Promote Access to Comprehensive Services

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About this Project

CLASP's *Charting Progress for Babies in Child Care* project highlights state policies that support the healthy growth and development of infants and toddlers in child care settings, and provides online resources to help states implement these policies. The foundation of the project is a policy framework comprised of four key principles describing what babies and toddlers in child care need and 15 recommendations for states to move forward. The project seeks to provide information that links research and policy to help states make the best decisions for infants and toddlers.

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By Elizabeth Hoffmann[1]

Very young children develop in the context of their physical and mental health and the capacity of their families and other caregivers to address the full range of early childhood development. All babies and toddlers in child care need parents, providers, and caregivers supported by and linked to community resources. To support this goal, CLASP recommends that states 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.

This document presents research supporting the recommendation to promote access to comprehensive services. Visit www.clasp.org/babiesinchildcare for materials related to this recommendation, including ideas for how state child care licensing, subsidy, and quality enhancement policies can move toward this recommendation; state examples; and online resources for state policymakers.

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.[2] 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.[3] 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.[4]

Demographics and family and environmental risk factors can put babies at risk for unhealthy development.[5] The first three years of life are a critical time of growth and development. Examples of risk factors include: low birth weight,[6] food insecurity,[7] maternal depression,[8] child abuse or neglect,[9] and environmental hazards.[10] 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.[11] 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.[12] 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.[13] 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.[14]

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.[15] 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).[16] 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.[17] 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.[18]

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.[19] 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.[20] (Multiple preventive visits per year are recommended for very young children by the American Academy of Pediatrics,[21] 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

From Helene Stebbins and Jane Knitzer, *Improving the Odds for Young Children Project,* National Center on Children in Poverty

"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."[22]

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 year[43]—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]

Visit www.clasp.org/babiesinchildcare for dynamically updated information related to this recommendation, including:

- **Policy Ideas** that states can use to move toward this recommendation
- **State Examples** profiling initiatives of policies under this recommendation
- **Online Resources** for state policymakers

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