



Comprehensive Services: Charting Progress for Babies in Child Care Research-Based Rationale

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Project Recommendation

Link necessary services for vulnerable babies and toddlers to child care settings: Link comprehensive health, mental health, and family support services for vulnerable babies and toddlers to all child care settings, and provide culturally and linguistically appropriate service information to parents, providers, and caregivers.

“To thrive, young children need regular visits to the doctor even when they are healthy; they need stimulating early learning opportunities; and they need stable, nurturing families who have enough resources and parenting skill to meet their basic needs. These are the ingredients that put young children on a pathway to success.” —Helene Stebbins and Jane Knitzer, National Center on Children in Poverty²

What does the research say about the need for comprehensive services for vulnerable babies and toddlers in child care?

Babies need good health and supported families.

For babies and toddlers, early learning experiences occur within the context of their physical and mental health and the relationships they have with their families and other caregivers, building brain

architecture that lays the foundation for success later in life.³ Quality health care and good nutrition, both for pregnant mothers and infants and toddlers, is essential for a child’s healthy development and can help reduce early childhood health impairments.⁴ Parents and families require personal and economic resources to provide for their infants’ and toddlers’ basic needs. Programs and policies that support families (for example by reducing economic hardship, promoting healthy parent-child relationships, or treating parental health conditions) also promote infants’ and toddlers’ healthy development.⁵

Demographics and family and environmental risk factors can put babies at risk for unhealthy development.⁶

The first three years of life are a critical time of growth and development. Examples of risk factors include: low birth weight,⁷ food insecurity,⁸ maternal depression,⁹ child abuse or neglect,¹⁰ and environmental hazards.¹¹ Infants and toddlers with some of these risk factors may experience attachment disorders, score lower on indicators of school readiness and behavior at age 3, or exhibit signs of post-traumatic stress disorder.¹² Infants and toddlers may experience multiple risk factors, resulting in a higher cumulative risk. A research study examined maternal mental health, substance use, and domestic violence in the first year of a baby’s life. As the number of risk factors in a child’s first year increased, so did the likelihood of the child having problems with aggression, anxiety/depression, and inattention/hyperactivity at age 3.¹³ Infants and toddlers who have been maltreated often experience multiple risk factors for developmental delays. A study of infants and toddlers with substantiated cases of child maltreatment found that over half (55 percent) had at least five risk factors for developmental problems.¹⁴ Extended exposure to some risk factors has been shown to cause “toxic stress” in infants and toddlers—a prolonged activation of stress hormones that negatively impacts the way connections in their brains develop.¹⁵

Economic hardship can increase risk factors for babies and toddlers.

Research studies and policy interventions may focus on low-income children as a proxy for vulnerable children. Although families at all income levels are vulnerable when they experience challenges that put children at risk for unhealthy development, such as domestic violence, child maltreatment, substance abuse, and depression, many challenges are disproportionately prevalent among low-income families.¹⁶ Infants and toddlers are more likely to be poor than any other age group: 21 percent of children under age 3 live below the poverty level, and 43 percent of children under age 3 live in low-income families (below 200 percent of the federal poverty level).¹⁷ Research on children under age 3 living in poor or low-income families indicates that these children may be at risk for unhealthy development, as these families may lack the resources to provide consistent food, shelter and other basics.¹⁸ For instance, infants and toddlers are more likely to live in households experiencing food insecurity: 18 percent of children under age 3 live in a food insecure household, compared to 12 percent of the overall population.¹⁹

Many vulnerable babies and toddlers and their families are unable to access appropriate developmental services.

Young, low-income children are less likely to have a usual source of health care, be rated by caregivers as very healthy, or have health insurance.²⁰ Further, infants and toddlers are not receiving the comprehensive health services they need. The means-tested Medicaid program contains a comprehensive and preventive set of services for children known as the Early and Periodic Screening and Diagnostic Testing benefit (EPSDT), which includes screening, vision, dental, hearing, and health care services.²¹ (Multiple preventive visits per year are recommended for very young children by the American Academy of Pediatrics,²² but states may set their own schedules for how often screening services are required under EPSDT.) The national benchmark targets 80 percent of eligible children in a state to receive an EPSDT screening annually.²³ Using the most recent year of data available, states varied on the rate at which eligible toddlers (ages 1-2) received at least one EPSDT visit in the prior year, from 95 percent of toddlers in Massachusetts to 42 percent of toddlers in Arkansas.²⁴ Only eight states achieved the 80 percent benchmark for toddlers to receive at least one EPSDT visit.²⁵ Most infants under age 1 receive screenings as newborns; 41 states met the 80 percent benchmark for infants to receive at least one EPSDT visit in the prior year, according to the most recent year of data available.²⁶

A substantial proportion of vulnerable children with disabilities may not be receiving available intervention services during their first three years of life, the period in which early intervention services can be most effective.²⁷ The Individuals with Disabilities Education Act (IDEA) Part C provides services to infants and toddlers with disabilities and developmental delays (states may also choose to serve children at risk of developmental delays, although few do so).²⁸ In 2007, only 2.5 percent of infants and toddlers received IDEA Part C services nationwide, although rates varied by state.²⁹ In comparison, IDEA Part B includes services for preschool children aged 3-5, and 6 percent of preschool-age children nationwide received services in 2007.³⁰ Approximately 17 percent of all children under age 18 are affected by developmental disabilities.³¹

Infants and toddlers living in low-income families with primary languages other than English are also less likely to receive recommended preventive care than infants and toddlers in low-income families whose primary language is English.³² Access to information and services is particularly difficult for these parents if service providers do not speak their native language or information is not appropriately translated. Young children of immigrants are more than twice as likely as children of U.S.-born citizens to be in fair or poor health and to lack a regular source of health care. They are also more than twice as likely to be uninsured.³³ A quarter of all babies and toddlers have at least one foreign-born parent.³⁴ Immigrant families must navigate unfamiliar, and sometimes intimidating, programs and services to access supports that their young children need.

Connecting vulnerable babies and their families to necessary services as early as possible can improve outcomes.

Vulnerable infants and toddlers need access to comprehensive services supporting their health, mental health, and families.³⁵ Neuroscience suggests that early interventions for vulnerable children should begin at birth or even prenatally,³⁶ since earlier interventions are more likely to affect the trajectory

of a child's entire life. Research shows that young children who experience toxic stress respond to early treatment.³⁷ Interventions that provide intensive services for vulnerable children *and* connect parents to needed supports can help families experiencing multiple risk factors that threaten their infant's or toddler's development.³⁸

Many vulnerable babies and toddlers and their families who could benefit from comprehensive services can be reached through their child care settings.

The majority (73 percent) of children under age 3 with employed mothers have a regular, nonparental child care arrangement. Similar rates of child care use exist for infants and toddlers with employed mothers in low-income families.³⁹ Child care providers and caregivers have daily interaction with young children and their parents in what are often non-stigmatizing and accessible settings, and they often develop strong, supportive relationships with both the child and family, setting a positive context for delivering preventive services.⁴⁰ Since vulnerable families may have less access to health care, mental health care, and social services, it is particularly important for child care settings serving vulnerable infants and toddlers to provide access to comprehensive services. State policies can help link child care providers and caregivers with the comprehensive services that children need. Quality child care that supports the full range of young children's developmental needs also provides an important support for families with babies and toddlers, but access is limited.

A comprehensive approach to delivering supportive services and early care, such as Early Head Start, improves outcomes for babies and parents.

Early Head Start is a comprehensive early care and child development program for infants, toddlers, and pregnant women living in poverty, as well as other designated special populations (such as those in the child welfare system or those who are homeless). However, less than 3 percent of eligible infants and toddlers receive Early Head Start under current funding levels.⁴¹ Infants and toddlers in Early Head Start may receive early care and developmental services in a center-based program option, a home-based program, a combination of those two settings, or in a family child care option.

Federally-funded Early Head Start programs must follow the Head Start Program Performance Standards, which were specifically designed to address the comprehensive physical, social, emotional, and educational needs of low-income children and families by ensuring children receive appropriate health screenings and necessary follow-up treatment, access to a medical home, and preventive care.⁴² As a result, infants and toddlers enrolled in Early Head Start have better outcomes on indicators of health and well-being. For example, in 2006, 93 percent of infants and toddlers in Early Head Start received all possible immunizations appropriate for their age by the end of the program year⁴³—higher than national averages. According to the Centers for Disease Control and Prevention, 80 percent of all young children nationwide (aged 19-35 months) received their recommended vaccination series in 2006. Among young children living in poverty, only 76 percent received their recommended immunizations.⁴⁴ The Performance Standards also provide family support through partnerships, identifying social service needs, and service provision or referral.⁴⁵ Research has shown that the comprehensive Early Head Start approach positively impacts children's cognitive, language and social-

emotional development; parents' progress toward self-sufficiency; and a wide range of parenting outcomes.⁴⁶

How can state child care licensing, subsidy, and quality enhancement policies ensure vulnerable babies and toddlers in child care receive comprehensive services?

States can use multiple, promising approaches to link elements of comprehensive services to child care.

States have found that having comprehensive educational and social services available directly or through referral is one of the characteristics of quality child care.⁴⁷ The Strengthening Families project, developed by the Center for the Study of Social Policy and currently operating in at least seven states, aims to reduce child abuse and neglect by offering family supports and services through child care and early education programs to build “protective factors” for vulnerable families.⁴⁸ In addition to helping children have healthy social and emotional development, child care settings can facilitate positive parenting skills, social and community connections, knowledge of child development, and access to services that families need, such as mental health services. When families have these protective factors, the incidence of child maltreatment is reduced.⁴⁹ To facilitate access for all families, family support staff and coordinators must be culturally and linguistically representative of participating families.

Other examples include the Infant Toddler Initiative of Healthy Child Care Washington (HCCW). HCCW reaches out to all child care settings in Washington through child care health consultants who provide technical assistance, information, referrals, and child development knowledge to child care providers. An evaluation of HCCW found that participating child care providers increased their knowledge and use of practices promoting social and emotional health, physical health, cognitive development, and communication with parents.⁵⁰

To promote positive mental health, Connecticut's statewide Early Childhood Consultation Partnership (ECCP) funds behavioral health consultants to work with child care providers and parents to address socio-emotional needs of children from birth to age 5. A random-assignment evaluation of the ECCP program found statistically significant decreases in children's behavior problems, as rated by their child care and early education providers.⁵¹

In order to be successful, state policies on delivering comprehensive services to vulnerable infants and toddlers should be culturally and linguistically appropriate.

Families from different cultures may have differing views and experiences with provision of mental health and family support interventions and the acceptableness or stigma associated with accessing

such services. Recently arrived immigrants, in particular, may be unaware of the existence of available services or may have difficulty accessing them.⁵² A trusted child care provider can both explain the value and need for such services and assist families in accessing culturally and linguistically appropriate services.

States can ensure that materials on comprehensive services available in the state are culturally and linguistically appropriate. Any information that is available for parents or providers should consider the primary languages and literacy levels of the state's populations. Materials should be competently translated and easy to read at a low literacy level. Ethnic media and links with community-based organizations for information dissemination can also help ensure that information on the importance of comprehensive services reaches all families in the most appropriate formats. States can also reach out to child care providers as important disseminators of information to parents.

States can build on the two-generational approach of the comprehensive federal Early Head Start program, which has had positive impacts on babies and families.

Twenty states report building on the comprehensive Early Head Start (EHS) program through state funding and/or policies.⁵³ There are two models states use to bring the comprehensive frame of EHS to child care. One approach is to provide resources and assistance directly to child care providers to help them deliver services that meet EHS standards; **Oklahoma** is following this model. Six states use a second approach, supporting partnerships between EHS and center-based and family child care providers to improve the quality of care in different ways. For example, an **Iowa** pilot creates partnerships between EHS and family child care and family, friend, and neighbor care settings and requires that EHS programs implement the home-based model with children in those settings. **Kansas** facilitates EHS-child care partnerships to actually deliver EHS in child care settings. **Nebraska** uses the partnerships to leverage federal expertise and resources to improve quality of child care partners.

States can use direct contracts within their child care subsidy system to provide comprehensive services for infants and toddlers.

Most states provide child care assistance to low-income working families primarily through vouchers or certificates. States may also contract directly with providers for child care. In a contracts model, states make a contractual agreement with a child care provider to serve a set number of children who are eligible for assistance. As part of the contract, states can choose to require that child care providers meet higher-quality standards beyond basic licensing requirements, such as requiring the provider to offer families comprehensive services or provide referrals. For example, Illinois requires contracted providers to report how they connect families to community services and what referrals they make for families. They are also required to make regular contact with Family and Community Resource Centers. Some states pay contracted providers at a higher rate to meet the costs of comprehensive services. For example, Massachusetts contracts with certain child care centers to provide additional services and supports for abused and neglected children and pays the contracted providers an additional \$15 per day. In order to successfully use contracts to help provide infants and toddlers with comprehensive services critical to their development, states should also provide technical assistance, monitoring, evaluation, and other supports to contracted child care providers.⁵⁴

What policies can states use to move toward this recommendation?

To move toward this recommendation, states may use multiple policy levers, starting from different points. Potential state policies include:

Licensing

- Require in state licensing that child care providers deliver comprehensive services for vulnerable babies and toddlers or link vulnerable children to community resources, and award grants to help providers meet these requirements.
- Require in state licensing that child care centers address six comprehensive areas of child development: social, physical, language/literacy, cognitive/intellectual, emotional, and cultural.⁵⁵
- Require in state licensing that child care providers receive pre-service training including first aid certification, certification in infant and pediatric CPR, child abuse identification, developmental screening, nutrition, and methods to reduce disease and injury in child care settings.⁵⁶

Subsidy

- Provide higher subsidy reimbursement rates to child care providers who deliver comprehensive services to vulnerable babies and toddlers or link vulnerable children to community resources.
- Link the state child care subsidy payment rate structure to the state Quality Rating and Improvement System (QRIS) so that child care providers receive higher rates for screening, referral, and provision of comprehensive services to vulnerable babies and toddlers.
- Create contracts that pay higher rates and require providers to provide screening, referral, and comprehensive services to vulnerable babies and toddlers.
- Provide a single enrollment form that includes child care subsidy eligibility, the Supplemental Nutrition Assistance Program (formerly Food Stamps), state child health insurance programs, and other social service programs.
- Provide higher subsidy reimbursement rates for infants and toddlers who have been identified with developmental delays or other special needs.
- Allow family, friend, and neighbor caregivers receiving child care subsidies to participate in the federal Child and Adult Care Food Program (CACFP), and put in place policies that make it easier for all providers and caregivers to have continuous access to the program.

Quality Enhancement

- Embed provision of screening, referral, and comprehensive services for vulnerable babies and toddlers in child care into the levels of a state Quality Rating and Improvement System (QRIS).

Deliver components of comprehensive services in child care settings:

- Create a statewide network of infant and toddler health and mental health specialists to provide technical assistance to infant and toddler providers, caregivers, and parents.
- Support child care health consultants with training on infant/toddler development so that they can better serve child care settings where babies are in care.
- Create new child care settings or expand the ability of existing center and family child care settings to build on the Early Head Start model by funding child care settings to deliver services that meet the federal Head Start Performance Standards.
- Ensure that all eligible child care providers and caregivers have access to the federal Child and Adult Care Food Program (CACFP) in order to provide healthy, nutritious meals and snacks to infants and toddlers in their care.
- Create new child care settings delivering comprehensive services in immigrant and language-minority communities.
- Fund child care partnerships with Early Head Start programs to allow children in all child care settings, including family, friend and neighbor care, to receive Early Head Start screening and referral services.
- Fund connections between family resource coordinators and child care centers to help parents access resources in their community, such as health care, WIC, the Supplemental Nutrition Assistance Program (formerly Food Stamps), social services, and health care.
- Ensure that infant/toddler health and mental health specialists, family resource coordinators, and others working with providers and parents are culturally and linguistically representative of families with infants and toddlers and/or have training in cultural competency.
- Fund initiatives to provide parent support services, such as home visits, new parent discussion groups, family literacy programs, and birth to three child development classes, in child care settings, and provide services in multiple languages.
- Provide guidance to child care programs on eligibility for publicly-funded health services for children and parents who are not U.S. citizens.

Improve child care provider and caregiver understanding of the comprehensive service needs of babies and their families:

- Create community-based support networks for family, friend, and neighbor caregivers of babies and toddlers that link children to health and screening services by connecting with trusted community resources such as libraries, museums, immigrant serving organizations, public health, mental health and early intervention, senior service, and public television resources.
- Provide training opportunities and support for child care providers and caregivers on how to recognize, work with, make referrals for, and follow up with vulnerable families, including those struggling with poverty, domestic violence, substance abuse, child abuse, and neglect.
- Provide training opportunities and support for child care providers and caregivers on the use of screening tools to identify potential health and developmental concerns for babies and toddlers and how to refer families for services and programs that can support parents in nurturing their children's development, including referrals to IDEA Part C early intervention.

- Disseminate information to all providers and caregivers on how to access services for special needs infants and toddlers and their families, in culturally and linguistically appropriate ways using multiple languages and multiple formats.
- Ensure parents in immigrant communities with babies and toddlers in child care are aware of community services by using face-to-face communications through trusted messengers, including immigrant-serving organizations, and disseminating translated materials appropriate for parents with low literacy levels.
- Develop information on the connections between infant health/mental health and maternal mental health, as well as resources for serving infants and their mothers, and disseminate it in multiple languages and multiple formats to providers, caregivers, families, and community health professionals.

Coordinate state systems to connect elements of comprehensive services with child care:

- Coordinate state Medicaid and early childhood policies to allow federal funds to support consulting and therapeutic services necessary for vulnerable infants and toddlers in child care and their families, including Early and Periodic Screening and Diagnostic Testing (EPSDT) services.
- Coordinate policies between state child care systems and IDEA Part C state early intervention systems to better serve infants and toddlers with special needs.
- Coordinate state child care system policies with other state systems that provide developmental services to infants, toddlers, and their families, such as WIC, the Supplemental Nutrition Assistance Program (formerly Food Stamps), social services, and health care.
- Ensure that Child Find and other services designed to identify children at-risk of developmental delays are including child care centers and family child care providers in their target service areas.

What are some other project recommendations that affect this issue?

- **Screen babies and toddlers for health and developmental delays:** In order to determine what health and mental health comprehensive services infants or toddlers may need, health professionals need to conduct developmentally appropriate screenings.
- **Partner with parents of babies and toddlers in child care:** By encouraging partnerships with parents and parent involvement in child care, providers can build relationships with families and assess what comprehensive services may be needed.
- **Monitor and provide technical assistance to infant and toddler providers:** State monitors and technical assistance providers can also help child care providers ensure they are offering comprehensive services or referrals needed by infants and toddlers and their families.
- **Promote stable, quality care for babies and toddlers through subsidy policy:** Since about half a million children under the age of three received child care services supported by the Child Care and Development Block Grant (CCDBG) in an average month in 2007,⁵⁷ improving subsidy

policy—including the amount of CCDBG funding per child—can help low-income children access the comprehensive services they need.

- **Ensure that babies and toddlers in centers are in small groups with sufficient numbers of providers:** When center-based child care providers have appropriate numbers and ratios of infants and toddlers in their care, providers are better able to identify and respond to comprehensive service needs of children and families.
- **Ensure babies and toddlers in family child care are in small groups with sufficient numbers of providers:** When family child care providers have appropriate numbers and ratios of infants and toddlers in their care, providers are better able to identify and respond to comprehensive service needs of children and families.

Online resources for state policymakers

Resources about comprehensive services in child care may also refer to these issues as “whole child” development, socio-emotional development, infant/toddler mental health, or school readiness.

Information on comprehensive services and Early Head Start:

- The requirements for comprehensive services throughout the **Head Start Program Performance Standards** (which govern federally funded Early Head Start programs) provide examples of services that vulnerable infants and toddlers need.
- Head Start’s **Early Childhood Learning and Knowledge Center** provides information on child development, family and community partnerships, and Early Head Start programs.
- The report **Building on the Promise: State Initiatives to Expand Access to Early Head Start for Young Children and their Families**, by CLASP and ZERO TO THREE, provides state models for expanding Early Head Start. **Detailed profiles** of ten state initiatives are also available.
- The **Early Head Start National Resource Center** has published a technical assistance paper entitled, **Developmental Screening, Assessment, and Evaluation: Key Elements for Individualizing Curricula in Early Head Start Programs**. This paper is also available **in Spanish**.

Information on coordinating state systems to connect elements of comprehensive services with child care:

- **Improving the Odds**, a project of the **National Center on Children in Poverty** (NCCP), provides national, regional, and **state profiles** on comprehensive indicators of early childhood development. See what your state is doing in the areas of health and nutrition, early care and learning, and parenting and economic supports, that could offer opportunities to bring comprehensive services to child care.

- The Maternal and Child Health Bureau has awarded grants to 48 states under its **Early Childhood Comprehensive Systems (ECCS) Initiative**, to help states build systems for young children with five components: access to health care and medical homes, socio-emotional and mental health, early care and education, parenting education, and family support. **Project THRIVE** at the **National Center on Children in Poverty (NCCP)** provides additional resources to these state grantees on comprehensive systems, including **ECCS state summaries**.
- The Early Childhood Systems Working Group has created a visual tool of a **State Early Childhood Development System**, linking early learning; special needs/early intervention; health, mental health, and nutrition; and family support.
- **Part C of the Individuals with Disabilities Education Act (IDEA)** requires states to identify and serve infants and toddlers with disabilities and developmental delays. The **National Early Childhood Technical Assistance Center** (NECTAC) provides further information on states' IDEA Part C **policies**, **contacts**, and other resources.
- The **Strengthening Families** project, developed by the **Center for the Study of Social Policy** and currently operating in at least seven states, aims to reduce child abuse and neglect by offering family supports and services through child care and early education programs to build “protective factors” for vulnerable families.
- The **Food Research and Action Center** has materials **explaining the Child and Adult Care Food Program (CACFP)** and how state administrators can use the program to provide nutritious meals and snacks and training/monitoring in all child care settings, including family, friend, and neighbor settings. **Geraldine Henchy** is the director of nutrition policy and early childhood programs.
- The Child Care Bureau's **National Child Care Information and Technical Assistance Center (NCCIC)** runs the **PACT Initiative**—Partnerships, Alliances, and Coordination Techniques—on building comprehensive early care and education systems. NCCIC has several other resources available on other portions of their website, such as a table of **state governance structures** for early child care and education programs.
- The **Urban Institute**'s 2008 paper, **Designing Subsidy Systems to Meet the Needs of Families**, recommends strategies for states seeking to align their child care subsidy systems with other state support systems that low-income families access.

Information on providing comprehensive services in a culturally competent way:

- The Annie E. Casey Foundation's toolkit, **Building Culturally and Linguistically Competent Services to Support Young Children, Their Families, and School Readiness**, includes information on planning and implementation, family-friendly communication, provider training, and other resources.
- The **National Center for Cultural Competence** at Georgetown University's Center for Child and Human Development provides resources and tools, research and evidence, and promising practices for developing linguistic and cultural competence in services.
- **CLAS**, the Culturally and Linguistically Appropriate Services Early Childhood Research Institute, has several online resources, such as materials for early childhood professionals on **Working with Culturally and Linguistically Diverse Families** and **Review Guidelines**. These online

resources help child care providers evaluate the appropriateness of their activities and materials on topics including emotional/social development, child assessments, and family support networks.

Information on infant/toddler specialists and child care consultants:

- The National Infant and Toddler Child Care Initiative at ZERO TO THREE has catalogued states with infant/toddler specialists and specialist networks.
- The Healthy Child Care Consultant Network Support Center has state profiles on how states are using consultants to promote children’s healthy development in child care settings. Information can also be compared across states.

Information on “making the case” for investments in comprehensive services:

- The Center on the Developing Child at Harvard University has written several publications, such as A Science-Based Framework for Early Childhood Policy, which reviews research from neuroscience, behavioral science, developmental science, economics, and early childhood program evaluations to inform a wide array of policies that invest in children.
- The Birth to Five Policy Alliance works to shift the odds for the nation’s most vulnerable children and has collected a set of materials to make the case for investing in young children’s comprehensive development.
- A toolkit by the State Early Childhood Policy Technical Assistance Network (SECPTAN), entitled Seven Things Policy Makers Need to Know about School Readiness, emphasizes the importance of comprehensive services in early care and education. For example, see the briefing papers within the toolkit entitled “Nurture as well as Nature Matters,” “Quality Matters,” and “Investments Pay Off.”
- Docs for Tots has a series of resources relating to advocacy for comprehensive services, such as talking points and presentations that include resources focused on infants and toddlers.

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² Helene Stebbins and Jane Knitzer, *Highlights from the Improving the Odds for Young Children Project: State Early Childhood Policies*, National Center for Children in Poverty, 2007, 12, http://www.nccp.org/publications/pdf/text_725.pdf.

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⁴ *A Science-Based Framework for Early Childhood Policy*, 12.

⁵ For information on how family support policies fit into early childhood systems, see, for example, *State Early Childhood Development System*, Early Childhood Systems Working Group, 2007, <http://childcareandearlyed.clasp.org/ECDSsystemAndCoreElementsToShare.pdf> and *User Guide to the State Early Childhood Profiles*, National Center for Children in Poverty, n.d., http://www.nccp.org/profiles/pdf/EC_user_guide.pdf.

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¹³ Robert C. Whitaker, Sean M Orzol, and Robert S. Kahn, "Maternal Mental Health, Substance Use, and Domestic Violence in the Year After Delivery and Subsequent Behavior Problems in Children at Age 3 Years," *Archives of General Psychiatry* 63, no. 5 (2006): 551-560.

¹⁴ Barth, Scarborough, Lloyd et al., *Developmental Status and Early Intervention Service*, 11. All infants and toddlers had at least one risk factor, namely child maltreatment. Other risks associated with developmental delays that the study examined were poverty, domestic violence, caregiver substance abuse, caregiver mental health problem, low caregiver education, biomedical risk condition, single caregiver, teen-aged caregiver, four or more children in home, and minority status.

¹⁵ *A Science-Based Framework for Early Childhood Policy*, 9; *Excessive Stress Disrupts the Architecture of the Developing Brain*, National Scientific Council on the Developing Child, 2008, 4,

http://www.developingchild.net/pubs/wp/Stress_Disrupts_Architecture_Developing_Brain.pdf. Risk factors identified include family economic hardship, maternal depression, child abuse or neglect, parental substance abuse, and family violence.

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¹⁸ See, for example, *Consequences of Growing Up Poor*, ed. Greg Duncan and Jeanne Brooks-Gunn, 1997 and *Poverty and Brain Development in Early Childhood*, National Center for Children in Poverty, 1999, http://www.nccp.org/publications/pdf/text_398.pdf. Other work has examined low-income children living below 200 percent of the federal poverty level; see, for example, Elizabeth Gershoff, *Low Income and the Development of America's Kindergartners*, National Center for Children in Poverty, 2003, http://nccp.org/publications/pdf/text_533.pdf. For discussion of how the current federal poverty measure does not represent adequate income levels and how to construct adequate basic family budgets, see Jared Bernstein, Chauna Brocht, and Maggie Spade-Aguilar, *How Much is Enough? Basic Family Budgets for Working Families*, Economic Policy Institute, 2000, <http://www.epi.org/books/HowMuchIsEnoughFINAL.pdf>.

¹⁹ CLASP analysis of December 2007 Current Population Survey – Food Security Supplement data, retrieved from the U.S. Census Bureau.

²⁰ *Health Data for All Ages*, National Center for Health Statistics, Centers for Disease Control and Prevention, http://www.cdc.gov/nchs/health_data_for_all_ages.htm. Data on children ages 0 through 4 available through online interactive tables; includes children whose general health was rated as "excellent" or "very good."

²¹ Centers for Medicare and Medicaid Services Web site, "EPSDT Benefits," http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/02_Benefits.asp.

²² The American Academy of Pediatrics recommends seven preventive health care visits before an infant reaches 12 months and then six preventive visits between ages 1-3. American Academy of Pediatrics/Bright Futures, *Recommendations for Preventive Pediatric Health Care*, 2008, <http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>.

²³ In 1990, the Health Care Financing Administration, now the Centers for Medicare and Medicaid Services, set a benchmark for states to achieve an 80 percent participation rate for all children eligible for EPSDT services by 1995. Eighty percent continues to be used as a benchmark figure.

²⁴ Centers for Medicare and Medicaid Services, Form CMS-416 Annual EPSDT Participation Data by State, Available for download at http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp. Data analyzed was the most recent information reported by each state: 2002 for Maine; 2003 for West Virginia; 2005 for Iowa, Kentucky, Mississippi, and Vermont; and 2006 for all other states.

²⁵ The eight states meeting the 80 percent benchmark for toddlers (ages 1 and 2) to receive at least one EPSDT visit were Massachusetts (95 percent), Ohio (83 percent), Iowa (83 percent), Washington (83 percent), Maine (82 percent), Florida (80 percent), Connecticut (80 percent), and the District of Columbia (80 percent).

²⁶ Centers for Medicare and Medicaid Services, Form CMS-416 state data analyzed by most recent year available.

²⁷ American Academy of Pediatrics, Committee on Children with Disabilities, "Developmental Surveillance and Screening of Infants and Young Children," *Pediatrics* 108, no. 1 (2001): 192-196.

²⁸ The text of the Act is available through the Department of Education, at <http://idea.ed.gov/explore/view/p/root/statute,I,C>. As of July 2006, only six states (CA, HI, MA, NH, NM, and WV) were serving infants and toddlers at risk of developmental delays with IDEA Part C funds. Jo Shackelford, *State and Jurisdictional Eligibility Definitions for Infants and Toddlers with Disabilities Under IDEA*, National Early Childhood TA Center, NECTAC Notes 21, July 2006, <http://www.nectac.org/~pdfs/pubs/nnotes21.pdf>.

²⁹ IDEA Data Web site, Table 8-1, "Infants and toddlers receiving early intervention services under IDEA, Part C, by age and state: Fall 2007," *Data Tables for OSEP State-Reported Data*, http://www.ideadata.org/arc_toc9.asp#partcCC.

³⁰ Calculation using data from IDEA Data Web site, Table 1-1, "Children and students served under IDEA, Part B, by age group and state: Fall 2007," and Table C-3, "Estimated resident population ages 3 through 5, by state: 1998, 2006 and 2007."

³¹ Centers for Disease Control and Prevention Web site, "Monitoring Developmental Disabilities," <http://www.cdc.gov/ncbddd/dd/ddsurv.htm>.

³² Adam L. Cohen and Dimitri A. Christakis, "Primary language of parent is associated with disparities in pediatric preventive care," *Journal of Pediatrics* 148, no.2 (2006): 254-8.

³³ Randy Capps, Michael Fix, Jason Ost, Jane Reardon-Anderson, and Jeffrey S. Passel, *The Health and Well-Being of Young Children of Immigrants*, Urban Institute, 2005, http://www.urban.org/UploadedPDF/311139_ChildrenImmigrants.pdf. Seven percent of children of immigrants are reported by their parents to be in poor or fair health, compared to 3 percent of children of U.S.-born citizens; 22 percent of children of immigrants are uninsured, compared to 11 percent of children of U.S.-born citizens.

³⁴ Calculated from U.S. Census Bureau, Table C5, "Nativity Status of Children Under 18 Years and Presence of Parents by Race, and Hispanic Origin for Selected Characteristics," *America's Families and Living Arrangements: 2007*, 2008, <http://www.census.gov/population/www/socdemo/hh-fam/cps2007.html>.

³⁵ Stebbins and Knitzer, *Improving the Odds for Young Children*.

³⁶ *A Science-Based Framework for Early Childhood Policy*, 3.

³⁷ *Excessive Stress Disrupts the Architecture of the Developing Brain*, 7.

³⁸ Knitzer, *Promoting Resilience*, 6. See also Knitzer and Lefkowitz, *Pathways to Early School Success*, 16-18.

³⁹ Jennifer Ehrle Macomber, Gina Adams, and Kathryn Tout, *Who's Caring for Our Youngest Children? Child Care Patterns of Infants and Toddlers*, Urban Institute, 2001, <http://www.urban.org/url.cfm?ID=310029>. Sixty-five percent of infants and toddlers living in poverty and 72 percent of infants and toddlers living between 100 percent and 200 percent of the federal poverty level with employed mothers have a regular, nonparental care arrangement.

⁴⁰ Carol Horton, *Protective Factors Literature Review: Early Care and Education Programs and the Prevention of Child Abuse and Neglect*, Center for the Study of Social Policy, 2003, 7, <http://www.cssp.org/uploadFiles/horton.pdf>.

⁴¹ National Women’s Law Center calculations based on data from the U.S. Office of Head Start on number of enrolled children in 2006 and Census Bureau data on children in poverty by single year of age in 2006.

⁴² Head Start Program Performance Standards, 45 CFR 1304.20(b)(c), http://www.access.gpo.gov/nara/cfr/waisidx_06/45cfr1304_06.html. For more information, see also Rachel Schumacher, *Promoting the Health of Poor Preschool Children: What Do Federal Head Start Performance Standards Require?* Center for Law and Social Policy, 2003, http://www.clasp.org/publications/HS_health.pdf.

⁴³ CLASP analysis of 2006 Head Start PIR data.

⁴⁴ The Centers for Disease Control and Prevention administers the National Immunization Survey, which examines vaccinations received by children aged 19-35 months. The reported recommended vaccination rates are for the five vaccine series known as the 4:3:1:3:3 combined series. Rates reported here are for July 2005 – June 2006, to more accurately match the Head Start 2006 program year. *Vaccines and Immunizations, Statistics and Surveillance*, http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_0506.htm.

⁴⁵ Head Start Program Performance Standards, 45 CFR 1304.40(1)(b), http://www.access.gpo.gov/nara/cfr/waisidx_06/45cfr1304_06.html. For more information, see Rachel Schumacher, *Family Support and Parent Involvement in Head Start: What Do Head Start Program Performance Standards Require?* Center for Law and Social Policy, http://www.clasp.org/publications/HS_fam_supp.pdf.

⁴⁶ *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start*, U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation, 2002, <http://www.mathematica-mpr.com/publications/pdfs/ehsfinalsumm.pdf>.

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⁴⁸ Strengthening Families Through Early Care and Education Web site, “About Strengthening Families,” <http://www.strengtheningfamilies.net/index.php/about>.

⁴⁹ Strengthening Families Through Early Care and Education Web site, “Electronic Library: Evidence,” http://www.strengtheningfamilies.net/index.php/main_pages/electronic_library/category/evidence/.

⁵⁰ *Healthy Child Care Washington: Evaluation Report, April 2006 – March 2007*, prepared for the Washington State Department of Health, 2007, 29, <http://www.healthychildcare-wa.org/DOH%20HCCW%202007%20EOY%20Report%20FINAL%2008-30-07.pdf>.

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⁵⁶ See *A Vision for the Reauthorization of Child Care*, <http://www.nwlc.org/pdf/ChildCareReauthorizationVision.pdf>, 2008, and NACCRRA, *We Can Do Better*.

⁵⁷ U.S. Department of Health and Human Services, Child Care Bureau, FFY 2007 CCDF Data Tables (Preliminary Estimates), http://www.acf.hhs.gov/programs/ccb/data/ccdf_data/07acf800_preliminary/list.htm. See also Hannah Matthews, *Child Care and Development Block Grant Participation in 2007*, 2008, http://clasp.org/publications/ccdbgparticipation_2007.pdf.