## every day in oklahoma...

140 babies are born

- 6 of the babies are born to children
- 53 of the babies are born without adequate prenatal care
- 11 of the babies are born too small

136 allegations of serious child abuse and/or neglect are investigated

- 35 incidents are confirmed to be child abuse and/or neglect

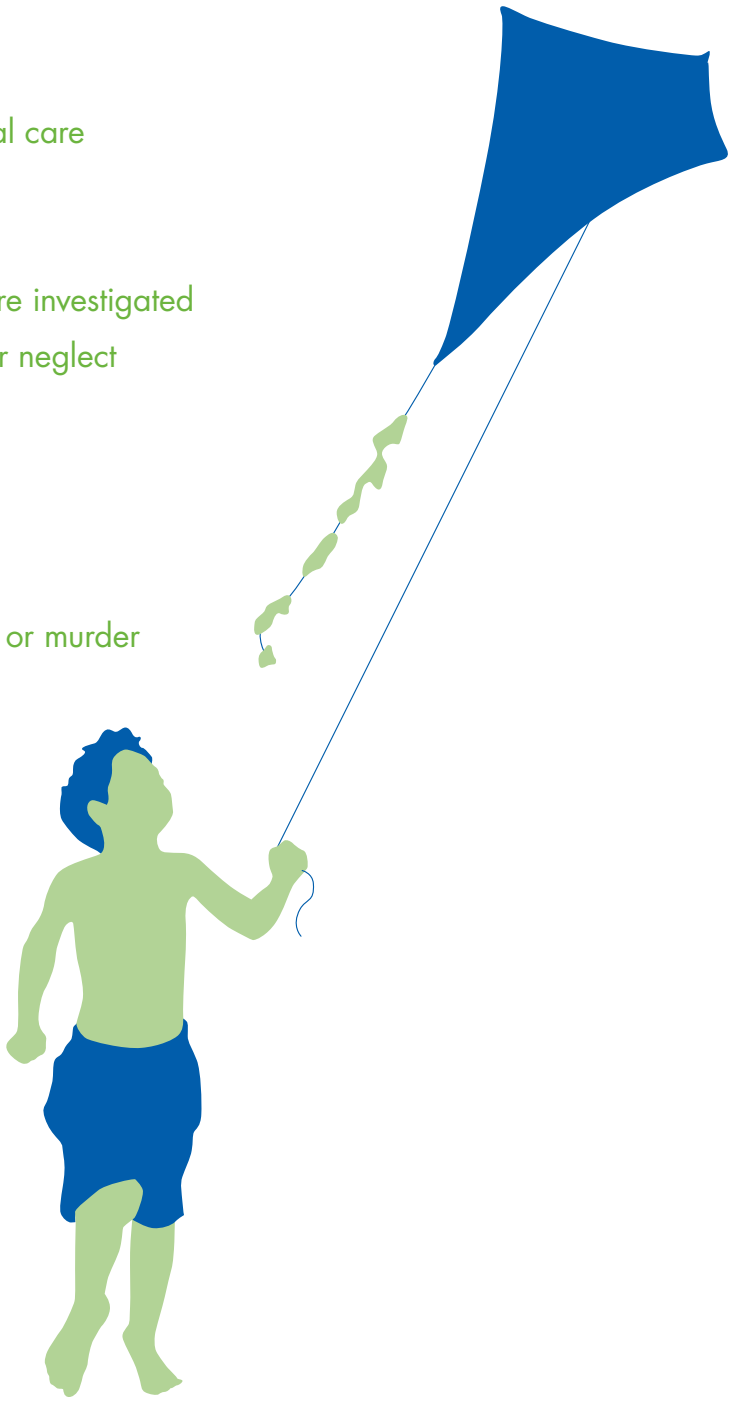
17 children quit high school without graduating

65 children are arrested for a crime

- 2 of those are arrested for a violent crime, like rape or murder

At least 2 young people will die

- 1 of those will be a baby



# oklahoma KIDS COUNT partnership

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## 2006–2007 Oklahoma KIDS COUNT Factbook

A publication which reports on the well-being of children and youth in Oklahoma. Data from the Oklahoma KIDS COUNT Factbook is included on the website for the Oklahoma Institute for Child Advocacy at http://www.oica.org.

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The National KIDS COUNT Databook is an annual publication that reports on the well-being of children, youth and families in the United States. The publication is free and available through: **The Annie E. Casey Foundation, 701 St. Paul Street, Baltimore, MD 21202, 1-410-547-6600, or online at www.kidscount.org.**

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oklahoma KIDS COUNT partnership is supported by...

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Oklahoma Department of Commerce

**Mike Fogarty**
Oklahoma Health Care Authority

## oklahoma institute for child advocacy board of directors 2006

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# about OICA

The Oklahoma Institute for Child Advocacy (OICA) is a broad-based, multi-issue organization that promotes programs and policies designed to improve the health and well–being of Oklahoma's children and youth. Its work provides a critical link between the provision of programs and services at the local level and the policy-making process at the state level. For more information go to www.oica.org or call 405.236.5437

## OICA accomplishes positive change for children and youth through three principle strategies:

### 1. Creating Awareness 2. Taking Action 3. Changing Policy

### advocacy

Multi-Issue Legislative Action
Data, Publications and Training
Leadership Development
Strategic Communications

### maternal & child health

Promoting Perinatal and Pediatric Health
Advancing Fitness and Nutrition
Education and Awareness
Statewide Collaboration and Outreach

### youth initiatives

Promoting Positive Youth Development
Research and Publications
State and National Collaboration
Special Projects

### children's behavioral health

Anti-Stigma Campaign
Research, Publications and Training
Promoting Best Practices

# KIDS COUNT leadership

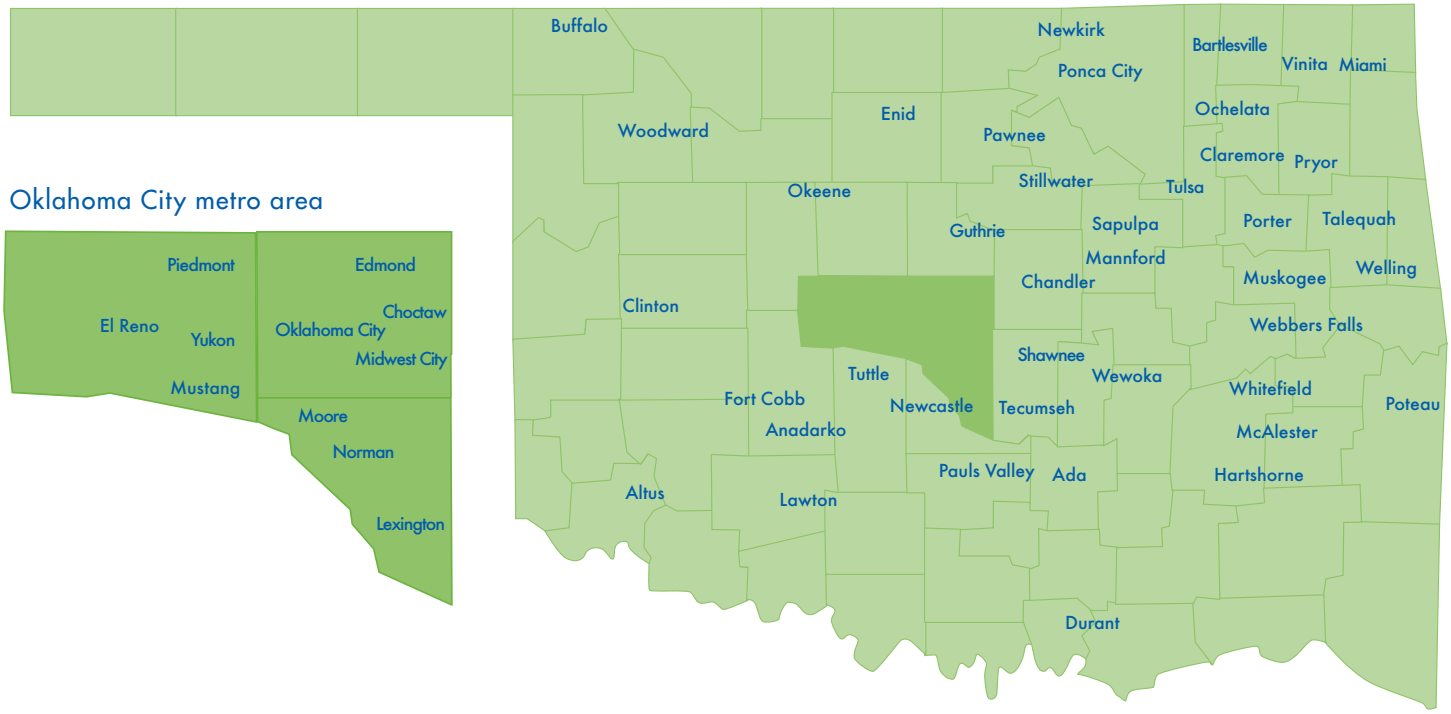
## Leaders Build Relationships

Members of each Oklahoma KIDS COUNT Leadership Class work locally and across the state with others who are interested in improving the lives of Oklahoma's children and youth. Leaders have the opportunity to network with policy makers, community leaders, social service providers and concerned citizens.

## Leaders Help Solve Problems

One tenet of KIDS COUNT is that local people solve local problems. Each Leader receives technical assistance and leadership training to support them in their role as a resource person on children and youth issues. Individuals who are a part of KIDS COUNT guide their own communities toward creating a better life for children and youth.

## KIDS COUNT leader network (leaders from classes I through XII)



## Leaders Work For Children And Youth

Children and youth are our voiceless, voteless citizens. KIDS COUNT Leaders elevate public awareness of pertinent issues on behalf of children and youth. Through media releases and events, community meetings, Child Watch Visits, Round Table discussions and other publicity activities, Leaders generate public interest and provide helpful information on issues important to children and youth.

## Leaders Make A Difference

They are Leaders who care about children and youth. They lead others to the cause. The work that they do lifts them up as role models to all members of the community. Through Oklahoma KIDS COUNT, they have the resources, connections and support to improve the lives of children and youth.

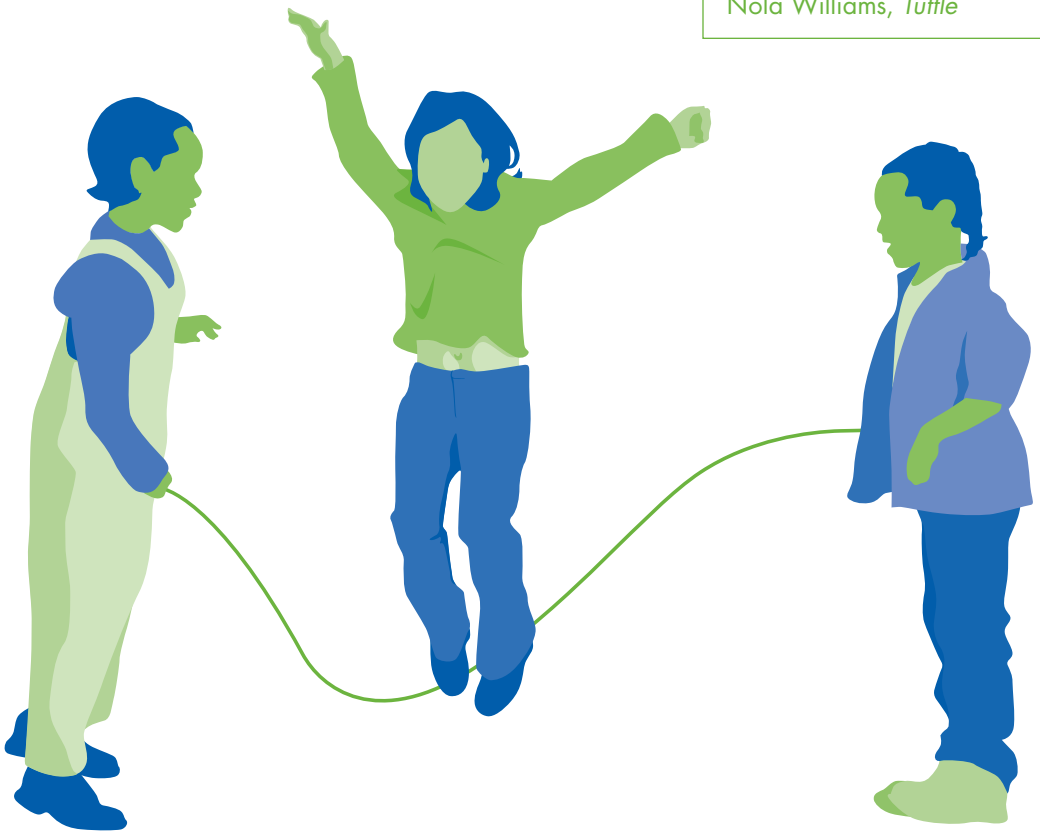
Individuals from all racial, ethnic, religious, socioeconomic, professional and political backgrounds, from high school age to senior citizens are encouraged to apply.

KIDS COUNT Leaders must be available to attend the KIDS COUNT Advocacy Camp which is held the first Friday and Saturday in August.

The year-round application process for Oklahoma KIDS COUNT Leadership is easy! Applications must be received by the third Monday in June for the next consecutive class. Please contact Ann Patterson Salazar at 405/236-5437 extension 102, or apsalazar@oica.org, if you have any questions, or go to www.oica.org to download an application.

## 2006 KIDS COUNT Leaders Class XII

Charlotte Bell, *Oklahoma City*
Deidra Carpenter, *Oklahoma City*
Brittany Scott Couch, *Oklahoma City*
Rockolyn Daniels, *Muskogee*
Jon Dodson, *Oklahoma City*
Gwen Downing, *Norman*
Amy Fleske, *Norman*
Lisa Fry, *Oklahoma City*
Jayma Gregory, *Ada*
Regina Hall, *Stillwater*
Kim Henneha, *Stillwater*
Tonya James, *Muskogee*
Yohnikka Jones, *Oklahoma City*
Juana Lily Macias, *Oklahoma City*
Emma G. Mullendore, *Choctaw*
Brandy Smith, *Oklahoma City*
Cheryl Waldeck, *Tulsa*
Ginger Welch, *Oklahoma City*
Nola Williams, *Tuttle*



# state overview & findings

This eleventh Oklahoma KIDS COUNT Factbook continues to measure progress (or lack of progress) for children and youth in our state from the middle of the 1990s, quantifying the impact of recent social and policy changes on the well-being of Oklahoma's children, families and communities. **KIDS COUNT Factbook indicators, for which change over time is tracked, include low birthweight infants (less than 5 ½ pounds), very low birthweight infants (less than 3 pounds, 5 ounces), births to young teens (ages 15–17), births to older teens (ages 18 & 19), births to teens (ages 15–19), confirmations of**

*(continued on page 10)*

## Oklahoma

Number of Children (2004): 859,870
Children are 24.4% of the state population

Number of Poor Children (2003): 181,398
Child Poverty Rate (2003): 21.1%

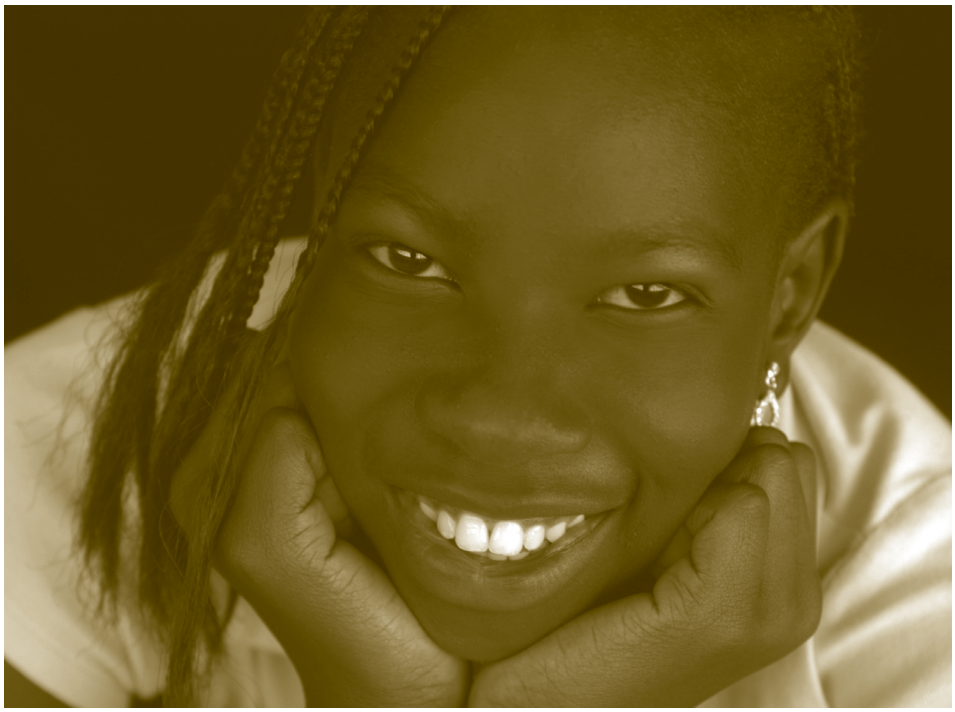
| Indicator | Base Data | - Worsened / Improved + | Recent Data |
|---|---|---|---|
| **Birthweight** | | | |
| Low Birthweight (<5.5lbs) | 7.1% of live births, 1994-96 | -11.6% | 7.9% of live births, 2002–04 |
| Very Low Birthweight (<3 lbs, 5oz) | 1.2% of live births, 1994-96 (<3 lbs, 5oz) | -8.0% | 1.2% of live births, 2002–04 |
| **Births to Teens** | | | |
| Births to Young Teens (ages 15–17) | 38.1/1000 girls 15-17, 1994-96 | 22.8% | 29.4/1000 girls 15-17, 2002–04 |
| Births to Older Teens (ages 18–19) | 103.1/1000 girls 18-19, 1994-96 | 8.3% | 94.5/1000 girls 18-19, 2002–04 |
| Births to Teens (ages 15–19) | 63.6/1000 girls 15-19, 1994-96 | 11.4% | 56.3/1000 girls 15-19, 2002–04 |
| Child Abuse & Neglect | 14.3 confirmed/1000 children, FY 1995-97 | -2.9% | 14.7 confirmed/1000 children, FY 2003–05 |
| High School Dropouts | 3.7% youth <age 19, SY 2001/02-2003/04 | 6.3% | 3.5% youth <age 19, SY 2002/03-2004/05 |
| Violent Crime Arrests | 363.3/100,000 youths 10-17, 1994-96 | 39.9% | 218.3/100,000 youths 10-17, 2002–04 |
| **Mortality** | | | |
| Infant Mortality (<age 1) | 8.4/1000 live births, 1994-96 | 5.5% | 7.9/1000 live births, 2002–04 |
| Child Death (ages 1–14) | 33.1/100,000 children 1-14, 1994-96 | 21.0% | 26.2/100,000 children 1-14, 2002–04 |
| Teen Death (ages 15–19) | 100.1/100,000 teens 15-19, 1994-96 | 19.1% | 81.0/100,000 teens 15-19, 2002–04 |
| Child & Teen Death (ages 1–19) | 51.0/100,000 youth 1-19, 1994-96 | 18.9% | 41.4/100,000 youth 1-19, 2002–04 |

*(continued from page 9)*

**child abuse & neglect, high school dropouts, juvenile violent crime arrests, infant mortality (under age 1), child death (ages 1–14), teen death (ages 15–19) and child/teen death (ages 1–19).**

*There is little change.* This year the same eight indicators which improved in recent years report further improvement over comparable data from the middle of the 1990s. In addition, data available in a consistent format for the first time in several years allowing comparison of high school dropout rates over time also demonstrates slight improvement from the early 2000s. For the most part, the recent better rates were stronger in this current comparison. For only one of these indicators, **infant mortality**, did the improvement slow.

**Births to Young Teens (ages 15–17)**
**Births to Older Teens (ages 18 & 19)**
**Births to Teens (ages 15–19)**
**High School Dropouts**
**Juvenile Violent Crime Arrests**
**Infant Mortality (under age 1)**
**Child Death (ages 1–14)**
**Teen Deaths (ages 15–19)**
**Child & Teen Death (ages 1–19)**



*Entrenched problems continue to resist improvement.* The same three indicators *worsened* when compared to data from the middle of the 1990s.

**Low Birthweight Infants**
(less than 5 ½ pounds)
**Very Low Birthweight Infants**
(less than 3 pounds, 5 ounces)
**Child Abuse & Neglect Confirmations**

Large numbers of Oklahoma children reap the benefits of the improvements recorded in these pages. At the same time, many other young Oklahomans experience pain and face seemingly insurmountable challenges. As this 2006–2007 Oklahoma KIDS COUNT Factbook is prepared, more than one hundred eighty thousand (181,398) Oklahoma children live in poverty. Each year, almost thirteen thousand (12,882) children are abused or neglected. The number of deaths resulting from child abuse and neglect remains high. Each year, more than six thousand (6,034) youth quit high school before graduating. Another thirteen hundred (1,352) children do not even make it that far in school. Each year, more than seven thousand (7,041) teens ages 15 through 19 become mothers. Each year, nearly nine hundred (867) children and youth are arrested for murder, rape, aggravated assault or robbery. Each year, four hundred (402) Oklahoma babies do not live to see their first birthday. Another four hundred (384) children and youth do not live to see their twentieth. Children facing such significant adversity in childhood who do live into adulthood will have an increased likelihood of being met with poor adult health status and early death.

a state profile: adverse childhood experience

# adverse childhood experience

**For most Oklahoma children time heals nothing. Traumatic experiences and exposure to family dysfunction during childhood result, decades later, in poor adult health status, early death and crippled communities.**

**Childhood experience can explain much of Oklahoma's present. Oklahomans currently face momentous and expensive challenges: the highest occurrence of mental illness in the nation, the only state in which physical health status worsened during the 1990s, and the fourth largest per capita prison population of any state.**

**Improved childhood experience will contribute greatly to a brighter Oklahoma. As Oklahoma's youngest citizens experience less adversity during childhood, fewer will adopt risky behaviors, improving their futures and Oklahoma's.**

## adverse childhood experience, state of oklahoma

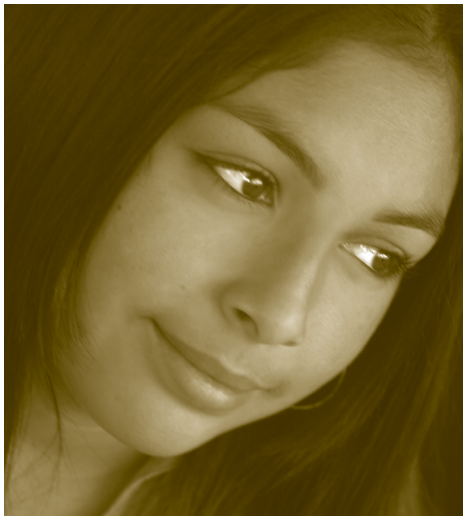
| parental divorce or separation | incarcerated family member | mentally ill household member | substance abusing household member | violence against mother |
|---|---|---|---|---|
| 5.2 divorce & annulment/1,000 residents | 47.7 index crimes/1,000 residents | 11.0% psychological distress rate | 5.1% substance abuse rate | 16.3 protective orders filed/1,000 adult women |
| household or family dysfunction ACEs | | | | |
| child maltreatment ACEs | | | | |
| 3.9 child abuse confirmations/1,000 children | | | 13.0 child neglect confirmations/1,000 children | |
| psychological, physical & sexual abuse | | | emotional & physical neglect | |

# the adverse childhood experience (ACE) study

**The Adverse Childhood Experience, or ACE, Study, one of the largest investigations of this type ever conducted, documents a direct correlation between the traumas and family dysfunction suffered in childhood with poor adult health status and premature death decades later.** The ACE Study, a collaborative research project between the Centers for Disease Control and Prevention (CDC) and the Department of Preventive Medicine at Kaiser Permanente (KP) in San Diego, was prompted by the 1980s observations of Dr. Vincent J. Felitti. As he was conducting a Kaiser Permanente weight loss program, Dr. Felitti noticed that some of his most successful patients were dropping out of the program. In follow-up interviews with over 200 of these patients, he made a series of startling discoveries. Child sexual abuse was very common among these patients, typically preceding the onset of their obesity problem. Many patients indicated their conscious awareness of an association between their childhood abuse and their current obesity. Finally, and perhaps most counterintuitive, Dr. Felitti reported that for many of these patients, their problem was not their obesity. Rather obesity was their protective solution, a way to deal with problems they could not talk about.

From Dr. Felitti's clinical observations, the CDC's Dr. Robert Anda designed research protocols to compare current adult health status to childhood experiences decades earlier. With the help of over 17,000 members of the Kaiser Permanente Health Plan, who agreed to cooperate through detailed biomedical and psychological evaluations, the ACE Study produced remarkable insight into how childhood experiences evolve into risky behaviors, which, in turn, evolve into disease and premature death.

The CDC-KP ACE Study examined a population of typical, middle class, employed adults with health insurance, more or less evenly divided between males and females. Because the average participant was 57 years old, the ACE Study could measure the effect of adverse childhood experiences on adult health status a half century later.

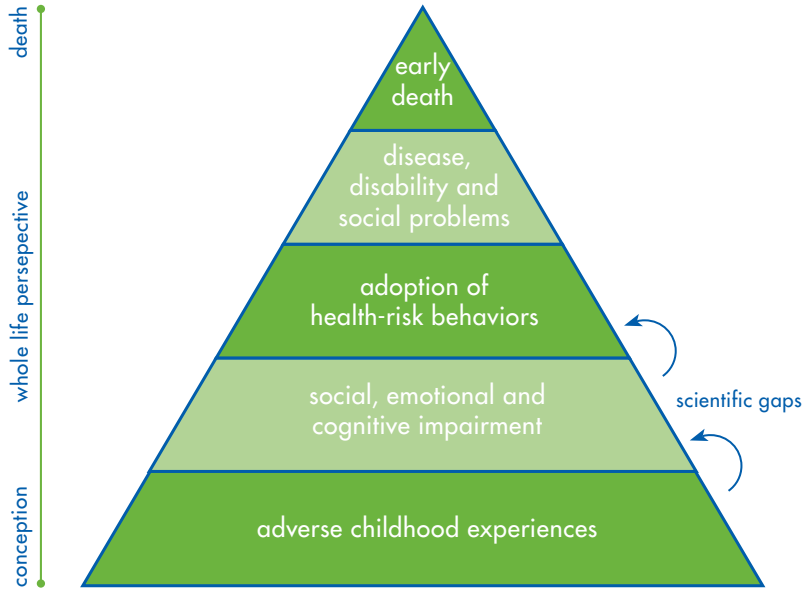


## the adverse childhood experience (ACE) framework & methodology

**The ACE Pyramid represents the conceptual framework for the CDC-KP ACE Study.** The arrows depict the study's design to assess two "scientific gaps." First is an assessment of adverse childhood experiences as the underlying reason for risk behaviors that lead to an individual's social, emotional and cognitive impairment. Second is an assessment of how such impairments result in an individual's adoption of behaviors which put their health at risk. The resulting health and social consequences occur higher up the pyramid.

A complete medical evaluation was abstracted for every person included in the CDC-KP ACE Study, compiling a medical history, laboratory results and physical findings, including the presence of disease conditions. Each responded to a questionnaire designed to gather the participant's health-related behaviors, self-rated health appraisal and adverse childhood experiences (ACEs).

### ACE Pyramid: Conceptual Framework




## adverse childhood experience (ACE)

**Borrowing from those experiences frequently mentioned in Dr. Felitti's weight loss program interviews, the ACE Study identified ten adverse childhood experiences (ACEs). Half (5) of the ACEs were experiences perpetrated against the child. Half (5) of the ACEs measured dysfunction within the child's household or family.**

The ACE Study constructed a "score" by which to analyze the findings. A person experiencing none of the 10 adverse experiences during their childhood was assigned an ACE score of 0; a person experiencing any 4 adverse experiences during their childhood was assigned an ACE score of 4; and so on.

The ACE Study concluded that adverse childhood experiences are much more common than recognized or acknowledged. Only about one-third of the average, middle-class population studied had a childhood free from adverse childhood experience. One in eight suffered through four or more adverse experiences during their childhood.

The findings affirm the long-held belief that risk factors do not occur in isolation, but are interrelated and appear in clusters. If a child lives in a home where domestic abuse occurs, for example, it is likely that additional dysfunctional household members live with the child or the child is also a victim of abuse or neglect. In fact, the ACE Study found that given an exposure to one adverse childhood experience, there is an 80% likelihood of exposure to another. This suggests that studying each risk factor separately could lead to a limited understanding of the true burdens carried by children into their adult lives.

| number of adverse childhood experiences (ACE score) | women | men | total |
|---|---|---|---|
| 0 | 34.5% | 38.0% | 36.1% |
| 1 | 24.5% | 27.9% | 26.0% |
| 2 | 15.5% | 16.4% | 15.9% |
| 3 | 10.3% | 8.6% | 9.5% |
| 4 or more (up to 10) | 15.2% | 9.2% | 12.5% |

## adverse childhood experience (ACE)

| ACE Category | Definition for Inquiry into Childhood Experience |
|---|---|
| **Child Maltreatment** | |
| Emotional Abuse | Often or very often a parent or other adult in the household swore at you, insulted you, or put you down and/or sometimes, often or very often acted in a way that made you think you might be physically hurt. |
| Physical Abuse | Sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at you and/or ever hit so hard that you had marks or were injured. |
| Sexual Abuse | An adult or person at least 5 years older ever touched you or fondled you in a sexual way, and/or had you touch their body in a sexual way, and/or attempted oral, anal, or vaginal intercourse with you and/or actually had oral, anal, or vaginal intercourse with you. |
| Emotional Neglect | Emotional neglect was defined using scale scores that represent moderate to extreme exposure on the Emotional Neglect subscale of the Childhood Trauma Questionnaire (CTQ) short form. Respondents were asked whether their family made them feel special, loved, and if their family was a source of strength, support, and protection. |
| Physical Neglect | Physical neglect was defined using scale scores that represent moderate to extreme exposure on the Physical Neglect subscale of the Childhood Trauma Questionnaire (CTQ) short form. Respondents were asked whether there was enough to eat, if their parents' drinking interfered with their care, if they ever wore dirty clothes, and if there was someone to take them to the doctor. |
| **Household or Family Dysfunction** | |
| Mother Treated Violently | Your mother or stepmother was sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at her and/or sometimes, often, or very often kicked, bitten, hit with fist, or hit with something hard, and/or ever repeatedly hit over at least a few minutes and/or ever threatened or hurt by a knife or gun. |
| Household Substance Abuse | Lived with anyone who was a problem drinker or alcoholic and/or lived with anyone who used street drugs. |
| Household Mental Illness | A household member was depressed or mentally ill and/or a member attempted suicide. |
| Parental Separation or Divorce | Parents were ever separated or divorced |
| Incarcerated Household Member | A household member went to prison. |

## adverse childhood experience (ACE) study findings

**Physical abuse was the most prevalent adverse childhood experience reported, having an incarcerated household member the least. Gender differences surfaced. For child maltreatment ACEs, boys were more often exposed to physical abuse and physical neglect, and girls more often exposed to emotional abuse, emotional neglect and sexual abuse. Girls were more commonly exposed to any one of the five household/ family dysfunction ACEs (mother treated violently, household substance abuse, household mental illness, parental separation or divorce, and incarcerated household member.)**

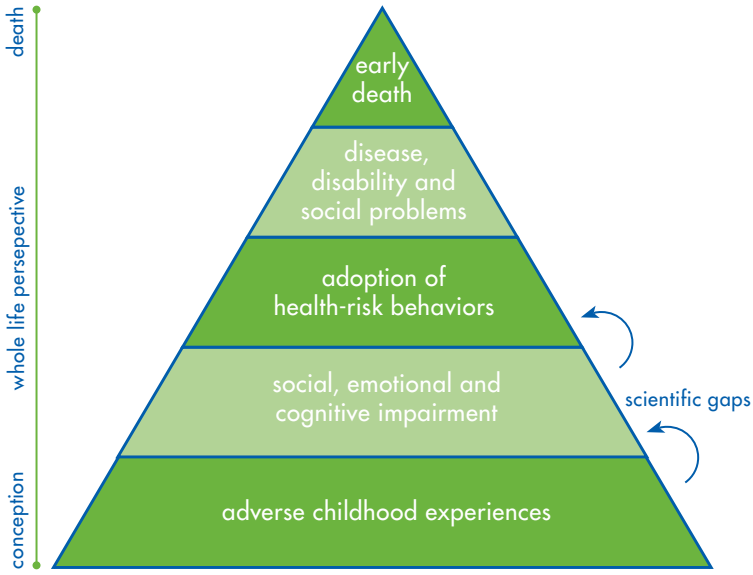
| adverse childhood experience (ACE) | women (n = 9.367) | men (n = 7,970) | total (n = 17,337) |
|---|---|---|---|
| emotional abuse | 13.1% | 7.6% | 10.6% |
| physical abuse | 27.0% | 29.9% | 28.3% |
| sexual abuse | 24.7% | 16.0% | 20.7% |
| emotional neglect | 16.7% | 12.4% | 14.8% |
| physical neglect | 9.2% | 10.7% | 9.9% |
| mother treated violently | 13.7% | 11.5% | 12.7% |
| household substance abuse | 29.5% | 23.8% | 26.9% |
| household mental illness | 23.3% | 14.8% | 19.4% |
| parental separation or divorce | 24.5% | 21.8% | 23.3% |
| incarcerated household member | 5.2% | 4.1% | 4.7% |

Adverse childhood experiences have a powerful relationship to adult health status half a century later. The ACE Study draws an unsettling connection between adverse childhood experiences and a myriad of risky adult behaviors (alcoholism, drug abuse, suicide attempts, smoking, multiple sex partners, physical inactivity, severe obesity, and so on). The greater the number of harmful experiences suffered by a child, the higher the likelihood that the child will adopt any one or several of these risk behaviors as a means to cope with or cover their pain.

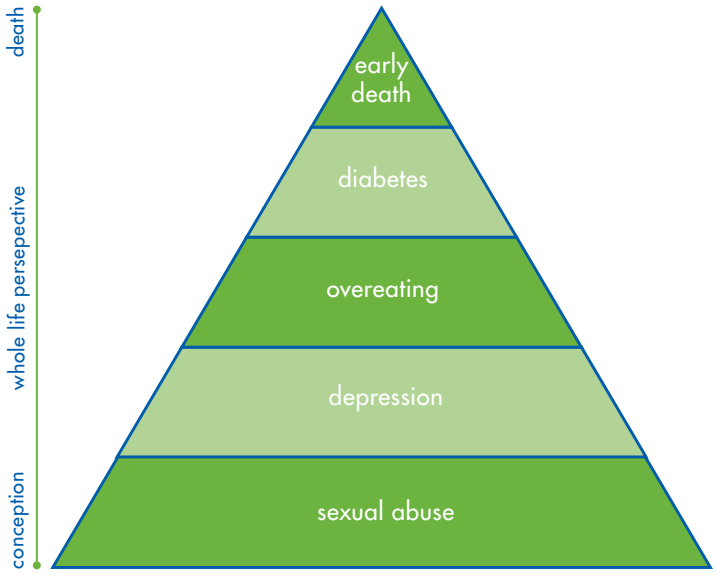
In adulthood, the resulting behaviors directly link to the chronic diseases that are the most common causes of death and disability in Oklahoma, including heart disease, cancer, stroke, diabetes and mental illness. These findings suggest that the impact of adverse childhood experiences on adult health status is strong and cumulative, making ACEs a leading cause of morbidity and mortality in adult life.

The following twin ACE Pyramids juxtapose the conceptual framework with an example drawn from the finding of the ACE Study.

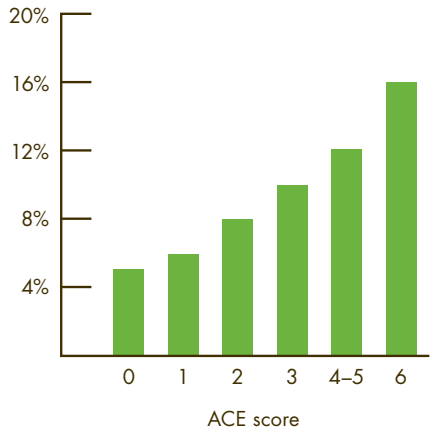
### ACE Pyramid: Conceptual Framework



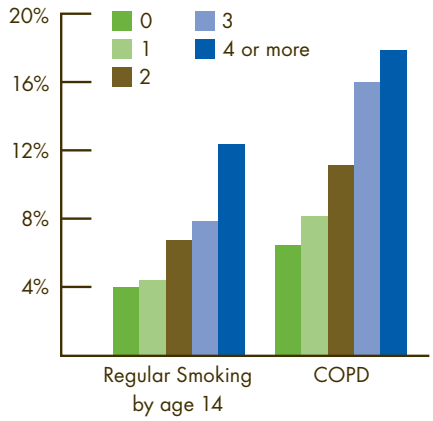

### ACE Pyramid: Real Life Scenario



## ACEs & current smoking




## ACEs, smoking & COPD




## adverse childhood experience (ACE) study implications

Traditionally, a risk behavior is linked with its resulting consequence. Common pairings include tobacco use with lung cancer, non-use of seat belts with motor vehicle deaths, and lack of physical activity with stroke. The public health response has been to educate the public to change their behaviors – to quit smoking, wear seat belts, and get moving.

The ACE Study indicates that what is commonly viewed as a problem behavior may instead be a solution behavior for a person trying to comfort themselves and cope with childhood trauma. Providing a single illustration, the ACE Study found a direct and graded association between the number of ACEs in a person's history, tobacco use, and onset of chronic obstructive pulmonary disease (COPD).

For years, public health campaigns have attempted to reduce smoking by asking people to change their behaviors. The ACE Study suggests that efforts to reduce smoking will not be successful without first understanding and dealing with the underlying reason for such behavior — adverse childhood experience. This requires a different kind of response from the medical, public health and social sciences communities.

## conclusion: the complexities of adverse childhood experience (ACE)

**The 2006–2007 Oklahoma KIDS COUNT Factbook highlights the fate of children who are traumatized and exposed to family dysfunction. Oklahoma and its communities clearly face momentous and expensive challenges when decades later these very children become ill or die prematurely.**

**For most Oklahoma children time heals nothing. Compassion, understanding and commitment are required to improve their futures and Oklahoma's.**

**To begin the process of understanding, watch for and read the series of issue briefs created by the Oklahoma Institute for Child Advocacy (OICA) in conjunction with this 2006–2007 Oklahoma KIDS COUNT Factbook.**

***Findings and Overview of the Adverse Childhood Experience (ACE) Study***

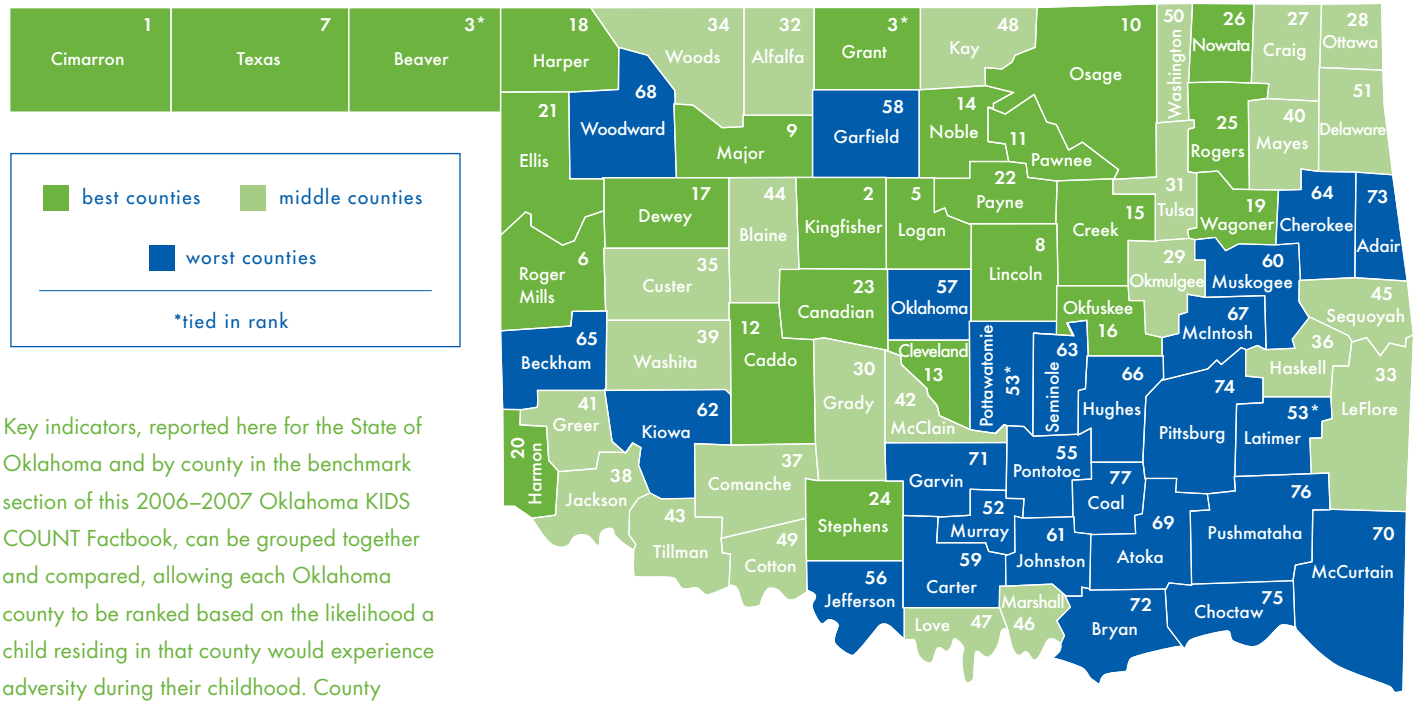
***Child Maltreatment ACEs,*** Covering Emotional Abuse, Physical Abuse, Sexual Abuse, Emotional Neglect and Physical Neglect of Oklahoma Children

***Violence Against Mothers ACE,*** Covering Domestic Violence Witnessed by Oklahoma Children

***Mental Illness & Substance Abuse ACEs,*** Covering Oklahoma Children Living in Households in which a Member is Mentally-Ill, Abuses Drugs or Alcohol or is Suicidal

***Absent Family ACEs,*** Covering Oklahoma Children With Family Members Absent as a Result of Parental Separation, Divorce or Incarceration

## ranking of county adverse childhood experience indicators oklahoma counties, 2002–2005




Key indicators, reported here for the State of Oklahoma and by county in the benchmark section of this 2006–2007 Oklahoma KIDS COUNT Factbook, can be grouped together and compared, allowing each Oklahoma county to be ranked based on the likelihood a child residing in that county would experience adversity during their childhood. County indicators are weighted to replicate the relative importance of each type of adverse childhood experience in the CDC-KP ACE Study. The worse the county rank, the more likely children living there will accumulate ACEs. One half of each county's ACE Index is comprised of indicators measuring Child Maltreatment (confirmed child abuse and confirmed child neglect). The other half of each county's ACE Index is comprised of indicators measuring Household or Family Dysfunction (divorce, index crime, psychological distress, substance abuse and protective orders). Based on these indicators, Cimarron County is best, Coal County is worst.

# oklahoma's economic clusters & state benchmark indicators

# oklahoma's economic clusters

The 2006–2007 Oklahoma KIDS COUNT Factbook again divides Oklahoma's 77 counties into five clusters with similar conditions based on four economic factors:

***Child Poverty Rates*** (2003 US Census)—the best measure of the presence of very poor children in a community

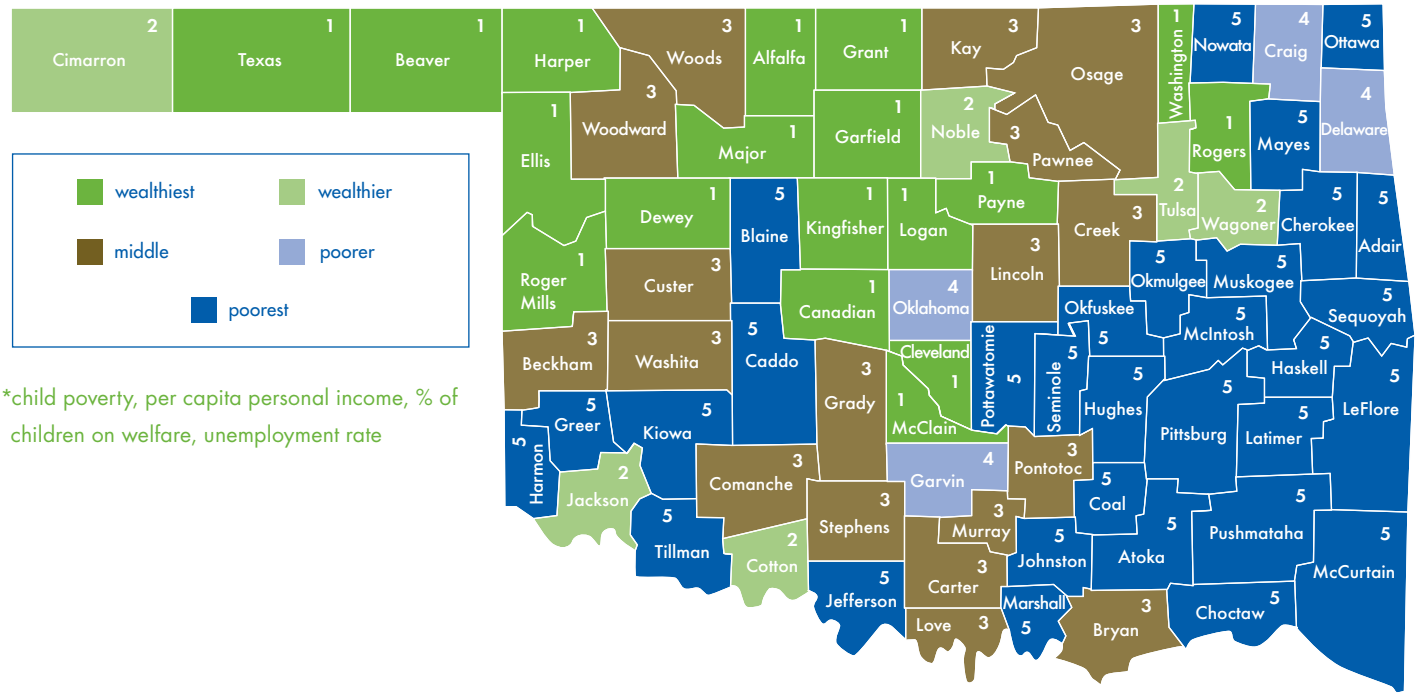
***Per Capita Personal Income*** (2002–2004 Average Annual)—the most current measure of income levels of people in a community

***Percent of Children Receiving Temporary Assistance to Needy Families (TANF)*** (FY2003–FY2005 Average Annual)—the most current measure of children required to survive on inadequate resources

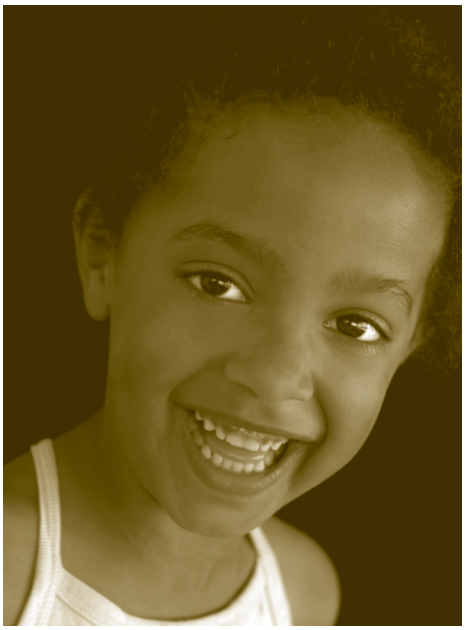
***Unemployment Rates*** (2002–2004 Average Annual)—the best measure of people's ability to improve economic conditions through work

Taken together, these factors provide a comprehensive picture of a county's economic status in a manner which can be ranked, grouped into clusters, updated and tracked from year to year. Each county is ranked on each of the four factors. The four individual county rankings are combined into an "Economic Index" in which the lower the number, the wealthier the county. Each county is ranked again according to its "Economic Index" and grouped into one of five economic clusters: wealthiest, wealthier,

## county economic index: rankings of various economic factors*, 2002–2004 (fy2003–fy2005)




*child poverty, per capita personal income, % of children on welfare, unemployment rate



middle, poorer or poorest. Changes in local economic conditions resulted in placing several Oklahoma counties in a different cluster than in prior years. Each cluster is composed of approximately twenty percent (20%) of the state's population.

These five clusters continue to illustrate the diverse economic environments in which Oklahoma children live. Oklahoma's wealthiest counties remain primarily concentrated in the northwestern corner of the state, with a few adjacent to Oklahoma's two largest urban counties (Oklahoma and Tulsa). The poorest counties remain primarily concentrated in the southeastern corner, with substantial numbers found in the southwest and the northeast.

Similar to past years, the profiles of the five clusters reveal clear patterns in Oklahoma's economic landscape. Twice the number of children live in poverty in Oklahoma's 31 poorest counties than do in the state's 18 wealthiest counties. Children in Oklahoma's poorest counties are twice as likely to be on welfare. Incomes are the lowest, unemployment rates are the highest, and economic distress is entrenched in these poorest, mostly rural Oklahoma counties.

The cluster of Oklahoma's 18 wealthiest counties has the best indicators for ten of

## comparing profiles: oklahoma's economic clusters

| | All Counties | Cluster 1<br>Wealthiest Counties |
|---|---|---|
| Total Population (2004) | 3,523,553 | 711,174 (20.2%) |
| Child Population (2004) | 859,870 | 162,072 (18.8%) |
| Number of Counties | 77 (100.0%) | 18 (23.4%) |
| Percent of Child Population Residing in Metropolitan Counties | 64.6% | 66.4% |
| Percent of Child Population Residing in Mid-Size Counties | 14.1% | 23.0% |
| Percent of Child Population Residing in Rural Counties | 21.3% | 10.6% |
| Number and Percent of Children Living in Poverty (2003) | 181,398 (21.1%) | 24,944 (15.3%) |
| Average of County Per Capita Incomes (2002–2004) | $26,832 | $25,409 |
| Average Monthly Number and Percent of Children Receiving TANF (FY2003–FY2005) | 26,074 (3.0%) | 2,575 (1.6%) |
| Average of County Unemployment Rates (2002–2004) | 5.1 | 3.4 |
| Average Annual Percent of Low Birthweight Babies, < 5 1/2 lbs (2002–2004) | 7.9% | 7.0% |
| Average Annual Percent of Very Low Birthweight Babies, < 3 lbs, 5 oz (2002–2004) | 1.2% | 1.0% |
| Average Annual Rate of Births to Young Teen Girls ages 15–17 (2002–2004) | 29.4/1,000 young teen girls | 18.3/1,000 young teen girls |
| Average Annual Rate of Births to Older Teens ages 18–19 (2002–2004) | 94.5/1,000 older teen girls | 56.0/1,000 older teen girls |
| Average Annual Rate of Births to Teens ages 15–19 (2002–2004) | 56.3/1,000 teen girls | 35.7/1,000 teen girls |
| Average Annual Rate of Child Abuse/Neglect Confirmations (FY2003–FY2005) | 14.7/1,000 children | 12.1/1,000 children |
| Average Annual High School Dropout Rate (SY2002/2003–2004/2005) | 3.5% | 2.8% |
| Average Annual Violent Crime Arrest Rate of Youth ages 10–17 (2002–2004) | 218.3/100,000 youth | 100.2/100,000 youth |
| Average Annual Rate of Infant Mortality (2002–2004) | 7.9/1,000 births | 6.9/1,000 births |
| Average Annual Death Rate among Children ages 1–14 (2001–2003) | 26.2/100,000 children | 23.3/100,000 children |
| Average Annual Death Rate among Teens ages 15–19 (2001–2003) | 81.0/100,000 teens | 66.0/100,000 teens |
| Average Annual Death Rate among Children & Teens ages 1–19 (2001–2003) | 41.4/100,000 youth | 36.4/100,000 youth |
| Average of County ACE (Adverse Childhood Experience) Indexes | 34.7 | 23.0 |