ages 0–17 by health insurance coverage status at the time of interview and metropolitan status, 2018**



NOTE: A child was considered uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), a state-sponsored or other government-sponsored health plan, or a military plan. A child also was defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. Private health insurance includes children covered by any comprehensive private insurance plan (including health maintenance organizations and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Public health insurance includes children who do not have private coverage, but who have Medicaid or other state-sponsored health plans, including CHIP. The U.S. Office of Management and Budget classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

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

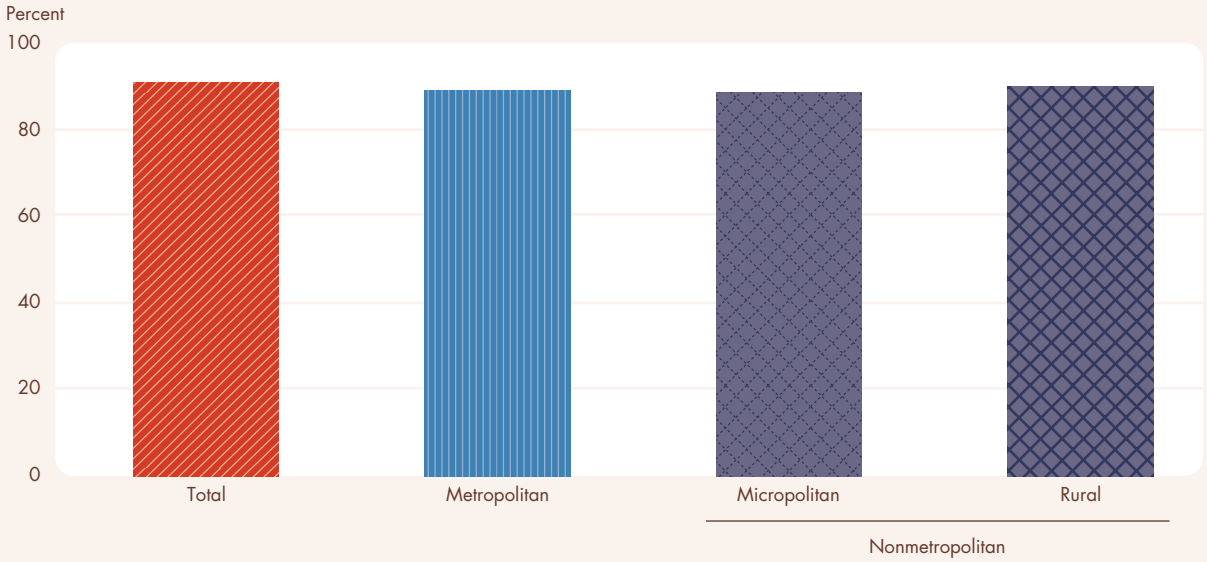
- In 2018, 55% of children ages 0–17 had private health insurance, 37% had public health insurance, and 5% were uninsured.
- The percentage of children ages 0–17 who were uninsured was higher for those living in micropolitan counties (8%) compared with those living in metropolitan counties (5%).
- The percentage of children ages 0–17 with private health insurance was higher for those living in metropolitan counties (56%) compared with those living in micropolitan counties (47%).
- The percentage of children ages 0–17 with public health insurance was lower for those living in metropolitan counties (36%) compared with those living in micropolitan (43%) and rural counties (45%).

Bullets contain references to data in Table BRIEF7 at childstats.gov. Endnotes begin on page 27.

Oral Health—Dental Visits

Dental caries (i.e., cavities) is one of the most common diseases of childhood.[29] Oral health care is essential for treatment of dental caries and to safeguard oral health.[30] 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 age 1.[31]

Figure 9 **Percentage of children ages 5–17 with a dental visit in the past year by metropolitan status, 2018**



NOTE: Children were identified as having a dental visit in the past year by asking parents, "About how long has it been since your child last saw a dentist?" Parents were directed to include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists. The U.S. Office of Management and Budget classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

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

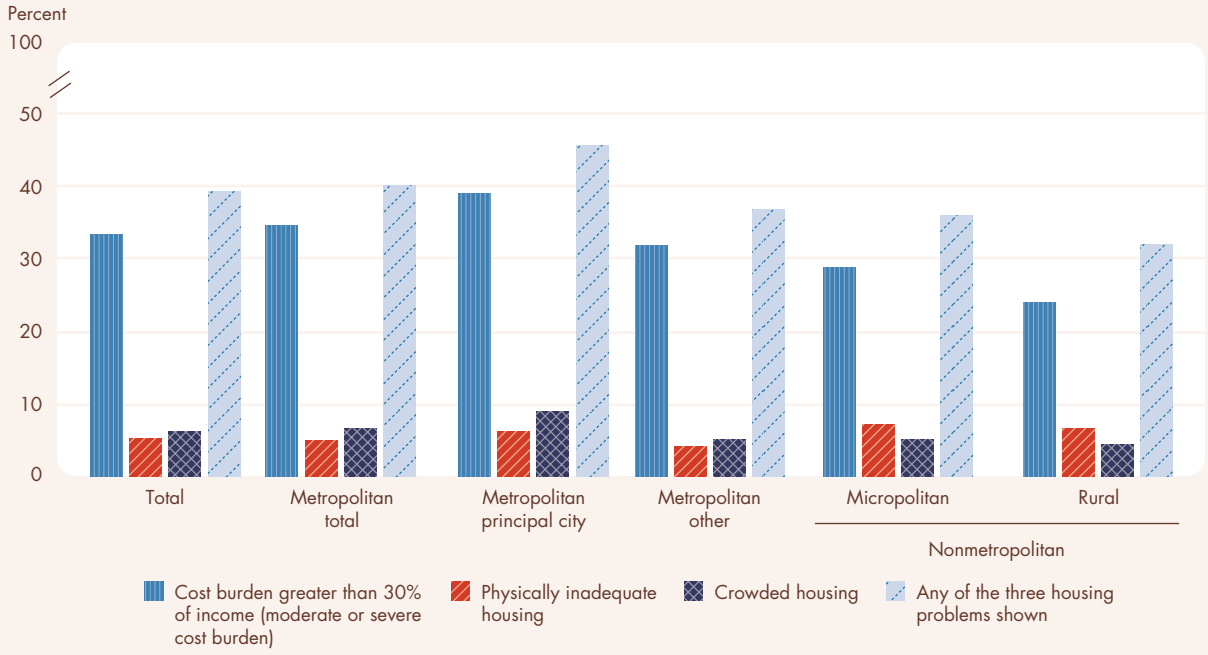
- In 2018, 91% of children ages 5–17 had a dental visit in the past year.
- The percentage of children ages 5–17 with a dental visit in the past year was 91% for children living in metropolitan counties, 88% for children living in micropolitan counties, and 90% for children living in rural counties. There was no statistically significant difference in dental visits in the past year by metropolitan status.

Bullets contain references to data in Table BRIEF8 at childstats.gov. Endnotes begin on page 27.

Housing Problems

Housing that is inadequate, crowded, or too costly can pose serious problems to children's physical, psychological, and material well-being.[32,33] Housing cost burdens, especially at high levels, are risk factors for negative outcomes for children, including eviction and homelessness, overcrowding, poor nutrition, frequent moving, lack of supervision while parents are at work, and low cognitive achievement.[34–36] The percentage of households with children that report living in physically inadequate,[37] crowded, or costly housing provides insight into how differing housing types, conditions, and costs of different housing markets affect housing choices and children's well-being. Housing problems are presented for metropolitan, micropolitan, and rural areas, with further breakdowns between principal cities and other, suburban portions of metropolitan areas to shed light on challenges such as high housing costs that are found in urban centers.

Figure 10 **Percentage of households with children ages 0–17 that have housing problems by metropolitan status, 2017**

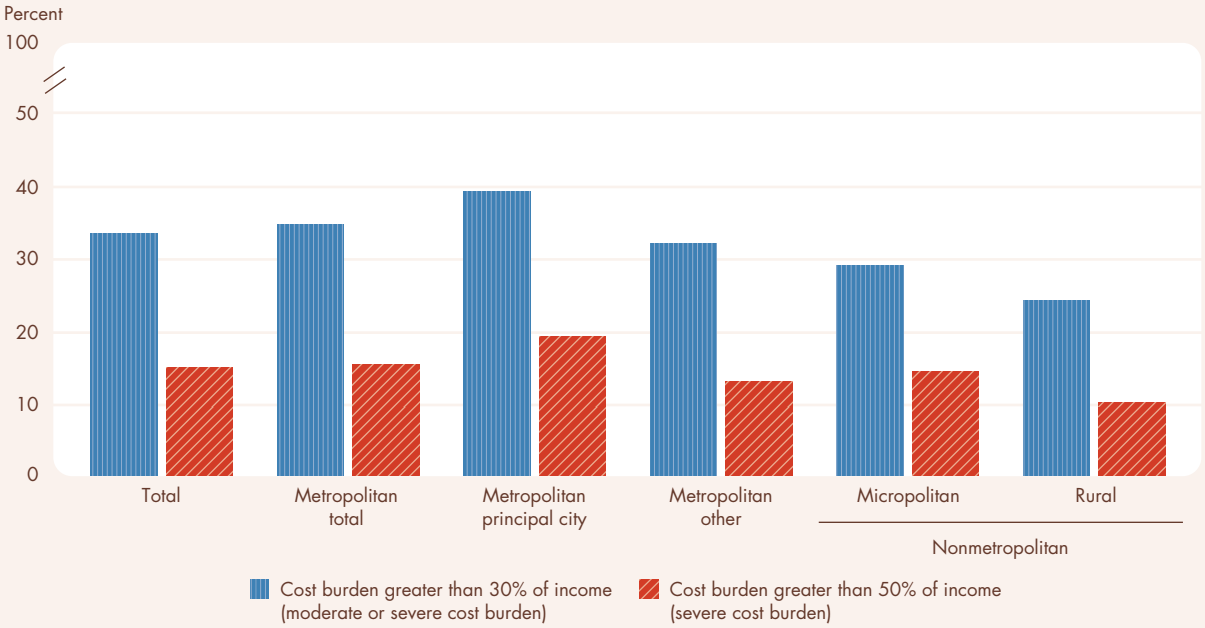


NOTE: The U.S. Office of Management and Budget classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas. Principal cities of metropolitan areas also are identified.

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

- In 2017, 39% of U.S. households with children had one or more of three housing problems: physically inadequate housing, crowded housing, or a housing cost burden greater than 30% of household income.[38]
- Households with children faced greater prevalence of housing problems in principal cities of metropolitan areas (46%) than elsewhere in metropolitan areas (37%), or in micropolitan (36%) or rural (32%) areas.
- In 2017, about 5% of households with children had problems with physically inadequate housing. Problems with physically inadequate housing were less prevalent in the nonprincipal city portions of metropolitan areas than in the principal cities, micropolitan areas, or rural areas.
- Housing cost burdens were the most common type of housing problem, affecting 33% of households with children in 2017. The prevalence was greater in principal cities of metropolitan areas (39%) than in nonprincipal city portions (32%), micropolitan areas (29%), or rural areas (24%).

Figure 11 **Percentage of households with children ages 0–17 that have moderate or severe housing cost burdens by metropolitan status, 2017**



NOTE: The U.S. Office of Management and Budget classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas. Principal cities of metropolitan areas also are identified.

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

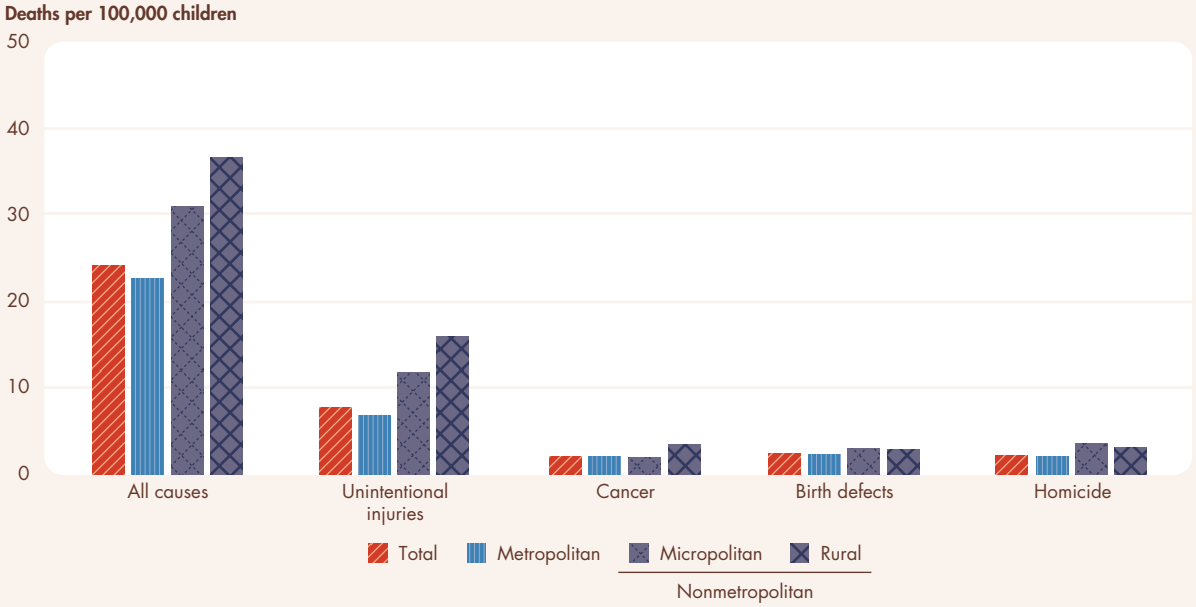
- The proportion of families with children having severe housing cost burdens, defined as paying more than half of their income for housing, was 15% in 2017.
- Severe cost burdens were significantly more likely to occur in principal cities of metropolitan areas (19%) than in nonprincipal city portions (13%), micropolitan areas (14%), or rural areas (10%).
- Among families with children experiencing any cost burden, 45% had severe cost burdens.

Bullets contain references to data in Table BRIEF9 at childstats.gov. Endnotes begin on page 27.

Child and Adolescent Mortality

Medical and public health advances have contributed to reductions in the number of deaths among children and adolescents.[39] Deaths from infectious disease and cancer have declined with the introduction of vaccination, antibiotics, and the improved detection and treatment of cancer.[40] However, 19,660 deaths occurred among those ages 1–19 in 2018.[41] Knowing the patterns of the leading causes of death for this age group may help target medical and public health interventions.[39,40]

Figure 12 **Death rates among children ages 1–4 by selected leading causes of death and metropolitan status, 2018**

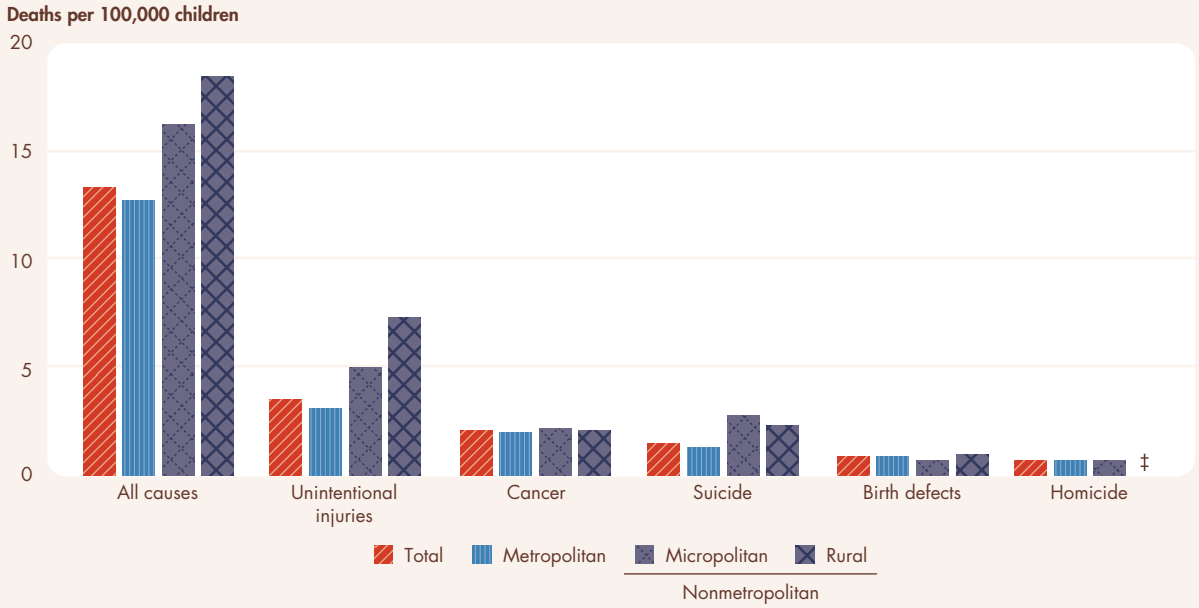


NOTE: Underlying causes of death are based on the *International Classification of Diseases,* 10th revision. Unintentional injuries is another term for accidents. Unintentional injury deaths are identified by codes V01–X59 and Y85–Y86. Cancer (malignant neoplasms) deaths are identified by codes C00–C97. Birth defect (congenital malformations, deformations, and chromosomal abnormalities) deaths are identified by codes Q00–Q99. Homicide deaths are identified by codes U01–U02, X85–Y09, and Y87.1. The U.S. Office of Management and Budget classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

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

- In 2018, the all-cause death rate among children ages 1–4 was 24 deaths per 100,000 children. Children in rural counties had the highest death rate (36 per 100,000), followed by children in micropolitan counties (31 per 100,000) and metropolitan counties (23 per 100,000).
- The death rate for unintentional injuries was 8 deaths per 100,000 children. Unintentional injury death rates were highest for children in rural counties (16 per 100,000), followed by micropolitan counties (12 per 100,000) and metropolitan counties (7 per 100,000).
- In 2018, the death rates among children ages 1–4 was 2 per 100,000 each for cancer, birth defects, and homicide. There was no statistically significant difference by metropolitan status for these causes of death.

Figure 13 **Death rates among children ages 5–14 by selected leading causes of death and metropolitan status, 2018**



‡ Reporting standards not met; the number of deaths is too few to calculate a reliable rate.

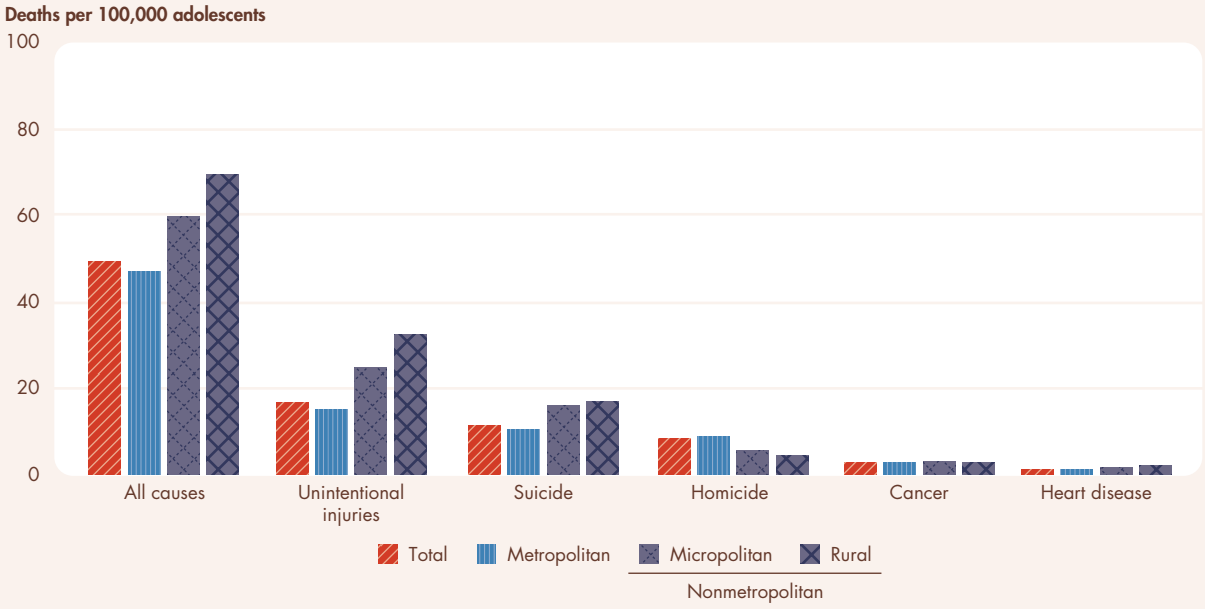
NOTE: Underlying causes of death are based on the *International Classification of Diseases,* 10th revision. Unintentional injuries is another term for accidents. Unintentional injury deaths are identified by codes V01–X59 and Y85–Y86. Cancer (malignant neoplasms) deaths are identified by codes C00–C97. Suicide deaths are identified by codes U03, X60–X84, and Y87.0. Most suicides in the 5–14 age group are among those ages 10–14. Birth defect (congenital malformations, deformations, and chromosomal abnormalities) deaths are identified by codes Q00–Q99. Homicide deaths are identified by codes U01–U02, X85–Y09, and Y87.1. The U.S. Office of Management and Budget classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

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

- In 2018, the all-cause death rate among children ages 5–14 was 13 deaths per 100,000 children. Children in rural counties had the highest death rate (18 per 100,000), followed by children in micropolitan counties (16 per 100,000) and metropolitan counties (13 per 100,000).
- Unintentional injuries were the leading cause of death among children ages 5–14 in 2018 (3.5 per 100,000), followed by cancer (2.1 per 100,000), suicide (1.5 per 100,000), birth defects (0.9 per 100,000), and homicide (0.7 per 100,000).
- Death rates for unintentional injuries was highest for children in rural counties (7 per 100,000), followed by micropolitan counties (5 per 100,000) and metropolitan counties (3 per 100,000).
- Death rates from suicide were higher for children in rural (2 per 100,000) and micropolitan (3 per 100,000) counties than in metropolitan counties (1 per 100,000).
- In 2018, there was no statistically significant difference by metropolitan status for death rates from cancer, birth defects, and homicide among children ages 5–14.

Child and Adolescent Mortality—cont.

Figure 14 **Death rates among adolescents ages 15–19 by selected leading causes of death and metropolitan status, 2018**



NOTE: Underlying causes of death are based on the *International Classification of Diseases,* 10th revision. Unintentional injuries is another term for accidents. Unintentional injury deaths are identified by codes V01–X59 and Y85–Y86. Suicide deaths are identified by codes U03, X60–X84, and Y87.0. Homicide deaths are identified by codes U01–U02, X85–Y09, and Y87.1. Cancer (malignant neoplasms) deaths are identified by codes C00–C97. Heart disease deaths are identified by codes I00–I09, I11, I13, and I20–I51. The U.S. Office of Management and Budget classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

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

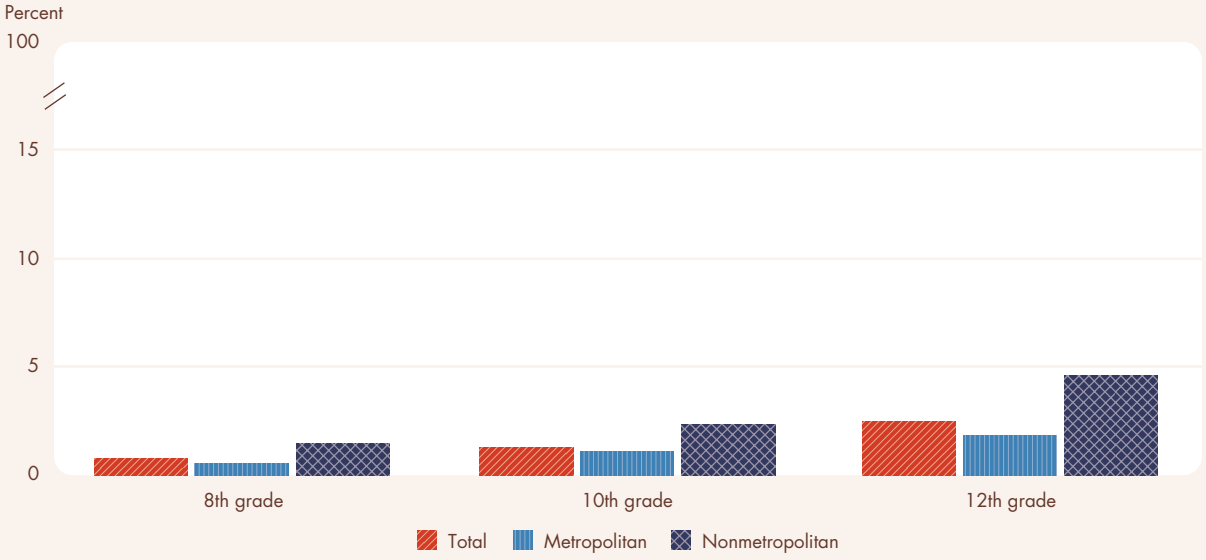
- In 2018, the all-cause death rate among adolescents ages 15–19 was 49 deaths per 100,000 adolescents. Adolescents in rural counties had the highest death rate (69 per 100,000), followed by adolescents in micropolitan counties (59 per 100,000) and metropolitan counties (47 per 100,000).
- Unintentional injuries were the leading cause of death among adolescents ages 15–19 in 2018 (17 per 100,000), followed by suicide (11 per 100,000), homicide (8 per 100,000), cancer (3 per 100,000), and heart disease (1 per 100,000).
- Death rates for unintentional injuries were highest for adolescents in rural counties (32 per 100,000), followed by micropolitan counties (25 per 100,000) and metropolitan counties (15 per 100,000).
- Death rates for suicide were higher for adolescents in rural (17 per 100,000) and micropolitan counties (16 per 100,000) than in metropolitan counties (11 per 100,000).
- Death rates for homicide were higher for adolescents in metropolitan counties (9 per 100,000) than in micropolitan (6 per 100,000) and rural counties (5 per 100,000).
- Death rates for heart disease were higher for adolescents in rural counties (2 per 100,000) than in metropolitan counties (1 per 100,000).
- In 2018, there was no statistically significant difference by metropolitan status for death rates from cancer among adolescents ages 15–19.

Bullets contain references to data in Table BRIEF10 at childstats.gov. Endnotes begin on page 27.

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.[42] More than 480,000 annual deaths are attributable to tobacco use, making tobacco more lethal than all other illicit substances. Nearly 90% of smokers start smoking before age 18. Each day, more than 1,500 youth, ages 12–17, smoke their first cigarette, and another nearly 1,000 youth and young adults who are occasional smokers become daily smokers.[43] The high rate of incidence and the consequences of cigarette smoking underscore the importance of studying patterns of smoking among adolescents. However, the rates represented here do not reflect data on vaping among youth.

Figure 15 **Percentage of 8th-, 10th-, and 12th-grade students who reported smoking cigarettes daily in the past 30 days by metropolitan status, 2019**



NOTE: Daily cigarette smoking is defined as the use of one or more cigarettes per day in the past 30 days. The U.S. Office of Management and Budget classifies some counties as within a metropolitan statistical area. The remaining counties are considered nonmetropolitan. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

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

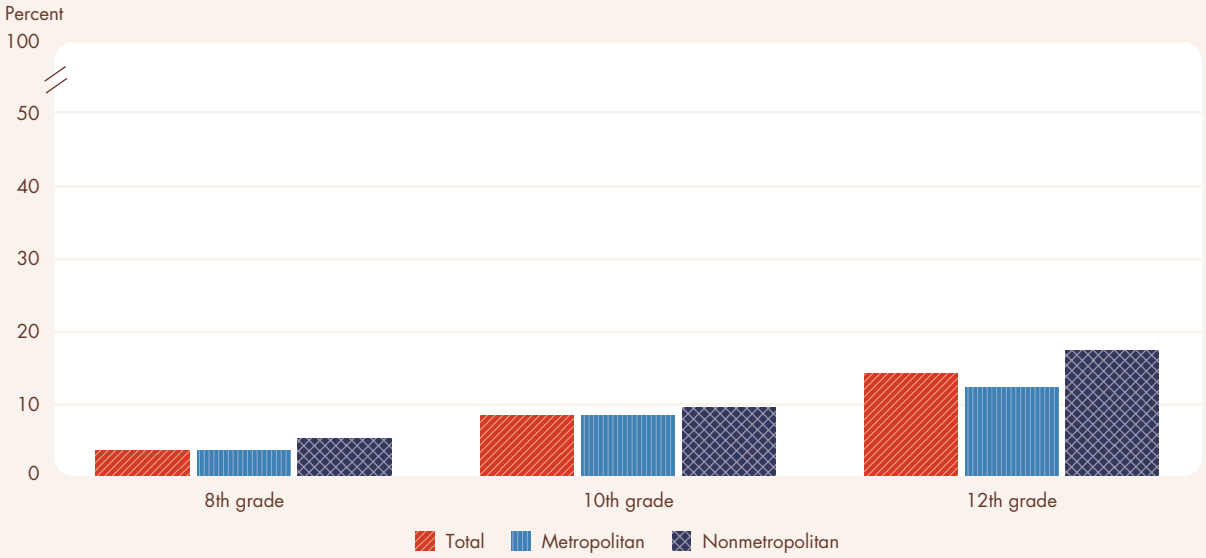
- Approximately 1% of 8th- and 10th-grade students and 2% of 12th-grade students reported smoking cigarettes daily in the past 30 days in 2019.
- In 2019, 5% of 12th-grade students living in nonmetropolitan areas reported daily cigarette use in the past 30 days. This was higher than the 2% of 12th-grade students living in metropolitan areas reporting daily cigarette use in the past month.
- Among 10th-grade students living in nonmetropolitan areas in 2019, 2% reported daily cigarette use in the past month compared with 1% of 10th-grade students living in metropolitan areas.
- There was no significant difference between the 2% of 8th-grade students living in nonmetropolitan areas compared with the 1% of 8th-grade students living in metropolitan areas who reported daily cigarette use in the past 30 days.
- Overall, a higher percentage of 8th-, 10th-, and 12th-grade students living in nonmetropolitan areas reported daily cigarette use in the past 30 days.

Bullets contain references to data in Table BRIEF11 at childstats.gov. Endnotes begin on page 27.

Alcohol Use

Alcohol is the most common psychoactive substance used by adolescents. Its use is associated with motor vehicle accidents, injuries, and deaths; problems in school and the workplace; and fighting, crime, and other serious consequences.[44] 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.[45]

Figure 16 **Percentage of 8th-, 10th-, and 12th-grade students who reported having five or more alcoholic beverages in a row in the past 2 weeks by metropolitan status, 2019**



NOTE: Binge drinking is defined as having five or more alcoholic beverages in a row in the past 2 weeks. The U.S. Office of Management and Budget classifies some counties as within a metropolitan statistical area. The remaining counties are considered nonmetropolitan. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

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

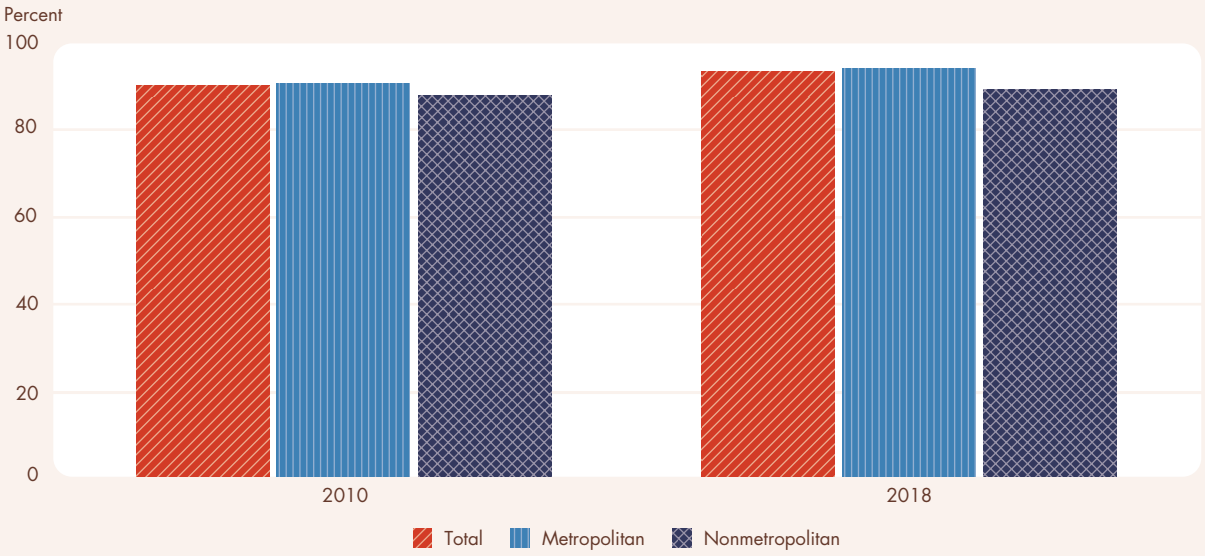
- In 2019, 4% of 8th-, 9% of 10th-, and 14% of 12th-grade students reported binge drinking.
- Binge drinking was reported by 18% of 12th-grade students living in nonmetropolitan areas compared with 14% of 12th-grade students living in metropolitan areas.
- Among 10th-grade students, there was no significant difference in reported binge drinking, with 10% of those living in nonmetropolitan areas and 8% of those living in metropolitan areas reporting use.
- Likewise, binge drinking among 8th-grade students did not differ by geographic area, with 5% of those living in nonmetropolitan areas and 4% of those living in metropolitan areas reporting use.

Bullets contain references to data in Table BRIEF12 at childstats.gov. Endnotes begin on page 27.

High School Completion

A high school diploma or its equivalent is a prerequisite for many entry-level jobs and necessary for the pursuit of postsecondary education. Therefore, the attainment of a high school diploma or its equivalent is one indicator that a person has acquired the basic academic, social, and other life skills needed to function in today's society. Persons who graduated from high school tend to have better economic and life outcomes than their peers who did not graduate.[46] Therefore, it is important to measure the percentage of young adults ages 18–24 with a high school diploma or equivalent and investigate how this percentage varies across time and for different groups of students.

Figure 17 **Percentage of young adults ages 18–24 who have completed high school by metropolitan status, 2010 and 2018**



NOTE: Diploma equivalents include alternative credentials obtained by passing examinations such as the General Educational Development (GED) test. This figure excludes those still enrolled in high school or enrolled in a lower education level. The U.S. Office of Management and Budget classifies some counties as within a metropolitan statistical area. The remaining counties are considered nonmetropolitan. Nonmetropolitan counties include counties in micropolitan statistical and rural areas. Total includes those whose household metropolitan status was "not identified," which is not separately shown.

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

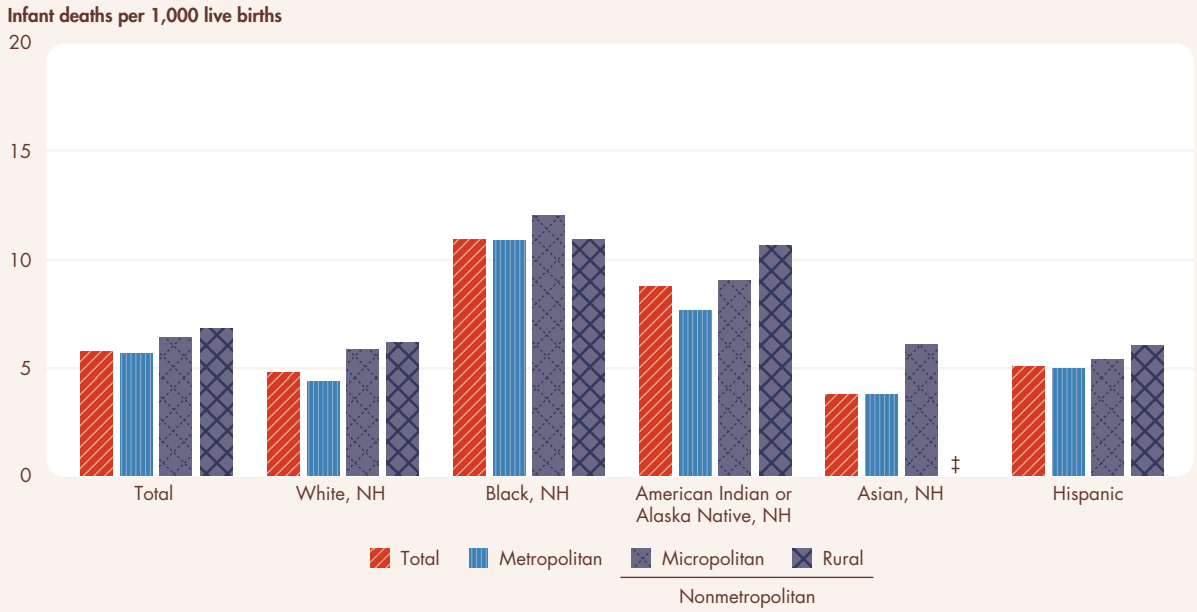
- In 2018, about 94% of young adults ages 18–24 had completed high school with a diploma or an alternative credential, such as a General Educational Development (GED) certificate. The high school completion rate has increased since 2010, when it was 90%.
- In 2018, the high school completion rate for young adults who lived in metropolitan areas was 94%, which is higher than the 89% high school completion rate for their peers living in nonmetropolitan areas.
- Between 2010 and 2018, the high school completion rate for young adults who lived in metropolitan areas increased from 91% to 94%, whereas the completion rate for young adults who lived in nonmetropolitan areas was not measurably different between these two years (88% in 2010 and 89% in 2018). In both 2010 and 2018, the completion rate for young adults who lived in metropolitan areas was higher than the rate for young adults who lived in nonmetropolitan areas.

Bullets contain references to data in Table BRIEF13 at childstats.gov. Endnotes begin on page 27.

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.[47,48]

Figure 18 **Death rates among infants by race and Hispanic origin of mother and metropolitan status, 2017–2018**



‡ Reporting standards not met; the number of deaths is too few to calculate a reliable rate.

NOTE: NH = non-Hispanic origin. Infant deaths are deaths before an infant's first birthday. Among Native Hawaiian or Other Pacific Islander infants, the number of infant deaths is generally too small to meet reliability standards and therefore are not shown. Race refers to the mother's race. The 1997 U.S. Office of Management and Budget (OMB) standards on race and ethnicity are used to classify persons into one of the following racial groups: White, Black or African American, Asian, and American Indian or Alaska Native. All categories are single race. Included in the total, but not shown separately, are people reporting two or more races. Data on race and Hispanic origin are collected and reported separately. Persons of Hispanic origin may be of any race. The OMB classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

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

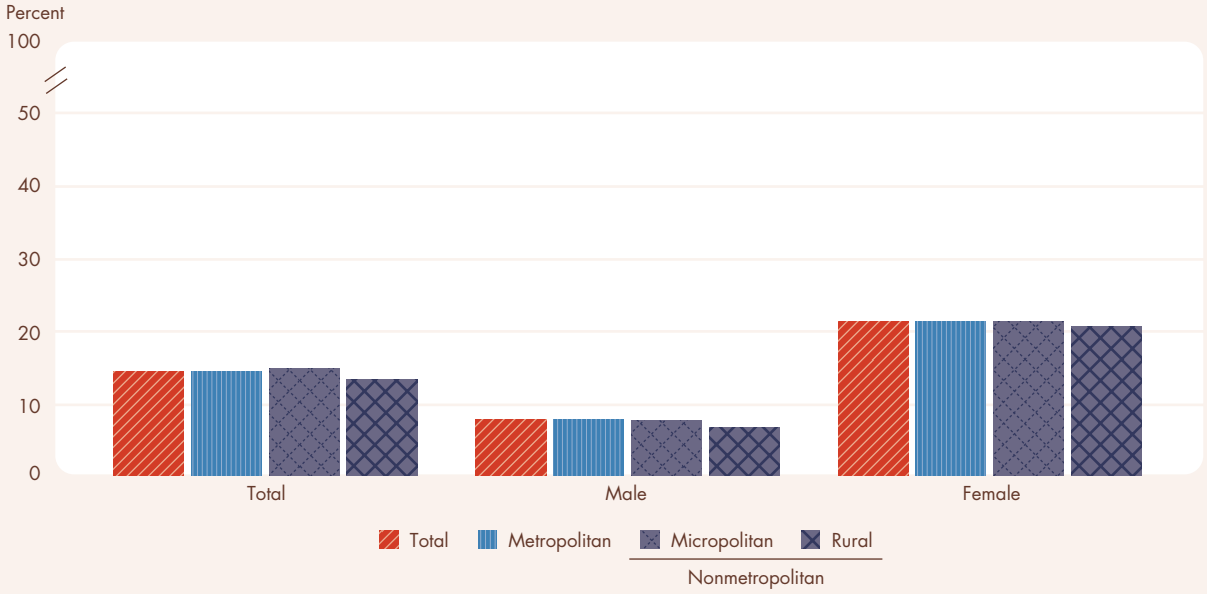
- In 2017–2018, the infant mortality rate was 6 infant deaths per 1,000 live births. Infant mortality rates were highest in rural counties (6.8 per 1,000), followed by micropolitan counties (6.4 per 1,000) and metropolitan counties (5.6 per 1,000).
- In 2017–2018, the mortality rate was 11 per 1,000 for Black, non-Hispanic; 9 per 1,000 for American Indian or Alaska Native, non-Hispanic; 5 per 1,000 for White, non-Hispanic; 5 per 1,000 for Hispanic; and 4 per 1,000 for Asian, non-Hispanic infants.
- For White, non-Hispanic infants in 2017–2018, the mortality rate was higher for those living in rural and micropolitan counties than those living in metropolitan counties.
- For Black, non-Hispanic and Asian, non-Hispanic infants in 2017–2018, the mortality rate was higher for those living in micropolitan counties than those living in metropolitan counties.
- For Hispanic and American Indian or Alaska Native, non-Hispanic infants in 2017–2018, the mortality rate was higher for those living in rural counties than those living in micropolitan and metropolitan counties.

Bullets contain references to data in Table BRIEF14 at childstats.gov. Endnotes begin on page 27.

Adolescent Depression

Depression has a significant impact on adolescent development and well-being.[49] 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.[50–52] Depressive episodes often persist, recur, or continue into adulthood.[53] Youth who have had a major depressive episode (MDE) in the past year are at a 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.[43,54,55]

Figure 19 **Percentage of youth ages 12–17 who experienced a major depressive episode (MDE) in the past year by gender and metropolitan status, 2018**



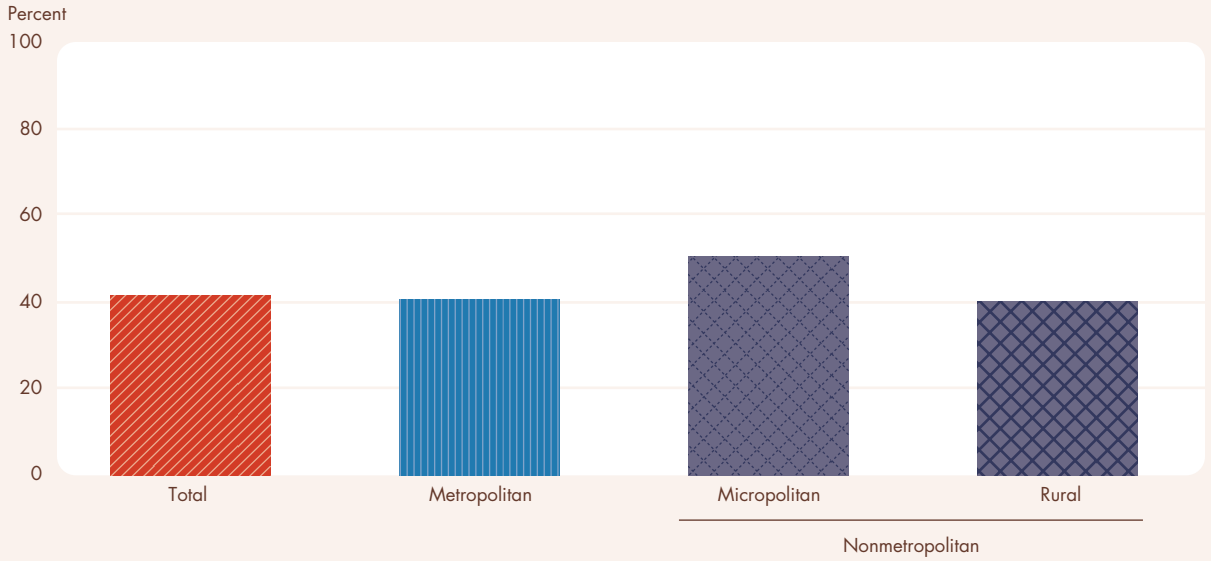
NOTE: MDE is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities plus at least four additional symptoms of depression (such as problems with sleep, eating, energy, concentration, and feelings of self-worth) as described in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. The U.S. Office of Management and Budget classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

SOURCE: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health.

- In 2018, 14% of the population ages 12–17 had at least one MDE during the past year, which did not differ by metropolitan status (14% in metropolitan areas, 15% in micropolitan areas, and 13% in rural areas).
- Among youth ages 12–17 in 2018, however, the prevalence of MDE was more than twice as high among females (22% in metropolitan areas, 22% in micropolitan areas, and 21% in rural areas) as among males (8% in metropolitan areas, 8% in micropolitan areas, and 7% in rural areas).

Adolescent Depression—cont.

Figure 20 **Percentage of those receiving treatment for depression among youth ages 12–17 with at least one major depressive episode (MDE) in the past year by metropolitan status, 2018**



NOTE: MDE is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities plus at least four additional symptoms of depression (such as problems with sleep, eating, energy, concentration, and feelings of self-worth) as described in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. The U.S. Office of Management and Budget classifies counties as within a metropolitan or a micropolitan statistical area. The remaining counties are not classified and are considered rural in this report. Rural counties may include small urban areas, as well as completely rural areas. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

SOURCE: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health.

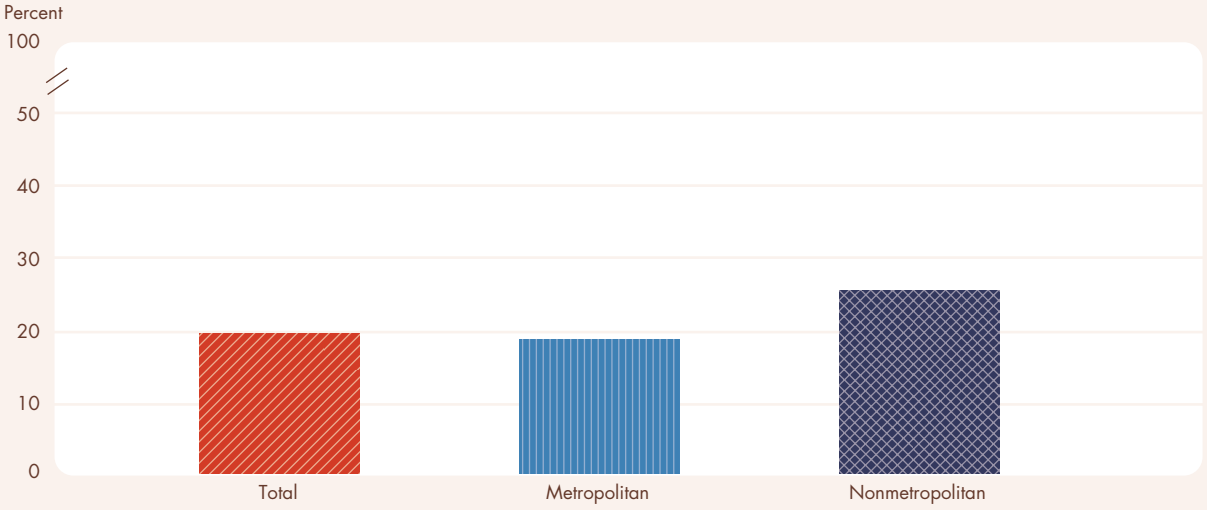
- The percentage of youth with at least one MDE in the past year receiving treatment for depression was 41% in 2018, which did not differ by metropolitan status (41% in metropolitan areas, 50% in micropolitan areas, and 40% in rural areas).

Bullets contain references to data in Tables BRIEF15, BRIEF16, BRIEF17 at childstats.gov. Endnotes begin on page 27.

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.[56,57] The consequences of obesity for children and adolescents often are psychosocial but also include high blood pressure, diabetes, early puberty, and asthma.[57,58] The prevalence of obesity among U.S. children changed relatively little from the early 1960s through 1980; however, after 1980, it increased sharply.[59] In addition to individual factors, such as diet and physical activity, social, economic, and environmental forces may have contributed to the increased prevalence of obesity.[60]

Figure 21 **Percentage of children ages 6–17 with obesity by metropolitan status, 2013–2018**



NOTE: Obesity for children and adolescents is defined as a body mass index (BMI) at or above the sex- and age-specific 95th percentile from the 2000 Centers for Disease Control and Prevention Growth Charts (https://www.cdc.gov/growthcharts/). BMI is a measure of body fat based on height and weight. It is calculated as a person's weight in kilograms divided by the square of height in meters. The U.S. Office of Management and Budget classifies some counties as within a metropolitan statistical area. The remaining counties are considered nonmetropolitan. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

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

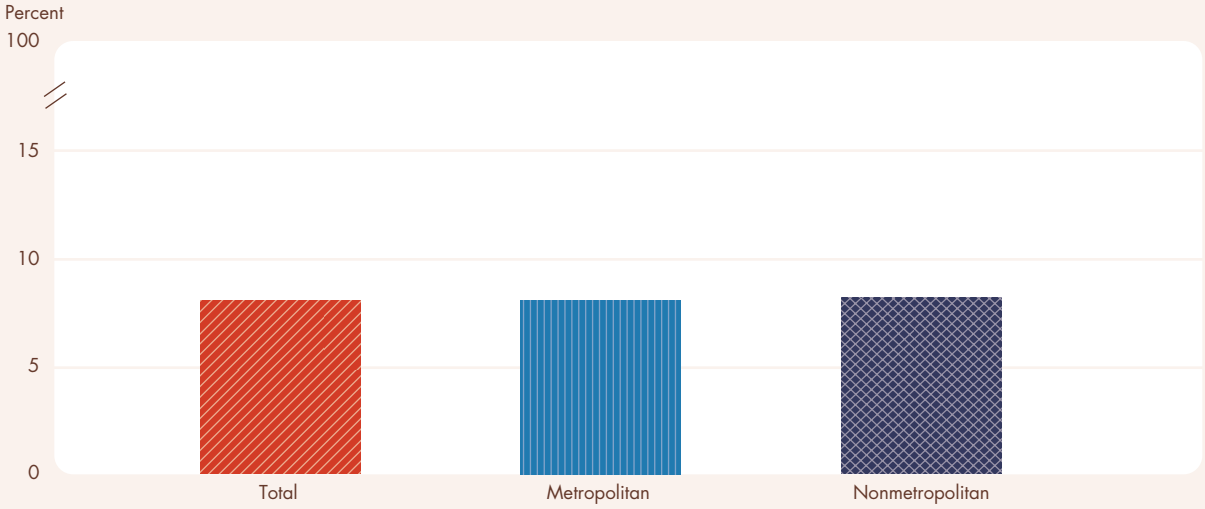
- In 2013–2018, 20% of children ages 6–17 had obesity.
- The percentage of children ages 6–17 with obesity was higher for those living in nonmetropolitan counties (25%) compared with those living in metropolitan counties (19%).

Bullets contain references to data in Table BRIEF18 at childstats.gov. Endnotes begin on page 27.

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 management of their asthma, typically with medication. Some children with asthma may, however, suffer serious attacks that greatly limit their activities, result in visits to emergency rooms or hospitals, or, in rare cases, cause death.[61] 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.[62–66]

Figure 22 **Percentage of children ages 0–17 who currently have asthma by metropolitan status, 2016–2018**



NOTE: Children are identified as ever diagnosed with asthma by asking parents "Has a doctor or other health professional EVER told you that your child has asthma?" If the parent answered YES to this question, they were then asked "Does your child still have asthma?" The question "Does your child still have asthma?" was introduced in 2001 and identifies children who currently have asthma. The U.S. Office of Management and Budget classifies some counties as within a metropolitan statistical area. The remaining counties are considered nonmetropolitan. Nonmetropolitan counties include counties in micropolitan statistical and rural areas.

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

- In 2016–2018, 8.1% of children ages 0–17 were reported to currently have asthma.
- In 2016–2018, the percentage of children ages 0–17 in metropolitan areas reported to currently have asthma was 8.1%. The percentage of children who currently have asthma was 8.2% in nonmetropolitan areas. There was no statistically significant difference in the percentage of children reported to currently have asthma by metropolitan status.

Bullets contain references to data in Table BRIEF19 at childstats.gov. Endnotes begin on page 27.

Notes to Indicators

[1] National Center for Health Statistics. (2001). *Health, United States, 2001: With urban and rural chartbook.* Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/data/hus/hus01.pdf

[2] Agency for Healthcare Research and Quality. (2017). *National healthcare quality and disparities report chartbook on rural health care* (AHRQ 17(18)-0001-2-E). Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/chartbooks/qdr-ruralhealthchartbook-update.pdf

[3] Meit, M., Knudson, A., Gilbert, T., Yu, A., Tanenbaum, E., Ormson, E., . . . & Popat, S. (2014). *The 2014 update of the rural-urban chartbook.* Rural Health Reform Policy Research Center. Retrieved from https://ruralhealth.und.edu/projects/health-reform-policy-research-center/pdf/2014-rural-urban-chartbook-update.pdf

[4] U.S. Census Bureau. (2016). *Measuring America: Our changing landscape* [Infographic]. U.S. Census Bureau. https://www.census.gov/library/visualizations/2016/comm/acs-rural-urban.html

[5] Parker, K., Horowitz, J., Brown, A., Fry, R., Cohn, D. & Igielnik, R. (2018). W*hat unites and divides urban, suburban and rural communities.* Pew Research Center. Retrieved from https://www.pewsocialtrends.org/2018/05/22/what-unites-and-divides-urban-.suburban-and-rural-communities/

[6] Holder, K. A., Fields, A., & Lofquist, D. (2016). Rurality matters. *Random Samplings, U.S. Census Bureau.* 2016. https://www.census.gov/newsroom/blogs/random-samplings/2016/12/rurality_matters.html

[7] Semega, J., Kollar, M., Creamer, J., & Mohanty, A. (2019). *Income and poverty in the United States: 2018* (Current Population Reports P60-266). Washington, DC: U.S. Census Bureau. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-266.pdf

[8] National Center for Health Statistics. (2019). *2018 National Health Interview Survey (NHIS): Summary health statistics.* https://www.cdc.gov/nchs/nhis/shs/tables.htm

[9] Strosnider, H., Kennedy, C., Monti, M., & Yip, F. (2017). Rural and urban differences in air quality, 2008–2012, and community drinking water quality, 2010–2015—United States. *MMWR Surveillance Summaries, 66*(13), 1–10. Retrieved from https://www.cdc.gov/mmwr/volumes/66/ss/ss6613a1.htm

[10] National Advisory Committee on Rural Health and Health Care Services. (2015). *Mortality and life expectancy in rural America: Connecting the health and human service safety nets to improve health outcomes over the life course.* Retrieved from https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2015-mortality.pdf

[11] 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas, 75 Fed. Reg. 37246 (proposed June 28, 2010). Retrieved from https://www.federalregister.gov/documents/2010/06/28/2010-15605/2010-standards-for-delineating-metropolitan-and-micropolitan-statistical-areas

[12] U.S. Office of Management and Budget. (2013). *Revised delineations of metropolitan statistical areas, micropolitan statistical areas, and combined statistical areas, and guidance on uses of the delineations of these areas* (OMB Bulletin No. 13-01). Washington, DC: Author. Retrieved from https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/bulletins/2013/b13-01.pdf

[13] Martinez, G., Copen, C. E., & Abma, J. C. (2011). Teenagers in the United States: Sexual activity, contraceptive use, and childbearing, 2006–2010 National Survey of Family Growth. *Vital and Health Statistics Series, 23*(31), 1–35. Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

[14] Ventura, S. J., Hamilton, B. E., & Mathews, T. J. (2014). National and state patterns of teen births in the United States, 1940–2013. *National Vital Statistics Reports, 63*(4). Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_04.pdf

[15] Hoffman, S. D., & Maynard, R. A. (Eds.). (2008). *Kids having kids: Economic costs and social consequences of teen pregnancy.* Washington, DC: Urban Institute Press.

[16] Child Welfare Information Gateway. (2013). *Long-term consequences of child abuse and neglect.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubpdfs/long_term_consequences.pdf

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

[18] Strohschein, L. (2005). Household income histories and child mental health trajectories. *Journal of Health and Social Behavior, 46*(4), 357–359. https://doi.org/10.1177/002214650504600404

[19] Duncan, G., & Brooks-Gunn, J. (Eds.). (1997). *Consequences of growing up poor.* New York, NY: Russell Sage Press.

[20] 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. https://doi.org/10.1177/000312240607100507

[21] 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). Cambridge, MA: National Bureau of Economic Research. Retrieved from https://www.nber.org/papers/w14599.pdf

[22] 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 2018, the poverty threshold for a family with two adults and two children was $25,465. For further details, see https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html.

[23] Anderson, S. A. (Ed.). (1990). Core indicators of nutritional state for difficult-to-sample populations. *Journal of Nutrition, 120*(11S), 1555–1600. https://doi.org/10.1093/jn/120.suppl_11.1555

[24] 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). Washington DC: U.S. Department of Agriculture, Economic Research Service. Retrieved from https://www.ers.usda.gov/webdocs/publications/43763/37672_eib-113.pdf?v=0

[25] American Academy of Pediatrics. (2015). 2016 recommendations for preventive pediatric healthcare. *Pediatrics, 137*(1), 25–27. Retrieved from https://pediatrics.aappublications.org/content/pediatrics/137/1/e20153908.full.pdf

[26] Kaiser Commission on Medicaid and the Uninsured. (2012). *The uninsured and the difference health insurance makes* [Fact sheet]. Menlo Park, CA: Kaiser Family Foundation. Retrieved from https://www.kff.org/wp-content/uploads/2013/01/1420-14.pdf

[27] Howell, E. M., & Kenney, G. M. (2012). The impact of the Medicaid/CHIP expansions on children: A synthesis of the evidence. *Medical Care Research and Review, 69*(4), 372–396. https://doi.org/10.1177/1077558712437245

[28] Selden, T. M., & Hudson, J. L. (2006). Access to care and utilization among children: Estimating the effects of public and private coverage. *Medical Care, 44*(5), I-19–I-26. https://doi.org/10.1097/01.mlr.0000208137.46917.3b

[29] Dye, B. A., Li, X., & Thornton-Evans, G. (2012). *Oral health disparities as determined by selected Healthy People 2020 oral health objectives for the United States, 2009–2010* (NCHS Data Brief, No. 104). Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

[30] Centers for Disease Control and Prevention, Division of Oral Health. (2019). *Children's oral health* [Website]. Retrieved from https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html

[31] Segura, A., Boulter, S., Clark, M., Gereige, R., Krol, D. M., Mouradian, W., . . . & Keels, M. A. (2014). Maintaining and improving the oral health of young children. *Pediatrics, 134*(6), 1224–1229.

[32] Breysse, P., Farr, N., Galke, W., Lanphear, B., Morley, R., & Bergofsky, L. (2004). The relationship between housing and health: Children at risk. *Environmental Health Perspectives, 112*(15), 1583–1588. https://doi.org/10.1289/ehp.7157

[33] Krieger, J., & Higgins, D. L. (2002). Housing and health: Time again for public health action. *American Journal of Public Health, 92*(5), 758–768. https://doi.org/10.2105/ajph.92.5.758

[34] Bridge, C., Flatau, P., Whelan, S., Wood, G., & Yates, J. (2003). *Housing assistance and non-shelter outcomes* (AHURI Final Report No. 40). Sydney, AU: Australian Housing and Urban Research Institute. Retrieved from https://www.ahuri.edu.au/__data/assets/pdf_file/0016/2167/AHURI_Final_Report_No40_Housing_assistance_and_non_shelter_outcomes.pdf

[35] Cutts, D. B., Meyers, A. F., Black, M. M., Casey, P. H., Chilton, M., Cook, J. T., & Frank, D. A. (2011). U.S. housing insecurity and the health of very young children. *American Journal of Public Health, 101*(8), 1508–1514. https://doi.org/10.2105/AJPH.2011.300139

[36] Newman, S. J., & Holupka, C. S. (2014). Housing affordability and child well-being. *Housing Policy Debate, 24,* 116–151. https://doi.org/10.1080/10511482.2014.899261

[37] Physically inadequate units are defined as those with moderate or severe physical problems. Common types of problems include lack of complete plumbing for exclusive use; unvented room heaters as the primary heating equipment; and multiple upkeep problems, such as water leakage, open cracks or holes, broken plaster, or signs of rats. See definition of housing adequacy in Appendix A: Subject Definitions and Table Index of the American Housing Survey for the United States: 2017 (U.S. Census Bureau 2018). Retrieved from https://www.census.gov/programs-surveys/ahs/tech-documentation/def-errors-changes.html

[38] Paying 30% or more of income for housing may leave insufficient resources for other basic needs. See Citro, C. F., & Michaels, R. T. (1995). *Measuring poverty: A new approach.* Washington, DC: National Academy Press. Retrieved from https://www.census.gov/library/publications/1995/demo/citro-01.html

[39] Guyer, B., Freedman, M. A., Strobino, D. M., & Sondik, E. J. (2000). Annual summary of vital statistics: Trends in the health of Americans during the 20th century. *Pediatrics, 106*(6), 1307–1317. https://doi.org/10.1542/peds.106.6.1307

[40] National Center for Health Statistics. (2018). *Multiple cause of death data file 2020.* Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

[41] Cunningham, R. M., Walton, M. A., & Carter, P. M. (2018). The major causes of death in children and adolescents in the United States. *New England Journal of Medicine, 379*(25), 2468–2475. https://www.nejm.org/doi/10.1056/NEJMsr1804754

[42] U.S. Department of Health and Human Services. (2014). *The health consequences of smoking—50 years of progress. A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK179276/pdf/Bookshelf_NBK179276.pdf

[43] Substance Abuse and Mental Health Services Administration. (2019). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, Populations Survey Branch. Retrieved from https://store.samhsa.gov/product/key-substance-use-and-mental-health-indicators-in-the-united-states-results-from-the-2018-national-survey-on-Drug-Use-and-Health/PEP19-5068

[44] U.S. Department of Health and Human Services, Office of the Surgeon General. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health.* Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf

[45] National Institute on Alcohol Abuse and Alcoholism. (2004/2005). Alcohol and development in youth—A multidisciplinary overview. *Alcohol Research and Health, 28*(3), 107–176. Retrieved from https://pubs.niaaa.nih.gov/publications/arh283/toc28-3.htm

[46] Office of Disease Prevention and Health Promotion. (n.d.) *High school graduation* [Website]. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/high-school-graduation

[47] Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Curtin, S. C., & Matthews, T. J. (2015). Births: Final data for 2013. *National Vital Statistics Reports, 64*(1), 1–65. Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf

[48] Ely, D. M., Driscoll, A. K., & Mathews, T. J. (2018). *Infant mortality by age at death in the United States, 2016* (NCHS Data Brief No. 326). Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/data/databriefs/db326-h.pdf

[49] Mojtabai, R., Olfson, M., & Han, B. (2016). National trends in the prevalence and treatment of depression in adolescents and young adults. *Pediatrics, 138*(6), e20161878. https://doi.org/10.1542/peds.2016-1878

[50] Substance Abuse and Mental Health Services Administration. (2008). *The NSDUH report: Major depressive episode among youths aged 12 to 17 in the United States: 2004 to 2006.* Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Retrieved from https://ntrl.ntis.gov/NTRL/dashboard/searchResults/titleDetail/PB2009115665.xhtml

[51] Van Lieshout, R. J., & MacQueen, G. (2008). Psychological factors in asthma. *Allergy, Asthma and Clinical Immunology, 4*(1), 12–28. https://doi.org/10.1186/1710-1492-4-1-12

[52] Goodman, E., & Whitaker, R. C. (2007). A prospective study of the role of depression in the development and persistence of adolescent obesity. *Pediatrics, 110*(3), 497–504. https://doi.org/10.1542/peds.110.3.497

[53] Weissman, M. M., Wolk, S., Goldstein, R. B., Moreau, D., Adams, P., Greenwald, S., . . . Wickramaratne, P. (1999). Depressed adolescents grown up. *Journal of the American Medical Association, 281*(13), 1701–1713.

[54] Shaffer, D., Gould, M. S., Fisher, P., Trautman, P., Moreau, D., Kleinman, M., & Flory, M. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry, 53,* 339–348. Retrieved from https://doi.org/10.1001/archpsyc.1996.01830040075012

[55] Substance Abuse and Mental Health Services Administration. (2007). *The NSDUH report: Depression and the initiation of alcohol and other drug use among youths aged 12 to 17.* Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

[56] Singh, A. S., Mulder, C., Twisk, J. W. R., van Mechelen, W., & Chinapaw, M. J. M. (2008). Tracking of childhood overweight into adulthood: A systematic review of the literature. *Obesity Review, 9*(5), 474–488. https://doi.org/10.1111/j.1467-789X.2008.00475.x

[57] Whitlock, E. P., Williams, S. B., Gold, R., Smith, P. R., & Shipman, S. A. (2005). Screening and interventions for childhood overweight: A summary of evidence for the U.S. Preventive Services Task Force. *Pediatrics, 116*(1), e125–e144. https://doi.org/10.1542/peds.2005-0242

[58] Lakshman, R., Elks, C. E., & Ong, K. K. (2012). Childhood obesity. *Circulation, 126*(14), 1770–1779. https://doi.org/10.1161/CIRCULATIONAHA.111.047738

[59] Ogden, C. L., Flegal, K. M., Carroll, M. D., & Johnson, C. L. (2002). Prevalence and trends in overweight among US children and adolescents, 1999–2000. *Journal of the American Medical Association, 288*(14), 1728–1732. https://doi.org/10.1001/jama.288.14.1728

[60] Barlow, S. E., & the Expert Committee (2007). Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. *Pediatrics, 120*(Suppl. 4), S164–S192. https://doi.org/10.1542/peds.2007-2329C

[61] Centers for Disease Control and Prevention. (2018). *Asthma in children.* Retrieved from https://www.cdc.gov/vitalsigns/pdf/2018-02-vitalsigns.pdf

[62] U.S. Environmental Protection Agency. (2013). *Integrated science assessment of ozone and related photochemical oxidants* (EPA/600/R-10/076F). Retrieved from https://cfpub.epa.gov/ncea/isa/recordisplay.cfm?deid=247492

[63] U.S. Environmental Protection Agency. (2019). *Integrated science assessment (ISA) for particulate matter* (EPA/600/R-19/188). Retrieved from https://cfpub.epa.gov/ncea/isa/recordisplay.cfm?deid=341593

[64] U.S. Department of Health and Human Services. (2006). *The health consequences of involuntary exposure to tobacco smoke: A report of the Surgeon General.* Atlanta, GA: Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK44324/

[65] Gern, J. E. (2004). Viral respiratory infection and the link to asthma. *Pediatric Infectious Disease Journal, 23*(1 Suppl), S78–S86. https://doi.org/10.1097/01.inf.0000108196.46134.a6

[66] Lemanske, R. F., Jr., & Busse, W. W. (2003). Asthma. *Journal of Allergy and Clinical Immunology, 111*(2 Suppl), S502–S519. Retrieved from https://www.jacionline.org/article/S0091-6749(02)91356-4/fulltext

America's Children at a Glance

	Previous value (year)	Most recent value (year)	Change between years
Demographic Background			
Child population*			
Children ages 0–17 in the United States	73.3 million (2018)	73.0 million (2019)	↓
Children as a percentage of the population*			
Children ages 0–17 in the United States	22.4% (2018)	22.3% (2019)	↓
Racial and ethnic composition*			
Children ages 0–17 by race and Hispanic origin**			
White, non-Hispanic	50.5% (2018)	50.2% (2019)	↓
Black, non-Hispanic	13.7% (2018)	13.7% (2019)	NS
American Indian or Alaska Native, non-Hispanic	0.8% (2018)	0.8% (2019)	NS
Asian, non-Hispanic	5.0% (2018)	5.0% (2019)	NS
Native Hawaiian or Other Pacific Islander, non-Hispanic	0.2% (2018)	0.2% (2019)	NS
Two or more races, non-Hispanic	4.3% (2018)	4.4% (2019)	↑
Hispanic	25.4% (2018)	25.6% (2019)	↑
Family and Social Environment			
Family structure and children's living arrangements			
Children ages 0–17 living with two married parents	65% (2018)	66% (2019)	↑
Births to unmarried women			
Births to unmarried women ages 15–44	41.0 per 1,000 (2017)	41.1 per 1,000 (2018)	↑
Births to unmarried women among all births	39.8% (2017)	39.6% (2018)	↓
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	88% (2012)	85% (2016)	NS
Children ages 3–5, not yet enrolled in kindergarten with employed mothers, who were in center-based care arrangements	67% (2012)	70% (2016)	NS
Children of at least one foreign-born parent			
Children ages 0–17 living with at least one foreign-born parent	26% (2018)	26% (2019)	NS
Language spoken at home and difficulty speaking English			
Children ages 5–17 who speak a language other than English at home	23% (2017)	23% (2018)	NS
Children ages 5–17 who speak a language other than English at home and who have difficulty speaking English	4% (2017)	4% (2018)	NS
Adolescent births			
Births to females ages 15–17	8 per 1,000 (2017)	7 per 1,000 (2018)	↓

* Population estimates are not sample derived and are not subject to statistical testing. Change between years identifies differences in the proportionate size of these estimates as rounded.

** Percentages may not sum to 100 because of rounding.

Legend NS = No statistically significant change ↑ = Statistically significant increase ↓ = Statistically significant decrease

	Previous value (year)	Most recent value (year)	Change between years
Family and Social Environment—cont.			
Child maltreatment*			
Substantiated reports of maltreatment of children ages 0–17	9.1 per 1,000 (2017)	9.2 per 1,000 (2018)	↑
Economic Circumstances			
Child poverty and family income			
Children ages 0–17 in poverty	17% (2017)	16% (2018)	↓
Children living in families with medium income	29% (2017)	30% (2018)	NS
Secure parental employment			
Children ages 0–17 living with at least one parent employed year-round, full time	77.9% (2017)	79.3% (2018)	↑
Food insecurity			
Children ages 0–17 in households classified by USDA as "food insecure"	17% (2017)	15% (2018)	↓
Health Care			
Health insurance coverage			
Children ages 0–17 who were uninsured at time of interview	5% (2017)	5% (2018)	NS
Usual source of health care			
Children ages 0–17 with no usual source of health care	4% (2017)	5% (2018)	NS
Immunization			
Children ages 19–35 months with the 4:3:1:3*:3:1:4 combined series	71% (2016)	70% (2017)	NS
Oral health			
Children ages 5–17 with a dental visit in the past year	89% (2017)	91% (2018)	↑
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	62% (2017)	64% (2018)	NS
Secondhand smoke			
Children ages 4–11 with any detectable blood cotinine level, a measure for recent exposure to secondhand smoke	37% (2013–2014)	37% (2015–2016)	NS
Drinking water quality			
Children served by community water systems that did not meet all applicable health-based drinking water standards	8% (2017)	7% (2018)	NS
Lead in the blood of children			
Children ages 1–5 with blood lead greater than or equal to 5 µg/dL	2.6% (2007–2010)	0.9% (2013–2016)	↓
Housing problems			
Households with children ages 0–17 reporting shelter cost burden, crowding, and/or physically inadequate housing	39% (2015)	39% (2017)	NS

* Population estimates are not sample derived and are not subject to statistical testing. Change between years identifies differences in the proportionate size of these estimates as rounded.

Legend NS = No statistically significant change ↑ = Statistically significant increase ↓ = Statistically significant decrease

	Previous value (year)	Most recent value (year)	Change between years
Physical Environment and Safety—cont.			
Youth victims of serious violent crimes			
Serious violent crime victimization of youth ages 12–17	8 per 1,000 (2017)	6 per 1,000 (2018)	NS
Child injury and mortality			
Injury deaths of children ages 1–4	10 per 100,000 (2017)	10 per 100,000 (2018)	NS
Injury deaths of children ages 5–14	6 per 100,000 (2017)	6 per 100,000 (2018)	NS
Adolescent injury and mortality			
Injury deaths of adolescents ages 15–19	40 per 100,000 (2017)	37 per 100,000 (2018)	↓
Behavior			
Regular cigarette smoking			
Students who reported smoking daily in the past 30 days			
8th grade	1% (2018)	1% (2019)	NS
10th grade	2% (2018)	1% (2019)	NS
12th grade	4% (2018)	2% (2019)	↓
Alcohol use			
Students who reported having five or more alcoholic beverages in a row in the past 2 weeks			
8th grade	4% (2018)	4% (2019)	NS
10th grade	9% (2018)	9% (2019)	NS
12th grade	14% (2018)	14% (2019)	NS
Illicit drug use			
Students who reported using illicit drugs in the past 30 days			
8th grade	7% (2018)	9% (2019)	NS
10th grade	18% (2018)	20% (2019)	NS
12th grade	24% (2018)	24% (2019)	NS
Sexual activity			
High school students who reported ever having had sexual intercourse	40% (2017)	38% (2019)	NS
Youth perpetrators of serious violent crimes			
Youth offenders ages 12–17 involved in serious violent crimes	9 per 1,000 (2017)	8 per 1,000 (2018)	NS
Education			
Family reading to young children			
Children ages 3–5 who were read to 3 or more times in the last week	83% (2012)	81% (2016)	NS

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)	240 (2017)	241 (2019)	↑
8th graders (0–500 scale)	283 (2017)	282 (2019)	↓
12th graders (0–300 scale)	153 (2013)	152 (2015)	↓
Average reading scale score of			
4th graders (0–500 scale)	222 (2017)	220 (2019)	↓
8th graders (0–500 scale)	267 (2017)	263 (2019)	↓
12th graders (0–500 scale)	288 (2013)	287 (2015)	NS
High school completion			
Young adults ages 18–24 who have completed high school	93% (2017)	94% (2018)	NS
Youth neither enrolled in school* nor working			
Youth ages 16–19 who are neither enrolled in school nor working	8% (2018)	8% (2019)	NS
College enrollment			
Recent high school completers enrolled in college the October immediately after completing high school	67% (2017)	69% (2018)	NS
Health			
Preterm birth and low birthweight			
Infants less than 37 completed weeks of gestation at birth	9.9% (2017)	10.0% (2018)	↑
Infants weighing less than 5 lb. 8 oz. at birth	8% (2017)	8% (2018)	NS
Infant mortality			
Deaths before first birthday	5.8 per 1,000 (2017)	5.7 per 1,000 (2018)	↓
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% (2017)	6% (2018)	NS
Adolescent depression			
Youth ages 12–17 with past-year major depressive episode	13% (2017)	14% (2018)	↑
Activity limitation			
Children ages 5–17 with activity limitation resulting from one or more chronic health conditions	11% (2017)	10% (2018)	NS
Obesity			
Children ages 6–17 who had obesity	20% (2011–2014)	20% (2015–2018)	NS
Asthma			
Children ages 0–17 who currently have asthma	8% (2017)	8% (2018)	NS

* School refers to high school and college.

Legend NS = No statistically significant change ↑ = Statistically significant increase ↓ = Statistically significant decrease