

# America's Children in Brief: Key National Indicators of Well-Being, 2022



# 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 2022 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.ojp.gov>

National Institute of Justice

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

Office of Juvenile Justice and Delinquency Prevention

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

## Department of Labor

Bureau of Labor Statistics

<https://www.bls.gov>

Women's Bureau

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

## Department of Transportation

National Highway Traffic Safety Administration

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

## Environmental Protection Agency

Office of Children's Health Protection

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

## Office of Management and Budget

Statistical and Science Policy Office

<https://www.whitehouse.gov/omb/>

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# America's Children in Brief: Key National Indicators of Well-Being, 2022



# Introduction

*This year's America's Children in Brief: Key National Indicators of Well-Being continues a tradition of collaboration by agencies across the Federal Government to advance the understanding of what our Nation's children and families may need to help ensure bright, healthy futures.*

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

## About This Report

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. The Forum annually updates all 41 key indicators of well-being for children on its website (<https://www.childstats.gov/>), depending on data availability. The Forum alternates publishing a detailed report of these 41 indicators, *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, 2022

This year's *America's Children in Brief* highlights selected special feature indicators related to COVID-19 to address the impact of this pandemic on child well-being. Indicator titles are COVID-19 Immunization, Child Food Insufficiency, Housing Instability, Pandemic Health Care and Child Care, How Schools Adapted to Pandemic Response, Summer Enrichment Programs, Child and Adolescent Mortality, and Substance Use and Mental Health of Adolescents. In addition to the focus on COVID-19, this brief 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 regular indicators.

Three special feature indicators in this brief rely on the Household Pulse Survey (HPS) as a data source.<sup>1</sup> The HPS was developed by the U.S. Census Bureau in collaboration with multiple Federal agencies in response to the COVID-19 pandemic. It is designed to collect data quickly and efficiently from U.S. households to produce timely information on the effects of the COVID-19 pandemic on the population. The survey asks respondents about educational, employment, health, housing, and food-related outcomes, as well as other topics, and offers an important new way to monitor the impact of COVID-19 on America's families with children. The HPS is different from other surveys traditionally used to provide data for *America's Children*. The survey was designed to go into the field quickly, be administered via the internet, and produce data for the public in near realtime. As such, data from the HPS may not meet some of the Census Bureau's traditional statistical quality standards. Readers should also be aware that this survey has several brief data collection phases. Where applicable, breaks in trend lines and data collection dates are shown in indicator figures to help ensure accurate data interpretation. Findings reported for early in the month corresponds to the 1st–10th, middle of the month to the 11th–20th, and end of the month to the 21st–last day of the month. Otherwise, indicator figure notes address specific details about the way data are displayed.

## Conceptual Framework for Key National Indicators

The key national indicators of child well-being identified by the Forum are featured in an alternate full report publication and 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; and
- *Representative* of large segments of the population.

## 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 Office of Management and Budget (<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. Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected separately and presented in the greatest detail possible considering the quality of the data, the amount of missing data, and the number of observations. 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>.

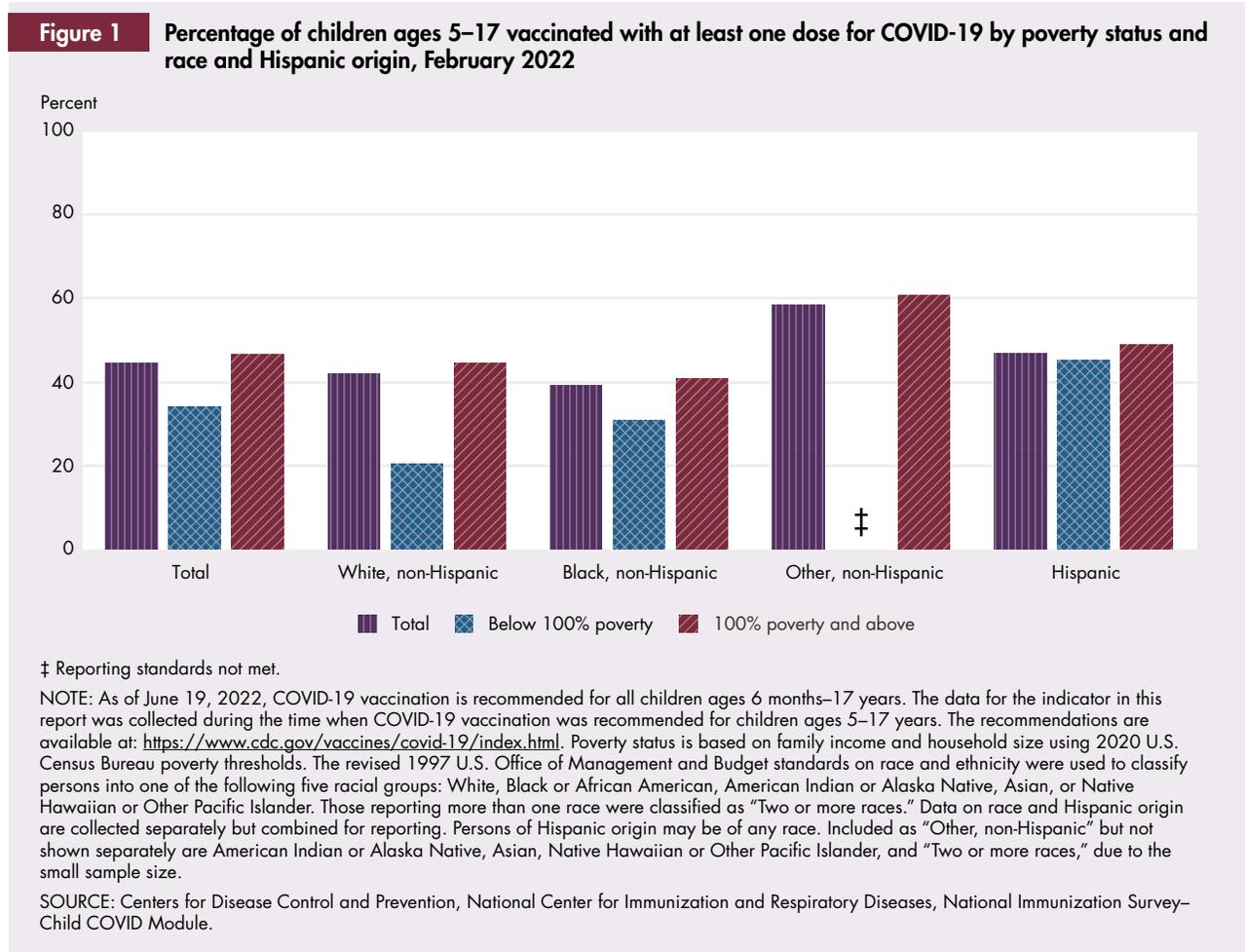
## For Further Information on the Forum

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.

# COVID-19 Immunization

As of November 2021, the Centers for Disease Control and Prevention recommended the Pfizer COVID-19 vaccine for all children ages 5–17 to protect against severe illness.<sup>2</sup> Data on vaccination coverage can be used to identify groups of children who may be more likely to be unvaccinated and at a greater risk for severe COVID-19 illness.<sup>3</sup>



- In February 2022, approximately 45% of children ages 5–17 had received at least one dose of the COVID-19 vaccine.
- Overall, children in families with incomes below the poverty threshold had lower one-dose COVID-19 vaccination coverage (34%) than did children in families with incomes at or above the poverty level (47%).
- Among White, non-Hispanic children, those in families with incomes above the poverty threshold had higher one-dose COVID-19 vaccination coverage (45%) than did those in families with incomes below the poverty threshold (21%).
- Among children in families with incomes below the poverty threshold, one-dose COVID-19 vaccination coverage was greater for Hispanic children (45%) than for White, non-Hispanic children (21%). There were no statistically significant differences in coverage between Hispanic or White, non-Hispanic children and Black, non-Hispanic children.
- Among children in families with incomes above the poverty threshold, children of an Other, non-Hispanic race or ethnicity had greater one-dose COVID-19 vaccination coverage (61%) than did Hispanic children (49%), White, non-Hispanic children (45%), and Black, non-Hispanic children (41%).

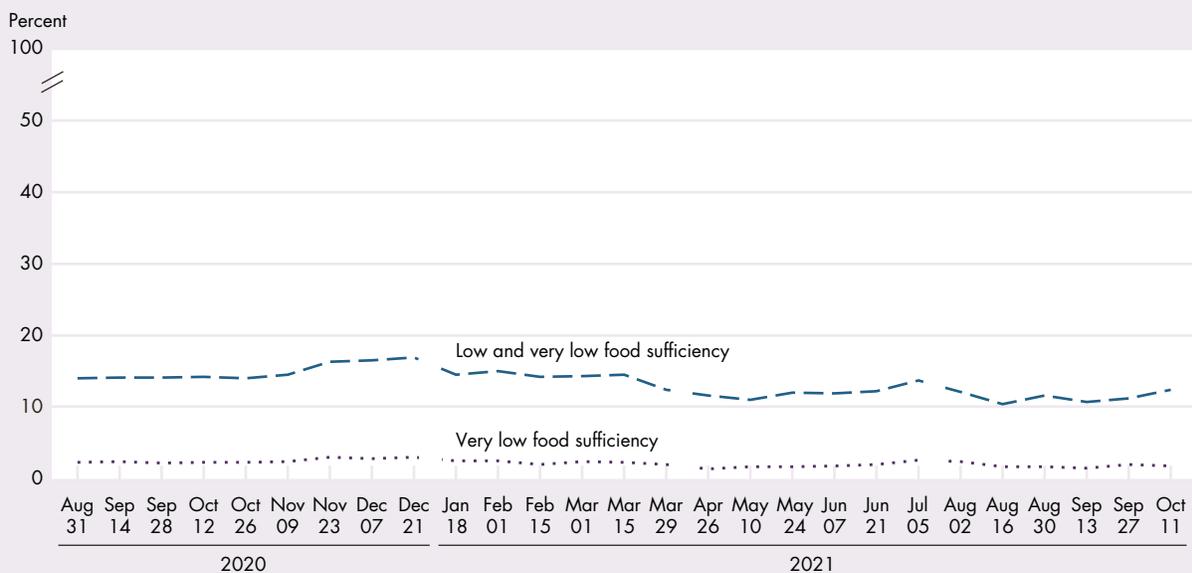
*Endnotes begin on page 27.*

# Child Food Insufficiency

The U.S. Department of Agriculture’s Economic Research Service monitors the annual prevalence of food insecurity in U.S. households with data from the Current Population Survey Food Security Supplement. Food insecurity means that households were, at times, unable to acquire adequate food for one or more household members because the households had insufficient money and other resources for food.

Food insufficiency is a simpler measure of whether or not there was enough to eat in the last 7 days. It is related to food insecurity but is often considered to be a more severe form as households that suffer from food insufficiency are likely to also have very low food security. Food insufficiency has been measured during the COVID-19 pandemic with the use of the Household Pulse Survey.<sup>4</sup> Child food insufficiency means a household’s children were not eating enough food sometimes or often in the last 7 days because the household could not afford enough food. Food insufficiency is related to children’s health and well-being. Studies have shown that food insecurity contributes to poorer physical and mental health and developmental outcomes and is negatively associated with education outcomes.<sup>5</sup>

**Figure 2** Prevalence of child food insufficiency in households with children, August 19, 2020–October 11, 2021



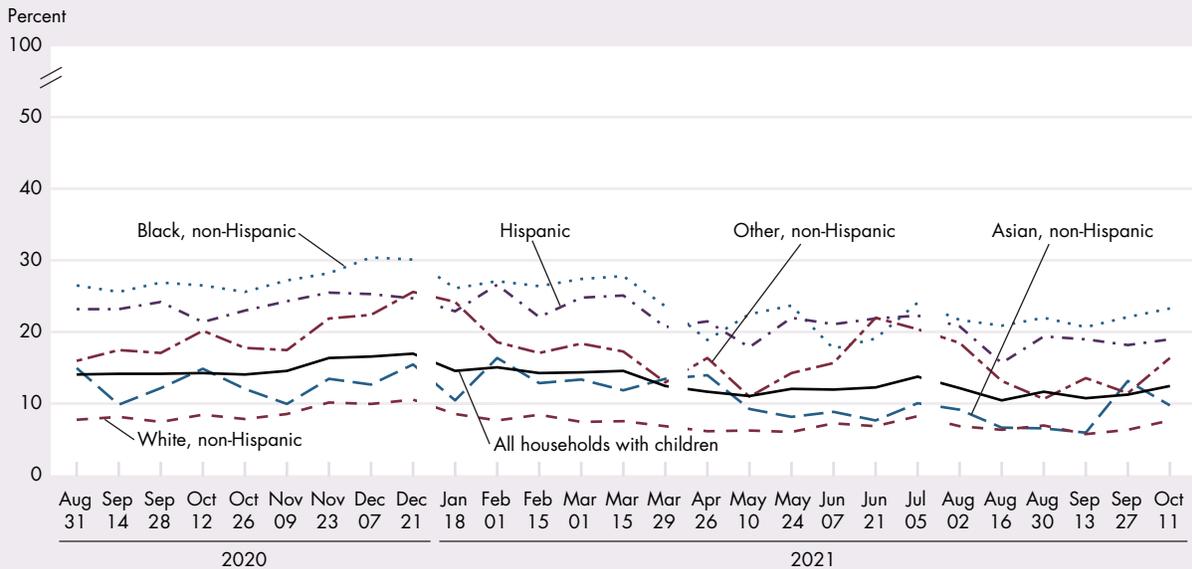
NOTE: Dates shown are the last day of each Household Pulse Survey (HPS) 13-day data collection period. Adult respondents were asked to indicate whether this statement was often true, sometimes true, or never true in the last 7 days for the children living in the household who are under age 18: “The children were not eating enough because we just couldn’t afford enough food.” Responses of “often true” indicate very low food sufficiency, and “sometimes true” indicates low food sufficiency, while “never true” indicates food sufficient. Child food insufficiency includes low and very low food sufficiency. The child food insufficiency question was not included in the HPS data collection until week 6; therefore, the above figure presents data for Phase 2 through Phase 3.2. These phases encompass four data collection periods from August 19, 2020, to October 11, 2021. Data were not collected during December 22, 2020–January 5, 2021, March 30–April 13, 2021, and July 6–20, 2021.

SOURCE: U.S. Census Bureau, Household Pulse Survey. Tabulated by U.S. Department of Agriculture, Economic Research Service.

- As of mid-October 2021, the prevalence of child food insufficiency (low and very low food sufficiency) was 13%, meaning 13% of households with children reported that children in the household sometimes or often did not have enough to eat in the last 7 days. The prevalence of very low child food sufficiency was 2%, meaning 2% of households with children reported that children often did not have enough to eat in the same time period.
- The prevalence rates of child food sufficiency varied across the pandemic. Child food insufficiency peaked at 17% in December 2020, meaning 17% of households with children reported that children in the household sometimes or often did not have enough to eat in the last 7 days. Child food insufficiency decreased to 11% in mid-August 2021, the lowest prevalence rate reported during 2020 and 2021.
- Very low child food sufficiency followed a similar pattern. The prevalence of very low food sufficiency peaked at 4% in November and December 2020, meaning that 4% of households with children reported that their children often did not have enough to eat in the last 7 days. Very low child food sufficiency decreased to a low of 2% in mid-August 2021.

# Child Food Insufficiency—Continued

**Figure 3** Prevalence of child food insufficiency in households with children by race and Hispanic origin, August 19, 2020–October 11, 2021



NOTE: Dates shown are the last day of each Household Pulse Survey (HPS) 13-day data collection period. Adult respondents were asked to indicate whether this statement was often true, sometimes true, or never true in the last 7 days for the children living in the household who are under age 18: “The children were not eating enough because we just couldn’t afford enough food.” Responses of “often true” indicate very low food sufficiency, and “sometimes true” indicates low food sufficiency, while “never true” indicates food sufficient. Child food insufficiency includes low and very low food sufficiency. The child food insufficiency question was not included in the HPS data collection until week 6; therefore, the above figure presents data for Phase 2 through Phase 3.2. These phases encompass four data collection periods from August 19, 2020, to October 11, 2021. Data were not collected during December 22, 2020–January 5, 2021, March 30–April 13, 2021, and July 6–20, 2021. The revised 1997 U.S. Office of Management and Budget standards on race and ethnicity were used to classify persons into one of the following five racial groups: White, Black or African American, American Indian or Alaska Native, Asian, or Native Hawaiian or Other Pacific Islander. Those reporting more than one race were classified as “Two or more races.” Data on race and Hispanic origin are collected separately. Persons of Hispanic origin may be of any race. Included as “Other, non-Hispanic” but not shown separately are American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, and “Two or more races,” due to the small sample size.

SOURCE: U.S. Census Bureau, Household Pulse Survey. Tabulated by U.S. Department of Agriculture, Economic Research Service.

- In mid-October 2021, child food insufficiency affected 23% of Black, non-Hispanic households, 19% of Hispanic households, and 17% of Other, non-Hispanic households—compared with 8% of White, non-Hispanic households and 10% of Asian, non-Hispanic households.
- Black, non-Hispanic and Hispanic households experienced higher rates of child food insufficiency as compared to All Households with Children for

all survey periods in 2020 and 2021. White, non-Hispanic households experienced lower prevalence rates of child food insufficiency than All Households with Children in all survey periods in 2020 and 2021.

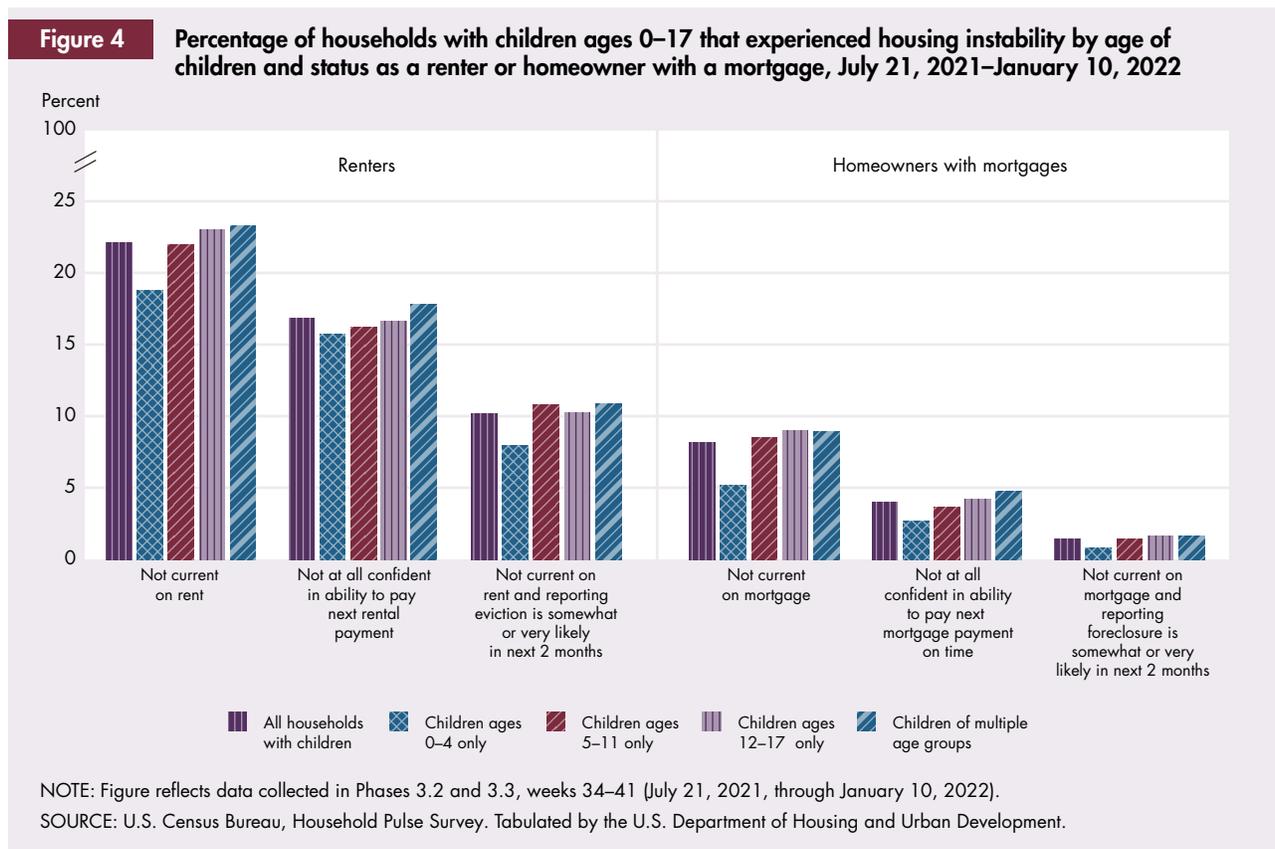
- Other, non-Hispanic and Asian, non-Hispanic households were not consistently above or below the prevalence rates for All Households with Children.

*Endnotes begin on page 27.*

# Housing Instability

The COVID-19 pandemic and associated economic disruption of 2020–2021 posed severe challenges for national housing markets. The Centers for Disease Control and Prevention imposed national eviction moratoria as public health measures for most of a year-long period beginning September 4, 2020. Numerous government agencies took parallel actions, including federal, state, and local foreclosure moratoria that affected homeowners, renters, landlords, and financial institutions. Housing instability associated with financial difficulties, family instability, or health problems poses substantial risk to children and their caregivers, including risk of homelessness and increased risk of COVID-19 infection.<sup>6,7,8,9</sup>

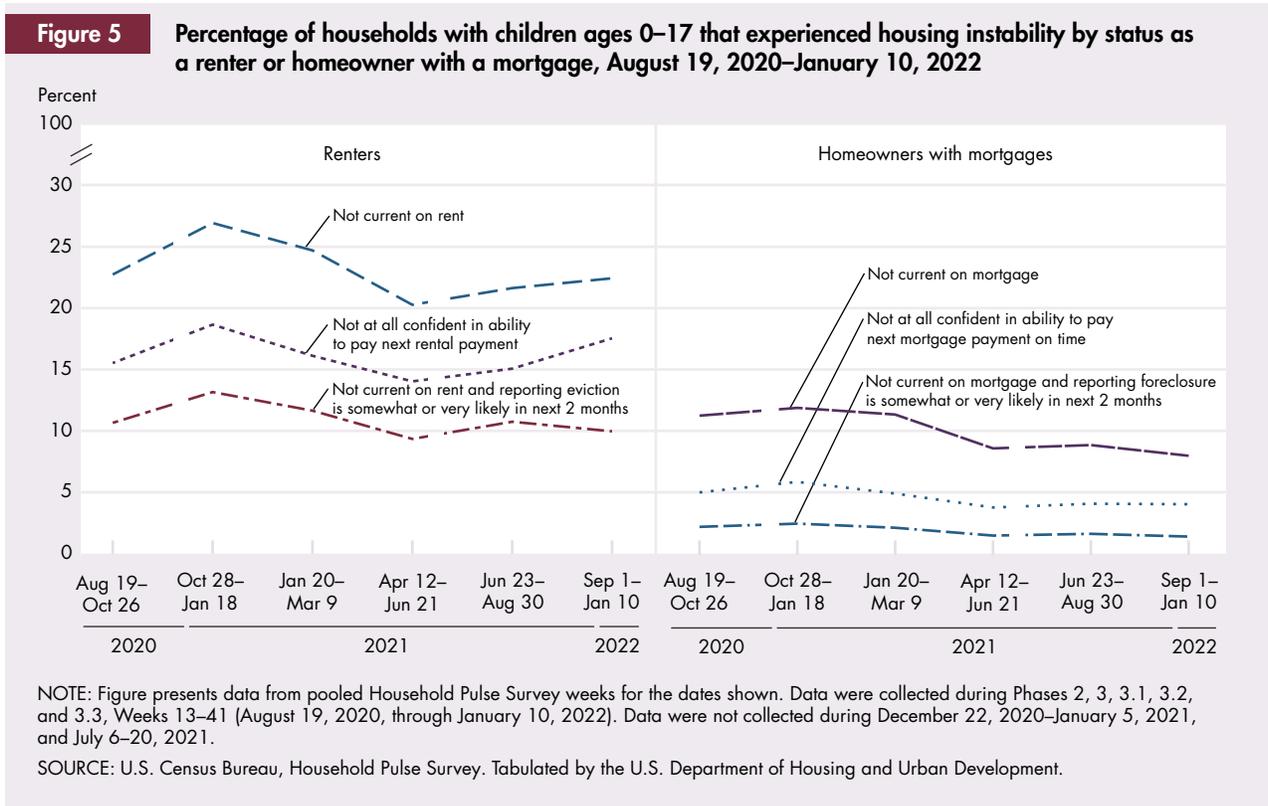
The most recent available data from the American Housing Survey show that, in 2019, there were an estimated 12.8 million renter households with children. There were another 22.9 million owner households with children, of which 17.7 million households had mortgages.<sup>10</sup> Financial difficulties reported include being behind on payments, lacking confidence in ability to make payments during the next 2 months, and perceiving a risk of eviction or foreclosure within 2 months.



- About 22% of renter households with children were not current on rent during July 21, 2021–January 10, 2022. About 17% anticipated future housing instability, reporting that they were not at all confident they could make the next rent payment.
- About 10% of renter households with children reported that eviction was somewhat or very likely within the next 2 months.
- Among homeowners with children and a mortgage, 4% were not at all confident in making the next mortgage payment and 2% reported that foreclosure was somewhat or very likely in the next 2 months.
- Homeowner households with children reported housing instability at lower rates than renter households with children. Among homeowners with children and a mortgage, 8% reported being behind on their mortgage payments during July 21, 2021–January 10, 2022.
- Both homeowner and renter families were less likely to experience several types of housing instability if they have only preschool-age children ages 0–4 rather than older children for whom school disruptions may create increased caregiver demands and for whom expenditures for housing, food, medical care, and transportation are generally greater.<sup>11</sup>

# Housing Instability—Continued

Over the course of the pandemic, the economic downturn, employment layoffs, health problems, and child care needs caused significant financial distress that households may have experienced in waves. Several courses of Federal stimulus and transfer payments during 2020 and early 2021, including child tax credit payments in 2021, may at various points have helped reduce housing payment difficulties and housing instability.<sup>12</sup>



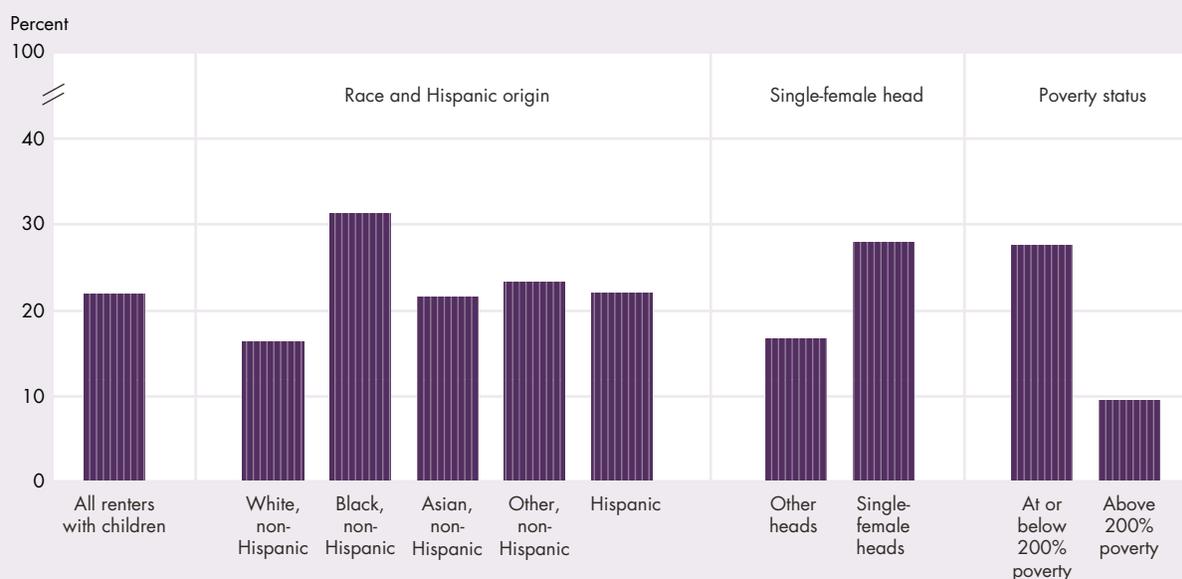
- For renter and homeowner households with children, most measures of finance-related housing instability reached their peak during October 28, 2020–January 18, 2021 and their lowest level during April 12–June 21, 2021 before some types of problems again grew more prevalent.
- Renter households with children experienced improvements in each measure of housing instability between October 28, 2020–January 18, 2021 and April 12–June 21, 2021. For example, the percentage of households who were not at all confident in their ability to pay their next rent payment decreased from 19% in the earlier period to 14% during the later period.
- Renter households with children experienced renewed housing instability by several measures during late 2021, but problems were not as severe as previously. During the most recent period of September 1–January 10, 2022, the percentage not current on rent was 22% compared with 27% at the peak levels of a year earlier, and the percentage behind on rent and reporting eviction was either somewhat or very likely within 2 months was 10% compared with 13% at the peak.
- During the most recent period, 18% of renters with children were not at all confident in making their next rent payment, a rate that is not different from the highest value of 19% reported during October 28, 2020–January 18, 2021.
- Among homeowner households with children and mortgage debt, the prevalence of housing instability during the most recent period was improved by all three measures relative to the peak levels observed during October 28, 2020–January 18, 2021. For example, by September 1, 2021–January 10, 2022, some 8% of homeowner households with children were not up to date on mortgage payments, compared with 12% in late 2020; 4% were not at all confident in making their next mortgage payment, down from 6% in late 2020; and 1% thought foreclosure was somewhat or very likely during the next 2 months, down from 3% in late 2020.

# Housing Instability—Continued

Among renters, those from racial and ethnic minority groups and those in single-female-headed households may experience additional risk. There are substantial disparities in housing instability for these populations and varying experiences during the pandemic.

The risk of housing instability among families with children is strongly associated with household income. Federal Poverty Guidelines provide a benchmark for material deprivation that adjusts for family size. In 2021, the poverty level for a family of four was \$26,500.<sup>13</sup> About 8.7 million renters with children had incomes less than 200% of the poverty level in 2021, more than twice the 4.1 million renters with children that had incomes greater than 200% of the poverty level. There are substantial disparities in the rate of housing instability among renters with children with incomes above and below 200% of the poverty level. These data were collected during the period that the labor market was regaining strength and restrictions on eviction were ending.

**Figure 6** Percentage of renter households with children ages 0–17 that were not current on rent by race and Hispanic origin, single-female head, and poverty status, June 23, 2021–January 10, 2022



NOTE: Figure reflects data collected in Phases 3.2 and 3.3, Weeks 33–41 (June 23, 2021, through January 10, 2022), except for poverty status, which reflects data collected in Weeks 34–41 (July 21, 2021, through January 10, 2022). Data were not collected during July 6–20, 2021. Households are categorized by income as a percentage of Federal Poverty Guidelines. Categorization is subject to minor error because incomes in Household Pulse Survey data are grouped into ranges. The 1997 U.S. Office of Management and Budget standards on race and ethnicity were used to classify persons into one of the following four racial groups: White, Black, Asian, and Other. The “Other, non-Hispanic” category may include persons of the following races: American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander or a combination of “Two or more races.” Data on race and Hispanic origin are collected separately. Persons of Hispanic origin may be of any race.

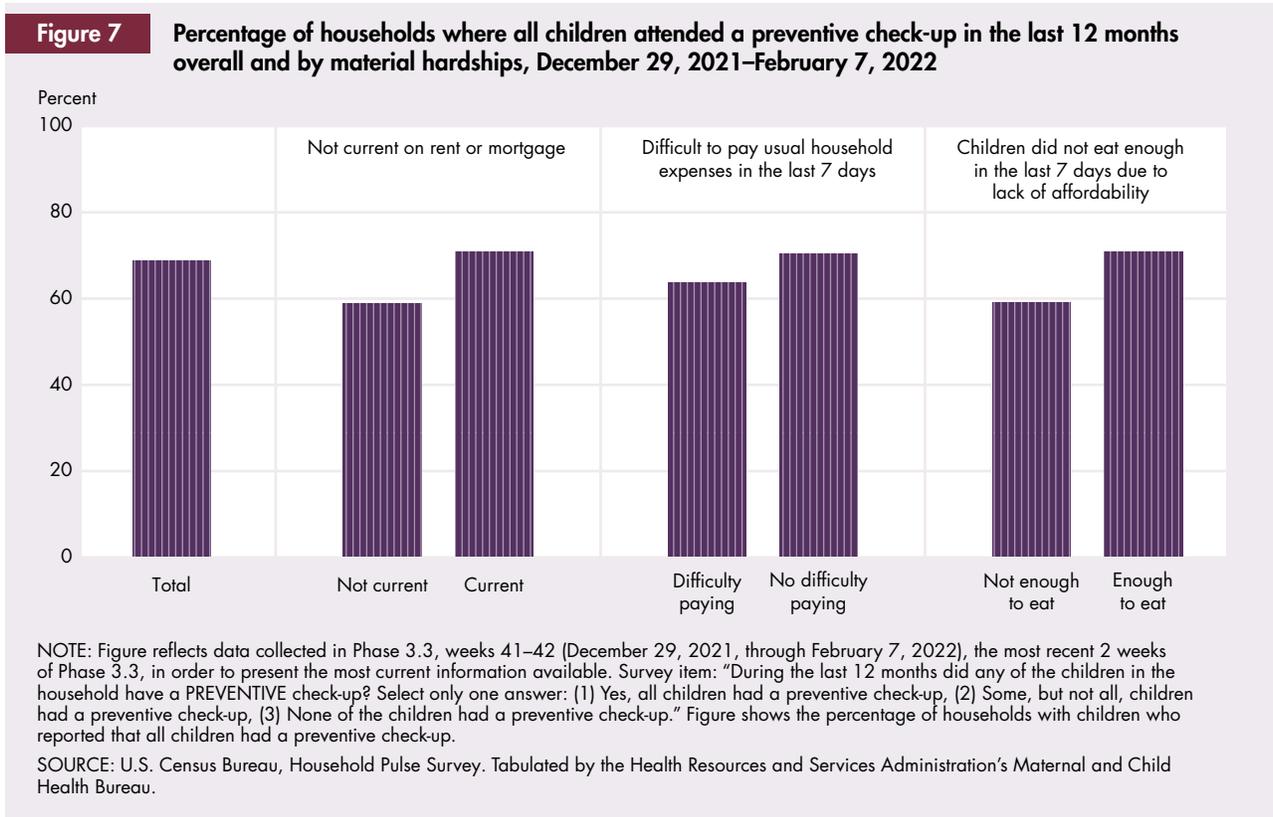
SOURCE: U.S. Census Bureau, Household Pulse Survey. Tabulated by the U.S. Department of Housing and Urban Development.

- Among renter households with children, households of racial and ethnic minority groups were more likely than White, non-Hispanic households to be behind on rent during June 21, 2021–January 10, 2022.
- Being behind on rent was more likely to be reported by Black, Non-Hispanic (32%), Hispanic (22%), and Other, non-Hispanic (24%) households than for White, Non-Hispanic households (16%). The prevalence for Asian, Non-Hispanic (22%) was not significantly different from that of White, Non-Hispanic households.
- Single-female-headed renter households with children also were more likely to be behind on rent (28%) than were other heads of households (17%).
- During the same period, 22% of renter households with children were behind on rent. Those with incomes at or below 200% poverty were more likely to be behind on rent (28%) compared to those with incomes above 200% poverty (10%).

*Endnotes begin on page 27.*

# Pandemic Health Care and Child Care

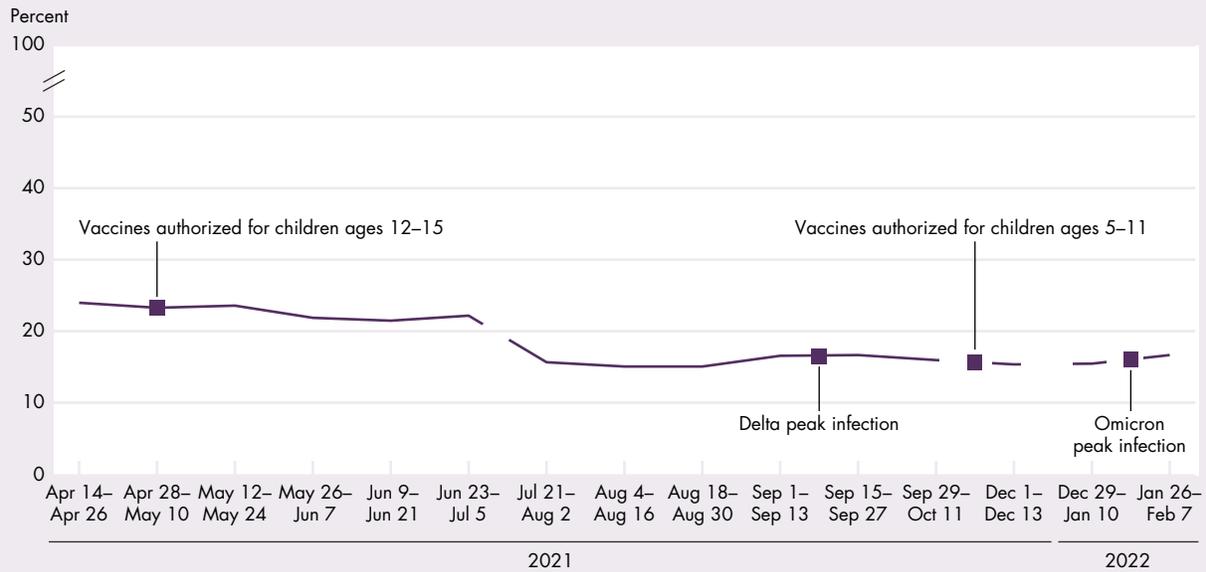
The COVID-19 pandemic has posed a number of challenges for accessing health care and child care. Disruption of preventive health care can lead to challenges in the identification of health conditions, providing routine vaccinations, tracking developmental milestones, intervening early on identified health concerns, and providing support to families.<sup>14</sup> Telemedicine was widely adopted during the pandemic, which provided easier access to both sick and preventive care, while also protecting against the spread of disease. Recent Household Pulse Survey research shows that households experiencing material hardships—such as difficulty paying rent or mortgage, food insufficiency, or difficulty paying household expenses—were more likely to report missed/delayed preventive visits than those who did not experience material hardships.<sup>14</sup> Working from home or workplace closures were also experienced by many parents or caregivers. Because of these workplace changes, parents or caregivers often experienced material hardships and/or lost the access to child care, which contributed to work-related disruptions.



- From late December 2021 to early February 2022, approximately 68% of households with children reported that all children had a preventive check-up in the past 12 months.
- The percentage of households with all children having a preventive check-up was lower in households experiencing material hardship than in households that did not experience material hardships, including not being current on rent or mortgage (58% versus 70%), difficulty paying usual household expenses (64% versus 71%), and children not eating enough because of lack of affordability (58% versus 70%).
- According to poverty and insurance status, the percentage of households with all children having a preventive check-up was highest among households with a poverty status equal to or greater than 400% (78%) and those with privately insured adults (73%), and lowest among households with a poverty status of less than 138% (61%) and those with uninsured adults (53%), respectively.

# Pandemic Health Care and Child Care—Continued

**Figure 8** Percentage of households with any children who had a telehealth visit in the last 4 weeks, April 14, 2021–February 7, 2022



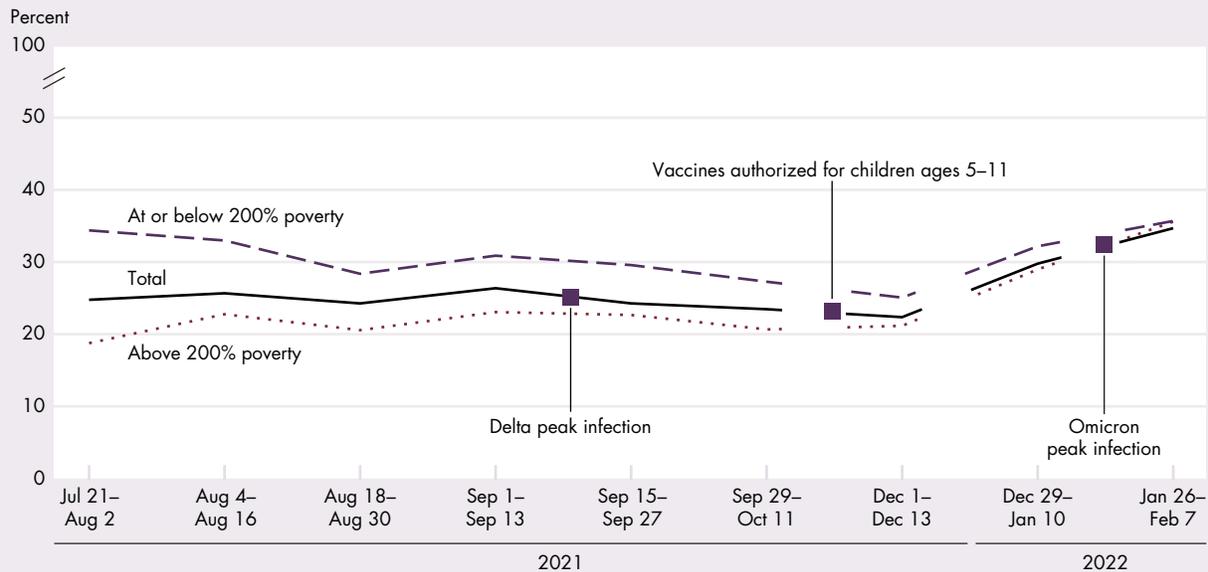
NOTE: Figure reflects data collected in Phase 3.1 through Phase 3.3, weeks 28–42 (April 14, 2021, through February 7, 2022), all weeks the survey item was fielded. Data were not collected or available during July 7–19, 2021, October 13–November 29, 2021, December 15–27, 2021, and January 12–24, 2022. Survey item: “At any time in the last 4 weeks, did any children in the household have an appointment with a doctor, nurse, or other health professional by video or by phone? Select only one answer: (1) Yes, (2) No.”

SOURCE: U.S. Census Bureau, Household Pulse Survey. Tabulated by the Health Resources and Services Administration’s Maternal and Child Health Bureau.

- The percentage of households with any children who had a telehealth visit in the last 4 weeks decreased from 24% (mid- to late April 2021) to 17% (late January–early February 2022).
- According to race/ethnicity and insurance status, children’s telehealth visits were highest among households with adults who identified as Hispanic (18%) and adults with public insurance (19%), and lowest among households with adults who identified as White, non-Hispanic (15%) and adults with no insurance (14%).

# Pandemic Health Care and Child Care—Continued

**Figure 9** Percentage of households experiencing disrupted child care arrangements overall and by poverty status, July 21, 2021–February 7, 2022

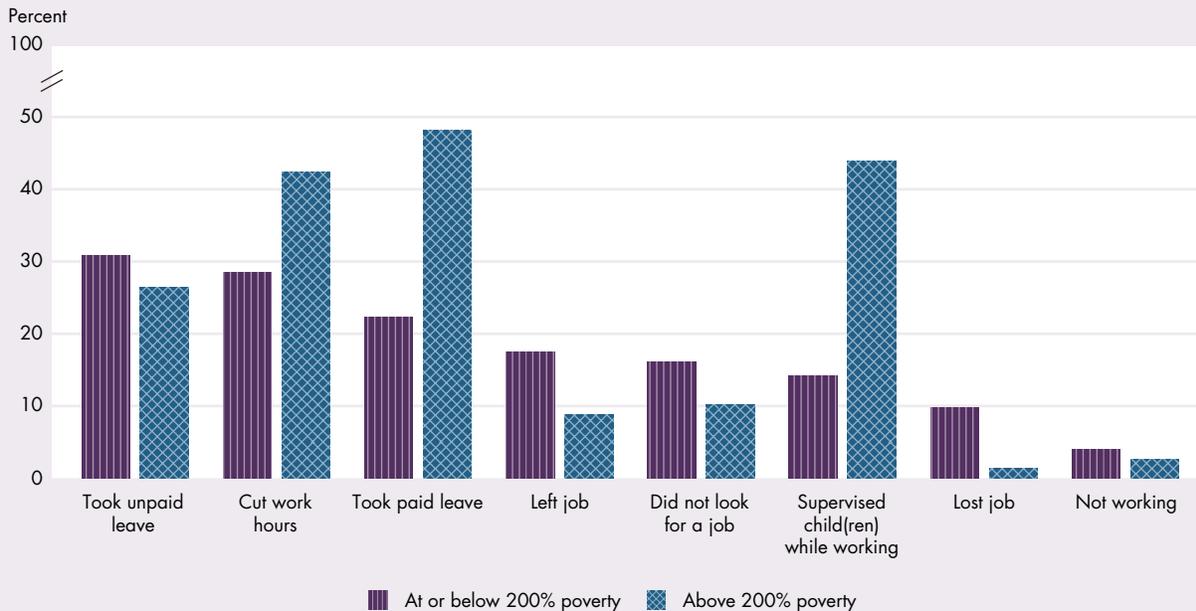


NOTE: Figure reflects data collected in Phase 3.2 through Phase 3.3, weeks 34–42 (July 21, 2021, through February 7, 2022), all weeks the survey item was fielded. Data were not collected or available during October 13–November 29, 2021, December 15–27, 2021, and January 12–24, 2022. Survey item: “At any time in the last 4 weeks, were any children in the household unable to attend daycare or another child care arrangement as a result of child care being closed, unavailable, unaffordable, or because you are concerned about your child’s safety in care? Please include before school care, after school care, and all other forms of child care that were unavailable. Select only one answer: (1) Yes, (2) No, (3) Not applicable.” Figure data only include households with children who answered “Yes” or “No.” Households with children who answered “Not applicable” were excluded from the denominator. Households with missing data on poverty status were included in the overall estimates of disrupted child care, but excluded from the estimates by poverty status. Poverty status is based on family income and household size using 2020 U.S. Census Bureau poverty thresholds.

SOURCE: U.S. Census Bureau, Household Pulse Survey. Tabulated by the Health Resources and Services Administration’s Maternal and Child Health Bureau.

- Disrupted child care among households with children in a child care arrangement ranged from 25% of households (late July 2021) to 35% (early February 2022).
- With the exception of the last data collection period (early February 2022), the percentage of households reporting disrupted child care was higher among households with incomes at or below 200% poverty (25% to 34%), compared with households with incomes above 200% poverty (19% to 29%). During the period ending with February 7, 2022, both income groups had the same prevalence of disrupted child care (36%).
- Reports of disrupted child care were highest among households with adults who identified as Black, non-Hispanic or Other, non-Hispanic (36%) and Hispanic (32%), and lowest among households with adults who identified as Asian or Pacific Islander, non-Hispanic (27%). Additionally, reports of disrupted child care were highest among households with adults who had a bachelor’s degree or higher (36%) and lowest among adults who had less than a high school diploma or an alternative credential such as a General Educational Development (GED) certificate (27%).

**Figure 10** Percentage of households reporting work-related impacts among households that experienced child care disruptions by poverty status, December 29, 2021–February 7, 2022



NOTE: Figure reflects data collected in Phase 3.3, weeks 41–42 (December 29, 2021, through February 7, 2022), the most recent 2 weeks of Phase 3.3, in order to present the most current information available. Survey item: “Which if any of the following occurred in the last 4 weeks as a result of child care being closed, unavailable, unaffordable, or because you are concerned about your child’s safety in care? Select all that apply: (1) You (or another adult) took unpaid leave to care for the children, (2) You (or another adult) used vacation, or sick days, or other paid leave in order to care for the children, (3) You (or another adult) cut your work hours in order to care for the children, (4) You (or another adult) left a job in order to care for the children, (5) You (or another adult) lost a job because of time away to care for the children, (6) You (or another adult) did not look for a job in order to care for the children, (7) You (or another adult) supervised one or more children while working, (8) Other (specify), (9) None of the above.” Figure data only include households with children who reported any child care disruptions in the last 4 weeks. Poverty status is based on family income and household size using 2020 U.S. Census Bureau poverty thresholds.

SOURCE: U.S. Census Bureau, Household Pulse Survey. Tabulated by the Health Resources and Services Administration’s Maternal and Child Health Bureau.

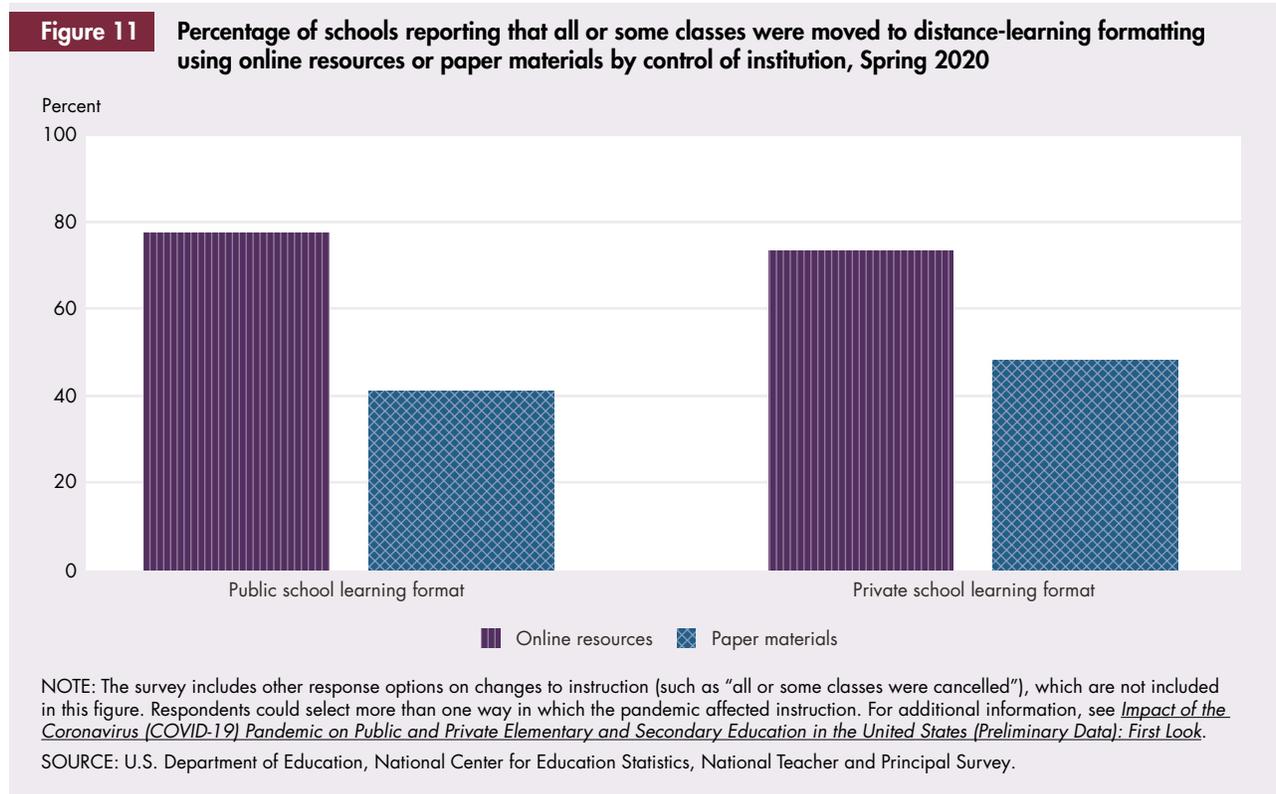
- As a result of child care disruptions, many households with children experienced work-related impacts, with notable differences by income level: Households with incomes at or below 200% poverty more frequently took unpaid leave (31%), left a job (18%), did not look for a job (16%), or lost a job (10%), while

households with incomes above 200% poverty more frequently took paid leave (48%), cut work hours (43%), and supervised children while working (44%).

*Endnotes begin on page 27.*

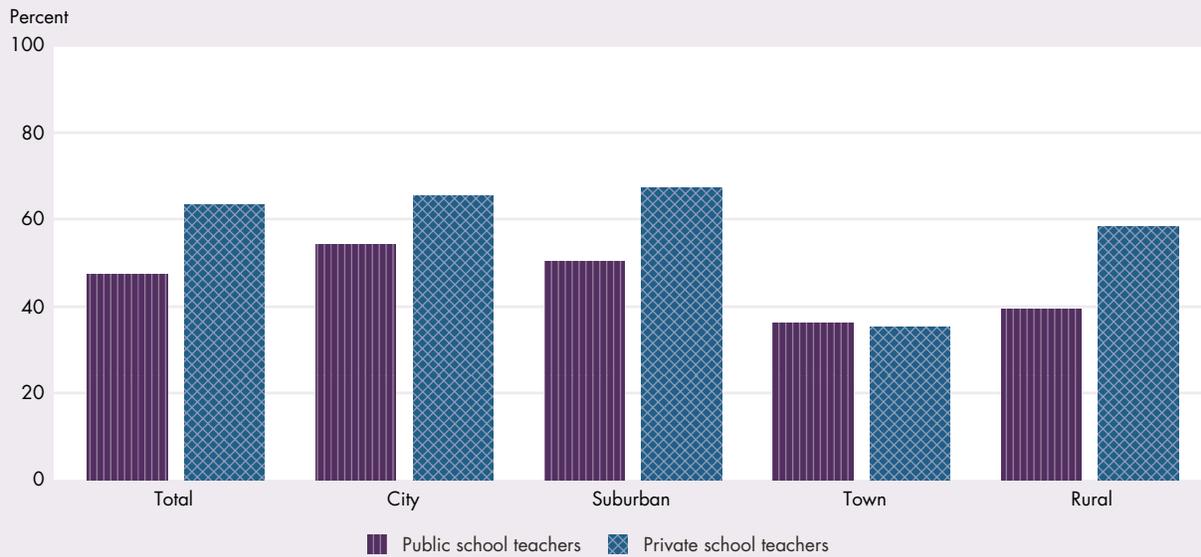
# How Schools Adapted to Pandemic Response

The emergence of the COVID-19 pandemic brought major disruptions to the traditional education structure as schools quickly transitioned to online education programs in the spring of 2020 in an effort to mitigate the spread of COVID-19. During this time, schools adapted to the COVID-19 pandemic with changes to instruction; real-time interactions between teachers and students; computer distribution to students; and internet access for students. These data were collected in the National Teacher and Principal Survey.<sup>15</sup>



- During the COVID-19 pandemic in the spring of 2020, a higher percentage of public schools than of private schools (77% versus 73%) reported moving classes to online distance-learning formats. Conversely, a lower percentage of public schools than of private schools (41% versus 48%) reported moving classes to a distance-learning format using paper materials. There was no measurable difference in the rates of cancelling classes between public and private schools (9% and 10%).
- Eighty-four percent each of public schools in cities and suburban areas moved classes to online distance-learning formats. These were higher than the rates in towns and rural areas (70% and 67%). A similar pattern was observed for private schools, where private schools located in cities and suburban areas (both 79%) had higher rates of moving classes to online distance-learning formats than did private schools in towns and rural areas (64% and 59%).
- Among public schools, both middle schools and high schools (80% and 81%) had higher rates of moving classes to online distance-learning formats than primary schools (76%). Among private schools, no measurable difference in the rates of moving classes to online distance-learning formats was observed by school level.<sup>16</sup>
- About 32% of public schools with less than 35% of students who were approved for Free or Reduced Price Lunch (FRPL) reported moving classes to a distance-learning format using paper materials. This rate was lower than public schools with higher percentages of students who were approved for FRPL. For example, 48% of public schools with 75% or more of students who were approved for FRPL reported moving classes to a distance-learning format using paper materials.

**Figure 12** Percentage of school teachers who taught real-time lessons to classes who could ask questions during the lesson through a video or audio call by community type and control of institution, Spring 2020

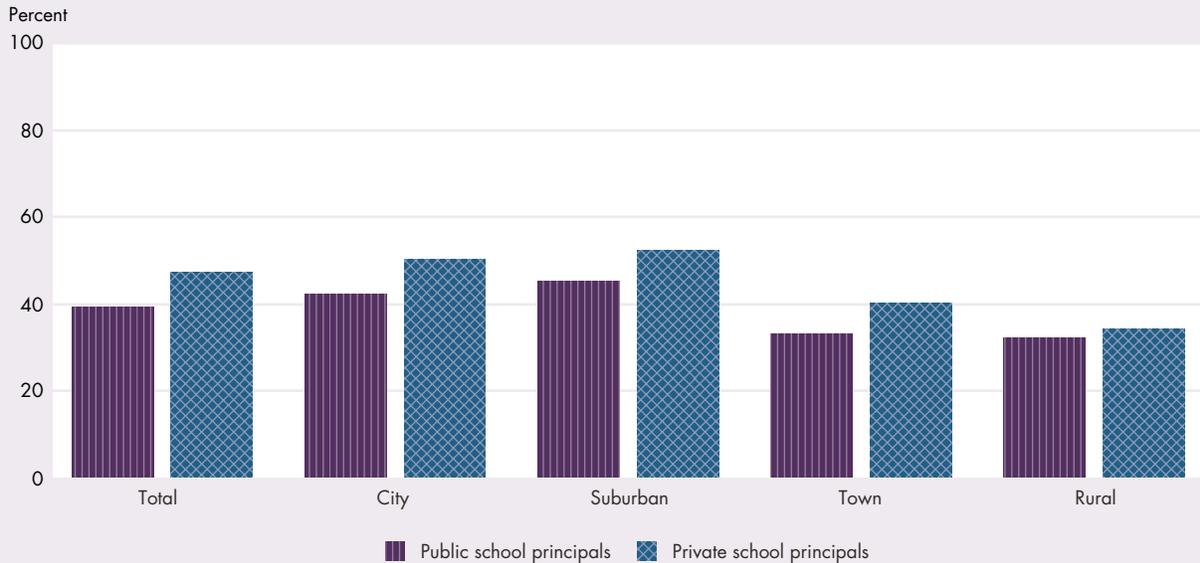


NOTE: The survey includes other response options on types of real-time interaction (such as having “unscheduled sessions with students as needed through a video or audio call”), which are not included in this figure. Respondents could select more than one type of real-time interaction. For additional information, see *Impact of the Coronavirus (COVID-19) Pandemic on Public and Private Elementary and Secondary Education in the United States (Preliminary Data): First Look*.

SOURCE: U.S. Department of Education, National Center for Education Statistics, National Teacher and Principal Survey.

- During the COVID-19 pandemic in the spring of 2020, public school teachers (47%) reported that they taught real-time lessons to classes who could ask questions through a video or audio call at a lower rate than private school teachers (63%).
- The percentage of school teachers who taught real-time lessons to classes who could ask questions through a video varied by community type. The rate for public school teachers was higher for those in city schools (54%) than those in suburban schools (50%), rural schools (39%), and schools located within towns (36%).
- Among private schools, the rate was lower for teachers in towns (38%) than those teaching at suburban schools (67%), city schools (65%), and rural schools (58%).

**Figure 13** Percentage of school principals who reported their school distributed computers or digital devices to students who did not have access to one at home by community type and control of institution, Spring 2020



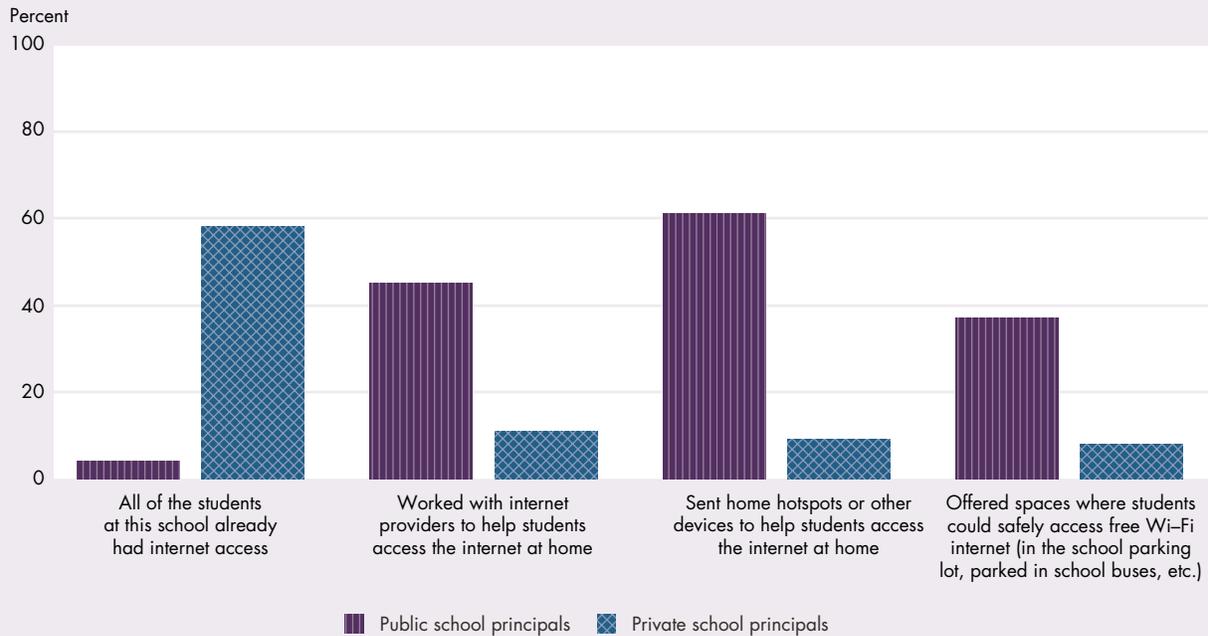
NOTE: The survey includes one additional response option (“we did not distribute any computers or digital devices to any students to take home”), which is not included in this figure. For additional information, see *Impact of the Coronavirus (COVID-19) Pandemic on Public and Private Elementary and Secondary Education in the United States (Preliminary Data): First Look*.

SOURCE: U.S. Department of Education, National Center for Education Statistics, National Teacher and Principal Survey.

- In the spring of 2020, during the COVID-19 pandemic, a lower percentage of public school principals than of private school principals (39% versus 47%) reported distributing computers to students who did not have access to computers or digital devices at home.<sup>17</sup>
- About 42% and 45% of public school principals in city and suburban schools, respectively, reported that their school distributed computers to students who did not have access to computers or digital devices at home. These percentages were higher than the percentages for public school principals in town and rural schools (33% and 32%). Private school principals reported a similar pattern. Private school principals in city and suburban schools (50% and 52%) reported higher rates of their school distributing computers to students who did not have access to one at home than did private school principals in rural schools only (34%).
- Among principals of smaller public schools (those with less than 200 students enrolled), 33% reported that their school distributed computers to students who did not have access to computers or digital devices at home. This was lower than the percentages for principals of larger public schools (ranging from 38% to 42%).<sup>18</sup>

# How Schools Adapted to Pandemic Response—Continued

**Figure 14** Percentage of school principals who reported that their schools worked with internet providers to help students access internet at home, sent home hotspots or other devices, and offered spaces where students could safely access free Wi-Fi internet by control of institution, Spring 2020



NOTE: The survey includes other response options on ways of helping students with their internet access (such as “other” and “did not take any steps to help students access the internet”), which are not included in this figure. Respondents could select more than one way of helping students. For additional information, see [Impact of the Coronavirus \(COVID-19\) Pandemic on Public and Private Elementary and Secondary Education in the United States \(Preliminary Data\): First Look](#).

SOURCE: U.S. Department of Education, National Center for Education Statistics, National Teacher and Principal Survey.

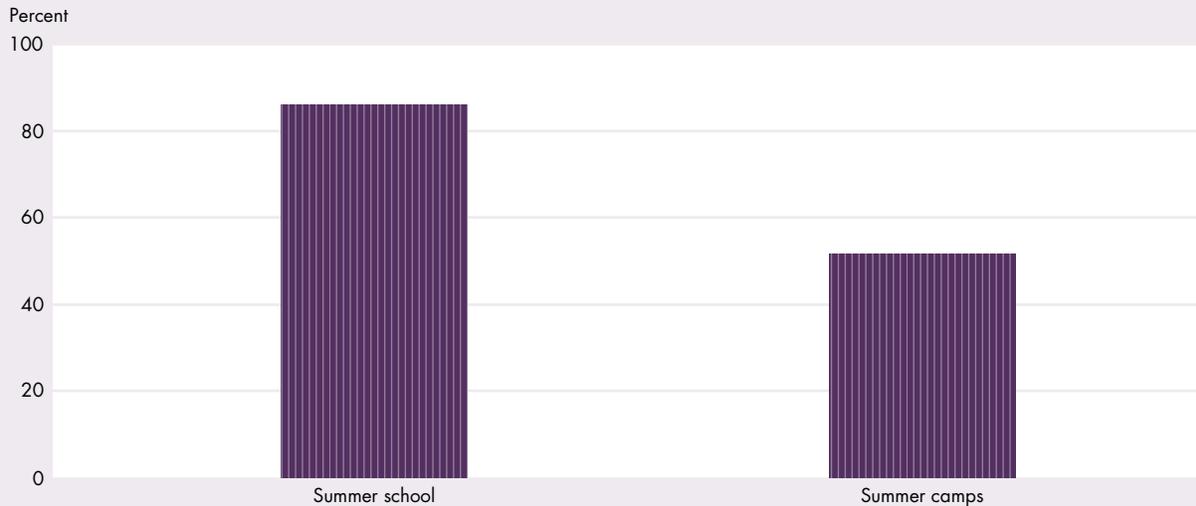
- During the COVID-19 pandemic in the spring of 2020, internet access at home varied across students attending public and private schools. Public school principals reported 4% of students at their school already had internet access at home. Private school principals reported 58% of students at their schools already had internet access at home.
- School principals reported taking various steps to help students access the internet at home at higher rates than private school principals.<sup>19</sup> For example, 61% of public school principals responded that their school sent hotspots or other devices to students at home, compared to 9% of private school principals. Public school principals also reported working with internet providers to help students access the internet at home and offering spaces where students could safely access free Wi-Fi at higher rates than private school principals.
- About 52% of public school principals in city schools and 49% in suburban schools reported that their school worked with internet providers to help students access the internet at home. These percentages were higher than the percentages for public school principals in town and rural schools (42% and 36%).
- Public school principals in city and suburban schools (75% and 69%) also reported that their school sent home hotspots or other internet devices at higher rates than those in town and rural schools (both 49%). Public school principals in town and rural schools reported offering spaces where students could access free Wi-Fi at higher rates (47% and 46%) than those in city and suburban schools (30% and 27%).

*Endnotes begin on page 27.*

# Summer Enrichment Programs

Many students have experienced enrollment disruptions due to the COVID-19 pandemic. Public schools can address pandemic-related learning needs by offering summer enrichment programs, including summer school and summer camps, to their students. The American Rescue Plan Elementary and Secondary School Emergency Relief (ARP ESSER) fund provides nearly \$122 billion to states and school districts to help safely reopen schools, sustain the safe operation of schools, and address the impact of the pandemic. The ARP ESSER fund specifically requires that states invest in evidence-based initiatives to address the impact of lost instructional time, such as summer programs.<sup>20</sup> The School Pulse Panel survey collected data on schools' offering of summer enrichment programs in 2021.<sup>21</sup>

**Figure 15** Percentage of public schools that offered summer school and summer camps to address students' pandemic-related learning needs, Summer 2021



NOTE: This figure is based on experimental data. While estimates have been weighted and adjusted for non-response, these experimental data should be interpreted with caution.

SOURCE: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, School Pulse Panel.

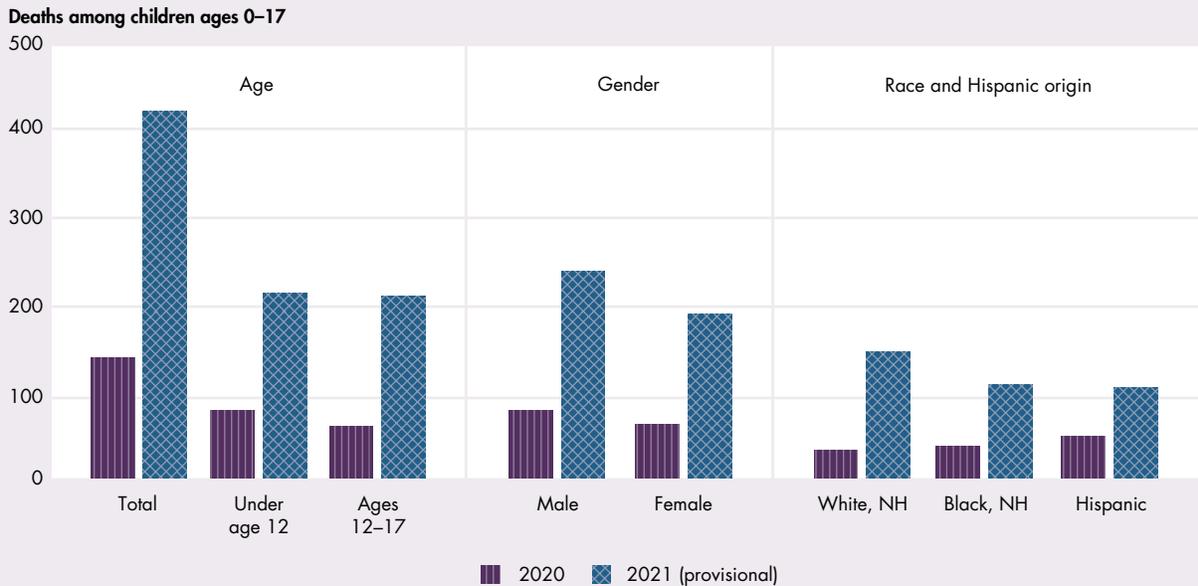
- During the summer of 2021, about 85% of public schools offered summer programs and 51% offered summer camps to their students to address pandemic-related learning needs.

*Endnotes begin on page 27.*

# Child and Adolescent Mortality

Although illness and hospitalization are lower among children and adolescents with COVID-19 compared with adults, COVID-19 can lead to severe symptoms that might require admission to an intensive care unit or result in death.<sup>22,23,24,25</sup> Children and adolescents with one or more underlying medical conditions are at greater risk of severe symptoms.<sup>26</sup> In the United States, one in four children has a chronic condition, including asthma, obesity, diabetes, or neurodevelopmental disorders.<sup>27,28</sup>

**Figure 16** Number of deaths from COVID-19 among children ages 0–17 by age, gender, and race and Hispanic origin, 2020 and 2021 (provisional)



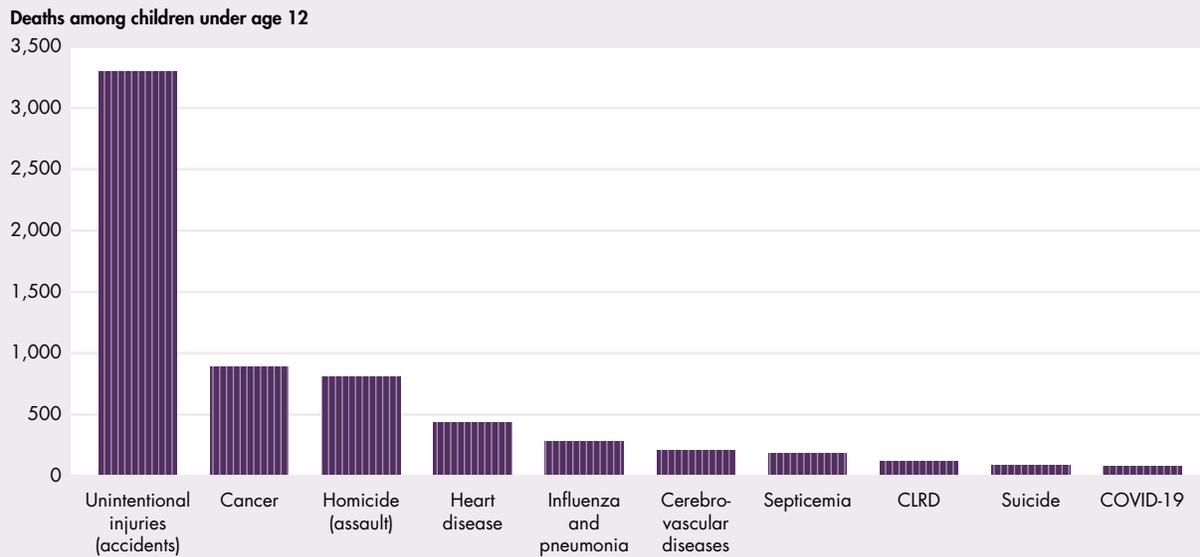
NOTE: NH = non-Hispanic origin. Deaths from COVID-19 are classified according to the underlying cause-of-death code \*U07.1 from the *International Classification of Diseases, 10th Revision*. It can take several weeks for death records to be submitted to the National Center for Health Statistics, processed, and tabulated. Therefore, the data shown in this figure may be incomplete and will likely not include all deaths that occurred during the given time periods, especially data for 2021. Provisional deaths for 2021 are based on a current flow of mortality data in the National Vital Statistics System. Provisional counts include deaths occurring in the 50 states and the District of Columbia that have been received through April 16, 2022, as of May 1, 2022. Data on race and Hispanic origin are collected and reported separately. The race categories are based on the 1997 U.S. Office of Management and Budget standards on race and ethnicity and all categories are single race. Persons of Hispanic origin may be of any race. The "Total" includes children who classify as American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, and "Two or more races." The number of deaths for these race groups are not shown separately because the number of deaths are too small to meet reporting standards.

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

- In 2020, 141 children ages 0–17 died from COVID-19 (0.2 deaths per 100,000 population). In 2021, deaths from COVID-19 among children increased to 434 (0.6).
- In both 2020 and 2021, the number of deaths due to COVID-19 among children under age 12 were higher than the number among adolescents ages 12–17. However, the rates were higher among adolescents.
- Males were more likely to die from COVID-19 than females in both 2020 and 2021 based on number of deaths and rates. Among males, deaths increased from 79 in 2020 to 241 in 2021. Among females, deaths increased from 62 in 2020 to 193 in 2021.
- From 2020 to 2021, deaths from COVID-19 increased for all race and Hispanic-origin groups shown.
- In both 2020 and 2021, Black, non-Hispanic children had higher death rates from COVID-19 (0.4 and 1.2) than Hispanic (0.3 and 0.6) and White, non-Hispanic (0.1 and 0.4) children.

# Child and Adolescent Mortality—Continued

**Figure 17** Number of deaths for selected leading causes of death among children under age 12 by cause of death, 2020



NOTE: CLRD = chronic lower respiratory diseases. Cause of death is classified according to the *International Classification of Diseases, 10th Revision*. Provisional 2021 data are not used for leading causes of death because any reclassifications of cause of death in final data may affect the rank order of causes. Rates are less likely to change due to a few reclassified deaths because they are based on the number of deaths per 100,000 population.

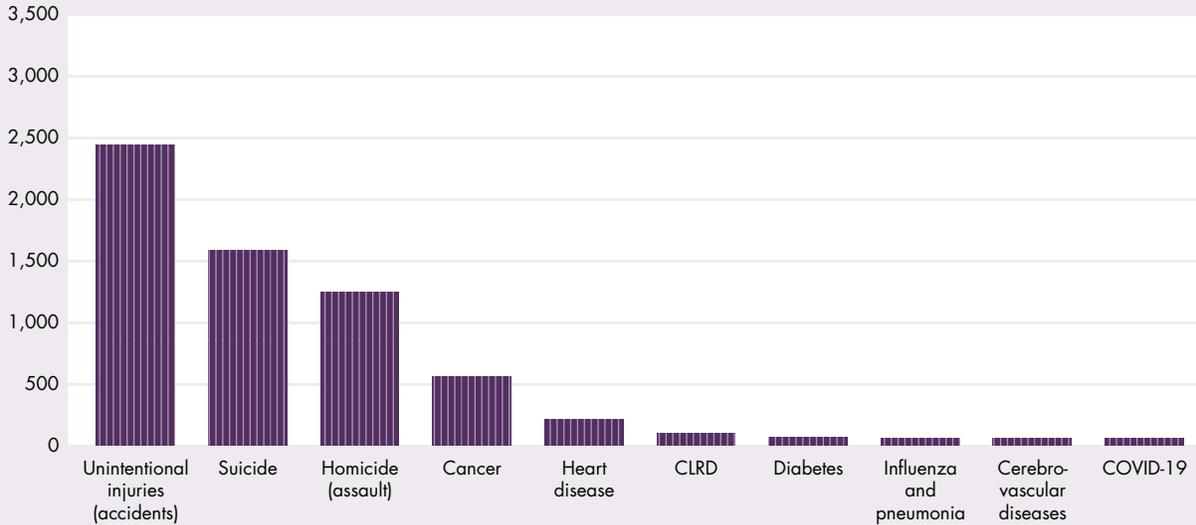
SOURCE: National Center for Health Statistics, National Vital Statistics System.

- In 2020, unintentional injuries were the leading cause of death among children under age 12, accounting for 12.5% of deaths. Deaths from COVID-19 accounted for only 0.3% of deaths among children.
- Among children under age 12 in 2020, 3,300 died from unintentional injuries; 893 died from cancer; 806 died from homicide; 438 died from heart disease; 284 died from influenza and pneumonia; 208 died from cerebrovascular diseases; 185 died from septicemia; 120 died from chronic lower respiratory diseases; 87 died from suicide; and 80 died from COVID-19.

# Child and Adolescent Mortality—Continued

**Figure 18** Number of deaths for selected leading causes of death among adolescents ages 12–17 by cause of death, 2020

Deaths among adolescents ages 12–17



NOTE: CLRD = chronic lower respiratory diseases. Cause of death is classified according to the *International Classification of Diseases, 10th Revision*. Provisional 2021 data are not used for leading causes of death because any reclassifications of cause of death in final data may affect the rank order of causes. Rates are less likely to change due to a few reclassified deaths because they are based on the number of deaths per 100,000 population.

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

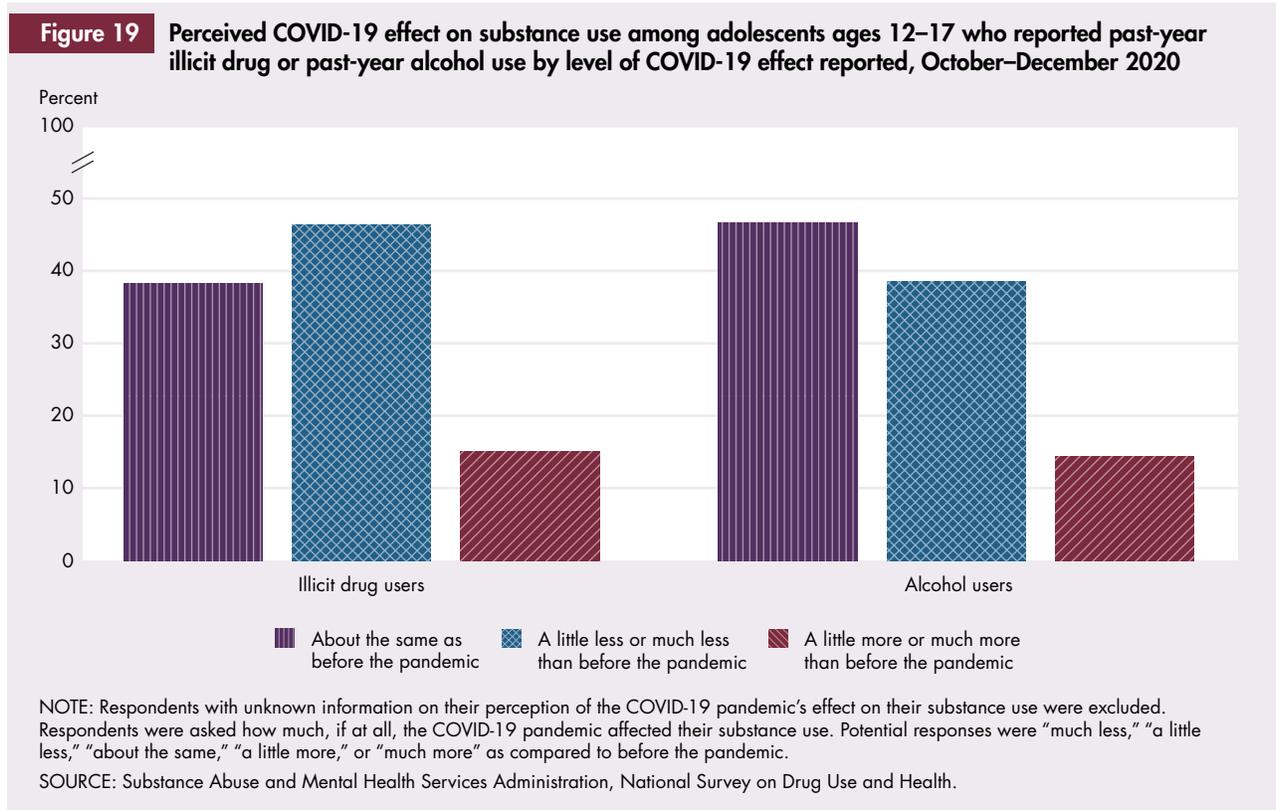
- In 2020, unintentional injuries accounted for 31.4% of deaths among adolescents ages 12–17, followed by suicide (20.4%) and homicide (16.1%). Deaths from COVID-19 accounted for only 0.8% of deaths among adolescents.
- Among adolescents ages 12–17 in 2020, 2,446 died from unintentional injuries; 1,592 died from suicide; 1,253 died from homicide; 568 died from cancer; 219 died from heart disease; 102 died from chronic lower respiratory diseases; 75 died from diabetes; 66 died from influenza and pneumonia; 64 died from cerebrovascular diseases; and 61 died from COVID-19.

*Endnotes begin on page 27.*

# Substance Use and Mental Health of Adolescents

The COVID-19 pandemic and the measures taken to combat it created challenges in the everyday lives of Americans, including affecting their mental health and substance use. Poor mental health among children was a substantial public health concern even before the pandemic.<sup>29</sup>

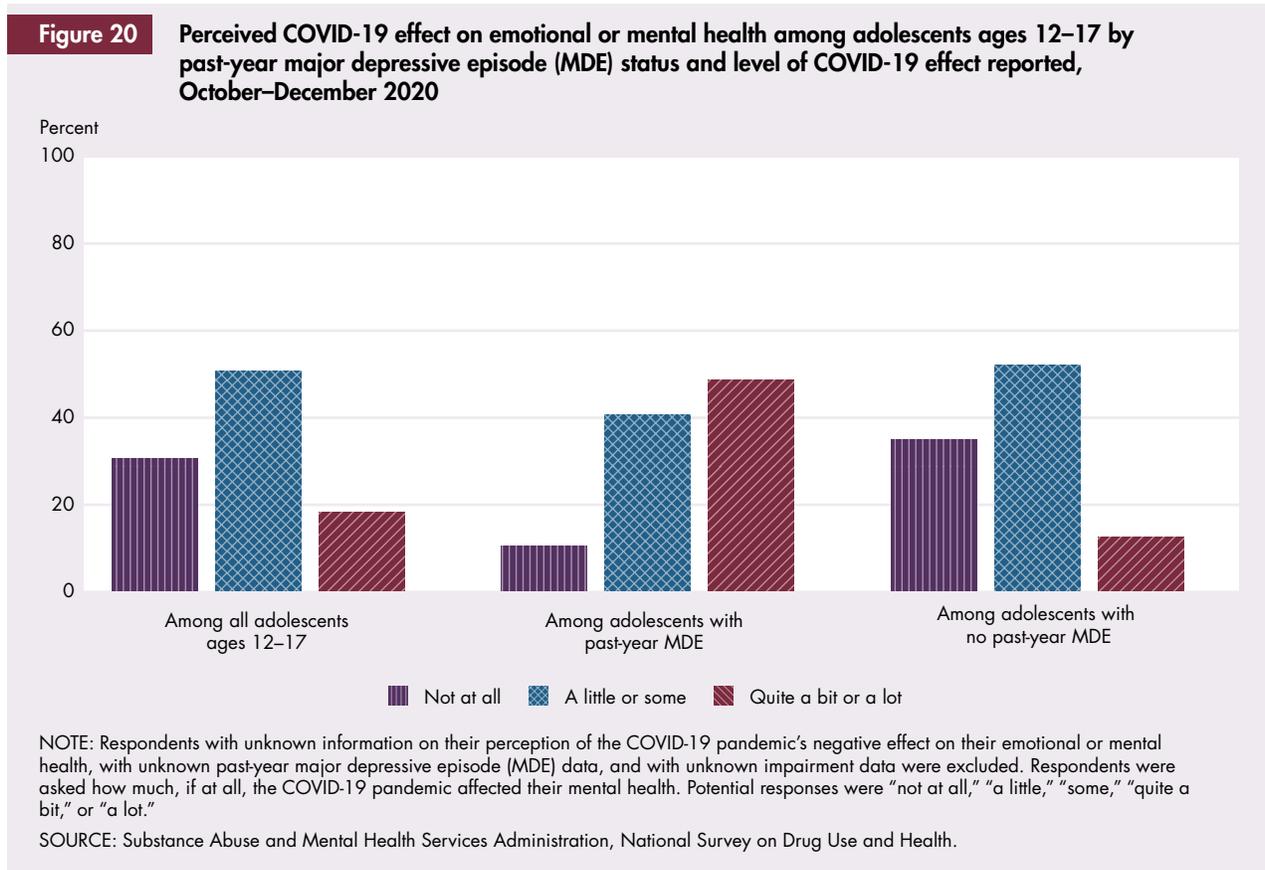
The COVID-19 pandemic may also have affected access to substance use treatment in different ways. In response to the COVID-19 pandemic, for example, health care providers (including behavioral health care providers) turned to virtual (or telehealth) services as a means of delivering services while also limiting in-person contact.



- In October–December 2020, about 46% of adolescents ages 12–17 who used illicit drugs in the past year perceived that they were using those substances “a little less or much less” than they did before the COVID-19 pandemic began. This is compared with 15% of adolescents ages 12–17 who perceived that they were using those substances “a little more or much more.”
- About 39% of adolescents ages 12–17 who drank alcohol in the past year perceived that they were drinking “a little less or much less” than they did before the COVID-19 pandemic began. This is compared with 15% of adolescents ages 12–17 who perceived that they were drinking “a little more or much more.”

# Substance Use and Mental Health of Adolescents—Continued

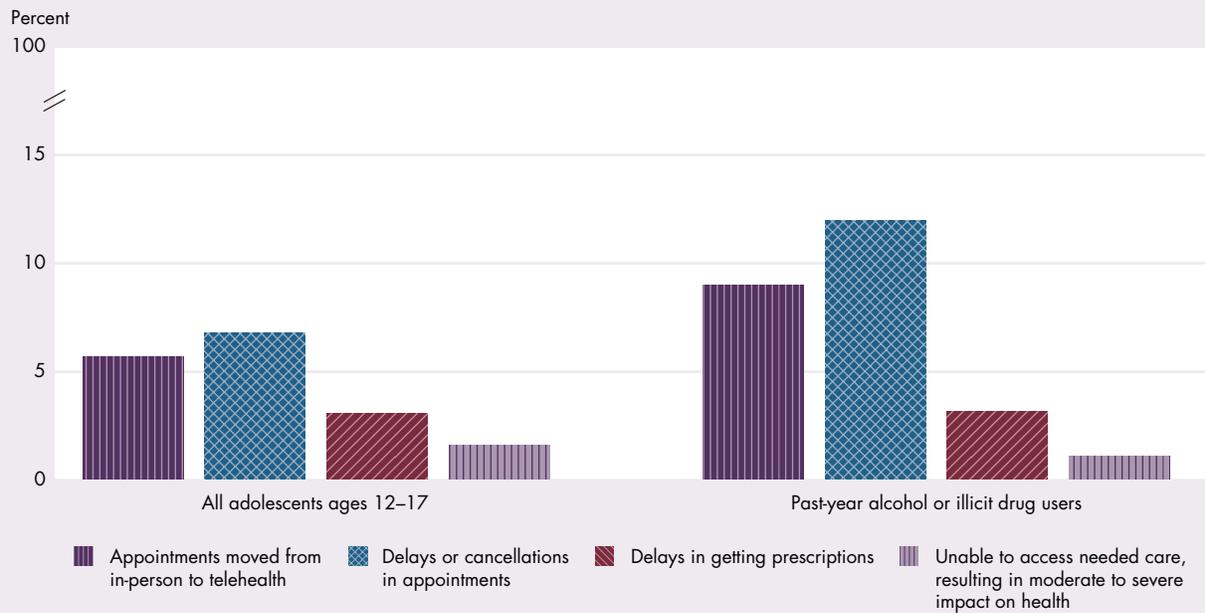
Depression has a significant impact on adolescent development and well-being.<sup>30</sup> Adolescent depression can adversely affect school and work performance, impair peer and family relationships, and exacerbate the severity of other health conditions such as asthma and obesity.<sup>31,32,33</sup> Depressive episodes often persist, recur, or continue into adulthood.<sup>34</sup> Youth who have had a major depressive episode (MDE) in the past year are at greater risk for suicide and are more likely than other youth to initiate alcohol and other drug use, experience concurrent substance use disorders, and smoke daily.<sup>35,36,37</sup> The COVID-19 pandemic may have exacerbated the effect of MDE on adolescents.<sup>38</sup>



- In October–December 2020, almost 1 in 5 adolescents (18%) perceived that the COVID-19 pandemic negatively affected their mental health “quite a bit or a lot,” and an additional 51% perceived “a little or some” negative effect on their mental health.
- Adolescents ages 12–17 who had a past-year MDE or a past-year MDE with severe impairment were more likely than those without a past-year MDE to perceive that the COVID-19 pandemic negatively affected their mental health “quite a bit or a lot” (49% and 55%, respectively). In comparison, 13% of adolescents without a past-year MDE perceived the COVID-19 pandemic negatively affected their mental health “quite a bit or a lot.”

**Figure 21**

**Perceived COVID-19 effect on access to substance use treatment among all adolescents ages 12–17 and among those who reported substance use in the past year by type of COVID-19 effect reported, October–December 2020**



NOTE: Respondents who reported that the respective question did not apply to them were classified as not having experienced that effect. Respondents with unknown information on their perception of the COVID-19 pandemic's effect on their access to substance use treatment were excluded.

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

- In October–December 2020, among all adolescents ages 12–17, about 6% had their substance use treatment appointments moved from in-person to telehealth, 7% experienced delays or cancellations in appointments, 3% experienced delays in getting prescriptions, and 2% were unable to access needed care, resulting in a moderate to severe impact on health.
- Among adolescents with past-year alcohol or illicit drug use, 9% had their substance use treatment appointments moved from in-person to telehealth, 12% experienced delays or cancellations in appointments, 3% experienced delays in getting prescriptions, and 1% were unable to access needed care, resulting in a moderate to severe impact on health.

*Endnotes begin on page 27.*

# Notes to Indicators

- <sup>1</sup> For more information see <https://www.census.gov/data/experimental-data-products/household-pulse-survey.html>.
- <sup>2</sup> Centers for Disease Control and Prevention. (2022, January 11). *COVID-19 vaccines for children and teens*. <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/children-teens.html>
- <sup>3</sup> Centers for Disease Control and Prevention. (2021, November 2). *COVID-19 vaccine equity for racial and ethnic minority groups*. <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/vaccine-equity.html>
- <sup>4</sup> The Household Pulse Survey (HPS) includes an indicator of child food insufficiency for U.S. households, defined as follows: Child food insufficiency means a household's children were not eating enough food sometimes or often in the last 7 days because the household could not afford enough food (based on a self-report to a single item). Low food sufficiency among children means a child did not have enough to eat sometimes in the last 7 days. Very low food sufficiency among children means a child did not have enough to eat often in the last 7 days. The food-sufficiency item in the HPS asks about the food eaten in the household in the last 7 days to assess rapid changes in food sufficiency. Household adults are asked the following: "In the last 7 days, which of these statements best describes the food eaten in your household? Select only one answer. (1) Enough of the kinds of food (I/we) wanted to eat; (2) Enough, but not always the kinds of food (I/we) wanted to eat; (3) Sometimes not enough to eat; (4) Often not enough to eat." Adults who select (1) are classified as living in households with full food sufficiency, while those who select (2) are classified as living in households with marginal food sufficiency. Those who select (3) or (4) are counted as having low and very low food sufficiency, respectively. Those who respond with (3) or (4) are classified as food insufficient, which means that a household did not have enough to eat in the last 7 days. Adults who select (2), (3), or (4) and have children under age 18 living in the household are then asked to indicate whether the next statement was often true, sometimes true, or never true in the last 7 days for the children living in the household who are under age 18: "The children were not eating enough because we just couldn't afford enough food. (1) Often true; (2) Sometimes true; (3) Never true." Adults who respond with (1) are classified as having children with full food sufficiency. Adults who select (2) are classified as having children with low food sufficiency, while those who select (3) are classified as having children with very low food sufficiency. Food insufficiency includes both low and very low food sufficiency. Data from the HPS and other sources are not entirely comparable. As such, there is not a directly comparable measure of food insufficiency prior to the COVID-19 pandemic. Technical information about how food insufficiency is measured in the HPS can be found at <https://www.ers.usda.gov/topics/food-nutrition-assistance/foodsecurity-in-the-us/measurement/#insufficiency>.
- <sup>5</sup> Coleman-Jensen, A., McFall, W., & Nord, M. (2013). *Food insecurity in households with children: Prevalence, severity, and household characteristics, 2010-11*(EIB-113). U.S. Department of Agriculture, Economic Research Service. <https://www.ers.usda.gov/publications/pub-details/?pubid=43765>
- <sup>6</sup> Clark, R. E., Weinreb, L., Flahive, J. M., & Seifert, R. W. (2019). Infants exposed to homelessness: Health, health care use, and health spending from birth to age six. *Health Affairs*, 38(5), 721–728. <https://doi.org/10.1377/hlthaff.2019.00090>
- <sup>7</sup> Collinson, R., & Reed, D. (2019). Retrieved from *The Effects of Evictions on Low-Income Households*. Unpublished manuscript. [https://www.law.nyu.edu/sites/default/files/upload\\_documents/evictions\\_collinson\\_reed.pdf](https://www.law.nyu.edu/sites/default/files/upload_documents/evictions_collinson_reed.pdf)
- <sup>8</sup> Benfer, E. A., Vlahov, D., Long, M. Y., Walker-Wells, E., Pottenger, J. L., Jr., Gonsalves, G., & Keene, D. E. (2021). Eviction, health inequity, and the spread of COVID-19: Housing policy as a primary pandemic mitigation strategy. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 98(1), 1–12. <https://doi.org/10.1007/s11524-020-00502-1>
- <sup>9</sup> Leifheit, K. M., Linton, S. L., Raifman, J., Schwartz, G. L., Benfer, E. A., Zimmerman, F. J., & Pollack, C. E. (2021). Expiring eviction moratoriums and COVID-19 incidence and mortality. *American Journal of Epidemiology*, 190(12), 2503–2510. <https://doi.org/10.1093/aje/kwab196>
- <sup>10</sup> Estimates of households with children by housing tenure are from the 2019 American Housing Survey (AHS). The AHS includes homeowners who do not report mortgage information among those who do not have a mortgage.
- <sup>11</sup> Lino, M., Kuczynski, K., Rodriguez, N., & Schap, T. (2017). *Expenditures on children by families, 2015*(Miscellaneous Publication No. 1528-2015). U.S. Department of Agriculture, Center for Nutrition Policy and Promotion. <https://www.fns.usda.gov/resource/2015-expenditures-children-families>
- <sup>12</sup> Weinstock, L. R. (2021). *COVID-19 and the U.S. economy* (CRS Report No. R46606). Congressional Research Service. <https://crsreports.congress.gov/product/pdf/R/R46606>
- <sup>13</sup> Federal Poverty Guidelines, informally Federal Poverty Levels, are found at <https://aspe.hhs.gov/topics/poverty-economicmobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2021-poverty-guidelines>.
- <sup>14</sup> Lebrun-Harris, L. A., Sappenfield, O. R., & Warren, M. D. (2021). Missed and delayed preventive health care visits among US children due to the COVID-19 pandemic. *Public Health Reports*. <https://doi.org/10.1177/00333549211061322>

# Notes to Indicator—Continued

- <sup>15</sup> For additional information, see *Impact of the Coronavirus (COVID-19) Pandemic on Public and Private Elementary and Secondary Education in the United States (Preliminary Data): First Look*.
- <sup>16</sup> School levels for public schools are reported as primary, middle, high, or combined, while school levels for private schools are reported as elementary, secondary, or combined.
- <sup>17</sup> The survey includes two other response options: “we distributed computers or digital devices to all students to take home” and “we did not distribute any computers or digital devices to any students to take home.” Forty-five percent of public school principals, compared with 20% of private school principals, reported that their school distributed computers to all students. Sixteen percent of public school principals reported that their schools did not distribute computers to any students, while 34% of private school principals reported that their schools did not distribute computers to any students. For additional information on the full range of pandemic-related questions and topics covered in the 2020–21 NTPS, see *Impact of the Coronavirus (COVID-19) Pandemic on Public and Private Elementary and Secondary Education in the United States (Preliminary Data): First Look*.
- <sup>18</sup> Enrollment levels for public schools are reported as fewer than 200 students, 200–499, 500–749, 750–999, and 1,000 or more, while enrollment levels for private schools are reported as fewer than 200, 200–499, 500–749, and 750 or more.
- <sup>19</sup> Four percent of public school principals reported that all students at their school already had internet access, while 58% of private school principals reported so. For additional information on the full range of pandemic-related questions and topics covered in the 2020–21 NTPS, see *Impact of the Coronavirus (COVID-19) Pandemic on Public and Private Elementary and Secondary Education in the United States (Preliminary Data): First Look*.
- <sup>20</sup> More information about the American Rescue Plan Elementary and Secondary School Emergency Relief Fund is available on the U.S. Department of Education, Office of Elementary and Secondary Education’s website at <https://oese.ed.gov/offices/american-rescue-plan/american-rescue-plan-elementary-and-secondary-school-emergency-relief/>.
- <sup>21</sup> Full results from the 2021 School Pulse Panel Summer survey are available on the Institute of Education Sciences website at [https://ies.ed.gov/schoolsurvey/sppsummer/spp\\_summer.xlsx](https://ies.ed.gov/schoolsurvey/sppsummer/spp_summer.xlsx).
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# America's Children at a Glance

	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
<b>Demographic Background</b>			
<b>Child population<sup>a</sup></b>			
Children ages 0–17 in the United States	74.2 million (2020)	73.6 million (2021)	↓
<b>Children as a percentage of the population<sup>a</sup></b>			
Children ages 0–17 in the United States	22.4% (2020)	22.2% (2021)	↓
<b>Racial and ethnic composition<sup>a</sup></b>			
Children ages 0–17 by race and Hispanic origin <sup>b</sup>			
White, non-Hispanic	49.7% (2020)	49.4% (2021)	↓
Black, non-Hispanic	13.7% (2020)	13.8% (2021)	↑
American Indian or Alaska Native, non-Hispanic	0.8% (2020)	0.8% (2021)	NS
Asian, non-Hispanic	5.4% (2020)	5.4% (2021)	NS
Native Hawaiian or Other Pacific Islander, non-Hispanic	0.2% (2020)	0.2% (2021)	NS
Two or more races, non-Hispanic	4.6% (2020)	4.7% (2021)	↑
Hispanic	25.6% (2020)	25.7% (2021)	↑
<b>Family and Social Environment</b>			
<b>Family structure and children's living arrangements</b>			
Children ages 0–17 living with two married parents	67% (2020)	65% (2021)	↓
<b>Births to unmarried women</b>			
Births to unmarried women ages 15–44	40 per 1,000 (2019)	39 per 1,000 (2020)	↓
Births to unmarried women among all births	40% (2019)	41% (2020)	↑
<b>Child care</b>			
Children ages 3–5, not yet enrolled in kindergarten with employed mothers, whose primary child care arrangement was nonparental care on a regular basis	85% (2016)	86% (2019)	NS
Children ages 3–5, not yet enrolled in kindergarten with employed mothers, who were in center-based care arrangements for any amount of time	70% (2016)	69% (2019)	NS
<b>Children of at least one foreign-born parent</b>			
Children ages 0–17 living with at least one foreign-born parent	25% (2020)	25% (2021)	NS
<b>Language spoken at home and difficulty speaking English</b>			
Children ages 5–17 who speak a language other than English at home	23% (2018)	23% (2019)	NS
Children ages 5–17 who speak a language other than English at home and who have difficulty speaking English	4% (2018)	4% (2019)	NS
<b>Adolescent births</b>			
Births to females ages 15–17	7 per 1,000 (2019)	6 per 1,000 (2020)	↓
<b>Child maltreatment<sup>a</sup></b>			
Substantiated reports of maltreatment of children ages 0–17	8.9 per 1,000 (2019)	8.4 per 1,000 (2020)	↓

See notes at end of table.

Legend: NC = Not calculated

NS = No statistically significant change

↑ = Statistically significant increase

↓ = Statistically significant decrease

# America's Children at a Glance—Continued

	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
<b>Economic Circumstances</b>			
<b>Child poverty and family income</b>			
Children ages 0–17 in poverty	14.4% (2019)	16.1% (2020)	↑
Children living in families in extreme poverty	6.2% (2019)	7.6% (2020)	↑
<b>Secure parental employment</b>			
Children ages 0–17 living with at least one parent employed year-round, full-time	80.2% (2019)	71.7% (2020)	↓
<b>Food insecurity</b>			
Children ages 0–17 in households classified by the USDA as “food insecure”	15% (2019)	16% (2020)	↑
<b>Health Care</b>			
<b>Health insurance coverage</b>			
Children ages 0–17 who were uninsured at the time of interview	5% (2019)	5% (2020)	NS
<b>Usual source of health care</b>			
Children ages 0–17 with no usual source of health care	3% (2019)	2% (2020)	NS
<b>Immunization</b>			
Children ages 24 months with the combined 7-vaccine series	70% (2016) <sup>c</sup>	70% (2017) <sup>c</sup>	NS
<b>Oral health</b>			
Children ages 5–17 with a dental visit in the past year	91% (2019)	89% (2020)	↓
<b>Physical Environment and Safety</b>			
<b>Outdoor air quality</b>			
Children ages 0–17 living in counties with pollutant concentrations above the levels of the current air quality standards	64.1% (2018)	50.5% (2019)	↓
<b>Secondhand smoke</b>			
Children ages 4–11 with any detectable blood cotinine level, a measure for recent exposure to secondhand smoke	37% (2015–2016)	36% (2017–2018)	NS
<b>Drinking water quality</b>			
Children served by community water systems that did not meet all applicable health-based drinking water standards	9% (2018)	7% (2019)	NS
<b>Lead in the blood of children</b>			
Children ages 1–5 with blood lead greater than or equal to 5 µg/dL	2.6% (2007–2010)	0.8% (2013–2018)	↓
<b>Housing problems</b>			
Households with children ages 0–17 reporting shelter cost burden, crowding, and/or physically inadequate housing	39% (2017)	38% (2018)	↓
<b>Youth victims of serious violent crimes<sup>d</sup></b>			
Serious violent crime victimization of youth ages 12–17	6 per 1,000 (2019)	4 per 1,000 (2020)	NS
<b>Child injury and mortality</b>			
Injury deaths of children ages 1–4	9 per 100,000 (2019)	10 per 100,000 (2020)	↑

See notes at end of table.

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# America's Children at a Glance—Continued

	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
<b>Physical Environment and Safety—cont.</b>			
<b>Child injury and mortality—cont.</b>			
Injury deaths of children ages 5–14	6 per 100,000 (2019)	7 per 100,000 (2020)	↑
<b>Adolescent injury and mortality</b>			
Injury deaths of adolescents ages 15–19	37 per 100,000 (2019)	46 per 100,000 (2020)	↑
<b>Behavior</b>			
<b>Regular cigarette smoking</b>			
Students who reported smoking daily in the past 30 days			
8th grade	0.8% (2020)	0.4% (2021)	NS
10th grade	1% (2020)	1% (2021)	NS
12th grade	3% (2020)	2% (2021)	NS
<b>Alcohol use</b>			
Students who reported having 5 or more alcoholic beverages in a row in the past 2 weeks			
8th grade	5% (2020)	3% (2021)	↓
10th grade	10% (2020)	6% (2021)	↓
12th grade	17% (2020)	12% (2021)	↓
<b>Illicit drug use</b>			
Students who reported using illicit drugs in the past 30 days			
8th grade	9% (2020)	6% (2021)	↓
10th grade	18% (2020)	11% (2021)	↓
12th grade	22% (2020)	21% (2021)	NS
<b>Sexual activity</b>			
High school students who reported ever having had sexual intercourse	40% (2017)	38% (2019)	NS
<b>Youth perpetrators of serious violent crimes<sup>d</sup></b>			
Youth offenders ages 12–17 involved in serious violent crimes	5 per 1,000 (2019)	4 per 1,000 (2020)	NS
<b>Education</b>			
<b>Family reading to young children</b>			
Children ages 3–5 who were read to 3 or more times in the last week	81% (2016)	85% (2019)	↑
<b>Mathematics and reading achievement</b>			
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)	152 (2015)	150 (2019)	NS

See notes at end of table.

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# America's Children at a Glance—Continued

	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
<b>Education—cont.</b>			
<b>Mathematics and reading achievement—cont.</b>			
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)	287 (2015)	285 (2019)	↓
<b>High school completion</b>			
Young adults ages 18–24 who have completed high school	94% (2019)	94% (2020)	NS
<b>Youth neither enrolled in school<sup>e</sup> nor working</b>			
Youth ages 16–19 who are neither enrolled in school nor working	10% (2020)	9% (2021)	↓
<b>College enrollment</b>			
Recent high school completers enrolled in college the October immediately after completing high school	66% (2019)	63% (2020)	NS
<b>Health</b>			
<b>Preterm birth and low birthweight</b>			
Infants less than 37 completed weeks of gestation at birth	10.2% (2019)	10.1% (2020)	↓
Infants weighing less than 5 lb 8 oz at birth	8.3% (2019)	8.2% (2020)	↓
<b>Infant mortality</b>			
Deaths before first birthday	6 per 1,000 (2018)	6 per 1,000 (2019)	NS
<b>Emotional and behavioral difficulties</b>			
Children ages 4–17 reported by a parent to have serious difficulties with emotions, concentration, behavior, or getting along with other people	6% (2018)	6%* (2019)	NC
<b>Adolescent depression</b>			
Youth ages 12–17 with past-year major depressive episode	16% (2019)	17%** (2020)	NC
<b>Activity limitation</b>			
Children ages 5–17 with activity limitation resulting from one or more chronic health conditions	11% (2017)	10% (2018)	NS
<b>Obesity</b>			
Children ages 6–17 with obesity	20% (2011–2014)	20% (2015–2018)	NS
<b>Asthma</b>			
Children ages 0–17 who currently have asthma	8% (2018)	7%* (2019)	NC

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

\*\* Due to methodological changes between 2019 and 2020, exercise caution when comparing estimates from 2020 with prior years.

<sup>a</sup> Population estimates are not sample derived and thus not subject to statistical testing. Change between years identifies differences in the proportionate size of these estimates.

<sup>b</sup> Percentages may not sum to 100 because of rounding.

<sup>c</sup> Data years refer to birth years of children receiving vaccinations.

<sup>d</sup> The 2020 National Crime Victimization Survey (NCVS) weights include an additional adjustment to address the impact of modified field operations due to COVID-19. For more information on the weighting adjustments applied in 2020, see the Source and Accuracy Statement for the 2020 NCVS in the NCVS 2020 Codebook (<https://www.icpsr.umich.edu/web/NACJD/series/95>) and *Criminal Victimization, 2020* (NCJ 301775, BJS, October 2021).

<sup>e</sup> School refers to high school and college.

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