

**An Overview of State-Level Data on Child Well-Being Available through the  
Federal Statistical System**

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## Executive Summary

Over the last decade the power of states to develop more effective policies and programs to improve the well-being of children has been substantially strengthened by the increasing availability of high quality child well-being indicator data at the state level. Much of these data have been developed by or under the guidance of federal statistical agencies. We believe it is a good time to take stock of the strengths of the existing data collection system, and to identify opportunities to improve that system in ways that will better serve the needs of children and the policy makers who serve them. In this paper we provide an overview of Federal<sup>1</sup> sources of social indicator data on children's well-being that provide estimates at the state-level, that is, for children in individual states.<sup>2</sup> Twenty-one major survey and administrative data sources are summarized and discussed. (See Table 2.) Areas of strength are identified, as are important gaps and opportunities for future development. In addition, we provide an Appendix that includes systematic one- to two-page summaries for each of the data sources reviewed for purpose, content, and periodicity.

Several important opportunities are identified for increasing and preserving child indicator data available on a state by state basis. These include:

- Increase data collected between infancy and age ten; consider fielding a new survey of young children
- Field the NSCH more frequently than every four years in order to provide policy makers with current data
- Increase data collection and measurement development in the following areas: socioemotional development, peer and neighborhood influences
- Preserve recent gains, especially the National Survey of Children's Health (NSCH) and the American Community Survey (ACS)
- Collect more self-reported data for older children and adolescents to collect reliable data on such topics as emotional well-being, attitudes, and delinquency, especially in the NSCH
- Increase the collection of data on positive development and positive social contexts
- Collect data for large samples of low-income families with children to support detailed analyses of this policy-critical population subgroup
- Consistently identify rural/urban location on public data sets to support separate estimates for rural and urban children
- Ensure adequate support for processing vital statistics birth and death data.

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<sup>1</sup> Federal data collection programs are currently the only source of indicator data on child and youth well-being that are comparable across states. Comparability allows states to compare their own experience to those of similar and neighboring states, and allows federal agencies to assess need and monitor progress across states in a fair and consistent manner. Private organizations like KIDS COUNT report comparable data collected through federal programs, but do not collect their own original data. One exception is the National Survey of America's Families, which was collected by the Urban Institute, Child Trends, and Westat. However, this survey ended in 2002.

<sup>2</sup> We exclude otherwise rich sources of child well-being data such as the Panel Study of Income Dynamics and the National Household Education Surveys because they are national in focus and are not capable of producing estimates for individual states.

Existing data are assessed according to the topics covered, frequency of measurement, populations covered, geographic coverage (which states), and the capacity to produce subgroup estimates. Topical areas reviewed include:

- *child and youth well-being* (health, education and intellectual development; and social/emotional and civic well-being);
- *demographic and economic factors* (e.g., age, race, family structure, income); and
- *social contextual influences* affecting well-being (family, peers, school, and community).

Our findings and recommendations are summarized below.

### *Topical Coverage*

While the breadth of indicator data available at the state level has grown significantly in the last few years, there are substantial gaps where data are thin or nonexistent. Filling those gaps would substantially strengthen state-level planning and monitoring efforts, as well as Federal planning and accountability efforts vis-à-vis the states. For example, policy makers would benefit from knowing the health status and child care arrangements of children in each state, as well as the nation. In addition, it is vital that recent additions to the data collection system such as the National Survey of Children's Health and the American Community Survey be maintained and strengthened in the coming decade.

- Health. Across the four child well-being areas, health outcomes are clearly the most thoroughly covered domain. Of particular importance is the SLAITS data collection system, which supports three major periodically collected state-level surveys including the National Immunization Survey (NIS), the National Survey of Children's Health (NSCH), and the Children with Special Health Care Needs survey (CSHCN). Such information informs services and planning to meet children's needs for health care. Other surveys providing health data for some or all states include the Youth Risk Behavior Survey (YRBS), the National Health Interview Survey (NHIS), and the National Survey of Drug Use and Health (NSDUH).
- Education. Educational child well-being data features the assessments gathered for public schools through the National Assessment of Educational Progress (NAEP), now mandatory every other year in mathematics and reading for 4<sup>th</sup> and 8<sup>th</sup> grade, as well as high school graduation and dropout data from the Common Core of Data and educational attainment data from Current Population Survey (CPS)—though the CPS estimates require combining several years of data. Education and intellectual development data for younger children (below the 4<sup>th</sup> grade) are limited to a few questions on developmental delay and grade repetition on the NSCH, and attendance data in the American Community Survey. With strong policy interest in pre-school and early elementary school, more data are needed for younger children.
- Social/Emotional/Civic Development. Data are very limited in this domain of well-being. Available data are mostly negative, focusing on depression, emotional disturbance, and violence. Data on positive outcomes are limited to a few questions in the National Survey

of Children's Health (NSCH) concerning social competence and volunteering activities. Positive constructs such as conflict resolution skills, tolerance, and hope are lacking.

- Family Context. The current data system provides family demographic, income and poverty measures at the state level and below. The American Community Survey (ACS), already produces annual estimates for areas with a population as small as 65,000, and will eventually provide such estimates down to the neighborhood level. The Current Population Survey has also provided such data at the state level, though it is less precise than estimates from the ACS, especially for less populous states. On the other hand, measures related to family functioning, also very important to good child development, are largely absent except for a small number of questions on the NSCH. In addition, it is not always possible to identify all biological parents in the child's household, particularly if the parents are not married.
- Peer Context. Data on peer characteristics and influences are virtually nonexistent at the state level, limited to a few questions related to drug use and bullying in the NSCH, The National Survey of Drug Use and Health (NSDUH), and the Youth Tobacco Survey (YTS). Especially for teens, data on peer behaviors and influences could inform the development and content of youth programs.
- School Context. There is a great deal of data collected about the school environment related to education policy, teacher and curriculum characteristics, and types of social problems in the schools. These data are collected largely from teachers and school administrators, though, and so lack any student assessments of the school as an environment for learning. These data are also largely confined to public schools at the state level.
- Community Context. Thanks to the decennial census and the American Community Survey, there is a solid set of the demographic and income-related indicators of community context (e.g., poverty levels, rates of female headship). In addition, through the NSCH there are important parent assessments of neighborhood cohesion and supports, safety, and negative influences, though only every four years.

### *Regular Tracking*

Most of the data sources reviewed produce new estimates every year or two. Notable exceptions are the NSCH and the CSCHN, which are scheduled to be fielded every four years. This schedule represents a significant gap in our information because the NSCH collects many important measures that are not covered by other data sources. In addition, data are not always released in a timely manner, making them less valuable for informing policy.

### *Population Coverage*

The most obvious coverage gap in the existing data system is the modest amount of data collected between infancy and adolescence. Between the ages of three and nine, the ACS and the NSCH are the main sources of data, and while they both supply some important demographic information and the NSCH supplies considerable information on well-being, they present a

picture of well-being that is far from complete (e.g., data on education and intellectual development are limited).

### *Geographic Coverage*

In the last few years, basically since 2000, there has been significant expansion in the amount of state-level data available for the 50 states and the District of Columbia. However, the territories, like the Virgin Islands, Guam, American Samoa, the Northern Marianas, and Puerto Rico, are not consistently represented in most data collection activities covered in this report.

### *Capacity to Produce Subgroup Estimates*

Most of the data sources reviewed have adequate sample sizes to produce basic subgroup estimates by such characteristics as age, gender, poverty status, and race. However, they are much more limited in their capacity to produce subgroup estimates for more than one characteristic at a time, compared with the national-level surveys which have much larger sample sizes. For example, it would be difficult in most cases to get a reliable estimate of the percent of poor Hispanic children ages 0-5 with a particular characteristic at the state level.

All data systems are challenged by fiscal constraints, and these constraints are starting to affect the availability of information. For example, vital statistics data (birth and death data) for the last month of FY2006 may not be processed due to federal budget shortfalls. Hence, while there is reason to be pleased with recent gains in state level data on children, the gains are precarious, and important gaps remain.

# An Overview of State-Level Data on Child Well-Being Available through the Federal Statistical System

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*Socio-Demographic Surveys and Administrative Data*

- The American Community Survey (ACS)
- Census Population Estimates and Projections
- Census Small Area Income and Poverty Estimates (SAIPE)
- The Current Population Survey (CPS)
- Decennial Census
- Vital Statistics Birth Data
- Vital Statistics Death Data

*Health and Safety Data Sources*

- Children with Special Health Care Needs survey (CSHCN)
- National Health Interview Survey (NHIS)
- National Immunization Survey (NIS)
- National Survey of Children's Health (NSCH)
- National Survey of Drug Use and Health (NSDUH)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Youth Risk Behavior Survey (YRBS)
- Youth Tobacco Survey (YTS)

*Education*

- Common Core of Data (CCD)
- Enrollment and High School Graduation Projections
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- Adoption and Foster Care Analysis Reporting System (AFCARS)
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## **Introduction**

The capacity to monitor the health and development of children is essential for strong government planning, for goal-setting and tracking, and for accountability efforts designed to improve children's lives. Most of those activities take place at the state level or at the community level, so it is critical that states have rich stocks of data to draw from about the children in their own state. It is equally important that the Federal government has access to data that are comparable across states to aid in their own activities. Federal funds support many of the programs designed to improve child and youth well-being, which are nevertheless administered at the state level and below. Responsible Federal agencies have a strong interest in access to high quality state-level data to effectively target limited funds, to treat states equitably, and to hold states accountable.

In this paper we offer an overview of Federal sources of social indicator data on children's well-being available at the state level and below. Twenty-one major survey and administrative data sources are summarized and discussed. Administrative data are collected by agencies in the course of their work, such as reports of child abuse and neglect and records of birth and death. Surveys, on the other hand, draw a representative sample of a population, such as a state, and conduct interviews or otherwise collect information from the sampled person, family, or household. Areas of strength are identified, as are important gaps and opportunities for future development. In addition, we provide an Appendix that includes systematic one- to two-page summaries for each of the data sources reviewed for purpose, content, and periodicity. Valuable surveys such as the Survey of Income and Program Participation (SIPP) and the National Survey of Family Growth are not described here because, while they provide estimates for the nation as a whole, they cannot provide estimates for individual states. Some administrative data sources that do collect data at the state level, such as the National TANF Datafile, were omitted because of their narrow focus and because other sources offer similar information that are better suited for the production of social indicator data.

## How are State-Level Data on Child Well-Being Used by Federal and State Policy Makers? Some Examples

Since the early 1990s there has been a steady expansion in the use of child well-being indicator data to support policy and program development at all levels of government. Common uses include:<sup>3</sup>

- *Description*, to understand the characteristics of the population;
- *Monitoring and needs assessment* to identify areas of emerging need;
- *Goals tracking* to monitor progress towards measurable social goals (e.g., “we will achieve a 25 percent reduction in teen birth over the next decade”);
- *Accountability* to hold agencies, governments, and entire communities accountable for improving the lives of children in specific ways; and
- *Reflective practice*, so that governments and communities can use these data to continuously improve their program design and policies.

The use of social indicators at the state level has particularly increased over the last decade as states have taken on greater responsibility for the design and execution of programs affecting children and their families in a process sometimes referred to as devolution.<sup>4</sup>

A number of major federal programs use indicator data to help states set goals and to monitor their progress in meeting these goals. For example, Healthy People 2010, the nation’s most comprehensive health promotion initiative, sets achievable health goals for the nation in consultation with the states, and works with states who adapt them to guide their own health promotion efforts. Many states monitor indicators such as the teen birth rate and the proportion of children fully immunized. New sources of data such as the Youth Risk Behavior Survey (see below) have been developed specifically to provide states with the means to monitor their progress under this initiative.

A second major federal program, No Child Left Behind, uses student assessment data to hold states accountable for adequate yearly progress toward broader education goals. Each state has its own system of assessment and goals specific to those assessments. Repeated failure to make adequate yearly progress can result in mandatory corrective actions and sanctions. In addition to the state specific assessments, all states are also required to participate in the National Assessment of educational Progress (NAEP), which provides assessments that are comparable across states and allows states to evaluate how they are performing relative to others. (See below for details)

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<sup>3</sup> For a more detailed discussion see Brown, B., and Corbett, T. (2003). Social indicators as tools of public policy. in Roger Weissberg, H. Walberg, M.U. O’Brien, & C.B. Kuster (Eds.), Long-term Trends in the Well-being of Children and Families, Washington DC: CWLA Press, pp. 27–49.

See also Moore, K.A., Brown, B., Scarupa, H. (February 2003). The Uses (and Misuses) of Social Implications for Public Policy. *Research Brief*. Washington, D.C.: Child Trends.

<sup>4</sup> Brown and Corbett (2003).

Beyond federal programs, many states have independently embraced the systematic use of social indicator data to guide state and community-level policies intended to improve the well-being of children and their families, and the general population. The state of Vermont has been a long-time leader in this area, taking a strong “outcomes-based” approach to state health and education policy development at the state and local levels. Central to this effort is the collection and dissemination of timely and regularly updated social indicators of child well-being. Government and private organizations and individuals are all seen as necessary partners in these efforts, and indicators play a key role in coordinating and informing their work. Annual reports at the state and community levels are widely disseminated and used in the policymaking process.<sup>5</sup>

States have also adopted an indicators-based approach on more specific issues, sometimes banding together for mutual support and guidance. Recently 17 states came together to form the National School Readiness Indicators Initiative. This group identified a core set of indicators that could be used across states to guide school readiness policy decisions, and individual states also identified other indicators that were relevant to their own particular political and economic context.<sup>6</sup> Results are being incorporated into plans for promoting school readiness in participating states.

### **What are the Characteristics of a Strong State-Level Data System on Children?**

For this review we have emphasized the following characteristics as essential for a strong state-level system of indicators of child well-being:<sup>7</sup>

#### *Comprehensiveness*

All domains of child well-being should be adequately represented by the data including key measures of physical and behavioral health, social and emotional development, civic engagement, education and intellectual development. In addition, indicators of the social influences that shape child development and well-being from the family, peer, school, and neighborhood or community, should also be included. While they are not themselves measures of well-being, they strongly influence well-being and are often the primary targets of policies and programs intended to improve the lives of children.

#### *Comparability*

Indicators should be comparable across states to facilitate valid comparisons. (See Table 1) Comparability allows states to compare their own experience to those of similar and neighboring states, and allows federal agencies to assess need and monitor progress across states in a fair and consistent manner. All of the data sources reviewed in this paper meet or attempt to meet this

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<sup>5</sup> For additional information see Murphey, D. (2006) Vermont Well-Being 2006: A Social Indicators Sourcebook. Vermont Agency of Human Services.

<sup>6</sup> For details, see Rhode Island KIDS COUNT. (2005) Getting Ready: Findings from the National School Readiness Indicators Initiative, A 17 State Partnership. [http://www.gettingready.org/matriarch/MultiPiecePage.asp\\_Q\\_PageID\\_E\\_318\\_A\\_PageName\\_E\\_NationalSchoolReadinessIndicat](http://www.gettingready.org/matriarch/MultiPiecePage.asp_Q_PageID_E_318_A_PageName_E_NationalSchoolReadinessIndicat)

<sup>7</sup> For a more detailed treatment see Moore, K.A. (1997) Criteria for indicators of child well-being. In R., Hauser, B. Brown, and W. Prosser (Eds) *Indicators of Children's Well-Being*. New York: Russell-Sage Foundation.



criterion, though some are more successful than others. While many states, like Florida, participate in all of the data collection efforts reviewed in this paper, others, like Wyoming and Massachusetts, do not participate in several of the voluntary surveys, so their experience cannot be compared to other states on topics covered by those surveys. As a practical matter, comparability across states requires that data collection be coordinated at the Federal level, at least in the vast majority of cases.

### *Regular Tracking*

To be useful as policy and planning tools, indicators need to be tracked over time, updated regularly, and released in a timely manner. This allows for the early identification of emerging needs, and the timely assessment of whether goals are being met. The optimal interval for measurement can depend on many factors including the importance of the outcome for policy, how quickly the outcome can change, and so on. Stock market averages are updated continuously. Social indicators are not updated so often nor need be. Many are updated on an annual or biennial basis, while others are updated less frequently.

### *Capable of Producing Estimates for Key Subgroups*

It is important that a data system be capable of generating separate, reliable estimates for children from a variety of social backgrounds including groups defined by gender, race, income level, and disability status. The reduction of disparities across select social groups is a central focus of the *Healthy People 2010* and the *No Child Left Behind* initiatives, two major Federal initiatives that rely heavily on social indicator data to monitor progress. Producing estimates for subgroups requires samples at the state level that are larger than many data systems have.

## **What Data are Currently Available?**

Child Trends has reviewed 21 major Federal sources of state-level data on children, youth, and their families. The Appendix provides one-to-two page summaries for each of the data sources including a basic description, how often data are gathered, what states are covered, age groups covered, sample size, limitations, web site information, and what well-being outcomes and contextual influences are measured. What follows is a brief summary of each data source. Only regularly fielded surveys and administrative data sources are included. A summary of content across data sources is provided in Table 2.

### *Social, Demographic and Economic Surveys and Administrative Data*

Socio-Demographic measures include measures related to family and household structure and composition, population counts, income and employment data, as well as basic data on birth and death. There are five major Federal data sources that provide basic socio-demographic data on children and their families at the state level. These sources include: the Decennial Census; the American Community Survey; Small Area Income and Poverty Estimates (SAIPE); Vital Statistics Birth and Death data; and the Current Population Survey (CPS). All but the CPS are also the primary sources of Federal child and family data at the community level. In addition, the Census Bureau produces model-based population estimates at the state and county levels for



children under the age of 18. All provide estimates for each of the 50 states and the District of Columbia.

#### Decennial Census and The American Community Survey

The Decennial Census is collected every ten years, and has traditionally provided social and economic data down to the neighborhood level and basic demographic data down to the block level. The American Community Survey (ACS), fully implemented in 2005, will provide annual estimates for places with a population as small as 65,000 beginning in 2006, and will provide 5-year rolling averages down to the census tract level (areas with populations between about 2500 and 8000) beginning in 2010. The current plan, assuming the ACS continues to be funded, is to limit the 2010 census to essential “short form” information, while the ACS collects virtually all of the detailed social and economic information formerly collected through the decennial census. This represents a major step forward in data collection, with the ACS providing strong *annual* estimates at the state level that were previously available only once per decade.

The ACS and Decennial Census include only a few measures of child well-being including chronic health conditions, school enrollment status and educational attainment. They do collect important background characteristics of the child including age, sex, race and ethnic origin, and citizenship. Employment and income data are also collected for those ages 16 and above. There is a wealth of detailed data collected on the households in which children live including household and family structure, and income and employment. In addition, the ACS will help to provide population estimates that can be used by other data systems to estimate population rates (for example, the teen birth rate).

#### Population Estimates and Projections

The Census Bureau also produces annual estimates of the population by single year of age and gender at the state and county levels. Estimates are also provided separately by race and Hispanic origin, by single year of age at the state level, and by 5-year age groups at the county level. Population projections based on the 2000 census are currently available at the state level through the year 2030, for age groups 0-4, 5-13, and 14-17.

#### Small Area Income and Poverty Estimates Program (SAIPE)

Through this program, run by the Census Bureau with support from other Federal agencies, estimates of child poverty are generated at the state, county, and school district levels. These estimates are derived using models that draw upon many sources of data as model inputs, including the Current Population Survey, IRS income tax return data, food stamp administrative data, and population estimates. There is a 3-year time lag in the estimates (2003 estimates are the latest estimates available in 2006).

#### The Current Population Survey (CPS)

The CPS is a monthly survey whose primary purpose is collecting income, labor force, and employment information on the U.S. civilian population. The Annual Social and Economic Supplement, collected in March of each year, collects more detailed information about work experience, income, noncash benefits, and migration. In 2001, its sample size was expanded specifically to support annual estimates of child health insurance coverage for every state and the District of Columbia. Like the ACS, this data source has few measures of child well-being. The

relatively small sample sizes for many states also limit the estimates that can be produced. Producing state-level estimates for population subgroups may require that data be aggregated across several years, reducing its utility by making it less current. The Census Bureau regularly publishes state-level estimates on insurance coverage and poverty for children under the age of 18.

#### Vital Statistics Birth and Death Data

These are administrative data sources that compile information gathered on virtually all births and deaths in the U.S. based on birth and death certificates. Data are collected in each of the 50 states, Washington, D.C., and the Territories. Population counts and rates (e.g., teen births per 1,000 females ages 15-19) are regularly reported down to the state level by the Centers for Disease Control and Prevention. Individual state agencies and state KIDS COUNT organizations regularly report this information at the county level, though this often requires combining multiple years of data in order to produce reliable rates.<sup>8</sup>

Data collection is based on standardized birth and death certificates, which are revised approximately every 11 years. There is some variation across states, as states transition to the new versions at different rates, and some states do not collect all of the information on the standard certificates. Overall, however, there is substantial uniformity in what is collected across states.

Birth data include measures related to the newborn from which one can generate indicators of low birth weight and premature birth, abnormal conditions or anomalies, and whether the infant is being breastfed. Gender, race and Hispanic origin are also recorded. Parental characteristics include age (used to generate teen birthrates) and marital status (used to generate nonmarital birth rates), educational attainment, race and Hispanic origin. Pre-birth information includes timing and frequency of pre-natal care received, maternal smoking, and WIC receipt.

Death data include detailed information on cause of death using standardized international ICD-10 codes.<sup>9</sup> The data are commonly used to produce overall death rates (infant, teen, etc), as well as indicators for leading causes of death (e.g., suicide, homicide, injury-related death rates). Data are collected on age, gender, race, Hispanic origin, and employment status and type.

Due to a federal budget shortfall it appears that vital statistics data for the final month of 2006 may not be processed.

#### *Health and Safety Data Sources*

Historically, administrative data have been the primary sources of state-level data collected through the Federal statistical system. Vital Statistics birth and death data (discussed above) remain an important data resource, and are still the primary Federal resource for health-related

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<sup>8</sup> When small numbers of occurrences are involved, random fluctuations from year to year (say from 2 deaths to 4 and back to 2 again) will result in large increases and decreases in the death rate that do not represent meaningful trends. To avoid this problem, it is common practice to look at trends based on multi-year averages.

<sup>9</sup> ICD codes are from the International Statistical Classification of Diseases and Related Health Problems, published by the World Health Organization.



Over 5,000 families with children under the age of 18 in each state were contacted in order to locate 850 families who had children with special health care needs. A modest amount of health data related to immunization and medical conditions were collected on children in the 5000+ households, and much more detailed information was gathered on those determined to have special health care needs. The survey was first fielded in 2000-2002, and a second round is in the field in 2005-2006. All 50 states and the District of Columbia are included.

#### National Survey of Drug Use and Health (NSDUH)

The NSDUH is the primary source of data on illegal drug use among the non-institutionalized population of the U.S. ages 12 and older. In addition to data on the prevalence, patterns, attitudes, and consequences of drug use, the survey also provides data on mental health, substance abuse and dependence, and substance abuse treatment. There are also questions about the family, peer, school, and community environments as they relate to drug use. Youth ages 12-17 and 18-24 were over sampled to allow for state-level estimates for these age groups. This is an annual survey.

State estimates are generated using statistical models due to limited sample sizes for smaller states. Even with over-sampling, small state sample sizes for youths mean that state-level estimates for population subgroups (e.g. by race, gender, income) are very limited.

#### Small Area Health Insurance Estimates (SAHIE)

SAHIE is a recently developed program to produce estimates of health insurance coverage for the total population and for children under age 18 at the county and state levels. It is the only source of county-level estimates for health insurance coverage. Estimates are produced based on models that incorporate data from a number of sources including Medicaid and Food Stamp records, federal tax return data, population estimates, and the March Current Population Survey. Estimates under this program are still considered experimental, so we have chosen not to include it in the paper's appendix of data resource descriptions. For additional information, visit <http://www.census.gov/hhes/www/sahie/index.html>.

#### Youth Risk Behavior Survey (YRBS)

The YRBS is designed to monitor major youth health risk behaviors in six broad areas: tobacco use; dietary behaviors; physical activity; alcohol and other drug use; behaviors related to injury and violence; and sexual behaviors contributing to unintended pregnancy and STDs. It is used, among other purposes, to monitor progress towards meeting Healthy People goals in reducing negative youth health behaviors and their consequences. Students in grades 9-12 have been surveyed every second year since 1990. In 2005, 44 states and 21 major cities participated. Also in 2005, a special middle-school version of the survey was conducted in selected states.

Some states do not field certain questions viewed as sensitive in the survey, often those having to do with sexual behaviors. States are also free to add their own questions. Typically, some states are unable to achieve a CDC-certified representative sample, so that the resulting estimates are not reliably representative of high school students in that state. For example in 2005, about ninety percent of the participating states—or 40 states-- had representative samples.

### Youth Tobacco Survey (YTS)

The YTS was designed to help states in the design, implementation, and evaluation of youth tobacco prevention and control programs. The survey provides data in the following seven areas: tobacco use, tobacco use cessation, tobacco-related attitudes and knowledge, role of advertising and media in tobacco use, minors' access to tobacco, environmental tobacco smoke, and tobacco-related curriculum in schools. Students in middle school and high school (grades six through 12) are included in the surveys.

Over 20 states currently participate in the survey, fielding it every year or two at the state's discretion. Sample sizes can vary greatly from state to state. States with smaller samples are more limited in their ability to produce statistically reliable estimates for population subgroups.

### Pregnancy Risk Assessment Monitoring System (PRAMS)

PRAMS is designed to provide data needed to help states improve the health of newborns, infants, and their mothers, and to reduce infant mortality. Areas covered include prenatal care, obstetric history, maternal use of alcohol and cigarettes, domestic abuse, contraception, economic status, maternal stress, early infant development and health status; breastfeeding; well-child visits; maternal nutrition; pregnancy intendedness; and parenting practices. States can also develop and add questions of their own. In addition, survey data are combined with birth certificate data for all participants, so that analyses can take advantage of the data collected from both sources.

Surveys are fielded continuously throughout the year, though not all participating states field surveys every year. Currently 38 states and New York City participate.

### National Health Interview Survey (NHIS)

The NHIS is a comprehensive health survey that is used to track and monitor illness, to estimate the prevalence of health problems, access barriers and use of health care, and to measure progress towards national health goals for the U.S. civilian population. Basic health data are collected for every member of the household. More detailed information is collected on a single "sample child" and "sample adult" within the household. When the sample adult is also the sample child's parent, the NHIS is a unique source of detailed data on parental health.

Data are gathered on a wide variety of topics related to child health including: basic health status; limitations; injury; hearing and vision difficulties; socio-emotional problems; positive social behaviors; contact with the health care system; difficulties paying for care; and health insurance coverage and periods of non-coverage. Extensive sociodemographic data for the family are also gathered.

Estimates can be produced at the state level for many states, though less populous states are not separately identified but are combined into multi-state groups due to small sample sizes. In addition, to protect respondent confidentiality, random statistical noise is introduced into the raw data containing state identifiers. Sample sizes allow for subgroup estimates in the larger states.





or the risk of maltreatment. In addition, data are available on the characteristics of the perpetrator and the caretaker (usually a parent). Data on child welfare services received are also available.

### Adoption and Foster Care Analysis Reporting System (AFCARS)

The AFCARS system monitors all children in state foster care systems and all adopted children placed by the state's child welfare agency or private agencies under contract with the welfare agency. Data are collected on many aspects of each child's physical and mental health; the reason they have been placed in foster care; as well as characteristics of the parents and the foster/adoptive family. Data on children in foster care include average length of stay, and outcome or disposition on exit from foster care (e.g., emancipation or adoption). All 50 states, the District of Columbia, and Puerto Rico participate in the AFCARS reporting system.

## DISCUSSION

Over the last fifteen years social indicators have become increasingly indispensable tools for planning, goals-setting, and accountability at all levels of government and between levels of government.<sup>12</sup> The progressive devolution of government responsibility from the federal to the state level that has occurred during that period has only amplified the need for more and better data at the state level. Within this climate, the expansion of federally organized efforts to track child and youth well-being at the state level is a clear acknowledgement of the growing importance of such data to support federal planning and accountability efforts with the states, and its importance to the states themselves as they seek to improve the lives of their own children.

The question has always been whether state-level data collection efforts would be able to catch up with that growing need. Our conclusion is that substantial progress has been made, but that that progress is precarious, and there are critical gaps yet to be filled.

In addition, we note that technological improvements over the last 20 years have significantly improved the cost-effectiveness and quality of survey data collection, both in-person and by telephone. To be cost-effective, surveys that are designed to produce state-level estimates overwhelmingly rely on telephone administration due to the sheer number of households that must be contacted. Recent declines in response rates have increased the cost of data collection somewhat (e.g., for follow-up contacts and incentives). However, research indicates that well-designed and well-executed telephone surveys are a cost effective means of producing high quality estimates that one can use with confidence for research and for making policy decisions.<sup>13</sup>

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<sup>12</sup> Brown, B. and Corbett, T. (2003). Social indicators as tools of public policy. in Roger Weissberg, H. Walberg, M.U. O'Brien, & C.B. Kuster (Eds.), Long-term trends in the well-being of children and families, Washington DC: CWLA Press, pp. 27-49.

<sup>13</sup> Keeter, Scott, Carolyn Miller, Andrew Kohut, Robert Groves, and Stanley Presser. 2000. "Consequences of Reducing Nonresponse in a Large National Telephone Survey." *Public Opinion Quarterly* 64:125-48. See also Groves, R., Fowler, F., Couper, M., Lepkowski, J, Singer, E., and Tourangeau, R. (2004). *Survey Methodology*. page 7. Hoboken: John Wiley and Sons.

In 1990, the amount of federally sponsored state-level indicator data available on children's well-being was quite thin. Resources included administrative data from the vital statistics system, decennial census information, and education data collected through the Common Core of Data. The only periodically collected *survey* data providing state-level information on children's well-being was the Schools and Staffing Survey (SASS) and the Pregnancy Risk Assessment Monitoring System), both launched in the mid-1980s. The Current Population Survey was also used to produce state estimates, but required combining three or more years of data in order to produce reasonable estimates for smaller states.

Since the early 1990s, there has been a significant expansion of state-level data collected through surveys and assessments by the Federal government, with a lot of the activity taking place since 2000. Several strategies have been employed to accomplish this task, including:

- fielding new surveys and administrative data collection activities (NIS, NSCH, CSHCN, ACS, NCANDS, AFCARS);
- the redesign and expansion of the sampling frames of existing surveys to allow for state-level estimates (CPS, NHIS);
- the creation of statistical models to create synthetic state estimates (NSDUH, SAIPE);
- making previously voluntary state surveys mandatory for all states (NAEP); and
- adding new questions to existing data collection activities (CSHCN, birth certificate data).

### *Topical Coverage*

#### Health

Of all the domains reviewed for this report, health clearly has the lead in terms of well-being data for children. Data from the NSCH, CSHCN, NSDUH and Vital Statistics are available for all states. Most states also participate in the YRBS, PRAMS, and the YTS. Substantively, these data sources cover a broad spectrum of physical and emotional conditions and health-related behaviors, immunizations, health insurance coverage, as well as data on access to and experience of health care. There is, particularly for youth, a strong focus on negative health behaviors, such as substance abuse. Data are most plentiful for children ages 12 and older (YRBS, YTS, and NSDUH), and for infants and toddlers (birth data, PRAMS, NIS). State-level health data for children between the ages of two and eleven are not as plentiful, though the NSCH offers health and some other well-being data for all children under age 18.<sup>14</sup> In addition, data on some risky teen behaviors (e.g. sexual activity, delinquency, though not drug use) are not available through youth report for all states, which is problematic since reports or risky behaviors from parents are much less accurate.

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<sup>14</sup> The NHIS has also been used to develop state-specific estimates of health for children of all ages, though primarily for selected more populous states.



lacking, and even the potential set of negative peer influences is not well explored in comparison to the measures available in national level surveys.

### School Context

The NAEP and SASS provide a great deal of data on teacher and curriculum characteristics, educational policy, teacher/student ratios, and levels of social problems in the schools, as well as policies and programs intended to address those problems. These data are collected largely from teachers and school administrators, though, and so lack any student assessments of the school as an environment for learning. In addition, several of the health-focused surveys include questions on drug use in school, as well as the presence of curricula that specifically address drug use, smoking, and HIV/AIDS. There is a notable lack of data on pre-school availability, quality, and attendance at the state level.

### Community Context

Indicators of community context can include sociodemographic measures (e.g., levels of poverty, percent children in two-parent households, percent of working-age men who are employed), health and safety measures (e.g., environmental hazards, crime levels, and presence of gangs), as well as positive measures (e.g., measures of social cohesion and cooperation, presence of adults who youth can talk to about problems), and presence of social resources (e.g., adequate level and quality of after-school programs).

The existing data system is fairly strong in sociodemographic indicators at the community level thanks to the decennial census, and to the ACS, which will begin producing census tract-level estimates in 2009. In addition, the NSCH includes a limited set of measures of community cohesion and supports, and measures of perceived safety and negative influences. No other data sources reviewed contain such measures.

### *Regular Tracking*

Most of the data resources reviewed here put out new estimates every year or two. The ACS, when it began producing state-level data in 2000, was a major advance for tracking sociodemographic characteristics of children and their families. Prior to that time there was only the census, which is conducted every 10 years, and the CPS, which suffers from small sample sizes for many states that greatly limit what could be produced.

Three surveys, however, are repeated only every four years: the NSCH, the CSHCN, and SASS. The NSCH is the vehicle for a substantial number of important and unique measures that are not available elsewhere including measures of neighborhood quality; family functioning; social and emotional development; and some health data for young children. The NSCH, when it came on the scene in 2003, filled a number of important gaps in the system of state-level indicators of child well-being. There is a strong argument to be made that it, like most of the other data sources reviewed here, should be repeated more frequently.

### *Population Coverage*

The most obvious coverage gap in the existing data system is the lack of data collected between infancy and adolescence. Between the ages of three and nine, the ACS and the NSCH are really the main sources of data, and while they supply some important demographic, health, and developmental outcomes they present far from a complete picture of well-being. This leaves us knowing relatively little at the state level about nearly half of all children under the age of 18.

In addition to coverage of the general population, one must consider the coverage of special, high needs populations of children that are of particular interest to policymakers. Several data collection systems are focused on high risk populations including the NCANDS (abused and neglected), the AFCARS (adoption and foster care), and the CSHCN (special health care needs). Noteworthy gaps in this regard include institutionalized children (e.g., those in prison or youth detention centers; those in long-term health care facilities), and youth who have dropped out of school. Most survey data are limited to the civilian, noninstitutionalized population, though in 2006 the ACS has started collecting data on persons living in group quarters (e.g., detention facilities, prisons, and group homes). And, since much of the data collected on teens is taken in school (e.g., NAEP, YRBS, YTS), much less is known about the status of dropouts.

### *Capacity to Produce Subgroup Estimates*

The capacity to produce reliable subgroup estimates is largely a function of sample size. Most of the data sources covered here have large enough sample sizes to produce basic breaks one variable at a time by age group, gender, race/ethnicity (except in states where certain groups are scarce), and socioeconomic status. But, even when sample sizes are relatively large, one can quickly run up against limits. The NSCH, for example, has about 2000 families with children ages 0-17 for each state. If one is interested in a characteristic for pre-school children we are already down to a sample size of about 600; for pre-school children in poor families, about 120; and for poor, black, pre-school children, perhaps 20 or fewer in states with small black populations. For analyses of low-income populations, sample sizes would benefit from being twice as large.

Some data sources have sample sizes that are too small in less populated states to produce reliable estimates. The NSDUH addresses this by using statistical modeling techniques. Those who use the CPS will often combine multiple years of data in order to obtain sample sizes that are large enough to produce the estimates they need.

### *Geographic Coverage*

With the advent of the ACS, the NSCH, the CSHCN, with the mandatory expansion of the NAEP, and with full implementation of the NCANDS and the AFCARS, all of which have taken place since 2000, there is now quite a bit of comparable data available across all 50 states and the District of Columbia for some domains of child well-being. Prior to that time, the state data system as a whole was much more dependent on voluntary participation, and often states opted not to participate. Even now, though, a number of states fail to benefit from the data collected through surveys like the YRBS, the YTS, and the PRAMS because they do not participate.

The territories, like the Virgin Islands, Guam, American Samoa, the Northern Marianas, and Puerto Rico, are not consistently represented in most data collection activities covered in this report. They are all included in decennial census, vital statistics, and the CCD data collection. None are covered by the NSCH, and only Puerto Rico is covered by the ACS. None are regularly covered by the NAEP. Puerto Rico participates in the AFCARS and NCANDS. Finally, for most of these data sources we reviewed one cannot produce separate estimates for distinct Native American tribes.

### **Targets of Opportunity for Increasing State-Level Data on Children’s Well-Being**

- *Preserve Recent Gains.* Over the last decade a greater emphasis on state responsibility and accountability for social policy, and fiscal pressures to spend more wisely and effectively, have resulted in a substantial increase in the amount of state-level data available on children, youth and their families available to guide state decisions. Of particular importance here is the establishment of the American Community Survey (ACS), the National Survey of Children’s Health (NSCH), the Survey of Children with Special Health Care Needs (CSHCN), and mandatory state participation in the National Assessment of Educational Progress (NAEP). While the need for such data to inform wise decisions at the state level is only likely to increase as states face mounting fiscal challenges, the future availability of these data is far from assured. Indeed, the same fiscal pressures that make such data more valuable to policy makers at the state and federal levels may threaten these valuable data sources. The ACS has had a rocky history of financing, and therefore the preservation and stabilization of the ACS is an important goal for those interested in a strong system of state-level indicator data.<sup>15</sup> The NSCH, NIS, and CSHCN are all dependent on the SLAITS data collection system. If that system were to be threatened, say through elimination of funds to collect NIS data, it would threaten the future of multiple surveys of great importance to a strong state-level data collection system. It is important, therefore, that SLAITS be both protected and, optimally, its use expanded into new data collection activities. In addition, it is critical that the integrity of the vital statistics data system, the primary data source on birth and death in this country, be protected against crippling budget shortfalls that would threaten the integrity of the system.
- *Increase Coverage Between Infancy and age Ten.* As we mentioned above, data are scarce for children in this age group, and do not really become plentiful until about age 12. There are a number of national surveys including the National Survey of Early Child Health (NSECH) and the National Longitudinal Surveys (Birth and Kindergarten Cohorts) that contain many strong measures of health and development for children from infancy through the fifth grade. These could be adapted for a new state survey using the SLAITS system. Alternatively, additional measured from these and other sources could be added to the NSCH. The federal No Child Left Behind initiative has caused many

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<sup>15</sup> The ACS will also produce annually updated estimates down to the neighborhood level, making it a critical tool to guide local planning.

states to focus on promoting early school readiness, and such data would be very valuable in guiding such efforts and monitoring progress.

- *Field the NSCH more Frequently.* As mentioned above, the NSCH fills many important holes in the existing system of state-level data collection on children, but it is fielded only once every four years. Policy, however, generally moves at a faster pace and for most purposes (monitoring progress, accountability, informing program improvements) requires annual or at least semi-annual updates. Assessments for No Child Left Behind, for example, are collected annually. More frequent collection of NSCH data would allow states to use its valuable health and developmental data as part of its regular annual or semi-annual cycles of policy development and program design to an extent that is not currently possible.
- *More Data Collection and Measurement Development on Socioemotional Development, Peer and Neighborhood Influences.* These are all areas that we identified as underdeveloped in existing state-level data sources. While measures of positive socioemotional development already exist and could be easily added to existing or new surveys, measures of peer and neighborhood influences are less well defined and may need to be developed.
- *Collect More Self-Reported Data for Older Children and Adolescents.* For some topics, self-reported information is essential. For example, teen self-reports regarding sexual activity, substance abuse, and delinquency are necessary; one cannot rely on parent reports because teens often hide these activities from their parents. More generally, older children and adolescents can best report on their own attitudes, values, beliefs, and goals. Accordingly, information supplied by older children and adolescents themselves is needed to provide full coverage. The NSDUH does interview all adolescents ages 12-17 about drug use and related issues. The YTS asks tobacco-related questions of those in grades six through 12, and the YRBS asks a variety of health-risk questions to youth in grades 9 through 12. NAEP asks selected education-related questions, but the range of information is limited. A strategy that included interviews of older children and adolescents could be expanded to data sets like the NSCH and the NHIS, which would considerably broaden the topics available based on self-report.
- *Increase Positive Measures.* Driven by policy concern for social problems, data collected have tended to focus on assessing negative behaviors such as violence, crime, and school dropout. However, conceptualizing and monitoring positive outcomes and positive social contexts represents an important direction for expansion so that the indicators system can better reflect the strong policy and program emphasis on positive development that has increasingly defined both youth and early childhood programs over the years. Examples of positive measures that have recently become available through the NSCH include volunteering, citizenship, social competence, family activities, parent/child closeness, and neighborhood support and cohesion. Examples of positive indicators that research indicates are important but are not yet available at the state level would include measures of moral development and spirituality, self-regulated learning, generosity, and school

engagement.<sup>16</sup> Data on positive outcomes could be particularly valuable in guiding the work of private child and youth-serving organizations at the state level that often focus on these aspects of development.

- *Collect Data for Large Samples of Low-Income Families with Children.* Low-income families are the focus of many policy and program efforts. To monitor the well-being of children in low-income families, and families that receive welfare assistance and other public benefits, it is critical to have adequate sample sizes for all states.
- *Include rural/urban measure on public use data sets so that child well-being can be assessed separately for rural and urban areas within states.* Several important surveys we have reviewed here (e.g., NSCH) do not provide the information needed to make separate estimates for rural and urban populations within states. The challenges facing children and youth can vary substantially between urban and rural environments, as can the policy responses needed to address those challenges. The capacity to produce separate estimates for urban and rural populations is therefore important to policymakers, particularly in those states with substantial rural populations.

## Conclusion

Since the early 1990s there has been steady growth in the use of social indicator data to guide policy and program development intended to improve the lives of children and their families. There has been a devolution of control over social policy from the federal to the states which has led to an increased need for state-level data on children to support greater planning and goals-tracking on the part of states, as well as greater accountability for results.<sup>17</sup> At the same time, technological advances have made the collection of such data more economical and more accessible to end users.<sup>18</sup>

Over time, the Federal statistical system has responded by increasing the breadth of data available to the states for identifying emerging areas of need and monitoring progress towards improving the lives of their children, while also increasing the capacity of the federal government to monitor and hold states more accountable. This data task is something for which the federal government is particularly well-suited, as it can achieve great cost efficiencies while producing high quality data that are comparable across states.

While the growth of available state-level data has been in many respects impressive, the resulting data system has a somewhat tenuous existence and includes significant gaps. By stabilizing the current data collection system and filling in the key gaps we have identified, one can

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<sup>16</sup> See Moore, K., and Lippman, L. (2005). What do Children Need to Flourish? Conceptualizing and Measuring Indicators of Positive Development. Springer.

<sup>17</sup> See Brown, B., and Corbett, T. (2003) Social indicators as tools of public policy. In R. Weissberg, H Walberg, M. O'Brien, and C. Kuster (Eds), Long-Term Trends in the Well-Being of Children and Youth. Washington, D.C.: CWLA Press.

<sup>18</sup> Kingsley, Thomas (1998) Neighborhood indicators: Taking advantage of the new potential. Washington, D.C.: The Urban Institute.

substantially strengthen the capacity of state governments as well as actors in the private sector to improve the lives of children and youth.

# Appendix

## Individual Data Sources: Summary Content

### **Socio-Demographic Surveys and Administrative Data**

- The American Community Survey (ACS)
- Census Population Estimates and Projections
- Census Small Area Income and Poverty Estimates (SAIPE)
- The Current Population Survey (CPS)
- Decennial Census
- Vital Statistics Birth Data
- Vital Statistics Death Data

### **Health and Safety Data Sources**

- Children with Special Health Care Needs survey (CSHCN)
- National Health Interview Survey (NHIS)
- National Immunization Survey (NIS)
- National Survey of Children's Health (NSCH)
- National Survey of Drug Use and Health (NSDUH)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Youth Risk Behavior Survey (YRBS)
- Youth Tobacco Survey (YTS)

### **Education**

- Common Core of Data (CCD)
- Enrollment and High School Graduation Projections
- National Assessment of Educational Progress (NAEP)
- Schools and Staffing Survey (SASS)

### **Child Welfare**

- Adoption and Foster Care Analysis Reporting System (AFCARS)
- National Child Abuse and Neglect Data System (NCANDS)

## The American Community Survey (ACS)

- Description: The ACS provides annual estimates of demographic, housing, social, and economic characteristics for all states, as well as for all cities, counties, metropolitan areas, and population groups of 65,000 people or more. For communities smaller than 65,000 people, data will be available at census tract level by 2009.
- Periodicity: Annual
- Coverage: All 50 states, the District of Columbia, and Puerto Rico (Puerto Rico data available for 2005 only)
- Sample Size: 2,000,000 households annually.
- Age Groups: 0-17, 18 and above
- Respondent: Householder
- Sponsors: U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau
- Web site: <http://www.census.gov/acs/www/>
- Limitations: Provides few direct measures of well-being.

### **CHILD CHARACTERISTICS**

#### Health

Long-lasting health conditions (ages 5 and older); difficulty functioning due to health conditions (ages 5 and older); births (female, age 15 and older).

#### Education/Intellectual Development

School enrollment; highest level of education completed; current grade in school; public/private school.

#### Social/Emotional/Civic Well-Being

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#### Demographics

Age; sex; race; citizenship; Hispanic origin; receipt of Food Stamps; language spoken at home; employment; total income; wage/salary income.

### **CONTEXTUAL INFLUENCES**

#### Family

Family structure; number of people in household; marital status; race; Hispanic origin; housing type and amenities; citizenship; highest level of education completed; English proficiency; military service; employment; commute time to work; on layoff; seeking employment; number of weeks worked; type of employment; total income; wage/salary income; Social Security income; Supplemental Social Security income; public assistance income.

#### Peers

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School

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Community

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## Census Population Estimates and Projections

**Description:** The Population Estimates Program publishes total resident population estimates and demographic components of change (births, deaths, and migration) each year by demographic characteristics (age, sex, race, and Hispanic origin) for the nation, states and counties. These estimates are used in federal funding allocations, as denominators for vital rates and per capita time series, as survey controls, and in monitoring recent demographic changes.

**Periodicity:** Annual

**Coverage:** All 50 states, the District of Columbia, and Puerto Rico

**Sample Size:** N/A

**Age Groups:** 0-17, 18 and above

**Respondent:** N/A

**Sponsors:** U.S. Census Bureau

**Web site:** <http://www.census.gov/popest/estimates.php>

**Limitations:** N/A

### **CHILD CHARACTERISTICS**

#### Health

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#### Education/Intellectual Development

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#### Social/Emotional/Civic Well-Being

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#### Demographics

Age; sex; race; Hispanic origin.

### **CONTEXTUAL INFLUENCES**

#### Family

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#### Peers

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#### School

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Community

Age; sex; race; Hispanic origin; county.

## Census Small Area Income and Poverty Estimates (SAIPE)

- Description:** The SAIPE program provides estimates of selected income and poverty statistics in years that the decennial census is not administered. Estimates encompass all states and counties, including the total number of people in poverty under age 18 and the number of “related children” ages 5 to 17 living in poor families. Poverty estimates are also available for related children ages 5 to 17 for all school districts.
- Periodicity:** State and county estimates, yearly since 1995; school district estimates, yearly since 1999
- Coverage:** All 50 states and the District of Columbia
- Sample Size:** N/A
- Age Groups:** 0-17, 18 and above
- Respondent:** N/A
- Sponsors:** U.S. Census Bureau
- Web site:** <http://www.census.gov/hhes/www/saipe/index.html>
- Limitations:** Poverty estimates are useful but often not very precise at the county or district level, especially for sparsely populated areas. Estimates at the state level are considerably more precise.

### **CHILD CHARACTERISTICS**

#### Health

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#### Education/Intellectual Development

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#### Social/Emotional/Civic Well-Being

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#### Demographics

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### **CONTEXTUAL INFLUENCES**

#### Family

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#### Peers

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#### School

School enrollment numbers; grade ranges of schools; related children ages 5-17 in poverty.

Community

All people in poverty; children under age 18 in poverty; related children ages 5-17 in poverty; median household income.



income; receipt of Food Stamps; WIC benefits; occupation; type of employment; full-time employment; highest level of education attained; hours worked per week; high school/college enrollment; adjusted gross income; searching for employment.

Peers

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School

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Community

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## Decennial Census

- Description:** The Decennial Census collects data every 10 years about households, income, education, homeownership, and more for the United States, Puerto Rico, and its territories. The data are used for a wide variety of purposes including: reapportionment of the seats in the House of Representatives; distribution of funds for government programs such as Medicaid; planning the right locations for schools, roads, and other public facilities; helping real estate agents and potential residents learn about a neighborhood; and identifying trends over time that can help predict future needs.
- Periodicity:** Every 10 years (2000)
- Coverage:** All 50 states and the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Northern Marianas.
- Sample Size:** In 2000, population of 281,421,906 nationally; state numbers range from 572,059 (DC) to 33,871,648 (CA). About 1 in 6 households are selected to answer the long form questionnaire, from which most of the data are collected.
- Age Groups:** 0-17, 18 and older
- Respondent:** Household head
- Sponsors:** U.S. Census Bureau
- Web site:** <http://www.census.gov>
- Limitations:** Only conducted every 10 years; few direct measures of well-being. In 2010, the long-form of the Census is scheduled to be replaced by the American Community Survey and only the short-form will be administered to the population. Those measures that are included on the short-form are starred (\*) below.

### **CHILD CHARACTERISTICS**

#### Health

Long-lasting health conditions; difficulty functioning due to health conditions.

#### Education/Intellectual Development

School enrollment; public/private school; current grade level; highest level of education completed.

#### Social/Emotional/Civic Well-Being

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#### Demographics

\*Sex; \*age; \*Hispanic origin; \*race; \*relation to head of household; marital status; language spoken at home; English proficiency; citizenship; employment (age 16 and up); commute time (age 16 and up); type of employment (age 16 and up); hours/weeks worked (age 16 and up); total income (age 16 and up); wage/salary income (age 16 and up); public assistance income (age 16 and up).

## **CONTEXTUAL INFLUENCES**

### Family

\* Sex; \* age; \* Hispanic origin; \* race; \*relation to head of household; marital status; language spoken at home; English proficiency; highest level of education completed; citizenship; long-lasting health conditions; difficulty functioning due to health conditions; grandchildren living at home; military service; employment; commute time to work; on layoff; seeking employment; type of employment; hours/weeks worked; wage/salary income; Social Security income; Supplemental Social Security income; public assistance income; retirement income; total income.

### Peers

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### School

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### Community

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## National Vital Statistics: Birth Data

- Description:** Federal law mandates that vital statistics be collected and made available at the state and national level. The National Vital Statistics System, with the collaboration of the individual States, is responsible for improving the quality, uniformity and availability of these vital statistics. Although multiple records are assessed, the birth data provide critical information based on registered live births in the United States. Data are based on the standard certificate of a live birth and include information on the child's health status, family demographic information, as well as maternal health and behavior during pregnancy and birth. Vital statistics help identify various health and social issues facing the U.S. population, allow trends to be tracked over time and for comparisons among various populations.
- Periodicity:** Continuous, 1933\*- Present
- Coverage:** All 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Northern Marianas
- Sample Size:** U.S. (excluding territories): Approximately 4.1 million reported births per year; state birth numbers range from approximately 6,500 births (VT) to approximately 550,000 births (CA) in 2005 (data for 2005 are still preliminary).
- Age Groups:** Newborns
- Respondent:** Parent report; hospital staff report
- Sponsors:** National Center for Health Statistics and the Vital Statistics Cooperative Program, Centers for Disease Control and Prevention
- Web site:** <http://www.cdc.gov/nchs/births.htm>
- Limitations:** The U.S. Standard Certificate of Live Birth was revised in 2003. As of 2004, 13 states (FL, ID, KS, KY, NE, NH, NY, PA, SC, TN, TX, VT, WA) have implemented the revised birth certificate. The remaining 37 states, New York City, and the District of Columbia collected and reported data based on the previous version of the Standard Certificate. As a result, not all measures are comparable across states. The Vital Statistics System also uses data from the U.S. Census Bureau to calculate population estimates. Currently, states who have not yet implemented the revised Certificate of Live Birth collect racial birth certificate data that are incompatible with current U.S. Census data racial categories. As a result, some birth rate estimations by race are subject to error. This is particularly the case for smaller population groups.
- Note:** \*Although data were collected previously, 1933 is considered the earliest year when accurate and complete registration of births and deaths are available for the U.S. (with the exception of AK, HI).

### **CHILD CHARACTERISTICS**

#### Health

Premature birth; labor & delivery characteristics; birth weight; healthy at birth; abnormal conditions and congenital anomalies at birth; plurality of birth; infant death; breastfeeding.

## **Socio-Demographic Surveys and Administrative Data**

Education/Intellectual Development

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Social/Emotional/Civic Well-Being

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Demographics

Age; gender; geographic location of birth.

**CONTEXTUAL INFLUENCES**

Family

Parental age; maternal geographic location (birth & current); paternal geographic location of birth; maternal urban/rural marker; marital status of mother; parental educational level; parental race and Hispanic origin; WIC receipt; maternal previous birth history/outcomes; parity; maternal prenatal care; maternal height and prenatal weight; maternal smoking; maternal prenatal risk factors and health status; maternal morbidity.

Peers

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School

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Community

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## National Vital Statistics: Mortality Data

- Description:** Federal law mandates that vital statistics be collected and made available at the state and national level. The National Vital Statistics System, with the collaboration of the individual States, is responsible for improving the quality, uniformity and availability of these vital statistics. Mortality data provide critical information based on registered deaths in the United States. Data are based on the standard certificate of death and include information on the cause(s) of death, health status, and demographic information of the deceased. Vital statistics on mortality help identify characteristics of the dying population, life expectancies, and mortality trends over time and across populations. The scope and duration of data collection make the National Vital Statistics a rich and invaluable source of information on the health and social welfare of people in the United States.
- Periodicity:** Continuous, 1933\*- Present
- Coverage:** All 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Northern Marianas
- Sample Size:** U.S. (excluding territories): Approximately 2.4 million reported deaths per year (~28,000 infant deaths); State samples range from approximately 3,000 deaths (AK) to approximately 200,000 deaths (CA)
- Age Groups:** All
- Respondent:** Funeral director; Medical certifier
- Sponsors:** Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) and the Vital Statistics Cooperative Program
- Web site:** <http://www.cdc.gov/nchs/deaths.htm>
- Limitations:** The U.S. Standard Certificate of Death was revised in 2003. As of 2004, five areas (CA, ID, MT, NYC, NY) have implemented the revised death certificate. The remaining 46 states, and the District of Columbia collected and reported data based on the previous version of the Standard Certificate. As a result, not all measures are comparable across states. The Vital Statistics System also uses data from the U.S. Census Bureau to calculate population estimates. Currently, states who have not yet implemented the revised Certificate of Death collect racial death certificate data that are incompatible with current U.S. Census data racial categories. As a result, some death rate estimations by race are subject to error. This is particularly the case for smaller population groups.
- Note:** \*Although data were collected previously, 1933 is considered the earliest year when accurate and complete registration of births and deaths are available for the U.S. (with the exception of AK, HI).

### **CHILD CHARACTERISTICS**

#### Health

Detailed cause of death (including accidents & injuries, substance use); health conditions; pregnancy within the past year.

Education/Intellectual Development  
Educational attainment.

Social/Emotional/Civic Well-Being  
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Demographics  
Gender; age; geographic location (birth & current); urban/rural marker; family structure;  
race and Hispanic origin; employment type.

**CONTEXTUAL INFLUENCES**

Family  
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Peers  
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School  
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Community  
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## Survey of Children with Special Health Care Needs (CSHCN)

- Description:** The CSHCN collects information of the prevalence of special health care needs of children and their families, and its effects on their lives. The survey covers child health status, access to medical care, health insurance coverage, coordination of care, and impact and involvement of the family in the child's health care.
- Periodicity:** 2000-2002, 2005-2006
- Coverage:** All 50 states and the District of Columbia
- Sample Size:** 850 children with special health care needs in each state; 5,000 without special health care needs nationally.
- Age Groups:** 0-17
- Respondent:** Parent or guardian knowledgeable about child's health care needs
- Sponsors:** Maternal and Child Health Bureau of the Health Resources and Services Administration and Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services
- Web site:** [http://www.cdc.gov/nchs/about/major/slaits/cshcn\\_05\\_05.htm](http://www.cdc.gov/nchs/about/major/slaits/cshcn_05_05.htm)
- Limitations:** Rates of uninsurance in the CSHCH are lower than other national surveys, which may be due to question design differences.
- Note:** Measures in bold are those asked of all children (children with special health care needs and those without). Measures not in bold are asked only about children with special health care needs. The 2000-2002 version of this survey included over 2700 children without special health care needs in each state in order to estimate state-level health care coverage.

### CHILD CHARACTERISTICS

#### Health

**Immunizations; medications (currently need or use); condition requiring prescription medication; condition requiring medical care, or mental health or education services; limited or prevented from doing same things as peers; special therapy such as OT, PT, speech, treatment or counseling; condition expected to last 12 months or longer; need or use more medical care or services than peers.** In past year... how often condition affects ability to do things like peers; extent condition affects ability to do things like peers; stability of health care needs; severity of difficulties caused by health problems.

Specific health difficulties: eyeglasses or contacts; hearing aids; respiratory problems; difficulty swallowing, digesting food, or metabolism; blood circulation; repeated or chronic physical pain; difficulty with self-care, coordination or moving around (using hands for newborns); asthma; diabetes (use insulin); heart problem; blood problems; cystic fibrosis; cerebral palsy; muscular dystrophy; epilepsy or other seizure disorder; migraine or frequent headaches; arthritis or joint problems; allergies. Use of health services: routine preventative care; care from specialty doctor; preventative dental care; prescription medications; physical, occupational, or speech therapy; mental health care or

counseling; substance abuse treatment or counseling; home health care; eyeglasses or vision care; hearing aid or hearing care; mobility aids or devices; communication aids or devices; medical supplies; durable medical equipment; Early Intervention Services; Special Education Services; number of emergency room visits in past year; number of times hospitalized in last year; usual source of health care when sick or need health advice (specify type); usual source of routine preventative care; has a personal doctor, nurse, etc (specify); ever have delay or not receive health care (list reason – no transportation, no insurance, language barrier, etc.); referrals (need one in past year, difficulty getting one); support/satisfaction with support for coordinating child's care.

How often doctors...spend enough time with child; listen to you; are sensitive to your family's values and customs; give you specific info needed; feel like a partner in your child's care. Doctor talks about transition to care as adult, would this be helpful; discusses healthcare of child as adult; encourages child to take responsibility for his or her health care needs. Difficulties in trying to use services (reasons, satisfaction); health insurance type/source of coverage; coverage status in past year; extent of coverage.

#### Education/Intellectual Development

Difficulty with learning, understanding, or paying attention; difficulty with speaking, communication or being understood; ADD; autism or ASD; Down Syndrome; mental retardation or developmental delay.

#### Social/Emotional/Civic Well-Being

Specific difficulties with: feeling anxious or depressed; behavior problems; making and keeping friends; depression or other emotional problems.

#### Demographics

**Age; age of siblings; gender; race/ethnicity.**

### **CONTEXTUAL INFLUENCES**

#### Family

Provide care at home for child (hrs/week); time spent coordinating care (hrs/wk); financial burden of child's health problem; family member stopped working or cut down on work to care for child; additional income needed to pay for medical expenses; use of respite care, genetic counseling, or mental health care or counseling; use/availability of interpreter to speak with doctors or health care providers; how much paid out of pocket for child's health care in past year; ; highest level of education of anyone in household; primary language spoken in household; respondent's relationship to child; number of people in household; other parent living in household; adopted (U.S. or foreign, child in foster care first); household income; SSI receipt; cash assistance from state or county welfare agency

#### Peers

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School

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Community

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## National Health Interview Survey (NHIS)

- Description:** The NHIS is a comprehensive health survey that is used to track and monitor illness, estimate the prevalence of health problems, use of health care and barriers to access, and to measure progress towards national health goals. The survey targets households and allows for data on children and their parents.
- Periodicity:** Annual, 1997- to present (survey has been conducted since 1975, but in a different format)
- Coverage:** All 50 states and the District of Columbia, but states are combined into groups when sample sizes are small. For a single year of data, one can produce estimates for approximately the 14 most populous states.
- Sample size:** Data are collected from about 43,000 households, or 106,000 people of all ages.
- Age Groups:** 0-17
- Respondent:** Parent
- Sponsors:** National Center for Health Statistics, Centers for Disease Control and Prevention
- Web site:** [http://www.cdc.gov/nchs/products/elec\\_prods/subject/nhisstat.htm](http://www.cdc.gov/nchs/products/elec_prods/subject/nhisstat.htm)
- Limitations:** States are combined into groups when sample sizes are too small. Sample does not include patients in long-term medical facilities, persons on active military duty, or U.S. citizens living in other countries.
- Notes:** Measures in bold are only available if child was selected as the sample child. Measures in italics are only available if parent is the sample adult in the household. To protect the respondents' confidentiality, statistical noise, or variation is added to the NHIS public-use data with State identifiers at the variable level and record level so that respondents cannot be identified. These state files may soon be removed from public access, and state-level data may be accessible only by working through the Research Data Center at the National Center for Health Statistics.

### CHILD CHARACTERISTICS

#### Health

Limited in kind or amount of play, personal care, walking, or work; specific limitation; duration of specific limitations; condition status; cause of limitation; duration of cause of limitation; status of cause of limitation; health status; delayed or unmet medical care; overnight hospital stay; home visits; frequency of contact or visits with health care professional; injury; health insurance (type, extent of coverage, how paid for, reasons for periods of non-coverage); **birth weight; ever told child has specific health conditions; hearing or vision problem; difficulties with emotions, concentration, behavior, or getting along with others (length, burden of family, how they interfere with school, friends, seen doctor); seen or talked to various types of health care professionals in past 12 months; inability to pay for prescriptions, eyeglasses, or mental health services; time since last dentist visit; well-child check-up in past 12 months; often**

**complains of headache, stomachache or illness; hyperactivity; ER visits; office visits; home visits; surgery; time since last talked to health care professional;**

Education/Intellectual Development

Special education of EIS; days of school missed due to injury/illness; Head Start attendance.

Social/Emotional/Civic Well-Being

**Emotional problems; pro-social behaviors; conduct problems;**

Demographics

Gender; race/ethnicity; age; nativity; citizenship status.

**CONTEXTUAL INFLUENCES**

Family

Family size; household and family relationships; family size; family structure and type; highest level of education; highest level of education of adult in household; region; type of living quarters;; marital status and cohabitation; length of US residency; work status and history in past year; earnings; sources of income; availability of employer-based health insurance; SSI/TANF/food stamp receipt

Parent:

*employment status and type of job; health problems (specific problem, duration); pregnancy status; symptoms of depression; health status relative to past year; health problem that requires special equipment; difficulties with activities and cause; smoking and drinking; parental exercise; BMI; usual source of health care; health care use in past 12 months; reasons for not receiving health care; HIV/AIDS and TB knowledge; time spent living in shelter/on street or in jail or prison*

Peers

**Peer relationships:**

**Prefers to play alone/be alone; has at least one good friend; liked by other children/youth; picked on or bullied by other children/youth; gets along better with adults than peers.**

School

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Community

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### Education/Intellectual Development

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### Social/Emotional/Civic Well-Being

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### Demographics

Age; gender; WIC benefits; Census region based on state of residence; income-to-poverty-ratio; first-born status; race and ethnicity; geographic mobility status (state of residence at birth versus current state of residence); IAP area of current residence; state of residence; child lives in state with a Hepatitis B entry law for day care/Head Start.

## **CONTEXTUAL INFLUENCES**

### Family

Number of people in household; number of children less than 18 years in household; age of mother; marital status of mother; education of mother.

### Peers

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### School

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### Community

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## National Survey of Children's Health (NSCH)

- Description:** The survey was designed to produce national and state-specific estimates for various physical, emotional, and behavioral health indicators for children. It includes measures of children's experiences in the health care system and questions about the family and respondent perceptions of the child's neighborhood. The telephone administered survey was conducted under the direction of the National Center for Health Statistics.
- Periodicity:** 2003, expected to be fielded every four years
- Coverage:** All 50 states and the District of Columbia
- Sample Size:** 102,353 interviews completed with approximately 2,000 completed interviews per state and the District of Columbia
- Age Groups:** 0-17 years
- Respondent:** Parent or guardian who lives in household and knows the most about the health and health care of the child
- Sponsors:** Primary funding provided by: the Maternal and Child Health Bureau, Health Resources and Services Administration, with additional support from the Center for Disease Control's National Center for Infectious Diseases using funds provided by the National Vaccine Program Office.
- Web site:** <http://www.cdc.gov/nchs/about/major/slaits/nsch.htm>
- Limitations:** The NSCH is based entirely on parent-reported data and data are limited by the amount of information a respondent remembers or is willing to report. The phone interview format excludes families who do not live in homes with telephones (attempts are made to correct for this in the weighting process). Children living in institutional settings are not included. Educational measures are very limited.

### **CHILD CHARACTERISTICS**

#### Health

Overall child health status; functional limitations; height; weight; underweight/overweight; dental health; child injury; developmental delays; chronic illness/disability; frequent illness; health-related behaviors (physical activity/exercise, nutrition, adequate sleep); hearing/vision problems; asthma; breastfeeding; parental concerns about eating disorder and substance use.

#### *Health care receipt and coverage:*

Health care coverage (public or private) and consistency; S-CHIP coverage; preventive health care (medical and dental); childhood immunization (hepatitis A); hospitalization due to accident or injury; prescription medication; use of special health care services or equipment; medical home.

#### Education/Intellectual Development

Parental and health professional concerns about child's learning, development, and behavior; types of child care (e.g. child care center, family-based child care, nanny or relative care in home, nursery school, preschool or kindergarten, Head Start or Early Start program); child care burden on parents; school enrollment (public, private, or home-

school); problems (behavioral or academic) in school; grade repetition/behind for age; reads for pleasure; television/video game/computer time.

### Social/Emotional/Civic Well-Being

Problem behaviors; positive and negative social competence; internalizing behaviors (sad, unhappy or depressed); after-school/extracurricular activities (sports, clubs or organizations, volunteer, work for pay); religious attendance; emotional well-being.

### Demographics

Race and Hispanic origin; age; gender; language spoken in home; family structure; immigrant status; parental employment status; highest household educational attainment; family income; poverty status; children in foster care; TANF receipt; food stamps receipt; free/reduced lunch receipt; WIC receipt; child care subsidy receipt; state or residence; residential turbulence.

## **CONTEXTUAL INFLUENCES**

### Family

Family outings and activities; meals together; parent/guardian-child closeness; parent/guardian-child relationship; parental/guardian concerns of raising child; conflict resolution; monitoring/limit-setting/supervision/rules (media); child is read stories; parental engagement.

### *Parental Health:*

General parental health (physical and mental); parent physical activity; parent health care coverage (public or private); household tobacco use; parental aggravation; parental sense of social support.

### Peers

Bullying.

### School

Perceived school safety; school type.

### Community

Neighborhood cohesion/trust; perceived safety of child in neighborhood; level of support in neighborhood; level of negative influences in neighborhood; perceived home safety.

## National Survey on Drug Use and Health (NSDUH)

- Description:** The NSDUH is the primary source of data on illegal drug use among the non-institutionalized population of the U.S. ages 12 and older. In addition to data on the prevalence, patterns, and consequences of drug use, the survey also provides data on mental health, substance abuse and dependence, and substance abuse treatment.
- Periodicity:** Annual, 1971-present
- Coverage:** All 50 states and the District of Columbia, with 8 states (CA, FL, IL, MI, NY, OH, PA, and TX) as large sample states. Youth ages 12-17 and young adults ages 18-25 are oversampled.
- Sample Size:** 67,784 total; 3,541 to 3,711 for large sample states, 856 to 964 for other states
- Age Groups:** 12 and older
- Respondent:** Adolescent or adult
- Sponsors:** Substance Abuse Services & Mental Health Administration, U.S. Department of Health & Human Services
- Web site:** <http://oas.samhsa.gov/nhsda.htm#NHSDAinfo>
- Limitations:** Data from 2002 are not comparable to previous years due to changes made to the survey, such as quality control procedures and incentive payments for respondents. The survey is only representative of the civilian non-institutionalized population and does not include active military (shown to have lower rates of drug use), those living in institutionalized group quarters, and the homeless (both shown to have higher rates). Currently, 22 measures are available at the state level. State estimates for states not part of the large state sample are produced using modeling based on small area estimation (SAE) techniques and county and Census tract data.
- Notes:** **State estimates are only produced for the measures in bold.** This survey was formerly called the National Household Survey on Drug Use. Certain sections of the survey, such as “Adult Mental Health Utilization”, “Social Environment”, and “Adult Depression” were only asked to respondents ages 18 and older.

### CHILD CHARACTERISTICS

#### Health

Health status; current health conditions; pregnant; emergency room or hospital visits; carried handgun; sold illegal drugs; stole; physical attack; health insurance type, extent of coverage, consistency of coverage in past year, reason for lack of coverage; ever smoked; would smoke if friend offered; will smoke in next year; age smoked first cigarette; frequency of smoking in past month; brand and type smoked most often; how old/when started smoking every day; use of snuff, chewing tobacco, cigar, tobacco from pipe; ever tried alcohol; age at first drink; frequency of use on past month/year; **number of occasions had 5 or more drinks; Marijuana, cocaine, crack, heroin, hallucinogens, inhalants, pain relievers, tranquilizers, stimulants, sedatives, any illicit drug:** Age at first use; frequency of use in past month/year; heroin (smoked, sniffed/snorted, injected); used blunt; use needle to inject other drugs (specify); how long since last use; needle use and

sharing practices; time spent using or obtaining/getting over effects of drugs and alcohol; **set limits or tried to stop**; experienced symptoms after cut back or stopped; how drinking/drugs effected physical; emotional, personal life; last time obtained marijuana (method/source, frequency, amount, cost); **perceived harm from/feelings about smoking, drinking, and using various drugs**; difficulty in obtaining drugs; approached by someone selling illegal drug in past 30 days; risk taking; seat belt use (as driver/passenger); dependence on cigarettes; how cigarettes affect friendships and social life; patterns of use (influences/relative satisfaction); **treatment or counseling for drug or alcohol dependence** (by type of drug, treatment facility, duration, payment method, why did not receive).

#### Education/Intellectual Development

Feelings about school, schoolwork, and courses; encouragement from teachers; grades received.

#### Social/Emotional/Civic Well-Being

Depression: length and types of feelings experienced; length and **extent of feelings**, problems (eating, sleeping, energy at the same time); at worst time when had depression and other problems: age, physical symptoms, emotional symptoms, problems with daily activity, suicide ideation or attempt; first time feeling sad, empty, depressed and had other physical/mental problem: age, how long it lasted, did feelings cause problems at home, school, or work, unable to go to school, treatment received, medication taken, how often experienced various feelings during worst month; treatment and counseling for conditions not related to drugs or alcohol in past 12 months: type, number to times visited/received service, reason admitted to service.

#### Demographics

Age; gender; race/ethnicity; highest level of education; nativity; number of times moved in last 12 months/5 years; place of birth; how long lived in U.S.; attending school; grade; type of school; full or part-time student; number of days of school missed due to injury or illness/skipped in past month; high school diploma or GED; reason did not complete high school; ever in jail or detention center (ages 12-17); foster care (ages 12-17). For those 15 and older - employment (status, type, duties, reason for unemployment, days of work missed in last month due to injury or illness); workplace drug and alcohol policy (testing or counseling)

### **CONTEXTUAL INFLUENCES**

#### Family

Parent /child conversation about dangers of drugs and alcohol; parent opinion about drug prevention; parental opinion on drinking, smoking, and doing drugs; parental monitoring and encouragement; arguments with respondent; income (specify type): household roster (age, gender, relationship to respondent).

#### Peers

Opinion of close friends about drinking, smoking, using drugs.

### School

Attended school/home schooled; participated in school-based activities; special class at school about drugs; lecture/film/discussion about drugs in regular class; use of cigarettes, marijuana, drink alcoholic beverages by classmates.

### Community

Has someone to talk to about a problem; importance of religion; friends share religious beliefs; participated in community or church or faith-based activities (types); seen alcohol and drug abuse prevention message outside of school; frequency of religious services attendance.



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Social/Emotional/Civic Well-Being

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Demographics

Age; gender; geographic location of birth.

**CONTEXTUAL INFLUENCES**

Family

Maternal stress; maternal health insurance; parents' age; parity; maternal previous birth history/outcomes; WIC receipt; poverty/income; receipt of cash assistance; domestic violence; pregnancy intention; maternal sexual behavior & contraception; maternal prenatal nutrition/vitamin intake; maternal height and prenatal weight; maternal prenatal care; maternal HIV/AIDS; maternal smoking; maternal drinking; infant smoking exposure; maternal health parenting practices; maternal geographic location (birth & current); paternal geographic location of birth; maternal urban/rural marker; family structure; parental educational level; parental race and Hispanic origin; maternal prenatal risk factors and health status; maternal morbidity.

Peers

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School

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Community

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Peers

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School

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Community

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## Youth Tobacco Survey (YTS)

- Description:** The YTS was designed to help states in the design, implementation, and evaluation of youth tobacco prevention and control programs. The survey provides data in the following seven areas: tobacco use, tobacco use cessation, tobacco-related attitudes and knowledge, role of advertising and media in tobacco use minors' access to tobacco, environmental tobacco smoke, and tobacco-related curriculum in schools.
- Periodicity:** States can choose whether to conduct the survey annually, or every other year. A national survey is also conducted every other year.
- Coverage:** In 2000: AL, AZ, AK, CA, CT, CO, DE, FL, GA, HI, IL, IN, IA, KY, MD, ME, MI, MN, MS, NH, NY, ND, OH, TN, TX, VT, WV, WI, and WY. In 1998, 3 states collected data and in 1999, 13 states collected data. Estimates at the county or health region level are possible.
- Sample Size:** State sample sizes ranged from 583 (ME) to 33,586 (MD)
- Age Groups:** Grades 6-12
- Respondent:** Students
- Sponsors:** Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health
- Web site:** [http://www.cdc.gov/tobacco/data\\_statistics/surveys/YTS/index.htm](http://www.cdc.gov/tobacco/data_statistics/surveys/YTS/index.htm)
- Limitations:** The survey began in 1998 and state participation in the first two rounds was low. In all but four states, private schools are excluded. Data are weighted and are representative of the relevant populations with the exceptions of middle schools in Hawaii and high schools in Arizona, Maine, and Vermont. Demographic variables available are limited.
- Notes:** The core questionnaire contains 63 questions, and states may add questions if desired. The YTS has the same sampling method and question wording on tobacco-related questions as the Youth Risk Behavior Surveillance System (YRBSS), which allows states to use data from both surveys for high school students.

### **CHILD CHARACTERISTICS**

#### Health

Use tobacco (smokeless tobacco, cigarettes, cigars, pipes, bidis, or kreteks); experimented with tobacco; age began using tobacco; brand of cigarettes usually smoke; strength of intention to remain non-smoker; perceived health risks of tobacco use; short- and long-term likelihood of quitting tobacco use; where buys or obtains cigarettes and tobacco; whether ID needed when buying tobacco; knowledge of state laws on sale of tobacco; how receptive students are to tobacco advertising; awareness and exposure to anti-smoking messages.

#### Education/Intellectual Development

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#### Social/Emotional/Civic Well-Being

Perceived social benefits of tobacco use.

Demographics

Gender; grade; race/ethnicity;

**CONTEXTUAL INFLUENCES**

Family

Exposure to tobacco smoke at home and in car.

Peers

Extent of peer pressure to use tobacco.

School

Smoked tobacco on school property; what has been taught about tobacco use in school.

Community

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## Common Core of Data (CCD)

- Description:** The CCD is designed to provide an official listing of elementary and secondary education public schools and public school districts in the United States. The CCD also provides basic information on these schools including demographic information of students and staff, fiscal school data and other general descriptive characteristics of the schools at the district and state level.
- Periodicity:** Annual
- Coverage:** All 50 states and the District of Columbia, the Bureau of Indian Affairs, Department of Defense dependents schools (overseas and domestic), Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Northern Marianas. Data reported at the school, district and state levels.
- Sample Size:** Approximately 94,000 public schools; approximately 17,000 public school districts.
- Age Groups:** School-age (Pre-K through 12<sup>th</sup> grade)
- Respondent:** Administrator report (State Education Agencies)
- Sponsors:** National Center for Education Statistics, U.S. Department of Education
- Web site:** <http://nces.ed.gov/ccd/>
- Limitations:** Data are not collected at the individual child level. The aggregate statistics, therefore, are primarily helpful in describing the contextual environment but not the personal characteristics of a child. In cases where 12<sup>th</sup> grade samples are small, high school completion data are suppressed to protect confidentiality. State agencies vary in their data collection and reporting systems which results in variation across states or instances where measures are unavailable for comparison.

### **CHILD CHARACTERISTICS**

#### Health

Students with IEPs (Individualized Education Plans).

#### Education/Intellectual Development

High-school completion/drop-out rates; average daily attendance.

#### Social/Emotional/Civic Well-Being

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#### Demographics

Age; grade/enrollment in school; eligibility for free/reduced-price lunch; migrant status; language spoken in home/linguistic isolation; race and Hispanic origin.

### **CONTEXTUAL INFLUENCES**

#### Family

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## Peers

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## School

Geographic location; grade span offered; number of students by grade and gender; school type; number of teachers; number of students eligible for free/reduced-price lunch; number of migrant students; number of English Language Learners; number of IEP students; student race and Hispanic origin by grade, gender and total.

## Community (School district/Local Education Agency and State-level)

Geographic location; number of students Pre-K-12<sup>th</sup> grade and ungraded; grade span offered (*School district level only*); number of instructional and support staff; number of students who completed high school; high school completer race and Hispanic origin by gender; number of dropouts (*School district level only*); dropout race and Hispanic origin by gender and grade (*School district level only*); fiscal data (state/local/federal revenue & expenditures); average daily attendance (*State-level only*).



## National Assessment of Educational Progress (NAEP)

- Description:** The NAEP assessments test subject area achievement of American students in the 4<sup>th</sup> and 8<sup>th</sup> grade in reading, mathematics, science, and writing at the state-level. NAEP also gathers background information on students, teachers, and schools in order to provide a context for student achievement and to meet federal reporting requirements. Demographic subgroup breaks such as race, gender, and parental education are also available.
- Periodicity:** Every two years for 4<sup>th</sup> and 8<sup>th</sup> grade students at the state level. State-level estimates were first collected in 1990.
- Coverage:** In 2005, all 50 states, the District of Columbia and the Department of Defense Education Activity (DoDEA) participated. Data were also collected for a third trial assessment of 10 urban school districts: Atlanta, Austin, Boston, Charlotte, Chicago, Cleveland, Houston, Los Angeles, New York City, and San Diego. Data by select years were available for Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Northern Marianas.
- Sample Size:** In 2005, 163,000 4<sup>th</sup> grade students and 152,800 8<sup>th</sup> grade students were assessed in mathematics. An average of 2,500 students is sampled from each state. In 2005, state samples for mathematics for 4<sup>th</sup> grade ranged from 1,800 in Wyoming to 10,700 in California.
- Age Groups:** 4<sup>th</sup> and 8<sup>th</sup> grade
- Respondent:** Student; teacher; principal or head of school
- Sponsors:** National Center for Education Statistics, U.S. Department of Education
- Web site:** <http://nces.ed.gov/nationsreportcard/>
- Limitations:** Assessment does not include home schooled children. The background questionnaire does not include questions on family structure or poverty. State assessments of mathematics and reading are mandated by federal law, but assessing other subjects is voluntary.
- Notes:** **This survey review is based largely on 2005 mathematics questionnaires.** The NAEP *national* assessment also includes 12<sup>th</sup> grades students, and additional subject areas, such as civics and U.S. history. State assessments are identical to those given nationally.

### CHILD CHARACTERISTICS

#### Health

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#### Education/Intellectual Development

Reading, mathematics, and science proficiency; type of math class currently taking/expected to take next year; pages read per day for school or homework; days absent in past month; how often uses computer for math at school (by specific activity); calculator use (how, type); difficulty/effort/importance of doing well on NAEP math assessment.

8<sup>th</sup> and 12<sup>th</sup> grade: Time spent on computer doing work for math class; how often use the specific computer programs for math homework; use of computer to learn math in after school programs (8<sup>th</sup> only), computer use when doing math work; play math computer games in math class (8<sup>th</sup> only)/outside of math class; use of calculators in class/outside of class (basic, scientific, graphing); use calculator to check work, calculate answers to homework, use for classwork during lesson, for quizzes and test. 12<sup>th</sup> grade: type of high school program; math courses taken since 8<sup>th</sup> grade; currently taking math course; AP math course; online math course.

### Social/Emotional/Civic Well-Being

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### Demographics

Race/ethnicity; non-English language spoken in home; mother/father highest level of education.

## **CONTEXTUAL INFLUENCES**

### Family

Receives newspaper at least 4 times a week; receives magazines regularly; number of books in home; home computer, encyclopedia in home; talks about school with family.

### Peers

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### School

#### *Teacher:*

Race/ethnicity; number of years teaching at elementary or secondary level; current certification from another state; highest academic degree; number of advanced math and math education classes taken; professional development activities; leadership responsibilities for math at your school; undergraduate/graduate major or minor in math; math-related subject or education (4<sup>th</sup> includes other subjects); teaches math only (4<sup>th</sup> grade); number of years teaching math in grades 6-12 (8<sup>th</sup> grade); math classes teaching this year (8<sup>th</sup> grade); hours of instruction in a typical week; computer available for teacher and student; how many in classroom (in their classroom, in lab); how often students use computer for various activities; how often teacher uses computer for various activities; availability of tech support, software, training at school for computer use; extent students are permitted to use calculators; kinds they usually use; who sets calculator policy at school; how often students use calculators for various activities.

#### *School:*

Grades taught; do all students follow same calendar; hours of instruction that students receive; current enrollment; percentage of students who are limited-English proficient; type of school; participation in National School Lunch Program; how NSLP eligibility is determined; percentage of students eligible; percentage of students who receive targeted Title I services; gifted and talented program; instruction provided in student's home language; ESL; special education.

4<sup>th</sup> grade: time each day required to spend on math; grouped by ability; placements evaluation; placement specialist. 8<sup>th</sup> grade: percentage of students who enroll in more than one math class a year for remediation/advancement; percentage of students enrolled in various math classes; are students assigned to classes by ability; percentage of students who transfer levels in 9<sup>th</sup> grade. 12<sup>th</sup> grade: number of students in last year's graduating class; percentage going to two-year colleges, 4-year colleges, or voc/tech or business school; number of years of coursework in math required for graduation; advanced math courses available; offers online test prep or courses.

Community

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## Schools and Staffing Survey (SASS)

**Description:** SASS is a national survey of primary and secondary schools (both public and private) which asks teachers, administrators, and school districts about the environment within their schools. Many survey questions are repeated in each survey cycle, allowing the investigation of trends over time. SASS has four main components: the School Questionnaire, the Teacher Questionnaire, the Principal Questionnaire, and the School District Questionnaire. SASS emphasizes teacher demand and shortage; staffing patterns; teacher recruitment and hiring practices; types of programs and services offered; school-level student, teacher, and administrator characteristics; and general conditions in schools. SASS also collects data on many other topics, including principals' and teachers' perceptions of school climate and problems in their schools; teacher compensation; certification; workload, perceptions and attitudes about teaching; and basic characteristics of the student population.

**Periodicity:** Every three to four years (2003)

**Coverage:** All 50 states plus the District of Columbia

**Sample Size:** 45,000 teachers; 9,000 schools; 4,700 school districts

**Age Groups:** School-age

**Respondent:** Administrator, teacher

**Sponsors:** Institute of Education Sciences, National Center for Education Statistics, U.S. Department of Education

**Web site:** <http://nces.ed.gov/surveys/sass/>

**Limitations:** Since the focus of SASS is on the school and teacher experiences, it does not provide much information on child well-being such as health, achievement, and social involvement. While some questions relate to student characteristics, students are not interviewed. It does provide good information about the type of school environment that students are in. Also, the ability to produce state-level estimates is restricted to users who have a special license from the National Center for Education Statistics, as this information includes state identifiers which could link sampled schools, principals, or teachers to the districts in which they are associated.

### **CHILD CHARACTERISTICS**

#### Health

Frequency of: alcohol use; illegal drug use; student pregnancy; poor student health.

#### Education/Intellectual Development

Frequency of: tardiness; absenteeism; class cutting; drop outs.

#### Social/Emotional/Civic Well-Being

Frequency of: physical conflicts among students; robbery; vandalism; weapons possession; physical abuse of teachers; racial tensions; bullying; verbal abuse of teachers; widespread disorder in classrooms; disrespect toward teachers; gang activities; student apathy; lack of parental involvement; poverty; students unprepared to learn.

Demographics

Number of students enrolled; number of migrant students; number of male students; race/Hispanic student distribution; National School Lunch Program; number enrolled in free/reduced lunch; number of students receiving Title 1 services.

**CONTEXTUAL INFLUENCES**

Family

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Peers

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School

Grade levels offered in school; number of teachers hired; total number of teachers; number of students in classroom; number of hours spent teaching English/Math/Social Studies/Science; teacher education (BA, MA, Ph.D., etc); teacher certification type; teacher working conditions; teachers coaching/sponsoring student groups; number of computers; internet access; lack of space for instruction; gifted/honors program; Advanced Placement classes; community service requirement; number of community service hours required.

Community

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## Adoption and Foster Care Analysis Reporting System (AFCARS)

- Description:** AFCARS is funded by the federal government to provide case specific information on all adopted children who are placed by the state’s child welfare agency or by private agencies under contract with the public welfare agency. In this federally mandated collection system, states are also required to collect data on all children in foster care, particularly those children whom the state child welfare agency has responsibility for care, supervision, and placement.
- Periodicity:** Continuous. States submit data to AFCARS twice a year, first reporting period ends April 30 and the second September 30. The Children’s Bureau combines submissions for the two reporting periods and removes duplicate records.  
1995 to present.
- Coverage:** All 50 states, the District of Columbia, and Puerto Rico.
- Sample Size:** The number of children in foster care as of September 30, 2005 (the most current data available) is approximately 513,000. The number adoptions of children with Public Child Welfare Agency involvement is approximately 51,000 in 2005.
- Age Groups:** 0 and above
- Respondent:** State (public child welfare agency)
- Sponsors:** Funding for project was provided by the Children’s Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services. The data is archived and made available by the National Data Archive on Child Abuse and Neglect at Cornell University, Ithaca, NY.
- Web site:** <http://www.acf.hhs.gov/programs/cb/systems/index.htm#afcars>
- Limitations:** Pre-1998 fiscal year datasets are not as reliable as subsequent datasets because fiscal penalties were not applicable. There is an inconsistent reporting of adopted and foster children across states.

### **CHILD CHARACTERISTICS**

#### Health

Diagnosed disability; visually or hearing impairment; physical disability; other diagnosed conditions; reason for the removal from home and placed in foster care (child alcohol abuse, child drug abuse, child disability, child behavior problem).

#### Education/Intellectual Development

Mental retardation.

#### Social/Emotional/Civic Well-Being

Emotionally disturbed.

#### Demographics

State; child birth date; gender; race; Hispanic origin; foster care payments; adoption subsidy; public assistance.

## **CONTEXTUAL INFLUENCES**

### Family

Biological mother/father birth date; marital status of biological mother; date the court terminated the biological mother/father's parental rights; foster/adoptive family structure; foster/adoptive parent birth date; foster/adoptive parent race or Hispanic origin; pre-adoptive relationship to adoptive parent (step-parent, other relative, foster parent, non-relative); reason for the removal from home and placed in foster care (physical abuse, sexual abuse, neglect, alcohol abuse parent, drug abuse parent, parent death, parent incarceration, caretaker inability to cope, abandonment, relinquishment, inadequate housing).

### Peers

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### School

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### Community

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## National Child Abuse and Neglect Data System (NCANDS)

**Description:** Child-specific data of investigated reports of maltreatment to state child protective services agencies are reported in the NCANDS Child File. It is a federally-sponsored annual national data collection effort for tracking the volume and nature of child maltreatment reporting. States submit their data after their administrative system is mapped to the NCANDS data structure. The data consists of all investigations and assessments of alleged child maltreatment that received a disposition in the reporting year.

**Periodicity:** Continuous, began 1990

**Coverage:** 50 states, the District of Columbia, and Puerto Rico

**Sample Size:** In 2005, an estimated 899,000 children were determined to be victims of child abuse and neglect by child protective services agencies

**Age Groups:** 0-17; limited information on those 18 and older

**Respondent:** State report

**Sponsors:** Original data collected under the authority of the Children's Bureau with funding provided by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. The data is archived and made available by the National Data Archive on Child Abuse and Neglect (NDACAN) at Cornell University, Ithaca, NY.

**Web site:** <http://www.acf.hhs.gov/programs/cb/systems/index.htm#ncands>

**Limitations:** NCANDS reports with data for all states are available from the U.S. Department of Health and Human Services, Administration on Children, Youth and Families in *Child Maltreatment* publications, but only aggregate counts by state are available for 1990-2005 from (NDACAN). There are also restricted usage files of case-level data, but only for certain states that are available for researchers. 44 states and the District of Columbia in 2004 agreed to archive their NCANDS Child File data with NDACAN: AK, AL, GA, ND, OR, and WI did not submit data. States vary considerably on how they define maltreatment and how they investigate and count cases, so comparability across states is problematic. If the child died due to maltreatment, certain demographic characteristics are suppressed for confidentiality reasons.

### **CHILD CHARACTERISTICS**

#### Health

Prior victim of maltreatment; maltreatment type (physical abuse, neglect or deprivation of necessities, medical neglect) and disposition level (substantiated, indicated or reason to suspect, alternative response victim, alternative response nonvictim, unsubstantiated); alcohol abuse; drug abuse; visually or hearing impaired; physically disabled; other medical condition.

#### Education/Intellectual Development

Mental retardation; learning disability.

Social/Emotional/Civic Well-Being

Maltreatment type (sexual abuse, psychological or emotional maltreatment) and disposition level (substantiated, indicated or reason to suspect, alternative response victim, alternative response nonvictim, unsubstantiated); emotionally disturbed; behavior problems.

Demographics

State; county; age; gender; race/ethnicity; living arrangement (family structure); military status of family; public assistance; financial problems.

**CONTEXTUAL INFLUENCES**

Family

*Caretaker(s)*

Alcohol abuse; drug abuse; mental retardation; emotionally disturbed; visually or hearing impaired; learning disability; physically disabled; other medical conditions; domestic violence; inadequate housing.

*Perpetrator(s)*

Relationship to child; age; gender; race/ethnicity; military member; prior abuser, type of maltreatment inflicted on child/youth.

*Services available for the child and family*

Post investigation services; family support services; family preservation services; foster care services; adoption services; case management services; counseling services; day care services; educational and training services; employment services; family planning services.

Peers

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School

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Community

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Diagnosed disability; visually or hearing impairment; physical disability; other diagnosed conditions; reason for the removal from home and placed in foster care (child alcohol abuse, child drug abuse, child disability, child behavior problem).

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Mental retardation.

#### Social/Emotional/Civic Well-Being

Emotionally disturbed.

#### Demographics

State; child birth date; gender; race; Hispanic origin; foster care payments; adoption subsidy; public assistance.

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### Family

Biological mother/father birth date; marital status of biological mother; date the court terminated the biological mother/father's parental rights; foster/adoptive family structure; foster/adoptive parent birth date; foster/adoptive parent race or Hispanic origin; pre-adoptive relationship to adoptive parent (step-parent, other relative, foster parent, non-relative); reason for the removal from home and placed in foster care (physical abuse, sexual abuse, neglect, alcohol abuse parent, drug abuse parent, parent death, parent incarceration, caretaker inability to cope, abandonment, relinquishment, inadequate housing).

### Peers

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### Community

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Maltreatment type (sexual abuse, psychological or emotional maltreatment) and disposition level (substantiated, indicated or reason to suspect, alternative response victim, alternative response nonvictim, unsubstantiated); emotionally disturbed; behavior problems.

Demographics

State; county; age; gender; race/ethnicity; living arrangement (family structure); military status of family; public assistance; financial problems.

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Family

*Caretaker(s)*

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Peers

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School

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Community

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