

**THE STATUS OF WOMEN AND GIRLS IN DALLAS COUNTY  
LITERATURE REVIEW AND DATA EXTRACTION**

Prepared by: Elizabeth Fawcett

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School of Community Service

University of North Texas

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## Table of Content

Section	Section Title	Page
	Table of Content .....	i
	Table of Tables .....	ii
I.	Introduction.....	1
II.	General Studies of the Status of Women in Texas	
	A. The Senior Way 2001 .....	2
	B. The Best Cities for Women 2002.....	4
III.	Studies of the Health of Women and Girls in Dallas County	
	A. 2001 Dallas County Health Checkup.....	7
	B. Dallas Area Health Care Use: Study of Insured, Uninsured, and Medicaid Enrolled Children .....	21
IV.	Studies of Child and Teen Issues in Dallas County	
	A. Beyond ABC: Growing Up in Dallas County – Assessing Our Children’s Quality of Life, 2002 .....	38
	B. A Report on Teen Pregnancy, December 1999 .....	47
	C. We’re Bored, Not Bad – Conclusions and Recommendations From the “Teens Speak Out” Study.....	50
	D. Developmental Assets: A Profile of Your Youth – Dallas Public Schools .....	52

## Table of Tables

No.	Table Title	Page
1.	Service areas and their zip codes .....	8
2.	Demographics by service area: 2000 Census total population, racial/ethnic diversity of general population, and female population by age group.....	10
3.	Top ten age adjusted causes of death of women in Dallas county by service area.....	11
4.	Women’s health statistics: Female population age (15-44), birth rate, percent births to teens, percent low birth weight, and infant mortality rate.....	14
5.	Demographic characteristics.....	23
6.	Income profile of demographic characteristics.....	25
7.	Area profile of demographic characteristics.....	26
8.	Percent using hospital ER for non-emergent conditions.....	28
9.	Why chose hospital ER for treatment of non-emergent conditions.....	29
10.	Reasons child did not receive needed medical care.....	30
11.	Insurance status by race and age of girls who accessed First Care, June-July 1999 .....	31
12.	Usual source of sick care and usual source of well care by race and age of girls who accessed First Care, June-July 1999 .....	32
13.	Frequency which parent can get child sick care treatment and well care when desired by race and age of girls who accessed First Care, June-July 1999 .....	34
14.	Degree of difficulty experienced when trying to get child medical care by race and age of girls who accessed First Care, June-July 1999 .....	35
15.	Time in past six months that child needed medical care but didn’t get it by race and age of girls who accessed First Care, June-July 1999.....	36

## Table of Tables (cont'd)

No.	Table Title	Page
16.	Degree to which parent worries about having enough money to pay for child's medical care and about getting child's medical care by race and age of girls who accessed First Care, June-July 1999 .....	37
17.	Selected health indicators for quality of life measures of Dallas children .....	39
18.	Selected economic security indicators for quality of life measures of Dallas children .....	41
19.	Selected education indicators for quality of life measures of Dallas children.....	43
20.	Percentage students in Dallas County public school districts who are at risk of not being successful .....	43
21.	Selected safety indicators for quality of life measures of Dallas children.....	45
22.	Identified service gaps regarding teen pregnancy in Dallas County and recommended actions.....	49
23.	Recommendations to improve pregnancy prevention programs for teens in Dallas .....	51
24.	Percent of boys and girls in Dallas public schools reporting each of the 20 external assets .....	53
25.	Percent of boys and girls in Dallas public schools reporting each of the 20 internal assets.....	54

## **I. Introduction**

The purpose of this research project is to assess the needs of women and girls in Dallas County, Texas. This document summarizes recent research that focuses on Dallas County and/or Texas that is relevant to the research at hand.

Primary areas of interest were defined by the Dallas Women's Foundation as: Economic, Health Housing, Abuse/Safety, Justice System/Legal Issues, Support Systems, Transportation, Childcare, Education, Family, Special Populations, Older Women, and Women's Achievements. Studies summarized in this report reflect many of these areas.

This report is organized by study. It begins with general studies of the status of residents of Texas and Dallas County. Next are studies of health and health care for adults and children in Dallas County. Finally, studies about child and teen issues are summarized. A short summary of each study is provided with many of the findings and conclusions in table form. In instances where original study data were able to be broken down by sex, data on females is presented.

## **II. General Studies of the Status of Women in Texas**

### **A. The Senior Way 2001, (19 December 2001). Community Assessment 2001—Dallas County (Draft), United Way of Metropolitan Dallas, Inc.**

The United Way of Metropolitan Dallas, Inc., conducted a needs assessment for senior citizens (age 60 and over) in Dallas County in 2001. Data were derived from various sources, including the 2000 U.S. Census, The Texas Department on Aging, the Dallas Urban League, United Way CISTR Data, United Way 2000 Needs Assessment, and Texas Department of Protective and Regulatory Services. The complete community needs assessment, which includes the needs of other groups, is expected to be available on the United Way web site, [www.unitedwaydallas.org](http://www.unitedwaydallas.org), in 2002.

The United Way reports that the senior (age 60 and over) population is expected to double by 2020. Currently there are just under 150,000 seniors age 65 to 85 in Dallas County. There are about 20,000 seniors over 85. The United Way projects that by 2020 over 350,000 residents of Dallas County will be between 65 and 85 years of age. About 50,000 seniors aged over age 85 will also reside in Dallas County. Currently, “a preponderance of seniors live north of Interstate Highway 30 in north and east Dallas. However, there appear to be greater concentrations of lower income seniors among those living in southern Dallas County” (p.7).

Current and future senior citizens of Dallas County, especially minorities and women, are expected to require greater community resources than are currently available. The average life expectancy is greater for women than for men; therefore, there are more senior women than men in Dallas County. As age increases, chronic disease and disability increases. Arthritis, Alzheimer’s disease, osteoporosis, chronic disability, and sedentary lifestyles are health problems that affect the functioning of seniors. In 2000, 116,826 people aged 60 and over in

Dallas County suffered from arthritis, and 32,900 people aged 60 and over had osteoporosis.

The prevalence of arthritis and osteoporosis increase with age. Both diseases disproportionately affect women. Of people aged 60 and older in Dallas County, 10.6 percent have Alzheimer's disease. Of Dallas County seniors aged 85 and older, approximately 50 percent suffer with Alzheimer's. The needs for home health assistance, mental health care, and daily living assistance, including meal preparation or delivery can be expected to increase in the next 20 years in Dallas County.

Aged minorities and unmarried women, especially the oldest, are more likely to live in poverty than non-minority males. Currently, "1 of every 11 seniors in Dallas County lives in poverty" (p.12). The need for greater economic assistance for livelihood and home repair, as well as the need for greater employment opportunity for able seniors is expected to increase in the next 20 years.

The United Way's stated priorities for meeting the needs of the seniors of Dallas County are to:

- \* increase accessibility to existing community services.
- \* increase efforts to help the well elderly be involved in the community and sustain good health and financial well being.
- \* expand the following services: nutritional services; physical health, hospice, and home care services; mental health services; nursing home ombudsmen services; and prescription drug accessibility
- \* promote programs that utilize volunteers.
- \* encourage and support efforts to maintain elderly in the least restricted environment (p. 5).

**B. The Best Cities for Women 2002**  
Produced by Margot Gilman  
Ladies Home Journal, April 2002

The Ladies Home Journal (LHJ) listed 57 of the nation's largest cities (population over 300,000) and 143 of the smaller cities and ranked all 200 of them according to which ones were the best for women. Using Fast Forward, a demographic tracking firm in Oregon, LHJ examined crime rates, educational achievements, child-care quality, and the presence of women in local government. Other lifestyle factors such as commuting times and divorce rates were also examined. LHJ assessed the quality of health care coverage based on the likelihood that residents would receive dental care, suffer from high blood pressure or high cholesterol, develop asthma, or contract a cold. Finally, LHJ examined the availability of well-paying jobs and business opportunities for women.

Dallas County was well represented in their rankings. Below are a list of cities within Dallas County that made the ranks of LHJ's best cities for women. The cities are listed with their ranking from 1 to 200, with the best cities having lower number ranks.

**Best Big Cities:**

#44 Dallas

Overall rankings for selected categories:      Women professionals #173  
Educational attainment #58  
Breast cancer #11  
Divorce rate #54

**Best Small Cities**

#9 Plano

Overall rankings for selected categories:      Women professionals #178  
Educational attainment #4  
Breast cancer #7  
Divorce rate #18

#23 Garland

Overall rankings for selected categories:

Women professionals #181  
Educational attainment #71  
Breast cancer #61  
Divorce rate #98

#54 Mesquite

Overall rankings for selected categories:

Women professionals #176  
Educational attainment #100  
Breast cancer #76  
Divorce rate #142

#78 Irving

Overall rankings for selected categories:

Women professionals #166  
Educational attainment #57  
Breast cancer #75  
Divorce rate #159

Cities with low rates of violent crimes, crimes against property and rape.

#12 Plano

#15 Mesquite

#16 Garland

#37 Irving

#172 Dallas

Cities that are healthy – Ranked according to measures of women’s health behaviors such as smoking, exercising, getting Pap smears, health care accessibility, and disease incidence.

#48 Plano

#143 Irving

#150 Dallas

#151 Mesquite

#164 Garland

Cities with high rates of high school graduation, greater spending per pupil, low student/teacher ratio, and high educational attainment for women.

#13 Plano

#86 Irving

#89 Garland

#90 Dallas

#102 Mesquite

Cities with good economies – Measured by recent job growth, cost of living, unemployment rates, family income, and home values.

- #7 Plano
- #8 Mesquite
- #9 Garland
- #36 Irving
- #106 Dallas

Cities which held good jobs for women – Measured by number of women professionals in the community, female managers, sexual harassment and discrimination cases, salary gap between men and women, and number of women-owned businesses.

- #69 Garland
- #106 Plano
- #136 Mesquite
- #140 Irving
- #153 Dallas

Cities that ranked highly in the lifestyle category had favorable measures for culture, climate, commute time, air and water quality, voting percentages, marriage-divorce ratio, divorce rate, number of single men compared to single women, weather factors affecting women's hair and skin, and number of toilets.

- #3 Plano
- #96 Garland
- #122 Dallas
- #135 Irving
- #143 Mesquite

Cities where child care is easily accessible.

- #59 Plano
- #70 Dallas
- #72 Garland
- #138 Irving
- #185 Mesquite

### **III. Studies of the Health of Women and Girls in Dallas County**

#### **A. 2001 Dallas County Health Checkup**

S. Sue Pickens, M.Ed., Timothy Swanson, Michelle Kelleher Tietz, MBA  
Parkland Health & Hospital System, Department of Strategic Planning and Population  
Medicine

The 2001 Dallas County Health Checkup is an evaluation of Dallas County residents' health consisting of data drawn from local, state, and federal sources. Sources include Dallas County vital statistics as well as reportable illnesses, 2000 U.S. Census Data, and eight community surveys and reports (Community Assessment: Focus on Health, Greater Dallas, 1999; Beyond ABC: Growing Up in Dallas County; 1998 Parkland COPC Community Health Status Survey; two (2) Behavioral Risk Factor Surveillance System, Dallas County 1998 and 1998-2000; NRC 2001 Healthcare Market Guide; Dallas/Ft. Worth Hispanic Consumer Survey, 2000; and two (2) sets of Diabetes target Focus Groups).

Sue Pickens, M.Ed., and other staff of Parkland Health & Hospital System's Department of Strategic Planning and Population Medicine provided data on key health indicators for women in each of Dallas County's service areas for the Dallas Women's Foundation. Table 1 shows the zip codes that comprise each of the twelve service areas. The service areas are: Grand Prairie, Stemmons Corridor, Irving, Mesquite/Garland/Rowlett, Northern Corridor, Vickery, Northwest Oak Cliff, Southeast Dallas, South Dallas, West Dallas, South Oak Cliff, and East Dallas.

According to the 2000 Census, the total population of Dallas County is 2,218,898. Women make up approximately 50 percent of Dallas County's population. Women make up greater than 50 percent of the population in the age groups (45-64) and (65+). Dallas County is racially/ethnically diverse. Whites represent 44.3 percent of Dallas County's population. Hispanics make up 29.9 percent. African Americans comprise 20.1 percent. Asians make up 3.9

percent. American Indians are 0.4 percent of the population. One-and-three-tenths percent of the population of Dallas County consists of those who are of two or more races. Finally, 0.1 percent are identified as “Other”.

**Table 1. Service areas and their zip codes.**

<b>SERVICE AREA</b>	<b>ZIP CODES</b>
<b>Grand Prairie</b>	75050, 75051, 75052
<b>Stemmons Corridor</b>	75201, 75202, 75207, 75208, 75219, 75220, 75229, 75235, 75247
<b>Irving</b>	75001, 75063, 75006, 75015, 75019, 75038, 75039, 75060, 75061, 75062, 75234, 75261
<b>Mesquite/Garland/Rowlett</b>	75040, 75041, 75042, 75043, 75044, 75048, 75150, 75182, 75088
<b>Northern Corridor</b>	75080, 75081, 75205, 75225, 75230, 75240, 75244, 75248, 75251
<b>Vickery</b>	75231, 75238, 75243
<b>Northwest Oak Cliff</b>	75104, 75106, 75115, 75118, 75123, 75137, 75138, 75208, 75211, 75233, 75236, 75237, 75238, 75249
<b>Southeast Dallas</b>	75141, 75149, 75159, 75172, 75180, 75181, 75217, 75253
<b>South Dallas</b>	75210, 75215
<b>West Dallas</b>	75212
<b>South Oak Cliff</b>	75134, 75146, 75203, 75216, 75224, 75232, 75239, 75241
<b>East Dallas</b>	75204, 75206, 75214, 75218, 75223, 75226, 75228, 75246

Table 2 illustrates the demographic characteristics of each service area. It shows the total population from the 2000 Census, the racial/ethnic diversity, and the number of females, broken down by age group, in each service area. The Mesquite/Garland/Rowlett service area is the most populous, with a 2000 Census population count of 322,179, followed by Irving, with a population of 296,640, and then Northwest Oak Cliff with a population of 261,970.

Service areas with the highest percentages of pre-school and school aged children are Grand Prairie, South Dallas, South Oak Cliff, and West Dallas. The Northern Corridor, South Oak Cliff, South Dallas, and East Dallas have large older adult (65+) populations. East Dallas

and Vickery have a large percentage of working age adults, whereas South Dallas and West Dallas have fewer than average working age adult populations.

Northwest Oak Cliff and Southeast Dallas are the county's most ethnically diverse areas, with Whites, African Americans, and Hispanics each making up roughly a third of the population. South Dallas and South Oak Cliff are predominantly African American. Stemmons Corridor and West Dallas have the largest Hispanic populations in the county. Irving has a comparatively large Asian population.

Table 3 lists the top ten age-adjusted mortality rates for women in each service area. These numbers tell how many deaths were the result of the specified cause of death per 100,000 female deaths in 2000. They are age-adjusted in order to remove the effects that unequal distributions of age within the service area populations cause. Heart disease, cancer, and stroke are the leading causes of death for women in all the Dallas County service areas, as they are the top 3 causes of death for the Dallas County population as a whole, Texas, and the United States. Flu/pneumonia, diabetes, chronic obstructive pulmonary disease (COPD), and septicemia are also common causes of death for women. The significance of other leading causes of women's deaths such as HIV/AIDS, cirrhosis of the liver, homicide, suicide, and accidents varies among the service areas.

**Table 2. Demographics by service area: 2000 Census total population, racial/ethnic diversity of general population, and female population by age group.**

SERVICE AREA	2000 CENSUS TOTAL POPULATION	GENERAL POPULATION DIVERSITY							FEMALE POPULATION BY AGE GROUP			
		White	Hispanic	African American	Asian	American Indian	Two or more races	Other	0-4: infant/preschool age	5-17: school age	18-64: working age	65+: seniors
Grand Prairie	103,605	46.2%	35.9%	11.8%	4.0%	0.6%	1.4%	0.2%	4,427	10,734	32,102	3,310
Stemmons Corridor	150,288	35.7%	50.8%	9.8%	2.4%	0.3%	0.8%	0.1%	5,411	12,530	42,984	9,481
Irving	296,640	53.1%	29.1%	7.5%	8.1%	0.4%	1.5%	0.2%	11,232	26,407	99,184	12,256
Mesquite/Garland/Rowlett	322,179	59.7%	21.3%	10.9%	6.0%	0.4%	1.5%	0.2%	13,018	30,992	104,877	15,315
Northern Corridor	257,645	70.0%	16.4%	5.8%	5.9%	0.3%	1.5%	0.2%	7,253	19,551	87,324	18,650
Vickery	142,887	39.4%	24.4%	28.4%	4.9%	0.3%	2.3%	0.2%	4,249	10,563	51,069	6,662
Northwest Oak Cliff	261,970	31.0%	39.3%	27.0%	1.3%	0.4%	0.9%	0.1%	11,500	27,990	80,238	13,093
Southeast Dallas	246,630	39.6%	32.0%	25.3%	1.4%	0.4%	1.1%	0.1%	11,215	26,728	74,854	13,161
South Dallas	29,037	3.7%	13.5%	81.8%	0.3%	0.1%	0.7%	0.0%	1,287	3,060	8,404	2,676
West Dallas	23,846	2.4%	62.0%	34.2%	0.0%	0.1%	0.4%	0.1%	1,167	2,608	5,889	1,081
South Oak Cliff	181,187	10.3%	25.1%	63.3%	0.3%	0.2%	0.8%	0.1%	7,607	18,695	57,486	10,794
East Dallas	205,559	46.3%	34.9%	13.2%	3.0%	0.4%	1.1%	0.1%	7,607	18,694	56,486	10,794

**Table 3. Top ten age adjusted causes of death of women in Dallas County by service area.**

<b>AGE ADJUSTED DEATH RATES, 2000 LEADING CAUSES OF DEATH FOR WOMEN (per 100,000 female deaths)</b>										
<b>SERVICE AREA</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>Grand Prairie</b>	Heart disease (237.93)	Cancer (152.86)	Stroke (68.29)	Flu/pneumonia (22.16)	COPD (21.52)	Diabetes (20.93)	Accidents (15.71)	Cirrhosis of the liver (3.61)	Homicide (3.58)	Suicide (3.32)
<b>Stemmons Corridor</b>	Heart disease (193.73)	Cancer (139.31)	Stroke (66.77)	Diabetes (28.74)	COPD (18.31)	Flu/pneumonia (10.55)	HIV/AIDS (7.16)	Septicemia (5.28)	Homicide (3.00)	Accidents (2.59)
<b>Irving</b>	Heart disease (165.32)	Cancer (130.26)	Stroke (42.51)	COPD (22.68)	Diabetes (15.20)	Flu/pneumonia (14.26)	Accidents (7.36)	Septicemia (6.78)	Suicide (4.39)	Cirrhosis of the liver (2.24)
<b>Mesquite/Garland/Rowlett</b>	Heart disease (212.94)	Cancer (147.31)	Stroke (56.56)	Flu/pneumonia (30.76)	Diabetes (26.43)	COPD (16.87)	Septicemia (13.50)	Accidents (4.50)	Suicide (3.84)	Homicide (2.94)
<b>Northern Corridor</b>	Heart disease (163.23)	Cancer (134.07)	Stroke (59.90)	Flu/pneumonia (14.25)	COPD (9.55)	Diabetes (9.36)	Septicemia (8.57)	Accidents (5.06)	Suicide (3.52)	Not reported
<b>Vickery</b>	Heart disease (163.23)	Cancer (134.07)	Stroke (75.91)	Flu/pneumonia (24.62)	COPD (23.02)	Diabetes (16.01)	Accidents (13.88)	Suicide (6.39)	Homicide (5.88)	HIV/AIDS (5.85)
<b>Northwest Oak Cliff</b>	Heart disease (250.14)	Cancer (174.57)	Stroke (68.99)	Diabetes (32.21)	Flu/pneumonia (24.99)	COPD (18.53)	Accidents (10.66)	Septicemia (10.14)	Homicide (4.47)	Cirrhosis of the liver (4.30)
<b>Southeast Dallas</b>	Heart disease (313.10)	Cancer (195.52)	Stroke (75.91)	Diabetes (36.32)	Septicemia (26.77)	Flu/pneumonia (26.05)	COPD (24.69)	Accidents (10.23)	Cirrhosis of the liver (6.43)	Suicide (5.26)
<b>South Dallas</b>	Heart disease (490.19)	Cancer (195.52)	Stroke (68.00)	Diabetes (54.23)	COPD (51.11)	Septicemia (43.54)	Flu/pneumonia (15.75)	HIV/AIDS (15.12)	Homicide (12.98)	Cirrhosis of the liver (7.62)
<b>West Dallas</b>	Heart disease (349.15)	Cancer (348.44)	Stroke (76.59)	COPD (66.18)	Diabetes (52.84)	Accidents (19.03)	Homicide (16.52)	Flu/pneumonia (13.59)	Septicemia (13.59)	Suicide (8.70)
<b>South Oak Cliff</b>	Heart disease (321.27)	Cancer (202.57)	Stroke (72.68)	Diabetes (39.85)	COPD (25.88)	Flu/pneumonia (20.04)	HIV/AIDS (10.85)	Septicemia (9.61)	Homicide (9.54)	Accidents (7.79)
<b>East Dallas</b>	Heart disease (206.87)	Cancer (182.35)	Stroke (60.14)	Flu/pneumonia (23.24)	COPD (20.96)	Diabetes (14.75)	Accidents (13.69)	Septicemia (12.34)	Homicide (5.13)	Cirrhosis of the liver (2.00)

Table 4 illustrates indicators of women's health including natality, percent births to teens under 18 years of age, percent babies born with low birth weight (LBW), and infant mortality rate (IMR). Birth rates are dependent upon the number of women in the population aged 15-44, so the 2000 Census count of number of women aged 15-44 is included in the table. Note that the birth rate in West Dallas is very high (98.8) as a result of a small population at risk of giving birth (4,833). The county average is 84.5 births per 1,000 females aged 15-44 from 1990-1999.

Teen pregnancy has been cited as a major problem in other studies of Dallas County. South Dallas has the highest percentage of births to teens in Dallas County (16.2 percent) followed by West Dallas (13.6 percent). These figures are much higher than the county average of 5.72 percent in 1999.

Low birth weight (LBW) means a baby was born at a weight less than 2500 grams or less than 5.9 pounds. It is often associated with premature birth, poor nutritional status of the mother, multiple births, and maternal age under 20 or over 40. LBW puts the infant at risk of death soon after birth, serious health problems, and physical or mental disability. The county's percentage of LBW babies was 7.8 percent in 1999. The South Dallas, West Dallas, and South Oak Cliff service areas had percentages of LBW babies born in 2000 much higher than the county average. South Dallas had 12.8 percent births to LBW babies. West Dallas had 12.4 percent, and South Oak Cliff had 9.8 percent.

Infant mortality rate (IMR) is traditionally considered to be of great significance to public health. A high IMR is believed to be indicative of unmet health needs and unfavorable environmental factors. Dallas County's average IMR in 1999 was 6.4 infant deaths per 1,000 live births. The South Oak Cliff and Southeast Dallas service areas had the highest infant

mortality rates in the county in 2000. South Oak Cliff had 8.8 IMR, and Southeast Dallas had 8.3 IMR.

**Table 4. Women’s health statistics: Female population age (15-44), birth rate, percent births to teens, percent low birth weight, and infant mortality rate.**

<b>SERVICE AREA</b>	<b>FEMALE POPULATION, 2000 AGE (15-44)</b>	<b>BIRTH RATE: (# births per 1,000 females age (15-44) in 1999)</b>	<b>PERCENT BIRTHS TO TEENS (AGE &lt; 18), 2000</b>	<b>PERCENT LOW BIRTH WEIGHT, 2000</b>	<b>INFANT MORTALITY RATE: (infant deaths per 1,000 live births, 1999)</b>
<b>Grand Prairie</b>	23,901	70.9	7.1%	6.5%	5.6
<b>Stemmons Corridor</b>	30,566	125.7	5.6%	7.1%	6.7
<b>Irving</b>	72,399	73.6	6.5%	7.5%	6.7
<b>Mesquite/Garland/Rowlett</b>	74,679	72.0	4.6%	6.9%	5.2
<b>Northern Corridor</b>	56,993	66.5	2.2%	7.0%	5.0
<b>Vickery</b>	37,825	85.8	3.8%	8.7%	7.7
<b>Northwest Oak Cliff</b>	59,488	89.0	8.1%	8.1%	6.1
<b>Southeast Dallas</b>	56,371	91.3	7.6%	7.9%	8.3
<b>South Dallas</b>	6,141	74.0	16.2%	12.8%	7.4
<b>West Dallas</b>	4,833	98.8	13.6%	12.4%	3.7
<b>South Oak Cliff</b>	41,386	79.0	9.7%	9.8%	8.8
<b>East Dallas</b>	41,386	89.3	7.3%	5.5%	5.4

The 2001 Community Health Checkup lists recommended programs to meet unmet health needs for the county as a whole and for each service area. Recommendations and unmet needs for the county and each service area are listed below:

### **Dallas County**

- Heart disease treatment, cholesterol, high blood pressure, and diabetes management programs that are culturally competent
- Traffic, automobile, and injury prevention programs
- HIV prevention programs
- Adult and teen alcohol and drug abuse prevention and treatment services
- Preschool and school age after school and recreational programs
- Accessible immunization programs
- Low birth weight services
- Immunizations for children
- Mental illness
- Lack of insurance
- Access to primary care
- Support at home
- Pediatric and adolescent health services
- Prenatal care services
- High risk pregnancy services
- Family planning and parenting programs
- Transportation
- Nutrition services
- Geriatric programs
- Suicide prevention
- Dental health services
- HIV/AIDS prevention
- High school retention programs
- Mental health services
- Health education and wellness

(p. II.A8).

### **Grand Prairie**

- Pediatric and adolescent health care services
- Services and activities targeted at preschool and school age children
- Prenatal care and high risk pregnancy services
- Teen pregnancy prevention programs
- Family planning and parenting programs
- HIV prevention programs
- Adult and teen alcohol and drug abuse prevention and treatment services
- Accessible immunization programs

- Public transportation
  - Heart disease prevention and treatment programs
  - Diabetes prevention, treatment, and management programs
  - Injury prevention programs
  - Suicide prevention programs
  - Accessible, affordable primary health care services
  - Motor vehicle crash prevention programs
  - Asthma treatment programs
- (p. II.B2-II.B3)

### **Stemmons Corridor**

- HIV/AIDS prevention programs
  - Responsible dating and family planning educational services
  - Prenatal and high risk pregnancy services
  - Family planning services
  - Nutrition programs
  - Primary health care services
  - Alcohol and drug abuse prevention and treatment programs for adults and teens
  - High blood pressure and diabetes management programs
  - Injury prevention programs for motor vehicle crashes
  - Violence prevention programs
  - Communicable disease and sexually transmitted diseases education and prevention programs
  - Dental programs
  - Immunization programs
  - Programs addressing the needs of the elderly
  - Prevention programs for pneumonia, flu, and respiratory ailments
  - Injury prevention programs
  - Tuberculosis prevention programs
  - Asthma chronic care treatment programs
- (p. II.C3)

### **Irving**

- Injury prevention programs
- Hypertension and diabetes education and management programs
- Responsible dating and family planning educational services
- Prenatal and high risk pregnancy services
- Heart disease prevention and management programs
- Alcohol and drug abuse prevention and treatment programs for adults and teens
- Accessible and affordable dental care for adults and children
- Preschool and school age after school and summer programs
- Affordable, accessible pediatric primary care
- Suicide prevention programs and mental health services
- Childhood immunization programs

- Affordable primary care to ensure early diagnosis of chronic conditions (p. II.D2-II.D3).

### **Mesquite/Garland Rowlett**

- Dental conditions
  - Parenting and family planning programs
  - Access to primary care
  - Traffic and accident injury prevention programs
  - Alcohol and drug abuse education for adults and teens
  - Services targeted at preschool and school age children
  - Pediatric and adolescent health care services
  - Affordable, accessible dental care programs
  - Heart disease prevention, treatment, and management programs
  - Diabetes prevention, treatment, and management programs
  - Health information services
  - High risk pregnancy programs
  - Wellness programs
  - Falls prevention and injury prevention access or insurance availability
  - High risk pregnancy programs
  - Transportation
- (p.II.E3)

### **Northern Corridor**

- Services for the elderly, i.e. nursing homes, day hospitals, home health care, senior citizen centers
  - Retirement planning
  - Family planning and parenting programs
  - Prenatal care and high risk pregnancy services
  - Immunization program for vaccine preventable diseases
  - Nutrition services
  - Selected areas require preschool and school age children's programs and summer programs for teens
  - Diabetes, cholesterol, and high blood pressure management services
  - Traffic control and motor vehicle accident injury prevention programs
  - Alcohol and drug abuse educational services
  - Mental health services
  - Falls and injury prevention
  - Adult immunizations
  - Diabetes education and management services
  - HIV/AIDS education and prevention
- (p.II.F2-II.F3)

## **Vickery**

- Family planning and parenting programs
  - Prenatal care and high risk pregnancy services
  - Nutrition services
  - Cholesterol and high blood pressure management services
  - Traffic control and motor vehicle accident injury prevention programs
  - Alcohol and drug abuse educational services
  - Preschool and school age children's programs
  - Teen alcohol and drug abuse prevention activities
  - After school programs
  - Summer programs for teens
  - Mental health services
  - Sexually transmitted disease education and prevention
  - Immunizations for adults and children
  - Injuries
  - Asthma education and prevention
  - Suicide prevention
  - Primary care services
  - Diabetes prevention and management programs
- (p.II.G3)

## **Northwest Oak Cliff**

- Programs for preschool and school age children
  - Employment opportunities for all ages
  - Job training for teenage and young adults
  - Adult literacy programs
  - Injury prevention programs including crime prevention activities
  - Nutrition programs
  - Neighborhood child watch programs
  - Primary care services
  - General health promotion
  - High school retention programs
  - Family planning and parenting programs
  - Teen pregnancy prevention programs
  - Sexually transmitted disease prevention
  - Alcohol and drug treatment, prevention, and education services for adults and teens
  - Prenatal and high risk pregnancy programs
  - Low cost, high quality day care services
- (p.II.H3)

## **Southeast Dallas**

- Pediatric health services
- Services targeted at preschool and school age children
- Prenatal care and high risk pregnancy services

- Family planning and parenting programs
  - Responsible dating and teen pregnancy prevention programs
  - Access to public transportation
  - Alcohol and drug abuse prevention and education services
  - High blood pressure and diabetes management program
  - Access to affordable dental services
  - Accessible primary care
  - Communicable disease and sexually transmitted disease control
  - Health seeking behavior improvements
  - Adult and child immunizations
  - Nutrition education
  - Lead amelioration services
- (p.II.I3)

### **South Dallas**

- Senior health services such as a PACE program
  - Senior primary care health services
  - Pediatric health services
  - Services targeted a preschool and school age children
  - Prenatal care and high risk pregnancy services
  - Family planning and parenting programs
  - High school retention programs
  - Employment opportunities
  - Alcohol and drug abuse prevention and education services
  - High blood pressure and diabetes management program
  - Accessible and affordable primary care
  - Heart disease prevention programs
  - Affordable, accessible, and quality day care programs
  - Injury prevention programs
  - Adult and child immunizations
  - Communicable and sexually transmitted disease prevention and education
  - Asthma treatment and education
  - Vaccine preventable disease programs
- (p.II.J3)

### **West Dallas**

- Preschool and day care programs
- Programs for school age children
- AIDS treatment programs
- Responsible dating and family planning educational services
- Prenatal and high risk pregnancy services
- Nutrition programs
- Accessible and affordable primary health care services
- Alcohol and drug abuse prevention and treatment programs for adults and teens

- High blood pressure and diabetes management programs
  - Teen violence prevention programs
  - High school retention programs
  - Economic and job opportunities
  - Teen pregnancy prevention
  - Transportation
  - Animal control
  - Immunizations for all ages
- (p.II.K3)

### **South Oak Cliff**

- Adult education programs
  - Senior health services such as a PACE program
  - Senior primary care health services
  - Pediatric health services
  - Services targeted at school age children
  - Prenatal care and high risk pregnancy services
  - Family planning parenting programs
  - High school retention program
  - Employment opportunities
  - Alcohol and drug abuse prevention and sex education services
  - High blood pressure and diabetes management program
  - Access to affordable dental services
  - Accessible primary care
  - Injury prevention
  - Nutrition programs
  - Communicable disease prevention programs
- (p.II.L3-II.L4)

### **East Dallas**

- Pediatric and adolescent health care services
- Services and activities targeted at high school aged children
- Prenatal care and high risk pregnancy services
- Teen pregnancy prevention programs
- Family planning and parenting programs
- HIV prevention programs
- Adult and teen alcohol and drug abuse prevention and treatment services
- Accessible immunization programs
- Public transportation
- Heart disease prevention and treatment programs
- Diabetes prevention, treatment, and management programs
- Injury prevention programs
- Suicide prevention programs
- Accessible affordable primary health care services

- Motor vehicle crash prevention programs
  - Immunization sensitive and infectious disease prevention programs
- (p.II.M2-II.M3)

**B. Dallas Area Health Care Use: Study of Insured, Uninsured, and Medicaid Enrolled Children**

Lonnie Roy, PhD.

Children's Medical Center of Dallas, Department of Planning and Business Development

In this study insurance status and use of health care services were investigated among two stratified random samples. The first sample consisted of 1,606 randomly selected households from the general population of Dallas County and selected parts of Collin and Denton Counties. It was stratified by both income level and urban/rural residence. The three income levels used for stratification were: 1) less than \$20,000; 2) at least \$20,000, but less than \$35,000; and 3) \$35,000 or more (p.53). These categories were selected because they would maximize the likelihood of selected households that included children without health insurance and those with Medicaid in order to permit statistical comparison with the groups defined in the second sample. The second sample was drawn from 612 randomly selected patients seen in Children's Medical Center of Dallas' First Care Services during the months of April and May 1999, from a list of 5,676 patients (margin of error = +/- 3.7 percent; 95 percent confidence level). This sample was stratified by insurance type. To ensure representative proportions of each payer type, produce a +/- 6 percent margin of error with a 95 percent confidence level for each payer type, and to maximize cost efficiency, these stub-strata were disproportionately sampled (p.56). Respondents were parents or guardians of children under the age of 15 years and were surveyed in telephone interviews conducted by the Survey Research Center at the University of North Texas (SRC). Data were collected from June through July 1999.

First Care is “a pediatric fast track service associated with and adjacent to Children’s emergency center. Lower acuity patients who present in the emergency center are triaged to First Care for treatment. First Care is staffed by pediatricians and pediatric physician extenders” (p.iv).

Table 5 indicates the demographic characteristics of the two samples. Of the Children’s First Care sample, only about 38 percent resided in suburban areas, compared to 76 percent of the general population sample. The greatest percentage of the general population sample had household incomes \$75,000 or greater annually (27 percent), whereas the greatest percentage of the Children’s First Care Sample had household incomes of between \$10,000 and \$19,999 annually (33 percent). The greatest percentage of the general population sample’s highest level of education attained was Bachelor-level education (24 percent), whereas the greatest percentage of the Children’s First Care Sample’s highest level of education attained was High School or GED (36 percent). The majority of both samples were married. Among the general population close to 76 percent were married, and among the Children’s First Care sample about 56 percent were married. Fifty-six percent of the general population sample was White, whereas almost 46 percent of those who accessed First Care were Hispanic. Of the general population sample, only 17 percent were uninsured. Of the First Care sample, however, 48 percent were uninsured.

**Table 5. Demographic characteristics (Weighted Data)\***

<b>Variable</b>	<b>Children's First Care Sample</b>		<b>Population Sample</b>	
<b>Total Sample</b>	<b>Count</b>	<b>Percent</b>	<b>Count</b>	<b>Percent</b>
<b>Area</b>				
Urban	378	62.4%	381	23.7%
Suburban	228	37.6%	1225	76.3%
<b>Income</b>				
<\$10,000	135	22.8%	91	5.7%
\$10-19,999	196	33.2%	192	12.0%
\$20-34,999	154	26.1%	284	17.7%
\$35-49,999	49	10.0%	307	19.1%
\$50-74,999	29	4.9%	293	18.2%
\$75,000+	18	3.0%	439	27.3%
<b>Education</b>				
<High School	161	26.3%	171	10.7%
HS or GED	223	36.4%	304	18.9%
Trade/Voc	38	6.2%	81	5.0%
Some College	119	19.4%	333	20.7%
AA	26	4.2%	119	7.4%
BA	32	5.2%	380	23.7%
Grad Educ	14	2.3%	217	13.5%
<b>Marital Status</b>				
Married	340	55.8%	1218	75.9%
Never Married	169	27.8%	155	9.7%
Divorced	44	7.2%	160	10.0%
Widowed	9	1.5%	10	0.6%
Separated	47	7.7%	61	3.8%
<b>Race</b>				
White	91	14.9%	898	56.1%
Hispanic	279	45.7%	324	20.3%
Black	225	36.9%	289	18.1%
Other	15	2.5%	89	5.6%
<b>Medical Insurance</b>				
Yes	315	51.7%	1329	82.8%
No	294	48.3%	277	17.2%
<b>Type of Insurance</b>				
Mgd Care	82	13.2%	836	52.0%
Medicaid	202	33.0%	150	9.3%
Uninsured	294	48.3%	177	17.2%
Other	3	0.5%	191	11.9%
Don't Know	19	3.0%	101	6.3%
Undeterminable	12	2.0%	52	3.2%
<b>Adults Responsible for Health Care in the Household</b>				
1	205	33.7%	565	35.6%
2	339	55.8%	973	61.3%
3+	64	10.5%	49	3.2%

**Table 5. Demographic characteristics (cont'd)**

Variable	Children's First Care Average		Population Average	
	Count	%	Count	%
<b>Total Sample</b>	612		1606	
<b>Usual Source of Sick Care</b>				
Private Physician's Office	200	32.8%	1265	79.1%
Hospital Emergency Room	163	26.7%	88	5.5%
Community /Public/Other Clinics	247	40.5%	246	15.4%
<b>Usual Source of Well Care</b>				
Private Physician's Office	209	34.7%	1260	79.2%
Hospital Emergency Room	19	3.2%	17	1.1%
Community/Public/Other Clinics	373	62.1%	313	19.7%
<b>Medical Home</b>				
Private Physician's Office	156	26.0%	1184	74.7%
Community Health Center	223	37.2%	192	12.1%
None	221	36.8%	209	13.2%
<b>Disability Present</b>				
Yes	38	6.2%	91	5.7%
No	573	93.8%	1515	94.3%
<b>Overall Health Status</b>				
Poor/Fair	72	11.8%	59	3.7%
Good	147	24.1%	209	13.0%
Very Good	163	26.7%	515	32.1%
Excellent	229	37.5%	821	51.2%
Avg No. Adults Responsible for Child's Health Care in the Home	1.81		1.68	
Avg No. Children <15 in Household	2.12		1.80	
Avg Age of Oldest Child in Household	6.20		7.97	
Avg Age of Child Included in Survey	3.24		7.10	
Avg No. Physician Visits Past 6 Months	1.77		1.53	
Avg No. Hours of Work Missed Past 6 Months to Care for Sick Child	24.22		13.47	
Avg No. of School Days/Day Care Missed Past 6 Months Due to Illness	7.14		3.40	

\*Total N's will vary because of incomplete responses

Table 6 illustrates the income profile of these demographic characteristics. It shows that those in the lowest income bracket (under \$20,000) have less access to health care relative to those in the middle income bracket (\$20,000 to \$34,999) or higher income bracket (\$35,000 or more), as measured by percentage of people within each group to have health insurance, what type of health insurance they have, where they receive their health care, and whether or not they have a medical home. It also indicates that those in the lowest income level group missed more

school or day care days (4.07), missed more hours from work (21.2), had more emergency room visits (1.78), and more physician visits (2.65) relative to the middle or higher income level groups. For all of the these categories, the Children’s First Care sample averaged higher losses and greater need for medical care than the lowest income bracket (7.14, 24.2, 1.77 and 3.06, respectively).

**Table 6. Income profile of demographic characteristics**

Variable	Income Under \$20,000		Income \$20,000 - \$34,999		Income \$35,000 or More		First Care Percent
	Count	Percent	Count	Percent	Count	Percent	
<b>Medical Insurance</b>							
Yes	162	57.0%	191	67.3%	976	94.0%	51.7%
No	122	43.0%	93	32.7%	62	06.0%	48.3%
<b>Type of Insurance</b>							
Mgd Care	51	18.0%	114	40.1%	670	64.6%	13.2%
Medicaid	87	30.7%	33	11.6%	29	2.80%	33.0%
Uninsured	122	43.1%	93	32.7%	62	6.00%	48.3%
Other	5	01.8%	20	07.0%	166	16.0%	00.5%
Don’t Know	15	5.3%	21	07.4%	65	6.30%	03.0%
Undeterminable	3	1.1%	3	01.1%	45	4.30%	02.0%
<b>Usual Source of Sick Care</b>							
Physician’s Office	132	46.6%	188	66.7%	946	91.3%	32.8%
Hospital ER	37	13.1%	28	09.9%	23	02.2%	26.7%
Community Health Center	114	40.3%	66	23.4%	67	06.5%	40.5%
<b>Usual Source of Well Care</b>							
Physician’s Office	121	43.2%	181	66.7%	958	92.9%	34.7%
Hospital ER	6	02.1%	28	09.9%	6	00.6%	03.2%
Community Health Center	153	54.6%	66	23.4%	67	06.5%	62.1%
<b>Medical Home</b>							
Physician’s Office	102	36.4%	160	57.3%	922	89.8%	25.5%
Community Health Center	102	36.4%	54	19.4%	37	03.6%	37.6%
None	76	27.1%	65	23.3%	68	06.6%	36.9%
Avg No. Physician Visits Past 6 Months (Child)							
	2.65		2.40		2.25		3.06
Avg No. Emergency Room Visits Past 6 Months (Child)							
	1.78		1.56		1.46		1.77
Avg No. Hours of Work Missed Past 6 Months to Care for Sick Child							
	21.2		14.5		11.0		24.2
Avg No. of School Days/Day Care Missed Past 6 Months Due to Illness							
	4.07		3.41		3.25		7.14
<b>Medical Home</b>							
Physician’s Office	102	36.4%	160	57.3%	922	89.8%	89.8%
Community Health Center	102	36.4%	54	19.4%	37	03.6%	03.6%
None	76	27.1%	65	23.3%	68	06.6%	06.6%

Table 7 shows these demographic characteristics in relation to whether the respondent resided in an urban or suburban area. Poverty, lower educational attainment, Hispanic ethnicity, lack of health insurance, and less access to health care with greater average number of physician visits and emergency room visits, as well as greater impact on attendance at work or school/daycare were more highly associated with urban residency than with suburban residency.

**Table 7. Area profile of demographic characteristics**

Variable	Urban		Suburban		First Care Percent
	Count	Percent	Count	Percent	
<b>Income</b>					
<\$10,000	46	12.1%	45	03.7%	22.8%
\$10-19,999	77	20.3%	115	09.4%	33.2%
\$20-34,999	91	24.0%	192	15.7%	26.1%
\$35-49,999	91	24.0%	216	17.6%	10.0%
\$50-74,999	41	10.8%	252	20.6%	04.9%
\$75,000+	33	08.7%	405	33.1%	03.0%
<b>Education</b>					
<High School	78	20.5%	93	07.6%	26.3%
HS or GED	104	27.4%	199	16.2%	36.4%
Trade/Voc	28	07.4%	53	04.3%	06.2%
Some College	84	22.1%	249	20.3%	19.4%
AA	24	06.3%	95	07.8%	04.2%
BA	39	10.3%	342	27.9%	05.2%
Grad Educ	23	06.1%	194	15.8%	02.3%
<b>Marital Status</b>					
Married	249	65.5%	969	79.2%	55.8%
Not Married	131	34.5%	255	20.8%	27.8%
<b>Race</b>					
White	92	24.3%	806	66.0%	14.9%
Hispanic	146	38.5%	178	14.6%	45.7%
Black	125	33.0%	164	13.4%	36.9%
Other	16	04.2%	73	05.6%	02.5%
<b>Medical Insurance</b>					
Yes	278	73.0%	1052	85.9%	51.7%
No	103	27.0%	173	14.1%	48.3%
<b>Type of Insurance</b>					
Mgd Care	51	18.0%	114	40.1%	13.2%
Medicaid	69	18.1%	81	06.6%	33.0%
Uninsured	103	27.0%	173	14.1%	48.3%
Other	28	07.3%	163	13.3%	00.5%
Don't Know	23	06.0%	78	06.4%	03.0%
Undeterminable	6	01.6%	46	03.8%	02.0%

**Table 7. Area profile of demographic characteristics (cont'd)**

Variable	Urban		Suburban		First Care
	Count	Percent	Count	Percent	Percent
<b>Adults Responsible for Health Care in the Household</b>					
1	149	39.5%	416	34.4%	33.7%
2	214	56.8%	759	62.7%	55.8%
3+	14	03.7%	35	02.9%	10.5%
<b>Usual Source of Sick Care</b>					
Private Physician's Office	242	63.9%	1023	83.9%	32.8%
Hospital Emergency Room	38	10.0%	49	04.0%	26.7%
Community Health Center	99	26.1%	147	12.1%	40.5%
<b>Usual Source of Well Care</b>					
Private Physician's Office	238	63.1%	1023	84.3%	34.7%
Hospital Emergency Room	9	02.4%	9	00.7%	03.2%
Community Health Center	130	34.5%	182	15.0%	62.1%
<b>Medical Home</b>					
Physician's Office	212	56.5%	972	80.3%	25.5%
Community Health Center	81	21.6%	112	09.3%	37.6%
None	82	21.9%	126	10.4%	36.9%
Avg No. Adults Responsible for Child's Health Care in the Home		1.66		1.69	1.81
Avg No. Children <15 in Home		1.92		1.77	2.12
Avg Age of Oldest Child		8.27		7.88	6.20
Avg No. Physician Visits Past 6 Months (Child)		2.56		2.27	3.06
Avg No. Emergency Room Visits Past 6 Months (Child)		1.66		1.51	1.77
Avg No. Hours of Work Missed Past 6 Months to Care for Sick Child		18.34		11.93	24.2
Avg No. of School Days/Day Care Missed Past 6 Months Due to Illness		3.74		3.29	7.14

Table 8 indicates that of those who accessed health care for non-emergent conditions at the hospital's emergency room, 92 percent said their child received treatment by the hospital for the condition. Of those whose children did not receive care for the condition, 76 percent were told to go elsewhere for the child's care. Other reasons for the child not receiving health care were not determinable.

**Table 8. Percent using hospital ER for non-emergent conditions**

Hospital Use	Yes		No		Total	
	Count	Percent	Count	Percent	Count	Percent
Used hospital ER in past 6 months	262	16.3%	1344	83.7%	1605	100.0%
Used hospital ER for Non-emergent condition	167	63.7%	95	36.3%	262	100.0%
Child treated by hospital for condition	154	92.1%	13	7.9%	167	100.0%
Caregiver told to go elsewhere for child's treatment	10	76.0%	3	24.0%	13	100.0%

Reasons for choosing the hospital emergency room for the treatment of a non-emergent condition are presented in Table 9. The greatest percentage of those who sought care in the ER for their child's non-emergent treatment did so because their physician's office was not open when the child needed care (almost 82 percent). About 59 percent could not go to their physician's office or clinic during their operating hours. Only about 23 percent stated that their child did not have another physician, and only 16 percent didn't have enough money to take their child to a physician's office or health clinic. Clearly, use of the emergency room for non-emergent care is associated with lack of access to care in a physician's office or clinic.

**Table 9. Why chose hospital ER for treatment of non-emergent conditions**

Reason	Yes		No		Total	
	Count	Percent	Count	Percent	Count	Percent
Child doesn't have another physician	38	22.5%	130	77.5%	167	100.0%
Couldn't go to physician's office or other clinic during their office hours	97	58.6%	69	41.4%	166	100.0%
Child's usual physician's office not open when needed	137	81.6%	31	18.4%	167	100.0%
Wait too long at usual physician's office or clinic	20	11.8%	147	88.2%	166	100.0%
Couldn't get appointment soon enough at usual physician's office or clinic	60	36.0%	107	64.0%	167	100.0%
Usual physician told caregiver to go to a hospital emergency room	63	37.5%	104	62.5%	167	100.0%
Didn't have enough money to go to the child's usual physician or clinic	27	16.2%	140	83.8%	167	100.0%
Caregiver didn't know where else to go	41	24.6%	126	75.4%	167	100.0%
Caregiver couldn't get child to another physician's office or clinic	15	8.9%	152	91.1%	167	100.0%
Chose ER for other reasons	22	13.0%	145	87.0%	167	100.0%

As can be seen in Table 10, the greatest percentage of reasons cited as to why their child did not receive needed health care was because respondents could not afford to pay for care (48 percent) and/or because their child did not have health insurance (50 percent). Other reasons had to do with physician availability at a time in which the parent/caregiver could take their child to the doctor (43 percent said there was difficulty in getting an appointment, 40 percent said they could go during the doctor's office hours, 39 percent said the wait was too long in the physician's office, and 30 percent said no physician was available).

**Table 10. Reasons child did not receive needed medical care**

Reason	Yes		No		Total	
	Count	Percent	Count	Percent	Count	Percent
Couldn't afford to pay for care	59	48.1%	64	51.9%	123	100.0%
Child doesn't have insurance	62	50.1%	62	49.9%	123	100.0%
Physician doesn't accept Medicaid	15	13.6%	97	86.4%	113	100.0%
Illness wasn't serious enough	31	25.9%	87	74.1%	118	100.0%
Wait too long in physician's office	49	39.7%	74	60.3%	123	100.0%
Difficulty getting an appointment	54	43.6%	70	56.4%	123	100.0%
No physician was available	38	30.7%	85	69.3%	123	100.0%
Couldn't go during office hours	50	40.9%	72	59.1%	122	100.0%
Didn't know where to go	24	19.5%	99	80.5%	123	100.0%
No transportation	19	15.0%	105	85.0%	123	100.0%
Difficulty selecting a doctor	37	29.7%	86	70.3%	123	100.0%
Physician not on insurance plan	19	17.0%	94	83.0%	113	100.0%
Other reasons	6	4.6%	118	95.4%	123	100.0%

Of the total 612 in the Children's First Care population, 260 were girls aged 0 to 17 years. Data were extracted from this study in order to look at the experience of girls in regard to selected variables. A summary of findings for selected variables for girls aged 0 to 17 is illustrated in Tables 11 through 16, broken down by race/ethnicity and age group.

Table 11 indicates the cross-tabulations of the variability of insurance status by race and age group of female patients that were seen at First Care during June-July 1999. It may be noteworthy to point out that the girls in the oldest age group for all races/ethnicities combined were most likely to be uninsured. Comparing Whites, Blacks, and Hispanics, Hispanics were the most likely to be uninsured for all age groups, followed by Blacks, then Whites.

**Table 11. Insurance status by race and age of girls who accessed First Care, June-July 1999**

RACE	AGE		INSURANCE STATUS		
			INSURED	MEDICAID	UNINSURED
<b>White</b>	0-6 years	#	9	8	12
		%	31.0	27.6	41.4
	7-13 years	#	2	4	7
		%	15.4	30.8	53.8
	14-17 years	#	----*	----	1
		%	----	----	100
<b>Black</b>	0-6 years	#	11	25	29
		%	16.9	38.5	44.6
	7-13 years	#	3	4	8
		%	20.0	26.7	53.3
	14-17 years	#	----	1	5
		%	----	16.7	83.3
<b>Hispanic</b>	0-6 years	#	16	40	46
		%	15.7	39.2	45.1
	7-13 years	#	2	2	10
		%	14.3	14.3	71.4
	14-17 years	#	----	----	3
		%	----	----	100
<b>Asian</b>	0-6 years	#	1	----	----
		%	100	----	----
	7-13 years	#	----	----	----
		%	----	----	----
	14-17 years	#	----	----	----
		%	----	----	----
<b>Other</b>	0-6 years	#	1	4	4
		%	11.1	44.4	44.4
	7-13 years	#	----	1	----
		%	----	100	----
	14-17 years	#	----	----	1
		%	----	----	100
<b>Total</b>	0-6 years	#	38	77	91
		%	18.4	37.4	44.2
	7-13 years	#	7	11	25
		%	16.3	25.6	58.1
	14-17 years	#	----	1	10
		%	----	9.1	90.9

Table 12 indicates the cross-tabulations for usual source of sick care and usual source of well care. Emergency room use for acute and well care may be indicative of the parents' inability to access care outside the emergency department. The patients in this population usually use community/public health clinics for both sick care and well care. Blacks relied on

emergency room use most heavily compared to either Hispanics or Whites for both sick care and well care.

**Table 12. Usual source of sick care and usual source of well care by race and age of girls who accessed First Care, June-July 1999**

RACE	AGE		USUAL SOURCE OF SICK CARE			USUAL SOURCE OF WELL CARE		
			Doctor's Office	Hospital ER	Comm/Pub Health Clinic	Doctor's Office	Hospital ER	Comm/Pub Health Clinic
White	0-6 years	#	22	2	5	19	----	10
		%	75.9	6.9	17.2	65.5	----	34.5
	7-13 years	#	7	----	5	8	----	4
		%	58.3	----	41.7	66.7	----	33.3
	14-17 years	#	1	----	----	----	----	----
		%	100	----	----	----	----	----
Black	0-6 years	#	21	25	19	22	5	37
		%	32.3	38.5	29.2	34.4	7.8	57.8
	7-13 years	#	3	5	6	5	----	9
		%	21.4	35.7	42.9	35.7	----	64.3
	14-17 years	#	1	2	3	1	----	4
		%	16.7	33.3	50.0	20.0	----	80.0
Hispanic	0-6 years	#	26	27	49	27	1	73
		%	25.5	26.5	48.0	26.7	1.0	72.3
	7-13 years	#	3	4	8	3	----	11
		%	20.0	26.7	53.3	21.4	----	78.6
	14-17 years	#	----	----	3	----	----	3
		%	----	----	100	----	----	100
Asian	0-6 years	#	----	----	1	----	----	1
		%	----	----	100	----	----	100
	7-13 years	#	----	----	----	----	----	----
		%	----	----	----	----	----	----
	14-17 years	#	----	----	----	----	----	----
		%	----	----	----	----	----	----
Other	0-6 years	#	2	2	5	4	----	5
		%	22.2	22.2	55.6	44.4	----	55.6
	7-13 years	#	----	----	1	----	----	1
		%	----	----	100	----	----	100
	14-17 years	#	----	----	1	----	----	1
		%	----	----	100	----	----	100
Total	0-6 years	#	71	56	79	72	6	126
		%	34.5	27.2	38.3	35.3	2.9	61.8
	7-13 years	#	13	9	20	16	----	25
		%	31.0	21.4	47.6	39.0	----	61.0
	14-17 years	#	2	2	7	1	----	8
		%	18.2	18.2	63.6	11.1	----	88.9

Table 13 indicates the frequency which the interviewee states he/she can get their child sick care treatment and well care appointments when desired. Generally, interviewees were able to get their child care when they wanted to.

Table 14 indicates the degree of difficulty experienced by interviewees regarding trying to get their child medical care. A majority of the people interviewed stated that getting their child medical care was very easy or fairly easy. Among interviewees, greater percentages of Blacks and Hispanics said they had either a somewhat difficult or very difficult experience trying to get their child medical care, relative to Whites.

According to the data in Table 15, most interviewees did not forego needed health care in the six months prior to the interview. Looking at all races/ethnicities combined, it appears that girls in the older age group, 14-17 had a greater percentage occurrence of an instance where they did not get needed medical care in the past six months.

Table 16 depicts the degree to which parents worry about getting medical care for their child and being able to pay for medical care for their child. For all races/ethnicities combined, for all age groups, over 40 percent of interviewees “often” worry about having enough money to pay for their child’s care. The findings appear to be similar for interviewees that worry about getting their child medical care when needed. Although it may be a function of a small number of children in the oldest age group (14-17), it appears that the percentage of parents that worry about these variables increases as their child ages. Hispanics appear to worry the most for all age groups about paying for health care and about being able to get needed health care for their child.

**Table 13. Frequency which parent can get child sick care treatment and well care when desired by race and age of girls who accessed First Care, June-July 1999**

RACE	AGE		GETS SICK CARE TREATMENT WHEN DESIRED				GETS WELL CARE APPT WHEN DESIRED			
			NEVER	RARELY	SOMETIMES	ALWAYS	NEVER	RARELY	SOMETIMES	ALWAYS
White	0-6 years	#	1	----	1	28	----	----	4	26
		%	3.3	----	3.3	93.3	----	----	13.3	86.7
	7-13 years	#	----	----	1	11	----	1	2	9
		%	----	----	8.3	91.7	----	8.3	16.7	75.0
	14-17 years	#	----	1	----	----	----	----	1	----
		%	----	100	----	----	----	----	100.0	----
Black	0-6 years	#	----	----	13	51	1	2	13	49
		%	----	----	20.3	79.7	1.5	3.1	20.0	75.4
	7-13 years	#	----	----	----	14	----	----	1	13
		%	----	----	----	100.0	----	----	7.1	92.9
	14-17 years	#	----	----	4	2	1	----	1	4
		%	----	----	66.7	33.3	16.7	----	16.7	66.7
Hispanic	0-6 years	#	5	11	21	63	8	4	27	59
		%	5.0	11.0	21.0	63.0	8.2	4.1	27.6	60.2
	7-13 years	#	----	2	6	7	4	1	5	4
		%	----	13.3	40.0	46.7	28.6	7.1	35.7	28.6
	14-17 years	#	----	----	1	1	----	----	1	1
		%	----	----	50.0	50.0	----	----	50.0	50.0
Asian	0-6 years	#	----	----	----	1	----	----	----	1
		%	----	----	----	100.0	----	----	----	100.0
	7-13 years	#	----	----	----	----	----	----	----	----
		%	----	----	----	----	----	----	----	----
	14-17 years	#	----	----	----	----	----	----	----	----
		%	----	----	----	----	----	----	----	----
Other	0-6 years	#	1	----	2	6	----	----	3	6
		%	11.1	----	22.2	66.7	----	----	33.3	66.7
	7-13 years	#	----	----	1	----	----	1	----	----
		%	----	----	100.0	----	----	100.0	----	----
	14-17 years	#	----	----	----	1	----	----	----	1
		%	----	----	----	100.0	----	----	----	100.0
Total	0-6 years	#	7	11	37	149	9	6	47	141
		%	3.4	5.4	18.1	73.0	4.4	3.0	23.2	69.5
	7-13 years	#	----	2	8	32	4	3	8	26
		%	----	4.8	19.0	76.2	9.8	7.3	19.5	63.4
	14-17 years	#	----	1	5	4	1	----	3	6
		%	----	10.0	50.0	40.0	10.0	----	30.0	60.0

**Table 14. Degree of difficulty experienced when trying to get child medical care by race and age of girls who accessed First Care, June-July 1999**

RACE	AGE		DIFFICULTY GETTING CHILD MEDICAL CARE			
			VERY EASY	FAIRLY EASY	SOMEWHAT DIFFICULT	VERY DIFFICULT
White	0-6 years	#	19	8	1	1
		%	65.5	27.6	3.4	3.4
	7-13 years	#	7	2	1	2
		%	58.3	16.7	8.3	16.7
	14-17 years	#	----	----	----	----
		%	----	----	----	----
Black	0-6 years	#	30	20	7	8
		%	46.2	30.8	10.8	12.3
	7-13 years	#	10	1	1	1
		%	76.9	7.7	7.7	7.7
	14-17 years	#	2	----	3	1
		%	33.3	----	50.0	16.7
Hispanic	0-6 years	#	42	33	17	9
		%	41.6	32.7	16.8	8.9
	7-13 years	#	6	2	2	1
		%	54.5	18.2	18.2	9.1
	14-17 years	#	1	----	----	----
		%	50.0	----	----	----
Asian	0-6 years	#	1	----	----	----
		%	100.0	----	----	----
	7-13 years	#	----	----	----	----
		%	----	----	----	----
	14-17 years	#	----	----	----	----
		%	----	----	----	----
Other	0-6 years	#	7	1	----	1
		%	77.8	11.1	----	11.1
	7-13 years	#	----	----	----	1
		%	----	----	----	100.0
	14-17 years	#	----	1	----	----
		%	----	100.0	----	----
Total	0-6 years	#	99	62	25	19
		%	48.3	30.2	12.2	9.3
	7-13 years	#	23	5	4	5
		%	62.2	13.5	10.8	13.5
	14-17 years	#	3	2	3	1
		%	33.3	22.2	33.3	11.1

**Table 15. Time in past six months that child needed medical care, but didn't get it, by race and age of girls who accessed First Care, June-July 1999**

RACE	AGE		TIMES IN PAST 6 MTHS. THAT CHILD NEEDED MEDICAL CARE, BUT DIDN'T GET IT	
			NO	YES
White	0-6 years	#	28	1
		%	96.6	3.4
	7-13 years	#	10	2
		%	83.3	16.7
14-17 years	#	----	1	
	%	----	100.0	
Black	0-6 years	#	58	8
		%	87.9	12.1
	7-13 years	#	12	3
		%	80.0	20.0
14-17 years	#	2	4	
	%	33.3	66.7	
Hispanic	0-6 years	#	86	15
		%	85.1	14.9
	7-13 years	#	8	6
		%	57.1	42.9
14-17 years	#	3	----	
	%	100.0	----	
Asian	0-6 years	#	1	----
		%	100.0	----
	7-13 years	#	----	----
		%	----	----
14-17 years	#	----	----	
	%	----	----	
Other	0-6 years	#	6	3
		%	66.7	33.3
	7-13 years	#	1	----
		%	100.0	----
14-17 years	#	1	----	
	%	100.0	----	
Total	0-6 years	#	179	27
		%	86.9	13.1
	7-13 years	#	31	11
		%	73.8	26.2
14-17 years	#	6	5	
	%	54.5	45.5	

**Table 16. Degree to which parent worries about having enough money to pay for child's medical care and about getting child's medical care by race and age of girls who accessed First Care, June-July 1999**

RACE	AGE		WORRY ABOUT ENOUGH \$\$ TO PAY FOR CHILD'S MEDICAL CARE				WORRY ABOUT GETTING CHILD MEDICAL CARE WHEN NEEDED			
			NEVER	SELDOM	OCCASIONALLY	OFTEN	NEVER	SELDOM	OCCASIONALLY	OFTEN
White	0-6 years	#	15	4	3	7	14	3	5	8
		%	51.7	13.8	10.3	24.1	46.7	10.0	16.7	26.7
	7-13 years	#	5	2	1	4	5	2	1	4
		%	41.7	16.7	8.3	33.3	41.7	16.7	8.3	33.3
	14-17 years	#	----	----	----	1	----	----	----	1
		%	----	----	----	100.0	----	----	----	100.0
Black	0-6 years	#	26	4	5	31	21	10	11	21
		%	39.4	6.1	7.6	47.0	33.3	15.9	17.5	33.3
	7-13 years	#	7	1	2	4	8	1	----	5
		%	50.0	7.1	14.3	28.6	57.1	7.1	----	35.7
	14-17 years	#	2	----	----	4	1	----	2	3
		%	33.3	----	----	66.7	16.7	----	33.3	50.0
Hispanic	0-6 years	#	19	11	22	50	11	11	19	60
		%	18.6	10.8	21.6	49.0	10.9	10.9	18.8	59.4
	7-13 years	#	3	2	----	8	3	1	5	6
		%	23.1	15.4	----	61.5	20.0	6.7	33.3	40.0
	14-17 years	#	----	----	----	3	----	----	----	3
		%	----	----	----	100.0	----	----	----	100.0
Asian	0-6 years	#	1	----	----	----	----	----	1	----
		%	100.0	----	----	----	----	----	100.0	----
	7-13 years	#	----	----	----	----	----	----	----	----
		%	----	----	----	----	----	----	----	----
	14-17 years	#	----	----	----	----	----	----	----	----
		%	----	----	----	----	----	----	----	----
Other	0-6 years	#	3	----	1	5	6	----	1	2
		%	33.3	----	11.1	55.6	66.7	----	11.1	22.2
	7-13 years	#	----	----	1	----	----	----	----	1
		%	----	----	100.0	----	----	----	----	100.0
	14-17 years	#	----	----	----	1	----	----	1	----
		%	----	----	----	100.0	----	----	100.0	----
Total	0-6 years	#	64	19	31	93	52	24	37	91
		%	30.9	9.2	15.0	44.9	25.5	11.8	18.1	44.6
	7-13 years	#	15	5	4	16	16	4	6	16
		%	37.5	12.5	10.0	40.0	38.1	9.5	14.3	38.1
	14-17 years	#	2	----	----	9	1	----	3	7
		%	18.2	----	----	81.8	9.1	----	27.3	63.6

## **IV. Studies of Child and Teen Issues in Dallas County**

### **A. Beyond ABC: Growing Up in Dallas County—Assessing Our Children’s Quality of Life, 2002.**

Julia Easley, LMSW and the Growing Up in Dallas County Advisory Board and Technical Advisors , Ed.  
Children’s Medical Center of Dallas and the Coalition for North Texas Children, 2002.

Beyond ABC, 2002 is the fourth edition of this quality of life assessment (the first conducted in 1990) of Dallas County children newborn to age 17. It uses an indicator model that covers four areas considered to be significant for children: health, economic security, education, and safety. Data for this assessment was provided by local non-profit, city, county, school district, state, and federal agencies. Selected indicators for each area and their measures are located in Tables 17 through 20 below.

Table 17 lists selected health indicators for quality of life measures of Dallas children. According to the principles of this document’s publisher, “all children deserve to be free from hunger and preventable disease and to receive regular health care” (p.21). Children without insurance is a problem in Dallas County. Children who lack health insurance are less likely to see a doctor for routine and preventive health care, and they are less likely to be immunized against preventable childhood illnesses. In Dallas County approximately 68,000 uninsured children are eligible for CHIP or Medicaid.

Early prenatal care is recommended for all pregnant women. Early prenatal care may help avoid LBW, which may lead to serious physical or developmental problems in the baby. In 2000, 76.3 percent of women in Dallas County received prenatal care beginning in the first trimester of pregnancy. The goal is 90.0 percent.

**Table 17. Selected health indicators for quality of life measures of Dallas children**

<b>HEALTH INDICATOR</b>	<b>MEASUREMENT</b>
Children without insurance	17.0% of Texas Children are without either private health care coverage, Medicaid or CHIP. In Dallas County approximately 68,000 uninsured children are eligible for CHIP or Medicaid (p.23).
Early prenatal care	76.3% of women in Dallas County received prenatal care beginning in the first trimester of pregnancy in 2000. The goal is 90.0% (p.23).
Adolescent pregnancy	In 2000 the pregnancy rate was 31.9 pregnancies per 1,000 population of adolescent females in Dallas County ages 13 to 17 (p.26).
Medicaid children receiving dental care	In 2000 43,174 eligible Dallas County children received dental care through Medicaid. This was only 29% of eligible children (p.28).
Immunizations	In 2000 68.9% of 2 year olds in Dallas County were vaccinated against vaccine-preventable diseases on schedule and at the appropriate age. The goal is 90% (p.29).
Mental illness	In 2000 it was estimated that 120,252 Dallas County children had a diagnosable mental illness. This comprises 20% of all children in Dallas County (p.31).
Substance abuse	In 2000, among Dallas Public Schools students in grades 6-12, 44.0% admitted to using alcohol, 17.8% admitted to using tobacco, 20.4% admitted to using marijuana, and 3.4% admitted to using inhalant within the past month when surveyed (p.34).

Texas ranks as third worst in the nation in the rate of teen births. In 2000 there were 2,452 live births and 461 abortions to females ages 13 to 17. This document cites the findings of the Dallas Commission on Children and Youth Committee Report on Teen Pregnancy—service gaps in the areas of structured activities, transportation, shelter, supportive services in school settings, family therapy, and education emphasizing the responsibilities of teen parents exist and need to be addressed.

Only 29 percent of children eligible to receive dental care through Medicaid received such care in 2000. “There is an acute shortage of dentists serving children with low incomes, and Texas Department of Health reimburses these dentists on a fee-for-service basis at just 50-60 percent of their usual fees” (p.28). There were only 182 dentists in Dallas County in 2000 who accepted Medicaid clients.

Texas has the nation's lowest rate of immunizations among 2 year-olds. Only 68.9 percent of 2-year-olds in Dallas County had received age-appropriate and on-time vaccinations for vaccine-preventable diseases in 2000. The goal is 90 percent.

According to a Surgeon General Report on Mental Health in 1999, there is a 20 percent prevalence rate of children estimated to have a diagnosable mental illness or addictive disorder that causes some impairment. An estimated 11 percent of these disorders result in significant functional impairment. Since one in six Texas children have no health coverage, accessing mental health care for their children can be difficult for many Dallas County parents. In 2000 there were an estimated 120,252 Dallas County children who had a diagnosable mental illness.

Substance abuse is also a problem for Dallas County youth. Alcohol is the most widely abuse drug among Dallas County high school students. Tobacco is considered a gateway drug – that is, it leads to the use of other drugs. Marijuana is a commonly used illegal substance by Dallas teens. Its use is associated with experimentation with other drugs. Inhalant use is also a problem that can lead to irreversible brain damage and death.

Table 18 shows selected economic security indicators for quality of life measures of Dallas children. According to the tenets of this research, “all children deserve a secure future and the opportunity to grow up in an economically stable family” (p. 34). Texas ranks 41<sup>st</sup> in the nation for its percentage of children who live in poverty. In 2000, 19.6 percent of Dallas County children were living in poverty (annual income of \$17,050 or less for a family of four). One in ten of those children can be assumed to have been living in extreme poverty (family income less than half of the poverty level). “Poverty is associated with poor outcomes for children in their health, education, emotional welfare, and delinquency. . . . Approaches to alleviate the effects of child poverty include job training and increasing jobs that pay living wages” (p.37).

**Table 18. Selected economic security indicators for quality of life measures of Dallas children**

ECONOMIC SECURITY INDICATORS	MEASUREMENT
Children living in poverty	In 2000, and estimated 117,023 Dallas County children, or 19.6% were living in poverty (annual income of \$17,050 or less for a family of four) (p.37).
WIC (Special supplemental food programs for women, infants and children)	In 2000 62% of eligible infants, children and women received services in local WIC program offices. The goal is 85% (p.39).
Subsidized housing units	In 2000, there were 15,641 subsidized Section 8 family and public housing units provided through the Dallas Housing Authority for families with children and low-to-moderate incomes in Dallas County (p.40).
Affordable housing units lost	In 2000, 4,469 affordable housing units were lost due to changes in federal policy (p.41).
Homeless youth	In 2000 there was a total of 1,425 homeless youth in Dallas-area shelters (p.42).
Unemployed youth	In 2000, 14.2% of youth ages 16 to 19 in the Dallas-Fort Worth metropolitan area who were not in school were unemployed (p.42).

Adequate subsidized housing and affordable housing are also problems in Dallas County. “According to the U.S. Department of Housing and Urban Development (HUD), 42 percent of renters in Dallas County are unable to afford the fair market value of \$781 a month for a two-bedroom apartment. There has been a shift from providing subsidized housing in public housing projects to issuing vouchers to be used in the private housing market. But the average waiting time for a family to receive a voucher is 18-24 months. There are about 5,000 eligible families on waiting lists” (p.40). Since 1996, 4,469 affordable apartment units in Dallas County have been lost because their owners did not choose to continue their Section 8 contracts.

Homelessness is problem for Dallas County youth. “Homelessness causes children to change schools often, to repeat grades and to be absent frequently from school. In addition, their school experience often is negative because of inadequate clothes and school supplies” (p.42). According to the City of Dallas’ annual homeless census, in January 1999 there were 642 homeless children living in shelters or on the streets of Dallas. A count of the number of

homeless youth served by the Salvation Army, YMCA Casa Shelter, and Promise House yielded 1,425 homeless children in 2000.

“Unemployment is a significant risk factor for juvenile delinquency and crime” (p.42). In 2000, 14.2 percent of unemployed youth ages 16 to 19 in Dallas County who were not in school, were unemployed.

Table 19 contains selected education indicators for quality of life measures of Dallas Children. Guiding principles of this document state, “all children deserve an education that prepares them to meet the future and inspires them to achieve their potential” (p.42). The ability to read early in life is associated with academic success. In 2000, just less than half of all third-graders mastered all objectives on the reading section of the Texas Assessment of Academic Skills (TAAS) tests in all Dallas County public school districts. Thirteen percent of Dallas public school district third-graders did not read well enough to meet even the minimum standards.

In 2000, 74.1 percent of children passed the TAAS test in all subjects in all grades in all Dallas County public school districts. This test measures “academic learning and higher-order thinking and problem-solving skills” that are considered essential for mastery before advancing to the next grade (p.46). However, 44.9 percent of students in Dallas County public school districts were identified as being at risk of failure in course work or TAAS tests or falling below grade level in achievement tests. These students are at increased risk for dropping out. Table 20 indicates the percentage of students at each Dallas County public school district who have been identified as at risk of academic failure.

**Table 19. Selected education indicators for quality of life measures of Dallas children**

<b>EDUCATION INDICATORS</b>	<b>MEASUREMENT</b>
Third-grade students reading at grade level or better	In 2000, 49% of third-graders in Dallas County public school districts mastered all objectives on the reading section of the TAAS tests. The goal is 90% (p.45).
Students passing all TAAS tests	In 2000, 74.1% of students in all Dallas County public schools in all grades passed the TAAS test in all subjects. The goal is 90.0% (p.46).
Students at risk of not being successful in school	In 2000 44.9% of students were identified as being at risk of failing coursework or TAAS tests or falling below grade level in achievement tests in Dallas County public school districts. Table 20a. indicates the percent at-risk for each school district in Dallas County (p.47).
Longitudinal dropout rate	By 2000, 7.6% of students dropped out based on the number of students enrolled in the 7th grade compared to the same group of students in the 12th grade for all Dallas County public school districts. The goal is 5.0% (p.48).
Child care facilities meeting national standards	Of the 2,288 licensed or registered child care facilities in Dallas County, only 64, less than 1% are accredited by the National Association for Education of Young Children (NAEYC) (p.50).
Eligible children in subsidized child care	In 2000, 20,149 eligible children received child care services free or at a reduced price. Subsidies were available for only 8.3% of eligible families in Texas (p.50).

**Table 20. Percentage students in Dallas County public school districts who are at risk of not being successful**

<b>DISTRICT</b>	<b>PERCENT</b>
Carrollton Farmers Branch	32.0
Cedar Hill	29.5
Coppell	8.3
Dallas	54.3
DeSoto	24.8
Duncanville	33.8
Garland	52.1
Grand Prairie	44.6
Highland Park	0.3
Irving	55.2
Lancaster	54.7
Mesquite	25.5
Richardson	37.8
Sunnyvale	14.4
Wilmer Hutchins	23.3
Dallas County Composite	44.9

(p.47).

Students who drop out of school are at risk of experiencing limited economic opportunities, and are estimated to cost the state of Texas billions of dollars in diminished competitiveness. It is estimated that Dallas County loses one-third of its students per graduating class between their 7<sup>th</sup> grade year and their 12<sup>th</sup> grade year. “Poor and minority children are at a higher risk of dropping out. In Dallas County, one-half of Hispanic and African American students will drop out of school. . . . Recommendations for dropout prevention include increased parental involvement and partnership in schools, including ongoing training and information for parents, improved bilingual programs, smaller schools, smaller classrooms and reconnection centers for students who have left school” (p.48).

“In the United States 3 out of 5 young children are in child care because their parents are in the labor force” (p.50). Experiences in child care are critical to the children’s development. “[C]hildren in better child care and early education programs have stronger language, pre-mathematics and social skills than those in lower quality child care settings” (p.50). The National Association for the Education of Young Children (NAEYC) has a voluntary accreditation system that is the national standard of excellence in child care. Less than 1 percent of Dallas County child care facilities are NAEYC accredited.

Subsidized child care is needed by “working families with low incomes, families on welfare who are enrolled in job training or entering employment, and children in the protective system” (p.50). But in 2001, subsidies were available to only 8.3 percent of eligible families in Texas. In October 2001, more than 2,642 children were on the waiting list for subsidized child care in Dallas County.

The final area indicative of quality of life is safety. Table 21 illustrates selected safety indicators for quality of life measures of Dallas children. This document states that “all children

deserve to grow up free from abuse, violence and the devastation of alcohol and other drugs” (p.51). The report shows, however that Dallas children face significant problems with safety. While the true prevalence of child abuse and neglect is not known, it is estimated that 167 in 1,000 Dallas County children are abused or neglected. “According to the Texas Commission on Children and Youth, being abused or neglected as a child increases the odds of arrest as a juvenile by 53 percent, as an adult by 38 percent and for violent crime by 38 percent.” They are also “six times as likely to commit suicide, 24 times as likely to commit sexual assault and 50 times as likely to abuse drugs or alcohol. . . . Adults who were abused as children are six times as likely to abuse their own children” (p.53). “Child deaths related to child abuse and neglect and other violence escalated from 13 in 2000 to 30 as of November 2001” (p.43).

**Table 21. Selected safety indicators for quality of life measures of Dallas children**

SAFETY INDICATORS	MEASUREMENT
Child abuse and neglect prevalence	In 2000 167 children per 1,000 population of Dallas County children are projected to be abused or neglected (p.53).
Child abuse and neglect: Confirmed victims	In 2000 there were 4,802 confirmed victims of child abuse and neglect for which Child Protective Services (CPS) provided remedial services (p.54).
After-school programs slots available	In 2000, there were after-school program slots available for only 12.5% of children aged 5-11 with working parents (p.55).
Runaway reports	In 2000, there were 1,126 runaway reports received by the Dallas County Juvenile Department (p.59).
Gang members	In 2000 there were 956 youths known to be in gangs according to Dallas Police Department Gang Unit criteria (p.60).
Commitments to the Texas Youth Commission (TYC)	In 2000 273 additional youth were ruled to be delinquent for violation of a penal law punishable by imprisonment or confinement in jail, and were committed to TYC (p.61).

Other research in this review has stated that one of the service gaps faced by Dallas County youth is Dallas County’s lack of adult-supervised after-school programs. It is estimated that only 12.5 percent of children ages 5-11 with working parents have after-school programs

available to them. Since juvenile crime appears to be most likely to occur between the hours of 3:00 p.m. and 8:00 p.m., “children and youth need more safe places and activities during non-school hours” (p.55).

According to the Texas Commission on Children and Youth, children who run away from home often suffer from child abuse and neglect. However, running away puts children in grave danger. “Runaways are more likely to be robbed, raped or murdered. They are more likely to commit suicide, become criminals, abuse drugs or alcohol, become prostitutes or become infected with HIV” (p. 59). In 2000 there were 1,126 runaway reports received by the Dallas County Juvenile Department.

Gang violence is a problem for all areas of Dallas County. Programs aimed at reducing the numbers of victims of gang violence as well as the number of known gang members have shown success. The number of known gang members has dropped from 2,178 in 1996 to 956 in 2000.

The Texas Youth Commission (TYC) is where youth who have been judicially ruled to be delinquent for violation of a penal law punishable by jail time or imprisonment are incarcerated for rehabilitation. In 2000 there were 273 additional youth commitments to the TYC. According to the Texas Commission on Children and Youth, “45 percent of young people committed to TYC are seriously emotionally disturbed, 48 percent are chemically dependent and 50 percent are gang members” (p.61). Early intervention and screening and treatment for mental illness and drug abuse are among strategies for controlling such serious juvenile crime.

Recommendations made in this document for the improvement of the quality of life of Dallas County’s children include:

- Increasing investment in proven effective prevention and early intervention services for Dallas county children and youth, including quality child care, parent education,

home visitation for family at risk of child abuse, non-school hours activities with transportation, mental health services, substance abuse prevention education, youth development programs and stable affordable housing for families with low-incomes.

- Focusing on building developmental assets in Dallas' children and youth to increase their commitments, values and competencies and strengthen their external networks of support, which nurture positive development.
  - Helping Dallas County's poorest children get access to health care and dental care by assisting families with the Medicaid enrollment process.
- (p.5).

**B. A Report on Teen Pregnancy, December 1999**

Dallas Commission on Children and Youth, Committee on Teen Pregnancy  
Lee Schimmel, Chair

This report, developed by a committee comprised of representatives from various service agencies, identifies important demographic information and service gaps regarding teen pregnancy and parenting in Dallas County. Service gaps identified included: opportunities for adolescents to participate in structured and supervised activities; transportation to activities; safe and affordable housing/shelter for teen mothers; access to family therapy; programs aimed at teens in special school settings; education emphasizing "intensity of responsibility as a teen parent;" and civil and legal assistance designed specifically for teen mothers. The service gaps and recommended actions are located in Table 22. This report and its recommendations were also cited in Beyond ABC: Growing Up in Dallas County, 2002.

"Dallas County continues to lead the state in the number of births to teens. There were 2,459 births to teen moms aged 17 and under in Dallas County in 1997. This number constituted 14% of the total births in the state. The Dallas ZIP codes where most teens give birth reflect lower incomes and higher juvenile crime than other parts of the city and county. They include codes 75216 in South Dallas and parts of East Oak Cliff, 75217 in sections of Pleasant Grove and Southeast Dallas, and 75211 in West Oak Cliff. Approximately 83% of teen births in Dallas

County are to mothers in poverty. The fastest growing homeless adult population living in poverty in Texas are single women with small children.”

**Table 22. Identified service gaps regarding teen pregnancy in Dallas County and recommended actions (from p.6)**

SERVICE GAP	RECOMMENDED ACTION
“Opportunities for adolescents to participate in structured and supervised activities”	“Structured in-school, after-school, weekend and summer programs that offer teen girls and boys separate opportunities to participate in team building sports related activities, performing arts and community service activities. Components of these programs should also include career awareness, family and sex education, academic assessment and homework help, with the goal of fostering lifetime participation in individual sports and other activities.”
“Transportation to activities”	“Free transportation for youth traveling to and from activities via DART.”
“Safe and Affordable housing/shelter is difficult to obtain for teen mothers”	“Expansion of the existing Promise Housing programs for homeless parenting teens and duplication of the program by other agencies. Also identification of clusters of apartments in public housing areas that would serve primarily teen mothers with centralized apartment where support services would be offered funded by the housing Authority.”
“Family Therapy”	“Encourage and train non-profit agencies to enroll teen parents in Medicaid, NorthSTAR and Children’s Health Insurance Program (CHIP) to provide the funding for payment of therapeutic services, e.g. individual, group and family therapy.”
Special school settings	“Develop supportive services in school sites where Youth and Family Centers are located, that will provide immediate identification and case management for pregnant girls to discourage school dropout. Provide parenting education and baby care instruction, tutoring and career counseling, childcare, transportation and other services.”
“Education emphasizing ‘intensity of responsibility as a teen parent’.”	“Develop a program in middle schools and high schools in areas of highest teen pregnancy rates, that emphasizes abstinence through education, experiential exercises with the realistic baby dolls, and focus on personal responsibility in individual sexual development.”
“Civil legal assistance designed specifically for teen mothers”	<p>Regular evening workshops for teens and their parents to learn about he law, their rights and responsibilities, including information about how to:</p> <ul style="list-style-type: none"> <li>A. Establish paternity</li> <li>B. Establish child support responsibility</li> <li>C. Establish responsibility for health care coverage for the child and enrollment of mother and child in appropriate health care coverage and benefit programs.</li> </ul> <p>“Legal assistance to prevent homelessness and to help in locating housing for teen mothers is also recommended.”</p>

**C. We're Bored, Not Bad--Conclusions and Recommendations from the "Teens Speak Out" Study**

Susan M. Wolfe, MA, Kathryn Allen, MPA, Leslie Linton, & Lisa Hawkins  
Planned Parenthood of Dallas and Northeast Texas, Girls Incorporated of Metropolitan Dallas & African American Men of Peace Development Corporation, October 1997

This study was conducted with the aim of determining how to improve pregnancy prevention programs for teens in Dallas County. Participants in the study were 53 males and 64 females (N=117) aged 11 to 18 years, who were recruited from various community agencies in the Dallas area that is also served by Dallas Healthy Start. Participants were predominantly African American and Hispanic. Data were collected from self-report survey instruments and focus groups. This study concluded that a lack of constructive use of their time is the primary problem faced by participants. Participating adolescents have services needs in the areas of: educational assistance, career planning, employment, medical care, money management, psychological and spiritual counseling, fun and recreation, and advocacy with teacher and school administrators.

In regard to service needs, they were often unaware of or did not know how to access the various services available, did not meet the financial requirements and guidelines for services, were turned away because the service provider had reached its capacity, or did not have reliable transportation to the facility.

Information collected about the participants' experiences with school and education in the Dallas Public School System determined that they often felt unsafe. Girls indicated that sexual harassment was a problem. Many of the participants reported a lack of supervised after-school activities.

It is noteworthy that in the area of relationships and personal attributes, this study found a lack of association between self-esteem and other personal attributes and sexual activity. And, it

also suggested that intervention programs that are fun and aim to increase skills, such as athletics, arts or academics, might be more beneficial than interventions that aim to improve self-esteem and personal characteristics.

Regarding romantic relationships, values, and attitudes, it was found that a secure parental attachment to father was related to less peer sexual activity. Forty-five percent of participants were sexually active. Of concern were the findings that 25 percent of the youth surveyed agreed with the statement that “people cannot stop themselves from having sex,” and 45 percent were too embarrassed to buy condoms. Feelings of ambivalence towards pregnancy as well as a desire to become pregnant or to impregnate also were expressed.

Some of the recommendations to address these findings are listed in Table 23 below.

**Table 23. Recommendations to improve pregnancy prevention programs for teens in Dallas**

Area of need	Recommendations
Service	<ol style="list-style-type: none"> <li>1. brochure for adolescents that describes available services and how to access</li> <li>2. expand availability of mentoring programs</li> <li>3. increase availability of tutoring and educational services, including career planning</li> <li>4. provide more job training and job placement programs</li> <li>5. access to psychological and spiritual counseling</li> <li>6. access to skill training programs</li> <li>7. access to recreational activities</li> </ol>
School and education	<ol style="list-style-type: none"> <li>1. increase efforts to reduce truancy and unexcused absence</li> <li>2. address issues of sexual harassment</li> <li>3. college preparation programs</li> <li>4. increase availability of supervised activities after school, evenings, and on weekends</li> <li>5. recruit unsupervised teens into supervised activities</li> </ol>
Relationships and personal attributes	<ol style="list-style-type: none"> <li>1. provide programs that intervene in father-adolescent relationships, and encourage father involvement in children’s lives</li> <li>2. provide interventions that promote more positive relationships among males and older adolescents with their peers</li> <li>3. provide interventions that encourage parental monitoring</li> </ol>
Romantic relationships, values and attitudes	<ol style="list-style-type: none"> <li>1. develop methods to limit the seriousness of romantic relationships</li> <li>2. interventions to delay onset of sexual activity</li> <li>3. contraceptive education and empowerment</li> <li>4. parental education on how to talk to their children about sex</li> </ol>

**D. Developmental Assets: A Profile of Your Youth--Dallas Public Schools**  
Prepared by the Search Institute for Camp Fire Boys and Girls, March 1999

The Youth Developmental Assets Survey, conducted in December 1998, was developed by the Search Institute, a non-profit research and educational organization specializing in studies of children and adolescents. The survey measures 40 external and internal “assets” that prior research indicates are negatively associated with youth risk-taking behaviors, such as substance abuse, delinquency, school truancy, or early sexual activity. External assets include:

- Support, care and love from families, neighbors, and many others, including organizations and institutions that provide positive supportive environments.
- Empowerment to be valued by the community and have opportunities to contribute to others. For this to occur, children must be safe and feel secure.
- Boundaries and expectations to know what is expected of them and whether activities and behaviors are “in bounds” or “out of bounds.”
- Constructive use of time for growth through creative activities, youth programs, congregational involvement, and quality time at home.

Internal assets include:

- Commitment to life-long education and learning.
- Positive values that guide their choices.
- Social competencies that equip them to make positive choices, to build relationships, and to succeed in life.
- Positive identity and strong sense of their own power, purpose, worth, and promise. (p.12, *Beyond ABC: Growing Up in Dallas County*, 2000).

“Ideally, all youth would experience 31 of the 40 developmental assets. In the Dallas Public Schools sample, 7 percent of youth experienced 31-40 assets and 35 percent experienced 21-30 assets” (p.F-2, *Focus on Health*). Nearly 2,000 7<sup>th</sup>, 9<sup>th</sup>, and 11<sup>th</sup> grade students in Dallas Public Schools completed the survey. Table 24 shows the 20 External Assets and the percentage of Dallas Public Schools 7<sup>th</sup>, 9<sup>th</sup>, and 11<sup>th</sup> grade boys and girls that reported possessing these assets. We see from Table 24 that girls tended to fair better than boys on external assets. The assets that were claimed in the highest percentage by girls were Religious Community (70 percent), Family Support (68 percent), School Boundaries (65 percent), and High Expectations

(63 percent). The assets for which girls reported lower percentages than boys are Family Support (68 percent compared to boys' 73 percent), Parent Involvement in Schooling (37 percent compared to boys' 40 percent), Safety (33 percent compared to boys' 47 percent), and Youth Programs (44 percent compared to boys' 55 percent).

Table 25 shows the 20 Internal Assets and the percentage of Dallas Public Schools 7<sup>th</sup>, 9<sup>th</sup>, and 11<sup>th</sup> grade boys and girls that reported possessing these assets. Again, we see that overall, a greater percentage of girls reported having these assets. The assets that were claimed in the highest percentage by girls were Achievement Motivation (76 percent), Integrity (74 percent), Positive View of Personal Future (72 percent), Responsibility (70 percent), and Honesty (70 percent). The assets for which girls reported lower percentages than boys fell under the category of "personal identity". They were Self-esteem (53 percent compared to boys' 58 percent) and Sense of Purpose (52 percent compared to boys' 59 percent).

**Table 24. Percent of boys and girls in Dallas public schools reporting each of the 20 external assets**

ASSET TYPE	ASSET NAME	PERCENT BOYS	PERCENT GIRLS	TOTAL PERCENT
<b>SUPPORT</b>	1. Family Support	73	68	70
	2. Positive Family Communication	27	31	29
	3. Other Adult Relationships	31	36	33
	4. Caring Neighborhood	36	38	37
	5. Caring School Climate	20	25	23
	6. Parent Involvement in Schooling	40	37	39
<b>EMPOWERMENT</b>	7. Community Values Youth	24	29	26
	8. Youth as Resources	27	27	27
	9. Service to Others	45	50	48
	10. Safety	47	33	39
<b>BOUNDARIES AND EXPECTATIONS</b>	11. Family Boundaries	47	56	52
	12. School Boundaries	59	65	62
	13. Neighborhood Boundaries	55	57	56
	14. Adult Role Models	21	24	22
	15. Positive Peer Influence	63	66	65
	16. High Expectations	59	63	61
<b>CONSTRUCTIVE USE OF TIME</b>	17. Creative Activities	16	22	19
	18. Youth Programs	55	44	49
	19. Religious Community	64	70	67
	20. Time at Home	47	56	52

**Table 25. Percent of boys and girls in Dallas public schools reporting each of the 20 internal assets**

ASSET TYPE	ASSET NAME	PERCENT BOYS	PERCENT GIRLS	TOTAL PERCENT
<b>COMMITMENT TO LEARNING</b>	21. Achievement Motivation	63	76	69
	22. School Engagement	52	64	58
	23. Homework	45	52	49
	24. Bonding to School	46	55	50
	25. Reading for Pleasure	14	24	19
<b>POSITIVE VALUES</b>	26. Caring	50	62	56
	27. Equality and Social Justice	57	68	63
	28. Integrity	60	74	68
	29. Honesty	66	70	68
	30. Responsibility	60	70	65
	31. Restraint	39	60	50
<b>SOCIAL COMPETENCIES</b>	32. Planning and Decision-making	27	33	30
	33. Interpersonal Competence	26	51	39
	34. Cultural Competence	34	45	40
	35. Resistance Skills	34	44	39
	36. Peaceful Conflict Resolution	25	33	30
<b>POSITIVE IDENTITY</b>	37. Personal Power	34	40	37
	38. Self-esteem	58	53	56
	39. Sense of Purpose	59	52	55
	40. Positive View of Personal Future	72	72	72

This report is cited in Beyond ABC: Growing Up in Dallas County, 2002, where its recommendations are listed as follows:

**Youth:** Be a peer helper or volunteer with younger children.

**Adults:** Build a sustained, caring relationship with a youth; volunteer in a school; learn the names of the children and teens who live near you and greet them by name.

**Families:** Eat at least one meal together each day; limit TV watching; read to your children; articulate your values

**Schools:** Make it a priority to provide caring environments; reach out to increase parental involvement; expand and strengthen co-curricular activities.

**Youth organizations:** Involve youth in leadership and planning; develop expectations and boundaries and enforce appropriate consequences.

**Congregations:** Foster inter-generational relationships; offer regular parent education; listen to what youth say they want and let them lead.

**Neighborhood groups:** Create service projects linking adults and youth; sponsor creative activities and events that help people get to know their neighbors.

**Businesses:** develop family-friendly policies that allow parents and all employees to be active in their children's lives; provide opportunities for all employees to volunteer.

**Government:** Make asset development a top priority through policy, training and resources; initiate efforts to name shared values and boundaries.  
(p.12).