Child development theories focus on explaining how children change and grow over the course of childhood. Such theories center on various aspects of development including social, emotional, and cognitive growth.

The study of human development is a rich and varied subject. We all have personal experience with development, but it is sometimes difficult to understand how and why people grow, learn, and act as they do.

Why do children behave in certain ways? Is their behavior related to their age, family relationships, or individual temperaments? Developmental psychologists strive to answer such questions as well as to understand, explain, and predict behaviors that occur throughout the lifespan.

In order to understand human development, a number of different theories of child development have arisen to explain various aspects of human growth.

The Background of Child Development Theories

Theories of development provide a framework for thinking about human growth and learning. But why do we study development? What can we learn from psychological theories of development? If you have ever wondered about what motivates human thought and behavior, understanding these theories can provide useful insight into individuals and society.

How Our Understanding of Child Development Has Changed Over the Years

Child development that occurs from birth to adulthood was largely ignored throughout much of human history. Children were often viewed simply as small versions of adults and little attention was paid to the many advances in cognitive abilities, language usage, and physical growth that occur during childhood and adolescence.

Interest in the field of child development finally began to emerge early in the 20th century, but it tended to focus on abnormal behavior. Eventually, researchers became increasingly interested in other topics including typical child development as well as the influences on development.

How Studying Child Development Allows Us to Understand Changes That Take Place

Why is it important to study how children grow, learn and change? An understanding of child development is essential because it allows us to fully appreciate the cognitive, emotional, physical, social, and educational growth that children go through from birth and into early adulthood.

Some of the major theories of child development are known as grand theories; they attempt to describe every aspect of development, often using a stage approach. Others are known as mini-theories; they instead focus only on a fairly limited aspect of development such as cognitive or social growth.

Major Child Development Theories

The following are just a few of the many child development theories that have been proposed by theorists and researchers. More recent theories outline the developmental stages of children and identify the typical ages at which these growth milestones occur.

Freud's Psychosexual Developmental Theory

Psychoanalytic theory originated with the work of Sigmund Freud. Through his clinical work with patients suffering from mental illness, Freud came to believe that childhood experiences and unconscious desires influenced behavior.

According to Freud, conflicts that occur during each of these stages can have a lifelong influence on personality and behavior.

Freud proposed one of the best-known grand theories of child development. According to Freud's psychosexual theory, child development occurs in a series of stages focused on different pleasure areas of the body. During each stage, the child encounters conflicts that play a significant role in the course of development.

His theory suggested that the energy of the libido was focused on different erogenous zones at specific stages. Failure to progress through a stage can result in a fixation at that point in development, which Freud believed could have an influence on adult behavior.

So what happens as children complete each stage? And what might result if a child does poorly during a particular point in development? Successfully completing each stage leads to the development of a healthy adult personality. Failing to resolve the conflicts of a particular stage can result in fixations that can then have an influence on adult behavior.

While some other child development theories suggest that personality continues to change and grow over the entire lifetime, Freud believed that it was early experiences that played the greatest role in shaping development. According to Freud, personality is largely set in stone by the age of five.

Freud's Stages of Psychosexual Development

Erikson's Psychosocial Developmental Theory

Psychoanalytic theory was an enormously influential force during the first half of the twentieth century. Those inspired and influenced by Freud went on to expand upon Freud's ideas and develop theories of their own. Of these neo-Freudians, Erik Erikson's ideas have become perhaps the best known.

Erikson's eight-stage theory of psychosocial development describes growth and change throughout life, focusing on social interaction and conflicts that arise during different stages of development.

While Erikson's theory of psychosocial development shared some similarities with Freud's, it is dramatically different in many ways. Rather than focusing on sexual interest as a driving force in development, Erikson believed that social interaction and experience played decisive roles.

His eight-stage theory of human development described this process from infancy through death. During each stage, people are faced with a developmental conflict that impacts later functioning and further growth.

Unlike many other developmental theories, Erik Erikson's psychosocial theory focuses on development across the entire lifespan. At each stage, children and adults face a developmental crisis that serves as a major turning point. Successfully managing the challenges of each stage leads to the emergence of a lifelong psychological virtue.

Erikson's Stages of Psychosocial Development

Behavioral Child Development Theories

During the first half of the twentieth century, a new school of thought known as behaviorism rose to become a dominant force within psychology. Behaviorists believed that psychology needed to focus only on observable and quantifiable behaviors in order to become a more scientific discipline.

According to the behavioral perspective, all human behavior can be described in terms of environmental influences. Some behaviorists, such as John B. Watson and B.F. Skinner, insisted that learning occurs purely through processes of association and reinforcement.

Behavioral theories of child development focus on how environmental interaction influences behavior and are based on the theories of theorists such as John B. Watson, Ivan Pavlov, and B. F. Skinner. These theories deal only with observable behaviors. Development is considered a reaction to rewards, punishments, stimuli, and reinforcement.

This theory differs considerably from other child development theories because it gives no consideration to internal thoughts or feelings. Instead, it focuses purely on how experience shapes who we are.

Two important types of learning that emerged from this approach to development are that classical conditioning and operant conditioning. Classical conditioning involves learning by pairing a naturally occurring stimulus with a previously neutral stimulus. Operant conditioning utilizes reinforcement and punishment to modify behaviors.

Piaget's Cognitive Developmental Theory

Cognitive theory is concerned with the development of a person's thought processes. It also looks at how these thought processes influence how we understand and interact with the world. Piaget

proposed an idea that seems obvious now, but helped revolutionize how we think about child development: *Children think differently than adults*.

Theorist Jean Piaget proposed one of the most influential theories of cognitive development. His cognitive theory seeks to describe and explain the development of thought processes and mental states. It also looks at how these thought processes influence the way we understand and interact with the world.

Piaget then proposed a theory of cognitive development to account for the steps and sequence of children's intellectual development.

- **The Sensorimotor Stage:** A period of time between birth and age two during which an infant's knowledge of the world is limited to his or her sensory perceptions and motor activities. Behaviors are limited to simple motor responses caused by sensory stimuli.
- **The Preoperational Stage:** A period between ages 2 and 6 during which a child learns to use language. During this stage, children do not yet understand concrete logic, cannot mentally manipulate information and are unable to take the point of view of other people.
- **The Concrete Operational Stage:** A period between ages 7 and 11 during which children gain a better understanding of mental operations. Children begin thinking logically about concrete events but have difficulty understanding abstract or hypothetical concepts.
- **The Formal Operational Stage:** A period between age 12 to adulthood when people develop the ability to think about abstract concepts. Skills such as logical thought, deductive reasoning, and systematic planning also emerge during this stage.

Piaget's Four Stages of Development

Bowlby's Attachment Theory

There is a great deal of research on the social development of children. John Bowbly proposed one of the earliest theories of social development. Bowlby believed that early relationships with caregivers play a major role in child development and continue to influence social relationships throughout life.

Bowlby's attachment theory suggested that children are born with an innate need to form attachments. Such attachments aid in survival by ensuring that the child receives care and protection. Not only that, but these attachments are characterized by clear behavioral and motivational patterns. In other words, both children and caregivers engage in behaviors designed to ensure proximity. Children strive to stay close and connected to their caregivers who in turn provide a safe haven and a secure base for exploration.

Researchers have also expanded upon Bowlby's original work and have suggested that a number of different attachment styles exist. Children who receive consistent support and care are more likely to develop a secure attachment style, while those who receive less reliable care may develop an ambivalent, avoidant, or disorganized style.

Attachment Theory

Bandura's Social Learning Theory

Social learning theory is based on the work of psychologist Albert Bandura. Bandura believed that the conditioning and reinforcement process could not sufficiently explain all of human learning. For example, how can the conditioning process account for learned behaviors that have not been reinforced through classical conditioning or operant conditioning?

According to social learning theory, behaviors can also be learned through observation and modeling. By observing the actions of others, including parents and peers, children develop new skills and acquire new information.

Bandura's child development theory suggests that observation plays a critical role in learning, but this observation does not necessarily need to take the form of watching a live model. Instead, people can also learn by listening to verbal instructions about how to perform a behavior as well as through observing either real or fictional characters display behaviors in books or films.

Social Learning Theory

Vygotsky's Sociocultural Theory

Another psychologist named Lev Vygotsky proposed a seminal learning theory that has gone on to become very influential, especially in the field of education. Like Piaget, Vygotsky believed that children learn actively and through hands-on experiences. His sociocultural theory also suggested that parents, caregivers, peers and the culture at large were responsible for developing higher order functions.

In Vygotsky's view, learning is an inherently social process. Through interacting with others, learning becomes integrated into an individual's understanding of the world. This child development theory also introduced the concept of the zone of proximal development, which is the gap between what a person can do with help and what they can do on their own. It is with the help of more knowledgeable others that people are able to progressively learn and increase their skills and scope of understanding.

Sociocultural Theory

A Word From Verywell

As you can see, some of psychology's best-known thinkers have developed theories to help explore and explain different aspects of child development. While not all of these theories are fully accepted today, they all had an important influence on our understanding of child development. Today, contemporary psychologists often draw on a variety of theories and perspectives in order to understand how kids grow, behave, and think.

These theories represent just a few of the different ways of thinking about child development. In reality, fully understanding how children change and grow over the course of childhood requires looking at many different factors that influence physical and psychological growth. Genes, the environment, and the interactions between these two forces determine how kids grow physically as well as mentally.

https://www.verywellmind.com/child-development-theories-2795068

What is Early Childhood Education?

Early childhood education is a broad term used to describe any type of educational program that serves children in their preschool years, before they are old enough to enter kindergarten. Early childhood education may consist of any number of activities and experiences designed to aid in the cognitive and social development of preschoolers before they enter elementary school.

How and where early childhood education is provided can be very different from one state to the next – or even from one school to the next within the same state. Preschool education programs may be designed specifically for either three-, four-, or five-year olds, and they may be provided in childcare and daycare or nursery school settings, as well as more conventional preschool or pre-kindergarten classrooms. These programs may be housed in center-based, home-based, or public school settings, and they may be offered part-day, full-day or even on a year-round schedule to include summers.

Early childhood education programs also differ in terms of funding and sponsorship, and can be privately run, operated by a local school system, or operated through a federally funded program like Head Start.

Federal, State and Privately Funded Early Childhood Education Programs

One of the first early childhood education initiatives in the U.S. was the Head Start program, which was created in 1965. This federally funded education initiative, which is funded by the Department of Health and Human Services, provides children from families with a lower-socioeconomic status or those who qualify under a specific at-risk category with free access to early childhood education programs.

Many early childhood education programs in the U.S. now operate under the auspices of Title I of the Elementary and Secondary Act. Local educational agencies may apply to state agencies through Title I; those that are approved through the state are then funded with federal money. The No Child Left Behind Act encourages the use of Title I funds for preschool programs.

The National Institute for Early Education Research reported that 28 percent of America's four-year-olds (or 1.4 million) were enrolled in a state-funded preschool program during the 2012-13 school year, with 40 states and Washington D.C. all offering state-funded preschool programs. State pre-k programs continue to be the primary program for four-year-olds in the majority of states, with recent statistics showing that 85 percent of all four-year-olds enrolled in preschool were enrolled in a program that receives state funds.

Georgia was the first state in the nation to introduce a statewide universal pre-k program, which provides early childhood education to all four-year-olds in the state. Since then, New York, Oklahoma, and Florida have followed suit.

Finally, early childhood education programs may be run by private for-profit companies, by churches, or as part of a private school curriculum. It is common for these types of early childhood education programs to be tuition-based.

The Elements of an Early Childhood Education Program

There has been much debate over the years about what type of program qualifies as simply care and what type of program qualifies as education. Another concern of today's early childhood education programs is ensuring that they are of high quality.

The Early Education for All Campaign (www.strategiesforchildren.org), a coalition of leaders who work to ensure that children in Massachusetts have access to high-quality early education, recognizes early childhood education as "…warm, nurturing care and enriched learning experiences designed to simulate a child's development in all key developmental areas."

The National Education Association recognizes that a high-quality early childhood program includes five, critical components:

- Provides a well-rounded curriculum that supports all areas of development
- Addresses child health, nutrition, and family needs as part of a comprehensive service network
- Assesses children to enhance student learning and identify concerns
- Employs well-educated, adequately paid teachers
- Provides small class sizes and low teacher-child ratios

The U.S. Department of Education recognizes that the effectiveness of an early childhood program is dependent upon a number of factors:

- A quality staff
- An appropriate environment
- Consistent scheduling
- Parental involvement
- Proper grouping practices

This federal agency also recognizes additional characteristics of a high-quality early education program:

- A balance between individual, small group, and large group activities
- A balanced schedule that does not result in rushed or fatigued children
- A clear statement of goals and a comprehensive philosophy that addresses all areas of child development
- A strong foundation in language development, early literacy, and early math
- Access to a safe, nurturing, and stimulating environment, along with the supervision and guidance of competent, caring adults
- Engages children in purposeful learning activities and play, which is instructed by teachers who work from lesson and activity plans
- Nutritious meals and snacks
- Teachers and staff who regularly communicate with parents and caregivers
- Teachers who frequently check children's progress

The Early Education for All Campaign outlines the quality characteristics of high-quality early childhood education curriculum and activities:

- Balanced: The curriculum should provide a balance of play and structured activities, including teacher- and child-initiated exploration.
- Based on a child's developmental needs: Activities, materials, and schedules should be appropriate to a child's age and support all developmental domains.
- Well-planned: The curriculum should reflect current research on child development and should include specific learning goals for children.

Preschool Teachers and their Role in a High-Quality Preschool Program

According to the Early Childhood-Head Start Task Force (a joint effort between the U.S. Department of Education and the U.S. Department of Health and Human Services), preschool teachers teach and nurture our youngest children. These early childhood educators help these young learners become successful learners, readers, and writers.

As such, preschool teachers play an important role in the lives of preschoolers, some of whom may lack adequate experiences at home. These professionals help children:

- Become familiar with books and other printed materials
- Develop language abilities
- Increase their knowledge
- Learn letters and sounds
- Learn to count
- Recognize numbers

Preschool teachers may use a number of strategies for teaching the above skills while they nurture their students' natural curiosity and their zest for learning. Preschool teachers can accomplish their teaching goals by:

- Building children's background knowledge and thinking skills
- Checking children's progress
- Communicating with parents and caregivers
- Creating a learning environment for young children
- Helping children develop listening and speaking skills
- Reading aloud to children
- Teaching children about books
- Teaching children about letters
- Teaching children about numbers and counting
- Teaching children about print
- Teaching children about the sounds of spoken language

https://www.preschoolteacher.org/what-is-early-childhood-education/

Community Resources

Children's Health & Education Reinforced in Supportive Homes *C.H.E.R.I.S.H. program provide comprehensive services to families of preschool students such as education, basic need, and health support services.*	Northern NV: (775) 303-7944 Southern NV: (702) 408-8131	Email Northern NV: bcambra@childrenscabinet.org Email Southern NV: mcunningham@childrenscabinet.org
Child Find *Asses children for special education eligibility, develop IEP, connects families to community resources, works with NV Early Intervention.*	Clark County: (702) 799-7463	Email (Clark County): hermavb@nv.ccsd.net
Las Vegas Urban League Early Childhood Connection *Provide early childhood development assistance such as child care subsidy, resource and referral, and education and training.*	Clark County: (702) 473-9400	Website: www.lvul.org
Nevada Early Intervention Provides services/evaluations to children birth until three with developmental delay or disabilities.	(800) 522 -0066	Email: ProjectAssist@dhhs.nv.gov
Nevada Home Instruction for Parents of Preschool Youngsters *Nevada H.I.P.P.Y. provide an evidence-based home visiting program to parents of 3, 4 or 5 y/o that support the parents in their roles as child's first educator.*	(702) 731-8373 (702) 648-1885	Email: abtriche@sunrisechildren.org
Nevada Hands and Voices *A parent-driven program that provides support to families with deaf/hard of hearing children.*	Northern NV: 775-351-1959 Southern NV: 702-321-3291	Website: https://www.nvhandsandvoices.org/
Nevada P.E.P. *Provides information, services, and training to families of children with disabilities.*	Clark County: (702) 388-8899 Reno/Sparks: (775) 448-9950 Toll Free: (800) 216-5188	Website: https://www.nvpep.org/
Spirit Therapies *Support families with children who have down syndrome, muscular dystrophy, Angelman's syndrome, and other disabilities by offering physical and therapeutic services.*	Client: (702) 219-1728 Volunteer: (702) 580-7816	Email: info@spirittherapies.org Email: volunteer@spirittherapies.org Website: https://www.spirittherapies.org/index.html
Solace Tree *Provides support to children, teens, and adults who are grieving loss or struggling emotionally and mentally.*	Reno, NV: (775) 324-7723	Email: info@solacetree.org Website: http://www.solacetree.org/
Tick Tock Therapy *Dedicated to providing individualized family-centered pediatric therapy services such as speech therapy, screenings, and social groups.*	(800) 966-0535	Email: office@ticktalktherapy.com Website: http://www.ticktalktherapy.com/Home_Page.html
Clark County Library (Vroom) *Connecting people of all ages from community to resources such as activity groups, computer use, employment assistance, and adult learning.*	(702) 734-READ	https://lvccld.org/

The State of Nevada's Babies

STATE OF BABIES YEARBOOK 2019

Where children are born can affect their chances for a strong start in life. Babies need good health, strong families, and positive early learning experiences to foster their healthy brain development and help them realize their full potential.

This fact sheet provides a snapshot of how infants, toddlers, and their families are faring with respect to these three developmental domains. For each domain, selected child or family indicators and policy indicators are highlighted and compared to national averages. Important demographic information is also included. A summary table of all indicators is provided on the last page, for reference.

Nevada's Rankings

KEY G Getting Started R Reaching Forward O Improving Outcomes W Working Effectively

Overall
GROW
Getting Started

Good Health
GROW
Getting Started

Strong Families
GROW
Getting Started

Positive Early Learning Experiences
GROW
Getting Started

Demographics

Infants and toddlers in Nevada

Overview

Nevada is home to 111,170 infants and toddlers, representing 3.7 percent of the state's population. As many as 51 percent live in households with incomes less than twice the federal poverty line (in 2017, about $50,000 a year for a family of four), placing them at economic disadvantage. America's youngest children are diverse and are raised in a variety of family contexts. A broad array of policies and services are required to ensure that all of them have an equitable start in life.

NEVADA NATIONAL AVERAGE

Race/ethnicity of infants and toddlers

	NEVADA	NATIONAL AVERAGE
Hispanic	40.7%	26.1%
Non-Hispanic White	34.8%	49.3%
Non-Hispanic Black	10.0%	13.8%
Non-Hispanic other	8.2%	5.1%
Non-Hispanic Asian	5.4%	4.9%
American Indian/Alaska Native	0.9%	0.8%

Working moms

	NEVADA	NATIONAL AVERAGE
Mothers in the Labor Force	64.0%	61.5%

Poverty status of infants and toddlers

	NEVADA	NATIONAL AVERAGE
Above Low-Income	49.3%	55.4%
Low-Income	28.4%	22.0%
In Poverty	22.3%	22.7%

Infants and toddlers in poverty, by race

	NEVADA	NATIONAL AVERAGE
Hispanic	29.8%	30.8%
Non-Hispanic Black	29.1%	39.5%
Non-Hispanic Other	20.3%	20.0%
Non-Hispanic White	12.7%	14.6%

Family structure

	NEVADA	NATIONAL AVERAGE
2-Parent Family	70.9%	76.3%
1-Parent Family	27.7%	21.5%
No Parents Present	1.4%	2.2%

Grandparent-headed households

	NEVADA	NATIONAL AVERAGE
	8.6%	9.4%

Rural/Non-metro area

	NEVADA	NATIONAL AVERAGE
Living Outside of a Metro Area	5.1%	8.7%

Good Health
In Nevada

GROW

What is Good Health?

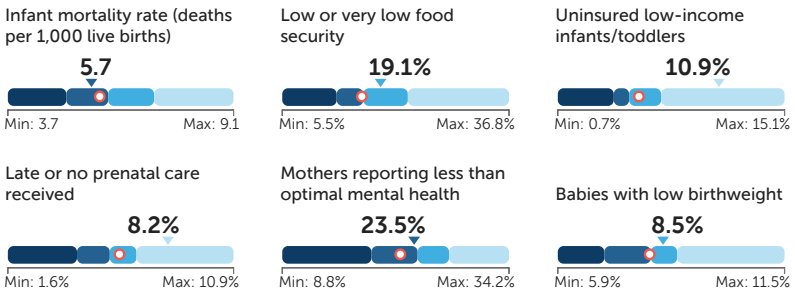
Good physical and mental health provide the foundation for babies to develop physically, cognitively, emotionally, and socially. The rate of brain growth is faster in the first 3 years than at any other stage of life, and this growth sets the stage for subsequent development. Access to good nutrition and affordable maternal, pediatric, and family health care are essential to ensure that babies receive the nourishment and care they need for a strong start in life.

Nevada falls in the Getting Started (G) tier of states when it comes to the overall health of infants and toddlers. The state's low ranking in the Good Health domain primarily reflects indicators in the Getting Started (G) tier, including those for the health care access and affordability subdomain. However, most child health indicators are in the Improving Outcomes (O) tier, such as preventive dental care and recommended vaccines received among infants and toddlers.

Six Key Indicators of Good Health

KEY ⟵ Range of all state values ⟶ ▼ Nevada ○ National average

G Getting Started R Reaching Forward O Improving Outcomes W Working Effectively



Good Health Policy in Nevada

Medicaid expansion state	Yes ☑
State Medicaid policy for maternal depression screening in well-child visits	Allowed
Medicaid plan covers social-emotional screening for young children	Yes ☑
Medicaid plan covers IECMH services at home	Yes ☑
Medicaid plan covers IECMH services at pediatric/family medicine practices	Yes ☑
Medicaid plan covers IECMH services at ECE programs	Yes ☑

Strong Families
In Nevada

GROW

What Defines Strong Families?

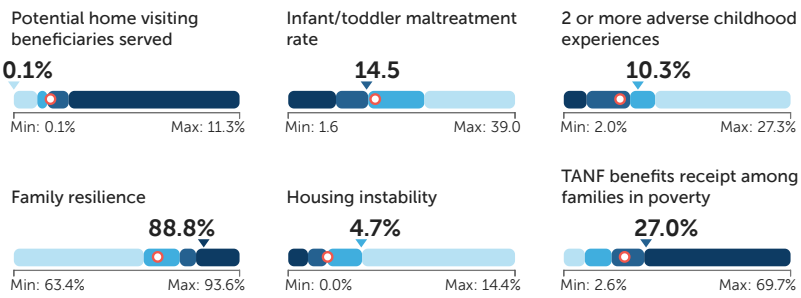
Young children develop in the context of their families, where stability and supportive relationships nurture their growth. All families of infants and toddlers benefit from support with parenting, and many—particularly those challenged by economic instability—need access to resources that help them meet their children's daily and developmental needs. Important supports include home visiting services, child welfare systems that are responsive to young children's needs, and family-friendly employer policies that provide paid sick and family leave.

Nevada falls in the Getting Started (G) tier of states when it comes to indicators of Strong Families. The state's low ranking in this domain is primarily due to indicators related to access to basic needs and supports scoring in the Reaching Forward (R) and Getting Started (G) tiers, such as housing instability and crowded housing. However, with respect to child welfare indicators, such as the state's infant/toddler maltreatment rate, Nevada is primarily in the Reaching Forward (R) tier.

Six Key Indicators of Strong Families

KEY ⟵ Range of all state values ⟶ ▼ Nevada ○ National average

G Getting Started R Reaching Forward O Improving Outcomes W Working Effectively



Strong Families Policy in Nevada

Paid sick time that covers care for child	No ⊗
Paid family leave	No ⊗

Positive Early Learning Experiences

In Nevada

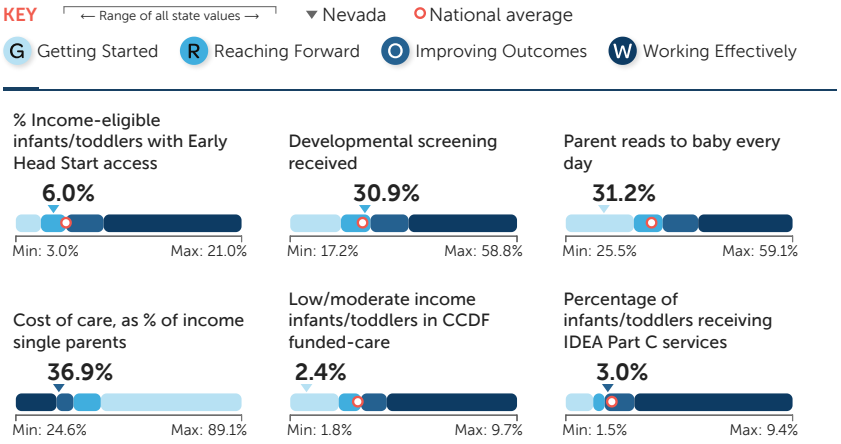
GROW

What Defines Positive Early Learning Experiences?

Infants and toddlers learn through play, active exploration of their environment, and, most importantly, through interactions with the significant adults in their lives. The quality of babies' early learning experiences at home and in other care settings has a lasting impact on their preparedness for life-long learning and success. Parents who require child care while they work or attend school need access to affordable, high-quality care options that promote positive development.

Nevada scores in the Getting Started (G) tier of states when considering key indicators related to early care and education and early intervention for infants and toddlers. The state's low ranking in the Positive Early Learning Experiences domain primarily reflects indicators in the Getting Started (G) tier. However, Nevada is in the Improving Outcomes (O) tier on indicators such as the percentage of parents singing songs to babies daily, and the state's average infant care costs as a percentage of single parents' incomes.

Six Key Indicators of Positive Early Learning Experiences



Positive Early Learning Experiences Policy in Nevada

Families above 200% of FPL eligible for child care subsidy	No

All indicators for Nevada

G Getting Started R Reaching Forward O Improving Outcomes W Working Effectively

Good Health

G Eligibility limit (% FPL) for pregnant women in Medicaid	**165.0** *National average: 200.0*	G Uninsured low-income infants/toddlers	**10.9%** *National average: 5.8%*
R Low or very low food security	**19.1%** *National average: 16.5%*	O Infants ever breastfed	**83.5%** *National average: 83.2%*
G Infants breastfed at 6 months	**49.9%** *National average: 57.6%*	G Late or no prenatal care received	**8.2%** *National average: 6.2%*
O Mothers reporting less than optimal mental health	**23.5%** *National average: 22.0%*	G Preventive medical care received	**88.0%** *National average: 90.7%*
O Preventive dental care received	**34.9%** *National average: 30.0%*	R Babies with low birthweight	**8.5%** *National average: 8.2%*
O Infant mortality rate (deaths per 1,000 live births)	**5.7** *National average: 5.9*	O Received recommended vaccines	**71.9%** *National average: 70.7%*

Strong Families

R Housing instability	**4.7%** *National average: 2.5%*	G Crowded housing	**17.7%** *National average: 15.6%*
O TANF benefits receipt among families in poverty	**27.0%** *National average: 20.6%*	O Infant/toddler maltreatment rate	**14.5** *National average: 16.0*
R Unsafe neighborhoods	**5.5%** *National average: 6.3%*	W Family resilience	**88.8%** *National average: 82.6%*
G 1 adverse childhood experience	**28.1%** *National average: 21.9%*	R 2 or more adverse childhood experiences	**10.3%** *National average: 8.3%*
R Infants/toddlers exiting foster care to permanency	**97.7%** *National average: 98.4%*	G Potential home visiting beneficiaries served	**0.1%** *National average: 1.9%*

Positive Early Learning Experiences

G Parent reads to baby every day	**31.2%** *National average: 38.2%*	O Parent sings to baby every day	**58.5%** *National average: 56.4%*
R % Income-eligible infants/toddlers with Early Head Start access	**6.0%** *National average: 7.0%*	G Cost of care, as % of income married families	**14.3%** *National average: N/A*
O Cost of care, as % of income single parents	**36.9%** *National average: N/A*	G Low/moderate income infants/toddlers in CCDF funded-care	**2.4%** *National average: 4.2%*
R Developmental screening received	**30.9%** *National average: 30.4%*	O Infants/toddlers with developmental delay	**0.4%** *National average: 1.1%*
O Percentage of infants/toddlers receiving IDEA Part C services	**3.0%** *National average: 3.1%*		

Children's Advocacy
ALLIANCE
an independent voice
for nevada's children

2018
NEVADA CHILDREN'S REPORT CARD

Overall Grade

D

2018 Summary of Grades

Health D

Access to Health Care	F-
Prenatal/Infant Health	D+
Immunizations	C-
Childhood Obesity	B-
Dental Health	F+
Mental Health	C-
Sexual Health	D-

D

SAFETY: C-

Child Maltreatment	C
Youth Homelessness	D
Juvenile Violence	D+
Child Deaths & Injuries	C
Substance Abuse	B

C-

EDUCATION: F

School Readiness	F-
Student Achievement	F
High School Completion	F-
Funding	F

F

ECONOMIC WELL-BEING: D

Employment	C+
Housing	D-
Poverty	D
Income	D

D

How Grades are Determined: By State Ranking (Where Available)

1-3 = A+	11-13 = B+	21-23 = C+	31-33 = D+	41-43 = F+
4-7 = A	14-17 = B	24-27 = C	34-37 = D	44-47 = F
8-10 = A-	18-20= B-	28-30 = C-	38-40 = D-	48-51 = F-

The following symbols indicate Nevada's progress on the indicators, not necessarily where the state ranked compared to other states. There are instances where Nevada's indicator has improved, but our rank has gone down (due to other state's improving more than Nevada). Because the grades are based on Nevada's rank, this may result in a lower grade, despite improvements on the indicator.

Making a Difference in a Child's Life

Children's Advocacy Alliance (CAA) is an independent voice dedicated to achieving public policy wins in the areas of child safety, health and school readiness. CAA creates lasting change by tackling the biggest issues that kids and families face in Nevada.

Serving as a leading advocate for children in Nevada since 1998, the CAA is comprised of community leaders dedicated to improving the lives of children and families. To achieve our goals, CAA:

- Brings people together to build consensus around priorities and to leverage our collective strength towards real reform;
- Collects, analyzes and shares research and information with people who make decisions impacting Nevada's children and families; and
- Builds public will through education, outreach and advocacy to solve expansive and chronic problems facing kids and families.

When we come together to face the biggest issues for kids and families, we can create more and longer-lasting change. By pooling our resources to put government on the side of Nevada's children, we can make a bigger difference together than we could have done alone.

How You Can Help:

Become a friend of CAA by supporting our work on the issues you care most about, like ensuring our kids are safe from abuse and neglect, that every child enters school ready to learn, and that all of our kids are healthy. We share your passion for change, and by joining our team, you'll see your investments go further and reach more kids with advocacy.

Go online at **www.caanv.org** and click "donate" to make a contribution today.

The CAA is a 501(c)3 nonprofit organization – all donations and contributions to CAA may be tax deductible. Please contact your financial advisor for additional information.

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Health D

ACCESS TO HEALTHCARE: F-

Access to Health Care grade considers: the number of children without insurance; children who have a medical home; and patient to provider ratios (per 100,000). In 2017, Nevada ranked 47th in the nation for percentage of children without health insurance* at 8%, a decrease from 9.6% in 2014. With the implementation of the ACA, Nevada had the highest percent increase of coverage in the nation and continues to improve within the state of Nevada. Nevada ranks 51st in the percentage of children with a medical home and 48th in patient provider ratios at 70.1 per 100,000, an increase of only .3 from the previous period. **This indicator changed from the previous report card to include 18-year-olds.*

PRENATAL/INFANT HEALTH: D+

Prenatal/infant health is based upon: the percentage of pregnant women receiving late or no prenatal care; infant and child mortality; and low birth weight babies. Nevada's ranking dropped in its infant and child mortality rates, increasing from 5.1 per 1,000 to 5.7 per 1,000, decreasing its ranking from 13th to 17th in the nation. There was also a slight increase in the percentage of low birth weight babies, increasing from 8.0% to 8.5%, decreasing the ranking from 23rd to 30th overall. The most significantly improved data point in this area was women receiving late or no prenatal care, which dropped from 9% to 8.2% in 2016. Despite this decrease, Nevada's ranking dropped from 43rd to 46th, primarily because other states saw more significant reductions in this same time period, with a U.S. average of 6.2%.

IMMUNIZATIONS: C-

The immunizations grade is based on the percentage of children aged 19 to 35 months receiving recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines, and new to this year's report card, adolescents who are up to date on the HPV vaccinations. In 2016, Nevada ranked 24th in the nation for children aged 19 to 35 months receiving recommended doses of DTaP, polio, MMR, Hib, hepatitis B, and PCV vaccines, with a percentage of 71.9%, a substantial increase from 2015 where Nevada ranked 37th with a percentage of 67.7%. Nevada ranked 29th in the nation for adolescents who are up to date on their HPV vaccinations at 49%, slightly above the U.S. average of 48.6%.

CHILDHOOD OBESITY: B-

Childhood Obesity consists of: the percentage of 9th-12th grade students whose Body Mass Index (BMI) is at/or above the 85th percentile but not higher than the 95th percentile (overweight) and whose BMI is higher than the 95th percentile (obese); students not physically active 5 days per week for 60+ minutes; and those students who reported that they did not consistently eat fruit*. Nevada ranked 8th in the nation for the percentage of students who are overweight at 14.3% and 19th for those who are obese at 14% (a decrease from 15% and increase from 12.2%, respectively, in 2017). Inactivity increased from 49% in 2015 to 53.6% in 2017. In Nevada, 7.5% of youth reported not consistently eating fruit, compared to the U.S. average of 5.6%. **This indicator changed from the previous report card from vegetables to fruit.*

DENTAL HEALTH: F+

Since the previous report card, the dental health indicator has changed to reflect the preventative dental health care of children 0-18 instead of 9th-12th graders and includes the percentage of children who have had no preventative dental care visits in the past year and whose teeth were described as being in fair or poor condition. Nevada ranks 42nd for both indicators in the nation, respectively, for these two categories with 6.1% of children having fair to poor teeth and 20.1% of our children receiving no preventive dental care.

MENTAL HEALTH: C-

The Mental Health grade is based upon: mental health treatment; attempted suicides; and teen suicide rates. Nevada ranks 41st in the nation for mental health

treatment in which children needed mental health treatment or counseling in the past 12 months and did not receive it. Nevada's attempted suicide rate has greatly decreased, moving from 10.7% in 2015 to 7.4% in 2017, increasing our rank from 30th to 9th. However, Nevada's suicide rate has increased from 2.29 to 4.2 (per 100,000 children ages 0-18), decreasing our rank from 16th to 32nd.

SEXUAL HEALTH: D-

Sexual Health is based upon five indicators: teen birth rate; sexual activity; condom use; any birth control use; and sexually transmitted disease rates. With 18.9% of Nevada school students not using any type of birth control, the state ranks 31 out of 37 states. However, the teen birth rate in Nevada has decreased, moving from 29 births per 1,000 females ages 15 to 19 in 2015 to 24 per 1,000 births per 1,000 females in 2017 giving Nevada a ranking of 32nd. Nevada ranks 18 out of 39 states for condom use and is slightly above average for STI rates for Chlamydia and Gonorrhea, but has decreased ranking from the previous report card at 31st and 30th respectively. The Syphilis rate for teens in Nevada has slightly decreased from 25.1 per 100,000 in 2014 to 22.9 per 100,000 in 2017, but still is below the U.S. average of 14.8 per 100,000

Safety C-

CHILD MALTREATMENT: C- ↔

Nevada's child maltreatment grade is based upon total child maltreatment, but also looks at physical, sexual and neglectful maltreatment. Nevada's grade has remained stable over the past few report cards, going from 15th to 17th in the nation. For physical, sexual and neglectful maltreatment, Nevada ranked 38th, 20th, and 32nd respectively. This contributed to Nevada's ranking of 30th in the nation for Foster Care Placement, in which an average of 5 children were removed from their homes and placed in foster care per 1,000 children in 2016.

YOUTH HOMELESSNESS: D ↔

In 2017, Nevada placed 51st in the nation for child and youth homelessness, with 2,166 unaccompanied homeless children and youth (231.8 per 100,000) reported in the U.S. Department of Housing and Urban Development's 2017 Annual Homeless Assessment Report to Congress. Nevada again had the highest rate of unsheltered unaccompanied children and youth in the United States with no improvement at 89.2% of unaccompanied homeless children and youth under 25 found living in the streets-rather than in shelters-during the 2017 Point-In-Time Count. These statistics continue to show that Nevada severely lacks adequate shelter for unaccompanied homeless youth in Nevada. Nevada ranked 12th in the nation for the total share of homeless families.

JUVENILE VIOLENCE: D+ ↓

The Juvenile Violence ranking is based upon: high school violence; weapons on school property; dating violence; fear of violence; and juvenile justice. In 2017, 9% of Nevada's high school students felt unsafe attending school; 26th in the nation. While the ranking for the state has improved since the last report card, the percentage has slightly increased from 8.5% in 2015. Nevada ranked 15th out of 38 states for students reporting to have brought a weapon to school at 4.7% and 5th in the nation for the percentage of students who have been in a fight on campus at 5.9%, an improvement from 6.8% in 2015. Nevada ranked 5th out of 39 and 11th out of 29 states, respectively, for both physical and sexual dating violence with 6.7% experiencing physical and 10.3% experiencing sexual dating violence (both decreases from 2015). Nevada ranked 42nd for juvenile justice with 209 per 100,000 youth residing in juvenile detention, correctional and/or residential facilities.

CHILD DEATHS AND INJURIES: C ↔

Child deaths and injuries is based upon: overall child deaths; road traffic injuries and deaths; and new to this report card, combined unintentional injuries, homicide, and suicide. In 2016, Nevada ranked 34th in the nation for child deaths with 20 deaths per 100,000 children, a slight increase from 2014. This number is slightly above the national average of 17 deaths per 100,000. Nevada ranked 10th in the nation for transportation related deaths in 2016– a slight improvement from 13th in 2014. In 2016, Nevada ranked

16th in the nation for combined unintentional injuries, homicide, and suicide rates at 16.9 per 100,00 deaths, not so different from the national average of 16.5 per 100,000 deaths.

SUBSTANCE ABUSE: B

Nevada continues to improve in the percentage of high school students who smoke cigarettes (6.7%) and who use smokeless tobacco (3%), ranking 9th and 2nd respectively in 2017. Nevada has greatly improved in students who use any type of tobacco, decreasing from 30.4% in 2015 to 11.5% in 2017, ranking 6th in the nation. New to this report is students who use electronic vapor products. Nevada ranks 22nd out of 32 in high school students ever using an electronic vapor product at 42.1%. Nevada ranked 11th in alcohol use with 25.8% of students reporting they currently consume alcohol. Approximately 17.9% of high schoolers smoke marijuana, ranking Nevada 14th out of 42 states. Nevada continues to rank low for ecstasy use, which comes in at 24th out of 31 states and has slightly improved for prescription drug use at 26th out of 39 states. For inhalants and heroin use, Nevada ranks 20th out of 30 and 18th out of 36, respectively. Overall, substance abuse has declined in the state but it is important to note that the use of electronic vapor products is on the rise

Education F

SCHOOL READINESS: F-

The School Readiness grade is comprised of preschool enrollment, availability, and spending per capita. Nevada is currently 48th in the nation for preschool enrollment, a slight improvement from the last report card; only 36.7% of 3- and 4-year olds are currently enrolled. Of the 36.7% of enrolled students, only 12% are enrolled in State preschool, Special Education, or Head Start- ranked 48th in the nation. Nevada ranks 41st for state spending per capita for states that offer preschool programs, currently investing $65.79, a slight improvement from 2015, but still significantly below the national average of $955.22. Given the limited capacity of public preschool programs, efforts have also been made to increase access to high quality early learning programs. Between September 2015 and March 2018, Nevada increased monthly subsidy (child care assistance) caseload by 4188 children, an increase of 77.86%.

STUDENT ACHIEVEMENT: F

Student Achievement is based upon 4th grade reading, 8th grade math and postsecondary participation. There has been a slight increase in the percent of reading and math score at or above proficiency; reading scores have increased from 29% to 31% and math scores from 26.1% to 27%. Nevada still remains near the bottom for both rankings, 43rd for reading and 41st for math. Nevada ranks 50th overall for postsecondary participation, with just 41% of young adults enrolled in postsecondary education or with a degree.

HIGH SCHOOL COMPLETION: F-

Nevada ranked 49th in the nation for high school dropouts (teens age 16 to 19 who are not in school and have not yet graduated from high school) in 2016 at 7%- a slight increase from the last report card at 6%. High school graduation rates have increased greatly, from 60% for the class

of 2012 to 73.6% for the class of 2016. However, Nevada still ranks low at 49th in the nation, and is below the national average of 84.1%. It is hopeful that continuing investments in education will help to increase all of these numbers in the coming years.

FUNDING: F ↑

Per pupil expenditures is calculated for grades pre-kindergarten through 12th grade for public elementary and secondary education. Actual expenditures for the 2015-2016 fiscal year were $8,960 compared to $11,762 nationally. Nevada ranked 43rd in this category, a slight increase from the last report card. Nevada's low per pupil expenditure continues to cause high student-teacher ratios. Nevada is ranked 48th in the nation with a continuing average of 20.6 compared to 16 nationally. In 2013, Nevada ranked 14th overall in the nation for categorical funding, allocating over 200 million dollars. Nevada has since increased categorical funding amounts in the past two sessions (2015 and 2017), investing nearly 500 million more dollars.

Economic Well-Being D

EMPLOYMENT: C+ ↑

The employment grade is comprised of the percentage of children whose parents lack secure employment and the unemployment rate of parents. In 2016, Nevada ranked 33rd in the nation for the percentage of children whose parents lack secure employment at 30%, a slight improvement from 32% in 2014. We also saw a great improvement in unemployment for parents, dropping from 6% in 2014 to 3% in 2017.

HOUSING: D- ↑

In 2016, 34% of children lived in a household with a high housing cost burden, where more than 30 percent of the monthly income was spent on rent, mortgage payments, taxes, insurance, and/or related expenses. This is a decrease from 2014 at 37% respectively. For children in low-income households with a high housing cost burden, Nevada is at the national average at 61% and ranks 28th in the nation overall.

POVERTY: D ↑

The poverty grade is based upon the percentage of children in poverty (100 percent poverty) and children in extreme poverty (50 percent poverty), and new to this report card is children who live in households that were food insecure at some point during the year. Nevada ranked 31st for children in poverty (100 percent poverty) at 19%. This is the same as the national average and is a decrease from 22% reported in 2014. Children in extreme poverty has slightly improved from 10% in 2014 to 7% in 2017 and ranks 29th in the nation. In 2016, 20.5% of children in Nevada were food insecure at some point during the year, ranking 39th in the nation.

INCOME: D ↑

The income grade is determined by the number of teens ages 16-19 not attending school and not working and low-income working families with children. Nevada is currently 30th in the nation for teens aged 16-19 not attending school and not working at 6%, a decrease from 9% in 2014. In 2016, Nevada ranked 38th in the nation for low-income working families with children at 24%, a slight decrease from 26% in 2014.

We Can
Improve Our Grades

To ensure the safety and well-being of our children, and their families, the Children's Advocacy Alliance supports policies to:

- Increase prevention programs and interventions that reduce the need for child welfare and juvenile justice engagement.
- Improve programs and practice necessary to support children and families involved in child welfare or juvenile justice.
- Protect children from violence, abuse, injury or death within their homes and communities.

To ensure that every child in Nevada has the opportunity to enter school ready to learn, the Children's Advocacy Alliance supports policies to:

- Increase access to high quality, affordable child care for all children.
- Improve parent education and family support programs designed to enhance the confidence and competency of all parents and support them in their role as their children's first and most important teachers.
- Ensure a highly qualified and appropriately compensated early childhood workforce.

To ensure that children have every opportunity to grow up healthy, the Children's Advocacy Alliance supports policies to:

- Increase access to high quality, affordable health care, including oral health and mental health.
- Promote on-time, recommended childhood immunizations.
- Improve access to food that supports good nutrition, including an adequate supply of fruits and vegetables.
- Enable communities to provide a safe place to run and play, offering ample opportunities for physical activity.
- Increase access to high quality, and on-time, prenatal care.

Children's Advocacy
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