NC Child
The Voice for North Carolina's Children

NCIOM

NORTH CAROLINA Child Health REPORT CARD 2019

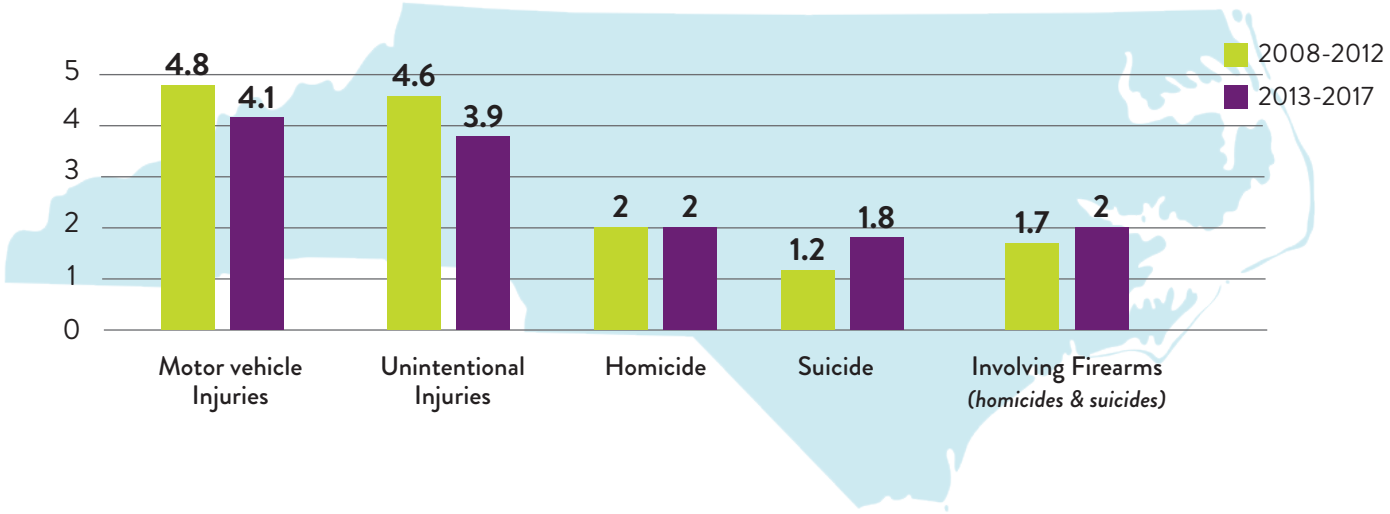
Focus On: YOUTH SUICIDE

Secure Homes & Neighborhoods

Children's health is influenced by where they live, play, and learn. 43% of children in North Carolina live in poor or low-income homes (less than 200% of the federal poverty level), and from 2012-16, 13% of kids lived in high-poverty neighborhoods. Children living in families that cannot afford the basics in life often have reduced access to safe living conditions, healthy food, and opportunities for exercise, all of which increase their risk for poor health. To improve children's health and well-being, North Carolina needs to ensure economic development, safe housing, and other policies to support healthy families.

GRADE	INDICATOR	DATA YEARS	CURRENT	BASE	% CHANGE	AFRICAN AMERICAN or BLACK	AMERICAN INDIAN	ASIAN	HISPANIC or LATINX	OTHER	WHITE
F	***Housing & Economic Security***										
	Children who live in high-poverty neighborhoods	2012-16, 2008-12	13.0%	12.0%	8.3%						
	Children who live in poor or low-income households *(<200% FPL)*	2017, 2013	43.0%	49.0%	-12.2%	64.0%		29.0%	71.0%	48.0%	31.0%
B	***Environmental Health***										
	Children who have an asthma diagnosis	2016-17, 2012	15.1%	17.5%	-13.7%	14.7%					13.0%
D	***Child Abuse and Neglect***										
	Children who are investigated for child abuse or neglect	SFY 2017, SFY 2013	5.6%	5.7%	-1.8%	8.7%	6.9%		3.9%	10.9%	4.6%
	Children who exit to a permanent living situation within 24 months	SFY 2016, SFY 2012	66.3%	69.1%	-4.1%	63.6%	82.5%			61.8%	67.6%

North Carolina Resident Child (Ages 0-17) Death Rates by Type of Death/per 100,000



Access to Care

Access to health care is an important determinant of children's health, and health insurance is critical to ensure affordable access to care. North Carolina has made tremendous strides in enrolling children in health care coverage that allows them access to preventive care services such as well child visits, immunizations, and dental cleanings. The health and well-being of parents and other caregivers is critical to their ability to serve as nurturing caregivers for children. The number of parents without health insurance has decreased from 20.6% in 2011 to 13.5% in 2016. Ensuring that parents and other caregivers have access to prevention and treatment for mental and physical health problems is an essential step towards providing the safe, supportive, nurturing environments in which children thrive.

GRADE	INDICATOR	DATA YEARS	CURRENT	BASE	% CHANGE	AFRICAN AMERICAN or BLACK	AMERICAN INDIAN	ASIAN	HISPANIC or LATINX	OTHER	WHITE
C	***Oral Health***										
	Kindergarten students with untreated tooth decay	2016-2017, 2013	14.3%	13.0%	10.0%	18.3%	20.3%	19.9%	15.4%	14.6%	11.4%
D	***School Health***										
	School counselor ratio	2014-15, 2010-11	1:378	1:375							
	School nurse ratio	2016-17, 2013-14	1:1,073	1:1,160							
B	***Health Services Utilizations and Immunization***										
	Children with Medicaid who received a well-child checkup in the past year	2017, 2013	57.7%	57.2%	0.9%						
	Children ages 19-35 months w/ appropriate immunizations	2017, 2014	73.6%	83.0%	-11.3%	79.7%			76.4%		69.9%
	Adolescents ages 13-17 who have received 1 or more HPV vaccinations	2017, 2016	66.8%	57.5%	16.2%	77.2%			74.4%		62.3%
A	***Insurance Coverage***										
	Children with health insurance coverage	2017, 2013	95.2%	93.7%	1.6%						
	Parents without health insurance coverage	2016, 2011	13.5%	20.6%	-34.5%	13.7%	21.1%	10.1%	53.7%	15.5%	8.7%

Healthy Births

The health of people of childbearing age is essential to improving the health of our state and future generations. Women's health before and during pregnancy is inextricably linked to the health and well-being of their babies and families. The most serious negative pregnancy outcomes, including infant death and low birth weight, are largely determined by a woman's health prior to and during the first weeks of pregnancy. Unaddressed or poorly managed health issues like tobacco use, diabetes and hypertension - conditions which all disproportionately affect poor women and women of color - increase the likelihood of pregnancy complications and contribute to racial and ethnic disparities in birth outcomes. Disparities in infant mortality, the leading cause of child death in North Carolina, have persisted, with African American babies more than twice as likely as white babies to die in the first year of life.

GRADE	INDICATOR	DATA YEARS	CURRENT	BASE	% CHANGE	AFRICAN AMERICAN or BLACK	AMERICAN INDIAN	ASIAN	HISPANIC or LATINX	OTHER	WHITE
B	***Breastfeeding***										
	Newborns who are breastfed exclusively for at least 6 months	2015, 2012	27.0%	23.1%	16.9%						
C	***Preconception and Maternal Health and Support***										
	Women aged 18-44 with health insurance coverage	2017, 2013	80.4%	73.5%	9.0%	81.8%	91.7%		42.4%	84.1%	88.1%
	Women who receive early prenatal care	2016, 2012	69.0%	71.3%	-3.2%	61.4%	61.8%		58.0%	67.3%	75.6%
	Pregnancy-related deaths per 100,000 live births *(Women who die during pregnancy or shortly after childbirth)*	2009-13, 2004-08	18.0	16.2	11.1%						
D	***Birth Outcomes***										
	Infant mortality rate per 1,000 live births	2016, 2012	7.2	7.4	-2.7%	13.4	7.6		6.0	6.2	5.0
	Babies who are born before 37 weeks of pregnancy	2016, 2012	10.4%	11.5%	-9.6%	13.8%	13.1%		9.0%	8.8%	9.4%
B	***Teen Births***										
	Rate of births to teen girls ages 15-19 per 1,000	2016, 2012	21.8	31.8	-31.4%	27.5	43.6		39.6	9.7	15.5

Health Risk Factors

Many additional factors impact children's ability to be healthy and well. Like family economic security, education is tightly intertwined with health; success in school and the number of years of schooling positively impact health across the lifespan. More than 2 out of 5 children in North Carolina do not read at grade level at the end of third grade, with persistent racial disparities in both third-grade reading and high school graduation rates. Access to healthy and nutritious food also impacts children's health. In North Carolina, nearly one in three kids between age 10 and 17 are overweight or obese. At the same time, more than one in five kids live in households that don't have reliable access to affordable, nutritious food. Investments in education and food security will lead to healthier kids and stable families.

GRADE	INDICATOR	DATA YEARS	CURRENT	BASE	% CHANGE	AFRICAN AMERICAN or BLACK	AMERICAN INDIAN	ASIAN	HISPANIC or LATINX	OTHER	WHITE
D	***Healthy Eating & Active Living***										
	Children ages 10-17 who are overweight or obese	2016-17, 2011-12	30.7%	31.4%	-2.2%	43.3%			40.5%	35.2%	21.4%
	Children who live in food insecure households	2016, 2014	20.9%	24.6%	-15.0%						
D	***Tobacco, Alcohol, and Substance Use***										
	High school students who currently use:										
	Current cigarette use	2017, 2013	12.1%	15.0%	-19.3%	8.2%		7.7%	8.9%	12.1%	13.9%
	Electronic vapor products	2017, 2015	22.1%	29.6%	-25.3%	18.4%		14.1%	16.7%	24.2%	24.5%
	Alcohol (including beer)	2017, 2013	26.5%	32.2%	-17.7%	22.7%		11.9%	25.6%	28.3%	28.8%
	High school students who have ever used:										
	Prescription pain medicine without a prescription	2017	15.0%			16.3%		6.0%	13.8%	20.9%	13.5%
D	***Mental Health***										
	High school students who attempted suicide in the past year	2017	8.2%			11.1%		5.1%	9.3%	17.9%	5.1%
	Past-year major depressive episode among adolescents aged 12-17	2017, 2014-15	13.3%	12.4%	7.3%	9.5%	16.3%	11.3%	13.8%	16.9%	13.1%
	Adolescents aged 12-17 with major depressive episode who recieved treatment for depression	2017, 2011-15	41.5%	40.5%	2.5%	35.1%			32.7%	44.8%	47.5%
C	***Education***										
	Third grade students reading at grade level	SY 2016-2017, SY 2012-2013	57.8%	60.2%	-4.0%	40.9%	42.3%	76.4%	42.6%	62.1%	71.9%
	High school students who graduate on time	SY 2017-2018, SY 2014-2015	86.3%	85.6%	0.8%	83.2%	84.3%	93.3%	79.9%	84.1%	89.5%

SUICIDE
is the second leading ***cause of death*** for children ages 10-17

Special Issue: Youth Suicide

Suicide is rising as a leading cause of death for children and adolescents. According to the North Carolina State Center for Health Statistics, the rate of youth suicide in North Carolina has nearly doubled over the previous decade.[1] Despite this worrying trend, significant barriers remain for many who need access to mental health services.

Thoughts of suicide and suicide attempts are more common among children who experience mental health issues like anxiety and depression. However, mental health is only one of a variety of factors that impact youth suicide. Other factors include adolescents' still-developing impulse control, access to "lethal means of self-harm" such as firearms and prescription drugs, and exposure to a range of personal and social risk factors.[2]

SOME RISK FACTORS CAN INCLUDE:

PERSISTENT STRESS

ACUTE LOSS or REJECTION

BULLYING

CHILDHOOD ABUSE

TRAUMA

SOCIAL ISOLATION

FAMILY VIOLENCE or DISRUPTION

Gender and sexual orientation can also have significant impact on suicide risk, because of the social discrimination that LGBTQ youth experience. In North Carolina, 16% of high school students in 2017 reported seriously considering suicide. This figure included 12% of heterosexual students, and a staggering 43% of gay, lesbian, or bisexual students.[3]

STAKEHOLDERS CAN PREVENT YOUTH SUICIDE BY:

- *Reducing barriers to mental health care*
- *Making it harder for youth to get access to lethal means (e.g., safe storage of firearms and prescription drugs)*
- *Ensuring that caring adults in a child's life are trained to detect and address risk factors for dying by suicide. These include caregivers, as well as school safety personnel such as nurses, social workers, and psychologists.*

The influence of caring and well-trained adults, combined with evidence-based solutions that reduce family and community stressors, can prevent dangerous feelings of hopelessness in children and adolescents. Effective strategies include strengthening our crisis response system; increased investment in behavioral health systems; more partnerships between schools and behavioral health providers; and screening more children and youth for mental health needs. By pursuing these solutions, stakeholders can promote a healthier, stronger North Carolina and keep our children safe.

Youth suicide rate nearly **DOUBLED** *from 2008 to 2017*

National Suicide Prevention Lifeline

1-800-SUICIDE

DEMOGRAPHICS

In **North Carolina** there were **120,099** live births & **2,301,190** children under the age of 18 in **2017**

	TOTAL CURRENT	AFRICAN AMERICAN or BLACK	AMERICAN INDIAN	ASIAN	HISPANIC or LATINX	OTHER	WHITE
Number of babies born (Live births)	**120,099**	28,950	1,592		18,461	5,782	65,314
Percent of total live births	**100%**	24.1%	1.3%		15.4%	4.8%	54.4%
Children under age 18 (%)	**100% (2,301,190)**	22.8% (524,563)	1.2% (29,175)	3.1% (71,658)	16.1% (370,303)	5.8% (133,550)	61.7% (1,420,559)

DISPARITIES BY RACE PERSIST IN NORTH CAROLINA ACROSS MANY AREAS OF CHILD WELL-BEING:

WHITE	AFRICAN AMERICAN or BLACK	HISPANIC or LATINX	
31.0%	64.0%	71.0%	*Children in Poor or Low-Income Households*
21.4%	43.3%	40.5%	*Children 10-17 Who are Overweight or Obese*
71.9%	40.9%	42.6%	*3rd Grade Students Reading at Grade Level*

INFANT MORTALITY rate per **1,000** live births

White	5.0
Hispanic	6.0
Black	13.4

GRADES AND CHANGE OVER TIME: Grades are assigned by a panel of health experts to bring attention to the current status of North Carolina children in salient measures of health and well-being. Grades are subjective measures of how well children in North Carolina are faring in a particular area, and are not meant to judge the performance of state agency or agencies providing data or services. Please note that several agencies have made a great deal of progress in recent years, which may not be reflected in these grades.

Percent changes have not been given for population count data involving small numbers of cases. Grades and trends are based on North Carolina's performance year-to-year, disparities by race/ethnicity, and what level of child health and safety North Carolina should aspire to, regardless of how we compare nationally.

Data sources and additional references can be found online at: www.nciom.org or www.ncchild.org

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QUESTIONS?

NC Child
The Voice for North Carolina's Children
3101 Poplarwood Court, Suite 300
Raleigh, NC 27604
www.ncchild.org | 919.834.6623

NCIOM
Keystone Office Park
630 Davis Drive, Suite 100
Morrisville, NC 27560
www.nciom.org | 919.445.6500