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ABSTRACT

This document represents the first phase of Maryland's comprehensive child development plan. It includes: (1) statistical information on Maryland's children and their families, including population and demographic trends, income, health and social services and out-of-home care programs, (2) a definition of comprehensive child care and child development and the identification of services required to meet that definition, (3) a description of the legal base through which public programs and services are provided for young children and their families, (4) a review of licensing statutes and regulations for out-of-home child care, with recommendations for an improved system, (5) information and recommendations major child development programs and services including group and family day care, health and social services, educational programs, nutrition and child abuse, (6) priorities expressed by the county 4-C Councils and the Baltimore City 4-C Council, (7) the amount and source of Federal grants-in-aid for children's services and their allocation by program and political subdivision, (8) a discussion of the status of training for child care, child development and early childhood education personnel, (9) the volume, nature and scope of the child development services provided by voluntary agencies and hospitals, (10) an annotated list of major studies pertaining to Maryland's children, (11) major recommendations for an interagency structure with parent and citizen participation, and a statewide network for coordinating comprehensive child development services. (GO)

A Maryland State Plan For Coordinated Child Development Services

MARYLAND 4-C COMMITTEE, INC., Community Coordinated Child Care

A MARYLAND STATE PLAN
FOR
COORDINATED CHILD DEVELOPMENT SERVICES

An Appalachian Regional Commission Project
prepared for the Maryland Department
of Employment and Social Services
by the Maryland 4-C Committee, Inc.,
1974

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Urie Bronfenbrenner, *Two Worlds of Childhood: U.S. and U.S.S.R.*, p. 1, © 1970 by Russell Sage Foundation.

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Preface

In the fall of 1970, the Appalachian Regional Commission, a Federal Agency, initiated a Child Development Program and addressed itself to "programs to enhance the physical and mental well being of and provide for the full development of the children of the Appalachian Region."[1] This program illustrates the increasing investment of the Appalachian Regional Commission in the development of human resources. Maryland was eligible to participate in the program because three of its counties, Allegany, Garrett and Washington, fall within the large area encompassing parts of 13 states designated as the Appalachian Region.

The Child Development Program of the Commission has particular significance and relationship to the program of the Maryland 4-C Committee in that both agencies subscribe to the need for interagency coordination of children's services. Full recognition is given by both agencies that the needs of children do not fit neatly into the service role of separate agencies such as Health, Education and Social Services. The result has been that comprehensive child development services have not been made readily available. Though funds are a prerequisite for the provision of services, the essential failure to date impinges on the organizational structure of the service delivery system.

The Appalachian Regional Commission Child Development Program also meshes with other basic premises held by the 4-C:

- A respect for the expertise and the programs of the specialized state agencies;
- A respect for the unique resources and priorities of individual communities;
- The need for a process in which cooperation - interagency, state and local - is clearly seen as beneficial to each participating agency and community;
- The importance of high quality services for children;
- The need to provide fully integrated services for children and their families.

[1] Dr. Irving Lazar, "Organizing Child Development Programs," *Appalachia*, January 1970

There are two parts to the Appalachian Regional Commission Child Development Program:

- Grants to assist states in planning statewide child development programs.
- Grants to assist states in the operation of child development projects within the portion of the state designated as Appalachia.

Maryland elected to participate in both aspects of this program through the Department of Employment and Social Services by an Executive Order of May 14, 1971. Child Development Projects under this source of funding are now in operation in Allegany, Garrett, and Washington Counties through subcontracts with the Department. Additionally, a subcontract was awarded to the Maryland 4-C Committee in April 1973 to initiate the design of a Statewide Comprehensive Child Development Plan. This report is devoted to that endeavor. It is addressed to children, prenatal to age six, and their families, in conformance with the guidelines established by the Appalachian Regional Commission. Its thrust is preventive rather than remedial. It rests on the premise that early deficiencies in nutrition, health care, and child rearing produce problems that are difficult and expensive to reverse in later years.

It is recognized that this report is a beginning step toward the objective of providing Maryland's young children with the opportunities to realize their full potential. For the Maryland 4-C Committee, the preparation of the report proved, surprisingly, to be an adventure into the unknown. During the course of 10 months, the Committee uncovered much of a positive nature that is taking place in Maryland for the benefit of its children. Conversely, there were many findings that display an urgent need for better communication, cooperation and coordination, the framework within which sound planning can take place.

The Maryland 4-C Committee believes that it has perfected and set into motion a planning process which is capable of moving forward to achieve the goals it shares for children with the Appalachian Regional Commission. The planning process stresses the involvement of all organizations and individuals concerned with the well-being of young children as the most hopeful avenue in achieving an integrated, coordinated child development program.

Hundreds of Marylanders participated directly in the preparation of the plan. Appreciation on behalf of all participants is expressed to the Department of Employment and Social Services for this opportunity. Individually and collectively, the project evolved into a meaningful educational tool which brought about a much broader understanding of the need for the integration of all the components intrinsic in comprehensive services to young children and their families.

Marjorie D. Teitelbaum,
Project Director

Introduction

The Maryland 4-C Committee—its purpose, structure and program.

The establishment of the Maryland 4-C (Community Coordinated Child Care) Committee, Inc. in 1969 represents the culmination of efforts by public and private agencies as well as by citizens who recognized the urgent need for better coordination of child development programs in Maryland.

The Maryland 4-C Committee is a quasi-governmental agency committed to the orderly expansion and coordination of comprehensive programs of child care, child development and early childhood education embracing *all* of Maryland's children. Starting with an original budget of $9,000 and a skeletal staff, the Maryland 4-C Committee was granted *full recognition* by the Federal Regional Office of the Department of Health, Education, and Welfare on April 10, 1973.

Special attention has been directed to developing a coordinating structure with a three-part base consisting of (1) government professionals who plan, provide, fund and regulate services; (2) private professionals who plan and provide private sector services; and (3) parents, the consumers of children's services. As an *interagency* and *multidisciplinary* body, the 4-C policy-making board has representation from the following agencies, which, in part, have provided its funding: the Department of Employment and Social Services, the Department of Education, the Department of Health and Mental Hygiene and Model Cities of Baltimore. In addition, there is representation from the Department of Economic and Community Development, the Department of State Planning as well as from institutions of higher education among others.

Across the State, the 4-C has endeavored to mobilize the active interest of public, voluntary and civic groups concerned with services for children. Representatives from this broad constituency serve on the 200-member 4-C Advisory Council. These groups, comprising several thousand people, are kept abreast of child care and child development activities on the local, State and Federal levels by means of a newsletter, *The Maryland 4-C News*. In addition, an Annual Spring Meeting attracting statewide attendance is held.

Recognizing the importance of the local community in planning and coordinating functions, the Maryland 4-C Committee has organized local 4-C councils in 14 of the 24 political subdivisions of the State. A map indicating

their locations is included in the Appendices. Since its founding, the Maryland 4-C Committee has viewed the local community's assessment of needs and priorities as a critical factor in the improvement of the design and delivery of children's services. The work of the Montgomery County 4-C Council, which is Maryland's only funded local 4-C, has received wide attention.

Another important phase of the 4-C program is concerned with staff training at all levels in the field of child care, child development and early childhood education. On the premise that the effectiveness of services for children requires appropriately trained personnel, the 4-C has given sustained attention to the coordination and expansion of training programs. In the course of this activity, the 4-C was designated as a resource to the community colleges in the State for curriculum organization for child development and early childhood education and has published the manual, *Training for Child Care: Suggested Content for Minimum Training Requirements*, which is used statewide in the training of day care center staff. In conjunction with this publication, the Maryland 4-C served as the coordinating structure for an interagency Manpower Development Training Act project that provided 64 hours of classroom training in early childhood education to over 700 child care workers in Maryland.

The preparation of this State Plan is the most recent program activity of the 4-C. In April 1973, the Department of Employment and Social Services subcontracted with the Maryland 4-C Committee to develop a statewide comprehensive child development plan, with planning grant funds for child development planning the Department had received from the Appalachian Regional Commission. As a basis for local and State planning for this project, the Maryland 4-C Committee compiled statistics on Maryland's children and their families in the fall of 1973, which are presented in Chapter V. These data cover a wide range of components, including family composition, prenatal care, health, social services, education, adoption, foster care, etc.

As work moved forward on this State Plan spanning a period of 10 months, the 4-C Committee received the assistance of the three State agencies providing services to young children, keeping in mind the joint statement made by the chiefs of these departments (Departments of Education, Health, and Social Services) on July 7, 1969:

> We, the undersigned, agree to design and initiate a program of community coordinated child care in Maryland . . .
> We agree to work together to develop mutually satisfying plans of care for differing populations of children: to obtain estimates of real need in order that all children will be served: to set up working committees to study, recommend, and take cooperative action in the areas of training, program, research, facilities development and administration: and to encourage and assist local 4-C organizations.

This document represents a continuation of these mutual commitments.

Acknowledgments

Many persons, agencies, institutions and organizations have given their assistance and cooperation in the preparation of this Plan.

We acknowledge, first, our appreciation to the Maryland State Departments of Employment and Social Services, Education, and Health and Mental Hygiene, without whose cooperation this report would not have been possible. Our appreciation is due, as well, to the Department of State Planning, the Regional Planning Council, the Department of Legislative Reference, the Department of Economic and Community Development and the Health and Welfare Council of Central Maryland, Inc.

In addition, we also thank the many institutions of higher education, voluntary agencies and hospitals for their responses to our survey forms.

We are indebted particularly to the County 4-C Councils and to the Baltimore City public agency planning group for their assessment of needs and priorities. Through the planning process spanning many weeks, this latter group spearheaded the formation of the Baltimore City 4-C Council which is already at work on priorities identified as meriting prime attention. Acknowledgment is made, also, of the assistance given by many members of the statewide 4-C Advisory Council composed of some 200 persons.

Special appreciation is expressed to Marjorie D. Teitelbaum, Executive Director of the Maryland 4-C Committee, for her leadership and untiring efforts as the Project Director of this endeavor. We are very much indebted to Dr. John A. Owens, Vice President, for his perceptive guidance and contributions throughout this project.

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The Maryland 4-C Committee, Inc.

Chapter I

Population and Deployment of Service Providers

MARYLAND'S POPULATION CHARACTERISTICS*

The State Plan as a resource for planning based on population statistics.

For more than twenty years Maryland has been among the fastest growing states in the nation. By 1970 Maryland had risen to a position of the 18th largest state in the nation. The rate of population increase for the State during the period from 1950 to 1970 was approximately twice that of the nation as a whole.

The major growth regions in the State in terms of absolute numbers were the Washington Suburban and Baltimore Regions as shown in Table 1. (See Map 1 for a delineation of regions in Maryland.) On the basis of percentage population growth, however, the Washington Suburban Region has been the most rapidly developing area. The Southern Maryland Region also has shown relatively high percentage increases in population, reflecting the region's location on the periphery of Washington, D.C. The Frederick Region can be classified as having a moderate population growth rate, while the Western Maryland and Upper and Lower Eastern Shore Regions fall into a low growth category.

Anne Arundel, Calvert, Carroll, Charles, Harford, Howard, Montgomery and Prince George's Counties grew faster than the State average, each experiencing over a 30 percent increase. All of these counties are within the sphere of influence of metropolitan areas and therefore subject to the impact of suburban growth. Baltimore, Cecil, Frederick, Queen Anne's, St. Mary's, Washington, and Wicomico Counties gained between 10 and 30 percent

*Abstracted from *Maryland Population and Housing Statistics 1970 Census*, Maryland Department of State Planning, August 1971.

TABLE 1
Population Change in Maryland by Region, 1950-1970

Region	Population			Percent Change	
	1950	1960	1970	1950-1960	1960-1970
Western Maryland	189,701	195,808	209,349	3.2	6.9
Frederick	62,287	71,930	84,927	15.5	18.1
Baltimore	1,457,181	1,803,745	2,070,670	23.8	14.8
Washington Suburban	358,583	698,323	1,183,376	94.7	69.5
Southern Maryland	64,626	87,313	115,748	35.1	32.6
Upper Eastern Shore	99,274	121,498	131,322	22.4	8.1
Lower Eastern Shore	111,349	122,072	127,007	9.6	4.0
State Total	2,343,001	3,100,689	3,922,399	32.3	26.5

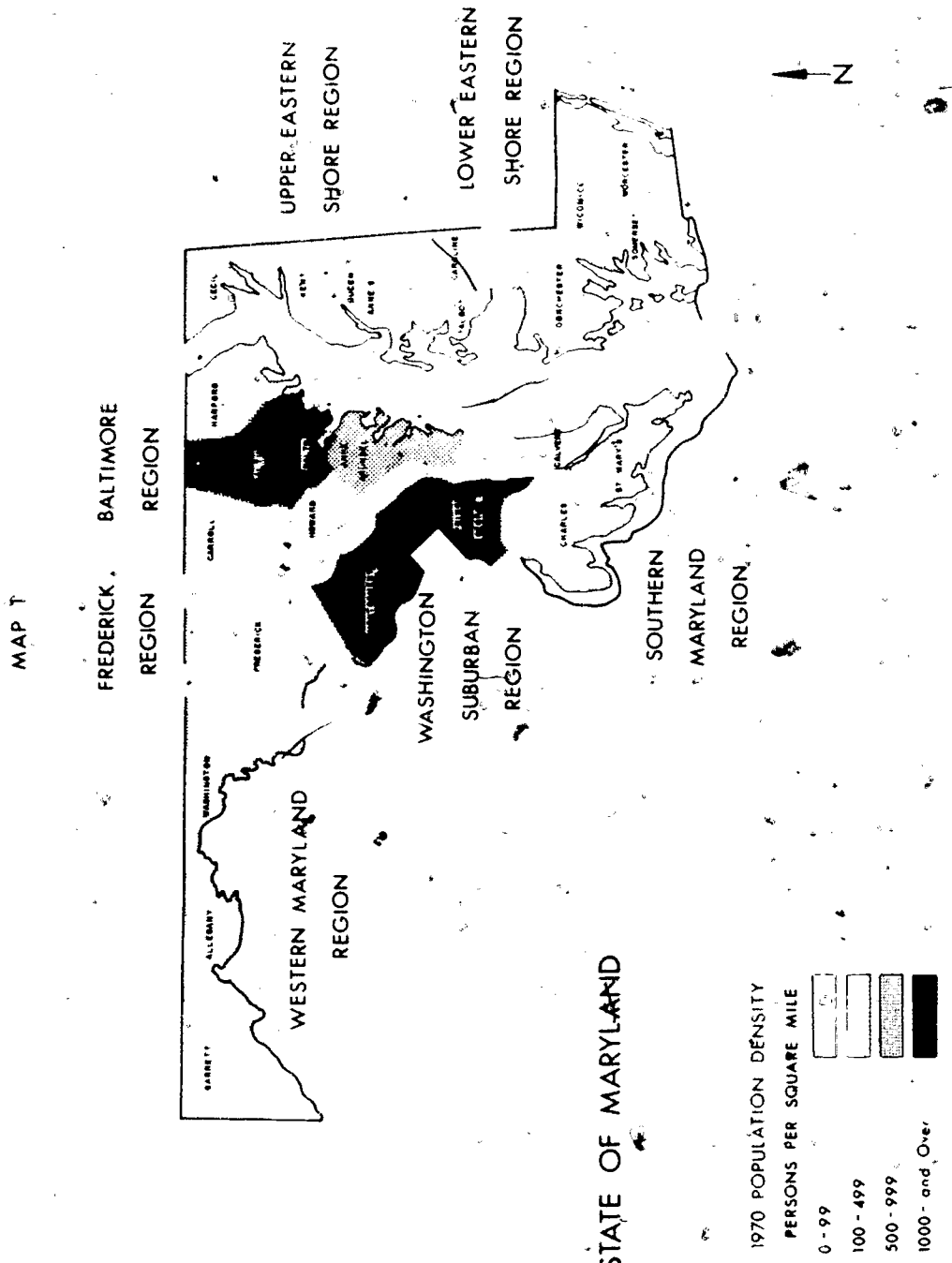
during the same period. Caroline, Garrett, Kent, Talbot and Worcester Counties each had a population gain of less than 10 percent during the decade. Three counties lost population, namely, Allegany, Dorchester and Somerset Counties.

Baltimore City lost population during both the 1950s and 1960s with a reported total population decline of 3.5 percent (33,625 persons) between 1960 and 1970. Such population losses have been common to many large cities owing to out-migration of white city residents to the suburbs in increasing numbers, a trend which has tended to outpace both natural population increases and in-migration. If the trend continues into the present decade, it will exercise an increasingly important influence on the city's future.

TABLE 2
Urban Population in Maryland by Region, 1950, 1960 and 1970

Region	1950		1960		1970	
	Urban Population	Percent of Total	Urban Population	Percent of Total	Urban Population	Percent of Total
Western Maryland	84,227	44.4	88,643	42.3	86,096	41.1
Frederick	21,925	35.2	25,299	35.2	27,207	32.0
Baltimore	1,199,260	82.3	1,490,183	82.6	1,744,574	84.3
Washington Suburban	264,993	73.9	591,330	84.7	1,075,152	90.9
Southern Maryland	0	0.0	7,039	8.1	16,504	14.3
Upper Eastern Shore	20,351	20.5	15,928	13.1	20,904	15.9
Lower Eastern Shore	32,403	29.1	35,410	29.0	33,498	26.4
State Total	1,616,671	69.0	2,253,832	72.7	3,003,935	76.6
United States	96,160,515	64.0	124,714,055	69.9	149,335,000	73.5

MAP 1


N
UPPER EASTERN SHORE REGION
LOWER EASTERN SHORE REGION
BALTIMORE REGION
FREDERICK REGION
WASHINGTON SUBURBAN REGION
SOUTHERN MARYLAND REGION
WESTERN MARYLAND REGION
STATE OF MARYLAND
1970 POPULATION DENSITY
PERSONS PER SQUARE MILE
0 - 99
100 - 499
500 - 999
1000 - and Over

The greatest share of the urban population is concentrated in the Baltimore-Washington Corridor, which comprises a substantial portion of both the Baltimore and Washington Suburban Regions. The two regions have gained an increasingly larger share of the State's total population over the past two decades, as is clearly indicated by the fact that 83 percent of the State's population resided in the Baltimore and Washington Suburban Regions in 1970 as compared to 77.5 percent in 1950. This increased population concentration will likely accentuate the numerous problems associated with urban and suburban living.

Garrett County, the westernmost county in the State, had the lowest population density in 1970 with 32.5 persons per square mile, while Dorchester, Queen Anne's and Worcester Counties on the Eastern Shore each had approximately 50 persons per square mile. Wicomico County, with a population density of 142.5 persons per square mile, is an exception to the rule, an anomaly explained by the dominance of Salisbury as a regional trade center for the southern Eastern Shore.

STATE DEMOGRAPHIC TRENDS

Major demographic trends taking place in Maryland are: (1) the rural to urban movement of population, (2) the shift of population, particularly white, from central cities to the suburban periphery, (3) the relative growth of the non-white urban population and (4) the increase in number of places of medium size (5,000 to 25,000 persons). Certain changes in the population structure can be identified as well, e.g., the decline in fertility rates during recent years and the importance of migration as factors in determining the age-sex structure of an area's population.

Rural Area Out-Migration

The outlying regions of the State, Western Maryland and the Upper and Lower Eastern Shore Regions, experienced net out-migration from 1960 to 1970. The amount of net out-migration from these regions was neither large in size nor necessarily representative of all counties within the region. For example, a net out-migration of 6,108 persons from Allegany and Garrett Counties from 1960 to 1970 was offset partially by a net in-migration of 3,871 persons during the same period in Washington County. Likewise, Queen Anne's, Talbot and Wicomico Counties on the Eastern Shore experienced net in-migration, although all other Eastern Shore counties showed a net out-migration.

There appears to be an unmistakable racial pattern in the Southern Maryland and Lower Eastern Shore Regions which experienced a net in-migration of white persons and a net out-migration of non-white persons (Table 3). This is explained at least in part by the residential preferences and

retirement plans of white persons seeking amenities in these two regions, on the one hand, and the lack of employment opportunities for the resident non-white population, on the other.

TABLE 3
Net Migration by Racial Grouping and Region, 1960-1970

Region	Net Migration 1960-1970		
	Total	White	Non-white
Western Maryland	−2,237	−2,237	*
Frederick	5,004	5,004	*
Baltimore	52,378	17,922	34,456
Washington Suburban	327,545	258,971	68,574
Southern Maryland	7,320	9,294	−1,974
Upper Eastern Shore	−2,734	−1,332	−1,402
Lower Eastern Shore	−2,604	2,040	−4,644
State Total	384,672	289,921	94,751*

*Exact data not available for counties with less than ten percent non white population.

Urbanization and Suburbanization

In terms of absolute population increase, the Baltimore and Washington Suburban Regions were the major growth areas in the State from 1960 to 1970. A significant feature of suburban growth in both regions has been an increase in the number of places in certain population size ranges. In the Baltimore Region, for example, the number of towns with a population size ranging between 5,000 and 10,000 persons increased from three in 1960 to seventeen in 1970. The number of places in the State with populations of 25,000 to 50,000 increased from three to seven through the addition of Annapolis, Glen Burnie, Pikesville and the Woodlawn-Woodmoor area. In the Washington Suburban Region, the number of small urban places ranging in size from 5,000 to 10,000 persons increased from six in 1960 to thirty-three in 1970. In addition, the number of places in the 10,000 to 25,000 category expanded from five to nineteen during the same period.

The growth of numerous population clusters on the urban periphery gives rise to many problems. Increased demands are placed on public facilities and services.

A second component of suburbanization can be derived from an examination of net migration patterns in the Baltimore and Washington Suburban Regions. The metropolitan cities of each region, Baltimore and Washington, D.C., each experienced a net out-migration of over 130,000 white persons from 1960 to 1970 and net in-migration of over 30,000 non-whites. By contrast, the counties in the Baltimore Region all sustained significant amounts of net in-migration. Similarly, over 65 percent of the

population growth in the Washington Suburban Region from 1960 to 1970 resulted from net in-migration.

Suburban area net in-migration has been predominantly white. Non-white net in-migration comprised only 1.6 percent of total net in-migration in the counties of the Baltimore Region and 20.9 percent of net in-migration in the Washington Suburban Region. The higher proportion of non-white immigrants in the latter region is at least partially a result of employment opportunities in the Federal Government.

Age-Sex Structure of the Population

Census data on age, sex and race are essential in assessing the needs of Maryland's residents and in the formulation of forward-looking programs required to meet those needs. Each age group places different demands on our social system.

The presence or absence of young adults in the childbearing years has an effect on the number of births and therefore the number of children in a region. Where there are few young adults, there is the likelihood that the number of young children in the population will also be proportionately small. This has been the experience in some regions of Maryland, particularly the Western Maryland and Lower Eastern Shore Regions. Even in areas with many young adults, a change in the age structure of the population is occurring as the result of a lower birth rate. The average Maryland family is becoming slightly smaller, decreasing from 3.74 persons per family in 1960 to an average of 3.64 persons per family in 1970. Not only is the typical American family smaller than in the past, but its age distribution also differs. Compared with 1950, today's family has fewer children under 5 years old and more over 16 years. The average age of parents with young children is slightly higher than their counterparts of 20 years ago and smaller families are being planned by today's young couples.

Table 4 shows the population 0 to age 6 as a percent of the total population by county – 1960 and 1970. One of the most striking features of population growth from 1960 to 1970 was the decline in the general fertility rate, or number of births to women of childbearing age. For the State as a whole, the general fertility rate dropped from 119 to 81 births per thousand women of childbearing age between 1960 and 1970. A considerable difference existed between general fertility rates for the white population and those for the non-white population in 1960 (Table 5). While the non-white general fertility rate was still higher than that for the white population in 1970, the gap between the two lessened significantly from a difference of 44 births per thousand females of childbearing age in 1960 to 23 births in 1970.

There are a number of reasons for the declining fertility rate. Perhaps the most significant is the now widely accepted practice of birth control.

The decline in the fertility rate will have an impact on government programs and decisions nationally as well as in Maryland. As a specific example, there were 344,573 children in the State under 5 years of age in 1970, 21,947 less than in 1960. A decline in the number of young children in Maryland is related clearly to the fact that there were 8,160 fewer births in Maryland in 1970 than in 1960. Only five counties had a greater number of births in 1970. Of these five counties, Prince George's County, the most rapidly growing county in the State, was the only one with an appreciable increase in number of births (3,765 births).

Racial Distribution of Population

The proportion of non-whites in Maryland's population has gradually risen from 16.6 percent of the total population in 1950 to 18.6 percent of

TABLE 4
Population 0-6 As Percent of Total Population, by County
1960 and 1970

	1960			1970		
	0-6	Total Population	0-6 as % of Total Population	0-6	Total Population	0-6 as % of Total Population
Maryland	505,324	3,100,699	16.3	504,256	3,922,399	12.8
Baltimore City	140,117	939,024	14.9	111,055	905,759	12.3
The Counties:						
Allegany	11,013	84,169	13.1	9,200	84,044	10.9
Anne Arundel	35,321	206,634	17.1	38,936	297,539	13.1
Baltimore	84,617	492,428	17.2	72,370	621,077	11.7
Calvert	3,163	15,826	20.0	3,195	20,682	15.4
Caroline	2,868	19,462	14.7	2,333	19,781	11.8
Carroll	7,125	52,785	13.5	8,225	69,006	11.9
Cecil	8,273	48,408	17.1	7,430	53,291	13.9
Charles	6,612	32,572	20.3	8,268	47,678	17.3
Dorchester	3,980	29,666	13.4	3,285	29,405	11.2
Frederick	10,624	71,930	14.8	10,747	84,927	12.7
Garrett	3,064	20,420	15.0	2,804	21,476	13.1
Harford	13,217	76,722	17.2	16,387	115,378	14.2
Howard	6,386	36,152	17.1	8,625	61,911	13.9
Kent	2,241	15,481	14.5	1,762	16,146	10.9
Montgomery	60,111	340,928	17.6	64,108	522,809	12.3
Prince George's	66,451	357,395	18.6	99,409	660,567	15.1
Queen Anne's	2,551	16,569	15.4	2,075	18,422	11.3
St. Mary's	8,060	38,915	20.7	7,919	47,388	16.7
Somerset	2,704	19,623	13.8	2,031	18,924	10.7
Talbot	3,081	21,578	14.3	2,447	23,682	10.3
Washington	12,828	91,219	14.1	12,557	103,829	12.1
Wicomico	7,482	49,050	15.3	6,084	54,236	11.2
Worcester	3,635	23,733	15.3	2,914	24,442	11.9

Source: Research Division, Department of State Planning.

the total in 1970. The 1970 non-white population was enumerated at 729,378 persons, of which 96 percent were Negroes (Table 6).

The white population in Maryland increased by 24.1 percent from 1960 to 1970. The Negro population in Maryland increased by 35.3 percent from 1960 to 1970.

The Baltimore Region had the largest number of non-whites in the 1970 Census. Of the 501,571 non-whites in the region, 97.7 percent were Negro and 2.3 percent were of other racial backgrounds (Table 7). Most of these non-whites live in Baltimore City, which has 59 percent of the State's non-white population. The Washington Suburban Region had the next largest number of non-whites with 128,001; in this region many more non-whites belong to races other than Negro than in the other regions of Maryland.

GEOGRAPHICAL AND DEMOGRAPHIC DEPLOYMENT OF MANPOWER AND SERVICE PROVIDERS IN RELATIONSHIP TO NEED

The State Plan as a description of differential needs for services.

While in area Maryland is a small State, her geography is remarkably varied. Two geographical barriers, the Chesapeake Bay and the Appalachian Mountain range, historically have rendered areas of the State remote and not easily accessible to State Government. Until the advent of the Bay Bridge and of interstate highways, these areas organized with remarkable autonomy, developing their own standards and services independently of central State planning. Local resources, both professional and financial, often have been critical restraints; but, nevertheless, programs have developed.

A third area of Maryland also has been neglected at the State level because of its unusual location. This area is the section of Southern Maryland on the western shore of the Bay. While metropolitan Washington, D.C. provides the natural center for urban service resources, it cannot provide governmental plans or resources for this section of Southern Maryland. Therefore, Western Maryland, the Eastern Shore, and the Southern Maryland sections have been and continue to be areas with gaps in services, restricted influence in governmental planning and priority setting and autonomous local government structures.

Demographically, Maryland again presents a heterogeneous situation. As suggested above, any time an area lies close to a metropolitan center and in another political jurisdiction, problems in service deployment occur. Private services can be purchased from metropolitan vendors despite the jurisdictional change. Public services, however, do not flow readily across the

TABLE 5
General Fertility Rates by Racial Grouping and Region — 1960 and 1970

Region	General Fertility Rates (Number of births per thousand women of childbearing age)					
	1960			1970		
	Total	White	Non-white	Total	White	Non-white
Western Maryland	102	102	101	83	83	67
Frederick	110	105	171	85	83	105
Baltimore	117	107	152	79	73	95
Washington Suburban	122	120	157	81	78	108
Southern Maryland	169	153	213	116	110	133
Upper Eastern Shore	121	116	149	89	85	105
Lower Eastern Shore	113	94	157	130	137	112
State Total	119	111	155	81	77	[illegible]

TABLE 6
Maryland Population by Racial Grouping, 1950, 1960 and 1970

	1950		1960		1970	
	Number	Percent	Number	Percent	Number	Percent
White	1,954,975	83.4	2,573,919	83.0	3,193,021	81.4
Negro	385,972	16.5	518,410	16.7	701,341	17.9
Other races	2,054	.1	8,360	.3	28,032	.7
State Total	2,343,001	100.0	3,100,689	100.0	3,922,399	100.0

TABLE 7
Population by Race, by Region, 1970

Region	Total	White	Negro	Other Races	Percent Non-white
Western Maryland	209,349	203,855	5,099	395	2.6
Frederick	84,927	78,800	5,931	196	7.2
Baltimore	2,070,670	1,569,099	490,224	11,347	24.2
Washington Suburban	1,183,376	1,055,375	113,394	14,607	10.8
Southern Maryland	115,748	85,298	29,516	934	26.3
Upper Eastern Shore	131,322	109,490	21,449	383	16.6
Lower Eastern Shore	127,007	91,104	35,728	175	28.3
State Total	3,922,399	3,193,021	701,341	28,032	18.6

jurisdictional boundaries. Those who can afford to purchase services frequently fail to comprehend why economically disadvantaged in such areas complain about deficient services, or why government officials should engage in vigorous efforts with State planning officials for additional services. Maryland's geography sets up several such situations, each identified by the major city which serves the private sector:

1. Washington, D.C.
2. Wilmington, Delaware
3. Morgantown, West Virginia
4. Pittsburgh, Pennsylvania

Maryland contains only one large city, Baltimore. This densely populated city headquarters most State planning and implementation functions, concentrating State professional resources in and around Baltimore City. The city itself is a major provider of human services and has nurtured a large network of multidisciplinary persons. The concentration of professional resources in Baltimore is further enhanced by numerous professional schools including The Johns Hopkins School of Medicine, the University of Maryland School of Social Work and Community Planning, University of Maryland School of Dentistry, University of Maryland School of Medicine, etc. Therefore, within Baltimore City there is available a network of wide ranging, sophisticated services. This does not mean that the City residents are served adequately. The development of centers of highly sophisticated professionals has tended to foster a situation where difficult problems can be solved quickly and easily but where simple problems often are difficult to resolve. Baltimore's service configuration appears to be strongest at the point of the child with serious problems and weakest at the point of insuring optimal developmental life experiences.

While Baltimore is Maryland's only large city, the areas around Washington, D.C. have developed large urban populations with unique and interesting demographic qualities. Montgomery County, credited with being the country's wealthiest county, provides a major residential community for Federal employees and other affluent persons who work in the District. Montgomery County, having a wealth of resources, has been deploying a network of service programs which sufficiently exceed State plans and guidelines as to allow the County to develop with remarkable autonomy. Prince George's County, the other major Maryland county contiguous to the District, has attracted considerably less affluent residents than Montgomery County and has major difficulties in maintaining an acceptable balance between deployment of services and population increases.

Still another urban development of an unfolding nature is the new town of Columbia, located between Baltimore and Washington in previously rural Howard County. Within Columbia a high priority has been claimed for the

development of human services, financed, created, and administered along different lines. For example, the city has a network of child development and day care services partially funded by a city assessment. Other interesting services include the prepaid medical plan, the Columbia Parks, the recreation programs, and the student summer employment program. Columbia's strengths and problems should be carefully illumined in planning for human services.

The majority of Maryland is still dominated by a rural pattern of organization. The major services for children in rural areas tend to be provided by the private physicians and public health and by the public school. Special services tend to be coordinated by the physician in preschool years and by the school thereafter. Because developmental screening and diagnostic services are frequently minimal in rural areas, there is a tendency for under-identification of nonphysical problems. Typical deficiencies in treatment resources further reduce efforts toward early identification of problems. As opposed to metropolitan areas, sophisticated multidisciplinary resources tend to be minimal in rural areas. Especially acute are psychological services and social intervention therapy services to families.

It is hard to imagine a small state having regions with more diverse groups, geography, professional resources, economic dynamics, racial dynamics, and social values. Maryland in many ways comprises a remarkable microcosm of the United States values. When viewed in this way, our efforts at planning, integrating services, deploying resources more equitably take on broader dimensions.

Chapter II

Goals, Process, Definition of Child Development and Service Components

A STATEMENT OF GOALS

The State Plan as an initial statement of essential concepts and components in planning child development services and programs.

When there is a discrepancy between what "is" and what "ought to be," there is by definition a "problem." When people agree that a significant discrepancy exists that should not exist, their most obvious recourse is to organize to eliminate the discrepancy. Most major problems are sufficiently large so that no single individual can solve the problem. A group process, therefore, is indicated if planning is to have any degree of realism. Following the identification and general description of the problem, there is need for a statement about the nature and breadth of the group's purpose and goals.

The 4-C is committed to the full elimination of the discrepancy between what the developmental experiences of children frequently are and what these experiences should be. It is committed to providing the organizational framework for the coordination of child development programs for Maryland's children.

The goal in the development of a comprehensive plan is to make possible an environment in which each child has the maximum opportunity and support in developing his full potential. This requires that present and future programs be committed to the well-being of the *whole child* –physical, psychological and social–and to the well-being of the family and community. Therefore, it is essential that the needs and resources of parents and the community be an integral part of the planning and proposed implementation of a comprehensive State plan.

The report which follows reflects the interaction of members of the Maryland 4-C Committee, the 13 county 4-C Councils and the newly

organized Baltimore City 4-C Council. All of these structures are composed of interagency, multidisciplinary personnel representing health, education and social services, parents who have children enrolled in child development programs, interested citizens, and representatives of professional groups. All subscribe to the following *Statement of Goals*:

A. All persons should have equal access to developmental services, regardless of their ability to pay or of other circumstances such as geographical location. Systems of payment should be based upon a sliding fee scale from none to full payment.

B. Protection should be insured the individual's rights in regard to human dignity, privacy and confidentiality.

C. Funding sources should provide for each of the following:
   1. A full range of child and family services:
      a. Continuous facilitation of optimal normal physical, psychological and social development.
      b. Earliest possible identification of non-optimal development through a process of periodic screening.
      c. Diagnostic and corrective intervention services for all identified problems.
   2. A full range of manpower trained in human services, including training for upgrading at all levels.
   3. Research into origins of adaptive and non-adaptive behavior and their treatment.
   4. Public education and other population-oriented programs of prevention and sharing.

D. The individual should have freedom of choice among the full range of services and the providers of those services.

E. Consumers as well as providers of services should have the opportunity to participate in the development and in the enhancement of human services delivery systems.

F. Redress for grievances resulting from personal services should be available from review bodies which include both consumers and professionals.

G. The quality and availability of provided services should be evaluated continuously by both consumers and professionals. Research into the efficiency and effectiveness of all parts of the system should be conducted both internally and under independent auspices.

H. Systems providing human services should:
   1. Be responsive to the findings of review bodies, to the results of research, and to the emergence of new concepts of service.
   2. Be designed to achieve effectiveness of purpose.

3. Develop and utilize a process(es) consonant with the Statement of Goals.

I. The planning process and the emergent system should be:

1. Responsive to the needs of various regions and to the diversity of local values and resources.
2. Building consistently toward a statewide network of services offering a continuity of programs for adults as well as for children.
3. Free of discrimination and segregation in all facets—race, sex, economic status, social class, handicap, education, etc.

J. Program operating standards should be developed which:

1. Legally define and sanction the critical minimum program level beneath which no program will be allowed to operate.
2. Provide guidelines that promote multiple, unique service programs of high quality.

K. Paramount consideration should be given to serving the interests of children in order to enable them to develop physically, psychologically and socially in a climate of freedom and dignity. However, services also must be provided to adults if the mission outcome is to be achieved.

Note: In several instances, the individual goals listed above were adapted from a position paper of the American Psychological Association.*

THE PLANNING PROCESS

The planning process by which this document was produced has started to effect motion toward achieving the 4-C Statement of Goals in more than half of the political subdivisions of the State as well as at the State level. The experience of Baltimore City can be used to illustrate this point. Because the City has the largest population of young children, input into the Plan from this subdivision was considered essential. As there was no local 4-C Council, the following strategy was agreed upon.

City public agencies serving children would be asked to send appropriate personnel to a joint planning session convened by the Maryland 4-C Committee. Such a meeting was attended on September 25, 1973 by 20 persons representing the City Departments of Education, Health, Social Services, Planning, Housing and Community Development, Model Cities, etc. There was also parent and citizen representation. People attending this initial

*American Psychological Association: National health insurance position adopted by APA Board of Directors. APA *Monitor*, Vol. 2, Nos. 8 and 9, 1971.

meeting were asked to describe the plans, priorities and programs for children for which they were responsible.

It became evident to those in attendance that the staff providing services within a single agency were not necessarily acquainted with the services, eligibility requirements or plans of other programs or services provided through that same agency. There was even less awareness of the programs, level and source of funding, and service boundaries under the auspices of other agencies. At the same time there was an immediate recognition that one program alone, or even one agency alone, cannot meet the comprehensive needs of young children. The group soon recognized that they shared a number of mutual problems hindering their efforts to deliver quality services to young children. Insufficient staff and under-trained staff, for example, were identified early as general barriers to service delivery.

By consensus of the group, additional planning sessions—seven in all—were held at weekly intervals. On invitation, additional agencies joined the planning sessions. Even in the early weeks, the process of sharing information (communication) led to several cooperative efforts on an interagency basis. For example, the Department of Education extended the use of its grant to train family day care mothers under the Social Services Administration as well as nonpublic day care staff in centers licensed by the Department of Health.

In the seventh meeting, the group gave full expression to the value of these open meetings of sharing which had already effected initial steps toward coordination of programs. By formal action, the group agreed to spearhead the organization of a Baltimore City 4-C Council. Not only has the group taken the initial steps to meet the 4-C guidelines for broad composition by including more parents, voluntary agencies, church groups and private centers, but also it has received the full support of the Mayor.

The unmet needs identified underscore the necessity of interagency communication and cooperation. The public agency planning group began the process: *communication precedes cooperation which, in turn, precedes coordination.*

CHILD DEVELOPMENT—ITS MEANING AND IMPORTANCE

The constancy of a democratic society is dependent upon the extent to which all of its citizens have opportunity for optimum development—physical, emotional, social and intellectual. Concern and provision for child development are an essential first step toward the realization of this goal.

In recent years, medical, social and educational research have underscored repeatedly the critical nature of the early years in relation to development of the individual. Medical research indicates that nutrition during prenatal and early life has far-reaching effects on individual

development. According to social sciences research, the quality of interaction with others during the early years contributes to or impairs development—perhaps for a lifetime. Research has indicated that significant kinds of development occur in the early years. Early childhood, then, is a critical period—a time when important competencies, habits and attitudes are being formed; a time when foundations for a lifetime style of living and learning are established.

The child is a complex organism. His intellectual development, for example, may be far ahead of or lag far behind his social or physical maturity. Yet his growth in one area affects everything he does. The support for growth varies widely among individuals. One child, born with sound physical structure and health, may have the good forture to live with both parents who love him, who are concerned about his welfare and who become informed about resources available to support them in the responsibilities of parenthood. Equally interested, concerned, informed parents may find they have a child whose development will be complicated by problems stemming from birth defects. Another child may have become separated from his parents as a result of death, illness, marked economic stress or similar serious problems; his future becomes clouded with uncertainties.

Opportunity, then, is conditioned by social, economic, scientific, educational and environmental factors. A child and his development must be viewed within the context of his family, his community and the resources inherent in his environment. The magnitude of developmental opportunity for each child can be equal only to the resources and supportive quality of his environment.

A strong, well-conceived and well-coordinated child development program is required to ensure maximum opportunity for optimum development for *all* children. To achieve equalization of opportunity such a program demands that attention be focused upon:

- developmental patterns and needs of children ages 0-6
- prevention rather than remediation
- family structures and related needs
- resources required to support optimum development of children ages 0-6; ability of families and communities to provide those resources; alternatives for provision of required services, avoiding segregation of any kind
- systems for collecting data, identifying needs, allocating resources, coordinating services and avoiding duplication of effort
- assurance of program continuity for children ages 0-6
- involvement of the concerned public—parents, professionals, legislators, representatives of businesses, etc.
- dissemination of information

Well-planned, comprehensive services for young children and their families can do much to promote positive development, to prevent disabilities, to reduce the need for and cost of remedial efforts and to strengthen the productive power of the individual. Neither Maryland nor its children can afford less than a strong child development program.

SERVICE COMPONENTS

The State Plan as an initial identification and definition of service components in a comprehensive child development plan.

A comprehensive program for child development will encompass a wide variety of service components: Two service categories can be used: (1) services currently available that present a comprehensive approach and (2) services that should be available in order to meet the child's total needs. The purpose of this section is to define selected services in the first category. It is not to be considered a comprehensive listing of all services but rather an initial effort to define some of the major services provided to children and their families. The definitions presented are the working definitions used by existing Maryland governmental organization.

Department of Health and Mental Hygiene

Family Planning Services

Family planning services are medically accepted contraceptive and/or sterility care and/or advice to men and women who need and want such services.

Prenatal Care

Prenatal care means the provision of all necessary services to pregnant women to prevent illness in both mother and baby and to treat any illness that occurs. Such services also include delivery services for the mother and at least six weeks postnatal care.

Child Health Services

Child health services include general health supervision, preventive services such as immunization and screening, and the treatment of illness.

Group Day Care Centers

As defined by the Department of Health and Mental Hygiene, group day care centers are agencies or institutions offering or supplying group day care to five or more children who have not the same parentage for a portion or all of a day and on regular schedule more than once a week. Regulatory

and licensing responsibility for group day care centers resides in the State Department of Health and Mental Hygiene. Therefore, the definition is listed here even though group day care centers are operated by a variety of sponsors.

Nutrition Services

Nutrition services are aimed at assuring every child access to adequate kinds and amounts of food provided in an appropriate environment in order to contribute to optimal physical, social and psychological development. Such services include assessment of food provided and nutritional status; nutrition education and counseling to meet normal and therapeutic needs; provision of, or referral to, resources for appropriate group care food services (e.g., in group day care); and supplementary food assistance and/or special feeding equipment for the handicapped.

Handicapped Child

A child is handicapped if he cannot learn or work to do things other children his age can do and if he is thereby hindered in realizing his full physical, psychological and social potential.

Crippled Children's Services

A program of services for children who are crippled or who are suffering from conditions which lead to crippling. The purpose of such a program is to develop, extend and improve services for locating such children; to provide for medical, surgical, corrective and other services and care; and to provide facilities for diagnosis, hospitalization and aftercare.

Mental Retardation

A mentally retarded person has significantly sub-average intellectual functioning that originated during the developmental period and that is associated with impaired ability to respond appropriately to the environment.

Department of Employment and Social Services–
Social Services Administration

Child Welfare Services

Child welfare services are services concerned with (a) children whose needs are unmet within the family or by other social institutions and (b) the problems such children present to themselves, to their families and to the community. Child welfare services are designed to remedy these problems and unmet needs (a) by strengthening or reinforcing the ability of parents to give affection, care and guidance a child should have, including help to him

in his relations to other social institutions; (b) by supplementing the care which the family can give; (c) by meeting or compensating for certain deficiencies or inadequacies in such care; or (d) by substituting, when necessary, for the care the child is expected to receive from his own parents and restoring such care to him whenever possible.

Foster Care

Foster care provides a child with substitute family care for a planned period when (a) the child's own family cannot care for him for a temporary or extended period and (b) when adoption is neither desirable nor possible.

Adoption

Adoption programs serve children who cannot be reared by their natural parents and who need and can benefit by new and permanent family ties established through legal adoption. The programs aim at making appropriate adoptive placements for such children.

Protective Services

The child on whose behalf protective services should be given is (a) one whose parents (or others responsible for him) do not provide, through either their own or community resources, the love, care, guidance and protection required for the child's healthy growth and development; and (b) one whose physical or emotional condition or situation gives observable evidence of the injurious effects of failure to meet at least the child's minimum needs. When the evidence is physical, child abuse has occurred; when it is not physical, the child has been neglected.

Single Parent Services

Services are provided to unmarried parents or prospective parents, persons planning or having had premature termination of a pregnancy, those requesting adoption for their child or children, and youth at risk (e.g., "persons lacking sufficient maturity to cope with environmental influences which seem likely to promote illegitimacy"). The program is designed to help the primary client and family meet the problems related to the birth of an unplanned child and to prevent such occurrences in the future.

Family Day Care

Family day care means care given in lieu of parental care to from one to not more than four children under the age of 16 in a facility located outside of the home of the child's parents or legal guardian for a part of a 24-hour day with compensation paid for such care. A family day care home is defined as the facility where the care is provided.

Aid to Families with Dependent Children (AFDC)

AFDC is aimed at helping families with social and health problems associated with economic need stemming from the death, absence, incapacitation or unemployment of a parent. AFDC provides money payments and services for all of Maryland's eligible applicant children and their families.

Department of Education

Compensatory Education Programs

Compensatory education programs supplement regular education programs by aiming at the provision of positive stimulation of the intellectual abilities of disadvantaged children and youth; this embodies a positive program for identifying such people. Essentially, compensatory education programs aim at helping disadvantaged children and youth to achieve scholastically more nearly like other children. A disadvantaged child or youth is defined as one who, because of environmental conditions, is not achieving scholastically commensurate with his potential abilities and who needs assistance to help compensate for the inability to profit from the normal education program.

ESEA Title I

Title I of the Elementary and Secondary Education Act, passed in 1965, provides financial assistance to local school districts in planning and operating special programs for educationally deprived children. It is a supplementary program, designed to upgrade the educational opportunities of children from disadvantaged backgrounds; it is not a general aid program.

ESEA Title III

Title III of the Elementary and Secondary Education Act authorizes the development and operation of preschool projects demonstrating methods that promise to contribute substantially to the solution of critical educational problems. Preschool projects are one of several Title III priorities.

Special Schools for the Handicapped

Special school is construed to mean a school operated under public or nonpublic auspices for the purpose of offering special education and training to handicapped children on a regular basis, providing continuous appropriate experiences under a qualified teacher to help the child attain academic achievement as near normal as possible and/or to develop skills that permit him to become a self-supporting or partially self-supporting and self-respecting member of the community.

A handicapped child is one with a physical, mental and/or emotional impairment which, in the judgment of the Department of Education, makes

a special education and training program necessary or desirable to help the child attain scholastic achievement as near normal as feasible. Children who suffer from mild, moderate, severe or profound hearing loss are included in this definition.

Kindergarten Programs

Educational programs for children five years of age.

Nonpublic Nursery Schools and Nonpublic Kindergartens

A nonpublic nursery school is a school operated under nonpublic auspices enrolling pupils under five years of age on a regular basis.

A nonpublic kindergarten is a school operated under nonpublic auspices enrolling pupils five years of age on a regular basis.

Community Action Agency (or Department of Education)

Head Start Programs

Head Start programs provide educational, cultural enrichment, nutritional and social services to poor and/or handicapped children, so that they may enter school on equal terms with their less-deprived peers. The children are also involved in activities with their parents, who participate in program policymaking.

Chapter III

The Service Delivery System

The State Plan as a description of the public service delivery system at the State level and the legal basis for that system.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Within the Department of Health and Mental Hygiene, five Administrations provide services to children ages 0-6 and their families:

I. Preventive Medicine Administration
II. Mental Retardation Administration
III. Mental Health Administration
IV. Medical Care Programs Administration
V. Juvenile Services Administration

I. Preventive Medicine Administration

Article 43 of the Maryland Annotated Code, effective 1951, instructs the Department of Health and Mental Hygiene (DHMH) to "investigate the causes of diseases and institute preventive measures for their control."

Within the Department of Health and Mental Hygiene, the Preventive Medicine Administration is the primary vehicle for carrying out this mandate. It is within this Administration that such medical, dental, nursing, nutrition, social work, physical therapy, occupational therapy, psychology, speech and hearing therapy services are provided for mothers and children.

More specifically, the Division of Maternal and Child Health (MCH) assumes the prime responsibility as set forth in Section 38 of Article 43 of

investigating "the causes of infant mortality and the diseases of pregnancy, parturition, infancy, and early childhood" and for initiating "preventive measures for their control" while promoting "the welfare and hygiene of maternity and infancy . . ." MCH participates in providing family planning services, and serves children from birth to age 6 in a variety of ways. The Division funds and develops programs, offers consultation and training, engages in public education and also provides direct services, usually via local health departments (LHDs).

Through the MCH-administered Federal Family Planning Grant program, the Federal Maternal and Child Health Formula Grant and the Baltimore City Federal Grant Services, the MCH promotes family planning services. These services are available in clinics operated by LHDs or the Planned Parenthood Association of Maryland. Baltimore City's LHD has a direct Federal grant to provide family planning services.

Arrangements are made for therapeutic abortions by MCH to those women referred by LHD or Planned Parenthood. MCH pays for those not under Title XIX providing the patient meets MCH eligibility requirements.

The permissibility of abortion (when birth would cause maternal death, impair maternal physical or mental health, when the child might be born deformed or retarded or if pregnancy resulted from rape) is established by Section 137 of Article 43.

Under a Federal grant, a screening and public education program for sickle cell anemia is being conducted in Talbot and Dorchester Counties.

MCH is also active in the field of prenatal care. Prenatal services are offered through clinics, high-risk maternity programs, and the Baltimore City Maternal and Infant Care Service Project. Clinics for prenatal care operate throughout the State, usually in conjunction with LHD clinics. MCH assists LHDs with clinic staffing and training of personnel, provides consultation services and supplies health record forms. MCH is responsible for program planning and administration in this field.

Under Title XIX of the Social Security Act of 1965, subsidized delivery services are available for eligible women. MCH acts as a consultation, coordination and referral resource for these services. LHD prenatal clinics arrange hospital delivery services for both Title XIX and other patients and can provide delivery service for eligible high-risk mothers with financial assistance from MCH.

MCH similarly aids the LHD in offering postnatal services to mother and child.

MCH arranges care for premature infants and will assist in hospital payment if eligibility requirements are met.

MCH assists in a program in outlying counties to fly eligible premature and high-risk babies into Baltimore City Hospitals or the University of Maryland's Intensive Care Unit, where they receive care unobtainable in the

areas in which they were born. MCH also provides a grant to the hospital for medical staff and provides transport incubators.

Phenylketonuria testing is required for all newborn infants in Maryland by Section 38A of Article 43. MCH administers and coordinates the entire program after initial hospital screening of infants.

Immunization and other preventive services, as well as various other services for eligible infants and preschool children, are provided by MCH—mainly through LHD clinics and day care programs.

To assist LHD clinics, MCH offers professional consultation, funds for some clinic staff and fees for some physician services. Relevant LHD services include Child Health Clinics to provide general medical supervision and preventive services for children; nurse conferences providing health appraisal; immunizations and health maintenance advice; Immunization Clinics providing immunizations only; and pediatric consultations for patients referred from other sources.

Maryland has one Maternal and Infant Care Project located in the Baltimore City Health Department; it was approved by MCH and currently funding of the project is direct to Baltimore City Health Department from the Department of Health, Education, and Welfare. The State also has two Children and Youth Projects, one administered through the Baltimore City Health Department and one through The Johns Hopkins Hospital. Both of these projects provide centralized, comprehensive health programs for disadvantaged children.

MCH group day care responsibilities derive from Article 43, Sections 707-717 of the Annotated Code of Maryland (1965). A group day care center cares for five (5) or more children. The language of the statute, in its Declaration of Policy, its definition of a group day care center, and in the direction given to the State Department of Health and Mental Hygiene in regard to the adoption and promulgation of rules and regulations, addresses itself to legislative and administrative concern for prevalent varying types of out-of-home care required by parents and not provided for in other statutes.

Within the Maternal and Child Health Division the Day Care Unit administers the State Day Care Licensing Program and provides staff development training to the decentralized licensing staffs to insure quality control of licensing procedures. It assists local health department staffs in the provision of consultation to group day care centers in such areas as child development, health services including nutrition and psychology, social services, health education, environmental health and safety. It is active in providing course training in child development and early childhood education to operators of group day care centers.

In addition, some local health departments provide health services to children in Community Action Agency-sponsored day care centers under contract with that agency.

Inherent in the mandate of Section 38 of Article 43, to promote the health of mothers and children and initiate preventive measures for the control of diseases, is the responsibility to provide nutritional care services. To this end, public health nutritionists are assigned to various programs directed to mothers and children where they function primarily in an advisory, promotional capacity. In some instances, they provide direct services on a demonstration basis to selected counties (Howard, Carroll, Harford, Washington, Allegany, and Garrett) in anticipation that after a specified length of time, the local health departments will perpetuate the services.

A pilot project initiated in October 1971, with the financial assistance of a voluntary agency (Maryland Food Committee), provided for the distribution of iron fortified infant formula to high-risk infants on the Eastern Shore, in selected areas of Baltimore City, Prince George's and Anne Arundel Counties. In 1973, a grant from the Office of Economic Opportunity permitted expansion of the program in many of these areas to include a larger number of infants. A program of iron fortified infant formula distribution also operates in areas of Baltimore City covered by the Model Cities Program.

Nutrition and diet counseling of mothers and pregnant women, individually and in groups, is provided by nutritionists as well as public health nurses, particularly in those county health departments which do not have a staff nutritionist. State level nutritionists provide continuing nutrition education to staff nurses for this purpose.

One part-time nutritionist is assigned to the child day care program in the Division of Maternal and Child Health. She provides technical consultation to other staff at the State level, advises child day care administrators and local coordinators, collaborates locally in planning workshops, and provides consultation in the specific area of child day care to local county public health nutritionists.

The Genetics Screening Program also has a full-time public health nutritionist assigned to it. The function of this nutritionist is primarily to provide direct assistance to phenylketonuria children and their families by providing direct counseling, educational materials, and liaison with other care facilities and services.

Local health departments which have full- or part-time nutritionists are: Anne Arundel County, Baltimore City, Baltimore County, Montgomery County, and Prince George's County.

Article 43, Section 40 of the Annotated Code of Maryland designates DHMH as the agency responsible for administering

> a program of services for children who are crippled or who are suffering from conditions which lead to crippling, and to supervise the administration of those services included in the program which are not administered directly by

> it. The purpose of such programs shall be to develop, extend and improve services for locating such children, and providing for medical, surgical, corrective and other services for care, and for facilities for diagnosis, hospitalization and aftercare.

Section 12, Article 43 deems it a DHMH responsibility, upon receipt of reports of the names and addresses of physically handicapped children, to have, insofar as possible, each such child examined by a deputy health officer, or by any other qualified physician if without expense to the State, for the purposes of ascertaining the nature and extent of the physical disability and required treatment and to report this with a recommendation to both the State Board of Education and the Board of Education in the county where the child resides.

Article 77, Section 102, defines the "handicapped child" and stipulates that the State budget include items for the education of handicapped children under the age of six.

The Division of Crippled Children's Services (CCS) provides direct services through clinics and other facilities and indirect services through consultations, funding of service programs and training programs.

Maryland CCS sets standards for approval of various facilities used for crippled children, but licensing, safety and sanitation regulations are the responsibility of other DHMH Bureaus. No formal agency regulations govern CCS; Federal regulations and guidelines apply only to CCS program activities funded under Titles XIX and V of the Social Security Act.

CCS authorizes care for crippled children at three major university hospitals and five special children's hospitals and pays for this care, using Federal Titles V and XIX and State funds. Title V funds are also used to support programs providing training of staff to work with crippled children, such as the John F. Kennedy Institute.

Indirect CCS services (sometimes offered cooperatively with other agencies such as the March of Dimes) include provisions for resource development in the form of staff training, facility expansion, and expansion of financial resources by use of Federal funds. Individual patients' needs are reviewed on both local and State levels by appropriate CCS staff.

More directly, CCS operates specialty consultation clinics which provide diagnostic, evaluation and treatment planning for children with acquired and congenital motor abnormalities; neurologic disorders; oral facial deformities; cardiac defects; speech, language, hearing and vision problems; mental retardation and complex learning disabilities. These LHD-run clinics staffed by the State specialists are provided throughout the State. Specialty consultation clinics extend the specialized services of the larger medical centers to more remote areas. Consultants focus on diagnosis of the crippled child's special need and consult with the primary physician on managing his patient. Treatment will be effected by the primary

physician when possible. The clinics in this category include plastic, speech diagnostic, hearing conservation, cerebral palsy, neurological, orthopedic, seizure, vision, cardiac, and multi-problem.

Maryland CCS also has a program to purchase needed care for the treatment of crippled children. Included in this program are general and special hospital inpatient and outpatient care, special facilities services including dental care, and special therapies, drugs, appliances, aides, etc.

CCS also cooperates and has written agreements with other agencies in Maryland. Several federally-funded projects are administered by CCS including an integrated cleft palate clinic, child abuse and diabetic counseling services, epilepsy service and training programs and a Regional Heart Project.

In early identification of the handicapped, Crippled Children's Services cooperates with the Division of Maternal and Child Health, and Day Care Programs, providing diagnosis and treatment services for those children referred. As an example, infants who are diagnosed as having PKU are usually treated with a combination of special formula, dietary regime and close monitoring by medical, nursing, nutritional and psychological services. Financial assistance is provided to these families if eligible by Crippled Children's Services.

The Division of Dental Health offers direct services to children through community and hospital facilities and acts in an advisory capacity. No State or Federal regulations directly govern the Division although the Division's Policy Statement authorizes it to become involved with any other administration where its services are needed.

A mobile dental van provides services for preschool and school-age children in Kent, Queen Anne's, Caroline and Talbot Counties. Comprehensive dental care is provided for eligible handicapped children in Children's and Kernan's Hospitals and Kennedy Institute. Both inpatient and outpatient services are offered utilizing grants from the Division of Dental Health.

The Dental Health Hygienist in the Division conducts educational programs for and encourages teachers of young children to introduce dental hygiene as part of the preschool curriculum. At present, this is done on a limited basis, but statewide expansion is planned.

II. Mental Retardation Administration

The Mental Retardation Administration (MRA) of the State Department of Health and Mental Hygiene has jurisdiction over the care, custody and treatment of the mentally retarded through Articles 59 and 59A of the Annotated Code of Maryland.

Article 59 as amended and Article 59A of the Annotated Code of Maryland provide for the

- organization and administration of the Mental Retardation Administration;
- organization and administration of public facilities providing services for the mentally retarded;
- licensing and inspection of private facilities;
- financing of mental retardation services; and
- comprehensive plan of day programs and residential services for the "non-retarded developmentally disabled" as defined and in operation as of July 1, 1974.

Pursuant to Section 8, Article 59A, Annotated Code of Maryland, implementation of responsibility for programs for the mentally retarded can include:

> providing or encouraging, by consultation, cooperation, contract or direct operation, all necessary services to facilitate the early detection, accurate evaluation, proper referral, adequate protection, and optimal development of mentally retarded persons in need of services, whether a residential program or a program providing less than 24-hour care.

The Secretary of the Department of Health and Mental Hygiene has the authority to regulate services for the mentally retarded. Services are provided in day care centers for the mentally retarded, group homes, small residential centers and hospitals.

In conjunction with local health departments, the MRA funds private, nonprofit organizations to render day care services to the mentally retarded. The Administration licenses and supervises these programs through the *Regulations and Minimum Standards Governing Operation of Group Day Care Services for Mentally Retarded Persons Receiving Financial Support Under General Local Health Services Appropriation (10.05.02).* These regulations were adopted January 31, 1964, revised August 21, 1970, and are currently again under revision.

Mentally retarded children ages three to six, who are classified as severely retarded, profoundly retarded, and in some cases, moderately retarded, are provided service in group day care centers. As of June 30, 1973, about 295 children ages three to six were cared for in 28 State-funded centers and in one center for age two and over. Of these 29 centers, seven are in Baltimore City and seven are in Baltimore County.

Residential facilities for the mentally retarded are licensed by the MRA as special hospitals with adaptations for special needs of the population served. Guidelines used are the Standards for Residential Facilities for the Mentally Retarded, adopted May 5, 1971 by the Joint Commission on Accreditation of Hospitals.

Approximately 16 children each are placed in residential centers at Kemp Horn in Washington County and Bello Machre in Anne Arundel

County. The Administration purchases care for approximately 13 children in private residential centers such as Foxleigh Developmental Center in Baltimore County.

Under Article 59A, Section 19 of the Annotated Code, certain State hospitals and facilities are maintained under the general jurisdiction of the Mental Retardation Administration. Approximately 45 children ages three to six reside at Great Oaks in Prince George's/Montgomery Counties, 60 at Highland Health Facility in Baltimore City, and 22 children from birth to age six are cared for at Rosewood Center in Baltimore County. Holly Center in Salisbury will open in June 1974 to serve children from birth to six.

Although the MRA supports group homes for mentally retarded, there are no children under six years of age being served in group homes or in the other hospitals under the jurisdiction of MRA, such as Henryton State Hospital.

III. Mental Health Administration

Article 59 of the Annotated Code of Maryland, 1969 Supplement, is known in brief as the *Mental Hygiene Law*. The Mental Health Administration (MHA) is the Administration within the Department of Health and Mental Hygiene responsible for "fostering and preserving the mental hygiene" of the citizens of Maryland. The law provides for the care and treatment mostly of adults although the involuntary admission of youngsters is included. In the case of children and youth, psychosocial evaluation and family therapy are conducted so that children 0-6 (in families already involved) would benefit indirectly.

Article 52A, Section 6, Annotated Code, stipulates additional services for children adjudicated by the Juvenile Courts and committed to the Secretary of the Department of Health and Mental Hygiene (DHMH). Under 52A the MHA is responsible for those children labelled mentally handicapped. A very small percentage of the child population is identifiable within the 0-6 category.

Those institutions providing services under the above Articles 59 and 52A are RICA (Regional Institute for Children and Adolescents), Crownsville Hospital Center, Eastern Shore Hospital Center and Springfield Hospital Center.

The Regional Institute for Children and Adolescents (RICA) in Catonsville is currently the only hospital under the Mental Health Administration solely devoted to psychiatric hospitalization for 11-year-olds and under. The population as of September 1973 was 80 children. In January 1974, two children under six years of age were hospitalized.

The Regional Institute for Children and Adolescents provides an array

of services for emotionally disturbed ambulatory children through age 11 on a residential basis and day services for a limited number of adolescents through age 17. The treatment program is concerned with the total management of the child. Specific services include inpatient and outpatient service, emergency service, partial hospitalization, day treatment, consultation and educational services. While these services may be considered discrete programs, easy movement between services is attempted so that each individual treatment program will capitalize on the developing assets of the child and constantly adjust to meet his medical, psychosocial and educational needs. It is the intent of the Regional Institute for Children and Adolescents to involve local community mental health resources in the program to the greatest extent possible.

Crownsville, in Anne Arundel County, provides consultant services to the Southshore and Millersville elementary schools. Professional staff from Crownsville Hospital Center meet weekly as a team with teachers, parents, and children within these two schools. There are some direct referrals that result, but mostly the help is in better management planning of those involved.

Crownsville also runs a one-week summer camp program for those children involved in the above case management. The camp, known as Arlington Echo, is a Board of Education project. Last year there were approximately 55 children, some of whom were 0-6. Crownsville staffs it; the Maryland Mental Health Association funds it.

Eastern Shore Hospital Center in Dorchester County has a children's evaluation unit. Children are referred from mental health clinics or private pediatricians. There are ten inpatient beds for children, and during 1973 four of those beds were used for children under six. A school program has been designed, but to date funding is inadequate for proper staffing to make this a therapeutic treatment unit. Springfield Hospital Center has an adolescent program which provides psychosocial evaluation so that children 0-6 in families so involved would benefit indirectly.

Article 43 of the Annotated Code of Maryland provides authority for licensing of private facilities by the Department of Health and Mental Hygiene. Licensing Regulations 43G05, for example, are covered in the *Standards for Related Institutions–Residential Treatment Centers for Emotionally Disturbed Children and/or Adolescents.*

The Federal Community Mental Health and Mental Retardation Act (Public Law 88-164) of 1963 set up guidelines for states to obtain funds for instruction, staffing, and programming in Community Mental Health.

The State of Maryland in 1965 prepared a five-year comprehensive plan for Community Mental Health Services, including services to children. Within budgetary limits the Mental Health Administration has developed programs to provide these services from 1965 to date.

Community Mental Health Grants within the Mental Health Administration provide monies to local agencies to develop additional programs within their agencies. For example, the Children's Guild, Inc. has two such programs: (1) Preventive Mental Health and Education for six-year-olds for the purpose of providing (in collaboration with the Sinai Hospital Psychiatric Department) mental health services for first-grade level children whose emotional disturbance and behavioral disorders prevent their participation in regular public school education; and (2) a preschool therapeutic educational satellite program with a two-fold purpose–(a) providing therapeutic education and management for emotionally disturbed children ages 3-5 (prior to attending school) and counseling for parents and (b) training for paraprofessionals.

Another example of a program for children with special needs is that of the American Foundation for Autistic Children, which has a program of clinical services for autistic children and personnel training. Its purposes are (1) to provide therapeutic training for autistic children for whom there is now an almost total lack of public or private facilities for therapy and training, (2) to counsel and instruct parents in therapeutic techniques, (3) to provide professional and semi-professional personnel with opportunities for instruction and training in therapeutic techniques and thereby help alleviate critical manpower shortage in the field of mental health, (4) to constantly improve training techniques in the light of experience and (5) to disseminate information to the professionals and the public so that knowledge may be shared with the community and made available to other groups and individuals working to help mentally ill and/or retarded children.

Community Mental Health Programs with spin-off benefits to children might include the counseling of families of alcoholics, which programs exist throughout the State.

In conjunction with local health departments, Community Mental Health monies are currently being budgeted for:

1. Psychiatric evaluation, counseling, and treatment of disturbed school children in Baltimore City.
2. Family counseling, child evaluation and treatment in Allegany and Garrett Counties.
3. Psychiatric day care for children in Prince George's County. The purpose is to avoid hospitalization for those too ill to benefit from outpatient services yet not too sick to leave home and community for part of the day.
4. Family counseling, child evaluation and treatment in Allegany and Garrett Counties. The purpose is to demonstrate the manner in which early identification of disturbing family problems and the provision of needed counseling can solve many family difficulties

and prevent more serious emotional and behavioral problems. A secondary objective is to begin working toward the development of a day care facility so that the need for hospitalization can be avoided.

5. Evaluation and referral with emphasis on adolescents, children and elderly in Carroll County.
6. Consultation on behavior problems to teachers and physicians and evaluation and treatment of children in Cecil County.
7. Aftercare; day care; psychological testing and treatment of emotionally disturbed children; family counseling in Harford County.

Article 43, Sections 1-J (1969), Annotated Code of Maryland, established Advisory Boards to report annually to local health officers, governing bodies, and the Commissioner of Mental Hygiene. These boards are responsible for information gathering on mental health needs (including those of children) in the counties, including what programs exist and what programs need to be developed.

Article 43, Section 603 (1972) established Advisory Boards in State facilities. These boards are responsible for investigating the appropriateness of existing treatment programs (including programs for children) and then advising the institution superintendent and reporting annually to the Secretary of Health and Mental Hygiene.

IV. Medical Care Programs Administration

The Medical Assistance Program Administration (MAPA) is authorized by Title XIX of the Federal Social Security Act to provide maternal and child medical services to all children and mothers on medical assistance. However, MAPA has delegated the administrative responsibility for screening of children to the Division of Maternal and Child Health within the Preventive Medicine Administration of the Department of Health and Mental Hygiene described above. MAPA receives State funds and Federal matching funds and then appropriates these funds (for screening Title XIX eligible children) to local health departments. The program is controlled and evaluated by HEW.

General medical screening and follow-up are provided children ages 0-6 through the local county and city health departments, as described above under MCH programs.

V. Juvenile Services Administration

Article 52A of the Annotated Code of Maryland, effective July 1, 1967, recognized the Juvenile Services Administration as the agency to provide services to children involved with the courts. The Courts and Judicial Proceedings Article, Title 3, Subtitle 8, Sections 3-801 to 3-842 effective

January 1, 1974 further defines the responsibilities of the Administration. Section 3-810 of the Article authorizes a preliminary inquiry to determine whether a petition should be filed:

> In the case of a child alleged to be delinquent, in need of supervision, neglected, dependent, or mentally handicapped, the intake consultant or other person authorized by the court shall make such an inquiry and approve or disapprove the filing of the petition.

The Administration's involvement with children ages 0 to 6 is usually at the intake level, where the staff is responsible for screening complaints alleging the child to be dependent, neglected, or mentally handicapped. Most of the children in this age group coming to Juvenile Services Administration attention fall into one of these categories. After screening, services deemed necessary are rendered for the mentally handicapped by the Mental Health Administration or for those dependent or neglected, by the Department of Social Services. The intake procedure is consistent throughout the State.

In Fiscal 1972, 2,751 children 10 years of age and under were given screening services. The Administration estimates that 90 percent of these children were between the ages of 8 and 10.

STATE DEPARTMENT OF EDUCATION

Within the State Department of Education, four divisions are responsible for providing programs and services to children 0-6:

I. Division of Compensatory, Urban and Supplementary Programs
II. Division of Certification and Accreditation
III. Division of Instruction
IV. Division of Administration and Finance

The local departments of education also provide some services on an individual basis.

I. Division of Compensatory, Urban and Supplementary Programs

In March of 1973, most authority over all of the State Department of Education's early childhood programs (preschool and kindergarten) was delegated by the Bureau of Educational Programs with the approval of the State Superintendent of Schools to the Division of Compensatory, Urban and Supplementary Programs. Included in this category are public kindergarten and all compensatory and supplementary programs.

A. Public Kindergarten

Article 77, Section 73 of the Annotated Code of Maryland, effective July 1, 1971, required public schools that did not already provide

kindergarten programs to phase in such programs by September of 1973. The State Department of Education has developed *Guidelines for Early Childhood Education* (Maryland School Bulletin, Volume XLVII, Number 4, September 1972) which enumerate guidelines for Early Childhood Programs, including kindergartens.

In 1972-73, approximately 60,000 children were enrolled in the State's 821 public kindergartens. The programs provide half-day experiences for five-year-olds, except in Somerset, Charles and Garrett Counties and Baltimore City, where some of the Federal programs are equivalent to full-day kindergarten. As of September 1973, after the introduction of kindergartens in the Cecil County Schools, kindergarten programs are available in all local school systems.

B. Compensatory and Supplementary Programs

1. Title I

Title I of the Elementary and Secondary Education Act (ESEA) of 1965 provides authorization and funding for programs designed to meet the special educational needs of educationally deprived children, with a special focus on preschool and elementary programs.

Local educational agencies submit Title I proposals to the State Department of Education for approval. Approved applications must meet ESEA Title I guidelines and regulations. Programs may serve children who attend schools only with the highest concentration of disadvantaged children, as outlined in Federal criteria.

Twenty-two counties in Maryland have Title I programs involving approximately 9,000 public school children age five. Kindergarten classes in selected schools receive Title I funds to supplement the normal kindergarten program for economically disadvantaged children. The funds are used mainly for teacher's aides so that children may receive more individual attention. Some health and social services are also provided. Upon referral from appropriate sources, local health departments screen the children, and if the need for special services is shown, Title I may finance them. For example, if the child needs glasses or clothing, and DESS is unable to provide them immediately, money can be made available from Title I funds.

At the suggestion of the Division of Compensatory, Urban and Supplementary Programs, four model early childhood learning centers using State and Title I funds were started. Somerset County has a full-day comprehensive kindergarten program (Assist a Child) involving 40 five-year-olds which stresses cognitive and affective development. Project IVY (Involving the Very Young) in Baltimore City involves 475 children ages six months to four years in a half-day program emphasizing language development and works with parents to improve parent-child relations. Two other

programs stress cognitive and affective development in three- and four-year-olds: the Baltimore City Early School Admissions project enrolls over 1,000 children and the Washington County Early Childhood project serves less than 100.

2. Title III

Title III of ESEA authorizes the development and operation of preschool projects demonstrating methods that promise to contribute substantially to the solution of critical educational problems. Federal guidelines are spelled out in the Title III legislation and in *A Manual for Project Applicants and Grantees, Special Programs and Projects.*

Maryland has seven Title III early childhood programs, three of which are in their third and final year of Title III funding. The Model Early Childhood Learning Program in Baltimore was started in 1970 with 3- and 4-year-old children. It now has over 600 children enrolled. The Carroll County Early Intervention to Prevent Learning Problems involves 20 children ages 5-7 years in a control group and 20 children ages 5 and 6 years in an experimental special half-day program that provides early assessment to prevent learning disabilities. Charles County's Early Childhood Program operates four full days a week, serving 83 disadvantaged and handicapped children. Four-, five- and six-year-olds are grouped in a multi-age learning situation.

Montgomery County's Early Childhood Services for Visually Impaired Children involves 35 children ages 0-8. An itinerant teacher and social workers work with parents while children ages 0-5 attend a morning learning development center. Multi-handicapped children attend an afternoon session of mental stimulation and orientation to environment. Title III funding ends in FY 1973, but the project may be continued by the County Board of Education.

Four Title III Projects (innovative and exemplary) were developed for disadvantaged children in the spring of 1973. Howard County's Early Childhood Education Project provides full-day language and self-concept development for 25 four-year-olds. "Growing Together" in Prince George's County is an interagency early childhood development center for 170 children ages 2-5. These full-day programs involve children from various socio-economic levels on a fee and non-fee basis. A half-day Exemplary Program for Self-Concept Development and Language Improvement serves 60 Anne Arundel County three- and four-year-olds. The Baltimore County Continuum in Early Childhood Education stresses language development, parent involvement and health care in a half-day program for 135 four- and five-year-olds.

3. State Programs

In the fall of 1973, the State assumed responsibility for the Model Early Childhood Program begun originally by Baltimore City in 1970. The Program stresses cognitive development and individualized instruction and serves 568 three-, four- and five-year-olds. Based on this model, two counties have initiated full-day programs for four-year-olds emphasizing cognitive development and parent involvement. The St. Mary's Early Childhood Learning Program enrolls 100 children, while Wicomico serves 125.

II. Division of Certification and Accreditation

In conjunction with its regulatory responsibilities in the field of nonpublic education, the State Department of Education, Division of Certification and Accreditation, is responsible for the approval of nonpublic kindergartens and nursery schools except those operated by bona fide church organizations. As such the Department's authority stems from Article 77, Section 12, Annotated Code of Maryland, which requires that:

> Every private school or educational institution, however designated, which offers a program of . . . kindergarten, or nursery school work . . . except those operated by bona fide church organizations, must secure a certificate of approval issued by the State Superintendent of Schools before it may begin or continue to operate or function in this State.

The same section authorizes the State Superintendent of Schools to issue rules and regulations to supplement and implement the above provisions. Accordingly, nonpublic nursery school and kindergarten standards are enumerated in Bylaw 912:2 of the Code of Bylaws of the State Board of Education. Standards cover: personnel, instructional programs, physical facilities and equipment, finance, health, fire and safety, zoning, transportation, admission requirements, length of the school day, the school calendar, and pupil records.

In addition, Bylaws 911:1 and 911:2 are pertinent to understanding the jurisdiction of the State Department of Education over nonpublic nursery schools and kindergartens.

Bylaw 911:1 states that no person, firm, association, or corporation shall use the name "school" or words of like import in such a manner as to connote the offering of a program of nursery school or kindergarten work unless a certificate of approval has been issued by the State Superintendent of Schools. This regulation does not apply to schools operated by bona fide church organizations.

Bylaw 911:2 exempts day nurseries, child care centers, and similar institutions from the jurisdiction of the State Department of Education. Such institutions cannot be approved or accredited by the Department. When an individual, partnership, group, cooperative, or corporation operates

both a day care center and a nursery school, the Department of Education has jurisdiction only over the nursery school which must be organized as an entity separate and distinct from the day care center. Furthermore, educational programs in day nurseries or day care centers are not subject to the jurisdiction of the Maryland State Department of Education and cannot be approved or accredited.

According to the Maryland State Department of Education, a nursery school is an institution for organized instruction of children under five years of age. Its primary purpose is to provide an instructional program for the intellectual, social, emotional, and physical growth and development of the children enrolled. It is an educational institution which uses pedagogical methods and objectives, gives special attention to early learning needs, operates in sessions of about two and one-half hours, generally follows the local public school calendar, closes during the summer months, and usually limits enrollment to a narrow age range. The Department of Education requires that the purpose, philosophy, and objectives of those institutions subject to its jurisdiction be written, disseminated, and interpreted to the constituent community.

III. Division of Instruction—Office of Special Education

Article 77, Sections 99-106 of the Annotated Code of Maryland (amended 1972) authorizes the State Board of Education to provide for handicapped children. Article 77, Section 102 authorizes the Governor to appropriate money for the education and training of handicapped children under six years of age and defines "handicapped child." Section 99 requires local boards of education to provide transportation to and from the school or educational facility for handicapped children. Section 100 establishes rules and regulations for examination, classification and education of the handicapped and authorizes funds for special treatment. When the City of Baltimore or any of the counties inaugurates a special program to meet the needs of physically, mentally or emotionally handicapped children, the State will provide funding. If the City or counties do not provide such special programs and local handicapped children attend a school within or outside of the State of Maryland approved by the local board of education, the State of Maryland will reimburse the parents of the child if they are bona fide residents of Maryland.

Maryland State Board of Education Bylaw 412, revised through June 24, 1970, establishes guidelines and regulations for "Preschool Handicapped Children." This defines educational program standards for preschool handicapped children and enumerates the kinds of handicaps children must have to be eligible for services. Accordingly, preschool programs for handicapped children in the State serve 308 children in classes for the

trainable mentally retarded, hearing impaired, occupationally handicapped, vision impaired, multiple handicapped, specific learning disordered, language impaired, emotionally handicapped and speech impaired. Eight counties provide full- and half-day programs for preschool handicapped children. A listing of the specific counties and the children served follows:

Preschool Programs for Handicapped Children in the State (1972-73)

County	Handicap Served	No. of Children	Length of Program FD-Full Day HD-Half Day
1. Garrett	Trainable M.R.	37	FD
2. Washington	Trainable M.R.	7	FD
	Occupationally Handicapped	7	FD
	Hearing Impaired	7	FD
3. Prince George's	Hearing Impaired	11	FD
	Emotionally Impaired	9	FD
4. Montgomery	Trainable M.R.	21	FD
	Occupationally Handicapped	1	FD
	Hearing Impaired	21	FD
5. Frederick	Trainable M.R.	2	FD
	Occupationally Handicapped	2	FD
	Emotionally Handicapped	16	FD
6. Carroll	Specific Learning Disordered	73	FD
7. Anne Arundel	Trainable M.R.	19	FD
	Hearing Impaired	7	FD
	Language Impaired	1	FD
8. Baltimore County	Trainable M.R.	26	HD
	Occupationally Handicapped	6	HD
	Hearing Impaired	4	HD
	Language Impaired	13	HD
	Multiple Handicapped	11	HD

IV. Division of Administration and Finance–Food Services Section

Article 77, Section 126 of the Annotated Code of Maryland, effective July 1, 1970, requires every Maryland public school to provide subsidized and/or free feeding programs for children meeting eligibility standards promulgated by the State Board of Education. This law includes and expands the National School Lunch Act of 1946 and its amendments.

The Board of Education, in compliance with Bylaws 521, 522, and 522.3, Code of Bylaws of the Maryland State Board of Education, has adopted the standards of the Department of Agriculture for the subsidized feeding programs in Maryland.

Every Maryland public school provides a subsidized or free lunch for every child, including those in kindergarten. Some schools also provide a free or subsidized breakfast. Every school district is eligible to receive funds for

such programs. Maryland also subsidizes the State's private school feeding programs. Preschool children attending school, who are considered as a part of the school's minimum program of education, are eligible to participate in all food service programs available at the school, namely: school lunch, school breakfast and/or special milk.

Under Section 13 of the National School Lunch Act, the State Board of Education administers money and commodities to nonprofit day care centers that apply and agree to meet the USDA and State nutrition regulations. A subsidized breakfast, lunch, dinner, and a morning and afternoon supplement can thereby be provided. Section 13 also applies to Head Start Centers effective January 1974.

Some non-food assistance, such as food service equipment, etc., is also available for all school districts, based on need.

The Education Department's Food Services Section has also provided educational materials on nutrition to local school systems for use in their health education curricula. However, since local personnel determine whether this material will be used, the program's impact varies widely across the State.

LOCAL DEPARTMENTS OF EDUCATION

A. Project Head Start

Head Start in the public schools is under the same authority and regulations as programs delivered directly by Community Action Agencies. School Head Start programs are also guided by the State Department of Education's *Guidelines for Early Childhood Education.* In Maryland, five counties have Head Start programs in connection with the public schools: Howard, Washington, Carroll, Prince George's and Montgomery Counties.

The Howard County CAA began funding a public school Head Start program in June of 1965. One hundred thirty-five children ages 2½ to 5 years are enrolled in part-day and full-day programs.

Washington County enrolls 90 three- and four-year-olds in a full-day Head Start program begun in 1965. For financial reasons, this number will be reduced to 72 in the fall of 1974.

Because there is no local CAA in Carroll County, the public school system is funded directly by the Office of Child Development as a single-purpose agency to direct and deliver Head Start services. In June 1965, Carroll County began a six-week summer Head Start program for children ages four and five. These part-day experiences provide for 120 children.

Head Start in the Prince George's County Public Schools involves 210 four-year-olds in a full-year part-day program.

Montgomery County initiated Head Start in the public schools in the

summer of 1965. The full-year program enrolls 750 four-year-olds in both part-day and full-day programs.

B. The Appalachian Regional Commission Program

The Appalachian Regional Commission Development Act of 1965 authorized HEW to create a program to provide child development services in selected areas throughout the region. Washington County's Board of Education is the sponsor of the local Appalachian Regional Commission Project, which began June 1, 1973. This early childhood development program involves 200 three- and four-year-olds and includes an extended day program for 25 children whose parents work or otherwise require the service.

C. Early Childhood Program

Bylaw 311:2 of the Maryland State Board of Education, revised June 24, 1970, allows county boards of education and the Board of School Commissioners of Baltimore City to establish prekindergarten programs, subject to regulations these boards may formulate, with the approval of the State Board of Education. These programs are covered by *Guidelines for Early Childhood Education*, State Department of Education, September 1972.

Since September 1972, Washington County has had a Tuition Program for Early Childhood Education which enrolls 18 three- and four-year-olds.

DEPARTMENT OF EMPLOYMENT AND SOCIAL SERVICES

Social Services Administration

Within the Department of Employment and Social Services (DESS), the Social Services Administration (SSA) provides programs for children and their families. SSA programs serve children by direct supportive and economic services to families. However, the services described here are those directly influencing the preschool child. Also described at the end of this section is the Appalachian Child Development Program under DESS.

The general legal basis for SSA's involvement with children is Article 88A, Section 3 of the Annotated Code of Maryland (1951). This designates DESS as the central coordinating and directing agency for all Maryland social service and public assistance activities, including Aid to Families with Dependent Children (AFDC), general public assistance, aid to the permanently and totally disabled, and child welfare services. It also charges DESS with supervising "all public and private institutions having the care, custody or control of dependent, abandoned or neglected children, except those institutions under the authority of the State Department of

Juvenile Services." Section 13 of Article 88A permits local departments of social services to carry out child welfare programs under DESS supervision.

Article 88A, Section 19 stipulates that all child welfare programs will be administered by SSA. Three Divisions of SSA's Bureau of Services administer the programs discussed here:

I. Division of Day Care
II. Division of Policy and Program Development, Services
    Adoption
    Foster Care
    Protective Services
    Services to Adults
    Services to Families with Dependent Children
III. Division of Special Services

I. Division of Day Care

The Division of Day Care was established in compliance with the *Guides on Federal Regulations Governing Service Programs for Families and Children: Title IV, Parts A and B, Social Security Act*, April 1969. Section 220.18 of the Act requires that adequate care be

> assured for children of mothers or other caretaker relatives who are referred and enrolled in the Work Incentive Programs or are required by the agency to accept training or employment from other sources. Such care must be provided by the agency, secured without cost or purchased from other sources for all such children in need of care. Out-of-home care may be provided in family day care homes, group day care homes and day care centers . . . such child care services are similarly needed by mothers who voluntarily engage in training or employment not under or through the auspices of the WIN program and States are urged to make these services available.

Since day care is a child welfare program, SSA's day care involvement is also authorized by Article 88A, Sections 3 and 13, described above. However, by Maryland State Law, Article 43, Sections 707-717 inclusive, the Department of Health and Mental Hygiene licenses all group day care centers. The Social Services Administration operates group day care centers for eligible children and purchases care for eligible children in private centers.

Section 32A of Article 88A assigns responsibility for licensing family day care homes to DESS as defined in this section:

> Family day care means care given in lieu of parental care to from one to not more than four children under the age of sixteen, in a facility located outside of the home of the child's parents or legal guardian, for a part of a twenty-four hour day, if compensation is paid for the care. A family day care home is defined as the facility where the care is provided.

Pursuant to State and Federal legislation, DESS rules further specify group and family day care program standards. Section 7.02.13.12 of the rules sets standards for family day care homes. These standards involve health of the applicant and the day care family; the applicant's ability to provide day care; physical facilities of the day care home; how the day care program is conducted (with regard to adult supervision, activities, food, health of the children) and the procedure for day care placements by child placement agencies.

Section 7.02.13.06 of the rules sets standards for all child care institutions covering physical plant, institutional programs, dietary services, etc. SSA develops its own operating standards for day care which comply with health department licensing regulations. SSA day care programs now operate under DESS guidelines established September 30, 1969 which also comply with Federal Interagency Day Care Requirements promulgated by HEW, September 23, 1968 for all federally-funded day care programs.

DESS day care services include group day care, family day care, care of the older child, family day care licensing and purchase of care. Through local departments of social services the Department operates group day care centers for children ages 3-6. In July of 1973, 29 such centers (11 in Baltimore City) served 1,307 children. The Department also purchases care from licensed private centers where the local social service department's own day care resources are insufficient. These centers must meet Federal and SSA requirements and sign contracts with their local department. Care was purchased for 1,981 children from 96 of these centers in July of 1973.

SSA recruits and develops family day care homes for children either chronologically or developmentally under age 3 and for older children with special needs best met in a family home. Licensed and supervised by local departments, these homes serve up to 4 children for a part of the 24-hour day for compensation. Some of these homes (2,581 were licensed as of July 1973) serve purchase-of-care children.

SSA day care programs are funded by Federal AFDC (Aid to Families with Dependent Children) funds and by State funds. State day care services are available only to those entitled to services in accordance with eligibility criteria stipulated in the regulations pertaining to Title IV-A of the Social Security Act. Priority is given to AFDC families enrolled in the Work Incentive Program in counties where that program operates. A local department of social services may participate financially when it wishes to provide day care service for children who do not meet these eligibility criteria.

II. Division of Policy and Program Development, Services

The legal authority for programs under this Division is derived generally from Article 88A, Sections 3 and 13, Annotated Code of Maryland, 1951.

In compliance with Section 3 requiring DESS to administer child welfare services, including the care of neglected and dependent children, DESS supervises foster care programs, which are operated by local departments. Title 7 of the DESS *Rules* outlines State foster care regulations for applications, eligibility, payments, etc., and sets standards for DESS licensing of foster homes. Every foster home used by local departments must be licensed.

The local department assumes responsibility for the care of a child when:

- The child is committed to the department's care, or
- There is a voluntary application by the parent or parent surrogate, or
- Emergency shelter care is needed pending or following court action for children who have been abused, abandoned or otherwise left without a responsible adult's care.

These children receive care in foster family homes approved and supervised by the local department. When children have special needs which a department foster family cannot meet, or have characteristics which would prevent them from benefiting from family life, the department will purchase care from a licensed voluntary agency or institution having specialized group or familial facilities. Some foster homes can meet needs for emergency placement or short-term care while the department works with parents to determine the best plan for the child's care. Regular foster homes provide care for the child for the anticipated duration of placement away from his parents which varies according to the child's needs and family circumstances. When long-term care is needed, every effort is made to provide adoptive parents for any child without parental ties who is available for adoption and long-term care in a permanent foster home for those who are not. The local departments of social services pay a set rate for foster care as determined by the State agency and approved by the Legislature through the use of State and Federal funds. The child's parents are required to provide support in line with the scale set by the agency or by the court. DESS arranges with the State Department of Health for medical care for foster children, all of whom are certified for Medicaid. Additionally, foster care funds are used for essential medical appliances or consultation from specialists if not available through the Medical Care Program, the Crippled Children's Program or other established programs. Payments for care were made to foster homes for 8,455 children in July 1973.

The DESS role in adoptions stems from several legal authorizations. Article 88A, Section 3 (Child Welfare Services) and Sections 19 through 32 (Child Care), Annotated Code of Maryland, gives general jurisdiction over child welfare services to DESS.

Article 16, Sections 67(a), 72(b) and 75 (Adoption Law), Annotated Code of Maryland, pertains to subsidized adoption, guardianship with right to consent to adoption and/or long-term care short of adoption and the possibility of requesting guardianship with the right to consent to adoption and/or long-term care short of adoption for children who have been in regular foster care for a period of two years with no meaningful contact with or from their biological parents.

The goal of Adoption Service (Permanent Planning for Children) is to facilitate the most appropriate permanent plan at the earliest possible moment for each child who comes into pre-adoptive foster care or who is legally freed for adoption after placement in regular foster care. Every effort is made to include the natural parent(s) in such planning. To reach this goal the Administration has the responsibility to recruit, screen and study prospective adoptive families in accordance with the needs of the children it has in care who are current or possible candidates for adoptive placement.

DESS child abuse and neglect activities are based in part on Article 27, Section 35A of the Annotated Code of Maryland. That section authorizes the Department to protect abused children. Additionally, DESS and the local departments are granted supervisory authority over all public and private institutions having the care, custody or control of neglected children (Article 88A, Sections 3, 13).

Local departments are required by law to investigate reports of child abuse or neglect and to render appropriate services on the child's behalf. This includes, when indicated, petitioning the juvenile court for the added protection that either commitment or custody would provide. Maryland protective service regulations are contained in DESS *Rules* (7.02.15). Policies and procedures are detailed in Volume 2 of the DESS *Programs Manual.*

Article 88A, Sections 3(a), 13(a) and (b) and 44A, Annotated Code of Maryland, 1951, provides the legal foundation upon which Maryland Family Planning Services are based. SSA and the local departments typically refer clients who need family planning help to local health department or Planned Parenthood clinics. Section 7.02.08 of the DESS *Rules* describes referral procedures:

> A mother of childbearing age applying for public assistance or other social services is to be advised of the availability of family planning services. In cases involving married parents living together, the availability of such services shall be discussed with both parents.
>
> Although it would not be general policy to refer a girl under 16 or an unmarried girl whose pregnancy resulted from incest or use of force, referrals may be made in such instance if it is believed that it may prevent other out-of-wedlock pregnancies. The local director establishes conditions under which such referrals are made with or without supervising approval.
>
> When the individual wishes, referral is to be made to the local health department, the family physician, any hospital where the service is available, or an available Planned Parenthood Clinic.

> Under no circumstances is acceptance of family planning services to be a prerequisite for, or an impediment to, eligibility for the receipt of any other service or assistance from the Administration.

Article 88A, Sections 3 and 13, regarding Child Welfare Services and Article 88A, Section 4A, Prevention and Control of Illegitimacy, of the Annotated Code of Maryland, authorizes DESS Services to Single Parents. Section 7.02.10 of the DESS *Rules* regulates the administration of these services, and the *Programs Manual*, Volume 2 dictates policy and procedures.

Services are provided to unmarried parents, persons planning to or having had premature termination of a pregnancy, those requesting adoption for their child or children, and youth at risk (i.e., "persons lacking sufficient maturity to cope with environmental influences which seem likely to promote illegitimacy"). The Program is designed to help the primary client and family to meet the problems related to the birth of an unplanned child. This is accomplished through counseling, including family planning counseling, and activation of departmental and community resources. Additionally, any service that may help strengthen clients' family life (thus promoting the healthy growth and development of children and reducing illegitimacy) may be obtained via the single parent service. When specialized services must be purchased within the community, the Department assumes financial responsibility beyond the client's ability to pay (if such expenditures are within current DESS budgetary limitations). Approximately 1,600 Marylanders are served by the single parent service yearly.

The Federal Social Security Act, Title IV A, authorizes Federal matching of State funds. AFDC is aimed at helping families with social and health problems associated with economic need stemming from the death, absence, incapacitation or unemployment of a parent. Article 88A, Sections 3(a), 5A, 44A-83 and Article 30, Sections 11-30 of the Annotated Code of Maryland established DESS as the State agency responsible for AFDC administration.

Federal HEW regulations specify who is eligible for AFDC grants and some of the programs and services to be made available to AFDC families. State regulations, incorporating these Federal standards, are established in DESS *Rules*, 7.02.09.

AFDC provides money payments and services for all of Maryland's eligible applicant children and their families. (Payment levels are State-determined within Federal limitations.) Emergency assistance is also provided—for example, provision of temporary shelter, food and fuel; replacement of essential clothing needed because of loss due to catastrophe; purchase of essential appliances and furnishings or essential home repairs for home owners, etc.

Individuals certified by local officials as AFDC-eligible are automatically eligible for Medicaid (provided by local health departments) and for

food stamps. Food stamp program rules are otherwise determined by the U.S. Department of Agriculture, but DESS must bear program administrative costs.

Finally, all other SSA services are available to AFDC recipients. Services offered specifically to AFDC eligibles include the following:

1. Assessment with the family as to the particular family's situation, needs, possible solutions to problems and wish for service; with the development of a service plan for each family which needs and can use the service.
2. Self-support services related to employment in order to enable the family to achieve economic independence to the extent feasible. This would include determination of a person's appropriateness for referral; referring those appropriate to WIN (Work Incentive Program) for employment training and job placement; and providing child care to enable the parent to reach employment objectives.
3. Help with special problems when children live with relatives other than parents.
4. Help with regard to other problems of family living and child rearing. This may involve use of appropriate services within the Department as well as referral to other community programs. Examples of programs that may be helpful to the family are Day Care, Homemaker Services, Foster Care, Adoption, Family Planning, Service to Single Parents, etc.

(*Programs*, Volume 2, Maryland State Department of Social Services, September 1970.)

When needed services are not available within the Department, purchase agreements are made with other agencies. These services are funded with 25 percent State funds and 75 percent Federal funds.

III. Division of Special Services

Article 88A, Sections 3a and 13b, Annotated Code of Maryland, gives State and local departments of social services authority to provide service and public assistance activities including aid to permanently and totally disabled and child welfare programs.

The Division of Special Services has responsibility for the following services which are of benefit to children:

1. Homemaker Services
2. Licensing of Agencies, Group Homes and Institutions
3. Purchase of Services
4. Vocational Rehabilitation Services
5. Volunteer Services

Authority for Homemaker Services and purchased services is derived from Title IV, Parts A and B of the Social Security Act. Regulations regarding Title IV funding have been suspended by new HEW regulations, 221.9b11; therefore, a legal base for Homemaker Services and Vocational Rehabilitation Services is presently in preparation.

Homemaker Services

Homemaker Services are a supportive service administered by local departments of social services in which trained and supervised paraprofessional staff provide household assistance, instruction, personal care and other services to families with children, the aged, disabled, and blind who, because of physical and mental disabilities, need assistance to maintain themselves in their own homes. The service provides assistance to create a safe, wholesome home environment to improve individual functioning and to enable clients to utilize other community health and social services as needed.

Family Services mean care for adult individuals in their own homes, helping individual caretaker relatives to achieve adequate household and family management. For children, this means services to meet the needs of the child for personal care, protection and supervision, especially in those situations where it is needed to prevent neglect or abuse in accordance with a social service plan in which the homemaker service supplements and supports other social services.

Adult Services mean care of individuals in their own homes, helping to maintain, strengthen and safeguard individual functioning, preventing institutionalization and providing enabling services to institutionalized persons who, with assistance, possess the ability to regain independent living in the community.

Licensing of Agencies, Group Homes and Institutions

Article 88A, Sections 19 through 32A, Annotated Code of Maryland, grants licensing authority for child care facilities.

Licensing of Child Care Facilities provides resources for placement, care and protection of children unable to remain in their own homes. Licensure includes development and ongoing revision of standards, consultation to interested groups and individuals wanting to provide resources for children, and conducting studies and evaluations of these facilities at the time of initial licensing and periodically thereafter.

Purchase of Services

The Purchase of Services program provides for departments of social services to expand their services by purchasing them from other State and local agencies, from nonprofit, proprietary or private agencies, from organizations or from individuals. Under this program, the Maryland

Department of Employment and Social Services contracts with the Health and Welfare Council of Central Maryland, which in turn contracts with voluntary agencies that provide services to eligible families and individuals.

Vocational Rehabilitation Services

The legal bases for Vocational Rehabilitation Services are (1) the Vocational Rehabilitation Public Welfare Amendments of 1962, Public Law 543, (2) the Social Security Act of 1935, Public Law 271, and (3) the Social Security Act of 1964.

The Vocational Rehabilitation Program enables disabled public assistance recipients to achieve and maintain the highest feasible level of self-support through paid employment by means of cooperative efforts between the Vocational Rehabilitation Division of the State Department of Education and the Social Services Administration of the State Department of Employment and Social Services. The following four programs are included within the Vocational Rehabilitation Program:

A. Cooperative VR/DSS Program—This is a statewide team approach of a Department of Social Services caseworker and a Vocational Rehabilitation counselor working together to provide services to disabled and blind individuals in order to secure the necessary social services and vocational rehabilitation services.

B. 1115 Demonstration Project—This is a new team approach in rehabilitating disabled public assistance recipients by use of Community Service Aides, who are former disabled public assistance clients from the community, and incentive payments to the clients to meet special expenses while participating in the program. This program is in operation in Baltimore City, Allegany, Dorchester and Prince George's Counties.

C. Vocational Rehabilitation Expansion Grant—Federal funds provide for six caseworkers to help carry out the team effort in the demonstration areas and the Tri-County area of Charles, Calvert and St. Mary's Counties.

D. Purchase of Vocational Rehabilitation Services—The Vocational Rehabilitation Division of the State Department of Education has utilized the Purchase of Service funds from the State Department of Employment and Social Services in order to provide case services to additional public assistance applicants and recipients for whom these case services funds were inadequate.

Volunteer Services

Volunteer Services is a program to assist the local agency in providing supplementary direct and indirect services to eligible families with children and to adults eligible for services to supplement the efforts of the various

departments' staffs, to increase public understanding of the agency and the persons it serves, and for utilizing citizen participation in advisory bodies. Such supplementary services might include tutoring, skilled management training for the blind, telephone reassurance to the elderly, etc.

Appalachian Child Development Program

The Executive Order of May 14, 1971 established the Interagency Committee on Childhood Development in the Department of Employment and Social Services advisory to the program administered by the Office of Childhood Development in that department. The Secretary or Director of each of the following departments, or his designee, serves on this committee: Department of Health and Mental Hygiene; Department of Education; Department of Economic and Community Development; Department of Planning with the Secretary, or his designee, of the Department of Employment and Social Services serving as chairman.

The committee was established to meet the Appalachian Regional Commission Child Development Program requirements for a State Interagency Advisory Council on child development. This program is a primary responsibility of the Office of Childhood Development and involves the administration of an Appalachian Regional Commission Child Development Project Grant in the amount of $729,479 through subcontracts with local agencies in Maryland's Appalachian counties: Allegany, Garrett and Washington.

Additionally, the Office of Childhood Development subcontracted with the Maryland 4-C Committee to develop a Statewide Comprehensive Child Development Plan with Appalachian Regional Commission Planning Grant funds. This document is addressed to that objective.

Governor's Commission on Children and Youth

The Governor's Commission on Children and Youth within the Department of Employment and Social Services was created by Executive Order of the Governor on March 14, 1972. It is composed of thirty-two members, ten of whom are youths (ages 14-22). The charges to the Commission are:

a. To collect, compile, and disseminate to the public on a continuing basis information about the problems and needs of children and youth.

b. To promote research on needs for children and youth.

c. To bring together public and private agencies to plan coordinated programs for children and youth.

d. To advocate the participation of children and youth in decision-making in public and private agencies whose programs concern children and youth.

e. To evaluate and make recommendations on legislation affecting children and youth.

f. To assist the Governor's Youth Advisory Council in its projects.

g. To hold conferences for children and youth.

FEDERAL PROGRAMS UNDER THE ECONOMIC OPPORTUNITY ACT OF 1964

The Federal Economic Opportunity Act (EOA) of 1974, as amended, authorized the establishment of two programs involving children ages 0-6:

I. Project Head Start – Day Care

II. Family Planning

EOA also defines and establishes the Community Action Agencies (CAAs), which administer most of these programs.

I. Project Head Start

Title II, Part B of the EOA authorizes the Federal Government to provide educational, nutritional and social services to poor and handicapped preschool children and their families and to involve them in activities with their parents. The children who participate in these programs do so in order to enter school on equal terms with their otherwise less-deprived peers. The program was originally administered by the Office of Economic Opportunity (OEO), but since July 1, 1973, Head Start has been fully under the Office of Child Development in HEW.

The law provides that any Community Action Agency (CAA) funded under EOA is eligible for assistance, and that local organizations operate Head Start programs as "delegate agencies" of the CAA. When no CAA exists in an area any other public or private nonprofit agency meeting certain requirements may apply for a Head Start grant.

In Howard, Prince George's, Montgomery and Washington Counties, the Boards of Education are delegate agencies of the local Community Action Agencies for Head Start. Carroll County Board of Education is the prime sponsor of its Head Start program since there is no local CAA. In all other counties with Head Start programs, the local CAA is the sponsoring agency.

Federal guidelines are established in *Head Start Child Development Programs: A Manual of Policies and Instructions*, September 1969, supplemented by *Head Start Program Performance Standards*, January 1973. A Head Start center that receives Title IV-A funds via DESS purchase-of-care

must also comply with the *Federal Interagency Day Care Requirements*. Maryland Head Start centers must also meet *Regulations Governing Group Day Care Centers* (Maryland State Department of Health and Mental Hygiene, 10.02.01, effective December 1, 1971).

All but three Maryland counties have full-year Head Start programs. Caroline and Cecil Counties have no Head Start programs, and Carroll County has a summer program. Elsewhere, Head Start centers provide part-day, full-day and extended-day (or "day care") services to children, depending on their needs and the funding available. In spring 1973, 2,837 children ages 3 to 6 were enrolled in about 115 Maryland centers.

II. Family Planning

Title II of the EOA authorizes Federal programs to provide voluntary family planning assistance and services including information, medical help and supplies, to low-income persons. Originally administered by OEO, this program was transferred to HEW in July 1973. Because of this change, there is currently uncertainty about Federal family planning regulations. The present guidelines are contained in "Community Action for Health: Family Planning."

The Anne Arundel County Family Planning Unit of the CAA provides information, education and referral services to all whom the project can reach, regardless of income. Referrals are made to the local health departments for those who require medical services. Some contraceptives and family counseling are also supplied by the service. The extensive outreach program involved at least 2,300 people in the first nine months of 1973.

Baltimore City has two EOA family planning projects. The CAA-sponsored Family Planning Center on North Avenue provides comprehensive family life services that involve both parents and children, while educational outreach programs offer family planning information to individuals and groups throughout the city. This project reaches approximately 5,000 people each year. Medical services offered include medical examinations, cancer tests, contraceptive consultation and prescription, etc. Approximately 3,000-4,000 persons are served by the medical services yearly. These programs are available to all residents of Baltimore City.

Provident Comprehensive Health Center in Baltimore City also provides family planning services and maternal care under EOA. Provident serves from 50-100 people each month in its clinic.

Chapter IV

Revenue Sharing and Grants-In-Aid

GENERAL REVENUE SHARING

The State Plan as an alert to urge increased interest in the allocation of Revenue Sharing funds for child development services.

On October 20, 1972, the "State and Local Fiscal Assistance Act of 1972" (Revenue Sharing) was signed into law. The primary purpose of this law is to distribute, over a five-year period, some 30 billion dollars in Federal funds to *state* and *local* governments.

There are relatively few Federal restrictions attached to the use of General Revenue Sharing. Wide latitude is granted in determining spending priorities within the following broad "high priority" categories: (a) maintenance and operational expenses for public safety; environment; public transportation; health; recreation; libraries; social services for the poor or aged; and financial administration and (b) ordinary and necessary capital expenditures authorized by law. Additionally, Revenue Sharing funds may not be used as matching funds for other Federal funds nor may they be used in violation of the Civil Rights Law.

Revenue Sharing funds appropriated to Maryland are shown in the following table:

TABLE 8
Revenue Sharing Funds Appropriated to Maryland

	State	Local	Total
Fiscal 1973	$40,769,000	$ 81,538,000	$122,307,000
Fiscal 1974	54,445,000	108,890,000	163,335,000
Fiscal 1975	41,000,000	82,000,000	123,000,000

Source: Maryland Department of Legislative Reference.

Most of the $94,000,000 of Revenue Sharing funds appropriated to the State of Maryland for Fiscal 1973 and 1974 were put into the State Retirement Funds, according to the Department of Budget and Fiscal Planning. Subsequently, the original monies in the Retirement Fund were transferred and used to balance the budget. It would appear that the State's position is one of caution in using Revenue Sharing funds in ways where there could be no question about compliance with Federal regulations such as the Accounting, Federal Audit and the Civil Rights Laws. Local governmental units, apparently, are also taking a similarly cautious position. If a local unit of government would, for example, be found in violation of the Civil Rights Law, both the local government and the State would stand to lose that portion of Revenue Sharing funds involved in the violation. It is known, for instance, that Maryland was considering using Revenue Sharing funds for school aid. This plan was abandoned when one of the county boards of education became involved in litigation on charges of discrimination in hiring practices. If found guilty, the county would have lost its Revenue Sharing funds granted to the county board of education and the State would also lose its Revenue Sharing funds granted to the Board of Education. Thus, in order to safeguard its Revenue Sharing funds, each level of government is inclined to allocate Revenue Sharing funds to areas that clearly satisfy the Federal regulations and then transfer the original funds in these projects to other areas. At least one county in Maryland is placing its Revenue Sharing funds in the general fund.

For the purposes of this report, a number of inquiries were made to State officials to ascertain if any of the Revenue Sharing funds had been allocated to child care at either the State or local level in Maryland. In each case, the answer was negative or the agency had no information.

While inquiries in Maryland failed to obtain any information that any Revenue Sharing funds have been allocated to child care either on a local or State level, it is known that other states have done so. Two hundred thousand dollars from approximately $1,600,000 Revenue Sharing funds received by Ann Arbor, Michigan have been assigned to child care centers and the Ann Arbor-Washtenaw County 4-C. In addition, Federal reports indicate that some of the other states are allocating substantial amounts of Revenue Sharing funds for health, education, and social programs.

Recommendations:

- The combined public and private community of interests representing the field of child development has an obligation to understand Revenue Sharing and its method of distribution.
- A coalition of the above interests at the local level should be formed for the purpose of insuring that state legislators and local county officials set

priorities for expending Revenue Sharing funds to include comprehensive child care and child services.

- The new federalism concept of General Revenue Sharing along with renewed emphasis on accountability and cost effectiveness require new strategies because of complexities of the law and the competition for funds. Regional workshops to inform the many interested in child care and child development should be considered.

Groups may find helpful a model method for follow-through on Revenue Sharing priorities which was developed by the Montgomery County 4-C Council, 14 South Maryland Avenue, Rockville, Maryland 20850.

The Office of Youth Development, Division of Youth Activities, Department of Health, Education, and Welfare, Room 1651, Donohoe Building, 330 Independence Avenue, S.W., Washington, D.C. 20201 has developed an informative Revenue Sharing Briefing Packet which is available on request.

FEDERAL GRANTS-IN-AID AWARDED TO MARYLAND

The State Plan as an instrument to inform the child development community about a planning resource published by the Department of State Planning.

The Department of State Planning is designated by the Governor as the central information agency to receive notices of Federal Grants-in-Aid made to the State of Maryland and its political subdivisions. Federal agencies awarding the grants have the responsibility of reporting them to this State agency on standard forms. Based on this information, a Monthly Report and an Annual Report on Grants-in-Aid are published and circulated to the various State agencies. During the three years that Maryland has been receiving this information, reports have become increasingly comprehensive and accurate. However, omissions and errors still exist in the data submitted by Federal authorities. Certain programs such as the Food Stamp Program and the Appalachian Regional Commission Child Development Grants, for example, are not included.

The Maryland 4-C Committee, with assistance from the Department of State Planning, analyzed the Third Annual Report of Federal Grants-in-Aid awarded in Maryland, July 1, 1972 to June 30, 1973, for the purpose of identifying Federal reported Grants-in-Aid *potentially* earmarked for services for children 0 to age six and their families. The word "potentially" must be used because a breakdown of funds for specific age groups is not available.

Categories established to determine these Federal Grants-in-Aid potentially available were: (1) direct services to children 0-6 such as Head Start or day care programs; (2) direct services to families of children 0-6, such as

Maternal and Child Health Services; (3) other services to children 0-6 such as programs for retarded, handicapped or educationally deprived children; (4) indirect services to families of children 0-6 such as family planning services, family health programs and general social services.

Tables 9 and 10 represent the first known attempt to define the number and amounts of Federal Grants-in-Aid potentially providing services for Maryland's children 0-6 and their families. The information presented

TABLE 9
Comparison of Federal Grants-in-Aid Awarded to Maryland State Agencies for FY 1973 as Reported by Federal Agencies Which Fund Services Potentially Available to Children Aged 0-6 and Their Families

State Agencies	Contributors				Total
	Federal	State	Local	Other	
Education	$33,601,244	$ 0	$ 0	$ 0	$33,601,244
Higher Education	530,940	0	121,696	0	652,636
Employment and Social Services	28,073,416	22,689,770	0	0	50,763,186
Health and Mental Hygiene	3,595,964	1,933,642	56,235	1,815	5,587,656
Total	$65,801,564	$24,623,412	$177,931	$1,815	$90,604,722

Source: Federal Grants-in-Aid awarded in Maryland, July 1, 1972 to June 30, 1973, Department of State Planning.

cannot be considered totally precise or comprehensive, because of the lack of a breakdown into age groups previously mentioned. With this reservation, the tables indicate that:

1. In Fiscal Year 1973, three political subdivisions, Caroline, Cecil, and Harford Counties, with a total population of 188,450 including 26,150 children aged 0-6, did not receive *directly* any Federal Grants-in-Aid for assistance in providing services to young children and their families.
2. In Fiscal Year 1973, the State of Maryland contributed matching funds to only four political subdivisions: Anne Arundel ($2,000), Garrett ($7,738), and Prince George's ($996,447) Counties and Baltimore City ($510,366), with $22,140 provided to miscellaneous organizations.
3. The total amount of Federal Grants-in-Aid received by the State Departments of Education, Higher Education, Employment and Social Services and Health is $90,604,722, while the total amount received by the combined political subdivisions is $34,867,814.

TABLE 10
Comparison of Federal Grants-in-Aid Awarded to Maryland Political Subdivisions for FY 1973 as Reported by Federal Agencies Which Fund Services Potentially Available to Children Aged 0-6 and Their Families

Political Subdivisions	Contributors				Total
	Federal	State	Local	Other	
Allegany					
Head Start	$148,697	$ 0	$123,764	$ 0	$ 272,461
Health	160,178	0	10,700	37,548	208,426
TOTAL	$308,875	$ 0	$134,464	$37,548	$ 480,887
Anne Arundel					
Head Start	$150,080	$ 0	$ 74,760	$ 0	$ 224,840
Health	654,858	2,000	294,004	11,000	961,862
TOTAL	$804,938	$2,000	$368,764	$11,000	$1,186,702
Baltimore					
Head Start	$270,304	$ 0	$ 97,211	$ 0	$ 367,515
TOTAL	$270,304	$ 0	$ 97,211	$ 0	$ 367,515
Calvert (Member Southern Maryland Tri-Counties Council Calvert, Charles and St. Mary's Counties)					
TOTAL	$ 0	$ 0	$ 0	$ 0	$ 0
Caroline					
TOTAL	$ 0	$ 0	$ 0	$ 0	$ 0

Source: Federal Grants-in-Aid awarded in Maryland, July 1, 1972 to June 30, 1973, Department of State Planning

TABLE 10 (Continued)
Comparison of Federal Grants-in-Aid Awarded to Maryland Political Subdivisions for FY 1973 as Reported by Federal Agencies Which Fund Services Potentially Available to Children Aged 0-6 and Their Families

Political Subdivisions	Contributors				Total
	Federal	State	Local	Other	
Carroll					
Head Start	$ 30,960	$ 0	$10,327	$0	$ 41,287
TOTAL	$ 30,960	$ 0	$10,327	$0	$ 41,287
Cecil					
TOTAL	$ 0	$ 0	$ 0	$0	$ 0
Charles (Also member Southern Maryland Tri-counties Council)					
Early Childhood Program	$328,513	$ 0	$ 0	$0	$328,513
TOTAL	$328,513	$ 0	$ 0	$0	$328,513
Dorchester					
Head Start	$ 46,007	$ 0	$20,225	$0	$ 66,232
TOTAL	$ 46,007	$ 0	$20,225	$0	$ 66,232
Frederick					
Head Start	$ 74,302	$ 0	$27,337	$0	$101,639
TOTAL	$ 74,302	$ 0	$27,337	$0	$101,639
Garrett					
Head Start	$138,398	$ 0	$41,760	$0	$180,158
Health	15,136	7,738	7,398	0	30,272
TOTAL	$153,534	$ 7,738	$49,158	$0	$210,430
Harford					
TOTAL	$ 0	$ 0	$ 0	$0	$ 0

Source: Federal Grants-in-Aid awarded in Maryland July 1 1972 to June 30, 1973. Department of State Planning

TABLE 10 (Continued)
Comparison of Federal Grants-in-Aid Awarded to Maryland Political Subdivisions for FY 1973 as Reported by Federal Agencies Which Fund Services Potentially Available to Children Aged 0-6 and Their Families

Political Subdivisions	Contributors				Total
	Federal	State	Local	Other	
Howard					
Head Start	$215,923	$ 0	$ 72,781	$ 0	$ 288,704
TOTAL	$215,923	$ 0	$ 72,781	$ 0	$ 288,704
Kent					
(Member Kent/Queen Anne's Talbot Area Council)					
TOTAL	$ 0	$ 0	$ 0	$ 0	$ 0
Montgomery					
Head Start	$860,522	$ 0	$1,979,181	$ 0	$2,839,703
TOTAL	$860,522	$ 0	$1,979,181	$ 0	$2,839,703
Prince George's					
Head Start	$361,094	$996,447	$ 151,584	$1,325,935	$2,835,020
Health	269,616	0	135,219	0	404,835
TOTAL	$630,670	$996,447	$ 286,803	$1,325,935	$3,239,855
Queen Anne's					
(Member Kent/Queen Anne's Talbot Area Council)					
TOTAL	$ 0	$ 0	$ 0	$ 0	$ 0
St. Mary's					
(Member Southern Maryland Tri-County Council)					
TOTAL	$ 0	$ 0	$ 0	$ 0	$ 0
Somerset					
Head Start	$156,260	$ 0	$ 45,484	$ 0	$ 201,744
TOTAL	$156,260	$ 0	$ 45,484	$ 0	$ 201,744

Source: Federal Grants-in-Aid awarded in Maryland July 1, 1972 to June 30, 1973 Department of State Planning.

TABLE 10 (Continued)
Comparison of Federal Grants-in-Aid Awarded to Maryland Political Subdivisions for FY 1973 as Reported by Federal Agencies Which Fund Services Potentially Available to Children Aged 0-6 and Their Families

Political Subdivisions	Contributors				Total
	Federal	State	Local	Other	
Talbot					
(Member Kent-Queen Anne's-Talbot Area Council)					
TOTAL	$ 0	$ 0	$ 0	$ 0	$ 0
Washington					
Head Start	$ 221,197	$ 0	$ 56,141	$ 0	$ 277,338
Health	65,527	0	10,693	4,955	81,175
TOTAL	$ 286,724	$ 0	$ 66,834	$ 4,955	$ 358,513
Wicomico					
(Member Shore-Up, Inc.)					
TOTAL	$ 0	$ 0	$ 0	$ 0	$ 0
Worcester					
(Member Shore-Up, Inc.)					
TOTAL	$ 0	$ 0	$ 0	$ 0	$ 0
Baltimore City					
Head Start	$ 1,072,959	$ 0	$ 267,464	$ 0	$ 1,330,423
Day Care	22,100	0	0	3,230	25,330
Education	17,644	0	0	18,548	36,192
Health					
Dept. of	4,659,697	61,000	437,333	4,264,319	9,422,269
Hospitals	2,251,418	414,366	77,889	1,497,480	4,241,153
CAA	1,818,710	0	0	659,574	2,478,284
Other	1,999,525	35,000	3,519,444	265,757	5,819,726
TOTAL	$11,842,053	$510,366	$4,302,130	$6,708,908	$23,363,457

Source: Federal Grants-in-Aid awarded in Maryland, July 1, 1972 to June 30, 1973, Department of State Planning.

TABLE 10 (Continued)
Comparison of Federal Grants-in-Aid Awarded to Maryland Political Subdivisions for FY 1973 as Reported by Federal Agencies Which Fund Services Potentially Available to Children Aged 0-6 and Their Families

Political Subdivisions	Contributors				Total
	Federal	State	Local	Other	
Southern Maryland Tri-County Council (Calvert, Charles and St. Mary's Counties)					
Head Start	$ 423,893	$ 0	$ 106,080	$ 0	$ 529,973
Day Care	20,000	0	5,000	0	25,000
TOTAL	$ 443,893	$ 0	$ 111,080	$ 0	$ 554,973
Kent-Queen Anne's Talbot Area Council					
Head Start	$ 147,183	$ 0	$ 79,871	$ 0	$ 227,054
TOTAL	$ 147,183	$ 0	$ 79,871	$ 0	$ 227,054
CAA Shore Up, Inc. (Wicomico and Worcester Counties)					
Head Start	$ 435,580	$ 0	$ 192,181	$ 0	$ 627,761
TOTAL	$ 435,580	$ 0	$ 192,181	$ 0	$ 627,761
Miscellaneous					
Health	$ 279,288	$ 22,140	$ 0	$ 70,017	$ 371,245
Day Care	3,915	0	0	7,685	11,600
TOTAL	$ 283,003	$ 22,140	$ 0	$ 77,702	$ 382,845
TOTALS	$17,319,244	$1,538,691	$7,843,831	$8,166,048	$34,867,814

Notes:

1. Programs for this listing have been grouped by function, e.g., "health" does not mean a department of health but rather all health programming for the respective subdivisions, except Baltimore City.
2. In instances where a county is a member of a multi-county subdivision which is the funding recipient, the name of the appropriate multi-county subdivision is indicated within the county listing.
3. "Miscellaneous" includes the following recipients: The Chesterwye Day Care Center in Queen Anne's County, Health Planning Council of Appalachian Maryland, Western Maryland Health Care Corporation, Sacred Heart Hospital, Cumberland, and the Community Counseling Center, Inc., Cumberland.

Source: Federal Grants-in-Aid awarded in Maryland, July 1, 1972 to June 30, 1973, Department of State Planning.

It is believed that if more regular use were made of the Department of State Planning reports on Federal Grants-in-Aid by the total child care and child development community, especially the public agencies, this planning resource could be improved and become a very helpful planning tool for both the State and local communities. A coordinating structure should be assigned the responsibility of preparing regular abstracts from this publication for appropriate circulation. Grants received by State and local communities not included in the Planning Department's publication should be reported promptly to the latter agency so that Federal authorities can be made more responsive in their reporting activities.

In addition, the coordinating structure should be assigned the responsibility for providing information and technical assistance to *all* political subdivisions about funding opportunities through Federal sources.

Further exploration is needed to determine the State's criteria for the distribution of matching and support funds for locally awarded grants.

Chapter V

Statistics on Maryland's Children and Their Families

The State Plan as a statistical description of Maryland's children.

As a tool for coordinating and planning comprehensive child development services, the Maryland 4-C Committee collected the best available data on Maryland's children and their families.

The data in Tables 11 through 21 bear on the service needs of children ages 0 through 5 and their families. They were prepared to serve as background information for those concerned with the delivery of services to children and their families. Among these people are officials of State and local public and voluntary agencies, service consumers, professionals, citizens, and the members of the Maryland 4-C Committee and the local 4-C Councils. Sources of the data are indicated in footnotes on each table.

It will be noted that the statistics do not all cover the same time period. They are, however, the most recent data available at the time of writing this report.

USES OF THE DATA

The statistics contained in the following tables have a variety of uses. Among the most important is the assessment of gaps between the need for particular services and the number of persons actually receiving such services. Although precise measurement of such gaps is a complex, time-consuming process, the figures can be used for rough, order-of-magnitude labeling of service needs. This may be done by identifying a target population for a particular service and comparing the size of that population with the number of persons receiving the service. For example, one might take the target population for subsidized pediatric care to be all poor children ages 0

through 5. This number then would be compared with the number of patients in health department well-child clinics, with the number of children receiving Medical Assistance, and perhaps with the total of these two figures.

The same example will point up some of the limitations of this method. In this case, the target population might include the near-poor families. In a certain locality, poor children might receive subsidized pediatric care from non-governmental clinics which would not be included in the data on well-child clinics. However, despite such limitations, if the target population is considerably larger than the population shown to be using such services, it appears probable that there is substantial unfilled need.

To determine need with greater accuracy suggests that further in-depth investigation is needed. It is recommended that the present data be used as a basis for further questions. Clarification of these questions may reveal the existence of more recent or more detailed data, the existence of more usable definitions, or, most important of all, the existence of a need for new program development.

DEFINITIONS

AFDC–Aid to families with dependent children. This is the Department of Employment and Social Services program popularly known as "welfare." Statistics on AFDC children include all school-age children. An approximation of the number of preschool children is obtained by dividing the number of AFDC children by three.

Completed Adoptions–Adoptions (includes all ages) in which all legal requirements and court proceedings have been completed.

Day Care (Family and Group)–*Family* day care homes are those licensed by the local department of social services to provide care for up to four children in private homes. *Group* day care centers are those licensed by local health departments to provide care for five or more children. Some group day care centers house half-day programs approved as nursery schools by the State Department of Education.

Day Care (Full-day and Half-day)–Half-day centers operate in either the morning or the afternoon but not in both. Full-day centers operate in both morning and afternoon.

ESEA Program–Elementary and Secondary Education Act program for the disadvantaged. This is a compensatory education program for disadvantaged children funded under Title I of the ESEA.

Foster Care–Subsidized care of children in homes or institutions provided by the departments of social services. The data in Table 13 concerning

foster care are for children of any age. Data for children under six are not available.

FY–Denotes the July through June fiscal year. For example, FY 1972 means the period from July 1, 1971 to June 30, 1972.

Low-Weight Birth–Baby born weighing less than 2,500 grams (approximately five and one-half pounds). Generally, a high incidence of such births is indicative of serious infant health deficiencies.

Subsidized Day Care–Local departments of social services pay for day care for needy children by purchasing care from private centers or by operating public centers.

Subsidized Family Planning Services–Includes counseling, contraceptive distribution, and other outpatient services provided by public clinics. The "Dryfoos-Polgar-Varky" formula, developed for Planned Parenthood–World Population, has been used to estimate the number of women in a given area who need these services. The estimate is based on age distribution, income levels, and urban/rural mix in the area.

Therapeutic Abortions–Abortions performed in Maryland by physicians acting in accordance with the Maryland abortion law. In this report, the data on abortions do not include those performed out-of the State on Maryland residents.

Well-Child Clinic Patients–An estimate of the number of children ages 0 through 4 years who received at least one routine checkup at a local health department clinic. The data do not include children who received checkups in other than local health departments.

CHILD CARE AND CHILD DEVELOPMENT PROGRAMS VARY ACROSS THE STATE

The early years of life constitute a critical period of physical, social, emotional, and intellectual growth. The importance of proper nutrition, positive social interaction with adults and peers, experience which stimulates concept and language development, and attention to physical and emotional health has been established. Ideally, these components of development are the responsibility of the family. However, in a complex society resources beyond those within the family are required to maintain health and achieve optimum development.

The need for child development programs in Maryland is attested to by a few representative statistics. In 1970 Maryland had a total population of 3,922,399 of which 2,006,078 (51.1 percent) were female. Of these women, 624,507 (31.1 percent) were in the labor force. Of those women in the labor

force, 89,696 had children ages 0 through 5 in their families. This number represents approximately one-third of all mothers with children ages 0 through 5. A further indicative statistic is that there are 43,478 children, ages 0 through 5, who are members of 23,398 female-headed households. These family situations frequently require that mothers be away from their children during the day, which may interfere with the mothering process.

Equally significant are situations in which mothers are unable to properly care for their children because of physical or mental illness or the demands made by severe illness or problems of other members of the family. Statistics do not reveal the incidence of these cases, but their effects are far-reaching in child development.

In 1970 there were 423,085 children ages 0 through 5 in Maryland. It is impossible to arrive at any accurate estimate of the number of developmental programs available for these children, but it seems probable that many of the children who need such programs are not being served.

The availability and utilization of programs for children and their families vary widely across the State, as indicated in Tables 13, 18, 19, 20, and 21. For example, in seven counties there was no subsidized day care for children in fiscal year 1972. Ten counties had no prekindergarten enrollment, and Cecil County had no kindergarten public enrollment although there was some nonpublic kindergarten enrollment in this county. Cecil County now has a public kindergarten program.

At present, there is no single, central unit for the collection, storage, and publication of comprehensive data about children in Maryland. The difficulty in obtaining the data in this report—despite the willing cooperation of the Departments of Health and Mental Hygiene, Education, and Employment and Social Services—points up the problem and suggests a major issue. Better communication and cooperation are needed among these departments in order to improve the recording of information concerning young children, so that services can be maximized, resources used optimally and efficiently, and wasteful duplication avoided. Improvements in the collection and preparation of data and regular evaluation are basic to the future planning for the children of Maryland.

DEMOGRAPHY AND FAMILY COMPOSITION

Table 11 presents data showing the total population, white and non-white, in Maryland's counties and Baltimore City as of 1970. The population ranged from a high of 905,759 in Baltimore City to a low of 16,146 in Kent County. The non-white population was concentrated in Baltimore City, with 425,922, as compared with Garrett County's 70.

To plan child development services and programs for the 423,085

TABLE 11

Population of Maryland Areas, Children 0 through 5, and Children as Percent of Population, by Race, 1970*

Name of Area	Population			Children 0 through 5			Children 0 through 5 as Percent of Population		
	Total	White	Non-white	Total	White	Non-white	Total	White	Non-white
Allegany	84,044	82,857	1,187	7,747	7,628	119	9.2	9.2	10.0
Anne Arundel	297,539	262,499	35,040	32,452	28,554	3,898	10.9	10.9	11.1
Baltimore	621,077	598,989	22,088	60,527	58,111	2,416	9.8	9.7	10.9
Calvert	20,682	12,888	7,794	2,696	1,419	1,277	13.0	11.0	16.4
Caroline	19,781	15,790	3,991	1,943	1,427	516	9.8	9.0	12.9
Carroll	69,006	66,127	2,879	6,932	6,660	272	10.0	10.1	9.5
Cecil	53,291	50,194	3,097	6,282	5,905	377	11.8	11.8	12.2
Charles	47,678	33,940	13,738	6,923	4,691	2,232	14.5	13.8	16.3
Dorchester	29,405	20,289	9,116	2,779	1,683	1,096	9.5	8.3	12.0
Frederick	84,927	78,882	6,045	9,032	8,229	803	10.6	10.4	13.3
Garrett	21,476	21,406	70	2,391	2,383	8	11.1	11.1	11.4
Harford	115,378	105,282	10,096	13,703	12,367	1,336	11.9	11.8	13.2
Howard	61,911	56,573	5,338	7,102	6,511	591	11.5	11.5	11.1
Kent	16,146	12,167	3,979	1,449	996	453	9.0	8.2	11.4
Montgomery	522,809	493,934	28,875	53,347	49,468	3,879	10.2	10.0	13.4
Prince George	660,567	561,476	99,091	84,208	68,901	15,307	12.8	12.3	15.5
Queen Anne	18,422	13,921	4,501	1,723	1,254	469	9.4	9.0	10.4
St. Mary	47,388	38,758	8,630	6,691	5,329	1,362	14.1	13.8	15.8
Somerset	18,924	11,826	7,098	1,723	897	826	9.1	7.6	11.6
Talbot	23,682	17,923	5,759	2,013	1,395	618	8.5	7.8	10.7
Washington	103,829	100,262	3,567	10,562	10,295	272	10.2	10.3	7.6
Wicomico	68,236	42,652	11,584	5,020	3,620	1,380	9.3	8.6	11.7
Worcester	24,442	16,424	8,018	2,429	1,408	1,021	9.9	8.6	12.7
Baltimore City	905,759	479,837	426,922	93,410	39,258	54,152	10.3	8.2	12.7
The State	3,922,399	3,194,885	727,514	423,085	328,439	94,646	10.8	10.3	13.0

*Source: U.S. Census of Population 1970, General Population Characteristics PC (1)-B22, Maryland Tables 34 and 35

Maryland children ages 0 through 5, knowledge of their geographic distribution is essential; this is presented in Table 11. The data show that 22 percent of the children lived in Baltimore City, 20 percent in Prince George's County, 14 percent in Baltimore County, and 13 percent in Montgomery County, for a total of 69 percent—or more than two-thirds—of the State's children. By contrast, seven counties—Caroline, Garrett, Kent, Queen Anne's, Somerset, Talbot, and Worcester—had fewer than 2,500 children in these age groups. The children in these seven counties totalled only 13,671, or three percent, of the State's child population.

Counties with a high percentage of young children in their population should expect to budget a larger proportion of public funds and services for this age group. Table 11 provides the percentages of children in each county. There was wide variation ranging from a low of 8.5 percent in Talbot County to a high of 14.5 percent in Charles County. Calvert and St. Mary's Counties, also in Southern Maryland with Charles County, have large percentages of young children.

Table 12 shows the number of families that have young children, the number of families with only a male head of family, the number with a female head of family, and the number of children in each of these two categories. The absence of one or the other adult member of the family has child development implications. However, the number of male-headed families with small children in Maryland is less than one percent of all families with young children, whereas female-head families (that is, without a male parent) constitute 8.7 percent of all families. The variation around the State is indicated by Baltimore's 22.5 percent of female-headed families contrasted with Howard County's 3.5 percent and Garrett County's 3.7 percent. The variation by race is even greater; in Baltimore, 9.9 percent of white families are female-headed whereas 33.8 percent of the non-white families are female-headed.

Table 12 also shows the number of children ages 0 through 5 living in families in each area. It should be noted that these figures do not include children in institutions or those living with persons other than their own parents, which explains why these figures are slightly smaller than the figures in Table 11 that show the number of children.

FOSTER CARE, ADOPTIONS, AND CHILD ABUSE

Foster care and adoptions are child services resulting from illegitimate births, neglect, parental death, illness, or divorce. Table 13 provides data showing the number of illegitimate births and their rates per 1,000 live births, the number of children receiving foster care, and the number of completed adoptions. The table also shows the number of cases of suspected

TABLE 12

Number of Families with Children 0 through 5 and Number of Children in Such Families; Number of Male-Headed and Female-Headed Families with Children 0 through 5, by Race and Area, 1970

Name of Area	All Families with Children 0-5*			Children 0-5**	Husband-wife Families with Children 0-5*			Male-headed Families with Children 0-5*			Female-headed Families with Children 0-5*		
	Total	White	Non-white		Total	White	Non-white	Total	White	Non-white	Total	White	Non-white
Allegany	5,036	4,974	62	7,680	4,703	4,655	48	37	36	1	296	283	13
Anne Arundel	21,179	19,263	1,916	31,830	19,990	18,438	1,552	178	132	46	1,011	693	318
Baltimore	40,771	39,400	1,371	59,373	38,751	37,542	1,209	217	195	22	1,803	1,663	140
Calvert	1,333	876	457	2,832	1,209	835	374	20	7	13	104	34	70
Caroline	1,187	969	218	1,814	1,061	900	161	20	14	6	106	55	51
Carroll	4,611	4,481	130	6,873	4,387	4,277	110	40	36	4	184	168	16
Cecil	3,830	3,661	169	6,638	3,626	3,488	138	28	26	2	176	147	29
Charles	3,928	3,029	899	7,222	3,656	2,927	729	45	21	24	227	81	146
Dorchester	1,630	1,157	473	2,794	1,405	1,076	329	34	12	22	191	69	122
Frederick	9,796	9,434	362	8,903	9,439	9,169	270	66	55	11	291	210	81
Garrett	1,455	1,454	1	2,568	1,386	1,385	1	15	15		54	54	
Harford	8,944	8,238	709	13,745	8,403	7,811	592	53	42	11	488	382	106
Howard	4,634	4,329	305	6,995	4,444	4,186	258	28	21	7	162	122	40
Kent	877	680	197	1,399	798	650	148	17	5	12	62	25	37
Montgomery	35,796	33,462	2,334	52,694	34,049	31,989	2,060	225	182	43	1,522	1,291	231
Prince George	55,859	46,522	9,317	83,443	52,085	43,873	8,212	393	270	123	3,361	2,379	982
Queen Anne	1,067	861	206	1,580	970	825	145	23	6	17	74	30	44
St. Mary	4,072	3,484	588	6,978	3,754	3,314	440	47	30	17	271	140	131
Somerset	954	600	354	1,711	824	560	264	13	1	12	117	39	78
Talbot	1,236	987	249	1,948	1,108	926	182	10	7	3	118	54	64
Washington	6,996	6,837	159	10,319	6,485	6,374	111	57	54	3	454	409	45
Wicomico	3,244	2,606	638	4,960	2,919	2,458	461	36	17	19	289	131	158
Worcester	1,386	954	432	2,457	1,233	912	321	21	4	17	132	38	94
Baltimore City	52,893	25,030	27,863	89,038	40,002	22,281	17,721	986	267	719	11,905	2,482	9,423
The State	268,694	219,285	49,409	415,794	242,687	206,851	35,836	2,609	1,455	1,154	23,398	10,979	12,419

*Source: U.S. Census of Population 1970, General, Social, and Economic Characteristics, PC(1)-B22, Maryland, Table 36.

**Source: U.S. Census of Population 1970, 2nd Count Summary Tape, Table 7.

child abuse; these undoubtedly err on the low side, since many cases are not known and reported.

The columns in Table 13 showing the ratio of the number of illegitimate births per 1,000 live births permits comparison among the counties. Baltimore City was highest in 1972, with Dorchester County next. The lowest rates were found in Baltimore, Garrett, Montgomery, and Howard Counties. The picture was different when the areas were compared only for whites or only for non-whites. Baltimore City was highest for whites; but for non-whites, Queen Anne's County led the list, with the other Eastern Shore counties of Talbot, Somerset, Dorchester, Worcester, Wicomico, and Kent not far behind. The lowest non-white rates were in Montgomery and Baltimore Counties.

By comparing the number of completed adoptions of all ages (those for which all legal and court action has been completed) with the number of illegitimate births one can draw some conclusions about the utilization of adoption services. However, such conclusions must be tempered with several constraints. Adoptions may occur at any age and are not necessarily related to birth status. Also, an adoption in one area may involve a birth that occurred elsewhere. The fact that the number of illegitimate births far outnumbered the number of completed adoptions may merely indicate that many such babies were never put up for adoption. However, in those counties where the number of adoptions approached the number of illegitimate births, it might be concluded that such counties were more successful in providing adoption services.

Table 13 indicates that there were 549 suspected cases of child abuse of children of all ages in fiscal year 1972 in the State. Undoubtedly, these figures are far less than the actual incidence of child abuse. Table 13 does not show the ratio of cases of child abuse to the most susceptible age group, those from infancy through five years, because in many counties the number of cases is too small for statistical analysis. In the State as a whole, the 549 cases amounted to a rate of 13.0 cases per 10,000 children. In Baltimore City, the rate was 33.9, the highest in the State, and Harford County was next with 18.2 per 10,000 children. Low rates were found in Montgomery County (4.9), Prince George's County (3.9), and Baltimore County (7.8). The numbers in the smaller counties were too small for analysis. Thirteen counties reported three or fewer cases for the year.

The complexities of child abuse are discussed more intensively in Chapter XI of this report.

FAMILIES BELOW THE POVERTY LEVEL

Table 14 provides 1970 U.S. Census data on the number of families with children ages 0 through 5 years that have incomes below the poverty level. Poverty does not necessarily by itself produce developmental problems

TABLE 13

Children Receiving Foster Care, FY 1972, Completed Adoptions 1971, Illegitimate Births, 1972, and Suspected Child Abuse, FY 1972, by Area

Name of Area	Children Receiving Foster Care, FY 1972*	Completed Adoptions, 1971**	Illegitimate Births, 1972†						Reports of Suspected Cases of Child Abuse, FY 72‡
			Number			Rate per 1000 live births			
			Total	White	Non-white	Total	White	Non-white	
Allegany	213	63	73	64	9	66	60	300	11
Anne Arundel	372	186	427	169	258	91	42	403	34
Baltimore	903	422	363	262	101	48	37	229	47
Calvert	69	13	101	10	91	246	46	484	3
Caroline	172	14	50	12	38	193	64	528	1
Carroll	241	91	69	54	15	71	58	469	6
Cecil	300	50	94	68	26	102	78	510	10
Charles	149	28	205	39	166	208	86	568	3
Dorchester	84	No report	130	21	109	322	90	637	3
Frederick	662	29	130	70	60	100	99	531	7
Garrett	79	18	19	19	0	48	48	0	2
Harford	363	96	167	84	83	83	47	399	25
Howard	119	41	68	35	33	63	37	284	2
Kent	64	6	41	10	31	202	67	574	1
Montgomery	668	298	384	230	154	56	38	185	26
Prince George	1,227	501	1,074	424	650	93	50	227	33
Queen Anne	90	5	50	8	42	218	46	724	2
St. Mary	154	53	110	30	80	107	36	430	2
Somerset	172	19	79	8	71	285	49	623	2
Talbot	48	1	64	8	56	223	39	675	2
Washington	337	86	117	96	21	79	68	344	8
Wicomico	327	15	167	31	136	212	68	591	1
Worcester	119	20	106	8	98	319	41	710	1
Baltimore City	6,000±	723	5,378	539	4,839	405	103	601	317
The State	12,743	3,728	9,466	2,299	7,167	162	53	477	549

*Source: Maryland Department of Employment and Social Services, Division of Research and Analysis. The figures indicate the number of children receiving foster care on the first day of the fiscal year plus all those added during the fiscal year.

**Source: Maryland Department of Employment and Social Services, June, 1972. "Completed adoptions" are those adoptions in which all legal requirements have been completed.

†Source: Maryland Department of Health and Mental Hygiene, Center for Health Statistics, Annual Vital Statistics Report, Maryland, 1972, Table 17.

‡Source: Maryland Department of Employment and Social Services, Annual Report, 1972.

in children that require supplemental or remedial experiences. However, some of the conditions that lead to or accompany poverty do necessitate many child development services.

Maryland had, in 1970, 29,459 families with 48,356 children under six that were below the poverty level. Almost half, 44.9 percent of the families and 45.5 percent of the children, lived in Baltimore City, and 23.6 percent of all Baltimore City's children ages 0 through 5 lived in families below the poverty level.

Within the scope of the data provided in this chapter, it is impossible to show every relationship between factors. Thus, Table 14 does not indicate the percentage of all families, with children ages 0 through 5, that live below the poverty level. However, this information can be easily obtained by dividing each figure in the left-hand column of Table 14 by the comparable figure in the same column of Table 12. This calculation shows that 10.9 percent of Maryland's families with young children were below the poverty level. In contrast, 25.0 percent of Baltimore City's families with young children were below the poverty level, whereas only 4.2 percent of Montgomery County's families were below the poverty line.

The effect of poverty upon the family is increased for the female-headed family - the family without an adult male. In 1970 Maryland had 14,928 female-headed families below the poverty level, and more than half of these 8,738 families - lived in Baltimore City. Data for male-headed families were combined with husband-wife families because they are negligible in number. The total number of male-headed families at all economic levels was only 2,609 for the entire State, so the number of male-headed families below the poverty level would be insignificant.

The stereotype of female-headed families with large numbers of children is not supported by these data. In no county nor in Baltimore City is the number of children as many as two per family on the average.

BIRTH RATES, FAMILY PLANNING, AND THERAPEUTIC ABORTIONS

The Maryland birth rate for calendar year 1972 was 14.4 births per 1,000 population, or 58,310 new babies. The rate for whites was 13.3, and the rate for nonwhites was 18.9, as shown in Table 15. This crude birth rate was the lowest ever observed in Maryland,[1] and there is some evidence that the rate is going even lower. The lowest rate was experienced in Talbot County and the highest in St. Mary's County. However, crude rates are not satisfactory for making comparisons because of the differing compositions of

[1] Maryland Department of Health and Mental Hygiene, Center for Health Statistics, *Annual Vital Statistics Report Maryland 1972* Page

[2] Maryland Commission for

TABLE 14

Families with Children 0 through 5 that Have Incomes Below the Poverty Level, 1970
and Families with Children 0 through 5 Receiving AFDC in FY 1972

Name of Area	Families with Children 0-5 With Incomes Below the Poverty Line, 1970*						AFDC, FY 72	
	Total		Husband-wife and Male-headed Families**		Female-headed Families			
	Families	Children	Families	Children	Families	Children	Families	Estimated Number of Children Age 0 thru 5†
Allegany	694	1,098	450	732	244	366	611	483
Anne Arundel	1,643	2,476	917	1,495	626	981	2,397	1,918
Baltimore	1,672	2,452	960	1,449	712	1,003	1,936	1,465
Calvert	328	674	218	462	113	212	350	388
Caroline	304	481	178	308	166	173	240	214
Carroll	432	664	223	399	109	165	313	240
Cecil	408	764	265	484	143	280	382	311
Charles	421	631	312	476	139	255	840	836
Dorchester	390	653	247	459	143	194	327	289
Frederick	531	836	309	539	222	317	407	340
Garrett	409	782	342	658	67	124	216	194
Harford	740	1,140	448	670	292	470	758	654
Howard	246	345	112	161	134	184	224	186
Kent	134	219	88	142	46	77	139	102
Montgomery	1,514	2,396	887	1,373	657	1,023	1,889	1,499
Prince George	3,235	5,368	2,012	3,400	1,223	1,968	4,718	4,230
Queen Anne	213	295	144	188	69	97	115	86
St. Mary	716	1,299	488	898	228	401	539	498
Somerset	349	633	216	331	133	291	181	163
Talbot	253	359	136	199	117	160	107	90
Washington	916	1,486	604	1,048	312	438	763	623
Wicomico	513	726	284	402	229	324	760	628
Worcester	328	565	232	369	126	196	59	64
Baltimore City	13,230	22,015	4,492	7,754	8,738	14,261	33,895	30,860
The State	29,459	48,396	14,531	24,466	14,928	23,890	52,136	46,369

*Source: U.S. Census of Population, Fourth Count Summary Tape, Table 84

**Male-headed families comprise less than one percent of all family units in the State

†Source: Maryland Department of Employment and Social Services, Division of Research and Analysis. Figures in this column are estimated on the assumption that one-third of the child recipients of AFDC are age 0 through 5

the population. A county with a large proportion of older persons is apt to have a low crude birth rate even though its women of child-bearing age may have as high as or higher a birth rate than those in other areas. So great care must be used in analyzing the rates in Table 15.

The columns of subsidized family planning in Table 15 show the estimated need, the number of active recipients, and the percent of the estimated need that are active recipients. The estimated need is based on a formula developed for Planned Parenthood–World Population which takes into account the number of women of child-bearing age related to income.

The percent of the estimated need that receive subsidized family planning varied widely throughout the State, from a high of 77.1 percent in Worcester County to a low of 14.9 percent in Allegany County. However, there appears to be no direct relationship between the percentage of recipients and the birth rate. For example, Worcester County with 77.1 percent recipients had a birth rate of 13.4, but Allegany County with only 14.9 percent recipients also had a low birth rate of 13.1. But, as stated earlier, extreme caution must be used in making comparisons based on crude birth rates.

The data on abortions in Table 15 must be considered as having certain limitations. The total, 8,928 abortions, did not include 671 abortions performed in one Baltimore hospital that failed to report the residence of the women. Also not included were those abortions performed in the District of Columbia, or elsewhere out of the State, to women residing in Maryland. We may expect that there were also some illegal abortions performed which do not appear in the statistics.

There were wide variations in the numbers of abortions among the counties and also in the ratio of abortions to live births. In addition there were racial differences. In Baltimore City, where whites outnumber non-whites slightly, non-white abortions outnumbered white abortions by three to one. Baltimore City led all areas with 349.3 abortions per 1,000 live births, while Garrett County was lowest with 15 abortions per 1,000 live births.

Wide variations among the counties may indicate wide variations in the availability or the acceptability of family planning services. It may also be related to economic status, religious attitudes, and geographic location of the counties. A new factor to be introduced shortly is the announced policy that Medicaid will no longer pay for abortions.

INFANT MORTALITY, LOW WEIGHT BIRTHS AND PRENATAL CARE

The frequency of infant mortality and low weight births are important to a study of child development services. Infant mortality is defined as the

TABLE 15

Live Births and Birth Rates by Race, 1972, Subsidized Family Planning, FY 1972, and Therapeutic Abortions by Race, FY 1972, by Area

Name of Area	Live Births 1972* Number Total	Number White	Number Non-white	Rate per 1000 Population Total	Rate White	Rate Non-white	Subsidized Family Planning, FY 72** Est. Need	Active Recipients	Recipients as % of Est. Need	Therapeutic Abortions, FY 72† Total	White	Non-white
Allegany	4,104	4,074	30	13.1	13.0	23.4	3,064	455	14.9	91	86	5
Anne Arundel	4,702	4,062	640	15.1	14.7	18.3	5,326	1,903	35.7	626	478	148
Baltimore	7,579	7,138	441	11.8	11.6	17.2	8,587	1,573	18.3	1,667	1,470	197
Calvert	410	222	188	17.9	14.7	24.2	648	294	45.6	36	15	21
Caroline	259	187	72	12.9	11.6	18.3	732	229	31.3	48	33	15
Carroll	971	939	32	14.1	14.2	10.8	1,507	322	21.4	116	109	7
Cecil	923	872	51	17.2	17.2	16.7	1,170	328	28.0	65	54	11
Charles	987	695	292	18.1	17.6	20.7	1,219	411	33.7	43	14	29
Dorchester	404	231	173	13.9	11.7	15.3	1,069	420	39.3	59	27	32
Frederick	1,303	1,190	113	14.2	14.5	15.1	2,083	863	41.5	103	85	18
Garrett	399	399	0	[illegible]	18.2		1,140	307	26.9	6	5	1
Harford	2,005	[illegible]	207	[illegible]	15.9	[illegible]	2,307	1,020	44.2	239	187	52
Howard	1,074	[illegible]	136	14.1	14.0	15.0	1,010	571	56.5	165	130	35
Kent	203	149	[illegible]	12.2	[illegible]	[illegible]	636	270	42.5	42	32	10
Montgomery	6,290	[illegible]	[illegible]	[illegible]	[illegible]	21.[illegible]	7,625	[illegible]	17.4	280	226	34
Prince George's	11,409	[illegible]	[illegible]	16.4	[illegible]	[illegible]	10,660	2,441	22.9	332	239	93
Queen Anne's	[illegible]	[illegible]	[illegible]	[illegible]	11.9	[illegible]	602	[illegible]	[illegible]	30	16	14
St. Mary's	[illegible]	[illegible]	[illegible]	[illegible]	20.1	21.9	1,607	308	25.4	[illegible]	17	18
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	18	10	[illegible]
Talbot	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	64	36	28
Washington	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	12.1	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1,997	910	[illegible]	117	70	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	26	12
Baltimore City	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

* [illegible] Annual Vital Statistics Report, Maryland 1972, Table 11

** [illegible]

† [illegible] memorandum dated December [illegible] 1972. [illegible]

death of an infant under one year of age; the infant mortality rate is the number of infant deaths per 1,000 live births. Frequently these rates are used as an indication of the quality of infant and maternity services.

Low-weight births have been widely used as an indication of infant mortality. Infants weighing 2,500 grams (five and one-half pounds) or less are classified as premature, and those weighing more than 2,500 grams are considered mature.

Good prenatal care and obstetrical services and good nutrition can decrease the proportion of infants born with low weight and the number of deaths during infancy. Conversely, a high incidence of low-weight births or of infant mortality may indicate inadequate services for prenatal and postnatal care.

Table 16 provides data showing the number and rate of infant deaths in 1972 and the number and rate of low-weight births in the same year. The infant mortality rate of 16.4 infant deaths per 1,000 live births in Maryland was the lowest in the history of the State and was even lower than the rate for the United States.[1] In 1940 the infant mortality rate for the State was 49.2; it has decreased steadily since that time. The same trend has been observed for whites and non-whites. The white rate decreased from 41.7 in 1940 to 14.2 in 1972, while the non-white rate also decreased, from 76.6 in 1940 to 23.0 in 1970.

Lower rates than that in the State were recorded in Baltimore County, Anne Arundel, Harford, and Montgomery Counties. Other counties in the table with low rates had too few deaths for one to have confidence in the rates. The same caution must be observed in looking at counties with rates higher than the State rate, although St. Mary's County and possibly Washington County should be scrutinized. Baltimore City had a rate of 19.8, considerably higher than the State rate although not the highest in the State.

The ratio of low-weight births to live births points up even more vividly the need for prenatal care and the differences between the races. With a statewide rate of 76 low-weight births per 1,000 live births, whites had a rate of only 59 whereas the non-white rate was 124. Baltimore led the list with a total rate of 112, or 71 for whites and 138 for non-whites.

One may speculate about the degree of relationship between low-weight births and infant deaths. In this report there has not been a statistical correlation made between the two rates, and the results of such a calculation would be doubtful because of the small numbers of infant deaths in some counties. However, an interesting exercise can be performed quickly by looking at those eight jurisdictions that had 24 or more infant deaths in 1972: Anne Arundel, Baltimore, Harford, Montgomery, Prince George's, et

[1] Maryland Department of Health and Mental Hygiene, Center for Health Statistics, *Annual Vital Statistics Report*, Maryland, 1972. Page xvii and Table 9.

TABLE 16

Infant Deaths and Rates per 1000 Live Births, and Low Weight Births and Rates per 1000 Live Births, 1972, by Race and Area*

Jurisdiction/Area	Infant Deaths			Per 1000 live births			Low Weight Births**			Per 1000 live births		
	Total	White	Non-white	Total	White	Non-white	Total	White	Non-white	Total	White	Non-white
Allegany	18	18		16.3	16.8		65	63	2	59	59	67
Anne Arundel	69	55	14	14.7	13.5	21.9	301	224	77	64	55	120
Baltimore	101	94	7	13.3	13.2	15.9	468	431	37	62	60	84
Calvert	11	8	3	26.8	36.0	16.9	34	12	22	83	54	117
Caroline	5	2	3	19.3	10.7	41.7	19	8	11	73	43	153
Carroll	17	17		17.5	18.1		62	58	4	64	62	125
Cecil	17	15	2	18.4	17.2	39.2	63	55	8	68	63	157
Charles	17	9	8	17.2	12.9	27.4	71	36	35	72	52	120
Dorchester	13	4	9	32.2	17.2	52.6	40	16	24	99	69	140
Frederick	15	14	1	11.5	11.8	8.8	77	68	9	59	57	80
Garrett	9	9	-	22.6	22.6	-	23	23	-	58	58	-
Harford	30	25	5	15.0	13.9	24.0	144	119	25	72	66	120
Howard	14	11	3	13.0	11.5	25.9	65	53	12	61	55	103
Kent	3	1	2	14.8	6.2	37.0	17	5	12	84	34	222
Montgomery	90	76	14	13.1	12.5	16.8	383	305	78	56	50	94
Prince George's	184	130	54	16.1	15.2	18.9	797	509	288	70	60	101
Queen Anne's	3	3	-	12.9	17.1		15	6	9	64	34	155
St. Mary's	24	15	9	23.4	17.9	48.4	80	56	24	78	67	129
Somerset	4	2	2	14.4	12.3	17.5	19	7	12	69	43	105
Talbot	6	4	2	20.9	19.6	24.1	26	15	11	91	74	133
Washington	26	26		17.6	18.3		89	82	7	60	58	115
Wicomico	15	9	6	19.0	16.1	26.1	68	36	32	86	64	139
Worcester	5	2	3	18.1	10.3	31.7	31	14	17	93	72	123
Baltimore City	263	69	198	19.8	12.5	24.6	1480	372	1108	112	71	138
The State	989	614	345	16.4	14.2	23.0	4437	2673	1864	76	69	124

*Source: Maryland Department of Health and Mental Hygiene, Center for Health Statistics, Annual Vital Statistics Report, Maryland, 1972

**Weighing 2,500 grams or less.

Mary's, and Washington Counties and Baltimore City. If the rates for infant deaths and for low-weight births are listed side by side for each county, it will be observed that as one rate increased the other rate also increased, and as one decreased the other also decreased. This suggests that there may be a very real relationship between the two.

The number of mothers who received no prenatal care at all during their pregnancies was very small in 1972, as shown in Table 17. The total number in the State was 624, which amounted to only 1.1 percent of all births. (Note that the number of births is not exactly the same as the number of pregnancies.) Among whites, less than one percent of the births were without prenatal care, and for non-whites it was 2.2 percent.

The number of births occurring where there was no prenatal care during the first trimester of pregnancy was considerably higher: 28.5 percent, or 22.5 percent for whites and 40.0 percent for non-whites. These data on percentages of births without first-trimester prenatal care are large enough to permit some comparisons of counties. Low rates were found in Baltimore (however), Anne Arundel, Howard, Carroll, Montgomery, Talbot, and Washington Counties. The highest rates were in St. Mary's (highest), Dorchester, Frederick, Garrett, Kent, and Somerset Counties and Baltimore City.

HEALTH DEPARTMENT CLINICS

Local health departments provided prenatal care in all but one county, St. Mary's, in 1972 and provided services to children under five years of age in every county in the State, as indicated in Table 18. Approximately 29 percent of the babies born in 1972 were delivered to mothers who had received health department prenatal care. There are no available data on the number of women receiving prenatal care from private sources, but it seems probable that the percentage is much higher.

It might be expected that counties with a high economic level would have a smaller percentage of their pregnant women receiving health department prenatal care. This seems to be supported by Montgomery and Baltimore Counties, where the ratio of maternity clinic patients to live births was 7.7 percent and 9.0 percent respectively. Somerset, Worcester and Somerset Counties had ratios of 78.8 percent and 62.8 percent respectively. However, the relationship is by no means absolute. Garrett and Kent Counties have 14.0 percent and 12.7 percent respectively.

The number of children who received preventive services from local health departments through age four is shown in Table 18 with ratios for the number of children under one year of age and the number from one through four. One might expect a close relationship between the number of maternity clinic patients and the number of children under one year of age

TABLE 17

Number of Births without Prenatal Care during First Three Months of Pregnancy, and Number of Births without Prenatal Care During Entire Pregnancy, by Race and Area, 1972*

Area of Residence	1972 Births–No Prenatal Care During First 3 Months of Pregnancy						1972 Births–No Prenatal Care At All		
	Number			Percent of All Births			Number		
	Total	White	Non-white	Total	White	Non-white	Total	White	Non-white
Allegany	309	296	13	39.2	38.0	43.3	4	4	
Anne Arundel	970	719	251	20.6	17.*	39.2	31	20	11
Baltimore	972	858	114	12.8	12.0	25.9	34	31	3
Calvert	126	41	85	30.*	18.*	48.2	2		2
Caroline	85	52	33	33.6	27.8	48.6			
Carroll	321	205	116	25.9	21.8	50.0	8	8	
Cecil	293	273	20	18.3	31.2	41.2	9	8	1
Charles	338	199	139	34.2	27.2	51.6	12	5	7
Dorchester	166	63	103	41.1	27.0	60.2	5	3	2
Frederick	640	559	81	49.1	47.0	71.7	18	12	3
Garrett	164	164		41.1	41.1				
Harford	587	484	103	27.8	25.3	49.8	8	6	2
Howard	178	145	33	16.6	15.1	28.4	12	10	2
Kent	91	63	26	44.8	43.6	48.1	4	2	2
Montgomery	1,464	1,178	286	21.2	19.8	34.2	38	27	8
Prince George	3,382	2,086	1,296	29.6	24.4	45.3	129	68	61
Queen Anne	70	45	25	30.0	28.2	43.1	1	1	
St. Mary	329	183	146	51.6	45.6	78.5	11	5	6
Somerset	146	48	62	39.7	29.4	54.4	4	1	3
Talbot	87	59	28	19.9	14.2	33.7	2		2
Washington	416	291	19	20.9	20.5	33.1	10	8	2
Wicomico	258	133	122	32.3	23.8	53.0	6	1	5
Worcester	123	47	76	37.0	24.2	55.1	5	1	4
Baltimore City	5,134	1,313	3,821	38.9	25.6	47.8	277	66	211
The State	16,647	9,737	6,910	28.3	22.5	46.0	624	287	337

*Source: Maryland Department of Health and Mental Hygiene, Center for Health Statistics, Annual Vital Statistics Report, Maryland 1972. Adapted from data in Table 21.

TABLE 18

Maternity Clinic Patients and Children Served by Well Child Clinics of Local Health Departments by Race and Area, FY 1972*

Area of Origin	Health Dept. Maternity Clinic Patients, FY 72			Children Served by Health Department Well Child Clinics, FY 1972								
				Total (0-4 years)			Under 1 year			1 Years		
	Total	White	Non-white	Total	White	Non-white	Total	White	Non-white	Total	White	Non-white
Allegany	175	166	12	1,397	1,366	31	510	496	14	1,087	1,070	17
Anne Arundel	1,160	522	638	5,588	3,292	2,296	1,770	1,062	708	3,818	2,230	1,588
Baltimore	685	596	89	8,454	4,647	807	1,373	1,147	226	4,081	3,500	581
Calvert	52	47	5	884	782	732	230	41	189	654	111	543
Caroline	114	45	69	883	307	276	182	114	68	401	193	208
Carroll	229	204	25	614	539	75	154	126	28	460	413	47
Cecil	262	222	47	645	462	83	191	165	26	454	297	57
Charles	350	87	263	994	161	833	328	56	272	666	105	561
Dorchester	305	76	229	439	99	340	141	27	114	294	68	226
Frederick	111	549	62	1,043	709	334	317	222	95	726	487	239
Garrett	56	56	0	1,017	1,017	0	330	330	0	687	687	0
Harford	506	403	103	1,356	992	364	533	391	142	823	601	222
Howard	187	121	66	826	623	203	254	188	66	572	435	137
Kent	79	30	49	624	302	322	204	95	109	420	207	213
Montgomery	528	322	206	2,339	1,412	927	786	485	301	1,553	927	626
Prince George's	867	382	485	6,240	2,474	3,766	2,163	858	1,305	4,077	1,616	2,461
Queen Anne's	92	36	56	424	222	202	130	73	57	294	149	145
St. Mary's	0	0	0	1,157	689	468	360	194	166	797	495	302
Somerset	174	38	136	252	77	175	119	29	90	133	48	85
Talbot	101	93	108	417	169	248	133	57	76	284	112	172
Washington	198	190	8	1,010	930	80	311	283	28	699	647	52
Wicomico	373	136	237	367	120	247	350	115	235	17	5	12
Worcester	260	74	186	692	201	491	242	70	172	450	131	319
Baltimore City	9,229	2,234	6,995	26,774	5,500	21,274	10,134	2,068	8,066	16,640	3,432	13,208
The State	16,823	6,725	10,098	61,132	26,558	34,574	21,145	8,592	12,553	39,987	17,966	22,021

Source: Maryland Department of Health and Mental Hygiene, Division of Maternal and Child Health.

seen in a health department clinic. But examination of the data by counties shows some counties with fewer infants seen than mothers and the opposite in other counties.

One might also expect that the number of children ages one through four would be three to four times as great as the number under one year, but this is not true in many counties, and the dropout rate appears to be excessive. In the State as a whole the number in the one-through-four group is less than twice the size of the under-one-year group.

CHILDREN RECEIVING MEDICAL ASSISTANCE UNDER TITLE XIX

Table 19 provides data on the number of children under four and one-half years who received any type of medical assistance in fiscal year 1972 under the State Medicaid program. The other data in this report concern children ages 0 through 5, but because of the method by which the State's computer determines age it is impossible to obtain data on children up to five. Consequently, the upper age is four and one-half in Table 19. Also, the figures in this table refer to children who actually received some form of medical assistance during the year; they do not indicate the number of children that are in families enrolled in the Medical Assistance Program who received no medical assistance during the year.

The number of children who received medical assistance (Table 19) can be cautiously compared with the number of children under six in the total population (Table 11). Throughout the State approximately 12 percent of the children received medical assistance. As would be expected, the percentage is low in several counties—approximately four percent in Baltimore, Howard, and Montgomery Counties. On the other hand, the figure was just over 28 percent in Baltimore City and approximately 20 percent in Caroline, Dorchester, Somerset, and Talbot Counties.

PRESCHOOL CHILD DEVELOPMENT NEEDS

In Maryland there were 89,696 women in the labor force with children ages 0 through 5 years, as shown in Table 20. How many of these are women without an adult male in the family is not known, although it is known that there were 23,398 female-headed families with children under six in 1970. How many of these were part of the labor force is the unavailable statistic. The children of working mothers constitute one of the highest priorities for enrollment in some form of day care.

The number of children in day care centers compared with the number of women in the labor force varies widely by county. (Note that not all

TABLE 19

Number of Children Who Received Any Type of Medical Care Under the Maryland Medical Assistance Program (Medicaid), by Age and Race, by Area, FY 1972.*

Name of Area	Children Who Received Medicaid, FY 72								
	Total (0-4½ years)			Under 6 months			6 months to 4½ years		
	Total	White	Non-white	Total	White	Non-white	Total	White	Non-white
Allegany	1,110	1,060	50	64	61	3	1,046	999	47
Anne Arundel	2,449	1,476	973	59	32	27	2,390	1,444	946
Baltimore	2,429	2,147	282	74	67	7	2,355	2,080	275
Calvert	406	131	275	12	7	5	394	124	270
Caroline	394	195	199	15	8	7	579	187	192
Carroll	647	561	86	23	21	2	624	540	84
Cecil	747	601	146	17	14	3	730	587	143
Charles	1,099	325	774	40	15	25	1,059	310	749
Dorchester	552	122	430	24	9	15	528	113	415
Frederick	715	467	248	32	21	11	683	446	237
Garrett	485	485	0	27	27	0	458	458	0
Harford	1,008	741	267	37	28	9	971	713	258
Howard	311	232	79	13	10	3	298	222	76
Kent	176	76	100	14	8	6	162	68	94
Montgomery	2,221	1,504	717	81	57	24	2,140	1,447	693
Prince George's	4,808	2,579	2,229	128	77	51	4,680	2,502	2,178
Queen Anne's	157	69	88	7	3	4	150	66	84
St. Mary's	659	269	390	28	12	16	631	257	374
Somerset	351	88	263	9	4	5	342	84	258
Talbot	391	115	276	17	4	13	374	111	263
Washington	1,255	1,166	89	57	53	4	1,198	1,113	85
Wicomico	747	235	512	32	11	21	715	224	491
Worcester	178	49	129	17	3	14	161	46	115
Baltimore City	26,477	5,461	21,016	701	143	558	25,776	5,318	20,458
The State	49,772	20,154	29,618	1,528	695	833	48,244	19,459	28,785

*Source: Maryland Department of Health and Mental Hygiene. Maryland Medical Assistance Program.

TABLE 20

Women in Labor Force with Children 0 through 5, 1970; Use of Group Day Care Centers, 1973; and Family Day Care Homes and Children Receiving Subsidized Day Care, FY 1972, by County

Name of Area	Women in Labor Force with Children 0-5, 1970*		Group Day Care Centers, Oct. 1973**						Family Day Care Homes, FY 72†	Children Receiving Subsidized Day Care, FY 72†	
	All women over 15		Full-day		Half-day‡		Total			In Pvt. Centers	In Pub. Centers
	Total	Black	Centers	Children	Centers	Children	Centers	Children			
Allegany	1,030	31	9	261	4	229	13	490	33	182	–
Anne Arundel	5,898	1,035	33	1,129	23	802	56	1,931	101	204	119
Baltimore	10,721	763	52	2,153	66	3,092	118	5,245	287	23	53
Calvert	531	301	3	71	5	119	8	190	4	–	–
Caroline	382	104	5	106	1	25	6	131	7	89	–
Carroll	1,733	74	12	232	5	156	17	388	105	45	66
Cecil	1,343	106	4	143	5	164	9	307	42	32	92
Charles	1,369	458	5	148	5	336	10	484	16	–	–
Dorchester	893	373	4	105	3	71	7	176	22	6	145
Frederick	2,091	223	8	321	14	460	22	781	132	48	94
Garrett	360	0	3	48	0	0	3	48	–	–	–
Harford	2,422	347	14	665	7	332	21	997	36	–	48
Howard	1,172	159	8	304	9	338	17	642	26	27	–
Kent	338	131	2	37	3	57	5	94	9	–	–
Montgomery	9,605	1,008	55	2,570	108	5,264	163	7,834	347	591	58
Prince George's	20,478	5,658	96	3,793	37	2,318	133	6,111	177	164	112
Queen Anne's	409	142	0	0	3	87	3	87	2	6	6
St. Mary's	1,147	272	5	194	6	248	11	442	33	37	106
Somerset	440	201	7	205	0	0	7	205	20	–	–
Talbot	546	179	3	73	6	130	9	203	10	7	–
Washington	1,991	56	11	242	4	204	15	446	80	–	–
Wicomico	1,572	427	9	279	2	142	11	421	149	25	–
Worcester	607	264	6	228	2	27	8	255	21	–	–
Baltimore City	22,648	14,906	117	4,734	47	1,783	164	6,517	710	953	684
The State	89,696	27,198	471	18,041	365	16,384	836	34,425	2,369	2,439	1,577

*Source: U.S. Census of Population, 1970. General Social and Economic Characteristics. PC(1)-C22. Maryland. Tables 121 and 126.

**Source: Maryland Department of Health and Mental Hygiene. Division of Maternal and Child Health.

†Source: Maryland Department of Employment and Social Services.

‡Includes Centers operating on a "before and after school" or on an "hourly" basis.

women in the labor force are actually working; some may have just entered the labor force and are looking for their first job, and others may be temporarily unemployed.) If the number of children in family day care homes (2,312) is added to the number in group day care centers (34,425) the total is 36,738; this may be compared to the 89,696 women in the labor force for a ratio of 41 children per 100 women in the labor force. Baltimore County has 51 per 100 women, Baltimore City has 35, Anne Arundel has 33, Cecil has 27, and at the upper end Kent County has 110 children per 100 women.

There were 2,369 licensed family day care homes in fiscal year 1972. One-third of these—710—were in Baltimore City, as indicated in Table 20. All but Garrett County had some licensed family day care homes. Data showing the number of children in family day care are not available.

It can probably be assumed that many of the women who have children under six and who are below the poverty level are in the labor force. Therefore, it is disappointing to note in Table 20 that seven counties had no children receiving subsidized day care either in private or in public centers. These counties were Calvert, Charles, Garrett, Kent, Somerset, Washington, and Worcester. Several other counties had very few children in subsidized centers.

Table 21 provides statistics on the number of children enrolled in public and nonpublic prekindergarten and kindergarten. (Note that although this table also contains data on the handicapped children, the statistics on prekindergarten and kindergarten enrollment are not concerned with handicapped children.)

There were 13,077 children enrolled in prekindergarten as of September 30, 1972, but in 10 counties there was no prekindergarten enrollment. Almost half of the public enrollment was in Baltimore City and more than one-third was in the Montgomery-Prince George's area. In contrast, there were 65,171 children enrolled in kindergarten, and every county in the State had some enrollment. Only one county, Cecil, had no public kindergarten children. Cecil County began its public kindergarten program in September 1973.

Table 21 also provides data on the number of prekindergarten and kindergarten children enrolled in programs funded by Title I of the Elementary and Secondary Education Act (ESEA). In the 1973/74 school year, there were 10,682 children enrolled, and all but three counties had such programs for disadvantaged children. Of these children, 1,874 were enrolled in prekindergarten programs. In addition, there were 352 prekindergarten and kindergarten enrollees under Title III, ESEA.

TABLE 21

Number of Handicapped and Mentally Retarded Children; Children Enrolled in Prekindergarten and Kindergarten; and Children in ESEA Programs, by Area

Name of Area	Handicapped Children 0-5*		Enrollment, Sept. 30, 1972**						1973-74 ESEA Enrollment†
			Prekindergarten			Kindergarten			
	Total	Mentally Retarded	Total	Public	Non-Public	Total	Public	Non-Public	
Allegany	79	4	132	–	132	1,152	1,065	87	74
Anne Arundel	379	23	649	10	639	5,315	4,987	328	475
Baltimore	763	48	2,349	–	2,349	9,208	8,127	901	371
Calvert	29	4	–	–	–	444	417	27	113
Caroline	33	1	–	–	–	307	307	–	101
Carroll	182	1	–	–	–	1,239	1,239	–	–
Cecil	97	8	–	–	–	217	–	217	–
Charles	100	3	180	99	81	1,032	1,019	13	139
Dorchester	41	1	–	–	–	329	329	–	152
Frederick	217	10	210	–	210	1,459	1,382	77	–
Garrett	118	7	–	–	–	362	362	–	133
Harford	130	24	145	–	145	2,369	2,265	104	262
Howard	54	1	459	–	459	1,685	1,486	199	137
Kent	27	1	–	–	–	250	232	18	75
Montgomery	251	23	3,609	602	3,007	9,357	8,406	951	320
Prince George's	340	46	2,461	190	2,271	12,162	11,494	668	947
Queen Anne's	27	2	–	–	–	258	258	–	75
St. Mary's	95	5	76	40	36	988	877	111	150
Somerset	18	1	–	–	–	281	281	–	70
Talbot	53	2	34	–	34	313	275	38	90
Washington	311	19	186	165	21	1,698	1,638	60	319
Wicomico	52	2	209	75	134	916	874	42	360
Worcester	53	16	–	–	–	441	424	17	166
Baltimore City	1,238	130	2,378	1,129	1,249	13,569	12,436	1,133	6,153
The State	4,687	382	13,077	2,310	10,767	65,171	60,180	4,991	10,682

*Source: State of Maryland, Data System for the Handicapped. Data Book: Table IV for 12/01/73. The data show unduplicated children as reported by the State Department of Education, Social Services Administration, Juvenile Services Administration, Mental Health Administration, Mental Retardation Administration, and Preventive Administration. Note that the figures for "Mentally Retarded" are a part of the figures in the "Total" column.

**Source: Maryland State Department of Education, Division of Research, Evaluation, and Information Systems. Statistics on Enrollment and Number of Schools, Public and Non-Public: September 30, 1972. Tables 4-6. Note: The prekindergarten figures include children in non-public approved nursery schools.

†Source: Maryland Department of Education. Data are for prekindergarten and kindergarten children, and are from applications for grants received from Local Education Agencies by the ESEA Title I Office of the State Department of Education. Not included are 362 children enrolled in prekindergarten and kindergarten under ESEA, Title III.

MARYLAND'S HANDICAPPED CHILDREN

The Maryland Special Services Information System, formerly the Data System for the Handicapped, provided the statistics on children under six years of age in Maryland that are known to be handicapped in some way. The categories of handicap are: vision disabilities, speech and language disabilities, hearing, physical/orthopedic problems, ill-defined psychosomatic conditions, psychological disturbances, sexual deviation/alcoholism/drug dependence, adjustment reaction/emotionally handicapped, behavior disorder, specific learning/language disabilities, mental retardation, multiple handicap, and a very small miscellaneous group called "other."

In Table 21, the totals of all types of handicapped are presented. Only one type is singled out to be included in the table—the mentally retarded. The number of mentally retarded may appear to be small, but the data are limited to those under six years of age and are those known to one of the six cooperating organizations.

A list of the organizations and a description of the entire program for collecting data on the handicapped follows in the next section of this chapter.

Recommendations:

- There is no single central unit for the collection, storage, analysis, and publication of comprehensive data about children in Maryland. Some such system is strongly recommended.
- The data in this chapter should be used to point up further questions and suggest areas for more intensive investigation. The data also will suggest the need for new or improved child development programs.
- The difficulty in obtaining data, even from two different divisions within an agency, suggests the need for better communication and coordination among agencies and within agencies.
- It will be noted that some data in this report are for a calendar year and others are for a fiscal year. It would be helpful in analyzing and comparing data if this could be standardized.
- The only data available for children in family day care homes are for children subsidized by the Social Services Administration. These constitute a small part of all children in family day care homes. It is strongly recommended that data be collected on *all* children enrolled in family day care homes.
- Because of the difficulty of making comparisons of birth rates between counties, or races, when crude birth rates are used, it is suggested that consideration be given to using a more refined rate such as a fertility rate.

THE MARYLAND SPECIAL SERVICES INFORMATION SYSTEM (SSIS)*

The State Plan as an illustration of interagency coordination for the purpose of identifying and planning for a population group in need of special services.

The Maryland Special Services Information System (SSIS) is an interagency system which gathers and coordinates information concerning handicapped children and youths (ages 0-21) in the State of Maryland for the purposes of planning and programming services. Cooperating agencies are the Maryland State Department of Education and the Social Services Administration of the Department of Employment and Social Services and the following Administrations in the Maryland Department of Health and Mental Hygiene: Juvenile Services Administration, Mental Health Administration, Mental Retardation Administration, and Preventive Medicine Administration.

Initially funded through the Elementary and Secondary Education Act (ESEA) under a Title IV-B grant in August 1971, the SSIS began collecting data on a statewide basis January 1, 1973. The system is managed by the State Department of Education and controlled by the SSIS Governance Committee which comprises the administrative heads of the participating agencies or their delegates. In addition to assuring the proper functioning of SSIS, the Governance Committee is greatly concerned with insuring the confidentiality of the children involved. This protection is also a main objective of the Parent-Interest Group Advisory Committee, which serves in an advisory and monitoring capacity. In line with guarding individual identity, SSIS codes each child's name by what is known as the Russell Soundex Code. All identifying information is then destroyed. However, one copy of names and codes is sent to the local agency that originally supplied the information.

Each child included in SSIS must first be diagnosed as handicapped by a qualified examiner, i.e., a physician, a psychiatrist, or a psychologist. He must also be receiving services or waiting for services paid for at least partially by the State. While not required by all counties participating in the system, the Governance Committee recommends parental permission before a child is entered in SSIS.

Information gathered by SSIS is published in a Quarterly Data Report. Six tables presented in the June 30, 1973 Report were: Multiple Agency Enrollment; Total Number of Children Receiving In-State and Out-of-State Purchase of Care; Comparison of Services or Programs Needed with Services

*The Data System for the Handicapped was renamed the Maryland Special Services Information System (SSIS) in the spring of 1974.

or Programs Available; Distribution of Children by Handicapped Condition, Age, Sex, Race, Ethnic Background, and County of Residency; Average Lag Time and Range in Days Between Date of Referral and Date Service Began; and Summary of Handicapped Children in Maryland Public School Classes.

Expanded information from the data collected is available only to the agency to which the information directly pertains, in accordance with the statement of policies and procedures for the Special Services Information System.

As the SSIS is still in its early stages, continuing efforts are being made to find the most effective uses for the data gathered. Suggested revisions of information gathering and categorization are accepted from the participating agencies and the Parent-Interest Group Advisory Committee. The recommendations of the Parent-Interest Group Advisory Committee are considered equally with those of the participating agencies.

Some of the major benefits anticipated by the SSIS Governance Committee are:

1. Accurate assessment of current programs.
2. Accurate planning for future programs and services.
3. Elimination of duplicate services.
4. Added impact in gaining support from the public and the Legislature.
5. Determination of unidentified population in need of service.

In the past, data concerning the handicapped have been scarce and of questionable validity, on both State and national levels. As this data system for the handicapped is the first working system of this nature, it may be viewed as a possible model for other states.

Chapter VI

Statutes, Regulations and Licensing For Out-Of-Home Programs

The State Plan as an instrument to describe the need for coordination of statutes, licensing and regulations.

The relatively recent emergence of varied early childhood programs, including day care, which have a major social impact upon our society, has significant implications for Maryland in the statutes which support the regulation of these programs. In terms of group day care alone, 17 percent more children were enrolled in day care centers in Maryland in 1973 than in 1969 (34,325 Maryland children were enrolled in day care in October 1973).

If early childhood programs in Maryland are to be positive institutions, provision and *safeguards* for the *quality* of care are factors of prime consideration. Licensing and regulation are two of the means which can provide this control by maintaining minimum program standards. Leadership for effective licensing and regulation must come from the State. The content and clarity of the laws constitute the degree of authority given administrative agencies to license and regulate out-of-home care, educational, therapeutic and recreational programs. In essence, the general licensing laws of Maryland require close scrutiny and public understanding if they are to serve the best interests of Maryland's children.

According to Norris E. Class, a nationally known licensing expert, the licensing of child care facilities is rarely seen for what it really is—a *preventive* program, a program not to treat problems but to prevent misfortunes from befalling children.*

There are several Maryland laws addressed to the safeguarding of children in out-of-home care, educational, therapeutic and recreational

*Norris E. Class, *Children*, September-October 1968, Department of Health, Education, and Welfare, page 192.

programs. These laws are covered in the Articles of the Annotated Code of Maryland and its Supplements, and they form the statutory bases for regulation of the above activities. Several agencies of the State have been designated by statute to write, promulgate, adopt and make effective rules and regulations specific to certain types of those activities.

The administrative authority for licensing responsibility in Maryland is placed in three State agencies: (1) the Department of Employment and Social Services, (2) the Department of Health and Mental Hygiene, and (3) the Department of Education.

Identified below are the seven segments of Maryland's child population receiving out-of-home care, educational, therapeutic and recreational services; the applicable statutes in the Annotated Code of Maryland; and the agencies which are assigned the safeguarding of each segment:

1. Children in public school programs—State Department of Education. Article 77, Section 11.
2. Children in nonpublic school programs, including those in State Department of Education-approved nursery schools and kindergartens—State Department of Education. Article 77, Section 12.
3. Children in centers for retarded persons—State Department of Health and Mental Hygiene. Article 59A, 1971 Supplement.
4. Children (four or fewer) in family day care homes—Social Services Administration. Section 32A, Article 88A.
5. Children in 24-hour substitute care in child placement and child care institutions—Social Services Administration. Article 88A, Sections 20, 20A, 20B, 21, 1973 Supplement.
6. Children in group day care centers under private, nonprofit, religious and public auspices—State Department of Health and Mental Hygiene. Article 43, Sections 707-717.
7. Children in summer day camps and recreational programs—State Department of Health and Mental Hygiene. Article 43, general health laws.

The regulatory documents and statutory bases are named below by delegated State agency and type of out-of-home activity. Information will cover six facets of the system (public schools are excluded).

STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE

10.02.01, Regulations Governing Group Day Care Centers. 22 pp. Adopted: October 1971. Effective: December 1971. Statutory base: Article 43, Sections 707-717, Annotated Code of Maryland.

The statute provides for the licensing of group day care centers of five

or more children under State regulations. Operationally, the licensing is decentralized and administered by Deputy State Health Officers through local departments of health. Four jurisdictions—Baltimore City, Baltimore County, Prince George's County and Montgomery County—have local child care ordinances (the earliest dated 1932) and, by virtue of these ordinances, have authority to license nonpublic nursery schools and kindergartens as well as group day care centers with local regulations.

Under State regulations, group day care has been regulated since 1956. Whereas the 1956 State regulations and earlier local ordinances made adequate provision for environmental safety in facilities and called for minimal health measures, they lacked safeguards for the daily care of children and for the promotion of the children's growth and development.

Current regulations address themselves to all aspects of a child care facility—the adults and children, the operation, the materials and equipment used and the structure itself. They cover such aspects as licensing policy and procedure, admission policies, health program for adults and children, food service and nutrition, staff qualifications, children's programs, equipment, the physical plant, safety and sanitation. In general, current regulations fall into three categories: child and adult health; child development; and environmental health and safety. Those portions of the regulations dealing with child development create a baseline for the provision of non-detrimental emotional and mental health care. For example, the regulations require introductory training of child care workers and directors consisting of 64 hours of early childhood education specifically directed to the needs of children ages two to six and stipulate maximum group sizes, staff/child ratios, children's play equipment and materials.

The Preventive Medicine Administration, Division of Maternal and Child Health, publishes annually a *Directory of Licensed Group Day Care Centers* and statistical charts of numbers of centers and numbers of children by type of operation, by sponsorship, and by size of enrollment.

10.03.24, Regulations Governing Camps. 6 pp. Adopted: April 30, 1965. Last amended date: November 17, 1970. Last effective date: December 1, 1970. Statutory base: Article 43, 1957 Edition and 1961 Supplement, Annotated Code of Maryland.

Children in summer day camps are protected only by regulations governing the layout, construction, operation and maintenance of camps. There are no admission requirements, no staff/child ratios or group sizes specified, no requirements that personnel be trained (for example, swimming instructors), and no provisions made for the personal comfort and safety of individual children. Camp facilities are now enrolling preschool children, and there is great concern for this age group among those who license such facilities.

10.05.02, Regulations Governing Operations of Group Day Care Services for Mentally-Retarded Persons Receiving Financial Support Under General Local Health Services Appropriation. 17 pp. Adopted: January 31, 1964. Amended: July 30, 1970. Effective: August 21, 1970. Statutory base: Article 59A, Section 20, Annotated Code of Maryland.

The objectives of the day care center for mentally-retarded children are twofold: (1) to provide opportunities for the maximum development of the capabilities of each mentally-retarded person under its care and (2) to provide means of educating the parents of the retarded in sharing the total responsibility of care and training. The day care center must be operated by a board as specified in Section .73 of the regulations. The day-to-day supervision of day care centers shall be directed by suitable, qualified, responsible adults, assisted by adequate numbers of experienced persons. Minimum qualifications for these individuals are as follows:

Director—shall have had professional training, preferably in special education for the retarded, and shall serve at least part-time in this program. A college degree is desirable.

Training Assistant—should be experienced in working with mentally-retarded children and have a minimum of a high school education.

Group day care services for mentally-retarded persons shall:

- Provide care for six or more retarded persons.
- Provide regular or repeated care for these persons on a greater than once-a-week schedule.
- Provide non-residential care only.

The regulations also stipulate that:

- Each day care center be comprised of one or more units, each of which is made up of six retarded persons. Four or more additional persons shall be justification for an additional unit.
- These regulations shall not apply to the services and facilities operated by official boards of education nor to the children under their care.
- The board is the executive authority and policy-making group of a nonprofit corporation which operates group day care services for mentally-retarded persons.

STATE DEPARTMENT OF EDUCATION

Bylaw 912:2, Standards for Nonpublic Nursery Schools and Kindergartens. 10 pp. Adopted: May 31, 1972. Statutory base: Article 77, Section 12, Annotated Code of Maryland.

Nonpublic nursery schools and kindergartens, except those operated by bona fide church organizations, are subject to the jurisdiction of the Maryland State Department of Education by authority of Article 77, Section 12, Annotated Code of Maryland. These institutions must be approved by the State Superintendent of Schools in accordance with Bylaw 912:2, *Standards for Nonpublic Nursery Schools and Kindergartens*, before they may begin or continue to operate or function in Maryland.

The standards—published as *Maryland School Bulletin*, Volume XLVIII, October 1972, Number 2, by the Maryland State Department of Education—were adopted on May 31, 1972 by the Maryland State Board of Education.

The current standards are a revised edition of those adopted in June 1961. The history of nonpublic school legislation goes back to a statute passed in 1947.

The general purpose of the standards stemming from the present statute is to establish minimum requirements for nonpublic schools in the areas of personnel, instructional programs, administration, physical facilities and equipment, finances, health, fire and safety, zoning and transportation in order to ensure quality education for young children.

At least six months prior to the date an applicant plans to open a school, he should consult the Maryland State Department of Education for an orientation conference with an accreditation specialist. At the time of the conference Part I of the Application for Approval is explained and the following forms required by the standards are distributed: Form A, Purpose, Philosophy and Objectives; Form B, Instructional Program; Form E, Instructional Materials and Equipment; Form F, Facilities; Form G, Fiscal Data and Personnel Record Blanks. Part I should be received and reviewed at least six weeks prior to the opening date of the school. These forms are utilized in the process of evaluating the goals the school is striving to accomplish and the extent to which the program is meeting the needs of the enrolled pupils.

Based upon a satisfactory application, the applicant is authorized to operate the school in a letter signed by the accreditation specialist and the Assistant State Superintendent in Certification and Accreditation. By September 15 of the first year of its operation the school receives Part II of the Application: Form C, Administration; Form D, Personnel; and Form H, Public Relations. Following receipt and review of Part II, the accreditation specialist makes an on-site evaluation visit to the school. Within 30 days of the evaluation visit action is taken regarding approval and, based upon a satisfactory evaluation report, tentative approval is granted. The accreditation specialist makes a second on-site evaluation visit to the school by February 15 of the second year of operation. Based upon a satisfactory evaluation report, which verifies that the provisions of the statutes,

standards, rules and regulations governing the school have been met, a Certificate of Approval is issued to the school.

The standards require teachers to have earned a bachelor's degree from an accredited institution and 12 semester hours in the field of early childhood education—including courses in both human growth and development and early childhood methods—as a part of or in addition to the degree. In Montessori schools, teachers are required to have earned a bachelor's degree from an accredited institution and a Montessori diploma for the level which they are teaching from an institution accepted by the State Department of Education.

The standards recommend the following number of pupils per teacher:

Age	Number of Pupils Per Teacher
Two-Year-Olds	8
Three-Year-Olds	12
Four-Year-Olds	16
Five-Year-Olds	20

To assist teachers in meeting the diversified needs of all of the pupils enrolled in a class, the standards call for a paid or volunteer aide assigned to each class. As a protection for the pupils, a second adult must be available to each class. No matter how small the school, it is required that two adults always be present.

The system of reporting requires approved schools to submit an annual report on forms prescribed by the State Department of Education which address the areas of administration, school calendar, enrollment, health and fire inspections, personnel, instructional materials and equipment, and fiscal data. Approved schools are visited periodically subsequent to submitting their annual reports. They are encouraged to consult with State Department of Education personnel at any time.

STATE DEPARTMENT OF EMPLOYMENT AND SOCIAL SERVICES

Standards for Family Day Care Licensing and the Family Day Care Law. Rule 600. 9 pp. Effective: 1966. Statutory base: Article 88A, Section 32A, 1966 Supplement, Annotated Code of Maryland.

Under the law, persons and agencies are required to secure a license if they are regularly taking care of one or more (but not more than four) children not related to them by blood or marriage. The statute also excludes from licensing close friends of parents or legal guardians providing care on an occasional basis, duly appointed foster parents, and those persons not

receiving compensation for the service. The law carries a provision for legal action against those violating the law.

Family day care homes have been licensed since 1966 under State standards. The licensing is decentralized and carried out by local departments of social services.

Agencies and/or corporations may be licensed to provide family day care. Applicants must be between the ages of 21 and 70. They must provide a physician's statement as to the soundness of their physical and mental health and documentation of a negative TB test for themselves and the residents of their household. The applicant must be of good character, not having been convicted of any crime involving moral turpitude, and must supply the names of three references. The applicant must be aware of the rules, such as not providing convalescent or nursing care in the home. Persons providing foster care are now allowed to have a family day care license by a revision made in 1973. The applicant shall have an adequate income and must provide a financial statement.

Licenses are good for one year only and licensees must maintain accurate records for each child for whom care is provided. Local health departments inspect family day care homes for general environmental health and safety and submit reports of their findings to local departments of social services.

Under the provisions entitled "Conduct of the Home," the regulations call for adult supervision at all times, for suitable activities and adequate nutrition. In the case of illness of the licensee, the parents must be notified promptly. There must be a home telephone. The home should have adequate play space outdoors. Each applicant must submit an emergency plan in case of an accident or illness..

If a license is denied, suspended or revoked, the licensee may appeal, in writing, to the Social Services Administration.

Local departments of social services also purchase care for eligible children in family day care homes which they license. Children who are clients of social services may be placed only in licensed homes and shall be removed should there be grounds for suspension of the license. The number of children for whom care is purchased is reported each month to the Social Services Administration. There is no reporting system for those family day care homes who do not serve children eligible for services from the Social Services Administration.

To secure a family day care license, the applicant contacts the local department of social services. Information about the procedure, including an application form, is supplied by mail. After the application form is returned, a family day care worker visits the applicant to determine the suitability of the individual and the home. The family day care worker also discusses with the applicant many of the different facets of family day care and may point

out that this job can be considered self-employment, with all the benefits of appropriate tax deductions as determined by the Internal Revenue Service. Also discussed are the advisability of liability insurance, the Social Services Administration's rates for its clients and the general rules and regulations that relate to licensing. The family day care worker notifies the appropriate agencies (Departments of Housing, Fire and Health) to secure necessary approval of the premises. Upon receipt of all papers, the license is issued designating the ages and number of children the applicant is licensed to care for.

In some jurisdictions, when homes are not filled, the licensee may notify the family day care worker, who can then make referrals to her.

Rule 7.02.13, Regulations for Licensing for 24-hour Care of Children. 48 pp. Adopted: August 1970. Effective: October 1, 1970. Statutory base: Article 88A, Sections 19-32, Annotated Code of Maryland.

Regulations governing 24-hour care of children are set forth in Rule 7.02.13—*Licenses for Care of Children of the Department of Employment and Social Services*. This Rule has its legal base in Article 88A, Sections 19 through 32, of the Annotated Code of Maryland. The rule in current use was adopted August 1970 and effective October 1, 1970. It is subject to periodic revision with participation by affected parties, and is now in process of revision to bring it into conformity with the new law enacted during the 1973 Legislative session. The Department's Information Pamphlet #19 (48 pages) containing the Rule, and copies of the Child Care Law, are available upon request.

Legislative policy affirms that the basic purpose of the child care law is the protection of children:

> The condition of childhood is such that a child is not capable of protecting himself, and when its natural parents for any reason have relinquished its care to others, there arises the possibility of certain risks to the child, which in turn require comparable and off-setting measures. When the interest of a child and those of an adult are in conflict, the doubt should be resolved in favor of the child.

The regulations govern the placement and care of children to 18 years of age in foster family care, child care institutions and group homes, with certain exceptions such as arrangements by the courts or other governmental departments. The regulations provide for consultation, review, regulatory supervision and evaluation of the licensed facilities.

In January 1974 there were 11 licensed child placement agencies, 21 child care institutions and 15 group homes. The Department publishes a list of licensed facilities for general use, a *Directory of Child Care Resources in Maryland* for agency use, and a report of licensing activity in its Annual Report to the Governor.

FEDERAL REQUIREMENTS

Federal Interagency Day Care Requirements. Issued pursuant to Section 522 (d) of the Economic Opportunity Act and approved by the Department of Health, Education, and Welfare; Office of Economic Opportunity and Department of Labor. September 23, 1968, 17 pp.

The Requirements constitute mandatory policy applicable to all day care programs and facilities funded in whole or in part through Federal appropriation (e.g., Title IV of the Social Security Act; Titles I, II, III, and V of the Economic Opportunity Act, etc.).

The policy covers family day care, group day care homes and day care centers. In addition, the requirements cover both the administering agency and the operating agency.

The Requirements prescribe environmental standards, educational services, social services, health and nutrition services, staff training, parent involvement, administration, coordination and evaluation.

Further, the Requirements stipulate that administering agencies must develop specific requirements and procedures within the framework of the Federal Interagency Requirements to maintain, extend and improve their day care services. Additional standards developed locally must be at least equal to those required for licensing or approval as meeting the standards established for such licensing. Under no circumstances may they be lower. The policy states that it is the intent of the Federal Government to raise and never to lower the level of day care services in any state.

The responsibility for enforcement rests with the administering agency, i.e., for Title IV programs, the responsibility rests with the State Department of Employment and Social Services; for Head Start programs, the responsibility resides with the HEW Regional Office of Child Development in Philadelphia. Acceptance of Federal funds is an agreement to abide by the Requirements. State agencies are expected to review programs and facilities at the local level for which they have responsibility and make sure that the Requirements are met. Noncompliance may be grounds for suspension or termination of Federal funds.

LICENSING PLAN FOR CHILDREN IN OUT-OF-HOME CARE

Present Licensing System

When the statutes which safeguard children in out-of-home care, educational, therapeutic and recreational programs and the regulations emanating from them are pulled together in one place and displayed, as they are here, it is possible to see the wide range of licensing services offered to Maryland's children and their families (Figure 1). Discussion will focus on six facets of the system (excluding public schools).

It is important to note that in addition to the minimum standards and regulations which must be met in order that an individual, agency or institution may offer a particular child care, recreational or educational service to the public, there are standards and guidelines—as distinct from regulations—which, if met, promise the receiver of services a quality of performance beyond the minimal. Examples of these are the *Guidelines for Early Childhood Education* developed by the State Department of Education for the guidance and care of younger children now entering school systems; standards under which the Social Services Administration conducts its group day care centers; the standards of the American Camping Association; and, on the national level, the standards of the Child Welfare League of America, which the Maryland 4-C Committee has adopted as a viable description of quality care.

In looking at the wide range of licensing services, Maryland's total licensing system emerges as one which attempts to address itself to the needs of children in specific types of programs and to the needs of their parents.

When a parent seeks a nonpublic nursery school or kindergarten, he should be assured that there is an approved method of instruction, accredited teachers and so forth. If the parent's need is for day care, he should be assured that his child will be safe, that he will be with adults trained to care for him, and that he will have many opportunities to indulge in developmental activities and routines appropriate to his age and conducive to his growth and development. The parent of a mentally-retarded child should be assured that caring and competent staff will bring that child to the realization of his full potential. For the proper protection of children, the courts and placement personnel must know that Maryland child care institutions and child placement agencies meet basic licensing standards and can provide good substitute care.

Problems with the Present System

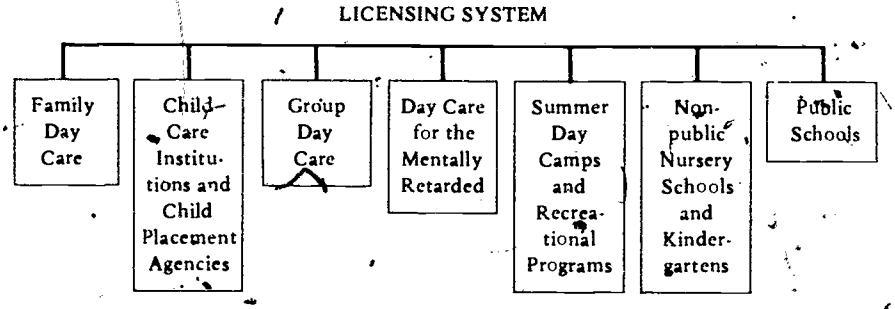
The total licensing system—one which meets diverse parental requirements and children's needs—has great potential, but it also has many difficulties.

The first difficulty is that it is not now seen nor has it ever been seen as a *total system* by licensing agencies, by administrators and workers, and by the general public. In order for an object or an activity to be seen, it must be visible. The State Plan should be regarded as part of the process of lending visibility to Maryland's licensing system.

The second difficulty with our total licensing system is that the borderlines of the out-of-home services which are regulated by different agencies are not clearly defined. For instance, there is some feeling among licensing workers that there is a false dichotomy between the type of program which should be offered in a nonpublic nursery school and that

which should be offered in a group day care center. Another problem in the licensing system is that mentally retarded and other handicapped children are being admitted to Head Start centers as required by Federal guidelines. This raises serious question concerning the training of Head Start center personnel to serve these children, especially without staff increases.

FIGURE 1
Licensing System for Out-of-Home Care



Another problem area is the issue of whether religious facilities—which are exempted from approval as schools by the State Department of Education—should be licensed by the Health Department. The two agencies must now define very precisely what is a nursery school and what is a group day care center. The troublesome aspect of mending border fences is that as soon as one is mended another falls into disrepair. For instance, now that summer camping and recreational services are being offered to children as young as two years of age, there is great concern among those who license such facilities that summer camps and recreation centers, as they are now regulated, do not meet the developmental needs of preschool children. Consideration should be given to providing these children the kinds of minimum safeguards and program standards provided, for instance, in the regulations for group day care centers.

A major deficiency in Maryland's licensing system is that no one knows the full extent of out-of-home programs for young children.

There are indications that the agencies with licensing responsibilities are attempting to refine their reporting systems in order to obtain more accurate statistics on the numbers of children in early childhood programs. The State Department of Health and Mental Hygiene is now discussing the possibility of computerizing specific information about children in group day care centers on a more regular basis.

Because licensing is not seen as a total system, each agency keeps its own statistics as best it can, given the constraints of staff and computer or record-keeping capability. For instance, family day care homes and the children in them are assessed only if the Social Services Administration purchases care for the children. If it is true, as national extrapolations

suggest, that family day care is the more prevalent type of out-of-home care, then Maryland *needs* to know the number of children in at least the licensed facilities and needs to concentrate services in this area.

As it now stands, administrators of licensing programs are accountable for reporting to the heads of their respective agencies. The heads of agencies are accountable to specific committees of the State Legislature; some have advisory committees, and some make efforts to report to the public. These latter efforts usually consist of making information available upon request. While this is within the bounds of public duty, it does not increase the visibility of the licensing activity and it does little toward making visible the total range of licensing services provided by the State.

Still another difficulty with Maryland's licensing system is the funding of this most important preventive service for families and children. The approach to funding is circular. Without knowing the extent of out-of-home care, a budget cannot be presented which will adequately reflect need. For example, without adequate funding for family day care licensing workers, the numbers of children in family day care homes cannot be known. If group day care figures can be taken as an indicator, the number of children in out-of-home care is rising steadily. The State's funding effort has not kept pace with this rise. Lack of visibility, for instance, of the licensing program for group day care resulted in a funding *cut* after the new day care regulations—which imply an *increase* in licensing staff—went into effect.

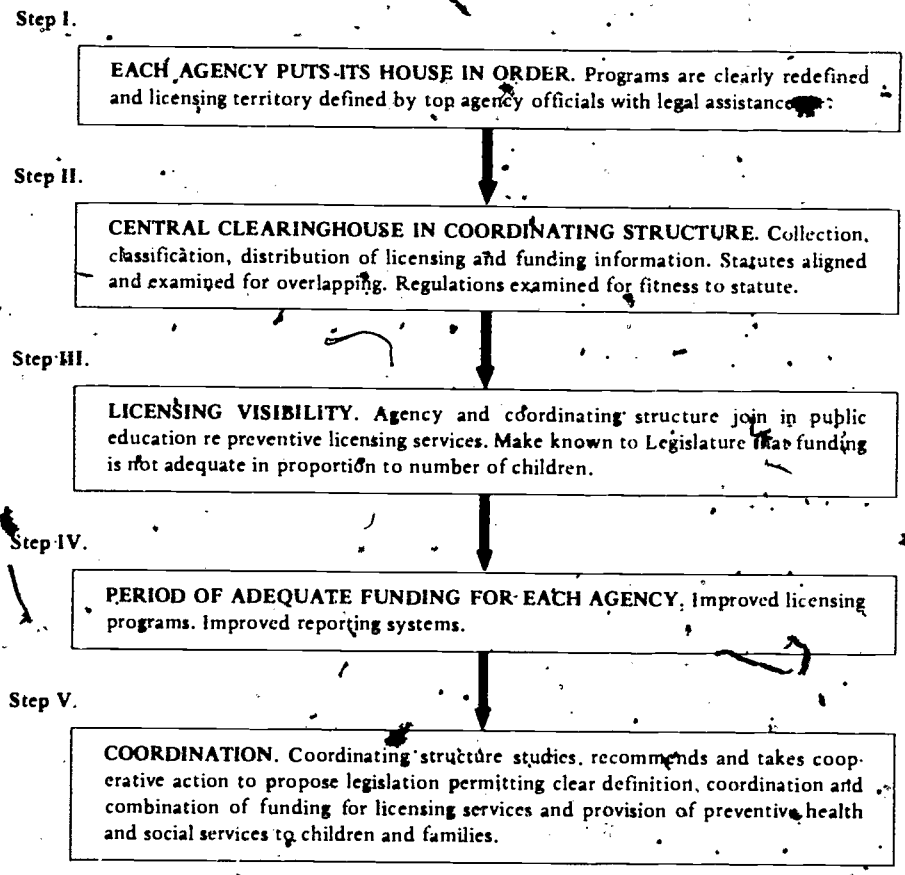
The Plan

One of the purposes of a State plan is to set into motion processes whereby State agencies may cooperate and coordinate their licensing activities in order to make their activities visible and, more important, understandable to the general public.

The State planning process would be immeasurably aided by a central clearinghouse located in a coordinating structure, such as recommended in Chapter XV, where all known information about the numbers of children in early childhood programs could be tabulated. Staffing of this coordinating structure is implied. Gaps in reporting would be noted and assistance given to an agency which, for whatever reasons, could not provide needed information. The central clearinghouse should be accountable to the Governor. In order to achieve coordination of licensing activity, changes need to be made leading purposefully toward coordination.

The following schemata (Figure 2) describes steps in a developmental process whereby Maryland may view its licensing system as a preventive service for its children. There are indications from the several agencies that we are now in Step I.

FIGURE 2
Schemata for Coordination of Licensing Out-of-Home Care



Progress Is Under Way

Early in 1973, the Department of Health and Mental Hygiene, Preventive Medicine Administration, established a multidisciplinary State Day Care Unit to advise in the administration of the group day care licensing program. It is important to note that an Assistant State's Attorney and the State Fire Marshal are cooperating members of this Unit. Its task is to bring into working relationship the four groups in the State with an interest in or responsibility for group day care—the State Legislature, the Day Care Licensing Advisory and Study Committee, the local health departments with deputized responsibility for licensure, and the State Day Care Unit.

The Day Care Licensing Advisory and Study Committee was established in the fall of 1972 by the Secretary of Health and Mental Hygiene, and its membership is composed of providers of care, concerned citizens, agency personnel and parents of children in centers operated under various auspices. The charges to the Advisory Committee are related to group day care and

the December 1971 regulations: (1) to study the regulations as they affect the quality of care; (2) to reassess the new regulations; (3) to advise the Department on their implementation and enforcement; and (4) to report to the Secretary of Health and Mental Hygiene. A preliminary report is expected by August 1974.

The establishment of the Unit and the Advisory Committee has helped to heighten the visibility of group day care licensing.

Another factor serving to awaken Maryland's interest in licensing and regulations for children's programs generally was the Department of Health and Mental Hygiene and the Department of Employment and Social Services joint decision to invite a nationally recognized expert in child care licensing to Maryland late in 1973 and again in 1974, when opportunity to hear him was afforded a wide group of interagency personnel involved in child care licensing.

The State Departments of Education and Health and Mental Hygiene are meeting with legal assistance to resolve the issues created by what appear to be conflicting statutes.

Lastly, the interagency work and cooperation in the development of this section of the State Plan served to focus attention on this essential area of child care and child development.

Chapter VII

Comprehensive Planning For Children Requires Better Coordination

The State Plan as a discussion of existing legal mandates, funding levels, and service delivery and information systems as key to coordinated planning.

LAWS, FUNDING AND THE SERVICE DELIVERY SYSTEMS

The Mandate to Provide Human Services

The State of Maryland is mandated by numerous state laws to provide various services to all children living within its boundaries. The nature and scope of this mandate is described more fully in Chapter III, on the legal base. The various laws mandating delivery of service have produced large-scale delivery systems which reach into the lives of all Maryland's citizens. The delivery systems of Maryland's Departments of Health and Mental Hygiene, Education, and Employment and Social Services have grown in response to the various laws.

The Mandate as the Sum of the Fragmented Laws

The various laws were never conceived as a single unified effort to meet the comprehensive needs of Maryland's children. Rather, the laws have been passed over decades, with each new mandate tending to be focused on a single issue such as child abuse, group day care, retardation, preschool immunization, free public education and so forth. The sum effect has been to produce an increasingly broad, sometimes conflicting, mandate for Maryland governmental agencies to deliver a vast range of services for children.

Program Fragmentation

The manner in which the mandate has occurred—one law followed by another—has produced a corresponding program fragmentation within Maryland's governmental agencies and their service delivery systems. With the passage of a new mandate and a budget allocation, the responsible agency must endeavor to generate the administrative and service capacity to implement the law. This process has produced a host of categorical programs which are mandated, funded and administered independently of other programs but which are addressed frequently to the same service recipients. This trend to fragmented programs has been accelerated by the Federal Government with its wide-ranging categorical program approach through Grants-in-Aid from the 1930s to the present.

Autonomous Program Within the System

Once an independent legal base and independent funding are established, the dynamics of increased autonomous functioning readily follow. When the program funding level is less than that needed to meet the mandate, the trend toward being autonomous is accelerated as the agency attempts to prevent infringement on "its" mandate and inadequate resources. Inadequate funding places the administrative team in a defensive stance. The services are legally mandated; hence, failure to deliver—even though unrealistically funded—places the administrator in the position of being vulnerable both to judgments of poor administration and to the sanctions implicit in the law. The passage of a law does not insure automatically the allocation of adequate resources to meet the dimensions of the programs required. The law merely provides the mandate and the sanctions.

Effects of Gaps Between Mandates and Funding Levels

In inadequately funded public programs where staff must live in noncompliance with the law, such staff tends to act defensively. Information which would reveal the gaps between the mandated program and the delivered program is accumulated poorly if accumulated at all. Information acquired by the agency tends not to be disseminated unless it is favorable. Outsiders attempting to study and describe the reality of the program are viewed as threats and find cooperation at a minimum. Another effect is the unleashing of efforts to gain greater power in order to get everything in order. Such efforts lead to power conflicts. The struggle to increase one agency's budget at the expense of another ensues. Budget battles increase the tendency toward territoriality and, in the end, fragment the system and deprive the clients.

Fragmentation and the Consumer

When independent legal mandates with clear noncompliance sanctions are combined with inadequate program allocations, the consequences can be severe and undesirable for the client-recipients. Independent delivery systems may require the clients to get to numerous locations in order to receive a series of needed services. Next, the client needing multiple services often discovers that eligibility requirements vary from one subsystem to the next: eligibility for prenatal care does not insure eligibility for food stamps or vice versa, although the needs are mutually dependent. Normally, with each new service program the client is required to repeat the eligibility process, duplicating and wasting the time and energies of both the client and the total system.

Within subdivisions of the total State delivery system the long reach of the original law—whether State or Federal—continues to impinge on children and their welfare. For example, Medicaid children qualify for screening, diagnosis and treatment services but their parents do not; the federally-sponsored family planning program is limited to the provision of family planning services only. Similar examples can be found readily in the systems delivering social and educational services.

Law and Funding Must Be in Scale

It is important that the interplay between the legal base of services and the funding of services be sharpened and coordinated. Unmet needs occur whenever the mandate is not matched with appropriate funding.

In order that funding be in proportion to the legal mandate, three recommendations are made.

Recommendations:

1. That a coordinating structure be authorized to continue defining the existing legal base of publicly provided services to children so that:
   a. Each agency has a precise legal base profile.
   b. Gaps can be shown between laws passed but only partially implemented or not implemented.
   c. An accurate base for a unified, comprehensive human services act can be constructed.
2. That the flow of appropriated monies be examined:
   a. For their flow through the systems to the client.
   b. For points of blockage.
   c. For points of duplication in usage.
   d. For recommendations of greater efficiency.
3. That funds allocated for the provision of services be proportionate to the mandate as established by law.

TOWARD THE INTEGRATION OF MARYLAND'S FRAGMENTED SERVICE DELIVERY SYSTEMS THROUGH INTEGRATED INFORMATION

A Great Gap in Program Planning Information

Although a detailed picture of the degree of fragmentation in the delivery of public services to children and their families within Maryland cannot yet be described, sufficient evidence is available to identify inadequate information as a basic bottleneck problem. Requests to Maryland's State agencies for basic program information frequently have revealed that information was not available, leaving the agency staff with the options of not responding, of providing something which was known but not requested, or of providing a general response which was inadequate. Workable plans require sound information. Adequate information about Maryland's children and their needs is an urgent priority for program planning.

Toward an Integrated Information System

The acquisition of adequate planning information should be given a top priority among and within the State agencies delivering services. Realistic plans cannot emerge until adequate information is available. It is recommended that a coordinating structure be designated and funded to integrate and expand current reporting systems into a multipurpose information system to include the agencies of Health and Mental Hygiene, Employment and Social Services and Education. Such a structure is discussed in Chapter XV.

Person Centered Rather Than Problem Centered

Fragmentation of information has been the trend in "reporting systems" because of the need to document services provided through Federal categorical programs. Each funded category of need has tended to produce its own system. Reporting systems normally are based on reporting of *problems*. Accordingly, the existing reporting systems of the several agencies serving children represent only a portion of the population. Because families frequently have more than one problem and seek multiple services, the populations overlap. Complex problems occur in comparing these reporting systems because of the difficulty of determining the number of problems for which a particular person has received services. Information systems should move from being "problem centered" to become "person centered." It is recommended that a coordinating structure be charged with the integration of existing reporting systems into a practical, useful information system organized first by "person" and second by "problem."

Planning for All Children

The recommendation is made that the integration of all information systems proceed to meet the needs of "normal" children as well as the needs of children with "problems" in order to meet the needs of both groups adequately. The reasons for this strategy are:

1. The "normal" child comprises the largest number of children the information system would be required to manage.
2. It is from the "normal" population that individuals with specific problems become identified.
3. A total population information system could insure the linkage of "normal" child programs, such as preventive health care, day care and schools, with "speciality" diagnostic and treatment programs by means of comprehensive screening programs.
4. Eligibility certification and entry into the total system would become possible at any point within the system and would occur only once.
5. Development of such a comprehensive system would raise and require resolution of numerous critical issues such as rights of access to information, how information is to be released, what information is to be released, to whom information is to be released, and how it is to flow. These key issues are not as likely to surface in the design of systems addressed to "problem" populations where personal and legal rights have a long history of being neglected and/or violated. Resolution of these issues for the "normal" population will determine the articulation of all subsystems including those seen in such special services as retardation, mental hygiene, and juvenile services.
6. The greatest mass of societal resources for children is being spent on the "normal" child. Increase in the efficiency of these systems should have high cost benefits because of the large numbers involved. Service output should be able to increase substantially even within the constraints of existing resources.

Potential Dangers in Information Systems

Information systems should be regarded as highly sensitive instruments because of their potential for abuse. Therefore, a high priority must be assigned to the organization of these systems and the designation of the agency or structure under whose control they should be placed. All such systems must be organized openly, intentionally, and by broad consensus. Legal sanctions and restrictions are needed to support these principles. Until sanctions can be defined and codified in the law, strong guidelines must be

developed, and the emergent system must be open continuously for review to insure conformity with these guidelines.

Suggested Guidelines for Information Systems

1. Personnel access to any centralized information system should be limited and controlled at both initial employment and subsequent job performance.
2. Identification of information on a single individual should be possible but only for service enhancement to that individual (or family unit) with informed, written, legal release.
3. No data or reports capable of identifying an individual should be available to any persons or legal entities not providing a direct, primary, helping service to the client.
4. The client is to be provided full access to all information on him contained within the system.
5. Access to information acquired on any individual should require the client's legal permission. No personal or legal entity—be it Federal, State, local, public or private—is to be privy to information on any individual without a legal, voluntary release form being completed by the individual or by the legal guardian.
6. Group data on 50 or more persons, where no individual is identifiable, are to be considered public knowledge and are to be available without major restraints. Such data become the basis for program evaluation, feedback, refinement, and planning.
7. Population group data should be consistently acquired, refined and reduced to where clear plans can be made and program results publicly observed and monitored. Those responsible for the information system should be required to publish information evaluating its operation on the basis of factors (on a critical minimum of descriptive parameters), yet to be defined, on a periodic basis not greater than once a year.

Benefits of an Information System

Among the benefits that can be expected from an integrated information system are:

1. Direct enhancement of services to the client.
2. Reduction of professional work time spent reporting to multiple systems.
3. Increased efficiency through correctional feedback at all governmental levels.
4. Elimination of duplication of service.

5. Positive tracking of the flow of an individual within parts of the system.
6. Automatic monitoring of breakdowns in the subsystems.
7. Integrated screening, diagnosis, treatment and service mechanisms.
8. Development of cost-effectiveness indices for both the parts of the system and the whole system.
9. Planning benefits:
   a. Projection of future needs, programs, manpower and services.
   b. Determination of unidentified populations.
   c. More precise and just allocation of resources.
   d. Determination of characteristics of the populations served.
   e. Identification of ineffective programs.
10. Identification of needs on the part of certain agencies for specific services from other agencies in order to render programs more effective.
11. Ability to provide information to groups to whom the system is legally accountable (legislative bodies and the public).
12. Availability of the entire system for research.

Chapter VIII

Local Unmet Needs—Counties Identify Their Individual Needs and Priorities

The State Plan as a reflection of "felt" needs by 4-C Councils in 11 counties.

County 4-C Councils provided a valuable grass-roots source of information regarding specific child care needs. In this section a summary of county needs and priorities as determined by the individual 4-C Councils is presented. In the following section, there is a review of conclusions reached by representatives from each of the county 4-C Councils and the Baltimore City public agency planning group at an all-day planning session held November 7, 1973.

Each county 4-C Council was asked to meet in the fall of 1973 to draw up a listing of its needs for comprehensive child care services.

Eleven of the 13 county 4-C Councils contributed to this survey; two local councils failed to participate. These felt needs, combined with demographic profiles of each county, were examined for relationships such as unique regional differences, demographic similarities and patterns of service, etc.

Since each county council was permitted a free choice in the number of needs listed, the data were categorized for ease of reporting. To some degree the classification scheme reflects several problems in the field of child care services and planning. The lack of standardized definitions and labeling of services, the lack of concept clarity in delineating differences between gaps in services and the lack of differentiation of overall goals from specific objectives are a few of the limitations of the classification scheme. The final classification system evolved into 11 major categories: Child Care Programs, Health Services, Services for Handicapped Children, Social Services, Outreach Programs, Manpower Training and Development, Coordination and

Delivery of Services, Transportation, Parent Education, Support Services, and Public Education.

The survey results and demographic characteristics of the counties are reported. Demographic characteristics are taken from Tables 11, 12 and 14 included in Chapter V. Only individual 4-C Council "felt" needs are listed. For brevity, areas not included in the individual responses are not listed.

COUNTY PROFILES–DEMOGRAPHIC AND CHILD CARE NEEDS*

Garrett County

Demographic Data

Total population, 1970	21,476
Children 0-5, 1970	2,391
Percent of total population	11.1
Families with children 0-5, 1970	1,455
Female-headed families with children 0-5, 1970	54
Families with children 0-5 below poverty line, 1970	409
Children 0-5 in families with incomes below poverty line, 1970	782
AFDC families, FY 1972	216
AFDC children 0-5, FY 1972	194

Child Care Needs

Child Care Programs

Request for group child care services combining day care services and early child development activities; family centers; family day care. Recommend that each day care and child development program include a health component coordinated with the County Health Department.

Health Services

See a distinct need for preventive care, acute care, family planning, maternity care, and dental care. Feel that much of the inadequacy of the medical services in Garrett County results from the interaction of problems in financing, facilities, personnel and organization.

Outreach Programs

Request for additional home visitors.

Manpower Training and Development

Request training programs for family day care mothers.

*The Department of Employment and Social Services reporting system includes school-age children. To estimate the number of preschool-age AFDC children, in each instance the total figure has been divided by three.

Coordination and Delivery of Services

Recommend removing eligibility requirements based on family income; provision of services for all children based on need; coordinated health component.

An analysis of Garrett County data reveals preferences for certain types of child care services: (1) combined day care-child development programs and health services and (2) outreach services. This suggests two solutions to the problem of serving a widely dispersed population: (1) several compact, multi-purpose service centers located at carefully selected sites throughout the county and (2) in-home services.

Allegany County

Demographic Data

Total population, 1970	84,044
Children 0-5, 1970	7,747
Percent of total population	9.2
Families with children 0-5, 1970	5,036
Female-headed families with children 0-5, 1970	296
Families with children 0-5 below poverty line, 1970	694
Children 0-5 in families with incomes below poverty line, 1970	1,098
AFDC families, FY 1972	611
AFDC children 0-5, FY 1972	483

Child Care Needs

Child Care Programs

Request day care for children of working parents; day care for children in outlying areas; school-age day care programs to include before- and after-school care, holiday, and summer vacation care; a co-op system to exchange sitter services; recreation programs, specifically after-school supervision of playgrounds.

Health Services

More dental care; more services for speech problems; more comprehensive care. Correction of administrative problems such as problems with medical cards; long waits for appointments; failure to fill drug prescriptions after six months which necessitates more doctor's visits; patients have to wait too long at health department to see staff.

Social Services

"Hot-line" for help in finding and receiving emergency services.

Manpower Training and Development

Screening and training for volunteer help.

Coordination and Delivery of Services

Funds for recreation programs and the use of the Y.M.C.A. for children's activities.

Transportation

Transportation to the health department.

Public Education

Child guidance workers and psychologists for elementary schools and classes for the emotionally disturbed.

Washington County

Demographic Data

Total population, 1970	103,829
Children 0-5, 1970	10,567
Percent of total population	10.2
Families with children 0-5, 1970	6,996
Female-headed families with children 0-5, 1970	454
Families with children 0-5 below poverty line, 1970	916
Children 0-5 in families with incomes below poverty line, 1970	1,486
AFDC families, FY 1972	763
AFDC children, FY 1972	623

Child Care Needs

Coordination and Delivery of Services

Washington County focused its priorities on needs for funds, coordination and effective communication and the need for Federal legislation authorizing a comprehensive child development program such as proposed in the Mondale bill. See need for locating funds to continue programs now funded by the Appalachian Regional Commission. Support a regional effort in the area of planning. Note a duplication of effort on part of some agencies which may be based on inadequate communication. See need for legislation which would enhance the general objectives of the 4-C–expanded, quality child care and child development programs. Urge a closer liaison with elected officials at all levels.

Dorchester County

Demographic Data

Total population, 1970	29,405
Children 0-5, 1970	2,779
Percent of total population	9.5
Families with children 0-5, 1970	1,630

Female-headed families with children 0-5, 1970	191
Families with children 0-5 below poverty line, 1970	390
Children 0-5 in families with incomes below poverty line, 1970	653
AFDC families, FY 1972	327
AFDC children 0-5, FY 1972	289

Child Care Needs

Child Care Programs

"*Quantity* of *quality* child care facilities is probably the most important need for Dorchester County." Request for more licensed family care and group care centers. This priority is based on a survey which indicated a need for day care facilities to accommodate 282 additional children.

Cecil County

Demographic Data

Total population, 1970	53,291
Children 0-5, 1970	6,282
Percent of total population	11.8
Families with children 0-5, 1970	3,830
Female-headed families with children 0-5, 1970	176
Families with children 0-5 below poverty line, 1970	408
Children 0-5 in families with incomes below poverty line, 1970	734
AFDC families, FY 1972	382
AFDC children 0-5, FY 1972	311

Child Care Needs

Child Care Programs

Request more before- and after-school day care; recreational programs for children of all ages.

Coordination and Delivery of Services

Request the following: communication network ("Action Line") through which to receive and to send information about children; existing community agencies to fund recreational programs; existing community agencies to administer day care and recreational services.

Transportation

Assigned high priority to this area.

Cecil County suggested having voluntary organizations expand their current functions in order to deliver the needed services.

Baltimore County

Demographic Data

Total population, 1970	621,077
Children 0-5, 1970	60,527
Percent of total population	9.8
Families with children 0-5, 1970	40,771
Female-headed families with children 0-5, 1970	1,803
Families with children 0-5 below poverty line, 1970	1,672
Children 0-5 in families with incomes below poverty line, 1970	2,452
AFDC families, FY 1972	1,936
AFDC children 0-5, FY 1972	1,465

Child Care Needs

Child Care Programs

Request quality group day care facilities for preschool as well as older children; part-time as well as full-time child care; part-time family day care for children attending kindergarten.

Coordination and Delivery of Services

Request a strong coordinating organization to work with all personnel who provide services to young children and their families; a concerted effort to locate funding resources.

Parent Education

Need to seek ways of increasing parent involvement in programs.

Why does Baltimore County 4-C focus so sharply on a few need areas? In contrast the two other urban, densely populated, multi-services counties participating in this study list over 30 needs. One possible explanation for this difference is the proximity of Prince George's County and Montgomery County to Washington, D.C. The Washington "bedroom" counties tend to vote more "liberally," which in turn may predispose them to a more expansive approach to social services.

Howard County

Demographic Data

Total population, 1970	61,911
Children 0-5, 1970	7,102
Percent of total population	11.5
Families with children 0-5, 1970	4,634
Female-headed families with children 0-5, 1970	162
Families with children 0-5 below poverty line, 1970	246
Children 0-5 in families with incomes below poverty line, 1970	345

AFDC families, FY 1972	224
AFDC children 0-5, FY 1972	186

Child Care Needs

Child Care Programs

Emergency day care; day care services for children under two years of age which include infant services; family day care and weekend care; before- and after-school day care; day care for single parents and parents just above the poverty income guidelines.

Health Services

Suggest a county-wide system to provide single parents and limited income families with a group medical plan, group dental plan, and health screening.

Services for Handicapped Children

Request day care.

Social Services

Request parent crisis resource center; counseling for single parents and low-income families; and child abuse services for potential and actual cases.

Manpower Training and Development

Request a training program for day care staff and licensing personnel.

Coordination and Delivery of Services

Suggest coordination among decision-making agencies in order to curtail duplication of services; efforts to make services for children accessible for all children; local, State and Federal subsidies for day care; publicity and public education for quality day care (including laws, regulations, and availability of facilities); referral systems and central location for information.

Transportation

Priority rating.

Parent Education

Seek suggestions for parent involvement.

Support Services

Need for adequate, healthful housing.

Public Education

Need for a "family social worker" liaison between the Board of Education and families and for educational screening.

Carroll County

Demographic Data

Total population, 1970	69,006
Children 0-5, 1970	6,932
Percent of total population	10.0
Families with children 0-5, 1970	4,611
Female-headed families with children 0-5, 1970	184
Families with children 0-5 below poverty line, 1970	332
Children 0-5 in families with incomes below poverty line, 1970	564
AFDC families, FY 1972	313
AFDC children 0-5, FY 1972	240

Child Care Needs

Child Care Programs

Request day care services for the middle-income family; recreational and before- and after-school programs especially for low-income families.

Health Services

Request screening for dental, vision and hearing problems for three- and four-year-old children.

Services for Handicapped Children

Request services for crippled children and those having speech and hearing impairments.

Manpower Training and Development

Request training programs for all community services people: all levels of service personnel, health personnel, camp personnel, etc.

Coordination and Delivery of Services

Suggest compilation of a handbook of community services to be updated and distributed yearly; funding for day care services for middle-income families.

Transportation

Requested for recreation and counseling services.

Support Services

Request low-cost housing and legal aid services especially for adoption.

Montgomery County

Demographic Data

Total population, 1970	522,809
Children 0-5, 1970	53,347
Percent of total population	10.2

Families with children 0-5, 1970	35,796
Female-headed families with children 0-5, 1970	1,522
Families with children 0-5 below poverty line, 1970	1,514
Children 0-5 in families with incomes below poverty line, 1970	2,396
AFDC families, FY 1972	1,859
AFDC children 0-5, FY 1972	1,499

Child Care Needs

Child Care Programs

Request for licensed family day care; drop-in day care; 24-hour day care; day care centers; before- and after-school care; service for infants and toddlers; baby-sitter co-op.

Health Services

Request more health services in general; prenatal care; health start programs; diagnostic resources; parent health services; mental health services; nutrition program training.

Services for Handicapped Children

Request therapeutic day care services; referral system for retardates; respite in-home care for families of retarded children.

Social Services

Request more social workers; more family counseling; foster homes; counseling arrangements for working parents; services for single parents; crisis center.

Outreach Programs

Request more outreach home start programs.

Manpower Training and Development

Request training for family day care mothers; training and accreditation of personnel on all levels; improve programs to help administrators upgrade skills.

Coordination and Delivery of Services

Request coordination of Federal and State public relations; publicity and public education; more effective use of existing facilities; upgrading of proprietary day care facilities; increase in quality developmental programming for children; art and music in current programs; funding for support services, to meet training costs, to update materials, and for transportation; increase efforts to obtain funds from: Federal Government, State government, local government, private sector, and business; need services for in-between income groups; need an ombudsman for children; legislation: clarification and unification of child care services

standards and licensing requirements; clearer guidelines and legislation; new programs: child care provisions by employers and innovative programs; technical assistance in all areas.

Transportation

Request transportation for clients to and from services.

Parent Education

Request training programs for parenting and prenatal care.

In view of our suggestion that Montgomery County 4-C Council's study of its needs may be a useful model for other communities engaged in self-study projects, we are presenting some of their recommendations on funding sources for child care services that warrant exploration, as a further illustration of community problem solving. This material is not incorporated in the data analysis.

1. Study funding regulations to achieve innovative interpretation possibilities.
2. Use county adult education funds and resources.
3. Third party payment: (a) insurance and (b) education funding through Board of Education and/or Health Department.
4. Private sector—child care as an employee benefit.
5. Start with HEW demonstration programs.

St. Mary's County

Demographic Data

Total population, 1970	47,388
Children 0-5, 1970	6,691
Percent of total population	14.1
Families with children 0-5, 1970	4,072
Female-headed families with children 0-5, 1970	271
Families with children 0-5 below poverty line, 1970	716
Children 0-5 in families with incomes below poverty line, 1970	1,299
AFDC families, FY 1972	539
AFDC children 0-5, FY 1972	498

Child Care Needs

Child Care Programs

Request group day care centers; preschool learning centers; before- and after-school care.

Health Services

Request prenatal services.

Outreach Programs

Request for home start programs.

Coordination and Delivery of Services

Request information about services offered in other areas of county; suggest central data resource of services; coordination between Board of Education and other community agencies.

Parent Education

Request pre- and postnatal instruction in form of parent discussion groups.

Public Education

Request full-time nurse/health educator; "education for parenthood" courses.

Prince George's County

Demographic Data

Total population, 1970	660,567
Children 0-5, 1970	84,208
Percent of total population	12.8
Families with children 0-5, 1970	55,839
Female-headed families with children 0-5, 1970	3,361
Families with children 0-5 below poverty line, 1970	3,235
Children 0-5 in families with incomes below poverty line, 1970	5,358
AFDC families, FY 1972	4,718
AFDC children 0-5, FY 1972	4,230

Child Care Needs

Child Care Programs

Request for day care facilities; before- and after-school care (including full day on school holidays); day care for moderately ill children of working mothers; family day care for infants; drop-in centers for parents and children; and play areas suitable to a child's developmental and safety requirements.

Health Services

Request for services in prenatal care; nutrition; mental health and dental; free inoculations.

Services for Handicapped Children

Inclusion of these children whenever feasible in day care centers for normal children; special day care centers for severely handicapped; and therapeutic nursery centers.

Social Services

Request for child abuse program; increase efficiency and effectiveness of foster care; provision of round-the-clock emergency care for all economic levels; single-parent counseling.

Outreach Programs

Request home visitors for sick children who normally attend day care centers.

Manpower Training and Development

Request sensitivity training programs for professionals who work with young children; orientation programs for foster parents; recruitment of men into the field of child care services.

Coordination and Delivery of Services

Request for public relations including advertising of services; monitoring all proposed legislation affecting children; adequate and consistent enforcement of laws affecting children; clearinghouse for information on children.

Parent Education

Request parent discussion groups; sensitivity training.

Support Services

Request more AFDC and tax relief to reduce turnover in foster care.

Prince George's 4-C Council indicates preference for a new type of multi-purpose center to deliver the needed services. These neighborhood community centers would provide the following: prenatal services, single-parent counseling; care for moderately ill children of working mothers; play areas; parent discussion groups; drop-in centers for parents and children; day care facilities. These centers should be incorporated into neighborhoods on the same basis as schools and libraries.

SUMMARY AND CONCLUSIONS

Eleven out of 13 counties with 4-C Councils in Maryland participated in an informal survey in order to determine local 4-C perceptions of child care needs. Demographic data for each of the surveyed counties were included in an effort to determine the presence or absence of significant relationships between felt need and certain geographic-population characteristics of the counties. Table 22 presents a summary of the requested needs by category.

Although the needs reported often seem to have little relevance to demography, a few interpretations and conclusions can be drawn. First, almost without exception, all participating counties requested additional

TABLE 22
Number of Counties Indicating Needs By Category

	Allegany	Baltimore County	Carroll	Cecil	Dorchester	Garrett	Howard	Montgomery	Prince George's	St. Mary's	Washington*	Total
I. Child Care	X	X	X	X	X	X	X	X	X	X		10
II. Health Services	X		X			X	X	X	X	X		7
III. Handicapped			X				X	X	X			4
IV. Social Services	X						X	X	X			4
V. Outreach						X		X	X	X		4
VI. Training	X		X			X	X	X	X			6
VII. Coordination	X	X	X	X		X	X	X	X	X	X	10
VIII. Transportation	X		X	X			X	X				5
IX. Parent Education		X					X	X	X	X		5
X. Support System			X				X		X			3
XI. Public Education	X		X				X			X		4

*Washington County's response was placed in the Coordination category. However, it implies a need for the continuation and expansion of comprehensive child development programs.

programs for their children. Thus, Category I–Child Care Programs–would seem to rate priority attention. An equal priority area, Category VII–Coordination–receives comment from 10 out of the 11 participating counties. Requests for coordination range from coordination and sharing of facilities, agencies and programs to appeals for money.

Requests for a multiplicity of health care needs (Category II) ran a close second and requests for in-service training for all personnel and special training for day care personnel also received prime attention. Surprisingly, requests for social services and additional expanded public education do not command a high priority. Montgomery, Prince George's and Howard Counties list the greatest number of needs. At least two explanations of this phenomenon are possible. One might be the high population density of these counties and their proximity to Washington, D.C. Secondly, this erudite population is continuously reminded of the many social services available through mass media. Thus, they are more inclined to be informed about possible social programs and to ask for the services they have been conditioned to expect.

On the other hand, the rural counties–having smaller populations and being further away from urban centers–tend to be less informed about social programs that could be made available. They request less as reflected in their "felt" needs.

Montgomery County, probably the "wealthiest" county in Maryland (in per capita family income) has a funded and staffed county 4-C Council. Its method of conducting a self-study of local needs is both sophisticated and comprehensive. It could be a model for future studies of this nature and is included in the Appendix. This group has financial resources at its disposal that enable it to conduct more statistically sound surveys. A study of this type would have more impact and interpretive significance if more counties could have participated and if a more formalized method including documentation of needs could have been used. Nevertheless, the results obtained do reflect the need for additional programs, training and coordination.

Several counties made suggestions as to how their needs could be met. In general, the rural areas could envision scattered services in the more populous areas–with increases in coordination and transportation services. The urban areas felt the need for more funds and perhaps a new type of multi-purpose community facility–a kind of neighborhood clinic which would provide a multiplicity of health care services and social services as well as day care for the children.

Looking to the future, information retrieval and dissemination, communication and transportation seem to be keys to increasing the effectiveness and efficiency of any comprehensive child care program. Computers, multi-media educational programs and centralized data banks

equipped for instant retrieval and dissemination capabilities will be prominent in the future. England, Australia, Canada and India are already experimenting with these methods in the allied health professions, and Maryland has recently begun a data system for the handicapped. The results bear watching.

With respect to day care needs, there is need for more information on which to base decisions. A logical next step would be an on-going assessment in greater depth. The Urban Institute has developed evaluation procedures that can be used by city agencies and local community groups in assessing day care arrangements available in their own communities.* The approach to the study and the specific research methodology employed is simple and emphasizes the use of community residents to evaluate day care services in their own neighborhoods. By being actively involved, community residents can play important roles in defining objectives and the measures of effectiveness used in a study.

Schedules for telephone interviews, sample forms, coding, and analysis procedures are outlined to provide data useful in assessing the quality of day care services in a local community, and thereby developing the impetus at a local level for any needed change. Various ways that the data yielded might be analyzed are illustrated. Community profile forms, tables comparing quantitative and qualitative data on day care centers, graphic presentations, and sample cross tabulations are provided. Procedures for sampling and data collection, guidelines for day care interviews, training for interviewers, and detailed cost estimates for this type of community assessment are included.

All of the research instruments and procedures were used in several nearby communities, both low and middle income.

COUNTIES AND BALTIMORE CITY ARRIVE AT INITIAL CONSENSUS

The State Plan as a means for representatives from local political jurisdictions to arrive at joint initial consensus on unmet child development needs.

An all-day planning session was sponsored by the Maryland 4-C Committee on November 7, 1973. It was attended by representatives from the 13 county 4-C Councils and the Baltimore City public agency planning group for the purpose of sharing, describing and endeavoring to rank by priority the various unmet needs of young children. It is significant to note that the priorities arrived at during this planning session coincide with the

*Richard B. Zamoff and Jerolyn R. Lyle, *Assessment of Day Care Services and Needs at the Community Level: Mt. Pleasant* (The Urban Institute, Washington, D.C., November 1971, 56 pages).

independently determined priorities expressed by the individual county 4-C Councils as reported in the previous section and collated in Table 22.

Both of these methods employed to assess local needs for child development resulted in a top priority for the need to *expand quality child care and child development programs*. This prime need meshes with a mutually shared priority for the *need for coordination of services and programs* followed by the *need for training of staff*. This planning session, which was attended by 43 participants, illustrates the group process method.

Following is a summary of the categories of need, which illustrates the kinds of services the participants at the planning session desired.

Child Care—Child Development

Overwhelming support was given the provision of more day care, and emphasis was also placed on the development of before- and after-school care programs and care in unusual hours and during the summer. Specific recommendations under this category include:

a. An increase of payment scale for family day care mothers.
b. An increase of payment scale for purchase of care.
c. More flexible eligibility requirements for publicly subsidized day care.
d. A recognition that day care is here to stay and that public facilities, especially schools, should be designed and built with day care needs in mind.
e. Alternatives of care (diversity of kinds of programs) to be made available to parents.
f. Drop-in care, cited as a generally unmet need.
g. More recreational programs under jurisdiction of Departments of Education and Bureau of Parks.
h. Expansion of programs for the handicapped child with attention to his special needs.
i. Better accessibility of some programs, which would eliminate a barrier to utilization of present facilities.

Coordination

Coordination of the delivery system is sought on both the administrative and the consumer levels. Both would have the effect of providing better services, with focus on the "whole" child, and would assist in reaching an expressed goal of providing a continuity of services and programs from birth on, with individualized rather than depersonalized attention. All recommendations in the area of coordination speak to the service delivery system. Some specific recommendations follow:

a. There was general consensus that there should be a community resource center (a coordinating structure) which would gather, publish and disseminate information about child care and child development resources in the community. This structure would also have the responsibility of making referrals to appropriate resources. These resources should include a crisis resource center where children could be placed out of their homes in emergency situations.

b. In urban areas, a computer system of day care center vacancies—both family and group—would be of great assistance in making placements. Staff is insufficient to do this manually. The result is under-utilization on one hand and denial of service on the other.

c. A way should be found to afford the consumer a meaningful voice in the licensing system.

d. There was general consensus that interagency cooperation and coordination at both the State and local levels is imperative if the needs of young children are to be met. It was suggested that public schools make space available for school age day care.

Training

The quality of a program is largely determined by the capabilities and attributes of its staff. Members in attendance urged that training be made available to all levels of staff working with children and that this training should emphasize "sensitive" or "humanized" training. Such training should be made available to the range of personnel from professionals such as physicians, nurses, and head teachers to the paraprofessional ranks of aides, janitors, cooks, bus drivers, etc. This firm consensus for more and better training includes the training of parents and volunteers and singles out for special attention, foster parents and fathers of young children. Training should be flexible and should include in-home training where indicated.

There was general recognition that persons with degrees are not necessarily best equipped to provide healthy experiences for young children. Interest was expressed in perfecting a system such as CDA (Child Development Associates) which affords career recognition and advancement based on competencies in working with children. Some persons in attendance urged that the trainers (especially faculty at the college level) be screened and trained before being assigned as the trainers of teachers and other child care workers. Generic skills in child development were stressed as a desirable trend with opportunity afforded for staff to transfer these skills to various child development settings.

A critical unmet need is for the training of family day care mothers. Immediate attention should be addressed to the provision of such training.

Another area of training cited as largely unmet is the need for parent education, which should be offered in a continuum in the public school

system and become mandatory at the high school level. The establishment of a relationship of the parent with the community resources, especially the school, should start at the earliest possible time.

A more effective means must also be found to disseminate information about the content, depth and focus of college courses, especially at the community college level. This would be beneficial for use by the growing field of child care and child development personnel.

Health

The range of recommendations for more adequate health programs reflects the importance given this component. Generally, there was a plea for individualized health services embracing both *preventive* and curative programs, and *expansion* in both directions was urged. Dental care was cited as an important unmet need. There is need for more sick and well baby clinics. In rural areas, mobile facilities should be established. The need for nutrition education is widespread across the State. The need for pediatricians is acute in some rural counties. Diagnostic services are not generally available. Specific mention was made of the need for early diagnosis followed by treatment. This would include retardation, vision and hearing difficulties, emotional or mental health problems, and dental needs. Health care should embrace the whole family—parents and siblings as well as the young child.

Funding

The need for more realistic public assistance grants was singled out as a critical area, if Maryland's children are to be served comprehensively. In an ideal situation, eligibility for services should be based on a child's needs rather than family income.

Long-range coordinated planning for children's services would necessarily have to be closely linked to joint agency budgeting processes.

Many children in families having incomes close to, though above, the poverty level are in need of services.

Lastly, there was general recognition of the need for major Federal legislation such as expressed in the Mondale Child Development bill.

Legislation

There was reaffirmation of the thesis that this country does not give a *real* priority to its children. Public officials are often not sympathetic to or supportive of the needs of children and their families.

Legal services, supported by public funds, were cited as a major need for poor children and their families.

The area of enforcement of laws and regulations pertaining to children's services was highlighted and the statement made that *enforcement*, with no

exceptions, is required if children are to be protected. The area of child abuse was mentioned as requiring legislative review and perhaps change.

Transportation

Transportation is a generally unmet need for the handicapped child and especially for the handicapped child in Baltimore City. The lack of transportation in rural areas, however, was also cited as a grave situation. Transportation must be made generally available if children are to get to health facilities. The suggestion was made that the transportation facilities of the Boards of Education might offer relief in certain urgent situations. In rural areas, the use of mobile health units could offer an alternative delivery system.

Support Systems

In this general catch-all category may be found the most urgent needs in Maryland. Lack of adequate numbers of trained staff was generally cited as having the effect of denying services to children. This lack cuts across all agencies.

Income maintenance and adequate housing were recognized as basic support factors required for a comprehensive plan for children.

The areas of foster care, adoption, child abuse were again mentioned under this category as requiring more attention.

Chapter IX

Parents' Role In Programs For Children

The State Plan as a means of strengthening the role of parents in child development programs.

Probably one of the areas needing most development and creative response is the provision for parent voices in the planning, implementation and evaluation of services for young children and their families.

In successful communication, a meaningful exchange of ideas can take place only when the prime components are actively involved. Parent involvement needs to move from passive roles, where parents are the recipients of aid and information, to more active roles in which parents are aides, decision makers and teachers of their own children. Examples of this kind of action are cooperative nursery and kindergarten groups in the State which for the past 30 years have been training grounds for parents and teachers working together, including parents in policy making and personnel selection.

Throughout the nation there is grave concern by parents that they have no meaningful voice in the policies that shape educational programs. At the same time, many administrators and teachers are not receptive to letting non-certified, non-professional and non-education establishment parents control programs. Yet active parent participation provides input as to whether particular programs actually serve the real needs of children and the community, supplying also a needed note of practicality.

The growth of interest and national investment in early education is the result of influence and pressure from many sources, particularly from major ethnic groups and the civil rights movement. Pressure from such social and political sources did not end with the legislation that provided additional educational resources through Project Head Start . . . it began.

Federal programs, such as Head Start and Parent-Child Centers, have given parents an opportunity to participate in the decisions affecting their children's education and care. They have helped to create a trend toward the legitimatization of community control, specifically in these areas of early education and child care.

Such participation is seen as essential in order to assure a continuity of influence and interaction between programs and parents with respect to the child's experiences, especially the transmission of cultural and ethnic values. It can be expected that minority and other pressure groups will continue to expect to be an integral part of planning and decision making.

The constituency of the decision-making body is a major determinant of the delivery system as well as the program organization and the level of financial support. While consumer participation is preferable, unfortunately the greater the role the consumer plays in the decision-making process of a program, the less likely is that program to be adequately financed. In contrast, for example, the owner of proprietary services makes the program decisions and the consumer is inclined to express satisfaction by continued patronage. Feedback is usually immediate. If the consumer need is not met, support is withdrawn.

In general, the more distant the source of support, the more complex the decision-making process and the less real authority and choice for the operating body. Public funds are controlled by the granting agency and become the legal responsibility of every agency through which they flow. Each imposes choices and limits, leaving fewer options to local bodies. The voice of the parent, as chief advocate for the child, ceases to be heard.

However, if parents are to be included in planning for their children, they must not be patronized or "used" by administrators. If participation becomes another exercise in futility, this can do more harm than good and only serve to increase alienation, cynicism and unrest.

If State and local departments do not seek productive liaison in program planning and acknowledge responsibility in this role, they will find themselves *reacting* rather than *acting*—and not always constructively—to demands for more information, more involvement and more control of program policies and practices.

Federal program guidelines for the Maryland 4-C Committee require that parents being served by child care programs must make up at least one-third of any 4-C policy committee. The Maryland 4-C has sought parents from a variety of programs and localities to serve on its Board. Those parents who participate in the 4-C process have a unique opportunity to share in planning that affects the lives of children in the community—through policy making, program management and operation, and allocation of funding and other resources.

Citizen influence in decision making taps new ideas and energy and

provides leverage to bring about reform in improving the quality of services. The continued development of a force consisting of parents and citizens requires the thoughtful attention of all who are concerned about the participatory process.

The conviction of the value of citizen participation results in several recommendations.

Recommendations:

- Concerned parties should guard against any limitations on citizen participation. The concept embodied in the New Federalism–that programs are amenable to cost accounting solutions–is not applicable to social programs. The valuable contributions of the consumer's voice should be protected and not superseded by systems and accounting concepts.
- The Advisory Committee on Day Care to the Maryland State Department of Social Services which calls for one-third parent membership should be reinstituted. See the section on Day Care in Chapter X for further elaboration of this point.
- Encouragement should be given to research efforts in Maryland on the impact of parent participation on child development programs, especially day care. In Head Start programs, parent participation is built into the program, but little is known of its actual impact on Maryland's day care programs.

Chapter X

Day Care and Early Childhood Education Programs In Maryland

DAY CARE IN MARYLAND

The State Plan as an appeal for more and better family and group day care

We see them all the time . . . the children who weep bitterly because they don't want to go to the babysitter's house, the "big sister" in second grade who must remember every day to pick up her brother in first grade and her sister in kindergarten, the young children who sit in empty houses or roam the streets until their mother gets home, and the mothers themselves who worry about what is happening to their children while they work.*

We see, every day, children who need day care. And we know that Maryland needs more day care—not to get welfare mothers to accept employment but to protect and nurture the children whose mothers do work or, for any number of reasons, are not in a position to give them the home care they need. During the course of the development of this document, the 4-C had occasion to consult with a highly respected professional who has been identified with the child care and child development field since the 1930s and closely associated with the development of day care in the State since 1964. She urged:

> *More and better care for the children of Maryland goes without saying, and this includes the need for improvement of much of the existing day care.* It also includes the development of a network of "before- and after-school care" and embraces the development of a better tie-in system of family day care and group day care for the following reasons: It would bring about a more workable arrangement for parents needing day care services; would promote the coordination of training opportunities, and would lead toward the continuum of care for children in day care programs.

*From "Day Care: A Public School Administrator's View," Robert R. Spillane, *Childhood Education*, November 1972.

This expressed need for better and more day care is also the number-one priority of the combined 14 local 4-C Councils. (See Chapter VIII, which summarizes local needs and priorities, and Chapter VI, which discusses licensing of out-of-home care programs.)

GROUP DAY CARE

The State Plan as a presentation of trends in day care under public and private auspices.

Several tables are presented which indicate the trend toward *quantity* of rather than *quality* in day care services available in Maryland, the location of these programs, and their auspice.

A sharp increase in the numbers of children enrolled in licensed group day care centers in relation to the number of centers in which these children were enrolled (1968-1973) is shown on Table 23.

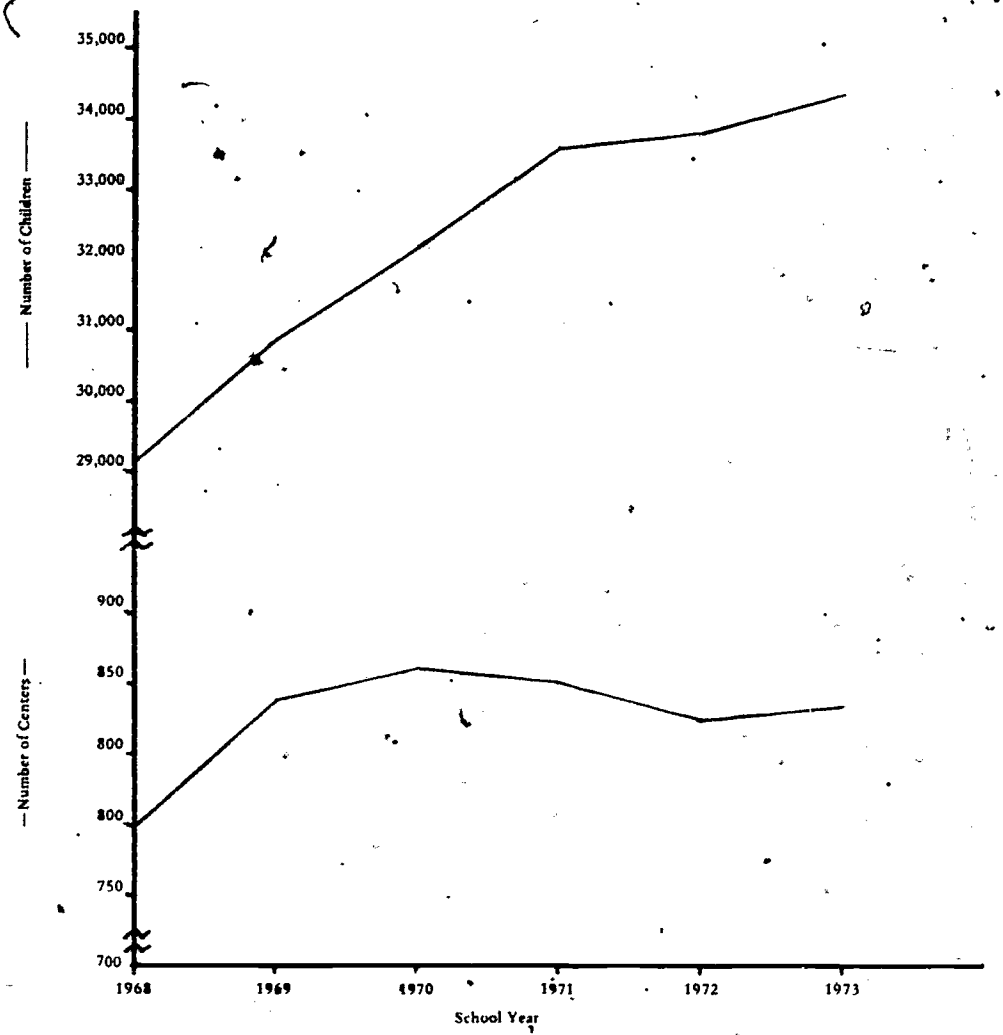
Table 24 illustrates the definite trend toward full day care centers and describes the drop-off in both numbers of children enrolled and numbers of centers operating on a half-day basis.

The number of licensed group day care centers in Maryland by location, sponsorship and size of enrollment in October 1973 is given on Table 25, and Table 26 gives statistics on the number of licensed group day care centers in Maryland and the number of children enrolled by location and type of operation in October 1973.

Data on Tables 23, 24, 25 and 26 include the public day care centers operated by the Social Services Administration; proprietary and nonprofit centers; licensed Head Start centers (excluding some Head Start programs which are operated by the Boards of Education in Prince George's and Montgomery Counties); parent cooperatives; and the Martin Luther King, Jr. Parent and Child Center. The data also include nonpublic nursery schools and kindergartens approved by the State Department of Education in Baltimore, Montgomery, and Prince George's Counties and Baltimore City because each of these four jurisdictions has a local child care ordinance covering the facilities included in this table. The data do not include nonpublic nursery schools and kindergartens in the remaining 20 jurisdictions, nor do they include prekindergarten programs in public schools financed by Federal ESEA or Migrant funds.

Table 27 shows the location of the 30 group day care centers operated by the Social Services Administration (February 1974). It will be noted that public day care under this department is not currently offered in 13 of Maryland's 24 political subdivisions: Allegany, Washington, Garrett, Howard, Queen Anne's, Talbot, Worcester, Kent, Caroline, Wicomico, Somerset, Charles and Calvert Counties.

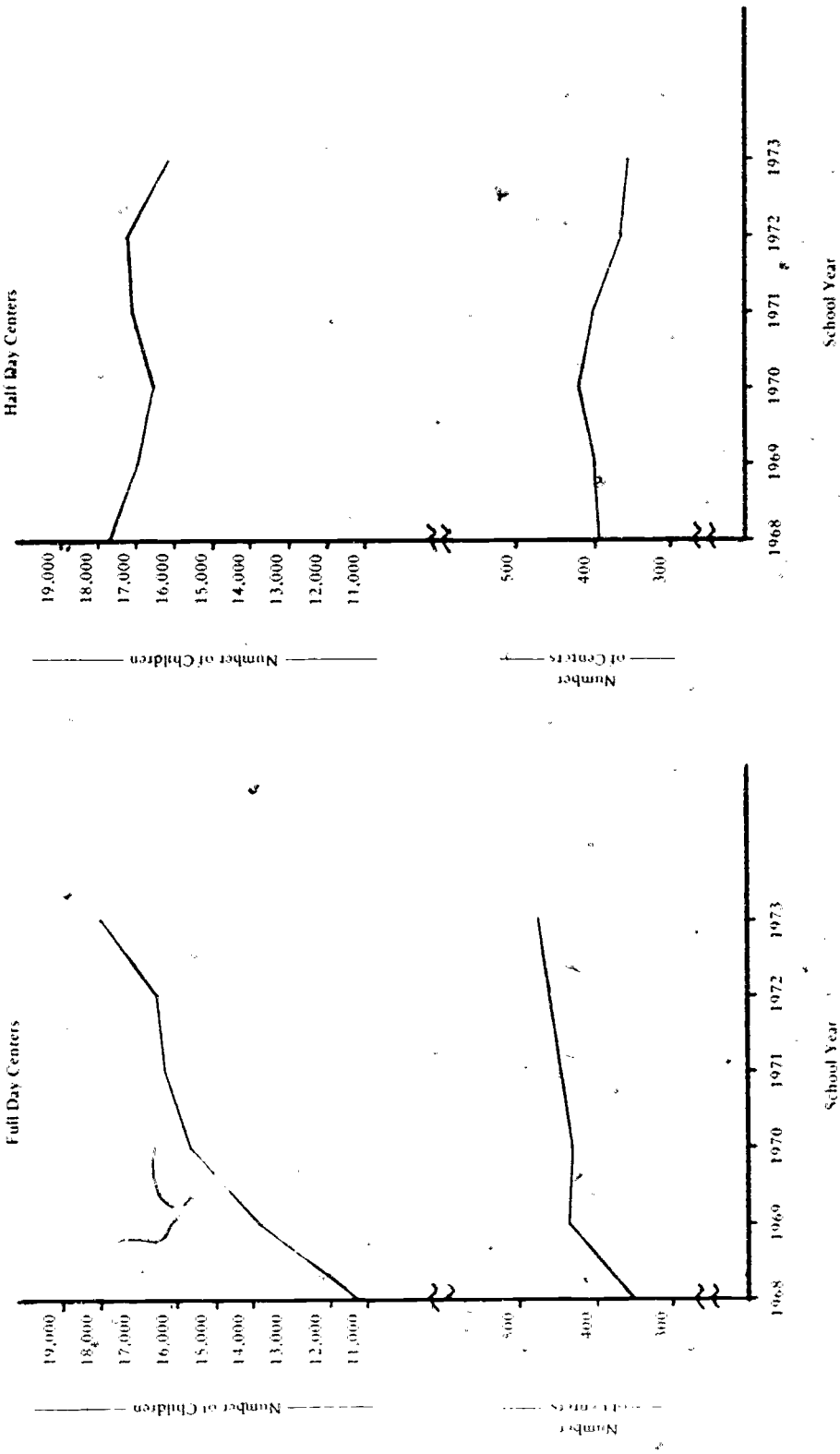
TABLE, 23
Number of Licensed Group Day Care Centers and Number of Children in Licensed Group Day Care Centers in Maryland, 1968-1973 School Years



Source: Maryland State Department of Health and Mental Hygiene, Preventive Medicine Administration, Division of Maternal and Child Health Care, February 1974.

TABLE 24

Number of Licensed Group Day Care Centers Operating Full Day and Half Day and Number of Children in Full and Half Day Centers in Maryland, 1968-1973 School Years



Source: Maryland State Department of Health and Mental Hygiene, Preventive Medicine Administration, Division of Maternal and Child Health, February 1974.

TABLE 25
Number of Licensed Group Day Care Centers in Maryland
By Location, Sponsorship and Size of Enrollment
October 1973

Location	Total	Sponsorship				Size of Enrollment		
		Public	Private Non-Profit	Religious	Proprietary	5-20	21-40	41 & Over
Maryland	836	113	130	261	332	247	288	301
Baltimore City	164	35	26	60	43	46	55	63
Total Counties	672	78	104	201	289	201	233	238
Allegany	13	7	1	4	1	5	4	4
Anne Arundel	56	9	3	17	27	18	25	13
Baltimore	118	8	17	60	33	28	51	39
Calvert	8	3	–	2	3	3	5	–
Caroline	6	–	1	2	3	3	3	–
Carroll	17	2	5	3	7	8	6	3
Cecil	9	1	–	5	3	4	2	3
Charles	10	3	–	4	3	4	4	2
Dorchester	7	3	2	2	2	3	4	–
Frederick	22	4	2	5	11	7	9	6
Garrett	3	3	–	–	–	3	–	–
Harford	21	3	–	11	7	3	8	10
Howard	17	–	–	3	14	10	3	4
Kent	5	1	–	–	4	2	3	–
Montgomery	163	2	54	46	61	38	55	70
Prince George's	133	8	15	24	86	33	40	60
Queen Anne's	3	2	–	1	–	1	1	1
St. Mary's	11	6	1	4	–	2	2	7
Somerset	7	4	–	2	1	3	2	2
Talbot	6	3	1	3	2	6	1	2
Washington	15	2	1	2	10	9	1	5
Wicomico	11	1	3	1	6	3	4	4
Worcester	8	3	–	–	5	5	–	3

Source: Maryland Department of Health and Mental Hygiene, Preventive Medicine Administration, December 1973.

TABLE 26
Number of Licensed Group Day Care Centers in Maryland
and Number of Children Enrolled By Location
and Type of Operation, October 1973

Location	Number of Centers					Number of Children Enrolled				
		Type of Operation					Type of Operation			
	Total	Full Day	Full & Half Day	Half Day	Other*	Total	Full Day	Full & Half Day	Half Day	Other*
Maryland	836	406	65	354	11	34,425	14,211	3,830	16,049	335
Baltimore City	164	112	5	47	–	6,517	4,500	234	1,783	–
Total Counties	672	294	60	307	11	27,908	9,711	3,596	14,266	335
Allegany	13	8	1	4	–	490	228	33	229	–
Anne Arundel	56	33	–	23	–	1,931	1,129	–	802	–
Baltimore	118	47	5	66	–	5,245	1,634	519	3,092	–
Calvert	8	3	–	5	–	190	71	–	119	–
Caroline	6	–	5	1	–	131	–	106	25	–
Carroll	17	12	–	5	–	388	232	–	156	–
Cecil	9	4	–	5	–	307	143	–	164	–
Charles	10	4	1	5	–	484	118	30	336	–
Dorchester	7	4	–	3	–	176	105	–	71	–
Frederick	22	8	–	13	1	781	321	–	455	5
Garrett	3	3	–	–	–	48	48	–	–	–
Harford	21	12	2	7	–	997	470	195	332	–
Howard	17	5	3	4	5	642	200	104	263	75
Kent	5	2	–	3	–	94	37	–	57	–
Montgomery	163	45	10	104	4	7,834	1,696	874	5,029	235
Prince George's	133	63	33	36	1	6,111	2,058	1,735	2,298	20
Queen Anne's	3	–	–	3	–	87	–	–	87	–
St. Mary's	11	5	–	6	–	442	194	–	248	–
Somerset	7	7	–	–	–	205	205	–	–	–
Talbot	9	3	–	6	–	203	73	–	130	–
Washington	15	11	–	4	–	446	242	–	204	–
Wicomico	11	9	–	2	–	421	279	–	142	–
Worcester	8	6	–	2	–	255	228	–	27	–

*Includes centers operating on a "before- and after-school" or on an "hourly" basis.

Source: Maryland Department of Health and Mental Hygiene, Preventive Medicine Administration, December 1973.

In addition to operating the centers listed on Table 27, the Social Services Administration–through the local departments of social services–purchases day care from private and nonprofit centers for AFDC children in all political subdivisions of the State except Garrett, Washington, Calvert, Charles, St. Mary's, Somerset and Worcester Counties.

Table 28, prepared by the Social Services Administration, presents data on the 30 public day care centers this department operates relating to capacity, enrollment, waiting list and numbers of children on public assistance in these centers as of December 31, 1973. Percent of occupancy is also given.

FINDINGS OF A 1971 STUDY OF DAY CARE IN MARYLAND

The State Plan as a summary of characteristics of day care as noted in a 1971 study.

In the spring of 1972, Kirschner Associates, Inc. presented its report, *Day Care in Maryland: A Study of Child Development Needs and Resources*, a major study pertaining to day care in Maryland contracted by the Department of Employment and Social Services.

The major research effort was devoted to identifying (1) the number and types of day care facilities; (2) the general characteristics of day care facilities, such as enrollment, staff, and equipment; and (3) the key agencies responsible for the organization and administration of day care.

With respect to numbers and characteristics, the findings–based on research in 1971–were as follows:

1. There were 862 day care centers in Maryland serving 32,224 children. This represented a 13 percent increase in full-day day care centers and a 2.3 percent decrease in half-day day care centers in Maryland during 1970/71.
2. The largest single category of buildings housing day care facilities was churches (35 percent).
3. Four-year-olds comprised 48 percent of the children in part-time day care and 38 percent of the children in full-time day care.
4. There was a minimal number of handicapped children in day care centers.
5. Private centers were more likely to serve meals than were public centers.
6. Physicians services were more available in private centers while nurses services were more available in public centers.
7. Vision screening and hearing tests were the health services most frequently included in day care centers.

TABLE 27.
Day Care Centers Under the Administration of the Social Services Administration, Department of Employment and Social Services, February 1974

Baltimore City:

Cherry Hill Day Care Center
Cherry Hill Presbyterian Church
819 Cherry Hill Road
Baltimore, Maryland 21225

Edmondson Village Day Care Center
3816 Edmondson Avenue
Baltimore, Maryland 21229

Hedrick Beals Day Care Center
1912 Madison Avenue
Baltimore, Maryland 21217

Holy Trinity Day Care Center
2320 West Lafayette Avenue
Baltimore, Maryland 21216

Kirk Avenue Day Care Center
Kirk Avenue and 22nd Street
Baltimore, Maryland 21218

Lower Park Heights Day Care Center
2621 Oswego Avenue
Baltimore, Maryland 21215

Montebello Day Care Center
Hillen Road and 30th Street
Baltimore, Maryland 21218

O'Donnell Heights Day Care Center
6201-6207 Fortview Way
Baltimore, Maryland 21224

Park Day Care Center
2401 Alaska Court
Baltimore, Maryland 21230

St. Augustine Day Care Center
300 South Broadway
Baltimore, Maryland 21231

St. Martin's Day Care Center
31-35 North Fulton Avenue
Baltimore, Maryland 21223

Union Square Day Care Center
Lombard and Calhoun Streets
Baltimore, Maryland 21223

Anne Arundel County:

North County Day Care Center
United Methodist Church of Riviera Beach
710 Fort Smallwood Road
Pasadena, Maryland 21122

Robinwood Day Care Center
Robinwood Community Center Building
Forest Drive and Tyler Avenue
Annapolis, Maryland 21403

Baltimore County:

Essex United Methodist Church
Maryland Avenue and Woodward Drive
Baltimore, Maryland 21221

Carroll County:

Developmental Day Care Center
95 Carroll Street
Westminster, Maryland 21157

Springfield Presbyterian Church
Obrech Road
Sykesville, Maryland 21784

Cecil County:

Cecil County Day Care Center
Court House
Elkton, Maryland 21921

Dorchester County:

Day Care Center
303 Aurora Avenue
Cambridge, Maryland 21613

Hurlock Day Care Center
South Main Street
Hurlock, Maryland 21643

Frederick County:

Day Care Center
First Baptist Church
217 Dill Avenue
Frederick, Maryland 21701

Frederick County Day Care Center II
211 South Jefferson Street
Frederick, Maryland 21701

Harford County:

Bel Air Day Care Center
312 Baltimore Pike
Bel Air, Maryland 21014

Montgomery County:

Takoma Park Day Care Center
310 Tulip Avenue
Takoma Park, Maryland 20012

Prince George's County:

Bladensburg Day Care Center
4825 Edmondston Road
Bladensburg, Maryland 20710

TABLE 27 (continued)
Day Care Centers Under the Administration of the Social Services Administration, Department of Employment and Social Services, February 1974

Prince George's County: (continued)	St. Mary's County:
Bowie-Laurel Center*	Lexington Park Day Care Center
11722 Pumpkin Hill Drive	15 Lincoln Avenue
Apt. 2912	Lexington Park, Maryland 20653
Laurel, Maryland 20810	
South County Day Care Center	Oakville Day Care Center
Gibbons United Methodist Church	Route 247
Gibbons Church Road	Mechanicsville, Maryland 20659
Brandywine, Maryland 20613	
	Great Mills Day Care Center
	c/o Little Flower School
	Great Mills, Maryland 20634

*The Bowie-Laurel Center was closed since this table was prepared.
Source: Social Services Administration, Department of Employment and Social Services, February 1974.

8. Where health services were provided, they were most likely to be paid for by an outside source.
9. Developmental records were more likely to be kept in public centers than in private centers.
10. Observation of a sample of day care centers revealed that, with some exceptions, the majority of centers appeared to provide adequate care for children. This statement is not to be considered an evaluation of the quality of the programs.
11. Public centers were most likely to involve parents in various activities.
12. Public and private centers report to various organizations. Thirty-four percent of the public day care centers reported to churches, the largest single place of reporting. It is evident that churches play an important role in sponsoring day care programs in Maryland.
13. Only 10 percent of centers provided transportation for children.
14. Eighty-seven percent of public centers obtained funds from parents.
15. Only one percent of day care centers had not been inspected within the last year.
16. Sixty-two percent of day care center directors saw the need for additional day care centers for children of working mothers. Fifty-eight percent saw the need for additional facilities providing full-time day care.
17. Twenty-two of the centers surveyed charged more than $20 per week per child. No day care center charged more than $40 per week per child.
18. Occupancy rate of family day care homes was 70 percent of licensed capacity.

TABLE 28
Report On State-Operated Day Care Centers, Social Services Administration
December 31, 1973

Location and Name of Day Care Center	Maximum Capacity (Children)	End of Month Enrollment (Children)	On Waiting List (Children)	Percent Occupancy	Number of Children On Public Assistance	Number of Families In WIN Programs
Total State	1,526	1,269	77	83.2	779	105
Baltimore City-Total	664	532	0[2]	80.1	318	33
Cherry Hill	45	35	0	88.9	21	1
Edmondson Village	75	72	0	96.0	37	4
Hedrick Beals	45	27	0	60.0	16	1
Kirk Avenue	45	45	0	100.0	22	2
O'Donnell Heights	45	30	0	66.7	29	4
Park	42	40	0	95.2	27	8
St. Augustine	37	30	0	81.1	19	6
St. Martin's	75	66	0	88.0	48	0
Trinity	35	35	0	100.0	15	2
Union Square	45	38	0	85.0	26	0
Homestead-Montebello	90	80	0	88.9	30	5
Lower Park Heights	85	34	0	40.0	28	0
Counties-Total	862	737	77	85.5	461	72
Anne Arundel-Total [1]	90	87	7	96.7	66	6
North County	55	50	0	90.9	34	3
Robinwood	35	37	7	105.7	32	3
Baltimore						
Essex	40	42	6	105.0	36	0
Carroll-Total [1]	95	92	0	96.8	44	7
Developmental #1	50	51	0	102.0	25	3
Developmental #2	45	41	0	91.1	19	4
Cecil						
Cecil County	75	43	0	57.3	22	6
Dorchester-Total [1]	90	60	2	66.7	38	10
Cambridge	45	36	0	80.0	21	7
Hurlock	45	24	2	53.3	17	3
Frederick-Total [1]	124	105	9	84.7	41	10
Dill Avenue #1	71	63	2	88.7	29	5
Jefferson Street #2	53	42	7	79.2	12	5
Harford						
Bel Air	70	72	7	102.9	45	3
Montgomery						
Takoma Park	50	43	3	86.0	29	7
Prince George's	126	100	40	79.4	87	9
Bladensburg	51	49	17	96.1	37	4
Bowie-Laurel	45	33	20	73.3	32	5
South County	30	18	3	60.0	18	0
St. Mary's	102	93	3	91.2	53	14
Lincoln	42	38	2	90.5	24	4
Oakville	40	36	1	90.0	23	5
Great Mills	20	19	0	95.0	6	5

[1] Total for county having two or more day care centers.
[2] None reported due to decentralization.
Source: Social Services Administration, Department of Employment and Social Services, December 31, 1973.

FAMILY DAY CARE

The State Plan as a means to call attention to greatly needed improvements in family day care.

The first legislation concerned with day care in Maryland was recommended as a result of the Governor's Commission to Study Day Care Services for Children. Initial meetings of this group were held in 1962, and as a result of their studies, legislation was drafted authorizing the licensing of day care facilities.

Licensing of family day care was assigned to the Department of Public Welfare (now designated the Department of Employment and Social Services), as recommended by the Governor's Commission. The bill was passed by the State Legislature in 1966 and funds to initiate the licensing service were first budgeted in 1967. Prior to that time, Baltimore City had set up a series of family day care homes under a grant of Federal funds received from the Office of Economic Opportunity.

Growth in the Number of Family Day Care Homes

In *Profiles of Children*, the 1970 report of the White House Conference on Children, Chart 105 shows the number and capacity of "Licensed or Approved Day Care Centers and Family Day Care Homes: U.S., 1965-69"; clearly indicated is a steady increase in the numbers of approved facilities. Currently, the Department of Health, Education, and Welfare receives voluntary reports from states. Its records are incomplete, with seven states not reporting for 1972. However, for the year 1972 there was a 20 percent increase in the number of licensed family day care homes in those states that did report. Maryland shows an even larger increase than the nationwide average in numbers of licensed family day care homes: from March 1971 to July 1972, there was an increase of 34.2 percent; and from July 1972 to July 1973, there was an increase of 31.9 percent, as shown on Table 29.

Referring again to this table, it is noted that the number of social workers has some relationship to the increase in number of family day care homes. As pointed out in the Kirschner Associates, Inc. 1972 report:

> Counties with social service staff members assigned full-time to development of the day care home program have more licensed homes than counties without such individuals.

Despite the gratifying increases made to date in the numbers of family day care homes, there is inadequate funding for the numbers of social workers required for this program. The figures indicate that many workers

TABLE 29
Licensed Family Day Care Homes

County and Other Jurisdictions	Number of Licensed Family Day Care Homes			Number of Workers
	March 1971	July 1972*	July 1973*	
Allegany	17	20	43	1
Anne Arundel	64	80	104	2
Baltimore	153	225	313	2
Calvert (See St. Mary's)	4	2	8	½
Caroline	5	7	17	0
Carroll	97	71	110	1
Cecil	24	36	25	1
Charles	12	11	37	1
Dorchester	9	18	22	0
Frederick	98	82	99	2
Garrett	0	0	0	0
Harford	28	26	24	1
Howard	8	25	45	0
Kent	3	5	9	0
Montgomery	175	290	405	3
Prince George's	110	159	284	2
St. Mary's	18	23	25	½
Somerset	14	16	18	1
Talbot	4	8	12	1
Queen Anne's	1	0	1	0
Washington	27	63	87	1
Wicomico	66	133	190	2
Worcester	9	22	17	0
Baltimore City	412	635	646	16
Totals	1,458	1,957	2,561	37
Percent Increase		34.2%	31.9%	

*From Maryland Department of Social Services, Annual Report, July 1973.

are assigned 50 to 150 licensed homes each. Since the number of family day care homes in Baltimore had increased to 831 by January 1974, the caseloads in the city are even larger than indicated on Table 29 as of July 1973.

If the state is to carry out the original intent of public funding for licensing family day care homes, sufficient funds should be budgeted so that family day care workers have reasonable caseloads of not more than 50 licensees. Counties that have 10 or more licensed homes should have the services of a worker assigned specifically to family day care.

To improve the standards of care being offered in family day care homes, groups of family day care homes could be organized in geographic areas. One licensee in each group might be given additional training and perform a supervisory role. The supervisor might also be responsible for setting up a lending library of books, toys and records for the use of family day care homes in that area.

The following figures show the ages of children cared for in family day care homes:

	Kitschner Report (full-day)	Kitschner Report (part-day)	Keyserling Report*	Allen Report**
Under 1 year old	29%	4%	7%	8%
1-year-olds	–	–	11%	11%
2-year-olds	37%	7%	21%	26%
3-year-olds	18%	5%	20%	16%
4-year-olds	16%	9%	13%	8%

*Mary Dublin Keyserling, *Windows on Day Care*, New York, N.Y.: National Council of Jewish Women, 1972, page 139.

**Rebecca B. Allen, *Family Day Care as Observed in Licensed Homes in Montgomery County, Maryland*, Seminar Paper, xeroxed, 1972, page 25.

According to these figures, 56, 39 or 45 percent of children in family day care homes are under three years of age; 74, 59 or 61 percent are under four years old. As stated in *Windows on Day Care* (Keyserling Report):

> The day care homes observed were much more commonly used for the care of infants and toddlers than were the day care centers.

With this in mind, trainers should stress the importance of including information on the development of infants and toddlers.

Reporting on "Child Development Input in the Family Day Care Program" in the Pacific Oaks College publication *Community Family Day Care Report* (1971), Judith Vanni states:

> It was apparent that the mothers have gross misunderstandings about what to expect from their children at various stages of development. Consequently, the children are constantly being mislabeled as bad while exhibiting only normal child-like behavior.

Since children of various ages are served by family day care, those providing this care should be trained in a full continuum of child development.

Maryland currently reimburses family day care homes in which care is purchased by the Social Services Administration at $70 per month per child in Montgomery County, Prince George's County and Baltimore City. All other counties are reimbursed at $65 per month per child–slightly above the national average cited in the Pacific Oaks report:

> Few family day care mothers are receiving sums of money that reflect the time, energy, materials and food they put into their programs. The average pay is $15 per week.

In Montgomery County, a majority of the family day care homes charge the general public $25 to $30 per week per child. This is causing a critical shortage of slots for children placed by Social Services due to the reluctance of family day care homes to accept the inadequate reimbursements. The

Keyserling report shows fees that vary from none (free services) to $100, with a majority ranging from $5 per week to $24 per week. That report cites an average of $15 per week per child.

Recommendations:

While Maryland is performing well above the national average in requiring licenses for its family day care homes, it is believed that only the "tip of the iceberg" is being reached. Reports from both an OEO Survey and the Women's Bureau reveal that only two to five percent of family day care homes in the entire country are licensed. If there is to be good care for children, Maryland needs to make substantial progress by providing:

- Sufficient number of workers to manage licensing.
- Publicity announcing the requirements for licensing.
- Adequate training for family day care mothers.
- Adequate organization and supervision of family day care homes.
- Improved reporting system for number and ages of children in family day care homes.
- Additional support for family day care homes, such as providing appropriate equipment and adequate reimbursement, especially for Social Services clients.

ADVISORY COMMITTEE ON DAY CARE

The State Plan as a means to advocate the reactivation of a broad-based advisory committee on day care to the Social Services Administration.

Under a Federal mandate, as expressed in Title IV-A of the Social Security Act, a committee must be established at the State level to serve in an advisory capacity to the Social Services Administration in its day care programs. This committee must have broad-based representation. One-third of the membership must be consumers—parents of the children being served. The other two-thirds should include representatives of other State agencies, private agencies, professional organizations, and civic groups.

An Advisory Committee was established following the termination in 1965 of the Governor's Commission to Study Day Care Services for Children and functioned until 1971. The charge to the Committee was:

> to address itself to a continuous review and evaluation of those day care needs which arise from the special conditions and circumstances of childhood, as well as those which arise from difficult family situations, including employment of the mother. With a focus on prevention and rehabilitation, the Committee is to make necessary recommendations for the purpose of extending or improving this Department's services so that these needs are effectively met.

A revision of the charge in 1969 contained the stipulation that parents of children enrolled in the day care program comprise one-third of Committee membership.

During the six years of its existence, the Committee made significant contributions to the day care operations of the Maryland State Department of Social Services (now the Social Services Administration). It took part in developing the content of the family day care licensing law, enacted by the State Legislature in 1966; it gave its support to the day care center regulations promulgated by the State Department of Health and Mental Hygiene; it participated in the development of operational standards for group day care centers; it helped to develop a procedure for purchase of care; it encouraged the exchange of information with public and private agencies operating day care programs in the State.

Recommendation:

- The Advisory Committee ceased to function in 1971 and has not been recalled. It seems essential to reconstitute this Committee both because it is required by Federal regulations and because it has made and would continue to make a sizable contribution to the day care operations of the Social Services Administration. Consideration could be given to locating this Committee within the coordinating structure recommended in Chapter XV.

EARLY CHILDHOOD PROGRAMS UNDER THE STATE DEPARTMENT OF EDUCATION, DIVISION OF COMPENSATORY, URBAN AND SUPPLEMENTARY PROGRAMS

The State Plan as a summary of prekindergarten (Titles I and III) and public kindergarten programs in Maryland.

In fulfillment of the intent of Congress through Public Law 89-10 as amended by Public Law 90-247 and Public Law 91-230, the Elementary and Secondary Education Act (ESEA), Title III has been administered in Maryland, which sought solutions to critical educational needs.

As stated in the Title III Administrative Manual,

> a sizeable number of our youth are not acquiring the basic skills necessary to function in today's society, particularly in view of rising social and economic expectations for both individuals and groups. Therefore, a critical need exists to help youth acquire and use basic skills.

At its meeting on December 17, 1969, the State Board of Education directed the Title III staff of the State Department of Education to work with appropriate members of the staff of the Baltimore City Public Schools

in the development of an early childhood proposal. Comprehensively planned and implemented, this project is known as the Baltimore City Model Early Childhood Learning Program.

Prior to that mandate, significant changes had been made since 1965 in the development and strengthening of programs in early childhood education with the aid of Title I funds.

In 1966, Title I programs in 14 local educational agencies (LEAs) served children in grades one through 12 and included all phases of curriculum from reading to commercial subjects. In 1971, Baltimore City was the only LEA serving children beyond the sixth grade under Title I (with the exception of the special Baltimore County Title I program for children in institutions for the neglected and delinquent, which served children at the secondary level). Sixteen of the remaining 23 LEAs focused Title I services only on children in the prekindergarten, kindergarten or first-grade through third- or fourth-grade levels. Figure 3 gives the enrollment in prekindergarten programs under ESEA, Title I, 1967-1974.

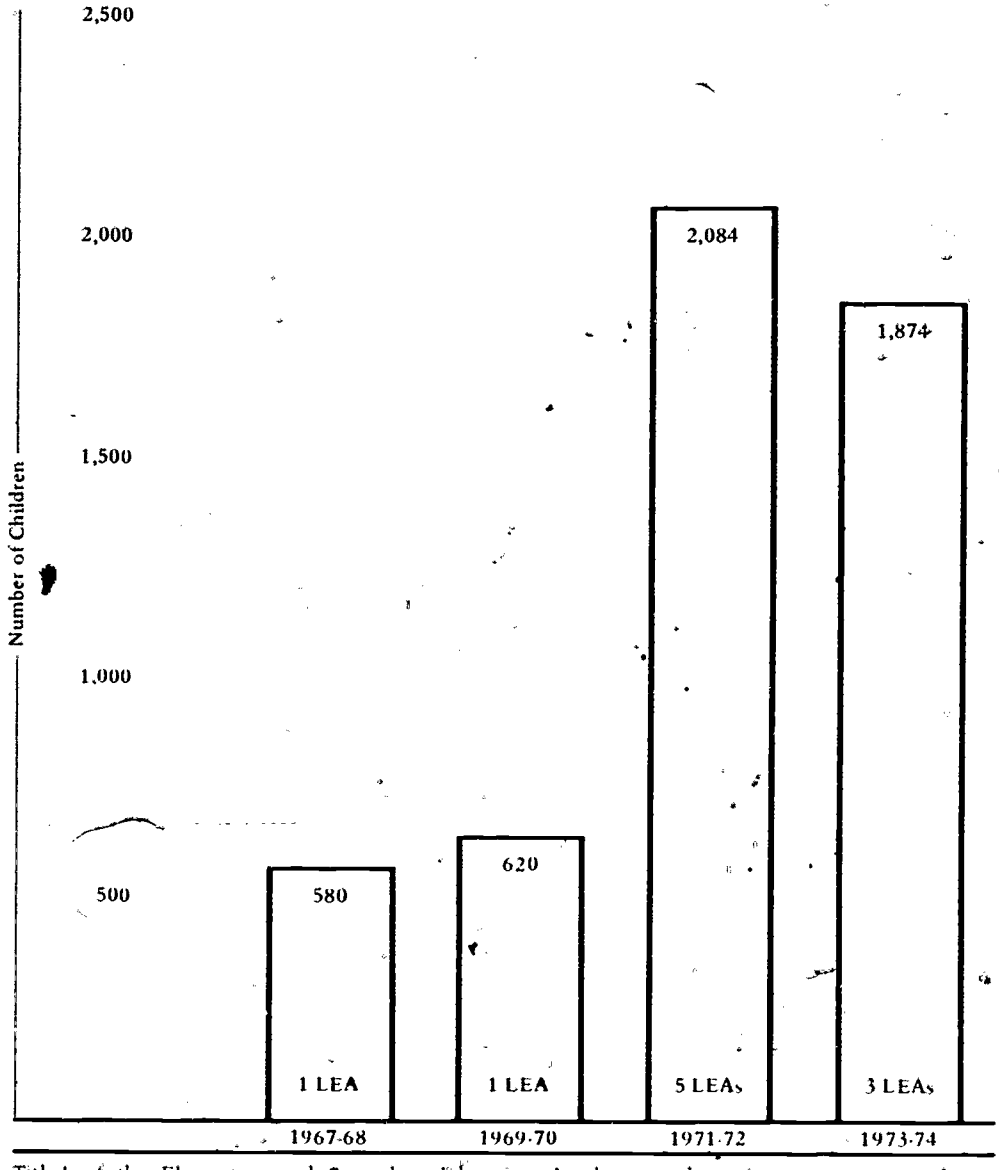
During the 1971/72 school year, 21 LEAs included Title I participants at the kindergarten level. Somerset County is operating a pilot full-day kindergarten program for disadvantaged children, funded partially through Title I funds. Carroll County's Title III project is an experimental kindergarten program directed at early identification of children with learning problems so that these problems may be corrected before the child experiences frustration or failure.

Baltimore City, St. Mary's County and Wicomico County use State funds to operate prekindergarten programs for disadvantaged children. Charles County has a five-year project funded under the Commissioner's discretionary 15 percent of Title III, a component of which is an experimental instructional grouping of disadvantaged four-, five- and six-year-olds. This project was the product of a cooperative effort involving the Early Childhood Education staff and the Title III staff of the Division of Compensatory, Urban and Supplementary Programs and the Charles County LEA staff. Table 30 describes Title I and Title III prekindergarten programs in the various political subdivisions of the State.

In April 1972, the Maryland State Board of Education established early childhood education as one of five areas of concern that "shall be given the highest priority." This declaration was strengthened in September 1972 by the publication of *Guidelines for Early Childhood Education*, a cooperative effort of agencies and groups concerned with the education and welfare of children on the State, local and national levels.

With the knowledge that many factors contribute to the child's lack of achievement, the State Board of Education continues to be committed to the establishment and operation of strong comprehensive programs of early childhood education. Such programs are designed to enable educationally

FIGURE 3
ESEA Title I Prekindergarten Enrollment in Maryland
1967-1974



Title I of the Elementary and Secondary Education Act has served to give recognition to the importance of prekindergarten education for disadvantaged children in Maryland. LEA–Local Education Agency.

Source: The Maryland State Department of Education.

disadvantaged children to acquire basic cognitive skills at a crucial time in their intellectual development and to prevent serious learning problems that make later remedial efforts necessary.

TABLE 30
Prekindergarten Programs

Program Name	Funding Source	Beginning Date	# of Children	Age Range	Half or Full Day
Anne Arundel County					
An Exemplary Program for Self-Concept Development and Language Improvement with Three- and Four-Year-Olds	ESEA, Title I	1973	60	3-5	Half Day
Baltimore City					
A. Baltimore Parent-Infant Center for Education	ESEA, Title I	1974	32	6 mos.–4 yrs.	Full Day (Tuesday Wednesday and Thursday)
B. Early School Admissions	ESEA, Title I	1962	1,270	4	Half Day
C. Follow Through	ESEA, Title I	1969	1,025	5-9	Half Day and Full Day
D. Involving the Very Young	ESEA, Title I	1968	490	2-4	Half Day
E. Model Early Childhood Learning Program	ESEA, Title I (State funding)	1970	640	3-7	Half Day and Full Day
Baltimore County					
Continuum in Early Childhood Education	ESEA, Title III	1973	50	4-5	Half Day
Carroll County					
Early Intervention to Prevent Learning Disabilities	ESEA, Title III	1971	80	5-6	Half Day and Full Day
Charles County					
Title III Early Childhood Program	ESEA, Title III Section 306	1971	120	4-6	Full Day

Source: Maryland State Department of Education.

TABLE 30 (Continued)
Prekindergarten Programs

Program Name	Funding Source	Beginning Date	# of Children	Age Range	Half or Full Day
Howard County					
Early Childhood Education Center	ESEA, Title III	1973	23	3-4	Full Day
Montgomery County					
Early Childhood Services for Visually Impaired Children	ESEA, Title III	1971	26	1½-4	Half Day
Prince George's County					
Growing Together	ESEA, Title III	1973	110	2-5	Half Day and Full Day
St. Mary's County					
St. Mary's Early Childhood Learning Program	State Funding	1973	92	4	Full Day
Somerset County					
Assist A Child - Full-Day Prekindergarten and Kindergarten Program	ESEA, Title I	1972	81	4-5	Full Day
Washington County					
Early Childhood Project	ESEA, Title I; HEW	1968	115	4	Full Day
Wicomico County					
Wicomico Early Childhood Learning Program	State Funding	1973	118	4	Full Day
TOTAL 16 programs			TOTAL: 4,332		

Source: Maryland State Department of Education

PUBLIC KINDERGARTENS IN MARYLAND

The State Plan as a document which describes the impact of a Federal program (Title I) as a stimulating factor in the provision of kindergarten programs in each of Maryland's subdivisions.

Things have changed in Maryland. No longer does Maryland consider a child to be of "school age" only when he is six years old and able to start first grade. This traditional view assumes that all children should be at home with their mothers during the early years of life and that planned educational experiences are inappropriate at such ages. This point of view has been changed principally because of the volume of well-documented research, particularly with disadvantaged children, indicating that an environment of planned educational experiences can be very beneficial in the early years so critical to their development.

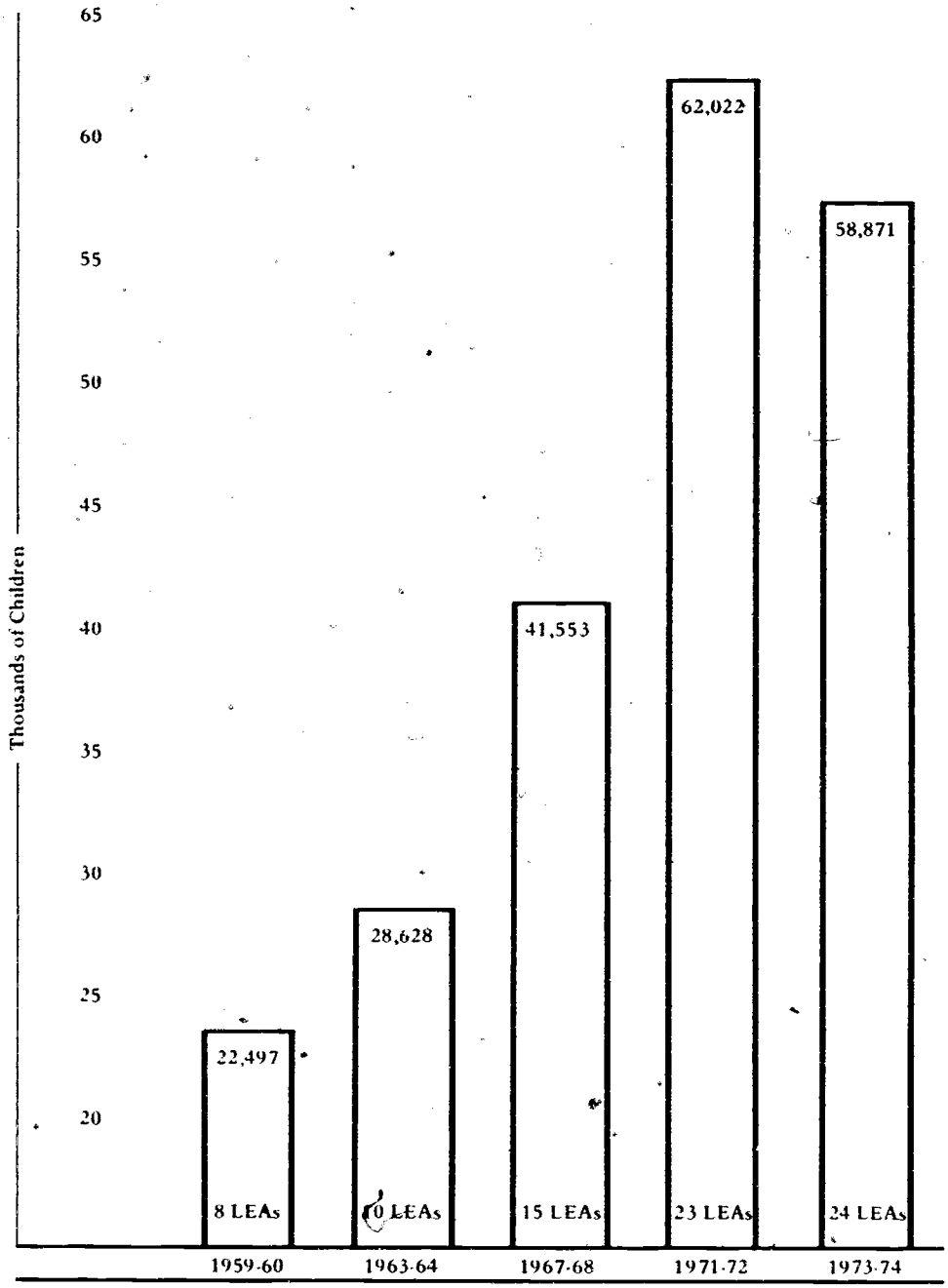
Another related break with the traditional concept is the changing role of women. More and more of Maryland mothers are seeking employment outside the home and consequently need care for their young children. These current developments in research and lifestyles are reflecting the obvious need to provide formal education for many children before the age of six.

Early childhood education programs are still in the beginning stage in most school systems in Maryland. The Maryland General Assembly in 1966 provided the State's share of the cost of kindergartens. Many school systems did not provide the local share of funds for kindergartens; consequently, such school experiences were not provided for most five-year-old children, even in the 15 school systems where kindergartens were partially in operation. However, kindergartens had been provided in Baltimore City for over 50 years prior to State funding of such programs.

The success of the ESEA, Title I programs for disadvantaged five-year-old children contributed in large measure to the action of the Maryland General Assembly, which by a 1970 amendment required every school system in the State to provide kindergarten programs by September 1973. Cecil County became the last school system to provide a kindergarten program, in September 1973. Figure 4 shows the growth of kindergarten programs in Maryland and gives enrollment figures for the period 1959-1974. Parents in all areas of the State still have the option of keeping children at home until age six.

Garrett County is the only school system in Maryland that provides a full-day program for all kindergarten children. In some Title I programs, funds are used to expand half-day kindergartens to full-day programs.

FIGURE 4
Kindergarten Enrollment in Maryland Public Schools
1959-1974



The growth of kindergarten programs in the Maryland public schools reflects an increasing awareness by educators of the importance of early schooling.

Source: The Maryland State Department of Education.

Typical kindergarten programs operate for two and one-half hours per day with a ratio of approximately 15-20 children to one adult.

Some counties, such as Charles, Somerset and Washington, are experimenting with innovative programs in one or two schools in their respective systems. In addition, some systems are providing model programs for four-year-olds. In all of these projects, there is a strong emphasis on parent involvement, staff training, curriculum development, and refinement of screening and evaluation procedures. It is the hope of the Maryland State Department of Education that these seeds of innovation will grow into statewide programs which provide the best educational environment for Maryland's children and meet the current needs of its citizens.

NONPUBLIC NURSERY SCHOOLS AND KINDERGARTENS

The State Plan as a source of statistical information pertaining to nonpublic educational programs for young children.

In Maryland there are a number of private nursery schools and kindergartens which offer educational programs to children between the ages of two and five. The Division of Certification and Accreditation, State Department of Education, has regulatory responsibility for the approval of these nonpublic kindergartens and nursery schools with the exception of those operated by bona fide church organizations, which are exempt from compliance with Bylaw 912:2 of the Code of Bylaws of the State Board of Education. For a discussion of the certification and accreditation process, the reader is referred to Chapter III, pertaining to the Division of Certification and Accreditation, State Department of Education.

Nonpublic nursery schools and kindergartens embrace a variety of methods and philosophies including the Montessori method, the British Infant School orientation, the open space concept, the traditional child development method, and combinations of any of these as well as cooperative programs.

The following data pertain to nonpublic nursery schools and kindergartens operating with the approval of the Division of Certification and Accreditation, State Department of Education (excluding those facilities sponsored by bona fide church organizations) as of September 30, 1973.

Type	Number of Schools	Number of Pupils
Nursery schools	80	3,260
Nursery school/kindergartens (including Montessori schools)	42	2,166
Kindergartens	3	103
Montessori schools (nursery school–third grade)	8	928
Totals	133	6,457

Table 31 shows nonpublic school enrollment, numbers of schools and teachers. The table includes facilities approved by the State Department of Education as well as those sponsored by bona fide church organizations.

HEAD START

The State Plan as a description of a child development program that focuses on the "whole child."

Head Start, authorized by the Federal Economic Opportunity Act of 1964, is a response to the problems that jeopardize the full development of the young child. The law authorizes the Federal Government to provide educational, health, nutritional, and social services to poor and handicapped preschool children and emphasizes the importance of parent involvement in the program.

The Head Start program is especially significant because it signalled to the nation for the first time the need for *comprehensive* services to the child rather than services that focus on only one aspect of life. It brought to national visibility in the dramatic Head Start summer of 1965 the importance of looking at the "whole child" and at all of the forces that influence his development.

Serious risks to health, education, and general well-being are encountered by children living in poverty. Many of the problems of poverty begin before birth, and their impact is apparent during the preschool years. Children of poverty are often handicapped in their ability to communicate in a "school setting," particularly through speech, because of their limited experiences and lack of knowledge of the broader world around them. By the time they reach school age, they may already have lost confidence and a sense of their own self-worth and importance. Motivation for academic learning is often limited. They also bring with them problems associated with poor nutrition and inadequate and insufficient medical and dental attention.

Since July 1973, Head Start has operated under the Office of Child Development in the Department of Health, Education, and Welfare. The Federal Region III Office of Child Development funds grantees in Maryland—in most instances community action agencies. The grantee may choose to operate the Head Start program itself or it may delegate the operation to another agency such as a public or nonprofit agency that meets Head Start requirements (Table 32). In some instances it may be to the grantee's advantage to delegate the operation of all or part of the program to another agency such as a community service agency, church or board of education, in order to draw upon that agency's resources.

In fiscal 1973, $4,546,697 was appropriated to Maryland Head Start grantees. Only Caroline, Carroll and Cecil Counties have no full-year Head

TABLE 31

Nonpublic School Enrollment, Number of Schools and Teachers: State of Maryland: September 30, 1973

Local Unit	Number of Pupils						Number of Schools							Total Number of Different Teachers
		Elementary						Prekindergarten and/or Kindergarten Only*	Elementary	Secondary	Combined Schools			
	Grand Total	Total	Prekindergarten	Kindergarten	Other Elementary	Secondary	Grand Total				Total	Middle	Other	
Total State	126,321	93,349	13,921	5,462	73,966	32,972	607	248	240	66	53	5	48	6,957.0
Allegany	2,055	1,494	144	47	1,303	561	9	2	6	1	–	–	–	102.9
Anne Arundel	7,289	5,430	993	301	4,226	1,859	35	19	10	3	3	–	3	364.6
Baltimore City	28,625	19,242	1,615	1,156	16,471	9,383	115	37	50	15	13	4	9	1,665.7
Baltimore	25,391	18,857	2,758	1,128	14,971	6,534	115	50	43	14	8	–	8	1,479.4
Calvert	625	514	20	24	470	111	4	1	2	–	1	–	1	37.3
Caroline	151	110	–	–	110	41	2	–	1	–	1	–	1	17.0
Carroll	363	363	32	11	320	–	4	1	3	–	–	–	–	16.0
Cecil	1,641	1,194	13	144	1,037	447	10	3	4	1	2	–	2	110.9
Charles	1,764	1,524	83	50	1,391	240	8	2	4	2	–	–	–	59.5
Dorchester	61	61	–	21	40	–	1	–	1	–	–	–	–	5.2
Frederick	1,717	1,458	258	67	1,133	259	14	7	4	2	1	–	1	87.4
Garrett	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Harford	2,287	1,264	246	141	877	1,023	10	5	3	1	1	–	1	124.1
Howard	2,831	2,831	1,088	100	1,643	–	29	20	9	–	–	–	–	161.7
Kent	173	173	–	17	156	–	2	–	2	–	–	–	–	14.0
Montgomery	22,875	17,533	3,818	893	12,822	5,342	126	59	47	11	9	–	9	1,376.7
Prince George's	21,770	16,846	2,638	1,069	13,139	4,924	86	35	36	10	5	–	5	951.9
Queen Anne's	240	124	48	–	76	116	3	1	–	1	1	–	1	22.5
St. Mary's	2,907	1,972	48	98	1,826	935	14	3	7	2	2	1	1	142.1
Somerset	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Talbot	881	575	31	41	503	306	3	1	1	–	1	–	1	51.0
Washington	1,873	1,114	37	74	1,003	759	10	–	3	3	4	–	4	114.3
Wicomico	541	541	141	61	339	–	6	2	4	–	–	–	–	32.8
Worcester	261	129	–	19	110	132	1	–	–	–	1	–	1	20.0

*Schools with prekindergarten only are as follows: Anne Arundel, 11; Baltimore City, 23; Baltimore, 31; Calvert, 1; Carroll, 1; Cecil, 1; Charles, 1; Frederick, 4; Harford, 3; Howard, 16; Montgomery, 50; Prince George's, 21; Queen Anne's, 1; Talbot, 1; Wicomico, 1; Total, 166.

Source: Division of Research, Evaluation, and Information Systems, Maryland State Department of Education.

Start programs. Carroll County operates the only summer program—a six-week program for approximately 90 children. Plans are to convert this summer program to a part-day full-year program in September 1975.

Head Start programs are encouraged to provide continuity of services, including linkages to schools and health delivery systems, after the child leaves the Head Start program. The Office of Child Development has not issued official guidelines regarding continuity of services and, as a result, there is no formal system in Maryland for follow-up procedures. In most instances, health forms, testing information and, occasionally, teacher observation data are forwarded (with parent permission) by Head Start personnel to the public schools.

Minimum length of a part-day program is 15 hours per week. Full-year Head Start programs may operate for periods of up to 12 months for either part of a day or a full day. The minimum length of a full-year program is eight months, for at least 15 hours a week. In order to define more clearly the services provided, the categories listed in Table 33 have been classified "part-day" and "full-year" according to whether the children attend part of a day or a full day. Full-year/full-day would indicate that children are present for more than 15 hours per week but less than six hours a day. When a program is operated for more than six hours a day, it is considered a Head Start day care program. Head Start programs must meet State and Federal licensing requirements and Head Start Performance Standards. All programs, whether center-based or home-based (outreach), provide the full range of comprehensive services.

In Maryland, 61 percent of Head Start children are enrolled in part-day programs, 29 percent in full-year programs, eight percent in Head Start day care programs, and two percent in outreach programs. Programs were encouraged to find innovative ways (other than five-day center attendance) to serve children and families in the fall of 1972. Summer Head Start programs for children who will be attending kindergarten or elementary school for the first time in the fall will operate in Carroll County only beginning June 30, 1974.

Head Start is primarily for children just under school age but may occasionally include younger or older children. Children under age three are served in the Martin Luther King, Jr. Parent and Child Center in Baltimore, described in the next section of this chapter.

According to the U.S. Census of 1970, there were approximately 25,000 children between the ages of three and six in Maryland whose family incomes fell below the 1970 federally-defined poverty level of $4,000 annual income for a family of four. Head Start programs serve 2,901 Maryland children.

While the poverty line determines eligibility for Head Start, once a child is admitted to the program he remains eligible until he enters school, unless

TABLE 32
Head Start in Maryland—Grantees and Delegate Agencies

County	Grantee(s)	Delegate Agency(ies)
Allegany	Community Action Committee of Allegany County	None
Anne Arundel	Community Action Agency of Anne Arundel County	None
Baltimore	Baltimore County Community Action Agency	1. Salem Lutheran Child Dev. Center 2. East Towson Child Dev. Center
Calvert	Southern Md. Tri-County Community Action Committee, Inc.	None
Caroline	None	None
Carroll	Board of Education of Carroll County	None
Cecil	None	None
Charles	Southern Md. Tri-County Community Action Committee, Inc.	None
Dorchester	Dorchester County Community Development Corporation	None
Frederick	Community Services Agency of Frederick County	None
Garrett	Garrett County Community Action Committee, Inc.	None
Harford	Baltimore County Community Action Agency	None
Howard	Community Action Agency of Howard County, Md., Inc.	Howard County Dept. of Education
Kent	Kent-Queen Anne's-Talbot Area Council, Inc.	None
Montgomery	Montgomery County Community Action Agency	1. Board of Education of Montgomery Co. 2. Boyds, Inc.
Prince George's	Prince George's County Board of Education	None
Queen Anne's	Kent-Queen Anne's-Talbot Area Council, Inc.	None
St. Mary's	Southern Md. Tri-County Community Action Committee, Inc.	None
Somerset	Somerset Co. Head Start, Inc.	None
Talbot	Kent-Queen Anne's-Talbot Area Council, Inc.	None
Washington	Community Action Council of Washington County	1. Board of Education of Washington Co. 2. Washington County Child Dev. Center

TABLE 32 (continued)
Head Start in Maryland—Grantees and Delegate Agencies

County	Grantee(s)	Delegate Agency(ies)
Wicomico	Shore-Up, Inc.	None
Worcester	Shore-Up, Inc.	None
Baltimore City	Mayor and City Council of Baltimore City/Community Action Agency	1. Dept. of Social Services 2. St. Veronica's Day Care 3. Harvey Johnson Day Care 4. Knox Day Care

the family income rises more than $3,000 above the poverty level. In such case, the child may complete the remainder of the program year. Children from a family on welfare are considered eligible, even when family income is above the poverty line.

At least 90 percent of the children enrolled in each class must be eligible under family income standards. Amendments to the Economic Opportunity Act require that, on a national basis, at least 10 percent of the enrollment opportunities in Head Start be made available to handicapped children. Handicapped children are defined as mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, or crippled or having any other health impairment which necessitates special education and related services. According to an informal telephone survey made in January 1974, 278 preschool children—or approximately nine percent of the total Head Start enrollment in Maryland—has been identified as handicapped.

The organizational structure of every Head Start center must provide the opportunity for Head Start parents to influence the character of programs affecting the development of their children. They are given many opportunities to develop a richer appreciation of a young child's needs and how to satisfy them. They are involved in decision making and in the development of program activities that they consider helpful and important. For example, at least 50 percent of each agency's policy council or committee must be parents of Head Start children currently enrolled in that program. Individuals other than parents serving on these policy groups must be elected by the parents. Every Head Start program must hire or designate a coordinator of parent activities.

Parents are one of the categories of persons who must receive preference for employment as paraprofessionals in the Head Start program. In addition, they are encouraged to participate in the classroom as observers and volunteers. Head Start programs are required to develop a plan to assure

parent participation and to offer parent education programs that are responsive to needs expressed by the parents. Classroom personnel are required to visit parents in their homes at least three times a year, provided such visits are acceptable to the parents.

Experts in early childhood education have begun to speak to a question of prime importance to Head Start planners and programmers: "What kinds of parent involvement enhance the development of children?" A summation of research findings in *Day Care: Resources for Decisions*, a publication of the OEO Office of Planning, Research, and Evaluation edited by Edith H. Grotberg, Ph.D., indicates some tentative conclusions about the impact of the parent participation program:

> Programs which attempt to involve parents as primary teachers of their own children appear to have positive effects on the cognitive development and achievements of their children (Klaus and Gray, 1965; Weikard and Lambie, 1967; Gordon, 1969; Levenstein, 1969; Karnes, *et al.*, 1970). These effects appear to spread to other siblings and to children in the neighborhood who are not involved in the program (Klaus and Gray, 1965; Miller, 1968; Gordon, 1969), although it is difficult to identify the factors which led to these effects.
>
> Participation may have some impact on the development of competence and self-esteem in the parents involved (Miller, 1968; Scheinfeld, 1969; Badger, 1970). It can be noted that these programs actively engage and involve parents in teaching their own children while emphasizing respect for their potential worth as individuals and confidence in this potential for continuous development. None use psychotherapy or counseling techniques and formal lectures, but each has attempted in some way to provide models for imitation, to provide support for the parents' problems and concerns in all aspects of family life, and to express a firm commitment to self-determination and the elevation of self-esteem.
>
> Parents involved in Head Start programs express a strong positive attitude toward their child's experience in the project. They feel that Head Start had a positive impact on their own lives, through means of providing opportunities to make new friends, engaging in more activities outside the home, reading more, and getting assistance from a social agency. . . .

Following is a conclusion drawn by Edward F. Zigler, Ph.D., formerly the director of the Office of Child Development, HEW, and former chief of the Children's Bureau:

> Direct involvement of Head Start parents in policy making roles has also led to an improved family life for thousands of parents and children. . . .

Head Start programs are encouraged to keep a training profile on each staff member. This profile includes all preservice and inservice program training, area and state workshops attended, etc.

As originally conceived, Head Start supplementary training funds were set aside to be used for training for college credit directed toward a bachelor's degree. In order to use these funds, it is necessary that college credit be obtained for the training. In 1973, 102 persons in Maryland were

receiving credits through supplementary training funds. By September 1974, classroom personnel with less than 45 hours of college credit were to be phased into competency-based programs when they became available.

From the inception of Head Start it has been recognized that training should be linked to the established accreditation system. Studies cited in *Day Care: Resources for Decision* have established that people working in far from optimal conditions can still find satisfaction in their work, once they know their certificates give them access to the academic ladder. Given options, some decide they do not want to go on for a degree but still desire to increase their competencies. Supplemental training/credit cost payments can be applied to any competency-based training. Many problems loom: competency-based training is a totally new approach to education and highly expensive to develop; competency-based training programs have not been developed in this region except at the University of Maryland, Baltimore County; also, assessment tools must be devised. A coordinated examination of competency-based training and the Child Development Associate (CDA) concept should be explored by agencies and organizations concerned with training child care workers.

The Head Start Bi-State Training Office, located at the University of Maryland, College Park, functions primarily as a training and resource center serving local programs in Maryland and Delaware. The Bi-State Office works with parents, staff, community representatives, Regional Resource and Training Center personnel and Regional Office specialists, in order to:

- Achieve program improvement and encourage innovation
- Insure that parents are included in all aspects of the Head Start program
- Facilitate mutual self-help and develop better working relationships between Head Start program(s), parents, staff, governing boards, etc.

Most Head Start training is done at the local level, as many local programs can do their own preservice and inservice training and can rely on local resources for technical assistance. The Bi-State Office provides appropriate audio-visual and printed materials etc. from its Resource Center and assists local programs in planning. Bi-State staff may serve as members of a local training team when the training cannot be handled by the local staff and when there is no alternate trainer available. With the Federal Region III Office of Child Development, the Bi-State Office participates in program monitoring activities.

The Head Start program as a model and method for compensatory education has been studied, analyzed and evaluated since its inception with varied and often confusing conclusions. It is not the purpose of this report to examine closely Head Start as a model early intervention program for the "disadvantaged" child but only to note that it is, in fact, a large-scale

enabling effort to provide the children of poverty and their families the opportunities to develop their full potential.

Roughly 12 percent of the children eligible for Head Start in Maryland are actually enrolled. One county reports that it was "unable to find any more eligible children." Other programs that wish to expand are limited because of fixed funding levels.

According to Table 33, it appears that possibly no local program is reaching all of its eligible poverty children. Does the fact that a center cannot be opened until there are 15 eligible children deter recruitment efforts, particularly in more rural areas? Are recruitment efforts being frustrated by the lack of available personnel or the failure to coordinate recruitment activities with local public and private agencies? Is lack of funds hampering expansion? Are some of these children in subsidized day care programs, DESS day care centers, child development centers or are they just "out there somewhere," out of the reach of programs and services designed just for them?

Some local Head Start programs have made adjustments in accordance with community needs while some have not. A Head Start day care program in a community of working parents may be an example of a defined need and priority. Perhaps in sparsely-populated rural areas, home-based Head Start programs would be the more viable alternative to the child development center.

As of January 1, 1974, the United States Department of Agriculture has announced that *all* Head Start programs will be eligible to participate in the USDA Special Food Service Program for Children. This program provides food assistance to child care institutions in the form of partial cash reimbursement for the cost of breakfast, lunch, supper or between-meal supplements. Head Start programs previously had been excluded from participation. This new regulation provides an opportunity for OCD Regional Offices and grantees to insure that *all* Head Start children receive meals reimbursed through either the National School Lunch and Breakfast Program or the Special Food Service Program for Children.

Recommendations:

- Many handicapped preschoolers are receiving help or therapy in the morning, which precludes their participation in educational programs. It is recommended that agencies giving therapy coordinate their efforts with those programs having a social base in order to meet the *total* needs of these children. There is also reason to believe that there are substantial numbers of eligible handicapped children who are not registered in Head Start because their families are not aware that they are eligible.
- Descriptive studies at the national level on the incidence of various health problems of low-income children have indicated that effective follow-up

TABLE 33
Head Start Programs in Maryland

	Full Day Head Start	Day Care Head Start	Summer Head Start	Part Day Head Start	Outreach	Handicapped	Number of Centers
Allegany	83	0	0	0	0	5	4
Anne Arundel	149	0	0	0	0	11	5
Baltimore	125	0	0	0	0	9	8
Calvert	45	0	0	45	0	6	3
Caroline	0	0	0	0	0	0	0
Carroll	0	0	Begin 6/74	0	0	0	N/A
Cecil	0	0	0	0	0	0	0
Charles	53	0	0	52	0	7	3
Dorchester	31	0	0	0	0	3	1
Frederick	0	0	0	63	0	8	1
Garrett	0	0	0	60[1]	0	20	4
Harford	30	0	0	0	0	2	1
Howard	0	30	0	105	0	7	8
Kent	0	10	0	37	0	8	1
Montgomery	0	20	0	735	15[2]	104	39
Prince George's	0	0	0	210	0	N/A	10
Queen Anne's	0	6	0	40	0	2	4
St. Mary's	52	0	0	53	0	7	2
Somerset	105	0	0	0	0	5	5
Talbot	0	8	0	51	0	3	3
Washington	0	0	0	90	0	11	5
Wicomico	60	0	0	0	0	(16)	2
Worcester	120	0	0	0	0		2
Baltimore City	0	170	0	238	30	46	8[3]
State	833	244	0	1,779	45	278	119

[1] Served ½ time at home.
[2] 4 days/week at home.
[3] Includes the Martin Luther King Center and Satellite Center.
Figures in columns (1) through (7) were obtained through a telephone survey of each local Head Start program director's office by the 4-C Committee in January 1974.

from referrals occurs in as few as 50 percent of the cases, particularly in the area of mental health referrals. The serious inequities in distribution of health care are well known, and there is no reason to believe that Maryland differs significantly. Health care delivered directly to recipients should provide quality treatment and adequate follow-up. Health care services, such as nutrition education, integrated into a program for young children could fill many gaps that exist for the poor in the present health services delivery system. The American Academy of Pediatrics through a grant from HEW/OCD has a group of Head Start consultants which is available to any program in need of help in developing health service coverage.

- In the absence of a formal Head Start follow-through program, joint responsibility for a follow-through or continued effort should be assumed by parents, Head Start staff, social services personnel, health personnel and public school staff to assure that ameliorative and remedial efforts continue with Head Start children as they enter public school. Every public school should include as part of its intake procedure for kindergarten and first grade-children assessment of preschool experience including Head Start. Statewide guidelines should be established for transmittal of appropriate information regarding preschool experiences which includes data other than simply an immunization record.

THE MARTIN LUTHER KING, JR. PARENT AND CHILD CENTER IN BALTIMORE

The State Plan as a device to single out an innovative Head Start program serving very young children and their parents.

The Martin Luther King, Jr. Parent and Child Center complements the Head Start program by including in its program children under the age of three, Head Start's minimum age. The Center underscores its preventive as well as its remedial function.

The two major goals of the Center are: (1) to foster the intellectual, emotional, social and physical development of economically disadvantaged children while they are at the peak of their learning capacity and (2) to operate a model center for trainees in new techniques of early childhood education.

Supplementary but closely related goals are:

- To motivate children by stimulating them at critical learning stages;
- To train mothers (whose situation warrants it) for employment outside the home and to place them, as part of a total attempt to uplift the family's position.

- To provide physical and emotional aid to overburdened mothers, together with guidance and training in precepts of child care and development which can be woven into the fabric of home life;
- To offer quality nutritional, medical, psychological and other supportive services to the child and his family;
- To demonstrate to the economically deprived a means of participating in the life of the community which will lead them ultimately to initiate contacts of their own;
- To try out techniques for stimulating cognitive and motor learning through which the educational potential of each child will be realized;
- To present to the parents the training and educational programs for which they feel the greatest need.

The program of the Center evolved from the expressed desires of parents living in the Lafayette-Douglass public housing project who wanted a center—a laboratory—that would assist them in their own development as parents; would provide employment opportunities; would enable them to enter the mainstream of community life.

The Martin Luther King, Jr. Center is one of 36 federally-funded parent and children centers in the country. It is limited by space to 20 children but is funded for 100. Therefore, an outreach program to parallel the Center program has developed; this accommodates 80 children. A satellite center has been established, which is funded through the purchase of care program of the Social Services Administration.

As part of The Johns Hopkins Hospital medical complex, the Martin Luther King, Jr. Center has enjoyed a close and continuing relationship with the pediatrics departments of the hospital. They have given help and counseling with both the medical and emotional problems which the Center encounters.

Recognizing the great impact of siblings, the Center initiated a summer camp for older brothers and sisters between the ages of five and eight. It has continued through the support and contributions of churches and community agencies.

COOPERATIVE NURSERY SCHOOLS

The State Plan as a means of describing cooperative nursery schools, which offer educational experiences and care for some 3,000 young children in Maryland.

Parent cooperative nursery schools are unique educational experiences for both parents and children. Organized on parents' initiative and operated by parents' energy, planning and participation, parent cooperatives offer an

example of a basic democratic process—citizen initiative in meeting citizen needs.

The characteristic element is the parents' cooperation, not only in the organization and business of the school but also in the education of the children. Usually each mother—or father—after orientation assists the teacher on a regular basis. Because a large part of the staff is provided cooperatively, operational costs are low and tuition is within reach of many families who could not otherwise afford nursery school for their children.

All good nursery schools and preschool groups provide opportunities for parent contacts, but cooperatives go farthest because their very nature requires parent participation in planning, maintenance and staffing. Parent cooperatives contribute to mental health by giving parents a sense of belonging and reducing the psychological isolation that so many young mothers face.*

In Maryland, cooperative nursery schools serve approximately 3,000 children in 75 or more nursery schools that belong to the Maryland Council of Parent Participation Nursery Schools or its associate, the Baltimore Council of Cooperative Nursery Schools. Of the 55 member schools of the Maryland Council, 36 are located in Montgomery County, 12 in Prince George's County, two in Howard County, and three in Anne Arundel County. There are also two in the District of Columbia. The 20 schools in the Baltimore Council include 11 in Baltimore City, three in Baltimore County, two in Howard County, and four in Anne Arundel County. It is usual for cooperative nurseries to cluster around council areas, but there are also several individual schools in other parts of Maryland.

The average size of a cooperative nursery is from 30 to 60 children (in two to four classes), but some have as many as 120 children and some serve as few as 16 children. Tuition ranges from $16 to $35 per month for two to five half-days per week of service, with the requirement that the mother serve as one of the two or more teacher aides on a regular basis. Approximately 75 percent or more of these schools are located in churches, and the remainder use various community buildings or recreation centers. Housing is the single greatest problem for co-ops, and if access to empty public school classrooms were made available (as is done in California), a large number of new co-ops could be formed with the help of the two Councils' "Aid to New Schools" Committees.

All of the cooperative nursery schools meet the Regulations Governing Group Day Care Centers of the State Department of Health and Mental Hygiene. Fifty-six of these nursery schools are approved by the State Department of Education. Teachers in the latter schools comply with the

*Katharine Whiteside Taylor, *Parents & Children Learn Together*, Teachers College Press, Columbia University, New York, 1967.

regulations as prescribed by the Maryland Standards for Nonpublic Nursery Schools and Kindergartens. (This figure does not include nonpublic nursery schools operated by bona fide church organizations.)

The Maryland Council of Parent Participation Nursery Schools, Inc. (MCPPNS) is the oldest council of the 30 Co-op Nursery Councils in the United States and Canada, which collectively represent 90,000 parents. It was founded in 1944 as the Montgomery County Council of Cooperative Nursery Schools by seven local co-op schools. It became the Maryland Council in 1969, at which time it numbered 28 member schools.

MCPPNS offers many services to its member schools including extensive officer and teacher training; parent education programs; a group insurance rate; a visiting psychologist; seminars; a monthly newsletter; a directory of schools; and a handbook, "How to Organize and Administer a Cooperative Nursery School," which is recognized nationwide as an outstanding school administration manual. The Maryland Council also offers an annual spring conference, featuring up to 32 different workshops about the teaching and parenting of young children, which is usually attended by from 400 to 600 parents and teachers.

APPALACHIAN CHILD DEVELOPMENT PROGRAM UNDER THE DEPARTMENT OF EMPLOYMENT AND SOCIAL SERVICES

The State Plan as an informational source about federally-funded child development projects in Maryland's Appalachian counties.

In May 1973 the Maryland Department of Employment and Social Services was awarded a demonstration project grant from the Appalachian Regional Commission (ARC) in the amount of $729,479 for a comprehensive child development program in Allegany, Garrett, and Washington Counties, Maryland's Appalachian counties.

With the concurrence of the Maryland Interagency Committee on Childhood Development, which was established by the Governor's Executive Order of May 14, 1971, the Department entered into four separate contracts—with the Garrett County Community Action Committee, Inc., the Community Action Committee of Allegany County, Inc., the Washington County Board of Education, and the Regional Education Service Agency (RESA).

According to DESS the specific objectives of the comprehensive child development program are:

- To develop and demonstrate alternative delivery systems through which each eligible child and his family can receive quality services...

- To involve parents directly in the educational and overall development of their children by strengthening their role and skill as the child's permanent and most important provider;
- To provide health care and improve the general conditions of the home and family;
- To coordinate, locally and regionally, with concerned agencies, organizations and individuals in utilizing existing resources;
- To identify gaps in existing services and resources and to make proper recommendations;
- To implement the State's Comprehensive Child Development Plan.

Garrett County Community Action Agency **$131,006**

The Comprehensive Child Development Project of Garrett County, Maryland, is composed of three distinct service delivery systems which attempt to meet the physical, social, emotional and cognitive needs of children 0-5 throughout the County. The three service delivery systems are as follows: a family center with 30 children, a mobile van that serves 35 children, and four home visitors who serve a total of 62 children.

Allegany County Community Action Agency **$220,070**

There are two model child development centers providing services for 90 children. There is also an outreach effort serving 60 handicapped preschoolers in the community with coordinated health and social services. The scope of the training program would include all interested preschool workers in Allegany County. There is to be cooperative preschool curriculum planning with the Allegany County Board of Education.

Washington County Board of Education **$269,663**

Children ages 0-5 from disadvantaged backgrounds will experience health, educational, social, nutritional, and psychological programs designed to optimize chances for satisfactory performance in kindergarten and grades one, two and beyond. Currently 125 children are being served in three centers and 25 children are in the Home Start program.

Regional Education Service Agency **$34,705**

The Regional Education Service Agency of Allegany County was funded on June 1, 1973 for $34,705 by the University of Maryland Extension Service. With the additional funds from ARC, the contractor was able to hire eight additional family aides to work in the Appalachian counties. These aides have been trained in early childhood development and nutrition. Families with annual incomes of less than 125 percent of OEO guidelines are eligible to participate in the Family Aide Program.

All subcontracts were reviewed by the Western Maryland 4-C Councils and approved by the Western Maryland Child Development Council before they were accepted by the Department of Employment and Social Services.

A self-evaluation format has been designed by the Office of Program Planning and Evaluation, DESS, and is currently in use. Three separate evaluations are being conducted in each subcontract.

Chapter XI

Several Representative Child Development Services

PARENT EDUCATION PROGRAMS IN MARYLAND

The State Plan as a vehicle to promote concerted attention to the need for State-level responsibility for parent education programs and their coordination.

The following discussion is an overview of parent education programs in Maryland for parents of young children, both those under the auspices of the public school systems in selected counties and in Baltimore City as well as those developed by private school or counseling groups. Parent education in various forms is also an important part of the programs of other agencies and groups outside the school systems. Those that were located are mentioned in this report with the acknowledgment that this is a far from complete review of opportunities in Maryland for parents to find help in enhancing their parenting skills. In fact, the difficulty of arriving at any comprehensive picture of parent education in Maryland points up the great need for coordination of this important public service both within and among agencies and groups around the State.

There are several reasons why education for parents of young children is receiving increasing attention today:

- A better understanding of how infants and young children grow and learn, what helps and what hinders their growth, how much they learn in the years of early childhood before the traditional age of school entrance, the importance of early stimulation, of parent/child interaction.
- Recognition of the roles of parents or parent-surrogates as the first and most important teachers of their children.

- The complexity of the world in which young children are growing up—more stimulation, more pressures, more choices facing both parents and children.
- Increasing numbers of teenage or young adult parents who are barely out of their own childhood or adolescence, many of whom are not mature enough to take on a nurturing role.

What should be the goals of education for parenting? Each program will have its specific objectives, depending on its sponsorship, setting and clientele. But if we believe that support for the family is important in a democratic, pluralistic society that values individual fulfillment, then the goals of parent education need to encompass the following:*

- To help parents enhance their parenting skills, by building on their strengths and competencies and developing positive self-concepts rather than compensating for present deficits or past failures. The core of the parent educator's belief must be that parents, like everyone else, deal with their needs and concerns in the best way they know how at any given time.
- To help parents develop an autonomous base from which they will make their own decisions consistent with their goals for their children's development. This begins with helping parents clarify their own values and continues with helping them examine the alternatives available to them in living by these values. It puts a premium on involving parents in their own learning and moves away from a didactic, "cookbook" approach of "what to do when."
- To develop content—information, concepts, relationships among ideas—that is meaningful across a broad range of classes, cultures and subgroups: that recognizes and respects differences while dealing with common threads of human growth and development and family living.
- To develop a variety of settings and ways of offering parent education so that the opportunity and content may be pervasively available to prospective and present parents at various stages of their family's cycle as they feel the need for this kind of support. The climate also needs to be one conducive to encouraging parents to assess their own needs as adults independent of their parenting role.

*We are particularly indebted to Evelyn M. Pickarts and Jean M. Fargo for their valuable discussion of goals in *Parent Education Toward Parental Competence*, Appleton-Century-Crofts, 1971.

What is going on around the State in parent education? A highlight would certainly be the following:

Head Start

Wherever Head Start, a federally-funded program for preschool-age children, principally for those who are educationally deprived, has been located and whatever agency or group has directed it, a crucial part of the program has been involvement of parents in policy making and program development, participation by parents in the classroom and education to enhance parenting skills. While the parent involvement aspect of Head Start has had varying degrees of success in different locations, it has, at the very least, drawn attention to the importance of parents in their young children's learning and has broken the ice in some jursidictions that had not looked kindly on parents' participation in their children's school education.

Martin Luther King, Jr. Parent-Child Center

Located in Baltimore City, this is one of the outstanding parent-child centers in the country. Parents are involved in its program in a wide variety of ways, including an outreach program in which visits are made to the homes of parents whose children are not yet involved in the Center.

Health and Mental Hygiene,
Social Services, Cooperative Extension Services

Since the programs of these agencies are described elsewhere in this report, including expressed or implied parent involvement, only a brief mention of their parent education programs will be made here. Health departments offer classes in pregnancy and childbirth. Some follow this up with varying kinds of programs for parents and children through well-baby clinics. Courses such as parent effectiveness training may be sponsored by a county health department. Public health nurses are involved in providing continuous parent education both in homes and in clinics.

Social Services works with foster and adoptive parents and family day care mothers to promote good parenting skills. Parents of young children on various types of public assistance receive periodic counseling. Child day care centers directed by the Department are expected to have at least periodic meetings with the parents.

The Cooperative Extension Service, in addition to its Family Aide Program described elsewhere, includes parent education in its TV programs from Baltimore City, is developing discussion group programs for parents, and is beginning an experimental Preparation for Parenthood Program for 4-H members in Montgomery County which is now being field tested by the Office of Child Development, HEW.

The Maryland Council of Parent Participation
Nursery Schools, Individual Psychology Association,
Parent and Child, Parent Effectiveness Training

These are among the groups outside of the public agencies for whom parent education is a major if not the principal objective. They are more active in some counties than in others, particularly in the larger urban jurisdictions. Various church groups also sponsor similar programs for members of their congregations.

Libraries

Toy-lending libraries, discussion groups for parents, special programs for young children with concurrent programs for their parents, special reading lists, film programs are some of the ways in which public libraries are using their own special facilities to promote parent education.

A variety of programs is being carried on in Baltimore City and in many of the counties under the public school systems, often with Federal funding.

Baltimore City

The recently opened Baltimore Parent-Infant Center (Department of Education) works with infants from six months of age and their parents, meeting in separate groups three days a week, six hours a day. The IVY (Involving the Very Young) centers take young children two and one-half to four years of age five days a week. Their mothers must attend a discussion group once a week. Neighborhood Schools for Parents meet three days a week. Parents bring their children six months to four years to a nursery while they work with an adult basic education teacher. Parent Observation and Discussion Groups allow parents to bring their children to a nursery where they observe their children and then meet with the teacher to discuss their observations. The Early Admissions Program provides the parents with home-based activities to reinforce what is taught in the school program. The Model Early Childhood Program involves parents in almost all aspects of the program—assisting in the classroom, designing curricular activities, attending training sessions, making materials for their children to use at home.

Baltimore County

Classes for four-year-olds in three areas of the County stress language development for the children and provide for close involvement of the parents in the program. An increasing number of parents of kindergarten and first-grade children are working in the classroom. Groups of parents are making materials for parents to borrow and take home to use with their children. Parent Observation Classes are available.

Carroll County

In a program for kindergarten children with learning difficulties special emphasis is put on working with parents through special parent meetings (on Sunday), home visits by the teachers and the use of parent volunteers in the classroom.

Montgomery County

Toy Talk is a series which demonstrates ways to use toys to stimulate parent/child interaction in general and language development in particular. Single-parent seminars are held for 10 sessions three times a year. Parent/Child Development classes are similar to the Observation Classes described above. A Family Communication Course is based on the principles of Parent Effectiveness Training. Parent/Teacher Conference Workshops help parents and teachers enhance their communication with each other concerning the courses for students and are participating in the field testing of the Office of Child Development's Preparation for Parenthood Program.

Prince George's County

An extensive program of discussion groups for parents, led by trained parent leaders, includes groups for parents of preschool and kindergarten children, for parents who have children in a special education program, and most recently for parents who have children in an early identification program (birth to age five). The last-named group is designed to work with parents and young children who have handicaps that may lead to learning difficulties. Parent/Child Development Classes are offered through Adult Education as well as a course in "How to Help Your Elementary School Child." An Early Childhood Education Project trained tutors to make home visits to parents of infants to demonstrate techniques of infant stimulation. Two Early Childhood Development Centers for children from two to five years of age include parent involvement and education as a principal component. A monthly publication, *Bridgings*, sent to all parents of kindergarten children and widely distributed through the County Memorial Library and the Health and Social Services Departments, suggests ways in which parents can work with their young children at home to guide and support their development.

Somerset County

An all-day kindergarten program with emphasis on learning stations and peer-tutors invites parents in for classroom observation, special stations on their child's birthday, and periodic parent-teacher conferences.

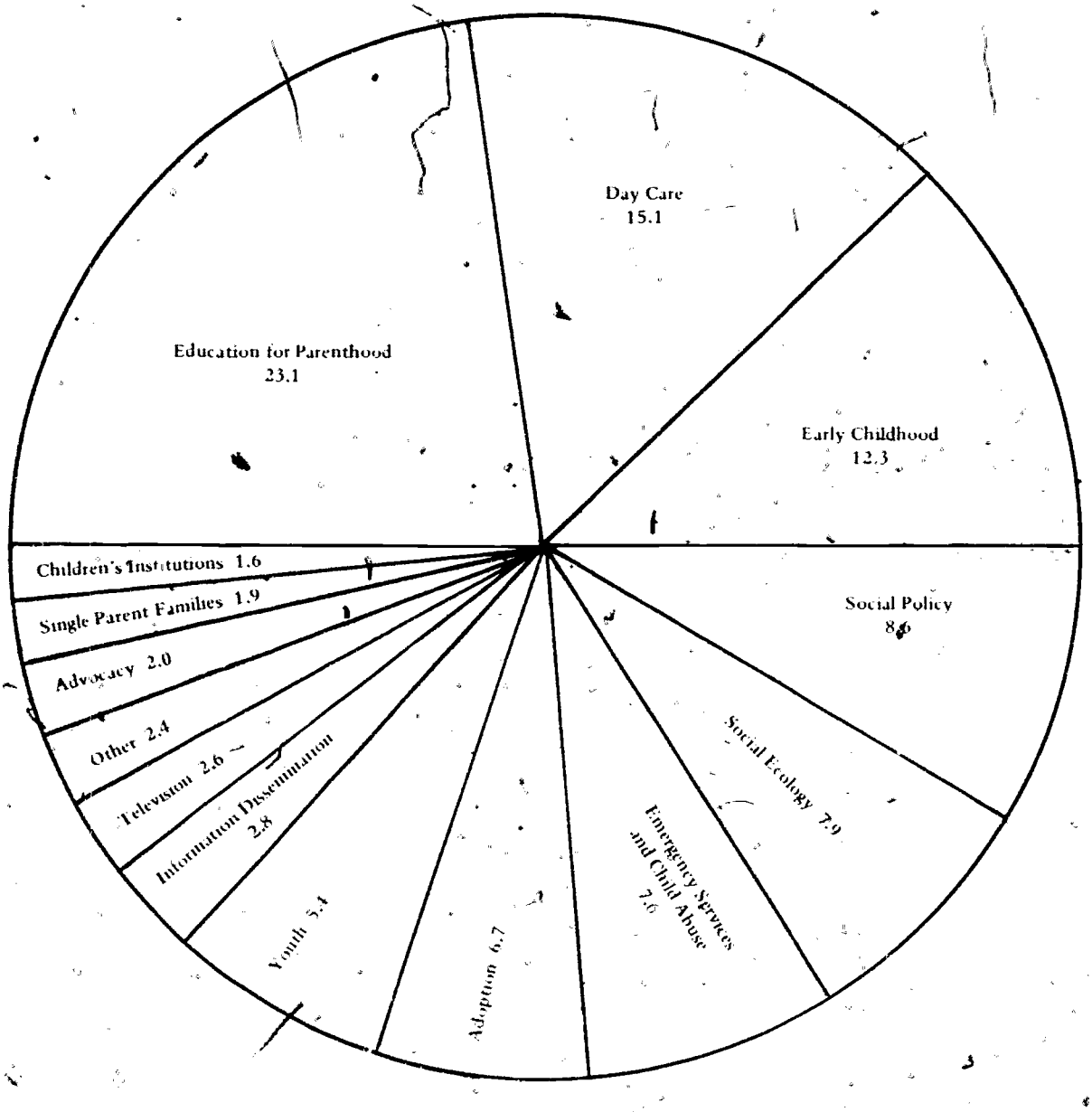
What is going on at the State level in parent education? With all this activity going on in the counties and Baltimore City, no one agency at the State level has assumed major responsibility for parent education. It is true that parent education is considered an important part of many different programs, but there is little specific communication among those particularly concerned in working with parents as parents, except as individuals seek out or accidentally run across their counterparts from other agencies or jurisdictions. Within recent years only two statewide conferences on parent education have been held: one under the auspices of the Institute for Child Study, University of Maryland, in June 1970, with the theme "Parent Education—Where Is It Now?, Where Is It Going?"; the other in March 1973, jointly sponsored by the Division of Instruction, Maryland State Department of Education and the Maryland 4-C Committee, with the theme "Developing Creative Leadership in Parent Education." No additional conferences or statewide meetings on parent education are currently being planned, so far as is known.

Recommendations:

- The State Department of Education needs a coordinator of parent education to focus attention on this important aspect of early childhood education as well as on parent participation and involvement in a variety of ways throughout the child's school years.
- There should be a State-based Parent Education Council or Clearinghouse to gather and exchange information among agencies and groups concerning parent education programs and to take the lead in identifying, assessing and promoting quality parent education programs among the member agencies and groups. Consultation and training need to be readily available to those whose local resources are limited. Summer workshops would be an ideal vehicle for statewide training. The reader is referred to Chapter XV, where the need for a coordinating structure is discussed.
- Particular emphasis needs to be placed on developing the parent involvement and education aspects of early childhood education programs so that equal importance is given to programs for parents and programs for their children.

Figure 5 illustrates the high priority assigned to research on parent education by the Office of Child Development, HEW.

FIGURE 5
Allocation of Child Welfare Research and Demonstration Projects By Content Area, FY 73



Source: Research and Evaluation Division, Office of Child Development, HEW

HEALTH CARE SERVICES

The State Plan as a description of health services available to children and their families with acknowledgment that the present delivery system fails to document the magnitude of unmet health needs which are, by general consensus, very great.

Health care services for children 0-6 in Maryland are primarily the responsibility of the Divisions of Maternal and Child Health (MCH) and Crippled Children's Services (CCS) under the Preventive Medicine Administration, State Department of Health and Mental Hygiene.

Division of Maternal and Child Health

The Division of Maternal and Child Health funds and develops programs; provides consultation, referral and training; and emphasizes public education. Most of MCH direct health care services, however, are provided through the local health departments (LHDs). Additional direct health services are provided through: child and youth projects; day care centers; hospitals and hospital affiliated clinics receiving special funds; school health programs; and private organizations and physicians.

Services offered by MCH affecting children 0-6 are generally organized into five broad categories:

1. General Family Services
2. Services to Women of Childbearing Age
3. Services to Newborn
4. Services to Infants
5. Services to Preschoolers

1. *General Family Services* under MCH include: a Poison Information Project, nutrition education and counseling services, and, when appropriate, referral to community resources for financial or food assistance. Local public health nurses make home visits to families in their district, giving a large range of services including health appraisal, referral and information services as well as coordination with other agencies. A Genetics Program of medical and laboratory diagnosis and education and genetics counseling is conducted by MCH in addition to a special genetics counseling project at Sinai Hospital. Projects not under the auspices of MCH but related to the field of genetics are offered at the Pediatric Genetic Counseling Clinic, John F. Kennedy Institute, as well as the Tay-Sachs screening project at The Johns Hopkins Hospital.

2. *Services to Women of Childbearing Age* include family planning, therapeutic abortions; prenatal, delivery and postnatal care. Family planning programs currently in operation in Maryland are: the Federal Maternal and Child Health Formula Grant, City of Baltimore Federal

Grant Services; Federal Grant to Baltimore Family Planning; and Family Planning for Teen-Aged Girls at Sinai Hospital. Although funded through MCH, the last two programs operate independently of MCH. In addition to LHD clinics, family planning services are also provided through the Planned Parenthood Association of Maryland. Data for fiscal year 1972 indicate 26,319 women received subsidized family planning services—29 percent of the estimated number needing such services, according to computations based on the "Dryfoos-Polgar-Varky formula" developed by Planned Parenthood–World Population.

MCH coordinates and arranges for therapeutic abortions referred by LHDs and Planned Parenthood. Fees are paid by MCH for eligible women not covered under Title XIX of the Social Security Act. Delivery services are arranged by prenatal clinics operated through LHDs; financial aid is also available under Title XIX. Postnatal clinics for mothers and infants are organized under LHDs. However, MCH has no direct responsibility for the Baltimore Maternal and Infant Project No. 501.

Gynecological consultation services are available through LHDs. MCH coordinates and arranges for sterilizations for medically and financially eligible women. Funds for this come directly from MCH or from Title XIX. Sterilization for men (vasectomy) is also available.

3. *Services to Newborn* focus on care of the premature. Through LHDs, the Maryland State Police Helicopter Service flies eligible premature and high-risk infants from three counties to Baltimore City Hospitals' Intensive Care Unit. MCH provides transport incubators and a grant for staff to Baltimore City Hospitals. MCH also administers and coordinates phenylketonuria (PKU) screening and treatment. PKU screening is required for every newborn in Maryland.

4. *Services to Infants* center mainly around the LHD child health clinics, which provide professional health consultation and comprehensive care. Nurse conference clinics involving public health nurses and support personnel evaluate general health and immunization status and provide health education. Special clinics provide immunization only, while pediatric consultation clinics are available to children referred for special services.

5. *Services to Preschool Children* offer a continuation of many of the infant health services. Child health clinics such as nurse conference, immunization and pediatric consultation clinics are aimed at preventive services and general medical care. The HEW Public Health Service report *Selected Child Health Services on MCHS for Maryland, School Year Ending June 30, 1972*, shows that 27,399 children 0-4 received well-child conference service. Another 15,064 received DPT, 15,428 received immunizations for polio, 9,058 for measles, and 10,762 for rubella. In

1970, there were 48,356 children 0-5 in Maryland families with incomes below the poverty line; it would be helpful to determine what percentage of children in families below the poverty line received adequate immunization.

MCH is responsible for supervision of all phases of group day care including licensing, inservice training, provision of educational materials, and inspection of facilities. There are two child and youth projects offering comprehensive, centralized health programs for disadvantaged children in Baltimore City. However, MCH has no direct responsibility for these programs. The Lead Poisoning Screening and Case Finding Program in Baltimore City is under the direction of MCH.

Division of Crippled Children's Services

Special health care services to crippled children are the responsibility of Crippled Children's Services (CCS). These direct services are offered on both State and local levels through State-operated facilities.

Multi-diagnostic clinics staffed by CCS personnel provide multi-disciplinary evaluation and diagnosis through LHDs. The clinic board is usually composed of a pediatrician, certified social work consultant, psychologist and local public health nurse. It may also call upon the resources of additional consultant personnel in order to provide comprehensive evaluation and treatment programming for children with congenital defects; neurosensory disorders; mental retardation; speech, hearing and visual problems; complex learning disabilities.

Specialty consultation clinics such as: cardiac, orthopedic, neurological, cerebral palsy, speech diagnostic and hearing conservation are available, free of charge, for diagnostic purposes to crippled children in areas distant from large medical centers. Under the Purchase of Care program, crippled children are provided with care (on both inpatient and outpatient bases), appliances, drugs and special therapy. Care for eligible crippled children in Children's, Kernan and Kennedy Institute Hospitals is funded under Title XIX of the Social Security Act.

Through its central offices, CCS administers federally-funded special crippled children's projects such as a cleft palate clinic and a regional heart project.

Other Crippled Children's Services such as early identification of the handicapped, genetics screening and PKU treatment are conducted as coordinated inter-agency programs enlisting the resources of other State, local and private agencies.

Title XIX and Health Screening

Federal funds are available through several programs, the major ones being Titles V and XIX of the Social Security Act.

Title XIX of the Social Security Act is aimed primarily at providing comprehensive and continuing health care services to children who are eligible for Medicaid. Based on "early and periodic screening, diagnosis and treatment" (EPSDT), Title XIX is planned to reach and evaluate the whole child through a coordinated and integrated process.

As of June 1, 1973, all states were required to provide EPSDT services to all Medicaid recipients under 21. Procedures for EPSDT are determined by the state agency which administers Title XIX, in Maryland by the State Department of Health and Mental Hygiene, Division of MCH. Title XIX recommended *minimum* guidelines include:

1. health and developmental history
2. assessment of physical growth
3. developmental assessment
4. inspection for obvious physical defects
5. screening tests
6. assessment of nutritional and immunizational status

It is the State's responsibility to provide diagnostic services for children whose screening indicates the need for further evaluation and treatment. Delivery of health screening under Title XIX is accomplished through LHDs. Initial and periodic screening are to be conducted on a large scale whenever possible. Reporting of screening findings, effective and rapid diagnosis and treatment are stipulated in Title XIX. To achieve this end, each state is to establish a data system to record the health care history of each child in order to prevent duplication of diagnosis and screening and to allow detailed analysis of program costs and benefits. The data gathered are to be divided into two age groups: 0-6 and 6-20.

The screening tests should include: visual, dental, hearing, anemia, sickle cell (elective), tuberculin, urine (sugar, albumin and bacteria), and lead poisoning (1-6 years).

Title XIX also recommends that results of screenings be discussed with the parents. Families should also be given assistance in following up recommendations and obtaining needed care.

Section 13 of Title XIX stipulates that the state agency should publicize the EPSDT program in a variety of ways in order to reach eligible and potentially eligible individuals and casefinders such as caseworkers, public health nurses, teachers, pharmacists and community groups attached to churches, schools, health and recreation centers, etc. All media such as posters, flyers, pamphlets, radio, TV and newspaper announcements should be used. Information should be given about whom the program is intended to serve, its goals, and specific directions about where to go and what to do to have a child screened. Messages should be simple, clear and free of administrative jargon.

Recommendations:

- Health care services to children 0-6 in Maryland are extensive, yet gaps do exist, owing in part to lack of public awareness. A statewide program publicizing child health services such as recommended in Title XIX would bring about greater effectiveness in meeting the health needs of Maryland's children.
- The dimensions of unmet health needs are known to be large. Readers are referred to Chapter XVI for a listing of publications pertaining to the health needs of children. The Title XIX program calls for a data system embracing each child. The State Department of Health is currently developing plans and taking initial pilot action in this area. At such time as a data system is in operation, an accurate evaluation of unmet health needs will be possible. The present fragmented health delivery system does not lend itself to describing unmet needs other than by general consensus that there are large numbers of children and families who are not being reached.

  Throughout planning sessions for the development of this report, there were urgent pleas that *treatment* be made available after the screening and diagnosis.

LEAD POISONING

The State Plan as a means of identifying and ascertaining the dimensions of a serious health hazard.

Since 1931, lead paint poisoning in children has been a major concern of the Baltimore City Health Department. Investigations produced the alarming fact that an indeterminate number of the less severe cases go undetected, with the presence of lead poisoning manifested by learning difficulties and behavior problems that suggest lifelong maladjustment.

In 1972, the Baltimore City Health Department received from the Department of Health, Education, and Welfare a grant, matched by the City, that permits it to screen at least 6,000 children a year for lead poisoning. Focus of the program is on children one to three years of age, so that the disease can be detected at its earliest and most treatable stage. In addition to the screening of children, there has been enforcement of the lead ordinances prohibiting the use of lead paint in the interior of homes and an education program directed to families of children having higher than normal blood readings.

The Health Department's Year End Report for 1973 cites great progress. It noted:

> The simple finger prick method of testing was used this year to test nearly 6,500 children. Although the number of reported lead poisonings is higher

this year than last, this statistic is a plus because it means that the lead poisoning program is finding more cases early that might otherwise have gone undetected, until serious physical or mental damage had been done.

It is known that the incidence of lead poisoning is highest in older urban areas such as Baltimore City. This may account for the fact that no lead poisoning cases have been reported by any of the other jurisdictions of Maryland in recent years. However, old houses with lead paint doubtless exist in some of the less populated parts of the State, and when funds become available, the Department of Health and Mental Hygiene is planning to initiate screening for lead poisoning in selected areas.

Lead poisoning appears to be a nationwide problem. HEW reports that in its first year of granting screening money to 42 communities, 30,000 children had potentially dangerous levels of lead in their bloodstreams and approximately 4,600 required treatment.

The Baltimore City Health Department recommends elimination of toxic paints from the homes of children with elevated blood lead and public recognition of this disease and its long-term consequences.

Recommendation:

- Counties that have old housing should be on alert for lead poisoning as a health hazard for young children. Screening for lead poisoning is one of the optional areas under Title XIX. Selected counties should be encouraged to take advantage of this program and undertake, at the very minimum, a demonstration screening program for lead paint poisoning.

FOOD AND NUTRITION

The State Plan as a device to call attention to a critical unmet need.

In the past several years, there has been much progress in the area of food and nutrition for the children of Maryland. However, lack of knowledge of existing Federal, State and local programs, varying standards and regulations, and lack of understanding of eligibility requirements hinder the effectiveness of many programs.

An allied problem has been the limited interest in nutrition education. The Maryland State Department of Education has now acted to fill this gap, at least for children of school age. It has developed a comprehensive health education curriculum which includes nutrition for kindergarten through grade 12. Copies of the curriculum guide have been distributed to all local school systems, and the curriculum is being implemented in many areas. Each local school system has responsibility for nutrition and health education and may elect to follow the new curriculum.

In 1969, the Baltimore City Model Cities Agency received a grant through the Department of Housing and Urban Development to distribute formula to all babies born in the Model Cities area. Approximately 3,000 babies per year have been reached through this program. In June of 1974, funds will no longer be available.

In 1970, the Maryland Food Committee, a volunteer task force, funded a program for Iron-Fortified Infant Feeding (IFIF) in the Cherry Hill section of Baltimore City. Administered by the Baltimore City Health Department and modeled on the already existing Model Cities program, it added a research component through the cooperation of The Johns Hopkins Hospital School of Hygiene and Public Health.

IFIF provides free iron-fortified formula to infants for nine months in addition to a nutrition education program for participating mothers. In the 1971 IFIF program, 40 percent of the 260 infants involved were anemic and smaller and lighter than normal. After eight months on the program, the anemia was largely corrected and height/weight curves significantly improved.

In May 1973, an Office of Economic Opportunity grant of $277,000 for the IFIF Federal pilot program began reaching 1,800 Maryland babies in Baltimore and three counties on the Eastern Shore. Another 700 infants are also enrolled through Maryland Food Committee programs.

Congress allocated $20 million for fiscal 1973 and 1974 for a pilot supplemental feeding program under the U.S. Department of Agriculture entitled the Women's, Infant's and Children's Supplemental Feeding Program (WIC). The program serves pregnant and lactating women as well as infants up to four years. In Maryland there are grants totalling $249,000 under WIC awarded to the following sponsors: Anne Arundel County OEO; The Johns Hopkins Hospital; Provident Hospital in Baltimore City; Prince George's County Health Department; Garrett County Health Department; and The Johns Hopkins University. In addition, the Carroll County Health Department will receive funds under the WIC program starting July 1, 1974.

While these programs are effective for those involved, there are still many infants whose families cannot afford the proper diets necessary to meet their needs. In 1970, there were 48,356 children 0-5 in Maryland whose family income was below the poverty line.

In addition to maternal and infant nutrition, an area of great concern in Maryland is the nutrition of children in group and family day care.

The Maryland State Department of Health and Mental Hygiene—under its *Regulations Governing Group Day Care 10.02.01*, Sections .51 through .60, and .62 through .65—establishes regulations and standards for preparation and storage of foods, publishes menus and issues nutritional guidelines for children in group day care. Similar regulations for licensed family day

care exist under the auspices of the Department of Employment and Social Services.

The organization and administration of day care programs is shared by the Departments of Health and Social Services on both State and local levels and by the State Department of Education. The State Health Department, Preventive Medicine Administration, has responsibility for facilities, health services, staff qualifications and training, and sanitation. The county health departments, however, are directly responsible for licensing, inspection and enforcement of regulations. Often, due to limited staff, actual contact with centers is minimal—at times limited to an annual visit. Nutrition education is offered only occasionally, at irregular intervals. In the *Group Day Care Licensing Report* of the Department of Health (1973), the 19 responding counties reported a total of 22 persons assigned to nutrition as supervisory inspectors. All 19 counties offered nutrition guidance and consultation from the Health Department, but five counties reported a need for additional nutrition personnel.

Additional supervision and support of nutrition programs in group day care is provided by the Department of Education which administers the federally-funded food program for day care, Section 13 of the National School Lunch Act. One of the provisions of the Act is the Special Food Service Program, which applies directly to all public and nonprofit day care centers. This program provides the following reimbursements for food costs: breakfast, 15 cents; lunch, 30 cents; supplemental foods, 10 cents. In those centers where 75 percent of the children come from low-income families, the law provides funding on an 80-20 basis. Participating centers must follow Federal guidelines in establishing quantity and type of foods served. Menus and budgets must be submitted regularly for inspection. In contrast to the open-ended funding of the School Lunch Act, funds for day care feeding are allotted by formula to the states. Maryland has never spent all of its allotment because it is December before the amount is known and, since the State must pay any overages, the Department of Education is careful to stay within its estimate of the allotment. To date, the State has been reluctant to accept back-up funding from the Maryland Food Committee to cover possible shortages.

Additional food programs available are: Free and Reduced Price Lunch (NSLA), Free Breakfast (Child Nutrition Act), Summer Program (NSLA), and Special Milk Programs (CNA). The Free Lunch Program has been extended to all preschool programs including Head Start and kindergartens located in public schools.

Statistics for October 1973 indicate that there were 34,425 children in group day care centers. According to the Department of Education, as of January 1, 1974, there were 141 centers serving 4,200 to 4,400 children

through the Special Food Services Program. There were, however, 504 public, nonprofit private and church-affiliated group day care centers licensed by the Maryland Department of Health and Mental Hygiene as of October 1973.

Little is known of nutrition programs specifically for the handicapped in Maryland. Thirty-nine percent of the 320 centers responding in the Kirschner Report (1972) indicated a willingness to care for handicapped children. Actually, only 919 handicapped children were enrolled in group day care. Six counties had no handicapped children in group day care, and nine counties had 10 or fewer handicapped children enrolled.

State regulations for nutrition in family day care state:

> An adequate well-balanced diet shall be provided for each child in day care. If the child is in day care ten (10) hours or more a day, such diet shall consist of the total daily nutritional requirements of the child. . . .

As "total daily nutritional requirements" are not clearly defined and there is no formal training program for family day care personnel, nutritional education and information are left primarily to each subdivision. Prince George's County currently conducts a nutrition program through a public health nurse while other counties educate through group training, family day care associations, or newsletters. At best, these efforts produce personnel competent to provide children with nutritionally sound diets, but they can also allow personnel with little or no nutrition education to create gaps which could result in dietary deficiencies for children.

Cost is another significant factor in determining the quality and quantity of food in family day care. There are no food subsidies to family day care in Maryland. Food costs for children whose care is purchased by the local departments of social services must come from the $65-$70 per month per child allowance.

Another Federal food program which has the potential to reach many malnourished children in Maryland is the Food Stamp program. This program enables low-income families to increase their food allowances on a predetermined scale. Statewide participation, however, is about 28 percent of those eligible, according to the Maryland Food Committee *Fourth Annual Report* (June 1973). The Maryland *Social Services Statistical Report* for September 1973 shows that there were 246,899 individuals in 87,806 households participating in the Food Stamp program. The Department of Employment and Social Services, OEO, and the Maryland Food Committee have worked together in an outreach program designed to help more eligible families participate in the Food Stamp program. The Food Stamp allotment is based on family size. The Food Stamp program could be made much more helpful to pregnant women if the Food Stamp allotment could be increased to include the unborn child at a specific point in pregnancy. This would

require a change at the Federal level. As the program is presently administered, the welfare grant to cover pregnancy is counted as income which tends to raise the purchase price for the same number of stamps. One noticeable gap in the Food Stamp program is the absence of a nutrition education program, which would enable participants to gain substantially from their increased buying power.

The Head Start program includes nutrition education for all staff, parents and children involved with the program. The Head Start Program Series Booklet No. 3 is an excellent guide to nutrition education as well as menus and serving sizes. On the State level, the Department of Health is available to conduct workshops in nutrition as requested, and each local health department also has nutritionists available. There is, however, no program specifically designed to provide nutrition education for children 0-5 in Maryland.

Recommendations:

- State-sponsored nutrition education for children below school age, to complement the plan now being developed by the State Department of Education for kindergarten through grade 12.
- Clarification and enforcement of the State's nutrition requirements for group and family day care, so that there is consistency in their implementation throughout the State.
- Increase of the 55-cent daily food allowance allocated to day care centers, to bring it into line with today's inflated food prices.
- A well-structured nutrition education program, available and accessible to Food Stamp recipients.
- An intensified effort to reach the thousands of children throughout the State who continue to be hungry and malnourished.

THE EXPANDED FOOD AND NUTRITION EDUCATION PROGRAM

The State Plan as a source of information on nutrition education services to rural and urban poor.

This program was initially funded in 1968 by the Federal Extension Service, and in 1969 the hiring of aides to conduct a nutrition education program with low-income families began on a six-month trial period. More than 8,900 aides were employed under the program to serve 500 counties, independent cities, and Indian reservations in the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands. In 1970 the appropriation

was expanded, and money was made available from regular Smith-Lever Act funds.

As part of this nationwide effort to reach rural and urban poor and help improve the quality of their living, the Expanded Food and Nutrition Education Program was initiated in Maryland in January 1969 in Allegany, Caroline, Charles, Dorchester, Garrett, Queen Anne's, St. Mary's, and Wicomico Counties and Baltimore City, with 49 aides participating. By March 1970, the program had become operational in five additional counties—Anne Arundel, Montgomery, Prince George's, Somerset and Washington—making a total of 14 units distributed throughout the State. Calvert County was added in 1971 and Howard in 1973; in July 1972, it became necessary to withdraw the program from Queen Anne's County.

The program is administered by the Cooperative Extension Service of the University of Maryland, which maintains an office with program and supervisory personnel in every county served. The program is supported by Federal, State, and local funds.

Currently there are approximately 75 aides employed in these 15 units who assist, during the period of a year, approximately 3,250 families representing 15,000 people, of whom 10,000 are children.

In its initial stages, people were made aware of the program by the "knock at the door" method. Now, in addition, referrals come from other agencies, ministers, public officials, civic leaders, and program participants themselves.

Extension aides are hired primarily from the communities in which they live and from the ranks of the disadvantaged. There are no educational requirements beyond the ability to write a clear and accurate report, the ability to communicate verbally, and the desire to help people. Aides are recruited, trained, and supervised by county extension home economists with the assistance of other members of the county and State staffs and cooperating agencies. Intensive training is provided for these aides during the initial three-week period. Additional inservice training is provided weekly with periodic regional and statewide training taking place.

In working with the families, aides place primary emphasis on improving nutrition. Other subjects closely related to nutrition are taught; these include financial management, health and sanitation practices, services available to the family for referral assistance, family relations and planning as these affect diets and nutrition, gardening and food production, and food preservation.

Aides cooperate with the 4-H and Youth Department of the Extension Service to provide youth with a variety of educational experiences.

HOMEMAKER SERVICES

The State Plan as a way of highlighting an important component of comprehensive child development services which merits greater visibility and expansion.

The major purposes of the Homemaker Services, initiated in 1967, are to sustain homes during a family crisis, to improve homemaking and child care routines and practices, and to assist ill, elderly and disabled persons in their own homes.

The program operates within the Division of Special Programs of the Social Services Administration of the Maryland Department of Employment and Social Services. The State has responsibility for supervising local programs. Funding comes from all three levels of government—Federal, State and local.

Of the 2,954 cases served by homemakers in fiscal 1973, 58 percent were families with children. This percentage varied from a high of 87 percent in Howard County to 40 percent in Kent County, with Queen Anne's, Somerset and Talbot Counties not providing any Homemaker Services in fiscal 1973. Somerset County has begun to offer homemaker services for fiscal 1974. Queen Anne's and Talbot Counties are without the necessary matching funds to initiate a program. Current record keeping does not indicate how many of these families had children under six—the age group on which this Plan is focused.

Specific services offered under this program include:

- Full responsibility for child care and household management during the mother's absence from the home.
- Instruction for family members in various aspects of household organization and management including budgeting, shopping and nutrition.
- Housekeeping service.
- Demonstration of homemaking skills and care of infants and older children.
- Identification and appropriate follow-up of problems such as substandard housing, need for Food Stamps and medical care, school difficulties, need for legal or other professional services.
- Transportation, when indicated. In the counties, homemakers are required to have automobiles to provide transportation for their clients. They are reimbursed for their mileage. In Baltimore City, homemakers do not supply transportation but may accompany clients who must travel for medical or related purposes.
- Assistance with special diets.

- Special Homemaker Services projects such as group instruction regarding child care and homemaking responsibilities including projects planned cooperatively with other community resources.

The wide range of services is indicative of the trend of the Homemaker Services to address itself to more than the traditional role of a homemaker who serves only during an immediate crisis. More and more, the homemaker is seen as an effective part of a team which combats the social problems that often trap children and their families. Homemakers are used to provide assistance in Protective Services cases of child abuse or neglect. They can provide emotional and psychological support when either mother or child is handicapped, disturbed, or retarded. In short, the homemaker can make for happier children and more secure family life.

Homemaker Services are available to:

- Any family or individual receiving AFDC or Supplementary Security Income.
- Any family potentially eligible for AFDC, with the following conditions: To a family of four whose monthly income does not exceed $632, the service is free. Above $632 and up to $948 a month, fees are set on a sliding scale. Children in Protective Services are eligible for Homemaker Services regardless of family income.
- Any adult who receives assistance under Federal categories of aged, blind, or disabled or under Medicare.

Homemaker Services are generally available only during the hours 8:30 A.M. to 4:30 P.M. Only in occasional emergency situations is additional time provided. In an emergency situation requiring 24-hour service to a family with children, service is available for five days and nights. Thereafter, service reverts to the 8:30 to 4:30 hours. Homemaker Services are rarely provided on weekends, unless a severe emergency exists.

The duration and extent of the Homemaker Services depend, in general, on the severity of physical and emotional problems, the goals established, and the client's ability to assume responsibility. Ideally, service is terminated when the family has reached a degree of self-confidence and a sense of well-being. Usually termination involves a gradual reduction of time as family members are able to assume additional responsibilities. In the case of a chronically ill mother with small children, service may be continued on a part-time basis for an extended period.

The personnel plan for the State of Maryland lists four levels for Human Service Aide. Minimum qualifications at the entry level require that an applicant be 18 years of age and pass a medical examination to determine physical ability to perform the expected duties.

Though the entry requirements are minimal, inservice training is provided on all levels. New personnel from the counties are given an initial

three-week training program including 12 hours of the Red Cross Home Nursing Course and three hours in infant care techniques. Thereafter, one-day workshops are held for homemakers and their supervisors at quarterly or semi-annual intervals.

In fiscal 1973, staff-development funds were significantly reduced and allowed for only one workshop that year. Funds have been again allocated for fiscal 1974 and plans are to reinstate the inservice training.

Training content for the Homemaker Services has included:

- Child development from conception to adulthood, covering physical, mental and emotional growth.
- Protective services for such problems as deprivation, mental retardation, alcoholism and drug abuse.
- Health care. All homemakers are required to take the Red Cross Home Nursing Course as a first step; additional training is offered for the care of the ill, the blind and the disabled.
- Home management techniques including meal planning, consumer education and housekeeping practices.
- Legal information illustrating the rights of both clients and homemaker. Advocacy role playing is also demonstrated.

Baltimore City provides its own training program which follows much the same format and content as that provided for the other subdivisions of the State. Both the State training program and that of the City are necessarily limited by the amount of money budgeted for this purpose. In both instances, staff has indicated a desire to provide more and better training for homemaker personnel if additional funds were made available.

Since its inception in 1967, the Homemaker Services program has grown. It was significantly expanded in fiscal 1972, when responsibility was assumed for providing service to adults under Title XVI of the Social Security Act. The program has been maintained at this increased level for fiscal 1973 and 1974. Currently, 267 Homemaker Services personnel are providing for the eligible adults and families of the State.

Recommendations:

There are a number of factors presently existing in the Homemaker Services which, if altered, could greatly enhance their delivery:

- The *hours of service* are a very limiting aspect affecting the scope and depth of Homemaker Services. The homemakers of Baltimore City, except in rare instances, work 8:30 A.M. to 4:30 P.M. on five-day-a-week schedules. This means that at least 133 of the State's 267 homemakers, or almost half, are not available for evening or weekend services. This creates a very serious gap in the potential

breadth of services available. It may be necessary to recruit applicants who are not tightly bound by familial responsibilities to fill homemaker positions. Homemaker Services in the remainder of the State's subdivisions are available in the evenings and on weekends only when localities have available persons of limited home responsibilities. However accomplished, it is extremely important that the length of time per day and per week be increased.

- The extent and depth of the *training* provided for homemaker applicants is limited in most instances by budgetary requirements to about three initial weeks and periodic workshops thereafter. We would agree with and support the inclination of the Homemaker Services staff that if the role of the homemaker is expanded, then the training must likewise be expanded and refined. At the State level, the program plans to include more in-depth training on care of the elderly, since the recent caseload reflects a greater proportion of clients over 65 years of age.

  It would seem equally imperative to increase the depth and scope of the training in order to emphasize the emotional and psychological support that homemakers are beginning to offer. Multi-problem family situations can be dealt with effectively only if personnel are highly and appropriately trained. Three weeks is insufficient to provide such an education.

- *Public information* regarding the availability and functions of the Homemaker Services is not as easily obtainable as it might be. If the service is to be truly effective, there must be broad public understanding of and support for its program. This can happen only if the public is well-informed. With broader dissemination of information regarding the program, perhaps a greater need for the Homemaker Services may be discerned.

- A fourth suggestion which might enhance program delivery of the Homemaker Services comes from the State level of the program itself. It is felt that *closer coordination of the pertinent departments and agencies at both the State and local levels* would be very advantageous. The Homemaker Services at the State level seriously espouse a teamwork approach to the problems with which homemakers must deal. The homemaker, the homemaker supervisor, the social worker, the family, public health nurses, doctors, etc., are all, hopefully, involved in determining the need and extent of service required. The State level makes no specific coordination suggestions but recommends only that the closer the working relationship between involved agencies, the greater the level and quality of services provided.

- A final recommendation pertains to *the size of the program itself.* For the entire State of Maryland in fiscal 1973, 267 homemakers served 2,954 separate cases, 1,724 or 58 percent of which were families with children. Since there were 52,136 AFDC families in Maryland in 1970, it is not difficult to suggest that only a fraction (3.3 percent) of this potential consumer group has had contact with the program. Larger budgetary allocations would permit expansion of this service to more AFDC families. It is not known how many potentially eligible AFDC families exist who could benefit from these services.

  A corollary to the above recommendation rests on the 4-C position that services related to child care such as Homemaker Services should be made available under some auspice to *all* families regardless of economic status. Under these circumstances, the recommendation is made to bring to the attention of voluntary agencies this important service with the thought that additional private agencies will be interested in providing it. More importantly, until such time as Queen Anne's and Talbot Counties provide this service, community agencies might be encouraged to do so.

FAMILY AIDE PROGRAM

The State Plan as an overview of an Appalachian program with benefits for children.

The Family Aide Program, which operates in the Appalachian Counties of Allegany, Garrett, and Washington, is designed to assist disadvantaged families to meet the many problems that confront them and to know and understand the community resources that are available to them. The program is jointly administered by the Regional Education Service Agency and the University of Maryland Cooperative Extension Service. It is coordinated with the social and health agencies of the respective counties.

The family aide, who is a paraprofessional, works with 30 to 40 low-income families both individually—in their homes—and in groups. She becomes a trusted friend and adviser to whom the family feels free to confide the pressures and problems that are menacing family life. In addition to her role as counselor, she is also an educator, especially in the areas of consumer competence, nutrition and early childhood development. She also helps the family to understand the various functions and uses of available community resources and to define the kinds of services they need and want. She makes the appropriate referral and assists the family in determining its eligibility.

The Family Aide Program (FAP) began operations in January 1972. Currently there is one Family Aide Unit of five aides in each of the three counties of Appalachian Maryland. In addition to these aides, FAP employs two inservice training technicians in each county to provide training and first-line supervision for both the Family Aide Unit and the Expanded Food and Nutrition Education Program (EFNEP) Aide Unit. Professional supervision is provided by home economics supervising agents in the County Extension Offices, and overall coordination and support are provided by the Regional Education Service Agency (RESA) through the FAP program coordinator.

In calendar year 1973, family aides worked with approximately 650 families. As of December 21, 1973, 369 families were enrolled in the program. These families represent a total of 1,696 persons, of whom 363 are preschool-age children and 688 are children of school age. The enrollment figures, by county, are:

	Allegany	Garrett	Washington
Program Families	155	117	97
Total Persons	748	483	465
Preschool-Age Children (0-5)	179	74	110
School-Age Children (6-19)	295	217	176

The Family Aide Program approach to child development is based on the assumption that the most effective means of influencing a child's development is through the home environment of which the key elements are the attitudes that are exhibited by family members toward each other. These attitudes can be modified to a certain extent by the educational and support roles performed by the family aide.

Of parallel significance in a child's development is his family's relationship to the community. The attitudes that low-income persons and persons of marginal means have towards the larger community are determined by their experiences.

Recommendation:

- To have more effective coordinated community child care, a concerted effort needs to be made by individuals, agencies and organizations concerned with social welfare to provide mechanisms to integrate low-income/marginal-means persons into the mainstream of their communities. To this extent, the roles that organizations such as local 4-C Councils, civic clubs, homemaker groups, PTAs and fraternal groups can play in facilitating this integration should be encouraged.

THE CHILD ABUSE AND NEGLECT SYNDROME

The State Plan as a signal for coordinated action and legislative consideration.

Someone has correctly observed that child abuse is whatever the judge says it is. The observation has many implications for decisions of public policy, legislation, use of public funds, judicial and legal practice, education and training.

To understand this multi-dimensional problem, it is necessary to know that the term refers to a broad spectrum of parent/child and family behavior, from mild physical and emotional neglect to violent physical and emotional abuse; it includes failure-to-thrive babies, "accident-prone" and malnourished children, sexually exploited and abused children, and—at the extreme—badly battered and dead children.

It is also useful to remember that this interpersonal, intra-family behavior exists in the context of widespread societal indifference to infants and children suffering the effects of inadequate food, shelter, clothing, supervision, education, medical and dental care, and, in many cases, of racial or ethnic prejudice. In addition to these "impersonal" forms of violence, there is a cultural acceptance of physical violence against children—corporal punishment inflicted by parents, teachers and custodians. (Physical violence perpetrated by one adult against another is assault and battery and punishable by law.)

Recent revisions of the laws governing abuse and neglect in some states—Massachusetts and Colorado, for example—reflect this understanding. Their primary purpose is the protection of children through services to support and strengthen the skills of even the most abusive parents. The focus is on the threat to the child's mental and physical health resulting from a family crisis. This crisis may be temporary and acute or it may be chronic—a continuing series of crises. Punishment of the neglecting or abusing parent is not a feature.

Broad definitions of what constitutes child abuse are designed to facilitate early identification through prompt reporting and early intervention through community health and social services.

Legal definitions are usually more specific. In most of the 50 states, child abuse is limited to physical injury. Only seven states class child abuse as a crime. Of these only Maryland imposes a penalty of 15 years. The others generally impose five or less. Maryland law, revised in 1973, requires *anyone* who has reason to suspect or believe that a child has sustained "physical injury . . . as a result of cruel or inhumane treatment or as a result of

malicious act(s) . . ." at the hands of his parents or caretakers to report to the local social service agency or the police.*

Anyone who reports is immune from liability (cannot be successfully sued) if the report was made "in good faith." All professionals who come into contact with children are required to report suspected cases of abuse in writing to the social service agency and to the State's Attorney. This includes physicians, mental health professionals, dentists, nurses, practical nurses, educators, probation and parole officers, correctional officers, and all law enforcement officers. Professionals have immunity from both civil and criminal liability.

The law charges the local department of social services with the investigation and validation of the complaint, the protection of the child, the provision of health and social services to the family, and the coordination of all supplementary services. Each local department may maintain a central registry; the State Department of Employment and Social Services is required to maintain a statewide registry. This charge is consistent with the tradition and practice of social service in the United States, which has provided protective services for abused, neglected, abandoned, dependent and delinquent children through voluntary agencies for almost a hundred years and through public agencies since the 1930s.

Reports have increased since the provision of immunity. Nevertheless, there are two serious obstacles to widespread reporting by professionals and lay citizens.

Dr. Vincent DeFrancis, Director of the American Humane Association's Children's Division and one of the nation's leading authorities on child abuse legislation, calls Maryland's revised law "schizophrenic." Though intended to facilitate and increase case-finding through early reporting, he says, the law is in fact punitive because it is in the criminal code; he calls it "the most grossly punitive law in the country." Until the jail penalty for the abusing parent is eliminated, most professionals and laymen will continue to be reluctant to report, he says. Families and children who go unreported go unassisted.

More seriously, the law has an "enormous loophole," Dr. DeFrancis adds, because it requires the person reporting to make a "diagnostic evaluation" that injury was inflicted out of cruelty or malice. Once an individual has concluded that the abuser did not *intend* to be cruel or malicious, he says, he is legally relieved of the obligation to report.

In consequence of the "schizophrenic" character of the law, two

*Maryland's Child Abuse Law, Article 27, Section 35A of the Annotated Code, was amended by the 1974 Legislature. The amendment expands the definition of child abuse to include sexual abuse and provides immunity from civil liability and criminal penalty for physicians or health care institutions examining or treating a child without the consent of the parents or guardian in certain cases.

investigations must go forward simultaneously, each at cross-purposes with the other. The State's Attorney investigates for the purpose of possible prosecution, while the social services agency investigates to determine the child's need for protection and parents' need for service and support.

Most citizens ask: Why should a "child abuser" get help instead of punishment? The answer to that question is based on available knowledge about people who neglect and abuse their children. The popular impression is that only "crazy," "sick"—i.e., psychotic—people could do "such a thing." If they are not sick, then they are pure mean and deserve only the worst punishment, many believe.

Who really are the "child abusers"? How do they get that way? Why are they so different from the rest of us? (Or are they?)

The most widely-respected researchers suggest in formal language what cartoonist Walt Kelly said through his celebrated *Pogo*: "We have met the enemy and they are us." Psychiatrists on the Child Abuse Team of the University of Colorado's Medical Center point out that abusive parents appear no different from the first dozen people you might stop on a downtown street. Some researchers—David Gil of Brandeis University, for example—indicate that your chances are better on a street in a poor, crowded tenement section of a large-city ghetto. All agree that all seriously neglecting and abusing parents have many major problems in personal and social adjustments, but only one in 10 is truly "sick"—either psychotic (out of touch with reality) or sociopathic (amoral, unable to have feelings of sympathy, empathy, compassion, remorse, guilt). Only this 10 percent is beyond help of any kind. For the other 90 percent, concrete, coordinated and practical health services and help with the practical problems of daily life, together with counseling and emergency relief when necessary, are sufficiently successful so that after a year—or two at the most—there is no further danger to the children, and family functioning is improved.

Many generalizations in the literature about abusing and neglecting families are made from studies of extremely small samples.* Many of them are contradictory from one study to another; some researchers contradict themselves in the same monograph. Some conclusions about such families are nothing more than assumptions, restated in a different form: Only mentally ill (psychopathologic) persons could abuse children. This person has abused this child. Therefore, he is mentally ill.

There is a good deal of reliable information and experience, however, and a general consensus on many fundamentals.

To the most frequent question, "How often does it happen?", the best answer is "No one knows." There are no reliable statistics, because most

*HEW funded a National Clearinghouse on Child Abuse and Neglect operated by the American Humane Association, to collect national data beginning July 1973.

abuse goes unreported. It occurs at home, with no witnesses. (Husbands and wives usually protect each other.) The American Humane Association estimates half a million abused and neglected children yearly; 30,000 to 40,000 physically abused, 100,000 sexually abused, and probably 200,000 psychologically damaged. Other estimates of abuse described as conservative put the total at 60,000 to 250,000 a year. Some go as high as a million. Kempe and Helfer suggest a ratio of 300 per million population. All agree that the reports are "the tip of an iceberg."

Maryland reported 2,000 cases from 1966 to 1971. All areas of the country have reported sharp increases in reporting over the last two years.

It is widely agreed that:

- Serious neglect and abuse is the result of patterns of learned behavior; children grow up to raise their children as they were raised.
- Adults who abuse their children emotionally and physically are unable to form close, trusting relationships with others. They are emotionally isolated from any other person and unable to seek help.
- Generally, the neglecting, abusing adult is severely disabled in his capacity to meet the ordinary demands of daily life; he feels inadequate, overwhelmed, confused and guilty.
- The dependency needs (normal developmental needs) of these adults were never fulfilled by their own parents. Emotionally, they are still children, unable to tolerate the normal needs of their own children for care, supervision and protection, for love that carries no price-tag.
- Such parents look to their infants and children for the love and care they never received when they were children.
- Abusing and neglecting families are usually families with many serious problems. They tend to be unstable and disorganized.
- These characteristics may be found in all socio-economic levels. Where there is an accumulation of added stress—poverty, discrimination, deprivation, unemployment, illness, poor housing—there is a far greater incidence of abuse. The affluent can buy relief from their tensions, including the services of a private physician who generally does not report abuse.
- These parents lack skills in nurturing, child care, homemaking, maintenance, money management, social relations; they need to be taught.
- Where two adults live in an abusing home, one is an active abuser; the other is passive or accepting and sometimes even subtly engineers the abuse.
- Such adults have unrealistic ideas of the ability of children to control their behavior, to perform as expected, at each developmental stage.

Like their own parents, their criticism of the children is intense, pervasive and continuous. They punish harshly "for the children's own good."

- The child who receives the abuse is usually somehow different. He may be unwanted, illegitimate, colicky, overactive (or seen as such), bright, retarded, handicapped, may be seen as too ugly or too beautiful; or he may resemble a hated spouse or parent.
- Some family crisis usually precipitates the abuse. From the point of view of more adequate parents, it may be a very small matter—a broken washing machine or a complaint about an unmade bed.
- A physically abused child is obviously also emotionally abused. His siblings live in an emotionally abusive atmosphere. One or more may also have been physically abused.
- Abused children believe that they deserve their "punishment" because they are "bad," therefore unlovable. As adults they feel worthless and cannot ask for help, feeling that they "do not deserve it."

"Why should such a person get help instead of prison?" In all justice, child abuse authorities argue, they do deserve it. However, to punish in the light of all that is known is to render them even more inaccessible to rehabilitation.

Prison for the parent, or removal for the child, only compounds the problems for the community, at a cost far greater than early intervention to prevent repeated abuse. The cost of foster care (averaging nationally $2,000 a year), police and social investigations, court and legal fees, hospitalization of abused children and examination for mental competency of parents at public expense totals in the millions of dollars for each state. The human costs to families and individuals and to the commun..y are incalculable.

In addition to the American Humane Society, the Child Welfare League, the United States Congress (which approved 60 million dollars for prevention and treatment programs), the United States Department of Health, Education, and Welfare (HEW), and other national groups as well as many Maryland groups have put a priority on developing solutions to the problem. These include the Maryland 4-C Committee, the Maryland Conference of Social Concern, the governments of Prince George's and Montgomery Counties (each has a Task Force on Child Abuse and a Child Protection Team), the 4-C Councils of Montgomery, Prince George's and Frederick Counties, and the Citizens for Child Advocacy of Montgomery County. Sinai Hospital in Baltimore has a federally-funded Child Abuse Project. The Johns Hopkins Hospital and the University of Maryland Hospital are developing a cooperative program with Baltimore City Protective Services. The role of the State Department of Employment and Social

Services, which convened a statewide conference on January 8, 1974, has been discussed and the role of the Maryland General Assembly suggested.

The critical questions are these: What is to be done? What works? What system is most effective in maintaining the child safely in his home with his own parents?

The key to the solution, Dr. DeFrancis and other authorities insist, is an integrated, coordinated, cooperative approach that cuts across traditional lines of public and private agencies, professional and lay roles. Such an approach must be supervised by a single, accountable person. Research projects like the Bowen Center in Chicago, and public agency programs like that in Honolulu, suggest that such services are optimally effective when they are housed in one physical setting. Authorities believe that a system of integrated health, social and educational services supplied at one neighborhood center is the ideal. Such services include legal assistance; financial, personal and marital counseling; medical and dental care; basic and special education; job training and job finding; instruction in homemaking (domestic arts), child care and child development; day care and baby-sitting; crisis shelter and temporary foster homes; group therapy; home visitors as family aides; and recreation. Some services must be available for emergencies on a 24-hour basis, such as crisis counseling and emergency shelter. (This should be mandated by State law.) All services must be personal, intensive and sustained. They should be non-exclusionary and supplied on the basis of need.

In addition, DeFrancis and others point out that protective services and social workers supplying such services must be selected carefully for stability, maturity, and the emotional capacity to provide support to resistant, fearful, uncooperative and hostile parents over long periods. These personal qualities must be enhanced by adequate experience and highly specialized training.

Serious neglect and psychological abuse are not included in the definition of abuse in the Maryland Law. This would require action by the State Legislature. The Legislature must go further, however, and mandate an adequate level of funding for hiring *and* training a sufficient number of qualified protective service workers *for public education* and for comprehensive health and mental health services.

Professional faculties and associations of medicine, law, social work and education need to educate their members to the problem. Broad-based research studies with careful controls must be initiated and the findings used to refine predictive tools for medical, health and protective service personnel.

Judge Robert Watts of the Supreme Bench of Baltimore City urges the establishment of Family Courts to deal with all aspects of family dysfunctioning. They would eliminate many of the adversary features

characteristic of intervention by the State. Professional witnesses could be advisory to the court and not, as now, retained by the prosecution or the defense.

Most important is the need to correctly identify the central issue: "... the major concern (is) not 'child abuse' but persons. The children (do) not reflect specific scars from the abuse, but reveal that they (are) in the broadest sense the children of their parents. The abuse itself (is) but one tree in the forest ..."*

Child Welfare, Vol. 52, No. 9, page 588.

Chapter XII

Evaluation and Monitoring

The State Plan as an incentive for effective evaluation and monitoring related to goals and priorities.

Evaluation and monitoring can be important tools only if they can take place against a backdrop which views the child's needs and that of his family as a composite whole. In Maryland's currently fragmented delivery system, which by law assigns certain responsibilities or programs to particular agencies, these programs have a tendency to become ends in themselves—i.e., day care, foster care, etc. There is danger in viewing the particular program as an end in itself. The thrust of evaluation and monitoring should be based on the broad goals and priorities set by the nation, state or local community. The individual program should be measured against the priorities and goals rather than measured as an end in itself. It can be argued that only the local community can decide how best to recognize a particular risk or determine a particular goal or priority, i.e., what services to offer.

There is in Maryland today a multiple delivery system, with each component offering relatively discrete services for particular age groups. What is needed, instead, is for the State to set the goals and priorities for its children and then evaluate and monitor programs within that context. No community in Maryland has set up an effective preventive or treatment program for children who are in need of comprehensive child development services (interagency delivery system). This report therefore emphasizes the need to set priorities and goals from which services or programs are developed. It is in this context that evaluation and monitoring should take place.

A wide range of evaluation and monitoring procedures exists within the three State agencies responsible for services to young children and their

families. Most variance is within the State Department of Health and Mental Hygiene and the State Department of Employment and Social Services, since monitoring and evaluation for these programs is done at the local level. In the Maryland State Department of Education, accreditation takes place at the State level, resulting in more continuity.

Whether a common set of program standards, regulations, and mechanisms for coordination at the State and local levels would produce greater effectiveness in relation to effort is a question that needs careful consideration.

SOCIAL SERVICES ADMINISTRATION, DEPARTMENT OF EMPLOYMENT AND SOCIAL SERVICES

Day care centers operated by the Social Services Administration are monitored and evaluated through local agencies. There are no funds for administration except in Baltimore City, where there are six administrators for day care.

Purchase of day care is monitored and evaluated by a representative in the local agency (case worker or supervisor). This is effective in small counties but not in larger counties. The current DESS budget requests 10 positions for day care administrators for the large counties such as Prince George's, Anne Arundel, etc.

Before purchasing care, an On-Site Visit Form is completed and an evaluative consultation is held with the Health Department coordinator. Contracts to purchase group day care are reviewed and renewed annually.

Family day care homes are monitored and evaluated locally. There are suggested guidelines, and monitoring depends on the availability of staff. An evaluation form is being created which would provide more consistent statewide guidelines.

Major contracts awarded by DESS contain a monitoring and evaluation clause calling for consultation, joint conferences, observation and periodic record review at specified times. This is usually accomplished on an informal basis, since there is no staff for a more formalized monitoring procedure.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Different monitoring and evaluation mechanisms exist in each program area of the Preventive Medicine Administration. There is increasing pressure to expand the role of monitoring.

Group day care centers seem to be effectively monitored for fire, safety, sanitation, etc. in local jurisdictions where all day care center licensing is done.

Monitoring the program for the full period of time a child stays in a day care center is more difficult. Suggested evaluation forms are available but are not used statewide. Procedures for program evaluation are greatly facilitated in those counties that have a day care coordinator.

DEPARTMENT OF EDUCATION

Title I, Elementary and Secondary Education Act (ESEA) programs, which are federally-funded, are written by the subdivisions and approved by the State for the U.S. Office of Education. Each program is monitored and evaluated through periodic on-site visits and consultations. No separate State guidelines are necessary, since Maryland complies with the guidelines of the Office of Education.

Title III, Elementary and Secondary Education Act (ESEA) proposals are developed along specified guidelines, and each program has its own procedure for monitoring and evaluation. These programs are also federally-funded.

Nonpublic nursery schools and kindergartens seeking approval must submit a written statement of purpose, philosophy and objectives. An on-site visit determines whether these are carried out as stated and evaluates the school from many angles. Tentative approval is granted for one year and a certificate issued in the second year if the school has achieved the desirable goal. Annual reports are required from all certified schools.

* * *

At present, licensing or certification of approval, in the case of nonpublic schools and kindergartens, is one of the major tools for safeguarding children in out-of-home care. It provides for public regulation of facility, staff, type of program, etc. The burden of proof of compliance lies initially with the licensee. Yearly renewal of licenses or maintenance of certificates of approval calls for some type of inspection or report. However, after the license is granted, the burden of proof for noncompliance lies with the department or agency—and it is difficult to take away a license. An agency can usually write a report but does not have the legal sanction to close a program.

Licensing should not be a catch-all for all program monitoring. There should be other approaches to insuring quality of care that operate beyond the licensing arena, such as clustering, and coordination of programs and codes that set forth the rights of children. It is essential to look beyond licensing as a regulatory safeguard when planning for children's services.

Quality can often be upgraded by fiscal supervision or control. Some states practice fiscal control in purchase of care and differentiate center types on the basis of qualifications of staff, amount of support services.

adult-child ratio, and facility. An amount to be paid is then set according to the quality of care being purchased.

Consideration should be given to the following:

- Standards applicable to *all* types of day care.
- All situations subject to inspection for compliance. (This may be a more appropriate means of evaluating the quality of family day care than licensing.)
- Given program standards and a grievance procedure, consumers of day care could share a portion of the responsibility for evaluation.

EVALUATION

It should be noted that two distinct types of evaluation exist. *Summative* evaluation occurs after the fact and looks at the effects of what did happen. *Formative* evaluation occurs during a program and looks at the effects of what that program is doing.

Summative evaluation is usually done by persons outside of the program. Standardized measures are often chosen—more for their familiarity to professional evaluators and semiprofessional consumers of the evaluation than for their validity or reliability in assessing factors crucial to the intent and worth of a program. Whether evaluating a single program or a series of them, stress on numbers can distort purpose. The importance of selecting measures for summative evaluation which accurately assess the true goals of a program—as agreed upon by the evaluating agency and the people whom the program is supposed to serve—cannot be overestimated.

Evaluation as a *process* is synonymous with the term "formative evaluation." The process is concerned with the impact a program has on young children and their families as the project is in action. Regular information derived from formative evaluation can make the experience of summative evaluation less stressful, especially for those involved in a program.

Reducing the threat factor is an essential step if any evaluation is to be productive. Threat can be reduced during the planning stages by involving the community in planning the project and listing the program goals. Establishing rapport with all those involved also reduces threat. A final way is to allow the project participants (staff, parents, etc.) to protest any of the evaluation techniques used.

Since the evaluation influences decision making, it is necessary to state the goals of a program specifically in order to determine whether the program is accomplishing what is desired. It is important to note that program goals are value-oriented. Administrators, funding sources, profes-

sional groups, consumers, and the general public do not share the same values.

Evaluation provides information to improve programs, but there must be a willingness to change ideas in the light of new information. Evaluation procedures must be planned and designed with care in order to determine what measures should be used to derive information and under what conditions and at what times these measures can be used most effectively. This is a continuous process and needs open communication for effective feedback.

Finally, evaluation must be useful as an internal tool and to produce effective change in the program as well as to inform decision makers with the facts about the program. Evaluation is a vital, on-going process which must take place to avoid misuse and misdirection of energy and effort.

Recommendations:

- Much more emphasis should be placed on evaluation, the results of which should be made available to decision makers in their selection of programs to be funded.
- Evaluation should be related to established goals and priorities.
- Monitoring and evaluation are areas that should be of central concern to a coordinating structure such as recommended in Chapter XV.

Chapter XIII

Training Programs In Child Development and Early Childhood Education In Maryland *

The State Plan as a series of recommendations pertaining to training needs.

At the present time, training programs for teachers and others in the area of child development and/or early childhood education in Maryland vary considerably in terms of number, length of training sessions, and, no doubt, in quality and effectiveness. The 1973 survey of training revealed that programs might be held on a one-time basis to several times yearly. They varied from informal seminars and workshops based on specific community needs to very comprehensive and sophisticated doctoral programs. For the most part, however, formal training is concentrated in the "corridor" or Central Maryland region with the Eastern Shore and Appalachian areas offering fewer formal programs and more informal training based on community need.

Geographically, Maryland is really three separate states. The central or "corridor" region (comprising 11 counties) is bordered by a north-south mountain chain to the west and to the east by the Chesapeake Bay. The mountains and water have acted as natural geographic deterrents to the free flow of information and services to the three mountain counties in the west and the eight shore counties in the east.

The socio-economic situations as well as the cultural patterns of the people in the mountain and shore counties are different from the central or "corridor" counties. The "corridor" counties, with easy geographic access to Washington, D.C. and Baltimore, have enjoyed superior transportation

*The information contained in this chapter was developed from a survey conducted in the fall of 1973 by the Maryland 4-C Committee in an attempt to determine the nature and extent of training in the State.

and communication systems. The Eastern Shore and the "mountain" counties—with scattered populations—have had difficulty in obtaining and maintaining adequate transportation.

The child development and early childhood education programs offered across the State (as reported in the 4-C training survey in late 1973) reflect the very real problems that exist. Thus, any meaningful examination of the adequacy of training programs in the State must be accomplished in terms of the local situations.

The Eastern Shore counties have a rather scattered, less dense population than the central part of the State and are more rural in character. There are two community colleges (Ocean City and Chesapeake) and two four-year colleges (Salisbury State and the University of Maryland, Eastern Shore). All of these institutions offer courses in early childhood development and/or early childhood education. There is a four-year degree program in early childhood education at Salisbury State College. In addition, the University of Maryland offers extension courses in Queen Anne's County, as do other State colleges in various eastern counties. Aside from these formal college-level programs, training for teachers and other child care personnel has been scattered. According to local 4-C Councils, the Eastern Shore needs additional child care facilities and training programs for child care workers, family day care workers, and training opportunities in parent effectiveness.

An examination of high school programs in these counties also suggests the need for more child development and related courses. It would seem appropriate for high schools serving an essentially rural and agrarian population to offer a variety of programs in the vocational areas, including programs in family life and child care.

In the western part of the State, each of the three counties—Garrett, Allegany, and Washington—has two-year community colleges. One four-year college, Frostburg State College, serves the area. All of these institutions offer course work in child development and related areas. It is possible to earn a bachelor's degree in early childhood education at Frostburg State. Responses received on the survey forms suggest that, aside from a few units of study in the home economics area at the high school level, there has been little training in child development available in these counties in the past. The University of Maryland has an active extension program in home economics in and around Cumberland. Local 4-C Councils reported a great need in this area for child care programs, before- and after-school child care, and comprehensive health care services. Since the training survey was conducted, however, many types of leadership training programs and child services have been developed through the combined efforts of State and local agencies.

The situation in the "corridor" counties is quite different. The

counties immediately contiguous to Washington, D.C. have access to a wide scope of training programs at all levels. There are doctoral programs in early childhood education, special education, and human development; master's degree and baccalaureate programs in early childhood education are also available. Many programs have been offered at the non-degree level through county health departments, departments of social services, high schools, Head Start, etc. A similar situation exists in the greater Baltimore area. With the exception of doctoral level training in the area of early childhood education and development, there have been active baccalaureate and master's degree programs in the region for many years. Several of the community colleges in Baltimore City and nearby counties offer terminal two-year programs as well as more limited transfer programs in the general area of child development and early childhood education. Again, Head Start programs have been prominent in Baltimore City and the nearby counties. Credit and non-credit, formal and informal training classes have been offered under the auspices of State and county agencies (health, social services, education).

Training programs for volunteers to work in child care programs of many types have been organized by the Maryland Committee for the Day Care of Children, Inc. The public schools have regularly cooperated with State and private colleges and universities in conducting seminars and workshops in child development and related subjects as part of their inservice training for teachers, administrators and paraprofessionals as well as offering some types of training through their adult education programs.

Utilizing Manpower Development Training Act (MDTA) funds, State agencies, in cooperation with the Maryland 4-C Committee, initiated training of child care personnel in July 1972. This project supplied a needed impetus to the training programs offered across the State. The Regulations Governing Group Day Care Centers (State Department of Health and Mental Hygiene, December 1971) require that directors and senior staff of day care centers have at least 64 classroom hours of early childhood education specifically directed to the needs of children ages two to six years. Through MDTA (under the leadership of the Maryland 4-C Training Committee) a major part of this task has been accomplished. The curriculum to accomplish this training is well established in the State, and even now, without MDTA funds, it is anticipated that training will proceed in the community colleges and four-year colleges as it has for several years.

Despite the many training opportunities offered across the State, there are some glaring deficiencies in both training and facilities. Although Baltimore City and a few counties have made a good start, training programs for family day care mothers are needed statewide. Community-based parent education programs and inservice programs to upgrade present teachers in early childhood development must be continued on a statewide

basis. As in Central Maryland, the Eastern Shore and the western counties are sorely in need of training programs for paraprofessionals and others to work in the health delivery services.

One answer to the need for leadership training in comprehensive child care may be to develop more flexible delivery systems in the community colleges and the four-year institutions, perhaps through the use of various types of media and individualized instruction. The final answer in any event should be considered in terms of taking the training to the outlying areas; thereby eliminating maintenance of expensive physical plants to house the educational activity.

State high schools need to expand their curricula in family life and child development. Boys as well as girls need knowledge in the parent and homemaker areas. Confining the child development units to the home economics course offerings, as is the usual practice, tends to limit the enrollees.

The "corridor" counties seem unanimously agreed upon their need for more day care facilities, before- and after-school care for all age levels of children, and parent education programs. Perhaps because of the character of the population in these counties, they seem to attract volunteers interested in working in programs with children. Although this specific area of training does not appear in any of the summary tables, some has been done and it continues to be a definite training need. Working with and training volunteers is a rather unique skill. Programs of this nature require skilled professionals working in close conjunction with community resource people.

SUMMARY OF TRAINING NEEDS

Summarizing the training needs of teachers and others in the field of child development and/or early childhood education for an entire state is a formidable task. In a state that includes such varied groups of people, as well as definite rural, suburban and urban regions, the training needs will depend on factors that preclude the drawing of generalizations applicable to all situations. Yet, based on the results of the 4-C training survey and the thinking of a wide representation of professional and nonprofessional persons, certain recommendations do seem to have a bearing upon the needs of the state as a whole.

Recommendations:

- Perhaps the foremost recommendation that might be made is that interaction and cooperation among all the agencies and institutions having to do with the education and welfare of young children must be promoted

in every manner possible. This is a necessary prerequisite to improved training programs for all those who will hold leadership positions in programs delivering services to children. Parents themselves, teachers, assistants, volunteers, directors, administrators and supervisors—all must be included. Training programs should be interdisciplinary in nature and reflect the best thinking of all who are responsible for and interested in the total welfare of the State's children.

- A second recommendation regarding training programs is that they incorporate those competencies that will insure that all trainees accept children as total organisms who must be helped to function within their present environment including family and community. Competencies established as necessary for trainees should be broadly based, not limited to the simplistic, measurable skills which are too frequently mistaken for the standard of adequate child care and education.

Some specific recommendations may be made under various categories, as follows:

At the college level:

- Include in all child development and early childhood education programs, courses or units of study on human relations and our changing, multicultural society.
- Include intensive study of child development, behavior, and learning for all persons who will be working with young children as well as those who will be directing and administering such programs.
- Include courses and/or programs designed to train individuals in management techniques and supervisory skills necessary to operate quality programs of all types for young children.
- Incorporate community resource people into various aspects of training programs to teach segments or units in areas of their expertise.
- Provide some method of screening in order to establish minimum personal and intellectual attributes for individuals to work effectively with young children.
- Incorporate internship methods of training at both undergraduate and graduate levels; investigate sources for funding such programs; or use work-study methods to compensate students and placement agencies for services rendered.
- Organize special courses for public school personnel, including administrators, to keep them up to date and sensitive to children's needs. These courses may very well be different in nature from the traditional campus-based course work. (For instance, consider using different delivery systems such as taking the course "to them," changing the scope and

content to fit a media system "loaned out" with self-study provisions and individual conferences; include observation of quality demonstration programs of various types for young children.)

- Establish quality training programs for family day care mothers. (Open-entry/open-exit, individualized programs at the community college level might fill this gap and provide the needed flexibility in hours.)
- Establish a method for facilitating transfer students in their programs when they desire to change from two- to four-year programs. There are many common elements in the course work found in two- and four-year institutions that could be transferred.
- Design and implement some method of evaluating prior experience and establish a "credit for experience" system based on performance criteria.
- Study the "Child Development Associate" program as designed at the national level to determine its suitability for the needs of Maryland.

At the community level:

- Develop community-based training programs for family day care mothers and parent effectiveness programs.
- In conjunction with nearby training institutions, identify exemplary programs for children and make them observation centers and/or field training locations tied in with college training programs, noncredit training, and training for volunteers.
- Develop career ladders for all levels of personnel involved with comprehensive child development and child care. Many programs requiring paraprofessionals offer special training for them. If these programs are not performance based, it is difficult to evaluate them effectively and thus consider the training as suitable for transfer to another program. A successful career ladder program depends upon accurate skill analysis, appropriate job description, and task-related and evaluated educational methods at each step of the ladder.
- Incorporate courses of study in the general area of child development, parenting and homemaking at the high school level. Include both boys and girls.
- Establish a statewide resource information retrieval and dissemination center for all areas of child development programs, training facilities and coordinating services (see Chapter XV).

The future:

The following three factors will determine the feasibility, nature and direction of expanding training programs in the future.

1. *Federal funding.* Although Federal programs for the welfare and education of young children are sometimes indefinite and short-lived, there is still a national interest in maintaining services of all kinds for children. While some programs have been discontinued, others are certain to be developed. Many early childhood programs, especially day care and infant stimulation programs, fall into this category. There is an increasing interest in serving children with special needs. Individual states usually follow Federal leads in assigning priority to certain areas. Maryland has been a leader in such programs and should continue to be so.

2. *Population changes.* While the preschool population seems to be declining in some areas, quality programs for young children are still needed. Over the past two years the position of supply and demand has shifted in teacher education, but the supply has not yet caught up with the demand for well-trained teachers in early childhood education or for children with developmental disabilities.

   The fact that there are fewer provisionally certificated teachers needing to take courses to meet full certification requirements is a positive factor in improving quality education for all children. Although there appears to be a trend in some counties and school districts toward ceasing to reimburse teachers for educational courses to upgrade their skills, there is no reason to assume that teachers and child care workers will cease to try to improve their professional knowledge and skills at their own expense. Currently there seems to be a decrease in demand for teachers. However, the standards for quality programs have never reached the level deserved by our children. No matter what form programs for training teachers and child care personnel may take in the future, there will continue to be a demand for those who are well prepared. To preserve the *status quo* in the fields of education, health care services, and social services for young children and their families would be disastrous.

   Historically, society has looked to the higher-level educational institutions to initiate change and reform in educational practice. New teachers entering the field were expected to bring with them the cumulative results of research and innovativeness in theory and practice. If, after the student entered the profession, he or she no longer received stimulation from the bastions of research and innovative training and practice, the profession could be expected gradually to approach a stagnant level. This is true as well in the other disciplines dealing with child care, health, and welfare.

3. *Working mothers.* One factor that seems to magnify the need for continued quality training programs in early childhood development and education is the fact that more women are going out to work earlier and are staying longer. In addition, they are not taking as much time out to

TABLE 34
Agencies and Institutions in Maryland Participating in Training Survey*

Allegany County
1. Board of Education
2. Allegany Community College

Anne Arundel County
1. Anne Arundel County Health Department
2. Anne Arundel Community College

Baltimore City
1. Antioch College, Homestead Montebello Center
2. Antioch College, Center for Social Research and Action
3. Coppin State College
4. Community College of Baltimore—Health Science Program
5. Community College of Baltimore—Early Childhood Education
6. Morgan State College
7. Baltimore City Health Department—Division of Child Care
8. Maryland State Department of Health and Mental Hygiene
9. Board of Jewish Education

Baltimore County
1. Towson State College
2. Baltimore County Department of Health
3. Catonsville Community College
4. Essex Community College
5. Goucher College—Psychology Department
6. Goucher College—Education Department
7. University of Maryland, Baltimore County—Division of Education
8. Villa Julie College

Calvert County
1. Board of Education of Calvert County

Carroll County
1. Carroll County Board of Education
2. Carroll County Health Department
3. Western Maryland College
4. Mount St. Mary's College

Cecil County
1. Cecil Community College

Charles County
1. Charles County Community College

Frederick County
1. Frederick County Health Department
2. Board of Education of Frederick County
3. Hood College

Garrett County
1. Garrett County Board of Education
2. Garrett Community College

rear families. Thus, the need for day care facilities and programs at all socio-economic levels will continue to be a pressing need. At the lower socio-economic levels, infant stimulation programs, compensatory programs of all types and special programs for the exceptional child seem to be an area of need. Programs to train directors and master teachers at these levels will need to be expanded. Courses in administration and supervision of day care facilities for young children need to be added to college curricula at both two- and four-year institutions. In this area also, there is a need to train more aides and volunteers. Finally, while the nature of the training may shift, all those who prepare themselves to work with young children and their families must be exposed to the best possible programs the State can offer.

TABLE 34 (Continued)
Agencies and Institutions in Maryland Participating in Training Survey*

Harford County
1. Board of Education of Harford County
2. Harford Community College, Community Services
3. Harford County Health Department

Howard County
1. Howard Community College
2. Howard County Department of Education–Home Economics and Vocational Education Departments
3. Howard County Health Department
4. Howard County Public Schools
5. Antioch College, Columbia Center

Kent County
1. Kent County Board of Education

Montgomery County
1. Montgomery College
2. Montgomery County Public Schools
3. Montgomery County Health Department
4. Columbia Union College

Prince George's County
1. University of Maryland–Department of Education
2. University of Maryland–Department of Psychology
3. University of Maryland–Department of Health Education
4. University of Maryland–Department of Sociology
5. University of Maryland–Department of Food and Nutrition
6. Prince George's Community College
7. Bowie State College–Education Department
8. Bowie State College–Social Work Department
9. Bowie State College–Graduate Office
10. Head Start Bi-State Training Office at University of Maryland
11. Prince George's Department of Health

St. Mary's County
1. St. Mary's College of Maryland
2. St. Mary's County Health Department
3. St. Mary's County Board of Education

Talbot
1. Chesapeake College

Washington County
1. Hagerstown Junior College

Wicomico County
1. Wicomico County Health Department
2. Wicomico County Board of Education

Worcester
1. Ocean City College

*This table reflects all agencies and institutions returning the survey forms.

Chapter XIV

Child Development Services In Voluntary Agencies and Hospitals

The State Plan as an initial overview of the child development programs provided by voluntary agencies and hospitals.

CHILD DEVELOPMENT SERVICES IN VOLUNTARY AGENCIES

Agencies that depend upon volunteers, donations and charitable drives are often pioneers in bringing special services to children. The need for such pioneer efforts may arise from a group of parents who band together to obtain services for their children when such services are not generally or publicly available. They may begin by serving a group of children for whom the public has a naturally sympathetic response; or a group of children that is small in number or who are so scattered that the usual activities of public service departments do not reach them.

When a child development service is recognized as needed by all children with a categorical problem, and when public opinion insists that the service not be dependent upon spontaneous organizing and giving, these services may then become the responsibility of a public agency. This move may be accompanied by a loss of those characteristics which are typical of pioneers and volunteers: enthusiasm, response to challenge, vigorous concern for individual clients, and the experience of discovery by the volunteer.

The report that follows is an initial attempt to describe the child development services available to Maryland's children through private and voluntary agencies. Attention is directed here to those agencies to which preschool children may be referred for problems affecting their development. An initial description of the accessibility of services in terms of distance, time and cost is included.

A survey questionnaire was mailed to 418 voluntary agencies and hospitals believed to be offering services to children 0 to 6 years and their families. Agency names and addresses were obtained from the *1972 Directory of Community Service in Maryland*, published by the Health and Welfare Council of Central Maryland, Inc. To reach out-of-state agencies used by Maryland residents, questionnaires were also mailed to agencies in Washington, D.C., northern Virginia and Delaware. Because of limitations in time, the questionnaires were mailed only once and tabulated within two months of mailing. A total of 111 responses were received. This represents an overall return rate of 26 percent. None of the agencies responded to the entire questionnaire but selected those questions which relate to their specific functions.

Outreach

Three agencies stated that a majority of their clients were contacted by outreach. Fourteen out of 42 provided transportation for a majority of their clients. Four out of 40 agencies gave a majority of their services in the child's home.

Services provided seven days a week is a mode of outreach used by 11 out of 44 agencies. Sixteen agencies out of 46 were open and answered calls seven days a week. Five agencies out of 44 responding are open to provide services 24 hours per day and 11 out of 45 are open 24 hours per day to answer calls.

Home visits, provision of transportation, 24-hour availability and services every day in the week are remarkable illustrations of outreach. They support the characterization of voluntary agencies as enthusiastic in their mission to serve children.

Services for Middle-Income Families

Child development services may be intensive and may extend over a long period of time. High-income families may purchase services for their children, and families receiving public assistance may also receive certain child development services. Families between the high-income and low-income groups may have great difficulty in obtaining services. Many voluntary agencies, therefore, design their program to meet the needs of these middle-income families.

Five agencies out of 31 who answered the question stated that a majority of their clients needed or received public subsidy in obtaining child development services. Nine agencies out of 43 served a majority of clients who paid partial fees. Twenty-one out of 43 agencies gave free services to a majority of their clients.

Regionalization of Services

The capacity of agencies to serve a region beyond their own city or county is reflected in questions on how clients reach agencies and on the proportion of clients coming from outside the county or outside the State.

Twenty-four agencies out of 42 answering the question received a majority of their clients by referral. This large proportion (56 percent) shows how children need a network of professional persons to help them reach specific services.

Five agencies out of 32 received a majority of their clients from outside the county or State. Apparently this small proportion specifically address themselves to children and families from a broad area.

From the count of children receiving the child development services within the past year, the findings show that case finding and speech therapy services display a regional pattern.

Since many agencies responded to the questionnaire by stating that they did not record the number of clients or number of visits according to the residence of the family, an obvious recommendation for agencies that intend to develop a regional impact or that intend to obtain referrals from a wider area would be to keep statistics for an annual report on the zip code or county of residence of all clients.

Volunteer Services

Volunteers give their time in various capacities—administration, fund raising, direct services, etc. On the basis of this preliminary survey, it is not possible to estimate what proportion of an agency's services was provided by volunteers.

Geographic Distribution of Services

The answers received in the sample enumerated 22,980 services to children or their families in a one-year period. By geographic distribution, 21,057 of these services were provided in Anne Arundel County, Baltimore City, Montgomery County and Prince George's County. These constitute 94 percent of the services enumerated.

Fifty-three percent of the non-hospital Maryland agencies that received questionnaires were in Baltimore City and the above-named three counties. These same political units are the residence of 61 percent of the people of the State and 58.6 percent of the children ages 0-6 years (see Table 35). Why 94 percent of the reported services are rendered in areas with 53 percent of the agencies is not known. Without more complete reporting it is not possible to say whether children in the other 20 counties are receiving similar services.

Kinds of Child Development Services Reported

The total services reported in the sample cover a broad range of needs: health services, parent education, education of the handicapped children, counseling, placement, etc. (see Table 36). Several categories indicate that they are characteristically provided by private agencies: education of parents serving 7,529 families, education of preschool handicapped serving 4,438 children, speech therapy for 663 preschool children, and family group therapy serving 203 families.

TABLE 35
Percent of Children Served According to Political Areas of Residence
(Sample from Mailed Questionnaire)

Political Jurisdiction	Percent
Baltimore City	40
Counties:	
Baltimore	16
Prince George's	9
Harford	7
Anne Arundel	4
Carroll	4
Montgomery	4
Allegany	3
Charles	2
Howard	2
Wicomico	1
Caroline	1
Cecil	1
St. Mary's	1
Talbot	1
Washington	1
Worcester	1
Calvert	<1
Garrett	<1
Frederick	0
Somerset	0
	<100

Table 36 can be used to orient the reader toward quantities of each service, but it gives no information about the supply of, or demand for, each service. The response to this survey indicates the need for greater investment in data collecting so that this kind of essential information may be an intrinsic part of public agency records. This would make possible the identification of, and planning for, the unmet needs of the children involved and also would show the extent to which these needs are being met.

Sources of Support for Child Development Services

The agencies were asked what percentage of their income comes from various sources. One agency received 100 percent of its support from fees

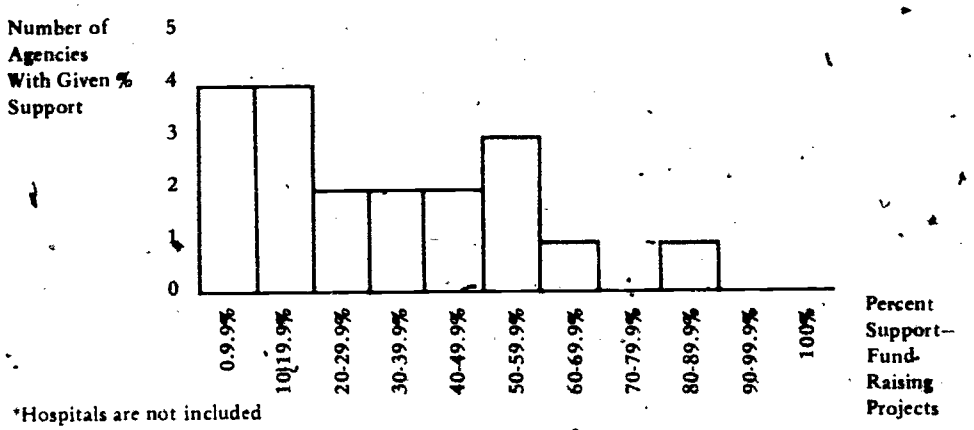
TABLE 36
Child Development Services Received By Families From a Sample of Responding Agencies

Service	No. of Families Served	Percent of Sample
Counseling		
General	3,263	
Child protection	43	
Marital	207	
Family emotional problems	471	
Play therapy	80	
Family group therapy	203	
Other	18	
Total	4,285	18.7
Education of Parents		
Newsletter	3,189	
General	2,376	
Education for childbirth	553	
Child rearing	626	
Health care	505	
Other	380	
Total	7,529	32.9
Education of Handicapped		
General	2,809	
Cerebral palsy	462	
Deaf	108	
Emotionally disturbed	449	
Retarded	552	
Other	58	
Total	4,438	19.3
Health Services		
Screening	4,783	
Speech therapy	663	
Physical therapy	388	
Other	283	
Total	6,117	26.8
Placement and Care Services		
Adoption	196	
Foster care	220	
Homemaker services	108	
Residential care	87	
Total	611	2.7
Grand Total	22,980	100.4%

from clients, while five received all of their support from local and/or State governments.

Agencies providing child development services describe support by fees from clients, fees and dues from members of the voluntary organization, fund-raising projects, united and combined fund appeals, foundations and

FIGURE 6
Number of Agencies* According To Proportion of Support By Type of Funding
Fund-Raising Projects

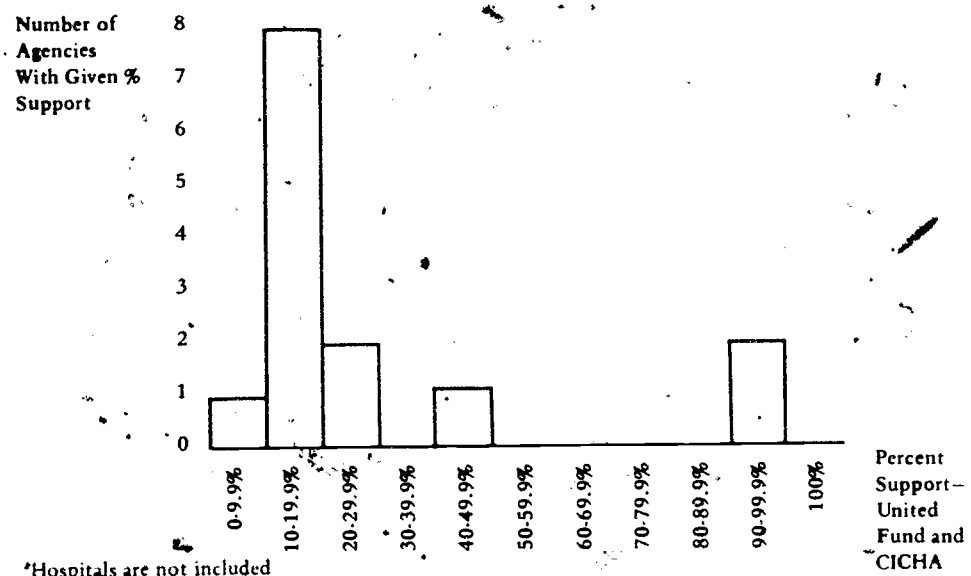


*Hospitals are not included

religious institutions, local and State governments and the Federal Government.

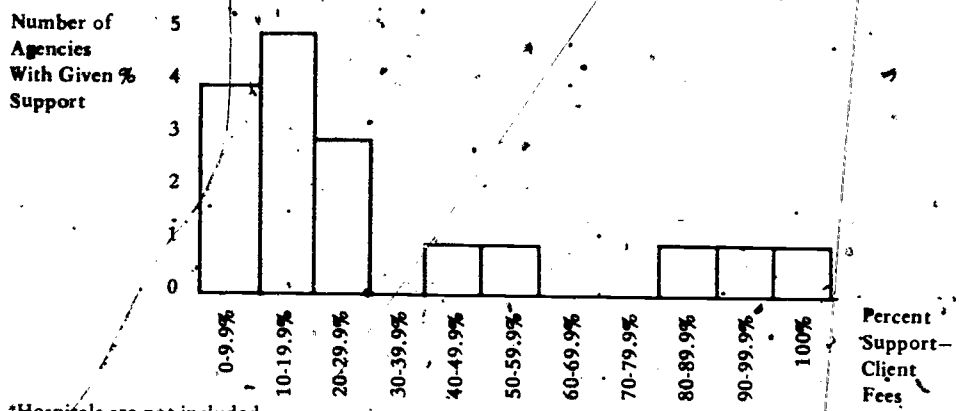
Figures 6 to 10 show the number of agencies reporting support from a major source of funds according to the proportion received from that source. Eleven out of 17 agencies received less than 30 percent of their income from clients. Eleven out of 14 agencies received 20 percent or less of their income

FIGURE 7
Number of Agencies* According To Proportion of Support By Type of Funding
United Fund and CICHA



*Hospitals are not included

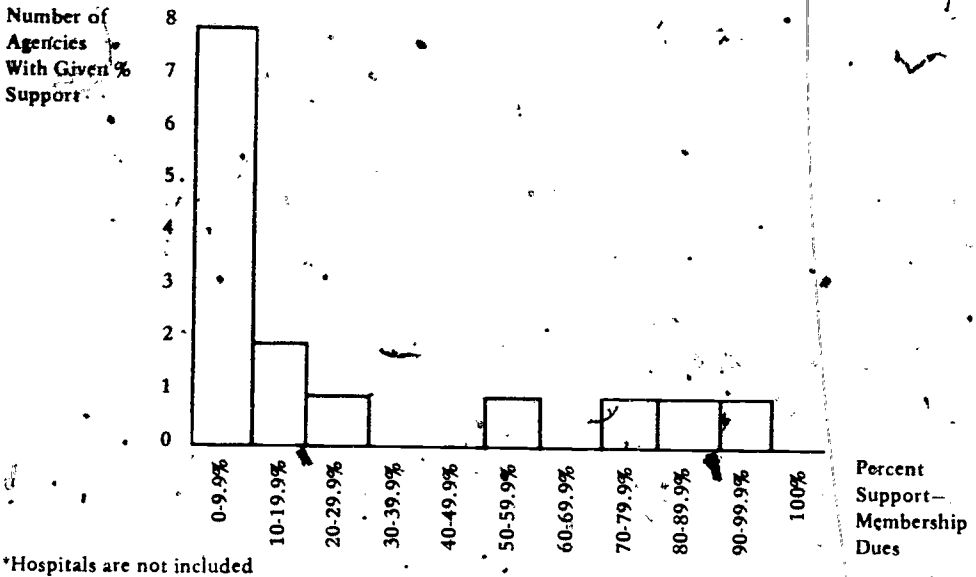
FIGURE 8
Number of Agencies* According To Proportion of Support By Type of Funding
Client Fees



*Hospitals are not included

from membership dues and fees. One agency reported 85 percent of its income from fund-raising projects, while 17 out of 19 agencies received less than 60 percent of their income from fund-raising projects. While two agencies received 90 to 99 percent of their income from the United Fund and CICHA, nine out of 15 received less than 30 percent of their income from these sources. While one agency reported 90 percent support from

FIGURE 9
Number of Agencies* According To Proportion of Support By Type of Funding
Membership Dues



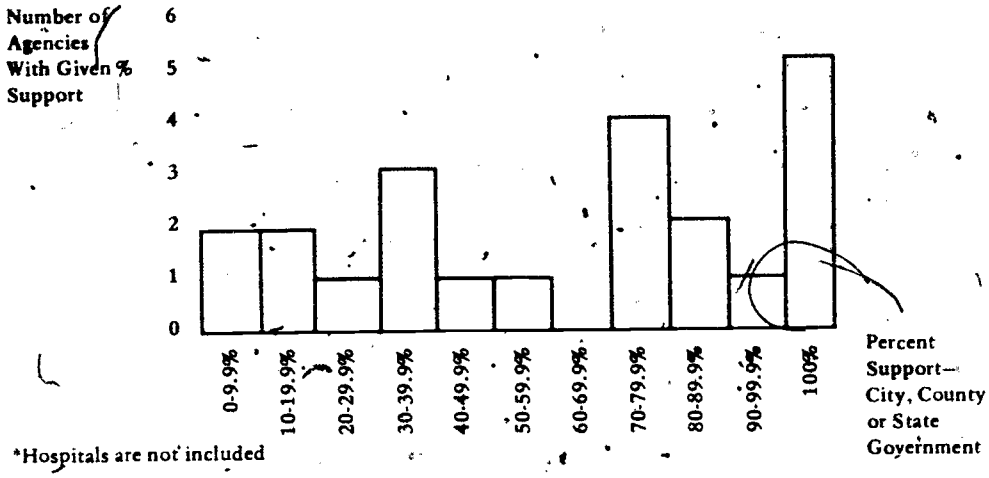
*Hospitals are not included

foundations and religious institutions, seven out of eight reported 15 percent or less. The 22 agencies reporting income from city, county or State government were scattered throughout the range. Three agencies reported income from the Federal Government, one receiving as much as 25 percent.

Comparing the proportion of income from each source estimated for 1973 with the 1972 income, agencies estimated slight increases in proportion of income from membership dues and fees and an increased proportion of income from foundations and religious institutions. On the average, agencies estimated a smaller proportion of income from fund-raising projects in 1973.

Of the agencies responding, city, county and State governments provided the majority of income for the largest number of agencies. Decrease in funding from these sources would have a dire effect upon agency activities.

FIGURE 10
Number of Agencies* According To Proportion of Support By Type of Funding
City, County or State Government



*Hospitals are not included

CHILD DEVELOPMENT SERVICES IN MARYLAND HOSPITALS*

This pediatric study addresses itself to medical problems that have important consequences in child development. These include: mental retardation, cerebral palsy, seizures, lead poisoning, failure to thrive, speech defects, and multiple congenital handicaps. Allied health personnel who provide child development services to children with these problems include: clinical psychologists, physical therapists, social workers, nutritionists,

*In cooperation with the Maryland Chapter of the Academy of Pediatrics. Detailed questionnaires about policies, procedures and personnel were completed by 42 out of 44 hospitals serving children in Maryland.

audiologists and ophthoptists. Some hospitals have teams made up of physicians and allied health professionals to serve children with behavior problems.

Whether a hospital plans services for these children or employs these professionals is related to the size of the hospital. Major medical centers are more likely to include child development personnel for these special groups of children. Table 37 lists problems which require these services and compares the number of small hospitals that request referrals of children with these problems with the number of larger hospitals requesting referrals of such children. Of 19 small hospitals, only two indicated interest in receiving more referrals of children with seizures or with failure to thrive, and only one showed interest in more referrals of children with speech defects. Two of the smaller hospitals desired more referrals of children with multiple congenital handicaps.

TABLE 37
Numbers of Large and Small Hospitals in Maryland Requesting More Referrals of Children With Conditions Requiring Child Development Services

	Large or Specialized Hospitals	Small General Hospitals	Total
Number Of Hospitals In Group	23	19	42
Conditions			
Mental Retardation	8	0	8
Cerebral Palsy	5	0	5
Seizures	8	2	10
Lead Poisoning	6	0	6
Failure to Thrive	12	2	14
Multiple Congenital Handicaps	6	2	8
Speech Defects	1	1	2

Table 38 shows the number of large and small hospitals that employ allied health personnel for child development services. Physical therapists are available in 27 hospitals, nutritionists in 34, and social workers in 19. Among the 19 small hospitals, 13 employ nutritionists and 11 employ physical therapists. None of the small hospitals provides ambulatory services designed for children with behavior problems.

We may infer from these figures that small hospitals are less likely to provide child development services. They define their roles more specifically in the service of children who are acutely ill or injured. When child development services are related to a medical problem, families that ordinarily use small hospitals must be referred to larger medical centers. These medical centers show marked differences in their readiness to manage

TABLE 38
Numbers of Large and Small Hospitals That Employ Allied Health Professionals

	Large and Specialized Hospitals	Small General Hospitals	Total
Number of Hospitals in Group	23	19	42
Allied Health Professionals			
Clinical Psychologist	6	3	9
Physical Therapist	16	11	27
Social Worker	15	4	19
Nutritionist	21	13	34
Audiologist	12	2	14
Team Serving Children with Behavior Problems	13	0	13

problems with social and emotional components and in their staffing of allied health professionals.

Outreach

Although the characteristic role of hospitals does not include outreach, one hospital provides transportation of children to the hospital for services and also gives services in the child's home.

TABLE 39
Child Development Services For One Year By Six Primary-Care General Hospitals

	No. of Families Served
Education of Parents	
Family planning	1,660
Childbirth education	1,470
Nutrition	1,651
Child Rearing General	369
Health care	1,605
Cognitive stimulation	312
Behavior problems	319
Health Services	
Genetic diagnosis and counseling	770
Family planning services	476
Prenatal care	609
Child health supervision	995
Pregnancy interruption	178
Counseling	
Child protection	124
Marital problems	318
Family emotional problems	271

Primary-Care Hospitals Giving Perinatal Services

Perinatal services are basic in the prevention of a broad range of child development problems. They include: pregnancy interruption, family planning, education in family planning for medical services, childbirth, nutrition, genetic diagnosis and counseling, and prenatal care. Five general hospitals reported the number of these services given by place of residence. It is noteworthy that patients coming to Memorial Hospital in Cumberland and to the Sacred Heart Hospital in Cumberland were all from Allegany County. Those coming to Church Home and Hospital in Baltimore were all from Baltimore City. Those coming to Holy Cross and Washington Sanitarium were from both Montgomery County and Prince George's County. These hospitals are relatively small compared with the large perinatal service of The John Hopkins Hospital, Baltimore City Hospitals, University of Maryland Hospital and Sinai Hospital. The pattern of these services can be seen in Table 39. Only one of three small general community-oriented hospitals provides genetic counseling services which require highly specialized personnel.

Chapter XV

Summary Recommendation—The Need For A Coordinating Structure

The State Plan as a document presenting a single major conclusion: The need for an interagency structure with parent and citizen participation, as well as a statewide network for the coordination of comprehensive child development services.

The current child development scene in Maryland—as documented in this Plan—illustrates to a marked degree the effects of piecemeal, unilateral, uncoordinated policy planning. Sufficient documentation is presented to verify that Maryland does not have an overall policy for its children and that there is much unmet need for services embracing the various components of health, social services and education. The cost of operating programs is unknown, as is their efficiency. No one knows; for example, the cost to the State of licensing a day care center, much less the total dollars being expended on children's programs and services.

During the course of this study we found many excellent programs in Maryland designed to meet the emotional, physical and educational needs of children. Some are very successful. Many, however, fail to reach a large number of children who could benefit from these services. A number are dependent upon uncertain funding, which is damaging to morale and which creates dissension among competing agencies. In the final analysis, if comprehensive services to children are to be effective, they must be both *accessible* and *continuing*.

We also identified and worked with a large cadre of multidisciplinary professionals and citizens greatly interested in collaborating to meet more effectively the comprehensive needs of Maryland's children. The production of this Plan was a challenging learning experience for the hundreds involved.

Ample evidence was found to document that the present fragmented delivery system stimulates the continuation of *unilateral* planning for specific programs. There is little, and often a lack of, joint planning across agency lines. Compilation and dissemination of essential planning data are inadequate. The availability, sources and amounts of funds for children's services also lack sustained attention. Such inadequacies deny agencies the opportunity to develop a mutually shared policy for children, including the identification of and the priorities essential for the particular populations most in need.

These findings, which are based on 10 months work, prompt a single, major conclusion: the need for a coordinating structure. At present there is no single, formal structure in Maryland which provides the various segments of this complex service delivery network the opportunity for regular exchange of information for the purpose of coordination and planning. There is an absence of a reliable information base upon which to make sound judgments on unmet needs for planning purposes. Little is known about the role of voluntary agencies as their services relate to programs offered by public agencies! Unilateral planning leads to competition for funds and even to competition for clients.

A most critical issue is the absence of a funded structure having both the authority and the capacity (funding and staff) to pull together the various sections of this splintered system through *coordination*.

Fragmentation of the administrative and delivery systems, as reported in previous chapters, is a major cause of dissatisfaction among both providers and recipients of services for young children. Three departments (Education, Health and Mental Hygiene, and Employment and Social Services) have the major responsibilities for children's programs. Within these three agencies, there are 12 major divisions, each, in turn, having a number of subdivisions responsible for certain services. Additionally, each of these State agencies has counterparts in the 24 political subdivisions of the State. Numerous statutes, sometimes conflicting or unclear, passed at various times and subject to frequent amendment, provide the authority for the delivery systems. The mutual interests of these three departments are obvious. Each offers services based on a range of specialized disciplines, which, in combination, serve the needs of the "whole" child and his family.

To bring coordination to the dispersed delivery system, consideration was given to a *vertical organization* such as a Department of Children's Services. Such a department would include the interests of older children as well, because the same scattered distribution of services exists for them. Such a department or office would focus on the State's concern for children and could lead to a hierarchy of priority considerations which now are diffused.

A vertical structure has its own problems, however, in its relationships

to the varied programs provided by existing major agencies, such as the handling of income maintenance and the integration of adult/family services. Not the least of the difficulties would be the radical departure from present government structure. It is important that any further action should *simplify* the delivery of services rather than compound the process. Further study of the merits of a single department is needed before serious consideration of this approach can be recommended.

Immediate attention should be directed both to more realistic planning for the future and to fuller coordination and utilization of existing Maryland resources. The following are recommended for carrying out better planning coordination.

Recommendations:

- A council (structure) including representatives of several groups–government agencies that deliver children's services, organizations outside government with primary interest in children, and parent groups–should be charged with coordination and planning of children's services. This council should have statewide representation and should meet regularly. It should discuss the content and the administration of existing and proposed services for children and should disseminate information about these services. It also should coordinate and periodically review the development of a comprehensive plan for children's services. Each review should include the assignment or ratification of priorities for the enhancement of existing programs and for the initiation of new programs. This council should facilitate the implementation of the plan and make recommendations as necessary.

- In addition to the State-level coordinating structure there should be local (county or multi-county) groups similar in structure to the umbrella State body. Each local group should be represented on the statewide body. Local groups would coordinate the planning and the implementation of services for children at the local level as well as generate recommendations for statewide action as indicated by local needs.

- The coordinating structure, comprising both State and local groups, should be established by statute and should be located administratively in an agency that does not provide direct services for children. Effective coordination, more effective delivery of services and the elimination of duplicated effort (cost reduction) are so essential that they require special consideration. If large-scale service systems are to be the responsibility of government, then coordination and planning to make these programs efficient and effective are the responsibility of government. The coordinating mechanism should avoid any possibility of one agency establishing a position of dominance over all others. It is unfair to expect an

agency to be responsible not only for its own internal coordination but also for the activities of its peers. The seeds of non-effectiveness are inherent in such a proposal. Effective coordination depends on having a mutually accepted structure capable of relating to all levels of all agencies as well as to their systems of service delivery. Few can tolerate the paradox of living within a "first among equals" structure.

- The Secretaries and Superintendent of the agencies having departments serving children should contribute continuously to one comprehensive plan for children's services until they are able to adopt formally a single, unified plan. This plan should then be reviewed regularly in advance of acceptance of new funds and programs in order to insure continuous coordination of changes in the service delivery system. The chiefs of the agencies have the responsibility for responding to recommendations made by the coordinating structure with respect to the State Plan. The coordinating structure should have the responsibility to present quarterly its recommendations for policy consideration to the top decision makers and, when appropriate, to the Governor. Effective coordination of children's services will need to involve *all* levels of Maryland's government.

The above recommendations are interrelated. It is characteristic of citizen groups that have official status in government to wish to assume a policy role. Citizen groups cannot adopt policy because there is no way of assuring that they are representative, and they have no legal accountability. If, however, at the request of government, citizens give their time and best efforts on behalf of their fellow citizens–young children in this instance–access to decision makers should be assured. Citizens should know that their views will be heard, if not always agreed to, by those with authority to act.

In recent years, a few states have established offices of child development by legislative action. Several other states have designated a coordinating office or structure by Executive Order. Maryland has an Executive Order naming an Interagency Committee on Childhood Development located within the Department of Employment and Social Services. The Maryland 4-C Committee and consultants from the Office of Child Development, Region III, HEW, believe that a coordinating structure located in an agency that is a direct provider of services to children is not likely to be effective because it cannot provide the objective meeting ground necessary for the full cooperation of the other agencies involved.

The preparation of this State Plan and its major recommendation, as well as the subsidiary recommendations throughout the document, represents the best thinking on the part of many hundreds of Marylanders, including service delivery staff in the State Departments of Health and Mental Hygiene, Employment and Social Services, and Education; the local 4-C Councils in the political subdivisions; a large segment of the statewide

Advisory Council to the 4-C; and many others consulted for expert opinion.

In summary, this document represents the first phase of a statewide comprehensive child development plan. It is Maryland's first concerted effort to pull together and analyze statistics and program information from a wide variety of sources pertaining to comprehensive child development services for the State's young children and their families. It includes:

1. The best available statistical information on Maryland's children and their families, including population and demographic trends, income, health and social services, out-of-home care programs, etc.
2. A definition of comprehensive child care and child development and the identification of services that are required to meet that definition.
3. A description of the complex organizational structure (legal base) through which public programs and services are provided for young children and their families.
4. A review of the various licensing statutes and regulations for out-of-home child care with recommendations for an improved system.
5. Factual information pertaining to major child development programs and services including group and family day care, health and social services, educational programs, nutrition, child abuse, etc. as well as recommendations for their improvement and expansion.
6. Priorities of needs for programs and services as expressed by the county 4-C Councils and the Baltimore City 4-C Council.
7. An initial effort to ascertain the amount and source of Federal grants-in-aid for children's services and their allocation by program and political subdivision.
8. A discussion of the status of training for child care, child development and early childhood education personnel with a series of recommendations urging continued attention to this prime underpinning for improved programs and services for children.
9. Findings based on a first attempt to ascertain from voluntary agencies and hospitals the volume, nature and scope of the child development services they provide.
10. An annotated list of major studies published in the last 10 years pertaining to Maryland's children.
11. The presentation of a single major conclusion for an interagency structure with parent and citizen participation, as well as a statewide network for the coordination of comprehensive child development services.

Chapter XVI

Child Development Publications and Library Facilities

The State Plan as a review of Maryland studies and reports relating to children and recommendations for their availability.

Major studies and reports pertaining to Maryland's children published within the last ten years are listed. Recommendations and observations pertinent to comprehensive services for children ages 0-6 and their families are noted.

Adoption Services in Maryland, Health and Welfare Council of Central Maryland, Inc., April 1973, 58 pages.

Major in-depth study of adoption services in the State with data compiled from surveys, interviews, records of public and private agencies. There are specific recommendations affecting delivery of services and implementation as well as trends for the future.

Allen, Rebecca B., *Family Day Care as Observed in Licensed Homes in Montgomery County, Maryland*, 1971, 37 pages, mimeo.

This study was conducted in Montgomery County to determine whether care offered in family day care homes is adequate in quality and what can be done to ensure high-quality care. From data collected in day care homes, the relative merits and disadvantages of family day care and group day care are summarized. Recommendations include counseling service for working parents, consultants to assist day care mothers and training for family day care mothers.

Bibliography for Regional Health Planning, Regional Planning Council, Baltimore, May 1969, 48 pages.

Recently published reports, studies, guides and proposals relative to health planning in the Baltimore Region. Child care resources are listed.

Child Care Workers in Baltimore . . . Training and Jobs, Health and Welfare Council of the Baltimore Area, Inc., 1969, 27 pages.

Report of a one-year project to provide training for 100 persons for child care work in the Baltimore area. Purpose of the project is explained along with problems encountered, results and recommendations.

Childhood Resources, Inc., *A Model for the Nation . . . Child Care and Early Learning at Columbia, Maryland*, September 1971, 149 pages.

A comprehensive study of child care and early learning, 1971 through 1981, prepared for the Columbia, Maryland Board of Early Childhood. Background notes summarize the importance of early childhood and the needs of young children. Current programs in Columbia are reviewed in terms of organization, operation, staff recruitment and training, parent education. There is a critique on present facilities and a summary of expenditures including cost comparisons. Survey data give a demographic profile, collection results and indications of program needs. Recommendations and rationale are given for comprehensive services, training and demonstration centers, family life education, staff development, coordination, operational costs and future directions.

Children . . . Our First Priority, Conference sponsored by the University of Maryland and the State Department of Education, May 1973, 91 pages.

Report of the third annual conference with manuscripts of major speakers on Human Relations, Who Speaks for Children? and Developing Full Human Potential. In-depth discussion groups are reported on Trends in Evaluation, the Legislative Process. Values and Attitudes, and Trends in Research. Also included are summaries of numerous mini-workshops.

Comprehensive Health Plan for the State of Maryland–Health Facilities and Services, Maryland Comprehensive Health Planning Agency, Baltimore, Maryland, July 1973, 238 pages.

This Plan sets forth certain principles, goals and policies applicable to the planning and development of health facilities in Maryland and presents some guidelines for the health planning process. Included are data, from both public and private sectors, useful in the planning of health facilities and services with suggested sources of additional information. Analysis highlights significant situations and trends in Maryland's health care system. The Plan deals with the entire spectrum of personal health care services and their associated facilities, incorporating a "levels-of-care" approach and stressing

the development of a coordinated health system responsive to the community.

Continuum of Learning: 0 through 6, Conference sponsored by the University of Maryland and the State Department of Education, May 1972, 40 pages.

Second annual conference report with manuscripts of presentations on Continuum of Learning, Appalachian Family Aide Program, and Implications of the Naturality of Language Learning. Work sessions include: Infant Education, Implications of Movement Activity, Research on Young Children in Naturalistic Settings, and Individualized Learning in First Grade.

Cost Benefits of Three Types of Day Care in Maryland, Report by Abt Associates Inc. for the Department of Employment and Social Services, April 1974.

This report was requested by the 1973 Maryland General Assembly to "study all aspects of the delivery of Day Care services to the poor toward achieving a balance between program and unit cost which would indicate a desirable emphasis and plan for the delivery of Day Care services within current resources." Included are data, analysis, and evaluation of a survey of all State-operated day care centers, all purchase of group care, and a sample of family day care homes to enable the Department and the Legislature to choose the particular type of service or mix most effective and feasible.

Day Care for Children . . . a Preventive Service, Governor's Commission to Study Day Care Services for Children and the State Department of Public Welfare, 1963, 96 pages.

The proceedings of Maryland's first statewide Conference on Day Care Services for children, in which more than 800 lay and professional community members participated. The focus was on education of the entire community with no specific action recommendations from the Conference as a whole. This document reproduces in full the formal papers presented at general sessions and gives detailed summary reports of 12 group sessions, including a Perspective on the Child (Infant and Toddler, Preschool Age, School Age) and a Perspective on the Community (Role of Day Care in Strengthening Family Life). Panel members of each group included over 60 national and State leaders in fields of early childhood, health, education, child care, social services, government and law.

Day Care Needs in Maryland, Report by the Health and Welfare Council of the Baltimore Area, Inc. for the Governor's Commission to Study Day Care Services for Children, October 1964, 60 pages.

A study of the day care needs of children in Maryland including a definition of terms and a brief history of day care. Existing facilities and costs, standards, licensing procedures, supervision and relationships of existing agencies are summarized. Efforts to develop, establish and improve day care in the State are noted. Some specific recommendations: high-level cooperation between State and local departments of health, education and welfare; upgrading standards; clarification and strengthening of departmental responsibility; development of training opportunities; establishment of need priority; joint activities of health, education, social services and voluntary agencies; expansion of services; public financing of day care development.

Directory of Community Services in Maryland, 14th edition, Health and Welfare Council of Central Maryland, Inc., 1972, 318 pages.

This directory of more than 1,700 agencies and organizations is intended to assist all persons concerned with the needs of people to find the services that match the problem. Included are a limited number of hospitals as well as proprietary day care centers which are approved for purchase of care. Also included are listings for health, welfare, education, library, recreation, employment, court, corrections, police and planning services.

Edds, Rachel, *Day Care in Baltimore*, draft for Baltimore Community Renewal Program, Department of Planning, February 1973, 28 pages.

This monograph supplies data on child care in Baltimore City including data by census tract. Needs are examined for children under 2 years, 2 to 5 years, and before- and after-school care for children 6 to 12 years. With supporting tables and illustrations, it analyzes the demand for day care, supply of child care, existing day care centers, child care deficiencies, characteristics of areas with high demand. Descriptions and costs of child care centers and family day care are included along with a schedule of City action to provide day care for low-income children in 1983.

Fourth Annual Report, Maryland Food Committee, Inc., June 1973, 7 pages.

The report includes background information on the Maryland Food Committee, causes of "hidden hunger," and statistics on under-nutrition among infants and children in Maryland. Some results of the Committee's Pilot Iron-Fortified Infant Formula Program are reported as well as the progress and problems involved in making sure that poor people have access to federally-funded feeding programs. A financial statement is included.

Guidelines for Early Childhood Education, Maryland State Department of Education, September 1972, 48 pages.

The importance, goals and need for family and community involvement in early childhood education are reviewed in a bulletin with many attractive photographs. There are excellent summaries of factors to be considered in planning an early childhood program: the child, physical facilities, staff, curriculum, grouping, scheduling, evaluation. Appropriate procedures are given for initiating or modifying programs. Also included are recommendations for the use of these guidelines, which were developed cooperatively by State and local representatives and adopted by the State Board of Education for the development of early childhood programs in each subdivision.

Guidelines for Planning the Kindergarten Program, Maryland State Department of Education, December 1970, 37 pages.

State Department of Education standards for planning kindergarten programs. Guidelines cover: staffing, curriculum, facilities, materials, equipment, transportation, parent involvement and evaluation.

Howard, Margaret W., *How to Start a Day Care Center in Montgomery County*, Montgomery County 4-C Council, June 1973, 29 pages.

This pamphlet gives step-by-step procedure to assess the need, get licensing, and start operation of a day care center in Montgomery County. Information on State and County requirements for zoning, licensing and staffing is included as well as budget and legal considerations.

Incidents of Suspected Child Abuse in Maryland . . . January 1 to December 31, 1971, Department of Employment and Social Services, July 1972, 26 pages.

This report of the incidence of child abuse is not a measure of the extent of this problem but reflects the characteristics of families involved.

Interim Report on Food Needs of Children in Day Care in Maryland, Maryland Food Committee, Inc., April 1972, 11 pages.

Concerned about the quality and quantity of food available to children in day care in the State, the Maryland Food Committee conducted a survey to determine the food needs of day care centers. This report includes data on types of centers serving food, costs of meals served and total costs per child per day, sources of funding, and centers needing help with food costs. It is urged that any future planning include adequate funds for food for young children.

John Howard Association, *Comprehensive Long-Range Master Plan*, Department of Juvenile Services, State of Maryland, May 1972, 190 pages and appendices.

A survey and consultation report in response to a legislative mandate to develop an overall long-range master plan including departmental goals, objectives, needed programs, program performance measurements, and a time schedule for implementation and financing. The report covers areas of prevention, treatment and control of juvenile delinquency with evaluation of present operations in order to provide a sound basis for recommendations for the future. Attention is given to related services and other programs which have an important bearing on the volume of juvenile referrals.

Jones, Cynthia, *A Plan for the Children of Maryland*, The Maryland Council of Parent Participation Nursery Schools, Inc., February 1972, 29 pages, mimeo.

This study focuses on ways of reaching the most young children at the least cost with the emphasis on reaching parents as the most effective way to improve the quality of child care. Three existing programs in Maryland for children 0 to 3 years and their parents are discussed. Innovative programs for children 3 to 5 years and their parents are suggested along with costs of existing programs. Methods of training are urged to increase the effectiveness of cooperation between parent and professional. Also included are a discussion of standards, budget priorities, criticism of the DESS Kirschner Report, suggested first steps, and a bibliography.

Kindergarten, Early Childhood Conference sponsored by the University of Maryland and the Maryland State Department of Education, May 1971, 44 pages.

Manuscripts by State and national leaders at this conference include 11 kindergarten-related subjects, including: Priorities for the Five-Year-Old, What Research Says About Young Children, Parent Involvement, Staffing, Curriculum, Facilities, Learning.

Kirschner Associates, Inc., *Day Care in Maryland... A Study of Child Development Needs and Resources*, Maryland State Department of Employment and Social Services, March 1972, 82 pages and appendix.

This study was contracted to develop a data base for planning and expansion of day care services in Maryland. Specific objectives included: determination of number and types of day care facilities, characteristics of these facilities (enrollment, staff, equipment), determination of basic agencies responsible for the organization and administration of day care, recommendations for future planning and administration of day care. This is not an evaluative study but an effort to identify and describe the current status of day care in the State. Data and information were gathered from three major sources: State and county agencies, all licensed day care facilities in the State (centers and homes) and public school programs, six meetings

across the State with State and local representatives of day care organizations.

Levy, Judy (ed.), *Directory of Services for Handicapped Children*, John F. Kennedy Institute for Rehabilitation of the Mentally and Physically Handicapped Child, 1973, 102 pages.

A listing of services in Maryland for children, adolescents and young adults with physical, mental and emotional handicaps, other special health conditions and learning problems.

Mandate for Action, Report from the Task Force on the Non-Retarded Developmentally Disabled, Department of Health and Mental Hygiene of State of Maryland, June 1973, 68 pages.

Summaries of a series of regional hearings to fulfill a legislative mandate to define "non-retarded developmentally disabled" and identify the unmet needs of this group. Noting that not a single need area in this field is now adequately met, the Task Force makes recommendations for programs, funding and administration. A summary of major findings is quoted from a New York State study with residential models and costs.

Maryland 4-C Committee, *Critique . . . Analysis of Day Care in Maryland*, January 1973, 15 pages, mimeo.

A critical evaluation of the Kirschner Associates Report–*Day Care in Maryland . . . A Study of Child Development Needs and Resources*–with a narrative discussion of findings and inconsistencies in relation to recommendations made in the 1972 report.

Maryland Standards for Nonpublic Nursery Schools and Kindergartens, Maryland State Department of Education, October 1972.

Bylaw 912:2 adopted by the Maryland State Board of Education on May 31, 1972. Regulation includes a statement of purpose, philosophy and objectives, personnel, instructional programs, administration, physical facilities and equipment, finances, health and safety.

Maryland State Comprehensive Plan for Community Mental Health Services, State Board of Health and Mental Hygiene, 1965, 175 pages.

A section on "Services for Children and Adolescents" (pages 40-49) includes a discussion of existing services for preschool children and recommendations based on needs to be filled and evolving comprehensive community programs. There is an annotated bibliography of conference reports and papers published in Maryland from 1955 to 1965 pertinent to comprehensive mental health services.

Miller, Ann, and Marion D. Persons, *Report of Resident Working Mothers and the Day Care of Their Children in Baltimore City in 1964*, Division of Child Day Care, Baltimore City Health Department, January 5, 1965, 15 pages.

This survey made in Baltimore City during the summer of 1964 shows the number of families using day care, distribution of working mothers and licensed day care facilities, type of care used. Interviews classify care as adequate, inadequate and questionable; recommendations include more space for day care and joint planning for centers by Health and Welfare Departments.

Regulations Governing Group Day Care Centers 10.02.01, Maryland State Department of Health and Mental Hygiene, 22 pages.

Regulations effective December 1, 1971 . . . includes licensing policy and procedure, space requirements, safety and sanitation, food service, health, staff, program, equipment, and records.

Standards for Family Day Care Licensing and the Family Day Care Law, Maryland State Department of Employment and Social Services, 9 pages, 1966.

Copy of Section 32A, Article 88A, Annotated Code of Maryland–the Family Day Care Licensing Act and Rules and Regulations for Family Day Care Licensing.

These Are Your Children, a report of the Citizens Health Council on Chidren's Needs, Regional Planning Council, Baltimore, Maryland, January 1974, 35 pages.

This working document is under study by the RPC. It provides a baseline and direction for future planning as well as criteria and guidelines for review of proposals dealing with emotionally-disturbed children. While it focuses on needs of emotionally-disturbed children and adolescents, the report speaks for *all* children in the region. Problem areas are outlined and recommendations made. Included are a report on the Maryland Data System for the Handicapped and a summary of the State Department of Education's programs and plans for handicapped children.

Three Year Program Plan, Preventive Medicine Administration, Maryland State Department of Health and Mental Hygiene, 1973, 28 pages.

This plan includes background material on the six major programs within the Administration, their program priorities and objectives. Of special interest are sections on Maternal and Child Health and Dental Services.

Current programs to be expanded are Child Day Care and Family Planning. New programs include Comprehensive Child Health Services for Southern Maryland with cost implications and time schedule.

Training for Child Care . . . Suggested Content for Minimum Training Requirements, Maryland 4-C Committee, Inc., August 1972, 32 pages.

A summary, compiled by the 4-C Training Committee, of qualifications for personnel in early childhood programs as required by State Departments of Health and Mental Hygiene, Education, Employment and Social Services. In addition, there are five curriculum guides for training personnel who need 64 classroom hours in early childhood education to meet regulations of Maryland State Department of Health and Mental Hygiene governing group day care centers. Interpretations of these regulations and suggested background reading are included.

Washington Center for Metropolitan Studies, *Population Characteristics Reflecting Needs for Day Care in Montgomery County*, Montgomery County 4-C Council, October 1973, 32 pages and appendix.

The report examines characteristics of the County's population which reflect needs for day care services and relates them to the availability and capacity of licensed day care facilities in the County . . . a start at building a factual basis necessary for more effective planning by the County 4-C Council, the County government, and other concerned groups. Detailed maps and tables are included to document who needs day care, changing needs, and recommended areas for further research.

AGENCY LIBRARIES

What Now Exists

At present each of the State agencies providing services to children maintains its own library. There is no central index or cross-reference file of related materials from the other State agencies. During the course of the preparation of this report it was found that a number of published studies and reports are not in the library of the agency that sponsored them. One librarian noted that the card file contained no reference to studies pertaining to young children published by that agency over the past 14 years. It appears that there is no policy requiring a copy of published studies and reports be sent to the agency library.

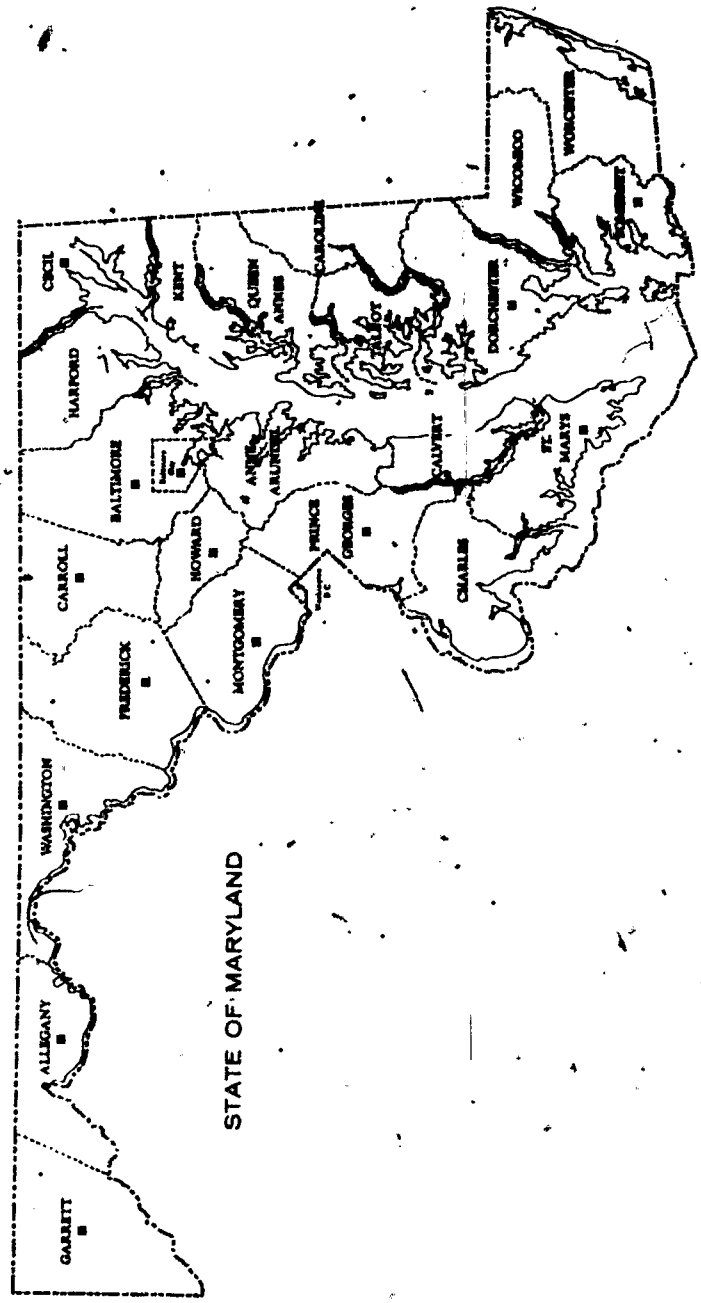
Recommendations:

- Consideration should be given to establishing a Central State Agency Library or, at least, a Central State Agency Index of all Maryland studies.

conference reports and papers pertaining to services to young children and their families.

- Each of the State agencies providing services to children should implement a policy requiring that reports and studies published under its auspice should be sent at time of publication to the Central Library or the Agency Library.
- There would be more potential use of available data and information if librarians at the Agency or Central Library issued an annual annotated listing of new acquisitions.

Appendices



■ Locations of Local 4-C Councils

00257

CCCC
COMMUNITY COORDINATED CHILD CARE
MONTGOMERY COUNTY 4-C COUNCIL
14 South Perry St., Rockville, Md., 20850
telephone 301-279-1773

17 October 1973

To: Members of Policy Board

From: Jean Bryant, Chairman–4-C Council
Franc Balzer, Vice Chairman–4-C Council

Re: Development of needs and priorities for input into the Maryland State Comprehensive Child Development Plan

The Maryland State 4-C Committee has asked us to assess our County's un-met needs for children and families, then to contribute that data for use in a state-wide Comprehensive Child Development Plan.

Ten 4-C members will interview five selected county agencies/organizations using the questionnaire attached, thus providing input from 50 groups throughout the county.

We are sharing the questionnaire for your information, but even more importantly, because we need your own evaluation of the status of child care services in Montgomery County. Please communicate your ideas on the problems, as you see them, by filling in the questionnaire and sending it into the office.

Your response–by phone or in writing by Tuesday, October 23 will be greatly appreciated since we must prepare a report of all information received to take to a meeting of all counties in Maryland–early in November.

CCCC
COMMUNITY COORDINATED CHILD CARE

MONTGOMERY COUNTY 4-C COUNCIL
14 South Perry St. Rockville, Md., 20850
telephone 301-279-1773

17 October 1973

To: Representatives of Montgomery County Organizations or Agencies concerned with providing services to children 0-6 and their families

From: Jean Bryant, Chairman–4-C Council
Franc Balzer, Vice Chairman–4-C Council

Re: Development needs and priorities for input into the Maryland State Comprehensive Child Development Plan

The Maryland State 4-C Committee has asked us to assess our county's un-met needs for children 0-6 and their families. Within the next week someone from the 4-C's will be calling you. In the meantime would you give these questions careful thought:

1. What is the major purpose of your organization/agency (particularly as it relates to children 0-6, and their families)?

2. In your experience, and that of others in your organization/agency, what would you say are the needs of children 0-6 and their families, that are *not being met* by existing public and private services?

3. In your experience, and that of others in your organization/agency, what would you say are the needs of those *providing* services to children 0-6 and their families, that are not being met by public and private agencies? (i.e. information clearinghouse, standard rules of eligibility, etc.)

4. Do you have any reports that substantiate your position?
   Yes _____ No _____
   If yes: Are these reports available?
   If no: How would you suggest this kind of factual information be gathered?

5. Would you have any recommendations about how such services should be funded?

6. Would you have any other comments you would like to make?

CCCC
COMMUNITY COORDINATED CHILD CARE

MONTGOMERY COUNTY 4-C COUNCIL
14 South Perry St. Rockville, Md., 20850
telephone 301-279-1773

Recorder: _____

Date: _____

Name: _____

Title: _____

Organization/Agency: _____

Address: _____

Office Phone: _____

Home Phone: _____

1. What is the major purpose of your organization/agency (particularly as it relates to children 0-6, and their families)?

2. In your experience, and that of others in your organization/agency, what would you say are the needs of children 0-6 and their families, that are *not being met* by existing public and private services?

3. In your experience, and that of others in your organization/agency, what would you say are the needs of those *providing* services to children 0-6 and their families, that are not being met by public and private agencies? (i.e. information clearinghouse, standard rules of eligibility, etc.)

2/15/74

CCCC
COMMUNITY COORDINATED CHILD CARE
MONTGOMERY COUNTY 4-C COUNCIL
14 South Perry St. Rockville, Md., 20850
telephone 301-279-1773

Needs and Priorities Questionnaire Page Two

4. Do you have any reports that substantiate your position?

Yes _____ No _____

If yes: Are these reports available?

If no: How would you suggest this kind of factual information be gathered?

5. Would you have any recommendations about how such services should be funded?

6. Would you have any other comments you would like to make?

2/15/74

MARYLAND 4-C COMMITTEE, INC.
COMMUNITY COORDINATED CHILD CARE
SURVEY OF
AGENCY & INSTITUTIONAL TRAINING/EDUCATIONAL PROGRAMS

The purpose of this survey is to identify existing and proposed pre-service and in-service training or educational programs for personnel in comprehensive child care services. Would you please:

1. Provide the information requested below as it pertains to your agency or institution. (Use the back of the survey if necessary).
2. Include data covering the period from September 1972 to September 1973 and projections for academic years 1974 and 1975.
3. Return in the enclosed self-addressed, stamped envelope by _____.

Thank you.

* * * * * * * *

Name of Agency/Institution

Address _____ Phone Number
Street

_____
City State Zip Code County

Your Name _____ Phone Number

Your Position _____

I. What training/educational programs do you offer in the field of comprehensive child development services? (Complete one section only—A, B, or C below).

A. Four-year college/university

Level	Major or Area	Field Experience Included		Number of Students			
				Enrolled	Completing		
		Yes	No		'73	'74	'75
1. Bachelor's							
2. Master's							
3. Advanced Graduate							
4. Doctoral							
5. Other (describe)							

B. Two-year college/post-secondary institution

1. Certification Program							
2. Degree Program (Occupational)							
3. Degree Program (Transfer)							
4. Degree Program (Transfer or Occupational)							
5. Other (describe)							

C. High School Programs

	Course(s)						
1. Home Economics							
2. Social Studies							

3. Health

4. Other (describe)

II. What short-term training/educational programs (e.g., workshops, institutes, etc.) do you offer in the field of comprehensive child development services?

A. Workshops, Institutes

Content Area and/or Title	Length of Workshop	No. of Times Offered Per Year	Number of Students			
			*Enrolled	Completing		
				'73	'74	'75

*Please give total numbers enrolled for the year (September 1972-1973)

B. Other short-term training opportunities

Area-Title	Numbers

III. What is the primary occupational goal for students in your program(s)? (See list below and circle those which apply)

01 head-teacher
02 teacher
03 teacher assistant
04 child development associate
05 community aide

06 work-study student
07 volunteer
08 pre-service student (high school, college, organizations)
10 resource people
11 home extension agent

12 homemaker
13 family aide
14 family day care mother
41 program coordinator
42 program director

31 nurse
51 social worker
52 psychologist
53 physician
54 psychiatrist

32 cook
55 assistant cook
33 dietician
34 bus driver
56 maintenance engineer

57 clerical
58 bookkeeper
61 secretary
62 receptionist
63 speech and hearing

64 therapist (play)
99 other (specify)

IV. If your program is two years or less, what are the educational prerequisites for the students (i.e. courses, experiences, etc.)?

Program	Prerequisites

V. What new training/educational program(s) are you anticipating in the future?

Title	No. of Students Expected	Year of Implementation	Job Categories of Students*

*See job category list—Question III, pp. 4-5

All respondents will receive a copy of the findings of this survey which will be mailed to the institutional address. We thank you for your cooperation.

9/73

MARYLAND 4-C COMMITTEE

SURVEY OF CHILD DEVELOPMENT SERVICES

FOR

CHILDREN AGES 0 TO 6 AND THEIR FAMILIES

To be completed by: Voluntary Agencies Serving Children Ages 0 to 6 and Their Families in Maryland

To be compiled by: Maryland 4-C Committee, Inc.
(Community Coordinated Child Care)
1123 North Eutaw Street – Suite 600
Baltimore, Maryland 21201
(301) 383-5620

Purpose of Survey: To estimate how many children ages 0 to 6 and their families received Child Development Services in Maryland

To describe service patterns within the State of Maryland

To facilitate informed planning of services to children ages 0 to 6 and their families

Name of Agency _____

Address _____

_____

_____
City County Zip Code

Telephone _____

Name of Person Completing Form _____

Title of Person Completing Form _____

TABLE I

SERVICES PROVIDED BY VOLUNTARY AGENCIES TO CHILDREN 0-6 AND THEIR FAMILIES IN MARYLAND COUNTIES

Please count the number of clients (children 0-8 years and their families) according to county of residence who received each of the Child Development Services listed in 1972*

Child Development Services for Children ages 0-6 and their Families only	Allegany	Anne Arundel	Baltimore City	Baltimore	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	St. Mary's	Somerset	Talbot	Washington	Wicomico	Worcester	Total	Percent of all Services **	Your fee for this Service	Average number of visits per year for child or family
1 Counseling																												
Child Protection																												
Marital Problems																												
Family Emotional Problems																												
Pregnancy Interruption																												
Play Therapy																												
Family Group Therapy																												
2 Education of Parents																												
Family Planning																												
Childbirth																												
Nutrition																												
Child Rearing																												
Health Care																												
Cognitive Stimulation																												
Behavior Problems																												
3 Education of Handicapped Children (0-8)																												
Aphasic																												
Blind																												
Cerebral Palsy																												
Deaf																												
Emotionally Disturbed																												
Retarded																												
Gifted																												
4 Health Services																												
Genetic Diagnosis and Counseling																												
Family Planning (Med. Serv.)																												
Prenatal Care, Obstetrical																												
Child Dentistry																												
Health Supervision Pediatric																												
Case Finding, Screening																												
Physical Therapy																												
Speech Therapy																												
5 Homemaker Services																												
6 Placement Services																												
Adoption																												
Child Protection																												
Foster Care																												
7 Residential Care																												
Handicapped Short Term (less than one month)																												
Handicapped Long Term (one month and more)																												
Non Handicapped Short Term																												
8 Other (Specify)																												
TOTAL COUNT OF ABOVE SERVICES ***																												
TOTAL NUMBER OF CLIENTS IN EACH COUNTY ****																												
PERCENTAGE OF RESIDENTS FROM EACH COUNTY *****																												
CHECK COUNTY WHERE YOU HAVE OFFICES																												

* A child receiving more than one kind of Child Development Service will be counted more than once

** If your agency does not count each service given to a client, please estimate the percent of clients using each service

*** Please add all the numbers listed in the above columns. This total may include several services for a given child

**** Count each child client only once

***** Please estimate the percentage of your clients from each county. Note: The row total should be 100

TABLE 2

ACCESSIBILITY OF SERVICES

Please check the appropriate category based on your general policies or experience.

DAYS OF WEEK	7 Day Week	5 – 6 days	Less than 5 days
You are open to answer calls			
You are open to provide services			

HOURS OF DAY	24 hours per day	Less than 24 hours but greater than 7 hours per day	Less than 7 hours
You are open to answer calls			
You are open to provide services			

What proportion of clients are in the following categories?

METHOD OF REACHING YOU	Referred to you	Seek you without referral	You locate by outreach methods	TOTAL
	_____ %	_____ %	_____ %	100%

INCOME	Receiving Public Support	Receiving or needing public subsidy	Families not needing public support or subsidy	
	_____ %	_____ %	_____ %	100%

PAYMENT	Free services	Partial fee	Full fee	
	_____ %	_____ %	_____ %	100%

FOLLOW-UP AFTER CONTACT	Contact but fail to receive service	Receive partial service	Receive full service	
	_____ %	_____ %	_____ %	100%

RACE	White race	Black race	Other	
	_____ %	_____ %	_____ %	100%

RESIDENCE	Reside within County of your Office(s)	Reside outside County but in State	Out of State	
	_____ %	_____ %	_____ %	100%

TRANSPORTATION	Receive transportation from you	Provide own transportation easily	Have difficulty arranging transportation	
	_____ %	_____ %	_____ %	100%

SITE OF SERVICE	Service given in client's home	Service given in Agency Office	Service given via telephone or other	
	_____ %	_____ %	_____ %	100%

If you serve a specific religious group please complete the following:

DENOMINATION _____	Specific eligible religious group	Other	
	_____ %	_____ %	100%

TABLE 3

SOURCES OF SUPPORT FOR CHILD DEVELOPMENT SERVICES

Please estimate percent of Total Income from each of these sources and state percent of Total and Predicted Incomes for 1972 and 1973.

	Percent of INCOME from each source 1972	Percent of ESTIMATED INCOME from each source 1973
Fees from clients	_____ %	_____ %
Fees and dues to members of your voluntary organization	_____ %	_____ %
Fund raising projects	_____ %	_____ %
United Fund and Combined Industry Appeal (CHICA)	_____ %	_____ %
Foundations and Religious Institutions	_____ %	_____ %
City or County Government and State Government	_____ %	_____ %
Federal Government	_____ %	_____ %
Percent of Total Budget Allocated for children and their families	_____ %	_____ %

VOLUNTARY SUPPORT

Please estimate contribution of volunteers to your program.

What percent of total volunteer man hours are given to the following:

Administration _____ %
Fund Raising _____ %
Direct Service to Clients* _____ %

*Children 0–6 and their families

ESTIMATE OF UNMET NEED

What proportion of children 0–6 years of age who are eligible for and in need of your services do you believe you reach? _____ %

If your operating budget were to be increased what service or services would be initiated or increased?