file: Early Childhood Prof. Development

naeyc

National Association for the Education of Young Children
1509 16th Street, N.W., Washington, DC 20036-1426
202-232-8777 800-424-2460
FAX 202-328-1846 http://www.naeyc.org

Facsimile Cover Sheet

Date 4/4/00

To Anne O'Leary

456-2878

FAX number

From Adele Ext. 627

Number of pages (including this one)

Remarks

THANKS

March 8, 2000

United States Senate
Committee on Health, Education, Labor and Pensions
Washington, DC 20510

Dear Senator:

We are writing to urge you to vote in favor of the Early Childhood Educator Professional Development amendment to be offered by Senator Dodd to S. 2, the Elementary and Secondary Education Act. This amendment would provide competitive grants to local partnerships that focus on two important goals for children's success in school: early literacy and violence prevention.

If children are to read at grade level, their early childhood educators must have the training to help young children develop pre-literacy skills. Research shows that children who attend early childhood education programs led by highly qualified educators are more likely to have these skills and to succeed in school. Yet, only about forty percent of preschool teachers have a high school diploma and just ten percent have a two-year degree from a community or junior college. Many preschool teachers receive only ten hours of training each year. By focusing on the professional development of early childhood educators, particularly in literacy, many more children will be able to succeed in school.

These grants also would be used to train early childhood educators in identifying and preventing behavioral problems or violent behavior. As evidenced by the recent tragedy in Michigan, violence prevention must begin with very young children. With the skills and knowledge on how to effectively help young children deal with anger and conflict without violence and identify and refer children for other needed services, early childhood educators can make a difference on this important issue.

We urge you to vote yes on this amendment.

Sincerely,

American Federation of School Administrators
American Federation of Teachers
American Psychological Association
Center for the Child Care Workforce
Children's Defense Fund
Child Welfare League of America
Council for Exceptional Children
Division for Early Childhodd, CEC
Fight Crime: Invest in Kids
National Association for Bilingual Education
National Association for the Education of Young Children
National Association of School Psychologists
National Council of Jewish Women
National Education Association
National Head Start Association

National Women's Law Center
School Social Work Association of America

O:\KOS\KOS00.162 S.L.C.

Dodd #3

AMENDMENT NO. ____ Calendar No. ____

Purpose: To provide for early childhood educator professional development.

IN THE SENATE OF THE UNITED STATES—106th Cong., 2d Sess.

S. 2

To extend programs and activities under the Elementary and Secondary Education Act of 1965.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. DODD

Viz:

At the end of title II, insert the following:

SEC. ___. EARLY CHILDHOOD EDUCATOR PROFESSIONAL DEVELOPMENT.

Title II (20 U.S.C. 6601 et seq.) is amended by adding at the end the following:

"PART ___—EARLY CHILDHOOD EDUCATOR PROFESSIONAL DEVELOPMENT

"SEC. ___1. PURPOSE.

"In support of the national effort to attain the first of America's Education Goals, the purpose of this part is to enhance the school readiness of young children, par-

ticularly disadvantaged young children, and to prevent them from encountering reading difficulties once they enter school by improving the knowledge and skills of early childhood educators who work in communities that have high concentrations of children living in poverty.

"SEC. ___2. PROGRAM AUTHORIZED.

"(a) GRANTS TO PARTNERSHIPS.—The Secretary shall carry out the purpose of this part by awarding grants, on a competitive basis, to partnerships consisting of—

"(1)(A) one or more institutions of higher education that provide professional development for early childhood educators who work with children from low-income families in high-need communities; or

"(B) another public or private, nonprofit entity that provides such professional development;

"(2) one or more public agencies (including local educational agencies, State educational agencies, State human services agencies, and State and local agencies administering programs under the Child Care and Development Block Grant Act of 1990), Head Start agencies, or private, nonprofit organizations; and

"(E) to the extent feasible, an entity with demonstrated experience in providing violence prevention education training to educators in early childhood education programs.

"(b) PRIORITY.—In awarding grants under this part, the Secretary shall give priority to partnerships that include 1 or more local educational agencies which operate early childhood education programs for children from low-income families in high-need communities.

"(c) DURATION AND NUMBER OF GRANTS.—

"(1) DURATION.—Each grant under this part shall be awarded for not more than 4 years.

"(2) NUMBER.—No partnership may receive more than 1 grant under this part.

"SEC. ___3. APPLICATIONS.

"(a) APPLICATIONS REQUIRED.—Any partnership that desires to receive a grant under this part shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

"(b) CONTENTS.—Each such application shall include—

"(1) a description of the high-need community to be served by the project, including such demo-

graphic and socioeconomic information as the Secretary may request;

"(2) information on the quality of the early childhood educator professional development program currently conducted by the institution of higher education or other provider in the partnership;

"(3) the results of the assessment that the entities in the partnership have undertaken to determine the most critical professional development needs of the early childhood educators to be served by the partnership and in the broader community, and a description of how the proposed project will address those needs;

"(4) a description of how the proposed project will be carried out, including—

"(A) how individuals will be selected to participate;

"(B) the types of research-based professional development activities that will be carried out;

"(C) how research on effective professional development and on adult learning will be used to design and deliver project activities;

"(D) how the project will coordinate with and build on, and will not supplant or dupli-

cate, early childhood education professional development activities that exist in the community;

"(E) how the project will train early childhood educators to provide services that are based on developmentally appropriate practices and the best available research on child, language, and literacy development and on early childhood pedagogy;

"(F) how the program will train early childhood educators to meet the diverse educational needs of children in the community, including children who have limited English proficiency, disabilities, or other special needs; and

"(G) how the project will train early childhood educators in identifying and preventing behavioral problems or violent behavior in children;

"(5) a description of—

"(A) the specific objectives that the partnership will seek to attain through the project, and how the partnership will measure progress toward attainment of those objectives; and

"(B) how the objectives and the measurement activities align with the performance indi-

cators established by the Secretary under section ____6(a);

"(6) a description of the partnership's plan for institutionalizing the activities carried out under the project, so that the activities continue once Federal funding ceases;

"(7) an assurance that, where applicable, the project will provide appropriate professional development to volunteer staff. as well as to paid staff; and

"(8) an assurance that, in developing its application and in carrying out its project, the partnership has consulted with, and will consult with, relevant agencies and early childhood educator organizations described in section ____2(a)(2) that are not members of the partnership.

"SEC. ____4. SELECTION OF GRANTEES.

"(a) CRITERIA.—The Secretary shall select partnerships to receive funding on the basis of the community's need for assistance and the quality of the applications.

"(b) GEOGRAPHIC DISTRIBUTION.—In selecting partnerships, the Secretary shall seek to ensure that communities in different regions of the Nation, as well as both urban and rural communities, are served.

"SEC. ___5. USES OF FUNDS.

"(a) IN GENERAL.—Each partnership receiving a grant under this part shall use the grant funds to carry out activities that will improve the knowledge and skills of early childhood educators who are working in early childhood programs that are located in high-need communities and serve concentrations of children from low-income families.

"(b) ALLOWABLE ACTIVITIES.—Such activities may include—

"(1) professional development for individuals working as early childhood educators, particularly to familiarize those individuals with the application of recent research on child, language, and literacy development and on early childhood pedagogy;

"(2) professional development for early childhood educators in working with parents, based on the best current research on child, language, and literacy development and parent involvement, so that the educators can prepare their children to succeed in school;

"(3) professional development for early childhood educators to work with children who have limited English proficiency, disabilities, and other special needs;

"(4) professional development to train early childhood educators in identifying and preventing behavioral problems or violent behavior in children;

"(5) activities that assist and support early childhood educators during their first three years in the field;

"(6) development and implementation of early childhood educator professional development programs that make use of distance learning and other technologies;

"(7) professional development activities related to the selection and use of diagnostic assessments to improve teaching and learning; and

"(8) data collection, evaluation, and reporting needed to meet the requirements of this part relating to accountability.

"SEC. ___5. ACCOUNTABILITY.

"(a) PERFORMANCE INDICATORS.—Simultaneously with the publication of any application notice for grants under this part, the Secretary shall announce performance indicators for this part, which shall be designed to measure—

"(1) the quality and assessability of the professional development provided;

"(2) the impact of that professional development on the early childhood education provided by the individuals who are trained; and

"(3) such other measures of program impact as the Secretary determines appropriate.

"(b) ANNUAL REPORTS; TERMINATION.—

"(1) ANNUAL REPORTS.—Each partnership receiving a grant under this part shall report annually to the Secretary on the partnership's progress against the performance indicators.

"(2) TERMINATION.—The Secretary may terminate a grant under this part at any time if the Secretary determines that the partnership is not making satisfactory progress against the indicators.

"SEC. ___7. COST-SHARING.

"(a) IN GENERAL.—Each partnership shall provide, from other sources, which may include other Federal sources—

"(1) at least 50 percent of the total cost of its project for the grant period; and

"(2) at least 20 percent of the project cost in each year.

"(b) ACCEPTABLE CONTRIBUTIONS.—A partnership may meet the requirement of subsection (a) through cash or in-kind contributions, fairly valued.

"(c) WAIVERS.—The Secretary may waive or modify the requirements of subsection (a) in cases of demonstrated financial hardship.

"SEC. ___8. DEFINITIONS.

"In this part:

"(1) HIGH-NEED COMMUNITY.—

"(A) IN GENERAL.—The term 'high-need community' means—

"(i) a municipality, or a portion of a municipality, in which at least 50 percent of the children are from low-income families; or

"(ii) a municipality that is one of the 10 percent of municipalities within the State having the greatest numbers of such children.

"(B) DETERMINATION.—In determining which communities are described in subparagraph (A), the Secretary shall use such data as the Secretary determines are most accurate and appropriate.

"(2) LOW-INCOME FAMILY.—The term 'low-income family' means a family with an income below the poverty line (as defined by the Office of Management and Budget and revised annually in accordance

with section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2))) applicable to a family of the size involved for the most recent fiscal year for which satisfactory data are available.

"(8) EARLY CHILDHOOD EDUCATOR.—The term 'early childhood educator' means a person who provides care and education to children at any age from birth through kindergarten.

"SEC. ___9. FEDERAL COORDINATION.

"The Secretary and the Secretary of Health and Human Services shall coordinate activities under this part and other early childhood programs administered by the two Secretaries.

"SEC. ___0. AUTHORIZATION OF APPROPRIATIONS.

"For the purpose of carrying out this part, there are authorized to be appropriated $50,000,000 for fiscal year 2001 and such sums as may be necessary for each of the 4 succeeding fiscal years.".

THE WHITE HOUSE
Office of Legislative Affairs, Senate Liaison

Telephone: (202) 456-6493 Fax: (202) 456-6468

Fax Cover Sheet

To: Ann O'Leary

From:
- ___ Karen Robb
- X Joanna Slaney
- X Joel Wiginton
- ___ Julie Anderson
- ___ Mike Williams
- ___ Hildy Kuryk
- ___ Bobby Conner
- ___ Alon Kupferman

Fax: 6-2878 Phone: _____

Date: 5/9 Pages including cover sheet: 30

Message: _____

CO-SPONSORS-EARLY LEARNING AMDT.

5/9/00
11:45 AM

REPUBLICAN	DEMOCRAT
Stevens	Kennedy
Jeffords	Dodd
Bond	Kerry
Voinovich	Lautenberg
Domenici	Murray
Cochran	Bingaman
G. Smith	Durbin
Chafee	Robb
Murkowski	Wellstone
Roberts	Baucus
Snowe	Rockefeller
	Feinstein
	Mikulski
	Boxer

EARLY LEARNING OPPORTUNITIES ACT AMENDMENT

Senators Stevens, Kennedy, Jeffords, Dodd, Bond, Kerry, Voinovich, Lautenberg, Domenici, Murray, Cochran, Bingaman, G. Smith, Durbin, Chafee, Baucus, Murkowski, Robb, Rockefeller, Roberts, Wellstone, Feinstein, Mikulski, Snowe, and Boxer

PURPOSE -- The purpose of this amendment is to increase the availability of voluntary programs, services, and activities that support early childhood education and promote school readiness of young children (age birth to 6) by helping parents, caretakers, child care providers, and educators who desire to incorporate appropriate developmental activities into the daily lives of pre-school age children, and to facilitate broader involvement of the community to develop a cohesive network of early learning opportunities. The Secretary of HHS is responsible for administering this initiative in collaboration with the Secretary of Education.

COORDINATION OF FEDERAL PROGRAMS -- The legislation requires and provides the authority to the Secretaries of the Department of Health and Human Services and Education to develop effective mechanisms to resolve conflicts between early learning programs and remove barriers to the creation of a community-driven, unified system of services, activities, and programs for young children and their families.

PRESERVING PARENTAL RIGHTS AND ROLES -- While the legislation focuses on providing more opportunities for parents to participate in activities designed to promote early learning, it is essential that participation be voluntary. The bill clearly states that parents are not required to participate in any programs, services or activities funded under this part and reinforces that parents are their child's first and most effective teacher.

FEDERAL FUNDING -- $3.25 billion over three years for a discretionary grant program to the states; $750,000,000 in the first year, increasing to $1 billion in the second year and $1.5 billion in year 3.

GRANTS TO STATES-- The federal share is 85% for the first two years of the grant, decreasing to 80% in the second and third years, and to 75% for the remainder of the initiative. There is a broad definition of how states can meet the match requirements including cash or in-kind facilities, equipment or services. The funds are allocated to the states based equally on the population of children aged 4 or under and the number of children aged 4 or under who are living in poverty. There is a small state minimum of .4% and a 1% set-aside for Indian Tribes, Native Alaskans, Hawaii Natives, and the Outlying areas. States are not permitted to use the funds to supplant existing funding for child care, Head Start, and other early learning programs.

LIMIT ON ADMINISTRATIVE COSTS -- Administrative costs are limited for both the Department of Health and Human Services (3%) and the States (2% for state-level coordination of services, 2% for administrative costs, and 3% for training/technical assistance/wage incentives).

STATE ELIGIBILITY -- To receive a grant allotment, States must submit an application, designate a lead entity, ensure that funds are distributed on a competitive basis throughout the state, ensure that a broad array/variety of early learning programs, activities, and services receive funds

(OVER)

and develop mechanisms to ensure compliance with the requirement of the initiative. States also are required to develop performance goals based on an assessment of needs and available resources and annually report the State's progress towards meeting those goals.

AWARDING GRANT TO LOCALITIES -- States must award grants consistent with the performance goals set by the State. To the maximum extent possible, states will ensure that a broad variety of early learning programs which provide a continuity of services across the age spectrum will be funded. The state must funds programs that help increase parenting skills, that provide direct activities for young children, as well as improve the skills of child care providers. Local Councils receiving funds will work with local educational agencies to identify cognitive, social, and developmental abilities which are expected to be mastered prior to a child entering school. Programs, services and activities funded under this initiative will represent developmentally appropriate steps to mastery of those abilities. Preference is given to grants which include services to areas of greatest need (as defined by the state), and to grants which increase local collaboration to maximize the use of existing resources. There is no definition of entities eligible to receive grants, in order to facilitate the broadest possible participation among local community resources.

USE OF FUNDS -- Local Councils receiving funds from the State grant allotment will distribute the funds to community resources to:

1) Help parents, care givers, child care providers, and educators increase their capacity to facilitate the development of cognitive, language comprehension, expressive language, social-emotion, and motor skills and promote learning readiness in their young children;
2) Promote effective parenting
3) Enhance early childhood literacy
4) Develop linkages among early learning programs within a community and between early learning programs and health care services for young children
5) Increase access to early learning opportunities for young children with special needs, by facilitating coordination with other programs serving this population
6) Increase access to existing early learning programs by expanding the days or times that the young children are served, by expanding the number of children served, or improving the affordability of the programs for low-income children; and
7) Improve the quality of early learning programs through professional development and training activities, increased compensation, and recruitment and retention incentives, for early learning providers.
8) Remove ancillary barriers to early learning, including transportation difficulties and absence of programs during non-traditional work times.

ACCOUNTABILITY -- The State is primarily responsible for monitoring the use of funds by state grantees. If the State determines that the grantee is not complying with the requirements of the grant, the state must inform the grantee of the problems, provide training and technical assistance to help them correct the problems, and if that fails, terminate the grant.

AVAILABILITY OF FUNDS -- The State has 3 years to expend the funds received under the State's allotment. Any unexpended funds will be used by HHS to fund research-based early learning demonstration projects.

O:\KOS\KOS00.418 S.L.C.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To provide for early learning programs, and for other purposes.

IN THE SENATE OF THE UNITED STATES—106th Cong., 2d Sess.

S. 2

To extend programs and activities under the Elementary and Secondary Education Act of 1965.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. [redacted] Stevens, Kennedy, Jeffords, Dodd, Bond, Kerry, Voinovich, Lautenberg, Domenici, Murray, Cochran, Bingaman, G. Smith, Durbin, Chafee, Robb, Murkowski, Wellstone, Baucus, Rockefeller and Feinstein, Roberts, Mikulski, Snowe, Baker

Viz:

On page 922, after line 18, insert the following:

PART D—EARLY LEARNING OPPORTUNITIES

SEC. 11401. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This part may be cited as the "Early Learning Opportunities Act".

(b) FINDINGS.—Congress finds that—

(1) medical research demonstrates that adequate stimulation of a young child's brain between birth and age 5 is critical to the physical development of the young child's brain;

(2) parents are the most significant and effective teachers of their children, and they alone are responsible for choosing the best early learning opportunities for their child;

(3) parent education and parent involvement are critical to the success of any early learning program or activity;

(4) the more intensively parents are involved in their child's early learning, the greater the cognitive and noncognitive benefits to their children;

(5) many parents have difficulty finding the information and support the parents seek to help their children grow to their full potential;

(6) each day approximately 13,000,000 young children, including 6,000,000 infants or toddlers, spend some or all of their day being cared for by someone other than their parents;

(7) quality early learning programs, including those designed to promote effective parenting, can increase the literacy rate, the secondary school graduation rate, the employment rate, and the college enrollment rate for children who have participated in voluntary early learning programs and activities;

(8) early childhood interventions can yield substantial advantages to participants in terms of emo-

tional and cognitive development, education, economic well-being, and health, with the latter 2 advantages applying to the children's families as well;

(9) participation in quality early learning programs, including those designed to promote effective parenting, can decrease the future incidence of teenage pregnancy, welfare dependency, at-risk behaviors, and juvenile delinquency for children;

(10) several cost-benefit analysis studies indicate that for each $1 invested in quality early learning programs, the Federal Government can save over $5 by reducing the number of children and families who participate in Federal Government programs like special education and welfare;

(11) for children placed in the care of others during the workday, the low salaries paid to the child care staff, the lack of career progression for the staff, and the lack of child development specialists involved in early learning and child care programs, make it difficult to attract and retain the quality of staff necessary for a positive early learning experience;

(12) Federal Government support for early learning has primarily focused on out-of-home care programs like those established under the Head

Start Act, the Child Care and Development Block Grant of 1990, and part C of the Individuals with Disabilities Education Act, and these programs—

(A) serve far fewer than half of all eligible children;

(B) are not primarily designed to provide support for parents who care for their young children in the home; and

(C) lack a means of coordinating early learning opportunities in each community; and

(13) by helping communities increase, expand, and better coordinate early learning opportunities for children and their families, the productivity and creativity of future generations will be improved, and the Nation will be prepared for continued leadership in the 21st century.

SEC. 11402. PURPOSES.

The purposes of this part are—

(1) to increase the availability of voluntary programs, services, and activities that support early childhood development, increase parent effectiveness, and promote the learning readiness of young children so that young children enter school ready to learn;

(2) to support parents, child care providers, and caregivers who want to incorporate early learning activities into the daily lives of young children;

(3) to remove barriers to the provision of an accessible system of early childhood learning programs in communities throughout the United States;

(4) to increase the availability and affordability of professional development activities and compensation for caregivers and child care providers; and

(5) to facilitate the development of community-based systems of collaborative service delivery models characterized by resource sharing, linkages between appropriate supports, and local planning for services.

SEC. 11403. DEFINITIONS.

In this part:

(1) CAREGIVER.—The term "caregiver" means an individual, including a relative, neighbor, or family friend, who regularly or frequently provides care, with or without compensation, for a child for whom the individual is not the parent.

(2) CHILD CARE PROVIDER.—The term "child care provider" means a provider of non-residential child care services (including center-based, family-based, and in-home child care services) for com-

pensation who or that is legally operating under State law, and complies with applicable State and local requirements for the provision of child care services.

(3) EARLY LEARNING.—The term "early learning", used with respect to a program or activity, means learning designed to facilitate the development of cognitive, language, motor, and social-emotional skills for, and to promote learning readiness in, young children.

(4) EARLY LEARNING PROGRAM.—The term "early learning program" means—

(A) a program of services or activities that helps parents, caregivers, and child care providers incorporate early learning into the daily lives of young children; or

(B) a program that directly provides early learning to young children.

(5) INDIAN TRIBE.—The term "Indian tribe" has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

(6) LOCAL COUNCIL.—The term "Local Council" means a Local Council established or designated

under section 11414(a) that serves one or more localities.

(7) LOCALITY.—The term "locality" means a city, county, borough, township, or area served by another general purpose unit of local government, an Indian tribe, a Regional Corporation, or a Native Hawaiian entity.

(8) PARENT.—The term "parent" means a biological parent, an adoptive parent, a stepparent, a foster parent, or a legal guardian of, or a person standing in loco parentis to, a child.

(9) POVERTY LINE.—The term "poverty line" means the poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2))) applicable to a family of the size involved.

(10) REGIONAL CORPORATION.—The term "Regional Corporation" has the meaning given the term in section 3 of the Alaskan Native Claims Settlement Act (43 U.S.C. 1602).

(11) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(12) STATE.—The term "State" means each of the several States of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

(13) TRAINING.—The term "training" means instruction in early learning that—

(A) is required for certification under State and local laws, regulations, and policies;

(B) is required to receive a nationally or State recognized credential or its equivalent;

(C) is received in a postsecondary education program focused on early learning or early childhood development in which the individual is enrolled; or

(D) is provided, certified, or sponsored by an organization that is recognized for its expertise in promoting early learning or early childhood development.

(14) YOUNG CHILD.—The term "young child" means any child from birth to the age of mandatory school attendance in the State where the child resides.

SEC. 11404. PROHIBITIONS.

(a) PARTICIPATION NOT REQUIRED.—No person, including a parent, shall be required to participate in any program of early childhood education, early learning, par-

ent education, or developmental screening pursuant to the provisions of this part.

(b) RIGHTS OF PARENTS.—Nothing in this part shall be construed to affect the rights of parents otherwise established in Federal, State, or local law.

(c) PARTICULAR METHODS OR SETTINGS.—No entity that receives funds under this part shall be required to provide services under this part through a particular instructional method or in a particular instructional setting to comply with this part.

SEC. 11405. AUTHORIZATION AND APPROPRIATION OF FUNDS.

There are authorized to be appropriated to the Department of Health and Human Services to carry out this part—

(1) $750,000,000 for fiscal year 2001;

(2) $1,000,000,000 for fiscal year 2002; ~~and~~

(3) $1,500,000,000 for fiscal year 2003; ~~and~~

~~(4) such sums as may be necessary for each of the fiscal years 2004 and 2005.~~

SEC. 11406. COORDINATION OF FEDERAL PROGRAMS.

(a) COORDINATION.—The Secretary and the Secretary of Education shall develop mechanisms to resolve administrative and programmatic conflicts between Federal programs that would be a barrier to parents, care-

1 givers, service providers, or children related to the coordi
2 nation of services and funding for early learning pro-
3 grams.

4 (b) USE OF EQUIPMENT AND SUPPLIES.—In the case
5 of a collaborative activity funded under this part and an-
6 other provision of law providing for Federal child care or
7 early learning programs, the use of equipment and
8 nonconsumable supplies purchased with funds made avail-
9 able under this part or such provision shall not be re-
10 stricted to children enrolled or otherwise participating in
11 the program carried out under this part or such provision,
12 during a period in which the activity is predominately
13 funded under this part or such provision.

14 **SEC. 11407. PROGRAM AUTHORIZED.**

15 (a) GRANTS.—From amounts appropriated under
16 section 11405 the Secretary shall award grants to States
17 to enable the States to award grants to Local Councils
18 to pay the Federal share of the cost of carrying out early
19 learning programs in the locality served by the Local
20 Council.

21 (b) FEDERAL SHARE.—

22 (1) IN GENERAL.—The Federal share of the
23 cost described in subsection (a) shall be 85 percent
24 for the first and second years of the grant, 80 per-
25 cent for the third and fourth years of the grant, and

75 percent for the fifth and subsequent years of the grant.

(2) NON-FEDERAL SHARE.—The non-Federal share of the cost described in subsection (a) may be contributed in cash or in kind, fairly evaluated, including facilities, equipment, or services, which may be provided from State or local public sources, or through donations from private entities. For the purposes of this paragraph the term "facilities" includes the use of facilities, but the term "equipment" means donated equipment and not the use of equipment.

(c) MAINTENANCE OF EFFORT.—The Secretary shall not award a grant under this part to any State unless the Secretary first determines that the total expenditures by the State and its political subdivisions to support early learning programs (other than funds used to pay the non-Federal share under subsection (b)(2)) for the fiscal year for which the determination is made is equal to or greater than such expenditures for the proceding fiscal year.

(d) SUPPLEMENT NOT SUPPLANT.—Amounts received under this part shall be used to supplement and not supplant other Federal, State, and local public funds expended to promote early learning.

SEC. 11408. USES OF FUNDS.

(a) IN GENERAL.—Subject to section 11410, grant funds under this part shall be used to pay for developing, operating, or enhancing voluntary early learning programs that are likely to produce sustained gains in early learning.

(b) LIMITED USES.—Subject to section 11410, Lead State Agencies and Local Councils shall ensure that funds made available under this part to the agencies and Local Councils are used for 8 or more of the following activities:

(1) Helping parents, caregivers, child care providers, and educators increase their capacity to facilitate the development of cognitive, language comprehension, expressive language, social-emotional, and motor skills, and promote learning readiness.

(2) Promoting effective parenting.

(3) Enhancing early childhood literacy.

(4) Developing linkages among early learning programs within a community and between early learning programs and health care services for young children.

(5) Increasing access to early learning opportunities for young children with special needs, including developmental delays, by facilitating coordination with other programs serving such young children.

(6) Increasing access to existing early learning programs by expanding the days or times that the young children are served, by expanding the number of young children served, or by improving the affordability of the programs for low-income families.

(7) Improving the quality of early learning programs through professional development and training activities, increased compensation, and recruitment and retention incentives, for early learning providers.

(8) Removing ancillary barriers to early learning, including transportation difficulties and absence of programs during nontraditional work times.

(c) REQUIREMENTS.—Each Lead State Agency designated under section 11410(c) and Local Councils receiving a grant under this part shall ensure—

(1) that Local Councils described in section 11414 work with local educational agencies to identify cognitive, social, emotional, and motor developmental abilities which are necessary to support children's readiness for school;

(2) that the programs, services, and activities assisted under this part will represent developmentally appropriate steps toward the acquisition of those abilities; and

(3) that the programs, services, and activities assisted under this part collectively provide benefits for children cared for in their own homes as well as children placed in the care of others.

(d) SLIDING SCALE PAYMENTS.—States and Local Councils receiving assistance under this part shall ensure that programs, services, and activities assisted under this part which customarily require a payment for such programs, services, or activities, adjust the cost of such programs, services, and activities provided to the individual or the individual's child based on the individual's ability to pay.

SEC. 11408. RESERVATIONS AND ALLOTMENTS.

(a) RESERVATION FOR INDIAN TRIBES, ALASKA NATIVES, AND NATIVE HAWAIIANS.—The Secretary shall reserve 1 percent of the total amount appropriated under section 11405 for each fiscal year, to be allotted to Indian tribes, Regional Corporations, and Native Hawaiian entities, of which—

(1) 0.5 percent shall be available to Indian tribes; and

(2) 0.5 percent shall be available to Regional Corporations and Native Hawaiian entities.

(b) ALLOTMENTS.—From the funds appropriated under this part for each fiscal year that are not reserved

under subsection (a), the Secretary shall allot to each State the sum of—

(1) an amount that bears the same ratio to 50 percent of such funds as the number of children 4 years of age and younger in the State bears to the number of such children in all States; and

(2) an amount that bears the same ratio to 50 percent of such funds as the number of children 4 years of age and younger living in families with incomes below the poverty line in the State bears to the number of such children in all States.

(c) MINIMUM ALLOTMENT.—No State shall receive an allotment under subsection (b) for a fiscal year in an amount that is less than .40 percent of the total amount appropriated for the fiscal year under this part.

(d) AVAILABILITY OF FUNDS.—Any portion of the allotment to a State that is not expended for activities under this part in the fiscal year for which the allotment is made shall remain available to the State for 2 additional years, after which any unexpended funds shall be returned to the Secretary. The Secretary shall use the returned funds to carry out a discretionary grant program for research-based early learning demonstration projects.

(e) DATA.—The Secretary shall make allotments under this part on the basis of the most recent data available to the Secretary.

SEC. 11410. GRANT ADMINISTRATION.

(a) FEDERAL ADMINISTRATIVE COSTS.—The Secretary may use not more than 3 percent of the amount appropriated under section 11405 for a fiscal year to pay for the administrative costs of carrying out this part, including the monitoring and evaluation of State and local efforts.

(b) STATE ADMINISTRATIVE COSTS.—A State that receives a grant under this part may use—

(1) not more than 2 percent of the funds made available through the grant to carry out activities designed to coordinate early learning programs on the State level, including programs funded or operated by the State educational agency, health, children and family, and human service agencies, and any State-level collaboration or coordination council involving early learning and education, such as the entities funded under section 640(a)(5) of the Head Start Act (42 U.S.C. 9835 (a)(5));

(2) not more than 2 percent of the funds made available through the grant for the administrative costs of carrying out the grant program and the

costs of reporting State and local efforts to the Secretary; and

(3) not more than 3 percent of the funds made available through the grant for training, technical assistance, and wage incentives provided by the State to Local Councils.

(c) LEAD STATE AGENCY.—

(1) IN GENERAL.—To be eligible to receive an allotment under this part, the Governor of a State shall appoint, after consultation with the leadership of the State legislature, a Lead State Agency to carry out the functions described in paragraph (2).

(2) LEAD STATE AGENCY.—

(A) ALLOCATION OF FUNDS.—The Lead State Agency described in paragraph (1) shall allocate funds to Local Councils as described in section 11412.

(B) FUNCTIONS OF AGENCY.—In addition to allocating funds pursuant to subparagraph (A), the Lead State Agency shall—

(i) advise and assist Local Councils in the performance of their duties under this part;

(ii) develop and submit the State application;

(iii) evaluate and approve applications submitted by Local Councils under section 11413;

(iv) ensure collaboration with respect to assistance provided under this part between the State agency responsible for education and the State agency responsible for children and family services;

(v) prepare and submit to the Secretary, an annual report on the activities carried out in the State under this part, which shall include a statement describing how all funds received under this part are expended and documentation of the effects that resources under this part have had on—

(I) parental capacity to improve learning readiness in their young children;

(II) early childhood literacy;

(III) linkages among early learning programs;

(IV) linkages between early learning programs and health care services for young children;

(V) access to early learning activities for young children with special needs;

(VI) access to existing early learning programs through expansion of the days or times that children are served;

(VII) access to existing early learning programs through expansion of the number of young children served;

(VIII) access to and affordability of existing early learning programs for low-income families;

(IX) the quality of early learning programs resulting from professional development, and recruitment and retention incentives for caregivers; and

(X) removal of ancillary barriers to early learning, including transportation difficulties and absence of programs during nontraditional work times; and

(vi) ensure that training and research is made available to Local Councils and

that such training and research reflects the latest available brain development and early childhood development research related to early learning.

SEC. 11411. STATE REQUIREMENTS.

(a) ELIGIBILITY.—To be eligible for a grant under this part, a State shall—

(1) ensure that funds received by the State under this part shall be subject to appropriation by the State legislature, consistent with the terms and conditions required under State law;

(2) designate a Lead State Agency under section 11410(c) to administer and monitor the grant and ensure State-level coordination of early learning programs;

(3) submit to the Secretary an application at such time, in such manner, and accompanied by such information as the Secretary may require;

(4) ensure that funds made available under this part are distributed on a competitive basis throughout the State to Local Councils serving rural, urban, and suburban areas of the State; and

(5) assist the Secretary in developing mechanisms to ensure that Local Councils receiving funds

under this part comply with the requirements of this part.

(b) STATE PREFERENCE.—In awarding grants to Local Councils under this part, the State, to the maximum extent possible, shall ensure that a broad variety of early learning programs that provide a continuity of services across the age spectrum assisted under this part are funded under this part, and shall give preference to supporting—

(1) a Local Council that meets criteria, that are specified by the State and approved by the Secretary, for qualifying as serving an area of greatest need for early learning programs; and

(2) a Local Council that demonstrates, in the application submitted under section 11413, the Local Council's potential to increase collaboration as a means of maximizing use of resources provided under this part with other resources available for early learning programs.

(c) LOCAL PREFERENCE.—In awarding grants under this part, Local Councils shall give preference to supporting—

(1) projects that demonstrate their potential to collaborate as a means of maximizing use of re-

sources provided under this part with other resources available for early learning programs;

(2) programs that provide a continuity of services for young children across the age spectrum, individually, or through community-based networks or cooperative agreements; and

(3) programs that help parents and other caregivers promote early learning with their young children.

(d) PERFORMANCE GOALS.—

(1) ASSESSMENTS.—Based on information and data received from Local Councils, and information and data available through State resources, the State shall biennially assess the needs and available resources related to the provision of early learning programs within the State.

(2) PERFORMANCE GOALS.—Based on the analysis of information described in paragraph (1), the State shall establish measurable performance goals to be achieved through activities assisted under this part.

(3) REQUIREMENT.—The State shall award grants to Local Councils only for purposes that are consistent with the performance goals established under paragraph (2).

(4) REPORT.—The State shall report to the Secretary annually regarding the State's progress toward achieving the performance goals established in paragraph (2) and any necessary modifications to those goals, including the rationale for the modifications.

SEC. 11412. LOCAL ALLOCATIONS.

(a) IN GENERAL.—The Lead State Agency shall allocate to Local Councils in the State not less than 93 percent of the funds provided to the State under this part for a fiscal year.

(b) LIMITATION.—The Lead State Agency shall allocate funds provided under this part on the basis of the population of the locality served by the Local Council.

SEC. 11413. LOCAL APPLICATIONS.

(a) IN GENERAL.—To be eligible to receive assistance under this part, the Local Council shall submit an application to the Lead State Agency at such time, in such manner, and containing such information as the Lead State Agency may require.

(b) CONTENTS.—Each application submitted pursuant to subsection (a) shall include a statement ensuring that the local government entity, Indian tribe, Regional Corporation, or Native Hawaiian entity has established or designated a Local Council under section 11414, and the

Local Council has developed a local plan for carrying out early learning programs under this part that includes—

(1) a needs and resources assessment concerning early learning services and a statement describing how early learning programs will be funded consistent with the assessment;

(2) a statement of how the Local Council will ensure that early learning programs will meet the performance goals reported by the Lead State Agency under this part; and

(3) a description of how the Local Council will form collaboratives among local youth, social service, and educational providers to maximize resources and concentrate efforts on areas of greatest need.

SEC. 11414. LOCAL ADMINISTRATION.

(a) LOCAL COUNCIL.—

(1) IN GENERAL.—To be eligible to receive funds under this part, a local government entity, Indian tribe, Regional Corporation, or Native Hawaiian entity, as appropriate, shall establish or designate a Local Council, which shall be composed of—

(A) representatives of local agencies directly affected by early learning programs assisted under this part;

(B) parents;

(C) other individuals concerned with early learning issues in the locality, such as representative entities providing elementary education, child care resource and referral services, early learning opportunities, child care, and health services; and

(D) other key community leaders.

(2) DESIGNATING EXISTING ENTITY.—If a local government entity, Indian tribe, Regional Corporation, or Native Hawaiian entity has, before the date of enactment of the Early Learning Opportunities Act, a Local Council or a regional entity that is comparable to the Local Council described in paragraph (1), the entity, tribe or corporation may designate the council or entity as a Local Council under this part, and shall be considered to have established a Local Council in compliance with this subsection.

(3) FUNCTIONS.—The Local Council shall be responsible for preparing and submitting the application described in section 11413.

(b) ADMINISTRATION.—

(1) ADMINISTRATIVE COSTS.—Not more than 3 percent of the funds received by a Local Council under this part shall be used to pay for the adminis-

trative costs of the Local Council in carrying out this part.

(2) FISCAL AGENT.—A Local Council may designate any entity, with a demonstrated capacity for administering grants, that is affected by, or concerned with, early learning issues, including the State, to serve as fiscal agent for the administration of grant funds received by the Local Council under this part.

Reports from early childhood intervention hearing...

Testimony of Jane Knitzer, Ed.D.

Deputy Director

National Center for Children in Poverty

Columbia University School of Public Health

New York, New York

Hearing on "Early Childhood Interventions: Public-Private Partnerships"

Congress of the United States

House of Representatives

Committee on Government Reform and Oversight

Subcommittee on Human Resources

July 16, 1998

Testimony of Jane Knitzer, Ed.D.
Deputy Director
National Center for Children in Poverty
Columbia University School of Public Health
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My name is Jane Knitzer. I am the Deputy Director of the National Center for Children in Poverty (NCCP) and, on behalf of the Center, I very much appreciate the opportunity to testify before you on how states are seeking to enhance the well-being of infants and toddlers, preschoolers, and their families.

The National Center for Children in Poverty is a nonpartisan research organization that is part of the Columbia University School of Public Health. Our mission is to identify and promote strategies to reduce poverty and to improve the life chances of low-income young children (from birth to age six) and their families. NCCP conducts state-by-state demographic analyses of young child poverty rates (see Appendix A), and carries out research intended to improve policies and practices for young children and their families. For example, we are part of the team documenting the lessons learned from Starting Points, the initiative of the Carnegie Corporation to help states and communities focus attention on young children and families.

Every two years, NCCP also issues a report entitled *Map and Track: State Initiatives for Young Children and Families*. This report identifies existing state programs for young children, if individual states are encouraging community planning efforts on behalf of young children, and if states have made enhancing outcomes for young children a priority at the highest levels of government. The report also provides state-specific information on demographic indicators of young child and family well-being and information about welfare decisions of special relevance to young children. All 50 states provide data and review the profiles before publication.

In my testimony today I would like to do four things: first, describe briefly the overall findings from the 1998 edition of *Map and Track*, second, highlight some of the states' major strategies, particularly giving examples of public-private partnerships; third, identify some of the critical issues the report raised; and fourth, talk about the implications for future state and federal policies.

The Overall Findings

There is growing recognition across the states about the importance of developing comprehensive programs for infants, toddlers, and preschoolers. These programs are comprehensive in the sense that they seek to enhance the young child's development, help parents meet the challenges of parenting and link both parents and children to other needed support services (See Appendix B for an overview map).

- Almost half of the states (24) report supporting statewide comprehensive programs for infants and toddlers. Since 1996, ten states have started or added new programs. These new programs appear to be at least in part developed in response to the emerging information about the importance of early brain development in young children. Funding levels range from one or two million dollars to $31 million.

  Program strategies include: outreach to new parents (typically, these aim to be universal); comprehensive programs for high-risk infants and toddlers; parenting education and family support initiatives to provide basic information to families and to strengthen infant-parent relationships; and, initiatives to meet special needs (for example, programs to meet the needs of parents with mental illness or substance abuse).

- Thirty-four states report expanding or supplementing existing programs for pre-school age children. State expenditures for these programs range from $300,000 to $200 million.

  Program strategies include comprehensive prekindergarten programs, state support for Head Start, parent education, family support and family literacy efforts, and "enabling grants" to communities to design a mix of services tailored to community needs.

- Ten states report explicit, deliberate efforts to link these types of comprehensive programs with the implementation of welfare reform.

These states report three strategies: using TANF and/or state dollars to expand or target services to families with young children receiving or at risk of receiving welfare; explicitly encouraging parents to participate in parenting programs either in lieu of, or in tandem with, work requirements, and giving priority for enrollment in comprehensive programs to young children in families receiving or at risk of receiving public assistance.

There is also recognition of the importance of looking beyond support for individual "programs" to supporting the development of systems of early care and education. Thus a growing number of states report efforts to engage community stakeholders in planning processes to better meet the needs of the young children and families in their communities. Most typically these efforts are linked to state-level planning and broader systems reform efforts.

- Just over half (27) of the states report community mobilization strategies linked with state-level strategies to promote systemic change on behalf of children. Fourteen of these have a clear focus on young children and families.

The process by which states are implementing these new planning and systems varies. For example, Hawaii has developed Good Beginnings, a public-private partnership focusing on children that works through a state-level council with four counties to develop community-based partnerships as well. In Georgia, much of the planning and community mobilization takes place through the public/private state Family Policy Council, which works with community partnerships to achieve five designated results for children, including for the youngest, ensuring that they enter school ready to learn.

The extent and type of commitment to young children and families varies considerably from state to state. Some states report only programs, others program and community mobilization strategies. Only a handful of states report sustained, high-level comprehensive initiatives that encompass a variety of state-initiated strategies.

- In 1998, eight states, Colorado, Georgia, Minnesota, North Carolina, Ohio, Oregon, Vermont, and West Virginia, met our criteria for comprehensive initiatives – some combination of high-level leadership, integrated program and community mobilization strategies, continued commitment to increased funding, and a framework for state action. These were the same eight states identified in the 1996 edition of *Map and Track*.

The Issues

The national picture that emerges then is mixed. The good news is that there is widespread recognition of the importance of developing supportive early learning experiences. More and more states appear to be recognizing that promoting the well-being of young children and families is everybody's business: parents, business leaders, community leaders, and services providers. There has been an increase ~~in~~ the number of programs for infants and toddlers and their families, and an expansion of support for preschoolers in most of the states that have already recognized the importance of early learning experiences for children.

A trend is also visible toward providing enabling funds to communities (or sometimes school districts) encouraging them to design services that are tailored to the particular needs of a community. Further, although overall levels of state investments in comprehensive programs for young children and families remain relatively low, the number of programs with increases in funding over a two-year period outweighs those with reduced funding.

At the same time, there are clear inequities across the states in access to comprehensive programs, in funding levels, and in leadership. There are still no statewide programs for infants and toddlers in 26 states, and none for preschoolers in 16 states. Most troubling, only 20% of the states report deliberate efforts to ensure a focus on young children in implementing welfare reform. Even fewer states report any efforts to respond to issues of great concern to practitioners – the level of stress in many families with young children, often related to domestic violence, substance abuse, and mental illness, as well as challenging behaviors in young children. A few states, such as Vermont, are partnering with mental health, substance abuse, and early intervention agencies to invent a secondary support system to help these most vulnerable families, but special national attention to this issue is required.

With respect to the use of public-private partnerships focused on the well-being of young children and families, states are taking a variety of approaches. In some instances, the public-private partnership involves foundations and government either within the states or across multiple states. In other instances, such as Colorado Bright Beginnings, the business community is deeply engaged in the partnerships. In still other instances, the aim is to engage a broad variety of stakeholders at the community level – making sure that early childhood is everybody's business. For example, this is the strategy of the North Carolina Smart Start Partnership for North Carolina's Children. Smart Start, now in 55 of the state's counties, and soon to be statewide, joins local partners from the public sector, private sector, and families to improve access to health care and the quality of early childhood services for its young children. A statewide public-private

partnership provides leadership, technical assistance, and resource development. In Florida, there has been a major effort to "partner" in a different way with key policy makers, providing them with information about early brain development.

The states providing the most leadership are using many different pathways to build a sustained commitment to young children and families over time. (See Appendix C for description of the initiatives in the eight states with the most comprehensive efforts..). For example, Colorado's First Impressions has four goals: (1) universal health care for children; (2) universal volunteer home visits and support for new parents; (3) improved quality, affordability, accessibility of child care; (4) and "child-oriented" communities. Colorado has used its Carnegie Corporation Starting Points grant to create the Warm Welcome program, and is involving the business community in paying for home visits as a benefit. Prior to that, Colorado invested in a prekindergarten program and developed a state-level management strategy to build a system of supports to young children and families, through a Children's Cabinet and a state-level management team. To strengthen the local infrastructure for early care and education the state has begun a pilot effort in 12 counties. It has also established a pilot mental health project for young children.

In West Virginia the approach is different. Starting Points Centers have been established as part of West Virginia's pre-existing community mobilization strategy, known as the Family Resource Network. These Centers in turn, are becoming the hubs for the delivery of a variety of services, including those related to welfare reform. The state has also funded a prekindergarten program. Leadership for the overall initiative is provided by the Early Childhood Implementation Commission which is a part of the Cabinet on Children and Families.

In Ohio, three basic goals drive the community mobilization and program development effort: ensuring access to early care and education for every family that wishes it, improving child health, and increasing family stability. The state began with a state-level Family and Children First Council, then invited counties to develop their own councils. Initially in a few counties, such councils now exist in each of Ohio's 88 counties, with the state providing technical assistance and support. These councils are now beginning not to just plan, but also to manage resources. All have family members as part of them. The state has also invested significantly in a state-funded Head Start program, and most recently, in Early Start, an early intervention home visiting program for young children and families at risk by virtue of environmental and biological risk factors. (Particularly noteworthy is that the state has targeted TANF dollars for this program and made it available to those receiving or at risk of receiving welfare.)

The states providing the strongest leadership on behalf of young children and families share several characteristics. (1) The effort is bipartisan and involves leaders from both inside and outside the government. (2) Efforts to build community support co-exist with efforts to fund programs and increase resources for effective services. There is an interweaving of multiple, deliberate strategies. (3) In most instances, there is a clear framework for action, reflected in statements of basic goals for young children. (4) The states all started in different places, with different mixes of services and leadership, but the vision and the commitments have continued to evolve. (5) The need for more resources is critical; infrastructure development and community mobilization is necessary, but not sufficient. 6) New partnerships do bring new resources to the table.

Implications and Recommendations

Taken together, there are two central messages from *Map and Track.* First, states are making progress focusing on young children and families, but with some exemplary exceptions, neither state leadership nor state investment is deep enough across all the states. Second, *Map and Track* not only documents the current state of the art of early childhood initiatives but it also points to new directions that might be supported either by the states or the federal government or both, which are provided in detail below.

- Distinctions among different types of program approaches are blurring as states strive to create program approaches, whatever the age focus, to address parenting issues, child development issues and adult development issues, including literacy and employment skills.

- Flexibility in how dollars can be used, along with careful planning processes and accountability mechanisms, are critical. Program-by-program funding streams, rigid eligibility, and funding criteria make developing supportive communities for young children more complex. States need to be able to mix and match dollars to help communities create the needed system of supports to young children and families that are tailored to community need.

- Building community support structures on behalf of young children and families takes time, technical assistance from the states or others, and seems to work best if there are clear objectives. Support for these activities can come from public or private funds, or some combination, but is crucial to the success of program efforts.

- Incentives to states to promote positive outcomes for young children and their families in the context of welfare reform is important, since so much of the effort to implement welfare reform is adult driven.

- Identifying and testing new strategies to help programs serving families with young children better meet the needs of the most troubled families would strengthen their efficacy.

- Investments are needed in evaluations of program, community mobilization or comprehensive state strategies on behalf of young children and families. Further, although states are setting outcome based goals, in many places, administrative data systems do not have the capacity to track these outcomes. The few evaluations that do exist, however, are encouraging.

- Sustaining systems-change efforts poses a challenge across the states. Efforts to expand understanding of the importance of investing in early childhood at all levels of government and with public-private partnerships may be key to ensuring that the efforts that are now underway will withstand changes in administrations.

Taken together this suggests ways in which federal initiatives might support state efforts; such an agenda might include ensuring that federal dollars can be used flexibly to enhance developmental outcomes for young children and families; providing incentives to states to develop comprehensive community mobilization, planning and networking capacity on behalf of young children and families; promoting positive outcomes for young children in families affected by welfare changes; developing consultation and other strategies to promote the well-being of young children at risk of poor learning and behavior disorder; and encouraging the evaluation of statewide comprehensive programs for young children and families. Implementing such an agenda would go a long way to support the states in their efforts to ensure that the next generation does in fact, as the national goal calls for, enter school ready to learn.

Early Childhood Poverty

RESEARCH BRIEF 1

Young Child Poverty in the States—Wide Variation and Significant Change

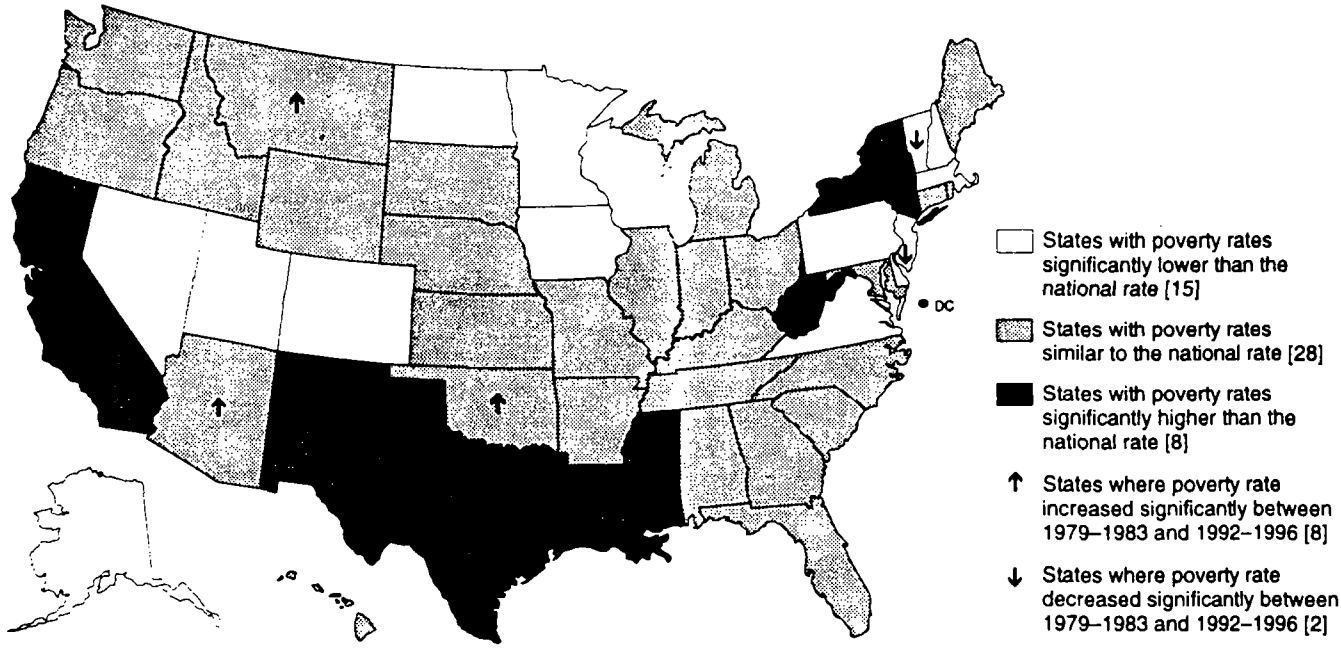
Young Child Poverty in the States—Wide Variation and Significant Change examines the differences in poverty rates for children under age six among the 50 states and the changes that have taken place between 1979–1983 and 1992–1996. The poverty rates are based on data from the Current Population Survey of the U.S. Bureau of the Census, with 1996 being the most recent year for which poverty data have been collected. (Five years of data are aggregated to increase the statistical reliability of the poverty estimates.) This research brief summary provides baseline information on state young child poverty rates to help establish a context in which individual state child poverty trends can be better understood as the nation enters a new era of increased state responsibility for children's well-being.[1]

Highlights from the research brief include the following:

Rates of Poverty, Extreme Poverty, and Near Poverty Among the States

State young child poverty rates (YCPRs) range from under 12 percent in New Hampshire and Utah to 40 percent or more in Louisiana and West Virginia.[2] The District of Columbia and seven states—the large states of California, New York, and Texas, plus Louisiana, Mississippi, New Mexico, and West Virginia—have young child poverty rates that significantly exceed the 1992–1996 national rate of 24.7 percent. Fifteen states have rates of poverty that are significantly lower than the national rate.

Poverty rates of children under age six, by state, 1992–1996



[1] For example, states have vastly increased responsibility for welfare legislation. A key provision of the 1996 federal welfare overhaul (The Personal Responsibility and Work Opportunity Reconciliation Act) requires each state to provide an annual current estimate of its child poverty rate by May 31st, starting in 1998. If that rate exceeds the previous year's rate by more than 5 percent, and this increase can be attributed to the effects of welfare reform, then the state must submit a corrective action plan. The logic of this requirement is clear: two-thirds of welfare recipients are children, and welfare reform cannot be deemed a success if it leads to higher child poverty rates. At this writing, the federal government is still in the process of determining the methodologies necessary for the states to fulfill the obligations outlined for them in the welfare reform act.

[2] Poverty, extreme poverty, and near poverty are defined as living in families with incomes below 100 percent, 50 percent, and 185 percent of the poverty line, respectively. In 1996, the official federal poverty line was $16,036 for a family of four and $12,516 for a family of three. The YCPR is the percentage of children under age six who live in families with incomes below the poverty line.

Extreme poverty among young children varies to an even greater extent across the states. Eight states and the District of Columbia (including the large states of Florida, New York, and Texas) have extreme poverty rates that are significantly higher than the U.S. average of 11.7 percent. Rates are significantly lower than the U.S. average in fifteen states.

The near poverty rate among young children ranges from less than 30 percent in Massachusetts and New Jersey to greater than 60 percent in Mississippi, West Virginia, and the District of Columbia. Eleven states—including California, Florida, and Texas—and the District of Columbia have near poverty rates that are significantly higher than the national average of 44.2 percent, whereas 12 states have rates that are significantly lower than the national rate.

Changes in State Poverty from 1979–1983 to 1992–1996

Nationally, the YCPR climbed from 22.0 to 24.7 percent between 1979–1983 and 1992–1996, an increase of 12 percent. The number of young children in poverty grew from an average of 4.4 million to 5.9 million over that same period. More than half of the total increase (773,000) in the number of poor young children can be attributed to the nation's three most populous states: California, New York, and Texas. Each of the these states experienced disproportionately steep rises in its young child poverty rate (YCPR) over the last two decades and now has a significantly higher rate of young child poverty than the nation as a whole. Collectively, these three states had 28 percent of the children under age six, yet they accounted for 53 percent of the increase in the number of poor young children. Five smaller states also experienced statistically significant increases in their YCPRs, including Oklahoma (53 percent), Montana (51 percent), Arizona (46 percent), West Virginia (45 percent), and Louisiana (40 percent). Two states experienced significant decreases of over 25 percent: New Jersey (26 percent) and Vermont (39 percent).

Overall, the YCPR increased by more than 20 percent in 15 states and fell by more than 20 percent in five states; however, due to sample sizes the trends can only be deemed statistically significant in ten states. The fact that only ten states show statistically significant changes does not imply that other states' YCPRs did not change, even dramatically. For many states the number of individuals interviewed by the Census Bureau was simply insufficient to draw such a conclusion.

Why Do State Poverty Trends Differ?

This research brief from the National Center for Children in Poverty (NCCP) identifies three key demographic factors that help to explain the differences among the states in the growth of their YCPRs—the proportions of young children with: (1) single mothers (family structure), (2) mothers who completed high school (parental education), and (3) at least one parent employed full-time (parental employment).

The increase in the nationwide proportion of young children with single mothers was 25 percent. However, state trends varied from large increases in New Mexico (99 percent), Kentucky (88 percent), Montana (84 percent), and Nebraska (77 percent), to decreases in New Jersey (-15 percent), Arkansas (-6 percent), Maryland (-4 percent), and the District of Columbia (-3 percent).

Variation also existed in the changes of the proportion of young children with mothers who completed high school. The proportion increased nationally by 4 percent, but increases were much more pronounced in Mississippi (17 percent), Arkansas (16 percent), and Indiana (16 percent). The proportion actually decreased in the District of Columbia (-12 percent) and eight states, including Montana (-7 percent) and California (-6 percent).

Although the employment scene improved for the nation over this time period, with a 3 percent increase in the proportion of young children with at least one parent employed full-time, the situation differed dramatically among the states. Full-time employment rates for parents of young children deteriorated in the District of Columbia (-18 percent) and in many states, including New Hampshire (-14 percent) and Connecticut (-13 percent). In contrast, six states saw improvements of 15 percent or more—Alaska (48 percent), Hawaii (21 percent), Arkansas (17 percent), Virginia (16 percent), Delaware (15 percent), and Washington (15 percent).

NCCP's statistical analysis[3] finds that changes in family structure, parental education, and parental employment variables account for all of the change in the YCPR in seven states and none of the change in 12 states. The median percentage of the change in the YCPR that is explained by changes in these variables is substantial—30 percent. NCCP's analysis suggests that all three factors combine to influence rates of states' growth in their YCPRs and that policymakers would do well to recognize that multiple demographic, economic, and policy variables are behind state child poverty trends. Indeed, California, New York, and

[3] Details of these analyses are available from NCCP.

Change in the percentage and number of children under age six in poverty, by state, 1979–1983 to 1992–1996

	1979–1983		1992–1996		% Change in rate	Change in number
	Rate	Number	Rate	Number		
USA	***22.04***	***4,420,791***	***24.67***	***5,877,075***	***12***	***1,456,284***
Connecticut	14.75	30,440	23.96	67,250	62	36,810
Wyoming	12.50	6,075	19.38	7,710	55	1,635
Oklahoma	**20.94**	**54,643**	**32.03**	**92,384**	**53**	**37,741**
Montana	**17.22**	**14,626**	**25.95**	**20,019**	**51**	**5,393**
Arizona	**19.76**	**49,025**	**28.89**	**124,350**	**46**	**75,325**
West Virginia	**27.65**	**48,739**	**39.99**	**47,962**	**45**	**-777**
Louisiana	**29.14**	**133,557**	**40.65**	**158,447**	**40**	**24,890**
Kentucky	21.37	73,950	29.37	90,042	37	16,092
District of Columbia	33.09	13,791	44.17	23,424	33	9,632
Maryland	13.94	40,545	18.57	94,425	33	53,879
Texas	**24.39**	**358,482**	**30.27**	**572,180**	**24**	**213,698**
California	**23.40**	**516,759**	**28.97**	**950,269**	**24**	**433,510**
Missouri	19.38	81,911	23.95	102,202	24	20,291
New York	**23.75**	**338,754**	**28.76**	**464,551**	**21**	**125,797**
Minnesota	14.30	55,640	17.19	68,142	20	12,503
Ohio	19.55	188,078	23.06	223,470	18	35,392
New Mexico	28.82	39,598	33.99	58,049	18	18,450
North Carolina	20.90	94,869	24.59	144,267	18	49,398
Nevada	14.22	10,790	16.63	20,938	17	10,148
North Dakota	14.79	9,744	17.26	8,613	17	-1,131
Michigan	22.82	188,947	25.75	225,755	13	36,809
Maine	20.20	18,634	22.45	19,567	11	933
Massachusetts	14.99	66,137	16.65	84,557	11	18,420
Wisconsin	14.60	64,074	16.16	73,080	11	9,006
New Hampshire	10.85	7,761	11.85	12,236	9	4,475
Georgia	21.93	107,270	23.74	152,241	8	44,971
Kansas	18.84	41,567	20.23	50,245	7	8,678
Illinois	23.27	232,025	24.27	271,889	4	39,864
Indiana	20.60	107,121	21.47	118,010	4	10,889
Colorado	16.66	43,763	17.23	55,659	3	11,896
Iowa	16.64	41,564	17.09	45,228	3	3,664
Florida	26.35	199,106	26.55	313,231	1	114,125
Washington	18.31	69,858	18.44	89,168	1	19,310
Oregon	20.34	50,535	20.13	51,635	-1	1,101
Nebraska	19.42	29,290	18.71	29,478	-4	188
Tennessee	28.90	114,313	27.83	123,466	-4	9,153
Virginia	18.41	79,434	17.43	92,544	-5	13,110
Mississippi	38.01	87,044	35.49	86,319	-7	-726
South Carolina	25.90	88,330	23.99	74,702	-7	-13,628
Arkansas	30.04	60,633	27.02	59,990	-10	-643
Pennsylvania	20.60	179,593	18.38	179,569	-11	-23
Idaho	24.59	26,458	21.74	22,397	-12	-4,061
South Dakota	24.94	18,767	21.92	13,437	-12	-5,330
Rhode Island	24.47	16,862	20.39	15,266	-17	-1,596
Hawaii	22.03	20,490	18.35	19,015	-17	-1,475
Utah	14.14	32,778	11.36	26,338	-20	-6,440
Alabama	32.46	118,385	25.86	100,936	-20	-17,449
Alaska	18.01	9,452	13.78	8,749	-23	-703
Delaware	20.07	10,709	15.27	8,750	-24	-1,959
New Jersey	**20.88**	**119,125**	**15.37**	**107,412**	**-26**	**-11,713**
Vermont	**21.91**	**10,754**	**13.31**	**7,521**	**-39**	**-3,233**

* States in bold letters had significantly positive or significantly negative growth as indicated. Other states may have had similar changes but because of small sample sizes t[illegible] changes are not considered statistically significant at a 90 percent confidence interval. Changes in poverty rates are rounded to the nearest whole number.

Texas each has a large and growing immigrant population. In preliminary analyses, NCCP finds that immigration constitutes an important but not exclusive factor in the growth of family poverty in these states. In collaboration with other researchers, NCCP plans to examine these factors in greater depth over the next year.

Conclusion

The dramatic state variation in both the levels of the YCPR and their rate of growth over time underscores the importance of focusing upon poverty at the state level. The analyses described here also suggest the difficulty, given current data sources, of meeting the requirements of the 1996 federal welfare reform to track annual changes of as little as 5 percent in state YCPRs. Substantially larger samples of state populations will be needed to measure meaningful differences in state poverty rates obtained from two adjacent years of data. While methodological advances are needed to track poverty in the states on a year-to-year basis, this challenge cannot be allowed to discourage a vigorous national debate about how to address the problem of widespread young child poverty in a time of growing national prosperity. NCCP hopes that this publication will focus greater attention on young child poverty within individual states and also help to encourage a "race to the top" among the states to find the most effective strategies to prevent young child poverty.

This document summarizes Early Childhood Poverty Research Brief 1. Copies of the full publication are available for $5.00 each from NCCP, 154 Haven Avenue, New York, NY 10032; Tel: (212) 304-7100; Fax: (212) 544-4200 or 544-4201; E-mail: nccp@columbia.edu. Checks should be made payable to Columbia University.

Early Childhood Poverty Research Briefs

This research brief series has been established to present timely research findings on the nature, scope, and impact of young child poverty in the United States, primarily based on analyses by the National Center for Children in Poverty (NCCP). This series will explore the causes and consequences of young child poverty as well as identify promising strategies to reduce the incidence of young child poverty. As with much of NCCP's work, there will be a strong state and local focus on young child poverty and related issues.

Support for this Early Childhood Poverty Research Brief was provided in part by generous funding from the Charles Stewart Mott Foundation in addition to core support from the Carnegie Corporation of New York and the Ford Foundation. NCCP takes responsibility for the facts and opinions presented in the research brief.

Early Childhood Poverty Research Brief 1
Young Child Poverty in the States—
Wide Variation and Significant Change

by Neil G. Bennett, Director of Demographic Research and Analysis and Jiali Li, Associate Research Scientist at NCCP

Editor: Julian Palmer
Design and Production: Telly Valdellon

NATIONAL CENTER FOR CHILDREN IN POVERTY
Columbia School of Public Health

154 Haven Avenue
New York, NY 10032

TEL (212) 304-7100
FAX (212) 544-4200 / 544-4201
WEB http://cpmcnet.columbia.edu/dept/nccp/

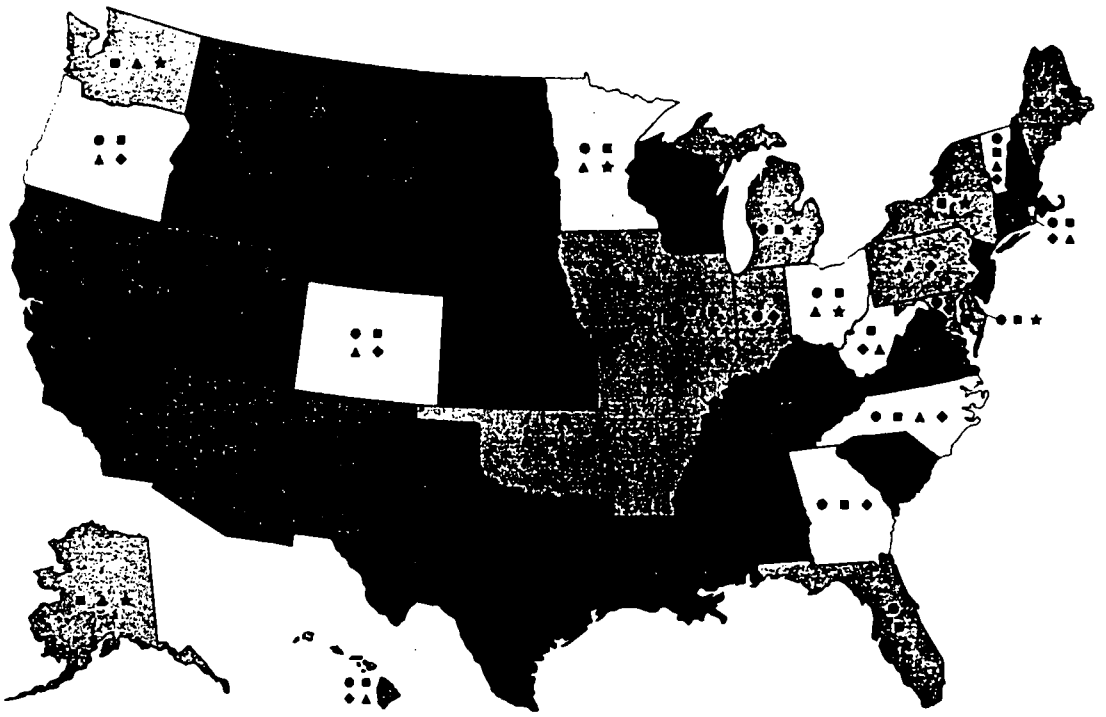
NATIONAL CENTER FOR CHILDREN IN POVERTY (NCCP) was established in 1989 at the School of Public Health, Columbia University, with core support from the Ford Foundation and the Carnegie Corporation of New York. The Center's mission is to identify and promote strategies that reduce the number of young children living in poverty in the United States, and that improve the life chances of the millions of children under age six who are growing up poor.

The Center:

- Alerts the public to demographic statistics about child poverty and to the scientific research on the serious impact of poverty on young children, their families, and their communities.
- Designs and conducts field-based studies to identify programs, policies, and practices that work best for young children and their families living in poverty.
- Disseminates information about early childhood care and education, child health, and family and community support to government officials, private organizations, and child advocates, and provides a state and local perspective on relevant national issues.
- Brings together public and private groups to assess the efficacy of current and potential strategies to lower the young child poverty rate and to improve the well-being of young children in poverty, their families, and their communities.
- Challenges policymakers and opinion leaders to help ameliorate the adverse consequences of poverty on young children.

Map 1.1

State-by-State Strategic Approaches for Enhancing the Well-Being of Young Children and Families



States funding comprehensive initiatives that combine high-level leadership, integrated program and community mobilization approaches, continued commitment to increased funding, and a framework for state action [8]

States funding both community mobilization strategies for young children with potential to serve young children and comprehensive programs [17]

States funding only comprehensive programs [18]

States not funding any comprehensive programs [7]

● States funding programs for infants and toddlers [24]

■ States funding programs for preschool-aged children [34]

▲ States funding programs for children from ages 0–6 and their families [25]

◆ States with young child-focused community mobilization strategies [14]

★ States with community mobilization strategies with potential to focus on young children [13]

P States funding only *pilot* programs [3]

States Funding:			
Comprehensive Initiatives [8]	**Community Mobilization and Comprehensive Programs* [17]**	**Comprehensive Programs Only [18]**	**No State Initiatives [7]**
Colorado	Alaska	Arizona	Alabama (P)
Georgia	Arkansas	California	Idaho*
Minnesota	Delaware	Connecticut	Mississippi (P)
North Carolina	Florida	Kansas	Nebraska (P)
Ohio	Hawaii	Kentucky	North Dakota**
Oregon	Illinois	Louisiana	South Dakota
Vermont	Indiana	Massachusetts	Wyoming
West Virginia	Iowa	Montana	
	Maine	Nevada	
	Maryland	New Hampshire	
	Michigan	New Jersey	
	Missouri	New Mexico	
	New York	South Carolina	
	Oklahoma	Tennessee	
	Pennsylvania	Texas	
	Rhode Island	Utah	
	Washington	Virginia	
		Wisconsin	

* Idaho is funding a clearinghouse for information regarding infants and toddlers.

** These include community mobilization strategies focused on both young children and all-aged children.

Box 2.12

Providing Leadership and Vision: States with Comprehensive Initiatives on Behalf of Young Children and Families in 1996 and 1998

Colorado: First Impressions

- Colorado's First Impressions focuses exclusively on young children. It has four goals: universal health care for children; universal volunteer home visits and support for new parents; improved quality, affordability, and accessibility of early care and education programs; and "child-oriented" communities. Early efforts included funding of statewide programs (e.g., prekindergarten and family centers) and state-level strategies through a Children's Cabinet to manage the initiatives. Since *Map and Track '96* Colorado has added a new focus on infants and toddlers through Bright Beginnings, its voluntary home visiting program that has been facilitated by a Starting Points grant from the Carnegie Corporation. It has also increased its effort to engage the business community in partnerships on behalf of young children and families, and to continuously make the case to a wide range of stakeholders about investing in Colorado's children. Most recently, the state's Office of Budget and Planning, working with First Impressions, has published a "Children's Investment Prospectus," highlighting the state's accomplishments, shortfalls, and investment opportunities on behalf of young children and families.* To strengthen the local infrastructure for early care and education and create a seamless network of services, the state has initiated a Consolidated Child Care Pilot Program in 12 communities. It has also established a pilot program to develop community-based early childhood mental health strategies.

Georgia: Initiative For Children and Families

- Georgia's efforts on behalf of young children and families are embedded in a state and community mobilization initiative that links a state Family Policy Council with community strategies through ten Community Partnerships sites and 86 Family Connection sites (an increase from 56 reported in *Map and Track '96).* Program development strategies include a rapidly expanding comprehensive prekindergarten program and a screening program for all newborns, coupled with efforts to pilot test various home visiting strategies (facilitated by participation as a Starting Point grantee) and connect families, as necessary, with home visiting and other follow-up services. Georgia has also made a substantial investment in developing a system for tracking the results of its efforts and making data available to county-level planning groups.

Minnesota: Various Program and Planning Initiatives

- In Minnesota, the emphasis is on program development strategies. These include: a parent education program that serves 40 percent of eligible families; learning readiness grants targeted to preschoolers; and, since *Map and Track '96,* four programs for infants and toddlers—pilot Early Childhood Family Education (ECFE) Infant Development Grants (an extension downward of the ECFE program), an at-home infant child care program for low-income parents of infants who are eligible for child care subsidies but wish to remain at home, a state supplement to the federal Early Start program and a pilot home visiting program. Minnesota also has local Family Services Collaboratives in 51 counties with specific provisions to plan services and supports for pregnant women and young children.

North Carolina: Smart Start

- North Carolina's Smart Start focuses exclusively on young children and their families. The aim is to improve both the supply and quality of child care and child health services. Originally a pilot in a limited number of counties, Smart Start is now in half of the counties, with planning grants going to the remainder. Funding has grown from $68 million reported in *Map and Track '96* to $92 million. Originally overseen by the state, there is now a state-level public/private partnership that includes a local advisory board from the Smart Start sites. This state-level partnership sets policies, integrates training and technical assistance, and works to ensure that business contributions grow. At the local level, Smart Start boards, made up of a cross section of leaders and family members, work to increase service access and quality in response to local needs. Political support for the effort is growing across the state. The scholarship to child providers program that North Carolina has pioneered, and that is linked to Smart Start, has also become a model that other states are seeking to replicate.

Ohio: Family and Children First

- Ohio's initiative focuses on all aged children and families in the context of three basic goals: ensuring access to early care and education for every family that wishes it; improving child health; and increasing family stability. Since 1991, the state has increased funding for children and families by 39 percent, a substantial amount of which has been focused on young children and families. The state began with a state-level Family and Children Council, then invited counties to develop local councils. These are now in all 88 counties. The state provides increased training and technical assistance to the Councils, as well as some funds to support local coordinating efforts. Since *Map and Track '96,* the state has increased funding for the state Head Start supplement (from $145 million to $181 million), expanded Early Start, an outreach program for high-risk infants and toddlers, using state and TANF dollars, and developed wellness block grants for preventive health care to be administered by the local Councils.

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* Colorado Office of State Planning and Budgeting. (1998). *Children's investment prospectus.* Denver, CO: Colorado Office of State Planning and Budgeting.

Box 2.12

Providing Leadership and Vision: States with Comprehensive Initiatives on Behalf of Young Children and Families in 1996 and 1998 *(cont'd)*

Oregon: Various Program and Planning Initiatives

- Oregon's efforts focus on children and their families with specific programs targeted to young children. The programs include those aimed at infants and toddlers, an integrated prekindergarten Head Start program, a Healthy Start program for first-time parents continuing to age five, and enabling grants to communities entitled Great Start. Oregon's community mobilization strategies link its State Commission on Children and Families with local commissions. The state has also strongly promoted the use of "Benchmarks" data to drive program, planning, and policy outcomes, including outcomes for young children. A related interagency collaboration involving the federal, state, and local levels permits negotiations about regulations, and waivers where necessary, to help collaborative efforts achieve the results measured by the Benchmarks.

Vermont: Success By Six

- Vermont's comprehensive initiative focuses exclusively on young children and families. A network of regional Parent-Child Centers are the hub of planning and service delivery, particularly for very young children. An Early Childhood Work Group made up of state officials and community leaders provides overall direction. An umbrella framework, Success By Six, helps to integrate programs and community mobilization. Each community's efforts have developed differently, but all feature core family-supportive services including welcome baby visits, family literacy, parent-child interaction groups, parent education groups, home visiting services, screenings, training for early childhood staff, integration with Vermont's Reach-Up welfare program and most recently, an effort to develop a statewide regionally-based early childhood mental health network linked with the Parent-Child Centers. The state is also focusing on infrastructure development. In 1996, after a year-long collaborative process, all the state commissioners of early childhood service agencies joined 30 leaders of private and non-profit organizations and providers in signing the Early Childhood Service Agreement, which sets forth detailed goals and objectives of integrating services and making them universal.* Also in 1996, after a consensual process, the state developed core standards and a self-assessment tool for center-based early childhood programs. A similar effort regarding family child care is underway.** The state is also helping communities use data through a Community Planning Profile to achieve desired outcomes for young children and families.

West Virginia: Various Program and Planning Initiatives

- West Virginia focuses on children and families of all ages in its community mobilization strategy, the Family Resource Network, but has also funded a prekindergarten initiative. Since *Map and Track '96*, it has increased its focus on young children and families. As a Starting Points grantee, it has developed nine Early Starting Points Centers that are integrated into its Family Resource Networks. The aim is to use those centers as a service integration hub, including linking them with the state's welfare reform implementation, particularly for families with young children. Leadership for the overall initiative is provided through a Cabinet on Children and Families and, as a part of that, an Early Childhood Implementation Commission. The Commission's charge is to foster school readiness by linking various on-going initiatives, such as the Head Start Collaboration Project, and the state's efforts to promote transition to school in order to create a comprehensive focus on young children. West Virginia is also developing a process to select outcomes and indicators for West Virginia's children that can be both county-specific and tracked over time.

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* The Early Childhood Work Group. (Fall 1996). *Vermont core standards and self assessment tool for center-based early childhood programs.* Waterbury, VT: Vermont Office of the Secretary, Agency of Human Services.

** Vermont Agency of Human Services & Vermont Department of Education. (1997). *Serving children, serving families: Coordinating early care and education in Vermont. A Report to the Vermont General Assembly.* Waterbury, VT: Vermont Agency of Human Services and Vermont Department of Education.

IN PRESS - THE FUTURE OF CHILDREN

Prenatal and Infancy Home Visitation by Nurses:

Recent Findings

David L. Olds
University of Colorado

Charles R. Henderson, Jr.
Cornell University

Harriet Kitzman
University of Rochester

John Eckenrode
Cornell University

Robert Cole
University of Rochester

Robert Tatelbaum
University of Rochester

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I. INTRODUCTION

Many of the most pervasive and intractable problems faced by young children and parents in our society today can be traced to adverse maternal health-related behaviors during pregnancy, compromised care of the child, and stressful conditions in families' homes that interfere with parental and family functioning. These problems include infant mortality, pre-term delivery, low birthweight, and neurodevelopmental impairments in young children resulting from poor prenatal health;[1,2,3] child abuse and neglect, and accidental childhood injuries resulting from dysfunctional caregiving;[4] youth violence resulting from a combination of neurodevelopmental impairment and harsh and neglectful caregiving;[5,6,7] and diminished economic self-sufficiency of parents resulting from closely spaced pregnancy, educational failure, and sporadic workforce participation.[8]

Through 1993, we published a series of papers on a randomized trial of prenatal and infancy home visitation by nurses in Elmira, New York (N=400) that was designed to reduce these problems through the improvement of maternal health and behavior. The program was focused on women who were either unmarried, adolescents, or poor. Early results showed significant promise for the program, and were reviewed in an article on the effects of prenatal, infancy and early childhood home visitation published in 1993.[9]

At the time the 1993 review article was written, some of the program effects evaluated through the child's fourth year of life had been published. Compared to counterparts randomly assigned to receive comparison services, women who were nurse-visited experienced greater informal and formal social support, smoked fewer cigarettes, had better diets, and exhibited fewer kidney infections by the end of pregnancy. (There also was a non-significant decrease in the number of hypertensive disorders of pregnancy.) Babies born to nurse-visited women

identified as smokers were 75% less likely to be born prematurely, that is, before 37 weeks of gestation.[10]

From birth through the child's second birthday, nurse-visited children born to women with all three risk characteristics used for sample recruitment (poor, unmarried, or teen-aged) were 80% less likely to have been identified through state Child Protective Service Records as a victim of child abuse or neglect than were their counterparts in the comparison group. Moreover, nurse-visited children were seen in the emergency department 56% fewer times than were children in the comparison condition during the second year of their lives – that is, when children are more likely to be injured because of their increased mobility but immature motor development. These findings were corroborated by observations of the children's homes and parents' reports of their care of their children.[11]

During the first four years after delivery of the first child, nurse-visited women who were low-income and unmarried at registration were found to have 42% fewer subsequent pregnancies and 84% greater participation in the work force.[12] An economic evaluation of the program from the standpoint of savings to government showed that for low-income women the discounted cost savings to government exceeded the cost of the program before the children were four years of age.[13]

Given these encouraging results, beginning in the late 1980's many groups urged us to develop the program in new communities on a much wider scale. They reasoned that the program worked and that at-risk families in our society deserved the program. We chose not to replicate the program outside of research contexts, however, for three reasons.

First, we did not know whether the findings produced early in the life of the child would endure. Other preventive interventions had produced effects that washed out after the program

ended. We needed to see enduring benefit before we could justify a public investment in this service.

Second, we did not know whether the findings from the Elmira program were limited to the population studied (primarily whites living in a Central New York county) or whether they might apply to a wider range of communities and populations. In particular, we needed to be sure that this was a program that would work with minorities living in urban areas.

Third, we needed to develop the program protocols and methods of training nurse home visitors to the point that new programs based upon this model would reliably reproduce the essential elements of the program tested in the randomized trials. Many programs examined in research settings are subsequently altered or watered down in the process of being scaled up, often leading to reduced effectiveness. We wanted to avoid that fate for the current program and needed to be able to provide clear guidance for new communities about what, exactly, they should do to replicate the program.

In the meantime, several national groups used the findings from the Elmira trial to promote a variety of home-visitation models in spite of the fact that the promoted programs bore little resemblance to the program tested in Elmira. Some programs employed paraprofessional visitors who began during pregnancy but had little follow-up during infancy. Others began after delivery and employed paraprofessionals as home visitors. Rarely were such programs designed explicitly to promote maternal life course (plan future pregnancies, stay in school, find work, etc.). We did not discourage organizations using data from the Elmira trial to promote such a wide variety of program types because, for all we knew at the time, the Elmira findings might be reasonably applied to a many types of programs. We chose, instead, to focus our efforts on conducting a follow-up of the Elmira study to examine the durability of the early effects,

replicating the program in a major urban area (Memphis, Tennessee) and refining the program protocols and training. If the program were truly effective, we then could help new communities develop the program in accordance with the proven model so that they could be reasonably sure of achieving the effects observed in the randomized trials.

As the results of new randomized trials of other home visitation programs became available, however, we grew increasingly concerned that the findings from Elmira did not have broad applicability to all types of home visitation programs. Two reviews of randomized trials of prenatal and early childhood home visitation programs showed that such programs needed to adhere to certain standards to produce desired effects on maternal and child health.[14,9]

More recently, in light of the considerable proliferation of programs of home visitation by lay community health visitors, without solid evidence that such visitors could achieve the same results as has been found with nurses, we developed a third trial in Denver (N=735) in which nurse home visitors were contrasted with trained lay community health visitors when both visitor types were provided the same protocols developed in the Elmira and Memphis trials. This study was designed to determine the extent to which absence of effects for programs delivered by paraprofessionals is due to the background of the visitors or to the program protocols typically followed by paraprofessional visitors.

In this paper, we summarize findings from the Elmira trial that have been published since 1993 – the point at which we published the most recent review of this evidence [9] – and summarize findings from the Memphis replication study. Outcomes from the Denver trial are not yet available, although data on differences between the nurse and paraprofessional home visitors in implementation of the program are briefly summarized here. Before we summarize these findings, we outline the epidemiological and theoretical foundations of the program and its

content and methods. It is important to understand these features of the program in order to interpret its effects.

II. DEVELOPMENTAL EPIDEMIOLOGY

The program tested in this series of randomized trials has been firmly grounded in epidemiology and theories of child development. Kellam has referred to the integration of these disciplines in guiding prevention science as *developmental epidemiology.*[15] In planning the original Elmira trial, we noted that although the problems identified above cut across all segments of U.S. society, they were more common among children born to poor, adolescent, and single parents. This observation led to our decision to focus recruitment on women bearing first children who were either adolescent, unmarried, or from low-income families. Any pregnant woman bearing a first child was accepted into the study, irrespective of her age, marital status or income, however, in order to avoid creating a program stigmatized because it served only the poor or people with problems. Given that the beneficial effects of the Elmira program (described below) were concentrated on women who were unmarried and from low-income families, we modified the sampling designs in Memphis and Denver to focus more exclusively on low-income women, the vast majority of whom were unmarried and adolescent.

All three of the trials focused on women who had no previous live births because we reasoned that offering them services during the transition to parenthood would increase their receptivity to offers of help. Moreover, from the standpoint of a public health strategy, this approach held the promise of improving the life chances of subsequent children because parents who received these services were hypothesized to have better skills for managing the demands of pregnancy and early care of subsequent children after they had been helped with their first child. In addition, to the extent that the rates of rapid successive births were reduced, parents would be

able to focus their caregiving resources on a smaller number of children. The program was directed toward improving the outcomes of pregnancy, parents' caregiving skills (and the corresponding health and development of the child), and the early life course of the mothers.

In designing the program, we reviewed the literature to determine behavioral and contextual conditions that were consistently and uniquely associated with the adverse maternal and child outcomes that we wished to affect. We analyzed the literature to determine the extent to which these risk factors were likely to be causally related to the outcomes of interest and which were simply markers for maladaptive functioning. Those thought to be causally related to the outcome of interest and that were potentially modifiable with social and behavioral interventions became the primary candidates for targeted interventions to reduce the adverse maternal and child outcomes identified for prevention. Theory played an important role in helping us integrate the epidemiologic data into a coherent developmental framework regarding the proximity of risk to adverse outcome, the developmental progression of maladaptive functioning, and how clinical interventions might be applied to reduce risk. It is important to note that the epidemiologic evidence indicated that some of the problems targeted for prevention early in the program were also risks for later antisocial behavior. This is best illustrated by reference to Figure 1.

A. Modifiable Risks for Low Birthweight, Preterm Delivery, and Fetal Neurodevelopmental Impairment

Epidemiologic evidence on risks for low birthweight indicates that prenatal exposure to tobacco, alcohol, and illegal drugs are established risks for compromised fetal growth[1] and, to a lesser extent, shortened length of gestation.[1] Similarly, prenatal exposure to these substances increases the likelihood of compromised neurodevelopmental impairment.[2,3,16-21] While the

evidence on these risks was not as coherent at the start of this series of trials 20 years ago as it is today, we chose to promote a reduction in use of all of these substances as a precaution.

Evidence also indicated that other prenatal behaviors, such as inadequate weight gain,[22] inadequate diet,[22] inadequate use of office-based prenatal care,[23] and unattended obstetric complications, such as genitourinary tract infections and hypertensive disorders[23] increased the risk for low birthweight, preterm delivery, and compromised neurologic development.

These observations guided the development of the content covered in the prenatal program protocols.

B. Modifiable Risks for Child Abuse and Neglect and Injuries to Children

We made an explicit inventory of risks for child abuse and neglect and organized them according to their levels of immediate proximity to parental behavior. At a proximal level, risk assessment focused on the mother's psychological immaturity and mental health problems that affect parents' competencies in caring for their infants.[24,25] At a more distal level, risks focused on those environmental conditions that create stressful conditions in the household that interfere with parents' care of their children, such as unemployment,[26] poor housing and household conditions,[27] marital discord,[28] and isolation from supportive family members and friends.[29,30] A history of punitive, rejecting, abusive, or neglectful caregiving on the parent's own part was considered a risk factor, especially if it occurred in the presence of other risks.[31,4]

C. Modifiable Risks for Welfare Dependence and Compromised Maternal Life-Course Development

One of the major risks for compromised maternal educational achievement and workforce participation is rapid, successive pregnancies, particularly among unmarried women. Proximal risks for rapid successive pregnancies include women's having limited visions for their futures in

the areas of education and work,[8] as well as a limited sense of control over their life circumstances and over contraceptive practices in particular.[32,33,34]

D. Modifiable Risks for Early-Onset Antisocial Behavior

More recently, we have analyzed risks for early-onset antisocial behavior[2,35,36] and determined that the impact of the program on maternal and child health early in the life cycle reduces risks for these problems. Children who exhibit early-onset antisocial behavior are more likely to develop violent behavior during adolescence and are hypothesized to become chronic offenders.[5] Figure 1 provides a framework for integrating our thinking about how these diverse influences converge in producing childhood-onset conduct disorder and how this program of prenatal and early childhood home visitation by nurses reduces its risks. Children who develop early-onset disorder are more likely to have subtle neurodevelopmental deficits (such as compromised intellectual or language functioning and attention deficit disorder) combined with harsh, punitive, and rejecting parenting.[6,7] Maternal life-course factors also predict the development of antisocial behavior, in that children with these behaviors are more likely to come from large families, with closely spaced children, where parents themselves are involved in substance abuse and criminal behavior.[37]

III. THEORETICAL FOUNDATIONS

The program has been grounded in theories of human ecology,[38,39] self-efficacy,[40] and human attachment.[41] The earliest formulations of the program gave greatest emphasis to human ecology, but as the program has evolved, it has been grounded more explicitly in theories of self-efficacy and attachment.[11]

A. Human Ecology Theory

Human ecology theory emphasizes the importance of social contexts as influences on human development.[38] Parents' care of their infants, from this perspective, is influenced by characteristics of their families, social networks, neighborhoods, communities, and the interrelations among these structures. This theory focuses the home visitors' attention on the systematic evaluation and enhancement of the material and social environment of the family.

While this theory provides an elaborated conception of the environment, the original formulation of the theory tended to treat the immediate settings in which children and families find themselves as shaped by cultural and structural characteristics of the society, with little consideration given to the role that adults (in particular, parents) can play in selecting and shaping the settings in which they find themselves.[38] Consequently, self-efficacy and attachment theories were integrated into the model to provide a broader conception of the parent–setting relationship.

B. Self-Efficacy Theory

Self-efficacy theory provides a useful framework for understanding and promoting women's health-related behavior during pregnancy, their care of their children, and their own personal development. This theory distinguishes two cognitive influences on motivation: efficacy expectations and outcome expectations.[40] Outcome expectations are individuals' estimates that a given behavior will lead to a given outcome. Efficacy expectations are individuals' beliefs that they can successfully carry out the behavior required to produce the outcome. Individuals' perceptions of self-efficacy can influence their choice of activities and settings and can determine how much effort they put forth in the face of obstacles.

Self-efficacy theory influenced the design of the program by focusing the nurses' attention on both the mothers' beliefs about the consequences of their behavior and on building

their confidence for behavioral change. Much of the educational content of the program was focused on helping women understand what is known (or thought about) the influence of particular behaviors on the health and growth of the fetus, on women's own health, and on the subsequent health and development of the child. This represented an effort to bring women's outcome expectations into alignment with the best evidence available. Improvements in individuals' behavior depends upon their confidence in their ability to change. Because individuals gain confidence if they actually observe their accomplishments, the home visitors emphasize methods of enhancing self-efficacy that rely on women actually carrying out parts of the desired behavior. The visitors help parents establish realistic goals and small achievable objectives that, once accomplished, will increase parents' reservoir of successful experiences, and in turn will increase their confidence in taking on larger challenges.

While self-efficacy theory provides powerful insights into human motivation and behavior, it is limited in several respects. First, it is primarily a cognitive-behavioral theory. It attends to the emotional life of the mother and other family members only through the impact of behavior on women's beliefs or expectations, which, in turn, affect emotions. It also attends to environmental influences in only a cursory way. These shortcomings of self-efficacy theory have been addressed in the program with attachment and human ecology theories.

C. Attachment Theory

Attachment theory posits that infants are biologically predisposed to seek proximity to specific caregivers in times of stress, illness, or fatigue in order to promote survival.[41] This organization of behavior directed toward the caregiver is called "attachment." Stated simply, a growing body of evidence indicates that children's trust in the world and their later capacity for empathy and responsiveness to their own children once they become parents can be traced to the

degree to which their needs were responded to sensitively and competently as they were growing up.[42]

Attachment theory has affected the design of the home-visitation programs in three fundamental ways. The first has to do with its emphasis on the visitors' developing an empathic relationship with the mother and other family members. The establishment of a relationship based on empathy and respect was expected to help women eventually trust others and to promote more sensitive, empathic care of their children. The second has to do with an emphasis in the program on helping mothers and other caregivers review their own childrearing histories and make decisions about how they wish to care for their children in light of the way they were cared for as children. And third, attachment theory has led to the explicit promotion of sensitive, responsive, and engaged caregiving in the early years of the child's life.[43,44]

While attachment theory provides a rich set of insights into the origins of dysfunctional caregiving and possible preventive interventions focused on parent-visitor and parent-child relationships, it gives scant attention to the role of infants' constitutional differences as independent influences on parental behavior, and it provides inadequate attention to issues of parental motivation for change in caregiving. It also minimizes the importance of the current social and material environment in which the family is functioning as influences on parents' capacities to care for their children. For more systematic treatments of these issues, we turned to self-efficacy and human ecology theories.

The nurses thus have been equipped with a set of theory-driven program protocols that guide their efforts to help women improve their health-related behaviors, their care of their children, their planning of subsequent pregnancies, the completion of their education, and participation in the work force.

IV. PROGRAM DESIGN

A. Frequency of Visitation

The frequency of home visits changes with the stages of pregnancy and can be adapted to the mother's needs. Mothers typically are enrolled through the end of the second trimester of pregnancy. Visits are scheduled once a week during the first month after enrollment, which assists the new mother and the home visitor to establish a trusting relationship. Thereafter, visits are scheduled every other week until the birth of the baby. Nurses again visit weekly for 6 weeks after the baby is born, helping the new mother and newborn adjust. From the child's 2nd to 21st postnatal month, visits are scheduled twice a week. From the 21st to 24th postnatal month, visits are scheduled once a month. In Elmira and Memphis the nurses completed an average of 9 (range 0-16) and 7 (range 0-18) visits during pregnancy respectively; and 23 (range 0-59) and 26 (range 0-71) visits from birth to the child's second birthday. In calculating these rates of completed visits, all cases assigned to the nurse-visited conditions were included in the denominator, irrespective of the families' dropping from the program for any reason. Each visit lasted approximately 75-90 minutes.

B. Nurses as Home Visitors

This program calls for nurses to be the home visitors. We have chosen nurses because of their formal training in women's and children's health and because of their competence in managing the complex clinical situations often presented by at-risk families. We have hypothesized that nurses' abilities to address effectively mothers' and family members' concerns about the complications of pregnancy, labor, and delivery, and the physical health of the infant provide nurses with increased credibility and persuasive power in the eyes of family members. Moreover, through their ability to teach mothers and other family members to identify emerging

health problems and to use the health-care system to address those problems, they enhance their clinical effect through the early detection and treatment of disorders. Each nurse carried a caseload of 20-25 families and received regular clinical supervision.

C. Program Content

During the home visits, the nurses carry out three major activities. They promote adaptive change in women's behavior thought to affect the outcomes of pregnancy, the health and development of the child, and maternal life course; they help women build supportive relationships with family members and friends; and they link women and their family members with other health and human services. The nurses follow detailed visit-by-visit program protocols. The content of the protocols is organized developmentally to reflect challenges that women are likely to confront at different stages of pregnancy and during the first 2 years of the child's life. Specific assessments are made of maternal, child, and family functioning, and specific educational content and psychosocial interventions are prescribed, depending upon the nature and degree of vulnerability revealed in the assessments.

V. OVERVIEW OF RESEARCH DESIGNS, METHODS AND FINDINGS

In each of the three studies of the program described above, women were randomized to receive either home visitation services during pregnancy and the first two years of the children's lives or comparison services. While the nature of the home-visitation services was essentially the same in each of the trials, the comparison services were slightly different. The designs and methods employed in each of the trials are outlined below.

A. Elmira Design and Methods

The first study was conducted in a small, semi-rural county of approximately 100,000 residents in the Appalachian region of New York State. The program was conducted through

Comprehensive Interdisciplinary Developmental Services, Inc.

Pregnant women were actively recruited for the study through their sources of prenatal care if, at intake, they had no previous live births, they were at less than 26 weeks of gestation, and they had any one of the following characteristics that predispose to infant health and developmental problems: (i) young age (<19 years); (ii) single parent status; and (iii) low socioeconomic status. Any woman who asked to participate was enrolled, however, regardless of her age, marital status, or income, if she had no previous live birth. This approach avoided creating a program that was stigmatized as being exclusively for the poor and created sample heterogeneity, enabling us to determine if the effects of the program were greater for families at higher risk. Five hundred women were invited to participate and 400 enrolled, 85% of whom were either low-income, unmarried, or <19 years of age at registration; none had a previous live birth. Eighty-nine percent of the sample was Caucasian. There were no sociodemographic differences between those who enrolled and those who declined, although participation was higher among African-Americans. We stratified the sample on a number of demographic factors and then randomly assigned participating women to one of four treatment groups.

Families in Treatment 1 (n=94) were provided sensory and developmental screening for the child at 12 and 24 months of age. Based upon these screenings, the children were referred for further clinical evaluation and treatment when needed. Families in Treatment 2 (n=90) were provided the screening services offered those in Treatment 1 plus free transportation for prenatal and well-child care through the child's 2nd birthday. There were no differences between Treatments 1 and 2 in their use of prenatal and well-child care (both groups had a high rate of completed appointments). Therefore, these two groups were combined to form a single comparison group. Families in Treatment 3 (n=100) were provided the screening and

transportation services offered Treatment 2 but in addition were provided a nurse who visited them at home during pregnancy. Families in Treatment 4 (n=116) were provided the same services as those in Treatment 3, except that the nurse continued to visit through the child's 2nd birthday. For assessment of the prenatal phase of the program, Treatments 1 and 2 were combined and compared to the combination of Treatments 3 and 4.

Assessments of outcomes were made by interviews, observations of mother-child interaction, observations of conditions in the home, and reviews of medical and social service records by individuals who were not aware of the women's and children's treatment assignment. Details of the research design and methods can be found in our earlier reports.[11,12,35]

B. Elmira Results

At the stage of randomization, the treatment conditions were essentially equivalent on all background characteristics examined. Moreover, at the 15-year follow-up, assessments were completed on over 90% of the women and children originally randomized who did not die or where there was no adoption. Low attrition and no treatment-control differences in background characteristics on those assessed after enrollment means that the estimates of program effects were not biased by loss of families. All analyses of program effects were based upon an intention-to-treat approach, that is data were employed for outcome analyses irrespective of the degree of program participation.

It is important to note that we hypothesized that the effects of the program would be greater for families who experienced greater stress and had fewer resources to cope. We tested this hypothesis by focusing the analysis on low-income unmarried women.

1. Caregiving and Child Development Results. With few exceptions, the beneficial effects of the program on caregiving outcomes were not present for the sample overall. Nurse-

visited at-risk women and their children, on the other hand, consistently exhibited lower rates of adverse outcomes indicative of grossly deficient care of the child.

As noted in our earlier reports, nurse-visited children born to low-income, unmarried teens had 80% fewer verified cases of child abuse and neglect during the first two years of the child's life. Moreover nurse-visited children, irrespective of risk, were seen in the emergency department 56% fewer times for injuries during the second year of the child's life. As indicated in Figures 2 and 3, the effect of the program on child abuse and neglect and emergency-department encounters was greater among children whose mothers had little sense of control over their lives (measured at registration during pregnancy).

The impact of the program on health-care encounters for injuries endured during the two-year period after the end of the program: irrespective of risk, children of nurse-visited women were less likely to receive emergency room treatment (1.00 vs 1.53 visits, $p<.001$) and to visit a physician (0.34 vs 0.57, $p=.03$) for injuries and ingestions than were their comparison-group counterparts.[44] The impact of the program on state-verified cases of child abuse and neglect, on the other hand, was attenuated during the 2-year period following the end of the program.[45]

We hypothesized that this pattern of results was probably due to increased surveillance for child abuse and neglect in the nurse-visited group, given that nurses were mandated to report suspected maltreatment and that they linked families with needed community services -- where their parenting needs were likely to be more completely assessed by other service providers.[45]

An examination of the living conditions and emergency-department encounters for the "maltreated" children showed that nurse-visited "maltreated" children lived in homes that were more conducive to children's development, as indicated by higher HOME scores; their homes were substantially safer; and the children themselves had far fewer emergency-room encounters

and physician visits in which injuries were detected. We have interpreted these differences as a reflection of greater surveillance for child abuse and neglect, leading to more frequent identification of less serious forms of maltreatment in the nurse-visited condition.[46]

This interpretation has been reinforced with results from a 15-year follow-up of the Elmira sample[32] in that the program-control differences in rates of state-verified reports of child abuse and neglect grew between the children's fourth and fifteenth birthdays. Overall, during the 15-year period after delivery of their first child, in contrast to women in the comparison group, those visited by nurses during pregnancy and infancy were identified as perpetrators of child abuse and neglect in 0.21 versus 0.46 verified reports ($p < .001$). This effect was greater for women who were unmarried and from low-SES households at registration ($p < .001$).[32]

2. Prenatal Tobacco Exposure, Prenatal Home Visitation, and Development in the First 4 Years of the Child's Life. While there were no overall program effects on children's mental development, children born to women who smoked a moderate to heavy amount when they registered in the program during pregnancy and who received prenatal home visitation had significantly higher IQ scores at 3 and 4 years of age than did their counterparts in the comparison group.[16,17] As shown in Figure 4, control-group children born to women who smoked 10 or more cigarettes per day during pregnancy had mental development scores that declined over the first 4 years of the child's life, in contrast to their counterparts in the comparison group whose mothers did not smoke during pregnancy.[16] In the nurse-visited condition, children born to women who smoked 10 or more cigarettes at registration during pregnancy had mental development scores in infancy, toddlerhood, and the preschool period that were the same as those who did not smoke at all or who smoked only a few cigarettes per day.[17] These beneficial effects of prenatal home visitation held for the group visited only during

pregnancy and were not explained by differences in measured aspects of the postnatal environment.

In light of this, it is important to note that we reported earlier that control-group mothers reported that their six-month old infants were more irritable than did those visited by nurses.[11] We have now conducted analyses that show that these effects were concentrated exclusively in infants born to women who smoked during pregnancy and that the positive program effects held for children whose mothers were visited only during pregnancy, as well as those visited in pregnancy and infancy. These findings have led us to focus greater attention on the role that an improvement in prenatal health can play in reducing subtle neurodevelopmental impairment in children.

3. Maternal Life Course 15 Years after Delivery of First Child. During the 15-year period after delivery of their first child, unmarried women from low socioeconomic (SES) households showed a number of enduring benefits. In contrast to their counterparts in the comparison condition, those visited by nurses during pregnancy and infancy had 1.1 versus 1.6 subsequent births ($p = .02$), 65 versus 37 months between the birth of their first and 2nd children ($p = .001$), 60 versus 90 months on welfare ($p = .005$), 0.41 versus 0.73 behavioral problems due to substance abuse ($p = .03$), and 0.18 versus 0.58 arrests by self-report ($p < .001$). New York State records revealed that they had 0.16 versus 0.90 arrests ($p < .001$).[35]

4. Antisocial Behavior Among the Fifteen-Year-Old Adolescents. In contrast to adolescents born to poor, unmarried women in the comparison group, those visited by nurses during pregnancy and the first two years of the child's life reported fewer instances of running away (0.60 vs. 0.24, $p=.003$), fewer arrests (0.45 vs. 0.20, $p=.03$), fewer convictions/violations of probation (0.47 vs. 0.09, $p<.001$), fewer life-time sex partners (2.48 vs. 0.92, $p=.003$), fewer

cigarettes smoked per day (2.50 vs. 1.50, p=.10), and fewer days having consumed alcohol in the last six months (2.49 vs. 1.09, p=.03). Parents of nurse-visited children reported that their children had fewer behavioral problems related to use of drugs and alcohol (0.34 vs. 0.15, p=.08). There were no program effects on other behavioral problems.

5. Cost Analysis. The Rand Corporation has recently conducted an economic evaluation of the program that extends the estimate of cost savings beyond those reported in our earlier report.[5,47] While there were no net savings to government or society for serving families in which mothers were married and of higher social class, as indicated in Figure 5, the savings to government and society for serving families in which the mother was low-income and unmarried at registration exceeded the cost of the program by a factor of 4 over the life of the child. This figure shows, moreover, that the return on the investment was realized well before the child's fourth birthday. The primary cost savings were found in reduced welfare and criminal-justice expenditures, and increases in tax revenues.

6. Conclusion. In general, as expected, the beneficial effects of the program were greater for families at greater risk as defined by women's being unmarried or from lower-SES households. These findings were encouraging, but by themselves insufficient to form a foundation for policy and practice. In order for scientific findings to serve as a guide in this regard, they must first be replicated. The scientific credibility of such findings increases if they can be reproduced with different populations living in different contexts and in different times.

C. Memphis Design and Methods

The Memphis trial was designed to determine if the effects of the Elmira program could be replicated when it was conducted through an existing health department and when it served a large sample of low-income African-American women, children, and their families living in a

major urban area. We hypothesized that the effects of the program would be found in the same outcome domains as we observed in Elmira and that the same background variables would moderate the effect of the program. So, for example, we hypothesized explicitly that the effect of the program on birthweight and length of gestation would be greater for women who smoked cigarettes and were young teens (<16 years of age at registration). Even though the program effect on hypertensive disorders of pregnancy in Elmira was not statistically significant, we hypothesized that the program would reduce the rates of pregnancy-induced hypertension in Memphis, given high rates of this problem in African-American pregnant women bearing first children.

In planning this study, we conducted extensive pretest and pilot work in Memphis and learned, among other things, that the rate of state-verified cases of child abuse and neglect among low-income first-born children in Memphis was too low (3-4%) to serve as a viable outcome in this setting. We therefore chose not to hypothesize program effects on rates of state-verified cases of child abuse and neglect, but instead hypothesized that the program would produce effects on children's health-care encounters for injuries that would be like those observed in Elmira - i.e., greater for women with few psychological resources. In Memphis, we hypothesized that the effects would be greater for women with more mental-health symptoms and limited intellectual functioning in addition to limited sense of control, as observed in Elmira.[48] Finally, given that the effects of the Elmira program were greater for women who were unmarried and from low-income families, we focused recruitment in Memphis on this population.

The program was conducted through the Memphis/Shelby County Health Department. From June 1990 through August 1991, 1290 women were invited to participate and 1,139 enrolled through the obstetrical clinic at the Regional Medical Center in Memphis. Women were

recruited if they were less than 29 weeks of gestation, had no previous live births, no specific chronic illnesses thought to contribute to fetal growth retardation or preterm delivery, and at least two of the following sociodemographic risk conditions: (i) unmarried, (ii) less than 12 years of education, (iii) unemployed. There were no differences in the sociodemographic characteristics of those who enrolled and those who declined, except that African Americans were more likely to participate than were whites. At registration, 92% of the 1139 women registered were African-American, 98% were unmarried, 65% were aged 18 or younger, 85% came from households with incomes at or below the federal poverty guidelines, and 9% smoked cigarettes. The details of the research design and methods are described in greater detail in our original report.[48]

1. Treatment Conditions. After completion of informed consent and baseline interviews, identifying information on the participants was entered into a computer program that randomized women to one of four groups. Women in Treatment 1 (n = 166) were provided free transportation for scheduled prenatal care appointments; they did not receive any postpartum services or child development screenings. Women in Treatment 2 (n = 515) were provided the free transportation plus developmental screening and referral services for the child at 6, 12, and 24 months of age. Women in Treatment 3 (n = 230) were provided the free transportation and screening offered Treatment 2 plus intensive nurse home-visitation services during pregnancy, one postpartum visit in the hospital before discharge, and one postpartum visit in the home. Women in Treatment 4 (n = 228) were provided the same services as those in Treatment 3; in addition, they continued to be visited by nurses through the child's 2nd birthday.

For the evaluation of the prenatal phase of the program, Treatments 1 and 2 were combined to form a single comparison group, which was contrasted with combined Treatments 3

and 4 (nurse-visitation during pregnancy). For the postnatal phase of the study, Treatment 2 was contrasted with Treatment 4.

As in Elmira, outcome assessments were conducted by individuals who did not know the treatment assignment of the participating women and children. Data were derived from interviews, observations of mother-infant interaction, observations of conditions in the home, and reviews of mothers' and children's medical and social-service records.

In interpreting the findings from this trial, it is important to note that it was conducted during a nursing shortage, which led to fairly high rates of staff turn-over because nurses left their jobs with the health department to earn more in competing hospitals. Given that these kinds of factors are likely to buffet the program as it is administered in other community settings, the Memphis findings may provide a good estimate of what the program might be able to achieve if it were replicated on a large scale.

D. Memphis Results

At the stage of randomization, the nurse-visited and control groups were essentially equivalent on all background characteristics examined. For those individuals on whom subsequent assessments were conducted, these groups remained equivalent on background characteristics. Moreover, postnatal assessments were conducted on a large portion of the women originally assigned to Treatments 2 and 4. Office-based assessments were completed at 24 months postpartum, for example, on 96% of the cases for which there was no fetal or child death. Low attrition and no nurse-visited-control differences in background characteristics on those assessed after enrollment means that the analyses of program effects are not likely to have been biased by loss of participating families. All analyses of program effects were based upon an intention-to-treat approach, that is data were employed for outcome analyses irrespective of the

degree of program participation.

1. Prenatal Findings. There were no treatment main effects on birthweight, low birthweight, length of gestation, spontaneous preterm delivery, indicated preterm delivery, or Apgar scores. Nevertheless, by the 36th week of pregnancy, nurse-visited women were more likely to use other community services than were women in the control group ($p = .01$). They also were more likely to be working ($p = .06$), an effect that was particularly strong among women who were not in school when they were randomized (8% vs. 2%, $p = .01$). There were no program effects on women's use of standard prenatal care or obstetrical emergency services after registration in the study, but nurse-visited women who were in school at the time of registration had twice as many pre-delivery hospitalizations as their counterparts in the comparison condition (0.18 versus 0.09, $p = .003$). This difference was not explained by any coherent pattern of diagnoses associated with those hospitalizations.[48]

In contrast to women in the comparison group, nurse-visited women had fewer yeast infections after randomization and fewer instances of Pregnancy-Induced Hypertension (PIH) ($p=.05$ and $p=.02$, respectively). Women with PIH who received a nurse home visitor had mean arterial blood pressures during labor that were 3.5 points lower ($p=.05$) than those in the comparison group, an indication of less severe cases.[48]

2. Dysfunctional Caregiving and Child Development. During their first 2 years, nurse-visited children overall had fewer health-care encounters in which injuries and ingestions were detected than did children in the comparison condition ($p = .05$), an effect that was accounted for primarily by a reduction in outpatient encounters ($p = .02$). Nurse-visited children also were hospitalized for fewer days with injuries and/or ingestions than were children in the comparison condition ($p < .001$). The program effects on both total health-care encounters and

number of days hospitalized with injuries and ingestions were greater for children born to women with few psychological resources (indicated by a combination of low intellectual functioning, high levels of mental-health symptoms, and limited sense of mastery/self efficacy). Figures 6 and 7 illustrate the concentration of positive program effects in women with few psychological resources. Note the similarity in pattern of results shown in these figures with the child-abuse-and-neglect and emergency-department visits findings in the Elmira study displayed in Figures 2 and 3.

An explanation for the difference in number of days children were hospitalized with injuries can be found in the nature of their problems. As can be seen in Table 1, nurse-visited children were hospitalized at older ages and for substantially less serious reasons. The three nurse-visited children who were hospitalized with injuries and ingestions were admitted when they were 12 months of age or older (and thus mobile), while six (43%) of the 14 comparison children were hospitalized when they were younger than 6 months of age (and thus immobile). Eight (57%) of the 14 comparison-group hospitalizations involved either fractures and/or head trauma, while none of the nurse-visited hospitalizations did. Two of the three nurse-visited children were hospitalized with ingestions. These profiles suggest that many of the comparison-group children were hospitalized for longer durations because of seriously deficient care. These differences in injuries were corroborated by maternal reports of breast-feeding and beliefs about caregiving, observations of the home environments, and the two-year olds' behavior towards their mothers.

Nurse-visited mothers reported that they attempted breast-feeding more frequently than did women in the comparison group ($p = .006$), although there were no differences in duration of

breast-feeding. By the 24th month of the child's life, in contrast to their comparison-group counterparts, nurse-visited women held fewer beliefs about child-rearing associated with child abuse and neglect-lack of empathy, belief in physical punishment, unrealistic expectations for infants ($p = .003$). Moreover, the homes of nurse-visited women were rated on the HOME scale as more conducive to children's development ($p = .003$). There was no program effect on observed maternal teaching behavior, but children born to nurse-visited mothers with low levels of psychological resources were observed to be more communicative and responsive toward their mothers than were their comparison-group counterparts (17.9 versus 17.2; $p = .03$). There were no program effects on the children's use of well-child care, immunization status, mental development, or reported behavioral problems.

3. Maternal Life Course. At the 24th month of the first child's life, nurse-visited women reported 23% fewer second pregnancies and 32% fewer subsequent live births than did women in the comparison group ($p=.006$ and .01, respectively). Nurse-visited women and their first-born children relied upon welfare for slightly fewer months (.7) during the 2nd year of the child's life than did comparison-group women and their children ($p=.07$). There were no program effects on reported educational achievement or length of employment.[48]

E. Comment on Elmira and Memphis Results

Many of the beneficial effects of the program found in the Elmira trial that were concentrated in higher risk groups, have been reproduced in the Memphis replication. Overall, these two trials indicate that the program has achieved two of its most important goals -- the reduction in dysfunctional care of children and the improvement of maternal life course. Its impact on the third goal -- the improvement of pregnancy outcomes (in particular, the reduction

of preterm delivery and low birthweight) -- was equivocal.

In the Elmira trial, the program produced the anticipated reduction in cigarette smoking, improvement in diet, and increases in women's use of needed social services and informal social support. There was an increase in the birthweight of infants born to women who were very young (i.e., less than 17 years of age at registration) and a reduction in the rates of preterm delivery from 10% to 2% among women identified as smokers (those who smoked five or more cigarettes per day at registration). It is important to note that 55% of the Caucasian women in the Elmira trial smoked cigarettes during pregnancy.

The program impact on preterm delivery and the birthweight of babies born to young adolescents and women identified as smokers in Elmira was not replicated in Memphis, although the program did produce the anticipated effects on women's use of other human services and on the rates of Pregnancy Induced Hypertension (PIH). The absence of corresponding effects on the rates of preterm delivery among smokers in Memphis is probably a reflection of the very low rates of cigarette smoking among African-Americans. Nine percent of the Memphis sample overall smoked cigarettes, and only 7% of the African-Americans smoked. Reproductive-tract infections (another major risk for preterm delivery), on the other hand, were much higher among African-Americans.[48]

This lack of correspondence between the results of the two trials emphasizes the importance of basing preventive interventions on sound epidemiologic evidence -- that is, a clear understanding of the modifiable risks for the disorder that one wishes to prevent. In this case, the pattern of risks was quite different for Caucasians in Central New York State than for African-Americans in Memphis. While the program can reduce cigarette smoking, it is more of a challenge to affect reproductive-tract infections, given that many infections begin prior to

pregnancy, are relatively asymptomatic, and are not easily detected outside of office-based medical settings after pregnancy has already progressed.[49]

The impact of the program on the rates of dysfunctional caregiving among higher risk families found in Elmira was substantially replicated in Memphis where the population served was at much higher risk overall. Recall that the beneficial effects of the program in Elmira on dysfunctional care during the child's first two years of life (reflected in rates of state-verified cases of child abuse and neglect and on emergency-department encounters) were concentrated on women who were unmarried and from low-SES households. In Memphis, (where 98% of the sample was unmarried, all were from low-SES families) we found corresponding effects for health-care encounters in which injures were detected, for observations of the home environments, and for parents' reports of caregiving and childrearing beliefs. The beneficial effects of the program on caregiving-related outcomes, while strong enough to emerge as program "main effects," were concentrated among women with lower levels of psychological resources at the time of registration. The effect of the program on health-care encounters in which injuries were detected and on the number of days that children were hospitalized with injuries, for example, was limited to children born to women with few psychological resources.

Moreover, in contrast to children in the comparison group, children of nurse-visited mothers in Memphis who had few psychological resources were observed to be more responsive and communicative toward their mothers. Infant-attachment research suggests that toddlers' behavior toward their mothers reveals the extent to which their mothers are sensitive and responsive rather than hostile, intrusive, or neglectful toward them, with toddlers' behavior being a better indication of the quality of the parent-child relationship over time than currently observed behaviors of parents.[50,51]

The Elmira program produced important effects on a host of maternal life-course outcomes from the birth of the first child to that child's 15th birthday. Among women who were unmarried and from low-SES households at registration, those who were visited by nurses during pregnancy and infancy had fewer subsequent children, fewer months on welfare, fewer behavioral impairments from use of alcohol and drugs, fewer arrests and convictions, and fewer days jailed during the 15-year period after birth of their first child.

In Memphis, the program reproduced the most important outcome with respect to maternal life-course -- a reduction in the rate of subsequent pregnancy. This is important given that future maternal life course effects depend heavily upon the prevention of subsequent pregnancy and an increase in the interval of subsequent pregnancies. In the Elmira trial, the beneficial effects of the program on life-course outcomes for teens were not reflected in increased rates of employment, greater educational achievements, or in reduced welfare dependence while the program was in operation (i.e., 2 years postpartum). It was reflected instead in the reduced rate of subsequent pregnancy, which positioned the teen mothers to eventually find work,[12] become economically self-sufficient, and eventually avoid substance abuse and criminal behavior.[35]

There is some indication in the Elmira trial that the program reduced the rates of neurodevelopmental impairment associated with cigarette smoking during pregnancy.[2,16,17] Given the simultaneous impact of the program on the rates of dysfunctional care and compromised maternal life-course (major risks for early-onset conduct disorder),[32,52,53,54] it is not all that surprising that the 15-year-old children born to women who were unmarried and low SES exhibited fewer arrests and convictions, and lower rates of cigarette smoking, alcohol use, and promiscuous sexual activity.

VI. PROGRAM IMPLEMENTATION IN DENVER TRIAL

The Denver trial was designed to gain insight into the reasons that previous trials of home-visitation programs that employed paraprofessionals either failed or produced very modest effects.[9,55] In the Denver trial, the paraprofessionals hired as home visitors were required to have a high school education, but no advanced training in the helping professions. We set this requirement because many programs employ paraprofessionals who come from the communities they serve on the premise that shared backgrounds and experiences will increase the visitors' ability to form effective relationships and promote adaptive functioning among the visited families. To further enhance the test of this theory, all of the paraprofessional visitors in Denver were required to be parents themselves. The nurses, on the other hand, all had bachelors degrees in nursing and were not required to be parents, although many were. Both groups were provided essentially the same training and program protocols, although, as one would expect, the nurses were provided more in-depth training regarding physical health and were expected to deal with health issues more extensively.[55]

Denver Design and Methods

From March, 1994 through June, 1995, 1178 consecutive low-income pregnant women with no previous live births were invited to participate from 21 antepartum clinics in the Denver metropolitan area. Low-income status was operationalized by the women's having no private insurance or their qualifying for Medicaid. Medicaid status as the time extended to women at or below 133% of the federal poverty guidelines.

Compared to women who either actively refused (n=244) or were invited but not contacted before delivery (n=199), those who accepted (n=735)were more likely to be of Mexican-American descent and were less likely to smoke cigarettes. These groups were

equivalent on other major sociodemographic characteristics, such as maternal age, language preference (English versus Spanish), and marital status. The rates of acceptance into the research was lower than in Elmira and Memphis, probably because of the large number of prenatal clinics involved, which meant that many women were invited in writing but did not have the study explained to them in a face-to-face interview, where their questions about the study might be answered.

84% of those enrolled were unmarried, 45% Mexican American, 34% Anglo non-Mexican American, 16% African-American, and 5% American Indian/Asian. 87% of the women enrolled were unmarried. The average age at registration was 19.8 years. The women were randomly assigned to treatment and control conditions using a computer program that stratified women by sociodemographic characteristics prior to allocation.

Women in Treatment 1 (n = 255) were provided developmental screening and referral services for the child at 6, 12 and 24 months of age. Those in Treatment 2 (n = 236) were provided the free screening services offered Treatment 1 plus intensive nurse home-visitation during pregnancy and the first two years of the child's life. Women in Treatment 3 (n = 244) were provided the free screening services offered Treatments 1 and 2 plus intensive home-visitation during pregnancy and the first two years of the child's life delivered by well-trained and supervised paraprofessionals.

Both groups of visitors were provided extensive pre-service and on-going training in the program model and were provided updated visit-by-visit protocols previously tested in Elmira and Memphis. They also were provided excellent clinical supervision, with the 10 nurses having a single full-time supervisor (a 1:10 supervisor to staff ratio) and the paraprofessionals having two full-time licensed clinical social workers as supervisors (for a

1:5 ratio).

Although outcome data on the mothers and children are not yet available, differences between nurses and paraprofessionals in the nature and quantity of program implementation have been reported. Data on program implementation were derived from encounter forms that the nurses and paraprofessionals completed after every home visit, and from administrative records. [55]

Differences between Nurses and Paraprofessionals in Program Implementation

Nurses and paraprofessionals completed essentially the same number of visits during pregnancy (approximately 6.5 visits), but the nurses completed an average of 5 more visits from birth to the child's second birthday (22 versus 17). This may be accounted for by a higher rate of staff turn over among the paraprofessionals (17 paraprofessional visitors hired over the life of the study), compared to no staff turn-over among the 10 nurses. The average visit by the paraprofessionals was about 7 minutes longer (81 minutes compared to 74 minutes, $p < .001$). The nurses spent a slightly larger portion of their time during the visits addressing the mothers' and children's physical health (23% versus 20%, $p<.001$) while the paraprofessionals spent more time on the mothers' life course development (18% versus, 16%, $p<.001$), their friend and family relationships (19% versus 15%, $p<.001$), and on the health and safety of the environment (15% versus 8%, $p<.001$). We did not expect to find that the nurses would spend more time on promoting parents' care of their children, but they did (39% versus 28%, $p<.001$). [55]

We expect that these differences in program implementation will affect the visitors' influence on maternal and child functioning, which will be the subject of additional reports in the near future.

VII. POLICY IMPLICATIONS AND PROGRAM REPLICATION

One of the clearest messages that has emerged from this program of research is that the functional and economic benefits of the nurse-home-visitation program are greatest for families at greater risk. In the Elmira study, it was evident that most married women and those from higher socioeconomic households managed the care of their children without serious problems and that they were able to avoid lives of welfare dependence, substance abuse and crime without the assistance of the nurse home-visitors. Similarly, their children on average avoided encounters with the criminal justice system, the use of cigarettes and alcohol and promiscuous sexual activity. Low-income, unmarried women and their children in the comparison group, on the other hand, were at substantial risk for these problems and the program of prenatal and infancy home visitation was able to avert many of these untoward outcomes for this at-risk population. This led to substantial cost-savings to government when the program was focused on this higher risk group. Among families at lower risk, on the other hand, the financial investment in the service was a loss. This suggests that this program will produce its greatest effects when it is focused on those in greatest need. This pattern of results challenges the position that these kinds of programs ought to be made available on a universal basis. Not only is the universal approach likely to be wasteful from an economic standpoint, but it may lead to a dilution of services for those families who need them the most, because of insufficient resources to serve everyone well.

During the past five years, new studies have been reported that have led us to doubt the effectiveness of home-visitation programs that do not adhere to the elements of the model studied in these trials, including the hiring of nurses.[56] These results should give policy makers and practitioners pause as they consider investments in home visitation programs without careful

consideration of program structure, content, and methods. With the increased focus on brain development in the first three years of life, [57] there is increased pressure to fund programs at this stage in the life cycle. It would be a mistake to do so, however, without solid scientific evidence that the particular model promoted is able to achieve its intended effects, given the failure of most programs that have been carefully tested.

It is increasingly clear that the evidence from the Elmira and Memphis studies cannot be generalized to programs that do not conform to the model tested in those trials. Even if the results of the Denver trial show benefits for the paraprofessionals, the beneficial effects must be understood in the context of the thoroughly developed program protocols and excellent clinical supervision they were provided. The difficulties faced by other home visiting programs tested in the past may be due to the particular program models tested or to the background of the visitors employed (or both). The outcomes of the Denver trial and randomized trials of other model programs (e.g., Parents as Teachers, Healthy Families America, Comprehensive Child Development Program summarized in this issue) as well as the Early Head Start program currently under investigation in the Head Start Bureau should provide additional guidance to policy makers in the near future. Even when communities choose to develop programs based on models with good scientific evidence, all too often the programs are watered down and compromised in the process of being scaled up. We have recently begun work that addresses this problem.

In 1995, we were invited by the US Department of Justice to develop the program studied in Elmira and Memphis in several high-crime neighborhoods around the country. We accepted the invitation because the results from the Memphis replication study and the Elmira follow-up were promising. We intend to use the Justice Department initiative to learn more about what is

required to develop the program in new communities with fidelity to its essential elements. Under the Justice Department initiative we are establishing the program in six communities in the country, including Los Angeles, Fresno, and Oakland California; Oklahoma City, Oklahoma; St. Louis, Missouri; and Clearwater, Florida.

In this program-replication phase (which will soon expand to include 15-20 additional sites beyond the Justice Department initiative), state and local governments are securing financial support for the program out of existing sources of funds, such as TANF (Temporary Assistance to Needy Families), Medicaid, Maternal and Child Health Block-Grant, child-abuse, and crime-prevention dollars. They are making this investment in part because the evidence indicates that the program will reduce future expenditures. This means that the cost of this program, which in 1998 dollars is about $7,000 per family for 2½ years of service, can be shared by a variety of government agencies. This, in turn, reduces the strain on any one agency's budget.

We wish to emphasize that we do not believe we can replicate this program on a large scale in a short period of time without compromising its effectiveness. We believe that it makes sense to develop a larger number of demonstration sites only after we have learned from our first group of sites how to develop the program successfully in a variety of new contexts. In the next phase of this work, we are building in provisions for learning about new implementation efforts so that we can develop the program in an even larger number of sites as quickly as is possible without losing program effectiveness.

Acknowledgments

The work reported here was made possible by support from many different sources. These include the Administration for Children and Families (90PD0215/01 and 90PJ0003), Biomedical Research Support (PHS S7RR05403-25), Bureau of Community Health Services, Maternal and Child Health Research Grants Division (MCR-360403-07-0), Carnegie Corporation (B-5492), Colorado Trust (93059), Commonwealth Fund (10443), David and Lucille Packard Foundation (95-1842), Ford Foundation (840-0545, 845-0031, and 875-0559), Maternal and Child Health, Department of Health and Human Services (MCJ-363378-01-0), National Center for Nursing Research (NR01-01691-05), National Institute of Mental Health (1-K05-MH01382-01 and 1-R01-MH49381-01A1), Pew Charitable Trusts (88-0211-000), Robert Wood Johnson Foundation (179-34, 5263, 6729, and 9677), US Department of Justice (95-DD-BX-0181), and the W. T. Grant Foundation (80072380, 84072380, 86108086, and 88124688).

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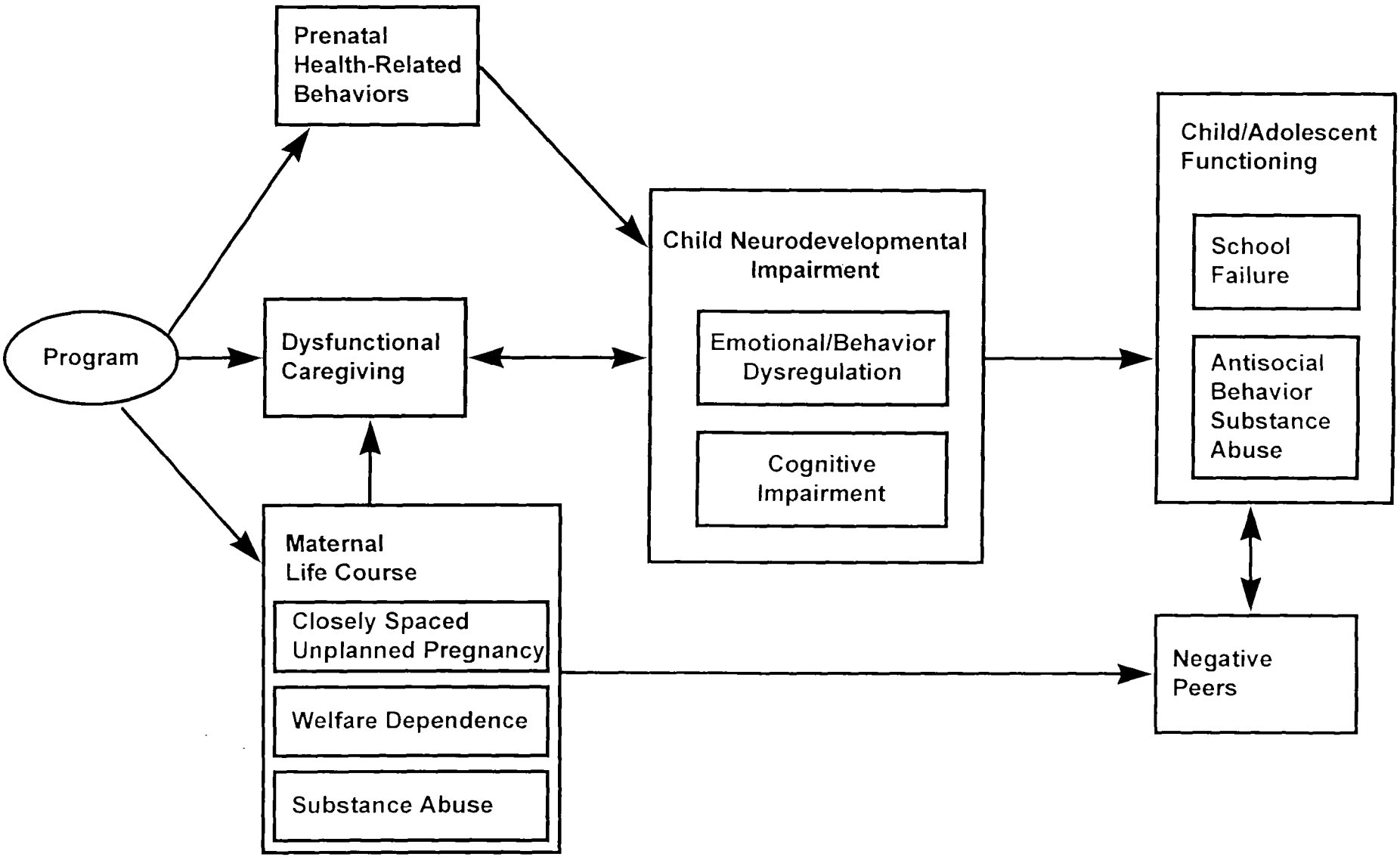


Figure 1. Conceptual model of risk domains to be affected by prenatal and infancy home visitation and influence on child and adolescent health and development

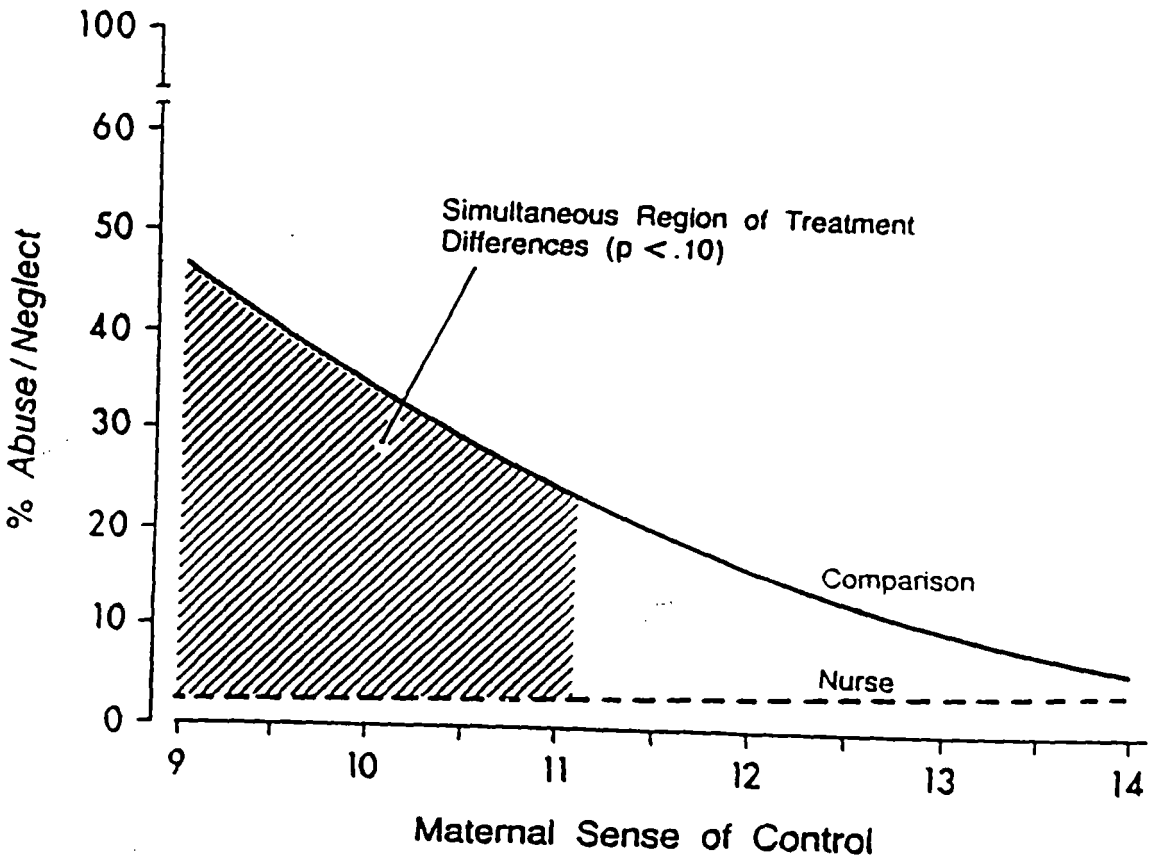


Figure 2. Estimated nurse-comparison differences in the rates of child abuse and neglect as a function of maternal sense of control - Elmira. (Reprinted with permission from Olds, D.L., Henderson, C.R., Chamberlin, R., Tatelbaum, R. Preventing child abuse and neglect: a randomized trial of nurse home visitation. *Pediatrics.* 1986;78(1):65-78.)

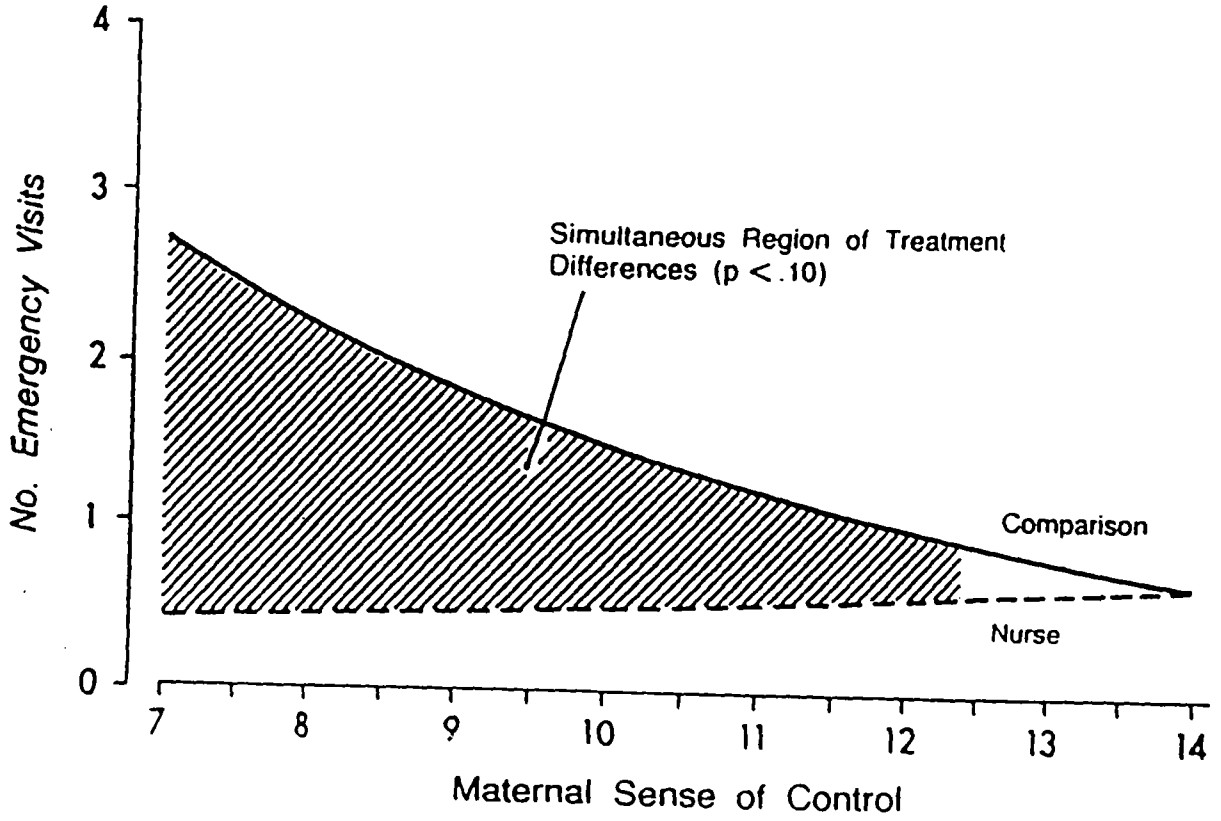


Figure 3. Estimated nurse-comparison differences in the number of children's emergency department visits during second year of child's life as a function of maternal sense of control - Elmira. (Reprinted with permission from Olds, D.L., Henderson, C.R., Chamberlin, R., Tatelbaum, R. Preventing child abuse and neglect: a randomized trial of nurse home visitation. *Pediatrics.* 1986;78(1):65-78.)

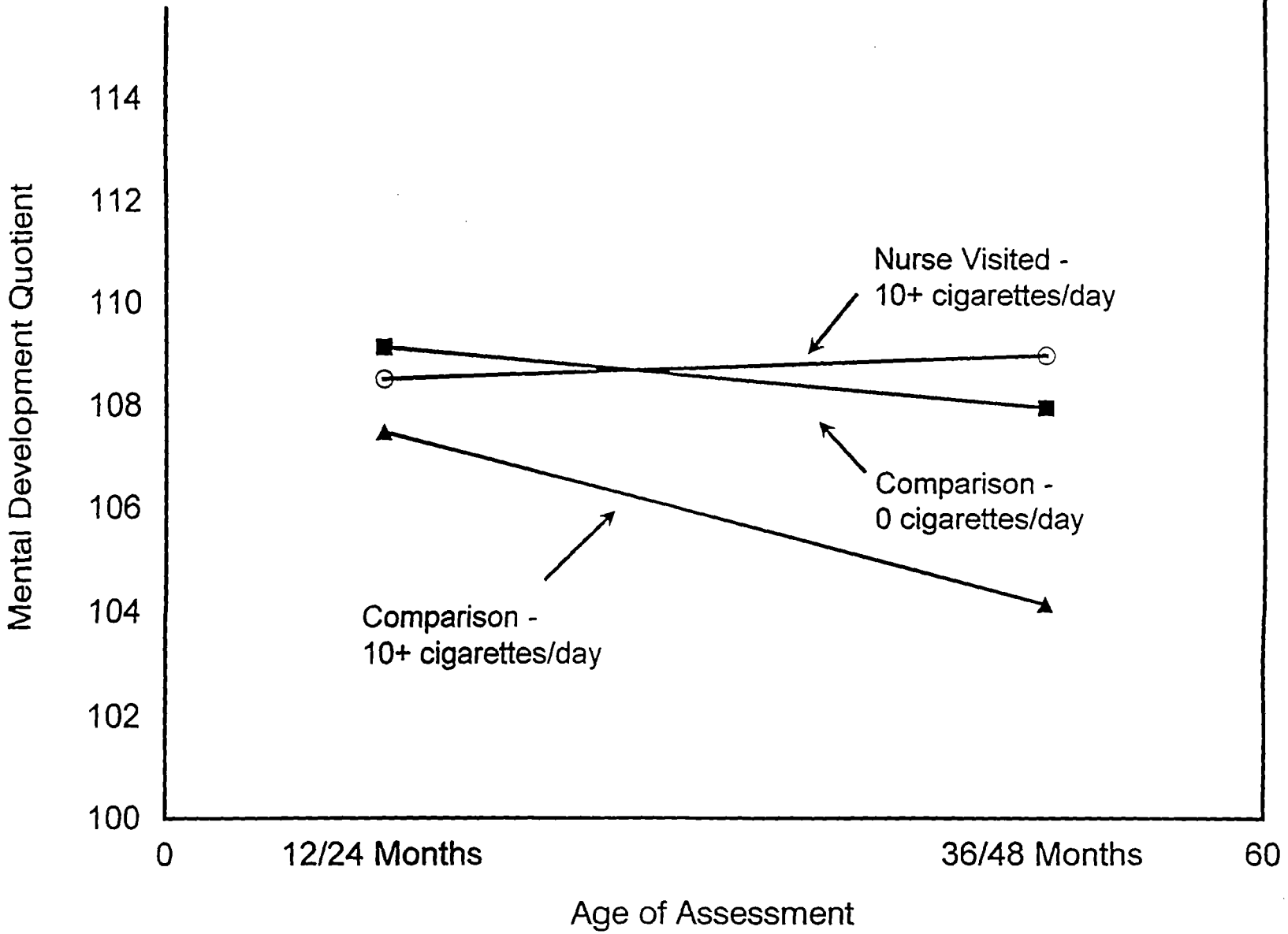


Figure 4. Mental development during first four years of life among children whose mothers smoked 10 or more cigarettes per day at registration during pregnancy and those whose mothers did not smoke

Cumulative Cost Savings: Elmira Home Visits (High-Risk Families)

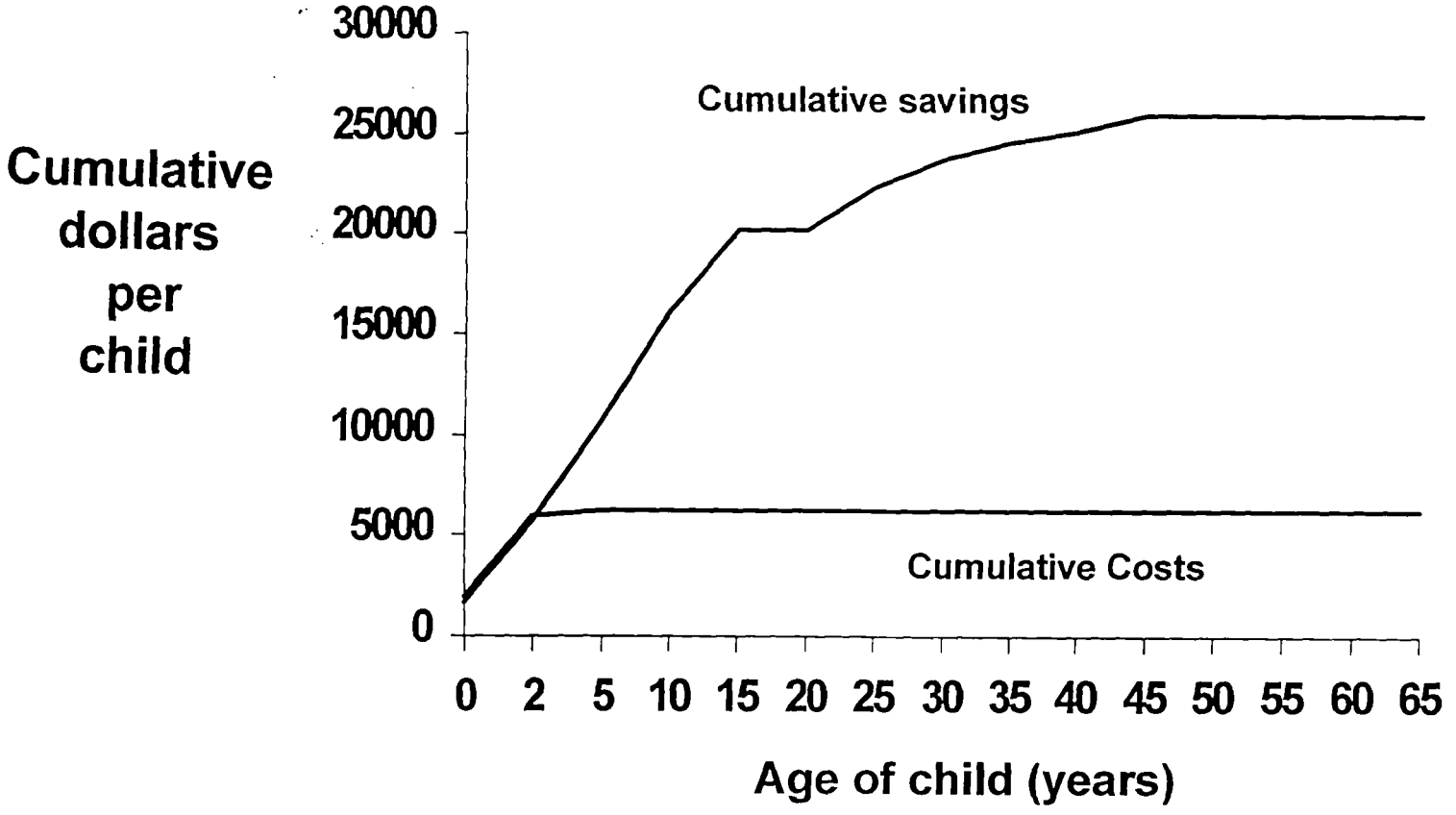


Figure 5. Cumulative costs and savings by age of child - high-risk families (headed by women who were low-income and unmarried at registration) - Elmira. (Reprinted with permission from Karoly, L.A., Greenwood, P.W., Everingham, S. S., Houbé, J., Kilburn, M.R., Rydell, C.P., Sanders, M., & Chiesa, J. *Investing in our Children. What We Know and Don't Know about the Costs and Benefits of Early Childhood Interventions.* 1998. Santa Monica, CA:RAND.)

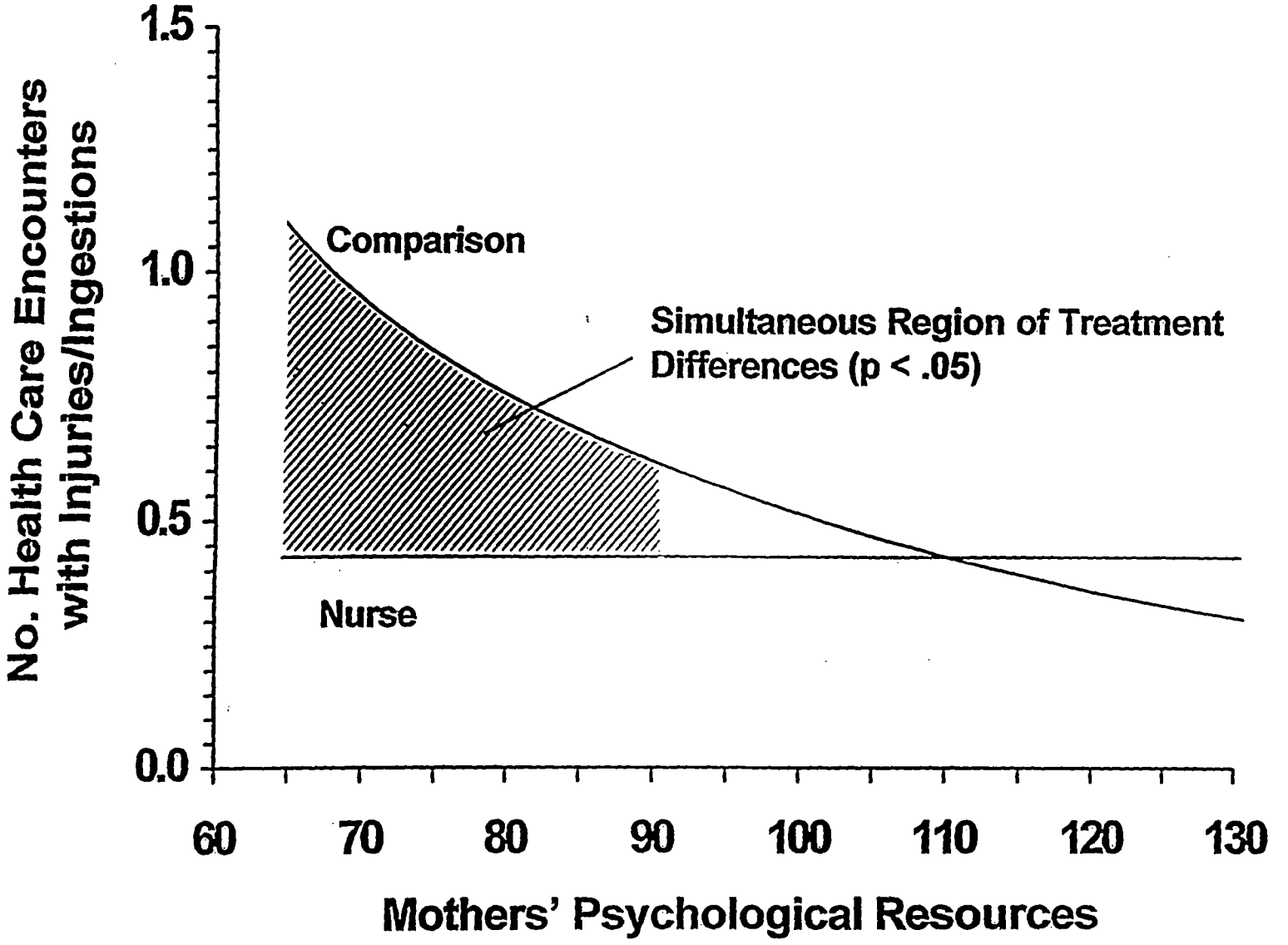


Figure 6. Estimated nurse-comparison differences in number of children's health-care encounters with injuries/ingestions as a function of maternal psychological resources - Memphis.

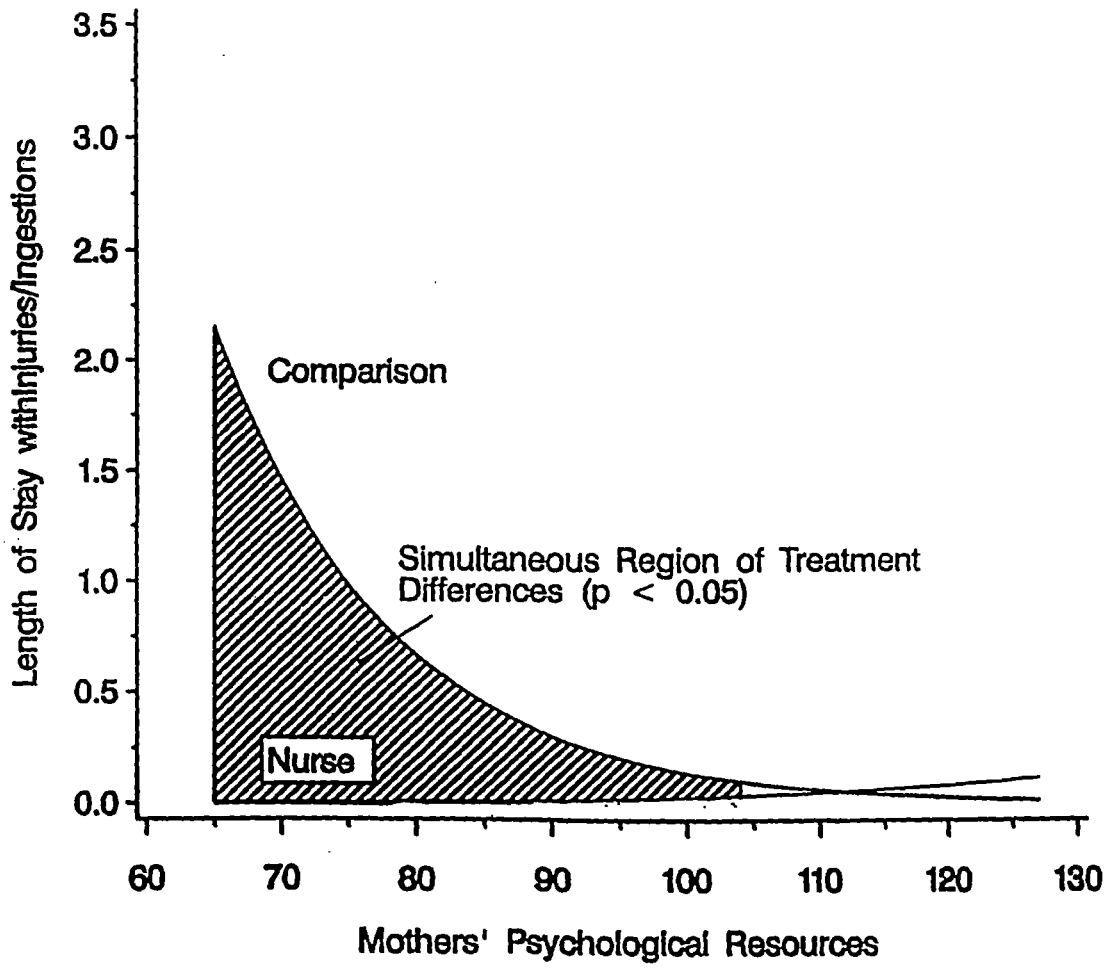


Figure 7. Estimated nurse-comparison differences in number of days children were hospitalized with injuries/ingestions as a function of maternal psychological resources - Memphis.

MEMORANDUM

To: Nicole R., Jen K.

From: Areej

Re: Early Childhood Intervention Hearing

Date: July 17, 1998

The purpose of this memorandum is to give a brief summary of the testimony given at the early chidhood intervention hearing held on July 16. This was the third hearing being held to discuss early childhood development programs. Previous hearings had included positive testimony about the success of programs such as Healthy Start and Early Head Start. However, a complete evaluation of these programs is still in progress to determine how effective and sustainable they really are.

Specifically, the hearing attempted to address two points:

1) How are investments in early childhood programs contributing to successful outcomes?

and 2) How can these successes be measured and replicated as states implement welfare reform and the demand for quality child care increases?

Panel 1 included three witnesses--

Felicia Pearson, young single mother participating in the *Healthy Familys* program: Ms.Pearson described the role the program had played in her life. During her pregnancy, she suffered from depression and was hospitalized. A psychiatrist recommended that she become involved in the program. Since then, she has been visited on a weekly basis by her family support worker who helped her manage the stress in her life both before and after her pregnancy, as well as learn how to stimulate and take care of her son. She believes that the program made a huge difference in her life and believes that early intervention programs should be made available for all families.

Lincoln Almond, Governor of R.I.: Governor Almond discussed the problems his state faced such as low and middle income families not being able to afford quality child care, welfare moms having difficult transition to workfare, etc. He also briefly outlined some of the scientific and economic benefits that research suggests will be the likely effects of early childhood programs. His testimony focused on the programs that R.I. has developed to guarantee child care and health care to all working families in order to ensure that "all children enter school ready to learn and leave school ready to work." State is using

all of its child care block grant (11 million), Title XX (1.5 million), and state funds (13 million) to support these programs.

- Rite Care program: state's health insurance program; since being created in 1994 has increased access to health care for children and improved the quality of the care; backed up success of program with a number of statistics such as an increase in percentage of infants who were up-to-date with their immunizations, a decrease in emergency room visits, etc.

- Starting Right: program that was just initiated this year and will be implemented over the next three; designed to provide "quality, affordable, and accessible" early education programs and comprehensive child care; changes include expanding the state's child care subsidy program, developing pilot projects linking similar programs (such as schools, child care, Head Start, and preschool), increasing number of children in Head Start, enhancing services to low-income children, offering health insurance coverage to child care center employers and partially subsidized health care coverage to licensed centers participating in the state's program, etc.

Rob Reiner. I Am Your Child Campaign: Discussed a number of times how a child's early influences and environment in life directly correlate to the person they become. Mr.Reiner also talked about the history of his campaign, why he became interested in this issue, and the goals he hopes to achieve. Also briefly described without much detail several state programs that have been successful in addressing this issue. Concluded testimony by speaking about the California Children and Families Initiative which has qualified for the Nov. ballot and proposes linking together health care, child care, intervention programs for families at risk, and parent education.

General conclusion reached at the end of Panel 1 was the need for outreach and an integrated system in which similar programs/organization s pertaining to child development are linked.

Panel 2 consisted of four witnesses:

Dr. Lynn Karoly, Rand Corporation: Discussed a study conducted by Rand involving the cost benefits of early childhood intervention. The report concluded that these programs do indeed yield significant benefits for both the children as well as the parents. She listed a number of statistics as evidence such as 73% reduction in juvenile crime, higher earnings, a 33% reduction of use of the welfare system, etc. Ended testimony by stating that an early child intervention program can pay for itself in reduced government expenditures.

Dr. Jane Knitzer, National Center for Children in Poverty: Discussed findings from a study conducted by NCCP including:

- Overall, states are recognizing the need for early childhood development programs: more than half the states support comprehensive programs (enhance the child's development as well as support parents); 34 states have expanded or supplemented existing programs for pre-schoolers; ten states have made explicit efforts to link these comprehensive programs to welfare reform.

- Many states are beginning to engage communities in planning early care and education systems to better meet the needs of their families rather than supporting individual programs; Half of the states have linked state level strategies with community mobilization strategies;

- This year, eight states met NCCP's criteria for comprehensive initiatives (high level leadership, integration of program and community strategies, commitment to increased funding, and framework for state action)-- Dr. Knitzer detailed some of these initiatives.

She also discussed different approaches that states are taking with respect to the use of public-private partnerships. Concluded that states are making progress focusing on young children and families, but for the most part there is not enough state investment nor leadership. Also made several recommendations such as ensuring that federal dollars can be used flexibly to create needed systems, to provide incentives to states to develop comprehensive programs, and to encourage the evaluation of statewide programs.

Dr. David Olds, Professor of Pediatrics and Preventive Medicine: Dr.Olds's testimony focused on his twenty year study of a program of prenatal and early childhood home visitation by nurses. He discussed the background of the study, the standard program protocol used by the nurses, and the results of the trials conducted. He concluded that there were very few benefits for higher

income, married women and their children. However, the program was found to reduce many of the problems facing high-risk families. For instance by the first child's fifteenth birthday, nurse-visited, low-income, unmarried mothers had fewer months on welfare, fewer births, fewer arrests and convictions, and fewer verified reports of child abuse while their children had fewer instances of running away and also fewer arrests and convictions. Dr.Olds stressed the need to develop programs that share the essential elements of the program tested in his trials otherwise it is not likely that the same results will be produced. Currently the program has been established in 14 communities and he is studying how to develop it on a larger scale. He is also working to develop a system of regional replication centers but estimated that this project will take 20 years. Dr.Olds ended his testimony by emphasizing that we should be careful not to expand programs before research on their effectiveness is completed. He cited his concern over the expansion of the Head Start program which he believes has not been clinically developed enough to produce meaningful results.

Peter Burki, Dependent Care Connection: Discussed the science behind why it's necessary to have quality child care. Also mentioned a number of statistics in the increase of dual working households, single families, etc and stated the need for developing a standard set of indicators for "school readiness." Brought up interesting idea that communities should be classified as high risk rather than individual families and that additional resources should be given to these communities (similar to France's educational zones).

Hearing adjourned early-- ended with committee asking for more information about the "fade-out" effect.

Quality Early Learning Programs

The U.S. Department of Health and Human Services is strongly committed to enhancing the quality of child care and early childhood programs. It is critical to invest in the resources to improve early learning and development for our youngest children, to ensure health and safety in child care, and support parents as they raise their children. A vast body of scientific research demonstrates that the quality of early care experiences is critical to a child's cognitive, social emotional, and physical development. These early experiences are an essential part of school readiness and provide the foundation for success later in life. For these reasons, we support the Clinton Administration's efforts to improve early learning and the quality and safety of young children in child care through a variety of activities including promoting early learning and early childhood educator professional development.

Promoting Early Learning:

The President proposes to expand the Child Care and Development Block Grant to help working families. This block grant is the primary federal subsidy program to pay for child care creating better, safer, and more affordable child care, thereby allowing low-income parents to work. The proposal is set to increase the block grant to provide challenge grants to communities (distributed by states) to improve early learning and the quality and safety of child care for children ages zero to five. Research shows that children's experiences in the earliest years are critical to their development and ability to reach school ready to learn. The budget provides $600 million to States to provide challenge grants to communities to help get children ready to learn.

Early Childhood Educator Professional Development:

Well-trained educators are crucial to improving the quality of early childhood education programs and thus, young children's learning. By providing professional development opportunities to equip early childhood educators with the tools they need to help children develop language and literacy skills, the Early Childhood Educator Professional Development initiative would enhance the chances for future academic success of young children. Building on research indicating that the quality of the language and literacy environment in early childhood programs predicts later language development, reading success, and other academic outcomes for children, the initiative authorizes competitive grants to local partnerships of entities that provide professional development for teachers (such as universities) and other agencies such as local school districts or Head start agencies. Funds would be used to provide professional development opportunities based on the best available research on children's language and literacy development to early childhood educators who work in a variety of settings and serve high concentrations of children living in poverty.

CHILD CARE INITIATIVE

For six years, the President has sought to help working families balance the demands of work and family. In this budget, he proposes a significant new investment in strengthening child care -- making it better, safer, and more affordable for working families. The budget includes the following:

- **Expanding the Child Care Block Grant to Create Better, Safer and More Affordable Child Care:**

  Providing Child Care Subsidies to a Half Million Additional Children: The President proposes to expand the Child Care and Development Block Grant to help working families struggling to afford child care. This block grant is the primary federal subsidy program to pay for child care, enabling low-income parents to work. Funds are distributed by formula to the states to operate direct child care subsidy programs, as well as to improve the quality and availability of care. Today, however, millions of families who are eligible for assistance with their child care costs do not receive any help. In FY 1997, states provided child care assistance to only 1.25 million of the 10 million low-income children eligible for assistance. The President's budget significantly increases investment in the child care block grant by increasing funding for child care subsidies by $1.2 billion to provide child care subsidies for 500,000 more families in 2000.

  Promoting Early Learning: The President proposes to increase the block grant to provide challenge grants to communities (distributed by states) to improve early learning and the quality and safety of child care for children ages zero to five. Research shows that children's experiences in the earliest years are critical to their development and ability to reach school ready to learn. The budget provides $600 million to States to provide challenge grants to communities to help get children ready to learn.

  Improving Child Care Quality: Last year, Congress fully funded the President's request to increase investment in improving child care by providing States with additional resources for quality enhancement efforts such as performing inspections of child care facilities, providing resource and referral services for parents, assisting providers with training and scholarships, and creating networks for family day care providers. The President's FY 2000 budget provides $173 million for this initiative.

- **Giving Greater Tax Relief for Child Care to Three Million Working Families:** The Child and Dependent Care Tax Credit provides tax relief to taxpayers who pay for the care of a child under 13 or a disabled dependent or spouse in order to work. The credit is equal to a percentage of the taxpayer's employment-related expenditures for child or dependent care, with the amount of the credit depending on the taxpayer's income. The budget proposes to increase the credit for families earning under $60,000, providing an additional average tax cut of $345 for these families and eliminating income tax liability for almost all families with incomes below 200% of poverty ($35,000 for a family of four) that claim the maximum allowable child care expenses. The President's budget includes $5 billion over five years to expand the Child and Dependent Care Tax Credit for nearly 3.3 million working families paying for child care.

- **Providing Tax Relief to Parents Who Stay at Home:** The President proposes an initiative to enable parents who stay at home with children under the age of one to take advantage of the Child

and Dependent Care Tax Credit by claiming assumed child care expenses of $500. The President's budget provides an average tax credit of $178, at a cost of $1.3 billion over five years, which will benefit 1.7 million parents.

- **Creating New Child Care Tax Incentives for Businesses:** The President proposes to create a new tax credit for businesses that provide child care services for their employees, by building or expanding child care facilities, operating existing facilities, training child care workers, or providing child care resources and referral services. The credit covers 25% of qualified costs, but may not exceed $150,000 per year. The President's budget includes approximately $500 million over five years for these tax credits.

- **Serving over a Million Children through After-School:** The President proposes to triple funding for the 21st Century Learning Center Program, which supports the creation and expansion of after-school and summer school programs throughout the country. The program increases the supply of after-school care in a cost-effective manner, primarily by funding programs that use public school facilities and existing resources. In awarding these new funds, the Education Department will give priority to school districts that are ending social promotion by requiring that students meet academic standards in order to move to the next grade. The President's budget includes $600 million in FY 2000 to help roughly 1.1 million children each year participate in after-school and summer school programs.

- **Increasing Head Start:** Head Start, one of the President's highest priorities, is America's premier early childhood development program. It supports working families by helping parents get involved in their children's educational lives and by providing services to the entire community. The budget provides $5.267 billion, a $607 million increase over 1999 levels for Head Start. This increase would enable the program to serve 42,000 additional children in 2000 and will keep the program on track to reach the President's goal of serving 1 million children by 2002.

- **College Campus-Based Child Care:** These budget proposes $5 million to establish and support child care services on college campuses. These new resources will help increase low-income parents' access to higher education.

THE CLINTON ADMINISTRATION CHILD CARE INITIATIVE

Ensuring affordable, accessible, safe child care. The President's child care initiative responds to the struggles our nation's working parents face in finding child care they can afford, trust and rely on. The President's balanced budget includes a package of proposals to help working families pay for child care, build a good supply of after-school programs, improve the safety and quality of care, and promote early learning.

Expanding the Child Care Block Grant to Create Better, Safer, and More Affordable Child Care:

- **Providing Child Care Subsidies to More than One Million Additional Children.** The President's budget would expand the Child Care and Development Block Grant to help working families struggling to afford child care. This block grant is the primary federal subsidy program to pay for child care, enabling low-income parents to work. Funds are distributed by formula to the states to operate direct subsidy programs, as well as to improve the quality and the availability of care. Today, however, millions of families who are eligible under federal law for assistance with their child care costs do not receive any help. In FY 1997, states provided child care assistance to only 1.25 of the roughly 10 million low-income children eligible for assistance. **The President's budget request would increase funding for child care subsidies by $7.5 billion over five years, enabling the program to serve an additional 1.15 children by FY 2004.**

- **Promoting Early Learning.** The President's budget increases the block grant to provide challenge grants to communities (distributed by states) to promote early learning and improve the quality and safety of child care for children ages zero to five. Research shows that children's experiences in the earliest years are critical to their development and ability to reach school ready to learn. **The President's budget includes $3 billion over five years to help get children ready to learn.**

- **Improving Child Care Quality.** Last year, Congress fully funded the President's request to increase investment in improving child care by providing states with additional resources for quality enhancement efforts such as performing inspections of child care facilities, providing resource and referral services for parents, assisting providers with training and scholarships, and creating networks for family day care providers. **The President's budget includes $173 million for this effort to improve quality.**

Greater Tax Relief for Child Care to Three Million Working Families. The Child and Dependent Care Tax Credit provides tax relief to taxpayers who pay for the care of a child under 13 or a disabled dependent or spouse in order to work. The credit is equal to a percentage of the taxpayer's employment-related expenditures for child or dependent care, with the amount of the credit depending on the taxpayer's income. The President has proposed increasing the credit for families earning under $60,000, providing an additional average tax cut of $354 for these families and eliminating income tax liability for nearly all families with incomes below 200 percent of poverty ($35,000 for a family of four) that claim the maximum allowable child care expenses. **The President's budget includes $5 billion over five years to expand the Child**

and Dependent Care Tax Credit for nearly three million working families paying for child care.

Providing Tax Relief to Parents Who Stay at Home. The President believes that we should support parents in whatever choice they make for the care of their children. Therefore, he proposed to enable parents who stay at home with children under one to take advantage of the Child and Dependent Care Tax Credit by claiming assumed child care expenses of $500. **The President's budget will provide an average tax cut of $178, at a cost of $1.3 billion over five years, which will benefit 1.7 million parents.**

Creating New Child Care Tax Incentives for Businesses. The President proposed to create a new tax credit to businesses that provide child care services for their employees, by building or expanding child care facilities, operating existing facilities, training child care workers, or providing child care resource and referral services. The credit covers 25 percent of qualified costs, but may not exceed $150,000 per year. **The President's budget includes approximately $500 million over five years for these tax credits.**

Expanding After-School Opportunities. The President proposed to triple funding for the 21st Century Community Learning Center Program, which supports the creation and expansion of after-school and summer school programs throughout the country. Experts agree that school-age children who are unsupervised during the hours after school are more likely to use alcohol, drugs, and tobacco, commit crimes, receive poor grades, and drop out of school than those who are involved in supervised, constructive activities. The program increases the supply of after-school care in a cost-effective manner, primarily by funding programs that use public school facilities and existing resources. In awarding these new funds, the Education Department will give priority to school districts that are ending social promotion by requiring that students meet academic standards in order to move to the next grade. **The President's budget includes $600 million in FY 2000 to help roughly 1.1 million children each year participate in after-school and summer school programs.**

Expanding Head Start and Early Head Start. The President budget includes a significant new investment in Head Start, our nation's premier early childhood development program, which prepares low-income children for a lifetime of learning and development by providing early, continuous and comprehensive child development and family support services. The President's budget includes an additional $607 million in FY 2000 to reach an additional 42,000 children with Head Start and Early Head Start services, enabling the program to serve 877,000 low-income children. The President is committed to reaching his goal of enrolling one million children in Head Start by 2002, and doubling the number of infants and toddlers in Early Head Start.

DATE: 11-12-99

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 INDEPENDENCE AVE., SW
WASHINGTON, D.C. 20201

PHONE: (202) 690-6311 FAX: (202) 690-8425

OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
HUMAN SERVICES LEGISLATION
ROOM 413 H HUMPHREY BUILDING

TO : Ann O'Leary

OFFICE :

ROOM NO :

PHONE NO :

FAX NO : 456-2878

FROM:

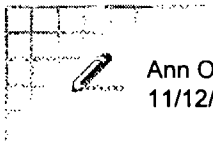
[X] MARY M. BOURDETTE
[ ] BARBARA P. CLARK
[ ] LAUREN HIGGINS
[X] AMY LOCKHART
[ ] LULA BARNES

TOTAL PAGES INCLUDING COVER): 2

REMARKS: Following is the paragraph on the Early Learning Fund we promised to send over as follow-up to the meeting on Jeffords' ESEA Proposal.

We are strongly committed to enhancing the quality of child care and early childhood programs. It is critical that we invest resources to improve early learning and development for our youngest children, to ensure health and safety in child care, and support parents as they raise their children. A vast body of scientific research demonstrates that the quality of early care experiences is critical to a child's cognitive, social, emotional and physical development. These early experiences are an essential part of school readiness and provide the foundation for success later in life.

We support efforts to improve early learning and the quality and safety of young children in child care through a variety of activities, including: expanding training for child care providers (including training in early childhood development, first aid and CPR); providing home visits and parent education; helping parents recognize high quality care through consumer education; helping child care providers meet licensing and accreditation standards; reducing group sizes and the ratio of children to staff; improving compensation for child care providers (and thereby reducing turnover); linking child care providers to health professionals; supporting the inclusion of young children with special needs in quality child care settings; and creating and sustaining family child care networks to connect child care home providers to education and support. Particular focus should be on increasing language development, emergent literacy and early childhood development. The Administration has proposed a $3 billion (over five years) Early Learning Fund to accomplish these objectives.



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Attached are paragraphs on 21st Century Learning Centers and the Early Childhood Professional Development proposal.

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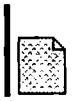 - Ann O' Leary document.doc

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"Fleming, Scott" <Scott_Fleming@ed.gov>
"Kelley, Thomas" <Thomas_Kelley@ed.gov>
"Cohen, Mike" <Mike_Cohen@ed.gov>

Early Childhood Educator Professional Development

Well-trained educators are crucial to improving the quality of early childhood education programs and thus, young children's learning. The Early Childhood Educator Professional Development initiative would enhance the chances for future academic success of young children by providing professional development opportunities to equip early childhood educators with the tools they need to help children develop language and literacy skills. Building on research indicating that the quality of the language and literacy environment in early childhood programs predicts later language development, reading success, and other academic outcomes for children, the initiative authorizes competitive grants to local partnerships of entities that provide professional development for teachers (such as universities) and other agencies such as local school districts or Head start agencies. Funds would be used to provide professional development opportunities based on the best available research on children's language and literacy development to early childhood educators who work in a variety of settings and serve high concentrations of children living in poverty.

21st Century Community Learning Centers

The President is proposing a $400 million increase in funding for Fiscal year 2000 for the 21st Century Community Learning Centers program which provides grants to public schools and their partners to offer extended learning time to students and community members in a community school setting. Giving children more time to learn in enriching after-school, weekend and summer programs can help all students achieve to high standards. Research shows that students in after school programs show improved achievement in math, reading and other subjects. After school programs also keep children of all ages safe and out of trouble. In three years time, the 21st Century Community Learning Centers program has expanded from $1 million demonstration program in fiscal year 1997 to a $200 million program that will serve about 400,000 students and over 200,000 adults this year. Approximately 4000 communities applied for these funds in fiscal years 1998 and 1999; together requesting nearly $900 million in assistance.

United States General Accounting Office

GAO

Report to Congressional Requesters

November 1999

EDUCATION AND CARE

Early Childhood Programs and Services for Low-Income Families

GAO/HEHS-00-11

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-281005

November 15, 1999

The Honorable Judd Gregg
Chairman, Subcommittee on Children and Families
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable William Goodling
Chairman, Committee on Education
and the Workforce
House of Representatives

The Honorable Michael N. Castle
Chairman, Subcommittee on Early Childhood,
Youth, and Families
Committee on Education and the Workforce
House of Representatives

Billions of federal and state dollars annually support multiple programs to address the early childhood care and education needs of low-income families. Information from these programs on the availability and accessibility of care and services that children receive is of great interest for several reasons.[1] Recent developments in the 1996 welfare reform legislation require more welfare families, including those with very young children, to find and keep jobs. Also, much attention has been given to the relationship between child care experiences and school readiness. Finally, the existence of multiple funding sources for early childhood care and education has increased some states' interest in using program collaboration.

Recently, a number of congressional proposals have been made to increase federal child care funding. Therefore, you asked us to describe (1) programs and services funded at the federal and state levels that directly provide early childhood care and education for the general population of low-income children up to age 5, (2) state and local assessments of the relative difficulty low-income parents face in obtaining care for their children, and (3) the collaborative efforts among child care officials and early childhood education officials to address these parents' difficulties. Much of our data came from a survey of child care

[1]In this report, "early childhood care and education" includes care that is provided to low-income children whose parents are out of the home in work activities and who may be in a center or a home, as well as care that is focused on a child's education, such as care that preschools and Head Start provide.

administrators and departments of education in all 50 states and the District of Columbia and from a survey of all 537 child care resource and referral agencies in the membership database of the National Association of Child Care Resource and Referral Agencies (NACCRRA).[2] We also visited Colorado, North Carolina, Ohio, and Oregon, which the National Governors Association had identified as leaders in collaborative efforts for early childhood care and education, and we visited two counties, one mostly rural and one mostly urban, in each of these states. We interviewed program officials at all levels and early childhood researchers, and we reviewed related reports of research organizations. We did work in accordance with generally accepted government auditing standards between August 1998 and October 1999. (See appendix I for more details on our methodology.)

Results in Brief

The federal government invested about $11 billion in FY 1999 on early childhood care and education programs for low-income children through a range of programs and the states invested almost $4 billion for such programs.[3] The Department of Health and Human Services (HHS) provides most of the federal support for early childhood care and education, about $8 billion, through the Head Start program and the Child Care and Development Fund (CCDF), which subsidizes the child care expenses of low-income working parents. Other HHS and Department of Education programs provide the remaining funding for early childhood care and education. Thirty-two states reported funding preschool programs, 15 states reported providing state money to supplement Head Start, and 19 states reported child care programs that provided funding to communities. Our survey results showed that educationally oriented services (for example, numeracy and literacy activities) were the most common services providers offered in centers and homes. Providers were less likely to include other services, such as family social services or medical referrals.

[2]NACCRRA's membership database contains 537 of an estimated 800 agencies nationwide.

[3]We included only major programs that low-income parents can use to obtain child care. For the total federal funding figure, we included only programs that directly provide (1) child care or education or (2) funds to provide child care and education for low-income children up to age 5. We did not include programs that support but do not provide funding for child care, such as the U.S. Department of Agriculture's Child and Adult Food program, child care tax expenditures at the federal and state levels, programs with a limited eligibility, or the Stewart B. McKinney Homeless Assistance Act. For a detailed list of other sources of federal funding available for child care, see Federal Child Care Funding (GAO/HEHS-98-70R, Jan. 23, 1998). The $4 billion figure for state funding represents data from our survey on state expenditures. This does not represent the entire state investment but it does reflect state contributions for programs within the scope of our review.

Although a number of federal and state programs provided significant funds for early childhood care and education, some types of child care were still difficult for low-income families to obtain, including infant and toddler care; care for children who have special needs, such as children with physical disabilities; and care for children during nonstandard hours (evenings and weekends). In contrast, a majority of the survey respondents indicated that care for 3- and 4-year-olds was generally not difficult to obtain. Child care administrators identified three major barriers to finding care for low-income children—cost of care, especially for infants and toddlers; availability; and accessibility, such as transportation to get to providers, described as more difficult in rural and remote areas.

Some states and localities are using collaborative initiatives to better bridge child care programs and early childhood education programs as well as the federal and state programs. During our visits to Colorado, North Carolina, Ohio, and Oregon, officials at all levels reported that collaboration among child care and early childhood education program officials and nonprofit organizations improved the availability of education and care services for low-income families and enhanced the quality of care. Officials from these states reported using in these collaborative efforts similar strategies to provide incentives for local collaboration, such as additional funding. For example, in Ohio CCDF and Head Start officials pool resources by sharing staff to add full day care to the half-day Head Start program and to add Head Start services, such as nutrition and medical care, to day care programs. All the states we visited reported increased availability of full-time care for 3-to-5-year-olds as a result of collaborative efforts and more limited success in increasing the availability of infant and toddler care or care during nonstandard hours. However, barriers to collaboration still remain, according to state officials and survey respondents. Factors they identified as impeding collaboration included differing eligibility requirements; "turf" issues, such as concerns about losing program authority; lack of information on different programs; and the lack of funding to support collaborative activities. These barriers generally reflect the division between the child care and early childhood education communities.

The types of care that currently have the greatest need for support are infant and toddler care, care during nonstandard hours, and care for children with special needs. In the states we visited, collaborative efforts have yielded some positive results in addressing child care and education needs. Information on them may be useful to other states and communities.

Background

Early childhood care and education are generally provided in three types of settings: in the child's home, in the home of a provider, and in a center or other nonresidential setting. Providers in a home setting that are regulated by the state are required to meet certain operating standards established by state or local governments, such as a maximum number of children per staff. Unregulated providers may or may not meet such standards. Most care provided in centers is regulated, although some states exempt centers if they are sponsored by a religious group or government entity. Further, within a particular setting—whether a home or a center—the specific services provided can range from solely child care assistance to a full continuum of services such as children's educational activities, immunization referrals, and developmental assessments and parental literacy and job training, referrals to social services, and parenting-skill training.

Historically, early childhood care programs and early childhood education programs have existed as separate systems with different goals. The primary goal of child care programs has been to subsidize the cost of care for low-income parents who are working or engaged in education and training activities. At the federal level, child care is primarily supported by CCDF. In contrast, early childhood education programs have generally focused on helping children become ready to begin school. The largest such program is Head Start. This split is also reflected at the state level in child care subsidy programs and preschool programs.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) is directed at increasing low-income families' reliance on work rather than welfare. This legislation established Temporary Assistance for Needy Families (TANF), a program designed to help welfare recipients move into the workforce. Previously, under Aid to Families with Dependent Children, most states exempted single parents with children younger than 3 from participating in education, training, or work-related activities. However, under the new welfare reform legislation, most states exempt only single parents with very young children, and most recipients are now required to participate in work or work-related activities.[4] In addition, increased emphasis on moving people off welfare and into work activities may result in parents with low skills being employed in

[4]TANF has no exemption based on the age of children but allows states to exempt parents with children younger than 1. Twenty-four states exempt parents with children up to 1 year of age, 15 states exempt parents with children 6 months of age or younger, and 4 have no exemption related to children's ages. Two states allow counties to set the exemption age. The 5 other states have exemptions at various ages older than 1 year. In addition, the states may not reduce or terminate assistance to a single custodial parent of a child younger than 6 who has demonstrated the inability (as determined by the state) to obtain needed child care.

evening-shift and weekend work activities. As a consequence, this legislation could increase the demand for some types of child care, specifically infant and toddler care and nonstandard hour care, for both families on welfare and those moving into the workforce.[5]

Concern over the kind of services low-income children receive while their parents work has been underscored by research. Although the relative importance of recent neurological research on early brain development is controversial, a large body of research from child development experts and quality-of-care studies indicates that developmentally appropriate experiences for very young children are beneficial. In addition, concern in many states over the number of children who arrive in school with poorly developed skills necessary for learning, such as fine motor and general cognitive skills as well as social skills, adds to the interest in what kind of care and services are most effective for school readiness.

Federal and State Government Programs Fund a Variety of Early Childhood Care and Education Services

In 1999, the federal government provided approximately $11 billion through multiple programs administered by HHS and Education to fund a variety of early childhood care and education services—mostly targeted to low-income children. In addition, many states support care and education by funding preschool programs and providing grants to communities to increase the supply of child care. These programs are often targeted to a specific population, such as children up to 3 or 3- and 4-year-olds from low-income families. Our surveys of state child care administrators and resource and referral agencies provide information on the variety of services offered in home and center settings. These services most often focus on educational activities but also occasionally include meals, immunization referrals, parental support services, and social service referrals.

Head Start and CCDF Provide Most Support for Early Childhood Care and Education

Of the $11 billion in federal support for early childhood care and education for low-income children, almost $8 billion is provided through Head Start and CCDF, as shown in table 1.

[5]See Welfare Reform: Implications of Increased Work Participation for Child Care (GAO/HEHS-97-75, May 29, 1997) and Welfare Reform: States' Efforts to Expand Child Care Programs (GAO/HEHS-98-27, Jun. 13, 1998), for a more complete discussion of welfare reform and child care.

Table 1: Major Federal Programs That Funded Early Childhood Care and Education for Low-Income Children in Fiscal Year 1999

Program	Target age	Department	Funding in millions
Head Start			$4,660
Early Head Start	Birth to 3	HHS	349.4
CCDF	Birth to 12[a]	HHS	3,167
TANF			
Funds transferred to CCDF	Birth to 12	HHS	636[b]
Funds used for child care	Not specified	HHS	259[b]
Social Services Block Grants	Not specified	HHS	285[c]
Title I, part A	Pre-K through 12	Education	936[d]
Individuals with Disabilities Education Act			
Preschool Grants	3 to 5	Education	374
Grants for Infants and Families with Disabilities	Birth to 2	Education	370
Even Start	Birth through 8	Education	135
21st Century Learning Centers	All	Education	200

[a]According to HHS, it does not track the amount of funds spent by age group, including birth to 5 years.

[b]Figure is for fiscal year 1998.

[c]Total fiscal year 1999 appropriation was $1.9 billion. The states have historically reported spending on average about $285 million from Social Services Block Grants on child care, or 15 percent.

[d]Total fiscal year 1999 appropriation was $7.8 billion. In previous years, an estimated $156 million, or 2 percent, supported pre-K programs and $936 million, or 12 percent, supported pre-K and kindergarten children.

Head Start, established in 1965, focuses on providing early childhood education and developmental services for low-income preschool children and their families through grants to local agencies. Specifically, services for children focus on education (such as literacy activities), socioemotional development (such as activities developing self-concept), physical and mental health (such as immunizations), and nutrition (such as meal and nutrition awareness). The program also provides some parental support services (such as, referrals to social services). Head Start primarily serves 3- and 4-year-olds in part-day and full-day programs.[6] At least 90 percent of the children enrolled in a program must come from families whose income is at or below the federal poverty line or who are

[6]In Head Start Programs: Participant Characteristics, Services, and Funding (GAO/HEHS-98-65), we reported that 93 percent of the children were in part-day and part-year programs and 63 percent were 4 years old.

receiving public assistance.[7] In fiscal year 1999, an estimated 1,520 grantees participated in Head Start, serving slightly more than 831,000 children. Early Head Start, which began in 1995, was designed to enhance the development of infants and toddlers and to promote healthy family functioning and healthy prenatal outcomes for pregnant women. For fiscal year 1999, the Congress earmarked $349.4 million for Early Head Start. The program reports having served 39,000 infants and toddlers in that year.

The other major HHS program is CCDF, which in fiscal year 1999 provided $3.2 billion to states to subsidize child care expenses for children younger than 13 in low-income working families. Federal law allows the states to use CCDF to help working families or families preparing for work with an income of less than 85 percent of the state median income. In practice, however, many states establish lower income eligibility levels. Federal regulations also require that the states target a portion of CCDF funds to welfare recipients working toward self-sufficiency or to families at risk of welfare dependency and that they use at least 4 percent of their total CCDF funds for quality improvements and offer additional services to parents.[8] CCDF funds subsidize child care through certificates that parents can use to pay the child care providers they select. Some states also use contracts to fund slots in child care programs. Preliminary HHS data over the 6-month period January to June 1997 indicate that voucher use was fairly evenly split between home and center settings.[9]

Other HHS and Education programs also support child care and education in various ways, sometimes with different program goals. For example, HHS's TANF program provided about $900 million for child care in fiscal year 1999 to support parents in work activities. In addition, Social Services Block Grants (SSBG) is a flexible source of funds that the states may use to support a wide variety of social services, including child care. In Education, the Even Start program has adult literacy and parenting education, as well as early childhood care and education for children through 8 as goals. This program is funded with $135 million and serves

[7]According to 1999 HHS guidelines, $13,880 per year for a family of three is the federal poverty level for the 48 contiguous states and the District of Columbia; the level is higher in Alaska and Hawaii.

[8]Additional services to parents include services such as resource and referral counseling regarding the selection of appropriate child care. In addition, for fiscal year 2000, the Congress has established several earmarks above the 4 percent minimum quality expenditure requirement—$173 million for quality activities, $50 million for improving the quality of infant and toddler care, and $19 million for child care resource and referral and school-age child care activities.

[9]Preliminary data on types of care being used by children subsidized by block grants indicate that on average about 11 percent of the children are cared for in home, 30 percent are with family child care, 4 percent are with group homes, and 55 percent are using centers.

about 40,000 families. In addition, title I of the Elementary and Secondary Education Act supports programs and services for educationally disadvantaged children; funding for early childhood education is estimated to have been about 12 percent, or $936 million, of the total $7.8 billion in fiscal year 1999. The Individuals with Disabilities Education Act (IDEA), another Education program, has a Grants for Infants and Families with Disabilities program. Services such as speech therapy are provided to assist the states in creating statewide systems of programs to make available early intervention services to all children with disabilities aged birth through 2 years old and their families at home or in whatever early childhood care or education setting children attend. The IDEA Preschool Grants program provides states with funding to enable children with disabilities to receive special education and related services for preschool children. Finally, 21st Century Community Learning Centers may support early childhood care and education. The $200 million program funds school-community partnerships to keep schools open after school and in summer as a safe haven for enhanced learning.

Most States Fund Early Childhood Programs

Forty-three states, including the District of Columbia, reported that in fiscal year 1999 they provided their own state funding, beyond the amounts required to match federal contributions, to support early childhood programs.[10] Table 2 provides information on funding and enrollment in such programs.

Table 2: Types of Programs States Funded in Fiscal Year 1999

Type	Number of states[a]	Estimated funding	Number of children
Early childhood education	32	$1.7 billion	613,000
Child care program supplements	19	1.7 billion	351,000
Head Start supplements	15	155 million	48,000

[a]Some states supported more than one type of program, but in total 43 states had at least one.

Thirty-two states reported funding preschool programs that generally operated as part of the public school system. Also, 15 states provided funds to supplement the Head Start program by expanding it to serve more children, by increasing teacher salaries, or by providing transportation to Head Start facilities. Finally, 19 states administered programs that helped

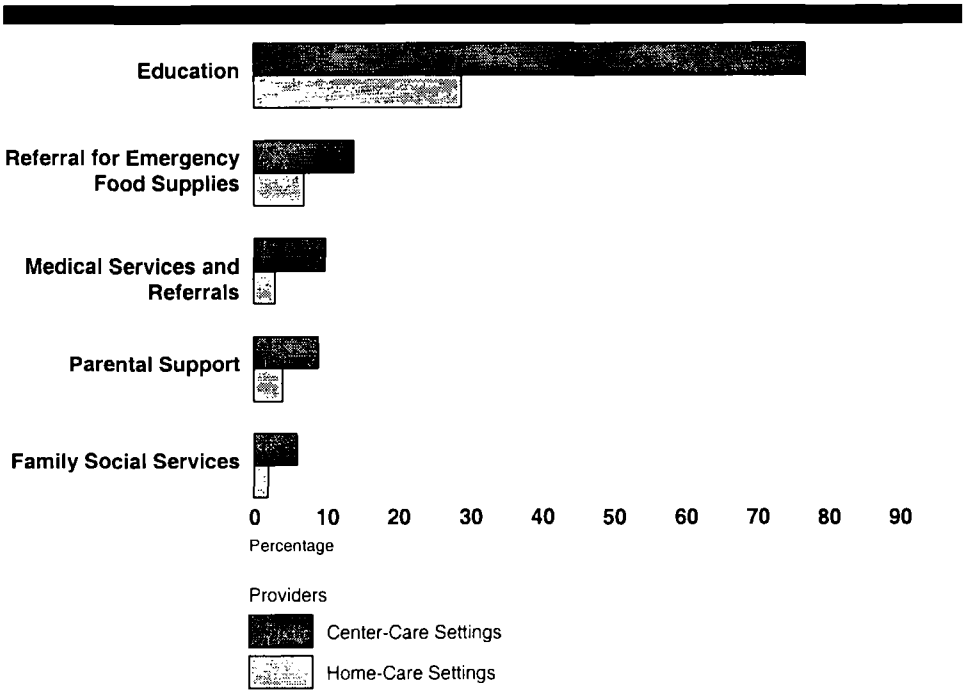
[10]In order to draw down their federal allotments, the states must meet a maintenance of effort requirement and contribute matching funds. We excluded programs funded by a state match and programs with a limited eligibility, such as programs only for teenagers.

fund child care for communities by providing grants to communities to address their child care needs. These funds could be used in a variety of ways, such as for preschools, for child care, to give providers training, and for assistance in meeting licensing requirements. Of the 43 states, 20 provided some funding for infant and toddler care, generally through funds to communities. The number of children served by state early childhood care and education programs ranged from several hundred in five states to nearly 140,000 in Texas.

Education Is the Most Frequently Provided Service

Resource and referral agencies reported in responding to our survey that providers in home and center settings offered a range of services, but educational programs in centers were by far the most common, as shown in figure 1. The proportion of providers offering other services was much lower. Generally, centers provided more services than were provided in homes. For instance, about 10 percent of the resource and referral agency respondents stated that all or most centers provided parental support services or medical referrals; fewer agencies reported that all or most home care settings provided these same services. According to census data, about 70 percent of low-income families met their child care needs in the home.

Figure 1: Percentage of Providers That Offer Services as Reported by Resource and Referral Agencies



Similarly, our survey of state child care administrators showed that most state-funded programs offered educational services. In addition, most also offered parental support activities, meals for the children enrolled, and referrals for medical services.

Some Types of Care Are Difficult to Obtain

Although the federal and state governments support many programs for early childhood care and education for low-income children, some types of care such as infant and toddler care are still difficult to obtain. State child care administrators reported that the high cost of care, its unavailability, and inaccessibility to providers were significant barriers to low-income families in obtaining the types of care they needed.

Collectively, our surveys, which covered all states and many communities across the country, showed that obtaining care for infants and toddlers, for children with special needs, and during certain hours posed the most difficulty for low-income families. Figure 2 shows the responses on the difficulty of obtaining different types of care from the resource and referral agency survey; the responses of the child care administrators

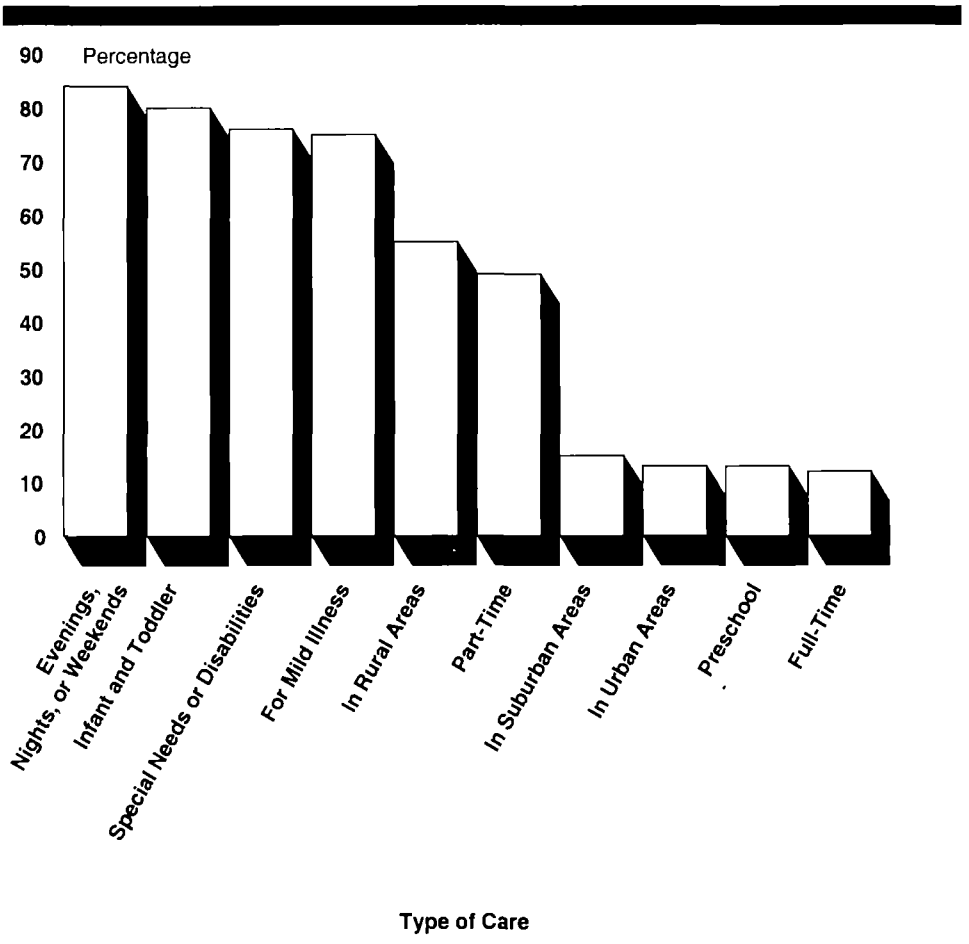
identified similar difficulties. Our previous work, based on limited case studies, also identified obtaining care as a problem for infants and toddlers.[11] Resource and referral survey responses, however, reported that care for preschool children generally was not difficult to find.[12] Slightly more than half of child care administrators reported that there was sufficient full-time care for preschoolers. Respondents provided additional comments on the difficulties in obtaining care. For example, they reported that finding one place that provided care for children of different ages in the same family such as an infant and a preschooler was difficult. The need for infant care and care during nonstandard hours may be particularly important for TANF recipients. According to a recent study, more than a quarter of former welfare recipients and a similar proportion of low-income mothers work night hours.[13]

[11]See Welfare to Work: Child Care Assistance Limited; Welfare Reform May Expand Needs (GAO/HEHS-95-220), and GAO/HEHS-98-27.

[12]Our survey does not reflect whether or not the care available is considered quality care.

[13]"Assessing the New Federalism: An Urban Institute Program to Assess Changing Social Policies," discussion paper, Urban Institute, Washington, D.C., 1999.

Figure 2: Percentage of Resource and Referral Agencies Reporting That Care Is Difficult or Very Difficult to Obtain



Child care administrators reported that high cost is a barrier, whether parents are seeking care for preschoolers or care for infants and toddlers. Care for infants and toddlers is generally more costly than preschool care mainly because of the higher staff-to-child ratio required. The subsidy provided in states does not always cover the cost of available care for infants and toddlers. Resource and referral agencies reported in our survey that about 80 percent of their centers and 70 percent of their home care providers accepted children with subsidies. Smaller subsidies allow states to provide subsidies to more families but can limit the families' ability to find affordable care. For example, officials in Colorado estimated that the average child care assistance subsidy is just 62 percent of the cost of quality care.

More than half of the state child care administrators cited the inaccessibility of care, often related to transportation difficulties, as another major barrier to low-income families seeking child care. Transportation was especially problematic in rural areas. For preschool care, arrangements sometimes have to be made to move children from a half-day educational program to a supplementary care program for the rest of the day.

Collaboration Has Positive Outcomes but Barriers Remain

To address the difficulties in obtaining certain types of care, states and localities are using collaborative initiatives to bring together the different program authorities involved in funding and providing care, with the goals of increasing the availability of various types of care and enhancing the services provided. However, according to state officials, collaboration does not eliminate all gaps in care, and collaborative initiatives are sometimes limited because of barriers such as differing eligibility requirements.

States Reported That Collaborative Initiatives Have Resulted in Positive Outcomes

In Colorado, Ohio, North Carolina, and Oregon, collaborative efforts combined state and federal funds from a variety of sources to increase the availability of child care and education settings available to low-income families. Collaboration was usually accomplished through interagency coalitions or organizations that tried to fit together different care and education options to meet communities' and parents' needs. These states also offered communities incentives to collaborate, either in the form of waivers to state regulations or as additional funds. Some of the efforts were enhanced by Head Start collaboration grants to local grantees.

Child Care and Education Collaborative Initiatives Implemented in Four States

In Colorado, the state legislature created the Community Consolidated Child Care Pilot Program to encourage communities to design consolidated programs of comprehensive early childhood care and education services for children in low-income families aged 6 weeks through 5 years old. At a minimum, pilot communities were required to consolidate funding from the Colorado Preschool Program, operated under the authority of local school districts and child care money administered by local boards of county commissioners, thereby encouraging the education and child care systems to come together. Initially, the legislature provided no financial incentives to encourage pilot counties to collaborate; however, in future years, additional funds will be made available to enable the collaborations to further increase child care availability.

The Colorado legislature authorized the state Department of Human Services to waive state laws or rules that would prevent the pilot communities from implementing collaborative projects. Waivers included requiring only a single application for multiple programs and broadening program eligibility to meet specific community needs. For example, two pilot counties raised the income eligibility level for the state child care subsidy so that low-income working parents' child care expenses would not increase substantially as their income increased.

North Carolina's Smart Start initiative provided state funds ($24.4 million in 1998) to assist communities in improving and expanding their existing programs for children and families and in designing and implementing new programs. The primary goal of Smart Start is to ensure that North Carolina's children enter school healthy and ready to learn. A prerequisite for the receipt of Smart Start funds is that representatives from various community organizations must form local partnerships for children to plan for and direct the distribution of the funds to local service providers. Initially funding twelve partnerships, Smart Start partnerships now operate throughout the state. Local partnerships were funded both to increase the availability of child care and to improve center or provider quality.

Created in 1992, Ohio's Family and Children First Initiative focuses a diverse group of agencies and organizations on achieving better outcomes for children and their families. The goal is to promote collaboration among state and local governments, nonprofit organizations, businesses, and families to ensure that children are ready to learn. Its three key objectives are making infants healthier, increasing access to quality preschool and child care, and improving services for family stability. The Early Childhood Coordination Committee is charged with bringing Ohio's Head Start program, Ohio's public preschool program, and its subsidized child care program into a coordinated system of care. At the county level, the initiative has supported the funding and development of councils composed of several child care organizations, including both child care programs and education programs. Each county council received a $20,000 state grant for these collaboration activities. Ohio also provided $181 million in state funds to expand Head Start services to more eligible families. Further, by combining Head Start with CCDF funds, the state has enabled children in poor working families to receive a full day of care.

In 1993, Oregon's legislature created the Commission on Children and Families to support community-based planning and decisionmaking and to

encourage collaborative partnerships to change the state's system of delivering services and develop supports for children and families. Local commissions were to include citizens, community groups, businesses, service providers, and government. In 1997, the commission directed $58.4 million, primarily from state and federal government sources, to the local commissions on children and families in each of its 36 counties. Collaboration among different programs operating in the community was a prerequisite for receiving a grant.

Head Start Support for Collaboration

Collaborative efforts were also being fostered through federal programs. For example, in 1990, HHS began to award collaboration grants to a few states to promote more integrated service delivery systems and to encourage collaboration between Head Start and other programs. By 1997, all states were funded. The Congress also increased funding for Head Start for fiscal years 1998-99, in part to increase enrollment numbers. Recognizing that an increasing proportion of Head Start families work and that many who receive public assistance are participating in welfare reform initiatives in response to TANF, HHS gave priority to funding more full-day, full-year care. Head Start encouraged programs to consider combining Head Start expansion funds with other child care and early childhood funding sources to deliver services through partnerships such as community-based child care centers. In addition, the 1998 amendments encouraged collaboration and have resulted in a performance indicator, the measure by which Head Start grantees are evaluated, that indicates the extent to which a Head Start grantee is collaborating with other community providers in providing linkages to child care.

Positive Outcomes Reported

As a result of these initiatives, the states reported positive outcomes in terms of increased child care and services. Colorado officials reported a larger increase in the number of children served in pilot counties than elsewhere in the state. For example, according to the director of one pilot collaboration project, the project's efforts have enabled it to increase child care by 61 percent and to essentially meet the need for care and education for 3- to 5-year-olds. Similarly, Ohio reported that the collaboration between state and federal Head Start and Ohio preschool and child care programs has enabled Ohio to increase not only the amount of care available to low-income children but also their access to Head Start services. The state reported that it currently serves 84 percent of its children who are eligible for Head Start in state or federal Head Start programs, compared with a national average of 38 percent. In North Carolina, an evaluation of the Smart Start program reported a 12 percent increase in credentialed child care providers. Officials in one county

credited Smart Start with a 25 percent increase in the number of child care centers meeting the state's highest standard for center-based care. Likewise, state officials in Oregon identified positive outcomes that have resulted from its collaborative efforts, including increased numbers of preschool programs, licensed providers, and home-based care for infants and toddlers and the initiation of a career development program for providers. Oregon also reported that it increased the number of group homes by 25 percent.

Barriers to Collaboration

Collaboration has, according to state officials, clearly resulted in positive outcomes; however, barriers to collaboration still remain. State program administrators and resource and referral agency respondents identified several barriers, including differing eligibility requirements, "turf" issues or concerns that an official's authority or power would be lessened, insufficient funds, and lack of information on programs. Program administrators said that the differing eligibility requirements between Head Start and CCDF made collaboration difficult. Head Start's income eligibility standard requires that 90 percent of enrollments be at or below the federal poverty level, whereas CCDF funds may be used for families with income up to 85 percent of state median income, which generally allows the states to give subsidies to families who make more than the federal poverty level. Thus, collaboration between these programs to achieve objectives, such as full day coverage, might be difficult because some children may be eligible only for CCDF.

In citing turf issues as barriers to collaboration, the respondents expressed concern that officials' power or authority would be reduced and that they would be unwilling to share program funds. These issues often reflected the division of child care organizations from early childhood education organizations. Child care programs were generally administered through human services agencies, whereas preschool education programs were generally administered by the education departments and public school agencies. One state official said that with the separate funding, regulations, and goals, the child care and education offices have not traditionally understood the importance of each other's role in a child's development.

Resource and referral agency and state administrator respondents also frequently cited a lack of information on the various programs that fund child care and education as a barrier to collaboration. For example, one respondent commented that a lack of understanding of the different

agencies' and organizations' policies and service delivery hindered collaboration. In one state, an official told us that the people who work in child care do not know the requirements for facilities and training that exist in the education department and that are very different from theirs and vice versa.

Respondents reported that insufficient funds also hindered their ability to collaborate. Lack of funding to support collaborative initiatives was widely cited as a barrier, with respondents specifically citing a lack of staff, training, and transportation as hampering collaboration with other organizations.

Conclusions

The implementation of TANF has put more low-income children in care outside the home and put them in care earlier in their lives. While efforts to provide programs of care for preschool children appear to generally meet the demand for such care, care for infants and toddlers, care during nonstandard hours, and care for children who have special needs are still not available, affordable, or accessible. As a result, these are the types of care most in need of support. Some states and localities have been using collaborative initiatives to increase the number of full-day providers and to enhance the quality of program services, and these have positively addressed families' and children's needs. The methods they have used may be helpful to other states and localities as they attempt to address their own needs.

Agency Comments

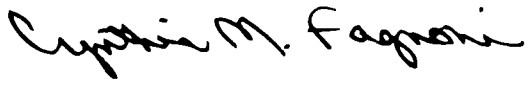
We provided Education and HHS with a draft of this report for their review. HHS responded with comments that are printed in appendix II. In its comments, HHS wrote that this report will be helpful as it continues its efforts to work with states and communities to meet the needs of low-income preschool children and their families. HHS fully supports our conclusions about the need for care for working low-income families. It provided additional information about the types of care and the adequacy of the care it says is needed, as well as descriptions of various initiatives to support collaborative efforts to meet such needs.

At our meeting with Education officials, including representatives from different Education program offices, Education said that it generally agrees with our findings and conclusions. In addition, Education provided us with information about its ongoing and planned efforts to promote

literacy and coordination with other programs. Where appropriate, we made technical changes that both departments provided.

We are sending copies of this report to the Honorable Donna E. Shalala, Secretary of the Department of Health and Human Services; the Honorable Richard W. Riley, Secretary of the Department of Education; and others who are interested. We will also make copies available to others upon request.

If you or your staff have any questions about this report, please contact me on (202) 512-7215. Other staff who contributed to this report are listed in appendix III.



Cynthia M. Fagnoni
Director, Education, Workforce, and
Income Security Issues

Contents

Abbreviations

CCDF	Child Care and Development Fund
HHS	Department of Health and Human Services
IDEA	Individuals with Disabilities Education Act
NACCRRA	National Association of Child Care Resource and Referral Agencies
SSBG	Social Services Block Grants
TANF	Temporary Assistance for Needy Families

Scope and Methodology

This appendix contains detail on our surveys of state child care administrators, state departments of education, and members of the National Association of Child Care Resource and Referral Agencies as well as our case studies in four states.

Survey Methodology

We conducted two surveys to obtain information about activities at the state level. We sent questionnaires to the child care administrators in all 50 states and the District of Columbia to get information about the funds that states allocate for early childhood programs, the source of the funds, the characteristics of state-administered child care programs—including the types of care and services they provided and their availability of care—difficulties low-income families encounter finding care, how the states attempt to gauge the adequacy of the supply of care, and factors that foster or hinder collaboration among early childhood programs. We also sent questionnaires to the departments of education in each state and the District of Columbia to get information about state-administered early education programs. Of the 51 questionnaires we sent to the child care administrators, 50 were returned—a response rate of 98 percent. Of the 51 questionnaires we sent to state departments of education, 49 were returned—a response rate of 96 percent.

Because limited information was available on services from most federal programs, we surveyed resource and referral agencies which have access to information on various types of care and services provided through centers and home care providers because of their role in referring low-income parents to potential child care providers. We used the membership list of the National Association of Child Care Resource and Referral Agencies. We sent a questionnaire to each agency listed as a member of the association, excluding 32 members that we sent to agencies that were not resource and referral agencies or that were sublocations of larger resource and referral agencies. The response rate was 80 percent: 428 of the 537 questionnaires we sent were returned.

According to early childhood care and education experts, a survey of the NACCRRA members was most likely to yield credible local perspectives on child care programs and an acceptable response rate. However, our survey should not be considered to be an overall measure of child care services at the local level. Some resource and referral agencies are not NACCRRA members, and some child care providers may not be registered with their local agencies. According to the association, about three-fourths of child care resource and referral agencies are members.

Our compilation of programs does not include every program with which a state addresses early childhood issues. We excluded from our survey results any reported programs that did not use state or local funds over and above those required by federal maintenance of effort or matching requirements. We also excluded funds and any reported programs that did not serve children directly.

Case Studies

We developed in-depth information about early childhood programs, particularly their collaboration efforts, in Colorado, Ohio, Oregon, and North Carolina and two localities within each of those states. We chose states that the National Governors Association and others considered to have integrated approaches to child care and established frameworks for state action. We also selected states to get a mix of geographic regions. We met with states' officials and also visited at least one primarily urban jurisdiction and at least one primarily rural jurisdiction. We interviewed state officials in the education and human services and social services departments. We talked with state officials responsible for preschool programs, early childhood education, title I, the Individuals with Disabilities Education Act, child care subsidies, and child care provider licensing. We also talked with officials of private and nonprofit organizations involved in early childhood education or care issues. We reviewed documentation on these issues. In the two localities we visited in each state, we interviewed officials responsible for similar programs and activities at the local level and reviewed documentation about their programs.

Comments From the Department of Health and Human Services

Now GAO/HEHS-00-11.

DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Office of the Assistant Secretary, Suite 600
370 L'Enfant Promenade, S.W.
Washington, D.C. 20447

October 26, 1999

Ms. Cynthia M. Fagnoni
Director, Education Workforce
and Income Security Issues
Health, Education, and Human Services Division
United States General Accounting Office
Washington, D.C. 20548

Dear Ms. Fagnoni:

Enclosed are the Administration for Children and Families' comments on the U.S. General Accounting Office Draft Report, Early Childhood Care and Education. Programs and Services for Low Income Families (GAO/HEHS-00-186). We fully support the report's conclusions about the need for high quality care for working low-income families and have provided some additional contextual information. We have also responded to the conclusions and other areas of the report with general comments and technical corrections.

We appreciate the opportunity to comment on the draft report. If you have questions or need further information, please contact Frank Fuentes, Deputy Associate Commissioner of the Child Care Bureau, at 401-7256.

Sincerely,

Olivia A. Golden
Assistant Secretary
for Children and Families

Enclosure

Now GAO/HEHS-00-11.

COMMENTS OF THE ADMINISTRATION FOR CHILDREN AND FAMILIES ON THE U.S. GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ON, "EARLY CHILDHOOD CARE AND EDUCATION: PROGRAMS AND SERVICES FOR LOW-INCOME FAMILIES " (GAO/HEHS-00-186)

The Administration for Children and Families (ACF) appreciates the opportunity to review and comment on the above-captioned report. This General Accounting Office (GAO) report will be of help to ACF as we continue our efforts to work with States and communities to meet the needs of this country's low-income preschool children and their families. We fully support the report's conclusions about the need for high quality care for working low-income families. In our comments below, we provide some additional contextual information, as well as provide some general comments and technical corrections.

General Comments

The draft report highlights difficulties related to the availability and affordability of care, and therefore supports the need for additional investments. The President's child care initiative proposes more than $19 billion over five years for child care, the single largest investment in child care in this country's history. The proposal would expand assistance through the Child Care Development Fund (CCDF) for working families, enhance child care tax credits, and give communities the resources to improve the quality of care for children across income levels.

Unmet Need. The draft GAO report contains a detailed discussion of significant Federal and State investments in early childhood programs. Despite these investments, many of these programs--including CCDF, Head Start, and many State pre-kindergarten programs--only serve a portion of eligible children. For example, nationally, in an average month in 1998, only 1.5 million of the 9.9 million low and moderate-income children eligible for CCDF assistance under State eligibility criteria actually received help through the program—just 15 percent of eligible children. As a result, many families are on waiting lists to receive child care subsidies. The gap between eligibility and receipt of services would be greater if States had chosen to define the eligible population to include all of the low- and moderate-income working families that are potentially eligible under Federal law. If all States set eligibility limits at the maximum levels allowed under Federal law, 85 percent of State median income, an estimated 14.7 million children would have been eligible for subsidies in fiscal year 1998, of whom only 10 percent were served. (*Access to Child Care for Low-Income Working Families*, HHS Report, using preliminary state administrative data for the months of April – September 1998, and eligibility estimates generated from the Urban

Institute's TRIM3 microsimulation model based on three years' worth of Current Population Survey data).

Now page 12.

Affordability. The draft report briefly discusses cost of care as a barrier (page 15). Other data reinforce this finding and provide a fuller picture about why cost is a barrier. National survey data show that child care expenses are often the second or third largest item in a low-income working family's household budget. In 1993, child care expenses averaged 18 percent of family income, or $215 per month, for poor families paying for care for one or more preschool children while their mother worked. For families with income of less than $14,400, ($1,200 per month), the average share of income devoted to child care was even higher--25 percent, or one-fourth of the family income (Census Bureau, SIPP, fall 1993).

Infant and Toddler Care. We appreciate the concerns expressed in the report about the difficulty many child care administrators perceive in families finding quality child care/child development programs for infant and toddler age children. In FY 1995, the Congress and this Administration established the Early Head Start program, which in FY 1999 served more than 39,000 low-income infant and toddler age children and their families. We are hopeful that in future years, we will be able to continue expanding this program to reach many more of our country's low-income infants and toddlers. The President's FY 2000 proposal would, for example, if appropriated, increase Early Head Start enrollment by almost 5,000 children and families. Improving infant and toddler care has also been a priority for the Child Care Bureau.

Now page 11.

Quality. Footnote 13 (on page 14) indicates that the GAO survey does not reflect whether or not the care available is considered quality care. The latest report from the Cost, Quality and Child Outcomes Study found that the quality of child care programs attended by preschool children had a lasting impact on their school performance. Too many children, however, are exposed to poor care—this is true for all types of settings. A 1994 HHS Inspector General Study, *Nationwide Review of Health and Safety Standards at Child Care Facilities*, found more than 1,000 violations in 169 child care facilities in five States. According to other research, almost half of the infants and toddlers in child care centers are in rooms rated at less than minimal quality. When families cannot get help in paying for child care, it is harder for them to find quality care that helps prepare their children for school success.

Collaboration

We are particularly pleased that the report highlights successful collaboration among early childhood programs, which has been a priority of this

Now page 15.

Administration. It is gratifying to see that Federal efforts to support collaboration are now leading to results at the State and local levels.

The draft report discusses Head Start support for collaboration (p.19). We appreciate that the needs of many Head Start parents are no longer being met by part-day, part-year Head Start programs and we will, therefore, continue our efforts, started a few years ago, to focus all future Head Start expansion efforts on serving children in program models that meet the needs of working low-income families; i.e. full-day, full-year Head Start. We will insist that programs seek to work together with other partners so that the costs of a full-day, full-year program are shared among many funding streams, so that Head Start dollars will be able to be used to reach as many new children and families as resources permit. We also appreciate the concerns expressed about the need for care during non-standard hours. Many Head Start programs do offer services outside of standard work hours. We will continue to work with our programs to help them explore ways to be as responsive as possible to the needs of working families with unusual working schedules. We are fully committed to working together with States and communities to improve linkages between Head Start and other services for low-income families with pre-school age children. In addition, the 1998 reauthorization of Head Start has additional language facilitating collaboration with child care providers at the local level.

In addition to the Head Start initiatives highlighted in the draft report, there have been other Federal efforts, including Child Care Bureau initiatives and joint Head Start-Child Care activities. For example, the Child Care and Head Start Bureaus recently launched a new training and technical assistance initiative - *Quality in Linking Together: Early Education Partnerships* (QUILT). The QUILT project will work to engage States in developing a strategic approach that supports and fosters early education partnerships at the local level. The Bureaus have also jointly sponsored a number of workshops and leadership forums, including a Head Start/Child Care/Pre-Kindergarten meeting this October with teams from 21 States. Last month, the Head Start and Child Care Bureaus issued a letter to all grantees to share opportunities for collaboration. The letter described several collaborative approaches and included sample budgets from three programs that are blending funds for full-day, full-year services.

The Bureaus are also supporting collaboration through several other technical assistance projects in addition to the QUILT. For example, the Child Care Bureau funds projects that support collaborative efforts around serving children with disabilities, create linkages with the health community, and encourage public-private partnerships.

In addition to technical assistance, we are developing policies that support collaboration. The Child Care and Development Block Grant Act requires coordination of child care services with other child care and early childhood development programs. The Administration expanded this provision through regulation to require coordination with education, Temporary Assistance for Needy Families (TANF), public health, and employment services, as well as to encourage collaboration with a number of other programs, including Head Start. States must describe their coordination efforts in their child care plans that are submitted every two years.

We are also working to correct misinterpretations of rules that may be barriers to partnerships. For instance, the Child Care Bureau provided guidance to prevent unwarranted problems in audits of agencies that use funding from different Federal programs. The Bureau also issued a memorandum clarifying the flexibility available to States in defining eligibility across early childhood programs, including subsidized child care (to address the eligibility issue identified on page 21 of the GAO report). In a similar manner, the Head Start Bureau has issued clarifications of policies on collecting fees, sharing equipment and supplies, and recruiting and enrolling children on a year-round basis to make it easier to partner with child care and pre-kindergarten providers.

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GAO Contacts and Staff Acknowledgments

GAO Contacts

Harriet Ganson, Assistant Director, (202) 512-9045
Mary Roy, Evaluator-in-Charge, (202) 512-7072

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GUIDANCE: EXAMPLES OF QUALITY EXPANSION ACTIVITIES

Background

States are faced with many challenges in making sure families have access to child care that is affordable and of high quality. The new quality earmark under the Child Care and Development Fund provides a real valuable opportunity for States to develop strategies that meet the increasing need for quality child care. This new earmark for FY 2000 of $172 million is above in addition to the CCDF required 4% quality expenditure requirement. In addition, Congress has also continued the earmarks for improving the quality of infant and toddler care and for school-age and child care resource and referral activities.

In order to achieve and maintain self-sufficiency, parents must be able to access safe, reliable child care programs. Coordination and collaboration with other agencies and programs is extremely important to meet the needs of children and families, to maximize resources and avoid duplication. Linking child care programs with the health community, including the Healthy Child Care America grantees, Head Start programs, education and supportive services within the State and community will help build a delivery system that provides high quality child care for all children. An important part of the delivery system also includes activities that support professional development, training, and compensation for child care providers.

Purpose of Guidance:

The purpose of this document is to continue to disseminate provide examples of state initiatives activities to enhance the quality of child care services to children and families. This guidance does not contain new rules or policies; rather, it is intended to be as a reference tool to that offers examples of services, supports, and activities quality initiatives that States may wish to consider in addition to activities currently funded. activities. This guidance highlights some does not attempt to identify all possible appropriate uses of the FY 2000 quality earmark funds, but provides a list of State representative illustrative examples of quality improvement activities in the following areas:

- Professional Development and Compensation;
- Grants to Providers/Local Communities;
- Healthy Child Care America and Other Health Activities;
- Special Needs/Inclusive Child Care;
- Monitoring and On-Site Visits;
- Infant and Toddler Programs; and
- Quality Activities that Support Cultural Diversity

We encourage States to consult this guidance as they develop similar efforts or other innovative approaches to provide quality initiatives for children and families.

Professional Development and Compensation

One of the best indicators of quality in early childhood programs is a high level of provider training, education and professional development. of providers. Research also shows that consistent care -- where the child is able to build a relationship with the provider over time -- is key to quality. Investments in professional development and increased compensation help to promote employee retention and reduce turnover. Recruiting new providers, in partnership with resource and referral agencies or other organizations, is also necessary to developing an expanded supply. A variety of approaches have included: the development of professional publications; a director's credential, scholarships for educators; distance

learning opportunities, and incentives for providers to attain accreditation through appropriate recognized bodies.

Montana:

Montana's Merit Pay program is a training incentive program available to owners, operators and employees of registered or licensed child care facilities. Providers may choose to participate in either a 60 or 30 hour track of pre-approved training in early childhood education, child development or child related business practices during the year. Once their training plan is completed and verified, they receive either a $400 (60 hours) or $200 (30 hours) Merit Pay award. This popular program has proven to be highly successful in encouraging providers to better their education and skills in the early child care field.

New York:

The New York State Office of Children and Family Services and the State University of New York (SUNY) Early Childhood Education & Training Program offer video conference training for child care providers. These trainings consist of live broadcasts of experts and child care providers and offer opportunities for interaction and activities to apply what participants have learned. The video conferences are free to child care providers and are designed for child care providers in a variety of settings. Through a number of statewide downlink sites approximately 5,000 people participate in each video conference training. The video conference series won the 1998 award for excellence and innovation from the National Association for Training and Professional Development.
The video conference allows the State to reach some 5,000 individuals through each training via the numerous downlink sites across the State.

North Carolina:

North Carolina has developed a pilot program (to go statewide July 1, 1999) which offers health insurance benefits to child care staff through the T.E.A.C.H. Early Childhood Health Insurance Program. Drawing on Using CCDF quality improvement funding, the State pays one third of the cost of individual health insurance for child care staff in eligible programs. In order for a center or home to be eligible, either: 1)all teaching and administrative staff must have a two or four year degree in early childhood education or child development, or 2) the center or home must have at least one staff member (depending on the size of the child care facility) participating in the T.E.A.C.H. Early Childhood Associate, Bachelor, or Model/Mentor Teacher Program.

The program allows each center to choose its own health insurance coverage. The center or home must agree to cover one third of the cost of an individual health insurance plan for each eligible employee.

Texas:

The Texas Workforce Commission has committed $250,000 in CCDF funds for the continued publication of the *Texas Child Care Quarterly*. Since 1977 the journal has been mailed free of charge to all state regulated child care programs and family day homes in the state. Staff in these programs can use it to earn self-study training credit to meet state licensing requirements. Standard features include articles on child growth and development, hands-on

activities for children, book and product reviews, regulatory information, and a four-page pullout parenting newsletter. The journal is also available to the general public by subscription.

Grants to Providers/Local Communities

Grants and loan programs offer a variety of educational and quality incentive opportunities for child care, early education and school age staff. Grants also provide funding to expand and improve services to low income families. Some states have provided grants to local communities to reinforce their commitment to quality improvement. The amounts and uses of these grants vary according to the needs of each local community.

Florida:

Through Florida's Caring for Kids Program, a mini-grant and loan program is assisting providers with expenses related to facility start-up and meeting licensing and accreditation standards. Mini-grants of up to $500 are awarded to licensed and registered child care providers and up to $250 to informal providers. Loans range from $1,000 to $10,000.

Kansas:

Kansas offers grant funds to local communities to be used for eight different components: (1) Center-based establishment or expansion; (2) School-Age establishment or expansion; (3) Employer sponsored establishment or support -- $50,000 maximum available with 50% cash match required; (4) Center-based quality enhancement; (5) Family Resource Center establishment or expansion; (6) Provider training, recruitment and/or retention; (7) Head Start wrap around; and (8) Local Child Care Advisory Group Grants.

Maine:

The Office of Child Care and Head Start has developed and awarded two health pilot grants to determine the feasibility of incorporating Head Start Health Performance Standards into child care centers. This program was established to encourage collaboration between local Head Start Programs and child care centers, and to increase access to health screenings in child care centers. The goals of the pilot are: 1) to develop a health assessment, screening and evaluation process; 2) to work with parents to develop a plan to enhance their children's health; 3) to provide information to families about the importance of a medical home and health care resources; 4) to assist families in obtaining health insurance; 5) to connect child care programs with local resources; and 6) to use health information and resources to meet the individual needs of children.

South Carolina:

South Carolina implemented three pilot grants to assess the status of the self-arranged (informal) care in the State's Advocates for Better Care (ABC) Child Care Program and to provide technical assistance to these providers. The purpose of the technical assistance grants is to enhance the quality of child care services by providing a voluntary on-site contact with non regulated providers participating in the ABC Child Care Program. Those Providers serving children from birth to 3 years of age receive top priority for assistance. In addition, the

State announced a new cash bonus for caregivers who that complete South Carolina's ABC Child Care Credential. A $200 bonus is awarded to caregivers earning a 60-hour credential and a $100 bonus is awarded to caregivers earning a 30-hour credential.

Healthy Child Care America and Other Health Activities

To date, 51 States and/Territories have successfully implemented Healthy Child Care Activities at the State and local level targeting activities to improve the health and safety of children in child care. The Maternal and Child Health Bureau provided the initial funding to States and Territories in the amount of $50,000 per year for three years, ending in May 1999. In many States, CCDF Child Care and Development Fund quality dollars are being used to support healthy child care collaborative initiatives. Healthy Child Care America provides an ideal opportunity for child care and health to collaboratively support safe, nurturing child care environments for children; promote access to medical services; and conduct outreach activities to enroll eligible children in Medicaid and other health insurance programs under the State Children's Health Insurance Program (CHIP). Many States make health consultants available to child care programs as a way to ensure health and safety, as well as to support health promotion. The Healthy Child Care America programs have made outstanding progress and include activities such as immunizations, health consultation, injury prevention, health screening, nutrition and safety education. Some specific state initiatives include:

Alabama:

Healthy Child Care Alabama (HCCA) is focusing on decreasing the incidence of injury, illness, and death that occur in child care programs and improving the integration of health in out-of-home child care programs through direct consultation with child care providers. An automated system has been developed to track and analyze child care injury reports submitted to the Department of Human Resources. The automation of the injury reports will allows staff to analyze the data on a statewide or county basis and implement outreach prevention strategies for child care programs. This collaborative initiative is being supported by the Healthy Child Care America grants and the CCDF Child Care and Development Fund.

Iowa:

Healthy Child Care Iowa (HI) links child health and child care programs and services within the context of the family support service system through state systems development activities. Through an Interagency Agreement between the Department of Human Services and the Department of Public Health, CCDF Child Care and Development Funds supports are used to place child care health consultants in each of the State's five (5) resource and referral agencies to provide technical assistance to child care programs. In addition, funds from the Social Security Disability Insurance support a community health consultant to work with the program activities.

Missouri:

Healthy Child Care Missouri (HCCMO), a program of the Missouri Department of Health, funded by CCDF, Maternal and Child Health grants, and Health Systems Development grants, contracts with more than 100 local health departments to provide consultation and technical assistance to home and center-based child care providers. In a six-month period, nurse consultants provided approximately 1,000 hours of free child care consultation and training

services for 1,560 child care facilities and 4,000 staff who care for approximately 26,000 young children.

Pennsylvania:

Healthy Child Care Pennsylvania (HCCPA), and the Early Childhood Education Linkage System (ECELS), provide health professional consultation, training, and technical assistance to improve early childhood programs in Pennsylvania. These programs include child care centers, Head Start, family child care homes, group homes and nursery schools. Services include linkages between health professionals and child care programs for young children, telephone advice on health and safety issues, a video lending library, a quarterly newsletter *Health Link*, and health and safety training. CCDF Child Care and Development Funds and other funding sources are used to support the activities. of the Pennsylvania Healthy Child Care activities.

Mental Health

Child care programs can promote healthy emotional development of young children by informing and guiding child care providers and families in ways that encourage sensitive and age-appropriate care. Training and technical assistance of providers in the area of mental health supports the early identification and intervention with children that have been exposed who reflect the ill effects of exposure to violence, substance abuse, child abuse and neglect, or other emotional and behavioral problems. Linkages between child care and mental health can play a key role in linking families to mental health services.

California:

California's Mental Health Consultant Services Project proposal proposal focuses on the promotion of, inclusion of, and elimination of barriers for children with special behavioral and social needs. The Project will work to establish services to meet the identified mental health needs of the children and families served in child care programs by . Their objectives are to developing three mental health service models to address the special needs of children with challenging behaviors in child care settings. They will provide training on managing difficult behaviors, when and how to access mental health services child care providers; and training of mental health providers to work with children zero to five years of age within the child care setting. Strategies will be designed and facilitated to promote communication and collaboration between child care and mental health professionals and families; and assist low-income families to locate and utilize available funding for mental health and social services and promote mental health in child care setting by developing and coordinating services.

Michigan:

Michigan has identified the need to strengthen links between child care settings and mental health services in two areas: 1) Child care consultation and 2) access to mental health direct services. To address these issues, funding through an Interagency agreement between the Michigan Family Independence Agency and the Michigan Department of Community Health, funding has been provided to create a regional child care consultation service. This direct

service component will be staffed with a mental Health and a public health consultant. The public health consultant will provide or assure consultation, technical assistance and training for all child care providers, as well as build and maintain linkages between the child care and health communities. The mental health consultant will provide consultation services to child care providers, including appropriate screenings, recognizing behavioral symptoms, discussing child behavior, supporting parents, and training child care providers on how to deal with these symptoms.

Special Needs/Inclusive Child Care

Access to resources, professional development activities, and technical assistance is key to providing appropriate care for all children, including children with special needs. States are developing several strategies to offer this support to providers. Kansas, for example, is examining the establishment of a one-time grant program to encourage and enable child care providers to care for children with disabilities. Other State initiatives that address the importance of inclusive child care include:

California:

In California, Project Exceptional was developed, produced and disseminated through with CCDF funds. This curriculum is specifically designed to increase the opportunities for children with disabilities to participate in typical child care and development programs. In addition, The Child Care Health Program Healthily has been expanded to include developmental disabilities and behavioral specialists. Through an in-state taller phone line, child care providers and parents receive information on health, safety, developmental, nutritional and behavioral concerns.

Oregon:

The State of Oregon's Child Care Division (CCD) has committed CCDF funds to develop a strategic plan and a pilot project to improve access to child care for children with disabilities. This effort is also taking place between CCD and the local tribal communities. Oregon CCDF funds also support child care resource and referral services across the state to help families locate successful child care placements for children with special needs.

Monitoring and On-Site Visits*:*

Monitoring, particularly through unannounced inspections, is an effective strategy for ensuring quality care in child care settings. States are using on-site visits not only to enforce standards but to provide technical assistance to providers, as well. The standards that are enforced are also important, for example, state requirements that allow fewer infants and toddlers per provider can be key to improving quality.

Illinois:

Illinois hired 75 additional licensing staff, . This representing a 40% increase in total licensers. This and will allow the state to meet the requirement of one annual inspection visit per facility. In addition, at the end of three years, all licensers hired from outside the state government must have early childhood education or relevant experience. Within the Department of Social Services, if an individual wants to transfer internally from the Department of Social Services to the licensing unit, he/she must have 18 hours of training in

early education.

Maryland:

In Maryland, full day training workshops were provided for all monitoring staff on topics of infant/toddler development and behavior management to enhance their ability to provide technical assistance to family child care providers and center staff.

Nebraska:

Beginning May 1, 1998, the State of Nebraska's Child Care Licensing Program began requiring annual/semi-annual unannounced inspection visits to all licensed child care programs. Centers and preschools licensed for 30 or more children receive two unannounced visits per year. Family child care homes, including those licensed through a self certification process, centers and preschools licensed for fewer than 30 children receive one unannounced visit each year. Aggregate information is available regarding the frequency of non-compliances noted at visits. Such data enables organizations delivering training to address actual deficiencies cited seen in child care settings. Conducting more frequent and unannounced visits to all child care programs provides a more accurate picture of the compliance history of programs and enables the specialists to provide more consultation and technical assistance to assist programs in meeting and exceeding licensing regulations.

Infant and Toddler Programs:

Recent brain research studies tells us reveal that warm, responsive child care is critical to the development of young children. We know that the quality of young children's experiences in the first three years of life has a decisive, long lasting impact on their well-being and ability to learn. In response to this information and with the additional funding available to States to increase the supply of quality care for infants and toddlers, States have targeted specific activities for infants and toddlers. Activities include: training of child care providers, program linkages with Head Start and Early Head Start Programs, utilizing health consultants in child care programs, providing start-up grants to providers for equipment and supplies, and hiring infant- toddler specialists who are outstationed in the child care resource and referral agencies to help parents make informed choices of care. State examples include:

Wisconsin:

The Wisconsin Office of Child Care, Department of Workforce Development has contracted with the Wisconsin Early Childhood Association to be the fiscal agent and coordinate a new Infant Toddler Initiative (ITI). The purpose of ITI is to develop and sustain an infant toddler teacher training, scholarship and enhanced compensation system. Funded with CCDF Infant /Toddler Quality Supply Building funds, it is designed to fit into or be the first stage of a larger initiative for all Wisconsin teachers and providers. The Wisconsin Head Start Association will be involved in the development of the ITI to ensure linkages with Early Head Start. It includes the development of an Infant-Toddler Credential which will be awarded upon completion of a required number of academic credits in infant toddler teacher core knowledge areas from a college or university in Wisconsin.

Washington:

The State Department of Social and Health Services developed an interagency agreement with the Department of Health (DOH) to administer conduct outreach on infant and toddles activities through local public health jurisdiction pilot sites. DOH-sponsored will provide training and technical assistance will enable to the local jurisdictions that will to provide observation, consultation and technical assistance to local infant/toddler caregivers. This project will begin with 9 pilot sites, and will expand by at least 9 more sites in Fall 1999.

Quality Activities That Support Cultural Diversity

The changing demographics of communities has led to a heightened awareness and commitment by on the part of states to ensure culturally competent child care systems. A culturally diverse child care setting enriches the quality and educational experience for all children enrolled.

Minnesota:

The Minnesota Department of Children, Families & and Learning, were have solicited Requests for Proposals to improve the affordability and availability of a high quality and culturally responsive child care system in the State. Proposals may address provider recruitment in specific cultural communities; staff training in the area of cultural differences and anti-bias approaches; multicultural curriculum development; purchase of multicultural materials; outreach to specific cultural communities; technical assistance; parental outreach in cultural communities; training of trainers in the area of cultural competence; and mentoring programs.

Washington:

The King County Diversity Inclusion Project was developed to improve the access to childhood services for families traditionally underserved. families. Two major accomplishments of the project have been to improve access of underserved families to child care services, and improve the cultural relevancy of child care programs. The project is administered through the child care resource and referral agency. An expanded database provides information on subsidy programs, Head Start, special needs, and related family services. Translation service is available to families where English is not the primary language. Training (197 hours) of training is provided to child care programs serving geographically and culturally diverse families. Special services, including mental health consultation and physical therapy services are provided on site. Materials are purchased to help programs in their delivery of care with respect to anti-bias, culturally relevant or multicultural programs and environments. The project is administered through the child care resource and referral agency.