Indicator Name: Early Childhood Screening

Indicator Description:

This is a measure of child screenings completed, as reported by parents through the National Survey of Children's Health (NSCH). This measure asks parents, "During the past 12 months, was [child's name] screened for being at risk for developmental, behavioral and social delays using a parent-reported standardized screening tool during a health care visit?"

Importance:

Early identification of the need for services, in conjunction with delivery of family-oriented services, can support a child's ability to successfully meet developmental milestones. Developmental delays, learning disorders, and behavioral, social, or emotional problems are estimated to affect 1 in every 6 children in the United States, yet fewer than one third of these children are identified as needing help before school begins. Studies have shown that children who receive early treatment for developmental delays are more likely to graduate from high school, hold jobs, live independently, and avoid teen pregnancy, delinquency and violent crime, making early identification a key goal for improving children's outcomes (Ages & Stages, 2016).

Limitations:

Self-report relies on the parent or caregiver's ability to recall filling out a specific survey; lack of accurate recall may underestimate the prevalence. More accurate sources for screening rates, such as medical records, are not available.

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. More information on the importance of screening is available from the Centers for Disease Control and Prevention at http://www.cdc.gov/ncbddd/childdevelopment/screening.html. Ages and Stages, "Why Screening Matters" Brooks Publishing Co. (2016). Accessed online at http://agesandstages.com/research-results/why-screening-matters/.

Numerator: Number of children who received a screen for developmental, behavioral, and social delays

Denominator: Children aged 10 months to 5 years

Wisconsin: 33.7 %

National: 30.8 %

Best State: NC = 58 %

Worst State: MS = 17.5 %

Indicator Name: Early Intervention through the Birth to 3 Program

Indicator Description:

This is a point-in-time measure of the number of infants and toddlers with delays or disabilities receiving Birth to 3 Program services through Individuals with Disabilities Act (IDEA) Part C, which includes speech, physical and occupational therapy, special education, case management and other services as needed to support a family's ability to care for and raise a successful child.

Importance:

This is a high-quality metric, collected annually by the state Part C program, which tracks the percent of children served through early intervention. Early intervention using evidence-based practices has been show to increase school performance and decrease need for services later in life (Guralnick, 1997).

Limitations:

State comparisons cannot readily be made as states define different levels of eligibility into the program. For more information about eligibility criteria see http://ectacenter.org/topics/earlyid/partcelig.asp.

Source: Wisconsin data obtained from Birth to 3 Program State Annual Performance Report, online at https://www.dhs.wisconsin.gov/birthto3/reports/apr-2013c-wi.pdf. (2014). National and comparison data from ECTA, http://ectacenter.org/partc/partcdata.asp. Guralnick, Michael, Ed. The Effectiveness of Early Intervention. Paul H Brooks Publishing, Baltimore, MD (1997).

Numerator: Number of children receiving early intervention services on a single day

Denominator: Children aged 0-3

Wisconsin: 2.81 %

National: 2.82 %

Best State: MA = 8.89 %

Worst State: AR = 1 %

Indicator Name: Early Prenatal Care

Indicator Description:

This metric captures the number of pregnancies in which prenatal care began in the first trimester, that is, in the first three months after conception.

Importance:

Early engagement in prenatal care increases the likelihood of a healthy infant and mother (Ryan, 1980). Additionally, up to 25% of pregnant women experience heightened stress, depression, and anxiety which can be addressed through prenatal care. (Kingston, 2014).

Limitations:

Early prenatal care is an indicator of increased access to needed services and supports for pregnant women. However, the degree to which prenatal care improves the health of the mother and child may be confounded by socioeconomic status, as women with increased financial means frequently plan pregnancy, start prenatal care early, and have a higher level of education, all of which tend to have a positive effect on the child.

Connecticut, Rhode Island, and New Jersey are excluded from this calculation as they have non-standard birth certificate reporting.

Appointment frequency is not routinely collected on the birth certificate in all states and thus is not accounted for, though may impact outcomes.

Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007-2014, on CDC WONDER Online Database, February 2016. Accessed at http://wonder.cdc.gov/natality-current.html. Ryan Jr, G. M., Patrick J. Sweeney, and Abiodun S. Solola. "Prenatal care and pregnancy outcome." American Journal of Obstetrics and Gynecology 137.8 (1980): 876-881. Kingston, Dawn, et al. "Study protocol for a randomized, controlled, superiority trial comparing the clinical and cost-effectiveness of integrated online mental health assessment-referral-care in pregnancy to usual prenatal care on prenatal and postnatal mental health and infant health and development: the Integrated Maternal Psychosocial Assessment to Care Trial (IMPACT)." Trials 15.1 (2014): 1.

Numerator: Number of births in which the mother began prenatal care in month one, two, or three of her pregnancy

Denominator: Total number of births

Wisconsin: 79.3 %

National: 70.8 %

Best State: VT = 87.7 %

Worst State: AK = 56.3 %

Indicator Name: Eighth Grade Math Proficiency

Indicator Description:

This metric looks at the percent of students who receive a proficient math score of 299 or higher, indicating that they can complete tasks in geometry, algebra, measurement, number properties, and probability.

Importance:

There are many potential measures of school readiness; however, eighth grade math performance scores have been significantly correlated with secondary school success and post-secondary readiness more accurately than any other metric (AIR, 2013). The National Assessment of Educational Progress (NAEP) tracks the mathematical skill of students across the US, making this a highly-utilized, comparable metric with available historical trends. Such trends in the NAEP metric can, over time, demonstrate the effects of educational and social policies across Wisconsin, the US, and other countries.

Limitations:

NAEP is not a longitudinal study, and each year includes a different cohort of children. We are not able to track trends in a single cohort of children across time.

NAEP results should not be compared to individual state assessments, as they may track different achievement metrics.

Source: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, NAEP, accessed at http://www.nationsreportcard.gov/reading_math_2015. American Institutes for Research (AIR), Predictors of Postsecondary Success (2013), accessed at https://www.cde.state.co.us/postsecondary/americaninstitutesforresearchpredictorsofpostsecondarysuccess.

Numerator: Number of students who scored 299 or higher in mathematics

Denominator: Eighth grade students in private and public schools, including students with disabilities and/or English language learners

Wisconsin: 41 %

National: 33 %

Best State: MA = 51 %

Worst State: AL = 17 %

Indicator Name: Feeling of Neighborhood Safety

Indicator Description:

This question asks parents if they believe their child is safe in their neighborhood. Parents answer the question, "How often do you feel [child name] is safe in your community or neighborhood?"

Importance:

A persistent feeling of safety decreases the likelihood of exposure to toxic stress and violence, supporting a child's well-being and helping to prevent mental illness through building resilience (Cutrona, 2006). This measure reveals information about the communities in which children grow up, including a child's potential risk of witnessing or experiencing violence, and the child's ability to live and play in his or her community, free of fear. This measure is also important for its ability to separate out the feeling of fear of crime from actual crime (as measured in other OCMH indicators), which has its own, lasting effects on social and emotional development (Fowler & Mangione, 1986).

Limitations:

"Community" and "neighborhood" may be defined differently by each respondent, leading to differences by demographic group or region.

Source: National Survey of Children's Health (NSCH) 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. Cutrona, Carolyn E., Gail Wallace, and Kristin A. Wesner. "Neighborhood characteristics and depression an examination of stress processes." Current Directions in Psychological Science, 15.4 (2006): 188-192. Fowler, F. J., Jr., & Mangione, T. W. A three-pronged effort to reduce crime and fear of crime: The Hartford experiment. In D. P. Rosenbaum (Ed.), Community crime prevention: Does it work? (pp. 87-108). Newbury Park, CA: Sage. (1986).

Numerator: Number answering "Usually" or "Always"

Denominator: Children aged 0-17

Wisconsin: 89.5 %

National: 86.6 %

Best State: ID = 94.7 %

Worst State: DC = 72.6 %

Indicator Name: Four-Year Old Kindergarten Attendance

Indicator Description:

This is a measure of the percent of four-year-olds who are enrolled in any state-funded 4K, not including Special Education, or Head Start.

Importance:

This metric tracks the percent of children enrolled in quality early education, which has demonstrated widespread benefits for all children, with particularly positive effects for minority racial groups. Though enrollment in 4K is not mandated, parents are likely motivated to enroll their children because 4K programs reduce the cost of child care by providing an educational placement for children; 4K has no eligibility requirements aside from age; and these programs provide education based on learning standards (DPI, 2016). Enrollment in 4K leads to increased readiness for further education, as well as enhanced individual characteristics, such as self-control, and self-esteem (NIEER, 2014; Bainbridge, 2005; Wong, 2008). Additionally, 4K attendance may be a marker of available educational resources (e.g., tracking prioritization of early education by local and state governments).

Limitations:

The early advantage experienced by children in 4K depends on the quality of the 4K program, a factor that is not tracked in this metric. Standards, however, are in place and can be found online at the Wisconsin Model Early Learning Standards.

This metric does not differentiate between half-day and full-day 4K.

Source: Wisconsin Department of Public Instruction (DPI). Admissions and Early Entrance to Four- and Five-Year-Old Kindergarten. Accessed online at http://dpi.wi.gov/early-childhood/kind/admission (2016). National Institute for Early Education Research (NIEER). The State of Preschool 2014. Accessed online at http://nieer.org/wp-content/uploads/2016/08/Yearbook2014_full3.pdf (2014). Bainbridge, Jay, et al. "Who gets an early education? Family income and the enrollment of three-to five-year-olds from 1968 to 2000." Social Science Quarterly 86.3 (2005): 724-745. Wong, Vivian C., et al. "An effectiveness-based evaluation of five state pre-kindergarten programs." Journal of Policy Analysis and Management 27.1 (2008): 122-154.

Numerator: Number of four-year-olds enrolled in any state-funded 4K program, full or half day

Denominator: Children aged 4

Wisconsin: 70.6 %

National: 29 %

Best State: FL = 79.5 %

Worst State: HI,ID,IN,MS,MT,NH,ND,SD,UT,WY = 0 %

Indicator Name: Parents with Higher Education Degrees

Indicator Description:

This metric is obtained from the birth record, showing the percent of births to a mother with an associate's, bachelor's, master's, or doctorate degree.

Importance:

Higher parental education is correlated with better parenting skills, though the exact mechanism of the relationship is not well understood. Some contributing factors include increased executive functioning in the parents, increased social support seen in those who obtained higher education, increased wages and higher socioeconomic status, and/or the ability to access high-quality health services and childcare (Desai, 1998).

Limitations:

Paternal education level is also linked with child achievement but was unavailable for this report.

The impact of maternal education level may be confounded by socioeconomic status.

Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007-2014, on CDC WONDER Online Database, February 2016. Accessed at http://wonder.cdc.gov/natality-current.html. Desai, Sonalde, et. al. "Maternal education and child health: Is there a strong causal relationship?" Demography 35.1 (1998): 71-81.

Numerator: Number of births to a mother who had an associate's degree or higher

Denominator: Total number of births

Wisconsin: 44.3 %

National: 37.7 %

Best State: MN = 53.1 %

Worst State: NV = 26.1 %

Indicator Name: Positive Adult Mentor

Indicator Description:

This metric identifies youth who have a mentor. This measure asks parents, "Does [child's name] have at least one adult mentor in his or her school, neighborhood, or community?"

Importance:

The National Scientific Council on the Developing Child (NSCDC) reports that the "single, most common finding is that children who end up doing well have had at least one stable and committed relationship" (NSCDC, 2015). Though parents can fulfill the role of mentor, this metric specifically asks about a mentor from within the child's community. Strong relationship between mentor and mentee additionally correlate with increased positive outcomes for youth who have faced past adversity (Dubois, 2015). Ensuring that every youth has a positive, supportive adult is also one of the US governments Healthy People 2020 goals (https://www.healthypeople.gov/2020/topics-objectives/topic/Adolescent-Health/).

Limitations:

This metric is reported by parents and may over-estimate their children's positive relationships with adults. Youth-reported data show a lower percent of youth with a strong adult relationship (Wisconsin YRBS, 2013), however there is no national comparison for this data.

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. Youth Risk Behavior Survey (YRBS), Wisconsin 2013, accessed at https://nccd.cdc.gov/youthonline/App/Default.aspx. DuBois, David L., et al. "Effectiveness of mentoring programs for youth: A meta-analytic review." American Journal of Community Psychology 30.2 (2002): 157-197. National Scientific Council on the Developing Child. Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper 13. http://www.developingchild.harvard.edu. (2015).

Numerator: Number of children with one or more adult mentors

Denominator: Children aged 6-17

Wisconsin: 94.2 %

National: 89.4 %

Best State: SD = 98.1 %

Worst State: CA = 79.8 %

Indicator Name: Spending on Health/Wellness Promotion

Indicator Description:

This metric is an approximation of the state's fiscal investment in mental health promotion as reported by the Legislative Fiscal Bureau, and sorted to include money spent on prevention services, such as health education, temporary cash assistance, abuse and neglect prevention, and programs specifically aimed at reducing ACEs in young children such as Brighter Futures. This includes state dollars only, with no county funding.

Importance:

Many mental health problems that coalesce in adulthood can be prevented or reduced in severity by prevention, early identification and referral to services (Van Landeghem, 2007). Furthermore, specific programs funded through health promotion and illness prevention dollars have been shown to improve children's test scores, decrease alcohol and drug use, and reduce teen pregnancy (Aos, 2004).

Limitations:

Direct outcomes for participants of these programs are not always captured.

The funding allocation for health and wellness was calculated at the state level, though some state money is provided in block grants to the counties for local allocation towards prevention or treatment. County funding directed to health and wellness was estimated.

Source: Financial information from the Informational Papers 24, 44, 47, 48, 49, 50, 56, 60, Wisconsin Legislative Fiscal Bureau, 2015, accessed through the Office of Children's Mental Health Annual Report to the Legislature, (2015). Population data from Wisconsin Interactive Statistics on Health, Population Module, https://www.dhs.wisconsin.gov/wish/population/form.htm. Aos, Steve, et al. "Benefits and costs of prevention and early intervention programs for youth." (2004). Accessed at www.wsipp.wa.gov. Van Landeghem, Karen, and Catherine A. Hess. "Children's Mental Health: An Overview and Key Considerations for Health System Stakeholders." Washington, DC: The National Institute for Health Care Management and Educational Foundation (2005). Accessed at http://www.nihcm.org/pdf/CMHReport-FINAL.pdf.

Numerator: Dollars spent on programs aimed to support social and emotional development of children, to prevent child abuse and other ACEs

Denominator: Residents (All Ages)

Wisconsin: $237 $ per resident

National: Not Available $ per resident

Best State: = Not Available $ per resident

Worst State: = Not Available $ per resident

Indicator Name: ACE: Death of Parent

Indicator Description:

This is a proxy measure for toxic stress and is included as an Adverse Childhood Experience (ACE). This question asks parents, "Did [child's name] ever live with a parent or guardian who died?"

Importance:

Death of a parent or caregiver was not in the original list of ACEs, but has been included in the National Survey of Children's Health (NSCH) because of its impact on a child's psychological well-being, both short- and long-term (Nickerson, 2011).

Limitations:

This metric does not account for the death of non-parent caregivers or siblings, nor a parent who lived outside the home.

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. Nickerson, Angela, et al. "The impacts of parental loss and adverse parenting on mental health: Findings from the National Comorbidity Survey-Replication." Psychological Trauma: Theory, Research, Practice, and Policy, 5.2 (2013): 119.

Numerator: Number of children who experienced the ACE

Denominator: Children aged 0-17

Wisconsin: 2.6 %

National: 3.1 %

Best State: CT = 1.4 %

Worst State: DC = 7.1 %

Indicator Name: ACE: Divorce

Indicator Description:

This is a proxy measure for toxic stress and is included as an Adverse Childhood Experience (ACE). This asks parents, "Did [child's name] ever live with a parent or guardian who got divorced or separated after [child's name] was born?"

Importance:

Divorce is correlated with decreased school achievement, poor behavior, decreased self-confidence, and more distant relationships with both parents. Research suggests that these outcomes are in response to stresses related to single-parenthood, or absence of a consistent second parent; economic disadvantage; or family conflict and instability (Amato, 1991).

Limitations:

The National Survey of Children's Health (NSCH) does not include never-married parents as an ACE.

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. Amato, Paul R., and Bruce Keith. "Parental divorce and the wellbeing of children: a meta-analysis." Psychological Bulletin, 110.1 (1991): 26.

Numerator: Number of children who experienced the ACE

Denominator: Children aged 0-17

Wisconsin: 19.8 %

National: 20.1 %

Best State: DC = 15.2 %

Worst State: OK = 29.5 %

Indicator Name: ACE: Experienced Neighborhood Violence

Indicator Description:

This is a proxy measure for toxic stress and is included as an Adverse Childhood Experience (ACE). This question asks parents, "Was [child's name] ever the victim of violence or witness any violence in [his/her] neighborhood?"

Importance:

Witnessing violence has been linked to increased child and youth violence, psychological distress and increased mental health issues (Kitzmann, 2003). Witnessing community violence was not an original part of the ACE study, but was added by the National Survey of Children's Health (NSCH), and the World Health Organization's ACE International Questionnaire, as a valid measure of acute and prolonged stress. Neighborhood cohesion provides a sense of “belonging” or “togetherness” among residents, which may be affected by witnessing or experiencing neighborhood violence. A number of studies have observed an association between youth living in a disadvantaged neighborhood and internalizing problems, such as depression and anxiety (Singh, 2012). Actual and perceived neighborhood safety can influence behavior. For example, youth living in neighborhoods where they do not feel safe may be less likely to participate in community activities (Leventhal, 2009).

Limitations:

The NSCH is completed by the parent or caregiver, who may not be aware of all of the instances of their child's exposure to community violence.

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. Kitzmann, Katherine M., et al. "Child witnesses to domestic violence: a meta-analytic review." Journal of Consulting and Clinical Psychology, 71.2 (2003): 339. Singh, Gopal K., and Reem M. Ghandour. "Impact of neighborhood social conditions and household socioeconomic status on behavioral problems among US children." Maternal and Child Health Journal 16.1 (2012): 158-169. Leventhal, Tama, Véronique Dupéré, and Jeanne Brooks-Gunn. "Neighborhood influences on adolescent development." Handbook of Adolescent Psychology (2009).

Numerator: Number of children who experienced the ACE

Denominator: Children aged 0-17

Wisconsin: 7.5 %

National: 8.6 %

Best State: NJ = 5.2 %

Worst State: DC = 16.6 %

Indicator Name: ACE: Experienced Racism

Indicator Description:

This is a proxy measure for toxic stress and is included as an Adverse Childhood Experience. This question asks parents, "Was [child's name] ever treated or judged unfairly because of [his/her] race or ethnic group?"

Importance:

A measure of racism was not in the original list of ACEs, but early experiences of racism have measurable and broad negative impacts on health (R. Williams, 2000; Chae, 2015).

Limitations:

The National Survey of Children's Health (NSCH) is completed by the parent or caregiver, who may not be aware of all of the instances of his/her child's exposure to racism or unfair treatment.

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. R. Williams, David, and Ruth Williams-Morris. "Racism and mental health: the African American experience." Ethnicity and Health, 5.3-4 (2000): 243-268. Chae, David H., et al. "Association between an internet-based measure of area racism and black mortality." PloS One, 10.4 (2015): e0122963.

Numerator: Number of children who experienced the ACE

Denominator: Children aged 0-17

Wisconsin: 2.5 %

National: 4.1 %

Best State: VT = 1.8 %

Worst State: AZ = 6.5 %

Indicator Name: ACE: Jailed Parent or Guardian

Indicator Description:

This is a proxy measure for toxic stress and is included as an Adverse Childhood Experience. This question asks parents, "Did [child's name] ever live with a parent or guardian who served time in jail or prison after [he/she] was born?"

Importance:

The number of children whose parents are in state or federal prisons has been steadily increasing across the US since the 1980s (Glaze, 2008). There is a well-documented link between parent criminality and youth behavioral and social problems, specifically conduct disorder and attention-deficit/hyperactivity disorder (Phillips, 2002). Research suggests that these outcomes are in response to stresses related to single-parenthood, or absence of a consistent second parent; economic disadvantage; or family conflict and instability (Amato, 1991). Additionally, having a parent removed from the home places children at risk of experiencing a severed parent-child bond, which may have profound implications for the child's social and emotional development. (Bowlby, 2012; Hess, 1991).

Limitations:

The National Survey of Children's Health (NSCH) is completed by the parent or caregiver, who may unwilling to disclose a history of incarceration.

This metric does not include incarceration of a non-custodial parent.

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. Glaze, Lauren E., and Laura M. Maruschak. Parents in prison and their minor children. Washington, DC: US Department of Justice, Office of Justice Programs, 2008. Phillips, Susan D., et al. "Parental incarceration among adolescents receiving mental health services." Journal of Child and Family Studies, 11.4 (2002): 385-399. Amato, Paul R., and Bruce Keith. "Parental divorce and the wellbeing of children: a meta-analysis." Psychological Bulletin, 110.1 (1991): 26. Bowlby, John. The making and breaking of affectional bonds. Routledge (2012). Hess, Peg M., and Gail Folaron. "Ambivalences: A challenge to permanency for children." Child Welfare: Journal of Policy, Practice, and Program (1991).

Numerator: Number of children who experienced the ACE

Denominator: Children aged 0-17

Wisconsin: 6.6 %

National: 6.9 %

Best State: NJ = 3.2 %

Worst State: KY = 13.2 %

Indicator Name: ACE: Lived with Someone who had a Problem with Alcohol or Drugs

Indicator Description:

This is a proxy measure for toxic stress and is included as an Adverse Childhood Experience. This asks parents, "Did [child's name] ever live with anyone who had a problem with alcohol or drugs?"

Importance:

A child living with anyone who has alcohol or drug problems is at risk of experiencing additional ACEs, such as child abuse and neglect. These children are also at risk of future substance use issues and depression (Anda, 2002).

Limitations:

The National Survey of Children's Health (NSCH) is completed by the parent or caregiver, who may be unwilling to report his/her drugs or alcohol use.

There may be more reliable data sources that provide information about adult alcohol and substance dependence, such as the National Survey on Drug Use and Health, but these do not collect data specific to parents.

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. Anda, Robert F., et al. "Adverse childhood experiences, alcoholic parents, and later risk of alcoholism and depression." Psychiatric Services (2002).

Numerator: Number of children who experienced the ACE

Denominator: Children aged 0-17

Wisconsin: 10.1 %

National: 10.7 %

Best State: NY = 6.4 %

Worst State: MT = 18.5 %

Indicator Name: ACE: Parent or Relative with Mental Illness

Indicator Description:

This is a proxy measure for toxic stress and is included as an Adverse Childhood Experience. This question asks parents, "Did [child's name] ever live with anyone who was mentally ill or suicidal, or severely depressed for more than a couple of weeks?"

Importance:

Living with someone with a mental illness is a measure of potential household dysfunction, as mental illness may preclude a parent from fully engaging with his or her children, in addition to potentially exposing a child to additional stressors due to direct (e.g. abuse) and indirect (e.g. poverty) causes (Petterson, 2001). Parental mental illness is correlated to children's negative behavior and general poor mental health (Goodman, 2011).

Limitations:

The National Survey of Children's Health (NSCH) is does not distinguish between treated or untreated mental illness.

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. Petterson, Stephen M., and Alison Burke Albers. "Effects of poverty and maternal depression on early child development." Child Development, 72.6 (2001): 1794-1813. Goodman, Sherryl H., et al. "Maternal Depression and Child Psychopathology: A Meta-Analytic Review." Clinical Child and Family Psychology Review, 14.1 (2011):1-27.

Numerator: Number of children who experienced the ACE

Denominator: Children aged 0-17

Wisconsin: 9.7 %

National: 8.6 %

Best State: CA = 5.4 %

Worst State: MT = 14.1 %

Indicator Name: ACE: Socioeconomic Hardship

Indicator Description:

This is a proxy measure for toxic stress and is included as an Adverse Childhood Experience. Parents answer the question, "Since [child's name] was born, how often has it been very hard to get by on your family's income, for example, it was hard to cover the basics like food or housing? Would you say very often, somewhat often, not very often, or never?"

Importance:

Food insecurity, or other physiological needs, can be sources of chronic stress that hinder a child's ability to develop successful relationships, learn effectively, or otherwise go through normal childhood development (Maslow, 1943).

Limitations:

The National Survey of Children's Health (NSCH) is completed by the parent or caregiver who may be unwilling to

admit financial difficulties.

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. Maslow, Abraham Harold. "A theory of human motivation." Psychological Review, 50.4 (1943): 370.

Numerator: Number answering "Very Often" or "Somewhat Often"

Denominator: Children aged 0-17

Wisconsin: 25.4 %

National: 25.7 %

Best State: MD = 20.1 %

Worst State: AZ = 34.2 %

Indicator Name: ACE: Witnessed Domestic Violence

Indicator Description:

This is a proxy measure for toxic stress and is included as an Adverse Childhood Experience (ACE). This question asks parents, "Did [child's name] ever see or hear any parents, guardians, or any other adults in his/her home slap, hit, kick, punch, or beat each other up?"

Importance:

Witnessing violence has been linked to increased psychological distress, increased mental health issues (Kitzmann, 2003), and increased likelihood of the young person committing acts of violence (Howarth, 2013). Children who witness domestic abuse have outcomes similar to children who were physically abused themselves (Kitzmann, 2003).

Limitations:

The National Survey of Children's Health (NSCH) is completed by the parent or caregiver who may be unable or unwilling to acknowledge early negative childhood experiences. This question may be under-reported due to the victim's disempowerment or concern that a disclosure may compromise the family's safety. Data from other national surveys such as the National Survey of Children's Exposure to Violence (NatSCEV), which uses child self-report data, find that almost a quarter of children witnessed violence in their homes, schools, or communities (Wolak, 1998).

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. Kitzmann et. al. Child Witness to Domestic Violence: A Meta-Analytic Review. Journal of Consulting and Clinical Psychology, 71.2 (2003). Howarth, Emma, and Gene Feder. "Prevalence and physical health impact of domestic violence." Domestic violence and mental health. London: RCPsych Publications (2013): 1-17. Wolak J, et al. "Effects of Partner Violence on Children." In "Partner violence: A comprehensive review of 20 years of research." Thousand Oaks: Sage Publications. (1998)

Numerator: Number of children who experienced the ACE

Denominator: Children aged 0-17

Wisconsin: 6.8 %

National: 7.3 %

Best State: CT = 5 %

Worst State: OK = 11.1 %

Indicator Name: ACE: Two or More

Indicator Description:

This is the composite score of all ACEs and is a proxy measure for a higher level of toxic stress. Parents are asked to answer questions about these experiences as they relate to their child. This score encompasses nine experiences regarding family stress and violence, developed specifically for the National Survey of Children's Health (NSCH), based on existing literature and a team of experts.

Importance:

The ACEs literature has found an increased likelihood of engaging in risky health behaviors and facing poor health outcomes for those with two or more ACEs (Felitti, 1998; Anda, 2010). Recent research has also found that ACEs have an immediate impact on adolescent mental health outcomes; in a study using Medicaid data, only 11 percent of youth (age 12-17) without any ACEs had a mental health problem, compared to 44 percent of youth with five or more ACEs who had a mental health problem (Lucenko, 2012).

Limitations:

Though there is substantial evidence of the potential negative impact that ACEs may have on an individual, resilience factors can mitigate or completely prevent negative outcomes.

This data cannot be compared to adult ACE scores or distributions.

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. Felitti, Vincent J., et al. "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine, 14.4 (1998): 245-258. Anda, Robert F., et al. "Building a framework for global surveillance of the public health implications of adverse childhood experiences." American Journal of Preventive Medicine, 39.1 (2010): 93-98. Lucenko, B., et al. "Adverse childhood experiences associated with behavioral health problems in adolescents." Findings from administrative data for youth age 12-17. Department of Social and Health Services, Washington State (2012).

Numerator: Number of children who experienced two or more adverse experiences

Denominator: Children aged 0-17

Wisconsin: 22.5 %

National: 22.6 %

Best State: NJ = 16.3 %

Worst State: OK = 32.9 %

Indicator Name: Children in Poverty

Indicator Description:

This metric is the percent of children under age 18 who live in families with incomes under 200% of the Federal Poverty Level (FPL), defined by family income and size.

Importance:

Financial strain can lead to family stress and difficult choices about how to prioritize meeting their basic needs. Poverty is also associated with more frequent stressful experiences, such as family conflict, divorce, and abuse, which can lead to delays in accessing health care, poor nutrition, unstable housing, and violence. The stressful experiences associated with chronic and episodic poverty have been identified as risk factors for mental health symptoms among children and youth (Duncan, 1994).

Limitations:

FPL is not adjusted based on cost of living across the US.

Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2015 American Community Survey. Accessed at http://datacenter.kidscount.org/data/tables/47-children-below-200-percent-poverty#national. FPL is based on household makeup and total income. FPL definitions can be found here: https://www.healthcare.gov/glossary/federal-poverty-level-FPL/. Duncan, Greg J., Jeanne Brooks-Gunn, and Pamela Kato Klebanov. "Economic deprivation and early childhood development." Child Development, 65.2 (1994): 296-318.

Numerator: Number of children in families under 200% of FPL

Denominator: Children aged 0-18

Wisconsin: 36.9 %

National: 42.8 %

Best State: NH = 24.8 %

Worst State: MS = 56.4 %

Indicator Name: Mothers Experiencing Stressors During Pregnancy

Indicator Description:

This measure combines thirteen potential stressors that a mother could face during pregnancy, including emotional (close family member getting sick or dying); financial (mother or her partner losing a job, not having enough money to pay bills, moving houses); partner (intense arguing or separating from partner, partner not wanting mother to be pregnant); or trauma-related stress (being in a fight, mother or partner being jailed, being homeless, close family member having a problem with drinking/drugs).

Importance:

Maternal stress during pregnancy has the potential to trigger physiological changes in the fetus, leading to negative child outcomes (DiPietro, 2012). Women who experience stress during pregnancy, particularly stress related to their partner, are more likely to develop symptoms of post-partum depression, which may lead to negative outcomes for the child (Stone, 2015). This metric is included in the Association of Maternal and Child Health Programs (AMCHP) Life Course Indicators because of the multi-generational impact, along with the long-term implications for public health (AMCHP, 2013). The data are collected through the Pregnancy Risk Assessment Monitoring System (PRAMS), providing a consistent and reliable source of information.

Limitations:

Only 26 states report PRAMS data, limiting available state comparisons.

Mothers may experience other critical stressors during pregnancy that are not captured in any of these questions.

PRAMS is completed after the pregnancy, which may introduce bias due to self-reporting and recall.

Only pregnancies leading to live births are included in the PRAMS sample.

Source: PRAMS 2011, accessed at https://chronicdata.cdc.gov/. DiPietro, Janet A. "Maternal stress in pregnancy: considerations for fetal development." Journal of Adolescent Health, 51.2 (2012): S3-S8. Stone, Sarah Lederberg, et al. "Stressful events during pregnancy and postpartum depressive symptoms." Journal of Women's Health 24.5 (2015): 384-393. AMCHP. Life Course Indicator: Stressors During Pregnancy. Life Course Metrics Project. (2013) accessed online at http://www.amchp.org/programsandtopics/data-assessment/LifeCourseIndicatorDocuments/LC-56_Stressors%20During%20Pregnancy_Final-12-16-2013.pdf.

Numerator: Number of mothers who reported three or more stressors in the 12 months before giving birth

Denominator: Mothers aged 18 to 44

Wisconsin: 22.5 %

National: 25.2 %

Best State: GA = 17.7 %

Worst State: AK = 39.9% %

Indicator Name: Single Parent Households

Indicator Description:

This metric is the percent of children living in single parent families, including mother- or father-headed families.

Importance:

Children living in single-parent households often have less stability, fewer rules, harsher discipline, and less supervision, all of which may impede social-emotional development. These children often live in more economically disadvantaged families, which can negatively impact the child's development (Amato, 2005). Compared to children in two-parent families, children in single-parent households are more likely to drop out of school, have a teen pregnancy, or experience their own divorce in adulthood (Sapharas, 2016).

Limitations:

The exact mechanism for increased stress on a child in a single-parent family is not known, and a parent may be able to counteract the potential disadvantage through enhanced parenting, a supportive family/community, and additional financial resources.

This metric does not account for live-in partners or close relatives that may have frequent contact with a child.

Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey and 2002 through 2014 American Community Survey (ACS), accessed at http://datacenter.kidscount.org/data/tables/106-children-in-single-parent-families. Amato, Paul R. "The impact of family formation change on the cognitive, social, and emotional wellbeing of the next generation." The Future of Children, (2005): 75-96. Sapharas, Nicole K., et al. "Effects of Parental Divorce or a Father's Death on High School Completion." Psychology in the Schools, 53.8 (2016): 861-874.

Numerator: Number of children living with their own parent in a household with male or female head, with no partner present

Denominator: Child residences aged 0 to 18, in all living arrangements, including dual parent, or living alone

Wisconsin: 32 %

National: 34.9 %

Best State: UT = 19.5 %

Worst State: DC = 53.3 %

Indicator Name: Substantiated Child Abuse or Neglect

Indicator Description:

This metric captures incidents of abuse or neglect that have been substantiated or proven by Child Protective Services (CPS). Abuse and neglect are federally defined as "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation or an act or failure to act which presents an imminent risk of serious harm."

Importance:

The link between substantiated child abuse or neglect and the negative impact on children's mental health is well documented (Norman, 2012). The most common form of maltreatment is neglect, which has the potential to disrupt a child's typical behavioral, social, and emotional development. National data on child abuse and neglect are presented to Congress through the Child Welfare Outcomes: Report to Congress, and are tracked as part of Healthy People 2020.

Limitations:

Different definitions of abuse/neglect may exist across states, as defined per state statutes and policies.

This metric only includes documented, substantiated cases of abuse or neglect which may result in reporting bias for low-income and minority children, and the exclusion of less severe, yet still impactful, incidents (Dubowitz, 2002).

This metric is a unique count of children; cases where a single child is involved in multiple substantiations are still only counted once; this metric is an underestimate of the total number of substantiated reports.

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2014). National Child Abuse and Neglect Data System. Accessed online at http://www.acf.hhs.gov/cb/resource/child-maltreatment-2014-data-tables. National comparison data from http://www.acf.hhs.gov/sites/default/files/cb/cm2014.pdf. Norman, Rosana E., et al. "The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis." PLoS Med, 9.11 (2012): e1001349. Dubowitz, Howard, et al. "Child neglect: Outcomes in high-risk urban preschoolers." Pediatrics, 109.6 (2002): 1100-1107.

Numerator: Number of unique children with substantiated claims of abuse or neglect

Denominator: Children aged 0 to 18, per 1,000

Wisconsin: 3.6 per 1,000

National: 9.4 per 1,000

Best State: PA = 1.2 per 1,000

Worst State: MA = 22.9 per 1,000

Indicator Name: Youth Experiencing Cyber Bullying

Indicator Description:

This metric asks about being bullied electronically, including being bullied through "e-mail, chat rooms, instant messaging, Web sites, or texting". Bullying is defined as unwanted aggressive behavior(s), indicating a power imbalance. This metric does not include in-person bullying. This question asks students, "During the past 12 months, have you ever been electronically bullied? (Count being bullied through e-mail, chat rooms, instant messaging, Web sites, or texting.)"

Importance:

Bullying includes actions to exclude or isolate others, as well as physical, verbal, and, as is the case with social media, written attacks intended to hurt or instill fear. Students who are bullied tend to have higher rates of depression and anxiety, have more frequent physical complaints, experience less academic success, and exhibit worse personal outcomes, such as lower levels of self-esteem and higher levels of suicide ideation (Kowalski, 2014). Bullying often begins early and can continue from childhood into adolescence. Cyber bullying acknowledges the increasing presence of technology, along with the added impact of anonymity which may accompany cyber bullying (Thomas, 2014).

Limitations:

Low rates of school participation in the Youth Risk Behavior Survey (YRBS) in 2015 prevented data from being statistically accurate, so the most recent data are from 2013.

The following states are not included in the comparison: MN, AZ, CA, CO, IN, IA, MO, PA.

Source: YRBS, Wisconsin 2013, accessed at https://nccd.cdc.gov/youthonline/App/Default.aspx. Kowalski, Robin M., et al. "Bullying in the digital age: A critical review and meta-analysis of cyberbullying research among youth." Psychological Bulletin, 140.4 (2014): 1073. Thomas, Hannah J., et al. "Integrating traditional bullying and cyberbullying: Challenges of definition and measurement in adolescents–A review." Educational Psychology Review, 27.1 (2015): 135-152.

Numerator: Number of students reporting "Yes"

Denominator: High school youth (all grades)

Wisconsin: 17.6 %

National: 14.8 %

Best State: MS = 11.9 %

Worst State: ME = 20.6 %

Indicator Name: Availability of Child, Family, School Social Workers

Indicator Description:

This measure uses Bureau of Labor Statistics data to identify the ratio of Child, Family, and School Social Workers to the general population.

Importance:

Social workers frequently provide mental health services to children and families.

Limitations:

This is a statewide estimate and does not account for regional variations or scarcity in rural areas.

These occupational employment numbers are estimates calculated with data collected from employers, not direct counts of providers.

Source: Bureau of Labor Statistics, accessed at bls.gov.

Numerator: Number of social workers

Denominator: Number of residents, per 100,000

Wisconsin: 60 per 100,000

National: 93 per 100,000

Best State: MA = 312 per 100,000

Worst State: LA = 20 per 100,000

Indicator Name: Availability of Psychiatrists

Indicator Description:

This measure is the ratio of psychiatrists to the general population, calculated from the Bureau of Labor Statistics data. This is not a measure specific to child psychiatrists.

Importance:

Psychiatrists frequently provide mental health services to children and families, specifically medication and referrals.

Limitations:

This is not a measure specific to child psychiatrists.

This is a statewide estimate and does not account for regional variations or scarcity in rural areas.

These occupational employment numbers are estimates calculated with data collected from employers, not direct counts of providers.

Availability of psychiatrists does not provide information about the number who are taking new patients, or who take patients with various types of insurance, such as Medicaid.

Source: Bureau of Labor Statistics, accessed at bls.gov.

Numerator: Number of psychiatrists

Denominator: Number of residents, per 100,000

Wisconsin: 5.7 per 100,000

National: 7.6 per 100,000

Best State: DC = 36.5 per 100,000

Worst State: NV = 1.4 per 100,000

Indicator Name: Availability of Psychologists

Indicator Description:

This measure uses Bureau of Labor Statistics data to calculate the ratio of psychologists to the general population. This is not a measure specific to child psychologists.

Importance:

Psychologists frequently provide mental health services to children and families.

Limitations:

This is not a measure specific to child psychologists.

This is a statewide estimate and does not account for regional variations or scarcity in rural areas.

Tracking the availability of psychologists does not provide information about the number of providers who are taking new patients, or who take patients with various types of insurance, such as Medicaid.

These occupational employment numbers are estimates calculated with data collected from employers, not direct counts of providers.

Source: Bureau of Labor Statistics, accessed at bls.gov.

Numerator: Number of psychologists

Denominator: Number of residents, per 100,000

Wisconsin: 34.5 per 100,000

National: 33.5 per 100,000

Best State: MA = 73.4 per 100,000

Worst State: LA = 8.3 per 100,000

Indicator Name: Insurance Coverage in Children

Indicator Description:

This measure indicates the percentage of 0-18 year olds who are covered by any type of insurance, including employer-sponsored, individual, Medicaid, or other public insurance. In Wisconsin, this includes coverage by BadgerCare Plus or the Children's Health Insurance Program (CHIP), Social Security, and others. Insurance coverage refers to comprehensive coverage (that is, not just dental, vision, life, or disability insurance), at the time of the survey.

Importance:

Insurance coverage is a precursor to ensuring that all children have access to health care, including early intervention, prevention and check-ups, along with mental health services such as therapy, medication, or hospitalizations. Though the 2010 Patient Protection and Affordable Care Act mandated insurance for all Americans (officially beginning in 2014), there remain uninsured children in Wisconsin, necessitating the tracking of basic insurance coverage.

Limitations:

Insurance coverage is for a specific point in the year, and not necessarily for the full year.

This metric does not reflect quality, accessibility, or service delivery model of the insurance company, such as within or outside of a medical home, nor what type of insurance they have, such as whether it is private, public, within an HMO, or fee-for-service.

Source: Current Population Survey, Annual Social and Economic Supplement, 2015, accessed at http://www.census.gov/cps/data/cpstablecreator.html. Additional details about the types of insurance coverage included are available at www.census.gov.

Numerator: Number of 0-18 year olds with employer-sponsored, individual, Medicaid, or other public insurance

Denominator: Children aged 0 to 18

Wisconsin: 94.3 %

National: 94.7 %

Best State: CT = 99 %

Worst State: AZ = 87.3 %

Indicator Name: Mental Health Hospitalizations

Indicator Description:

This metric is the number of inpatient mental health or psychiatric hospitalizations based on diagnosis for children in private or public hospitals and for all insurance payers. The following mental health and substance use disorder categories are included: anxiety disorder, attention-deficit disorder, conduct disorder, dementia, cognitive, developmental, impulse control, mood, personality, schizophrenia, alcohol or substance related disorders, and suicide. Hospitalization data are reported by the Wisconsin Department of Health Services (DHS) to the national dataset.

Importance:

The National Institute of Mental Health, state agencies, and local health systems track inpatient mental health, or psychiatric hospitalizations as a measure of response to and treatment for individuals with mental illness. Because effective community services are correlated with reductions in psychiatric hospitalizations (Drake, 2008; Hoagwood, 2001).

Limitations:

This metric tracks overall number of discharges from the hospital and provides no information related to the number of times a child may have been admitted.

Hospitalizations are reported by each state government to be tracked federally. States may have different tracking and reporting requirements. Individual state data is not publically available due to privacy concerns.

Source: US & State Comparison Data: Nationwide Inpatient Sample, 2000-2013, Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality. Retrieved from http://hcupnet.ahrq.gov/ Wisconsin data from the Wisconsin Hospital Association database, administered by DHS. Drake, Robert E., et al. "A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders." Journal of Substance Abuse Treatment, 34.1 (2008): 123-138. Hoagwood, Kimberly, et al. "Evidence-based practice in child and adolescent mental health services." Psychiatric Services (2001).

Numerator: Number of children admitted to the hospital for mental health reasons (any mental health diagnosis)

Denominator: Children aged 0 to 18, per 100,000

Wisconsin: 223 per 100,000

National: 199 per 100,000

Best State: Pacific Region (AK, CA, HI, OR, WA) = 67 per 100,000

Worst State: West North Central (IA, KS, MN, MO, ND, NE, SD) = 362 per 100,000

Indicator Name: Receive Treatment for Depression

Indicator Description:

This measure identifies the percent of youth (aged 12-17) who have been diagnosed with depression, who have also received any treatment for depression, as asked in the National Survey on Drug Use and Health (NSDUH). The treatment type is not specified.

Importance:

Depression is the leading cause of disability in the world, yet many of the negative effects of depression can be reliably improved through identification and treatment (Marcus, 2012).

Limitations:

Approximately 10% of individuals with depression are undiagnosed and thus not included in this measure (Li, 2009).

This metric does not include information about frequency of treatment.

NSDUH is a self-report survey which has the potential to underestimate treatment, though self-report data are typically valid for reporting "any" versus "none" treatment frequencies as was done in NSDUH (Roberts, 1996).

It is likely that there is lower treatment prevalence for other mental health diagnoses (Jacobi, 2004).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health.

Downloaded and calculated on 7/21/2015. Marcus, Marina, et al. "Depression: A global public health concern." WHO Department of Mental Health and Substance Abuse (2012): 6-8. Li, Chaoyang, et al. "Prevalence and correlates of undiagnosed depression among US adults with diabetes: the Behavioral Risk Factor Surveillance System, 2006." Diabetes Research and Clinical Practice, 83.2 (2009): 268-279. NIMH. “Use of Mental Health Services and Treatment Among Children” Health and Education Statistics. Accessed online at nimh.nih.gov (2016).

Numerator: Number of adolescents (age 12-17) with one or more major depressive episode who received any treatment

Denominator: Number of adolescents with major depressive episodes.

Wisconsin: 31.1 %

National: 35.9 %

Best State: NH = 57.9 %

Worst State: AR = 23 %

Indicator Name: Spending on MH/SA Treatment

Indicator Description:

This metric is the total state investment ($) in mental health (MH) and substance abuse (SA) treatment and services for children and adults as reported by the Legislative Fiscal Bureau. Expenditures include treatment services such as stays in psychiatric hospitals, mental health outpatient services, wraparound, and treatment foster care. This includes state dollars only, with no county funding.

Importance:

The Substance Abuse and Mental Health Services Administration (SAMHSA) tracks expenditures as a way to compare service spending across domains (e.g., inpatient, outpatient, community) and the impact that services have on overall population wellness (SAMHSA, 2013).

Limitations:

This metric only includes state dollars, though much of the funding for children with complex mental health issues comes from county tax levies.

While the Wisconsin Office of Children's Mental Health has made efforts to identify the amounts and destination for the agency finances, there may be mis-tracked funds.

This metric includes funding for both children and adult programs.

Source: Financial information from the Informational Papers 24, 44, 47, 48, 49, 50, 56, 60, Wisconsin Legislative Fiscal Bureau, 2015, accessed through the Office of Children's Mental Health Annual Report to the Legislature, 2015. (http://children.wi.gov/Documents/OCMH%202015%20Annual%20Report%20to%20Legislature.pdf) Population data from Wisconsin Interactive Statistics on Health, Population Module, https://www.dhs.wisconsin.gov/wish/population/form.htm. SAMHSA. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2009. HHS Publication No. SMA-13-4740. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

Numerator: Dollars spent on mental health or substance use disorder treatment

Denominator: Number of residents

Wisconsin: $704 $ per resident

National: Not Available $ per resident

Best State: = Not Available $ per resident

Worst State: = Not Available $ per resident

Indicator Name: Alcohol Usage Among Youth

Indicator Description:

This represents the percent of high school youth who have used alcohol within the last 30 days. Alcohol is specified as beer, wine, wine coolers, and liquor such as rum, gin, vodka, or whiskey, not for religious purposes. Youth are asked, "During the past 30 days, on how many days did you have at least one drink of alcohol?"

Importance:

Underage drinking poses significant health risks to youth, including increased likelihood of physical or sexual assault, and future alcohol dependence or drug use (Anderson, 2009). In addition to engaging in risky behaviors while under the influence of alcohol, youth who engage in heavy drinking may experience stunted neurodevelopment, which can decrease overall brain function (Brown, 2000). Youth with a high frequency of drinking alcohol are more likely to have gotten drunk and to binge drink (having five or more drinks in a row), compounding potential problems (Windle, 2003).

Limitations:

Self-report of a sensitive topic such as illicit alcohol use is likely under reported.

The following states are not included in the comparison: MN, AZ, CA, CO, IN, IA, MO, PA.

Source: Youth Risk Behavior Survey, Wisconsin 2013. Data from the CDC YRBS Youth Online, accessed at https://nccd.cdc.gov/youthonline/App/Default.aspx. Anderson, Peter, et al. "Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies." Alcohol and Alcoholism, 44.3 (2009): 229-243. Brown, Sandra A., et al. "Neurocognitive functioning of adolescents: Effects of protracted alcohol use." Alcoholism: Clinical and Experimental Research, 24.2 (2000): 164-171. Windle, Michael. "Alcohol use among adolescents and young adults." Population, 45.5.9 (2003): 19-15.

Numerator: Number of youth having 1 or more drink on at least one day in the past 30 days

Denominator: High school youth (all grades)

Wisconsin: 32.7 %

National: 34.9 %

Best State: UT = 11 %

Worst State: NJ = 39.3 %

Indicator Name: Foster Care Placements

Indicator Description:

This measure indicates the rate of children entering into Out-of-Home care through an intervention by the child welfare system. Types of placements include licensed family foster care, treatment foster care, pre-adoptive foster homes, group homes and residential care centers, unlicensed relatives or non-relatives, and court-ordered placements.

Importance:

Out-of-Home placements occur to protect children from serious neglect, psychological, emotional and or physical risks. Yet, once removed from their home, these children are at risk of experiencing severed parent-child bonds (Hess, 1991). Such disintegration of the parent-child bond, even if the parent is abusive or neglectful, might have profound implications for a child's development (Bowlby, 2012). Children in foster care or other Out-of-Home placements are also often exposed to traumatic events before removal from home, in addition to potentially experiencing the removal itself as traumatic (Lang, 2016).

Limitations:

These data are entered by county systems and thus accuracy depends on uniform data reporting by local programs.

Source: Wisconsin data from eWiSACWIS Out-of-Home Caseload Summary Report, 2014 (http://dcf.wisconsin.gov/cwreview/reports/OOHC-Y.htm) Comparison state data from Child Trends analysis of data from the Adoption and Foster Care Analysis and Reporting System (AFCARS), made available through the National Data Archive on Child Abuse and Neglect (http://datacenter.kidscount.org). Lang, Jason M., et al. "Building Capacity for Trauma-Informed Care in the Child Welfare System Initial Results of a Statewide Implementation." Child Maltreatment (2016). Hess, Peg M., and Gail Folaron. "Ambivalences: A challenge to permanency for children." Child Welfare: Journal of Policy, Practice, and Program (1991). Bowlby, John. The making and breaking of affectional bonds. Routledge (2012).

Numerator: Number of children removed from their home and placed in Out-of-Home care

Denominator: Individuals up to 18 years of age, per 10,000

Wisconsin: 36.03 per 10,000

National: 33.89 per 10,000

Best State: VA = 20 per 10,000

Worst State: WV = 100 per 10,000

Indicator Name: General Poor Mental Health (Youth)

Indicator Description:

This is a proxy metric for poor mental health or depression found in the Youth Risk Behavior Survey (YRBS). This question asks youth, "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?"

Importance:

Self-reported feelings of sadness and hopelessness is a straight-forward indication of how youth in Wisconsin are fairing.

Limitations:

This is not a diagnostic tool for depression, simply one metric that may indicate presence of the disease.

The following states are not included in the comparison: MN, AZ, CA, CO, IN, IA, MO, PA.

Source: YRBS, Wisconsin 2013. Data from the CDC YRBS Youth Online, accessed at https://nccd.cdc.gov/youthonline/App/Default.aspx.

Numerator: Number of students reporting "Yes"

Denominator: High school youth (all grades)

Wisconsin: 24.6 %

National: 29.9 %

Best State: NE = 19.5 %

Worst State: AZ = 36.4 %

Indicator Name: Homeless Youth

Indicator Description:

This metric includes homeless children aged 3-5 through grade 12, as well as ungraded youth (enrolled in classes with no grade-designations, but are of school age). “Homeless” means that the students “lack a fixed, regular, and adequate night-time residence,” (dpi.wi.gov) which may include living in temporary housing, public spaces, cars, or other locations not regularly used as sleeping facilities.

Importance:

Homelessness is an extreme stressor for a child or youth. Homeless children are more likely to repeat a grade or fail out of school, and to have experienced additional stressors such as physical or sexual abuse, or neglect (Edidin, 2012). These children are among the most marginalized with the greatest need for services (Rohde, 2001).

Limitations:

This metric only includes homeless youth who attend school, which is likely an underestimation of the total number of homeless youth.

Source: Federal Data Summary, School Years 2011-12 to 2013-14: Education for Homeless Children and Youth. 2015. Accessed at http://www2.ed.gov/programs/homeless/data-comp-sy13-14.pdf. Edidin, Jennifer P., et al. "The mental and physical health of homeless youth: a literature review." Child Psychiatry & Human Development, 43.3 (2012): 354-375. Rohde, Paul, et al. "Depression, suicidal ideation and STD-related risk in homeless older adolescents." Journal of Adolescence, 24.4 (2001): 447-460.

Numerator: Number of homeless individuals

Denominator: Individuals enrolled in any school program, aged three to 18 year old

Wisconsin: 16 per 1,000

National: 20 per 1,000

Best State: CT = 4 per 1,000

Worst State: DC = 41 per 1,000

Indicator Name: Illegal Drug Usage in Teens

Indicator Description:

This metric includes marijuana, cocaine, heroin, hallucinogens, and inhalants, along with the non-medical usage of prescription pharmaceuticals.

Importance:

Substance use and mental health issues are often co-occurring as youth who have mental health issues may self-medicate with alcohol and drugs. Between 60% and 90% of youth with substance use issues also have a diagnosable mental health issue (Hawkins, 2009). Youth who use illegal substances are more likely to be involved in the juvenile justice system. Negative consequences of youth substance use can also include truancy, delinquent behavior, poorer academic outcomes, and ongoing substance abuse and financial instability in adulthood (Cerda, 2016).

Limitations:

Asking about illicit drug use is a sensitive subject, and particularly in interviewer-based surveys such as the National Survey of Drug Use and Health (NSDUH), may lead to under reporting.

The NSDUH does not include homeless populations, non-civilians, or those in institutions such as jails or hospitals.

Source: NSDUH: Comparison of 2012-2013 and 2013-2014 Population Percentages. Accessed at http://www.samhsa.gov/data/sites/default/files/NSDUHsaeShortTermCHG2014/NSDUHsaeShortTermCHG2014.htm. Hawkins, Elizabeth H. "A tale of two systems: Co-occurring mental health and substance abuse disorders treatment for adolescents." Annual review of psychology 60 (2009): 197-227. Cerdá, Magdalena, et al. "Persistent Cannabis Dependence and Alcohol Dependence Represent Risks for Midlife Economic and Social Problems: A Longitudinal Cohort Study." Clinical Psychological Science (2016): 2167702616630958.

Numerator: Number of adolescents who used of any of nine categories of drugs within the past month

Denominator: Adolescents aged 12 to 17 years old

Wisconsin: 9.34 %

National: 9.18 %

Best State: IA = 6.31 %

Worst State: CO = 14.58 %

Indicator Name: Juvenile Arrests

Indicator Description:

This metric is the rate of arrests for 43 offenses including violent, drug, gambling and larceny crimes among the population of 10 to 18 year olds.

Importance:

Juvenile arrest rates are used as a measure of a long-term negative outcome for children facing adversity. Taking into account the risk/resilience model, we see that over 90% of youth involved in juvenile justice have at least one traumatic experience (Abram, 2004), and 65 to 70% experience mental illness (NCSL, 2011). The impact of an arrest itself can lead to, or exacerbate, mental illness (Lambie, 2013).

Limitations:

Data come from the US Department of Justice's voluntary Uniform Crime Reporting program, which does not include Florida.

Uniform Crime Reporting data are generally regarded as valid and reliable as a measure. However, it may underestimate overall criminal behavior, particularly for non-violent crimes, as it only captures activities that are confirmed by law enforcement.

Source: United States Department of Justice. Federal Bureau of Investigation. Uniform Crime Reporting Program Data: Arrests by Age, Sex, and Race, 2014. ICPSR36394-v1. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2016-04-28. http://doi.org/10.3886/ICPSR36394.v1. Abram, Karen M., et al. "Posttraumatic stress disorder and trauma in youth in juvenile detention." Archives of General Psychiatry, 61.4 (2004): 403-410. Lambie, Ian, and Isabel Randell. "The impact of incarceration on juvenile offenders." Clinical Psychology Review, 33.3 (2013): 448-459. NCSL. "Juvenile Justice Guidebook for Legislators." Published November 2011, accessed online at http://www.ncsl.org/documents/cj/jjguidebook-mental.pdf.

Numerator: Number of youth arrested for any offense

Denominator: Residents between 10 and 18, per 1,000

Wisconsin: 109 per 1,000

National: 39 per 1,000

Best State: AL = .6 per 1,000

Worst State: WI = 109 per 1,000

Indicator Name: Mental Illness in Young Adults

Indicator Description:

This metric shows the percent of young adults with any mental illness, which is defined as having "a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder."

Importance:

Knowing the number of young people with a diagnosable mental illness increases an understanding of the breadth of the issue of children's mental health in Wisconsin. Tracking prevalence of mental illness across time may also help identify how policies and programs affect rates of treating or preventing mental illness in a population. The National Survey on Drug Use and Health (NSDUH) is the most comprehensive national survey to ask about mental illness for the purposes of gathering a statewide estimate, and has comprehensive survey methodology in place to ensure quality.

Limitations:

The NSDUH does not include homeless populations, non-civilians, or those in institutions such as jails or hospitals.

Tracking prevalence is particularly unreliable for difficult-to-diagnose diseases such as most mental illnesses, and is likely to be under-diagnosed and under-reported.

NSDUH does not provide information about severity of mental illness.

Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012, 2013, and 2014, accessed at http://www.samhsa.gov/data/sites/default/files/NSDUHsaeShortTermCHG2014/NSDUHsaeShortTermCHG2014.htm

Numerator: Number of young adults with a diagnosis of any mental illness

Denominator: Young adults aged 18 to 25

Wisconsin: 20.05 %

National: 19.75 %

Best State: MS = 16.29 %

Worst State: NH = 26.49 %

Indicator Name: School Suspensions & Expulsions

Indicator Description:

This metric is the percent of students receiving an out-of-school suspension or expulsion.

Importance:

The majority of school suspensions are for low-level misconduct, yet being suspended doubles the likelihood that a child will drop out of school (Losen, 2013; Lamont, 2013).

Limitations:

Breaking certain rules requires suspensions or expulsions by state statute or federal law, however, suspensions happen under the authority of the local school district and are based on local district laws. For this reason, variability by state may be due to differences in children's behaviors, or district policies regarding suspensions and expulsions.

Decreases in suspension rates may show increasing student ability to respond appropriately to difficult or triggering situations (Luiselli, 2005), or changing school practices (e.g. likelihood to suspend) in response to behaviors.

Source: U.S. Department of Education, Office for Civil Rights, Civil Rights Data Collection, "2011-12 Discipline Estimations by State" and "2011-12 Estimations for Enrollment." Accessed through the National Center for Education Statistics, at http://nces.ed.gov/programs/digest/d15/tables/dt15_233.40.asp?current=yes. Losen, Daniel J., and Tia E. Martinez. "Out of school and off track: The overuse of suspensions in American middle and high schools." K-12 Racial Disparities in School Discipline (2013). Lamont, Jeffrey H., et al. "Out-of-school suspension and expulsion." Pediatrics, 131.3 (2013): e1000-e1007. Luiselli, James K., et al. "Whole-school positive behaviour support: effects on student discipline problems and academic performance." Educational Psychology, 25.2-3 (2005): 183-198.

Numerator: Number of public elementary and secondary school children suspended or expelled

Denominator: Number of students enrolled in public elementary and secondary schools

Wisconsin: 5.64 %

National: 6.62 %

Best State: HI = 1.39 %

Worst State: DC = 13.39 %

Indicator Name: Teen Birth Rate

Indicator Description:

This is the rate of live births for females aged 15 to 19.

Importance:

The teen birth rate is a negative outcome reflecting likely limited social supports that the teen mom received during her childhood (Kearney, 2012; Kotchick, 2001), and predicts future socioeconomic struggles such as unemployment and lower education (Bissell, 2000). Children born to teen parents are at risk of emotional, behavioral, and socioeconomic difficulties (Lehr, 2016). Teen pregnancy is also correlated with risky sexual behavior and contracting sexually transmitted infections (Kotchick, 2001). Preventing teen pregnancy is one of the Centers for Disease Control and Prevention's (CDC) top priorities.

Limitations:

Planned pregnancies are not differentiated from unplanned pregnancies.

This metric captures only live births; abortions, stillbirths, or spontaneous abortions are not included.

Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007-2014, on CDC WONDER Online Database, February 2016. Accessed at http://wonder.cdc.gov/natality-current.html. For additional information about birth patterns in the US, see http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_12.pdf. Kearney, Melissa S., and Phillip B. Levine. "Why is the teen birth rate in the United States so high and why does it matter?." The Journal of Economic Perspectives, 26.2 (2012): 141-166. Kotchick, Beth A., et al. "Adolescent sexual risk behavior: A multi-system perspective." Clinical Psychology Review, 21.4 (2001): 493-519. Bissell, Mary. "Socio-economic outcomes of teen pregnancy and parenthood: A review of the literature." The Canadian Journal of Human Sexuality, 9.3 (2000): 191. Lehr, Marijane, et al. "Parenting Stress, Child Characteristics, and Developmental Delay from Birth to Age Five in Teen Mother–Child Dyads." Journal of Child and Family Studies, 25.3 (2016): 1035-1043.

Numerator: Number of live births to mothers 15 to 19 years old

Denominator: Number of female residents 15 to 19 years old, per 1,000

Wisconsin: 16.8 per 1,000

National: 24.2 per 1,000

Best State: MA = 9.7 per 1,000

Worst State: OK = 52.5 per 1,000

Indicator Name: Youth Suicide Rate

Indicator Description:

This metric is the rate of suicides by any means for youth ages 12 to 18.

Importance:

Mental health issues, specifically eating disorders, substance use, schizophrenia, and mood disorders, present strong risk factors for suicide (Harris, 1997). While a main risk factor for suicide is often mental illness, additional risk factors include family history of suicide, physical illness, ACEs, and access to lethal methods (Anda, 2010; Stack, 2003).

Limitations:

The specific cause of suicide is not well known; suicide rate cannot be used as a measure for any singular program or initiative.

Rhode Island and the District of Columbia were not included in the state comparisons due to small numbers.

Source: CDC Violent Death Reporting System, available at http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html. Harris, E. Clare, and Brian Barraclough. "Suicide as an outcome for mental disorders. A meta-analysis." The British Journal of Psychiatry, 170.3 (1997): 205-228. Anda, Robert F., et al. "Building a framework for global surveillance of the public health implications of adverse childhood experiences." American Journal of Preventive Medicine, 39.1 (2010): 93-98. Stack, Steven. "Media coverage as a risk factor in suicide." Journal of Epidemiology and Community Health, 57.4 (2003): 238-240.

Numerator: Number of youths who completed suicide

Denominator: Children aged 12 to 18, per 100,000

Wisconsin: 7.28 per 100,000

National: 5.33 per 100,000

Best State: NJ = 3.01 per 100,000

Worst State: SD = 16.52 per 100,000

Indicator Name: Employment (Young Adults)

Indicator Description:

This metric is the number of youth who are employed, either full or part time. It is provided by the Bureau of Labor Statistics, based on estimates from the Current Population Survey.

Importance:

Employed youth have more, positive outcomes, such as lower juvenile arrest rates (Allan, 1989). Youth employment also starts youth on a path to self-sufficiency, supporting their development of career readiness skills and self-esteem. Youth who are employed while enrolled in high school are less likely to drop out, and, if coupled with school-to-career programs, are more likely to enroll in college after graduation (Child Trends Databank, 2015).

Limitations:

Type and duration of employment is not included here but can have a significant effect on the beneficial impact of employment; youth who are either under employed or over employed (working more, longer hours) may see negative consequences such as low job satisfaction, or, for those who are dually occupied with school and employment, poor scholastic outcomes (Allan, 1989).

Source: Bureau of Labor Statistics, Local Area Unemployment Statistics, from http://www.bls.gov/lau/home.htm#ex14. Allan, Emilie Andersen, and Darrell J. Steffensmeier. "Youth, underemployment, and property crime: Differential effects of job availability and job quality on juvenile and young adult arrest rates." American Sociological Review, (1989): 107-123. Child Trends Databank. (2015). Youth employment. Available at: http://www.childtrends.org/?indicators=youth-employment.

Numerator: Number of employed youth

Denominator: Civilian, non-institutional population of individuals aged 16 to 24 years old

Wisconsin: 58 %

National: 47.6 %

Best State: IA = 67 %

Worst State: MS = 35 %

Indicator Name: Flourishing Behaviors (Adolescents)

Indicator Description:

Flourishing as a concept contains multiple dimensions of physical health, mental and emotional health, caring, empathy and resilience. This is a composite measure created by the National Survey of Children's Health (NSCH) using three separate questions: (1) adolescent shows interest and curiosity in learning new things, (2) adolescent stays calm and in control when faced with a challenge, and (3) adolescent finishes tasks and follows through with plans.

Importance:

Protective factors can support children and youth's successful development. This benchmark provides context to the World Health Organization's specification that health is not simply the "absence of disease" but the existence of positive psychosocial functioning (Keyes, 2007). Flourishing is positively correlated with increased school success, being in a protective home and a generally safe environment, and decreased school absences. Furthermore, flourishing behaviors are seen less in adolescents with social, emotional, or behavioral diagnoses (Bethell, 2013).

Limitations:

This construct of flourishing is limited to a small set of variables defined by NSCH and could potentially include many more concepts.

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. Keyes, Corey LM. "Promoting and protecting mental health as flourishing: a complementary strategy for improving national mental health." American Psychologist, 62.2 (2007): 95. Bethell, Christina. "Resilience and protective factors in childhood: Understanding the relationship of positive health indicators to home, school, and community environment." 141st American Public Health Association Annual Meeting and Exposition (November 2-November 6, 2013). APHA, 2013.

Numerator: Number of adolescents with all three measures of flourishing

Denominator: Children and adolescents aged 6 to 17

Wisconsin: 49.7 %

National: 47.7 %

Best State: SD = 54.3 %

Worst State: DC = 36 %

Indicator Name: Flourishing Behaviors (Children)

Indicator Description:

Flourishing as a concept contains multiple dimensions of physical health, mental and emotional health, caring, empathy and resilience. This is a composite measure created by National Survey of Children's Health (NSCH) by combining four aspects of a child: (1) child is affectionate and tender, (2) child bounces back quickly when things don't go his/her way, (3) child shows interest and curiosity in learning new things, and (4) child smiles and laughs a lot.

Importance:

Being affectionate, being resilient, and having curiosity are indicative of a child's long-term success (Lippman, 2011). These early markers of success have implications for lasting positive effects on a children's social and emotional well-being (Keyes, 2003).

Limitations:

This construct of flourishing is limited to a small set of variables, defined by NSCH, and could potentially include many more concepts.

Source: NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org. Lippman, Laura H., Kristin Anderson Moore, and Hugh McIntosh. "Positive indicators of child wellbeing: A conceptual framework, measures, and methodological issues." Applied Research in Quality of Life, 6.4 (2011): 425-449.

Numerator: Number of children who meet all four measures of flourishing

Denominator: Children aged 6 months to 5 years

Wisconsin: 78.6 %

National: 73.2 %

Best State: WY = 85.2 %

Worst State: NY = 63.3 %

Indicator Name: High School Graduation Rate

Indicator Description:

This metric is the adjusted cohort graduation rate for the number of youth who graduate in 4 years with a regular high school diploma.

Importance:

Youth who graduate from high school on time are more likely to go on to post-secondary education, and to have higher earnings over their lifetime contributing more economic benefits to society through increased tax payments and decreased utilization of public services (food or housing assistance). Graduated youth also typically see better overall health outcomes, making healthier choices and abstaining from risky behaviors such as drug use and premarital sex (Alliant for Excellent Education, 2011).

Limitations:

This metric includes only youth who received a regular high school diploma. Acquisition of a GED or other High School equivalence is not included.

Some states differ in their reporting of graduation rates, particularly for children with disabilities. Full details of how data are obtained can be found at nces.ed.gov.

Source: Common Core of Data, accessed via the National Center for Education Statistics, online at http://nces.ed.gov/ccd/tables/ACGR_RE_and_characteristics_2013-14.asp. Alliance for Excellent Education. The high cost of high school dropouts: What the nation pays for inadequate high schools. Washington, DC: 2011, retrieved from www.all4ed.org/files/HighCost.pdf. Alliance for Excellent Education. Healthier and wealthier: Decreasing health care costs by increasing educational attainment (Issue Brief). Washington, DC: 2006, retrieved from http://all4ed.org/reports-factsheets/healthier-and-wealthier-decreasing-health-care-costs-by-increasing-educational-attainment/.

Numerator: Number of students who received regular high school graduation diploma

Denominator: High school youth who began in the cohort year

Wisconsin: 88.6 %

National: 82.3 %

Best State: IA = 90.5 %

Worst State: DC = 61.4 %

Indicator Name: Home Ownership (Adults)

Indicator Description:

This metric is from the Behavioral Risk Factor Surveillance System (BRFSS), showing the percentage of adults 18 and over who own their own home.

Importance:

Homeownership is a mark of economic and social success. Homeownership is also associated with increased feelings of stabilization for families. As such, having stable housing can decrease mental stress, and may be associated with higher quality home environments, greater cognitive achievement, and fewer challenging behaviors, independent of socioeconomic status and other factors (Haurin, 2002). Tracking homeownership alongside other measures such as poverty and community safety, provides a more complete picture of overall well-being.

Limitations:

BRFSS includes only non-institutionalized individuals with a cellphone or land line.

This metric does not differentiate between people who own their house outright versus those who carry mortgage debt.

These are crude rates of homeownership, unadjusted for differences in cost-of-living in various geographies, such as by city, state, or rural versus urban.

There are potential negative consequences of homeownership, such as the burden of mortgage debt on individuals, and augmenting societal problems of segregation, sub-urbanization, and pollution (Nettleton, 1998; Shlay, 2005).

Source: BRFSS, administered by the CDC. Data from 2014, accessed at https://chronicdata.cdc.gov/. Haurin, Donald R., Toby L. Parcel, and R. Jean Haurin. "Does homeownership affect child outcomes?" Real Estate Economics, 30.4 (2002): 635-666. Nettleton, Sarah, and Roger Burrows. "Mortgage debt, insecure home ownership and health: an exploratory analysis." Sociology of Health & Illness, 20.5 (1998): 731-753. Shlay, Anne B. "Low-income homeownership: American dream or delusion?" Urban Studies, 43.3 (2006): 511-531.

Numerator: Number of adults who own their own home

Denominator: Individuals aged 18 to 64

Wisconsin: 71.1 %

National: 70.6 %

Best State: WV = 76.4 %

Worst State: DC = 44.8 %

Indicator Name: Positive Mental Health (Adults)

Indicator Description:

This metric measures the absence of depression in adults through the Behavioral Risk Factor Surveillance System (BRFSS). Though positive mental health is necessarily more than just the absence of mental health issues, national surveys focus on the presence of distress, not well-being. This question asks, "Have you ever been told that you have a form of depression?"

Importance:

This metric is a proxy for the percent of adults who have positive mental health. Individuals free from depression experience higher, more productive functioning in life, suggesting that tracking the population free from depression has merits in providing information about the population's overall state of the mental well-being (Keyes, 2005).

Limitations:

Depression is one metric of mental health, and low rates do not preclude the possibility of other mental health issues.

Higher rates of depression may indicate increasing access to diagnostic tools and care, not a truly rising incidence of depression.

BRFSS includes only civilian, non-institutionalized adults with cellphone or landline.

An ideal metric of positive mental health would include several domains, such as feeling part of a community, being fulfilled in work and home life, and engaging in meaningful activities, both at work and in personal time.

Source: BRFSS, administered by the CDC. Data from 2014, accessed at https://chronicdata.cdc.gov/. Keyes, Corey LM. "Mental illness and/or mental health? Investigating axioms of the complete state model of health." Journal of Consulting and Clinical Psychology, 73.3 (2005): 539.

Numerator: Number of people with no diagnosis of depression

Denominator: Residents over age 18

Wisconsin: 83 %

National: 81.1 %

Best State: HI = 89.3 %

Worst State: OR = 76 %

Indicator Name: Young Adults with Postsecondary Education

Indicator Description:

This metric is from the Current Population Survey (CPS) and includes young adults with associates or bachelor's degrees from a college or university, or a master's, professional, or doctorate degree.

Importance:

Higher educational attainment is significantly correlated with increased job readiness, higher wages, and better health (Fletcher, 2009). Such attainment is difficult for young adults who struggle with mental health issues. This metric tracks overall success for young people.

Limitations:

CPS includes only civilian, non-institutionalized adults with cellphone or landline.

CPS was designed to calculate national estimates for employment, making state estimates are less stable.

Source: Current Population Survey (CPS), Annual Social and Economic Supplement, 2015, accessed at http://www.census.gov/cps/data/cpstablecreator.html. Fletcher, J. M., & Frisvold, D. E. "Higher education and health investments: does more schooling affect preventive health care use?" Journal of Human Capital, 3.2 (2009): 144.

Numerator: Number of 25 to 34 year-olds who received an associates or bachelor's degree, or higher

Denominator: Residents aged 25 to 34

Wisconsin: 45.7 %

National: 46.5 %

Best State: DC = 79.7 %

Worst State: NC = 35.11 %