Assessing the Needs

of

Nevada County's Children

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A Report Prepared for the First 5 Nevada County Commission
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"…even as Americans demand a greater focus on children, public investments are shifting away from them. In California, this is leading to children who are increasingly unhealthy yet lack health insurance, failing in school or unable to enroll in preschool, and living in families that lack the most basic supports to be safe and secure." California Report Card 2005/Children Now

PART I: INTRODUCTION

Why Assess Needs?

As of January, 2005 Nevada County's population was 98,955; children 0-18 comprised 20% of the total. Just over 5% (5,223) of the population were children under six. First 5 Nevada County has a mandate to serve those young children and their families and caregivers, to create and implement "…an integrated, comprehensive, and collaborative system of information and services to enhance optimal early childhood development." An important component of the mandate was to design and implement a strategic plan. That plan is dynamic rather than static. It is continually reexamined and modified to fit the ever changing needs of the children of Nevada County. Assessing needs is an equally dynamic process, for the County's population and the services and programs that are available to that population are in continuous flux.

In late 2005 the First 5 Commission decided a comprehensive, broad-based needs assessment would be valuable as it takes a closer look at First 5's guiding principles and investment strategy. The Commission believes that such an assessment will:

- ensure that First 5's Strategic Plan reflects local needs;
- guarantee that its decisions are based on solid information and evidence;
- help the Commission set priorities;
- assist in evaluating the outcomes of First 5-funded programs and services.
- help guide policy and program development;
- provide crucial information on which to base funding allocations;
- identify gaps in service;
- provide valuable information to organizations who serve children and caregivers.

The needs of Nevada County's children and their caregivers have been assessed by a number of local organizations that serve those populations. However, there is no single report that organizations can access that gives the "big picture" of children's needs. This report strives to do just that: "harvest" the wide range of information from the literature, data bases and previous needs assessments and bring that information together in one comprehensive report.

What is Included in This Needs Assessment?

In addition to local needs assessments, there is a considerable amount of data and an extensive body of literature that can be drawn upon to identify both the indicators that measure and the factors that impact the optimal early childhood development of young children. In order to aggregate the disparate assessments and provide an in-depth look at the needs of children 0 to 5, First 5 has compiled national, state, regional and local data and conducted a literature review.

First 5 also designed a Provider Survey as a way to elicit current perceptions of unmet needs and gaps in services, which was administered to a large sample of organizations and individuals who serve young children. These qualitative rather than quantitative "data" were collected from people with many years of experience. We wanted to tap into the breadth and depth of their expertise; that makes their input into this report particularly meaningful and relevant.

Utilizing all of the above sources of information, this report identifies for the First 5 Nevada County Commission:

- key indicators that measure optimal early childhood development, including the health and well being of young children;
- key factors that impact the development, health status and well being of children;
- the needs of Nevada County's children 0 to 5 and their families;
- which needs are not being met or only partially being met.

A word about the data in this report: The statistical data must be taken with a grain of salt. There is an old saying: "There are lies, damn lies and statistics." It is easy to misinterpret ~ or over interpret ~ data, making inferences or generalizations that the numbers don't support. For instance, you will read in this report that Nevada County is ranked fourth of all counties in the State in white infant mortality rates, but 18th in black infant mortality rates, a startling disparity. However, that rate is based on 667.7 white births (three-year average) and no black births (three-year average). In addition, some of the data we have for Nevada County are regional data (we have such a small population that collecting data for us alone is just not seen as cost-effective), and some data was collected on children older than five. Finally, because different governmental agencies collect some of the same data, there can be differences in data reporting, and often the time between the collection of the data and its publication can be two-three years or more. Nevertheless, data can provide useful guideposts.

PART II: FRAMING OUR VIEW OF CHILDREN'S NEEDS

Nevada County's children will be resilient, optimistic, and healthy; they will be safe, capable, and strong, and know it; they will grow up in a family and community that will prepare them for success. First 5 Vision Statement

A useful construct we can use to frame our view of children's needs is the iconic Hierarchy of Needs, formulated by Abraham Maslow in the 1950's. This frame can help us see the "big picture" of needs, rather than focusing on discreet, individual needs. While Maslow's hierarchy has been refined through the years, the basic elements remain the same. The hierarchy is most often graphically represented as a pyramid, with each level of needs serving as a foundation for the others. The first four levels of needs are often referred to as "deficiency needs," i.e., needs that impede our physical, psychological and emotional growth if they aren't met. They are universal and must be met if an individual is to realize her/his potential for becoming all she/he is capable of ~ the "growth need" of self-actualization. As these needs relate to children, they are:

Physiological Needs: infants and children must have their hunger, thirst and bodily comfort needs met. Bodies crave food, liquid, oxygen, sleep, freedom of movement, a moderate temperature; they need to be free of disease. If the body is deprived of these needs, we will feel distress and be able to focus our energies only on satisfying those needs. Another need that is crucial for infants that was not included in Maslow's original research is "sensory-driven neural activity," which is critical for healthy brain development; touch is one of those activities. There is now considerable evidence that infants will not thrive if the physiological need for touch ~ caressing, holding, stroking ~ is not satisfied.

Safety/Security Needs: Infants and children have a need to feel safe and secure; out of danger; out of harm's way. As the physiological needs are met, the need for security comes to the fore. These needs are primarily psychological in nature. Children need to feel they live in a predictable world, one that is stable and consistent and holds few surprises. For example, most children prefer a set bedtime routine and will become distressed if that routine is disrupted. In addition, we now know that bonding and attachment are key needs that must be met if infants are to thrive.

Love and Belongingness Needs: Infants and children need to feel loved and accepted. These needs fully emerge once the physical and safety needs are met. To Maslow belongingness combined both the urge to give as well as to receive love. To give love is to include and accept selected others into our world: we "belong" to them and they to us. Maslow believed that the desire for love and belonging was the lowest level of unmet needs for most Americans.

Esteem Needs: There are two types of esteem needs: self-esteem, which comes from a sense of mastery or competence; and the esteem others have for us. Children need to achieve and they need recognition, approval and attention. These are needs that surface once the other three need levels are met.

Self-Actualization Needs: Only after the four levels of "deficiency needs" are met does the need for self-actualization, a "growth need" materialize. It comes as a

desire to realize our full potential, to become all that we are capable of becoming. Self-actualization takes many forms including a quest for knowledge, understanding, beauty, self-fulfillment, meaning in life. These needs are not likely to be ones young children have. Indeed, many of us don't move out of the esteem needs level and if we do it's usually well into our adulthood.

Although Maslow emphasized that we must move through each level if we are to even have the hope of becoming self-actualized, our needs are often not linear, resembling a spiral more than a pyramid. For instance, a child may have moved into the "esteem" level ~ enthralled with mastering a task, caught up in a sense of achievement. Then her parents separate and her need for security becomes the primary focus of her world.

Our role as caregivers and service providers is to do all we can to meet children's deficiency needs so that, as adults, they can move toward self-actualization; so that the vision of First 5 might become a reality. And, because children develop within the context of the family, we must also strive to meet the needs of parents so that they can support their child's growth.

PART III: CHILDREN'S NEEDS: WHAT WE KNOW AND HOW WE KNOW IT

The research literature provides us with a long list of children's needs, and identifies key indicators that can help us assess whether those needs are being met. In addition, we know there are factors that influence those key indicators. For example, immunization levels, an indicator of the physical health of children, can be influenced by factors such as access to medical care and parenting education.

In addition to the literature, there is a wealth of data to be gleaned from numerous national, state and county sources. Information on needs also can be harvested from local agencies who have made assessments in the process of developing their strategic plans or applying for grant monies, including from First 5. First 5 Nevada County, itself, is a source of information on needs, assessed as the Commission applied for external monies or made decisions about the use of Prop 10 funding. In addition, surveys of Nevada County providers of services are a valuable source of information about children and caregiver needs.

Nevada County's Population Demographics

Before we explore indicators and factors, it would be useful to take a look at Nevada County's population demographics, broken out by zip code. Not all zip codes have been included, which means that adding up the zip code figures will not equal the Nevada County figures. It is worth keeping in mind that these statistics are from the 2000 Census. However, demographic data that is more current are mostly considered to be projections.

NEVADA COUNTY DEMOGRAPHICS BY ZIP CODE[1]
Population, Race, Age Under Six
U.S. Census 2000

	Nevada County	95945 Grass Valley	95946 Penn Valley	95949 Grass Valley	95959 Nevada City	95960 North San Juan	95975 Rough & Ready	95977 Smart-ville	96161 Truckee
TOTAL	92,033	23,957	9,746	17,761	17,367	492	1,597	1,010	15,840
White	85,473	22,288	9,159	16,897	16,168	455	1,504	940	14,087
Hispanic	5,177	1,270	532	671	593	36	46	38	1,980
Under 6	4,889	1,363	456	785	795	18	65	64	1,095

As we can see, Grass Valley (downtown and surrounding area) has the largest population (26% of county total), and the most white residents (24% of total) and children under six (28% of total). Southern Grass Valley, which includes Alta Sierra and South County, and Nevada City and surrounding area have the next largest population. However, Truckee, fourth in numbers of residents, has the largest percentage of Hispanic residents (38% of total Hispanic population) and the second largest percentage of children under six (22%). In fact, Grass Valley (95945) and Truckee have 63% of the county's Hispanic residents, and over 50% of children under six. Hispanics comprise 5.6% of the County's population.

The number of children under age 6 in North San Juan (18) is much lower than any other area, 3.7% of the population on "the Ridge." Children under age 6 comprise 5.7% of Grass Valley's population (95945), 4.4% of South County (95949), 4.6% of Nevada City's, 4.7% of Penn Valley's and 6.9% of Truckee's.

California Department of Finance (CDF) projections estimate Nevada County's population at 98,955 as of January, 2005, a 9.3% increase from the Census 2000 data. CDF estimates the Hispanic population for 2005 to be 6,365, just over an 8% increase from 2000. If those numbers are accurate, Hispanics would comprise 6.4% of the population, an increase of less than 1% in five years.

Yes, Nevada County has a majority population of Caucasians. However, we are now experiencing an in-migration of Latinos, most of whom are new immigrant families. Systems that serve immigration populations well honor their culture and language and are culturally competent. Latinos often struggle to acculturate. Making certain that Latino families can access and utilize the services they need to be healthy and productive members of the community is part of every health and human service organization's responsibility.

Moving now into using Maslow's the Hierarchy as our frame, let's see what we know about children's needs.

[1] Not all communities are represented. Not included are: Washington, Cedar Ridge, Chicago Park, Soda Springs and Floristan.

Physiological Needs

Physiological needs are primarily biological and are the strongest needs individuals have. Until physiological needs are met, an individual's primary motivation is to fulfill them. Children, of course, depend on adults or society to meet these needs.
In this area of need we looked at such indicators as:

- infant mortality
- incidence of low birth weight
- immunization levels
- air pollution/environmental quality
- prevalence of asthma
- obesity
- injury rates
- dental health
- food security
- sensory-driven neural activity, e.g., touch

Factors we examined included:

- availability of and accessibility to medical and dental services
- health insurance enrollment rates
- early prenatal care
- support for breastfeeding
- availability of nutrition information and healthful foods
- availability and access to recreation, including active play.

We examined data collected by several sources, including (but not limited to) the California Department of Health Services and the Department of Finance, First 5 California, First 5 Nevada County and Nevada County Human Services Agency. The following three sources were particularly helpful:

- The County Health Status Profiles, which is compiled by the Center for Health Statistics at the behest of the California Department of Health Services and the California Conference of Local Health Officers. The focus of the data are on those indicators recommended by the United States Public Health Service for monitoring progress toward achieving goals set forth in Healthy People 2010.

- The California County Data Book, which is compiled from a variety of sources and is utilized by Children Now, a national organization with "chapters" in each state, to issue an annual "Report Card."

- First 5 California, which has compiled an extensive data base as it has made decisions on where to focus Prop 10 monies.

- First 5 Nevada County, in partnership with United Way, who recently completed a second version of KidsCAP, A Report to the Community on the Well-Being of Nevada County's Babies and Young Children. Reflected in the report are data drawn from several sources. Telephone and face-to-face interviews with parents and caregivers, conducted locally, make up the heart of KidsCAP.

- Nevada County Human Services Agency, specifically Community Health and Adult and Family Services, which collects public health data, and Medi-Cal, Women, Infants and Children (WIC) and other data pertinent to this needs assessment.

Indicators: Infant Mortality and Low Birth Weight
Factors: Prenatal Care and Breastfeeding

To begin, we will take a look at the indicators of infant mortality and low birth weight and the factors of prenatal care and breastfeeding. As stated in County Health Status Profiles, infant mortality "…is a universally accepted and easily understood indicator…" Low birth weight can result in early, even a lifetime of, health problems and may indicate a lack of access to prenatal care. As a Policy Brief published by UCLA[2] states:

> Preconceptional and prenatal care are the cornerstones to a healthy start: They prevent birth defects and reduce the risk of low birthweight and prematurity, which account for the majority of infant deaths and disabilities.

Therefore, if a pregnant woman does not receive prenatal care, we need to identify whether such services are available and how they are delivered.

The advantages of breastfeeding, not just to infants, but to mothers, families and society, have been well documented through extensive research. The County Health Status Profiles states:

> Breastfeeding provides advantages with regard to the general health, growth, and development of infants, while significantly decreasing their risk for a large number of acute and chronic diseases. There are also a number of studies that indicate possible health benefits for mothers such as less postpartum bleeding, rapid uterine involution, and reduced risk of ovarian cancer and post-menopausal breast cancer. In addition to individual health benefits, breastfeeding provides significant social and economic benefits to the nation, including reduced health care costs and reduced employee absenteeism for care attributable to child illness.

[2] UCLA Center for Healthier Children, Families and Communities, California Policy Research Center. *Policy Brief Number 19.*

Considerable amounts of data pertinent to Nevada County have been collected about these indicators and factors, including the following:

COUNTY HEALTH STATUS PROFILES 2005
AND
CALIFORNIA COUNTY DATA BOOK 2005
(Re rank: 1-58, with 1=best)

INDICATORS	NEVADA COUNTY Health Status Profiles	NEVADA COUNTY Data Book 2005	CALIFORNIA	HEALTHY PEOPLE 2010 GOAL
Infant Mortality All Races/All Ethnic Groups (2000-2002)	1.3 deaths; 1.7/1,000 (803.3 live births; 3-year average) **RANK: 4/58**[3]	LNE: Low Number Event (10 or fewer over 3 years)	5.5/1,000 (Born in 1 year)	4.5/1,000 (Born in 1 year)
Infant Mortality Asian/PIs	0.0 deaths; 0.0/1,000 (16.7 live births: 3-year average) **RANK: 4**		4.4/1,000	4.5/1,000
Infant Mortality Black	0.0 deaths0.0/1,000 (1 live birth: 3-year average) **RANK: 18**		11.6/1,000	4.5/1,000
Infant Mortality Hispanic	0.3 deaths; 3.0/1,000 (112 live births; 3-year average) **RANK: 10**		5.2/1,000	4.5/1,000
Infant Mortality White	1.0 deaths; 1.5/1,000 (667.7 live births; 3-year average) **RANK:4**		4.8/1,000	4.5/1,000
Low Birth Weight* (2001-2003) * 5.8lbs. or less	5.6% (824 live births; 3-year average) **RANK: 19** (Data not broken out by ethnicity)	5.6% **RANK: 18**	6.4%	5%
FACTORS				
Prenatal Care: Not Begun During 1st Trimester (2001-2203	15.6% **RANK: 19** (Data not broken out by ethnicity)		13.6%	10%
Prenatal Care: Early/Adequate	69.8% **RANK: 39** (Data not broken out by ethnicity)	84.4% **RANK: 19**	77.7%	90%
Breastfeeding: Initiated During Early Postpartum	92.6% (739 births with known feeding method) **RANK: 8** (Data not broken out by ethnicity)		83.3%	75%

[3] Ranking based on a three-year average of the birth cohort infant death rates, which are per 1,000 live births, not on individual infant deaths. Nevada County's death rates are considered statistically unreliable.

An analysis of the data tells us that Nevada County is doing exceptionally well at keeping white infant mortality to low levels, exceeding both the State's numbers and Healthy People 2010's goal. While we might yearn for no deaths, a three-year average of 1.5 out of 1,000 allows us to rank fourth in the state. There have been so few Black and Asian/Pacific Islander births over the past three years that the rankings are meaningless. However, Hispanic infant mortality is more of a concern. While the three-year average of three deaths per 1,000 is below both the state average and the Healthy People goal, it is twice the white infant mortality average. As the Latino/ Hispanic population continues to increase, efforts to offer services and programs that focus on such areas as prenatal care tailored to that population will need to increase.

Receiving prenatal care is critical to a healthy birth, and here Nevada County is not doing as well. Close to 16% of pregnant women do not receive prenatal care in their first trimester, two percentage points higher than the current State percentage. The Healthy People goal is 10%, i.e., the goal is that 90% of pregnant women receive prenatal care in their first trimester. Nevada County's state-wide ranking is 19, which is surely not optimal. To compare, only 7.6% of number one ranked Marin County's pregnant women do not receive prenatal care.

When we look at the percentage of women who do receive prenatal care beginning in their first trimester, an interesting discrepancy arises. According to the Health Status Profiles, Nevada County is ranked 39th, yet the County Data Book indicates that the County is ranked 19th. A closer look at the data explains the difference. The County Data Book ranking, which shows over 84% of women receive first trimester prenatal care, uses raw data: the actual number of women who seek care before the fourth month. The Health Status Profile utilizes the "Adequacy of Prenatal Care Utilization Index." That index looks at two dimensions: the timing of the initiation of care, i.e., the month prenatal care began; and the number of visits from the beginning of care to delivery. Thus, adequate care is defined as prenatal care begun by the fourth month and 80-109% of the recommended visits over the course of the pregnancy (the 109% figure reflects those women who exceeded the recommended number of visits).

According to KidsCAP data, the percentage of Nevada County Hispanic women who receive prenatal care in the first trimester is considerably lower than for white women, although the trend line went up in the three years beginning in 1999. In 1999, 42.9% of Hispanic women received care; that rose to 67.9% in 2001.

KidsCAP data give us yet another picture of early prenatal care. Of those parents who responded to the 2005 telephone survey questions on prenatal care (N=169), 97.5% who received prenatal care initiated it within the first trimester.

Children Now's California Report Card 2005, utilizing data on infant mortality, low birth weight and prenatal care, gives the state a "B+" on infant health, while at the same

time expressing concern about the racial disparities. We can see evidence of those disparities in Nevada County.

With regard to breastfeeding, Nevada County mothers are considerably above the Healthy People goal of 75% and the State-wide percentage of 83.3%. Almost 93% of Nevada County women initiate breastfeeding during early postpartum, resulting in a ranking of eighth out of 58 counties. Available data does not report on the numbers of women who continue to breastfeed beyond early postpartum. Mothers who initially breastfeed may not continue the practice, particularly if they don't have breastfeeding support services to assist them.

NOTE: See Part V, Comments Section, for recently released data from the *County Health Status Profiles 2006*.

The County's Women, Infants and Children Supplemental Nutrition Program collects data on the WIC participants who breastfeed. Let's look at the statistics on WIC mothers who breastfeed exclusively or use a combination of breastfeeding and formula feeding with their infants (defined as one year of age and under).

Infant Feeding Choices of WIC Participants Issued Food Vouchers[4]
Nevada County

	Total Infants	Exclusively Breastfed	Percent Breastfed	Combo Fed	Percent Combo
4/03	315	87	28.2	79	25.6
7/03	325	103	31.7	89	27.4
10/03	297	88	29.6	65	21.9
1/04	320	107	33.4	68	21.3
4/04	323	111	34.4	75	23.2
7/04	308	115	37.3	55	17.8
10/04	291	107	36.8	72	24.7
1/05	287	102	35.5	66	23.0
4/05	322	116	36.0	77	23.9
10/05	336	122	36.3	65	19.3

Although these data cannot be compared to the Health Status Profiles data, which was collected on twice the number of infants and only at early postpartum, it is interesting to note that a much lower percentage of WIC infants were breastfed exclusively. It may be that a percentage of the mothers whose breastfeeding rates are reported in the Profiles stopped breastfeeding after a month or two and the WIC data may more accurately reflect reality. In any case, Nevada County's high ranking needs to be viewed with caution.

[4] Infant Feeding Choices for Certified Participants Issued FI (food instrument, i.e., food voucher or check). California Department of Health Services, WIC Program. Not all available data are presented, including data on "formula only" infants.

Indicator: Immunizations

Another indicator that children's physiological needs are being met is immunization levels. First and foremost, immunizations protect children from infectious diseases such as measles, mumps, pertussis (whooping cough), chickenpox, polio, hepatitis and diphtheria, some of which could result in death. Indeed, the State deems immunizations so critical to children's health they are a requirement for entry into kindergarten. In addition, as KidsCAP points out that since children are immunized during well-baby visits when they are 0-2, "…immunizations may be an indication of whether young children are receiving regular check-ups and medical care."

Whether to immunize one's child, which has been an almost universally accepted practice, has, nevertheless, always had its critics. Some people believe that it is better to allow your child to contract diseases, such as chickenpox and measles, rather than run the risk that the vaccine itself might lead to untoward consequences, such as autism. Public health professionals, researchers and the medical profession work hard to educate the public about the benefits of immunizing children and challenge the viewpoint of those whose claims of deleterious effects have yet to be substantiated. Nevertheless, there continues to be a knowledge gap about how important immunizations are to children's health and to the health of the community. KidsCap 2005 presented data on what is happening in Nevada County.

Children with All Required Immunizations
KIDSCAP 2005[5]

	2002	2003	2004
Children Enrolled in Public Child Care Centers:			
Nevada County	86.1% (N=236)	84.2% (N=347)	77.3% (N=163)
California	94.8% (N=85,452)	94.6% (N=90,520)	95.1% (N=96,396)
Children Enrolled in Private Child Care Centers			
Nevada County	91.4% (N=395)	80.5% (N=663)	77.5% (N=448)
California	93.7% (N=260,013)	92.2% (N=261,811)	92.5% (N=279,936)
Children Enrolled in Head Start:			
Nevada County	93.2% (N=110)	79.5% (N=62)	68.8% (N=64)
California	96.0% (N=74,341)	96.2% (N=73,992)	96.5% (N=80,793)
Children Enrolled in Kindergarten			
Nevada County	79.0% (N=825)	77.3% (N=836)	80.3% (N=856)
California	92.3% (N=479,348)	92.5% (N=475,163)	92.9% (N=473,705)

[5] The data presented in that report came from several sources, including Nevada County Human Services Agency (Community Health) and the Immunization Branch of the State Department of Health Services.

KIDSCAP 2005[6]
Children with Personal Belief Exemptions from Immunizations

	2002	2003	2004
Children Enrolled In Public Child Care Centers:			
Nevada County	2.6% (N=7)	7.3% (N=30)	1.0% (N=2)
California	0.7% (N=671)	0.8% (N=740)	0.7% (N=734)
Children Enrolled in Private Child Care Centers			
Nevada County	6.9% (N=30)	6.0% (N=47)	8.7% (N=50)
California	1.7% (N=4,734)	1.8% (N=5,230)	1.7% (N=5,155)
Children Enrolled in Head Start			
Nevada County	6.8% (N=8)	5.1% (N=4)	15.1% (N=14)
California	0.3% (N=227)	0.3% (N=210)	0.3% (N=243)
Children Enrolled in Kindergarten			
Nevada County	12.6% (N=132)	11.2% (N=121)	9.5% (N=101)
California	1.1% (N=5,742)	1.2% (N=5,938)	1.2% (N=6,340)

The data show us that Nevada County's young children are lagging behind the state in their immunization levels. In the three years encompassing 2002-2004, they have been anywhere from 2% to 32% below state-wide percentages; the state-wide percentages have remained constant. For those children in child care, an average of 82% have been fully immunized over those three years; the state-wide average has been 94.6%. It is important to note that the data are for children with all required immunizations. Parents may have chosen to immunize their child against some diseases and not others. Nevertheless, the discrepancy between the county and the state percentages is noteworthy.

A further look at this data show us that the immunization levels of children enrolled in child care, whether public, private or Head Start, has steadily decreased. For example, in 2002 86.1% of children enrolled in public child care center were fully immunized. That dropped to 77.3% in 2004. The drop had been even more dramatic for those children enrolled in private child care (a drop of 13.9 percentage points) or Head Start (a drop of 24.4 percentage points). Immunization levels for children enrolled in kindergarten have increased, but only slightly (1.3 percentage points).

Other useful data points to examine are the percentages of children whose parents/ caregivers claim a personal belief exemption from immunization for them. Here, too, the differences between the county and state-wide percentages are worth examining. The state-wide percentages have remained constant and at low levels (although it's interesting to note that exemptions claimed in private child care center and in Kindergarten are about 1% above those claimed in public child care centers and Head Start). Nevada County percentages have ranged from 1% to 15.1%. The three-year average in child care centers is 6.6% (state-wide average=.9%); while the average in kindergarten is 11.1% (state-wide average=1.16%).

[6] Ibid.

It might be useful to compare Nevada County data with other rural, mountain communities.

Children with All Required Immunizations[7]
2004 Child Care Assessment Results

	2004
Children Enrolled in All Child Care Centers:	**Nevada County: 76.53% (N=675)**
Sierra County	89.36% (N=47)
Lassen	87.36% (N=242)
Plumas	81.88% (N=131)
Siskiyou	69.37% (N=317)
Children Enrolled in Kindergarten	**Nevada County: 80.3% (N=856)**
Sierra County	93.55% (N=29)
Lassen	83.42% (N=327)
Plumas	83.07% (N=157)
Siskiyou	79.61% (N=371)

Children with Personal Belief Exemptions from Immunization[8]
2004 Child Care Assessment Results

	2004
Children Enrolled in All Child Care Centers:	**Nevada County: 7.48% (N=66)**
Sierra County	6.38% (N=3)
Lassen	3.25% (N=9)
Plumas	6.88% (N=11)
Siskiyou	14.44% (N=66)
Children Enrolled in Kindergarten	**Nevada County: 9.47% (N=101)**
Sierra County	3.23% (N=1)
Lassen	5.36% (N=21)
Plumas	10.58% (N=20)
Siskiyou	11.16% (N=52)

What do these comparisons tell us? If we look at the data about children in child care centers, only Siskiyou County has a smaller percentage than Nevada County of children who had all their required immunizations in 2004 (7.16 percentage points difference). This is also true with children enrolled in kindergarten: Only Siskiyou County had a smaller percentage than Nevada County ~ but not by much (.69 percentage points).

Data for "personal belief exemptions" is similar. For children enrolled in child care centers in 2004, only Siskiyou County had a larger percentage of exemptions: 6.96 percentage points higher than Nevada County. The kindergarten data shows us that two counties had a larger percentage of "personal belief exemptions:" Plumas County (1.11 percentage points higher) and Siskiyou (1.69 percentage points higher).

[7] California Department of Health Services, Immunization Branch.
[8] Ibid.

Siskiyou County is considerably more isolated than Nevada County, which may account for its lower rates of immunization. Rural communities often attract people who want to get away from not only the urban/suburban lifestyle, but from government entities they may feel are watching over their shoulders and/or dictating how they must live their lives. This may be a characteristic of the most isolated parts of Nevada County. Also, we do not have data on immunization levels in the growing Latino population, including undocumented Latinos who may be fearful of seeking health care.

Indicator: Air Pollution and Asthma Prevalence

Nevada County ~ land of fresh, mountain air free of the pollution that hangs over many of California's urban areas. That was true once, but no longer. Anyone who has watched the Sacramento news shows that show the ozone levels on the weather map knows that ozone levels creep up from the valley, spreading through the foothills. Western Nevada County seems to be a particular target for unhealthy air. Let's take a look at the three years beginning in 2001.

OZONE DAYS PER YEAR
Exceeding State Standard of 0.09 Parts per Million
(California County Data Book 2005)

	2001	2002	2003	3 Year Average
Ozone Days	21	24	23	23 **Rank: 35** (1-58; 1= best)

Ranking 35th out of 58 counties should ring an alarm bell. Santa Clara County is ranked 27th; Orange County is 30th. Indeed, several urban/suburban counties have fewer days that exceed the state standard.

Scorecard.org, which calls itself "The Pollution Information Site," presents information about the six criteria air pollutants that have National Ambient Air Quality Standards established by the Clean air Act. The pollutants on which they report are carbon monoxide, lead, nitrogen dioxide, ozone, particulate matter and sulfur dioxide. The site's sources are two databases from the U.S. Environmental Protection Agency: the National Emissions Trend database, and the Aerometric Information Retrieval System database. Environmental engineers and other specialists developed the site and have an advocacy focus. Scorecard provides data about national, state and county air pollution. The amount of information they present is impressive. We will look at just a small part of their data.

- Air Quality Rankings: Health Risks, Exposure and Emissions
  - Nevada County ranks among the "dirtiest/worst" counties in the U.S. in the 8 emissions[9] measured (1999 data). All but one of the 8 were at the 70th percentile or higher (the higher the percentile the worse the air quality).
  - Of the 7 exposure measures (2002 data), Nevada County ranked among the "dirtiest/worst" in 3 (60th percentile or higher): air quality index, I-hour average ozone concentration and 8-hour average ozone concentration. Nevada County ranked much better in particulate matter concentration ~ in all but one measure the county is at the 30th percentile or lower.
  - When health risks were measured ("person-days in exceedence of national air quality standards for ozone"), Nevada County was at the 90th percentile.
  - Nevada County fared better when ranked with other counties in California. In only a few measures was Nevada County above the 50th percentile on the "cleanest/best" "dirtiest/worst" continuum.
  - When ranked with other California counties in health risks, Nevada County was at the 40th percentile.

- Population exposed to unhealthy levels of criteria air pollutants: ozone
  - Nevada County exceeded the National Ambient Air Quality Standards (2002 data) by 2,979,069 person-days. This tells us how often people experienced air quality that is in violation of Clean Air Act Standards for Nevada County.

- Exposures to Criteria Air Pollutants
  - Nevada County was rated "unhealthful" on the percentage of days with unhealthful air quality for sensitive populations.
  - The county was rated as "hazardous" as a result of a 90th percentile ranking in 2003 on the Air Quality Index.

This data shows us that air pollution and its impact on the citizenry of Nevada County is a serious problem that needs to be addressed.

One of the reasons we need to pay attention to how many days ozone is problematic is its correlation to asthma, although it is important to note that the exact causes of asthma are unknown. Asthma can be triggered by pollen, dust mites, mold, animal dander, respiratory infections and smoke. The California Department of Health Services states: "The development of asthma is determined by the interaction between genetics and environmental factors."

According to the Environmental Health Investigation Branch of the State Department of Health Services, it is difficult to follow changes in asthma's prevalence and incidence because data isn't available. There are readily available rates on asthma-related

[9] Various measures ranked: Carbon monoxide, nitrogen oxide, particulate matter, sulfur dioxide and volatile organic compound.

hospitalizations, but most people who are receiving medical treatment for the management and control of asthma are not hospitalized.

The California Health Interview Survey, conducted by telephone in 2001 and 2003 (included in the California County Data Book 2005), provided the following prevalence data:

- In 2001, 10.5% of Nevada County children, ages 0-17 were diagnosed with asthma, compared to 13.3% state-wide.
- In 2003, 17.3% of the county's children were diagnosed, compared to 14.8% state-wide.

Even with limited data we can see the upward trend. The KidsCAP survey resulted in the following data, which is specific to children 0-5:

- Percent of children diagnosed with asthma:
    - 2003 telephone survey (N=176): 18.3%
    - 2005 telephone survey (N=178): 15.0% (76.7% receiving treatment)
    - 2005 face-to-face survey (N=314): 13.1% (66.7% receiving treatment)

Although the KidsCAP survey show a downward trend, it's important to note that the number of respondents were a small sample of the population.

Asthma can be controlled if children are under medical care and receive treatment. Perhaps even more alarming than the prevalence data that are emerging is the percent of children who are diagnosed, but who are not receiving treatment. This may be indicative of a lack of access to medical care or a lack of understanding by the parent that asthma is a treatable medical condition.

Indicator: Obesity[10]

In September, 2004, The Institute of Medicine released "Preventing Childhood Obesity: Health in the Balance." This highly respected, non-profit organization, a component of the National Academy of Science, sounded the loudest alarm among many set off by health care organizations. The Centers for Disease Control and Prevention reported that the percentage of overweight children in the United States has tripled in the last three decades. For children between the ages two and five, the obesity rate had doubled between the early 1970's and 2000. It seemed that almost overnight

[10] "Obese" is defined as children who are considered both overweight and at risk of overweight using child-specific body mass index (BMI) scores. BMI is an direct measure of body fat calculated as the ratio of a person's weight in kilograms to the square of a person's height in meters (can be converted into a non-metric measurement). CDC considers a child overweight when his/her BMI is at or above the 95th percentile for their age and gender; at risk for overweight when the BMI is between the 85th and 95th percentile.

childhood obesity became the focus of every media outlet in the country. Finally, some said, this problem was beginning to get the attention it needed.

Obesity is a complex and systemic problem. Poor nutrition and inactivity are the leading contributors to this growing predicament. We live in a society where the car is king, sidewalks have become obsolete, and television and video games are at the top of leisure-time activities. In Nevada County we have the "rural factor:" roads unsafe for walking, houses often spread far apart (making spontaneous play more difficult) and isolated communities. In addition, the sheer abundance of unhealthy foods is amazing: an explosion of food choices at grocery stores, more and more convenience stores and fast food establishments, super-sized meals, thousands of television ads designed to trigger food consumption ~ the wonder is that everyone in the United States isn't overweight. Richard Jackson, M.D., MPH, former State Public Health Officer and currently on faculty at UC, Berkeley's School of Public Health, put it this way:

> Yes, the obesity epidemic is partly because we humans don't always have the self-discipline and willpower that we need, but largely the epidemic originates from an unhealthy environment ~ a dangerous nutritional, advertising, and built environment.

Children see upwards of 40,000 ads per year for junk food and sodas, and grocery stores line their shelves, at just the right height for young eyes, with enticing packaging of the foods and drinks they see on TV. Children don't recreate as they once did. Fear for children's safety, parents who are sedentary, and, as Dr. Jackson says, "…a built environment that makes it hard to walk, run or play," all contribute to the increase in obesity.

The number of hours children and youth spend in front of a screen ~ watching TV, playing video games, using the computer ~ contributes to a sedentary life. It's estimated that the average school child spends about 25% of his/her awake time in front of a TV or computer screen ~ more than any other activity. According to a report issued by the Kaiser Family Foundation in 2003, more than a third of children under six and 26% of children under two have a TV in their room.[11]

Obesity also has an impact on the economy. According to "Shape Up America," founded by C. Everett Koop, M.D. to combat obesity:

> Medical researchers, using prospective studies and national health statistics, put the cost of obesity at more than $100 billion annually. This includes $45.8 billion in direct costs, such as hospital care and physician services-or 6.8 percent of all health care costs. Further obesity cost the economy $18.9 billion a year for such indirect costs as lost output caused by death or disability from weight-related

[11] As reported in: Childhood Obesity, A Supplement to the New York Times, January 2006.

diseases. The number of work days lost to illness attributable to obesity amounts to 53.6 million days per year. The lost productivity costs employers an additional $4.06 billion annually.

While young children, of course, are not represented in these figures, the worry (and likelihood) is that overweight children will turn into overweight adults with all the concomitant health risks.

Another interesting effect of obesity is that in a perverse way it can be good for the economy, thus making prevention and treatment even more problematic. A January 22, 2006 article in the *Washington Post* , "Why America Has to Be Fat," cites factors identified by economists that make changing our fat society into a thinner one a challenge. The article brings out these economic facts:

- Revenue from "obesity industries" will likely top over $315 billion this year, including $133.7 billion for fast-food restaurants and $1.8 billion for diet books.
- Potato chip sales were $6.2 billion in 2004, carbonated beverages sales were $37 billion.
- Cookie sales were at $3.9 billion, $244 million of which was from Oreos alone.

Children Now, in its "Report Card 2005," gives California a "D" and states: "Childhood obesity puts children at risk for physical and emotional problems, places long-term strains on our health system, and threatens to reduce life expectancy for the first time in modern history." And there is considerable evidence that obesity follows children into adulthood, leading to chronic medical problems. A study by UCLA/RAND "…found that the effects of obesity are similar to 20 years of aging, and that obese adults have 30 percent to 50 percent more chronic medical problems that those who smoke or drink heavily."[12]

Asthma and sleep apnea are associated with being overweight. And for the first time, physicians are diagnosing young children with hypertension and type II diabetes, formerly called adult-onset diabetes. Hypertension, over time, is correlated with heart disease. The long term consequences of type II diabetes include blindness, poor circulation sometimes leading to amputation of limbs, heart and kidney disease and death. Type II diabetes is treatable and even curable with proper nutrition and exercise, but the best approach is to prevent it ~ with proper nutrition and exercise.

Information about obesity in young children is hard to come by. However, in an article in *Zero to Three* published in January 2005[13], we are told that children who are overweight at age 3 are almost eight times more likely to be overweight in adulthood.

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[12] Ibid.

[13] Lumeng, J. (January, 2005). What can we do to prevent childhood obesity. *Zero to Three vol. 25* (3), 13-19.

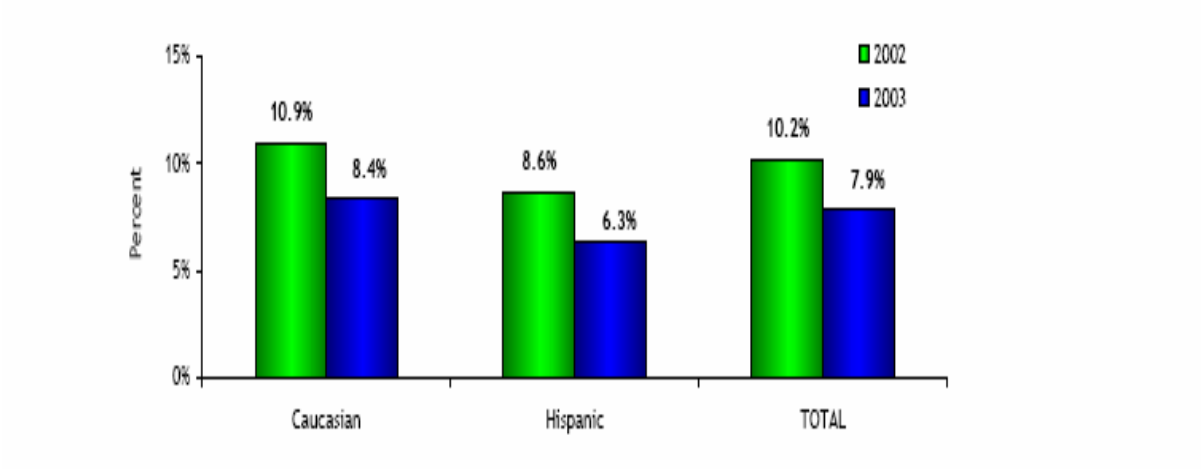
Children who are overweight under 3 years of age are no more likely than overweight toddlers to be overweight in adulthood.

While there is not much data on obesity in children under six, we do have information on older children. Unless obesity in our youngest children is prevented, they are likely to be represented in future data. Here are some pertinent statistics about childhood obesity in California, courtesy of Children Now:

- 28% of 5th, 7th and 9th graders are overweight, an increase of 6% since 2001.
- 35% of Latino children, 32% of Native American children and 21% of white children are overweight.
- 66% of teens, ages 12-17, drink soda daily, 48% eat fast food daily and just 25% get the recommended 5 servings of fruits and vegetables per day.

KidsCAP 2005 reported the following data for Nevada County's young children.

Percentage of Nevada County Children Who Are Overweight[14]
Ages 0-<5



Nevada County's Women, Infants and Children (WIC) program collects data on the young children who participate in this supplemental nutrition program. Data is available for children from 2-5 years of age in both Grass Valley and Truckee. Here's what that data tell us.

[14]Applied Survey Research (2005). *KidsCap 2005: A Community Assessment Report on the Wellbeing of Nevada County's Babies and Young Children.* First 5: San Jose CA. Source: The Pediatric Surveillance System, a component of the Centers of Disease Control and California's Department of Health Services.

Nevada County WIC Children[15]
Overweight or At Risk of Overweight
April 2005 and February 2006

WIC Site/ Age of Children	Number Overweight April 2005	Number Overweight Feb. 2006	At Risk of Overweight April 2005	At Risk of Overweight Feb. 2006	Overweight + Risk of Overweight Totals		Total Children in WIC	
Grass Valley					4/05	2/06	4/05	2/06
Age 2	11	14	20	19	30	33		
3	9	17	21	29	30	46		
4	12	17	28	26	40	43		
5	No data	2	No data	4	NA	6		
TOTAL	**32**	**50**	**69**	**78**	**100**	**128**	**559**	**602**
Truckee					4/05	2/06		
Age 2	2	3	2	1	4	4		
3	5	3	3	7	8	10		
4	6	4	6	7	12	11		
5	0	0	1	1	1	1		
TOTAL	**13**	**10**	**12**	**16**	**25**	**26**	**120**	**159**
Nevada County TOTALS	**45**	**60**	**81**	**94**	**125**	**154**	**679**	**860**

As we can see, 6.63% of all children who participated in the WIC program in April 2005 were overweight, compared to 6.98% in February 2006. Children who were at risk of being overweight in April 2005 comprised 11.9% of the total number of WIC children; 10.93% in February 2006. In April 2005, 18.41% of the total number of WIC children, therefore, were either overweight or at risk for overweight. In February 2006, that percentage had dropped a bit, to 17.91%.

While the numbers of Nevada County children who are overweight may not have reached epidemic proportions, there is definitely cause for concern. Yes, the percentage of overweight children ages 0-<5 decreased from 10.2% in 2002 to 7.9% in 2003. However, national and state trends show an upward trajectory and should serve as a warning.

Indicator: Dental Health

Oral health is an important aspect of physical health. Dentists recommend that a child's first visit occur before the age of one with subsequent visits every six months. According to the Children's Dental Health Project, oral health problems may lead to trouble with eating and speaking, low self-esteem and missed school. Care of primary teeth also sets a lifelong pattern of good dental hygiene. Indeed, Children Now is unequivocal about the need for dental health: "Keeping our children free of oral disease is vital to their good general health, growth and quality of life." Good oral health is

[15] Data supplied by Nancy Piette, WIC Coordinator

predicated on two things: knowledge about its importance, even from an early age, and access to affordable dental health care.

In February, 2006 the Dental Health Foundation (DHF) released a report that identified tooth decay in children as a significant problem in California.[16] And First 5 California, which has launched a statewide initiative called "First Smiles," calls early childhood caries a "silent epidemic," and states that it is the most prevalent chronic disease of early childhood.

The DHF report is based on screenings conducted in 186 elementary schools which involved over 21,000 kindergartners and third graders. Although the data are on children older than the 0-5 group we are investigating, the condition of kindergartner's teeth is a result of the care they received in previous years. Dr. Dave Perry, the Chair of DHF, declares tooth decay as the "single most widespread disease in California," and has this to say about the impact of tooth decay:

> Severe tooth decay can make children sick. Kids with tooth decay are prone to repeated infections in their ears, in their ears, their sinuses, and other parts of their bodies, because their infected teeth are continually pouring pathogens into their systems. Kids can't study when they hurt. They can't sit still, they can't focus.

Here are some startling statistics about tooth decay in California's children:

- By the time children are in kindergarten more than 50% already have decay, 19% have rampant decay and 28% have untreated decay.
- By third grade, tooth decay affects almost 2/3 of children.
- 28% ~ 750,000 ~ of elementary school children have untreated tooth decay.
- Of the 25 states surveyed, only Arkansas ranked below California in children's dental health.
- Almost ¾ of low-income elementary school children have had a cavity as compared to about ½ of children who are not low-income.

The study divided the State into six regions. Nevada County was included in a region, North and Mountain Communities, with 21 other counties. While it may be difficult to generalize from the data of 22 counties, it is worth looking at what the study found.

[16] Dental Health Foundation (2006). *Mommy, It Hurts To Chew: The California Smile Survey: An Oral Health Assessment of California's Kindergarten and 3rd Grade Children*.

ORAL HEALTH STATUS OF REGION 5's KINDERGARTEN CHILDREN[17]
(Includes Nevada County)

VARIABLE	REGION 5 (n=317)
% white non-Hispanic	55.4 (n=176)
English spoken at home (% yes)	71.5 (n=227)
% with caries experience	47.2 (n=150)
% with untreated decay	22.5 (n=71)
% with rampant caries	17.4 (n=55)
% needing treatment	12.0 (n=38)
% needing urgent treatment	1.1 (n=3.5)

The range of caries experience across the six regions studied was 42.1% to 62.1%, while the percent with untreated decay was 22.1% to 39.1%. In both cases, the region with the lowest incidence of caries experience/untreated decay was Region 6, which included seven Central Valley counties (Colusa, El Dorado, Placer, Sacramento, Sutter, Yolo, Yuba). Region 4, comprising 12 Central/Southern Farm counties, had the highest incidence.

As dental professionals can attest, there can be a gap in knowledge about the importance of "baby teeth." Caregivers may not know that baby teeth need to remain in the mouth until adult teeth push them out. One contributor to caries in young children is "baby bottle dental disease," caused by allowing an infant or toddler to sleep with baby bottles in their mouths, filled with milk or juice ~ even soda. Any efforts at prevention need to address this issue.

The California Health Interview Survey 2003, which combined Nevada, Sierra and Plumas Counties' responses, discovered that 51.1% of children ages 2-5 had never been to a dentist, up from 29.8% reported in the 2001 CHIS. Children Now reports that 47% of California's children, ages 2-4, had never been to a dentist. In their California Report Card 2005, they gave the state a "C-" in the area of dental insurance and access.

[17] Ibid.

The KidsCap interviews provide the following additional information:

AGE OF FIRST DENTAL VISIT & LENGTH OF TIME SINCE CHILD'S LAST VISIT
In Percentages

FIRST VISIT	2003 TELEPHONE	2005 TELEPHONE	FACE-TO-FACE
6 months - < than 1 year	4.1	10.4	4.2
1 year	19.2	28.0	13.7
2 years	39.5	37.9	32.6
3 years	26.5	16.9	33.2
4 years	4.6	6.7	14.7
5 years	NA	0.0	1.6
Don't know	6.1	0.0	0.0
Number of Respondents	**104**	**116**	**190**
LENGTH OF TIME SINCE LAST VISIT			
Less than a year ago	54.3	65.8	53.7
1 year ago, but less than 2 years ago	1.9	0.3	7.0
2 year ago or more	0.7	0.0	1.6
Never	40.9	33.9	37.7
Don't know	2.1	0.0	0.0
Number of Respondents	**176**	**177**	**313**

What we can see is the majority of 2003 respondents, 66%, first took their child to the dentist at either two or three years of age. The majority of the 2005 telephone respondents, 65.9%, had improved that by a year; their children saw the dentist for the first time when they were either one or two. The majority of the 2005 face-to-face respondents, 65.8%, told the interviewer that their child had first gone to the dentist at either age two or three. In all three interviews, the majority of those interviewed stated their child had last been to a dentist less than a year ago. However, over 1/3 of the respondents indicated their child had never been to the dentist.

Indicator: Injury Rates

The number of Nevada County's non-fatal, unintentional injuries that resulted in hospitalization for children 0-5 has decreased since 1998 from 14 to 11 per year. What follows is a list of reasons for hospitalization and the numbers of children who were injured.

NON-FATAL, UNINTENTIONAL INJURIES: NUMBERS/REASONS HOSPITALIZED[18]
Children ages 0-5

NATURE OF INJURY	1998	1999	2000	2001	2002	2003
Burns	0	1	0	2	0	0
Cut/pierce	0	1	0	1	0	0
Drowning/submersion	1	0	1	1	0	0
Fall	8	10	8	7	5	3
Motor vehicle-occupant	1	0	0	0	0	1
Poisoning	0	2	0	0	3	2
Struck by object	0	0	1	0	1	0
Suffocation	1	0	2	2	1	0
TOTAL CASES*	**14**	**20**	**14**	**15**	**15**	**11**

*Total cases represent all unintentional non-fatal hospitalized injuries. Only selected cases appear in the chart.

These figures show us that falls is by far the most frequent reason for injury, almost six times more frequent than poisoning, the next highest reason. The six-year hospitalized injury average is 11; if falls were eliminated, or even reduced to five per year, the average would drop to an average of 4 or 5. We do not have information on what caused the falls ~ and falls are endemic to childhood. Nevertheless, education on fall prevention for parents might mitigate hospitalization numbers.

Factor: Access to Health Care/Health Insurance

A key factor in the health and well-being of children is access to health care; having health insurance often determines accessibility. The cost of health care is so high that paying cash for medical services is frequently out of the question. California Report Card 2005 tells us that without health insurance children are:

- 8 times less likely to have a regular source of health care;
- 4 times more likely to do without needed surgical or dental care;
- 5 times more likely to utilize high-cost emergency room care.

In addition, children may not receive preventive health screenings and immunizations, or parents may delay treatment for asthma or other health problems.

Children Now gives California a "B minus" on health insurance and backs that grade up with the following numbers (except where noted, data is for children 0-18):

- 14% of children living in poverty lack health insurance, while only 2% of children in the highest-income groups do.
- 13% of Latino children lack health insurance compared to 3% of white children.
- 800,000 children in the state are uninsured; 5% are children under the age of 6.

[18] California Department of Health Services, Center for Health Statistics, EPIC Branch, 2005.

Here's what we know about Nevada County's children, as gleaned from KidsCAP 2005:

NUMBERS ELIGIBLE FOR MEDI-CAL: NEVADA COUNTY[19]
Ages < 1 Year-9 Years of Age
2000-2002[20]

	2000	2001	2002	3-Year Average
Age under 1 year	7	6	9	7.33
Ages 1-4	678	624	826	709.33
Ages 5-9	744	646	757	715.67

Between 2001 and 2002, there was over a 13% increase in the number of children ages 1-4 who were eligible for Medi-Cal and over an 8% increase for children 5-9. Why the numbers for children under 1-year of age are so low is worth exploring. Let's look at what we know about children who were beneficiaries of Medi-Cal in 2005.

MEDI-CAL BENEFICIARIES 2005: NEVADA COUNTY[21]

	January		**April**		**July**	
TOTAL	**8,055**		**8.144**		**8,157**	
AGE						
0-5	1,293	16.05%	1,294	15.95%	1,332	16.3%
6-10	833	10.34%	848	10.45%	833	10.2%
11-15	867	10.76%	849	10.46%	856	10.5%
16-20	702	8.72%	704	8.68%	687	8.4%
21-25	436	5.41%	441	5.44%	472	5.8%
26-30	439	5.45%	444	5.47%	453	5.6%
31-35	392	4.87%	402	4.95%	418	5.1%
36-40	395	4.90%	407	5.02%	404	5.0%
41-45	454	5.64%	454	5.60%	442	5.4%
46-50	410	5.09%	422	5.20%	417	5.1%
51-55	358	4.44%	369	4.55%	373	4.6%
56-60	283	3.51%	291	3.59%	285	3.5%
61-65	222	2.76%	218	2.69%	219	2.7%
66+	971	12.05%	971	11.97%	966	11.8%
FEMALES, 16-40	1,529	33.0%	1,561	33.33%	1,585	33.4%
ETHNICITY						
White	6,755	83.86%	6,810	83.93%	6,824	83.7%
Hispanic	743	9.22%	749	9.23%	764	9.4%

The statistics remained fairly constant over the six months reported. The highest percentage of Medi-Cal beneficiaries were young children, with over 1,000 in the 0-5 age bracket. There were, in fact, 500 fewer beneficiaries in the next age bracket, 6-10

[19] *KidsCAP 2005* . Source: RAND, California Statistics Center, 2003.
[20] As of April 2003, County-level data are no longer available in order to comply with the Health Insurance Portability and Accountability Act (HIPAA)
[21] Medical Care Statistics Section (MCSS), California Department of Health Services. www.dhs.ca.gov/mcss.

years of age. Only three of the five-year cohorts came close to 1,000 beneficiaries: 6-10, 11-15 and 66+. One-third of all beneficiaries are females who are of childbearing age (16-40). Almost 84% of Medi-Cal recipients are white, but it's important to remember that whites make up 93% of the County's total population. Hispanics are disproportionately represented. While they comprise about 6% of the total population, they comprise about 9% of the Medi-Cal population.

Healthy Families is designed to provide health insurance for the children of working parents whose income is at 200% of the poverty level. Let's look at enrollment in that program, by zip code, as reported in KidsCAP 2005.

ENROLLMENT IN HEALTHY FAMILIES: NEVADA COUNTY BY ZIP CODE[22]
August 2005

ZIP CODE	AREA	NUMBER ENROLLED
95945/95949	Grass Valley, Bear River, Peardale, Alta Sierra	990
95959	Nevada City and Surrounding Area	300
95946	Penn Valley	216
96160/96161/96162	Truckee and Surrounding Area	260
95712/95728/95924/ 95960/95975	Chicago Park/Cisco & Kingvale/Cedar Ridge/ North San Juan/Rough and Ready	64
TOTAL		**1,830**

Enrollment numbers in Healthy Families can change over the year because of the number of seasonal jobs in Nevada County. A family's eligibility may depend on when they apply. For instance, a child whose parent works in construction may be eligible in January but make too much money if the parent applies in September. It's also possible that in a seasonal job situation, the family's income is below the 200% level in January, making the child eligible for Medi-Cal but not Healthy Families. Some families are willing to apply for Healthy Families, which is an HMO-type program, but may not be willing to apply for Medi-Cal because they perceive it to be "welfare."

Enrollment trends for both Medi-Cal and Healthy Families also tell a story.

Medi-Cal & Healthy Families Enrollment Trends[23]
Nevada County: 7/01-7/04

	07/01	07/02	07/03	07/04
Medi-Cal	6,633	7,617	7,759	7,934
Healthy Families	1,375	1,890	1,971	1,902

Between 2001 and 2002 there was almost a 15% increase in the number of Medi-Cal recipients. Between 2002 and 2004, there was only a 4% increase. Healthy Families

[22] KidsCAP. Source: Managed Risk Medical Insurance Board, Health Families, Current Enrollment by zip code, 2005.
[23] California Health Care Foundation. www.chcf.org/topics/medi-cal.

enrollment saw a 27% increase between 2001 and 2002, but only a fraction of an increase between 2002 and 2004. The Healthy Families numbers can be explained in part by the decrease in state funding for outreach.

KidsCAP telephone and face-to-face interviews provide additional information about the percentage of Nevada County parents who have either health insurance or Medi-Cal, or whose report that their children have health insurance. Let's look at the 2003 and 2005 telephone interviews first.

- In 2003, of 176 respondents, 94.2% of parents had health insurance or Medi-Cal.
- In 2005, of 176 respondents, 87.9% of parents had health insurance or Medi-Cal.

That 6.3% decrease from 2003 to 2005 is a statistically significant difference.

- In 2003, of 176 respondents, 96.1% of parents reported their child had health insurance.
- In 2005, of 176 respondents, 92.8% of parents reported their child had health insurance.

That 3.3% decrease is not statistically significant.

The 2005 face-to-face interviews, with 313 respondents, resulted in notably different percentages from the telephone interviews.

- 65.2% of parents had health insurance or Medi-Cal, or 22.7 % less than the parents interviewed by phone in 2005.
- 80.3% of parents reported their child had health insurance, or 12.5% less than those responded in the telephone interview.

An important difference between the KidsCAP phone and face-to-face interviews is that the face-to-face interviews were conducted at state-funded preschools that are mandated to serve a low-income population. In addition, interviews were conducted with people who did not have (could not afford, in some cases) telephones and those who are mono-lingual Spanish. Also, Eastern Nevada County includes a substantial number of undocumented Hispanics who may fear a visit from INS if they apply for Medi-Cal, even though services are available to them.

Another program available to financially-qualified parents is the Child Health and Disability Prevention program, which provides a full physical, including hearing, vision, dental screening, nutritional assessment, immunizations and variety of tests. If problems are found, a public health nurse works with the families to get follow-up care for their child. In 2005 there were 3056 assessments (this does not reflect the number of children served, since a child may have multiple assessments).

An additional access issue is the dearth of physicians who accept Medi-Cal payment. Parents in Western County may take their children to one of two community clinics: Miners Family Health Center (a pediatrician joined the staff 12/05) in Nevada City; and Sierra Family Clinic in the San Juan Ridge area. In the Truckee area two physicians are willing to accept Medi-Cal and Tahoe Forest Hospital has a primary care clinic that also sees Medi-Cal recipients. Both sides of the county have family planning clinics. There are more choices for families enrolled in Healthy Families or have other types of insurance.

The local agency, Helpline, that is designated to be a central source of "Information and Assistance" for county residents, often receives calls from people who are looking for doctors and dentists who accept Medi-Cal. For instance, during the six months beginning July 1, 2005, they received 58 calls asking about dentists who accept Medi-Cal or Medi-Cal with limitations and 22 calls about doctors who accept Medi-Cal.

Access to dental care is problematic for children whose parents do not have dental insurance through their employer. According to the County Data Book, 23.7% of Nevada County's children ages 2-18 (under 2 if a tooth was present) lacked dental insurance in 2003. This information came from the California Health Interview Survey 2003, which combined Nevada, Sierra and Plumas Counties' responses.

Without dental insurance, few people can afford dental care. In addition, pediatric dentists are rare in the county. There are two dental clinics that serve children on Denti-Cal, Healthy Families or are uninsured. The one in Grass Valley, sponsored by Sierra Nevada Children's Services, sees only children, 18 and under. Operating one day per week, this clinic has served 2,000 children (0-18) since it began service in 2003. Sierra Family Medical Clinic on "the Ridge" also serves children (and people of all ages) who are either uninsured or are covered by Denti-Cal and Healthy Families.

Indicator: Food Security

Young children must have nutritious food on a consistent basis for optimum development of their bodies and minds. Lactating mothers also need to eat healthy meals in order to produce nourishing breast milk. Without readily available, high quality food children are at risk for health and behavioral problems; hunger is not a body or character builder.

Household food security, defined by the U.S. Department of Agriculture as the resources to "…access at all times enough food for active healthy living" is closely linked with economic security. Poverty, which will be discussed in the "Safety Needs" section, can mean a household cannot afford fresh fruits and vegetables or protein. It can also signify that the end of the month means no food at all. According to the "California Report Card 2005," there is an increasing number of parents unable to afford food for their families. In fact, the California Health Interview Survey discovered that 38% of

low-income parents were not able to afford food for their families in 2003, up from 35% in 2001.

According to the California Food Policy Advocates (CFPA)[24] there were 9,000 low-income adults in Nevada County reporting hunger or food insecurity; 19,161 other persons (children, grandparents, other relatives) lived in these households.

The Health Interview Survey also discovered a rise in food stamp recipients in households with children 0-11 from 10% in 2001 to 15% in 2003. Yet Nevada County lost over $2 million in food stamp benefits and over $550,000 in school nutrition reimbursement because they were underutilized.[25]

Food assistance programs include the "Child and Adult Care Food Program."[26] Here's the data on utilization by child care centers of this program:

NEVADA COUNTY PROFILE FOR CHILD CARE FOOD PROGRAM[27]
Federal Fiscal Year 2003-04

PROGRAM PARTICIPATION	CHILD CARE CENTERS
Number of Approved Sites	2
Free Enrollment (# of meals)	23
Reduced Enrollment (# of meals)	6
Paid Enrollment (# of meals)	5
Total Enrollment	**34**
Average Daily Participation	31

According to CFPA, 1,841 adults and children are eligible to participate in the program through center participation, yet 1,810 are "not served," over 98%, which ranks the county as second worst in the state. Data specific to children in child care are not available.

The Women, Infants and Children Supplemental Nutrition Program is another source of food. A program of the U.S. Department of Agriculture, WIC provides checks (vouchers) to pregnant and lactating women and their infants and young children that can be "cashed in" for specific food products at grocery stores. Foods that are on the WIC voucher list include cheese, peanut butter, beans and cereal. Currently checks cannot be used for fruits and vegetables, although there is growing pressure on the USDA to include them.

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[24] According to their web site, www.cfpa.net, CFPA is a statewide public policy and advocacy organization dedicated to improving the health and well-being of low-income Californians by increasing their access to nutritious and affordable food.

[25] Touched by Hunger, A County-by-County Report on Hunger and Food Insecurity in California, 2005. See www.cfpa.net.

[26] According to CFPA, The Child and Adult Care Food Program is the only program that provides funding for meals served in a childcare setting to children up to age 12 and impaired adults.

[27] California Department of Education, Nutrition Services Division.

According to the California WIC program, 76% of Nevada County's women, infants and children who were eligible for WIC were enrolled in WIC. These estimates were developed in January 2005 using data for April 2003.[28] Statewide the estimate was 82%. In 12 counties the population is so sparse that data are not meaningful. Estimates of enrollments in the other 45 counties (not including Nevada) ranged from 48% (Sacramento County) to 100% (five counties). Eighteen counties had higher enrollment estimates than Nevada County, 27 had lower estimates.

If we look at the actual participation numbers, we get another view of WIC in Nevada County. The State Department of Health Services sets a participation or caseload number for each county, i.e, they determine how many clients the county should serve. The state, with input from the county, can change that number, based on the percentage of "participation to caseload." The current caseload assigned to Nevada County is 1,450 women, infants and children. That number could be increased if the county begins to serve more than 1,450 (100% or above "participation to caseload") on a regular basis. Here are the quarterly caseload percentages for the County beginning in 2003:

WIC Eligible Participants Issued Checks: Nevada County[29]
and
Participation to State Caseload: 1,450

	Participation	Participation to Caseload
4/03	1,408	97.1%
7/03	1,398	96.4%
10/03	1,357	93.6%
1/04	1,431	98.7%
4/04	1,445	99.7%
7/04	1,345	92.8%
10/04	1,220	84.1%
1/05	1,251	86.3%
4/05	1,429	98.6%
7/05	1,450	100%
10/05	1,437	99.1%

In all but two of the months reported above Nevada County came close to the State's participation goal of 1,450. The July 2004 figures show a dip, as do the next two months' figures (not presented). Between May 2004 and October 2004 there was a steady decline in the participation to caseload percentages. The participation numbers started increasing in November 2004. There was a one-month decline in December 2004, but otherwise participation kept rising, culminating in a 100.3% participation to caseload in December 2005 (not presented). The decline in participation may be

[28] California Supplemental Nutrition Program for Women, Infants and Children (WIC). www.wicworks.ca.gov. The numerator was the certified WIC participants enrolled; the denominator was the WIC eligible population based on 2000 Census income data at 185% poverty level, updated with 2002 California Department of Finance personal income estimates.
[29] California Department of health Services, WIC Program.

explained in part by the two moves WIC had to make, first to a temporary site and then in October 2004 to a permanent site.

Project MANA, in Truckee, report that in the months of October, November and December, they distributed food to 535 families and served 120 WIC families. An average of 46% of the families they served were Caucasian, 54% were Hispanic and 55% were clients with children 0-5.

No child should go to bed or to school hungry. Indeed, all children should live with the assurance that food will be there when hunger signals the need to eat.

Indicator: Sensory-Driven Neural Activity

The science of brain development has helped us understand that children's brains are amazingly plastic at birth. As a Policy Brief published by UCLA[30] states, "Most of the brain's functional capacity doesn't develop until after birth, since the synapses connecting the neurons (brain cells) haven't fully formed." Almost all of children's brain cells do develop while they are in the womb, so most of the "scaffolding" (as the Brief says) for synaptic connections are in place when they emerge into the world. But babies need to have experiences that stimulate brain activity in order for those connections to take place. This is how the Brief explains it:

> Experiences that stimulate activity in particular brain regions facilitate the growth of connections in those regions, so that synapses can be said to form in a "use-dependent" manner. The brain's response to external stimuli (e.g., the taste of warm milk, the feeling of a mother's caress, the sound of a father's voice) is known as sensory-driven neural activity. Synaptic firing under the influence of new, external stimuli leads neurons to form connections to other neurons that have also been activated by sensory stimuli and experiences. Sensory-driven neural activity steers a young child's brain circuitry toward increasing organization

Touch is one of those "sensory-driven neural activities." There is, in fact, over 40 years of research that supports the theory that touch is crucial to infant development.

Research into touch and its impact began the 1950's with Harry and Margaret Harlow's work with infant monkeys. They found that monkeys deprived of maternal attention in infancy were invariably depressed, hyperactive to touch, hyperactive generally, socially inept, given to outbursts of violence, and often held themselves and rocked.[31] In the years since, observation of human infants and research into brain development have

[30] UCLA Center for Healthier Children, Families and Communities, California Policy Research Center. *Policy Brief Number 13.*

[31] Harlow, H.F. (1958), The nature of love. *American Psychologist 13*, 673-685.

expanded what Harlow postulated: touch is as important to our health and well-being as our sense of hearing, smell, taste and sight.

Frederick Leboyer, a French obstetrician may have said it best: "Being touched and caressed…is food for the infant. Food as necessary as minerals, vitamins and proteins."[32] And Ashley Montagu, in his seminal 1986 book, *Touching: Significance of the Skin*, discusses the importance of touch as a way to help infants "…transition from the womb to the world." Observation of infant orphans that are "warehoused" in institutions have shown anecdotally that not only may those babies fail to thrive, they may die.

James Prescott, a developmental neuropsychologist who was with the National Institute of Child Health and Human Development, believes that touch is an "essential sensory nutrient" for the developing brain. He theorizes that touch sensory deprivation results in brain dysfunction, which manifests itself in abnormal behaviors, such as depression, alcohol and drug abuse/addiction and violence.

Research has suggested that if premature infants receive even 15 minutes of massage a day, they gain weight faster, which leads to discharge from the hospital sooner than their non-massaged counterparts. There is some evidence that infant immune systems are enhanced if they are held and caressed. Parents are now routinely taught to provide skin-to-skin contact with their new baby, not only because of the physical benefits to the infant, but as part of the bonding/attachment process.

Not surprisingly, we do not have data on whether our children have enough touch in their lives to enhance their brain development and set them on the path to mental health. Parents need to understand the benefits of touching. For early childhood educators and kindergarten teachers, touching children in their care has become problematic. Because of the concerns about child abuse that have arisen in our society in the last decade or so, many caregivers and teachers are afraid to have their touch misinterpreted and have decided little or no touching is the safer route to take. An article published by the Association of Early Childhood Educators in Canada states:

> "…there is (correctly) a strong focus on trying to prohibit sexual and inappropriate touch. But when appropriate touch is not encouraged, as often happens, then all touch has the potential to become sexualized. Children don't learn to distinguish between appropriate and inappropriate touch. They miss out on a whole range of valuable touch experiences – friendly, nurturing, reassuring, comforting and healing. We should be instilling a sense of what appropriate touch is. Research shows that touch is critical for human development and well-being. Let us encourage the expression of appropriate touch in society.

[32] Leboyer, Frederick. (1997). *Loving Hands*. New York: Newmarket Press (paperback edition).

Summary and Conclusions: Physiological Needs

What have we learned from the data and literature about the physiological needs of young children? And what do the data tells us about whether the needs of young children in Nevada County are being met? Let's look at those questions side by side.

What Are the Needs?	Are the Needs Being Met in Nevada County?
Low infant mortality	Pretty well, but room for improvement. ▪ Ranked 4th in the State in infant mortality for whites (1.5/1,000 live births; HP goal is 4.5/1,000, regardless of ethnicity). ▪ Ranked 10th in the State in infant mortality for Hispanics, with a rate 2x that for white infants.
Early/adequate prenatal care	Not as well as they could be. ▪ Almost 16% of pregnant women do not get early prenatal care; Healthy People (HP) 2010 goal is 10%. ▪ Health Status Profiles tells us that 70% of pregnant women do get adequate prenatal care, but HP 2010 goal is 90%. State rank: 39 (County Data Book 2005 stats: 84% get early care; rank is 19th).
Healthy birth weights	Not bad but could be better. ▪ HP 2010 goal is no more than 5% of infants will be born with low birth weight; Nevada County is at 5.6% (State Rank: 19th).
Breastfeeding, begun early postpartum.	Depends on whose data we look at. ▪ Health Status Profiles says that Nevada County is ranked 8th in the State, with almost 93% of women initiating breastfeeding in early postpartum. HP goal is 75%. ▪ WIC participants' figures are lower: roughly 35% of WIC mothers "exclusively" breastfeed; about 22-23% combine breastfeeding with formula feeding.
Immunizations at high levels.	A red flag warning. ▪ Nevada County is lagging behind state-wide levels, most recently by 20% or more. ▪ Parents in Nevada County claim a "personal belief exemption" at much higher levels than state-wide. ▪ Comparing Nevada County to four other rural, mountainous counties we see our immunization percentages are quite a bit lower than all but one of those counties.
Freedom from air Pollution, i.e., clean air.	Another red flag. ▪ A 3-year average of ozone days/year that exceeded State standards places Nevada County 39th of 58 counties. ▪ In air quality, health risks, exposures and emissions, Nevada County ranks among the "dirtiest/worst" in the U.S. on most measures. However, the county did fare better when compared to other CA counties. ▪ The county was rated as "hazardous" due to a 90th percentile ranking in the 2003 Air Quality Index.

Low levels of asthma	Cause for concern. ▪ In 2001, 10.5% of Nevada County's children, 0-17, were diagnosed with asthma (13.3% state-wide). ▪ In 2003, 17.3% were diagnosed (14.8% state-wide).
Low rates of obesity	Attention must be paid. ▪ The percentage of children 0-<5 who are overweight dropped from 10% to 8% between 2002 and 2003, but national and state trends are moving upward. ▪ The percentage of overweight older children in the county has increased by 6% since 2001. ▪ Almost 18% of young children (ages 2-5) who participate in the WIC program are overweight or at risk for overweight. ▪ Children who are overweight at age 3 are almost 8 times more likely to overweight as adults (overweight under 3 isn't a predictor of adult obesity).
Healthy baby teeth and access to dental care.	Cause for alarm. ▪ 47% of kindergartners screened in a 21-county region that included Nevada County had caries experience. ▪ State-wide, 50% of kindergartners already have tooth decay. ▪ 51% of children in a 3-county 2003 study that included Nevada County had never been to a dentist (up from 30% in 2001). ▪ Over 1/3 of KidsCAP interviewees had never taken their child to a dentist. ▪ Low-income families, particularly, have trouble accessing dental care although the two clinics that offer it are making a difference.
Low injury rates.	The picture is unclear, mostly because of lack of data. ▪ Unintentional injuries that require hospitalization in children 0-5 have decreased from 14 to 11 since 1998, although there were 15 hospitalizations in 2001 and 2002. ▪ 66 children have been hospitalized since 1998. ▪ Falls were the cause of hospitalization in 41 out of 66 times over a 6-year period.
Access to medical care.	Could be better. ▪ Few physicians accept Medi-Cal payment. ▪ Between 2001 and 2002 there was over a 13% increase in the numbers of children 0-4 who are eligible for Medi-Cal. ▪ KidsCAP telephone interviews showed there was over a 6% decrease between 2003 and 2005 in the percentage of parents who had health insurance or Medi-Cal. ▪ KidsCAP 2005 face-to-face interviews showed that 23% fewer parents (than those interviewed by phone) had health insurance or Medi-Cal. ▪ Enrollment in Healthy Families needs further examination. HF enrollment increased 27% between 2001 and 2002, but only a fraction of an increase between 2002 and 2004.

Abundant, healthy food.	Can be problematic, particularly for low-income families. ▪ State-wide, 38% of low-income parents were not able to afford food for their families. ▪ Over 28,000 adults and children in Nevada County are touched by hunger and food insecurity. ▪ Food assistance programs, such as the food stamp program and school nutrition programs, are severly underutilized in the county, resulting in a loss of over $2.5 million in benefits. ▪ Only 76% of those eligible for WIC had enrolled (based on 4/03 data).
Experiences that stimulate brain activity.	No data available, but parents/caregivers need to know of its importance. ▪ Sensory activities, such as touch, are crucial to brain development. ▪ Touch and skin-to-skin contact also facilitate the bonding/attachment process.

Safety/Security Needs

Continuing to use Maslow's Hierarchy of Needs as our frame, let's now look at children's "safety needs." To feel safe, children need to live in a predictable world surrounded by people who lovingly attend to them. Primarily psychological in nature, a safe environment can be predicated on such things as set routines and an ordered world, free from chaos. In this section we will examine such indicators as:

- poverty levels
- the unemployment rate
- reports of child abuse
- domestic violence
- bonding and attachment

We will consider such factors as:

- single-family households
- self-sufficiency standard
- housing costs/affordability
- parental substance abuse
- divorce rate
- child custody conflict.

Sources of data, beyond those we used to explore physiological needs, included the Economic Development Department, the Center for Applied Research Solutions, the California Policy Research Center, the National Center for Children in Poverty and the child development literature.

Indicator: Poverty

As the California Report Card 2005 says, "The economic security of families affects every aspect of children's lives." We have long-known that poverty is the greatest predictor of poor health, including shorter life spans. Besides contributing to physical health problems, poverty often leads to developmental and behavioral problems in children. Poverty can impact access to health care, stability of the family and psychological and emotional well-being.

Children Now gives California a "D+" in "economic and food security." In the Report Card they tell us:

- 20%, or 1 in 5, of California's children under age 5 live in poverty[33].
- 42% of children under age 18 live in low-income families[34], compared to 39% nationally.
- 35% of children under 18 live in families where no parent has full-time, year-round employment, compared to 33% nationally.

The National Center for Children in Poverty[35] provides us with additional information about low-income families in California.

- 80% of children whose families do not have a high school degree live in low-income families.
- 42% of children in low-income families live with a single parent.
- 61% of Latino children live in low-income families, compared to 22% of white children.
- 44% of children under age 6 live in low-income families.
- 36% of children in rural areas live in low-income families, compared to 49% in urban areas.
- 60% of children of immigrant parents live in low-income families.

The Center also tells us that nationally the proportion of young children living in low-income families began rising again in 2000 after a decade of decline. Between 2000 and 2004 the number of children under age 6 who were poor increased by 14%.

[33] The poverty level for a family of 2 children and 2 adults in 2006 is $20,000.
[34] A family of 2 children and 2 adults in 2006 would be considered low-income if the household income is less than $40,000 (research published by the Economic Policy Institute suggests that, on average, families need an income equal to about two times the federal poverty level to meet their most basic needs; families at that level are referred to as low income).
[35] National Center for Children in Poverty, Mailman School of Public Health, Columbia University. www.nccp.org.

Let's look at how many of Nevada County's children are living in poverty.

CALIFORNIA COUNTY DATA BOOK 2005
CHILDREN LIVING IN POVERTY: NEVADA COUNTY
2000-2002

Children in Poverty	2000	2001	2002	3-year Average
Number of Children	2,365	2,083	2,058	2,169
Percentage of Children	11.4%	10.4%	10.4%	10.7%

State-wide, 19% of children 18 and under live in poverty. Nevada County is ranked 10th in the state, which means that 48 counties have a higher percentage of poverty. Placer County is ranked 1st, with a 2000-2002 average percentage of 6.8%. Let's compare our rural county 3-year average with other rural counties.

- Lassen: 16%, ranked 26th
- Plumas: 15.5%, ranked 24th
- Sierra: 13.2%, ranked 17th
- Siskiyou: 23.4%, ranked 45th

According to the Census 2000 Summary, the vast majority of Nevada County children 0-5 who live in poverty reside in the 95945 and 95949 zip codes. Of the total number of young children living in poverty in the county, 65% (312), live in Grass Valley, Peardale, the Bear River area and Alta Sierra. About 19% (N=90) of Nevada County's poor young children live in Nevada City, and 10.4% (N=50) live in Truckee and the surrounding area.

Other useful data points to examine are per capita personal income and median income, both reported in KidsCAP. Comparisons with the median income of the above four counties and California, as reported in the County Data Book 2005, are included.

PER CAPITA PERSONAL INCOME
MEDIAN INCOME
2000-2002

Per Capita Income	2000	2001	2002
Nevada County	29,435	31,241	31,092
California	32,363	32,655	32,845
Median Income			
Nevada County	46,777	46,171	47,478
Lassen County	37,358	36,128	36,831
Plumas County	38,225	37,431	38,558
Sierra County	37,770	36,679	36,588
Siskiyou County	30,589	29,720	30,285
California	45,836	47,064	47,323

While Nevada County's per capita income is a bit below the state's, the median income is a bit over. However, Nevada County's median income is substantially over the other four rural counties'. Nevada County attracts retirees, many of them "equity emigrants" who sold their homes in the high-price housing markets of Southern California and the San Francisco Bay Area and often brought with them considerable amounts of cash and investments. The Truckee area, with its proximity to world-renowned Lake Tahoe, attracts people who are in the upper tax bracket (although some build second homes in the area and are not permanent residents). Nevada County also has a booming (albeit relatively small) high tech industry, is popular with tourists and is becoming a well-known grape-growing/wine-production region. The other four counties do not have as diverse an economic base and, while generally no smaller geographically than Nevada County, have a smaller population base.

If we look at the median income in Nevada County by zip code, an interesting picture emerges. The following is from the 2000 Census, so is not as current as the County Data Book reports.

NEVADA COUNTY MEDIAN FAMILY INCOME BY ZIP CODE
U.S. Census 2000
1999 Figures

County	95945 Grass Valley	95946 Penn Valley	95949 Grass Valley	95959 Nevada City	95960 North San Juan	95975 Rough & Ready	95977 Smart-ville	96161 Truckee
52,697	41,423	55,938	57,086	52,588	53,125	55,469	45,272	62,123

The range of median income is from $41,423 to $62,123. There is considerable disparity between the areas with the highest and lowest incomes. The median income for the part of Grass Valley in the 95945 zip code, which includes downtown, is almost $21,000 lower per year than Truckee's.

Factor: Single-Family Households

Another contributor to poverty is the make-up of the family. Single-parent households are more likely to be poor than those with two parents. As reported above, 42% of California's children in low-income families live with a single parent. While we do not have data on how many children in Nevada County live in single-parent homes, we do have national and state percentages, thanks to the American Community Survey (conducted by the U.S. Census Bureau). According to the Survey, 29% of children under 18 live in single-parent households. That percentage remained constant for the years 2002-2004. The United States percentage in 2004 was 31%. Although we can't assume Nevada County percentages are the same as the state-wide ones, even if we say that 25% of the county's children live with one parent that would mean approximately 5,000 children under18 are in single-parent homes, over 1,000 of whom might be under age 6.

Factor: Self-Sufficiency Standard

Looking at the County's per capita and median income doesn't tell us if residents can meet their basic needs for housing, food, medical care, etc. One measure that can help us ascertain that is the "Self-Sufficiency Standard." This measure was developed for a project of the National Economic Development and Law Center called Californians for Family Economic Self-Sufficiency. The KidsCAP reports the figures for Nevada County, and includes the following definition:

> It is a measure of how much money working adults need to meet their family's basic needs for housing, child care, food, transport, medical care and taxes without any public subsidies such as welfare or food stamps.

Here was the amount of money families of different sizes needs to have for each of the above needs in 2002 and 2003:

SELF-SUFFICIENCY STANDARD: NEVADA COUNTY[36]
By Type of Expense and Family Structure
2002 and 2003

	Adult and Infant		Adult and Preschooler		Two Adults and Infant		Two Adults and Preschooler	
Monthly Costs	2000	2003	2000	2003	2000	2003	2000	2003
Housing	$699	$778	$699	$778	$699	$778	$699	$778
Child Care	595	606	487	500	595	606	487	500
Food	241	266	249	276	394	437	402	446
Transportation	209	251	209	251	395	481	395	481
Health Care	285	286	261	298	344	324	321	336
Miscellaneous	203	219	190	210	243	263	230	254
Taxes	455	362	407	334	547	416	497	378
Earned Income Tax Credit (-)	0	0	0	0	0	0	0	0
Child Care Tax Credit (-)	-40	-65	-40	-68	-40	-58	-40	-60
Child Tax Credit (-)	-42	-83	-42	-83	-42	-83	-42	-83
Hourly Self-Sufficiency Wage	$14.80	$14.88	$13.75	$14.18	$8.91 per adult	$8.98 per adult	$8.38 per adult	$8.60 per adult
Monthly Self-Sufficiency Wage	2,604	2,619	2,421	2,495	3,135	3,163	2,949	3,029
Annual Self-Sufficiency Wage	$31,249	$31,433	$29,050	$29,945	$37,623	$37,951	$35,382	$36,346

Anyone who lives in Nevada County will look at some of these figures and know they are unrealistic, most notably the amount designated for housing. It's important to note

[36] Pearce, D., Brooks, J. (2003). *The Self-Sufficiency Standard for California 2003.* Prepared for Californians for Family Economic Self-Sufficiency, a project of the National Economic Development and Law Center.

that the amount allocated for housing is based on "fair market rent,"[37] which has gone up to $838 for a two-bedroom rental in 2005. Alarmingly, KidsCAP reports that of the 304 parents interviewed face-to-face, 275 said they spend over 75% of their household take-home pay on rent/housing costs.

The self-sufficiency standard does not address what it would cost for a family to purchase a home. In 2005 the median price for a single-family home in Nevada County was $460,000, up from $288,483 in 2002. According to a recent article in *The Union*, a daily newspaper in Western Nevada County, it would cost $32,700 a year to pay for the taxes, property insurance and mortgage on that median-priced home ~ and that assumes a 20% down payment of $92,000. While this is rarely the case in California these days, a household should be paying no more than 30% of their income in home costs[38]. Again, assuming a family purchased a median-priced home, their annual income would need to be over $98,000. If 50% of their income went toward home costs, which is not uncommon, the family income would still need to be $65,400, over $5000 per month. Even purchasing a home that cost less than the median would "strap" many families.

It is not surprising that Nevada County has an "affordable housing" crisis on its hands. Concern about the dearth of low-cost housing, including rental units, is wide-spread. Helpline reports that during the six months between July 1, 2005 and December 31, 2005, they received 102 calls about subsidized rental housing and 89 calls about emergency housing; 21 calls came from people who are homeless.

Indicator: Unemployment

Rates of unemployment are also worth investigating, as they correlate to poverty and tell us about the health of the local economy. Here are the rates over five years for Nevada County, compared to California and the Nation, as reported by the State's Employment Development Department.

AVERAGE ANNUAL UNEMPLOYMENT RATE[39]
NEVADA COUNTY AND CALIFORNIA
2000-2004

	2000	2001	2002	2003	2004
Nevada County	3.6	3.7	4.5	5.5	5.2
California	4.9	5.4	6.7	6.8	6.2
United States	4.0	4.7	5.8	6.0	5.5

[37] The US Department of Housing and Urban Development (HUD) defines fair market rent as those rental units at the 40th percentile, i.e., 40% of units are less expensive, 60% are more expensive.
[38] HUD defines "affordable housing" as housing that costs a household no more than 30% of its annual income.
[39] The unemployment rate is the number of people per 100 who are out of work and are actively searching for employment.

Nevada County's unemployment rate has consistently been below the State's and Nation's ~ but it's catching up. There was a steady rise between 2000 and 2003, as there has been in California, with a slight dip for both in 2004.

Interestingly, if we look at areas within the county as KidsCAP 2005 did, Nevada City and Penn Valley have seen a big jump in the unemployment rate, beginning in 2003. In 2002, Nevada City's rate was 4.6/100, comparable to the county-wide rate. But in 2003 that rate jumped to 8.5/100 and dipped only slightly in 2004, to 8.1/100. Similar figures held true for Penn Valley. In 2002, Penn Valley's unemployment rate was 4.1, then jumped to 7.6 in 2003, dipping slightly to 7.3 in 2004. What factors contributed to the downturn in employment? Other areas, including Grass Valley and Truckee, were within a range of 3.8-4.9.[40]

Indicator: Child Abuse and Neglect

Child abuse, whether physical, sexual or emotional, and neglect, whether severe or moderate, have long-lasting effects. Teens and adults who were abused are more likely to commit suicide, be depressed, abuse drugs and alcohol, and experience behavioral problems. They also are more likely to continue the cycle of abuse by abusing their own children. Child abuse can occur across the socio-economic continuum, although poverty and financial distress are contributing factors. It is often linked with parental substance abuse and/or domestic violence. Child abuse may lead to children being deprived of their most important safety needs: predictability, stability and a loving home. They may, in fact, have to be removed from their parents and placed in foster care. Let's look at Nevada County's child abuse and foster care statistics, as reported in KidsCAP.

SUBSTANTIATED CHILD ABUSE CASES BY AGE: NEVADA COUNTY[41]
1998-2004

AGE	1998	1999	2000	2001	2002	2003	2004
Under 1							
Number	18	12	5	15	15	17	13
Percent	6.9%	8.2%	3.8%	10.8%	11.7%	12.2%	7.8%
1-2							
Number	36	17	14	17	7	12	18
Percent	13.7%	11.6%	10.8%	12.2%	5.5%	8.6%	10.8%
3-5							
Number	44	31	24	30	23	22	31
Percent	16.8%	21.1%	18.5%	21.6%	18.0%	15.8%	18.6%
TOTAL*	**262**	**148**	**130**	**146**	**13**	**139**	**167**

* Total numbers reflect three other allegation categories not reported here.

[40] *KidsCAP* Source: State of California, Employment Development Department, Labor Market Information Division, Labor Market Data, 2005.

[41] Percentages represent percent of total cases. Data from the Center for Social Services Research, University of California (http://cssr.berkeley.edu/CWSCMSReports). 2005. As reported in *KidsCAP 2005*.

These figures tell an interesting story. For children under one year of age, there was a dramatic drop in substantiated cases in 2000 from the previous two years. However, the numbers for the next three years jumped up, close to 1998 and 1999 levels. For children 1-2 years of age, the numbers of cases in 1999 and beyond were half what they were in 1998, which seems to be an anomalous year. And consistently the highest number of cases was found in children 3-5 years of age. The year 1998 evidenced the highest number in all age groups. Percentages of cases per total number of children in the County are up and down, with little consistency, for children under 1 through age 5.

Another interesting set of data to examine is the types of abuse.

SUBSTANTIATED CHILD ABUSE CASES BY ALLEGATION: NEVADA COUNTY[42]
1998-2004

Allegation	1998	1999	2000	2001	2002	2003	2004
Sexual Abuse							
Numbers	24	13	5	6	7	9	17
Percent	9.2%	8.8%	3.8%	4.1%	5.3%	6.5%	10.2%
Physical Abuse							
Numbers	41	14	16	19	17	9	13
Percent	15.6%	9.5%	12.3%	13.0%	12.9%	6.5%	7.8%
Severe Neglect							
Numbers	20	*	*	*	*	*	0
Percent	7.6%	2.0%	1.5%	1.4%	0.8%	1.4%	0.0%
General Neglect							
Numbers	66	47	57	93	72	83	92
Percent	25.2%	31.8%	43.8%	63.7%	54.5%	59.7%	55.1%
Emotional Abuse							
Numbers	22	20	18	*	*	0	0
Percent	8.4%	13.5%	13.8%	0.7%	2.3%	0.0%	0.0%
Caretaker Absence/Incap.							
Numbers	87	51	30	16	26	34	41
Percent	33.2%	34.5%	23.1%	11.0%	19.7%	24.5%	24.6%

Factor: Parental/Caregiver Substance Abuse
Indicator: Domestic Violence

Abuse of alcohol and other substances is a contributing factor in child abuse and domestic violence, and there is ample evidence that those who have been abused or

[42] * Numbers and percentages between 1 and 4 are masked to protect confidentiality. Percentages represent percent of total cases. *Kidscap. Source:* Center for Social Services Research, University of California. As reported in *KidsCAP 2005.*

subjected to violence may struggle with the consequences of that abuse throughout their lives. We know that[43]:

- Children living with domestic violence experience unnaturally high levels of anxiety.
- Even a single event can cause children to suffer Post Traumatic Stress Disorder.
- Truancy, theft, insomnia, temper tantrums, difficulties in school, overly aggressive and disruptive behavior in boys and withdrawn and passive behavior in girls ~ all occur at higher levels in children who live in violent homes.
- Children who live with domestic violence are nine times more likely than other children to grow up to be batterers or become victims of domestic violence themselves.

Approximately 33% of women have experienced serious trauma in their lives. Research shows this trauma is correlated with substance abuse, mental health problems, and child abuse and neglect. Despite the growing need and the recent research illustrating how detrimental these problems can be to infants and young children, most commonly, appropriate treatment is simply unavailable, according to the Recommendations for the President's New Freedom Commission on Mental Health, presented in October 2002 by the California Mental Health Directors Association and the California Institute for Mental Health.

The Nevada County Domestic Violence and Sexual Assault Coalition reports that 60% to 70% of their clients in 2003 were assaulted or abused by persons affected by alcohol or drugs, and 90% of these clients had children in the home. The Nevada County Maternal Child Health Coordinator reports that 33% of the pregnant women referred to public health as "at risk" in 2002/03 were drug affected; while 36.4% of those referred in 2003/04 were drug affected. The county also reports that 10% of the babies born in 2002 in Western County were born drug affected.

In order to provide the State and Counties with data that would assist in developing substance abuse prevention policies and programs, the California Department of Alcohol and Drug Programs identified 26 community-level indicators that "…would serve as direct and indirect measures of alcohol and other drug use prevalence and related problems."[44] These indicators are organized into four major domains: community factors, family factors, school factors and individual and peer factors. It is beyond the scope of this report to summarize all of the indicators, but it is worth looking at some of them. Besides Nevada County statistics, there is a County "cluster" statistic. That compares each indicator to a three-year average rate for a subset of counties that are considered to be similar in demographic characteristics to the county under consideration. Nevada County is "clustered" with nine other rural counties.

[43] Reported on the Domestic Violence and Sexual Assault Coalition, Nevada County, web site, www.dvsac.org
[44] Community Indicators of Alcohol and Drug Abuse Risk, Nevada County 2004. Prepared by Center for Applied Research Solutions, Inc., Folsom, CA.

SELECTED COMMUNITY INDICATORS
OF
ALCOHOL AND DRUG ABUSE RISK 2004[45]
Three Year Average Rates and State Ranking

	Adult Arrests: Drug Violations Rate per 1,000 1999-2001	Adult Arrests: DUI Rate per 1,000 1999-2001	Deaths Due to Alcohol & Drug Use Rate per 100,000 1998-2000
Nevada County	4.6	10.9	29.1
California	10.3	8.4	26.5
County Cluster	8.1	13.7	35.6
Statewide Ranking	4th	27th	32nd

Although Nevada County's arrest rate for drug violations is considerably lower than the California rate and we rank fourth, the rates for DUI and alcohol and drug deaths is higher than the California rate and we rank in the bottom third for both. And, like many rural and increasingly urban counties methamphetamine use seems to have grown exponentially in the last few years. These statistics may not accurately reflect that growing ~ and devastating ~ problem.

SELECTED COMMUNITY INDICATORS
OF
ALCOHOL AND DRUG ABUSE RISK 2004
Three Year Average Rates and State Ranking

	Child Abuse: Emergency Response Dispositions per 1,000 2000-2002	Foster Care Placements Rate per 1,000 2000-2002	Domestic Violence Calls for Assistance Rate per 100,000 1999-2001
Nevada County	91.0	5.8	3.6
California	68.6	10.3	8.7
County Cluster	119.4	9.0	9.1
Statewide Ranking	32nd	15th	1st

If we look at the Nevada County Sheriff's Department tally of domestic violence calls, we can see that the number declined substantially between 2002 and 2003.

Domestic Violence Calls
1998-2003

Domestic Violence Calls	1998	1999	2000	2001	2002	2003
	177	178	144	147	175	60

[45] Ibid.

Why the calls decreased by almost 2/3 would be worth exploring to ascertain whether they are truly representative of the incidence of domestic violence in the county. We do know that domestic violence is severely under-reported nationally ~ the actual incidence is 10 times higher. We also know that 80% of children witness the violence if they live in a home where it occurs.[46]

Violence in the home, even if the children are not abused, has almost as much impact on the children's well-being and sense of safety as direct abuse. And violence against the child's mother (women are ten times more likely than men to be victimized) can become violence against the child.

Factor: Divorce Rate and Child Custody Conflict

The build-up to divorce and its aftermath can have a devastating impact on young children, as we will discuss in the next section. Here's what we know about divorce in Nevada County.

DIVORCE STATISTICS
U.S Census 2000

	Nevada County	**California**	**United States**
Men	4,114 11.2% (Total population, over 15: 36,708)	7.9%	8.6%
Women	5,302 13.8% (Total population, over 15: 38,532)	11.0%	10.8%

As the statistics show us, Nevada County has a higher percentage of divorced men and women than either the State or the Nation, according to the U.S. Census Bureau. The percentage of divorced men in Nevada County is substantially higher. The reasons for that are worth considering. Is it connected to alcohol and drug abuse in the county? Or may there not be enough services, particularly affordable ones that can help couples resolve their differences and conflicts? What else may account for the high number of divorces?

Divorce often brings with it conflict over which parent is awarded custody of the child. Indeed, most would agree that the decision about child custody may be the most emotionally charged of all the issues related to divorce. Too often the child becomes a pawn as parents engage in emotional and psychological battle.

Indicator: Bonding and Attachment

If children, particularly infants, are to thrive rather than merely survive, bonding and attaching to a parent are crucial. Bonding is defined as, "…a unique relationship

[46] Reported on the Domestic Violence and Sexual Assault Coalition, Nevada County, web site, www.dvsac.org

between two people that is specific and endures through time."[47] From that definition we can see that bonding is mutual: the parent must bond with the infant; the infant must bond with the parent. Attachment, too, is mutual. Attachments are, "…specific, enduring, emotional bonds whose existence is of major importance in the process of sociopersonality development."[48] Indeed, "…intimate attachments to other human beings are the hub around which a person's life revolves throughout life and into old age."[49]

A well-known proponent of infant massage has stated:

> Bonding and attachment involve a reciprocal interactive system Between parent and infant in which both individuals are active participants. Through complex motor and sensory abilities, infants evoke responses from adults who are sensitive and committed to observe, understand and respond appropriately to their infant's cues. Harmonious interactions with consistent caregiver are vital to the infant's well-being and development.[50]

It's one thing to identify the security needs of bonding and attachment as critical to a child's social and psychological development; over 40 years of research has made them bellwethers in child development. It's quite another to quantify them. But experts in child development are in agreement: if a child does not attach to her/his primary caregiver, that's child's future is bleak. Here is what the experts say:

> The research of Scerbo and Kolko and of Brennan, cited in *Ghosts from the Nursery*, have all concluded that the formation of a securely attached relationship with a primary caregiver, beginning in the first year after birth, is the interactive process most protective against later violent behavior. This relationship provides the foundation of three key protective factors to mitigate against later aggression: the learning of empathy or emotional attachment to others; the opportunity to learn to control and balance feelings, especially those that can be destructive; and the opportunity to develop capacities for higher levels of cognitive processing.[51]

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[47] Klaus, M. and Kennell. H.J. (1982). *Parent-infant bonding*, *2nd ed.* Springfield, Missouri: Mosby.
[48] Bornstein, M.H. and Lamb. M. E. (1992). *Development in infancy: an introduction*. New York: McGraw-Hill, Inc.
[49] Bowlby, J. (1969). *Attachment and loss*. New York: Basic Books.
[50] Dellinger-Bavolek, J. "Infant Massage: Communicating Love Through Touch" International Journal of Childbirth Education, Vol. 11 No. 4, 1994

[51] Scerbo, A.S. and Kolko D. J., "Emotion Regulation as a Protective Factor in Childhood Aggression," paper presented at the 75t Annual Meeting of the Western Psychological Association, Los Angeles, 1995. Brennan, P.A. et al, "Psychophysiological Protective Factors for Male Subjects at High Risk of Criminal Behavior," American Journal of Psychiatry, 154:853-855, 1997. Ghosts from the Nursery by Robin Karr-Morse and Meredith S. Wiley, 1997, Atlantic Monthly Press, New York, p. 184. Cited on www.greatkidsinc.org.

We know that there are things that promote attachment and others that impede it. Attachment occurs when parents gaze at, rock, play with, read to (even infants), and talk to their child ~ and are tender with and respectful toward their child from the very beginning.

Impediments to attachment include the emotional state of the parent. A Policy Brief on brain development in children, reports that, "One group of parents whose children may be at risk for insecure attachment and prolonged stress is depressed mothers."[52] The brief tells us that about 40% of mothers are mildly depressed immediately postpartum and 10% are moderately or severely depressed. And the depression often does not resolve itself or shows up later. Clinical depression affects 16% of mothers with infants and toddlers, 25% of mothers of 17-month-olds and 17% of mothers of 35-month-olds. This depression has a profound impact on children, as the brief describes:

> Studies suggest that depressed mothers are either more intrusive and controlling or less attentive and engaged than mothers who aren't. Their children tend to be more irritable, display sadness and anger more frequently, and have higher and more persistently elevated levels of the stress hormone cortisol. In animal studies, high and persistent levels are associated with atrophy of the hippocampus, a brain region involved in memory and learning. One conclusion is that maternal depression may have a permanent effect not only on a child's sense of security, but on the ability to retain memories and therefore learn.

The consequence of postpartum depression on mothers and their children and the importance of treatment have moved out of the shadows and into the light of growing public acceptance and understanding. However, much remains to be done to remove the stigma of this mental illness, and soon-to-be parents should be given information about the signs of depression and where to seek professional help if symptoms occur. Other psychological problems, parental drug abuse, spousal abuse, and lack of effective parenting skills all impede attachment. Social support ~ connecting parents with other new parents ~ can show parents they are not alone in their struggles with early child rearing and help them find new ways of relating to their infant or toddler.

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[52], UCLA Center for Healthier Children, Families and Communities, California Policy Research Center. *Policy Brief Number 13.*

Summary and Conclusions: Safety/Security Needs

What have we learned from the data and literature about the need for safety that every child craves? And what do the data tells us about whether those needs are being met in Nevada County? Let's try to answer those questions.

What Are the Needs?	Are the Needs Being Met in Nevada County?
Economic security: freedom from poverty	Pretty well, but room for improvement. ▪ Ranked 10th in the State, with almost 11% of children under 18 (3-year average, 2000-2002) living in poverty. State-wide, 19% live in poverty. ▪ State-wide 61% of Latino children, 44% of children under age 6, 36% of children in rural areas and 60% of children of immigrant families live in low-income families. ▪ Nevada County's per capita income is a bit below the state's; median income is a bit over. ▪ There is a considerable disparity (over $20,000) between the areas with the highest (Truckee) and lowest (Grass Valley) median income.
Economic security: low unemployment	Depends on where children live. ▪ Nevada County's unemployment rate (5.2/100 in 2004) has consistently been below state (6.2/100) and national (5.5/100) rates, but has begun to catch up. ▪ Both Nevada City and Penn Valley have seen a big jump in unemployment, beginning in 2003. Nevada City's rate was 8.1/100 in 2004; Penn Valley's was 7.3/100.
Economic security: single family households that have adequate income.	Data is not available for Nevada County, however if we extrapolate from state and national data, there is cause for concern. ▪ 29% of California's children under 18 live in single-parent households, a figure that remained constant from 2002-2204. ▪ Nationally, 31% of children under 18 live in single-parent households.
Economic security: self-sufficiency	Not very well. ▪ Families with young children struggle to earn enough to pay for housing and child care. ▪ The vast majority (275/304) of KidsCAP face-to-face interviewees say they spend over 75% of their income on rent/housing. ▪ Child care can cost up to $7,200/year, and there is a waiting list for subsidized child care.
Affordable housing	A cause for alarm. ▪ In 2005 the median price for a single-family home was $460,000, up from $288,483 in 2002, a 60% increase in 3 years. ▪ "Fair market rent" for a two-bedroom rental was $838 in 2005, up from $778 in 2003, almost an 8% increase. ▪ There is a considerable waiting list for subsidized rental housing.

Freedom from child abuse	The picture is unclear. ▪ The highest percentage of cases in all years between 1998 and 2004 were found in children 3-5 years of age. ▪ The highest percentage (by far) of types of abuse was found in the "general neglect" category, over 50% of the total cases. ▪ The number of substantiated child abuse cases dropped from 262 in 1998 to 167 in 2004, with even fewer cases in the intervening years.
Does not live in a home with domestic violence.	Another cloudy picture. ▪ The number of domestic calls to the sheriff's department declined by 2/3 between 2002 and 2003, a dramatic drop that warrants a closer look. ▪ Nationally, domestic violence occurs 10 times more often than is reported.
A home free from substance abuse	A red flag. ▪ Nevada County's arrests for drug violations were relatively low (4.6/1,000) between 1999 and 2001, which resulted in a ranking of 4th lowest in the state. ▪ County rates for DUI arrests and deaths due to alcohol and drug abuse were considerably higher; the county ranked in the bottom third of counties. ▪ The county's Domestic Violence and Sexual Assault Coalition reported that in 2003 60-70% of their clients, 90% of whom had children in their home, were assaulted or abused by persons affected by alcohol. ▪ In 2002, 10% of children born in western Nevada County were born drug affected.
Parents able to handle divorce and custody	Cause for concern. ▪ Nevada County has a higher percentage of divorced men and women than either the state or nation: 11.2% of men are divorced (7.9% in CA; 8.6% in U.S.); 13.8% of women are divorced (11% in CA; 10.8% in U.S.). ▪ Conflict between divorcing parents over child custody is such a problem that a system has been created to work toward mitigating its impact.

Bonded/attached to parents.	No statistics exist, but parents must be taught the importance of early bonding/attachment. ▪ Over 40 years of research shows that both are crucial to an infant's well-being and development. ▪ According to research, "…the formation of a securely attached relationship with a primary caregiver, beginning in the first year after birth, is the interactive process most protective against later violent behavior." ▪ Attachment helps children learn empathy and to control their feelings (especially destructive ones), and develop a capacity for higher levels of cognitive processing. ▪ Impediments to parental attachment, which often include psychological issues such as postpartum depression or domestic or drug abuse, need to be acknowledged and addressed.

Love/Belongingness Needs

Love and belongingess needs are perhaps the most difficult, if not impossible, to measure. Therefore, rather than looking at an array of data bases, we conducted a more in-depth review of the literature that helped identify how young children's love and belongingness needs can be met.

We know more about love and belongingness from their absence, i.e., we have some idea about what happens to humans if love is withheld or becomes connected to behaviors that some say are loving, yet to an outside observer are clearly not. When a parent repeatedly hits a child or continuously berates her and then says, "It's for your own good," or "I'm doing this because I love you," the child can become very confused about what constitutes love. Love deprived can lead to love depraved ~ young children growing into sociopathic adults can be the consequence of twisted love. Indeed, empathy, feeling or understanding what another feels, is learned in the first few years of life. A recent book, cited on the Great Kids, Inc. web site[53], written by arguably the best known pediatrician in the country, T. Berry Brazelton, and his co-author, emphasizes:

> …the importance of empathy in parent child relationships, noting that morality comes from empathy. They state that empathy is developed through nurturing interactions with caregivers and parents and that we can feel empathy only if someone has been empathetic and caring with us.[54]

[53] www.greatkidsinc.org, known for the widely-praised, "Growing Great Kids, An Interactive Childe Development Curriculum.

[54] Brazelton, B.T. and Greenspan, S. (2000) *The Irreducible Needs of Children*. Perseus Publishing/A Merloyd Lawrence Book.

The need infants and children have to feel loved and accepted is "hardwired" into them. Individuals, even very young ones, need social relationships. If those relationships are not present or do not provide affection and acceptance, a child will feel alienated and lonely. However, if the belongingness needs are satisfied, children are much more likely to be confident and resilient. If children feel loved, they will be more willing to go out into the world and take the risks that can lead to success and mastery. Children also must feel they "belong" to someone ~ feel included and accepted into another's world. Maslow believed that most Americans do not have these needs met, which keeps them from moving into and through the next level, esteem needs.

It is important to keep in mind that other caregivers besides the parents can help satisfy a child's love and belongingness needs. Child care providers, grandparents, other family members ~ all can provide valuable messages to a child that she is loved. Indeed, they can mitigate the impact of a parent who may be incapable of giving the love necessary for a child's sense of security. Nationally recognized, The Program for Infant/Toddler Caregivers (PITC) emphasizes the role caregivers can have when they clearly state: "The goal of PITC is to help caregivers recognize the crucial importance of giving tender, loving care..."

Establishing a reciprocal, loving relationship is important to a child's social and emotional functioning. Reciprocity evolves as the child experiences love from a parent or caregiver and begins to individuate. As the child is loved, so, too, does he love.

In addition, the behavior of the caregiver is critical to a child's understanding of how to be in the world. As the Policy Brief says:

> [Children] learn to regulate emotional responses to individuals and events through perception of their caregiver's behavior. If the relationship is secure, a child learns to rely on the caregiver to help regulate her response to stressful situations and, over time, begins to regulate her own behaviors.

Dr. Jane Nelson, well-known child development expert and author of the seminal book, Positive Discipline (1981), has identified four criteria for effective discipline. The first criterion states that, "Effective discipline helps children feel a sense of connection (belonging and significance)."

Summary and Conclusions: Love/Belongingness Needs

A child's birthright is to be loved; her/his need for love is immeasurable. Indeed, love cannot be measured. There are no data bases extant that will help us assess whether Nevada County's children are receiving love and are feeling a sense of belonging. Yet, those who serve young children and their families can find ways to work with parents and caregivers to increase their knowledge about the importance of being loving and

assist them in learning the behaviors/skills that show love to a child. The child development literature is replete with what happens to children deprived of love and what characteristics parents and caregivers must evidence if a child is to fell loved. What have we learned from that literature?

What Are the Needs?	Are the Needs Being Met in Nevada County?
Love and acceptance, and a sense of belonging.	No way to know. However we know that… ▪ Love is crucial to children's health social and psychological development. ▪ Empathy is developed through interactions that are nurturing; we can feel empathy only if we have experienced empathy from another. ▪ Caregivers other than parents can help satisfy a child's need for love. Indeed, they can mitigate the impact of a parent who may be incapable of providing enough love. ▪ Children learn to reciprocate love if they receive love. ▪ Effective discipline, what Dr. Jane nelson call positive discipline, "…helps children feel a sense of connection (belonging and significance)."

Esteem Needs

Once ~ and if ~ a child's needs for love and belongingness are satisfied, as are her physiological and safety needs, she has a strong foundation for her esteem needs to be fulfilled. Esteem needs are about a sense of mastery or competence and the need for recognition, approval and attention. Children need to develop self-esteem, a component of which is to receive the esteem of others. Esteem results in a sense of self-confidence and of being a valued individual.

As with love and belongingness, esteem is hard to measure, and, like love, it is often gauged by its absence. Low self-esteem is evidenced by poor performance in school, including preschool, inappropriate behaviors, trouble with relationships, etc. There are, nevertheless, areas we can explore that have an impact on esteem and should be considered in policy decision, funding allocations and program planning.

The indicators and factors we will examine have a large impact on whether a child enters kindergarten ready to learn. First 5 California has invested funds in all 58 counties through its School Readiness (SR) Initiative, the goal of which "…is to ensure that more of California's children are ready to succeed in school and life by the time they enter kindergarten."[55] The First 5 SR Initiative adopted the National Education Goal Panel's definition of school readiness, which includes the following:

> …children need to have a broad range of skills and well being in five areas: (1) health and physical development; (2) cognition

[55] First 5 California web site: www.first5.org

> and general knowledge; (3) communicative skills; (4) emotional well-being and social competence; and (5) approaches to learning.[56]

In the area of esteem needs we will look at such indicators as:

- social development
- emotional development
- Mental development
- Physical development

Factors we will consider include:

- living in a stimulating environment
- access to and participation in parenting education
- access to and enrollment in quality childcare
- access to special education and mental health services

Sources of data and information, in addition to those already mentioned, include the California Department of Education, the Child Care Coordinating Council of Nevada County, First 5 Parenting Information Survey, Desired Results from Nevada County, and the First 5 Nevada County School Readiness Project.

Indicators: Social and Emotional Development and Mental and Physical Development

According to the National Center for Children in Poverty:

> Social and emotional development in young children has to do with *how young children feel about themselves* (such as confident, always scared, eager to learn, proud of their culture, afraid of being wrong), *how they behave* (such as constantly fighting, easily upset, able to deal with conflict), and *how they relate to others*, especially people who matter to them (for example, parents, teachers, and friends).[57]

Social and emotional development begins at home, of course. The stage for healthy development is set by the child's earliest relationships. Parents are their child's first teachers. They teach their child not only the ABCs, but also how to behave, how to relate to others and, ultimately, how they feel about themselves. If parents give their child attention and approval, and recognize the child's efforts and appreciate her/him for who s/he is, the child will develop a sense of mastery and competence.

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[56] *The Reliability of the Modified Desired Results Developmental Profile (MDRDP): Results from the 2004 Kindergarten Entry Profiles (KEP).* (September 2005). Statewide Data Collection and Evaluation, First 5 California.

[57] Knitzer, J. and Lefkowitz, J. (2005). *Resources to promote social and emotional health and school readiness in young children and families: a community guide.* New York: National Center for Children in Poverty, Columbia University, Mailman School of Public Health.

Early childhood educators play a valuable role in the social and emotional development of the children in their care. While we would all hope that every child receives the kind of love and attention that nurtures her growing sense of self and provides good role modeling, that is not always the case. Quality childcare, which includes well-trained providers who understand how critical their relationship can be to children and their families, can moderate what a child may be learning (or not learning) at home.

Early learning has blossomed as a field of study in the last two decades. The research that has been done in the past 20 years has much to tell us about young children's development. Knitzer and Lefkowitz, in their recent report and guide cited by the National Center for Children in Poverty, summarize some of the important findings from early learning research, which includes[58]:

- Most young children are "eager to learn" and have the skills to succeed.
- The brain develops most rapidly in the first 3 years of life.
- Almost all children are born "wired to learn."
- Social, emotional, and cognitive learning are all interconnected in young children (more than in older children).
- A significant group of young children experience problems in developing the social, emotional and behavioral strategies necessary to succeed in school.

Knitzer and Lefkowitz are also clear that "intentional social and emotional strategies can make a difference" in a child's development. They state that:

- Improved parenting with infants and toddlers has been linked to improved cognitive, behavioral, and language skills in 3 year olds.
- Parents who have learned how to better manage their young children's behavior report positive outcomes at home and at school.
- Class-room based strategies to help young children master social and emotional skills have been linked to improved reading ability.

A local source of data on child development that encompasses all four of the above indicators (social, emotional, mental and physical development) is "Desired Results." Developed by the California Department of Education, Child Development Division, Desired Results "…is a system by which educators can document the progress make by children and families in achieving [the results desired from child care] and by which they can retrieve information to help practitioners improve child care and development services."[59]

[58] Ibid.
[59] Introduction to Desired Results, California Department of Education web site: www.cde.ca.gov

All California Department of Education-funded child care and development program are expected to utilize the Desired Results system, which encompasses the following six desired results:

1. Children are personally and socially competent.
2. Children are effective learners.
3. Children show physical and motor competence.
4. Children are safe and healthy.
5. Families support their children's learning and development.
6. Families achieve their goals.

Four developmental domains are integrated throughout the Desired Results system: cognitive, social-emotional, language, and physical development.

In Nevada County there are several centers and family child care sites that participate in the Desired Results system. Because the system requires participants to collect a large amount of data on each of the children in their care, a full report of even one site's results is beyond the scope of this report. For instance, within the first four children's results listed above, there are over 50 measures that comprise each child's individual profile. Nevertheless, we examined two Western County center's desired results and culled from the aggregated data some sense of whether the children at those centers have "fully mastered," or "almost mastered" specific skills, or are "emerging" or have "not yet" emerged on mastering those skills.

At Center One, 24 children, ages three through five, were observed on the first four results and the 50+ measures that quantify the results. The observations were made in April 2005, the third time during the school year children were measured. At Center Two, we looked at one of five classrooms we have data for; 30 four-year-old students were observed in this particular classroom. The results are not a measure of the groups "before and after," i.e., some children were in their first year of preschool, others were about to graduate to kindergarten. It is difficult ~ and unwise ~ to compare the two centers, and we won't make generalizations, but the following are examples that give a flavor for how these two groups of children are doing and perhaps provide a snapshot of how Nevada County's preschoolers are doing. See Appendix A for charts of results for both centers.

Desired Result 1: Children are Personally and Socially Competent

Except for some notable exceptions, most of the children are personally and socially competent in many of the observed areas. Eighty-three percent (83 %) and above have fully or almost mastered 14 of the 16 skills in Center One. Over 90% have fully or almost mastered 8 of the skills; all of the children have mastered two of the 16 skills. The two skills that have been fully/almost mastered by the fewest children at Center

One are behavioral skills; over 20% have not yet mastered or are just beginning to master impulse control and conflict resolution.

Center Two had a wider range: 51% to 100% mastery on observed items. Eighty percent (80%) and above have fully or almost mastered eight of the 15 skills; 91% and above have fully or almost mastered eight of the skills. There were four skills that 68% or fewer of the children have mastered, two of which are the same behavioral skills that Center One's students had more difficulty mastering.

Desired Result 2: Children Are Effective Learners

In this area the results are mixed. At Center One, 75% to 100% of the children had fully/almost mastered 16 of the 28 items; 42% to 50% had mastered three of the 28. One-third to just under 75% of the children had almost/fully mastered the remaining 10 items. The item that the fewest number of children (10/24) had mastered, "knows 10 or more letter names, especially those in their own name," is a surprise since we would expect that more children would know the letters in their names.

At Center Two, 75% to 100% of the children had almost/fully mastered 20 of the 23 skills; 92% to 100% had mastered 12 of those 20 skills. Two of the skills, "acts out plays and stories," and "uses pretend writing," had 48% mastery.

Desired Results 3: Children Show Physical and Motor Competence

At Center One, six of the eight physical and motor competence items have been fully/almost mastered by ¾ or more of the children. Only two items, both having to do with functions of getting dressed, fell below 75%.

Center Two observed five skills (of eight) that all of the children have mastered. The other three skills have been mastered by 80% to 92% of the children.

Desired Results 4: Children are Safe and Healthy

At Center One, three of the six safety and health items have been mastered by 20 children or more. The three items that fewer children (16-17) have mastered are more complicated behaviors, although two certainly are critical if children are to remain safe in their classroom ("knows how to follow routines in emergency situations," and "communicates dangerous behavior to another"). Only 16 of the 24 children are willing to try new food on their own, although research tells us that children are more likely to eat new foods if presented in a setting that includes their peers.

At Center Two, four of the six skills have been mastered by all of the children; one other by 96%. Only "tries new food on own" had low mastery: just over ½ of the students are willing to do that.

Yet another early learning assessment to look at is one that First 5 California developed as part of its School Readiness Initiative evaluation. The "Modified Desired Results Developmental Profile" (MDRDP) was completed by kindergarten teachers as part of the Kindergarten Entry Profiles (KEP). The MDRDP "…collects information about children's readiness for school along four of the five National Education Goal Panel domains: cognitive and general knowledge, communicative skills, social and emotional development, and approaches to learning."[60] The instrument was tested for reliability.

In addition to the MDRDP, family interviews were conducted by telephone. Families were asked about "…children's health and physical development, preschool and home experiences prior to kindergarten, kindergarten transition activities, family literacy activities, and child and family demographic information."[61]
Statewide data is available at First 5 California's web site. First 5 also reported on individual school-level results for Fall 2004.[62] Looking at one school's results, while not generalizable to other schools, might be instructive. A caveat: "…the data for each child represent that child and the characteristics associated with that child, and may not be representative of data for other children at that school."[63]

Data was collected on 129 students (out of 135 eligible to participate) in seven kindergarten classes; 74 were white, 50 were Hispanic or Latino, 2 were African-American and 4 were other. English was the primary language for 88 children and Spanish for 42 children (n=130 rather than 129 for unknown reasons). Ninety-three family interviews were completed.

The MDRDP checklist provides the following information on the 129 children entering kindergarten:

- Cognition and General Knowledge (12 items):
  - 7% of children had "fully mastered" all items on the checklist.
  - 31% had fully or almost mastered all items.

- Communicative Skills (6 items):
  - 21% of children had fully mastered all items on the checklist.
  - 51% had fully or almost mastered all items.

- Emotional Well-Being and Social Competence (9 items):
  - 23% of children had fully mastered all items on the checklist.
  - 53% had fully or almost mastered all items.

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[60] *Reliability of the Modified Desired Results Developmental Profile (MDRDP)*. (September 2005). First 5 California
[61] Ibid.
[62] The names of the schools where Desired Results and the Modified Desired Results Developmental Profiles were used cannot be published.
[63] *First 5 School Readiness Initiative Evaluation: Kindergarten Entry Profiles, School-Level Results*. (Fall 2004). First 5 California.

- Approaches to Learning (3 items):
    - 21% of children had fully mastered all three items.
    - 59% had fully or almost mastered all three.

The family interviews also provide interesting information.

- 27% of parents expressed concern about their child's emotional well-being; 26% about how their child behaves.
- Only 77% report they have health insurance (compared to 90% nationally).
- 44% of parents say they tell stories to their child daily.
- Only 18% attended any support groups to help with parenting; 26% attended a parenting class; 33% participated in any parenting service.
- 95% has a smoke-free environment.
- 86% reported their child had attended preschool, Head Start or center-based child care program.
- 98% said they were invited to visit their child's classroom and school before school started; 92% received information sent home to prepare their child for kindergarten (compared to 66% nationally); 97% got materials or advice about how to help child learn at home.
- 55% reported that starting school was "very easy" for their child; 18% stated that it was "somewhat hard."

Also available for analysis is the 5 Nevada County School Readiness Project 2003 survey, which was administered again as part of this needs assessment. And additional information about school readiness can be gleaned from testing conducted by the Grass Valley School District. Here are some interesting points to ponder:

- Entering kindergartners in the Grass Valley School District were deficient in the following skill areas that most prevent them from being successful in school (utilizing a scale of 1-10, where 1=most deficient): social skills (2.43); primary language (3.0); behavioral skills (4.14); attention span (4.43); pre-academic skills (4.57); and communication, i.e., using language to solve problems and asking for help (5.29).
- In Truckee's two largest (out of three) elementary schools, Spanish is the primary language for 20% of the students, and 27% receive a free or reduced lunch. For Truckee Elementary, the largest of the three schools, both figures reflected a 10% increase in five years.
- When teachers at Truckee Elementary completed an assessment on entering kindergartners, children who spoke English as their primary language scored 20 points higher than those speaking Spanish; white children scored 17 points higher than Latino children.
- Of the 185 children who entered Kindergarten in the Grass Valley School District in Fall 2003, and were tested for phonemic awareness, 86% were "Below Basic

(BB)" on letter sound identification; 55% were BB on letter name identification; 58% were BB on concepts of print; and 43% were BB on "reads site words

Factor: Living in a Stimulating Environment

In order for children to be ready for the learning that takes place in preschool, children should live in a home that provides the appropriate stimulation. For children to develop cognitively they should be read to, talked to and played with. Reading to a child from a young age not only helps with attachment, it also prepares the child conceptually, enabling her to learn to read. As KidsCAP 2005 states:

> According to a study by the University of Michigan, one very important way for children to develop print concepts is for their parents and family members to read to them; "Joint book reading with family members helps children develop a wide range of knowledge that supports them in school-based reading."[64]

In addition to reading to a child for conceptual learning, the presence of books in the home and the child witnessing parents who enjoy reading can promote an attitude that books and reading are fun and are an important component to enjoying life. Going to the library and securing a library card are also beneficial. KidsCAP 2005 asked parents of young children about their reading and library behaviors. They discovered that of the 176 parents interviewed, either they or another family member read or show a picture book to their child:

- every day: 77%
- 3-6 times a week: 18.5%
- 1-2 times per week: 3.2%

The 2003 California Health Interview Survey reported that 65.3% of parents in Nevada, Plumas and Sierra counties read to their 0-4 year-old every day.

With regard to library utilization, KidsCAP reports that of the 2005 telephone respondents, 74.6% (n=177) have a library card and 36.5% (n=132) go to the library often, and 56.6% go to the library sometimes. Only 6.9% of the respondents said the "never" go to the library.

Parents also need to play with their child, because it fosters brain development as well as attachment ~ and they don't need to spend large sums of money on toys. As the Great Kids, Inc. web sites states:

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[64] University of Michigan, Center for the Improvement of Early Reading Achievement. (1998). *Improving the Reading Achievement of America's Children*.

> A new report from the National Academy of Science called "The Science of Early Childhood Development" emphasizes that fancy toys are not necessary to brain development. That "...the full range of early childhood competencies can be achieved in typical everyday environments..."

Factor: Access to and Participation in Parenting Education

Effective parenting is, to some degree at least, a learned not instinctual set of behaviors. When we were a society of geographically close, extended families, parenting skills were passed down from one generation to another. That more traditional method of learning to parent has been largely lost and parents have had to turn to other sources. Parents now learn by observing other parents who are good role models, by taking classes taught by child development experts, through support groups and friends, by reading parenting books or articles or watching TV.

In 2005, First 5 Nevada County conducted a Parenting Information Needs Survey. The survey asked questions with multiple, "check all that apply" response possibilities. Here's what the survey told us:

1. Preferred learning mode:
    a. 37 of the 61 respondents chose "on my own, from books," with the next closest, selected by 28 of the 61, was "in a group with expert leader."
    b. "On my own without help" was selected by 10 respondents.
2. Whom parents prefer to receive information from:
    a. "Experienced parent" was the most frequently checked choice (38/61), with "trained parent educator" coming in second (33/61) and "child development expert third (30/61).
    b. "Minister" was the least selected choice (11/61).
3. Where parents prefer to get parenting information:
    a. "Books" was selected much more frequently (37/61) than any other choice; "doctor" and "friends" were the next most frequently checked (25/61).
    b. "TV" (1/61) and the "Internet" (3/61) were the least selected choices.
4. Preferred goals of parenting education activities:
    a. Three goals were selected most frequently (31/61): "getting to know other kids," "learning about child development," and "engaging in parent-child activities." "Getting help with child's behavior" was selected 26 times.
    b. "Getting support from other parents" was the least frequently selected (15/61).
5. Topics of Interest to Parents:
    a. Parents were given 15 topics to select and, as with other questions, could select any that interested them. The two most frequently selected were "positive discipline" (44/61) and "family life skills" (38/61).
    b. The least selected choice was "divorce" (10/61).

KidsCAP 2005 asked parents of young children several questions related to participation in parenting education. Here are some of the responses they received:

- 57% (n=316) of the face-to-face survey participants and 37.5% (n=178) of the telephone respondents told the interviewer they had participated in a local event for parents in the last year. Events included support groups, Mommy-and-Me class, workshops, home visiting.
- In a multiple response questions that asked why they had not participated in any local events for parents, telephone respondents selected "not interested" most frequently (58.9%) and "not knowing about the program/event" second most frequently (37.4%); no other response approached those two in frequency.
- Face-to-face respondents, when asked the same question, selected "no time" most frequently (41.5% as compared to 13.8% of telephone respondents). The second most frequent response (34.8%) was "not knowing about the program/event."
- In another multiple response questions that asked where parents get information about activities and services for their child and family, over ¾ of the face-to-face respondents selected "friends and family members/word of mouth" as one of their responses; just over 50% of the telephone respondents selected that response.

So, what can we learn from the responses to these local surveys? While surveys are problematic because the respondent may want to please the interviewer or be seen in a favorable light, the data suggest the following:

- Those who offer events or programs for parents and children need to use every avenue at their disposal to get the word out.
- Plan the event far enough in advance that word of mouth can build and generate anticipation or "buzz."
- Events should focus on what parents are interested in, not what those putting on the event think parents need. When over 50% of respondents indicate they have not attended an event because they are "not interested," those putting on events need to look at what they need to offer that would be of interest.
- It appears that positive discipline, getting help with behavior and family life skills are topics that would draw parents, as would the opportunity to get to know other kids and engage in parent-child activities.
- Not having enough time to attend events is an issue, but not as big a one as many professionals think. Nevertheless, taking the event to the parent and offering shorter events is something to consider.
- Parents appear to want to meet with other parents ~ and have an expert as the leader or facilitator.

With regard to focusing on what parents are interested in: In some cases, agencies and other entities are required to offer certain information. Agency needs shouldn't be ignored, but there are ways to bring that information into an event that places parental needs first. Also, successful, parent-centered events breed more events. The word

gets out. Then agencies can work in even more information they deem to be part of their mission.

Parenting education must also be delivered with great sensitivity to cultural differences in parenting behaviors. Sometimes parent beliefs and approaches about caregiving conflict with the philosophies or ideologies of agencies, professionals or even governmental policies. It is important to respect the parents and their cultural differences and examine assumptions, including that, as professionals, we know what's best.[65]

Factor: Access to and Enrollment in Quality Childcare

In 2000, the Institute of Medicine/National Academy of Science conducted an analysis of early childhood research.[66] That analysis led IOM/NAS to conclude that "…early childhood development is even more rapid, dramatic, and important than we knew."[67] There seems to be little question that children's earliest experiences have a profound impact on their later accomplishments and functioning. Recently reported empirical evidence stresses the long term social benefits of quality child care.

A Position Statement jointly issued in 2002 by the National Association for the Education of Young Children (NAEYC) and the National Association of Early Childhood Specialists in State Departments of Education (NAECS/SDE), entitled "Early Learning Standards, Creating the Conditions for Success," asserts that:

- High-quality early childhood education can promote intellectual, language, physical, social, and emotional development, creating school readiness and building a foundation for later academic and social competence.
- Significant expansion of professional development is essential if all early childhood teachers and administrators are to gain the knowledge, skills and dispositions needed to implement [quality] early learning…

We know that millions of children are now in some form of child care in the United States. Whether young children are being cared for by a relative or neighbor or in family or center-based child care, almost six million infants and toddlers (up to age 3) are in child care an average of 25 hours a week.[68] Millions more three-to-five-year-olds are in child care, often full time (30 or more hours per week). As of 1999, 61% of children under five spend time on a regular basis each week in nonparental care; 39%

[65] Casper, V., Cooper, Finn, R.M., Donahue, C. and Stott, F. (May, 2003). Caregiver Goals and Societal Expectations. *Zero to Three 23*, (5).
[66] Shonkoff, J.P. and Phillips, D.A. (Eds.) (2000). *From Neurons To Neighborhoods, The Science Of Early Childhood Development.* Washington, D.C.: National Academy Press.
[67] WestEd. (August 2002). *Urgency Rises for Quality Child Care: Policy Brief*. Available at: www.WestEd.org/policy.
[68] The David and Lucile Packard Foundation. *The Future of Children, Caring for Infants and Toddlers (Spring/Summer 2001). Vol 11, No.1*. www.futureofchldren.org.

in attendance for 35 hours or more per week.[69] We know there is a need for quality child care. Yet often the quality of care is inadequate and, in some cases, damaging.[70]

Federal and state investments in child care has grown to $20 billion per year, mostly in the form of subsidy vouchers for low-income families and tax credits. Nevertheless, parent fees account for 60% of the national expenditures on child care ~ the only educational service that relies so heavily on parents to pay the cost.[71]

Before we further examine what defines quality in child care, let's look at child care statistics in Nevada County. As reported in The 2005 California Child Care Portfolio[72]:

- The percentage of women in the work force increased by 31% between 1990 and 2000, the 10th highest percentage increase in the state.
- 63% of women who have a child under 6 are in the work force.
- There are 142 child care sites in the County, 46 child care centers and 96 family child care homes. The number of informal sites is not known.
- As of 2005 there were an estimated 8,907 children ages 0-13 with parents in the labor force, down from 9,825 in 2003. Data is not available for children 0-5. There were 3,021 licensed child care slots in 2005.
- Full time child care in a licensed center is estimated to cost $5,638 per year. Current annual housing cost (2-bedroom rental unit): $10,176.
    - For families with one minimum wage earner ($14,040 annual income) and one preschooler in a licensed center, child care is 40% of the family's budget (housing is 72%).
    - Families with two minimum wage earners ($28,080) and one preschooler, child care is 20% of the family's budget (housing is 36%).
    - Families with an income of $73,732 (2 entry level public school teachers), child care costs drop to 8% of budget (housing is 14%).

It is apparent from this data that an increasingly higher percentage of women in the County are working, perhaps in part because of the high cost of housing. Therefore, more child care slots are required to accommodate the child care needs of working mothers. The U.S. Census Bureau projects that by the year 2010 parents will comprise 85% of the labor force, which will necessitate a more comprehensive child care system that is designed to meet the needs of so many working parents. In addition, Nevada County's birth rate grew about 5% in the past five years, but is projected to increase by 15% by 2008, creating an even greater need for child care slots.

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[69] Whitebrook, M. and Sakai, L. (2004). *By a Thread. How Child Care Centers Hold on to Teachers, How Teachers Build Lasting Careers*. Kalamazoo, Michigan: W.E. Upjohn Institute for Employment Research.

[70] Cost, Quality, Outcomes Study Team (1995). *Cost, quality, and child outcomes in child care centers, executive summary, second edition*. Denver: Economics Department, University of Colorado at Denver. As cited in WestEd (August, 2002).

[71] Whitebrook, op.cit., p.3.

[72] The 2005 California Child Care Portfolio – a project of the California Child Care Resource and Referral Network. www.rrnetwork.org.

We also can see that the number of available slots, at lease licensed slots, is less than half of what is needed. However, a caveat about that data: the estimated number of slots is for children through age 13. While it is difficult to verify, many of the older children may be going to neighbors or friends homes or are "latch key" children, going home to an empty house.

One concern is that there was a 15% drop in the number of family child care homes between 1998 and 2005 (113 down to 96), although the numbers remained steady between 2000 and 2005.[73] Another issue is the number of slots available for infants. According to The Child Care Portfolio, there were 65 infant slots in 2003 and 70 slots in 2005, compared to 1,017 and 1,153 slots for children ages 2-5. Infant care comes with stringent state requirements, including more trained staff. It's worth noting that Nevada County ranks 31st of 58 counties in availability of preschools.

The Child Care Coordinating Council of Nevada County conducted an extensive needs assessment of child care needs in 2004. The Council began in 1991 as a result of federal law, and its stated mission is "…to promote county-wide and other partnerships and to advocate for quality child care choices thorough education and collaboration."[74] The Council does not limit its child care focus to children six and under. However, through a combination of reviewing and analyzing several data bases and conducting parent focus groups and a survey of Nevada County employees, the Council identified key issues and needs pertinent to this needs assessment. The following is a summary of some of what they discovered:

- Parents who participated in the focus groups said that:
    - There is a need for child care in the evenings, on the weekends and holidays.
    - The high cost of child care is a concern, particularly in areas where the cost of living is high.
    - Transportation to child care is needed.
    - Child care subsidy funding for poor working parents is insufficient.
    - The quality of child care is a concern, and those programs considered to offer the highest quality had the longest waiting lists.
    - Finding emergency or sick care is very difficult.
- Nevada County employees who completed the survey (45 of 1,000 distributed) said that:
    - There is a need for full-time, sick child, drop-in, evening and weekend care.
    - The cost of child care and the unavailability of child care when needed were the primary reason that 27% of respondents said their child care needs had not been met in the last 12 months.
- Subsidy funding serves approximately half of the children who are eligible (in July 2004, 502 children were receiving subsidies and 487 were on the waiting list). Of

[73] The Child Care Portfolio, 2001 and 2003 – a project of the California Child Care Resource and Referral Network.
[74] Child Care Coordinating Council of Nevada County. (June 2003). Strategic Plan 2003-2006.

those receiving subsidies, 15% are newborn-2 years of age and 35% are 2-5 years of age.

Turning our attention back to the issue of child care quality, we know there is a synergy between the quality of the program and the quality of the staff. High quality programs support healthy cognitive, language, physical, and social-emotional development. They must have a philosophical and professional foundation.[75] They must be attuned to diversity in culture and language. They must be inclusive, i.e., have the capacity to respond to children with disabilities and special needs. They must foster parent involvement.[76] In addition, effective preschools[77]:

- Provide a warm, nurturing, and communicative relationship between child and teacher.
- Offer a setting that is well-equipped with learning materials and toys.
- Encourage mutual listening, talking and responding.
- Encourage children to use reasoning and problem-solving.
- Provide daily opportunities for art, music and movement, dramatic play, science, math, sand and water play.
- Use materials and activities to promote understanding and acceptance of diversity.

Two other components are important to quality: continuity of staff and a child-centered approach to the curriculum. Children need stability in their relationships and teachers who focus and build on their individual interests in order to master the competencies and build the self-esteem they will need for a life that will move toward self-actualization.

Continuity of staff goes hand in glove with retention of staff, yet early childhood educators earn far less than elementary school teachers, even when they have comparable education. Only a few categories of workers, e.g., fast food workers and movie ushers, earn less. Low pay and low prestige (often they are not even recognized as professional) not only drive early childhood educators out of the profession, but discourage others from entering the field. High rates of turnover, not surprisingly, abound.[78]

A lot goes into creating a quality child care program/preschool; a high quality staff of professionals who are well compensated is needed to make that happen. As WestEd's Policy Brief states:

> Caregivers must know the stages of [child] development…
> Well-trained caregivers observe and record each child's

[75] WestEd. (August 2002).
[76] Building Blocks, op. cit.
[77] Ibid.
[78] Whitebrook, op.cit., p. 6.

> development and use that information to identify special needs and communicate with parents. They know that the human brain continues to develop after birth and understand their critical role in a child's moment-to-moment construction of himself. Professionals of this caliber must be adequately compensated or they will leave the field.

Nevada County has a persistent problem with retaining quality child care providers. Certainly the amount providers are paid and the benefits they receive are primary factors in retention. There also is a need to raise the level of professionalism within the child care workforce.

Here's what we know about the child care workforce[79]:

- The average salary of child care workers in Nevada County in 2001 was $17,420, compared to an entry-level public school teacher's $25,433 annual salary. A survey of Nevada County providers in 2003 reported that 66% earned less than $20,000 per year.
- 69% of Nevada County Family Child Care providers had a gross annual income of $30,000 or under.
- Less than 30% of surveyed child care providers in Nevada County who work in licensed centers in Nevada County received vacation or sick leave, medical or dental insurance, or retirement benefits. No family home care providers or exempt providers reported receiving benefits from their employment.
- 48% of the respondents to the child care survey indicated that cost and time were the primary barriers to enrolling in classes or workshops. Other barriers were: location of the training (46%); lack of a substitute (32%); and lack of child care for their own children (22%).
- When 108 Nevada County child care providers were asked what one thing they would improve about the early care and education field, 57% said better pay.
- 88% of respondents to the 2003 workforce survey stated they intended to continue working in child care.

First 5, the Child Care Coordinating Council, Sierra Nevada Children's Services, Gold Country Association for the Education of Young Children, Sierra College are working to enhance and improve quality. Collaboration has been a key component to these efforts. Here are some highlights:

- The First 5 Commission, with the assistance of the Council, child care providers and experts in child development and First 5 Nevada County staff, initiated the Educator Support Program in 2001 that provides stipends and other benefits to child care providers who fulfill specific professional development requirements.

[79] Most of the data/information comes from the Workforce Survey 2003 (Feb. 2004), conducted by Social Entrepreneurs, Inc. for the Child Care Coordinating Council of Nevada County. N=183.

- Sierra College has expanded its Human Development courses at both its Grass Valley and Truckee locations, partly in response to the demand created by First 5's Educator Support program.
- First 5 offers PAK (Professional Advancement for Kids) Scholarships, which awards up to $500 to providers for attendance at workshops, conferences or other trainings that improve their professional skills.
- The Council, through the AB 212 program, offers stipends for professional development to early childhood educators who are employed at state-subsidized childcare, preschool or after school sites.
- First 5 awards mini-grants up to $1,000 to providers or organizations for a variety of projects and programs that impact young children.
- Gold Country Association for the Education of Young Children began an annual event that encourages kindergarten teachers, school administrators and others to "shadow" an early childhood educator for a day or half a day, with the goal of making a child's transition to kindergarten easier.
- GCAEYC sponsors Day of the Young Child as a venue for parents, early childhood educators and service providers to learn about each other.

Another component of quality child care is ensuring that families are engaged in child care. As stated in a Children Now "Preschool Policy Brief,"[80]

> Research on the 2000 cohort of the Head Start FACES study indicated that children with parents who were more involved in the program scored higher on vocabulary, book knowledge, early writing, early math, and letter identification tasks.

The Policy Brief points out that, "Family engagement also demonstrates to children the value their parents place on education." And low-income families particularly benefit from being engaged with their child's care facility because they can connect with other families. In addition, they can feel encouragement to further their own education and their sense of well-worth is often improved.

There are unique benefits to parents of English Language Learners (ELL)/immigrant children.

> One researcher outlined three such benefits that support children's academic success: maintenance of native language, maintenance of culture, and high expectations.[81]

Parents whose children are learning English as a second language can contribute what one researcher calls "social capital," which can support their children and communities.

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[80] Children Now. (December 2004). Preschool Issues Concerning English Language Learners and Immigrant Children: The Importance of Family Engagement, A Preschool Issue Brief. www.childrennow.org.
[81] Ibid.

> Social capital includes the resources a person has access to through their social networks, such as knowing a referral source for a certain service, understanding the history of a community, or membership in community groups... Parents use this cultural and social capital to support their educational participation.[82]

As with parenting education, child care staff must value and build on what all parents bring to interactions, including the rich heritage of their cultures.

The California Department of Education, in its *Coordinated Compliance Review Training Guide*, lists four components that should be part of and child care program's parent involvement plan:[83]

- an open-door policy that encourages parents to participate in daily activities;
- an orientation for parents on program philosophy, program goals and objectives, program activities, eligibility criteria and priorities for enrollment, fee requirements, and due process procedures;
- two parent-teacher conferences to discuss the child's progress, scheduled annually; and
- program activities that meet cultural, linguistic, and other special needs of children and families.

It takes work to engage families in a meaningful way. Research shows it's worth the effort, benefiting the children, their families and the community in sometimes unexpected ways.

Quality childcare also means that the needs of children with disabilities are attended to. As the California Department of Education says in its *Prekindergarten Learning Development Guidelines*:[84]

> Inclusion of children with disabilities or other special needs brings benefits and challenges to the early childhood setting. To ensure that all children, including those with special learning or developmental needs, have access to quality educational programs requires collaboration, flexibility, and the willingness to change on the part of children, parents, teachers, specialists, and administrators. Additional adaptations may be required in the planning of daily environment, curriculum, and instructional practices and in the management and implementation of a program to ensure that the individual goals for all children are met.

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[82] Ibid.
[83] Ibid.
[84] California Department of Education, Child Development Division. (2000). *Prekindergarten Learning Development Guidelines*. 56. Sacramento, CA.

As the *Guidelines* goes on to say: "Inclusion as an overarching program goal supports the growth and development of all children."

So, how is Nevada County doing in meeting the needs of children with disabilities? Nevada County, like all counties in the state, is part of a Special Education Local Plan Area, which includes the county's 10 school districts and the Nevada County Superintendent of Schools (NCSoS). According to the NCSoS web site (www.nevco.k12.ca.us): "The SELPA serves approximately 1370 special education students from age 0 to 22, with disabilities ranging from speech and language to the severely orthopedically impaired. The basic goal of the SELPA is to ensure that these students receive appropriate programs and services in the most effective, efficient and cost-effective manner practicable."

There are a number of programs in place to support young children with disabilities and their families.

- Each school district in the county employs a Special Education Administrator who works with children with disabilities and their families beginning at age 3 through graduation.
- The Nevada County Superintendent of Schools (NCSoS) runs an Infant Program for babies and toddlers with moderate to severe disabilities, an all-home-based program that utilizes teachers and aides for home visits and serves an average of 24-28 very young children at Champion Mine Family Resource Center.
- NCSoS also offers a preschool program for older children with moderate to severe disabilities, with an annual enrollment of about 15 children, also at Champion Mine Family Resource Center.
- The Grass Valley School District offers the all-county Parent Participation Preschool Intervention Program for children age 3-kindergarten age, which currently serves approximately 40 children (35 families).
- Nevada County Human Services Agency, through the California Children Services (CCS) program, works with families with an income below $40,000 and whose children qualify medically for specific services, with a public health nurse providing medical case management. Children with certain medical conditions receive physical and occupational therapy regardless of income. The monthly average active cases I in CSS is 322.5 and there were 522 referral to CCS in 2005.[85]

Factor: Access to Special Education and Mental Health Services

More than 1 million children in California experience an emotional or behavioral disorder each year, and more than 600,000 children do not receive adequate treatment.[86] And

[85] Figures supplied by Alice Litton, Coordinator, California Children Services, Nevada County Community Health.
[86] Young Hearts and Young Minds: Making A Commitment to Children's Mental Health, *Little Hoover Commission Report # 161*, October, 2001.

31% of children who lag behind in kindergarten do so because of socio-emotional issues, according to recent studies.

In 2000, The Institute of Medicine/National Research Council, in 2000, issued a comprehensive study called *From Neurons to Neighborhoods: The Science of Early Childhood Development*, a landmark study which emphasized the importance of children's social and emotional development to their overall well-being. The report called for larger investments in children's mental health, including developmental and behavioral screens.

The IOM study also recognized the value of well-designed intervention programs That would help children with serious health conditions, including mental and emotional problems. There is growing recognition that some childhood mental illnesses can be prevented, and many others can be prevented from causing long-term damage if there is early, prompt, and appropriate intervention. But this requires making early identification and intervention a higher priority; it means that children of all ages must have access to mental health screens and assessments, both on a routine basis and when they show signs of possible emotional, behavioral, or developmental difficulties.

While there is no mental health data collection system for young children, special education mental health referrals to Nevada County for (older) children in school have risen by 20% since 2001; two-thirds of those children qualified for Medi-Cal or Healthy Families funding.[87]

Data from First 5 Nevada County's Healthy and Happy pilot project, which provided childcare consultation (assessment, early intervention and referrals) and training services in two neighborhoods in 2003-2004, show that consultants responded to 86 calls about the behaviors of young children in 15 months. Of these, 55 needed short-term interventions, such as parent and caregiver coaching, environmental changes, etc. Referrals to other services (such as hearing tests or special education) were made for 13 children, and 18 children were referred for therapy.

Unfortunately, young children with mental health problems often go unserved until they start school, by which time their issues have worsened. Young children with mental health problems are underserved because mental health interventions for this age group are relatively new. In addition, Nevada County's babies and young children are often geographically isolated from services. And our growing population of Latino young chldren live in mostly monolingual Spanish speaking families who encounter additional barriers to services.

[87] Data from Nevada County Behavioral Health, Children's Mental Health Program, Maren Petrie, Children's Mental Health Program Director.

Mental health interventions for the vast majority of babies and young children consist of relationship-based interventions – in other words, parents and caretakers are key to improving mental health outcomes for most young children.[88]

Early childhood educators must certainly be involved in the mental health of the children in their care. An article in *Zero to Three* speaks to this when they report on a Child Care Bureau Bulletin (Issue 25) article:[89]

> The creation of child care and mental health partnerships has been highlighted as an essential action step to support the provision of early childhood mental health services.

Early assistance to a child and his/her parents or caregivers can avoid later, more serious consequences. Children with untreated cognitive and emotional disorders cannot learn adequately at school or gain from healthy social interactions that enable them to be healthy and productive adults. They are at increased risk for school failure, dropping out, drug use, and other risk-taking behaviors.[90]

Treatment for preschoolers, toddlers and infants focuses on prevention and early intervention, and, equally important, it focuses on helping families and caretakers address the socio-emotional challenges they face. Some children are withdrawn, isolated and depressed. Early intervention can help these children before their mental health problems become deep-seated.[91]

While the majority of Nevada County's population is Caucasian, the county is experiencing an in-migration of Latinos, most of whom are new immigrant families. "Racial and ethnic minorities bear a greater burden for unmet mental health needs, and thus suffer a greater loss of their health and productivity…. The mental health field must increase the knowledge base regarding proven practices for the many cultural and ethnic populations we serve*",* according to the Report of the President's New Freedom Commission on Mental Health", presented in October 2002 by the California Mental Health Directors Association and the California Institute for Mental Health.

Summary and Conclusions: Esteem Needs

A child's esteem needs are met through mastery ~ becoming competent and receiving recognition, approval and attention for that competence. Through mastery they

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[88] Egeland, B. and Strofe, L.A. (1993). Resilience as a Process. *Development and Psychopathology, Vol. 5*. 517.
[89] Collins, R., Mascia, J., Kendall, R., Golden, O., and Schock, L. (March 2003*). Promoting Mental Health in Child Care Settings: Caring for the Whole Child, Zero to Three,. Volume 23.* 30,39.
[90] Hawley, T. (1998). The lasting effects of early relationships. *Zero to Three.* 5. National Center for Children in Poverty. (2000). Using mental health strategies to move the early childhood agenda and promote school readiness. *Starting Points: Meeting the Needs of our Youngest Children.* New York: Carnegie Corporation.
[91] National Center for Children in Poverty. Making Dollars Follow Sense. *Financing Early Childhood Mental Health Services to Promote Healthy Social and Emotional Development in Young Children*. www.nccp.org

become confident and develop self-esteem. Esteem, like love, is hard to measure and is often gauged by its absence. Children with low self-esteem perform poorly, behave inappropriately and often have trouble with relationships. What needs can be met that will enhance self-esteem? And how is Nevada County doing vis-à-vis those needs?

What Are the Needs?	Are the Needs Being Met in Nevada County?
Positive social and emotional development.	No way to know, although an assessment used locally (Desired Results; see below) can provide some information. However we know that… ▪ Social and emotional development has to do with how young people feel about themselves, how they behave and how they relate to others. ▪ The stage for healthy social and emotional development begins at home; children must receive their parent's attention, approval, recognition and appreciation. ▪ Quality childcare can moderate what a child may be learning or not learning at home about themselves, how to behave and how to relate to others. ▪ Children are eager to learn. ▪ Improved parenting is crucial. ▪ If a child masters social and emotional skills his/her cognitive and language skills are likely to improve.
Acquisition of early mental and physical skills.	Although young children are being assessed for these skills, it is difficult to generalize. However, we know that… ▪ There are early mental and physical proficiencies that serve as benchmarks for the development of these skills. ▪ Desired Results is being used by several preschools to rate children on a long list of competencies to determine levels of mastery. ▪ Examining data from two local centers who use Desired Results, we find that there are both mental and physical skills that a large number of children have mastered ~ and skills that a fairly large number of children have yet to master. ▪ In family interviews conducted by First 5 California, over ¼ of parents expressed concern about their child's behavior and emotional well-being.
Live in a stimulating environment.	Difficult to measure, although we know that… ▪ Being read to helps children develop important print concepts. ▪ The presence of books and seeing parents enjoy reading can promote a positive attitude toward reading. ▪ ¾ of KidsCAP phone interviewees said they read to their child every day, although the "social desirability" factor needs to be taken into consideration in the responses. ▪ An equally large number of KidsCAP interviewees said they had a library card; more than 1/3 go to the library often and over ½ go to the library sometimes. ▪ Playing with children fosters brain development; "fancy" toys are not necessary.

Parents with good parenting skills.	Another "difficult to measure" need ~ and one too often unrecognized by the parents themselves. However, this is what we know about parenting education in Nevada County. ▪ A survey of local parents found that parents have identifiable preferences about where to get parenting information, and have clear goals for parenting activities. ▪ The same survey found that the two topics that most interested parents were positive discipline and family life skills. ▪ Almost 60% of KidsCAP telephone interviewees said they had not participated in any local events for parents because they were not interested. ▪ Face-to-face KidsCAP interviewees said that not having time was the biggest barrier to participation (41.5%). ▪ A majority of both phone and face-to-face interviewees said they learned about activities and services from friends and family members via word of mouth.
Quality childcare.	Concerted efforts are being made in the county to ensure quality child care, which is a burgeoning need. ▪ 63% of women who have a child under 6 work. ▪ The U.S. Census Bureau predicts that by 2010 parents will comprise 85% of the work force. ▪ As of 2005 there were almost 9,000 children (0-13) with parents in the work force in Nevada County; there were just over 3,000 licensed child care slots. ▪ There is a felt need for child care in the evenings, on weekends and holidays; on a full time basis; and when an emergency arises or a child is sick. ▪ There is concern about the cost of child care and that there often is a waiting list for places that people perceived to have the highest quality of care. ▪ High quality early childhood education promotes cognitive, physical, social and emotional development and creates readiness for school. ▪ Being attuned to diversity in culture and language, and being inclusive by responding to the needs of children with disabilities and special needs, are important aspects of high quality. ▪ Low pay, lack of benefits and low prestige are major barriers to retention of child care providers; continuity of staff is crucial to high quality. ▪ Early childhood educators must have education and training in child development. ▪ Several local agencies/organizations have been/are working collaboratively to develop a strong network of support for early childhood educators that includes finding ways for them to network and enhance their education and training. ▪ Parent engagement is a component of quality care because of the benefits to parents, their children and the center/FCC itself.

The availability of special education and mental health services.	There is definite need for improvement. ▪ Over one million of California's children experience a behavioral or emotional disorder each year; more than 600,000 do not receive adequate treatment. ▪ 31% of children who lag behind in kindergarten do so because of social/emotional issues. ▪ Children with untreated cognitive and emotional disorders cannot learn adequately at school or gain from healthy social interactions, and are at increased risk for school failure, dropping out and drug use. ▪ Early identification and intervention must be a high priority if long-term damage from mental illness is to be prevented. ▪ Latinos and other minorities, "…bear a greater burden for unmet mental health needs." ▪ Special education mental health referrals to Nevada County for school-age children have increased by 20% since 2001. ▪ First 5's pilot project, Healthy and Happy, which provided consultation (assessments, early intervention and referrals) to child care providers and parents, resulted in 86 calls about the behaviors of young children in 15 months. ▪ Because of the dearth of services, young children who struggle with mental health problems often go unserved until they start school.

CONCLUSIONS: MOST PRESSING UNMET NEEDS

Before we briefly venture into the peak of Maslow's pyramid, self-actualization, we'll try to identify the unmet needs that could use the most attention from the community. This is not as easy as it may sound, for the following reasons:

1. Some needs are difficult to address because the factors that impact them are, to some degree, out of the control of this community. The need for clean air comes to mind.
2. It's difficult to know if some of the needs are being met since their very nature makes them difficult/impossible to measure. We don't definitively know, for instance, if children are taking part in experiences that stimulate brain activity…or are having interactions that promote bonding and attachment with their parents/caregivers…or are receiving the attention, approval and recognition they need for healthy social and emotional development.
3. Some needs require community-wide solutions that most likely will take years of commitment and effort. Providing affordable housing and ensuring that children live in homes free of substance abuse are examples of those kind of needs.

With that caveat, here are what the data (and inferences made from the research literature) seem to tell us are the most pressing unmet needs in Nevada County.

NEVADA COUNTY'S TOP UNMET NEEDS*

PHYSIOLOGICAL NEEDS	SAFETY/SECURITY NEEDS	LOVE/BELONGINGNESS NEEDS	ESTEEM NEEDS
1. Access to medical and dental care.	1. Affordable housing.	1. Feeling loved and accepted.	1. Quality childcare.
2. An increase in immunization levels.	2. Families that are self-sufficient.		2. Parents with good parenting skills.
3. Adequate prenatal care.	3. A home free from substance abuse.		3. Positive social and emotional development.
4. Lower rates of obesity.	4. Children who are bonded/attached to their parents.		4. Availability of mental health services and special education.
5. Clean air, i.e., freedom from air pollution and low levels of asthma.			

*Not rank ordered.

Self-Actualization

Maslow described the need for self-actualization as, "…the desire to become more and more what one is, to become everything one is capable of becoming."[92] Usually this pull toward fulfilling our potential occurs only after our "deficiency" needs, the bottom three layers of the pyramid, have been satisfied. Self-actualization takes on the many forms described earlier in this report: a quest for knowledge, understanding, beauty, peace, self-fulfillment, meaning in life.

Abraham Maslow began his work on the theory of motivation that would become his Hierarchy of Needs by studying extraordinary people: Abraham Lincoln, Albert Einstein, Eleanor Roosevelt, Frederick Douglass, Martin Buber, Albert Schweitzer to name just a few. He ultimately identified them as "self-actualized" human beings. These humans were loving, fair, realistic, self-sufficient, spontaneous, creative, unselfish, nice. Other characteristics of people who Maslow said had reached their full human potential included a playful spirit, a history of successful risk-taking, an honest directness and a way of moving through life that appears effortless.

His years of study netted relatively few self-actualized people, and few of us can imagine ourselves in such a transcendent level of being. Those he did find were mature, not just in years but in the process of living. Many of us have had moments of

[92] Maslow, A. (1970). *Motivation and Personality, 2nd ed*. New York: Harper & Row, New York.

transcendency, "peak experiences," as Maslow called them, when we've felt joy and great happiness and have been able, even briefly, to live out of that joy.

We have seen children express that kind of joy ~ a sense of awe and marvel at the world and what's in it. However, that's about as far as young humans can go; it is difficult for them to act out of that joy to better the world. They have too many needs yet to fulfill, too many years yet to experience.

But wouldn't we wish that for all children: to have all their physiological, safety and esteem needs met so that they can become what we wish for them to become, fully realized? Perhaps the following quote says it best:

> It is not possible to care about children and not care for their parents, families, and all of those whose privilege and responsibility it is to be involved with them ~ and those who can offer children a view and experience of themselves and a world that is promising, engaging, reliable, and joyful. For most of us, nothing represents hope, however elusive, more than a baby. Any baby could be better than we are; any baby might be someone who could right wrongs, see justice done, and be happy doing it.[93]

[93] Pawl, J. (September 2003). "Hope is a baby. *Zero to Three.* 4.

PART IV: PROVIDER SURVEY

Introduction

An important component of the First 5 needs assessment is the "Provider Survey." The survey was designed to tap into the considerable experience and expertise that service providers possess. We asked that organizations/individuals share with First 5 what they believe to be the critical unmet needs and gaps in services for young children and those who care for them. The responses add a richness to the needs assessment that otherwise would be missing.

Methodology

We asked representatives of a variety of organizations throughout Nevada County to participate in the survey. The five categories of respondents were:

- Non-profit staff
- Nevada County Human Services Agency staff
- Superior Court representatives
- Early Childhood Educators
- Principals of Elementary Schools and Kindergarten Teachers: Grass Valley, Nevada City and Truckee.

While the list of organizations we chose to survey was never intended to be exhaustive, a large number of organizations received a survey. We enlisted several individuals to help us identify to whom to send the surveys. They included:

- Jeff Brown, HSA Director and First 5 Commissioner
- Kim Bradley, Executive Director of the Tahoe Truckee Community Collaborative
- Marcia Westbrook, Program Coordinator, Childhood Coordinating Council
- Kristin McGrew, School Readiness Coordinator, Grass Valley
- Ruth Hall, School Readiness Coordinator, Truckee
- Eddy Sitzer, Coordinator, Family Connections
- Mary Anne Kreshka, Educator Support Program Lead Advisor
- Rebekah Shurtleff, ESP Advisor, Truckee

Ultimately, 119 individuals received the survey and a cover letter that explained the objectives of the needs assessment, urged their cooperation in completing the survey and informed them of the deadline for return. See Appendix B for a complete list of those who received the survey and Appendix C for the cover letter.

We used open-ended questions about unmet needs and gaps in services as the heart of the survey, believing that would give participants a freer rein and provide us with responses that had breadth and depth. Surveys were developed for each category of

organization, although all but the ones sent to principals and kindergarten teachers were very similar. See Appendix D for samples of the surveys.

Surveys were distributed in the following two ways:

- Non-profit, Superior Court, early childhood education, and elementary school participants received their surveys and cover letters by mail. The cover letter informed them they could complete the survey by e-mail if they wished.
- HSA surveys were distributed by Director Brown through the County's e-mail system.

A stamped, self-addressed envelope was included with the mailed surveys.

The majority of surveys were mailed in January 18 and participants were given a deadline of January 30. A smaller number of surveys were mailed the next week; a deadline of February 3 was set for that group.

Results

Survey Response Rate(s)

In order to receive as many completed surveys as possible, once the deadline had passed a substantial amount of time was spent following-up with those who had been sent the surveys but had not returned them. What follows is information about the response rate for each of the five organizational categories[94]:

PROVIDER SURVEYS
Numbers Sent/Returned and Response Rate

Organizations	Numbers Sent	Numbers Returned	Response Rate
Non-Profits			
Western County	23	19	82.6%
Truckee	16	11	68.8%
TOTAL	39	30	**TOTAL: 76.9%**
Human Services Agency	15	12	**80.0%**
Superior Court	3	2	**66.7%**
Early Childhood Educators			
Western County	29	11	39.3%
Truckee	8	3	33.3%
TOTAL	37	14	**TOTAL: 37.8%**
Principals/Kindergarten Teachers	25	15	**60.0%**
GRAND TOTAL	**119**	**73**	**61.3%**

[94] Not included in the figures is one survey (non-profit category) returned "addressee unknown." Two people who responded to the survey chose to write letters rather than answer the questions directly.

In two instances, two people combined responses and only returned one survey. In other words, the table represents the number of people who were sent surveys, but the return numbers reflect the number of surveys we received. If we consider that 119 people received surveys, we could say that 75 people returned them, which increases the response rate to 63%.

Response rates for surveys traditionally hover around the 20-30% levels. However, many of those who were sent surveys have a collaborative relationship with First 5 or have benefited from First 5 funding, so we expected the response rate to have been higher. In addition, we made considerable effort to follow up with those individuals who had not responded, calling or e-mailing more than once if the first follow-up contact did not result in a response.

If we look at individual categories, we can see that the non-profits in Western County and the Nevada County Human Services Agency responded to the survey at the highest rates, 82.6% and 80% respectively. Truckee non-profits and the Superior Court responded at lower levels, but both rates were close to 70%. The next highest response rate, 60%, is found in the principal/kindergarten teacher category. Early childhood educators responded at the lowest levels: 37.8% when both sides of the county are included in the figures. If ECE surveys were removed from both the sent and returned totals, the overall response rate jumps from 61.3% to 72%.

The lower number of responses from early childhood educators can probably be explained by a variety of factors. First, child care providers are notoriously overworked, often have their own families with young children, and may not have found any time to complete a survey that required thought and reflection. Second, in many instances those surveyed have little or no staff to help identify the unmet needs and gaps in services; conferring with others might have made the task seem less daunting.

Initially we hoped for an 80% return rate, which most likely was unrealistic. Over 60% of those sent surveys returned them, which is a respectable number that provided us with interesting responses to analyze.

Survey Results: Introduction

When we looked at the responses to the surveys something immediately jumped out: some people were unclear about the difference between “unmet needs” and “gaps in services.” The intent was for respondents to identify a need and indicate what service (either not in existence or inadequate to meet the need) might fill that need. For instance, an unmet need might be, “higher rates of immunization.” A gap in service might be, “more parent education about the importance of immunizations.” Clearly, we needed to be more explicit in the cover letter (or on the survey) about the differences, perhaps giving an example that demonstrated that difference. Nevertheless, respondents articulated a plethora of unmet needs and gaps in services.

We aggregated the responses by tallying what respondents listed under "children," "families," and "caregivers." We reviewed the aggregated responses, then made a broad determination about categories, which were assigned codes. We identified 22 code categories, and also designated a code for responses that didn't seem to fit those categories ("non-categorized"). See Appendix F for "Key to Codes." Then each unmet need/gap in service that respondents listed was assigned a code and aggregated according to code. We then had groupings of unmet needs and gaps in services, which we totaled so that the most pressing unmet needs and service gaps emerged.

We will report on the survey results two ways. First, we will look at the coded results by each organizational category, e.g., what unmet needs and gaps in services were identified by non-profits, by Superior Court, etc. Second, we will look at the totality of results, combining the responses from all organizations.

Survey Results: Unmet Needs

Because the survey asked respondents to list five unmet needs (some respondents listed more, some less), there were many needs listed. In most of the coded categories there are many needs subsumed under an over-arching need code (refer to Appendix E for Key to Codes). For instance, "childcare" includes quality, accessibility, affordability, availability of financial assistance, extended and holiday hours, etc. The same is true for "health care": many different needs were identified under the rubric of health care. Other categories were more discrete. "Dental services," for instance, only includes availability and accessibility of dental care. What is reported here are the over-arching needs.

Unmet Needs: Non-Profit Results

See Appendix F for a spreadsheet and a bar graph of the response totals. What you will see is that the respondents from the non-profit sector identified the top five (six in Truckee due to ties) unmet needs as:

WESTERN COUNTY	TRUCKEE	ALL COUNTY
1. Child Care	1. Child Care	1. Child Care
2. Mental/Behavioral Health	2. Latino/Multi-Cultural	2. Health Care
3. Affordable Housing (tie)	3. Nutrition (tie)	3. Transportation
3. Transportation (tie)	3. Professional Development (tie)	4. Latino/Multi-Cultural (tie)
5. Health Care	5. Health Care (tie)	4. Recreation (tie)
	5. Recreation (tie)	

Unmet Needs: Human Service Agency Results

See Appendix G for a spreadsheet and bar graph of the response totals. As they show us, the top five unmet needs identified by HSA staff are:

1. Health Care
2 Dental Services (tie)
2. Childcare (tie)
4. Affordable Housing (tie
4. Transportation (tie)

Unmet Needs: Superior Court Results

See Appendix H for spreadsheet and bar graph of the response totals. The top five unmet needs (all tied) as identified by the two respondents from Superior Court are:

1. Abuse/Violence (tie)
1. Drug/Alcohol Abuse (tie)
1. Mental Health (tie)
1. Parent Education (tie)
1. Supervised Visitation (tie)

Unmet Needs: Early Childhood Educator Results

See Appendix I for a spreadsheet and graph of the response totals. They show us that the five unmet needs mentioned most frequently by early childhood educators are:

1. Childcare
2. Parent Education
3. Health Care
4. Mental/Behavioral Health (tie)
4. Recreation (tie)

Unmet Needs: Principal/Kindergarten Teachers Results

See Appendix J for a spreadsheet and graph of the response totals. Elementary school principals and kindergarten teachers identified the top unmet needs as:

1. Parent Education (by far the most frequent response)
2. Social/Emotional Growth
3. Mental Health
4. Nutrition
5. Child Care (tie)
5. Health Care (tie)

5. School Readiness (tie)

Unmet Needs: All County/All Respondents Results

See Appendix K for a spreadsheet of the Grand Totals. The two bar graphs on the following pages show us the responses by respondent category and the grand totals.

Taking a look at the total responses, these are the top 10 unmet needs mentioned most frequently in the 73 returned surveys, in rank order:

UNMET NEED	RANK	NUMBER OF RESPONSES (480 total*)	PERCENT OF TOTAL RESPONSES
CHILDCARE	1	69	14.4%
PARENT EDUCATION	2	57	11.9%
HEALTH CARE	3	52	10.8%
MENTAL/BEHAVIORAL HEALTH	4	32	6.7%
TRANSPORTATION	5	31	6.5%
AFFORDABLE HOUSING	6	30	6.3%
RECREATION	7	29	6.0%
NUTRITION	8	24	5.0%
DENTAL CARE/SERVICES	9	21	4.4%
LATINO/MULTI-CULT SERVICES	10	18	3.8%

* Does not include responses that were "non-categorized."

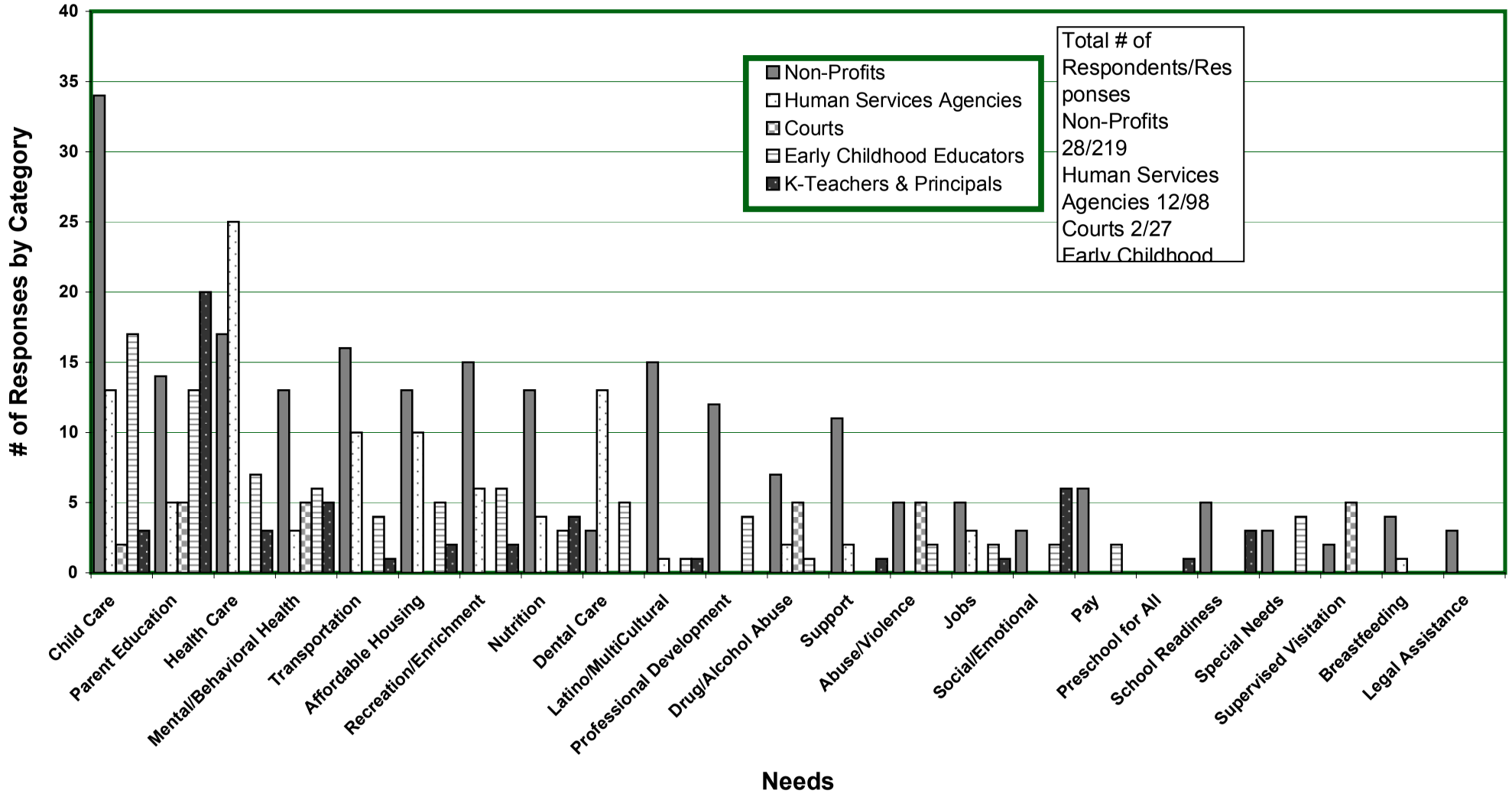
Unmet Needs Comparison: Provider Survey and Research/Data

If we look at the top unmet needs identified in Part I with the top unmet needs identified via the Provider Survey we see that there are striking similarities and a few surprising differences. Let's look at them side-by-side.

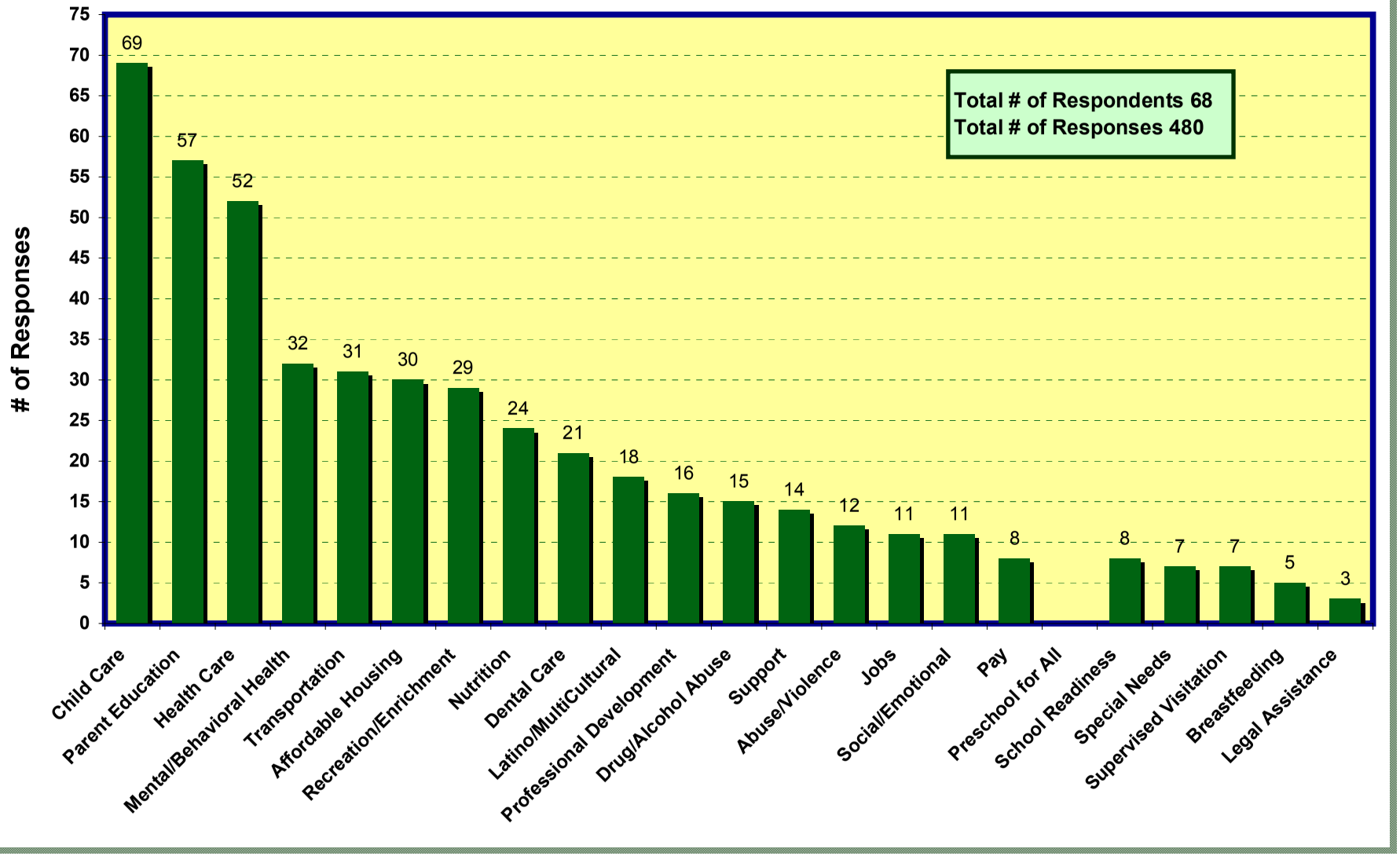
Unmet Needs: Research/Data and Provider Survey Comparison

Maslow Need	Unmet Need	Research	Survey
Esteem	Quality childcare/professional development (childcare providers).	X	X
All	Parents with good parenting skills.	X	X
Physiological	Availability of/access to health care.	X	X
Esteem	Availability of mental/behavioral health services.	X	X
NA	Availability of transportation.		X
Safety/Security	Affordable housing.	X	X
Physiological	Recreation.	X	X
Physiological	Lower rates of obesity/better nutrition.	X	X
Physiological	Availability of/access to dental care.	X	X
All	Latino/multi-cultural services.	X	X
Physiological	An increase in immunization levels.	X	

Unmet Needs: Totals by Category of Respondents



Grand Totals: Unmet Needs: All Respondents



Physiological	Adequate prenatal care.	X	
Physiological	Clean air,i.e., freedom from air pollution/low levels of asthma.	X	
Safety/Security	Families that are self-sufficient.	X	
Safety/Security	A home free from substance abuse.	X	
Safety/Security	Children who are bonded/attached to their parents.	X	
Love/Belong-ingness	Feeling loved and accepted.	X	
Esteem	Positive social and emotional development.	X	

The similarities between the two lists are readily apparent: Quality childcare (and its availability); access to health and dental care and mental health services; good parenting skills/parent education; lower levels of obesity (nutrition); access to recreation (linked to preventing obesity); and affordable housing all rose to the tops of both lists. Availability of transportation was not examined in Part I.

The differences in unmet needs identification may not be as readily apparent because some of the needs may have been subsumed in what the provider respondents said but did not clearly explicate. The last three in the above table are examples of needs that everyone in child development/services surely would agree are requisite to the well being of children. Other unmet needs, specifically clean air/reduction in asthma and economic self-sufficiency, were not identified as top priorities. Freedom from substance abuse was listed by survey respondents a few times, but, surprisingly, was not frequently identified as an unmet need.

That leaves two needs that were identified in Part I, with strong support from the data, as critical to children's health, and are ones not being fully met in Nevada County: High levels of immunization and adequate prenatal care. Nevada County's immunization levels are lagging behind state-wide levels, recently by 20% or more. In addition, parents claim a "personal belief exemption" at much higher levels than parents throughout the state.

With regard to prenatal care, it is important to note the difference between prenatal care that begins in the first trimester and adequate prenatal care. The former does not ascertain how early pregnant women sought care and whether they continued going to their prenatal appointments. If we look at the numbers on the latter, the data tell us that 70% of the county's pregnant women receive adequate care, which ranks us 39th out of 58 counties. The goal stated in Healthy People 2010 is 90%.

Survey Results: Gaps in Services

As mentioned above, presenting and interpreting the results of the survey question that asked respondents to list five gaps in services is problematic. Several respondents wrote in "See Needs." We decided to aggregate only those gaps that were explicitly listed as gaps. The codes for the responses are the same as for unmet needs.

Gaps in Services: Non-Profit Results

See Appendix L for a spreadsheet and a bar graph of the response totals. What you will see is that the respondents from the non-profit sector identified the top five gaps in services as:

Western County	Truckee	All County
1. Child Care 2. Health Care (tie) 2. Mental/Behavioral Health (tie) 4. Recreation/Enrichment (tie)	1. Nutrition 2. Child Care (tie) 2. Health Care (tie) 2. Recreation/Enrichment (tie)	1. Child Care 2. Health Care 3. Mental/Behavioral Health 4. Parent Education (tie) 4. Recreation (tie)

Gaps in Services: Human Service Agency Results

See Appendix M for a spreadsheet and bar graph of the response totals. As they show us, the top gaps in services identified by HSA staff are:

1. Health Care
2 Dental Services (tie)
2. Childcare (tie)
4. Transportation
5. Drug/Alcohol (tie)
5. Latino/Multi-Cultural (tie)
5. Nutrition (tie)
5. Parent Education (tie)

Gaps in Services: Superior Court Results

See Appendix N for spreadsheet and bar graph of the response totals. The top five gaps in services (all tied) as identified by the two respondents from Superior Court are:

1. Abuse/Violence (tie)
1. Drug/Alcohol Abuse (tie)
1. Mental Health (tie)
1. Parent Education (tie)
1. Supervised Visitation (tie)

Gaps in Services: Early Childhood Educator Results

See Appendix O for a spreadsheet and graph of the response totals. They show us that the gaps in services mentioned most frequently by early childhood educators are:

1. Childcare
2. Professional Development
3. Parent Education (tie)
3. Health Care (tie)
5. Dental Services (tie)
5. Social/Emotional Growth (tie)
5. Substitutes (tie)

Gaps in Services: Principal/Kindergarten Teachers Results

See Appendix P for a spreadsheet and graph of the response totals. Elementary school principals and kindergarten teachers identified the top gaps in services as:

1. Parent Education
2. Child Care (tie)
2. Support (tie)
4. Mental/Behavioral Health (tie)
4. Nutrition (tie)
4. Professional Development (tie)

Gaps in Services: All County/All Respondents Results

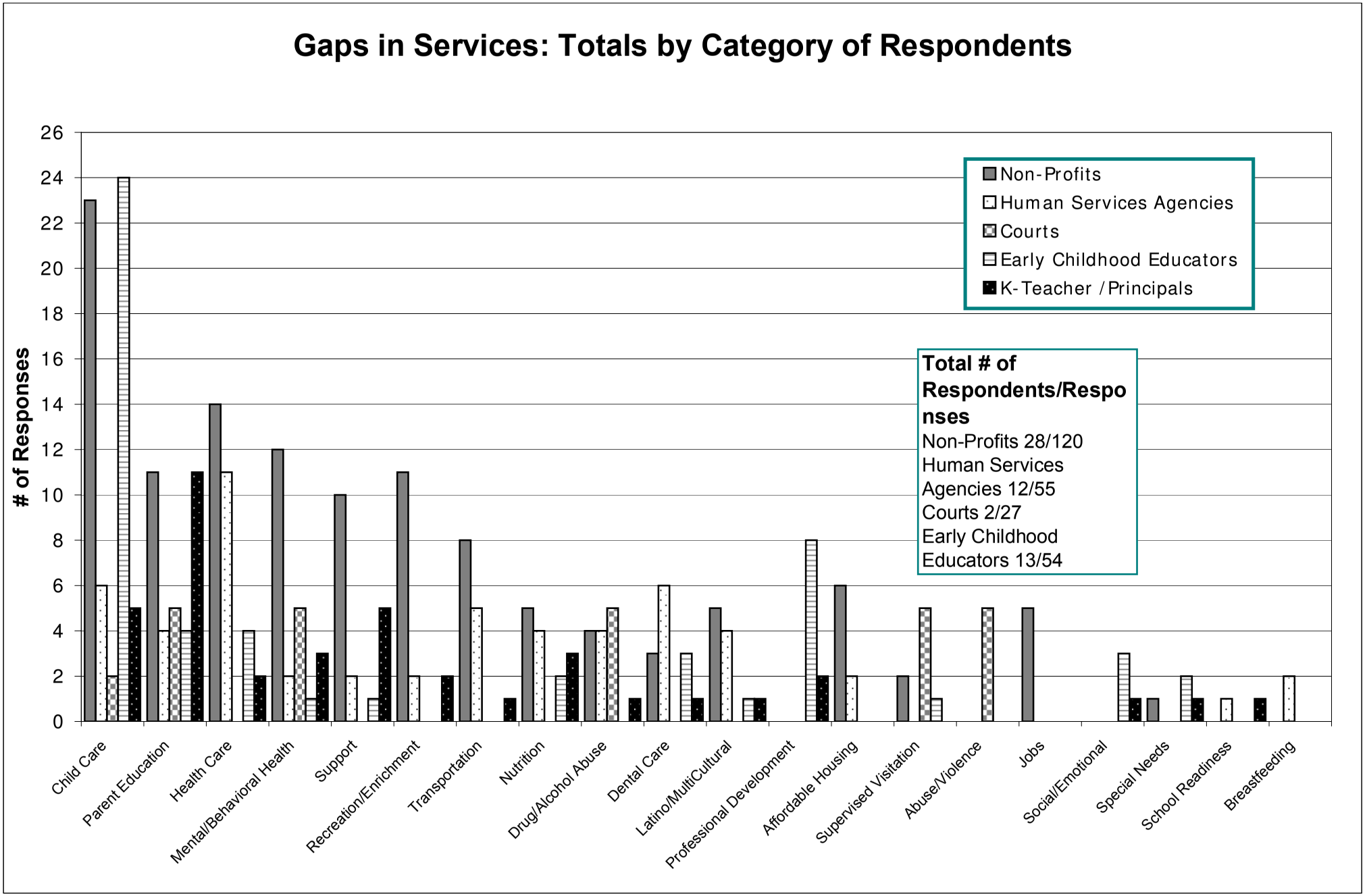
See Appendix Q for a spreadsheet of the Grand Totals. The two bar graphs on the following pages show us the responses by respondent category and the grand totals. Taking a look at the total responses, these are the top 10 gaps in services mentioned (including three that tied) most frequently in the 73 returned surveys, in rank order:

GAPS IN SERVICES	**RANK**	**NUMBER OF RESPONSES** (296 total*)	**PERCENT OF TOTAL RESPONSES**
CHILD CARE	1	60	20.3%
PARENT EDUCATION	2	35	11.8%
HEALTH CARE	3	31	10.5%
MENTAL/BEHAVIORAL HEALTH	4	23	7.8%
SUPPORT	5	18	6.1%
RECREATION/ENRICHMENT	6	15	5.1%
NUTRITION (tie)	7	14	4.7%
TRANSPORTATION (tie)	7	14	4.7%
DRUG/ALCOHOL ABUSE (tie)	7	14	4.7%
DENTAL CARE/SERVICES	10	13	4.4%

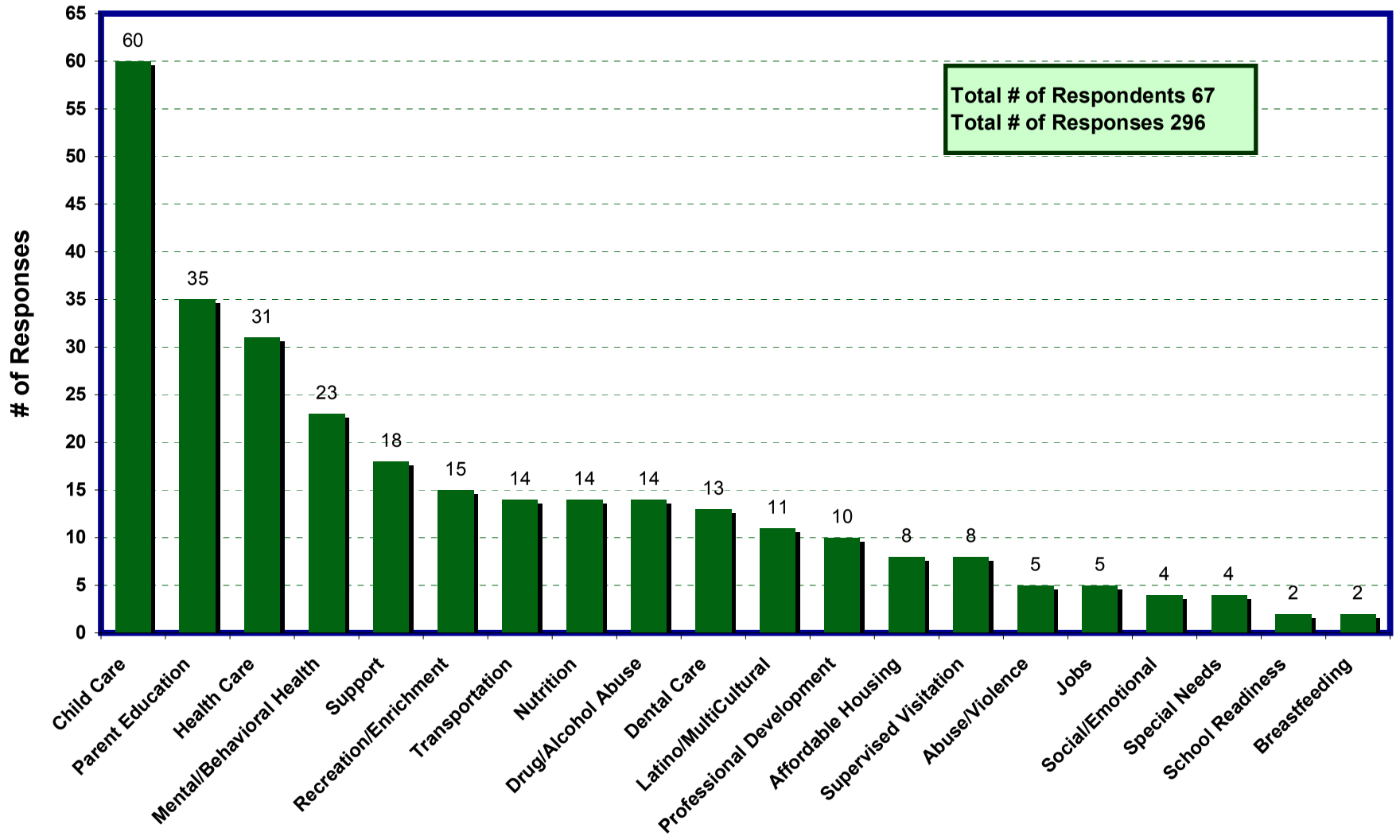
* Does not include those responses that were "not-categorized."

It's not surprising that the gaps in services identified as most pressing reflect the unmet needs that were most frequently cited. In fact, there are only two differences in the

Gaps in Services: Totals by Category of Respondents



Grand Totals: Gaps in Services: All Respondents



lists. The unmet needs most frequently mentioned includes "affordable housing" and "Latino/multi-cultural services," neither of which are on the "gaps in services" list. Conversely, "support" and "drug/alcohol abuse" are on the list of most frequently identified gap, but are not on the "unmet needs" list.

School Readiness

Included in the surveys that were distributed to elementary school teachers and kindergarten teachers were a series of questions that asked them about their perceptions of the school readiness of incoming kindergarten students. These results are interesting to look at and certainly influenced what the principals and teachers identified as unmet needs and gaps in services.

When they were asked: How Ready Are the Kids?, they responded:

Skills

- Areas in which children are least prepared (rank < 5/10)
    1. Large Motor Skills
    2. Pre Academic Skills
    3. Attention Span
- Areas in which children are somewhat prepared (rank < 7 / 10)
    4. Primary Language
    5. Small Motor Skills
    6. Interested and Creative
    7. Behavioral Skills
        i. Self-Help/Hygiene

Influences Impacting Children's Preparedness Negatively

1. (Tie) Lack of family skills to promote school readiness and
2. Lack of Significant Adult Involvement in child's life
3. Entering kindergarten before 5th birthday
4. Family Instability
5. Lack of quality preschool experiences
6. Health Issues
8. Difference between pre-K experiences and kindergarten

When they were asked: How Ready Are the Schools?, they identified the following issues of concern:

- Teachers report that only 80% of entering kindergartners are proficient in English
- Teachers report that 24% are not proficient in English OR their primary language
- Teachers report that 11% of children have noticeable untreated tooth decay

- Only 13% of families have the change to visit the school and meet with the teacher before the first day of school
- Only 35% of teachers have the opportunities to visit pre-K facilities
- 51% of teachers report that no formal transition activities occur with preschools and day care.

Final Thoughts

Those who serve young children in Nevada County are a dedicated group. They are committed to working diligently to ensure the well-being of our littlest citizens. Often they must strive toward that end with limited resources, little public support and not enough ~ never enough ~ time. Perhaps they do it because they believe the words written by Kahlil Gibran over 80 years ago.[95]

Speak to Us of Children

And a women who held a babe against her bosom said,
Speak to us of Children

And he said:

Your children are not your children.

They are the sons and daughters of Life's longing for itself.

They come through you but not from you,

And though they are with you, yet they belong not to you.

You may give them your love but not your thoughts.

For they have their own thoughts.

You may house their bodies but not their souls,

For their souls dwell in the house of tomorrow, which you cannot visit, not even in your dreams.

You may strive to be like them, but seek not to make them like you.

For life goes not backward nor tarries with yesterday.

You are the bows from which your children as living arrows are sent forth.

The archer sees the mark upon the path of the infinite, and He bends you with His might that His arrows may go swift and far.

Let your bending in the archer's hand be for gladness;

For even as he loves the arrow that flies, so He loves also the bow that is stable.

[95] Gibran, K. (1923). *The Prophet*. New York: Alfred A. Knopf. 18-19.

Part V: Comments from the Commissioners and the Public

On March 30, 2006, a PowerPoint of the needs assessment results was presented to the First 5 Nevada County Commission and interested parties from the community. The presentation was filmed by NCTV. Comments from the commissioners and community members were compiled in "Minutes from the Special Meeting, Thursday, March 30, 2006." Those minutes follow this section (immediately before the "List of Appendices").

During the discussion captured in the minutes, Jeff Brown, Commission Vice-Chair and Director of the Nevada County Social Services agency, said that 2006 *County Health Status Profiles* were to be released the following week. Below is a comparison between the 2005 and 2006 data.

HEALTH STATUS PROFILES, 2005/2006 COMPARISON

INDICATORS	NEVADA COUNTY Health Status Profiles 2005	NEVADA COUNTY Health Status Profiles 2006
Infant Mortality All Races/All Ethnic Groups (2000-2002)	1.3 deaths; 1.7/1,000 (803.3 live births, 3-year average) **RANK: 4/58**[96]	1.3 deaths; 1.6/1,000 (824 live births, 3-year average) **RANK: 4/58**
Infant Mortality Asian/PIs	0.0 deaths; 0.0/1,000 (16.7 live birth, 3-year average) **RANK: 4**	0.0 deaths; 0.0/1,000 12.3 live births, 3-year average) **RANK: 7**
Infant Mortality Black	0.0 deaths0.0/1,000 (1 live birth, 3-year average) **RANK: 18**	0.0 deaths; 0.0/1,000 (1.7 live births, 3-year average) **RANK: 15**
Infant Mortality Hispanic	0.3 deaths; 3.0/1,000 (112 live births, 3-year average) **RANK: 10**	0.0 deaths; 0.0/1,000 (115.3 live births, 3-year average) **RANK: 1**
Infant Mortality White	1.0 deaths; 1.5/1,000 (667.7 live births; 3-year average) **RANK:4**	1.3 deaths; 1.9/1,000 (687.7 live births, 3-year average **RANK: 6**
Low Birth Weight* (2001-2003) * 5.8 lbs. or less	5.6% (824 live births; 3-year average) **RANK: 19** (Data not broken out by ethnicity)	6% (820.7 live births, 3-year average) **RANK: 23**
FACTORS		
Prenatal Care: Not Begun During 1st Trimester (2001-2203	15.6% **RANK: 19** (Data not broken out by ethnicity)	13.9% **RANK: 19**
Prenatal Care: Early/Adequate	69.8% **RANK: 39** (Data not broken out by ethnicity)	69.9% **RANK: 42**
Breastfeeding: Initiated During Early Postpartum	92.6% (739 births with known feeding method) **RANK: 8** (Data not broken out by ethnicity)	94.4% (741 births with known feeding method) **RANK: 2**

[96] Ranking based on a three-year average of the birth cohort infant death rates, which are per 1,000 live births, not on individual infant deaths. Nevada County's death rates are considered statistically unreliable.

As we can see from the data, Nevada County has improved considerably in the indicator of Hispanic infant mortality, moving in rank from 10th to 1st. In addition, the county has moved from 8th to 2nd in breastfeeding initiated during early postpartum. However, in three other indicators/factors, the county is ranked lower than in 2005: white infant mortality (ranked 4th in 2005, 6th in 2006); low birth weight (ranked 19th in 2005, 23rd in 2006); and early/adequate prenatal care (ranked 39th in 2005, 42nd in 2006).

Let's compare Nevada County's Health Status Profiles with the Profiles of three other rural, mountainous communities, as was suggested by Dr. Ken Cutler, chair of the First 5 commission.

COUNTY HEALTH STATUS PROFILES 2006

Indicator	Nevada County	Lassen County	Plumas County	Siskiyou County
Infant Mortality All Races/All Ethnic Groups (2000-2002)	1.3 deaths; 1.6/1,000 (824 live births, 3-year average) **RANK: 4/ 58**	2.3 deaths; 8.3/1,000 (282 live births, 3-year average) **RANK: 57**	0.7 deaths; 3.9/1,000 (170 live births, 3-year average) **RANK: 15**	1.3 deaths; 3.0/1,000 (443.7 live births, 3-year average) **RANK: 7**
Infant Mortality Hispanic	0.0 deaths; 0.0/1,000 (115.3 live births, 3-year average) **RANK: 1**	0.3 deaths; 8.2/1,000 (40.7 live births, 3-year average) **RANK: 52**	0.0 deaths; 0.0/1,000 (12.3 live births, 3-year average) **RANK: 4**	0.0 deaths; 0.0/1,000 (75 live births, 3-yer average) **RANK: 2**
Infant Mortality White	1.3 deaths; 1.9/1,000 (687.7 live births, 3-year average **RANK: 6**	1.0 deaths; 4.5/1,000 (221.7 live births, 3-year average) **RANK: 30**	0.7 deaths; 4.4/1,000 (151 live births, 3-year average) **RANK: 27**	1.3 deaths; 4.1/1,000 (327.3 live births, 3-year average) **RANK: 21**
Low Birth Weight* (2001-2003) * 5.8 lbs. or less	6% (820.7 live births, 3-year average) **RANK: 23**	5.4% (300.7 live births, 3-year average) **RANK: 11**	6.7% (178.7 live births, 3-year average) **RANK: 44**	7.3% (457 live births, 3-year average) **RANK: 56**
FACTORS				
Prenatal Care: Not Begun During 1st Trimester	13.9% **RANK: 19**	18.5% **RANK: 37**	14.0% **RANK: 20**	23.1% **RANK: 42**
Prenatal Care: Early/Adequate	69.9% **RANK: 42**	77.4% **RANK: 17**	68.2% **RANK: 49**	69.4% **RANK: 45**
Breastfeeding: Initiated During Early Postpartum	94.4% (741 births with known feeding method) **RANK: 2**	88.4% (200.7 births with known feeding method) **RANK: 29**	91.0% (137.7 births with known feeding method) **RANK: 14**	89.7% (325.7 births with known feeding method) **RANK: 23**

In all but two areas, low birth weight and early and adequate prenatal care, Nevada County outranked all of the three comparison counties. Only Lassen County had a better ranking than Nevada County in low birth weight; the other two counties' rankings were considerably worse. Lassen also had a much better ranking in early and adequate prenatal care. Certainly, mothers who receive early and adequate prenatal care are less likely to deliver low birthweight infants. Therefore, Lassen's rankings in infant

mortality, also correlated with prenatal care, are perplexing since they are much worse than might be expected.

In some cases, most notably in the areas of white infant mortality and breastfeeding initiated early postpartum, the difference in ranking between Nevada County and the other counties is startling. The reasons for the disparities are difficult to ascertain, although Nevada County's demographics show a well-educated population, which correlates with breastfeeding.

The March 30th discussion included the observation that the population demographics included in the report (page 5) might be misleading since not all zip codes were included, and the area commonly called the "Ridge" encompasses not only the North San Juan zip code (95960), but a portion of Nevada City's zip code (95959). The following table is drawn from data reported by the United States Census and the California Department of Finance and included in KidsCAP 2005. It shows changes in the population since 1999 and may give a clearer picture of the county's demographics. The 2005 data are estimates.

POPULATION DISTRIBUTION BY JURISDICTION: NEVADA COUNTY

	January 1999	**January 2005**	**99-05 % change**
Grass Valley	9,925	13,006	31.0
Nevada City	2,910	3,050	4.8
Truckee	12,550	15,567	24.8
Unincorporated	64,900	67,242	3.6
TOTAL	90,300	98,955	9.6

It might also be useful to compare the county's total population distribution and the county's child population (age 0-5) distribution by white and Hispanic ethnicity.

POPULATION DISTRIBUTION BY ETHNICITY: NEVADA COUNTY

	1999	**2005**	**99-05 % Change**
White			
Number	87,607	88,662	1.2
Percent	93.2	89.0	
Hispanic			
Number	4,587	6,365	38.8
Percent	4.9	6.4	
White (ages 0-5)			
Number	4,946	4,355	-11.9
Percent	87.7	83.4	
Hispanic (ages 0-5)			
Number	561	531	-5.3
Percent	9.9	10.2	

The data show us that there has been an almost 40% increase in the county's Hispanic population, although the actual numbers have increased by fewer than 2,000. The estimates for 2005 show a decrease in both the white and Hispanic 0-5 population.

The results of the Provider Survey piqued the interest of those who attended the community presentation, particularly because child care was identified as a need/gap in service by so many who responded to the survey. As is mentioned in the minutes of the March 30th meeting and can be seen in the "Key to Codes," found in Appendix E (page 14), there were many different aspects of child care that survey respondents listed, including (but not limited to): the need for extended hours, holiday and respite care; the quality and accessibility of childcare; the affordability of and financial assistance for child care; and the quality of play space and equipment. The next most frequently mentioned needs, parent education and health care, did not have quite the breadth of responses.

The richness of the discussion that ensued during the March 30th meeting is captured to a large degree in the minutes that are attached to this section of the report. Further examination of the data and research presented in these pages may bring even more depth to the discussion "table" as decisions are made about resource allocation and grant making.

FIRST 5 NEVADA COUNTY
CHILDREN AND FAMILIES FIRST COMMISSION

Champion Mine Family Resource Center
400 Hoover Lane
Nevada City, CA 95959

Jean Soliz-Conklin, Executive Director
Phone: (530) 265-0611 ext. 224
Fax: (530) 265-0524
linked to: www.first5nevco.org

Minutes from the Special Meeting
Thursday, March 30, 2006
Nevada City Council Chambers
317 Broad Street, Nevada City, CA 95959

Commissioners Present: Dr. Ken Cutler (Chair), Jeff Brown (Vice-Chair), Jon Byerrum, Dr. Brent Packer
Staff Present: Jean Soliz-Conklin, Janice LeRoux, Randy McKean, Lindsay Dunckel
Interested Parties: See **Attachment A**

1. **Call To Order**: 6:10 p.m. by Chairman Ken Cutler. Ken thanked everyone for coming after a busy day of work. He explained Commissioner Ted Owens could not be there.

2. **Introductions—**Ken introduced the author of the Needs Assessment, Cynthia Schuetz, who has an MPH and PhD in Community Health Education, and thanked her for the work she had put into the project. He explained the format of the evening's presentation. Introductions were made by the audience.

3. **The First 5 Nevada County 2006 Needs Assessment—**Presented by Cynthia Schuetz, Ph.D.

   a. **Presentation #1: Report on the Research, Public Data and Parent Opinions**

      i. **PowerPoint Presentation—**Cynthia presented the first part of the Needs Assessment (see **Attachment B**).

      ii. **Commission Questions/Discussion**—Commissioner Jeff Brown said it was great to see all of this information in one place and linked together. He confirmed with Cynthia that she did not include information from certain Nevada County zip codes because they had a very low population. Jeff asked if the figure of 18 children 0-5 for North San Juan was correct. Cynthia said her source was the U.S. Census, but said she had questioned this figure, as well. Ariel Lovett of Sierra Nevada Children's Services (SNCS) said the problem may be that "95960" is the official zip code for North San Juan, and is a very small area geographically. The other areas of the Ridge fall into the "95959" zip, which is officially considered Nevada City. Commissioner Jon Byerrum observed that just looking at zip codes can skew data, and said it might be a good idea to look for other data sources that could help break out the data.

      Jeff noted the State of California would be releasing the 2006 County Health Status Report on Monday, April 3. He thought perhaps the numbers in this draft Needs Assessment could be adjusted, if possible, after consulting that report. He said the County was doing better and worse in some areas, but said there were no radical changes from previous figures. Cynthia said that information could be added as an addendum.

      Jeff noted, with regard to prenatal care, that the infant mortality rate was great in Nevada County—the 2006 report says the County is down to 1½; non-white infant mortality is zero. He said that although the County can do better in prenatal care, the current outcomes are very good. Jon said he liked Cynthia's statistic on African-American infant mortality, and her comments on how data can be misinterpreted. Ken asked Jeff how the County was doing with regards to low birth weight and prematurity. Jeff said it is pretty good compared to national average, but based on the data in the new study he referred to earlier, Nevada County is 23rd out of 58 counties in California.

      Ken said some of the information in the report leads to new questions, such as the findings on low immunization rates and prenatal care. As an example, Ken asked if there was a way to survey more people, or to find out who are taking personal exemptions from the services and where they are located in the County. Jon said he thought many exemptions may be among charter and home study children, and thought this may be an area in which they could target intervention. Ken said he had had the same suspicions, as well.

Sandee Gustavson of the Care Campus commented they see a number of exemptions in immunizations. She said it tends to be younger parents, and, citing the autism scare, she said she thought many parents are trying to be more healthy without understanding the whole picture. Ken said trying to give them information is one approach.

Ken asked Cynthia if she could connect the prenatal data with insurance coverage. Jeff said it would be nice to see how our numbers compared to those of other rural counties.

Colleen Williams of Great Beginnings said she thought the figure of 16% for the gap in prenatal care was right, from her perspective of working with MediCal moms in Truckee. She said she had seen a lot of late entries into prenatal care. Ken asked her what she thought the reasons for this were. Colleen said she thought access was a big issue—because of paperwork and processing, there is a wait of 30-45 days for a MediCal card. She cited other reasons such as substance abuse, domestic violence, and transportation.

Jeff confirmed with Cynthia that with regards to injury reports, there were so few deaths that mortality rates did not tell her anything. Ken said the number of unintentional injury seemed very low. Cynthia said it was reliable data, from the county data book. Ken said he thought it must be a reporting issue.

iii. **Community Questions/Discussion**—Fran Freedle of KARE asked if differences would pop out if data was divided by eastern and western county, as she felt these populations were very different. Cynthia replied that it was very difficult to get data just for the county, as it was often mixed in with other counties. She said this kind of analysis would be a worthy endeavor, but beyond the scope of this report. Jon commented it was striking how high levels of poverty were concentrated in just a couple of geographic areas.

Kaili Sanchez from Project MANA asked why there was not more data concerning child abuse and domestic violence in the Safety and Security section of the report. Cynthia said it was very difficult to get the data. She requested the data from local sources and was unable to get it from them. She recognized this as a hole in the report. Ken said that if people knew of information sources that were not covered by the report that they thought should be included, they should forward the information to the Commission.

b. Presentation #2: Report on the Opinions of Service Providers and Educators

i. **PowerPoint Presentation**—During the presentation, Jeff asked about gaps in services. He said he was very surprised dental care was ranked so low when we know so many kids lack insurance coverage and suffer from dental disease. Cynthia was not sure why that was, except perhaps it was simply not a “hot” topic. Jon said it could be due to the dental clinics in the County. He said that in forums he attended 10 years ago, dental and transportation always ranked among the top three concerns.

ii. **Commission Questions/Discussion**—Ken thanked Cynthia. He urged attendees to go through the full report and put in their comments. Commissioner Brent Packer said he thought there was some useful data in the report, and said he liked the graphics and color. Cynthia thanked Maxima Kahn for her help in preparing the charts and the data for the report.

Jeff said it would be interesting to see how the Commission’s investments-to-date correlated with the findings of this report. Ken asked Jean to do this. Jon noted the staff had done this in the past, and thought this would be helpful.

Jon noted childcare came up as respondents’ top concern. He asked Cynthia what the issues were—not enough childcare in the County, was it too expensive, quality? Cynthia said there were many issues connected to childcare, which contributed to its high numbers, and referred Jon to the Key to Codes section of the report, which lists concerns. She said she could take a closer look at the raw data, if requested. Jon said such an examination may indicate how to proceed with regard to this issue.

Jon asked if information from forums and discussion groups First 5 had sponsored in the past was included in the report. Cynthia said it was, and referred him to the research section, where items such

as the modified desired results from School Readiness meetings were included. Cynthia confirmed for Ken that this data correlated with survey results.

iii. **Community Questions/Discussion—**Sandee Gustavson said she thought childcare concerns may be cost, but noted that the cost of childcare in Nevada County is low when compared to other cities. She noted incomes are low in the County. Colleen Williams said affordability may be the issue, or that people's money is going for other things. Jon noted the statistic that people are putting 75% of their disposable income into housing.

Kristen McGrew noted substance abuse didn't come up as an issue. She thought many of the parenting issues, such as lack of bonding, could be from substance abuse.

Ruth Hall said that in Truckee, much of the issues concerning childcare affordability have to do with the divide between the rich and poor: poor people can't afford childcare, wealthier people are shopping for childcare, which creates waiting lists at those perceived as quality providers, and the middle class is locked out. She said she believed it was a market issue, where economics are driving the perception.

Bonnie Taylor from Child Advocates said they had problem in filling out the survey because they were unsure where to put child abuse issues. She thought many who filled out the survey may have tried to put it concerns about child abuse in the parenting section.

Mary Anne Kreshka said the lack of public programs for infants and toddler care may have raised the childcare issue. Cynthia noted the lack of off-hours care was mentioned many times. Jon said childcare is one area where Commission may need to get more data to pinpoint issues. He noted that although there are state preschools, toddler and infant care is not subsidized, and cost can become prohibitive.

Bonnie Taylor thanked Cynthia for her work, and said the report would be helpful to everyone working with children.

Ken thanked everyone for coming, and congratulated Cynthia on the report, noting it would be very helpful as the Commission moved forward.

4. **Adjournment:** By Ken Cutler at 8:15 p.m.

Attachment A
Meeting Attendees – March 30, 2006

Name		Agency
John	Church	NCTV
Bruce	Conklin	First 5 Yuba County
Warren	Daniels	Community Recovery Resources
Ruth	Hall	Truckee School Readiness Coordinator
Fran	Freedle	KARE Crisis Nursery
Sandee	Gustavson	Care Campus
Maxima	Kahn	First 5 Nevada County—Contractor
Mary Anne	Kreshka	Sierra College
Bill	Locker	Sierra Nevada Children's Services
Ariel	Lovett	Sierra Nevada Children's Services
Kristen	McGrew	Grass Valley School Readiness
Jim	Perkins	Interested Party (Dr. Schuetz's husband)
Nancy	Piette	Women Infant Children (WIC)
Kaili	Sanchez	Project MANA
Cynthia	Schuetz	First 5 Nevada County—Contractor
Bonnie	Taylor	Child Advocates of Nevada County
Colleen	Williams	Great Beginnings

Assessing the Needs of Nevada County's Children

LIST OF APPENDICES

APPENDIX A

Desired Results Charts
Two Western Nevada County Child Care Centers

Desired Result 1: Children are Personally and Socially Competent

Fully/Almost Mastered: Highest to Lowest Percentage

Items	Center 1/ 16 items Fully/ Almost Mastered (3-5 year olds, n= 24)	Center 2/ 15 items Fully/ Almost Mastered (4 year olds, n= 30)
Engages in cooperative pretend play activities with peers	100% (24)	96% (29)
Engages in conversations that develop a thought or idea	100% (24)	91% (27)
Identifies self by categories of gender, age or social group	96% (23)	100% (30)
Demonstrates confidence in own abilities	96% (23)	96% (29)
Experiments w/ using more complex grammar & parts of speech	95% (23)	92% (28)
Seeks adult help when appropriate	92% (22)	100% (30)
Expresses empathy or caring for others	92% (22)	68% (20)
Comforts self with adult guidance	91% (22)	74% (22)
Shows concern about fairness within peer group regardless of group differences.	88% (21)	75% (23)
Interacts & cares for children who are not like themselves.	84% (20)	NA
Follows rules when participating in routine activities.	83% (20)	80% (24)
Follows two-step requests that are sequential but not necessarily related.	83% (20)	100% (30)
Participates in songs, rhymes, games, and stories that play with sounds of language.	83% (20)	51% (15)
Responds & makes verbal greetings when appropriate.	83% (20)	96% (29)
Exhibits impulse control and self-regulation.	79% (19)	68% (20)
Negotiates with peers to resolve social conflicts with adult guidance.	75% (18)	68% (20)

Desired Result 2: Children Are Effective Learners

Fully/Almost Mastered: Highest to Lowest Percentage

Items	Center 1/ 28 items Fully/ Almost Mastered (3-4 year olds, n= 24)	Center 2/ 23 items Fully/ Almost Mastered (4 year olds, n= 30)
Observes and examines natural phenomenon through senses.	100% (24)	96% (29)
Stays with or repeats a task.	96% (23)	96% (29)
Uses size words such as many, big and little appropriately.	96% (23)	100% (30)
Engages in discussion about books.	96% (23)	88% (24)
Combines activities, materials and equipment in new ways.	92% (22)	80% (24)
Draws a picture related to a story and talks	92% (22)	96% (29)

about his or her drawing.		
Pretends to read books.	88% (21)	84% (25)
Completes increasingly complex puzzles.	87% (21)	100% (30)
Understands that numbers represent quantity.	87% (21)	100% (30)
Uses measuring implements.	87% (21)	100% (30)
Recognizes squares, circles, triangles.	87% (21)	NA
Understand that letters make up words.	84% (20)	92% (28)
Demonstrates an understanding of different rates of speed.	83% (20)	100% (30)
Acts out plays, stories or songs.	79% (19)	48% (14)
Describes how items are the same or different.	79% (19)	96% (29)
Orders objects from smallest to largest.	76% (18)	100% (30)
Independently accesses/uses art materials & comments on it.	75% (18)	NA
Demonstrates spatial awareness by positioning objects or using appropriate directional works, e.g. up, down.	74% (18)	NA
Uses pretend writing during play activities.	71% (17)	48% (14)
Writes three or more letters or numbers.	71% (17)	76% (23)
Recognizes print in the environment.	71% (17)	80% (24)
Predicts outcomes in changes of materials & cause and effect relationships based on past experiences.	71% (17)	NA
Estimates.	66% (16)	76% (23)
Matches and names similar patterns.	66% (16)	100% (30)
Writes three of more letters or numbers.	62% (15)	76% (23)
Describes landmarks in the community	50% (12)	NA
Makes three or more letter-sound correspondences	46% (11)	75% (23)
Knows 10 or more letter names, especially those in their own name	42% (10)	NA

Desired Results 3: Children Show Physical and Motor Competence

Fully/Almost Mastered: Highest to Lowest Percentage

Items	Center 1/ 8 items Fully/ Almost Mastered (3-4 year olds, n= 24)	Center 2/ 8 items Fully/ Almost Mastered (4 year olds, n= 30)
Jumps forward with both feet.	96% (23)	100% (30)
Catches a large ball with two hands.	91% (22)	100% (30)
Skips or gallops.	84% (20)	80% (24)
Manipulates two small objects at the same time.	79% (19)	100% (30)
Uses tools for increasing precision.	79% (19)	100% (30)
Shows rhythmic movement.	75% (18)	80% (24)
Gets dressed with minimal help.	71% (17)	100% (30)
Fastens buttons.	71% (17)	92% (28)

Desired Results 4: Children are Safe and Healthy

Fully/Almost Mastered: Highest to Lowest Percentage

Items	Center 1/ 6 items Fully/ Almost Mastered (3-4 year olds, n= 24)	Center 2/ 6 items Fully/ Almost Mastered (4 year olds, n= 30)
Takes care of own toileting needs.	96% (23)	100% (30)
Washes and dries hands before eating and after toileting.	91% (22)	100% (30)
Knows first and last name.	83% (20)	100% (30)
Knows how to follow routines in emergency situations.	71% (17)	100% (30)
Communicates dangerous behavior to another.	70% (17)	96% (29)
Tries new food on own.	68% (16)	56% (17)

APPENDIX B

Provider Survey Distribution List

NON-PROFIT AGENCIES

Bill Locker, Executive Director
Sierra Nevada Children's Services

Bonnie Taylor, Executive Director
Child Advocates of Nevada County

Marcia Westbrook, Coordinator
Child Care Coordinating Council

Eddy Sitzer, Coordinator
Family Connections

Gail Johnson, Executive Director
Sierra Adoption Services

Becky Stonestreet, Leader
La Leche League

Mike Mann, Supervisor
Alta California Regional Center

Jonelle Jerram Parker, Acting Executive Director
Domestic Violence and Sexual Assault Coalition

Alison Schamber-Sharp, Executive Director
KARE Crisis Nursery

Jennifer Hughes
RidgeLine

Sara Morrison, Project Director
RSVP (Helpline)

Tanya Rentz, MFT
Spanish Counseling Services

Scott McFarland, Executive Director
Miners Family Health Center

Peter VanHouten, M.D.
Sierra Family Medical Clinic

Lindy Beatie, Executive Director
United Way

Nancy Wilbourne, Program Coordinator
Literacy Council of Nevada County

Susan Love
Team 3 Family Counseling Center

Ann Guerra, Executive Director
FREED Center for Independent Living

Kimberly Parker, Executive Director
Sierra Nevada Memorial Hospital Foundation

Warren Daniels, Executive Director
Community Recovery Resources

Joyce Smith
CAL SAFE Infant Toddler Center
Silver Springs High School

Donna Chamberlain
Birth & Early Parenting Educators

Cathy Le Blanc, Program Planner
San Juan Ridge Family Resource Center

Truckee

Kim Bradley, Executive Director
Community Collaborative of Tahoe Truckee

Ruth Hall, Coordinator
School Readiness Program

Carol Meagher, Director
Kidzone Museum

George LeBard, Executive Director
Project MANA

Stephanie Castleman
Sierra Nevada Children's Services

Marta Cerna
Truckee Family Resource Center

Colleen Williams
Tahoe Forest Hospital, Special Delivery Program

Wendi Steffen, Service Coordinator
Alta Regional

Janice Eastburn, Service Coordinator
Alta Regional

Susie Coyote, Executive Director
Wellspring Counseling

Margarita de Nevarez
Family Resource Center

Monina Vazquez
Wellspring Counseling Center

Jill Whisler/Maria Martin
Wellness Dietitians
Tahoe Forest Hospital

Cindy Bansen
Tahoe Forest Hospital
Great Beginnings/Lactation Consultant

Laurie Martin
Tahoe Truckee Unified School District

Chris Carter
Tahoe Women's Services

NEVADA COUNTY HUMAN SERVICES AGENCY

Jeff Brown, Director
Nevada County Human Services Agency
(Director Brown distributed the surveys to his staff)

Dr. Brent Packer, Public Health Officer
Director, Community Health

Nancy Piette, Coordinator/Senior Nutritionist
Women, Infants and Children Program
Community Health

Allice Litton, Coordinator
Children's Medical Services (2 surveys)
Community Health

Doug Bond, Program Chief
Behavioral Health

Kim Honeywell, Coordinator
HIV Prevention
Community Health

Kathryn Kestler, Public Health Nurse
Community Health

Vicki Cole Petch, Clinical Nurse
Community Health

Cynthia Bryan, Program Manager
Benefits and Employment Division
Department of Social Services

Judith Caldwell, Senior Health Technician
Community Health

Cheryl Montague, Director
Public Health Nursing
Community Health

Felicia Sabonya, Coordinator
Tobacco Use Prevention
Community Health

Mary Graebner, Coordinator
Maternal/Child Health Program
Community Health

Robyn Gauldin, Acting Program Manager
Truckee

SUPERIOR COURT

Judge Sean Dowling

Gretchen Serrata, Family Law Facilitator

Serge Aronow/Carmella Smith, Family Court Services

EARLY CHILDHOOD EDUCATORS

Mary Ann Kreshka
Sierra College Child Development Center

Elizabeth MacKenzie
Little Friends Child Development Center

Cindy Santa Cruz
Ready Springs Community Preschool
Diane West
Sierra College Child Development Center

Kimberly Butcher
Bearcat Discovery Center

Irma Calderon
Placer Community Action Council (Head Start)

Sarah Cammon
Small Wonders Child Care

Dana Campbell Dills
Seven Hills Clubhouse

Polly Frey
Polly's Childcare

Brenda Frey
Brenda's Childcare

Karen Rhode
Karen's Daycare

Janel Sunde
A Child's Garden Preschool

Nora Turpin
Nora's Playschool

Lisa Parman
A Child's Place

Barbara Price
Little Creek Nursery

Carolyn Stover
Wild Duckies Preschool

Carolyn Tate
Kid's Stuff Child Care

Jody Veerkamp
Little Creek Nursery

Annie Toor
Kentucky Flat Head Start

Claudia Dondero, Site Supervisor
North San Juan Child Development Center

Corinne Watson
Kentucky Flat Head Start

Pamela Whitley
4-H Afterschool Program, Ready Springs

Debbie Biddinger
Tall Pines Nursery School Parent Co-op

Jeanette Clark
Hennessey 4-H Program

Lupe Peterson
Kinderland

Tommie Conlen and Lisa Sheetz
Champion Mine Infant Program

Louise Ullom, Director
Sonshine Preschool & Kindergarten

Sandee Gustavson, Director
Care Campus

Linda Fischer
Our Kid's Place

Truckee

Rebekah Shurtleff
Tahoe Forest Children's Center

Leticia Aguilar
Lety's Daycare

Maria Gonzalez
Maria's Childcare

Marie Smith
Marie's Place

Alicia Lopez-Alcaraz
Alicia's Childcare

Mary Lee Schaffarzick
Tahoe-Donner Recreation and Park District

Christine Sproehnle
Christine Sproehnle's

Cindy Maciel, Program Manager
STEPP Program

Arleen Wallace
STEPP Center

ELEMENTARY SCHOOL PRINCIPALS/
KINDERGARTEN TEACHERS

Truckee Elementary School

Principal: Cathy Valle
Kindergarten Teachers
Chris Duner
Amalia Niewendorp
Julia Lawrence
Mardiece Patrick
Betsy Depew
Marian Teller

Scotten School
Principal: Brian Buckley
Kindergarten Teachers
Lynn Dell
Marilyn Geary
Lois Johnson
Sue Yoshioka

Hennessy School
Principal: Margaret Eli
Kindergarten Teachers
Linda Bennett
Lori Imel
Faye Nightingale
Cynthia Wiberg

Nevada City Elementary
Principal: Susie Barry
Kindergarten Teachers
Daria Kieswetter
Tiffany Looney
Vanessa Lackey

Gold Run Elementary
Principal: Kate Wiley
Kindergarten Teachers
Ernie McDaniel
Antonina Shumaker
Susan Mahaffy

Appendix C

Champion Mine Family Resource Center
400 Hoover Lane
Nevada City, CA 95959

Jean Soliz-Conklin, Executive Director
Phone: (530) 265-0611 ext. 224
Fax: (530) 265-0524
linked to: www.first5nevco.org

Hello on behalf of First 5 Nevada County. I hope 2006 has gotten off to a good start for you and your organization. Our "new year" includes an in-depth report on the needs of Nevada County's children, prenatal through age 5, and their families and caregivers; I have been hired as the consultant to prepare the report and am writing to ask your assistance in that endeavor. The First 5 Commission wants to tap into your considerable experience and expertise, and are asking that you share with us what you believe to be the critical unmet needs and gaps in services for young children and those who care for them.

The needs assessment will be used by the Commission to decide where to target resources. It also will be useful to all of the agencies that serve young children as they plan for the future and search for funding. The report will "harvest" the wide range of information from the literature, data bases and previous needs assessments and bring that information together in one comprehensive report. In addition, we will survey select groups and individuals in order to enhance what currently exists. We need your help in making this report as meaningful and relevant as possible.

The report will include:

- what we currently know about the needs of children;
- what we don't yet know;
- what services and programs currently exist for young children, their families and caregivers;
- what gaps in services and programs exist.

We know many of you have conducted your own needs assessments. If you have, we would like to know what you learned, so we hope you will be willing to share with us any documentation of needs you have on file. In addition, I have designed a brief questionnaire which we would like you to complete and return to us. Some of you will receive this letter and the survey via e-mail. You may respond online and send it to me at the address listed below, or run off a copy and use snail mail or fax. **If you have received this in hard copy format and would like me to e-mail it so that you can respond electronically, please let me know.**

The Commission needs and values your input, so if I do not receive a response from you, expect an e-mail message or phone call. If you have any questions, please call or e-mail Cynthia Schuetz, 268-0960/cschuetz@jps.net.

This project's success depends on your input, so thank you in advance for your cooperation and assistance. You will receive a copy of the report once it is completed. On Thursday evening, March 30, 6:00-8:00 PM, we will present results of this study to the community at the Nevada City Council Chambers, 317 Broad St. We hope you will attend.

PLEASE COMPLETE AND RETURN THE QUESTIONNAIRE BY MONDAY, JAN. 30
TO: Cynthia Schuetz, PhD, MPH, C/o First 5, 400 Hoover Lane, Nevada City 95959
FAX: 265-0524; E-MAIL: cschuetz@jps.net

Appendix D

Champion Mine Family Resource Center
400 Hoover Lane
Nevada City, CA 95959

Jean Soliz-Conklin, Executive Director
Phone: (530) 265-0611 ext. 224
Fax: (530) 265-0524
linked to: www.first5nevco.org

NEVADA COUNTY HUMAN SERVICES AGENCY QUESTIONNAIRE

Please remember the questions focus on children 0-5 and their families and caregivers. Answer only those questions that relate to the work you do with those specific groups. For example, the services you offer may not include ones directed to young children's caregivers, so you won't be able to respond to questions related to that group. *(Please put N/A, not applicable, by questions that do not relate to your agency.)*

NAME OF AGENCY: _____

NAME & TITLE OF PERSON COMPLETING THIS SURVEY:

_____

PHONE NUMBER: _____ E-MAIL: _____

I. What services/programs do you provide to young children and/or their families and caregivers?

Children: _____

_____

_____

Families _____

_____

_____

Caregivers: _____

_____

_____

II. How was the need for the services/programs you provide to young children and/or their families or caregivers determined?

_____

_____

_____

_____

_____

III. Please list below what reports or data you have that would help us better understand the needs of Nevada County's young children and their families and caregivers.

_____

_____

_____

_____

_____

IV. Based on your experience and expertise, what are the top five unmet needs of young children, their families and caregivers in Nevada County?

Children:	Families:	Caregivers:
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
5. _____	5. _____	5. _____

V. What do you perceive to be the top five gaps in services or programs to young children and their families in our County?

Children:	Families:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

VI. On what do you base your perception?

_____

_____

_____

_____

THANK YOU FOR YOUR HELP!

You will receive a copy of the report once it is completed. We will present results of this study to the community on Thursday evening, March 30, from 6:00-8:00 p.m., at the Nevada City Council Chambers, 317 Broad Street, NC; we hope you will attend.

PLEASE RETURN BY MONDAY JANUARY 30

ADDRESS: First 5, 400 Hoover Lane, Nevada City 95959

FAX: 265-0524 E-MAIL: cschuetz@jps.net

Appendix E

A KEY TO THE CODES

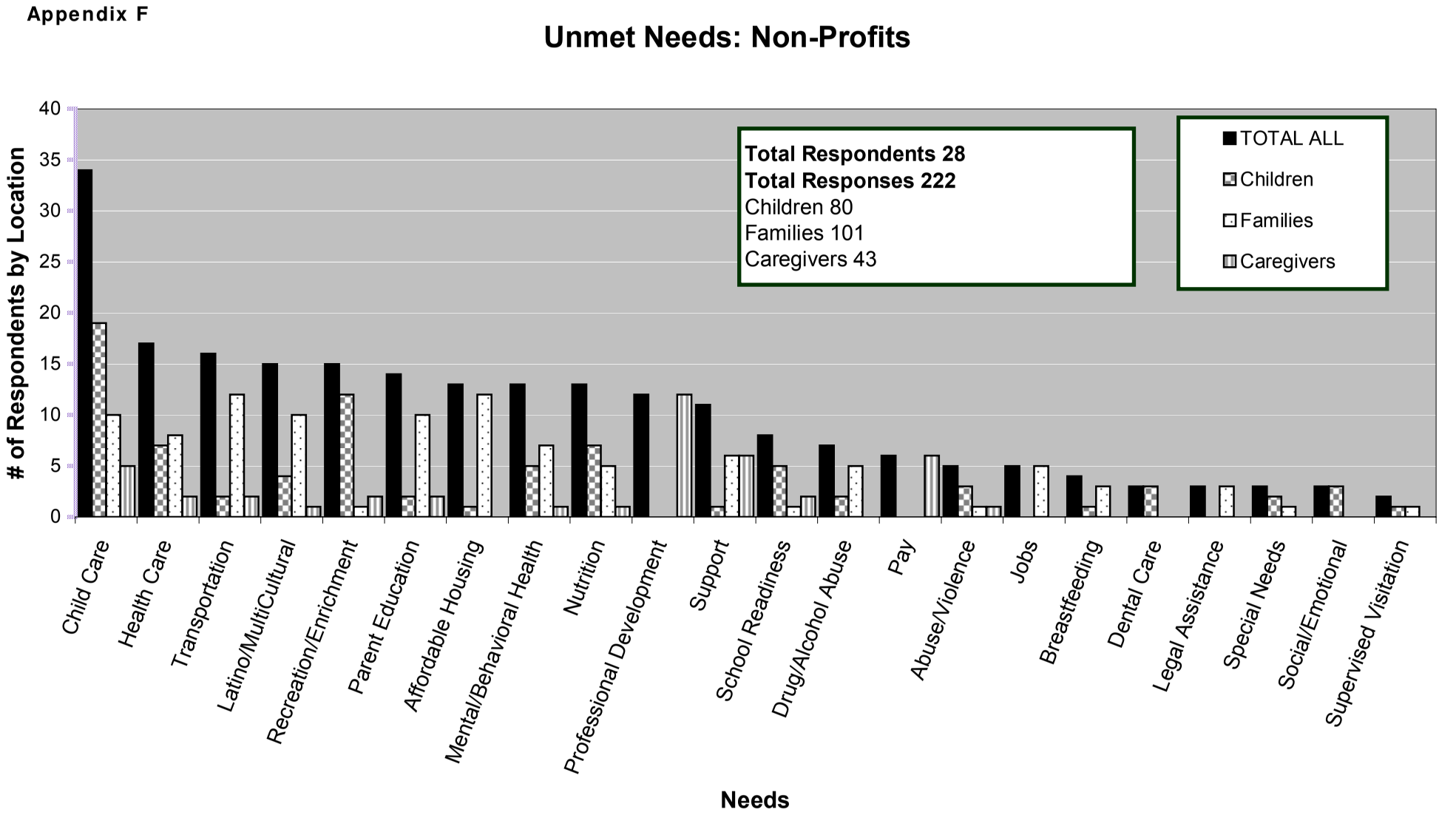
CODE	DESCRIPTION
Abuse/ Violence	Domestic abuse, violence, neglect
Affordable Housing	Affordable Housing
Breastfeeding	Breastfeeding Education and Support
Child Care	Childcare—includes all ages from infant up, quality of, accessibility of, affordable, financial assistance for, including increased subsidy monies, extended hours, holiday and respite care, quality playspace and equipment, afterschool programs, need for substitutes
Dental Care	Dental Services—includes dentists who accept MediCal DentiCal
Drug/ Alcohol Abuse	Drug & Alcohol Abuse—counseling, treatment, all issues related to
Health Care	Health Care—all health care related problems/issues, including insurance, affordable, access, and doctors who accept MediCal/CMSP/CHDP, need for specialized medical and health services, increase in public health specialists and services
Immunizations	Immunizations
Jobs	Jobs—includes opportunities, good/better pay, job training, career counseling
Legal Assistance	Legal Assistance
Latino/ MultiCultural	Latino/Multicultural—language support and literacy, Spanish speaking staff, multicultural integration, immigration assistance
Mental/ Behavioral Health	Mental/Behavioral Health—includes emotional support, counseling and treatment for all ages
Nutrition	Nutrition—education, diet, obesity, food security
Pay	Better pay and benefits for child care providers
Parent Education	Parent Education—includes home visits and all forms of Parent Education
Preschool for All	Preschool For All—all issues concerning, including those not in favor
Recreation	Recreation—includes equipment, parks & spaces, opportunities, affordable, as well as enrichment activities, classes, includes parent/child play, access to
Special Needs	Special Needs—programs, one on one assistance, and childcare for
School Readiness	School Readiness, Literacy Development
Social/ Emotional	Social/Emotional Growth and Development—includes social skills, manners, hygiene, role models
Substitutes	Substitute Early Childhood Education Teachers
Support	Support for families and caregivers, including grandparents, including support groups and resource centers, accessing resources
Supervised Visitation	Supervised Visitation—includes child custody and foster and adoptive children with birth parents
Professional Development	Professional Development—includes training and education for childcare providers and teachers, professional connections, licensing, ECE for K-3 teachers
Transportation	Transportation—includes carseats and traffic safety

Appendix F

Unmet Needs: Non-Profits

CODE	Children	Truckee	Western County	Families	Truckee	Western County	Caregivers	Truckee	Western County	TOTAL ALL
Child Care	19	7	12	10	1	9	5	2	3	34
Health Care	7	3	4	8	3	5	2	1	1	17
Transportation	2	1	1	12	4	8	2		2	16
Latino/MultiCultural	4	2	2	10	6	4	1	1		15
Recreation/Enrichment	12	6	6	1		1	2	1	1	15
Parent Education	2	1	1	10	5	5	2		2	14
Affordable Housing	1		1	12	2	10				13
Mental/Behavioral Health	5		5	7	1	6	1		1	13
Nutrition	7	4	3	5	3	2	1	1		13
Professional Development							12	8	4	12
Support	1		1	6	5	1	6	1	5	11
School Readiness	5	2	3	1		1	2		2	8
Drug/Alcohol Abuse	2		2	5		5				7
Pay							6	1	5	6
Abuse/Violence	3	1	2	1	1		1		1	5
Jobs				5	2	3				5
Breastfeeding	1		1	3	3					4
Dental Care	3	2	1							3
Legal Assistance				3		3				3
Special Needs	2		2	1		1				3
Social/Emotional	3		3							3
Supervised Visitation	1		1	1		1				2
Total # of Responses	80	29	51	101	36	65	43	16	27	222

Appendix F

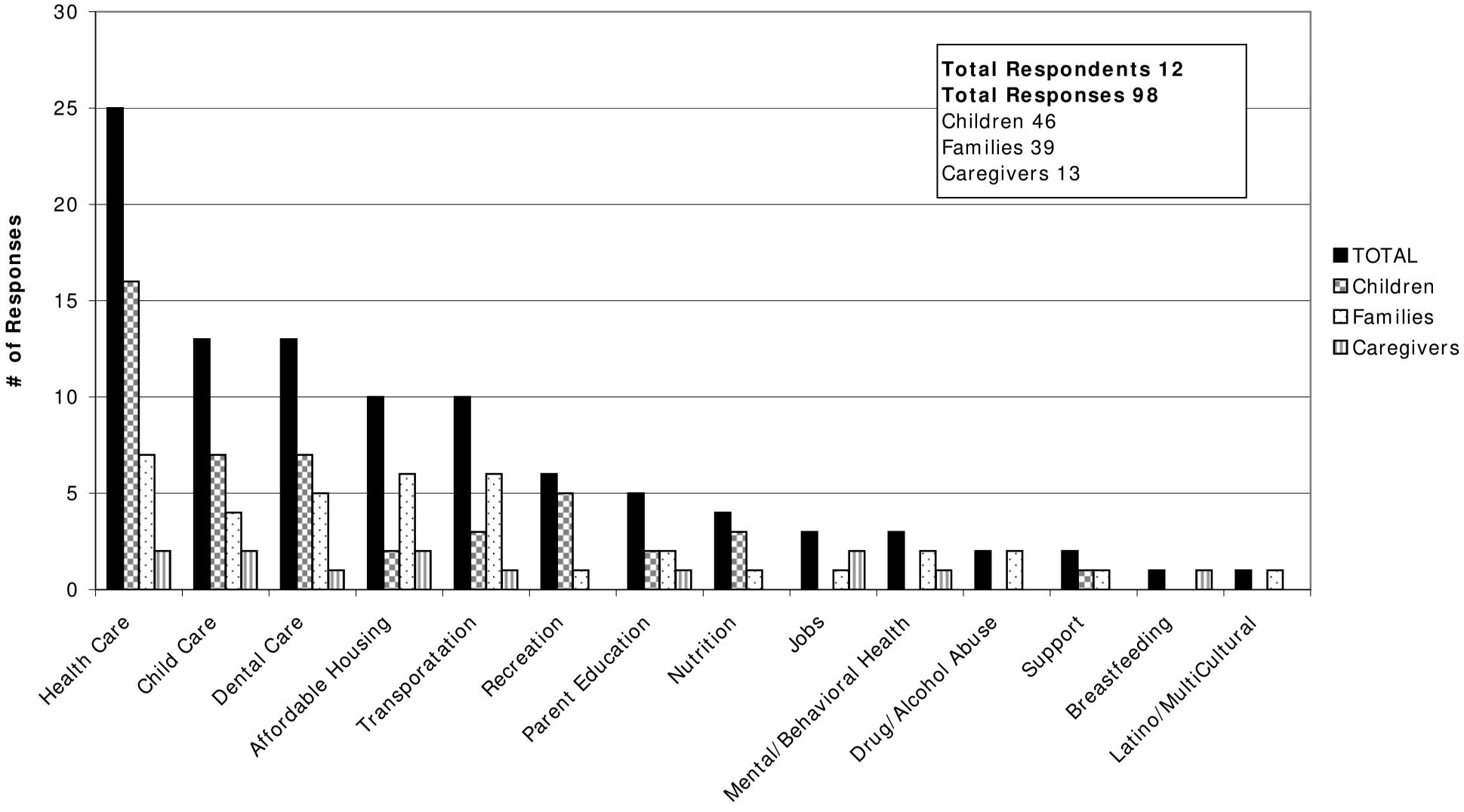

Unmet Needs: Non-Profits
# of Respondents by Location
40
35
30
25
20
15
10
5
0
Total Respondents 28
Total Responses 222
Children 80
Families 101
Caregivers 43
TOTAL ALL
Children
Families
Caregivers
Child Care
Health Care
Transportation
Latino/MultiCultural
Recreation/Enrichment
Parent Education
Affordable Housing
Mental/Behavioral Health
Nutrition
Professional Development
Support
School Readiness
Drug/Alcohol Abuse
Pay
Abuse/Violence
Jobs
Breastfeeding
Dental Care
Legal Assistance
Special Needs
Social/Emotional
Supervised Visitation
Needs

Appendix G Unmet Needs: Human Services Agencies

CODE	Children	Families	Caregivers	TOTAL
Health Care	16	7	2	25
Child Care	7	4	2	13
Dental Care	7	5	1	13
Affordable Housing	2	6	2	10
Transporatation	3	6	1	10
Recreation	5	1		6
Parent Education	2	2	1	5
Nutrition	3	1		4
Jobs		1	2	3
Mental/Behavioral Health		2	1	3
Drug/Alcohol Abuse		2		2
Support	1	1		2
Breastfeeding			1	1
Latino/MultiCultural		1		1
Total # of Responses	46	39	13	98

Appendix G

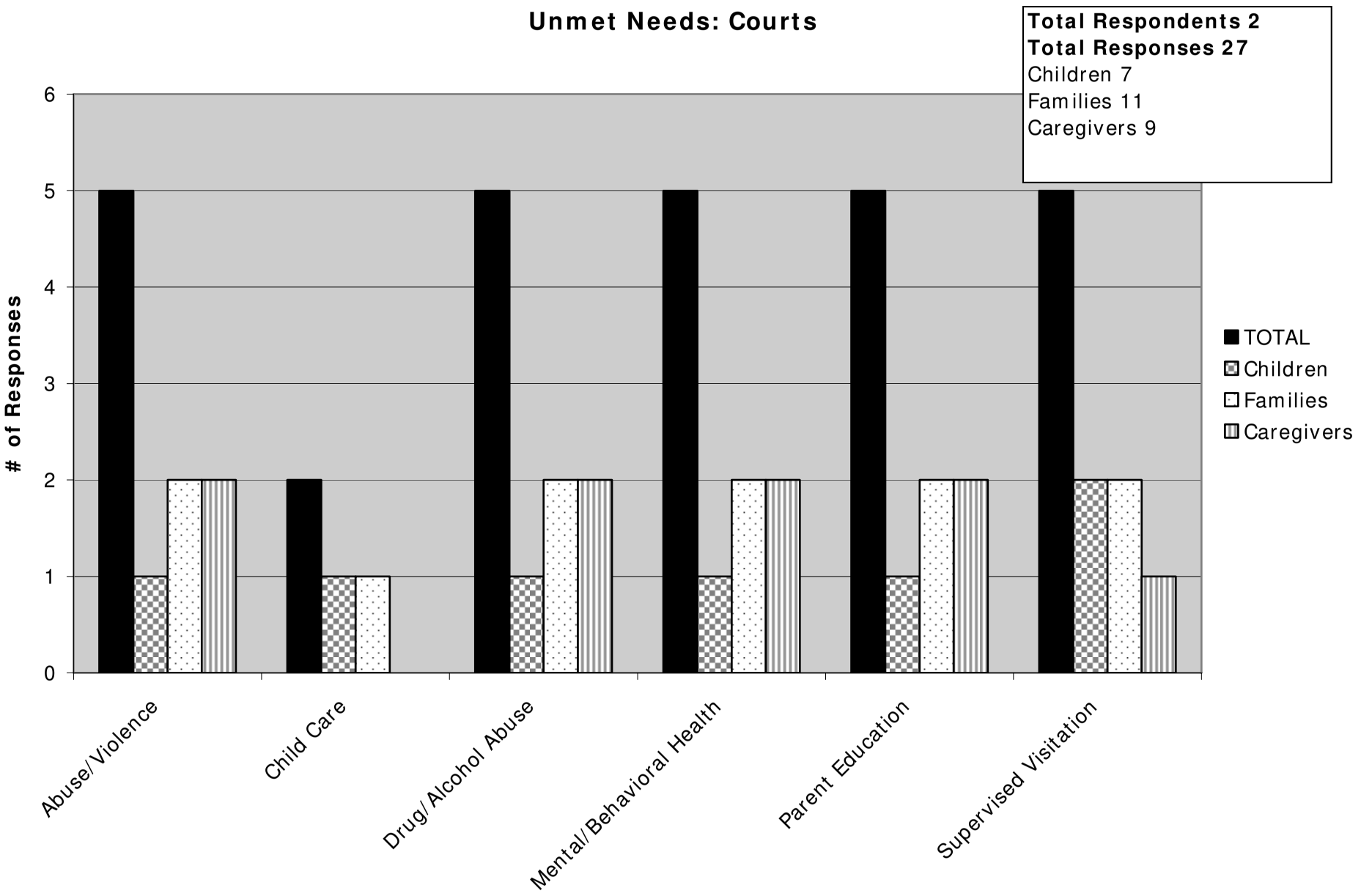
Unmet Needs: Human Services Agencies



Appendix H **Unmet Needs: Courts**

CODE	Children	Families	Caregivers	TOTAL
Abuse/Violence	1	2	2	5
Child Care	1	1		2
Drug/Alcohol Abuse	1	2	2	5
Mental/Behavioral Health	1	2	2	5
Parent Education	1	2	2	5
Supervised Visitation	2	2	1	5
Total # of Responses	7	11	9	27

Appendix H

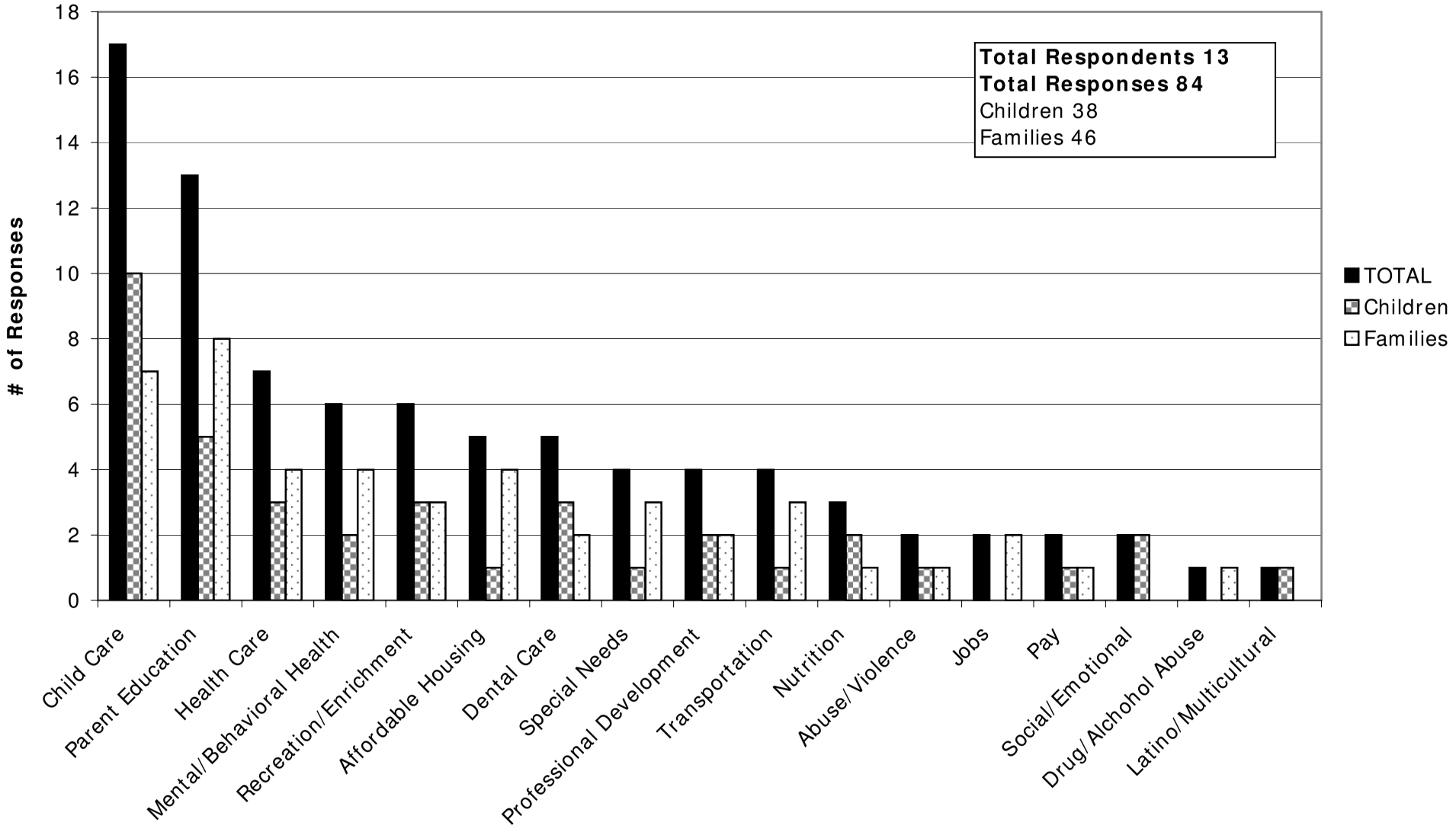

Unmet Needs: Courts
Total Respondents 2
Total Responses 27
Children 7
Families 11
Caregivers 9
# of Responses
0
1
2
3
4
5
6
TOTAL
Children
Families
Caregivers
Abuse/Violence
Child Care
Drug/Alcohol Abuse
Mental/Behavioral Health
Parent Education
Supervised Visitation

Appendix I **Unmet Needs: Early Childhood Educators**

CODE	Children	Families	TOTAL
Child Care	10	7	17
Parent Education	5	8	13
Health Care	3	4	7
Mental/Behavioral Health	2	4	6
Recreation/Enrichment	3	3	6
Affordable Housing	1	4	5
Dental Care	3	2	5
Special Needs	1	3	4
Professional Development	2	2	4
Transportation	1	3	4
Nutrition	2	1	3
Abuse/Violence	1	1	2
Jobs		2	2
Pay	1	1	2
Social/Emotional	2		2
Drug/Alchohol Abuse		1	1
Latino/Multicultural	1		1
Total # of Responses	38	46	84

Appendix I

Unmet Needs: Early Childhood Educators

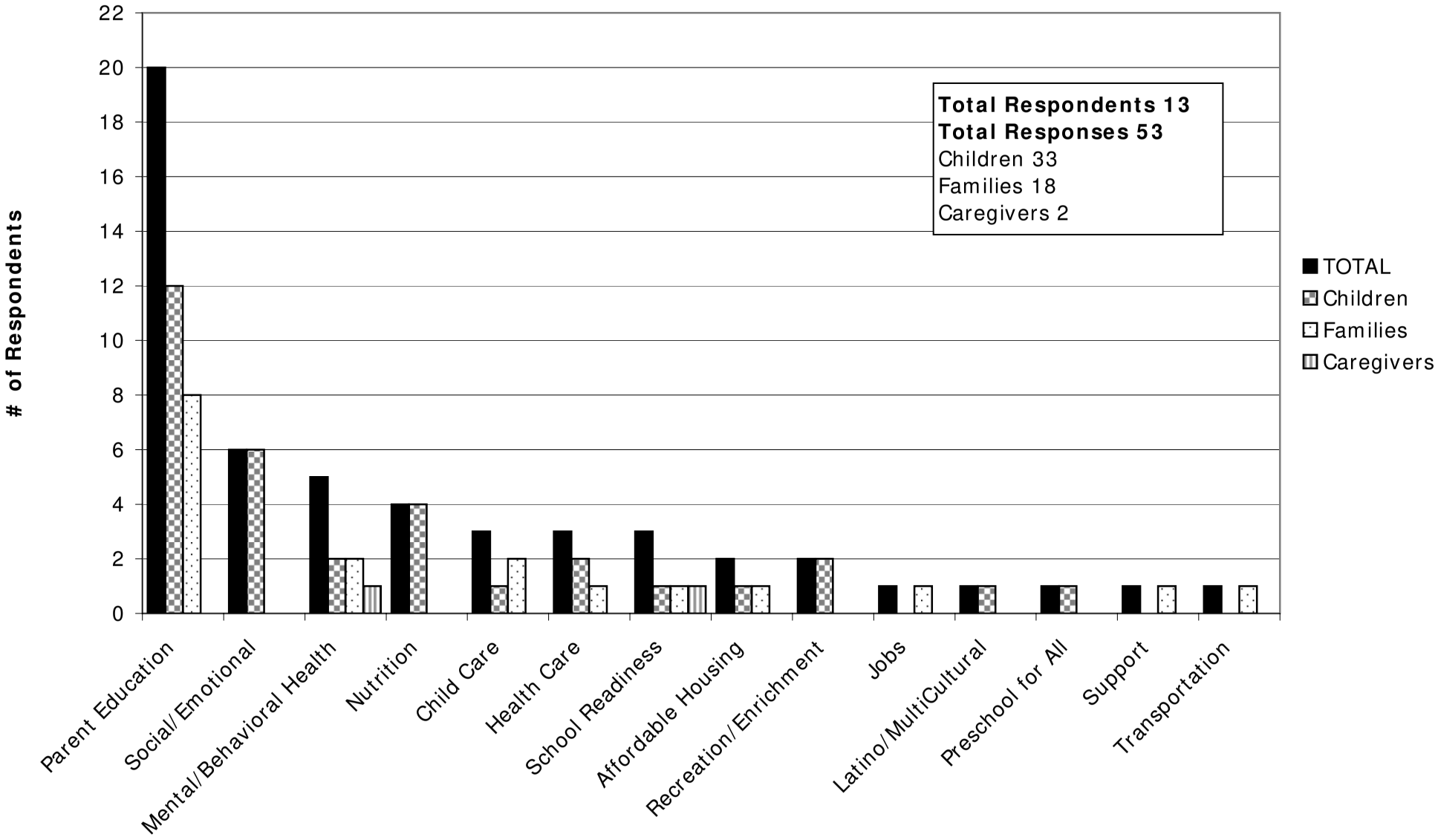


Appendix J Unmet Needs: Kindergarten Teachers and Principals

CODE	Children	Families	Caregivers	TOTAL
Parent Education	12	8		20
Social/Emotional	6			6
Mental/Behavioral Health	2	2	1	5
Nutrition	4			4
Child Care	1	2		3
Health Care	2	1		3
School Readiness	1	1	1	3
Affordable Housing	1	1		2
Recreation/Enrichment	2			2
Jobs		1		1
Latino/MultiCultural	1			1
Preschool for All	1			1
Support		1		1
Transportation		1		1
Total # of Responses	33	18	2	53

Appendix J

Unmet Needs: Kindergarten Teachers & Principals



Appendix K

Unmet Needs: Grand Totals

NEED	Non-Profits	Human Services Agencies	Courts	Early Childhood Educators	K-Teachers & Principals	TOTALS	RANK
Child Care	34	13	2	17	3	69	1
Parent Education	14	5	5	13	20	57	2
Health Care	17	25		7	3	52	3
Mental/Behavioral	13	3	5	6	5	32	4
Transportation	16	10		4	1	31	5
Affordable Housing	13	10		5	2	30	6
Recreation/Enrichment	15	6		6	2	29	7
Nutrition	13	4		3	4	24	8
Dental Care	3	13		5		21	9
Latino/MultiCultural	15	1		1	1	18	10
Professional	12			4		16	11
Drug/Alcohol Abuse	7	2	5	1		15	12
Support	11	2			1	14	13
Abuse/Violence	5		5	2		12	14
Jobs	5	3		2	1	11	15
Social/Emotional	3			2	6	11	15
Pay	6			2		8	17
Preschool for All					1		
School Readiness	5				3	8	17
Special Needs	3			4		7	19
Supervised Visitation	2		5			7	19
Breastfeeding	4	1				5	21
Legal Assistance	3					3	22
Total # of Responses	219	98	27	84	53	480	

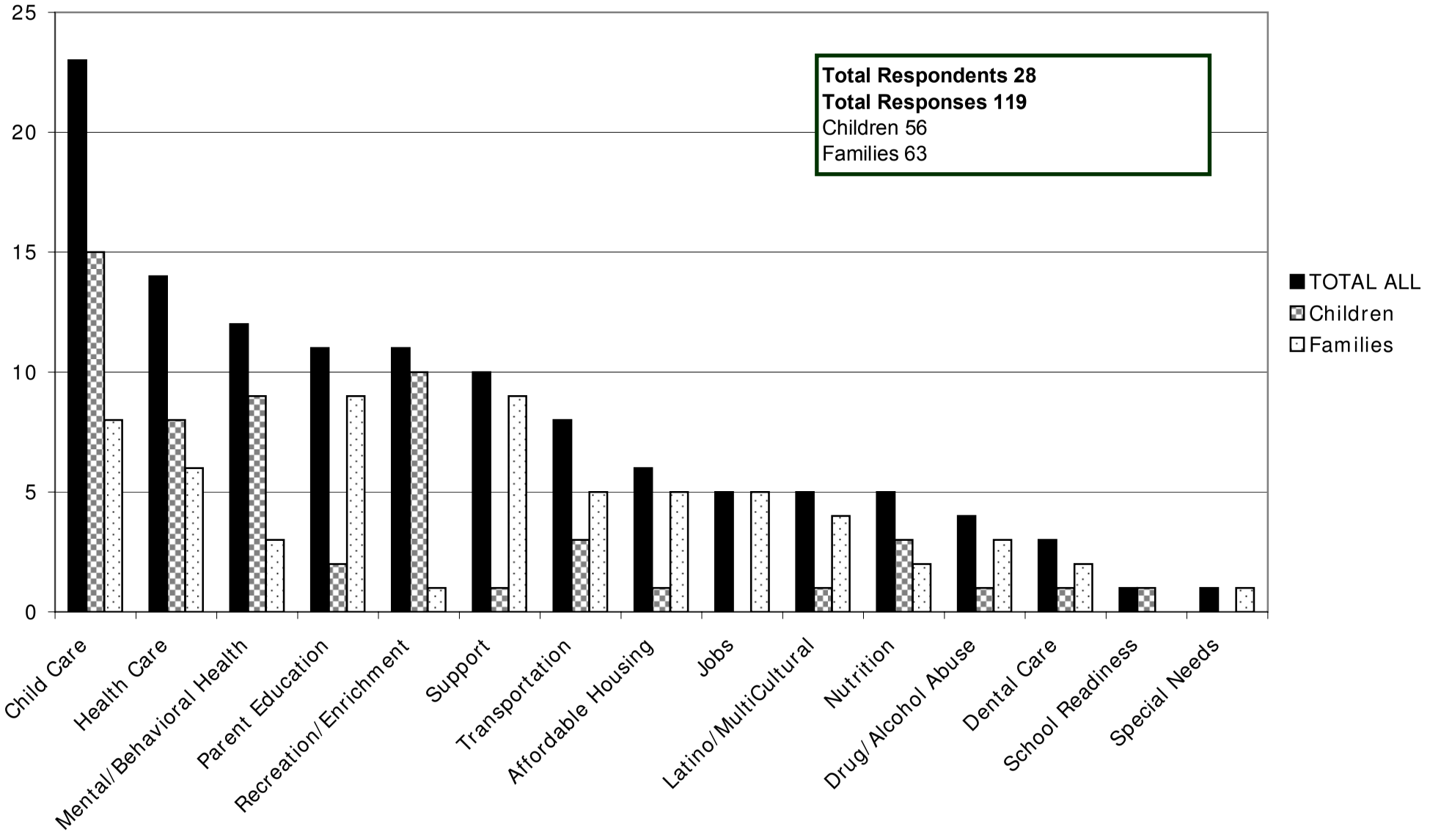
Appendix L

Gaps in Services: Non-Profits

CODE	Children	Truckee	Western County	Families	Truckee	Western County	TOTAL ALL
Child Care	15	1	14	8	1	7	23
Health Care	8	1	7	6	1	5	14
Mental/Behavioral Health	9		9	3		3	12
Parent Education	2		2	9	5	4	11
Recreation/Enrichment	10	1	9	1	1		11
Support	1		1	9	4	5	10
Transportation	3	1	2	5	1	4	8
Affordable Housing	1		1	5	1	4	6
Jobs				5	3	2	5
Latino/MultiCultural	1		1	4	4		5
Nutrition	3	2	1	2	1	1	5
Drug/Alcohol Abuse	1		1	3		3	4
Dental Care	1		1	2		2	3
School Readiness	1	1					1
Special Needs				1		1	1
Total # of Responses	56	7	49	63	22	41	119

Appendix L

Gaps in Services: Non-Profits

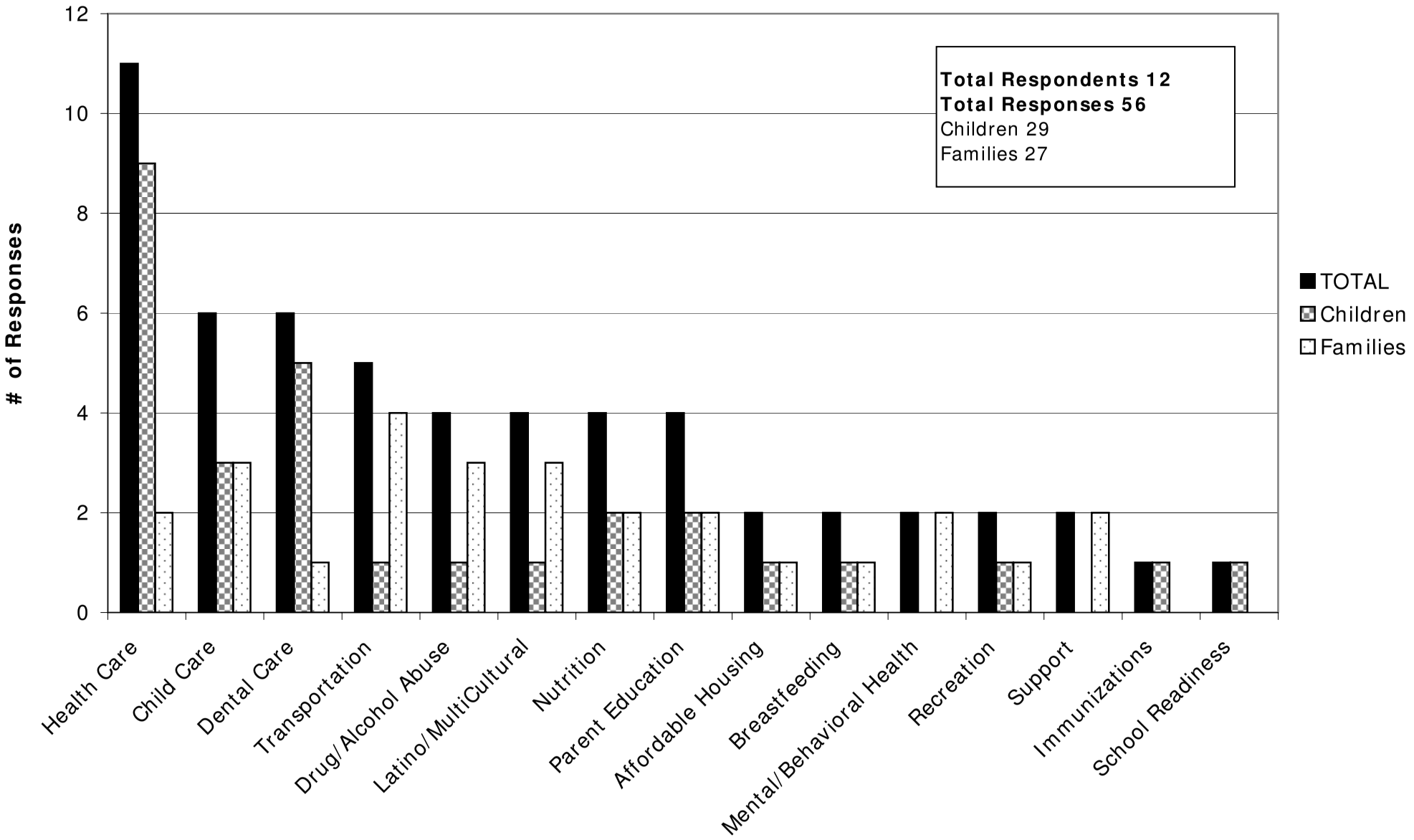


Appendix M **Gaps in Services: Human Services Agencies**

CODE	Children	Families	TOTAL
Health Care	9	2	11
Child Care	3	3	6
Dental Care	5	1	6
Transportation	1	4	5
Drug/Alcohol Abuse	1	3	4
Latino/MultiCultural	1	3	4
Nutrition	2	2	4
Parent Education	2	2	4
Affordable Housing	1	1	2
Breastfeeding	1	1	2
Mental/Behavioral Health		2	2
Recreation	1	1	2
Support		2	2
Immunizations	1		1
School Readiness	1		1
Total # of Responses	29	27	56

Appendix M

Gaps In Services: Human Services Agencies



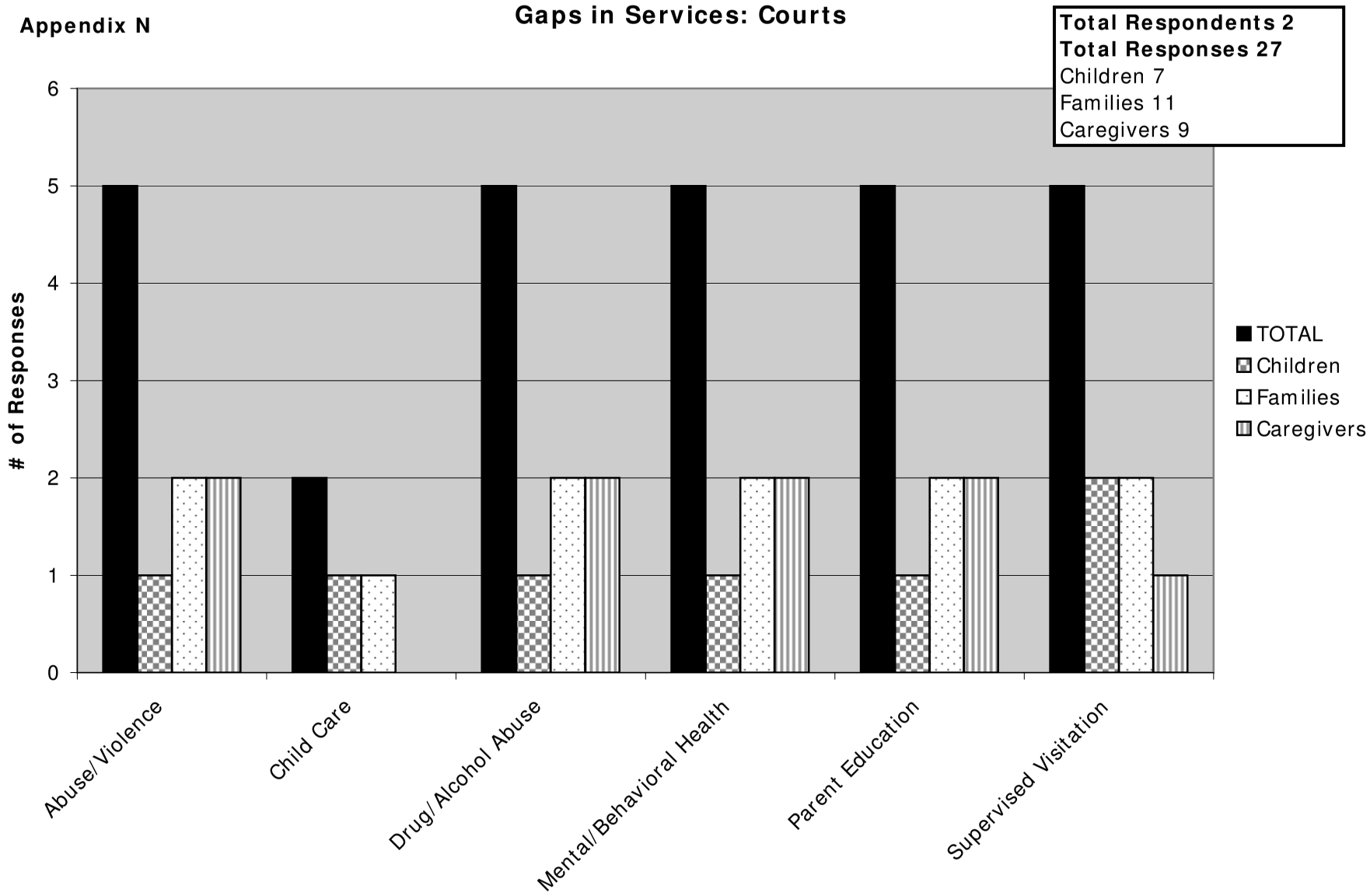
Appendix N

Gaps in Services: Courts

CODE	Children	Families	Caregivers	TOTAL
Abuse/Violence	1	2	2	5
Child Care	1	1		2
Drug/Alcohol Abuse	1	2	2	5
Mental/Behavioral Health	1	2	2	5
Parent Education	1	2	2	5
Supervised Visitation	2	2	1	5
Total # of Responses	7	11	9	27

Appendix N

Gaps in Services: Courts

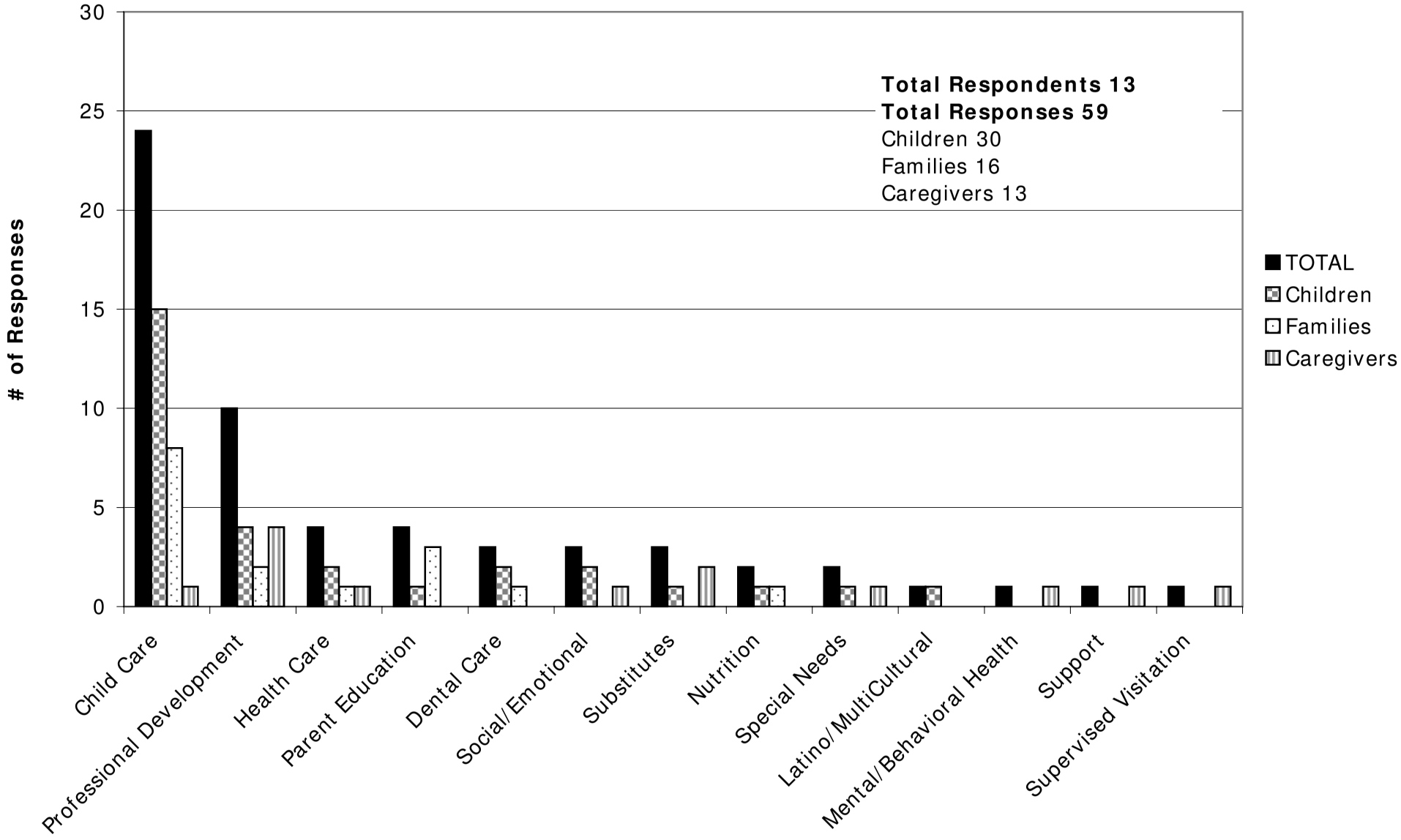


Appendix O **Gaps in Services: Early Childhood Educators**

CODE	Children	Families	Caregivers	TOTAL
Child Care	15	8	1	24
Professional Development	4	2	4	10
Health Care	2	1	1	4
Parent Education	1	3		4
Dental Care	2	1		3
Social/Emotional	2		1	3
Substitutes	1		2	3
Nutrition	1	1		2
Special Needs	1		1	2
Latino/MultiCultural	1			1
Mental/Behavioral Health			1	1
Support			1	1
Supervised Visitation			1	1
Total # of Responses	30	16	13	59

Appendix O

Gaps in Services: Early Childhood Educators

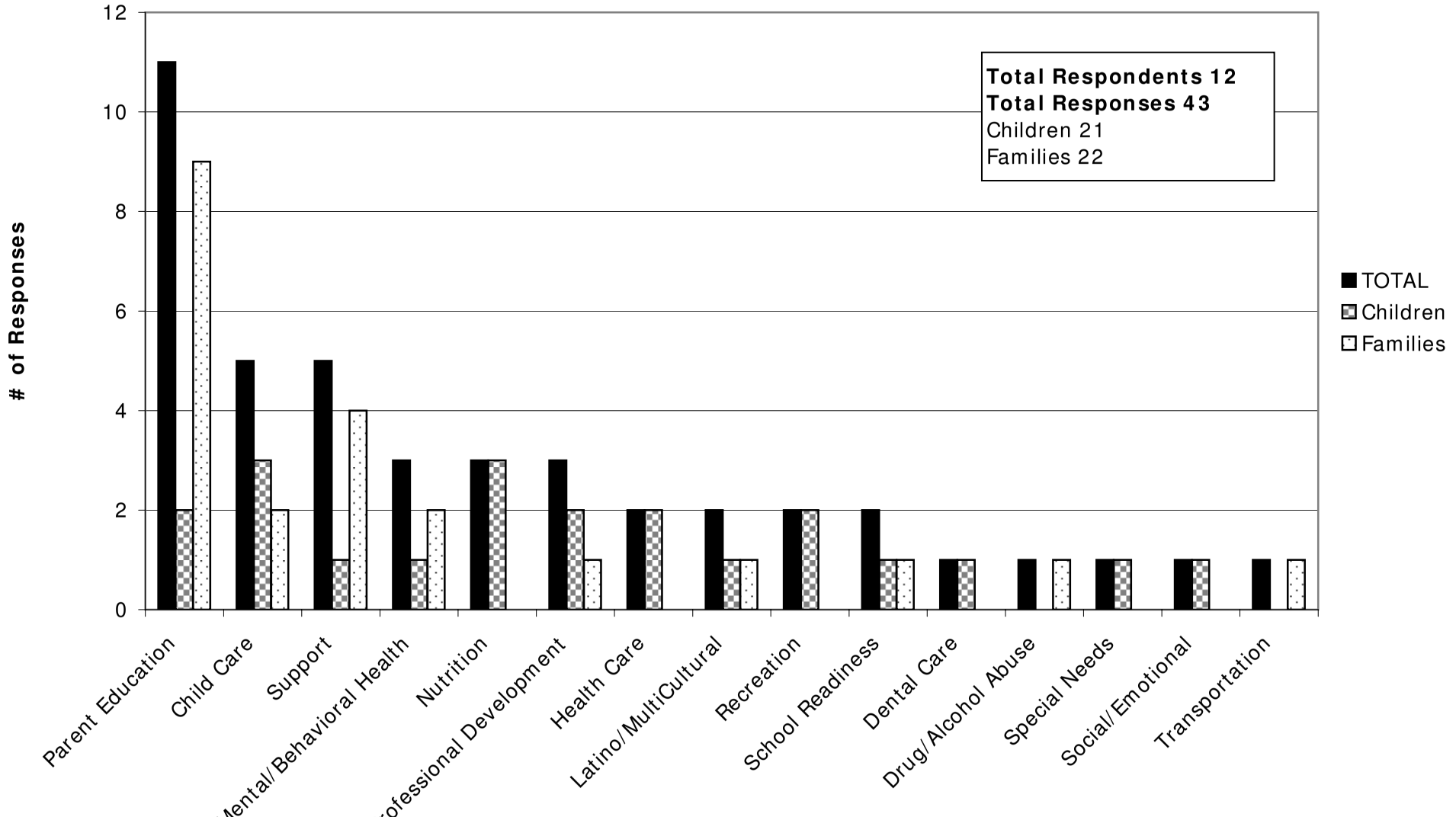


Appendix P **Gaps in Services: Kindergarten Teachers Principals**

CODE	Children	Families	TOTAL
Parent Education	2	9	11
Child Care	3	2	5
Support	1	4	5
Mental/Behavioral Health	1	2	3
Nutrition	3		3
Professional Development	2	1	3
Health Care	2		2
Latino/MultiCultural	1	1	2
Recreation	2		2
School Readiness	1	1	2
Dental Care	1		1
Drug/Alcohol Abuse		1	1
Special Needs	1		1
Social/Emotional	1		1
Transportation		1	1
Total # of Responses	21	22	43

Appendix P

Gaps in Services: Kindergarten Teachers & Principals

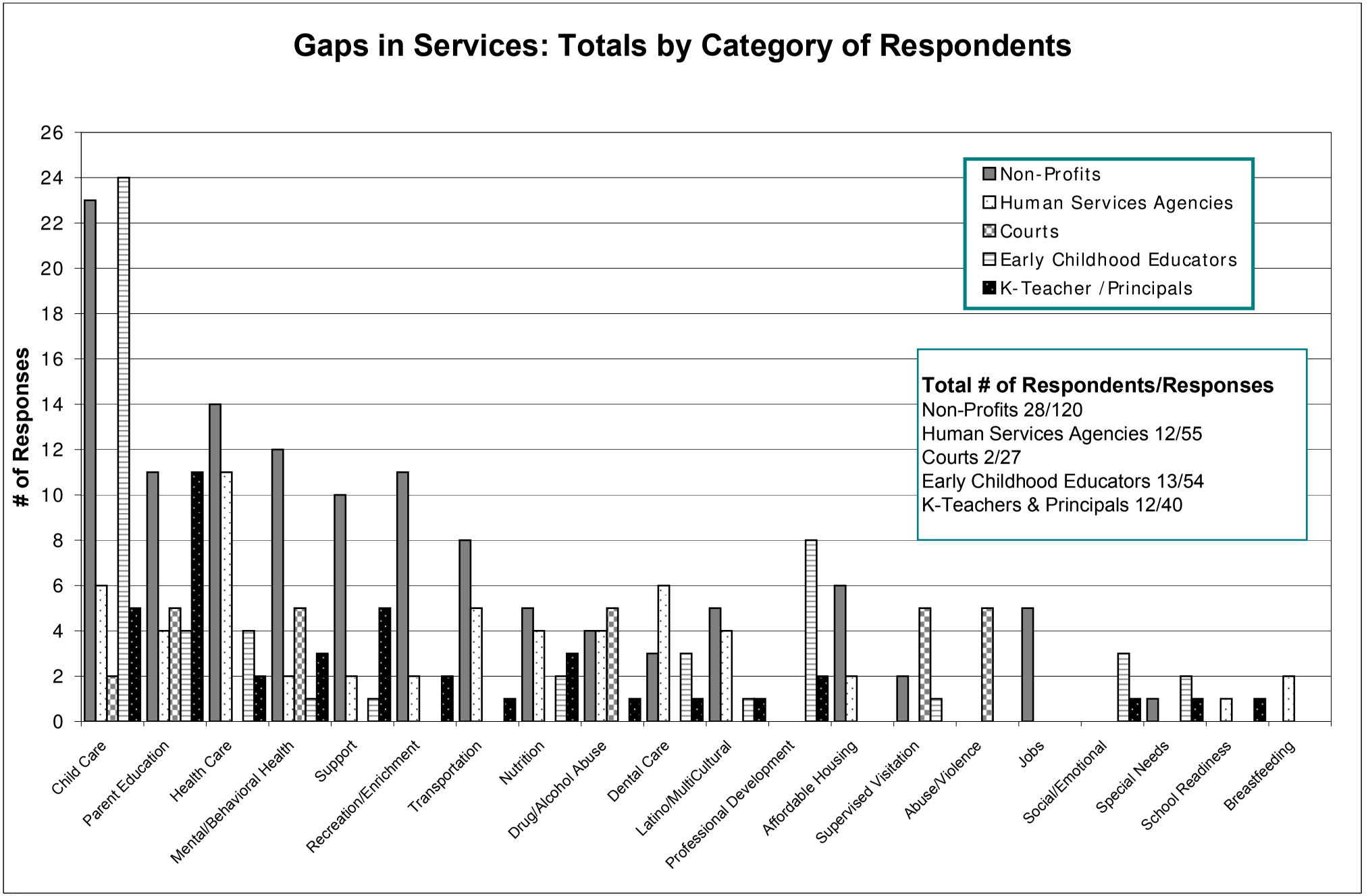


Appendix Q

Gaps in Services: Grand Totals

CODE	Non-Profits	Human Services Agencies	Courts	Early Childhood Educators	K-Teacher /Principals	TOTALS	RANK
Child Care	23	6	2	24	5	60	1
Parent Education	11	4	5	4	11	35	2
Health Care	14	11		4	2	31	3
Mental/Behavioral	12	2	5	1	3	23	4
Support	10	2		1	5	18	5
Recreation/Enrichment	11	2			2	15	6
Transportation	8	5			1	14	7
Nutrition	5	4		2	3	14	7
Drug/Alcohol Abuse	4	4	5		1	14	7
Dental Care	3	6		3	1	13	10
Latino/MultiCultural	5	4		1	1	11	11
Professional				8	2	10	12
Affordable Housing	6	2				8	13
Supervised Visitation	2		5	1		8	13
Abuse/Violence			5			5	15
Jobs	5					5	15
Social/Emotional				3	1	4	17
Special Needs	1			2	1	4	17
School Readiness		1			1	2	18
Breastfeeding		2				2	19
Total # of Responses	120	55	27	54	40	296	

Appendix Q


Gaps in Services: Totals by Category of Respondents
# of Responses
26
24
22
20
18
16
14
12
10
8
6
4
2
0
Non-Profits
Human Services Agencies
Courts
Early Childhood Educators
K-Teacher / Principals
Total # of Respondents/Responses
Non-Profits 28/120
Human Services Agencies 12/55
Courts 2/27
Early Childhood Educators 13/54
K-Teachers & Principals 12/40
Child Care
Parent Education
Health Care
Mental/Behavioral Health
Support
Recreation/Enrichment
Transportation
Nutrition
Drug/Alcohol Abuse
Dental Care
Latino/MultiCultural
Professional Development
Affordable Housing
Supervised Visitation
Abuse/Violence
Jobs
Social/Emotional
Special Needs
School Readiness
Breastfeeding