Shifting to results-based accountability is a difficult stage in reforming family and children's services. Heretofore, these services have been more concerned with the number of clients seen or papers processed than in their clients' quality of life. This document should help communities find the data they need to measure qualitative outcomes. It provides a core list of conditions, for example, birthweight, immunizations, substance abuse, and teen suicide. Information on defining outcomes, finding the data to measure outcomes, and analyzing the data to assess local performance is listed. Also listed are various state and local data collection offices which may be able to help groups collect and appraise their data. Each definition for the outcome had to define the problem accurately, reflect data that were readily available, and be usable over time and across jurisdictions. This rigor in defining conditions will: (1) help communities determine the outcomes on which data are already being collected; (2) provide them a baseline to measure future progress; and (3) highlight areas where they should focus their work. Appendices list organizations, by state, that collect data on topics such as child welfare, juvenile justice, and other areas. Also appended are U.S. standard birth and death certificates. (Contains 25 references.) (RJM)
Finding the Data: A Start-Up List of Outcome Measures with Annotations

Improve Outcomes for Children Project
Center for the Study of Social Policy

BEST COPY AVAILABLE
Finding the Data: A Start-Up List of Outcome Measures with Annotations

A Companion Document to “The Case for Shifting to Results-Based Accountability”
ACKNOWLEDGEMENTS

This document was prepared by the Center for the Study of Social Policy, as well as by Brett Brown of Child Trends, and consultant Judith Weitz.

This document is a product of the Improved Outcomes for Children Project, which the Center coordinates in conjunction with the Harvard Project on Effective Services (Lisbeth Schorr) and the National Center on Education and the Economy. We gratefully acknowledge the financial support of the Lilly Endowment, Carnegie Corporation, Danforth Foundation, New American Schools Development Corporation and Pew Charitable Trusts.

This document incorporates and builds on work conducted by Janet Levy through the Joining Forces project, sponsored by the Council of Chief State School Officers and the American Public Welfare Association, which in turn was assisted by the work of Nick Zill and Christine Nord (formerly of Child Trends and now of Westat).

In addition, we gratefully acknowledge the use of information from the following organizations in order to prepare the lists of state and local data offices:

- American Public Welfare Association (State Child Welfare Agency Directors)
- Council of Chief State School Officers (Directory of Chief State School Officers)
- Drugs and Crime Data Center and Clearinghouse (Statistical Analysis Centers and Uniform Crime Reports Contacts)
- National Association of State Alcohol and Drug Abuse Directors (Membership list)
- National Center on Child Abuse and Neglect (State Liaison Officers for Child Abuse and Neglect)
- U.S. Department of Commerce, Bureau of the Census (State Data Center Program Coordinating Organizations)
- The Annie E. Casey Foundation (KIDS COUNT Grantees)

If you have questions or comments, please contact:
Frank Farrow, Director
Sara Watson, Coordinator
Improved Outcomes for Children Project
c/o Center for the Study of Social Policy
1250 Eye St. NW, Suite 503
Washington, DC 20005
(202) 371-1565
(202) 371-1472 (fax)

Design by Pamela Reznick
© 1995 Center for the Study of Social Policy
# Table of Contents

## Acknowledgements

## Introduction 1

## Technical Notes 3

## Child and Youth Outcomes: A Start-up List 5

### Annotations

- Low Birthweight 9
- Prenatal Care 11
- Nonmarital Teen Births 13
- Immunizations 16
- Untreated Vision or Hearing Problems 17
- Abuse and Neglect 19
- Children in Out-of-Home Care 21
- Child Poverty 23
- High School Dropout 25
- Substance Abuse 28
- Violent Youth Crime 30
- Teen Suicide 32
- Teen Homicide 34
- Accidental Deaths 35
- Sexually Transmitted Disease and AIDS/HIV Among Teens 37
- Youth Idleness 39

## Appendices

- Appendix A: Chief State School Officers 42
- Appendix B: State Alcohol and Drug Abuse Directors 45
- Appendix C: State Child Abuse and Neglect Offices 48
- Appendix D: State Child Welfare Agency Directors 51
- Appendix E: State Data Center Program Coordinating Organizations 54
- Appendix F: Statistical Analysis Centers 64
- Appendix G: Uniform Crime Reports Contacts 66
- Appendix H: Vital Statistics Offices 68
- Appendix I: KIDS COUNT Grantees 70
- Appendix J: Standard Certificate of Birth 73
- Appendix K: Standard Certificate of Death 75

## References 77

## About the Improved Outcomes for Children Project 79
INTRODUCTION

One of the most fundamental, necessary, and difficult stages in reforming family and children’s services is shifting to results-based accountability. This means moving from a system in which success is measured by the number of clients seen or papers processed, to one in which success is measured by whether the lives of children, youth and families are made better.

The companion paper to this document, “The Case for Shifting to Results-Based Accountability” by Lisbeth Schorr, explains the argument for, and cautions about, this shift. Results-based accountability helps provide communities and front-line workers the freedom, authority and responsibility to do “whatever it takes” to improve the lives of children and families. It can facilitate the cross-systems collaborations that are necessary to develop comprehensive approaches. It can greatly clarify which strategies are effective and which are not.

But results-based accountability also has risks. It requires significant new “infrastructure” in order to be used fairly. It can be misused and result in “creaming” or discrimination. It can emphasize quantifiable outcomes at the expense of outcomes that are more subtle but no less important. Ultimately, it should result in re-allocation of funds away from ineffective strategies to effective ones; communities will need to prepare for these changes.

Despite these cautions, there is widespread agreement that this shift is the right direction for communities to take. While building the necessary capacity for implementing new accountability systems is a long process, virtually every community can begin by taking two steps. First, states and communities need to agree on their own set of outcomes that reflect the results they want for their children, youth and families. Second, they can collect data on those outcomes, report those data to the public, and incorporate them in management feedback and accountability systems. Collecting and reporting initial data gives the community a baseline to measure its future progress; the reporting of subsequent data shows the community how it’s doing. Data on outcomes also help the community determine the areas where they should focus their work.

“The Case for Shifting to Results-Based Accountability” provides a set of outcomes that communities can use as a starting point for developing their own “desired results.” These outcomes reflect a “minimalist” set of readily quantifiable, well-known indicators of well-being. This document, “Finding the Data: A Start-up List of Outcome Measures with Annotations,” was developed to help
communities determine the outcomes on which data are already being collected, and find the data on their community. The aim was to do as much of the “leg-work” as possible in order to make it easier for states and communities to determine how their families were doing.

For each of the outcomes in the core list contained in “The Case for Shifting to Results-Based Accountability” this document provides information about:

- how that outcome can be measured,
- what cautions should be heeded in collecting data, and
- where data can be found on a national, state and local level.

The appendices in the back list many organizations, by state, that collect data on topics such as child welfare, juvenile justice, educational scores, child health and other areas. These organizations should provide a wealth of information about the status of children, youth and families in your community.

We hope that this document helps facilitate your community’s use of outcomes to improve the lives of its families, youth and children. We welcome your feedback.
While many audiences may find this document useful, its primary purpose is to assist communities that are trying to measure outcomes to find the data they need to do so. For each outcome on the core list, this document provides information on defining the outcome, finding the data to measure the outcome, and analyzing the data to assess local performance. It includes lists of various state and local data collection offices that may be able to help state and local groups collect and analyze their data. It also includes copies of the standard certificate of birth and the standard certificate of death to show how and what data are routinely collected for these two events.

Each definition for the outcome was crafted to meet several criteria. The definition had to define the problem accurately, reflect data that were readily available, and be useable over time and across jurisdictions. Two particular issues warrant further explanation: the choice of age ranges and the use of rates, percents and numbers in the definitions.

**Age-Breaks**

Most indicators are focused on measuring the condition of children among specific age-groups. There are three reasons for these age breaks. First, in some cases, such as the number of untreated vision or hearing conditions of children entering school, the age-breaks were chosen to measure a condition at the time in a child’s life when that condition will have a particularly significant impact on the child’s development. Second, in other cases, such as teen homicides, ages 15-19, the age breaks were chosen to maximize ready access to published data. Third, in many cases, particularly among the teen indicators, the age-breaks were chosen to reflect the ages for which the condition is most prevalent. If the age range includes ages for which the condition is very rare, the overall rate will seem artificially low.

However, it also may be revealing to review data for other age groups, such as for instance, births to younger single teens as well as single teens ages 15-17, in order to fully understand trends and to inform preventive and early intervention strategies. It is important to bear in mind that selecting these age ranges does not imply that communities should not care about events in children and adolescents outside these age ranges. Communities may well decide to use different ranges depending on local priorities.
Numbers, Percents and Rates

Each indicator is expressed as either a number (such as number of child abuse cases); a percent (number per 100) or rate (number per 1000 or other population size). Each is an important means of conveying information with data. Each of them tells us something slightly different, and should be used and interpreted with that in mind. For example, if the child population is on the rise in a particular area, the number of children experiencing some difficulty may be on the rise and require a policy response, even though the rate or percent of children with such problems stays constant or even drops. The number is also important in determining the level of resources that may be needed to address the problem. Alternatively, when the rates of problems increase, the appropriate policy response may differ somewhat depending on whether the actual number of children with such problems is rising or falling.

When reporting rates or percents, it is important that one furnish some means for the reader to gauge their precision. Reporting the raw numbers on which they are based can provide the reader some sense of the figure’s precision. It can also provide the audience with a sense of the scope of the problem—sometimes, knowing that 10 children in a community have been arrested for a violent crime is more powerful than reading the rate and having to do one’s own translation. While the definitions do not state this explicitly, it is also important that rates and percents omit from both the numerator and the denominator cases for which data are missing. For example, in calculating the rate of low birthweight births, one should not include in either the number of low birthweight births, or the number of total births, those cases for which the weight is not available.

In deciding whether to use a percent (per 100) or rate (per 1000 or other number), communities should choose the format that results in a number that is meaningful to the audience with which it is communicating. Percents are the more common format, but for rarer occurrences, it can be easier to visualize 5 children per 1000 experiencing a problem than 0.5 children per 100.

Our work on this issue continues to evolve, and the authors would welcome feedback from readers. We are especially interested in the experiences of communities that are trying to measure these outcomes for their own children and youth.

---

1 Some of this information is taken from Brett Brown and Nick Zill, A Review of the First Seven State Kids Count Annual Reports, 1992.
CHILD AND YOUTH OUTCOMES
A Core List to Serve as a Starting Point

Healthy Births
- Lower rates of low birthweight births
- Higher rates of early prenatal care
- Lower rates of births to single mothers under 18

Two-Year Olds Immunized

Children Ready for School
- Immunizations complete
- No untreated vision or hearing problems
- School-readiness traits as identified on sample basis

Children Succeeding In Elementary School, Middle School, High School
- As indicated by lower rates of school drop-out, and by
- Academic achievement measures demonstrating competency over challenging subject matter in grades 4, 8 and 12

Children and Youth Who Are Healthy, Safe, and Prepared for a Productive Adulthood
- Children not abused or neglected
- Children living in own family
- Children living in families with incomes over the poverty line
- Youth Avoiding
  - Early unmarried childbearing
  - Substance abuse
  - Arrests for violent crime
  - Suicide
  - Homicide
  - Accidental death
  - Sexually transmitted diseases and HIV/AIDS
  - Idleness: not in school and not employed

1 “The Case for Shifting to Results-Based Accountability” includes a discussion of this measure.
2 This assumes that communities will be utilizing separately developed indicators of school success.
3 This is an imperfect but measurable proxy for children living in safe, nurturing, loving environments.
**INDICATOR**

**Low Birthweight**: percent of babies born low birthweight

**Definition**

Percent of births that are below 5.5 pounds (2500 grams).

The indicator is constructed by dividing the number of births below 5.5 pounds by the total number of births for a particular year, and multiplying by 100.

\[
\text{Low birthweight births/total births} \times 100
\]

**Significance**

The weight of a baby at birth is a key indicator of newborn health, and is directly related to infant survival, health and development. Low birthweight infants are more likely to die during the first year. In the U.S., such infants account for nearly two-thirds of all infant deaths through age 28 days. They are also more likely to experience disabilities and health problems such as mental retardation, developmental delays, visual and hearing defects, chronic respiratory ailments, autism, and learning difficulties, that interfere with normal development and progress in school.

**Facts**

In 1990, 289,417 low birthweight babies were born in this country, representing 7 percent of all births. Rates were 5.7 percent for whites, 6.1 percent for Hispanics and American Indians, and 13.3 percent for African-Americans. The percent of babies born low birthweight has not fallen nationally since 1980.

A national goal of 5.0 percent low birthweight births by the year 2000 has been set by the Federal government as part of its Healthy People 2000 effort. A target of 9 percent has been set for African-American births.

**Data Sources**

Birthweight is reported on the standard certificate of birth in all states (see Appendix J). The data are reported by mother’s residence, not the location of the hospital.

NATIONAL: National and state level data are available from the Federal government in printed form and as machine readable data. Data are published in a monthly “Monthly Vital Statistics Report”, and an annual Vital Statistics of the United States, Volume I—Natality. For these publications, however, there is a three-year lag between the end of the calendar year and the publication date. In addition, machine (computer) readable data are available from the office listed below. These files contain the information from each individual birth record, and can be very useful for those wishing to do their own data analyses.

Natality Branch/Division of Vital Statistics
National Center for Health Statistics (NCHS)
6525 Belcrest Road, Room 840
Hyattsville, MD 20782
(301) 436-8954

\(^1\) As noted in the introduction, all rates include in the numerator and the denominator only those cases for which the data is known—for this outcome, both the number of births below 5.5 pounds and the total number of births would include only those cases for which the birthweight was known.
In addition, the Federal Public Health Service (in the U.S. Department of Health and Human Services) produces an annual publication titled *Child Health USA*, that reports national data on low birth weight and many other measures of child health. This publication can be ordered from the following source:

National Maternal and Child Health Clearinghouse  
8201 Greensboro Drive  
McLean, VA 22102  
(703) 821-8955

STATE: State and local data are available from the bureau of vital statistics in each state, usually located within the state health department, which is responsible for collecting birth certificate data and reporting it to the National Center for Health Statistics (see Appendix H). Some state level data also appear in the NCHS publications listed above. Data from the state health department will generally be more recent than that available from NCHS.

LOCAL: Local data are available from state health departments. Local health departments may also keep track of birth data for the locality, and may have their own publications.

Data are available for states and for civil divisions within states (e.g. by county, city, town and village). In some areas, data are available by census tract, though the absolute incidence of low birthweight is likely to be low and the rates unstable at this fine geographic level.

This measure can be produced separately by race, age, marital status and educational level of mother in all states. As of 1991, 49 states and the District of Columbia separately identify Hispanic children, up from 30 states in 1986. For this reason, however, retrospective data on Hispanic children may not be available in some states.

Since 1989, race specific birth data from the birth certificate have been tabulated based on the race of the mother. Previous to that, such tabulations were based on the race of the non-white parent (if any) or, if both were nonwhite, on the race of the father. One must therefore be cautious about interpreting race-specific trends involving years before and after 1989, as this change will have some small effect on the number of children identified with a particular race.

The most recent available data may be up to two years old in some states, and three years old from the National Center for Health Statistics.

---

6 In six states (California, Connecticut, Michigan, Nevada, New York and Texas), the marital status of the mother is not asked directly, but is inferred by comparing parent and child surnames. There are several conditions to analyze this proxy; for example, if both mother and father have the same surname, or if the father and child have the same surname, the assumption is that the parents are married. Texas began to collect data on marital status in 1994. For two states, New York and Washington, data on mother’s education has been available through the federal data system only since 1992.

7 In Hawaii, the child was identified as Hawaiian if either parent was Hawaiian.
States now link birth and death certificates, which makes it possible to tabulate infant mortality for specific birth weights.

**RELATED MEASURES**
In addition to measuring the portion of babies born low birthweight, it may be useful to identify very low birthweight babies, that is, babies weighing less than 3.5 pounds (1500 grams) at birth. Such babies are at the highest risk of dying, and of experiencing significant problems in health and development. The incidence of such births may be too small, however, to be useful for small jurisdictions.

**INDICATOR**
**Prenatal Care:** percent births to mothers receiving prenatal care in the first trimester.

**DEFINITION**
The percent of births to women receiving prenatal care in the first trimester.

The indicator is constructed by dividing the number of births where the mother received prenatal care in the first three months of pregnancy by the total number of births for a particular year, and multiplying by 100.

\[
\frac{(\text{Births with early care})}{(\text{Total births})} \times 100
\]

**SIGNIFICANCE**
The receipt of early and ongoing prenatal care increases the chances of delivering healthy, full-term, normal weight babies. Early prenatal care can encourage good health habits during pregnancy, can lead to early detection of medical problems, and can become a gateway to parenting support and education and assistance with nutrition, housing and other needs. All of these are associated with improved birth outcomes. The benefits are greatest for women who are at the highest risk of poor birth outcomes such as teenage mothers, poor women and women of color. Early care can also reduce health care costs associated with neonatal intensive services for low birthweight babies.

**FACTS**
In 1991 76 percent of all mothers in the U.S. received prenatal care in first trimester. Nationwide, this rate has changed little since 1979. However, because of changes in policies and programs in some states and communities, rates of early prenatal care receipt have improved in these localities.

Seventy-nine percent of white mothers and 62 percent of black mothers received first trimester prenatal care in 1990. For mothers under the age of 18, rates in 1990 were 52 percent and 43 percent for whites and blacks, respectively.

As part of the Healthy People 2000 effort, the Federal government has set as a goal that 90 percent of all pregnant women receive prenatal care in the first trimester by the year 2000.

Approximately six percent of all U.S. mothers received late (third trimester) or no prenatal care.

**DATA SOURCES**
The month at which prenatal care began is reported on the standard certificate of birth in all states. The data are reported by mother's residence, not the location of the hospital.
NATIONAL: National and state level data are available from the Federal government in printed form and as machine (computer) readable data. Data are published in a monthly "Monthly Vital Statistics Report", and an annual Vital Statistics of the United States, Volume I—Natality. For these publications, however, there is a three-year lag between the end of the calendar year and the publication date. Their Advanced Data series often presents health data with a 2 year lag, though it is a less complete source of information. In addition, machine (computer) readable data are available from the office listed below. These files contain the information from each individual birth record, and can be very useful for those wishing to do their own data analyses.

Natality Branch/Division of Vital Statistics
National Center for Health Statistics (NCHS)
6525 Belcrest Road, Room 840
Hyattsville, MD 20782
(301) 436-8954

STATE: State and local data are available from the bureau of vital statistics in each state, usually located within the state health department, which is responsible for collecting birth certificate data and reporting it to the National Center for Health Statistics (see Appendix H). Some state level data also appears in the NCHS publications listed above. Data from the state health department will generally be more recent than that available from NCHS.

LOCAL: Local health departments may also keep track of birth data for the locality, and may have their own publications.

Data are available for states, and for civil divisions within states (e.g. by county, city, town and village). In some areas, data are available by census tract.

This measure can be produced separately by race, age, marital status and educational level of mother in all states. As of 1991, 49 states and the District of Columbia separately identify Hispanic children, up from 30 states in 1986. For this reason, however, retrospective data on Hispanic children may not be available in some states.

Since 1989, race specific data taken from the birth certificate have been tabulated based on the race of the mother. Previous to that, such tabulations were based on the race of the non-white parent (if any) or, if both were nonwhite, on the race of the father. One must therefore be cautious about interpreting race-specific trends involving years before and after 1989, as this change will have some small effect on the number of children identified with a particular race. The most recent available data may be up to two years old in some states, and three years old from the National Center for Health Statistics.

In six states (California, Connecticut, Michigan, Nevada, New York and Texas), the marital status of the mother is not asked directly, but is inferred by comparing parent and child surnames. In two states, New York and Washington, information on mother's educational level has been available through the federal data system only since 1992.

In Hawaii, the child was identified as Hawaiian if either parent was Hawaiian.
RELATED MEASURES

Children whose mothers received late (third trimester) or no prenatal care face the highest levels of risk. For that reason, it may be useful also to track the percent of all births to mothers who receive late or no prenatal care. In 1990, 6 percent of all births fell into this category, though in some areas and among some groups the rate is considerably higher. The information necessary to produce this indicator is also recorded on the standard certificate of birth.

It is important both that prenatal care begin early, and that it be provided continuously throughout pregnancy. The outcome as described indicates only when care started, not whether it was provided regularly and with appropriate frequency throughout pregnancy. It is desirable, therefore, to measure not only the timing of initial care, but the frequency of care also. All of the necessary data are available on the standard certificate of birth.

INDICATOR

NONMARITAL TEEN BIRTHS: Rate of nonmarital births to teen women ages 15-17

DEFINITION

The annual rate per 1000 women ages 15-17 who have nonmarital births.

The indicator is constructed by dividing the number of live births to single women ages 15-17 by the total number of women ages 15-17 in a given year, and multiplying the result by 1000.

\[
\left( \frac{\text{Births to single teen women ages 15-17}}{\text{all women ages 15-17}} \right) \times 1000
\]

SIGNIFICANCE

Single teen parenthood is a predictor of future economic hardship for both parent and child. Young mothers are less likely to finish high school, and are far more likely to be poor, unmarried, and welfare dependent than those giving birth at later ages. Children born to single teen mothers are more likely to be disadvantaged as children and as adults.

FACTS

In 1991, 188,226 babies were born to mothers ages 15-17 in the U.S. Of that total, approximately 78 percent were nonmarital births. The percent of births that were nonmarital was about 67 percent for whites, and 96 percent for African-Americans of that age.

The annual nonmarital birth rate for females ages 15-17 was approximately 30 per 1000 in 1991. The rate for whites of that age was 21 per 1000, and 81 per 1000 for African-Americans.

DATA SOURCES

Mother's age and marital status at birth are reported on the standard certificate of birth in all states. The data are reported by mother's residence, not the location of the hospital.

NATIONAL: National and state level data are available from the Federal government in printed form and as machine readable data. Data are published in a monthly "Monthly Vital Statistics Report", and an annual Vital Statistics of the United States, Volume I—Natality. For these publications, however, there is a
three-year lag between the end of the calendar year and the publication date. In addition, machine (computer) readable data are available from the office listed below. These files contain the information from each individual birth record, and can be very useful for those wishing to do their own data analyses.

Natality Branch/Division of Vital Statistics
National Center for Health Statistics (NCHS)
6525 Belcrest Road, Room 840
Hyattsville, MD 20782
301) 436-8954

Estimates of the total number of teen females in a particular jurisdiction for a particular year are available for the nation and for states from the Population Estimates Branch, U.S. Bureau of the Census (301) 763-5002. These estimates are not routinely produced for sub-state jurisdictions such as cities and counties. Those interested in obtaining substate level estimates should contact their State Data Center (see Appendix E).

STATE: State and local data are available from the bureau of vital statistics in each state, usually located within the state health department, which is responsible for collecting birth certificate data and reporting it to the National Center for Health Statistics (see Appendix H). Some state level data also appears in the NCHS publications listed above. Data from the state health department will generally be more recent than that available from NCHS.

LOCAL: Data are available for states, and for civil divisions within states (e.g. by county, city, town and village) from the state health department. In some areas, data are available by census tract, though the absolute incidence is likely to be low and the rates unstable at this fine geographic level. Local health departments may also keep track of birth data for the locality, and may have their own publications.

These data can be produced separately by race or hispanic origin, age, and educational level of mother in all states. As of 1991, 49 states and the District of Columbia separately identify Hispanic children, up from 30 states in 1986. For this reason, however, retrospective data on Hispanic children may not be available in some states.

Since 1989, race-specific data from the birth certificate have been tabulated based on the race of the mother. Previous to that, such tabulations were based on the race of the nonwhite parent (if any) or, if both were nonwhite, on the race of the father. One must therefore be cautious about interpreting race-specific

---

10 In six states (California, Connecticut, Michigan, Nevada, New York and Texas), the marital status of the mother is not asked directly, but is inferred by comparing parent and child surnames. In two states, New York and Washington, information on mother’s education has only been available through the federal data system since 1992.

11 In Hawaii, the child was previously identified as Hawaiian if either parent was Hawaiian.
trends involving years before and after 1989, as this change will have some small effect on the number of children identified with a particular race.

Most recent available data may be up to two years old in some states, and three years old from the National Center for Health Statistics.

The age range for this indicator has been limited to 15-17. Births before age 15 are rare, though they may be more significant in areas with very high teen birth rates. Therefore, including younger ages would make the overall rate seem artificially low.

**RELATED MEASURES**

There are a number of alternative indicators of teen birth that are commonly used. One such indicator is the percentage of all births that are to single teens. However, changes in this indicator may result from a number of causes. A rise in the birth rate of 15-17 year olds would produce an increase in the proportion of all births to women under age 18, if the post-teen birth rate remained the same. However, a drop in the birth rate of women ages 18 and over could easily produce the same result. For this reason, interpretation of trends in this indicator should be done with caution.

For some purposes, it is useful to look at another indicator of teen birth that can be calculated from birth certificate data; the percent of all births to teens that are second or higher order births. Having a second birth while still a teen further increases the probability of school dropout, welfare receipt, and poor birth outcomes for children. The indicator is also a reasonable measure of the community's capacity to provide adequate family planning and other social supports for first time teen mothers.

Another related indicator is the percent of births to mothers with less than a high school education. Research shows a significant relationship between maternal education and child well-being, especially in school achievement. In families in which the mother has less than a high school education, there is a high likelihood of poverty, that children are more likely to experience difficulties in school, and that children will leave school early. The highest grade completed by the mother is reported on the standard certificate of birth for all states as of 1992.

To track the formation of new at-risk families, one could measure the percent of first births that are to mothers with less than a high school education or diploma. In 1990, approximately 22 percent of all first births were to mothers without a high school education. To track the total portion of the child population that is at-risk at any one time because of the educational status of the mothers, one could measure the percent of all children (rather than births) whose mother has less than a high school credential. This information comes from the Decennial Census, and for most states from the annual March Current Population Survey, by race, living arrangement, etc. Several years of CPS data would be needed to produce reliable estimates for all but the largest states.

It is also important to bear in mind that births to single teens are not a function of the mother alone. The vast majority of fathers to children born to single teen mothers do not live with the mother or child; many have limited or no long-term involvement with the child. With an increased public policy emphasis on encouraging and enforcing long term financial involvement of nonresident fa-
thers, the percent of men fathering children with single teen mothers is also an important indicator. Unfortunately, the coverage of the data available on birth certificates regarding fathers is not good, as many single teen mothers fail to report any information on the father.

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>IMMUNIZATIONS: percent of children who have been completely immunized by age two.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFINITION</td>
<td>The percent of all two-year olds who have received the full schedule of age-appropriate immunizations against diphtheria, tetanus, pertussis, measles, mumps, rubella, and polio.</td>
</tr>
<tr>
<td></td>
<td>This indicator is measured by dividing the number of fully immunized two-year olds by the total number of two-year-olds and multiplying by 100.</td>
</tr>
</tbody>
</table>
|           | \[
|           | \( \frac{\text{Fully immunized two-year-olds}}{\text{total two-year-olds}} \times 100 \) |
| SIGNIFICANCE | Proper and timely immunization effectively protects children from a host of debilitating and sometimes deadly childhood diseases. The Federal Public Health Service currently recommends that children receive nine different vaccines (all requiring multiple doses) given in five to seven visits between birth and school entry, most before age 2. |
|           | If immunization campaigns are related to an emphasis on connecting the family with an ongoing source of quality health care, measuring the immunization status of two-year olds may also be a proxy measure for the proportion of very young children getting access to at least minimal well-child care. |
| FACTS | Using a combination of survey and medical record data, the Centers for Disease Control estimates that immunization rates for 1-4 year olds in 1985 (the last year for which national estimates are available) were approximately 75 percent for measles, mumps, polio, rubella, and DPT. However, based on 1990 and 1991 data for 19 urban areas and one rural area, the Centers for Disease Control and Prevention estimates that only 44 percent of children had been fully vaccinated by their second birthday. |
|           | Rates of full immunization for children in kindergarten and first grade are close to 100 percent due to the nearly universal requirement that all children attending school be fully immunized. |
|           | As part of the Healthy People 2000 effort, the Federal government has recommended that by the year 2000, at least 90 percent of children should have completed their basic immunization series by age two. |
| DATA SOURCES | NATIONAL: National estimates of immunization rates among preschool children have not been available since 1985. The Centers for Disease Control, Division of Immunization has resumed collecting data and producing these estimates, which will be available on an annual basis starting in 1994. Estimates for 2 year
olds will be produced. For more information contact the Division of Immunization at (404) 639-8235.

STATE: The immunization status of two year old children is not routinely reported by state or local health departments. However, some state health departments have conducted surveys. These surveys are based on a retrospective review of school-entry immunization records. These data are available for some states through the Centers for Disease Control, Division of Immunization (see above). Alternatively, contact the State Data Center (See Appendix E).

LOCAL: Data on immunization of 2 year olds may be available from the local health department or, if such data are collected retrospectively at the time of entry into school, from the local school board.

Any immunization data gathered on the basis of parental report rather than medical records may underestimate the level of immunization by 25 percent or more. Parents often do not recall accurately, or are not aware that their child has been immunized. (This methodology may also overestimate immunization levels if parents erroneously assume or claim that their children have been immunized.) Whenever possible, immunization data should be based directly on medical records.

While it is important to track the incidence of childhood infectious diseases, these data are not a good substitute for measuring the immunization status of children. They may substantially underestimate immunization status since a child may be inadequately immunized but will not show up in infectious disease counts unless there is an outbreak of that disease in his or her community.

One may also wish to track the percent of children entering kindergarten who are fully immunized. In most cases, however, these rates are close to 100 percent because full immunization is required prior to school entry in most localities.

UNTREATED VISION OR HEARING PROBLEMS:
percent of children with untreated vision or hearing problems at school entry.

Number of children at initial school entry (usually kindergarten) who have an untreated vision or hearing problem divided by the total number of children entering school, and multiplied by 100.

((Number of children entering school with untreated vision or hearing problem/total number of children entering school) x 100)

Problems with vision and hearing can interfere with a child's ability to learn. These are problems for which screening is simple and inexpensive; most conditions requiring correction are fairly easy to treat.
In 1990, the U.S. DHHS estimated that about 1 million children (one to two percent) have hearing impairments. By age 16, nearly twenty percent have simple refractive errors (such as near-sightedness or far-sightedness) that impair vision.

NATIONAL: The latest National Health and Nutrition Examination Survey (NHANES III) is a large and comprehensive survey of the health of the U.S. population ages 2 months and older. The survey includes approximately 14,000 children under the age of 18, and was carried out over a six year period, from 1988-1994. All children were given hearing and vision examinations as part of the survey. As of March, 1994 no data on hearing and sight problems of children had been published, but there are plans to do so in the future. For information on publications containing data from NHANES III, contact:

Division of Health Examination Statistics/NCHS
6525 Belcrest Road, Room 1000
Hyattsville, MD 20782
(301) 436-7068

STATE: While there is no centralized state data system for reporting data on untreated vision and hearing problems, some data for specific populations may be available from state health or education departments. State policies regarding school entrance and periodic screening of school children for vision and hearing problems vary by state and by local school district.

Every state has an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for Medicaid-eligible children under age 21 which requires screening, diagnosis, and treatment of eligible children for vision and hearing problems. EPSDT is administered by the state agency designated to handle Medicaid. Responsibility for screening and follow-up treatment may be assigned to state agencies other than the agency administering Medicaid and the EPSDT program. EPSDT coordinators are within departments of health, welfare, social services, or umbrellas human resources and human services agencies.

LOCAL: Local school district offices, as well as individual schools, may have data on untreated vision and hearing problems.

In some communities these and other health data may be collected as part of a regular school entry screening program, but may not be tallied into school-wide or system-wide incidences and rates. If the data are gathered, however, it may be simple and relatively inexpensive to keep formal tallies.

Untreated vision and hearing problems are among a number of conditions which can affect a child’s ability to learn. A broader indicator might include data on the number or percent of children who have other untreated developmental disabilities or delays, or health conditions, such as high lead levels, poor nutritional status, learning disorders, or asthma.

Communities may also want to track untreated vision, hearing, or other health problems throughout childhood as some may show up after school entry.
**INDICATOR**

**ABUSE AND NEGLECT**: substantiated cases of child abuse or neglect.

**DEFINITION**

Number of cases in a given year in which abuse or neglect of children has been substantiated.

**SIGNIFICANCE**

For healthy development, children need a safe and nurturing family environment. This measure suggests the extent to which children's security is threatened rather than protected by the adults on whom they are most dependent.

Child abuse or neglect can result in physical harm, death, or profound developmental and behavioral problems. Abused and neglected children may be at greater risk of becoming delinquents and of mistreating their own children.

**FACTS**

In 1992, an estimated 1.2 million children were substantiated victims of abuse and neglect (in this context, substantiated means that the appropriate child protection agency investigated the accusation and found sufficient cause to open a case). In that year, more than 2.9 million children were reported abused or neglected, about triple the number in 1980. Nationwide, about 40 percent of reported cases are substantiated. This rate has remained constant since the mid-1980's.

Not all states report on the age of abused and neglected children. However, on average in 1991, an estimated 7.6 percent of the children who were substantiated as being abused were neglected were under one year of age, 31.8 percent between the ages of 1 and five, 38.3 percent between the ages of six and twelve, and 20.8 percent were thirteen and older.

Though the probability of abuse and neglect is higher among minority children, over half (54.7 percent) of abused and neglected children are white. Slightly over half are female (53.2 percent). Parents are the most common perpetrators of abuse and neglect. Neglect is more frequent than abuse.

A national goal of less than 25.2 reported (as opposed to substantiated) cases of child abuse and neglect per 1000 children by the year 2000 has been set by the Federal government as part of its Healthy People 2000 effort. In 1991, the rate was approximately 45 per 1000, up from 30 per 1000 in 1985.

**DATA SOURCES**

NATIONAL: There are two regularly published sources of data on child abuse and neglect. The first is an occasionally updated "working paper" series published by the National Center on Child Abuse and Neglect (NCCAN—the data system is called the National Child Abuse and Neglect Data System (NCANDS)).

National rates of substantiated cases of child abuse and neglect are published on an annual basis, and are available from the sources listed below. These data, which are often available for states as well, are available by age, race, and sex of children; form of maltreatment; and relationship to perpetrator. These reports and papers from the NCANDS working paper series are available from the following source:
In addition, the National Committee for the Prevention of Child Abuse, a private organization, has since 1986 conducted an annual survey of states, and publishes the following information: national estimates on child abuse and neglect reports and fatalities; state estimates of fatalities; nationally averaged substantiation rates for child abuse and neglect reports; and percentage change in child abuse and neglect reports and forms of maltreatment by state. The most recent report, titled “Current Trends in Child Abuse Reporting and Fatalities” is available from the following source:

National Committee for the Prevention of Child Abuse
332 South Michigan Avenue
Suite 1600
Chicago, Illinois 60604
(312) 663-3520

STATE: Reports of the number of substantiated cases of child abuse and neglect are available for most states in the NCANDS “working paper” publications cited above. Data for substantiated cases not available through the Clearinghouse may be available through state agencies.

All states have a central registry of reported cases of child abuse and neglect maintained by the division of child protective services usually within state departments of social or human services (see Appendix C).

LOCAL: Most city or county jurisdictions maintain a central registry of reported and substantiated child abuse and neglect cases in the division of child protective services within social services departments.

Comments

Data on substantiated cases of child abuse and neglect may not be comparable across states, because states have different ways of recording the data. Some states keep them by incident, while others keep them according to family (where multiple incidents may have occurred). Users need to know how the data are kept in their state or locality.

Data on child abuse and neglect can be affected by jurisdictional variations in definitions of child abuse and neglect, counting procedures for reports, investigation procedures, methodologies for collecting statistics, and program policies and capacities. One should therefore use extreme caution in comparing rates across jurisdictions. In addition, one needs to be aware of significant changes in these factors within a jurisdiction, as they may affect the number of cases reported independently of the actual incidence of child abuse and neglect.

Related Measures

To compare jurisdictions or track changes over time, one should follow social trends, including abuse and neglect, using percentages or rates rather than ab-
solute numbers. Unlike raw numbers, rates will tell you unambiguously whether the risk of a child's being abused or neglected is increasing or decreasing. Unfortunately, annual estimates of the child population (necessary to the production of percentages and rates) are not generally available below the state level except at the time of the decennial census. If such estimates are available for the community, then the rate may also be calculated. Such estimates may be available from the State Data Center (see Appendix E). Annual estimates are available at the national and state level from the Population Estimates Branch, U.S. Bureau of the Census (301) 763-5002.

Because of the relatively rare incidence of this problem, the child abuse or neglect rate is commonly expressed as a rate per 1000. It is measured by dividing the number of cases of indicated abuse or neglect by the total number of children under age 18 and multiplying by 1,000.

Although abuse and neglect cases are commonly reported together, they are distinct outcomes, the former involving actual physical or emotional attacks. For some purposes it may be fruitful to track them separately, identifying where one, the other, or both are present. For example, abuse is most effectively addressed by a different set of remedies than neglect. Communities will need to know the scope of each separate problem before they can make decisions on programs or services to address them.

Most communities track reported as well as substantiated cases of child abuse and neglect. In addition, the national goal refers to reported rather than substantiated cases (see above).

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>CHILDREN IN OUT-OF-HOME CARE: number of children under 18 in out-of-home care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFINITION</td>
<td>Number of children who were placed in temporary or permanent out-of-home care (or “substitute” care) through child welfare agencies for at least one day in the year, including placement in a foster family home, group home or shelter, non-finalized adoptive home 12, or other substitute care facility (e.g. maternity home, mental retardation or correctional facility).</td>
</tr>
<tr>
<td>SIGNIFICANCE</td>
<td>The number of children in foster or substitute care reflects on the well-being of children and the functioning of the child welfare system. It is a rough index of social conditions and the conditions within families which pose substantial risk to children. Family instability, poverty, crime, violence, homelessness, substance abuse, and serious illness may contribute to the need to find alternative care. Data on the number, condition, length of stay, and outcomes for children in foster care indicate in addition how well the child welfare system is functioning to protect and nurture children.</td>
</tr>
</tbody>
</table>

12 Non-finalized adoptive home here means a home in which the parents intend to adopt the child but have not yet completed the process.
As explained in the Comments section below, it is important to recognize that increases or decreases in the number of children in out-of-home care are not intrinsically good or bad. Numbers may increase or decrease for a variety of reasons, and any presentation of the data must be accompanied by analysis to indicate if changes indicate beneficial trends.

**FACTS**

In Fiscal Year 1992, a total of 659,000 children were served by the states’ child welfare system. In June 1992, a one-day census found 442,000 in foster care of some kind, a 68 percent increase over the number a decade before.

In 1991, an annual “checkpoint” day found that 69,237 juveniles were being held for delinquent offenses in public or private juvenile detention, corrections, and shelter facilities.

A 1988 one-day census showed that there were 1,676 juveniles in county and municipal jails. A 1990 one-day census indicated there were 3,600 children under age 18 in state and Federal correctional facilities.

### DATA SOURCES

**NATIONAL:** A voluntary survey of states has been conducted annually since 1982. While in 1991 all states responded, not all states report on all questions. And in previous years, not all states reported. Definitions and reporting periods vary among states. In 1986, Congress mandated an improved data reporting and tracking system. This new system is expected to be in place by the end of 1995. For more information, contact:

Voluntary Cooperative Information System (VCIS)
American Public Welfare Association
810 First Street, N.E., Suite 500
Washington, D.C. 20002-4267
(202) 682-0100

**STATE:** Every state has a child welfare agency which reports annual data on children under its custody (see Appendix D). These agencies are most often within departments of human services, human resources or social services.

**LOCAL:** Local data may be available from county or city child welfare agencies.

### COMMENTS

Each state has its own legal, administrative and programmatic structure for its child welfare programs. It is important to identify changes in service capacity and policy changes in reviewing trend data. A new emphasis on preventive and rehabilitative service to keep families together rather than removing children from their homes may be reflected in a decrease in the child welfare population. Similarly, budget cuts decreasing child welfare service workers may also limit follow-up on reported cases of child abuse and neglect and therefore a decrease in the number of children placed in substitute care. Because this indicator is so important, and yet quantitative data on it are especially difficult to collect and interpret, communities may want to continually re-investigate means to measure performance on this outcome.

More than two-thirds of foster children are removed from their homes because of neglect, caretaker incapacity or absence. Parental use of illegal drugs...
and abuse of alcohol are important contributing factors to the decision to remove a child. Other reasons for removal include physical and sexual abuse, child delinquency, parental incapacity or unwillingness to care for a child's disability, and other reasons.

Most children are placed in foster family homes. There is a growing interest in kinship care, placement with family relatives. Group homes and special shelters are also used.

It is difficult to put together a coherent picture of all children in out-of-home care. Some data are collected by facility or program (e.g. number of children in county and city jails), and some collected by the agency (e.g. corrections, mental health, child welfare) that places children in a variety of facilities or programs. Cross-tabulating the two is difficult.

RELATED MEASURES

The percent of placements of children in substitute care that are repeat placements reflects the capacity of the child welfare agency to marshal the family supports necessary to ensure children's safety and well-being once they are returned home.

Children need stability to thrive. Measuring the length of stay of children in foster care and the number of placements while in care assesses the capacity of the child welfare system to meet this need. On average, by the end of the 1980's children were spending less time in substitute care but experiencing an increase in the number of separate placements during their continuous stay.

Every ten years when the Decennial Census is taken, it is also possible to measure the number of children who live away from their families in group quarters (e.g. prisons, mental hospitals, juvenile facilities), rooming homes, and emergency shelters). These are not just children sponsored by the child welfare system but also those placed by other state agencies, including corrections and mental health. Data are available by state, county, city, and census track and by age, gender and race. Contact the state data center (see Appendix E). Census data will reflect the location of the placement site rather than the residence of the parents.

INDICATOR

CHILD POVERTY: the percent of children in poverty.

DEFINITION

The percent of children living below the Federally established poverty line.

The indicator is constructed by dividing the number of poor children under the age of 18 by the total number of children under age 18, and multiplying the result by 100.

\[
\text{((Children under 18 in families under poverty line/total children under 18) x 100)}
\]

The Federal poverty definition takes into account both income and family size, with higher income cutoffs for larger families. The poverty line is a multiple (3 times) of the amount of money it takes on average to feed a family of a particular size an adequate diet for a year.
SIGNIFICANCE
Growing up in poor and low income families has been associated with a host of negative outcomes for children including less adequate prenatal care, low birthweight and higher infant mortality, slower cognitive development, lower levels of school readiness, and lower levels of educational and socioeconomic attainment as adults.

FACTS
In 1991, there were an estimated 13.7 million children living in poverty in the U.S. This represents a 7.4 percent increase over 1990. In 1990, 18.2 percent of all children were poor. Poverty rates for African-American and Hispanic children were much higher, at 39.7 percent and 32.2 percent, respectively.

There is a great deal of variation across states in the percent of children who are poor, ranging from a low of 7.4 percent in Connecticut to a high of 33.6 percent in Mississippi.

In 1992, the poverty line for a family of four was $13,950.

DATA SOURCES
NATIONAL: Annual national estimates of child poverty rates are produced by the Federal government based on data from the March Current Population Survey, and from the Survey of Income and Program Participation (SIPP). They are available in the following Census publication (there is a separate publication for each year):


To order, call Census Customer Services at (301) 763-4100.

STATE: Annual estimates of the percent of children in poverty can be produced for specific states using data from the March Current Population Survey. Due to small state sample sizes in this data set, reliable estimates for most states can only be produced by combining up to five years worth of survey data. State estimates generated using this technique are published annually in the Kids Count Data Book, which can be ordered from the Annie E. Casey Foundation. These estimates may not be very reliable for states with the smallest populations.

Kids Count, Annie E. Casey Foundation
111 Market Place, Suite 420
Baltimore, MD 21202
(410) 234-2872

LOCAL: Child poverty rates at the substate level (e.g. counties, cities, metropolitan areas) are available every 10 years from the decennial census. Estimates for 1990 are published in the Census publication series titled General Population Characteristics, 1990. There is a separate report for each state. These reports are available in many libraries, and can be ordered from the Census Data User Services (301) 763-4100.

For years falling between decennial censuses, local estimates of child poverty are generally not available. Researchers in New York state have recently developed a technique for producing county level child poverty estimates using both decennial census data and annual administrative data for means-tested program
participation (e.g. AFDC). This technique is explained in detail in the following publication, which can be requested from the authors:

Postcensal Estimates of Poverty for New York State Counties by Seth Leon and Nancy Dunton
New York State Department of Social Services
40 N. Pearl St., 16D, Albany, NY 12243

This method is specific to New York state, and may not be applicable to other states without modification. Contact representatives of the State Data Center (see Appendix E) to see whether similar estimation procedures have been developed for specific counties in a given state.

Comments
Because the cost of living can differ substantially from county to county and state to state, the Federal poverty level will represent greater hardship in those areas where the cost of living is higher.

Some may wish to use AFDC, Food Stamp recipiency or participation in the subsidized school lunch program to track child poverty, because such data are available for counties and states on an annual basis. However, the number of children living in families receiving AFDC or Food Stamps is quite sensitive to changes in program eligibility requirements, and in interpretation and local enforcement practices of existing eligibility rules. Variations across these dimensions over time and across jurisdictions make this an unreliable proxy measure for trends in the child poverty rate.

Related Measures
The official poverty rate measure defines a rather austere level of existence. Available research suggests that children who are “near poor” also suffer disadvantages compared to children who are better off materially. Some government means-tested programs allow participation of families that earn some percentage above the poverty line. One may wish to track the percent of children living at or below 133 percent, 150 percent, or 200 percent of the Federal poverty line.

Indicator
High School Dropout: The percent of students ages 15 and older who drop out of school during a 12-month period.\(^{13}\)

Definition
The percent of students ages 15 and older and enrolled in grades 10-12 who leave school without graduating during a 12-month period.

The indicator is constructed by identifying all secondary school students age 15 and older who are enrolled in grades 10-12 at the beginning of the school year, and who are not enrolled and have not graduated by the beginning of the

\(^{13}\) This age cut-off was chosen because most of the available data is segmented at this point. In addition, few states allow drop-out before age 15, and so the rate is much lower at younger ages. Including younger children would therefore artificially deflate the rate.
SIGNIFICANCE
next school year. This number is divided by the total number of students ages 15 and older enrolled in grades 10-12 at the beginning of the year, and multiplied by 100.

\[
\frac{\text{(Students enrolled at start of one year but not enrolled or graduated at start of next year/students enrolled at start of initial year)}}{\text{students enrolled at start of initial year}} \times 100
\]

Dropping out of high school can have serious negative long term consequences for youth. Those who drop out are significantly less likely to be regularly employed well into their twenties. The jobs available to those who have dropped out generally do not pay well, are unstable, and have limited opportunities for upward mobility.

For young women, dropping out of school is associated with a higher probability of subsequently becoming a teen mother, further restricting the opportunities of the young mothers and increasing the risks their children face as they grow up.

FACTS

In 1990, the annual dropout rate for persons ages 15 and older and in grades 10-12 was approximately 4 percent. Rates were somewhat higher for African-American students at about 5 percent, but considerably higher for Hispanic students at 8 percent.

Since 1973, annual dropout rates have decreased by about one-third overall, and by over 40 percent for African-American students.

The percent of students who drop out permanently is of course considerably higher than the annual dropout rate. In 1990, 15.7 percent of all persons ages 20-24 had not completed high school.

The Department of Education has adopted as a goal for the year 2000 that at least 90 percent of all children will graduate from high school.

DATA SOURCES


STATE: State level estimates based on October CPS data are not currently produced. By combining data for 3-5 years, it is possible, though statistically very complicated, to produce state level estimates. Such estimates can only be produced for the larger states (perhaps the 10 or 15 most populous), because only one-half the survey sample can be used to produce this particular indicator.

Some state departments of education may produce this or a similar indicator measuring annual high school dropout rates (see Appendix A).

LOCAL: Local school districts may keep this or a similar indicator. If they do not, such information can be produced based on student records. As a practical

\[\text{A dropout is identified as one who is not graduated, not enrolled in the school system, and for whom there is no evidence (such as a request for records) of having transferred to another school system.}\]
matter, however, this may prove difficult if student records are not computerized and very complete.

**COMMENTS**

The recommended indicator is subject to substantial yearly fluctuations, largely in response to changes in the economy. To minimize these fluctuations, it is advisable to compare three-year averages (e.g. 1990-92, 1991-93, 1992-94, etc.). This technique will minimize year-to-year changes, but will highlight longer term trends more accurately.

Some secondary schools are ungraded; they should use age ranges and enrollment in the school rather than grade levels to determine drop-out rates.

**RELATED MEASURES**

There are several useful indicators related to high school dropout that can be produced, each with its own strengths and limitations. This annual measure is recommended over a measure of permanent dropout (e.g. the percent of 20-24 year olds who never finish high school) for several reasons. First, as a practical matter, data of this sort are very expensive to collect at the local level, requiring a large, random sample survey of the local population of 20-24 year olds. Second, such data will be less sensitive to recent changes in high school completion trends since one is looking at an older age group.

However, those two conditions notwithstanding, the proportion of youth ages 20-24 who are not high school graduates is an excellent measure of permanent dropout at the national level, and over time. National estimates are available on an annual basis from the Digest of Education Statistics, published by the National Center for Education Statistics. To order, call (202) 219-1651.

In calculating high school dropout rates, there is some question as to whether those receiving their GED (general education development) certificate should be included with those who have received a high school diploma. Available research suggests that GEDs are worth considerably less in the labor market than actual degrees. For most purposes, we recommend that those receiving GED's be treated separately.

The Department of Education maintains and publishes several measures related to high school dropout. One looks at the proportion of ninth graders who graduate four years later. This is produced by taking the total number of high school graduates in a school system (or state) and dividing by the total number of ninth graders enrolled four years earlier. This is a very easily produced statistic, and can be reasonably useful so long as there is not a lot of migration into or out of the school district in the intervening years; this would artificially inflate or deflate the true graduation rate. Such an indicator, even if otherwise accurate, will underestimate the total percent of students who graduate from high school, since some will take longer than four years to graduate, while others will return and finish their degree at a later age.
**INDICATOR**

**SUBSTANCE ABUSE**: abuse of alcohol and use of illegal drugs by youth in grades 7-12.

**DEFINITION**

The percent of youth in grades 7-12 who have consumed five or more drinks of alcohol on a single occasion in the last 30 days.

The percent of youth in grades 7-12 who have taken illegal drugs (other than alcohol) within the last 30 days.

These indicators are constructed by dividing the number of youth in grades 7-12 who have consumed five or more drinks of alcohol on a single occasion (or taken illegal drugs) by the total number of youth in grades 7-12, and multiplying by 100.

\[
\text{Indicator} = \left( \frac{\text{Youth in grades 7-12 who have abused alcohol (or taken illegal drugs)}}{\text{all youth in grades 7-12}} \right) \times 100
\]

**SIGNIFICANCE**

The consumption of alcohol and use of illicit drugs places adolescents at risk of health, education and social problems and physical danger. Drug use and alcoholic consumption are both a precursor and reflection of low self-expectations and poor performance, lack of parental and community supports and options. Illicit drug use is higher among those teens who have no post-high school plans. High-risk activity at an early age is often a predictor of later problem behavior.

**FACTS**

In 1991, a survey of students in grades 9-12 revealed that 51 percent had consumed alcohol in the previous 30 days, and 31 percent had consumed five or more drinks on one or more occasions in the last 30 days. Fifteen percent had smoked marijuana, and 2 percent had used cocaine within the last 30 days. Another 1991 study found that an estimated 1.2 million adolescents ages 12-17 had ever used at least one illicit drug, and an estimated 4.6 million had reported ever using alcohol. Overall the rates of alcohol and illicit drug use by adolescents were lower in 1991 than at any time since the late 1970's though it remains a problem.

In fiscal year 1991, 60,561 children under age 18 were admitted for alcohol treatment. Most were males. Most were white. In fiscal year 1991, 75,784 children under age 18 were admitted for drug treatment. Most were male and white, though the differences were not as great between males and females and whites, blacks and Latinos as for alcohol treatment.

**DATA SOURCES**


15 These children received treatment in facilities and programs that received funds administered by the state alcohol and drug abuse agencies.
If you wish to procure the survey for analysis, contact:

National Institute on Drug Abuse  
Division of Epidemiology and Prevention Research  
Rockwall II, Suite 615  
5600 Fishers Lane  
Rockville, MD 20857  
(301) 443-7980

Similar data are gathered through the Youth Risk Behavior Surveillance System, an annual survey of students in grades 9-12. Results of this are published, and are available to the public through the following source:

Centers for Disease Control and Prevention  
Division of Adolescent and School Health  
4770 Buford Highway NE  
Mail stop K33  
Atlanta, GA 30341-3724  
(404) 488-5330

The Monitoring the Future survey has been collecting information on drug and alcohol use by high school seniors on an annual basis since 1975. To order publications containing the results of this survey, including information on drug and alcohol use, contact:

Patrick O’Malley  
Institute for Social Research  
University of Michigan  
Ann Arbor, MI 48106-1248  
(313) 763-5043

Caution should be exercised in data from this study and the Youth Risk Behavior Surveillance Survey, however, since both they fail to cover high school dropouts, students who are arguably most at risk.

STATE: Every state has an agency that collects data on substance abuse (see Appendix B). These agencies are within state departments of health or mental health.

In addition, 43 states and 13 large cities now conduct their own semi-annual Youth Risk Behavior Survey, in coordination with the national Youth Risk Behavior Surveillance System run by the Centers for Disease Control. These surveys are expected to continue at least through the year 2000. For information on participating states and cities, please contact:

Centers for Disease Control and Prevention  
Division of Adolescent and School Health  
4770 Buford Highway NE  
Mail stop K33  
Atlanta, GA 30341-3724  
(404) 488-5330
LOCAL: Local data may be available from health departments or from school systems. In addition, some large cities participate in the Youth Risk Behavior Surveillance System (see above).

COMMENTS

Because drug use is a sensitive issue, surveys will tend to under-report the actual incidence of alcohol and drug use among youth.

Surveys that interview only students (such as the Youth Risk Surveillance Surveys) do not include dropouts, those most likely to have alcohol and drug problems. This becomes a significant problem for older teens, as youth begin to drop out of high school at around the tenth grade.

RELATED MEASURES

Tobacco use is another major health hazard for the fetuses of pregnant teens, and is a precursor of future use and poor health outcomes into adulthood. The surveys reviewed above also collect data on tobacco use among youth, and communities may want to monitor these data as well.

---

INDICATOR

**VIOLENT YOUTH CRIME:** Number of arrests for violent crime among youths, ages 10-17.

DEFINITION

The number of arrests of youths ages 10-17 for homicide, forcible rape, robbery, or aggravated assault, including repeat arrests of the same youth within the given year.

SIGNIFICANCE

Arrests of youthful offenders for violent crimes is a measure of anti-social and self-destructive behavior. It is an indicator of more severe dysfunction than arrests for any crime.

FACTS

In 1991, it is estimated that 130,000 youth arrests were made for rape, robbery, homicide, or aggravated assault—42,000 more arrests than in 1986. The national juvenile violent crime arrest rate per 100,000 youths ages 10-17 was 466 in 1991, a 48 percent increase in the rate since 1986 when it was 314 arrests per 100,000 youths ages 10-17.

In 1991, black youths were five times more likely to be arrested for a violent crime than white youths. However, the white juvenile violent crime rate between 1986 and 1991 increased more rapidly than the black rate.

Male juveniles were seven times more likely than females to be arrested for a violent crime. However, between 1986 and 1991, the rate for females increased more rapidly than the rate for males.

While juvenile arrests for violent crimes represent a small portion of all juvenile arrests, they are a significant proportion of all arrests for violent crime.

DATA SOURCES

NATIONAL: “Crime in the United States: Uniform Crime Reports” provides annual reports by state, age, and gender for 28 offenses. Offenses are reported
according to the jurisdiction in which the arrest was made. These reports can be ordered from:

National Criminal Justice Reference Service  
U.S. Department of Justice  
Rockville, Maryland 20850  
(800) 851-3420

Special runs for particular localities will be produced for a fee by the Law Enforcement and Support group within the Federal Bureau of Investigation, (202) 324-5015. The resulting data are available on hard copy or computer tape.

STATE: State data are available from the publication listed above. In forty-one states and the District of Columbia, there is a state Uniform Crime Reports contact from which state and local data can be obtained (see Appendix G).

State departments of public safety, state police departments or associations of police chiefs and sheriffs, or state bureaus of investigation may publish state and local annual crime statistics by sex, race, age and offense. Not all jurisdictions regularly report this information, however.

All fifty states have criminal justice statistical analysis centers that function as data and clearinghouse centers (see Appendix F).

LOCAL: City or county departments of public safety, local police departments of sheriffs' offices may be able to provide data not retrievable from the above state and Federal sources.

Comments

Arrests are not a count of youthful offenders but of incidents. An offender may be reported more than once during the year.

The number of arrests can vary substantially from jurisdiction to jurisdiction and over time due to differences or changes in juvenile arrest policies. The tracking of violent crimes rather than all crimes has been recommended because they are less affected by variations in juvenile arrest policy. In addition, the relationship between arrests and conviction is tighter than for nonviolent crimes.

Juvenile arrest rates can also be affected by changes in the size of the juvenile population. For example, if a locality is experiencing a rapid increase in population size through in-migration, the absolute number of arrests will increase even though the arrest rate stays the same.

Related Measures

Ideally one should follow social trends, including violent crime, using percentages or rates rather than absolute numbers. Unlike raw numbers, rates indicate unambiguously whether the rate of youth arrests for violent crime is increasing or decreasing. (However, it is important to bear in mind that since the data are based on number of arrests, not number of people arrested, the rate does not reflect an individual's chance of being arrested.) Unfortunately, annual estimates of the child population ages 10-17 (necessary to the production of percentages and rates) are not generally available below the state level accept at the time of the decennial census. If such estimates are available for the community, then the rate may also be calculated. To see if such estimates are available, contact that State
Data Center for your state (see Appendix E). Annual estimates are available at the national and state level from the Population Estimates Branch, U.S. Bureau of the Census (301) 763-5002.

The juvenile violent crime arrest rate is the number of arrests of youths ages 10-17 for violent crimes divided by the number of youths of the same age, multiplied by 100,000. This rate is commonly reported as “per 100,000” because arrests are relatively rare events.

\[
\text{Arrests of youth ages 10-17 for violent crimes/total youth ages 10-17} \times 100,000
\]

For greatest accuracy, rates will need to be adjusted for under-reporting, since most states have fewer than 100 percent of all localities reporting crime statistics. For advice concerning such adjustments for a particular locality, contact the Law Enforcement and Support group within the Federal Bureau of Investigation, (202) 324-5015.

### INDICATOR

**TEEN SUICIDE:** Number of teen suicides among youth ages 15-19.

### DEFINITION

The number of youths per 100,000 ages 15-19 who die each year from suicide.

### SIGNIFICANCE

The incidence of teen suicides is an indicator of teenage stress, mental health and community and family support. A high incidence of youth suicides reflects inadequacies in family and social supports, health and mental health services, and opportunities for success and a sense of well-being.

The risk of suicide is heightened among those youths with a history of mental illness or mental disorder, drug or alcohol abuse, recent behavioral changes such as a depression or truancy, previous attempts at suicide or suicide by a family member. Also at greater risk are those teens in stressful situations, such as parental divorce or separation, an unwanted pregnancy, loss of a parent or close friend, sense of failure or humiliation.

Morbidity due to failed suicide attempts has important public health significance. Failed attempts can result in brain damage, internal injuries or permanent disability and continued emotional stress.

### FACTS

Between 1985 and 1990 a total of almost 12,000 teens ages 15-19 committed suicide. The teen suicide rate for this age group was 11.1 per 100,000 teens in 1990.

Male teens are more likely than females to commit suicide. White teens are twice as likely as black teens to commit suicide. White male teens are at greatest risk.

Sixty-seven percent of youths ages 15-19 who commit suicide do so with firearms. A national goal to reduce suicides among youths ages 15 through 19 to no more than 8.2 per 100,000 youths of the same age by the year 2000 has been set by the Federal government as part of its *Healthy People 2000* effort. A target to reduce by 15 percent the incidence of injurious suicide attempts among adolescents is also included.
The cause of death is reported on the standard death certificate in all states. Data are reported by residence, not by the location of the suicide.

NATIONAL: National data on suicide is published in the following annual volume, which is available in most research libraries: *Vital Statistics of the United States, Volume II—Mortality*, published by the National Center for Health Statistics.

STATE: State and local data are available from the bureau of vital statistics in each state (see Appendix H), usually located within the state health department. Data may also be available from the state departments of public safety.

LOCAL: Data on the number of teen suicides in a locality may be available from state or local departments of health or public safety.

Because the number of suicides each year is small, this indicator may not be a useful benchmark in many communities and some states. Data on suicides may be under-reported. Social stigma and guilt or cultural factors may contribute to an under-reporting of suicides by families, physicians and others. Some suspected cases may be reported as accidents.

To compare jurisdictions or to track changes over time, one should follow social trends, including teen suicide, using percentages or rates rather than absolute numbers. Unlike raw numbers, rates will tell you unambiguously whether the risk of youth suicide is increasing or decreasing. Unfortunately, annual estimates of the youth population ages 15-19 (necessary to the production of percentages and rates) are not generally available below the state level accept at the time of the decennial census. If such estimates are available for the community, then the rate may also be calculated. To see if such estimates are available between censuses, contact that State Data Center for your state (see Appendix E). Annual estimates are available at the national and state level from the Population Estimates Branch, U.S. Bureau of the Census (301) 763-5002.

The rate is constructed by dividing the number of teenagers ages 15-19 who die each year from suicide by the total number of youths ages 15-19 and multiplying by 100,000. This rate is commonly reported as “per 100,000” because suicides are relatively rare events.

$$\left( \frac{\text{Teens ages 15-19 who die by suicide}}{\text{total teens ages 15-19}} \times 100,000 \right)$$
**INDICATOR**

**TEEN HOMICIDE:** teen homicide rate among youth ages 15-19.

**DEFINITION**

The number of deaths due to homicide in any given year per 100,000 youths ages 15-19.

**SIGNIFICANCE**

The incidence of teen deaths by murder is an indicator of teen delinquent behavior, hostility and anger. It is also a reflection of access to firearms. Most teenage murder victims are killed by other teenagers.

It is also an indicator of community safety—the perception of risk which when heightened may diminishes lives and may lead to mental health and behavioral problems; the actual risk of harm or murder to others; and the availability or trafficking of destructive agents such as guns, alcohol, and drugs.

Most teen homicides involve the use of firearms. However, the use of drugs, the support of drug use or interactions related to drug use are also common factors associated with teen homicides.

**FACTS**

In 1990, there were 3,042 deaths from homicides among adolescents age 15-19 for a rate of 17.0 homicides per 100,000 teens.

Homicide is the second leading cause of death among fifteen-to-nineteen year olds. It is the leading cause for males in this age group and for both male and female African-American teenagers. In 1990, the death rate from homicide for black youths was eight times the rate for whites and has been increasing dramatically in recent years.

**DATA SOURCES**

The cause of death is reported on the standard death certificate in all states. Data are by residence, not the location of the homicide.

**NATIONAL:** National data on homicide are published in the following annual volume, which is available in most research libraries: *Vital Statistics of the United States, Volume II—Mortality*, published by the National Center for Health Statistics, Division of Vital Statistics.

**STATE:** State and local data are available from the bureau of vital statistics in each state (see Appendix H), usually located within the state health department. Data may also be available from the state departments of public safety.

**LOCAL:** Data on the number of teen homicides in a locality may be available from state or local departments of health or public safety.

**COMMENTS**

Because the number of teen homicides each year is small, this indicator may not be a useful benchmark in many communities and some states.

**RELATED MEASURES**

To compare jurisdictions or to track changes over time, one should follow social trends, including teen homicide, using percentages or rates rather than absolute numbers. Unlike raw numbers, rates will tell you unambiguously whether the risk of youth homicide is increasing or decreasing. Unfortunately, annual esti-
mates of the youth population ages 15-19 (necessary to the production of percentages and rates) are not generally available below the state level except at the time of the decennial census. If such estimates are available for the community, then the rate may also be calculated. To see if such estimates are available between censuses, contact that State Data Center for your state (see Appendix E). Annual estimates are available at the national and state level from the Population Estimates Branch, U.S. Bureau of the Census (301) 763-5002.

The rate is constructed by dividing the number of teenagers ages 15-19 who die each year from suicide by the total number of youths ages 15-19 and multiplying by 100,000. This rate is commonly reported as “per 100,000” because suicides are relatively rare events.

\[
\left( \frac{\text{Teens ages 15-19 who die by homicide}}{\text{total teens ages 15-19}} \right) \times 100,000
\]

Another child and community safety measure is the number of deaths by firearms among children of all, or specified ages. In 1991, 5,261 children birth through age 19 died as a result of a firearm injury from homicides, suicides, and accidents.

The prevalence of childhood injuries that do not result in death but are serious enough to require medical attention is another measure of child safety. Data, however, are scattered. National data are collected by a number of different agencies depending on the cause of the injury (e.g. burns, traffic injuries, suicide attempts, etc). No state currently has a childhood injury tracking system. Hospital emergency rooms are not required to maintain data on released patients or to code the cause of an injury. However, about a dozen states have passed legislation mandating that hospital collect with their patient data an “external cause of event code” on how and where an injury occurred.

---

**INDICATOR**

**ACCIDENTAL DEATHS:** number of accidental deaths per 100,000 among children and youths ages 1-19.

**DEFINITION**

Number of children ages 1-19 who die each year as a result of unintentional injuries (e.g. traffic fatalities, fires and burns, drownings, poisonings/choking, firearms, and falls).

**SIGNIFICANCE**

This measure is an indicator of risk to children's health, and of risk-taking behavior, especially among older adolescents. It is also a measure of the adequacy of a broad range of public health and accident prevention strategies, including public education, product development and use (e.g. bike helmets, safety belts, smoke detectors, etc.), and risk reduction and treatment resources (e.g. alcohol abuse prevention and treatment, poison control centers, recreation options). Fatalities from accidents are higher in lower-income areas because of many factors, including poorer emergency and medical care, and more hazardous environments (e.g. older roads and cars, and housing).
FACTS

In 1990, 13,777 children aged 1-19 died of accidental injury. The age range broke out into 2,566 deaths for ages 1-4; 1,777 for ages 5-9; 1,879 for ages 10-14; and 7,561 for ages 15-19.

For all age groups, motor vehicle injuries are the leading cause of injury-related death. Other causes include fires and related burns, firearms, falls and drownings. The motor vehicle accident death rate for fifteen-to-nineteen year-olds is five times the rate of any other category of unintended injury. Male teens are more likely than females to die in a motor vehicle accident. White males are at greatest risk.

DATA SOURCES

The cause of death is reported on all standard certificates of death in every state (see Appendix K). The data are reported by residency, not by the location of the accidental death.

NATIONAL: National data on causes of death are published in the following annual volume, which is available in most research libraries: Vital Statistics of the United States, Volume II—Mortality, published by the National Center for Health Statistics, Division of Vital Statistics.

STATE: State and local data are available from the bureau of vital statistics in each state, usually located within the state health department. Data may also be available from the state departments of public safety.

LOCAL: Data on the number of deaths from accidents in a locality may be available from state or local departments of health or public safety.

COMMENTS

To compare jurisdictions or to track changes over time, this indicator should be expressed as a rate in order to control for the impact of demographic changes.

RELATED MEASURES

To compare jurisdictions or to track changes over time, one should follow social trends, including accidental death, using percentages or rates rather than absolute numbers. Unlike raw numbers, rates will tell you unambiguously whether the risk of accidental death is increasing or decreasing. Unfortunately, annual estimates of the population ages 1-19 (necessary to the production of percentages and rates) are not generally available below the state level except at the time of the decennial census. If such estimates are available for the community, then the rate may also be calculated. To see if such estimates are available between censuses, contact that State Data Center for your state (see Appendix E). Annual estimates are available at the national and state level from the Population Estimates Branch, U.S. Bureau of the Census (301) 763-5002.

The rate is constructed by dividing the number of children ages 1-19 who die each year from accidents by the total number of children ages 1-19 and multiplying by 100,000. This rate is commonly reported as “per 100,000” because accidental deaths are relatively rare events.

\[
\text{Rate} = \left( \frac{\text{Children ages 1-19 who die from accidents}}{\text{Total children ages 1-19}} \right) \times 100,000
\]

Because motor vehicle fatalities make up such a large portion of accidental deaths, it may be advisable to track the incidence of motor vehicle fatalities. In
addition to data compiled by offices of vital statistics, each state has an agency
responsible for compiling data on fatal motor vehicle accidents based on death
certificates. This agency varies from state to state but includes state departments
of transportation, of motor vehicles or state police. The state and local data are
fed into the Fatal Accident Reporting System. FARS data are collected continu-
ously by local police departments and reported to the National Highway and
Traffic Safety Agency by the state agency. NHTSA publishes monthly fact sheets
and quarterly and annual reports. Data are reported by single-year ages, rela-
tionship of children to the vehicle, related causes. There is a two to three month
lag between collection and publication of data. These publications can be or-
dered from the following source:

National Highway and Traffic Safety Administration
National Center for Statistics and Analysis
U.S. Department of Transportation
400 7th St., SW
Washington, D.C. 20590
(202) 366-4198

Jurisdictions may also want to track accidental injury rates in addition to death
rates. Injuries cause their own stream of additional societal and personal costs.
These would yield far greater numbers and therefore give a more detailed picture
of the problems causing both injury and death. However, injury data are more
difficult to find and to classify—communities may need to use hospital discharge
data or other disparate sources to find this information.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFINITION</td>
<td>The number of new cases each year of each sexually-transmitted disease, AIDS and HIV infection among youth ages 15 through 19. The most common sexually-transmitted diseases include gonorrhea, syphilis, chlamydia, and genital herpes. Each of these diseases should be tracked separately.</td>
</tr>
<tr>
<td>SIGNIFICANCE</td>
<td>The incidences of sexually-transmitted diseases are indicators of adolescent risk-taking behavior (i.e. unprotected sexual activity) which can lead to poor health outcomes. HIV/AIDS among teens and adults are transmitted primarily through the risk behaviors of unprotected sexual activity and drug use, though it is also transmitted through blood transfusions. These indicators are also in part a measure of teens' access to health education and care and family planning services. Sexually-transmitted diseases are preventable and curable. HIV is preventable and while it is not presently curable, its impact can be managed through care.</td>
</tr>
</tbody>
</table>
Since the 1970's, teen sexual activity among adolescents has increased and with it the spread of sexually-transmitted diseases and HIV infection among teens.

As of July, 1992, 3,898 cases of AIDS were reported among children under age 13 and 872 among young people ages 13 through 19.

As of July, 1992, 8,911 cases of AIDS were reported among the young adult population, ages 20-24. These cases represent one in five of all cases. Because the latency period between HIV infection and AIDS symptoms is up to nine years, many of these young adults were probably infected as teenagers. By the end of 1991, there were an estimated 10,000 to 20,000 symptomatic HIV-infected infants, children, and youths.

Although still outnumbered by males, females are more represented in adolescent HIV infection and AIDS than they are among adult cases. The majority of infected adolescent females are African-American or Latina. CDC estimates that the number of AIDS cases is increasing almost twice as fast among women as among men.

Of the 12 million cases of sexually-transmitted diseases estimated to occur annually, 3 million (25 percent) are among teenagers. Chlamydia is the most common sexually-transmitted disease among teens. In 1990, 183,865 cases of gonorrhea were reported among teenagers, ages 15-19, and 5,184 cases of syphilis. While the number of cases of gonorrhea has been on the decline since 1980, the number of cases of syphilis has been rising since 1985.

A national goal to reduce the incidence of gonorrhea to no more than 750 cases among adolescents aged 15-19 per 100,000 adolescents of the same age has been set by the Federal government as part of its Healthy People 2000 effort. There are goals for perinatal HIV infection and other sexually-transmitted diseases. However, they are not specific to this population.

NATIONAL: National data on rates of HIV/AIDS infection are published annually by the U.S. Department of Health and Human Services/Public Health Service/Centers for Disease Control and Prevention. The series is titled "HIV/AIDS Surveillance Reports". To order the report, contact:

National AIDS Clearinghouse
(800) 458-5231

The Centers for Disease Control and Prevention also publishes "Morbidity and Mortality Weekly Report," which has national data on trends in teen rates of sexually transmitted diseases.

STATE: The Centers for Disease Control and Prevention collects data on AIDS, gonorrhea, and syphilis from every state. However, reporting on HIV infection and other sexually-transmitted diseases is not required. Not all states collect data on all such diseases. As of April 1990, only 32 states reported HIV infections and 33 states reported chlamydial infections. See the publications listed above for available state data.

Every state health department has a communicable diseases surveillance system, located in an office of epidemiology or communicable (infectious) diseases.
Data are available by disease, age, race, gender, and county. Issues of confidentiality may preclude getting data by smaller civil divisions.

LOCAL: Local data are available from state health departments. Local health departments may also keep track of health data for the locality, and may have their own publications.

**COMMENTS**

Data are reported by case, not individual. Since an individual can have more than one case of a disease, the data do not reflect accurately the number of people infected. Data are reported by each disease for which data are collected. If disease data are not already aggregated into a sexually-transmitted disease rate, it is important to consult with experts regarding the appropriate weighting of each disease in constructing an overall rate. No one disease, however, constitutes an accurate measure of overall disease rates since the incidence and trends of each vary.

Among reporting states, there are differences in reporting requirements, and in compliance with reporting requirements by public and private health providers which may affect the data and its consistency over time and among states.

**RELATED MEASURES**

For the more common sexually transmitted diseases (e.g. gonorrhea and chlamydia) it will be possible, and for many purposes preferable, to track the rate per 100,000 rather than the absolute number. The rate is shown as “per 100,000” because the incidence is still relatively rare. The production of these rates requires that one have estimates of the size of the total population age 15-19 for the geographic area of interest. Between censuses, such estimates are produced by the Federal government for states. Contact your state data center for additional information (see Appendix E).

---

**INDICATOR**

**YOUTH IDLENESS:** The percent of youth ages 16-24 who are not productively engaged.

**DEFINITION**

The percent of youth ages 16-24 who are not working, not in the military, not in school, and not married to one so engaged.

The indicator is constructed by dividing the total number of idle youth ages 16-24 by the total number of persons ages 16-24, and multiplying by 100.

\[
\text{((Idle person ages 16-24/total person ages 16-24) x 100)}
\]

**SIGNIFICANCE**

It is important that children make a smooth transition to becoming independent adults. A number of roles are commonly adopted, simultaneously or in succession, as part of that transition process including the roles of student, worker, spouse and homemaker. This indicator measures the percent of youth who are engaged in none of the roles associated with making a successful transition to becoming an independent adult.
Using data from the March Current Population Survey, the Population Reference Bureau estimates that, in 1990, 5 percent of all youth ages 16-19 were idle during the week preceding the survey. In some areas, and among some groups, this rate is much higher.

**DATA SOURCES**

**NATIONAL:** National estimates can be produced using data from the March Current Population Survey, and are currently published in the annual *Kids Count Data Book* of the Annie E. Casey Foundation.

Kids Count, Annie E. Casey Foundation  
111 Market Place, Suite 420  
Baltimore, MD 21202  
(410) 234-2872

In addition, the raw data are available on CD-Rom from Census Data User Services: (301) 763-4100

To identify idle youth using this data source, one must look at marital status, major activity during the week preceding the survey, and major activity of the spouse in the week preceding the survey. The production of such estimates requires that one have substantial computer programming capabilities. Those lacking such capabilities may wish to contact their state data center (see Appendix E).

**STATE:** State level estimates for this indicator can be produced using the data source described above, though for most states this requires combining 3-5 years of data. State estimates appearing in the *Kids Count Data Book* are produced using this technique. Estimates may not be reliable for states with very small populations (see Appendix I).

**LOCAL:** Estimates for substate localities can be produced every 10 years using data from the decennial census. Such estimates will be artificially high, however, in counties containing state and Federal detention facilities. It is therefore best to eliminate those in detention centers from the equation before estimating the percent of youth who are idle at the substate level.

**COMMENTS**

Available data allow only for estimates based on activities in the week preceding the survey. Ideally, one would prefer to identify those who are idle for substantial periods of time, perhaps half the year or more. Beginning in 1996, the Survey of Income and Program Participation, a survey fielded by the Bureau of the Census, will produce the data and sample sizes necessary to make reliable national estimates using this longer time span.

Some of those identified as "idle" are in fact productively employed in the informal economy doing off-the-books (but otherwise legitimate) work. Few of these jobs, however, supply the level of income and the regularity of employment associated with being an independent adult.

**RELATED MEASURES**

For young men, homemaking is still a rare role, though not so rare as in the past. For that reason, operational definitions of idleness that do not include homemaking will produce reasonably good estimates of idleness among males.
APPENDIX A

Chief State School Officers

The authors wish to thank the Council of Chief State School Officers for permission to duplicate this list.

ALABAMA
MR. EDWARD RICHARDSON
SUPERINTENDENT OF EDUCATION
ALABAMA DEPT. OF EDUCATION
GORDON PERSONS OFFICE BUILDING
50 NORTH RIPLEY STREET
P.O. BOX 302102
MONTGOMERY, AL 36130-2101
(334) 242-9700

ALASKA
DR. SHIRLEY L. HOLLOWAY
COMMISSIONER OF EDUCATION
ALASKA DEPARTMENT OF EDUCATION
801 WEST 10TH STREET, SUITE 200
JUNEAU, AK 99801-1894
(907) 465-2800

AMERICAN SAMOA
MR. TAUTALATASI TUATOO
DIRECTOR OF EDUCATION
AMERICAN SAMOA DEPARTMENT OF EDUCATION
Pago Pago, AS 96799
(011-684) 633-5237

ARIZONA
MS. LISA GRAHAM
SUPERINTENDENT OF PUBLIC INSTRUCTION
ARIZONA DEPT. OF EDUCATION
1535 WEST JEFFERSON
PHOENIX, AZ 85007
(602) 542-5460

ARKANSAS
MR. GENE WILHOIT
DIRECTOR
GENERAL EDUCATION DIVISION
ARKANSAS DEPARTMENT OF EDUCATION
FOUR STATE CAPITOL MALL, ROOM 304 A
LITTLE ROCK, AR 72201-1071
(501) 682-4204

CALIFORNIA
MS. DELAINE A. EASTIN
SUPERINTENDENT OF PUBLIC INSTRUCTION
CALIFORNIA DEPARTMENT OF EDUCATION
721 CAPITOL MALL
SACRAMENTO, CA 95814
(916) 657-4768

COLORADO
DR. WILLIAM T. RANDALL
COMMISSIONER OF EDUCATION
COLORADO DEPARTMENT OF EDUCATION
201 EAST COLFAX AVENUE
DENVER, CO 80203-1799
(303) 866-6806

CONNECTICUT
DR. THEODORE S. SERGI
(ACTING) COMMISSIONER OF EDUCATION
CONNECTICUT DEPARTMENT OF EDUCATION
163 CAPITOL AVENUE
ROOM 303, STATE OFFICE BUILDING
HARTFORD, CT 06106-1630
(203) 566-5061

DELAWARE
DR. PASCAL D. FORGIONE, JR.
SUPERINTENDENT OF PUBLIC INSTRUCTION
DELWARE DEPARTMENT OF PUBLIC INSTRUCTION
TOWNSEND BUILDING, #279
FEDERAL & LOCKERMANN STREETS
DOVER, DE 19901
(302) 739-4601

DISTRICT OF COLUMBIA
DR. FRANKLIN L. SMITH
SUPERINTENDENT OF PUBLIC INSTRUCTION
DISTRICT OF COLUMBIA PUBLIC SCHOOLS
THE PRESIDENTIAL BUILDING
415 12TH STREET, N.W.
WASHINGTON, DC 20004
(202) 724-4222

FLORIDA
MR. FRANK T. BROGAN
COMMISSIONER OF EDUCATION
FLORIDA DEPARTMENT OF EDUCATION
CAPITOL BUILDING, ROOM PL 08
TALLAHASSEE, FL 32301
(904) 487-1785

GEORGIA
MS. LINDA SCHRENO
SUPERINTENDENT OF SCHOOLS
GEORGIA DEPARTMENT OF EDUCATION
2066 TWIN TOWERS EAST
205 BUTLER STREET
ATLANTA, GA 30334
(404) 656-2800

IDAHO
DR. LILLIAN GONZALEZ
DIRECTOR
DEPARTMENT OF DEFENSE DEPENDENTS SCHOOLS
DEPARTMENT OF DEFENSE OFFICE OF DEPENDENTS SCHOOLS
4040 NORTH FAIRFAX DRIVE, 9TH FLOOR
ARLINGTON, VA 22203-1635
(703) 696-4247

ILLINOIS
DR. JOSEPH A. SPAGNOLO, JR.
SUPERINTENDENT OF EDUCATION
ILLINOIS BOARD OF EDUCATION
100 NORTH FIRST STREET
SPRINGFIELD, IL 62777
(217) 782-2221

INDIANA
DR. JUDELLEN K. REED
SUPERINTENDENT OF PUBLIC INSTRUCTION
INDIANA DEPARTMENT OF EDUCATION
STATE HOUSE, ROOM 229
INDIANAPOLIS, IN 46204-2798
(317) 232-6665

IOWA
DR. AL RAMIREZ
DIRECTOR OF EDUCATION
IOWA DEPARTMENT OF EDUCATION
GRIMES STATE OFFICE BUILDING
EAST 14TH & GRAND STREETS
DES MOINES, IA 50319-0146
(515) 281-3436

KENTUCKY
MR. WILMER CODY
COMMISSIONER OF EDUCATION
KENTUCKY DEPARTMENT OF EDUCATION
CAPITOL PLAZA TOWER
500 MERO STREET
FRANKFORT, KY 40601
(502) 564-3141

GUAM
MR. ROLAND TAIMANGLO
(INTERIM) DIRECTOR OF EDUCATION
GUAM DEPARTMENT OF EDUCATION
POST OFFICE BOX DE
AGANA, GM 96910
(671) 475-0457

HAWAII
DR. HERMAN M. AIZAWA
SUPERINTENDENT OF EDUCATION
HAWAII DEPARTMENT OF EDUCATION
1390 MILLER STREET, #307
HONOLULU, HI 96813
(808) 586-3310

IDAHO
DR. ANNE C. FOX
SUPERINTENDENT OF PUBLIC INSTRUCTION
IDAHO DEPARTMENT OF EDUCATION
LEN B. JORDAN OFFICE BUILDING
650 WEST STATE STREET
P.O. BOX 83720
BOISE, ID 83720
(208) 334-3300
<table>
<thead>
<tr>
<th>State</th>
<th>Name</th>
<th>Title</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louisiana</td>
<td>Dr. Raymond G. Arveson</td>
<td>Superintendent of Education</td>
<td>Louisiana Dept. of Education 626 North 4th St., 12th Fl., Baton Rouge, LA 70804-9064</td>
<td>(504) 342-3602</td>
</tr>
<tr>
<td>Maine</td>
<td>Dr. Wayne L. Mowatt</td>
<td>Commissioner of Education</td>
<td>Maine Department of Education State House Station #23, Augusta, ME 04333</td>
<td>(207) 287-5800</td>
</tr>
<tr>
<td>Maryland</td>
<td>Dr. Nancy S. Grasmick</td>
<td>Superintendent of Schools</td>
<td>Maryland Dept. of Education 200 West Baltimore St., Baltimore, MD 21201</td>
<td>(410) 767-0462</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Dr. Robert V. Antonucci</td>
<td>Commissioner of Education</td>
<td>Massachusetts Department of Education 350 Main St., Malden, MA 02148</td>
<td>(617) 388-3300</td>
</tr>
<tr>
<td>Michigan</td>
<td>Mr. Arthur Ellis (Interim)</td>
<td>Superintendent of Public Instruction</td>
<td>Michigan Dept. of Education 608 West Allegan St., Lansing, MI 48933</td>
<td>(517) 373-3334</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Dr. Tom Burnham</td>
<td>Superintendent of Education</td>
<td>Mississippi Department of Education 550 High St., Room 501, Jackson, MS 39201</td>
<td>(601) 359-3513</td>
</tr>
<tr>
<td>Missouri</td>
<td>Dr. Robert E. Bartman</td>
<td>Commissioner of Education</td>
<td>Missouri Department of Elementary &amp; Secondary Education 205 Jefferson St., 6th Floor, Jefferson City, MO 65102</td>
<td>(314) 751-4446</td>
</tr>
<tr>
<td>Montana</td>
<td>Ms. Nancy Keenan</td>
<td>Superintendent of Public Instruction</td>
<td>Montana Office of Public Instruction 106 State Capitol, Helena, MT 59620</td>
<td>(406) 444-3680</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Dr. Douglas D. Christensen</td>
<td>Commissioner of Education</td>
<td>Nebraska Dept. of Education 301 Centennial Mall, South, 6th Floor, P.O. Box 94987, Lincoln, NE 68509-4987</td>
<td>(402) 471-5020</td>
</tr>
<tr>
<td>Nevada</td>
<td>Ms. Mary L. Peterson</td>
<td>Superintendent of Public Instruction</td>
<td>Nevada Dept. of Education 700 East 5th St., Carson City, NV 89710</td>
<td>(702) 687-3100</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Dr. Elizabeth M. Twomey</td>
<td>Commissioner of Education</td>
<td>New Hampshire Department of Education 101 Pleasant St., Concord, NH 03301</td>
<td>(603) 271-3144</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Dr. Leo E Klachholz</td>
<td>Commissioner of Education</td>
<td>New Jersey Department of Education 225 East State St., Trenton, NJ 08625-0500</td>
<td>(609) 292-4450</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Mr. Alan D. Morgan</td>
<td>Superintendent of Public Instruction</td>
<td>New Mexico Department of Education Education Building 300 Don Gaspar, Santa Fe, NM 87501-2786</td>
<td>(505) 827-6516</td>
</tr>
<tr>
<td>New York</td>
<td>Mr. Richard Mills</td>
<td>Commissioner of Education</td>
<td>New York Education Department 111 Education Building Washington Avenue, Albany, NY 12234</td>
<td>(518) 474-5844</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Mr. Bob R. Etheridge</td>
<td>State Superintendent of Public Instruction</td>
<td>North Carolina Department of Public Instruction Education Building 301 North Wilmington St., Raleigh, NC 27601-2825</td>
<td>(919) 715-1299</td>
</tr>
<tr>
<td>North Dakota</td>
<td>Dr. Wayne G. Sanstead</td>
<td>Superintendent of Public Instruction</td>
<td>North Dakota Department of Public Instruction State Capitol Building, 11th Floor 600 Boulevard Avenue, East Bismarck, ND 58505-0440</td>
<td>(701) 328-4572</td>
</tr>
<tr>
<td>Northern Mariana Islands</td>
<td>Mr. William S. Torres</td>
<td>Commissioner of Education</td>
<td>Northern Mariana Islands Department of Education P.O. Box 1370 CK Saipan, MP 96950</td>
<td>(671) 322-6451</td>
</tr>
<tr>
<td>Ohio</td>
<td>Mr. John Goff</td>
<td>Superintendent of Public Instruction</td>
<td>Ohio Department of Education 65 South Front St., RM 810 Columbus, OH 43215-4183</td>
<td>(614) 466-3304</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>Ms. Sandy Garrett</td>
<td>Commissioner of Public Instruction</td>
<td>Oklahoma Department of Education Hodge Education Building 2500 North Lincoln Boulevard Oklahoma City, OK 73105-4599</td>
<td>(405) 521-3301</td>
</tr>
<tr>
<td>Oregon</td>
<td>Ms. Norma Paulus</td>
<td>Superintendent of Public Instruction</td>
<td>Oregon Department of Education 255 Capitol St., Salem, OR 97310-6203</td>
<td>(503) 378-3573</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Dr. Eugene W. Hickok, Jr.</td>
<td>Secretary of Education</td>
<td>Pennsylvania Department of Education 333 Market St., 10th Floor Harrisburg, PA 17126-0333</td>
<td>(717) 787-5820</td>
</tr>
</tbody>
</table>
PUERTO RICO
MR. VICTOR R. FAJARDO
SECRETARY OF EDUCATION
PUERTO RICO DEPARTMENT OF EDUCATION
POST OFFICE BOX 190759
SAN JUAN, PR 00919-0759
(809) 751-5372

RHODE ISLAND
MR. PETER MCMARTIN
COMMISSIONER OF EDUCATION
RHODE ISLAND DEPARTMENT OF EDUCATION
22 HAYES STREET
PROVIDENCE, RI 02908
(401) 277-2031

SOUTH CAROLINA
DR. BARBARA S. NIELSEN
STATE SUPERINTENDENT OF EDUCATION
SOUTH CAROLINA DEPARTMENT OF EDUCATION
1006 RUTLEDGE BUILDING
1429 SENATE STREET
COLUMBIA, SC 29201
(803) 734-8492

SOUTH DAKOTA
MS. KARON SCHAACK
(Acting) SECRETARY OF EDUCATION
SOUTH DAKOTA DEPARTMENT OF EDUCATION & CULTURAL AFFAIRS
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
(605) 773-3134

TENNESSEE
MS. ADA JANE WALTERS
COMMISSIONER OF EDUCATION
TENNESSEE DEPARTMENT OF EDUCATION
SIXTH FLOOR, GATEWAY PLAZA
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TN 37243-0375
(615) 741-2731

TEXAS
DR. MICHAEL A. MOSES
COMMISSIONER OF EDUCATION
TEXAS EDUCATION AGENCY
WILLIAM B. TRAVIS BUILDING
1701 NORTH CONGRESS AVENUE
AUSTIN, TX 78701-1494
(512) 463-9895

UTAH
DR. SCOTT W. BEAN
SUPERINTENDENT OF PUBLIC INSTRUCTION
UTAH OFFICE OF EDUCATION
250 EAST 500 SOUTH
SALT LAKE CITY, UT 84111
(801) 538-7510

VERMONT
(VACANT)
COMMISSIONER OF EDUCATION
VERMONT DEPARTMENT OF EDUCATION
120 STATE STREET
MONTPELIER, VT 05620-2301
(802) 828-3135

VIRGINIA
DR. WILLIAM C. BOSHER, JR.
SUPERINTENDENT OF PUBLIC INSTRUCTION
VIRGINIA DEPARTMENT OF EDUCATION
101 NORTH 14TH STREET
JAMES MONROE BUILDING
RICHMOND, VA 23219
(804) 225-2755

VIRGIN ISLANDS
DR. JAMES E. CHEEK
(Acting) COMMISSIONER OF EDUCATION
VIRGIN ISLANDS DEPARTMENT OF EDUCATION
44-46 KONGENS GADE
CHARLOTTE AMALIE, VI 00802
(809) 774-2810

WASHINGTON
MS. JUDITH A. BILLINGS
SUPERINTENDENT OF PUBLIC INSTRUCTION
WASHINGTON DEPARTMENT OF PUBLIC INSTRUCTION
OLD CAPITOL BUILDING, WASHINGTON & LEGION
P.O. BOX 47200
OLYMPIA, WA 98504-7200
(360) 586-6904

WEST VIRGINIA
DR. HENRY R. MAROCKIE
STATE SUPERINTENDENT OF SCHOOLS
WEST VIRGINIA DEPARTMENT OF EDUCATION
1900 KANAWHA BOULEVARD, EAST BUILDING 6, ROOM B-358
CHARLESTON, WV 25305
(304) 558-2681

WISCONSIN
MR. JOHN T. BENSON
SUPERINTENDENT OF PUBLIC INSTRUCTION
WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION
125 SOUTH WEBSTER STREET
P.O. BOX 7841
MADISON, WI 53707-7841
(608) 266-1771

WYOMING
MS. JUDY CATCHPOLE
STATE SUPERINTENDENT OF PUBLIC INSTRUCTION
WYOMING DEPARTMENT OF EDUCATION
2300 CAPITOL AVENUE, 2ND FLOOR
HATHAWAY BUILDING
CHEYENNE, WY 82002-0050
(307) 777-7675

COUNCIL OF CHIEF STATE SCHOOL OFFICERS
MR. GORDON M. AMBACH
EXECUTIVE DIRECTOR
COUNCIL OF CHIEF STATE SCHOOL OFFICERS
ONE MASSACHUSETTS AVENUE, NW SUITE 700
WASHINGTON, DC 20001-1431
(202) 408-5505
APPENDIX B
State Alcohol and Drug Abuse Directors

The authors wish to thank the National Association of State Alcohol and Drug Abuse Directors, Inc. for permission to duplicate this list.

ALABAMA
O’NEILL POLLIGUE, DIRECTOR
DIVISION OF SUBSTANCE ABUSE SRVCS
AL DEPT OF MENTAL HEALTH & MENTAL RETARDATION
200 INTERSTATE PARK DRIVE
P.O. BOX 3710
MONTGOMERY, AL 36193
(205) 270-4650
FAX: (205) 240-3195

ALASKA
LOREN A. JONES, DIRECTOR
DIVISION OF ALCOHOLISM AND DRUG ABUSE
AK DEPT OF HEALTH & SOCIAL SERVICES
P.O. BOX 110607
JUNEAU, AK 99811-0607
(907) 465-2071
FAX: (907) 465-2185

AMERICAN SAMOA
REPEKA M. HOWLAND, M.P.H.R.N.
DEPUTY DIRECTOR OF SOCIAL SERVICES
DIVISION
DEPT OF HUMAN RESOURCES
GOVERNMENT OF AMERICAN SAMOA
PAGO PAGO, AS 96799
(684) 633-4606
FAX: (684) 633-5379

ARIZONA
TERM GOENS, PROGRAM MANAGER
OFFICE OF SUBSTANCE ABUSE
DIVISION OF BEHAVIORAL HEALTH SVCS
AZ DEPT OF HEALTH SERVICES
2122 EAST HIGHLAND
PHOENIX, AZ 85106
(602) 381-8996
FAX: (602) 533-9143

ARKANSAS
JOE M. HILL, DIRECTOR
ARKANSAS BUREAU OF ALCOHOL AND DRUG ABUSE PREVENTION
108 E 7TH STREET
400 WALDON BUILDING
LITTLE ROCK, AR 72201
(501) 682-6650
FAX: (501) 682-6610

CALIFORNIA
ANDREW M. MECCA, DR.P.H., DIRECTOR
GOVERNOR’S POLICY COUNCIL ON DRUG & ALCOHOL ABUSE
1700 K STREET, 5TH FLOOR
EXECUTIVE OFFICE
SACRAMENTO, CA 95814-4037
(916) 445-1943
FAX: (916) 323-5873

COLORADO
ROBERT AUKERMAN, DIRECTOR
ALCOHOL AND DRUG ABUSE DIVISION
COLORADO DEPT OF HEALTH
4300 CHERRY CREEK DRIVE, SOUTH
DENVER, CO 80222-1530
(303) 692-2930
FAX: (303) 782-4883

CONNECTICUT
SHER HOROSKO, ASSISTANT TO THE COMMISSIONER FOR SUBSTANCE ABUSE
CT DEPT OF PUBLIC HEALTH & ADDICTION SERVICES
130 WASHINGTON STREET
HARTFORD, CT 06106
(203) 566-4282
FAX: (203) 566-8401

DELAWARE
THOMAS M. FRITZ, DIRECTOR
DE DIVISION OF ALCOHOLISM, DRUG ABUSE & MENTAL HEALTH
1901 N. DUPONT HIGHWAY
NEW CASTLE, DE 19720
(302) 577-4461
FAX: (302) 577-4486

DELWARE
THOMAS M. FRITZ, DIRECTOR
DE DIVISION OF ALCOHOLISM, DRUG ABUSE & MENTAL HEALTH
1901 N. DUPONT HIGHWAY
NEW CASTLE, DE 19770
(302) 577-4461
FAX: (302) 577-4486

DISTRICT OF COLUMBIA
MAUDE R. HOLT, ADMINISTRATOR
DC ALCOHOL AND DRUG ABUSE SVCS
ADMINISTRATION
1300 FIRST STREET, N.E., SUITE 300
WASHINGTON, DC 20002
(202) 727-9393
FAX: (202) 535-2082

FLORIDA
PAMELA PETERSEN
DEPUTY ASSISTANT SECRETARY
ALCOHOL AND DRUG ABUSE
FL DEPT OF HEALTH & REHAB SVCS
1317 WINWOOD BLVD., BLDG. 6, ROOM 183
TALLAHASSEE, FL 32301
(904) 488-8304
FAX: (904) 487-2239

GEORGIA
THOMAS W. HESTER, M.D., DIRECTOR
GA ALCOHOL AND DRUG SVCS SECTION
2 PARCHMITE STREET, NE
4TH FLOOR
ATLANTA, GA 30302
(404) 657-6400
FAX: (404) 657-6424

GUAM
MARTYN L. WINGFIELD, DIRECTOR
DEPT OF MENTAL HEALTH AND SUBSTANCE ABUSE
790 GOVERNOR CARLOS G. GAMACHO ROAD
TAMUNING, GU 96911
(671) 646-9126-69
FAX: (671) 649-6948

HAWAII
ELAINE WILSON, DIVISION CHIEF
ALCOHOL & DRUG ABUSE DIVISION
HI DEPT OF HEALTH
P.O. BOX 5378
HONOLULU, HI 96801
(808) 586-3962
FAX: (808) 586-4016

IDAHO
TINA KLAMT, M.A., CHIEF
BUREAU OF SUBSTANCE ABUSE
DIV OF FAMILY & COMMUNITY SVCS
IDAHO DEPT OF HEALTH & WELFARE
450 WEST STATE STREET
BOISE, ID 83702
(208) 334-5935
FAX: (208) 334-5964

ILLINOIS
JAMES E. LONG, DIRECTOR
IL DEPT OF ALCOHOLISM AND SUBSTANCE ABUSE
100 WEST RANDOLPH, SUITE 5-600
JAMES R. THOMPSON CENTER
CHICAGO, IL 60601
(312) 814-2291
FAX: (312) 814-2419

INDIANA
JOHNIE UNDERWOOD
DEPUTY DIRECTOR
DIVISION OF MENTAL HEALTH
BUREAU OF ADDICTION SVCS
2-353, 402 W. WASHINGTON STREET
INDIANAPOLIS, IN 46204-2739
(317) 232-7816
FAX: (317) 233-3472

IOWA
JANET ZWICK, CHIEF
DIVISION OF SUBSTANCE ABUSE & HEALTH PROMOTION
IA DEPT OF PUBLIC HEALTH
LUCAS STATE OFFICE BUILDING
3RD FLOOR
DES MOINES, IA 50319
(515) 281-4417
FAX: (515) 281-4958
<table>
<thead>
<tr>
<th>State</th>
<th>Name</th>
<th>Title</th>
<th>Address</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>KANSAS</td>
<td>ANDREW O’DONOVAN, COMMISSIONER</td>
<td>KS ALCOHOL AND DRUG ABUSE SVCS</td>
<td>200 SW OAKLEY, BIDDLE BUILDING TOPEKA, KS 66606-1861</td>
<td>(913) 296-3925</td>
<td>(913) 296-0511</td>
</tr>
<tr>
<td>KENTUCKY</td>
<td>MICHAEL TOWNSEND, DIRECTOR</td>
<td>DIVISION OF SUBSTANCE ABUSE</td>
<td>KY DEPT OF MENTAL HEALTH &amp; MENTAL RETARDATION SVCS 275 EAST MAIN STREET</td>
<td>(502) 564-2880</td>
<td>(502) 564-3844</td>
</tr>
<tr>
<td>LOUISIANA</td>
<td>JOSEPH WILLIAMS, JR.</td>
<td>ASSISTANT SECRETARY</td>
<td>OFFICE OF ALCOHOL AND DRUG ABUSE LA DEPT OF HEALTH AND HOSPITALS 1201 CAPITOL ACCESS ROAD</td>
<td>(207) 287-6330</td>
<td>(207) 287-4334</td>
</tr>
<tr>
<td>MAINE</td>
<td>MARLENE MCMULLEN-PELSOR</td>
<td>DIRECTOR</td>
<td>OFFICE OF SUBSTANCE ABUSE</td>
<td>(406) 444-2827</td>
<td>(406) 444-4920</td>
</tr>
<tr>
<td>MARYLAND</td>
<td>RICK SAMPSON, DIRECTOR</td>
<td>BD STATE ALCOHOL &amp; DRUG ABUSE ADMINISTRATION</td>
<td>201 WEST PRESTON STREET BALTIMORE, MD 21202</td>
<td>(410) 225-6925</td>
<td>(410) 333-7206</td>
</tr>
<tr>
<td>MASSACHUSETTS</td>
<td>DENNIS MCCARTY, PH.D., DIRECTOR</td>
<td>MASSACHUSETTS DIVISION OF SUBSTANCE ABUSE SERVICES</td>
<td>150 TREMONT STREET BOSTON, MA 02111</td>
<td>(617) 727-7985</td>
<td>(617) 727-9288</td>
</tr>
<tr>
<td>MICHIGAN</td>
<td>KAREN SCHROCK, CHIEF</td>
<td>MICHIGAN DEPT OF PUBLIC HEALTH CENTER FOR SUBSTANCE ABUSE SVCS 3423 N. LOGAN/MARTIN L. KING BLVD</td>
<td>PO. BOX 30195 LANSING, MI 48909</td>
<td>(517) 335-8808</td>
<td>(517) 335-8837</td>
</tr>
<tr>
<td>MINNESOTA</td>
<td>CYNTHIA TURNURE, PH.D., DIRECTOR</td>
<td>CHEMICAL DEPENDENCY PROGRAM DIVISION</td>
<td>MN DEPT OF HUMAN SERVICES 444 LAFAYETTE ROAD ST. PAUL, MN 55155-3823</td>
<td>(612) 296-4610</td>
<td>(612) 296-6244</td>
</tr>
<tr>
<td>MISSISSIPPI</td>
<td>HERBERT LOVING, ACTING DIRECTOR</td>
<td>DIVISION OF ALCOHOL &amp; DRUG ABUSE MS DEPT OF MENTAL HEALTH ROBERT E. LEE STATE OFFICE BLDG 11TH FLOOR JACKSON, MS 39201</td>
<td>(601) 359-1288</td>
<td>(601) 359-6295</td>
<td></td>
</tr>
<tr>
<td>MISSOURI</td>
<td>MICHAEL COUNTY, ACTING DIRECTOR</td>
<td>DIVISION OF ALCOHOL &amp; DRUG ABUSE MO DEPT OF HEALTH 1706 E. ELM STREET JEFFERSON CITY, MO 65109</td>
<td>(314) 751-4942</td>
<td>(314) 751-7814</td>
<td></td>
</tr>
<tr>
<td>MONTANA</td>
<td>DARRYL BRUNO, ADMINISTRATOR</td>
<td>ALCOHOL AND DRUG ABUSE DIVISION DEPT OR CORRECTIONS AND HUMAN SERVICES 1539 11TH AVENUE HELENA, MT 59601-1301</td>
<td>(406) 444-2827</td>
<td>(406) 444-4920</td>
<td></td>
</tr>
<tr>
<td>NEBRASKA</td>
<td>MALCOLM HEARD, DIRECTOR</td>
<td>DIVISION OF ALCOHOLISM &amp; DRUG ABUSE NE DEPT OF PUBLIC INSTITUTIONS PO. BOX 94728 LINCOLN, NE 68509-4728</td>
<td>(402) 471-2851 EX. 5583</td>
<td>(402) 479-5143</td>
<td></td>
</tr>
<tr>
<td>NEVADA</td>
<td>ELIZABETH BRESHEARS, CHIEF</td>
<td>BUREAU OF ALCOHOL AND DRUG ABUSE NV DEPT OF HUMAN RESOURCES 503 EAST KING STREET ROOM 500 CARSON CITY, NV 89710</td>
<td>(702) 687-4790</td>
<td>(702) 687-5980</td>
<td></td>
</tr>
<tr>
<td>NEW HAMPSHIRE</td>
<td>GERALDINE SYLVESTER, DIRECTOR</td>
<td>NH OFFICE OF ALCOHOL &amp; DRUG ABUSE PREVENTION 105 PLEASANT STREET CONCORD, NH 03301</td>
<td>(603) 271-6119</td>
<td>(603) 271-6116</td>
<td></td>
</tr>
<tr>
<td>NEW JERSEY</td>
<td>JOHN W. FARRELL, DEPUTY DIRECTOR</td>
<td>DIVISION OF ALCOHOLISM, DRUG ABUSE AND ADDICTION SVCS NJ DEPT OF HEALTH, CN 362 TRENTON, NJ 08621-0362</td>
<td>(609) 292-9068 OR 7385</td>
<td>(609) 292-3816</td>
<td></td>
</tr>
<tr>
<td>NEW MEXICO</td>
<td>GERALDINE SALAZAR, DIRECTOR</td>
<td>BEHAVIORAL HEALTH SERVICES DIVISIONSNA HAROLD RUNNELS BLDG, RM 3200-N 1190 ST. FRANCIS DRIVE SANTA FE, NM 87501</td>
<td>(505) 827-2601</td>
<td>(505) 827-0007</td>
<td></td>
</tr>
<tr>
<td>NEW YORK</td>
<td>MARGUERITE T. SAUNDERS, COMMISSIONER</td>
<td>NY DEPT OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES 1450 WESTERN AVENUE ALBANY, NY 12203-3526</td>
<td>(518) 457-2061</td>
<td>(518) 457-5474</td>
<td></td>
</tr>
<tr>
<td>NORTH CAROLINA</td>
<td>JULIAN E KEEH, M.D., DIRECTOR</td>
<td>ALCOHOL AND DRUG SERVICES NC DIVISION OF MENTAL HEALTH DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES 325 NORTH SALISBURY STREET RALEIGH, NC 27611</td>
<td>(919) 733-4670</td>
<td>(919) 733-9455</td>
<td></td>
</tr>
<tr>
<td>NORTH DAKOTA</td>
<td>JOHN ALLEN, DIRECTOR</td>
<td>DIVISION OF ALCOHOLISM &amp; DRUG ABUSE ND DEPT OF HUMAN SERVICES PROFESSIONAL BUILDING 1389 EAST CAPITOL AVENUE BISMARCK, ND 58501</td>
<td>(701) 224-2769</td>
<td>(701) 224-3008</td>
<td></td>
</tr>
<tr>
<td>OHIO</td>
<td>LUCEILLE FLEMING, DIRECTOR</td>
<td>OH DEPT OF ALCOHOL &amp; DRUG ADDICTION SERVICES TWO NATIONWIDE PLAZA, 12TH FLOOR 280 N. HIGH STREET COLUMBUS, OH 43215-2537</td>
<td>(614) 466-3445</td>
<td>(614) 752-8645</td>
<td></td>
</tr>
<tr>
<td>OKLAHOMA</td>
<td>ANN LOWRANCE, ACTING DIRECTOR</td>
<td>SUBSTANCE ABUSE SERVICES OK DEPT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES PO. BOX 53277, CAPITOL STATION OKLAHOMA CITY, OK 73152-3277</td>
<td>(405) 271-8653</td>
<td>(405) 271-7413</td>
<td></td>
</tr>
</tbody>
</table>
# APPENDIX C

## State Child Abuse and Neglect Offices

The authors wish to thank the National Center of Child Abuse and Neglect for permission to duplicate this list.

### ALABAMA

Mary Carswell  
DePT oF HuMAN RESOURCES  
DIVISION oF FAmily & ChildREN’S SVCS  
50 N. Ripley Street  
MONTGOMERY, AL 36130-1801  
(205) 242-9300  
(205) 242-1086 FAX

### ALASKA

Lisa Rollin  
Social WorKer IV  
DIVISION oF FAmily & YOuth SVCS  
P.O. BOX 110630  
JUNEAU, AK 99811-0630  
(907) 465-3456  
(907) 465-3190 FAX

### AMERICAN SAMOA

Fualau Hanipale  
AssISTAnt DIrectoR  
American Samoa Government  
DePT oF HuMAN RESOURCES  
Social Services DIvIsION  
Pago Pago, AS 96799  
684-633-1222, EXT. 159

### ARIZONA

Beth Rosenberg  
OPERATIONS MANAGER  
DePT oF eConOMIC sECURITY  
ADMIN oF FAmily, YOuth AND FAmilies  
1789 West Jefferson  
SITE CODE 940-A  
Phoenix, AZ 85003  
(602) 542-2285  
(602) 542-3330 FAX

### ARKANSAS

Billye Burke  
DePT oF HuMAN SERVICES  
DIVISION oF CHILDREN & FAmily SVCS  
P.O. BOX 1437-830  
626 Donaghey Plaza South  
Little Rock, AR 72203-2437  
(501) 682-8541  
(501) 682-6571 FAX

### CALIFORNIA

Robert L. Green  
Office oF Child Abuse PREVEnTion  
CaliforNia DePT oF社ial sERVICES  
744 P Street, MS 19-82  
SACRAMENTO, CA 95814  
(916) 445-2771  
(916) 445-2898 FAX

### COLORADO

Janet Motz, MSW  
PROGRAM MANAGER, CHILD PROTECTION  
COLORADO DEPT oF社ial SVCS  
225 E. 16TH STREET  
SUITE 475  
DENVER, CO 80203  
(303) 894-7747  
(303) 894-7743 FAX

### CONNECTICUT

Gail Mason  
FAMILY SUPPORT & COMMUNITY LIVING  
DEPT oF CHILDREN & YOuth SERVICES  
170 Sigourney Street  
HARTFORD, CT 06105  
(203) 566-7298  
(203) 566-8022 FAX

### DISTRICT oF COLUMBIA

Rick Lyles  
ActING DePUTY MANAGER  
FAMILY SERVICES ADMINISTRATION  
Randall Building, 214  
First AND eye sTeetS, Sw  
WASHINGTON, DC 20024  
(202) 727-5947  
(202) 727-0851 FAX

### FLORIDA

A. Leon Polhill  
CHILDREN AND FAmilies PROGRAM MANAGER  
DePT oF HEALTH & REHABILITATIVE SERVICES  
2811-A Industrial Plaza Drive  
Tallahassee, FL 32301  
(904) 488-4900  
(904) 922-4247 FAX

### GEORGIA

Jerry Gouge  
Georgia DePT oF HuMAN RESOURCES  
DIVISION oF FAMILY & CHILDREN SVCS  
878 Peachtree Street, N.E., RM 502  
ATLANta, GA 30309  
(404) 657-3408  
(404) 853-9105 FAX

### HAWAII

Janice Low  
ASSISTANT MANAGER  
PROGRAM DEVELOPMENT—CHILD PROTECTIVE SERVICES  
DePT oF HuMAN SERVICES  
P.O. BOX 339  
HONOLULU, HI 96809-0339  
(808) 586-5794  
(808) 586-5700 FAX

### IDAHO

Patricia Haller  
Grants/contracts OffICER  
DePT oF HEALTH & WELFARe  
DIVISION oF FAMILY & CHILDREN SERVICES  
450 W. State Street  
Boise, ID 83720  
(208) 334-5700  
(208) 334-6699 FAX  
(208) 334-6525 - CONFIRMING NUMBER

### ILLINOIS

Anthony Jenkins  
ILLINOIS DePT oF CHILDREN AND FAMILY SERVICES  
STATE REGIONAL OFFICE BUILDING  
#10 Collinsville Avenue  
SUITE 301  
EAST ST. LOUIS, IL 62201  
(618) 583-2136  
(618) 583-2141 FAX

### INDIANA

Tim Elliott  
Supervisor, Institutional CHILD PROTECTIVE SERVICE UNIT  
DIVISION oF FAMILY AND CHILDREN  
INdiana family and social services administration  
INdiana government center South  
402 west WashinGton street  
ROOM W364  
INDIANAPOLIS, IN 46204  
(317) 232-4431  
(317) 232-4331 FAX

### IOWA

Marino Mayer  
DIVISION acFS  
BUREAU oF INDIVIDUAL AND FAMILY SUPPORT AND PROTECTIVE SERVICES  
IOWA DePT oF HuMAN SERVICES  
HOOVER STATE OFFICE BLDG, 5TH Floor  
Des Moines, IA 50319  
(515) 281-8726  
(515) 281-4597 FAX

### KANSAS

Donovan Rutledge  
KANSAS DePT oF SOCIAL & REHABILITATIVE SERVICES  
YOUTH AND ADULT SERVICES  
300 SW Oakley, SMITH-WILSON BUILDING  
Topeka, KS 66606  
(913) 296-4659  
(913) 296-4649 FAX
OKLAHOMA
KATHRYN SIMMS, M.S.W.
PROGRAM SUPERVISOR
CHILD ABUSE AND NEGLECT SECTION
CHILD WELFARE SERVICES
DIVISION OF CHILDREN & YOUTH SERVICES
DEPT OF HUMAN SERVICES
P.O. BOX 23352
OKLAHOMA CITY, OK 73125
(405) 521-2283
(405) 521-6684 FAX

OREGON
CONNIE JACOBY
DEPT OF HUMAN RESOURCES
CHILDREN SERVICES DIVISION
198 COMMERCIAL STREET, SE
SALEM, OR 97371
(503) 378-4722
(503) 581-6198 FAX

PALAU
YUJI MESUBED, M.O.
MINISTER OF HEALTH
BUREAU OF HEALTH SERVICES
REPUBLIC OF PALAU
MACDONALD MEMORIAL HOSPITAL
P.O. BOX 602F
KORO, PALAU 96940
680-488-2813
680-488-1907 (BEHAVIORAL HEALTH)
680-488-1211 FAX
680-488-1725 FAX

PENNSYLVANIA
JOSEPH SPEAR
DIRECTOR OF CHILD PROTECTIVE SVCS
HEALTH & WELFARE BUILDING ANNEX
DEPT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PA 17105-2675
(717) 787-3984
(717) 787-0414 FAX

PUERTO RICO
MARIA I. SOLDEVILA DE WALSH
DIRECTOR
DIVISION OF PROGRAM DEVELOPMENT
FAMILIES WITH CHILDREN PROGRAM
P.O. BOX 11398
SANTURCE, PR 00910
(809) 723-2127
(809) 723-1223 FAX

RHODE ISLAND
KENNETH M. FANDETTI
EXECUTIVE DIRECTOR
CHILD PROTECTIVE SERVICES
DEPT FOR CHILDREN & THEIR FAMILIES
610 MT PLEASANT AVENUE, BLDG 1
PROVIDENCE, RI 02908
(401) 457-4950
(401) 521-4570 FAX

SOUTH CAROLINA
ELIZABETH WILLIAMS
ASSISTANT DIRECTOR
DIVISION OF CHILD PROTECTIVE & PREVENTIVE SERVICES
OFFICE OF CHILD, FAMILY & ADULT SVCS
DEPT OF SOCIAL SERVICES
P.O. BOX 1520
COLUMBIA, SC 29202-1520
(803) 734-5670
(803) 734-6220 OR 5597 FAX

SOUTH DAKOTA
MERLIN WEYER
SOUTH DAKOTA DEPT OF SOCIAL SVCS/CPS
KNEIP BUILDING
700 GOVERNOR'S DRIVE
PIERRE, SD 57501
(605) 773-3227
(605) 773-4855 FAX

TENNESSEE
SUSAN C. STEPPE
DIRECTOR, CHILD PROTECTIVE SVCS
TENNESSEE DEPT OF HUMAN SERVICES
400 DEADERICK STREET
NASHVILLE, TN 37248-9300
(615) 741-5927
(615) 741-4165 FAX

TEXAS
PAT K. DEVIN, W-409
DIRECTOR, CHILD PROTECTIVE SVCS
TEXAS DEPT OF PROTECTIVE AND REGULATORY SERVICES
P.O. BOX 149030
AUSTIN, TX 78714-9030
(512) 450-3313
(512) 450-3782 FAX

UTAH
PAT ROTHERMICH
CPS SPECIALIST
UTAH DEPT OF HUMAN RESOURCES/DFS
120 NORTH 200 WEST
P.O. BOX 45500
SALT LAKE CITY, UT 84145-0500
(801) 538-4096
(801) 538-4016 FAX

VERMONT
CYNTHIA K. WALCOTT
POLICY AND PRACTICE CHIEF DIVISION OF SOCIAL SVCS
DEPT OF SOCIAL AND REHABILITATION SERVICES
103 SOUTH MAIN STREET
WATERBURY, VT 06771-2401
(802) 241-2131
(802) 241-2980 FAX

VIRGIN ISLANDS
DILSA ROHAN
P.O. BOX 539
ST. THOMAS, VI 00801
(309) 774-0930

VIRGINIA
RITA KATZMAN
CHILD PROTECTIVE SVCS UNIT
DEPT OF SOCIAL SERVICES
730 EASTBROAD STREET 23219-1849
RICHMOND, VA 23229-8699
(804) 692-1259
(804) 692-2215 FAX

WASHINGTON
RICHARD WINTERS
DEPT OF SOCIAL & HEALTH SERVICES
DIVISION OF CHILDREN & FAMILY SERVICES
P.O. BOX 45710
OLYMPIA, WA 98504
(206) 586-0636

WEST VIRGINIA
KATHIE D. KING, MSW
CPS PROGRAM SPECIALIST
OFFICE OF SOCIAL SERVICES
DEPT OF HEALTH & HUMAN RESOURCES
ROOM 850, BUILDING 6
STATE CAPITOL COMPLEX
CHARLESTON, WV 25305
(304) 558-7980
(304) 558-2059 FAX

WISCONSIN
JANET BREIDEL, CPS
BUREAU FOR CHILDREN, YOUTH AND FAMILIES
DEPT OF HEALTH AND SOCIAL SERVICES
1 WEST WILSON STREET, ROOM 465
P.O. BOX 7851
MADISON, WI 53707
(608) 267-2245
(608) 264-6750 FAX

WYOMING
STEVE VAJDA
DEPT OF SOCIAL SERVICES
HATHAWAY BUILDING 3322
CHEYENNE, WY 82002
(307) 777-6081
(307) 777-7747 FAX
## APPENDIX D

### State Child Welfare Agency Directors

The authors wish to thank the American Public Welfare Association for permission to duplicate this list.

<table>
<thead>
<tr>
<th>State</th>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA</td>
<td>Paul Vincent</td>
<td>Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family and Children’s Services Division</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alabama Dept of Human Resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50 North Riely Street</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Montgomery, AL 36130-1801</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(205) 242-9500</td>
</tr>
<tr>
<td>ALASKA</td>
<td>Deborah R. Wing</td>
<td>Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Division of Family &amp; Youth Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alaska Dept of Health &amp; Social Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PO. Box H-05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Juneau, AK 99811-0630</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(907) 465-3191</td>
</tr>
<tr>
<td>ARIZONA</td>
<td>Marsha Porter</td>
<td>Program Administrator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Division of Social Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Administration for Children, Youth &amp; Families</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Arizona Department of Economic Security</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1400 West Washington, 3rd FLR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Site Code 940A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phoenix, AZ 85005</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(602) 542-3981</td>
</tr>
<tr>
<td>ARKANSAS</td>
<td>Beverly Jones</td>
<td>Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Division of Children and Family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Arkansas Dept of Human Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>626 Donaghey Building</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7th &amp; Main Streets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PO. Box 1437, Slot #626</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Little Rock, AR 72203-1437</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(501) 682-8772</td>
</tr>
<tr>
<td>CALIFORNIA</td>
<td>Chief</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family &amp; Children’s Services Operations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bureau</td>
</tr>
<tr>
<td></td>
<td></td>
<td>744 P Street, MS 9-101</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sacramento, CA 95814</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(916) 445-2777</td>
</tr>
<tr>
<td>COLORADO</td>
<td>Susan Klein-Rothschild</td>
<td>Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child Welfare Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colorado Dept of Social Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1575 Sherman Street</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Denver, CO 80203-1714</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(303) 866-5932</td>
</tr>
<tr>
<td>CONNECTICUT</td>
<td>Rose Alma Senatore</td>
<td>Commissioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Connecticut Dept of Children and Youth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>170 Sigourney Street</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hartford, CT 06103</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(203) 566-5356</td>
</tr>
<tr>
<td>DELAWARE</td>
<td>Thomas P. Eichler</td>
<td>Secretary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Delaware Dept of Social Services for Children, Youth &amp; Their Families</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1825 Faulkland Road</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wilmington, DE 19805</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(302) 633-2500</td>
</tr>
<tr>
<td>DISTRICT OF COLUMBIA</td>
<td>Beverly Davis</td>
<td>Administrator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Children and Family Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Florida Dept of Health and Rehabilitative Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1317 Windwood Boulevard</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Building &amp; Room 314</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tallahassee, FL 32399-0700</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(904) 488-8762</td>
</tr>
<tr>
<td>GEORGIA</td>
<td>Anne Plant</td>
<td>Interim Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Division of Family &amp; Children Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Georgia Dept of Human Resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>878 Peachtree Street NE, Room 421</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Atlanta, GA 30309</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(404) 894-6386</td>
</tr>
<tr>
<td>GUAM</td>
<td>Marylou Tajeron</td>
<td>Supervisor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child Welfare and Protective SVCS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guam Dept of Public Health &amp; Social Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PO. Box 2816</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Agana, GU 96910</td>
</tr>
<tr>
<td>HAWAII</td>
<td>Linda Yoneyama</td>
<td>Administrator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family and Children’s Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hawaii Dept of Human SVCS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PO. Box 339</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Honolulu, HI 96809</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(808) 586-5680</td>
</tr>
<tr>
<td>IDAHO</td>
<td>Ken Paterson</td>
<td>Administrator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Division of Family and Children’s SVCS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Idaho Dept of Health and Welfare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>450 West State Street, 10th Floor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Boise, ID 83720</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(208) 334-5700</td>
</tr>
<tr>
<td>INDIANA</td>
<td>Sharon Pierce</td>
<td>Deputy Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child Welfare/ Social Services Div</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family Support Administration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Indiana Dept of Public Welfare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>402 West Washington Street, #W314</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Indianapolis, IN 46204-2716</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(317) 232-4420</td>
</tr>
<tr>
<td>IOWA</td>
<td>Federico Brid</td>
<td>Administrator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Division of Adult, Children &amp; Family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Iowa Dept of Human Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hoover State Office Building, 5th Flr</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Des Moines, IA 50319</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(515) 281-5521</td>
</tr>
<tr>
<td>KANSAS</td>
<td>Carolyn Risley Hill</td>
<td>Acting Commissioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Commission on Youth and Adult SVCS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kansas Dept of Social and Rehabilitative Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Smith-Wilson Building</td>
</tr>
<tr>
<td></td>
<td></td>
<td>300 S. W. Oakley Street</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Topeka, KS 66606</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(913) 296-4653</td>
</tr>
<tr>
<td>KENTUCKY</td>
<td>Peggy Wallace</td>
<td>Commissioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Department of Social Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kentucky Cabinet for Human Resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>275 East Main Street</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frankfort, KY 40621</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(502) 564-4650</td>
</tr>
<tr>
<td>LOUISIANA</td>
<td>Louis Plauche</td>
<td>Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bureau of Child and Family Child Welfare Program Development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Louisiana Dept of Social Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PO. Box 3318</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Baton Rouge, LA 70821</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(504) 342-4005</td>
</tr>
<tr>
<td>MAINE</td>
<td>Meris Bickford</td>
<td>Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bureau of Child and Family SVCS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maine Dept of Human Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>221 State Street</td>
</tr>
<tr>
<td></td>
<td></td>
<td>State House Station #11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Augusta, ME 04333</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(207) 289-2971</td>
</tr>
</tbody>
</table>

54
<table>
<thead>
<tr>
<th>State</th>
<th>Name</th>
<th>Title</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryland</td>
<td>Linda M. Heisner</td>
<td>Director</td>
<td>Office of Family and Children's Svcs</td>
<td>(410) 333-0200</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maryland Dept of Human Resources</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>311 West Saratoga Street</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Baltimore, MD 21201</td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Linda K. Carlisle</td>
<td>Commissioner</td>
<td>Dept of Social Services</td>
<td>(617) 727-0900</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>24 Farnsworth Street</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Boston, MA 02210</td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td>Harold Gazar</td>
<td>Deputy Director</td>
<td>Family Svcs Administration for Child and Family Services</td>
<td>(517) 335-6158</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Michigan Dept of Social Svcs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>215 South Grand Avenue, Suite 515</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lansing, MI 48909</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>Denise Revels Robinson</td>
<td>Director</td>
<td>Family and Children's Svcs Division</td>
<td>(612) 296-5288</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Minnesota Dept of Human Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>444 Lafayette Road</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>St. Paul, MN 5515</td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>Betty M. Daugherty</td>
<td>Director</td>
<td>Division of Family &amp; Children's Svcs</td>
<td>(601) 354-6664</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mississippi Dept of Human Svcs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>313 West Pascagoula Street</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Jackson, MS 39225-3806</td>
<td></td>
</tr>
<tr>
<td>Missouri</td>
<td>Carmen Schulze</td>
<td>Director</td>
<td>Division of Family Svcs</td>
<td>(314) 751-4247</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Missouri Dept of Social Svcs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>P.O. Box 88</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Jefferson City, MO 65103</td>
<td></td>
</tr>
<tr>
<td>Montana</td>
<td>Thomas Olsen</td>
<td>Director</td>
<td>Montana Dept of Family Svcs</td>
<td>(406) 444-5900</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>P.O. Box 8005</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Helena, MT 59604</td>
<td></td>
</tr>
<tr>
<td>Nebraska</td>
<td>Christine Hanus-Schulenberg</td>
<td>Administrator</td>
<td>Human Services Divison</td>
<td>(402) 471-9308</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nebraska Dept of Social Svcs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>P.O. Box 95026</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lincoln, NE 68509-5026</td>
<td></td>
</tr>
<tr>
<td>Nevada</td>
<td>Thom Reilly</td>
<td>Deputy Administrator</td>
<td>Division of Child &amp; Family Svcs</td>
<td>(702) 486-7650</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nevada Dept of Human Resources</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Building 6, 815</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6171 West Charleston Boulevard</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Las Vegas, NV 89158</td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Lorrie Lutz</td>
<td>Director</td>
<td>Division for Children &amp; Youth Svcs</td>
<td>(603) 271-4451</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>New Hampshire Dept of Health &amp; Human Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6 Hazen Drive</td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>Nicholas Scalera</td>
<td>Director</td>
<td>Division of Youth &amp; Family Services</td>
<td>(609) 292-6920</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>New Jersey Dept of Human Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CN 71</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Trenton, NJ 08625</td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>C. Wayne Powell</td>
<td>Secretary</td>
<td>New Mexico Dept of Children, Youth and Families</td>
<td>(505) 827-7602</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>P.O. Drawer 5160</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Santa FE, NM 87502-5160</td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>Frank Puig</td>
<td>Deputy Commissioner</td>
<td>Division of SVs and Community Development</td>
<td>(518) 474-9428</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>New York State Department of Social Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>40 North Pearl Street</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Albany, NY 12243</td>
<td></td>
</tr>
<tr>
<td>North Carolina</td>
<td>Sylvia Stikeleather</td>
<td>Chief</td>
<td>Children's Services Section</td>
<td>(919) 73309467</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Division of Social Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>North Carolina Dept of Human Resources</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>323 North Salisbury Street</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Raleigh, NC 27611</td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td>Donald L. Schmid</td>
<td>Director</td>
<td>Children &amp; Family Services Division</td>
<td>(701) 224-2316</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>North Dakota Dept of Human Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>600 East Boulevard Avenue</td>
<td></td>
</tr>
<tr>
<td>Ohio</td>
<td>Jerry Bean</td>
<td>Chief</td>
<td>Bureau of Operations and Coordination</td>
<td>(614) 466-2208</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Office of Child Care and Family Svcs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ohio Dept of Human Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>63 East State Street, 9th Floor</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>Bill Carey</td>
<td>Administrator</td>
<td>Children's Services Division</td>
<td>(503) 378-4374</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Oregon Dept of Human Resources</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>198 Commercial Street, SE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Salem, OR 97310</td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>George B. Taylor</td>
<td>Deputy Secretary</td>
<td>Office of Children, Youth &amp; Families</td>
<td>(717) 787-4756</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pennsylvania Dept of Public Welfare</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>P.O. Box 2675</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Harrisburg, PA 17105-2675</td>
<td></td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>Maria Soldevilla</td>
<td>Program Director</td>
<td>Services to Families &amp; Children</td>
<td>(809) 723-2127</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Puerto Rico Dept of Social Svcs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>P.O. Box 11398</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Santurce, PR 00910</td>
<td></td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Linda D'Mario Rossi</td>
<td>Director</td>
<td>Rhode Island Dept for Children and Families</td>
<td>(401) 457-4750</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Providence, RI 02908</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>P.O. Box 1520</td>
<td></td>
</tr>
<tr>
<td>South Carolina</td>
<td>Ramona Foley</td>
<td>Director</td>
<td>Division of Substitute Care</td>
<td>(803) 734-5670</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>South Carolina Dept of Social Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1531 Confederate Avenue</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>P.O. Box 1520</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Columbia, SC 29202-1520</td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>Judith Hines</td>
<td>Program Administrator</td>
<td>Child Protective Services</td>
<td>(701) 224-2316</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Office of Program Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>South Dakota Dept of Social Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>700 Governors Drive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pierre, SD 57501</td>
<td>(605) 771-3227</td>
</tr>
</tbody>
</table>
TENNESSEE
BETTY GAYLE
ASSISTANT COMMISSIONER
SOCIAL SERVICES
TENNESSEE DEPT OF HUMAN SERVICES
CITIZENS PLAZA
400 DEADERICK STREET
NASHVILLE, TN 37248-0001
(615) 741-5924

TEXAS
JANICE CALDWELL, DR.P.H.
EXECUTIVE DIRECTOR
TEXAS DEPT OF PROTECTIVE &
REGULATORY SERVICES
P.O. BOX 149030, M/C W-639
AUSTIN, TX 78714-9030
(512) 450-4435

UTAH
LYNN SAMSEL
DIRECTOR
DIVISION OF FAMILY SERVICES
UTAH DEPARTMENT OF SOCIAL SERVICES
120 NORTH 200 WEST
P.O. BOX 45000
SALT LAKE CITY, UT 84145-0500
(801) 538-4100

VERMONT
STEPHEN R. DALE
DIVISION DIRECTOR
DIVISION OF SOCIAL SERVICES
DEPT OF SOCIAL AND REHABILITATION
SVCS
VERMONT AGENCY OF HUMAN SERVICES
102 SOUTH MAIN STREET
WATERBURY, VT 05676
(802) 241-2251

WYOMING
JIM MITCHELL
ADMINISTRATOR
YOUTH SERVICES DIVISION
WYOMING DEPT OF FAMILY SVCS
HATHAWAY BUILDING
2300 CAPITOL AVENUE
CHEYENNE, WY 82002
(307) 777-6095

WASHINGTON
ANONA JOSEPH
ASSISTANT SECRETARY
CHILDREN'S ADMINISTRATION
WASHINGTON DEPT OF SOCIAL &
HEALTH SERVICES
P.O. BOX 45040
OLYMPIA, WA 98504-5040
(206) 386-4031

WEST VIRGINIA
DIRECTOR
OFFICE OF SOCIAL SERVICES
WEST VIRGINIA DEPARTMENT OF HEALTH
AND HUMAN RESOURCES
BUILDING 6, ROOM 850
STATE CAPITOL COMPLEX
CHARLESTON, WV 25305
(304) 558-7980

WISCONSIN
LINDA HISGEN
DIRECTOR
BUREAU FOR CHILDREN, YOUTH &
FAMILIES
DIVISION OF COMMUNITY SERVICES
wisconsin dept of health & social
svcs
P.O. BOX 7851
MADISON, WI 53707-7850
(608) 266-6799

AMERICA
# APPENDIX E

## State Data Center Programs

The authors wish to thank the United States Department Bureau of the Census for permission to duplicate this list.

State Data Center Program Coordinating Organizations (Includes Business and Industry Data Center Initiative Components)

Since 1978, the State Data Center (SDC) Program has provided training and technical assistance in accessing and using Census data for research, administration, planning, and decisionmaking by the government, the business community, university researchers, and other interested data users. The Business and Industry Data Center (BIDC) Program, initiated in 1988, supports the business community by expanding SDC services to government, academic, and non-profit organizations that directly serve businesses.

The SDC/BIDC organizations also provide additional services denoted by various codes beneath their entry, and defined on the last page.

For more information on the SDC/BIDC programs, contact the Data User Services Division, Bureau of the Census, Washington, D.C. 20233-8300, (301) 763-1580.

March 30, 1994

## ALABAMA

<table>
<thead>
<tr>
<th>SDC/BIDC Organization</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA PUBLIC LIBRARY SERVICE</td>
<td>6030 MONTICELLO DRIVE, MONTGOMERY, AL 36130</td>
</tr>
<tr>
<td>MR. VINCE THACKER</td>
<td>(205) 277-7330</td>
</tr>
<tr>
<td>ALASKA</td>
<td>ALASKA STATE DATA CENTER</td>
</tr>
<tr>
<td>RESEARCH &amp; ANALYSIS</td>
<td>DEPARTMENT OF LABOR</td>
</tr>
<tr>
<td>P.O. BOX 25004</td>
<td>JUNEAU, AK 99802-5504</td>
</tr>
<tr>
<td>*MS. KATHRYN LIZIK</td>
<td>(907) 465-6026</td>
</tr>
<tr>
<td>FAX (907) 465-2101</td>
<td>T, CD, MAP, TGR, NL</td>
</tr>
<tr>
<td>OFFICE OF MANAGEMENT AND BUDGET</td>
<td>DIVISION OF POLICY</td>
</tr>
<tr>
<td>POUCH AD</td>
<td>JUNEAU, AK 99811</td>
</tr>
<tr>
<td>MR. J effrey HEDER</td>
<td>(907) 465-3640</td>
</tr>
<tr>
<td>DEPARTMENT OF EDUCATION</td>
<td>DIVISION OF LIBRARIES AND MUSEUMS</td>
</tr>
<tr>
<td>ALASKA STATE LIBRARY</td>
<td>POUCH G</td>
</tr>
<tr>
<td>JUNEAU, AK 99811</td>
<td>MS. PATIENCE FREDRICKSON</td>
</tr>
<tr>
<td>(907) 465-2927</td>
<td>CD, OL</td>
</tr>
<tr>
<td>DEPARTMENT OF COMMUNITY &amp; REGIONAL AFFAIRS</td>
<td>DIVISION OF MUNICIPAL &amp; REGIONAL ASSISTANCE</td>
</tr>
<tr>
<td>POUCH BH</td>
<td>JUNEAU, AK 99811</td>
</tr>
<tr>
<td>MS. LAURA WALTERS</td>
<td>(907) 465-4750</td>
</tr>
<tr>
<td>CD</td>
<td></td>
</tr>
<tr>
<td>INSTITUTE FOR SOCIAL &amp; ECONOMIC RESEARCH</td>
<td>UNIVERSITY OF ALASKA</td>
</tr>
<tr>
<td>3211 PROVIDENCE DRIVE</td>
<td>ANCHORAGE, AK 99508</td>
</tr>
<tr>
<td>MR. JIM KERR</td>
<td>(907) 766-7770</td>
</tr>
<tr>
<td>T, OL, CD, MAP, TGR</td>
<td></td>
</tr>
<tr>
<td>ARIZONA (BIDC)</td>
<td>ARIZONA DEPARTMENT OF ECONOMIC SECURITY</td>
</tr>
<tr>
<td>DES 045Z</td>
<td>FIRST FLOOR, SOUTHEAST WING</td>
</tr>
<tr>
<td>1789 WEST JEFFERSON ST.</td>
<td>PHOENIX, AZ 85007</td>
</tr>
<tr>
<td>*MS. BETSY JEFFRES</td>
<td>(602) 542-5984</td>
</tr>
<tr>
<td>FAX (602) 542-6474</td>
<td>T, CD, NL, MC</td>
</tr>
<tr>
<td>CENTER FOR BUSINESS RESEARCH</td>
<td>COLLEGE OF BUSINESS ADMINISTRATION</td>
</tr>
<tr>
<td>ARIZONA STATE UNIVERSITY</td>
<td>TEMPE, AZ 85287</td>
</tr>
<tr>
<td>MR. TOM REX</td>
<td>(602) 965-3961</td>
</tr>
</tbody>
</table>

* DENOTES KEY CONTACT SDC
+ DENOTES KEY CONTACT BIDC
ASSOCIATION OF BAY AREA GOVERNMENTS
METRO CENTER
8TH AND OAK STREETS
P.O. BOX 2050
OAKLAND, CA 94604-2050

MS. PATRICIA PERRY
(510) 464-7937
CD, TGR

SOUTHERN CALIFORNIA ASSOCIATION OF GOVERNMENTS
818 WEST 7TH STREET, 12TH FLOOR
LOS ANGELES, CA 90017

MR. JAVIER MINJARES
(213) 236-1800
T, CD, MAP, TGR, MC

SAN DIEGO ASSOCIATION OF GOVERNMENTS
FIRST FEDERAL PLAZA
401 B STREET, SUITE 800
SAN DIEGO, CA 92101

MS. KAREN LAMPHERE
(619) 236-5300
T, CD, MAP, TGR, MC

STATE DATA CENTER PROGRAM
UNIVERSITY OF CALIFORNIA-BERKELEY
2538 CHANNING WAY
BERKELEY, CA 94720

MS. ILONA EINOWSKI/FRED GEY
(510) 642-6571
T, OL, CD, TGR, FT

ASSOCIATION OF MONTEREY BAY AREA GOVERNMENTS
445 RESERVATION ROAD, SUITE G
P.O. BOX 838
MARINA, CA 93933

MR: STEVE WILLIAMS
(408) 883-3750
CD, TGR, MC

COLORADO
DIVISION OF LOCAL GOVERNMENT
COLORADO DEPARTMENT OF LOCAL AFFAIRS
1313 SHERMAN STREET, ROOM 521
DENVER, CO 80203

*MS. REBECCA PICASO
(303) 866-2156
FAX (303) 866-2803
T, CD, OL, MAP

BUSINESS RESEARCH DIVISION
GRADUATE SCHOOL OF BUSINESS ADMINISTRATION
UNIVERSITY OF COLORADO-BOULDER
BOULDER, CO 80309

MS. GINNY HAYDEN
(303) 492-8227

NATURAL RESOURCES & ECONOMICS DEPARTMENT OF AGRICULTURE
COLORADO STATE UNIVERSITY
FORT COLLINS, CO 80523

MS. SUE ANDERSON
(303) 491-5706

DOCUMENTS DEPARTMENT
THE LIBRARIES
COLORADO STATE UNIVERSITY
FORT COLLINS, CO 80523
MS. SUZANNE TAYLOR
(303) 491-1880

CONNECTICUT
POLICY DEVELOPMENT AND PLANNING DIVISION
CONNECTICUT OFFICE OF POLICY AND MANAGEMENT
80 WASHINGTON STREET
HARTFORD, CT 06106-4459

*MR. BILL KRAYNAK
(203) 566-4971
FAX (203) 566-1589
T, MAP, TGR, NL, MC

GOVERNMENT DOCUMENTS
CONNECTICUT STATE LIBRARY
231 CAPITOL AVENUE
HARTFORD, CT 06106

MR. ALBERT PALKO
(203) 566-4971
OL

CAPITOL REGION COUNCIL OF GOVERNMENTS
221 MAIN STREET
HARTFORD, CT 06106

BARBARA MACFARLAND
(203) 522-2217

DELAWARE (BIDC)
DELAWARE DEVELOPMENT OFFICE
99 KINGS HIGHWAY
P.O. BOX 1401
DOVER, DE 19903

*MR. NICK LESLIE
(302) 739-4271
FAX (302) 739-5749
OL, CD, TGR, MC

COLLEGE OF URBAN AFFAIRS AND PUBLIC POLICY
UNIVERSITY OF DELAWARE
GRAHAM HALL, ROOM 286
ACADEMY STREET
NEWARK, DE 19716

MR. ED RATLEDGE
(302) 487-2651
OL, CD, NL

DISTRICT OF COLUMBIA
DATA SERVICES DIVISION
MAYOR'S OFFICE OF PLANNING
ROOM 570, PRESIDENTIAL BLDG.
415 12TH STREET, N.W.
WASHINGTON, DC 20004

*MRS. GAN AHUJA
(202) 727-6533
FAX (202) 727-6964

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
777 NORTH CAPITOL ST. NE, SUITE 300
WASHINGTON, DC 20002-4201

MR. ROBERT GRIFFITHS
MS. CAROL HUSKEY
(202) 962-3200

FLORIDA (BIDC)
FLORIDA STATE DATA CENTER
EXECUTIVE OFFICE OF THE GOVERNOR
REA/OBP
THE CAPITOL, ROOM 1604
TALLAHASSEE, FL 32399-0001

*MS. VALERIE JUGGER
(904) 487-2814
FAX (904) 922-6200
CD, MC

CENTER FOR THE STUDY OF POPULATION INSTITUTE FOR SOCIAL RESEARCH
654 BELLEMY BUILDING,R-93
FLORIDA STATE UNIVERSITY
TALLAHASSEE, FL 32306-4063

DR. IKE EBERSTEIN
(904) 644-1762
CD, TGR, MC

STATE LIBRARY OF FLORIDA
R.A. GRAY BUILDING
TALLAHASSEE, FL 32399-0250

MS. LISA CLOSE
(904) 487-2651
OL, CD, NL

BUREAU OF ECONOMIC ANALYSIS
FLORIDA DEPARTMENT OF COMMERCE
107 WEST GAINES STREET
315 COLLINS BUILDING
TALLAHASSEE, FL 32399-2000

+MR. NICK LESLIE
(302) 739-4271
FAX (302) 739-3014
CD, FT

GEORGIA
DIVISION OF DEMOGRAPHIC & STATISTICAL SERVICES
GEORGIA OFFICE OF PLANNING AND BUDGET
254 WASHINGTON STREET, S.W., ROOM 640
ATLANTA, GA 30334

*MS. MARTY SIK
(404) 636-0911
FAX (404) 636-3828
Services Provided by SDC/BIDC Organizations

GENERAL
T TAPE COPIES, PRINTOUTS, EXTRACTS, AND SOFTWARE FOR ACCESSING AND DOWNLOADING CENSUS DATA.
OL ONLINE DATA SERVICES.
CD CD-ROM PRODUCTS AND SERVICES.

GEOGRAPHIC
MAP MAPPING CAPABILITIES.
MC ABILITY TO COPY CENSUS MAPS.
TGR TIGER

OTHER
NL NEWSLETTER, TECHNICAL JOURNAL.
FT FOREIGN TRADE

NOTE: IF YOU PLAN TO PUBLISH ANY INFORMATION FROM THIS ADDRESS LIST, YOU SHOULD BE AWARE THAT CHANGES ARE MADE REGULARLY. PLEASE CONTACT THE STATE AND REGIONAL PROGRAMS BRANCH OF THE BUREAU OF THE CENSUS AT 301-763-1580 FOR THE LATEST LISTING.
## APPENDIX F
### Statistical Analysis Centers

The authors wish to thank the Drugs and Crime Data Center and Clearinghouse for permission to duplicate this list.

### Alabama
- **Alabama Criminal Justice Information Center**
  - 770 Washington Avenue
  - Montgomery, AL 36130
  - (205) 242-4900

### Alaska
- **University of Alaska**
  - 2211 Providence Drive
  - Anchorage, AK 99508
  - (907) 786-1819

### Arizona
- **Arizona Criminal Justice Commission**
  - 1501 West Washington Street
  - Suite 207
  - Phoenix, AZ 85007
  - (602) 342-1928

### Arkansas
- **Special Services Section**
  - Arkansas Crime Information Center
  - One Capitol Mall
  - Little Rock, AR 72201
  - (501) 682-2222

### California
- **Bureau of Criminal Statistics and Special Services**
  - P.O. Box 903427
  - Sacramento, CA 94203-4270
  - (916) 739-5568

### Colorado
- **Division of Criminal Justice**
  - Dept of Public Safety
  - 700 Kipling Street, Suite 3000
  - Denver, CO 80215
  - (303) 239-4442

### Connecticut
- **Policy Development and Planning Division**
  - Office of Policy Management
  - 80 Washington Street
  - Hartford, CT 06106
  - (203) 566-3522

### Delaware
- **Statistical Analysis Center**
  - 60 The Plaza
  - Dover, DE 19901
  - (302) 739-4846

### District of Columbia
- **Office of Criminal Justice Plans and Analysis**
  - 717 14th Street NW, Suite 500
  - Washington, DC 20005
  - (202) 727-6554

### Florida
- **Uniform Crime Reports Section**
  - Special Services Bureau
  - Florida Dept of Law Enforcement
  - P.O. Box 1489
  - Tallahassee, FL 32302
  - (904) 487-4808

### Georgia
- **Georgia Criminal Justice Coordinating Council**
  - 222 South Vineyard Street
  - Honolulu, HI 96813
  - (808) 548-6714

### Hawaii
- **Crime Prevention Division**
  - Dept of the Attorney General
  - 6111 Clinton Street
  - Boise, ID 83704
  - (208) 334-2162

### Idaho
- **Support Service Bureau**
  - Dept of Law Enforcement
  - 120 South Riverside Plaza
  - Suite 1016
  - Chicago, IL 60606-3997
  - (312) 793-8550

### Illinois
- **Information Resource Center**
  - Illinois Criminal Justice Information Authority
  - 120 South Riverside Plaza
  - Suite 1016
  - Chicago, IL 60606-3997
  - (312) 793-8550

### Iowa
- **Division of Criminal Justice and Juvenile Planning**
  - Lucas State Office Building
  - Des Moines, IA 50319
  - (515) 242-5816

### Kansas
- **Kansas Bureau of Investigation**
  - 120 S. 29th Street
  - Topeka, KS 66612
  - (913) 232-6000

### Kentucky
- **Office of the Attorney General**
  - State Capitol, Room 116
  - Frankfort, KY 40601
  - (502) 564-4002

### Maine
- **Maine Criminal Justice Date Center**
  - Dept of Corrections
  - State House, Station 111
  - Augusta, ME 04333
  - (207) 289-2711

### Maryland
- **Maryland Justice Analysis Center**
  - Institute of Criminal Justice and Criminology
  - University of Maryland
  - College Park, MD 20742
  - (301) 405-4699

### Massachusetts
- **Massachusetts Committee on Criminal Justice**
  - 100 Cambridge Street, Room 2100
  - Boston, MA 02202
  - (617) 727-0237

### Michigan
- **Office of Criminal Justice**
  - Lewis Cass Building
  - P.O. Box 30026
  - Lansing, MI 48909
  - (517) 373-6510

### Minnesota
- **Criminal Justice Statistical Analysis Center**
  - State Planning Agency
  - 638 Cedar Street
  - St Paul, MN 55155
  - (612) 296-7819

### Montana
- **Montana Research Planning Bureau**
  - Board of Crime Control
  - 303 North Roberts Street
  - Helena, MT 59620
  - (406) 444-3604

### Nebraska
- **Uniform Crime Reporting Section**
  - Nebraska Commission on Law Enforcement and Criminal Justice
  - P.O. Box 94946
  - Lincoln, NE 68509
  - (402) 471-3982

### New Hampshire
- **New Hampshire Department of Public Safety**
  - Division of State Police
  - Uniform Crime Report Unit
  - 10 Hazen Drive
  - Concord, NH 03305
  - (603) 273-2093

### New Jersey
- **Division of State Police**
  - Box 7068
  - Trenton, NJ 08628-0068
  - (609) 882-2000

### New York
- **New York State Division of Criminal Justice Services**
  - Statistical Services
  - Executive Park Tower
  - Stuyvesant Plaza
  - Albany, NY 12203
  - (518) 457-8381
## APPENDIX G

### Uniform Crime Reports Contacts

The authors wish to thank the Drugs and Crime Data and Clearinghouse for permission to duplicate this list.

<table>
<thead>
<tr>
<th>State</th>
<th>Agency</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Alabama Criminal Justice Information Center</td>
<td>858 South Court Street, Montgomery, AL 36130</td>
<td>(205) 832-4930</td>
</tr>
<tr>
<td>Alaska</td>
<td>Uniform Crime Reporting Section</td>
<td>5700 East Tudor Road, Anchorage, AK 99507</td>
<td>(907) 269-5659</td>
</tr>
<tr>
<td>Arizona</td>
<td>Arizona Dept of Public Safety</td>
<td>8300 E. McDowell, Phoenix, AZ 85008</td>
<td>(602) 223-2263</td>
</tr>
<tr>
<td>Arkansas</td>
<td>Arkansas Crime Information Center</td>
<td>One Capitol Mall, Little Rock, AR 72201</td>
<td>(501) 682-2222</td>
</tr>
<tr>
<td>California</td>
<td>Bureau of Criminal Statistics</td>
<td>P.O. Box 93427, Sacramento, CA 94203</td>
<td>(916) 739-5166</td>
</tr>
<tr>
<td>Colorado</td>
<td>Colorado Bureau of Investigation</td>
<td>690 Kipling Street, Denver, CO 80215</td>
<td>(303) 239-2300</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Uniform Crime Reporting Program</td>
<td>294 Colony Street, Meriden, CT 06450</td>
<td>(203) 238-6594</td>
</tr>
<tr>
<td>Delaware</td>
<td>Delaware State Police</td>
<td>State Bureau of Identification</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 430, Dover, DE 19903-0430</td>
<td>(302) 739-5876</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>Data Processing Division</td>
<td>Metropolitan Police Department</td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>Uniform Crime Reports Section</td>
<td>Special Services Bureau</td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>Georgia Crime Information Center</td>
<td>Georgia Bureau of Investigation</td>
<td></td>
</tr>
<tr>
<td>Hawaii</td>
<td>Crime Prevention Division</td>
<td>Department of the Attorney General</td>
<td></td>
</tr>
<tr>
<td>Idaho</td>
<td>Criminal Identification Bureau</td>
<td>Department of Law Enforcement</td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>Bureau of Identification</td>
<td>Illinois Department of State Police</td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>Iowa Department of Public Safety</td>
<td>Wallace State Office Building</td>
<td></td>
</tr>
<tr>
<td>Kansas</td>
<td>Kansas Bureau of Investigation</td>
<td>1620 Southwest Tyler Street</td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>Records Section</td>
<td>Kentucky State Police</td>
<td></td>
</tr>
<tr>
<td>Maine</td>
<td>Uniform Crime Reporting Division</td>
<td>Main State Police</td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>Uniform Crime Reporting Section</td>
<td>Central Records Division</td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Criminal History Systems Board</td>
<td>1010 Commonwealth Avenue, Boston, MA 02215</td>
<td>(617) 727-0090</td>
</tr>
<tr>
<td>Michigan</td>
<td>Uniform Crime Reporting Section</td>
<td>Michigan State Police</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>Criminal Justice Information Systems</td>
<td>1246 University Avenue, St. Paul, MN 55104</td>
<td>(612) 642-0670</td>
</tr>
<tr>
<td>Montana</td>
<td>Montana Board of Crime Control</td>
<td>303 North Roberts Street, Helena, MT 59620</td>
<td>(406) 444-3604</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Uniform Crime Reporting Section</td>
<td>Nebraska Commission on Law Enforcement and Criminal Justice</td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>New Hampshire Department of Public Safety</td>
<td>Uniform Crime Report Unit 10 HAZEN DRIVE</td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>Division of State Police</td>
<td>Box 7068, West Trenton, NJ 08628—68</td>
<td>(609) 882-2000</td>
</tr>
<tr>
<td>New York</td>
<td>New York State Division of Criminal Justice Services</td>
<td>Executive Park Tower, Albany, NY 12203</td>
<td>(518) 457-8381</td>
</tr>
</tbody>
</table>
## Appendix H
### Vital Statistics Offices

<table>
<thead>
<tr>
<th>State</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALABAMA</strong></td>
<td>State Department of Public Health, P.O. Box 5625, Montgomery, AL 36103</td>
<td>(205) 613-5418</td>
</tr>
<tr>
<td><strong>ALASKA</strong></td>
<td>Department of Health &amp; Social Services, Bureau of Vital Statistics, P.O. Box 110675, Juneau, AK 99811-0675</td>
<td>(907) 465-3391</td>
</tr>
<tr>
<td><strong>AMERICAN SAMOA</strong></td>
<td>Registrar of Vital Statistics, Pago Pago, AS 96799</td>
<td>(684) 633-1222 Ext 214</td>
</tr>
<tr>
<td><strong>ARIZONA</strong></td>
<td>State Department of Health, P.O. Box 3887, Phoenix, AZ 85030</td>
<td>(602) 255-2501</td>
</tr>
<tr>
<td><strong>ARKANSAS</strong></td>
<td>State Department of Health, 4815 West Markham Street, Little Rock, AR 72201</td>
<td>(501) 661-2336</td>
</tr>
<tr>
<td><strong>CALIFORNIA</strong></td>
<td>State Department of Public Health, 305 S Street, Sacramento, CA 95814</td>
<td>(916) 445-2684</td>
</tr>
<tr>
<td><strong>COLORADO</strong></td>
<td>Colorado Department of Health, 150 Washington Street, Denver, CO 80220</td>
<td>(303) 331-4887</td>
</tr>
<tr>
<td><strong>CONNECTICUT</strong></td>
<td>State Department of Health, 150 Washington Street, Hartford, CT 06106</td>
<td>(203) 566-6545</td>
</tr>
<tr>
<td><strong>DELAWARE</strong></td>
<td>State Department of Health &amp; Social Services, Dover, DE 19901</td>
<td>(302) 739-4721</td>
</tr>
<tr>
<td><strong>DISTRICT OF COLUMBIA</strong></td>
<td>DC Department of Human Resources, Vital Records Section, 613 G Street, NW, 9th Floor, Washington, DC 20001</td>
<td>(202) 727-9281</td>
</tr>
<tr>
<td><strong>FLORIDA</strong></td>
<td>Office of Vital Statistics, P.O. Box 210, Jacksonville, FL 32231</td>
<td>(904) 359-6900</td>
</tr>
<tr>
<td><strong>GEORGIA</strong></td>
<td>Department of Human Resources, Vital Records Services, Atlanta, GA 30334</td>
<td>(404) 656-4900</td>
</tr>
<tr>
<td><strong>GUAM</strong></td>
<td>Department of Public Health &amp; Social Services, Agana, GU 96910</td>
<td>(671) 734-4589</td>
</tr>
<tr>
<td><strong>HAWAII</strong></td>
<td>State Department of Health, P.O. Box 3378, Honolulu, HI 96801</td>
<td>(808) 586-4533</td>
</tr>
<tr>
<td><strong>IDAHO</strong></td>
<td>Bureau of Vital Statistics, State House, Boise, ID 83720</td>
<td>(208) 334-5988</td>
</tr>
<tr>
<td><strong>ILLINOIS</strong></td>
<td>State Department of Public Health, Springfield, IL 62707</td>
<td>(212) 782-6553</td>
</tr>
<tr>
<td><strong>INDIANA</strong></td>
<td>State Department of Health, P.O. Box 1964, Indianapolis, IN 46206</td>
<td>(317) 633-0274</td>
</tr>
<tr>
<td><strong>IOWA</strong></td>
<td>State Department of Health, Des Moines, IA 50319</td>
<td>(515) 281-4944</td>
</tr>
<tr>
<td><strong>KANSAS</strong></td>
<td>Bureau of Vital Statistics, 900 S.W. Jackson, Topeka, KS 66612-2221</td>
<td>(913) 296-1400</td>
</tr>
<tr>
<td><strong>KENTUCKY</strong></td>
<td>Department of Human Resources, Vital Statistics, 275 E. Main Street, Frankfort, KY 40621</td>
<td>(502) 564-4212</td>
</tr>
<tr>
<td><strong>LOUISIANA</strong></td>
<td>Office of Vital Records, P.O. Box 60630, New Orleans, LA 70160</td>
<td>(504) 568-5152</td>
</tr>
<tr>
<td><strong>MAINE</strong></td>
<td>State Department of Health and Welfare, Augusta, ME 04330</td>
<td>(207) 289-3184</td>
</tr>
<tr>
<td><strong>MARYLAND</strong></td>
<td>Division of Vital Records, P.O. Box 68760, Baltimore, MD 21203</td>
<td>(301) 725-5988</td>
</tr>
<tr>
<td><strong>MASSACHUSETTS</strong></td>
<td>Registrar of Vital Statistics, Boston, MA 02111</td>
<td>(617) 734-7388</td>
</tr>
<tr>
<td><strong>MICHIGAN</strong></td>
<td>Office of Vital &amp; Health Statistics, Lansing, MI 48909</td>
<td>(517) 335-8655</td>
</tr>
<tr>
<td><strong>MINNESOTA</strong></td>
<td>State Department of Health, Minneapolis, MN 55440</td>
<td>(612) 623-5121</td>
</tr>
<tr>
<td><strong>MISSISSIPPI</strong></td>
<td>State Board of Health, Jackson, MS 31216</td>
<td>(601) 960-7981</td>
</tr>
<tr>
<td><strong>MISOURI</strong></td>
<td>Department of Health, Bureau of Vital Records, Jefferson City, MO 65102</td>
<td>(314) 751-8400</td>
</tr>
<tr>
<td><strong>MONTANA</strong></td>
<td>State Department of Health, Helena, MT 59620</td>
<td>(406) 444-2614</td>
</tr>
<tr>
<td><strong>NEBRASKA</strong></td>
<td>State Department of Health, P.O. Box 95007, Lincoln, NE 68509-5007</td>
<td>(402) 471-2871</td>
</tr>
<tr>
<td><strong>NEVADA</strong></td>
<td>State Department of Vital Statistics, 505 E. King Street, Room 102, Carson City, NV 89710</td>
<td>(702) 687-4480</td>
</tr>
</tbody>
</table>
APPENDIX I
Primary Contacts for State KIDS COUNT Projects

Funded by the Annie E. Casey Foundation, KIDS COUNT grantees collect and publish data on major indicators of children and family well-being. Each grantee publishes an annual report showing the status of children and families in the state; the Foundation publishes an annual compilation of state data. To obtain the Foundation’s annual KIDS COUNT report, contact the Annie E. Casey Foundation, 701 St. Paul Street, Baltimore, MD 21202; telephone (410) 547-6600. The authors wish to thank the Annie E. Casey Foundation for permission to duplicate this list.

ALABAMA
ART TURNER
PROJECT DIRECTOR—KIDS COUNT
ALABAMA POWER FOUNDATION
P.O. BOX 2641,17N - 0010
BIRMINGHAM, AL 35291
(205) 250-2224
(205) 250-1860 (FAX)

ALASKA
NORM DINGES
UNIVERSITY OF ALASKA—ANCHORAGE INSTITUTE OF SOCIAL AND ECONOMIC RESEARCH
3211 PROVIDENCE DRIVE
ANCHORAGE, AK 99508
(907) 786-7710
(907) 786-7743 (FAX)

ARIZONA
GAIL JACOBS
PROJECT DIRECTOR
CHILDREN'S ACTION ALLIANCE
4001 NORTH 3RD STREET - SUITE 160
PHOENIX, AZ 85012
(602) 266-0707
(602) 263-8792 (FAX)

ARKANSAS
AMY ROSSI
EXECUTIVE DIRECTOR
ARKANSAS ADVOCATES FOR CHILDREN & FAMILIES
103 EAST 7TH STREET - SUITE 931
LITTLE ROCK, AR 72201-4531
(501) 371-9678
(501) 371-9681 (FAX)

CALIFORNIA
AMY ABRAHAM
CHILDREN NOW
1212 BROADWAY - SUITE 530
OAKLAND, CA 94612
(510) 763-2444
(510) 763-1974 (FAX)

COLORADO
SHANNA SHULMAN
KIDS COUNT COORDINATOR
COLORADO CHILDREN'S CAMPAIGN
1600 SHERMAN STREET - SUITE B-300
DENVER, CO 80203-1604
(303) 839-1580
(303) 839-1354 (FAX)

CONNECTICUT
MICHELLE DOUCETTE CUNNINGHAM
KIDS 2000 PROJECT DIRECTOR
CONNECTICUT ASSOCIATION FOR HUMAN SERVICES
880 ASYLUM AVENUE
HARTFORD, CT 06105
(203) 522-7762
(203) 520-4234 (FAX)

DELAWARE
MARY ANN POLING
KIDS COUNT PROJECT DIRECTOR
UNIVERSITY OF DELAWARE
121 TOWNSEND HALL
NEWARK, DE 19717-1303
(302) 831-4966
(302) 831-4987 (FAX)

WASHINGTON, DC
CARRIE L. THORNHILL
PRESIDENT
THE COMMITTEE ON STRATEGIES TO REDUCE CHRONIC POVERTY OF THE GREATER WASHINGTON RESEARCH CENTER
1129 20TH STREET, NW - SUITE 204
WASHINGTON, DC 20036
(202) 466-6680
(202) 466-7967 (FAX)

FLORIDA
KATHY SHANLEY
KIDS COUNT PROJECT DIRECTOR
FLORIDA MENTAL HEALTH INSTITUTE UNIVERSITY OF SOUTH FLORIDA
13301 BRUCE B. DOWNS BLVD
TAMPA, FL 33612
(813) 974-6279
(813) 974-4406 (FAX)

GEORGIA
LAURIE DOPKINS
KIDS COUNT PROJECT DIRECTOR
GEORGIA OFFICE FOR CHILDREN
3091 MAPLE DRIVE - NE - SUITE 114
ATLANTA, GA 30305
(404) 365-8968
(404) 365-9009 (FAX)

HAWAII
MARCIA HARTSOCK
KIDS COUNT PROJECT DIRECTOR
UNIVERSITY OF HAWAII CENTER ON THE FAMILY
2515 CAMPUS ROAD - MILLER HALL 103
HONOLULU, HI 96822
(808) 956-1447 (FAX)

IDAHO
SHARON H. HIXON
IDAH0 OFFICE FOR CHILDREN
1109 MAIN STREET - 4TH FLOOR
BOISE, IDAHO 83720-7000
(208) 334-2613
(208) 334-3267 (FAX)

ILLINOIS
AMI NAGLE
VOICES FOR ILLINOIS CHILDREN
208 S. LASALLE STREET - SUITE 1580
CHICAGO, IL 60604
(312) 456-0060
(312) 456-0088 (FAX)

INDIANA
JUDITH ERICKSON
DIRECTOR OF RESEARCH SERVICES
INDIANA YOUTH INSTITUTE
333 N. ALABAMA AVENUE - SUITE 200
INDIANAPOLIS, IN 46204
(317) 634-4222
(317) 685-2264 (FAX)

IOWA
MIKE CRAWFORD
KIDS COUNT PROJECT DIRECTOR
CHILD & FAMILY POLICY CENTER
100 COURT AVENUE, SUITE 312
DES MOINES, IA 50309
(515) 280-9027
(515) 243-5941 (FAX)

KANSAS
JOYCE MARTIN
KIDS COUNT PROJECT DIRECTOR
KANSAS ACTION FOR CHILDREN
715 S. W. 10TH STREET
P. O. BOX 463
TOPEKA, KS 66601-0463
(913) 232-0550
(913) 232-0699 (FAX)

KENTUCKY
DEBRA MILLER
DEPUTY DIRECTOR
KENTUCKY YOUTH ADVOCATES, INC.
624 SHELBY STREET
FRANKFORT, KY 40601
(502) 875-4865
(502) 875-2507 (FAX)
David Richart  
Executive Director  
Kentucky Youth Advocates, Inc.  
2034 Frankfort Avenue  
Louisville, KY 40206  
(502) 895-8167  
(502) 895-8225 (FAX)

Judy Watts  
President & CEO  
Agenda for Children  
P.O. Box 51837  
New Orleans, LA 70151  
(504) 586-8509  
(504) 895-8225 (FAX)

Kris Sahonchik  
Maine Children’s Alliance  
University of Southern Maine  
Center for Child & Family Policy  
96 Falmouth Street  
Portland, ME 04103  
(207) 780-4430  
(207) 780-4417 (FAX)

Ellie Goldberg  
Executive Director  
Maine Children’s Alliance  
PO Box 2446  
Augusta, ME 04338  
(207) 775-2500  
(207) 623-1868 (FAX)

Mary Lou McPherson  
Michigan State University Kids  
Count Coordinator  
Institute for Children, Youth & Families  
300 N. Washington Square - Suite 401  
Lansing, MI 48933  
(517) 353-6617  
(517) 432-2022 (FAX)

Minnestoa  
Diane Benjamin  
Kids Count Director  
Children’s Defense Fund - Minnesota  
550 Rice Street  
St. Paul, MN 55103  
(612) 227-6121  
(612) 227-2553 (FAX)

Carolyn Hendrixson  
Congregations Concerned for Children  
Greater Minneapolis Council of Churches  
122 West Franklin Avenue - Suite 218  
Minneapolis, MN 55404  
(612) 870-3660  
(612) 870-3663 (FAX)

Mississippi  
Alma Ellis  
Kids Count Project Coordinator  
Mississippi Forum on Children & Families  
585 Woodland Hills Building  
3000 Old Canton Road  
Jackson, MS 39216  
(601) 366-9083  
(601) 982-8053 (FAX)

Missouri  
Ruth Ehresman  
Director of Program  
Citizens for Missouri’s Children  
2717 Sutton Avenue - Suite 200  
St. Louis, MO 63143  
(314) 647-2003  
(314) 644-5437 (FAX)

Montana  
Elizabeth Roeth  
Executive Director  
Healthy Mothers, Healthy Babies  
The Montana Coalition  
P.O. Box 876  
Helena, MT 59624  
(406) 449-6611  
(406) 449-3703 (FAX)

Nebraska  
Kay Snyder Moore  
Executive Director  
Voices for Children in Nebraska  
7521 Main Street - Suite 103  
Omaha, NE 68127  
(402) 597-3100  
(402) 597-2705 (FAX)

Keith Mueller  
Dept of Preventive & Societal Medicine  
University of Nebraska Medical Center  
600 South 42nd Street  
Omaha, NE 68198-4350  
(402) 559-5260  
(402) 597-2705 (FAX)

New Hampshire  
Cheyne Foreman  
Kids Count Director  
The New Hampshire Alliance for Children & Youth  
125 Airport Road  
Concord, NH 03301  
(603) 225-0900  
(603) 225-4346 (FAX)

New Jersey  
Eloisa Hernandez  
Kids Count Director  
New Mexico Advocates for Children & Families  
PO Box 2666  
Albuquerque, NM 87125-6666  
(505) 841-1710  
(505) 841-1702 (FAX)

New Mexico  
Alice Otero  
Kids Count Director  
New Mexico Advocates for Children & Families  
PO Box 2666  
Albuquerque, NM 87125-6666  
(505) 841-1710  
(505) 841-1702 (FAX)

New York  
Camille Wood  
Kids Count Administrator  
Greene County Youth Bureau  
HC85 Box 910  
Cairo, NY 12144  
(518) 622-3430  
(518) 622-9834 (FAX)

North Carolina  
Julie Rehder  
Program Manager  
North Carolina Child Advocacy Institute  
1318 Dale Street - Suite 110  
Raleigh, NC 27605-1275  
(919) 834-6623  
(919) 829-7299 (FAX)

North Dakota  
Ann Lochner - Director  
North Dakota Kids Count!  
University of North Dakota  
Gillette Hall, RM 3  
P.O. Box 7090  
Grand Forks, ND 58202-7090  
(701) 777-4086  
(701) 777-4257 (FAX)
## APPENDIX J
### Standard Certificate of Birth

<table>
<thead>
<tr>
<th>U.S. STANDARD CERTIFICATE OF LIVE BIRTH</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CHILD'S NAME (First, Middle, Last)</td>
<td></td>
</tr>
<tr>
<td>2. DATE OF BIRTH (Month, Day, Year)</td>
<td></td>
</tr>
<tr>
<td>3. TIME OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>4. SEX</td>
<td></td>
</tr>
<tr>
<td>5. CITY, TOWN, OR LOCATION OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>6. COUNTY OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>7. PLACE OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>□ Hospital</td>
<td></td>
</tr>
<tr>
<td>□ Freestanding Birthing Center</td>
<td></td>
</tr>
<tr>
<td>□ Clinic/Doctor's Office</td>
<td></td>
</tr>
<tr>
<td>□ Resident</td>
<td></td>
</tr>
<tr>
<td>□ Other (Specify)</td>
<td></td>
</tr>
<tr>
<td>8. FACILITY NAME of not institution, give address and number</td>
<td></td>
</tr>
<tr>
<td>9. I certify that this child was born alive at the place and time and on the date stated.</td>
<td></td>
</tr>
<tr>
<td>10. DATE SIGNED (Month, Day, Year)</td>
<td></td>
</tr>
<tr>
<td>11. ATTENDANT'S NAME AND TITLE (If other than certified (Type/Print) Name</td>
<td></td>
</tr>
<tr>
<td>□ M.D.</td>
<td></td>
</tr>
<tr>
<td>□ D.O.</td>
<td></td>
</tr>
<tr>
<td>□ C.N.M.</td>
<td></td>
</tr>
<tr>
<td>□ Other Midwife</td>
<td></td>
</tr>
<tr>
<td>□ Other (Specify)</td>
<td></td>
</tr>
<tr>
<td>12. CERTIFIER'S NAME AND TITLE (Type/Print)</td>
<td></td>
</tr>
<tr>
<td>□ M.D.</td>
<td></td>
</tr>
<tr>
<td>□ D.O.</td>
<td></td>
</tr>
<tr>
<td>□ Hospital Admin.</td>
<td></td>
</tr>
<tr>
<td>□ C.N.M.</td>
<td></td>
</tr>
<tr>
<td>□ Other Midwife</td>
<td></td>
</tr>
<tr>
<td>□ Other (Specify)</td>
<td></td>
</tr>
<tr>
<td>13. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)</td>
<td></td>
</tr>
<tr>
<td>14. REGISTRAR'S SIGNATURE</td>
<td></td>
</tr>
<tr>
<td>15a. MOTHER'S NAME (First, Middle, Last)</td>
<td></td>
</tr>
<tr>
<td>15b. MAIDEN SURNAME</td>
<td></td>
</tr>
<tr>
<td>16a. BIRTHPLACE (State or Foreign Country)</td>
<td></td>
</tr>
<tr>
<td>16b. RESIDENCE—STATE</td>
<td></td>
</tr>
<tr>
<td>16c. COUNTY</td>
<td></td>
</tr>
<tr>
<td>16d. CITY, TOWN, OR LOCATION</td>
<td></td>
</tr>
<tr>
<td>17. DATE OF BIRTH (Month, Day, Year)</td>
<td></td>
</tr>
<tr>
<td>18. DATE FILED BY REGISTRAR (Month, Day, Year)</td>
<td></td>
</tr>
<tr>
<td>19a. STREET AND NUMBER</td>
<td></td>
</tr>
<tr>
<td>19b. INSIDE CITY LIMITS? (Yes or no)</td>
<td></td>
</tr>
<tr>
<td>20. MOTHER'S MAILING ADDRESS (Same as residence, enter Zip Code)</td>
<td></td>
</tr>
<tr>
<td>21. FATHER'S NAME (First, Middle, Last)</td>
<td></td>
</tr>
<tr>
<td>22. DATE OF BIRTH (Month, Day, Year)</td>
<td></td>
</tr>
<tr>
<td>23. BIRTHPLACE (State or Foreign Country)</td>
<td></td>
</tr>
<tr>
<td>24. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. Signature of Parent or Other Informant</td>
<td></td>
</tr>
</tbody>
</table>

(Continued on next page)
### INFORMATION FOR MEDICAL AND HEALTH USE ONLY

#### 20. PREGNANCY HISTORY

<table>
<thead>
<tr>
<th>LIVE BIRTHS</th>
<th>OTHER TERMINATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Do not include this child)</td>
<td>(Spontaneous and induced at any time after conception)</td>
</tr>
</tbody>
</table>

#### 21. MEDICAL RISK FACTORS FOR THIS PREGNANCY

(Check all that apply)

- Anemia (Hgb. <10g. <10 g.)
- Cardiac disease
- Acute or chronic lung disease
- Diabetes
- Gestational diabetes
- Hypertension
- Preeclampsia
- Toxemia
- Uterine bleeding

#### 22. OTHER RISK FACTORS FOR THIS PREGNANCY

(Complete all risks)

- Tobacco use during pregnancy: Yes/No
- Average number of cigarettes per day
- Alcohol use during pregnancy: Yes/No
- Average number of drinks per week
- Weight gained during pregnancy, lbs.

#### 23. OBSTETRIC PROCEDURES

(Check all that apply)

- Amenorrhea
- Electronic fetal monitoring
- Induction of labor
- Simulation of labor
- Tocolysis

#### 24. MEDICAL HISTORY (Specify each section)

- 25. MOOTHER MARRED? (At birth, conception, or any time between) Yes/No

#### 26. DATE OF LAST LIVE BIRTH

(month, year)

#### 27. EDUCATION

(Specify only highest grade completed)

- Elementary/Secondary (0-12)
- College (1-4 or 5+)

#### 28. RACE—American Indian, Black, White, etc.

(Specify below)

- American Indian
- Black, etc.
- White

#### 29. RACE—Specify: Hispanic

(Specify only highest grade completed)

- American Indian
- Black, etc.
- White

#### 30. DATE LAST NORMAL MENSTRUAL PERIOD

(month, year)

#### 31. MONTH OF PREGNANCY PRENATAL CARE BEGAIN—First, Second, Third, etc. (Specify)

#### 32. PRENATAL VISITS—Total Number

(Do not include this child)

#### 33. BIRTH WEIGHT (Specify unit)

#### 34. CLINICAL ESTIMATE OF GESTATION (Weeks)

#### 35. METHOD OF DELIVERY (Check all that apply)

- Vacuum
- Forceps
- breech

#### 36. ABNORMAL CONDITIONS OF THE NEWBORN

(Check all that apply)

- Anemia (Hgb. <10 g.
- Maternal diabetes
- Hypertension
- Preeclampsia
- Toxemia
- Uterine bleeding

#### 37. CONGENITAL ANOMALIES OF CHILD

(Complete all risks)

- Anemia (Hgb. <10 g.
- Maternal diabetes
- Hypertension
- Preeclampsia
- Toxemia
- Uterine bleeding

#### 38. MEDICAL RISK FACTORS FOR THIS PREGNANCY

(Check all that apply)

- Anemia (Hgb. <10 g.
- Cardiac disease
- Acute or chronic lung disease
- Diabetes
- Gestational diabetes
- Hypertension
- Preeclampsia
- Toxemia
- Uterine bleeding

#### 39. OBSTETRIC PROCEDURES

(Check all that apply)

- Amenorrhea
- Electronic fetal monitoring
- Induction of labor
- Simulation of labor
- Tocolysis

#### 40. COMPLICATIONS OF LABOR AND/OR DELIVERY

(Check all that apply)

- Dental problems
- Birth defects
- Other medical problems

#### 41. METHOD OF DELIVERY (Check all that apply)

- Vacuum
- Forceps
- breech

#### 42. ABNORMAL CONDITIONS OF THE NEWBORN

(Check all that apply)

- Anemia (Hgb. <10 g.
- Maternal diabetes
- Hypertension
- Preeclampsia
- Toxemia
- Uterine bleeding

#### 43. CONGENITAL ANOMALIES OF CHILD

(Complete all risks)

- Anemia (Hgb. <10 g.
- Maternal diabetes
- Hypertension
- Preeclampsia
- Toxemia
- Uterine bleeding

#### 44. MEDICAL RISK FACTORS FOR THIS PREGNANCY

(Check all that apply)

- Anemia (Hgb. <10 g.
- Cardiac disease
- Acute or chronic lung disease
- Diabetes
- Gestational diabetes
- Hypertension
- Preeclampsia
- Toxemia
- Uterine bleeding

#### 45. OBSTETRIC PROCEDURES

(Check all that apply)

- Amenorrhea
- Electronic fetal monitoring
- Induction of labor
- Simulation of labor
- Tocolysis

#### 46. MEDICAL HISTORY (Specify each section)

- 27. EDUCATION

(Specify only highest grade completed)

- Elementary/Secondary (0-12)
- College (1-4 or 5+)

#### 28. RACE—American Indian, Black, White, etc.

(Specify below)

- American Indian
- Black, etc.
- White

#### 29. RACE—Specify: Hispanic

(Specify only highest grade completed)

- American Indian
- Black, etc.
- White

#### 30. DATE LAST NORMAL MENSTRUAL PERIOD

(month, year)

#### 31. MONTH OF PREGNANCY PRENATAL CARE BEGAIN—First, Second, Third, etc. (Specify)

#### 32. PRENATAL VISITS—Total Number

(Do not include this child)

#### 33. BIRTH WEIGHT (Specify unit)

#### 34. CLINICAL ESTIMATE OF GESTATION (Weeks)

#### 35. METHOD OF DELIVERY (Check all that apply)

- Vacuum
- Forceps
- breech

#### 36. ABNORMAL CONDITIONS OF THE NEWBORN

(Check all that apply)

- Anemia (Hgb. <10 g.
- Maternal diabetes
- Hypertension
- Preeclampsia
- Toxemia
- Uterine bleeding

#### 37. CONGENITAL ANOMALIES OF CHILD

(Complete all risks)

- Anemia (Hgb. <10 g.
- Maternal diabetes
- Hypertension
- Preeclampsia
- Toxemia
- Uterine bleeding

#### 38. MEDICAL RISK FACTORS FOR THIS PREGNANCY

(Check all that apply)

- Anemia (Hgb. <10 g.
- Cardiac disease
- Acute or chronic lung disease
- Diabetes
- Gestational diabetes
- Hypertension
- Preeclampsia
- Toxemia
- Uterine bleeding

#### 39. OBSTETRIC PROCEDURES

(Check all that apply)

- Amenorrhea
- Electronic fetal monitoring
- Induction of labor
- Simulation of labor
- Tocolysis
REFERENCES


**Improved Outcomes for Children Project**

This project works with states and local communities that are trying to reform both their educational and human services systems to ensure that children arrive at school, everyday, ready to learn. The project uses a five-part framework to help communities enact long-term reforms:

- identify outcomes and remain accountable for results,
- develop collaborative governance structures at the state and local level,
- provide effective services and supports,
- develop financing strategies that support long-term reform, and
- develop the capacity of professionals and lay people to work in a reformed system.

**Products**

<table>
<thead>
<tr>
<th>Products</th>
<th>Basic Design/Systems Approach</th>
<th>How to's/Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OVERALL FRAMEWORK</strong></td>
<td>• A Framework for Improving Outcomes for Families and Children</td>
<td>• Diagnostic Checklist for States, Schools and Communities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community Resource Guide to Improving Results for Children, Youth, and Families</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Building Capacity for Community Partnerships</td>
</tr>
<tr>
<td><strong>OUTCOMES</strong></td>
<td>• The Case for Shifting to Results-Based Accountability</td>
<td>• Finding the Data: A Start-Up List of Outcome Measures with Annotations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Moving to Accountability</td>
</tr>
<tr>
<td><strong>GOVERNANCE</strong></td>
<td>• Collaborative Strategies in Five Communities of the National Alliance for Restructuring Education</td>
<td>• First Steps: Beginning the Process of Community Governance</td>
</tr>
<tr>
<td></td>
<td>• Changing Governance to Achieve Better Results for Children and Families</td>
<td></td>
</tr>
<tr>
<td><strong>SERVICES AND SUPPORTS</strong></td>
<td>• Services and Supports to Improve Outcomes for Families and Children</td>
<td>• Providing Services and Supports for Children, Youth and Families: What Schools Can Do</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Achieving the Goal of Every Young Child Ready for School: A Community Planning Guide</td>
</tr>
<tr>
<td><strong>FINANCING</strong></td>
<td>• Financing Reform of Family and Children's Services: An Approach to the Systematic Consideration of Financing Options</td>
<td>• A Strike for Independence: How a Missouri School District Generated Two Million Dollars to Improve the Lives of Children</td>
</tr>
<tr>
<td></td>
<td>• From Outcomes to Budgets: An Approach to Outcome-Based Budgeting for Family and Children's Services</td>
<td></td>
</tr>
<tr>
<td><strong>PROFESSIONAL DEVELOPMENT</strong></td>
<td>• A Staff Development Framework</td>
<td>• Draft Curriculum for Family-Centered Training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Needs and Resources Assessment for Family-Centered Training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lessons Learned</td>
</tr>
</tbody>
</table>

(Forthcoming products are in italics. Please contact CSSP for ordering information.)
I. DOCUMENT IDENTIFICATION:

Title: Finding the Data

Author(s): Center for the Study of Social Policy

Corporate Source: Same as author

Publication Date: 1995

II. REPRODUCTION RELEASE:

In order to disseminate as widely as possible timely and significant materials of interest to the educational community, documents announced in the monthly abstract journal of the ERIC system, Resources in Education (RIE), are usually made available to users in microfiche, reproduced paper copy, and electronic/optical media, and sold through the ERIC Document Reproduction Service (EDRS) or other ERIC vendors. Credit is given to the source of each document, and, if reproduction release is granted, one of the following notices is affixed to the document.

If permission is granted to reproduce and disseminate the identified document, please CHECK ONE of the following two options and sign at the bottom of the page.

Check here For Level 1 Release:
Permitting reproduction in microfiche (4" x 6" film) or other ERIC archival media (e.g., electronic or optical) and paper copy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

Sample

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

Check here For Level 2 Release:
Permitting reproduction in microfiche (4" x 6" film) or other ERIC archival media (e.g., electronic or optical), but not in paper copy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN OTHER THAN PAPER COPY HAS BEEN GRANTED BY

Sample

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

Documents will be processed as indicated provided reproduction quality permits. If permission to reproduce is granted, but neither box is checked, documents will be processed at Level 1.

"I hereby grant to the Educational Resources Information Center (ERIC) nonexclusive permission to reproduce and disseminate this document as indicated above. Reproduction from the ERIC microfiche or electronic/optical media by persons other than ERIC employees and its system contractors requires permission from the copyright holder. Exception is made for non-profit reproduction by libraries and other service agencies to satisfy information needs of educators in response to discrete inquiries."

Signature: Cheryl Rogers

Printed Name/Position/Title: Cheryl Rogers Sr. Associate

Organization/Address: CSSP
1250 Eye St NW #503
Wash, DC 20005

Telephone: 202/371-1565
Fax: 202/371-1972
E-Mail Address: D:

Date: 7/1/96

(over)
III. DOCUMENT AVAILABILITY INFORMATION (FROM NON-ERIC SOURCE):

If permission to reproduce is not granted to ERIC, or, if you wish ERIC to cite the availability of the document from another source, please provide the following information regarding the availability of the document. (ERIC will not announce a document unless it is publicly available, and a dependable source can be specified. Contributors should also be aware that ERIC selection criteria are significantly more stringent for documents that cannot be made available through EDRS.)

Publisher/Distributor:

Address:

Price:

IV. REFERRAL OF ERIC TO COPYRIGHT/REPRODUCTION RIGHTS HOLDER:

If the right to grant reproduction release is held by someone other than the addressee, please provide the appropriate name and address:

Name:

Address:

V. WHERE TO SEND THIS FORM:

Send this form to the following ERIC Clearinghouse:

However, if solicited by the ERIC Facility, or if making an unsolicited contribution to ERIC, return this form (and the document being contributed) to:

ERIC Processing and Reference Facility
1301 Piccard Drive, Suite 100
Rockville, Maryland 20850-4305

Telephone: 301-258-5500
FAX: 301-948-3695
Toll Free: 800-799-3742
e-mail: ericfac@inet.ed.gov

(Rev. 3/96/96)