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2011 Legislative Briefing Book

Nevada Institute for Children's Research and Policy

UNLV, School of Community Health Sciences

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Nevada Institute For Children's Research & Policy

UNLV

NICRP

2011 Legislative Briefing Book

HEALTH SCIENCES |

School of Community Health Sciences

2011 Legislative Briefing Book

This briefing book was prepared by the Nevada Institute for Children's Research and Policy, School of Community Health Sciences, UNLV with the assistance and contributions of individuals and organizations throughout Nevada.

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Introduction

The purpose of the Nevada Institute for Children’s Research and Policy (NICRP) Legislative Briefing Book is to provide a quick snapshot of some of the most pressing issues facing Nevada’s children in order to provide advocates and policymakers with a stepping stone in creating positive changes to improve the lives of Nevada’s children. While this book will not cover every issue facing our children, it is intended to highlight some of those where state policy may have an impact, covering issues in education, health, safety and security, and the juvenile justice system.

Diligent efforts need to be made during the 2011 Legislative Session to improve policies, procedures and services for Nevada’s children. Nevada has continually been ranked as one of the poorest states when it comes to statistics regarding children and social policy. Given the current economic strains on our State, it is vitally important to focus on preventing cuts to necessary programs while looking ahead to see what we can improve upon. Although most advocates and particularly policymakers would like to create policies that will provide immediate positive feedback, it is important to realize that effective social change takes time. As such, much emphasis should be placed on developing quality, comprehensive systems and implementing evidence-based preventive strategies to researched-based risk indicators.

This book is intended to be a compilation of statistics and policy recommendations from across the state, with contributions from practitioners, agencies, organizations, individuals and others who work with and advocate for the well-being of children in Nevada.

In light of the current economic situation, the briefing book also includes a special section on the Nevada Values Coalition, which demonstrates Nevada’s organizations abilities to join together, make recommendations, and support decisions that will improve our state as a whole.

Thank you for your support!



Denise Tanata Ashby

Executive Director, NICRP

Nevada Values Coalition

SHARED GOALS FOR NEVADA'S HEALTHY FUTURE

Nevada's government provides essential state services for all Nevadans through state and local employees, including teachers, police officers, and social service workers. Prior to the economic turn down in 2007, in comparison to other states, Nevada already had the smallest number of state employees per capita and ranked near the bottom of many indicators of health/well-being. Since 2007 our state government has experienced four rounds of budget cuts. We believe it is time to stop cutting essential services and start on the path to economic recovery through thoughtful, responsible management.

The current crises that Nevada faces will impact us for decades, and as a result we need to answer some fundamental questions: What kind of a state do we want to live in? Do we want a healthy, functioning community and well-supported public systems and services? How can we improve our fiscal system?

Well-educated students, well-trained workers, a healthy environment and functioning infrastructure are the foundations of a strong economy. Now more than ever we need our public systems and structures to respond to the economic situation, to provide support and protection to those hardest hit by the economic downturn, and to pave the way for a robust recovery. This is no time to dismantle the tools we need to move our state forward. Any responsible approach to addressing the current budget shortfall requires a hard and balanced look at both how we spend money and how we bring it in. Taxes need to be part of the equation.

Proposals are being made to go back to the budgets of 2007 which are estimated to be approximately \$5.2 billion. Higher education has already cut 20% of their budgets and lost 900 employees. In 2011, we must look at what this budget means for our state.

- Caseloads in all the main programs like Food Stamps and Medicaid have gone through the roof since 2007, so the proposed scale-back will require major elimination of programs, services and eligibility groups.
- Under the Affordable Care Act we cannot legally cut Medicaid eligibility groups, which means the only legally allowable areas to cut are reductions in rates and optional services. However, while these reductions may be legal, they are devastating and unwise policy.
- Medicaid has been kept afloat by the federal government with the increased FMAP (federal matching rate), a temporary fix, and caseloads are projected to continue to rise as the unemployment rate rises (\$500 million cost to state).

Before examining the need for additional revenue, it is essential to look at possible changes to make government more efficient. The following ideas in the Human Services area are being proposed:

- Consolidation of all DHHS services in the rural areas. Shift the focus from jobs to services—consider contracting with local service providers and counties.
- Consider contracting with Tribal Health, VA Health, or private health care organizations where they exist to expand their services to serve additional rural populations.

- Allow existing publicly funded Treatment (addiction) Agencies to also contract to implement rural General Mental Health Services.

It is often said that we must all tighten our belts and share in the sacrifice to get our state back on track. Yet if our deficit is addressed with cuts alone, the sacrifices are shared solely by those seniors, people with disabilities and children who need the education and human services that make up over 80% of our state's budget. Compared to other states our tax burden is extremely light. To have the kind of Nevada which we value and which it will attract new business we must together invest in an infrastructure in which we can be proud.

WHAT DOES OUR COMMUNITY WANT?

We believe in order for our communities and state to remain healthy, state and local governments, non-profits, businesses, and citizens need to work together on ALL of the following strategies: revenue building, efficiencies, and collaborations with state and local governments, non-profits, and businesses.

Harmful strategies: Cutting large chunks of services (meat cleaver), just cutting, or pushing services down to local governments without consultation, could cause less savings (emergency mode of services more expensive and lost federal dollars) and have harmful impacts on our people.

For more information about the Nevada Values Coalition, including the vision, strategies and stakeholders, please visit the website at: <http://www.nevadavalues.org/>.

**Nevada Values
Coalition**

Early Childhood Education

Policy Issue

Nevada lacks an adequate level of affordable, accessible and quality early childhood education programs which provide the foundation for learning and success in school and beyond.

The returns on early childhood education (ECE) are multi-faceted, and researchers have begun to put an economic value on the numerous ways educating our youngest children benefits communities and society as a whole. A child who is supported and challenged through quality early educational programs is more likely to complete high school and become a productive member of the community.

Students who have had a quality ECE are:

- better equipped for primary grade learning than those who do not receive it;
- make greater gains in language, reading and math; and
- have superior academic achievement, including better grades and higher standardized test scores.

Quality early education for at-risk children can produce an annual rate of return as high as 16% - higher than most stock portfolios. It should be at the top of any state's economic development agenda.

~Art Rolnick, Senior Vice President, Federal Reserve Bank of Minneapolis

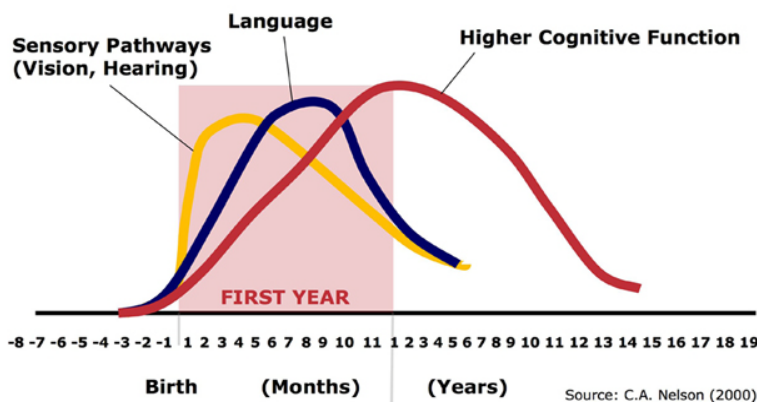
Brain Development

Great strides have been made in understanding brain development and the impact of early stresses on a child's long-term well being. Research has shown that the quality of the earliest relationships and experiences contributes to school success, health, and future workforce productivity.¹ Quality early childhood programs provide a positive environment to foster those early relationships and encourage full brain development during those critical beginning years.

 Center on the Developing Child
HARVARD UNIVERSITY

Human Brain Development

Neural Connections for Different Functions Develop Sequentially



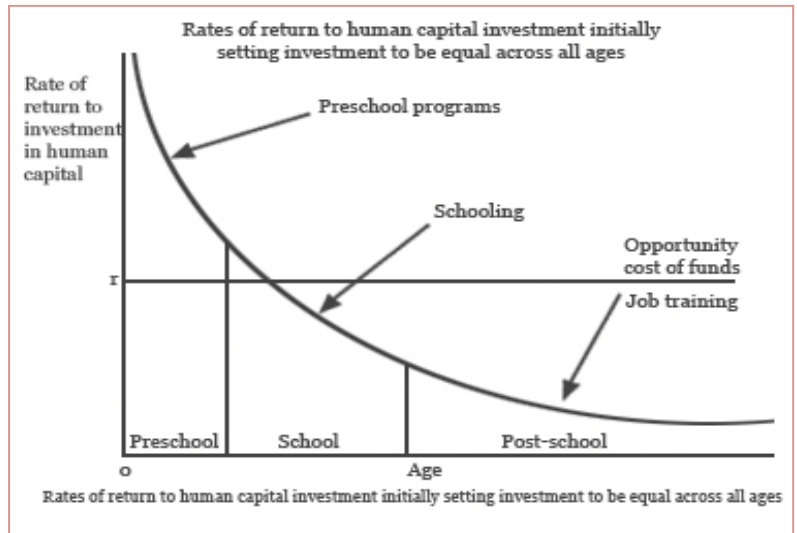
The brain is most flexible, or “plastic,” early in life. As it becomes more mature and specialized, it is less capable of reorganizing and adapting to new or unexpected challenges, and plasticity declines. With brain development occurring more rapidly between birth and age 5 than during any other subsequent period, **more than 85% of the foundation for communications, critical thinking problem solving, and teamwork is developed by age 5**, before children enter kindergarten.²

Economic Investments in Early Childhood

While the majority of brain development occurs before a child enters school, 95% of public investment in education occurs after age 5.³ Several longitudinal studies have shown that quality ECE provides significant short-term and long-term benefits to not only individual children, but to society as a whole.⁴

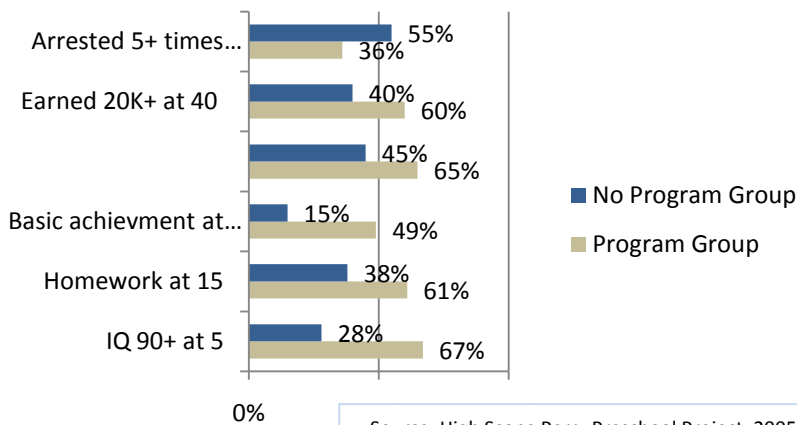
The benefits shown in these studies include:

- reductions in crime rates, teen pregnancy, welfare dependency, job training costs, special education costs, and grade retention,
- increases in school success, graduation rates, workforce readiness, job productivity, and community engagement, and
- a benefit-to-cost ratio between 5.15 and 17.1 %, and return rates as high as 16%.⁵



One of the most well known longitudinal studies looking at the long-term impacts of high quality ECE programs is the High Scope Perry Preschool Project. From 1962–1967, at ages 3 and 4, the subjects were randomly divided into a program group that received a high-quality preschool program based on High Scope's participatory learning approach and a comparison group who received no preschool program. In the study's most recent phase, 97% of the study participants still living were interviewed at age 40. Additional data were gathered from the subjects' school, social services, and arrest records. The study found that adults at age 40 who had the preschool program had higher earnings, were more likely to hold a job, had committed fewer crimes, and were more likely to have graduated from high school than adults who did not have preschool.

Major Findings: High Scope Perry Preschool Study at 40



Quality and Access in Nevada

In 2008 licensed child care facilities in Nevada met only 31.14% of the demand for child care.⁶ (Demand is based on the number of children ages 1-5 who have all available parents in the work force.) The Child Care Resource and Referral agencies (CCR&R) of Nevada -- which assist parents in looking and paying for child care services -- reported that the most common problem described by parents was that there were not enough openings for their children, or that centers were not open for a requested scheduling.

Sixty percent of Nevada children under the age of 6 have all available parents in the work force, while the availability of licensed child care and preschool resources remain extremely limited. Nevada ranked 26th out of 38 states in availability of preschool for three-year-olds, and ranked 36th out of 38 in availability of preschool for 4-year-olds.⁷ The number of openings for children to enroll in either Early Head Start or Head Start programs is inadequate to meet the needs of Nevada's children. There are just four Early Head Start programs serving pregnant women and children ages 0-3 years, seven Head Start regional grantees serving children 3-5 years, three Tribal grantees, and one Migrant/Seasonal grantee,

for a total of 3,135 slots across the 23 sites. This creates room for 13% of Nevada’s eligible children, leaving approximately 87% who are greatly in need of services.⁸ Just 30 of the 415 licensed child care centers in Nevada are nationally accredited.⁹ This means that less than 3,912 quality placements are available to prepare the 235,939 young children in our state.

Of the 23 national standards for healthy development activities, 20 were partially met by Nevada regulations, 3 standards were not met, and 0 standards were fully met.¹⁰ Nevada also does not require that child care center directors undergo any early childhood education pre-service training, or ongoing training.¹¹ The only requirement is that the director must have his/her CDA credentials, while most other states require a CDA credential *and* up to 4,000 hours of experience or a bachelor’s degree.

In addition to requiring very little training for directors, the issue is compounded by the low hourly wages for teachers. In 2009 child care workers in Nevada earned an average of \$9.55 an hour (\$19,850 annually).¹² This leads to rapid turnover rates for child care providers - 65.81% of all child care workers in Nevada have worked at their current location for 3 years or less.¹³ It is very unfortunate that despite overwhelming evidence demonstrating the importance of ECE, Nevada does not require that ECE teachers and directors demonstrate preparedness, nor is their influence valued, as evidenced by their low pay.

Affordability

*In a national survey, parents stated that their two most important concerns regarding childcare were quality and cost.*¹⁴ Sixty-five percent of parents in southern Nevada believe lack of affordable or quality care is a major or moderate societal issue.¹⁵ Across the country, many parents struggle with the cost of child care. This is particularly true of parents in Nevada. While child care subsidies are available to families with income at or below 75% of the state median income, many families still cannot cover the cost of care. In 2008, half of Nevada’s workforce earned \$30,534 or less a year. The average annual cost for center-based care in Nevada for infants was about \$9,000; for prekindergarten care the cost decreased to about \$7,100 – these child care costs are among the most expensive in the nation.¹⁶ For single parents in Nevada earning the median income, infant care costs account for 30% of gross pay. Even in a two-earner household, with each individual earning the median salary or less, the cost of infant care is still at least 15% of the household’s gross pay. By comparison, an undergraduate full-time student at UNLV will pay about \$4,432 for tuition and fees for the 2010-2011 school year.¹⁷

Cost Comparisons

- **\$30,534:** Annual median income for a Nevada family
- **\$9,000:** Annual average cost for infant care in Nevada
- **\$7,100:** Annual average cost for prekindergarten care in Nevada
- **\$4,432:** Annual cost of UNLV tuition for an undergraduate student

Quick Facts:

From 2005 to 2008 Nevada served only 2% of all 4 year olds in its pre-school program.

In the beginning of 2009, Nevada had 3,035 children on its waiting list for child care assistance.

Nevada scored a 7 out of 10 on the national quality standard checklist for preschool.

Nevada’s high school graduation rate is the worst in the country at 45%.

High school dropouts from 2008 cost Nevada \$5.1 billion in lifetime earnings.

Young children who participate in high quality early childhood programs are 20% more likely to graduate from high school than those who do not.

High quality early childhood education programs can produce a rate of return as high as 16%.

~ National Institution for early Childhood Research (NIEER); CWLA, Nevada’s Children (2010); National Institute for Early Education research, The State of Preschool 2008; Nevada Dropout Prevention Summit, Civic Enterprises, LLC & Peter D. Hart Research Associates. (2008, November); Perry Preschool Project: Nevada Business Summit on Early Childhood Investments

POLICY RECOMMENDATIONS FOR NEVADA: EARLY CHILDHOOD EDUCATION

- Revise Nevada Administrative Code standards for **teacher/director qualifications** to ensure that early childhood teachers have the education and experience necessary to provide developmentally appropriate education.
- Implement and fully support the Silver Stars **Quality Rating Improvement System** in Nevada to assist parents in choosing a quality early childhood program.¹⁸
- Increase the amount of funding for **state pre-kindergarten programs** in public schools. The percentage of the population that is currently being served is low. Ensure matching funds to maximize federal funding available to support quality early childhood education throughout the state.
- Implement a **public-private scholarship program** for low-income parents to send their children to a high-quality school of their choice (from a pool of schools that have met high quality standards).
- Support a **WAGES program** (Work and Gain Economic Self Act) in Nevada to link increases in child care professionals' education to benefits and increased pay.
- Provide appropriate **supports and transition policies for K-12 public schools** to ensure smooth transitions from quality early childhood programs to kindergarten and primary grades, including full-day kindergarten programs, particularly for low-income families.

Access to Healthcare

Policy Issue

Nevada currently ranks last in the nation when it comes to providing health coverage for children. Currently 17.1% (120,800) of Nevada's children have no health coverage, which is almost double the national rate.

Nevada has been ranked among the bottom five states in several quality indicators related to children's healthcare.¹⁹ The Patient Protection and Affordable Care Act, signed into law by President Obama in March 2010, will incrementally improve the access and quality of health care for many children. However, Nevada must still endeavor to create a better state health care system by modifying programs and processes, accepting increased federal funding and matching those funds as appropriate to leverage additional funding for high quality programs.

Insured vs. Uninsured

In Nevada, 82% of children with health insurance see a doctor while only 56% of uninsured children receive the benefit of similar medical attention,²⁰ and uninsured children are ten-times more likely to lack much-needed medical care.²¹

Children with insurance:

- have an easier time focusing during class
- participate more in activities
- are not absent from school as often

When children are hospitalized, those without health insurance are 60% more likely to die than those who are insured.

~Center on Budget and Policy Priorities, Improving Children's Health, 2007

Access to health insurance will save the lives of many children. In 2008, one of the leading causes of natural child deaths was a treatable chronic illness. Of the children who die every year, it is estimated that roughly 37.8% of them could have been saved if they had health insurance.²² In addition, children who are born underweight because of various causes such as lack of prenatal care and pre-birth stress, have an 80% chance of being in a special needs program in school.²³

It is also important to recognize that not all insurance coverage results in the same benefits. Children who qualify for Medicaid are more likely to have poor health, be overweight, or have chronic or behavioral health problems than those who have access to private insurance.²⁴ Many of these children need regular doctor visits to keep them from regressing and daily prescriptions so they can develop normally and optimally function in school.²⁵

Cost and Economic Impact

In 2006 it cost \$1,795 to cover each child Medicaid enrollee, with Nevada paying about 54% of the cost, or about \$969 per child per year.²⁶ In 2009 the Federal Medical Assistance Percentage (FMAP) was even higher, with Nevada paying only 36.07% of the costs.²⁷ Of the \$2.9 billion Medicaid budget that was passed by the Legislature in June 2009, \$868 million – less than a third – came from the general fund. Because of this matching arrangement, the economic influence of Medicaid is enhanced and provides low-income families with health insurance that costs Nevada only \$1 for every \$2.77 spent.

Providing state-funded healthcare for families who could otherwise not afford it benefits not only those who are directly assisted – it benefits privately insured families as well. Those working poor who lack healthcare because they cannot afford it create higher premiums for those who have private health insurance. In 2005, cost shifting because of

unpaid and underpaid expenses resulted in additional costs for private health insurance. In 2010 it is estimated that for an individual in Nevada, the extra cost will be \$748 a year, or \$1,685 for a family.²⁸

Expanding Medicaid coverage and ensuring continued coverage through adulthood also saves money for Medicare. Research has found that individuals who were not continuously covered by health insurance before they enrolled in Medicare cost the program \$1,000 more per year.²⁹ Several states have already expanded and reformed their Medicaid programs in an effort to cover a greater number of residents who desperately need healthcare, to contain costs, and to make the system more efficient.³⁰ Each state's program varies slightly but they all found that "money was being spent inefficiently because the uninsured were less likely to obtain preventative care and more likely to delay seeking care until an illness reached an advanced state. Therefore, increasing the number of people with coverage was a means to making the health care system more efficient."³¹ All three states funded the changes with payments from individuals, families, employers, and federal Medicaid funding; and a Savings Offset Payment (SOP) in Maine sustained its program after the initial expansion.³² The objective of the SOP is to recapture the savings generated by all elements of the health reform, which incorporate the savings produced by reducing the number of uninsured and underinsured people, unnecessary emergency room visits, etc. Those savings are used to purchase or subsidize coverage for individuals.³³

Infusing money into the economy through Medicaid creates jobs for Nevadans, encouraging the "multiplier effect." Bringing money into the state through the Medicaid program generates spending in three areas:

1. business activity (increased output of goods and services),
2. employment (the number of new jobs created), and
3. employee earnings (wage and salary income associated with new jobs).³⁴

"Regardless of the economic model, all studies show Medicaid spending has a positive impact on state economies. The magnitude of the impact is dependent on state Medicaid spending, a state's matching rate (FMAP), and the economic conditions within a state."

~Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid in State Economies: A Look at the Research. Policy Brief (2009)

In 2005, every \$1 million invested in Medicaid resulted in "more than \$2.4 million in new business activity and more than 21 newly created jobs."³⁵

Health Care Reform

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act. The implications and roles for individual states and the details of many of the provisions are not yet clear. However, the act will meaningfully alter the health care system in Nevada, providing coverage and access for more children. Some of the health care reforms will be phased in, while many of them will take effect in September, 2010. Some of the key provisions for children include:

- **Extends SCHIP funding;** increases outreach and enrollment grants
- Children will **not be able to be excluded** from plans because of pre-existing conditions
- Expands the healthcare workforce and parents can select **any participating physician**
- Children who age out of foster care **MUST** have the option to **remain on Medicaid** until the age of 26
- Dependents will be allowed to **remain on their parents' coverage** until the age of 26
- \$25 million in funding for **Childhood Obesity Demonstration Project**. Grants for creating a comprehensive systematic model for reducing childhood obesity.
- Requires each state to design a **public awareness campaign** for obesity-related services available through Medicaid under the guidance of the Secretary.
- New plans require coverage of basic pediatric services, and **oral and vision coverage**.
- New plans must cover **prevention and wellness** benefits without deductibles or cost sharing.
- Parents will have access to **child-only policies** that will not be affected by loss of job, or changing jobs.
- New plans in the health insurance exchange will have **caps on out-of-pocket expenses**, like co-pays and deductible, and will provide premium assistance for those who need it.

Quick Facts:

- Medicaid currently provides coverage for about 116,000 of Nevada's children, or 53% of eligible children.
- One out of six children has no health insurance in NV. That's over 120,000 children.
- 66,300 of those uninsured children are eligible for full or partial public health assistance (based on their federal poverty level, FPL).
- 86% of percent of Nevada's uninsured children are from working families.
- 70% of Nevada's uninsured children are from households that are at or below twice the federal poverty level.

~ Childrenshelathcampaign.org; Statehealthfacts.org.

POLICY RECOMMENDATIONS FOR NEVADA: ACCESS TO HEALTHCARE

- Adopt state laws and regulations which will allow for **seamless implementation of the Patient Protection and Affordable Care Act**, including maximum state matches to leverage additional federal dollars into the state.
- Allow **presumptive eligibility** for children and pregnant women under the Medicaid program to avoid delays in seeking necessary preventive and prenatal care.
- **Eliminate abrupt discontinuation** of coverage for children. Provide a grace period, and direction for where they can go for medical assistance once coverage is discontinued. Implement a **twelve-month continuous eligibility** option. Under this option, parents and families would only have to provide income documentation once a year and enrolled children could be guaranteed stable coverage for at least a year.
- **Ensure coverage** of both preventive and emergency medical, dental, ocular and mental health services for children enrolled in Nevada Check-Up.
- Improve **state outreach efforts** and designate funds to public health program awareness for lower income families.
- Establish a system of **incentives for providers** to serve Medicaid patients, particularly in rural areas of the state.
- Establish a system of **comprehensive school based clinics** throughout the state to provide medical, dental, vision and mental health services to children and families in the community.

Access to Prenatal Care

Policy Issue

Nevada ranks 47th in the percentage of women receiving adequate prenatal care, Nevada mothers are less likely to begin prenatal care in the first trimester, and Nevada has a high percent of babies born with low birth weight.

What is adequate prenatal care?

The overall health and well being of a child begins in pregnancy. According to the March of Dimes, “women who receive prenatal care are more likely to have access to:

- screening and diagnostic tests that can help to identify problems early;
- services to manage developing and existing problems; and
- education, counseling, and referral to reduce risky behaviors like substance use and poor nutrition.”

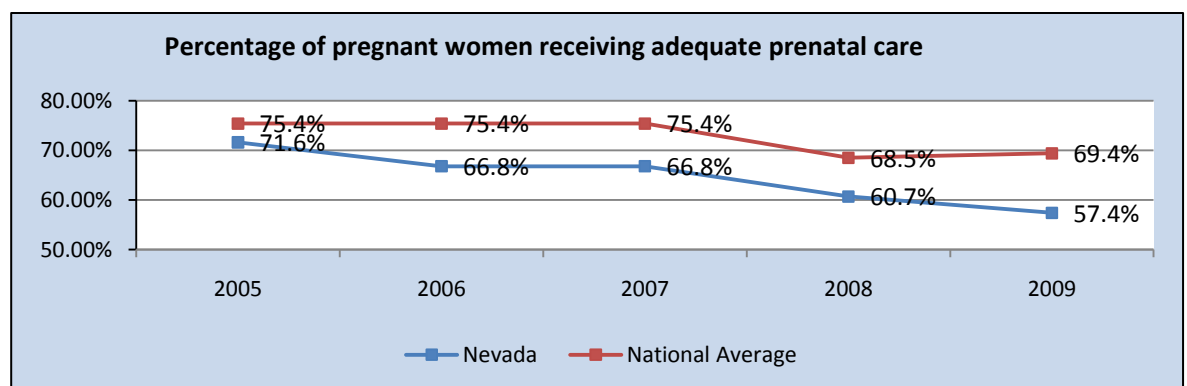
Adequate prenatal care begins immediately after the expectant mother has confirmed that she is pregnant during the first trimester. Medical attention is given to both the mother and developing baby and consists of routine visits to a health care provider as well as the mother’s caring for herself consistent with the health care provider’s advice.

The U.S. Department of Health and Human Services reports that babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die than those whose mothers received prenatal care. In Nevada, 8.3% of babies were born with low birth weight for 2005-2007. Late or no prenatal care is also a risk factor for pre-term birth. Nevada’s pre-term birth rate is 14.3%, much higher than the Healthy People 2010 goal of 7.6% or less. Pre-term births can result in a myriad of health problems both in the short and long term, including:

- mental retardation, learning & behavioral problems,
- cerebral palsy,
- lung problems, and
- vision and hearing loss.

In Clark County in 2008, over 50% (>100) of all natural child deaths were due to prematurity. Nearly 80% of those cases reported no prenatal care.

America’s Health Rankings reports that in the past five years, the percentage of pregnant women receiving adequate prenatal care in Nevada significantly declined from 71.6 percent (in 2005) to 57.4 percent (in 2009).



Data Source: America’s Health Rankings <http://www.americashealthrankings.org>

Disproportional Access to Prenatal Care

According to national and state data, **there is a health disparity across racial and ethnic groups**, with African American, Asian, Native American, and Hispanic women less likely to receive early prenatal care. The U.S. disparity score for prenatal care was 2.04, meaning that the share of women with late or no prenatal care was twice as high among women of color than White women.³⁶

Nationally, 16.2% of women initiated prenatal care late or did not receive prenatal care in 2007. In Nevada, it was 24.4%. The following table breaks down the rates of women by ethnicity/race. White women had the lowest rate for initiating prenatal care late or receiving no prenatal care for both the national average (11.1%) and for Nevada (15.4%). In every racial/ethnic category Nevada women did worse than the national average.

Table 1: Percent of Live Births with Late or No Prenatal Care (2007 data)

	Disparity Score ³⁷	All Women	White	All minority ³⁸	Black	Hispanic	Asian & NHPI	American Indian/ Alaska Native
U.S. Average	2.04	16.2%	11.1%	22.7%	23.9%	22.9%	14.7%	30.1%
Nevada	2.07	24.4%	15.4%	31.9%	30.0%	35.9%	19.8%	31.4%

Sources: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System; Health, United States, 2007. James, Cara V. et al. Putting Women's Health Care Disparities on the Map: Examining Racial & Ethnic Disparities at the State Level, June 2009.

Significant Barriers to Prenatal Care

Women who seek prenatal care are more likely to have higher incomes and intended pregnancies.³⁹ However, early care and continuous care is not readily available for some expectant mothers. Low-income and minority women are more likely to encounter barriers to access prenatal care, like the following:

- Lack of health insurance and/or financial resources
- Transportation to and from the health provider
- Lack of education about the importance of care
- Lack of family support
- Language and cultural differences
- Perinatal depression
- Domestic violence
- Poor nutrition

Lack of health insurance and/or financial resources to seek prenatal care is a primary barrier for low-income women. As a result, they tend to use prenatal care less and are among those at risk for delivering low birth weight babies. Although many of these women qualify for public health insurance coverage during their pregnancy, given the long wait times to process applications, many women are still not receiving prenatal care in a timely manner. Furthermore, given the risk and liability associated with births, most medical providers are reluctant to begin seeing new patients late in pregnancy.

POLICY RECOMMENDATIONS FOR NEVADA: PRENATAL CARE

- Fund and improve **programs and services designed to educate women** of childbearing age, targeting minority women, about the importance of routine primary care and prenatal care.
- Allow for **presumptive eligibility** for low-income women and teen mothers under the Medicaid program in order to avoid delays in seeking prenatal care.

Childhood Obesity

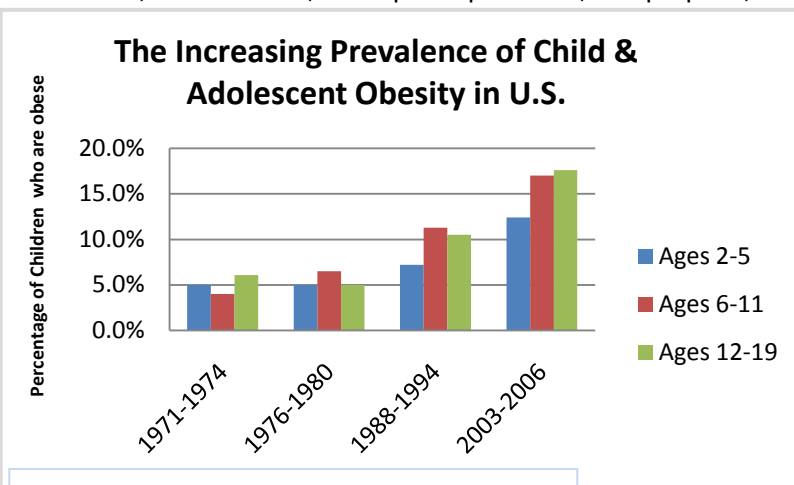
Policy Issue

Nevada ranks 23rd in the US for childhood obesity and 34% of Nevada’s children ages 10-17 are overweight or obese.

In the past three decades, child obesity has doubled and adolescent obesity has tripled.⁴⁰ Nationally, 16.4% of children and teens are obese, and an additional 31.6% are overweight.^{41,42} “Between 2003 and 2007, obesity prevalence increased by 10% for all U.S. children and by 18% for female children ...”⁴³ Nevada has not been detached from this trend. In Nevada, 15.2% of children ages 10-17 are obese, while 34.2% are overweight. Nevada policies should provide guidelines for schools and communities that promote healthy eating, physical activity and health education, in order to provide our children with the resources they need to build a healthy lifestyle.

The Impacts of Rising Childhood Obesity

Overweight prevalence in Nevada’s children has increased by 29% since 2003.⁴⁴ This is a serious problem because obese children are more likely to have a shorter lifespan and develop a variety of health problems, including hypertension, high cholesterol, liver disease, orthopedic problems, sleep apnea, asthma and more often, type 2 diabetes. They are also predisposed to be obese in adulthood.⁴⁵ Overweight children also experience consequences related to psychological stress from social discrimination and stigmatization.⁴⁶ American obesity is becoming an epidemic that costs more than \$147 billion in medical expenses in 2008.⁴⁷



Source: National Health and Nutrition Examination Survey

Factors Impacting Childhood Obesity

In general, childhood obesity is the result of an imbalance between the calories a child consumes and the calories a child uses to support normal growth, development, metabolism, and physical

activity. This imbalance results from factors including genetics, behavior, and the environment. The interaction of these variables is thought to cause obesity in children.⁴⁸ The eating and exercise habits that children form in their youth will impact their practices in adulthood which leads to obesity in adulthood.⁴⁹ Over the past several decades, physical activity for children has decreased, while access to convenience foods with poor nutritional value has skyrocketed, along with our children’s body mass. Because of budget cuts, many schools across the nation have reduced their physical education programs, leaving over 90% of schools providing less than the recommended amount of physical activity for students.⁵⁰

Furthermore, the impact of socio-demographic and behavioral factors on obesity cannot be ignored, as obesity disproportionately affects poor and minority children.⁵¹ Black and Hispanic girls statistically have higher incidences of obesity, which might be due to their increased risk of economic hardship and/or social disadvantages.⁵² A 2010 study analyzed these factors and found that “the adjusted odds of obesity or overweight [increase] significantly in relation to decreased levels of household income, lower neighborhood access to parks or sidewalks, lower levels of physical activity, and increased television viewing time and recreational computer use.”⁵³

Because the availability of local grocery stores with affordable, healthy foods correlates with the obesity level in the community, at least one state has created grants from its economic development financing to fund the building of supermarkets and farmers markets in underdeveloped, underserved areas.⁵⁴ In addition, sugar-sweetened beverages have been associated with weight gain, obesity, higher rates of diabetes and inadequate intake of important nutrients. Studies have indicated that a 10% increase in the price of sugar-sweetened beverages could reduce consumption of them by 8 to 11%. This extra revenue can be invested in public health programs.⁵⁵

Best Practices/ Efforts to Improve Childhood Obesity

A child's weight -- and accordingly her health and quality of life -- is affected by the practices and habits she forms at a young age. By supporting healthy eating, behaviors and health education, school settings can provide children and adolescents with valuable tools that will follow them into adulthood. For example, in a clinical school-based intervention program for 6th – 8th graders, the prevalence of obesity decreased among the girls who participated. This program used a randomized controlled field trial with girls from 5 schools over a 2 year period. "Planet Health" sessions were integrated into the schools' existing curricula. These sessions "focused on decreasing television viewing, decreasing consumption of high-fat foods, increasing fruit and vegetable intake, and increasing moderate and vigorous physical activity. Planet Health was designed to reduce obesity by increasing energy expenditure while promoting key dietary behaviors consistent with dietary guidelines."⁵⁶

The Centers for Disease Control (CDC) and Prevention also lists research-based strategies for obesity prevention in schools, called the School Health Index (SHI). The CDC provides a holistic approach with tips on how to implement their guidelines, changing schools into "healthy schools" that promote "health-enhancing behaviors and better health" including physical education and activity curriculums, planning guides, and 8 self-assessment modules. Currently, only 22% of Nevada schools utilize the SHI or a similar tool to evaluate their health promotion and obesity reduction policies and programs.⁵⁷

Policies promoting healthy eating and activities are also inadequate for child care centers. Nevada does have policies limiting foods of low nutritional value in licensed child care centers; however unlike most states, there are no specific meal requirement guidelines forcing menus to adhere to dietary standards. Nevada also lacks policies on vending machines that are in licensed child care centers, and has no expectations that children participate in at least moderate physical activity every day.⁵⁸

First Lady Michelle Obama has also brought national attention the childhood obesity epidemic. In response she has formed the "Let's Move!" initiative.⁵⁹ "Let's Move!" aims to raise awareness of this staggering trend while providing parents and schools with information that will help to solve the dilemma of childhood obesity within one generation. The action plan includes 70 specific recommendations in the areas of:

- Early Childhood;
- Empowering Parents and Caregivers;
- Increasing Physical Activity
- Health Food in Schools;
- Access to Healthy, Affordable Food; and

Formulating laws that address childhood obesity could help to lessen the epidemic, improve the quality of life of our children, increase their rate of learning, and lower the state's annual Medicaid bill.

Quick Facts

- In 2007, 34% of Nevada’s children ages 10-17 were overweight or obese.
- In Nevada in 2009, 35.7% of kindergarten children surveyed were either at risk of being overweight or were overweight.
- The economic consequences of obesity are great. From 1996 to 1998, Nevada’s Medicaid program spent \$56 million (10.1% of its budget) on health issues related to adult obesity.
- Evidence-based programs are available to assist communities in effectively reducing child obesity while educating children about healthy living.

~ Statehealthfacts.org: percent of children who are overweight or obese (2007); Statehealthfacts.org: State laws addressing childhood obesity, 2009; NICRP: 2008-2009 Nevada Kindergarten Health Survey; www.cdc.gov: Economic Consequences [of obesity].

POLICY RECOMMENDATIONS FOR NEVADA: CHILDHOOD OBESITY

- Encourage all Nevada schools to use the Center for Disease Control and Prevention **School Health Index** (“SHI”) to assess their policies, activities and programs in order to improve student health.
- Recommend that providers conduct **non-invasive diabetes screenings** as a part of routine health examinations for children of all ages. Report the results to parents.⁶⁰
- Increase and improve the collection of **Body Mass Index** (“BMI”) information for school-aged children and report the information to parents.^{61,62}
- Establish **minimum nutritional standards, including caloric content**, for foods sold at schools. Ban or limit vending machine sales of soda and other unhealthy snacks and replace with low fat, low calorie drink and snack options.⁶³
- Require that students spend a specific amount of **time in physical education classes** with meaningful physical activity. 54% of schools do not teach a required PE course in all the school grades. 20% do not offer opportunities for all students to participate in intramural activities or physical activity clubs.⁶⁴
- Allow portions of economic development financing to be used to **encourage supermarkets to be built in underdeveloped, underserved areas**.⁶⁵
- Create a small **snack and/or soda tax**.⁶⁶ As of January 1, 2009, 33 states had implemented a sales tax on soft drinks. The mean rate is 5.2%. Even if the tax is not high enough to deter people from purchasing them, the revenues from the taxes (which can be used for nutrition and health promotion programs, or to subsidize healthier foods) can be substantial.^{67,68}
- Establish **regulations for licensed child care centers** which require meals and snacks to follow to be consistent with Dietary Guidelines for Americans.
- Improve trail systems, sidewalks, bike paths, playgrounds and recreational facilities to provide **safe and appropriate outdoor recreational space** for children and families, with a particular emphasis on older and low income communities.
- “Enhance programmatic resources for **surveillance, monitoring, and prevention intervention research** on obesity” at the state level.⁶⁹

Child Welfare

Primary Policy Issue

A large percentage of families are struggling to provide for their children with limited resources and social support resulting in the involvement of child welfare agencies that are also under-resourced and under-funded.

The following information was adapted from the Community We Will Business Case⁷⁰ and the Child Welfare Network 2011 Legislative Policy Agenda.⁷¹

Nevada's child welfare system, like countless others across the country, is designed to protect the children of our community, ensuring they have a chance to thrive as healthy, hopeful children and grow into productive adults. It is intended to promote the safety and well-being of children by working to strengthen families at risk for abuse and neglect, ensuring the safety of children by placing them in foster care when they cannot remain safely at home, and finding them permanent families as quickly as possible when they cannot safely return to their own families.

The child welfare system is comprised of a wide variety of state, county and many different organizations and departments in the community such as: the courts, law enforcement, Office of the District Attorney, non-profit organizations, shelters, clinics, parenting support centers, and a wide array of other service providers

Prevention

When families are in trouble, and have come to the attention of the child welfare system we should invest in the family and the child by giving them the support they need to raise their own children safely. A large percentage of families are struggling to provide for their children with limited resources and social supports. In fact, a large majority of children who come into the child welfare system are there for neglect, as opposed to physical or sexual abuse.

Quick Facts:

- Low self-esteem and/or signs of depression, anxiety or antisocial behaviors. Often includes substance abuse, family history of abuse, and lack of knowledge of normal child development
- Parental substance abuse is reported to be a contributing factor for between one- and two-thirds of maltreated children in the child welfare system.
- Infants and younger children are more likely to be physically abused compared to teenagers, who are more likely to be sexually abused
- Children with disabilities (learning, chronic illness, etc.) may be at a greater risk for maltreatment because the demand to care for these children often increases the family stress, resulting in less attention or attachment with the child.

Preventing abuse and neglect and entry into foster care

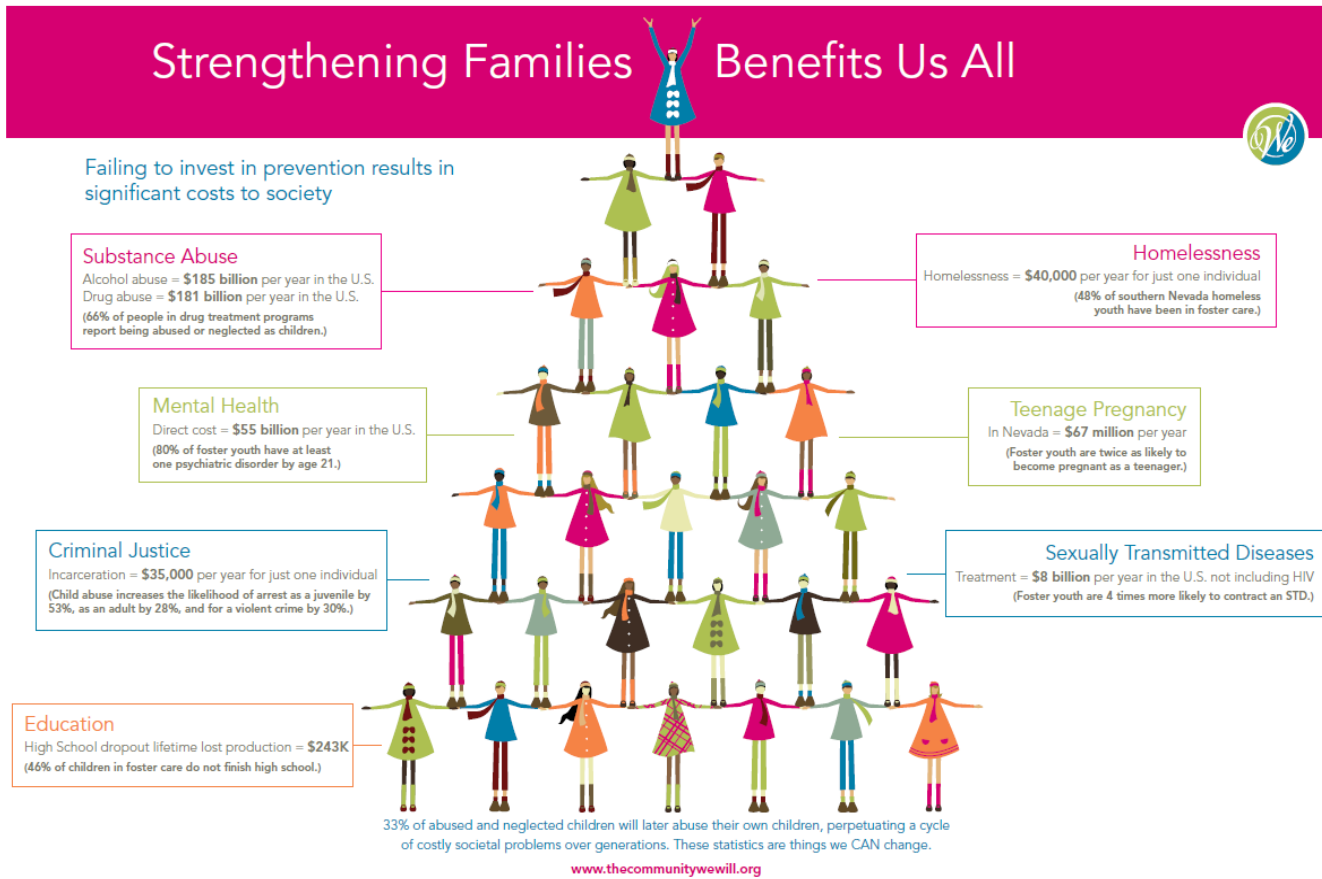
- Providing early and regular child and families screening and treatment of health and mental health issues
- Intervening early and comprehensively when families are at risk
- Wrapping at risk families with community services and supports, (e.g. housing, work force training and education programs)
- Providing education and support to parents and families
- Delivering high quality programs such as nurse family partnerships to work with new parents
- Increasing public awareness of abuse and neglect and how to prevent it
- Fully funding best practice early childhood education and intervention programs
- Ensuring access to high quality affordable day care
- Ensuring access to mental health and substance abuse programs
- Preventing teen pregnancy and providing supports for teens already pregnant or parenting

Improving outcomes for children and families in the child welfare system

- Providing high quality therapeutic care to abused and neglected children and their families to break the cycle of abuse
- Decreasing the time to permanency (which means a safe, long term home) for a child who enters foster care
- Providing support to foster parents and relative placements so that children heal and stabilize while in foster or relative care
- Increasing the continuum of services to effectively address the complex needs of children and families already involved in the foster care system
- Providing life skills training for children and adults in the child welfare system

Promoting safe exits and ensuring successful transitions for youth and families leaving the child welfare system

- Improve transitions back home by encouraging foster care providers to work with the families of the children in care (when safe and appropriate) to maintain relationships
- Connecting youth serving programs to holistically address the multiple needs of youth transitioning to adult independence
- Providing targeted wraparound services to help youth successfully transition to life on their own



foster care providers to work with the families of the children in care (when safe and appropriate) to maintain relationships

- Connecting youth serving programs to holistically address the multiple needs of youth transitioning to adult independence
- Wrap families who are parenting their children after being in foster care with services that will strengthen the family and keep children safe at home

FAILING TO INVEST IN PREVENTION RESULTS IN SIGNIFICANT COSTS TO SOCIETY.....

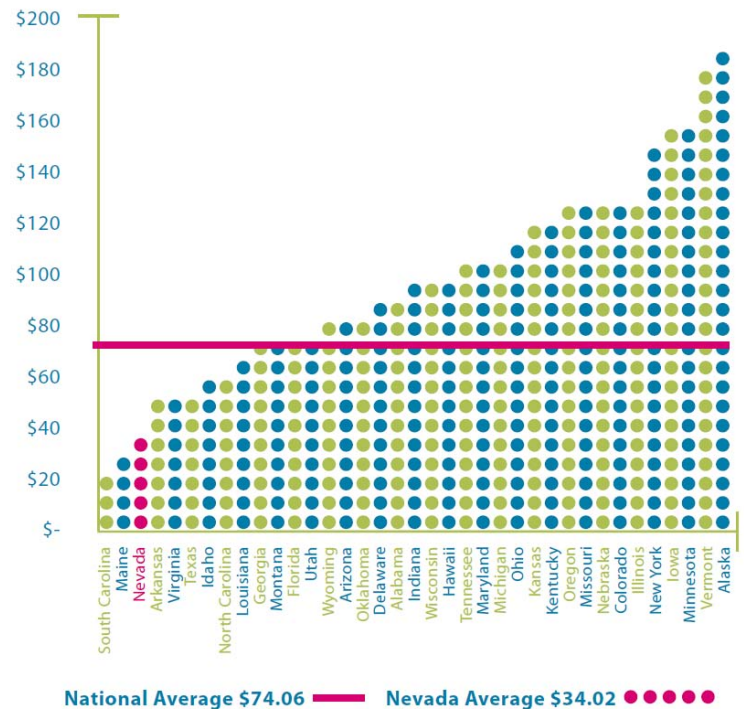
Child abuse and neglect costs United States taxpayers approximately \$103.8 billion each year, with a mere 25 percent of these costs attributable to child welfare services themselves. The remaining 75 percent of costs (\$70.7 billion) consist of indirect costs to society and involvement with other social service systems, such as the health care and criminal justice systems. Child abuse and neglect costs each Nevada household roughly \$95, for a statewide total of 79 million every year.

These serious societal problems and the costs associated with them justify a strategic, collaborative approach to strengthening families and preventing abuse. The terrible pain and trauma it causes to the child only makes the need to plan, implement and sustain reform efforts more urgent.

Nevada State Challenges in Child Welfare

States vary in regards to the amount of child welfare dollars per person; however, the national average is 118 percent greater than the amount spent in Nevada. A weakening economy, higher costs of energy and housing, increasing worker layoffs, and higher crime rates all suggest the potential for a higher marginal propensity to demand child welfare services and foster care in the near future.

Nevada’s unemployment rate is at a historical statewide high of 14.5%.⁷²This coupled with nation-leading declines in home prices and nation-leading levels of residential home foreclosure have pushed otherwise stable families into situations of crisis. Declining home values and decreased consumer spending have depleted state and local government revenues, leading to service funding shortfalls just when families need help the most. Now, arguably more than ever, our community needs to pull together to find solutions to problems that have only been exacerbated by recent economic events.



Source: Every Child Matters Education Fund, 2007

For the better part of the last 20 years, Nevada was ranked as the fastest growing state in the nation and has struggled to keep up with unprecedented growth. A 2008 Service Array Needs Assessment conducted by the Clark County’s Department of Family Services showed that:

- regardless of the service area or the specific service in question, the biggest factor impacting the ability to access services in Southern Nevada is the lack of availability relative to demand, and
- lack of information about service availability, suggesting the need for a central repository where those who need services can be matched with service providers.

Other issues and concerns repeated throughout the survey included the following:

- Long waiting lists
- Outdated agency lists
- Restrictions often preclude eligibility
- Limited program funding
- Lack of coordination & collaboration between agencies
- Lack of Preventative services
- Facilities and training are inadequate
- Programs lack structure and consistency
- Families lack of transportation

It is difficult, if not impossible, to aid families in crisis so that they may safely care for their children when we as a community are simply unable to provide the resources they so desperately need. This is what we must do together.

Return On Investment

Early prevention efforts are not novel and have proven to be a cost-effective strategy for many states and across a broad spectrum of health and human service sectors. Several studies have shown that high-quality prevention programs that provide services to at-risk parents in areas like substance abuse and mental health treatment, parenting education and training, family finances and housing assistance can produce several dollars worth of benefit for every dollar spent.

Investing in prevention translates to fewer dollars spent on foster care, welfare, juvenile justice and a host of other programs further down the road. A recent report estimates the lifetime monetary value of saving a single high-risk youth to be anywhere from \$2.6 million to \$5.3 million per youth. The average total cost of providing intensive family preservation services ranges from \$3,100 to \$10,000 per year. Compared to the lifetime cost to society for a high risk youth, this equates to a 255 to 532 times return on investment (ROI). It is important to note that not all programs produce the same results; therefore, it is imperative to carefully study evidence-based programs when designing policies to improve outcomes. The majority of recent research studies report that prevention and early intervention programs provide a healthy return per dollar of investment.

By investing additional dollars on the front end of the continuum of care, we could eventually save billions of dollars on foster care all the while supporting families, strengthening the community at large, and avoiding further childhood trauma.

POLICY RECOMMENDATIONS FOR NEVADA: CHILD WEFARE

- Develop a funding structure in Nevada that supports prevention services for children and families at risk of becoming involved with child welfare and for those who are currently involved with child welfare.
- Funding initiatives that support quality, evidence-based or promising, outcome driven
 - early intervention programs that are proven to reduce the incidence of entry into the child welfare and/or juvenile justice systems (including early home visiting programs and early childhood education programs); and
 - programs that support reunification and that meet the needs of children, youth and families to prevent recidivism into the child welfare and/or juvenile justice systems.
 - best practices to support children and youth within the child welfare system which take a comprehensive approach to meeting the current and future needs of the child.
- Adopt a foster child bill of rights.
- Establish a working group and/or interim legislative committee to review and provide recommended revisions to the language in NRS (and NAC 432B, as appropriate) to reflect a standard that is clear, and that can be implemented by all parties responsible for the removal of children from their homes. The recommended revisions of the work group/legislative committee would be introduced for consideration in the 2013 Nevada Legislative Session.
- Enhancement of Nevada 2-1-1 to ensure that the system is appropriately staffed, that all appropriate resources are available and up-to-date in the system, that staff are adequately trained to field inquiries for services, and that the system is accessible to all Nevadans via cellular phone service.

More details on these recommendations are provided in the Child Welfare Network 2011 Legislative Policy Agenda⁷³

Teen Pregnancy

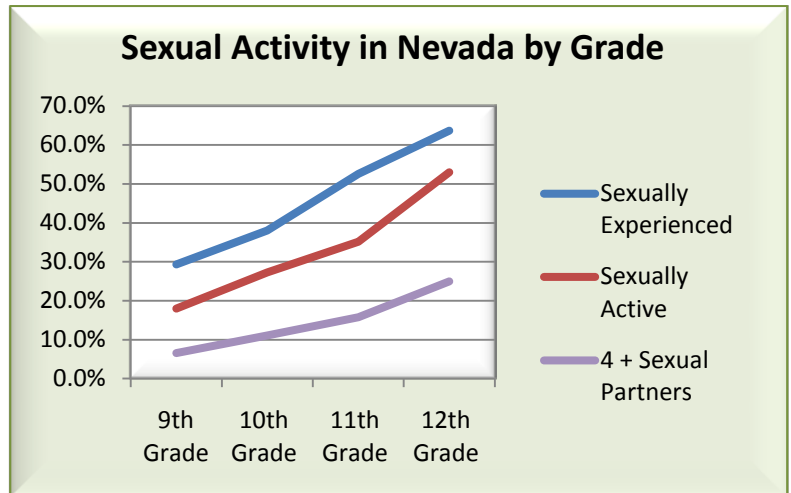
Policy Issue

Nevada has the second highest rate of teen pregnancies in the country. Ninety teenagers for every 1,000 in Nevada become pregnant every year compared to the national rate for teen pregnancies of 72 per 1,000.

Teen pregnancy is a national problem. In response to this issue, funding for teen pregnancy prevention efforts was modified in President Obama's 2010 Fiscal Year budget. A total of \$75 million in competitive grants is available for evidence-based and promising models that are either curriculum-based and teach youth about responsible behavior, relationships, and pregnancy prevention. Funding is also available for youth development programs that have the broad goal of decreasing risky behavior and teen pregnancy, permitting a variety of approaches.⁷⁴ At least an

additional \$25 million is available to develop new models. Examples of

evidenced-based programs are available through the Department of Health and Human Services. Nevada should adopt an evidence-based approach for sex education in order to reduce the high occurrences of teen pregnancies; each applicant for funds is able to choose which project suits its goals and needs.



The National Campaign to Prevent Teen Pregnancy
www.thenationalcampaign.org

Snapshot of Teen Pregnancy in Nevada

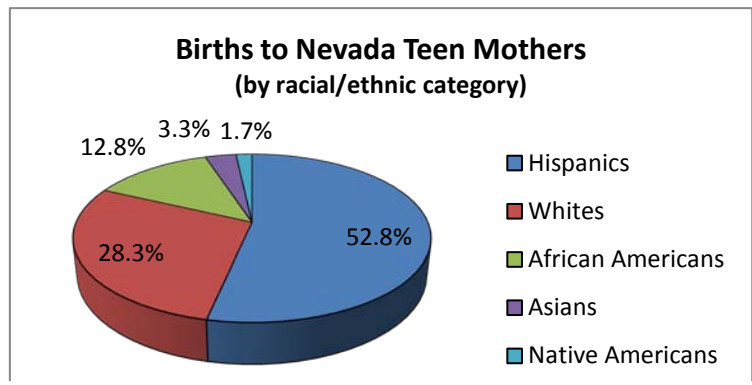
- Nevada has about 76,775 female adolescents aged 15 – 19.⁷⁵
 - Every year, about 7,070 of those adolescents become pregnant.⁷⁶
 - 35% of those teenagers become pregnant between the ages of 15 and 17.
 - Approximately 34% of pregnant teenagers have an abortion.⁷⁷
- 42.8% of Nevada adolescents report that they have had sex.⁷⁸
- 5.6% of high school students report that they had sex before the age of 13.⁷⁹
- By 12th grade, 25% of students report that they have had 4 or more sexual partners.⁸⁰
- 1/3 of high school students report that they have engaged in sexual intercourse within the previous 3 months.⁸¹

Teen Pregnancy and Low Birth Weight Babies

Pregnant women who receive too little, late or no prenatal care are at risk for costly pregnancy complications and poor birth outcomes. In particular, **teens are less likely to receive early prenatal care**, a disturbing trend as they are also more likely to have very low-birth weight infants who are at-risk for lifelong health complications.⁸² This is exacerbated by the fact that Nevada has one of the highest teen birth rates in the country.

- The 2007 national teen birth rate is 42.5 per 1,000 females ages 15-19⁸³ and the 2007 Nevada teen birth rate for the same age group is 46.3 births per 1,000 females.⁸⁴

- Teen pregnancy disproportionately affects Hispanics/Latinos, African Americans, foster children, the homeless and delinquents.⁸⁵ **Data by race reveals that Hispanic teens are at a much higher risk for teen pregnancy than other racial/ethnic teen groups.** Hispanic teen mothers, ages 15-19, have the highest teen birth rate in the country (81.7% for 2007) compared to the national average including all races (42.5%)⁸⁶. In 2007, births to Hispanic teen mothers in Nevada were 52.8% followed by whites (28.3%), African Americans (12.8%), Asians (3.3%) and Native Americans (1.7%).⁸⁷
- Approximately 40% of Nevada teen mothers ages 15 to 19 had delayed prenatal care (began in second or third trimester) or no prenatal care in 2007.⁸⁸
- Health disparities across racial/ethnic teen groups exist with white teens the most likely to have received prenatal care in the first trimester (62.7 percent), followed by Native American (60.0 percent), Asian (52.0 percent), black/African American (48.5 percent), and Hispanic (51.5 percent) teens.⁸⁹



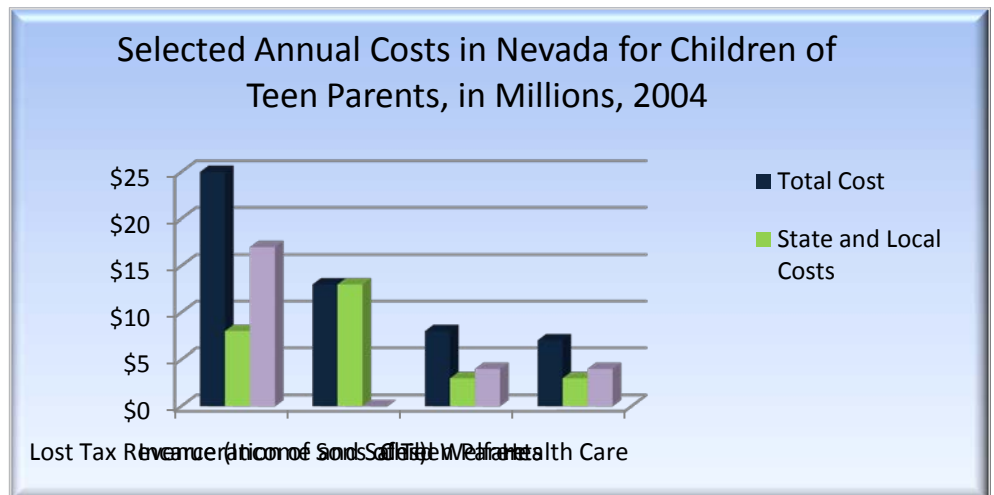
Data Source: Nevada KIDS COUNT, "Health Conditions and Health Care," <http://kidscount.unlv.edu>.

Teen Childbirth Costs

Teen childbirths cost Nevada taxpayers over \$30 million a year, with most of the costs related to the needs of the babies.⁹⁰ The younger the mother is, the greater the average costs for the state. The mean annual cost related to a child born to a mother age 17-years or younger in Nevada was \$3,040 in 2005. **Between 1991 and 2004, the teen birthrate in Nevada declined by 31%. It is estimated that just in 2004 this decrease saved Nevada taxpayers about \$37 million.**⁹¹

A cost-benefit study conducted by medical doctors concluded that compared with no prenatal care, any prenatal care saves between \$2,369 and \$3,242 per person, depending on when care is initiated. *All savings are related to reductions in the cost of caring for low-birth weight babies.*⁹² These observations suggest that significant cost-savings might be accomplished if the teen pregnancy rate is reduced and if pregnant teens were able to obtain prenatal care in a *timely fashion*.

In the United States there was a sharp drop in teen pregnancy in the early 2000s, mainly because of an increased use of contraceptives by sexually active teenagers. However, around 2005, teen use of contraceptives declined, while teen pregnancy and abortion rates quickly climbed.⁹³ This correlated with the requirement that sex education focus solely on promoting abstinence, eliminating instruction regarding options for safe sex. Additionally, studies have demonstrated the lack of efficacy of abstinence-only programs.⁹⁴



The Consequences of Teen Pregnancy

Teen parenthood also has an adverse affect on the teen mom, teen dad and the child. Teen parents are less likely to graduate from high school (, which equates to less earning power and an increased likelihood the teen parents will be impoverished.

Teen moms and their children have lower social well-being and poorer health. Teen pregnancy disproportionately affects Latinos, African Americans, foster children, the homeless and delinquents.⁹⁵ Teen moms are more likely to give birth to their babies prematurely, increasing the likelihood of birth defects, developmental problems and even death. In Nevada, 3,335 babies born to teen mothers were underweight.⁹⁶ **Children of teen mothers are also prone to experiencing abuse and/or neglect. Moreover, children who are unplanned have lower cognitive test scores, while children of teen mothers are more likely to repeat a grade.⁹⁷ The daughters of teen mothers are three times more likely to become teen mothers themselves when compared to the daughters of mothers who were age 20-21.⁹⁸**

What are the chances of a child growing up in poverty if: (1) the mother gave birth as teen, (2) the parents were unmarried when the child was born, and (3) the mother did not receive a high school diploma or GED.

- 27% of growing up in poverty if one of these things happens.
- 42% of growing up in poverty if two of these things happen.
- 64% of growing up in poverty if three of these things happen.

7% OF GROWING UP IN POVERTY IF NONE OF THESE THINGS HAPPEN.

(Zill, N., & O'Donnell, K. (2004). Child Poverty Rates by Maternal Risk Factors: An Update. Unpublished manuscript. WFSAT. Rockville, MD).

Adolescents in Nevada should be provided with the information they need to make informed, smart decisions regarding their sexual activity in order to prevent pregnancy, the transfer of diseases and to determine emotional preparedness. Currently, sex education is required in all public schools in Nevada, however, the type or extent of sex education is not specified. NRS 389.065 only requires that a school provide “[f]actual instruction concerning acquired immune deficiency syndrome; and instruction on the human reproductive system, related communicable diseases and sexual responsibility.”⁹⁹

This information has not been enough, as is evidenced by Nevada’s high teenage pregnancy rate. In 2006, Nevada had the second-highest teen pregnancy rate after New Mexico; 90 female adolescents for every 1,000 in Nevada between the ages of 15 and 19 became pregnant.¹⁰⁰

Prevention Efforts

Preventing pregnancies among teenagers can save taxpayers millions of dollars in childbirth costs and can prevent undesirable consequences like teens dropping out of school and low-birth weight babies. Funding family planning programs and increasing access to contraceptives and teen-friendly reproductive health care services, without the consent of a parent or guardian, can eliminate a barrier to teens that often do not use protection because they may not want their parents to know of their sexual activity.

- ***It is estimated that national public funded family planning programs prevents 385,800 unintended pregnancies among teens ages 15 to 19 annually, avoiding 154,700 teenage births and 183,300 abortions.***¹⁰¹

Moreover, it is not enough to increase access to contraceptives and health services. Disseminating accurate and complete information on abstinence, sexual diseases, and *contraceptive options* is also necessary. Twenty-eight teen pregnancy prevention programs that underwent rigorous screening by the Department of Health and Human Services were determined to be eligible for replication and funding. “Of those programs, 20 had evidence of impacts on sexual activity (reductions in sexual initiation, number of partners, or frequency of sexual activity), 9 on contraceptive use, 4 on

STDs, and **5 on pregnancy or births.**¹⁰² The approved programs are available for a variety of settings such as middle schools, high schools, community-based organizations or clinics. These programs are also available for a broad range of populations to meet community and organizational needs.

POLICY RECOMMENDATIONS FOR NEVADA: TEEN PREGNANCY

- Allow for **presumptive eligibility** for pregnant teenagers under the Medicaid program in order to avoid delays in seeking prenatal care.
- Disseminate **accurate and complete information** to teens on abstinence, sexual diseases, and contraceptive options.
- **Increase access** to contraceptives and reproductive health care.
- **Fund pregnancy-prevention programs and services designed to educate teens** on the responsibilities that come with having a newborn baby and potential consequences on both the overall well-being of the child and teen mother.
- Support and implement **sex education programs that have proven results** and that engage the teenagers and help them see the benefits of avoiding risky sexual behaviors and delaying parenthood.¹⁰³
- Enhance services and community-based, clinic, and pregnancy prevention programs designed to **educate minority youth and women of childbearing age about the importance of routine primary care and prenatal care.**
- **Fund youth programs** that keep youth involved in school and focused on positive life options.

Children's Mental Health

Primary Policy Issue

Statewide, there are inadequate community based services for youth with behavioral health problems including a lack of crisis intervention program. Also, there are inadequate community-based services for these youth in the juvenile justice system – services that would improve quality of life and reduce recidivism. Wraparound services need to be made available to all youth with behavioral health issues.

Death of Services for Mentally Ill Children in Nevada

In Nevada, many youth across the state are battling serious behavioral health problems such as depression and substance abuse, in particular prescription medication abuse (refer to Child Death section) and methamphetamine use. These serious behavioral health problems, if not address can lead to devastating outcomes such as attempted and/or completed suicide. This section will only address two issues related to children's mental health in detail, use of emergency rooms for behavioral health problems, and mental health problems within the juvenile offender population.

Use of Emergency Rooms for Children's Behavioral Health Problems

Due to lack of availability of appropriate services, over the last few years, hundreds of children have been warehoused in UMC's pediatric units, sometimes for months, while waiting for appropriate care. One-third of these children are between the ages of 10 and 14. 52.6% of the youths seen in emergency rooms are discharged without any immediate treatment. **Nearly half of the children discharged home are psychotic, suicidal or depressed at the time of their admission.** Over half of the youths admitted to emergency rooms for behavioral health crises are uninsured or on Medicaid, and these children spend almost twice as long in the emergency room as those children with commercial insurance benefits.

In Nevada, the number of youths entering emergency rooms for behavioral health problems has nearly doubled in the last 4 years. The National Center for Children in Poverty has identified youth emergency room visits for behavioral health care as a national problem. Over the past decade, child mental health-related visits to hospital emergency rooms have significantly increased across the United States and are symptomatic of the lack of community-based crisis services for children and youth behavioral health disorders.

For the past four years, in collaboration with the Southern Nevada Health District, the CCCMHC has been monitoring this increasing trend of children being admitted to emergency rooms for mental health issues. Over the past two years, at least 7 local emergency rooms have participated in a voluntary tracking system to provide data on the reason for such admissions, the demographics of the admissions, and the post-discharge disposition for these admissions.

Results indicate that increasing numbers of children were being admitted to local emergency rooms for behavioral health problems without any significant benefits to the children in need. Children with severe emotional disturbances need a cost-effective, efficient alternative where they can be received for assistance.

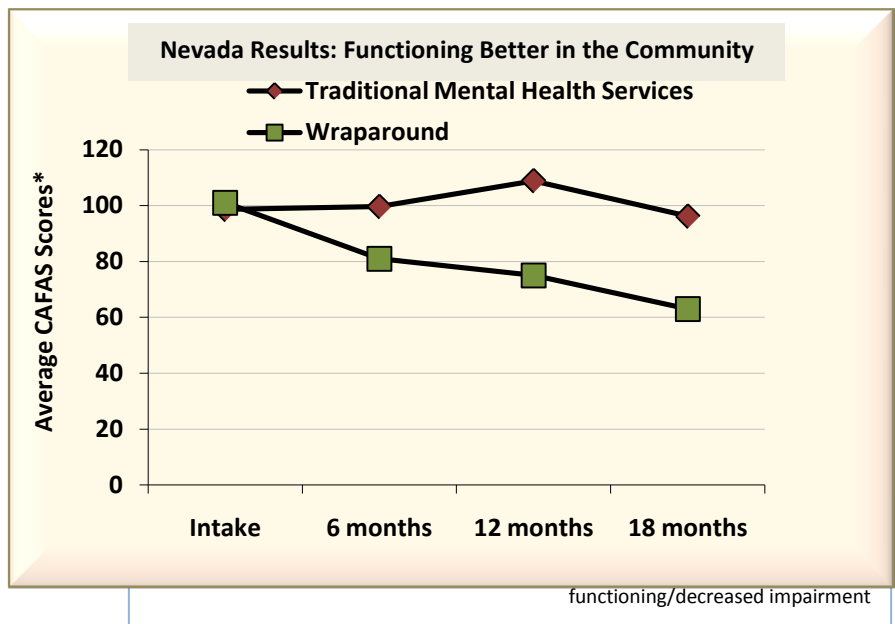
A crisis intervention program needs to be established in Southern, Northern and Rural Nevada for children with serious behavioral health problems. Such a program would provide these children with access to crisis services proven effective in preventing emergency room visits and reducing the need the inpatient psychiatric hospitalization.

Established in 2001, the Clark County Neighborhood Family Service Centers help children with serious emotional disturbances. It received its support from a 6-year, \$7 million Children’s Mental Health Services Community Initiative Grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. A local team of state and county managers administers the five centers which provide a range of behavioral health and social services to children and families in metropolitan Las Vegas. Participating agencies include: the Division of Child and Family Services, Health Division, Clark County Family Services, Clark County Juvenile Justice Services, and the Clark County School District. These centers have proven effective in improving the lives of children involved in the mental health and child welfare systems by using evidenced models such as the wraparound model of service delivery endorsed by the Child Welfare League of America.

These centers need to be strengthened and implemented statewide and although the Neighborhood Family Service Centers are available for ongoing treatment, a crisis intervention program is still needed.

The Benefits of Wraparound for Mentally Ill Juvenile Offenders

Youths in the Nevada juvenile justice system need access to holistic mental health services. About half (7,500) youths involved yearly with the juvenile justice system have a serious behavioral health problem. Juvenile delinquents in Clark County with serious emotional disturbance are likely to be repeat offenders but often do not get the clinical treatment that would be effective in reducing recidivism. It has been demonstrated in clinical studies that wraparound services for these juveniles are more effective in addressing and improving social, behavioral and emotional functions, and reducing self-destructive behavior than traditional mental health services.



Since 2002, the Clark County Children’s Mental Health Consortium has been studying the needs of youth involved in the county’s juvenile justice system and made recommendations to increase community-based services for this population. Youths and their families continue to have difficulty accessing the behavioral health services they need to remain at home. Youth with serious behavioral health disorders who need intensive community supports are of greatest concern. Across the nation, a wraparound approach with these youths has been found to relieve the symptoms of serious behavioral health disorders, reduce recidivism, and improve academic performance.

Traditional mental health (TMH) services have only short-term results for youth. “Placing youth in highly restrictive residential and psychiatric hospitals where they are safe is an expedient response, but youth in these settings still run away, are promiscuous, engage in self-destructive behavior, and have access to substances to abuse. Further, when youth are returned to the community, most therapeutic gains are not maintained.”¹⁰⁴

Quick Facts

- About 1 in 10 adolescents suffer from a severe mental illness.
- Few juvenile delinquents are able to access intensive care management or other community-based supports currently available through the Nevada Division of Child and Family Services and the Nevada Medicaid Program.
- In 2008, an unprecedented number of youth were in out-of-community placements in 2008.
- In a 2009 survey, caseworkers, families, and providers rated the current the current system as failing to provide coordinated care management for children with serious emotional disturbance.

An alternative approach to TMH is Wraparound in Nevada, also called WIN. *Wraparound is the practice of “wrapping multiple services around the family in a coordinated effort as specific needs require, rather than finding ways to fit families into predefined service categories.”*¹⁰⁵ Wraparound has been implemented in Nevada within the child welfare system with success. The approach is based on the premise that if families’ basic needs are met, they will experience comprehensive improved functioning and positive outcomes.

Many projects around the country have utilized the wraparound approach, and reported “improved school, social, emotional and behavioral functioning for children and youth and improved quality of life,” in addition to reduced “number of days in” and reduced “level of restrictiveness” of residential placements.¹⁰⁶ In a randomized control study in Nevada, youth with severe emotional disturbance (SED) who received WIN showed enhanced scores on the Child and Adolescent Functional Assessment Scale “when compared with youth receiving traditional child welfare case management.”¹⁰⁷ These results have been reproduced in other states.

POLICY RECOMMENDATIONS FOR NEVADA: CHILDREN’S MENTAL HEALTH

- Increase funding of the **Mental Health Services Block Grant** by at least \$100 million to support the safety net and improve availability and accessibility to services.
- Increase funding for **Medicaid and SCHIP reimbursement**, without undue barriers to coverage.
- Develop additional funding sources to **support community based mental health services** for children and families, particularly evidence-based services and capacity building aimed at preventing entry into the system (child welfare, juvenile justice or other).
- **Raise availability of programs** and facilities to avoid influx of mentally ill children in emergency rooms
- Improve **federal funding streams** to provide access to community based mental health services for youth without insurance.
- Support the **continuation of Statewide Family Networks** which are peer education and support programs in each state funded by SAMHSA.
- A **local systems management entity and financing plan** needs to be developed to support the management of the Clark County Neighborhood Family Services Centers and other core services for children with serious emotional disturbance. The Clark County Children’s Mental Health Consortium

should be strengthened to play a key role in overseeing the local management entity.¹⁰⁸ The following is needed for ***effective management***:

- (1) staff support for the local team administering the centers;
 - (2) mechanism or authority to pool funding to support essential behavioral health care functions and
 - (3) one organization to provide facilities management for all five centers.
- Funding is recommended to ***develop a wraparound program for at least 100 youths*** with serious behavioral health disorders in the Clark County Juvenile Justice System. Such a program will improve outcomes for these youths and reduce the high costs of out-of-community residential care.

Note: The Clark County Children's Mental Health Consortium contributed to this section.

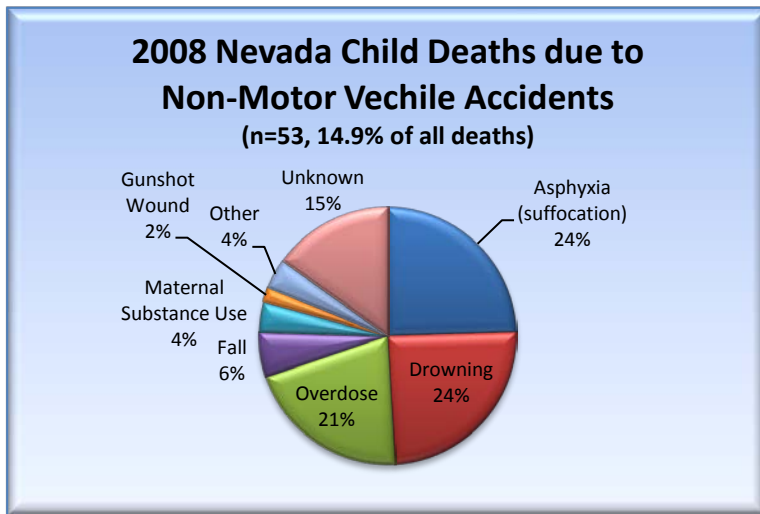
Child Death Prevention

Policy Issue

Unintentional injury and death in children is completely preventable. The primary causes of these injury related deaths in recent years are drowning in children ages 1 to 4 years and drug overdose in children ages 15 to 17. While other causes of death may show similar statistics these two causes have clear policy implications that may help to reduce the number of injury related deaths in children in Nevada.

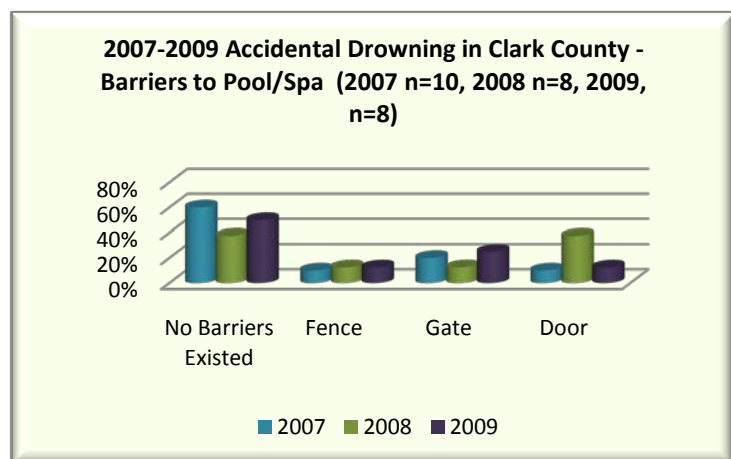
Local child death review teams in Nevada review child fatalities and record information about the circumstances of these deaths. This information is entered into a national database and the State Executive

Committee to Review the Death of Children uses this local data to compile an annual statewide report. According to the 2008 Statewide Child Death Report, the leading cause of non-natural deaths in children are non-motor vehicle related accidents at 14.9% of all child deaths. Within this category, drowning and overdose are among the top three causes of death and represent 45% of all of these deaths.



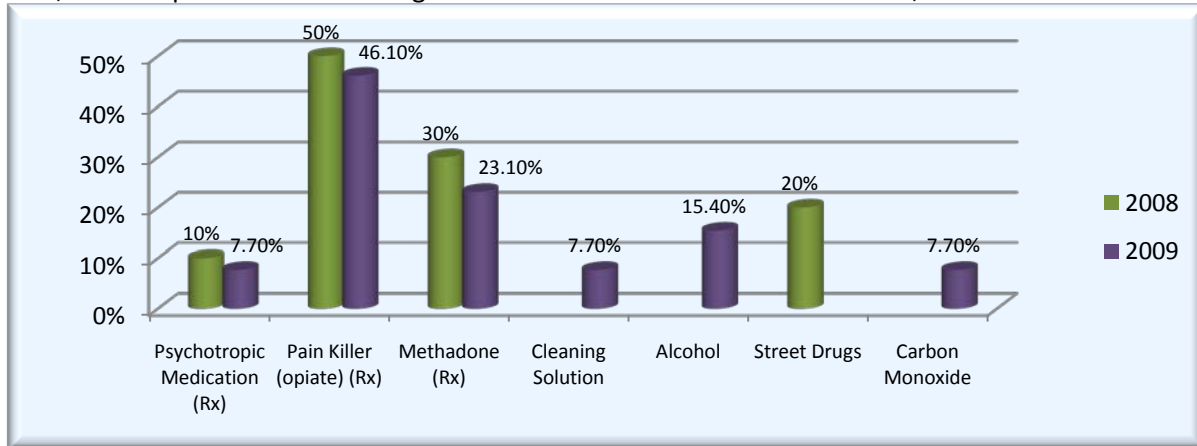
Accidental Drowning

According to the 2008 Statewide Child Death Report, 24% of all accidental child deaths not related to a motor vehicle were due to drowning. Nearly all drowning deaths in the state occurred in Clark County in 2008 (92%), and 75% of these deaths were among children ages 1 to 4 years. According to the Annual Report of Child Deaths in Clark County for 2009, 73% of drowning deaths were children ages 1 to 4 years and the majority occurred in a pool, hot tub or spa. In addition in 50% of the cases in Clark County in 2009 no barrier to the water existed, and in the other 50% with a barrier, children were able to breach the barrier because they were left open or unlocked. These statistics underscore the importance of proper supervision and layers of secure barriers around pools and spas in Nevada.



Accidental Overdose

The other leading cause of unintentional injury leading to death is accidental overdose. In 2008 there were 11 cases in the state (90% in Clark County) and in 2009 there were 13 cases in Clark County alone. According to Clark County data these deaths are most common among children between the ages of 15 to 17 years, which in 2009 represented 69% of all of these deaths in Clark County¹⁰⁹. The majority of these deaths were due to an overdose of prescription medications, primarily opiate based pain killers (46%) and methadone (23%). The prescriptions for these medications were not issued to the decedents in any of the cases reviewed, and this problem is increasing with a 300% increase from 2007 to 2008, and another 34% increase



from 2008 to 2009. Additionally in 2009, 69.2% of decedents had a history of substance abuse, while in only one third of those cases the child received treatment.

With the dramatic increase in these incidents in recent years – this is a serious issue of concern in our community. The primary issue at hand is access to prescription medications as well as limited resources for substance abuse treatment for youth.

Quick Facts:

- The number of unintentional injury deaths in Nevada for children ages 0-17 for the period 2000 – 2005 was 594; that is an average of 99 deaths per year.
- Children less than 1 year of age and those 15 to 19 years of age had the highest death rate of all age groups (38.3 and 36.3 per 100,000 population, respectively, years 2000-2005).

Specific Policy Recommendations for Nevada

Drowning Prevention

- **Create statewide polices on protective barriers for pools/spas**
- **Review Southern Nevada codes** regarding the specific exception to access barriers as long as the spa has a lockable cover, as well as issues related to pools constructed before the code was enacted.
- The County Assessor’s office or the Real Estate agency could be required to **mail information on how to create a safe pool environment** for children (only for houses that have pools) being that 80% of fatal drowning incidents were in a pool or spa.

Overdose Prevention

- Improve /*enhance substance abuse treatment* options for youth ages 14-17. More than 69% of youth who died from an accidental overdose in 2009 had a history of substance abuse and only one third of those received any treatment.
- Require *pharmacies to include information with prescriptions* about the dangers of the use of prescription drugs for recreational purposes. Include importance of securing and tracking drugs as well as information about options for proper disposal of unused medications.

Overall Prevention

- Update existing statute that governs child death review to at minimum expressly allow the use of de-identified data collected for child death review for *research and prevention* purposes to ensure that this valuable data can be analyzed and used in research.¹¹⁰

Girls in the Juvenile Justice System

Primary Policy Issues

The sexual exploitation of female children and adolescents in Nevada has increased as Las Vegas continues to be a major destination for prostitution. In addition, the number of girls in the juvenile justice system overall has outpaced the number of boys. Programs and rehabilitation facilities specifically geared to address the unique needs of underage prostitutes and delinquent girls need to be provided.

Child prostitution and trafficking is common in Las Vegas, and its victims pay a devastating price. Although there is consensus that child prostitutes are victims, services for these sexually exploited girls are minimal, necessitating that they be treated more like delinquents than victims, limiting their treatment and recovery. In addition, research has shown that girls are the fastest growing segment entering the juvenile justice system, as arrests for girls over boys has increased exponentially¹¹¹; simultaneously, girls in the system often have specific and more complex health, emotional and psychological needs that are not addressed by the programs in place for male offenders. Black and Hispanic girls also represent a disproportionate number of these victims: in 2006, African American girls comprised 14% of the school population and 33% of girls' detentions population. (Hispanic girls were 38% of the school population and 23% of the detention population.) Sexually exploited girls arrested in Clark County also receive harsher penalties than juveniles arrested for other misdemeanors.¹¹² Ignoring the needs of these girls perpetuates their victimization.

Rehabilitation for Sexually Exploited Girls

Because of the paucity of local services, often the Courts handling underage prostitution cases are forced to keep the children and adolescents in detention for an extended length of time because of a lack of alternative protected locations. While awaiting placement, in 2006 the average length of stay in detention for girls in Clark County was 17.2 days while the average length of stay for girls in Caliente was 43.8 days.

There are no comprehensive programs or shelters to help rehabilitate victims of child trafficking and/or prostitution, to teach them self-respect, to provide them with support and skills, and to protect them and help them find another way of life. "... [T]he reality is most of these girls don't make it out. And without more resources to help them, the vicious cycle of abuse will continue."¹¹³

"...the reality is most of these girls don't make it out. And without more resources to help them, the vicious cycle of abuse will continue."

~ Colleen McCarty,
Investigative Reporter: 8 News Now

Shared Hope International conducted a national sex-trafficking study, surveying the volume of sex trafficking in major cities. Out of the cities surveyed, **Las Vegas had the most victims, with approximately 150-200 child prostitutes apprehended per year, costing Clark County over a half million dollars a year to detain them.**¹¹⁴ As a result, the regulations in Nevada penalizing those who corrupt young girls have appropriately been made more virulent. Because of the law that Gov. Gibbons passed in June 2009, Nevada now has the most severe punishments in the country for those convicted of prostituting children.¹¹⁵ Now Nevada needs to improve its prevention and rehabilitation programs, to assist the vulnerable potential victims, and those girls who have already suffered.

In a study that surveyed girls in the Clark County Juvenile Detention Center, suggested programs for delinquent girls included: counseling, parenting programs, prostitution programs, drug and alcohol treatment, self-esteem programs, more physical activity, GED programs, more structured activities like cards and games, work skills programs and gang intervention.¹¹⁶ We anticipate that these needs are common in juvenile detention centers state wide.

Quick Facts

- Delinquent girls exhibit higher levels of psychopathology and family dysfunction, higher suicide risks, are more likely to suffer from trauma, unwanted sexual contact, substance abuse, involvement with other deviant peers, high-risk sexual behavior, STDs, and co-morbidity in mental health problems.
- 64% of females in detention report being sexually abused while only 18% of males report the same.
- The average daily population of girls in detention in Clark County for January through May 2007 was between 24 and 33. The capacity of the girls' detention unit is 24.
- In 2006 approximately 11 beds per day in the detention center were occupied by girls with prostitution-related charges. The average length of stay for this population was 19 days.
- About 60% of the girls detained for prostitution related offenses are from outside Clark County.
- In 2006 it cost Clark County approximately \$540,094 to detain girls for prostitution-related charges.

Policy Recommendations for Nevada: Girls in Juvenile Justice

- Provide **parenting classes** for pregnant teens who are in detention.
- Create community-based gender-responsive **detention alternatives** as an effective way to reduce inappropriate detention of girls and promote community relationships that can reduce detention returns. The program should increase girls' appearance in court and prevent re-offenses.
- The Department of Juvenile Justice should consider hiring a juvenile probation officer to serve as **case expeditor** to facilitate court processing and placement of girls in the community with support services.
- Formal court **conferences immediately prior to the detention hearing** should be instituted to provide parties a formal, routine way to meet and plan for girls' release from detention. Court conferences should be instituted as a formal part of the court proceedings to expedite release from detention.
- All JJ **data should be generated by gender, cross-referenced by race and ethnicity**. Gathering this level of data is important to monitoring the implementation of the Girls Work Plan and identifying additional issues as they arise.
- The state should **conduct a focused study on the impact of the juvenile justice process** on African American girls. A study of this population, including community asserts, and needs, and probation services and approaches would help identify solutions.
- There are **no residential facilities for domestic trafficked minors who are pregnant**. Neither Caliente, the state correctional facility, nor foster homes will take girls who are past their sixth month of pregnancy. Girls can stay in the WestCare residential facility but it is not secure, and they cannot continue with the WestCare GIRLSS program once they have had their child, although they can continue to stay in the residential facility.
- **Training on domestic minor sex trafficking** should be available and made a priority among all groups in the system (e.g., law enforcement, public defenders, district attorneys, probation and parole officers, juvenile counselors, Child Protective Services (Department Family Services /Division of Child and Family Services), therapists, service providers, outreach workers).

- There are no prevention programs in place in the Las Vegas school system to **educate children** on the harms of recruitment into prostitution by pimps. The community of Las Vegas would benefit from school education programs that outline the risks of prostitution including a focus on the recruitment tactics of traffickers/pimps and how to access resources.
- Strategies for **conducting victim-centered trials** (e.g. video-taping testimony, interviews by trained forensic psychologists, pre-adjudication therapeutic services) and protecting sexually traumatized children should be incorporated into all cases involving domestic minor sex trafficking.
- **Higher bail should routinely be set for perpetrators** of domestic minor sex trafficking.
- Engaging in prostitution with a child under 16 should be a **strict liability crime**. This act is technically statutory sexual seduction. However few, if any, buyers of prostituted juveniles are being charged under this statute. Enacting a charge against the buyer will demonstrate that prosecutions of sexual abusers are a priority in Nevada.¹¹⁷

*Recommendations adapted from Shared Hope International, The National Report on Minor Sex Trafficking: America's Prostituted Children, May 2009.*¹¹⁸

Data Infrastructure

Policy Issue

Policies and technology for the collection and sharing of data need to be improved in order to allow seamless data sharing among county and state agencies. A de-identified, comprehensive childhood database should be maintained and made available to the public to provide data for general research, grant writing, needs and best practices assessments and policy research.

Like many other states, Nevada faces challenges in the areas of children’s well-being, poverty, healthcare, and policy. These challenges, however, are particularly pressing in Nevada. Recent cross-national surveys rank Nevada near the bottom on issues such as children’s health insurance, immunizations, and student achievement.¹¹⁹ The distribution of children’s services and resources is somewhat fragmented throughout the state. This fragmentation presents significant challenges for policymakers, researchers, and state agencies working to meet the needs of children in the state. Resource and data availability are barriers to addressing these issues.

Data Accessibility

Childhood data is an important informational and analytical asset for all individuals and organizations who are interested in advancing early childhood education, policy, and welfare, such as public health officials, legislators, and researchers. Early education programs and policy depend upon the availability of accurate and timely data. To increase the efficiency of data reporting and collection, a centralized database is necessary. Increasingly, modern early childhood and public health policy and practice require advanced computer-assisted technology to serve the diverse needs of the public. A myriad of data are collected on a regular basis by state, federal, and private organizations. These data collection efforts usually involve the collection and reporting of specific type of data (e.g., health data, child welfare data, juvenile justice data, etc.). As a result, most state and federal databases are parsed in terms of type of information they gather, share, and provide. If an individual, a policy-maker, or a researcher needs to access certain early childhood data, they may need to access several data reporting agencies or databases instead of having the option to come to one comprehensive database for data needs. These data searches may be time ineffective and may not produce the desired result. The advances in early childhood education and welfare, children’s public policy, research, and needs assessments would be well-served by an effort to gather, store, and make available a wide variety of information, including, but not limited to health, welfare, and education-related data.

Currently, there is a gap in early childhood data provision for research, grant writing, needs and best practices assessments, and policy research. This gap demonstrates the need for an early childhood database that is available to the public ... The availability of this data could also improve cross-system, evidence-based, community prevention and intervention services.

POLICY RECOMMENDATIONS FOR NEVADA: DATA INFRASTRUCTURE

- Develop policies which will allow targeted data sharing among agencies which serve children and youth populations such as education, child welfare, juvenile justice, mental health, homeless youth providers, and other related agencies while protecting the youth's confidentiality.
 - Amend policies to **allow for limited access data sharing** improving the provision of appropriate services.
 - Establish stable and secure **funding sources for information technology** which allows data to be tracked, shared and analyzed to support evidence-based program enhancements.
- Mandate that public agencies collecting data report to the state in an electronic format at specific time intervals. Some examples of data needed are the following:
 - **Homelessness status** in early childhood
 - Nevada **SCHIP use** by 0-to-8 population
 - **Early Childhood Education Centers** and Home Care (number, utilization, price, etc.)
 - **Child welfare data** for the 0-to-8 population (e.g. placement, adoption, case load/ status)
 - **Zip code-specific data** in Immunization rates, Insurance coverage, family income
- Change the State of Nevada Demographer data to include date of birth for each individual. Reason: Currently, children are not even separately identifiable, as they are lumped in with the family unit.
- Develop incentives for agencies to collaborate and share information such as the creation of an **online database with de-identified data** readily available.
- Create more lenient laws regarding the use of data for research.

LEGISLATIVE COMMITTEE & CONTACT INFORMATION

Assembly Standing Committees

Commerce and Labor	Atkinson, Conklin, Bustamante Adams, Carlton, Daly, Horne, Kirkpatrick, Ocegüera, Ohrenschall, Segerblom, Ellison, Goedhart, Grady, Hardy, Hickey, Kite
Education	Bobzien, Dondero Loop, Aizley, Anderson, Diaz, Flores, Mastroluca, Munford, Neal, Hansen, Kirner, McArthur, Stewart, Woodbury
Legislative Operations and Elections	Segerblom, Flores, Conklin, Daly, Horne, Kirkpatrick, Ocegüera, Ohrenschall, Smith, Goicoechea, Grady, Hardy, Hickey, McArthur, Stewart
Government Affairs	Kirkpatrick, Bustamante Adams, Anderson, Benitez-Thompson, Flores, Munford, Neal, Pierce, Ellison, Goedhart, Livermore, Stewart, Woodbury
Health and Human Services	Mastroluca, Pierce, Benitez-Thompson, Brooks, Carrillo, Flores, Frierson, Hogan, Smith, Goicoechea, Hambrick, Hammond, Livermore, Sherwood
Judiciary	Horne, Ohrenschall, Brooks, Carrillo, Daly, Diaz, Dondero Loop, Frierson, Segerblom, Hammond, Hansen, Kite, McArthur, Sherwood
Natural Resources, Agriculture, & Mining	Carlton, Hogan, Aizley, Anderson, Bobzien, Bustamante Adams, Munford, Pierce, Ellison, Goedhart, Hansen, Kite, Livermore
Taxation	Kirkpatrick, Munford, Anderson, Benitez-Thompson, Bustamante Adams, Flores, Neal, Pierce, Ellison, Goedhart, Livermore, Stewart, Woodbury
Transportation	Dondero Loop, Frierson, Brooks, Atkinson, Benitez-Thompson, Carrillo, Diaz, Hogan, Neal, Hambrick, Hammond, Kirner, Sherwood, Woodbury
Ways and Means	Smith, Conklin, Aizley, Atkinson, Bobzien, Carlton, Hogan, Mastroluca, Ocegüera, Goicoechea, Grady, Hambrick, Hardy, Hickey, Kirner
Legislative Operations & Elections	Segerblom, Flores, Conklin, Daly, Horne, Kirkpatrick, Ocegüera, Ohrenschall, Smith, Goicoechea, Grady, Hardy, Hickey, McArthur, Stewart

Senate Standing Committees

Commerce and Labor	Schneider, Breeden, Copening, Parks, Halseth, Roberson, Settlemeyer
Finance	Horsford © Leslie (VC), Denis, Parks, Cegavske, Kieckhefer, Rhoads
Government Affairs	Lee (C), Manendo (VC), Schneider, Raggio, Settlemeyer
Education	Denis (C), Kihuen (VC), Leslie, Wiener, Cegavske, Gustavson
Judiciary	Wiener (C), Copening (VC), Breeden, Kihuen, Gustavson, McGinness, Roberson
Legislative Operations, etc	Parks (C), Denis (VC), Horsford, Cegavske, Settlemeyer
Natural Resources	Manendo (C), Parks (VC), Lee, Rhoads, Roberson
Revenue	Leslie (C), Horsford (VC), Denis, Schneider, Halseth, Hardy, McGinness
Health & Human Services	Copening (C), Wiener (VC), Kihuen, Leslie, Hardy, Kieckhefer,
Transportation	Breeden (C), Schneider (VC), Lee, Manendo, Halseth, McGinness, Rhoads
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