



November 2017

# CHILD WELL-BEING

## Key Considerations for Policymakers, Including the Need for a Federal Cross- Agency Priority Goal

Accessible Version

Enhancing the well-being of our children—one of the nation’s most valuable assets—requires a coordinated federal approach that takes into account the interrelatedness of federal actions and policies that aim to improve the lives of children.

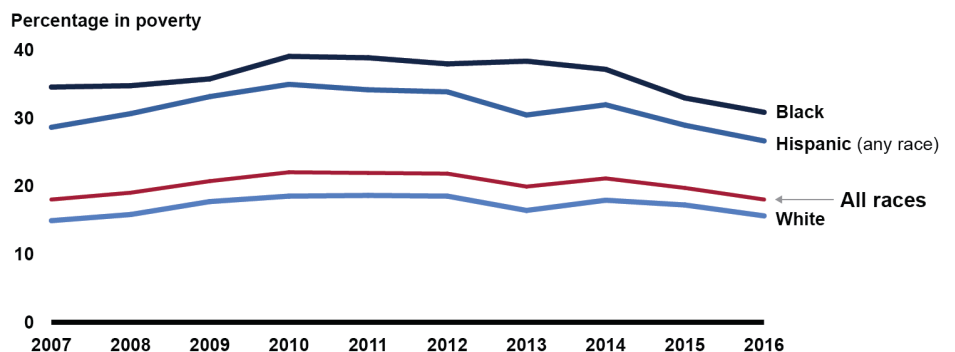
For this report, GAO reviewed published federal data on select child well-being indicators, and interviewed federal officials and officials from 18 organizations that conduct research on children and family issues, selected to provide balance and coverage by subject matter expertise and to provide a range of viewpoints.

## CHILD WELL-BEING

### Key Considerations for Policymakers, Including the Need for a Federal Cross-Agency Priority Goal

The long-term success of a nation depends in large part on how well families and society care for their children. Child well-being can be measured through various indicators that reflect a child’s family, physical, and social environments, health, and education. This report examines what is known about the state of child well-being and discusses selected experts’ views on what policymakers could consider when addressing it. While many factors influence a child’s well-being, poverty—particularly early in life—can have long-term consequences in many areas, such as the ability to be successful in school and work. In 2016, about 18 percent of children in the United States lived in poverty, with some groups faring worse than others.

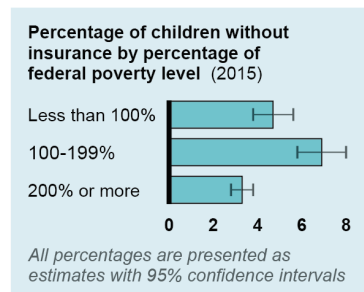
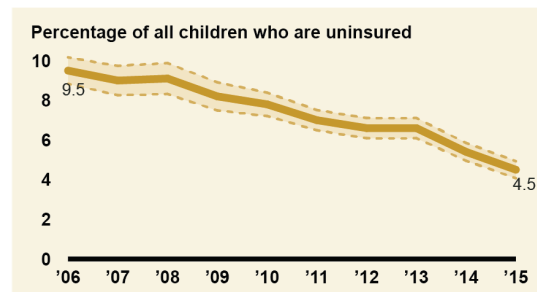
**Estimated Percentage of U.S. Children Living in Poverty, by Race and Ethnicity**



Source: U.S. Census Bureau, Current Population Survey, 2008 to 2017 Annual Social and Economic Supplements. | GAO-18-41SP

### Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others

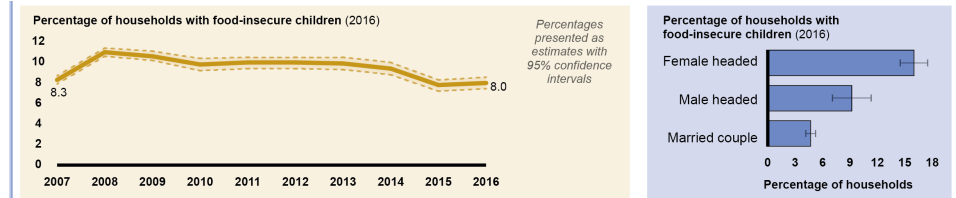
In recent years, the well-being of children in the United States has improved in some areas but not in others, and well-being continues to be generally worse for children who are minority, poor, and/or from families headed by single mothers (compared to married parents), according to the federal data GAO reviewed. Federal data show higher high school graduation rates and a greater percentage of children who have health insurance, although this varied based on children’s characteristics.



Source: U.S. Department of Health and Human Services’ National Health Interview Survey. | GAO-18-41SP

Areas where children have fared worse over the last decade include depression and student homelessness. In school year 2014-15, about 1.26 million students were identified as homeless by public school districts, compared to less than one million in school year 2005-06.

The percentage of households with food-insecure children—i.e. children who do not have access at all times to enough food for an active, healthy life—stayed about the same over the last decade, with female-headed households having the greatest percentage of food-insecure children.



Source: U.S. Department of Agriculture, Economic Research Service using data from the U.S. Census Bureau, Current Population Survey Food Security Supplement. | GAO-18-41SP

Note: Data are based on the U.S. Department of Agriculture's measure of food security calculated from responses to a series of questions about the conditions and behaviors that characterize households when they are having difficulty meeting basic food needs.

## Section 2: Experts Noted Several Considerations for Policymakers Seeking to Address the Multiple Dimensions of Child Well-Being

Experts interviewed by GAO expressed a range of viewpoints on how policymakers could address child well-being, such as considering the whole family when addressing the needs of children and coordinating efforts among federal, state, local, and non-governmental entities, among other areas. Experts suggested that policymakers consider ways to support a family's ability to provide the safe, supportive, and nurturing environment that children need. For example, some experts highlighted the role of policies that promote marriage or encourage the maintenance of two-income households.

With respect to coordination, experts discussed the importance of federal agencies coordinating with stakeholders inside and outside government to address child well-being. At the federal level, several experts suggested that efforts to address child well-being are hindered by insufficient coordination, noting that federal agencies generally lack the multidisciplinary structure needed for a coordinated approach. The Office of Management and Budget (OMB) is required to coordinate with agencies to develop federal government priority goals (known as cross-agency priority or CAP goals). These are long-term, outcome-oriented goals that cover a limited number of crosscutting policy areas. To date, child well-being has not been designated as a CAP goal. OMB is reviewing the current administration's priorities to help develop new goals. By highlighting child well-being as an overarching priority area and ensuring that this priority is reflected in agencies' strategic plans, OMB could help draw needed attention to federal efforts to improve child well-being.

### Recommendation for Executive Action

GAO recommends that OMB consider developing a goal that addresses a coordinated federal approach to child well-being among its next set of cross-agency priority, or CAP, goals, including working with relevant agencies to ensure their strategic plans include related goals and objectives. OMB neither agreed nor disagreed with the recommendation and noted that it is currently in the process of developing the next set of CAP goals.

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**Abbreviations**

CAP goals	Cross-agency priority goals
CDC	Centers for Disease Control and Prevention
ERS	Economic Research Service
HHS	U.S. Department of Health and Human Services
HUD	U.S. Department of Housing and Urban Development
K-12	Kindergarten through 12th grade
OMB	Office of Management and Budget

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## *Preface*

November 9, 2017

The well-being of the nation's children is critical to our country's prosperity, and understanding how children are faring across various areas is important to addressing their needs. The success of the nation depends in large part on how well families, and society as a whole, can ensure that its nearly 74 million children grow up in safe and healthy environments and become responsible and productive adults. Research suggests that adverse experiences in childhood can lead to negative outcomes throughout one's life—including poor health and academic performance, as well as unemployment, all of which not only adversely affect the individual, but also the strength of the nation's social and economic sectors.<sup>1</sup> While there is not a single definition of child well-being, it is widely considered to be influenced by a variety of factors, including the extent to which children's basic and other needs are met within the context of their families, communities, and society at large. Accordingly, child well-being can be measured across a range of indicators that reflect the family, physical, and social environments in which children live, as well as their health and educational experiences.

While many factors influence a child's well-being, living in poverty—especially early in life—can have wide-ranging ramifications in a host of

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<sup>1</sup>See the U.S. Department of Health and Human Services' Centers for Disease Control and Prevention-Kaiser Permanente's Adverse Childhood Experiences Study. This study—one of the largest investigations of childhood abuse and neglect and later-life health and well-being—found that the risk of negative health and well-being outcomes across one's life course (e.g., depression, unintended pregnancy, poor academic achievement, and poor work performance) increased as the number of challenges faced as children increased. The challenges in the study included abuse, neglect, and household challenges, such as divorce or parental mental illness.

areas.<sup>2</sup> Children who experience poverty are often more likely to face academic and social challenges, live in adverse conditions, and have poorer health than children who grow up in higher-income families. These adverse outcomes tend to limit the development of skills and abilities needed to contribute productively to the economy. From 2007 to 2016, the estimated percentage of all children living in poverty in the United States remained about the same at 18 percent, after peaking in 2010 at 22 percent, according to U.S. Census Bureau (Census) data.<sup>3</sup> Some groups of children fared worse than others. Black and Hispanic children, for example, experienced poverty at significantly higher rates than White children during this time period (see fig. 1).

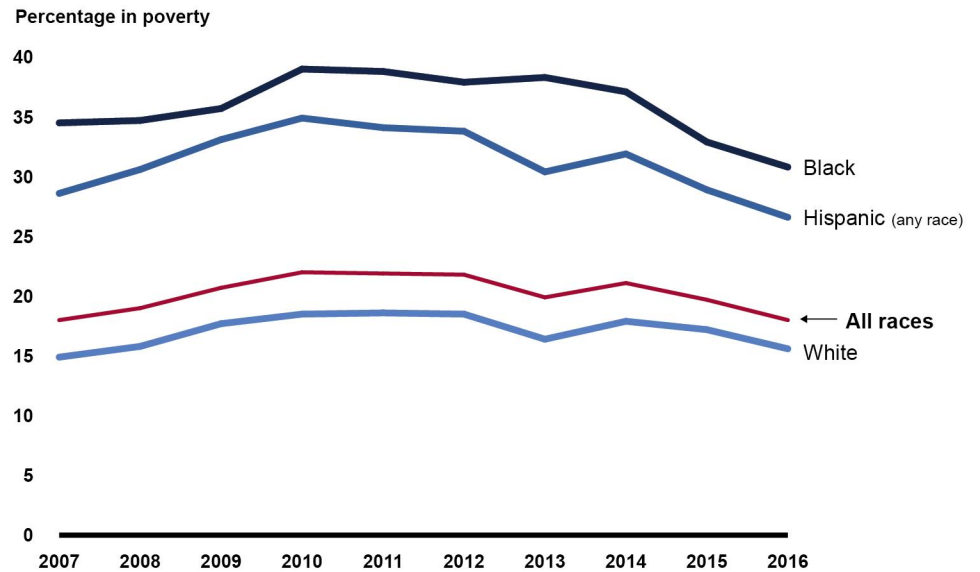
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<sup>2</sup>The official poverty thresholds—the income thresholds by which households are considered to be in poverty depending on their size and composition—are updated annually by the U.S. Census Bureau (Census) to reflect current prices. The U.S. Department of Health and Human Services (HHS) uses the official poverty thresholds to update the “federal poverty guidelines” each year, which are the basis for determining eligibility or funding distribution for certain federal programs. The federal poverty guidelines issued by HHS are a simplified version of the official poverty thresholds issued by Census and there are some differences between two measures. For instance, the HHS guidelines vary by family size, while the Census poverty thresholds vary by family size, number of children, and, for households with one or two people, whether these members are elderly. In addition, due to differences in the timing of when each measure is updated, the poverty guidelines are approximately equivalent to the poverty thresholds for the prior year. In determining a household’s income, the official measure considers cash income, but does not include additions to income based on the value of noncash assistance (e.g., food assistance) or reductions based on other necessary living expenses (e.g., medical expenses or taxes paid). In this report, references to the “federal poverty level” or “FPL” refer to Census’s federal poverty thresholds.

<sup>3</sup>According to the U.S. Census Bureau’s Current Population Survey, while the poverty rate for children under 18 remained about the same from 2007 to 2016, it decreased between 2014 and 2016 from an estimated 21.1 percent to 18.0 percent. The poverty estimates for 2007, 2010, 2014, and 2016 have a margin of error no larger than plus or minus 0.72 percentage points at the 95 percent level of confidence.



**Figure 1: Estimated Percentage of U.S. Children Living in Poverty, by Race and Ethnicity, 2007-2016**



Source: U.S. Department of Commerce, U.S. Census Bureau, Current Population Survey, 2008 to 2017 Annual Social and Economic Supplements. | GAO-18-41SP

Notes: The data include all children less than 18 years of age. Black=Black alone and White=White alone. Estimates for Black children have a margin of error no greater than plus or minus 2.3 percentage points at the 95 percent level of confidence. Estimates for Hispanic children have a margin of error no greater than plus or minus 1.7 percentage points at the 95 percent level of confidence. Estimates for White children and all children have a margin of error no greater than plus or minus 0.8 percentage points at the 95 percent level of confidence.

The federal poverty thresholds are updated by the U.S. Census Bureau each year; in 2016, the poverty threshold for a family of four people with two children was \$24,339.

Family composition also relates to poverty. For example, while an estimated 10 percent of families in the United States lived in poverty in 2016, single-parent families fared worse, according to Census data from the Current Population Survey.<sup>4</sup> Specifically, an estimated 27 percent of female-headed households and 13 percent of male-headed households lived in poverty in 2016, compared to 5 percent of households with married couples.<sup>5</sup>

<sup>4</sup>This refers to primary families. According to the U.S. Census Bureau, a primary family is a group of two or more people, one of whom is the householder, related by birth, marriage, or adoption and residing together. All such people (including related subfamily members) are considered as members of one family.

<sup>5</sup>These estimates of poverty by type of family have a margin of error no greater than plus or minus 1.3 percentage points at the 95 percent level of confidence. See Jessica L. Semega, Kayla R. Fontenot, and Melissa A. Kollar, U.S. Census Bureau, Current Population Reports, P60-259, *Income and Poverty in the United States: 2016*, U.S. Government Printing Office, Washington, D.C., 2017.

According to studies by the U.S. Department of Agriculture's Economic Research Service (ERS), children living in rural areas have higher poverty rates than children living in urban areas. ERS notes that the rise in rural child poverty is partly due to the fact that average incomes for rural families with children did not rise during the economic expansion of 2003-07, and fell during the 2007-09 recession and the early years of the recovery. In 2015, rural (nonmetropolitan) child poverty declined to about 24 percent and urban child poverty declined to about 20 percent.<sup>6</sup>

While families play an essential role in nurturing and providing for their children, the government also has a clear interest in promoting child well-being and does so in a variety of ways. States and localities help fund and administer programs to foster the well-being of children and families. The federal government also supports states by helping to fund many of these efforts. These include, for example, programs that provide medical, housing, food, and other types of assistance to eligible children and families, as well as those that promote equitable educational opportunities and tax policies. These programs can play a key role in enhancing the well-being of low-income families and children. While official poverty statistics incorporate cash assistance received by families, they do not reflect non-cash assistance provided by these government programs. The U.S. Census Bureau developed the Supplemental Poverty Measure as an alternative measure to take into account non-cash assistance provided by many government programs designed to assist low-income families. The

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<sup>6</sup>The specific rural child poverty data cited are derived from the American Community Survey, which, according to ERS, the U.S. Census Bureau recommends using because it has a much larger sample size than the Current Population Survey. However, as ERS states in its study on rural poverty, the American Community Survey does not allow for the same historical perspective as does the Current Population Survey, and the two surveys are not directly comparable, given that the design of the American Community Survey differs from that of the Current Population Survey in a variety of ways and may produce somewhat different poverty estimates. ERS did not provide a statement of sampling error associated with these estimates. See U.S. Department of Agriculture, Economic Research Service, "Poverty Overview" updated March 2017; <https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/poverty-overview.aspx>; and *Understanding the Rise in Rural Child Poverty, 2003-2014*, USDA, Economic Research Service, May 2016.

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Supplemental Poverty Measure rate for children was lower in 2016 than the poverty rate under the official poverty measure.<sup>7</sup>

In addition to administering programs that support low-income families, federal agencies also conduct and sponsor evaluations of programs and some have established goals designed to improve the state of child well-being. Federal agencies also collect and disseminate data that can be used to help gauge progress toward these goals and may also work together to address and draw attention to society-wide issues related to child well-being. For example, the United States Interagency Council on Homelessness, which includes 19 federal agencies, established goals to work together to end youth and family homelessness. A similar effort—Healthy People—provides a comprehensive set of 10-year national goals and objectives for improving the health of all Americans, including specific indicators pertaining to children.<sup>8</sup>

Many entities, including non-profit organizations and federal government agencies, recognize the importance of child well-being and have developed frameworks to measure how well children in the United States are faring. For example, the Federal Interagency Forum on Child and Family Statistics (the Forum) publishes an annual report that includes a summary of national indicators of child well-being.<sup>9</sup> The Forum is a collaboration of 23 federal agencies, and its mission is to foster

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<sup>7</sup>The U.S. Census Bureau developed the Supplemental Poverty Measure in 2010 with support from the U.S. Department of Labor's Bureau of Labor Statistics. This measure includes all the same components under cash income as the official measure, but adds non-cash benefits, such as housing and food assistance, and subtracts expenses, such as child care and medical expenses, to reach a final measure of household resources. According to a recent U.S. Census Bureau report, the poverty rate for children in 2016 was 15.2 percent when measured using the Supplemental Poverty Measure, compared to 18 percent using the official poverty measure. The 95 percent confidence interval for these estimates are (14.6, 15.8) and (17.4, 18.6), respectively. See U.S. Department of Commerce Economics and Statistics Administration, U.S. Census Bureau, *The Supplemental Poverty Measure: 2016, Current Population Reports, Revised September 2017*.

<sup>8</sup>A federal interagency workgroup led the Healthy People 2020 development effort. The workgroup drew on the diverse backgrounds of its member agencies, lessons learned from past Healthy People efforts, broad-based public comment, and the work of the Secretary of Health and Human Services' Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020.

<sup>9</sup>Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief: Key National Indicators of Well-Being, 2016*. Washington, D.C.: U.S. Government Printing Office. The Forum was established by section 6 of Executive Order 13045, 62 Fed. Reg. 19,885, 19,887 (Apr. 23, 1997).

coordination and collaboration and to enhance and improve consistency in the collection and reporting of federal data on children and families. The Forum also aims to improve the reporting and dissemination of information on the status of children and families. It does not, however, focus on programs or policies related to child well-being or coordinate efforts to improve or implement these programs among federal agencies, according to Forum officials. There are many other organizations and researchers—both domestically and internationally—that have also developed frameworks and published child well-being indicators (see app. II for a selected list of these organizations and associated frameworks).

This report (1) examines what is known about the state of child well-being in the United States and how it has changed in recent years, and (2) discusses selected experts' views on what policymakers could consider in addressing child well-being. We reviewed select federal data related to several indicators of child well-being and, after reviewing several child well-being frameworks and discussing these indicators with a variety of subject matter experts, we selected and categorized indicators along three main areas of a child's life: (1) family, physical, and social environment; (2) physical and mental health; and (3) early care and education (see fig. 2).

**Figure 2: Selected Indicators of Child Well-Being**



Source: GAO analysis of child well-being frameworks. | GAO-18-41SP

For each child well-being indicator, we reviewed published federal data for children overall over the most recent 10-year period, and by certain characteristics—race/ethnicity, income level/poverty status, and family composition—for the first and last years of the 10-year period, to the extent data were available. We assessed the reliability of the data by (1) reviewing existing information about the data and the system that produced them, and, in some cases, (2) interviewing agency officials knowledgeable about the data. We determined that the data were sufficiently reliable for the purposes of this report. We interviewed federal agency officials from the U.S. Office of Management and Budget (OMB), Department of Agriculture’s ERS, Department of Education’s National Center for Education Statistics, Department of Health and Human Services’ (HHS) Centers for Disease Control and Prevention (CDC), and HHS’s Assistant Secretary for Planning and Evaluation about child well-being issues and related data. We also interviewed officials with subject

matter expertise in child well-being from 18 non-governmental organizations that were selected to provide variation across areas of expertise and a wide range of viewpoints, including perspectives on the role of the federal government. The information and perspectives we obtained and present in this report should not be regarded as an exhaustive discussion that includes all viewpoints of experts on child well-being issues, nor is it generalizable to all child well-being experts. The viewpoints summarized in this report also do not necessarily represent the views of all the experts we interviewed, their organizations, or GAO. See appendix I for a complete discussion of our methodology.

We conducted this performance audit from March 2016 to November 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Readers who are interested in more in-depth discussions of child well-being issues may refer to the list of related GAO products at the end of this report (appendix IV). This report was prepared under the direction of Kathryn A. Larin, Director, Education, Workforce, and Income Security Issues, who may be reached at (202) 512-7215 or [larink@gao.gov](mailto:larink@gao.gov). GAO staff who made key contributions to this publication are listed in appendix V. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this publication. In addition, this publication will be available at no charge on GAO's website at <http://www.gao.gov>.



Gene L. Dodaro  
Comptroller General of the United States

# Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others

In recent years, the well-being of children in the United States has improved in some areas but not in others, according to the federal data we reviewed, and well-being continues to be generally worse for children who are minority, poor, and/or from families headed by single mothers (compared to married parents). For example, while data show greater health insurance coverage and higher high school graduation rates in recent years, children and youth fared worse in areas such as homelessness and major depression. Data also show that the disparities (also referred to as gaps) in well-being that exist among children across different racial/ethnic groups, income levels, and families of varying compositions have persisted, though, in some cases, these have narrowed over time. For example, the homicide rate of Black 15 to 19 year olds in 2014 was significantly higher than that of Whites in the same age group, though the gap in their homicide rates narrowed over the last decade. In another example, Black, Hispanic, and poor students' estimated average reading and math scores were worse than their White and non-poor peers, though the achievement gaps between Black and White students and between Hispanic and White students narrowed a few points for 4th and 8th grade, but stayed about the same for 12th grade. The gaps between poor students and their non-poor peers remained about the same across reading and math scores.

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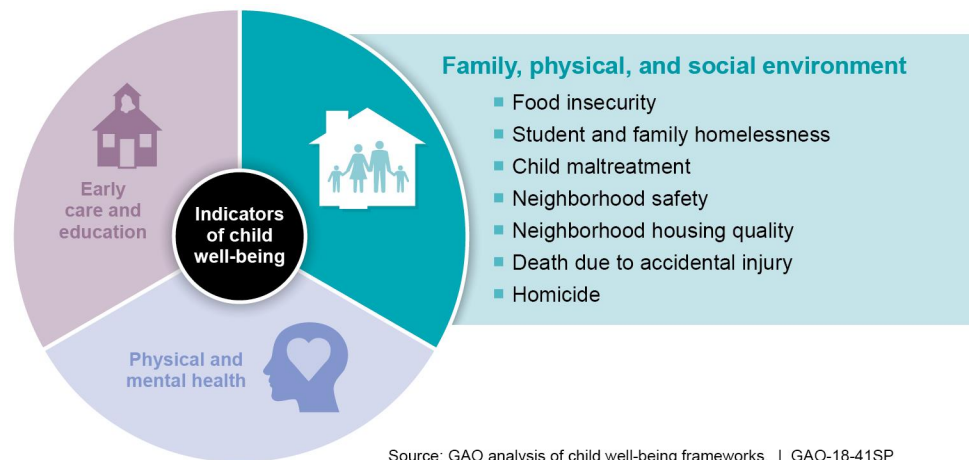
## Family, Physical, and Social Environment of Children

Over the last decade, federal data we reviewed show that changes in the family, physical, and social environments of children overall have been mixed, and, in general, children with certain characteristics have fared worse than others (see fig. 3 below for the indicators we reviewed). For

**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

example, the estimated percentage of households with food-insecure children was about the same in 2016 as in 2007; however, in 2016, the estimated percentage of Black and Hispanic households with food-insecure children was higher than that of White households, and single-mother households had higher estimated rates of food insecure-children than married-couple households in that same year.<sup>1</sup> In other areas, the family, physical, and social environment of children improved over time for children in certain age groups. From 2005 to 2014, death rates due to accidental injuries, such as drowning, decreased for all teenagers age 15 to 19.<sup>2</sup> However, the accidental death rate of American Indian/Alaska Native youth age 15 to 19 in 2014 was higher than that of their White peers. One area where children overall fared worse was homelessness; a greater number of enrolled public school students were homeless in school year 2014-15 than in 2005-06. (See figs. 4–10.)

**Figure 3: Family, Physical, and Social Environment Indicators of Child Well-Being**



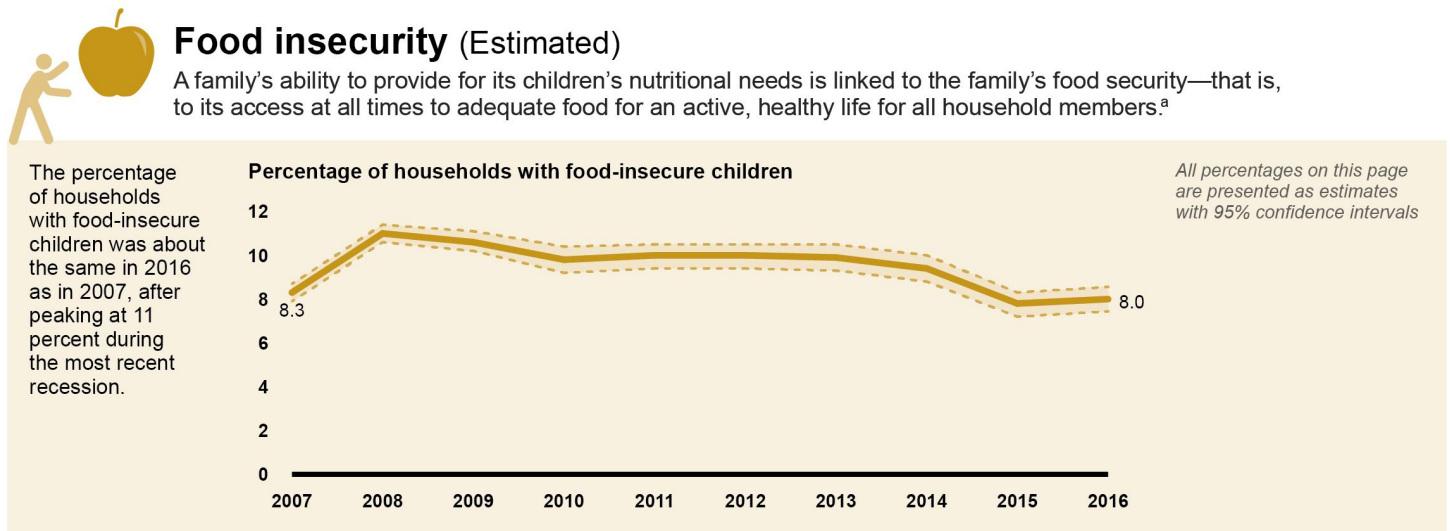
<sup>1</sup>According to the U.S. Department of Agriculture, households with food-insecure children are those households in which children do not have access at all times to enough food for an active, healthy life.

<sup>2</sup>Death rates due to accidental injuries also decreased for children ages 1-4, 5-9, and 10-14, but increased for infants under 1 year over the same period.

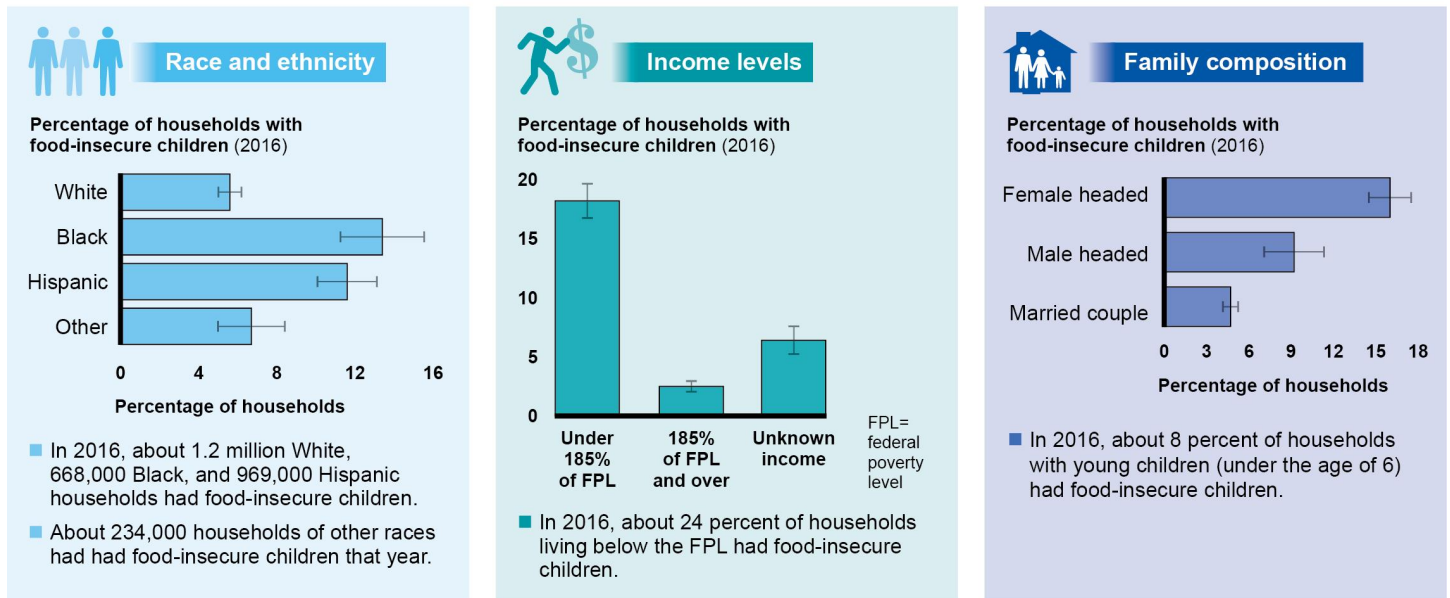


**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 4: Food Insecurity**



**2016:** Black, Hispanic, poorer, and/or female-headed households had the highest rates of food-insecure children.



Source: U.S. Department of Agriculture, Economic Research Service using data from the U.S. Department of Commerce, U.S. Census Bureau, Current Population Survey Food Security Supplement. | GAO-18-41SP

Notes: The household food security statistics are based on a measure of food security calculated from responses to a series of questions about conditions and behaviors that characterize households when they are having difficulty meeting basic food needs. Households are classified as having food-insecure children if they report two or more food-insecure conditions among the children in response to certain questions. For race and ethnicity data, "White"=White, non-Hispanic; "Black"=Black, non-Hispanic; and "Other"=Other, non-Hispanic. Hispanics may be of any race. For income level data, a household's poverty status was determined based on family income, size, and composition, using the U.S. Census Bureau's poverty thresholds (referred to in the figure as the "federal poverty level"). For more information, see Alisha Coleman-Jensen, Matthew P. Rabbitt, Christian A. Gregory, and Anita Singh, *Household Food Security in the United States in 2016*, ERR-237 (U.S. Department of Agriculture, Economic Research Service, September 2017).

<sup>a</sup>See Alisha Coleman-Jensen, Matthew P. Rabbitt, Christian A. Gregory, and Anita Singh, *Household Food Security in the United States in 2016*, ERR-237 (U.S. Department of Agriculture, Economic Research Service, September 2017).

**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 5: Student and Family Homelessness**

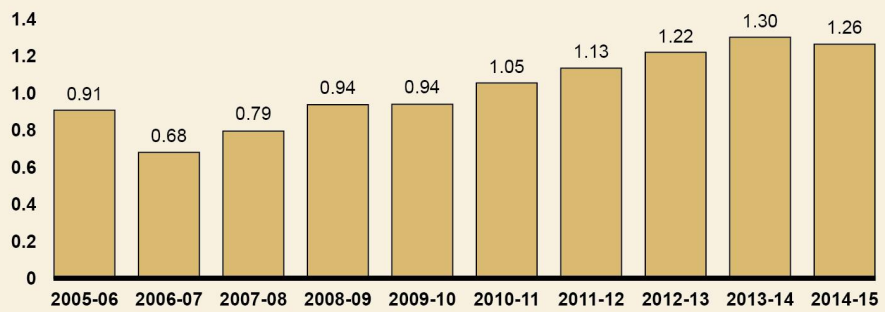


**Student and family homelessness**

Research suggests young children in families that experience homelessness are exposed to many developmental risks, such as poverty, family separation, violence, and school instability, which can contribute to behavioral issues and delays in academic skills<sup>a</sup>

In school year 2014-15, the majority of homeless students – more than 950,000 – were “doubled-up” (living with others due to a loss of housing, economic hardship, or a similar reason). About 95,000 homeless students were unaccompanied youth, that is, not in the physical custody of a parent or guardian, in school year 2014-15.

**Number of enrolled public school students who were homeless (in millions)**

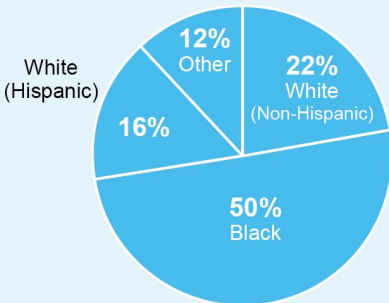


**2015:** Half of people in families with children who used an emergency shelter or transitional housing program were Black.



**Race and ethnicity**

People in families with children using an emergency shelter or transitional housing program (2015)

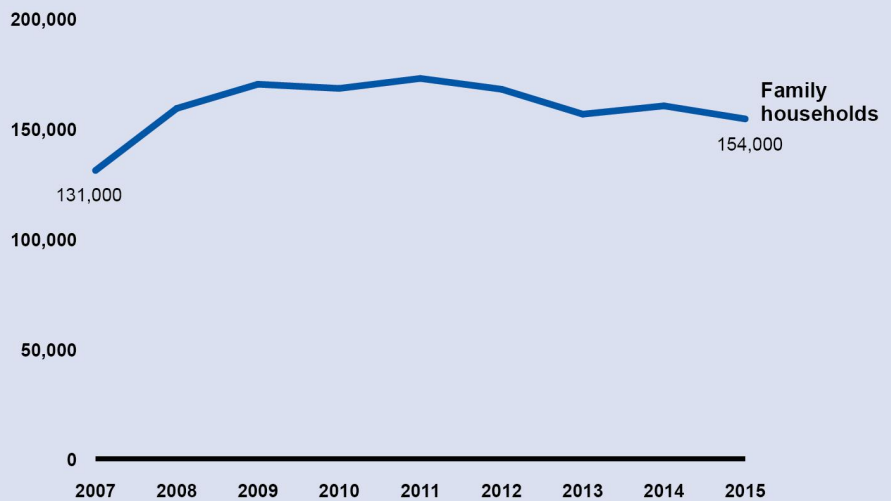


The percentage of White (non-Hispanic) and White (Hispanic) people in families with children using an emergency shelter or transitional housing program increased slightly from 2007 to 2015, while the relative share of all other groups decreased.



**Families with children**

One-year estimates of families using an emergency shelter or transitional housing program



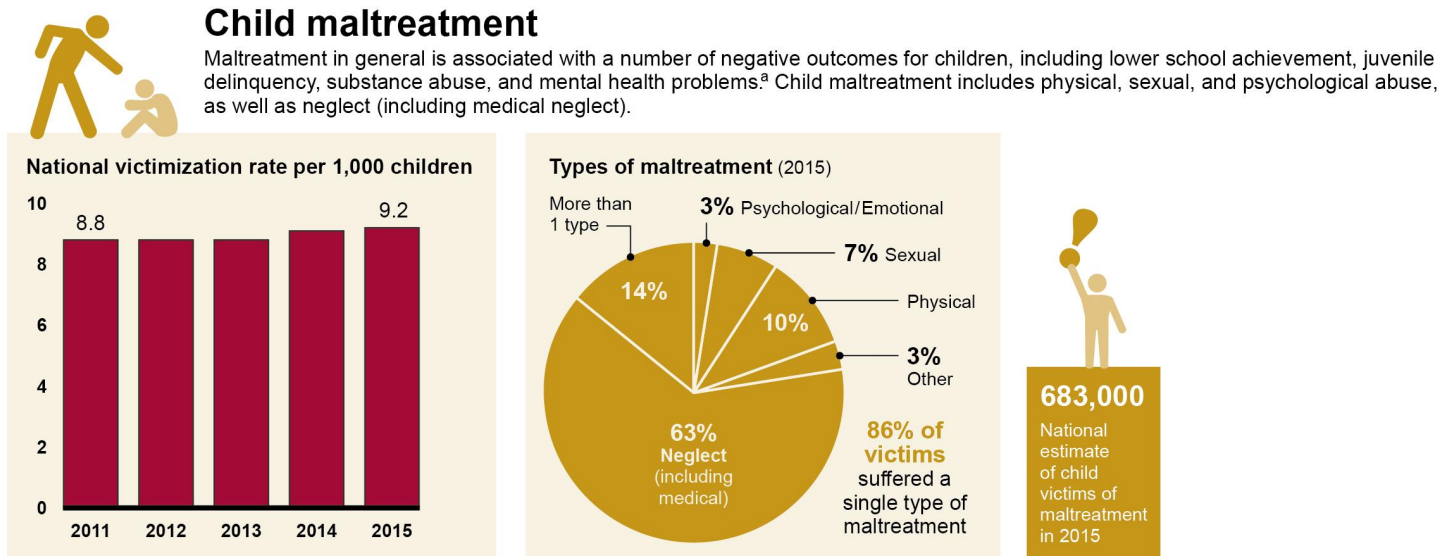
Source: U.S. Department of Education’s Consolidated State Performance Report data from the National Center for Homeless Education and Homeless Management Information System data from the U.S. Department of Housing and Urban Development. | GAO-18-41SP

Notes: According to the National Center for Homeless Education (NCHE), homeless students reported as enrolled in public school districts by state educational agencies represent an unduplicated count of students from the 50 states, the District of Columbia, and Puerto Rico. See NCHE, *Federal Data Summary: School Years 2012-13 to 2014-15, Education for Homeless Children and Youth* (Browns Summit, NC, 2016). According to the U.S. Department of Housing and Urban Development (HUD), the one-year estimates account for all people who used an emergency shelter or transitional housing program as part of a family with children at any time from October 1 through September 30 of the reporting year. HUD data do not include people who are “doubled-up.” See HUD, Office of Community Planning and Development, *The 2015 Annual Homeless Assessment Report (AHAR) to Congress Part 2: Estimates of Homelessness in the United States* (October 2016).

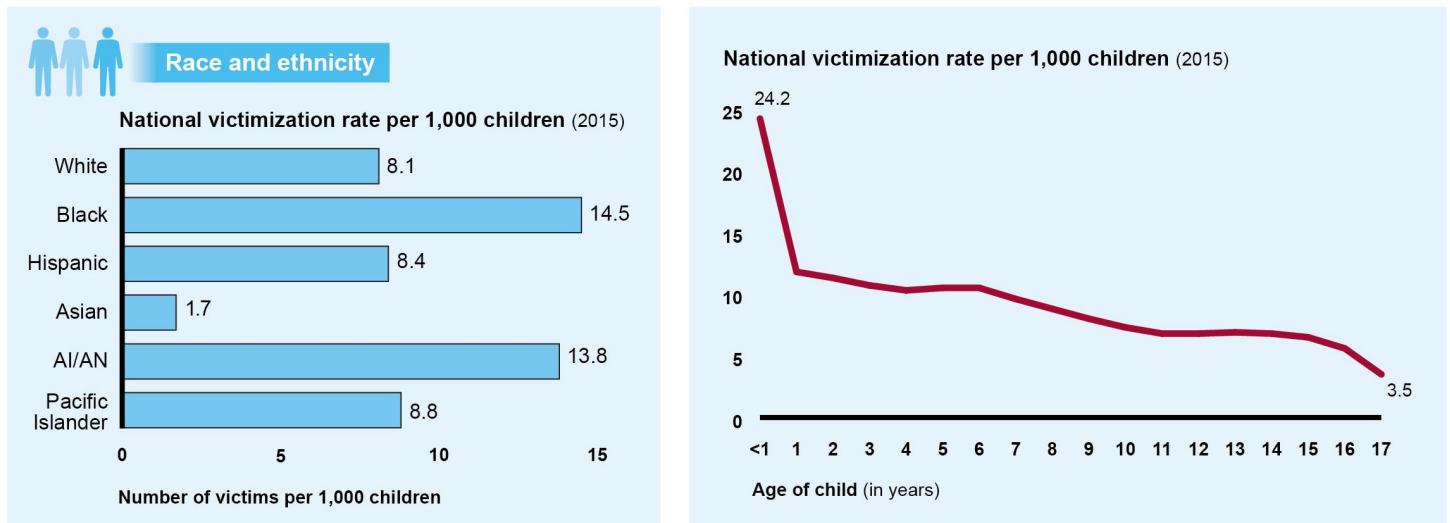
<sup>a</sup>See U.S. Department of Health and Human Services, *Well-being of Young Children after Experiencing Homelessness*, Homeless Families Research Brief OPRE Report No. 2017-06 (January 2017).

**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 6: Child Maltreatment**



2015: The child victimization rate differed by age, with the youngest children experiencing the highest rates.



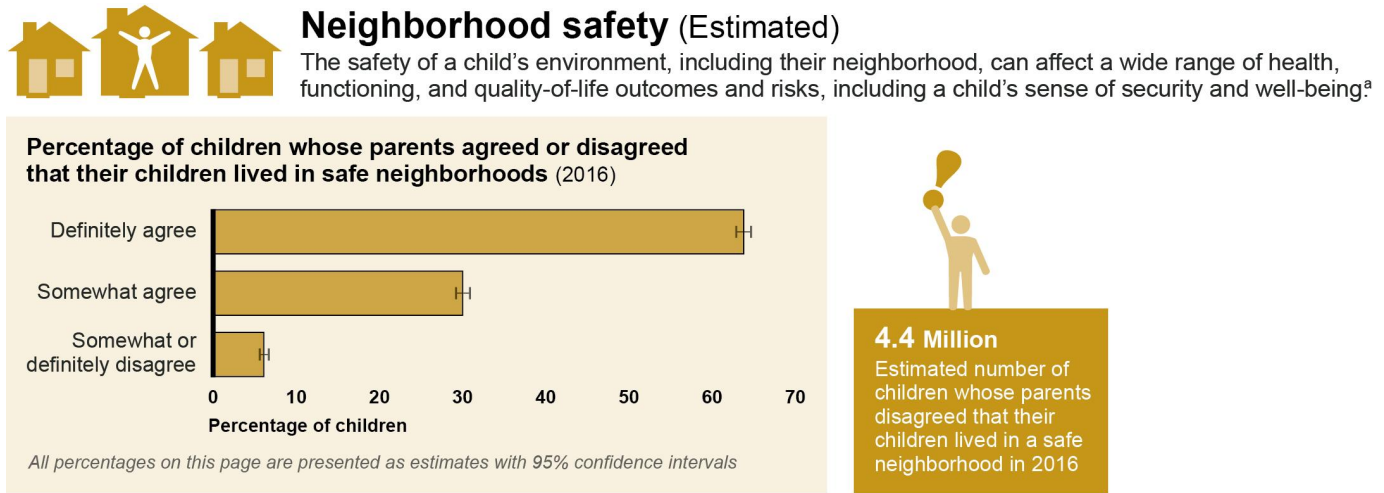
Source: U.S. Department of Health and Human Services' National Child Abuse and Neglect Data System. | GAO-18-41SP

Notes: All states have child abuse and neglect reporting laws that mandate certain professionals and institutions refer suspected maltreatment to a child protective services agency. Each state has its own definitions of child abuse and neglect, consistent with federal law. The Child Abuse Prevention and Treatment Act (CAPTA), as amended, defines child abuse and neglect as, at a minimum: any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm. Data are submitted voluntarily to the U.S. Department of Health and Human Services by the 50 states, the District of Columbia, and the Commonwealth of Puerto Rico, and collected in the National Child Abuse and Neglect Data System (NCANDS). In NCANDS, a victim is defined as a child for whom the state determined that at least one instance of maltreatment was substantiated or indicated. The number of victims is a unique count. For race and ethnicity data, counts associated with each racial group are exclusive and do not include Hispanic ethnicity. AI/AN=American Indian or Alaska Native. For more information, see U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *Child Maltreatment 2015* (2017).

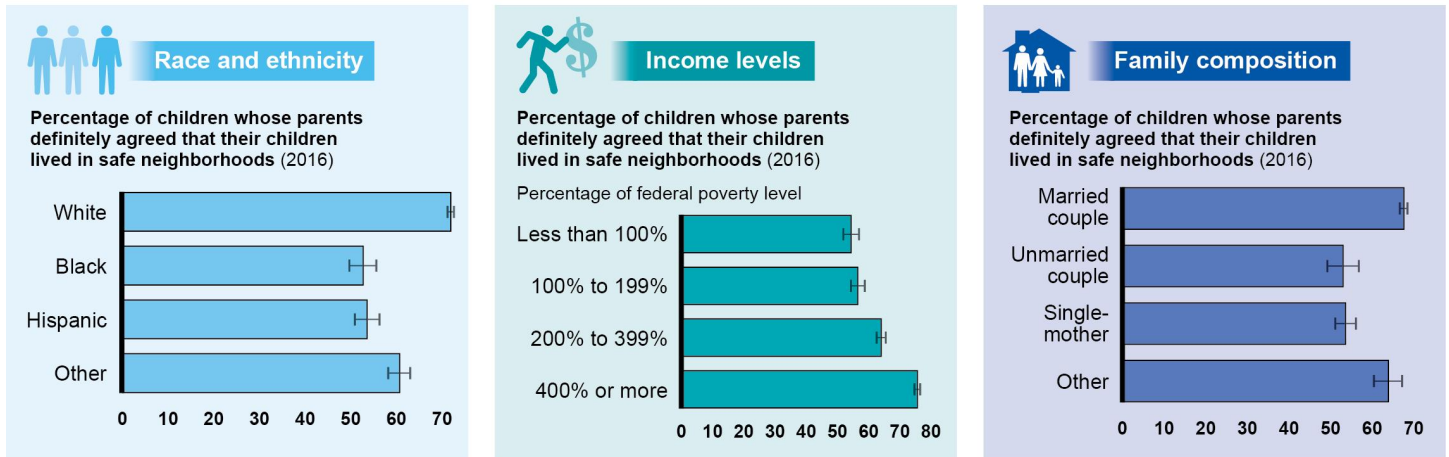
<sup>a</sup>See Federal Interagency Forum on Child and Family Statistics, *America's Children in Brief: Key National Indicators of Well-Being, 2016*. (Washington, D.C.: U.S. Government Printing Office).

**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 7: Neighborhood Safety**



**2016:** Parents of non-White children and lower income parents were less likely to agree that their children lived in a safe neighborhood.



Source: U.S. Department of Health and Human Services' National Survey of Children's Health. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health. | GAO-18-41SP

Notes: The 2016 National Survey of Children's Health (NSCH) asked the question, "Does this child live in a safe neighborhood?" Due to changes in the 2016 NSCH, including in the survey's mode of data collection, sampling frame, and question wording, data from the 2016 survey cannot be compared to estimates from previous iterations of the survey. For race and ethnicity data, "White"=White, non-Hispanic; "Black"=Black, non-Hispanic; and "Other"=Other, non-Hispanic. For family income level data, information on total family income during the previous calendar year and the number of adult and child family members living in the child's household was used to create an index of income relative to the U.S. Census Bureau's poverty thresholds (referred to in the figure as the "federal poverty level"). For family composition data, "Married couple"=two parents, currently married; "Unmarried couple"=two-parents, not currently married; "Single-mother"=single mother (currently married but living apart, formerly married, or never married); and "Other"=other family type, no parent reported. For more information, see the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child & Adolescent Health.

<sup>a</sup>See Healthy People 2020 Social Determinants of Health framework.

**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

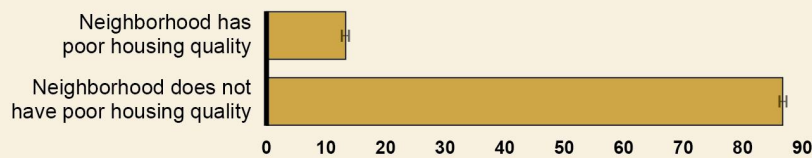
**Figure 8: Neighborhood Housing Quality**



**Neighborhood housing quality (Estimated)**

Research suggests poor housing quality (poorly kept or dilapidated housing) is a strong predictor of emotional and behavioral problems in children.<sup>a</sup>

**Percentage of children whose parents reported they lived in neighborhoods with poor housing quality (2016)**



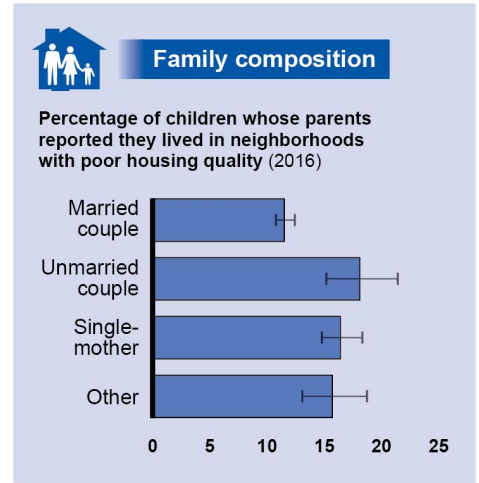
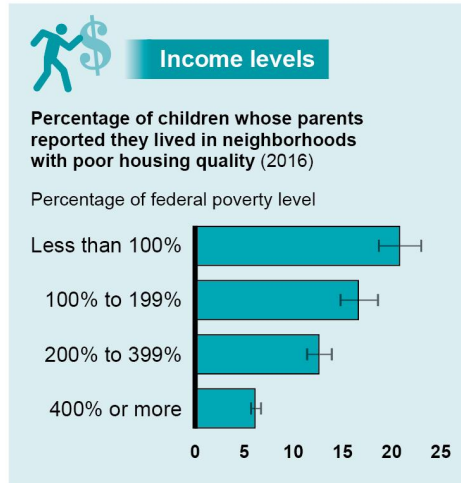
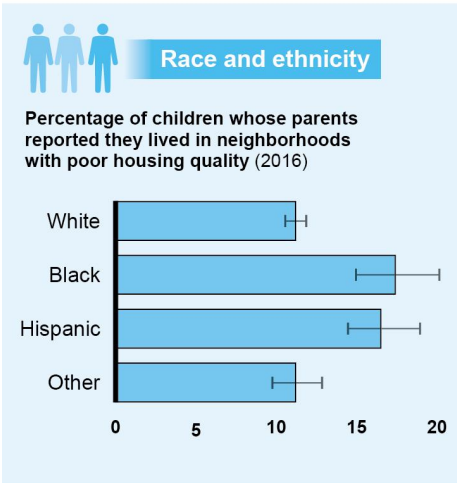
All percentages on this page are presented as estimates with 95% confidence intervals



**9.4 Million**

Estimated number of children whose parents reported they lived in neighborhoods with poor housing quality in 2016

**2016:** Children who were Black, Hispanic, or poor were most often reported to live in neighborhoods with poor housing quality.



Source: U.S. Department of Health and Human Services' National Survey of Children's Health. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health. | GAO-18-41SP

Notes: The 2016 National Survey of Children's Health (NSCH) asked the question, "In your neighborhood, is there poorly kept or rundown housing?" Due to changes in the 2016 NSCH, including in the survey's mode of data collection, sampling frame, and question wording, data from the 2016 survey cannot be compared to estimates from previous iterations of the survey. For race and ethnicity data, "White"=White, non-Hispanic; "Black"=Black, non-Hispanic; and "Other"=Other, non-Hispanic. For family income level data, information on total family income during the previous calendar year and the number of adult and child family members living in the child's household was used to create an index of income relative to the U.S. Census Bureau's poverty thresholds (referred to in the figure as the "federal poverty level"). For family composition data, "Married couple"=two parents, currently married; "Unmarried couple"=two-parents, not currently married; "Single-mother"=single mother (currently married but living apart, formerly married, or never married); and "Other"=other family type, no parent reported. For more information, see the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child & Adolescent Health.

<sup>a</sup>See U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *Housing's and Neighborhood's Role in Shaping Children's Future*, Evidence Matters (Fall 2014).

**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

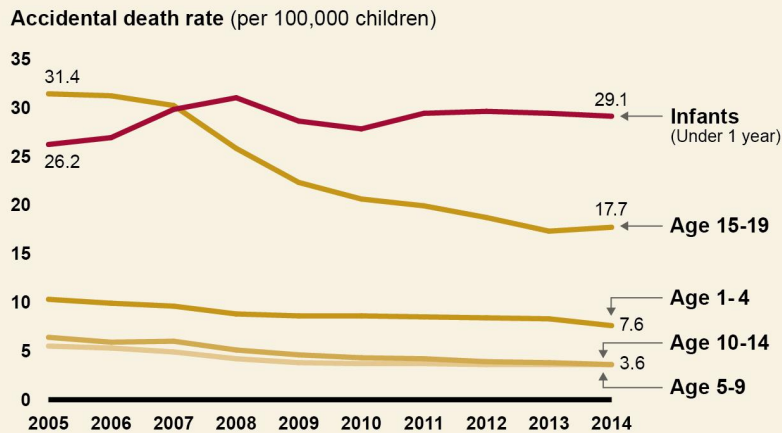
**Figure 9: Death Due to Accidental Injury**



**Death due to accidental injury**

Unintentional injuries—such as those caused by burns, drowning, falls, poisoning, and road traffic—were the leading cause of death for children age 1 year and older in 2014.<sup>a</sup>

The proportion of children dying from accidents declined since 2005 for all ages except infants. Infants replaced teens as the age group with the highest rate of death from an accidental injury.



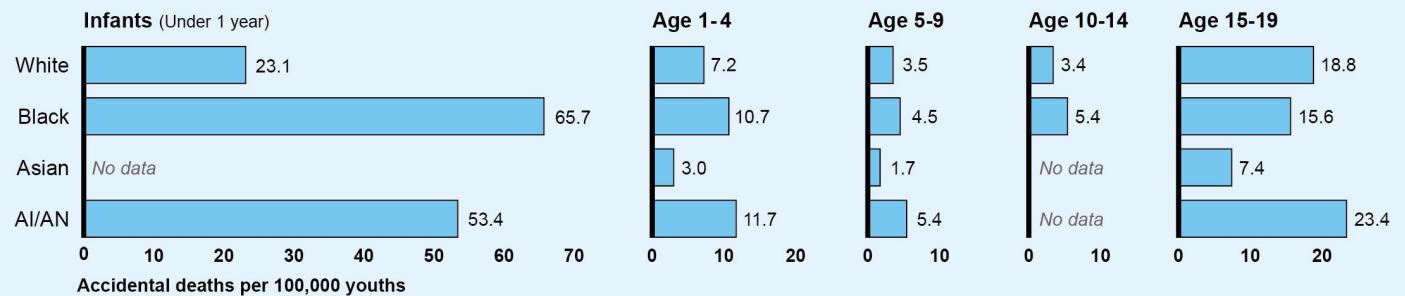
**7,600**  
Estimated number of children through age 19 who died due to an accidental injury in 2014

**2014:** For ages 15 to 19, American Indian/Alaska Native (AI/AN) youth had the highest rate of death due to accidental injury.



**Race and ethnicity**

**2014 accidental death rate (per 100,000 children)**



- In 2014, the accidental death rate of Hispanic children—who may be of any race—was lower than that of non-Hispanic Whites and non-Hispanic Blacks in every age group.
- From 2005 to 2014, the gap in the accidental death rate of White and Black infants widened, largely due to the increase in the rate for Black infants.
- From 2005 to 2014, gaps in the accidental death rates of White and youth of other races age 15-19 narrowed as the rate for each race fell over the period.

Source: U.S. Department of Health and Human Services' National Vital Statistics System. | GAO-18-41SP

Notes: Data are based on information from all death certificates filed in the 50 states and the District of Columbia in 2014, processed by the U.S. Department of Health and Human Services' (HHS) National Center for Health Statistics. The accidental death rate for infants is the number of infant deaths due to unintentional injuries per 100,000 live births in specified group. For other age groups, it is the number of deaths due to unintentional injuries per 100,000 population in specified group. Asian=Asian or Pacific Islander. Deaths for races other than White or Black should be interpreted with caution. Race and Hispanic origin are reported separately on the death certificate. Data for Hispanic origin should be interpreted with caution because of inconsistencies between reporting Hispanic origin on birth and death certificates (for infants) and misreporting of Hispanic origin on the death certificate (for other age groups). The term "no data" in the figure refers to data that do not meet the agency's standards of reliability or precision. See HHS, Centers for Disease Control and Prevention, *Deaths: Leading Causes for 2014*, National Vital Statistics Reports, Vol. 65, Number 5 (June 2016, amended June 2017).

<sup>a</sup>Specifically, unintentional injuries were the leading cause of death for each of the following age groups: 1-4 years, 5-9 years, 10-14 years, and 15-19 years. See HHS, Centers for Disease Control and Prevention, *Deaths: Leading Causes for 2014*, National Vital Statistics Reports, Vol. 65, Number 5 (June 2016, amended June 2017).

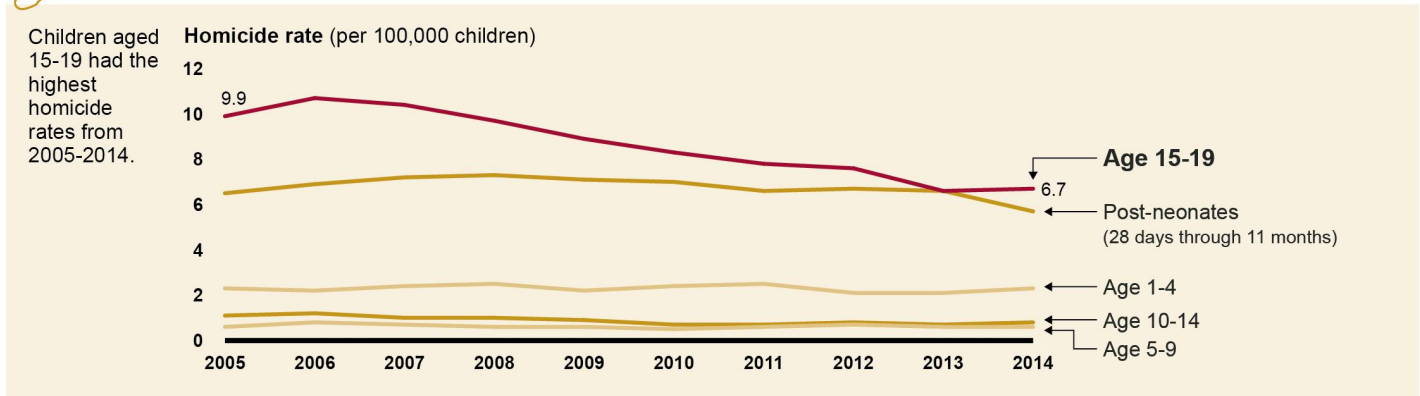
**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 10: Homicide**

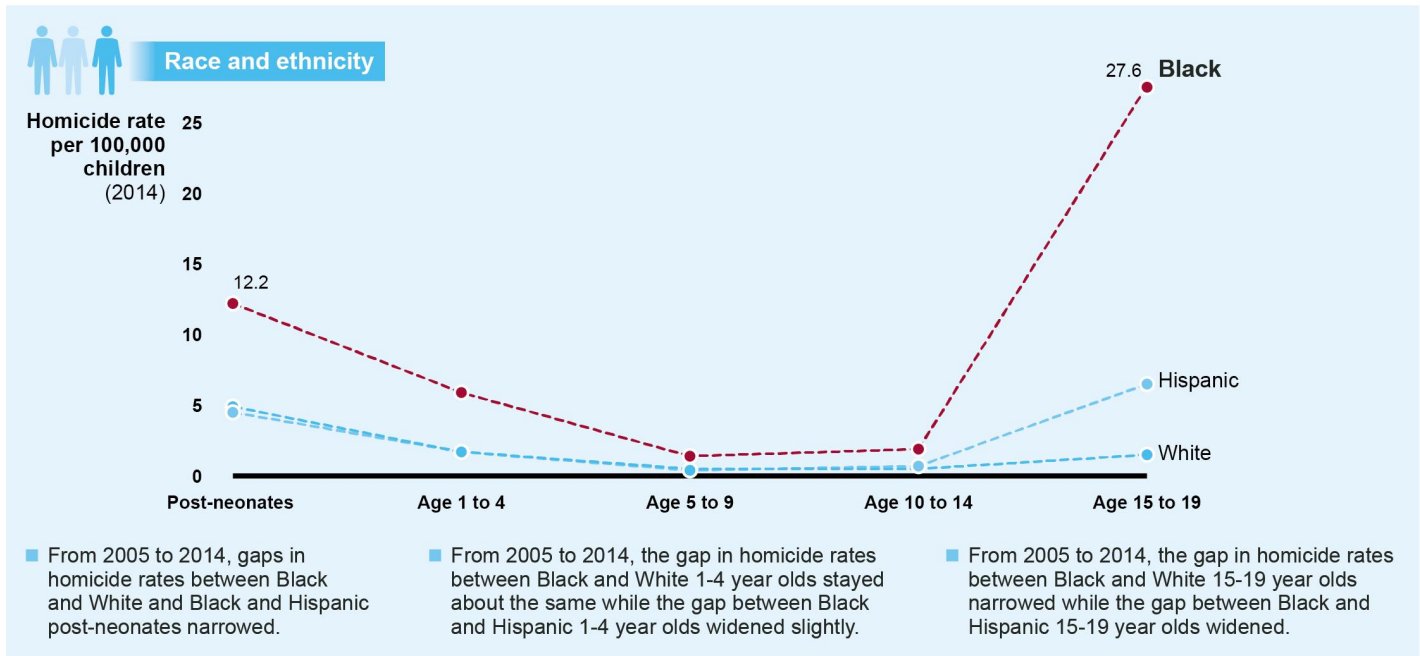


**Homicide**

In 2014, homicide ranked among the top five leading causes of death for all children aged 28 days and older.<sup>a</sup>



**2014:** Black children had the highest homicide rates in every age group.



Source: U.S. Department of Health and Human Services' National Vital Statistics System. | GAO-18-41SP

Notes: Data are based on information from all death certificates that were filed in the 50 states and the District of Columbia in 2014 and processed by the U.S. Department of Health and Human Services' (HHS) National Center for Health Statistics. Data are reported here for post-neonates rather than for all infants (under 1 year) as homicide was not among the top 10 leading causes of death for infants (all races, both sexes) from 2005 to 2014. The homicide rate for post-neonates is the number of deaths due to assault per 100,000 live births in specified group. For other age groups, it is the number of deaths due to assault per 100,000 population in specified group. "White"=Non-Hispanic White; "Black"=Non-Hispanic Black. Data for Hispanic origin include persons of any race. Deaths are based on race of decedent; live births are based on race of mother. Race and Hispanic origin are reported separately on the death certificate. Due to inconsistencies with reporting, data for Hispanic origin should be interpreted with caution. See HHS, Centers for Disease Control and Prevention, *Deaths: Leading Causes for 2014*, National Vital Statistics Reports, Vol. 65, Number 5 (June 2016, amended June 2017).

<sup>a</sup>Specifically, homicide ranked among the top five leading causes of death for each of the following age groups: post-neonates, 1-4 years, 5-9 years, 10-14 years, and 15-19 years. See HHS, Centers for Disease Control and Prevention, *Deaths: Leading Causes for 2014*, National Vital Statistics Reports, Vol. 65, Number 5 (June 2016, amended June 2017).

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## Physical and Mental Health of Children

According to the last 10 years of federal data we reviewed, children's physical and mental health has improved in some areas, worsened in others, or had no change overall across different health indicators, and children with certain characteristics fared worse than others (see fig. 11 below for the indicators we reviewed). Estimated health insurance coverage and access to medical and dental care (as measured by unmet medical and dental needs due to cost) improved for children of all income levels from 2006 to 2015, though access to care was significantly worse for the poorest children than for those from the highest income category in 2015. On the other hand, from 2005 to 2014, the suicide rate of youth age 15 to 19 rose slightly, and in both 2005 and 2014, non-Hispanic White youth had higher suicide rates than both non-Hispanic Black and Hispanic youth. These disparities increased due to higher reported rates for White youth.<sup>3</sup> Data on asthma show that the estimated percentage of children with asthma stayed about the same over the last several years, but a higher percentage of children with asthma in 2015 were Black versus White or Hispanic; in poverty versus from the highest income group; and/or lived with a single mother versus two parents. Similarly, 2016 data on obesity show that children age 10 to 17 who were Black, Hispanic, or poor had the highest reported rates of obesity. (See figs. 12-17.)

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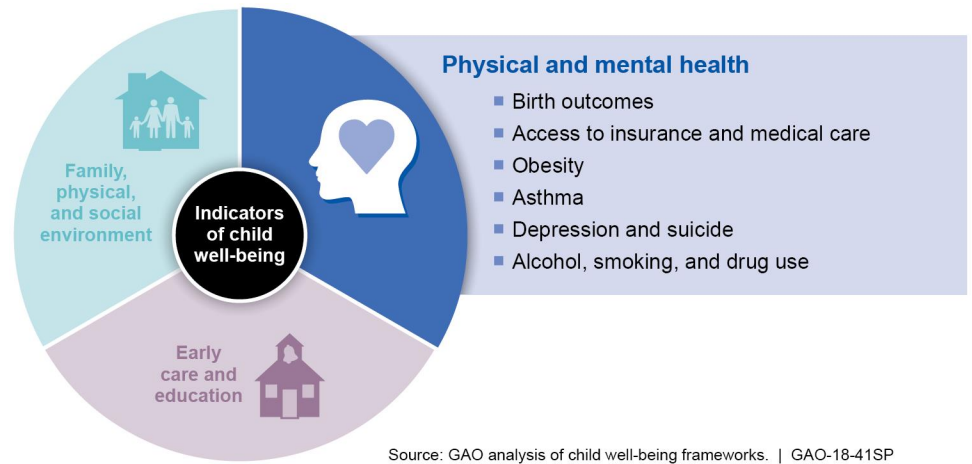
<sup>3</sup>However, death certificate data from the Centers for Disease Control and Prevention's National Vital Statistics System are limited by changes to the classification of death from 2005 to 2014 and the potential misclassification of suicide as the underlying cause of death. In 2005, the suicide rates among children age 15-19 per 100,000 youth in the population were: Non-Hispanic White (8.8); Non-Hispanic Black (4.5); and Hispanic (6.1). In 2014, the rates were: Non-Hispanic White (10.9); Non-Hispanic Black (4.5); and Hispanic (6.0).



**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 11: Physical and Mental Health Indicators of Child Well-Being**

AI



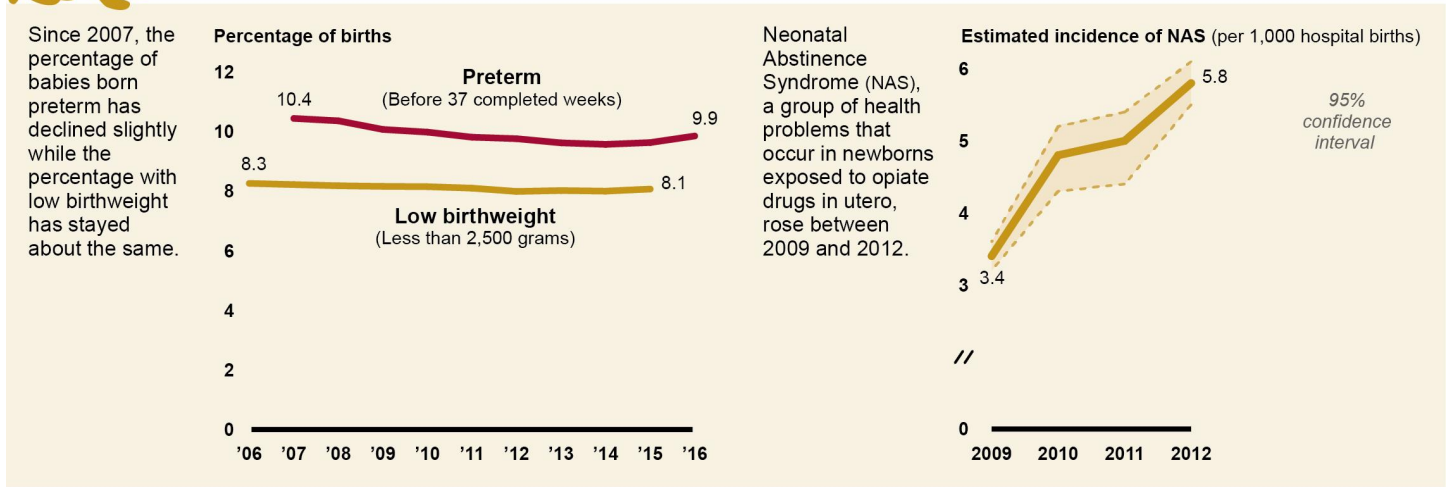
**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 12: Birth Outcomes**

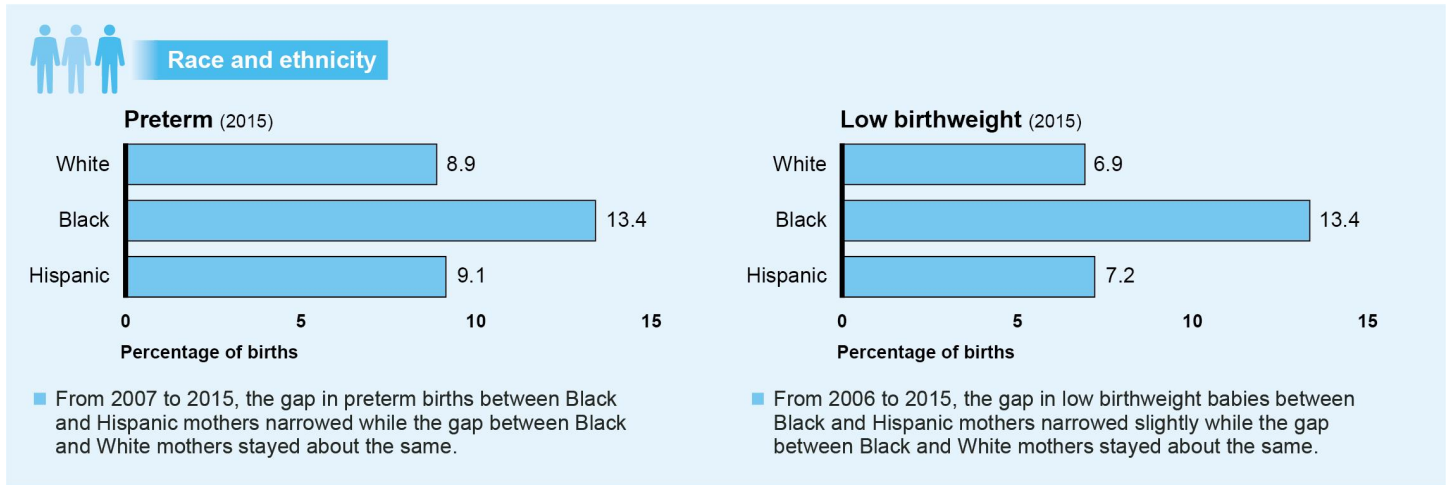


**Birth outcomes**

Infants born preterm or with low birthweight are at higher risk of early death and long-term health and developmental issues than infants born later in pregnancy or at higher birthweights. Many, but not all, preterm infants are also low birthweight, and vice versa.<sup>a</sup>



**2015:** A higher percentage of babies born to Black mothers were preterm and low birthweight than babies born to White and Hispanic mothers.



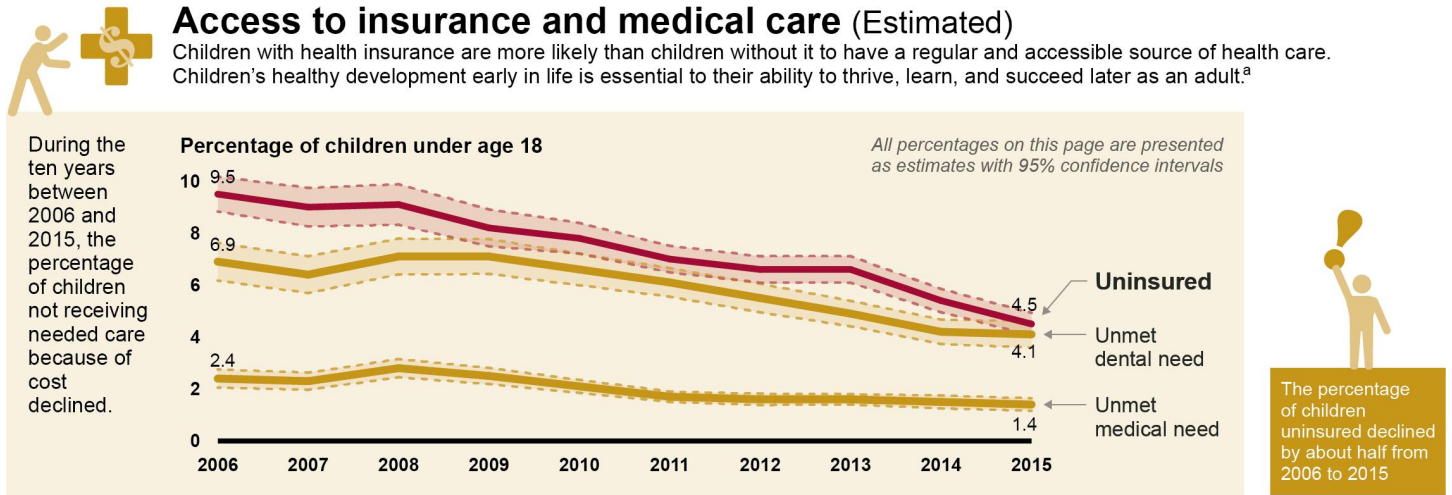
Source: U.S. Department of Health and Human Services' National Vital Statistics System, Kids' Inpatient Database for 2009 and 2012, and Nationwide Inpatient Sample in 2010 and 2011, Healthcare Cost and Utilization Project. | GAO-18-41SP

Notes: Data shown in this figure for 2015 and 2016 are based on information derived from birth certificates and includes information for all births occurring in the United States. The data are provided to the U.S. Department of Health and Human Services' National Center for Health Statistics through the Vital Statistics Cooperative Program. Preterm births are births of less than 37 completed weeks of gestation based on the obstetric estimate of gestation. Low birthweight is less than 2,500 grams. For race and ethnicity data, "White"=Non-Hispanic White; and "Black"=Non-Hispanic Black. Race and Hispanic origin are reported separately on birth certificates. Persons of Hispanic origin may be of any race. For more information, see U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Births in the United States, 2016*, National Center for Health Statistics Data Brief No. 287 (September 2017) and *Births: Final Data for 2015*, National Vital Statistics Reports, Vol. 66, Number 1 (January 2017). See also Patrick, S.W., et al. (2015). *Increasing Incidence and Geographic Distribution of Neonatal Abstinence Syndrome: United States 2009 to 2012*. *J Perinatol* 35(8), pp. 650-655.

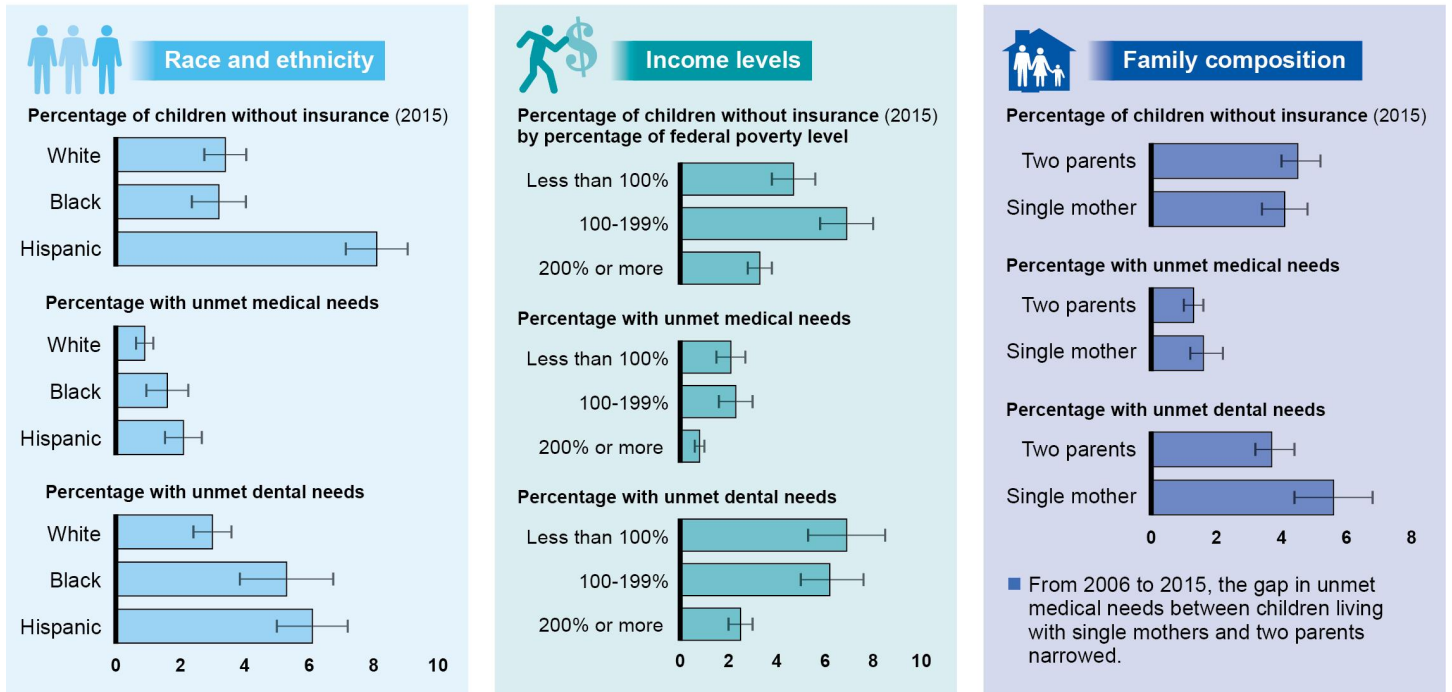
<sup>a</sup>See Federal Interagency Forum on Child and Family Statistics, *America's Children: Key National Indicators of Well-Being, 2015* (Washington, D.C.: U.S. Government Printing Office).

**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 13: Access to Insurance and Medical Care**



**2015:** A higher percentage of children who were Hispanic or near poor lacked health insurance than their peers.



Source: U.S. Department of Health and Human Services' National Health Interview Survey. | GAO-18-41SP

Notes: Data are based on household interviews of a sample of the population. "White"=White, single race (not Hispanic or Latino); "Black"=Black or African American only, single race (not Hispanic or Latino). Children who are of Hispanic or Latino origin may be of any race(s). "Two parents"=Mother and Father. A household's poverty status was determined using the U.S. Census Bureau's poverty thresholds for the previous calendar year (referred to in the figure as the "federal poverty level"). Near poor persons have incomes of 100 percent to less than 200 percent of the federal poverty threshold. See U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Summary Health Statistics: National Health Interview Survey.

<sup>a</sup>See Federal Interagency Forum on Child and Family Statistics, *America's Children in Brief: Key National Indicators of Well-Being, 2016* (Washington, D.C.: U.S. Government Printing Office) and U.S. Department of Health and Human Services, *Implementation of Project LAUNCH: Cross-site Evaluation Findings, Volume 1, OPRE Report 2014-87, 2014* (Washington, D.C.).

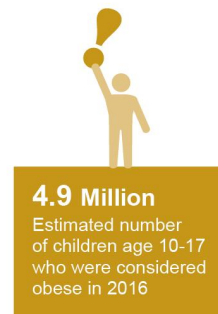
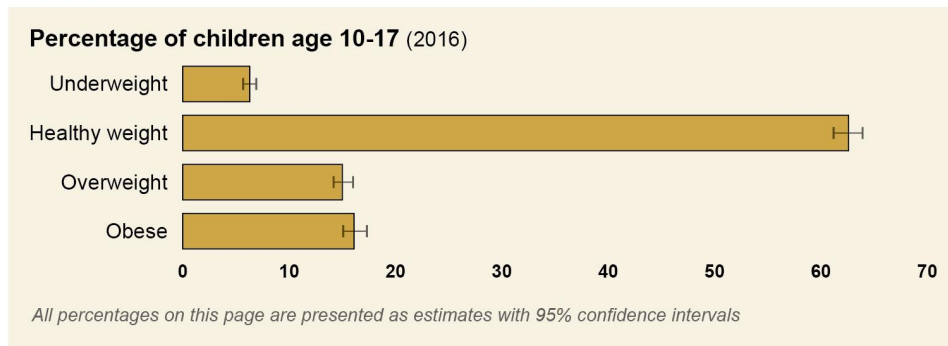
**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 14: Obesity**

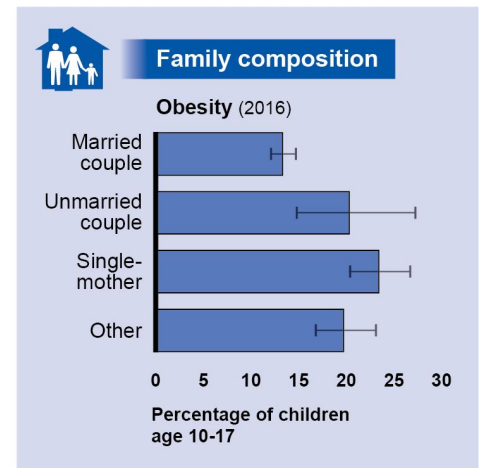
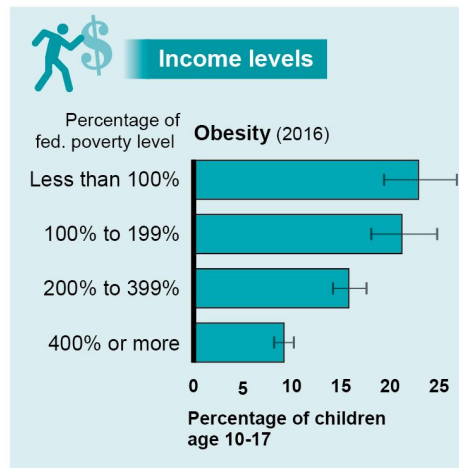
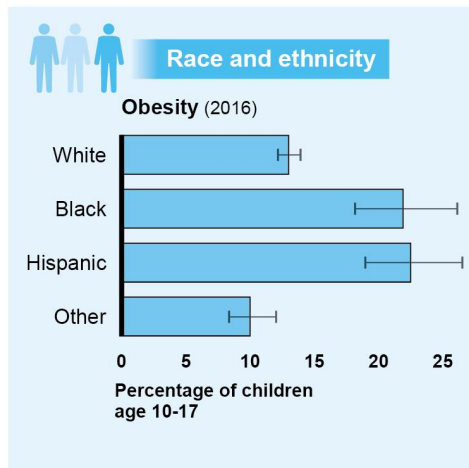


**Obesity (Estimated)**

Children with obesity often become adults with obesity, with increased risks for a wide variety of poor health outcomes, including diabetes, stroke, heart disease, arthritis, and certain cancers.<sup>a</sup>



**2016:** Children who were Black, Hispanic, or poor had the highest reported rates of obesity.



Source: U.S. Department of Health and Human Services' National Survey of Children's Health. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health. | GAO-18-41SP

Notes: The 2016 National Survey of Children's Health (NSCH) asked the question, "What is the weight status of children (age 10-17 years) based on Body Mass Index (BMI) for age?" Underweight=less than 5th percentile; Healthy weight=5th to 84th percentile; Overweight=85th to 94th percentile; and Obese=95th percentile or above. Due to changes in the 2016 NSCH, including in the survey's mode of data collection, sampling frame, and question wording, data from the 2016 survey cannot be compared to estimates from previous iterations of the survey. For race and ethnicity data, "White"=White, non-Hispanic; "Black"=Black, non-Hispanic; and "Other"=Other, non-Hispanic. For family income level data, information on total family income during the previous calendar year and the number of adult and child family members living in the child's household was used to create an index of income relative to the U.S. Census Bureau's poverty thresholds (referred to in the figure as the "fed. poverty level"). For family composition data, "Married couple"=two parents, currently married; "Unmarried couple"=two-parents, not currently married; "Single-mother"=single mother (currently married but living apart, formerly married, or never married); and "Other"=other family type, no parent reported. For more information, see the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child & Adolescent Health. The Centers for Disease Control and Prevention reported that the prevalence of obesity in 2011-2014 among preschool-aged children (2-5 years) was 8.9 percent; school-aged children (6-11 years) was 17.5 percent; and adolescents (12-19 years) was 20.5 percent.

<sup>a</sup>See Federal Interagency Forum on Child and Family Statistics, *America's Children in Brief: Key National Indicators of Well-Being, 2016*. (Washington, D.C.: U.S. Government Printing Office).

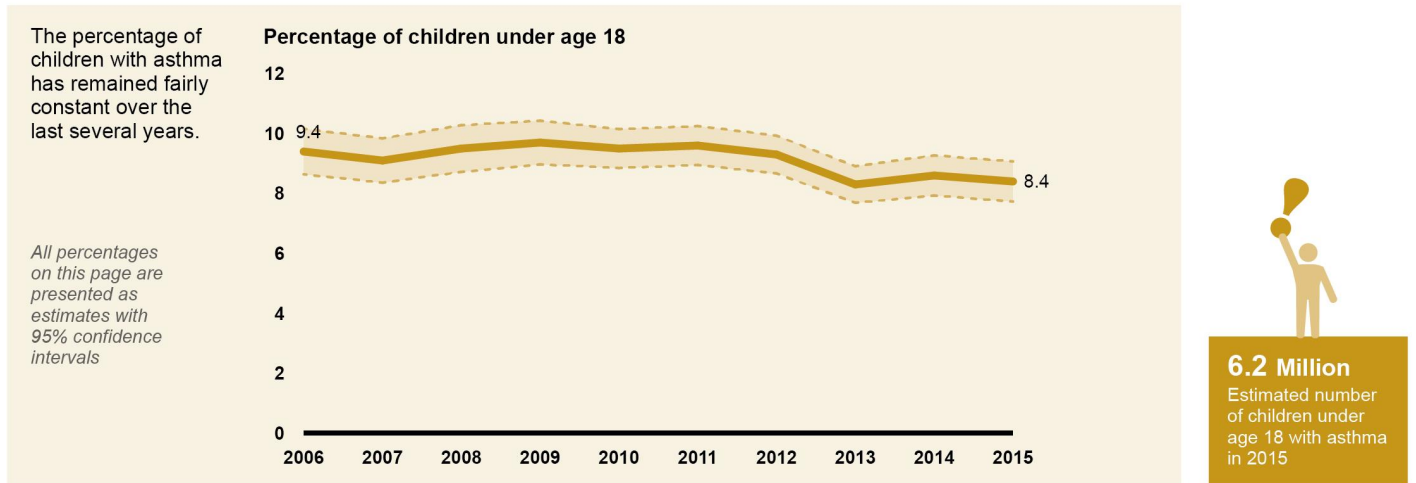
**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 15: Asthma**

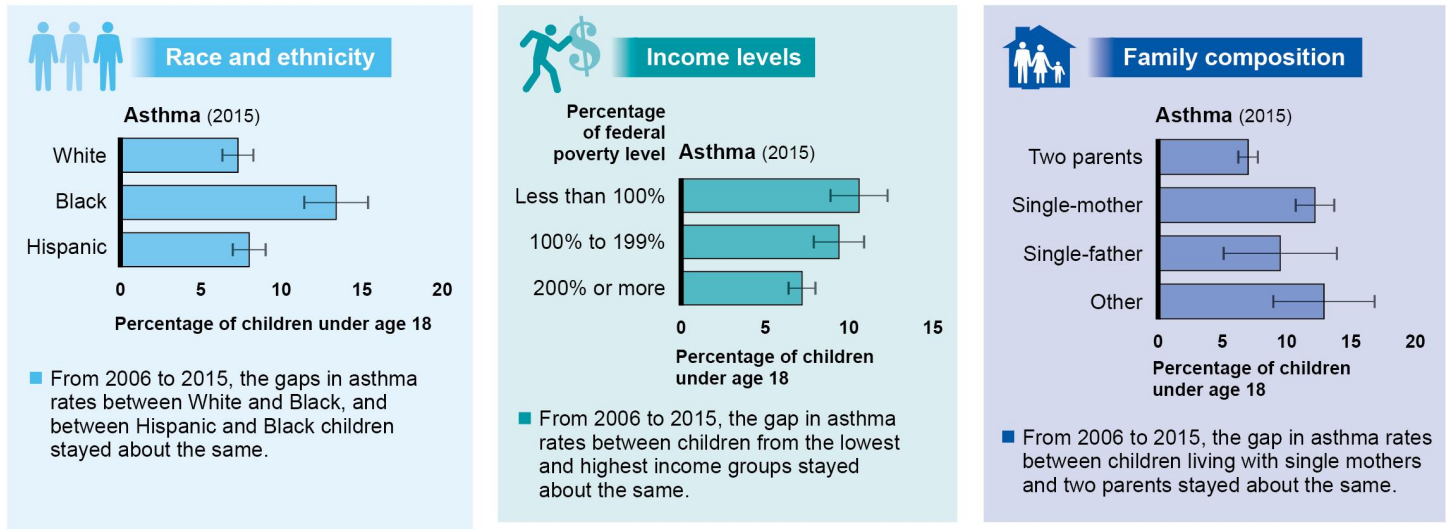


**Asthma (Estimated)**

Asthma—one of the most common diseases among children—is a disease of the lungs that can cause wheezing, difficulty breathing, and chest pain. A serious health concern, asthma contributes to missed school days and is costly to treat.<sup>a</sup>



**2015:** Children from families living in poverty had higher rates of asthma than those from the highest income group.



Source: U.S. Department of Health and Human Services' National Health Interview Survey. | GAO-18-41SP

Notes: Data are based on household interviews of a sample of the civilian noninstitutionalized population. The data are based on responses about the sample child, not all children in the family. For race and ethnicity data, "White"=White, single race, non-Hispanic; "Black"=Black, single race, non-Hispanic. Persons of Hispanic or Latino origin may be of any race or combination of races. For income level data, a household's poverty status was determined based on family income in the previous calendar year, size, and composition, using the U.S. Census Bureau's poverty thresholds for the previous calendar year (referred to in the figure as the "federal poverty level"). Family composition data refer to parents living in the household. "Two parents"=Mother and Father. Mother and father can include biological, adoptive, step, in-law, or foster relationships. "Single-mother"=Mother, no father; "Single-father"=Father, no mother; and "Other"=Neither mother nor father. Legal guardians are classified in neither mother nor father. For more information, see U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Summary Health Statistics: National Health Interview Survey.

<sup>a</sup>See Federal Interagency Forum on Child and Family Statistics, *America's Children in Brief: Key National Indicators of Well-Being, 2016*. (Washington, D.C.: U.S. Government Printing Office) and Centers for Disease Control and Prevention, *Asthma's Impact on the Nation: Data from the CDC National Asthma Control Program*.

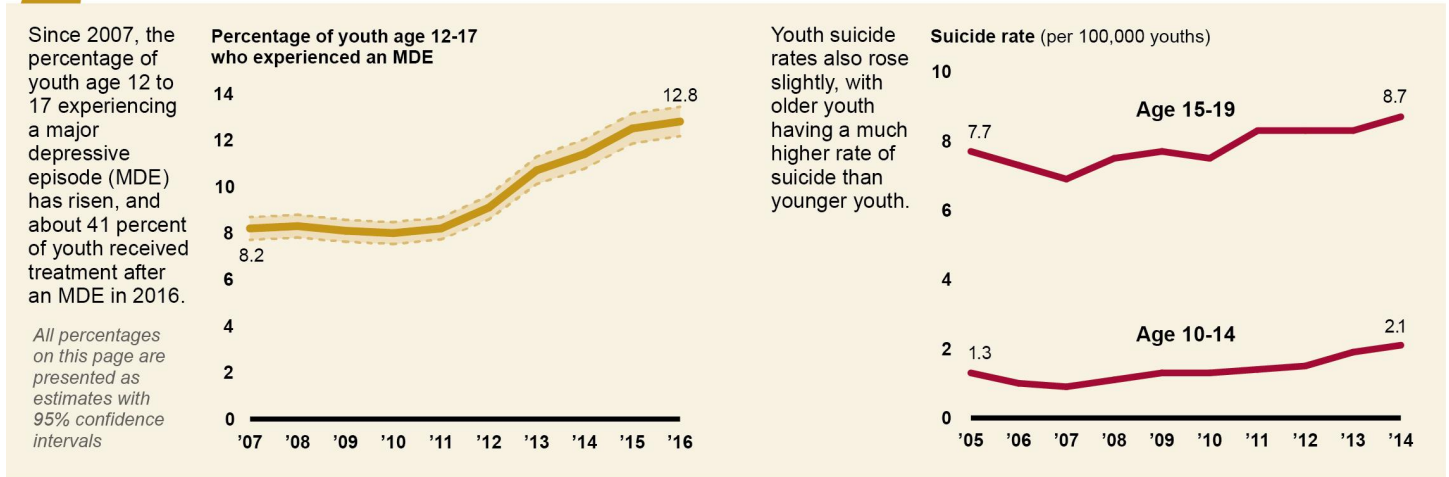
**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 16: Depression and Suicide**

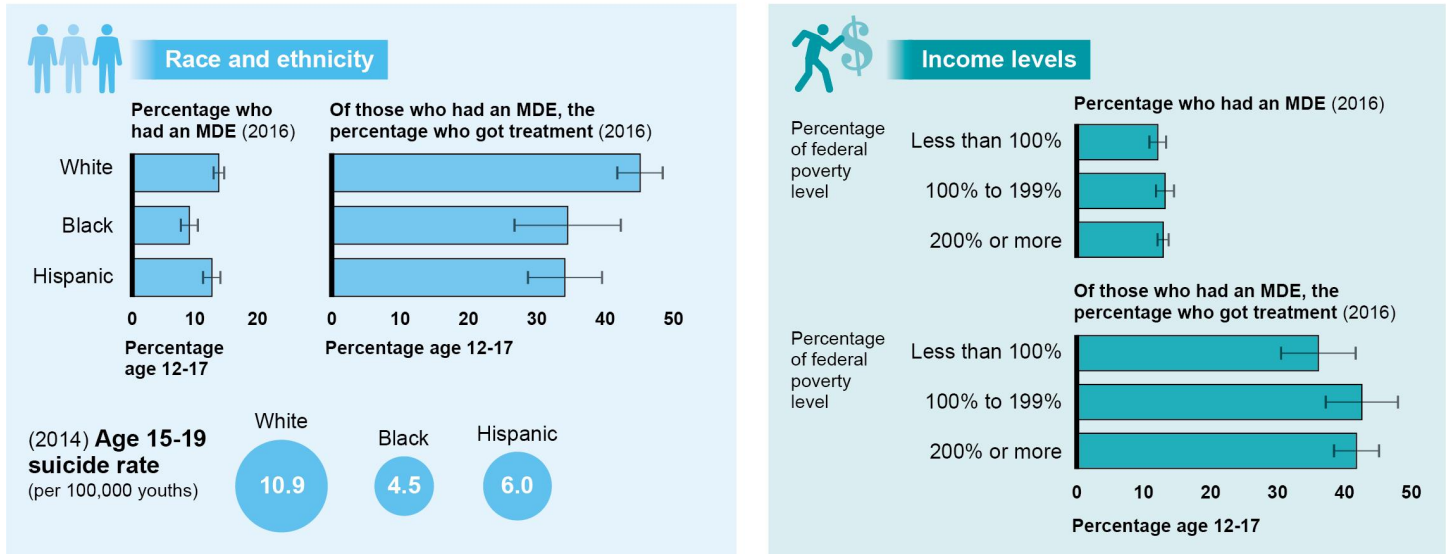


**Depression (Estimated) and suicide**

Adolescent depression can adversely affect school and work performance, impair peer and family relationships, and exacerbate the severity of other health conditions. Youth with major depressive episodes are at greater risk for suicide and are more likely to use alcohol and drugs compared to their peers.<sup>a</sup>



**2016:** A family's income level did not affect whether youth had an MDE or received treatment.



Source: U.S. Department of Health and Human Services' National Survey on Drug Use and Health and National Vital Statistics System. | GAO-18-41SP

Notes: Major Depressive Episode (MDE) specifies a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. The data refer to youth who had at least one MDE in the past year. Treatment is defined as seeing or talking to a health or alternative service professional or using prescription medication for depression in the past year. The data refer to youth who received treatment for depression in the past year for those with a past-year MDE. "White"=White, non-Hispanic; "Black"=Black, non-Hispanic. Persons of Hispanic origin may be of any race. Suicide data for Hispanic origin should be interpreted with caution. A household's poverty status was determined using the U.S. Census Bureau's poverty thresholds (referred to in the figure as the "federal poverty level"). See U.S. Department of Health and Human Services, *Results from the 2016 National Survey on Drug Use and Health: Detailed Tables* (September 2017) and *Deaths: Leading Causes for 2014*, National Vital Statistics Reports, Vol. 65, Number 5 (June 2016, amended June 2017).

<sup>a</sup>See Federal Interagency Forum on Child and Family Statistics, *America's Children in Brief: Key National Indicators of Well-Being, 2016* (Washington, D.C.: U.S. Government Printing Office).

**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 17: Alcohol, Smoking, and Drug Use**

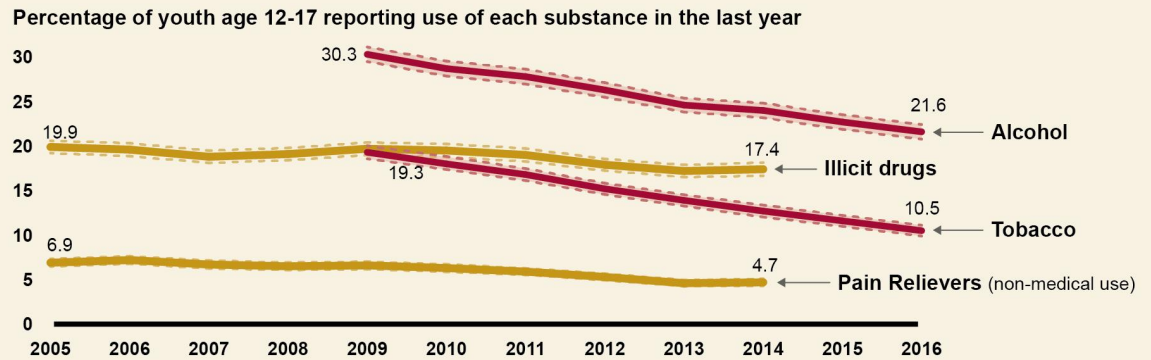


**Alcohol, smoking, and drug use (Estimated)**

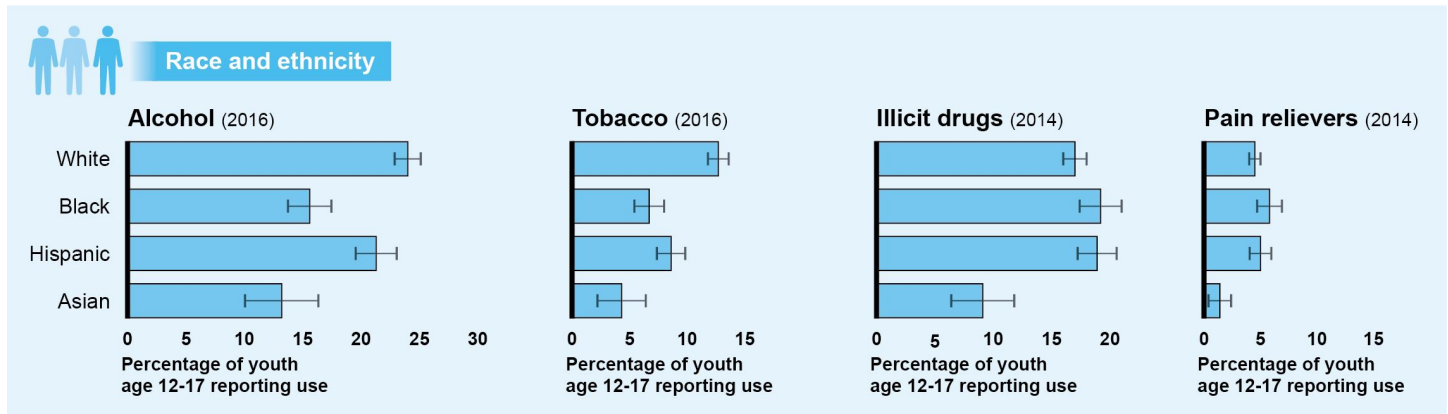
The adolescent years can be a critical risk period for substance use and development of substance use disorders. Substance use disorders in adolescence may affect key developmental and social transitions, and can interfere with normal brain maturation.<sup>9</sup>

In recent years, the decline in the percentage of youth ages 12 to 17 using alcohol and tobacco was greater than the decline in youth taking illicit drugs and pain relievers.

All percentages on this page are presented as estimates with 95% confidence intervals



**2016:** A higher percentage of White than Black youth used alcohol and tobacco; Asians had the lowest use of illicit drugs and pain relievers (2014).



Source: U.S. Department of Health and Human Services' National Survey on Drug Use and Health. | GAO-18-41SP

Notes: For race and ethnicity data, "White"=White, non-Hispanic; "Black"=Black, non-Hispanic; "Asian"=Asian, non-Hispanic. Persons of Hispanic origin may be of any race. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs. Tobacco products include cigarettes, smokeless tobacco (i.e., snuff, dip, chewing tobacco, or "snus"), cigars, or pipe tobacco. The most recent year for which data are presented for the use of illicit drugs and nonmedical use of pain relievers is 2014, due to multiple changes in 2015 that make 2015 and 2016 data non-comparable to earlier years' data. For more information, see U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Results from the 2016 National Survey on Drug Use and Health: Detailed Tables* (September 2017).

<sup>9</sup>See Federal Interagency Forum on Child and Family Statistics, *America's Children in Brief: Key National Indicators of Well-Being, 2016* (Washington, D.C.: U.S. Government Printing Office).

**Early Care and Education of Children**

Early care and education of children has shown improvement or no change for children overall, and children with certain characteristics fared worse, according to federal data we reviewed (see fig. 18 for the indicators we reviewed). For example, from 2005 to 2015, the estimated

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**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

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percentage of children enrolled in preschool stayed about the same for children overall, but Hispanic children (in 2015) and poor/near-poor children (in 2012) had lower percentages of preschool enrollment than White and non-poor children, respectively.<sup>4</sup> Data on student academic outcomes show that estimated average reading and math scores for students in 4th, 8th, and 12th grade generally stayed the same or slightly improved from 2005 to 2015, but average reading and math scores of Black, Hispanic, American Indian/Alaska Native (AI/AN) and poor students in these same grades were generally lower than White, Asian, and non-poor students in 2015.<sup>5</sup> The achievement gaps between Black and White students and between Hispanic and White students narrowed a few points in 4th and 8th grade, in part due to slightly larger average gains in Black and Hispanic scores, but stayed the same in 12th grade. The gaps between poor and non-poor students remained about the same. In addition, high school graduation rates reached an all-time high of 83 percent in 2014-15; however, rates of Black, Hispanic, AI/AN, and poor students lagged behind others.<sup>6</sup> Further, Black students were more likely than White students to be suspended from school for disciplinary purposes in school year 2013-14. (See figs. 19-25.)

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<sup>4</sup>In the federal data we relied on for this analysis, poor children were defined as those whose family incomes were below the U.S. Census Bureau's poverty threshold in the year prior to data collection; near-poor children were defined as those whose family incomes ranged from the poverty threshold to 199 percent of the poverty threshold; and non-poor children were defined as those whose family incomes were at or above 200 percent of the poverty threshold. The poverty threshold is a dollar amount that varies depending on a family's size and composition and is updated annually to account for inflation. Survey respondents were asked to select the range within which their income falls, rather than giving the exact amount of their income; therefore, the measure of poverty status is an approximation. See fig. 20.

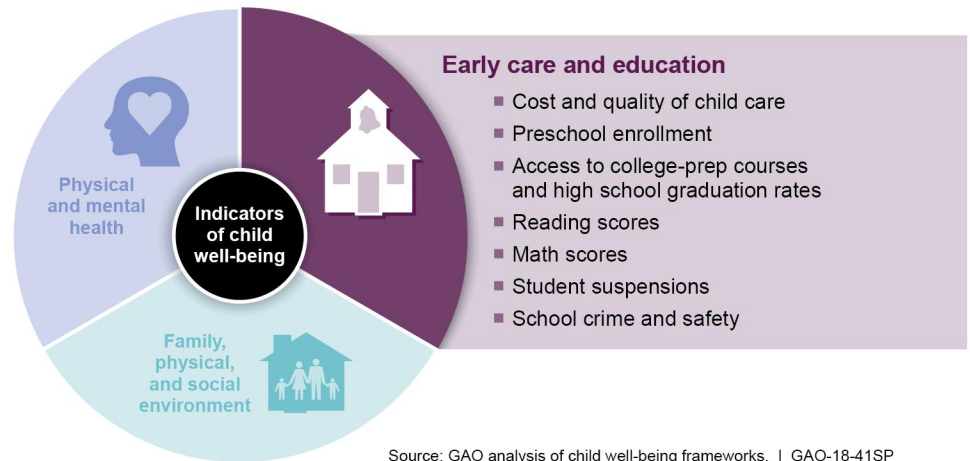
<sup>5</sup>For reading scores, poor students refer to those eligible for free or reduced-price school lunch, and non-poor students refer to those not eligible for free or reduced-price school lunch. For math scores, income level is measured at the school level. High-poverty schools refer to schools with 76 percent or more students eligible for free or reduced-price school lunch. Low-poverty schools refer to schools with 25 percent or fewer students eligible for free or reduced-price school lunch.

<sup>6</sup>Poor (or economically disadvantaged) refers to students who met state criteria for classification as economically disadvantaged.



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**Figure 18: Early Care and Education Indicators of Child Well-Being**



**Figure 19: Cost and Quality of Child Care**

**Cost and quality of child care (Estimated)**



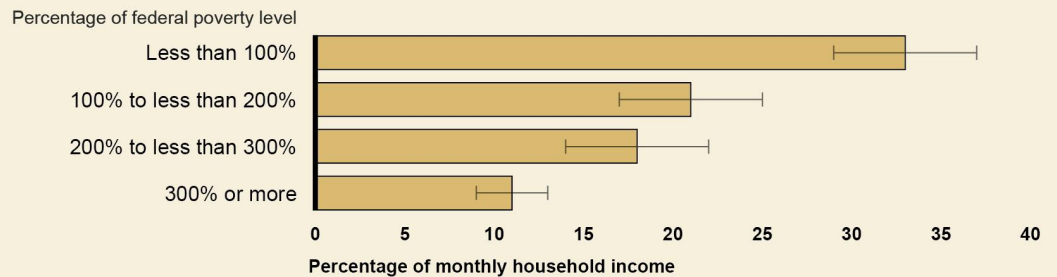
Researchers suggest that child care quality contributes to children’s developmental outcomes, higher quality care being associated with better developmental outcomes and poorer quality care being associated with poorer outcomes for children.<sup>a</sup>

**The cost burden of child care**

**2012:** Lowest-income households spent a higher proportion of their income on child care each month compared to all other households.

*All percentages on this page are presented as estimates with 95% confidence intervals*

**Percentage of monthly household income spent on Early Care and Education (ECE) in 2012**  
(Among households with spending on at least one regular ECE arrangement)



**Quality of child care**

■ **2005-06:** Center-based child care for children around age 4 was generally higher quality than home-based care for all households regardless of income levels.

*2005-06 is the latest year for which data on quality of child care are available*

- For families that used home-based child care, the majority of children from low socioeconomic status families had low-quality care while majorities of children from medium and high socioeconomic status families did not have low-quality care. (2005-06)
- For families that used Head Start or other center-based care, at least 80 percent of children were in medium- or high-quality care, regardless of the family socioeconomic status. (2005-06)

Source: U.S. Department of Health and Human Services’ National Survey of Early Care and Education household questionnaire and U.S. Department of Education’s Early Childhood Longitudinal Study, Birth Cohort, Longitudinal 9-month-Kindergarten-Restricted-Use Data File. | GAO-18-41SP

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Notes: Cost of child care measures parents' out-of-pocket costs for nonparental care. Cost of child care data were collected in 2012. Cost burden is calculated as the ratio of monthly household cost of care and the reported monthly income of the household in the month prior to the interview. Note that cost burden does not use the 2011 household income used for calculating the household poverty ratio. Poverty ratio is the ratio of a household's 2011 reported income to the 2011 federal poverty threshold defined for that household's size and age composition, using the U.S. Census Bureau's poverty thresholds for 2011 (referred to in the figure as "federal poverty level"). Socioeconomic status was measured by a composite score based on parental education and occupations and family income. For more information, see U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation (OPRE), *Early Care and Education Usage and Households' Out-of-Pocket Costs: Tabulations from the National Survey of Early Care and Education (NSECE)*, NSECE Tabulations, OPRE Report #2016-09 (August 2016) and U.S. Department of Education, Institute for Education Sciences, National Center for Education Statistics, *Digest of Education Statistics*.

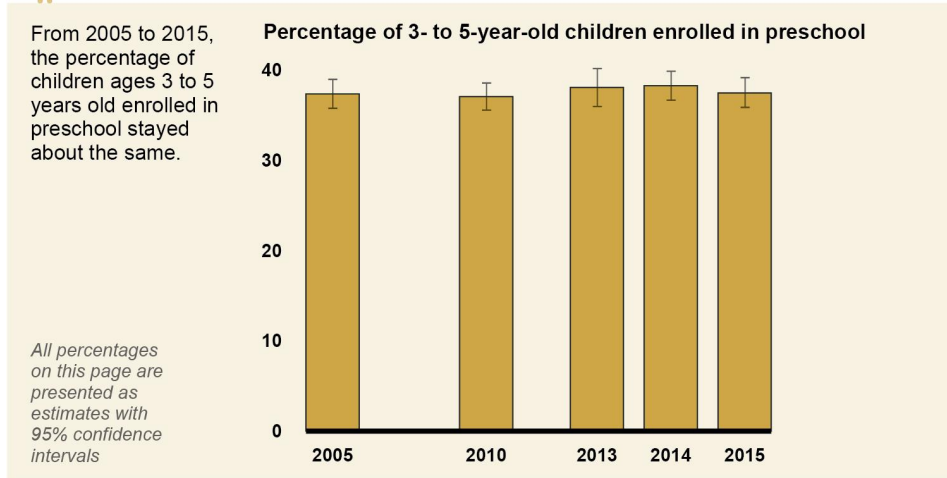
<sup>a</sup>See U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Child Care Quality: Does it Matter and Does it Need to be Improved?* (May 2000).

**Figure 20: Preschool Enrollment**

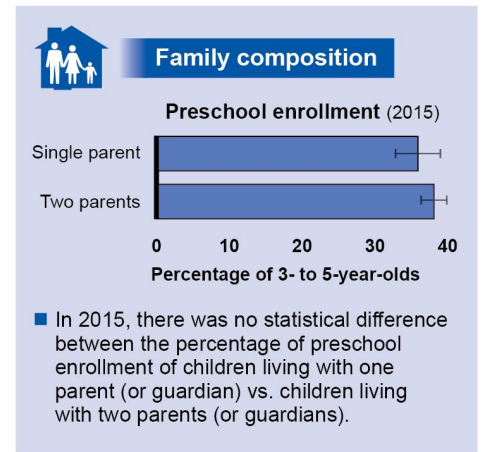
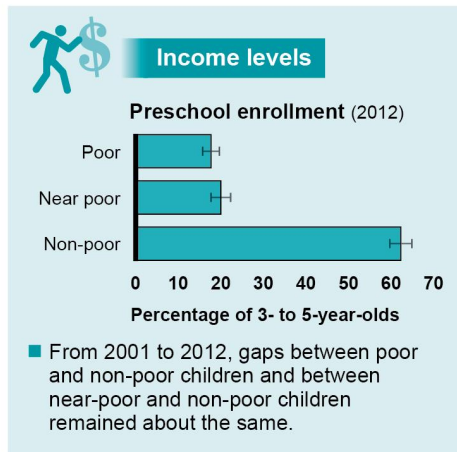
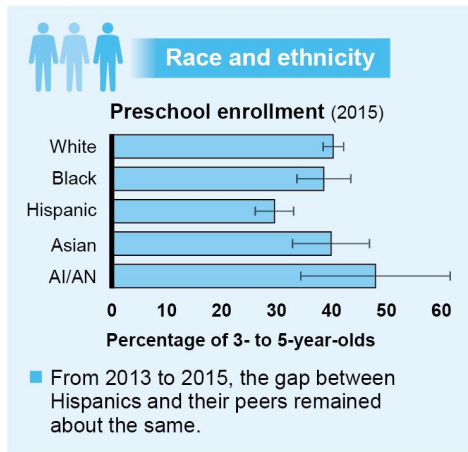


**Preschool enrollment (Estimated)**

The benefits of high-quality early learning include increased school readiness, lower rates of special education placements, improved high school graduation, and higher rates of college attendance and completion.<sup>a</sup>



Hispanic (in 2015) and poor/near-poor children (in 2012) had lower percentages of preschool enrollment than White and non-poor children, respectively.



Source: U.S. Department of Commerce, U.S. Census Bureau, Current Population Survey, October 2005-2015 and U.S. Department of Education, Early Childhood Program Participation Survey, 2001, 2005, and 2012. | GAO-18-41SP

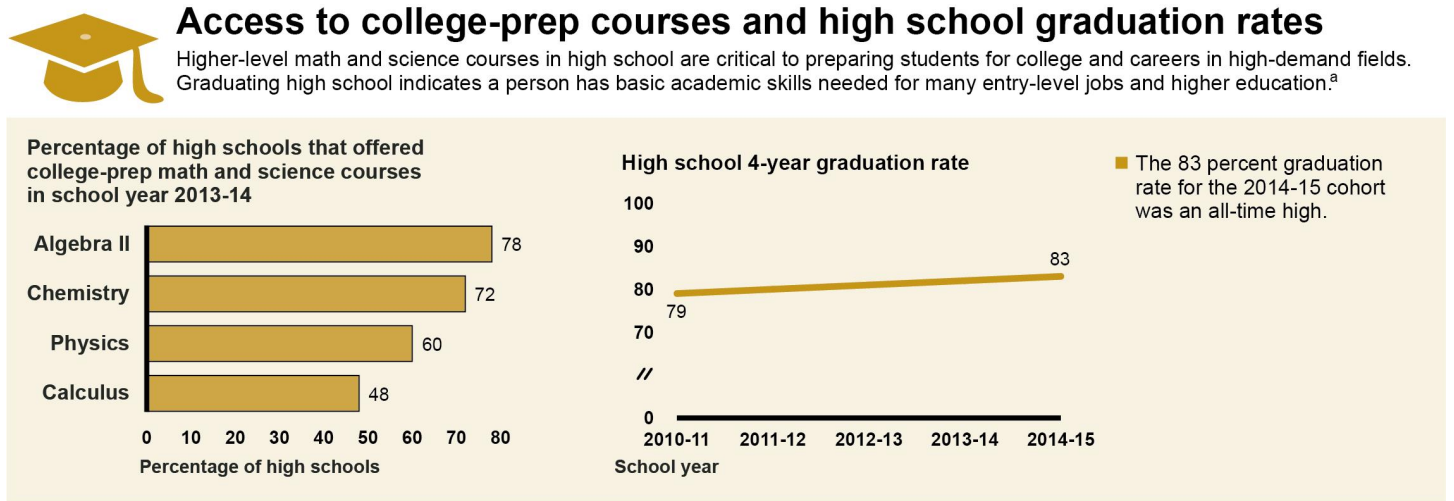
Notes: Preschool is defined as a group or class that is organized to provide educational experiences for children during the year or years preceding kindergarten. Data include public and private preschool. Race and ethnicity categories other than Hispanic exclude persons of Hispanic ethnicity. AI/AN=American Indian/Alaska Native. Poor children are those whose family incomes were below the U.S. Census

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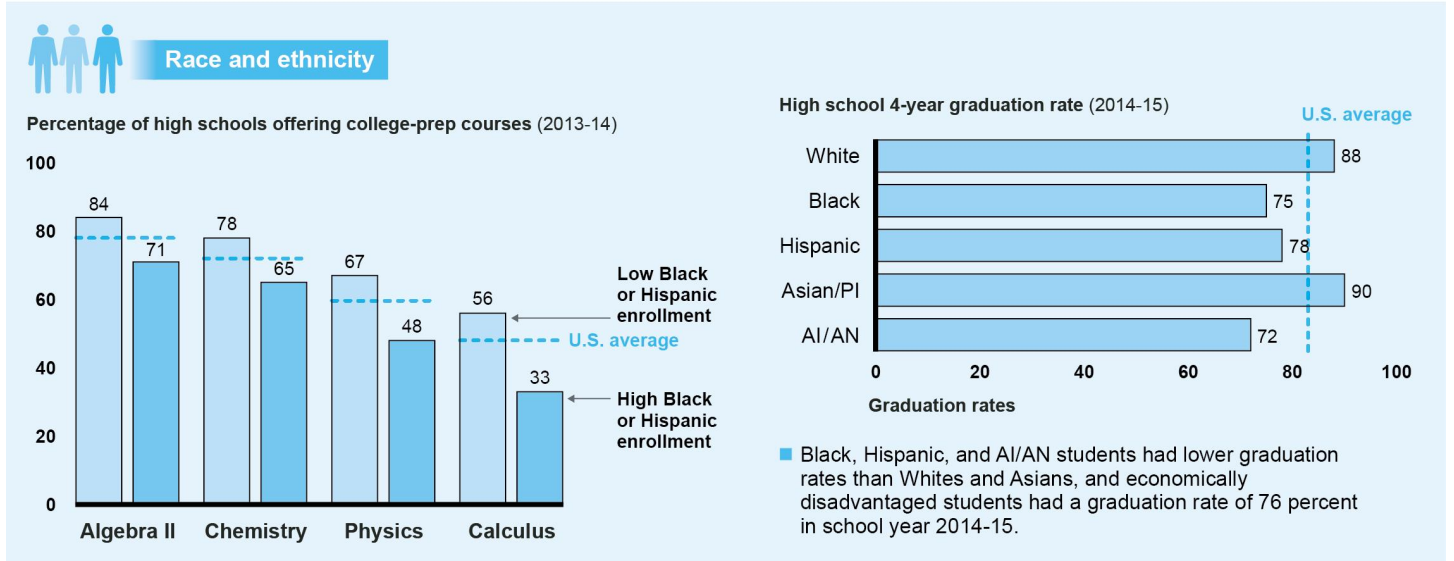
Bureau's poverty threshold in the year prior to data collection; near-poor children are those whose family incomes ranged from the poverty threshold to 199 percent of the poverty threshold; and non-poor children are those whose family incomes were at or above 200 percent of the poverty threshold. Survey respondents were asked to select the range within which their income falls, rather than giving the exact amount of their income, therefore, the measure of poverty status is an approximation. For more information, see U.S. Department of Education, Institute for Education Sciences, National Center for Education Statistics, *Digest of Education Statistics*.

<sup>a</sup>See U.S. Department of Education, Strategic Plan for Fiscal Years 2014-2018.

**Figure 21: Access to College-prep Courses and High School Graduation Rates**



**2013-14:** Schools with more Black or Hispanic students were less likely to offer high-level math and science courses than schools with fewer such students.



Source: U.S. Department of Education's Civil Rights Data Collection and Consolidated State Performance Report. | GAO-18-41SP

Notes: For access to college-preparatory courses, data include public schools only. Black=Black or African American; Hispanic=Hispanic or Latino of any race; Asian/PI=Asian/Pacific Islander; and AI/AN=American Indian/Alaska Native. High/Low Black and Hispanic student enrollment refers to schools with more than 75 percent and less than 25 percent Black and Hispanic student enrollment, respectively. For more information, see U.S. Department of Education, Office of Civil Rights, *2013-2014 Civil Rights Data Collection: A First Look: Key Data Highlights on Equity and Opportunity Gaps in Our Nation's Public Schools* (Issued June 7, 2016; Revised October 28, 2016). The adjusted cohort graduation rate (ACGR) is the percentage of public high school freshman who graduate with a regular diploma within 4 years of starting 9th grade. The cohort of students entering 9th grade for the first time is "adjusted" by adding students who transfer into the cohort and subtracting students who transfer

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out, emigrate to another country, or die. Race and ethnicity categories other than Hispanic exclude persons of Hispanic ethnicity. Economically disadvantaged refers to students who met state criteria for this classification. For more information, see U.S. Department of Education, Institute for Education Sciences, National Center for Education Statistics, *Digest of Education Statistics*.

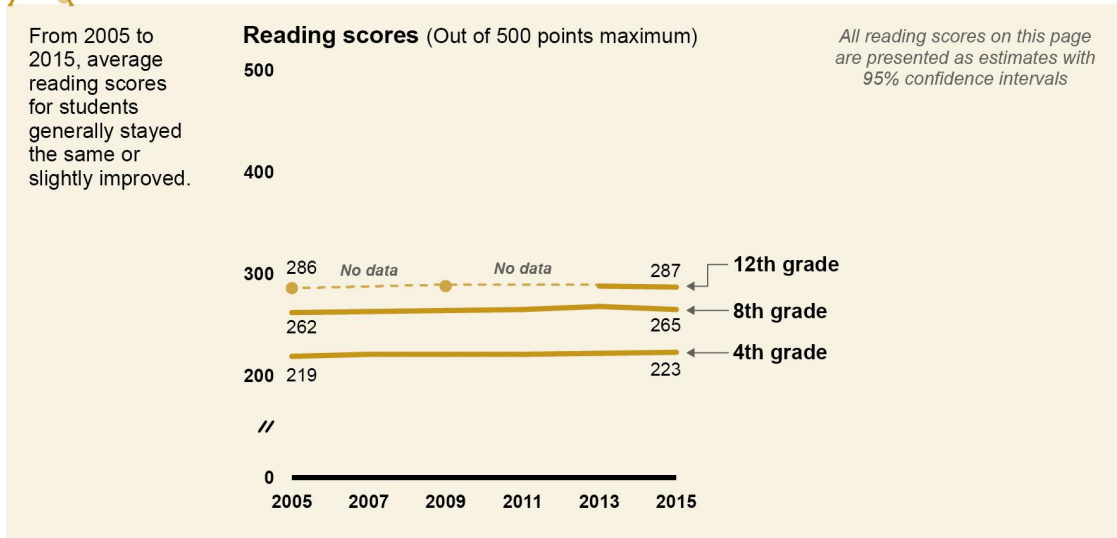
<sup>a</sup>See U.S. Department of Education, Office for Civil Rights, Protecting Civil Rights, *Advancing Equity: Report to the President and Secretary of Education Under Section 203(b)(1) of the Department of Education Organization Act, FY 13-14* (April 2015); U.S. Department of Education, Dear Colleague Letter on supporting access to science, technology, engineering, and math education (April 13, 2016); and Federal Interagency Forum on Child and Family Statistics, *America's Children in Brief: Key National Indicators of Well-Being, 2016* (Washington, D.C.: U.S. Government Printing Office).

**Figure 22: Reading Scores**

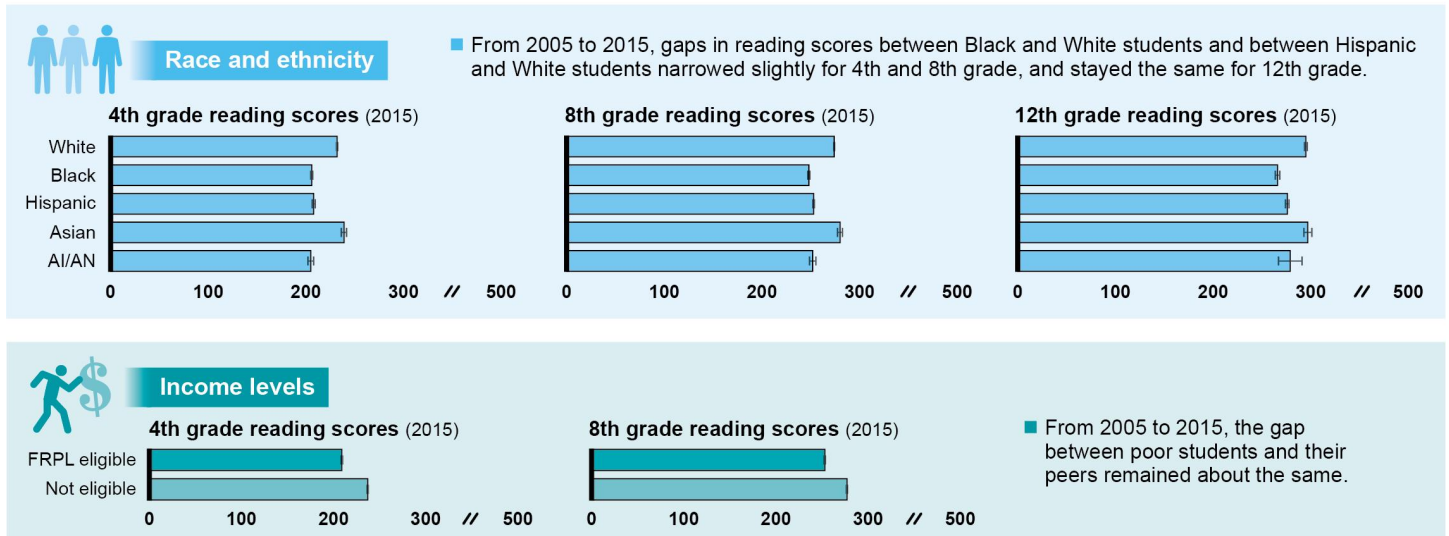


**Reading scores (Estimated)**

Research shows that children who read well in the early grades are far more successful in later years; and those who fall behind often stay behind when it comes to academic achievement. Students who cannot read well are much more likely to drop out of school and be limited to low-paying jobs throughout their lives.<sup>a</sup>



**2015:** Black, Hispanic, AI/AN, and poor students on average had lower reading scores than White, Asian, and non-poor students.



Source: U.S. Department of Education's National Assessment of Educational Progress. | GAO-18-41SP

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Notes: In most cases the sampling error is small enough at the scale shown that the associated 95 percent confidence intervals are not visible. Reading achievement levels: 4<sup>th</sup> grade: Basic=208, Proficient=238, Advanced=268; 8<sup>th</sup> grade: Basic=243, Proficient=281, Advanced=323; 12<sup>th</sup> grade: Basic=265, Proficient=302, Advanced=346. Race and ethnicity categories other than Hispanic exclude persons of Hispanic ethnicity. AI/AN=American Indian/Alaska Native. Asian=Asian/Pacific Islander. FRPL=Free or reduced-price lunch. Poor=eligible for FRPL. Non-poor=not eligible for FRPL. The U.S. Department of Health and Human Services' federal poverty guidelines are used to determine eligibility for FRPL. Data include public and private schools. See U.S. Department of Education, Institute for Education Sciences, National Center for Education Statistics, *Digest of Education Statistics*.

<sup>a</sup>See U.S. Department of Education, No Child Left Behind, Extra Credit Newsletter (2004).

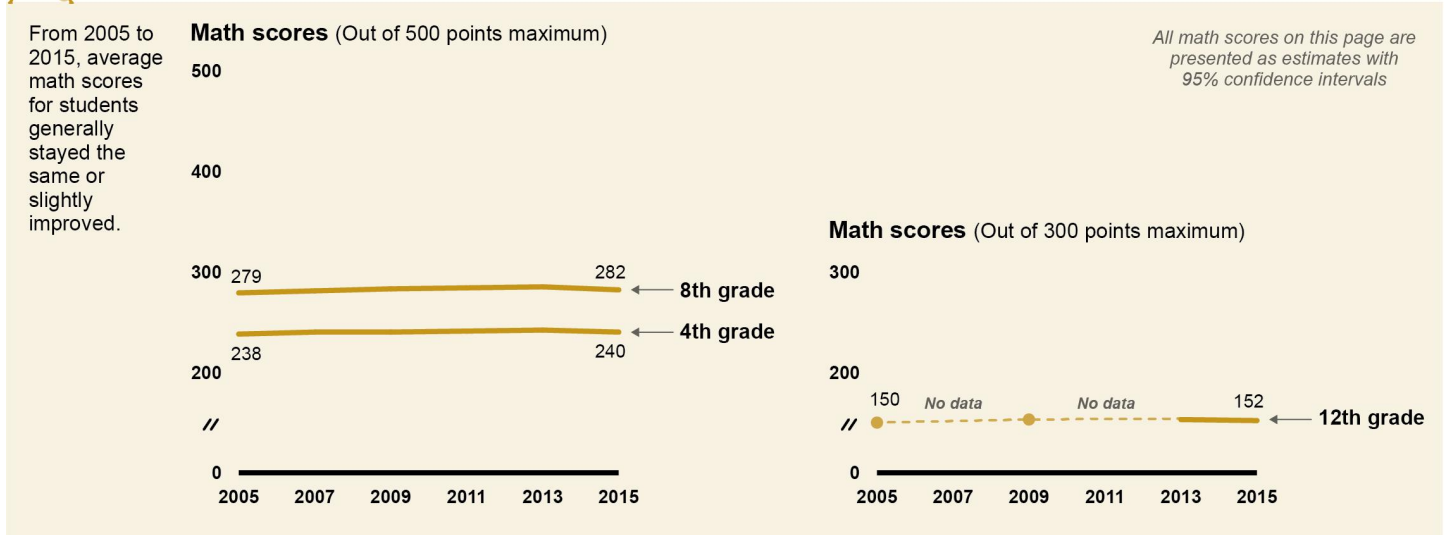
**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 23: Math Scores**

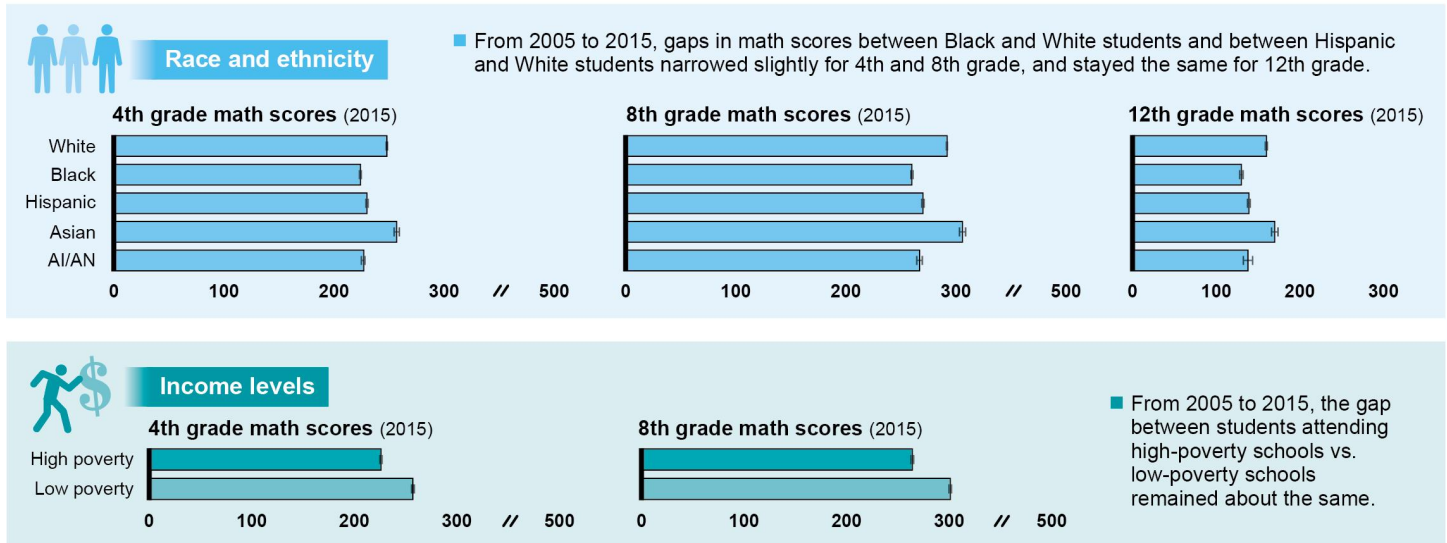


**Math scores (Estimated)**

To compete in the 21st century global economy, knowledge of and proficiency in mathematics is critical. Today's high school graduates need to have solid mathematics skills—whether they are headed for college or the workforce.<sup>a</sup>



**2015:** Students who were Black, Hispanic, AI/AN, or from high-poverty schools had lower math scores in 4th, 8th, and 12th grade than other students.



Source: U.S. Department of Education's National Assessment of Educational Progress. | GAO-18-41SP

Notes: In most cases the sampling error is small enough at the scale shown that the associated 95 percent confidence intervals are not visible. Math achievement levels: 4th grade: Basic=214, Proficient=249, Advanced=282; 8th grade: Basic=262, Proficient=299, and Advanced=333; 12th grade: Basic=141, Proficient=176, Advanced=216. Race and ethnicity categories other than Hispanic exclude Hispanic ethnicity. AI/AN=American Indian/Alaska Native. Asian=Asian/Pacific Islander. Data include public and private schools. High-poverty schools=schools with 76 percent or more students eligible for free or reduced-price school lunch (FRPL). Low-poverty schools=schools with 25 percent or fewer students eligible for FRPL. The U.S. Department of Health and Human Services' federal poverty guidelines are used to determine eligibility for FRPL. See U.S. Department of Education, Institute for Education Sciences, National Center for Education Statistics, *Digest of Education Statistics*.

<sup>a</sup>See U.S. Department of Education, *National Math Panel Factsheet* (2008).

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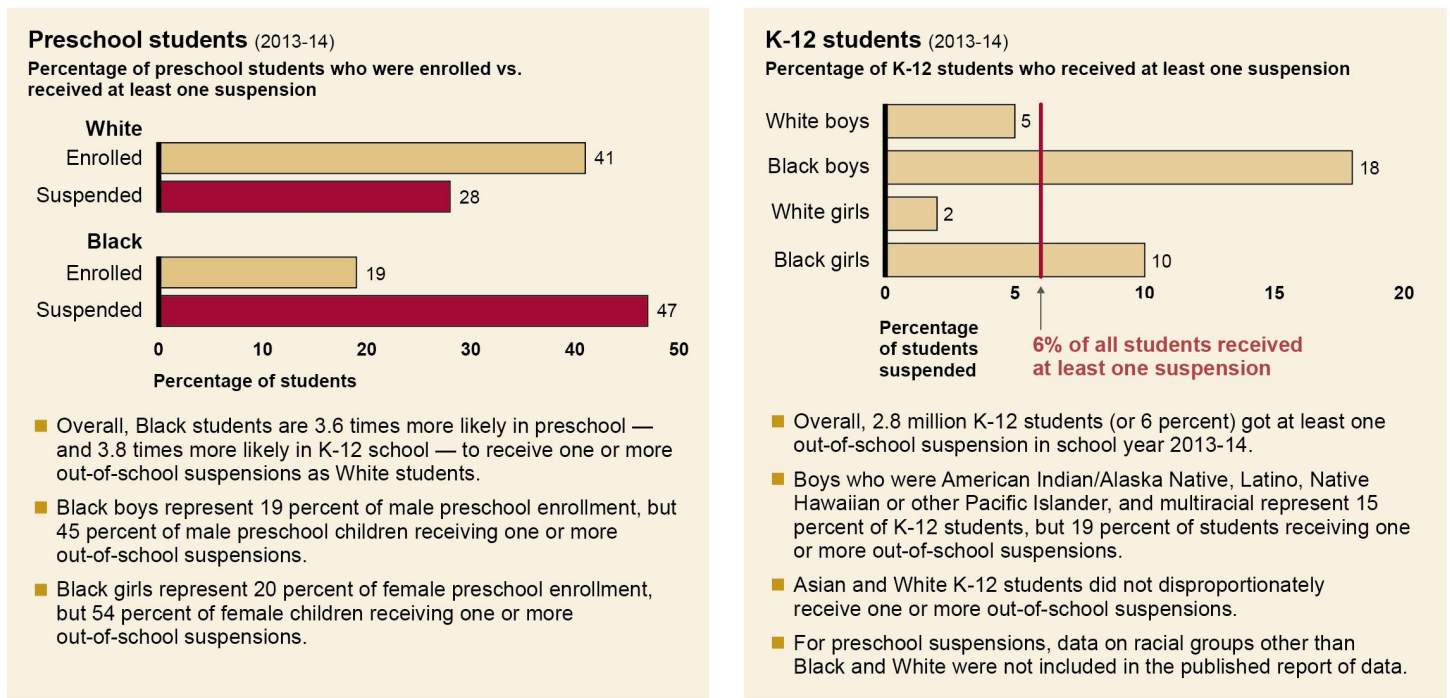
**Figure 24: Student Suspensions**



**Student suspensions**

Students who receive out-of-school suspensions are excluded from school for disciplinary reasons and lose important instructional time. These students are less likely to graduate on time and more likely to repeat a grade, drop out of school, and become involved in the juvenile justice system<sup>a</sup>

School year 2013-14: Boys were more likely than girls and Black students were more likely than White students to be suspended.



Source: U.S. Department of Education's Civil Rights Data Collection. | GAO-18-41SP

Notes: Out-of-school suspension refers to an instance when a child is temporarily removed from a regular school setting for at least half a day for disciplinary purposes to another setting (e.g., home or behavior center). Data include public schools only. Black=Black or African American; Hispanic=Hispanic or Latino of any race; and multiracial=two or more races. Percentages are rounded to the nearest whole number. For more information, see U.S. Department of Education, Office for Civil Rights, 2013-2014 Civil Rights Data Collection: A First Look: Key Data Highlights on Equity and Opportunity Gaps in Our Nation's Public Schools (Issued June 7, 2016; Revised October 28, 2016).

<sup>a</sup>See U.S. Department of Education, Office for Civil Rights, 2013-2014 Civil Rights Data Collection, A First Look: Key Data Highlights on Equity and Opportunity Gaps in Our Nation's Public Schools (June 2016); U.S. Department of Education, Rethink School Discipline: School District Leader Summit on Improving School Climate and Discipline, Resource Guide for Superintendent Action (Washington, D.C.: July 2015); and U.S. Department of Justice, Civil Rights Division and U.S. Department of Education, Office for Civil Rights, Dear Colleague Letter on Nondiscriminatory Administration of School Discipline (January 2014).

**Section 1: Federal Data Show That Child Well-Being Has Improved in Some Areas but Not in Others, and Children with Certain Characteristics Have Fared Worse than Others**

**Figure 25: School Crime and Safety**



**School crime and safety (Estimated)**

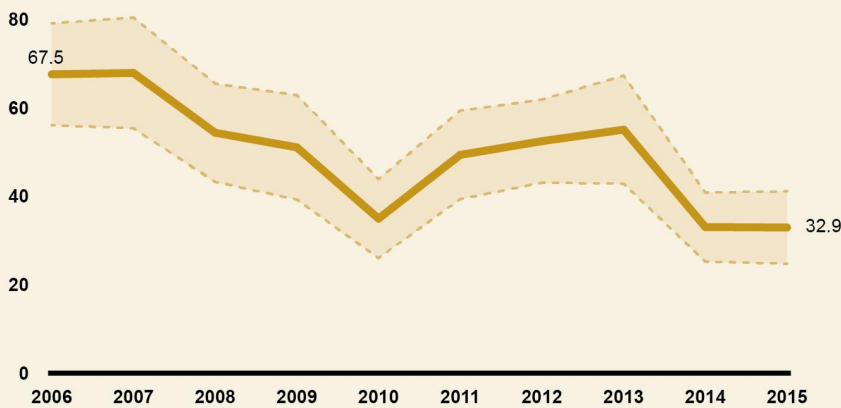
Violence frequently has dire and long-lasting impacts on young people who experience, witness, or feel threatened by it. In addition to causing direct physical harm to young victims, serious violence can adversely affect their mental health and development and increase the likelihood that they themselves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

From 2006 to 2015, the estimated number of nonfatal victimizations against students decreased by more than half, from about 1.8 million incidents to about 800,000.

Note: "Victimization" includes both theft and violent crimes.

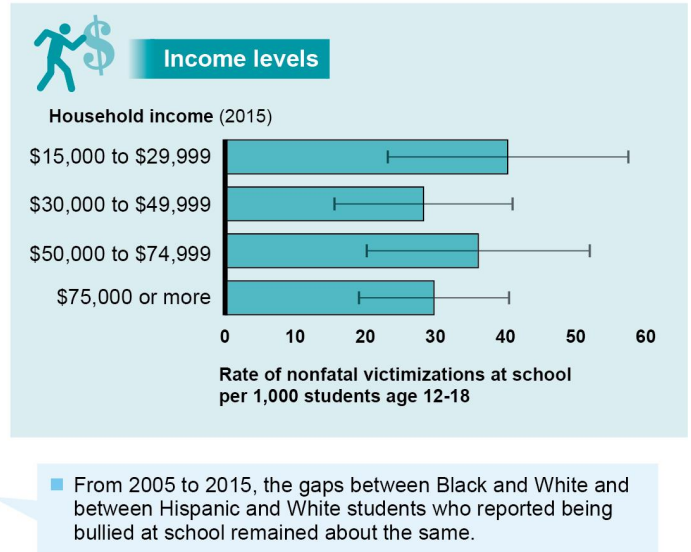
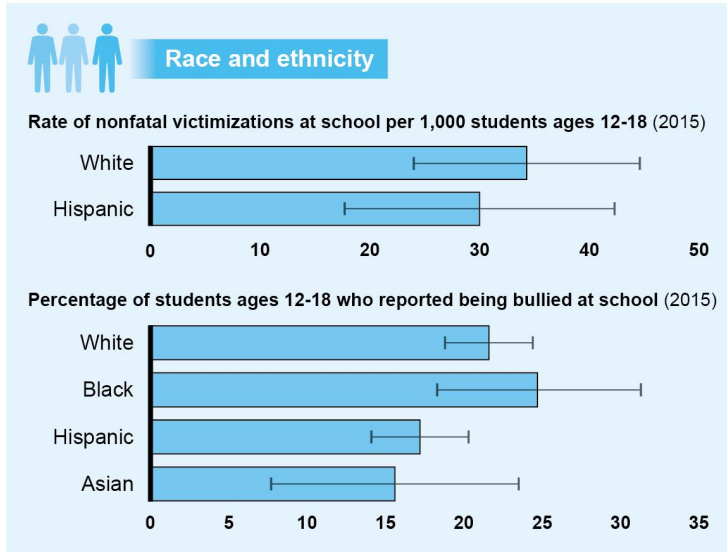
All percentages and rates on this page are presented as estimates with 95 percent confidence intervals

**Rate of nonfatal victimizations at school per 1,000 students age 12-18**



**6.0%**  
Percentage of students grades 9-12 who reported being threatened with or injured by a weapon on school property in 2015

**2015:** No statistical difference existed between rates of theft or violent crime at school for White or Hispanic students or by household income level.



Source: U.S. Department of Justice's National Crime Victimization Survey and School Crime Supplement and U.S. Department of Health and Human Services' Youth Risk Behavior Surveillance System. | GAO-18-41SP

Notes: Nonfatal victimizations include theft and violent crimes. Theft includes attempted and completed purse-snatching, completed pickpocketing, and all attempted and completed thefts, with the exception of motor vehicle thefts. Violent crimes include serious violent crimes (rape, sexual assault, robbery, and aggravated assault) and simple assault. At school includes inside the school building, on school property, and on the way to and from school. Race and ethnicity categories other than Hispanic exclude persons of Hispanic ethnicity. Due to methodological differences, use caution when comparing 2006 estimates to other years. Estimates for nonfatal victimizations of Black children and for children in households with income below \$15,000 were statistically unreliable. For more information, see U.S. Department of Education, Institute for Education Sciences, National Center for Education Statistics, *Digest of Education Statistics*.

<sup>a</sup>See Federal Interagency Forum on Child and Family Statistics, *America's Children in Brief: Key National Indicators of Well-Being, 2016*. (Washington, D.C.: U.S. Government Printing Office).



## Section 2: Experts Noted Several Considerations for Policymakers Seeking to Address the Multiple Dimensions of Child Well-Being

We discussed with experts from 18 organizations, who represent a range of viewpoints, several areas that policymakers could consider when seeking to address the multiple dimensions of child well-being: (1) considering the whole family; (2) focusing on the early years of childhood and adolescence; (3) considering the appropriateness of both targeted and universal interventions; (4) evaluating the effect of policy interventions and fostering innovation; and (5) coordinating among federal, state, local, and non-governmental entities (see app. III for a list of the organizations). As evidenced by our discussion above, child well-being may be measured across multiple indicators that reflect many areas of a child's life. However, according to the experts we consulted, as policymakers and practitioners work to improve child well-being, they need to consider that the various areas are interconnected and that the challenges children face in one area may significantly impact other aspects of their lives. For example, being homeless can negatively affect a child's mental health and academic achievement. Similarly, living in poverty affects not only the material resources of a family, but also negatively impacts the neighborhood in which they live, which can affect a child's safety. When poverty affects a child's health, the family's financial resources may be further strained given the costs of health care, thus exacerbating the negative effects of living in poverty.

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### Considering the Whole Family

Experts we consulted from organizations who represent a range of viewpoints suggested that policymakers consider ways to support a family's ability to provide the safe, supportive, and nurturing environment that children need, as a child's needs are intimately associated with those of their parents. They identified a range of strategies that recognize the critical role families play in ensuring child well-being. For example, the experts said that access to decent, stable, and affordable housing—one

of a family's greatest needs—can positively influence a child's school readiness and health and reduce the risk of maltreatment. Among the many ways identified by the experts to support family stability, including through policies that support work, asset building, and wealth creation, some experts highlighted the role of policies that promote marriage or encourage the maintenance of two-income households. They suggested that children in married or two-income households generally have greater access to the financial and non-financial resources (e.g., parental support) that are important to child well-being.

Experts also discussed approaches designed to address the needs of children and parents at the same time—so-called two-generation approaches. As an example, Head Start programs provide early education services to low-income children while offering support to families, such as services that promote housing stability, continued education, and financial security, according to some experts.<sup>1</sup> The experts said that involving parents in such interventions is especially important in maximizing the positive effects for children. In addition, they cited the need to involve parents in nutrition interventions for children, as parents are the ones who choose which foods to bring into the home. They provided the example of the Summer Electronic Benefits Transfer for Children program as one that addresses food insecurity for children whose families may not be able to provide sufficient food in the summer months.<sup>2</sup> Similarly, according to experts, parents should be partners in mental health interventions for their children. One such model that they said has shown positive results, known as Functional Family Therapy, brings the family into the process by coaching them on how to respond to youth who may be involved in delinquent or criminal behavior without the youth becoming more involved in the juvenile justice system.<sup>3</sup> To help

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<sup>1</sup>Head Start promotes the school readiness of young children from low-income families through agencies in their local community. Head Start and Early Head Start programs support the comprehensive development of children from birth to age 5, in centers and schools, child care partner locations, and in their own homes. Head Start services include services to support early learning, health, and family well-being.

<sup>2</sup>The Summer Electronic Benefits Transfer for Children program is a demonstration grant to states that provides families with children eligible for free and reduced-price school meals access to additional food benefits during the summer.

<sup>3</sup>According to the U.S. Department of Justice, although commonly used as an intervention program, the model is also an effective prevention program for at-risk adolescents and their families. Whether implemented as an intervention or a prevention program, it may include diversion, probation, alternatives to incarceration, and/or reentry programs for youth returning to the community following release from a high-security, severely restrictive institutional setting.

identify the particular needs of children and their families, the experts we spoke to identified various entry points to screen children and families for needed services, such as early childhood education programs, K-12 schools, and primary health care visits. However, experts suggested that trying to ensure that such screenings are done routinely through these entities is difficult; for example, such screenings can be disruptive to typical health care settings and are costly.

Experts further noted that interventions that address the needs of children and parents should be considered as part of a multi-faceted approach to address the adverse impact of poverty. For example, experts from one organization discussed the importance of health insurance to help treat maternal depression, which is prevalent in families with infants living in poverty and negatively affects the well-being of all children in the family. Experts also said that stress and the scarcity of resources associated with poverty affect the ability of parents to cope with challenges, and make it harder for these parents to manage everyday tasks and responsibilities. Moreover, low-income families generally have fewer supports than higher income families, such as paid leave that can support a parent's ability to stay home with a sick child. In another example, experts recognized the challenges children face in high-poverty neighborhoods—such as access to poorer quality schools and fewer neighborhood amenities—and a few identified school choice as an important option that attempts to break the link between a child and the challenges associated with attending a high-poverty school.

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## **Focusing on the Early Years and Adolescence**

While experts varied in the specific interventions they recommended, those we spoke to indicated that the earlier an intervention occurs, the better for the child, as a child's early years are critical to their development. Additionally, as previously described, they said that interventions are often particularly effective when they involve parents. For example, experts from one organization described a home visiting program in which nurses visit parents and their newborn children during the first few weeks of the child's life, with the goal of connecting parents with the community resources they need to raise a healthy child. As part of the program, nurses provide in-home health assessments of mothers and newborns and discuss the social conditions that affect the new family. According to the experts, the program has shown positive effects, including effects on parenting behaviors and father involvement, as well as reduced rates of infant hospitalization.

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**Section 2: Experts Noted Several Considerations for Policymakers Seeking to Address the Multiple Dimensions of Child Well-Being**

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Moreover, challenges children face can have cumulative effects on their well-being. For example, experts from one organization explained that challenges children may have at birth shape their ability to exhibit self-control. Children with a lack of self-control may be more likely to be suspended or expelled from school and to come into contact with the juvenile justice and prison systems later in life, according to these experts. In another example, experts noted that poverty can negatively affect brain development in children and lead to measurable gaps in language acquisition by 18 months of age and educational delays that are evident as a child reaches school age. More generally, according to experts, impacts from early investments can last for years, such as through improved educational outcomes, reduced special education costs, reduced contact with the juvenile justice system, and higher employment earnings.

While experts said interventions ideally take place early in a child's life, they also noted the importance of intervening with children of all ages. While much is known about early childhood development, one expert noted that less is known about what promotes the well-being of children ages 8-18 years. They said that interventions during adolescence may be particularly important, considering the continued brain development that occurs as social and peer pressures emerge. For example, adolescents may deal with a host of new challenges, including the stress of college admissions, avoiding unwanted pregnancy, and access to drugs. Further, experts we consulted suggested that interventions need to consider a child's developmental stage. For example, according to experts from one organization, while poverty generally has the greatest impact in early childhood, housing instability tends to affect children the most during the pre-teen years. Meanwhile, children may be more influenced by their peers at this age and less inclined to seek services recommended or initiated by their parents, such as mental health counseling. Experts from another organization identified various interventions with positive effects for students in high school, including requiring students to take a college admissions test, which they said was shown to increase the number of children from poor households going to college. In another example, they cited a program for at-risk male youth that provides school-based counseling, mentoring, educational enrichment, and anger management training, and has been shown to increase school engagement and performance and decrease student violence and arrests. Relatedly, because challenges to child well-being are interrelated, experts said that interventions in one area have effects in others. For example, if child maltreatment is reduced, so, too, is the need for mental health care.

## Considering the Appropriateness of Both Targeted and Universal Interventions

Both targeted and universal interventions may be appropriate to address child well-being, depending on various factors, according to the experts we consulted. Those representing a range of viewpoints generally agreed that scarce resources should be targeted to the most vulnerable children with the greatest need, since it is not cost-effective to provide services to those who would otherwise be able to pay for them. Poverty, as we have discussed, is detrimental to child well-being in myriad ways, as it underlies most child well-being challenges, makes them worse, and limits a child's opportunities for upward mobility. Experts from one organization said that evidence suggests targeted interventions, such as those that may help alleviate the effects of poverty, provide the most benefit.

However, programs for the poor risk isolating and stigmatizing high-need families and may compromise program quality by excluding higher-income children whose parents are in a position to demand quality, experts cautioned. While universal programs may cost more, they offer other benefits, according to some experts: They can be easier to access, allow low-income children to interact with peers across income levels, and may have broader political appeal (e.g., universal pre-k versus early education programs for low-income children), among others. Some experts identified policies they think should be universal. For example, experts from one organization suggested that school choice programs (including education savings accounts) be universally available to allow families to make their own decisions about which schools their children should attend.<sup>4</sup> In another example, experts said it is important to not differentiate interventions based on income for children in child welfare and juvenile justice systems, as all children in these systems should be considered vulnerable, regardless of their family income. Rather than having to choose between targeted and universal approaches, interventions may combine aspects of the two. For example, experts noted that one state's paid family leave policy, while broadly available,

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<sup>4</sup>Education savings accounts are state programs that provide public funds that eligible students may use for a broad set of educational expenses, such as private school tuition and fees, online learning programs, private tutoring, education therapies, or higher education expenses, depending on the program.

was changed to enable greater take-up by low-income families.<sup>5</sup> Additionally, universal programs that have fees based on a sliding scale can be accessible to all and allow families to pay according to their incomes.

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## Evaluating the Effect of Policy Interventions and Fostering Innovation

In designing interventions for child well-being, experts suggested there is an important role for both evaluation and innovation. They generally agreed that implementing evidence-based practices is essential to effectively address child well-being, and noted that randomized controlled trials, which are designed to isolate the effects of a particular intervention on a population, are the “gold standard” of evaluation.<sup>6</sup> At the same time, however, some experts noted that few interventions are evaluated using the high standard of randomized trials and identified challenges to the use of randomized trials for interventions that affect children; for example, they noted that it is unethical to provide benefits, such as food assistance or health insurance coverage, to a random selection of children that excludes others who also need these services. Experts said that these trials are expensive and may not always be well-suited to evaluate interventions for families with complex needs and circumstances that may require combined or sequenced interventions. It may also take a long time—sometimes years—for outcomes to be realized from interventions that can affect child well-being. Experts noted that policies aimed at prevention, for example, do not see immediate impacts. In light of such challenges, experts offered alternatives to randomized controlled trials,

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<sup>5</sup>Recent changes to this state’s law increased the wage replacement rate under the state unemployment compensation disability law and the family temporary disability insurance program, based on the worker’s wages, effective beginning 2018.

<sup>6</sup>Randomized controlled trials assign people, at random, to participate in a program or serve as a control group in order to compare outcomes for a program’s participants with the outcomes comparable people achieve without the program.

such as rapid-cycle evaluations and quasi-experimental methods.<sup>7</sup> One expert noted that the desire for perfect data should not be the enemy of using good data.

Experts also discussed how innovation may help build evidence about the effectiveness of interventions, given the difficulties noted above. Evaluations can help demonstrate the effectiveness of an intervention for a specific case or group; however, developing innovative ways to implement an intervention may demonstrate how it can work in different contexts, such as when an intervention is scaled to a larger population, or when a service provider faces challenges with limited staff, time, or funding for implementation. Experts suggested that introducing innovations is also important to understanding how to tailor evidence-based practices to certain populations for whom evidence is lacking (e.g., racial and ethnic minorities). Innovations that allow results to be put into practice quickly provide opportunities for policy to continuously improve, according to one expert. Experts from another organization said that sharing promising practices and lessons learned from innovating, including those that did not work, contributes to “practice-based evidence.” Citing tiered funding for a federal home visiting program that supports innovative and promising practices, some experts also said that program funding can foster innovation. With such variations in evidence, a few experts suggested the term “evidence-based” be further defined or expanded; however, one expert cautioned that the term was prone to overuse and that there is a tendency to call practices “evidence-based” regardless of whether evidence exists.

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<sup>7</sup>Rapid-cycle evaluations use behavioral sciences to improve and assess program and policy impact and are generally of a low-cost, iterative nature. See The White House Office of Social Innovation and Civic Participation, Find What Works, downloaded from <https://obamawhitehouse.archives.gov/administration/eop/sicp/initiatives/find-what-works> on June 26, 2017 and Baird, Peter, Dan Cullinan, Patrick Landers, and Leigh Reardon (2016), *Nudges for Child Support: Applying Behavioral Insights to Increase Collections*. OPRE Report 2016-01. Washington, D.C.: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Quasi-experimental comparison group design is employed by impact evaluations due to the difficulties in establishing a random process for assigning units of study to a program as well as the opportunity provided when only a portion of the targeted population is exposed to the program. This design also uses a treatment group and one or more comparison groups; however, unlike the groups in a true experiment, membership in these groups is not randomly assigned. See GAO, *Designing Evaluations: 2012 Revision*, [GAO-12-208G](#) (Washington, D.C.: January 2012).

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## Coordinating among Federal, State, Local, and Non-Governmental Entities

Experts we interviewed had different views on the role of government in addressing child well-being, but several experts said efforts to address the complex nature of child well-being are hindered by insufficient coordination at the federal level. More specifically, while experts provided some examples of federal coordination, such as in addressing education or disconnected youth, they said federal agencies generally operate in siloes and lack the multidisciplinary structure needed for a coordinated approach for child well-being. They said these siloes result in challenges such as multiple agencies addressing similar child well-being issues, disparate data that are difficult to share, and incompatible agency definitions. Looking across programs that affect the well-being of children, youth, and families, and finding ways to hold agencies accountable for working together on related issues is important to improve child well-being, experts said. Further, some experts noted that it would be valuable for the federal government to consider its investment in children in comparison to other subpopulations, such as seniors.

Experts also discussed the importance of federal agencies coordinating with stakeholders at other governmental levels and outside the government. One expert noted that health and human service agencies are not the only entities needed to address child well-being and suggested that community stakeholders work together to determine what resources are needed for the children in their community. State and local agencies may be better positioned to meet the needs of their communities, according to experts we consulted, who pointed to some promising local practices. For example, experts from one organization mentioned a school district that added a question to its enrollment form to help identify uninsured children who were eligible for health insurance coverage. In another example, some local areas use a case management entity to coordinate the needs of children and families across various agencies that may include juvenile justice, special education, and social services. Experts from one organization said that because some federal programs are administered through states, coordination across programs at the state level is important. Experts also emphasized the need to involve families, advocates, and non-governmental policy experts in such work. However, we also heard that challenges faced by states and localities, such as the limited capacity of service providers, limited funding, restrictions on data sharing, and the lack of dissemination of promising practices, constrain progress toward improving child well-being.



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Some of the experts we consulted provided suggestions for how the federal government could help address some of these challenges and improve its efforts to increase child well-being. More specifically, they said the federal role is important to:

- define child well-being and set federal minimum standards, or benchmarks, in various areas, including housing, health, and education;
- align child well-being goals and outcomes across programs and hold agencies accountable for working together, which can be particularly important as the benefits of investments in some systems, such as housing, may be reaped elsewhere, such as improvements in health;
- collect and disseminate data, including to identify child well-being disparities and analyze the causes, as well as provide leadership for data sharing efforts;
- support evaluation and research related to child well-being issues;
- support civil rights and equity for children, including through fair housing programs; and
- provide funding, training, and technical assistance to states and localities related to child well-being issues.

Other experts, however, offered contrasting views on the federal role. Some questioned what they saw as federal overreach in a few of these areas and noted the importance of determining whether federal action is warranted or appropriate. For example, one expert suggested that the federal government has limited authority to intervene with education, aside from its responsibility to ensure that states and school districts provide equitable educational opportunities. Experts from another organization said the federal government should help families help themselves by supporting work, rather than supplanting or displacing it with federal assistance. In that way, they said, the federal government could supplement the needs of families who are working but still cannot make ends meet.

The GPRA Modernization Act of 2010 requires OMB to coordinate with agencies to develop federal government priority goals (known as cross-

agency priority or CAP goals).<sup>8</sup> These are long-term, outcome-oriented goals that cover a limited number of crosscutting policy areas. According to OMB, these goals are identified in areas where increased cross-agency collaboration on outcome-focused areas is likely to improve progress. Prior CAP goals have addressed areas such as education and the workforce, including a goal designed to improve Science, Technology, Engineering, and Mathematics (STEM) Education.<sup>9</sup> The Act also requires that agency strategic plans include a description of how agency goals and objectives contribute to the cross-agency priority goals, and how agencies are working with each other to achieve these cross-agency priority goals. For example, as part of an effort to expand the impact of existing federal STEM education programs, the STEM Education Strategic Plan has been incorporated into a CAP goal since 2014, according to the Executive Office of the President's Office of Science and Technology Policy.<sup>10</sup> This step institutionalizes the STEM Education Strategic Plan through agency performance metrics and requires agencies to issue public implementation updates every quarter. The current priority goals cover the period from 2014-2018. To date, child well-being has not been designated as a CAP goal. OMB is reviewing the current administration's priorities to help develop the next set of CAP goals. OMB officials told us they expect to issue the next set of goals with the release of the fiscal year 2019 budget. By highlighting child well-being as an overarching priority area, and ensuring that this priority is reflected in agencies' strategic plans, OMB could help draw needed attention to improve collaboration among federal efforts to enhance child well-being.

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<sup>8</sup>The GPRA Modernization Act of 2010 established a new framework aimed at encouraging a more crosscutting and integrated approach to improving government performance, including processes to improve transparency and accountability. Pub. L. No. 111-352, 124 Stat. 3866 (2011). GPRAMA enhanced the Government Performance and Results Act of 1993 (GPRA), Pub. L. No. 103-62, 107 Stat. 285 (1993).

<sup>9</sup>CAP goals also include goals for management improvements needed across the federal government, including financial management, human capital management, information technology management, procurement and acquisition management, and real property management. At a minimum, CAP goals are to be updated or revised every four years. See a recent GAO report for a discussion on the implementation of the GPRA Modernization Act, including a discussion on selected CAP goals, [GAO-16-509](#) (Washington, D.C.: May 20, 2016).

<sup>10</sup>Executive Office of the President, Office of Science and Technology Policy, *Progress Report on Coordinating Federal Science, Technology, Engineering, and Mathematics (STEM) Education*. (Washington, D.C.: March 31, 2016).

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## Conclusions

Fostering the well-being of the nation's children requires attention to a multiplicity of interrelated factors that can contribute to child well-being and the role that families, communities, governmental and non-governmental organizations play in caring for these children. Appropriate interventions that address the needs of children can help them become responsible and productive adults who, in turn, contribute to the viability of the nation's social and economic sectors. Despite sustained efforts to improve the well-being of children, including those from economically disadvantaged families, some indicators have shown little improvement over the time period covered by the data in this report, and significant gaps between groups remain. For its part, the federal government funds and administers programs that are designed to improve the well-being of children and families, collects a range of data on various indicators of child well-being, and sponsors and conducts related research and evaluations, among other things. However, several experts noted that federal agencies tend to focus narrowly on their own mission and that there is not a coordinated federal approach for addressing child well-being. OMB is currently revising the federal government's priority goals (cross-agency priority or CAP goals) and expects to issue the next set of 4-year CAP goals with the fiscal year 2019 budget. A coordinated federal approach to child well-being, such as through a CAP goal, and subsequent agency strategic plans that describe how their goals and objectives contribute to the CAP goals, could provide the federal government an opportunity to better address the needs of children and families in ways that take into account the interrelatedness of federal actions and policies that aim to improve child well-being.

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## Recommendation for Executive Action

GAO recommends that the Director of OMB consider developing a goal that addresses a coordinated federal approach to child well-being among its next set of cross-agency priority (CAP) goals, including working with relevant agencies to ensure their strategic plans include goals and objectives related to the CAP goal. (Recommendation 1)

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## **Agency Comments**

We provided a draft of this report to the Office of Management and Budget (OMB) for review and comment. OMB staff provided us with oral comments and neither agreed nor disagreed with our recommendation that the agency consider developing a goal that addresses a coordinated federal approach to child well-being among its next set of cross-agency priority (CAP) goals. OMB staff reiterated that the agency is currently in the process of developing its next set of CAP goals, which are usually reserved for a limited set of priorities, and expects to announce these goals concurrent with the fiscal year 2019 budget. As part of the process, agency staff said they consult relevant Congressional committees and other stakeholders. OMB staff also provided technical comments, which we incorporated as appropriate.

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## Appendix I: Scope and Methodology

The objectives of this report were to examine (1) what is known about the state of child well-being in the United States and how it has changed in recent years, and (2) experts' views on what policymakers could consider when addressing child well-being. To address our objectives, we selected several indicators of child well-being based on our review of child well-being frameworks, reviewed federal data, and interviewed agency officials and a variety of subject matter experts about child well-being issues.

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### Review of Child Well-Being Frameworks

We reviewed 16 frameworks of child well-being indicators developed and published by several domestic and international organizations and researchers, and a federal inter-agency group (see app. II for a list of selected organizations and frameworks). Based on this review, and after discussing these indicators with a variety of subject matter experts, we selected and categorized indicators along the following areas of a child's life: (1) family, physical, and social environment, (2) physical and mental health, and (3) early care and education. (See fig. 2.)

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### Review of Federal Datasets

For each child well-being indicator, we reviewed published federal data for children over the most recent 10-year period, and by certain characteristics—race/ethnicity, income level/poverty status, and family composition—for the first and last year of this 10-year period, to the extent data were available. Based on our review of data, we identified and reported trends over time for children overall and any differences between children with certain characteristics, including whether differences persisted, narrowed, or widened. Data were not consistently available for every child well-being indicator over the most recent 10 years or by each of these characteristics; as a result we report information for only those years for which data were available.

Many of the data sources from which estimates were drawn are federal statistical surveys. For data that came from a statistical source, we reviewed the source agency's technical documentation for the survey. When the source publication did not provide the confidence interval for an estimate, we implemented agency technical guidance to

calculate the 95 percent confidence interval using the published weighted standard error. All national estimates produced from federal probability survey data are subject to sampling errors. We express our confidence in the precision of the results as a 95 percent confidence interval. This is the interval that would contain the actual population value for 95 percent of the samples the respective agency could have drawn. We assessed the reliability of the data by (1) reviewing existing information about the data and the system that produced them and, in some cases, (2) interviewing agency officials knowledgeable about the data. We determined that the data we reported were sufficiently reliable for the purposes of this report. For some indicators, data were not available for children for race/ethnicity, household income, and family composition. Additionally, the sub-group categories of children we reported on were not always an exhaustive list of those available in the federal data.

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## Interviews with Federal Officials and Child Well-Being Experts

We interviewed federal agency officials from the U.S. Office of Management and Budget (OMB), the Department of Agriculture's Economic Research Service, the Department of Education's National Center for Education Statistics, the Department of Health and Human Services' (HHS) Centers for Disease Control and Prevention, and HHS's Assistant Secretary for Planning and Evaluation about child well-being issues and related data. During these interviews, we asked agency officials about indicators of the well-being of children in the United States, federal data collected on these indicators, and federal efforts to address child well-being. With OMB officials, we also discussed their views on the cross-agency priority goals and the benefits to federal agencies and program areas of identifying specific areas, such as child well-being, as a priority goal.

We also interviewed officials from 18 non-governmental organizations that conduct research and activities related to children and families to obtain a range of perspectives on what policymakers should consider when addressing child well-being. We selected organizations to obtain balance and coverage across three criteria: (1) subject matter expertise, (2) a range of viewpoints, including perspectives on the role of the federal government, and (3) type of organization. Specifically, we included groups that had expertise on issues related to children's family, physical, and social environment; physical and mental health; and early care and

education. We included nonprofit, academic, and advocacy groups and reviewed published material from organizations' websites to help inform our selection. We used semi-structured questions to obtain experts' perspectives on the (1) child well-being indicators we selected, (2) need for any interventions to improve child well-being, and if so, (3) timing, type, and evaluation of interventions, and (4) role of federal, state, local, and private entities, if any, in interventions. We reported the results of our expert interviews to reflect the full range of perspectives, and identified areas of consensus and variation among expert views where appropriate. The information and perspectives we obtained and present in this report should not be regarded as an exhaustive discussion of all viewpoints of these experts on child well-being issues; nor is it generalizable to all child welfare experts. The viewpoints summarized in this report also do not necessarily represent the views of all the experts we interviewed, their organizations, or GAO. We provided a draft of this report for review to two external experts who are members of the Comptroller General's Advisory Board. The board is comprised of individuals with broad expertise in public policy and provides advice to GAO. We incorporated their comments throughout the report, as appropriate.

We conducted this performance audit from March 2016 to November 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Appendix II: Selected Child Well-Being Frameworks

Adamson, Peter. *Child Poverty in Perspective: An Overview of Child Well-Being in Rich Countries*, Innocenti Report Card 7. Florence, Italy: UNICEF Innocenti Research Centre, 2007.

Ben-Arieh, Asher. "Measuring and monitoring the well-being of young children around the world." Paper commissioned for the *Education for All Global Monitoring Report 2007: Strong foundations: early childhood care and education*, 2006.

Chapple, Simon, and Dominic Richardson. "Comparative Child Well-being across the OECD." *Doing Better for Children*, chapter 2. OECD, 2009.

Child Trends. *Child Trends Data Bank*. Bethesda, MD: Child Trends. Accessed on April 14, 2016.  
<https://www.childtrends.org/databank-indicators/databank-by-life-stage/>.

Child Trends. *Child Well-Being: Indicator List for Child Well-Being*. Bethesda, MD: Child Trends. Accessed on April 14, 2016.  
<https://www.childtrends.org/databank-indicators/databank-by-topics/>.

Children's Defense Fund. *The State of America's Children 2014*. Washington D.C.: Children's Defense Fund, 2014.

Diversitydatakids.org. Waltham, MA: The Heller School for Social Policy and Management at Brandeis University. Accessed on April 15, 2016.  
<http://www.diversitydatakids.org/>.

Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief: Key National Indicators of Well-Being, 2016*. Washington, D.C.: U.S. Government Printing Office, July 2016.

Fernandes, Liliana, Américo Mendes, and Aurora Teixeira. "A Weighted Multidimensional Index of Child Well-Being Which Incorporates Children's Individual Perceptions." *Social Indicators Research*, vol. 114, 2013.

Gutierrez, Florencia, and Laura Speer. *2016 KIDS COUNT Data Book: State Trends in Child Well-Being*. Baltimore, MD: The Annie E. Casey Foundation, 2016.



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Healthy People 2020 Leading Health Indicators. Accessed on November 25, 2016. <https://www.healthypeople.gov/2020/Leading-Health-Indicators>.

Land, Kenneth C., *Child and Youth Well-Being Index (CWI) Report (2014)*. Duke University Center for Child and Family Policy, 2014.

Land, Kenneth C., Vicki L. Lamb, Sarah O. Meadows, et al. "Measuring trends in child well-being: an evidence-based approach." *Social Indicators Research*, vol. 80, no. 1, 2007.

Lippman, Laura H., Kristin Anderson Moore, and Hugh McIntosh. *Positive Indicators of Child Well-Being: A Conceptual Framework, Measures and Methodological Issues*, Innocenti Working Paper No. 2009-21. Florence, Italy: UNICEF Innocenti Research Centre, 2009.

Moore, Kristin A., David Murphey, and Tawana Bandy. "Positive Child Well-Being: An Index Based on Data for Individual Children." *Maternal and Child Health Journal*, vol.16, no. 1, 2012.

Stagner, Matthew, Robert Goerge, and Pete Ballard. *Improving Indicators of Child Well-Being*. Chicago, IL: Chapin Hall at the University of Chicago, 2009.

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## Appendix III: List of Expert Organizations

American Enterprise Institute

American Psychological Association

American Public Human Services Association

The Annie E. Casey Foundation

The Brookings Institution

Cato Institute

Center for Child and Family Policy at Duke University

Center for Law and Social Policy

Chapin Hall at the University of Chicago

Child Trends

Children's Defense Fund

Georgetown University Center for Children and Families

The Heritage Foundation

MacArthur Foundation

Mathematica Policy Research

National Center for Missing & Exploited Children

The Pew Charitable Trusts

Urban Institute

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## Appendix IV: Related GAO Products

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### Family, Physical, and Social Environment

*Federal Low-Income Programs: Eligibility and Benefits Differ for Selected Programs Due to Complex and Varied Rules.* [GAO-17-558](#). Washington, D.C.: June 29, 2017.

*Foster Care: HHS Has Taken Steps to Support States' Oversight of Psychotropic Medications, but Additional Assistance Could Further Collaboration.* [GAO-17-129](#). Washington, D.C.: January 5, 2017.

*Supplemental Nutrition Assistance Program: More Information on Promising Practices Could Enhance States' Use of Data Matching for Eligibility.* [GAO-17-111](#). Washington, D.C.: October 19, 2016.

*Foster Care: Most Tribes Do Not Anticipate Challenges with Case Goal Changes, but HHS Could Further Promote Guardianship Assistance.* [GAO-16-625](#). Washington, D.C.: August 8, 2016.

*Supplemental Nutrition Assistance Program: Policy Changes and Calculation Methods Likely Affect Improper Payment Rates, and USDA Is Taking Steps to Help Address Recipient Fraud.* [GAO-16-708T](#). Washington, D.C.: July 6, 2016.

*Supplemental Nutrition Assistance Program: Enhanced Detection Tools and Reporting to Combat Recipient Fraud Are in Development.* [GAO-16-719T](#). Washington, D.C.: June 9, 2016.

*Unaccompanied Children: HHS Should Improve Monitoring and Information Sharing Policies to Enhance Child Advocate Program Effectiveness.* [GAO-16-367](#). Washington, D.C.: April 19, 2016.

*Emergency Management: Improved Federal Coordination Could Better Assist K-12 Schools Prepare for Emergencies.* [GAO-16-144](#). Washington, D.C.: March 10, 2016.

*Unaccompanied Children: HHS Can Improve Monitoring of Their Care.* [GAO-16-429T](#). Washington, D.C.: February 23, 2016.

*Temporary Assistance for Needy Families: Update on States Counting Third-Party Expenditures toward Maintenance of Effort Requirements.* [GAO-16-315](#). Washington, D.C.: February 10, 2016.

*Unaccompanied Children: HHS Can Take Further Actions to Monitor Their Care.* [GAO-16-180](#). Washington, D.C.: February 5, 2016.

*Electronic Monitoring: Draft National Standard for Offender Tracking Systems Addresses Common Stakeholder Needs.* [GAO-16-10](#). Washington, D.C.: October 26, 2015.

*Foster Care: HHS Could Do More to Support States' Efforts to Keep Children in Family-Based Care.* [GAO-16-85](#). Washington, D.C.: October 9, 2015.

*Child Welfare: Steps Have Been Taken to Address Unregulated Custody Transfers of Adopted Children.* [GAO-15-733](#). Washington, D.C.: September 16, 2015.

*School Nutrition: USDA Has Efforts Underway to Help Address Ongoing Challenges Implementing Changes in Nutrition Standards.* [GAO-15-656](#). Washington, D.C.: September 14, 2015.

*Federal Low-Income Programs: Multiple Programs Target Diverse Populations and Needs.* [GAO-15-516](#). Washington, D.C.: July 30, 2015.

*Unaccompanied Alien Children: Actions Needed to Ensure Children Receive Required Care in DHS Custody.* [GAO-15-521](#). Washington, D.C.: July 14, 2015.

*Youth Athletes: Sports Programs' Guidance, Practices, and Policies to Help Prevent and Respond to Sexual Abuse.* [GAO-15-418](#). Washington, D.C.: May 29, 2015.

*Domestic Food Assistance: Multiple Programs Benefit Millions of Americans, but Additional Action Is Needed to Address Potential Overlap and Inefficiencies.* [GAO-15-606T](#). Washington, D.C.: May 20, 2015.

*School-Meals Programs: Additional Verification Could Help USDA Ensure Legitimate Access.* [GAO-15-594T](#). Washington, D.C.: May 7, 2015.

*Victims of Child Abuse Act: Further Actions Needed to Ensure Timely Use of Grant Funds and Assess Grantee Performance.* [GAO-15-351](#). Washington, D.C.: April 29, 2015.

*Foster Care: HHS Needs to Improve the Consistency and Timeliness of Assistance to Tribes.* [GAO-15-273](#). Washington, D.C.: February 25, 2015.

*Nutrition Assistance: Additional Guidance Could Assist States in Reducing Risk of Online Sale of Infant Formula.* [GAO-15-94](#). Washington, D.C.: December 11, 2014.

*Temporary Assistance for Needy Families: Action Is Needed to Better Promote Employment-Focused Approaches.* [GAO-15-31](#). Washington, D.C.: November 19, 2014.

*Sex Offender Registration and Notification Act: Additional Outreach and Notification of Tribes about Offenders Who Are Released from Prison Needed.* [GAO-15-23](#). Washington, D.C.: November 18, 2014.

*Foster Children: HHS Could Provide Additional Guidance to States Regarding Psychotropic Medications.* [GAO-14-651T](#). Washington, D.C.: May 29, 2014.

*Foster Care: HHS Needs to Improve Oversight of Fostering Connections Act Implementation.* [GAO-14-347](#). Washington, D.C.: May 29, 2014.

*Foster Children: Additional Federal Guidance Could Help States Better Plan for Oversight of Psychotropic Medications Administered by Managed-Care Organizations.* [GAO-14-362](#). Washington, D.C.: April 28, 2014.

*School Lunch: Implementing Nutrition Changes Was Challenging and Clarification of Oversight Requirements Is Needed.* [GAO-14-104](#). Washington, D.C.: January 28, 2014.

*Child Welfare: Federal Agencies Can Better Support State Efforts to Prevent and Respond to Sexual Abuse by School Personnel.* [GAO-14-42](#). Washington, D.C.: January 27, 2014.

*WIC Program: Improved Oversight of Income Eligibility Determination Needed.* [GAO-13-290](#). Washington, D.C.: February 28, 2013.

*Registered Sex Offenders: Sharing More Information Will Enable Federal Agencies to Improve Notifications of Sex Offenders' International Travel.* [GAO-13-200](#). Washington, D.C.: February 14, 2013.

*Sex Offender Registration and Notification Act: Jurisdictions Face Challenges to Implementing the Act, and Stakeholders Report Positive and Negative Effects.* [GAO-13-211](#). Washington, D.C.: February 7, 2013.

*Supplemental Nutrition Assistance Program: Improved Oversight of State Eligibility Expansions Needed.* [GAO-12-670](#). Washington, D.C.: July 26, 2012.

*Supplemental Security Income: Better Management Oversight Needed for Children's Benefits.* [GAO-12-497](#). Washington, D.C.: June 26, 2012.

*Homelessness: To Improve Data and Programs, Agencies Have Taken Steps to Develop a Common Vocabulary.* [GAO-12-302T](#). Washington, D.C.: December 15, 2011.

*TANF and Child Welfare Programs: Increased Data Sharing Could Improve Access to Benefits and Services.* [GAO-12-2](#). Washington, D.C.: October 7, 2011.

*Domestic Violence, Sexual Assault, Dating Violence, and Stalking: National Data Collection Efforts Underway to Address Some Information Gaps.* [GAO-11-833T](#). Washington, D.C.: July 13, 2011.

*Missing Children: DOJ Could Enhance Oversight to Help Ensure That Law Enforcement Agencies Report Cases in a Timely Manner.* [GAO-11-444](#). Washington, D.C.: June 21, 2011.

*Combating Child Pornography: Steps Are Needed to Ensure That Tips to Law Enforcement Are Useful and Forensic Examinations Are Cost Effective.* [GAO-11-334](#). Washington, D.C.: March 31, 2011.

---

## Physical and Mental Health

*Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome.* [GAO-18-32](#). Washington, D.C.: October 4, 2017.

*Pediatric Trauma Centers: Availability, Outcomes, and Federal Support Related to Pediatric Trauma Care.* [GAO-17-334](#). Washington, D.C.: March 27, 2017.

*Federal Autism Activities: Agencies Are Encouraging Early Identification and Providing Services, and Recent Actions Could Improve Coordination.* [GAO-16-446](#). Washington, D.C.: May 20, 2016.

*Medicaid and CHIP: Increased Funding in U.S. Territories Merits Improved Program Integrity Efforts.* [GAO-16-324](#). Washington, D.C.: April 8, 2016.

*Provider Networks: Comparison of Child-Focused Network Adequacy Standards between CHIP and Private Health Plans.* [GAO-16-219](#). Washington, D.C.: February 5, 2016.

*Children's Health Insurance Program: Effects on Coverage and Access, and Considerations for Extending Funding.* [GAO-15-348](#). Washington, D.C.: February 27, 2015.

*Prenatal Drug Use and Newborn Health: Federal Efforts Need Better Planning and Coordination.* [GAO-15-203](#). Washington, D.C.: February 10, 2015.

*Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance.* [GAO-14-40](#). Washington, D.C.: November 21, 2013.

*Federal Autism Activities: Better Data and More Coordination Needed to Help Avoid the Potential for Unnecessary Duplication.* [GAO-14-16](#). Washington, D.C.: November 20, 2013.

*Dental Services: Information on Coverage, Payments, and Fee Variation.* [GAO-13-754](#). Washington, D.C.: September 6, 2013.

*Environmental Health: EPA Has Made Substantial Progress but Could Improve Processes for Considering Children's Health.* [GAO-13-254](#). Washington, D.C.: August 12, 2013.

*Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care.* [GAO-13-15](#). Washington, D.C.: December 10, 2012.

---

*Medicaid and CHIP: Considerations for Express Lane Eligibility.* [GAO-13-178R](#). Washington, D.C.: December 5, 2012.

*Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care.* [GAO-11-624](#). Washington, D.C.: June 30, 2011.

*Medicaid and CHIP: Reports for Monitoring Children's Health Care Services Need Improvement.* [GAO-11-293R](#). Washington, D.C.: April 5, 2011.

*Medicaid and CHIP: Given the Association between Parent and Child Insurance Status, New Expansions May Benefit Families.* [GAO-11-264](#). Washington, D.C.: February 4, 2011.

---

## Early Care and Education

*Early Learning and Child Care: Overview of Federal Investment and Agency Coordination.* [GAO-17-671T](#). Washington, D.C.: July 13, 2017.

*Indian Affairs: Actions Needed to Better Manage Indian School Construction Projects.* [GAO-17-447](#). Washington, D.C.: May 24, 2017.

*Indian Affairs: Further Actions Needed to Improve Oversight and Accountability for School Safety Inspections.* [GAO-17-421](#). Washington, D.C.: May 24, 2017.

*Youth with Autism: Federal Agencies Should Take Additional Action to Support Transition-Age Youth.* [GAO-17-352](#). Washington, D.C.: May 4, 2017.

*K-12 Education: Education Needs to Improve Oversight of Its 21st Century Program.* [GAO-17-400](#). Washington, D.C.: April 26, 2017.

*District of Columbia Charter Schools: Multi-Agency Plan Needed to Continue Progress Addressing High and Disproportionate Discipline Rates.* [GAO-17-165](#). Washington, D.C.: February 9, 2017.

*Youth with Autism: Roundtable Views of Services Needed During the Transition into Adulthood.* [GAO-17-109](#). Washington, D.C.: October 18, 2016.



*Child Care: Information on Integrating Early Care and Education Funding.* [GAO-16-775R](#). Washington, D.C.: September 14, 2016.

*School Choice: Private School Choice Programs are Growing and Can Complicate Providing Certain Federally Funded Services to Eligible Students.* [GAO-16-712](#). Washington, D.C.: August 11, 2016.

*K-12 Education: Education's Experiences with Flexibility Waivers Could Inform Efforts to Assist States with New Requirements.* [GAO-16-650](#). Washington, D.C.: July 7, 2016.

*K-12 Education: Better Use of Information Could Help Agencies Identify Disparities and Address Racial Discrimination.* [GAO-16-345](#). Washington, D.C.: April 21, 2016.

*Indian Affairs: Key Actions Needed to Ensure Safety and Health at Indian School Facilities.* [GAO-16-391T](#). Washington, D.C.: March 16, 2016.

*Indian Affairs: Key Actions Needed to Ensure Safety and Health at Indian School Facilities.* [GAO-16-313](#). Washington, D.C.: March 10, 2016.

*K-12 Education: Federal Funding for and Characteristics of Public Schools with Extended Learning Time.* [GAO-16-141](#). Washington, D.C.: November 30, 2015.

*K-12 Education: Internal Controls for Program Management and Oversight Can Help Ensure the Success of School Choice Programs.* [GAO-16-212T](#). Washington, D.C.: November 4, 2015.

*K-12 Education: Most Eighth Grade Students Are Not Proficient in Geography.* [GAO-16-7](#). Washington, D.C.: October 15, 2015.

*Indian Affairs: Further Actions on GAO Recommendations Needed to Address Systemic Management Challenges with Indian Education.* [GAO-15-597T](#). Washington, D.C.: May 13, 2015.

*Indian Affairs: Preliminary Results Show Continued Challenges to the Oversight and Support of Education Facilities.* [GAO-15-389T](#). Washington, D.C.: February 27, 2015.

*College-and-Career Readiness: States Have Made Progress in Implementing New Standards and Assessments, but Challenges Remain.* [GAO-15-104R](#). Washington, D.C.: December 12, 2014.

*Education of Homeless Students: Improved Program Oversight Needed.* [GAO-14-465](#). Washington, D.C.: July 31, 2014.

*Special Education: Additional Federal Actions Could Help Address Unique Challenges of Educating Children in Nursing Homes.* [GAO-14-585](#). Washington, D.C.: July 16, 2014.

*Early Learning and Child Care: Federal Funds Support Multiple Programs with Similar Goals.* [GAO-14-325T](#). Washington, D.C.: February 5, 2014.

*Indian Affairs: Management Challenges Continue to Hinder Efforts to Improve Indian Education.* [GAO-13-342T](#). Washington, D.C.: February 27, 2013.

*Individuals with Disabilities Education Act: Standards Needed to Improve Identification of Racial and Ethnic Overrepresentation in Special Education.* [GAO-13-137](#). Washington, D.C.: February 27, 2013.

*School Bullying: Legal Protections for Vulnerable Youth Need to Be More Fully Assessed.* [GAO-12-785T](#). Washington, D.C.: June 8, 2012.

*Charter Schools: Additional Federal Attention Needed to Help Protect Access for Students with Disabilities.* [GAO-12-543](#). Washington, D.C.: June 7, 2012.

*School Improvement Grants: Education Should Take Additional Steps to Enhance Accountability for Schools and Contractors.* [GAO-12-373](#). Washington, D.C.: April 11, 2012.

*Hurricanes Katrina and Rita: Temporary Emergency Impact Aid Provided Education Support for Displaced Students.* [GAO-11-839](#). Washington, D.C.: September 7, 2011.

*School Improvement Grants: Early Implementation Under Way, but Reforms Affected by Short Time Frames.* [GAO-11-741](#). Washington, D.C.: July 25, 2011.

*Disadvantaged Students: School Districts Have Used Title I Funds Primarily to Support Instruction.* [GAO-11-595](#). Washington, D.C.: July 15, 2011.

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*K-12 Education: Many Challenges Arise in Educating Students Who Change Schools Frequently.* [GAO-11-40](#). Washington, D.C.: November 18, 2010.

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## Appendix V: GAO Contact and Staff Acknowledgments

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### GAO Contact

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### Staff Acknowledgments

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# Appendix VI: Accessible Data

## Data Tables

**Data Table for Highlights Figure 1, Estimated Percentage of U.S. Children Living in Poverty, by Race and Ethnicity**

Year	All races	White	Black	Hispanic (any race)
2007	18	14.9	34.5	28.6
2008	19	15.8	34.7	30.6
2009	20.7	17.7	35.7	33.1
2010	22	18.5	39	34.9
2011	21.9	18.6	38.8	34.1
2012	21.8	18.5	37.9	33.8
2013	19.9	16.4	38.3	30.4
2014	21.1	17.9	37.1	31.9
2015	19.7	17.2	32.9	28.9
2016	18	15.6	30.8	26.6

Source: U.S. Census Bureau, Current Population Survey, 2008 to 2017 Annual Social and Economic Supplements. | GAO-18-41SP

**Data Table for Highlights figure 2**

Year	Estimated percentage of all children who are uninsured	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
2006	9.5	8.83	10.17
2007	9	8.26	9.74
2008	9.1	8.32	9.88
2009	8.2	7.49	8.91
2010	7.8	7.21	8.39
2011	7	6.49	7.51
2012	6.6	6.09	7.11
2013	6.6	6.09	7.11
2014	5.4	4.95	5.85
2015	4.5	4.07	4.93

percentage of federal poverty level (2015)	Uninsured	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Less than 100%	4.7	3.76	5.64
100-199%	6.9	5.8	8.0
200% or more	3.3	2.77	3.83

Source: U.S. Department of Health and Human Services' National Health Interview Survey. | GAO-18-41SP

**Data Table for Highlights figure 3**

Year	Estimated percentage of households with food-insecure children (2016)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
2007	8.3	7.9	8.7
2008	11	10.6	11.4
2009	10.6	10.2	11.1
2010	9.8	9.2	10.4
2011	10	9.4	10.5
2012	10	9.4	10.5
2013	9.9	9.3	10.5
2014	9.4	8.8	10
2015	7.8	7.2	8.3
2016	8	7.44	8.56

	Estimated percentage of households with food-insecure children (2016)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Female headed	16.0	14.50	17.50
Male headed	9.2	7.08	11.32
Married couple	4.7	4.16	5.24

Source: U.S. Department of Agriculture, Economic Research Service using data from the U.S. Census Bureau, Current Population Survey Food Security Supplement. | GAO-18-41SP

**Data Table Figure 1: Estimated Percentage of U.S. Children Living in Poverty, by Race and Ethnicity, 2007-2016**

Year	All races	White	Black	Hispanic (any race)
2007	18	14.9	34.5	28.6
2008	19	15.8	34.7	30.6
2009	20.7	17.7	35.7	33.1

Year	All races	White	Black	Hispanic (any race)
2010	22	18.5	39	34.9
2011	21.9	18.6	38.8	34.1
2012	21.8	18.5	37.9	33.8
2013	19.9	16.4	38.3	30.4
2014	21.1	17.9	37.1	31.9
2015	19.7	17.2	32.9	28.9
2016	18	15.6	30.8	26.6

Source: U.S. Department of Commerce, U.S. Census Bureau, Current Population Survey, 2008 to 2017 Annual Social and Economic Supplements. | GAO-18-41SP

**Data Table Figure 2: Selected Indicators of Child Well-Being**

**Indicators of child well-being**

- **Family, physical, and social environment:** Food insecurity; Student and family homelessness; Child maltreatment; Neighborhood safety Neighborhood housing quality; Death due to accidental injury; Homicide
- **Physical and mental health:** Birth outcomes; Access to insurance and medical care; Obesity; Asthma; Depression and suicide; Alcohol smoking, and drug use
- **Early care and education:** Cost and quality of child care; Preschool enrollment; Access to college-prep courses and high school graduation rates; Reading scores; Math scores; Student suspensions; School crime and safety

Source: GAO analysis of child well-being frameworks. | GAO-18-41SP

**Data Table Figure 3: Family, Physical, and Social Environment Indicators of Child Well-Being**

**Family, physical, and social environment**

- Food insecurity
- Student and family homelessness
- Child maltreatment
- Neighborhood safety
- Neighborhood housing quality
- Death due to accidental injury
- Homicide

Source: GAO analysis of child well-being frameworks. | GAO-18-41SP

**Data Table Figure 4: Food Insecurity**

**Food insecurity (Estimated)**

A family’s ability to provide for its children’s nutritional needs is linked to the family’s food security—that is, to its access at all times to adequate food for an active, healthy life for all household members.<sup>a</sup>

The percentage of households with food-insecure children was about the same in 2016 as in 2007, after peaking at 11 percent during the most recent recession.

Year	Estimated percentage of households with food-insecure children	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
2007	8.3	7.9	8.7
2008	11	10.6	11.4
2009	10.6	10.2	11.1
2010	9.8	9.2	10.4
2011	10	9.4	10.5
2012	10	9.4	10.5
2013	9.9	9.3	10.5
2014	9.4	8.8	10
2015	7.8	7.2	8.3
2016	8	7.44	8.56

2016: Black, Hispanic, poorer, and/or female-headed households had the highest rates of food-insecure children.

Race and ethnicity	Estimated percentage of households with food-insecure children (2016)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	5.6	5.01	6.19
Black	13.4	11.26	15.54
Hispanic	11.6	10.08	13.12
Other	6.7	4.99	8.41

- In 2016, about 1.2 million White, 668,000 Black, and 969,000 Hispanic households had food-insecure children.
- About 234,000 households of other races had had food-insecure children that year.



Income levels	Estimated percentage of households with food-insecure children (2016)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Under 185% of FPL	18.2	16.75	19.65
185% of FPL and over	2.5	2.05	2.95
Unknown income	6.4	5.24	7.56

FPL= federal poverty level

- In 2016, about 24 percent of households living below the FPL had food-insecure children.

Family composition	Estimated percentage of households with food-insecure children (2016)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Female headed	16.0	14.50	17.50
Male headed	9.2	7.08	11.32
Married couple	4.7	4.16	5.24

- In 2016, about 8 percent of households with young children (under the age of 6) had food-insecure children.

Source: U.S. Department of Agriculture, Economic Research Service using data from the U.S. Department of Commerce, U.S. Census Bureau, Current Population Survey Food Security Supplement. | GAO-18-41SP

**Data Table Figure 5: Student and Family Homelessness**

**Student and family homelessness**

Research suggests young children in families that experience homelessness are exposed to many developmental risks, such as poverty, family separation, violence, and school instability, which can contribute to behavioral issues and delays in academic skills.<sup>a</sup>

**Number of enrolled public school students who were homeless**

Academic year	Number of homeless students (in millions)
2005-06	0.907228
2006-07	0.679724
2007-08	0.794617
2008-09	0.93688
2009-10	0.939903
2010-11	1.05399
2011-12	1.13496
2012-13	1.21982
2013-14	1.30124
2014-15	1.26332

- In school year 2014-15, the majority of homeless students – more than 950,000 – were doubled-up (living with others due to a loss of housing, economic hardship, or a similar reason).
- About 95,000 homeless students were unaccompanied youth, that is, not in the physical custody of a parent or guardian, in school year 2014-15.

**2015:** Half of people in families with children who used an emergency shelter or transitional housing program were Black.

**Race and ethnicity**

*People in families with children using an emergency shelter or transitional housing program (2015)*

	Percentage
White (Non-Hispanic)	22.4
Black	50.1
White (Hispanic)	15.8
Other	11.7

- The percentage of White (non-Hispanic) and White (Hispanic) people in families with children using an emergency shelter or transitional housing program increased slightly from 2007 to 2015, while the relative share of all other groups decreased.

**Families with children**

*One-year estimates of families using an emergency shelter or transitional housing program*

<b>Year</b>	<b>Family households</b>
2007	130,968
2008	159,142
2009	170,129
2010	168,227
2011	172,767
2012	167,854
2013	156,540
2014	160,301
2015	154,380

Source: U.S. Department of Education’s Consolidated State Performance Report data from the National Center for Homeless Education and Homeless Management Information System data from the U.S. Department of Housing and Urban Development. | GAO-18-41SP

**Data Table Figure 6: Child Maltreatment**

**Child maltreatment**

Maltreatment in general is associated with a number of negative outcomes for children, including lower school achievement, juvenile delinquency, substance abuse, and mental health problems.<sup>a</sup> Child maltreatment includes physical, sexual, and psychological abuse, as well as neglect (including medical neglect).

**National victimization rate per 1,000 children**

<b>Year</b>	<b>Rate per 1,000</b>
2011	8.8
2012	8.8
2013	8.8
2014	9.1
2015	9.2

<b>Types of maltreatment (2015)</b>	<b>Percentage of those maltreated</b>
Psychological/Emotional	2.7
Sexual	6.5
Physical	10.3

Types of maltreatment (2015)	Percentage of those maltreated
Other	3.1
Neglect (including medical)	63.4
More than 1 type	13.9

- 86% of victims suffered a single type of maltreatment
- 683,000: National estimate of child victims of maltreatment in 2015

**2015:** The child victimization rate differed by age, with the youngest children experiencing the highest rates.

**Race and ethnicity**

	Rate per 1,000 children
White	8.1
Black	14.5
Hispanic	8.4
Asian	1.7
AI/AN <sup>b</sup>	13.8
Pacific Islander	8.8

**National victimization rate per 1,000 children (2015)**

	Age (in years)																		
	<1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	
<b>Rate</b>	24.2	11.8	11.3	10.7	10.3	10.5	10.5	9.6	8.8	8	7.3	6.8	6.8	6.9	6.8	6.5	5.6	3.5	

Source: U.S. Department of Health and Human Services' National Child Abuse and Neglect Data System. | GAO-18-41SP

**Data Table Figure 7: Neighborhood Safety**

**Neighborhood safety (Estimated)**

The safety of a child's environment, including their neighborhood, can affect a wide range of health, functioning, and quality-of-life outcomes and risks, including a child's sense of security and well-being.<sup>a</sup>

**Percentage of children whose parents agreed or disagreed that their children lived in safe neighborhoods (2016)**

	Estimate	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Definitely agree	63.8	62.8	64.8
Somewhat agree	30.0	29.1	31.0
Somewhat or definitely disagree	6.1	5.5	6.8

- **4.4 Million:** Estimated number of children whose parents disagreed that their children lived in a safe neighborhood in 2016

**2016:** Parents of non-White children and lower income parents were less likely to agree that their children lived in a safe neighborhood.

Race and ethnicity	Estimated percentage of children whose parents definitely agreed that their children lived in safe neighborhoods (2016)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	71.9	71.0	72.8
Black	52.7	49.5	55.8
Hispanic	53.6	50.7	56.5
Other	60.7	58.0	63.3

**Income levels**

Percentage of federal poverty level	Estimated percentage of children whose parents definitely agreed that their children lived in safe neighborhoods (2016)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Less than 100%	54.4	51.6	57.2
100% to 199%	56.5	54.0	59.0
200% to 399%	64.0	62.3	65.8

Percentage of federal poverty level	Estimated percentage of children whose parents definitely agreed that their children lived in safe neighborhoods (2016)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
400% or more	75.6	74.4	76.8

**Family composition**

	Estimated percentage of children whose parents definitely agreed that their children lived in safe neighborhoods (2016)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Married couple	67.6	66.4	68.7
Unmarried couple	53.0	49.0	57.0
Single-mother	53.6	50.9	56.3
Other	63.9	60.2	67.4

Source: U.S. Department of Health and Human Services' National Survey of Children's Health. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health. | GAO-18-41SP

**Data Table Figure 8: Neighborhood Housing Quality**

**Neighborhood housing quality (Estimated)**

*Research suggests poor housing quality (poorly kept or dilapidated housing) is a strong predictor of emotional and behavioral problems in children.<sup>a</sup>*

**Percentage of children whose parents reported they lived in neighborhoods with poor housing quality (2016)**

	Estimate	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Neighborhood has poor housing quality	13.3	12.5	14.0
Neighborhood does not have poor housing quality	86.7	86	87.5

- **9.4 Million:** Estimated number of children whose parents reported they lived in neighborhoods with poor housing quality in 2016

**2016:** Children who were Black, Hispanic, or poor were most often reported to live in neighborhoods with poor housing quality.

Race and ethnicity	Percentage of children whose parents reported they lived in neighborhoods with poor housing quality (2016)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	11.2	10.5	11.9
Black	17.4	14.9	20.2
Hispanic	16.5	14.4	19.0
Other	11.2	9.7	12.9

**Income levels**

Percentage of federal poverty level	Percentage of children whose parents reported they lived in neighborhoods with poor housing quality (2016)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Less than 100%	20.8	18.6	23.1
100% to 199%	16.6	14.7	18.7
200% to 399%	12.6	11.3	14.0

Percentage of federal poverty level	Percentage of children whose parents reported they lived in neighborhoods with poor housing quality (2016)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
400% or more	6.1	5.6	6.8

**Family composition**

	Percentage of children whose parents reported they lived in neighborhoods with poor housing quality (2016)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Married couple	11.5	10.7	12.5
Unmarried couple	18.1	15.1	21.5
Single-mother	16.4	14.7	18.4
Other	15.7	13	18.8

Source: U.S. Department of Health and Human Services' National Survey of Children's Health. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health. | GAO-18-41SP

Data Table Figure 9: Death Due to Accidental Injury

**Death due to accidental injury**

Unintentional injuries—such as those caused by burns, drowning, falls, poisoning, and road traffic—were the leading cause of death for children age 1 year and older in 2014.<sup>a</sup>

**Accidental death rate (per 100,000 children)**

	Infants (Under 1 year)	Age 1-4	Age 5-9	Age 10-14	Age 15-19
2005	26.2	10.3	5.5	6.4	31.4
2006	26.9	9.9	5.3	5.9	31.2
2007	29.8	9.6	4.9	6	30.2



2008	31	8.8	4.2	5.1	25.8
2009	28.6	8.6	3.8	4.6	22.3
2010	27.8	8.6	3.7	4.3	20.6
2011	29.4	8.5	3.7	4.2	19.9
2012	29.6	8.4	3.6	3.9	18.7
2013	29.4	8.3	3.6	3.8	17.3
2014	29.1	7.6	3.6	3.6	17.7

- The proportion of children dying from accidents declined since 2005 for all ages except infants. Infants replaced teens as the age group with the highest rate of death from an accidental injury.
- **7,600:** Estimated number of children through age 19 who died due to an accidental injury in 2014

**2014:** For ages 15 to 19, American Indian/Alaska Native (AI/AN) youth had the highest rate of death due to accidental injury.

**Race and ethnicity: 2014 accidental death rate (per 100,000 children)**

	Infants (Under 1 year)	Age 1-4	Age 5-9	Age 10-14	Age 15-19
White	23.1	7.2	3.5	3.4	18.8
Black	65.7	10.7	4.5	5.4	15.6
Asian <sup>b</sup>	No data	3	1.7	No data	7.4
AI/AN	53.4	11.7	5.4	No data	23.4

- In 2014, the accidental death rate of Hispanic children—who may be of any race—was lower than that of non-Hispanic Whites and non-Hispanic Blacks in every age group.
- From 2005 to 2014, the gap in the accidental death rate of White and Black infants widened, largely due to the increase in the rate for Black infants.
- From 2005 to 2014, gaps in the accidental death rates of White and youth of other races age 15-19 narrowed as the rate for each race fell over the period.

Source: U.S. Department of Health and Human Services’ National Vital Statistics System. | GAO-18-41SP

**Data Table Figure 10: Homicide**

**Homicide**

*In 2014, homicide ranked among the top five leading causes of death for all children aged 28 days and older.<sup>a</sup>*

**Homicide rate (per 100,000 children)**

	<b>Post-neonates (28 days through 11 months)</b>	<b>Age 1-4</b>	<b>Age 5-9</b>	<b>Age 10-14</b>	<b>Age 15-19</b>
2005	6.5	2.3	0.6	1.1	9.9
2006	6.9	2.2	0.8	1.2	10.7
2007	7.2	2.4	0.7	1	10.4
2008	7.3	2.5	0.6	1	9.7
2009	7.1	2.2	0.6	0.9	8.9
2010	7	2.4	0.5	0.7	8.3
2011	6.6	2.5	0.6	0.7	7.8
2012	6.7	2.1	0.7	0.8	7.6
2013	6.6	2.1	0.6	0.7	6.6
2014	5.7	2.3	0.6	0.8	6.7

**Race and ethnicity: Homicide rate per 100,000 children (2014)**

Black children had the highest homicide rates in every age group.

	<b>Post- neonates (28 days through 11 months)</b>	<b>Age 1-4</b>	<b>Age 5-9</b>	<b>Age 10-14</b>	<b>Age 15-19</b>
White	4.9	1.7	0.5	0.5	1.5
Black	12.2	5.9	1.4	1.9	27.6
Hispanic	4.5	1.7	0.4	0.7	6.5

- From 2005 to 2014, gaps in homicide rates between Black and White and Black and Hispanic post-neonates narrowed.
- From 2005 to 2014, the gap in homicide rates between Black and White 1-4 year olds stayed about the same while the gap between Black and Hispanic 1-4 year olds widened slightly.
- From 2005 to 2014, the gap in homicide rates between Black and

White 15-19 year olds narrowed while the gap between Black and Hispanic 15-19 year olds widened.

Source: U.S. Department of Health and Human Services' National Vital Statistics System. | GAO-18-41SP

**Data Table Figure 11: Physical and Mental Health Indicators of Child Well-Being**

**Physical and mental health**

- Birth outcomes
- Access to insurance and medical care
- Obesity
- Asthma
- Depression and suicide
- Alcohol, smoking, and drug use

Source: GAO analysis of child well-being frameworks. | GAO-18-41SP

**Data Table Figure 12: Birth Outcomes**

**Birth outcomes**

Infants born preterm or with low birthweight are at higher risk of early death and long-term health and developmental issues than infants born later in pregnancy or at higher birthweights. Many, but not all, preterm infants are also low birthweight, and vice versa.<sup>a</sup>

**Percentage of births**

	<b>Preterm (Before 37 completed weeks)</b>	<b>Low birthweight (Less than 2,500 grams)</b>
2006	NA	8.26
2007	10.44	8.22
2008	10.36	8.18
2009	10.07	8.16
2010	9.98	8.15
2011	9.81	8.1
2012	9.76	7.99
2013	9.62	8.02
2014	9.57	8
2015	9.63	8.07
2016	9.85	

- Since 2007, the percentage of babies born preterm has declined

slightly while the percentage with low birthweight has stayed about the same.

**Neonatal Abstinence Syndrome (NAS), a group of health problems that occur in newborns exposed to opiate drugs in utero, rose between 2009 and 2012.**

	Estimated incidence of NAS (per 1,000 hospital births)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
2009	3.4	3.2	3.6
2010	4.8	4.3	5.2
2011	5	4.4	5.4
2012	5.8	5.5	6.1

2015: A higher percentage of babies born to Black mothers were preterm and low birthweight than babies born to White and Hispanic mothers.

**Race and ethnicity**

	Percentage of births that were Preterm (2015)	Percentage of births that were Low birthweight (2015)
White	8.88	6.93
Black	13.41	13.35
Hispanic	9.14	7.21

- From 2007 to 2015, the gap in preterm births between Black and Hispanic mothers narrowed while the gap between Black and White mothers stayed about the same.
- From 2006 to 2015, the gap in low birthweight babies between Black and Hispanic mothers narrowed slightly while the gap between Black and White mothers stayed about the same.

Source: U.S. Department of Health and Human Services' National Vital Statistics System, Kids' Inpatient Database for 2009 and 2012, and Nationwide Inpatient Sample in 2010 and 2011, \_\_\_\_\_Healthcare Cost and Utilization Project. | GAO-18-41SP

**Data Table Figure 13: Access to Insurance and Medical Care**

**Access to insurance and medical care (Estimated)**

Children with health insurance are more likely than children without it to have a regular and accessible source of health care. Children's healthy development early in life is

essential to their ability to thrive, learn, and succeed later as an adult.<sup>a</sup>

- During the ten years between 2006 and 2015, the percentage of children not receiving needed care because of cost declined.

**Percentage of children under age 18**

	Uninsured	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	Unmet medical need	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	Unmet dental need	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
2006	9.5	8.83	10.17	2.4	2.05	2.75	6.9	6.17	7.63
2007	9	8.26	9.74	2.3	1.97	2.63	6.4	5.69	7.11
2008	9.1	8.32	9.88	2.8	2.45	3.15	7.1	6.41	7.79
2009	8.2	7.49	8.91	2.5	2.19	2.81	7.1	6.43	7.77
2010	7.8	7.21	8.39	2.1	1.85	2.35	6.6	5.99	7.21
2011	7	6.49	7.51	1.7	1.5	1.9	6.1	5.55	6.65
2012	6.6	6.09	7.11	1.6	1.38	1.82	5.5	4.95	6.05
2013	6.6	6.09	7.11	1.6	1.4	1.8	4.9	4.41	5.39
2014	5.4	4.95	5.85	1.5	1.25	1.75	4.2	3.73	4.67
2015	4.5	4.07	4.93	1.4	1.16	1.64	4.1	3.59	4.61

The percentage of children uninsured declined by about half from 2006 to 2015

**2015:** A higher percentage of children who were Hispanic or near poor<sup>b</sup> lacked health insurance than their peers.

**Race and ethnicity: Percentage of children under age 18 (2015)**

	Uninsured	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	Unmet medical need	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	Unmet dental need	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	3.4	2.75	4.05	0.9	0.63	1.17	3	2.41	3.59
Black	3.2	2.36	4.04	1.6	0.95	2.25	5.3	3.85	6.75
Hispanic	8.1	7.14	9.06	2.1	1.53	2.67	6.1	5	7.2

**Income levels: Percentage of children under age 18 (2015)**

percentage of federal poverty level	Uninsured	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	Unmet medical need	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	Unmet dental need	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval

percentage of federal poverty level	Uninsured	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	Unmet medical need	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	Unmet dental need	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Less than 100%	4.7	3.76	5.64	2.1	1.47	2.73	6.9	5.29	8.51
100-199%	6.9	5.8	8.0	2.3	1.61	2.99	6.2	4.95	7.45
200% or more	3.3	2.77	3.83	0.8	0.6	1.0	2.5	2.03	2.97

**Family composition: Percentage of children under age 18 (2015)**

	Uninsured	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	Unmet medical need	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	Unmet dental need	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Two parents	4.5	3.95	5.05	1.3	1.03	1.57	3.7	3.15	4.25
Single mother	4.1	3.41	4.79	1.6	1.15	2.05	5.6	4.4	6.8

- From 2006 to 2015, the gap in unmet medical needs between children living with single mothers and two parents narrowed.

Source: U.S. Department of Health and Human Services' National Health Interview Survey. | GAO-18-41SP

**Data Table Figure 14: Obesity**

**Obesity (Estimated)**

Children with obesity often become adults with obesity, with increased risks for a wide variety of poor health outcomes, including diabetes, stroke, heart disease, arthritis, and certain cancers.<sup>a</sup>

**Percentage of children age 10-17 (2016)**

	Estimate	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Underweight	6.3	5.6	7.0
Healthy weight	62.6	61.1	64.0
Overweight	15	14.1	16.1
Obese	16.1	15.0	17.4

- **4.9 Million:** Estimated number of children age 10-17 who were considered obese

in 2016

**2016: Children who were Black, Hispanic, or poor had the highest reported rates of obesity.**

Race and ethnicity	Estimated percentage of children age 10-17 considered obese in 2016	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	13.0	12.1	14.0
Black	21.9	18.1	26.2
Hispanic	22.5	18.9	26.6
Other	10.0	8.3	12.1

**Income levels**

Percentage of federal poverty level	Estimated percentage of children age 10-17 considered obese in 2016	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Less than 100%	22.9	19.3	26.9
100% to 199%	21.2	18	24.9
200% to 399%	15.8	14.1	17.7
400% or more	9.2	8.1	10.3

**Family composition**

	Estimated percentage of children age 10-17 considered obese in 2016	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Married couple	13.3	12	14.8
Unmarried couple	20.3	14.7	27.4
Single-mother	23.4	20.3	26.8
Other	19.7	16.7	23.2

Source: U.S. Department of Health and Human Services' National Survey of Children's Health. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health. | GAO-18-41SP

**Data Table Figure 15: Asthma**

**Asthma (Estimated)**

Asthma—one of the most common diseases among children—is a disease of the lungs that can cause wheezing, difficulty breathing, and chest pain. A serious health concern, asthma contributes to missed school days and is costly to treat.<sup>a</sup>

**The percentage of children with asthma has remained fairly constant over the last several years.**

Year	Estimated percentage of children under age 18 with asthma	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
2006	9.4	8.64	10.16
2007	9.1	8.36	9.84
2008	9.5	8.72	10.28
2009	9.7	8.97	10.43
2010	9.5	8.85	10.15
2011	9.6	8.95	10.25
2012	9.3	8.67	9.93
2013	8.3	7.69	8.91
2014	8.6	7.93	9.27
2015	8.4	7.73	9.07

- **6.2 Million:** Estimated number of children under age 18 with asthma in 2015

**2015:** Children from families living in poverty had higher rates of asthma than those from the highest income group.

**Race and ethnicity**

	Estimated percentage of children under age 18 with asthma	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	7.3	6.34	8.26
Black	13.4	11.42	15.38
Hispanic	8	6.98	9.02

- From 2006 to 2015, the gaps in asthma rates between White and Black, and between Hispanic and Black children stayed about the same.



**Income levels**

Percentage of federal poverty level	Estimated percentage of children under age 18 with asthma	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Less than 100%	10.6	8.89	12.31
100-199%	9.4	7.93	10.87
200% or more	7.2	6.38	8.02

- From 2006 to 2015, the gap in asthma rates between children from the lowest and highest income groups stayed about the same.

**Family composition**

	Estimated percentage of children under age 18 with asthma	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Two parents	7	6.24	7.76
Single-mother	12.2	10.67	13.73
Single-father	9.5	5.11	13.89
Other	12.9	8.96	16.84

- From 2006 to 2015, the gap in asthma rates between children living with single mothers and two parents stayed about the same.

Source: U.S. Department of Health and Human Services' National Health Interview Survey. | GAO-18-41SP

**Data Table Figure 16: Depression and Suicide**

**Depression (Estimated) and suicide**

Adolescent depression can adversely affect school and work performance, impair peer and family relationships, \_\_\_\_\_ and exacerbate the severity of other health conditions. Youth with major depressive episodes are at greater risk \_\_\_\_\_ for suicide and are more likely to use alcohol and drugs compared to their peers.<sup>a</sup>

Since 2007, the percentage of youth age 12 to 17 experiencing a major depressive episode (MDE) has risen, and about 41 percent of youth received treatment after an MDE in 2016.

Year	Estimated percentage of youth age 12-17 who experienced an MDE	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
2007	8.2	7.71	8.69
2008	8.3	7.81	8.79
2009	8.1	7.63	8.57
2010	8	7.53	8.47
2011	8.2	7.73	8.67
2012	9.1	8.59	9.61
2013	10.7	10.11	11.29
2014	11.4	10.77	12.03
2015	12.5	11.85	13.15
2016	12.8	12.17	13.43

**Youth suicide rates also rose slightly, with older youth having a much higher rate of suicide than younger youth.**

Year	Suicide rate per 100,000 youths Age 10-14	Suicide rate per 100,000 youths Age 15-19
2005	1.3	7.7
2006	1	7.3
2007	0.9	6.9
2008	1.1	7.5
2009	1.3	7.7
2010	1.3	7.5
2011	1.4	8.3
2012	1.5	8.3
2013	1.9	8.3
2014	2.1	8.7

**2016: A family’s income level did not affect whether youth had an MDE or received treatment.**

**Race and ethnicity**

	Estimated percentage of youth age 12-17 who experienced an MDE	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	13.8	12.94	14.66
Black	9.1	7.75	10.45
Hispanic	12.7	11.31	14.09

	<b>Of those who had an MDE, the estimated percentage who got treatment</b>	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	45.1	41.77	48.43
Black	34.5	26.74	42.26
Hispanic	34.1	28.69	39.51

**(2014) Age 15-19 suicide rate (per 100,000 youths)**

	Rate per 100,000 youths
White	10.9
Black	4.5
Hispanic	6

**Income levels (2016)**

<b>Percentage of federal poverty level</b>	<b>Estimated percentage of youth age 12-17 who experienced an MDE</b>	<b>Minimum estimate at the 95% confidence interval</b>	<b>Maximum estimate at the 95% confidence interval</b>
Less than 100%	12.1	10.85	13.35
100% to 199%	13.2	11.83	14.57
200% or more	12.9	12.04	13.76

<b>Percentage of federal poverty level</b>	<b>Of those who had an MDE, the estimated percentage of youth age 12-17 who got treatment</b>	<b>Minimum estimate at the 95% confidence interval</b>	<b>Maximum estimate at the 95% confidence interval</b>
Less than 100%	36.1	30.53	41.67
100% to 199%	42.6	37.21	47.99
200% or more	41.8	38.43	45.17

Source: U.S. Department of Health and Human Services' National Survey on Drug Use and Health and National Vital Statistics System. | GAO-18-41SP

**Data Table Figure 17: Alcohol, Smoking, and Drug Use**

**Alcohol, smoking, and drug use (Estimated)**

The adolescent years can be a critical risk period for substance use and development of substance use disorders. Substance use disorders in adolescence may affect key developmental and social transitions, and

can interfere with normal brain maturation.<sup>a</sup>

**Percentage of youth age 12-17 reporting use of each substance in the last year**

Year	Tobacco	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	Alcohol	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	Illicit drugs	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	Pain Relievers (non-medical use)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
2005	NA	NA	NA	NA	NA	NA	19.9	19.21	20.59	6.9	6.47	7.33
2006	NA	NA	NA	NA	NA	NA	19.6	18.87	20.33	7.2	6.77	7.63
2007	NA	NA	NA	NA	NA	NA	18.8	18.11	19.49	6.7	6.25	7.15
2008	NA	NA	NA	NA	NA	NA	19.1	18.41	19.79	6.5	6.07	6.93
2009	19.3	18.57	20.03	30.3	29.48	31.12	19.7	18.99	20.41	6.6	6.17	7.03
2010	18.1	17.37	18.83	28.7	27.86	29.54	19.5	18.76	20.24	6.3	5.87	6.73
2011	16.8	16.13	17.47	27.8	26.96	28.64	19	18.27	19.73	5.9	5.53	6.27
2012	15.2	14.57	15.83	26.3	25.48	27.12	17.9	17.25	18.55	5.3	4.93	5.67
2013	13.9	13.27	14.53	24.6	23.82	25.38	17.2	16.51	17.89	4.6	4.25	4.95
2014	12.7	12.03	13.37	24	23.18	24.82	17.4	16.66	18.14	4.7	4.29	5.11
2015	11.6	10.99	12.21	22.7	21.88	23.52						
2016	10.5	9.89	11.11	21.6	20.78	22.42						

**2016:** A higher percentage of White than Black youth used alcohol and tobacco; Asians had the lowest use of illicit drugs and pain relievers (2014).

**Race and ethnicity**

*Alcohol*

	Percentage of youth age 12-17 reporting use of alcohol	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	24	22.88	25.12
Black	15.6	13.74	17.46
Hispanic	21.3	19.54	23.06
Asian	13.2	10.06	16.34

*Tobacco*

	Percentage of youth age 12-17 reporting use	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	12.7	11.80	13.60
Black	6.7	5.41	7.99
Hispanic	8.6	7.37	9.83
Asian	4.3	2.20	6.40

*Illicit drugs*

	Percentage of youth age 12-17 reporting use	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	17	16.0	18.0
Black	19.2	17.36	21.04
Hispanic	18.9	17.23	20.57
Asian	9.1	6.36	11.84

**Pain relievers**

	Percentage of youth age 12-17 reporting use	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	4.5	3.97	5.03
Black	5.8	4.74	6.86
Hispanic	5	4.04	5.96
Asian	1.4	0.42	2.38

Source: U.S. Department of Health and Human Services' National Survey on Drug Use and Health. | GAO-18-41SP

**Data Table Figure 18: Early Care and Education Indicators of Child Well-Being**

**Early care and education**

- Cost and quality of child care
- Preschool enrollment
- Access to college-prep courses and high school graduation rates
- Reading scores
- Math scores
- Student suspensions
- School crime and safety

Source: GAO analysis of child well-being frameworks. | GAO-18-41SP

**Data Table Figure 19: Cost and Quality of Child Care**

**Cost and quality of child care (Estimated)**

Researchers suggest that child care quality contributes to children’s developmental outcomes, higher quality care being associated with better developmental outcomes and poorer quality care being associated with poorer outcomes for children.<sup>a</sup>

**The cost burden of child care**

2012: Lowest-income households spent a higher proportion of their income on child care each month compared to all other households.

**Percentage of monthly household income spent on Early Care and Education (ECE) in 2012**

(Among households with spending on at least one regular ECE arrangement)

Percentage of federal poverty level	Percentage of monthly household income	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Less than 100%	33	29	37
100% to less than 200%	21	17	25
200% to less than 300%	18	14	22
300% or more	11	9	13

**Quality of child care**

- 2005-06: Center-based child care for children around age 4 was generally higher quality than home-based care for all households regardless of income levels. (Note: 2005-06 is the latest year for which data on quality of child care are available).
- For families that used home-based child care, the majority of children from low socioeconomic status families had low-quality care while majorities of children from medium and high socioeconomic status families did not have low-quality care. (2005-06)
- For families that used Head Start or other center-based care, at

least 80 percent of children were in medium- or high-quality care, regardless of the family socioeconomic status. (2005-06)

Source: U.S. Department of Health and Human Services' National Survey of Early Care and Education household questionnaire and U.S. Department of Education's Early Childhood Longitudinal Study, Birth Cohort, Longitudinal 9-month-Kindergarten-Restricted-Use Data File. | GAO-18-41SP

**Data Table Figure 20: Preschool Enrollment**

**Preschool enrollment (Estimated)**

The benefits of high-quality early learning include increased school readiness, lower rates of special education placements, improved high school graduation, and higher rates of college attendance and completion.<sup>a</sup>

**Percentage of 3- to 5-year-old children enrolled in preschool**

Year	Estimate	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
2005	37.3	35.7	38.9
2010	37.0	35.5	38.5
2013	38.0	35.9	40.1
2014	38.2	36.6	39.8
2015	37.4	35.8	39.1

- From 2005 to 2015, the percentage of children ages 3- to 5-years old enrolled in preschool stayed about the same.

Hispanic (in 2015) and poor/near-poor children (in 2012) had lower percentages of preschool enrollment than White and non-poor children, respectively.<sup>b</sup>

**Race and ethnicity (2015) Percentage of 3- to 5-year-olds**

	Estimate	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	40.3	38.4	42.2
Black	38.6	33.7	43.5
Hispanic	29.6	26.1	33.1
Asian	39.9	32.9	46.9
AI/AN <sup>c</sup>	48.0	34.4	61.6

- From 2013 to 2015, the gap between Hispanics and their peers

remained about the same.

**Income levels (2012) Percentage of 3- to 5-year-olds**

	Estimate	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Poor	17.7	15.74	19.66
Near poor	20	17.69	22.31
Non-poor	62.3	59.71	64.89

- From 2001 to 2012, gaps between poor and non-poor children and between near-poor and non-poor children remained about the same.

**Family composition (2015) Percentage of 3- to 5-year-olds**

	Estimate	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
Single parent	35.9	32.82	38.98
Two parents	38.1	36.34	39.86

- In 2015, there was no statistical difference between the percentage of preschool enrollment of children living with one parent (or guardian) vs. children living with two parents (or guardians).

Source: U.S. Department of Commerce, U.S. Census Bureau, Current Population Survey, October 2005-2015 and U.S. Department of Education, Early Childhood Program Participation Survey, 2001, 2005, and 2012. | GAO-18-41SP

**Data Table Figure 21: Access to College-prep Courses and High School Graduation Rates**

**Access to college-prep courses and high school graduation rates**

Higher-level math and science courses in high school are critical to preparing students for college and careers in high-demand fields. Graduating high school indicates a person has basic academic skills needed for many entry-level jobs and higher education.<sup>a</sup>



**Percentage of high schools that offered college-prep math and science courses in school year 2013-14**

Academic subject	Percentage of high schools
Algebra II	78
Chemistry	72
Physics	60
Calculus	48

**High school 4-year graduation rate**

Academic year	graduation rate
2010-11	79
2011-12	80
2012-13	81
2013-14	82
2014-15	83

- The 83 percent graduation rate for the 2014-15 cohort was an all-time high.

**2013-14:** Schools with more Black or Hispanic students were less likely to offer high-level math and science courses than schools with fewer such students.

**Percentage of high schools offering college-prep courses (2013-14)**

	Low Black or Hispanic enrollment	U.S. average	High Black or Hispanic enrollment
Algebra II	84	78	71
Chemistry	78	72	65
Physics	67	60	48
Calculus	56	48	33

	High school 4-year graduation rate (2014-15)
U.S. average	83
White	88
Black	75
Hispanic	78
Asian/PI <sup>b</sup>	90

	High school 4-year graduation rate (2014-15)
AI/AN <sup>c</sup>	72

- Black, Hispanic, and AI/AN students had lower graduation rates than Whites and Asians, and economically disadvantaged students had a graduation rate of 76 percent in school year 2014-15.

Source: U.S. Department of Education’s Civil Rights Data Collection and Consolidated State Performance Report. | GAO-18-41SP

**Data Table Figure 22: Reading Scores**

**Reading scores (Estimated)**

Research shows that children who read well in the early grades are far more successful in later years; and those who fall behind often stay behind when it comes to academic achievement. Students who cannot read well are much more likely to drop out of school and be limited to low-paying jobs throughout their lives.<sup>a</sup>

**Reading scores (out of 500 points maximum)**

From 2005 to 2015, average reading scores for students generally stayed the same or slightly improved.

	4th grade reading scores	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	8th grade reading scores	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	12th grade reading scores	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
2005	219	218.6	219.4	262	261.6	262.4	286	284.8	287.2
2007	221	220.4	221.6	263	262.6	263.4	No data	No data	No data
2009	221	220.4	221.6	264	263.4	264.6	288	286.6	289.4
2011	221	220.4	221.6	265	264.6	265.4	No data	No data	No data
2013	222	221.4	222.6	268	267.4	268.6	288	286.8	289.2
2015	223	222.2	223.8	265	264.6	265.4	287	286	288

**2015:** Black, Hispanic, AI/AN,<sup>b</sup> and poor students on average had lower reading scores than White, Asian, and non-poor students.

**Race and ethnicity (2015)**

	4th grade reading scores (500 points maximum)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	8th grade reading scores (500 points maximum)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	12th grade reading scores (500 points maximum)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	232	231.4	232.6	274	273.6	274.4	295	293.6	296.4
Black	206	205	207	248	247	249	266	263.8	268.2
Hispanic	208	206.4	209.6	253	252.2	253.8	276	274.2	277.8
Asian <sup>c</sup>	239	236.3	241.7	280	277.5	282.5	297	292.9	301.1
AI/AN <sup>b</sup>	205	202.1	207.9	252	248.7	255.3	279	266.8	291.2

- From 2005 to 2015, gaps in reading scores between Black and White students and between Hispanic and White students narrowed slightly for 4th and 8th grade, and stayed the same for 12th grade.

**Income levels (2015)**

	4th grade reading scores (500 points maximum)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	8th grade reading scores (500 points maximum)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
High poverty	209	208.2	209.8	253	252.4	253.6
Low poverty	237	236.4	237.6	277	276.4	277.6

- From 2005 to 2015, the gap between poor students and their peers remained about the same.

Source: U.S. Department of Education’s National Assessment of Educational Progress. | GAO-18-41SP

**Data Table Figure 23: Math Scores**

**Math scores (Estimated)**

To compete in the 21st century global economy, knowledge of and proficiency in mathematics is critical. Today’s high school graduates need to have solid mathematics skills—whether they are headed for college or the workforce.<sup>a</sup>

**Math scores**

From 2005 to 2015, average math scores for students generally stayed the same or slightly improved.

Year	4th grade math scores (500 points maximum)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	8th grade math scores (500 points maximum)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	12th grade math scores (300 points maximum)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
2005	238	237.8	238.2	279	278.6	279.4	150	148.8	151.2
2007	240	239.6	240.4	281	280.4	281.6	No data	No data	No data
2009	240	239.6	240.4	283	282.4	283.6	153	151.6	154.4
2011	241	240.6	241.4	284	283.6	284.4	No data	No data	No data
2013	242	241.6	242.4	285	284.4	285.6	153	152	154
2015	240	239.4	240.6	282	281.4	282.6	152	151	153

**2015:** Students who were Black, Hispanic, AI/AN,<sup>b</sup> or from high-poverty schools had lower math scores in 4th, 8th, and 12th grade than other students.

**Race and ethnicity (2015)**

	4th grade math scores (500 points maximum)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	8th grade math scores (500 points maximum)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	12th grade math scores (300 points maximum)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	248	247.4	248.6	292	291.4	292.6	160	158.8	161.2
Black	224	223.2	224.8	260	259	261	130	128	132
Hispanic	230	229	231	270	269	271	139	137.4	140.6
Asian <sup>c</sup>	257	254.6	259.4	306	303.1	308.9	170	166.1	173.9
AI/AN <sup>b</sup>	227	225	229	267	264.5	269.5	138	132.5	143.5

- From 2005 to 2015, gaps in math scores between Black and White students and between Hispanic \_\_\_\_\_ and White students narrowed slightly for 4th and 8th grade, and stayed the same for 12th grade.

**Income levels (2015)**

	4th grade math scores (500 points maximum)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval	8th grade math scores (500 points maximum)	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
High poverty	226	225	227	264	262.6	265.4
Low poverty	257	255.6	258.4	301	299.8	302.2

- From 2005 to 2015, the gap between students attending high-poverty schools vs. low-poverty schools remained about the

same.

Source: U.S. Department of Education’s National Assessment of Educational Progress. | GAO-18-41SP

**Data Table Figure 24: Student Suspensions**

**Student suspensions**

Students who receive out-of-school suspensions are excluded from school for disciplinary reasons and lose important instructional time. These students are less likely to graduate on time and more likely to repeat a grade, drop out of school, and become involved in the juvenile justice system.<sup>a</sup>

**School year 2013-14:** Boys were more likely than girls and Black students were more likely than White students to be suspended.

**Percentage of preschool students who were enrolled vs. received at least one suspension (2013-14)**

	Percentage of students enrolled	Percentage of students suspended
White	41	28
Black	19	47

- Overall, Black students are 3.6 times more likely in preschool — and 3.8 times more likely in K-12 school — to receive one or more out-of-school suspensions as White students.
- Black boys represent 19 percent of male preschool enrollment, but 45 percent of male preschool children receiving one or more out-of-school suspensions.
- Black girls represent 20 percent of female preschool enrollment, but 54 percent of female children receiving one or more out-of-school suspensions.

**Percentage of K-12 students who received at least one suspension (2013-14)**

6% percent of all students received at least one suspension

Percentage of students suspended by race	
White boys	5% (1 percentage point less)
Black boys	18% (12 percentage points more)
White girls	2% (4 percentage points less)
Black girls	10% (4 percentage points more)

- Overall, 2.8 million K-12 students (or 6 percent) got at least one out-of-school suspension in school year 2013-14.
- Boys who were American Indian/Alaska Native, Latino, Native Hawaiian or other Pacific Islander, and multiracial represent 15 percent of K-12 students, but 19 percent of students receiving one or more out-of-school suspensions.
- Asian and White K-12 students did not disproportionately receive one or more out-of-school suspensions.
- For preschool suspensions, data on racial groups other than Black and White were not included in the published report of data.

Source: U.S. Department of Education’s Civil Rights Data Collection. | GAO-18-41SP

**Data Table Figure 25: School Crime and Safety**

**School crime and safety (Estimated)**

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

From 2006 to 2015, the estimated number of nonfatal victimizations against students decreased by more than half, from about 1.8 million incidents to about 800,000 (Note: Victimization includes both theft and violent crimes).

**Rate of nonfatal victimizations at school per 1,000 students age 12-18**

Year	Estimate	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
2006	67.5	56	79
2007	67.8	55.3	80.3
2008	54.3	43.2	65.4
2009	51	39.2	62.8
2010	34.9	26	43.8
2011	49.3	39.3	59.3
2012	52.4	43	61.8
2013	55	42.8	67.2
2014	33	25.2	40.8
2015	32.9	24.7	41.1

- **6.0%:** Percentage of students grades 9-12 who reported being threatened with or injured by a weapon on school property in 2015

**2015:** No statistical difference existed between rates of theft or violent crime at school for White or Hispanic students or by household income level.

**Race and ethnicity: Rate of nonfatal victimizations at school per 1,000 students ages 12-18 (2015)**

	Estimate	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	34.3	24.0	44.6
Hispanic	30	17.7	42.3

**Percentage of students ages 12-18 who reported being bullied at school (2015)**

	Estimate	Minimum estimate at the 95% confidence interval	Maximum estimate at the 95% confidence interval
White	21.6	18.8	24.4
Black	24.7	18.3	31.2
Hispanic	17.2	14.1	20.3
Asian	15.6	7.7	23.5

- From 2005 to 2015, the gaps between Black and White and between Hispanic and White students who reported being bullied at school remained about the same.

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**Income levels**

*Rate of nonfatal victimizations at school per 1,000 students age 12-18*

<b>Household income (2015)</b>	<b>Estimate</b>	<b>Minimum estimate at the 95% confidence interval</b>	<b>Maximum estimate at the 95% confidence interval</b>
\$15,000 to \$29,999	40.3	23.2	57.5
\$30,000 to \$49,999	28.3	15.6	41.0
\$50,000 to \$74,999	36.1	20.2	52.0
\$75,000 or more	29.8	19.1	40.5

Source: U.S. Department of Justice's National Crime Victimization Survey and School Crime Supplement and U.S. Department of Health and Human Services' Youth Risk Behavior Surveillance System. | GAO-18-41SP



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