

GOAL II: HEALTHY, THRIVING CHILDREN

"It is always the right time to do right for children, who are being born and formed in mind, body and spirit every minute as life goes on."

Marian Wright Edelman

Indicator Summary

Goal II Indicators	Data Source	Oregon Benchmark	County Relative to State	County Trend
HLO #4: Reduce child maltreatment	OPB (LEDS)	✓	☹	☹
HLO #5: Improve prenatal care	OPB (OHD)	✓	☺	☺
Infants with low birth weight	OHD		☺	☺
HLO #6: Increase immunizations	OPB (OHD)	✓	☺	NA
HLO #7: Reduce ATOD use during pregnancy	OPB (OHD)	✓	☺	☺
Pregnant women receiving treatment	OADAP			
HLO #8: Increase child care availability	OPB (ODE)	✓	☺	☺
HLO #9: Improve readiness to learn	OPB (CCD)	✓	☺	☺

☺ = good, positive trend ☺ = about the same, neutral, unclear trend ☹ = bad, negative trend NA = not available/not applicable

Local Factors Affecting the Data or Planning Analysis

- Size, geography, and road conditions of county makes it difficult to access services
- Sense of social isolation in remote areas of county

GOAL II: HEALTHY, THRIVING CHILDREN

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HLO#4 REDUCE CHILD MALTREATMENT

STRENGTHS AND ASSETS *(THIS SECTION IS CURRENTLY UNDER REVISION, AND WILL BE UPDATED IN THE NEXT SUBMISSION)*

Children

- Well child programs
- Child advocacy center

Family/Community

- High school-based child development centers
- Teen parent services
- Community-based promotion of awareness and prevention of child abuse
- Lane County prevention coordinator to facilitate and ensure efforts to address prevention efforts
- Residential treatment and detoxification is provided for adults including women with their children at Willamette Family Treatment Center
- Recovery support services are provided throughout the community by local organizations
- Local expertise in children's behavior and mental health
- Parenting resource directory
- Community Safety Net program
- Therapeutic parenting support
- Family support and skill building
- Intensive case management
- Programs that enhance child-parent interactions
- Information and short-term support services for lower risk families
- Long-term family support services and home visitations for higher risk families
- Family resource centers

Cultural

- Latino community effort that addresses family management issues in South Lane County
- Services to Latino children and parents

Gender

- Alcohol and drug residential care for pregnant women and women with children
- Women's parenting programs
- Support services for postpartum depression

Special Needs

- Services to high-risk teen and adult parents
- Mental health services for families with children with disabilities

Rural

- Universal risk screening
- Assessment and therapy

GAPS* AND BARRIERS *(THIS SECTION IS CURRENTLY UNDER REVISION, AND WILL BE UPDATED IN THE NEXT SUBMISSION)*

Children

- Adequate safe/nurturing foster care
- Affordable postpartum/newborn follow up
- Home visitation for subsequent births
- ATOD treatment for pregnant and parenting teen girls and their children
- Universal screening of newborns and their families, children 2-3, and entering school
- Therapeutic nurseries for all young children of at-risk families
- Limited system of early follow up for newborns

Family/Community

- Limited community awareness of the impact of maternal behaviors on the development of the child
- Timely and effective treatment of parents at risk of termination of parental rights
- Mental health services for postpartum depression
- Community norm that parents shouldn't need parenting education
- Waiting lists for services
- Support and assistance with housing, food, and health care
- Support to overcome patterns of family violence
- Secondary (selective) prevention services that target higher risk families with services that strengthen and support a healthy family climate
- Intervening (indicated) services to help stabilize family interaction and climate
- Parenting education
- Limited maternity case management

Cultural

- Spanish language/culture therapeutic nursery
- Mental health services in Spanish
- Non-English crisis mental health services
- Culturally sensitivity services
- Fear of law, deportation
- Limited availability of translation services, materials

Gender

- Treatment for pregnant and parenting teen girls and their children
- Mental health services for women
- Parenting programs for men

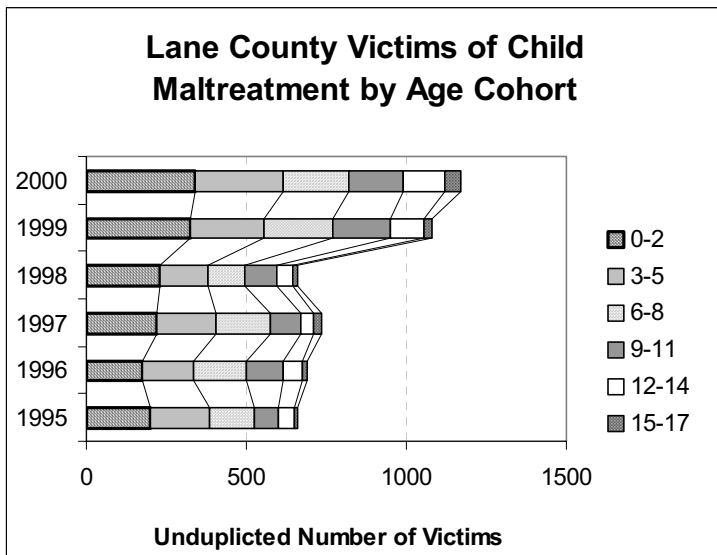
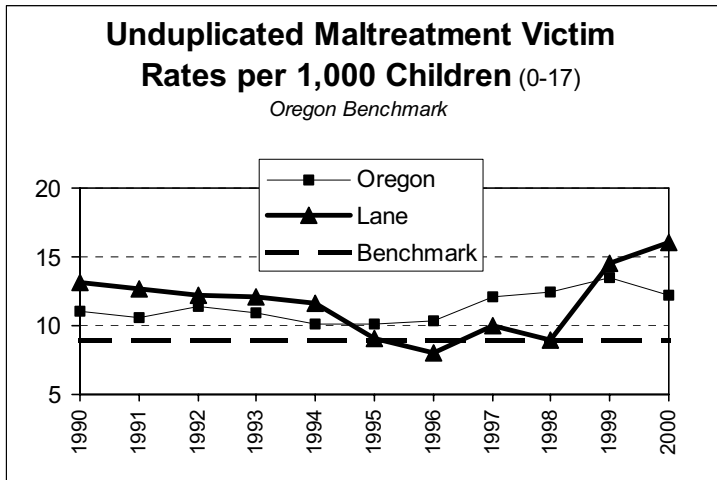
Rural

- Child development specialists
- Crisis services
- Maternity case management

** Gaps in services exist to varying degrees, either because they need to be developed, or in most cases because they need to be enhanced or expanded.*

HLO#4 REDUCE CHILD MALTREATMENT

DATA



ANALYSIS

#4: Unduplicated rate of children who are reported to Services to Children and Families for maltreatment per 1,000 children (0-17).

Source: Services to Children and Families (Law Enforcement Data System)

- The rate of confirmed cases of child abuse and neglect in Lane County had a steady downward trend from 1990 through 1996. In 1996 and 1998, the county's rate dipped below the statewide benchmark goal of 9 per 1,000 children, but soared upward in 1999. This trend continued in 2000, although the rate of increase subsided somewhat.
- Some factors affecting the reported cases of child abuse and neglect include the *Safety Net* program that serves as an additional catchment for families in crisis, and the growing domestic violence focus – domestic violence crimes must be reported if they occur in front of a child. Changes in identification and reporting of maltreatment may have influenced the reported rate of abuse in Lane County. An increased awareness of domestic violence and its impact on children, and the relatively new changes in criminal statutes (felony upgrade when assault is witnessed by child) has influenced reporting practices. In addition, home visiting services have increased and have resulted in a corresponding increase in early identification and reporting of maltreatment. Lastly, the community has increased its awareness of child maltreatment and its desire to respond to this issue.
- Although it may be possible to identify some of the reasons for the dramatic increase in child maltreatment, we must not underestimate the importance of the alarming statistics.

Child Maltreatment by Age of Victim

- When the child maltreatment data are analyzed by age of victim, a disturbing trend is revealed. While the number and rate for all age cohorts increased over the last few years, maltreatment among the youngest children has increased the greatest. The data are aggregated in 3-year age intervals.

HLO#4 REDUCE CHILD MALTREATMENT

PRIORITIES	STRATEGIES	RATIONALE
<p>A) Increase parent-child attachment by increasing parenting skills and nurturance.</p>	<p>A1) Identify families with high levels of stress and increased risk of poor childhood outcomes through universal screening.</p>	<p>A1) Universal screening provides identification of families with high levels of stress that decreases family stability and increases the risk for poor childhood outcomes (Katzev, 2001); and provide the opportunity for parental support and education.</p> <p>Citation: A. R. Katzev, C. C. Pratt, & W. McGuigan. <i>Oregon Healthy Start 1999-2000 Status Report</i>. Corvallis, OR: Oregon State University Family Policy Program, 2001.</p>
	<p>A2) Reduce isolation and provide parental support and education for families with high levels of stress through home visiting, parenting classes, and other community based services.</p>	<p>A2) Parental support for families with high levels of stress helps enhance family functioning, and helps families increase their ability to be strong and nurturing (Pratt et al, 1997).</p> <p>Home visiting improves family functioning through the development of trusting relationships, improvement in problem solving skills, and enhancement of community connections and support (Katzev, 2001).</p> <p>Support groups bring together parents who share common concerns and experiences; and provide opportunities for positive relationships, shared stress and joy, and shared learning. Parents with strong support systems are less stressed and better able to meet the needs of their children (Pratt et al, 1997).</p> <p>Citations: A. R. Katzev, C. C. Pratt, & W. McGuigan. <i>Oregon Healthy Start 1999-2000 Status Report</i>. Corvallis, OR: Oregon State University Family Policy Program, 2001.</p> <p>C. C. Pratt, A. Katzev, T. Henderson, and R. Ozretich. <i>Building Results: From Wellness Goals to Positive Outcomes for Oregon's Children, Youth, and Families</i>. Corvallis, OR: Oregon State University Family Policy Program, 1997.</p>

HLO#4 REDUCE CHILD MALTREATMENT

PRIORITIES	STRATEGIES	RATIONALE
B) Increase capacity and accessibility of community-based supports for families	B1) Increase capacity and access to community safety nets	B1) Universal screening provides identification of families with high levels of stress that decreases family stability and increases the risk for poor childhood outcomes (Katzev, 2001). Citation: A. R. Katzev, C. C. Pratt, & W. McGuigan. <i>Oregon Healthy Start 1999-2000 Status Report</i> . Corvallis, OR: Oregon State University Family Policy Program, 2001.
	B2) Increase support and access to community resource centers	B2-B4) Universal screening provides identification of families with high levels of stress that decreases family stability and increases the risk for poor childhood outcomes (Katzev, 2001); and provide the opportunity for parental support and education. Citation: A. R. Katzev, C. C. Pratt, & W. McGuigan. <i>Oregon Healthy Start 1999-2000 Status Report</i> . Corvallis, OR: Oregon State University Family Policy Program, 2001.
	B3) Increase support and access to respite services for families raising children with high special needs	
	B4) Enhance opportunities for community resource forums to help educate families about community options for parenting support	

HLO#4 REDUCE CHILD MALTREATMENT

PRIORITIES	STRATEGIES	RATIONALE
<p>C) Enhance child safety in family settings</p>	<p>C1) Design and expand programs specifically for children exposed to domestic violence.</p>	<p>C1) Intervention & Prevention for Children & Youth,” <i>Toolkit to End Violence Against Women</i> (2001). Washington DC: National Advisory Council on Violence Against Women and the Violence Against Women Office, “, chapter 9, pg 7.</p>
	<p>C2) Increase availability of safe parenting time centers and exchange sites for children and parents at risk of sexual or domestic violence or stalking.</p>	<p>C2) Schechter, S. & Edleson, J. (1998). <i>Effective intervention in domestic violence & child maltreatment cases: Guidelines for policy and practice</i>. Reno, NV: National Council of Juvenile and Family Court Judges, pg 111,</p>
	<p>C3) Report to child welfare when children are exposed to current domestic violence and subject to substantial risk of harm.</p>	<p>C3) “The presence of domestic violence is a risk for children. However, not all situations of domestic violence require a report to DHS or law enforcement.” Guidelines for when to make a report of a child exposed to domestic violence can be found in the Guide for Mandatory Reporters of Child Abuse (2002). Citation: “What You Can Do About Child Abuse: A Guide for Mandatory Reporters of Child Abuse,” (2001), Oregon Department of Human Services, pg 41-42.</p>
	<p>C4) Increase capacity and options for family visits in appropriate settings for children who have been removed from parental care.</p>	<p>C4) Best practice. The number one indicator of a child successfully returning to their parent's care is visitation. The more appropriate the setting and activities of the visitation, the more successful the visitations.</p>

HLO#5 IMPROVE PRENATAL CARE

STRENGTHS AND ASSETS *(THIS SECTION IS CURRENTLY UNDER REVISION, AND WILL BE UPDATED IN THE NEXT SUBMISSION)*

Children

- Low cost prenatal care clinic
- Early, comprehensive prenatal care

Family/Community

- Residential treatment and detoxification is provided for adults including women with their children at Willamette Family Treatment Center
- Recovery support services are provided throughout the community by local organizations
- Public and private providers work together to provide prenatal services

Cultural

- Services to Latino children and parents

GAPS* AND BARRIERS *(THIS SECTION IS CURRENTLY UNDER REVISION, AND WILL BE UPDATED IN THE NEXT SUBMISSION)*

Children

- Affordable health care and health insurance
- Families unable to afford the minimum contribution for OHP participation

Family/Community

- Community norm that people should help themselves
- Changing requirements of OHP
- Confusing health care system, restriction on available providers and medications
- Inability to afford minimal contributions for OHP participation
- Waiting lists, hours of service
- Need more maternity case management

Cultural

- Culturally sensitivity services
- Fear of law, deportation
- Limited availability of translation services, materials
- Affordable/no-cost prenatal classes in Spanish
- Additional culturally sensitive prenatal classes
- Fear of law, deportation
- Limited availability of translation services, materials
- Affordable/no-cost prenatal classes in Spanish
- Additional culturally sensitive prenatal classes

Gender

- Treatment for pregnant and parenting teen girls and their children
- Parenting programs for men

Special Needs

- Additional prenatal classes for families with special needs

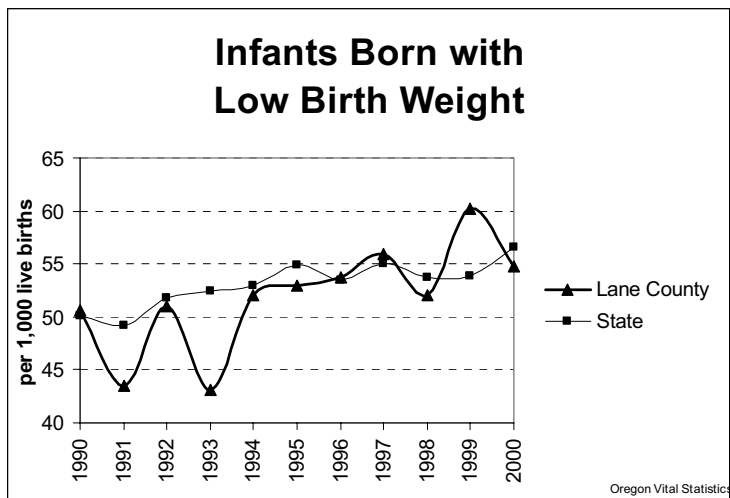
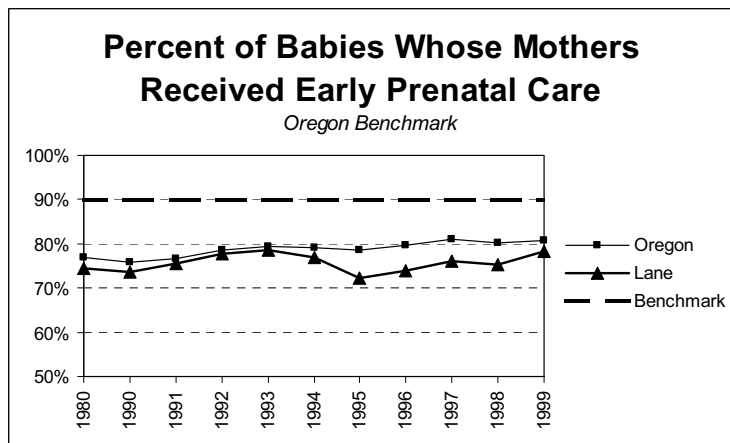
Rural

- Affordable/no-cost prenatal classes
- Maternity case management
- Additional low or no-cost prenatal care

**Gaps in services exist to varying degrees, either because they need to be developed, or in most cases because they need to be enhanced or expanded.*

HLO#5 IMPROVE PRENATAL CARE

DATA



ANALYSIS

#5: The percent of babies whose mothers received early prenatal care – beginning in the first trimester.

Source: Oregon Progress Board (Oregon Health Division)

- The statewide benchmark goal for babies whose mothers received early prenatal care is 90 percent. The state and county are well below that goal. Since 1980, the trend in Lane County has been variable, but has generally risen since 1995. From 1995 to 1998, Lane County dropped well below the state rate. In 1998, only 75 percent of babies in Lane County received early prenatal care compared to 80 percent for the state as a whole. In 1999, the percent in Lane County increased to 78 percent as compared to 81 percent for the state.

Other Relevant Data

Low Birth Weight

- The rate of infants with low birth weight has been variable but generally increasing since 1990. One possible factor affecting this upward trend was the increase in the teen pregnancy rate due to the propensity for teens to give birth to lower weight babies.

HLO#5 IMPROVE PRENATAL CARE

PRIORITIES	STRATEGIES ¹	RATIONALE
<p>A) Strengthen parental understanding of the importance of prenatal health and health care.</p>	<p>A1) Provide parental education about prenatal health and its impact on the unborn child through prenatal home visiting.</p>	<p>A1) Intensive prenatal nurse home visiting has been shown to boost the use of prenatal care, increase the utilization of other health resources, improve nutrition, increase participation in childbirth and parenting classes, and decrease maternal smoking (American Academy of Pediatrics, 1998). Citation: American Academy of Pediatrics, Council on Child and Adolescent Health. The Role of Home Visitation Programs in Improving Health Outcomes for Children and Families. <i>Pediatrics</i>, Vol 101 No. 3 March 1998.</p>
	<p>A2) Enhance community understanding of the importance of early prenatal care and its impact on the unborn through public education.</p>	<p>A2) An informed community is more likely to respond positively to health issues. Assuring an understanding of the effect of prenatal behaviors on the unborn child is the first step in educating potential parents and those around them. Individuals will act to prevent, control, or treat a health problem when they understand the importance of the health issue, their susceptibility to harm, and the benefits of action (Rippke et al, 2000) Citation: M. Rippke, L. Briske, L. O. Keller, and S. Strohschein. Public Health Interventions II. Minnesota Department of Health, 2000.</p>
	<p>A3) Ensure access to prenatal care and education for minority populations through community collaborations and outreach to minority populations.</p>	<p>A3) Collaboration increases the effectiveness and success of the common effort. It results in outcomes that are more likely to be creative and thorough than efforts untaken alone (Rippke et al, 2000). Outreach activities are most effective when acceptable and appropriate for the target population, and when the unique characteristics of the population are addressed (Rippke et al, 2000). Citation: M. Rippke, L. Briske, L. O. Keller, and S. Strohschein. Public Health Interventions II. Minnesota Department of Health, 2000.</p>

¹ Strategies are based on the Lane County Early Childhood Plan, and Annual Plan for Family Health Programs (Lane County Public Health Plan).

HLO#6 INCREASE IMMUNIZATIONS

STRENGTHS AND ASSETS *(THIS SECTION IS CURRENTLY UNDER REVISION, AND WILL BE UPDATED IN THE NEXT SUBMISSION)*

Children

- Well child health care

Youth

- Teen parent services

Family/Community

- Parenting resource directory
- Family support and skill building
- Information and short-term support services for lower risk families
- Long-term family support services and home visitations for higher risk families
- Family Resource Centers

Cultural

- Services to Latino children and parents

Rural

- Universal risk screening

GAPS* AND BARRIERS *(THIS SECTION IS CURRENTLY UNDER REVISION, AND WILL BE UPDATED IN THE NEXT SUBMISSION)*

Children

- Affordable postpartum/newborn follow up
- Home visitation for subsequent births
- Affordable health care and health insurance
- Limited system of early follow up for newborns
- Families unable to afford the minimum contribution for OHP participation

Family/Community

- Changing requirements of OHP
- Confusing health care system, restriction on available providers and medications
- Inability to afford minimal contributions for OHP participation
- Waiting lists, hours of service
- Need more maternity case management

Cultural

- Culturally sensitivity services
- Fear of law, deportation
- Limited availability of translation services, materials

Gender

- Treatment for pregnant and parenting teen girls and their children
- Parenting programs for men

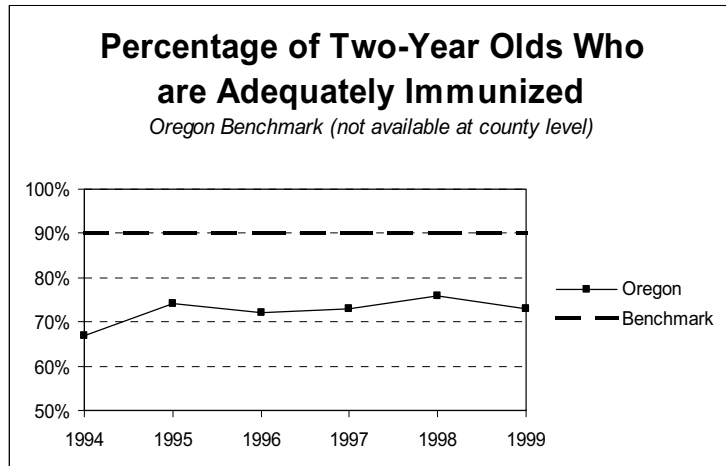
Rural

- Maternity case management

**Gaps in services exist to varying degrees, either because they need to be developed, or in most cases because they need to be enhanced or expanded.*

HLO#6 INCREASE IMMUNIZATIONS

DATA



ANALYSIS

#6: The percent of two-year olds who are adequately immunized.

Source: Oregon Progress Board (Oregon Health Division)

- This outcome measure was not used in Phase I. The data for this measure are not available at the county level; an alternative local indicator is needed.
- Although between 97% and 98% of children receive their complete series of immunizations before or shortly after starting school, rates of complete immunization are considerably lower among preschool children. This is unfortunate because preschool children are most vulnerable to communicable childhood diseases than can be prevented by vaccination.
- In all income levels, when immunizations are convenient for parents, rates of full immunization increase. In contrast, when parents are required to make appointments to obtain immunizations for their children, the rates of immunization drop

HLO#6 INCREASE IMMUNIZATIONS

PRIORITIES	STRATEGIES ¹	RATIONALE
<p>A) Improve immunization information available to families and care providers.</p>	<p>A1) Increase participation in Oregon Immunization ALERT by Lane County Providers.</p>	<p>A1) Oregon’s pre-school immunization rate improved by 7% in year 2000. In July 2001, Oregon Immunization ALERT won a national award for “Best Use of Registry Data to Improve Public Health” presented by Rosalyn Carter on behalf of the organization, Every Child by Two. The award was based on data collected and outcomes achieved.</p> <p>ALERT maintains 13.5 million immunizations for 950,000 children statewide ages 0-18. Public and private providers submit immunization data to ALERT and the system produces timely immunization records for providers. ALERT data is used to provide information, trends, and rates for providers, OMAP, and CDC. The information helps identify factors that contribute to low rates and measures interventions; and tracks uptake of new vaccines and schedule changes (Canavan, 2001).</p> <p>Citation: B. C. Canavan. <i>Using Registry Data to Improve Public Health</i>. Portland, OR: Oregon Department of Human Services, 2001.</p> <p>B. C. Canavan. <i>Oregon Immunization ALERT</i>, Portland OR: Oregon Department of Human Services, 2001.</p>
	<p>A2) Increase immunization compliance by collaborating with WIC to provide immunization screening.</p>	<p>A2) Children in families with low incomes are less likely to be fully immunized (Pratt et al, 1997). Many families have difficulty maintaining a current record of immunizations and up-to-date knowledge of recommended immunization schedules. Screening, education, and referral are provided for families with low incomes through this activity.</p> <p>Collaboration increases the effectiveness and success of the common effort. It results in outcomes that are more likely to be creative and thorough than efforts untaken alone (Rippke et al, 2000).</p> <p>Citations: C. C. Pratt, A. Katzev, T. Henderson, and R. Ozretich. <i>Building Results: From Wellness Goals to Positive Outcomes for Oregon’s Children, Youth, and Families</i>. Corvallis, OR: Oregon State University Family Policy Program, 1997.</p> <p>M. Rippke, L. Briske, L. O. Keller, and S. Strohschein. <i>Public Health Interventions II</i>. Minnesota Department of Health, 2000.</p>

HLO#6 INCREASE IMMUNIZATIONS

A3) Strengthen parental skills and knowledge through a public information campaign that highlights the importance of early immunizations.

A3) Individuals will act to prevent, control, or treat a health problem when they understand the importance of the health issue, their susceptibility to harm, and the benefits of action (Rippke et al, 2000).

Citation: M. Rippke, L. Briske, L. O. Keller, and S. Strohschein. Public Health Interventions II. Minnesota Department of Health, 2000.

¹ *Strategies are based on the Lane County Early Childhood Plan, and Annual Plan for Family Health Programs (Lane County Public Health Plan)*

HLO#7 REDUCE ATOD USE DURING PREGNANCY

STRENGTHS AND ASSETS *(THIS SECTION IS CURRENTLY UNDER REVISION, AND WILL BE UPDATED IN THE NEXT SUBMISSION)*

Children

- Low cost prenatal care clinic
- Well child programs
- Early, comprehensive prenatal care

Family/Community

- Lane County prevention coordinator to facilitate and ensure efforts to address prevention efforts
- Lane County Prevention Coalition – developed to encourage and support community partnerships by addressing the challenges and impact of drugs, alcohol, and tobacco on children and families.
- Residential treatment and detoxification is provided for adults including women with their children at Willamette Family Treatment Center
- Recover support services are provided throughout the community by local organizations
- Family support and skill building
- Intensive case management
- Information and short-term support services for lower risk families
- Long-term family support services and home visitations for higher risk families
- Service to recovering parents

Cultural

- Services to Latino children and parents

Gender

- Alcohol and drug residential care for pregnant women and women with children

Rural

- Assessment and therapy
- Services to recovering parents

GAPS* AND BARRIERS *(THIS SECTION IS CURRENTLY UNDER REVISION, AND WILL BE UPDATED IN THE NEXT SUBMISSION)*

Children

- Affordable health care and health insurance
- Families unable to pay the contribution for OHP participation

Family/Community

- Limited community awareness of the impact of maternal behaviors on the development of the child
- Family-friendly ATOD treatment programs
- Community norm that people should help themselves
- Changing requirements of OHP
- Waiting lists for services
- Selective prevention services that target higher risk families with services that strengthen and support a healthy family climate
- Indicated prevention services to help stabilize family interaction
- Confusing health care system, restriction on available providers and medications
- Need more maternity case management

Cultural

- Non-English alcohol and drug treatment
- Culturally sensitivity services
- Fear of law, deportation
- Limited availability of translation services, materials

Gender

- ATOD treatment for pregnant teen girls
- Mental health services for women
- Parenting programs for men

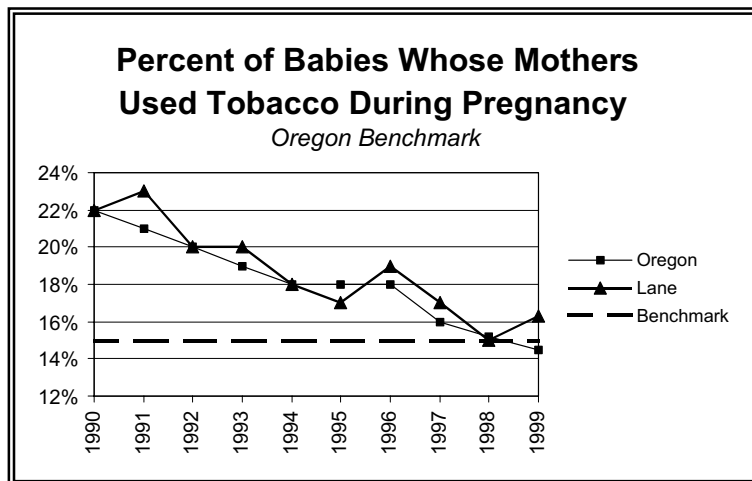
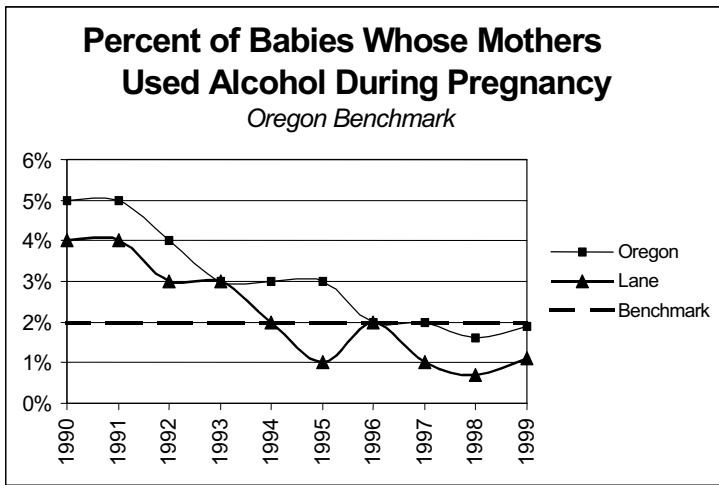
Rural

- Rural alcohol and drug treatment
- Maternity case management

**Gaps in services exist to varying degrees, either because they need to be developed, or in most cases because they need to be enhanced or expanded.*

HLO#7 REDUCE ATOD USE DURING PREGNANCY

DATA



ANALYSIS

#7a. Percentage of infants whose mothers reported using alcohol during pregnancy. Source: Oregon Progress Board (Oregon Health Division)

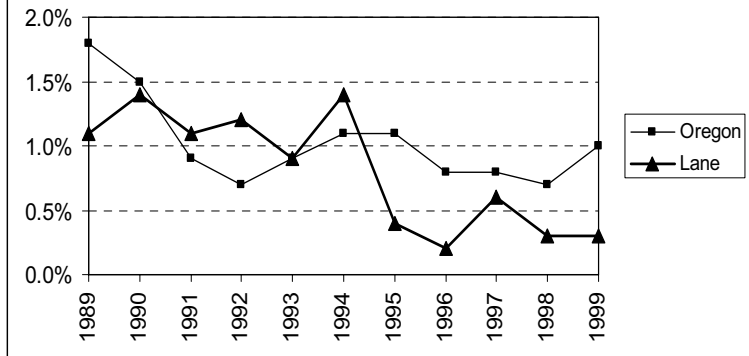
- The self-reported use of alcohol, tobacco, and other drugs by mothers during pregnancy has been variable but generally decreasing in Lane County and the state as a whole since 1990.
- The county has performed at or better than the statewide benchmark goal of 2 percent for pregnant women who use alcohol during pregnancy since 1996.

#7b. Percentage of infants whose mothers reported using tobacco during pregnancy. Source: Oregon Progress Board (Oregon Health Division)

- The statewide benchmark goal for infants born to mothers who used tobacco during pregnancy is 15 percent. The county and state have been above this goal since 1990 when 22 percent of infants had mothers who used tobacco during pregnancy through 1998 when the county dropped to 17 percent, and the state dropped to 16 percent – close to meeting the benchmark goal.
- In 1999, the state continued to improve, while Lane County bounced back up above 16 percent.

HLO#7 REDUCE ATOD USE DURING PREGNANCY

Percent of Babies Whose Mothers Used Illicit Drug During Pregnancy



#7c. Percentage of infants whose mothers reported using illicit drugs during pregnancy. Source: Oregon Progress Board (Oregon Health Division)

- Illicit drugs include: cocaine, heroin, marijuana, and methamphetamines.
- The percent of babies born to mothers who reported using illicit drugs during pregnancy has been variable but generally trending downward since 1990. In 1998 and 1999, the percentage was roughly 0.25%.

Pregnant Women Receiving AOD Treatment from State-Supported Treatment Centers



Other Relevant Data

Treatment for Alcohol or Other Drugs

Data from the Office of Alcohol and Drug Addiction Programs indicates that the rate of pregnant women receiving treatment for alcohol and other drugs has increased from about 17 per 1,000 live births in 1995 to 31 per 1,000 live births in 2000. During the same time period, the state rate was relatively flat. It is unclear at this time whether the increase in Lane County is due to increased need, or other changes such as increased funding and outreach.

HLO#7 REDUCE ATOD USE DURING PREGNANCY

PRIORITIES	STRATEGIES ¹	RATIONALE
<p>A) Increase knowledge of the importance of prenatal health and healthy behaviors.</p>	<p>A1) Provide parental education about prenatal behavior and its impact on the unborn child through prenatal home visiting, teen parent groups, and other prenatal support activities.</p>	<p>A1) Intensive parental nurse home visiting has been shown to boost the use of prenatal care, increase the utilization of other health resources, improve nutrition, increase participation in childbirth classes, and to decrease maternal smoking (American Academy of Pediatrics, 1998). Home visiting can help ensure positive pregnancy outcomes by helping to reduce unhealthy prenatal behaviors such as smoking and alcohol and drug use (National Commission to Prevent Infant Mortality, 1998).</p> <p>Citations: American Academy of Pediatrics, Council on Child and Adolescent Health. The Role of Home Visitation Programs in Improving Health Outcomes for Children and Families. <i>Pediatrics</i>, Vol.101 No. 3 March 1998.</p> <p>National Commission to Prevent Infant Mortality. Home Visiting: Opening Doors for America’s Pregnant Women and Children. Washington, DC: National Commission to Prevent Infant Mortality, 1989.</p>
	<p>A2) Provide residential and outpatient services for teen and adult pregnant or parenting women that is available and accessible to all, including minority and rural populations.</p>	<p>A2) Pregnant and parenting women who receive residential substance abuse treatment show reduced drug and alcohol use. Following residential treatment, women have been found to have “high rates of post-treatment abstinence from alcohol and drugs; reduced criminal behavior, and improvement in economic well-being, personal relationships, and parenting status” (SAMHSA, 2001).</p> <p>Citation: SAMHSA. Benefits of Residential Substance Abuse Treatment for Pregnant and Parenting Women: Highlights for a Study of 50 Centers for Substance Abuse Treatment Demonstration Programs. Washington, DC: September 2001.</p>
	<p>A3) Enhance community understanding of the negative impacts of ATOD on the unborn child through public education.</p>	<p>A3) Individuals will act to prevent, control, or treat a health problem when they understand the importance of the health issue, their susceptibility to harm, and the benefits of action (Rippke et al, 2000).</p> <p>Citation: M. Rippke, L. Briske, L. O. Keller, and S. Strohschein. Public Health Interventions II. Minnesota Department of Health, 2000.</p>

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HLO#8 INCREASE CHILDCARE AVAILABILITY

STRENGTHS AND ASSETS *(THIS SECTION IS CURRENTLY UNDER REVISION, AND WILL BE UPDATED IN THE NEXT SUBMISSION)*

- Childcare resource and referral services
- Child development centers in high schools

GAPS* AND BARRIERS *(THIS SECTION IS CURRENTLY UNDER REVISION, AND WILL BE UPDATED IN THE NEXT SUBMISSION)*

Children

- Additional infant and toddler care
- Increase low cost or subsidized childcare
- Employer supported childcare
- Additional quality childcare
- Childcare provider training in currently underserved areas and to fill other existing system gaps
- Affordable, accessible preschools

Family/Community

- Data from the local childcare resource and referral service indicates that the main areas of difficulty in finding service are infant/toddler; non-traditional hours; quality of service; “sick” childcare.
- Community norm that undervalues and underpays childcare providers – makes it difficult to attract competent, trained childcare workers
- Affordable childcare and after school care

Cultural

- Additional bilingual childcare in all locations
- Culturally sensitive services

Special Needs

- Child care for children with special needs

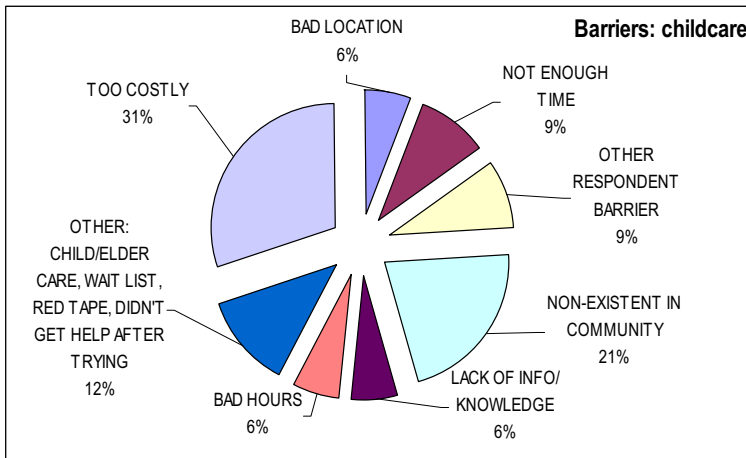
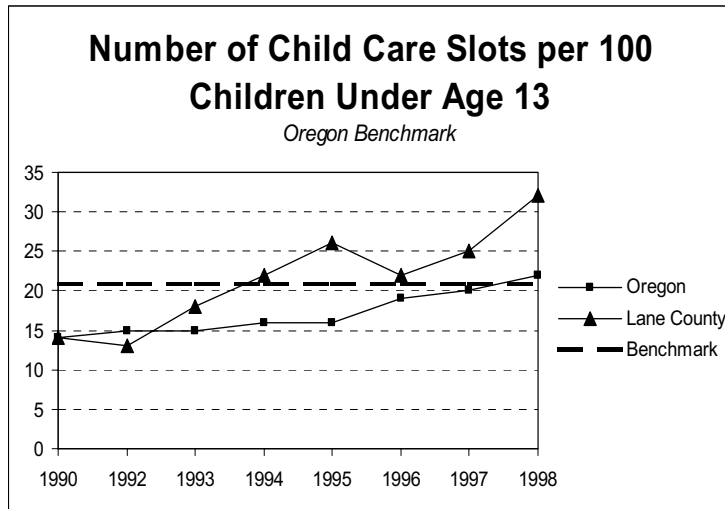
Rural

- Public transportation is unavailable for many Lane County residents. Rural families need effective, affordable transportation to link them to work, school, childcare, health care, and other services
- Very limited infant and toddler care throughout county
- Additional non-traditional hour care
- Additional care for sick children

**Gaps in services exist to varying degrees, either because they need to be developed, or in most cases because they need to be enhanced or expanded.*

HLO#8 INCREASE CHILDCARE AVAILABILITY

DATA



ANALYSIS

#8: Number of slots available for very 100 children under age 13.

Source: Oregon Progress Board (Child Care Division)

- Childcare availability has generally increased since 1996 in Lane County and statewide since 1990. Lane County has been above the statewide benchmark goal since 1994. The benchmark goal is 21 childcare slots per 100 children under age 13 – Lane County had 32 in 1998. This is the highest level of any county in Oregon.

Other Relevant Data

- Lane Family Connections at Lane Community College maintains a database of local childcare providers. The database includes over 800 childcare programs in Lane County. The estimated capacity in Lane County was about 11,000 childcare slots in June 2000 – of those slots, approximately 2,700 were available.
- Based on the LCCCF Community Survey, there is a perception in the community that there is not enough childcare available, yet 24 percent of the slots were vacant (over 2,700) at the time the survey was done according to the LCC Lane Family Connections childcare provider database.
- In the LCCCF Community Survey, 32 percent of families said that they needed childcare and only 23 percent said that they were able to find childcare. In the same survey, 21 percent of families who were unable to find childcare said that it was non-existent in their community and 31 percent said that it was too costly. Information suggests that many families cannot afford the cost of childcare, and that in many areas of the county, there is no infant and toddler care or non-traditional hour care. In addition, there is extremely limited childcare for children who have illnesses.

HLO#8 INCREASE CHILDCARE AVAILABILITY

- While the number of childcare slots appears to be sufficient on the surface, more analysis of the childcare situation is needed to determine if the type, location, and quality of childcare matches the specific needs of county residents
- Lane County has more childcare slots than it uses, yet families have trouble in obtaining childcare. This dichotomy exists because availability is linked to accessibility, flexibility, capability, affordability, and quality. It doesn't matter if childcare is available in Eugene if you live in Florence; it doesn't help if it is available during the day for children aged three to four if you work at night and have an infant. It doesn't matter if everyone on your street provides childcare if the quality of that care is unacceptable, or if the cost of that care is greater than what you can afford. For all of these reasons, there can be an abundance of childcare openings, and very few families that are able to take advantage of them.
- The quality of childcare also affects the perception of availability, and some slots remain unfilled because parents do not wish to use the childcare that is available due to its quality. Childcare quality is related to: provider-child ratios; the level of stimulation for language, cognitive, and physical development; provider training and supervision; learning materials and physical environment; health and safety practices; and parental support and involvement. The quality of childcare that is provided impacts the cognitive and social development of the children receiving the care.

HLO#8 INCREASE CHILDCARE AVAILABILITY

PRIORITIES	STRATEGIES	RATIONALE
<p>A) Increase quality of currently available childcare slots</p>	<p>A1) Provide developmentally appropriate environments through early childhood care provider training and enhanced compensation.</p>	<p>A1) Quality childcare provides an environment for young children that impacts their ability to develop a sense of emotional security, intellectual capacity, and social competence. A positive and sensitive relationship between the child and care provider is the most important component of quality in childcare. (Carnegie Task Force, 1994)</p> <p>Childcare provider training expands knowledge of early childhood growth and development, enhances the ability to interact appropriately with all children, and strengthens the ability to provide warm and sensitive care. Training standards ensure meaningful preparation for providers of childcare . (Carnegie Task Force, 1994)</p> <p>Childcare providers leave their jobs because of low pay and inadequate benefits; the rate of turnover for childcare providers is five times that for public school teachers; and the average rate of pay is half of that for early childhood professions in public education. (Carnegie Task Force, 1994)</p> <p>Citations: Carnegie Task Force. <i>Starting Points Meeting the Needs of Our Youngest Children</i>. New York: Carnegie Corporation, 1994.</p>
<p>B) Increase availability of high-quality, safe, accessible, affordable childcare</p>	<p>B1) Increase access to quality affordable early childhood care by addressing identified gaps in specialized populations and geographic areas, such as medically fragile, developmentally disabled, infant care, and rural and isolated areas</p>	<p>B1) Families often have difficulty locating childcare because the demand for child care is greater than its supply. This is especially true in low-income communities and for families who need infant care, odd-hour care, or out-of-school programs for their school-age children. (National Women’s Law Center, April 2002)</p> <p>Even if parents could find slots for their children, many would encounter substandard care. The Cost, Quality and Child Outcomes Study published in 1995 by researchers at the University of North Carolina, the University of Colorado, UCLA and Yale University, when using commonly accepted measurement tools, reported unacceptably high rates of poor quality care at child care centers around the nation. (Opening a New Window on Child Care, National Council of Jewish Women, 1999)</p>

HLO#8 INCREASE CHILDCARE AVAILABILITY

B2) Analysis of gaps in coordinated child care for school age children, such as before/after school, summer, and development of an action plan to address the identified gaps

B2) Families with school-age children face many hurdles. Childcare is often inaccessible and unaffordable. The Center for Research on Women at Wellesley College calculated in 1997 that 5 million children are left unsupervised after school each week. Instead of receiving the help they need to succeed in school, children across all income levels are spending many hours a week alone in setting where they are not learning anything to improve their emotional, intellectual and social development.

(Center for Research on Women at Wellesley College, 1997)

(*Opening a New Window on Child Care*, National Council of Jewish Women, 1999)

Lack of appropriate after-school care has a demonstrable negative impact on children and teens. Studies indicate that school-age children who are left alone after school are at greater risk of truancy, risk-taking behavior, substance abuse, poor grades, and stress. One 1999 study found that children who spent more time home alone in third grade displayed more behavior problems and these problems persisted to fifth grade.

(Assessment of the Environment Across the Lifespan, SL Friedman, TD Wachs, 1999)

HLO#9 IMPROVE READINESS TO LEARN

STRENGTHS AND ASSETS *(THIS SECTION IS CURRENTLY UNDER REVISION, AND WILL BE UPDATED IN THE NEXT SUBMISSION)*

- Respite care – in home and after school
- Therapeutic nurseries
- Childhood education expertise at local university/college
- Programs for children with disabilities and sensory impairments
- Local expertise in educational research

GAPS* AND BARRIERS *(THIS SECTION IS CURRENTLY UNDER REVISION, AND WILL BE UPDATED IN THE NEXT SUBMISSION)*

Family/Community

- Community norm that undervalues and underpays childcare providers – makes it difficult to attract competent, trained childcare workers
- Community and parent awareness of activities and experiences needed to prepare children for school

Cultural

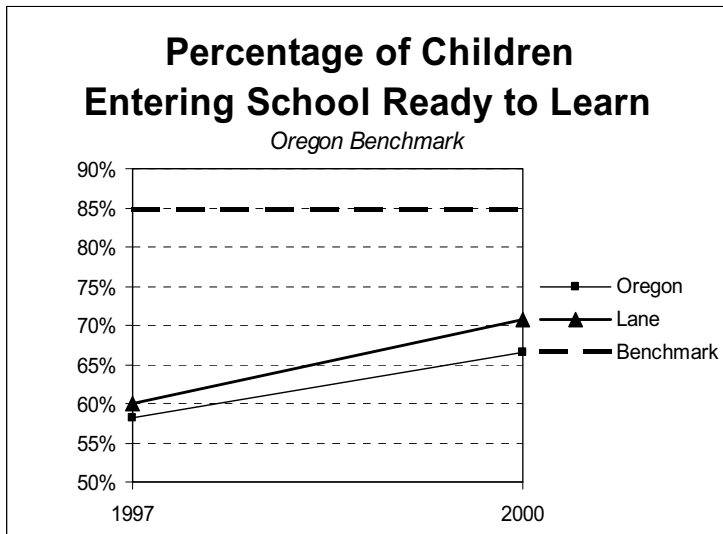
- Spanish language/culture early intervention services
- Limited non-English services
- Additional bilingual childcare in all locations
- Culturally sensitive services

Rural

- Public transportation is unavailable for many Lane County residents. Rural families need effective, affordable transportation to link them to work, school, childcare, health care, and other services
- General library services are limited to municipalities. Approximately one third of Lane County residents live in unincorporated areas or small towns without libraries. Access to libraries for adult education, parenting education, and children's activities is generally unavailable for these families. Library cards for non-residents of municipalities with libraries are costly. For low-income families, access and cost discourages library usage.
- Early literacy programs that help parents understand their role in a child's language development and readiness for school are not available throughout the county.

**Gaps in services exist to varying degrees, either because they need to be developed, or in most cases because they need to be enhanced or expanded.*

DATA



ANALYSIS

- According to assessments of children’s readiness to learn by teachers in 1997 and 2000, the rate increased from about 60 to 70 percent.
- Social skills, positive approaches to learning, the depth and breadth of children’s knowledge, language and literacy skills are related to developmental and experiential factors in the first five years of life. These include child characteristics such as age, gender, and cognitive and sensory experiences as well as the child’s home, childcare and preschool environments. “Readiness to Learn” measures the teacher’s perception of children’s readiness related to health and well being, social and emotional well being, cognitive knowledge, enthusiasm for learning, motor development, and language and literacy. The Oregon Benchmark goal for “Readiness to Learn” is 85 percent by 2005. The county and state overall are currently well below the benchmark goal.
- There is a strong correlation between readiness for school and educational success. Families have the primary role in the healthy development of a child’s emerging literacy, which impacts school achievement. Emergent literacy is the development of literacy-related skills and understanding prior to the beginning of formal education. These include oral language, awareness of the sounds that make up words, a positive attitude toward books, an awareness of the alphabet, and experience with writing tools.

HLO#9 IMPROVE READINESS TO LEARN

PRIORITIES	STRATEGIES	RATIONALE
<p>A) Increase opportunities for appropriate early childhood learning environments</p>	<p>A1) Enhance parental knowledge & skills through home visiting, parenting classes, and other support activities.</p>	<p>A1) As parents develop and understanding of the developmental expectations for their children, they learn to encourage the development of language, communication, and emerging literacy by providing developmentally appropriate activities. Home visitors help parents gain knowledge of child development and of ways that they can encourage language, communication, and emerging literacy for the children during their daily activities and interactions (Klass, 1996).</p> <p>Citation: C. S. Klass. <i>Home Visiting</i>. Baltimore, MD; Paul H. Brooks Publishing Company, 1996.</p>
	<p>A2) Identify children in need of special services through a system of early childhood developmental screening and referral.</p>	<p>A2) Early identification of developmental disabilities and delays allows for judicious and successful interventions that result in the best possible outcomes (Pratt, et al, 1997).</p> <p>Citation: C. C. Pratt, A. Katzev, T. Henderson, and R. Ozretich. <i>Building Results: From wellness Goals to Positive Outcomes for Oregon’s Children, Youth, and Families</i>. Corvallis, OR: Oregon State University Family Policy Program, 1997.</p>
<p>B) Increase family literacy</p>	<p>B1) Strengthen family involvement in literacy activities through parent education and support services for higher risk families that model and encourage reading and provide books and materials.</p>	<p>B) When families introduce children to the world of books early in their childhood, children are more likely to have appropriate language abilities when they enter school. Families who read or tell stories to their children are giving them a head start toward success in school.</p> <p>Citation: Payne, A.C., Whitehurst, G.J., and Angell, A.L. (1994). The role of home literacy environment in the development of language ability in preschool children from low-income families. <i>Early Childhood Quarterly</i>, 9, 427-440.</p>
	<p>B2) Promote library use for all families.</p>	