

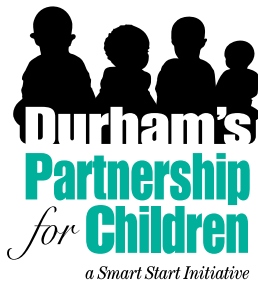


A Community Plan: Durham County's Strategic Plan for Infants and Toddlers

FULL REPORT

Durham's Partnership for Children, a Smart Start Initiative

2009



DURHAM COUNTY'S STRATEGIC PLAN FOR INFANTS AND TODDLERS A Community Plan

Introduction

Over the past decades, there has been an explosion of knowledge in the science of early childhood and brain development. Recent research in neuroscience, child development, and infant psychiatry have found that rapid brain development during the period from birth to age three establishes a critical foundation for healthy subsequent development. These findings confirm that at no time in a child's life is the nature of the environment, and especially the earliest relationships, more crucial than during the infant and toddler years. Essential capabilities related to cognition, language acquisition, emotional regulation, and interpersonal relatedness are developed through a continuous interplay of biology and experience.

Based on this foundation of evidence, researchers are now able to present a unified framework that can guide early childhood policies and practices that is grounded in a combination of cutting-edge neuroscience, developmental-behavioral research, and program evaluation. This research tells us that:

- **Early experiences** determine whether a child's **developing brain architecture provides a strong or weak foundation** for all future learning, behavior, and health.
- How young children **feel** is as important as how they **think**, and **how they are treated** is as important as **what they are taught**, particularly with regard to their **readiness to succeed in school**
- Healthy early development depends on **nurturing and dependable relationships**.
- **Substantial scientific evidence** indicates that poor nutrition, infections, neurotoxins, and chronic stress can **harm the developing brain**.
- Significant **parental mental health problems, substance abuse, and family violence** impose **heavy developmental burdens** on young children.
- If we really want to enhance children's **readiness to succeed in school**, then we must pay as much attention to their **emotional health and social competence** as we do to their **cognitive abilities and academic skills**.

And finally, for those members of a community that are concerned about the long-term outlook of a community, we must **enhance the value of our investments** in early childhood development, if we really want to **secure a promising economic, social, and political future** for our country.¹

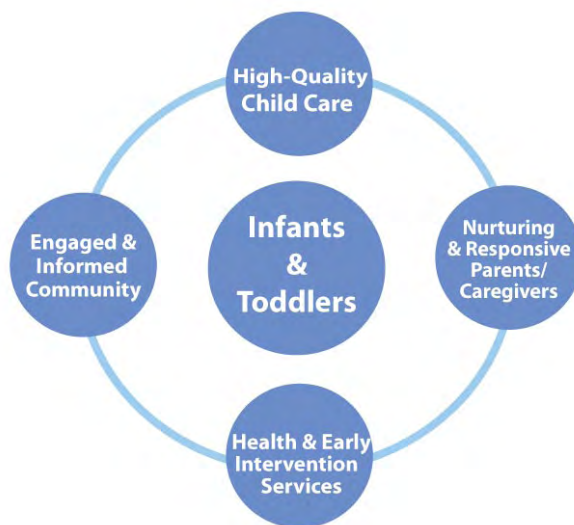
James H. Heckman, Ph.D., the 2000 Nobel Laureate in Economics, summarizes the urgency and motivation for this work: *"Policies that seek to remedy deficits incurred in early years are much more costly than early investments wisely made, and do not restore lost capacities even when large costs are incurred. The later in life we attempt to repair early deficits, the costlier the remediation process."*

¹ Adapted from - Center on the Developing Child at Harvard University (2007). *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*. <http://www.developingchild.harvard.edu>

Community Planning Process

Through the leadership of Durham's Partnership for Children, multiple community partners came together to develop a community developed and implemented plan that would accomplish two primary goals:

1. To assess the current status of infants and toddlers and their families in Durham; and
2. To develop a plan and framework for collaborating, seeking funding and aligning the community to ensure the healthy development of infants and toddlers and their ultimate success in school.



This process involved multiple meetings over a period of six months that included the analysis of various demographics, outcome measures, and other pertinent statistics to construct a complete picture of our youngest community members and their families. Another component of this process was to identify the strengths and resources available in Durham, which were found to be significant and yet not sufficient to meet the tremendous need of the community. Members of the community who participated in this process and the original data, resources needs and strategies can be found in Appendices A and B. To ensure that this planning body heard directly from families and family input was part of the process, a survey was conducted reaching 278 families with young children. The survey and the results can be found in Appendix C. Data from this survey is used throughout this document.

The planning group used a framework to organize the needs and strategies around a set of comprehensive and critical components for babies and toddlers. The group looked at four key areas: early care and education, family support, health/early intervention, and community awareness. Based upon the needs and the resources within Durham, this community planning body then developed a set of strategies to be included in a multi-year, communitywide plan for infants and toddlers and their families. The plan would then be implemented by various public and private entities within the community over the next few years. The process, specifically the selection of priorities and strategies, was grounded in research concerning risk factors and their respective impact on children and the results of program evaluation that has identified effective programs and services. The following report is the result of the work of the community planning group.

Current Picture of Children and Families in Durham

“Durham County enjoys a population and economic base that is diverse and growing. It has successfully transformed its economy from one based upon tobacco and textile products to a modern, cutting-edge economy with strong industry clusters in the life sciences, electronics and software, nanotechnologies, pervasive computing, advanced medical care, analytical instruments, nanoscale technologies, informatics, vehicle component parts, environmental product design and manufacturing, and financial services.” While considered a leading technology center in the US, a wide range of cutting edge products are also manufactured here. Those who call Durham home come from all over the world (64 distinct nationalities have been identified), and all walks of life. Yet, one of Durham's most significant distinguishing characteristics is the high educational attainment of its residents - 43% of adults over 25 years of age in Durham County have attained at least a bachelor's degree.”

Greater Durham Chamber of Commerce²

The above portrayal is an apt description of Durham; however, it is not a complete one for the purposes of this planning process and document. In building a system to meet the needs of children ages birth-3, we must look at a more comprehensive picture of our community. Perhaps a more appropriate description of Durham is a community that is comprised of a diverse set of individuals and families representing the edges of several continuums:

- the median household income is \$46,636 and yet nearly a quarter (22.9%) of children ages birth-5 are living in poverty (approximately \$20,00 for a family four in 2006)³;
- approximately half of young children are living in low-income families (low income is defined as at or below 200 percent of the federal poverty level);^{4 5}
- 34% of children are living with families where no parent had full-time, year round employment⁶;
- 43% of adults over 25 years of age in Durham County have attained at least a bachelor's degree⁷ and yet in 2007 8% of teens were high school dropouts⁸;

When examining the needs of children birth-3 and their families for the purpose of better preparing these children for school and ultimate success as adults, the following needs to be considered. In 2007, there were over 15,600 children between the ages of birth-3 in Durham County.⁹ Unfortunately, the available data describing children birth-3 and their families is limited. As a result, many of the incidence rates, prevalence rates and other information will be based on children ages birth-5 and their families. To describe this picture, data will be presented in the following categories: early care and education; family support (those factors that influence the family's ability to care for their children); health/early Intervention (those factors that affect the child's ability/capacity to develop) and community awareness.

² Greater Durham Chamber of Commerce website <http://www.durhamchamber.org/business> accessed 09/28/08.

³ U.S. Census Bureau, 2006 American Community Survey.

⁴ U.S. Census Bureau, 2006 American Community Survey.

⁵ The Federal poverty level for a family of four in 2006 was \$20,000.

⁶ Kids Count Data center <http://www.kidscount.org/datacenter/>

⁷ Chamber of Commerce

⁸ Kids Count

⁹ NC Office of State Budget and Management; Certified Population from <http://www.osbm.state.nc.us/demog/c07sag3.html> accessed 11/13/08

Early Care and Education

An estimated 62.5% of children under the age of six live in homes where either both parents or the single head of household are employed. This means there are more than 13,500 children birth-5 in need of some kind of child care arrangement (*Census, 2006*). Families with infants and toddlers face challenges in finding and affording high quality child care. In Durham County, approximately 27% of all infants, 31% of all one-year-olds and 39% of all two-year olds are enrolled in licensed child care (*CCSA, January 2008*). The quality of this child care varies greatly, with many of our youngest children not experiencing high quality care.

Quality early education starting at birth is associated with long-term positive outcomes for children. This is particularly important for low-income, at-risk children. However, infants and toddlers living in low-income families receiving child care subsidy in Durham are less likely to be receiving quality child care than other infants and toddlers and older children.

While there are approximately 3,909 infants living in Durham County and the child poverty rate is 22%, there are few infants from low-income families in high-quality subsidized child care (*2006 North Carolina Demographics data; 2006 American Community Survey*). In December 2007, there were only 21 infants in 5-star subsidized child care (including homes and centers). A small proportion of the youngest children receiving subsidy are in 5-star facilities; 8% of infants, 10% of one-year-olds and 15% of two-year-olds were in 5-star care as of December 2007 (*DACCA, 2007*).

While our community has made dramatic improvements in the quality of child care over the past five to seven years as seen through the increase in the average star rating of child placements, much of this progress has been experienced through a focus on high-quality pre-kindergarten. Through national, state and local emphasis on pre-kindergarten and because we have a strong collaboration between our local More at Four, Head Start, Title I and child care subsidy programs, the quality and access to programming for 4-year olds has risen in recent years. While great progress has been made for 4-year-olds, infants and toddlers have been left behind in this pre-kindergarten movement.

Access to quality child care for families of infants and toddlers is challenging both because of a lack of supply of this type of care and because of the cost of care. When asked about the greatest challenges families face in the Family Survey, half of respondents reported accessing child care was their greatest challenge. Respondents further identified barriers to access being: affordability (74% of responses), wait lists (28%) and not being able to find services (17%) (See Appendix C for survey results). Less than 3 of every 100 slots in 4- or 5-star programs were open and available to new parents needing child care for their youngest children in January, 2008. The average child care tuition rates for an infant in 4-star center are about \$908 per month or \$10,896 a year (*CCSA, 2008*).

Family Support

As research continues to demonstrate, the healthy development of a young child is highly correlated to and influenced by the family context that these children are raised. Factors

including parent education, parental stress and violence, social isolation and economic stability are all related to the family's ability to care for their children and the child health and development. There is strong evidence that link success in school to that of the educational level of the parents. In Durham, 1,053 or 25% of births in 2006 were to mothers with less than a high school education.¹⁰ Furthermore, of the children born in 2004, 4.23% were born to teen mothers.¹¹

Having a secure home is directly associated with the healthy development of children. Unfortunately, 539 people were homeless in Durham County in 2007, including 65 children.¹² Families are further stressed when there is violence in the home; the relationship between positive developmental outcomes is negatively correlated with domestic violence. In 2005-2006, Durham domestic violence programs served 682 clients.¹³ Making matters worse, 10% of mothers who give birth in North Carolina say they have no social support¹⁴, leaving these mothers more isolated and at-greater risk for neglecting or harming their children.

The Latino population in Durham has increased dramatically since 2000. In 2006, 24% of births in Durham were to Hispanic/Latino mothers.¹⁵ The current health and human service systems are being challenged to appropriately and adequately serve this increasing population. According to the 2000 United States census, approximately half of NC Latinos have limited English proficiency or are unable to speak English well. In addition to the challenge of managing communication, cultural gaps and fear of legal consequences may discourage Latinos from engaging in services and/or seeking care until needs become urgent problems, resulting in poorer outcomes.

Recent statistics reveal disturbing trends regarding child poverty. As stated above, 4,950 or 22.5% of children birth to age 5 live in poverty (Census, 2006). "Extensive research shows that children who grow up under conditions of poverty are more likely (relative to non-poor children) to be less successful in school, less productive as adults in the labor market, have lifelong health problems, and commit crimes and engage in other forms of problematic behavior. There are many reasons why low family income may be detrimental for young children. Early development can be compromised when parents cannot afford to provide nutritious meals, are unable to assure access to age-appropriate learning experiences both in the home and in early care and education settings outside the home, and cannot guarantee safe and growth-promoting neighborhood environments. Poverty and economic insecurity also can take a toll on parents' mental health, with depression and other forms of psychological distress profoundly affecting their interactions with their children."¹⁶

¹⁰ NC State Center for Health Statistics

¹¹ NC Action for Children, 2004

¹² Triangle United Way Point-in-Time Survey, 2007

¹³ North Carolina Council for Women/Domestic Violence Commission

¹⁴ PRAMS

¹⁵ NC State Center for Health Statistics

¹⁶ Center on the Developing Child at Harvard University (2007). *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*. <http://www.developingchild.harvard.edu>

Health/Early Intervention

The health and well-being of children ages birth to age 3 is multi-faceted and is organized into several categories below that affect a child's ability/capacity to develop including physical health, mental health, safety and developmental disabilities.

Health

Access to health care is strongly correlated to the poverty of the family and community. Unfortunately, available data regarding health coverage is limited to the entire population of children, ages 0-18, therefore the following relates to all children. In 2004, 10% of all children (0-18) in Durham were uninsured, 31% were enrolled in Medicaid and 5% were enrolled in NC Health Choice¹⁷. Unfortunately, the recent data trends are moving in the wrong direction. In 2005, 12% were uninsured, and with the most recent economic downturn we can expect the numbers of un-insured to increase. As a community we were somewhat successful in ensuring that our youngest children have access to medical care, 72% of Medicaid enrolled children ages birth-5 received preventive medical care (received at least one initial screening).¹⁸ However, it is not clear whether the general accepted standards of well-baby visits outlined by the American Pediatric Society have been met. The standard of care is that children under the age of 1 are seen eight (8) times and children under the age of 2 are seen an additional three (3) times.¹⁹

In terms of health outcomes, we were less successful in addressing the new epidemic of obesity. 23.5% of children ages 2-4 seen in North Carolina Public Health Sponsored WIC and Child Health Clinics were overweight in 2007 (570 out of 2,424 children) and additional 17.5 % were considered to be at-risk for being over-weight. Durham was ranked-ordered 99 of the 100 counties in NC; the statewide average is 15.3% for children who are overweight (NC-NPASS). And finally, it is quite disconcerting that while Durham County is ranked third in the state in terms of number of physicians,²⁰ it is ranked 14th for infant mortality (a core indicator of the overall well-being of children) overall and 42nd for infant mortality in other races than white.²¹

Another indicator that is disturbing is the rate of children born under-weight. The low birth weight rate for Durham was 9%. Broken down by race further delineates the issue, 6% of white births were considered low weight whereas the rate for minority births was 13%.²² These rates were comparable at the state level and yet for the minority population, these rates were closer to that of the world and the lesser developed countries.²³ Children with low birth weight experience a substantial burden of childhood disability, school-related difficulties, and increased utilization of special educational services once they reach school. This type of early malnutrition weakens children's physical and cognitive potential and even their non-cognitive

¹⁷ KIDS COUNT: Community Level Information on Kids, Durham County. http://www.kidscount.org/cgi-bin/cliiks.cgi?action=profile_results&subset=NC&areaid=33, retrieved 11/13/08

¹⁸ NC Division of Medical Assistance, Health Check participation Data, 2006-2007

¹⁹ Recommendations for Preventive Pediatric Health Care; Committee on Practice and Ambulatory Medicine; *Pediatrics* 2000;105:645-646

²⁰ North Carolina Health Professions Data System 2006 Total and Primary Care Physicians

²¹ Kids Count

²² Kids Count

²³ United Nations Children's Fund and World Health Organization, *Low Birth Weight: Country, regional and global estimates*. UNICEF, New York, 2004.

traits such as motivation and persistence, so it is costly for their future health, educational attainment, and socioeconomic success.²⁴

Nationally, the number of children with special needs, defined as those "who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type or amount beyond that required by children generally" is growing. National data shows that roughly 13% of all children fall into this category and that they account for 80% of pediatric health care expenditures.²⁵ When applied to the population of children under age 3 in Durham, this would mean that approximately 2,028 children have special needs. Data indicate that we are not meeting these estimated needs. In FY 07/08, 3.8% of children ages birth-3 (450 children) were identified and received early intervention services (NC Division of Public Health, Women's and Children's Health).

Mental Health

Research in the Great Smoky Mountain Area of NC found that some 30% of the children screened, have a diagnosable emotional or behavioral disorder; 25% had a moderate to severe impairment, and another 5% have a marked impairment (Costello et al. 1996). Campbell (1995) estimated that 10-15% of typically developing preschoolers have chronic, mild to moderate levels of behavior problems. Children in poverty were much more likely to develop behavior problems with prevalence rates approaching 30% (Qi & Kaiser, 2003). The proportions of preschool children meeting the criteria for the clinical diagnosis of conduct problems is estimated to range from 7-25% (Webster-Stratton & Hammond, 1997). The research to date has studied preschoolers, however the most recent research now demonstrates that the "prevalence and distribution of psychopathology" in younger children (specifically 1½-year-old children) seem to correspond to the distributions among older children.²⁶ Consequently, we can expect that 2,230 – 3,345 children, a conservative estimate, or 5,575 – 6,690 children at the high end will have serious mental health needs in Durham County. In 2007, the local public mental health agency, the Durham Center, served approximately 150 children with a mental health diagnosis.

Safety

Consistent with national trends, infants and young children ages 0-6 represent the fastest growing segment of the child welfare population in Durham, with over 1,200 involved with county child welfare services during SFY-2006. Of these children, 214 children ages 0-6 were found substantiated for abuse and neglect or in need of services.²⁷ Of those children, 52 were taken into custody, of which 58% were placed in foster care outside the home.²⁸ Our youngest children often appear at greater risk of emotional and behavioral problems due to inconsistent or unresponsive care in their formative years (Dicker et al., 2001 & Powell et al., 2007). Despite

²⁴ Stein, R. E. K., Siegel, M. J., & Bauman, L. J. (2006). Are Children of Moderately Low Birth Weight at Increased Risk for Poor Health? A New Look at an Old Question. *Pediatrics*, 118, 217-223.

²⁵ The National Center of Medical Home Initiatives for Children with Special Needs, <http://www.medicalhomeinfo.org/tools/insurers.html> retrieved 11/16/08.

²⁶ Skovgaard, A. M.; Houmann, T.; Christiansen, E.; Landorph, S.; Jørgensen, T.; Olsen, E.M.; Heering, K.; Kaas-Nielsen, S.; Samberg, V.; & Lichtenberg, A. (2007). The prevalence of mental health problems in children 1½ years of age - the Copenhagen Child Cohort 2000. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 48, 62-70.

²⁷ NC DHHS 2005-06

²⁸ Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., Weigensberg, E.C., and Lanier, III, P.J. (2008). NC Child Welfare Program. Retrieved November 3, 2008, from University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/cw/>

high rates of behavioral health service use for children in child welfare, many do not receive needed care. For example, in a study of maltreated children, only 6.6% of preschoolers had used mental health services in the past year, although 32% experienced significant clinical problems (Burns et al., 2004).

Developmental Disability

Once again, the complete picture for children under the age of 5 is limited by the data available. Unfortunately the NC Division of Mental Health, Developmental Disabilities, Substance Abuse Services, only captures data for all children (ages 0-18). Accordingly, the Division estimates that 3.21% of children have a developmental disability that requires supportive services approximately 715 children in Durham and approximately 22% (164) of these children with a developmental disability were served through the local mental health entity²⁹.

Durham's Community Strategic Plan for Infants and Toddlers

Based upon the community planning process described previously, the following vision, strategies and goals were developed to guide the community efforts around the needs of infants and toddlers for the next three (3) years.

Vision:

We envision a community where all infants and toddlers are nurtured in healthy, safe and age appropriate environments for optimal growth and development.

Early Care & Education

Goal:

Increase quality of existing child care programs and build the supply of high quality infant and toddler child care.

Specific Strategies:

Quality Professional Development:

- Conduct workforce study to learn more about the education level, salary and turnover among infant and toddler teachers.
- Develop a comprehensive workforce development plan for early childcare professionals inclusive of attachment/ relationship, mental health issues, screenings, evidence-based practices, multicultural/ multilingual competencies.
- Hold forums and trainings as opportunities for continuing education and on-going needs assessments for infant/toddler teachers.
- Provide salary supplements for infant/toddler teachers.

²⁹ NC MH/DD/SAS Community Systems Progress Indicators Report for Fourth Quarter SFY 2006-2007(April 1 –June 30, 2007)

Healthy and Safe Child Care Environments:

- Provide ongoing quality improvement support including on-site technical assistance and support.
- Identify/develop model infant and toddler classrooms (e.g., Ready Infant Toddler Classroom).
- Provide support around child/teacher ratio for infant/toddler classroom.
- Parent education specifically targeting parents of babies about the importance of quality child care.

Supply:

- Develop comprehensive financial model to support and expand high quality infant and toddler care. Model will include:
 - Acquire additional financial resources to develop/support high quality child care for infants and toddlers (e.g., Educare, Early Head Start, State funds).
 - Enhanced subsidy rate for infant and toddler slots, in combination with policy that does not allow providers to charge parent the difference between this rate and the private pay rate.
 - Develop model for employers to support/subsidize employees who need infant/toddler care, (e.g., flexible spending accounts, target large employers i.e., government, schools).

Family Support**Goal:**

Increase the availability of beneficial and accessible supports and services for effective parenting in the community.

Specific Strategies:

Develop a continuum of services and supports for primary care givers (parents, grandparents, foster care parents and others) that is easily accessible and culturally competent. The continuum would include basic education, skill acquisition, respite and support, and clinical services for individual caregivers (e.g., mental health treatment, substance abuse treatment).

- Expand capacity of existing evidence-based practices for children birth-3 and their families (e.g., Healthy Families, Parent-Child Interaction Therapy and Child-Parent Psychotherapy).
- Build capacity for additional evidence based practices for children birth-3 and their families such as Safe Care, Incredible Years for Infants and Toddlers.
- Engage and support congregations in their efforts in parent education and connecting parents with existing resources.
- Support network, play groups, play areas, resource centers for parents with focus on families with children not in child care.
- Engage “family, friend and neighbor care” caregivers (parents, grandparents, foster parents neighbors and others) in accessing and using supports, education and other services.
- Ensure coordination of services and supports across agencies that serve infants and toddlers and their families.
- Research, explore and examine potential and need for crisis nursery settings.
- Increase the continuum of services for teen parents.

- Increase access to adult literacy programs and other support services for parents and caregivers of young children.
- Study feasibility of warm-line to address parenting concerns.
- Encourage pediatricians and other health care professionals (family practitioners, nurse practitioners, etc.) to use simple screening tools with mothers to screen for *depression*.
- Encourage pediatricians and other health care professionals (family practitioners, nurse practitioners, etc.) to use simple screening tools with mothers to screen for *domestic violence*.
- Encourage pediatricians and other health care professionals (family practitioners, nurse practitioners, etc.) to use simple screening tools with mothers to screen for *substance abuse*.

Assist families to move out of poverty:

- Increase access of eligible families in Earned Income Tax Credit/TANF/Social Security benefits.
- Increase facilitation of families in accessing in-kind support: nutrition, housing, health care and child care.
- Develop long-term strategies to end poverty and build financial assets, such as Children's Savings Accounts.
- Explore strategies to address the needs of families for more accessible and financially viable transportation.
- Support End Poverty Durham's efforts in establishing the Commodity Distribution Center (a center for goods distribution and training program for the chronically unemployed).

Increase use of family-friendly policies and practices in business.

- Advocate for family-friendly work environments that offer
 - Paid parental leave during child's first year
 - Flexible work schedules for parents
 - Health insurance for family members
 - Sick leave policies

Health/Early Intervention (Child Oriented)

Goal:

Improve the physical and social emotional well-being of infants and toddlers.

Specific Strategies:

Establish training programs for professionals on early childhood development, services, screening, etc.

- Develop mechanism to train and support pediatricians in their role as the medical home.
- Train other professionals on early childhood development, services, screening, etc.
- Establish Touchpoints professional development program to enhance delivery of services to families by using relationship-building strategies and communication tools around key points in the development of young children.

Develop a continuum of services and supports to meet the health, mental health and early intervention needs of infants and toddlers

- Expand System of Care database (Network of Care) for birth-3 services.
- Expand services for children (birth-3) with special needs.

- Implement “medical homes³⁰” for all children, which will provide regular screening, assessment and referrals, follow-up and anticipatory guidance as appropriate.
- Increase access for eligible children in Medicaid or Health Choice and provide ongoing support for re-enrollment.
- Encourage and support families’ use of preventive health care by maintaining routine well-child visits.
- Encourage and support the use of WIC for both children and women during pregnancy.
- Identify models for parent education regarding nutrition and early childhood obesity.
- Explore resources for child care health consultant.
- Expand child care nutrition consultation program to focus on infants and toddlers.

Community Awareness

Goal:

Mobilize all components of the community to recognize the importance of promoting healthy infant growth and development and allocate resources (time, money, in-kind contributions, space) to meet the needs of these children and families.

Specific Strategies:

Develop communication plan that has measurable objectives and that will benchmark and measure progress. The plan will:

- Develop consistent messaging around birth-three for target audiences.
- Target communications plan to families, professionals and the community in order to educate and engage around birth-3 issues.
 - *Families:*
 - Educate families about available community resources.
 - Educate families about importance of quality child care, attachments, early literacy and other aspects of early childhood development.
 - *Professionals:*
 - Educate all professionals that have contact with young children and their families about child development and effective practices in working with families (e.g., Touchpoints training).
 - *Community:*
 - Educate the community about the importance of the birth-three age and what everyone can do to support infants/toddlers and their families.
 - Develop leadership in the community to serve as ambassadors to the community at-large and markets outside Durham. (Including faith community, medical providers, child care providers and businesses.)
 - Inform legislature regarding infants/toddlers- include voices from community.

³⁰ The American Academy of Pediatrics (AAP) first put forth the notion of the medical home in 1992 and has since updated its definition in 2002 to include an entity that provides care that “accessible, continuous, comprehensive, familycentered, coordinated, compassionate, and culturally effective”. In a true medical home, the physician engages in a relationship based on mutual trust and shared responsibility with the family.

Conclusion

As proven by this process and document, we have taken our responsibility “to **secure a promising economic, social, and political future** for our county” by investing in early childhood development seriously and with passion and have articulated the investments and strategies necessary to achieve these goals. The plan outlined above is the first step. Through smaller work groups and existing committees, we now intend to develop and implement specific actions that will lead to realization of these goals. This will include the identification of other partners whose agendas are consistent with a specific strategy and would then take primary responsibility for this activity. It is our intention to reconvene the larger community group on an annual basis to review our progress and make adaptations as appropriate.

Acknowledgements

Durham's Partnership for Children would like to thank Adele Spitz Roth of Spitz Roth & Associates for writing, researching and facilitating the planning group for this strategic plan. Durham's Partnership for Children would also like to thank the agencies, programs and individuals that participated in the planning process and completed the family survey. Durham County's Strategic Plan for Infants and Toddlers represents the thinking and planning of a wide cross section of experts and stakeholders in our community. We appreciate the time that was dedicated to contribute to this strategic plan. Partnership staff including Marsha Basloe, Kate Irish, Angelica Oberleithner, Karine Stallings, Trish Vandersea, Jeanette Maatouk, and Diana Graham provided key leadership and support in this strategic planning process including editing, survey design and analysis and graphic design.

Appendix A**Infant and Toddler Planning Group**

Name	Organization
Adele Spitz Roth	Durham's Partnership for Children Consultant
Amy Fulcher	Child Care Services Association
Angelica Oberleithner	Durham's Partnership for Children
Angie Welsh	Triangle United Way
Anitra Grove	Child Care Services Association
Ann Stock	End Poverty Durham
Barbara VanDewoestine	Durham's Partnership for Children Board/ Allocations Chair
Cheryl Kegg	Health Department
Christina Christopoulos	Duke Center for Child and Family Policy
Darnella Warthen	Durham's Alliance for Child Care Access
Deborah Horvitz	Durham's Partnership for Children Board
Erin Reiter	Child Care Services Association
Jan Williams	Healthy Families Durham
Jim Barbee	Triangle United Way
Kara Vample Turner	Parent and Primary Colors Day Care
Karen Appleyard	Duke Center for Child and Family Policy
Karine Stallings	Durham's Partnership for Children
Kate Irish	Durham's Partnership for Children
Katushka Olave	Immaculate Conception
Lanier DeGrella	Child Care Services Association
Linda Chappel	Child Care Services Association
Marlo Walston	Operation Breakthrough
Marsha Basloe	Durham's Partnership for Children
Maryann Crea	Immaculate Conception
Monnie Griggs	Child Care Services Association
Pat Harris	Welcome Baby
Robert Murphy	Center for Child and Family Health
Ted Whiteside	Durham's Partnership for Children

Appendix B

Infant Toddler Strategic Framework

VISION: to be developed later based on initial discussion

Early Care & Education

Data:

- An estimated 62.5% of children under the age of six live in homes where both parents or a single head of household are employed. There are more than 13,500 children birth-five in need of some kind of child care arrangement (Census, 2006).
- In February 2008 there were about 3,661 infants and toddlers (0-3) enrolled in a licensed child care setting (CCSA, 2008).
- This means approximately 27% of all infants, 31% of all one-year-olds and 39% of all two-year olds were enrolled in licensed child care.
- A small proportion of the youngest children receiving child care subsidy are in 5-star facilities; 8% of infants, 10% of one-year-olds and 15% of two-year-olds were in 5-star care as of December 2007 (DACCA, 2007). By comparison, 22-23% of all infants and toddlers from all families (regardless of income) are in 5-star care in Durham County (CCSA).
- Child care tuition rates for an infant in 4-star center are about \$908 per month (\$10,896 a year) (CCSA).
- Less than 3 of every 100 slots in 4- or 5-star programs were open and available to new parents needing child care for their youngest children (CCSA).

Family Support (Adult/parent oriented)

Data:

Many Durham families face multiple risk factors:

- *Limited financial resources:* 4,950 or 22.5% of children 0-5 live in poverty (Census, 2006).
- *Low levels of education:* 1,053 or 25% of births in 2006 were to mothers with less than a high school education (NC State Center for Health Statistics)
- *Language barriers and different cultural norms:* 24% of births in Durham in 2006 were to Hispanic/Latino mothers (NC State Center for Health Statistics)
- *Teen births:* 42.3 Teen Births per 1,000 (NC Action for Children, 2004).
- *Isolation:* 10% of mothers who give birth in North Carolina say they have no social support (PRAMS).
- *Homelessness:* In 2007, 539 people were homeless in Durham County, including 65 children (Triangle United Way Point-in-Time Survey, 2007).
- *Child abuse and Neglect:* 428 children were found substantiated for abuse and neglect or in need of services. Of these children, 214 (50%) were ages 0-6 (NC DHHS 2005-06)
- *Domestic violence:* In 2005-2006, Durham domestic violence programs served 682 clients (North Carolina Council for Women/Domestic Violence Commission).

Health/Early Intervention (Child oriented)

Data:

Child Health:

- 26.8% of children ages 2-4 seen in North Carolina
Public Health Sponsored WIC and Child Health Clinics were overweight in 2006 (648 out of 2,421 children). Durham has the highest rate in the State. Statewide avg is 15.2% (NC-NPASS).
- 72% of Medicaid enrolled children ages 0-5 received preventive medical care (received at least one initial screening). For our youngest enrolled children: 89% of infants, 80% of 1 year-olds and 64% of 2 year-olds received at least one screening (NC Division of Medical Assistance).

Early Intervention:

- In FY 06/07, 3.3% of children ages 0-3 (374 children) were identified and received early intervention services. This % has decreased as FY 05-06 results were 3.8% (419 children) (NC Division of Public Health, Women's and Children's Health).

Need additional data:

- Mental health prevalence & local penetration rates for children.
- Prevalence of "fragile" children or prematurity rate.
- PRAMS data broken down by County.

Community Awareness/Development

Data:

Data for current Community Awareness activities related to Infant and Toddler issues is difficult to capture. While the Partnership can quantify many of its activities (newsletters, events, etc.) it is difficult to find data that includes community awareness activities occurring across Durham.

Early Care & Education

Needs:

- Workforce development – pre service and in-service training (inclusive of hands-on training).
- Partner with universities and community colleges regarding training and professional development and bring them to the table in a meaningful manner (NCCU, Duke and Durham Tech).
- Adequate supply of affordable, high quality childcare.
- Quality providers – teachers, administrators, etc. with multicultural/multilingual competencies.
- Early childhood professionals are educated, trained and well compensated.
- Ongoing, continuous quality improvement support, including peer reviews and on-site technical assistance.
- Subsidy reimbursement rate would be equivalent to the Infant/Toddler market rate.
- Regulations at state level that support quality care, e.g., child/teacher ratio, space allocation.
- Market rate is appropriate to meet needs of infant/toddler care.
- Best practice models for early care for infant/toddlers.
- Workforce study on turnover.
- Increase the number of providers who serve infants & toddlers.
- Increase number of I/T teachers with a degree.
- Training/greater understanding about the need for I/T teachers to have degree/education.
- More advising at community colleges for I/T teachers.

Family Support (Adult/parent oriented)

Needs:

- Support for families who have children in “non-regulated” care (families, friends, neighbors).
- Family support – that is provided in a multicultural and multilingual manner, reflective of literacy levels and includes:
 - Access to health care.
 - Respite care.
 - Parent support inclusive of post-partum depression substance abuse treatment, mental health treatment and case management.
- Doulas
- Home visiting
- Expand family literacy programs
- Parents have greater capacity in their roles as parents, teachers, advocates and supporting each other – perhaps teach in public schools.
- Ongoing support for resource information and tools for families, providers, teachers, etc.
- Comprehensive data including parents within the workforce.
- Crisis nurseries or other mechanism for short-term care or respite.
- Increased number of beds/slots in shelters for families with DV concerns or who are homeless
- Additional play groups for children who are at-home with mothers or other caregivers.

Health/Early Intervention (Child oriented)

Needs:

- Children and parents need to have access to health care and mental health services, with a focus on parents who are young and/or at-risk of losing their children.
- Increased early childhood competencies of professionals serving children (i.e., health, mental health and early intervention) in the community (focus on the identification of issues).
- Sufficient service array to meet the needs of children and families, mental health, early intervention, mental health consultants to childcare facilities, etc., especially when “things go wrong”.
- Health care community/practitioners are knowledgeable and competent in early childhood development, developmental assessments and milestones, and provision of guidance and support.
- Child Care Health Consultant.

Community Awareness

Needs:

- Early childhood champions, especially within the business community and among men.
- The business community is fully supportive of childcare and understands the importance of supporting and caring for children ages 0-3.
- Greater awareness and Appreciation regarding the importance of early childhood development and care, how it relates to outcomes later in life - an attitude that as a community it is our mandate to meet the needs of these children and their families.
- Change the perception of many regarding the early education and care profession – services provided are not babysitting or day care.
- Durham SOC to address the needs of children ages 0-5.
- Political will.
- Community education – health care providers, business community, faith community.
- Communication plan – with an emphasis on respecting professionals and field.
- Leadership from governmental bodies and public school system – (need to have them get firsthand experience of childcare facilities).
- Policy changes.

Early Care & Education

Resources:

- 5-star rating system, which is part of licensure, and provides technical assistance and support.
- Relatively low child/teacher ratios.
- Duke, NCCU, Durham Tech and FPG.
- TEACH program (Teacher Education and Compensation Helps) of CCSA.
- Health insurance program of CCSA helps fund the cost of health insurance.
- Jim and Carolyn Hunt Child Care Resource Center
- Regional I/T specialists.
- Birth – Kindergarten teacher education programs in the general area.
- Access to some data and more in the future.
- NC Infant/Toddler Early Learning Guidelines (May 2008).
- Project Enlightenment – model classroom (funded by Wake County Schools).
- Durham DSS understands the needs and issues of early childcare.
- Zero To Three
- IBM and Duke child care partnerships fund I/T expansion –slots.
- WAGES\$.
- United Way and Partnership.
- 2010 census data.
- Durham Public Schools.

Family Support (Adult/parent oriented)

Resources:

- Healthy Families, Welcome Baby.
- Evidence based practices within the community – Parents as Teachers, Incredible Years, Healthy Families, Motherread and Parent-Child Interaction Therapy.
- Strong health department programs - Maternal Care Coordination.
- Wealth of health care resources.
- Bilingual family support services.
- Durham Connects – universal newborn home-visiting program.
- Durham Literacy Council.
- Significant number of schools, parks, libraries and faith organizations (430).
- First in Families.
- Exchange Clubs Family Center.

Health/Early Intervention (Child oriented)

Resources:

- Strong health department programs (Child Service Coordination).
- Wealth of health care resources. Durham Council for Children with Special Needs (LICC).
- Durham Connects – universal newborn home-visiting program.
- Evidence based practices within the community – Parents as Teachers, Incredible Years, Healthy Families, and Parent-Child Interaction Therapy.
- Children’s Developmental Service Agency. Duke Community Health Centers and clinics.
- Strong Couples/Strong Children.
- Results Based Accountability process.

Community Awareness

Resources:

- Corporations.
- Strong governments.
- Durham’s Partnership for Children.
- Duke, NCCU, Durham Tech and FPG.
- Academic community.
- Passion.
- Durham DSS understands the needs and issues of early childcare.
- Faith community – 430 entities.
- Healthy sense of volunteerism.
- Generous community – philanthropic community.
- United Way.
- Durham Congregations in Action.
- Durham CAN.
- End Poverty group.
- Durham’s 10-year Plan to End Homelessness.
- Higher than average median income.

Early Care & Education

Strategies:

- Provide bonuses for infant/toddler (I/T) slots for both parents and providers.
- Develop a comprehensive workforce development plan for early childcare professionals inclusive of attachment/relationship, screening, evidence-based practices.
- Training of other professionals on early childhood development, services, screening, etc.
- Provide supervision and on-site technical assistance and support.
- Identify/develop ideal or model I/T classroom.
- Hold forums for I/T teachers.
- Change child/teacher ratio for I/T classroom.
- Acquire additional financial resources.
- Salary supplements for I/T teachers.
- Enhanced subsidy rate in combination with policy that does not allow providers to charge parent the difference between this rate and the private pay rate.
- Parent education specifically targeting parents of babies about the importance of quality child care – PSA's e.g. "Parenting Counts" – Taleris.
- Employers support/subsidize employees who need I/T care e.g., flexible spending accounts, Indiana, NWLC; Target large employers i.e., government, schools, franchises – fast food.
- Inform legislature regarding I/T – use voices from community.

Family Support (Adult/parent oriented)

Strategies:

- Create a family support fund for each newborn.
- Support network, play groups, resource centers for parents with focus on families with children not in care.
- Increase capacity of Welcome Baby and Healthy Families.
- Develop strategies to reach all families.
- Ensure strong interface with Durham Connects.
- Research, explore and examine potential and need for crisis nursery settings.
- Train DSS foster families serving children ages 0-3 in early childhood issues (mental health).
- Increase the continuum of services for teen parents.
- Expand capacity of existing evidence based practices for children 0-3 and their families.

Health/Early Intervention (Child oriented)

Strategies:

- Develop mechanism to train and support pediatricians in their role as the medical home.
- Build in supports for transition points for both the child and family.
- Training of other professionals on early childhood development, services, screening, etc.
- Training professionals (multi-level) on 0-3 mental health issues (needs, referrals, treatments, etc.)
- Explore resources for child care health consultant.
- Train early childhood professionals on developmental and multi-cultural issues.
- Expand SOC database (Network of Care).
- Expand services for children (0-3) with special needs.

Community Awareness

Strategies:

- Develop communication plan.
- Benchmark and measure progress.

Crosscutting Issues:

- Transportation is accessible and serves the whole community.
- Money.
- Time.
- Understanding the “big picture.”
- Gap analysis –what exists and what’s needed.
- Mechanism for the planning group to stay connected and focused and have the group connect with other planning entities within the community.
- Greater involvement of families within this planning process.

Appendix C

Family Survey Highlights

Background and Methodology

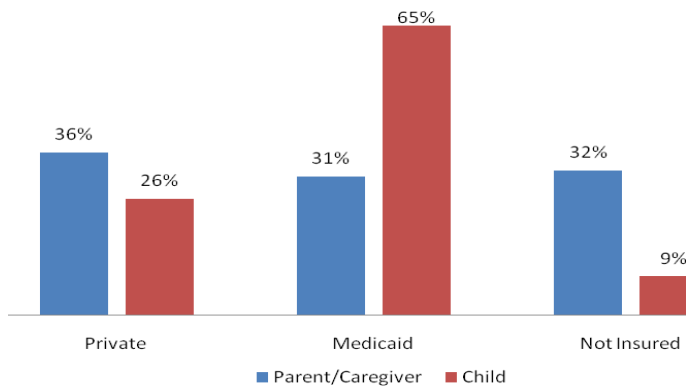
As part of a community planning process around the needs of infants and toddlers, a family survey was developed in collaboration with community partners to learn more about families of infants and toddlers in Durham County. The Family Survey was distributed in October 2008 in hard copy and online through community partners including Child Care Services Association, Durham’s Alliance for Child Care Access, Welcome Baby, Healthy Families Durham and the Health Department. The following provides highlights of the survey results. The survey was completed by 278 parents/caregivers. Response rates varied by question; results reflect responses to individual questions. It is important to note that the survey sample is not representative of the whole population of parents/caregivers in Durham County.

Demographics of Respondents

The Family Survey was completed by 278 parents/caregivers of young children in Durham County. Of the parents/caregivers that responded to the demographic questions, 93% (228) were female and 7% (18) were male. In terms of race/ethnicity of respondents, 53% (130) were Black/Non-Hispanic, 25% (61) Hispanic, 18% (43) White/Non-Hispanic, and 4% (10) were of other races. Nearly two-thirds (65%) of parents/caregivers were between 19-34 years old. Parents/Caregivers were able to provide demographic data for up to three children. Approximately 162 respondents were first-time parents or were caring for one child, 53 were caring for two children, and 33 respondents had three or more children. Over half (56%) of children were infants and toddlers ages birth to 36 months, and 81% of children were ages birth to 5.

Parents/Caregivers were asked to report the type of health insurance used for themselves and their children (Figure 1). Parents were about four times more likely to be uninsured than children with 9% of children being uninsured, compared to 32% of parents. Nearly two-thirds (65%) of children were insured through Medicaid, compared to 31% of parents. Parents were more likely to be covered by private insurance than their children (36% and 26%, respectively).

Figure 1 Type of Insurance Used by Parents/Caregivers and Children

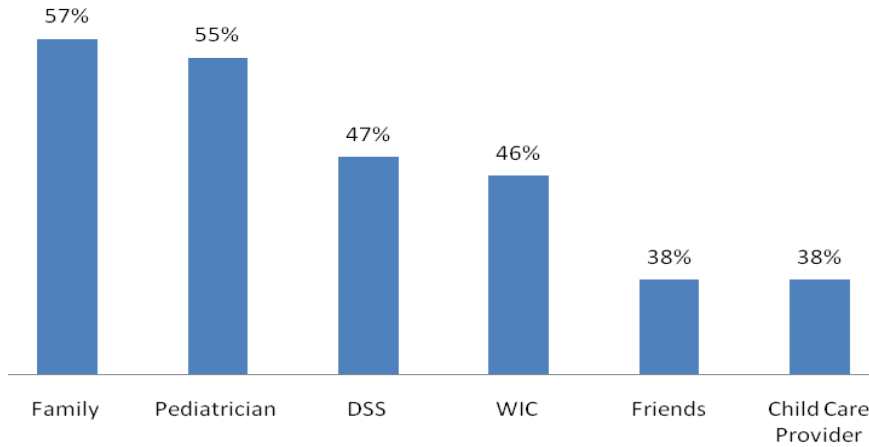


Note: Percentages are based on 222 responses.

Services and Supports that Families Report are Helpful

Families were asked to rate how helpful a list of services and supports have been over the past 12 months. The scale ranged from 'Not at all helpful' to 'Extremely Helpful.' As shown in Figure 2, parents/caregivers reported that family and pediatricians were the most helpful resources, followed by DSS, WIC, friends and child care providers. The top six responses are displayed below.

Figure 2 Services and Supports Ranked as 'Very Helpful' and 'Extremely Helpful' to Parents/Caregivers

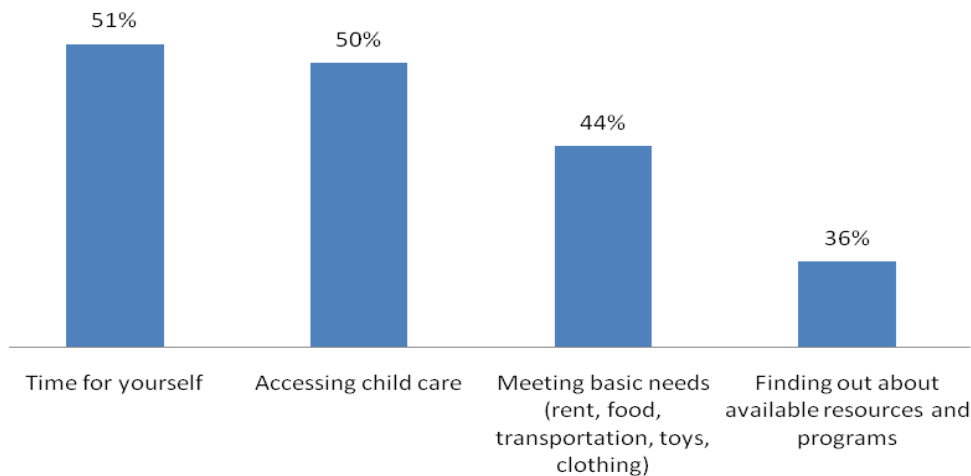


Note: The above data combines the 'very helpful' and 'extremely helpful' responses. Percentages are based on 277 responses.

Greatest Challenges that Families Face

Families were asked about the greatest challenges they face. A list of challenges was provided and respondents could also write in additional challenges. Half of respondents reported 'finding time for yourself' and accessing child care were their greatest challenges. The top four responses are shown in Figure 3.

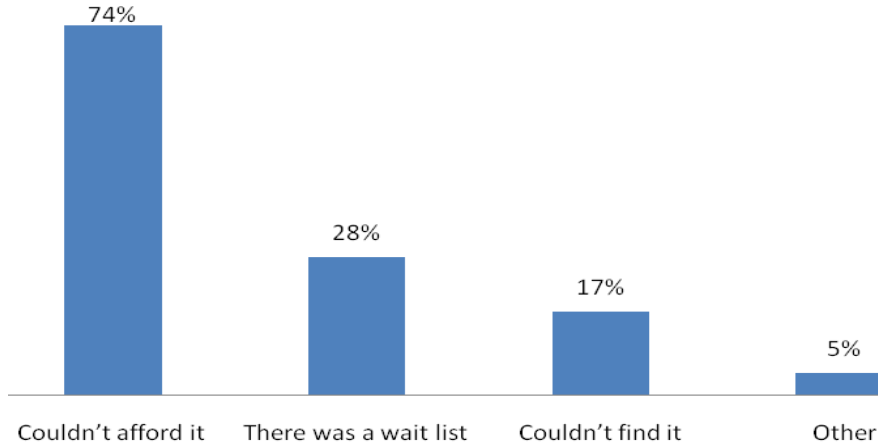
Figure 3 Greatest Challenges Facing Parents/Caregivers of Infants and Toddlers



Note: Percentages are based on 228 responses.

Respondents were asked to identify barriers to accessing health care services or child care (Figure 4). Affordability was the greatest barrier (74% of responses) followed by wait lists (28%) and not being able to find services (17%).

Figure 4 Barriers to Accessing Health Care Services or Child Care



Note: Percentages are based on 101 responses.

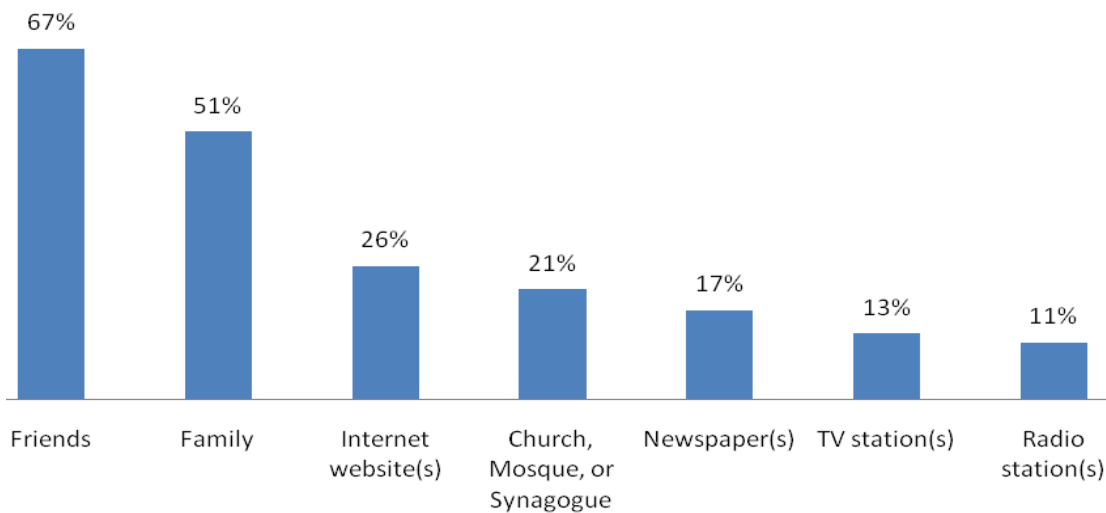
Services and Supports Needed

Parents/Caregivers had the opportunity to tell us what services and supports they are looking for in the community. This was an open-ended question and there were 78 responses. Most of the responses fell in the following categories: child care, programs for youth, support services/programs for parents, bi-lingual services, public assistance, and awareness of programs. Affordable child care is a support that many parents identified as a need in this open-ended question. Parents also reported looking for more youth programs “to keep young people out of the streets” and to help “kids to develop themselves.” Some expressed the need for more services such as parenting classes, counseling, support groups, and bilingual services. Public supports and services such as a “better transit system” and food stamps were noted by some parents and others expressed the need for “something for working mothers who are just making it.” While parents and caregivers expressed the need for many services and supports, they also noted that there needs to be more awareness about the services in the community. As one parent/caregiver stated, “the problem is making the services known to individuals.” Some suggestions for creating more awareness were creating “a resource guide to all programs/aids for single parents and their children in Durham” and “monthly forums to inform people about services available and how to access these needs.”

Where Families Get Information about Community Resources

Parents were asked where they get information about resources in the community. More than two-thirds (67%) of respondents reported that they use friends as a source of information and 51% of respondents identified family as an information source. Internet websites were selected by 26% of respondents. Newspapers, TV stations, and radio stations were the least common sources identified. Parents/Caregivers had the opportunity to write in other sources and to name specific internet sites, newspapers, TV stations, and radio stations used to learn about resources in the community. The *Herald Sun* was the most common newspaper listed. Search engines, such as Google, were the most common internet sites listed. Welcome Baby El Centro, Durham Connects, and Healthy Families were reported by some parents/caregivers as sources of information.

Figure 5 Information Sources about Resources in the Community



Note: Percentages are based on 226 responses.

Conclusion

The results from the Family Survey will be used to inform a larger collaborative planning process around the needs of infants and toddlers in Durham County. We would like to thank all of the community partners that helped distribute the Family Survey as well as the parents/caregivers who completed the survey. The information gathered will be useful to community partners that serve parents/caregivers with infants and toddlers. The full survey results are available by request. Please contact Kate Irish, Program and Evaluation Manager, Durham’s Partnership for Children for more information (kate@dpfc.net, 919.403.6960 ext. 226).