

**U**p·date • tr.v. up·dat·ed, up·dat·ing, up·dates. To bring up to date: update a text-book; update the files. n. 1. Information that updates something. 2. The act or an instance of bringing something up to date. 3. An updated version of something.

**E**·val·u·ate • tr.v. e·val·u·at·ed, e·val·u·at·ing, e·val·u·ates. 1. To ascertain or fix the value or worth of. 2. To examine and judge carefully; appraise. See Synonyms at estimate. 3. Mathematics To calculate the numerical value of; express numerically. [Back-formation from evaluation, from French évaluation, from Old French, from evaluator, to evaluate : e-, out (from Latin -, ex-; see ex-) + value, value; see value.]

# Focus on the First Years:

Update and Evaluation, 2009

Baltimore County Local Management Board  
Baltimore County, Maryland

June 2009

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*Suggested Citation:* Baltimore County Local Management Board (BCLMB). 2008. *Focus on the First Years: Update and Evaluation, 2009*. Baltimore, Md.: BCLMB, June.

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Report layout designed by InterGroup Services, Inc.

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## Executive Summary

This document is the third report on child health and well-being issued by the Baltimore County Local Management Board (LMB), the previous two reports having been released in 2002 and 2005. The 2002 report, *Focus on Families: Creating a Foundation for Child Well-Being* (BCLMB 2002), analyzed a variety of well-being indicators for Baltimore County children, divided into three age groups: infants and toddlers (ages 0-6), children (ages 6-12) and teenagers (ages 12-21). The 2005 project, *Focus on the First Years: Well-Being for Baltimore County's Youngest Residents* (BCLMB 2005), focused on matters pertaining to early childhood (i.e., ages 0-6).

The 2005 report's narrower focus resulted from an increased interest countywide in early-childhood issues. That project began with the 2003 formation of the LMB's Early Childhood Action Committee (ECAC) at the request of Baltimore County Executive James T. Smith, Jr., who charged the committee to develop an action plan to guide the allocation of county resources in matters related to the health and well-being of young children. This plan was ultimately contained within the 2005 report.

After the release of the 2005 report, the committee was reestablished as the Early Childhood Committee (ECC) and given the goals of implementing the action plan, monitoring for achievement of the plan's goals and adapting the plan as necessary over time. The committee was and is also tasked with improving collaboration among providers of early-childhood services, increasing the effectiveness of existing programs, informing parents and child-care providers about existing programs, educating parents about how to prepare their children for school, and identifying new funding streams for school-readiness programs.

The current report builds upon the 2005 report by providing an updated assessment of the various indicators of child health and well-being studied in the previous reports, as well as by continuing a strategic planning process initiated in 2000. Where possible, this report compares current information with that presented in the 2005 report, thus showing trends in child well-being in Baltimore County.

The information presented in this report reflects the status of child and family well-being according to recent data compared to prior information. This information is the foundation for the LMB's goals and objectives, as well as the basis for assessing progress.

As in the previous two reports, information is provided in this analysis not only for Baltimore County but also for the five neighboring jurisdictions: Anne Arundel County, Baltimore City, Carroll County, Harford County and Howard County. Additionally, as in the 2005 report, various Baltimore County sub-regions — i.e., census-designated places (CDPs) — are analyzed in order to outline disparities within the county and more accurately determine service needs at the community level. There are seven sub-regions evaluated in this report: Baltimore Highlands/Lansdowne; Reisterstown; Parkville; Dundalk; Woodlawn and Milford Mill; Mays Chapel and Lutherville/Timonium; and Essex and Middle River.

As background material, this report first provides updated demographic and economic information on county families. The report next proceeds to a detailed analysis of the 31 selected indicators of child health and well-being, organized into 10 “results,” which are in turn organized into 3 “issue areas.” (For a complete list of the ECC's selected issue areas, results and indicators, see table 1.) This analysis is followed by the ECC's updated goals and objectives for improving early-childhood services in Baltimore County.

The three issue areas deemed by the ECC to be crucial to the health and well-being of young children are: (1) family support, (2) health and safety and (3) early care and education. Indicators under the category of “family support” are those that affect entire families, such as poverty and unemployment rates, child homelessness and out-of-home placements. Indicators considered to be relevant to “health and safety” are those with a more direct relationship to child health and well-being, such as neonatal health indicators, child injuries and lead exposure. Lastly, indicators falling under the category of “early care and education” are those related to school readiness and availability of care.

The issue areas contain the following 10 “results” relevant to early-childhood health and well-being: (1) family cohesiveness, (2) family welfare, (3) family education, (4) family breakdown, (5) healthy births, (6) healthy childhood, (7) safe childhood, (8) child school-preparedness, (9) child school readiness and (10) care availability. The 31 indicators listed in table 1 are divided among these 10 results.

The result “family cohesiveness” groups indicators of family structure and stability: teen pregnancy, single motherhood and single-mother households. Since 2002, Baltimore County’s teen-birth rate has worsened (increasing 11.2 percent from 2002 to 2005). Similarly, the rate of single-mother or female-headed households in Baltimore County has also increased since the last report (7.1 percent since 2000) (BC 2001).

The result “family welfare” includes indicators such as free/reduced-price meal reciprocity, children living in poverty, and unemployment. An upward trend in free/reduced-price meal reciprocity leaves Baltimore County, with its 39.1 percent rate, the most-affected jurisdiction in the region, save Baltimore City (MSDE 2007c). Baltimore County also continues to lead the entire region in terms of rate of increase on this indicator (48.1 percent from 1997 to 2007). At 9.0 percent, Baltimore County’s percentage of families with children under 5 in poverty is the highest among all non-city jurisdictions. Baltimore County’s unemployment rate, however, decreased after the last report (from 4.8 percent in 2003 to 3.9 percent in 2005), though it should be emphasized that these data do not cover the current financial difficulties being seen nationwide.

With respect to education levels, as of 2000, Baltimore County had the region’s second-highest rate of people over 25 who had not finished high school (4.9 percent). As of 2006, however, Baltimore County has seen a 24.5 percent proportional reduction on this indicator (BC 2008). Sadly, births to under-educated mothers have not trended in the same direction; since the last report, there has been a 15.6 percent increase in the proportion of births that are to mothers without a high school diploma. Also, rates of residents who speak English as a second language, and of residents who speak it “less than very well,” have increased 11.2 and 4.2 percent, respectively.

The result “family breakdown” includes the indicators child homelessness, out-of-home placements and grandparent placements. From 2001 to 2006, Baltimore County experienced the greatest rate of increase in juvenile homelessness in the region, 93.4 percent. Out-of-home placements have also increased since the last report, to a rate of 8.4 per 1,000 child residents. Surprisingly, given the statistics on juvenile homelessness and out-of-home placements, grandparent placements in Baltimore County are relatively low, having decreased from 2.0 to 1.8 percent of households between 2000 and 2006 (BC 2002, 2008).

Under the result “healthy births,” the report next presents data on such indicators as infant mortality, low birth weights and prenatal care. Data on Baltimore County’s infant mortality rate between 1995 and 2006 reveal a rate increase of 2.9 percent, perhaps partly related to the fact that the percentage of county mothers receiving late or no prenatal care has increased from 2.2 to 2.8 percent since the last report (DHMH 2002b, DHMH 1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a). However, Baltimore County’s rate of low birth weights has decreased since 2002, to a rate of 8.9 percent. (DHMH 1995, 2002b, 2006).

As important as they are, the advantages conferred by a healthy birth can easily be negated by an unhealthy childhood. Therefore, this report also focuses on two indicators of “healthy childhood”: juvenile Medicaid reciprocity and childhood deaths. As of 2006 Baltimore County continues to have the second-highest rate of juvenile Medicaid enrollment in the region, at 27.3 percent (ACY 2007). The second indicator of “healthy childhood” assessed in this report, the child mortality rate, has also increased in Baltimore County, to 3.5 per 1,000 live births (DHMH 2006).

Hand in hand with child health goes child safety, a result that includes the following indicators: child injuries, child abuse/neglect and childhood lead exposure. Data for the years 2002 through 2005 show a 9.1 percent increase in injury hospitalizations in Baltimore County (DHMH 2005b). However, data regarding trends in child maltreatment from 1996 to 2005 show improvement on this indicator in Baltimore County, particularly among physical abuse

cases, which decreased by 49.1 percent during the period assessed. Despite overall improvements, the county's sexual-abuse rate continually increased between 2003 and 2005, from 2.30 to 2.51 per 10,000. Lastly, the lead poisoning rate in Baltimore County, now referred to as elevated blood lead level, also showed improvement (from 1.4 percent in 2002 to 0.45 percent in 2006).

The subsequent two results in this report include various school-related indicators. First, data are presented on "school preparedness" (i.e., measures of experiences and activities likely to increase a child's readiness to succeed later in school), including referrals to the Infants and Toddlers Program (I&T) and Head Start utilization. Current data show slight increases in referrals and utilization rates for both programs. When considered in tandem with poverty estimates for the county, these relatively small increases suggest a need for further outreach.

The next result is "child school readiness," which includes the following indicators: (1) kindergartners' scores on the Work Sampling System (WSS); (2) kindergartners' prior preschool attendance; (3) the rate of five-year-olds in preschool in a given year; and (4) the rate of preschoolers with individual education plans (IEPs). First, WSS scores show that child school readiness in Baltimore County has increased from 59.0 percent in 2004 to 77.0 percent in 2007 (MSDE 2007c). Furthermore, studies of the "achievement gap" between white and minority students in the county show great improvement, particularly among African-American and Asian students. Current estimates regarding home-cared kindergartners versus those who attended preschool show that a mere 58 percent of home-cared students were assessed at full readiness, compared to 89 percent who attended nursery school.

The final result contains two indicators relating to "care availability": children with working mothers and child-care costs. The rate of county children with working mothers has increased to 70.7 percent. For those working mothers who need child care, expense is often an obstacle. In fact, the child-care cost estimate for Baltimore County reveals that over 20 percent of the average family's household income is spent on child-care services.

In light of the results presented in this report, the LMB's Early Childhood Committee recognized the need for improved services for the county's youngest residents. After several meetings to develop a new, comprehensive set of goals and objectives, the ECC established a new plan through which progress toward service improvement could be measured. Based on the committee's newly defined plan, the LMB is committed to pursuing the following goals in the coming years:

- Assuring that all Baltimore County families with young children (ages 0-5) are aware of all public benefits and programs.
- Supporting parents and/or guardians in the central role they play in their children's development.
- Assuring that all Baltimore County families with children under five have access to health, mental health and behavioral consultation services.
- Assuring that children under five have access to comprehensive health and developmental screening with follow-up assessments as necessary, to enable early identification of problems, and referral to health and education interventions.
- Facilitating the provision of health care for women to ensure the birth of healthy babies.
- Encouraging collaboration among agencies to keep young children safe within their families, homes and communities.
- Monitoring progress toward the achievement of all goals and objectives.

Based on these newly defined goals, as well as related objectives and action steps, the LMB remains confident that improvements in early-childhood services will be achieved in the near future, and assures its continued support for collaborating agencies in all efforts to improve child well-being in Baltimore County.

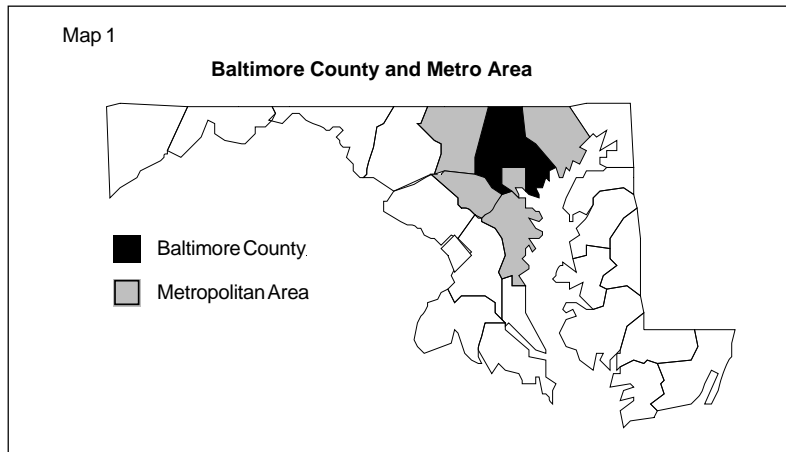
# Chapter 1. Introduction

This document is the third report issued by the Baltimore County Local Management Board (LMB) as part of an ongoing strategic planning process begun in 2000. The LMB is made up of the heads of those Baltimore County agencies that serve children in one way or another, as well as community members and families. As required by state law, there are LMBs in every county in Maryland. The goal of each LMB is to increase the health and well-being of children and families in its jurisdiction by identifying problems and devising quantifiable, data-driven plans for improvement. As part of this process, the Baltimore County LMB studies a variety of “indicators,” or measures of health and well-being, in the county and surrounding area, publishing its findings in periodic reports.

The LMB issued its first such report, *Focus on Families*, in 2002 (BCLMB 2002). *Focus on Families* was the work of three committees formed by the LMB in 2000, each charged with studying a specific age group: the Birth-6 Committee, the 6-12 Committee and the 12-21 Committee. The 2002 report sketched a broad overview of the state of families and children in Baltimore County.

On December 17, 2003, Baltimore County Executive James T. Smith announced the formation of the Early Childhood Action Committee (ECAC), a group of 25 local experts in early-childhood-related issues. ECAC’s membership included county employees, non-profit executives and citizen activists. The ECAC’s chair was Paula Boykin, the director of the Baltimore County Infants and Toddlers Program; the vice chair was Lynn Lockwood, the then-assistant director of the Baltimore County Public Library system.

The executive order establishing the ECAC also assigned various tasks to the committee: (1) improving collaboration



among existing providers of early childhood services, (2) increasing the effectiveness of existing programs, (3) informing parents about the existence of such programs, (4) educating parents about what they can do to help their children enter school ready to learn and (5) identifying untapped state, federal and private funding streams for school readiness programs. The LMB, led then and now by Executive Director Rosemary M. “Roe” Davis and assisted by Program Administrator Donald A. Schlimm, was to provide sponsorship and staff support for the ECAC’s activities.

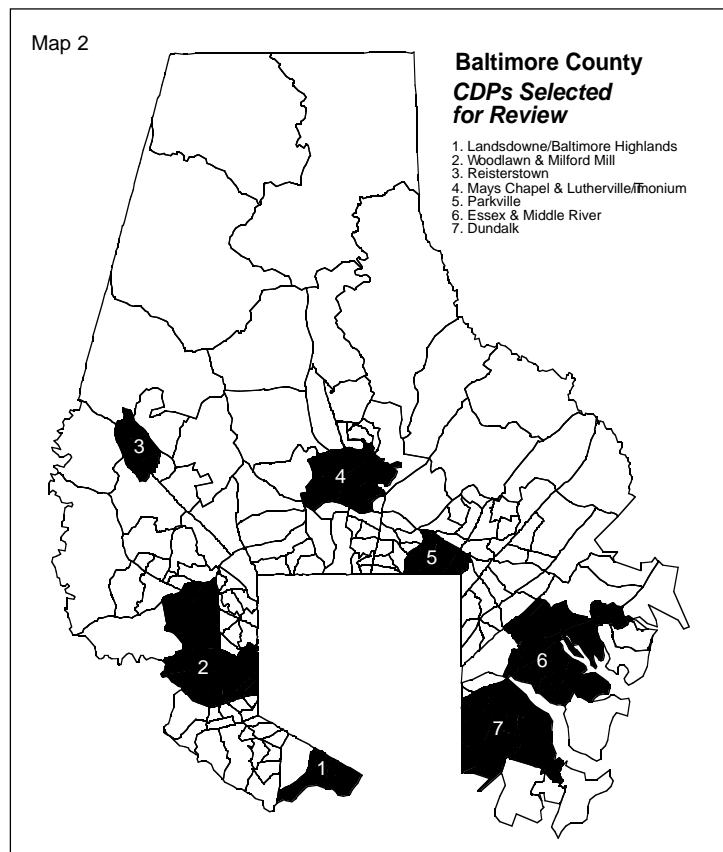


Table 1

<b>Area</b>	<b>Result</b>	<b>Indicator</b>
<b>Family Support</b>	<i>Family cohesiveness</i>	Births to 17s and under, rate Single-parent households, rate
	<i>Family welfare</i>	Poverty rate, children under 5 Poverty rate, households with children Free/reduced-price school lunch reciprocity Unemployment rate
	<i>Family education</i>	Overall adult educational attainment Births to undereducated mothers Limited English proficiency, adult and child
	<i>Family breakdown</i>	Child homelessness rates Child out-of-home placements Child relative placement Child grandparent placement
<b>Health &amp; Safety</b>	<i>Healthy births</i>	Mortality rate, infant Low-birth-weight rate Prenatal care service reciprocity
	<i>Healthy childhood</i>	Mortality rate, children 1-4 Child Medicaid reciprocity
	<i>Safe childhood</i>	Child Injury rate Child abuse & neglect rates Lead poisoning rate
<b>Early Care &amp; Education</b>	<i>Child school preparedness</i>	Infants & Toddlers program referral rate Head Start program utilization rate
	<i>Child school readiness</i>	Work Sampling System scores Kindergartners' prior preschool attendance 5-year-olds in preschool, rate Preschoolers with IEPs, rate
	<i>Child care availability</i>	Children with working mothers, rate Child-care costs as proportion of income Child-care subsidies as proportion of toddlers Child-care subsidy wait lists as proportion of child-care subsidies

In order to accomplish the mission outlined in the county executive's 2003 order, the ECAC examined statistical data on a range of indicators related to the health and well-being of very young children (a narrower focus than the one informing the LMB's first report). Based on that analysis, the ECAC then established a series of goals, objectives and action steps designed to improve services in those areas whose indicators were poor. In 2005, the LMB released a second report, *Focus on the First Years* (BCLMB 2005), detailing the statistical findings and the resulting goals and objectives. The ECAC was subsequently reestablished as the Early Childhood Committee (ECC).

## 1.1 Purpose

The purpose of the current report is to update as much of the statistical data contained in the 2005 report as possible. As such, the same indicators selected for study in 2005 remain in effect (see complete list in table 1). A summary of progress on the indicators since the last report is shown at exhibit 1. The indicators are grouped under three issue areas that the ECC decided were crucial to the health and well-being of young children: (1) family support, (2) health and safety and (3) early care and education. The category called "family support" includes indicators affecting entire families, such as poverty

rates, unemployment, child homelessness and out-of-home placements. Under “health and safety” are indicators with a more direct relationship to child health and well-being, such as neonatal health indicators (e.g., low birth weight), child injuries and lead exposure. The third area, “early care and education,” contains indicators related to school readiness and availability of child care.

As in the 2002 and 2005 reports, the statistical analysis in the current report concerns itself not only with data from Baltimore County but also from five neighboring jurisdictions (shown in map 1): Anne Arundel County, Baltimore City, Carroll County, Harford County and Howard County. Continuing a practice adopted in the 2005 report, this report also studies various sub-areas of the county — in this case, census-designated places (CDPs) — in order to illustrate how widely indicator performance may vary throughout the county. The ECC, then called ECAC, selected seven such areas for the 2005 report: four made up of single CDPs (Baltimore Highlands/Lansdowne, Reisterstown, Parkville and Dundalk); and three made up of combinations of two CDPs (Woodlawn and Milford Mill, Mays Chapel

and Lutherville/Timonium, and Essex and Middle River). These areas, shown on map 2, are referred to throughout this report as the “selected CDPs.” (As discussed in section 3.2, updated data were not available for some indicators at the CDP level.)

## 1.2 Involvement

A large number of people contributed time and expertise to produce the report you are now reading. The LMB’s Early Childhood Committee, formerly the Early Childhood Action Committee, guided and shaped the project, drawing on its members’ extensive technical and policy knowledge. (As was the case with the 2005 report, the committee membership changed very little during its work on this report, demonstrating the members’ strong commitment to the project.) The committee’s activities were coordinated by the LMB office, particularly by Roe Davis, its executive director, and Don Schlimm, its program administrator. As with the previous reports, statistical research was performed by InterGroup Services, Inc., a local consulting company.

### Exhibit 1

Baltimore County’s percentage of children entering kindergarten assessed by the Work Sampling System as “fully ready” increased from 55 percent (SY 2002-03) to 77 percent (SY 2006-07).

In Baltimore County, alone among the metro-area jurisdictions, the percentage of babies at low birth weight decreased from 9.3 percent (in 2002) to 8.9 percent (in 2006).

As of July 2008, data show that Maryland Children’s Health Program (MCHP) enrollment has exceeded the old Early Childhood Action Committee’s (ECAC) original goal of increasing enrollment by 20 percent (from 11,096 enrollees at the beginning of CY 2004 to 21,452 enrollees in 2008), with an additional 2,121 applications pending.

The Baltimore County Department of Health, Bureau of Mental Health set aside funds for behavioral consultations for child-care center staff and parents of young children, and furthered these services for Baltimore County’s families through a partnership with Project ACT of the Abilities Network, Inc.

Baltimore County early childhood partners worked with the American Academy of Pediatrics (Maryland Chapter) and the state Department of Health and Mental Hygiene (DHMH) to pilot the implementation of early and periodic screening, diagnosis and treatment (EPSDT) guidelines for developmental screening.

Baltimore County Infants and Toddlers Program staff members are distributing a statewide universal referral form to pediatricians throughout the county, making referrals for families more efficient and consistent.

The Baltimore County Infants and Toddlers Program has experienced a 16 percent increase in the number of children and families receiving services, demonstrating improved public awareness and family education strategies.

To better coordinate resources and programs that provide early care and education for Baltimore County families, the Baltimore County health department created an early childhood division, which provides more of a focus on supports and services to improve outcomes for young children and their families.

To support parents and caregivers as their children’s first teachers, the Baltimore County Public Library created early literacy activity centers in all 17 branches, and created Storyville, a one-of-a-kind early learning and literacy center at the Rosedale branch.

With the leadership of the Local Management Board, ECAC partners collaborated to launch the Focus on the First Years web site ([www.focusonthefirstyears.info](http://www.focusonthefirstyears.info)), to provide easier access and increase awareness of public services and programs amongst families and those individuals who provide supports to families in Baltimore County.

## Chapter 2. County Update

Our previous report began with a discussion of various demographic statistics intended to provide background and context for the indicator data presented later. In this chapter, we present an update of the demographic data we presented in 2005. (For reasons described in section 3.2, updated census data are not available at the CDP level.)

### 2.1 County at a Glance

Baltimore County was chartered in 1659. At that time, the county's borders contained territory that would eventually be ceded for the creation of Cecil County, Harford County, Carroll County and Baltimore City (Bunting and D'Amario 2000). The county is currently the fourth-largest and third-most-populous jurisdiction in all of Maryland. Throughout most of the 20th century, Baltimore County's economy relied heavily on manufacturing, transportation and other commerce made possible by its deep-water ports and proximity to the Chesapeake Bay.

Today, the county has entered and is busily adapting to a post-industrial phase. With its proximity to Baltimore City and access to graduates from the nearby high-quality colleges, the county is now home to a variety of technology, finance, medical and other businesses and organizations.

### 2.2 General Demographics

With 787,384 residents in 2006, Baltimore County is the third-most populous county in Maryland, behind only Montgomery County and Prince George's County (BC 2008). Figure 1 compares Baltimore County's 2006 population with those of the other five metro-area jurisdictions. The second-most populous metro-area jurisdiction is Baltimore City, with 631,366 residents, followed by Anne Arundel County (509,300), Howard County (272,452), Harford County (241,402) and Carroll County (170,260). All of these population counts are higher than the 2000 counts we reported last time, even — in a relatively recent shift from net losses to net gains — Baltimore City's (BC 2008). The county continues to enjoy steady population growth that, while it has slowed slightly in recent years, shows no sign of stopping any time soon. In the 2005 report, we observed that "at no point since 1990 has county population declined," and this continues to be the case for the years 1997-2006, as shown in table 2. Since 1997, Baltimore County's population has increased faster (9.3 percent) than that of the metro region (7.2 percent), although not as fast as either Maryland (10.3 percent) or the metro region if Baltimore City is excluded (11.4 percent).

### 2.3 Child Demographics

Young children are a focus of this report, and so table 3 displays the numbers of children under 5 in the metro-area counties, the metro region and Maryland as a whole. As in our 2005 report, which presented population data on this age group from the years 1995-2002, Baltimore County currently has the largest number of 0-4-year-olds in the area, 46,562. The county is followed by Baltimore City (44,833), Anne Arundel County (33,533), Howard County (17,562), Harford County (14,864) and Carroll County (9,839) (BC 2008).

In 2005, we reported that Baltimore County's population

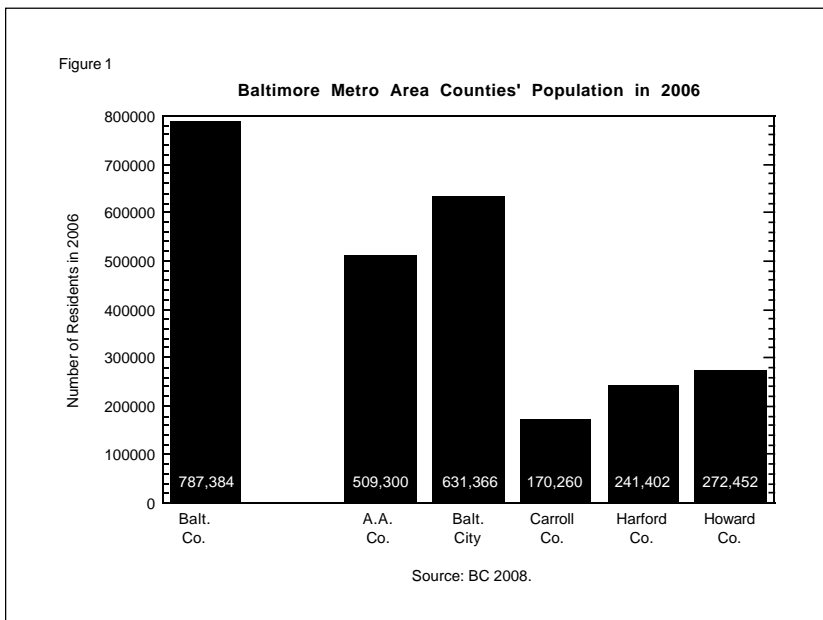


Table 2

**State, Regional and County Population Growth, 1997-2006:  
Population in Millions**

<b>Year</b>	<b>Maryland (x 1 million)</b>	<b>Metro Region (x 1 million)</b>	<b>Metro less City (x 1 million)</b>	<b>Baltimore Co. (x 1 million)</b>
1997	5.093	2.436	1.778	0.720
1998	5.130	2.441	1.795	0.722
1999	5.172	2.451	1.818	0.724
2000	5.312	2.517	1.868	0.756
2001	5.380	2.538	1.892	0.763
2002	5.441	2.554	1.917	0.769
2003	5.507	2.581	1.938	0.775
2004	5.553	2.597	1.956	0.780
2005	5.590	2.606	1.969	0.783
2006	5.616	2.612	1.981	0.787
<i>Growth, 1997-2006</i>	10.3%	7.2%	11.4%	9.3%

Source: BC 2001, 2008.

of 0-to-4-year-olds had declined slightly over the years 1995-2002. Over the most recent eight years now available, 1999-2006, this situation has reversed itself, and Baltimore County now leads its neighbors in the rate of growth of its population of children under 5. Baltimore County's growth rate

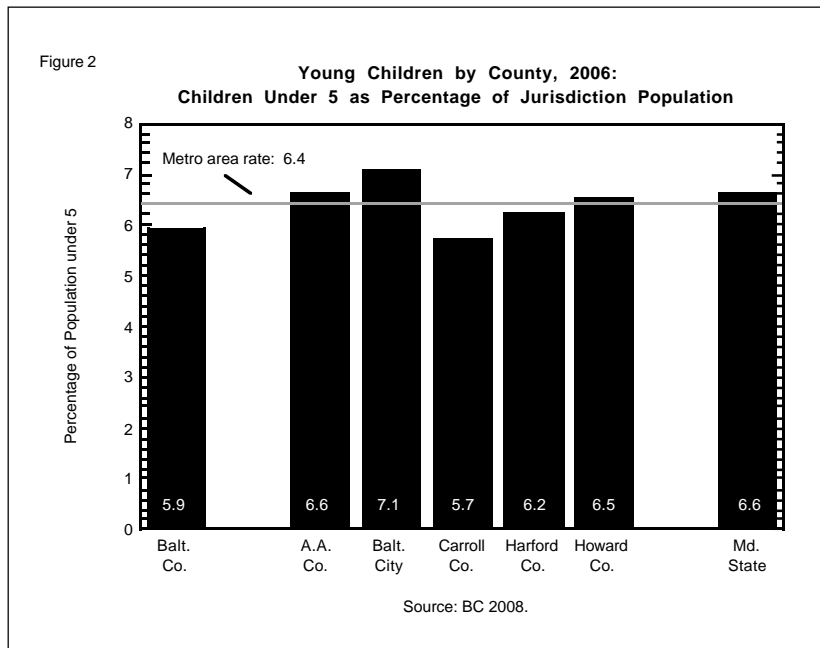
is 7.88 percent, followed by Anne Arundel County (6.52 percent) and Howard County (2.70 percent). The other three jurisdictions have seen decreases in the relative size of their populations of 0-to-4-year-olds since 1999. The smallest decrease was in Baltimore City (-2.58 percent), followed by Carroll

Table 3

**Young Child Population Trends by County and Year, 1999-2006:  
Number of Children Aged 0-4 by Jurisdiction**

<b>Jurisdiction</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>+/- %</b>
Baltimore Co.	43,160	45,252	45,299	46,287	45,803	46,677	47,238	46,562	7.88%
Anne Arundel Co.	31,480	33,083	33,344	33,759	34,008	34,344	34,543	33,533	6.52%
Baltimore City	46,020	41,694	42,534	44,862	44,009	46,557	47,197	44,833	-2.58%
Carroll Co.	10,170	10,110	9,912	9,686	9,576	9,670	9,726	9,839	-3.25%
Harford Co.	15,520	15,776	15,354	15,293	15,130	15,069	14,962	14,864	-4.23%
Howard Co.	17,100	18,248	18,069	18,200	18,132	18,102	18,148	17,562	2.70%
Maryland Statewide	346,850	353,393	356,302	365,545	364,507	374,578	381,487	368,199	6.16%
Metro Region	163,450	164,163	164,512	168,087	166,658	170,419	171,814	167,193	2.30%

Source: DHMH 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a.

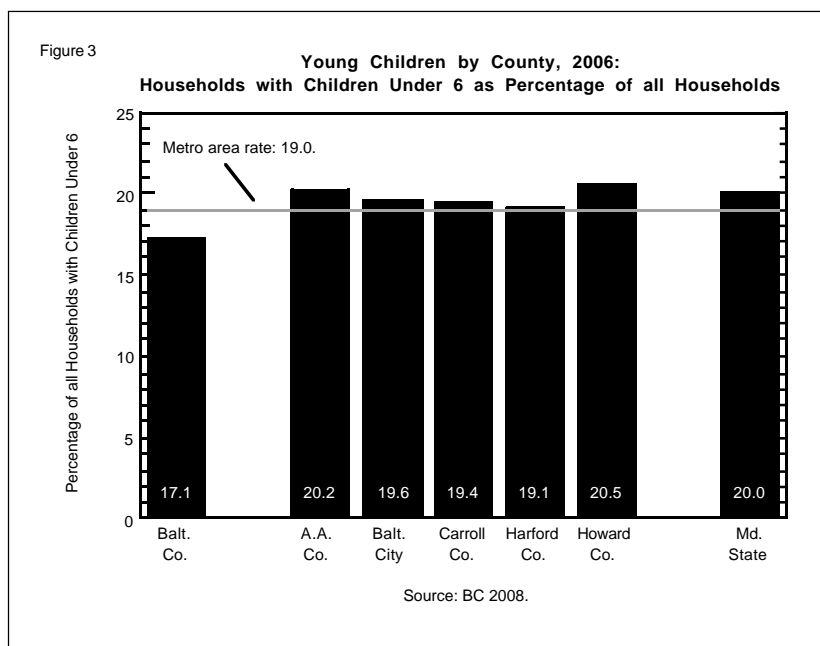


to last, behind Baltimore City (7.1 percent), Anne Arundel County (6.6 percent), Howard County (6.5 percent) and Harford County (6.2 percent). Only Carroll County has a lower proportion of under-5s among its residents than Baltimore County, and — at 5.7 percent — not by much. This is a change from 2000 (the data we reported in our 2005 report), when Baltimore County was in last place and Carroll County in fourth. Figure 2 also shows the 2006 percentages for the metro area and the state, 6.4 and 6.6, respectively (BC 2008).

County (-3.25 percent) and Harford County (-4.23 percent). Over the same period, the metro region saw a 6.16 percent increase (less than Baltimore County's), while the state saw only a 2.30 percent increase (BC 2008).

Figure 2 offers a slightly different view of this demographic, i.e., the percentage of each jurisdiction's population that consists of children under 5, as of 2006. Despite having the largest number of 0-to-4-year-olds, and despite leading its neighbors in the relative growth of this population, the Baltimore County rate (5.9 percent) comes in next

The U.S. Census Bureau also provides data on households, as opposed to individuals. Figure 3 shows the 2006 percentages of all households in each jurisdiction that have children under 6 (the most similar category of data available, rather than children under 5). In this case, Baltimore County comes in last, at 17.1 percent. First is Howard County (20.5 percent), followed by Anne Arundel County (20.2 percent), Baltimore City (19.6 percent), Carroll County (19.4 percent) and Harford County (19.1 percent). The metro-area rate is 19.0 percent, while the state's is 20.0 percent (BC 2008).



## 2.4 Racial Demographics

It will probably surprise no one to hear that the proportion of racial and ethnic minorities among Baltimore County's population continues to rise, but it is instructive to consider just how sizeable these changes have been. Figure 4 shows the relative proportions of African-Americans, Asian-Americans, Caucasians, Hispanics (a non-exclusive ethnic group) and Native Americans in Baltimore County for the years 1990, 2000 and 2006. In all cases

except that of Caucasians, the trend is upward. The African-American proportion grew from 12.4 to 24.4 percent; the Asian-American from 2.3 to 4.2 percent; the Hispanic from 1.2 to 2.7 percent; and the Native American from 0.2 to 0.3 percent. Caucasians, meanwhile, decreased from 85.0 to 68.7 percent of county residents (BC 2008).

Table 4 takes a longer view, considering minorities (i.e., non-whites) as one group. As the table shows, non-whites constituted a mere 3.6 percent of the county's population in 1970, compared to 18.6 percent of the state's population and 24.2 percent of the metro area's. By 2000, the county's proportional minority population was still lower (at 24.9 percent) than either the state's (34.0 percent) or the metro area's (32.2 percent). But, starting from such a lower level than either of the latter two entities, the county's rate of increase in proportional minority population during the years 1970-2000 was nothing short of astronomical, at 591.7 percent, compared to only 82.8 percent for the state and 33.9 percent for the metro area. The county's proportional rate of growth on this indicator continued to outpace the state's and area's through 2005; the county increase 2000-2005 was 17.7 percent, while the state's and area's were 5.6 and 5.9 percent, respectively. As a result, the county's 2005 propor-

tion of minority residents (29.3 percent) has edged even closer to those of the state and area, which currently have 35.9 and 34.1 percent, respectively.

## 2.5 Economics

As we reported in 2005, Baltimore County's economy continues to be primarily service based. Table 5 lists 20 employment categories represented in the county. Of these, the top 5 are (1) health care and social assistance (employing 15.87 percent of the workforce), (2) retail trade (15.80 percent), (3) accommodation and food services (8.32 percent), (4) finance and insurance (7.80 percent) and (5) manufacturing (7.35 percent). Of these, three have increased their share of the workforce since 1999,

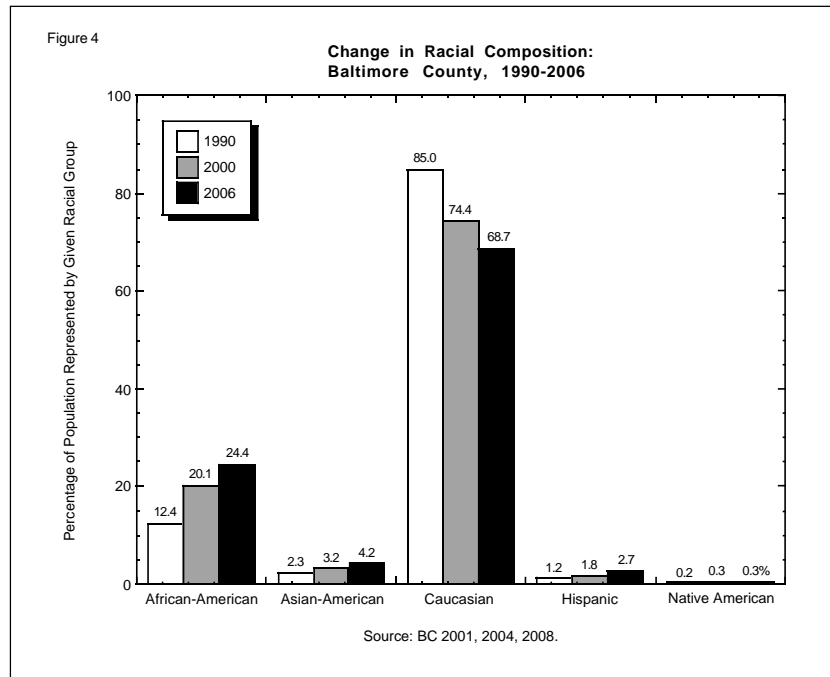


Table 4

**State, Regional and County Proportional Minority Population, 1970-2005:**  
**Minority Populations as Percentage of Entire Population**

<i>Jurisdiction</i>	<i>Year</i> 1970	<i>Year</i> 1980	<i>Year</i> 1990	<i>Year</i> 2000	<i>Growth</i> 70-00	<i>Year</i> 2005	<i>Growth</i> 00-05
Baltimore Co.	3.6%	10.0%	14.8%	24.9%	591.7%	29.3%	17.7%
Maryland Statewide	18.6%	25.1%	28.3%	34.0%	82.8%	35.9%	5.6%
Metropolitan Region	24.2%	27.2%	28.2%	32.2%	33.1%	34.1%	5.9%

Source: BC 2004; DOP 2004b, 2007.

Table 5

**Employment Type in Baltimore County, 1999 & 2005:  
Proportion Employed in Named Sector as a Percentage of Jurisdiction's Work Force**

<b>Sector</b>	<b>1999</b>	<b>2005</b>	<b>Change 99-05</b>
Forestry, fishing, hunting & agricultural support	0.02	0.03	50.0%
Mining	0.12	0.06	-50.0%
Utilities	0.24	0.15	-37.5%
Construction	6.34	7.08	11.67%
Manufacturing	9.50	7.35	-22.63%
Wholesale trade	4.08	4.40	7.84%
Retail trade	16.79	15.80	-5.9%
Transportation & warehousing	2.23	1.84	-17.49%
Information	2.33	2.70	15.88%
Finance & insurance	7.22	7.80	8.03%
Real estate, rental & leasing	2.64	2.51	-4.92%
Professional, scientific & technical services	6.74	7.33	8.75%
Management of companies & enterprises	2.92	2.45	-16.10%
Administration, support, waste management & remediation services	7.57	7.16	-5.42%
Educational services	1.85	2.29	23.78%
Health care & social assistance	14.97	15.87	6.01%
Arts, entertainment & recreation	1.20	1.48	23.33%
Accommodation & food services	7.69	8.32	8.19%
Other services (except public administration)	5.20	5.43	4.42%
Auxiliaries (except corporate, subsidiary & regional management)	0.39	n/a	n/a
Unclassified	0.06	0.03	-50.0%

Source: BC 1999, 2007a.

the most recent data presented in our 2005 report: health care and social assistance increased 6.01 percent; accommodation and food services increased 9.19 percent; and finance and insurance increased 8.03 percent. Retail trade and manufacturing, on the other hand, decreased by 5.9 and 22.63 percent, respectively (BC 2007a).

The fastest-growing categories over 1999-2005 were almost all in the lower half of the ranking by share of employees. The fastest-growing category, forestry, fishing, hunting and agricultural support, was 19th out of 20 in terms of share of employees (0.03 percent) in 2005, but that share represented a jump of 50 percent over its 1999 share. Next fastest growing was educational services. Ranked 14th by share of employees (2.29 percent), it had grown 23.78 percent since 1999. The third fastest was arts, entertainment and recreation (16th; share: 1.48 percent; growth: 23.33 percent), followed by information (11th; share: 2.70 percent; growth: 15.88 percent) and construction (8th; share: 7.08; growth: 11.67 percent) (BC 1999, 2007a).

The biggest decreases in employee share between 1999 and 2005 were in mining and "unclassified," which both saw drops of 50 percent, followed by decreases in utilities (37.5 percent), manufacturing (22.63 percent) and transportation and warehousing (17.49 percent) (BC 2007a).

From a discussion of employment, it is only natural to move next to income. Table 6 shows per capita incomes for the metro-area jurisdictions for the years 1970, 1980, 1990, 2000 and 2005. As can be seen in the table, Baltimore County and Baltimore City were the only two metro-area jurisdictions that saw less than 100 percent increases in per capita income between 1970 and 2000: 94.6 percent and 65.1 percent, respectively. However, in our 2005 report, which presented per capita income data through 2003, we wondered if a new trend might be developing, since the data then available showed the county in third place in per capita income growth between 2000 and 2003, the most recent year for which data were then available (DOP 2004a, 2004b, NASA 2008, DOP 2007).

Table 6

**State, Regional and County Per Capita Income, 1970-2005,  
In Constant 2000 Dollars**

<i>Jurisdiction</i>	<i>Year</i> <i>1970</i>	<i>Year</i> <i>1980</i>	<i>Year</i> <i>1990</i>	<i>Year</i> <i>2000</i>	<i>Year</i> <i>2005</i>	<i>Growth</i> <i>70-00</i>	<i>Growth</i> <i>00-05</i>
Baltimore Co.	18,406	23,389	29,825	35,823	39,801	94.6%	11.1%
Baltimore City	15,013	18,152	22,277	24,792	28,349	65.1%	14.3%
Anne Arundel Co.	15,755	21,911	28,303	36,464	40,942	131.4%	12.3%
Carroll Co.	15,120	20,781	26,866	32,371	33,073	114.1%	2.2%
Harford Co.	15,041	20,601	25,071	31,316	34,617	108.2%	10.5%
Howard Co.	19,224	27,939	35,015	43,648	47,160	127.0%	8.0%
Maryland Statewide	17,235	21,482	28,389	34,257	37,645	98.8%	9.9%
Metropolitan Region	16,272	21,192	27,082	33,282	37,078	104.5%	11.4%

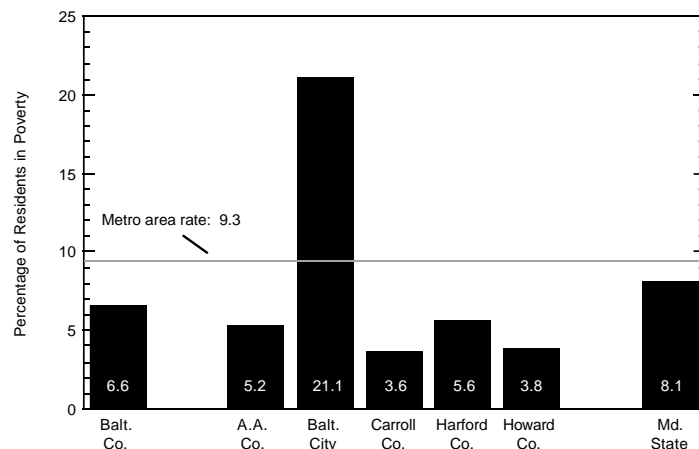
Source: DOP 2004a, 2004b, 2007; NASA 2008.

Indeed, this development is so far holding steady, for more recent data show Baltimore County’s per-capita-income growth still in third place compared to its neighbors, at 11.1 percent between the years 2000 and 2005. Baltimore City saw the highest increase (14.3 percent) over this same period, and Anne Arundel County’s increase (12.3 percent) also exceeded Baltimore County’s. These three were followed by Harford County (10.5 percent), Howard County (8.0 percent) and Carroll County (2.2 percent). In absolute terms, however, it was Howard County that had the highest actual 2005 per capita income, at \$47,160, followed by Anne Arundel County (\$40,942), Baltimore County (\$39,801), Harford County (\$34,617), Carroll County (\$33,073) and Baltimore City (\$28,349). The 2005 per capita income in Maryland was \$37,645, while that in the metro area was \$37,078 (DOP 2004a, 2004b, NASA 2008, DOP 2007).

This apparent increase in per capita income does not seem to have had much effect on the county’s poverty rate, however,

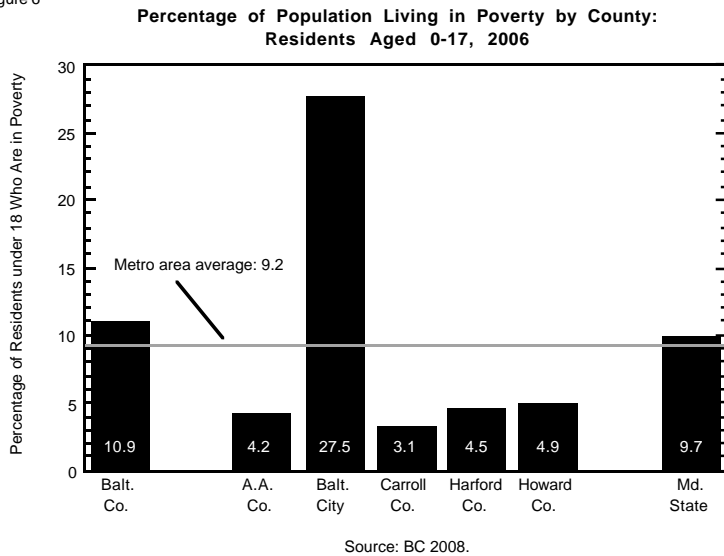
as can be seen in figure 5. In 2005, we reported data from the 2000 census showing that 6.7 percent of Baltimore County’s residents had incomes below the federal poverty line; by 2006, the year of the data presented in figure 5, this had barely changed to 6.6 percent, and the county was still second only to Baltimore City in terms of the proportion of residents living in poverty. The city’s rate was 21.1 percent, followed — as mentioned — by Baltimore County, which in turn was followed by Harford County (5.6 percent), Anne Arundel

Figure 5  
**Percentage of Population Living in Poverty by County:  
All Residents, 2006**



Source: BC 2008.

Figure 6



County (5.2 percent), Howard County (3.8 percent) and Carroll County (3.6 percent). The metro-area rate was 9.3 percent, and the state’s was 8.1 percent (BC 2008).

Even more disappointing, the 2006 rate of Baltimore County residents under the age of 18 who were living in poverty represented a 21.1 percent increase since 2000, while the area and state rates decreased during the same period by 30.3 and 9.3 percent, respectively. In 2000, the county’s rate was 9.0 percent, but — as shown in figure 6 — the 2006 rate was 10.9 percent. Baltimore City was the leader on this indicator, at 27.5 percent, followed — after Baltimore County — by Howard County (4.9 percent), Harford County (4.5 percent), Anne Arundel County (4.2 percent) and Carroll County (3.1 percent). The metro area rate was 9.2 percent; the state’s, 9.7 percent (BC 2008).

It is interesting to note that Howard County has the third highest rate of child poverty, considering that it is also the county with the highest per capita income. One possible explanation may be an increase in domestic and other low-wage workers in the county as wealthier people establish homes there.

Also, as shown later, in section 4.1.2, Howard County’s rate of female-headed households increased 20.2 percent between 2000 and 2006. Single motherhood is a circumstance associated

with poverty (NCPTP 2002), and, indeed, Howard County poverty data show quite a concentration of poverty in its female-headed families with young children, as discussed in section 4.2.3.

## Chapter 3. Methodology

This chapter describes the methodologies used in selecting indicators, researching data and deciding on goals and objectives.

### 3.1 Selection of Indicators

This report was conceived of as an update to the 2005 report; therefore, it adopts the same indicators used in that publication. Those indicators were selected over the course of several ECAC — now ECC — meetings in early 2004, when committee members considered examples from several similar projects performed in Maryland and then agreed on the fundamentals of (1) results and indicators and (2) goals and objectives.

For the results and indicators, it was determined that each needed to be directly related to the health and well-being of young children, each needed to be measurable and each needed to be comparable to data from other counties and the state as a whole. Goals and objectives, meanwhile, needed to address specific problems uncovered by the research; the action steps selected to achieve each goal needed to be realistically achievable; and the success or failure to achieve each goal or objective needed to be attributable to the committee's suggested strategies.

As part of this same process, the ECC also decided on the geographic areas about which data would be collected for each indicator. As in 2002, the ECC felt that Baltimore County data should be compared to data from those other counties making up the Baltimore metropolitan area, i.e., Baltimore City and Anne Arundel, Carroll, Harford and Howard counties. The thinking behind this comparison was that, since all six jurisdictions possess some similar attributes and face many of the same obstacles, it would be instructive for Baltimore County planners to see where their jurisdiction stands relative to these others.

In a departure from the process employed for the 2002 report, however, for the 2005 report the ECC decided to also collect data on certain selected areas within the county, so as to get a sense of the

disparities that a single, county-wide data point might otherwise conceal. After some review, it was determined that the most useful unit of subcounty analysis would be the “census-designated place” (CDP). CDPs are clusters of census tracts that conform more or less to residents' conception of given neighborhoods or named regions of a county. The Census Bureau also collects data at the ZIP-code level, but ZIP codes are often much larger than CDPs and cannot be said to describe cohesive neighborhood-like areas, so ZIP-level data would not have been as useful as CDP-level data.

Committee members worked with LMB staff and IGS, the consulting company, to select CDPs that were as representative as possible of the county's geographic, ethnic and economic mix:

- Lansdowne/Baltimore Highlands: In the southwest, a very low-income, predominantly white neighborhood.
- Woodlawn and Milford Mill: In the west, an established middle-income, African-American area.
- Reisterstown: In the northwest, a middle-income neighborhood with a substantial contingent of “new” whites, that is, recent immigrants, in large part from the former Soviet Union.
- Mays Chapel and Lutherville/Timonium: In the north, an established, middle- to upper-income white area.
- Parkville: In the northeast, an established middle-income, white neighborhood.
- Essex and Middle River: In the east, a fairly low- to middle-income area, predominantly white, but with increasing numbers of blacks and non-white immigrants.
- Dundalk: In the southeast, a low- to middle-income, long-established white neighborhood.

For a more detailed discussion of the original selection process for results/indicators, goals/objectives and intra-county areas, please see the 2005 report.

### 3.2 Comparative Research

Just as for the 2005 report, for this current report the LMB staff and IGS located data sources and compiled updated data for each indicator. Sources

included the U.S. Census Bureau, the state Department of Planning, the state Department of Health and Mental Hygiene, the state Department of Education, and many others. (See the bibliography for all sources.)

After this initial research was complete, IGS then prepared graphical representations of the collected data, in the form of bar graphs and — where historical data were available — trend-line graphs, just as it had done for the 2005 report. When graphs were not practical, the data were instead incorporated into tables. Though the original plan for this report was to update every category of data presented in the 2005 report, this did not turn out to be possible for census-based CDP-level data, as explained below.

By way of background, there are two main types of census data. The first type of census data are from the decennial census, last administered in 2000. The decennial census is the bureau's attempt to survey every household in the nation and this provides the most accurate information for the year it is given; obviously, however, one problem is that it is only given once every decade.

The second type of census material is from the relatively new American Community Survey (BC 2008). The purpose of the ACS is to supplement the decennial survey on an annual basis. As such, the ACS only attempts to contact a statistically representative sample of the population, rather than trying to reach everyone, as the decennial census tries to do. ACS data for various geographies are available from as early as 1999, but the full ACS was not administered until 2005. Those earlier "test" versions targeted more limited geographies than did the 2005 version and are not comparable to the decennial census (BC 2007b).

As of the 2005 survey, ACS data are now considered comparable to census 2000 data, with the exception of a very few data categories. Therefore, we used ACS data to update county-level census-based graphs in the current report to the year 2006 (the most recent year of ACS data available). However, such updates were not possible for CDP-level census data in this report (BC 2007b).

The reason we could not use ACS data to update CDP-level census data has to do with the ACS's emphasis on reporting from largest to smallest (first the nation, then the states, then the counties, etc.). That is, yearly sampling is performed in such a way as to sacrifice areas with populations less than 65,000: though each year of ACS surveying produces a data picture of the nation, states and counties, the bureau apparently does not contact enough households in each of the smaller entities to be able to report on them (BC 2007c). Since no Baltimore County CDPs have 65,000 or more residents, no updated census data were available at the intra-county level for this report.

Fortunately, data updates were available for all other CDP-level graphs and tables presented in 2005 with the exception of that report's figure 15, which showed the percentage of children under 5 living below the poverty level. However, figure 6 in the current report does show the percentage of all juveniles (i.e., everyone under age 18) living below the poverty level.

### 3.3 Selection of Goals and Objectives

As previously described, the purpose of this report is to provide an update of the LMB's 2005 publication, *Focus on the First Years*, itself a sequel to the LMB's well received 2002 report, *Focus on Families*. In addition to updating the statistical information presented in *Focus on the First Years*, the Early Childhood Committee also updated and adjusted the goals and objectives presented in that 2005 report.

Unlike in 2005, the ECC did not break into formal subcommittees for this round of planning. Instead, informal subcommittees composed of members specializing in the areas to be highlighted in the updated goals and objectives — e.g., substance abuse among pregnant women, access to prenatal care, etc.— were established as needed. These informal meetings assured the development of appropriate, practical goals for the coming years — goals that can be feasibly accomplished by committee members within their respective organizations, as well as by seeking the cooperation of collaborating agencies in the Baltimore area.

The process of setting the new goals and objectives involved many meetings of the Early Childhood Committee over a period of several months. IGS then compiled the results of the committee's deliberations. The ECC's final plan was approved and submitted to the full LMB for review on June 1, 2009. The final goals and objectives are found in chapter 5 of this report.

## Chapter 4. Results and Indicators

This chapter presents the statistical information on the LMB’s selected indicators of child and family well-being. It is this statistical information that is the basis for the LMB’s decisions concerning goals and objectives, as well as the basis for assessing progress toward such goals and objectives. Where possible, this chapter compares current information with that presented in the 2005 report, although changes in data-collection methodology and reporting prevent such comparisons in the cases of some indicators.

### 4.1 Family Cohesiveness

Under “family cohesiveness,” we group indicators that have more to do with the structure and stability of a family than with acute health or safety issues, although the latter are implicated here as well, if only indirectly. The “family cohesiveness” indicators discussed below are teen pregnancy, single motherhood and single-parent households.

#### 4.1.1 Teen Pregnancy and Single Motherhood

We consider teen pregnancy to be a counter-indicator of child and family well-being. This is not to judge the mothers themselves, who do after all find themselves in an extremely difficult situation. But, as we said in 2005, “no matter how devoted or conscientious a teenage mother may be, the fact is that teen pregnancy is associated with a host of negative outcomes for mother and child alike.”

These negative outcomes include elevated rates of premature birth and low birth weights, which in turn put babies at increased risk of infant death, deafness, blindness, respiratory problems and mental retardation (NCPTP 2002). As these babies grow up, they also face increased risk of failing in or dropping out of school (NCPTP 2002). Compared to women who have delayed pregnancy,

teen mothers themselves are also more likely to drop out of school, remain single, and experience poor health outcomes such as obesity and hypertension (NCPTP 2002).

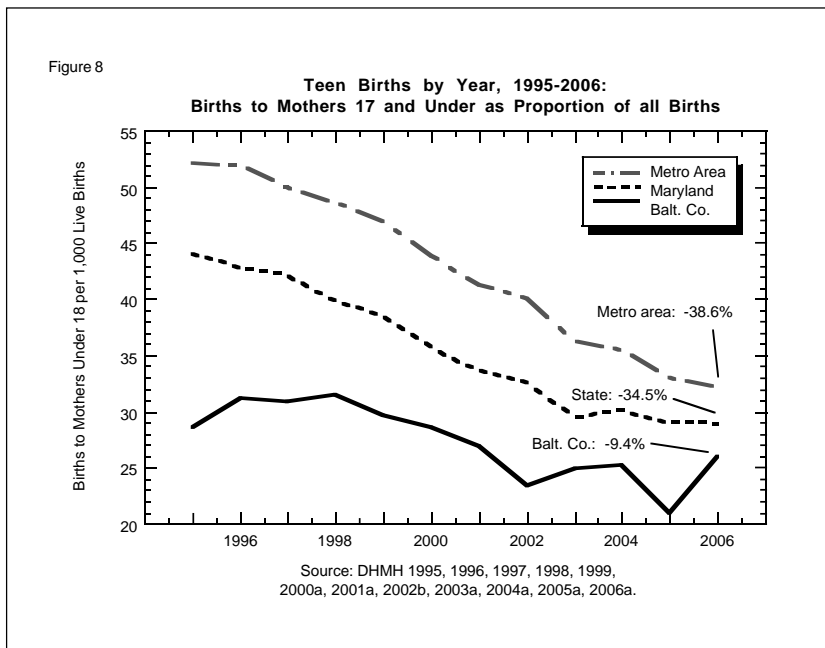
In 2005, we found that Baltimore County had had the third-highest rate of teen births out of all the metro-area jurisdictions in 2002, the most recent year of data then available. The county’s 2002 rate of births to teens was 23.3 per 1,000 births to all women, much lower than the city’s rate (90.5) but only slightly lower than the second-place jurisdiction’s, Anne Arundel County (25.5). As we put it in 2005, “Baltimore County has one of the higher rates of teen pregnancy among the metro counties.” However, the historical trend of this indicator over the years 1995-2002 tended toward decrease. The trend was consistently downward from 1998 (and close to flat 1996-1998). Over the entire period (1995-2002), the county’s rate decreased 18.3 percent, smaller than but similar to a metro-area decrease of 23.0 percent but substantially less than a statewide decrease of 26.1 percent (BCLMB 2005).

Current data show that the county’s relative performance on this indicator has worsened in the meantime, however. Figure 7, which presents teen births by county in 2006, shows not only that Baltimore County’s rate has increased 11.2 percent since 2002 (from 23.3 to 25.9 per 1,000) but also that Anne Arundel County’s rate has decreased enough that



Baltimore County now leads on this indicator among the non-city jurisdictions. Furthermore, only one other jurisdiction saw an increase over these years, Carroll County, where the rate rose from 13.7 per 1,000 in 2002 to 17.5 per 1,000 in 2006. Still in first place is Baltimore City, despite its dramatic 30.7 percent drop from 90.5 per 1,000 (in 2002) to 62.7 per 1,000. Second-place Baltimore County is followed by Anne Arundel County (19.7 per 1,000), Carroll and Harford counties (tied at 17.5 per 1,000), and Howard County (8.3 per 1,000). The state's rate is 28.8 per 1,000; the metro area's, 32.0 (DHMH 2006a).

Figure 8, which extends the last report's teen-births trend line up through 2006, gives a clearer sense of this rate's fluctuation over time. While the 1995-2002 portions of the three trend lines (the same portions we displayed in our 2005 report) showed a distinct downward tendency, figure 8 shows that — in Baltimore County — this trend immediately reversed itself during 2003 and 2004. And despite a sharp downturn between 2004 and 2005, the county's 2006 rate is noticeably higher than the 2002 rate, as described above. In aggregate, the trend line still shows an overall downturn over the years 1995-2006, but, because of the sharp rise in 2006, the overall rate of decrease is just 9.4 percent, as compared to the 18.3 percent decrease that the last report found for the years 1995-2002. It may be of interest to point out here that the actual *numbers* of teen births at each end of the Baltimore County trend line described above are 269 in 1995 and 258 in 2006, meaning that the county only experienced a 4.1 percent decrease in the number of teen births over this period. The considerably larger decrease in the *rate* of teen births per 1,000 live births to mothers of all ages is a result of the almost 6 percent increase in the number of births to non-teen mothers during this same period, from 9,148 in 1995 to 9,689 in 2006. (For more information on the overall birth rate in Baltimore



County, see section 4.5.) Between 1995 and 2006, the state's teen-birth rate decreased more than three and a half times as much as the county's rate, or 34.5 percent, while the area's rate decreased more than four times the county's rate, or 38.6 percent (DHMH 1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a).

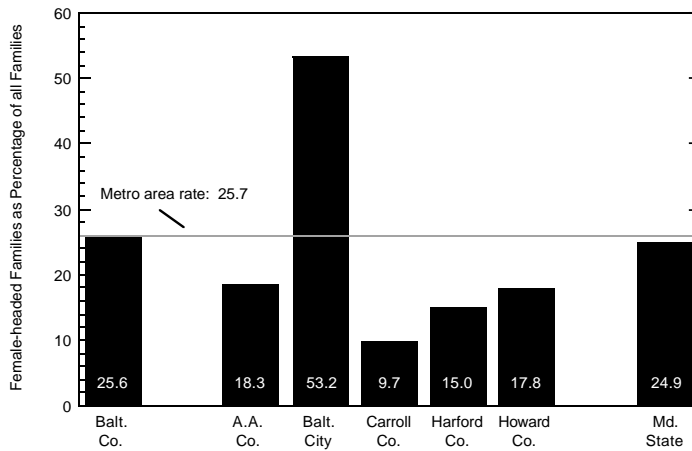
#### 4.1.2 Single-parent Households

To reiterate, teen mothers are more likely to remain unmarried than women who delay pregnancy (NCPTP 2002). As we said in 2005, "while no one wishes to disparage the effort and care that go into raising children alone, solo child-rearing is a circumstance associated with a variety of undesirable outcomes." These undesirable outcomes include an increased risk of the family's living in poverty; meanwhile, girls born to teen mothers are more likely than other children to give birth as teenagers themselves, while boys are more likely than other children to be incarcerated later in life (NCPTP 2002).

In 2005, we reported data on single-mother households from the 2000 census. At that time, Baltimore County led the non-city jurisdictions, with 23.9 percent of its households being female headed. The next highest rate was Anne Arundel County's, 18.1 percent, and the metro-area rate, driven upward by Baltimore City's rate of 52.2 percent, was 26.1 percent (BC 2001).

Figure 9

**Single-mother Households by County, 2006:  
Female-headed Families as Proportion of all Families**



Source: BC 2008.

In the ensuing years, most of the metro-area jurisdictions have seen increases in this rate, including Baltimore County. Figure 9 presents 2006 data on single-mother households. As the graph shows, the rate of female-headed households in Baltimore County has increased 7.1 percent since 2000, to 25.6 percent, nearly identical to the current metro-area rate of 25.7. Baltimore City has the highest rate (53.2 percent, up from 52.2 in 2000), followed by second-place Baltimore County, Anne Arundel County (18.3 percent, up from 18.1 in 2000),

Howard County (17.8 percent, up from 14.8 in 2000), Harford County (15.0 percent, down from 15.9 in 2000) and Carroll County (9.7 percent, down from 12.1 percent in 2000) (BC 2008).

## 4.2 Family Welfare

The “family welfare” indicators discussed in this section are all related to a family’s financial well-being. Of course, money is no guarantee of a safe and healthy childhood, but poverty is certainly not the optimal circumstance in which to raise healthy children.

### 4.2.1 Free/Reduced-price School Meals

Though the census does not report poverty data for young children as a population in non-census years, another way of estimating the extent to which children are affected by poverty is to examine the numbers of public-school students who receive free and reduced-price meals (F/RP). F/RP meals are a useful measure because they are provided through a federal program that bases eligibility on income levels. For children to receive

Table 7

**Free/Reduced-price School Meal Trends by County and Year, 1997-2007:  
Percentage of Children Receiving Service by Jurisdiction**

<i>Jurisdiction</i>	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	+/-%
Baltimore Co.	26.4	27.3	27.2	29.3	32.0	33.4	34.8	35.9	37.2	39.2	39.1	48.12%
Anne Arundel Co.	15.6	16.4	16.4	19.5	20.7	17.4	20.2	22.2	22.6	24.5	22.8	46.15%
Baltimore City	66.8	67.9	68.4	75.0	76.2	81.5	83.0	81.2	83.4	82.3	78.0	16.77%
Carroll Co.	9.5	9.3	9.2	10.5	9.7	8.9	9.5	10.4	10.5	11.7	13.6	43.16%
Harford Co.	17.4	17.6	16.8	12.3	19.4	18.7	20.4	23.4	23.4	24.7	24.6	41.38%
Howard Co.	10.0	10.6	10.3	10.8	10.0	9.8	7.2	5.0	10.2	11.4	12.8	28.00%
Maryland Statewide	30.9	30.9	30.5	35.0	36.0	36.7	37.3	37.1	38.1	38.8	38.0	22.98%
Metro Average	24.3	24.9	24.7	26.2	28.0	28.3	29.2	29.7	31.2	32.3	31.8	30.86%

Note 1: Figures from 1997 through 1999 are all grades; figures from 2000 through 2007 are elementary schools only.

Note 2: Metro figures are averages and are not directly comparable to the jurisdiction and state percentage figures.

Source: MSDE 2007c.

reduced-price meals, their families' incomes must be no more than 185 percent of the federal poverty line; to receive free meals, no more than 130 percent (FNS 2004). Because participation in this program is voluntary, it is worth pointing out that F/RP numbers may be lower than the actual numbers of children in given jurisdictions whose families' incomes fall into the above ranges.

In 2005, we presented F/RP-meals data for the years 1993 through 2003. At the time, we were struck not only by the fact that the county's rate of

F/RP-meal reciprocity (34.8 percent) was second only to Baltimore City's (83.0 percent) but also by the fact that the county's rate of increase in F/RP reciprocity over the years 1993-2003 (84.13 percent) was considerably higher than the rate of increase in any other metro-area jurisdiction, with the second-highest — Anne Arundel — ringing in at a comparatively low 54.20 percent (MSDE 2004c).

The overall picture described above is similar to what we now find for the years 1997 through 2007.

Table 8

**Free and Reduced-price Meal Reciprocity Trends by Area, 1997-2007:  
Percentage and Number of Receiving Free or Reduced Price Meals**

<i>SY Starting:</i>	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	+/- %
<b>L/BH</b>												
Total, FRPM	1,037	1,078	1,044	922	1,006	981	1,074	1030	1034	1098	1129	
Total, all	1,698	1,735	1,671	1,606	1,568	1,497	1,561	1506	1505	1593	1569	
<i>Pct. FRPM</i>	61.07	62.13	62.48	57.41	64.16	65.53	68.80	68.39	68.70	68.93	71.96	17.83%
<b>W&amp;MM</b>												
Total, FRPM	945	1,022	1,001	974	1,070	1,113	1,129	1100	1100	1254	1181	
Total, all	2,151	2,230	2,298	2,356	2,187	2,144	2,144	2108	2018	2136	2058	
<i>Pct. FRPM</i>	43.93	45.83	43.56	41.34	48.93	51.91	52.66	52.18	54.51	58.71	57.39	30.64%
<b>Rstwn</b>												
Total, FRPM	432	424	407	352	362	376	387	427	494	564	544	
Total, all	1,864	1,801	1,749	1,743	1,673	1,640	1,624	1641	1677	1705	1617	
<i>Pct. FRPM</i>	23.18	23.54	23.27	20.20	21.64	22.93	23.83	26.02	29.46	33.08	33.64	45.13%
<b>MC&amp;LT</b>												
Total, FRPM	31	24	41	38	30	39	37	38	40	45	59	
Total, all	1,002	986	998	963	930	897	915	923	888	881	951	
<i>Pct. FRPM</i>	3.09	2.43	4.11	3.95	3.23	4.35	4.04	4.12	4.50	5.11	6.20	100.65%
<b>Pkvl</b>												
Total, FRPM	226	236	242	203	243	252	293	306	324	351	375	
Total, all	1,313	1,274	1,195	1,171	1,094	1,090	1,068	1060	1041	1105	1093	
<i>Pct. FRPM</i>	17.21	18.52	20.25	17.34	22.21	23.12	27.43	28.87	31.12	31.76	34.31	99.36%
<b>E&amp;MR</b>												
Total, FRPM	1,540	1,460	1,535	1,292	1,375	1,323	1,325	1336	1302	1441	1343	
Total, all	2,145	2,026	1,995	2,004	1,951	1,843	1,832	1840	1804	1986	1888	
<i>Pct. FRPM</i>	71.79	72.06	76.94	64.47	70.48	71.79	72.33	72.61	72.17	72.56	71.13	-0.92%
<b>Ddlk</b>												
Total, FRPM	1,183	1,095	1,070	995	1,065	1,133	1,180	1240	1313	1345	1345	
Total, all	2,676	2,451	2,426	2,360	2,302	2,361	2,326	2351	2368	2467	2412	
<i>Pct. FRPM</i>	44.21	44.68	44.11	42.16	46.26	47.99	50.73	52.74	55.45	54.42	55.76	26.13%
<b>Baltimore Co.</b>	26.4	27.3	27.2	29.3	32.0	33.4	34.8	35.90	37.20	39.20	39.10	48.11%
<b>Md. Statewide</b>	30.9	30.9	30.5	35.0	36.0	36.7	37.3	37.10	38.10	38.80	38.00	22.98%

Source: MSDE 2007c.

As shown in table 7, Baltimore City still leads in F/RP-meal reciprocity, albeit with a slightly lower rate of 78.0 percent, and Baltimore County is still in second place, though with a slightly higher rate of 39.1 percent. These jurisdictions are followed by Harford County (24.6 percent), Anne Arundel County (22.8 percent), Carroll County (13.6 percent) and Howard County (12.8 percent). The statewide rate is 38.0 percent, while the average of the percentages from the metro area is 31.8 (MSDE 2007c).

Baltimore County also continues to lead in terms of rate of increase, 1997-2007, although by a good deal less than before (also shown in table 7). The Baltimore County rate of increase in F/RP-meal reciprocity was 48.12 percent, followed closely by Anne Arundel County (46.15 percent), Carroll County (43.16 percent), Harford County (41.38 percent), Howard County (28.00 percent) and Baltimore City (16.77 percent). During this same period, the state's rate increased 22.98 percent, while the average of the metro area's rates increased 30.86 percent (MSDE 2007c).

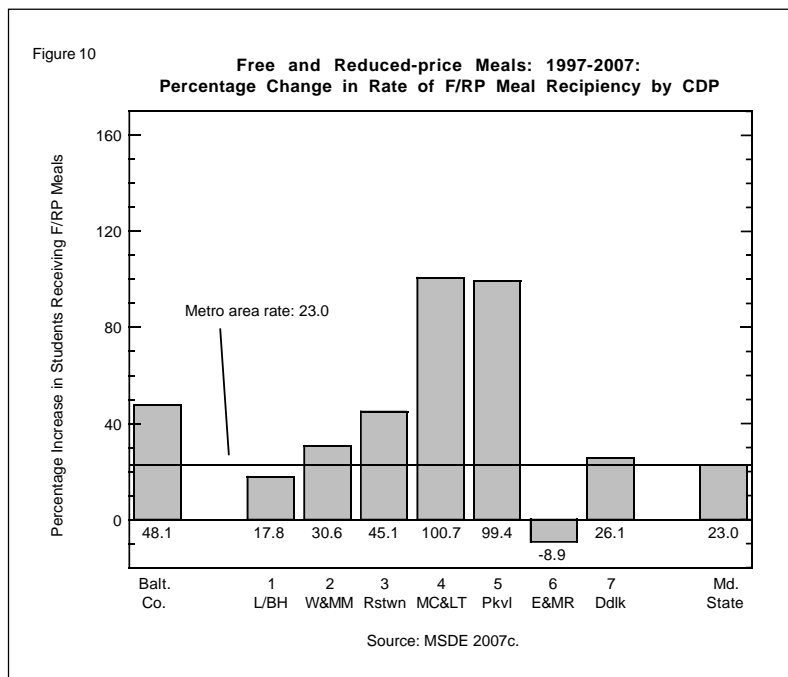
Among the CDPs studied for this report, relative rankings of F/RP reciprocity stayed fairly stable between 2003 (the most recent data available for our last report) and 2007, although rates of increase over time fluctuated. In 2003, the CDP with the highest rate of F/RP reciprocity was Essex and

Middle River, with a rate of 72.33 percent, followed by Lansdowne/Baltimore Highlands (68.80 percent), Woodlawn and Milford Mill (52.66 percent), Dundalk (50.73 percent), Parkville (27.43 percent), Reisterstown (23.83 percent) and Mays Chapel and Lutherville/Timonium (4.04 percent). Parkville saw by far the largest increase, 1993-2003, or 140.19 percent, followed by Woodlawn and Milford Mill (114.94 percent); the rest of the CDPs saw increases of less than 100 percent (MSDE 2007c).

Table 8 presents updated data on F/RP-meal reciprocity, this time for the years 1997 through 2007. As mentioned above, the relative ranking of CDPs by F/RP-meal reciprocity in 2007 (the most recent year of data available) remains similar to that we reported in 2005, with the only difference being the reversal of first and second place. This time, the leader is Lansdowne/Baltimore Highlands (71.96 percent), followed by Essex and Middle River (71.13 percent), Woodlawn and Milford Mill (57.39 percent), Dundalk (55.76 percent), Parkville (34.31 percent), Reisterstown (33.64 percent) and Mays Chapel and Lutherville/Timonium (6.20 percent) (MSDE 2007c).

However, the current leader in the rate of increase in F/RP-meal reciprocity is up from last place in our previous report. In 2003, Mays Chapel and Lutherville/Timonium had seen only a 14.45 percent increase in the proportion of children on F/RP in the previous 11 years. In 2007, however, this CDP's rate of increase over the previous 11 years jumped to 100.65 percent. Parkville followed, with an increase of 99.36 percent, while all the other CDPs showed increases less than half this size (MSDE 2007c). These changes in CDP-level rates of F/RP reciprocity are shown graphically in figure 10.

In 2007, the statewide F/RP-meal-reciprocity rate was 38.00 percent, while the metro area's was 39.20 percent. Since 1997, these rates have increased 22.98 and 48.11 percent, respectively (MSDE 2007c).

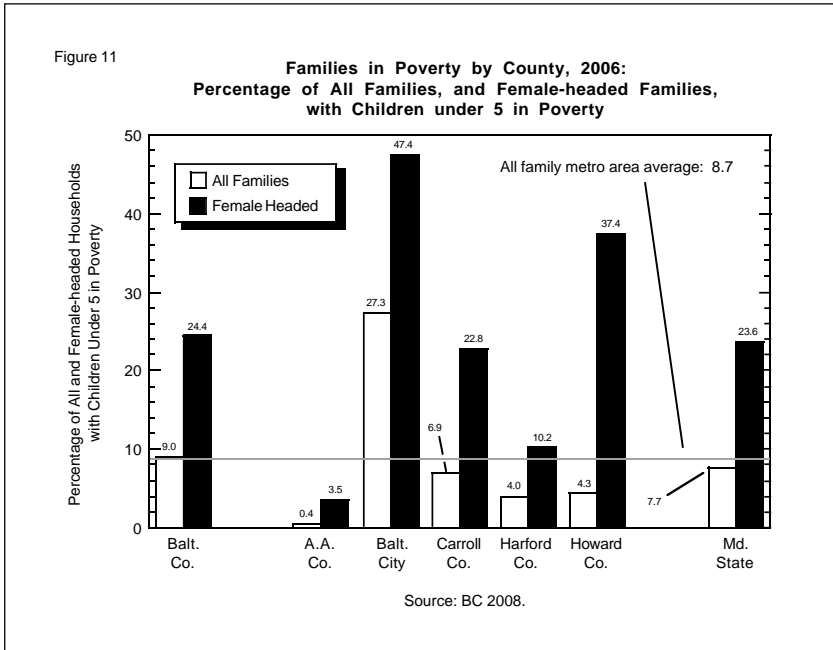


### 4.2.2 Children in Poverty

While the census does not report poverty data on young children as a population in non-census years, it does report poverty data on families with young children, a closely related statistic. Figure 11 shows the 2006 percentages of all households, and of female-headed households, that both (1) have children under 5 and (2) are in poverty. Baltimore County's rate of all families with children under 5 that are in poverty is the highest among the non-city jurisdictions, at 9.0 percent. Though the county's rate is less than a third that

of the city's (27.3 percent), the third-place finisher — Carroll County — lags considerably further behind, at 6.9 percent. Carroll County is followed by Howard County (4.3 percent), Harford County (4.0 percent) and Anne Arundel County (0.4 percent), while the metro-area and state rates are 8.7 and 7.7 percent, respectively (BC 2008). (The Anne Arundel figures are extraordinarily low, but these are what the census gives.) In all of these jurisdictions, the poverty rates of female-headed families with children under 5 vastly exceed the poverty rates of all families with children under 5, discussed above. Interestingly, despite leading the non-city jurisdictions not only on the latter indicator but also on overall poverty (see figure 5 in section 2.6), poverty affecting residents under 18 (see figure 6 in section 2.6) and F/RP-meal reciprocity (see table 7 in section 4.2.2), Baltimore County has only the third-highest rate of female-headed families with children under 5 in poverty, 24.4 percent. The highest rate is found once again in Baltimore City, 47.4 percent, followed by Howard County (37.4 percent), third-place Baltimore County, Carroll County (22.8 percent), Harford County (10.2 percent) and Anne Arundel County (3.5 percent). The state rate is 23.6 percent (BC 2008).

There are some significant differences between the situation described above and the one we reported in 2005. Examining 1999 poverty data (the most recent then available), we found that — while



Baltimore City had the highest poverty rates both for all families with young children and for female-headed families with young children (48.5 percent), and while Baltimore County was second-highest (at 8.3 percent) where all families were concerned, just as today — Baltimore County was actually in fourth place when it came to poverty rates of female-headed families with young children (26.8 percent) (BC 2008). Of further interest is that Baltimore County's current third-place finish on this indicator comes after a decrease of 9.0 percent. What this apparent contradiction means is that, however successful Baltimore County has been at lowering its poverty rate for female-headed families with young children, other counties have been even more successful. This success was most marked in Anne Arundel County, which reduced its poverty rate for female-headed families with children under 5 from 28.2 percent in 1999 to 3.5 percent in 2006, a remarkable 87.6 percent drop. Though such an extreme change could of course be the result of a data inaccuracy, it would certainly be worth a closer look at the precise circumstances behind Anne Arundel County's improvement in this area, to see if it is the result of special programs or interventions that might be adapted for use in Baltimore County. And militating against the likelihood of a data problem is the fact that Harford County, too, saw a rather large drop on this indicator over the same time period, from 35.5 percent in 1999 to 10.2 percent in 2006, or a decrease of 71.3 percent (BC 2008).

### 4.2.3 Unemployment

From a consideration of poverty, we turn to consideration of a closely related topic, unemployment. Before proceeding, it is important to explain what we mean by the term “unemployment.” In any community, of course, there may be many people who are not currently employed: homemakers, the elderly, young people and so on. On its surveys, the Census Bureau distinguishes between these categories and people who are (1) not currently employed and (2) have actively sought employment in the four weeks preceding survey administration (BLS 2004).

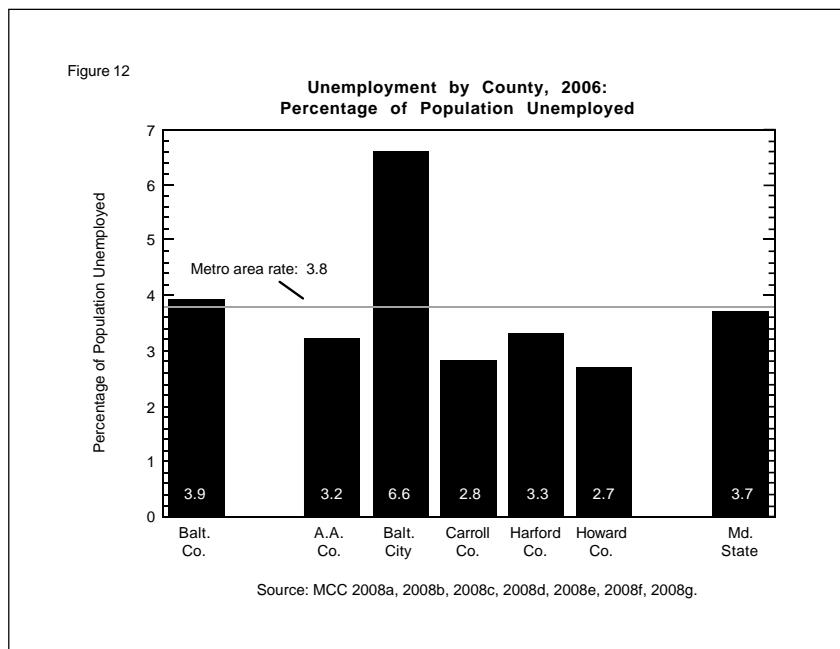
It is worth noting that this definition of unemployment risks excluding people who would otherwise be in the workforce but who have been unemployed long enough that they have grown discouraged and are no longer actively seeking work. In other words, official unemployment rates risk understating joblessness, particularly in areas like the Baltimore metropolitan region, where once broad-based employment sectors like manufacturing have collapsed and unemployment has, for many residents, become chronic.

Another detail to consider in any discussion of unemployment rates is the fact that economists define an unemployment rate of five percent as “full employment.” This definition is based on the idea that a certain level of unemployment will always exist due not only to firings or some work-

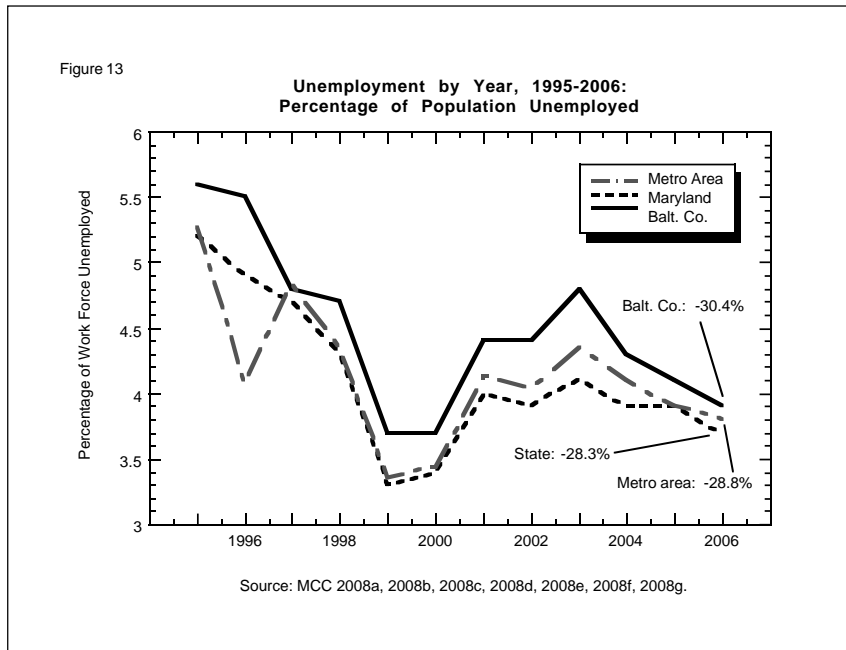
ers’ not possessing needed qualifications or credentials, but also to people finding themselves temporarily out of work during voluntary job changes. From the perspective of employers, unemployment rates below five percent may even be undesirable, since this is thought to result in difficulty finding sufficient applicants to fill new positions.

In 2005, we reported census-based data on unemployment rates in the Baltimore metro-area jurisdictions for 2003, the most recent data then available. At that time, all metro-area jurisdictions save Baltimore City had unemployment rates below five percent. The city’s rate was 8.4 percent, with Baltimore County next in line at 4.8 percent. These two jurisdictions were followed by Harford County (4.1 percent), Anne Arundel County (3.4 percent) and Carroll and Howard counties (tied at 2.7 percent). The average of all of the metro-area jurisdictions (as opposed to a rate) was 4.45 percent, while the statewide rate was 4.1 percent (MCC 2003, 2004a-f).

By 2006, four metro-area jurisdictions — including Baltimore County — had seen decreases in their unemployment rates. At the same time, Carroll County saw a tiny increase, while Howard County’s rate remained level. However, as can be seen in figure 12, the relative ranking remained essentially unchanged as of 2006. Baltimore City still led, with a 6.6 percent unemployment rate, followed by Baltimore County (3.9 percent), Harford County (3.3 percent), Anne Arundel County (3.2 percent), Carroll County (2.8 percent) and Howard County (2.7 percent). The metro region’s rate was 3.8 percent, while the state’s was 3.7 percent (MCC 2008a-g). To be sure, unemployment has risen since 2006: by November 2008, Baltimore County unemployment stood at 5.4 percent (EM 2009). However, such figures cannot be presented here because they are from a difference source from those shown on graphs 12 and 13.



These recent decreases come at the end of a long overall downward trend, though one that has had significant fluctuations. Figure 13 shows historical unemployment rates for Baltimore County, the metro area as a whole and Maryland during the years 1995-2006. In 2005, we presented these data through 2003 (the most recent year's data then available), at which point all three entities were experiencing a pronounced upswing in unemployment rates. But from 2003 through 2006, all three lines have trended downward once again. For the total period 1995-2006, Baltimore County's overall decrease was 30.4 percent, the metro area's was 28.8 percent and the state's was 28.3 percent. Also, during the period of decrease that began in 2003, Baltimore County's decrease has been slightly more pronounced than have the metro area's and state's (MCC 2008a-g).



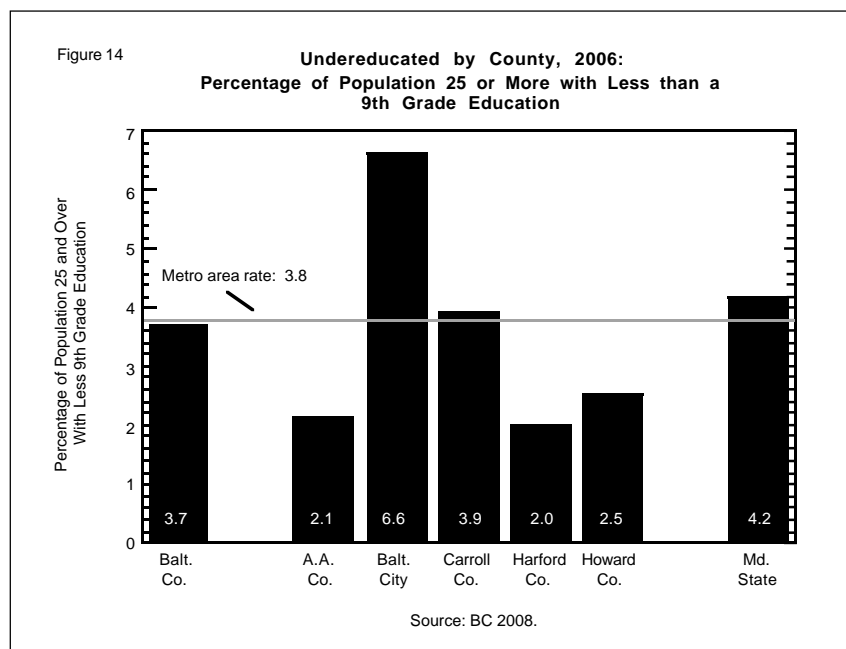
In 2005, we presented rates of people over 25 who had not gained a 9th-grade education (the most recent data available). The highest such rate was in Baltimore City, where 9.4 percent of over-25-year-olds did not have this attainment. Baltimore County had the next-highest rate, 4.9 percent, followed by Carroll County (4.6 percent), Harford County (3.9 percent), Anne Arundel County (3.7 percent) and Howard County (2.3 percent). The metro-area rate was 5.4 percent, and the state's was 5.1 (BC 2002). By 2006, however, Baltimore County's rate on this indicator had dropped fully 24.5 percent, more than the state's decrease (17.6 percent) though not as

### 4.3 Family Education

This section discusses several education-related indicators, from education levels among adults, to births to mothers lacking a high school diploma, to English proficiency.

#### 4.3.1 Adult Education

It is often stated that people with college degrees tend to earn more money than people without, but it is important to understand that what is being described here is not the addition of a little "surplus" income but, in many cases, the basis for simple survival, for "in any given year, the likelihood of slipping into poverty is about three times higher for high school dropouts than for those who have finished high school" (AEC 1999).



much as the metro area's (29.6 percent), as can be seen in figure 14. This drop was sufficient to move Baltimore County from second to third place, as well. Baltimore City still led, but with only 6.6 percent. Carroll County came next, with a rate of 3.9 percent, followed by Baltimore County (3.7 percent), Howard County (2.5 percent, the only increase), Anne Arundel County (2.1 percent) and Harford County (2.0 percent). The 2006 metro-area rate was 3.8 percent, while the state rate was 4.2 percent (BC 2008).

#### 4.3.2 Births to Undereducated Mothers

Because dropping out of high school carries with it a high risk of entering or remaining in poverty, dropouts who give birth place their children at risk of these outcomes as well. In fact, one study found that the offspring of an unmarried teen dropout is 10 times more likely to grow up in poverty than someone born to a married high school graduate (AEC 1999).

Our 2005 report presented data on births to undereducated mothers between the years 1995 and 2002, the most recent years of data then available. We found that, in 2002, Baltimore City had the highest rate of such births, which constituted 29.77 percent of all births in that jurisdiction. At the time, Baltimore County had the second-highest rate, 10.06 percent, followed by Anne Arundel County (9.45 percent), Harford County (8.27 percent), Carroll County (6.22 percent) and Howard County

(4.27 percent). The metro-area rate was 14.33, and the state rate was 13.47 percent. These rates had all increased over the years 1995-2002 except in Carroll County (DHMH 1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b; Sommers 2004).

Table 9 shows data on this indicator for the most recent available 10 years, 1997-2006. Looking at the 2006 column, some minor shifts in relative position since 2002 are apparent, in particular Baltimore County's move from second to third place. Also, all jurisdictions except Baltimore City have seen increases between 2002 and 2006. But the city's decrease — from 29.77 in 2002 to 28.72 in 2006 — was minor enough that it still holds the lead, followed by Anne Arundel County (11.21 percent), Baltimore County (11.17 percent), Harford County (8.42 percent), Howard County (8.08 percent) and Carroll County (7.23 percent). The 2006 metro rate is 15.31 percent, while the state's is 14.69 percent (DHMH 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a; Sommers 2007). Over the years 1997-2006, all metro area jurisdictions saw increases, except Baltimore City, where there was a decrease of 11.03 percent. The largest increase was in Howard County, at 115.47 percent, followed by Anne Arundel County (34.41 percent), Carroll County (24.66 percent), Baltimore County (15.63 percent) and Harford County (7.81 percent) (DHMH 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a; Sommers 2007).

Table 9

**Births to Undereducated Mothers Trends by County and Year, 1997-2006:**  
**Children Born to Mothers with No High School Diploma as Percentage of all Births in Jurisdiction**

<i>Jurisdiction</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>+/- %</i>
Baltimore Co.	9.66	9.21	9.67	9.81	9.12	10.06	9.82	9.61	10.57	11.17	15.63%
Anne Arundel Co.	8.34	8.59	7.94	8.42	9.21	9.45	8.01	10.31	11.17	11.21	34.41%
Baltimore City	32.28	31.45	31.08	30.93	30.21	29.77	29.42	28.60	29.44	28.72	-11.03%
Carroll Co.	5.80	5.62	7.06	5.75	5.25	6.22	5.98	6.33	6.65	7.23	24.66%
Harford Co.	7.81	8.31	8.75	9.72	9.43	8.27	8.36	7.66	7.96	8.42	7.81%
Howard Co.	3.75	4.10	3.32	3.59	3.97	4.27	4.74	5.24	6.13	8.08	115.47%
Maryland Statewide	12.15	12.78	13.15	13.17	13.05	13.47	13.13	13.54	14.22	14.69	20.91%
Metro Region	14.83	14.65	14.68	14.60	14.13	14.33	13.83	14.09	14.93	15.31	3.24%

Source: DHMH 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a; Sommers 2004, 2008.

In 2005 we wrote that “1 in 10 Baltimore County babies is born to a mother who has dropped out or otherwise not completed high school, which portends ill for the employability and general well-being of such children as they grow older.” Since then, this proportion has grown steadily and appears likely to keep doing so.

#### 4.3.3 Limited English Proficiency

A diverse community offers much of value to all of its residents, but, as we observed in 2005, “the fewer county residents there are who share the same language, the more that county’s resources will be stretched and the greater the chance that some residents may remain unaware, or unable to take advantage, of certain services available to them.” This section presents information on those county residents who speak English as a second language (ESL).

The 2005 report presented 2000 census data on residents over the age of 5 for whom English was not the first language as well as those who, in addition, reported speaking English “less than very well.” In both categories, Howard County was by far the leader, with 14.0 percent of its population falling into the former and 4.8 percent into the latter. But Baltimore County was in a solid second place, with 9.6 percent speaking English as a second language and 3.6 percent doing so less than very well, followed by Baltimore City (7.8 and 3.0 percent), Anne Arundel County (7.3 and 2.5 percent), Harford County (5.7 and 1.7 percent) and Carroll County (4.2 and 1.2 percent). The 2000 metro-area rate for English as a second language was 8.1 percent, while the state’s was 5.0 (BCLMB 2005).

Data from 2006 show increases in both categories for all metro-area jurisdictions except Harford County, with current (2006) rates shown in figure 15. (The Census Bureau did not report this category of data for Carroll County in 2006.) Howard

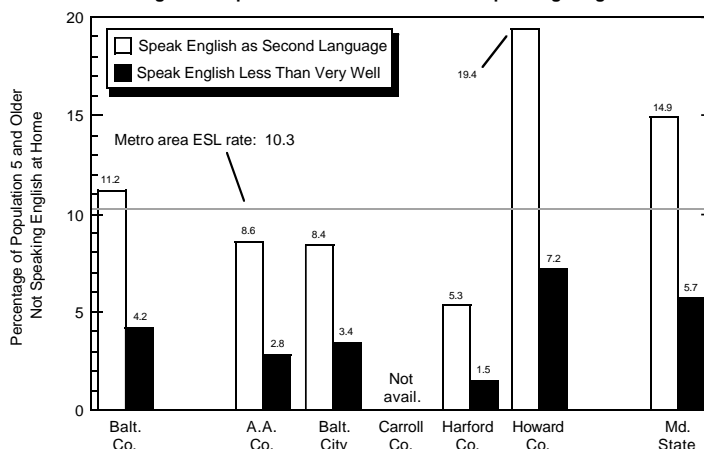
County still leads, with 19.4 percent of residents speaking English as a second language and 7.2 percent doing so less than very well, followed by Baltimore County (11.2 and 4.2 percent), Anne Arundel County (8.6 and 2.8 percent), Baltimore City (8.4 and 3.4 percent) and Harford County (5.3 and 1.5 percent). The metro-area ESL rate is 10.3 percent; the state’s is 14.9 percent (BC 2008).

Of even more pressing concern for the purposes of this report, of course, are the rates of children who speak English poorly enough that they require special services in school, a status that the Maryland State Department of Education (MSDE) calls “limited English proficiency” (LEP). Our 2005 report found that, as of 2003 (the most recent data then available), Howard County had the highest percentage of such students (4.2 percent), followed by Baltimore County (3.1 percent). To that point, however, Baltimore County had seen the second-lowest rate of increase on this indicator since 1993, with all other jurisdictions except Carroll County (which had seen no change at all compared to 1993) seeing increases between 200 and 500 percent.

It is interesting, then, to see in table 10 that, as of 2007, Baltimore County now has the largest proportion of LEP students (5.0 percent) in the metro area, albeit not much larger than Howard County’s (4.8 percent). These two are followed by Anne Arundel County (2.9 percent), Baltimore City (2.3

Figure 15

**English as a Second Language by County, 2006:  
Percentage of Population 5 and Above not Speaking English at Home**



Source: BC 2008.

Table 10

**Linguistic Trends by County and Year, 1997-2007:  
Percentage of Children with Limited English Proficiency by Jurisdiction**

<i>Jurisdiction</i>	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	+/-%
Baltimore Co.	1.3	1.3	2.1	2.2	2.5	2.9	3.1	3.3	3.6	4.2	5.0	284.62%
Anne Arundel Co.	0.6	0.7	0.6	0.9	1.7	2.1	2.2	2.3	2.5	2.6	2.9	383.33%
Baltimore City	0.5	0.5	0.7	0.9	1.1	1.5	1.4	1.6	1.8	2.2	2.3	360.00%
Carroll Co.	0.2	0.3	0.5	0.3	0.5	0.4	0.2	0.4	0.6	0	0.9	350.00%
Harford Co.	0.4	0.5	0.7	0.8	0.8	0.9	1.2	1.1	1.4	1.5	1.7	325.00%
Howard Co.	2.2	2.3	3.1	3.2	3.7	3.9	4.2	3.0	0	4.1	4.8	118.19%
Maryland Statewide	2.0	2.1	2.6	3.0	3.8	4.1	4.2	4.8	4.9	5.6	6.7	235.00%
Metro Average	0.9	0.9	1.3	1.4	1.7	2.0	2.1	2.0	1.7	2.4	2.9	222.22%

Note 1: Figures from 1997 through 1999 are all grades; figures from 2000 through 2007 are elementary schools only.

Note 2: Metro figures are an averages and are not directly comparable to the jurisdiction and state percentage figures.

Source: MSDE 2004c, 2007c.

percent), Harford County (1.7 percent) and Carroll County (0.9 percent). The metro area as a whole has a rate of 2.9 percent, and the state 6.7 percent. Table 10's data go back to 1997; since that time, the largest increase in the LEP percentage has been in Anne Arundel County (383.33 percent), followed by Baltimore City (360.00 percent), Carroll County (350.00) percent), Harford County (325.00 percent), Baltimore County (284.62 percent) and

Howard County (118.19 percent). Over the same period, the metro average (as opposed to rate) has increased 222.22 percent, while the state's rate has grown by 235.00 percent (MSDE 2007c).

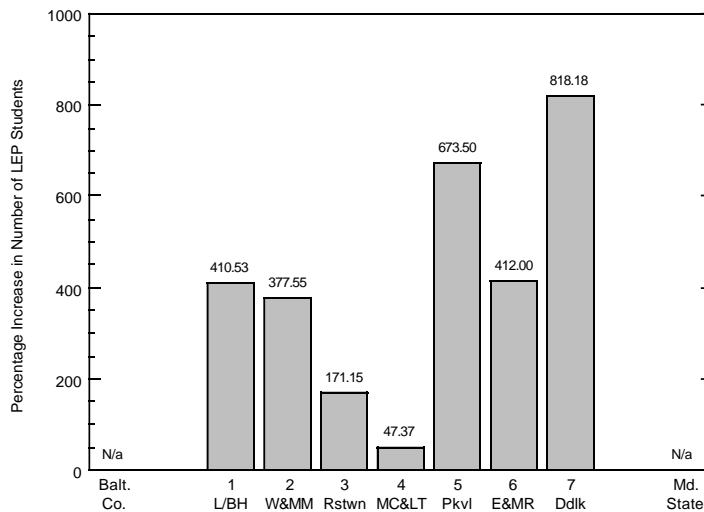
Within Baltimore County, most of the selected CDPs had higher 2007 rates of LEP students than did the county as a whole. Table 11 has Woodlawn and Milford Mill in the lead, with LEP students

representing 11.37 percent of the student body, followed by Reisterstown (8.72 percent), Essex and Middle River (6.78 percent), Dundalk (6.48 percent), Lansdowne/Baltimore Highlands (6.18 percent), Parkville (5.40 percent) and Mays Chapel and Lutherville/Timonium (2.94 percent) (MSDE 2007).

As for changes in the number, not rate, of LEPs among the selected CDPs from 1997 through 2007, figure 16 presents these in bar graph form. What is most striking here is the wide range of change, from a mere 47.37 percent in

Figure 16

**Limited English Proficiency, 1997-2007:  
Percentage Increase in Number of LEP Students by CDP**



Source: MSDE 2007c.

Table 11

**Limited English Proficiency Trends by Area, 1997-2007:  
Percentage and Number of Children Defined as LEP Students**

<i>SY Starting:</i>	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	+/- %
<b>L/BH</b>												
Total, LEP	19	16	28	24	29	49	48	51	64	76	97	
Total, all	1,698	1,735	1,671	1,606	1,568	1,497	1,561	1,506	1,505	1,593	1,569	
<i>Pct. LEP</i>	1.12	0.92	1.68	1.49	1.85	3.27	3.07	3.39	4.25	4.77	6.18	451.79%
<b>W&amp;MM</b>												
Total, LEP	49	64	92	99	115	134	122	130	149	197	234	
Total, all	2,151	2,230	2,298	2,356	2,187	2,144	2,144	2,108	2,018	2,136	2,058	
<i>Pct. LEP</i>	2.28	2.87	4.00	4.20	5.26	6.25	5.69	6.17	7.38	9.22	11.37	398.68%
<b>Rstwn</b>												
Total, LEP	52	59	73	79	83	71	99	107	106	127	141	
Total, all	1,864	1,801	1,749	1,743	1,673	1,640	1,624	1,641	1,677	1,705	1,617	
<i>Pct. LEP</i>	2.79	3.28	4.17	4.53	4.96	4.33	6.10	6.52	6.32	7.45	8.72	212.54%
<b>MC&amp;LT</b>												
Total, LEP	19	23	24	19	21	22	26	21	16	22	28	
Total, all	1,002	986	998	963	930	897	915	923	888	881	951	
<i>Pct. LEP</i>	1.90	2.33	2.40	1.97	2.26	2.45	2.84	2.28	1.80	2.50	2.94	54.74%
<b>Pkvl</b>												
Total, LEP	8	7	5	14	16	19	31	37	34	45	59	
Total, all	1,313	1,274	1,195	1,171	1,094	1,090	1,068	1,060	1,041	1,105	1,093	
<i>Pct. LEP</i>	0.61	0.55	0.42	1.20	1.46	1.74	2.90	3.49	3.27	4.07	5.40	785.25%
<b>E&amp;MR</b>												
Total, LEP	25	17	29	43	44	56	68	66	76	96	128	
Total, all	2,145	2,026	1,995	2,004	1,951	1,843	1,832	1,840	1,804	1,986	1,888	
<i>Pct. LEP</i>	1.17	0.84	1.45	2.15	2.26	3.04	3.71	3.59	4.21	4.83	6.78	479.49%
<b>Ddlk</b>												
Total, LEP	11	12	15	15	36	38	54	56	73	99	101	
Total, all	2,676	2,451	2,426	2,360	2,302	2,361	2,326	1,302	984	1,639	1,559	
<i>Pct. LEP</i>	0.41	0.49	0.62	0.64	1.56	1.61	2.32	4.30	7.42	6.04	6.48	1,480.49%
<b>Baltimore Co.</b>	1.3	1.3	2.1	2.2	2.5	2.9	3.1	3.3	3.6	4.2	5.0	284.6%
<b>Md. Statewide</b>	2.0	2.1	2.6	3.0	3.8	4.1	4.2	4.8	4.9	5.6	6.7	235.0%

Note: The MSDE does not report where fewer than five LEP students are present in a school (to protect the students' confidentiality). For the purposes of this table, incidents of fewer than five students are counted as zero students.

Source: MSDE 2004c, 2007c.

Mays Chapel and Lutherville/Timonium to a large 818.18 percent in Dundalk, albeit from a small 1997 base of only 11 LEP children. Four of the seven CDPs saw increases of 400 percent or more, and two saw increases larger than 600 percent, Parkville and the aforementioned Dundalk. Though these CDPs cannot necessarily be said to be representative of other parts of the county, one lesson is clear: some parts of the county are experiencing lightning-fast change from relative homogeneity to

increasing language diversity, while other areas are little unaffected.

#### 4.4 Family Breakdown

Policy makers working on issues of child health and well-being know that they can depend on the vast majority of parents' and guardians' having their children's best interests at heart. It is sometimes the case, however, that even parents with the

best of intentions may be unable to act on those intentions; at the same time, parents wrestling with their own problems — poor health, substance abuse, incarceration — may lose sight of their children’s best interests. Children whose families are no longer able to protect and provide for them adequately face risks from all sides — risks to their immediate physical safety as well as their long-term health. It is vital that we monitor these vulnerable children to ensure that we are doing everything we can to improve their prospects. Therefore, this section considers three indicators related to family breakdown: child homelessness, out-of-home placements and grandparent placements.

#### 4.4.1 Child Homelessness

It is difficult to imagine a circumstance more detrimental to a child’s well-being than homelessness. The problems extend well beyond the health risks and physical dangers of living on streets or in shelters, to difficulties in school due to inadequate rest, frequent moves and transfers, and lack of school supplies or supplemental learning resources in the family.

Our 2005 report presented the rate of homeless juveniles per 1,000 0-17-year-olds in each metro-area jurisdiction, for the years 2001-2003, the most

recent data then available. The 2003 data had Baltimore County’s rate of juvenile homelessness ranked third in the area, at 3.71 per 1,000, behind Baltimore City (13.12 per 1,000) and Anne Arundel County (3.79 per 1,000). And Baltimore County was one of only two metro-area jurisdictions to have seen an increase in this rate over the years 2001-2003, the other being Carroll County (DHR 2001, 2002, 2003).

Table 12 presents these same 2001-2003 data, along with data covering the years 2004-2006. Not surprisingly, given the increase in Baltimore County’s rate observed in the last report, the county now has the second-highest rate of juvenile homelessness among metro-area jurisdictions. Baltimore City still leads, at 13.12 per 1,000, followed by Baltimore County (5.84 per 1,000), Howard County (4.93 per 1,000), Harford County (3.23 per 1,000), Anne Arundel County (3.09 per 1,000) and Carroll County (2.63 per 1,000). The state and metro-area rates were similar to each other — and higher than Baltimore County’s — at 6.49 and 6.55 per 1,000, respectively (DHR 2001, 2002, 2003, 2004, 2005, 2006).

As also shown in table 12, over the years 2001-2006, Baltimore County had by far the greatest increase in its rate of juvenile homelessness, 93.38 percent, followed by Carroll County (16.37 percent) and Howard County (4.23 percent). The rest saw decreases, the smallest being in Harford County (6.92 percent), joined by larger decreases in Baltimore City (17.17 percent) and Anne Arundel County (39.29 percent). Given that the statewide and area rates have been on the decline as well (by 8.72 and 4.10 percent, respectively), it seems possible that Baltimore County may overtake them before long (DHR 2001, 2002, 2003, 2004, 2005, 2006).

Table 12

**Child and Youth Homelessness Trends by County and Year, 2001-2006:  
Number of Homeless Persons 0-17 per 1,000 of Total Population 0-17**

<i>Jurisdiction</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>+/- %</i>
Baltimore Co.	3.02	3.19	3.71	2.75	5.08	5.84	93.38%
Anne Arundel Co.	5.09	4.26	3.79	4.03	3.12	3.09	-39.29%
Baltimore City	15.84	17.19	12.85	13.42	12.78	13.12	-17.17%
Carroll Co.	2.26	3.41	2.69	2.37	2.54	2.63	16.37%
Harford Co.	3.47	3.91	3.46	4.03	3.08	3.23	-6.92%
Howard Co.	4.73	4.75	1.68	5.19	5.47	4.93	4.23%
Maryland Statewide	7.11	6.37	6.31	6.65	6.06	6.49	-8.72%
Metro Region	6.83	7.14	5.68	6.04	6.30	6.55	-4.10%

Note: Total 0-17 population data for 2003 not available, 2002 data used instead.

Source: DHR 2001, 2002, 2003, 2004, 2005, 2006; DHMH 2001a, 2002b, 2003a, 2004a, 2005a, 2006a.

**4.4.2 Out-of-home Placements**

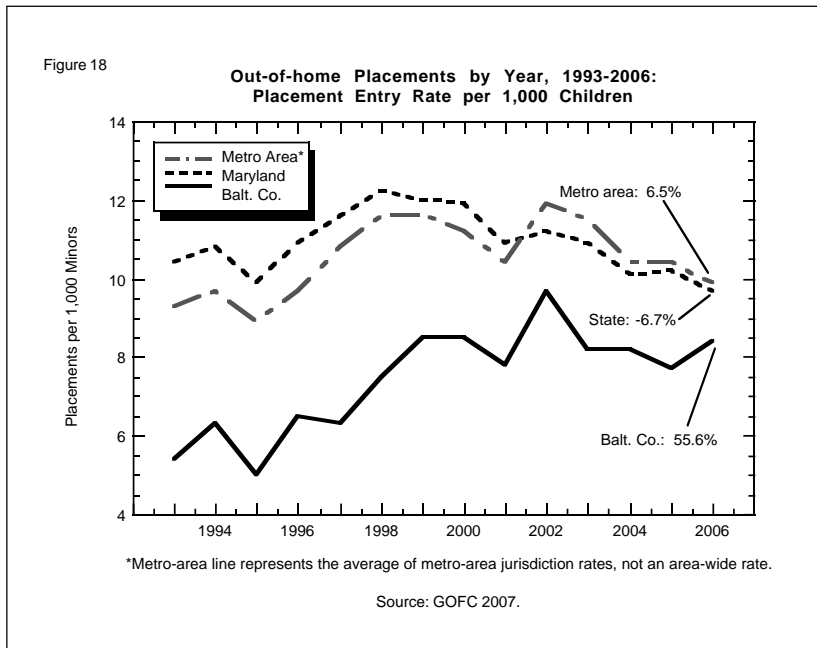
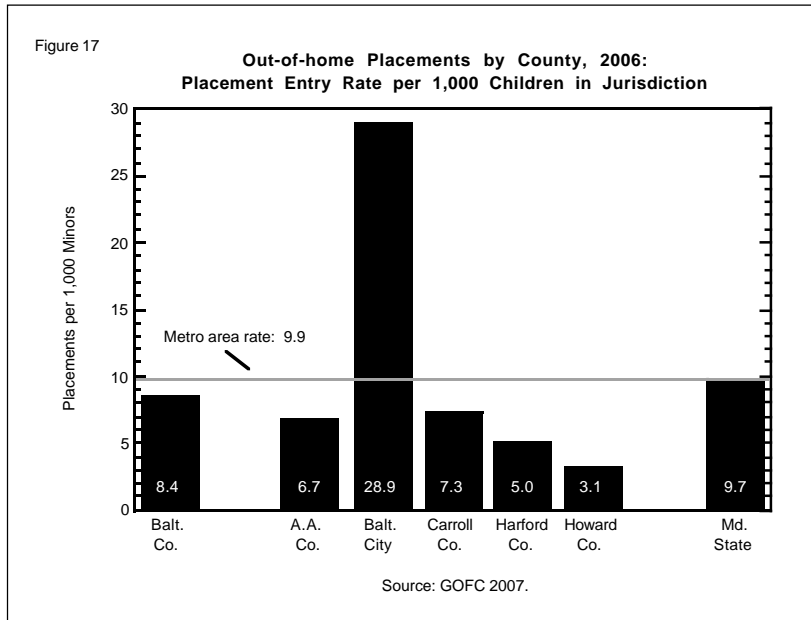
We turn now to the subject of out-of-home placements, or children who are being cared for by someone other than their parents or legal guardians. As used here, the term “out-of-home placement” refers to children in paid foster/kinship care, detention, RICA (Regional Institutes for Children and Adolescents) placements, community placements, intermediate care facilities, long-term/aftercare residential programs, purchase-of-care placements, individual family care placements, and public/non-public residential treatment centers. Publicly available data do not distinguish among out-of-home placements by age of child, so all data discussed below refer to children ages 0-18.

In our last report, we published data on out-of-home placements in 2003, the most recent data then available. Baltimore City was the clear leader, with 34.0 placements per 1,000 children. Baltimore County was in third place with 7.5 per 1,000, lagging only slightly behind Carroll County, which had a rate of 7.7 per 1,000. Since 1993, Baltimore County had seen a 38.9 percent increase in this rate, while the metro area had seen only a 15.1 percent increase (to 11.0 percent). The state’s 1993 and 2003 rates, 10.4 per 1,000, were identical (OCYF 2003).

Figure 17 shows 2006 data on out-of-home placements. As can be seen, Baltimore County’s rate has increased since 2003, and the county is now in second place. Baltimore City remains the leader, though with a significantly lower rate of 28.9 per 1,000, followed by Baltimore County (8.4 per 1,000), Carroll County (7.3 per 1,000), Anne Arundel County (6.7 per 1,000), Harford County (5.0 per 1,000) and

Howard County (3.1 per 1,000). Of these jurisdictions, Baltimore and Anne Arundel counties were the only ones to see an increase over this time. The state and area rates decreased as well, to 9.7 and 9.9 per 1,000, respectively (GOC 2007).

Figure 18 adds the years 2004-06 to the 1993-2003 trend line we published previously. Over this expanded period (1993-2006), Baltimore County’s rate increase is 55.6 percent. The metro area rate increase is only 6.5 percent, while the state has experienced a decrease of 6.7 percent (GOC 2007).



We noted in 2005 that, given the relative rates of change in this rate among the county, metro area and state, Baltimore County is on track to overtake the other two; the updated data continue to support the likelihood of such a possibility.

#### 4.4.3 Grandparent Placements

In addition to the more formal, publicly funded care situations discussed in the previous section, it is also sometimes the case that grandparents may become the caregivers for their grandchildren. In many cases, this circumstance is the best possible alternative to parental care that may have become untenable or even impossible for any number of reasons — health, death, incarceration, etc. — and so we do not mean to imply any criticism of grandparents who are filling this vital role. Nonetheless, we decided to include this indicator as one means among many of measuring the rate at which the primary family unit experiences problems or breakdowns.

We last reported data on grandparent caregivers — specifically, the rate of households in which grandparents care for their grandchildren — from the year 2000, the most recent data then available. At that time, the metro-area leader was Baltimore City, where 5.3 percent of households were home to grandparents caring for their grandchildren. Baltimore County, at third place with a rate of 2.0

percent, was one of only two other jurisdictions with a rate of 2 percent or higher (the other was Anne Arundel County, at 2.3 percent). The state rate was 2.6 percent, while the area’s was 2.8 percent (BC 2002).

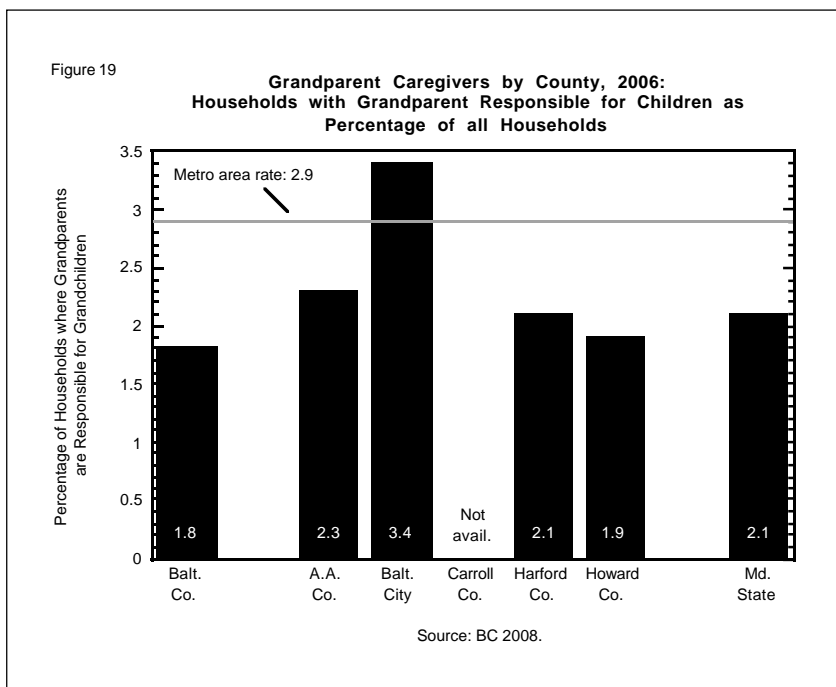
Figure 19 updates this indicator to the year 2006. In the ensuing years, Baltimore County was one of two jurisdictions to see a decrease in this rate, with the county’s decrease being substantial enough to move it down to fifth place. Baltimore City, still the leader, also experienced a decrease, to 3.4 percent. In second place — at 2.3 percent — is Anne Arundel County, the only jurisdiction where the 2006 rate was identical to the 2000 rate. Next comes Harford County (2.1 percent, an increase), followed by Howard County (1.9 percent, also an increase). Baltimore County is in fifth place, at 1.8 percent. Current census data on this indicator are not available for Carroll County: the county’s small population size does not yield enough sample cases for some census fields (BC 2008).

#### 4.5 Healthy Births

Few people need convincing of the importance of a child’s health *in utero* to his or her later physical and even mental development. However, a variety of factors — poverty, education, etc. — may still combine to pose health risks to a developing fetus.

This section considers three indicators of unhealthy births: infant mortality, low birth weights and prenatal care.

By way of context for the discussion of the indicators below, we offer figures 20 and 21. Figure 20 shows births per 1,000 residents (DHMH’s definition of “birth rate”) in Baltimore County, the state and the metro area, over the years 1995-2006. As the figure shows, the rate has fluctuated a good deal during this period. All three rates are currently lower than in 1995, but a steady upward trend — most pronounced in Baltimore



County — is visible since 2002. Over the total period shown in the graph, the metro-area rate has decreased the most (4.6 percent), followed by the decreases in Baltimore County (4.0 percent) and Maryland (3.9 percent) (DHMH 1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a).

Actual numbers of births, however, have been increasing during these same years, as shown in figure 21. Maryland's increase was largest, at 7.1 percent, followed by the increases in Baltimore County (5.6 percent) and the metro area (2.4 percent) (DHMH 1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a).

#### 4.5.1 Infant Mortality

Our 2005 report found Baltimore County to have the second-highest infant-mortality rate among the metro-area jurisdictions. Data from 2002 showed the county experiencing 7.9 infant deaths (i.e., deaths within the first year of life) per 1,000 live births. While the county's rate was well below that of Baltimore City (10.4 per 1,000), the leader on this indicator, the county also outpaced the next highest jurisdiction by a wide margin: the third-place finisher was Howard County, with a rate of only 6.6 per 1,000. The rest of the jurisdictions had rates of 5.9 per 1,000 or lower. The state's rate was 7.6 per 1,000, while the area's was 7.5 per 1,000 (DHMH 2002a).

Figure 22 shows 2006 infant-mortality rates in the metro area. Three jurisdictions, including Baltimore County, have experienced decreases since the 2002 data we presented last time. The Baltimore City rate has increased to 12.4 per 1,000.

Figure 20

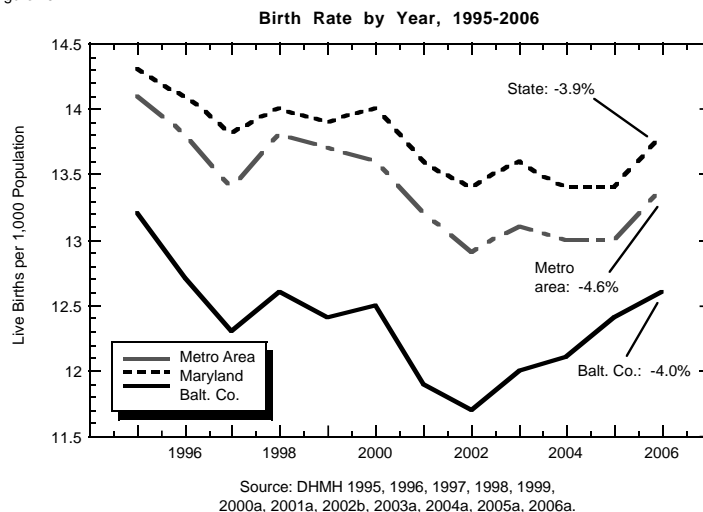
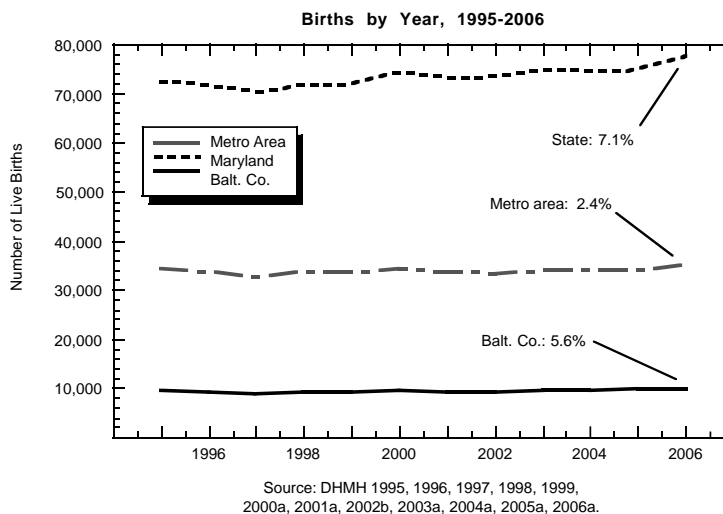


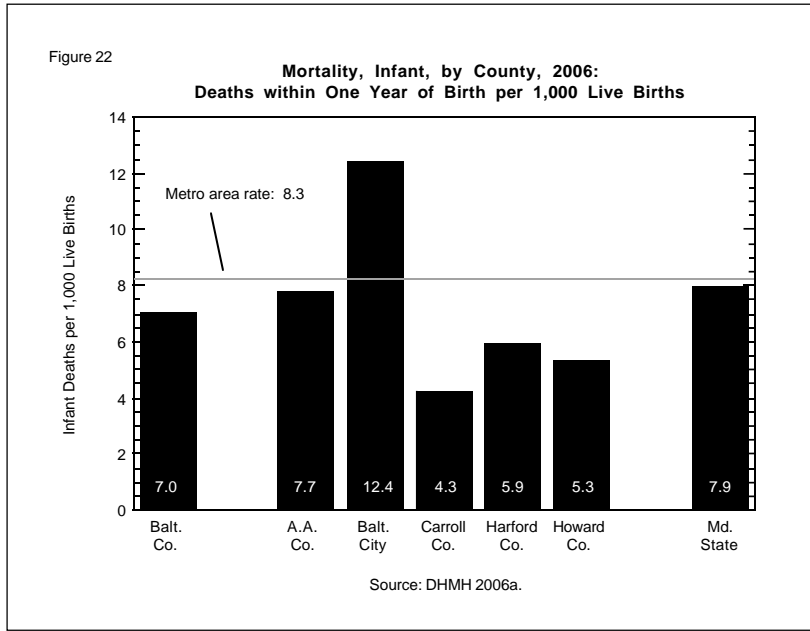
Figure 21



The next highest rate is in Anne Arundel County, now at 7.7 per 1,000, while Baltimore County's decrease from 7.9 to 7.0 per 1,000 moves it down to third place. Next come Harford (5.9 per 1,000), Howard (5.3 per 1,000) and Carroll (4.3 per 1,000) counties. The state rate has increased to 7.9 per 1,000, and the area rate has increased to 8.3 per 1,000 (DHMH 1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a).

Figure 23 reprints the same infant-mortality trend lines we published in 2005, which covered the years 1995-2002, with the addition of data from 2003-06. Over the years 1995-2006, both

Figure 22

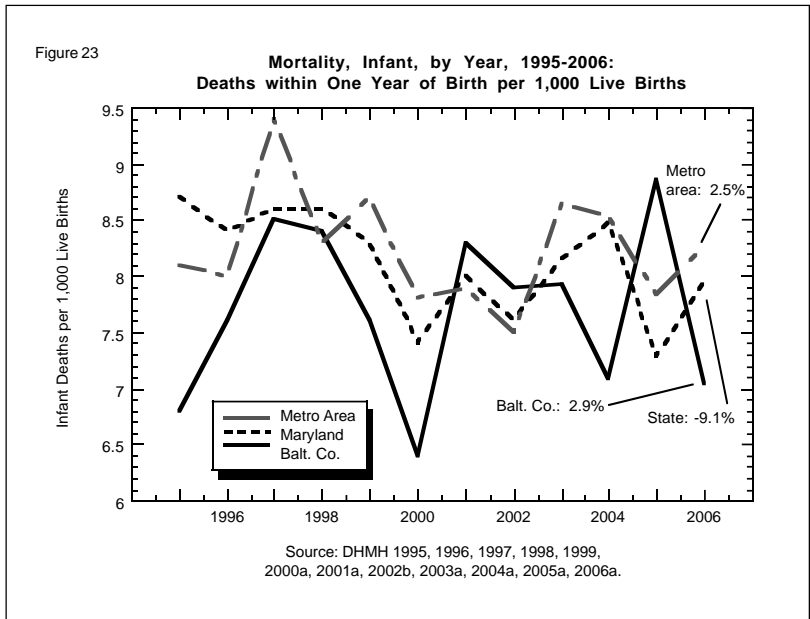


Baltimore County and the metro area have seen increases in infant mortality of 2.9 and 2.5 percent, respectively. Only the state's rate has declined during this period, 9.1 percent. As the steep climbs and rapid descents of the trend lines show, however, this rate is relatively unstable in all three entities, and in Baltimore County most of all. The county's only period of relative stability on this indicator occurred between 2001 and 2003, though the rates in those years were noticeably higher than now. The county's relatively low standing on this indicator, then, cannot be assumed to be the end of the story; judging by the historical trend, it is unfortunately possible that the county's rate may swing

dramatically upward once again (Mittendorfer-Rutz *et al.* 2004).

In our last report, we presented data showing that Baltimore County had the second-highest rate of low birth weights in the metro area, as of 2002, the most recent data then available. Baltimore City had the highest rate, 13.4 percent of live births, followed by Baltimore County at 9.3 percent. Aside from third-place Anne Arundel County (8.3 percent), the remaining jurisdictions all had rates under 7.5 percent. The state and area rates were 9.0 percent and 9.7 percent, respectively (DHMH 2002c).

Figure 23



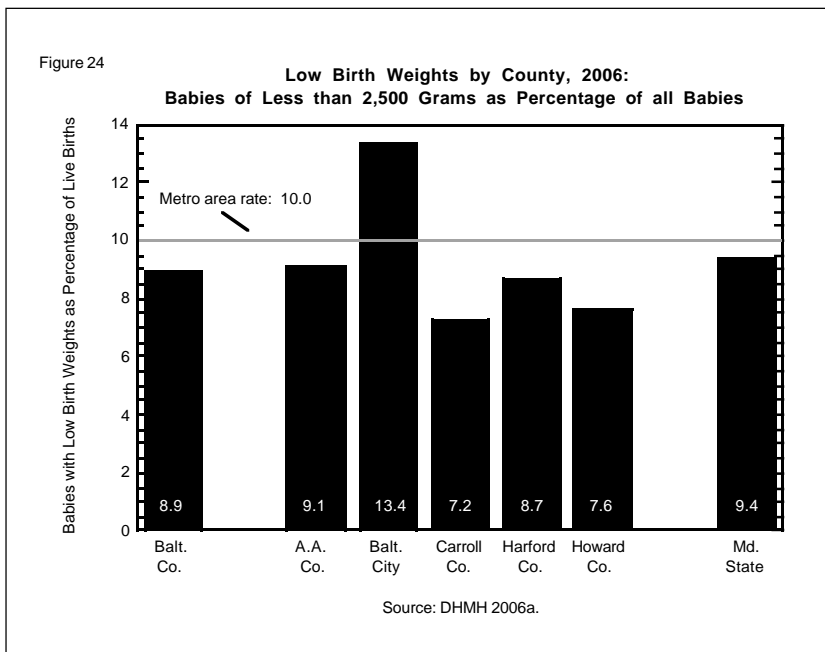
Along among the metro-area jurisdictions, Baltimore County's rate has decreased since 2002; the county has also dropped from second to third place. Figure 24 shows 2006 low-birth-weight data in the metro-area jurisdictions. Baltimore City leads once again, with an unchanged rate of 13.4 percent of live births having low birth weights. Anne Arundel County is now in second place, at 9.1 percent, followed by Baltimore County, where the rate is 8.9 percent. The next highest rate is in Harford County (8.7 percent), followed by Howard

County (7.6 percent) and Carroll County (7.2 percent). The state rate is 9.4 percent, and the area rate is 10.0 percent, both increases (DHMH 1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a).

In figure 25, we have extended the 1995-2002 low-birth-weight trend lines we published in 2005 to include 2003-2006. Over the years 1995-2006, Maryland, the metro area and Baltimore County have all experienced overall increases, though the county's increase was smallest. Maryland's rate has increased 10.6 percent; the area's, 9.9 percent; and Baltimore County's, 6.0 percent (DHMH 1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a). Of particular interest is the fact that the county's rate remained level between 2002 and 2005 and then decreased, even as the state and area rates mostly continued to rise. The one exception was in 2005, when the state and area both saw slight decreases, while the county's rate remained steady (1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a). Despite the modest size of Baltimore County's increase in this rate, however, an increase is an increase; there is apparently more work to be done if we are to reduce the occurrence of low birth weights in our county.

#### 4.5.3 Prenatal Care

Another important measure of infant health and well-being is the rate at which expectant mothers receive appropriate prenatal medical care, which in turn may reduce the chances of infant mortality or low birth weight, the two indicators discussed in the preceding sections. As we pointed out in



2005, the U.S. Department of Health and Human Services advises that “babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die, than those whose mothers received prenatal care (HRSA 2004). The National Institute of Child Health and Human Development argues that “getting early and regular prenatal care is one of the best ways to promote a healthy pregnancy” (NICHD 2004).

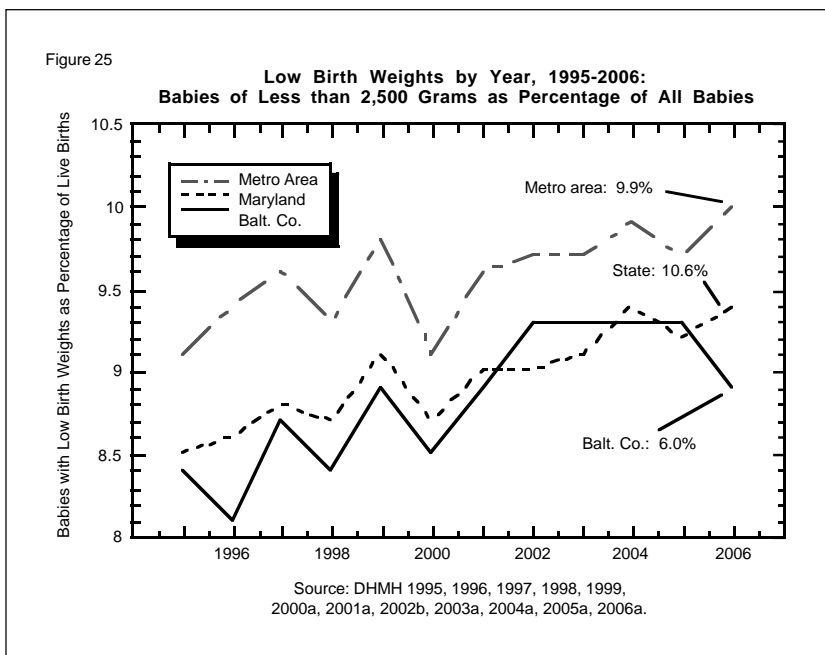
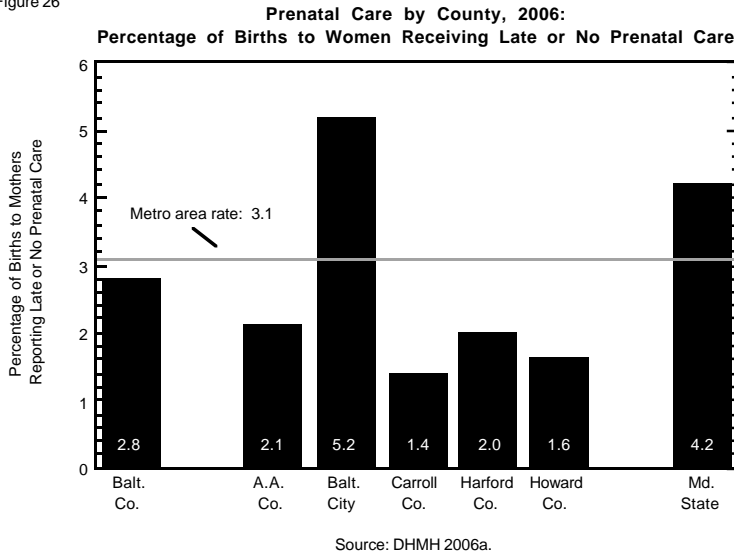


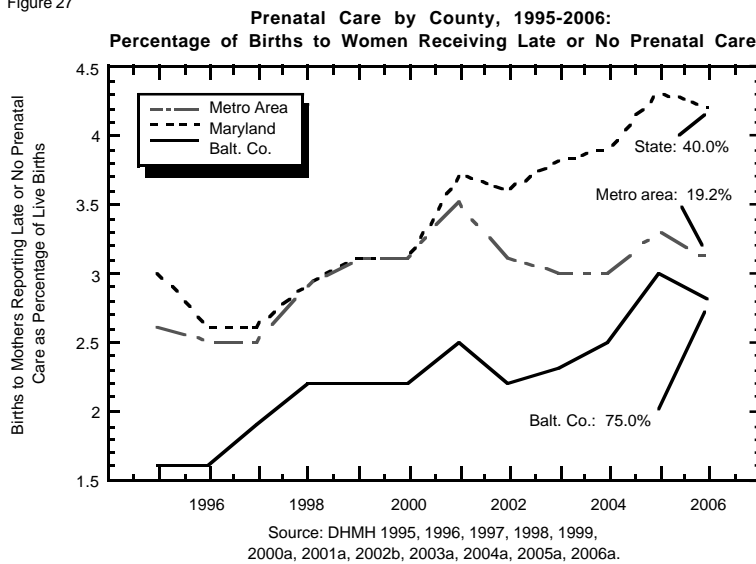
Figure 26



percent, and the area rate was 3.1 percent. Trends in the state, county and area were all upward over the years 1995-2002, with the county rate having climbed fastest during those years (DHMH 2002b).

Figure 26 updates the percentage of mothers receiving late or no prenatal care to the year 2006. All jurisdictions save Baltimore City have experienced increases in this rate during the intervening years, and Baltimore County remains in second place. Baltimore City still has the highest rate, 5.2 percent, followed by Baltimore County (2.8 percent), Anne Arundel County (2.1 percent), Harford County (2.0 percent), Howard County (1.6 percent) and Carroll County (1.4 percent). The state rate is 4.2 percent (also an increase since 2002), while the area rate, 3.1 percent, is the same as in 2002 (DHMH 1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a).

Figure 27



More detail on the increases in the rate of mothers receiving late or no prenatal care is available in figure 27, which adds 2003-2006 data to the 1995-

In 2005, we published 2002 data on births to mothers who either did not receive prenatal care or whose prenatal care commenced during their third trimester (the public-health definition of “late prenatal care”) in the metro-area jurisdictions. Baltimore City had the highest rate of mothers receiving late or no prenatal care, at 6.7 percent of all live births, while Baltimore County had the second-highest rate, at 2.2 percent. Anne Arundel and Harford counties were close behind Baltimore County, with rates of 2.0 percent and 1.9 percent, respectively, while Carroll and Howard counties’ rates were both 0.9 percent. The state rate was 3.6

2002 data published in our last report. Over the years 1995-2006, Baltimore County saw the largest increase in this rate, 75.0 percent. The state’s increase is just over half as great, at 40.0 percent, while the area’s increase was a much smaller 19.2 percent. As can be seen in the most recent portion of the graph — the years 2005 and 2006 — Baltimore County has come close to exceeding the area rate (1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a).

## 4.6 Healthy Childhood

As important as healthy births are, the advantages conferred thereby can easily be negated by an unhealthy childhood. Therefore, we also selected two indicators of healthy childhood: juvenile Medicaid reciprocity and childhood deaths, discussed in the following sections.

### 4.6.1 Child Medicaid Reciprocity

Medicaid is a federally funded, state-administered program that pays for medical care for low-income children and adults. In 2005, we presented data from the years 1990 and 2000 on the percentage of the under-18 population in each metro-area jurisdiction enrolled in Medicaid. All six jurisdictions had seen marked increases in this rate over that 10-year period, which seemed attributable to a combination of expanded eligibility guidelines and improved outreach (DLS 2001), as well as increasing child-poverty rates in Baltimore County and some other jurisdictions during those years (see figure 15 in BCLMB 2005). In both 1990 and 2000, Baltimore County had the second-highest rate of juvenile Medicaid enrollment.

Figure 28 compares the 2000 rates of juvenile Medicaid enrollment we presented last time with updated data from 2006. As of 2006, Baltimore County remains in second place on this indicator. Baltimore City has the highest rate, at 65.8 percent, followed — as mentioned — by Baltimore County (27.3 percent), Harford County (20.8 percent), Anne Arundel County (18.2 percent), Carroll County (13.8 percent) and Howard County (13.4 percent). In all six jurisdictions, these 2006 rates represent large increases since 2000 — in Baltimore County’s case, an increase of almost 70 percent (ACY 2007).

Such an increase is good news if it results merely from a continuation of the “improved outreach” mentioned above; i.e., if a population of eligible

but unserved children existed previously and has now been enrolled in a program that makes health care more affordable, so much the better. If, however, the increase results mainly from an increased proportion of children living in poverty, the county would seem to be facing a serious obstacle where child health and well-being are concerned. Unfortunately, the latter circumstance seems to be at least part of the explanation, since — as mentioned in section 2.6, above — the proportion of Baltimore County juveniles living in poverty has increased approximately 20 percent over this same period (i.e., 2000-2006). Given the host of health, academic, social and even legal problems that disproportionately affect children who grow up in poverty, more than one indicator seems to suggest that there is room for concern in Baltimore County where childhood poverty is concerned.

### 4.6.2 Child Mortality Rate

Under the heading of “healthy childhood,” we selected an indicator of, essentially, the direct opposite of this desired state: child mortality, or children who live beyond 1 but die before reaching 5, an occurrence that any jurisdiction would want to reduce as much as possible. The graph printed in our 2005 report contained errors; we reprint that graph here (figure 29), along with a graph showing updated data (figure 30).

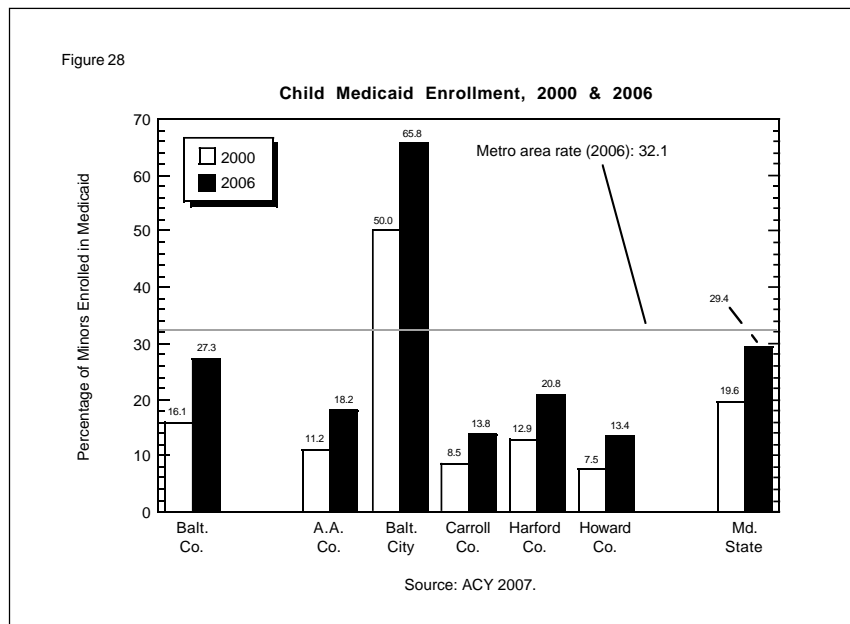
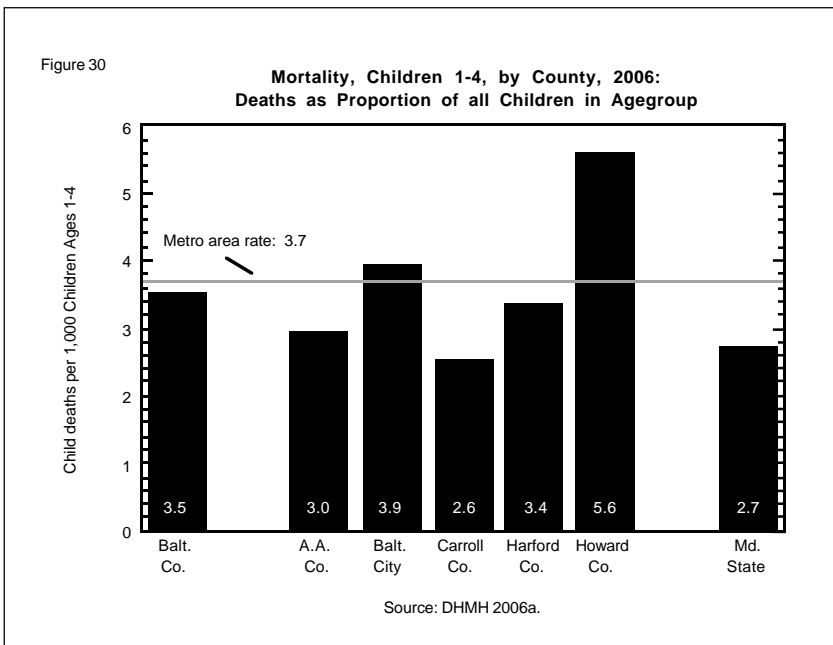
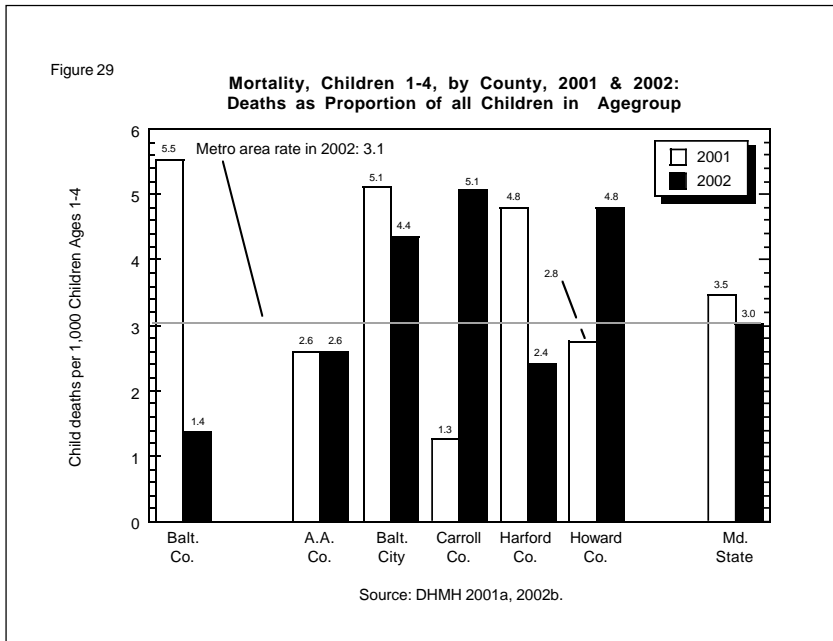


Figure 29 shows the deaths of children ages 1-4 per 1,000 children ages 1-4 in each metro-area jurisdiction for the years 2001 and 2002. In 2001, the leader on this indicator was Baltimore County, with a rate of 5.5 per 1,000. The city was next, with a rate of 5.1 per 1,000, followed by Harford County (4.8 per 1,000), Howard County (2.8 per 1,000), Anne Arundel County (2.6 per 1,000) and Carroll County (1.3 per 1,000). The 2001 state rate was 3.5 per 1,000. By 2002, Baltimore County's rate had plummeted to 1.4 per 1,000, leaving it in last place.

The highest 2002 rate was in Carroll County (5.1 per 1,000), followed by Howard County (4.8 per 1,000), Baltimore City (4.4 per 1,000), Anne Arundel County (2.6 per 1,000), Harford County (2.4 per 1,000) and, as mentioned above, Baltimore County (1.4 per 1,000). The 2002 state rate was 3.0 per 1,000, while the area was 3.1 per 1,000 (DHMH 1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a).

Figure 30 shows that — as of 2006 — the child-mortality rate has increased since 2002 in four metro-area jurisdictions, including Baltimore County. Now, Howard County leads on this unfortunate indicator, with a rate of 5.6 per 1,000, followed by Baltimore City (3.9 per 1,000), Baltimore County (3.5 per 1,000), Harford County (3.4 per 1,000), Anne Arundel County (3.0 per 1,000) and Carroll County (2.6 per 1,000). The 2006 state rate is 2.7 per 1,000; the area rate is 3.7 per 1,000 (DHMH 1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a).



## 4.7 Safe Childhood

After discussing child health, it only makes sense to consider child safety, a closely related topic. After all, the healthiest child in the world can still be struck down by avoidable injuries. Under this heading, we studied the following indicators: child injuries, child abuse/neglect and childhood lead exposure.

### 4.7.1 Child Injury

The Maryland Department of Health and Mental Hygiene (DHMH) collects and publishes data on injuries (quantified

by counting hospitalizations for treatment of injuries) in Maryland counties by age. In 2005, we presented DHMH data on injuries to children under 5. In 2000 — the year of the most recent data then available — there were 9.7 injury-related hospitalizations per 1,000 children under 5 in Baltimore City, the highest childhood-injury rate in the metro area. Baltimore County was in second place, with a rate of 7.1 per 1,000, followed by Carroll County (5.7 per 1,000), Harford County (5.1 per 1,000), Howard County (4.1 per 1,000) and Anne Arundel County (3.6 per 1,000). The state and area rates were 4.5 per and 6.4 per 1,000, respectively (DHMH 2000b, 2001b).

In 2002, DHMH changed its definition of “injury” to no longer include adverse effects from medications (Serpi 2008). As a result, injury data published in 2002 and later are not comparable to the 2000 data we reported in our last report. For a sense of the effect of this change on the injury rate, such “adverse effects” were responsible for about 40 percent of what DHMH reported as “injuries” in 2000, statewide (Serpi 2008).

Figure 31 shows injury hospitalizations — using this new definition of “injury” — of children under 5 in the metro area jurisdictions during 2005. Because of the definition change, all of the rates shown are much lower than the rates we published in 2005. Nonetheless, Baltimore City still leads on this indicator, with a rate of 6.1 injury hospitalizations per 1,000 children under 5. However, Baltimore County is no longer in second place; instead, the city’s rate is followed most closely by the rate in Harford County (4.0 per 1,000). Baltimore County is in third place, at 3.6 per 1,000, followed by Carroll County (2.9 per 1,000), Anne Arundel County (2.5 per 1,000) and Howard County (2.0 per 1,000). The state’s rate is 2.4 per 1,000; the area’s, 3.9 per 1,000 (DHMH 2006b).

Figure 32 offers a historical view of injuries to children

under 5 in the county, area and state, starting in 2002 — when DHMH changed its injury definition — and continuing through 2005. As shown, all three entities experienced increases in their rates during this period. The largest increase — 21.9 percent — was in the metro area, followed by the increases at the state (14.3 percent) and county levels (9.1 percent). It is difficult to conclusively define a trend, however, given such a relatively short number of years’ data (DHMH 2003b, 2004b, 2005b, 2006b).

#### 4.7.2 Child Abuse and Neglect

From a broad consideration of childhood injuries, we now shift to one specific source of childhood injuries, both physical and mental: child abuse and neglect. Abuse and neglect rob children of their very childhoods and exact a toll on the larger community as well, both in terms of the expense of the immediate response to instances of abuse and also in terms of the antisocial or abusive behavior that victims of this sort of crime sometimes enact later in life.

Table 13 presents rates of child physical and sexual abuse along with neglect (together, “maltreatment”) per 10,000 county residents, for the years 1996-2005. The table uses Maryland Child Protective Services figures for “indicated” findings, or cases in which investigation found credible evidence that maltreatment had actually occurred. The table has four sections, showing rates of phys-

Figure 31

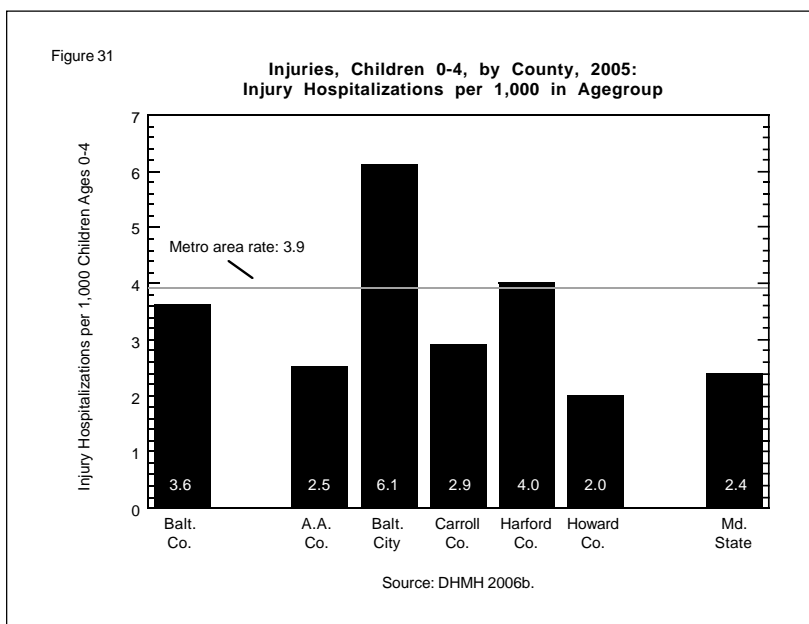
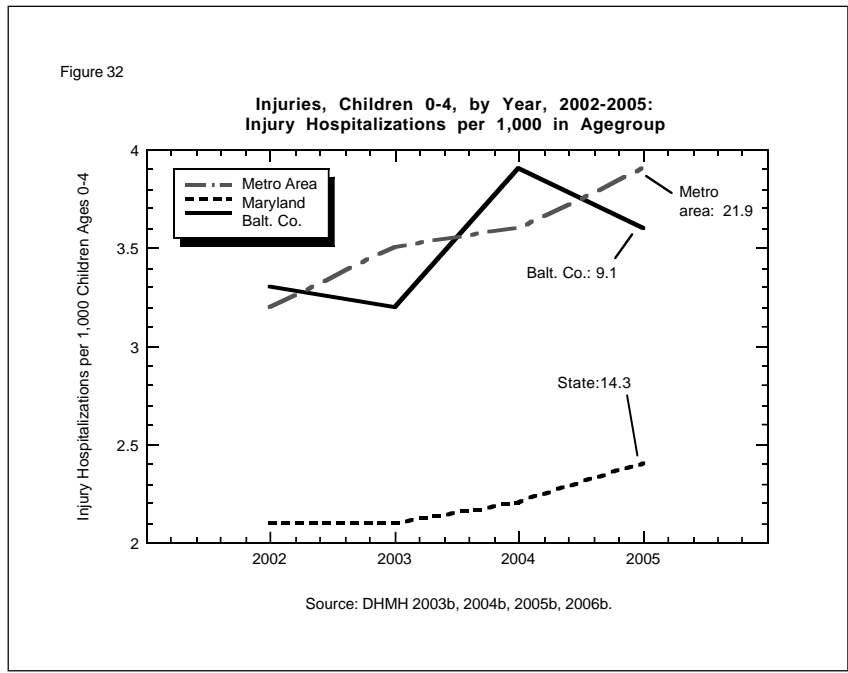


Figure 32



ical abuse, neglect, sexual abuse, and — at the top, in the section labeled “all maltreatment” — all of these subcategories combined.

In our previous report, we published child-maltreatment data from the years 1996-2003. Among the metro-area jurisdictions, Baltimore County had the fifth-lowest “all maltreatment” rate (8.75 per 10,000) in 2003. That same year, the county had the second-highest rate of physical abuse (3.40 per 10,000) and the third-highest rate of sexual abuse (2.30 per 10,000). More positively, Baltimore County had the lowest rate of neglect (3.05 per 10,000). The county’s rate in all four categories had decreased since 1996 (BC 2000; CPS 2003, 2007; DOP 2002, 2003a-d).

Examining table 13’s 2005 data (the most recent currently available), we find that the leader in the “all maltreatment” category is Baltimore City, with a rate of 28.24 indicated cases per 10,000 residents. Anne Arundel County has the next-highest rate, a considerably lower 9.87 per 10,000, followed by Carroll County (8.67 per 10,000), Baltimore County (8.40 per 10,000), Harford County (7.70 per 10,000) and Howard County (6.58 per 10,000). The state and area rates are 11.05 and 13.30 per 10,000, respectively. Since 1996, Howard County has seen the largest proportional reduction in this rate, or 45.89 percent, followed by Baltimore City (43.22 percent), Harford County (38.89 percent),

Baltimore County (25.86 percent) and Anne Arundel County (21.42 percent). Alone in the area, Carroll County experienced a proportional increase in the “all maltreatment” category since 1996, one of 8.51 percent. The state rate decreased 38.41 percent, while the area rate fell 40.33 percent (CPS 2007).

Baltimore City leads as well in the physical-abuse category, with a rate of 5.56 indicated cases per 10,000 residents. Next comes Baltimore County (2.73 per 10,000), followed by Anne Arundel County (2.59 per 10,000), Harford County (1.97 per 10,000), Howard County (1.45 per 10,000) and Carroll County (0.95 per 10,000). The state sees physical-abuse cases at a rate of 2.57 per 10,000; the area, 3.08 per 10,000. All metro jurisdictions as well as the area and state experienced proportional decreases in this rate since 1996. The largest such decrease was in Carroll County, where the rate fell more than two thirds (67.24 percent), followed by the decreases in Harford County (66.44 percent), Howard County (66.20 percent), Baltimore County (49.07 percent), Baltimore City (54.05 percent) and Anne Arundel County (33.93 percent). The state rate decreased 57.87 percent; the area rate decreased 54.51 percent (CPS 2007).

Baltimore City is once again the leader in the neglect category, with a rate of 20.48 indicated cases per 10,000 residents. Carroll County is in second place at 6.00 per 10,000, followed by Anne Arundel County (5.28 per 10,000), Harford County (4.31 per 10,000), Howard County (3.46 per 10,000) and, with the lowest rate in the area, Baltimore County (3.15 per 10,000). The state and area rates are 6.49 and 8.12 per 10,000. Since 1996, the largest proportional decrease has been in Howard County (40.96 percent), followed by decreases in Baltimore City (35.86 percent), Anne Arundel County (8.33 percent), Harford County (7.71 percent) and Baltimore County (5.41 percent). Carroll County was the only jurisdiction to

Table 13

**Child Maltreatment Trends by County and Year, 1996-2005:**  
**Rate of Indicated Cases per 10,000 Total County Population**

<i>Jurisdiction</i>	<i>1996</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>	<i>+/- %</i>
<b>All Maltreatment</b>											
Baltimore Co.	11.33	10.26	10.40	9.65	9.37	9.07	8.10	8.75	8.67	8.40	-25.86%
Anne Arundel Co.	12.56	10.48	9.23	9.10	11.17	11.64	10.51	10.32	9.91	9.87	-21.42%
Baltimore City	49.74	50.80	38.17	47.70	40.17	39.66	37.91	34.84	25.55	28.24	-43.22%
Carroll Co.	7.99	7.40	9.05	8.51	9.87	9.57	12.58	12.62	10.16	8.67	8.51%
Harford Co.	12.60	12.35	10.49	10.49	11.44	9.74	9.97	9.65	7.91	7.70	-38.89%
Howard Co.	12.16	9.33	11.06	8.39	9.89	10.53	8.11	7.83	5.63	6.58	-45.89%
Maryland Statewide	17.94	17.21	15.19	15.42	15.24	14.62	13.83	13.24	11.39	11.05	-38.41%
Metro Region	22.29	21.32	17.62	19.43	17.97	17.58	16.46	15.67	12.80	13.30	-40.33%
<b>Physical Abuse</b>											
Baltimore Co.	5.36	4.68	4.35	3.62	3.71	3.26	3.14	3.40	3.14	2.73	-49.07%
Anne Arundel Co.	3.92	3.56	2.64	3.34	3.78	3.86	2.92	3.08	3.05	2.59	-33.93%
Baltimore City	12.10	12.80	10.28	10.95	9.66	9.44	9.77	8.37	6.03	5.56	-54.05%
Carroll Co.	2.90	2.84	2.25	2.82	3.18	3.23	3.46	2.76	2.53	0.95	-67.24%
Harford Co.	5.87	4.92	4.64	3.93	4.21	3.68	2.77	2.84	2.81	1.97	-66.44%
Howard Co.	4.29	3.15	3.96	3.17	3.27	3.41	2.38	2.50	1.69	1.45	-66.20%
Maryland Statewide	6.10	5.66	5.11	4.80	4.88	4.51	4.16	3.84	3.18	2.57	-57.87%
Metro Region	6.77	6.46	5.47	5.43	5.23	5.00	4.66	4.37	3.62	3.08	-54.51%
<b>Neglect</b>											
Baltimore Co.	3.33	3.36	3.94	3.88	3.43	3.42	2.62	3.05	3.00	3.15	-5.41%
Anne Arundel Co.	5.76	4.47	4.40	4.43	4.86	5.51	5.22	5.31	5.46	5.28	-8.33%
Baltimore City	31.92	32.69	24.27	32.99	27.32	26.75	24.26	22.91	17.29	20.48	-35.84%
Carroll Co.	3.39	3.32	5.03	4.36	4.11	4.01	6.41	6.49	5.29	6.00	76.99%
Harford Co.	4.67	5.16	4.12	4.85	5.31	4.67	5.31	4.82	3.79	4.31	-7.71%
Howard Co.	5.86	5.12	5.57	4.07	5.04	5.48	4.31	3.71	3.04	3.46	-40.96%
Maryland Statewide	8.68	8.74	7.67	8.52	8.08	7.88	7.23	7.03	6.17	6.49	-25.23%
Metro Region	12.13	11.91	9.72	11.77	10.26	10.11	9.18	8.79	7.23	8.12	-33.06%
<b>Sexual Abuse</b>											
Baltimore Co.	2.64	2.20	2.11	2.15	2.23	2.36	2.34	2.30	2.53	2.51	-4.92%
Anne Arundel Co.	2.89	2.39	2.18	1.26	2.49	2.17	2.30	1.88	1.40	2.00	-30.80%
Baltimore City	5.72	5.31	3.63	3.74	3.18	3.47	3.85	3.56	2.23	2.20	-61.54%
Carroll Co.	1.70	1.25	1.77	1.34	2.58	2.33	2.70	3.37	2.35	1.72	1.18%
Harford Co.	2.07	2.27	1.73	1.71	1.92	1.39	1.89	1.94	1.32	1.42	-31.40%
Howard Co.	2.01	1.05	1.53	1.11	1.57	1.64	1.42	1.63	0.90	1.67	-16.92%
Maryland Statewide	3.16	2.77	2.38	2.06	2.24	2.18	2.4	2.32	2.04	1.99	-37.03%
Metro Region	3.39	2.93	2.42	2.21	2.46	2.45	2.60	2.49	1.94	2.10	-38.05%

Source: BC 2000; CPS 2003, 2007; DOP 2002, 2003a-d.

see an increase, and a substantial one at that: 76.99 percent. The state and area rates both fell, by 25.23 and 33.06 percent, respectively (CPS 2007).

Sexual abuse is the one child-maltreatment category in which Baltimore City is not the rate leader. As mentioned earlier, that unfortunate distinction is Baltimore County's, where the 2005 rate of indicated child-sexual-abuse cases is 2.51 per 10,000. The city follows next, with a rate of 2.20 per 10,000, followed by Anne Arundel County (2.00 per 10,000), Carroll County (1.72 per 10,000), Howard County (1.67 per 10,000) and Harford County (1.42 per 10,000). The state and region rates are 1.99 and 2.10 per 10,000, respectively. Baltimore City has experienced the largest proportional decrease in this rate since 1996, one of 61.54 percent, followed by decreases in Harford County (31.40 percent), Anne Arundel County (30.80 percent), Howard County (16.92 percent) and Baltimore County (4.92 percent). Carroll County saw a slight increase of 1.18 percent. The state's decrease during the same period was 37.03 percent; the area's, 38.05 percent (CPS 2007).

To summarize the table's main findings, although the county's 2005 "all maltreatment" rate represents an improvement since 2003, the county now has the fourth-highest overall maltreatment rate among its neighbors, where before it was in fifth place. The county's physical-abuse rate has also decreased since 2003 (from 3.40 to 2.73 per 10,000), though the county remains in second place relative to its neighbors. More ominously, the rate of child sexual abuse in the county has not only increased since 2003 (from 2.30 to 2.51), but Baltimore County now has the highest rate in the metro area. On the other hand, while Baltimore County's rate of neglect has increased slightly since 2003, the county still has a lower rate than any of its neighbors.

#### **4.7.3 Lead Poisoning Rate**

As we stated in 2005, "lead is an insidious and destructive enemy of children's health, with long-lasting and extremely detrimental effects that can even be passed from a lead-affected mother to her children" (BCLMB 2005). Lead poisoning can cause brain damage, learning disabilities, anger-management problems and chronic stomach aches,

all conditions that interfere greatly with a child's development, education and social skills. The most common cause of lead poisoning is the ingestion of lead-based house paint, which was still commercially available in this country as late as 1978. Children are most commonly affected, as their play and hygiene habits may lead them to transfer lead-paint chips or dust to their mouths; obviously, this is most likely to occur in areas with a high prevalence of older homes in disrepair. In Maryland, the highest lead-poisoning rates are in Baltimore City and parts of the Eastern Shore (MDE 2003).

In 2005, we presented data from the years 1998-2002 (the most recent data available) on both "elevated blood lead" levels and "lead poisoning." Baltimore City led in each of these categories in 2002, although Baltimore County was in second place both times. In the category of lead poisoning, Baltimore County was tied for second place with all of the other jurisdictions save Baltimore City (MDE 2000, 2001a, 2001b, 2002, 2003).

Starting in 2005, the Maryland Department of the Environment (MDE), which monitors lead safety in the state, eliminated the category of "lead poisoning" from its published reports, instead folding all cases into the elevated blood-lead category, which in turn was redefined to have a lower qualifying blood-lead level. As a result, data from before 2005 are not comparable with data from 2005 and later.

Accordingly, table 14 shows the percentage of children in each metro jurisdiction who fall under the new definition of elevated blood lead for the years 2005 and 2006 (the most recent data available). As of 2006, Baltimore City is the rate leader, with 3.12 percent of children there showing elevated blood-lead levels. Harford County comes next, at a rate of 0.46 percent, followed by Baltimore County (0.45 percent), Carroll County (0.36 percent), Howard County (0.27 percent) and Anne Arundel County (0.25 percent). The state and region rates are 0.91 and 1.46 percent, respectively. Half of the jurisdictions saw proportional increases in this rate between 2005 and 2006: the largest was in Carroll County (71.43 percent), followed by Howard County (50.00 percent) and Baltimore City (4.70 percent). By far the largest proportional decrease

was in Baltimore County (22.41 percent), followed by decreases in Anne Arundel County (7.41 percent) and Harford County (4.17 percent) (MDE 2006, 2007).

Though the current data are not comparable with the data we presented in our last report, it is nonetheless possible to make some broad observations. Since MDE's new expanded definition of elevated blood lead includes not only (1) all children who would formerly have been classified under the category of lead poisoning but also (2) additional children who would not have been counted before, it would not be surprising for the current rates of elevated blood lead levels to be the same or even higher than they were in 2002. However, Baltimore County's 2006 elevated blood-lead rate of 0.45 percent is actually nearly two thirds lower than the 2002 rate of 1.4 percent, suggesting considerable improvement in the county's lead-safety outreach and education efforts.

#### 4.8 Child School Preparedness

This section and the one following it both discuss various school-related measures. In this section, we present data on what we term "school preparedness," i.e., measures of experiences and activities likely to increase a child's readiness to succeed later in school. In the following section, we present data measuring how well-prepared — how "ready" — children in area schools actually are.

##### 4.8.1 Infants and Toddlers Program Referrals

The Maryland Infants and Toddlers Program (I&T) is a coordinated system of services, administered at the local level under the statewide supervision of the Maryland State Department of Education, with the purpose of early intervention on behalf of young children with disabilities (MSDE n.d. [b]). We consider I&T usage a school-preparedness indicator because of the clear disadvantage dis-

Table 14

**Lead Level and Poisoning Trends by County and Year, 2005-2006:  
Percentage of Children 0-6, by Jurisdiction, with Elevated Blood Lead**

<i>Jurisdiction</i>	<i>2005</i>	<i>2006</i>	<i>+/- %</i>
<b><i>Elevated Blood Lead</i></b>			
Baltimore Co.	0.58	0.45	-22.41%
Anne Arundel Co.	0.27	0.25	-7.41%
Baltimore City	2.98	3.12	4.70%
Carroll Co.	0.21	0.36	71.43%
Harford Co.	0.48	0.46	-4.17%
Howard Co.	0.18	0.27	50.00%
Maryland Statewide	0.92	0.91	-1.09%
Metro Region	1.44	1.46	1.39%

Note: Starting in 2005, the Maryland Department of the Environment stopped distinguishing between "elevated blood-lead level" and "lead poisoning," instead considering all children with a new, lower blood-lead level threshold to be at risk. Therefore, MDE blood-lead level data from prior to 2005 are not comparable to those from 2005 on.

Source: MDE 2006, 2007.

abled students face in gaining the academic and social skills necessary to succeed in school; in other words, if I&T were found to be underserving Baltimore County children, there would be that many more children who are less prepared to succeed in school.

In our last report, we presented the I&T referral rates in each metro-area jurisdiction for the years 1995-2003. In 2003, the most recent year's data then available, Baltimore County led the metro area on rate of I&T referrals (as, in fact, it had done consistently since 1999). The county's rate was 39.68 per 1,000 children ages 0-4; the state's and area's rates were 28.00 and 32.25 per 1,000, respectively (Szczepaniak 2004).

Table 15 shows I&T referrals for the years 1997-2006, the most recent 10 years currently available. The current leader is Baltimore City, with a rate of 39.28 I&T referrals per 1,000 children ages 0-4, followed by Howard County (36.95 per 1,000) and Carroll County (37.10 per 1,000). Baltimore County is now at fourth place, with a rate of 36.34 per 1,000, followed by Harford County (35.19 per 1,000) and Anne Arundel County (30.13 per 1,000). The state's rate is 31.41 per 1,000; the

area's, 35.89 per 1,000. Since 1997, Carroll County's rate of I&T referrals has increased 106.00 percent, the largest increase in the area, followed by Baltimore County (72.06 percent), Harford County (57.23 percent), Anne Arundel County (55.31 percent), Baltimore City (48.68 percent) and Howard County (43.22 percent). The state and area rates have increased 70.99 and 57.34 percent, respectively (Szczepaniak 2004, 2008).

Of course, the rate of I&T referrals is most useful as an indicator of children's well-being — specifically, their level of school preparedness — when considered along with the rate of children with disabilities in each jurisdiction, since a “low” rate is only low if children in need are not being served. Unfortunately, available data on childhood disability levels are generally in terms of numbers of children served, as with the indicator under discussion here, so a perfect comparison is not possible under the scope of this project. However, we may consider poverty as a partial, proxy measure of disability levels, since poverty is a condition less conducive to children's being born healthy, thus increasing the likelihood of childhood disabilities. Looked at this way, it is no surprise to see Baltimore City leading the metro region on the rate of I&T referrals, just as it does on poverty (see figures 5 and 6, above). It is a little surprising, though, to see Baltimore County — with the second-highest poverty rates in the area — lagging at fourth place in its rate of I&T refer-

als, a finding that may suggest a need for a closer look at this program's recruiting and outreach to be sure that all eligible children are being served.

#### 4.8.2 Head Start Utilization

Head Start is a federally and state-funded program whose purpose is to “promote school readiness and enhance social and cognitive development through the provision of health, educational, nutritional, social and other services” (MSDE n.d. [a]). In its most common manifestation, Head Start provides preschool education services along with meals for students and resources for parents. Like I&T (discussed above), Head Start usage is a school-preparedness measure because of the obstacles to success in school that so often accompany poverty. If Head Start is not as widely used in our county as it could be, the school readiness of some county children may suffer as a result.

In our last report, we presented data on Head Start usage in the metro area for the school years (SYs) 2002-2003 and 2003-2004, the most recent data then available. Figure 33 reprints the data from SY 2003-2004 (white bars) for ease of comparison with updated data from SY 2006-2007, also shown (black bars). In SY 2003-2004, Baltimore City led the area in the rate of entering kindergartners with Head Start experience: 12.9 percent. Next came Howard County (4.6 percent), Anne Arundel County (3.4 percent), Baltimore County (3.2 per-

Table 15

**Infants & Toddlers Referral Trends by County and Year, 1997-2006:  
Children Referred to Program, by Jurisdiction, per 1,000 Children Aged 0-4**

<i>Jurisdiction</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>+/- %</i>
Baltimore Co.	21.12	23.40	36.49	36.75	36.60	34.69	39.68	33.23	35.27	36.34	72.06%
Anne Arundel Co.	19.40	20.99	19.85	21.40	23.21	23.96	27.40	28.86	30.05	30.13	55.31%
Baltimore City	26.42	22.99	25.58	28.42	27.44	26.08	26.61	31.29	33.18	39.28	48.68%
Carroll Co.	18.01	20.74	19.86	21.86	25.42	30.77	34.17	31.02	37.22	37.10	106.00%
Harford Co.	22.38	21.96	25.52	25.86	30.61	31.32	31.58	35.64	33.82	35.19	57.23%
Howard Co.	25.80	26.28	26.61	29.15	33.59	29.62	35.77	33.70	37.03	36.95	43.22%
Maryland Statewide	18.37	19.03	21.55	23.58	24.55	24.83	28.00	28.19	29.02	31.41	70.99%
Metro Region	22.81	22.82	27.10	28.73	29.96	29.16	32.25	31.96	33.82	35.89	57.34%

Source: Szczepaniak 2004, 2008. DHMH 1997, 1998, 1999, 200a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a.

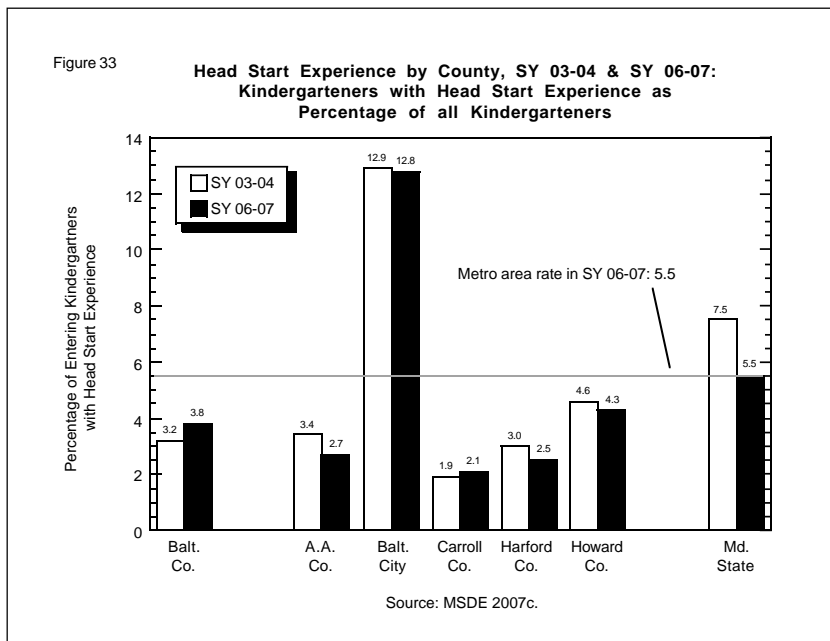
cent), Harford County (3.0 percent) and Carroll County (1.9 percent). The SY 2002-2003 rates in the state and area were 7.5 and 4.9 percent (the latter not shown), respectively (MSDE 2003a, 2004a).

These relative rankings have barely changed in the ensuing years, though the actual rates have fluctuated in most cases. As of SY 2006-2007, Baltimore City still leads, with an almost unchanged rate of 12.8 percent, followed by Howard County, with a somewhat lowered rate of 4.3 percent. Baltimore County — now at 3.8 percent — has moved from fourth to third place, a trade with Anne Arundel County, which — with its rate of 2.7 — has moved from third to fourth. The next-lowest rate is in Harford County (2.5 percent), and the lowest is in Carroll County (2.1 percent). The SY 2006-2007 state and area rates are identical at 5.5 percent (MD 2007c).

As with I&T referrals, Head Start usage is most useful as an indicator of school preparedness to the extent that it can be determined whether the program is serving all eligible children. Since qualification for the program is based on income, we can more directly tie the need for Head Start to poverty levels. Therefore, it does seem possible to argue that Baltimore County — second place in area poverty rates (see figures 5 and 6) — should probably be in second place on this indicator. Third place is close, however — besides, the county is one of only two jurisdictions that experienced an increase in this rate between SY 2003-2004 and SY 2006-2007, so whatever disparity does exist seems to be shrinking.

#### 4.9 Child School Readiness

By design, the early years of elementary school include training in what might be called “basic skills,” but it is a mistake to conclude from this that a child’s academic instruction commences only on the first day of kindergarten. Before arriving in



kindergarten, many children acquire a range of knowledge that makes their first year of school easier for both them and their teachers. In addition to basic counting, alphabet, art and play skills, such knowledge may include how to handle books, how to interact appropriately with other children, how to pay attention during story or instruction time, and so on. Many children — particularly those from households with highly literate parents, or who experience organized preschool settings — may acquire these skills almost effortlessly. But this outcome is far from a given, and children who live in poverty may be at particular risk of poor school readiness.

This section discusses the following indicators of school readiness: (1) kindergartners’ scores on the Work Sampling System (WSS), an assessment of school readiness administered each year in Maryland; (2) kindergartners’ prior preschool attendance, compared with their performance on the WSS; (3) the rate of children in preschool in a given year; and (4) the rate of preschoolers with individual education plans (IEPs), a tool used to customize instruction for students with disabilities.

##### 4.9.1 Work Sampling System

The Work Sampling System is a portfolio-based measure of kindergartners’ performance in seven “domains” — each a category of skills or attributes considered relevant to school success — that attempts to evaluate the children’s level of school

Table 16

**School Readiness by County and Year, SY 2003-2004 & SY 2006-2007:**  
**Percentage and Number of Children, by Ethnicity, Achieving a “Full Readiness” Composite WSS Score**

<b>SY 03-04</b>	<b>AII %</b>	<b>AII #</b>	<b>AI/N %</b>	<b>AI/N #</b>	<b>A/PI %</b>	<b>A/PI #</b>	<b>A-A %</b>	<b>A-A #</b>	<b>Wte %</b>	<b>Wte #</b>	<b>Hisp %</b>	<b>Hisp #</b>
Baltimore Co.	59	3,096	59	17	62	154	55	1,052	62	1,776	56	97
Anne Arundel Co.	55	2,369	50	18	65	91	41	354	60	1,823	40	83
Baltimore City	27	1,204	8	1	29	12	28	1,074	21	101	14	16
Carroll Co.	63	1,082	60	6	52	11	60	31	64	1,017	50	17
Harford Co.	76	2,040	65	13	79	62	65	289	78	1,627	65	49
Howard Co.	63	1,517	14	1	66	175	48	194	69	1,106	37	41
Maryland Statewide	55	26,360	51	125	64	1,517	46	7,787	64	15,326	41	1,605
<b>SY 06-07</b>	<b>AII %</b>	<b>AII #</b>	<b>AI/N %</b>	<b>AI/N #</b>	<b>A/PI %</b>	<b>A/PI #</b>	<b>A-A %</b>	<b>A-A #</b>	<b>Wte %</b>	<b>Wte #</b>	<b>Hisp %</b>	<b>Hisp #</b>
Baltimore Co.	77	5,102	70	28	79	315	73	1,804	81	2,685	69	270
Anne Arundel Co.	69	3,057	67	26	75	135	59	496	72	2,220	59	181
Baltimore City	58	3,212	57	8	67	31	59	2,785	54	290	47	96
Carroll Co.	60	1,096	48	10	74	28	49	41	60	989	58	28
Harford Co.	83	2,572	53	8	87	74	75	373	86	1,601	78	80
Howard Co.	71	1,974	75	6	76	317	60	309	75	1,265	46	77
Maryland Statewide	67	35,046	66	184	74	2,156	61	11,453	74	18,387	54	2,864

Key:                   %, percentage of children scoring at full readiness                   #, number of children scoring at full readiness  
AI/N, American Indian/Alaskan Native                   A/PI, Asian/Pacific Islander  
A-A, African-American                   Wte, White  
Hisp, Hispanic (may be of any race)

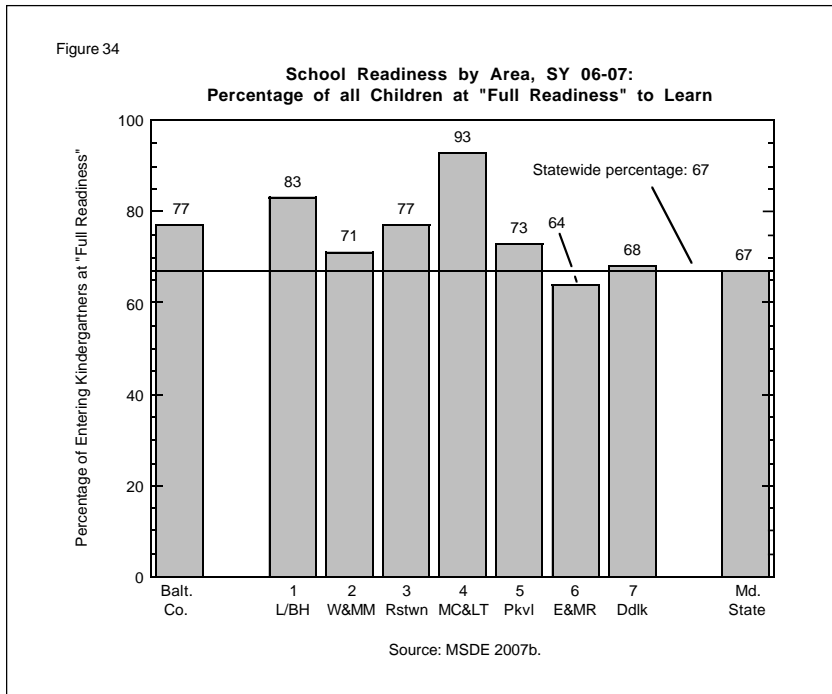
Source: MSDE 2004a, 2007a, 2007c.

readiness. These domains range from the strictly academic (for example, “mathematical thinking”) to more general areas such as “social and personal development.” Under the Work Sampling System, Maryland public-school kindergarten teachers observe and document their students’ abilities in each domain during the first eight weeks of school, submitting their findings as well as a variety of demographic information to MSDE’s Early Learning Office (Grafwallner 2004).

The Early Learning Office warns against placing too much emphasis on inter-county comparisons of Work Sampling System data, advising that the results are better suited for school systems wishing to track their own accomplishments than for quantifying differences across systems (Grafwallner 2004). Also, due to the small numbers of kindergarten students in any one school system (and the

even smaller number in some subsets, such as racial categories), it is very often true that what look like large differences — across school systems, or across time — may in fact be statistically insignificant. More specifically, “[a] direct comparison between the types of prior early care categories offers limited use since each of the categories represents different population groups” (MSDE 2003a). That said, the WSS is too rich a source of information about the experiences of Maryland students before starting school — information not readily available from any other source — to pass up as a data source for a project such as this one.

In our last report, we presented data on WSS-measured school readiness in each metro-area jurisdiction, for all students and broken down into racial/ethnic categories, as assessed during SYs



percent), Carroll County (60 percent) and Baltimore City (58 percent). Across Maryland, 67 percent of entering kindergartners are assessed as fully ready (MSDE 2007c).

White kindergartners are now the best prepared in Baltimore County, with 81 percent assessed at full readiness at the beginning of the 2006-2007 school year (n=2,685). Next come Asians, at 79 percent (n=315), followed by African-Americans (73 percent; n=1,804), Native Americans (70 percent; n=28) and Hispanics (69 percent; n=270) (MSDE 2007c).

2002-2003 and 2003-2004 (the first two years of WSS administration). (We used "composite" scores, which aggregate students' performance across the seven domains of learning mentioned above.)

Table 16 reprints SY 2003-2004 data from our last report for easy comparison with updated data from SY 2006-2007. As the table shows, in SY 2003-2004, the best-prepared students were in Harford County, where 76 percent of entering kindergartners were assessed as "fully ready," followed by Carroll County (63 percent), Howard County (also 63 percent), Baltimore County (59 percent), Anne Arundel County (55 percent) and Baltimore City (27 percent). In Baltimore County, the best-prepared racial or ethnic groups were Asians and whites (tied at 62 percent fully ready; n=154 and 1,776, respectively), followed by Native Americans (59 percent; n=17), Hispanics (56 percent; n=97) and African-Americans (55 percent; n=1,052) (MSDE 2003a, 2004a).

All metro-area jurisdictions save Carroll County have seen improvements in the ensuing years. The leader is still Harford County, where 83 percent of entering kindergartners are at full readiness (SY 2006-2007). Baltimore County is in second place with a rate of 77 percent, followed by Howard County (71 percent), Anne Arundel County (69

Figure 34 shows the percentage of kindergartners assessed fully ready during SY 2006-07 in each of the seven CDPs selected for closer study. Only two have full-readiness rates higher than the county-wide rate of 77 percent. These two rate leaders are Mays Chapel and Lutherville/Timonium (93 percent) and Lansdowne/Baltimore Highlands (83 percent). Reisterstown is tied with the county as a whole, at 77 percent, followed by Parkville (73 percent), Woodlawn and Milford Mill (71 percent), Dundalk (68 percent) and Essex and Middle River (64 percent). All of these rates represent increases since SY 2003-04 save Dundalk's, which fell from 72 percent to 68 percent (MSDE 2004a, 2007b).

Table 17 (next page) offers a view of CDP-level kindergarten readiness broken down into racial and ethnic categories, although in some cases this results in such small numbers of students that care must be taken not to impute more meaning to the resulting percentages than they will bear. Across almost all of the selected CDPs, Hispanics were less likely to be fully ready than kindergartners as a whole; in fact, it is only in Parkville that the rate of fully ready Hispanic kindergartners (80 percent) exceeds the CDP-wide rate (73 percent). The opposite was true of Parkville's Asian kindergartners, who were less ready compared to the CDP's kindergartners as a whole (Asians: 67 percent; all:

Table 17

**WSS School Readiness by Area, 2006-2007:**  
**Percentage and Number of Children, by Ethnicity, Achieving a "Full Readiness" Composite Score**

<i>SY 06-07</i>	<i>AI/N</i>	<i>A/PI</i>	<i>A-A</i>	<i>Wte</i>	<i>Hisp</i>	<i>All</i>
<b><i>L/BH</i></b>						
Total, ready	0	5	75	85	21	187
Total, all (n)	1	5	90	103	26	226
<i>Pct. ready</i>	0%	100%	83%	83%	81%	83%
<b><i>W&amp;MM</i></b>						
Total, ready	3	32	136	11	18	202
Total, all (n)	4	41	191	15	30	283
<i>Pct. ready</i>	75%	78%	71%	73%	60%	71%
<b><i>Rstwn</i></b>						
Total, ready	1	7	66	82	15	171
Total, all (n)	1	9	83	105	24	222
<i>Pct. ready</i>	100%	78%	80%	78%	63%	77%
<b><i>MC&amp;LT</i></b>						
Total, ready	-	11	4	112	2	129
Total, all (n)	0	12	4	120	3	139
<i>Pct. ready</i>	-	92%	100%	93%	67%	93%
<b><i>Pkvl</i></b>						
Total, ready	-	6	24	67	8	105
Total, all (n)	0	9	32	93	10	144
<i>Pct. ready</i>	-	67%	75%	72%	80%	73%
<b><i>E&amp;MR</i></b>						
Total, ready	1	2	93	48	14	158
Total, all (n)	2	3	145	71	27	248
<i>Pct. ready</i>	50%	67%	64%	68%	52%	64%
<b><i>Ddlk</i></b>						
Total, ready	6	10	21	151	10	199
Total, all (n)	9	12	36	214	20	292
<i>Pct. ready</i>	67%	83%	58%	71%	50%	68%
<b><i>Baltimore Co.</i></b>	70%	79%	73%	81%	69%	77%
<b><i>Maryland Statewide</i></b>	66%	74%	61%	74%	54%	67%

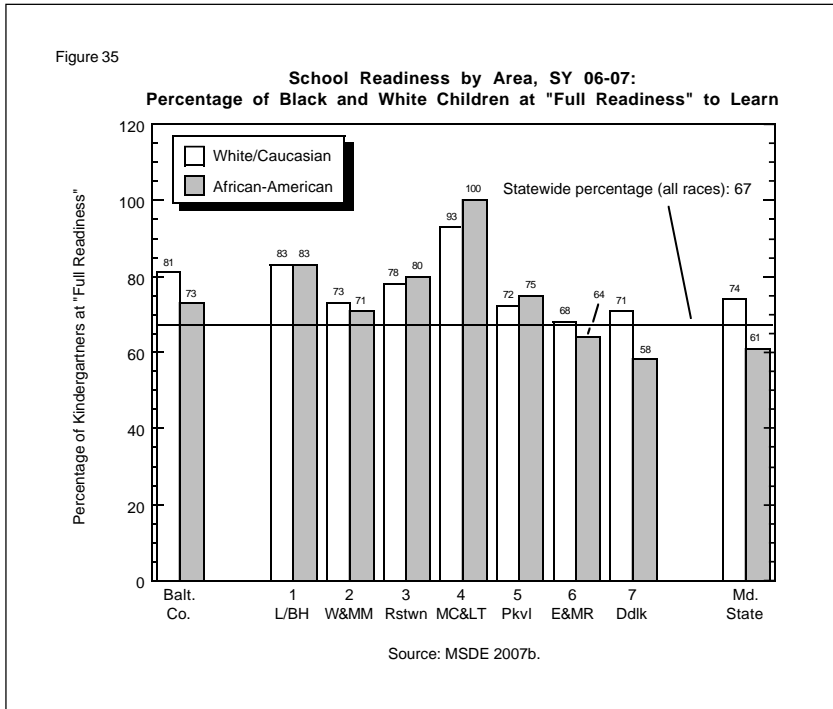
Key: AI/N, American Indian/Alaskan Native  
A-A, African-American  
Hisp, Hispanic  
A/PI, Asian/Pacific Islander  
Wte, White

Source: CC 2004, MSDE 2007b.

73 percent), the only CDP in which Asian kindergartners were not readier than the CDP's kindergartners as a whole. The rate of fully ready African-Americans tied or exceeded the rate of fully ready kindergartners as a whole in every selected CDP except Dundalk (African-Americans: 58 percent; all: 68 percent). White kindergartners were fully ready in proportions either tying or

exceeding CDP-wide proportions in all cases save Parkville (whites: 72 percent; all: 73 percent) (MSDE 2007b).

One important element in the discussion of any education-related indicator is what is commonly referred to as the "achievement gap," i.e., the academic disparity that is sometimes noticed between



Americans: 71 percent), Essex and Middle River (whites: 68 percent; African-Americans: 64 percent), and Dundalk (whites: 71 percent; African-Americans: 58 percent). In three CDPs, however, blacks were readier than whites: Reisterstown (whites: 78 percent; African-Americans: 80 percent) and Mays Chapel and Lutherville/Timonium (whites: 93 percent; African-Americans: 100 percent), and Parkville (whites: 72 percent; African-Americans: 75 percent). Whites and blacks were tied at 83 percent in Lansdowne/Baltimore Highlands (MSDE 2007b). Again, however, some of the groups of students in question are quite small; please consult table 17 for the total number of students in each racial/ethnic subcategory in a given CDP.

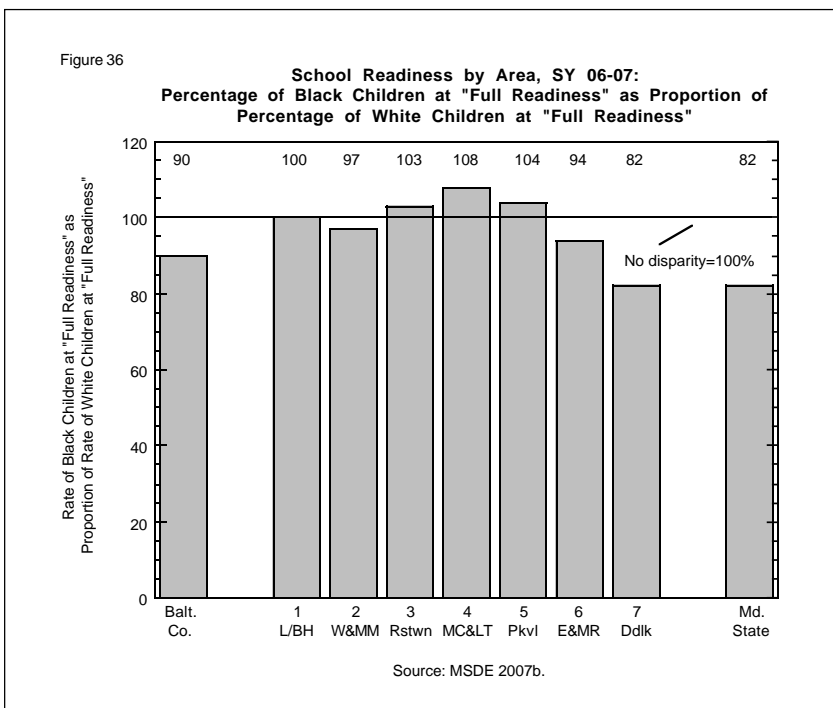
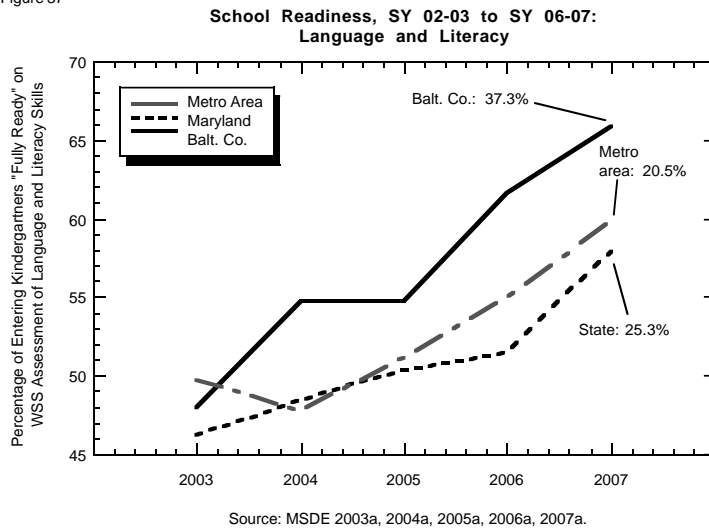


Figure 36 takes the disparities described above and considers them proportionally, i.e., each CDP's bar shows the rate of African-American kindergartners who are fully ready as a proportion of the rate of white children who are fully ready. As can be seen in the case of Lansdowne/Baltimore Highlands, where — as mentioned above — the two subgroups are tied, the lack of an achievement gap is represented on figure 36 as 100 percent; where black students are less ready than whites, the value is less than 100 percent, while CDPs where blacks are readier than whites show values higher than 100 percent. As can be seen, the largest achievement lags for African-Americans — proportionally speaking — are in Dundalk (where blacks are only 82 percent as likely as whites to be assessed as

white students and some minority students, particularly African-Americans. Figures 35 and 36 offer graphic representations of the differences in school readiness between black and white kindergartners in the selected CDPs, also for SY 2006-07. Figure 35 simply shows which students had a higher rate of "full readiness" WSS scores. In three CDPs, whites were readier than blacks: Woodlawn and Milford Mill (whites: 73 percent; African-

ed on figure 36 as 100 percent; where black students are less ready than whites, the value is less than 100 percent, while CDPs where blacks are readier than whites show values higher than 100 percent. As can be seen, the largest achievement lags for African-Americans — proportionally speaking — are in Dundalk (where blacks are only 82 percent as likely as whites to be assessed as

Figure 37



fully ready) and Essex and Middle River (94 percent) (MSDE 2007b). On the other hand, the figure also shows black students outpacing white ones in three CDPs: Reisterstown, Mays Chapel and Lutherville/Timonium, and Parkville.

Finally, as a footnote to this discussion, figure 37 shows trends in kindergartners' performance in one of the academic domains of learning, language and literacy, for SYs 2002-2003 through 2006-2007. The graph shows the percentage of entering kindergartners assessed as fully ready in language and literacy. Since SY 2002-2003, as the graph indicates, Baltimore County has seen an increase of 37.3 percent in this rate; its rate has been consistently higher than both the state's and area's, except during the first year shown. The metro area rate has increased 20.5 percent, while the state's has increased 25.3 percent (MSDE 2003a, 2004a, 2005a, 2006a, 2007b).

#### 4.9.2 Prior Preschool Attendance

Having discussed the relative school readiness of Baltimore County students, it makes sense to consider what experiences prior to entering school are more likely to produce "readier" beginning kindergartners. In general, the research suggests that the most reliable means of increasing a child's school readiness is by exposing him or her to some form of organized education setting prior to the commencement of kindergarten. As we reported last time, a 2004 study found that "children who attend center-based programs are at least two to three

months ahead developmentally of those who do not participate in these programs.... This relationship is strongest for children from low-income families" (Bridges *et al.* 2004). In other words, preschool experience — potentially helpful for all students — is also one means of bridging the achievement gaps that can exist between white students and those minorities whose families tend to have lower incomes.

Table 18 (overleaf) shows rates of students in Baltimore

County and the selected CDPs who were at full readiness on the WSS assessment at the beginning of SY 2006-2007, broken down by categories of care settings experienced prior to entering kindergarten, or what we refer to as "prior care experience." (Prior care experience is as reported by parents on registration materials; once again, there are very small actual numbers of students shown in some categories on the table.) As the body of research alluded to above would predict, those students who received only "home" care (i.e., informal care by a family member or baby sitter) are generally less likely to be assessed as fully ready. Only 58 percent of Baltimore County's previously home-cared kindergartners are at full readiness, the lowest rate out of all of the prior-care-experience categories. The best-prepared students are those who had attended nursery schools, of whom 89 percent are fully ready, followed by students who attended child-care centers (82 percent), pre-kindergarten (78 percent), Head Start (69 percent) and family centers (68 percent) (MSDE 2007b).

Lower readiness levels among home-cared students are also evident at the CDP level, shown on table 18 as well. Home-cared students are the least likely to be assessed at full readiness in three of the seven CDPs, and next to least likely in the remaining four. In three of the CDPs where home-cared students are not in last place, the prior-care-experience category they exceed is family center; in the fourth, Head Start (MSDE 2007b).

In general, the best-prepared students come from child-care centers and nursery schools. In each CDP, such students are in either first, second or third place in terms of readiness when compared to students from one of the other prior-care-experience categories. The next-best-prepared students are those who had attended pre-kindergarten, who are never in lower than fourth place when compared to students in the other categories. Head Start and family-center attendees tended to be the least

well prepared out of all of the students who were not home-cared in most CDPs and — as mentioned above — less well prepared than even home-cared students at times (MSDE 2007b).

Like the similar graphs used in our earlier discussion of racial achievement gaps, figures 38 and 39 offer graphical representations of the achievement gaps between home-cared and all kindergartners in the selected CDPs. Figure 38 compares the per-

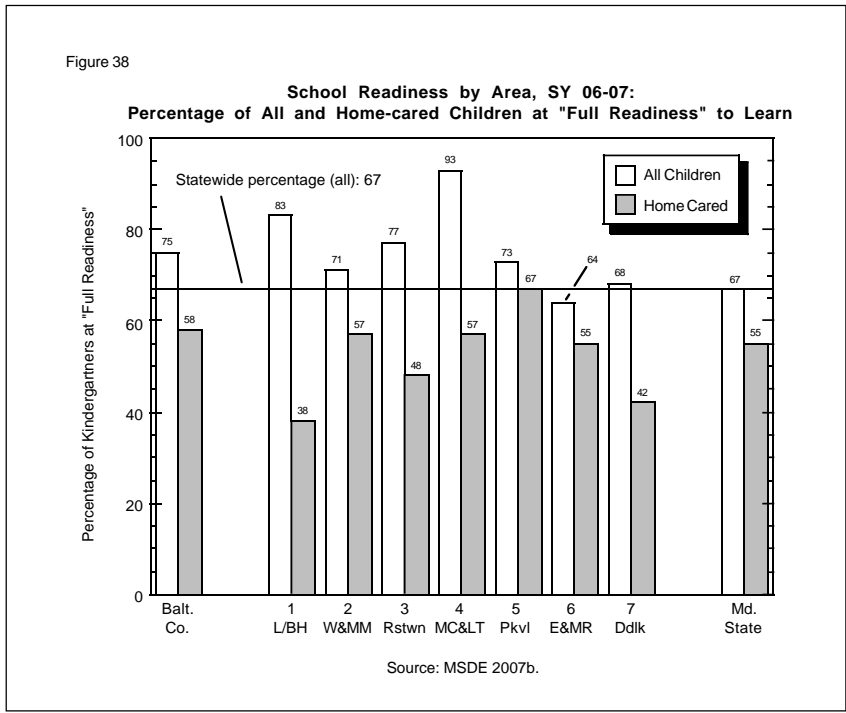
Table 18

**WSS School Readiness by Area, 2006-2007:  
Percentage and Number of Children, by Prior Care Type, Achieving a “Full Readiness” Composite Score**

<i>SY 06-07</i>	<i>Hd Strt</i>	<i>Pre-K</i>	<i>Center</i>	<i>Family</i>	<i>Nursery</i>	<i>Home</i>	<i>Evn Strt</i>	<i>All</i>
<b><i>L/BH</i></b>								
Total, ready	9	117	9	4	5	9	0	187
Total, all (n)	12	134	9	5	6	24	0	226
<i>Pct. ready</i>	75%	87%	100%	80%	83%	37.5%	0	83
<b><i>W&amp;MM</i></b>								
Total, ready	23	104	35	3	16	17	2	202
Total, all (n)	31	138	39	11	18	30	3	283
<i>Pct. ready</i>	74%	75%	90%	27%	89%	57%	67%	71%
<b><i>Rstwn</i></b>								
Total, ready	6	75	22	5	46	13	-	171
Total, all (n)	6	96	28	11	49	27	0	222
<i>Pct. ready</i>	100%	78%	79%	45%	94%	48%	-	77%
<b><i>MC&amp;LT</i></b>								
Total, ready	-	10	29	3	71	4	-	129
Total, all (n)	0	12	33	4	72	7	0	139
<i>Pct. ready</i>	-	83%	88%	75%	99%	57%	-	93%
<b><i>Pkvi</i></b>								
Total, ready	2	50	14	7	23	6	-	105
Total, all (n)	4	73	17	9	23	9	0	144
<i>Pct. ready</i>	50%	68%	82%	78%	100%	67%	-	73%
<b><i>E&amp;MR</i></b>								
Total, ready	6	105	16	5	1	12	1	158
Total, all (n)	14	154	20	7	1	22	1	248
<i>Pct. ready</i>	43%	68%	80%	71%	100%	55%	100%	64%
<b><i>Ddik</i></b>								
Total, ready	4	150	21	1	8	16	1	199
Total, all (n)	7	201	24	3	10	38	1	292
<i>Pct. ready</i>	57%	75%	88%	33%	80%	42%	100%	68%
<b><i>Baltimore Co.</i></b>								
	69%	78%	82%	68%	89%	58%	<i>n/a</i>	75%
<b><i>Maryland Statewide</i></b>								
	58%	70%	71%	65%	83%	55%	<i>n/a</i>	82%

Source: CC 2004; MSDE 2004c, 2007b, 2007c.

Figure 38

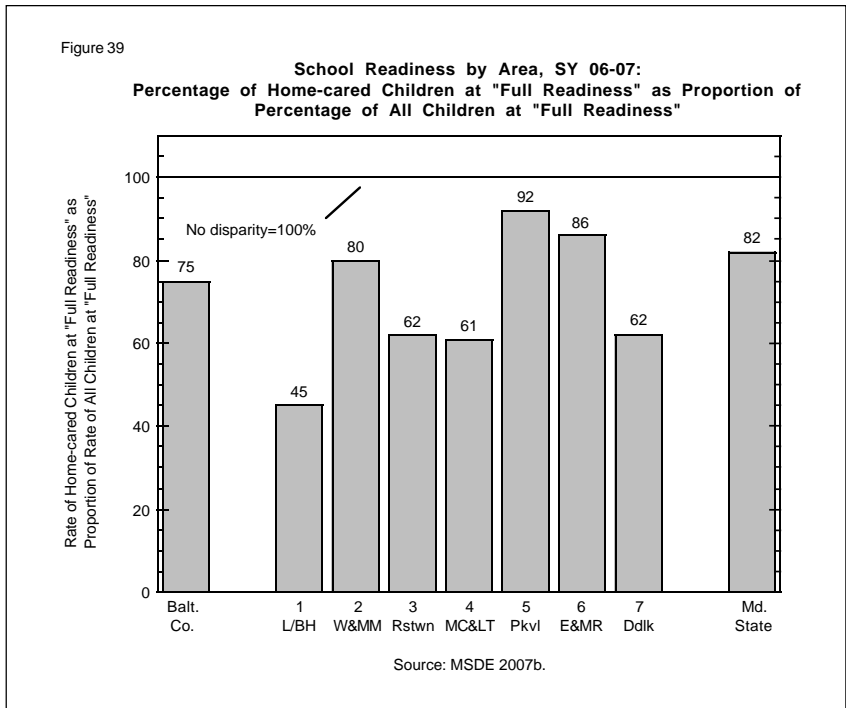


ner in Essex and Middle River, and better prepared than home-cared students county-wide (MSDE 2007b).

As figure 36 did for racial achievement disparities, figure 39 shows the proportional size of the gap between home-cared students entering kindergarten and *all* kindergartners in the selected CDPs. The rate of home-cared children at full readiness is shown as a proportion of all children at full readiness.

As in figure 36, for any CDP where no discrepancy existed, the value shown on figure 39 would be 100 percent; since here is no CDP where home-cared entering kindergartners match or exceed the readiness of all entering kindergartners, all of the CDPs have values less than 100. The biggest disparity is in Lansdowne/ Baltimore Highlands, where home-cared children are only 45 percent as likely to be assessed at full readiness as are kindergartners as a whole; large gaps are also evident in Reisterstown, Mays Chapel and Lutherville/ Timonium, Parkville and Dundalk, where home-cared students are all only around 60 percent as likely to be fully ready as are kindergartners as a whole.

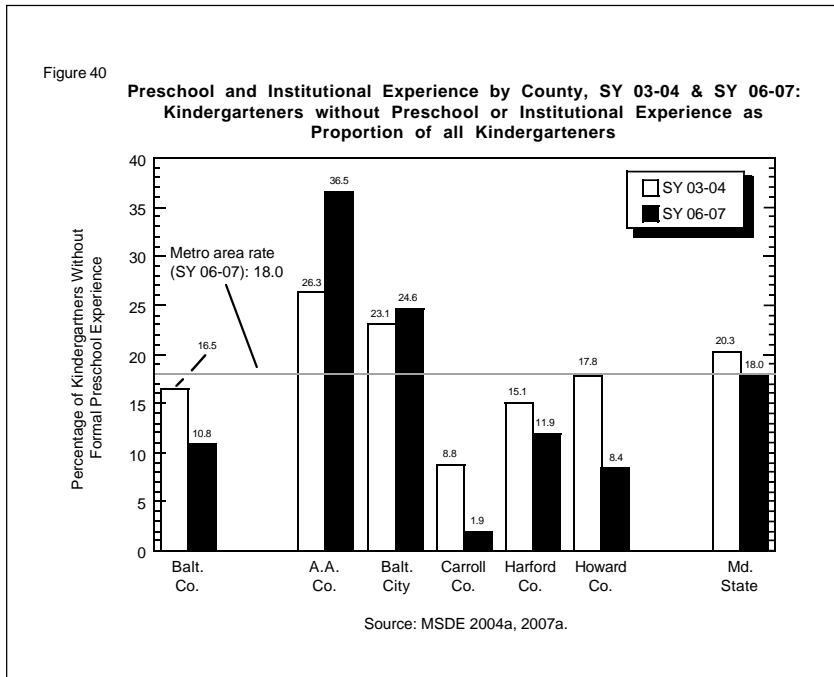
Figure 39



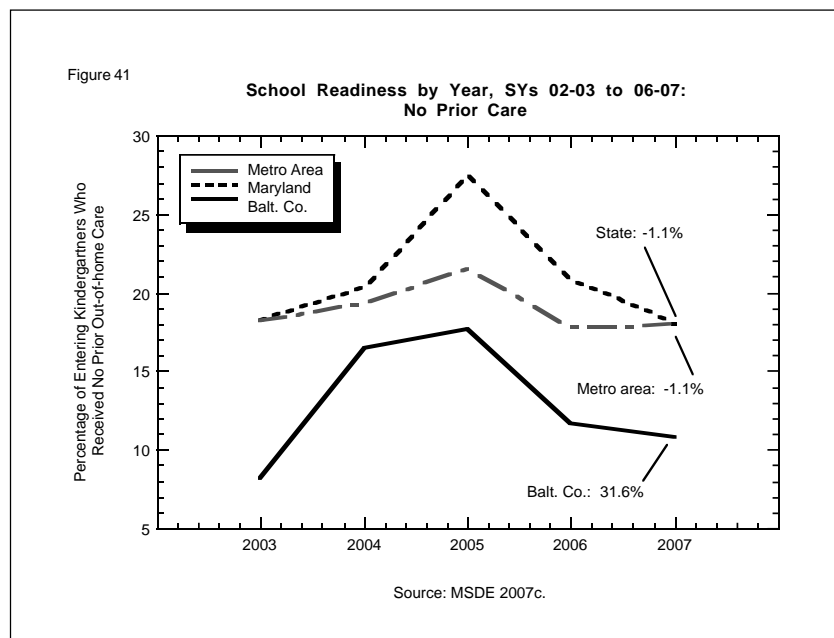
centages of all kindergartners in each CDP assessed as fully ready (white bars) to the percentages of home-cared students assessed as fully ready (gray bars). As mentioned above, there is no CDP in which home-cared students entering kindergarten are better prepared for school than are all entering kindergartners as a whole. However, it is interesting to note that home-cared students in Parkville are better prepared than any kindergart-

#### 4.9.3 Five-year-olds in Preschool

Having laid out evidence highly suggestive that formal preschool experience may improve school readiness, we now consider the overall rate at which county children actually attend preschool. Figure 40 offers a reverse image of this rate by showing the percentages of SY 2006-2007 entering kindergartners in each metro-area jurisdiction who



graph — for both of the years shown. In SY 2003-04, the jurisdiction with the smallest proportion of entering kindergartners who had not attended any form of preschool was Carroll County, with a rate of 8.8 percent. Next came Harford County, with a rate of 15.1 percent, followed by Baltimore County (16.5 percent), Howard County (17.8 percent), Baltimore City (23.1 percent) and Anne Arundel County (26.3 percent) (MSDE 2004a).

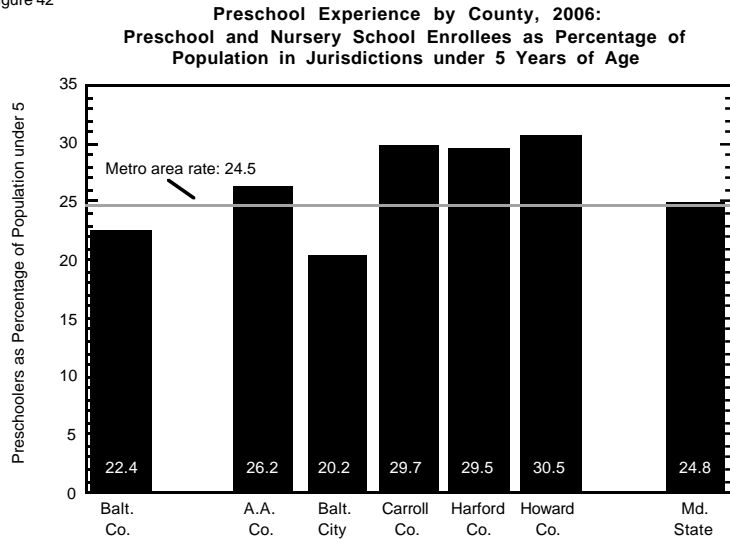


As of SY 2006-07, Carroll County still had the smallest proportion of entering kindergartners with no formal prior care experience, now even lower at 1.9 percent. (The decrease in this number between SYs 2003-04 and 2006-07 is so large as to suggest a flaw in the data; however, this is MSDE’s published figure.) Carroll County is followed by Howard County (8.4 percent), Baltimore County (10.8 percent), Harford County (11.9 percent), Baltimore City (24.6 percent) and Anne Arundel County (36.5 percent). The current rate for Maryland is 18.0 percent; the area, 18.0 percent too (MSDE 2004a, 2005a, 2006a).

did *not* attend any sort of preschool, center or other formal care setting. (Figure 40 also shows data from SY 2003-2004 for comparison.) While some home-cared children may arrive in kindergarten quite well prepared for school, it is nonetheless true that, in general, the more of a jurisdiction’s students who attend some form of preschool, the better it will be for that jurisdiction’s level of school readiness. Therefore, on figure 40, the shorter the bar, the better. As can be seen on the graph, Baltimore County is third from the bottom — with a low rate being the desirable kind on this

Figure 41 offers a historical view of the rate of kindergartners with no prior care since SY 2002-2003, the first year of WSS administration. As the figure shows, Baltimore County has consistently had a lower rate of such kindergartners — i.e., has had a higher rate of kindergartners with prior care experience — than both the metro area and the state. However, Baltimore County’s rate of kindergartners lacking prior care experience has increased 31.6 percent since SY 2002-2003. The

Figure 42



Source: BC 2008.

county’s current rate (the 10.8 percent mentioned above) is fairly low, but there was a peak in 2005 as high as about 17 percent. Since SY 2002-2003, both the state and area have seen identical decreases of 1.1 percent (MSDE 2004a, 2005a, 2006a).

The U.S. Census Bureau is another source of information on preschool attendance, collecting as it does a snapshot of who is currently attending preschool as part of its annual American Community Survey and the decennial census. We presented census data on preschool attendance in our last report, when we found that — as of 2000 — Baltimore County was nearly tied with Howard County for highest rate of preschool attendance, with both jurisdictions reporting around 30 percent of children under 5 as enrolled in preschool (BC 2002). (It is important to note that these percentages are not comparable to any of the percentages discussed above in this section or in the preceding section. The preceding percentages include any prior care experience before entering kindergarten, and so could count experiences from more than one year. The census figures discussed here only count children who are enrolled in preschool at one point in time and are smaller as a result.)

As of 2006, the year of the most recent data available, the proportions in both Howard and Baltimore counties have fallen, the latter more

drastically than the former (see figure 42). Howard County is still the leader, with a preschool-enrollment rate of 30.5 percent of children under 5, followed by Carroll County (29.7 percent), Harford County (29.5 percent), Anne Arundel County (26.2 percent), Baltimore County (22.4 percent) and Baltimore City (20.2 percent). In Maryland, 24.8 percent of children under 5 are in preschool, compared to 24.5 percent in the metro region (BC 2008).

#### 4.9.4 Preschoolers with IEPs

Under the federal Individuals with Disabilities Education Act (IDEA), public schools

must educate students in the “least restrictive environment” possible, meaning that every effort must be made to accommodate children with disabilities in the general classroom. One tool used for this purpose is an individual education plan (IEP), a formal document that specifies short- and long-term learning goals and special accommodations for each disabled student. As we stated in 2005, “a jurisdiction’s only appropriate goal where the IEP rate is concerned is to ensure that all students who require special services are receiving them, regardless of whether or not this increases said IEP rate” (BCLMB 2005).

In our last report we published data from SY 2002-2003 showing that Baltimore County had a relatively low rate of IEPs compared to its neighbors, coming in fifth place (ahead of Howard County). The highest rate was in Baltimore City, where 16.15 percent of K-12 students had IEPs, followed by Harford County (15.10 percent), Anne Arundel County (14.30 percent), Carroll County (13.10 percent), Baltimore County (12.52 percent) and Howard County (10.60 percent). The state’s rate was 13.05 percent, while the area’s was 13.80 percent (MSDE 2003b, 2003c).

Table 19 reprints the SY 2002-2003 data discussed above, along with data from all subsequent school

years through SY 2006-2007. As of SY 2006-2007, the table shows, the above rank order has fluctuated only slightly. Baltimore City is still the jurisdiction with the highest proportion of K-12 students with IEPs, at 16.95 percent, followed by Harford County (13.92 percent), Baltimore County (12.93 percent), Anne Arundel County (12.23 percent), Carroll County (12.11 percent) and Howard County (9.67 percent). Statewide, 12.55 percent of K-12 students have IEPs, compared to 13.29 percent in the metro area.

Interestingly, Baltimore County is one of only two jurisdictions (the other being Baltimore City) that have seen increases in their IEP rates since SY 2002-03; the county increase was 3.27 percent, somewhat smaller than the city's, which was 4.95 percent. Decreases ranged from 7.56 percent in Carroll County to 14.48 percent in Anne Arundel County (MSDE 2003b, 2003c, 2007c).

Table 19 also includes information on "mature IEPs," or existing IEPs established during one school year that have not been reviewed and updated as of the beginning of the next, as required by federal rules.

Baltimore County is the only metro-area jurisdiction to have had no mature IEPs in any of the five years shown on the table. As of SY 2006-2007, Anne Arundel County has the highest rate of mature IEPs, representing 2.44 percent of all IEPs in that jurisdiction, followed by Harford County (2.43 percent), Howard County (1.58 percent),

Baltimore City (0.62 percent) and Carroll County (0.14 percent). Since SY 2002-2003, the rate of mature IEPs has climbed in Howard County (558.33 percent), Baltimore City (313.33 percent) and Harford County (from a rate of 0.00 to 2.43 percent), while it has declined in Carroll County (85.57 percent decrease) and Anne Arundel County (40.20 percent) (MSDE 2003b, 2003c, 2007c).

Table 19

**Public School IEP Trends by County and Year, SY 2002-2003 to SY 2006-2007:  
IEPs as Percentage of Enrollment, All Grades, and  
Mature IEPs and Percentage of All IEPs**

<i>Jurisdiction</i>	<i>02-03</i>	<i>03-04</i>	<i>04-05</i>	<i>05-06</i>	<i>06-07</i>	<i>+/- %</i>
<b><i>IEPs as Percentage of Enrollment</i></b>						
Baltimore Co.	12.52	12.91	13.03	12.89	12.93	3.27%
Anne Arundel Co.	14.30	14.11	13.55	12.59	12.23	-14.48%
Baltimore City	16.15	16.69	16.86	17.09	16.95	4.95%
Carroll Co.	13.10	12.84	12.83	12.42	12.11	-7.56%
Harford Co.	15.10	15.18	15.05	14.60	13.92	-7.81%
Howard Co.	10.60	10.60	10.35	10.00	9.67	-8.77%
Maryland Statewide	13.05	13.09	12.88	12.76	12.55	-3.83%
Metro Region	13.80	13.97	13.87	13.55	13.29	-3.70%
<b><i>Mature IEPs as Percentage of All IEPs</i></b>						
Baltimore Co.	0.00	0.00	0.00	0.00	0.00	0%
Anne Arundel Co.	4.08	1.88	3.86	1.76	2.44	-40.20%
Baltimore City	0.15	0.67	0.56	0.45	0.62	313.33%
Carroll Co.	0.97	0.30	0.05	0.31	0.14	-85.57%
Harford Co.	0.00	0.00	0.00	0.00	2.43	n/a
Howard Co.	0.24	0.47	0.56	0.90	1.58	558.33%
Maryland Statewide	1.98	1.45	0.68	0.76	0.11	-94.44%
Metro Region	0.93	0.61	0.93	0.55	1.03	10.75%

Note 1: Baltimore City data exclude Edison schools' data.

Note 2: A "mature" IEP is one over a year old.

Source: MSDE 2002a, 2002b, 2003b, 2003c, 2004b, 2004d, 2005b, 2005c, 2006b, 2006c, 2007c.

Table 20

**Public and Private Preschool IEPs by County and Year, SY 2002-2003 to SY 2006-2007:  
Preschoolers with Disabilities as Percentage of all Preschoolers in Jurisdiction**

<i>Jurisdiction</i>	<i>02-03</i>	<i>03-04</i>	<i>04-05</i>	<i>05-06</i>	<i>06-07</i>	<i>+/- %</i>
Baltimore Co.	7.91	8.31	8.74	9.00	9.80	23.89%
Anne Arundel Co.	11.69	13.80	11.99	11.34	11.23	-3.93%
Baltimore City	15.35	15.04	15.76	13.07	12.75	-16.94%
Carroll Co.	11.27	10.55	14.02	14.75	13.68	21.38%
Harford Co.	15.48	16.08	15.28	14.66	10.10	-34.75%
Howard Co.	9.64	8.64	7.27	6.90	7.79	-19.19%
Maryland Statewide	10.27	10.70	11.07	10.99	11.08	7.89%
Metro Region	11.09	11.40	11.20	10.61	10.52	-5.14%

Note: Baltimore City data exclude Edison schools' data.

Source: MSDE 2002a, 2002b, 2002c, 2003b, 2003c, 2003d, 2004b, 2004d, 2004e, 2005b, 2005c, 2005d, 2006b, 2006c, 2006d, 2007c.

Shifting the discussion from mature IEPs back to IEPs in general, we find it interesting to note that, although Baltimore County has experienced relatively slow growth in its overall IEP rate from SY 2002-2003 through SY 2006-2007, the county has seen much faster growth during the same period in the IEP rate among preschoolers, as can be seen on table 20. In fact, the county has led the metro region in the growth of its preschool IEP rate, with an expansion of nearly one quarter (23.89 percent). The next highest — and only other — increase in this rate was in Carroll County (21.38 percent). The largest decrease was in Harford County (34.75 percent), followed by decreases in Howard County (19.19 percent), Baltimore City (16.94 percent) and Anne Arundel County (3.93 percent) (MSDE 2003b, 2003c, 2003d, 2006b, 2006c, 2006d).

Nonetheless, as of SY 2006-2007, Baltimore County has a low rate of preschoolers with IEPs compared to its neighbors. The highest rate is in Carroll County, where 13.68 percent of all preschoolers have IEPs, followed by Baltimore City (12.75 percent), Anne Arundel County (11.23 percent), Harford County (10.10 percent), Baltimore County (9.80 percent) and Howard County (7.79 percent). The state rate is 11.08 percent, while the area rate is 10.52 percent (MSDE 2003b, 2003c, 2003d, 2006b, 2006c, 2006d).

An IEP-related indicator that is on the rise in Baltimore County is the rate of IEPs among the cohort of students that began pre-kindergarten in the fall of SY 2002-2003 (see table 21). For this indicator, we measured the rate of IEPs among pre-kindergartners in

SY 2002-2003, kindergartners in SY 2003-2004, first graders in SY 2004-2005, and so on, with the idea that this would obtain information about more or less the same group of students each year. In our last report, we presented a similar table with data from SY 1999-2000 through SY 2003-2004, showing a more than 50 percent increase in that cohort's IEP rate over those years. This time, as table 21 shows, the increase — while still sizeable, at 27.91 percent — is nowhere near as large (MSDE 2003b, 2003c, 2003d, 2006b, 2006c, 2006d).

Nonetheless, the county has gone from being one of four metro-area jurisdictions to see increases (from SY 1999-2000 through SY 2003-2004, as shown in our previous report) to being the only jurisdiction to see an increase (from SY 2002-2003 through SY 2006-2007, as shown in table 21). The rest of the metro-area jurisdictions experienced decreases, led by Anne Arundel County (31.57 percent) and followed by Howard County (19.61 percent), Harford County (13.44 percent), Baltimore City (9.64 percent) and Carroll County (4.17 percent). The state saw an increase of 14.17 percent, while the area saw a decrease of 4.33 percent (MSDE 2003b, 2003c, 2003d, 2006b, 2006c, 2006d).

Were it not for the decreases in all of the other jurisdictions shown on table 21, one possible reason for Baltimore County's increase — an increase we have observed over two different time frames now — might be that disabilities are going undetected in the early grades and only coming to light as students

advance through the grades and encounter more challenging work. One would expect such a scenario to hold across jurisdictions, however, which does not appear to be the case. In light of this discrepancy, it would be interesting to examine Baltimore County's IEP policies and procedures to see what other explanations might exist.

#### 4.10 Care Availability

In addition to the benefits of certain types of child care in increasing children's school readiness, child care — both before and during a child's school years — is a practical necessity in many households, since it is the rare two-parent family these days that can survive on one parent's income, and since so many single parents find themselves raising children on their own. In order to earn the salaries on which their family's survival depends, then, most parents need access to some form of affordable child care.

Table 21

**Public and Private IEPs Tracked by County and Year, SY 2002-2003 to 2006-2007:  
Same Students with Disabilities as Percentage of all Students in Jurisdiction**

<i>Jurisdiction</i>	<i>SY 02-03</i>	<i>03-04</i>	<i>04-05</i>	<i>05-06</i>	<i>06-07</i>	<i>+/- %</i>
	<i>Pre-K</i>	<i>Kind.</i>	<i>1st G.</i>	<i>2nd G.</i>	<i>3rd G.</i>	
Baltimore Co.	7.99	8.81	9.54	9.31	10.22	27.91%
Anne Arundel Co.	11.69	6.27	6.99	7.19	8.00	-31.57%
Baltimore City	15.35	7.40	10.99	12.40	13.87	-9.64%
Carroll Co.	11.27	12.04	11.76	10.82	10.80	-4.17%
Harford Co.	15.48	8.47	11.95	13.09	13.40	-13.44%
Howard Co.	9.64	9.44	8.16	7.66	7.75	-19.61%
Maryland Statewide	9.03	7.40	8.87	9.51	10.31	14.17%
Metro Region	11.90	8.74	9.90	9.87	10.61	-4.33%

Note: Baltimore City data exclude Edison schools' data.

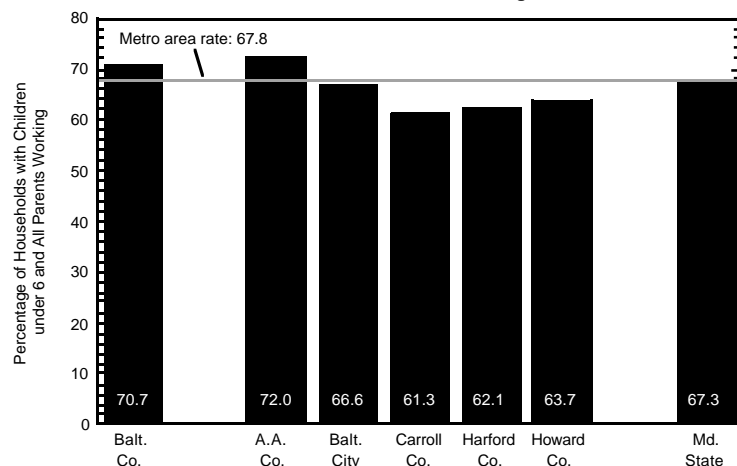
Source: MSDE 2002a, 2002b, 2002c, 2003b, 2003c, 2003d, 2004b, 2004d, 2004e, 2005b, 2005c, 2005d, 2006b, 2006c, 2006d, 2007c.

#### 4.10.1 Children with Working Mothers

That child care is a necessity for the majority of families is made clear by figure 43, which shows the percentage of all households in each metro-region jurisdiction with children under 6 in which all parents who live in the household have jobs. When we last reported data on this indicator, we found that — as of 2000, the most recent data then

Figure 43

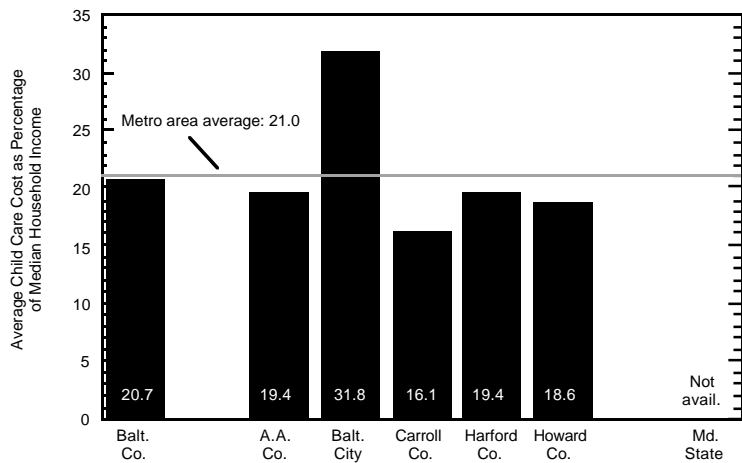
**Dual-job Families by County, 2006:  
Percentage of Households with Children under 6  
with All Parents Working**



Source: BC 2008.

Figure 44

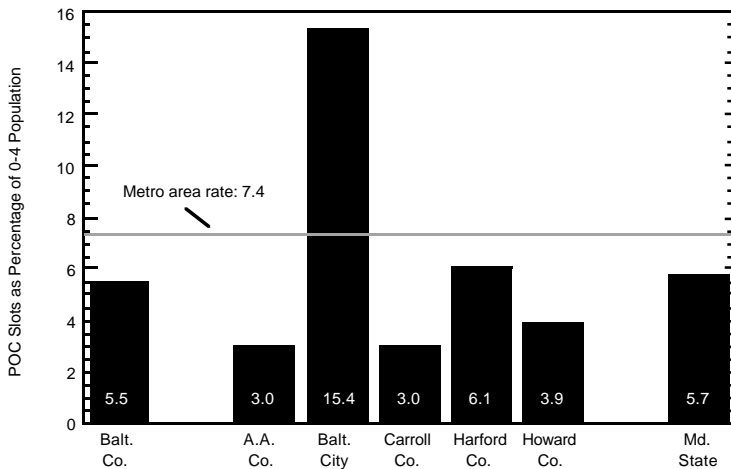
**Child Care as a Proportion of Income by County, 2006:  
Average Full-time Child Care Cost as Percentage of Household Income**



Source: MCC 2008a-g.

Figure 45

**Low-income Child Care Availability by County, 2006:  
POC Slots as Percentage of 0-4 Population**



Source: MCC 2008a-g.

available — about 64 percent of Baltimore County households fell into this category, the second-highest rate in the metro area. Now, as can be seen in figure 43, the county rate of dual-job families has climbed some 6 points, to 70.7 percent. Anne Arundel County, the leader in 2000, continues to show the highest dual-job-family rate, at 72.0 percent. Next comes Baltimore County, still in second place with the aforementioned rate of 70.7 percent, followed by Baltimore City (66.6 percent), Howard County (63.7 percent), Harford County (62.1 percent) and Carroll County (61.3 percent). The state

rate is 67.3 percent, while the area rate is 67.8 percent. In addition to Baltimore County, three other jurisdictions saw increases in this rate since 2000: Anne Arundel and Howard counties, and Baltimore City (BC 2008).

#### 4.10.2 Child-care Costs

For those parents who do need child care, expense is often an obstacle. The Maryland Child Care Resource Network (MCCRN), a public/private partnership administered by the Maryland Committee for Children, reports that cost is the second most common reason cited by parents who needed but could not obtain child care (the first was lack of vacancies in their preferred providers' centers) (MCC 2007). Indeed, for those families not fortunate enough to be able to rely on a family member to care for their children while the parents are working, child-care expenses are likely to eat up a sizeable portion of a family's total income; in Baltimore County, it is the second-largest single household expense, on average (MCC 2007).

MCCRN estimates child-care expenses for Maryland families by averaging the combined costs for "full-time care for an infant in a family child-care home and a preschooler in a child-care center," and then comparing the results to median-income data for each county (MCC 2003). The resulting percentages for the metro-area jurisdictions, from the year 2006, are shown in figure 44.

Given the low income levels in Baltimore City (see table 6), it should come as no surprise that — as shown in figure 44 — it is city families who can

expect to pay the largest proportion of their income for child care, or about 32 percent. Baltimore County, where the child-care-cost estimate is over 20 percent of median income, is in second place, followed by Anne Arundel and Harford counties (tied at 19.4 percent), Howard County (18.6 percent) and Carroll County (16.1 percent). A statewide figure is not available; a metro-area rate could not be calculated, but the metro-area average is 21.0 percent (MCC 2008a-f). For all jurisdictions save Baltimore City and Carroll County, these figures represent an increase since the 2000 data we reported previously. (A high percentage on this indicator does not necessarily equate to high absolute child-care costs; the percentage is also relative to median incomes, which vary considerably among these jurisdictions. See table 6.)

Maryland's Purchase of Care child-care subsidy program (POC) helps low-income families pay for child care. In our last report, we considered the availability of POC slots compared with the number of children on the POC waiting list. However, in 2007, it became state policy to serve anyone found eligible for the POC program, meaning that no one is placed on waiting lists anymore (Ramseur 2008).

Nonetheless, figure 45, which shows the number of currently funded POC slots as a percentage of the 0-4 population in each metro-area jurisdiction, still offers a useful view of the extent to which POC is needed and utilized in each jurisdiction. The largest proportional utilization is in Baltimore City, where as of 2006 the number of funded POC slots is equivalent to 15.4 percent of the under-5 population. Next comes Harford County (6.1 percent), Baltimore County (5.5 percent), Howard County (3.9 percent), Carroll County (3.0 percent) and Anne Arundel County (3.0 percent). Statewide, the rate is 5.7 percent, while the area's rate is 7.4 percent (DHMH 1995, 1996, 1997, 1998, 1999, 2000a, 2001a, 2002b, 2003a, 2004a, 2005a, 2006a, MCC 2008a-f).

## Chapter 5. Goals and Objectives

After several meetings to deliberate and discuss, the ECC approved its updated goals, objectives and action steps on February 6, 2009. The approved plan was then presented to the full LMB for review and accepted on June 1, 2009. The LMB-approved goals and objectives are presented in table 22 and discussed in detail throughout this chapter.

### 5.1 Progress to Date

As in previous years, the first three goals of the updated plan are to ensure that families (1) are aware of programs available to them, (2) understand the role families play in their children's development and (3) are able to access necessary health care and behavioral consultation services. The next three goals are to improve the health and well-being of children in Baltimore County by: (1) assisting families in the early identification of developmental, health and behavioral problems; (2) ensuring that pregnant women are accessing prenatal care; and (3) educating parents on child safety and injury prevention. The final goal requires the LMB to monitor progress toward achieving the other goals and objectives.

Before revising the goals and objectives published in the 2005 report, the LMB reviewed its progress so far. The following is a list of updates based on the LMB's 2005 action agenda.

*Public Awareness:* As per action step 1.1(f) of the 2005 plan, the LMB planned to hold a series of workshops to train early care and education (ECE) staff about existing public benefits and programs. This would enable them to relay information to the families with whom they work. This action step was accomplished through the publication of two public information resources, (1) the quarterly newsletter, *Links to Learning*, which was sent to child-care providers, and (2) a bookmark containing referral information for parents of young children.

These publications were distributed by collaborating agencies, such as the Baltimore County Public Library, to promote public awareness of programs

and of the importance of parental involvement to a child's early development. The publication of these resources also fulfilled objective 2.2 by using county agencies to promote public awareness of the importance of parental involvement in children's early education.

*Access to Services:* Goal 4 of the LMB's 2005 action agenda was to ensure that all Baltimore County families with children under 5 have access to health, mental health and behavioral consultation services. The first objective (4.1) under this goal was to increase the Maryland Children's Health Program (MCHP) enrollment in Baltimore County 20 percent by December 2009 (from 11,906 enrollees at the beginning of CY 2004 to 14,287). As of July 2008, data show that the county has already surpassed its goal, with 21,452 enrollees and 2,121 applications pending.

Several related action steps are still in progress. These include the development of an ongoing statistical summary of MCHP enrollment, a county-wide MCHP awareness campaign, and the tracking of enrollment by county census-designated place on an annual basis to target communities and populations with disproportionately high eligibility and low enrollment.

*Behavioral and Mental Health System:* Objective 4.2 of the LMB's 2005 action plan was to increase utilization rates of public behavioral and mental health services among families with children under 5 by 20 percent by December 2009 (from 505 children in CY 2003 to 606). While utilization rates have remained fairly consistent, the LMB decided that increased utilization might not necessarily be the best way to determine greater performance of the public mental health system. Instead, it is of greater importance to stress early identification of child developmental delays, timely referrals to public programs, and adequate health care, all of which ultimately decreases the occurrence of behavioral and mental health problems in children.

The action steps associated with this objective included activities that would fall to the Baltimore County Department of Health's Bureau of Mental Health (BMH). The BMH has been instrumental in advancing the public mental health system in

Baltimore County and has accomplished the action steps set forth in the 2005 agenda. These included publicizing the importance and availability of behavioral and mental health services, setting aside funds for behavioral consultations for child-care center staff and parents of young children, and participating in statewide initiatives for early-childhood mental health. Lastly, under action step 4.2(e), the BMH sought funding for new early-childhood-focused mental-health programs by partnering with five private community agencies. These partnerships led to the award of a multi-year grant for Project ACT (All Children Together), for the delivery of mental-health consultations to licensed child-care providers in Baltimore County.

*Physician Awareness:* Objective 5.1 of the 2005 plan reflected the LMB's desire to increase physician awareness of best practices in early-childhood developmental screening and the range of available referral opportunities. This has been undertaken by the Infants and Toddlers Program and the Bureau of Child, Adolescent and Reproductive Health (CARH), working with the Maryland chapter of the American Academy of Pediatrics (AAP) and the Maryland Department of Health and Mental Hygiene (DHMH). Through these partnerships, new Early and Periodic Screening, Diagnosis & Treatment (EPSDT) guidelines for developmental screening have been developed and implemented in Baltimore County. Other action steps under objective 5.1 have also been fully implemented. Information on best practices has been circulated to organizations with access to physicians through DHMH and the Maryland chapter of the AAP. A statewide universal referral form has been developed and will be disseminated to physicians in the near future.

*Infants and Toddlers Program:* Objective 5.2 of the 2005 action agenda stated the LMB's plan to increase the number of Baltimore County infants receiving services from the I&T program by 20 percent by December 2010 (from 1,701 enrollees in CY 2003 to 2,041). Though this deadline remains in the future, 2008 data show a 16 percent increase so far, with the program well on pace to achieve the committee's goal.

Action steps 5.2(a) through 5.2(c) of the 2005 agenda outlined specific ways that the LMB would accomplish its goal of a 20 percent increase in I&T program enrollees by December 2010. This included making the I&T program responsible for planning targeted public awareness and outreach activities, setting specific benchmarks for services to Baltimore County's youngest residents, and providing data on program utilization rates to the LMB to ensure adequate resource allocation for programs.

In its push toward this goal, the I&T program has implemented an annual public awareness action plan that focuses on outreach activities for primary referral sources, including neonatal intensive care units (ICUs), physicians and families. These activities have resulted in consistent increases in referrals to the program (1,755 children as of 2008, representing a 10 percent increase since *Focus on the First Years* was released in 2005). Lastly, the Baltimore County I&T program has submitted annual detailed reports to the LMB regarding service data, such as the number of staff members supporting the program and funding sources for all positions.

*Family Planning:* The LMB's 2005 plan stressed the need for increased availability of and participation in health department family planning clinic services (objective 6.3). While current data suggest a persistent need to increase use of family planning clinics in the county, much has been accomplished to improve access to services. Family-planning clinic sessions have been increased to 32-36 sessions per month and five late afternoon/early evening clinics have been added particularly to address the needs of teen clients. Outreach has also been undertaken to increase program linkages with middle and high schools and with school-based health centers, as well as to increase community awareness of available family-planning services.

*Healthy Start:* On June 30, 2008 the Department of Health and Mental Hygiene's Healthy Start program ended. The responsibility for the processing of the Maryland Prenatal Risk Assessment (MPRA) was transferred to the Administrative Care Coordination Unit (ACCU). This responsibility is limited to the review of the forms for com-

Table 22

**Early Childhood Committee Goals & Objectives,  
As Approved by the Local Management Board, June 2009**

**Goal 1.** Assure that all Baltimore County families with young children (birth through age five) are aware of all public benefits and programs.

**Objective 1.1.** Continue to use early-care and education (ECE) programs, and other programs that relate to young children, to provide information to families on existing county and state programs and benefits.

Action Step 1.1(a). Coordinate the development and publishing of a public-information marketing tool (e.g., bookmark).

Action Step 1.1(b). Update the *Focus on the First Years* (FOFY) web site (<http://www.focusonthefirstyears.info>).

Action Step 1.1(c). Develop partnerships to facilitate the use of existing channels to distribute information.

**Objective 1.2.** Continue to promote collaboration in the provision of outreach services for parents to ensure the best use of limited resources.

Action Step 1.2(a). Continue regular meetings of the ECC.

Action Step 1.2(b). Identify gaps in its own membership by service area and take steps to recruit accordingly.

Action Step 1.2(c). Use the ECC as a forum to enhance collaboration.

**Goal 2.** Support parents and/or guardians in the central role they play in their child's development.

**Objective 2.1.** Utilize the FOFY web site, by July 2009, to provide user-friendly educational materials that offer guidance to families as they support healthy early-childhood development.

Action Step 2.1(a). Appoint a small subcommittee of the ECC to advise and guide the layout and design, as well as the resources to be highlighted on the web site.

Action Step 2.1(b). Develop and begin implementing an 18-month "content" plan for the web site that details resources and materials.

**Objective 2.2.** Use county agencies and committee partners to promote public awareness of the FOFY web site and other resources available to Baltimore County families.

**Goal 3.** Assure that all Baltimore County families with children under five have access to health, mental health and behavioral consultation services.

**Objective 3.1.** Increase collaboration among participating agencies to foster prevention of developmental delays among children in Baltimore County.

Action Step 3.1(a). Educate collaborating agencies about the programs available to support pregnant women in providing health care to their child.

Action Step 3.1(b). Encourage collaborating agencies to refer women to the programs for which they may qualify.

**Objective 3.2.** Promote early identification of children with suspected delays and appropriate referral to the Baltimore County Infants and Toddlers Program for evaluation, so that services can be initiated in a timely manner.

Action Steps 3.2(a). Work with community physicians and hospital neonatal intensive care units (NICUs) to improve their knowledge of who should be referred, and how to facilitate the referrals.

Action Steps 3.2(b). Work collaboratively with the Maryland Department of Health and Mental Hygiene and the Maryland Chapter of the American Academy of Pediatrics to inform providers of health care for young children about: standards of care for developmental surveillance and screening, appropriate tools to assess development and the appropriate steps to take when there are concerns about a child's development.

*(Continued.)*

pletion, ensuring access to Medicaid programs for all eligible pregnant women and providing linkage to appropriate managed-care organization (MCO) sources and community resources. These funds cannot be used to provide case management. The health department has been revising how the problem of high-risk pregnancies will be addressed. As a result, pregnant women who fall in the high-risk category needing case management are now referred to the Perinatal Enrichment Program (PEP), a new part of the Early Childhood Division within Clinical Services. Public health nurses in PEP will follow those with needs that will not be addressed through the MCO or community resources, as well as all pregnant teens under the age of 18.

*Substance Abuse Treatment:* Objective 6.5 of the former plan states that the county Department of Health will increase the number of drug-affected pregnant women admitted to drug and alcohol treatment 18 percent by December 2009. While a lack of overall data for this objective has made it difficult to monitor progress, the health department has taken steps to ensure that all grant-funded, substance-abuse service providers admit any pregnant substance abuser requesting treatment within 48 hours, and allow her to remain in care for the duration of her pregnancy. Also, the health department has begun the process of developing a contact list of obstetrics and gynecology (OB/GYN) providers, which would offer a way for Baltimore County residents to inquire about available information and treatment. Pregnant women identified as having problems with tobacco use or substance abuse on their prenatal risk-assessment form will be referred for substance abuse treatment or tobacco cessation intervention through the ACCU review and the Prenatal Enrichment Program.

## **5.2 Updated Goals and Objectives**

The section provides a narrative of the changes and updates to the goals and objectives as discussed and approved by the ECC, 2008-2009.

### **5.2.1 Goal 1**

Current CDP-level data reflect fewer disparities related to child-care availability within Baltimore County than were noted in the previous report.

Nevertheless, the financial burden of child care continues to pose a great strain on families with young children. Therefore, the committee's first goal is to ensure that families with young children are aware of all public benefits and programs available to them. To accomplish this, the committee will continue to support early-care and education programs and inter-agency collaboration in the provision of outreach services to parents.

#### **5.2.1.1 Early-care and Education Programs:**

Objective 1.1 states that the LMB will continue to use ECE and other programs to provide information to families on existing county and state programs and benefits. This will be accomplished in a variety of ways. First, the LMB will coordinate the development and publishing of a public-information marketing tool in the form of a bookmark. The LMB will also continue to maintain the *Focus on the First Years* (FOFY) web site ([www.focusonthefirstyears.info](http://www.focusonthefirstyears.info)), another source of information for parents regarding public programs. Lastly, the LMB will develop partnerships to facilitate the use of other existing channels to distribute information.

**5.2.1.2 Collaboration:** To ensure the effective distribution of information regarding public programs and benefits, the LMB will strengthen partnerships with state and county agencies that provide services to families with young children. Objective 1.2 supports this commitment by pledging the continued promotion of collaboration in the provision of outreach services to parents to ensure the best use of limited resources. This collaboration will continue to be monitored through the ECC. To this end, the ECC will meet regularly to provide a forum for enhancing cooperation among member agencies. This will require the ECC to identify gaps in its own membership and take steps to recruit experts in service areas that are lacking representation. This committee will then be able to promote its efforts through a network of affiliated members.

#### **5.2.2 Goal 2**

As mentioned in chapter 4, families who take advantage of existing public programs make a tremendous difference in the overall success of their child's development. The LMB's second goal is to support parents and/or guardians in the central

(From previous page.)

**Objective 3.3.** Provide education to parents of young children about the importance of nutrition and physical activity for ensuring optimal growth and development.

Action Step 3.3(a). Encourage agencies to provide educational materials to child care programs that would educate both child-care providers and parents about appropriate nutrition and activity for toddlers and pre-school age children.

Action Step 3.3(b). Utilize the FOFY web site as a resource to convey information to parents.

**Objective 3.4.** Encourage collaboration among participating agencies to promote social and emotional development, positive family relationships, stable enrollment in child care, and school readiness.

Action Step 3.4(a). Educate parents through the FOFY web site and the efforts of each collaborating agency regarding social/emotional development and family relationships.

Action Step 3.4(b). Facilitate access to information about resources, education and training for child-care providers.

Action Step 3.4(c). Advocate for adequate resources to address mental-health concerns of young children and their families.

**Goal 4.** Assure that children under five have access to comprehensive health and developmental screening with follow-up assessments as necessary to enable early identification of problems, and referral to health and educational interventions.

**Objective 4.1.** Increase physician awareness of best practices in early childhood developmental screening and model developmental screening tools, as well as awareness of all appropriate referral opportunities.

Action Step 4.1(a). Partner with the Maryland chapter of the American Academy of Pediatrics and the Maryland Department of Health and Mental Hygiene's Center for Maternal and Child Health (within the Family Health Administration) to circulate information on best practices to physicians.

Action Step 4.1(b). Circulate information to physicians on referral steps for families when concerns are identified.

**Goal 5.** Facilitate the provision of health care for women to ensure the birth of healthy babies.

**Objective 5.1.** Promote access to family planning services administered by the Baltimore County Department of Health.

Action Step 5.1(a). Provide outreach and education regarding the importance and availability of family-planning services to the general community and schools.

Action Step 5.1(b). Encourage provision of services throughout the county and at a wide range of hours to make them more accessible.

**Objective 5.2.** Educate women of childbearing age on the importance of good nutrition and healthy lifestyles, prior to and during pregnancy, for ensuring healthy babies.

Action Step 5.2(a). Develop and disseminate educational materials through the library system, schools and other venues.

Action Step 5.2(b). Encourage referrals to the Women, Infants and Children (WIC) program for women who may be eligible for nutrition assistance during pregnancy.

**Objective 5.3.** Facilitate the connection of pregnant women to prenatal care.

Action Step 5.3(a). Educate the public about the increased availability of, and eligibility criteria, for Medicaid for pregnant women.

Action Step 5.3(b). Direct women to providers that offer services to pregnant Medicaid-eligible women.

(Continued.)

role they play in their children's development. As with goal 1, the LMB plans to achieve this goal by providing information to families with young children and through the promotion of collaboration efforts among relevant agencies.

**5.2.2.1 Guiding Families:** Objective 2.1 of the LMB's new action agenda states that, by July 2009, user-friendly educational materials that offer guidance to families on healthy early-childhood development will be available to the public on the FOFY web site. To achieve this objective, the ECC will appoint a small subcommittee to guide the layout and design of the web site, and to devise a list of resources that will be included. A content plan will be developed that details resources and materials that will be available on the web site throughout the ensuing 18-month period.

**5.2.2.2 Public Awareness of Available Resources:** Under objective 2.2, the LMB will use county agencies and committee partners to promote public awareness of the FOFY web site and other resources available to Baltimore County families.

### **5.2.3 Goal 3**

Early intervention programs, such as Head Start and the Infants and Toddlers Program, may help prevent developmental delays in young children. Goal 3 commits the LMB to (1) ensuring that all Baltimore County families with children under five have access to these and other health, mental health and behavioral consultation services by (2) informing the public about all available services. This will be done through collaboration and prevention efforts, continued evaluation of and referrals for possible developmental delays, promoting good nutrition and physical activity, and cooperation among relevant agencies.

**5.2.3.1 Collaboration and Prevention:** Objective 3.1, the first step toward ensuring access to health, mental health and behavioral consultation services, is to increase collaboration among participating agencies to reduce and prevent developmental delays among children in Baltimore County. This will be done by educating agencies about the programs available to support pregnant women in providing health care to their children, as well as encouraging agencies to refer women to the pro-

grams for which they may qualify. Examples of these programs include Medicaid, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and the Purchase of Care (POC) child-care subsidy program.

**5.2.3.2 Early Identification of Delays:** Objective 3.2 of the updated action agenda states that the LMB will promote early identification of developmentally delayed children, so that referrals to the Baltimore County Infants and Toddlers Program can be made and services initiated in a timely manner. This will be accomplished through increased cooperation with physicians and hospital neonatal intensive care units to improve knowledge of who should be referred and how. The next step will involve collaboration with DHMH and the Maryland Chapter of the American Academy of Pediatrics to inform local health-care providers about the signs of potential delays and what steps to take when delays are identified, including standards of care for developmental surveillance and screening, appropriate tools to assess development, and appropriate steps to take when there are concerns about a child's development.

**5.2.3.3 Nutrition and Physical Activity:** Teaching young children about the importance of good nutrition and physical activity is fundamental to a child's development and good health. The LMB recognizes that it is first necessary to educate parents about appropriate nutrition and activity for young children, so that they are then able to inform their children and promote healthy lifestyles in the home. Objective 3.3 highlights the LMB's commitment to ensuring optimal growth and development in young children in Baltimore County, in this case by encouraging local agencies to provide educational materials to child-care programs that would educate both child-care providers and parents about appropriate nutrition and physical activity for toddlers and pre-school-age children. The FOFY web site will also be used to convey information to parents on these matters.

**5.2.3.4 Social and Emotional Development:** Instability in the home can adversely affect the development of young children. The LMB's objective 3.4 aims to promote social and emotional development, positive family relationships, stable

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**Objective 5.4.** Facilitate expedited connection to care for pregnant women who need treatment for substance abuse or tobacco cessation.

Action Step 5.4(a). Work collaboratively with the Baltimore Regional Perinatal Advisory Group (RPAG) to promote education about, and facilitate referrals for, substance-abuse treatment for pregnant women.

Action Step 5.4(b). Promote education regarding the specific risk of tobacco use among pregnant women on the developing fetus.

**Objective 5.5.** Promote awareness of, and resources available to, pregnant and post-partum women through the public mental-health system.

Action Step 5.5(a). Educate the public on the risk of post-partum depression and the resources available to address it.

**Goal 6.** Encourage collaboration among agencies to keep young children safe within their families, homes and communities.

**Objective 6.1.** Educate parents and other caregivers concerning safety for young children at home and during travel.

Action Step 6.1(a). Ensure that information about safety for young children is easily accessible to families at libraries and health centers.

Action Step 6.1(b). Post appropriate injury-prevention and child-safety resources on the FOFY web site.

Action Step 6.1(c). Collaborate to identify inter-agency methods to distribute safety materials to families.

Action Step 6.1(d). Identify collaborative strategies to educate parents and caregivers regarding quality supervision of young children.

**Objective 6.2.** Identify, coordinate and enhance prevention services to reduce child abuse and neglect among Baltimore County children.

Action Step 6.2(a). Work collaboratively with the Child Advocacy Committee to identify inter-agency strategies to address this need.

**Goal 7.** Monitor progress toward the achievement of all goals and objectives established herein.

**Objective 7.1.** Immediately upon approval of this action agenda, the Early Childhood Committee (ECC), a standing committee of the Baltimore County Local Management Board, shall assume responsibility for coordinating and monitoring the implementation of recommendations outlined in this document. The committee will provide quarterly progress reports to the LMB and regular reports to the county administration.

**Objective 7.2.** Use programmatic data and supplemental, researched information to monitor goals and identify gaps in services.

*Approved June 1, 2009*

enrollment in child care and school readiness. This will be done by using the FOFY web site to educate parents on the services available from collaborating agencies. Other steps include facilitating access to information about resources, education and training for child-care providers, as well as advocating for adequate resources to address the mental-health concerns of young children and their families.

#### **5.2.4 Goal 4**

Developmental delays are not the only possible concerns during the early stages of development. In its fourth goal, the LMB expresses its commitment

to ensuring that children under five have access to comprehensive health and developmental screening, follow-up assessments, and referral to health and educational interventions. This will be done primarily through increased collaboration with local physicians.

**5.2.4.1 Physician Awareness:** Since physicians are well positioned to notice health and developmental concerns in young children, it is increasingly important that they be aware of best practices in early-childhood developmental screening and guidelines for referrals. The LMB will increase

physician awareness by partnering with the Maryland chapter of the American Academy of Pediatrics and DHMH's Center for Maternal and Child Health (within the Family Health Administration) to circulate information about the steps that should be taken when delays are identified. Most importantly, the LMB will see that physicians are informed of the appropriate referral steps when concerns are identified in children.

#### **5.2.5 Goal 5**

The fifth goal of the LMB's updated action agenda is to facilitate the provision of health care for expecting mothers, in order to improve the health of both mothers and babies. While the previous goals focus on the health and safety of young children, and how they relate to early-childhood development, the LMB would also like to stress the importance of health care for women of childbearing age. This includes access to necessary services and the promotion of good nutrition and healthy lifestyles for women prior to and during pregnancy.

**5.2.5.1 Family Planning:** Recent data show a spike in teen pregnancy and single motherhood in Baltimore County, circumstances linked to elevated risk of low birth weight in babies, families living in poverty, instability in the home, child injury, and infant and child death. The LMB believes that access to family-planning services is key to encouraging the birth of healthy babies to women prepared for motherhood.

Under objective 5.1, the LMB will promote access to family-planning services administered by the county Department of Health. This will be done through education outreach efforts targeting women in Baltimore County (including teens), explaining the importance and availability of family-planning services. The LMB will also advocate for the provision of services during non-traditional hours to improve accessibility.

**5.2.5.2 Ensuring Healthy Babies:** The next objective (5.2) relates to informing women of childbearing age about the importance of good nutrition and healthy lifestyles prior to and during pregnancy. To accomplish this objective, the LMB intends to develop and disseminate educational materials through the Baltimore County public library sys-

tem, local schools and other venues. It will also encourage referrals to WIC for women who may be eligible for nutrition assistance during pregnancy. Just as with information regarding public programs for early-childhood development and child safety, educational materials for pregnant women will also be readily available on the FOFY web site.

**5.2.5.3 Prenatal Care:** Objective 5.3 is another outgrowth of the LMB's interest in facilitating the connection of pregnant women to prenatal care. As mentioned in chapter 4 of this assessment, the U.S. Department of Health and Human Services warns that "babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die, than those whose mothers received prenatal care" (HRSA 2004). Unfortunately, recent data show that the percentage of county mothers not receiving necessary prenatal care has increased substantially over the past decade (by 75.0 percent from 1995-2006). To connect more pregnant women to prenatal care, the LMB will educate the public about the increased availability of and eligibility criteria for programs such as Medicaid for pregnant women. The LMB will also help direct women to providers that offer services to pregnant Medicaid-eligible women, thus ensuring that women who formerly could not access prenatal care due to financial constraints are now able to do so.

**5.2.5.4 Drug-abuse and Tobacco-cessation Treatment:** Objective 5.4 promotes expedited connection to care for pregnant women who need treatment for substance abuse or tobacco cessation. To achieve this objective the LMB will work collaboratively with the Baltimore Regional Perinatal Advisory Group (RPAG) to promote education about and facilitate referrals for substance-abuse treatment for pregnant women.

**5.2.5.5 Public Mental-health System:** The LMB's final objective (5.5) concerning the birth of healthy babies in Baltimore County touches on a subject that is often discounted — the role of the public mental-health system. The LMB pledges to promote awareness of and resources available to pregnant and post-partum women. So that signs of depression in pregnant women and those who have recently given birth are not ignored, the LMB's

updated action agenda stresses the importance of educating the public on the risk of depression — particularly post-partum — and the resources available to address it. Tackling the signs of mental instability and depression is fundamental in promoting child safety and well-being.

#### **5.2.6 Goal 6**

Goal 6 of the updated plan relates solely to child safety, reflecting the LMB's dedication to encouraging collaboration among agencies to keep young children safe within their families, homes and communities. This will be accomplished by educating parents on the importance of child safety and by coordinating and enhancing prevention services to reduce child abuse and neglect.

**5.2.6.1 Child Safety:** Recent data reveal a 9.1 percent increase in child injury hospitalizations in Baltimore County over the period 2002-2005, a cause for concern. Cases of lead poisoning, now referred to as elevated blood-lead level, decreased from approximately 1.4 percent in 2002 to 0.45 percent in 2006. However, despite this decrease, the LMB recognizes the hazard and encourages the testing for lead in all young children according to State and American Academy of Pediatrics guidelines. The LMB affirms in objective 6.1 that it first plans to educate parents and other caregivers concerning safety for young children at home and during travel. This will be done by ensuring that appropriate injury-prevention and child-safety information is easily accessible to families at public libraries, health centers and on the FOFY web site. Collaboration among committee members will identify methods for distributing safety materials to families, as well as identifying strategies to educate parents and caregivers regarding safe supervision of young children.

**5.2.6.2 Child Abuse and Neglect:** Objective 6.2 of the updated action agenda calls for the identification, coordination and enhancement of prevention services to reduce child abuse and neglect among Baltimore County children. This will be done through collaboration with the Baltimore County Department of Social Services' Child Advocacy Committee to identify inter-agency strategies for reducing instances of child abuse and neglect. While there has been great improvement in child-

maltreatment rates in Baltimore County — particularly with respect to instances of physical abuse, which decreased by 49.1 percent from 1996 to 2005 — cases of sexual abuse have nonetheless risen slightly in recent years (from 2.31 per 10,000 in 2003 to 2.51 in 2005).

#### **5.2.7 Goal 7**

As in the LMB's 2005 report, Goal 7 is different from the others in that it is an administrative goal, not a program-oriented goal. To ensure the achievement of the Early Childhood Committee's goals and objectives, goal 7 highlights the need for the LMB to monitor and report on its progress. It also shows the LMB's recognition of the role of the ECC in accomplishing these goals and objectives.

**5.2.7.1 Responsibility:** The first step toward achieving this goal, contained in objective 7.1, is that the ECC, a standing committee of the LMB, will assume responsibility for coordinating and monitoring the implementation of recommendations outlined in the updated action agenda. The ECC will be required to provide quarterly progress reports to the LMB and regular reports to the county administration.

**5.2.7.2 Monitoring Results:** The LMB's final objective (7.2) refers to the use of programmatic data and supplemental researched information to monitor goals and identify gaps in services. It is through this process that needs will be identified for future goals and objectives with measurable results.

## **Chapter 6. Conclusion**

### **6.1 Rationale**

This report is a sequel to two earlier reports prepared by the Baltimore County LMB. The first report, *Focus on Families*, was released in 2002 and made a detailed examination of a variety of indicators related to child health and well-being in Baltimore County.

In 2003, County Executive James T. Smith established a task force called the Early Childhood Action Committee. The ECAC was directed to (1) improve collaboration among existing providers of early childhood services, (2) increase the effectiveness of existing programs, (3) inform parents about existing programs, (4) educate parents about how to prepare their children for school and (5) identify untapped state, federal and private funding streams for school readiness programs.

To perform baseline statistical research under this mandate, the ECAC selected a list of results and indicators in three main issue areas. Under the rules the ECAC set itself, the results and indicators needed to be directly related to the health and well-being of young children, measurable, and comparable to data from other counties and the state as a whole. After reviewing the indicator data, the ECAC established goals and objectives intended to improve county performance on the worst indicators; the original and updated goals and objectives are discussed further in section 6.3.

Since this report is intended as an update of the 2005 report, the same list of indicators as in 2005 was in force; for the complete list, see table 1 at the beginning of this report. The ECAC is now called the Early Childhood Committee (ECC).

### **6.2 Findings**

The following sections summarize the findings of our statistical research. For more details on each indicator, please consult the expanded discussion in chapter 4.

#### **6.2.1 Background Household Statistics**

To provide background and context for the indicator data, we gathered a variety of demographic statistics. Among other things, this analysis found that Baltimore County has a relatively low proportion of residents under 5. With only 5.9 percent of its population falling into this age group, the county is in fifth place among the 6 metro-area jurisdictions on this statistic.

#### **6.2.2 Health and Safety**

The county's performance on certain indicators of neonatal health gives some cause for concern. The rate of mothers receiving late or no prenatal care is on the rise in the state, region and county but, of the three, it is the county's rate that has increased the fastest. Since 1995, this rate has risen 75.0 percent, compared to the state's 40.0 percent and the area's 19.2 percent. Perhaps partly as a result, the county has the third-highest rate of both infant mortality (7.0 per 1,000 live births) and low birth weights (8.9 percent of live births) in the metro area, though both rates have declined since the 2002 data we reported last time.

Baltimore County is also third compared to its neighbors where the mortality of young children and injuries to young children are concerned. In 2006, deaths of children ages 1-4 occurred at a rate of 3.5 cases per 1,000 such children; in 2005, in the same age group, there were 3.6 injury hospitalizations per 1,000. The county continues to improve where child abuse and maltreatment are concerned, with the rate of indicated cases having fallen more than a quarter since 1996. Lead exposure affects a few county children (0.45 percent of children under 7); the county's rate is third highest in the region, though it is far behind front runner Baltimore City.

#### **6.2.3 Family Support**

Teen births have declined in the county since 1996, although a sharp upturn in the rate between 2005 and 2006 bears watching. The proportion of families with children headed by single females has increased from 23.9 percent in 2000 to 25.6 percent in 2006.

The county's per capita income is the third highest in the region, though it has grown only about 11

percent since 2000, also the third-highest rate of growth in the region. In 2006, the county's unemployment rate was 3.9 percent, well lower than the 4.8 percent we reported in the previous report. However, since then the unemployment rate has risen sharply in the face of the severe recession that began in 2008. By November 2008, the rate had increased to 5.4 percent (EM 2009).

More than 6 percent of county residents — and more than 10 percent of residents 18 and younger — live in poverty, in both cases the second-highest rates in the area. Almost 4 percent of the population 25 and over has less than a ninth-grade education, a decrease from the 2000 rate of 4.9 percent. But births to mothers lacking high school diplomas — a risk factor for poverty for both mother and child — are up since 2002 (the data we last reported), and have increased almost 16 percent over the 10-year period 1997-2006; the current rate is 11.17 percent of all live births.

The county has the second-highest rate of both youth homelessness (5.84 percent of county juveniles) and out-of-home placements (8.4 placements per 1,000 juveniles), but only the fifth-highest rate of grandparent placements (1.8 percent of county families consist of grandparents caring for their grandchildren).

#### **6.2.4 Early Care and Education**

In Baltimore County, demand for the Infants and Toddlers program rose more than 70 percent over the 10-year period 1997-2006; although this was the second-highest increase in the metro area, Baltimore County's 2006 referral rate (36.34 per 1,000 children ages 0-4) was only fourth highest. The rate of Head Start experience among the county's entering kindergartners as of SY 2006-2007 is 3.8 percent, up from 3.2 percent in SY 2003-2004 (the last data we presented).

County children are less likely than they once were to have prior school experience when entering kindergarten. As measured by the census, only 22.4 percent of children under 5 were enrolled in preschool in 2006, down significantly from our previously reported rate of 30.4 in 2000. Similarly, the rate of kindergartners entering with no prior school experience of any sort has increased from

8.5 percent in SY 2002-2003 to 13.0 percent in SY 2006-2007. Child-care costs may contribute to the relative paucity of children with prior-school experience: the county continues to have the second-highest child-care costs in the area, when considered as a proportion of the median income. The number of Purchase of Care slots funded in the county is equivalent to 5.5 percent of the population under 5, the third-highest rate in the area.

Nonetheless, Baltimore County kindergartners starting school in SY 2006-2007 are vastly better prepared than in SYs 2002-2003 and 2003-2004, as measured by the WSS assessment: whereas the county scores we reported last time hovered between 50 and 60 percent, now more than 77 percent of incoming Baltimore County kindergartners are assessed as fully ready, the second-highest rate in the area. The county continues to maintain a relatively small achievement gap between African-American and white students. The proportion of black students assessed at full readiness is 90 percent of the proportion of similarly assessed white students, compared to 82 percent statewide.

As we found in 2005, WSS scores do suggest that home-cared children (children with no formal school-like experience before entering kindergarten) are indeed less well prepared for school than children who have been cared for outside the home. Countywide, home-cared children are only 55 percent as likely as other kindergartners to be fully ready to learn, similar to a statewide percentage of 56 percent. (Interestingly, these rates are sharply down from those in our last report, when both were near 85 percent.)

### **6.3 Goals and Objectives**

The planning process undertaken by the Early Childhood Committee involved updating and adjusting the existing goals and objectives to address the issues currently affecting young children (i.e., infants and toddlers) in Baltimore County.

The entire process of setting the new goals and objectives involved frequent meetings of the Early Childhood Committee over a period of several months. The ECC's final plan, approved and sub-

mitted to the full LMB for review on June 1, 2009 includes 7 goals, 18 objectives and 33 action steps. A complete list can be found in table 22, located in chapter 5 of this assessment.

In light of the results presented in this report, the LMB's Early Childhood Committee recognized the need for improved services for young children. After several months of planning, the ECC established a new agenda through which progress toward service improvement could be measured. Based on the committee's newly defined plan, the LMB is committed to pursuing the following goals in the coming years:

1. Assuring that all Baltimore County families with young children (birth through age five) are aware of all public benefits and programs.
2. Supporting parents and/or guardians in the central role they play in their child's development.
3. Assuring that all Baltimore County families with children under five have access to health, mental health and behavioral consultation services.
4. Assuring that children under five have access to comprehensive health and developmental screening with follow-up assessments as necessary, to enable early identification of problems, and referral to health and educational interventions.
5. Facilitating the provision of health care for women to ensure the birth of healthy babies.
6. Encouraging collaboration among agencies to keep young children safe within their families, homes and communities.
7. Monitoring progress toward the achievement of all goals and objectives.

While several of the ECC's new goals and objectives are similar to those previously established, some changes had to be made to reflect the current status of problems affecting young children in Baltimore County. The greatest change made was the removal of benchmarks regarding program

enrollment that were difficult to monitor and often inconclusive. Instead, the new plan focuses on outreach and collaboration efforts to educate the public about the early identification of delays, and the programs available to assist children in need. Lastly, more attention was given to matters relating to substance abuse and mental health in pregnant women and post-partum women than in the ECC's previous action agenda.

## 6.4 In Sum

The LMB's final goal is to monitor progress toward the achievement of all the goals and objectives developed in the ECC's planning process. The LMB recognizes that for this report and its findings to be effective, progress must be monitored from one assessment to the next in order to reveal trends and areas of concern. Reaffirming its commitment to this process, the LMB is proud to show Baltimore County the strides being made toward an even more promising future for our children.

— End —

# Appendix 1. Local Management Board

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