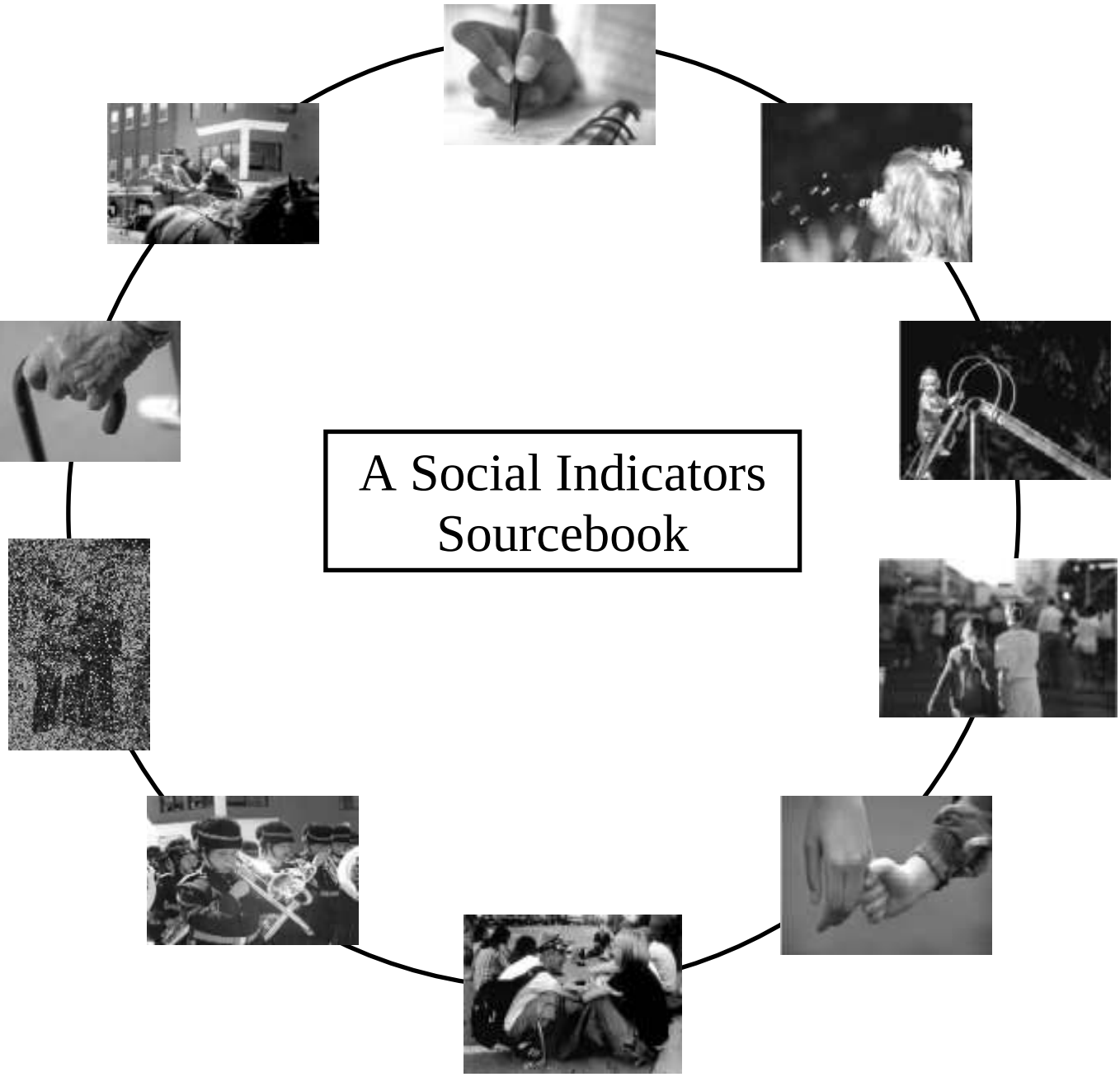
Vermont Well-Being 2006



A Social Indicators Sourcebook

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This report can be accessed through the World Wide Web:
http://humanservices.vermont.gov

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Cynthia D. LaWare, Secretary

June, 2006

Dear Vermonters,

Our core mission at the Agency of Human Services (AHS) is service, and we are committed to continuous enhancement of the services we provide. Our goal is to deliver on the high expectations of our clients and our community partners, and ultimately, improve the well-being of all Vermonters. Our work is aligned around four key practices: holistic service; customer focused; strength-based relationships; and results-oriented processes. And these key practices are targeted toward measurable indicators of well-being, grouped under fundamental outcomes important to the people we serve.

Those familiar with the work of AHS know that we, together with our community partners, were early adopters of an outcomes-based approach. Central to this work is having regular, reliable, and timely data on the indicators at statewide and local levels; an understanding of what's driving current trends; and, knowing what it will take to sustain progress.

This year's annual report, *Vermont Well-Being 2006*, has undergone a major redesign, to reflect the desire of many of our partners to consolidate a number of separate indicator reports.

Let me highlight here some of the features of this new document: For each of the Agency's ten outcomes you will see a number of indicators. Where possible, we present statewide trend data on the indicator as compared to national and international data. We then give some brief narrative context. Whenever available, we present "Data by Vermont Region" and we provide links to other resources related to the indicator.

By definition, these indicators are ones for which progress is achievable only by the combined efforts of public and private agencies, community-based organizations, and individuals. Performance measures, in contrast, are those measures that a single agency or program uses to demonstrate progress toward client outcomes and ensure accountability. Along those lines, the Agency of Human Services has adopted an "AHS Scorecard" which will be updated annually (see p. 2). Thus, we identify the "Related AHS Performance Measure," for those indicators where the Agency has committed to measuring its contribution to success.

Please let us know if the information contained in this report and the format support *your* efforts to make Vermont an even better place to live and work.

Sincerely,

Cynthia D. LaWare

Cynthia D. LaWare, Secretary
Agency of Human Services

VERMONT

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Introduction

Governing by results or outcomes is taking hold in many states and communities, and part of that development is the recognition of the importance of social indicators. These are the tools with which we take our bearings, chart and correct our course, and monitor conditions around us on an ongoing basis. Indeed, sometimes these are the *only* reasonably reliable instruments to help us see our way through the ever-shifting conditions of economic and social trends, public policy, and political rhetoric. The social indicators we have are certainly not perfect—in fact, they're often crudely conceived, slow to respond, and maddeningly imprecise. Nevertheless, we depend upon them to give us the best possible "reading" of where we are and where we're headed.

What constitutes success on any given indicator? In this report the context is Vermont's past performance, our standing relative to national norms, and (where available) our standing relative to other states. It is arguable that this approach sets our sights too low—that we risk being only "the best of a bad bunch." In some cases, state or national goals can point to a higher standard; in other cases, we can point to other countries that demonstrate what is achievable. For certain indicators, it is abundantly clear what the standard *should* be: *zero* child abuse, for example.

We try here to provide for each indicator a "story behind the data." This may highlight particular measurement issues, as well as related trends and strategies effective in "bending the curve" on that indicator. Of course, for each indicator there is much more to the "story" than what's here; in particular, there are local "stories" behind many indicators that account for variation in performance by region. We encourage interested readers to investigate these. Likewise, we have given some suggestions for readers interested in gaining further information about many of the indicators; these are only starting-points.

Users of this report should be aware of some cautions. Complex issues underlie many of the indicators, making it not always easy to agree on what is desirable. For example, while placement in regular classrooms may be appropriate for many children with disabilities, for others it is not; ever-higher rates of classroom inclusion, therefore, may or may not be a good thing. Because of Vermont's small population, there can be sizable year-to-year fluctuations in rates, particularly for "rare events," such as infant mortality. This issue is even more pronounced with data for sub-state regions; readers are advised that multi-year trends present a more balanced picture of performance. Just as state rankings can be misleading, particularly for single years, since they may mask relatively small differences among the states, so users are cautioned in making inferences about differences among sub-state regions on any indicator; even apparently large differences may not be statistically significant.

Ideally, data like these raise more questions than they answer. We hope they inspire our collective efforts to further improve well-being for Vermonters.

AHS Scorecard

	Previous Period's Data (statewide)	Most Recent Data (statewide)	Percent Change
Pregnant Women and Young Children Thrive			
Decrease the percentage of women enrolled in WIC who smoke in the last 3 months of pregnancy	33.3 (2003)	29.9 (2004)	-10%
Decrease the percentage of 2- to 4-year-olds enrolled in WIC who are overweight or at risk for obesity	30.2 (2003)	30.1 (2004)	0
Increase the percentage of two-year-olds who are fully immunized	90 (2003)	85 (2004)	-6%
Children Are Ready for School			
Increase the percentage of kindergartners who are judged "ready for school"	52 (2004)	42 (2005)	-19%
Children Succeed in School			
Increase the high school graduation rate	84.4 (2003)	85.2 (2004)	1%
Children Live in Safe and Supported Families			
Decrease the rate (per 1,000) of children in state custody	8.4 (2003)	8.1 (2004)	-4%
Youth Choose Healthy Behaviors			
Decrease the percentage of students in grades 8-12 who are overweight or at risk for obesity	26 (2003)	24 (2005)	-8%
Decrease the percentage of students in grades 8-12 who used marijuana in the past 30 days	25 (2003)	22 (2005)	-12%
Decrease the percentage of students in grades 8-12 who drank alcohol in the past 30 days	39 (2003)	37 (2005)	-5%
Decrease the percentage of students in grades 8-12 who report depression symptoms	23 (2003)	22 (2005)	-4%

	Previous Period's Data (statewide)	Most Recent Data (statewide)	Percent Change
Youth Successfully Transition to Adulthood			
Decrease the percentage of first births to unmarried teens without a high school diploma	7.8 (2002)	5.0 (2003)	-36%
Decrease the number of young adults (<20) who are first-time entrants into corrections custody	844 (FY04)	782 (FY05)	-7%
Adults Lead Healthy and Productive Lives			
Increase employment rate among adults receiving Reach Up services	24.9% (FFY04)	26.0% (FFY05)	4%
Decrease the percentage of Vermonters who smoke	19.5 (2003)	19.9 (2004)	2%
Decrease the percentage of adults who are "binge" drinkers	16.5 (2003)	16.1 (2004)	-2%
Elders and People With Disabilities Live With Dignity and Independence in Settings They Prefer			
Increase proportion of children with disabilities who live with their families		data under development	
Increase proportion of elders and people with disabilities receiving state-funded services in home and community-based settings		data under development	
Increase employment rate among adults receiving CRT, VR, BVI, DD and TBI services		data under development	
Communities Provide Safety and Support to Families and Individuals			
Reduce rate of new crimes committed within 3 years' of release	52% (2000 releases)	54% (2001 releases)	4%
Decrease the # of Vermonters incarcerated per 100,000 population	226 (2003)	233 (2004)	3%
Decrease the # of bed-nights in Vermont's homeless shelters	100,028 (2004)	101,647 (2005)	2%

Families, Youth, and Individuals Are Involved in Their Community's Decisions and Activities

All across Vermont (and, indeed, in many other states), communities are re-designing themselves, as they envision the kinds of outcomes they want for their families and individuals, develop systems to monitor their progress, and re-configure their resources to achieve measurable results. Of course, Vermont has a long tradition of small-town democracy, exemplified by Town Meetings, on which to build.

Unfortunately, there are warning signs that some of the supports for our democratic traditions are eroding. An increasing number of unfilled vacancies and uncontested races for local offices attests to the difficulty many people have making this civic contribution. Cynicism about the role of government, time pressures, and concerns about being targets for criticism all contribute to this reluctance.

Another disturbing trend is that the lowest rates of voter turnout are among the youngest voters—those aged 18 to 24. In 2004, only 42% of eligible voters in this age-group voted nationwide.[1] In order to reverse this trend, we need to help youth develop "civic competence"—the motivation, knowledge, and skills to get involved in their communities, including participating in the political system.

The other indicators available for this outcome come from a biannual survey of Vermont youth in grades 8-12. One focuses on the extent to which youth believe students are involved in decision-making at their school. Another measures youth participation in volunteer activities in their communities. Yet another looks at how frequently parents talk with their children about school.

National data show that many Americans participate as volunteers in their communities: more than one in four (28%) say they volunteered between September, 2001, and September, 2002. Rates of volunteering were highest among 35- to 54-year-olds, and higher among women than men.[2] In Vermont, over half (55%) of the respondents in a recent statewide telephone survey indicated they participated in volunteer work in the past year.[3] Unfortunately, we don't have reliable, statewide data on the many ways adult Vermonters are engaged in their communities, nor (except in the case of voting) are we able to compare Vermont with other states on this outcome, but this section begins to track an important dimension of community life.

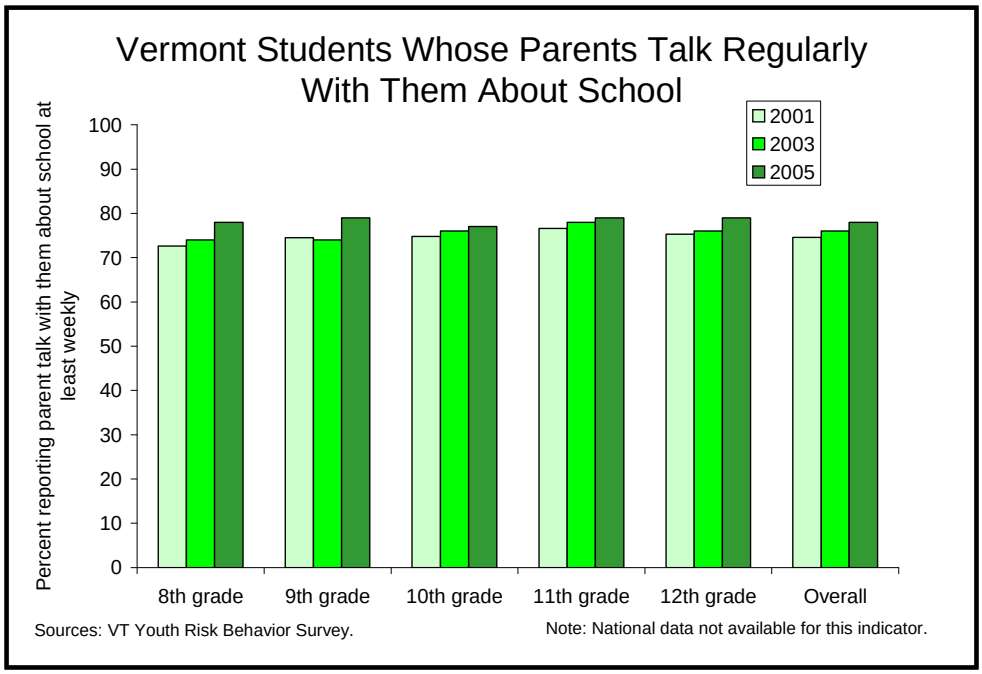
[1] U.S. Bureau of the Census. Voting and registration in the election of November 2004. Washington, DC.

[2] Bureau of Labor Statistics. Volunteering in the United States. United States Department of Labor. Washington, DC, December 2002.

[3] Bolduc V, & Kessel H. Pulse of Vermont: Quality of life study 2005. Prepared by the Center for Social Science Research at Saint Michael's College on behalf of the Vermont Business Roundtable. South Burlington, VT, 2005.

What We Want: Families, Youth, and Individuals Are Engaged in Their Community's Decisions and Activities

How We Measure Our Success:



	8th grade	9th grade	10th grade	11th grade	12th grade	Overall
2001	73	75	75	77	75	75
2005	78	79	77	79	79	78

The Story Behind the Data

Children whose parents are involved in their education, regardless of family income or background, are more likely to succeed—having regular attendance, earning better grades, and completing more years of schooling.[1] Young people who report feeling "connected" with their parents are less likely to engage in risky behaviors. Parental expectations regarding school achievement are also associated with lower levels of students' risk behaviors.[2]

Unfortunately, many types of parental involvement decline as children progress through school, in spite of evidence that adolescents, just as much as younger children, need their parents' continued support. For this indicator, at least, Vermont does not see this trend, which is encouraging. However, about one in five students reports talking about school with parents less than once a week.[3]

Data by Vermont Region

VT Counties	Grades 8-12		
	2001	2003	2005
Addison	72	75	76
Bennington	74	73	76
Caledonia	74	74	76
Chittenden	78	78	81
Essex	70	76	n/a
Franklin	70	72	73
Grand Isle	75	74	75
Lamoille	75	74	78
Orange	73	76	78
Orleans	70	70	73
Rutland	75	75	77
Washington	75	77	76
Windham	74	75	79
Windsor	75	76	79

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

For Additional Information

For more Vermont Youth Risk Behavior Survey data, go to www.state.vt.us/adap/yrbs2005statewidereport.pdf.

For more information about what works in promoting positive youth development, go to http://humanservices.vermont.gov/publications/what-works-promoting-positive-youth-development-in-your-community/view

[1] Henderson AT, & Mapp KL. A new wave of evidence: The impact of school, family, and community connections on student achievement. Southwest Educational Development Laboratory. 2002. Available at www.sedl.org/pubs/catalog/items/fam33.html.

[2] Resnick MD, Bearman PS, Blum R Wm, Bauman KE., Harris KM., Jones J, Tabor J, Beuhring T, Sieving RE, Shew M, Ireland M, Bearinger LH, & Udry JR. Protecting adolescents from harm: Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association*, *278*, 823-832, 1997.

[3] Vermont Department of Health and Vermont Department of Education. 2005 Vermont Youth Risk Behavior Survey. Burlington, VT: Author. 2005.

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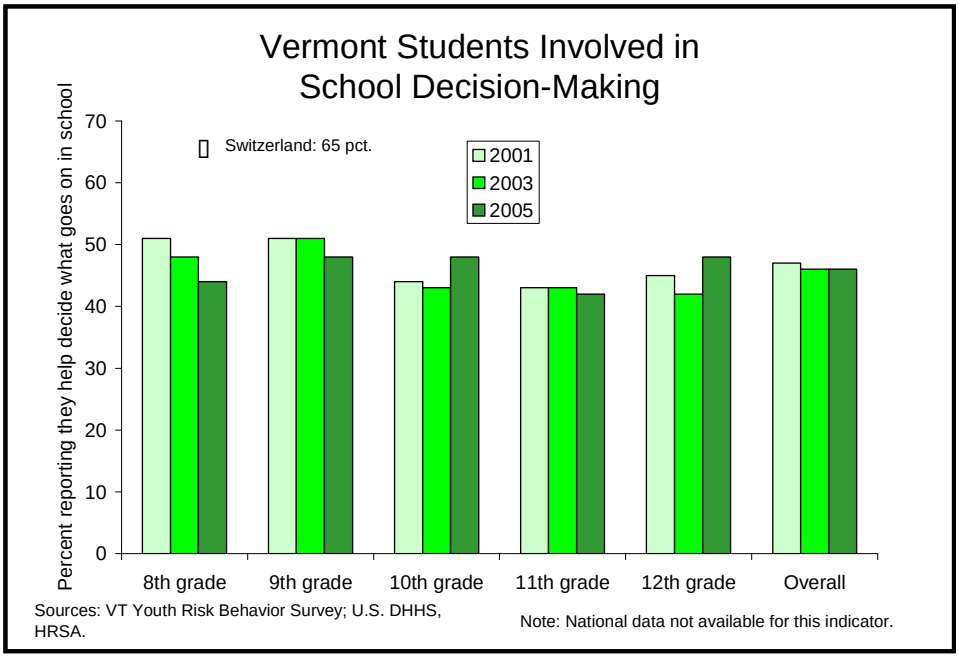

	8th grade	9th grade	10th grade	11th grade	12th grade	Overall
2001	51	51	44	43	45	47
2005	44	48	48	42	48	46

The Story Behind the Data

Skills of civic participation should be nurtured, and practiced, long before adulthood. School is a natural community for most young people, and an arena where important decisions affecting their lives are made.

Students who feel a strong sense of connection with their schools—a sense that they are treated fairly, that teachers and other adults there care about them, and that school is a safe (and stimulating) place—are less likely to engage in violence and substance abuse[1], and may be more likely to do better academically. The U.S. ranks among the lowest five countries in the percent of students reporting they participate in making school rules, according to a 29-nation survey.[2] Vermont now has three years' data from its biannual Youth Risk Behavior Survey on students' role in school decision-making. Data to date show this indicator as fairly stable, though there have been consistent year-to-year declines in engagement among eighth graders.[3]

Vermont has taken some important steps toward creating more opportunities for youth to be engaged in the settings that matter to them. Our State Board of Education includes two student members. Many local districts have school boards with either student representatives or advisors. Many of our Regional Partnerships have created youth councils that administer funds to support community-based programs aimed at promoting safe and drug-free activities for young people.

Data by Vermont Region

VT Counties	Grades 8-12		
	2001	2003	2005
Addison	45	46	46
Bennington	49	46	46
Caledonia	54	55	54
Chittenden	49	50	52
Essex	42	37	n/a
Franklin	44	39	42
Grand Isle	49	47	56
Lamoille	51	43	42
Orange	44	45	48
Orleans	47	44	37
Rutland	46	42	41
Washington	49	47	49
Windham	43	46	41
Windsor	47	47	43

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

For Additional Information

For more Vermont Youth Risk Behavior Survey data, go to www.state.vt.us/adap/yrbs2005statewidereport.pdf.

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[1] Resnick MD, Bearman PS, Blum R Wm, Bauman KE., Harris KM., Jones J, Tabor J, Beuhring T, Sieving RE, Shew M, Ireland M, Bearinger LH, & Udry JR. Protecting adolescents from harm: Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association*, *278*, 823-832, 1997.

[2] U.S. Department of Health and Human Services, Health Resources and Services Administration. U.S. teens in our world. Rockville, MD, 2003.

[3] Vermont Department of Health and Vermont Department of Education. 2005 Vermont Youth Risk Behavior Survey. Burlington, VT: Author. 2005.

What We Want: Families, Youth, and Individuals Are Engaged in Their Community's Decisions and Activities

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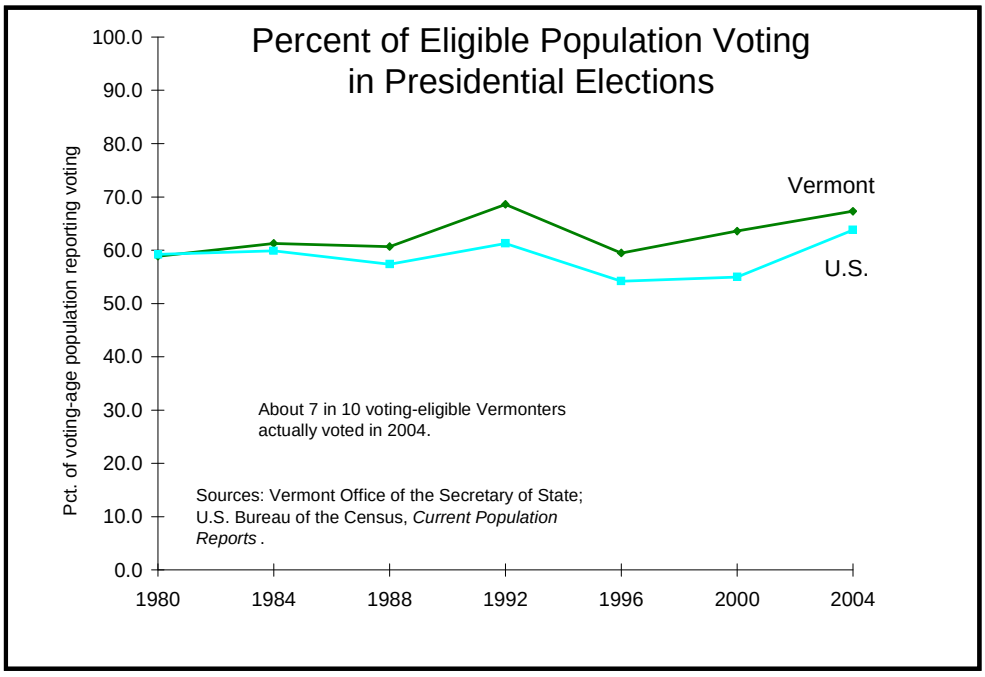

	1980	1984	1988	1992	1996	2000	2004
Vermont	58.9	61.3	60.7	68.6	59.5	63.6	67.3
U.S.	59.2	59.9	57.4	61.3	54.2	55.0	63.8
VT Rank	n/a	n/a	n/a	14	18	13	16

("1" is highest)

The Story Behind the Data

Voting in national elections every four years is a crude but important measure of the exercise of a fundamental right in our democracy. As in other states, Vermont's voter turnout (the percent of eligible voters who actually vote) varies with the perceived importance of the issues and candidate races on the ballot; it also is a measure of citizens' faith in their ability to "make a difference" through their votes.

Sadly, only a bare majority of the eligible population typically votes. In 2004 (the most recent presidential election year for which data are available), only 58% voted nationally. Americans cite time constraints as the single biggest reason they didn't vote; problems related to illness, disability, or a family emergency were cited second; apathy

about the political process was cited next most often.[1] Vermonters generally do somewhat better: 67% of eligible voters participated in 2004, 104,000 more Vermonters voting than in 1994.[2] There are some specific steps that the state might consider to increase participation, including standardizing polling hours, allowing same-day registration, and registration at the time of high school graduation.

Data by Vermont Region

VT Counties	1996	2000	2004
Addison	59.6	64.4	65.3
Bennington	62.2	62.2	66.0
Caledonia	56.5	61.4	60.6
Chittenden	58.9	63.9	67.0
Essex	52.8	59.9	57.2
Franklin	53.5	58.8	56.9
Grand Isle	69.8	70.3	68.3
Lamoille	57.2	64.2	64.5
Orange	63.0	70.0	66.2
Orleans	52.8	61.7	57.9
Rutland	57.9	60.2	62.0
Washington	61.2	66.9	68.2
Windham	58.8	63.3	67.3
Windsor	64.1	65.9	67.2

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

For Additional Information

Information for voters from Vermont's Secretary of State: http://vermont-elections.org/elections1/voters.html.

[1] U.S. Bureau of the Census. Voting and registration in the election of November 2004. Washington, DC.

[2] Ibid.

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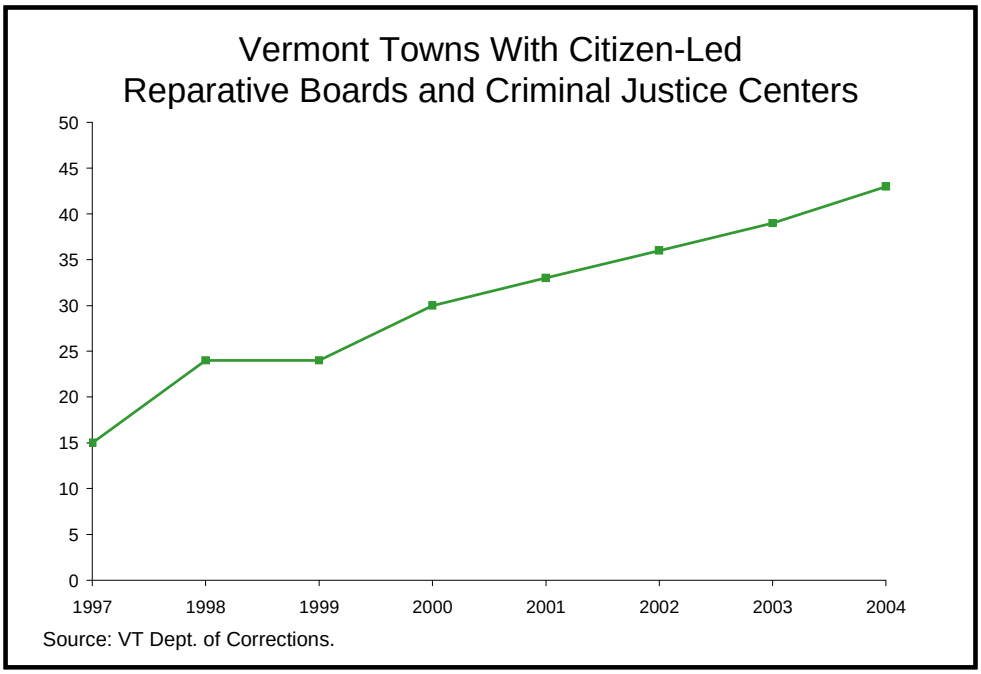


The Story Behind the Data

One of the most important functions of a community is to maintain for its residents a sense of safety and justice (see p. 229, *Communities Provide Safety and Support for Families and Individuals*). Restorative Justice is a growing movement that recruits local citizens to serve on boards or panels, or with Community Justice Centers, that respond to breaches of public safety by hearing from victims, requiring accountability from offenders, and establishing ways to repair the damage done to individuals and communities.

In Vermont, hundreds of citizens serve on more than 65 reparative boards or panels. In addition, as of September, 2005, there are 11 Community Justice Centers around the state, providing dispute mediation, mentoring, and opportunities for community dialogue, in addition to dealing with violations.[1]

Data by Vermont Region

AHS Districts Status as of 2005	
Barre	8 Reparative Boards, 2 Community Justice Centers
Bennington	3 Reparative Boards
Brattleboro	5 Reparative Boards, 1 Community Justice Center
Burlington	12 Reparative Boards, 2 Community Justice Centers
Hartford	6 Repartive Boards, 1 Community Justice Center
Middlebury	2 Reparative Boards
Morrisville	5 Reparative Boards
Newport	4 Reparative Boards, 1 Community Justice Center
Rutland	3 Reparative Boards, 1 Community Justice Center
Springfield	4 Reparative Boards, 1 Community Justice Center
St. Albans	7 Reparative Boards, 1 Community Justice Center
St. Johnsbury	4 Reparative Boards, 1 Community Justice Center

For Additional Information

To learn more about how to get involved with community justice efforts, contact the Department of Corrections:
www.doc.state.vt.us/volunteer_opportunities/community_reparative/.

[1] Vermont Department of Corrections. Facts & Figures, FY 2005.
www.doc.state.vt.us/pageflip/pageflip.pl/index?book=FF2005

Pregnant Women and Young Children Thrive

No period of life is more important to human development than the months leading up to and following birth. Studies reveal remarkable brain activity and sensitivity to features of the environment outside the womb, long before birth. For example, months prior to birth, the developing infant can distinguish sounds—in particular, language—in its immediate surroundings.

A healthy start begins with a healthy pregnancy and early, comprehensive prenatal care. It is important to ensure that services and supports are available during this critical time. Vermont has had a generally excellent record in providing access to good prenatal care for pregnant women, and in promoting healthy births. For example, our state was best in the nation in a recent ranking by percent of births which were preterm.[1] However, pregnant women who smoke (currently self-reported at about 18% in Vermont) or who use alcohol (self-reported at around 1%)[2] are important groups to reach with the message that avoiding or reducing these behaviors can directly improve outcomes such as rates of miscarriage, low birthweight, and mental retardation.

We also know that families with a newborn need lots of support. Vermont has set out to make sure every such family is offered a personal welcome from community members, and a connection to the supports the community offers.

Infancy and early childhood are periods of astonishing growth and development. The brain development research makes clear that this is a time of greatest malleability not only for what, but how, children think and feel. Connections among brain cells multiply rapidly during this period, and the quality of children's experience shapes which responses are strengthened, and which are diminished or lost. The fundamentals of health, language and other learning opportunities, human relationship, and emotional responsiveness established during this period will affect later success in all areas of life.

One reason for Vermont's positive record in this area is our high participation rate in the Special Supplemental Nutrition Program for Women, Infants, and Children, commonly known as WIC. WIC is a federally funded program that provides health screening, health and nutrition education, and food supplements, and assures access to health care, for low-income pregnant and postpartum women, and children 0-4 years old. According to the U.S. Department of Agriculture, 93% of the income-eligible population in Vermont are served by the program.[3] WIC has proven to be a highly cost-effective program: estimates are that every dollar spent on WIC saves $2-$4 in Medicaid costs.[4]

Our current indicators for this area focus on stark survival and basic preventive health care; we need to develop additional indicators that will gauge the well-being of our very youngest community members.

[1] The Annie E. Casey Foundation. The right start for America's newborns: City and state trends (1990-2001). www.aecf.org /kidscount/rightstart/index.htm, January 29, 2004.

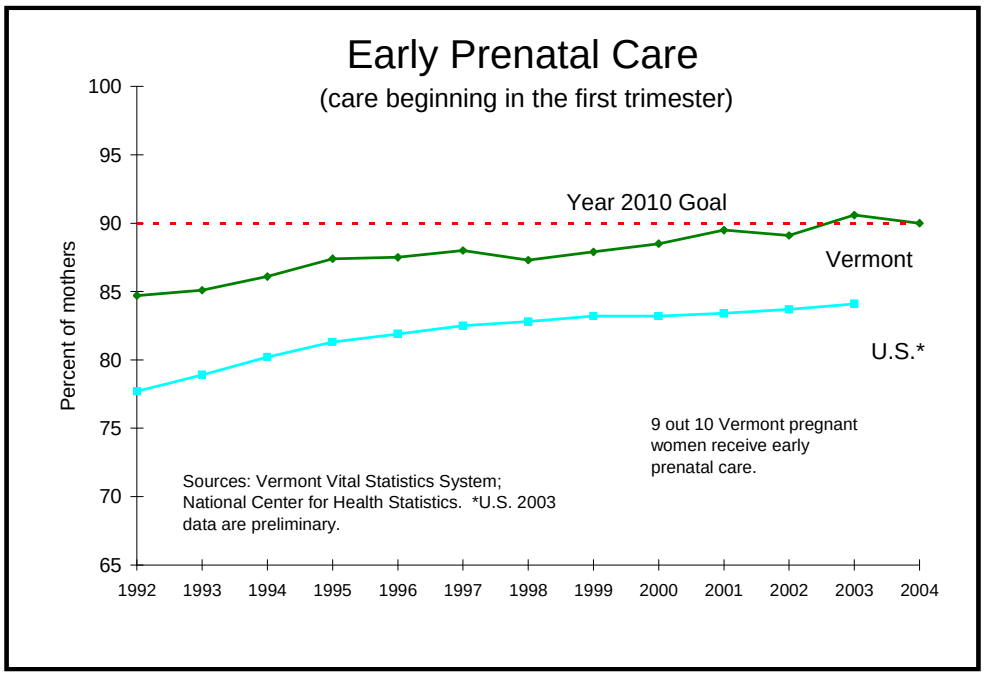
[2] Vermont Department of Health. Vital Statistics Data System. Burlington, VT.

[3] Vermont Department of Health. Personal communication with Donna Bister. Burlington, VT, March 2003.

[4] U.S. Department of Agriculture. Press conference on the Women, Infants & Children Program, Remarks of Secretary Dan Glickman. Washington, DC, May 13, 1997.

What We Want: Pregnant Women and Young Children Thrive

How We Measure Our Success:



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	84.7	85.1	86.1	87.4	87.5	88.0	87.3	87.9	88.5	89.5	89.1	90.6	90.0
U.S.	77.7	78.9	80.2	81.3	81.9	82.5	82.8	83.2	83.2	83.4	83.7	84.1	n/a
VT Rank	9	9	8	7	6	7	6	6	6	4	4	3	n/a
("1" is highest)													

The Story Behind the Data

Early, comprehensive prenatal care is one of the most important factors in ensuring a healthy pregnancy and birth. Early prenatal visits afford a woman and her health care provider opportunities to assess risks to a healthy pregnancy and birth, and to recommend appropriate responses. Conversely, lack of prenatal care is strongly associated with poor pregnancy and birth outcomes. National data indicate that women who receive little or no prenatal care are much more likely to deliver pre-term, and to have low birthweight babies. Much greater risk for maternal and infant mortality is also associated with lack of prenatal care.[1]

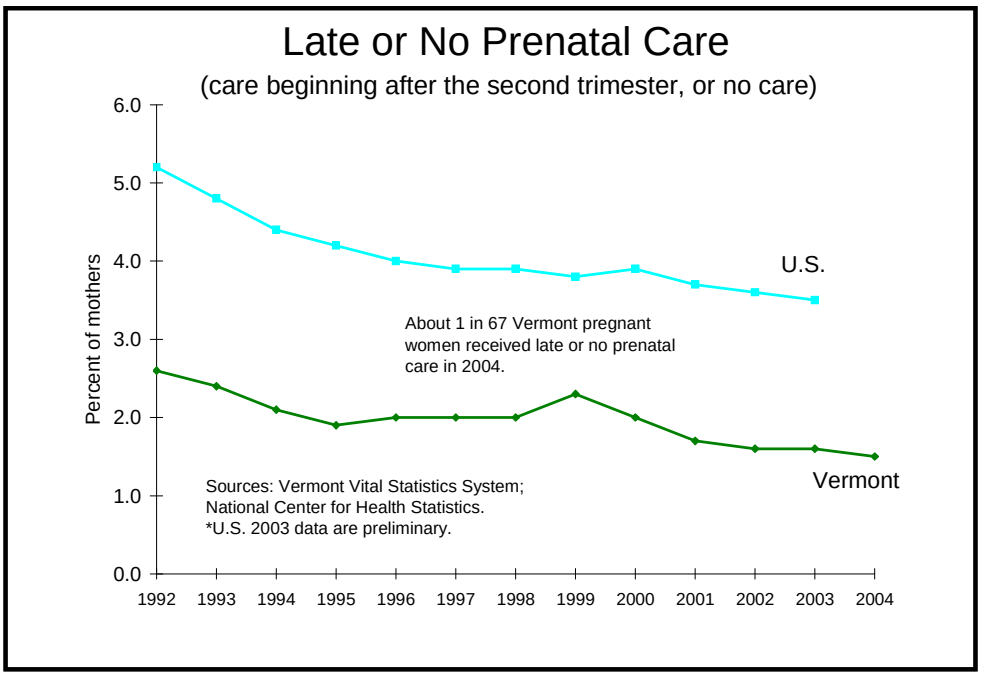
As of 2003 Vermont has met theYear 2010 goal to increase the proportion of pregnant women receiving first trimester care to 90%.[2] In 2003 Vermont ranked third best among the states. Nationally, rates of early prenatal care are much higher for whites

than for non-whites; among non-Hispanic whites, Vermont ranks 7th best on this indicator.[3]

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
Addison	87.7	85.4	88.8	89.3	90.1
Bennington	89.9	87.8	90.9	92.6	90.4
Caledonia	88.7	90.8	88.2	89.0	87.7
Chittenden	88.7	89.8	91.2	90.2	91.8
Essex	84.5	80.6	86.4	84.9	90.4
Franklin	90.7	91.9	93.2	92.9	94.1
Grand Isle	87.7	92.8	88.9	89.7	90.9
Lamoille	83.6	88.1	88.2	88.5	89.4
Orange	87.3	89.7	91.6	93.3	93.4
Orleans	84.7	88.8	86.0	84.6	94.2
Rutland	84.6	86.3	82.8	82.6	85.9
Washington	86.8	86.9	89.8	87.6	91.2
Windham	87.0	85.8	90.2	87.9	86.5
Windsor	91.1	88.0	89.4	87.0	90.1

For data by school supervisory union area, see the AHS *Community Profiles*: http://humanservices.vermont.gov/publications/community-profiles.



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	2.6	2.4	2.1	1.9	2.0	2.0	2.0	2.3	2.0	1.7	1.6	1.6	1.5
U.S.	5.2	4.8	4.4	4.2	4.0	3.9	3.9	3.8	3.9	3.7	3.6	3.5	3.6
VT Rank	8	6	6	4	4	5	4	9	11	3	4	4	n/a

("1" is lowest)

In 2004, only 1.5% of Vermont women who gave birth obtained late (after the sixth month of pregnancy) or no prenatal care,[4] compared to 3.6% for the nation.[5] As of 2003, Vermont ranked fourth best among states, and 6th best among states' rates for non-Hispanic whites.[6]

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
Addison	2.7	4.3	1.6	2.2	0.8
Bennington	1.3	0.9	1.5	1.9	1.5
Caledonia	3.5	0.6	2.2	1.5	2.3
Chittenden	2.3	2.7	1.5	1.2	1.4
Essex	1.4	6.5	7.6	3.8	3.8
Franklin	1.7	1.6	0.8	1.2	0.7
Grand Isle	4.1	2.9	0.0	1.7	0.0
Lamoille	4.7	1.2	1.4	1.5	1.9
Orange	1.1	1.9	0.8	0.7	2.2
Orleans	1.1	0.7	1.8	1.8	2.2
Rutland	3.1	1.4	3.4	2.8	3.2
Washington	2.6	2.5	1.6	1.6	1.3
Windham	3.0	2.7	2.2	1.8	2.7
Windsor	1.4	1.2	1.2	0.8	0.9

For Additional Information

Vermont Department of Health, *Women's Health Status Report*.
www.healthyvermonters.info/admin/pubs/WomenHealthStatus03.pdf

[1] Centers for Disease Control and Prevention. State-specific trends among women who did not receive prenatal care—United States, 1980-1992. *MMWR*, *43*, no. 50, December 23, 1994.

[2] Vermont Department of Health. Vital Statistics Data System. Personal communication with Michael Nyland-Funke, December 2004.

[3] Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, and Munson ML. Births: Final data for 2003. *National Vital Statistics Reports, 54*, no. 2. Centers for Disease Control and Prevention, September 2005.

[4] Vermont Department of Health. Vital Statistics Data System. Personal communication with Michael Nyland-Funke, December 2005.

[5] Hamilton BE, Martin JA, Ventura SJ, Sutton PD, and Menacker F. Births: Preliminary data for 2004. *National Vital Statistics Reports, 54*, no. 8. Centers for Disease Control and Prevention, December 2005.

[6] Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, and Munson ML. Births: Final data for 2003. *National Vital Statistics Reports, 54*, no. 2. Centers for Disease Control and Prevention, September 2005.

What We Want: Pregnant Women and Young Children Thrive

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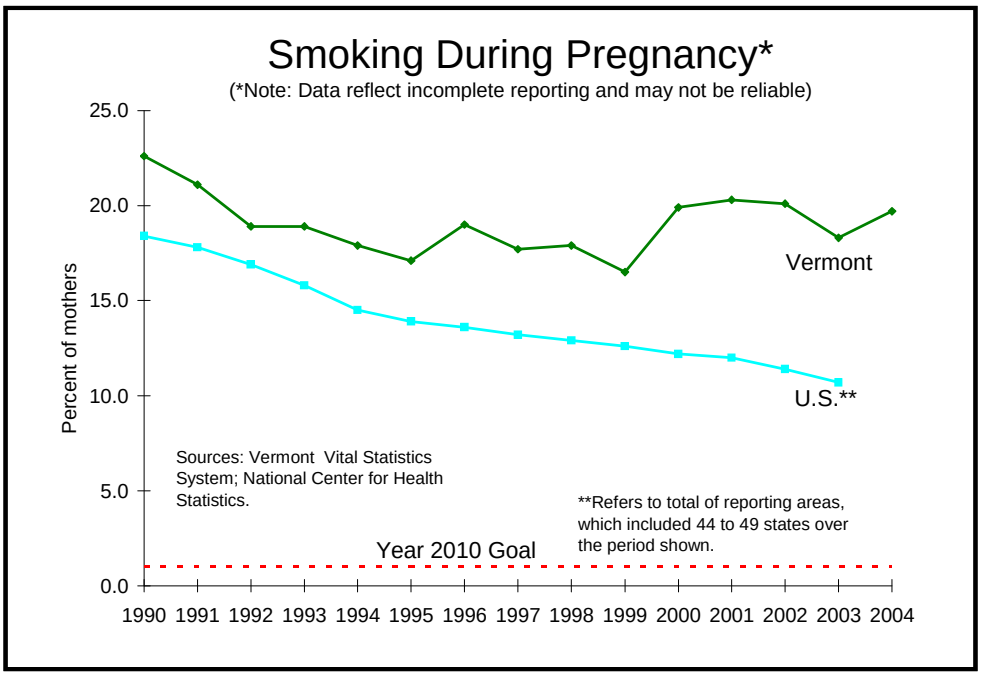

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	22.6	21.1	18.9	18.9	17.9	17.1	19.0	17.7	17.9	16.5	19.9	20.3	20.1	18.3	19.7
U.S.	18.4	17.8	16.9	15.8	14.5	13.9	13.6	13.2	12.9	12.6	12.2	12.0	11.4	10.7	n/a
VT Rank							41	n/a	n/a	32	n/a	46	47	n/a	n/a

("1" is lowest)

The Story Behind the Data

The damaging effects of cigarette smoking extend into the earliest stages of life. When a woman smokes during her pregnancy, her baby is at risk for a number of poor outcomes, including low birthweight, infant mortality, and health problems during childhood, including ear infections, overweight, and mental retardation.[1]

The nationwide costs annually attributable to smoking during pregnancy have been estimated at $1.4 to $2 billion (1995 dollars).[2] The encouraging news is that rates of smoking during pregnancy appear to be coming down (a 40% decline nationally between 1990 and 2002).[3] This is likely due to overall efforts to reduce smoking, as well as special efforts to reach pregnant women with this message.[4] In Vermont, we have seen inconsistent declines, and our rates have remained higher than national figures. Vermont

ranked 47th in 2002, among 49 states reporting these data. Vermont teens (ages15-19) are more than twice as likely to smoke during pregnancy as Vermont women overall, and, according to data collected by the Centers for Disease Control, have the highest rate of smoking during pregnancy for teens among all the states.[5] WIC program data suggest that low-income women are also much more likely to report smoking during pregnancy.[6] Moreover, it is likely that these data (both nationally, and in Vermont) are under-reported. The Department of Health has improved their data-reporting procedure for this indicator, and this may account for some or all of the recent increases in these figures.

Related AHS Performance Measure: Decrease the percentage of pregnant women enrolled in WIC who smoke.

For Additional Information

Our Smokers' Toll-Free Quit Line: 877-YES-QUIT (877-937-7848)

[1] Mathews TJ. Smoking during pregnancy, 1990-96. *National Vital Statistics Reports, 47*, no. 10. National Center for Health Statistics, 1998. Drews CD, Murphy CC, Yeargin-Alsopp M, and Decoufle P (1996). The relationship between idiopathic mental retardation and maternal smoking during pregnancy. *Pediatrics, 97*, no. 4, 547-553. Stathis, SL, O'Callaghan, M, Williams, GM, Najman, JM, Andersen, MJ, & Bor, W (1999). Maternal cigarette smoking during pregnancy is an independent predictor for symptoms of middle ear disease at five years' postdelivery. *Pediatrics, 104*, no. 2. Chen A, Pennell ML, Klebanoff MA, Rogan WJ, & Longnecker MP. Maternal smoking during pregnancy in relation to child overweight: Follow-up to age 8 years. *International Journal of Epidemiology, 35* (1) (2006), 121-130.

[2] Centers for Disease Control and Prevention. (1997). Medical-care expenditures attributable to smoking during pregnancy—United States, 1995. *MMWR, 46*, 1217-1220.

[3] Hamilton BE, Martin JA, and Sutton PD. Births: Preliminary data for 2003. *National Vital Statistics Reports, 53*, no. 9. Centers for Disease Control and Prevention, November 2004.

[4] Mathews TJ, op. cit.

[5] Centers for Disease Control and Prevention. Smoking during pregnancy—United States, 1990-2002. *MMWR, 53*, 911-917. October 2004.

[6] In 2004, 32% of women enrolled in WIC smoked during pregnancy. Centers for Disease Control and Prevention. 2004 Pregnancy Nutrition Surveillance: Vermont. Atlanta, GA: Author, 2005.

What We Want: Pregnant Women and Young Children Thrive

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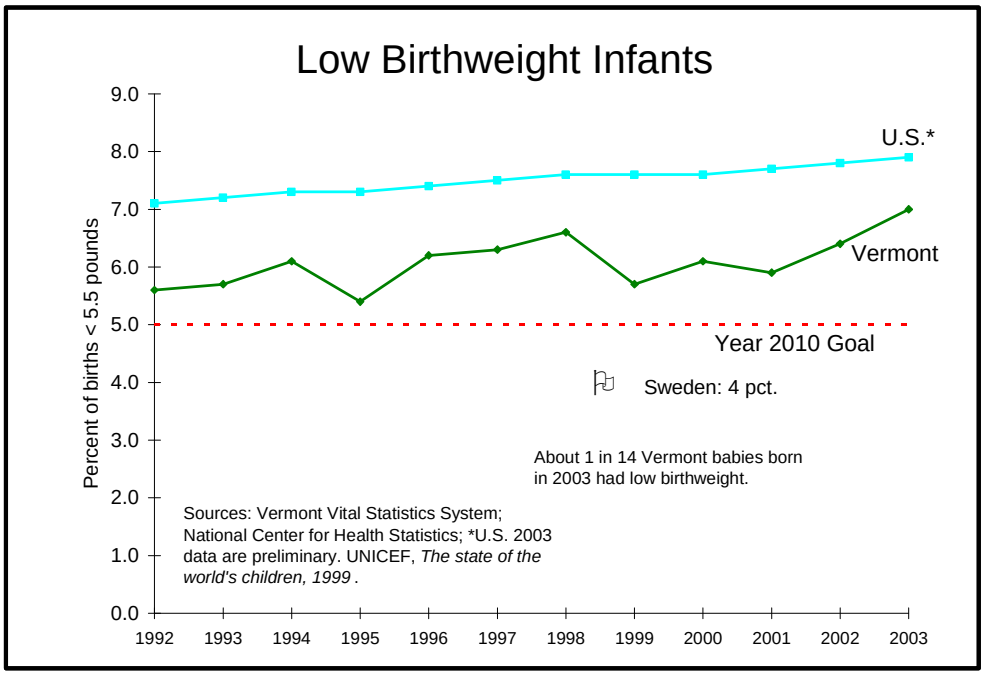

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	5.6	5.7	6.1	5.4	6.2	6.3	6.6	5.7	6.1	5.9	6.4	7.0	6.4
U.S.	7.1	7.2	7.3	7.3	7.4	7.5	7.6	7.6	7.6	7.7	7.8	7.9	8.1
VT Rank	10	10	12	3	9	10	11	2	5	4	8	16	n/a

("1" is lowest)

The Story Behind the Data

Low birthweight (5.5 pounds or less) is the greatest single risk to infant health. Low birthweight babies are nearly twice as likely to have severe developmental delays, birth defects, or long-term disabilities, including lower academic achievement.[1] Smoking, inadequate prenatal care, and teen pregnancy are three known factors associated with low birthweight.

Internationally, in recent years the United States ranks only 17th best among industrialized nations.[2] Fortunately, most babies born in Vermont have a healthy weight at birth. However, we are not succeeding in reducing the rate of low birthweight. Although we do not understand all that underlies this trend, smoking during pregnancy is a primary factor, and Vermont has much room for improvement here (see p. 22). In 2004, 6.4% of babies born in Vermont had a low birthweight .[3] The U.S. rate for 2003

was 7.9%. In 2003, Vermont ranked 16th lowest among the states.[4] The *Healthy Vermonters 2000* goal of no more than 5% low birthweight infants was not achieved, and has been carried over as the Year 2010 goal.

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
Addison	4.7	3.6	4.9	5.5	6.4
Bennington	5.0	7.5	4.9	9.0	5.5
Caledonia	8.6	5.5	6.1	5.0	6.9
Chittenden	5.3	6.4	7.0	4.8	6.9
Essex	5.6	7.8	10.1	9.1	5.6
Franklin	5.0	6.2	5.4	6.8	9.0
Grand Isle	6.3	6.8	4.5	9.2	8.5
Lamoille	7.5	9.3	4.4	6.4	8.6
Orange	3.6	7.3	5.6	7.0	6.1
Orleans	4.3	5.5	3.8	7.6	4.6
Rutland	5.9	6.1	5.5	8.5	8.4
Washington	8.1	4.2	5.3	5.8	8.1
Windham	5.2	4.6	7.7	5.9	4.6
Windsor	5.7	7.4	5.8	7.5	6.8

For data by school supervisory union area, see the AHS *Community Profiles*: http://humanservices.vermont.gov/publications/community-profiles.

[1] Vermont Department of Health. Memo on "The Health Status of Vermonters." Burlington, VT, June 1992. Conley D, and Bennett NG. Is biology destiny? Birth weight and life chances. *American Sociological Review*, *65*, 458-467. June, 2000. Breslau N, Paneth NS, and Lucia VC. The lingering academic deficits of low birth weight children. *Pediatrics*, *114*, 1035-1040. October 2004.

[2] UNICEF. The state of the world's children, 1999. New York, 1999. Based on data for 1990-97.

[3] Vermont Department of Health. Vital Statistics Data System. Personal communication with Michael Nyland-Funke, December 2004.

[4] Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, and Munson ML. Births: Final data for 2003. *National Vital Statistics Reports, 54*, no. 2. Centers for Disease Control and Prevention, September 2005.

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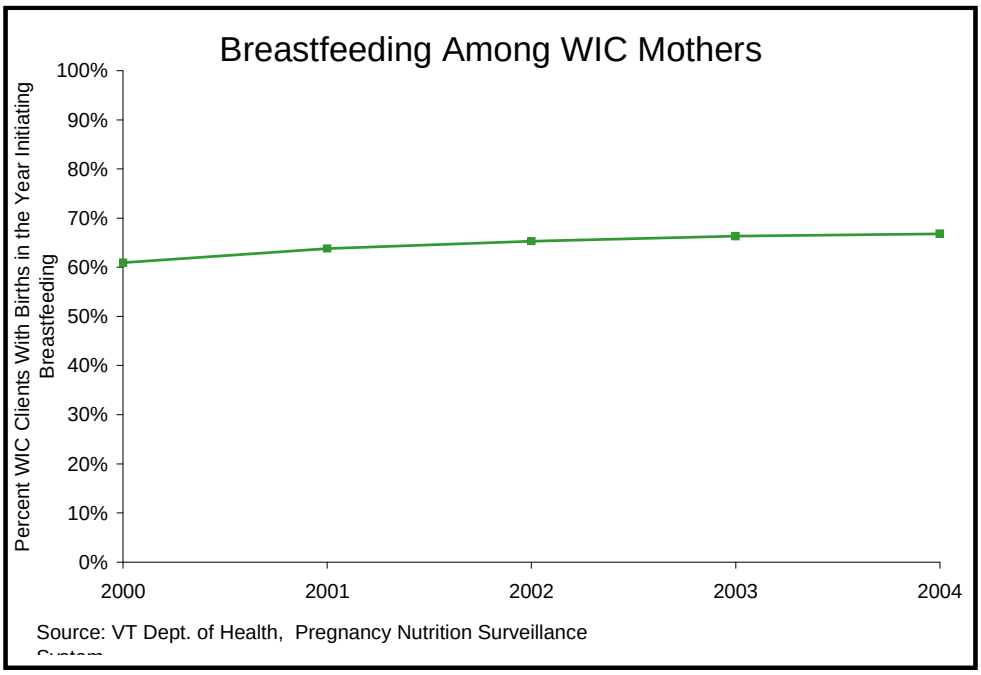

	2000	2001	2002	2003	2004
Vermont	60.9	63.8	65.3	66.3	66.8

(Note: National data are not available for this indicator.)

The Story Behind the Data

The benefits of breastfeeding, for both mother and baby, are well-established, although there are circumstances when breastfeeding is not possible or desirable for particular mothers or infants.[1]

Most recent mothers nationwide breastfeed their babies.[2] Accumulating research shows that breastfeeding makes important contributions, not only to infant health and development, but to mothers' health. Breastfeeding brings additional economic benefits to families, the health care system, and the workplace. More women should be encouraged to breastfeed their infants, and health care personnel, families, employers, and others need to lend their support.[3]

Data by Vermont Region

AHS Districts Percent	2000	2001	2002	2003	2004
Barre	62	63	67	66	69
Bennington	54	51	56	55	57
Brattleboro	70	70	72	73	76
Burlington	62	68	69	69	70
Hartford	72	78	77	76	74
Middlebury	68	75	78	78	78
Morrisville	77	78	78	76	76
Newport	55	66	60	67	68
Rutland	56	53	56	55	58
Springfield	47	54	65	62	66
St. Albans	50	49	49	49	53
St. Johnsbury	68	74	75	72	72

For Additional Information

Vermont Department of Health, Breastfeeding Resources:
http://healthvermont.gov/family/breastfeed/resources.aspx

[1] American Academy of Pediatrics. Breastfeeding and the use of human milk. *Pediatrics*, *115* (February 2005), 496-506.
[2] National Center for Health Statistics. Fertility, family planning, and reproductive health of U.S. Women: Data from the 2002 National Survey of Family Growth. Series Reports 23, no. 25 (PHS) 2006-1977. 2005.

[3] U.S. Department of Health and Human Services. HHS blueprint for action on breastfeeding, Washington, DC. U.S. Department of Health and Human Services, Office on Women's Health, 2000.

What We Want: Pregnant Women and Young Children Thrive

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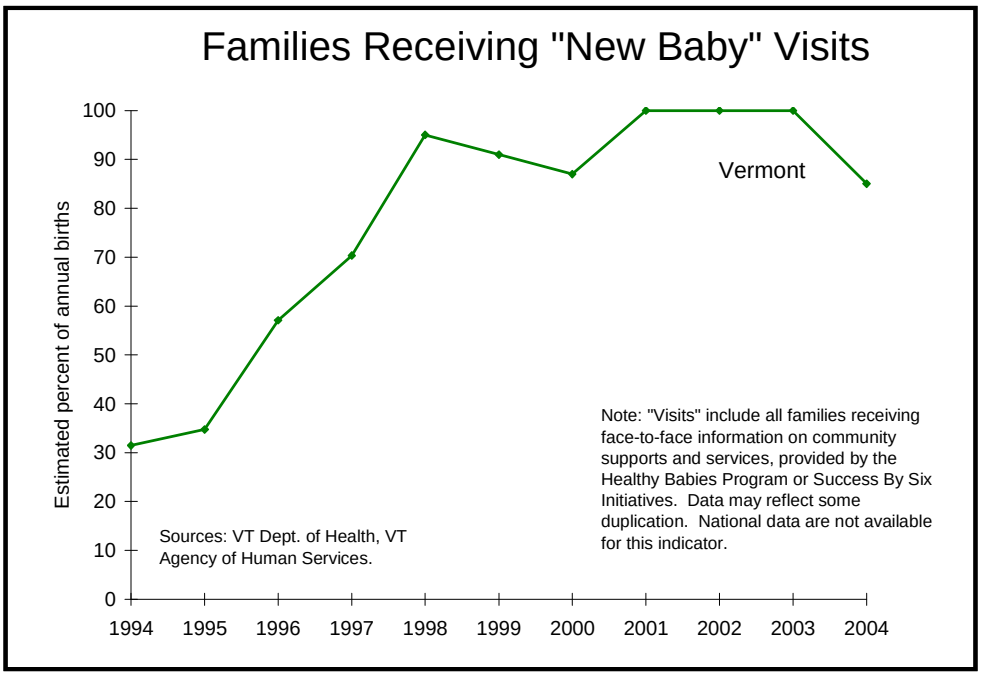

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	31	35	57	70	95	91	87	100	100	100	85

(Note: National data are not available for this indicator.)

The Story Behind the Data

A family with a newborn needs lots of help! Traditionally, help came from extended family and neighbors—and in many cases still does. However, especially today, not all families have ready access to the kinds of support they need: answers to questions about parenting, about caring for their baby, about where to turn for additional resources.

Home-visiting, which can be carried out by nurses or other professionals, or by trained community volunteers, can be an effective strategy for providing new families with helpful information, and a stronger connection to their communities. Home-visiting has also been shown to reduce the likelihood of child abuse and childhood injury, to help parents manage chronic illnesses of childhood, and to promote more positive parenting practices.[1]

Vermont may be the only state committed to offering a home visit to every family with a newborn. Not all families want, or need, a home visit, and sometimes helpful

information can be exchanged through a phone call, or in an office visit with a pediatrician or other service-provider. In 2004, through our Healthy Babies Program, and through the "Welcome Baby" programs of our Success by Six initiatives throughout the state, we estimate that we reached 85% of families with newborns face-to-face, personalized information on community supports and services.[2] We believe this modest early investment can pay huge dividends down the line.

Data by Vermont Region

AHS Districts Percent	2001	2002	2003	2004	2004
Barre	83.7	84.2	98.5	125.2	118.3
Bennington	117.5	115.6	149.1	192.3	43.5
Brattleboro	84.6	98.3	155.9	153.2	156.5
Burlington	65.7	104.5	117.4	80.6	73.0
Hartford	76.7	106.7	80.8	74.1	65.9
Middlebury	76.7	72.7	102.4	80.8	52.8
Morrisville	99.4	82.7	76.2	130.6	44.0
Newport	154.3	183.7	192.6	125.9	116.6
Rutland	76.8	97.0	61.3	64.0	132.5
Springfield	78.7	64.7	144.0	93.2	97.4
St. Albans	126.0	106.7	67.3	66.3	30.0
St. Johnsbury	71.7	106.7	117.6	137.7	75.5

For Additional Information

Success By Six Annual Report: http://humanservices.vermont.gov/publications/vermont-s-success-by-six-initiative/view

Healthy Babies, Kids, and Families:
www.dcf.state.vt.us/cdd/programs/prevention/hbkf/index.html

[1] Olds DL, & Kitzman H. Review of research on home-visiting for pregnant women and parents of young children. *The Future of Children*, *3*, no. 3, 53-92. Center for the Future of Children, The David and Lucile Packard Foundation, Winter, 1993. Kitzman, H, Olds DL, Henderson CR Jr., Hanks C, Cole R, Tatelbaum R, McConnochie KM, Sidora K, Luckey DW, Shaver D, Engelhardt K, James D, & Barnard K. Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing. *The Journal of the American Medical Association*, *278*, 644-652, 1997.

[2] Vermont Agency of Human Services. Community Profiles database. Waterbury, VT.

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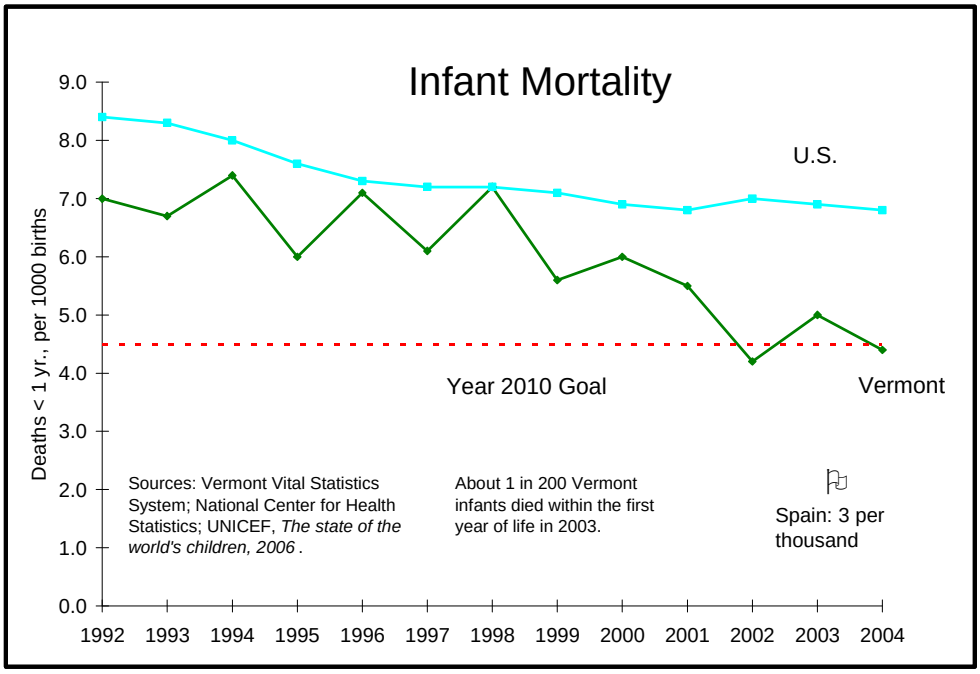

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	7.0	6.7	7.4	6.0	7.1	6.1	7.2	5.6	6.0	5.5	4.2	5.0	4.4
U.S.	8.4	8.3	8.0	7.6	7.3	7.2	7.2	7.1	6.9	6.8	7.0	6.9	6.8
VT Rank	11	2	20	7	23	10	16	9	10	7	1	5	n/a

("1" is lowest)

The Story Behind the Data

The infant mortality rate refers to the number of deaths of babies under one year old, per 1,000 live births. This indicator reflects both mothers' health and the quality of the health care system. Internationally (as of 1999), at least 29 industrialized countries (including Sweden, Japan, Germany, Canada, and Spain) had rates of infant mortality lower than that of the U.S.;[1] much of this difference is accounted for by our higher rates of low birthweight and preterm delivery.[2] The leading causes of infant death in Vermont include birth defects, complications associated with prematurity, and Sudden Infant Death Syndrome (SIDS).[3] Research has shown SIDS risk can be reduced if infants are put to sleep on their backs—a simple preventive measure.[4] Breastfeeding has also been shown to be associated with fewer infant deaths.[5]

Vermont generally has one of the lowest infant mortality rates in the nation. In 2004, there were 29 resident infant deaths, for a rate of 4.4 per 1,000 live births.[6] In 2003 (the most recent year for which rankings are available) Vermont ranked fifth lowest among states. However, Vermont's record is not as good when one looks at infant mortality just among whites, which are the overwhelming majority in our state.[7]

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
	Number of Infant Deaths				
Addison	4	2	0	1	2
Bennington	2	3	3	0	1
Caledonia	3	1	1	1	2
Chittenden	15	14	5	2	11
Essex	0	0	1	0	0
Franklin	2	4	4	5	9
Grand Isle	1	2	1	2	1
Lamoille	0	3	1	1	1
Orange	0	0	2	1	1
Orleans	2	1	0	1	1
Rutland	2	3	6	7	3
Washington	4	2	7	2	1
Windham	1	1	2	3	0
Windsor	1	3	2	1	0

[1] UNICEF. The state of the world's children, 2001. New York, 2001.

[2] Ibid.

[3] Vermont Department of Health. Health status report, '98: Selected Vermont health status indicators, 1993-1997. Burlington, VT, 1998.

[4] Hunt CE, Lesko SM, Vezina RM, McCoy R, Corwin MJ, Mandell F, Willinger M, Hoffman HJ, and Mitchell AA. Infant sleep position and associated health outcomes. *Archives of Pediatric & Adolescent Medicine*, *157*, 469-474. May 2003.

[5] Chen, A, & Rogan WJ. Breastfeeding and the risk of postneonatal death in the United States. *Pediatrics*, *113*, May 2004.

[6] Vermont Department of Health. Vital Statistics Data System. Personal communication with Michael Nyland-Funke, March 2006.

[7] Hoyer DL, Heron MP, Murphy SL, & Kung H-C. Deaths: Final Data for 2003. *National Vital Statistics Reports, 54*, no. 13. April 19, 2006.

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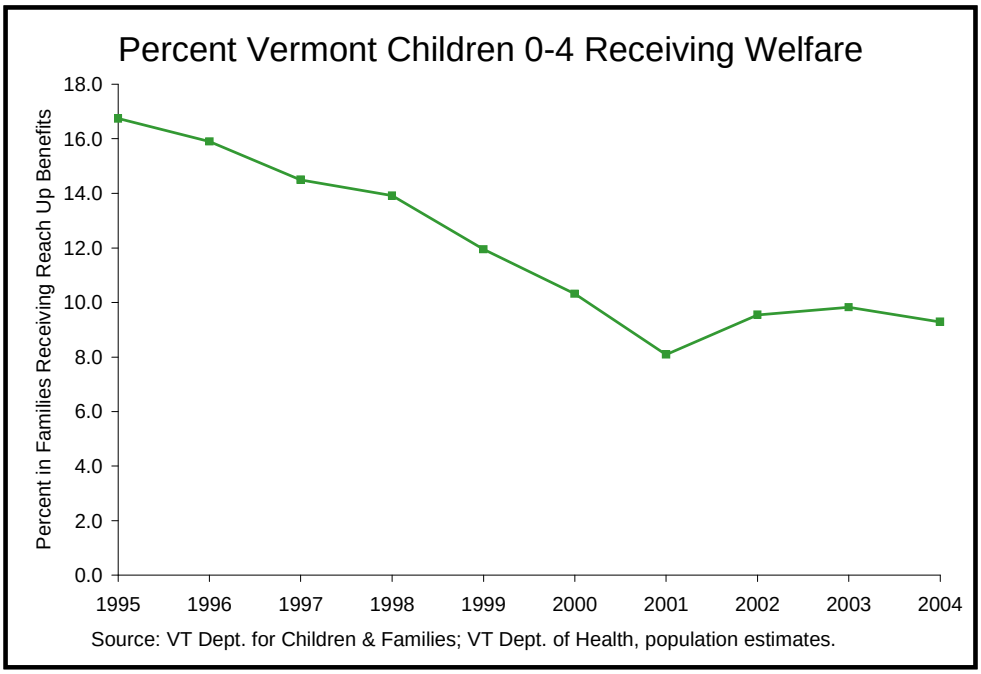

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	16.7	15.9	14.5	13.9	11.9	10.3	8.1	9.5	9.8	9.3

(Note: National data are not available for this indicator.)

The Story Behind the Data

Young children are arguably the most vulnerable victims of poverty (see p. 76). Unfortunately, poverty rates are highest in families with young children. This indicator highlights those Vermont families receiving Reach Up services. Reach Up (Vermont's TANF program, formerly Aid to Needy Families with Children) is available mostly to poor single-parents with children (see p. 248). While the welfare reform initiated in the mid-1990s was successful in getting many of these parents into paid employment, in many cases their wages do not lift them out of poverty. And, of course, their children require child care while the parent is working. Evidence to date is still inconclusive as to whether welfare reform has brought any net benefit to these children.[1] As the accompanying chart shows, these numbers declined steeply during the 1990s, then rose again with the economic downturn in the early years of the present decade.

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	7.2	6.0	5.6	6.4	6.2
Bennington	16.9	12.2	17.2	14.7	13.8
Caledonia	11.5	9.7	11.2	12.1	11.6
Chittenden	8.0	6.9	7.6	8.0	7.6
Essex	15.2	14.9	10.0	14.0	9.6
Franklin	10.9	8.5	9.6	10.0	0.0
Grand Isle	10.2	6.8	8.1	6.6	8.8
Lamoille	8.2	5.6	6.0	6.9	6.7
Orange	9.0	6.7	9.2	9.4	8.6
Orleans	13.4	10.0	10.3	12.5	12.9
Rutland	13.9	10.1	13.1	13.1	13.5
Washington	10.0	7.4	8.7	8.9	7.0
Windham	9.7	9.0	10.4	10.4	11.2
Windsor	10.2	6.5	9.0	9.1	8.0

For data by school supervisory union area, see the AHS *Community Profiles*: http://humanservices.vermont.gov/publications/community-profiles.

For Additional Information

Annual Report to the Governor and the General Assembly on Vermont's Reach Up Program: www.dsw.state.vt.us/wrp/wrppdf/RU_annu_rpt_2006.pdf

[1] Child Trends. The unfinished business of welfare reform: Improving prospects for poor children and youth. Washington, DC: Author. April, 2002.

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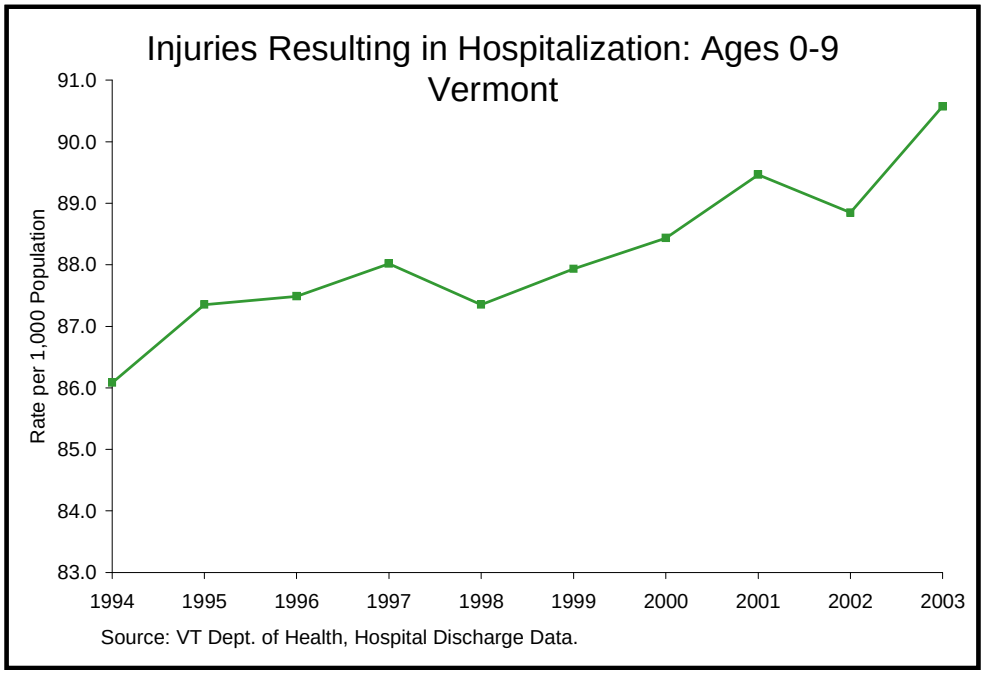

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Vermont	86.1	87.4	87.5	88.0	87.4	87.9	88.4	89.5	88.8	90.6

(Note: National data are not available for this indicator.)

The Story Behind the Data

Injuries are the leading cause of death in this age-group, and motor-vehicle crashes account for most of these. Adults can help prevent many injuries by ensuring the proper and consistent use of car safety seats and safety belts, bicycle/skate/ski/board helmets and other protective gear, and by keeping homes "child-safe."

Data for this indicator reflect only those injuries resulting in hospital admission; they do not include injuries treated in emergency rooms or doctors' offices. Thus, the data may be sensitive to regional differences in treatment practices.

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
Addison	87.7	85.4	88.8	89.3	90.1
Bennington	89.9	87.8	90.9	92.6	90.4
Caledonia	88.7	90.8	88.2	89.0	87.7
Chittenden	88.7	89.8	91.2	90.2	91.8
Essex	84.5	80.6	86.4	84.9	90.4
Franklin	90.7	91.9	93.2	92.9	94.1
Grand Isle	87.7	92.8	88.9	89.7	90.9
Lamoille	83.6	88.1	88.2	88.5	89.4
Orange	87.3	89.7	91.6	93.3	93.4
Orleans	84.7	88.8	86.0	84.6	94.2
Rutland	84.6	86.3	82.8	82.6	85.9
Washington	86.8	86.9	89.8	87.6	91.2
Windham	87.0	85.8	90.2	87.9	86.5
Windsor	91.1	88.0	89.4	87.0	90.1

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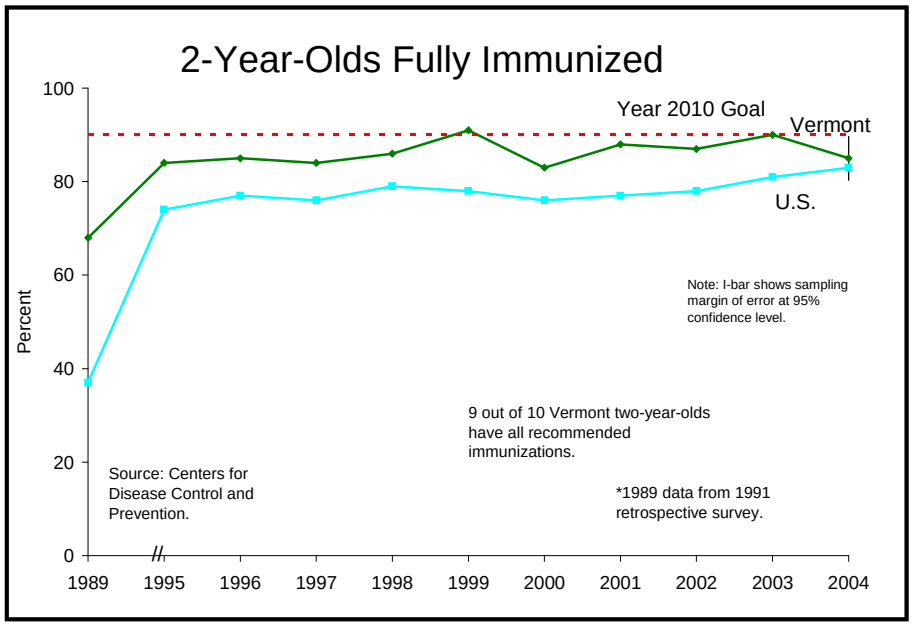


	1989	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	68	84	85	84	86	91	83	88	87	90	85
U.S.	37	74	77	76	79	78	76	77	78	81	83
VT Rank	2	3	3	4	6	1	8	1	3	3	15

("1" is highest)

The Story Behind the Data

These are a marker of ongoing, preventive health care for children. Good health, including recommended immunizations, is a prerequisite for success in school, as well as for overall development.

Immunizations are also among the most cost-effective investments in prevention: inexpensive in themselves, they pay dividends many times over in avoided health care costs—about $22 for every $1 invested.[1] Children should be vaccinated against childhood diseases such as diphtheria, pertussis, polio, mumps, measles, rubella, *H. influenza b*, hepatitis B, and chicken pox. According to a recent national survey, Vermont was fifteenth highest among the states in the percent of two-year-olds fully immunized.[2] Some young children in our state who do not have these immunizations have parents who are opposed to them; other families may be difficult to reach with this public health message. A *Healthy Vermonters 2010* goal is to have the proportion of children under age two fully immunized at no less than 90%. Already, the state distributes vaccines at no charge to doctors and clinics, reducing the cost to families.

Efforts to take our progress even further will be aided by a planned statewide immunization registry, which will allow more comprehensive monitoring of children's immunization status.

For Additional Information

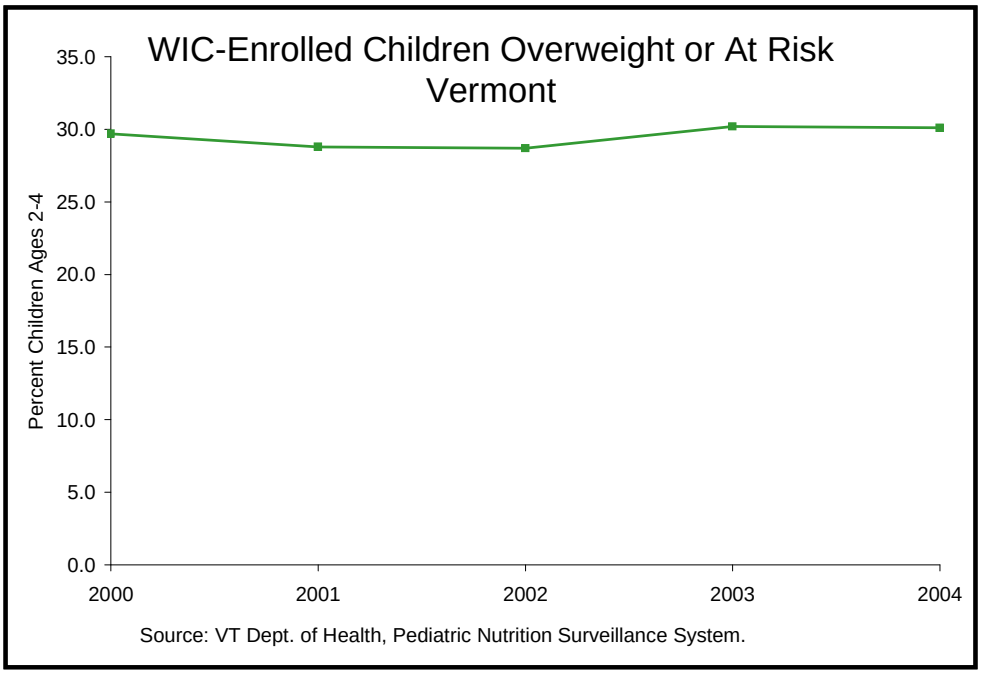
The AHS *Community Profiles* report immunization rates for kindergartners, by school supervisory union area. See http://humanservices.vermont.gov/publications/community-profiles.

[1] Hatziandreu EJ, et al. The costs and benefits of childhood immunization. The Battelle Medical, Technology, Assessment and Policy Research Program, Center for Public Health Research and Evaluation. Arlington, VA, 1993.

[2] Centers for Disease Control and Prevention. National, state, and urban area vaccination coverage among children aged 19-35 months—United States, 2004. *MMWR*, *54*, 717-721. Note: "Fully immunized" is defined as four doses of DTP vaccine (diphtheria, tetanus, pertussis), three doses of polio vaccine, one dose MMR vaccine (measles, mumps, rubella), and three doses of Hib (*Haemophilus influenza* type b) vaccine by age two.

What We Want: Pregnant Women and Young Children Thrive

How We Measure Our Success:



	2000	2001	2002	2003	2004
Vermont	29.7	28.8	28.7	30.2	30.1

(Note: National data are not available for this indicator.)

The Story Behind the Data

It is no longer news that Americans have a big weight problem. Less well known is how early in life unhealthy eating and exercise habits sometimes begin. More than half of the 50 states reported gains of more than 10 percent over the past decade in the prevalence of overweight among low-income two-to-four-year-olds.[1] Risk factors for childhood overweight can be present prenatally or even prior to pregnancy.[2] Practices recommended to protect against early childhood obesity include breastfeeding in infancy, and avoiding high-sugar and high-fat foods.[3]

Children who are treated for obesity have medical costs about three times as high as the average insured child. The annual health-care costs of childhood obesity nationally are estimated at $14 billion.[4]

The overweight problem takes on new dimensions when children reach school age. According to the National Academy of Sciences, schools need to provide opportunities for daily vigorous physical activity, adopt improved nutritional standards for foods and beverages sold at school, prohibit food-related advertising, and regularly

measure students' weight and height. Parents also should promote healthy eating and an active lifestyle, by introducing nutritious foods; encouraging healthy eating habits; restricting recreational television, computer, and video game use; and providing opportunities for active, physical play. Businesses, particularly those responsible for marketing and selling prepared foods and restaurant items, need to acknowledge their role in forming eating habits, healthful or otherwise.[5]

Data by Vermont Region

VT Counties	1994	1995	1996	1997	1998
Addison	28.0	17.0	28.0	31.0	24.0
Bennington	20.0	16.0	25.0	23.0	23.0
Caledonia	28.0	14.0	18.0	20.0	18.0
Chittenden	102.0	88.0	97.0	98.0	106.0
Essex	3.0	2.0	4.0	0.0	4.0
Franklin	45.0	36.0	39.0	35.0	36.0
Grand Isle	3.0	5.0	7.0	4.0	8.0
Lamoille	23.0	16.0	11.0	22.0	25.0
Orange	21.0	18.0	16.0	21.0	17.0
Orleans	17.0	19.0	21.0	18.0	26.0
Rutland	39.0	44.0	44.0	38.0	49.0
Washington	47.0	44.0	46.0	37.0	42.0
Windham	28.0	23.0	32.0	29.0	28.0
Windsor	43.0	25.0	30.0	36.0	27.0

For Additional Information

www.ActionForHealthyKids.org

[1] Sherry B, Mei Z, Scanlon KS, Mokdad AH, & Grummer-Strawn LM. Trends in state-specific prevalence of overweight and underweight in 2- through 4-year-old children from low-income families from 1989 through 2000. *Pediatrics, 158*, no. 12 (December 2004), 1116-1124.

[2] Salsberry PJ & Reagan PB. Dynamics of early childhood overweight. *Pediatrics, 116* no. 6 (December 2005), 1329-1338.

[3] Lederman SA, Akabas SR, Moore BJ, Bentley ME, Devaney B, Gillman MW, Kramer MS, Mennella JA, NessA, &Wardle J. Summary of the presentations at the conference on preventing childhood obesity, December 8, 2003. *Pediatrics, 114*, no. 4 (October 2004), 1146-1173.

[4] Thomson Medstat. Child obesity: Costs, treatment patterns, disparities in care, and prevalent medical conditions. Thomson Medstat Research Brief. 2006.

[5] The National Academies. Press Release: National effort urgently needed to combat childhood obesity; actions required by schools, families, communities, industry, and government. September 30, 2004. Washington, DC.

What We Want: Pregnant Women and Young Children Thrive

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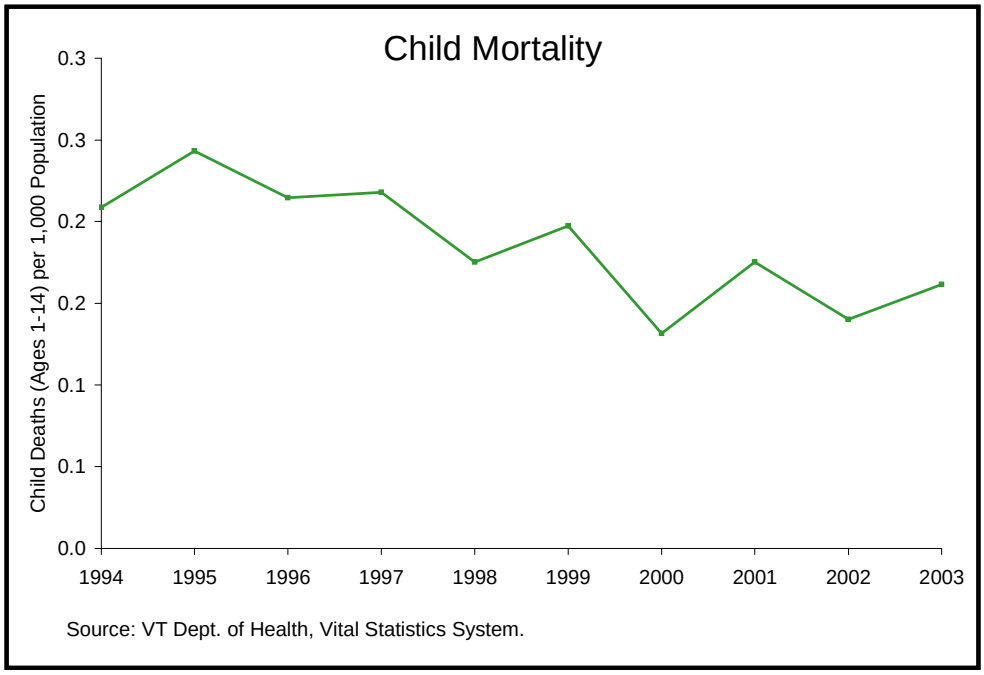


	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Vermont	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.2	0.1	0.2

The Story Behind the Data

The leading cause of death in children is motor-vehicle crashes, and other injuries. Fortunately, in Vermont very few children die of preventable causes. Nevertheless, adults need to provide adequate supervision at all times, keep homes and schools "child-safe," and teach children age-appropriate safety practices. In addition, research into preventing causes of child mortality must continue to make progress.

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
	Number of Child Deaths				
Addison	4	0	0	2	2
Bennington	1	4	0	1	1
Caledonia	1	1	3	1	0
Chittenden	4	2	5	4	4
Essex	0	0	0	1	0
Franklin	1	1	2	2	1
Grand Isle	0	0	0	0	0
Lamoille	6	1	0	0	0
Orange	0	0	2	0	2
Orleans	0	2	2	1	1
Rutland	0	2	4	1	0
Washington	1	0	0	0	3
Windham	2	2	1	0	0
Windsor	1	0	2	3	3

Children Are Ready for School

In 1990, the President and the governors of all 50 states adopted National Education Goals, the first of which reads, "by the year 2000 all children in America will start school ready to learn." We have become increasingly aware of the integral relationship between children's success in school and their well-being in other aspects of life. Children cannot succeed in school unless they are healthy and have a strong foundation of early experiences of love, support, and learning opportunities. Of course, schools must also be "ready" to meet the diverse experiences children bring.

Because of major structural changes in economic, family, and cultural life, more young children than ever before are in some kind of nonparental child care. In Vermont, approximately 22,000 children younger than six are in childcare while their parents work.[1] While Vermont's child care systems have received generally high ratings in national reviews, there are still significant gaps to be bridged in the areas of quality, affordability, and access.[2] A study commissioned by the Child Development Division of the Department for Children & Families showed wide discrepancies across the state in the capacity of child care in relation to need, in the adequacy of subsidized care reimbursement rates, and in the training, earnings, and employment benefits of child care workers.[3]

While there is no single consensus on what constitutes "readiness" for school, it is clear that only strong partnerships between families, schools, and communities will ensure that all children make the best possible start in school. One of the most important things parents can do is to read to their young children, beginning in the child's first year. The social and emotional, as well as linguistic cues communicated to children through this activity have an influence far beyond the moment. Schools and other community institutions must reach out to children and families in ways that meet their needs, long before formal schooling begins. Gauging children's readiness for school is an area that will require new assessment systems, together with shared agreement about its vital importance.

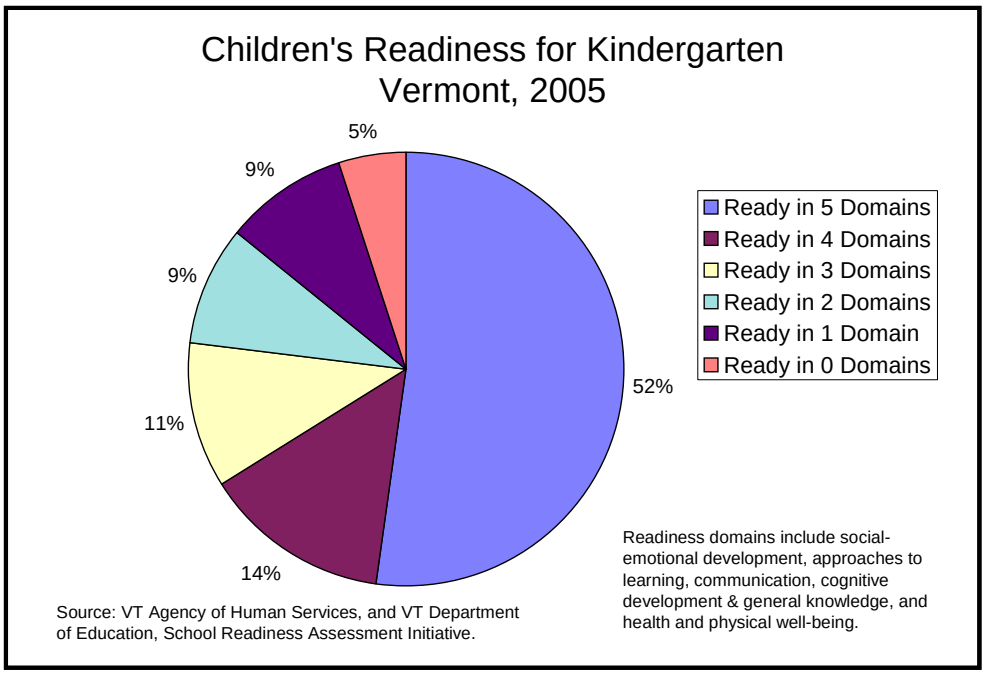
[1] Vermont Agency of Human Services. The Vermont Child Care Advisory Board's 2004 legislative report. Child Care Services Division. Waterbury, VT, 2004.

[2] Barnett WS, Hustedt JT, Robin KB, and Schulman KL. The state of preschool: 2004 state preschool yearbook. The National Institute for Early Education Research. New Brunswick, NJ, 2004.

[3] Child Care Services Division, Department of Social & Rehabilitation Services, State of Vermont. Vermont child care: Wages, benefits, and credentials. Prepared by Research Partners, a division of Marketing Partners, Inc., 2002.

What We Want: Children Are Ready for School

How We Measure Our Success:



	Ready in 5 Domains	Ready in 4 Domains	Ready in 3 Domains	Ready in 2 Domains	Ready in 1 Domain	Ready in 0 Domains
2005 Percent	41.6	18.5	12.1	11	10.7	6.1

The Story Behind the Data

Readiness to learn, and to succeed in school, has many dimensions. Good health, nutrition, and safety are important. So are emotional security, social skills, curiosity, and confidence. These conditions, in turn, reflect the resources of families and communities, and all the experiences young children have had. By the time a child enters kindergarten, skilled teachers can tell which children are coming to kindergarten with the prior experiences that will enable them to get the most from school, and which are not.

As part of a new assessment initiative begun in the 2000-01 school year, Vermont's kindergarten teachers are asked to report on their students' competence in four major areas*: approaches to learning cognitive development and general knowledge, communication*, and *social and emotional development*. Last year, data were received from 94% of the state's teachers, meaning the results paint a representative, though not definitive, picture of children's readiness to make the most of formal school experiences. The data show that a majority of kindergartners are entering school with a broad range of important attitudes and skills; however, a significant minority lack competence in several important domains. Both national and Vermont data suggest that some groups of kindergartners—for example, children from low-

income families, and those without preschool experience—are more vulnerable to lagging behind educationally.[1] Local communities can consult their own data to understand their children's performance

Data by Vermont Region

For data by school supervisory union area, see the AHS *Community Profiles*: http://humanservices.vermont.gov/publications/community-profiles

Related AHS Performance Measure:

Increase the percentage of kindergartners who are judged "ready for school."

For Additional Information

See early childhood resources on-line, including The Vermont School Readiness Series: http://humanservices.vermont.gov/publications/vsrs-vrp.

[1] Lee VE, & Burkam DT. Inequality at the starting gate: Social background differences in achievement as children begin school. Washington, DC: Economic Policy Institute, 2002. Wertheimer R, & Croan T, with KA Moore & EC Hair. Attending kindergarten and already behind: A statistical portrait of vulnerable young children. Washington, DC: Child Trends, Inc., December, 2003. Murphey, DA. Discriminant validity of a community-level measure of children's readiness for school. *Early Childhood Research & Practice*, *5*, no. 2, Fall 2003.

What We Want: Children Are Ready for School

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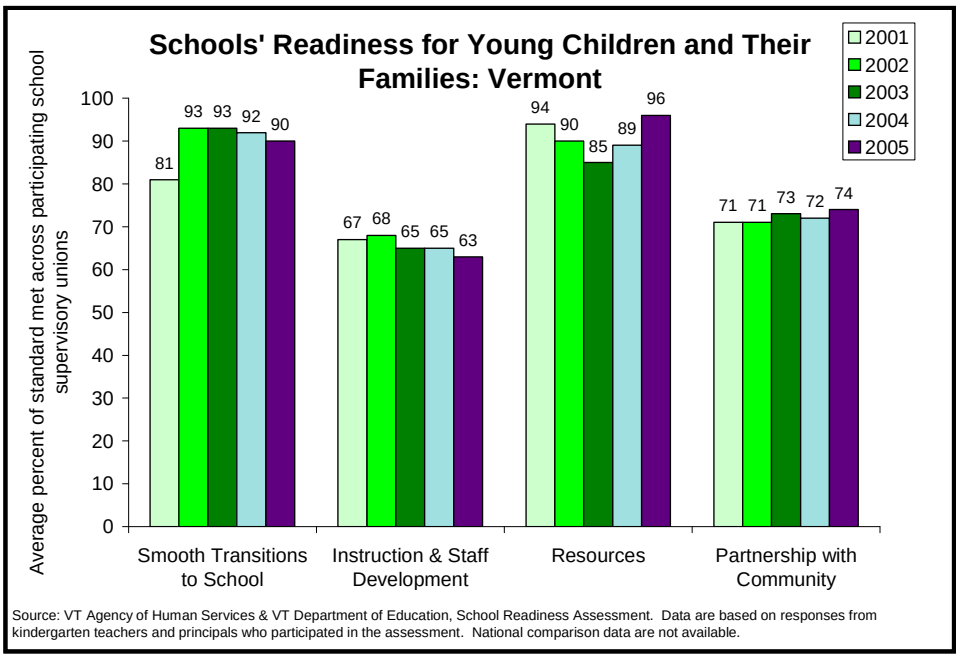

Source: VT Agency of Human Services & VT Department of Education, School Readiness Assessment. Data are based on responses from kindergarten teachers and principals who participated in the assessment. National comparison data are not available.

The Story Behind the Data

All of our children are coming to school, so our schools need to be prepared to give all of them a good start. Some children entering kindergarten have had extensive experience in formal child care settings; others have been in the care of parents, relatives, or friends. Some may have special needs with regard to language, physical or emotional health, or learning difficulties. All have needs as young learners that are different from those of older children.

Vermont's assessment of "ready schools" covers four areas*: smooth transitions to school, instruction and staff Development, resources*, and *partnership with community*, derived from reports of kindergarten teachers and principals. Members of Vermont's Early Childhood Workgroup set standards for each area, based on what they believe a "ready" school should exemplify. The results show that Vermont elementary schools get generally high marks for the resources they provide to teaching staff, and for easing the transition to formal schooling for young children and their families. More room for improvement exists in the areas of instruction and staff development, and schools' partnership with communities.

Data by Vermont Region

For data by school supervisory union area, see the AHS *Community Profiles*:
http://humanservices.vermont.gov/publications/community-profiles

For Additional Information

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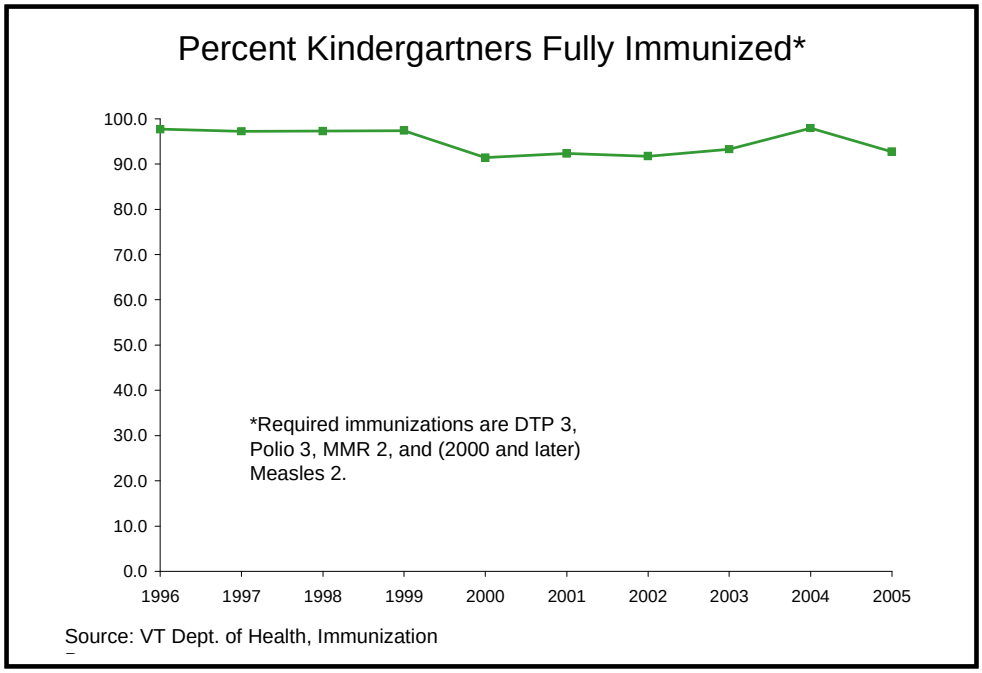

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Vermont	97.7	97.2	97.3	97.4	91.4	92.3	91.8	93.3	97.9	92.8

(Note: National data are not available for this indicator.)

The Story Behind the Data

Children who enter kindergarten having had the required vaccines are less likely to miss school because of serious illness; they are also more likely to have a regular source of ongoing health care. Although immunizations are required for school entry, some children are exempt for medical, religious, or philosophical reasons. On average, rates of immunization are high across our state; however, communities may want to examine their own data to see whether there are opportunities to improve their record locally.

Data by Vermont Region

For data by school supervisory union area, see the AHS *Community Profiles*: http://humanservices.vermont.gov/publications/community-profiles

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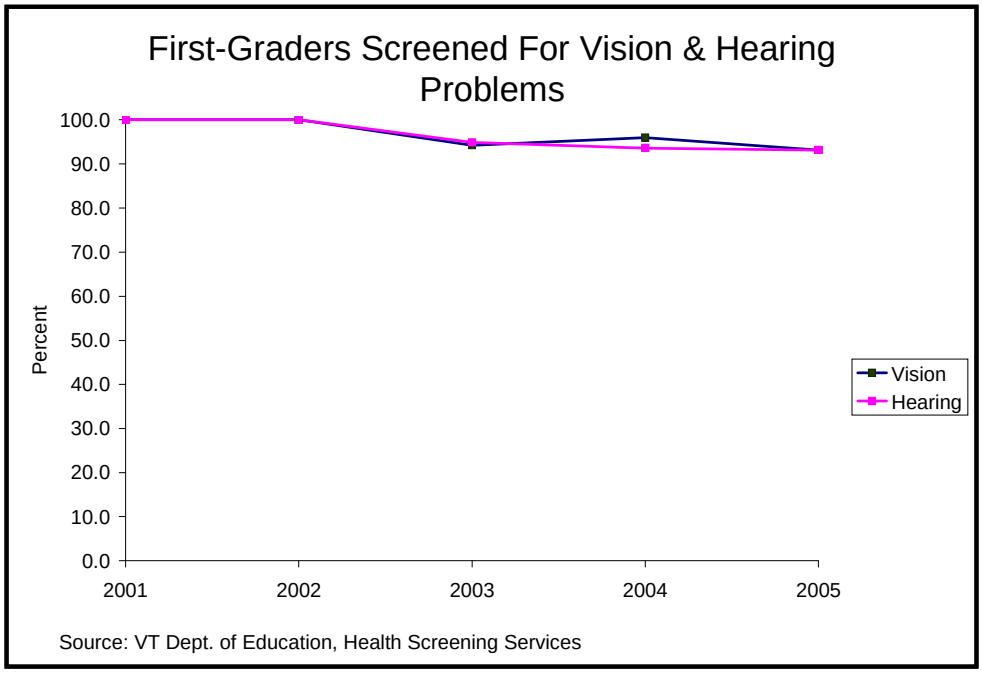


	2001	2002	2003	2004	2005
Vision	100.0	100.0	94.2	95.9	93.1
Hearing	100.0	100.0	94.9	93.6	93.1

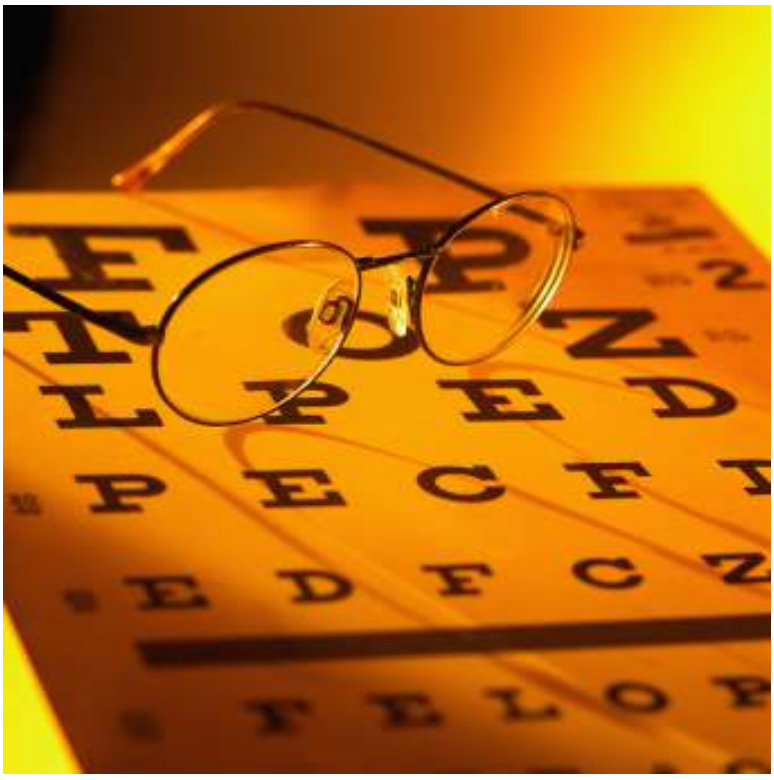
(Note: National data are not available for this indicator.)

The Story Behind the Data

Undetected problems with vision or hearing can be detrimental to children's learning, particularly in the areas of reading and writing. When properly corrected, vision or hearing deficits need not be a handicap. State law requires schools to assure that vision and hearing screening has taken place in grades 1-3, 5, 7, and 9, and vision screening in grade 10. Although required, some children may be missed, particularly if they are new to the district. School nurses collect this information and submit it to the Department of Education; however, issues remain around the reliability of the data.

Data by Vermont Region

For data by school supervisory union area, see the AHS *Community Profiles*: http://humanservices.vermont.gov/publications/community-profiles



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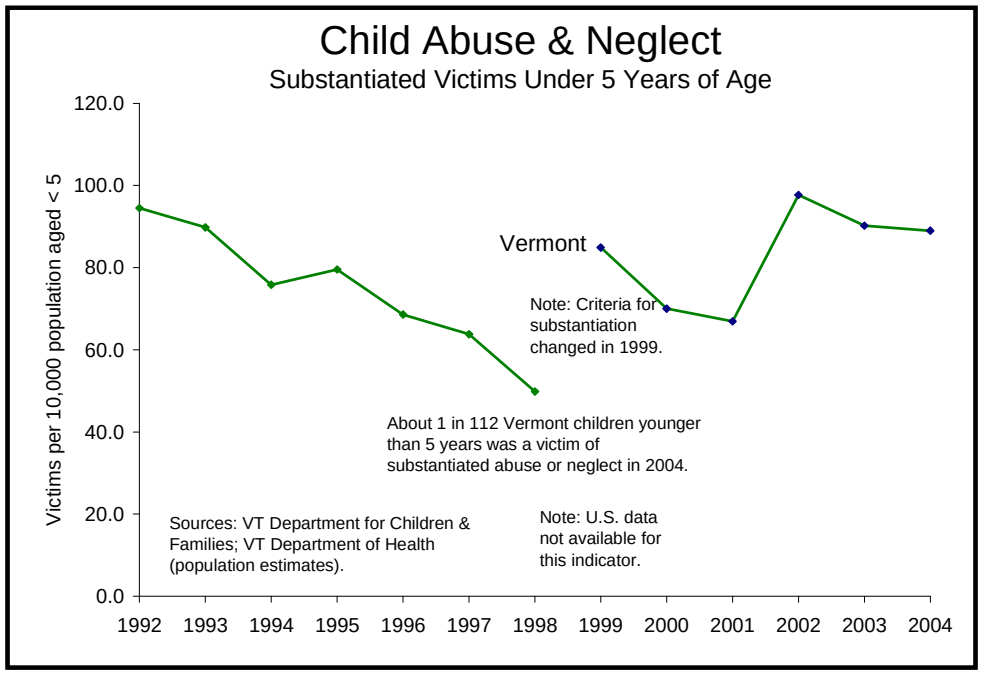


	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	94.5	89.8	75.8	79.5	68.6	63.8	49.8	84.9	70.0	66.9	97.7	90.2	89.0

(Note: National data are not available for this indicator.)

The Story Behind the Data

Being ready for school is not just about early opportunities for learning. Children must also bring to school the social and emotional foundations for success: for example, the ability to trust adults and peers, to cooperate with others, to take on new tasks confidently, to cope with frustration and setback, to make sound decisions. Children who have suffered abuse or neglect are poorly prepared to make the most of school.

Following three consecutive years of declines, the rate of abuse and neglect among Vermont's young children rose in 1999. We think we can attribute this to two policy changes instituted in 1999: a more-inclusive definition of "risk of harm," and significantly increased efforts to get community members to identify and report suspected abuse or neglect. Data for 2004 show a rate lower than the rates recorded for the previous two years. We will need to monitor this indicator closely, in order to be certain it does not reflect other negative trends.[1]

Data by Vermont Region

	2001	2002	2003	2004
	Number **of Substantiated Victims 0-4**			
VT Counties				
Addison	11	17	2	15
Bennington	17	47	18	19
Caledonia	14	6	20	19
Chittenden	85	90	115	77
Essex	1	2	2	3
Franklin	33	38	32	19
Grand Isle	6	6	2	2
Lamoille	14	3	7	8
Orange	5	8	11	16
Orleans	10	10	19	12
Rutland	22	20	16	22
Washington	27	23	27	42
Windham	18	19	9	15
Windsor	27	40	18	25

For Additional Information

See early childhood resources on-line, including The Vermont School Readiness Series: http://humanservices.vermont.gov/publications/vsrs-vrp.

[1] Vermont Department for Children & Families, Waterbury, VT, and Vermont Department of Health, population estimates, Burlington, VT.

Children Succeed in School

Success in school is an essential component of overall well-being in today's world. Well-educated workers, citizens, and neighbors are essential to Vermont's future as a place where people and communities thrive.

Vermont's commitment to education is demonstrated by our willingness to invest in elementary and secondary schools. Our per-pupil expenditures are 5th highest among states; we have the lowest ratio of pupils to teachers; and the average teacher salary in Vermont is 88% of the national average,[1] whereas Vermont wages overall are only 84% of the national average.[2] However, there are troubling signs that our schools are not all they should be: some have resources inadequate for high-quality learning opportunities; some have inadequate, or even unsafe, facilities; many face challenges from students with serious behavioral problems; and too many Vermont students "drop out" without finishing high school. Nationally representative data show that one in five school-age youth have only low levels of engagement with school.[3]

Forging stronger ties between the education and human services communities is our ongoing strategy for achieving the common goals of helping children be ready for school, succeed in school, make positive choices, and be well-prepared for work or higher education. Some of the key Agency of Human Services/Department of Education collaboration projects include:

- *Community Profiles*, which provide local data on over 40 indicators, including those reflecting our common outcomes;
- The Vermont School Readiness Assessment Initiative, an annual data collection on indicators of children's readiness for school, and schools' readiness for children;
- Partnerships which support special education services by maximizing federal Medicaid funds;
- Success by Six, which provides prenatal and post-partum care, parent education, and other support services through home visits to parents of newborns;
- Success Beyond Six, which provides funding to schools for identifying and treating children with emotional and behavior problems;
- Head Start Collaboration Project, which is working to create a unified system of child development and family support services in Vermont; and
- Partnerships, including the University of Vermont, which promote research into how best to achieve the outcomes we desire.

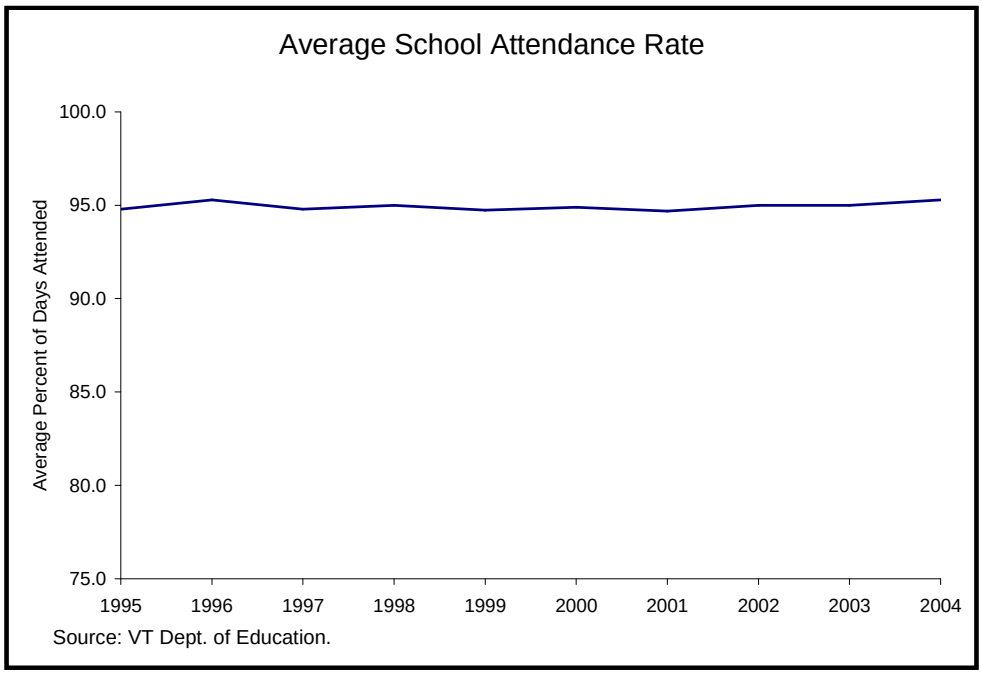
[1] National Center for Education Statistics. Digest of education statistics, 2004. U.S. Department of Education, NCES 2003060. Washington, DC, 2005.

[2] Bureau of Labor Statistics, U.S. Department of Commerce. Average annual pay by state and industry, 2004.

[3] Vandivere S, Moore KA, and Brown B. Child well-being at the outset of welfare reform: An overview of the nation and 13 states. The Urban Institute (Series B, No. B-23), 2000.

What We Want: Children Succeed in School

How We Measure Our Success:



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	94.8	95.3	94.8	95.0	94.7	94.9	94.7	95.0	95.0	95.3

(Note: National data are not available for this indicator.)

The Story Behind the Data

Obviously, students can't benefit from school if they're not there. Attendance is affected by illness, disability, planned vacations, and the student's (and his or her parents') commitment to school. Problems with school attendance ("truancy") can be an early sign of disengagement from school which, if unaddressed, can lead to school failure and/or dropping out. We need to develop a better indicator than average daily attendance, which shows little year-to-year variation. A more useful indicator might be the percentage of students who miss 10 or more days of school each year.

Data by Vermont Region

For data by school supervisory union area, see the AHS *Community Profiles*: http://humanservices.vermont.gov/publications/community-profiles.

For data by school, see the Department of Education's *School Reports*: http://crs.uvm.edu/schlrpt/.

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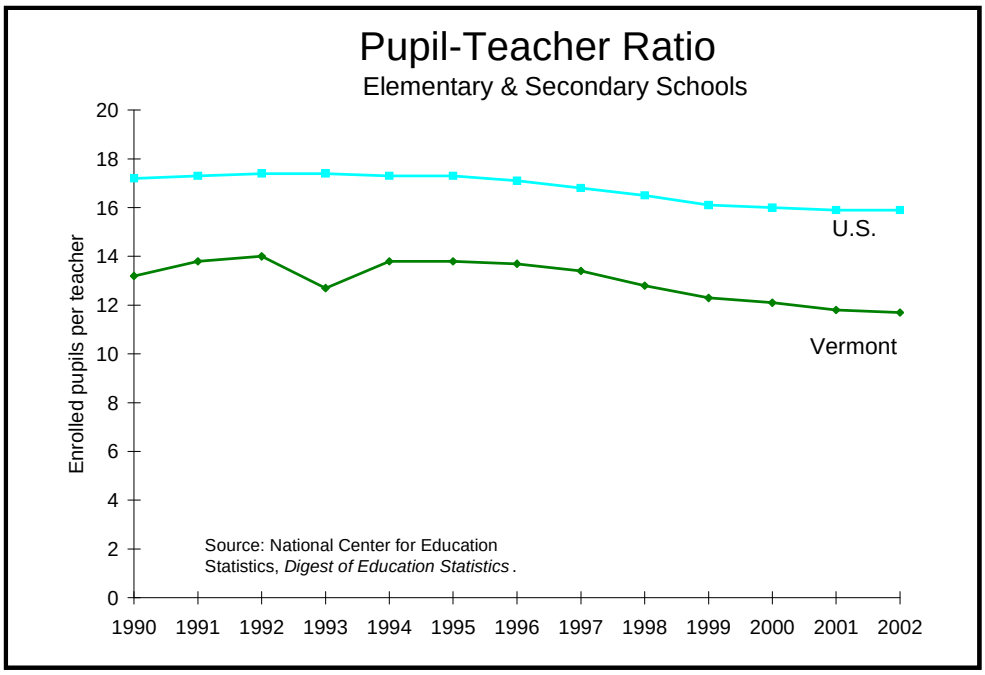

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Vermont	13.2	13.8	14.0	12.7	13.8	13.8	13.7	13.4	12.8	12.3	12.1	11.8	11.7
U.S.	17.2	17.3	17.4	17.4	17.3	17.3	17.1	16.8	16.5	16.1	16.0	15.9	15.9
VT Rank	1	1	1	2	2	1	2	1	1	1	1	1	1

("1" is lowest)

The Story Behind the Data

Research supports the importance for student achievement of smaller classes, particularly in the early grades.[1] Vermont's willingness to invest in education, along with our small population and rural character, allows our schools to have small classes. In 2002, Vermont ranked first in the nation in pupil-teacher ratio. There were an average of 11.7 Vermont students enrolled in public elementary and secondary schools for every one teacher, down from 15.3 in 1981. This compares to 15.9 for the nation.[2]

Data by Vermont Region

For data by school, see the Department of Education's *School Reports*: http://crs.uvm.edu/schlrpt/.

[1] Grissmer D, Flanagan A, Kawata J, and Williamson S. Improving student achievement: What NAEP test scores tell us. Rand Corporation, July 2000.

[2] National Center for Education Statistics. Digest of education statistics, 2004. Washington, DC: U.S. Department of Education, 2005.

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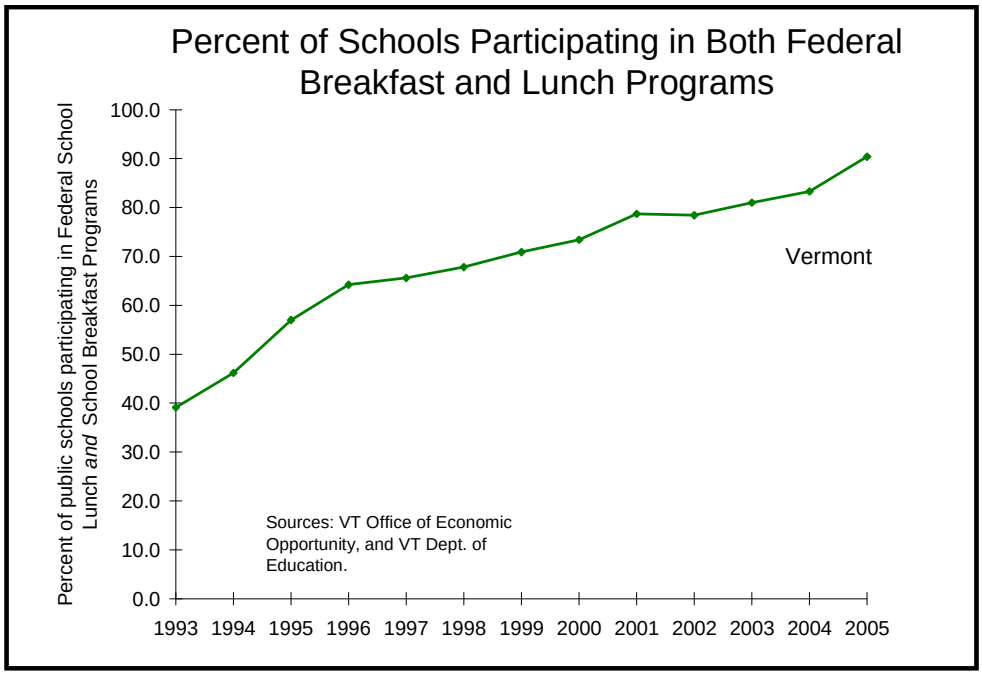


	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Vermont	39.1	46.2	57.0	64.2	65.6	67.8	70.9	73.4	78.7	78.4	81.0	83.3	90.4

(Note: National data are not available for this indicator.)

The Story Behind the Data

Research makes it clear that success in school (as measured, for example, by performance on standardized tests, attendance, incidence of behavioral and emotional problems, and need for special education) is affected by children's nutrition.[1] Simply put, a hungry or poorly-nourished student cannot do his or her best work in school.

Congress recognized this important connection, beginning in 1946, by funding the National School Lunch Program, administered by state education agencies with support from the U.S Department of Agriculture (USDA). Since 1975, USDA's School Breakfast Program has offered schools support with providing a nutritious start to the school day for many children who otherwise would start school hungry. Both programs offer reduced-price or free meals to children whose family meet low-income guidelines. The Summer Food Service Program offers free, nutritious meals to low-income children during school vacations.

In Vermont, with the lead of the Vermont Campaign to End Childhood Hunger, we are making steady progress in serving our hungry children, but there is still room for improvement. Goals must include having all schools offer both programs; as of the 2004-05 school year, 94%

of Vermont public schools had the lunch program, 91% had a breakfast program, and 90% had both.[2] A recent USDA report estimates that, during 2000-02, nearly 11% of households nationwide (9% in Vermont) experienced "food insecurity"; 3.3% (2% in Vermont) experienced outright hunger.[3]

Data by Vermont Region

For data by school, see the Department of Education's *School Reports*: http://crs.uvm.edu/schlrpt/.

For Additional Information

Vermont Campaign to End Childhood Hunger: www.vtnohunger.org

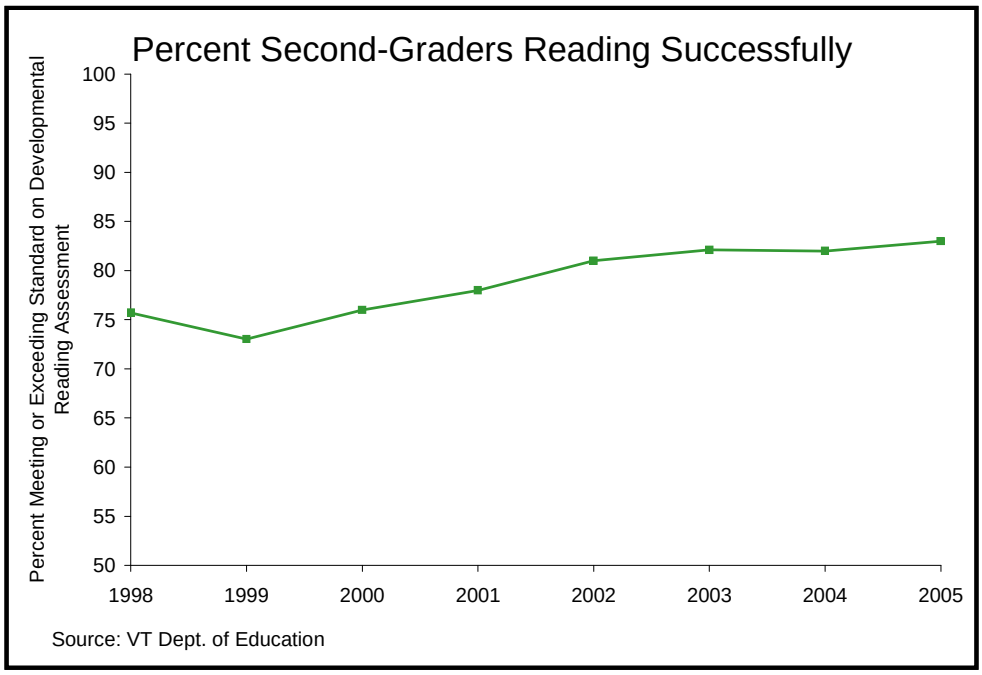
[1] Tufts University, School of Nutrition, Center on Hunger, Poverty, and Nutrition Policy. Statement on the link between nutrition and cognitive development in children, 1994. Kleinman RE, Murphy JM, Little M, Pagano M, Wehler CA, Regal K, and Jellinek MS. Hunger in children in the United States: Potential behavioral and emotional correlates. *Pediatrics, 101*, no. 1, January 1998.

[2] Vermont Office of Economic Opportunity and Vermont Department of Education. Data supplied by Mary Carlson, VT OEO, April 2006.

[3] Nord M, Andrews M, & Carlson S. Household food security in the United States, 2002. Food Assistance and Nutrition Research Report No. (FANRR35). U.S Department of Agriculture. Washington, DC, October, 2003. Households with "food insecurity" lack the resources to provide food for all of their members, and must limit what foods they buy and rely on public and/or private food assistance.

What We Want: Children Succeed in School

How We Measure Our Success:



	1998	1999	2000	2001	2002	2003	2004	2005
Vermont	76	73	76	78	81	82	82	83

(Note: National data are not available for this indicator.)

The Story Behind the Data

Reading is a skill fundamental for school success. Children who are poor readers often fall further and further behind, because so much of school work depends on reading skill. Children who are not reading well by second grade are unlikely to acquire average-level reading skills by the end of elementary school.[1]

In 1998, the Vermont Department of Education instituted an annual statewide reading assessment for second graders. Results show, on average, modest improvement since then in the proportion of students meeting or exceeding the standard. However, nearly one in five children perform below this level, and require intensive, explicit, and supportive instruction. Appropriate screening as early as kindergarten can help identify children who are likely to have trouble learning to read.[2]

Data by Vermont Region

For data by school supervisory union area, see the AHS *Community Profiles*: http://humanservices.vermont.gov/publications/community-profiles.

For data by school, see the Department of Education's *School Reports*: http://crs.uvm.edu/schlrpt/.

For Additional Information

Vermont Even Start Family Literacy Program: www.state.vt.us/educ/new/pdfdoc/pgm_earlyed/even_start_brochure_1005.pdf

[1] Torgesen JK. Preventing early reading failure. *American Educator*. Fall 2004.

[2] Ibid.

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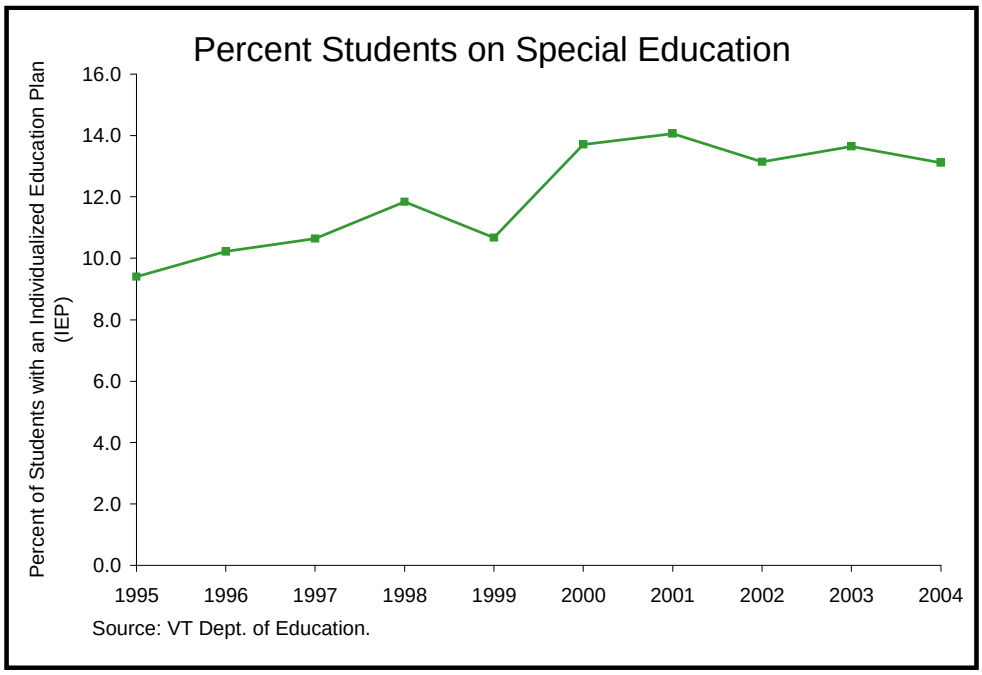
How We Measure Our Success:



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	9.4	10.2	10.6	11.8	10.7	13.7	14.1	13.1	13.6	13.1

(Note: National data are not available for this indicator.)

The Story Behind the Data

Students with recognized disabilities are entitled to special education services to ensure a "free appropriate public education." However, many accommodations are also available to children with disabilities who are not deemed eligible for special education. Special education services can be costly, draining resources away from other important school activities. In addition, there are significant administrative burdens for both schools and families associated with special education.

Not all special education-eligible disabilities are preventable, but many are. So, to a degree, the percentage of students with these disabilities indicates the potential for improved early identification and intervention with children and families *before* they reach school-age.

Data by Vermont Region

For data by school supervisory union area, see the AHS *Community Profiles*: http://humanservices.vermont.gov/publications/community-profiles.

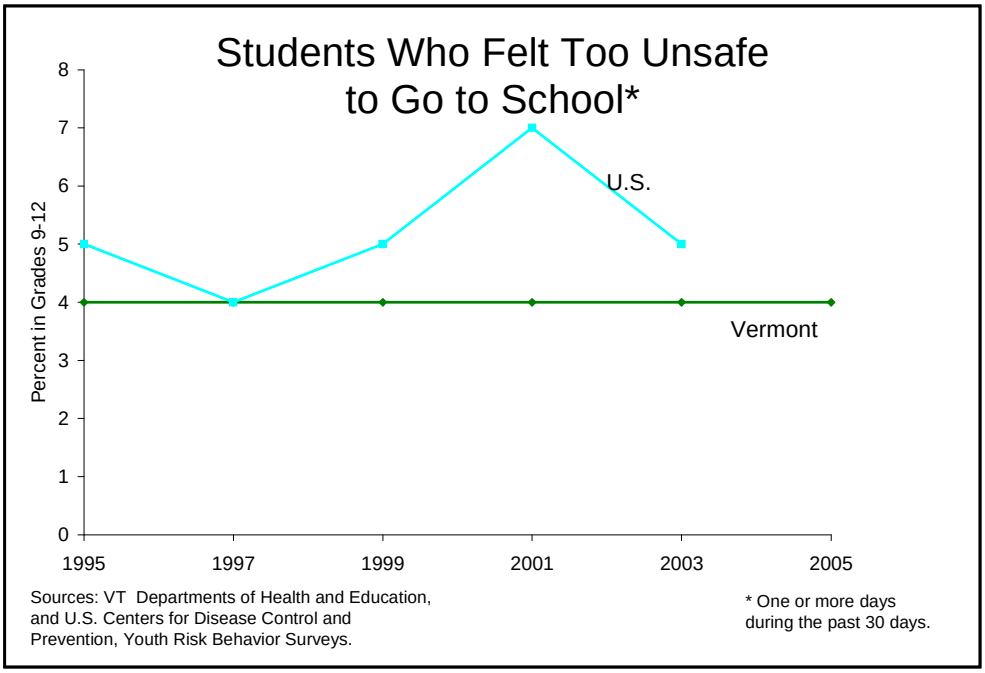
For data by school, see the Department of Education's *School Reports*: http://crs.uvm.edu/schlrpt/.

For Additional Information

Vermont Parent Information Center: www.vtpic.com

What We Want: Children Succeed in School

How We Measure Our Success:



	1995	1997	1999	2001	2003	2005
Vermont	4	4	4	4	4	4
U.S.	5	4	5	7	5	n/a

(Note: State rankings are not available for this indicator.)

The Story Behind the Data

We are fortunate that incidents of life-threatening violence in Vermont schools are very rare. More important to focus on are the less serious, but still corrosive behaviors and conditions that contribute to a climate of tension and fear that is not healthy for schools, communities, or children. Schools must be safe places—for students, teachers, and others—or learning is compromised. Teasing, bullying, disruptive, derogatory, threatening, or violent behaviors are part of a continuum that schools (and parents and communities together) must address.

The first of the indicators offered here deals with how safe youth feel at school, including going to and from school. In Vermont, about 4% of students in grades 9-12 report that they missed school on one or more of the past 30 days because they felt unsafe. Younger teens tend to feel more vulnerable than older students. Overall, there has been little change in these data since 1993.[1] Interestingly, 30% of U.S. 11- to 15-year-olds report they rarely or never feel safe *at* school, a proportion higher than that reported by students in Israel, Ireland, Northern Ireland, or Russia.[2]

Data by Vermont Region

VT Counties	2001	2003	2005
Addison	4	4	3
Bennington	3	5	4
Caledonia	5	4	3
Chittenden	4	4	4
Essex	6	2	n/a
Franklin	4	5	5
Grand Isle	3	8	4
Lamoille	8	4	4
Orange	5	4	4
Orleans	5	5	5
Rutland	6	5	6
Washington	5	4	5
Windham	6	5	5
Windsor	4	4	4

For Additional Information

For Youth Risk Behavior Survey data by school supervisory union, contact your local superintendent's office.

[1] Centers for Disease Control and Prevention. Youth risk behavioral surveillance—United States, 2001. *CDC Surveillance Summaries*, *MMWR*, *51* (no. SS-4), June 2002. Vermont Departments of Health, and Education. The 2003 Vermont Youth Risk Behavior Survey: Statewide report. Burlington, VT, 2003.

[2] U.S. Department of Health and Human Services, Health Resources and Services Administration. U.S. teens in our world. Rockville, MD, 2003.

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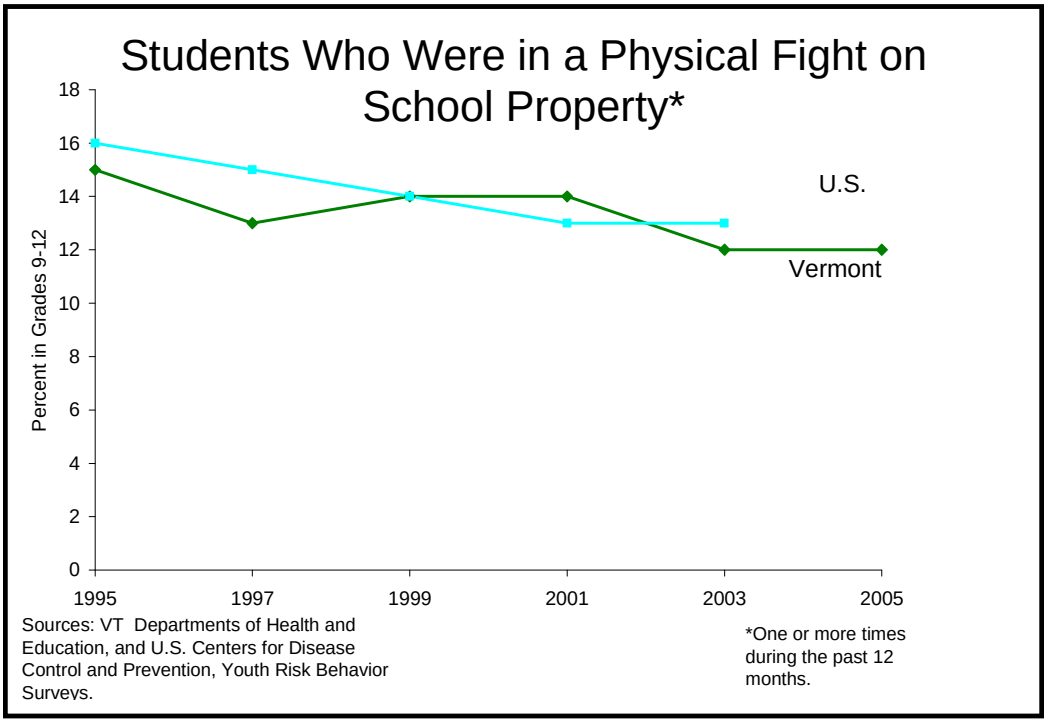

	1995	1997	1999	2001	2003	2005
Vermont	15	13	14	14	12	12
U.S.	16	15	14	13	13	n/a

(Note: State rankings are not available for this indicator.)

The Story Behind the Data

Here, Vermont's data are also similar, statistically, to U.S. figures. In 2003 about 12% of Vermont students in grades 9-12 reported that they had been in a physical fight on school property during the past 12 months. Again, there is an age-related trend in these data, with fewer students fighting at higher grade levels. Boys are more than twice as likely as girls, overall, to report fighting.[1]

Data by Vermont Region

VT Counties	2001	2003	2005
Addison	4	4	3
Bennington	3	5	4
Caledonia	5	4	3
Chittenden	4	4	4
Essex	6	2	n/a
Franklin	4	5	5
Grand Isle	3	8	4
Lamoille	8	4	4
Orange	5	4	4
Orleans	5	5	5
Rutland	6	5	6
Washington	5	4	5
Windham	6	5	5
Windsor	4	4	4

For Additional Information

For Youth Risk Behavior Survey data by school supervisory union, contact your local superintendent's office.

[1] Centers for Disease Control and Prevention , op. cit.

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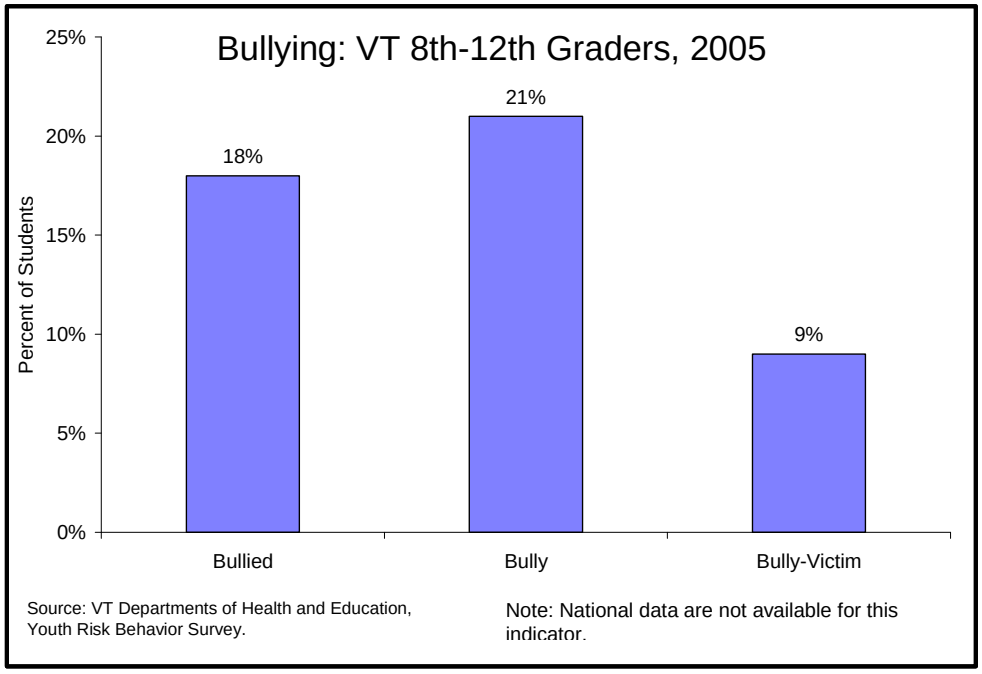

The Story Behind the Data

Violence takes many forms. Among children and teens, bullying can be a subtle but insidious threat to personal safety and well-being. Not all bullying takes place in school, or even "in person" (on-line bullying is rapidly growing phenomenon). However, there has been recent emphasis on the role schools can play in identifying, responding to, and preventing bullying.

Bullying can be defined in various ways. In 2005, for the first time, Vermont students completing the Youth Risk Behavior Survey (YRBS) responded to two questions about bullying. For purposes of the survey, bullying was defined as a pattern of behavior designed to belittle, embarrass, frighten, intimidate, or exclude another student; good-natured "teasing" was excluded. Students indicated whether, during the past 30 days, they had *been bullied*, or had *been a bully*. Research has indicated that youth in either role (victim or bully) are at elevated risk for a number of other problems. The group of youth who are *both* bullies and victims ("bully-victims"), according to this research, have the most adverse outcomes.[1]

Our Vermont data in many ways mirror these findings from other studies. Bullying appears to be more common in the earlier grades (31 percent of Vermont eighth-graders reported bullying, 26 being bullied), and boys are somewhat more likely than girls to say they have bullied (but not that they have been bullied). If anything, the Vermont data indicate that bullying is at least as much, if not more, of a problem in our state as elsewhere in the country.[2]

Data by Vermont Region

VT Counties Grades 8-12	2005 Were Bullied	2005 Bullied Someone
Addison	17	21
Bennington	15	20
Caledonia	17	22
Chittenden	17	19
Essex	n/a	n/a
Franklin	19	24
Grand Isle	17	27
Lamoille	17	23
Orange	19	26
Orleans	17	23
Rutland	18	22
Washington	19	25
Windham	17	22
Windsor	18	20

For VT YRBS data by school supervisory union, contact your local superintendent's office.

For Additional Information

Vermont Department of Education's "Model Bullying Prevention Plan":
www.state.vt.us/educ/new/pdfdoc/pgm_safeschools/pubs/bullying_prevention_04.pdf

[1] Glew GM, Fan MY, Katon W, Rivara FP, & Kernic MA. Bullying, psychosocial adjustment, and academic performance in elementary school. *Archives of Pediatrics and Adolescent Medicine, 159*, no. 11 (November 2005), 1026-1031. Juvonen J, Graham S, & Schuster MA. Bullying among young adolescents: The strong, the weak, and the troubled. *Pediatrics, 112*, no. 6 (December 2003), 1231-1237.

[2] Vermont Department of Health, and Vermont Department of Education. The 2005 Vermont Youth Risk Behavior Survey. Burlington, VT: Author. 2005. Nanse TR, Overpeck M, Pila RS, Ruan WJ, Simons-Morton B, Scheidt P. Bullying behaviors among US youth: Prevalence and association with psychosocial adjustment. *JAMA, 285*, no. 16 (April 25, 2001), 2094-2100.

What We Want: Children Succeed in School

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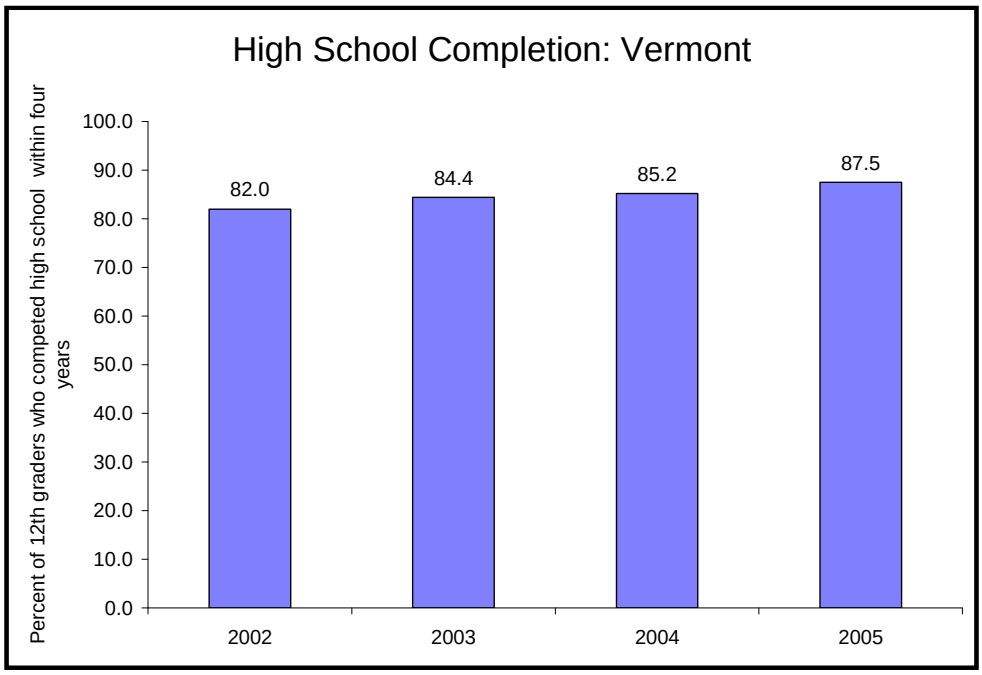

	2002	2003	2004	2005
Vermont	82.0	84.4	85.2	87.5

(Note: National data are not available for this indicator.)

The Story Behind the Data

A high proportion of Vermont adults, relative to those in many other states have completed high school.[1] However, we are losing ground. Recent data show Vermont only 15th best among states reporting the percent of public high school students who earn a diploma within four years.[2] And a recent "report card" on states' performance gave Vermont poor grades for the percentage of 18-24-year-olds with a high school credential, and for preparing students for college.[3]

Recent assessments of the academic performance of American students paint a disturbing picture. International comparisons, particularly on math and science performance, for example, place American students substantially behind their counterparts in many other countries.[4] In the vital area of reading literacy, a recent multinational assessment found that U.S. fourth-graders scored only twelfth highest among their counterparts in 34 other industrialized countries,[5] and in another cross-nation study 15-year-olds in the U.S. showed only average performance relative to

their peers in other countries in literacy, and below-average performance in math literacy and problem solving.[6]

Jobs that pay a livable wage require completion of at least high school, and often post-secondary training or a college education. On average, a high school dropout has an annual income only 40 percent of what a college graduate earns, and someone with only a high school diploma earns only a little more than half as much.[7]

Lack of basic education may also make it more difficult to manage appropriately the varied stresses of raising a family. A study by the Vermont Department of Health and the Agency of Human Services, Planning Division, found that the incidence of child abuse in homes where mothers had not completed high school was more than four times the rate in homes with better-educated mothers, controlling for other risk factors.[8] Dropouts are also heavily over-represented in our Corrections population.

Reliable measures of high school dropout are difficult to obtain. However, data from the Vermont Department of Education show that 768 students (2.4%) "dropped out" (withdrew from grades 9-12) during the 2004-05 school year. After remaining essentially stable over nearly two decades, the dropout rate in Vermont has declined in the last few years.[9] The Agency of Human Services has compiled *What Works: Helping Youth Stay in School in Your Community* to help communities identify successful strategies for reducing the numbers of youth not finishing school.[10]

In order to provide a better understanding of how well our schools are doing, the Vermont Department of Education, working with local schools, has developed a variety of assessment tools, including the student portfolio system, standards-based assessments, school report cards, school quality standards, and Action Plans.

Data by Vermont Region

For data by school supervisory union area, see the AHS *Community Profiles*: http://humanservices.vermont.gov/publications/community-profiles.

For data by school, see the Department of Education's *School Reports*: http://crs.uvm.edu/schlrpt/.

Related AHS Performance Measure: Increase the high school graduation rate.

For Additional Information

Vermont Department of Education, Truancy & Dropout Prevention: www.state.vt.us/educ/new/html/pgm_truancy.html

Vermont Department of Education, "High Schools on the Move": www.state.vt.us/educ/new/html/pubs/high_schools_on_the_move.html

[1] U.S. Census Bureau. Current population reports: Educational attainment in the United States—March 2000 (update) (P20-536). Washington, DC, December 2000.

[2] Kaufman P, Alt MN, and Chapman CD. Dropout rates in the United States: 2001. National Center for Education Statistics, November 2004.

[3] The National Center for Public Policy and Higher Education. Measuring up 2004: The state report card on higher education. 2004.

[4] The National Commission on Mathematics and Science Teaching for the 21st Century. Before it's too late: A report to the nation. U.S. Department of Education, 2000.

[5] Ogle LT, Sen A, Pahlke E, Jocelyn L, Kastberg D, Roey S, & Williams T. International comparisons in fourth-grade literacy: Findings from the Progress in International Reading Literacy Study (PIRLS) of 2001. National Center for Education Statistics. Washington, DC, April 2003.

[6] National Center for Education Statistics. Highlights from the 2000 Program for International Student Assessment (PISA). Office of Educational Research and Improvement, U.S. Department of Education, 2001.
International outcomes of learning in mathematics literacy and problem solving: PISA 2003 results from the U.S. perspective. Highlights, December 2004.

[7] Day JC, & Newburger EC. The big payoff: Educational attainment and synthetic estimates of work-life earnings. Current Population Reports. U.S. Census Bureau. Washington, DC, July 2002.

[8] Murphey DA, and Braner M. Linking abuse/neglect retrospectively to birth and home visit records: An initial examination. *Child Welfare*, *74*, 711-728. November/December 2000.

[9] Vermont Department of Education. Vermont public school dropout and high school completion report for the 2004-2005 school year. Montpelier, VT, April 2006.

[10] Vermont Agency of Human Services. What works: Helping youth stay in school in your community. Waterbury, VT, April 2002.

Children Live in Stable, Supported Families

Families are an important foundation for individual and community well-being. Families today may take a variety of forms, but all can be described as "a group of persons linked by feelings of trust, mutual support, and a common destiny."[1] One of the most profound changes in the U.S. in recent years has been in the number of children living in single-parent homes—which comprise 27% of all family households with children, according to 2000 estimates, compared to 11% in 1970.[2] Among 29 countries participating in a recent survey, the U.S. had the highest percentage of students (ages 11-15) living with single parents.[3]

Today, many parents (especially single parents) have less money and less time to devote to their children. Some national estimates show that about one in five children live in a "stressful" family environment, where parents are more likely to be "aggravated." These children are less likely to be engaged in school, and more likely to have behavioral and emotional problems.[4]

Income inequality among Vermont families has increased over the past two decades. Between the early 1980s and the early 2000s, the average income of the poorest fifth of families increased by about $4,000, while the avarage income of the richest fifth increased by more than $47,000. As a result, by the early 2000s, the wealthiest fifth of families had incomes six times as great, on average, than the incomes of the poorest fifth of families.[5]

Partly as a consequence of lower real incomes, more divorces, and more births to unmarried women, there are more mothers who are working. In 2000, 57% of married women with children under six were in the labor force, compared to 19% in 1960, according to national data. In Vermont, the corresponding figure for 2000 was 69%. Among married women with children 6-17 years old, 68% nationally and 80% in Vermont, are in the labor force.[6] And there is still a substantial "gender-gap" with respect to wages: women in Vermont earn about 78% of what Vermont men earn (median annual earnings).[7]

Nevertheless, most Vermont families and children are doing well, compared to families and children living in other states. We have accomplished dramatic reductions in child abuse and neglect, particularly in the youngest age-groups. We have continued to expand children's access to health insurance, so that cost will no longer be a barrier. Nevertheless, roughly one Vermont child in eight lives below the poverty line. One in four lives with a single parent, and the child support payments in more than a third of the cases are never collected.

[1] Definition is from the World Health Organization (WHO).

[2] U.S. Bureau of the Census. *Current Population Reports,* Series P20-537, "America's Families and Living Arrangements, 2000: Population Characteristics. June 2001.

[3] U.S. Department of Health and Human Services, Health Resources and Services Administration. U.S. teens in our world. Rockville, MD, 2003.

[4] Moore KA, and Vandivere S. Stressful family lives: Child and parent well-being. The Urban Institute, Washington, DC, 2000.

[5] Economic Policy Institute/Center on Budget and Policy Priorities. Pulling apart: A state-by-state analysis of income trends. Washington, DC, 2006.

[6] U.S. Census Bureau. Census 2000.

[7] Institute for Women's Policy Research. The status of women in the states 2004. Overview. November 2004.

What We Want: Children Live in Stable, Supported Families

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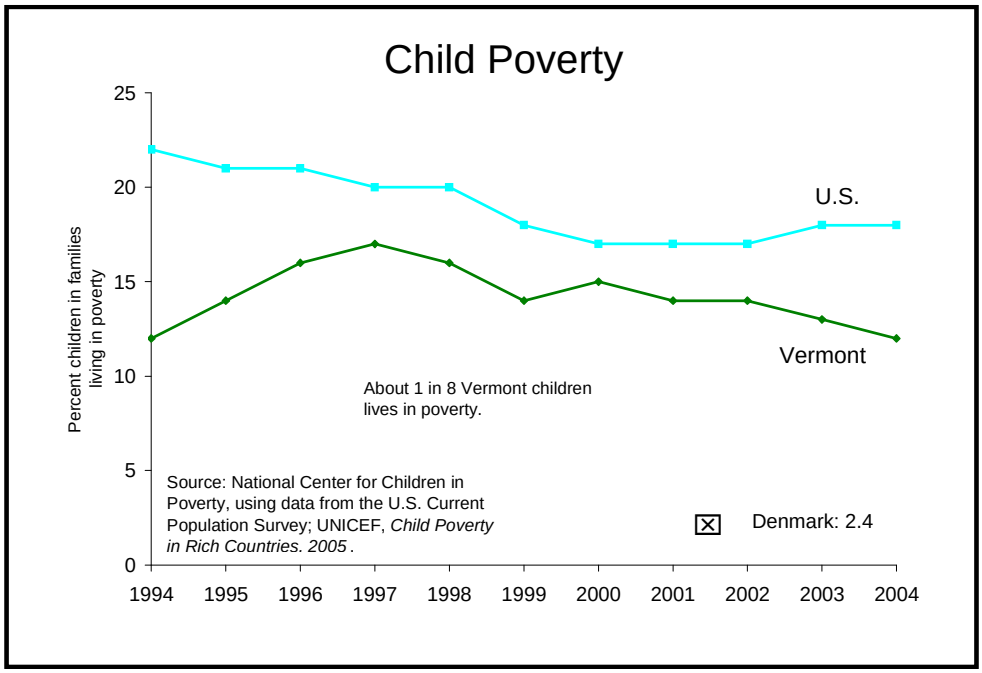

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	12	14	16	17	16	14	15	14	14	13	12
U.S.	22	21	21	20	20	18	17	17	17	18	18
VT Rank	1	4	15	16	15	13	18	16	19	11	5

("1" is lowest)

The Story Behind the Data

Poverty[1] poses the single greatest threat to healthy development, and young children are the poorest age group in America. In 2004, the nation's rate of children (under age 18) living below federal poverty level was 17.8%, compared to 11.3% for people 18 to 64, and 9.8% for those 65 and older.[1] Children in low-income families are at much greater risk for health problems and early death; for neglect and abuse; and for learning and behavioral problems.[2]

The rate of child poverty in the U.S. is more than double that of other industrialized nations. Among these, Denmark, Finland, Norway, and Sweden have all been able to reduce child poverty to less than 5%;[3] in the U.S. (and in Vermont) it has been above 10% for the past 20 years or more. However, Vermont children generally fare somewhat better than those in other states.

[1] See p. 182 for a discussion of the difficulty in measuring poverty.

Data by Vermont Region

VT Counties	1999
Addison	9.1
Bennington	13.4
Caledonia	16.6
Chittenden	8.0
Essex	17.3
Franklin	10.4
Grand Isle	9.2
Lamoille	10.7
Orange	11.4
Orleans	17.9
Rutland	13.3
Washington	9.1
Windham	12.0
Windsor	7.5

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

For Additional Information

National Center for Children in Poverty. Low-income children in the United States: National and state trend data, 1994-2004. Available at www.nccp.org.

[1] U.S. Census Bureau. Current Population Survey.

[2] Brooks-Gunn J, and Duncan GJ. The effects of poverty on children. *The Future of Children*, vol. *7*, no. 2 (Summer/Fall 1997). The David and Lucile Packard Foundation, 1997.

[3] United Nations Children's Fund (UNICEF). Child poverty in rich countries, 2005. *Innocenti Report Card No. 6.* Florence, Italy: UNICEF Innocenti Research Centre.

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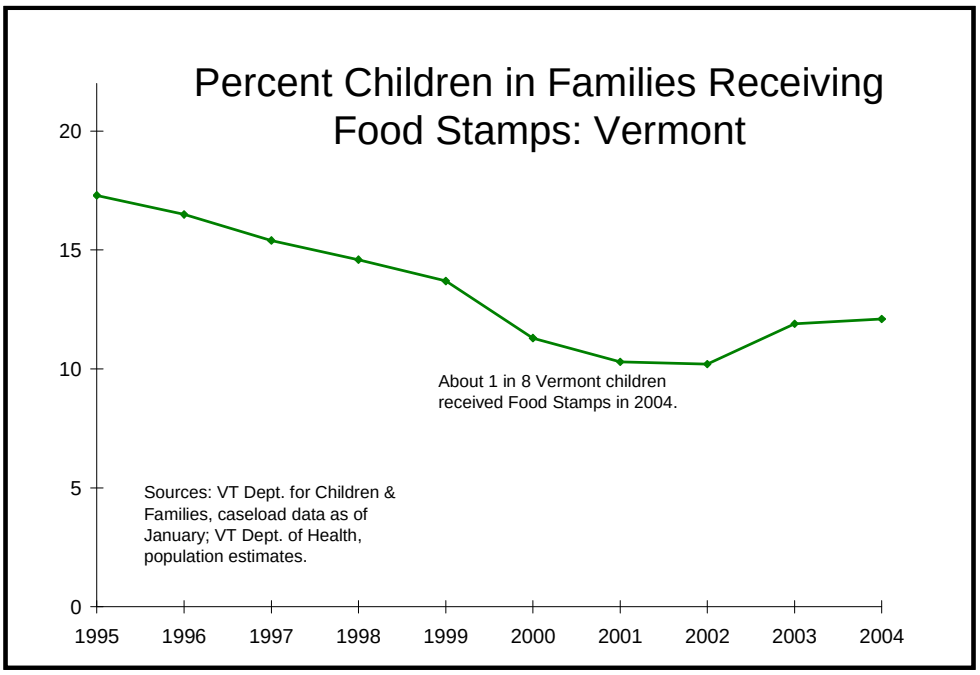

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	17.3	16.5	15.4	14.6	13.7	11.3	10.3	10.2	11.9	12.1

(Note: National data are not available for this indicator.)

The Story Behind the Data

An alternative method of assessing the extent of child poverty is to examine the percentage of children living in families that receive food stamps. Administrative data from Vermont's Department for Children & Families (which oversees the food stamp program in Vermont) are considered more accurate than the poverty estimates the federal Census Bureau prepares based on sample data. The eligibility standard for food stamps has been consistently at around 130% of poverty level. Enrollment data are sensitive to a number of factors, including public awareness of eligibility and willingness to accept this form of assistance; therefore, they likely do not include everyone who qualifies. Nevertheless, they provide a reasonable picture of year-to-year trends. The U.S. Department of Agriculture (which sponsors the Food Stamp Program) rates Vermont ninth best among the states in getting eligible people to participate in the Program.[1]

Although estimates vary somewhat, unquestionably many Vermont children live in families that are in severe economic hardship. Knowing what we do about the serious threats poverty poses to children's well-being, it is incumbent on us to address their needs. Recovering

more of uncollected court-ordered child support, which totals over $90 million, would make a substantial impact in the lives of many families. Reducing our rate of high school dropouts would raise economic prospects for many families with children: In 1995, the poverty rate nationally for children living with parents who dropped out of school was more than 10 times higher than the rate for children living in families where at least one parent had a college degree.[2] Expansion of school nutrition programs (see p. 58) is another opportunity to meet children's needs in a critical area on a regular basis.

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	8.5	7.3	6.1	8.6	8.2
Bennington	14.8	13.5	14.1	15.1	15.9
Caledonia	15.5	13.3	13.6	15.9	17.9
Chittenden	8.0	7.9	7.3	8.5	8.8
Essex	18.2	16.8	16.4	18.2	19.3
Franklin	12.1	11.1	10.5	12.3	12.4
Grand Isle	12.5	9.1	8.6	11.0	11.4
Lamoille	10.7	9.3	8.6	10.4	12.7
Orange	10.0	8.7	9.6	11.2	12.1
Orleans	19.5	15.8	17.4	20.6	19.7
Rutland	14.0	13.0	13.2	15.3	15.3
Washington	9.5	9.4	9.2	10.4	9.3
Windham	11.7	10.9	11.1	12.8	13.7
Windsor	11.7	10.9	8.6	10.9	11.3

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

For Additional Information

Food Research & Action Center: www.frac.org

[1] Food Research and Action Center. 2004 Food Stamp Program Access Index (PAI) state-by-state. Printed from www.frac.org/html/federal_food_programs/FSP/Participation_Rates_04.html

[2] The Annie E. Casey Foundation. Kids count data book: State profiles of child well-being, 1997. Baltimore, MD, 1997.

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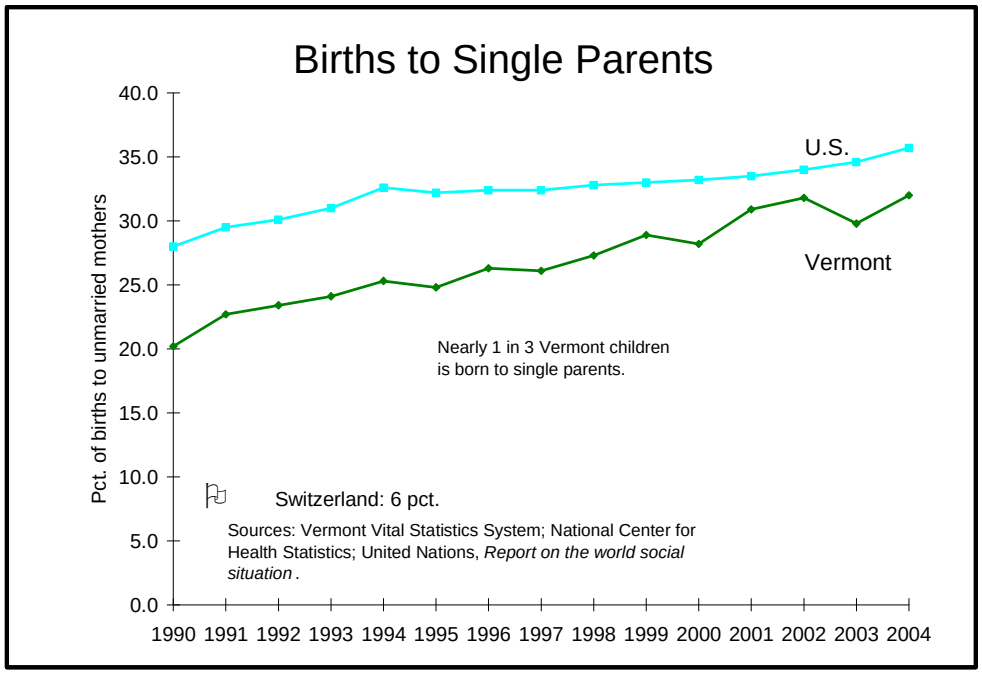


	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	20.2	22.7	23.4	24.1	25.3	24.8	26.3	26.1	27.3	28.9	28.2	30.9	31.8	29.8	32.0
U.S.	28.0	29.5	30.1	31.0	32.6	32.2	32.4	32.4	32.8	33.0	33.2	33.5	34.0	34.6	35.7
VT Rank	20	9	8	8	8	7	10	9	12	14	9	18	18	34	n/a

("1" is lowest)

The Story Behind the Data

Closely linked to the increase in child poverty is the trend in the number of single-parent families. This trend is apparent throughout the industrialized world, and is associated with major economic changes and with changes in the status of women.[1] More women are giving birth outside of marriage, and more children are being raised in families headed by single parents (mostly mothers).

Currently, about one-third of all births in the United States, and in Vermont, are to unmarried parents.[2] This proportion (both nationally and in Vermont) increased steadily over the past decade. Only about one-third of births to single parents are the result of intended pregnancies; among single teens, who account for about one-third of all non-marital births, only 10% are intended.[3] As noted below, single-parent families are much more likely to live in poverty, and to be dependent on public assistance.

Data by Vermont Region

County-level data are available in the annual Vital Statistics reports produced by the Vermont Department of Health. See www.healthyvermonters.info/pubs.shtml#vital.

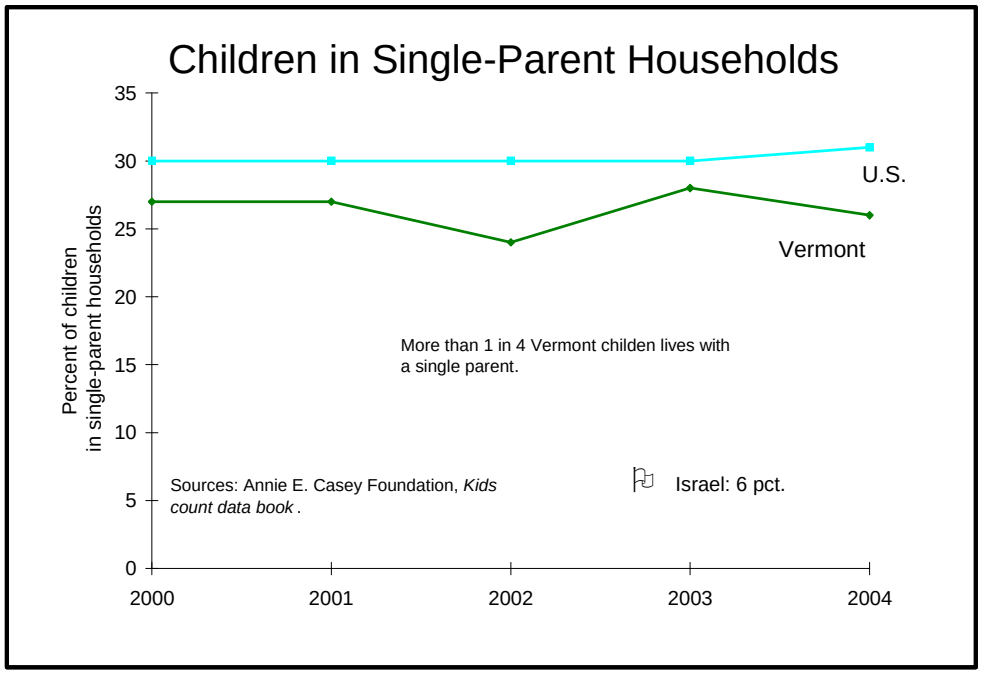
[1] United Nations Children's Fund (UNICEF). The progress of nations, 1996. New York, 1996.

[2] Martin JA, Hamilton BE, and Sutton PD. Births: Final data for 2003. *National Vital Statistics Reports, 54*, no.2. Centers for Disease Control and Prevention, 2005. Vermont Vital Statistics Data System. Personal communication with Michael Nyland-Funke. March 2006.

[3] Bumpass L. Teenage childbearing in the context of societal changes in family and fertility. *Focus,* vol. *17*, number 1. University of Wisconsin-Madison Institute for Research on Poverty, Summer 1995.

What We Want: Children Live in Stable, Supported Families

How We Measure Our Success:



	2000	2001	2002	2003	2004
Vermont	27	27	24	28	26
U.S.	30	30	30	30	31
VT Rank	17	18	6	16	11

("1" is lowest)

The Story Behind the Data

Whether because their parents never married, their parents separated or divorced, or a parent is deceased, more and more children are growing up in families with just one parent. In the United States, the number of children in these circumstances is growing at an unprecedented rate (the proportion has quadrupled since 1950). More than half of all children in the U.S. today will spend some time living with a single parent—typically, their mothers. National studies suggest that in general children do best when living with two biological parents in a non-conflictual marriage.[1] Whatever their family's configuration, children need to have a number of caring adults in their lives in order to thrive.

Single-parent families (especially those headed by women) are much more likely not only to be poor, but also to bear the many burdens associated with poverty. For example, among all families with children under 18, 15 percent had 2004 incomes below federal poverty level. However, among families with a single mother, 36 percent were in poverty. The median income

in 2004 for all families with at least one child under 18 years old was $52,973; for families headed by a single mother it was less than half that amount—$23,428.[2] Children in mother-headed families account for over half the U.S. children in poverty; in some other countries that have high rates of children in solo-mother families, government "safety net" programs help mitigate the effects of poverty; in the U.S., government programs have had a much less significant impact.[3]

Some, though by no means all, children in single-parent families are at risk for problems besides poverty. Other adverse outcomes disproportionately associated with children living in single-parent families are child abuse, substance abuse, health and emotional/behavioral problems, early sexual activity, injuries, and suicide.[4]

One correlate of these trends is the large number of children growing up having little contact with their fathers. In 2002 there were 16 million children living in families where no father was present.[5] A major reason for the declining presence of fathers in families is diminished economic opportunities for young men, especially for those with little education and few marketable skills. While the negative economic implications for these families are well understood, less well known is the growing evidence of the harmful effects father-absence can have on children's development and on their successful transition to adult roles, including an greatly increased risk of youth incarceration.[6]

Unfortunately, recent evidence suggests that most unmarried parents are scarcely able to support themselves and their children, even if they were to get married (and most expect to do so). Many of these parents have very little education, and many are unemployed; most live near or below the federal poverty line. Many have health problems. Marriage would not erase these barriers to self-sufficiency.[7]

[1] See, for example, Moore KA, Jekielek SM, & Emig C. Marriage from a child's perspective: How does family structure affect children, and what can we do about it? Child Trends, Inc. Washington, DC, June 2002.

[2] U.S. Bureau of the Census. Current Population Survey, 2005.

[3] UNICEF. The progress of nations, 1996. New York, 1996.

[4] Moore KA. Nonmarital childbearing in the United States. Executive Summary of A Report to Congress on Out-of-Wedlock Childbearing. U.S. DHHS, PHS 95-1257-1. 1995. Johnson RA, Hoffman JP, & Gerstein DR. The relationship between family structure and adolescent substance use. Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 1996. Sedlack AJ, & Broadhurst DD. Executive summary of the Third National Incidence Study of Child Abuse and Neglect. Washington, DC: DHHS, National Center on Child Abuse and Neglect, 1996. McLanahan S, & Sandefur G. Growing up with a single parent. Cambridge, MA: Harvard University Press, 1994. Weitoft GR, Hjern A, Haglund B, and Rosen M. Mortality, severe morbidity, and injury in children living with single parents in Sweden: A population-based study. *The Lancet, 363* (9354), January 2003.

[5] Fields J. Children's living arrangements and characteristics: March 2002. *Current Population Reports*. U.S. Census Bureau. Washington, DC, June 2003.

[6] The Annie E. Casey Foundation. Kids count data book, 1996: State profiles of child well-being. Baltimore, MD, 1996. Harper CC, & McLanahan SS. Father absence and youth incarceration. Unpublished paper, October 1999.

[7] Center for Research on Child Wellbeing. Is marriage a viable objective for fragile families? Fragile Families Research Brief, No. 9, Princeton University, Princeton, NJ, July 2002.

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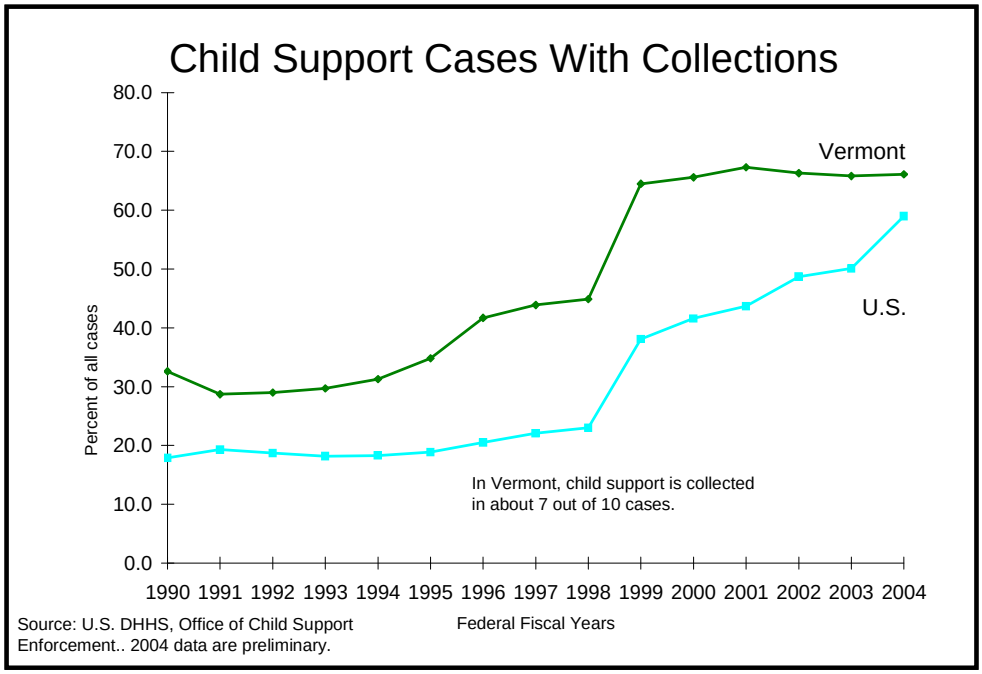

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	32.6	28.7	29.0	29.7	31.3	34.8	41.7	43.9	44.9	64.5	65.6	67.3	66.3	65.8	66.1
U.S.	17.9	19.3	18.7	18.2	18.3	18.9	20.5	22.1	23.0	38.1	41.6	43.7	48.7	50.1	59.0
VT Rank	1	1	1	1	8	6	1	1	1	3	7	9	11	7	8

("1" is highest)

The Story Behind the Data

As the number of single-parent families grows, payment of child support by non-resident parents is a critical part of gaining economic self-sufficiency for many families. Recent data show that child support reduces by a half-million the number of poor children in the U.S.[1]

The premise of child support is that both parents should continue to share the responsibility for supporting their children, whether or not they live with them. Of the approximately 28 million children in the nation who were living apart from at least one of their parents in 2002, about three-quarters received at least some payments from the non-resident parent in 2001. However, only 45% received the full ordered amount.[2] In this respect the U.S. lags behind many European countries, where some minimum level of child support is guaranteed.

In Vermont, about 55,000 children, or one-third of all the children in the state, are eligible for child support. Each year another 4,000 children of separated and divorcing parents,

and children born out-of-wedlock, become eligible for child support. The accumulated uncollected child support in Vermont exceeds $92 million.[3] Vermont's Office of Child Support, which establishes and enforces child support orders, was successful in collecting support in 66% of its cases in 2004. Vermont's rate was higher than the national rate of 59%, and was eighth highest among the states.[4] Studies have shown that stronger child support enforcement pays off: for example, for every dollar of child support received by a single mother, her income is likely to rise by nearly two dollars.[5]

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	84.8	93.2	93.4	89.5	88.1
Bennington	76.2	91.4	94.0	92.3	92.3
Caledonia	75.2	89.3	91.3	91.6	91.9
Chittenden	81.3	91.9	90.7	84.8	92.3
Essex	81.7	95.2	90.5	87.9	103.1
Franklin	79.1	91.8	92.4	91.8	93.8
Grand Isle	75.9	98.5	93.7	93.8	85.6
Lamoille	81.5	91.7	88.2	91.9	94.8
Orange	80.7	93.5	93.8	87.7	93.4
Orleans	77.8	92.1	92.6	94.7	93.8
Rutland	78.5	89.6	91.8	90.7	90.4
Washington	81.6	94.8	92.7	90.1	92.9
Windham	80.5	93.6	92.7	90.1	92.1
Windsor	81.1	94.9	93.7	91.6	91.2

For Additional Information

For Vermont Office of Child Support's Annual Report, go to
www.ocs.state.vt.us/Reports/2006_annual_report.pdf

[1] Sorensen E, & Zibman C. Child support offers some protection against poverty. The Urban Institute, Washington, DC, 2000.

[2] Grail TS. Custodial mothers and fathers and their child support: 2001. Current Population Reports. P60-225. U.S. Census Bureau. Washington, DC, October 2003.

[3] Vermont Office of Child Support. Report to Legislature: Implementation of Act 63. January 15, 2001.

[4] U.S. DHHS, Office of Child Support Enforcement. Child Support Enforcement FY 2004 preliminary data report. Available at http://www.acf.dhhs.gov/programs/cse/prgrpt.htm.

[5] Garfinkel I, Heintze T, & Huang C-C. Child support enforcement: Incentives and well-being. Joint Center for Poverty Research, 2001.

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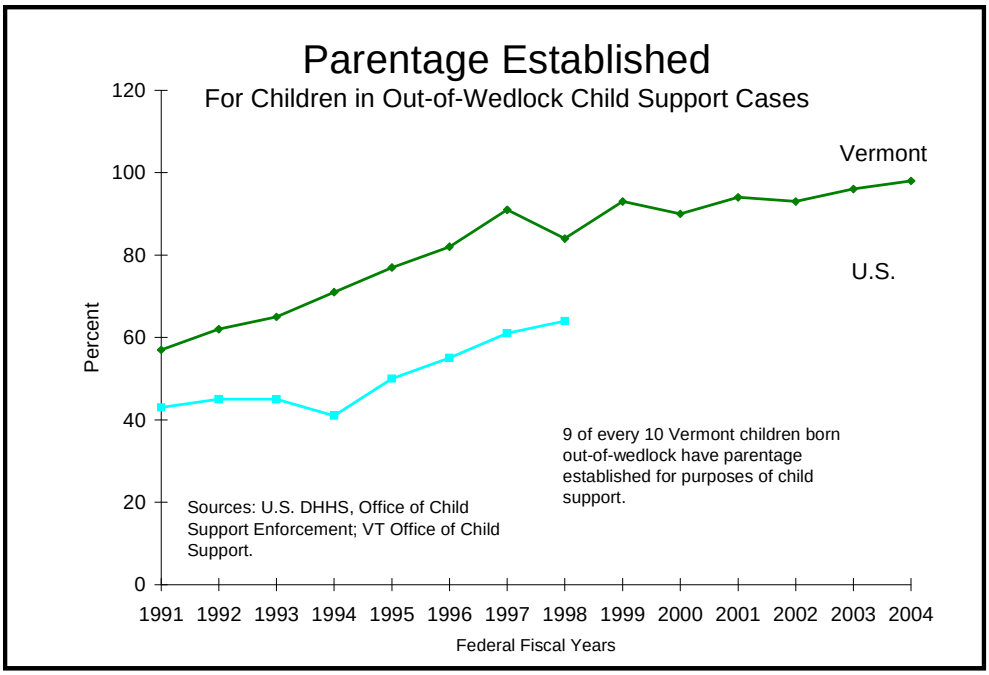

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	57	62	65	71	77	82	91	84	93	90	94	93	96	98
U.S.	43	45	45	41	50	55	61	64	n/a	72	78	84	84	85
VT Rank	15	8	6	4	2	3	1	3	n/a	n/a	n/a	n/a	n/a	n/a

("1" is highest)

The Story Behind the Data

As the proportion of children born to parents who are not married increases (now nearly one in three nationally and in Vermont), establishing legal parentage is of prime importance. In addition to the social, psychological, and emotional benefits to children, are the economic benefits: without establishment of legal parentage, a child has no claim on a share of his or her parent's income.

While nationally only about 60% of children born outside of marriage and entitled to child support benefits have had parentage established, Vermont has made steady gains in this important area. As of 2004, this proportion was at 98%;[1] Vermont ranked third best among the states in 1998.[2] In the future, federal legislation will require all states to establish parentage in at least 90% of unwed cases.

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	97.5	63.9	100.9	101.0	81.1
Bennington	94.6	80.4	109.4	109.5	73.7
Caledonia	101.2	72.1	101.9	96.3	79.8
Chittenden	92.7	92.3	106.2	102.5	78.0
Essex	100.0	30.8	83.8	84.0	79.0
Franklin	100.4	82.0	103.4	102.5	80.3
Grand Isle	96.0	28.7	80.2	80.4	80.7
Lamoille	100.8	58.1	97.2	97.3	81.4
Orange	96.2	66.0	103.0	103.1	77.8
Orleans	101.0	70.0	100.2	100.2	81.4
Rutland	94.2	88.6	109.7	109.7	76.4
Washington	99.7	81.1	103.5	103.5	82.5
Windham	97.5	78.6	104.9	108.4	77.9
Windsor	101.6	78.6	103.6	103.6	80.2

For Additional Information

For Vermont Office of Child Support's Annual Report, go to
www.ocs.state.vt.us/Reports/2006_annual_report.pdf

[1] Vermont Office of Child Support. Personal communication with Cindy Griffith, August, 2005.

[2] U.S. DHHS, Office of Child Support Enforcement. Twenty-third annual report to Congress. Washington, DC, 2000.

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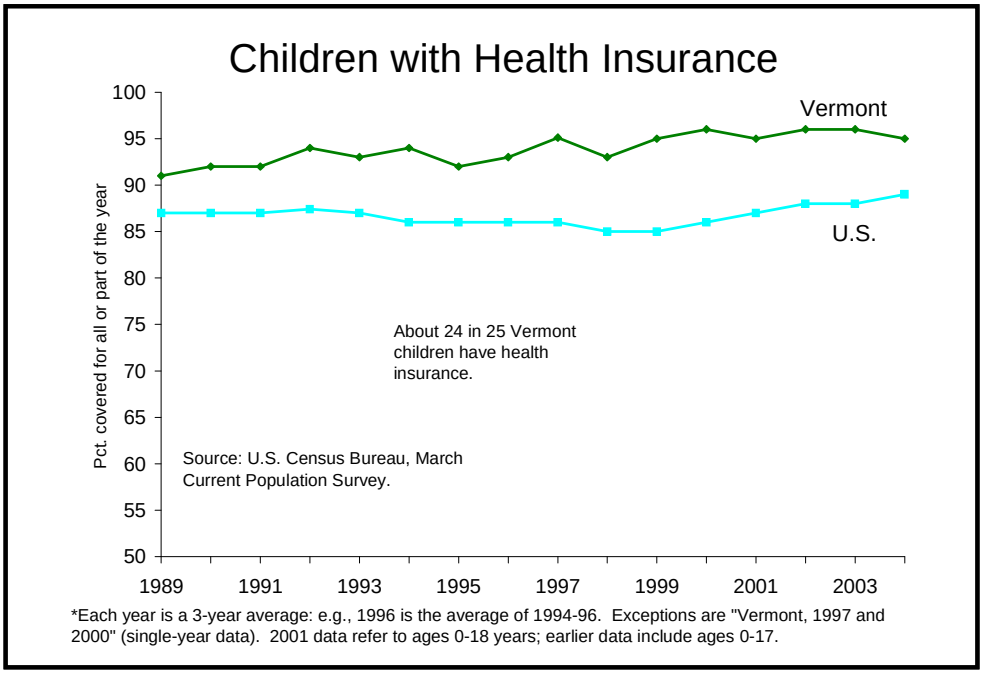

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	91	92	92	94	93	94	92	93	95	93	95	96	95	96	96	95
U.S.	87	87	87	87	87	86	86	86	86	85	85	86	87	88	88	89
VT Rank	n/a	12	14	9	3	1	2	1	n/a	n/a	n/a	n/a	2	n/a	n/a	n/a

("1" is highest)

The Story Behind the Data

Childhood is a critical time for growth and development. Regular medical check-ups and preventive care, as well as care for illnesses and injuries, are basic services all children should have. Studies have shown that, in comparison with children who are insured, children without health insurance are more likely to be in poor health; to have no usual doctor; to have fewer or no visits with a doctor; to use the emergency room more often; to be missing one or more recommended immunizations; and to be unable to get needed medical or dental care or services, including medications and eyeglasses.[1]

Vermont has taken giant strides toward making sure that no child is without medical care because of lack of health insurance. While on the national front, the number and percent of children *un*insured has grown, the percentage of Vermont children insured for all or part of the year has grown markedly since the mid-1980s. The most recent data show that, as of 2004, only

about 5% of Vermont children were without any health insurance, compared to 11% of children nationwide.[2] Federal legislation enabled us to expand eligibility for the "Dr. Dynasaur" program (Medicaid for children) for families with incomes up to 300% of poverty, and to enhance coverage for children who are under-insured. These measures give children in our state virtually universal access to coverage; according to several surveys, Vermont ranks first among states in the percent of poor children who have health insurance.[3]

[1] Families USA. Unmet needs: The large differences in health care between uninsured and insured children. Baltimore, MD, 1997.

[2] U.S. Census Bureau. Current Population Survey. Table HI-5. Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1987 to 2004.

[3] Blumberg SJ, Osborn L, Luke JV, et al. Estimating the prevalence of uninsured children: An evaluation of data from the National Survey of Children with Special Health Care Needs, 2001. National Center for Health Statistics. *Vital and Health Statistics*, series 2, no. 136. Washington, DC, 2004.

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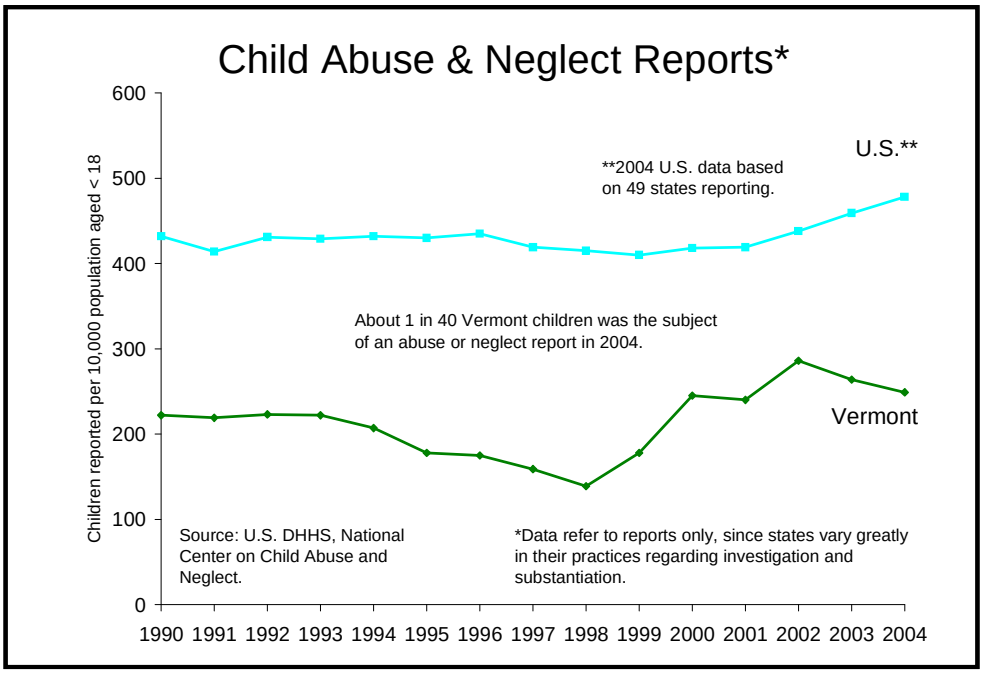

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	222	219	223	222	207	178	175	159	139	178	245	240	286	264	249
U.S.	432	414	431	429	432	430	435	419	415	410	418	419	438	459	478
VT Rank	5	3	3	4	3	2	2	3	3	3	7	6	10	5	3

("1" is lowest)

The Story Behind the Data

The abuse or neglect of children is a barometer of a community's ability to support families and protect its most vulnerable members. The immediate consequences of child maltreatment are stark and unmistakable; the long-term social costs of abuse are staggering.

For example, studies have found that children who had been maltreated were significantly more likely to be arrested as juveniles, and to be arrested for drug- and/or alcohol-related offenses in adulthood;[1] and childhood sexual abuse can increase the risk of adolescent pregnancy.[2] One authoritative estimate, which includes costs for medical care and mental health services, reduced future earnings, and dependence on public programs, put the annual cost of child abuse and neglect in Vermont alone at more than $25 million. If the intangible costs associated with quality of life are added in, the figure is more than $206 million.[3]

In 2004, 3,361 children in Vermont, about 264 out of every 10,000 children, were reported abused or neglected. The national rate was 478, and Vermont ranked third lowest among 49 reporting states.[4] In recent years, Vermont's rate of reports has consistently been well below the national average.

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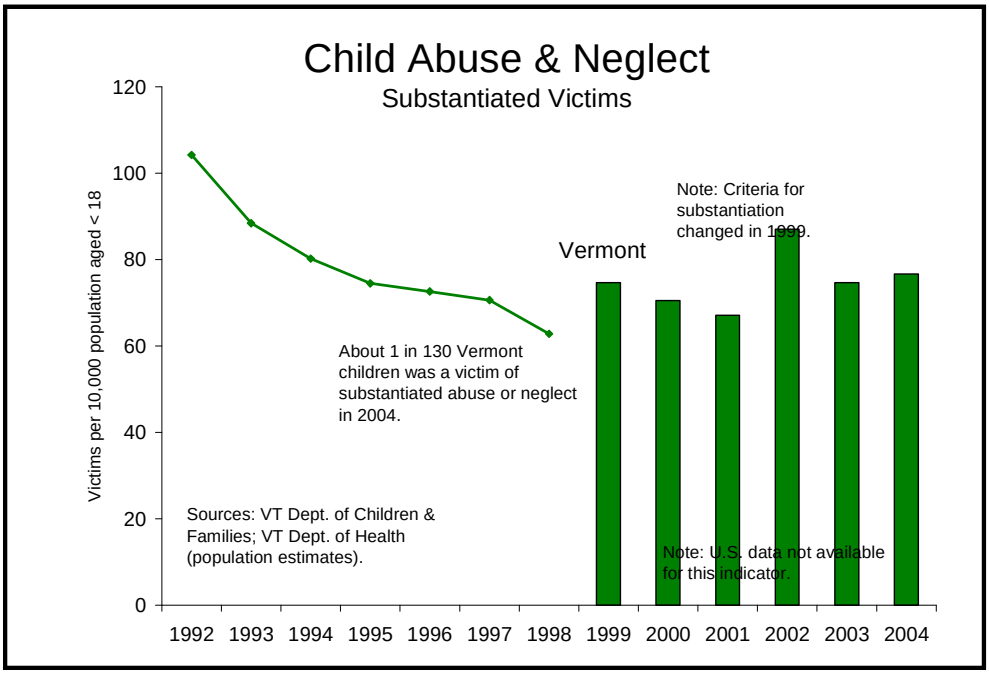

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	104.2	88.4	80.2	74.5	72.6	70.6	62.8	74.7	70.5	67.1	87.0	74.7	76.7

The Story Behind the Data

A more sensitive measure of child maltreatment is the number and rate of substantiated victims. Recent years have brought significant reductions in Vermont's child abuse rates. In 2004, there were 77 substantiated victims per 10,000 children. In 1999, the Division of Family Services, Vermont's child protection agency, widened its policy regarding "risk of harm" to children affected by parents' substance abuse.[5]

We think we can attribute at least some of the longer-term decline to our efforts to offer a home visit to every Vermont family with a young child (see p. 26). Our capacity is now developed statewide, and indications are that over 80% of families who are offered a home visit welcome the support. Abuse-prevention efforts that include school- and community-based programs, as well as supports for families, are helping to raise awareness and provide positive

parenting alternatives. *What Works: Preventing Child Abuse in Your Community*, published by the Agency of Human Services, contains more information on these successful approaches.[6]

In addition, as we see declining rates of child abuse, we can anticipate improvements in other, related areas, such as assignment to special education, high school dropout, substance abuse, teen pregnancy, youth suicide, delinquency, and corrections.

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	76.0	38.3	63.1	40.2	63.0
Bennington	117.6	55.2	122.7	70.1	90.3
Caledonia	34.6	80.9	90.8	110.2	89.6
Chittenden	76.5	84.0	103.1	84.5	65.9
Essex	30.2	37.0	91.3	84.8	74.5
Franklin	90.1	80.1	86.7	102.7	93.6
Grand Isle	70.1	66.4	79.4	85.3	60.7
Lamoille	26.6	18.6	36.5	69.2	73.7
Orange	51.2	36.7	74.3	82.7	81.4
Orleans	40.9	38.4	79.9	87.6	107.5
Rutland	52.9	65.4	54.7	35.8	55.7
Washington	82.9	68.1	99.2	78.2	88.4
Windham	77.8	68.8	63.7	63.7	64.0
Windsor	71.6	87.0	109.6	76.2	80.7

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

For Additional Information

The Family Services Division of Vermont's Department for Children & Families has more information at www.dcf.state.vt.us/fsd/

[1] National Institute of Justice. Childhood victimization and risk for alcohol and drug arrests. *Research Preview*. U.S. Department of Justice, Office of Justice Programs. Washington, DC, November 1995.

[2] Stock JL, Bell MA, Boyer DK, and Connell FA. Adolescent pregnancy and sexual risk-taking among sexually-abused girls. *Family Planning Perspectives, 29*, no. 4, August/September 1997.

[3] Analysis prepared by the Children's Safety Network Economics and Insurance Resource Center. National Public Services Research Institute. Landover, MD, 1994. Attachment to Miller TR, Cohen MA, and Wiersema B, "Crime in the United States: Victim costs and consequences." NPSRI, 1995.

[4] U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect Data System. Child Maltreatment 2004: Reports from the states to the National Center on Child Abuse and Neglect. Washington, DC, 2006. This is a "duplicated" count. For example, three incidents of abuse involving the same child are counted as three children. This method is used in order to compare Vermont with other states, the vast majority of which report duplicated counts.

[5] Vermont Department for Children and Families. Vermont child abuse and neglect, 2004. Waterbury, VT, 2005.

[6] Vermont Agency of Human Services. What works: Preventing child abuse and neglect in your community. Waterbury, VT, April 2000.

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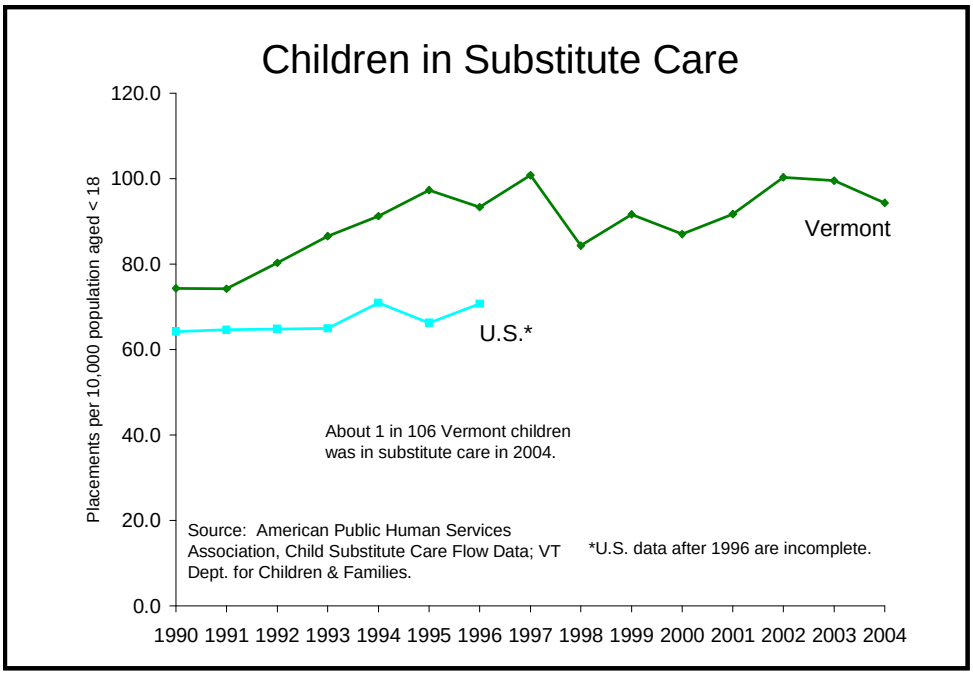

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	74.3	74.2	80.3	86.5	91.2	97.3	93.3	100.8	84.3	91.6	87.0	91.7	100.3	99.5	94.3
U.S.	64.2	64.6	64.8	64.9	70.9	66.2	70.7	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
VT Rank	46	48	48	43	36	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

("1" is lowest)

The Story Behind the Data

Abused or neglected children, as well as those who are delinquent or "unmanageable," are sometimes placed in foster homes or other substitute care. While substitute care can create a temporary "safe haven" from a harmful situation, most children and their parents are better served when they can maintain themselves as family units in their home communities, with proper support. Moreover, substitute care is generally a more expensive option, costing in Vermont, on average, $27,000 per child per year (counting just residential costs).[1]

As of the start of the federal fiscal year 2005 (October, 2004), there were 1,287 Vermont children living in substitute care, or 94.3 out of every 10,000 children.[2] It is important to note that, unlike most other states, Vermont includes both delinquents and status offenders in its count of children in substitute care. If the figures were adjusted for this difference, our rate would approximately equal the national average. Vermont is striving to reduce the number of youth in substitute care through intensive family-based services, and by seeking permanent living

arrangements (i.e., returning children to their homes as quickly as possible, or facilitating adoption). At the same time, we are seeking to expand our capacity to provide specialized foster care for troubled children and teens.

Related AHS Performance Measure: Decrease the rate of children in state custody.

[1] Vermont Department of Social and Rehabilitation Services. Personal communication from Marcel Rocheleau, January 2004.

[2] Vermont Department for Children & Families. Personal communication from Rich DiMatteo, March 2006.

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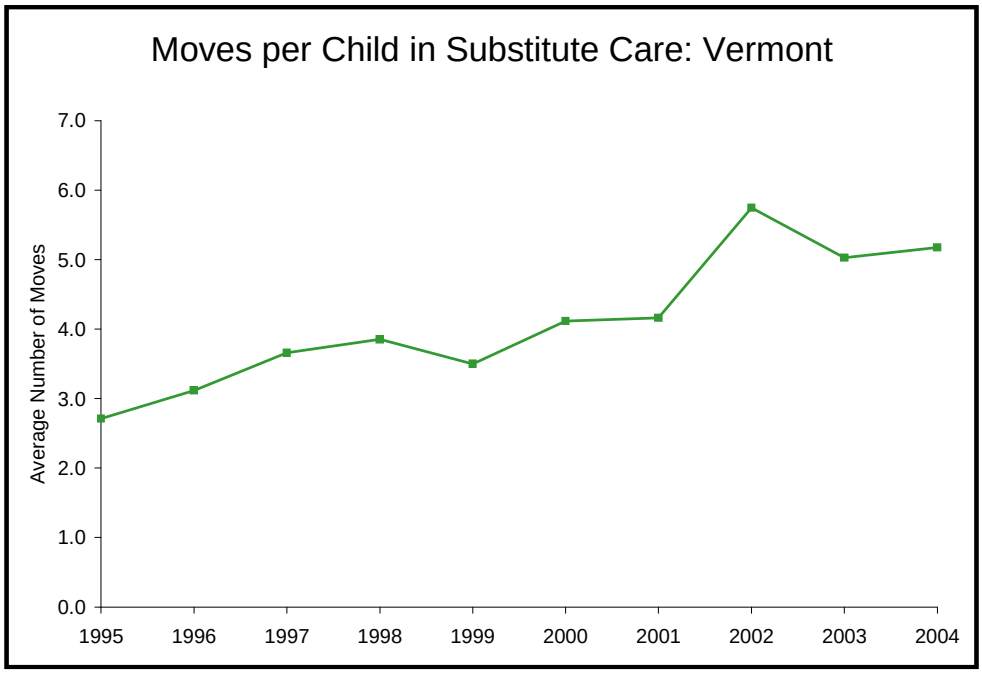

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	2.7	3.1	3.7	3.9	3.5	4.1	4.2	5.7	5.0	5.2

(Note: National data are not available for this indicator.)

The Story Behind the Data

All children thrive on stability—in their activities, settings of home and school, and relationships. For children temporarily placed in substitute care, stability is especially critical to their progress in getting back on the path to healthy development. Too many children experience a long series of placements before they leave foster care. This indicator shows the *average* number of placements; thus, it is sensitive to cases that have exceptionally high (or low) numbers of placements, and may not reflect the *typical* number. However, we have an interest in reducing instability for all children in substitute care, consistent with concerns for their safety.

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	2.6	3.0	5.5	3.5	2.5
Bennington	5.8	5.3	8.3	8.5	9.9
Caledonia	3.9	1.4	4.6	3.3	4.1
Chittenden	4.5	4.3	7.0	5.8	5.4
Essex	0.6	0.9	0.9	0.8	1.3
Franklin	4.6	4.4	6.1	5.0	5.6
Grand Isle	1.6	1.8	4.8	3.3	4.2
Lamoille	4.4	2.7	4.8	5.3	7.4
Orange	5.3	4.8	2.8	3.1	5.1
Orleans	2.4	3.9	2.8	3.5	4.0
Rutland	4.6	5.8	5.3	5.8	3.3
Washington	3.0	4.7	6.6	5.6	6.2
Windham	4.0	3.0	4.9	3.7	4.6
Windsor	5.4	3.7	4.8	4.9	5.1

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

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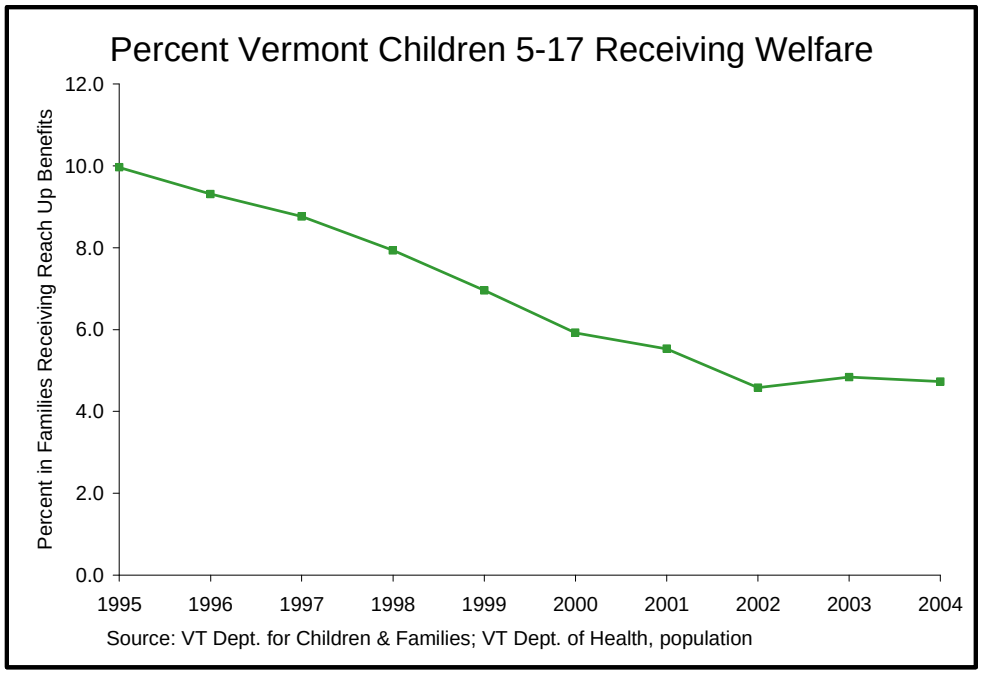


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	10.0	9.3	8.8	7.9	7.0	5.9	5.5	4.6	4.8	4.7

(Note: National data are not available for this indicator.)

The Story Behind the Data

Children living in low-income families with a single adult, or in some cases with two adults, may be eligible for "welfare"—Vermont's Reach Up program. These families receive financial and other forms of assistance while the adult(s) prepare, whenever possible, to become economically self-sufficient through paid employment. Children in poor families face a number of challenges (see p. 76). While welfare reform may ultimately prove to have been beneficial to these children, nationally the evidence to-date is mixed.[1]

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	3.5	3.3	2.5	2.9	2.8
Bennington	8.3	7.8	7.3	6.8	6.4
Caledonia	7.6	6.5	5.3	5.4	6.1
Chittenden	4.7	4.9	3.8	4.2	4.0
Essex	9.2	8.9	6.5	7.9	6.4
Franklin	6.5	5.7	5.0	4.9	5.5
Grand Isle	6.8	6.6	3.8	5.3	4.2
Lamoille	4.7	4.4	3.3	3.2	3.0
Orange	4.3	4.1	3.5	3.7	4.1
Orleans	9.2	7.1	6.1	6.9	6.3
Rutland	8.0	7.4	6.0	6.9	6.2
Washington	5.6	4.6	3.8	4.0	3.8
Windham	5.9	5.6	5.3	5.4	5.7
Windsor	4.9	4.9	4.0	4.2	3.8

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

[1] Moore KA, & Zaslow MJ. How welfare reform might affect children: Updating the conceptual model. Research Brief. Washington, DC: Child Trends. December 2004.

Youth Choose Healthy Behaviors

Adolescence sets the stage for adulthood. Decisions made and habits established during this period can have consequences lasting a lifetime. Although taking risks is a normal—and often positive—part of adolescence, not all risk-taking is wise. Behaviors that result in certain harm to oneself or others are to be avoided; *positive* risk-taking—on behalf of oneself or others—should be encouraged. Fortunately, we are beginning to learn more about what characteristics (of individuals, relationships, and communities) are associated with negative risk-taking, and, conversely, which characteristics foster positive choices. The Agency of Human Services' Planning Division has produced *What Works: Promoting Positive Youth Development in Your Community*, which describes a number of strengths-based approaches that help young people thrive.[1]

Young people who make healthy choices, and who are successful, resourceful, creative, and joyful, have strong *connections* with others—parents, other family members, and caring peers and adults; they have a sense of belonging. They are *competent* in multiple areas—academically, socially, emotionally—and exercise their skills to achieve their goals. They express *character* through making contributions to others, and developing a set of values. They acquire a sure *sense of who they are*—confidence in themselves, confidence in what the future holds for them, and the determination to make it happen.

In Vermont, some trends for youth are moving in a positive direction (use of alcohol, tobacco, and other drugs, teen pregnancies and births, for example), while others are still troubling. In the 2005 Vermont Youth Risk Behavior Survey (YRBS), one in nine students in grades 8-12 (11%) reported they had "made a plan" about how to commit suicide within the past 12 months. More than one in five (22%) reported they felt sad or hopeless continuously for two weeks or more. Fewer than half of students feel that they matter to people in their communities.[2] We must do more to help young people feel valued, and to engage them with positive challenges and opportunities.

Between 1999 and 2001, the "New Directions" initiative supported evidence-based alcohol and drug abuse prevention strategies for youth in 23 Vermont communities. Data from the New Directions evaluation show those communities achieved greater reductions in rates of abuse among students than were seen in the rest of the state.[3] We are using funds from the 1998 tobacco settlement in a similarly comprehensive approach, outlined in the Health Department's *Vermont Best Practices*, to cut smoking rates (for youth and adults) in half by 2010.[4] The 2005 YRBS data show reductions in grades 8 through 12 in cigarette smoking, and marijuana use; for alcohol use progress was mixed, with decreases evident only for grades 8, 9, and 12. [5] On this issue, and others, communities often need guidance about "what works." The Agency of Human Services' series of publications, designed to summarize effective programs and strategies, is one such tool.[6]

[1] Vermont Agency of Human Services. What works: Promoting positive youth development in your community. Planning Division. Waterbury, VT, 2000.

[2] Vermont Office of Alcohol and Drug Abuse Programs, and Vermont Department of Education. The Vermont Youth Risk Behavior Survey, 2005: Statewide report. Vermont Department of Health. Burlington, VT, 2005.

[3] Division of Alcohol & Drug Abuse Programs. New directions in prevention. Burlington, VT, Summer 2003.

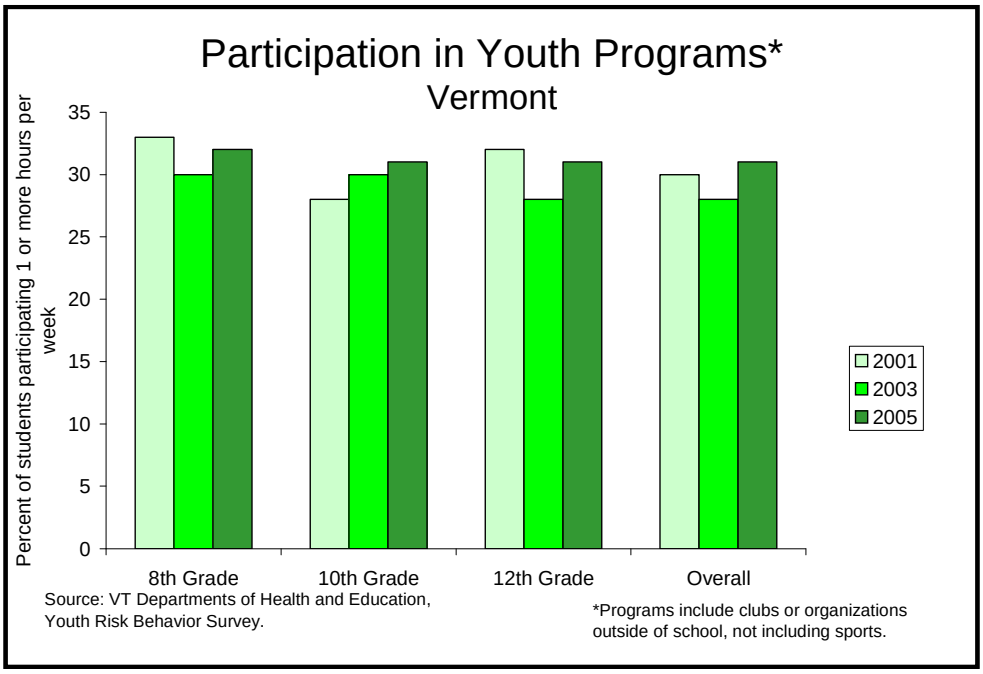
[4] Vermont Department of Health. Vermont Best Practices to cut smoking in half by 2010. Burlington, VT, 2000.

[5] Vermont Office of Alcohol and Drug Abuse Programs, and Vermont Department of Education. The Vermont Youth Risk Behavior Survey, 2005: Statewide report. Vermont Department of Health. Burlington, VT, 2005.

[6] As of this writing (April 2006) seven "what works" booklets are available: Preventing youth substance abuse; Preventing youth disruptive or violent behavior; Keeping youth in school; Preventing teen pregnancy; Promoting positive youth development, Preventing child abuse and neglect, and Restorative youth justice alternatives.

What We Want: Youth Choose Healthy Behaviors

How We Measure Our Success:



	8th Grade	10th Grade	12th Grade	Overall
2001	33	28	32	30
2003	30	30	28	28
2005	32	31	31	31

(Note: National data are not available for this indicator.)

The Story Behind the Data

Research shows that involvement in constructive, supervised extra-curricular activities is associated with reduced likelihood of involvement in risky behaviors such as school failure, drug use, and crime.[1] In addition, evidence is emerging that students who participate in such activities are also more likely to engage in other "thriving" behaviors.[2]

National surveys of voters show wide margins believe afterschool programs are essential in their communities, with safety and supervision for youth their top concerns.[3] Beginning in 2001, Vermont included in its statewide Youth Risk Behavior Survey several measures that have been shown to be related to positive development among young people. We expect to collect these data every other year. According to 2005 data, girls are somewhat more likely (35% overall) than boys (27% overall) to participate in these activities.[4]

Data by Vermont Region

VT Counties	2001	2003	2005
Percent in Grades 8-12			
Addison	31	33	32
Bennington	31	28	30
Caledonia	30	29	29
Chittenden	33	44	45
Essex	23	23	n/a
Franklin	27	25	25
Grand Isle	29	24	27
Lamoille	21	25	24
Orange	25	24	29
Orleans	25	26	26
Rutland	30	29	28
Washington	31	30	28
Windham	29	27	27
Windsor	30	28	30

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

For Additional Information

Vermont Out-of-School-Time Network (VOOST): www.voost.org.
www.afterschoolalliance.org

Harvard Family Research Project: http://gseweb.harvard.edu/~hfrp/

For more Vermont Youth Risk Behavior Survey data, go to www.state.vt.us/adap/yrbs2005statewidereport.pdf.

For more information about what works in promoting positive youth development, go to http://humanservices.vermont.gov/publications/what-works-promoting-positive-youth-development-in-your-community/view

[1] Scales, P. C., & Leffert, N. (1999). Developmental assets: A synthesis of the scientific research on adolescent development. Minneapolis: Search Institute.

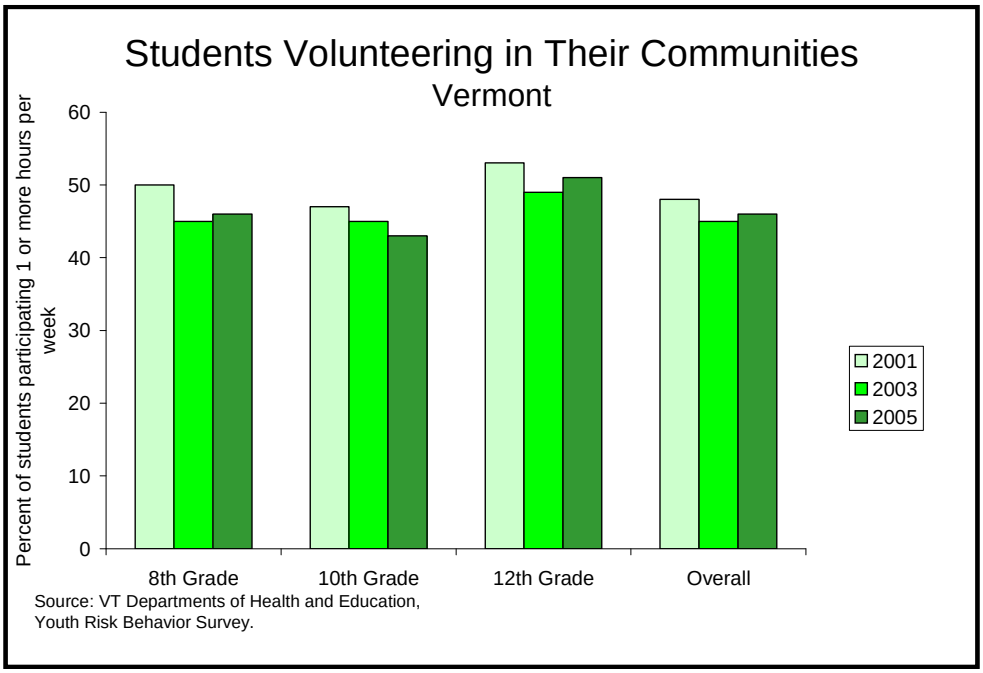
[2] Scales, P. C., Benson, P. L., Leffert, N, and Blyth, D.A. (2000). Contribution of developmental assets to prediction of thriving among adolescents. *Applied Developmental Science*, 4, no. 1, 27-46.

[3] The Afterschool Alliance. "Across demographic and party lines, Americans clamor for safe, enriching afterschool programs." A report on findings of the 2003 nationwide poll of registered voters on afterschool programs. www.afterschoolalliance.org, December 2003.

[4] Vermont Office of Alcohol and Drug Abuse Programs, and Vermont Department of Education. The Vermont Youth Risk Behavior Survey, 2005: Statewide report. Vermont Department of Health. Burlington, VT, 2005.

What We Want: Youth Choose Healthy Behaviors

How We Measure Our Success:



	8th Grade	10th Grade	12th Grade	Overall
2001	50	47	53	48
2003	45	45	49	45
2005	46	43	51	46

The Story Behind the Data

Through service learning, with community-based organizations, and in thousands of other ways, youth give back to their communities. By doing so, they develop habits of generosity, and learn valuable lessons about community-building.

Girls are slightly more likely (49% overall) to volunteer than are boys (43% overall). Despite these efforts, according to the same Youth Risk Behavior Survey, fewer than half (45%) of Vermont 8th- to 12th-graders feel valued by their community (see p. 244).[1]

Data by Vermont Region

VT Counties Percent	2001	2003	2005
Addison	46	43	44
Bennington	46	43	41
Caledonia	49	43	45
Chittenden	49	44	45
Essex	54	40	n/a
Franklin	46	43	41
Grand Isle	46	41	43
Lamoille	47	44	43
Orange	48	46	46
Orleans	47	47	41
Rutland	46	44	41
Washington	48	44	42
Windham	48	45	46
Windsor	50	47	46

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

For Additional Information

For more Vermont Youth Risk Behavior Survey data, go to www.state.vt.us/adap/yrbs2005statewidereport.pdf.

For more information about what works in promoting positive youth development, go to http://humanservices.vermont.gov/publications/what-works-promoting-positive-youth-development-in-your-community/view

[1] Vermont Office of Alcohol and Drug Abuse Programs, and Vermont Department of Education. The Vermont Youth Risk Behavior Survey, 2005: Statewide report. Vermont Department of Health. Burlington, VT, 2005.

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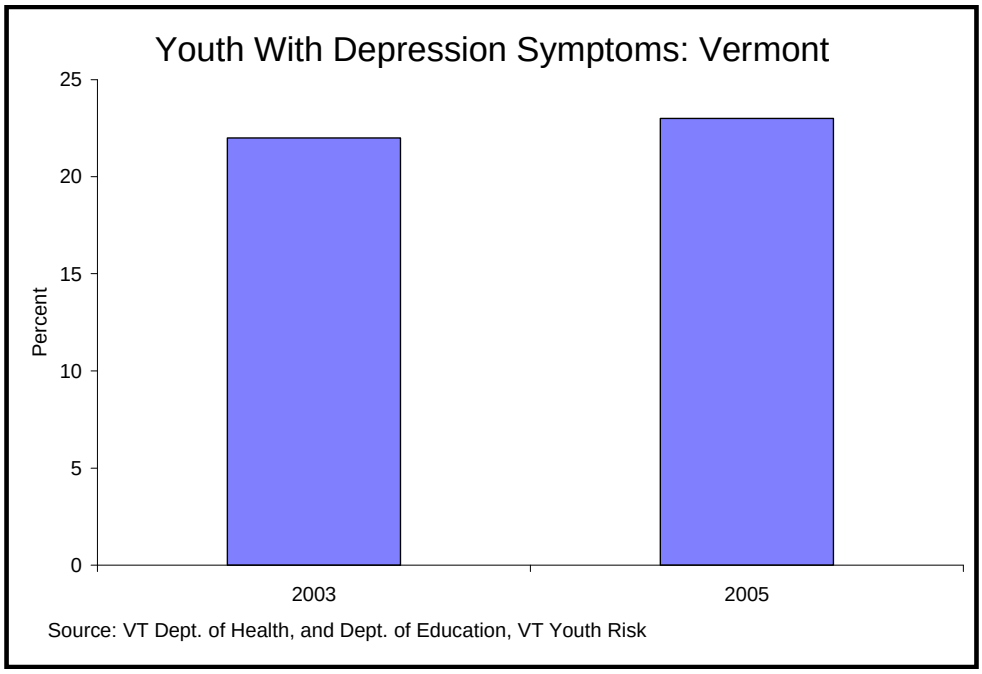


	2003	2005
VT Grades 8-12	22	23

The Story Behind the Data

Depression is a mental disorder that occurs among all age-groups, but is often undiagnosed and untreated. After stimulants, anti-depressants are the psychotropic medication most frequently prescribed for youth, despite the fact that none have been developed specifically for use with this age-group.[1] Vermont students in grades 8-12 are asked whether during the past 12 months, they "felt so sad or hopeless every day for at least two weeks that they stopped doing some usual activities." This item is considered to be a good indicator of depressive symptoms, which can be temporary or chronic.

Other symptoms of depression include increased irritability or agitation, poor school performance, changes in eating and sleeping patterns, problems with concentration, low energy, and drug and/or alcohol use. It is important for parents and others to know the warning signs for depression, so they can encourage youth to get treatment. Youth who have experienced depression are at greater risk for subsequent depressive episodes, and for suicide. Suicide is the second leading cause of death among Vermont youth (ages 15-24).[2] Risk factors for depression in this age-group include having parents who have mood disorders, experiencing chronic life stress, and transitions such as changing schools or having a stepparent move into the home. Effective interventions include cognitive-behavioral therapy, drug therapy, boosting the

supportiveness of the youth's environment, and reducing environmental stressors, such as poor housing conditions.[3]

Data by Vermont Region

VT Counties Percent	2003	2005
Addison	20	22
Bennington	23	22
Caledonia	25	25
Chittenden	23	21
Essex	n/a	n/a
Franklin	24	23
Grand Isle	27	21
Lamoille	26	22
Orange	23	25
Orleans	22	25
Rutland	25	24
Washington	25	23
Windham	23	25
Windsor	23	20

For data by school supervisory union area, contact your local superintendent's office.

Related AHS Performance Measure: Decrease the percentage of students in grades 8-12 who report symptoms of depression.

For Additional Information

Vermont Association for Mental Health, Resource Guide: www.vamh.org/2005vamhguide.pdf

National Mental Health Association, 800-969-NMHA, www.nmha.org

For more information about what works in promoting positive youth development, go to http://humanservices.vermont.gov/publications/what-works-promoting-positive-youth-development-in-your-community/view

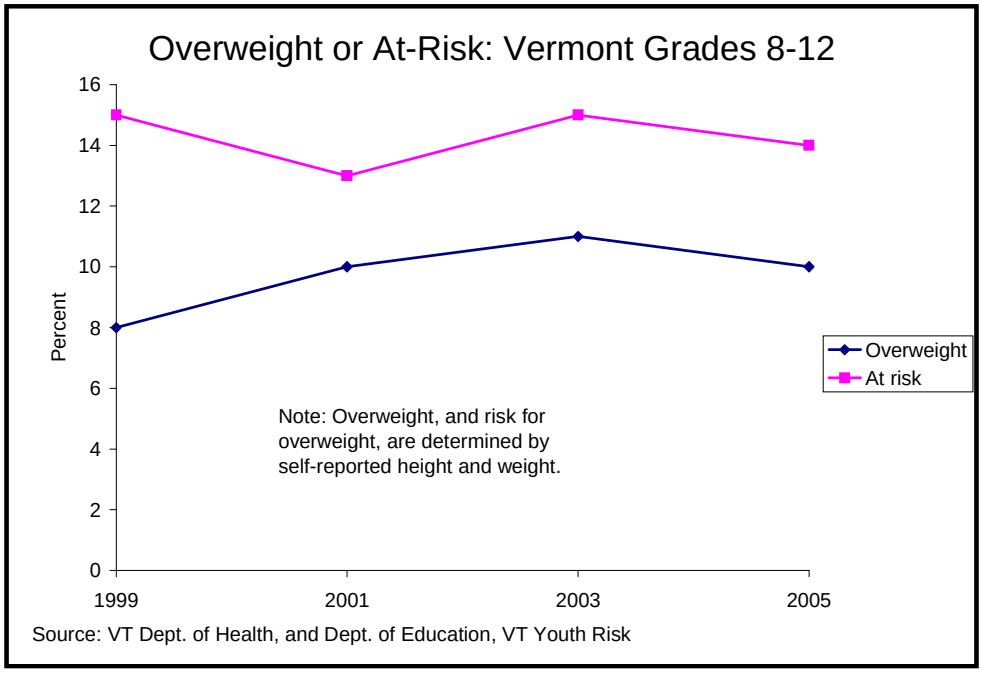
[1] Zito JM, Safer DJ, dosReis S, Gardner JF, Magder L, Soeken K, Boles M, Lynch F, & Riddle MA. Psychotropic practice patterns for youth: A 10-year perspective. *Archives of Pediatrics & Adolescent Medicine*, *157*, no. 1 (January 2003), 17-25.

[2] Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS). National Center for Injury Prevention and Control. 2003 data. Available at: www.cdc.gov/ncipc/wisqars/default.htm.

[3] National Mental Health Association. Fact sheet: Children's mental health matters. Available at www.nmha.org. Zaff JF, Calkins J, Bridges LJ, & Margie NG. Promoting positive mental and emotional health in teens: Some lessons from research. Child Trends Research Brief (September 2002). Washington, DC: Child Trends.

What We Want: Youth Choose Healthy Behaviors

How We Measure Our Success:



	1999	2001	2003	2005
Overweight	8	10	11	10
At risk	15	13	15	14

The Story Behind the Data

Overweight is prevalent within our teen population—nearly one in four eighth- through twelfth-graders is considered on the basis of their self-reported height and weight to be overweight, or at risk for overweight.[1] Another analysis shows 26 percent of Vermont 10- to 17-year-olds overweight or obese, in comparison to 31 percent nationwide; Vermont ranked sixth best.[2] In adolescence being overweight has significant negative consequences for physical and emotional health. As do younger children, teens need to exercise good judgment about what they eat, and be physically active. This may mean reducing time spent in sedentary activities such as television viewing and video games. Schools also continue to play an important role in promoting healthy weight; in particular, foods made available at school should contribute to good nutrition.[3]

Data by Vermont Region

VT Counties	2001	2003	2005
	Percent Overweight or At-Risk		
Addison	27	29	27
Bennington	25	28	24
Caledonia	27	30	29
Chittenden	20	22	23
Essex	28	31	n/a
Franklin	32	32	31
Grand Isle	22	36	27
Lamoille	24	30	30
Orange	28	31	29
Orleans	28	32	27
Rutland	27	33	30
Washington	23	24	24
Windham	26	27	29
Windsor	25	29	25

For data by school supervisory union area, contact your local superintendent's office.

Related AHS Performance Measure: Decrease the percentage of students in grades 8-12 who are overweight or at risk for obesity.

For Additional Information

For more Vermont Youth Risk Behavior Survey data, go to www.state.vt.us/adap/yrbs2005statewidereport.pdf.

For more information about what works in promoting positive youth development, go to http://humanservices.vermont.gov/publications/what-works-promoting-positive-youth-development-in-your-community/view

[1] Vermont Department of Health & Vermont Department of Education. Vermont Youth Risk Behavior Survey, 2005.

[2] Annie E. Casey Foundation. State differences in rates of overweight or obese youth. Kids Count Data Snapshot. March, 2006.

[3] Kubik MY, Lytle LA, & Story M. Schoolwide food practices are associated with body mass index in middle school students. *Archives of Pediatrics & Adolescent Medicine, 159*, no. 12 (December 2005), 1111-1114.

What We Want: Youth Choose Healthy Behaviors

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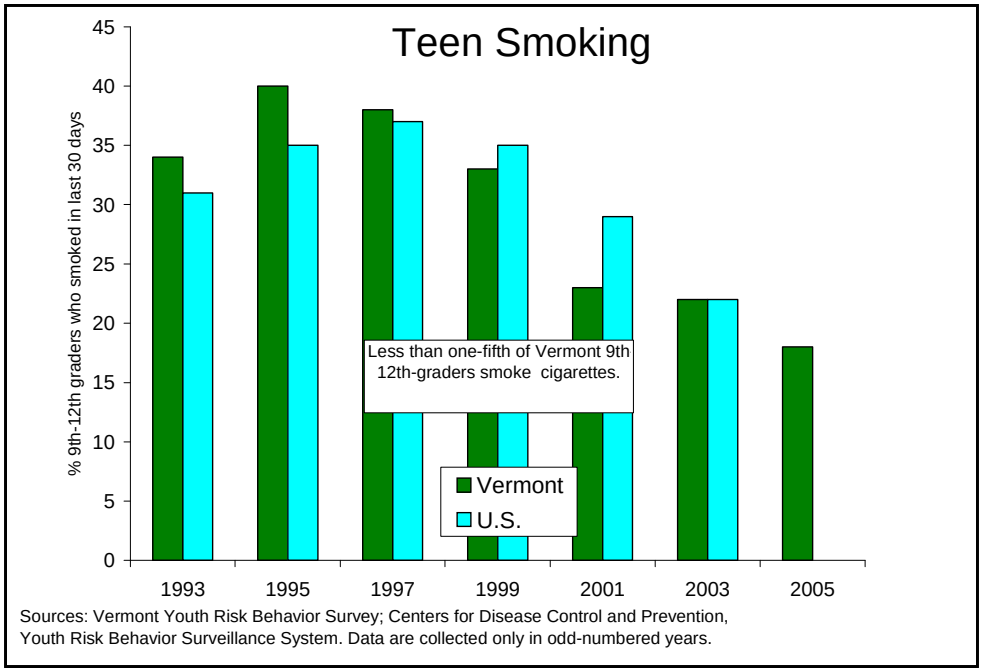


	1993	1995	1997	1999	2001	2003	2005
Vermont	34	40	38	33	23	22	18
U.S.	31	35	37	35	29	22	n/a

(State rankings not available.)

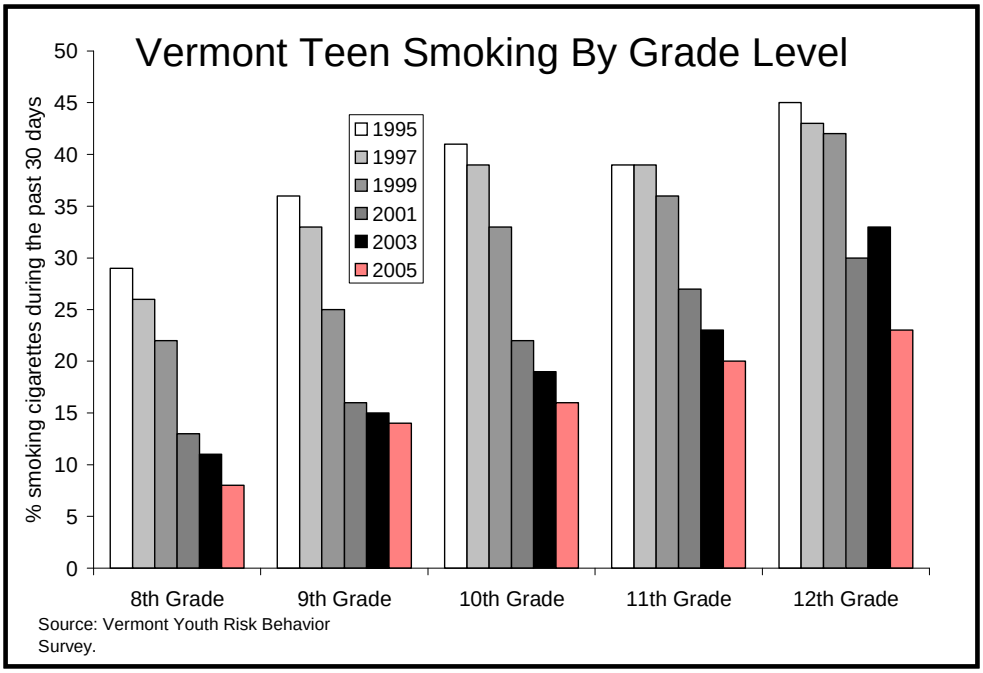
The Story Behind the Data

Smoking is the greatest single cause of avoidable death in our society. Among today's teen smokers, it has been projected that five million nationally (12,000 in Vermont) will die prematurely from tobacco-related illnesses.[1] Addiction to cigarette smoking commonly begins in the early teens, and the earlier smoking begins, the more difficult it is to quit. Among Vermont students who smoke, more than half started before age 13.[2]

Smoking among Vermont youth has declined significantly in recent years. In 2005, 18% of Vermont students in grades 9-12 reported smoking cigarettes in the past 30 days, the lowest figure in more than 10 years.[3] The national figure in 2003 was 22%.[4]

Analysis of Vermont's Youth Risk Behavior Survey data shows that the behavior of smoking is associated with other risky behaviors (use of alcohol, marijuana and other drugs, physical fighting, and sexual intercourse).[5] Keeping young people from starting to smoke could well contribute to preventing these other risk behaviors as well. Research suggests youth smoking may also lead to symptoms of depression and anxiety.[6]

Vermont's goal to reduce smoking rates in half by 2010 is one of the most ambitious in the nation; however, it is achievable. The recent decline in youth smoking rates suggests that a well-funded, comprehensive prevention effort involving communities, youth, schools, and health professionals, and supported by strong countermarketing, anti-tobacco policies, and enforcement can help this effort succeed. We know that the younger a person is when he or she begins smoking, the more damaging the health effects.[7]



	8th Grade	9th Grade	10th Grade	11th Grade	12th Grade
1995	29	36	41	39	45
1997	26	33	39	39	43
1999	22	25	33	36	42
2001	13	16	22	27	30
2003	11	15	19	23	33
2005	8	14	16	20	23

The most recent Vermont data show that smoking rates are coming down most dramatically (by more than half) among younger students (particularly eighth and ninth graders), who have been the focus of our recent prevention efforts. However, even among older students rates have fallen considerably.[8]

Data by Vermont Region

VT Counties Percent	1999	2001	2003	2005
Addison	28	22	15	16
Bennington	33	25	24	22
Caledonia	40	31	27	25
Chittenden	27	17	15	12
Essex	41	29	20	n/a
Franklin	36	25	21	17
Grand Isle	34	27	25	20
Lamoille	32	20	21	18
Orange	32	27	22	19
Orleans	36	26	20	23
Rutland	36	29	25	22
Washington	28	19	15	15
Windham	35	27	20	19
Windsor	27	23	18	14

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

Related AHS Performance Measure: Decrease the percentage of Vermonters who smoke.

For Additional Information

For more Vermont Youth Risk Behavior Survey data, go to www.state.vt.us/adap/yrbs2005statewidereport.pdf.

[1] Centers for Disease Control and Prevention. Projected smoking-related deaths among youth—United States. *MMWR*, *45*, no. 4, November 8, 1996.

[2] Vermont Office of Alcohol and Drug Abuse Programs. Personal communication from Kelly Hale Lamonda, January 2004.

[3] Vermont Office of Alcohol and Drug Abuse Programs, and Vermont Department of Education. The Vermont Youth Risk Behavior Survey, 2005: Statewide report. Vermont Department of Health. Burlington, VT, 2005.

[4] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance—United States, 2003. *CDC Surveillance Summaries*, May 21, 2004. *MMWR*, *53* (No. SS-2).

[5] Vermont Office of Alcohol and Drug Abuse Programs, and Vermont Department of Education. Unpublished data provided by Kelly Hale Lamonda, Vermont Department of Health. Burlington, VT, January 1999.

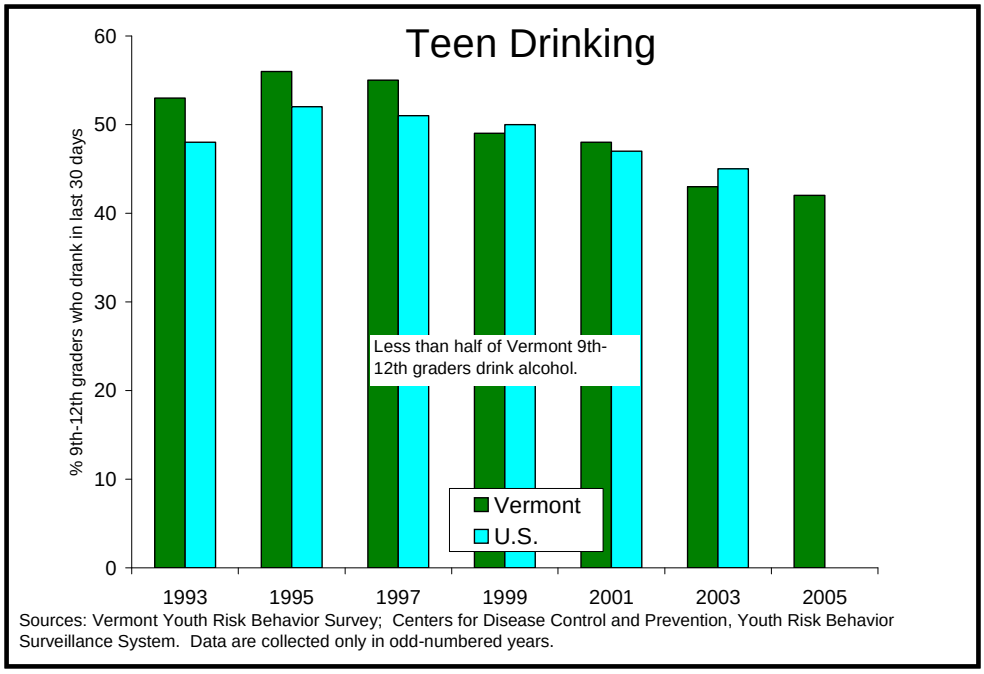
[6] Goodman E, and Capitman J (2000). Depressive symptoms and cigarette smoking among teens. *Pediatrics*, *106*, 748-755. Johnson JG, Cohen P, Pine DS, Klein DF, Kasen S, and Brook JS (2000). Association between cigarette smoking and anxiety disorders during adolescence and early adulthood. *Journal of the American Medical Association*, 284, 2348-2351.

[7] Centers for Disease Control and Prevention. Preventing tobacco use among young people: A report of the Surgeon General, At-A-Glance (1994). Accessed from http://www.cdc.gov/nccdphp/osh/94oshaag.htm#prvprgs, April 3, 1998.

[8] Vermont Office of Alcohol and Drug Abuse Programs, and Vermont Department of Education. The Vermont Youth Risk Behavior Survey, 2003: Statewide report. Vermont Department of Health. Burlington, VT, 2003.

What We Want: Youth Choose Healthy Behaviors

How We Measure Our Success:



Sources: Vermont Youth Risk Behavior Survey; Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System. Data are collected only in odd-numbered years.

	1993	1995	1997	1999	2001	2003	2005
Vermont	53	56	55	49	48	43	42
U.S.	48	52	51	50	47	45	n/a

(State rankings not available.)

The Story Behind the Data

Drinking is a major problem in Vermont, and problem alcohol use often begins in childhood. Youth drinking is associated with many other problem behaviors: other drug use, physical fighting, theft, skipping school, self-harming or suicidal behaviors, and involvement with law enforcement authorities.[1] In Vermont alone, the annual costs (including pain and lost quality of life) associated with youth alcohol use have been estimated at nearly $65 million.[2]

In 2005, 42% of Vermont students in grades 9-12 reported drinking within the past 30 days. Rates of alcohol use among teens have declined slowly in recent years, nationally and in Vermont. As is the case with cigarette smoking, we have seen greater recent progress in reducing drinking among younger students than with older students.[3]

Data by Vermont Region

VT Counties Percent	1999	2001	2003	2005
Addison	41	39	33	33
Bennington	46	41	38	36
Caledonia	45	45	41	41
Chittenden	40	36	33	33
Essex	63	54	38	n/a
Franklin	50	43	38	35
Grand Isle	42	38	44	35
Lamoille	45	41	41	37
Orange	44	44	39	35
Orleans	51	46	39	38
Rutland	46	41	40	39
Washington	43	37	36	33
Windham	47	47	44	38
Windsor	43	42	37	33

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

Related AHS Performance Measure: Decrease the percentage of students in grades 8-12 who drank alcohol in the past 30 days.

For Additional Information

For more Vermont Youth Risk Behavior Survey data, go to www.state.vt.us/adap/yrbs2005statewidereport.pdf.

[1] Substance Abuse and Mental Health Services Administration. News release: "Study shows strong relationship between adolescent behavior problems and alcohol use." March 1, 2000.

[2] Levy DT, Miller TR, and Cox CC. Costs of underage drinking. Pacific Institute for Research and Evaluation. Rockville, MD, October 1999. Cost estimates include medical care, work loss and other tangible costs, and pain and lost quality of life. Estimates cover alcohol-attributable traffic crashes, violence, burns, drowning, and suicide.

[3] Vermont Office of Alcohol and Drug Abuse Programs, and Vermont Department of Education. The Vermont Youth Risk Behavior Survey, 2003: Statewide report. Vermont Department of Health. Burlington, VT, 2003.

What We Want: Youth Choose Healthy Behaviors

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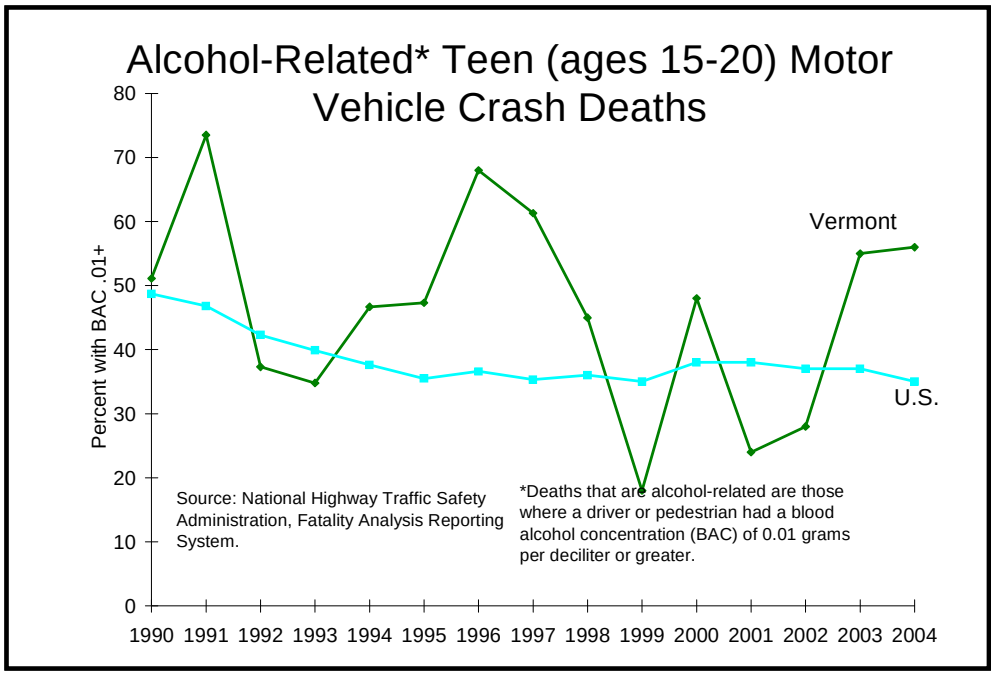

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	51	74	37	35	47	47	68	61	45	18	48	24	28	55	56
U.S.	49	47	42	40	38	36	37	35	36	35	38	38	37	37	35
VT rank	42	50	13	18	43	42	50	50	41	2	45	3	9	46	50

(1 is lowest)

The Story Behind the Data

Alcohol and driving don't mix, and the combination is even deadlier for younger drivers. Young drivers are learning to coordinate a number of complex driving-related judgments, and alcohol reduces the ability to make these, and other, decisions. While the percent of students who say they "drink and drive" has come down in recent years, it is still far too high.

In 2005, 15% of Vermont 12th graders reported that during the past 30 days they drove a car or other vehicle when they had been drinking alcohol, and 22% of 8th through 12th-graders reported they had been riders in a car driven by someone who had been drinking alcohol. These figures are both down considerably from 1997 (when they were 24% and 31%, respectively), suggesting that prevention efforts do make a difference.[1]

One way to grasp the tragic dimensions of this problem is to look at the proportion of all youth motor vehicle deaths that are alcohol-related. A few years ago, Vermont held the dubious distinction of ranking worst in the nation on this indicator. In 2002, our community-based efforts to reduce under-age drinking and alcohol-related teen highway deaths, including START

(Stop Teen Alcohol Risk Team), received national recognition.[2] Although in our small state the numbers involved are sufficiently small as to make for considerable year-to-year variation in the percentages, the recent trend suggests we cannot be complacent about this indicator.[3]

Related AHS Performance Measure: Decrease the percentage of students in grades 8-12 who drank alcohol in the past 30 days.

For Additional Information

Vermont Governor's Highway Safety Program: www.vthighwaysafety.com/home.html

Students Against Destructive Decisions: www.sadd.org

[1] Vermont Office of Alcohol and Drug Abuse Programs, and Vermont Department of Education. The Vermont Youth Risk Behavior Survey, 2005: Statewide report. Vermont Department of Health. Burlington, VT, 2005.

[2] Vermont Department of Health. Press release: Vermont Receives National Recognition for Reducing Underage Drinking. November 20, 2002.

[3] National Highway Traffic Safety Administration. Fatality Analysis Reporting System. Advance data provided by Jim Wright, October, 2002. "Alcohol-involved" is defined as crashes that involved someone with a blood alcohol concentration [BAC] of 0.10 grams per deciliter.

What We Want: Youth Choose Healthy Behaviors

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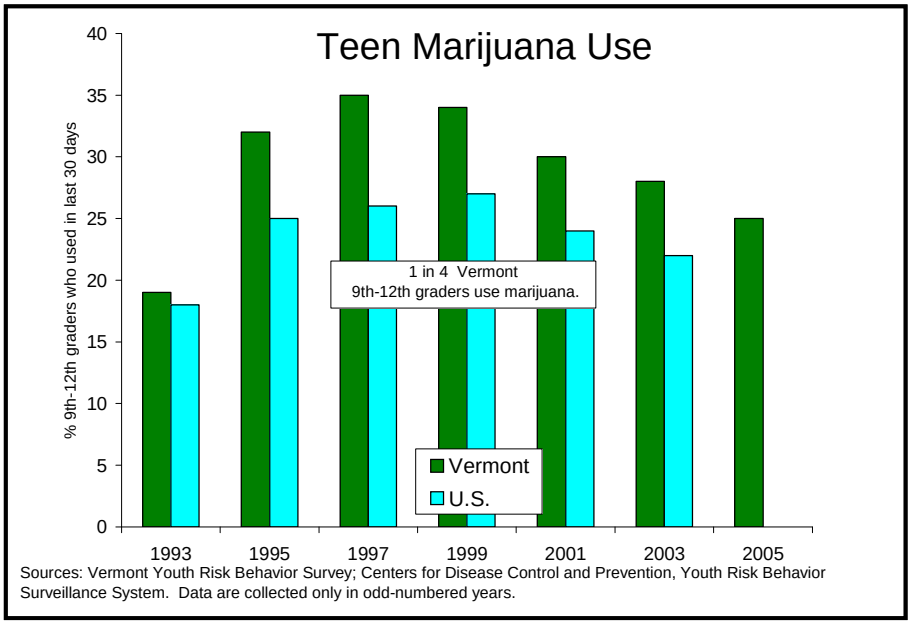


	1993	1995	1997	1999	2001	2003	2005
Vermont	19	32	35	34	30	28	25
U.S.	18	25	26	27	24	22	n/a

(State rankings not available.)

The Story Behind the Data

After alcohol and cigarettes, marijuana is the illicit drug used most by teens. The health risks associated with marijuana use, including damage to the lungs and cardiovascular system, and short-term loss of coordination, reasoning, and alertness are now well known.[1] In emergency department visits related to drug abuse among youth aged 12-19, marijuana is the drug most frequently reported.[2] Young people who smoke marijuana are also much more likely to use other harmful drugs, such as LSD, cocaine, or heroin.[3]

Among Vermont students in grades 9-12 in 2005, 25% reported smoking marijuana in the past 30 days; in 2003 the comparable U.S. figure was 22%. Vermont data show small but consistent declines from 1999 in marijuana usage among students between grades 8 and 12.[4] Nevertheless, a higher percentage (more than one in ten) of Vermont youth (ages 12-17) initiate use of marijuana than in any other state, according to recently released survey results.[5]

Data by Vermont Region

VT Counties Percent	1999	2001	2003	2005
Addison	27	26	21	19
Bennington	31	28	26	23
Caledonia	28	27	25	22
Chittenden	27	24	23	20
Essex	29	26	18	n/a
Franklin	29	24	23	19
Grand Isle	31	32	29	24
Lamoille	30	26	27	22
Orange	28	29	21	20
Orleans	34	26	23	23
Rutland	28	27	28	26
Washington	28	27	22	20
Windham	34	32	27	25
Windsor	28	29	25	21

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

Related AHS Performance Measure: Decrease the percentage of students in grades 8-12 who used marijuana in the past 30 days.

For Additional Information

For more Vermont Youth Risk Behavior Survey data, go to www.state.vt.us/adap/yrbs2005statewidereport.pdf.

[1] American Academy of Pediatrics. Legalization of marijuana: Potential impact on youth. Policy Statement of the Committee on Substance Abuse and Committee on Adolescence. *Pediatrics*, *113*, 1825-1826, June 2004.

[2] Office of Applied Studies, Substance Abuse and Mental Health Services Administration. *The DAWN Report*. Rockville, MD, August 2003.

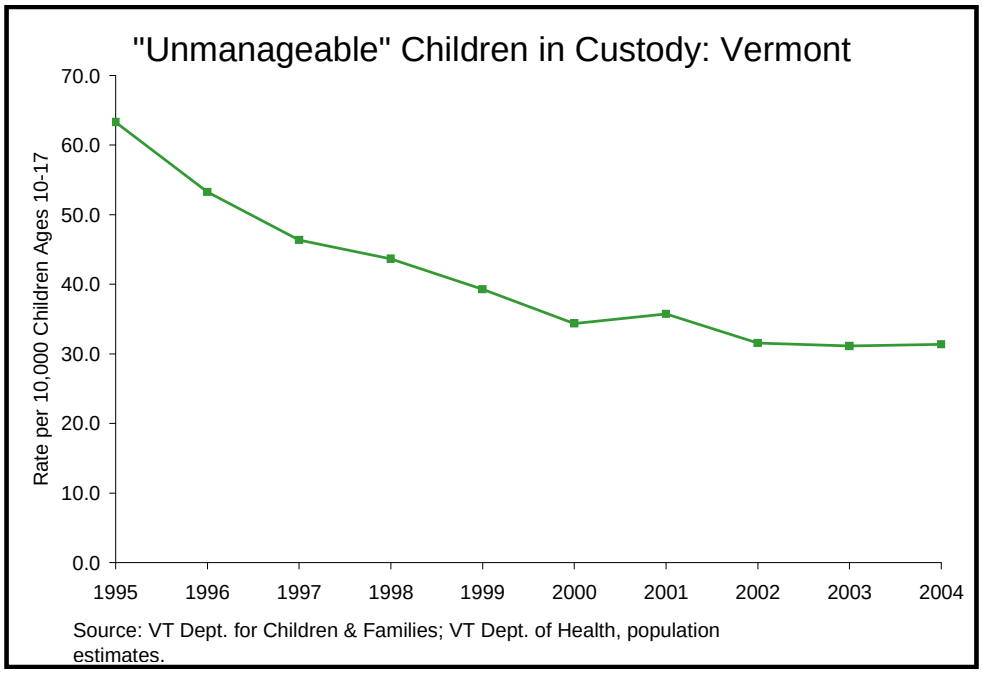
[3] The National Center on Addiction and Substance Abuse at Columbia University. Press release: CASA releases report: "Non-medical marijuana—rite of passage or Russian roulette?" July 13, 1999.

[4] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance—United States, 2003. *CDC Surveillance Summaries*, May 21, 2004. *MMWR*, 53 (No. SS-2). Vermont Office of Alcohol and Drug Abuse Programs, and Vermont Department of Education. The Vermont Youth Risk Behavior Survey, 2003: Statewide report. Vermont Department of Health. Burlington, VT, 2003.

[5] Wright D, and Sathe N. State estimates of substance abuse from the 2002-2003 national surveys on drug use and health. U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration. Rockville, MD, January 2005.

What We Want: Youth Choose Healthy Behaviors

How We Measure Our Success:



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	63.3	53.3	46.4	43.7	39.3	34.4	35.8	31.5	31.1	31.4

(Note: National data are not available for this indicator.)

The Story Behind the Data

Through their behavior, some youth present major challenges to parents, school personnel, and communities. When a young person's anti-social behavior is such that his or her parents cannot effectively exercise control, state authorities may need temporarily to assume custody of the child. In 2004, there was a daily average of 216 of such children in custody.[1] Most are young teens. In 1996, the state changed its practices so that children older than 15 years were no longer eligible for custody as "unmanageables."

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	36.7	39.2	40.1	29.7	37.1
Bennington	45.5	57.3	67.1	71.1	78.2
Caledonia	30.9	43.3	50.4	33.3	31.5
Chittenden	46.2	39.8	28.6	23.9	23.4
Essex	35.6	39.4	35.0	48.1	36.9
Franklin	59.4	49.1	41.0	32.2	26.9
Grand Isle	22.8	51.7	43.7	34.4	22.9
Lamoille	25.9	38.3	28.4	43.9	40.4
Orange	13.5	14.7	7.9	11.5	20.6
Orleans	35.7	23.5	26.0	35.0	39.0
Rutland	33.5	36.8	37.1	48.1	35.1
Washington	13.1	28.3	20.3	20.2	22.0
Windham	26.7	35.4	26.2	24.5	29.4
Windsor	21.7	14.4	15.6	20.0	26.9

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

Related AHS Performance Measure: Decrease the rate of children in state custody.

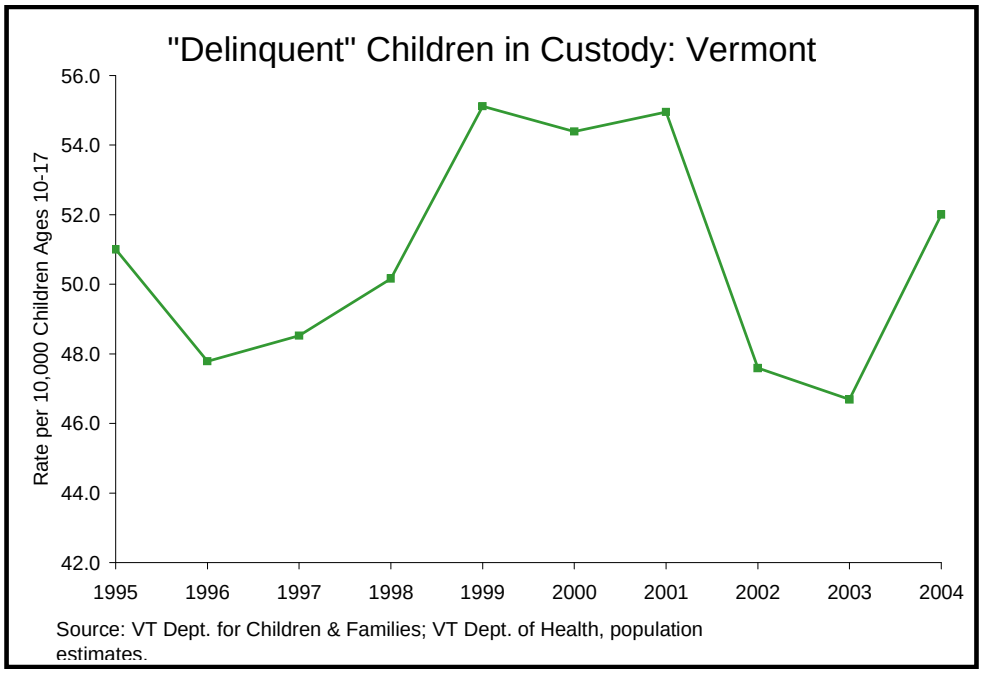
For Additional Information

What Works: Preventing Youth Destructive and Violent Behavior in Your Community: http://humanservices.vermont.gov/publications/ww-pydvb/view

[1] Vermont Department for Children & Families, Division of Family Services. Personal communication with Rich DiMatteo, March 2006.

What We Want: Youth Choose Healthy Behaviors

How We Measure Our Success:



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	51.0	47.8	48.5	50.2	55.1	54.4	55.0	47.6	46.7	52.0

(Note: National data are not available for this indicator.)

The Story Behind the Data

Youth are considered delinquent when they have committed offenses that would be crimes if they were adults. Delinquent youth are often placed in state custody while they work on correcting their behavior; other delinquents are on a probationary status with the state. In 2004, 358 Vermont delinquent youth were in the custody of the Department for Children & Families.

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	39.0	46.6	44.6	43.4	41.7
Bennington	81.9	84.7	80.5	87.7	95.4
Caledonia	54.1	51.4	40.3	33.3	22.9
Chittenden	66.8	63.7	53.5	46.5	57.5
Essex	0.0	13.1	11.7	12.0	49.1
Franklin	69.6	68.5	57.4	57.5	50.5
Grand Isle	22.8	38.8	54.6	45.9	57.1
Lamoille	51.7	49.8	53.3	54.9	51.4
Orange	21.5	11.8	13.1	20.1	20.6
Orleans	32.7	23.5	37.6	57.2	71.5
Rutland	63.0	64.8	46.3	41.0	62.9
Washington	71.4	75.4	61.0	55.9	53.4
Windham	55.3	54.1	48.6	49.0	52.4
Windsor	17.4	28.9	22.7	26.1	28.5

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

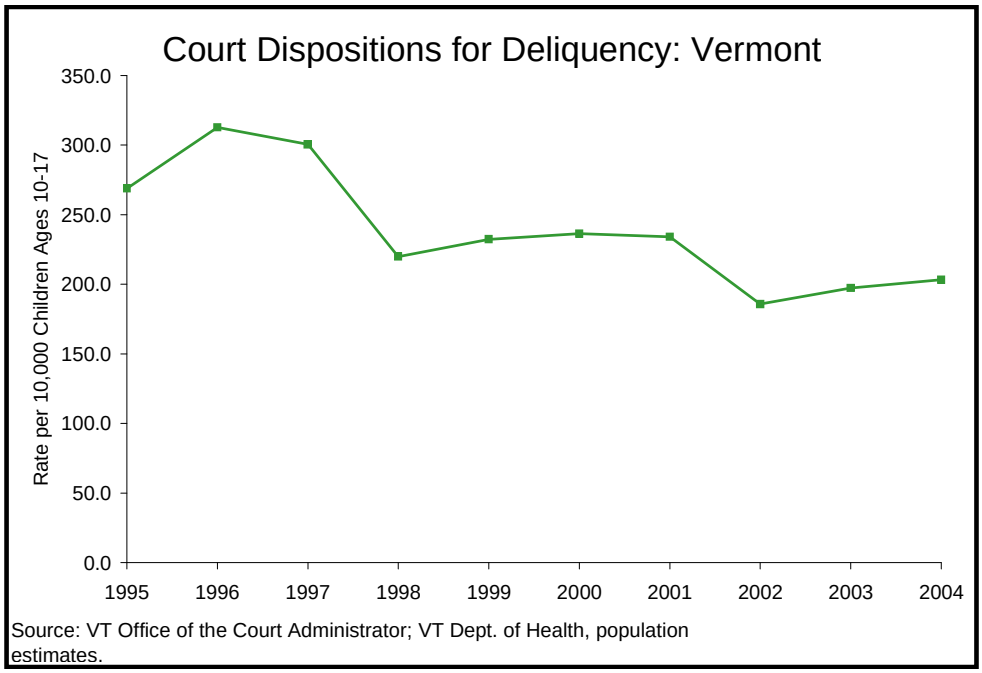
Related AHS Performance Measure: Decrease the rate of children in state custody.

For Additional Information

What Works: Preventing Youth Destructive and Violent Behavior in Your Community: http://humanservices.vermont.gov/publications/ww-pydvb/view

What We Want: Youth Choose Healthy Behaviors

How We Measure Our Success:



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	269.0	312.8	300.6	220.0	232.4	236.4	234.2	185.8	197.3	203.2

(Note: National data are not available for this indicator.)

The Story Behind the Data

Family Court may determine that a youth is delinquent—i.e., that he or she has committed an offense that would be considered a crime if they were an adult. The largest single category of these offenses are property offenses; violent and drug-related offenses are the next largest categories. In state fiscal year 2004, there were 1,399 delinquency dispositions.

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	291.6	227.9	158.3	153.0	213.3
Bennington	411.8	326.3	342.2	343.5	425.4
Caledonia	291.2	124.5	116.0	146.9	123.2
Chittenden	221.7	288.0	172.1	156.3	198.4
Essex	59.4	131.4	128.5	120.2	86.0
Franklin	190.0	238.7	162.3	226.8	185.0
Grand Isle	79.9	38.8	131.0	103.3	102.9
Lamoille	314.0	157.0	238.0	208.6	257.2
Orange	56.5	64.8	235.9	117.5	108.7
Orleans	264.5	155.9	153.3	301.9	162.4
Rutland	230.6	245.8	165.4	178.1	264.9
Washington	198.1	194.8	167.0	218.8	149.2
Windham	289.6	383.2	280.5	294.0	243.3
Windsor	227.2	226.4	145.9	170.5	160.0

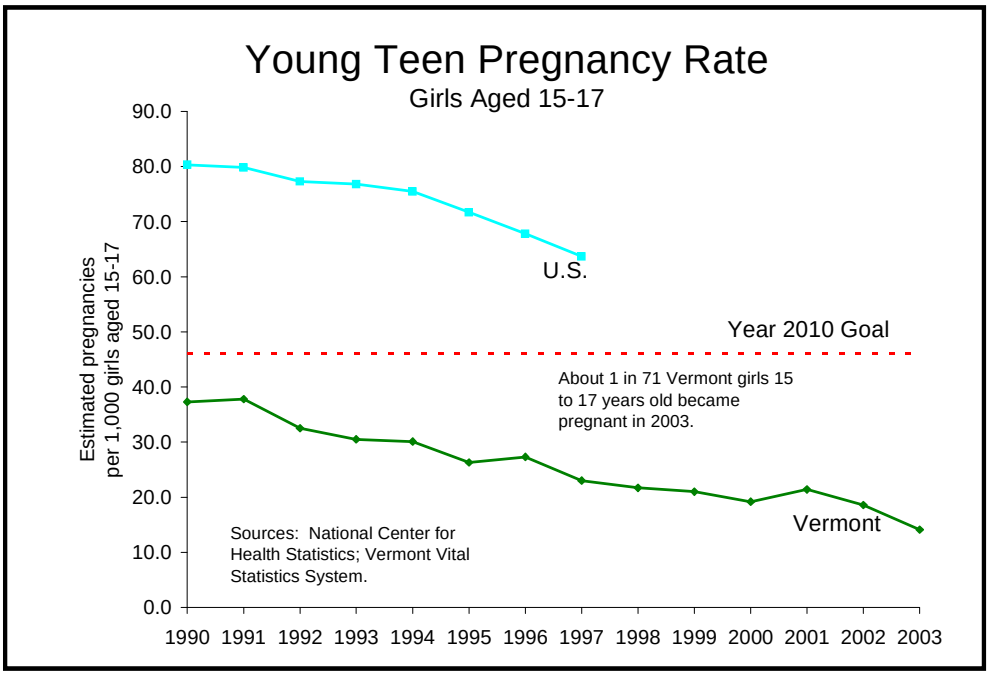
Related AHS Performance Measure: Decrease the rate of children in state custody.

For Additional Information

Vermont Juvenile Justice Commission Report:
www.dcf.state.vt.us/fsd/pubs&reports/JuvenileJustice.pdf

What We Want: Youth Choose Healthy Behaviors

How We Measure Our Success:



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Vermont	37.3	37.8	32.5	30.5	30.1	26.3	27.3	23.0	21.7	21.0	19.2	21.4	18.6	14.1
U.S.	80.3	79.8	77.3	76.8	75.5	71.7	67.8	63.7	n/a	n/a	n/a	n/a	n/a	n/a

(State rankings not available.)

The Story Behind the Data

The majority of teen pregnancies are unintended and/or the result of coercion.[1] Although pregnancy, childbearing, and parenting are risky choices throughout the teen years, they are especially so for teens younger than 18. Health threats (to mother and child), the potential for disrupted education, and diminished economic prospects are all greater for teens who become pregnant.

Moreover, the annual cost to taxpayers attributed to childbearing in this age-group has been estimated at $6.9 billion.[2] It is encouraging that pregnancy rates in Vermont among 15- to 17-year-olds in recent years are lower than at any time in recent history;[3] however, we need to see continued progress here, since the consequences associated with these events are often so detrimental for both parents and children.

Access to appropriate health care, comprehensive health and sexuality education where students learn responsible decision-making, and improved prospects for a bright future are some of the factors behind this declining trend. In addition, some research suggests that nearly half of adolescent girls who become pregnant have earlier been victims of sexual abuse, which is

associated with later risky sexual behavior.[4] If Vermont can continue its already remarkable progress in reducing child sexual abuse (see pp. 92-94), we may see even fewer of our young teens becoming pregnant.

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
Addison	22.7	10.0	18.5	12.3	2.5
Bennington	29.9	17.6	28.1	21.0	22.5
Caledonia	22.2	11.3	13.4	19.4	12.2
Chittenden	25.6	22.0	26.4	18.1	12.6
Essex	13.0	14.0	7.3	6.9	20.0
Franklin	22.1	21.8	15.2	18.5	12.1
Grand Isle	30.3	12.0	15.4	11.6	23.4
Lamoille	19.5	18.3	35.5	11.8	10.0
Orange	14.7	17.8	15.4	17.4	10.3
Orleans	21.1	22.8	13.8	17.4	14.4
Rutland	15.8	24.9	20.5	24.1	17.9
Washington	15.5	11.3	22.3	21.7	24.0
Windham	22.0	27.9	24.3	21.6	16.1
Windsor	16.7	17.6	16.4	16.6	6.3

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

For Additional Information

National Campaign to Prevent Teen Pregnancy: www.teenpregnancy.org

[1] Moore KA, Miller BC, Sugland BW, Morrison DR, Glei DA, and Blumenthal C. Beginning too soon: Adolescent sexual behavior, pregnancy, and parenthood: A review of research and interventions. Executive Summary. Accessed from the U.S. Department of Health and Human Services web site: http://aspe.os.dhhs.gov/hsp/cyp/xsteesx.htm.

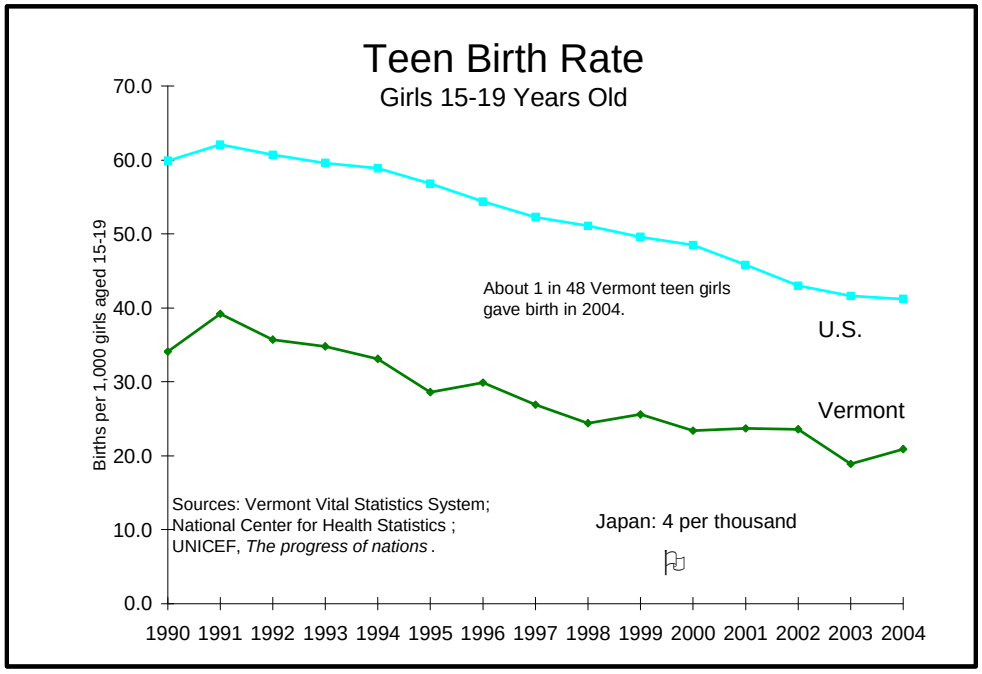
[2] Maynard R. (Ed.). Kids having kids: A Robin Hood Foundation special report on the costs of adolescent childbearing. The Robin Hood Foundation. New York, 1996.

[3] Vermont Department of Health. Vermont vital statistics: Annual reports, Burlington, VT.

[4] Stock JL, Bell MA, Boyer DK, and Connel FA. Adolescent pregnancy and sexual risk-taking among sexually abused girls. *Family Planning Perspectives*, *29*, no. 4, 1997.

What We Want: Youth Choose Healthy Behaviors

How We Measure Our Success:



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	34.1	39.2	35.7	34.8	33.1	28.6	29.9	26.9	24.4	25.6	23.4	23.7	23.6	18.9	20.9
U.S.	59.9	62.1	60.7	59.6	58.9	56.8	54.4	52.3	51.1	49.6	48.5	45.8	43.0	41.6	41.2
VT Rank	2	5	3	3	2	1	2	1	1	2	2	2	3	n/a	n/a

("1" is lowest)

The Story Behind the Data

The risks of childbearing at a very young age are well documented. National data show that, compared to older women, pregnant teens have higher rates of complications, maternal morbidity and mortality, premature birth, low-birthweight babies, miscarriages, and stillbirths.[1]

Compared to women who delay childbirth until their twenties, teen mothers are more likely to drop out of school, more likely to have more children, and less likely to complete high school or go on to college. Early childbearing is related to lower-status occupations, lower wages, and lower job satisfaction. Teen parents are disproportionately poor and dependent upon public assistance.

National data show the *children* of teen mothers tend to live in disadvantaged neighborhoods, attend low-quality schools, and score lower in achievement tests. They are more

likely to repeat a grade, have cognitive and developmental deficits, and experience high rates of family instability.[2] They are more likely to have poorer job prospects, to bear children while teens themselves, and to do so outside of marriage.[3] While poverty undoubtedly accounts for many of these effects, early parenting is an additional risk factor.

Vermont's teen birth rate has declined 52% since 1991, and is consistently one of the lowest in the country.[4]

Data by Vermont Region

County-level data are available in the annual Vital Statistics reports produced by the Vermont Department of Health. See www.healthyvermonters.info/pubs.shtml#vital.

[1] These problems are mostly attributed to inadequate prenatal care and poor nutrition, rather than to age, per se. Fortunately, teens in Vermont have access to a variety of new state and local prenatal care services: the percentage of pregnant teens who began prenatal care in the first trimester increased from 57% (1985-1987) to 75% (1996-1998). Source: Vermont Department of Health, Vermont vital statistics: Annual reports. Burlington, VT.

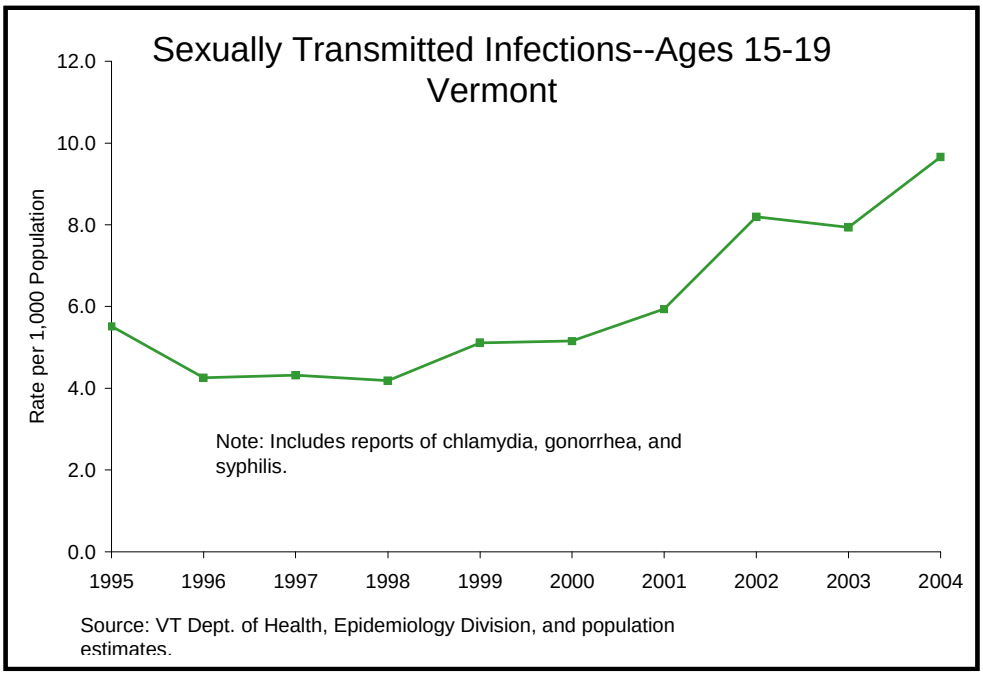
[2] National Research Council. Risking the future: Adolescent sexuality, pregnancy, and childbearing, Vol. 1. National Academy Press. Washington, DC, 1987. U.S. General Accounting Office. Families on welfare: Teenage mothers least likely to become self-sufficient. GAO/HEHS-94-115. Washington, DC, May 1994.

[3] Wolfe B. Teenage childbearing and economic incentives. *Focus*, vol. *17*, number 1. University of Wisconsin-Madison Institute for Research on Poverty. Summer 1995.

[4] Vermont Department of Health. Vermont vital statistics: Annual reports, Burlington, VT. Ventura SJ, Mathews TJ, and Curtin SC. Declines in teenage birth rates, 1991-1997: National and state patterns. *National Vital Statistics Reports, 47*, no. 12. National Center for Health and Statistics. December 1998.

What We Want: Youth Choose Healthy Behaviors

How We Measure Our Success:



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	5.5	4.3	4.3	4.2	5.1	5.2	5.9	8.2	7.9	9.7

(Note: National data are not available for this indicator.)

The Story Behind the Data

Pregnancy is not the only risk involved in premature sexual activity. Sexually transmitted infections can have serious, sometimes life-long, health consequences. If teens are sexually active, they need to use effective protection consistently. Not all types of pregnancy protection offer protection against sexually transmitted infections. More than one-quarter of Vermont youth (27 percent of students in grades 8-12) are sexually active. However, only 65 percent of those who are active used a condom during their last sexual experience.[1] The development of easier testing procedures may account for some of the recent increase in identified cases of sexually transmitted infections.

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	4.4	6.8	6.1	5.8	5.0
Bennington	2.3	4.7	8.0	14.3	10.9
Caledonia	2.9	6.4	4.9	9.3	10.7
Chittenden	8.3	8.5	10.2	9.6	9.1
Essex	4.4	4.6	22.0	2.0	4.3
Franklin	5.6	6.6	6.1	5.4	11.5
Grand Isle	2.3	0.0	13.1	11.9	1.9
Lamoille	4.7	2.8	9.6	10.5	12.1
Orange	3.6	2.9	8.0	2.5	6.1
Orleans	1.6	2.2	5.8	8.3	3.2
Rutland	5.3	4.3	10.1	7.2	14.8
Washington	3.6	5.9	6.6	7.8	12.8
Windham	4.2	6.0	9.0	6.3	8.8
Windsor	4.5	4.6	5.0	5.9	9.6

[1] Vermont Office of Alcohol and Drug Abuse Programs, and Vermont Department of Education. The Vermont Youth Risk Behavior Survey, 2005: Statewide report. Vermont Department of Health. Burlington, VT, 2005.

What We Want: Youth Choose Healthy Behaviors

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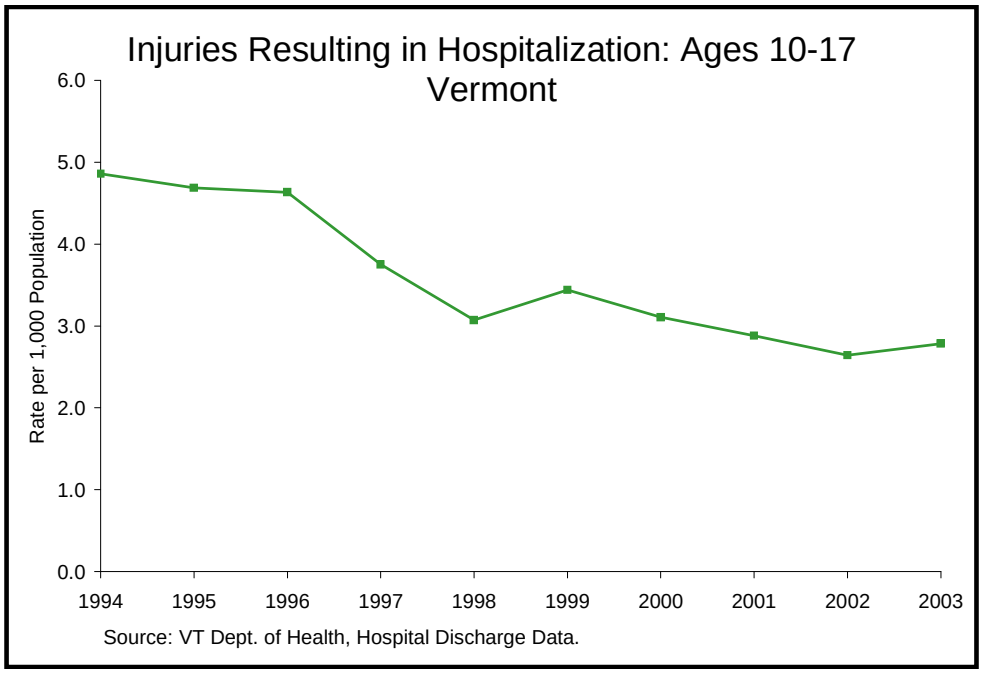

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Vermont	4.9	4.7	4.6	3.8	3.1	3.4	3.1	2.9	2.6	2.8

(Note: National data are not available for this indicator.)

The Story Behind the Data

Injuries are the leading cause of death in this age-group, with motor-vehicle crashes accounting for the majority of these injuries. However, many injuries that don't result in death can have life-long disabling effects, and nearly all are preventable. Important preventive measures include wearing safety belts while riding in any vehicle, wearing helmets and other protective gear while engaging in biking, skiing, and related sports.

In 2005, 83 percent of students in grades 8-12 reported they wear a safety belt consistently when riding in a car; girls are more likely than boys to use safety belts. Use of alcohol and other drugs also increases the likelihood of injury.[1]

Data for this indicator reflect only those injuries resulting in hospital admission; they do not include injuries treated in emergency rooms or doctors' offices. Thus, the data may be sensitive to regional differences in treatment practices.

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
Addison	5.0	4.6	2.7	3.6	3.4
Bennington	3.6	3.4	3.5	1.8	2.1
Caledonia	2.9	3.6	2.2	1.8	3.3
Chittenden	2.3	2.6	3.1	3.3	2.1
Essex	2.4	0.0	1.3	7.0	3.6
Franklin	2.0	1.5	2.3	1.5	1.4
Grand Isle	6.4	0.0	3.9	2.2	3.4
Lamoille	7.5	5.9	10.8	9.0	11.7
Orange	4.7	4.3	3.5	2.9	3.2
Orleans	4.4	4.5	2.9	4.6	2.5
Rutland	3.1	2.9	3.2	2.8	3.8
Washington	2.4	2.1	2.0	1.7	2.3
Windham	4.9	4.4	2.9	2.8	4.3
Windsor	4.2	3.3	2.9	1.8	2.6

[1] Vermont Office of Alcohol and Drug Abuse Programs, and Vermont Department of Education. The Vermont Youth Risk Behavior Survey, 2005: Statewide report. Vermont Department of Health. Burlington, VT, 2005.

What We Want: Youth Choose Healthy Behaviors

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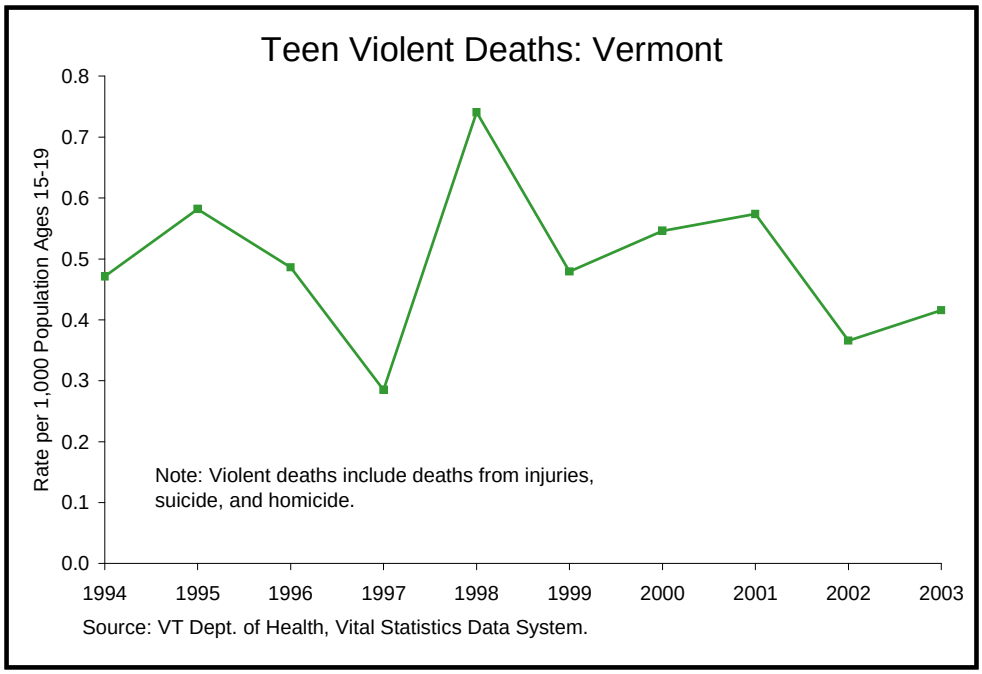


	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Vermont	0.5	0.6	0.5	0.3	0.7	0.5	0.5	0.6	0.4	0.4

The Story Behind the Data

Violent deaths—due to intentional or unintentional injury—are nearly always preventable. They result from carelessness, inattention, and, sometimes, insufficient social support. Motor vehicle and other "accidents" generally account for most violent deaths among teens. Substance abuse, fatigue, and untreated mental illness are often factors. Although thankfully the annual number of these deaths in Vermont is very small, each calls our attention to what could have been done to prevent it.

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
	Number of Deaths				
Addison	2	3	1	1	0
Bennington	1	3	2	0	0
Caledonia	1	2	0	1	1
Chittenden	4	4	2	2	3
Essex	1	2	0	0	1
Franklin	4	1	0	2	3
Grand Isle	0	0	0	0	3
Lamoille	0	0	0	0	0
Orange	0	0	0	0	2
Orleans	0	0	1	3	1
Rutland	1	4	4	2	1
Washington	4	3	2	2	2
Windham	1	3	1	3	1
Windsor	2	0	1	2	1

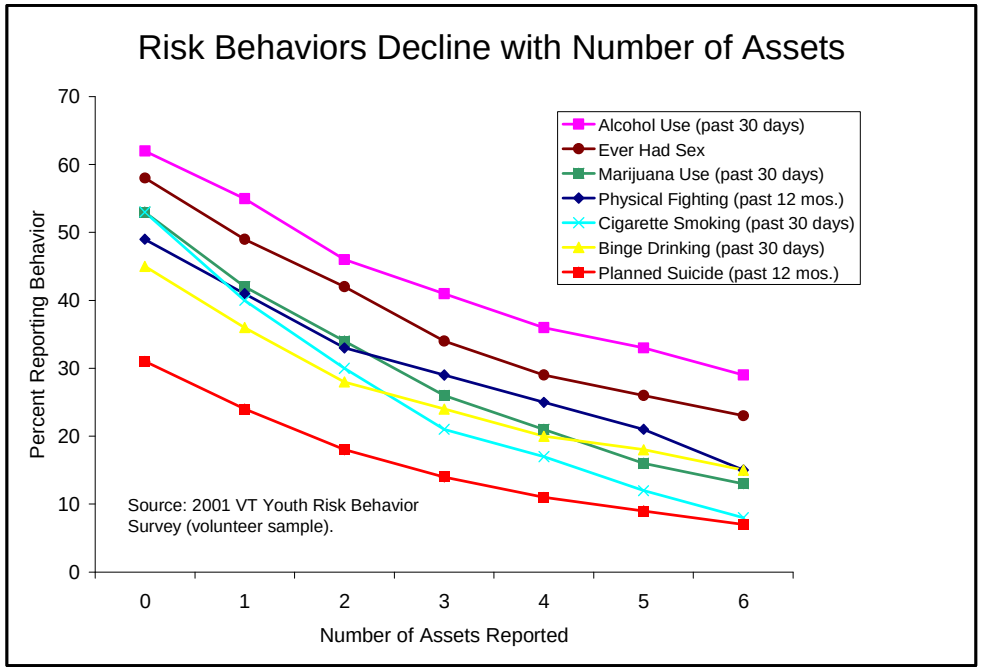
For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

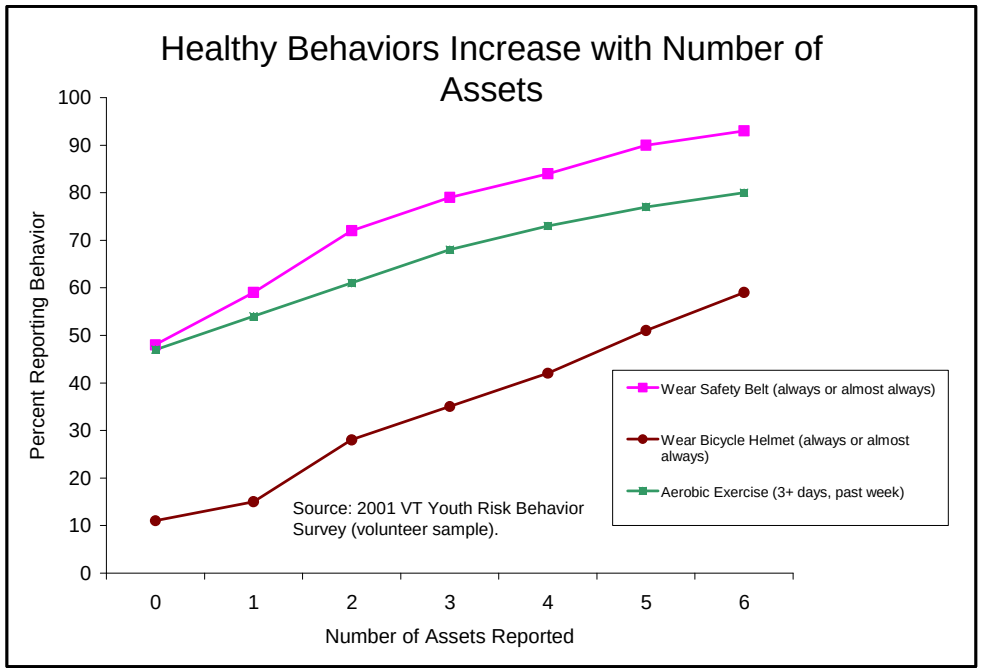
The Power of "Assets"

Increasingly, we know that we cannot define positive youth development as simply the absence of risk behaviors; we must also identify those strengths in the lives of young people that contribute positively to their well-being.

Strong connections with parents and other positive adult figures, competence in one or more skill-areas, independent decision-making, recognition for participation in meaningful activities—these are some of the factors experts agree are critical for all youth to be engaged, productive citizens.

Just how important are these? Recent analysis of Vermont Youth Risk Behavior Survey data shows the cumulative effect that just six "assets" have on the likelihood that teens will engage in either risk behaviors or healthy behaviors. The six are: getting good grades in school, talking with parents frequently about school, feeling that students help decide what goes on in school, participating in after-school programs (at least 1 hour per week), volunteering in the community (at least 1 hour per week), and feeling that "I matter" in the community. The more of these six assets students report having, the less likely they are to venture into risky behavior, and the more likely they are to adopt health-promoting practices.


Risk Behaviors Decline with Number of Assets
Percent Reporting Behavior
70
60
50
40
30
20
10
0
0
1
2
3
4
5
6
Number of Assets Reported
Alcohol Use (past 30 days)
Ever Had Sex
Marijuana Use (past 30 days)
Physical Fighting (past 12 mos.)
Cigarette Smoking (past 30 days)
Binge Drinking (past 30 days)
Planned Suicide (past 12 mos.)
Source: 2001 VT Youth Risk Behavior Survey (volunteer sample).


Healthy Behaviors Increase with Number of Assets
Percent Reporting Behavior
100
90
80
70
60
50
40
30
20
10
0
0
1
2
3
4
5
6
Number of Assets Reported
Wear Safety Belt (always or almost always)
Wear Bicycle Helmet (always or almost always)
Aerobic Exercise (3+ days, past week)
Source: 2001 VT Youth Risk Behavior Survey (volunteer sample).

Youth Successfully Transition to Adulthood

Moving from a status of youthful dependence to one of responsible adult participation in the community—economically, intellectually, socially, and otherwise—has always been a significant developmental challenge. Today, in a world that is increasingly competitive, and which appears to many to hold uncertain prospects for continued well-being, it is perhaps especially difficult. Too many of our youth are ill-equipped for the world of the 21st century, which requires excellent academic and interpersonal skills, as well as a strong grounding in personal, family, and community values.

Vermont has begun taking some important steps toward supporting these transitions through regional Workforce Investment Boards, the JOBS Initiative, the Vermont Student Assistance Corporation, and other state-and-local partnerships.

However, there are a number of disturbing signs regarding the well-being of many young adult Vermonters. Alcohol use, and use of illicit drugs (especially marijuana) are extraordinarily high among this group, and appear to be increasing in recent years. There is great unmet need for treatment services. The prevalence of indications of serious mental illness in this age-group is considerably higher than in the general Vermont population.[1]

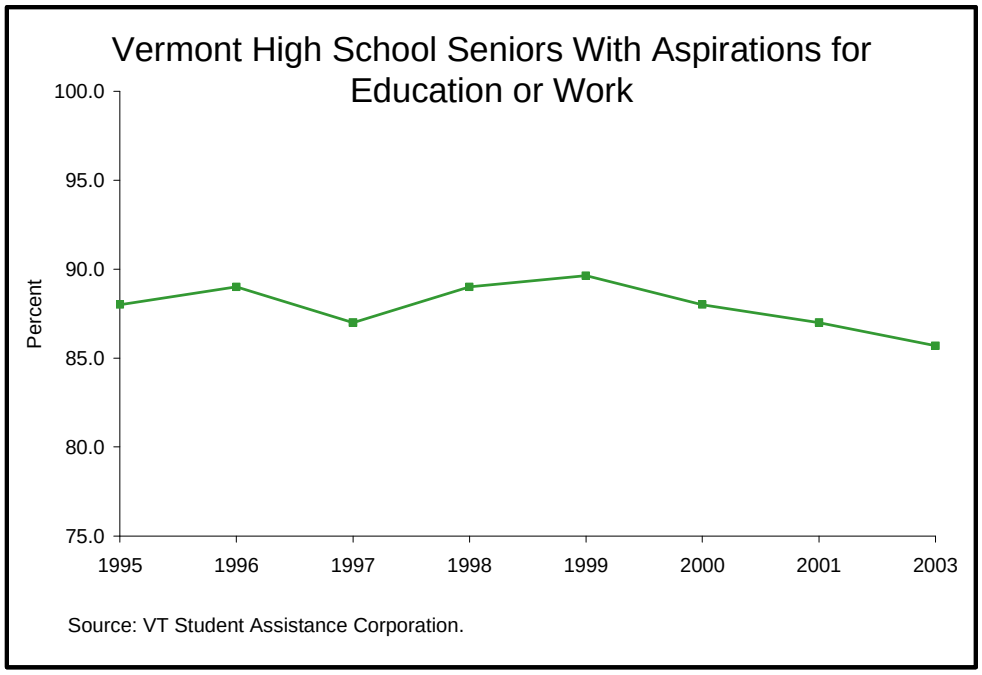
Some Vermont youth face exceptional challenges making the transition to adulthood. These include youth with disabilities, youth who have been in foster care, youth involved in the juvenile justice system, youth who are parents, and youth who have "dropped out" of school.[2]

[1] Wright D, and Sathe N. State estimates of substance abuse from the 2002-2003 national surveys on drug use and health. U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration. Rockville, MD, January 2005.

[2] Nelson, DW. Moving youth from risk to opportunity. In Kids count data book: State profiles of child well-being, 2004. The Annie E. Casey Foundation. Baltimore, MD, 2004.

What We Want: Youth Successfully Transition to Adulthood

How We Measure Our Success:



	1995	1996	1997	1998	1999	2000	2001	2003
Vermont	88.0	89.0	87.0	89.0	89.6	88.0	87.0	85.7

(Note: National data are not available for this indicator.)

The Story Behind the Data

Aspirations reflect young people's current views of themselves and their abilities, as well as their sense of the future and what they can attain. Having positive expectations for the future has been identified as part of a constellation of developmental "assets" for youth.[1] Young people who are committed to long-term goals may be more likely to refrain from a variety of risky behaviors. In contrast, youth who have no clear idea of what they will be engaged in following high school may be vulnerable to poor decisions and an attitude of hopelessness. In today's world, it is difficult to imagine becoming self-sufficient without pursuing either work or further education after leaving high school.

Data by Vermont Region

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

For Additional Information

Vermont Student Assistance Corporation: www.vsac.org

[1] Scales PC, & Leffert N. Developmental assets: A synthesis of the scientific research on adolescence. Minneapolis, MN: Search Institute. 1999.

What We Want: Youth Successfully Transition to Adulthood

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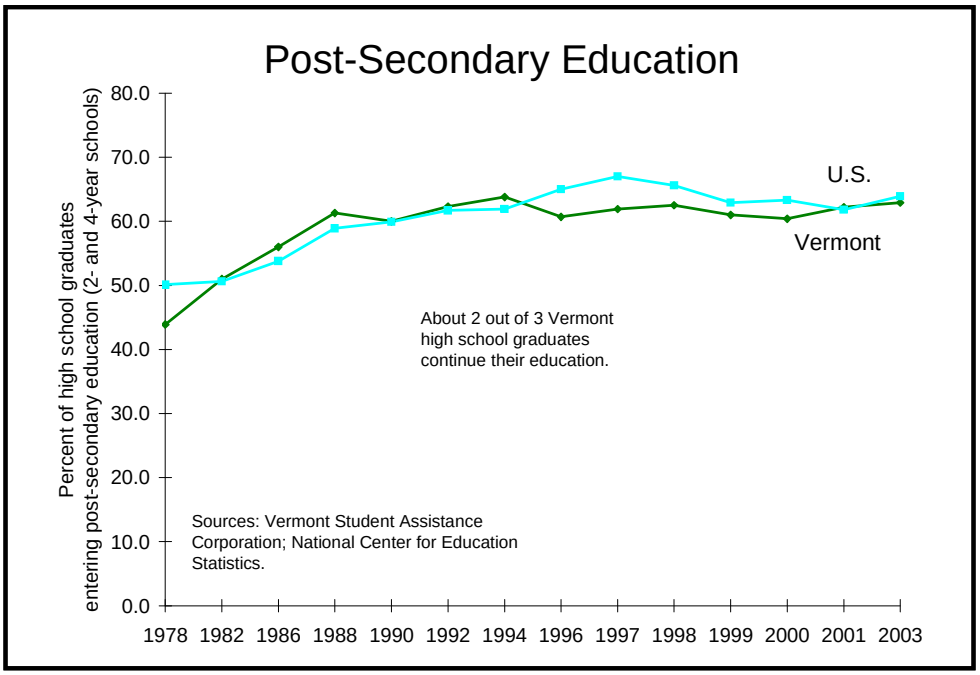

	1978	1982	1986	1988	1990	1992	1994	1996	1997	1998	1999	2000	2001	2002	2003
Vermont	43.9	51.0	56.0	61.3	60.0	62.3	63.8	60.7	61.9	62.5	61.0	60.4	62.2	n/a	62.9
U.S.	50.1	50.6	53.8	58.9	59.9	61.7	61.9	65.0	67.0	65.6	62.9	63.3	61.8	65.2	63.9

(State rankings not available.)

The Story Behind the Data

Today, most jobs paying a livable wage require not only a high school diploma, but also post-secondary training or a college education. Compared to the rate for college graduates, the unemployment rate for high school graduates is twice as high, and the unemployment rate for youth with fewer than four years of high school is four times as high.[1]

Fortunately, the percentage of Vermont's high school graduates who continue full-time in a college or vocational school has increased steadily over the last two decades. Data show that 63% of 2003 high school graduates continued in school, compared to 44% in 1978.[2]

Data by Vermont Region

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

Related AHS Performance Measure: Decrease the percentage of first births to unmarried teens without a high school diploma.

For Additional Information

Vermont Student Assistance Corporation: www.vsac.org

[1] Children's Defense Fund. The state of America's children, 1991. Washington, DC, 1991.

[2] Vermont Student Assistance Corporation. Senior Survey, Class of 2003. Winooski, VT. Data from 1996 and later reflect a higher response rate than obtained on previous surveys; therefore, these data may not be strictly comparable to previous years'.

What We Want: Youth Successfully Transition to Adulthood

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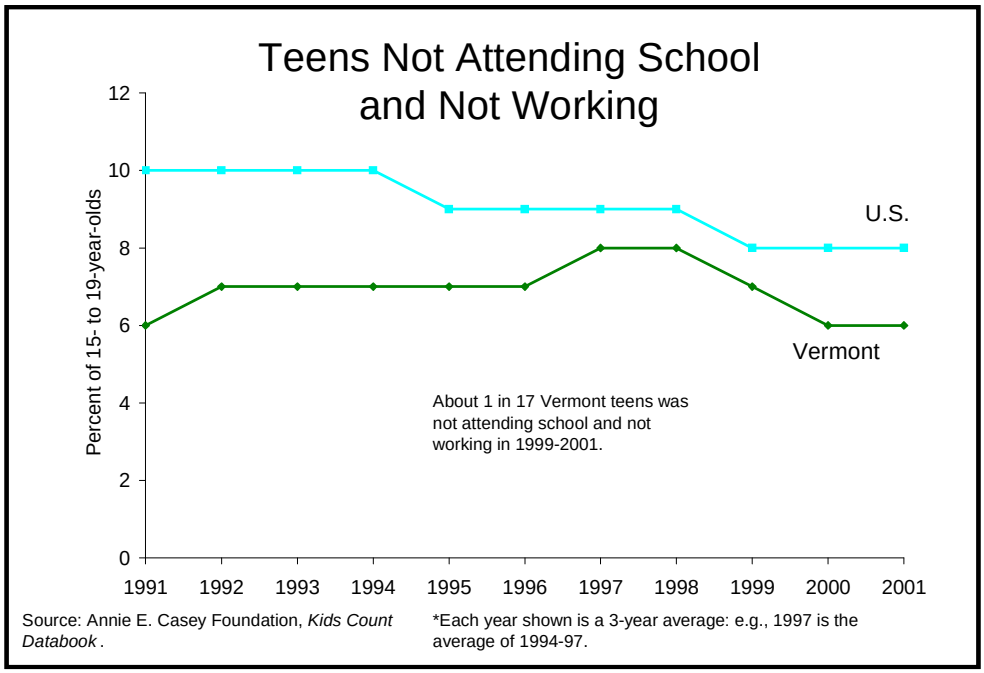

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Vermont	6	7	7	7	7	7	8	8	7	6	6
U.S.	10	10	10	10	9	9	9	9	8	8	8
VT rank	5	8	10	10	10	12	19	18	12	8	6

("1" is lowest)

The Story Behind the Data

Adolescence is a time for making commitments that will lead to economic self-sufficiency in adulthood. Some youth pursue further education right after high school; others develop their skills in the world of work, either as a prelude to further educational plans, or to begin a career path. Teens who find themselves in neither group are at a disadvantage, their progress toward financial independence stalled.

People who are unemployed for a significant part of their young adult years are more likely to have trouble finding and keeping a job in later life. To serve all our youth well, we must ensure that there are adequate opportunities for their progress. In addition, youth must be willing to commit their energies to this critical life-task.

Vermont's record on this indicator has been fairly stable over the past several years. For the most recent period (1999-01), 6% of Vermont's 15- to 19-year-olds were not attending school and not working. The comparable national average for that period was 8%.[1] Analyses of

the national trends on this indicator show disturbing rises in unemployment, underemployment, and "dropout" from the labor force among teens and young adults.[2]

[1] The Annie E. Casey Foundation. Kids count data book: State profiles of child well-being, 2004. Baltimore, MD, 2004.

[2] Sum A, and Khatiwada I. Still young, restless, and jobless: The growing employment malaise among U.S. teens and young adults. Jobs for America's Graduates. Alexandria, VA, 2004.

What We Want: Youth Successfully Transition to Adulthood

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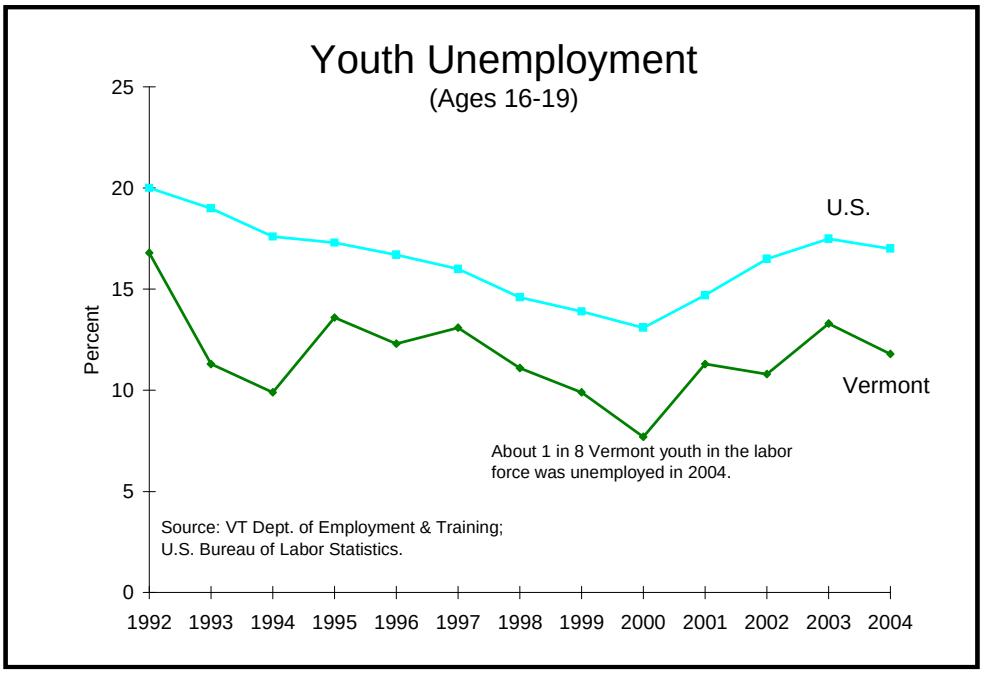

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	16.8	11.3	9.9	13.6	12.3	13.1	11.1	9.9	7.7	11.3	10.8	13.3	11.8
U.S.	20.0	19.0	17.6	17.3	16.7	16.0	14.6	13.9	13.1	14.7	16.5	17.5	17.0

(State rankings not available.)

The Story Behind the Data

Unemployment rates for 16- to 19-year-old youth typically are higher than those for any other age group, but tend to increase and decrease with the overall unemployment rates. In 2004, the youth unemployment rate in Vermont was 11.8%, and over the last decade has been as low as 5.5%, in 1988. Vermont's rate consistently has been lower than the national average.[1]

An important group of young people who need assistance in moving from school to work are those with severe disabilities. Vermont's JOBS ("Jump On Board for Success") Initiative works to place youth with severe emotional and behavioral disabilities, many of whom have histories of involvement with the criminal justice system or foster care. In state fiscal year 2005, the JOBS Initiative reported 193 of these youth were working in competitive jobs.[2] Vermont's "Career Start" project works with a number of sites statewide to improve transition outcomes for youth with disabilities.[3]

[1] U.S. Bureau of Labor Statistics, Current Population Survey.

[2] State of Vermont, Department of Aging and Disabilities. Personal communication with Glen McClintock. April 2006.

[3] For more information, see www.dad.state.vt.us/dvr/CareerStart/CRHome.htm.

What We Want: Youth Successfully Transition to Adulthood

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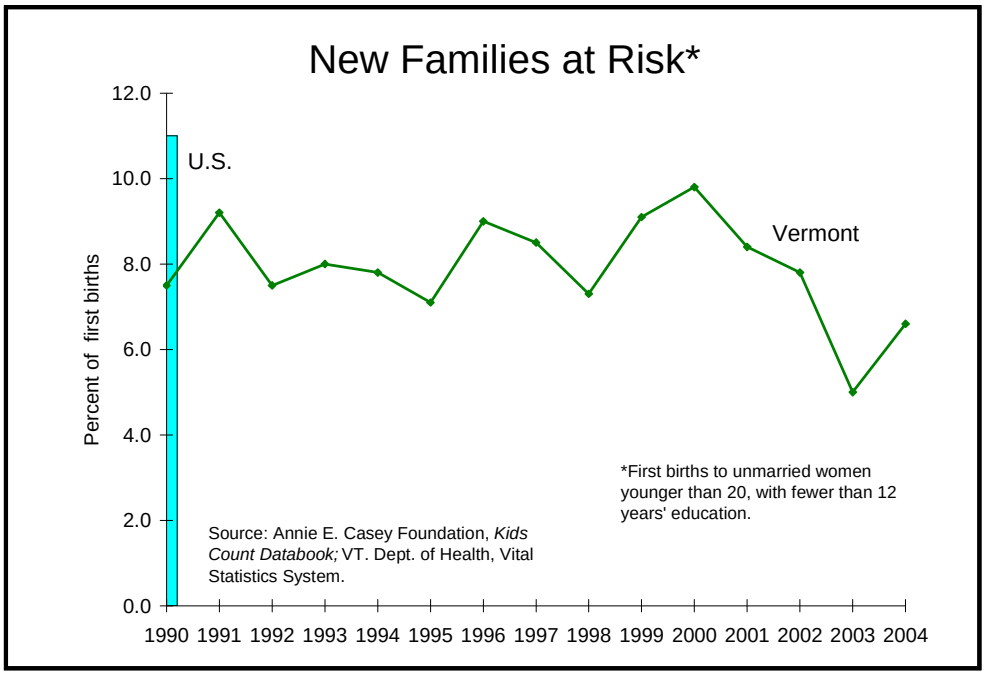

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	7.5	9.2	7.5	8.0	7.8	7.1	9.0	8.5	7.3	9.1	9.8	8.4	7.8	5.0	6.6
U.S.	11.0														
VT Rank	3														

("1" is lowest)

The Story Behind the Data

Early childbearing—especially outside of marriage, and especially before completing school—is often a prescription for serious problems. Considered separately, these circumstances (having a child while a teenager, becoming a single parent, not finishing school) are risky in themselves, though they might not spell trouble in every case. But in combination these three factors pose a nearly certain risk to healthy family development.

Children in these families are almost 10 times more likely to live in poverty as those with none of the risks.[1] These are our "new families at risk." By the same token, reducing the risk in even one of these areas—such as by encouraging a young mother to stay in school—can substantially improve family outcomes.

Vermont has proportionately fewer of these "new families at risk" than does the country as a whole; our rate for 2004 was 6.6%.[2] The only national comparison figure (11.0%) we have is for 1990, when Vermont ranked third lowest among the states.[3]

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
Addison	8.2	6.5	8.5	4.2	1.4
Bennington	12.9	16.8	13.1	11.0	9.9
Caledonia	10.9	4.4	11.8	8.6	5.5
Chittenden	8.5	7.5	7.0	5.8	3.6
Essex	7.4	10.3	7.7	9.1	12.0
Franklin	10.4	12.3	6.2	8.6	3.4
Grand Isle	10.3	3.4	14.3	4.3	10.0
Lamoille	5.1	3.1	9.7	2.5	4.6
Orange	10.7	10.4	9.6	9.4	4.1
Orleans	11.0	8.3	8.9	11.8	5.2
Rutland	6.6	10.0	9.0	11.7	7.9
Washington	6.9	4.0	6.5	6.4	4.4
Windham	12.4	12.2	9.6	11.0	8.0
Windsor	7.0	9.2	8.3	8.5	4.4

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

Related AHS Performance Measure: Decrease the percentage of first births to unmarried teens without a high school diploma.

[1] The Annie E. Casey Foundation. Kids count data book: State profiles of child well-being, 1993. Center for the Study of Social Policy. Washington, DC, 1993.

[2] Vermont Department of Health. Vital Statistics Data System. Burlington, VT, December 2005.

[3] The Annie E. Casey Foundation. Kids count data book: State profiles of child well-being, 1993. Center for the Study of Social Policy. Washington, DC, 1993.

What We Want: Youth Successfully Transition to Adulthood

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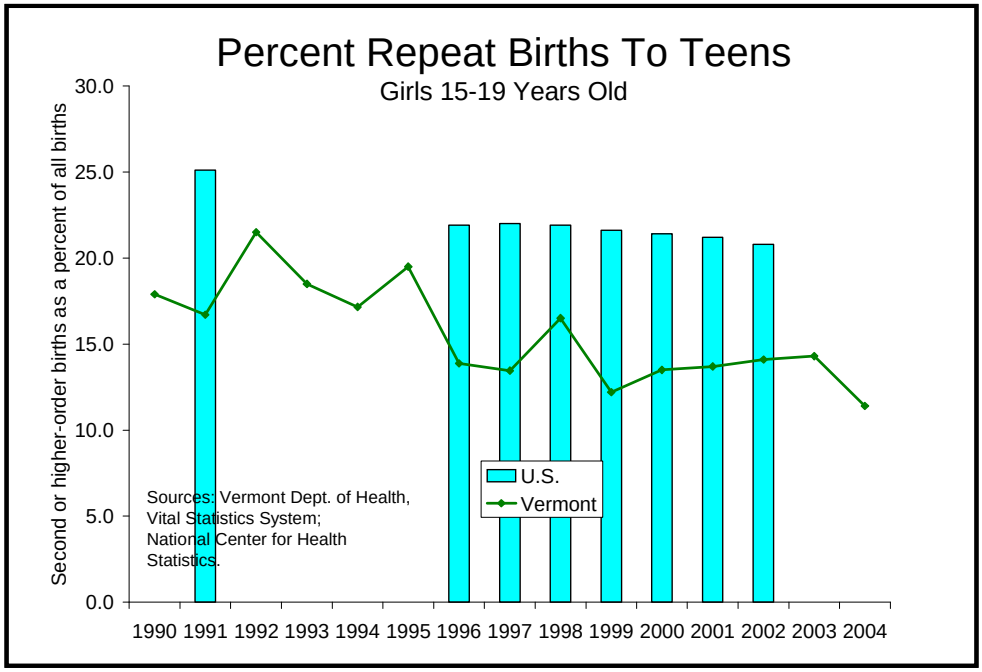

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	17.9	16.7	21.5	18.5	17.2	19.5	13.9	13.5	16.5	12.2	13.5	13.7	14.1	14.3	11.4
U.S.		25.1					21.9	22.0	21.9	21.6	21.4	21.2	20.8	20.1	n/a
VT Rank							2	1	5	2	2	2	2	3	n/a

("1" is lowest)

The Story Behind the Data

Although some older teens can responsibly assume the role of parent, a second birth for a mother who is still a teenager is likely to contribute to economic and other struggles. These parents will be much less likely to finish school, to find well-paying jobs, and to stay off public assistance.

Nationally, about one in five births to teens are repeat births, whereas in Vermont the ratio is closer to one in eight.[1] Some factors identified by research that reduce the likelihood that a teen will have a repeat birth are: staying in school; living with a parent or on her own, rather than with a husband, boyfriend, or other adult; and having a high school diploma or GED.[2] In Vermont, community-based home-visiting programs (see p. 26) help support teen parents to make sensible decisions around future childbearing.

[1] National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. Personal communication with Stephanie Ventura, March 2006. Vermont Department of Health. Vital Statistics Data System. Burlington, VT, January 2006.

[2] Manlove J, Mariner C, and Romano A. Postponing second teen births in the 1990s: Longitudinal analyses of national data. Child Trends, Inc. Washington, DC, 1997.

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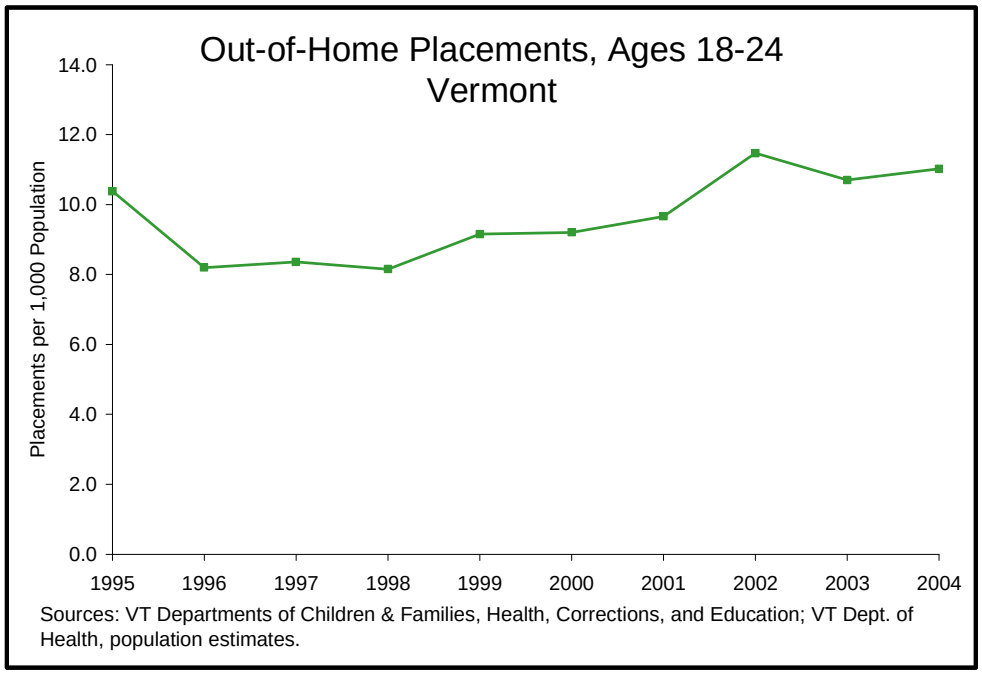

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	10.4	8.2	8.4	8.2	9.2	9.2	9.7	11.5	10.7	11.0

(Note: National data are not available for this indicator.)

The Story Behind the Data

The largest group of young people in out-of-home custody of the state are those who are incarcerated. Young adults commit a disproportionate share of crimes.[1] It is important for communities to help these young people turn their lives around; those who do not are likely to become a long-term burden on our public systems. Mental health and substance abuse treatment needs are great within this age-group.[2] There are smaller numbers of youth who are in the custody of the Departments of Education, Children & Family Services, and Health.

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	6.0	4.9	5.6	2.1	3.5
Bennington	15.8	16.9	20.2	15.5	20.7
Caledonia	10.0	7.6	9.7	9.0	10.8
Chittenden	7.8	7.4	8.8	10.7	10.9
Essex	11.9	14.4	25.6	14.2	19.3
Franklin	13.5	13.0	13.2	13.6	16.1
Grand Isle	12.9	6.0	12.1	6.3	0.0
Lamoille	7.8	8.1	6.8	9.2	9.9
Orange	6.8	6.2	10.5	6.5	6.1
Orleans	13.4	18.9	14.6	15.1	13.6
Rutland	7.8	10.2	12.4	13.1	10.8
Washington	11.4	11.3	15.7	9.8	9.5
Windham	16.8	9.3	17.3	10.9	10.5
Windsor	4.7	11.9	9.5	9.8	8.1

Related AHS Performance Measure: Decrease the number of young adults (<20) who are first-time entrants into corrections custody.

[1] Vermont Department of Public Safety. Vermont Crime On-Line: www.dps.state.vt.us/cjs/crime_04/vcon.htm

[2] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health. http://oas.samhsa.gov/2k4State/toc.htm

What We Want: Youth Successfully Transition to Adulthood

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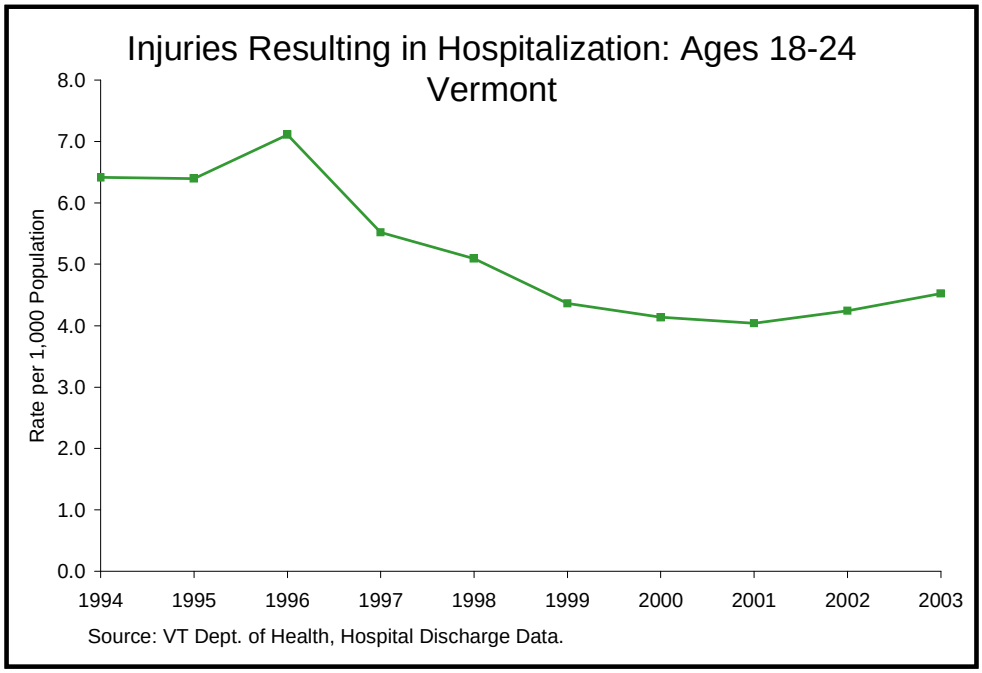

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Vermont	6.4	6.4	7.1	5.5	5.1	4.4	4.1	4.0	4.2	4.5

(Note: National data are not available for this indicator.)

The Story Behind the Data

Injuries are a leading cause of death and disability in this age-group. Alcohol use is a factor in many of these cases; young adults as a group are more likely than others to be heavy users of alcohol and other drugs.[1] Many injuries are the result of motor vehicle crashes.

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
Addison	2.0	2.2	3.7	2.4	2.5
Bennington	6.7	3.5	4.6	5.5	6.7
Caledonia	4.0	4.6	5.2	3.0	4.7
Chittenden	3.0	3.0	2.3	3.4	4.0
Essex	17.1	4.8	8.2	4.7	5.3
Franklin	2.9	6.6	5.4	7.2	6.1
Grand Isle	8.4	7.7	10.0	14.5	4.8
Lamoille	5.2	4.8	6.4	3.4	4.0
Orange	7.2	5.9	4.7	3.1	3.1
Orleans	7.5	8.6	6.9	5.2	6.5
Rutland	5.0	3.2	5.0	5.8	4.7
Washington	4.0	3.1	3.1	5.2	5.6
Windham	6.3	5.7	5.6	5.3	4.3
Windsor	7.2	8.3	4.3	3.4	4.3

[1] Substance Abuse and Mental Health Services Administration, Office of Applied Studies, National Survey on Drug Use and Health, 2003 and 2004.

What We Want: Youth Successfully Transition to Adulthood

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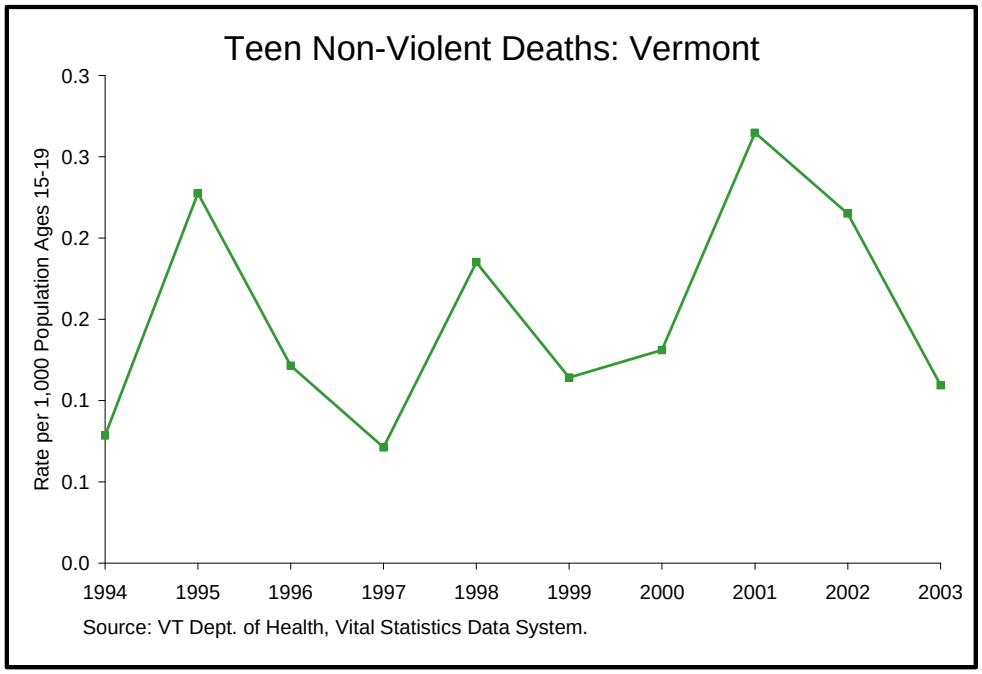

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Vermont	0.1	0.2	0.1	0.1	0.2	0.1	0.1	0.3	0.2	0.1

The Story Behind the Data

A small number of deaths in this age-group result from illnesses, including cancer and congenital disorders. Not all of these are preventable, given current medical knowledge. More research into causes and effective treatment is necessary to reduce further these numbers.

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
	Number of Deaths				
Addison	0	0	2	1	0
Bennington	0	0	0	0	2
Caledonia	0	1	0	2	0
Chittenden	2	1	4	3	0
Essex	0	0	0	0	0
Franklin	0	0	2	2	1
Grand Isle	0	0	0	0	0
Lamoille	0	0	2	0	0
Orange	1	0	1	0	0
Orleans	1	0	0	0	1
Rutland	1	1	1	0	0
Washington	0	2	0	0	0
Windham	0	1	0	2	0
Windsor	0	0	0	2	1

Adults Lead Healthy and Productive Lives

Vermont ranks high on many measures of health. Adult Vermonters get more exercise and are healthier, on average, than residents of many other states; and we have made health care accessible for more of our people. However, excessive alcohol use, and overweight, are two serious health problems for Vermonters.

In the past decade, economic security for many working Vermonters has become more difficult to achieve as the costs of basic necessities have climbed faster than their incomes. Economic inequality among Vermonters has increased. Vermont per capita income and wages trail national averages. Our poverty rate, declining during the 1980s, rose during the recession of the early 1990s, and has fallen only slowly since then.

The Joint Fiscal Office of the Vermont Legislature (using methodology developed by *The Vermont Job Gap Study* [see p. 189]) estimates that a livable wage for a family with two wage-earning parents and two children in 2005 is $12.66 per hour, for each earner.[1] The minimum wage, $7.25 as of January 1, 2006, meets only 57% of this level, which covers only basic needs and taxes. Job growth during the 1990s was concentrated in the occupational sectors paying the lowest wages (i.e., wholesale/retail trade and services sectors, and self-employment). Jobs in these areas are also less likely to have benefits, such as health insurance, and more likely to employ part-time, contingent, or seasonal workers. A 1999 report for the Vermont State Legislature estimated that 60,000 Vermonters were in families where there was at least one adult full-time worker who did not earn a livable income.[2] Welfare reform raises many unanswered questions: What jobs will people formerly on public assistance find? How will their children be cared for? What will *their* futures hold?

[1] Vermont General Assembly, The Joint Fiscal Office. Basic needs budgets and the minimum wage. Montpelier, VT, 2005. Wage figure refers to earners living in rural areas who have employer-assisted health care and whose families adopt a "low cost food plan."

[2] Kavet T, Brighton D, Hoffer D, and McCrate E. Act 21 research and analysis in support of the livable income study committee. Prepared for the Vermont State Legislature Livable Income Study Committee. Montpelier, VT, November 1999.

What We Want: Adults Lead Healthy and Productive Lives

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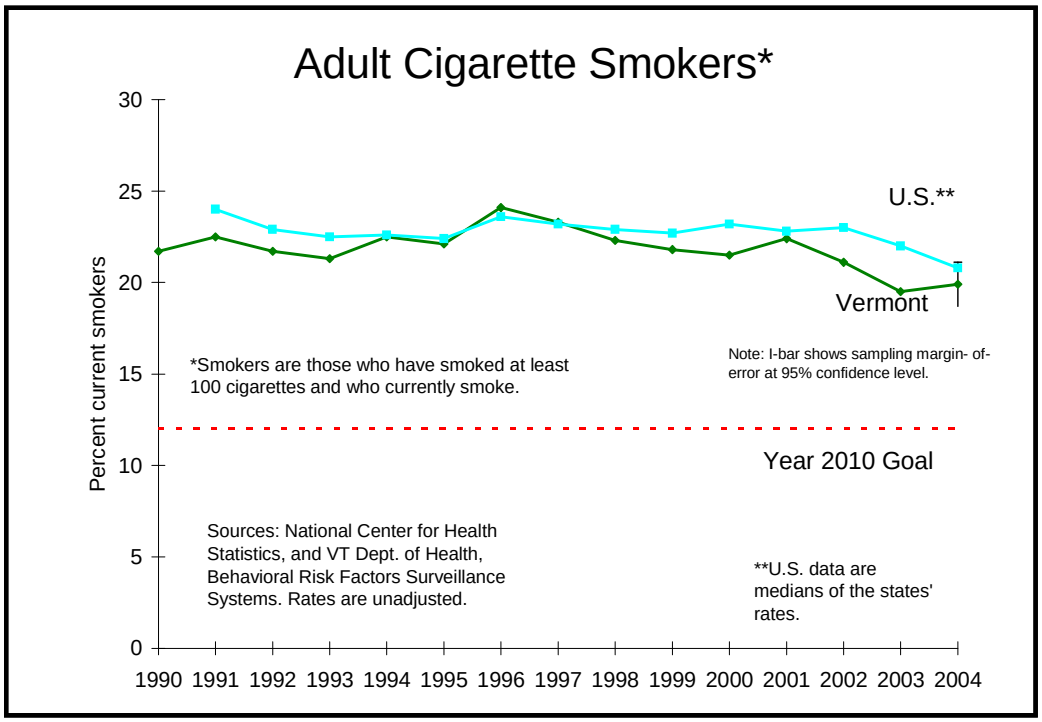


	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	21.7	22.5	21.7	21.3	22.5	22.1	24.1	23.3	22.3	21.8	21.5	22.4	21.1	19.5	19.9
U.S.		24.0	22.9	22.5	22.6	22.4	23.6	23.2	22.9	22.7	23.2	22.8	23.0	22.0	20.8
VT Rank	11	12	17	17	25	16	27	22	18	15	17	20	9	9	12

("1" is lowest)

The Story Behind the Data

Cigarette smoking is the greatest single cause of avoidable death. In Vermont, tobacco use underlies at least 20% of all deaths (from heart disease, cancer, stroke, lung disease, pneumonia, and other diseases).[1]

The direct medical costs in Vermont related to smoking have been estimated at $80 million annually,[2] and the total smoking-attributable costs in Vermont at $161 million (and rising).[3] In 2004, 19.5% of Vermont adults reported smoking cigarettes, down from about 30% in 1982. This was slightly lower than the median state prevalence, 20.8%. Vermont ranked 12th lowest among the states in 2004.[4]

Vermont receives approximately $29 million per year as part of the 1998 Multi-State Tobacco Settlement. A successful tobacco control strategy for Vermont will incorporate proven

elements of a comprehensive program. In Vermont, lower-income and young adults are the groups most likely to smoke.[5] *Healthy Vermonters 2010* calls for reducing the percentage of adults who smoke to 12% or less, so we are far from reaching the goal on this enormous health issue.

Data by Vermont Region

VT Counties	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004
Addison	23.7	20.4	20.4	21.1	20.8
Bennington	20.8	21.8	22.4	20.3	20.1
Caledonia	22.6	22.6	22.2	21.0	22.8
Chittenden	22.3	21.6	19.9	19.3	18.0
Essex	21.6	26.2	26.5	27.6	23.6
Franklin	25.4	24.1	23.7	24.0	24.8
Grand Isle	22.4	20.2	18.9	16.7	14.9
Lamoille	20.8	21.1	19.8	20.3	20.3
Orange	24.6	23.1	22.3	21.3	21.0
Orleans	23.9	25.3	23.6	22.7	22.7
Rutland	24.6	25.3	24.7	23.7	23.7
Washington	21.6	21.9	21.9	20.6	20.4
Windham	20.9	21.4	21.9	21.4	21.1
Windsor	19.9	19.5	20.0	20.4	20.3

Related AHS Performance Measure: Decrease the percentage of Vermonters who smoke.

For Additional Information

Our Smokers' Toll-Free Quit Line: 877-YES-QUIT (877-937-7848)

Vermont Tobacco Evaluation & Review Board: http://humanservices.vermont.gov/boards-committees/tobacco-board

[1] Vermont Department of Health. Memo on the "Health Status of Vermonters. Burlington, VT, June 5, 1992.

[2] Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion. Fact Sheet: "Tobacco Use in Vermont." Centers for Disease Control and Prevention (not dated).

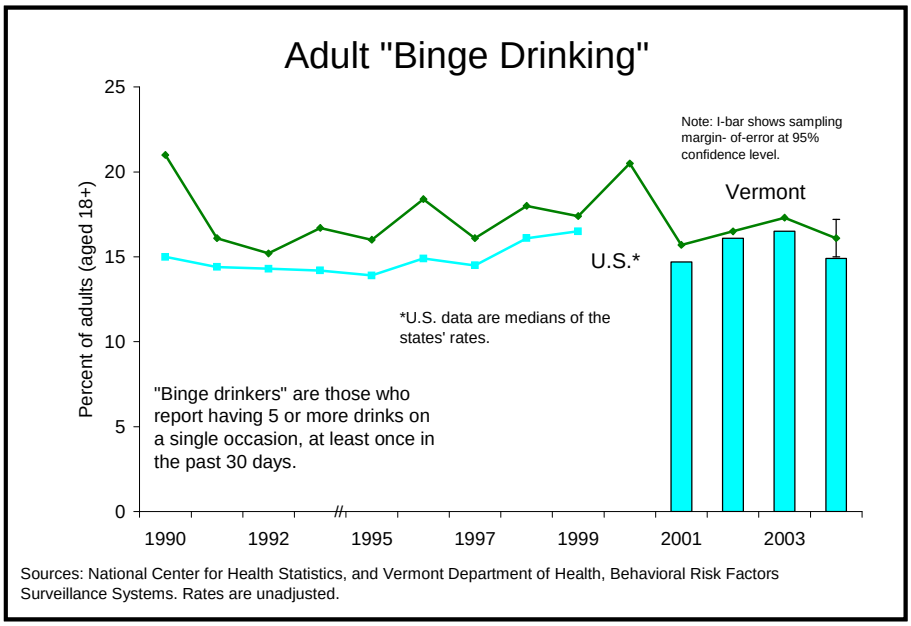
[3] Vermont Department of Health. Health status report '98. Burlington, VT, 1998.

[4] Centers for Disease Control and Prevention. Behavioral Risk Factors Surveillance System.

[5] Vermont Department of Health, Vermont Department of Education, Vermont Department of Liquor Control, and the Vermont Tobacco Evaluation & Review Board. Vermont tobacco control work plan, 2004 & 2005. Burlington, VT, January 2004.

What We Want: Adults Lead Healthy and Productive Lives

How We Measure Our Success:



	1990	1991	1992	1993	1995	1996**	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	21.0	16.1	15.2	16.7	16.0	18.4	16.1	18.0	17.4	20.5	15.7	16.5	17.3	16.1
U.S.	15.0	14.4	14.3	14.2	13.9	14.9	14.5	n/a	14.9	n/a	14.7	16.1	16.5	14.9
VT Rank	44	32	20	38	38	n/a	37	n/a	36	n/a	n/a	27	32	30

("1" is lowest)

The Story Behind the Data

Vermont has a drinking problem. Alcohol is often a factor in child abuse, domestic violence, and other violent crime; in suicide; in absenteeism and decreased productivity at school and on the job; and in many injuries and illnesses.[1] Children who live in alcoholic families miss more school, have more illnesses and injuries, and more behavioral problems.

Overall costs attributed to alcohol in Vermont were estimated, in 1990, at $236 million annually ($25 million in medical and treatment costs alone).[2] Unfortunately, most primary care physicians fail to diagnose the early signs of alcohol abuse, according to a national survey.[3]

During 2004, 16.1% of Vermont adults (ages 18 and over) reported binge drinking (drinking five or more drinks per occasion) at least once in the previous 30 days.[4] Vermont's rank among the states has improved from 44th (out of 45 states) in 1990, to 30th out of 50 states) in 2004. However, Vermont's rate remains higher than the national median, which is 14.9%.[5] In Vermont, “binge drinking” is much more prevalent among men, especially young

adults. Drinking among Vermont's college students is an area of particular concern, with "binge drinking" within the past two weeks reported by 50% of this group in a 1998 survey, for example.[6]

Data by Vermont Region

VT Counties	1999-2003	2000-2004	2001-2005	1999-2003	2000-2004
Addison	16.0	17.0	18.4	16.4	15.4
Bennington	15.6	14.9	15.7	15.6	14.1
Caledonia	12.9	14.1	14.4	15.5	16.7
Chittenden	22.0	21.6	20.9	20.5	18.5
Essex	19.5	19.9	17.4	16.3	10.8
Franklin	17.8	17.5	17.8	18.1	17.9
Grand Isle	16.5	15.3	18.0	17.4	20.1
Lamoille	17.6	18.2	19.2	18.6	18.7
Orange	16.0	16.5	16.1	18.2	16.9
Orleans	17.6	17.4	17.2	16.4	16.0
Rutland	18.1	18.1	17.9	17.7	16.3
Washington	16.5	14.8	14.4	15.4	16.5
Windham	13.3	15.0	13.8	13.1	13.1
Windsor	15.1	15.5	16.7	16.8	16.1

Related AHS Performance Measure: Decrease the percentage of Vermonters who are "binge" drinkers.

For Additional Information

Vermont Department of Health Alcohol Awareness Information:
http://healthvermont.gov/adap/aam2006/info.aspx

[1] Vermont Office of Alcohol and Drug Abuse Programs. Economic and human costs of alcohol abuse from 'cradle to grave.' Burlington, VT, October 14, 1996.

[2] Center for Substance Abuse Prevention. Costs of alcohol, tobacco, and other drugs. CSAP software. Substance Abuse and Mental Health Services Administration, DHHS, Washington, DC, 1990.

[3] The National Center on Addiction and Substance Abuse at Columbia University. Press Release: "CASA Releases Physician Survey." May 10, 2000.

[4] Vermont Department of Health. Vermont Behavioral Risk Factors Surveillance System. Burlington, VT.

[5] Centers for Disease Control and Prevention. Behavioral Risk Factors Surveillance System.

[6] Vermont Department of Health, Office of Alcohol and Drug Abuse Programs. Alcohol, tobacco, and other drug abuse prevention needs of Vermont college students: Results of the 1998 Core Alcohol and Drug Survey. August 1999.

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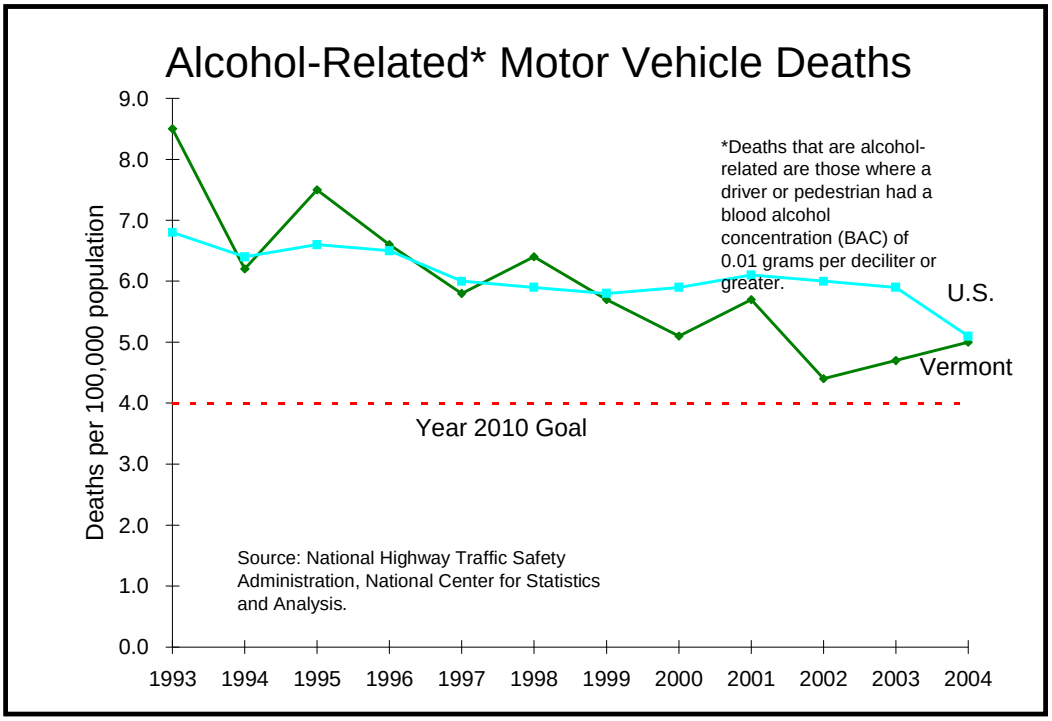

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	8.5	6.2	7.5	6.6	5.8	6.4	5.7	5.1	5.7	4.4	4.7	5.0
U.S.	6.8	6.4	6.6	6.5	6.0	5.9	5.8	5.9	6.1	6.0	5.9	5.1
VT Rank	36	23	28	24	22	26	23	19	23	11	10	22

("1" is lowest)

The Story Behind the Data

One particularly tragic reflection of Vermont's alcohol problem is the number of motor vehicle deaths that are alcohol-related. A goal of *Healthy Vermonters 2010* is to have no more than four such deaths per 100,000 people.

In 2004, the Vermont rate was 5.0, barely below the national rate of 5.1, and still above our 2010 goal. Among the states, Vermont ranked 22nd best. Thirty-two percent of all 2004 motor vehicle deaths in Vermont were alcohol-related, compared with 39 percent nationwide.[1] The average cost of each alcohol-related fatality in Vermont has been estimated at $3.6 million, which includes monetary costs, as well as lost quality of life.[2]

Vermont is one of 45 states that have lowered the standard for "DUI" to 0.08% blood alcohol concentration, and Congress has enacted legislation intended to push the other states to adopt this standard.

For Additional Information

Vermont Governor's Highway Safety Program: www.vthighwaysafety.com/home.htm

[1] National Highway Traffic Safety Administration. Traffic safety facts, 2004—Alcohol. National Center for Statistics and Analysis. Washington, DC, 2005.

[2] Taylor D, Miller TR, and Cox KL. Impaired driving state cost fact sheets. Pacific Institute for Research and Evaluation. Calverton, MD, 2002.

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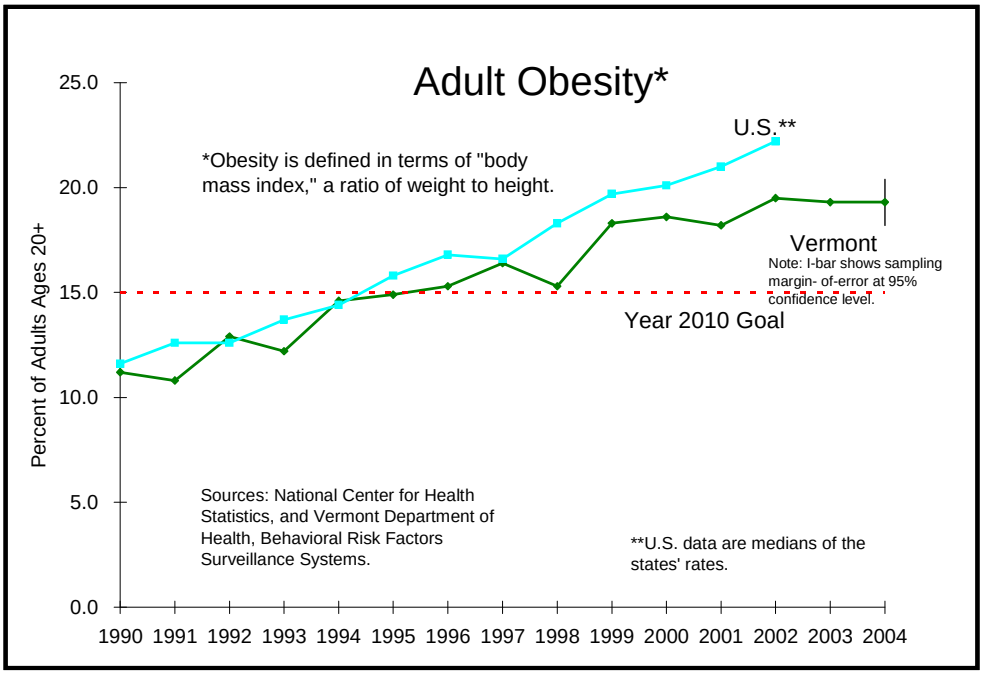

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	11.2	10.8	12.9	12.2	14.6	14.9	15.3	16.4	15.3	18.3	18.6	18.2	19.5	19.3	19.3
U.S.	11.6	12.6	12.6	13.7	14.4	15.8	16.8	16.6	18.3	19.7	20.1	21.0	22.2	n/a	n/a
VT Rank	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	5	17	n/a	n/a	9	n/a	n/a

("1" is lowest)

The Story Behind the Data

Overweight and obesity have been called a national "epidemic" by the U.S. Surgeon General, and may soon rival cigarette smoking as a cause of preventable disease and death. Nationwide, unhealthy weight due to poor diet and a sedentary lifestyle is responsible for an estimated 300,000 deaths per year.[1] Each of these risk factors (overweight and inactivity) can be reduced, at least in part, through healthier choices.

Recent estimates put the annual cost to society for obesity at around $117 billion in 2000, including $61 billion in direct costs.[2] The prevalence of overweight in our population is increasing in all age groups, and overweight children are likely to grow into overweight adults, unless they adopt healthier patterns of eating and exercise. In Vermont, adults between 45 and 64 years old are most likely to be overweight.[3] While the proportion of Vermont's population

overall who are obese is lower than the national average (20%, compared to 22%, in 2002), there is still reason for concern; the *Healthy Vermonters 2010* goal is to lower the rate to 15% or less.[4]

Data by Vermont Region

VT Counties	2001-04
Addison	19.9
Bennington	19.9
Caledonia	20.0
Chittenden	15.5
Essex	18.8
Franklin	21.3
Grand Isle	20.9
Lamoille	20.1
Orange	18.7
Orleans	22.2
Rutland	21.0
Washington	18.6
Windham	18.4
Windsor	17.0

Related AHS Performance Measure: Decrease the percentage of students in grades 8-12 who are overweight or at risk for obesity.

For Additional Information

Vermont Department of Health Obesity Prevention Plan:
http://healthvermont.gov/family/fit/obesity.aspx

[1] U.S Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. Public Health Service, Office of the Surgeon General. Washington, DC, 2001.

[2] Ibid.

[3] Vermont Department of Health. Health status report '98. Burlington, VT, 1998.

[4] Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Online Prevalence Data.

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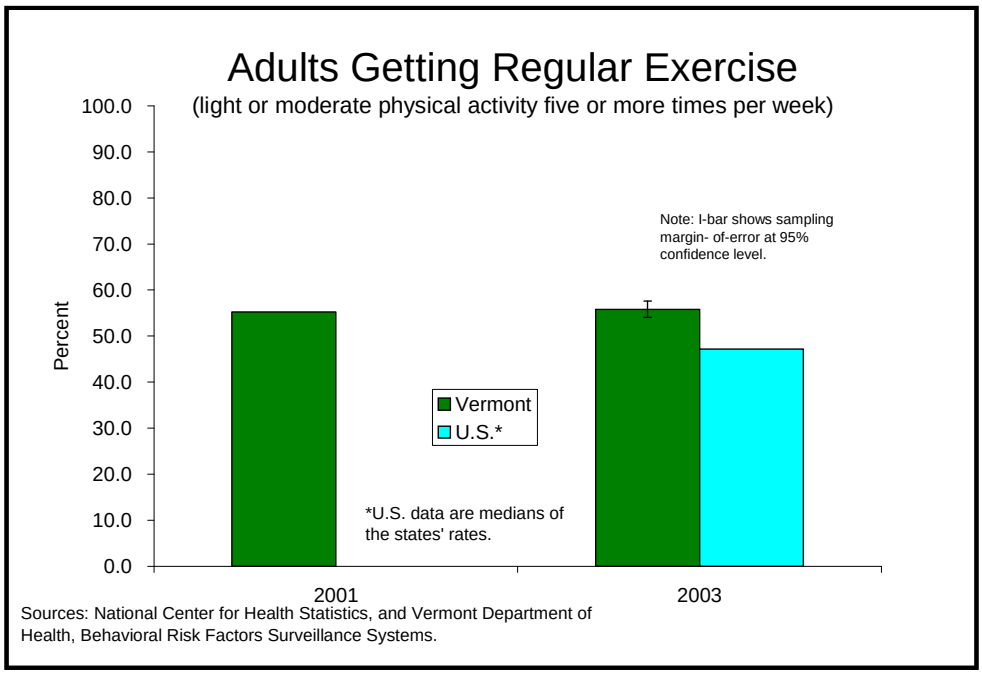

	2001	2003
Vermont	55.2	55.8
U.S.*	n/a	47.2
VT Rank	n/a	5

("1" is highest)

The Story Behind the Data

Regular physical activity increases life expectancy and promotes good overall health. Recent evidence suggests that moderate, regular activity has beneficial effects, even for people who may have other risk factors. "Everyday" kinds of activity, such as raking leaves or climbing stairs, produce some health benefits.[1] Yet, more than half of all adults do not get adequate exercise.

In recent surveys Vermonters score somewhat better than the national average in the proportion of its adults who exercise regularly (that is, some physical activity, lasting 30 minutes or more, five or more times a week): 56%, versus 47% nationally.[2]

Data by Vermont Region

VT Counties	2001-03
Addison	18.1
Bennington	18.7
Caledonia	21.1
Chittenden	15.4
Essex	19.7
Franklin	24.1
Grand Isle	16.0
Lamoille	17.4
Orange	21.8
Orleans	24.2
Rutland	21.4
Washington	18.1
Windham	17.2
Windsor	17.9

Related AHS Performance Measure: Decrease the percentage of students in grades 8-12 who are overweight or at risk for obesity: (2005)

[1] Dunn AL, Marcus BH, Kampert JB, Garcia ME, Kohl HW, and Blair SN. Comparison of lifestyle and structured interventions to increase physical activity and cardiorespiratory fitness. *Journal of the American Medical Association, 281*, January 27, 1999.

[2] A new definition of this indicator was adopted beginning in 2002. See also Vermont Department of Health. Healthy Vermonters 2010. Objective 22-2. Burlington, VT, 2000.

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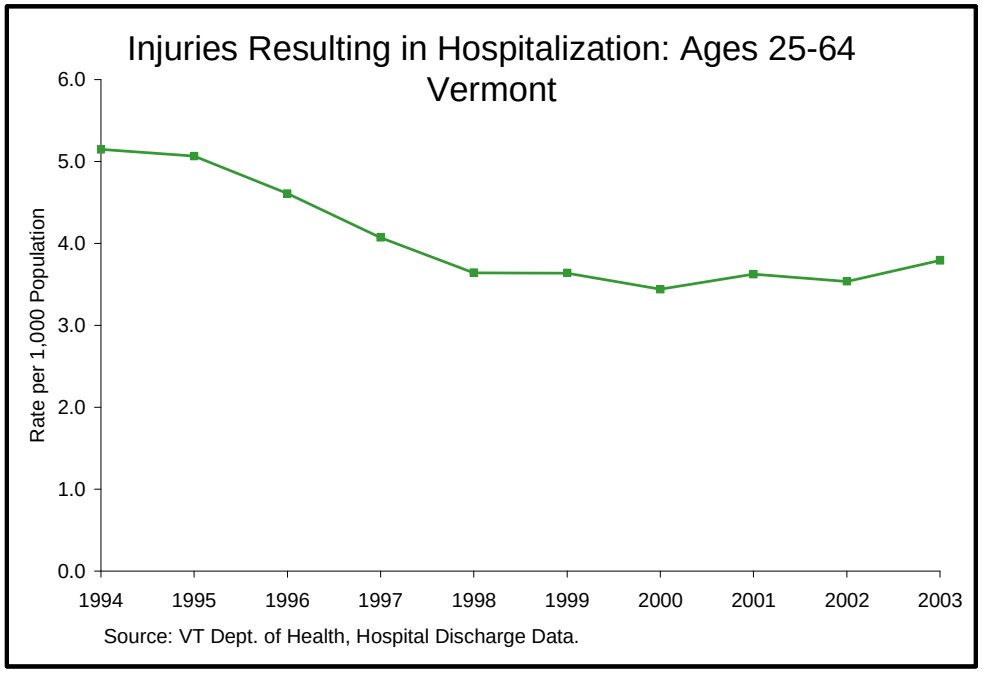

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Vermont	5.1	5.1	4.6	4.1	3.6	3.6	3.4	3.6	3.5	3.8

(Note: National data are not available for this indicator.)

The Story Behind the Data

Injuries serious enough to require hospitalization are responsible for heavy medical costs, lost work productivity, and short- or long-term disabilities, and remain the leading cause of death through age 34. Many such injuries are preventable. A large proportion occur in motor-vehicle crashes, where using safety belts can greatly reduce the likelihood of serious injury. Alcohol use increases the risk for many types of injury.[1]

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
Addison	2.5	2.7	3.8	4.0	3.3
Bennington	4.6	4.4	3.1	4.1	5.3
Caledonia	2.7	3.3	5.0	3.5	4.3
Chittenden	3.7	2.9	3.1	3.0	3.1
Essex	8.3	7.0	5.6	4.7	5.4
Franklin	2.4	2.6	3.1	3.2	3.6
Grand Isle	2.3	2.0	3.6	3.6	4.2
Lamoille	5.6	5.1	4.2	4.6	4.9
Orange	2.6	3.2	3.9	2.9	2.9
Orleans	4.6	5.6	4.5	5.2	4.3
Rutland	3.5	3.5	3.8	3.7	3.8
Washington	3.5	3.0	3.4	3.2	3.7
Windham	3.9	3.6	4.5	4.6	4.8
Windsor	4.2	3.9	3.4	2.9	3.8

[1] Vermont Department of Health. Health status report, ’02. Burlington, VT: Author. June 2002.

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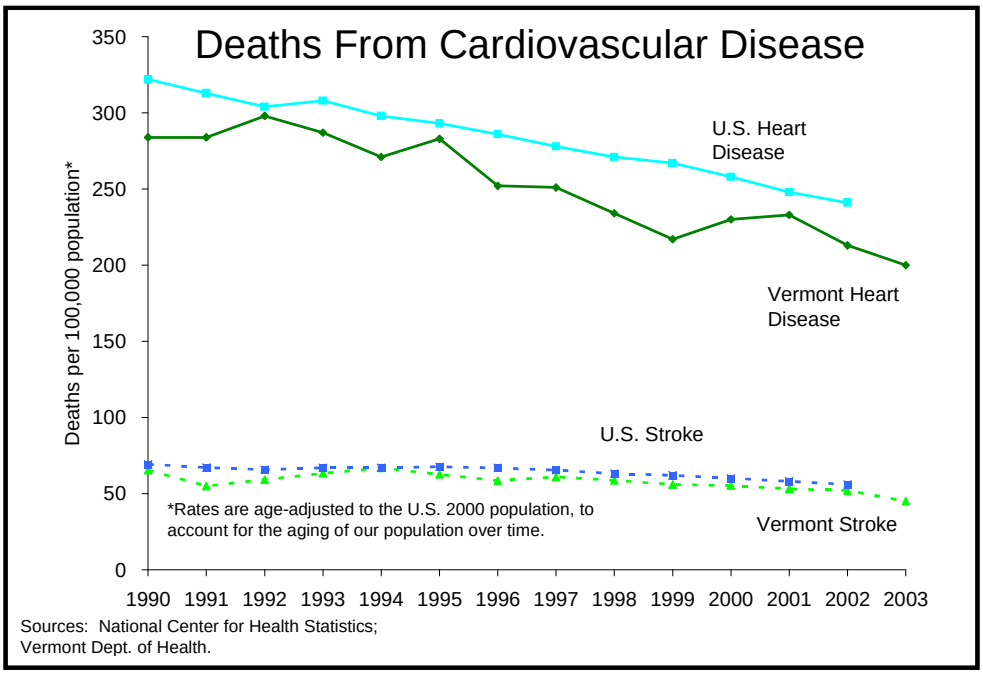

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
VT Heart Disease	284	284	298	287	271	283	252	251	234	217	230	233	213	200
U.S. Heart Disease	322	313	304	308	298	293	286	278	271	267	258	248	241	n/a
VT Stroke	65	55	59	63	67	63	58	61	59	56	55	53	52	45
U.S. Stroke	69	67	66	67	67	68	67	65	63	62	60	58	56	n/a

(State rankings not available.)

The Story Behind the Data

Cardiovascular disease, which includes heart disease and stroke, is the leading cause of death in Vermont, as it is in the nation. Hospital charges alone for cardiovascular disease in Vermont total more than $65 million annually.[1] And much of this mortality and debilitating illness is preventable.

There have been modest declines over the past decade in rates for both heart disease and stroke deaths.[2] However, recent data show that the proportion of adults with no recognized risk factors for these conditions decreased between 1991 and 2001—in Vermont, by about five percent, nationwide by about 14 percent. Thus, the burden associated with these diseases is expected to increase.[3] The risk of cardiovascular disease is greatly reduced by following healthy behaviors, such as limiting alcohol

consumption, maintaining proper weight, reducing dietary fat and cholesterol, getting regular physical exercise, and not smoking.

Data by Vermont Region

(Note: County data are for percent of adults who indicate they have been told by a doctor that they have had heart attack, myocardial infarction, angina, coronary disease, or stroke.)

VT Counties	2003-04
Addison	8.1
Bennington	9.3
Caledonia	8.5
Chittenden	8.1
Essex	7.7
Franklin	8.5
Grand Isle	8.4
Lamoille	6.1
Orange	7.1
Orleans	8.6
Rutland	9.0
Washington	7.2
Windham	7.0
Windsor	8.5

For Additional Information

Vermont Department of Health. Chronic disease profile: 2003-2004.
http://healthvermont.gov/research/chronic/Chronic_Disease_Profiles.pdf

[1] Vermont Department of Health. Health status report '98. Burlington, VT, 1998.

[2] Vermont Department of Health, Vital Statistics Data System. Personal communication with Michael Nyland-Funke, Burlington, VT, January 2005.

[3] Centers for Disease Control and Prevention. Declining prevalence of no known major risk factors for heart disease and stroke among adults—United States, 1991-2001. *MMWR*, *53*, no. 1, January 16, 2004.

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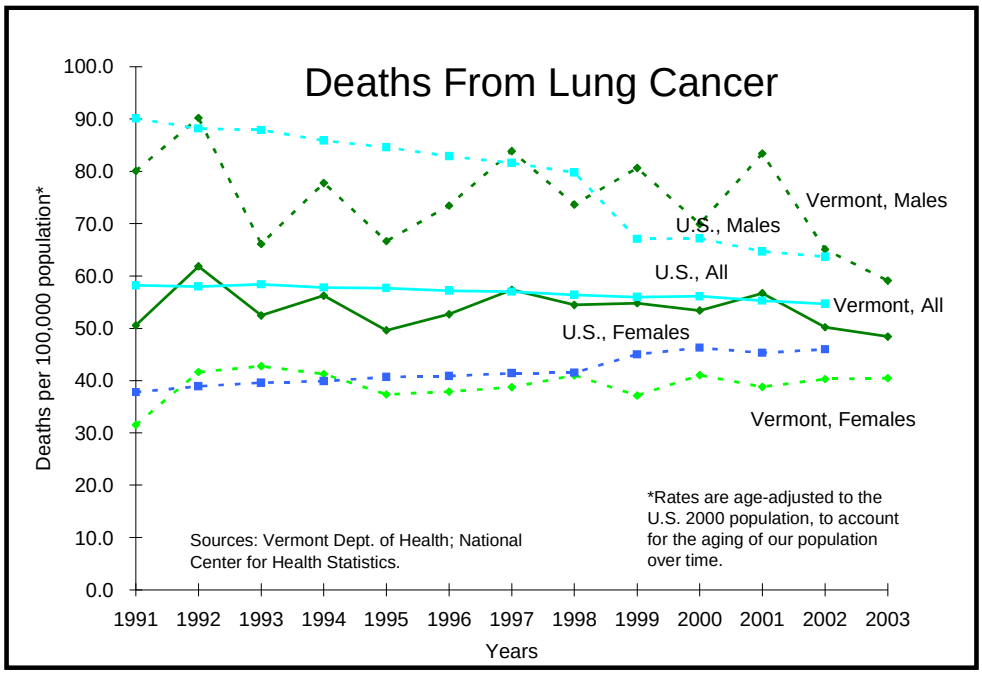

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Vermont, All	50.5	61.9	52.5	56.2	49.6	52.7	57.4	54.5	54.8	53.4	56.7	50.2	48.4
U.S., All	58.2	58.0	58.4	57.8	57.7	57.2	57.0	56.4	56.0	56.1	55.3	54.7	n/a

(State rankings not available.)

The Story Behind the Data

Cancer is the number-two killer, both in Vermont and in the U.S. as a whole. Lung cancer is the deadliest type, for both men and women, and much of it is preventable, with cigarette smoking the leading cause.[1] The rate of lung cancer deaths, while declining slightly among Vermont men, is increasing among women.[2]

Latest available data show that death rates from lung cancer in Vermont are similar to the national average for both men and women.[3] For some other types of cancers, we have seen more encouraging progress. Vermont's rate of deaths from breast cancer (the second-most fatal type for women) is lower than the U.S. average. However, Vermont's rates of colorectal and cervical cancers are worse.[4]

For Additional Information

Vermont Department of Health. Chronic disease profile: 2003-2004.
http://healthvermont.gov/research/chronic/Chronic_Disease_Profiles.pdf

Vermont Department of Health. Vermont state cancer plan.
http://healthvermont.gov/pubs/cancerpubs/state_cancer_plan.pdf

[1] Office of the. Surgeon General. The health consequences of smoking: A report of the Surgeon General. U.S. Department of Health & Human Services. Washington, DC, May 2004.

[2] Vermont Department of Health. Vital Statistics data system. Personal communication with Michael Nyland-Funke. Burlington , VT, February 2005.

[3] Vermont Department of Health, Vital Statistics Data System. Personal communication with Michael Nyland-Funke, Burlington, VT, February 2005; Kochanek MA, Murphy SL, Anderson RN, and Scott, C. Deaths: Final data for 2002. *National Vital Statistics Reports, 53*, no. 5, September 12, 2004.

[4] Vermont Department of Health. Cancer in Vermont: A report of 1995-1999 cancer incidence data from the Vermont Cancer Registry. Burlington, VT, March 2003.

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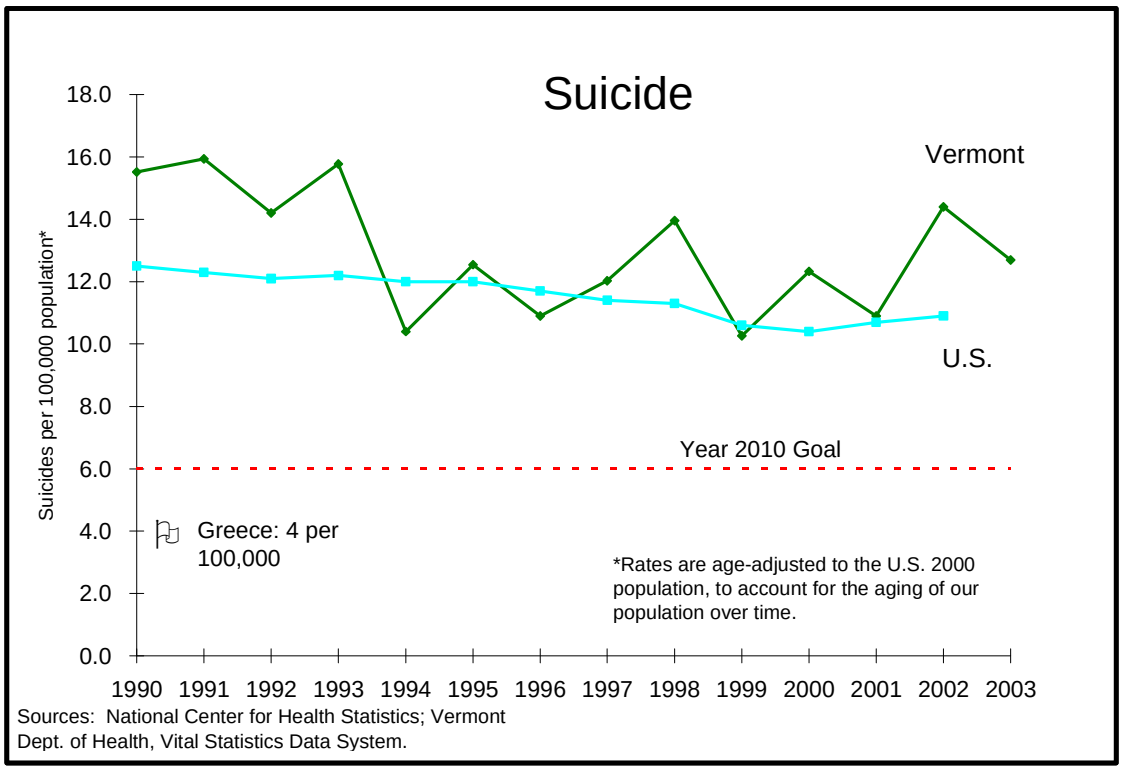

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Vermont	15.5	15.9	14.2	15.8	10.4	12.5	10.9	12.0	14.0	10.3	12.3	10.9	14.4	12.7
U.S.	12.5	12.3	12.1	12.2	12.0	12.0	11.7	11.4	11.3	10.6	10.4	10.7	10.9	n/a

(State rankings not available.)

The Story Behind the Data

Suicide is the eleventh leading cause of death, nationally, and tenth in Vermont.[1] According to a U.S. Surgeon General's report, suicide is "a serious public health problem."[2]

Many more Americans die from suicide than from homicide; additionally, half a million annually require emergency room treatment as a result of attempted suicide. Of course, suicide also causes great pain for those close to its victims. Among adolescents and young adults, U.S. rates of suicide nearly tripled between 1952 and 1996. Although youth suicides may be considered particularly tragic, in fact suicide rates are highest among the elderly, especially older men. The Surgeon General's report lists a number of risk and protective factors for suicide that

can inform prevention efforts. Some of the risk factors are previous suicide attempt, mental illness (especially when co-occurring with substance abuse), physical illness, and isolation. Some of the protective factors are good clinical care for physical, mental, and substance abuse disorders, restricted access to highly lethal methods of suicide (such as guns), and family and community support. [3]

For many years Vermont has had a rate of suicide that is high, relative to the nation's. In 2003, Vermont's age-adjusted rate was 12.7 per 100,000 population, compared to 10.9 for the nation in 2002.[4]

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
	Number of Deaths				
Addison	1	3	2	4	6
Bennington	6	3	0	4	4
Caledonia	4	5	2	4	2
Chittenden	8	15	20	20	20
Essex	1	2	0	2	1
Franklin	6	5	3	5	4
Grand Isle	0	0	1	1	1
Lamoille	2	3	1	4	0
Orange	1	7	3	4	5
Orleans	5	6	3	3	3
Rutland	13	10	8	7	9
Washington	5	8	10	12	6
Windham	4	2	9	8	7
Windsor	7	5	9	13	13

[1] Hoyert DL, Heron MP, Murphy SL, & Kung H-C. Deaths: Final data for 2003. *National Vital Statistics Reports*, *54*, no. 13, April 2006. Centers for Disease Control and Prevention. Vermont Department of Health. 2003 Vital Statistics. Burlington, VT, April 2005.

[2] U.S. Public Health Service. The Surgeon General's call to action to prevent suicide. Washington, DC, 1999.

[3] Ibid.

[4] Vermont Department of Health, Vital Statistics Data System. Personal communication with Michael Nyland-Funke, Burlington, VT, February 2005. Kochanek KD, Murphy SL, Anderson RN, and Scott, C. Deaths: Final data for 2002. *National Vital Statistics Reports*, *53*, no. 5, October 2004. Centers for Disease Control and Prevention.

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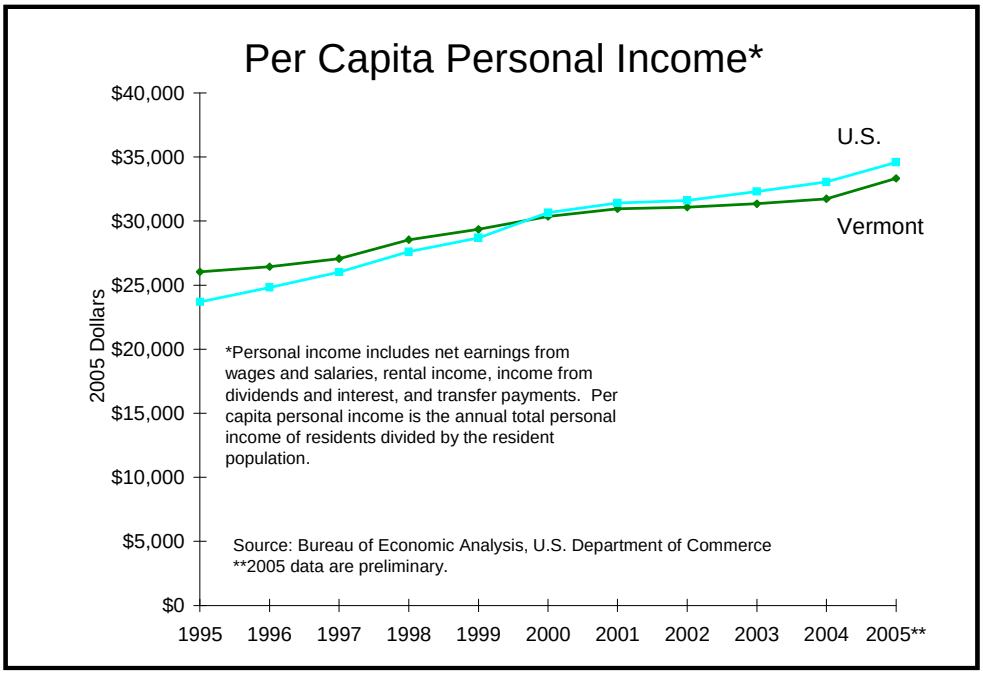


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005**
Vermont	$26,032	$26,444	$27,072	$28,542	$29,345	$30,364	$30,958	$31,084	$31,347	$31,737	$33,327
U.S.	$23,691	$24,819	$26,009	$27,599	$28,683	$30,642	$31,394	$31,615	$32,297	$33,041	$34,586
VT Rank	33	33	33	32	32	32	24	24	22	23	22

("1" is highest)

The Story Behind the Data

Although Vermont's per capita income and average wage trail the national figures, our state has gained some ground in recent years.

In 2005, our per capita personal income (PCI) was $30,534, which was 22nd highest among the states and about 96% of the national PCI. Between 1995 and 2005, Vermont's PCI increased 28% (after adjusting for inflation), whereas the nation's PCI increased 46%.[1] However, it is important to note that a per-capita measure obscures the wide disparity in income levels among the population. For example, the poorest fifth of Vermont families had an average annual income of $18,846 in the early 2000s, while that of the richest fifth was $112,505.[2]

Data by Vermont Region

VT Counties 2003 $	1999	2000	2001	2002	2003
Addison	$ 23,852	$ 25,549	$ 26,766	$ 27,630	$ 28,788
Bennington	$ 27,302	$ 29,191	$ 31,355	$ 31,942	$ 32,793
Caledonia	$ 21,409	$ 23,310	$ 24,290	$ 24,906	$ 25,873
Chittenden	$ 30,139	$ 32,241	$ 33,591	$ 34,772	$ 35,899
Essex	$ 17,895	$ 18,777	$ 18,869	$ 18,851	$ 19,126
Franklin	$ 22,266	$ 23,929	$ 24,969	$ 25,414	$ 26,184
Grand Isle	$ 26,110	$ 28,279	$ 28,885	$ 29,238	$ 30,418
Lamoille	$ 24,712	$ 28,832	$ 27,769	$ 28,947	$ 29,733
Orange	$ 22,453	$ 23,437	$ 24,819	$ 25,542	$ 26,441
Orleans	$ 20,183	$ 21,988	$ 23,318	$ 24,055	$ 25,017
Rutland	$ 24,455	$ 25,987	$ 27,402	$ 28,320	$ 29,475
Washington	$ 26,077	$ 28,394	$ 29,870	$ 30,735	$ 31,971
Windham	$ 26,047	$ 27,937	$ 28,664	$ 30,123	$ 31,023
Windsor	$ 27,423	$ 28,944	$ 29,672	$ 30,544	$ 31,765

[1] Bureau of Economic Analysis. News release: "Average income growth improved in 2003." U.S. Department of Commerce, September 28, 2004.

[2] Bernstein J, McNichol EC, Lyons K. Pulling apart: A state-by-state analysis of income trends. Economic Policy Institute/Center on Budget and Policy Priorities. Washington, DC, 2006.

Measuring Income and Poverty

Recent releases by the Census Bureau of state-level estimates for poverty and median household income have highlighted the critical need for more accurate data for these, and other, fundamental indicators of well-being. As state and local entities are moving more and more toward models of governing-by-results, having reliable local data is imperative.

The current source for much of these vital data, including health insurance coverage, as well as the poverty and income information, and including separate estimates for children, is the Census Bureau's Current Population Survey (CPS). The CPS is a telephone survey of a random sample of households, designed to produce reasonably accurate national estimates. However, as demand has grown for more state- (and even sub-state-) level data, the limitations of the CPS as a monitoring tool, particularly for smaller states, have become obvious. Simply put, most sample sizes at a state level are so small as to produce estimates that have unacceptably wide margins of error.

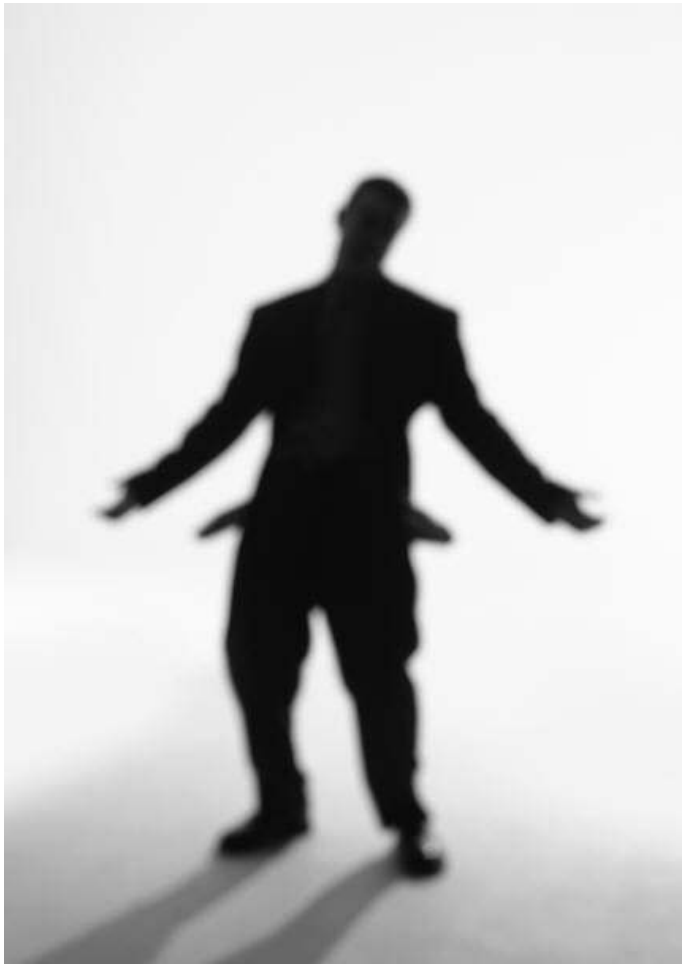
For example, the latest CPS figures show Vermont's median household income, averaged over 2002-2004, as $45,692. However, the standard error associated with this estimate means the figure could be as low as $44,463, or as high as $46,691. Similarly, the 2002-2004 poverty estimate for Vermont is 8.8%, but could be as low as 7.7%, or as high as 9.9%. There is a 1-in-10 chance that the "true" figures lie even further off these point-estimates.

The use of three- or even five-year averages partly mitigates the even greater unreliability of single-year data, but at the sacrifice of timeliness. With states increasingly being held accountable for the success of efforts in welfare reform, access to health care, and other experiments in devolution, it is essential for them to have timely, reliable data on key indicators. Important policy decisions should not be based on what are, in fact, crude measurements.

A different kind of measurement issue is: What counts as “poor”?

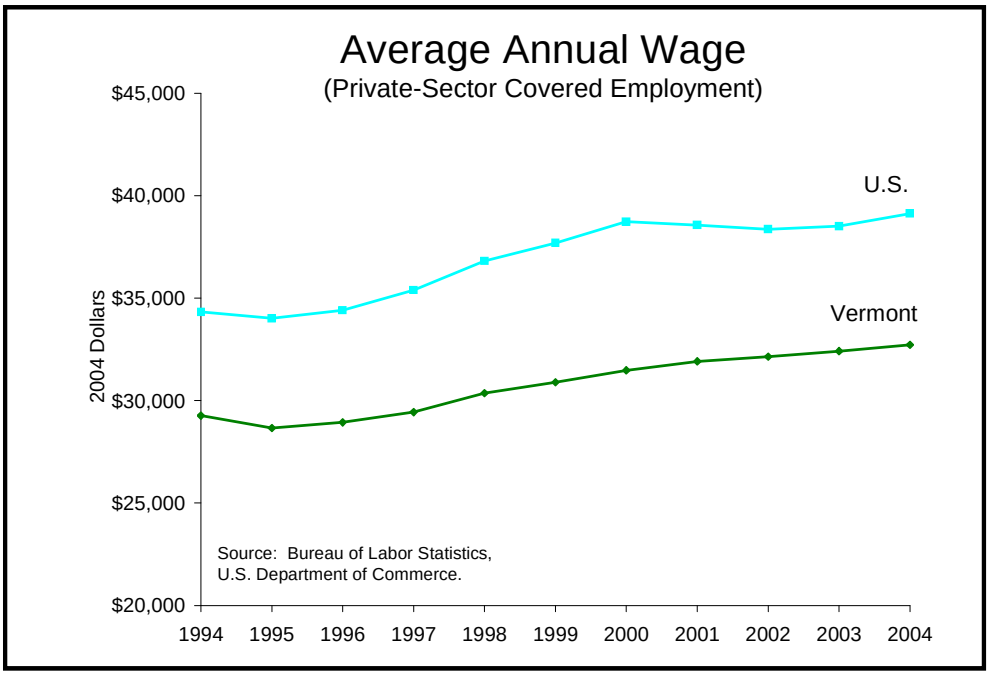
There is widespread consensus (including the National Research Council, the U.S. Government Accountability Office, and advocacy groups) that our official measure of poverty is inadequate. On the income side, it fails to capture several important types of non-cash resources, and tax-credits; on the expenses side, it does not take into account important types of job-related expenses, such as childcare, or taxes paid. It makes no adjustments for regional variations in the cost of living; and it is based on an outdated model of a typical family budget.

In contrast to this consensus, there is *disagreement* as to whether the current thresholds/guidelines (regardless of how they are arrived at) fairly describe the level of resources necessary for a household to sustain itself, even in a “poverty” lifestyle. Obviously, the two issues (one, a measurement issue; the other, a standard-setting issue) are related: the threshold we pick determines the extent of official poverty we find, but the threshold itself is defined by what's counted as income and expenses. (See “A ‘Livable Wage,’” p. 189, for another perspective on these issues.)



What We Want: Adults Lead Healthy and Productive Lives

How We Measure Our Success:



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	$29,269	$28,659	$28,938	$29,438	$30,358	$30,891	$31,476	$31,911	$32,145	$32,413	$32,721
U.S.	$34,326	$34,012	$34,410	$35,384	$36,809	$37,694	$38,729	$38,566	$38,367	$38,507	$39,134
VT Rank	33	35	36	39	35	35	33	32	33	33	34

("1" is highest)

The Story Behind the Data

Average annual wages (adjusted for inflation) in Vermont have risen for six consecutive years, after having declined for the previous three. However, Vermont's wages remain substantially below the U.S. average.

In 2004, the average annual Vermont wage was $32,721, which was about 84% of the national average; Vermont ranked 34th highest among states. Between 1994 and 2004, average annual wages in Vermont rose by nearly twelve percent in inflation-adjusted dollars, while nationally wages rose by fourteen percent.[1]

A key concern in today's economy is the continuing disparity between the earnings of men and women. Women make up nearly 50% of the labor force, in Vermont as in the U.S.[2] However, nationally, in 2004, on average a woman working full-time year-round earned only 76.5 cents for every dollar earned by a man.[3] In Vermont, the "gender gap" is narrower—81 cents in 1999 (the most recent data available), when Vermont had the second smallest gap among states, second only to California's.[4] While the gender gap has narrowed over recent years, both nationally and in Vermont, it is estimated

that the majority of that change can be attributed to falling real wages for men, rather than to rising wages for women.[5]

Data by Vermont Region

VT Counties 2004 $	2000	2001	2002	2003	2004
Addison	$ 29,930	$ 30,450	$ 31,123	$ 31,723	$ 33,032
Bennington	$ 27,527	$ 28,372	$ 28,810	$ 28,771	$ 30,472
Caledonia	$ 25,676	$ 25,667	$ 26,457	$ 26,567	$ 27,900
Chittenden	$ 37,651	$ 37,909	$ 37,992	$ 38,102	$ 39,133
Essex	$ 27,633	$ 27,659	$ 26,968	$ 24,956	$ 26,806
Franklin	$ 27,747	$ 27,780	$ 28,520	$ 29,252	$ 30,564
Grand Isle	$ 20,607	$ 20,525	$ 20,166	$ 20,739	$ 23,513
Lamoille	$ 23,119	$ 24,490	$ 24,941	$ 25,275	$ 26,996
Orange	$ 25,228	$ 25,820	$ 26,393	$ 26,709	$ 28,031
Orleans	$ 24,828	$ 24,722	$ 24,644	$ 25,713	$ 25,990
Rutland	$ 28,867	$ 29,517	$ 29,951	$ 30,608	$ 32,077
Washington	$ 30,076	$ 30,518	$ 30,614	$ 31,335	$ 32,509
Windham	$ 30,813	$ 31,444	$ 32,895	$ 33,118	$ 34,240
Windsor	$ 28,879	$ 28,482	$ 29,071	$ 29,230	$ 30,357

[1] U.S. Department of Commerce, Bureau of Labor Statistics. The figures reported here are for employees and wages subject to state and federal unemployment compensation laws, and exclude government employees. The average annual wage is computed from total wages divided by average employment for a year.

[2] U.S. Census Bureau. Census 2000.

[3] Institute for Women's Policy Research. The gender wage ratio: Women's and men's earnings. Fact Sheet #C350. August 2005.

[4] Caiazza AB (Ed.). The status of women in the states. Institute for Women's Policy Research. Fourth Edition, 2002-03. Washington, DC, undated.

[5] Institute for Women's Policy Research, and Vermont Governor's Commission on Women. The status of women in Vermont. Washington, DC, 1998.

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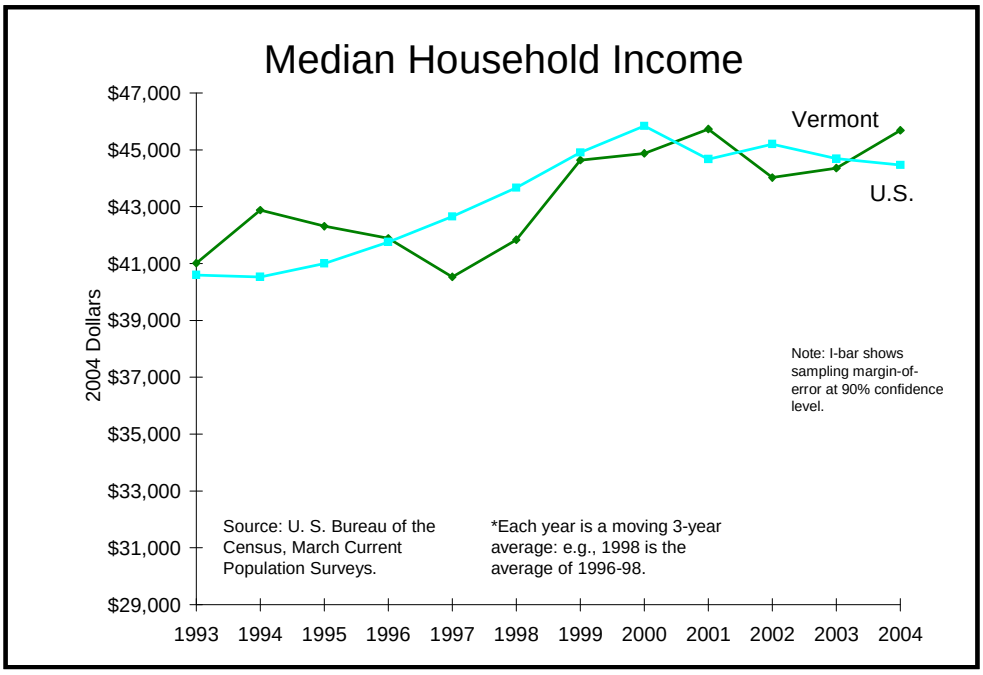

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	$41,017	$42,881	$42,316	$41,889	$40,536	$41,840	$44,639	$44,875	$45,730	$44,027	$44,363	$45,692
U.S.	$40,597	$40,532	$41,006	$41,757	$42,656	$43,669	$44,908	$45,842	$44,679	$45,206	$44,686	$44,473
VT Rank	24	11	26	21	31	28	22	27	29	28	25	19

("1" is highest)

The Story Behind the Data

After falling for two consecutive periods, during 2002-2004 Vermont's median household income rose to $45,692, compared to $44,473 for the nation (in 2004 dollars). Vermont ranked 19th highest among states on this measure. In terms of real (inflation-adjusted) dollars, Vermont has still not regained its 1999-2001 status on this measure.[1]

Household income is an important indicator, because of the rise in the number of dual-earner households, and because more people are living in non-family households. In general, our real median household income has increased only modestly over the past decade: the 2002-2004 average is $2,811 more (in inflation-adjusted dollars) than the 1992-1994 average.[2]

Nationally, consumer debt and personal bankruptcies are at all-time highs.[3]

Data by Vermont Region

(Note: The following figures are for median *family* income, which differs somewhat from median *household* income. Also, figures are not adjusted for inflation.)

VT Counties	1989	1999
Addison	$ 34,561	$ 49,351
Bennington	$ 33,513	$ 39,926
Caledonia	$ 29,877	$ 42,215
Chittenden	$ 43,972	$ 59,460
Essex	$ 29,096	$ 34,984
Franklin	$ 32,272	$ 46,733
Grand Isle	$ 33,629	$ 48,878
Lamoille	$ 31,772	$ 44,620
Orange	$ 31,066	$ 45,771
Orleans	$ 26,469	$ 36,630
Rutland	$ 32,743	$ 44,742
Washington	$ 35,396	$ 51,075
Windham	$ 32,593	$ 46,989
Windsor	$ 34,691	$ 49,002

A Livable Wage

The Vermont Job Gap Study, produced by the Peace & Justice Center (in Burlington, VT), has highlighted the dimensions, and the associated costs, of the deficit of "livable wage" jobs, an showed how closing this gap would result in tangible benefits, not only to poorer households, but to the state and federal programs on which many poorer Vermonters currently depend.

The *Job Gap Study* authors conservatively identified families' basic needs as including food, housing, childcare, transportation, health care, clothing, household and personal expenses, insurance, and taxes. They assumed a "no-frills" household budget—no allowances for eating out, vacations, savings for children's education, or any of the extras more comfortable families may take for granted. The authors carefully estimated Vermont-specific costs, where such information was available, and produced different estimates, depending on family size, and on whether a family lives in a rural or urban setting.

The *Job Gap Study* figures are updated biannually by the Joint Fiscal Office of the Vermont Legislature. According to the latest estimates, a "livable wage" in Vermont in 2005 ranged from $10.59 an hour (for a single person with no children, who has employer-assisted health insurance and follows a low-cost food plan), to $24.09 an hour (for a couple with two children, where one parent works and the other stays home, without employer-assisted health care, and following a moderate-cost food plan). These estimates are far higher than the minimum wage ($7.25 an hour in Vermont in 2006), and more than twice the federal poverty measure. Depending on family composition, between 20 and 80 perecent of families do not earn a livable wage—that is, they have insufficient income to meet basic needs. These families go without essentials, depend on the charity of others, go into debt, and work multiple jobs; they may put their health and safety at risk. Even with Vermont's relatively generous public assistance programs, poor working families typically do not achieve a livable income. In fact, only about half of Vermont jobs pay enough, even with two incomes, to meet basic needs, and competition is heavy for those that do. The *Job Gap Study* estimates that annually 58,000 Vermonters in the labor force cannot find full-time work at a livable wage for a single person, resulting in an income shortfall of about $123 million.

What if we were to close this gap? Some benefits would be immediate and tangible: increased revenues through state and federal taxes, and lowered payments through the Earned Income Tax Credit. Public assistance costs would decline. More subtle, perhaps, but with even greater impact, would be savings from avoided child poverty and the huge toll it takes on this and future generations. Just counting the tangible revenues and savings, the *net* cost of closing the job gap would be around $34 million. However, the state, through selective tax-cuts, could cushion the effect on employers (and on prices) of raising wages for low-income workers—a social investment in family self-sufficiency.

What We Want: Adults Lead Healthy and Productive Lives

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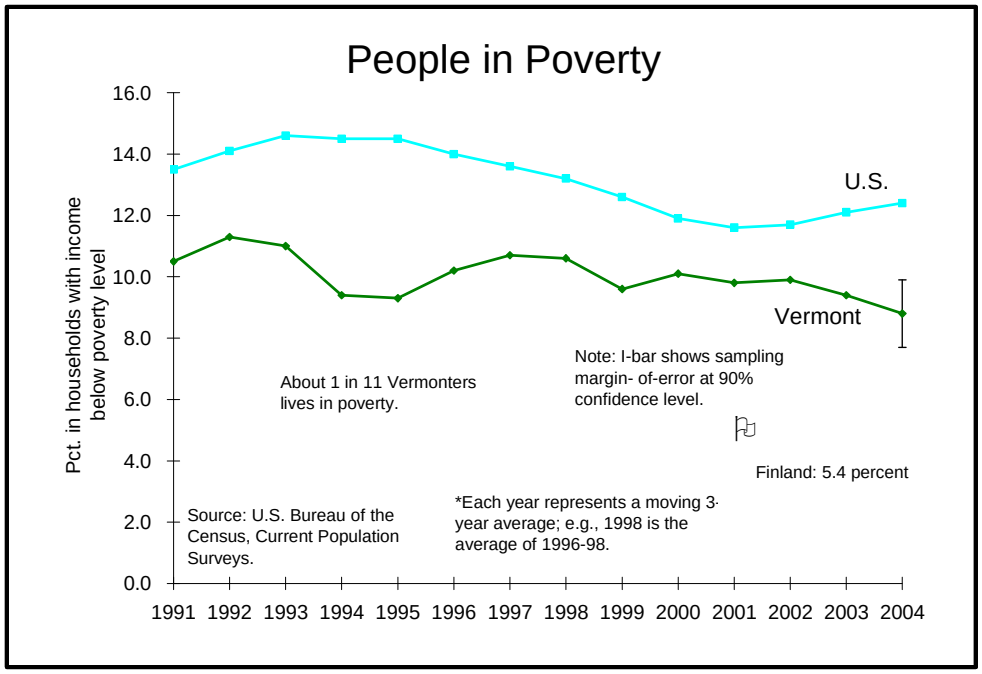

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	10.5	11.3	11.0	9.4	9.3	10.2	10.7	10.6	9.6	10.1	9.8	9.9	9.4	8.8
U.S.	13.5	14.1	14.6	14.5	14.5	14.0	13.6	13.2	12.6	11.9	11.6	11.7	12.1	12.4
VT Rank	13	19	15	3	7	11	17	18	13	21	19	21	14	6

("1" is lowest)

The Story Behind the Data

The poverty rate is the percentage of people in households reporting less than the poverty threshold income. In 2005, a family of four (two adults, plus two related children under 18 years) with an income under $19,806 was considered in poverty.[4]

According to the official definition, Vermont's poverty rate was 8.8% for 2002-04, which was 6th lowest among the states. The national figure was 12.4%. Since 1980, Vermont's poverty rate according to this measure has averaged nearly three points lower than the nation's.[5] However, we have not seen substantial change in our poverty rate over the past 15 years. (See p. 182 for a discussion of the difficulties involved in estimating poverty.)

Data by Vermont Region

VT Counties	1989	1999
Addison	9.7	8.6
Bennington	11.3	10.0
Caledonia	12.1	12.3
Chittenden	8.7	8.8
Essex	13.9	13.7
Franklin	10.2	9.0
Grand Isle	11.5	7.6
Lamoille	11.1	9.6
Orange	9.4	9.1
Orleans	14.9	14.1
Rutland	9.6	10.9
Washington	8.3	8.0
Windham	9.5	9.4
Windsor	9.4	7.7

For Additional Information

Vermont Livable Wage Campaign, Peace & Justice Center: www.vtlivablewage.org/

[1] DeNavas-Walt C, Proctor BD, and Mills RJ. Income, poverty, and health insurance coverage in the United States: 2003. *Current Population Reports*, P60-226. U.S. Census Bureau. Washington, DC, 2004.

[2] U.S. Census Bureau, Housing and Household Economic Statistics Division. March Current Population Survey data.

[3] American Bankruptcy Institute. Press release: Total bankruptcies eclipse the 2 million mark in 2005 as consumers file in record numbers prior to implementation of new bankruptcy law. March 26, 2006. U.S. Federal Reserve System. Consumer credit, February 2006. Statistical Release, April 7, 2006.

[4] U.S. Census Bureau. Poverty thresholds 2005. For 2006, the poverty *guideline* (used for determining eligibility for certain federal programs) is $9,810 for a one-person household, plus $3,400 for each additional household member. U.S. DHHS, http://aspe.hhs.gov/poverty/06poverty.htm .

[5] U.S. Bureau of the Census, Current Population Surveys.

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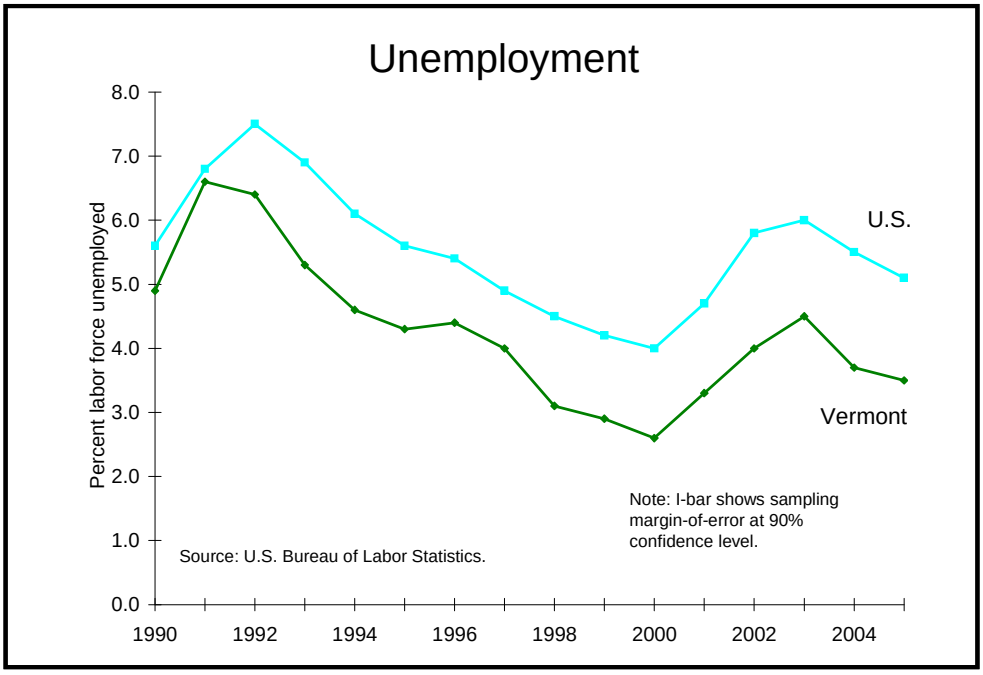

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Vermont	4.9	6.6	6.4	5.3	4.6	4.3	4.4	4.0	3.1	2.9	2.6	3.3	4.0	4.5	3.7	3.5
U.S.	5.6	6.8	7.5	6.9	6.1	5.6	5.4	4.9	4.5	4.2	4.0	4.7	5.8	6.0	5.5	5.1
VT Rank	17	13	18	14	15	13	16	13	10	8	7	9	3	10	4	3

("1" is lowest)

The Story Behind the Data

In the last decade Vermont, along with the rest of the country, experienced a remarkably sustained period of job growth and reductions in unemployment. Vermont added more than 50,000 new jobs between 1992 and 2000, and our unemployment rate declined from 6.6% to 2.9%.[1] However, beginning in 2001 unemployment began a rise that continued through 2003.

All unemployment figures count only those workers who are actively seeking work; they do not include those who may have given up their job search, or those who have had to settle for part-time employment, or jobs for which they may be over-qualified. Some economists suggest that, just as many jobs have left the U.S. (including Vermont) for other countries, so have many Americans "dropped out" of the labor force, and are thus invisible to the unemployment statistics.[2] While official unemployment in Vermont remains below the U.S. rate, many Vermonters are living on the margins of economic security; many households depend on dual incomes and/or multiple jobs to make ends meet.

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	2.6	3.3	3.3	3.9	3.5
Bennington	3.2	4.6	4.6	5.2	3.8
Caledonia	4.1	5.2	5.2	6.0	4.1
Chittenden	1.8	2.4	2.9	3.6	3.2
Essex	5.8	6.6	7.4	7.2	3.9
Franklin	3.3	4.2	4.1	5.2	4.1
Grand Isle	4.8	5.1	5.2	6.3	4.8
Lamoille	4.3	4.9	4.8	6.0	4.0
Orange	2.3	2.7	3.3	3.9	3.4
Orleans	5.9	7.1	7.0	7.6	5.0
Rutland	3.6	4.1	4.1	5.5	4.0
Washington	3.1	3.8	4.2	4.8	4.1
Windham	3.0	3.3	2.7	3.8	3.4
Windsor	2.3	2.8	3.0	3.7	3.2

[1] Vermont Department of Employment & Training. 2000 Employment and wages. Montpelier, VT, 2001. Figure includes only those jobs covered by unemployment insurance.

[2] Uchitelle L. "To understand U.S. jobs picture, connect the dots, and find the dots." New York Times, January 12, 2004.

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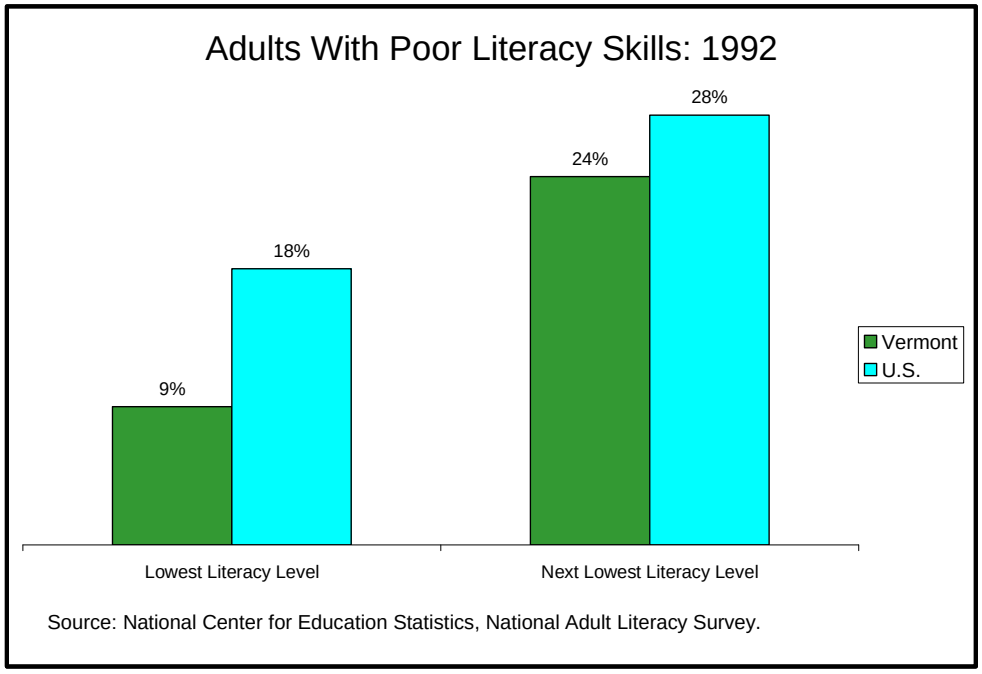

The Story Behind the Data

The times when an adult with little education and few skills could find a reasonably well-paying job are long gone. In today's economy the demand is for a skilled workforce that can be competitive in the world marketplace. And yet there are an estimated 80,000 Vermonters, aged 18-59, who lack the reading, math, and writing skills to function effectively. [1]

Most of these adults need to build on the basic literacy skills they have, in order to acquire the higher-level skills identified in the Vermont Common Core of Learning. However, a third of these lack even the basic skills.[2]

According to a 1992 national survey, 18% of U.S. adults, and 9% of Vermonters, have literacy skills at the lowest level. Some of these individuals may be able to manage brief routine tasks, such as locating a specific item on a form, or picking out information from a brief news article; others have difficulty even with these kinds of tasks. Another 24% of Vermonters (28% nationally), are in the next lowest level. Adults in these two lowest levels, according to survey administrators, "were far less likely than their more literate peers to be employed full-time, to earn high wages, and to vote. Moreover, they were far more likely to receive food stamps, to be in poverty, and to rely on nonprint sources (such as radio and television) for information about current events, public affairs, and government." On the survey, Vermont's average "combined mean proficiency score" of 283, compared with the national average of 273, was 11th best.[3]

The reasons for these deficits are various: poor or incomplete school experiences, poverty, handicapping conditions, recent immigration from non-English speaking countries, and lack of support for literacy in the home and/or community.

Literacy—or illiteracy—is often passed on from generation to generation: Children whose mothers lack a high school diploma have the lowest school completion and continuation rates, and are more than twice as likely to live in poverty as those children whose parents are high school graduates. By the same token, parents who have strong educational backgrounds themselves, and who value literacy and life-long learning, are much more likely to have children who are successful in school and later life.

Vermont, by some measures, ought to be a leader in promoting full literacy. Our state has a high proportion of college graduates among the adult population. We have the highest number of public libraries per capita of any state, as well as the greatest number of library books per capita.[4]

For Additional Information

Vermont Adult Education & Literacy:
www.state.vt.us/educ/new/html/pgm_adulted/esis/esis_enroll.html

[1] The Vermont Literacy Resource Center. Literacy facts and Information . . . 1995. Montpelier, VT, 1995.

[2] Ibid.

[3] Kirsch IS, Jungeblut A, Jenkins L, and Kolstad A. Adult literacy in America: A first look at the results of the National Adult Literacy Survey. Educational Testing Service, National Center for Education Statistics. September 1993.

[4] Chute A, and Kroe E. Public libraries in the United States: FY 1997. National Center for Education Statistics, U.S. Department of Education. Washington, DC, 2000. Public libraries includes branch outlets, but not bookmobiles.

Elders and People With Disabilities Live With Dignity and Independence in Settings They Prefer

For the most part, older Vermonters, and Vermonters with disabilities, aspire to the same outcomes of well-being we all desire: good health; safety; the support of families and communities; and useful and valued roles in community life. However, these Vermonters also face some special challenges, particularly in living in settings close to their families and communities, rather than segregated and isolated from those, and in receiving the specialized care and supports they may need to participate fully in life.

Each stage of life is dependent on others. Children cannot thrive if their parents (and, often, grandparents) are poorly supported. Success in school rests in part on the quality of experiences earlier in life, and in turn impacts the successful transition to adulthood. Thriving communities create opportunities for members across the lifespan to add value, both to current well-being and to the well-being of future generations. Growing old, and dealing with disability, is or will be a part of life for most of us. We cannot afford to ignore the challenges, and the gifts, offered by older people and people with disabilities, who will make up an increasing proportion of our population.

People With Disabilities

Disability usually refers to a limitation in life activities, such as working and daily living, caused by physical or mental impairments or other chronic conditions. Within that broad definition, however, prevalence estimates of the number of people with disabilities vary. All prevalence data on disabilities are based on self-reported and proxy responses to survey questions. This type of information is subject to reporting bias, due to the social stigma associated with some of these conditions. However, reports that focus on activity limitations, especially work-related ones, are considered by disability experts to be reasonably accurate.[1]

According to the 2000 Census, nearly one in five U.S. residents age 5 and above (19%, or nearly 50 million people) had some level of disability; this includes eight percent of people between 5 and 20, 19.2 percent of people ages 21-64, and 41.9 percent of people 65 and older.[2] A definition of disability that includes limitations caused by acute or short-term conditions *ever* experienced during one's life greatly increases prevalence estimates. For example, a National Institute of Mental Health survey of non-institutionalized adults found that about one-third of the individuals interviewed reported having a mental disorder at some point in their lives.[3]

National prevalence estimates for certain disabilities also vary according to age. Among children and adolescents (< age 18), the most prevalent causes of limitation are asthma, learning disability and mental retardation, mental illness, and speech and hearing impairments. For adults aged 18-44, the most prevalent causes are back disorders, orthopedic impairments, mental illness, and asthma. Among adults ages 45-69, heart disease, back disorders, arthritis, diabetes, and orthopedic impairments are most prevalent. For adults ages 70-84, the most prevalent conditions are heart disease, arthritis, back disorders, diabetes, and eye disorders. Among adults 85 and older, heart disease, arthritis, eye disorders and visual impairments, and dementia are the leading conditions.[4]

According to the 2000 Census, there were approximately 97,000 disabled Vermonters five years or older (17.1%). Vermont ranked 39th highest among the states in the proportion of its population who have disabilities.[5]

Vermont is doing many things well with respect to people with disabilities. We have shifted toward community-based services for people with psychiatric or developmental disabilities, dramatically reducing the population at our one state psychiatric hospital, and closing the Brandon Training School. But there is room for improvement, even in those areas where we compare favorably with other states. For example, the need for housing assistance among this population is great.

[1] Haber LD. Issues in the Definition of Disability and the Use of Disability Survey Data. In Disability Statistics: An Assessment: Report of a Workshop, Levine DB, Zitter M, and Ingram L, Eds. Committee on National Statistics, Commission on Behavioral and Social Sciences and Education, National Research Council. National Academy Press: Washington, DC, 1990.

[2] U.S. Census Bureau, 2000 Census.

[3] Ficke RC. Digest of data on persons with disabilities. National Institute on Disability and Rehabilitation Research. Washington, DC, 1996.

[4] LaPlante MP, and Carlson D. Disability in the United States: Prevalence and causes, 1992. National Institute on Disability and Rehabilitation Research, Office of Special Education and Rehabilitative Services, U.S. Department of Education. Washington, DC, August 1996.

[5] U.S. Bureau of the Census, 2000 Census.

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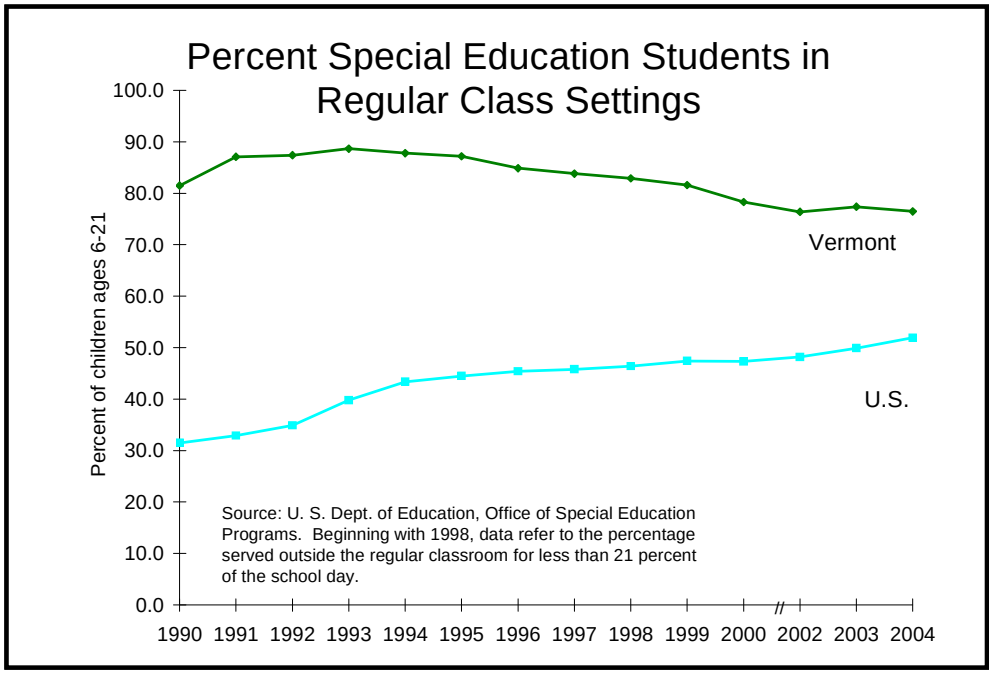


	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2002	2003	2004
Vermont	81.5	87.1	87.4	88.7	87.8	87.2	84.9	83.8	82.9	81.6	78.3	76.4	77.4	76.5
U.S.	31.5	32.9	34.9	39.8	43.4	44.5	45.4	45.8	46.4	47.4	47.3	48.2	49.9	51.9
VT Rank	1	1	1	1	1	1	1	1	1	1	1	2	2	2

("1" is highest)

The Story Behind the Data

There is no single consensus on how to assess the prevalence of disability among children. Disabilities can have serious negative effects on educational attainment. Many Vermont educators believe that students with disabilities should be "mainstreamed" into regular classrooms, rather than segregated from other students in resource rooms or separate classrooms. Vermont consistently ranks first among states in the percentage of special education students included in regular classrooms. During the 2003-2004 school year, Vermont's rate was 76.5%, compared to the national average of 51.9%.[1]

National sample data from 1997 showed that 2% of children under the age of three had a developmental delay or a condition that limited their use of arms or legs. Of children three to five years old, 3.4% had a developmental delay, or had difficulty walking, running, or playing. Among children aged six to 14, 11.2% had a disabling condition.[2]

The federal Individuals with Disabilities Education Act mandates that all children with disabilities have access to public education through special education and related services designed to meet their unique needs. During the 2003-04 school year, there were 12,382 Vermont children (6-21 years old) with disabilities who received services through this program.[3] Many more students received education support services related to other special needs. In 2005, another 1,242 young children received services through the Family, Infant, and Toddler Project.[4] The total number of Vermont children with "special health care needs" (based on claims data) was estimated a few years ago at over 39,000.[5]

Related AHS Performance Measure: Increase the proportion of children with disabilities who live with their families.

[1] U.S. Department of Education, Office of Special Education Programs. IDEAdata.org. Beginning with 1998, data refer to the percentage of children served outside the regular class for less than 21 percent of the school day.

[2] McNeil J. Americans with disabilities: 1997. *Household Economic Studies* (P70-73). U.S. Census Bureau, February 2001.

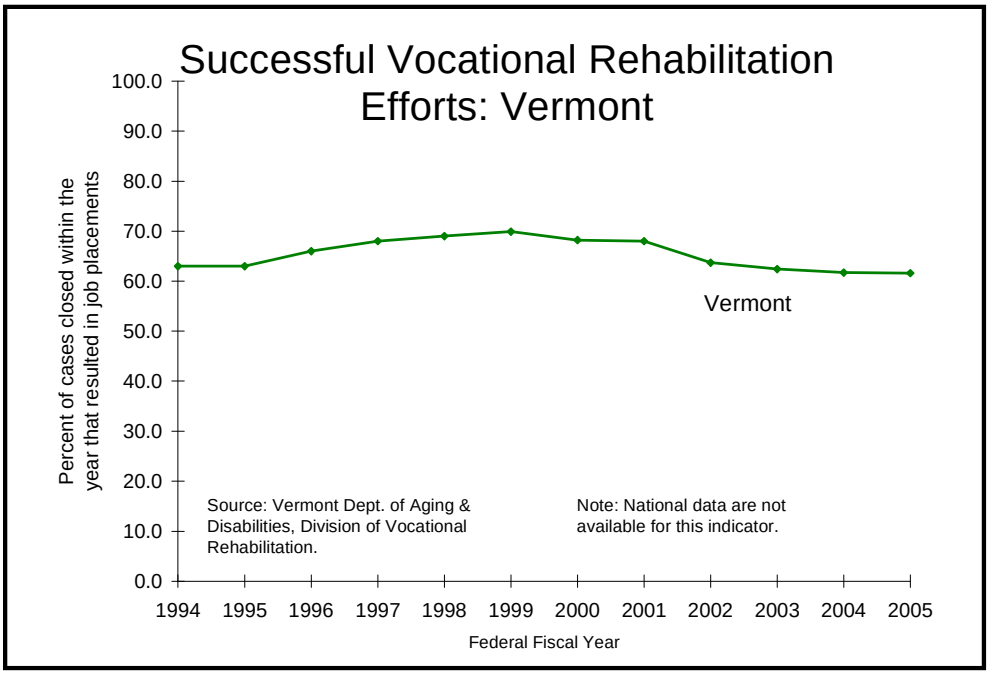
[3] U.S. Department of Education. Office of Special Education Programs, Data Analysis System.

[4] Personal communication with Kathy Boulanger, Vermont Family, Infant, and Toddler Project. May 2006.

[5] Vermont Department of Banking, Insurance, Securities, and Health Care Administration. Issues and limitations in applying a definition of children with special health needs to claims-based data. Montpelier, VT, October 1997.

What We Want: Elders and People With Disabilities Live With Dignity and Independence in Settings They Prefer

How We Measure Our Success:



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Vermont	63.0	63.0	66.0	68.0	69.0	69.9	68.2	68.0	63.7	62.4	61.7	61.6

The Story Behind the Data

Employment and a livable wage are goals shared by people with disabilities and by those working on their behalf. According to the 2000 census, Vermont ranked 17th highest among states for the percentage of people with disabilities who were in the labor force. Among non-institutionalized Vermonters ages 16-64, with work disabilities, 59.4% were in the labor force, up from 48.2% in 1990. The 2000 national figure was 55.9%.[1] However, in general, workers with disabilities have lower earnings than non-disabled workers. Mean earnings in 1999 of year-round, full-time workers ages 19 to 74 with a work disability were $33,877, compared to a mean of $40,991 for those without a work disability.[2]

Under the direction of the Rehabilitation Services Administration in the federal Department of Education, vocational rehabilitation services are available to help people with disabilities become employed, more independent, and more integrated into their communities. In federal fiscal year 2005, Vermont's Division of Vocational Rehabilitation assisted 1,420 Vermonters with significant disabilities to gain or retain employment; 41 percent of them were in full-time jobs when their cases were closed. Of those employed, 34% had a diagnosis of mental illness, 28% had a cognitive

disability, 19% had a mobility disability, and 10% had a sensory disability. According to the Rehabilitation Services Administration's rating system, Vermont was ranked as having the most effective agency of its type in New England, and the sixth most effective one in the nation. Vermont also ranks highest among the states in assisting Social Security beneficiaries to return to work[3]

Vermont's programs for the blind and visually impaired also receive high marks in comparison with other states. In terms of employment outcomes, including wages and cost of services, Vermont's Division for the Blind and Visually Impaired outperforms agencies in many larger states.[4]

For people with severe disabilities, supported employment is an indicator of their integration into the productive life of their communities. In contrast to what is typical in many states, where these individuals earn minimal wages in sheltered workshop jobs, in Vermont nearly all people receiving employment supports through community agencies are working in real jobs, for competitive wages, in their own communities. As of 2002, Vermont ranked first among the states on rates of participation in supported employment. Vermont's performance in this area is nearly five times higher than the national mean.[5]

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	0.8	0.8	0.8	0.6	0.5
Bennington	1.7	1.6	1.9	1.2	1.1
Caledonia	1.6	1.4	1.5	1.2	1.2
Chittenden	1.0	0.9	1.0	0.8	0.8
Essex	1.9	1.9	1.9	1.6	1.1
Franklin	1.7	1.5	1.7	1.3	1.2
Grand Isle	1.3	1.1	1.1	1.1	0.9
Lamoille	1.1	0.9	0.9	0.7	0.7
Orange	1.2	1.0	1.0	0.9	0.9
Orleans	1.9	1.7	1.7	1.4	1.3
Rutland	1.6	1.4	1.6	1.3	1.2
Washington	1.1	1.0	1.0	0.8	0.7
Windham	1.2	1.2	1.4	1.0	1.1
Windsor	1.0	1.0	1.1	0.9	0.7

Since people with disabilities are more likely to be unemployed, they are also more likely to be poor. Among Vermonters ages 21-64, the poverty rate in 1999 for people without disabilities was 5.5%; for people with disabilities in this age group the poverty rate was 14.2%.[6]

Americans with disabilities are also less likely than the non-disabled to be covered by health insurance (77.3% versus 82.9%, respectively); those who are covered are more likely to have government coverage (either solely, or in part) rather than private insurance. The disabled are also more likely to receive cash, food, or rent assistance, although most of those with a severe disability do not participate in such programs.[7] An additional hurdle faced by many disabled people in seeking employment is the possible loss of health care benefits; Vermont is a leader in allowing disabled people eligible under Social Security who work to purchase affordable Medicaid coverage.

In 1999, President Clinton signed into law the Ticket to Work and Work Incentive Act. This legislation substantially improves incentives for Vermonters with disabilities who receive SSDI or SSI benefits and who choose to work. It is anticipated that these provisions will enable many disabled people to contribute to their own economic security.

The Americans with Disabilities Act of 1990 specifies that employers may not discriminate against any qualified individual with a disability. Employers must provide reasonable accommodation, unless that would create an undue hardship on the operation of the business.

Related AHS Performance Measure: Increase the proportion of elders and people with disabilities receiving state-funded services in home and community-based settings.

[1] U.S. Bureau of the Census, Census 2000.

[2] U.S. Census Bureau. Public news alert: 11th anniversary of Americans with Disabilities Act. CB01-FF.10, July 11, 2001.

[3] Data supplied by Vermont Department of Aging & Disabilities, Division of Vocational Rehabilitation, personal communication with Tom Pombar. April 2006.

[4] Division for the Blind and Visually Impaired, Department of Aging & Disabilities. Waterbury, VT, 1997.

[5] Rizzolo MC, Hemp R, Braddock D, & Pomeranz-Essley A. The state of the states in developmental disabilities. American Association on Mental Retardation. Washington, DC, 2004.

[6] U.S. Census Bureau, 2000 Census.

[7] McNeil JM. Americans with disabilities: 1994-95. *Current Population Reports* (P70-61). U.S. Census Bureau. August 1997.

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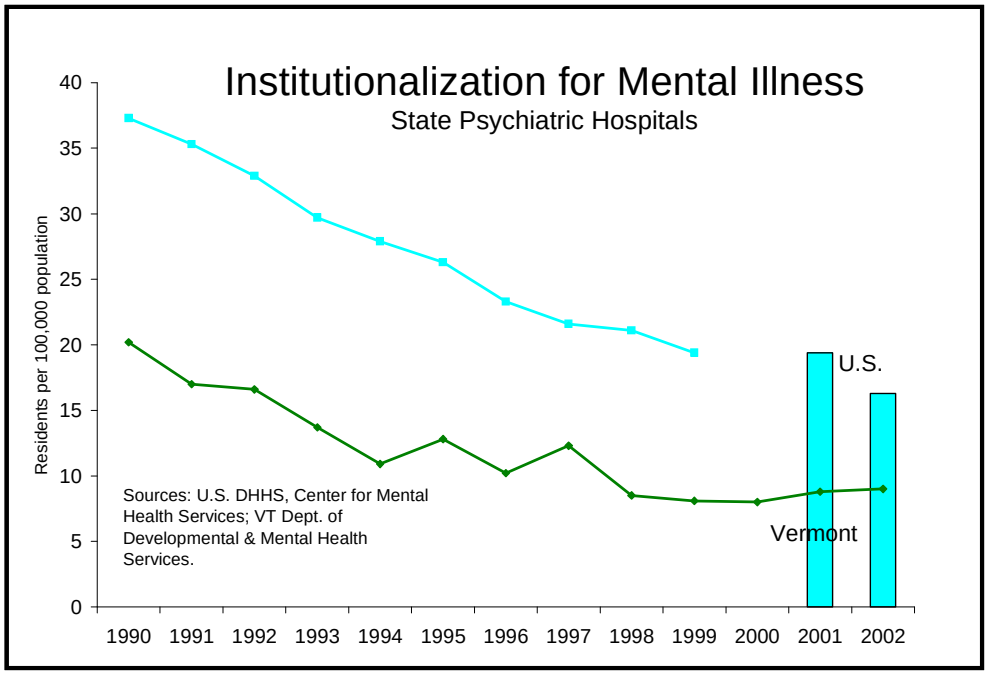

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Vermont	20.2	17.0	16.6	13.7	10.9	12.8	10.2	12.3	8.5	8.1	8.0	8.8	9.0
U.S.	37.3	35.3	32.9	29.7	27.9	26.3	23.3	21.6	21.1	n/a	n/a	19.4	16.3
VT Rank	11	n/a	9	5	3	11	4	13	4	n/a	n/a	7	4

("1" is lowest)

The Story Behind the Data

A goal of Vermont's system for people with mental health and developmental disabilities is to provide services in community settings, rather than in large institutions. Services provided through community mental health/developmental disability centers allow individuals to receive the services they need while living in their communities. In addition, services in community settings are less stigmatizing; less disruptive of relationships with families, friends, and employers; and give people more choices regarding where they live and the treatment they receive. As a result of this emphasis on community services, Vermont's institutionalization rate for people with mental illness has dropped 83% since 1980 (from 48 residents per 100,000 population in 1980, to 9 in 2002). Nationally, the rate for 2002 was 16.3, and Vermont ranked 4th lowest among the states.[1]

The Vermont State Hospital (founded over 100 years ago) is the only state-run psychiatric facility in Vermont. Admissions are restricted to people who have a major mental illness, and are a danger to themselves or to others. They are admitted only after community alternatives have been ruled out. The population at the Vermont State Hospital dropped 70% over the last decade, and as of December 31, 2005, there were 46 residents; the median length of stay for people is about five months.[2] Vermont aims to continue reducing reliance on the State Hospital by further developing community capacity to care for the severely mentally ill.

Related AHS Performance Measure: Increase the proportion of elders and people with disabilities receiving state-funded services in home and community-based settings.

[1] Atay J, Manderscheid R, Male A, & DeLozier J. Additions and resident patients at end of year, state and county mental hospitals, by age and diagnosis, by state, United States, 2001. U.S. DHHS, Center for Mental Health Services. Rockville, MD, 2002.

[2] Vermont Department of Health. Personal communication with John Pandiani, April 2006.

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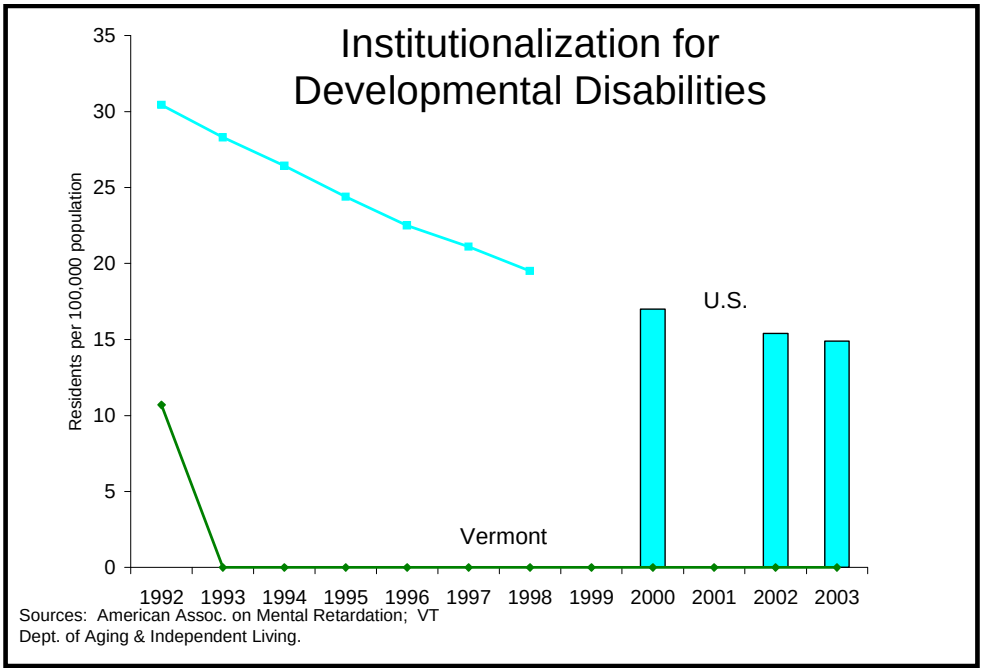

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Vermont	10.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
U.S.	30.4	28.3	26.4	24.4	22.5	21.1	19.5	n/a	17.0	n/a	15.4	14.9
VT Rank	21	n/a	n/a	n/a	1	1	1	1	1	1	1	1

("1" is lowest)

The Story Behind the Data

Vermont is one of eight states that no longer institutionalize people with developmental disabilities.[1] The Brandon Training School, which had provided services for people with developmental disabilities, was closed in November of 1993. Former residents now receive services through a system of 14 community agencies. Very few Vermonters with mental retardation or developmental disabilities, relative to national averages, reside in nursing facilities.[2] In 2004, the most recent year for which we have these figures, Vermont provided support services to over 1,200 families of people with developmental disabilities, and ranked 7th highest among the states in per family spending.[3]

Related AHS Performance Measure: Increase employment rate among adults receiving Community Rehabilitation & Treatment, Vocational Rehabilitation, Blind & Visually Impaired, Developmental Disability, and Traumatic Brain Injury services.

[1] Lakin KC, Prouty R, Polister B, and Coucouvanis K. States' initial response to the President's New Freedom Initiative: Slowest rates of deinstitutionalization in 30 years. *Trends & Milestones* (American Association on Mental Retardation), *42*, 241-244, June 2004.

[2] Division of Developmental Services, Department of Developmental and Mental Health Services. Annual report: 2004. Waterbury, VT, January 2004.

[3] Braddock D, Hemp R, Rizzolo MC, Coulter D, Haffer L, & Thompson M. The state of the states in developmental disabilities 2005. Preliminary Report. Department of Psychiatry and Coleman Institute for Cognitive Disabilities, The University of Colorado. 2005.

Elderly Vermonters

In many ways, older Americans enjoy a higher quality of life than ever before. They are living longer, with fewer disabilities, receiving more sophisticated health care, and are taking greater responsibility for their health and for health care decisions. On the other hand, poverty, insurance coverage, the cost and complexity of health care and long-term care, injuries, chronic health conditions, and suicide remain areas of concern. The magnitude of the issues associated with aging will be multiplied many times, as the “baby boom” generation ages, with the proportion of older people predicted to grow from 13% of the U.S. population in 2000 to 20% by 2030.[1]

In 2004, there were an estimated 80,762 Vermonters aged 65 and over, more than double the number in 1950; older Vermonters comprise about 13% of our population.[2] Vermont ranks 22nd in the percent of its population who are elders.[3] However, as the "baby-boomers" (people born between 1946 and 1964) reach age 65, the proportion of older Vermonters will grow to 20% by 2025.[4]

These trends reflect a combination of lower birth and mortality rates. The Vermont birth rate peaked in 1955 at 24 per 1,000 residents, declined over two decades, remained relatively stable from the late 1970s through the late ‘80s, and has been steadily decreasing since 1989. As of 2003, the birth rate was 10.6. Vermont's death rate has declined slowly over the last 30 years, and in 2003 was 8.3 per 1,000 residents.[5] Americans generally are living longer than ever before. Americans born in 1900 had an average life expectancy of 49 years for women, and 46 years for men. By 2003, average life expectancy at birth was 77.5 years.[6] People aged 65 in 1998 could expect to live an average of 17.8 additional years (16.0 years for men, 19.2 for women).[7] Chronic conditions are responsible for nearly three out of four deaths, and the majority of Americans 50 and older have one or more of these chronic health conditions.[8] The two leading causes of death for Vermonters aged 65 and over are heart disease and cancer. It is estimated that for every death, there are 22 hospitalizations. Chronic health problems related to aging are of major concern because they significantly affect day-to-day living. These include diabetes, arthritis, osteoporosis, incontinence, visual and hearing impairments, dementia, and Alzheimer's disease.[9]

The elder population, especially among the oldest age groups, is predominantly female, because women tend to live longer than men: about three times as many women as men live to be 85 years or older. Consequently, issues of aging (e.g., loss of a spouse, living alone, and surviving on a low, fixed income) tend predominantly to be issues confronting women.

Life changes common to the seventh and eighth decades can increase the risk of social isolation, bereavement, and low self-esteem. A recent survey of Vermont consumers of long-term care services found that 50% of them were satisfied with their social ties, compared with 83% of all Vermonters.[10] The informal support of relatives and friends has always played a major role in assisting elderly Vermonters.

We may sometimes forget that many older Vermonters *contribute to* their communities. A look at participation in just three programs (Foster Grandparents, Retired & Senior Volunteer Program, and Senior Companions) showed that, in 1998, about 5,000 elder volunteers contributed an estimated 700,000 hours, valued at $8 million.[11]

However, there are huge changes on the horizon as the “baby boomers” leave the paid workforce and join the pool of retirees, creating a severe challenge to our system of benefits for older people (including Social Security, and Medicare). In 1998, there were about three working people per retiree, but by 2030, that ratio will have fallen to two-to-one, and will continue declining, assuming

current trends.[12] The growing proportion of elders, living longer, will have a dramatic impact on the types, caseload volume, and costs of health care and other publicly-funded social services.

For example, national data show:

- Out-of-pocket spending by Medicare beneficiaries (ages 65+) on health care averaged $3,455 in 2003, or 22 percent of their income. Premiums, followed by prescription drugs, accounted for the greatest shares of those expenses.[13]
- Over 58% of elders aged 85 and over are considered disabled and are potential users of long-term care services. This compares to 14% of elderly between 65 and 74 years of age.[14]
- Nationally, in 2002, about 30% of the 65-and-older population not in institutions (such as nursing homes) lived alone, up from 27% in 1970.[15]

Vermont's Department of Disabilities, Aging, and Independent Living periodically surveys its clients. This survey provides data on quality of life and quality of care for older Vermonters receiving long-term care services. Results of the latest survey show that 86% of the individuals participating in services such as Adult Day programs, Medicaid Waiver home services, and special attendant care programs felt that the quality of assistance they received was good or excellent. Somewhat lower levels of satisfaction (81%) were found with the degree of choice and control consumers felt they had when planning for long-term care services.[16]

Additional data collected by the Department monitor economic and employment status, health-related behaviors, and health status. The Agency of Human Services and the Department of Disabilities, Aging, and Independent Living have worked closely with the Community of Vermont Elders (COVE), the five Area Agencies on Aging, and the Successful Aging Task Force to identify key measures of well-being to use both regionally and statewide.

[1] AARP, and Administration on Aging, U.S. Department of Health and Human Services. A profile of older Americans: 1999. Accessed through the Internet (http://pr.aoa.dhhs.gov/aoa/stats/profile/) January 21, 2000.

[2] Vermont Department of Health. Population estimates.

[3] Administration on Aging, U.S. Department of Health and Human Services. A profile of older Americans: 2003. Washington, DC, 2004

[4] U.S. Bureau of the Census. Projections of the population, by age and sex, of states: 1995 to 2025. Accessed through the Internet (http://www.census.gov/population/projections/state/stpjage.txt), March 20, 1999.

[5] Vermont Department of Health. 2003 Vital Statistics. Burlington, VT, February 2005.

[6] Hoyert DL, Heron MP, Murphy SL, and Kung H-C. Deaths: Final data for 2003. *National Vital Statistics Reports, 54*, no. 13. Centers for Disease Control and Prevention, April 2006.

[7] Administration on Aging, U.S. Department of Health and Human Services. A profile of older Americans: 2000. Accessed through the Internet (http://pr.aoa.dhhs.gov/aoa/stats/profile/) December 12, 2000.

[8] AARP. Beyond 50: A report to the nation on trends in health security. Washington, DC, May 2002.

[9] Vermont Department of Health. Hospital Discharge Data System. Burlington, VT, December, 1994.

[10] Vermont Department of Aging & Disabilities. 2002 Consumer Satisfaction Survey. Waterbury, VT.

[11] Vermont Agency of Human Services. The Year 2000: A time to assess our past and invent our future. Waterbury, VT, January, 1999.

[12] The Urban Institute. Policy challenges posed by the aging of America. Discussion briefing. May, 1998. Accessed through the Internet (http://www.urban.org/health/oldpol.html), March 20, 1999.

[13] AARP Public Policy Institute. Out-of-pocket spending on health care by Medicare beneficiaries age 65 and older in 2003. Washington, DC, 2004.

[14] U.S. General Accounting Office. Long-term care: Projected needs of the aging baby boom generation.. GAO/HRD-91-86. Washington, DC, June, 1991.

[15] Administration on Aging, U.S. Department of Health and Human Services. A profile of older Americans: 2003.

[16] Vermont Department of Aging & Disabilities. 2002 Consumer Satisfaction Survey. Waterbury, VT.

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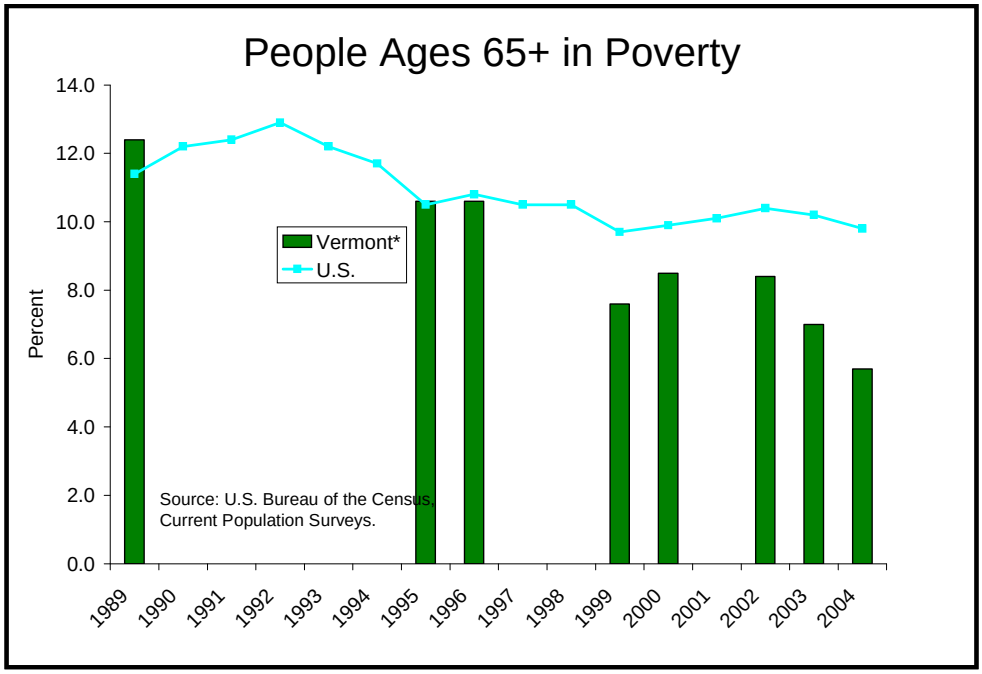

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont*	12.4						10.6	10.6	n/a	n/a	7.6	8.5	n/a	8.4	7.0	5.7
U.S.	11.4	12.2	12.4	12.9	12.2	11.7	10.5	10.8	10.5	10.5	9.7	9.9	10.1	10.4	10.2	9.8
VT Rank			30				22	27	n/a	n/a	10	24	n/a	14	10	2

("1" is lowest) (*VT rates and ranks for 1995, 1996, and 1999 are three-year averages)

The Story Behind the Data

Primarily as a result of the expansion of Social Security benefits, the economic status of elders as a group is much better now than it was 40 years ago. In 1959, over 35% of older Americans lived below the poverty level, compared to 9.9% in 2000. In Vermont, the 1979 poverty rate for elders was 13.8%, and in 2004 was 5.7%.[1]

Poverty among older people is related to race/ethnicity, sex, marital status, and health status. Nationally, elderly women are twice as likely to be poor as elderly men. Compared to those who are married, elderly men who are unmarried (i.e., widowed, divorced, separated, or never married) are twice as likely to be poor, and elderly women who are unmarried are four times as likely to be poor. Compared to non-poor elders, those who are poor are more likely to experience health impairments such as diabetes, heart disease, and hypertension, and limitations in activities as a result of health

conditions.[2] Among those elders aged 75 and older who require help in daily living activities, 43% have very low incomes (less than 30% of the state median).[3]

In general, older people have much higher health-related expenses than younger people. On average, one-fifth of their household income goes to out-of-pocket health care costs; among poor elders, these costs take one-third of household income.[4] With health care's increasing reliance on prescription medications to treat chronic illnesses, it is troubling that many older Americans don't fill their prescriptions because of cost considerations.[5]

Data by Vermont Region

VT Counties	1989	1999
Addison	12.2	8.0
Bennington	11.2	7.9
Caledonia	12.4	10.0
Chittenden	10.2	8.2
Essex	16.8	12.9
Franklin	16.5	10.3
Grand Isle	18.5	7.9
Lamoille	17.3	8.5
Orange	10.9	8.8
Orleans	17.8	10.9
Rutland	11.2	8.8
Washington	11.9	6.8
Windham	12.0	7.9
Windsor	11.8	7.6

[1] Ibid., and U.S. Bureau of the Census, Current Population Surveys.

[2] Vermont Department of Health. Vermont elders: Focus on health. Burlington, VT, November 1985. U.S. General Accounting Office. Elderly Americans: Health, Housing, and Nutrition Gaps Between the Poor and Nonpoor. GAO/PEMD-92-29. Washington, D.C., 1992.

[3] Vermont Housing Study, Special Needs Housing, Market Decisions, Inc. Burlington, VT, December, 1994.

[4] AARP Public Policy Institute. Out-of-pocket spending on health care by Medicare beneficiaries age 65 and older in 2003. Washington, DC, 2004.

[5] AARP. Beyond 50: A report to the nation on trends in health security. Washington, DC, May 2002.

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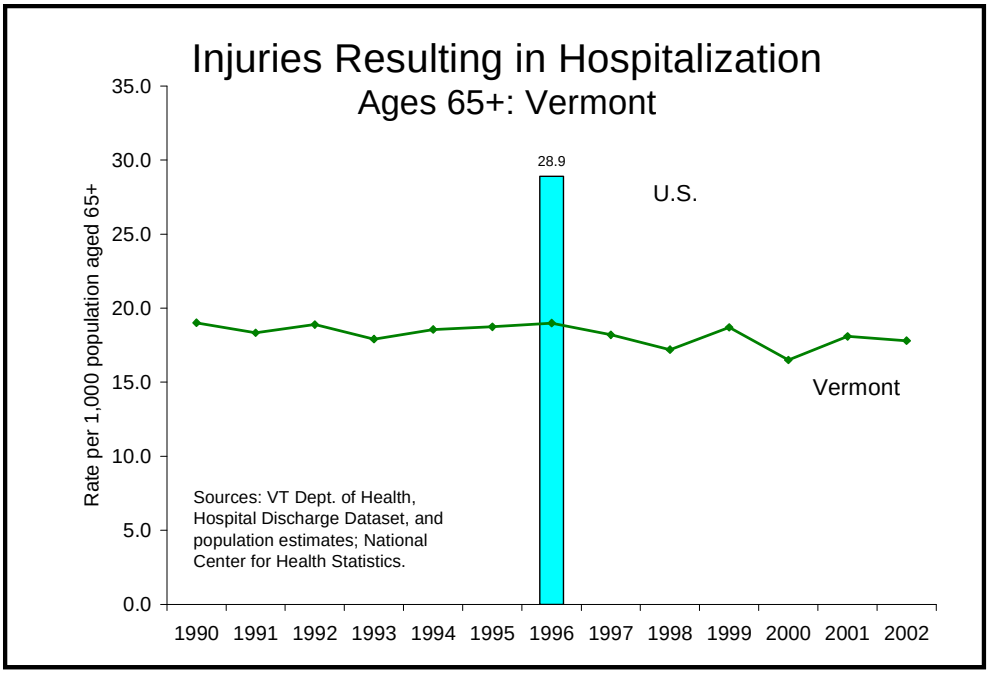

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Vermont	19.0	18.3	18.9	17.9	18.6	18.7	19.0	18.2	17.2	18.7	16.5	18.1	17.8	17.3
U.S.							28.9							

Note: State rankings are not available for this indicator.

The Story Behind the Data

With aging, people acquire a greater risk of injury, and injuries in later life are often more debilitating. In 2003, 97 older Vermonters (65 years and over) died from injuries.[1] Common causes of injuries to Vermonters over 65 years of age are falls, complications associated with medical procedures, and adverse effects of medications.

For example, one in 25 elderly Vermont women is admitted to the hospital each year because of injuries related to falls.[2] Osteoporosis (a degenerative bone disease) is most common among elderly women, and can increase the risks of serious injury; however, with proper treatment, osteoporosis is preventable. Ongoing education about preventive practices is necessary to protect our older population from injuries.

Data by Vermont Region

VT Counties	1999	2000	2001	2002	2003
Addison	3.7	11.1	7.4	14.5	21.2
Bennington	22.0	10.6	0.0	14.0	13.8
Caledonia	18.3	22.5	9.2	17.8	8.7
Chittenden	7.1	13.4	17.6	17.6	17.3
Essex	20.6	41.6	0.0	41.3	19.9
Franklin	18.6	15.3	9.1	15.0	11.5
Grand Isle	0.0	0.0	19.2	18.4	17.1
Lamoille	12.0	17.1	5.7	22.1	0.0
Orange	5.0	33.3	14.5	18.8	22.3
Orleans	25.2	30.5	15.7	15.0	14.3
Rutland	26.8	20.6	16.5	14.3	18.1
Washington	11.5	18.0	22.8	26.8	13.0
Windham	12.1	5.9	27.0	23.4	20.2
Windsor	16.6	11.4	20.6	29.1	28.5

According to the 2000 Census, there were 28,293 Vermonters 65 and older, or 38.6%, with a disability. The national percentage was 41.9%, and Vermont ranked 10th lowest among the states.[3] However, more than half of Americans over 50 now live with one or more chronic health conditions.[4]

Recent surveys indicate that nearly all poor elderly persons have health insurance coverage through Medicare. However, Medicare pays only about half of the health care expenses for poor elderly people. The rest is paid by the recipients themselves, and by Medicaid, private insurance, and other public sources such as a veteran's plan. In 2003, 93% of Medicare beneficiaries had supplemental coverage. The cost of "Medigap" policies, which cover items that Medicare does not—such as copayments and deductibles—is rising steeply, threatening the ability of many older people to maintain this coverage. Yet, premiums paid by older Americans for supplemental coverage account for 28% of their out-of-pocket costs—illustrating how significant the gaps are in Medicare coverage alone. Out-of-pocket health care spending by older consumers comprised 22% of their income, on average.[5]

[1] Vermont Department of Health. 2003 Vital Statistics. Burlington, VT, April 2005.

[2] Vermont Department of Health. Analysis of the Hospital Discharge Data System. Unpublished data provided by Jason Roberts. Burlington, VT, March, 2000.

[3] U.S. Bureau of the Census. Census 2000.

[4] AARP. Beyond 50: A report to the nation on trends in health security. Washington, DC, May 2002.

[5] AARP Public Policy Institute. Out-of-pocket spending on health care by Medicare beneficiaries age 65 and older in 2003. Washington, DC, 2004.

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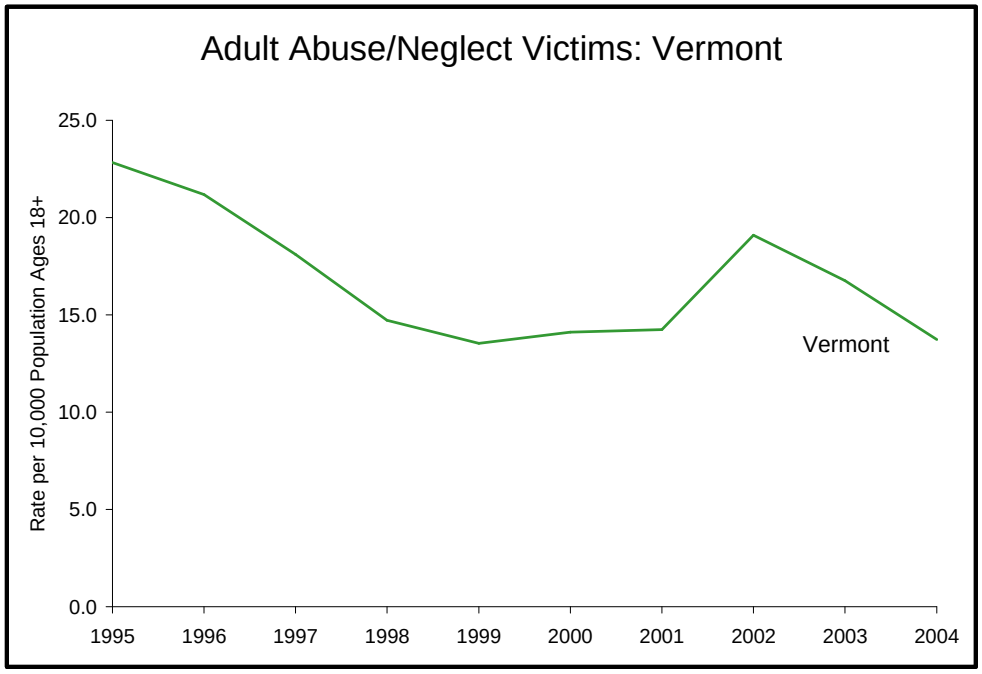


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	22.8	21.2	18.1	14.7	13.5	14.1	14.2	19.1	16.8	13.7

(National data are not available for this indicator.)

The Story Behind the Data

Vermont law mandates reporting of abuse, neglect, or exploitation of people 60 years of age and older, and those 18 and older who have a diagnosed disability. National data on elder abuse specifically suggest that the reported incidence of these kinds of maltreatment (not including incidents occurring in a non-domestic setting) represents only about one-sixth of the actual incidence. Among elders, the oldest are most likely to be victims of abuse. Women are more likely than men to be victims. Perpetrators in nine out of ten cases are family members.[1]

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	13.7	13.7	17.4	19.9	9.4
Bennington	11.0	11.1	22.1	15.5	14.8
Caledonia	14.0	14.2	27.6	14.4	15.2
Chittenden	11.2	11.0	16.1	13.7	10.1
Essex	22.9	22.7	18.6	20.6	19.3
Franklin	16.8	16.7	25.1	21.3	17.0
Grand Isle	13.5	13.4	18.4	12.5	11.7
Lamoille	11.9	11.9	16.0	17.3	19.0
Orange	11.4	11.6	17.8	12.5	11.5
Orleans	23.9	24.5	18.0	19.7	18.8
Rutland	18.5	18.6	24.5	18.9	17.5
Washington	18.5	19.4	23.0	20.3	16.4
Windham	7.4	7.8	14.0	16.1	12.4
Windsor	14.8	14.9	13.4	16.3	12.2

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

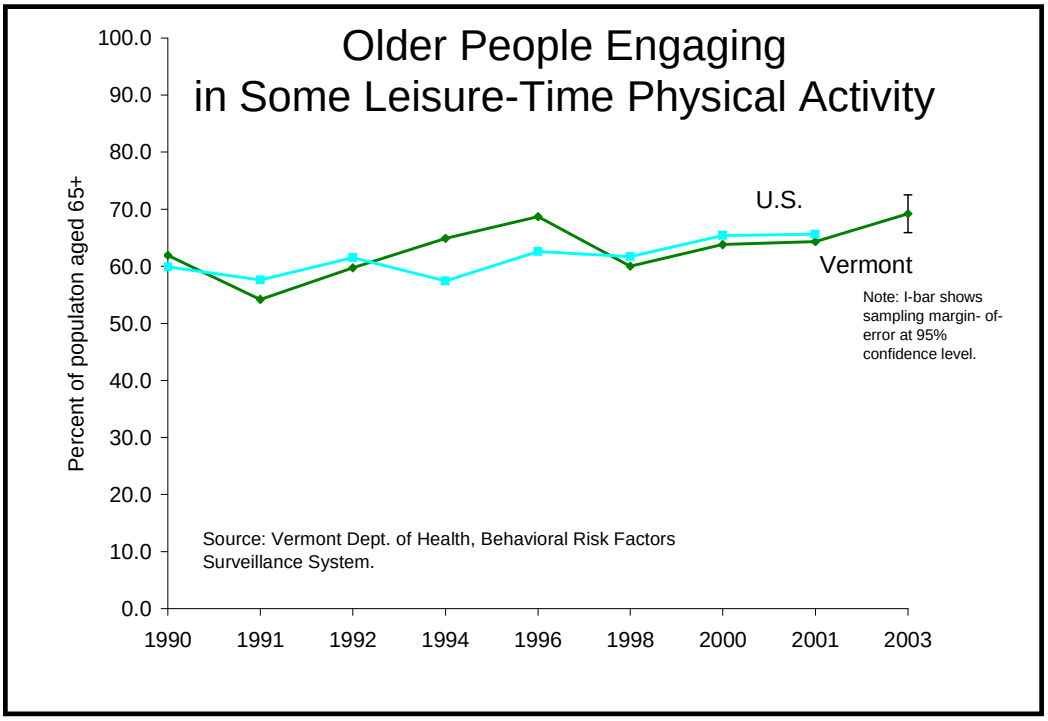
For Additional Information

Vermont Department of Disabilities, Aging, and Independent Living, Adult Protective Services Program: www.dad.state.vt.us/lp/aps.htm

[1] The National Center on Elder Abuse at The American Public Human Services Association in Collaboration with Westat, Inc. The National Elder Abuse Incidence Study: Final report. September 1998.

What We Want: Elders and People With Disabilities Live With Dignity and Independence in Settings They Prefer

How We Measure Our Success:



	1990	1991	1992	1994	1996	1998	2000	2001	2003
Vermont	61.9	54.2	59.7	64.9	68.7	60.0	63.8	64.3	69.2
U.S.	59.9	57.6	61.5	57.4	62.6	61.7	65.4	65.6	n/a

The Story Behind the Data

Estimates are that 70% of the physical decline often experienced by older people is related to lifestyle behaviors, *not* to aging itself. According to a 2003 survey, 69% of elderly Vermonters report some leisure-time physical activity; the most recent national data show 66% of elders engaging in such activity.[1]

Increased physical activity is associated with reduced incidence of heart disease, diabetes, and colon cancer, as well as fewer psychological problems such as depression and anxiety. Also, physical activity reduces the risk of osteoporosis, helps maintain body weight, improves strength, balance, and coordination, and increases longevity. All of these things promote the functional independence of older people.[2]

[1] Vermont Department of Health. Behavioral Risk Factors Surveillance System. Personal communication with Rod McCormick, January 2005.

[2] Centers for Disease Control and Prevention. State-specific changes in physical activity among persons aged ≥ 65 years--United States, 1987-1992. *MMWR*, vol. *44*, September 15, 1995.

What We Want: Elders and People With Disabilities Live With Dignity and Independence in Settings They Prefer

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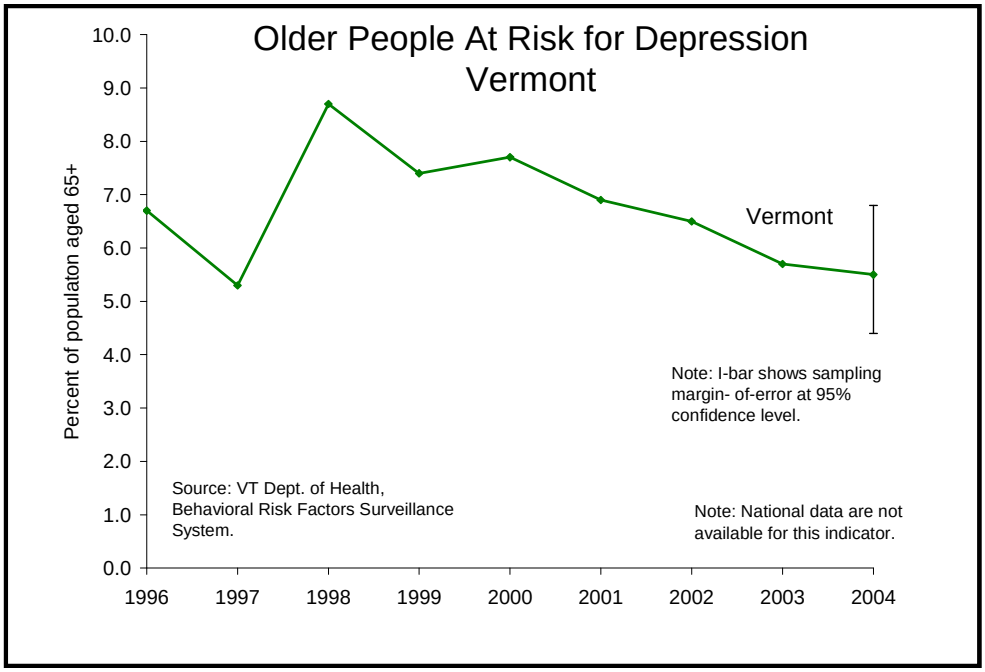

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	6.7	5.3	8.7	7.4	7.7	6.9	6.5	5.7	5.5

The Story Behind the Data

Older people may be at risk for depression because of the losses—of loved ones, of health, of employment, of income, and so on—that frequently accompany aging. Because many elderly people live alone, this may also contribute to feelings of isolation and loneliness that can lead to depression.

While temporary feelings of grief or loneliness are a normal part of human experience, depression that is prolonged and debilitating is not a normal part of aging, and can lead to further health problems and even suicide. In Vermont, as in the rest of the nation, the suicide rate is higher among people over 74 years old than it is in any other age group, and older men are particularly at risk.[1] Fortunately, in most cases clinical depression is treatable, allowing people to carry on fulfilling lives. Based on recent surveys, about 6% of Vermont elders are at risk for depression.[2] Families, neighbors, physicians, and others need to reach out to this group, so that these elders can get the support they need.

Data by Vermont Region

VT Counties	1998-2002	1999-2003	2000-2004
Addison	10.8	8.8	9.3
Bennington	8.4	7.9	7.1
Caledonia	7.9	4.8	5.1
Chittenden	7.5	6.7	6.6
Essex	n/a	9.4	13.1
Franklin	8.5	8.0	7.3
Grand Isle	n/a	7.0	6.5
Lamoille	5.0	3.8	2.1
Orange	6.9	7.7	7.0
Orleans	6.0	10.3	10.0
Rutland	6.6	6.2	5.2
Washington	6.4	5.8	5.8
Windham	6.6	4.2	4.8
Windsor	6.5	6.1	4.6

For Additional Information

Community of Vermont Elders: www.vermontelders.org

[1] Vermont Department of Health. 2003 Vital Statistics. Burlington, VT, April 2005.

[2] Vermont Department of Health. Behavioral Risk Factors Surveillance System.

What We Want: Elders and People With Disabilities Live With Dignity and Independence in Settings They Prefer

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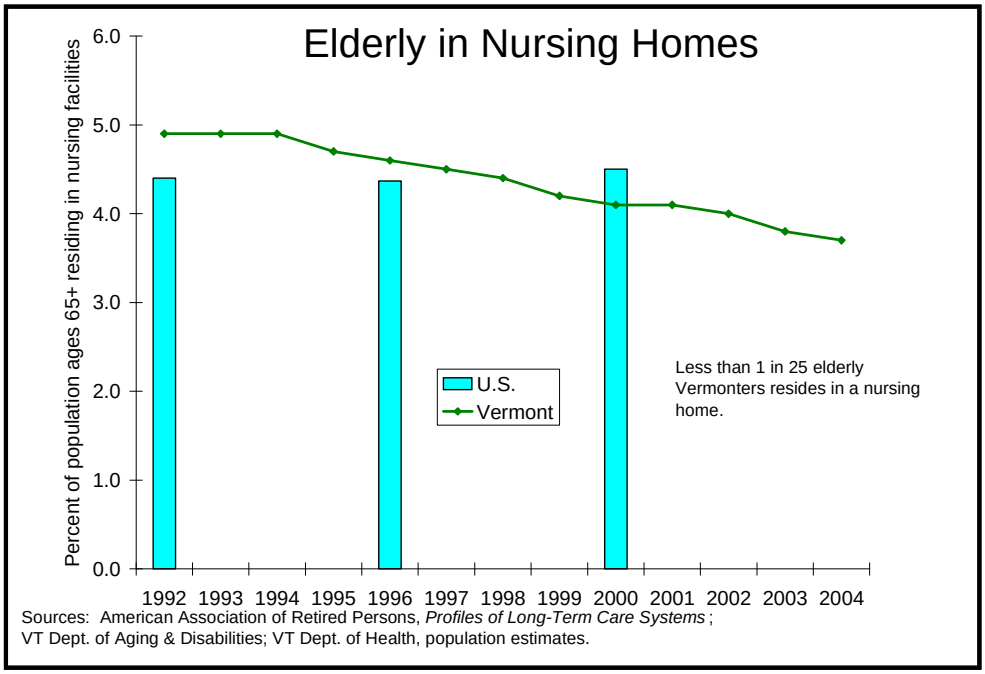


	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	4.9	4.9	4.9	4.7	4.6	4.5	4.4	4.2	4.1	4.1	4.0	3.8	3.7
U.S.	4.4				4.4	n/a	n/a	n/a	4.5	n/a	n/a	n/a	n/a
VT Rank					28	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

("1" is lowest)

The Story Behind the Data

Long-term care encompasses a range of services—personal, medical, mental health, and social—to meet the needs of people of all ages who have chronic health conditions; however, older adults are the majority of recipients. More than one-third of older Americans expect that they or a family member will need help performing everyday activities within the next three years.[1]

Long-term care can be provided in an institution, a community, or the home. The majority of long-term care (and the option generally most preferred) is provided informally, by families and friends. Indeed, one study found that more than half of seriously ill hospital patients would not want to live permanently in a nursing home, or would rather die than do so.[2]

However, many older adults worry that they may not be able to afford either nursing home or home care.[3] In addition, care for chronic conditions often requires coordination among multiple providers and support-networks, which is often lacking under our current fragmented health care "system."

As of 2004, less than one in 25 (3.7%) Vermonters aged 65 and over resided in nursing homes. Vermont has 3,475 nursing home beds.[4] Vermont is seeing a dramatic shift away from institutional care toward community based services, driven both by consumer preference, and by an overall healthier elder population. However, our capacity to provide community based services is inadequate to the demand; projections are that by 2013 the number of Vermonters needing community based care will increase by 42%.[5]

Vermont legislation (Act 160) passed in 1996 mandated a shift in state investments—away from institutional care, and toward greater support of families and individuals in their own homes and communities. We know that providing care in the least restrictive settings possible is the option preferred by elders and their families. The Act 160 legislation shifted a portion of Medicaid funds away from nursing homes and to home and community-based care settings. Prior to Act 160, only 12% of public dollars for long-term care services went to home- and community-based care; by 2004, that proportion has risen to 30%. [6]

In Vermont, long-term care accounts for a major share of the state Medicaid budget. Medicaid reimbursement for nursing home care averages $56,000 per year, per resident. Nursing home utilization in Vermont has dropped significantly in the years since Act 160 was passed. About one in five of the oldest Vermonters (ages 85+) lived in nursing homes in 1992; in 2003, only one in eight did. Occupancy rates have declined, and in terms of real numbers we expect 300 fewer residents in 2013 than in 2003. However, because nursing home care is an entitlement under Medicaid, those in need of care who cannot access Medicaid Waiver slots will continue to use nursing homes.[7]

The Department of Disabilities, Aging, and Independent Living (DAIL) is recommending that every Vermont county allocate a minimum of 40 Medicaid Waiver slots for home and community-based care for every 60 Medicaid-funded nursing home beds. To date, seven counties have met or exceeded this goal. If achieved, there would be sufficient savings to fund needed Medicaid Waiver slots and other home-based services.[8]

Two major areas of continuing challenge are recruiting and supporting caregivers, and developing accessible and affordable housing. DAIL recommends further improvements in wages and benefits for personal caregivers in all settings.[9] Incidentally, national studies show that caregivers who are 50 or older themselves contribute an average of 20 hours of care per week caring for people with disabilities; many of these caregivers experience physical or mental problems as a consequence.[10]

Expanded housing options are another critical component of the home and community-based care system. Home modification, shared housing, assisted living, adult foster care, and enhanced residential care are among the emerging choices. New financing strategies are needed to support many of these.[11]

Data by Vermont Region

VT Counties Pct. Waiver Slots	2002	2003	2004	2005
Addison	63	61	57	57
Bennington	9	11	13	14
Caledonia	37	36	37	40
Chittenden	42	42	43	45
Essex	0	0	0	0
Franklin	47	48	48	49
Grand Isle	100	100	100	100
Lamoille	25	28	30	32
Orange	49	48	83	84
Orleans	20	22	24	25
Rutland	28	29	29	31
Washington	29	29	28	30
Windham	40	40	41	41
Windsor	31	34	34	35

Related AHS Performance Measure: Increase proportion of elders and people with disabilities receiving state-funded services in home and community-based settings.

For Additional Information

Vermont Department of Disabilities, Aging, and Independent Living, Division of Disability & Aging Services, Reference Guide: www.dad.state.vt.us/WhatsNew/DDASreferenceguide.pdf

[1] AARP. Beyond 50: A report to the nation on trends in health security. Washington, DC, May 2002.

[2] Robert Wood Johnson Foundation. Press release: Study: Nearly a third of seriously ill patients would rather die than live in a nursing home. July 30, 1997.

[3] AARP. Beyond 50: A report to the nation on trends in health security. Washington, DC, May 2002.

[4] Vermont Department of Disabilities, Aging, and Independent Living. Personal communication with Julie Wasserman, April 2006.

[5] Wasserman J. Shaping the future of long term care and independent living, 2003-2013. VT Department of Aging and Disabilities,. Waterbury, VT, January 2004.

[6] Ibid.

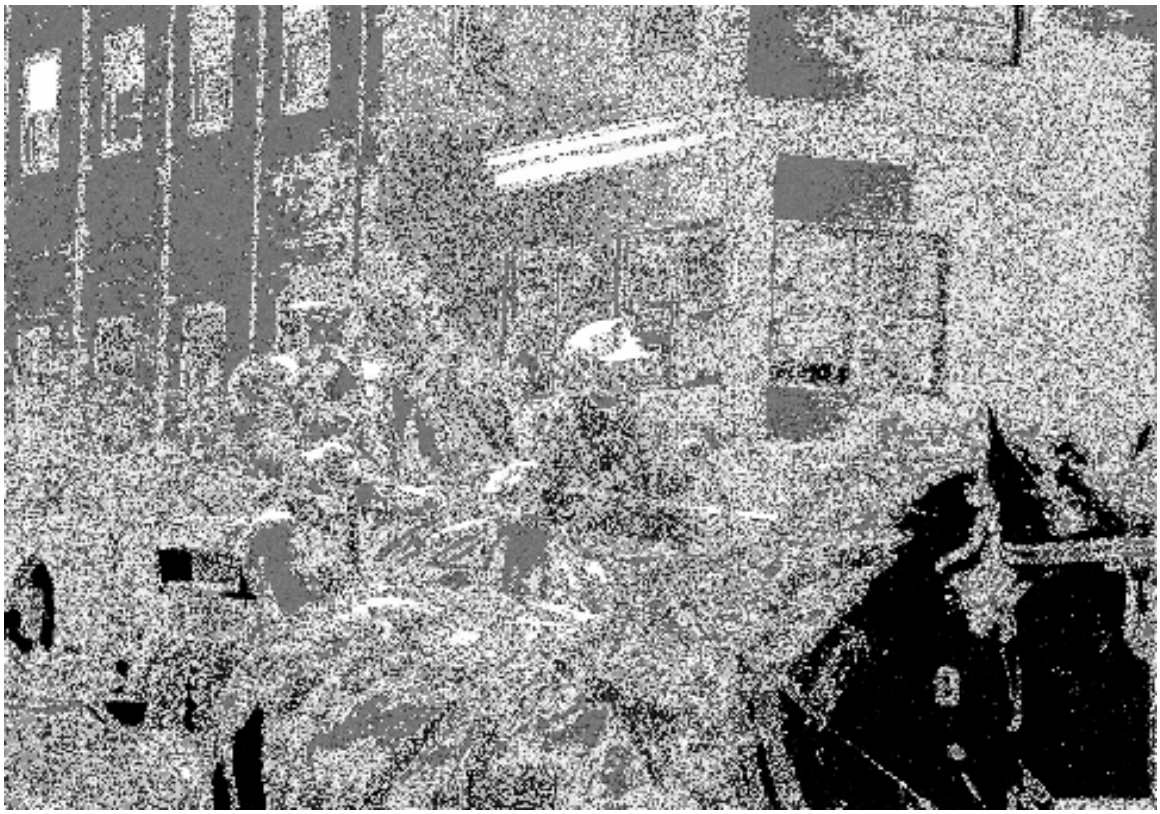
[7] Ibid.

[8] Ibid.

[9] Ibid.

[10] AARP. Beyond 50: A report to the nation on trends in health security. Washington, DC, May 2002.

[11] Wasserman J. Op. cit.



Communities Provide Safety and Support to Families and Individuals

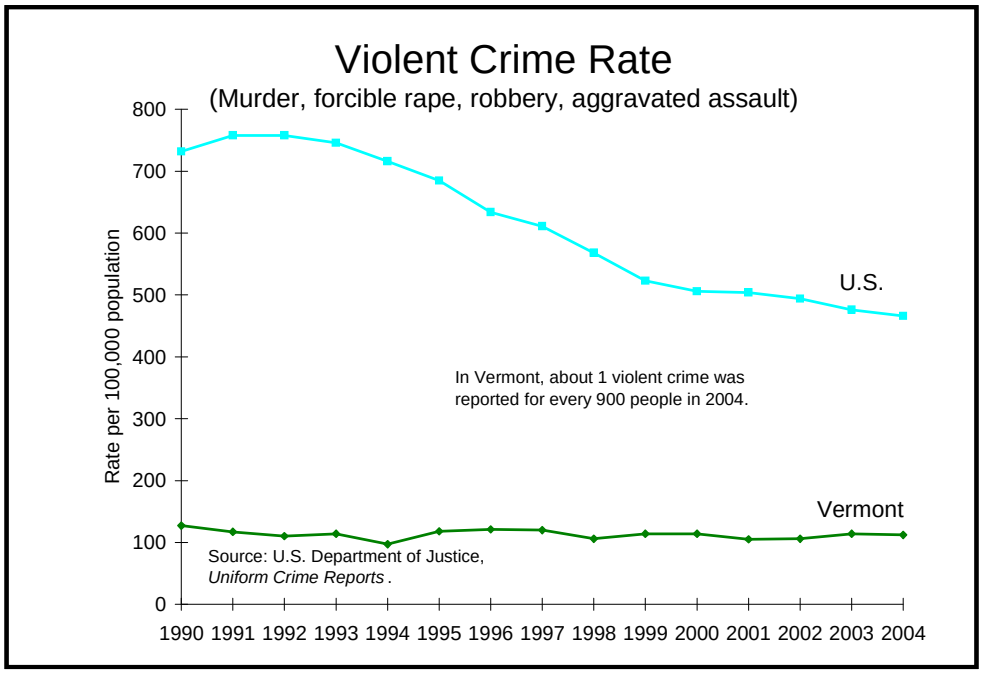
Our communities, over the years, have made Vermont the special place it is. Nonetheless, even the strongest of them do not always provide the supports that all their members need in order to thrive: safety, good physical health, basic economic security. Thus, while we treasure their many assets, we aspire to make our communities even more responsive to our people.

One of the most important aspects of the quality of life in Vermont communities is safety. We have the good fortune of having some of the lowest crime rates in the nation. However, our prisons are full-to-bursting, too many of our families experience domestic violence (often unreported), and too many of our communities are victimized by crimes large and small. On the brighter side, we have seen fairly steady declines in motor vehicle deaths—a major cause of death and serious injury.

Vermont has traditionally been very generous in providing public assistance to those with very low incomes. In addition, we are a national leader in making health insurance available to all people. However, we have severe shortages of safe, affordable housing. Health care costs continue to rise at an unsustainable rate. Declining budgets will mean making some difficult choices concerning the public services we maintain or expand.

What We Want: Communities Provide Safety and Support to Families and Individuals

How We Measure Our Success:



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	127	117	110	114	97	118	121	120	106	114	114	105	106	114	112
U.S.	732	758	758	746	716	685	634	611	568	523	506	504	494	476	466
VT Rank	2	n/a	2	2	2	3	3	3	2	4	3	2	2	3	3

("1" is lowest)

The Story Behind the Data

Vermont is one of the safest states in the nation in terms of violent crimes: murder, forcible rape, robbery, and aggravated assault. In 2004, Vermont's rate (the number of crimes known to police per 100,000 people) was less than one-fourth of the national average: 113, compared to 466 for the nation.[1]

Vermont's rate consistently ranks among the lowest in the nation. However, while the nation's violent crime rate has shown consistent declines over the past eight years, Vermont's rate has been fairly stable.[2]

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	63.9	58.0	120.4	62.4	13.6
Bennington	100.0	78.2	110.1	113.0	86.6
Caledonia	94.3	130.7	93.4	76.8	91.9
Chittenden	177.4	154.4	167.3	185.9	146.7
Essex	46.4	123.7	61.7	106.6	45.1
Franklin	143.1	106.9	116.5	123.3	128.3
Grand Isle	231.9	57.0	41.7	106.8	104.7
Lamoille	142.0	63.8	100.7	78.2	41.0
Orange	99.2	66.9	70.0	51.6	82.2
Orleans	79.9	83.2	93.8	88.6	25.6
Rutland	89.9	132.3	124.4	86.6	75.5
Washington	118.9	99.5	113.2	86.7	69.4
Windham	135.7	135.1	134.7	153.2	165.2
Windsor	81.9	107.5	99.9	117.4	60.3

Related AHS Performance Measure: Reduce the rate of new crimes committed within three years of release from corrections custody.

For Additional Information

Vermont Crime On-Line: www.dps.state.vt.us/cjs/crime_04/vcon.htm

[1] U.S. Department of Justice. Crime in the United States, 2003: Uniform crime reports. Washington, DC, 2004.

[2] Ibid.

What We Want: Communities Provide Safety and Support to Families and Individuals

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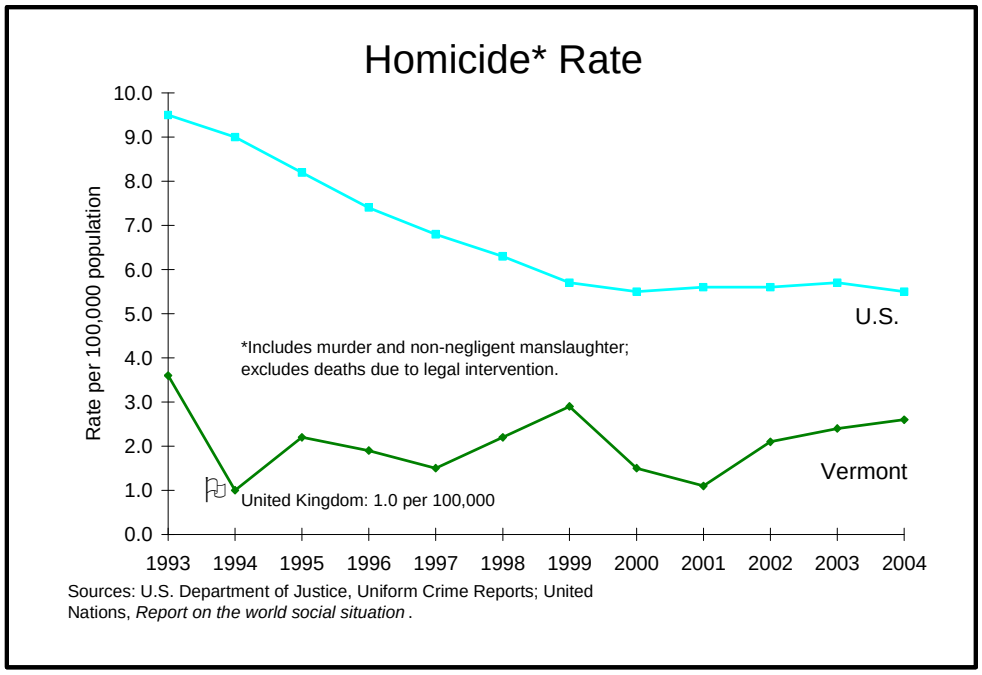

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	3.6	1.0	2.2	1.9	1.5	2.2	2.9	1.5	1.1	2.1	2.4	2.6
U.S.	9.5	9.0	8.2	7.4	6.8	6.3	5.7	5.5	5.6	5.6	5.7	5.5
VT Rank	11	2	7	3	4	8	13	5	2	6	10	14

("1" is lowest)

The Story Behind the Data

The United States has a rate of homicide (murder and non-negligent manslaughter) that is higher than in any other developed country.[1] Nationwide, homicide is the 14th leading cause of death.[2] Vermont is fortunate to have one of the lowest homicide rates in the nation.

In 2004, Vermont had a rate of 2.6 homicides per 100,000 population, compared to a rate of 5.5 for the country as a whole, and ranked fourteenth lowest among the states.[3] Vermont can realistically aspire to join the company of countries such as Denmark, Ireland, and the United Kingdom, all of which have homicide rates of around 1.0.[4] Most homicides in Vermont (like those in other states) involve within-family violence. Such deaths are also much more likely to occur in households that keep firearms.

For Additional Information

Vermont Crime On-Line: www.dps.state.vt.us/cjs/crime_04/vcon.htm

[1] United Nations. Report on the world social situation. New York, 1993.

[2] Kochanek KD, Murphy SL, Anderson RN, and Scott C Deaths: Final data for 2002. *National Vital Statistics Reports*, *53*, no. 5, October 2004. Centers for Disease Control and Prevention, Atlanta, GA.

[3] U. S. Department of Justice. Crime in the United States, 2003: Uniform crime reports. Washington, DC, 2004.

[4] United Nations. Report on the world social situation. New York, 1993.

What We Want: Communities Provide Safety and Support to Families and Individuals

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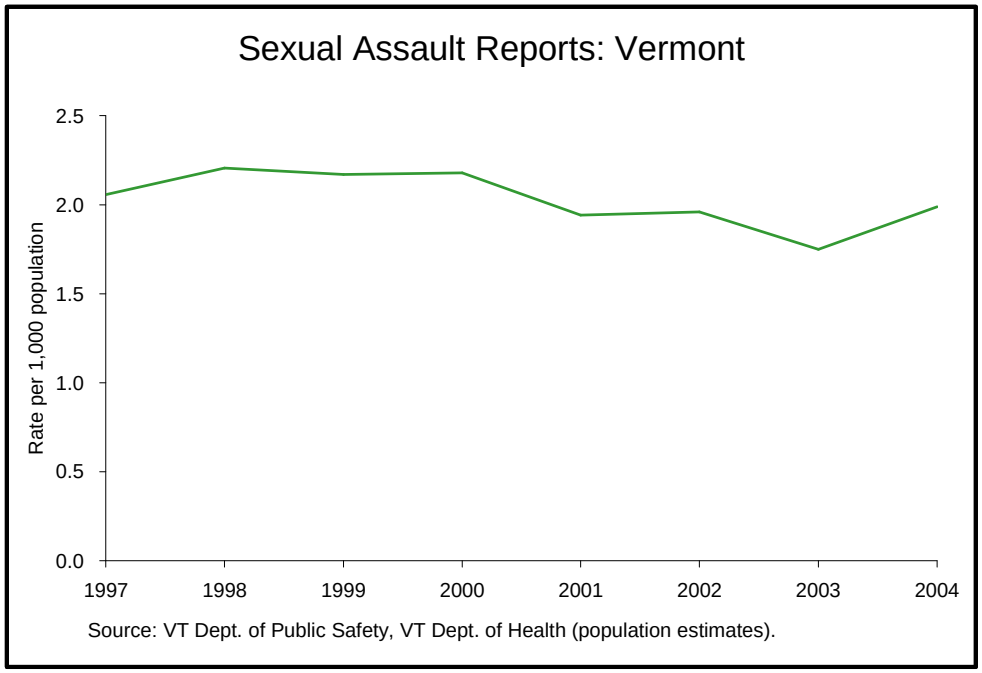

	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	2.1	2.2	2.2	2.2	1.9	2.0	1.7	2.0

(National data are not available for this indicator.)

The Story Behind the Data

"Sexual assaults," as reported to law enforcement agencies, includes rapes and other sex offenses. Offenders and victims may be of any age, and many assaults involve people intimately known to each other. Advocates and law enforcement personnel agree that many such crimes are not reported.

Prevention, identification, and punishment of sexual assault have received increased attention, nationally and in Vermont, in recent years. Trends in rates of reporting are difficult to interpret, because increases may be due to a number of factors, including increased willingness of victims and others to report such crimes.

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	2.2	1.9	1.6	1.4	0.4
Bennington	2.1	2.0	2.4	1.9	0.9
Caledonia	2.2	2.4	2.1	2.1	0.4
Chittenden	2.2	2.2	2.1	1.6	0.6
Essex	3.3	2.6	0.9	1.4	0.5
Franklin	3.1	2.2	2.2	1.8	0.9
Grand Isle	2.0	2.0	1.1	1.3	0.5
Lamoille	1.8	1.1	0.7	1.1	0.2
Orange	2.6	2.2	2.1	2.0	0.5
Orleans	1.7	0.8	1.7	2.2	0.5
Rutland	1.5	1.7	1.8	1.3	0.3
Washington	2.6	2.0	2.2	2.0	0.5
Windham	2.6	2.1	1.9	2.3	0.9
Windsor	1.7	2.0	2.1	1.8	0.7

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

Related AHS Performance Measure: Reduce the rate of new crimes committed within three years of release from corrections custody.

For Additional Information

Vermont Network Against Domestic and Sexual Violence: www.vtnetwork.org

What We Want: Communities Provide Safety and Support to Families and Individuals

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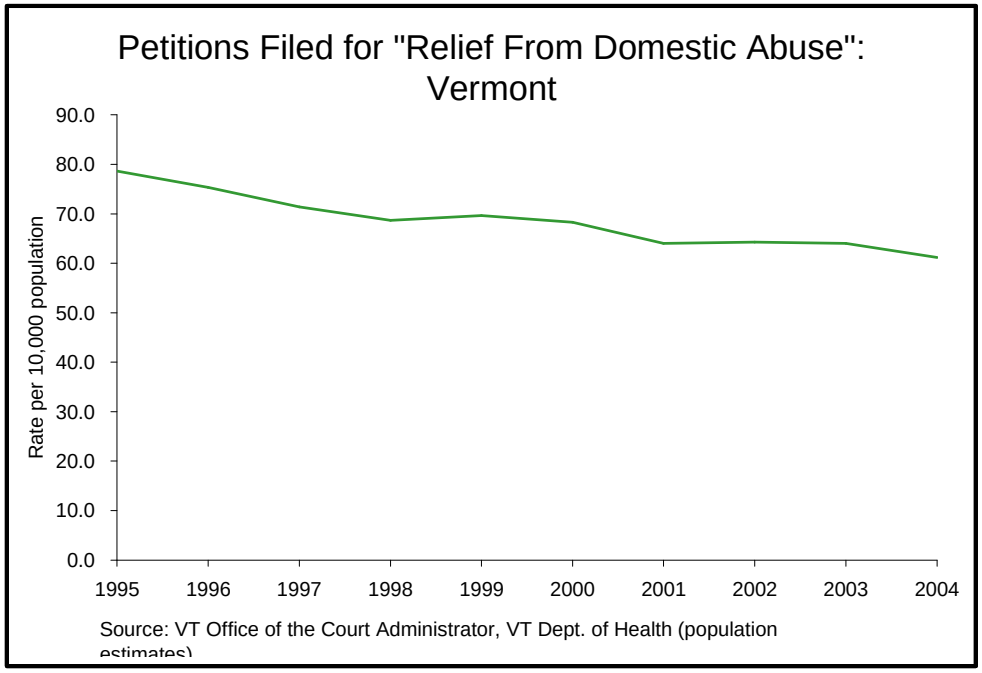

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	78.6	75.3	71.4	68.7	69.6	68.3	64.0	64.3	64.1	61.2

(National data are not available for this indicator.)

The Story Behind the Data

Domestic violence (violence among family members and intimate partners) is a huge, and largely hidden, social problem. Child abuse and neglect (see pp. 92-94) is sometimes considered separately from intimate partner violence (IPV). Reliable estimates of the scope of IPV are difficult to arrive at. Self-reports of victims indicated that nationally, in 1998, about 1 million violent crimes were committed against persons by their current or former spouses, boyfriends, or girlfriends.[1] The American Psychological Association reports data that suggest one-third of adult women will be assaulted by a partner during adulthood. Many assaults are deadly: approximately 30 percent of all female homicide victims in the U.S. are killed by their husbands, ex-husbands, or boyfriends. The number of women beaten and/or sexually assaulted by family members is probably more than 30 times as great. Both victims and perpetrators of IPV are more likely to abuse alcohol.[2] Domestic violence takes a huge toll on the physical and mental health of victims, on other family members' well-being, on social services, and on our economy.

A "relief from abuse" court order is legal protection available to victims of alleged domestic violence. A plaintiff, with assistance from a court worker, can file such a request at any time of day or night; not all filings result in signed court order. Still, many incidents of domestic violence go unreported.

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	48.4	52.2	42.4	43.4	48.8
Bennington	74.6	71.5	68.2	70.5	63.0
Caledonia	61.3	59.0	54.0	70.5	66.3
Chittenden	55.1	52.6	58.0	50.9	53.9
Essex	46.4	63.4	49.4	60.9	40.6
Franklin	83.9	92.1	90.2	94.0	76.3
Grand Isle	85.5	54.1	57.0	34.7	40.6
Lamoille	62.8	56.6	66.7	62.2	61.8
Orange	65.9	70.8	64.8	66.0	62.4
Orleans	58.6	51.8	41.7	53.5	64.3
Rutland	94.6	90.1	89.3	101.9	84.6
Washington	95.8	65.4	68.6	63.1	55.5
Windham	66.9	59.4	62.0	46.6	57.0
Windsor	54.0	56.2	58.0	61.0	57.4

Related AHS Performance Measure: Reduce the rate of new crimes committed within three years of release from corrections custody.

For Additional Information

Vermont Network Against Domestic and Sexual Violence: www.vtnetwork.org

[1] Rennison CM, & Welchans S. Intimate partner violence. Bureau of Justice Statistics Special Report U.S. Department of Justice. Washington, DC, May 2000.

[2] U.S. Federal Bureau of Investigation. Violence among family members and intimate partners. Special report in Crime in the United States, 2003. Washington, DC, 2004.

What We Want: Communities Provide Safety and Support to Families and Individuals

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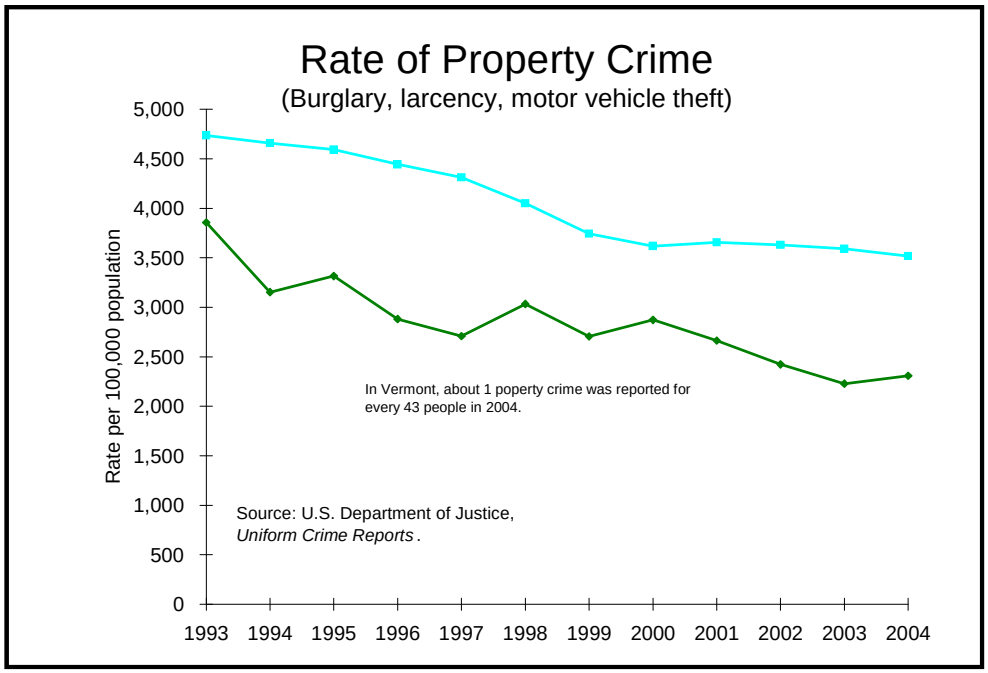

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	3,858	3,153	3,315	2,882	2,709	3,033	2,705	2,873	2,664	2,423	2,229	2,308
U.S.	4,737	4,658	4,593	4,445	4,312	4,051	3,744	3,618	3,656	3,631	3,591	3,517
VT Rank	13	8	8	6	4	10	7	12	9	10	4	3

("1" is lowest)

The Story Behind the Data

In 2004, Vermont's rate of property crimes (burglary, larceny-theft, and motor vehicle theft) was 2,308 per 100,000 people, compared to 3,517 for the U.S. Vermont ranked fourth lowest among the states. Over the last decade, property crime rates for the nation have steadily declined. Vermont's property crime rates, although consistently lower than the nation's, also follow a more uneven pattern.[1]

Data by Vermont Region

VT Counties	2000	2001	2002	2003	2004
Addison	2,001	2,077	2,145	2,248	708
Bennington	2,306	2,211	2,398	2,047	2,259
Caledonia	2,229	1,719	2,479	1,974	1,727
Chittenden	4,320	3,681	3,797	3,593	3,073
Essex	2,183	1,516	1,697	1,187	812
Franklin	2,763	2,523	2,645	3,184	2,500
Grand Isle	2,217	1,767	1,779	1,162	1,871
Lamoille	3,202	3,192	3,142	3,093	2,158
Orange	1,743	1,903	1,575	1,530	1,425
Orleans	2,127	2,136	2,023	1,679	1,494
Rutland	3,344	2,932	2,891	2,630	2,301
Washington	3,108	3,070	2,945	2,366	2,226
Windham	3,361	3,740	2,878	3,098	2,331
Windsor	2,079	2,258	1,949	1,730	1,632

Related AHS Performance Measure: Reduce the rate of new crimes committed within three years of release from corrections custody.

For Additional Information

Vermont Crime On-Line: www.dps.state.vt.us/cjs/crime_04/vcon.htm

[1] U.S. Department of Justice. Crime in the United States, 2004: Uniform crime reports. Washington, DC. 2005.

What We Want: Communities Provide Safety and Support to Families and Individuals

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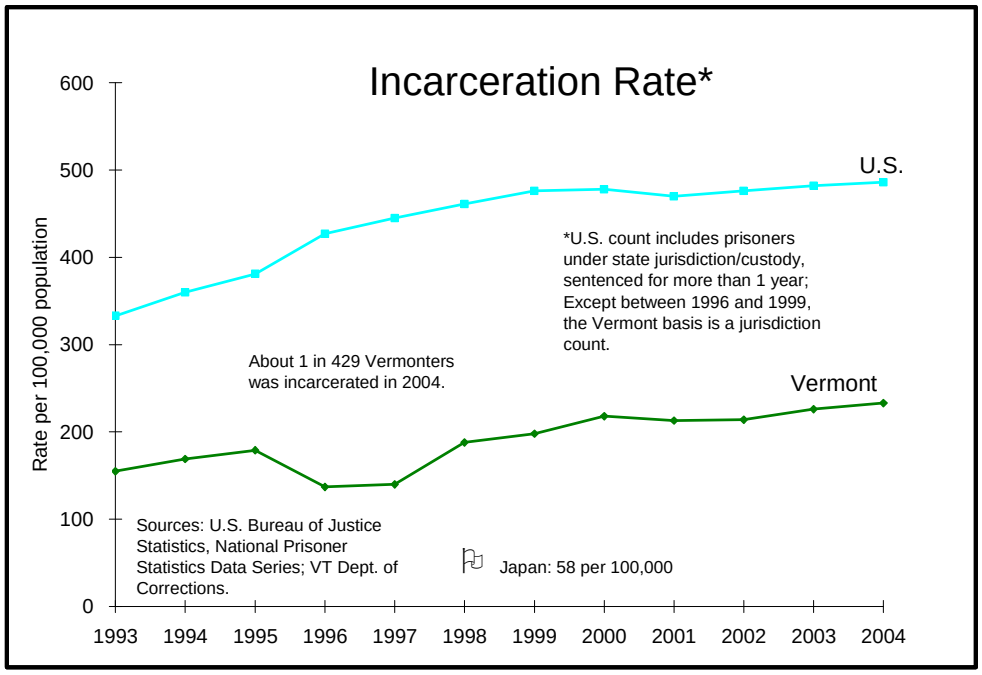


	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	155	169	179	137	140	188	198	218	213	214	226	233
U.S.	333	360	381	427	445	461	476	478	470	476	482	486
VT Rank	8	7	8	4	4	5	7	7	6	6	6	8

("1" is lowest)

The Story Behind the Data

Even though violent crime is declining, the United States incarcerates a greater proportion of its population than any other country in the world.[1]

Vermont's incarceration rate is relatively low (sixth lowest among the states in 2003), but it is climbing, even though data do not include prisoners placed out-of-state.[2] This demand is driven predominantly by society's tougher attitudes toward crime, including stronger sanctions for domestic violence, and drug- and alcohol-related offenses. As a matter of policy, but also increasingly by necessity, incarceration in Vermont focuses on the most violent offenders. Currently, only about 14% of the corrections population is incarcerated. Of those serving sentences of more than one year, nearly two-thirds are violent felons, compared to less than half nationally.[3]

Behind these numbers lie both hope and crisis. Vermont is a national leader in providing meaningful ways for offenders to restore themselves and their communities. Intermediate

sanctions, often in conjunction with treatment, which allow offenders to remain a part of their communities; local volunteer Reparative Boards which oversee creative and constructive restitution to victims and communities; and supervised community work crews which add tangible value to public facilities are all part of a Restorative Justice initiative that is changing the nature of corrections in Vermont. At the same time, there are unrelenting, dangerous pressures on our existing correctional facilities. Overcrowding threatens the safety of inmates and staff. There simply is not room for all offenders who *should* be in prison.

The population of women offenders, in particular, is inadequately housed and, in general, not well-served by corrections practices based on models which may be appropriate for male offenders. Many women offenders have low incomes and poorly developed job-skills; many have substance abuse and/or other mental health disorders; and most are mothers. Thus, this group presents a clear case for re-examining the role of our criminal justice system in building individual self-reliance and responsibility, and healthy, supportive communities.

Related AHS Performance Measures: Reduce the rate of Vermonters incarcerated.

For Additional Information

www.doc.state.vt.us/planning_and_research/introduction

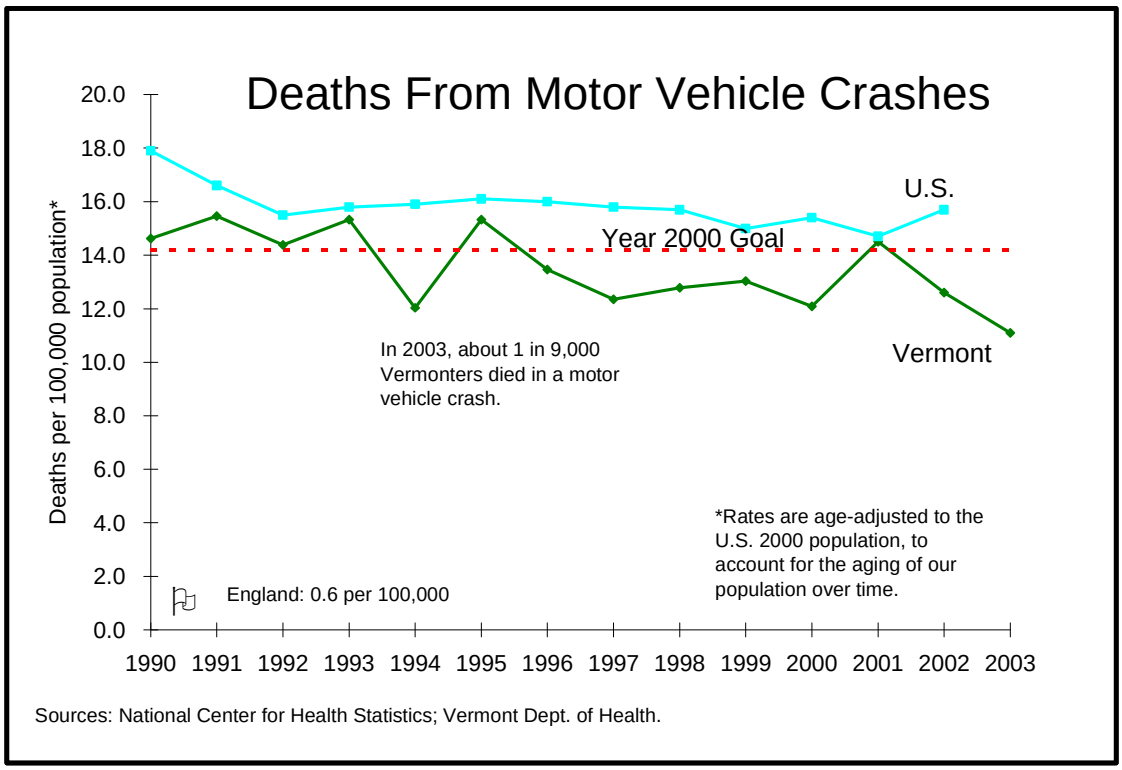
[1] The Sentencing Project. New incarceration figures: Rising population despite falling crime rates. Washington, DC, December 2004.

[2] Bureau of Justice Statistics. Prisoners in 2002. U.S. Department of Justice, July 2003.

[3] Vermont Department of Corrections. Personal communication with John Perry. Waterbury, VT, January 2005.

What We Want: Communities Provide Safety and Support to Families and Individuals

How We Measure Our Success:



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Vermont	14.6	15.5	14.4	15.3	12.0	15.3	13.5	12.3	12.8	13.0	12.1	14.5	12.6	11.1
U.S.	17.9	16.6	15.5	15.8	15.9	16.1	16.0	15.8	15.7	15.0	15.4	14.7	15.7	n/a

(State rankings are not available.)

The Story Behind the Data

Injuries sustained in motor vehicle crashes are a leading cause of death in Vermont, and are the number-one cause of death for teens and young adults. The long-term downward trend on this indicator has been encouraging; whether we can sustain that improvement remains to be seen.

The U.S. *Healthy People 2000* goal was to reduce such deaths to no more than 14.2 per 100,000 people. The past two years for which we have data saw substantial declines in Vermont's rate.[1] An important factor in whether crashes result in fatalities is safety belt use. According to 2004 data, an estimated 80% of Vermont drivers use safety belts, comparable to the nationwide use-rate, but lower than our rates in 2002-03.[2]

For Additional Information

Vermont Governor's Highway Safety Program: www.vthighwaysafety.com/

[1] Vermont Department of Health. Vital Statistics System. Personal communication with Michael Nyland-Funke, February 2005, Burlington, VT.

[2] National Center for Statistics and Analysis, National Highway Traffic Safety Administration. Safety belt use in 2004—Use rates in the states and territories. Washington, DC, November 2004.

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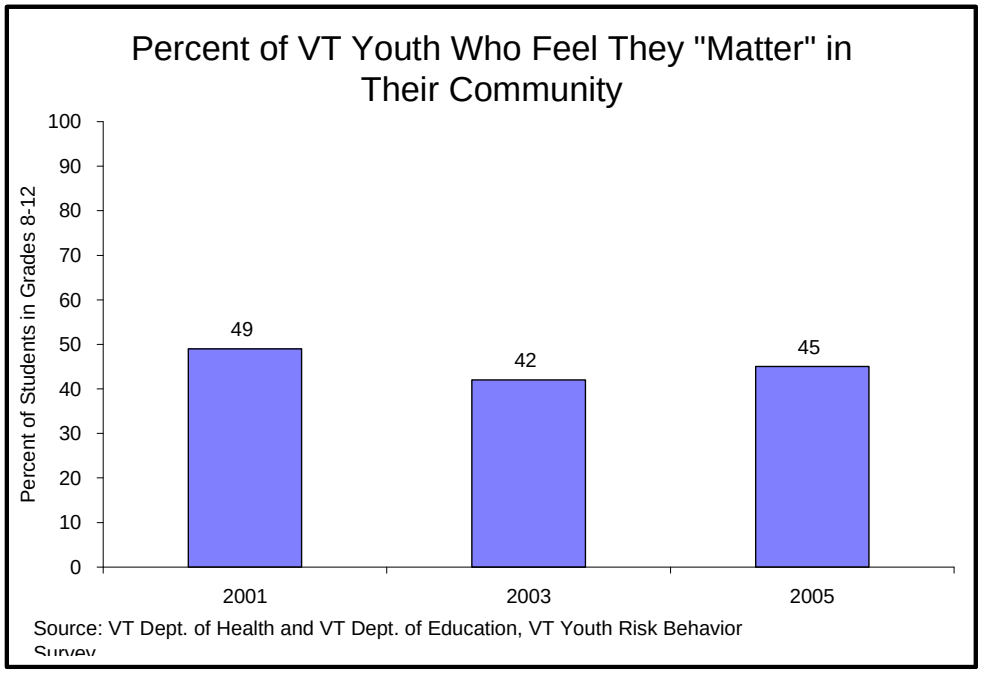


	2001	2003	2005
Grades 8-12	49	42	45

(National data are not available for this indicator.)

The Story Behind the Data

All members of our communities need to feel valued, to feel they "matter," if they are to participate fully in economic, social, and cultural life. For young people, being recognized by their communities for their contributions is particularly important in encouraging development of a positive identity, prosocial attitudes, and engagement in community activities. "Mattering" is an asset that has been identified by the National Research Council and Institute of Medicine as key to fostering positive youth development.[1]

Even though many of our youth devote significant amounts of time to volunteer activities in their communities, and contribute in many other ways, only a minority indicate that they feel they "matter."[2]

Data by Vermont Region

Grades 8-12 VT Counties	2001	2003	2005
Addison	41	45	47
Bennington	40	37	41
Caledonia	40	42	43
Chittenden	42	42	47
Essex	40	n/a	n/a
Franklin	39	39	37
Grand Isle	39	36	38
Lamoille	43	41	39
Orange	39	38	37
Orleans	44	45	40
Rutland	42	39	42
Washington	44	41	43
Windham	36	39	40
Windsor	42	42	43

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

For Additional Information

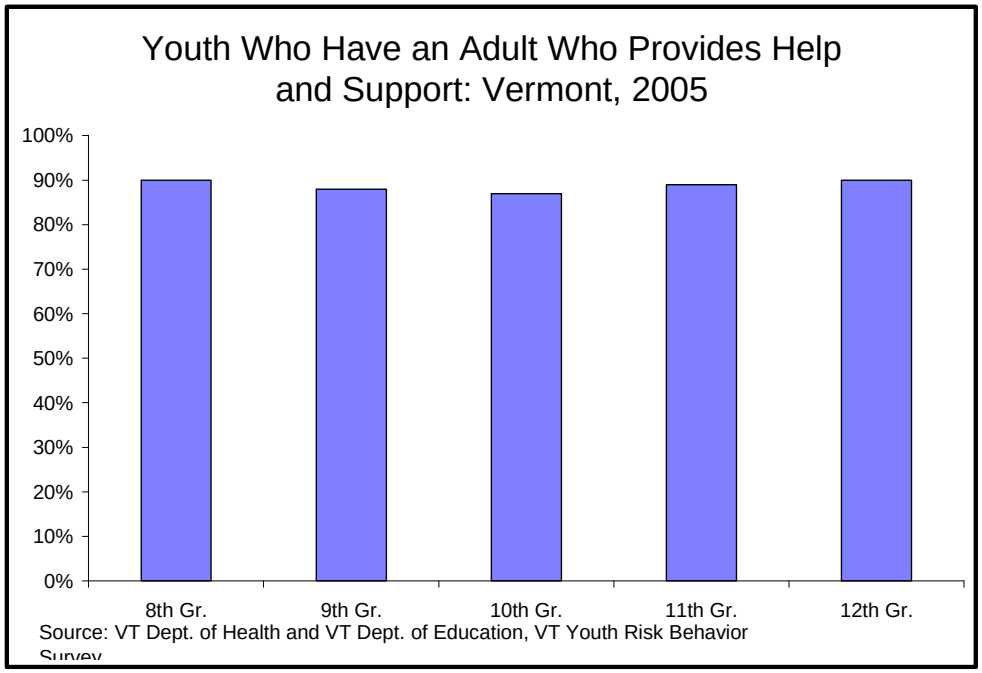
For more information about what works in promoting positive youth development, go to http://humanservices.vermont.gov/publications/what-works-promoting-positive-youth-development-in-your-community/view

[1] Eccles J, & Gootman JA (Eds.). Community programs to promote youth development. National Research Council and Institute of Medicine. Washington, DC: National Academy Press. 2002.

[2] Vermont Department of Health, and Vermont Department of Education. Vermont Youth Risk Behavior Survey, 2005. Burlington, VT: Authors. 2005.

What We Want: Communities Provide Safety and Support to Families and Individuals

How We Measure Our Success:



	8th Gr.	9th Gr.	10th Gr.	11th Gr.	12th Gr.
2005	90%	88%	87%	89%	90%

(National data are not available for this indicator.)

The Story Behind the Data

Nothing is more important throughout life than close, caring relationships with others. For young people, the consistent presence of one or more adults who communicate caring and support is critical to their success. Research has shown that, in many cases, youth who thrive in spite of serious developmental risks, do so because they have someone who is strongly committed their well-being.[1] These caring adults are often their parents, but can also be other relatives, friends, teachers, coaches, or clergy members. More formalized adult-youth mentor relationships have also been shown to be valuable aids to school success, avoidance of substance abuse, and social skills.[2]

Fortunately, most Vermont youth say they have one or more of these adults in their lives. The not-so-good news is that about one in ten surveyed students say they do not.[3] These youth are much more at risk for a number of health-compromising behaviors.[4]

Data by Vermont Region

VT Counties	Grades 8-12
Addison	90
Bennington	90
Caledonia	88
Chittenden	88
Essex	n/a
Franklin	88
Grand Isle	89
Lamoille	89
Orange	87
Orleans	89
Rutland	89
Washington	87
Windham	89
Windsor	89

For data by school supervisory union area, see the AHS *Community Profiles* http://humanservices.vermont.gov/publications/community-profiles.

For Additional Information

For more information about what works in promoting positive youth development, go to http://humanservices.vermont.gov/publications/what-works-promoting-positive-youth-development-in-your-community/view

Vermont Mentoring Partnership: www.vtmentoring.org

[1] Werner EE, & Smith RS. Vulnerable but invincible: A study of resilient children. New York: McGraw Hill. 1983.

[2] Jekielek MA, Moore KA, Hair EC, & Scarupa HJ. Mentoring: A promising strategy for youth development. Child Trends Research Brief. www.childtrends.org. February 2002.

[3] Vermont Department of Health, and Vermont Department of Education. Vermont Youth Risk Behavior Survey, 2005. Burlington, VT: Authors. 2005.

[4] Analysis conducted by VT Agency of Human Services, Planning Division. Data available on request.

What We Want: Communities Provide Safety and Support to Families and Individuals

How We Measure Our Success:

Welfare emphasizes gaining self-sufficiency through employment. The 1996 federal legislation that created the "Temporary Assistance to Needy Families"(TANF) program mandated time-limits on federal benefits, while giving states a great deal of leeway in how they implement many other aspects of their programs.
The federal legislation does not preclude states from using their own funds to help needy families. Vermont's seven-year welfare reform initiative (the Welfare Restructuring Project) ended June 30, 2001. The Vermont Legislature passed Act 147 during the 2000 session. This legislation provided direction for Vermont's welfare program and ensured the continuing availability of a "safety net" of support for the state's most vulnerable people. On July 1, 2001,Vermont implemented Reach Up, its TANF program, and aligned its policies with federal welfare reform law and TANF regulations.

Reach Up provides intensive, individualized case management services to all participating families. Each participant creates, with a case manager, a Family Development Plan (FDP). The FDP focuses on the family's strengths to address its needs in multiple areas, such as housing, transportation, food and clothing, education, and job readiness. The Reach Up program's intensified emphasis on work and work-related activities, including assistance with education and training, job-finding, and child care, is helping move more families toward self-sufficiency. Reach Up (formerly ANFC) caseloads have declined 51% between June of 1994 and June of 2005, partly because more Vermonters are working themselves off welfare.[1]

Historically, Vermont has provided relatively high public assistance benefits to low-income families, ranking among the top ten states in welfare benefits for at least two decades. According to federal reports, as of 2004 Vermont's average monthly assistance per family (includes cash payments and services) was $537, compared to a national average of $397; Vermont's payment was fifth highest among the states.[2] Vermont data for 2004 show the average monthly payment at $461.[3]

In addition to Reach Up, the state also offers a variety of other programs for low-income families. These benefits include food stamps; a state-funded Earned Income Tax Credit (which pays 32% of what families receive from the federal EITC, and is available even to those families with no tax liability); the Renter's Rebate; Medicaid, Dr. Dynasaur, and the Vermont Health Access Plan (VHAP); fuel assistance; and child care subsidies. A family of three, with an earner working full-time at minimum wage, who also receives these benefits, has the equivalent of a monthly income that is 228% of federal poverty level.[4]

Indications are that until entry-level wages rise, and high costs of necessities such as fuel and housing moderate, we can anticipate greater demands on non-governmental sources of social support. An important example of this largely-volunteer contribution is the help supplied by food shelves and community kitchens. According to a 2005 survey conducted by Vermont's Office of Economic Opportunity (OEO), there were 134 food shelves and 31 community kitchens in Vermont providing emergency food services, up from 70 and 14, respectively, in 1990.[5]

Between 2003 and 2005, the average monthly caseload of the food shelves grew by 23%, to 10,379 households; more than half (51%) of these households have minor children; 21% are households with an elderly person; 40% include an employed adult or one who is only temporarily out of work. The average number of meals served monthly by community kitchens is 22,716. Children and the elderly are the recipients of much (31%) of this support, too. Vermont OEO estimates that during a typical month at least 28,000 different individuals use one or both types of local food service.[6]

For Additional Information

Vermont Department for Children & Families, Economic Services Division:
www.path.state.vt.us

[1] Vermont Department for Children and Families. Personal communication from Karolyn Clark, April 2006.

[2] U.S. Social Security Administration. Annual Statistical Supplement, 2005. Washington, DC. 2006.

[3] Vermont Department for Children and Families. Personal communication from Karolyn White, April 2006.

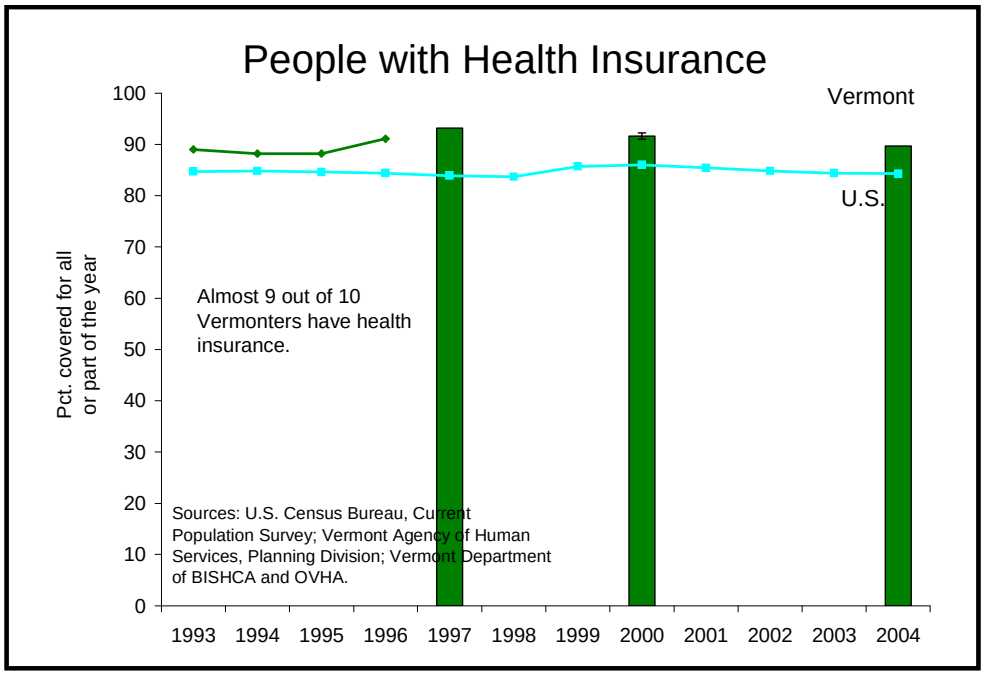
[4] Ibid.

[5] Vermont Department for Children & Families, Economic Services Division. Hunger in Vermont: Report on the 2005 survey of Vermont food shelves and community kitchens. Waterbury, VT: Author. April 2005.

[6] Ibid.

What We Want: Communities Provide Safety and Support to Families and Individuals

How We Measure Our Success:



	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Vermont	89.0	88.2	88.2	91.1	93.2	n/a	n/a	91.6	n/a	n/a	n/a	89.7
U.S.	84.7	84.8	84.6	84.4	83.9	83.7	85.7	86.0	85.4	84.8	84.4	84.3

(State rankings are not reliable.)

The Story Behind the Data

Medical and other health-related expenses can be financially devastating to people who lack health insurance. Those without insurance are also less likely to get the medical care they need, and more likely to be hospitalized for conditions avoidable through early intervention.[1]

The uninsured account for significant lost workplace productivity, higher health care costs, and thousands of premature deaths annually.[2] Even with the federally-administered Medicaid and Medicare programs, the poor are more than twice as likely to lack health insurance.[3] One reason is that most of the uninsured are "the working poor"—full-time workers or their dependents not poor enough to qualify for Medicaid. And, as costs rise, fewer employers offer coverage to their workers, and among those that do fees (premiums and/or co-pays) have become unaffordable for many employees.

An estimated 45 million people in the U.S. (16%) were without insurance during all of 2004.[4] The most recent reliable survey of Vermonters estimates that, as of 2004, 10.3% were without any form of health insurance.[5] The number of people without insurance for some portion of the year is much higher; best estimates put this at 24.9% of the non-elderly population

in Vermont for 2002-03.[6] One reason Vermonters have fared better than those in many other states is our enhanced Medicaid eligibility for children and pregnant women. In 1995, Vermont began offering health care coverage for previously uninsured low-income adults, under the Vermont Health Access Plan (VHAP).

For Additional Information

Vermont Department of Banking, Insurance, & Health Care Administration, Division of Health Care Administration: www.bishca.state.vt.us/HcaDiv/Data_Reports/a_data_reports_index.htm#HEALTH%20INSURANCE%20MARKET

Office of Vermont Health Access: www.ovha.state.vt.us/studies.cfm

[1] State Health Access Data Assistance Center., University of Minnesota. The coverage gap: A state-by-state report on access to care. Author. April 2006.

[2] Institute of Medicine of the National Academy of Sciences. Hidden costs, value lost: Uninsurance in America. Executive summary. Washington, DC, 2003.

[3] U.S. Census Bureau. Income, poverty, and health insurance coverage in the United States: 2004. *Current Population Reports* (P60-229), August 2005.

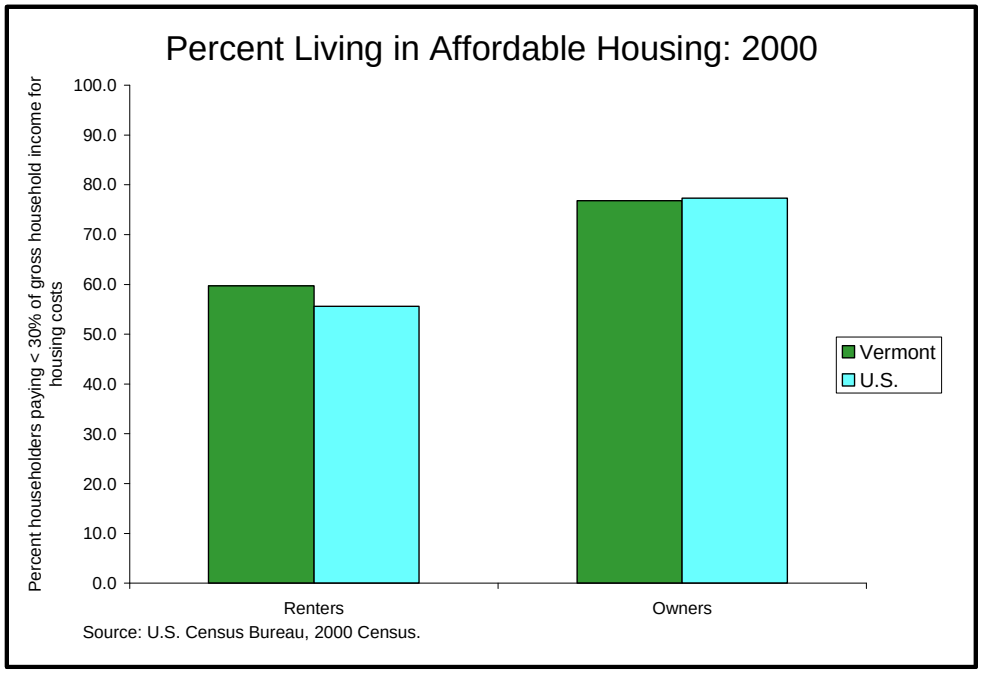
[4] Ibid. As with estimates of poverty, estimates of insurance status come from the Current Population Survey, where sample-sizes for many states are too small to produce very reliable estimates; see p. 113.

[5] Ibid.

[6] Families USA. One in three: Non-elderly Americans without health insurance, 2002-03. Washington, DC, June 2004.

What We Want: Communities Provide Safety and Support to Families and Individuals

How We Measure Our Success:



2000	Renters	Owners
Vermont	59.7	76.8
U.S.	55.6	77.3

The Story Behind the Data

Owning a home gives families a sense of security, builds ties to neighborhoods, schools, and communities, improves outcomes for children, and ultimately provides a buffer against poverty in old age.[1]

In 2000, Vermont's home ownership rate (the percentage of occupied housing units that are owned by occupants) was 69%. The national home ownership rate was 67%.[2] National data suggest that renters typically face multiple barriers to home ownership, including inability to make a down payment, having excessive debt, or having insufficient income for a mortgage.[3]

An indicator of the financial burden of housing is the percentage of household income paid for housing costs. Recent reports confirm a critical need for affordable housing. An analysis produced by the National Low Income Housing Coalition shows that a Vermont renter would need an hourly wage of $13.90 (nearly twice as much as the Vermont minimum wage) in order to afford the Fair Market Rent (FMR) for a 2-bedroom unit.[4]

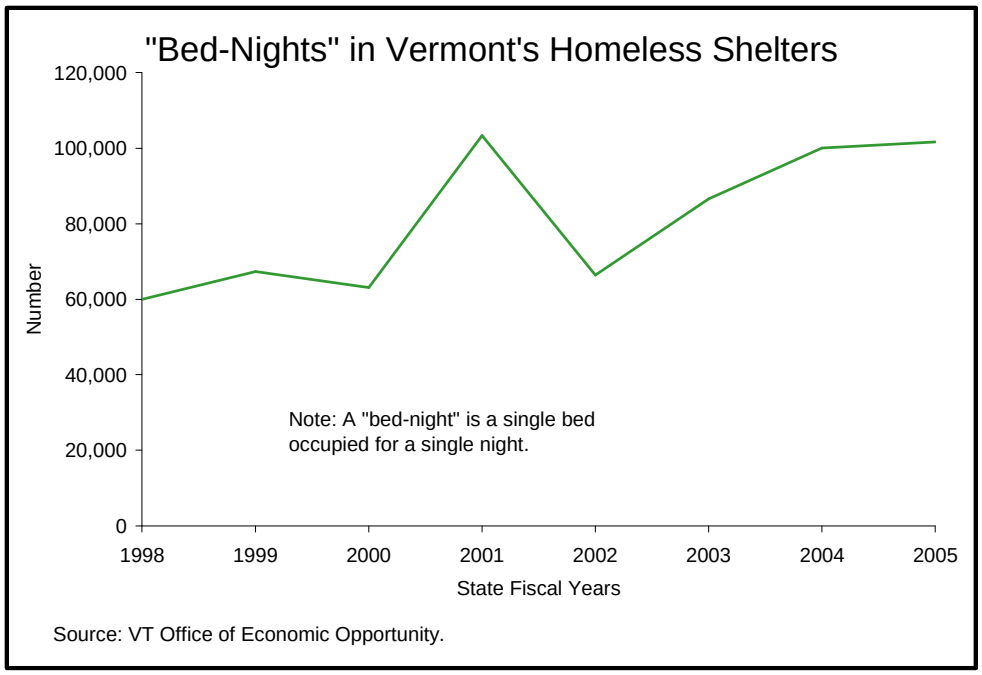
Data by Vermont Region

VT Counties	Renters	Owners
Addison	65.3	74.1
Bennington	56.5	75.2
Caledonia	60.2	77.1
Chittenden	56.3	78.7
Essex	65.1	80.3
Franklin	65.7	77.7
Grand Isle	65.2	71.4
Lamoille	60.8	72.5
Orange	67.4	75.5
Orleans	57.8	78.6
Rutland	57.0	76.4
Washington	62.5	77.4
Windham	61.3	75.4
Windsor	61.8	76.2

Another assessment reports that 73% of Vermont households have annual incomes below that necessary to purchase a median-priced home. In 2000, the median home value in Vermont was $111,500, compared to $119,600 for the nation. Vermont ranked 23rd highest among states.[5] Since 1996, the median sales price here has jumped by 87%, far exceeding the overall inflation rate, and the rate of increase in household incomes. In 2005, the median selling price for primary properties (excluding vacation homes) in Vermont was $182,000.[6] According to the Vermont Housing Council, Vermont currently has a shortage of 21,000 affordable rental units, and will need an additional 12,300 owner-occupied units by 2010.[7] Unfortunately, federal housing assistance for low-income Vermonters is declining.

In addition to having comparatively high housing costs, Vermont ranks low on indicators of housing quality.[8] The Vermont Housing Council report estimates that 9,000 Vermont households have housing that is moderately to severely substandard.[9] The rental housing stock, in particular, is facing problems associated with age: nearly half (48%) of rental units occupied in 2000 were 50 or more years old.[10]

How We Measure Our Success:



	1998	1999	2000	2001	2002	2003	2004	2005
Bed-Nights	59,972	67,350	63,111	103,308	66,372	86,608	100,028	101,647

The Story Behind the Data

Finally, the Vermont Office of Economic Opportunity estimates that on any given night 400 Vermonters are homeless, some in designated shelters, but many others not counted as homeless—as many as 14,000 by some estimates—are doubling up with friends or relatives, living in old camps, in cars, or motels. During the course of a year, an estimated 4,000 Vermonters are homeless at one time or other—the most vulnerable being single adults under age 65 living below poverty level, and families headed by single women. The face of homelessness in Vermont (as in the rest of the nation) has changed dramatically in recent years. About one in five homeless people are children; many homeless adults are working full-time. In State Fiscal Year 2005, Vermont's homeless shelters reported nearly 102,000 "bed-nights" (i.e., a single bed occupied for one night), a 52-percent increase in four years. The average length of stay in shelters is 26 days. more than twice as long as it was just six years ago.

Related AHS Performance Measure: Reduce the number of bed-nights in Vermont's homeless shelters.

For Additional Information

Vermont Housing Data: www.housingdata.org/

National Low Income Housing Coalition: www.nlihc.org

[1] Dietz RD. The social consequences of homeownership. Homeownership Alliance. Columbus, OH, June 2003.

[2] U.S. Bureau of the Census. Housing vacancies and homeownership annual statistics: 2000. Table 13. Washington, DC, February 2001.

[3] U.S. Census Bureau. Who could afford to buy a house in 1995? *Current Housing Reports*, August 1999.

[4] National Low Income Housing Coalition. Out of reach 2005. Washington, DC, 2005. A unit is considered affordable if the rent is no more than 30% of the renter's income. In Vermont, Fair Market Rent was calculated at $723 for a two-bedroom unit. A minimum-wage worker could afford monthly rent of no more than $377.

[5] U.S. Bureau of the Census, 2000 Census.

[6] Vermont Housing Awareness Campaign, and the Vermont Housing Council. Op cit.

[7] Vermont Housing Awareness Campaign, and the Vermont Housing Council. Between a rock and a hard place: Housing and wages in Vermont. 2005 update. Montpelier, VT, February 2006.

[8] Kaufman TL. Housing America's future: Children at risk. National Low Income Housing Coalition/Low Income Housing Information Service. Washington, DC, 1996.

[9] The Vermont Housing Council. Op. Cit.

[10] U.S. Census Bureau. 2000 Census.

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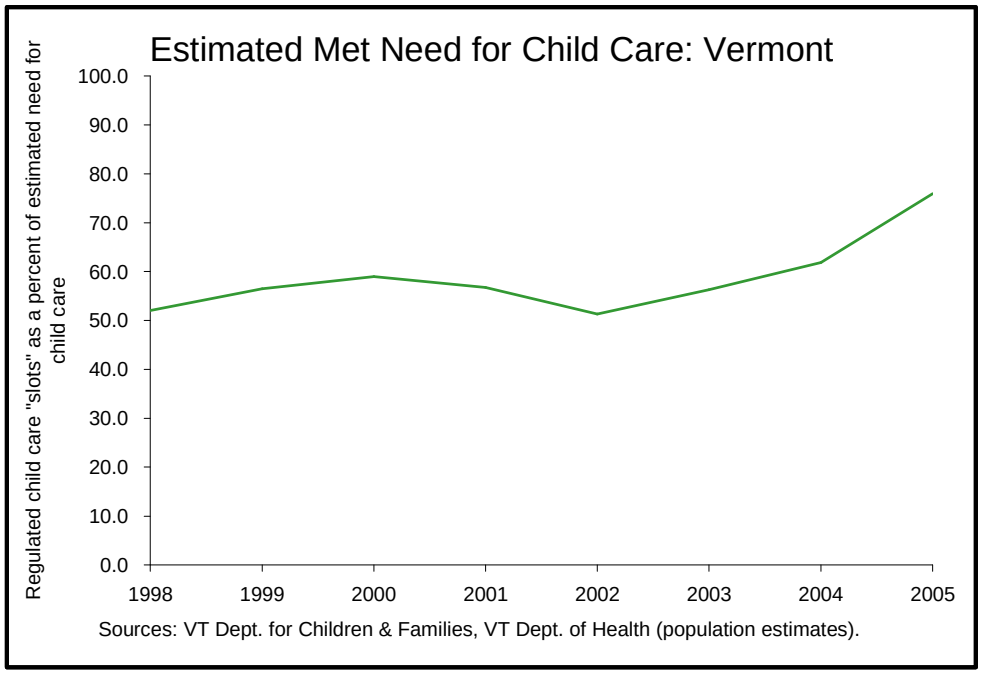

	1998	1999	2000	2001	2002	2003	2004	2005
Vermont	52.0	56.5	59.0	56.8	51.3	56.3	61.8	75.9

(National data are not available for this indicator.)

The Story Behind the Data

Safe and developmentally appropriate childcare benefits children, their parents, and our economy—both now and in the future. Communities that provide adequate high-quality, affordable childcare are making an investment in human capital that research shows is very cost-effective. A critical economic support for families, who increasingly require two incomes to make ends meet, good-quality childcare also helps children get ready for school success.[1]

Vermont has made good progress in expanding the supply of childcare that meets minimal standards of acceptability. But there is more to be done. Shortages by region, and particularly for infant care and "after-hours" care, continue. Upgrading quality remains a work-in-progress, dependent on significant investments in professional development and licensing staff.

Data by Vermont Region

AHS Districts	2001	2002	2003	2004	2005
Barre	57.3	53.0	62.6	66.7	70.8
Bennington	55.2	48.5	53.4	59.6	73.6
Brattleboro	50.8	46.3	52.9	59.8	66.0
Burlington	63.7	61.6	62.0	64.3	71.2
Hartford	41.9	38.0	39.7	47.1	57.6
Middlebury	56.7	50.2	54.8	62.1	53.4
Morrisville	74.3	64.1	64.1	76.1	81.8
Newport	54.0	45.6	50.9	55.4	63.0
Rutland	48.8	45.6	55.1	61.4	70.0
Springfield	65.8	54.7	60.7	66.7	70.3
St. Albans	53.8	48.1	50.4	57.5	61.0
St. Johnsbury	52.5	43.1	58.3	63.0	76.2

Related AHS Performance Measure:

Increase the percentage of kindergartners who are judged "ready for school."

For Additional Information

Vermont Child Care Advisory Board. Child care: 2006 Legislative Report. www.VermontCCAB.org

Child Care Fund of Vermont: www.storyofachild.org

See early childhood resources on-line, including The Vermont School Readiness Series: http://humanservices.vermont.gov/publications/vsrs-vrp.

[1] Lynch RG. Exceptional returns: Economic, fiscal, and social benefits of investment in early childhood development. Economic Policy Institute. 2004. Windham Child Care Association and the Peace & Justice Center. The economic impact of Vermont's child care industry. 2002.

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