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The MS KIDS COUNT program is made possible, in part, through grants from the Annie E. Casey Foundation and Mississippi State University’s Division of Agriculture, Forestry and Veterinary Medicine. This work is carried out through the Family and Children Research Unit, a division of the Social Science Research Center.
The Family and Children Research Unit (FCRU) conducts research on issues affecting the health, safety, education and economic well-being of children and families. It employs an interdisciplinary approach for program planning and evaluation while conducting basic and applied research to build effective service systems as well as inform state, local, and national policymakers. FCRU partnerships with public and private agencies allow for the development and implementation of common goals.
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We are pleased to present the 2008 MS KIDS COUNT Data Book. In addition to providing context and data on four key areas of children’s general well-being in Mississippi: their health, education, safety and economic well-being, two new solution-based features have been added to this year’s Data Book:

• “Moving Mississippi Forward: What Would It Take?” Section
  A new section examines the progress that will have to be made in order for Mississippi to move up in state rankings of children’s well-being.

• Success Stories
  These stories of success throughout Mississippi illustrate grassroots and systemic efforts to produce better outcomes for children. It is our hope that these stories will inspire similar efforts across the state.

As this year’s data were compiled and the stories of success written, we were reminded that the problems affecting Mississippi’s children and the solutions to them are incredibly interwoven, and that the early experiences of childhood are critical to their future. Giving is reciprocal, and there is a relationship between an adult’s ability to give back to society and the supports they received as a child. Consequently, when we fail to meet the intellectual, physical, social and emotional needs of a child, all citizens are affected—now and in future generations.

In order to overcome Mississippi’s economic struggles, which have become even more pressing in the wake of a national crisis, we must make solid investments to maximize the returns for our state’s future. One of the most enriching and effective ways this can be accomplished is by investing in Mississippi’s children, as capable children serve as the foundation for a productive and prosperous future society.

When Mississippians work across multiple disciplines and systems, Mississippi’s children benefit. Using the state’s varied resources and human capital to meet the needs of our children in new and creative ways paves the way for a brighter economic outlook for Mississippi and ensures the best possible environments for children.

Creating optimal environments for Mississippi’s children and their families is critical because the early developing architecture of the brain is dependent on the types of
experiences children have, starting from before birth and continuing into adulthood. Children who have access to healthy, secure, consistently safe and educationally sound environments have an opportunity for the best possible development.

However, children who are denied such environments and exposed to chronic and/or toxic levels of stress can experience damage to the very foundation on which their future lives must be built. Communities are only as strong as the foundations of the individuals of which they are comprised. Our future prosperity as a state depends on strong communities and the provision of optimal environments for children, where they can enjoy healthy development—intellectually, physically, socially and emotionally.

Many concerned citizens in Mississippi are finding solutions and working to provide optimal environments for children and their families. The success stories in this Data Book portray the results of countless hours of dedication, work and commitment of individuals and communities toward improving the lives of children and families across Mississippi. We have featured only four stories of success in Mississippi among numerous community-based programs that promote successful outcomes for children. It is a beginning. Our hope is that our annual summit can spark creativity and generate discussion among attendees representing the many other great programs in the state.

Also, we believe that the information in this Data Book will inspire its users to advocate for policy changes and additional resources to benefit children in the state, as well as support and create programs that use best practices, create optimal environments and yield positive outcomes for children. We each play an important role in shaping children’s environments, and it’s our goal at MS KIDS COUNT to provide a forum where ideas based on sound data and best practices can be shared and enhanced. Together, we can touch and improve lives.

Linda H. Southward
ACKNOWLEDGEMENTS

As we present our second annual MS KIDS COUNT Data Book, the number of individuals and groups for which we are grateful and must acknowledge continues to grow. To be sure, the help of the following individuals and groups creates a pathway for reaching the MS KIDS COUNT vision of being the research and development clearinghouse for information on issues pertaining to the health, education, safety and economic well-being of Mississippi’s children.

MS KIDS COUNT Advisory Board Members (listed on page 3)
The Annie E. Casey Foundation
Blue Cross/Blue Shield of Mississippi
The Phil Hardin Foundation
The Mississippi Center for Education Innovation
The Gilmore Foundation
Mississippi State University’s Social Science Research Center
Mississippi State University’s Division of Agriculture, Forestry and Veterinary Medicine’s Office of Agricultural Communications
Mississippi 4-H Youth Development

The individuals from each of the communities/programs whose success stories were highlighted include the following:

CATCH KIDS, Inc.
Kathryn Cobb                           Valerie Long
Allison Hailman Doyle                Phyllis Sims
Dr. James W. Griffin                 Judy Stokes
Dr. Edward Ivancic                   Lorrie Woodard
Susan Ling                           Issac Woodard

Jonestown Family Center for Education and Wellness and The Durocher Program
Sister Kay Burton                    Marquita Johnson
Jerome Coley                         Mary Mosley
Tunder Davis                         Sister Teresa Shields
Anganette Eagins

Forrest County Court Team for Maltreated Infants and Toddlers
Dr. Theodore Atkinson               Judge Michael McPhail
Josie Brown                          Tammy Miller
BeeJee Dickson                      Julie Norman
Jennifer Hartfield                  Lori Woodruff
Jeff Kresge

Quitman County Development Organization
Rosland Clinton-Strong           Luvenia K. Mamon
Sen. Robert L. Jackson            Pearl Watts
Andrea Jossell

Thanks to FrameWorks Institute personnel, Lynn Davey and Diane Benjamin, for their helpful suggestions.

The MS KIDS COUNT staff are simply the best! The research team of Dr. Ronald Cossman, Dr. Ginger Cross, Ms. Dorris Baggett, Ms. Heather Hanna, Ms. Jackie DesJarlais, Ms. Colleen McKee, Ms. Elizabeth Pellegrine and Ms. Meghan Dunaway.

The “success” of the success stories results in a team effort of Ms. Heather Hanna, Mr. Leighton Spann and Mr. Brian Utley.

The graphic design of Ms. Haley Montgomery of Dux D’Lux is unmatched!

The ongoing support of the Social Science Research Center under the leadership of Dr. Arthur G. Cosby is always consistent, strong and extremely appreciated.
MOVING MISSISSIPPI FORWARD:

WHAT WOULD IT TAKE?
10 National Indicators

The Annie E. Casey Foundation compiles state-level data on 10 indicators, or measures, of children’s well-being (shown in Figure 1). The Foundation uses these measures to rank all 50 states relative to one another, as well as to look at the nation as a whole. States are given a rank on each indicator, as well as an overall rank (shown in Figure 2) based upon all 10 indicators. The most recent data are for years 2005 and 2006. Rankings for individual years for each indicator (i.e., “MS rank” in Figure 1) indicate how our state is doing on these 10 measures of children’s well-being relative to all the other states. Changes in rates or percentages between two years (i.e., “MS change since 2000”) indicate whether or not our state is becoming relatively better or worse on a particular measure over time. Rankings and rates can be used to set goals for the status of children in a state. By identifying a target rate, such as the national rate (i.e., “U.S. average rate or %”), or a target ranking, such as the number-one ranked state in the nation, we can determine what changes would need to occur in our state in order to match that particular rate or ranking.

For each of the 10 indicators, MS KIDS COUNT examined Mississippi’s current ranking and rate and determined what it would take to match the national average and the number-one ranked state in the nation. The targets are shown as both rates and the number of children who would be affected if the new ranking or rate were achieved (shown in Figure 1). For the remainder of the “What Would It Take” section, we provide maps that display current rates (by state) for each of the 10 indicators, and discuss in more detail the changes required in Mississippi numbers to match the national average or the top state’s rate.
### KIDS COUNT Data Book Indicators: Mississippi

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>MS #</th>
<th>MS rate or %</th>
<th>MS change since 2000*</th>
<th>MS rank</th>
<th>U.S. average rate or %</th>
<th>Reduction in MS # required to achieve U.S. average rate or %</th>
<th>#1 ranked state's rate or %</th>
<th>Reduction in MS # required to achieve #1 ranked state's rate or %</th>
<th>Data Book Location (pg #)</th>
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<tr>
<td>Low-birthweight babies (less than 5.5 pounds)</td>
<td>2005</td>
<td>5,016</td>
<td>11.8%</td>
<td>Worse</td>
<td>50</td>
<td>8.2%</td>
<td>1,548</td>
<td>6.1%</td>
<td>2,442</td>
<td>12,72</td>
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<tr>
<td>Infant mortality (per 1,000)</td>
<td>2005</td>
<td>481</td>
<td>11.3%</td>
<td>Same</td>
<td>50</td>
<td>6.9%</td>
<td>190</td>
<td>4.5</td>
<td>292</td>
<td>13,71</td>
</tr>
<tr>
<td>Child deaths, ages 1-14 (per 100,000)</td>
<td>2005</td>
<td>190</td>
<td>33.1%</td>
<td>Same</td>
<td>49</td>
<td>20.1%</td>
<td>75</td>
<td>8.3</td>
<td>143</td>
<td>14</td>
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<tr>
<td>Teen deaths from all causes, ages 15-19 (per 100,000)</td>
<td>2005</td>
<td>219</td>
<td>101.1%</td>
<td>Same</td>
<td>48</td>
<td>65.1%</td>
<td>78</td>
<td>37.2</td>
<td>138</td>
<td>15</td>
</tr>
<tr>
<td>Teen births, ages 15-19 (per 1,000)</td>
<td>2005</td>
<td>6,411</td>
<td>60.5%</td>
<td>Better</td>
<td>48</td>
<td>40.5%</td>
<td>2,126</td>
<td>17.9</td>
<td>4,510</td>
<td>16</td>
</tr>
<tr>
<td>Teens (16-19) who are high school dropouts</td>
<td>2006</td>
<td>19,120</td>
<td>10.4%</td>
<td>Better</td>
<td>47</td>
<td>6.6%</td>
<td>6,929</td>
<td>3.5%</td>
<td>12,682</td>
<td>17,102</td>
</tr>
<tr>
<td>Teens (16-19) not attending school and not working</td>
<td>2006</td>
<td>21,615</td>
<td>11.7%</td>
<td>Same</td>
<td>48‡</td>
<td>7.8%</td>
<td>7,242</td>
<td>4.0%</td>
<td>14,206</td>
<td>18,102</td>
</tr>
<tr>
<td>Children living in families where no parent has full-time, year-round employment</td>
<td>2006</td>
<td>317,300</td>
<td>41.9%</td>
<td>Worse</td>
<td>48</td>
<td>32.9%</td>
<td>67,792</td>
<td>24.4%</td>
<td>132,558</td>
<td>19,53</td>
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<tr>
<td>Children in poverty (100%)</td>
<td>2006</td>
<td>220,420</td>
<td>29.5%</td>
<td>Worse</td>
<td>50</td>
<td>18.3%</td>
<td>83,669</td>
<td>9.6%</td>
<td>148,925</td>
<td>20,47</td>
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<tr>
<td>Children in single-parent families*</td>
<td>2006</td>
<td>307,383</td>
<td>44.6%</td>
<td>Same</td>
<td>50</td>
<td>31.9%</td>
<td>87,763</td>
<td>18.1%</td>
<td>182,496</td>
<td>21</td>
</tr>
</tbody>
</table>

Notes:
The values reported in Figure 1 were taken from the following sources:
- Population Reference Bureau (2008), analysis of data from the Centers for Disease Control, National Center for Health Statistics; and U.S. Census Bureau, American Community Survey.
- Refer to the Appendix section for further information on data sources, definitions and applicable notes for each indicator.
- Numbers reported in Figure 1 and this section of the data book may be slightly different than numbers reported in later sections due to rounding.

* Change since 2000 judgments were based on statistical significance calculations (90% CI) from the Population Reference Bureau (2008)
‡MS tied with 2 other states for the highest % on this indicator

**FIGURE 1**
KIDS COUNT Overall Rank

Note for map: The District of Columbia is shown on the map, but not included in rankings because it is not a state. Puerto Rico and the U.S. Virgin Islands are not included in maps or rankings.

Mississippi ranks

50th overall based upon 10 indicators of child well-being
11.8% of 42,395 babies born in Mississippi were classified as being low birthweight in 2005

Low-birthweight Babies:
Of 42,395 babies born in Mississippi in 2005, some 5,016, or 11.8%, were classified as having low birthweight (weighing less than 5.5 pounds). Relative to other states, our low-birthweight rate was the highest, and we ranked last, at 50th place. The national low-birthweight rate was 8.2%, which was approximately 30% less than Mississippi’s rate. For Mississippi to have achieved the national average, out of the 5,016 births, 1,548 fewer babies would have been born with low birthweight in the state in 2005. The number-one ranked state’s low-birthweight rate was 6.1%, which was almost half of our state’s rate. For Mississippi to have matched the number-one state (Alaska), out of the 5,016 births, 2,442 fewer babies would have been born with low birthweight in 2005.

Note for map: Rates for the District of Columbia are shown on the map but not included in rankings because it is not a state. Puerto Rico and the U.S. Virgin Islands are not included in maps or rankings.
Infant Mortality:
Of 42,395 births in Mississippi in 2005, some 481, or 11.3 per 1,000, resulted in death within the first year. Relative to other states, we had the highest infant mortality rate, and we ranked 50th place in the nation. Both low birthweight and premature delivery were the leading causes of death for these infants. The average infant mortality rate for the nation was 6.9 per 1,000, which was almost 40% less than Mississippi’s rate. For Mississippi to have achieved the national average, out of the 481 deaths, 190 babies would have had to survive their first year. The number-one ranked state’s infant mortality rate was 4.5 per 1,000, less than half of our state’s rate. For Mississippi to have matched the number-one state (Utah), out of the 481 deaths, 292 babies would have had to survive their first year.

Note for map: Rates for the District of Columbia are shown on the map but not included in rankings because it is not a state. Puerto Rico and the U.S. Virgin Islands are not included in maps or rankings.
Child Deaths:
Thankfully, the incidence of death among children ages 1-14 is rare. For that reason, the child death rate is expressed as deaths per 100,000 children of that age. Of the 574,142 children (ages 1-14) in Mississippi in 2005, some 190 died. Relative to other states, we had the second highest child death rate (33.1 per 100,000), and we ranked 49th in the nation. Only Louisiana had a higher rate. The national child death rate was 20.1 per 100,000, which was almost 40% less than Mississippi’s rate. For Mississippi to have achieved the national average, out of the 190 deaths, 75 child deaths would have had to be prevented. The lowest child death rate for any state was 8.3 per 100,000, which was approximately one-quarter of our state’s rate. For Mississippi to have matched the number-one state (New Hampshire), out of the 190 child deaths, 143 child deaths would have had to be prevented.

Note for map: Rates for the District of Columbia are shown on the map but not included in rankings because it is not a state. Puerto Rico and the U.S. Virgin Islands are not included in maps or rankings.
Teen Deaths:
The incidence of death among teens ages 15-19 is much greater than that for younger children. In both the state and the nation, motor vehicle crashes are by far the leading cause of death for this age group.\(^2\)\(^3\) Of the 216,518 teens (ages 15-19) in Mississippi in 2005, some 219 died (101.1 per 100,000). Relative to other states, we had the third highest teen death rate, behind Louisiana and Wyoming. We ranked 48\(^{th}\) place in the nation. The national teen death rate was 65.1 per 100,000, which was approximately 35% less than Mississippi’s rate. For Mississippi to have achieved the national average, out of the 219 teen deaths, 78 would have had to be prevented. The number-one ranked state’s teen death rate was 37.2 per 100,000, which was just over one-third of our state’s rate. For Mississippi to have matched the number-one state in the nation (Hawaii), out of the 219 teen deaths, 138 teen deaths would have had to be prevented.

Note for map: Rates for the District of Columbia are shown on the map but not included in rankings because it is not a state. Puerto Rico and the U.S. Virgin Islands are not included in maps or rankings.
of the 105,928 teen girls (ages 15-19) in Mississippi in 2005, \(6,411\) gave birth to a child

**Teen Births:**

Births to teenage females ages 15-19 are expressed as births per 1,000 girls in that age range. Of the 105,928 teen girls (15-19) in Mississippi in 2005, some 6,411 gave birth to a child (60.5 per 1,000). Relative to other states, we had the third highest teen birth rate, behind New Mexico and Texas. We ranked 48th place in the nation. The national teen birth rate was 40.5 per 1,000, which was one-third less than Mississippi’s rate. For Mississippi to have achieved the national average, out of the 6,411 teen births, 2,126 would have had to be prevented. The number-one ranked state’s teen birth rate was 17.9 per 1,000, which was less than one-third of our state’s rate. For Mississippi to have matched the number-one state in the nation (New Hampshire), out of the 6,411 teen births, 4,510 teen births would have had to be prevented.

**FIGURE 7**


Note for map: Rates for the District of Columbia are shown on the map but not included in rankings because it is not a state. Puerto Rico and the U.S. Virgin Islands are not included in maps or rankings.
Teens Who Are High School Dropouts:

All states are moving toward a new, four-year cohort graduation rate formula that tracks students during their last four years of school, as required by the federal Department of Education.\textsuperscript{4,5} Until all states have implemented and reported graduation rates using the new cohort formula, KIDS COUNT will continue to use rates derived from the American Community Survey. This annual survey samples households across the nation and extrapolates that data to the states and nation as a whole. Thus, states can be ranked relative to other states.

Of the 184,030 Mississippi teens ages 16-19 in 2006, some 19,120, or 10.4%, were reported to be high school dropouts. Relative to other states, we had the second highest high school dropout rate and tied with Nevada and New Mexico at 47\textsuperscript{th} place, ahead of Louisiana at 50\textsuperscript{th} place. The national high school dropout rate was 6.6%, which was approximately one-third less than Mississippi’s rate. For Mississippi to have achieved the national average, out of 19,120 dropouts, 6,929 dropouts would have had to be prevented. The number-one state’s high school dropout rate was 3.5%, which was approximately one-third of our state’s rate. For Mississippi to have matched the number-one ranking state in the nation (North Dakota), out of 19,120 high school dropouts, 12,682 would have had to be prevented.

\begin{figure}
\centering
\includegraphics[width=\textwidth]{map.png}
\caption{Teens Who Are High School Dropouts, 2006 (percent)}
\end{figure}

\textbf{Source:} The Annie E. Casey Foundation. KIDS COUNT State-level Data, 2008

\textbf{Note for map:} Rates for the District of Columbia are shown on the map but not included in rankings because it is not a state. Puerto Rico and the U.S. Virgin Islands are not included in maps or rankings.
Teens Not Attending School and Not Working:
Also from the American Community Survey comes a measure of teens who report that they are neither enrolled in school nor working. This is an alternative measure of the number of teens who are not in the workforce, military or school. Of the 184,030 Mississippi teens ages 16-19 in 2006, some 21,615, or 11.7%, were reported as not in school and non-working. Relative to other states, we were tied for the highest rate with New Mexico and Louisiana at 48th place. The national rate was 7.8%, which was approximately 35% less than Mississippi’s rate. For Mississippi to have achieved the national average, out of 21,615 teens ages 16-19 not in school and not working, some 7,242 would have had to be in school or working. The number-one ranked state’s non-working and not-in-school rate was 4.0%, which was approximately one-third of our state’s rate. For Mississippi to have matched the number-one ranked state in the nation (New Hampshire), out of 21,615 teens ages 16-19 not in school and not working, 14,206 teens ages 16-19 would have had to be in school or working.

Note for map: Rates for the District of Columbia are shown on the map but not included in rankings because it is not a state. Puerto Rico and the U.S. Virgin Islands are not included in maps or rankings.
Children Living in Families Where No Parent Has Full-time, Year-round Employment:

Another measure from the American Community Survey includes all children under the age of 18 living in families where no parent has full-time, year-round employment. This is an alternative measure of family and child poverty. Of the 757,480 Mississippi children under age 18 who lived with their families in 2006, some 317,300, or 41.9%, were reported to live in households with insecure employment. Relative to other states, we were tied with Alaska at 48th place, while Louisiana was in 50th place. The national rate was 32.9%, which was approximately 20% less than Mississippi’s rate. For Mississippi to have achieved the national average, out of 317,300 children in households with insecure employment, 67,792 children would have had a parent who found secure employment. The number-one ranking state’s rate was 24.4%, which was approximately 60% of our state’s rate. For Mississippi to have matched the number-one state in the nation (North Dakota), out of 317,300 children in households with insecure employment, 132,558 children would have had a parent who found secure employment.

Note for map: Rates for the District of Columbia are shown on the map but not included in rankings because it is not a state. Puerto Rico and the U.S. Virgin Islands are not included in maps or rankings.
Children in Poverty:
Of the 746,080 Mississippi children under age 18 for whom poverty status was determined (exemptions include children who are in military families, institutions or foster care) in 2006, some 220,420, or 29.5%, were reported to live in poverty (income below $20,444 for a family of four). Relative to other states, we were in 50th place. The national rate was 18.3%, which was approximately 40% less than Mississippi’s rate. For Mississippi to have achieved the national average, out of 220,420 children living in poverty, some 83,669 would have had to move out of poverty. The number-one ranked state’s rate was 9.6%, which was only approximately one-third of our state’s rate. For Mississippi to have matched the number-one state in the nation (New Hampshire), out of 220,420 children living in poverty, 148,925 children would have had to move out of poverty.

Note for map: Rates for the District of Columbia are shown on the map but not included in rankings because it is not a state. Puerto Rico and the U.S. Virgin Islands are not included in maps or rankings.
Children in Single-parent Families:

Of the 689,473 Mississippi children under age 18 who lived with a parent in 2006, 307,383, or 44.6%, were reported to live in a household with a single parent. Relative to other states, Mississippi was in 50th (last) place. The national rate was 31.9%, which was approximately 30% less than Mississippi’s rate. For Mississippi to have achieved the national average, out of 307,383 children living in single-parent households, some 87,763 would have had other living arrangements. The number-one ranked state’s rate was 18.1%, which was only approximately two-fifths of our state’s rate. For Mississippi to have matched the number-one state in the nation (Utah), out of 307,383 children living in single-parent households, 182,496 children would have had other living arrangements.

Note for map: Rates for the District of Columbia are shown on the map but not included in rankings because it is not a state. Puerto Rico and the U.S. Virgin Islands are not included in maps or rankings.
SAFETY

INTRODUCTION

All children deserve permanent family relationships that are safe, loving and nurturing. When children are supported by secure family relationships, they have an opportunity for optimal development. They form healthy attachments to others and are able to explore and participate in the world around them in a productive way. Healthy development as a result of inclusion in a positive and consistent family setting allows children to reach their full potential as they grow into adulthood and become productive community members.

Many children’s lives, however, are disrupted by abuse or neglect, resulting in removal from their homes. Nationwide, more than a half million children are in foster care as a result of abuse, neglect and/or abandonment. Entry into the foster care system can compound stress for an already vulnerable child by disrupting important family connections. Many children enter the foster care system at a very young age, when brain development is critical. The impacts of abuse and/or neglect, in addition to the loss of a parent, can create toxic levels of stress for young children. Such stress can impact brain development and affect children well into adulthood. Children who experience toxic stress are more likely to suffer from physical and emotional problems, have difficulties in school, and engage in delinquent behavior. As a result, communities and society as a whole pay a high price by having citizens who are less productive. Therefore, issues around foster care and adoption are critical for ensuring the best possible environments for children as well as communities.

“Children in foster care cannot count on things that all children should be able to take for granted—that they have constant, loving parents; that their home will always be their home; that their brothers and sisters will always be near; and that their neighborhoods and schools are familiar places. Some children in foster care don’t understand why they were removed from their birth parents and blame themselves.”

— The Pew Commission on Children in Foster Care

Given that children in foster care are so particularly vulnerable, careful oversight is needed to ensure their protection and optimal development. In order to serve the best interests of the child, decisions about foster care placements and reunification with a birth parent must be guided by trained professionals with the time to devote to managing their caseload. The Child Welfare League of America suggests that agencies conduct careful time studies to establish reasonable caseloads for child welfare workers.

“Child welfare work is labor intensive. Caseworkers must be able to engage families through face-to-face contacts, assess the safety of children at risk of harm, monitor case progress, ensure that essential services and supports are provided, and facilitate the attainment of the desired permanency plan. This cannot be done if workers are unable to spend quality time with children, families, and caregivers.”

— Child Welfare League of America
There are a number of ways for children to leave foster care, including reunification with their birth parent, adoption and “aging out” of the system. Reunification is preferable if deemed safe for the child. Of the half million children in foster care nationwide, roughly 130,000 are eligible for adoption. However, only around 50,000 eligible children are adopted each year from the foster care system. The average child waits to be adopted for more than two years, and over 25,000 age out of foster care annually without ever being adopted.

“When most children reach the age of 18, their parents continue to support and help them during their transition into adulthood. As the de-facto parents of foster children, we should do no less. We need to evaluate whether we are meeting that obligation, or whether we are simply showing these kids the door without sufficient support, resources and skills to succeed.”
— Congressman Jim McDermott, 2007

In the wake of a court settlement, Mississippi is working to improve its foster care system and increase the number of social workers and supervisors that work with children around the state. In addition, there are a number of programs that are helping children in foster care get the services they need. Now is the time for Mississippi citizens to support children in foster care by becoming foster care families, considering adoption and calling for statewide implementation of successful programs that provide needed services to children and families who are in the foster care system.

In this chapter, we explore issues related to children’s safety in Mississippi. First, we identify the problem by taking an in-depth look at data related to children’s safety in the state, including data on children in foster care, the location of foster care homes by county, the availability of social workers by county, adoptions by county and the location of Families First Resource Centers by county. Second, we offer potential strategies for improving children’s safety in Mississippi. We address the issue on two levels by exploring what can be done at the policy level as well as the grassroots, or community, level. To provide an example of the types of actions that can be taken at the grassroots level, we share a story about a successful program in south Mississippi that is applying best practices to foster care placements in Forrest County. It is our hope that this example will serve to stimulate thought and action for unique solutions that benefit Mississippi’s children.
Demographics of Children in Custody of the Mississippi Department of Human Services (Federal Fiscal Year 2007):  
In Federal Fiscal Year (FFY) 2007, some 5,446 children (2,615 males and 2,831 females) were served by the Mississippi Department of Human Services, Family and Children’s Services Division. Of those children, almost half were White (2,634), slightly more than half were Black (2,848) and a small fraction were American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, or undetermined (75). [FIGURE 13]  

The ages of children in custody ranged from less than 1 year (i.e., born in 2007) to 22-23 years (i.e., born in 1984). Approximately 1,543 children (28.3%) were under age 5; 1,976 (36.3%) were ages 5-12; 1,726 (31.7%) were ages 13-18; and 201 (3.7%) were over age 18 by the end of the 2007 calendar year. [FIGURE 14]  

Manner of Removal and Reason for Removal from the Home:  
Of the 5,446 children removed from the home, less than 1% (29) were voluntary, on behalf of the parent(s). The remaining 99.5% (5,417) were court ordered.  

There were multiple reasons cited for removing the child from the home, with an average of two reasons cited. The primary reason for removal was neglect (2,778 cases). Other top reasons cited for removal of the child included the caretaker’s inability to cope due to illness or other reasons, drug abuse by the parent (1,541 cases), inadequate housing (1,200 cases), child’s behavior problems (545) and physical abuse (541 cases). [FIGURE 15]
Resource Homes/Foster Care:

“The Mississippi Department of Human Services, Division of Family and Children’s Services, is responsible for...providing child welfare services that best promote safety, well-being, and permanency for Mississippi’s children and families. In administering and conducting service programs under this plan, the safety of the children is the paramount concern.”

Accredited resource homes (also known as foster homes) provide temporary housing for the children and young adults served by the Mississippi Department of Human Services, Family and Children’s Services Division. There were a total of 1,167 such homes in the state as of September 2008 (end of FFY 2008). The number of homes varies widely by county, from 0 resource homes in Issaquena County to 118 resource homes in Harrison County.1 [FIGURES 16, 17]

Nationally, the average length of stay in foster care was 28.3 months in FFY 2006.3

<table>
<thead>
<tr>
<th>Region #</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>225</td>
</tr>
<tr>
<td>2</td>
<td>166</td>
</tr>
<tr>
<td>3</td>
<td>150</td>
</tr>
<tr>
<td>4</td>
<td>155</td>
</tr>
<tr>
<td>5</td>
<td>104</td>
</tr>
<tr>
<td>6</td>
<td>130</td>
</tr>
<tr>
<td>7</td>
<td>237</td>
</tr>
<tr>
<td>STATE TOTAL</td>
<td>1,167</td>
</tr>
</tbody>
</table>

Note for Figure 13 (pg 25): An individual could be classified as more than one race. Thus, the sum of the numbers classified in each race will be higher than the total number of children served.1,4

Note for Figure 14 (pg 25): Age categories for Figure 14 were calculated based on the calendar year in which the child was born and the age that the child would be at the end of calendar year 2007. For example, a child born in calendar year 2002 would be 5 years old by the end of calendar year 2007.1,4

What were the case goals (nationally) for children in foster care? (FFY 2006)3

<table>
<thead>
<tr>
<th>Goal</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reunify with Parent(s) or Principal Caretaker(s)</td>
<td>49%</td>
</tr>
<tr>
<td>Adoption</td>
<td>23%</td>
</tr>
<tr>
<td>Long Term Foster Care</td>
<td>9%</td>
</tr>
<tr>
<td>Emancipation</td>
<td>6%</td>
</tr>
<tr>
<td>Goal Not Yet Established</td>
<td>6%</td>
</tr>
<tr>
<td>Live with Other Relative(s)</td>
<td>4%</td>
</tr>
<tr>
<td>Guardianship</td>
<td>4%</td>
</tr>
</tbody>
</table>

* Percent column may not equal 100 due to rounding.

FIGURE 17

Resource Homes by County

FIGURE 16

FIGURE 18
**Direct Service Workers:**
Direct service workers are responsible for providing services directly to clients. As of September 2008 (end of FFY 2008), there were a total of 435 direct service workers in the state. No county was without at least one direct service worker. [FIGURES 19, 20]

**Number of Direct Service Workers by Region:**

<table>
<thead>
<tr>
<th>Region #</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>97</td>
</tr>
<tr>
<td>2</td>
<td>74</td>
</tr>
<tr>
<td>3</td>
<td>61</td>
</tr>
<tr>
<td>4</td>
<td>59</td>
</tr>
<tr>
<td>5</td>
<td>62</td>
</tr>
<tr>
<td>6</td>
<td>51</td>
</tr>
<tr>
<td>7</td>
<td>31</td>
</tr>
<tr>
<td><strong>STATE TOTAL</strong></td>
<td><strong>435</strong></td>
</tr>
</tbody>
</table>

[FIGURE 19]

**Direct Service Workers by County**

Source: Mississippi Department of Human Services, December 2008

[FIGURE 20]
As of September 2008 (end of FFY 2008), there were a total of 97 Area Social Work Supervisors (ASWSs) in the state. Twenty-three counties were served by ASWSs in the state. Twenty-three counties were served by ASWSs in other counties. [FIGURES 21, 22]

**Number of Area Social Work Supervisors by Region**:

<table>
<thead>
<tr>
<th>Region #</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td><strong>STATE TOTAL</strong></td>
<td><strong>97</strong></td>
</tr>
</tbody>
</table>

[FIGURE 21, FIGURE 22]
Adoption:
There were a total of 321 children adopted in the state in FFY 2008 via the Mississippi Department of Human Services. However, there were another 90 children who were eligible for adoption and awaiting placement. In addition, there were 74 children who did not wish to be adopted. These totals do not include private adoptions or placements. [FIGURES 23, 24] In FFY 2007, 102 children “aged out” of the system or, in other words, became an adult.1

Adoption Numbers by County

Adoption Statistics by Region in Mississippi:

<table>
<thead>
<tr>
<th>Region #</th>
<th>Adoptions</th>
<th>Children in Need of Adoption</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>73</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>31</td>
<td>11</td>
</tr>
<tr>
<td>3</td>
<td>35</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>19</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>6</td>
<td>52</td>
<td>15</td>
</tr>
<tr>
<td>7</td>
<td>92</td>
<td>16</td>
</tr>
<tr>
<td>STATE TOTAL</td>
<td>321</td>
<td>90</td>
</tr>
</tbody>
</table>

Note for map:
The map shows adoptions by county. The totals do not include private adoptions or placements.

FIGURE 23

FIGURE 24

there were a total of 321 children adopted in the state in FFY 2008 via the Mississippi Department of Human Services
Nationally, 69% of adopting families were a married couple in FFY 2006, compared to 79% in Mississippi. Among all children adopted nationally, 2% were adopted by an unmarried couple, while 0% of Mississippi children were adopted by an unmarried couple. Nationally, 26% of children were adopted by a single female, while only 19% of Mississippi children were adopted by a single female. Finally, 3% of children were adopted by a single male (nationally), while 2% of Mississippi children were adopted by a single male.\textsuperscript{3,4} [FIGURE 25]

Nationally, 59% of adopted children were adopted by their foster parent in FFY 2006, compared to 69.1% in Mississippi. Twenty-six percent of children (nationally) were adopted by a relative, compared to 21.8% in Mississippi. Non-relatives adopted children in 15% of all adoptions nationally, while in Mississippi non-relatives adopted in 9.1% of the cases.\textsuperscript{3,5} [FIGURE 26]

<table>
<thead>
<tr>
<th>Family Structure</th>
<th>U.S.</th>
<th>MS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married Couple</td>
<td>69%</td>
<td>79%</td>
</tr>
<tr>
<td>Single Female</td>
<td>26%</td>
<td>19%</td>
</tr>
<tr>
<td>Single Male</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Unmarried Couple</td>
<td>2%</td>
<td>0%</td>
</tr>
</tbody>
</table>

What is the family structure of the child’s adoptive family? (FFY 2006)\textsuperscript{3,4}

<table>
<thead>
<tr>
<th>Relationship</th>
<th>U.S.</th>
<th>MS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Parent</td>
<td>59%</td>
<td>69.1%</td>
</tr>
<tr>
<td>Other Relative</td>
<td>26%</td>
<td>21.8%</td>
</tr>
<tr>
<td>Non-Relative</td>
<td>15%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Step-Parent</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

What was the relationship of the adoptive parent(s) to the child prior to the adoption? (FFY 2006)\textsuperscript{3,5}
Families First Resource Centers (FFRCs):
The goal of Families First Resource Centers is to strengthen and preserve the family unit through programs about abstinence, fatherhood, healthy marriage and parenting skills. FFRCs are currently sponsored by the Mississippi Department of Human Services and administered via the Division of Economic Assistance. Every county and community in the state is served by at least one FFRC. In counties where they do not have a physical office, programs are often presented in community facilities, or clients can travel to the main office for services.6,7 [FIGURE 27]

the goal of Families First Resource Centers is to strengthen and preserve the family unit through programs about abstinence, fatherhood, healthy marriage and parenting skills
A Policy Matters report points to several key initiatives to improve outcomes for abused and neglected children:

**Subsidies and Public Health Insurance for Guardianship Arrangements**

Subsidy levels and public health insurance benefits for guardianship arrangements should not be less than those for foster care, thereby creating no disadvantage for legal guardianship. In 2008, appropriations to the Department of Human Services for fiscal year 2009 for Kinship Care payments were approved in House Bill 1619. Kinship care is provided to a child in foster care by a grandparent or other relative. Medicaid benefits are available to eligible children in foster care, and youth may receive extended Medicaid coverage until age 21.

**Continuing Court Jurisdiction over Foster Care Youth**

Maintaining court jurisdiction of youth beyond age 18 can ensure better outcomes as they transition out of custody. Youth Court jurisdiction in Mississippi continues to age 20, and educational funding is available through the Mississippi ETV Program for youths in foster care ages 18-20 seeking to attend college. Independent living and transitional services are available to youth aging out of foster care in Mississippi through state, private and faith-based organizations.
Current Steps to Preserve and Strengthen Families in Mississippi

Mississippi currently has a number of programs and services that are designed to improve the foster care system in Mississippi. These programs 1) reduce the likelihood that children will enter the foster care system, 2) increase the odds that children are reunited with their birth parents if they do enter foster care, 3) reduce the amount of time children spend in foster care, and 4) address the needs of children who enter foster care.

For families of today who can benefit from additional knowledge, support and encouragement, Families First provides classes/workshops which promote effective parenting, healthy relationships, responsible fathering, and good decision-making for teens. Stability in the home translates into well-being for the children and families of our community, and indeed, everyone benefits.”
— Janice Cutshall, Director Tishomingo County Families First

Families First Resource Centers
Families First Resource Centers (FFRCs) are located throughout the state. All counties in Mississippi have access to some of the services they provide, though facilities are not located in each county (see Figure 27 on Page 31). FFRC staff either travel to surrounding counties to offer services or participants travel to the facility in a nearby county. FFRCs bolster prevention efforts by offering parenting classes and working with foster and adoptive families, among others, to strengthen relationships.11

Mississippi Department of Human Services (MDHS) Enhancements
In order to satisfy a settlement agreement that was reached in January 2008, the state of Mississippi is working to make changes to its foster care system. The settlement stipulates that the state will rebuild the infrastructure of the Department of Human Services, Division of Family and Children’s Services (DFCS) and “meet specific standards governing the care, treatment and services it provides to children in its custody.”12 Included in the settlement agreement are provisions to increase the numbers of social workers and social worker supervisors in Mississippi.

As of October 2008, improvements have included the following13:
- An increase in the DFCS Fiscal Year 2009 Budget
- Efforts toward meeting accreditation standards
  - DFCS has received manager training on accreditation processes and performance quality improvement
  - Technical assistance from the Council for Accreditation
- Hiring of a MDHS Deputy Administrator of DFCS
- Hiring of a DFCS Director of Performance and Quality Improvement
**Mississippi Citizens Review Board**
The review board consists of Mississippi citizens who oversee the child protection work of the Division of Family and Children’s Services. Primarily, the board reviews DFCS’s performance data and provides counsel to DFCS on agency management. The Citizens Review Board may also review DFCS policies, procedures, research and data of all types.14

**Mississippi Youth Programs Around the Clock (MYPAC)**
The Mississippi Division of Medicaid is now offering a home-and community-based program that provides services to youth with Serious Emotional Disturbance (SED). This program allows children to remain in their homes, rather than enter a psychiatric residential treatment facility. An individualized service plan is developed to not only meet the needs of the participants, but also their families. By offering these services, families are strengthened and the likelihood of separation and/or parental burn-out is lessened.15

**The Forrest County Court Team for Maltreated Infants and Toddlers**
The Court Team is a pilot program spearheaded by Zero to Three, an organization in Washington, DC. The program aims to address the needs of children from birth to age three who enter the court system as a result of abuse and/or neglect. The Court Team is led by Judge Michael McPhail of Forrest County Youth Court and also includes child development specialists, community leaders, child advocates, and child health professionals. For foster care cases concerning infants or toddlers, the Court Team develops a service plan that is customized to the needs of the child and family. The Court Team then seeks out the various services in the community which are necessary to meet the goals of the service plan. The Court Team continues to monitor cases by holding monthly meetings during which progress is assessed and the need for additional services is identified. Ideally, the Court Team works to provide parents with the tools needed to resume a healthy relationship with their child.16 The Forrest County Court Team is featured as our Success Story for the Safety Section.

“Child welfare services in Mississippi are improving dramatically and rapidly under new leadership and a reinvigorated work force. It is unfortunate that it took the stimulus of a class action lawsuit to set consistent progressive change in motion, and there is surely a long road ahead. But we are, unquestionably, moving in the right direction.”
— Dr. Michael D. Forster,
Citizens Review Board
Chairman

SAFETY
As incorporated into the Court Team approach, best practices for addressing the needs of young children in foster care include the following:

- Promoting frequent visits with birth parents
- Working with families to promote reunification
- Providing developmental assessments and services for children in foster care
- Providing assessment and services for families of children in foster care
- Placing children with relatives
- Providing individualized service plans for families and children in foster care
- Promoting a community-based approach to service delivery

**Other Steps to Preserve and Strengthen Families in Mississippi**

- Reinstate IV-E training funds for social workers trained in child welfare services
- Promote a career ladder within Division of Family and Children’s Services
- Statewide implementation of the Zero to Three Court Teams model
- Increase recruitment of foster and adoptive parents
- Increase visibility and funding of Families First Resource Centers
- Place licensed social workers in each school to coordinate services among the Mississippi Department of Human Services, Mississippi State Department of Health, Mississippi Division of Medicaid, and other state agencies and services
through positive and consistent interactions with **primary caregivers**, children are better able to reach their potential emotionally, socially and intellectually.

**SUCCESS STORY**

The Forrest County Court Team for Maltreated Infants and Toddlers

When children interact with primary caregivers who provide consistent, safe and secure environments and who are responsive to their physical and emotional needs, they learn to trust and to form healthy attachments. As they get older, their capacity for healthy attachment extends to a larger circle of people, and they learn to cope with separation from their primary caregivers. Consequently, these children also learn how to engage in positive social interactions and have adaptive coping skills. They develop the ability to be self-reliant and to self-regulate their emotions. As a result, they can fully engage and learn from their environments. Through positive and consistent interactions with primary caregivers, they are better able to reach their potential emotionally, socially and intellectually.¹

However, if young children do not have consistent security, protection and nurturing, they can be exposed to toxic levels of stress, which can affect the wiring of the brain and cause lasting harm. Young children who are maltreated can have difficulty with healthy attachment and self-control. Their emotional, social and intellectual development can be altered, and they are at greater risk for problems later in life, such as developmental delays, school failure, substance abuse and criminal behavior. They are also more likely to suffer from physical and mental illness. Furthermore, maltreated young children who are taken away from their caregivers still experience distress from the separation, even though the relationship was abusive.¹

Knowing the damage that maltreatment and/or disruptions to healthy attachments can cause to young children’s development, every effort should be made to ensure that all young children have access to positive and stable environments where their needs are met. However, many children in Mississippi have not only been subjected to maltreatment, but they have also entered a court system where they have been removed from their primary caregivers and often placed in multiple foster homes. As in many states, they have not benefited from a cohesive service plan to ensure they receive the best care possible. Through this fractured system, our state has decreased the odds that these children have developed healthy attachments or benefitted from optimal brain development. As a result, not only are the children adversely affected, but our communities also suffer economically and socially by having members of society who may obtain less education, suffer from depression and other illnesses, engage in criminal behavior and have greater difficulty participating in the workforce.
Nurturing Alliances

In response to cases he was seeing in Forrest County Youth Court, Judge Michael McPhail took a chance. In 2005, he inquired about a pilot program spearheaded by the Zero to Three organization in Washington, DC. Zero to Three had begun Court Teams in key sites around the country with the goals of “improving outcomes for maltreated infants and toddlers, reducing the recurrence of abuse and neglect and changing the court’s culture to focus on the needs of infants and toddlers.” Rather than focusing primarily on children’s misbehavior later in life, Court Teams address the needs of infants and toddlers from birth to age three who enter the court as a result of maltreatment and who are candidates for entry into foster care. The intention of this approach is to reduce the likelihood that the children will return to the court in the future and to improve their chances for optimal development and healthy attachment.

“When I first heard about the program I thought, ‘Hm…why are we targeting this population?’ Having worked in foster care, I know that teenagers are generally the most difficult to find a place for. They have behaviors that are difficult for us to deal with, so I thought, ‘okay, this is very different’ to start with infants. But the more I’ve gotten involved with the program, the more I see that is where we need to start.”

— Tammy H. Miller, Mississippi Children’s Home Services, Court Team Member (pictured on page 38)

Court Teams are led by a judge and typically employ a Community Coordinator to oversee daily operations. Court Teams also consist of many members of the community, including child development specialists, child advocates, community leaders and child health professionals. The Forrest County Court Team consists of up to 40 individuals who represent different organizations and agencies that provide services or...
advocate for children. These individuals bring together the resources of the community to address the needs of infants and toddlers whose families appear in Forrest County Youth Court, giving children the best odds for optimal development while in foster care placement and beyond.

The Court Team creates a service plan for foster care cases involving infants and toddlers and monitors the cases over time. Each service plan is individualized for the child and their family, and the need for various services in the community are identified and sought for the children and their families by the Court Team. Monthly meetings on each case allow the Court Team to assess the child and family’s progress and continually connect them with the services they need to reach the goals of the service plan.

In order to ensure that children develop healthy attachments, foster care placements are ideally with a relative. The Court Team encourages parent visits with the children and provides services to parents as a part of the service plan. The goal is to reunify the parent and child, but if this is not possible, the Court Team works to keep children’s placements to a minimum.

“Everything can happen under the Court Team umbrella. The family can start talking about their individualized service plan and the protective things we need to put into place, so this child can have continuity of relationships and safe, stable and secure placement.”
— Lori Woodruff, formerly with University of Southern Mississippi Social Work Department, Court Team Member

“We’re able to unravel the problems in the family and get to what will be the real permanent plan faster than if the court team was not in place, so children don’t stay in foster care as long. We get to a permanent plan faster.”
— Tammy H. Miller, Mississippi Children’s Home Services, Court Team Member (pictured on the left)

“You would be surprised what each move takes away and takes out of that child.”
— Josie Brown, Court Team Community Coordinator (pictured on page 43)
SAFETY

SUCCESS STORY

“As for parenting, we try to be a strengths-based resource. We try to come in and help parents to see ‘What is working here? What are you doing well?’ And then, ‘Where are the deficits? Where do you think you need some help?’ We give them information, and they’re like sponges.”
— Julie Norman, University of Southern Mississippi Institute of Disability Studies, Court Team Member

“The resources were always there, but we weren’t utilizing them. We work with every possible resource that’s here in the community to help that child get to permanency faster.”
— Josie Brown, Court Team Community Coordinator (pictured on page 43)

The Court Team works with parents to provide them with the services they need to resume a healthy relationship with their child, if possible. Mental health and substance abuse services are provided, as well as parenting classes and instruction in child development.

“We want parents to be independent, but also to be inter-dependent knowing that there are those who can help. We try to help them and give them those tools that they need so they can go out and be productive individuals and raise their families in a manner that’s socially acceptable, and that gives that child the ability to strive and become independent.”
— Judge Michael W. McPhail, Forrest County Youth Court Judge and Court Team Leader (pictured on page 37)

Ms. Josie Brown, Court Team Community Coordinator, states that the Court Team has benefited from collaborations with numerous local organizations, some expected and some unexpected. She lists Early Head Start, Pinebelt Mental Health and Forrest General Hospital as partners, as well as the founder of Rainbow Dance, a type of dance therapy, who works with the parents involved with the Court Team.

Court Team participants repeatedly credit community collaboration as the primary reason for their success. Not only does collaboration bring resources to the table for Forrest County infants and toddlers, it also allows new connections among Court Team members and strengthens the community as a whole.
because of the **Court Team’s efforts**, children are reunited with their parents or found a permanent home faster

“Every member of this team has a passion for the work and wants to get to the heart of the problem. Everybody’s got the same agenda: what’s best for these children…. It’s like being on an all-star team, and you’re winning. And the clients are winning, the kids are winning, and that’s just been an awesome experience.”
— Lori Woodruff, formerly with University of Southern Mississippi Social Work Department, Court Team Member (pictured on page 38)

Court Team members point to the vast array of services at one table. Many of the participants were not aware of the other services that were available or did not have a means to join forces with other organizations to benefit Forrest County children. Now, all of the agencies and local organizations are united. Ms. Josie Brown, Court Team Community Coordinator, states that “Court Team is like going to Wal-Mart. Everything you need is right around this table.”

“I think the main thing that has come out of the Court Team is that it has brought the services together. There now is coordination among the services.”
— Dr. Theodore Atkinson, Pediatrician, Court Team Member

“The positive would be getting around the table with everybody else, and we’re like, ‘This might actually work. If we’re careful, we might actually do something right here.’”
— Jeff Kresge, State Department of Health, Court Team Member
Families United

As a result of the Court Team’s efforts, children receive medical and developmental services, have fewer and more permanent placements in foster care and are more likely to be placed with a relative. They are reunified with parents or found a permanent home faster. Children visit with their parents more while in foster care, and parents receive the assistance and skill-building they need to meet their children’s needs and provide a protective, secure environment. Society benefits by having parents who are more stable and better able to participate in community life. In addition, children are able to form healthy attachments and benefit from experiences that foster optimal social, emotional and intellectual development.

“We’ve seen families move towards permanency faster. We’ve seen people get their children back.”
— Lori Woodruff, formerly with University of Southern Mississippi Social Work Department, Court Team Member (pictured on page 38)

“Visitation has increased tremendously. When I was a social worker, we usually had visitation once every three weeks. We have visitation now once, maybe three times a week.”
— Josie Brown, Court Team Community Coordinator (pictured on page 43)

“Clients tell me that they’ve never had the feeling that anyone cared. They’ve never been surrounded by a whole group of people that was really for their best interest. I’ve heard clients say, ‘I was devastated when my child was first taken away from me, but this program is the best thing that could have happened to me.’”
— Josie Brown, Court Team Community Coordinator (pictured on page 43)
Jennifer is a parent and Court Team client. She states that her experiences with the Court Team have given her the confidence to handle situations more effectively and to depend on herself. She knows now that she can ask for help. She has reenrolled in college and is majoring in social work. Furthermore, Jennifer wants to help others. She speaks at high schools and college campuses to share her experiences with other young people.

“My son will be two on September 25th, and I can’t help but smile and be grateful and thankful that I didn’t miss out on this. Everyday I go to the daycare, and I walk in and see him run to me, ‘Mommy! Mommy!’ I mean that just makes me melt.”

— Jennifer Hartfield, Parent and Court Team Client

“Our community relationships have grown. There are folks that probably didn’t know each other that now know each other. There’s more willingness to work together. And it’s not necessarily just tied to individuals, it’s tied to agencies. People come and go. And one day I won’t be here, but what I hope is this program will still be entrenched, institutionalized in what we do, that whomever succeeds me or whomever succeeds whomever in whatever position, they’ll be able to keep it going because of the goals of what we’re doing and folks realizing that we’re meeting our objectives.”

— Judge Michael W. McPhail, Forrest County Youth Court Judge and Court Team Leader (pictured on page 37)

Community professionals working with the program also benefit from training that is available for Court Teams. They have access to new materials and resources that aid their ability to act on children’s behalf, and they have new community contacts. This network approach benefits Forrest County as a whole.

**Program Support**

Federal funding has been made available to the Forrest County Court Team. The funding was initially procured by Senator Thad Cochran and is reevaluated every year. Local grants have been used to supplement the funding and to provide additional services.
“I think if we can show the successes of this particular program in Forrest County and our work with the Department of Human Services, the university, with our other community providers, that it can be a model that can be replicated by other jurisdictions across the state. Others will look and say, ‘Hey, in Mississippi, they are doing the right thing with regard to children and families.’”
— Judge Michael W. McPhail, Forrest County Youth Court Judge and Court Team Leader (pictured on page 37)

Bringing Others into the Circle
Court Team members agree that this program could, and should, be replicated throughout the state. Clearly, instituting this program on the state level would benefit all Mississippians by ensuring that all children have an opportunity for optimal development, a prerequisite for stable and prosperous communities.

Concerned citizens throughout the state acting on behalf of children, particularly those involved in child welfare and youth courts, can form exploratory groups to evaluate implementation of this program in their area. Furthermore, all citizens can advocate for state-level implementation with Mississippi policymakers.

“You have to gain an understanding of what you have in your particular community. You probably should do a community assessment and see what you do have, what your needs are, where they’re gaps in services, how you can link things together. You have to bring people together who want to cooperate. You have to have some leadership. You need a good program manager. You just need people who want to serve children and families.”
— Judge Michael W. McPhail, Forrest County Youth Court Judge and Court Team Leader (pictured on page 37)

Creation of Court Teams throughout the state would increase the quality of life for many of Mississippi’s children and families. It would also make headway in reducing the number of children in foster care for extended periods. Children would be more likely to grow into better educated, productive members of society. Attempting to change behaviors of adults who, as children, did not have access to stable, secure or nurturing environments is much harder than having a positive effect before a child’s brain has completely developed. Therefore, the Court Team approach is greatly needed in counties across Mississippi.
Child development is a foundation for community and economic development, as capable children become the foundation of a prosperous and sustainable society. When we give children enough food, safe housing, a proper education, adequate health care and other needed supports, they have a much better chance for healthy development. As a society, we need to ensure that all children have the opportunity to grow up healthy and ready to meet the challenges of adulthood.

When a child experiences excessive stress due to extreme poverty, abuse or an unstable home, their developing brain can be damaged, leading to learning and behavioral problems, as well as an increased susceptibility to physical and mental health problems in the future. If children begin life with a fragile foundation, it is more difficult for them to succeed in society and live up to their full potential. Therefore, addressing child poverty is really at the heart of helping children overcome any number of obstacles.

“When we invest wisely in children and families, the next generation will pay that back through a lifetime of productivity and responsible citizenship. When we do not make wise investments in the earliest years, we will all pay the considerable costs of greater numbers of school-aged children who need special education and more adults who are under-employed, unemployable, or incarcerated.” – National Scientific Council on the Developing Child, January 2007

Nationwide, nearly 2 out of every 10 children are growing up in families that are poor. A parent’s ability to secure adequate employment is a key predictor of child poverty; however, over half of children living in low-income families actually have at least one parent working full-time, year-round. This indicates that many jobs do not pay parents enough to support their families. Minority children are especially affected by poverty: Children of Black or Latino families are more than two times as likely as children of White families to struggle financially. Low-earning parents need higher wages, earned income tax credits and assistance with child care and health insurance to improve the well-being of their children.

“When parents can secure a steady income and build assets they are better able to meet the needs of their children.”
— Annie E. Casey Foundation

“More than a decade of research shows that increasing the incomes of low-income families—without any other changes—can positively affect child development, especially for younger children. Put differently, money matters for child development. Families with more money invest more in material resources that promote learning for their children. Parents with more money are also likely to be less stressed and depressed, both of which have been linked to poor social and emotional outcomes for children.”
— National Center for Children in Poverty, January 2007
In 2006, approximately 14% of children under 18 in Mississippi lived in extreme poverty.

In Mississippi, the lack of adequate resources for our children and families continues to take its toll on meeting basic human needs, and our state is at a crossroads. The positive actions we take today will help to build a healthy economic future for our state. The best way for Mississippi to ensure better child outcomes in all domains, including children’s physical and emotional health, their safety and their education, is to improve the earning potential of families and the prosperity of communities. Mississippi can benefit by applying an epidemiological lens to poverty (i.e., understanding the root causes and identifying systemic solutions).

In this chapter, we explore child poverty in Mississippi more specifically. First, we identify the problem by taking an in-depth look at data related to childhood poverty and related topics in the state. We also report findings from a 2007 MS KIDS COUNT survey regarding self-reported incomes of Mississippi residents. Second, we offer potential strategies for reducing child poverty. We address the issue on two levels by exploring what can be done at the policy level, as well as the grassroots, or community, level. To explore what actions can be taken at the grassroots level, we provide an example of one organization’s efforts to reduce poverty and promote community development in their Mississippi Delta county. It is our hope that this example will serve to stimulate thought and action for unique local solutions that can serve to augment state-level changes and benefit Mississippi’s children.

“Although most portrayals of poverty in the media and elsewhere reflect the experience of only a few, a significant portion of families in America have experienced economic hardship, even if it is not life-long. Americans need new ways of thinking about poverty that allow us to understand the full range of economic hardship and insecurity in our country. In addition to the millions of families who struggle to make ends meet, millions of others are merely one crisis—a health emergency, divorce, or job loss—away from financial devastation. In recent years, more and more families have become vulnerable to economic hardship.”

— National Center for Children in Poverty®
Children in Poverty:
In 2006, Mississippi had the highest percentage in the nation of children living in poverty (i.e., in families with incomes below 100% of the federal poverty level, defined as $20,444 for a family of two adults and two children in 2006). Using this definition, approximately 30% of Mississippi children were living in poverty in 2006, which was higher than the United States as a whole (18%) and other Southern states, including Arkansas (24%) and Georgia (20%). From 2000 to 2006, there was a statistically significant increase in the percentage of children living in poverty in Mississippi. Approximately 26%, or 199,000 children, were living in poverty in 2000, compared to almost 30%, or 220,000 children in 2006. For Mississippi, this means that almost one in three children are growing up in poverty.1,2,3,a [FIGURE 28]

Children In Extreme Poverty:
In 2006, Mississippi also ranked 50th in the nation with the highest percentage of children living in extreme poverty (i.e., in families with incomes below 50% of the federal poverty level, defined as $10,222 for a family of two adults and two children in 2006). Approximately 14%, or 101,000 children under age 18 in Mississippi, lived in extreme poverty in 2006, compared to 8% for the United States as a whole, 11% for Arkansas and 9% for Georgia.1,2,b [FIGURE 29]
**Under Age 18 in Poverty by County:**

According to the U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE), 30.2% of children under age 18 in Mississippi were living in poverty in 2005. [FIGURE 32](#)

Below are lists of the Mississippi counties with highest and lowest percentages of children in poverty:

**Highest:**
- Holmes 59.5%
- Issaquena 56.3%
- Coahoma 54.7%
- Humphreys 54.5%
- Sharkey 54.2%

**Lowest:**
- DeSoto 12.2%
- Rankin 13.3%
- Lamar 17.6%
- Union 18.1%
- Lafayette 18.8%

[FIGURE 30](#) [FIGURE 31](#) [FIGURE 32](#)
**All Ages in Poverty by County:**

In 2005, approximately 21.0% of Mississipians were living in poverty.\(^5\)\(^6\)\(^*\) [FIGURE 35]

Below are lists of the counties with highest and lowest poverty percentages:

<table>
<thead>
<tr>
<th>Highest:</th>
<th>Lowest:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issaquena</td>
<td>DeSoto</td>
</tr>
<tr>
<td>Holmes</td>
<td>Rankin</td>
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<tr>
<td>Coahoma</td>
<td>Lamar</td>
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<td>Humphreys</td>
<td>Madison</td>
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<tr>
<td>Sharkey</td>
<td>Union</td>
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</tbody>
</table>

\(^5\)\(^6\)\(^*\) FIGURE 33

\(^5\)\(^6\)\(^*\) FIGURE 34

Source: U.S. Census Bureau,
Small Area Income & Poverty Estimates

FIGURE 35
in 2005, approximately 21% of Mississippian were living in poverty

**Per Capita Personal Income by County:**

According to data from the U.S. Department of Commerce, Bureau of Economic Analysis, Mississippi’s average per capita personal income was $27,028 in 2006. [FIGURE 38]

Below are lists of the counties with highest and lowest per capita personal incomes:

**Highest:**
- Madison $41,503
- Warren $32,026
- Rankin $31,867
- Harrison $31,864
- DeSoto $31,589

**Lowest:**
- Jefferson $16,518
- Wilkinson $18,212
- Issaquena $18,266
- Benton $18,478
- Claiborne $19,236

Source: Bureau of Economic Analysis
Unemployment Rates by County:
In 2007, Mississippi’s average unemployment rate was 6.3%, compared to 4.6% for the United States as a whole. [FIGURES 41, 42] For Mississippi, this translated into 83,100 people in the civilian labor force who were unemployed.⁷,⁸

Below are lists of the counties with highest and lowest average annual unemployment rates:

**Highest:**
- Clay: 14.9%
- Jefferson: 13.6%
- Noxubee: 12.2%
- Claiborne: 11.2%
- Holmes: 11.0%

**Lowest:**
- Rankin: 4.1%
- DeSoto: 4.2%
- Lamar: 4.3%
- Jones: 4.6%
- Lafayette: 4.6%
National Unemployment Rates by County

Unemployment Rates by County, 2007 Annual Average (percent)

- 4.0% and under
- 4.1% - 5.0%
- 5.1% - 6.0%
- 6.1% - 7.0%
- 7.1% and over

Source: Bureau of Labor Statistics, Local Area Unemployment Statistics

FIGURE 42
**Children Living in Families Where No Parent Has Full-time, Year-round Employment:**

In 2006, Mississippi ranked 48th in the nation for the percentage of children living in families where no parent had full-time, year-round employment. Approximately 42% of Mississippi children lived in a family where no parent held full-time, year-round employment, which was higher than the United States as a whole (33%) and other Southern states, such as Arkansas (36%) and Georgia (34%). From 2000 to 2006, there was a statistically significant increase in the percentage of Mississippi children living in families where no parent held full-time, year-round employment. In 2000, approximately 36% or 267,000 children, lived in a family where no parent worked full-time year-round, compared to approximately 42%, or 317,000 children, in 2006.\(^1,2,3,4,5\) [FIGURE 43]

**Children Living in Low-income Households Where No Adults Work:**

In 2006, Mississippi ranked 50th in the nation with the highest percentage of children living in low-income households where no adults held even part-time employment. Approximately 9%, or 69,000 children, in Mississippi lived in low-income households where no adults worked. This more than doubled the national average of 4% and was higher than other Southern states, including Arkansas (6%) and Georgia (5%).\(^1,2,6\) [FIGURE 44]
in 2006, approximately 9% of Mississippi children lived in low-income households where no adults worked.

**MISSISSIPPI SURVEY RESULTS**

To measure attitudes and beliefs about children’s issues in Mississippi, MS KIDS COUNT conducted a random telephone survey of Mississippi households in October 2007. A total of 1,009 surveys were completed. Of these participants, 331 had one or more children currently living at home. The margin of error for the survey was plus or minus 3.1% with a 95% confidence interval.

- **Total 2006 Household Income Before Taxes:**
  
  In the 2007 MS KIDS COUNT survey, all respondents were asked about their total household income. Almost one-quarter (22%) declined to answer, while another 12% did not know their household income. Of the remaining respondents (66%), more than one-fifth (22%) reported household incomes of less than $20,000. Almost one-third (31%) reported household incomes of less than $30,000. [FIGURE 45]

![Total 2006 Household Income Before Taxes](image-url)
The National Governors Association’s Center for Best Practices notes that strategies, “particularly when combined together in a comprehensive approach, can help reduce the negative consequences of poverty for children and can result in opportunities for families to achieve economic success. State leaders can craft policies and programs that assist families in need of immediate help, that provide short-term assistance, and that address long-term needs. By supporting a wide range of approaches—including new programs, partnerships with the private sector, community-based efforts, and tax-based strategies—governors and other state leaders can help improve the lives of children and families while strengthening local economies.”

### Policies That Work

Evidence-based poverty reduction strategies that are already working in other states include the following:

1. **Earned Income Tax Credit (EITC) and Child Tax Credits**

   According to the Center for the Study of Social Policy, “The EITC is considered the most effective tax policy in history for lifting working families out of poverty.” By allowing working families, especially low-income families, to keep more of their income, states energize not only the economic possibilities for these families but also the state’s own economy. The EITC encourages working families to stay employed in order to better their financial standing and well-being. Child and Dependent Care Tax Credits (CADC) are another way states can offer assistance to low-wage families. A state tax credit can reduce the amount of money low-wage families spend on the cost of quality child care. As of January 2008, Mississippi offers no EITC and no CADC Tax Credit on state income taxes.

2. **Child Care Assistance to Low-income Families**

   Access to affordable, high-quality child care helps low-income families attain stable employment and fosters early childhood development that is crucial for helping children grow, learn and succeed in the future. States determine the income level at which families are eligible for child care subsidies. States can increase those eligibility levels to cover more low-wage families and provide the proper funding so families receive the assistance they need. In 2007, Mississippi maintained its eligibility threshold, but because of increases in income levels, eligibility effectively declined. As of February
2007, Mississippi had a waiting list for state-funded child care. Mississippi, however, joins 18 other states in charging the least amount of co-payment for child care from families at 150% of the federal poverty level.2

3. **Income and Work Support**
The Center for the Study of Social Policy notes, “A substantial body of research shows that state work force and public assistance policies that help increase family income can increase parents’ employment stability and improve outcomes for their children.”2 For families to move from public assistance to work, states can aid them with job training and support by partnering or collaborating with programs like Temporary Assistance for Needy Families (TANF) or the Workforce Investment Act (WIA). Mississippi does not offer TANF benefits to parents working 20 hours/week at minimum wage. Mississippi also has limited state and local collaboration for work force development.2

4. **Freedom from Predatory Lending Practices**
Abusive lending practices such as predatory mortgage lending and “payday” lending often take advantage of families, particularly low-income families, by “robbing” them of their earnings. Predatory mortgage lenders can charge prepayment penalties and high interest on loans, which can result in the foreclosure of homes. Payday lenders charge excessively high interest rates on payday loans. If the interest continues to build, and the borrower cannot pay it off, the chances of the borrower being able to obtain a conventional loan in the future can be ruined. As of December 2007, Mississippi had no laws protecting its citizens from predatory mortgage lending practices. Mississippi also allows payday lending.2

5. **Housing Location and Affordability**
Housing that is affordable and located near thriving job markets is vital for the economic success and well-being of a family. Through state housing trust funds, affordable homes can be made available to families who need low-income housing. Mississippi does not have a state housing trust fund, and Mississippi does not provide developer tax credits for the production of affordable housing. Mississippi does not target federal tax credits to increase the supply of affordable housing for vulnerable families with restricted access to private housing markets.2

6. **Marriage and Relationship Education**
As stated by the Center for the Study of Social Policy, “States that seek to promote financial stability for families and brighter futures for children can do so by promoting healthy family relationships.”2 Couples education and marriage preparation can teach couples effective ways to communicate with each other and solve interpersonal conflicts. Programs that deal with domestic violence can benefit couples in need and help reduce those instances of violence. States can also initiate healthy
relationship programs into public high schools, teaching students marriage and relationship skills. While Mississippi doesn’t offer state-sponsored, marriage-based skill-building services specifically, Mississippi Department of Human Services-sponsored Families First Resource Centers are helping citizens around the state improve overall relationship skills.³

7. Child Support

“Studies indicate that reliable child support improves children’s academic achievement and helps reduce conflict between parents.”² For low-income families, consistent child support payments can prevent them from turning to welfare. States can encourage child support payments by non-custodial parents by not counting the payments against families who apply for benefits and also by allowing for reasonable forgiveness on past-owed child support and interest. Mississippi has none of the three child support arrears, or past debt forgiveness, policies for low-wage custodial parents. Mississippi has child support interest provisions, but they are not enforced.²

“\textit{It’s striking how many states have taken on poverty as a top policy priority…No one even used the word ‘poverty’ in the past. It was all about helping working families}.”

— Jack Tweedie, National Conference of State Legislatures⁴

\textbf{Other Steps to Reduce Child Poverty in Mississippi}

- Conduct longitudinal assessments to determine regional, county, and community levels of overall poverty and child poverty rates

- Create public awareness of the negative impacts of children being born into poverty and the persistent impacts of poverty on a child’s life

- Create nonpartisan, multiple stakeholders at the executive level by naming a Mississippi Commission to Reduce Childhood Poverty that is charged with creating poverty targets and specific strategies to reduce childhood and overall poverty rates

- Review successes of other states that are already implementing poverty reduction strategies⁵
Every action of the QCDO is imbued with encouragement for civic participation

SUCCESS STORY

Quitman County Development Organization

In order for an actor to be able to play a great part, they must first have a theater production to act in. They must have practiced actors under which to study, a supportive setting on which to act out their part. Different people must be taking different roles, in concert, in order to make the play a success. Such a fine-tuned production takes a great deal of effort and attention, and without proper resources, sometimes the play stops.

Just as proper resources are required for a successful theater show, it also takes adequate support to create and maintain a vibrant community. In such a community, well-functioning, healthy adults can contribute economically and civically, and consequently, children can learn the roles they need to reach their God-given potential.

In Quitman County in the 1970’s, two men, Rev. Carl Brown and Robert L. Jackson, recognized that the show was coming to a stop and needed an influx of energy and revenue. Educational attainment was low, and jobs were scarce. Residents were disheartened, and the community was fractured.

The two men invested their efforts in the Quitman County Development Organization (QCDO), which in the 31 years since, has provided local residents with needed financial services, housing, leadership development, and educational support—the fundamental building blocks needed to establish a vibrant community in which children and other residents can thrive. And the goals of the QCDO haven’t stopped there. Every action is imbued with encouragement for civic participation. From the youngest to the oldest citizens, the QCDO seeks to nurture a sense of shared destiny by providing education and mentoring on topics ranging from entrepreneurship to holding public office.
Setting the Stage

“Each community needs to have a nonprofit engaged in the development of their children.” — Senator Robert L. Jackson, CEO (pictured on page 63)

Robust financial services are essential to the vitality of a community, and the economic stability of families is predicated on their ability to save, invest and borrow money. The QCDO has been a persistent force for the well-being of children and families in Quitman County by offering financial services that have led to increased saving among local citizens and the creation of businesses that feed the local economy, provide jobs and sustain area residents.

What is now known as the First Delta Credit Union is one of the first endeavors of the QCDO and remains the backbone of its operations. The First Delta Credit Union was started in 1981 and now serves Quitman, Panola, Tallahatchie and Coahoma Counties. As a credit union, it promotes savings among its members and provides loans for activities that can improve the community. Any citizen can become a member by making a deposit. With over 6,000 members and $6.1 million in assets, the credit union has made over $30,000,000 in loans since its inception, increasing the odds that area families have access to needed capital for life’s many transitions, whether it be a new home for a young couple or an entrepreneurial endeavor.

Microloans can be used to start small businesses or grow existing ones through the purchase of additional equipment, supplies and inventory. Business expansion can lead to not only increased jobs and income, but also greater availability of local services for families. For this reason, the QCDO has placed a strong emphasis on micro-enterprise development, particularly for women and minorities who might not otherwise have access to financial backing for entrepreneurial efforts. Technical support and loans ranging
from $1,500 to $250,000 have been made available through this program, which has spawned over 20 businesses and created over 60 jobs. The types of businesses range from early education and child care centers to trucking companies.

Home ownership is an important financial investment for families, and children who live in owned homes typically benefit from a higher quality environment. For children, the benefits of this less stressful living situation often get expressed through better grades and fewer behavior problems. Along with financial services, the QCDO has sought to heighten the availability of desirable and affordable housing for Quitman County residents. Housing renovation projects, home-ownership counseling, and home construction and sales have all been a part of the QCDO effort to ensure families have potential for home ownership and its accordant benefits. As a result of the QCDO’s efforts, over 500 more people live in desirable housing in the Quitman county area.

Some of the most progressive work of the QCDO has centered around financial education for children. Not only do adults have an opportunity to participate in the credit union, but area youth also have a credit union of their own. The Youth Credit Union Program (YCUP) currently has over $80,000 in assets, is youth operated and has 1,200 members ages 1-17. Members receive a picture ID, savings passbook, newsletter and access to financial workshops. YCUP workshops prepare youth to save, invest, manage and borrow money. The YCUP Board of Directors is comprised of elected youth ages 9-17, and all members have input in its management.

Being exposed to the arts and having outlets for creative expression are integral components of child development, yet many rural children have few opportunities to visit art galleries or engage in creative endeavors. Accordingly, the QCDO provides training for youth in the arts. The Delta Media Arts Program teaches participants techniques in documenting oral
“[It’s important] that they grow up and be productive, go off to college, find good jobs, and come back to the community and give back. And remember what the community gave to them, especially programs like this.”

— Luvenia K. Mamon, grandparent of program participant

“Leading economists conclude that investments in young children may be the best way to stimulate economic growth, and investments in young children’s social and emotional development may be the most productive of these investments.”

— National Scientific Council on the Developing Child²

“[I want my children to be able to pursue their dreams. I don’t want them to feel like...just because we’re from the Delta...they have limits. You know, be encouraged to work hard for whatever it is that you want. The sky’s the limit. It may be one of those hokey sayings, but it’s true—the sky is the limit.”

— Rosland Clinton-Strong, parent of program participant
Another youth-centered facet of the QCDO is the Rev. Carl Brown Education Center, which houses a computer learning center and summer enrichment programs, as well as several specialized educational programs designed to embrace parents as educational partners and enhance the efforts of local schools. The Early Childhood Program is a full-day program that is available for children ages 5 and under that features Raising a Reader, a program designed to foster a love for reading among very young children. Another program housed at the Education Center, The Children’s Village, is an after-school program that strengthens and expands the math and English skills of children ages 9 and under. The Children’s Village currently serves approximately 65 children and utilizes former participants as student volunteers. Also in the Rev. Carl Brown Education Center, children are encouraged to be leaders and develop business skills in the Smart Talk/Sweet Shop Store, which is a small store that is owned and operated by youth.

“Children have left this program to become leaders. Some of the young people who have gone through the program… are mayors; they’re running their own successful businesses, they’re CPAs, they are teachers.”

– Pearl Watts, QCDO Youth Director

“I was the salutatorian of my class, and I don’t think I would have done it without QCDO. I know everybody says, ‘Well, you just have to study real hard.’ But, you know, having that support system behind your back [really helps]. I received two scholarships from QCDO; they did scholarships for the whole entire senior class… The biggest benefit for me is… knowing that I have a purpose now. I think my purpose [is]… that I’m here to help people… I’m an aspiring doctor, and I don’t think I would have the courage to even be a biology major and go to medical school if it hadn’t been for QCDO.”

– Andrea Jossell, Age 17, QCDO Youth Participant, Sweet Shop Manager, and Volunteer Tutor
ECONOMIC WELL-BEING

SUCCESS STORY

“One of the things that QCDO has done for me [is that] I’m able to go out and speak. I used to be shy, but they have different programs where we have to prepare presentations... We have different national federation summits every year, so we have to go to a different place every year... We’ve been to New Orleans since Katrina. We’ve been to North Carolina. They’ve been to Puerto Rico, and you have to speak in front of all these people. So QCDO has really trained me to be a leader and to speak in front of a lot of people, and to just, you know, be successful.”

— Andrea Jossell, Age 17, QCDO Youth Participant, Sweet Shop Manager, and Volunteer Tutor (pictured on page 62)

In order to garner support for these endeavors, QCDO leaders obtain funding from government agencies, banking institutions, private donors, foundations and national credit associations. Ensuring adequate funding streams always remains an issue, but often, when the case is made for shared investment and mutually beneficial outcomes, leaders respond. Helping policymakers and other stakeholders understand the value of local investments for future productivity is key.

Repeat Performances

Sen. Robert L. Jackson, CEO, believes that the QCDO could serve as a model for similar efforts in other parts of the state. He suggests that the secret for success is the power of local citizens working together to identify and solve their community’s problems. Part of this process, as he sees it as a Mississippi Senator, can be getting involved in the political process and affecting policy. Another component is bringing in new resources to the community, as well as empowering citizens to generate more resources. Most importantly, Senator Jackson points to leadership. With quality leadership, he believes anything can happen.

“People make a project. So if you’ve got the right people, the project will probably be successful.”

— Senator Robert L. Jackson, CEO
Pearl Watts, QCDO Youth Director, suggests some basic steps for anyone wanting to take action in their community. She recommends getting a cross-section of people from the community together, including youth, the elderly, business people and others in order to see what the primary needs are. Next, she suggests evaluating community resources and developing a plan. Then there is the hard work of implementing the plan and making adjustments along the way.

**Rave Reviews**

The QCDO has been well-recognized for its work by entities such as the *Ladies Home Journal*, the Kellogg Foundation and Save the Children. Just this year, the QCDO has received awards ranging from the Southern Growth Policies Board 2008 Youth Innovator Award to Non-Profit of the Year for 2008 by the Community Foundation of Northwest Mississippi. Though many variables come into play when shaping an area’s financial picture, one fact is undeniable: Quitman County has fewer children living in poverty than it once did. Fourteen percent fewer children lived in poverty in 2005 than did in 1989.

To return to our theater analogy, the QCDO has orchestrated quite a production and set the stage for many great performances. By addressing the financial, housing, personal and educational needs of community residents, the QCDO has effectively strengthened families. They have ensured that local children have the types of opportunities that should be afforded to all children. By investing in community development, they have made an investment in children’s development, and it has been shown time and time again that investments in children are investments in the future. This is true for Quitman County, and it is true for the rest of the state.

“I think the key to success is putting your heart in and loving what you do.”

– Pearl Watts, QCDO Youth Director (pictured on page 62)
Beginning with the class of 2009, high school graduates from Chickasaw, Itawamba, Lee and Monroe counties will have guaranteed community college tuition to Northeast or Itawamba Community Colleges. The private-public partnerships that have made this possible include, but are not limited to, The Gilmore Foundation, CREATE Foundation, several Boards of Supervisors, and Three Rivers Planning and Development District. The program ensures a more educated workforce for Mississippi’s future by providing tuition and fees once students have applied for other eligible grants and scholarships.

“One many families face hardships in trying to provide an education beyond the high school level. I’m excited today’s announcement [Itawamba County Guaranteed Tuition Program] will have a significant impact on the hardworking families of Itawamba County and prevent such dire circumstances as taking out second mortgages or student loans in order to provide their children with two years of college education.”

— Danny Holley, President, Itawamba County Board of Supervisors

According to the U.S. Census Bureau, in 2006, a family of four (two adults and two children) was considered to be living in poverty if their annual income was below $20,444.1 Most Americans, however, do not agree with this figure. According to a recent report by the Center for Economic & Policy Research, more than two-thirds of Americans who were polled felt that an annual income of $30,000 met the poverty criteria. Furthermore, 70% said that an annual income of $40,000 was needed to make ends meet.2 Mississippi is one of 26 states where minimum wage is at the minimal federal level. The remaining 24 states’ minimum wage levels exceeded $6.55/hour prior to the federal mandate of July 2008.3 In 2006, approximately 54% of Mississippi’s children lived in low-income families with incomes below 200% of the federal poverty level (i.e., $40,888 for a family of two adults and two children). In contrast, 39% of children nationally lived in low-income families that year.3,4

Extreme poverty refers to families with household incomes of one-half of the federal poverty measure, which was $10,222 for a family of four (two adults and two children) in 2006. In Mississippi, approximately 14% of children (101,000) were in households with extreme poverty. Mississippi’s rate of extreme poverty was almost two times as high as the national rate of 8%.4 In real dollars, this equates to raising a family on $196.00/week, or approximately $28/day.
When families live in communities that offer a healthy environment with safe places to play and exercise; affordable, nutritious food options; and high-quality, easily accessible health care, children are given an opportunity for healthy development. Fostering children’s health saves lives and money and paves the way for a more productive and prosperous society. In fact, it has been shown that communities with unhealthy children are likely to suffer economically in the long run. Children who are in poor health can fall behind academically and are less likely to be healthy as an adult. Adults who have poor educational attainment or who suffer from poor health are much more likely to earn less in the job market or to be unemployed.

Since children’s brain development is, from birth, dependent on their environment to provide the right kinds of social stimulation, as well as a healthy diet and freedom from toxins and/or destructive illnesses, child health is crucial for child development. A sick child is deprived of opportunities for learning, needed social interactions and the ability to explore their environment. Furthermore, serious health problems that go untreated can directly attack children’s brain development.

Now is the time for Mississippers to ensure that our children are no longer faced with debilitating and/or deadly health problems, such as obesity, infant mortality, low birthweight and difficulties accessing the health care system. Smoking (i.e., children’s exposure to secondhand smoke, as well as adolescent smoking) is also a crucial public health issue since tobacco-related illnesses remain costly for individuals and the state.

Healthy children have energy, are able to participate in a full range of activities and are free of debilitating conditions. However, not all children in Mississippi are enjoying a healthy childhood. The Child and Youth Prevalence of Overweight Study found that, in 2005, almost half (48.3%) of middle
48.3% of middle school students in Mississippi were overweight or at risk of becoming overweight in 2005.

School students in Mississippi were overweight or at risk of becoming overweight.\textsuperscript{3} Since being overweight as a child can have significant health consequences for childhood as well as adulthood, being overweight is one of the most profound examples of a health problem that can thwart children’s development through limited activity and the progression of concurrent, degenerative health problems. Consequently, working toward its alleviation is one of the most important public health endeavors of our time.

“Obese children and adolescents are at risk for health problems during their youth and as adults. For example, during their youth, overweight children and adolescents are more likely to have risk factors associated with cardiovascular disease (such as high blood pressure, high cholesterol, and Type 2 diabetes) than are other children and adolescents.”

– Centers for Disease Control and Prevention, May 2008\textsuperscript{4}

Infant health sets the stage for later development, and healthy babies have the greatest chance of becoming vital and active children and adults. Despite national improvements in infant mortality, Mississippi’s rates in recent years have become worse and stagnated.\textsuperscript{5} Mississippi ranked last among all the states for having the highest number of low-birthweight babies and the highest number of infant deaths in 2005.\textsuperscript{6} Low birthweight can contribute to infant mortality, and surviving children with very low birthweights are more likely to suffer from “a variety of neurodevelopmental problems...Children born at very low birthweight without a major disability may have more subtle mental and emotional problems, such as attention deficit hyperactivity disorder (ADHD), behavioral problems, and reduced IQ.”\textsuperscript{7} Therefore, the advancement of Mississippi’s economic and social capital greatly depends upon the health of its infants.
“The 30 million low-birth-weight babies born annually (23.8% of all births) often face severe short- and long-term health consequences. Low birth weight is a major determinant of mortality, morbidity and disability in infancy and childhood and also has a long-term impact on health outcomes in adult life.”
— World Health Organization, 2008

Not only is it important to work toward preventive health measures, it is also crucial that children have access to health care should they become sick. Children who receive quality health services experience less time away from their usual activities and are therefore able to attend school and social engagements that promote optimal development. However, some children in Mississippi have barriers to accessing health care. A January 2008 report by the Center for Mississippi Health Policy notes that approximately 124,000 children in Mississippi are without health insurance coverage, and three out of four of these uninsured children are likely eligible for public coverage. One-third of the uninsured children had been covered by Medicaid or SCHIP in the past year. Three in four of uninsured children have an adult in their household who works full-time. In addition, health insurance coverage for children, both private and public, is on the decline.

“Good health is the foundation for children’s positive growth and development. Having health insurance can significantly improve children’s access to health care services and reduce the risk that illness or injury will go untreated or create economic hardships for families.”
— The Future of Children

approximately
124,000
children in Mississippi are without health insurance
Mississippi has seen improvement overall in the percentages of young people who smoke. However, the anti-smoking media campaign in the state has been scaled back, and it will take several years to know the effects. Any youth tobacco use is a concern given the health risks associated with smoking, and the use of other types of tobacco (snuff, chewing tobacco and cigars) is on the rise.11 Many states have successfully implemented programs to address these concerns and improve the health of children in their state. By addressing these problems in our own state immediately, we may be able to prevent future problems and enjoy some of the improvements seen in children’s health in other states. While improving child health, we can also improve children’s chances of high educational attainment and successful workforce participation as adults. Adults who participate in the workforce bring needed resources to the state and contribute to the economic prosperity of all citizens.

In this chapter, we explore issues related to children’s health in Mississippi. First, we identify the problem by taking an in-depth look at data related to children’s health in the state, including data on infant mortality and low birthweight; childhood obesity/overweight, nutrition and physical activity; tobacco use; and health insurance. We also report findings from a 2007 MS KIDS COUNT survey of Mississippi residents regarding their children’s health status and health care coverage, as well as their attitudes about child health screenings. Second, we offer potential strategies for improving children’s health in Mississippi. We address the issue on two levels by exploring what can be done at the policy level as well as the grassroots, or community, level. To provide an example of the types of actions that can be taken at the grassroots level, we share a story about a successful program in northeast Mississippi, CATCH KIDS, that provides needed services to children who have barriers to accessing health and dental care. It is our hope that this example will serve to stimulate thought and action for unique solutions that can serve to augment state-level changes and benefit Mississippi’s children.
**Infant Mortality:**

According to the Mississippi State Department of Health, there were 483 infant deaths in Mississippi in 2006 (i.e., deaths of children under 1 year of age). Three hundred of those deaths were to children who were less than 28 days old, and 183 were to children between 28 days and 1 year. Mississippi’s 5-year average infant mortality rate (deaths per 1,000 live births) for 2002-2006 was 10.5. Below are lists of the counties with the highest and lowest 5-year average infant mortality rates:

<table>
<thead>
<tr>
<th>Highest:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Coahoma</td>
<td>21.2</td>
</tr>
<tr>
<td>Noxubee</td>
<td>19.3</td>
</tr>
<tr>
<td>Humphreys</td>
<td>18.6</td>
</tr>
<tr>
<td>Claiborne</td>
<td>16.9</td>
</tr>
<tr>
<td>Sunflower</td>
<td>16.5</td>
</tr>
</tbody>
</table>

*FIGURE 46*

<table>
<thead>
<tr>
<th>Lowest:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Perry</td>
<td>3.5</td>
</tr>
<tr>
<td>Montgomery</td>
<td>4.8</td>
</tr>
<tr>
<td>Pike</td>
<td>5.2</td>
</tr>
<tr>
<td>Greene</td>
<td>5.3</td>
</tr>
<tr>
<td>Pontotoc</td>
<td>5.7</td>
</tr>
<tr>
<td>Wilkinson</td>
<td>5.7</td>
</tr>
</tbody>
</table>

*FIGURE 47*

According to data from the Centers for Disease Control and Prevention, Mississippi’s 2005 infant mortality rate was 11.3 deaths per 1,000 live births. This rate was significantly higher than other states in the region (e.g., Arkansas [7.9] and Georgia [8.2]) and the nation as a whole (6.9) in 2005, but was not significantly different than Mississippi’s rate for 2000 (10.7).  

*FIGURE 49*
Low-birthweight Babies:
According to the Mississippi State Department of Health, 12.4% of live births in Mississippi in 2006 (5,713 babies) were low birthweight, weighing less than 2,500 grams.\textsuperscript{1, b, d} Below are the lists of the counties with the highest and lowest percentages of low-birthweight babies:

**Highest:**
- Wilkinson 21.5%
- Issaquena 20.8%
- Jefferson 18.3%
- Benton 18.1%
- Attala 17.2%

**Lowest:**
- Itawamba 6.9%
- Prentiss 7.2%
- Tate 7.2%
- Hancock 8.3%
- Quitman 8.3%

According to state-level data from the Centers for Disease Control and Prevention, there was a statistically significant increase in the percentage of low-birthweight babies born in Mississippi from 2000 to 2005 (10.7% to 11.8%). Mississippi’s percentage of low-birthweight babies in 2005 (11.8%) was the highest in the nation, significantly higher than the nearby states of Arkansas (8.9%) and Georgia (9.5%), as well as the nation as a whole (8.2%).\textsuperscript{2, 4, 5, b, d} [FIGURE 53]
Overweight/Obesity:
According to 2007 data from the Youth Risk Behavior Surveillance System (YRBSS), 27.1% of 9th-12th graders in Mississippi described themselves as slightly or very overweight. This percentage was significantly lower than the percentage for the nation as a whole (29.3%), but was not significantly different from Arkansas (27.3%) or Georgia (28.5%). In that same year, 17.9% of students in Mississippi were defined as overweight, and 17.9% were defined as obese using body mass index calculations from self-reported height and weight. These percentages were significantly higher than those for the nation as a whole (15.8% overweight and 13.0% obese). In addition, Mississippi had a significantly higher percentage of students who were obese, compared to other Southern states (i.e., 13.9% for Arkansas and 13.8% for Georgia).[^6]

Recent research conducted on younger students (1st-8th graders) in Mississippi suggests that the actual prevalence of overweight in Mississippi students could even be higher than the YRBSS data indicates. The Child and Youth Prevalence of Overweight Study (CAYPOS), conducted by researchers at the University of Southern Mississippi, used actual height and weight measurements of 1st-8th graders in Mississippi and then compared results for 6th-8th graders with those of the YRBSS for middle school students. They found that, in 2003, 25.2% of 6th-8th graders from the CAYPOS were overweight, compared to 18.5% from the YRBSS. Another significant finding was that “a high percentage of children (1 in 4) are already overweight or at risk for becoming overweight in first grade.”[^7]

### FIGURE 54

2007 Student Reports on Overweight/Obesity-related Topics

**Notes:**
Figures 54, 55 and 56 were created using data from the Youth Risk Behavior Surveillance System (YRBSS).

**Bar Graphs:**
Bars with diagonal lines indicate that Mississippi was significantly different than the U.S. and/or other states. For example, if the U.S. bar is filled with diagonal lines, then Mississippi is significantly different than the U.S. Solid bars indicate the differences were not significant between Mississippi and the U.S. and/or other states.[^5]

The topic labels in Figure 54 are abbreviated versions of the YRBSS questions. For further information, visit the CDC’s YRBSS Web site at http://www.cdc.gov/HealthyYouth/yrbs/.

**in 2007,**

27.1% of Mississippi 9th-12th graders described themselves as slightly or very overweight
Results from the YRBSS indicate that Mississippi students may be exhibiting unhealthy dietary behaviors as well as a lack of physical activity, which may contribute to high rates of overweight/obesity.6

In 2007, compared to the nation as a whole, a significantly lower percentage of Mississippi students reported the following:6,6:

- Eating less food, low fat foods, or fewer calories to lose or keep from gaining weight (37.2% of Mississippi students)
- Eating fruit one or more times during the week before the survey (81.5% of Mississippi students)
- Eating green salad one or more times during the week before the survey (49.8% of Mississippi students)
- Exercising to lose or keep from gaining weight (56.8% of Mississippi students)
- Attending physical education classes one or more days in an average school week (35.9% of Mississippi students) [FIGURE 55]

In addition, a higher percentage of Mississippi students reported the following:6,6:

- Drinking soda (not including diet drinks) at least once per day during the week before the survey (47% of Mississippi students) [FIGURE 56]
- Watching television for three or more hours each day on school days (47.4% of Mississippi students)

47.4% of Mississippi 9th-12th graders reported watching television for three or more hours each day on school days.
Tobacco Use:

According to data from the YRBSS and Youth Tobacco Survey (YTS), student cigarette use in Mississippi is declining. Data from the YTS indicate that the prevalence of student smokers in Mississippi public high schools decreased from a high of 32.5% in 1999 to 18.7% in 2006 and from 23.0% in 1999 to 8.4% in 2006 for public middle school students. Figure 57 shows the significant declines in Mississippi student reports of cigarette smoking between 2003 and 2007 for the YRBSS. Compared to 2003, a significantly lower percentage of Mississippi 9th-12th graders in 2007 reported ever trying a cigarette (57.8%), smoking a cigarette before age 13 (17.0%), smoking on one or more of the past 30 days (19.2%), smoking 20 or more of the past 30 days (7.3%), smoking on school property within the past 30 days (4.0%), smoking every day for 30 days (11.6%), and smoking more than 10 cigarettes per day on the days they smoked (8.3%). However, the percentage of student smokers under age 18 who bought their own cigarettes in a gas station or store within the past 30 days (20.9%) and the percentage of students who tried to quit smoking within the past year (49.7%) did not significantly change between 2003 and 2007.

<table>
<thead>
<tr>
<th>Mississippi 9th- to 12th-grade Select Student Reports on Tobacco Use (2003 vs. 2007)</th>
<th>2003</th>
<th>2007</th>
<th>Direction of Change*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever tried cigarette smoking, even one or two puffs</td>
<td>65.6%</td>
<td>57.8%</td>
<td>Decreased</td>
</tr>
<tr>
<td>Smoked a whole cigarette before age 13</td>
<td>23.5%</td>
<td>17.0%</td>
<td>Decreased</td>
</tr>
<tr>
<td>Smoked cigarettes on 1 or more of the past 30 days</td>
<td>25.0%</td>
<td>19.2%</td>
<td>Decreased</td>
</tr>
<tr>
<td>Smoked cigarettes on 20 or more days during the 30 days before the survey</td>
<td>12.0%</td>
<td>7.3%</td>
<td>Decreased</td>
</tr>
<tr>
<td>Smoked cigarettes on school property on at least 1 day during the 30 days before the survey</td>
<td>6.3%</td>
<td>4.0%</td>
<td>Decreased</td>
</tr>
<tr>
<td>Ever smoked at least one cigarette every day for 30 days</td>
<td>16.4%</td>
<td>11.6%</td>
<td>Decreased</td>
</tr>
<tr>
<td>Among students reporting that they currently smoked cigarettes…</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoked &gt;10 cigarettes per day on the days they smoked during the 30 days before the survey</td>
<td>13.0%</td>
<td>8.3%</td>
<td>Decreased</td>
</tr>
<tr>
<td>For those &lt; 18 years, the percentage who usually obtained their own cigarettes by buying them in a store or gas station during the 30 days before the survey</td>
<td>16.7%</td>
<td>20.9%</td>
<td>No Change</td>
</tr>
<tr>
<td>Tried to quit smoking cigarettes during the 12 months before the survey</td>
<td>55.7%</td>
<td>49.7%</td>
<td>No Change</td>
</tr>
</tbody>
</table>

Notes:
The values and direction of change significance calculations reported in this table were taken from the Centers for Disease Control and Prevention’s (CDC) Youth Risk Behavior Surveillance System (YRBSS) Web site available at http://apps.nccd.cdc.gov/yrbss.

*Direction of Change judgments were taken from the YRBSS Web site and indicate statistically significant changes between 2003 and 2007 student reports.
of Mississippi students smoked their first cigarette before their 13th birthday

In 2007, approximately one-fifth (19.2%) of Mississippi 9th- to 12th-grade students reported being current smokers (i.e., smoking cigarettes on one or more of the past 30 days). In addition, almost 3 out of 5 students in Mississippi reported that they had tried cigarette smoking at some time in their lives (57.8%). This percentage is significantly higher than that of the nation as a whole (50.3%), but not significantly different than that of Arkansas (59.7%) or Georgia (56.9%). For 17% of Mississippi students, their first cigarette was smoked before their 13th birthday.\(^6\) [FIGURE 58]

In addition to data on cigarette smoking, the YRBSS and YTS provide information on prevalence of smokeless tobacco use (e.g., chewing tobacco, snuff, and dip) as well. Figure 59 shows data trends from the 1999–2006 YTS for smokeless tobacco use. In 2006, 9.7% of high school students and 7.7% of middle school students reported current smokeless tobacco use.\(^9\)

Notes:
Figure 58 was created using data from the Youth Risk Behavior Surveillance System (YRBSS), and Figure 59 was created using data from the Youth Tobacco Survey (YTS).

For Figure 58, bars with diagonal lines indicate that Mississippi was significantly different than the U.S. and/or other states. For example, if the U.S. bar is filled with diagonal lines, then Mississippi is significantly different than the U.S. Solid bars indicate the differences were not significant between Mississippi and the U.S. and/or other states.\(^7\) \(^8\)

The topic labels in Figure 58 are abbreviated versions of the YRBSS questions. For further information, visit the CDC’s YRBSS Web site at http://www.cdc.gov/HealthyYouth/yrbs/.
HEALTH

DATA SECTION

Health Insurance:

According to a recent report by the Center for Mississippi Health Policy (2008), on average, 15% of children (approximately 124,000) in Mississippi were uninsured from 2004-2006. The rate of uninsured children is higher for low-income families making less than 200% of the Federal Poverty Level (22% are uninsured).10

Figures 60 and 61 show uninsured rates by age group and race. For 2004-2006, the highest uninsured rate was for children between the ages of 13 and 18 (19.6%) and for Hispanic children (45.6%). With respect to absolute numbers, approximately 52.7% of uninsured children in Mississippi were African American; 33.6% were White; 10.6% were Hispanic; and 3.1% were Native American. Figures 60 and 61 also show that uninsured rates increased between 2000-2002 and 2004-2006 for all age and race/ethnic groups, with the exception of children between the ages of 1 and 5.10

Figure 62 shows that the majority of uninsured children in Mississippi (74%) live in households where at least one adult has full-time employment, and almost 4 out of 5 (78%) uninsured children live in a household where an adult works at least part-time.10

Notes:

Figures 60, 61, and 62 were created using data from the Current Population Survey, compiled by the Center for Mississippi Health Policy in a report entitled “Children’s Health Coverage in Mississippi.” For further information, see the full report online at http://www.mshealthpolicy.com/documents/ChildrensCoverageReportJan08web.pdf
In a MS KIDS COUNT/Social Science Research Center random survey of 1,009 Mississippi adults conducted in October 2007, we asked, “Do you believe that government programs, such as the State Children’s Health Insurance Program and Medicaid are providing health care coverage to all the children in Mississippi who need it?” In response, 61.8% of adults said no; 26.7% said yes; and 11.5% were unsure or did not know. [FIGURE 63]

Of the 1,009 Mississippi adults surveyed, 331 had one or more children currently living at home. A majority of parents who responded (n=299) agreed that in addition to immunization records and a birth certificate, a child should be required to have dental, vision and hearing screenings before entering school. Almost three-quarters (71.9%) of the respondents agreed that children should be required to have additional screenings. Of these, 22.1% strongly agreed, and 49.8% agreed. Almost one-quarter (24.4%) either disagreed or strongly disagreed. Only 3.7% were unsure. [FIGURE 64]

When asked the primary reason that their child misses school or child care, almost half of the parents who responded (n=137) cited colds or flu (48.2%). Of the remaining top four reasons, 7.3% cited asthma, 5.1% cited stomach problems, and 2.2% cited ear infections. The remaining 37.2% cited other, not sure, or child not in school or child care.
Parents have high estimations of their children’s health. When asked to indicate the state of their child’s health, almost half (46.0%) of respondents (n=137) rated it as excellent. More than a third (35.8%) rated their child’s health as very good, and 14.6% rated it as good. Thus, 96.4% of parents rated their child’s health as good to excellent. Only 3.7% of parents rated their child’s health as fair or poor. [FIGURE 65]

When asked if their child was covered by a health care plan, the vast majority (86.9%) of parents who responded (n=137) said that their child was covered, while 13.1% said their child was not covered. Of those parents who had coverage for their children (n=119), more than half (50.4%) had coverage through employer-provided insurance. Another 15.1% had coverage through the State Children’s Health Insurance Program (SCHIP), and almost a quarter (24.4%) had coverage through Medicaid. The remaining 10.1% had other types of coverage or refused to respond. Of those parents who did not have employer-provided health insurance coverage for their children (n=77), 31.2% said that the employer-provided insurance was too expensive; 9.1% said the insurance did not cover dependents; and 5.2% said it was not good coverage. In other words, 45.5% of parents with no employer-provided coverage for their child had complaints about the coverage. Another 26.0% did not have coverage because they were unemployed, and 28.6% either had other coverage, did not know or refused to answer. [FIGURES 66, 67, 68]
once children become overweight, the chances that they will remain overweight or become obese as adults are high

POLICY CONSIDERATIONS

Childhood Overweight/Obesity
Research has shown that children who are overweight are at a higher risk for developing heart disease and diabetes, as well as depression and other psychological problems. Once children become overweight, the chances that they will remain overweight or become obese as adults are high. To combat the rise of childhood overweight and obesity, other states have implemented the following school policies:

- Prohibiting elementary school students’ access to school stores and vending machines
- Assessing student height and weight and calculating BMI on an annual basis and providing parents with the results
- Incorporating health and nutrition education into the curriculum
- Requiring an established minimum amount of time for physical education
- Increasing family and community education on health, nutrition and obesity prevention measures

After considering many of these policies, the Mississippi Legislature enacted the Mississippi Healthy Students Act in 2007. The act requires schools to promote healthier and more nutritious food and beverages, healthier food preparation, and more physical activity and health education. The Bower Foundation has been instrumental in helping many schools carry out the goals of the Healthy Students Act, as well as promoting nutrition and physical activity, which directly affects student achievement. One of the grants they have funded is the Nutrition Integrity Grant that allowed a number of Mississippi Public Schools to purchase oven steamers as replacements for their kitchen fryers. Another grant funded by The Bower Foundation is the Committed to Move Grant. This grant gave physical education teachers funding to purchase authorized equipment and implement high-quality programs and assessments.

Other Steps to Prevent Childhood Overweight/Obesity in Mississippi

- Conduct community assessments of the “built” environment to offer safe playgrounds, walking and biking paths that will encourage physical activity
- Encourage Safe Routes to School programs throughout Mississippi
- Make healthy food more affordable by removing the 7% sales tax on it, while keeping the sales tax on junk food
- Facilitate application by communities and schools for federal grants to fund childhood obesity prevention programs, such as the Centers For Disease Control and Prevention’s Nutrition, Physical Activity and Obesity Program
HEALTH

POLICY CONSIDERATIONS

Infant Mortality/Low Birthweight

Some of the leading causes of infant mortality include premature births and low birthweight, Sudden Infant Death Syndrome (SIDS), birth defects, and maternal complications during pregnancy. Racial disparities, lack of timely prenatal care and the mother’s health contribute to infant mortality and low-birthweight babies. Recent research has examined the roles that chronic stress and racial disparities have on preterm births and low-birthweight infants. This is particularly important given the contextual factors in Mississippi associated with negative birth outcomes.

In 2005, Mississippi witnessed a sudden rise in infant mortality after years of making progress toward its decline. Prenatal care and health care coverage can prevent serious health problems in children. For eligible mothers and their children, Medicaid and the State Children’s Health Insurance Program (SCHIP) can help provide access to these services. Other states have streamlined the eligibility and renewal processes for Medicaid and have encouraged early and continuous access. Since 2005, Mississippi has required stringent paperwork and in-person interviews at a Medicaid office to determine eligibility and re-enrollment for Medicaid and SCHIP, and one study found declines in Medicaid enrollment between 2004 and 2006.

In 2007, an Infant Mortality Task Force was convened by Governor Barbour and included representatives from nine Public Health Districts. The task force has been working toward reducing infant mortality and improving access to health services for mothers and their children. One of the task force’s initiatives was carried out immediately, as they placed more Medicaid eligibility workers in local health departments. The Closing the Gap on Infant Mortality: African American-Focused Risk Reduction Program is working to decrease infant mortality in the African American community by filling in health care gaps for mothers and their infants. The Maternal Infant Mortality Surveillance System analyzes cases of infant death in an effort to understand the factors that contributed to those deaths.

Other Steps to Decrease Infant Mortality/Low Birthweight in Mississippi

- Ongoing hospital reviews of infant deaths
- Ongoing reviews of which counties and populations have persistently high neonatal and postneonatal infant mortality rates
- Establishment of county-level infant mortality review teams coordinated via the county Health Departments
- Assessment of the strengths and needs of mothers and families with low-birthweight babies
- Community supports for mothers of low-birthweight babies for at least one year, but ideally two years postpartum
- Implementation of Medicaid options for prenatal care in Mississippi
- Research on the effects of racial and geographical disparities on infant mortality rates
Children’s Health Insurance

Although there have been major investments in public health insurance for several years, the health status of children from more affluent families is far above that of low-income children. Low-income families still lag behind when it comes to affordable insurance and protection against illness and injury for their children. This is all the more alarming because good health is vital for positive growth and development in the lives of all children. It has been documented by research that children with untreated illnesses have a hard time keeping up in school. For example, one insurer in Pennsylvania found that 1 out of 5 children who were uninsured fell behind in school because of untreated vision problems. Leaving children uninsured pushes the burden of great unmet medical and mental health needs onto individuals and the state.

According to a report by the Center for Mississippi Health Policy (January 2008), there are declines in both private and public health insurance coverage in Mississippi, and these occur mostly in low-income families. The most recent census data indicates that “Mississippi currently has the sixth highest percentage of uninsured children in the nation.” Due to the current financial crisis, this number will likely continue to grow. Addressing this need for Mississippi’s children is critical for our state.

Policies That Work

Some of the initiatives that other states have implemented to reduce the number of uninsured include the following:

- Enrollment Simplification and Outreach – working with community-based organizations to set up enrollment sites in areas such as health clinics, schools and recreation centers
- Premium Assistance – using federal and state funds to subsidize premiums for low-income families to purchase private insurance coverage for those who are eligible through their employer
- Reinsurance – having multiple insurance companies share risk by purchasing policies from other insurers to limit total losses
- Risk Pools – having state-sponsored health insurance plans for individuals who have been denied coverage by private companies or who would not otherwise be eligible for public health insurance
- Eligibility Expansions – allowing states to raise eligibility levels to cover children in families with incomes greater than 200% of the Federal Poverty Level
- Tax Credits – providing assistance, in the form of child health care tax credits, to families with income between 200% and 300% of the Federal Poverty Level to help purchase private health insurance coverage
Other Steps to Reduce the Number of Uninsured Children in Mississippi

- Enroll children who are already eligible for existing programs
- Identify uninsured children by looking at those who are served by other government programs, such as the National School Lunch Program
- Work with health care providers, private employers and social service agencies to screen for eligible children and encourage their parents to enroll them
- Encourage small employers to offer health insurance coverage for their employees
- Subsidize employer-based coverage

Mississippi is in a position to increase the number of insured children because most of the uninsured are already eligible for public insurance programs such as Medicaid and SCHIP. It will require outreach to these eligible families and a change in enrollment procedures. In addition, initiatives such as premium assistance, shared premiums and tax credits prove most helpful because they take advantage of both employer and employee contributions. For children who are not able to access the health care system using Medicaid, SCHIP or private insurance due to other considerations, this section’s Mississippi Success Story offers one solution.
almost 82% of Mississippi adults felt that restaurants should be smoke-free, according to the Social Climate Survey of Tobacco Control.

Tobacco Use
There are two primary national data sources for monitoring youth tobacco issues, the Youth Tobacco Survey (YTS) and the Youth Risk Behavior Surveillance System (YRBSS). They were developed by the Centers for Disease Control and Prevention so that states would have the needed data to develop and implement programs to prevent youth from starting tobacco use and to help those who are tobacco users to quit. Data taken from these and other surveys reveal that the number of high school smokers in Mississippi has decreased since 1998. Similarly, the number of middle school smokers in Mississippi also decreased from 23% in 1999 to 8.4% in 2006. While male high school students were more likely to smoke than females in 1997, the smoking prevalence was the same for males and females by 2007.

Even though cigarette smoking among youth has decreased over the years, other tobacco products did not follow this trend. According to a 2005 Monitoring the Future national survey, “nearly 8% of high school seniors reported using smokeless tobacco in the past 30 days.” There is concern among parents that kids are experimenting with snuff, chewing tobacco and cigars, as well as flavored cigarettes, such as bidis (Asian cigarettes) and kreteks (clove cigarettes). These forms of tobacco also have serious health effects.

According to the Surgeon General’s most recent report, “the health effects of secondhand smoke exposure are more pervasive than previously thought. It is a serious health hazard that can lead to disease and premature death in children and nonsmoking adults.” It has been proven through scientific research that breathing a small amount of secondhand smoke is harmful to one’s health. Furthermore, it has been shown that secondhand smoke interferes with “normal functioning of the heart, blood and vascular systems in ways that increase the risk of heart attack.”

Many states have recently cut back on tobacco prevention efforts. Others such as California, Indiana, Massachusetts and Minnesota, who used to be national leaders in tobacco prevention and cessation programs, have joined Mississippi in cutting back. In fact, no state has been funding programs at the level recommended by The Centers for Disease Control and Prevention.

There is strong public support in Mississippi for smoke-free legislation, both among Democrats and Republicans. According to the Social Climate Survey of Tobacco Control, almost 82% of Mississippi
adults felt that restaurants should be smoke-free, and 76.1% felt that indoor work areas should be smoke-free. There are now 23 communities in Mississippi that have strong smoke-free ordinances for all indoor public places. Furthermore, research has demonstrated that these ordinances have not had a negative impact on employment and sales tax revenue in restaurants and bars.¹⁹

### Policies That Work

- **Smoke-free laws for restaurants and bars** – Twenty-six states and the District of Columbia have comprehensive smoke-free laws for restaurants, and 21 states and the District of Columbia have comprehensive smoke-free laws for bars.
- **Smoke-free laws for indoor work areas and other public places** – A total of 316 communities have ordinances prohibiting smoking in workplaces.
- **Universities with smoke-free air policies** – There are almost 150 colleges and universities in the U.S. with smoke-free campuses.
- **Use of multiple strategies and media channels** – In addition to conducting mass media education campaigns, other approaches have broad reach, such as brief interventions in health care settings.
- **Exposure of youth to messages over significant periods of time** – Youth may be exposed, for example, every day during the school year.
- **Use of youth-oriented graphics and testimonials** – Messages and materials initiated by other youth may be more effective in getting and holding their attention.

Use of smoke-free policies can serve to challenge the perception of smoking as a normal behavior, therefore changing attitudes and behaviors of youth about tobacco use.²² According to a national study, youth who worked in smoke-free workplaces were less likely to be smokers than youth who worked in places without smoking restrictions.²³

### Other Steps to Prevent Tobacco Use Among Youth

- Increasing the price of tobacco products
- Mobilizing the community to restrict minors’ access to tobacco products, such as posting warning signs in retail stores
- Implementing school-based interventions in combination with mass media campaigns²⁴
The concept of a healthy community is predicated on the notion that all residents have a chance to thrive. When children grow up as healthy as they can possibly be, they feel good, attend school and learn. They are able to engage in regular play activities and develop socially. Healthy children engage in pursuits that prepare them for later stages of life and allow them to become the active, healthy adults that communities, in turn, depend upon socially and economically.

Optimal brain development is dependent on children’s physical health, and once formed, provides a strong foundation on which the child can create a productive adulthood. If not optimally formed, however, it can be much harder and more costly to correct later on.

In order for children to be healthy, they must have a health care system to support them. Unfortunately, our health care system is not built to reach all children, and many children lack the pathways needed to receive a doctor’s care.

If a parent works hard, but their job just pays minimum wage, they may not be able to afford a car or have access to transportation when their child becomes sick. In many hourly wage jobs, parents simply cannot afford to take their child to the doctor during normal working hours without penalty from an employer. Furthermore, many children are without adequate health care coverage because their parents work jobs that do not offer it or they offer coverage with high deductibles. A lack of a flexible work schedule or transportation can also serve as barriers to obtaining coverage through Medicaid or SCHIP, which require workday office visits for enrollment. Therefore, many children can get stranded without a pathway to access the health care system.

CATCH Kids, Inc.

CATCH Kids, Inc.
The end result of children who do not receive needed medical treatments is having children whose conditions worsen. Routine medical problems can worsen, and serious problems can quickly become life-threatening. Sick children without access to health care often feel bad, miss school, fail to learn and get behind. They may learn to live with chronic pain from dental or other medical problems. They may not be able to play with other children or develop properly. Ill children cannot fully apply themselves and may develop low expectations for their abilities and accomplishments, hindering their ability to participate in life fully.

To address this problem, CATCH Kids, Inc. is building bridges for children without access to the health care system by bringing high-quality, free health care services to children who need it. With a desire for a truly healthy community where all children have access to the care they need, the stewards of CATCH Kids have employed ingenuity and a can-do spirit to create a medical and dental services delivery system that reaches many children who would normally not be served.

**Community Prescriptions**

CATCH Kids was started in Tupelo in 1998 as local doctors realized a need for services. The program is based on an American Academy of Pediatrics program called Community Access to Child Health (CATCH) that was created to foster wellness among all children. The CATCH program is predicated on the following ideas: 1) all children need medical homes, 2) local people can make a difference in their communities and 3) community members need to help and support each other.

In order to fulfill their community-based objectives, the founders of CATCH Kids have united volunteer workers and contributors from many different sectors. Local doctors, interns, nurses and dentists donate their time; parents of served children volunteer to promote the program in the community; area students create promotional materials for the program; local organizations partner with CATCH Kids to ensure that children in and beyond the Tupelo area are served; and an Advisory Board and a 21-member Corporate Board steer the direction of the organization. In addition, three dedicated staff members tend to the daily operations of the organization, and numerous organizations partner with CATCH Kids to extend services.
CATCH Kids gives all children an opportunity to develop and have a life trajectory that is not marred by health problems.

For me it’s a personal sense of self-satisfaction that I’m making a difference.”
— Dr. James W. Griffin, CATCH Kids Volunteer

“That’s why I’m practicing [medicine]—not to get reimbursed, but to help and improve the health needs of the community.”
— Allison Hailman Doyle, CATCH Kids Medical Volunteer

This type of collaboration gives volunteers and staff members a sense of civic mission and strengthens community ties as different people unite around a common purpose. It also meets the needs of families who can benefit from bridges to health care and ensures that all children have equal access. CATCH Kids gives all children an opportunity to develop and have a life trajectory that is not marred by health problems. The end result is a group of vibrant children who are ready to face life’s challenges and take their place in a healthy future community.

The Doctor Is In

Three community-based evening clinics, two in Tupelo and one in Okolona, provide free, high-quality medical services to children from 5:00 p.m. to 7:00 p.m., when parents are most likely to be able to access the services. The clinics are located in neighborhoods, so families living nearby can walk to see the doctor if transportation is a problem. If needed, referrals for dental services are made.

“One person couldn’t do it, and I don’t think even one organization could do it. Our collaborations with other programs enhance the services that we’re able to do. So it’s a community collaboration that does it.”
— Valerie Long, Nurse Practitioner and Executive Director of CATCH Kids, Inc. (pictured on page 90)
“One of the big problems that I see, especially in kids in this area, is dental care. There is a significant lack of care for children’s teeth, and I think one of the problems is…finances for third party reimbursement.”

— Dr. James W. Griffin, CATCH Kids Volunteer (pictured on page 88)

“A little boy had a lot of dental problems and he needed extensive work, and even though CATCH Kids did a limited amount, the director called around and found someone—a dentist that would do the rest of the care that the child needed. It meant a lot to the parent.”

— Allison Hailman Doyle, CATCH Kids Medical Volunteer (pictured on page 88)

“We do see a lot of children with dental problems, and they need a dental referral. Sometimes dental areas just get a little bit put off. Parents just don’t have the money for dental care, and so [if] the child complains enough, they bring them in. We’ll either see them in an acute situation, such as an abscess, or a pretty significant dental cavity.”

— Judy Stokes, CATCH Kids Volunteer Nurse
CATCH Kids has partnered with the Tupelo Housing Authority and Haven Acres Neighborhood Association to strategically place clinics in populous Tupelo neighborhoods. A partnership with Baby Steps in Okolona has allowed for placement of a CATCH Kids clinic there.

CATCH Kids has also expanded to offer 10 school-based clinics, where children can receive free medical care based on referral by the school nurse. These clinics are primarily located in the surrounding schools of Lee, Chickasaw and Pontotoc Counties, ensuring access for children in more remote towns. CATCH Kids health care providers visit the schools to treat children.

“We do see some children with Medicaid because that may not be the barrier. [One school child] had Medicaid, and they went to the emergency room, but it was basically a viral infection, and no antibiotics were needed. Medicaid doesn’t cover over-the-counter medicines. So the child actually had been seen, but he was not any better because he could not get the over-the-counter medication. Well, that’s when our program steps in. If our health care provider writes it as a prescription, we will pay for it, including any over-the-counters. And the school principal remarked after our first clinic, ‘The program has been here a week, and I can already see a difference because this child has had a runny nose ever since I [first] saw him, and he is improving!’”

— Valerie Long, Nurse Practitioner and Executive Director of CATCH Kids, Inc.

Six doctors, residents and nurse practitioners provide medical services to children ages 0-18 with barriers to care. Thanks to partnerships with local pharmacies, medications, even over-the-counter medications, are provided free of charge. The local pediatric clinic and the Family Residency Center provide additional services, such as lab work, for CATCH Kids and will see children at no cost.
**Injection of Funds**

CATCH Kids received a one-time, start-up grant from the CATCH Program, and the Health Resources and Services Administration also provided a five-year grant through its Healthy Tomorrows Program. Now CATCH Kids depends on volunteer labor, community fundraising, local grants and is a member of the United Way. The local medical center and health care foundation provide an annual grant as well as housing.

**Bridges to Health**

As a result of the efforts of CATCH Kids, many children receive routine care for a range of issues, such as ear infections and sports physicals. CATCH Kids also provides emergency care and makes referrals that have saved children’s lives.

“I remember having a kid come in that couldn’t breathe. [We] put her in the hospital. It felt really good to be able to take care of her.”
— Allison Hailman Doyle, CATCH Kids Medical Volunteer (pictured on page 88)

“When I had an abscess….they put a needle right there and opened it. I would have died. I’m glad that they were here for me.”
— Issac Woodard, CATCH Kids patient (pictured on page 92)

“We have seen a couple of children that needed to be referred to Memphis….Hats off to Dr. Ivancic, Dr. O’Dell, and Dr. Griffin….They saw that these children had additional care. And they followed up on them. That meant a lot.”
— Phyllis Sims, CATCH Kids Case Manager
children ages 0-18 with barriers to care are provided medical services from CATCH Kids.

CATCH Kids also treats more chronic problems, such as asthma, that can gradually affect children’s well-being and, if left untreated, have the potential over time to hinder their development.

“My son, Issac, had been to doctors before because he was having problems breathing…I think he was treated for almost two years for a common cold…CATCH Kids was the only place that found he had asthma…And when they treated him for asthma, no more problems.”
— Lorrie Woodard, mother of CATCH Kids patient

“My great niece had been hospitalized a couple of times for asthma, and just for her to be able to come here and keep her from having to go into the hospital, [it was great]. She loved Dr. Ivancic, and she would just hop up on the table with no qualms whatsoever.”
— Susan Ling, CATCH Kids Volunteer Nurse (pictured on page 89)

In 2007, CATCH Kids provided medical care for 883 children and assisted 55 children with approximately $35,000 of dental services. With the attention and dedication of all the people who make CATCH Kids a success, children who might otherwise fall through the cracks are able to receive high-quality medical and dental care. This care ensures that the suffering of sick children is minimized, and the children stay healthy and develop in a manner that every parent wants for their child. As a result, northeast Mississippi communities benefit from having improved child health and development, which equates to greater future productivity and prosperity for all citizens.
SUCCESS STORY

CATCH Kids Kudos

The successes of CATCH Kids have not gone unnoticed. In October 2008, Dr. Ed Ivancic, a CATCH Kids founder and veteran Tupelo pediatrician, received a Local Hero Award from the American Academy of Pediatrics Council on Community Pediatrics for his work with the organization. Dr. Ivancic and CATCH Kids Executive Director, Valerie Long, work hard to get the word out about their unique approach to serving children.

“I went with Valerie and Dr. Ivancic to a conference in Orlando, Florida, and we fixed up a large a brochure…to put on the wall. And you would be surprised how many people asked, ‘What is this? How do you get into this?’ and Valerie, our Executive Director, and Dr. Ivancic made contacts there to share information about the program.”
— Phyllis Sims, CATCH Kids Case Manager (pictured on page 91)

“We have parents who bring their children in who are extremely thankful that we’re here and that we’re open because their jobs would be in jeopardy if they had to take off work.”
— Dr. James W. Griffin, CATCH Kids Volunteer (pictured on page 88)

“[Parents are] just thankful that we’re open after five. I’ve heard that more than once. ‘I got off at five,’ and you know, ‘I’m just glad that ya’ll are here.’”
— Allison Hailman Doyle, CATCH Kids Medical Volunteer (pictured on page 88)

“My daughter had to do a project at school about community helpers. Well, all the other kids in the class did firemen, policemen, teachers. She wrote a paper on CATCH Kids, and this was in second grade. She got a 100!”
— Lorrie Woodard, mother of CATCH Kids patient (pictured on page 92)

CATCH Kids patients and their parents are also quick to share their gratitude and respect for the program’s staff and volunteers.
Next Appointment

Ms. Long states that the CATCH Kids model has applicability for other regions of the state. With a willing medical community and local citizenry, a similar program could be started anywhere. She notes the willingness of her staff and volunteers to assist interested parties.

The successes of CATCH Kids also point to implications for policymakers. Clearly, the program has identified and addressed the needs of a population that is underserved throughout the state. Therefore, Mississippi is in need of policies that institute state efforts to formally meet the needs of this population of children.

All Sewn Up

For the past 10 years, CATCH Kids has been providing a bridge to first-rate medical and dental services to children. In doing so, CATCH Kids is ensuring that all children have access to medical services and the ability to stay healthy. Physical health is important for children’s overall development and must be maintained in order to prevent the types of chronic problems that can rob a child of desired interactions and learning experiences, which are so crucial for optimal brain development. Productive adult lives are predicated on a solid developmental foundation as a child.

Because of CATCH Kids, northeast Mississippi benefits by having a younger generation of healthier children who will someday join the workforce and contribute to the local economy themselves. By receiving adequate health care, area children are ensured the best possible life trajectory that will not be thwarted by health problems, and northeast Mississippi communities are ensured a more healthy, productive and prosperous citizenry.

883 children received medical assistance from CATCH Kids in 2007

“Dr. Ivancic…has been an innovator for this program, and other states have modeled their programs after us, so we are definitely a model.”
— Judy Stokes, CATCH Kids Volunteer Nurse (pictured on page 89)

“I would be willing to go to another clinic and help them—not show them how to do it, but just say, you know, this is how we have done it.”
— Susan Ling, CATCH Kids Volunteer Nurse (pictured on page 89)
F.Y.I.

More than a quarter of Mississippi’s population is covered by Medicaid, one of the highest rates in the nation. However, according to the Policy Matters 2008 Data Update, Mississippi families could be aided by additional policy measures addressing health care coverage and benefits. Mississippi is in the bottom bracket for parent eligibility for Medicaid. Families who make up to 50% of the federal poverty level are eligible. Mississippi provides only emergency dental services to adult Medicaid patients. Also, mental health coverage is not at parity with physical health coverage in Mississippi. Some disorders are covered, but not all. Furthermore, Mississippi does not fund a wage replacement benefit for families taking family and medical leave. Enactment of policies that increase health care coverage and benefits have been shown to benefit families, improve health and increase productivity.
We are a stronger society when all members have an opportunity to contribute in a meaningful way, and one of the key components of active civic participation is having a high-quality education. In order for all citizens to have a chance to fulfill their academic and intellectual potential, we must understand the processes that influence educational attainment. By ignoring these and failing to provide the best environments for learning, we put our state’s future prosperity at risk.

Quality early learning environments have a domino effect. Early learning environments that are stable, nurturing and responsive literally wire the brain—creating a sturdy foundation, or brain architecture, for all the learning that follows. If a child’s early years are lacking in the types of experiences that develop children’s brain architecture for educational achievement, the void shows up in Kindergarten and elementary school. If not addressed then, the void carries on into secondary school, where children who are lagging behind often give up and drop out. Those who do graduate may not attempt college. These educational deficits that begin at such an early age and accumulate throughout the formative years shape a person’s destiny in tremendous ways. Self-esteem, income, place of residence, health care quality—the very context and quality of one’s life experiences—can depend on educational attainment.

Educational attainment strongly influences salary. Working people with a doctoral degree are the highest paid as a category. Here are comparisons of the salaries of working people with different levels of education:

<table>
<thead>
<tr>
<th>Educational Attainment</th>
<th>Percentage of Doctoral Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school education</td>
<td>28.6% of doctoral degree</td>
</tr>
<tr>
<td>High school education</td>
<td>40.3% of doctoral degree</td>
</tr>
<tr>
<td>Associate degree (2-year degree)</td>
<td>49.4% of doctoral degree</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>65.9% of doctoral degree</td>
</tr>
</tbody>
</table>

“**Young children are learning from their earliest weeks and months, and they thrive in a safe and nurturing environment that provides them with opportunities to learn. Without that environment, they lose opportunities for language and cognitive development that is the basis for later formal learning. Research has demonstrated that participation in intensive, high-quality early childhood education can improve school readiness and close the gap in early language development.**”

— The Annie E. Casey Foundation
among those who graduate in Mississippi, less than 10% who take the ACT meet all four of the college readiness benchmarks.

When a child is exposed to the right kinds of stimulation at an early age and brain architecture develops in a manner that prepares them for optimal learning, their outlook is much brighter. A child who is given the opportunity to receive high-quality early education and child care, as well as K-12 education, will be able to participate in learning in a way that grooms them for college and successful careers. Thus, lives are improved and society as a whole benefits by having individual members who are well-educated and ready to meet today’s global challenges.

“All children need the intellectual development, motivation and skills that equip them for successful work and lifelong learning. These result from having quality learning environments, challenging expectations and consistent guidance and mentoring... The number-one predictor of whether you will be successful in life is whether you graduate from high school. In today’s competitive global economy, effective education is more important than ever before.”

— America’s Promise Alliance

While there have been some signs of improvement, Mississippi has work to do in meeting the educational needs of its citizens. Without state-sponsored pre-Kindergarten or access to high-quality early education, many children are starting school ill-prepared, and their educational performance lags behind that of students in other states. Not surprisingly, the state’s high school graduation rate is low. Among those who do graduate in Mississippi, less than 10% who take the ACT meet all four of the college readiness benchmarks.

Unfortunately, in Mississippi, affordable high-quality preschool is out of reach for many families with young children, and Head Start, while very successful in preparing children for school, only has enough funding to serve about half of the preschool-age children who are eligible. Early Head Start serves fewer still—just under 3% of the infants and toddlers who are eligible.
“Research has found that… children who attend [high-quality early-childhood education] programs are less likely to drop out of school, repeat grades, or need special education than children who have not had such experiences. As adults, they are less likely to commit crimes, more likely to be employed, and likely to have higher earnings.”

– Lynn Olson in Education Week, January 2007

A lack of an educated workforce can thwart efforts to bring in industry, particularly in some of the state’s most impoverished areas, such as the Mississippi Delta, where residents could benefit the most. Furthermore, low-performing K-12 schools serve as a deterrent to incoming businesses that need to locate in areas with good schools in order to obtain and retain employees. These factors affect Mississippians in a profound way, limiting job opportunities and keeping wages low.

“When Mississippi education succeeds, Mississippi businesses succeed and Mississippi’s quality of life improves. Mississippi businesses must have a quality workforce to prosper and thrive.”

– Blake Wilson, president, Mississippi Economic Council

In this chapter, we explore educational attainment in Mississippi. First, we examine the issue by taking an in-depth look at data related to education in the state, including graduation and dropout rates, students’ test scores at various grade levels, and early education programs. We also report findings from a 2007 MS KIDS COUNT survey regarding the attitudes of Mississippi residents toward state-funded pre-Kindergarten. Second, we offer potential strategies for improving educational attainment in Mississippi. We address the issue on two levels by exploring what can be done at the policy level as well as the grassroots, or community, level. To provide an example of the types of actions that can be taken at the grassroots level, we share a story about a Mississippi Delta town where local residents and two nuns are working to improve early education and promote lifelong learning. It is our hope that this example will serve to stimulate thought and action for unique local solutions that can serve to augment state-level changes and benefit Mississippi’s children.
Graduation Rates by School District:

According to the Mississippi Department of Education, the graduation rate for the Class of 2007 was 73.8%, up slightly from 70.8% for the Class of 2006. Below are lists of school districts with the highest and lowest self-reported graduation rates:

Highest Districts:

<table>
<thead>
<tr>
<th>District</th>
<th>Class of 2007 Graduation Rate</th>
<th># in Cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enterprise</td>
<td>96.0%</td>
<td>61</td>
</tr>
<tr>
<td>Benoit</td>
<td>94.4%</td>
<td>19</td>
</tr>
<tr>
<td>Claiborne Co.</td>
<td>92.2%</td>
<td>147</td>
</tr>
<tr>
<td>Senatobia</td>
<td>89.3%</td>
<td>160</td>
</tr>
<tr>
<td>Lafayette Co.</td>
<td>87.7%</td>
<td>160</td>
</tr>
</tbody>
</table>

Lowest Districts:

<table>
<thead>
<tr>
<th>District</th>
<th>Class of 2007 Graduation Rate</th>
<th># in Cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw Co.</td>
<td>47.4%</td>
<td>47</td>
</tr>
<tr>
<td>Carroll Co.</td>
<td>48.6%</td>
<td>111</td>
</tr>
<tr>
<td>George Co.</td>
<td>50.0%</td>
<td>328</td>
</tr>
<tr>
<td>Quitman Co.</td>
<td>54.6%</td>
<td>113</td>
</tr>
<tr>
<td>Newton Co.</td>
<td>55.1%</td>
<td>64</td>
</tr>
</tbody>
</table>

Notes:

The rates presented in Figures 70, 71, and 72 are self-reported (by district) 4-year cohort graduation rates with the cohort beginning with students who entered 9th grade for the first time in 2003/2004 and including those who entered the class in a higher grade. Rates for very small cohorts should be interpreted with caution.

Agricultural high schools (i.e., Coahoma AHS, Forrest AHS, and Hinds AHS), MS School for Math and Science and the MS School for the Arts are not included in the table or in the map.
Dropout Rates by School District:
The dropout rate for Mississippi’s Class of 2007 was 15.9%, down slightly from 17.6% for the Class of 2006. This means that out of an average classroom of 30 students in Mississippi, approximately 5 drop out of school. Below are lists of school districts with the highest and lowest self-reported dropout rates:

**Highest Districts:**

<table>
<thead>
<tr>
<th>Class of 2007 Dropout Rate</th>
<th># in Cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carroll Co.</td>
<td>36.5%</td>
</tr>
<tr>
<td>Newton City</td>
<td>34.7%</td>
</tr>
<tr>
<td>Columbia</td>
<td>33.3%</td>
</tr>
<tr>
<td>Canton</td>
<td>33.0%</td>
</tr>
<tr>
<td>Greenwood</td>
<td>32.0%</td>
</tr>
</tbody>
</table>

**Lowest Districts:**

<table>
<thead>
<tr>
<th>Class of 2007 Dropout Rate</th>
<th># in Cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benoit</td>
<td>0.0%</td>
</tr>
<tr>
<td>Enterprise</td>
<td>0.0%</td>
</tr>
<tr>
<td>Leland</td>
<td>1.6%</td>
</tr>
<tr>
<td>Pontotoc City</td>
<td>2.1%</td>
</tr>
<tr>
<td>Pass Christian</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

**Notes:**
The rates presented in Figures 73, 74 and 75 are self-reported (by district) 4-year cohort dropout rates. Rates for very small cohorts should be interpreted with caution.

Agricultural high schools (i.e., Coahoma AHS, Forrest AHS, and Hinds AHS), MS School for Math and Science and the MS School for the Arts are not included in the table or in the map.
approximately 12% of Mississippi teens (ages 16-19) were not attending school or working in 2006.

- **Teens Who Are High School Dropouts:**
The American Community Survey collects information on “status dropout” rates. That is, the percentage of teenagers from a particular age group who are not enrolled in school and who have not obtained a high school diploma. Using this definition of “teens who are high school dropouts,” Mississippi tied with two other states (Nevada and New Mexico) and had the second highest percentage of teens aged 16-19 who were not enrolled in high school and were not high school graduates (10%) in 2006. Louisiana had the highest percentage (11%) that year. For Mississippi, the 2006 percentage is down significantly from 2000 (15%), but still significantly higher than the percentages for the nation as a whole (7%) and Arkansas (6%), but not Georgia (9%). In 2000, approximately 15%, or 25,000 Mississippi teens, between the ages of 16 and 19 were not enrolled in school and were not graduates, compared to approximately 10%, or 19,000 teens, in 2006. [FIGURE 76]

- **Teens Not Attending School and Not Working:**
In 2006, Mississippi tied with two other states (Louisiana and New Mexico) for having the highest percentage of teenagers ages 16-19 (12%) who were not attending school or working (full- or part-time). This is significantly higher than the nation as a whole (8%), Arkansas (9%) and Georgia (9%). From 2000-2006, there was no significant change in the percentage of Mississippi teens not attending school and not working (approximately 11%, or 18,000 teens, in 2000 compared to approximately 12%, or 22,000 teens, in 2006). [FIGURE 77]
Mississippi’s composite ACT score for graduating seniors in the Class of 2007 was 18.9, the lowest of any state in the nation. This is compared to 21.2 for the nation as a whole, 20.5 for Arkansas, and 20.3 for Georgia.\textsuperscript{7,8} According to the ACT, a benchmark score “is the minimum score needed on an ACT subject-area test to indicate a 50% chance of obtaining a B or higher or about a 75% chance of obtaining a C or higher in the corresponding credit-bearing college courses, which include English Composition, Algebra, Social Science and Biology.”\textsuperscript{9} Of the ACT-tested graduating seniors in the Class of 2007 in Mississippi, 57% met the College English Composition benchmark; 19% met the College Algebra benchmark; 35% met the College Social Science benchmark; and 13% met the College Biology benchmark. Only 9% of Mississippi students met all four ACT benchmark scores.\textsuperscript{9}

When making comparisons across states on the ACT, it is important to consider participation rates. Nationwide, less than one-half (42%) of graduating seniors in the Class of 2007 took the ACT. Participation rates ranged from 9% in Delaware and Rhode Island to 100% in Colorado and Illinois. In Mississippi, 96% of graduates took the ACT compared to 42% nationally, 75% in Arkansas and 34% in Georgia.\textsuperscript{7} It is possible that only a particular demographic of students take the ACT in states with lower participation rates. Similarly, only 1,077 Class of 2007 graduates in Mississippi took the SAT Reasoning Test\textsuperscript{TM}, and 98% of those test-takers were A and B students with an average high school GPA of 3.82.\textsuperscript{10}
**ACT Composite Scores by School District:**

Below are lists of the school districts with the highest and lowest ACT composite scores for graduating seniors in the Class of 2007:

<table>
<thead>
<tr>
<th>Highest Districts: *</th>
<th>ACT Score **</th>
<th>% who took college prep courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxford</td>
<td>21.8</td>
<td>41.0%</td>
</tr>
<tr>
<td>Union City</td>
<td>21.3</td>
<td>30.4%</td>
</tr>
<tr>
<td>Lamar Co.</td>
<td>21.2</td>
<td>52.4%</td>
</tr>
<tr>
<td>Ocean Springs</td>
<td>21.2</td>
<td>67.5%</td>
</tr>
<tr>
<td>Gulfport</td>
<td>21.0</td>
<td>41.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lowest Districts:</th>
<th>ACT Score **</th>
<th>% who took college prep courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humphreys Co.</td>
<td>14.8</td>
<td>41.4%</td>
</tr>
<tr>
<td>Benoit</td>
<td>14.9</td>
<td>-</td>
</tr>
<tr>
<td>Sunflower Co.</td>
<td>14.9</td>
<td>63.1%</td>
</tr>
<tr>
<td>Jefferson Davis Co.</td>
<td>15.3</td>
<td>44.8%</td>
</tr>
<tr>
<td>Claiborne Co.</td>
<td>15.4</td>
<td>37.8%</td>
</tr>
<tr>
<td>East Jasper</td>
<td>15.4</td>
<td>40.6%</td>
</tr>
<tr>
<td>Holmes Co.</td>
<td>15.4</td>
<td>38.9%</td>
</tr>
<tr>
<td>North Panola</td>
<td>15.4</td>
<td>33.3%</td>
</tr>
<tr>
<td>Quitman Co.</td>
<td>15.4</td>
<td>26.3%</td>
</tr>
<tr>
<td>West Bolivar</td>
<td>15.4</td>
<td>43.3%</td>
</tr>
</tbody>
</table>

**Notes:**

* Agricultural high schools (i.e., Coahoma AHS, Forrest AHS, and Hinds AHS), MS School for Math and Science and the MS School for the Arts are not included in the table or in the map.

** ACT score represents the average of all ACT test-takers from the 2007 estimated graduating class.

- Missing data

**FIGURE 79**

**FIGURE 80**

**FIGURE 81**

Source: Mississippi Department of Education
Graduating Seniors’ ACT Scores for English, Math, Reading & Science:
In every subject area, including English, Math, Reading and Science, Mississippi fell behind the average ACT scores of Arkansas, Georgia and the United States as a whole. In Mississippi, the 2007 subject area scores were 19.0 for English, 18.1 for Math, 19.1 for Reading, and 18.7 for Science, all out of a possible score of 36. [FIGURE 82]

8th Graders Who Scored at or Above Basic Level on NAEP for Writing, Math, Reading & Science:
For the most recent data available (2007 for Writing, Math and Reading and 2005 for Science) on the National Assessment of Educational Progress (NAEP), 8th graders in Mississippi scored significantly worse than Arkansas, Georgia and the United States as a whole in all subject areas, with the exception of Arkansas in the subject area of Reading. The percent of Mississippi 8th graders who scored at or above the basic level was 83% for Writing, 54% for Math, 60% for Reading and 40% for Science. [FIGURE 83]

4th Graders Who Scored at or Above Basic Level on NAEP for Math, Reading & Science:
For the most recent data available (2007 for Math and Reading and 2005 for Science), 4th graders in Mississippi scored significantly worse than Arkansas, Georgia and the United States as a whole in the subject areas of Math, Reading and Science. The percent of Mississippi 4th graders who scored at or above the basic level was 70% for Math, 51% for Reading and 45% for Science. [FIGURE 84]

Notes:
For Figures 83 and 84, diagonal lines indicate that Mississippi was significantly different than the U.S. and/or other states. For example, if the U.S. bar is filled with diagonal lines, it indicates that the U.S. is significantly different from Mississippi. Likewise, if the Arkansas or Georgia bars are filled with diagonal lines, it indicates that they are significantly different than Mississippi. Solid bars indicate that the differences were not significant between Mississippi and the U.S. or other comparison states.
Of the children participating in Mississippi, 82% were African American, much higher than the national average.

Nationally, 92% of programs were center-based, and 52% of those were 5-day, full-day programs. In 2006, some 29,628 children in Mississippi were enrolled in Head Start programs. The majority of these programs were center-based (97%) and operated on a full-day schedule for 5 days a week (72%). Nationally, 92% of programs were center-based, and 52% of those were 5-day, full-day programs. Of the children participating in Mississippi, 82% were African American, much higher than the national average of 31%. For the 2005-2006 program year, the average Head Start teacher’s salary in Mississippi was $17,891, compared to $24,737 for the nation as a whole.

According to a recent report by Pre-K Now titled, Votes Count: Legislative Action on Pre-K Fiscal Year 2009, Mississippi’s 2008-2009 Fiscal Year Budget includes no investment in pre-K, but does include “$3 million to expand existing child care resource and referral services and establish a high quality rating system.”

Head Start

In 2006, some 29,628 children in Mississippi were enrolled in Head Start programs. The majority of these programs were center-based (97%) and operated on a full-day schedule for 5 days a week (72%). Nationally, 92% of programs were center-based, and 52% of those were 5-day, full-day programs. Of the children participating in Mississippi, 82% were African American, much higher than the national average of 31%. For the 2005-2006 program year, the average Head Start teacher’s salary in Mississippi was $17,891, compared to $24,737 for the nation as a whole.
Would you support legislation to establish a statewide publicly funded pre-K program?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>83.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>11.5%</td>
<td>No</td>
</tr>
<tr>
<td>5.1%</td>
<td>Don't Know</td>
</tr>
</tbody>
</table>

Would you be willing to pay additional state taxes to fund pre-K?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>73.6%</td>
<td>Yes</td>
</tr>
<tr>
<td>19.0%</td>
<td>No</td>
</tr>
<tr>
<td>7.3%</td>
<td>Don't Know</td>
</tr>
</tbody>
</table>

Mississippi is the only Southern state to not provide universal state-funded pre-Kindergarten. In a *MS KIDS COUNT*/Social Science Research Center random survey of 1,009 Mississippi adults conducted in October 2007, we asked about support for pre-K and the willingness to pay for such a program.

When respondents were asked if they would “support legislation to establish a statewide publicly funded pre-K program,” an overwhelming majority (83.4%) said yes. Only 11.5% said no, and 5.1% either did not know or refused to respond to the question. [FIGURE 86]

We also asked all respondents (N=1,009) if they “would be willing to pay additional state taxes to fund pre-K?” Almost three-quarters (73.6%) said yes. Nineteen percent said no, they would not be willing to pay. Another 7.3% were undecided. [FIGURE 87]
To measure the level of financial support, we asked all those who were willing to pay additional taxes (N=620) how much they would be willing to pay. One-third was willing to pay $52 per year in additional taxes. Almost a quarter (23.5%) was willing to pay $260 per year in additional taxes. The willingness dropped off dramatically after that, with only 7.9% willing to pay $520 or more per year in additional taxes. However, more than a third (34.4%) was undecided as to what they would be willing to pay in additional taxes to support universal pre-K in Mississippi. [FIGURE 88]

All respondents (N=1,009) were also asked about school bonds. Specifically, they were asked, “Should the percentage of votes needed to pass a school bond be lowered from 60 to 55 percent?” A majority (55.1%) said yes. One-third (32.7%) said no, the passage threshold should not be changed. Some 12.3% did not know or refused to respond to the question. The results indicate that a simple majority of adults in the state favor lowering the threshold for school bond passage. [FIGURE 89]
Policies That Work
In 2003, the Annie E. Casey Foundation funded The Center for the Study of Social Policy, which in concert with the National Center for Children in Poverty and Child Trends, launched the Policy Matters Project. One of the earlier discussion papers produced by the Policy Matters Project was entitled Raising Educational Achievement: Recommendations for State Policy.\(^1\)

This document recommends the following state educational policies:

1. **Teacher Quality:**
Research has demonstrated that requiring all teachers to have a bachelor’s degree in the subjects they teach, as compared to a certificate in that area, enhances teacher quality and student performance. This is particularly paramount for schools with children who are from economically disenfranchised communities. Additional policies being used by other states for recruiting and retaining quality teachers include a range of financial bonuses for all levels of teachers (entry, midcareer, senior and former teachers). These may be in the form of tuition reimbursement, loan forgiveness, and/or housing incentives for teachers who are willing to work in low-performing schools or districts, or teacher salaries that are equivalent to the national average.\(^1\)

In 2005, Mississippi was one of 34 states that required teachers to have content-specific bachelor’s degrees for all initial certificates in order to boost teacher quality.\(^2\) Mississippi offers the Critical Needs Teacher Loan/Scholarship Program for juniors or seniors who are attending four-year colleges in Mississippi and agree to obtain a full-time position in Mississippi public school districts that have teacher shortages.\(^3\) The Mississippi Teacher Loan Repayment Program offers loan forgiveness to full-time teachers who teach in shortage areas.\(^4\)

2. **School Quality:**
Class size standards for Kindergarten through 3rd grade should have no greater than 17 children per teacher, based on research. Students who begin in small classes have greater achievement than those who attend larger-sized classes, and these positive effects remain through middle school. For grades 4-12, it is recommended that the maximum class size be 25 children per teacher.\(^1\)

The Improving Teacher Quality State Grant is a program that offers funding to states for the purpose of hiring and retaining highly qualified public school teachers and principals and also reducing classroom sizes.\(^5\) Mississippi distributes these funds to school districts across the state to provide them with the resources necessary to obtain high-quality educators. In Mississippi, teachers who are paid with the grant funds for the sole purpose of reducing class size must be highly qualified.\(^6\)
3. Student Achievement:
The research is clear that students who are absent more than 15 days per year are least likely to obtain a high school diploma. Higher absentee rates are most often associated with lower academic achievement and higher dropout rates. The Los Angeles Unified School Districts combine more traditional methods of preventing truancy and dropout prevention with the technologies that today’s students are most familiar with, such as MySpace, YouTube and text messaging.1,7

In 2007, Mississippi implemented The Mississippi State Dropout Prevention Plan, with the goals of increasing the graduation rate to 85% by 2018-2019, reducing the state dropout rate by 50% by 2011-2012, and reducing the statewide truancy rate by 50% by 2011-2012. In order to reach these goals, the State Plan will be following the National Dropout Prevention Center/Network’s 15 Effective Strategies for Dropout Prevention.8 Two statewide Dropout Prevention Summits were held in Mississippi where a teen panel discussed issues related to dropping out, and community leaders discussed local dropout prevention initiatives. To augment this program, a dropout awareness campaign called “On the Bus” has been implemented by the Department of Education. The campaign features TV commercials as well as radio and print ads, and it seeks to shed light on the major disadvantages Mississippi students face when they drop out of school. In addition, it highlights the costs for Mississippi taxpayers. The “On the Bus” Web site is a resource for students, parents of children who are at-risk, and people in the community who want to help out.9

“The trend lines show that we are making improvement in our graduation and dropout rates. Our dropout prevention initiatives that began in 2008 have us on track to meet our goal of reducing the dropout rate by 50 percent in the next five to seven years. The slight uptick in graduation rates from the year before we even began our dropout prevention focus gives us a good starting place.”

— Dr. Hank M. Bounds,
State Superintendent of Education10

The Mississippi Center for Education Innovation, funded by the W. K. Kellogg Foundation, is also working on a goal to “reach the national average on national assessments in the next five to seven years.”10 Currently, Mississippi falls near the bottom on the National Assessment of Educational Progress tests.8 Other concerns being addressed by The Mississippi Center for Education Innovation include dropout and 3rd-grade reading proficiency.
4. Community Connections:
Schools that have strong community connections are also more likely to have positive outcomes for children and youth. Service-learning programs have been demonstrated to be effective for a variety of outcomes for youth, including greater social competence, increased responsibility, higher scores on state basic skills tests, and improved classroom performance. These are particularly important among youth who have educational disadvantages.1

The National Youth Leadership Council is a service-learning program that helped students in the Gulf Coast region of Mississippi that was ravaged by Hurricane Katrina. A school in Moss Point, Mississippi took part in the 2006 Gulf Coast Walkabout Summer School Program. High school and younger students participated in service-learning projects that focused on either disaster preparedness, environmental restoration or oral history. This helped not only further the students’ academic skills (literacy and writing), but also enhanced their involvement and participation in the community.11

A 2008 Policy Matters Data Update also recommends fully funding public pre-Kindergarten programs. Not only will children benefit through an improved education and future employment outlook, but research shows that the community will succeed, as well, through a higher employment rate and less dependence on government services. Their research demonstrates that funding for pre-Kindergarten education is well worth the initial investment. Mississippi does not currently invest in a statewide public pre-Kindergarten program.12

Further steps to implement and expand these core policies will enrich the Mississippi educational system and ensure student achievement.

Other Steps to Improve Educational Outcomes in Mississippi

The Mississippi State Board of Education’s Quality Education Act of 2008 was endorsed by several Mississippi groups, including The Parents’ Campaign,13 and resulted in the following legislation:

- Full funding for the Mississippi Adequate Education Program, which is designed to ensure that every school district has sufficient funds to meet accreditation requirements
- Increased training and accountability for superintendents and school board members
- Funding for pilot early education and child care programs
- Increased funding for teachers’ supplies
- Removal of salary caps for teachers after 25 years
As outlined by Mississippi Building Blocks\textsuperscript{14}, the following legislation is specific to Mississippi and was created to implement early education and child care pilot programs.

**The Mississippi Early Learning Collaborative Grant**

In 2007, the Early Learning Collaborative Act was established. This act authorized a voluntary grant program for entities that provide services to four-year-old children, such as Head Start, child care and public pre-K programs. These entities, if eligible, would be able to access funds to expand or enhance their services. “While state appropriations were not allocated for this voluntary program, the Mississippi Board of Education has included a request of $3 million as part of their 2009 Legislative Priorities.”\textsuperscript{14}

**Mississippi Child Care Quality Step System (MCCQSS)**

The Mississippi State Early Childhood Institute was awarded a contract by the Mississippi Department of Human Services to create a voluntary pilot rating system. The program will span 60 counties and will work with child care centers to encourage the use of age-appropriate curriculum. The goal is to increase school readiness among children in the program.\textsuperscript{14}

**The Mississippi Child Care Resource and Referral System (MSCCR&R)**

The MSCCR&R can be utilized by child care professionals and parents. For child care professionals, the MSCCR&R aims to provide technical assistance, training, career building, educational opportunities and credentialing. For parents, the MSCCR&R seeks to inform parents about early education and child care opportunities as well as locations of programs in their area.\textsuperscript{14}

\begin{quote}
“What the Collaborative Act means is that Mississippi communities, large and small, will have an opportunity to boost the chances for school success for young children by ensuring they get a good, equitable and progressive start on their way to high school graduation and beyond.”

— Dr. Cathy Grace, Mississippi State University Early Childhood Institute
\end{quote}

\begin{quote}
“The commitment of the state to fully fund a Mississippi Child Care Resource and Referral Network is to be commended. The implementation of this network across the state will be a significant support piece for the early care and education community and families of young children. In order to improve the quality of care that children receive, the early care and education providers have to receive high quality training and technical assistance support.”

— Dr. Louise E. Davis, Mississippi State University
\end{quote}
The Governor’s State Early Childhood Advisory Council
A 2007 law requires that each state establish a council to advise the governor on early education and child care issues. In doing so, the council facilitates collaboration among agency and program administrators in order to determine best practices for children in the area of early education and child care.\(^4\)

The Council’s 2008 Recommendations\(^4\):

- Appoint an Executive Director for the Council to guide the activities associated with the recommendations made in the report
- Develop a family/child-centered information/data system and sharing process that will ensure significant improvement in the delivery of high-quality early care and education services
- Develop and implement a workforce development plan for individuals seeking to be employed as early childhood educators
- Develop a process by which early childhood services and management occurs for the purpose of supplying communities with information and coordinated service models for replication across the state
- Develop and implement a workforce development plan for individuals seeking to be employed as early childhood educators
- Develop a process by which early childhood services and management occurs for the purpose of supplying communities with information and coordinated service models for replication across the state
- Review and revise the existing registry requirements related to family child care homes
- Develop and implement a process by which health access issues are addressed for children ages 0-5

In addition, a Task Force on Underperforming Schools and Districts was established in 2008. They made recommendations for improving education in Mississippi, including greater transparency in school operations, increased accountability for superintendents and school board members, frequent school audits and the establishment of a teacher recruitment program and educational advisory councils for each county.\(^5\)
the best hope our society has for **future prosperity** is educating our children today

**SUCCESS STORY**

**The Jonestown Family Center for Education and Wellness and The Durocher Program**

The best hope our society has for future prosperity is educating our children today. Not only does high-quality education expand us intellectually, it gives us a depth to life, adds meaning through understanding, and deepens our capacity for empathy. Furthermore, our educational foundation is the basis for our future prosperity and ability to contribute to society.¹ Better educated children are better readers, more adept thinkers. As they grow older, they are more likely to participate civically by being employed, volunteering and voting.² They are less likely to engage in risky behaviors and more likely to be healthy and have a longer lifespan.³ As a composite of individual lives, the quality of society hinges decidedly upon citizens’ educational attainment.

It is now understood that learning does not begin when children are school age. Rather, it starts at birth and hinges on the interplay between genetics and life experiences. Young children’s development—the very architecture of their brains—relies on the community of adults with whom they interact. High-quality early education and child care is important because it employs models for interactions that produce the best learning and social outcomes for children. Consequently, capable children are able to fully engage academically and civically, and later as adults, they are able to serve as the bedrock of community and economic development.

In the aftermath of lost agricultural wages and disintegrating community infrastructure, many children in the Jonestown area of the Mississippi Delta were being denied the opportunity for high-quality early education. Working as teachers in the region in the late 1980’s, Sisters from the Holy Names Order recognized this need and began several programs. Since that time, their work has evolved to include not only high-quality early education for children, but also educational and personal development programs for older children, teens and adults.
By using proven educational methods and incorporating parents and adults who interact with children every day, The Jonestown Family Center for Education and Wellness creates a nurturing environment for children’s development that enhances brain architecture and strengthens family and community bonds. Through The Durocher Program, Jonestown teens and adults are developing leadership roles through volunteering and civic engagement activities that will benefit children and the community at large for years to come.

**The Foundation**

Sister Kay Burton came to the Mississippi Delta from the Holy Names Order in the Seattle area, where she taught at an inner city school. She wanted to better understand the rural South and African American heritage. After teaching in Clarksdale, Mississippi, for some time, she became aware of the need for teachers in Jonestown, Mississippi. Consequently, when she became the Sisters’ Provincial Director in 1984, she recruited several nuns, including Sister Teresa Shields, to teach in the area.

Later, in 1989, when Sister Kay had completed her tenure as Provincial Director, she returned to Jonestown to further her work in the Mississippi Delta. She began The Durocher Program, a volunteer service organization designed to engage residents in community development and improve the infrastructure of Jonestown. Sister Kay continues to work with The Durocher Program today. A few years later (1992), The Learning Center was opened by Sister Teresa, a parent volunteer and another nun in order to offer enhanced and more specialized early education services to children in Jonestown.

Recently, The Learning Center has been renamed The Jonestown Family Center for Education and Wellness in order to more accurately reflect its mission. The Center encompasses a Montessori School, a Toddler Program, After-school and Summer Programs, and a Fitness and Health Club. Furthermore, The Durocher Program has been expanded to not only include volunteer activities, but also GED education and a Girls to Women Program for teens and young adults seeking to become involved in the community and help others.
Brick and Mortar: Working with Children

Montessori School
The Center offers affordable full-day Montessori education to 25 preschool- and Kindergarten-age children. The Montessori school now occupies a separate building, and transportation is provided.

The staff is trained in the Montessori method, which is world-renowned for its effectiveness in teaching children through active learning and self-reliance. This model of learning provides a framework for positive interactions and facilitates language and other skills acquisition. Having access to such an innovative and proven educational method at an early age builds a strong intellectual, emotional and social foundation for Jonestown children and affords them the opportunity for future personal, academic and professional success.

“I can do it, Mama. I wanna do it for myself.” They teach you to do it yourself. My son, every time I try to do something for him now, he tells me that. And I’m glad because...it allows me to back up and allow him to do it himself, so he can practice and learn. ...And the way they teach...where they allow the kids to do what they decide to work on, I mean, I think that that’s the best way to teach kids—because you don’t know what interests them. And you know if [it] interests them,...they’re gonna try to put their all into it. My child actually knows the shapes of the country and states. He can tell you what state that is, and I was very impressed with that.”

— Tunder Davis, Mother of Program Participant
Toddler Program

Before children enter the Montessori program, they may attend the Center’s Toddler Program, which is designed to positively affect children’s development (i.e., their brain architecture) prior to preschool. By focusing on language and fine motor skills, as well as social development, this half-day program prepares children to learn and participate in preschool. Children enjoy a number of skill-building activities, including puzzles, books, finger plays, and outside time. The program, which Sister Teresa refers to as a “preschool for the preschool,” currently has 12 toddlers and their parents participating.

After-school and Summer Enrichment Programs

For two hours each day after school, children from grades 1-5 come to the Center to complete their homework and take part in a variety of activities. Currently, 30 students take part in the After-school Program and enjoy storytelling, singing, art and physical education. They also learn problem-solving and social skills. The Summer Enrichment Program extends these activities beyond the school year and augments them with interactive learning on special topics, such as healthy eating. School children in grades 1-8 participate.

When children have access to enriching programs such as these, they feel valued and consequently learn to value themselves and others. They have self-confidence and the well-rounded skills they need to maintain and build upon healthy development, which helps them meet the challenges they face as they grow older. Furthermore, the community benefits by having children who are likely to become solid contributors to the workforce and economy at large.

“The Center fostered a sense of focus and was a place that encouraged me to follow my dreams.”

— Akilah Miles, former Jonestown Family Center for Education and Wellness student, in the Clarksdale Press Register, October 7, 2008
children see parents modeling healthy lifestyles, which impacts their norms and self-expectations for personal fitness and achievement.

**Scaffolding: Working with Families, Teens and Adults**

**Fitness and Health Club**

The newest addition to the Center is a fitness club that provides Jonestown residents an affordable way to maintain their health. Weight training and cardio equipment is available for use by individuals and families. Learning and societal participation are predicated on physical fitness, and the Jonestown Family Center for Education and Wellness aims to address not only the wellness of the individual through education and fitness, but also the whole family. Given the high rate of obesity in the Mississippi Delta, promoting and providing facilities for health and wellness in the community contributes to the vitality of its residents. Children see parents modeling healthy lifestyles, which impacts their norms and self-expectations for personal fitness and achievement.

**Parental Involvement**

As their new name implies, the Center strives to serve families, not just children. In doing so, they create many opportunities for parents to learn along with their children. The Center offers Parent Workshops once a month and at special times during the year on topics ranging from child development to literacy. Parents also become actively involved through the Parents as Teachers Program, which provides them with knowledge about child development and lends peer encouragement. The Center supports their parents from the time they give birth, and siblings of students are given priority on the waiting list.

“Last year when I was in 3rd grade, I was gonna be in the spelling bee, but some of the words I didn’t know. So they went over them with me, and I learned some of the words. I [still] got out, but I tried my best. I feel great because I know that I can do it this year.”

— Jerome,
4th-grader and After-school Program Participant
“Whenever something is going on, they have the parent meetings, and they inform us. We continually stay involved because it’s a necessity that the parents come to the meetings. So, you automatically keep up with what’s going on in the program...I took the massage class for the babies. And they give out certificates if you go through the class and complete it. They always give you a certificate. Even if it’s not worth anything to somebody else—in the future you can show it and say, ‘Look, I covered these classes.’”

— Tunder Davis, Mother of Program Participant  
(pictured on page 116)

“One topic [that] is my favorite is potty training. We had a little class and they teach you to always encourage them and don’t discourage them...It shows me that if you work as a team,...it’s for the better of the children. You know, it takes more than just a parent or a grandparent to raise a child. It takes the teacher along with everybody else to [raise] a good, well-balanced child.”

— Anganette Eagins,  
Mother of Program Participant  
(pictured on page 116)

“We always invite the children for the parent workshops. They see their parents...enjoying learning and reading.”

— Sister Teresa Shields, Program Director  
(pictured on page 120)
The Durocher Program for Teens and Adults

Because children’s brain architecture is so strongly shaped by those around them and because brain development continues into adulthood, the Sisters seek to advance lifelong education. In doing so, they work with teens and young adults who want to further their education or give back to others. Sister Kay Burton teaches GED classes and operates the Volunteer Service Development Program, as well as the Girls to Women Program.

Through these programs, she provides opportunities for personal enrichment for teens and adults, including GED attainment, volunteer opportunities to help others and improve the community, and development of personal goals and conduct. As a result, Jonestown children benefit from having an enhanced community that boasts contributing teens and adults who have a greater potential to improve the area for children. Furthermore, a generational cycle of community involvement and mentorship is established.

“I’m proud of our Montessori graduates who are always on the honor roll and principal’s list.”

— Sister Teresa Shields, Program Director
“I came around to the conclusion that it wasn’t enough to educate. Education is absolutely primary, but that’s not enough. We have to encourage and help people to help others coming along behind them, so that’s why we have the Volunteer Service Program.”

— Sister Kay Burton (center), Program Director

**Volunteer Service Development Program**

With Sister Kay’s mentorship, Volunteer Service Development Program participants have procured new basketball and tennis courts, a track and field, a playground and a walking track for the city of Jonestown. They also work on home renovation projects for area residents and have rebuilt the local Resource Center. Furthermore, the volunteers work with the younger children during summer school. In addition to traditional academic studies, the volunteers provide recreational opportunities for the sixth through eighth graders, including swimming, playing chess, taking field trips and participating in plays.

This win-win arrangement enhances the learning of both participants and the younger children and teaches area residents that they can take roles of stewardship in their own community. Furthermore, the community receives much needed infrastructure support, not only by having enhanced facilities, but also by having a teen and adult workforce that is engaged and ready to care for Jonestown’s children.

“When I say to a group I need some help,…I get all kinds of help… I’ll help, I’ll help, I’ll help! …It’s thrilling to me.”

— Sister Kay Burton

**Girls to Women Program**

Young women participating in the Girls to Women program also take on volunteer activities. They deliver home-cooked meals on Thanksgiving to elderly community members, and they participate in literacy activities. One current program involves reading to their younger siblings and having their siblings read to them to reinforce the importance of literacy.
by encouraging young people to **become engaged** in their community, a sense of common ownership helps empower them to change their surroundings.

and education. Since younger children are so often influenced by their older siblings, this increases their learning and strengthens family bonds. Furthermore, the Girls to Women participants are able to take pride in their role as teachers, which prepares them for leadership positions.

One special project taken on by the Girls to Women participants was the creation of the Serenity Spot. Ninth- and tenth-grade members wrote a grant and petitioned the city for help in transforming a Jonestown eyesore, an overgrown piece of property with a collapsed building, into a place of beauty, complete with picnic bench and flowers. By encouraging young people to become engaged in their community, Sister Kay instills a sense of common ownership and helps teens feel empowered to change their surroundings, and consequently, their lives.

“*The most important thing about the Girls to Women program is the time our director has for us. Even on the weekend, on Sunday. If you need her, she’s right there. She took us to church with her... She dropped us off at school, too, when we needed a ride. She has so much time on her hands for us... [She is] teaching us about self-esteem and how to carry yourself in school, and educating us too. Sister Kay, she did a lot for us.*”

– Marquita Johnson,
Girls to Women Participant

“She took out time, she did with me... When I started GED classes at night, I was working from 8-4... I was working and doing everything as a widow and taking care of 4 children... And so every day [from] 5:00-7:00 or later, I was right there at Sister Kay's studying, going forward for that GED. And I got it. I'll tell anybody, 'go for it.' Life is a challenge. But change is sweet.”

– Mary Mosley, GED Program Participant

“When somebody just tells you it's gonna be alright, just those words alone can take you all the way.”

– Mary Mosley, GED Program Participant
Sister Kay has a medley of offshoots that have stemmed from her primary projects. She has orchestrated a carpentry program for boys that came about as a result of younger children watching her volunteers repair homes. She has a gardening program. And she pays a piano teacher to offer lessons to interested children because she believes so strongly in the importance of music education in young people’s lives. Sister Kay tends to residents of all ages by seizing opportunities as they arise for a variety of enriching experiences that lend themselves to holistic development.

**Investment**

Jonestown is not unlike a lot of towns in Mississippi where the economic landscape has shifted, leaving families without adequate infrastructure and support for education. However, community-level solutions are possible. Sister Kay states that similar programs are feasible around the state with volunteer coordination.

Catholic sponsorship and private donors have played a large role in the funding of the Sisters’ efforts. The Holy Names Sisters and various Catholic donors from the Pacific Northwest, where Sisters Teresa and Kay are originally from, have supported their efforts. Furthermore, the Phil Hardin Foundation has provided funding, and AmeriCorps volunteers have provided staff to initiate and maintain the Center. Sister Teresa states that they hope to garner more local support through funding, and they have just appointed a new Board of Directors to oversee future development. In order to secure funding, Sister Kay advises others that a sincere and sustained effort be made. She recommends a good heart and commitment. Once potential donors see good work, she notes, they will support it.

**Ribbon-Cutting**

Evidence of the Sisters’ successes is apparent in the waiting lists for their programs, the distances families drive to participate, the number of former students who return to volunteer, and the genuine “thank-yous” they commonly receive. Not surprisingly, the waiting list for the Montessori school currently extends to 2011. The progress in Jonestown was even highlighted in a New York Times article in 2002. But most of all, their successes are evident in the children themselves—their achievements, the degree to which they feel loved, important, respected.
“We want to make sure that every child and everyone that comes through these doors receives love, affection and learning. Whenever they come in, we want them to feel respect.”
— Sister Teresa Shields, Program Director (pictured on page 120)

The Sisters and The Jonestown Family Center for Education and Wellness are there to support families, provide lifelong education, and help build the educational foundation that all children need for the development of intricate and resilient brain architecture starting at an early age. Children who have a strong educational foundation are more likely to succeed academically, continue their education beyond high school, have successful careers and give back to the community. By experiencing a positive learning environment where mutual respect is the norm, children’s personal relationships are also enhanced, and a love of learning is ingrained. Furthermore, the work of The Durocher Program with teens and adults has begun a cycle of civic participation and ownership that will last beyond the work of the Sisters. Investing in the future through these programs is a great gift made by and given to the citizens of Jonestown.

New Web site Provides Information About Colleges in Mississippi

Mississippi recently developed an online resource to assist students, teachers, parents and others in learning about college and university opportunities in the state. In light of the new Web site (http://msedu.connect-technology.net/), Governor Barbour pronounced October 24, 2008, “The Knowledge to Get to College Day.” Promotion for the event included pep rallies at local schools, a televised ad campaign and a call to Mississippi universities to expand their outreach efforts.¹
REFERENCES, DATA SOURCES, DEFINITIONS, & NOTES

MOVING MISSISSIPPI FORWARD: WHAT WOULD IT TAKE?

What Would it Take References:


Definition(s):

*Percent of Children in Single-parent Families:
The percentage of children under age 18 who live with their own single parent, either in a family or subfamily. In this definition, single-parent families may include cohabiting couples and do not include children living with married stepparents. The estimates are made from the U.S. Census Bureau, American Community Survey.

SAFETY

Safety Introduction References:


Safety Data References:

1. Special tabulation by the Mississippi Department of Human Services, December 2008.


7. Personal communication (January 14, 2009). Janice Cutshall, Director of Tishomingo County Families First Resource Center.

Note(s):

*The Federal Fiscal Year (FFY) begins on October 1 and ends on September 30 of the following calendar year. Fiscal years are identified according to the calendar year in which they end. For example, federal fiscal year 2007 began October 1, 2006 and ended September 30, 2007.

*An individual could be classified as more than one race. Thus, the sum of the numbers classified in each race will be higher than the total number of children served.

*The age of children was calculated based on their calendar year of birth. Therefore children with a birth year could, at the close of the FFY be two possible ages, and are expressed as such. For example, children born in 2002 could be either 4 or 5 years old by September 30, 2007, depending on their birth date (i.e., those born after September 30, 2002, would be 4 years old and those born on or before September 30 would be 5 years old).

*Age categories were calculated based on the calendar year in which the child was born and the age that the child would be at the end of calendar year 2007. For example, a child born in calendar year 2002 would be 5 years old by the end of calendar year 2007.
APPENDIX

REFERENCES, DATA SOURCES, DEFINITIONS, & NOTES

Safety Policy References:


Economic Well-Being Introduction References:


Economic Well-Being Data References:


Safety Success Story References:


ECONOMIC WELL-BEING


APPENDIX

REFERENCES, DATA SOURCES, DEFINITIONS, & NOTES


Definition(s):

aChildren in Poverty:
The percentage of children under age 18 who live in families with incomes below 100 percent of the U.S. poverty threshold, as defined by the U.S. Office of Management and Budget. The federal poverty definition consists of a series of thresholds based on family size and composition and is updated every year to account for inflation. In calendar year 2006, a family of two adults and two children fell in the “poverty” category if their annual income fell below $20,444. Poverty status is not determined for people living in group quarters, such as military barracks, prisons, and other institutional quarters, or for unrelated individuals under age 15 (such as foster children). The data are based on income received in the 12 months prior to the survey.

bChildren in Extreme Poverty:
The percentage of children under age 18 who live in families with incomes below 50 percent of the U.S. poverty threshold, as defined by the U.S. Office of Management and Budget. The federal poverty definition consists of a series of thresholds based on family size and composition. In calendar year 2006, a family of two adults and two children were below 50 percent of the poverty level if their annual income fell below $10,222.

cUnder Age 18 in Poverty:
The percentage of children under age 18 who live in families with incomes below the U.S. poverty threshold, as defined by the U.S. Office of Management and Budget. The federal poverty definition was adjusted based on the size of the family. The estimates were made from the American Community Survey.

dAll Ages in Poverty:
The percentage of individuals of all ages who live below the U.S. poverty threshold, as defined by the U.S. Office of Management and Budget. The estimates were made from the American Community Survey.

*Per Capita Personal Income:
According to the U.S. Department of Commerce, Bureau of Economic Analysis, “personal income is the income that is
received by persons from all sources. It is calculated as the sum of wage and salary disbursements, supplements to wages and salaries, proprietors’ income with inventory valuation and capital consumption adjustments, rental income of persons with capital consumption adjustment, personal dividend income, personal interest income, and personal current transfer receipts, less contributions for government social insurance. This measure of income is calculated as the personal income of the residents of a given area divided by the resident population of the area. In computing per capita personal income, BEA uses the Census Bureau’s annual midyear population estimates.”

'Unemployment Rate:
According to the U.S. Department of Labor, Bureau of Labor Statistics, “unemployed persons [Current Population Survey] [are] persons aged 16 years and older who had no employment during the reference week, were available for work, except for temporary illness, and had made specific efforts to find employment sometime during the 4-week period ending with the reference week. Persons who were waiting to be recalled to a job from which they had been laid off need not have been looking for work to be classified as unemployed. Unemployment rate...represents the number unemployed as a percent of the labor force.”

'Children Living in Families Where No Parent Has Full-time, Year-round Employment:
The percentage of all children under age 18 living in families where no parent has regular, full-time employment. For children living in single-parent families, this means that the resident parent did not work at least 35 hours per week, at least 50 weeks in the 12 months prior to the survey. For children living in married-couple families, this means that either parent worked at least 35 hours per week, at least 50 weeks in the 12 months prior to the survey. Children living with neither parent also were listed as not having secure parental employment because those children are likely to be economically vulnerable.

'Children Living in Low-income Households Where No Adults Work:
Children under age 18 who live in low-income households where no adult worked (full- or part-time) in the 12 months prior to the survey. Low-income households are those whose income is less than 200 percent of the U.S. poverty line as determined by the U.S. Office of Management and Budget. The federal poverty definition consists of a series of thresholds based on family size and composition and is updated every year to account for inflation. In calendar year 2006, a family of two adults and two children were considered low-income if their annual income fell below $40,888. Children who live in group quarters (for example, institutions, dormitories, or group homes) are not included in the percentage calculation. The data are based on income received in the 12 months prior to the survey.

Note(s):

'Determining Statistical Significance (KIDS COUNT Indicators):
Significant differences between two years for one location (e.g., MS child poverty rate for 2000 vs. 2006) were determined using 2008 Data Book Indicator trend calculations made by the Population Reference Bureau (PRB). Some KIDS COUNT indicators, such as percent of low-birth-weight babies, were based on counts, not survey results extrapolated to the population. In determining significance between two years, the PRB adopted the methodology used by the reporting federal agency. In the case of percent of low-birth-weight babies (i.e., counts), PRB adopted the methodology used by the CDC to test for differences between two percentages.

Values shown in the Children in Poverty graph for 2005 are not directly comparable to the overall Mississippi percentage reported in the Under Age 18 in Poverty by County map because two different sources were used for poverty estimates. For state-level data (i.e., children in poverty), the U.S. Census Bureau, American Community Survey was used. For county-level data (i.e., under age 18 in poverty), the U.S. Census Bureau, Small Area Income and Poverty Estimates were used.

'2005 Small Area Income & Poverty Estimates [SAIPE] can not be compared to previous years as different data sources were used. For additional information including estimation details, please refer to the SAIPE web site: http://www.census.gov/hhes/www/saipe/.
Economic Policy References:


Economic Well-Being Success Story References:


Economic Well-Being Spotlight References:


Economic Well-Being FYI References:


HEALTH

Health Introduction References:


Health Data References:


REFERENCES, DATA SOURCES, DEFINITIONS, & NOTES


Definition(s):

*Infant Mortality Rate:
Infant deaths are deaths of children under one year of age. Infant mortality rate is deaths per 1,000 live births.

*Low-birthweight Babies:
Live births weighing less than 2,500 grams (5.5 lbs.) at birth.

Note(s):

*Values shown in the Infant mortality rate graph for 2000 - 2005 are not directly comparable to the Infant Mortality Rate by County map for 2002-2006 because two different sources were used for data. For state-level data (i.e., infant mortality [rate per 1,000 live births]): 2000-2005, the Centers for Disease Control and Prevention, National Center for Health Statistics were used. For county-level data (i.e., Infant Mortality Rate by County), data from the Mississippi State Department of Health were used.

*Values shown in the low-birthweight babies graph for 2000 - 2005 are not directly comparable to the Low-birthweight by County map for 2006 because two different sources were used for data. For state-level data [i.e., Low-birthweight babies: 2000-2005]], the Centers for Disease Control and Prevention, National Center for Health Statistics were used. For county-level data [i.e., Low-birthweight Babies by County], data from the Mississippi State Department of Health were used.

*Determining Statistical Significance (YRBSS):
The Centers for Disease Control and Prevention’s (CDC) Youth Risk Behavior Surveillance System (YRBSS) is a state-level survey. Statistically significant differences between two years for one location [e.g., MS 2003 vs. MS 2007] or between two survey locations [e.g., MS 2007 vs. U.S. 2007] were determined using the YRBSS “Youth Online: Comprehensive Results” comparison feature available at http://apps.nccd.cdc.gov/yrbss.
Health Policy References:


**Health FYI References:**


**EDUCATION**

**Education Introduction References:**


**Education Data References:**


REFERENCES, DATA SOURCES, DEFINITIONS, & NOTES


Definition[s]:

Graduation Rates by School District:
The values reported are 4-year cohort graduation rates with the cohort being students who entered 9th grade for the first time in 2003/2004. According to the Mississippi Department of Education, “a full cohort of students is constructed beginning with ninth graders. Additional students entering 9th grade that year plus students entering the next higher grade each successive year for four years are added. Students in the cohort who transfer out of the Mississippi public schools or die are subtracted from the total, to yield a denominator. The number of students in the cohort earning a diploma within four years is divided by the denominator to calculate the 4-Year cohort graduation rate.”

Dropout Rates by School District:
According to the Mississippi Department of Education, the 4-year cohort method tracks the same group of students from 9th grade through 12th grade. It accounts for students who leave the school district during that time and incoming students who are new to the class.

Teens Who Are High School Dropouts:
The percentage of teenagers between ages 16 and 19 who are not enrolled in school and are not high school graduates. Those who have a GED or equivalent are included as high school graduates in this measure. The measure used here is defined as a “status dropout” rate. Inclusion of the group quarters population in the 2006 ACS could have a noticeable impact on the universe population for this age group. Therefore, the 2006 and 2005 ACS estimates might not be fully comparable.

Teens Not Attending School And Not Working:
The percentage of teenagers between ages 16 and 19 who are not enrolled in school (full- or part-time) and not employed (full- or part-time). This measure is sometimes referred to as “Idle Teens” or “Disconnected Youth.” Inclusion of the group quarters population in the 2006 ACS could have a noticeable impact on the universe population for this age group. Therefore, the 2006 and 2005 ACS estimates might not be fully comparable.

ACT Composite Scores:
The ACT composite score is the average of the four test scores in the subjects of English, Math, Reading and Science. In each of the four subjects being tested, a student can earn a score of 1-36.

8th Graders Who Scored At or Above Basic Level on NAEP for Writing, Math, Reading, and Science:
The percentage of 8th grade public school students who reached either the Basic, Proficient or Advanced level in [subject
area], as measured by the National Assessment of Educational Progress [NAEP], which is conducted by the U.S. Department of Education.

4th Graders Who Scored At or Above Basic Level on NAEP for Math, Reading, and Science:
The percentage of 4th grade public school students who reached either the Basic, Proficient or Advanced level in [subject area], as measured by the National Assessment of Educational Progress [NAEP], which is conducted by the U.S. Department of Education.

Education Policy References:


**Education Success Story References:**


**Education FYI References:**

www.kidscount.org/cgi-bin/cliks.cgi

This Web site brings together data on the well-being of children collected by KIDS COUNT grantees from state and local sources. The unique system allows users to access state-specific inventories of data from local sources, such as health departments, human services agencies, and schools. The content of state pages is determined by a participating KIDS COUNT partner using data from local jurisdictions. We believe that CLIKS can be a powerful new tool for community leaders, policymakers, service providers, parents and others who want to take a closer look at the local factors that affect the lives of children and families.
www.ssric.msstate.edu/mskidscount

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The MISSISSIPPI KIDS COUNT program is made possible, in part, through grants from the Annie E. Casey Foundation and Mississippi State University’s Division of Agriculture, Forestry and Veterinary Medicine. This work is carried out through the Family and Children Research Unit, a division of the Social Science Research Center.