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ABSTRACT

This report contains suggestions for state level policy that move away from the deficit model of intervention and toward a policy of continuing support to all young children and their families. It includes information for evaluating programs and deals largely with methods of program implementation in four areas of early childhood: (1) education for parenthood, (2) health services, (3) day care, and (4) services to families with special needs (including families with handicapped children, teenage parents, or child abusing parents.) (JMB)

# The Role of the Family in Child Development

## Implications for State Policies and Programs



*Early Childhood Project*
*Report No. 15*

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*December 1975*

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# The Role of the Family in Child Development:

## Implications for State Policies and Programs

The fifteenth report of
The Education Commission of the States
Early Childhood Project

Education Commission of the States
Denver, Colorado 80203
Wendell H. Pierce, Executive Director

December 1975

*Additional copies of this report may be obtained for $3.50 from the Education Commission of the States, 300 Lincoln Tower, 1860 Lincoln Street, Denver, Colorado 80203, (303) 893-5200*

## FOREWORD

This report concerns the shaping of public policy at the state level in support of families and family life. It contains broad general principles to guide state action as well as suggestions for specific procedures and activities. It also includes guidelines for evaluating programs to determine whether they are indeed supportive of family structures and family living.

The principal author of the report, Bonnie Barrett Stretch, was a research associate with the early childhood project of the Education Commission of the States (ECS) until January 1975. John H. Niemeyer, president emeritus of the Bank Street College of Education and a member of the former ECS early childhood task force, assumed responsibility for the final editing of the manuscript. The report was guided in its development by the early childhood task force, which had among its membership some of the nation's most highly qualified and specialized experts in the area of early childhood.

Established in 1970, this advisory body has brought its expertise to bear on all of the major publications of the project, including this one, and has thereby caused these publications to be practical and creative, comprehensive and yet solidly grounded in theory. As a result of organizational changes within ECS, the task force was disbanded in October 1975.

While this report does reflect the cumulative insights of the task force, it does not necessarily represent in every aspect the professional opinions or personal beliefs of each of its members. We are grateful for the efforts that each member made to produce an accurate, substantive and comprehensive report.

The Education Commission of the States has long held a deep commitment to early childhood development. Insofar as the early years affect the later educational development of the individual—and there can be no doubt of their overriding importance in that regard—they form the foundation for the ultimate successes and failures of the educational system. Because ECS is vitally concerned with the success of the educational endeavor, we will maintain our commitment to enhancing those early years of development. This report is one expression of that commitment.

*Wendell H. Pierce*
*Executive Director*
*Education Commission of the States*

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# I. PUBLIC POLICY AND THE FAMILY

The family is the primary and most fundamental influence in a young child's development. During the first three years of life, a child's curiosity, social and motor skills, language abilities, sense of security, self-esteem, coping ability and moral values are burgeoning at a rate unequalled in subsequent years. Upon the successful development of these physical, emotional and cognitive processes depends much of a person's later capabilities and achievement. The kind and quality of care and guidance the young child receives during this period are therefore critical. Most of this care and guidance is usually in the hands of the child's family.

In effect, the family acts as a system for delivering to young children the educational and developmental stimulation and support that will critically influence their later lives. Yet our increasingly complex and changing society only partially acknowledges, in terms of practical support, the importance of this family role. At present, family services—including early health screening, family counseling, education for parenthood, preschooling, day care and homemaker and health aide services—are available in only a limited number of communities and usually only to families on welfare or otherwise deemed likely to require welfare assistance in the future.

Clearly, it is not only the poor, the handicapped or families in crisis that need support. There is much evidence that many parents and children of all socioeconomic backgrounds suffer from a degree of isolation unique to our modern, mobile society. Small families and our increasingly age-segregated communities often deny parents sufficient experience with children or the opportunity to learn child-rearing techniques from a variety of older persons. The informal supportive structures of the extended family and the stable community are being seriously eroded, and yet the society has not committed itself to providing similar supportive structures outside the family.

The cost of this lack of support is measurable in public dollars as well as in human toll. For example, 10 to 12 percent of the children in this country suffer from handicapping conditions that require some type of specialized service. Special education for handicapped children sometimes costs as much as 2.4 times the cost of a regular education program; institutionalization costs 5 times as much.[1] Yet, according to the report of the Joint Commission on Mental Health for Children, one-third of these handicapping conditions could be corrected or prevented by appropriate care in the preschool years. Until recently, however, identifying the needs of these children only when they enter the public school system at age 6 or older often came too late for effective intervention.[2]

## A. The Purpose of This Report

The purpose of this report is to offer helpful suggestions to states as to ways to move beyond the deficit model of intervention, which provides help only after a family crisis has occurred or a child's handicap requires special education programs. A coherent policy of continuing support to all young children and their families is needed if every child is to fulfill the potential with which he or she was born. The report draws on numerous examples of states already moving in this direction. The largest section of the report presents a range of program examples and methods of implementation in four major service areas—education for parenthood, health services, day care and services to families with special needs—areas directly affecting the family's child-rearing capability.

## B. A Sensitive Area

The concept of family support services remains one of great sensitivity, however. American praise for the institution of the family has long been accompanied by a hands-off policy. Attempts to support and guide the direction of family efforts in child-rearing can quickly raise fears for the sanctity of the family. Some persons and groups feel such efforts to be an intrusion into private life, bordering on socialism. Others fear the undermining of their cultural traditions and mores.

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[1] Handicapped Children's Education Project, *Financing Education Programs for Handicapped Children.* Regional Conference Highlights, Report No. 50 (Denver, Colo.: Education Commission of the States, 1974).

[2] Joint Commission on Mental Health of Children, *Crisis in Child Mental Health: Challenge for the 1970's* (New York: Harper and Row, 1970).

In many cases these are valid fears. Any program of aid to families must therefore clearly demonstrate its aim as support to parents in achieving more effectively their own goals for their children. *The goal of state-supported family and child services and programs discussed in this report is to increase the cohesiveness of the family and to encourage its independence in its child-rearing capacity.*

### C. Other Policy Considerations

While the emphasis of this report is on specific state-level actions to make better use of programs and policies that already exist, there are many important issues relating to the family and its needs in child-rearing that lie beyond these parameters. For example, states need to review the ways in which unemployment, welfare and housing practices affect family cohesion and viability. They need to examine laws and policies that influence business and industry practices affecting the family. And they should consider a continuing process to analyze the impact of government and other institutions on the quality of family life.[3]

Although these latter questions are beyond the scope of the main body of this report, they must form part of the background for any discussion of state policies toward young children and their families.

The family in the American social system has responded and adapted to the demands of business and industry and to the changing pressures and expectations of the larger society. This adaptability is, of course, an important source of vitality in the family's functioning on behalf of its members. It is equally true, however, that the demands for adaptability can be so great that critical family functions are seriously impaired. The need today is for conscious and consistent policies that will help strengthen the family, as well as give the family a new priority in state planning. *However, in no way does this report intend to suggest that the state should assume the major responsibility for the raising of children. That responsibility belongs properly and practically to the family.*

[3]Testimony by Edward Zigler, former director of the U.S. Office of Child Development and Urie Bronfenbrenner, professor, Cornell University, before the U.S. Senate Subcommittee on Children and Youth hearings on "American Families: Trends and Pressures," September 24-26, 1975. (Washington, D.C.: U.S. Government Printing Office).

## II. DEFINITION OF THE FAMILY

Families in America take many forms. The nuclear family of a married man and woman and their offspring is only one of many different arrangements. There remain variations of the extended family that may include grandparents, other relatives and close supportive friends. On the other hand, the high mobility of our society has left many families isolated and without sufficient support. Increased rates of divorce and the increasing numbers of unmarried mothers rearing their children have created unprecedented numbers of single-parent families. More fathers are receiving custody of the children in divorce cases. More mothers are working. More couples are living together and bearing children without being legally married.

Even federal agencies cannot agree on a definition of the family. The U.S. Bureau of Census defines the family as two or more persons related by blood, marriage or adoption, who reside together. The Family Assistance Plan includes in its definition all relatives living in the home with children. The food stamp program is addressed to households, which may include unrelated as well as related persons.

Family arrangements are increasingly varied. Each form has its own strengths and weaknesses, and each is capable, under favorable circumstances, of providing a cohesive, warm, supportive environment for the healthy development of children.

Since this report deals with child-rearing aspects of the family, the term "family" will be used here to refer to any adult arrangement that has as one of its functions the nurturing of an infant or a young child. By the same token, the term "parent" refers to any adult who has assumed responsibility for the physical, psychological, emotional and educational nurture, as well as proper protection, of a child. Often this is the biological mother; sometimes it is the father, a grandmother, an aunt or other relative. It could be a so-called fictive relative—someone personally close to the child but unrelated biologically or legally.

The close relationship of the married couple nurturing their own biological offspring is deeply engrained in our traditions, and the family thus constituted continues to be our basic social unit. Such broad definitions of family and parent as those suggested above must be taken seriously however, for they are necessary for an understanding of our changing and varied society. The aim of state programs must be to help families build on their strengths, not to penalize them for their weaknesses or their unconventionality.

## III. THE NEED FOR STATES TO PROVIDE SERVICES FOR PARENTS WITH YOUNG CHILDREN

Two assumptions have pervaded American attitudes toward families and child-rearing: (1) that the ability to raise children wisely is a natural talent possessed by most parents and (2) that child-rearing is always a joyful, positive experience. Partly as a result of these beliefs, no coherent policy of continuous family service has been developed in this country. Yet there is growing evidence that neither of these assumptions is entirely true. While raising children is one of the most rewarding of human experiences, with many joyful moments, it is also one of the most demanding.

Data gathered during the last two decades indicate that, for most couples, child-rearing is a seriously stressful experience—economically, emotionally and psychologically. For example, a study of 46 couples done by E. E. LeMasters, professor of Social Work and Sociology at the University of Wisconsin, reported a "general disenchantment with the parental role" expressed by many of these young parents after the birth of their first child. The couples were college-educated and in middle-class occupations, and most of them not only wanted but planned for the child. None were having unusual economic, psychological, emotional or physical difficulties. Yet 83 percent of this group declared they had experienced "severe crisis" in adjusting to the effects of the newborn on their lives. "Practically nothing in school or out of school got (these couples) ready to be fathers and mothers—*husbands* and *wives*, yes, but not *parents*," declared LeMasters in the conclusion to his study.[1]

The responsibilities and skills required in caring for young children too often take young parents by surprise. Guiding the development of a young child from helpless infant to mature adult is a complex and unrelenting task, and the pleasures of having children can be overshadowed by feelings of inadequacy, insecurity concerning child-rearing methods and lack of outside resources for advice, support, help and temporary relief from the continuous responsibilities of parenthood.

Furthermore, children are expensive. A recent study by the Commission on Population Growth and the American Future estimated that the cost of raising one child in the U.S. to age 18 is $34,464. This figure climbs to $98,361 if one adds a college education and an estimate of the wages the mother lost by taking care of the child instead of holding a paying job. The study concludes: "Having a child will not only mean giving up one life style for another, but also potentially giving up one standard of living for another."[2]

In light of this reality, the participation of mothers in the labor force has almost doubled—from 22 percent in 1950 to 42 percent in 1970. By 1980 working mothers of preschool children alone are expected to increase by over 1.5 million.[3]

For single parents or wives of low-income husbands, the ability to stay at home and care for children is a luxury not available except at the expense of public assistance. The following table indicates the distribution of family income nationally as of 1969. These figures include the income of working mothers. This is an important fact because a two-parent family in which the father earns $10,000 and the mother does not work has very different child-rearing needs from those of a family in which the father earns $6,000 and the mother $4,000.

**1970 Selected Statistics Related to Distribution of U.S. Family Income[4]**

| | |
|---|---|
| Total U.S. Population | 203.2 million |
| Children 0-5 | 17.0 million (8 percent of total) |
| Children 5-19 | 58.3 million (28 percent of total) |
| Number of families | 51.3 million |

| *1969 Income* | *Percent of families* |
|---|---|
| $0 – 3,999 | 15.2 |
| $4000 – 5999 | 10.8 |
| $6000 – 9999 | 26.7 |
| $10,000 – 14,999 | 26.6 |
| $15,000 – 24,999 | 16.0 |

[1] E. E. Le Masters, "The Crisis in Parenthood," in *Sourcebook in Marriage and Family*, Marvin B. Sussman, ed. (New York: Houghton-Mifflin, 1968).

[2] Sarane Spense Boocock, "The Status of the Child and Alternative Structures for Child Care Systems," speech presented at the annual meeting of the American Educational Research Association, April 18, 1974.

[3] U.S. Senate Committee on Finance, *Child Care: Data and Materials* (Washington, D.C.: U.S. Government Printing Office, 1971).

[4] Adapted from *Issues in the Design of a Delivery System for Day Care and Child Development Services to Children and Their Families*, Joan M. Bergstrom, Gwen Morgan, Wheelock College, for the Day Care and Child Development Council of America, Inc., May 1975, p. 7.

The stresses of child-rearing, coupled with lack of knowledge about child development and the parental role, prevent many parents from adequately meeting their children's needs. This situation was documented by a variety of statistics compiled for the 1970 White House Conference on Children:

> One-fourth of American children suffer from some degree of malnutrition; 50 percent of children under age 6 have substandard levels of vitamin A; 40 percent of children under age 2 have low values of vitamin C; and 50 percent of children under 2 have insufficient iron in their diets.
>
> Almost one-half the population under age 19 has not been adequately immunized against diphtheria-pertussis-tetanus. Fewer than 75 percent of persons in the same age group have been immunized against rubeola. The percentage of children ages 1 through 4 who are fully immunized against poliomyelitis has fallen from a high of 87.6 percent in 1964 to 67.7 percent in 1969.
>
> Fifteen thousand children under age 15 die each year from accidents; another 19 million are injured severely enough to need medical care. Most accidents involving children take place in the home.[5]

In addition, an estimated 35 percent of apparently normal children display behavioral difficulties by the age of 4.[6] And, perhaps most devastating of all, it is estimated that more than 60,000 children are victims of serious child abuse each year.[7]

The problem for many families is that supportive resources tend to be unavailable until family breakdown is complete. Then help comes too often in the form of crisis service, emergency wards, police and the courts. We know that very young children are especially responsive to preventive and corrective treatment, and that nearly one-third of later crippling conditions could be eliminated by treatment in the preschool years.

We also know that children with serious handicaps can often learn to manage their lives and to master tasks if help is given early. Yet the educational and medical systems do not track most of these children during the critical period between birth and the school entrance age, and no other system has been developed sufficiently to fill this gap. For example, of the 4 to 4.5 million preschool children whose mothers work, only about three percent have found places in licensed day care homes or centers. The majority of children are left in the care of neighbors, friends or relatives; and many are left entirely alone during the work day.[8]

Even when services for young children are available, individual programs tend to disregard the family as a unit and deal only with the child—medically, educationally or socially—as an isolated individual. In recent years, many public officials have recognized the need to provide comprehensive services to meet the developmental needs of young children. Often, however, fundamentally sound child development or child health services have not given full weight to the child's family situation or background. The resulting lack of continuity between program and home may prevent such programs from fully achieving their stated objectives for the child. Moreover, placing an expert between the parent and child in order to further a child's development can have the unintended effects of weakening the parent's confidence in his or her own child-rearing abilities, encouraging abdication to the expert the responsibility for the child.

The present arrangement of independent resources through hospitals, community health, welfare services and the schools is highly fragmented and fails for the most part to deliver significant aid to children and their families. Family needs are varied and interrelated. Integrated, coordinated services addressed to the family as a unit are required to meet these needs. States should develop a comprehensive coordinated service system applicable at state and local levels, available to families from all socioeconomic strata. Existing agencies and services should be examined and new structures considered to determine how best to establish a single-entry-access agency through which parents can obtain the full range of services applicable to their individual needs. Continuing services need to be readily accessible to all families long before serious difficulties are evident. Emphasis should be on identifying the need for assistance and providing such assistance early enough in the child's development for optimum benefit, and on supporting the family *as a unit*.

[5] White House Conference on Children, *Profiles of Children* (Washington, D.C.: U.S. Government Printing Office, 1970).

[6] Joint Commission on Mental Health of Children, *Crisis in Child Mental Health: Challenge for the 1970's* (New York: Harper and Row, 1970).

[7] Early Childhood Project, *Child Abuse and Neglect: Model Legislation for the States*, Report No. 71 (Denver, Colo: Education Commission of the States, 1975).

[8] U.S. Senate Committee on Finance, *op. cit.*

# IV. OBJECTIVES FOR STATE POLICIES AND PROGRAMS FOR PARENTS AND YOUNG CHILDREN

Services to support parents in their child-rearing tasks should lead to greater family cohesiveness and independence. In developing programs to pursue this broad goal, a specific set of objectives should be considered to ensure that state programs and policies contribute to strengthening the families they serve.

The following four objectives are suggested as an operational base for all state programs designed to serve young children and their parents:

1. *To make it possible for parents to become more involved in the lives of their children.* For a variety of reasons, American parents increasingly are less involved in the daily lives of their children. Recent studies of changes in child-rearing practices in the U.S. over a 24-year period reveal a decrease, especially in recent years, in all spheres of interaction between parent and child. In more families, both parents are employed outside the home, sometimes from choice, usually from economic necessity as well. But even during the periods when the parents are at home, only a small proportion of that time is devoted to interacting with—talking, playing, loving, disciplining, helping—their children.

Such factors as work hours, commuting, centralized schools and the professionalization of child care have contributed to age separation. Another factor tending to separate parent and child is the relatively low status granted to child rearing and child caring. Since our society has generally equated status with financial remuneration, persons who care for children have generally been considered to have relatively low positions in society—women, servants and persons in "nonproductive" years such as older persons who have retired. Thus, one of the consequences of the women's liberation movement is that, as women come to think more highly of themselves as human beings, those who believe in equating status and pay will also be less willing to perform the tasks in society that carry less weight and prestige, including the more tedious aspects of child care. Men have not yet moved to share equally the important task of child care. The ideology concerning shared parenting does seem to be changing, but there is a large gap between the ideology and the societal realities that often make it difficult or impossible for men to play an adequate parenting role.

Nonetheless, children need interaction with adults, as well as other children, in order to grow into fully developed human beings. In the earliest years, children are almost totally dependent on adults not only for health and safety, but for the experiences through which they can grow and develop. And it is partly through observing, playing and working with others older than themselves that they develop their capabilities and identity.

Care must be taken that family services do not inadvertently have the effect of withdrawing parents even further from responsibility for their children. Such programs must be designed to foster the kinds of conditions and situations in which parents can function more effectively. They must increase the parents' confidence in their child-rearing ability, not suggest that someone else (doctor, educator, home visitor) can do it better. One way to accomplish this is to ensure that parents have opportunities for participating in a variety of ways in all publicly supported child programs. Parents should be able to play an active part both in the planning and administration of program activities and sharing their insights with the professionals. Those who choose to should have the opportunity to help with groups of children as volunteers or aides.

Programs, whether in health, day care or education, should not be confined to centers but should reach out in appropriate ways to involve homes and neighborhoods in activities in behalf of the children. They should not, however, view the children's families as adjuncts to assist the programs; the programs exist as part of the support structure that families put together to help them meet the complex task of rearing their children.

Special attention should be given to new ways of involving fathers in programs for parents and children and to help them develop a more active responsibility for their children. Children need to receive care and attention from men as well as women.

Policies to support shared parenting need to be considered seriously by states. Increasingly, men have too small a share in the upbringing of children, and the whole family loses because of this. The traditional attitude toward sex roles is largely responsible for this situation. This attitude is being widely challenged, and there is much evidence of change. But shared parenting should also be encour-

aged through changes in business and employment practices. For example, employment laws could be changed to permit men and women to hold shared jobs or paired jobs with salaries, benefits and job security commensurate with the standard full-time job. Compulsory overtime, heavy travel schedules, frequent location transfers should be eliminated or reduced, whenever feasible, for parents with young children.[1]

Incentives to state governments, business and industry to introduce practices supportive of family life might include tax deductions, low-cost loans and matching funds for enterprises providing day care facilities, health care and other services, as well as resources and facilities that will increase the involvement of parents in the lives of children in the community. By commanding the major portion of adult time and energy, business and industry profoundly affect the quality of American family life. States should examine a variety of ways to encourage these institutions to revise their policies to support family life and provide opportunities for more adults and children to come together again.

2. *To help parents understand better the process of child growth and development.*
Parenting abilities are assumed to develop naturally as part of being human, or at least as part of having been a member of a family. But the small mobile families of today do not offer young people growing up the same opportunities for experiences with young children and observing parent roles as were provided in the larger families of two or three generations ago. Only five percent of households today contain an adult other than parents. The average family has approximately two children, compared to five in families 100 years ago. Moreover, in 1970 nearly one out of every five younsters between the ages of 14 and 17 did not live in a two-parent home.[2]

Parents and prospective parents need to learn more about the process of child growth and development and the role of the family in furthering that development. To that end, state education departments should examine ways in which family life education can be integrated throughout the elementary and secondary school curriculum. (Chapter 5, Education for Parenthood, pages 10-11, provides information on school-related parent education programs.)

[1]Testimony of Urie Bronfenbrenner, before the U.S. Senate Subcommittee on Children and Youth, *op. cit.*

[2]Testimony of Vincent P. Barabba, Director, Bureau of the Census, before the U.S. Senate Subcommittee on Children and Youth, *op. cit.*

At the same time, all programs dealing with the education, health and welfare of young children should be required to develop components of parent education directed toward several ends: (1) to educate parents about child development, including what behavior to expect at certain ages and the importance of this behavior in the child's personality growth and educational progress; (2) to inform parents about techniques and materials they can use to enhance their daily interactions with their child; and (3) to help parents become more knowledgeable about, and more involved in, the institutions affecting their child—including medical facilities, day care centers and preschools. The education of parents about their children should be an integral part of all programs and services for young children.

3. *To provide assistance that will increase the possibility of the family staying together rather than being separated.*
In recent years, professionals in a variety of fields, including health, mental health, social work and corrections, have begun to turn away from long-term institutional care toward community-based home care as a more positive approach to alleviating family problems. This change has come about primarily because the separation of child from family is a traumatic experience that often has psychological side effects more disruptive than if the family had been left intact despite the difficulties. Contributing to this danger is the fact that, by and large, child care institutions, in spite of their high cost, often are not staffed to provide children the positive parenting essential to their normal development. It is also true that, until recently, institutions such as foster care homes, orphanages, hospitals, detention homes and jails were burdened far beyond their capacity. A final contributing factor has been that institutionalized care is enormously expensive to the state.

This is not to say that all institutional care is being abandoned. Clearly there will always be extreme cases where children must be separated from their parents for the sake of their health or physical safety. But institutional care should be considered as only one among several options and selected deliberately as the best choice for the individual situation.

If community-based home care is to improve a family's situation while keeping the family together, however, services need to be more carefully coordinated and more immediately available to meet a family's needs. Without such comprehensive support, tending a handicapped child, an ill parent, a delinquent adolescent or an aging grandparent at home

can impose on a family a burden too heavy to bear. Crisis services such as emergency health and social services need to be coordinated with long-term services such as homemakers, visiting nurses and day care.

The availability of coordinated community services can often mean the difference between a temporary crisis and a long-term trauma. For example, when a parent falls ill, a homemaker service, contacted by the hospital, could make the difference between scattering the children to a variety of foster care situations and providing care in their own home until the crisis is past. In a long-term chronic situation, as with a handicapped child or a mentally ill parent, comprehensive community services can provide ongoing care to stabilize the situation and prevent the "revolving door" experience of intermittent crises and hospitalizations.

Such services are presently available in too few communities. States need to consider policies and incentives to encourage communities to coordinate comprehensive services to address the full spectrum of needs of the family as a unit. These incentives could include providing administrative expertise and priority in funding, as well as other forms of direct and indirect aid and services, to communities attempting to develop such a plan.

4. *To utilize the strengths of different cultural and ethnic values and different family forms.*

Basic to any state program that aims to inform and to involve parents in the education of their children is a respect for the culture and traditions of those families. At all socioeconomic levels in the U.S. today, there is a rich variety of cultures, each with its own special forms of family relationships and values. Far from being viewed as a problem, this diversity of cultures and backgrounds ought to be seen as a way of enriching approaches to programming. One culture can learn much from another culture's appreciation of childhood, parenthood, education and family life. Programs adapted to these special cultural needs may in turn suggest other values or approaches applicable to more general programs.

States seeking to develop a diversity of programs to meet ethnic needs will find it necessary to involve members of those groups in the planning and execution of their programs. Such involvement achieves two ends: (1) it enriches the planning process with the special perspective and ideas of those individuals who will be the program's recipients and (2) it facilitates the program's implementation by helping to ensure its relevance to community needs and its acceptability with respect to community values.

In addition to accommodating these ethnic and cultural considerations, state policies and programs affecting families also need to recognize the different issues and problems presented by changing family forms. With increasing frequency, children move from one family form to another. The infant of a newly married couple may enter a single-parent structure if the marriage breaks up. If the mother needs or desires to work, the child is confronted with the strengths and weaknesses of a dual-work family.

Human service systems intending to serve young children and their parents must be able to accommodate this diversity of family forms. Families should not have to conform to a certain style in order to be allowed to keep their children, nor should they have to reach a certain point of dissolution before they qualify for help. Services must be designed to fit family needs, instead of fitting the family to the requirements of formal, impersonal structures.

To promote the flexibility necessary to address the different strengths and weaknesses of individual family forms, states must involve family and community members in establishing service priorities and the implementation of programs that affect them. Federal programs such as Head Start and Community Action Projects have demonstrated that family participation in designing, operating and evaluating programs has contributed greatly to their success. State-level agencies should consider ways to achieve similar involvement, at both the state and community levels, in the planning and execution of their programs. State programs and policies need to move away from determining "solutions" to problems and toward the development of alternative support structures that are responsive and effective. Until recipients have some say in the services and the methods of delivery, interventions in family life, however gentle and however beneficial, may receive resistance and resentment.

# V. SOME STATE PROGRAM OPTIONS FOR STRENGTHENING FAMILIES WITH YOUNG CHILDREN

While most parents with young children approach the child-rearing task as a profoundly joyful experience, many find the burdens are heavier than they imagined, often heavier than one or two persons can successfully bear alone. The process of raising children represents the opportunity for personal growth and fulfillment. It also represents years of continuous responsibility facing a young couple financially, psychologically and emotionally.

Although society has acknowledged that a child's earliest years are critical to future growth and development, it has not yet fully recognized the importance of providing support services on an ongoing basis for parents in their demanding task of child-rearing. States need to explore ways to expand and improve their service capacity in four major areas of family need:

- Education for parenthood.
- Health services.
- Day care.
- Services to parents and children with special needs.

These services have in common several important elements. They aim to support families, not to replace them; they represent a preventive approach (i.e., they are not emergency services but ongoing services directed primarily at meeting needs before they become problems); they address needs common to many families, regardless of cultural or ethnic background or socioeconomic position.

The public demand for services in these areas has been great, but the available programs have generally been inadequate to meet the need. While surveys of most states would probably reveal a wide range of programs, too often a lack of collaboration among state and local agencies and a lack of coordinated statewide planning prevents a state from systematically serving the needs of its families.

The following sections suggest a variety of ways of providing for needs in the several areas. For the sake of convenience and clarity, some alternative services in each area are discussed separately. However, states should recognize that these areas of need are interdependent and that family programs should address these needs comprehensively. For example, day care centers must have liaison with health and social services. An early screening program must be able to refer a family to an agency—a hospital, a day care center, a home visitor program or a family counseling service—that can directly serve its needs.

The sections below discuss in some detail the extent of need in each area and a range of program approaches a state might contemplate in determining its own course of action. Choice of a specific approach in a specific area will depend on the needs and preferences of the families to be served and their communities. In any case, however, it is urged that states recognize that planning and coordination among the state departments and agencies providing these services will be required from the outset. Methods of implementing comprehensive program approaches are discussed in the next chapter.

## *EDUCATION FOR PARENTHOOD*

Parenthood is a major social role for which no credentials and no training are required by society. A variety of programs need to be available to help parents and prospective parents understand better the developmental needs of the young child and the complexity and significance of their role as parents. Information must be made available concerning:

- The social, physical, emotional and intellectual needs of young children.
- The similarities and differences in the ways that children develop.
- The role of the family in every child's development.

Even more basically, perhaps, adolescents need to know more about how a baby is conceived, the physical changes and demands of pregnancy and the fundamental health and safety requirements of caring for a newborn. One out of every ten 17-year-old girls in this country is a mother and 16 percent of these girls have at least two children.[1]

Parent education programs should be available to at least three specific groups of persons: (1) parents with infants or young children, (2) junior high and high school students and (3) teenage parents who may or may not still be

[1] *Children Out of School in America*, (Cambridge, Mass.: The Children's Defense Fund, 1974).

in school. This section of this chapter deals first with programs addressed to parents and next with school-based programs designed for junior high and high school students. Teenage parents represent an especially high-risk group and programs addressed to their special problems are discussed in detail in the fourth section of this chapter, which deals with programs for parents and children with special needs.

## A. Programs for Parents of Infants and Young Children

Parent education has become a component of an increasing number of educational, medical and social service programs directed toward the welfare of very young children. This emphasis recognizes the parents' role as the major educators of their preschool children and offers them new skills and knowledge to further the development of their children through their natural daily activities and relations. In addition, many programs teach parents how to impart basic skills to their child, how to recognize early psychological and physical difficulties and, where necessary, how to provide remedial help for any recognized deficiency, supplementing professional aid.

Because programs for educating parents can be offered in a wide range of settings and for several different purposes, it is not possible to establish a single set of criteria regarding their quality. However, two guidelines should be kept in mind. On the one hand, programs developed for parents by professionals in any field cannot be implemented successfully without serious input by the parents whom the program is to serve. On the other hand, while addressing the expressed needs of parents, the programs must be founded on a firm base of professional information and skills. A balance must be achieved between respect for the autonomy and private goals of the family and the value of the professional instruments and knowledge that can enhance the capabilities of the family in rearing its children.

The emphasis in parenting programs should not rest on imparting information but in teaching skills. For example, it is not enough to simply tell parents that it is better to speak to their children in full sentences; they should be shown ways of talking and playing with the child, criteria for selecting toys appropriate to the child's age and interests, and skills in reading to a child or telling a story. Parents need to know not only that play is the child's way of learning but also how, realistically, they can provide opportunities for exploration and discovery, for manipulation and for identification of the various elements of the environment.

Parent education programs have been useful components in a variety of institutional settings such as schools, hospitals, clinics and day care centers. In addition, a number of home-based programs, primarily for remedial purposes, have been developed and are beginning to be disseminated under the auspices of school systems, medical programs and state agencies. Less formal approaches such as drop-in centers and toy libraries have sprung up as independent projects or as adjuncts to larger programs. Two other approaches to education for parenthood are worthy of note: parent-implemented programs and the use of public media. Moreover, there are several model federal programs that offer comprehensive services to young children by working through the parents and the home setting.

Descriptions of such programs and settings are offered below as concrete examples of approaches states might sponsor or encourage.

1. *School-related parent education programs.* School-related parent education programs have long been offered under such traditional auspices as adult education and the Parent-Teachers Association. Most of these programs provide information on improved housekeeping, better money management, preparation of more nutritional meals and sewing. Many classes also include some instruction in child development and child management. The expectation is the same in both cases—that, with greater knowledge, parents will be able to better provide for the child's physical, social and emotional well-being. While such programs have had a loyal though limited following, little is known about their effect upon parent behavior.

Recently, new curricula for this type of program have been developed that focus specifically on improving certain skills of the parents. Mothers learn new songs and games to play with their children, and they learn to make educational games and toys from inexpensive household objects, such as counting books made from magazine pictures and sorting and matching activities using miscellaneous household items and an egg carton for a sorting tray. The emphasis on applied skills—things parents can do—rather than on general information appears to be effective in enhancing the interaction between parent and child.

a. *Family-oriented programs.* A far more extensive program has been developed by a school district in St. Cloud, Minnesota. Under

the Family Oriented Structured Preschool Activity program, any parent with a child between ages 2 and 5 may come to a center for a six-day orientation course of specific activities and materials for at-home learning. At the same time, the child is evaluated for skills in five areas. After the orientation week the parent is given an activity kit designed by staff members to enhance the child's abilities in any areas where he appeared weak. Enrichment kits are available for children whose abilities are exceptional. Parents can return weekly for conferences with staff members and every six weeks for group sessions with staff and other parents. The program is open without cost to parents of any social or economic group.[2]

b. *A comprehensive approach—the BEEP program.* An ambitious program that uses the schools as the sponsoring institution is the Brookline (Massachusetts) Early Education Project (BEEP). A combination center-home visitor program sponsored by the Brookline public schools in conjunction with Children's Hospital in Boston and the Preschool Project of the Harvard Graduate School of Education, BEEP offers a comprehensive approach to diagnostic and educational services for very young children and their parents, from the prenatal period until school entrance. By offering an unusual opportunity for pediatricians and educators to work together, BEEP can provide an array of services to families from a wide range of backgrounds.

Heavy emphasis is placed on diagnostic services so that no child progresses through the preschool years with an undetected educational or physical handicap. For most parents, these services provide reassurance about their child's health, as well as extensive information about growth and development. For parents whose children need extra help, a referral system ensures that once a handicap or potential deficiency is identified, parents can locate specialized medical care and can obtain follow-up services at once.

The aim of the BEEP education program is to provide resources for parents in their role as the child's first teacher. The program is founded on research that indicates that parents are an underused resource who, with training and guidance, can do much more than expected to educate and protect the health of their children. Each family is assigned a teacher on whom it can call for information and help. There are home visits and scheduled seminars. Parents can drop in at the center any time with their children to explore materials about early childhood, borrow books, pamphlets and toys; view films and videotapes on child development topics and other aspects of childhood; and learn about other recreational, educational or medical resources for young children in the Boston area.[3]

2. *Parent education in a medical setting.* A medical clinic, a maternity ward in a hospital or a well-baby or sick-baby clinic is an opportune setting for making initial contact with a parent before, during or shortly after the birth of the infant. Through the use of nurses, social workers and multimedia technology such as videotape or film strips, instruction can be given regarding pregnancy, nutrition, childbirth, the importance of the parental role and the process of infant and child development. Follow-up services through home visits can be arranged through the Visiting Nurses Association and other social services.

The Comprehensive Pediatric Care Center in Baltimore, for example, employs an interdisciplinary staff of physicians, nurses, nurses aides, social workers, a dental assistant and a community health aide. A major component of the program is the Parents' Club, which helped to establish a morning recreation program for neighborhood preschoolers and turned the clinic waiting room into a supervised play center where parents and children can discover new toys and new ways of playing together and relating to each other.

Counseling services regarding child care and family problems, as well as health care, are available through the clinic's professional staff. The Parents' Club allows parents to meet together to discuss problems and share experiences and provides the means for parents to be involved in determining the kind of health care they and their children receive.[4]

San Francisco General Hospital operates a program especially for 16- to 21-year-old girls who are pregnant. It provides counseling about pregnancy, nutrition, child development, birth control and family planning. The program is coordinated with other city services, such as education and social service, to

[2] For more information, contact School District 742, 13th Avenue and 7th Street South, St. Cloud, Minn.

[3] For more information, contact Mr. Donald Pierson, Director, Brookline Early Education Project, 40 Centre St., Brookline, Mass. 02146.

[4] Eugene Langellotto, "Involving Parents in a Children's Clinic," *Children*, November-December 1971. For more information, contact the Baltimore City Health Department, the Baltimore City Department of Social Services and the Greater Baltimore Medical Center.

provide a comprehensive program for young parents.

The major obstacle to providing a parent education program through a medical setting is frequently lack of knowledge on the part of pediatricians, gynecologists and other physicians about child growth and development, about nutrition and about the problems faced by new parents. Counseling techniques and affective aspects of patient care are not standard components of a medical education. Greater involvement of pediatric nurses, nurses aides and social workers would serve to alleviate this difficulty.[5]

3. *Parent education in day care settings.*
Less structured forms of parent education can be offered through day care centers. Parents should be encouraged to discuss the development of their child with the center professionals and should be permitted to observe or participate in the program. A day care center can be used in the same way as a school setting for instruction in child development and methods of discipline and in the use of specific skills, such as songs and games to enhance parent-child interaction.

4. *Home-based programs with a remedial purpose.*
Home-based parent training programs have been in existence on a small scale for a number of years, usually under the auspices of university research projects. Many are now being replicated with favorable results by a variety of public and private agencies, including family service agencies, public health programs and school systems.

The purpose of these programs is to enhance the cognitive development of young children from deprived environments by improving the ways in which his parents talk and play with him. Some, like the Home Visitors Program of the Georgia Department of Human Resources, have broader child development goals that include the cognitive. The key to the success of such efforts seems to be the emphasis placed on the parent as the child's primary educator and the active involvement of the parent in the education of his child.

Better known programs of this type include the Demonstration and Research Center for Early Education (DARCEE) at George Peabody College in Nashville, Tennessee; the Florida Parent Educator Program at the University of Florida; the Perry Preschool Project at the High/Scope Educational Research Foundation in Ypsilanti, Michigan; and the Mother-Child Program of the Verbal Interaction Project in Freeport, New York.

The Tennessee Department of Public Health in Applachian, Tennessee, has worked closely with DARCEE to develop and implement a training program for teams of nurses, social workers and home educators in a comprehensive program for families with young children. The Michigan Department of Education has adopted the parent education component of the High/Scope preschool program to help prepare preschool children for successful entry into the education system. In Pittsfield, Massachusetts, the school system has incorporated the Verbal Interaction Project as the first component in an educational support system that moves from infant education to Head Start to elementary school and Follow Through.

5. *Smaller, less structured program approaches.*
A number of relatively simple support services can be remarkably useful to parents. Drop-in centers where a parent can chat informally with other parents and find out about other professional services can do a great deal to ease the sense of isolation that afflicts so many parents.

Another program, which could be coupled with a program like the above or used alone, is a toy-lending library. Here, parents learn how to use a game or toy or puzzle to help their child develop a skill, learn a concept or solve a problem. They may then take the toy home for a week and try it with their own children. After the course, parents may continue to borrow toys and games from the library as often as they wish.

Toy libraries may be staffed almost exclusively by parents. With the help of a skillful kindergarten teacher or Head Start instructor, parents can learn to operate such a program after a week of special training and some assistance during the first couple of course sequences. In addition to former parent participants, volunteers can be trained in the same training program as parents and employed with equal success as aides, home visitors or toy demonstrators. The use of volunteers, of course, can cut program costs substantially.

Many parent education programs, in fact, may generate new staff from their participants. Parents who have been through a parent education course can, with two to four weeks of additional training, learn to pass on to

[5] For more information, contact the San Francisco General Hospital and the Office of the Superintendent, San Francisco Unified School District, 135 Van Ness Ave., San Francisco, Calif.

other parents the new skills they have learned regarding toy making, health and safety, playing with the child and observing the child's growth and development. Often a parent can communicate more easily with another parent than can a teacher or other professional. Parents with such interests could be encouraged to recycle their knowledge by becoming classroom aides, home visitors or toy demonstrators. They should be paid for such work, but their salaries would be only about half that of professionals doing the same work.

6. *Parent-implemented programs.*
One model that states might well explore for practical suggestions or guidelines is the parent education program, which for years has characterized many parent-cooperative nursery schools, play groups and centers. Parents typically work with professionals in the classrooms, have meetings to discuss child development and bring in experts to enhance their own and the professionals' learning. Cooperatives have tended to demonstrate (1) that participation offers the young parent of a first child an opportunity to end the isolation of caring for one child at home, as well as the opportunity to observe what other children of the same age are doing in the program and to learn how other mothers deal with problems similar to theirs; (2) that what is learned affects how later children will be reared; and (3) that this experience often leads to parents becoming community leaders when all their children are in school.

The parent-cooperative programs have evolved into a national organization—the American Council of Parent Cooperatives—comprising state and regional councils affiliated internationally through Parent Cooperative Preschools International.

Because parents must pay fees, "parent co-ops" tend to be a middle-class option. Some have developed arrangements with state agencies to accommodate a broader socio-economic spectrum, but states need to take greater initiative in this direction. A few cooperatives, like the Greeley, (Colorado) Parent-Child Center, are operated with great success by poverty-level families despite the constant struggle for public funding. States should consider ways to encourage this type of self-help parent-child educational and support service with small grants for start-up funds. State agencies could also work with parent-sponsored programs to open more co-ops to parents from lower-income levels.[6]

[6]Stanley Kruger, Education for Parenthood Pro U.S. Office of Education, Room 2181, 400 Mary Ave. SW, Washington, D.C. 20013.

An example of a parent-implemented program sponsored by a state agency is the Regional Intervention Program (RIP) of the Tennessee State Department of Mental Health. The purpose of this program is to teach parents effective techniques for preventing or overcoming emotional and behavioral problems in their young children. Parents participate in an orientation course on child management, taught by parents who are graduates of the RIP program. Only six staff members are professional, and most services are provided by parents. Since each mother pays for her training by guaranteeing to work for the program for six months, RIP has become a self-perpetuating parent-implemented system. The program also provides comprehensive social services that range from routine parent-to-parent emotional support for all parents to finding food, clothing, housing or jobs for individuals who need them.

7. *Media technology.*
States should consider expanding the use of television and radio for parent education. Funds should be provided to promote short public service announcements, repeated frequently, as well as longer programs produced in cooperation with public television and radio broadcasting and with local network affiliations. The Children's Television Workshop encourages this kind of use of local time in conjunction with their programs of "Sesame Street," "The Electric Company" and "Feeling Good."

Use of major media, of course, can serve to reach a large audience with information about the role of the parent in child development. Perhaps equally important, the media can help to impart to parenting a significance and status it presently lacks. To this end, public service announcements and filmed programs must be of high professional quality.

Filmed television shows can also be used by state and local parent and child programs as a supplement to other teaching approaches and as a tool to promote discussion in group meetings. Cable television could be used extensively to broadcast more specifically focused programs to individual communities.

8. *Model federal programs.*
Several federal programs address comprehensive services to poverty-level parents who have children under age 3, the usual enrollment age for Head Start programs. In contrast to Head Start, these programs concentrate on reaching the child through, not outside of, the parents and the home setting. Among the most prominent of these programs are the following:

a. *Parent and child centers* provide a variety of programs designed to stimulate the development of infants and toddlers from very deprived environments, along with a range of services to parents, especially mothers. These services include health care for parents and children, social services, day care, parent education programs, family management classes, job skills and opportunities for parents to participate as staff assistants and on policy advisory committees. Home visitor programs are directed toward improving child-rearing practices by providing information, demonstrating activities and giving temporary relief from isolation and loneliness.

b. *The child and family resource program* provides integrated delivery of services to children and families on an individualized basis, using existing Head Start programs as a nucleus and expanding services to additional families through a system of formal and informal linkages to community resources. Services cover the same range as Head Start—health, nutrition, mental health, education and social welfare—but are available to families with children from the prenatal period to 8 years of age.

c. *Home Start* has been described as helping parents do, or learn to do, the same kind of things for their children, in their own homes, that Head Start staff do for children attending Head Start Centers. The programs rely principally on home visitors who visit parents on a weekly basis, bringing them materials and ideas for playing with and teaching their children.

Television programs like "Sesame Street" and "Captain Kangaroo" as well as parent meetings, help supplement the work of the home visitor.

As in Head Start, Home Start draws on comprehensive community resources in the health, education and social service areas and helps parents learn to find and use these resources.

These federal programs lie entirely outside the state service systems, of course, but like Head Start before them, they provide enormous amounts of research and evaluation data, as well as working models of techniques and mechanisms for enhancing the parents' roles in providing for the education and welfare of their children.

## B. Programs for Adolescents

Programs to prepare adolescents for their roles as parents seem to fall naturally into the public school program, although such programs may also be sponsored by civic organizations such as the Boy Scouts, Boy's Clubs of America, 4-H, Girl Scouts and neighborhood and community centers. Since schools are the major institution serving all children, they have the opportunity to design programs to bring teenagers together with young children for the mutual benefit of both.

Consideration should be given to the age level at which such experiences are provided. In light of high dropout rates at the senior high school level, as well as increasing rates of pregnancy among senior high school girls, such offerings might best be made available at the junior high level. Programs that serve this age group can provide concomitant benefits to the students at a critical point in their own development. By studying the behavior of young children, adolescents can gain insights into their own behavior at the point of their own "identity crisis."

There are also advantages in providing courses at the senior high level, however. As students progress from adolescents to young adults—as they enter those years in which family life is typically established—such courses can have a very high degree of relevance to individual students and can also serve to minimize or reduce dropout rates as students achieve a better understanding of the responsibilities associated with parenthood and the demands that may soon be made upon them.

1. *Integration with school curricula.*
If such programs are to attract a wide range of students and provide them with effective child care experiences, careful consideration must be given to their design and placement in the curricular structure. Those programs that currently exist are generally considered to be the domain of the home economics department, because of the specialized training of their staff in child development. Present programs, however, reach only a small fraction of those who will eventually need parenthood education.

Most of these programs fail to provide students any actual experience with the young children they are ostensibly learning about. The programs usually are confined to one instructional department within the high school, rather than reaching out to the resources of the entire school system.

This is not to say that there are no home economics departments operating excellent programs. For example, the Texas Department of Education offers a broad-based, three-part program in homemaking education,

comprised of classroom courses in family living and child development, work-study opportunities as child-care aides and pre-employment laboratory training in child development. All three aspects provide experiences working with young children; all three (but especially the work-study program) attract relatively large numbers of boys—about one-third of the total homemaking enrollment. Although based in an existing instructional department, the Texas homemaking program reaches out to other departments and to the community as resources.

Not all departments are so flexible, however. The assignment of parenting programs to any single professional domain needs careful examination. Possibly more effective programs could be afforded through the combined efforts of a number of departments. Many disciplines have a contribution to make to the clear understanding of the changing nature of the family and the impact of the modern world on child-rearing practices..

Cooperation is required not only among departments within the high school but also among the various age divisions as well. Secondary school efforts should be articulated with elementary education and adult education, thus at least partially relieving the age segregation that so restricts young people's lives. The contributions of community agencies and individuals with particular professional competence should be incorporated into a team effort. Pediatricians, dentists, mental health nurses and parents could be extensively involved in the planning and implementation of such programs.

It is this kind of broad-based cooperation that the U.S. Office of Education and the Office of Child Development are hoping to encourage through their joint effort in developing programs across the country in "Education for Parenthood." Three major projects make up this program: (1) development and dissemination of a model curriculum for secondary school students, called "Exploring Childhood"; (2) a survey and report on other parenthood education curriculums and materials now being used in schools; and (3) grants to several national voluntary youth-serving organizations to promote parenthood education programs among young people in communities throughout the nation.

"Exploring Childhood" is designed as a one-year elective course for teenage boys and girls, adaptable to the needs of adolescents of varied cultural backgrounds. The curriculum combines classroom study with field-site experience in child care settings. Teachers guides, teacher training materials and a manual for school administrators interested in starting an "Exploring Childhood" program in their districts will be made available.

2. *Suggested approaches.*
No single approach to parenthood education can suit the concerns or resources of every community. However, states wishing to revise the home economics or family living curriculum at the junior high and high school levels should consider the usefulness of the following approaches to providing students with preparation for parenthood:

a. *Providing field experience with young children.* This must be considered a central factor in any program seeking to move beyond the traditional homemaking or family living classroom course. Some high schools have established and operated child development laboratories within their own buildings. Others have joined forces with nearby kindergartens or formed cooperative agreements with child care centers. The students can participate in the laboratory or center two or three days a week. On other days, they attend courses in child development, parenting or family living and learn to integrate their classroom learning with their actual experiences with young children.

The Montgomery County public school system in Maryland has instituted a year-long course at the senior high level that provides for student involvement in child development laboratories located in each of the system's high schools. Lab experience includes planning, observation, research and interaction with very young children. In addition to providing training for parenthood, students receive occupational training in child care. This type of laboratory learning is provided, on a rotating basis, to several thousand students each year.

Child centers, located within or near the high school, can provide opportunities for students in a variety of classes. Cooking classes may take responsibility for planning nutritive meals and get practical experience in the preparation and serving of food. Business students might participate in the center's administrative operation. Much of the basic center equipment, from furniture to blocks, might be made in the shop courses. The drama, music and arts departments could each offer their particular talents.

b. *Using films and other media.* Films, film strips and audio cassettes enable the instructor to bring case studies into the classroom that might be difficult to observe in

their natural setting. Videotapes of the students working in the center can provide an important dimension to the classroom critique.

c. *Providing work-study programs*, in which junior and senior high school students work part-time in Head Start, day care centers and other programs for children are now quite common. States that wish to encourage school programs that contribute to preparation for parenthood should first ascertain what is already being done at the local school level. Once information becomes available, a state might well bring together the educators who have already been involved in order to make plans for wider utilization of effective curriculum related to field experience.

d. *Providing career preparation.* These programs require more intensive and more supervised on-the-job training, with related classroom instruction. The aim is to provide students with marketable skills in addition to the general training in child development, child care and parenting.

While the above listing does provide examples of possible options for the consideration of state departments of education, it cannot be emphasized strongly enough that any approach or combination of approaches must be coordinated with the programs of other departments and agencies. An incoherent "layering on" of new programs, in addition to being needlessly expensive, cannot result in the targeting of scarce resources to meet the most urgent unmet needs of children and families.

## HEALTH SERVICES

### A. A Neglected Sector

Children's health care, unlike public education, is not a generally accepted public function. Only 20 percent of the costs of child health care services in this country are paid for by state and local government, and only 10 percent by the federal government (primarily through 65 federal health and nutrition programs for disadvantaged children). Nonpublic monies, such as out-of-pocket expenses or insurance plans, pay for the remaining 70 percent of child health care services. To a large extent there are no statewide mandates, no uniform standards for care quality, no reporting and no information gathering requirements.[1]

The basic difficulty in providing sufficient public support for child health lies in the dual nature of this country's medical system. On the one hand is the private system, in which the physician is paid directly by the patient or his insurer. This system serves the middle- and upper-socioeconomic classes and is by far the most prevalent and powerful. On the other hand is a growing public system, in which fees are paid from public revenue. The two systems operate side by side, sometimes using the same professionals, but coming together almost exclusively in large teaching centers and hospitals.

Neither the public nor the private system is entirely satisfactory. The public system is uneven in quality, fails to reach large numbers of children and generally does not offer comprehensive care to the individual. The private system, while capable of delivering excellent care to those who can find and pay for it, is expensive, inefficient and unevenly distributed.

Easy access to health care is particularly important in the case of children, who have frequent infections in the early years and who, as a minimal preventive measure, should see a physician and a dentist at least once a year. The preventive approach that is so effective in detecting and remedying childhood health problems requires that health services be readily available. Without such accessibility, familes tend to seek medical help only on an emergency basis.

Even for families who can afford health insurance, coverage for children is far from adequate. The largest gap in insurance coverage is for preventive and out-patient care. Yet the American Academy of Pediatrics estimates that 90 percent of child health care is delivered in an out-patient setting and that about half is for health maintenance (such as inoculations and checkups) and not acute illness.

A further problem preventing optimal child health care is the failure of the pediatric profession to address the total context of the growth and development of children. The profession has focused on physical growth of the child and some specific diseases. Knowledge from the fields of social and psychological development, nutrition, behavioral psychology, learning theory and child-rearing practices is usually not taught to medical students or pediatricians. Doctors and teachers come from completely separate profes-

[1] Sheldon H. White, *et al., Federal Programs for Young Children: Review and Recommendations*, Volume III, a publication of the Huron Institute and the U.S. Department of Health, Education and Welfare (Washington, D.C.: U.S. Government Printing Office, 1973).

sional backgrounds; hospitals and schools rarely interact directly. In this professional dichotomy, the children and their parents—and, of course, society—are the losers.

### B. General Guidelines for States

Child health services should be part of any state-level planning for children's services. In examining what steps to take to ensure adequate health care for children, states should consider the following four points as general guidelines:

- Greater priority in the health care system needs to be given to preventive and ambulatory care services particularly appropriate to children.
- Health problems particularly affecting children, such as congenital difficulties and handicaps, environmental dangers (accidents, lead paint poisoning, sanitation) and malnutrition and hunger, need to be assigned a higher priority within the medical community.
- Public funding for child health services should be expanded to be more commensurate with need. While funds remain inadequate, states might well consider using limited funds to offer incentives for the improvement of the ways in which private, local delivery systems use federal funds.
- Health services should be available to children who are in group day care centers and family day care systems, as well as to children who are at home.

### C. Major Existing Public Programs for Child Health

Most public health services administered by the states are federally supported programs directed specifically at low-income populations that consistently experience the highest rates of infant and maternal mortality and childhood illness. The following is a brief description of federally funded programs directed to specific needs of young children and their parents.

1. *Maternal and Infant Care.*
This program, originally funded under Title V of the Social Security Act, operates 60 projects across the country. It provides prenatal care and postnatal care through the infant's first year in areas with concentrations of low-income families. Its goals are to reduce the incidence of infant and maternal mortality and of mental retardation and other handicapping conditions associated with child-bearing.

Although not all projects have had equal success, the impact of the program has been generally acclaimed. In 1971 the federal Maternal and Child Health Service reported: "In the seven years before the initiation of M & I projects in 1964, the infant mortality rate in the U.S. fell only from 26.0 to 25.2 per thousand; in the seven years after, the rate fell from 25.2 to 19.8. For nonwhites, the comparable rates were 43.7 to 41.5 and 41.5 to 31.4 respectively."

Unfortunately the reach of maternal and infant care projects has been very limited, serving approximately only 129,000 mothers and 43,000 infants per year. In addition, only 33 of the 60 projects are located in states with the highest infant mortality rates.[2]

2. *Nutrition.*
There are 12 federal programs devoted exclusively to nutrition or food distribution, all of them administered by the U.S. Department of Agriculture. By far, the two largest programs are Direct Food Distribution and Food Stamps, neither of which is directed specifically at children's needs.

The most important nutrition program directed specifically at pregnant women, lactating mothers and infants and children up to age 4 is WIC, the Supplemental Food Program for Women, Infants and Children. The WIC program provides foods such as orange juice, iron-fortified milk and cereals, eggs, cheese and canned fruits high in vitamin C. These are distributed through local agencies, usually via the state health department, to low-income families with nutritional needs.

In addition, the Special Milk program, plus the nutritional components of maternal and infant care projects, and state maternal and child health services, attempt to reach infants and toddlers up to age 2, but with only minimal success. At present, food stamps probably serve the needs of more of these children than most other programs.

3. *Early and Periodic Screening, Diagnosis and Treatment (EPSDT).*
Possibly the most important new program in child health care is the EPSDT program, a major effort to provide preventive and corrective health care services directed specifically at children, defined as "Medicaid-eligible individuals under 21 years of age." It is administered at the federal level by the Social and Rehabilitation Service of the Department of Health, Education and Welfare. States are responsible for local planning and implementation.

EPSDT has been hailed as a model for

[2] *Ibid.*, Volume II.

developing a total care package for all children, not just the poor. It is clearly an important step toward making medical care a legal right in this country, since implementation is required by law.

The purposes of EPSDT are to provide a mechanism for entry into the health care system for children from needy families, to stimulate the use of existing health care services and to make services available to young people before health problems become chronic and expensive to treat, and before irreversible damage occurs.

Since the program's inception in 1967, however, the states have been extremely slow in implementing EPSDT programs, partly because of the extensive planning required of states if the program is to be implemented. Of the 13 million eligible children, less than 4 percent have received benefits. In 1972, Congress set financial penalties for states not in compliance with the law by fiscal year 1975. The penalty mandates a reduction of the federal share of Aid to Families with Dependent Children (AFDC) matching funds by one percent. Obviously, this penalty will have varying impact, ranging from as much as $10 million for the largest states to $20,000 for the smaller.[3]

During 1973, the states increased their implementation of EPSDT substantially. In the first quarter of 1973 only 13 states reported fully implemented programs. By the end of 1973, the number had grown to 23. Nonetheless, a majority of states continue to experience problems in implementation. According to the Department of Health, Education and Welfare, these problems fall basically into the following categories:

- In some areas the states are having difficulty enlisting provider participation.
- Many states lack adequate dental resources for diagnosis and treatment.
- Organizing services for the 6- to 20-year-olds is proving far more difficult than for children up to age 5.
- Information efforts in many states are minimal or ineffective, resulting in poor recipient participation.
- Some states are experiencing problems in reporting on numbers of individuals screened.
- Most states are experiencing problems in reporting number of individuals treated.
- Follow-up and case management to assure that individuals receive treatment is a problem in many states, primarily because of staff shortages.

Methods of implementation vary significantly among the states. A prime example of a successful program is in Maryland, where the State Department of Health and Mental Hygiene relies heavily on interagency cooperation, local health departments and public health nurses. Conceptually, the program is based on the notion of family-centered continuity of care. Implementation began with service providers in each county. The combination of EPSDT and general local health service funds enables the local health departments to offer services to all, not simply those eligible for Medicaid. Central to the program's success was the fact that the medical community and public interest groups were enlisted early in the planning. The most serious difficulties have been in building effective outreach and arranging support services, such as education, from other agencies. It has been suggested that better outreach services might be achieved through the participation of private-sector and volunteer groups.

In Michigan, the Department of Social Services contracted with the Department of Public Health, Bureau of Maternal and Child Health, to develop and administer the EPSDT program. The screening program has become a link in completing a state system of comprehensive services for mothers and children. The health department (state, district and local) is responsible for screening and for diagnostic and preventive services. The social services department provides outreach, notifies patients of their appointments and follows up on treatment plans and broken appointments. Response was reported to be enthusiastic, with 60 percent of the patients keeping their initial appointments. Of the several thousand screened, about half were referred for further diagnosis or treatment. The Michigan State Bureau of Maternal and Child Health has developed a manual on screening clinics for use by physicians, nurses and allied health personnel, as well as a data system for evaluating the program.

In Vermont and Maine the state Medicaid agencies have contracted with local physicians to meet the EPSDT requirement. The Colorado program is also built around the private physician, with referral to the State Health Department for hearing tests and to the Colorado Dental Service Corporation for dental services. The state also has a contract with the Colorado Handicapped Children's programs to provide further diagnosis and care.

[3] *Early and Periodic Screening, Diagnosis and Treatment*, conference proceedings (Washington, D.C.: Human Services Institute for Children and Families, 1974).

## D. New Approaches

1. *Comprehensive family-oriented health programs.*

There is growing awareness that preventive health services for children require attention to the family as a unit. Initiatives toward expanded family health programs have been under way for many years in both the public and private sectors. Prepaid group practice organizations, such as the Kaiser-Permanente system established more than a decade ago in California and the Health Insurance Plan (HIP) in New York, provide the prototype for a variety of recent federal projects.

Health Maintenance Organizations (HMOs), the general term for such prepaid plans, offer patients all medical and hospitalization services they require in return for a monthly or annual uniform per-capita fee. The emphasis is on primary care, preventive services and efficiency of operation. Advantages ascribed to HMOs are lower health costs for a family and less frequent use of hospitalization and surgery. In addition, such a contractual relationship between providers and patients is helping to establish a basis for legal rights to health care.

A variety of federal programs has developed on this model. One of the earliest was the Neighborhood Health Center (NHC) program initiated under the antipoverty program. Centers were specifically located to serve low-income persons and eligibility was usually limited to them.

The NHC program continues but is not being expanded. Federal interest has shifted to other models such as the Family Health Centers, which aim to enroll a representative mix of income groups. It is expected that capitation fees (on a sliding scale) and insurance reimbursements will eventually make these centers nearly self-sufficient. There is less emphasis on free services to the very poor and little community participation.

A bill passed by Congress in December 1973 aims to further the development of a variety of Health Maintenance Organizations. The bill overrides laws in 20 states that in effect prohibit HMOs. The bill authorized $325 million over five years for grants, contracts and loan guarantees to help HMOs start up. Perhaps the bill's most important provision requires every employer with workers covered by minimum wage laws to let any employee use his firm's health insurance contribution to join an HMO instead of staying in the company plan.[4]

[4] More information about Neighborhood Health Centers, Family Health Centers and Health Maintenance Organizations is available from the Bureau of Community Health Services, Health Service Administration, U.S. Department of Health, Education and Welfare.

These new directions can be seen as moves away from "welfare medicine" toward comprehensive health care for all. While the evidence is unclear as to whether such approaches improve the health of their consumers more than any other form of care, there are indications that Neighborhood and Family Health Centers and HMOs are more acceptable forms of care. Utilization patterns appear to have changed, including less emergency room care, fewer hospitalizations and more use of primary physicians. One major review of evaluations of prepaid group practice, presented to the American Public Health Association, reports findings particularly relevant to maternal and child health care. Prepaid group practice, the report states, tends to increase use of preventive health services (general checkups, prenatal and postnatal care), increase readiness to seek care (i.e., less delay), reduce substantially the disparity between high- and low-socioeconomic groups in the use of services, increase use of specialists for children and childbirth and decrease premature birth rates and rates of prenatal mortality.

2. *New personnel to ease manpower problems.*

The new emphasis on preventive and early treatment services and on universal medical coverage creates a demand for more and different kinds of medical personnel. Expanded use of middle-level professionals can make health care accessible to more people at less cost. Many states have revised their laws to permit responsibilities formerly reserved to doctors to be handled by professionals with other types of training. The following new medical positions have developed in recent years:

a. *Health aides.* Most health aides are members of the community where the health center is located and are usually trained on the job. Depending on the program, they may assist in administering screening tests, follow up on broken appointments and make home visits to patients. Aides sometimes help parents find housing and employment and otherwise act as advocates, or they may monitor and update immunization records, administer screening tests or act as family planning advisors.

b. *Physician assistants.* In the state of Washington, a program for employing discharged medical corpsmen as physician's assistants in civilian life has proved highly successful. The MEDEX program provides three

months training at medical school, then places ex-corpsmen in a one-year training program with general practitioners, most of whom are in rural areas. Almost all of the MEDEXs stay on after the training period and continue to work with the general practitioners, their former teachers turned employers. This type of program, now being replicated across the country, is particularly appropriate for rural areas where medical help is difficult to obtain.

c. *Pediatric nurse practitioners.* The American Nurses Association and the American Academy of Pediatrics have issued joint guidelines for the preparation of the "pediatric nurse associate," a relatively new effort to permit nurses to assume a large portion of the tasks traditionally performed by pediatricians. There are three chief models. The Denver model, developed by physicians at the University of Colorado Medical Center (who are generally acknowledged as the originators of formal pediatric nurse associate training programs) includes a package, complete with instruction sheets, that can be replicated throughout the country. Registered nurses in Denver can become pediatric nurse practitioners by participating in a continuous four-month training program.

The Boston model, operated by Massachusetts General Hospital, differs only slightly from the program in Denver. Rather than recruiting a class of nurses for a four-month course, the Boston group seeks nurses who are already employed and trains them on a part-time basis while they remain on their jobs. They may come to Boston for one or two days a week. The total course lasts four months. Although some pediatric nurse associates work in private offices, the majority are public health nurses who utilize their additional training to function relatively independently in community settings, particularly rural areas and urban poverty areas where there is a shortage of physicians.

The Rochester Model, sponsored by the University of Rochester School of Medicine, offers a four-month training program to bring nurses out of retirement to provide a portion of well-child care in private pediatric practice. There is a large pool of inactive nurses (estimated at 300,000) who might be interested in such re-employment. These nurses offer unique advantages to pediatric work, as they are likely to be long-term community members and parents themselves.

State laws are changing rapidly to respond to the new nursing concepts. For example, Washington's legislature revised its Nurse Practice Act to allow nurses to expand in areas of diagnosis and treatment. Idaho amended its Nurse Practice Act to include "acts of medical diagnosis or prescription of therapeutic or corrective measures." South Dakota amended its practice act to extend the role of the nurse in child health screening programs.

d. *The child health associate.* This program, also conceived at the University of Colorado Medical Center, prepares an individual who is not a doctor of medicine to give extensive health care, including some diagnosis and treatment, to both sick and well children. The three-year training program is offered to individuals who have completed two years of undergraduate work at any accredited institution of higher education. It includes two years of preprofessional training, plus one year of internship. The Colorado Child Health Associate Law regulates the practice of child health associates, defining their training, function, activities and degree of required supervision. Still unique in 1975, the law permits associates to write prescriptions for certain drugs approved by the board of examiners. The drugs—such as immunologic agents, antihistaminics, antidiarrheal agents and hematinics, as well as diagnostic agents to determine the presence of various disease—include the vast majority of those used in the ambulatory practice of pediatrics.

3. *Coordination between public and private health care.*

States need to initiate or refine a coordinated referral system so that public and private resources are fully utilized in a system integrated with other child development services. Health services in most states are administered in fragmented fashion by any number of agencies. Medicaid—by far the largest source of federal funds—is administered by state welfare departments. School health programs are under the aegis of state education departments. Other federal programs, such as Maternal and Infant Care, Neighborhood Health Centers and Head Start, may bypass state administration altogether, rendering coordination next to impossible.

At present, most statewide programs are provided through Medicaid. As in other areas of child services, states must commit themselves to moving beyond the welfare model in health care. One step toward achieving comprehensive care for all children could be a state plan developed with the active participation of persons from various medical professions and their state professional organizations.

Specialists in child development, possibly recruited from the state's universities or perhaps an innovative children's hospital, could also be involved in the planning. The inclusion

of such educators would open communication lines between the health and education professions so that child health services could be more truly child-oriented and would help develop a program of preventive health education for parents as well as children.

Ideally, a statewide health plan would be one component of a comprehensive state plan for children's services. This was the case in West Virginia, where the Division of Maternal and Child Health, in the state health department, was assigned to develop plans to expand existing health services for the state's Early Childhood Development Project. The plan called for comprehensive service to mother and child from the prenatal period until the child reaches age 5 and utilized such diverse facilities as five existing general hospitals, six diagnostic and treatment centers providing outpatient services, pediatric clinics and private physicians and dentists. To these were added mobile unit clinics, home visits by pediatric health nurses, vaccination and nutrition programs and the state's programs for crippled children.

Other states have developed different approaches to health care delivery. In Oregon, the Department of Human Resources brings together the health and welfare departments and several smaller agencies to provide these services with more efficient administration and greater visibility. In the state of Washington, a major reorganization in 1971 and 1972 placed the maternal and child health and crippled children's services in an Adult and Child Health Section, which also includes chronic disease, family planning and dental and nutrition services. A new California law authorizes the state health department to approve experimental pilot projects sponsored by nonprofit educational institutions or nonprofit community hospitals or clinics to develop new kinds and combinations of health care delivery systems.

In Massachusetts, the Comprehensive Health Agency is assigned the responsibility for health services planning. The Office for Children operates a hot line service called Help for Children. Anyone needing health services or child welfare services can call this number and a regional interdepartmental team then decides which department should provide the service. If there is no service available, or if the team disagrees, the office purchases the service. Thus, the child does not have to wait.

States might also consider bringing together through their planning efforts private practitioners of medicine, dentistry, optometry and psychology (individual or group); school health programs; local clinics run by hospitals, medical schools and other agencies; mental health associations; regional or local visiting nurse associations; voluntary agencies (e.g., Catholic, Protestant and Jewish welfare associations); Lions and other service clubs; local or regional associations for the blind or the prevention of blindness and associations for retarded children, cerebral palsy, tuberculosis and other special diseases.

The situation for both public and private health care in this country is extremely fluid and will probably continue to be so for the next several years. States can take advantage of changes in both sectors to promote a more rational articulation between the systems of care. In so doing, they can develop a higher level of services and, through the use of the sliding fee scale and prepayment models of Family Health Centers and other forms of HMOs, provide better services to all citizens, regardless of socioeconomic status.

## DAY CARE

### A. The Situation and Need

The demand for child care in the United States is enormous and increasing rapidly. Between 1950 and 1970 the participation of women in the labor force increased from 33 to 43 percent. During the same period, however, the participation of mothers in the labor force almost doubled—from 22 percent in 1950 to 42 percent in 1970. By 1980, working mothers of preschool children alone are expected to increase by over 1.5 million.[1] Today, between 4 and 4.5 million preschool children (under age 6) have mothers who work, and only about 3 percent of these children are in licensed day care homes or centers.[2] Even though the number of places in licensed facilities has risen rapidly in the past five years—from 250,000 to 700,000—the total picture has not improved. While the 450,000 were added, the number of children under age 6 whose mothers are working increased by 800,000.[3]

Furthermore, for the age groups under 6, most of the out-of-home care is for children

[1] U.S. Senate Committee on Finance, *Child Care: Data and Materials* (Washington, D.C.: U.S. Government Printing Office, 1971).

[2] White House Conference on Children, "Forum on Child Care," *Report to the President* (Washington, D.C.: U.S. Government Printing Office, 1970).

[3] Further information is available from the U.S. Senate Subcommittee on Children and Youth, Senator Walter F. Mondale, Chairman.

between the ages of 3 and 6; very little is provided for children younger than 3. Yet, families in need of day care—as well as the other types of support dealt with in this report—frequently need this assistance as much for the earliest years as for the years starting with age 3. Infants (several months to 1½ years) need a great deal of care, being largely or totally dependent upon adults for stimulation and social contact, as well as for physical health and well-being. Toddlers (1½ to 3 years) require somewhat less physical care but are still dependent on a maternal figure for stimulation, emotional and physical support and protection.

Still another serious need is for more adequate care for school-age children of employed parents. School hours rarely coincide with adult working hours, and school holidays and long vacations cause special problems for mothers who work. To reduce the neglect of school-age children is, therefore, another of the challenges facing the states as they plan ways to strengthen the family.

The demand for day care cuts across social and economic lines. An Alabama survey of state day care needs found "a majority of mothers need additional child-care services (79.8 percent), with the request being greater for full-day care than for half-day care services, regardless of residential locations, race, socioeconomic status or ages of children."[4] The largest users of day care are families whose incomes place them slightly above poverty level in the blue-collar or low- to middle-income brackets. These families must have two incomes to get by, and day care for their preschool and school-age children is a matter of economic necessity. But demand for day care by larger-income families is also growing. Day care is in demand not only by parents who wish or need to work, but by a wide range of social and health services as a necessary part of a comprehensive family support system. Day care can provide an isolated parent, or parents attempting to deal with a complexity of problems, with much-needed assistance while at the same time providing the child with valuable experiences of playing with and relating to other children. A day care setting may allow parents the opportunity to exchange ideas and share concerns about the growth of their children and can give them access to specialists in child development and child health. At the very least it can help combat the sense of helplessness and isolation that engulfs many families as they strive to meet the needs of growing children.

Before suggesting some state initiatives in day care programming, a brief survey of existing programs is in order.

### B. Three Approaches to Day Care

There are at least three formal approaches to day care—family day care provided in *private homes* (including group homes serving slightly larger numbers of children), care provided in *day care centers* and mixed systems *combining homes and centers.* Most arrangements made by parents are informal, however, leaving the child in the care of a relative or a neighbor.

1. *Family day care.*
Family day care is the most widely used type of formal day care, being essentially an extension of the even more common informal arrangements. According to a Westinghouse Learning Corporation survey in 1970, the majority (55 percent) of children in full-day care are cared for in private homes. Yet, despite state laws requiring licensure, less than two percent of these homes are licensed, as compared to almost 90 percent of the centers. These family day care arrangements often operate outside the law and are unregulated and unsupervised by any government or social services agency. A licensed or registered family day care home usually serves no more than six children, including the care-giver's own children, and of these no more than two may be infants. The primary caretaker is usually a family day care mother, a women who enjoys children and has either already reared her own or prefers to remain at home during the early years of her own children. While this permits her to earn extra money, most family day care mothers typically earn a poverty-level income.

Family day care is the type most selected not only by parents, but by social service agencies advising low-income families. Its popularity is due largely to the lack of other facilities and its low cost resulting from the level of payment to the care-giver.

Because the care-giver operating a family day care home is considered under the law to be self-employed, this type of child care falls into the "private for-profit" category described below in relation to centers.

Family day care systems or linked day care homes operating in a satellite relationship to a central administrative core that offers them ongoing training, supportive services and cen-

[4] UEC, Inc., *Alabama Day Care Needs and Day Care Resources,* final report (Alabama: Department of Pensions and Security).

tral administration are becoming popular. The system offers greater stability than the independent home, and a greater potential for quality. It is not cheaper than center care, however, if the cost of the support system is considered a part of the service. For cost purposes, a family day care system can be thought of as a decentralized center. Costs are largely determined by staff salaries and adult-child ratios, whether in centers or homes. Family day care, with its typical one-to-three ratio, is not in the long run a cheap answer to the day care need.

2. *Center-based day care.*
Only about three percent of the children in day care are in center-based care. Although little definitive information is available to explain the slow growth of center care, it may be assumed that the slow growth is a result of the fact that the high operating costs associated with generally desired quality programs cannot be met by parents who need the service and that the government has been reluctant to assist these families to meet their need for such child care.

The organizational forms and the variety of sponsorships of day care centers are described in the following four categories.

a. *Publicly supported centers.* Most publicly supported centers have been financed indirectly through the use of funds available under Title IV-A[5] of the federal Social Security Act (Aid to Families with Dependent Children), which provides 75 percent of the cost of day care services for certain children in low-income families. The state provides the other 25 percent in matching funds either through state appropriation, matching of in-kind contributions or local funds given to the state for this purpose. This program has two effects: it limits most publicly supported centers to poverty-level families, and it subjects those centers to federal funding regulations, which are usually higher than state licensing requirements.

One state with a substantial state-supported day care program is California, where the "Children's Centers" program is run by the state education department. Under a sliding fee schedule, parents may pay part or all of the cost of day care.

Another example of a state-supported day care program is Connecticut's, founded through the Department of Community Affairs, which includes funds for buildings.

b. *Private for-profit centers.* These centers, which are taxpaying, comprise at least 60 percent of the total number of day care centers.[6] There are two quite different forms, of which by far the larger is the proprietorship. This is the small, often Mom-and-Pop operation, serving working families earning very little money. Some of the best and some of the worst day care in the country is provided by proprietors. At best, they are small and responsive to parents' needs in such matters as hours, vacations and the like. The form of organization is simple and the proprietor, by taking full responsibility, has the freedom to make decisions without sharing the decision making with a board of directors. Mom-and-Pop day care centers do not pay their owners a salary; the "profit" is what the owner has left over to live on after all expenses are paid, usually considerably lower than the salary paid the administrator in a not-for-profit center.

The other legal form of for-profit centers is the corporation. Here decision making is shared with a board, and personal responsibility of the operator is reduced. For-profit corporate day care usually takes the form of a chain of centers, taking advantage of economies of scale. These centers, too, have often been found to be responsive to parents' needs and wishes. Again, quality ranges widely. This type of day care is more likely to serve middle-income families.

Like nonprofit centers, both of these types of for-profit centers are subject to state licensing regulations and, if they use federal funds, must also meet federal requirements. Strong state licensing is needed to prevent unscrupulous operators from unfairly competing against those who are paying the costs of maintaining quality care for children.

c. *Private nonprofit centers.* Like the for-profit corporation, nonprofit centers are incorporated and have boards of directors. They may be sponsored by a wide range of auspices, such as community service agencies, antipoverty agencies, parent cooperatives and others. Sometimes a nonprofit center is affiliated with a church. Some states exempt church-affiliated centers from licensure.

An example of a successful cooperative center is the Greeley Parent Child Center, a program for migrant seasonal and rural poor children and their families living in and around Greeley, Colorado.

Among nonprofit centers the quality varies

[5] In regard to Title IV-A see section on Title XX in this report (p. 41).

[6] U.S. Senate Committee on Finance, *op. cit.*

widely, depending on the commitment of the operators, the demands of the parents and the effectiveness of state licensing programs. Many of the better day care programs fall within this category, while others lack the financing and administrative skills to provide a quality program.

Most family day care systems are organized in relation to a private nonprofit administrative agency and are classified as nonprofit. However, such a system could legally be organized by a for-profit corporation.

d. *Emerging private sponsors.* Only recently have business and industry begun to provide day care for the families who work for them. Many industries that assist their employees in meeting child care needs do not themselves operate day care programs. One corporation, for example, has recently expanded its commitment to child care, but prefers that the centers be run by a private nonprofit organization that involves parents. This has been the pattern many industries have preferred. Unions have begun to demand that provision of day care services be written into their contracts. Universities and hospitals are also testing the feasibility of running employee day care centers. At least one state legislature has considered allowing employers a tax credit on net income for building day care facilities or purchasing equipment to be used by children of employees.

3. *Mixed systems.*
Mixed systems, which include both centers and day care homes brought together under one central administration, provide more options for parents and can combine the best features of both types of day care. Parents can keep their children close to home, while associated centers can provide curricula, materials and equipment, emergency service and staff training for comprehensive child care.

Examples of mixed systems include the Family Day Care Career Program in New York City and the Mile High Child Care Association in Denver, Colorado. The New York program comprises 21 subcenters, each administering 40 to 60 homes in the neighborhoods they serve. The system serves nearly 4,000 children. Mile High operates 12 centers and 250 day care homes, serving 1,200 children. The programs are coordinated by central offices, which provide technical support to the centers.

Sometimes family day care systems are mixed systems. For example, Massachusetts has contracted for day care with 25 family day care systems, some of which include a center as their hub.

A mixed-system approach can permit centralized funding and a systematic response to demand, while caring for large numbers of children in small decentralized facilities. On the other hand, red tape and delays may be found in systems more often than in single centers.

### C. Implications for State Initiatives

In planning statewide child care policies, states should encourage diversity of day-care programs. In addition to improving and expanding public facilities, states can offer a number of incentives to private efforts, including tax incentives to industries that develop quality day care services, low-cost loans for the construction or renovation of facilities and tax relief to families who have children in developmental day care. A fair and effectively implemented licensing program is an essential state role. Such a program functions as a major consumer protection, protecting the rights of children and their families while insuring the Constitutional rights of those who provide services.

1. *A major policy question.*
Should a state invest in programs designed to upgrade the quality of formal and informal family day care, or should it turn all its resources to increasing the availability and quality of group facilities? This has become a major policy question for many states considering greater investment in day care services.

As indicated above, when adequate rates can be paid to assure an appropriate salary for the day care mother, the operating cost of family day care is not cheaper than center-based day care. However, care in homes does not require the capital investment required by centers.

The issue, however, is not merely that of cost alone. It is also essential to determine the most appropriate way to meet the developmental and situational needs of each child and family. For many children and families, family day care may not only be the arrangement of choice, but also the arrangement of necessity, either because of availability or because of the assessed developmental needs of the child. Just as not every center is the right place for every child, not every home is right for every child, nor is one type of arrangement necessarily right for all children.

States should study patterns of use and need in their own communities, determine how families select a particular kind of day care

service and how satisfied they are with the service, evaluate the different strengths offered in different centers and homes and develop a means for assuring that a variety of arrangements are available so that an individual plan can be made in light of each child's needs.

2. *The question of quality.*
If day care services are to serve as an adequate extension of the family, providing warm, nurturing support for all facets of a child's growth, then day care facilities must provide for more than the child's physical safety. Just what constitutes a quality program continues to be a subject of professional debate, but there is no disagreement that any facility that cares for children from four to eight hours a day or longer must be staffed by persons who care about the social, emotional, cognitive and physical development of the children.

A federal study, *Standards and Costs for Day Care*, identifies and defines three quality grades:

- *Minimal:* the level essential to maintaining the health and safety of the child, but with relatively little attention to developmental needs.
- *Acceptable:* a basic program of developmental activities as well as minimum custodial care.
- *Desirable:* the full range of general and specialized developmental activities suitable to *individualized* development.

The minimal grade, primarily custodial, is regarded by many developmental experts as likely to be more harmful than beneficial to many children. Children subjected to such care for long periods of their early years, who do not otherwise receive needed stimulation and love, often show measurable losses in their mental, motor and social development. Yet many dare care arrangements fall below this minimal level and are in fact harmful or endangering to children.

3. *The costs of quality day care.*
The costs of quality day care, which are estimated as running up to $3,000 or more per child per year, are not always easily assessed. Also, states are cautioned that, because good day care programs usually include a high degree of nonmonetary elements in their budgets (for example, free space, volunteer time), comparison of budgets cannot be made solely on the basis of cash expenditures. Even minimal care as defined by federal regulations costs over $1,000 per child per year. Because of their higher adult-child ratio, quality day care home programs may cost as much as centers, despite the lack of a center facility to maintain. Only for infants and handicapped children are homes less expensive than centers. Adding extra services such as health and social services increases the cost per child by about $200 to $300, although it is questionable that the cost of these services should be attributed to day care. A day care home or center may be a good site for delivery of health care to children who are in day care, but health services are not day care services—they are services all children need regardless of whether they are at home with their families or in day care.

4. *The need for trained personnel.*
The lack of trained personnel to plan, direct and operate day care services is one of the greatest barriers to the expansion of child care, according to a federal report by the Auerbach Corporation. One of the reasons for this situation is, of course, that low salaries and a limited number of available positions in day care are slight inducements to those professionals who have the training and experience for planning and directing roles. Nevertheless, states should consider ways to encourage their higher education institutions to develop programs that will, as day care programs expand, produce professionals with the broad-based training required of planners and directors of day care programs. The highest priority in the use of state and federal funds available for training should probably be given to providing training to those persons who already are day care administrators and are in need of professional skills. Also, it would probably be wise for states to emphasize inservice training, providing free or low-cost courses and requiring that the staff in day care take such courses to meet licensing requirements.

One of the primary means of upgrading the quality of day care is to provide the caregivers with some training in child development as well as health and safety. Persons wishing to become day care mothers could be required to participate in workshops or courses relating to the care of young children. A major program of this type was undertaken by the Colorado Department of Education in conjunction with the Community College of Denver and the Mile High Child Care Association.[7]

Training could be expanded into a more substantial procedure providing day care mothers with the opportunity to advance up a

[7] U.S. Office of Education, *Developing Training Support Systems for Home Day Care* (Washington, D.C.: U.S. Government Printing Office, 1973).

career scale so that their talents might be used in the varying aspects of day care as aides, assistants, paraprofessional teachers, social workers, parent involvement specialists and managers.

The Family Day Care Career Program in New York City has two career development paths, one internal to the program and one outside the system for mothers seeking other types of careers. A vocations counselor works with each career mother to see that she receives testing, training and job placement as appropriate as possible to her interests and abilities.[8]

Despite their potential, however, these programs have a number of serious difficulties. Systems of family day care homes and single center programs do not usually have room for significant advancement of staff from within. One means of increasing promotion opportunity is to create more jobs within the core staffs by building a career ladder of aides, assistants, paraprofessionals and so on. But this is basically artificial because the promotions are not recognized outside the system, and more and more positions must be created since there is little turnover. Large mixed systems of homes and centers offer greater opportunity for more workers of different competencies, although these too are limited.

To offset the limitation of credentials and career mobility outside a particular day care system, the Child Development Associate Consortium is developing on a national level a competency-based credential (the CDA credential) to be awarded to individuals who demonstrate certain competencies with 3- to 5-year-old children. The primary purpose of the CDA credential is to upgrade the quality of staff working with young children in center-based programs by establishing criteria for competency at various staff levels.[9]

5. *Parent involvement.*

Active parent involvement is critical to the success of a day care program for a number of reasons. Perhaps the foremost reason is to insure that day care becomes a means for integrating parents in the lives of their children. Participation in the classrooms as teacher aides or in policy making as advisors or full participants gives parents a significant understanding and voice in an institution directly affecting their children's lives.

[8]Richard Ruopp, Brigid O'Farrell, *et al., A Day Care Guide for Administrators, Teachers and Parents* (Cambridge, Mass.: MIT Press, 1973).

[9]More information can be obtained from the Child Development Consortium, Suite 601 East, 7315 Wisconsin Ave., Washington, D.C. 20014.

Moreover, according to a number of observers, parent participation strengthens the quality of the program and ensures that it is designed to meet the needs of its constituency. Parents want programs that respect their rights as parents and the values and traditions of their cultural milieu. If they are actively involved in the program, they are more likely to understand and approve the program's policies and feel assured their children are learning the skills and values they consider essential.

Such parental support can do much to strengthen the day care program's relationship with the community and provide access to community resources. Parents may canvass their neighborhoods for contributions of supplies, equipment and money, organize fundraising events and obtain the services of community members with special skills. Carpenters, plumbers, lawyers and doctors may contribute their time and abilities to a program that has become a vital institution in their community. Parents become a unique manpower resource to the program, at the same time learning much about how to deal with the political and social forces in their communities.

In addition, parents need information about how their children are doing in the center and a chance to work along with the staff on their children's problems and progress. Parents who work in day care programs often feel they learn a great deal about their child and child development in general and can apply these insights and skills at home. No less important is the significance of parent involvement for the children. Not only does it enable the parent to understand and better meet the needs of his child, but it provides the child with a sense of continuity between the program and the home. It can be extremely valuable for a child's self-image to see his mother or father in a position of authority and responsibility in the center.

Despite its importance, parent participation is not easy to achieve. Most parents are already busy people and are often reluctant to give up more of their time. Many feel their child is in the hands of experts and there is nothing more that they can do. If day care is to strengthen and not weaken the family, that attitude needs to be corrected. If the day care program is not parent-initiated, obtaining parent involvement will require the deliberate efforts of the director. Parent participation tends to be highest in programs where parents have at least some decision-making authority, and where there are a variety of opportunities to get involved, such as parent teachers,

classroom aides, staff selection, administration and admissions policies. The state should make parent involvement an essential part of its programming for day care.

6. *Licensing and setting standards.*
In most states, the day care licensing authority is the department of welfare or its equivalent. Unfortunately, most of these departments are understaffed and the licensing staff may not be sufficiently trained in the specific needs of day care facilities. To obtain a license, a day care operator must meet fire, health and building regulations. Usually these are set individually by the separate departments and it is not unusual for them to contradict each other. It too often falls to the operator seeking the license to resolve these problems.

Clearly, what is needed is a more coordinated approach. There is a need for the power to coordinate various agencies, to issue provisional licenses, to revoke licenses and close unlicensed facilities and to allow for deviation from prescribed regulations under special circumstances. This is necessary to encourage rather than discourage the growth of new facilities. A recent project sponsored by the Office of Child Development entailed a careful review, by broadly representative task forces, of the various elements of day care licensing and the development of a set of licensing code guides. These may prove useful to states as a starting point in examining their own licensing standards and processes.

In addition to licensing, welfare departments administer most of the public day care programs, and there is often no central agency with authority to plan for statewide day care needs across the socioeconomic spectrum. The result in many cases is fragmentation and lack of quality control. The need is for an integrated network of day care services, including health, education and social services, to meet the multiple needs of various consumers. States should consider whether any existing department or agency can provide such a planning and coordinating function. Although most states administer day care services through the welfare department, California offers a system provided through the education department. And in Illinois the Department of Labor has developed day care programs in relation to the Work Incentive (WIN) program. Other possibilities are the health department, a large "umbrella" agency such as a department of community affairs or a coordinating agency such as an office of child development.

## SERVICES TO PARENTS AND CHILDREN WITH SPECIAL NEEDS

Services to meet special needs are necessarily an integral part of a comprehensive service system. Family situations representing special needs encompass a wide range of difficulties, including a mentally, physically or emotionally handicapped child, a mentally ill parent, a delinquent older child, teenage parents who are essentially still children themselves, child abusing parents and single parents who must bear alone the heavy financial, legal, social and psychological responsibilities for raising one or more children.

While each type of special difficulty may affect a minority of the population, the total number of persons involved is substantial. For example, 1 child out of 10 suffers from a condition that handicaps his or her ability to function fully in the average school setting. Approximately 60,000 children are seriously abused by their parents or caretakers each year, with the figures rising annually as reporting procedures improve. Nine million children, or one out of every seven persons under age 18, are being raised by only one parent, and 30 percent of these children are under age 6.[1] Many such parents are likely to need help from their community in rearing their children. Finally, as has been pointed out in the chapter on day care, families where both parents must work to maintain even a low income need the help of community resources for the fulfilling of their parental role.

These facts are particularly critical to the welfare of very young children for several reasons. First, young children are especially vulnerable to various sorts of family disruption, whether it be the throes of divorce or the stress of the presence of a mentally ill parent. Second, children under age 6 are the most common victims of child abuse, the most serious injuries falling generally on 2- and 3-year-olds. Third, very young children are most responsive to preventive and corrective treatment, and nearly a third of later crippling conditions can be eliminated if treatment is made available during the preschool years.

### A. State Efforts in Three Significant Areas

In recent years, states and the federal government have taken large strides in three areas of

[1] Georgia Dullea, "The Increasing Single-Parent Families," *The New York Times*, December 3, 1974.

special need, particularly important to the welfare of young children and their parents. These are the education and development of handicapped children, the prevention and treatment of child abuse and neglect, and programs for school-age parents. Following are brief descriptions of state efforts in these areas:

1. *Handicapped children.*
All 50 states now have laws that mandate (rather than permit) some kind of educational services for handicapped children. Only a small number of these, however, mandate comprehensive services for all children. Some require only planning, others mandate programs only when the local school district or parents in the community request such services. Most mandate selected services for certain categories of handicapped, although the list may be wide-ranging. Despite recognition of the benefits of providing help early, only a few states have mandated early education services for preschool-aged handicapped children. An increasing number of states have permissive legislation allowing programs for children below age 6 and sometimes as early as birth.[2]

State efforts for handicapped children have been accelerated in recent years by court decisions declaring the right of all children, regardless of handicap, to a free public education appropriate to each child's needs and capacities. In 1971, the U.S. District Court of the Eastern District of Pennsylvania ruled that the state must provide such education for mentally retarded children. In 1972, a federal court in Washington, D.C., ruled similarly, guaranteeing the right of all handicapped and emotionally disturbed children to a free education.

Other court decisions mandate an education appropriate to each child's needs, even when that includes toilet training and self-grooming, as well as the right to appropriate treatment and therapy within a reasonable period of time (usually 15 days after application) and the right to due process for parents questioning the placement of their child.

a. *Federal legislation.* The move toward providing educational services for all handicapped children has been supported by a wide range of federal legislation, including the Rehabilitation Act of 1973, the Education of the Handicapped Act and the Elementary and Secondary Education Act including the 1974 amendments. Each of these acts states, in effect, that school districts receiving federal monies may not maintain discriminatory policies or practices against handicapped children. Public education services must be provided to all children, with special services according to need, and in the least restrictive environment or a setting as close as possible to that of a regular classroom.

Federal concern for preschool-aged handicapped children has led to the development of the Federal Model Early Childhood Education Centers, which serve approximately 100,000 handicapped children each year. In addition, recent changes in Head Start regulations require that 10 percent of the children enrolled in these programs have a recognizable handicap. The Bureau of Education for the Handicapped and the Office of Child Development have funded several special projects to demonstrate the efficacy of integrating handicapped children into a regular preschool setting.

While the right to educational services can be seen as a definite victory for the welfare of handicapped children, the present emphasis on a single type of service, such as education, does not meet a handicapped person's total needs. Handicapped children require the services of a number of state and local agencies. They must first be identified, requiring the cooperation of doctors, nurses, social workers and school teachers; better screening and diagnostic procedures need to be developed; individualized and prescriptive education programs need to be designed. Yet the coordination among the education, social services and health agencies necessary to achieve these goals is too often minimal.

b. *Identifying the handicapped.* One of the major roadblocks to expanding state services for handicapped preschoolers is the difficulty in identifying such children. Because there is no formal institutional mechanism for checking on the development of children after they leave the hospital's newborn nursery until they enter school, early identification of handicaps is highly sporadic at best. Although diagnostic and testing instruments are themselves not yet entirely adequate, it is clear from the results of Head Start screening programs that many physical, mental and emotional handicaps can be detected and treated at an early age if the opportunity is presented.

There are several procedures for identifying preschool handicapped children that states might promote, including developing a "high risk" registry activated at the time of birth, coordinating referrals from well-baby clinics,

[2] Additional information is available from the Elementary/Secondary Department, Education Commission of the States, Denver, Colorado

nursery schools or day care centers and expanding the school census to assure reporting on all handicapped children from birth to age 21. An approach favored by the Rand Corporation report for the U.S. Department of Health Education and Welfare, *Improving Services to Handicapped Children*, is regular screening through "some type of 'free check-up' system" available to all children between ages 0 and 5.[3] Such a system for early screening and diagnosis has been discussed in the health care section of this chapter.

In addition to formal identification programs, persons in frequent contact with preschool children—parents, day care workers, nurses, pediatricians, nursery school and kindergarten teachers—should be given instruction in the use of relatively simple tests for signs of developmental deviations. Those who see children over a period of time are in a position to notice differences that may not be spotted by doctors in health examinations. Day care centers could be particularly useful in identifying actual or potential handicaps, in helping parents obtain suitable services and in providing some of the services to parents and children directly.

c. *New staff training programs.* The integration of handicapped children in Head Start, day care and preschool programs requires new training on the part of many professionals. Only a few such training programs are yet under way. These include a project at California State University in Northridge; Precise Early Education of Children with Handicaps (PEECH) at the University of Illinois in Champaign; the Early Childhood Development Training and Demonstration Center in Atlanta, Georgia; and Technical Assistance Development Systems (TADS) at the Frank Porter Graham Child Development Center at the University of North Carolina. The U.S. Bureau of Education for the Handicapped provides grants to states for preservice and inservice training of classroom teachers and paraprofessional personnel.

In addition, a number of studies and programs have shown that, with minimal training, parents can become effective teachers of their children, supplementing and strengthening the impact of whatever professional services are available and providing continuity between the home and outside resources. Such parent involvement is generally recognized as an essential ingredient in any program for preschoolers, but some believe it can also help to alleviate somewhat the manpower shortage of professionals trained to work with handicapped preschoolers.

The difficulties of identifying young children with handicaps, and of providing adequate manpower to meet their needs once identified, indicate the complexities states must face. Mandatory legislation must take into account many factors. It is not enough to mandate the establishment of programs unless provision is made for identification procedures, facilities, materials and staffing. Legislation and program development for handicapped preschoolers should include provision for planning, staffing, enforcement and program finance including transportation and multiagency coordination.

2. *Prevention and treatment of child abuse and neglect.*

The extent of the problem of child abuse and neglect in this country has already been cited: an estimated 60,000 children each year are seriously injured by their parents or caretakers. The majority of abused children are 2- and 3-year-olds. But these figures represent cases reported under current reporting laws and procedures that are largely inadequate. When a state enacts a stronger mandate, the numbers rise dramatically. In Florida, during the first year after the passage of a strong reporting law and the institution of a statewide toll-free "hot line," the number of reports of child abuse rose from 200 annually to 19,000, 60 percent (11,400) of which were valid.[4]

All 50 states have some legislation requiring the reporting of suspected child abuse to public authorities. The majority of these laws, however, fail to approach the problem from a preventive and multidisciplinary point of view. Child abuse is usually not a single assault, but a continuing trauma between parent and child. Most cases are characterized by a number of attacks committed over a period of time, progressively growing more damaging both in severity of the attack and in the cumulative effects. Such abuse is not limited to any economic or social group. It appears to be conditioned behavior passed from generation to generation.

Although strides have been made in the past two or three years, many state laws regarding child abuse have not yet addressed the complexity of the child abuse problem. The approach is often still punitive. The child

[3] James S. Kakalik, *et al.*, *Improving Services to Handicapped Children* (Santa Monica, Calif.: The Rand Corporation, 1974).

[4] Early Childhood Project, *Child Abuse and Neglect: Model Legislation for the States*, Report No. 71 (Denver, Colo.: Education Commission of the States 1975).

must be injured severely enough to provide sufficient evidence for a court case. Thus we have the situation of social service officials waiting for enough evidence, while the child remains in clearly recognized danger. When the case is brought to court, the parent may or may not be sent to jail. In most cases the term is short, and in a matter of months the child may be returned to a still more embittered parent.

A more positive approach is to reach out to the abusive parent with a prevention and treatment program before the child is seriously abused and before criminal charges are filed. Since most abusing parents were abused children themselves, a therapeutic approach can do more to break the abused child-abusive parent cycle than criminal prosecution.

The first step toward such early intervention is a strong child abuse reporting law that provides the following elements:

- Mandates reporting by professionals from all groups who deal with children (especially young children), including nurses, welfare agency personnel, day care center administrators, school administrators and teachers. Several states have recently passed laws mandating that *all* persons with reason to suspect child abuse must report it. Many laws mandate only doctors and nurses to report suspected abuse, but by the time injuries are severe enough for a doctor to see them, the case is already far advanced and the child may have suffered irreversible damage.

- Grants immunity from criminal or civil actions to all persons reporting in good faith suspected cases of child abuse, whether or not the person was specifically required to report under the law.

- Provides for noncriminal investigation of reported cases, for protective custody of children and for rehabilitative and ameliorative services for parents and children. A reporting system should be established that designates the state and community agency charged with child protection services, rather than the law enforcement agencies, as the primary receiving agency for such reports.

In addition, it is recommended that a state establish a central statewide registry to record all verified cases of child abuse. Besides its statistical value, such a registry can serve as a diagnostic aid in situations where a specific child or his siblings may have been reported to the registry for other injuries. It also serves to trace the parent who takes his child to different doctors and hospitals in order to avoid detection. It is essential, however, that such a registry have sufficient safeguards against improper use of its information.[5]

A strong reporting law, however, is only a first step in improving a state's capability to treat cases of child abuse or neglect. If the child is to be returned safely to his family, the report must be followed by a thorough investigation and the investigation must be followed by a program of supportive services for the child and his parents. In addition to the usual child protective and custody services, family counseling, day care and homemaker services are required to aid the family in its home setting. Professional services can be supplemented by other approaches such as the "lay therapist"—a nonprofessional who becomes a good friend to the parent, providing a long-term sustaining relationship that continues when other services are terminated or limited; self-help groups such as Parents Anonymous; and 24-hour "crisis nurseries" where parents can leave the child for a period of a few hours or a few days if necessary.

State child protective agencies should be empowered and encouraged to develop a multidisciplinary approach to the treatment of child abuse and to coordinate their work with other state agencies, including health, mental health, police and public prosecutors' offices, as well as family courts. They should also work more closely with private voluntary agencies such as Boys' Clubs, charities of religious denominations, the Visiting Nurse Association and Parents without Partners. High priority should be given to educating state agency personnel and all persons required by law to report suspected abuse about the nature and extent of the problem, the procedures for reporting and following up, and of their legal responsibility to do so.

In addition, a major public media campaign should be given high priority to educate the public at large about the nature and extent of the problem. This public information effort is necessary to expand public involvement in the reporting procedure and to mobilize support for funding the necessary protective and rehabilitative services.

In every state where strong new laws have been enacted, resources are needed to initiate and expand programs and services. Funds are required not only to train and educate existing agency personnel, but to lure additional

[5] A thorough discussion of child abuse reporting legislation, including a detailed model, can be found in *Child Abuse and Neglect: Model Legislation for the States*, Report No. 71 of the Education Commission of the States.

personnel. In Florida, for example, only half of the reports that flooded the state agency as a result of the new reporting law could be investigated.

States can receive some financial help through the federal government under the 1974 Child Abuse Prevention and Treatment Act. This was the first action by the federal government that recognized the prevention and treatment of child abuse and neglect as a national problem. It established a national clearinghouse within the Department of Health, Education and Welfare and provided for a demonstration grants program of $5 million for the first year, $20 million for the second year and $25 million each for the third and fourth years.

In order to qualify for the federal money, a state must already have a strong reporting law, a rehabilitative approach to services and a foundation for multidisciplinary and interagency cooperation. (Eligibility requirements are described in the ECS report, *Child Abuse and Neglect: Model Legislation for the States*, Report No. 71.)

3. *Programs for school-age parents.*
School-age parents (under age 18) constitute a high-risk group in regard to their own and their infants' physical and mental health and their social and educational well-being. Infant mortality for school-age mothers is nearly three times as high as for women 20 to 24 years of age and incidence of low birth-weight babies is greater among teenage mothers than any other age group. Low birth-weight not only decreases the chance for the baby's survival during the first year, but appears to have an adverse effect on the child's later development. Recent studies indicate low birth-weight babies are more likely to be mentally retarded, and generally have more perceptual and motor disturbances and more speech problems than normal-weight babies.

Girls in their teens have a greater probability of serious health problems during pregnancy and delivery than any other group except women over 40. Yet pregnancy is the major known cause of female school dropouts in the United States.[6]

Most young parents are ignorant of what to expect of an infant in his first year, often expecting him to sit alone at six weeks, be toilet-trained by six months and recognize wrongdoing before he is 1 year old. Being not yet mature themselves, many teenage parents understandably have difficulty coping with the demands and responsibilities of an infant. A large portion of teenage marraiges dissolve within a year.

In 1969 and again in 1971, the Supreme Court ruled that school-age girls who are pregnant and school-age mothers cannot be excluded from the regular school program unless a physician testifies that such attendance is harmful to the health of the child. Yet, less than one-third of the school districts in the United States make any provision for the education of pregnant girls. Those that do often serve only token numbers of these students. Alternative arrangements, such as adult education classes and homebound education, are often inferior in scope and content to that of regular school curriculum.

With respect to the aims of state education programs, keeping the pregnant teenager in the regular school program solves only part of the problem. Special services are required to meet the other needs of these students:

- Instruction and guidance in health and nutrition during pregnancy.
- Education regarding sex and childbirth. Despite their apparent experience, most teenagers are surprisingly ignorant of the facts of human sexuality.
- Family life education and preparation for the role of parent.
- Instruction in the care, health, nutrition and safety of the child.
- Information about birth control and the use of contraceptives.
- Provision of an infant care center where the parents can learn to care for their babies, and that can serve as a place to leave the baby while the parents are in school.

Programs for school-age parents should either provide directly or give adequate referral service to gynecological and pediatric care, to adequate living facilities, to help in meeting financial needs, to adoption counseling and services and to legal counseling and services.

All of the services described above should be open to young fathers as well as mothers. Whether the young parents are married or not, many of the boys and their families carry some responsibility for the girl or her child. For most young fathers, the pregnancy is an experience full of emotional confusion and anxiety. Usually little or no counseling is available to them. It is imperative that they, too, have better knowledge of themselves, their baby and the responsibilities of parenthood.

[6] Elizabeth M. Whelan and George K. Higgins, *Teenage Childbearing: Extent and Consequences* (Washington, D.C.: Consortium on Early Childbearing and Childrearing, 1973).

There are a number of ways states can take action to further the provision of comprehensive services to school-age parents in all communities. A gubernatorial statement formally calling attention to the Supreme Court rulings and endorsing the coordination of educational, health and social services for these students at the state and local levels may prompt local districts to develop programs and to make better use of state resources and funds for this purpose. Laws and policies could be introduced to assure that all pregnant students retain their educational rights and receive whatever other appropriate services are necessary. Although federal legislation (Title IX of the Education Amendments of 1972) guarantees pregnant students their educational rights, state legislation is needed for reinforcement and clarification.

Michigan has enacted a law forbidding the expulsion of pregnant students but allowing for voluntary withdrawal and for an "accredited alternative educational program" for such students, to be determined by the state board of education.

Other approaches are to amend the educational by-laws (as was done in Maryland) or the state administrative code (as was done in California). In Pennsylvania, a notification from the state attorney general's office prompted the department of education to inform all chief school administrators that no student could be expelled from school for being pregnant. Such laws or policies might also state that school systems have a responsibility to see that girls who do not choose to remain in regular school have an opportunity for equal education elsewhere, and that the school system has a responsibility to cooperate with other departments to see that needed services are provided.

The state could gear its day care policy to educational programs that have as their goal the preparation of young parents for employment above the poverty level. To reverse the welfare cycle, day care must be available to mothers who need to work, with earnings used to determine fees but not eligibility.

State funds could be made available to communities that launch special programs or services for pregnant teenagers. State funds may be supplemented from federal sources, such as the Office of Education, the Office of Child Development, the Maternal and Child Health Service, Model Cities and Title XX of the Social Security Act. Coordination of services at the state level to provide the education, health and social services required could be achieved either through a single existing agency, an interagency coordinating board, an independent state agency such as an office of child development or a department of community affairs. Technical assistance could be offered from individual state departments or from the coordinating agency to help communities launch such programs.

The state could set up model programs on a regional or county basis and in major cities to provide a full range of comprehensive coordinated services to school-age mothers and fathers. For example, the Delaware Adolescent Program, Inc. (DAPI), which started as a pilot project in the city of Wilmington, now operates three centers in the state's three counties, supported by federal grant under Title XX of the Social Security Act with assistance and funding from the State Department of Health and Social Service, the State Department of Physical Health and the State Department of Public Instruction.[7]

Staff for these comprehensive programs are usually provided through the agencies involved. For example, the education department provides accredited teachers and the health department furnishes public nurses. In addition, community volunteers and paraprofessionals can act as aides in most aspects of the program. In some communities, certain types of necessary staff, such as health aides or social workers, may not be available. The state may want to help such communities support a training program, through a hospital or a state university, to develop the needed professional and paraprofessional personnel.[8]

## B. General Principles

From the discussion of these three areas of special need affecting young children and their parents, several common principles become evident.

- Early identification and treatment of a

[7] *The DAPI Story* (Wilmington, Del.: The Delaware Adolescent Program, Inc.).

[8] A detailed discussion of state programs, policies and financing for programs for pregnant school-age girls is available in an "Information Series" packet of four bookelts published by the Consortium on Early Childbearing and Childrearing, Suite 618, 1145 19th St. NW, Washington, D.C. 20036.

Two other organizations that can provide technical assistance and information to state and local groups interested in improving services to school-age parents and their infants are: The National Alliance Concerned with School-age Parents, 3746 Cumberland St. NW, Washington, D.C. 20016; and the Interagency Task Force on Comprehensive Programs for School-age Parents, U.S. Office of Education, Room 2181, 400 Maryland Ave. SW, Washington, D.C. 20202.

problem is essential if substantial amelioration or correction is to be achieved.

- Services need to be addressed to both children and parents. Best results are achieved when the family is helped as a unit and the inherent parent-child dynamic is strengthened.

- No one type of service—such as health, social services or education—can adequately meet any of these needs. A comprehensive approach must be developed through the coordination of all state agencies serving young children and their parents.

- In response to new federal laws and court decisions mandating expanded and coordinated services, the education and training of agency staff at the state and local levels, and of other professionals dealing with young children and their parents, is required.

Perhaps the major difficulty with most state programs and services to meet special needs is that they are planned as a response to specific types of cases. For example, many state laws mandate treatment for specifically named handicaps. If a child's handicap does not fall into one of the named categories, then he or she is not eligible for aid. Some child abuse laws continue to mandate intervention only if the child is younger than 12 years of age. Many states fail to recognize that the mentally retarded, regardless of age, deserve the same protection from abuse as other children.

Piecemeal responses to individual needs leave many persons unprotected and unable to obtain aid. Legislators and other state policy makers should regard individual difficulties as parts of the broad spectrum of family needs and take steps to remove categorical and socioeconomic barriers to state services. The implication of recent federal legislation and court decisions (e.g., those regarding handicapped children and school-age parents) is that all citizens are entitled to the benefits of needed public services and that services and programs must be adapted to meet the needs of a wider range of persons.

# VI. DEVELOPING A COMPREHENSIVE APPROACH TO SERVICES FOR YOUNG CHILDREN AND THEIR PARENTS

It is clear that many services for young children and their parents are already available within the states. Too often, however, such services are fragmented among several state agencies and a variety of private and local groups are creating critical gaps, duplication and waste. What is required is a statewide comprehensive approach, initiated and supported at the highest levels of state government and implemented by local communities according to their need.

A coordinated, comprehensive program of services to young children and their parents should be preventive in orientation and provide services on a continuous, not solely an emergency basis. It should utilize to the greatest extent possible the family's own child-rearing and child-caring capabilities. Its primary goal should be to permit access to all services by all members of the community who need them, rather than restricting services to selected population within the community.

In the past three years a number of states have moved to establish a coordinated approach to planning and delivering services to young children and their families. Their experience suggests the following points:

- The importance of public recognition by the governor and legislature of services for young children and their parents as a state priority.
- The need for a state-level coordinating mechanism.
- The need for a state plan.
- The significance of community-level involvement for maintaining and expanding the state commitment.

## A. The Importance of Public Recognition

Such recognition can serve two purposes. First, it can focus public attention on the issue and make it visible as a state priority. Second, it can provide high-level impetus for coordination and cooperation among traditionally independent agencies and various interest groups.

In many states—particularly if services to parents with young children is a new concept—the governor, legislature or a U.S. Congressman might hold a statewide conference on the topic. The purposes of such a conference are several. Essentially, it provides a prominent forum in which the issues related to the needs of parents and young children can be aired, public attitudes assessed and direction and impetus offered from the governor and legislators. It also serves as an occasion for a preliminary gathering and presentation of data regarding the needs of families throughout the state and the ability of existing resources to meet those needs. And it provides an opportunity to bring together state and local leaders, representatives of the wide variety of groups involved in the field (including, for example, the American Academy of Pediatrics, the League of Nursing and the Parent-Teachers Association) and, of course, parents.

If such a state conference does not seem feasible, the governor could ask an existing state agency to sponsor a study of the state's needs and resources and report to him the results, or the legislature might undertake an interim study of the status of services to children and parents, preliminary to recommendations for a coordinating mechanism established by legislation or executive order. A legislative study of approaches to improved service delivery might start with the various alternatives discussed in this report.

Whatever techniques are adopted to focus public attention on this issue, a major outcome should be the identification of specific appropriate actions to advance a comprehensive service approach to serving parents and young children, to assure that existing programs and services directed to young children are supportive of the family as a unit and to utilize rather than bypass the family's child-rearing resources.

## B. The Need for a State-level Coordinating Mechanism

A coordinating and planning office is usually expected to assess state needs and resources for providing services to young children and their families, draw up a state plan for delivery of services and direct the implementation of the plan. To accomplish this, the office should have authority and staff to review department budgets and make recommendations, propose legislation and develop

public policy to further a comprehensive approach to improved service delivery.

In the past several years, 17 states have established state offices of child development or the equivalent. The experiences of these states suggest several elements essential to the effectiveness of a coordinating and planning mechanism directed specifically to improving services to young children and their parents. First, such an office needs to be established at a level sufficiently high in the governmental hierarchy to be able to effect the cooperation of directors of other agencies. The exact position will vary from state to state. Often the necessary status is best attained as an independent agency or as an agency within the governor's office.

If there is enough active interest on the part of the governor, a coordinating mechanism can also function well within an "umbrella" department of human services. This has been the case in Texas, where the Office of Early Childhood Development is located within the Department of Community Affairs. In West Virginia, on the other hand, the governor created by executive order an Interagency Council for Child Development Services comprised of the heads of the state agencies that provide services for children under age 5 and their parents. The governor himself serves as chairman of the council.

Attempts to place a coordinating and planning body within a special service agency, such as the department of education, tends to be less successful, because services are then often restricted to pre-existing concepts with which the agency is accustomed to working. Such a position usually affords neither the political status nor the independence necessary to obtain the cooperation and support of other state agencies providing child and family services.

The new office must be launched with a sufficiently strong mandate to allow it to carry out the difficult tasks of statewide planning and coordination of services for young children and their parents. A memorandum or directive from the governor may be a first step toward creating such a mandate, but ultimately the office should carry the authority of an executive order or actual legislation.

The staff of the office should be professional and full-time. Voluntary or part-time staff, or professionals who have other primary duties, will seldom have the commitment or the energy to develop more than an advisory capacity, leaving the office without sufficient stature to effect necessary changes.

Since its purpose is to bring together traditionally separate and independent agencies, each with its own set of approaches and priorities, a new office is likely to be resisted as a threat to the established governmental order. Therefore, even with a strong executive or legislative mandate, the office will require the active commitment of the governor, at least during its first years.

A mechanism found important in several states for furthering interagency cooperation in program planning and budgeting is an interagency council, established by executive directive to work with the coordinating office. Such a council is most effective when comprised of agency directors. By providing for the involvement of agency decision makers in the planning process, the council ensures greater cooperation in the implementing of a comprehensive service approach.

In most states, the new office acts primarily to coordinate planning and delivery of services. Actual program operation is carried out by existing agencies. The aim is to use the existing governmental structure more effectively and to control increasing expenditures by reducing the duplication of services and directing state planning toward a preventive orientation. The coordinating office may provide staff and technical assistance to agencies as needed to carry out the plan.[1]

### C. The Need for a State Plan

At the core of a comprehensive approach to child and family services is a state plan to coordinate the work of state and local, public and private agencies. Such a plan will enable a state to develop the means to use its manpower and budgetary resources for maximum impact and cost benefits.

There is a general agreement that competent planning and determination of priorities should be based upon a careful assessment of a state's present and future needs for early childhood and family services. Such an assessment is prerequisite to understanding both the magnitude and the nature of the need and is a necessary first step toward establishing a coordinated approach to services.

Need is usually determined by two factors: a standard or ideal, such as the kind of program, service, health statistic or other quality-

[1] Further discussion of approaches to creating a state coordinating mechanism is presented in two other reports of the Early Childhood Project: Report No. 30, *Establishing a State Office of Early Childhood Development: Suggested Legislative Alternatives*, 1972; and Report No. 55, *State Offices of Child Development*, 1975.

of-life indicator desired; and the present situation, an accurate assessment of the status quo. As part of the latter, the existing statutory mandates and permissions to the various state agencies are determined. "Need" of course, is the difference between the two.

Examination of the data regarding the state's needs and resources and future direction should take place within some sort of general framework articulating a state philosophy, goals and objectives consistent with the content of this report. For example, services should be designed to support families, not to supplant them; services should be preventive in orientation and available to all families on a continuous rather than an emergency basis; services should be coordinated on local and regional as well as state levels.

To have maximum impact, a needs assessment should be comprehensive in scope. It should be based on information gathered from a wide range of data regularly collected by a variety of human service agencies. Such data include population size, migration patterns of children and their families, numbers of deaths and live births, marriages and divorces, educational attainment, employment, income, sizes of households, health (including mental health and nutrition) and child care provisions. These categories can provide the basis for descriptions and comparisons of geographic areas and various populations, a reasonably accurate characterization of the present needs of young children and their families, and a projection of future needs.

Though extensive, however, these data should be regarded only as a beginning. To be realistic, a needs assessment must include some indication of what people really want and will want in services to parents and young children. For example, a large number of working mothers within a community usually indicates the need for some kind of day care provisions for their young children. But it does little good to build a day care center in a community where transportation is poor and the parents have developed more convenient arrangements for care of their children.

To ensure that action is suited to the need, several states have established local councils or committees through which communities are directly involved in the planning process for child and family services. These community councils can take stock of existing local services and programs, identify needs of families with young children and set priorities for dealing with these needs. This can be done through group meetings, individualized meetings, questionnaires and other data collection techniques. This phase is necessarily value-laden and populist and provides the opportunity for community attitudes and concerns regarding family programs and conditions to be aired.

These local councils should be encouraged to sponsor public forums on a local, or at least regional, basis. Such forums not only provide a more accurate realization of the expanse, depth and characteristics of child and family problems, but also permit local and parental involvement in the planning process.

A statewide household survey should be undertaken with the aide of these councils to verify and expand on the more general data discussed above, providing a community or consumer perspective. Besides obtaining more accurate demographic information, such a survey can focus on specific services, such as health care or child care arrangements, and the consumer's response to them—whether they fit consumer needs, expectations and financial limitations.

More detailed suggestions for implementing needs assessments of varying depth and detail are present in two other reports by the ECS Early Childhood Project: *Early Childhood Planning in the States: A Handbook for Gathering Data and Assessing Needs* and *Children's Needs: The Assessment Process.*

Once a comprehensive needs assessment is completed, state policy makers and the public will have a clearer idea of what services and programs exist, what further resources are needed and what kinds of services are desired. The general framework of philosophy, goals and objectives will be augmented by this assessment on the basis of new factual data. Based on the expressed concerns and priorities of parents and communities, a state plan can be structured.

A state plan, by its very nature, must be flexible and sensitive. To be effective it must be adaptable to the divergent sizes, cultures and complexity of resources of the many communities in the state. Planning strategy must give full consideration to existing local conditions.

For this reason, the first steps in designing a substantive program should be taken by the community councils, which can identify and consider alternative solutions and design a substantive program. The state can provide technical assistance to the community in the form of personnel, guidelines and funds to assure the proposed program will be consis-

tent with the requirements of the state plan. The plan can then be submitted to a regional council, if there is one, and then to the state for approval and funding.

In a statewide coordinated system, local committees or councils on children could continue to act as the central coordinating and planning mechanism at the community level. Serving a function analogous to the state coordinating agency, they would review local proposals, make recommendations and, to some degree, administer program funding. Actual services, however, would be operated in most cases by the usual agencies.

### D. Community-level Involvement

Active community involvement in the planning and implementation of child and family services is important because it provides more accurate information about local resources, needs and desires, helps to build flexibility into the state plan and ensures respect for local values, traditions and mores.

A further benefit from active community concern for child and family programs is the advocacy role that naturally emerges from such involvement. Advocacy of the state plan is a necessary part of the program's development. Impressing the importance of the state plan upon state decision makers is a significant aspect in obtaining needed funds and legislation. Hard data can assist such advocacy, but not efficiently; only a small amount of statistics can be meaningfully reported and digested. Without active public interest there is little likelihood that programs to meet established need will be adequately implemented. The legislature must be persuaded that the public wants what the planners say it needs.

The regional forums held in Texas as part of the state needs assessment procedure surprised planning directors with their impact as platforms for parental and community concerns for child and family services. The results of the forums provided geographically significant data for planning, but this information also gained new meaning for legislators by being reported by parents, community leaders and professionals in the field. Seven regional forums attracted a total of 1,000 persons who cited needs for education for parenting, improved health services, expanded child care for working parents and better coordination of services. Their demand for local coordination was underscored in replies to a questionnaire: 48 percent wanted services coordinated at the local level and 38 percent wanted them coordinated through a statewide system. Less than one percent preferred that each state agency provide services in its own way.

Nothing is so clear an advocate as the consistent articulate voice of the public. If momentum has been gained through public involvement in the planning process, it seems wise to maintain this involvement through active state-level support of local or regional commissions concerned with family and children's services. These may be newly developed organizations or existing groups such as Community Coordinated Child Care (4-C) or Commissions on Children and Youth. Often these organizations can work more effectively with the state plan if they are reorganized and given new powers.

In any case, the local committees should be composed largely of parents, with community leaders, representatives of public and private service agencies and professionals who work with children (such as doctors, teachers, nurses and social workers). There should also be representatives of private and volunteer organizations such as the PTA, the League of Women Voters and the United Fund, and representation from local service agencies.

Local councils are operating in a number of states. In Texas, many of them developed directly out of the original state planning process. Many members were involved in organizing the regional forums and others in implementing the household survey. In Massachusetts, Councils for Children were developed with the help of organizing funds from the state Office for Children and an extensive public information program. In Arkansas, Committees for Children have been established at the state, regional and local levels. In addition to an advocacy role, these committees furnish continuing input to the state planning effort and assist in selecting advisory boards for new programs as they begin in regions and communities. The committees could themselves organize for the operation of programs if they desired, but so far their role has been primarily child advocacy and the development of programs.

The Massachusetts Office for Children has developed 39 Councils for Children, each representing a cross-section of children's interests in every area of the state. Community representatives began by building upon the 4-C groups that already existed and by contacting every identifiable group related to children and drawing their representatives together as an organizing committee. A publicity campaign, complete with leaflets, mailings, newspaper and radio announcements and posters, summoned to a public organizing

meeting a diverse range of people whose common denominator was their active concern for children and their determination to have a voice in the state's policies affecting children and families.

In less than a year, these Councils for Children became vocal and effective advocates for children's services, vigorously informing legislators and state agency directors of their concerns. They played an active role in the development and passage of a consolidated budget for child and family services, providing $20 million in new state money during fiscal year 1975.

# VII. FUNDING ALTERNATIVES FOR COMPREHENSIVE STATE PROGRAMS

The total cost of statewide comprehensive services for young children and their parents is unquestionably high. In considering the effectiveness of such expenditures, however, states might keep in mind two points: (1) the cost to the state of *not* providing such services computed both in dollars and in the lives damaged because of the absence of needed experiences in early childhood and (2) that funds can be obtained from a variety of sources, private as well as public, and that their maximum use can be obtained through careful financial planning and service coordination at the state and local levels.

A precise estimate of the cost of a practicable comprehensive service approach is difficult to make. Basic costs vary widely among the states; different states may make different decisions about which services are or are not part of the program; funds for many services are buried in the general budgets of several agencies and are rarely identified as costs for children's services per se; and many expenses are met through donated goods and services from community sources, both public and private. In addition, an assessment of state needs will undoubtedly reveal a number of needs not now being met. The range of these needs and the subsequent costs of meeting them will vary widely from state to state.

Because of the complexity of these issues and the general inaccessibility of cost data, it seems more useful in this report to concentrate on approaches to state financial planning and sources of funds, rather than on dollar amounts.

## A. Approaches to Financial Planning

There are more than 200 federal programs providing funds that can be used, to some degree, to meet the needs of young children and their parents. Only a small number are specifically addressed to the needs of children, but even among these, objectives are often inconsistent, administration at federal and state levels is fragmented and financing is dispersed. In addition to federal programs, there are innumerable state, local and community resources—public and nonpublic—that can be directed to children's services.

In order to use these funds more effectively, states need to know where they are located, how they are currently being used and what regulations or statutes govern alternative uses. States can then examine ways of welding these resources together to finance a comprehensive state plan to achieve more efficient use of their money, expand the actual number of service recipients and reduce per-capita costs.

1. *Coordination of state agencies.*
It seems reasonable that the same planning and coordinating agency described in the preceding chapter be assigned the tasks of identifying all possible sources of revenues and developing a plan for the most efficient use of these resources.

One successful attempt to develop such a comprehensive state financial plan for children's services is the 1974 Massachusetts Children's Budget, the result of the coordinated efforts of four state agencies to secure a consolidated set of monies specifically marked for children's services. For more than a year, personnel from the Office for Children (OFC), the state's coordinating and planning agency for children's services, worked with the departments of Public Welfare, Mental Health, Public Health and Youth Services and the Executive Office of Education to analyze their budgets isolating those funds spent on children's programs. In addition to identifying the amount of funds, the OFC evaluated their expenditure by geographic area and types of services to determine overlaps and gaps in service delivery.

The OFC and the directors of each department also worked with local area councils for children to determine priorities and needs for children's services across the state. The four agencies submitted for the first time a consolidated budget rather than individual budgets competing for the same money. The single budget made visible the funds earmarked for children's services and permitted local groups to participate in the previously obscure process of preparing and passing the state budget. This effort secured $20 million in new state monies for children's services.

2. *Inventory of federal funds.*
Also needed is a similar inventory of major federal funds available for the support of state-administered services to children. This should include an analysis of how the uses of these funds are related to each other and where the potential exists for strengthening

these relationships and expanding service delivery. The state administers the vast majority of federal funds for children and, in principle at least, has substantial authority over how those funds are used. In practice, however, the funds too often are received by individual agencies and processed without regard to what other agencies are doing or what the needs are.

For example, most federal programs are addressed to the same population groups—the poor and chronically unemployed. This is true of Aid to Families with Dependent Children, Medicaid, Maternal and Child Health programs, the Work Incentive (WIN) program and programs financed under Title I of the Elementary and Secondary Education Act. The funds, however, are administered through several different state agencies. The same persons may be seeking all those services, but the service agencies are not coordinated and seldom communicate with each other.

3. *Expanding state fiscal authority.*
The maze of laws and regulations governing federal programs presents a major obstacle to the systematic development of integrated programs. It is possible, however, for states to expand their authority to develop more coordinated and more efficient child care services. Existing regulations under Office of Management and Budget (OMB) circulars enable states to initiate comprehensive plans of action in various policy areas. OMB Circular A-95, permits the state, especially the governor, to review the impact of proposed federal programs prior to their inception. It centralizes review responsibilities and facilitates more efficient planning and budgeting procedures. In a 1970 study, however, the U.S. Advisory Commission on Intergovernmental Relations concluded that states have failed to use the A-95 Circular to its fullest potential. Another OMB circular, A-98, permits states to establish standard reporting procedures concerning currently operating federal programs. A majority of child-related programs are included under the provisions of this circular. In examining state policies of child development, two analysts concluded in 1973 that if states used A-95 in conjunction with A-98, they could develop a "composite picture of program trends, thus allowing for tracking grants from application through funding stages. Such an information base would be essential for making intelligent choices in allocating and implementing child development services."[1]

A third OMB circular, A-102, provides the power to coordinate different federal programs and deliver integrated services, eliminates the need for separate bank accounts for individual federal programs and, most importantly, permits the waiver of the requirement that each federal program be administered by a single state agency. This last requirement "has greatly contributed to the development of watertight state agencies that behave more as extensions of their federal counterparts and less as cooperative members of a family of state agencies."[2] Circular A-102 thus permits the governor to coordinate policy planning and centralize financial control over closely related programs and services. The combined use of the three circulars could enable a state to move agressively to shape federal programs to the needs and priorities of its own communities.

## B. Sources of Federal Funds

As stated earlier, there are nearly 200 federal programs whose funds can be used to support services to young children and their parents. By tracking these down and using the funds to enhance individual aspects of comprehensive service programs, states and communities can frequently expand their funding resources. There are several federal programs, however, that direct large amounts of money specifically to the needs of young children and represent the major source of revenue for state support to children's services.

The major federal sources of revenue for child development programs include the following:

1. *For education.*
Title I of the Elementary and Secondary Education Act (ESEA) is intended to improve the ability of local school districts to deliver educational services to low-income families. A certain amount of these funds, as determined state by state through a complex formula, can be used to finance kindergarten programs for low-income children. Funds for the education of migrant children (Title I-Migrant) can be used to serve children under the age of 6.

Title VII of the ESEA provides funds for bilingual programs to meet the needs of children with limited ability to speak English or who come from a non-English-speaking background, including children under age 6. Under the Education Amendments of 1974 (P.L. 93-380) relating to education of the handicapped, ESEA funds may be used for

[1] David Nesenholtz and Jurgen Schmandt, "Social Policy and the New Federalism: The Case of Child Development Policy," *Public Affairs Comment*, August 1973, the Lyndon B. Johnson School of Public Affairs, University of Texas at Austin.

[2] *Ibid.*

early identification and assessment of handicapping conditions in children under 3 years of age. Properly directed, these funds might help supplement the screening programs carried out under EPSDT.

All titles of ESEA are administered through the state education agency and are presented to the states with no matching provisions. The only major federal education program not administered through the state education department is Head Start. In line with the practice of the Office of Economic Opportunity of utilizing local, public and private agencies, Head Start programs continue to be contracted directly from the federal government to local organizers. Many Head Start programs are, however, located in school systems.

*2. For health care.*

Two programs are available under Titles V and XIX of the Social Security Act. Title V, Maternal and Child Health, is intended to assist in reducing infant mortality and improving the health of infants and mothers living in rural or economically distressed areas. Funds are provided in matching grants with a federal-state ratio of 75 percent to 25 percent. The program is administered through the state health department and disbursement of funds to local health departments is left to the discretion of the state agency.

Title XIX is the Medicaid program, providing general health services for the needy, including children (ages 0 to 21) of poor families and children in foster care or state institutions. Approximately one-third of the children served are under age 6. The new Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program also falls under this Title. Both Medicaid and EPSDT funds are provided on a 75-25 matching basis and channeled through the state department of welfare and social services. (For more detailed discussion of these programs see Chapter V, Health Services.)

*3. For social services*

By far the largest source of funding for social services is Title XX (formerly Title IV-A) of the Social Security Act—Aid to Families with Dependent Children (AFDC). This program authorizes direct payments for children of low-income families in which the father is absent, incapacitated or dead. At the discretion of the state, coverage can be extended to low-income families with an unemployed father still present in the household. This title also provides the broadest authorization for day care for AFDC children. (For more discussion, see Chapter V, Day Care.) While other services, such as family planning or homemaker services. can also be offered under this program, the majority of activities consist of day care. Funds are provided on a 75-25 matching basis.

A second source of day care funds for AFDC children is Title IV-C of the Social Security Act, the Work Incentive (WIN) program, which provides day care to children of AFDC mothers who enter a work training program. Although this program offers the state a very attractive match of 90-10, it is largely underutilized. Among the reasons for this are the problems of training AFDC recipients for often nonexistent jobs, the limitations on the number of training slots and dependence on largely unsatisfactory home care.

Title XX is the largest and the most flexible funding source for social services. It has the largest potential client population, and a broad range of activities and services that qualify for federal matching grants. With the transition from Title IV-A to Title XX, state planning is subject to public review and comment within the state rather than to review and approval by the federal government.

The $2.5 billion ceiling for Title IV-A has also been imposed under Title XX. However in 1974, while $2.5 billion in federal money was allocated for Title IV-A services, only a little more than half this money was actually used. State departments have also been slow to implement EPSDT programs on a statewide level, although the money and the mandate have been available since 1968.

### C. Expanding Available Funds

States committed to providing comprehensive services to all young children and their families need to explore a variety of funding resources other than federal programs. Diversity of funding permits diversity of service to all members of the population. While almost all states are using the funds discussed above to some degree, several approaches can be taken to expand substantially the amount of monies available to the states.

Two reasons frequently cited for the failure to use maximum federal funds are the problems of raising sufficient state funds to match the federal funds and an aversion to extended "welfare" programs on the part of many state policy makers. Both objections can be over-

come by states committed to developing services to meet the needs of all their families.

1. *Using local and private monies.*
There are many sources in addition to the state coffers from which matching funds can be generated. Individual school districts and cities can appropriate funds. Moreover, funds from nonprofit organizations, such as the United Fund, along with foundation grants and publicly donated monies from private local sources, can all be applied to match federal sources. Two cities—Austin, Texas and Kansas City, Kansas—have appropriated their own matching funds for day care programs.

2. *Developing new state monies.*
Of course, many of the necessary funds must come from new state monies. The Massachusetts Children's Budget demonstrates that this is not an impossibility. Informed and involved citizens can quickly become effective advocates for children's services, persuading state legislators and administrators to make children a top state priority for tax dollars.

Many sources other than state revenue can be tapped to contribute to the development of comprehensive state services. The most direct approach would be payment for services by recipients on a sliding fee scale. States might also offer tax credits to private industries providing day care or extensive medical services for their employees.

3. *Meeting the costs of day care.*
Day care is perhaps the service most in demand and most expensive to provide. In addition to tax credits to industry, states might consider guaranteeing small business loans for persons wishing to start new centers. Low-interest loans could also be granted directly by the state. Present home care operators could be encouraged to upgrade the quality of their services by obtaining free staff training and free materials from state sources or from state-funded resource centers. Vocational rehabilitation money and WIN funds could be applied to train welfare mothers to start their own day care homes. WIN funds could also be used to provide inservice training for welfare mothers in day care centers. If such a training program were established, graduates might be employed on the payroll of a local industry and stationed in the day care program as a contribution of industry. WIN and Vocational Rehabilitation training would thus address two problems simultaneously—the lack of jobs for WIN recipients and the lack of day care places for their children.

The Women, Infants and Children (WIC) program sponsored by the U.S. Department of Agriculture supplies free juice, milk and eggs to children up to the age of 4, provided the mothers are registered at a local health department and are receiving regular physical checkups. At the state level, the coordinating unit for this program is the department of health. The use of the program by day care centers would reduce costs slightly and would enhance the nutritional and health programs for children and their mothers.

Numerous other relatively inexpensive measures are possible to expand the availability of day care. For example, if a potential day care mother needs to alter her home to meet federal or state licensing regulations or state and local building codes, states could underwrite a loan for this purpose. Social security regulations also permit grants for this purpose to persons who own their own homes.

Day care centers can be set up as part of a high school curriculum in family living or child development (see Chapter V, Education for Parenthood). As part of the school curriculum, the center would be financed partly by school district funds, including home economics and vocational education funds. In some states, such as Massachusetts where day care is by statute a function of the schools, facilities can be built using state building assistance funds. Partially staffed by professionally supervised high school students earning course credits, an excellent program for neighborhood preschoolers could be run at substantially lower cost than a center staffed by paid professionals and paraprofessionals. Supervised work-study students could help to relieve staff costs in other community day care centers.

Day care might be tacked onto a kindergarten program, providing a safe and pleasant environment for children whose parents cannot pick them up until after working hours. Thus a 9 a.m. to noon kindergarten facility could continue to be used throughout the afternoon by a relatively low-cost program. Or, a center might be started in conjunction with a senior citizens home, providing fulfilling experiences for both the older and younger persons, and simultaneously providing free staff to the program.

The South Carolina Office of Child Development is seeking other approaches to make maximum use of funding sources other than Title XX. Emergency Employment Act funds from the U.S. Department of Labor are used to staff child care centers, and Comprehensive Employment and Training Act funds, also from the Department of Labor, are providing child care services for persons enrolled in certain training programs. In addition, local revenue

sharing funds are helping to open day care centers and the state General Assembly has appropriated funds to be used primarily to assist centers in meeting licensing requirements. Other states and cities are also beginning to use both local revenue sharing funds and community development funds to open new day care centers and to keep existing ones in operation. Since day care is a labor-intensive service, they are also finding it possible to use public-service job positions as a way of partially funding their operations.

### D. Increasing State Responsibility for Financial Planning

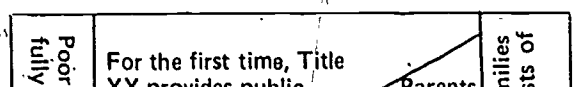
It is clear from many of the above facts that states have more latitude in guiding funding policies than is often supposed. They can do much to shape the use of federal resources and can generate further funds from private and local sources as well as from the state revenue.

Several recent actions by the federal government seem to encourage the trend toward placing greater responsibility on individual state governments to define the particular needs of their communities and design services and funding to meet those needs. The Maternal and Child Health Amendments of 1973 reallocated direct grants to projects to become part of the formula grants to the states. With stipulation that the states must develop plans to maintain the ongoing projects, the reallocation essentially turns over to the states the administration of 90 percent of monies allocated under the law.

The Education Amendments of 1974, P.L. 93-380, provides for the consolidation of a number of existing federal programs into two categories—Part B (Libraries and Learning Resources) and Part C (Educational Innovation and Support). Part B will combine the school library program, the guidance and counseling programs and the equipment program. Part C consolidates innovation, dropout prevention, health and nutrition programs and aid to strengthen state departments of education. According to a specific formula, over the next three years these funds are to be consolidated and distributed to the states for redistribution to the local education agencies according to a state plan.

Title XX also offers the states greater latitude in determining program eligibility and in planning services and service delivery. As mentioned above, Title XX substantially expands the population eligible to receive certain benefits of the Social Security Act. The title permits free services to persons with up to 80 percent of the median family income in a state and services on a sliding-fee basis for recipients having up to 115 percent of the median income level of the state. Programs allowed include, but are not limited to, training, employment, information, referral and counseling services; day care programs; child protection services; food and health support services; and programs designed to meet special needs, such as for the blind, retarded, physically handicapped and emotionally disturbed. The amendment leaves to the states the major responsibility of naming services, but sets certain parameters and makes suggestions as to what those services can include.

Title XX for the first time makes possible at some future date a single-entry, universally available service system. Those who are poor will be fully subsidized; those who are wealthy will pay the full cost of service; those in between will pay on a sliding scale according to their ability to pay, with federal and state matching funds making up the difference. Federal policy will no longer force segregation by economic category. The creative use of this opportunity for universally available service is up to each state. A model for the service system now made possible can be shown by the following figure:




These and other acts of the federal government tend to increase state authority in setting the direction of programs and funds to serve young children and their parents. States committed to providing services for all young children and their families are increasingly able to make maximum use of federal programs without being limited to serving only as implementors. The trend is to return the initiative for planning to the states, providing the opportunity for states to shape services to their own needs.

## VIII. RECOMMENDATIONS

### A. Recognize Many Family Forms

States should recognize that families in America take many forms, and that the nuclear family of a married man and woman and their offspring is only one of a range of different arrangements. Each form has its own strengths and weaknesses, and each is capable, under favorable circumstances, of providing a cohesive, warm and supportive environment for the healthy development of children.

### B. Establish a Common Set of Program Objectives

Services to support parents in their child-rearing tasks should lead to greater family cohesiveness and independence. In developing programs to pursue this broad goal, a specific set of program objectives should be considered to ensure that state programs contribute to the strengthening of the many and varied families they serve. The following objectives are suggested as an operational base for all state programs designed to serve young children and their parents:

- To assist parents to become more positively involved in the lives of their children.
- To help parents understand better the process of child growth and development.
- To provide experiences by which parents learn to meet more fully the developmental needs of their child.
- To provide assistance, when necessary, that will increase the possibility of the family staying together rather than being separated.
- To do this in a context that recognizes the importance of different cultural and ethnic values, traditions and mores and addresses the particular needs and concerns of individual families.

### C. Develop Expanded Services in Four Major Areas

States need to explore ways to expand their service capacity in four major areas of family need: education for parenthood, health services, day care and services to parents and children with special needs. These services have in common several important elements. They aim to support families, not to replace them; they represent a preventive approach rather than a remedial one; they address needs common to all families, regardless of cultural or ethnic background or socioeconomic position; they are not emergency services, but continuous, ongoing services directed primarily at meeting needs before they become problems.

1. *Education for parenthood.*
Education for parenthood should be an integral part of programs provided in a comprehensive system of child and family services. This is consistent with the objective of utilizing and supporting as much as possible the family's capacity to care for its own. Most parents need and want to know more about the social, physical, emotional and intellectual needs of young children, the similarities and differences in the ways that children develop, and the role that parents can play in their child's development.

Parent education may be most effective when it is the result of direct involvement in programs such as day care or preschool, or in planning and administration. Actual instruction in various aspects of child growth and development can be provided through hospitals and prenatal clinics, through maternal and child clinics, through child and family resource centers, through community organizations such as the Red Cross and Visiting Nurses and through the schools. Each of these agencies can introduce parents or potential parents to the information they need about the growth and development of their child, and when appropriate, can help them acquire needed skills.

It is recommended that states consider expanding the use of television and radio for parent education. Funds should be provided to promote short public service announcements, to be repeated frequently, as well as longer programs produced in cooperation with public television and radio broadcasting and with local network affiliations.

Parenting education should also be directed to adolescents to prepare them for their future roles as parents. State departments of education might consider newly developed approaches, some of which are suggested in this report, to revising home economics or family living curricula at the junior high and high school levels in order to provide the students

with experience with young children and to increase the enrollment of boys.

2. *Health services.*
In order to provide full health services to all its children, a state should consider the following steps:

- Extend publicly funded health and nutrition programs, such as Maternal and Infant Care and the Supplemental Food Program for Women, Infants and Children (WIC) to all women, children and families who require them, especially the "medically indigent" who are employed but cannot afford regular adequate health care for family members.

- Develop a program of early screening, diagnosis and testing that will be available and accessible to all preschool-age children throughout the state.

- Expand the use of family-oriented delivery systems such as family health centers, neighborhood health centers and health maintenance organizations.

- Adapt state laws to permit greater flexibility in training and practice of nurses and middle-level health personnel.

- Develop a statewide plan to coordinate existing public and private resources, deemphasizing hospitalization and encouraging preventive, diagnostic and ambulatory services.

3. *Day care.*
Quality day care should be available in some convenient form, whether center-based or home-based, on a sliding-fee basis to all who need it. States should aid communities in determining the services most suitable for their particular needs, taking the initiative to bring together a wide range of funding sources—federal, local and private—as well as developing new state monies for this purpose.

States should take steps to assure that day care programs are of a quality to provide a safe nurturing environment for the child, addressing all aspects of social, emotional, educational and physical development. In addition, states should make the opportunity for parent involvement an essential part of its programming for day care, through its fiscal requirements.

The states could improve their licensing process by a statutory requirement for the creation of a unified system out of the present fragmented regulatory activities stemming from four major statutory mandates: zoning, building and fire safety, sanitation and day care licensing. States should think through the relation of licensing to fiscal monitoring. Adequate staff to manage day care center licensing is an attainable goal for most states. It is recommended that licensing be centralized at the state level in order to guarantee the children of the state uniform interpretation and enforcement and equal protection. For family day care, new and creative ways to regulate should be initiated on an experimental basis.

*4. Services to parents and children with special needs.*
States need to develop legislation to promote comprehensive and rehabilitative approaches to helping parents and children with special needs. While this section of the report devotes special attention to three types of special situations particularly affecting the welfare of young children—the handicapped child, child abuse and school-age parenthood—several general principles for state action are recommended:

- Procedures for early identification of the problems need to be developed.

- Services should be addressed both to children and to parents, and the family should be aided as a unit.

- Since these needs require a mixture of services from the health, education and social sectors, as well as a continuum of programming, a coordinated comprehensive approach should be developed among all state agencies dealing with parents and young children.

- State policy makers should take steps to remove categorical and socioeconomic barriers to state services.

- Agency staff at the state and local levels should receive the necessary education and training required to implement a comprehensive and rehabilitative approach.

### D. Develop a Comprehensive Approach to Services for Young Children and Their Parents

To help reduce the duplication, waste and gaps in service resulting from the present fragmented approach to individual services, it is necessary that states develop a statewide comprehensive approach, initiated and supported at the highest levels of state government and implemented by local communities according to their need.

A coordinated comprehensive program of

services to young children and their parents should be preventive in orientation and provide services on a continuous, not solely an emergency, basis. It should utilize to the greatest extent possible the family's own child-rearing and child-caring capabilities. Its primary goal should be to permit access to all services by all members of the community who need them, rather than restricting services to selected populations within the community. On the basis of the experience of several states in recent years, the following steps appear necessary in the development of a comprehensive service approach at the state level:

- Initiative and commitment from the highest levels of the executive and legislative branches of state government, especially the governor.

- A state coordinating mechanism.

- A state plan for providing continuing and coordinated services to young children and their families.

- Systematic community and parental involvement in the planning and implementation of services for young children and their parents.

### E. Increase State Initiative in Developing and Coordinating Funding Sources

States should examine ways of welding together funds from a variety of resources to finance a comprehensive state plan. This will guarantee a more efficient use of available money and will expand the actual number of service recipients.

The maze of laws and regulations governing federal programs presents a major obstacle to the systematic development of integrated programs. It is possible, however, for states to expand their authority to develop more coordinated and more efficient child care services. Existing regulations under Office of Management and Budget (OMB) circulars permit states to initiate comprehensive plans of action in various policy areas. The combined use of these circulars could enable a state to move aggressively to shape federal programs to the needs and priorities of its own communities.

Many sources other than state and federal revenues can also be tapped to contribute to the development of comprehensive state services. States committed to providing such services for all young children and their families can explore a variety of funding resources other than federal programs. One beneficial result of such an approach is that diversity of funding permits diversity of service to all members of the population.

## EARLY CHILDHOOD PROJECT PUBLICATIONS

*Early Childhood Project Newsletter* (published bimonthly: no charge)

*Early Childhood Development: Alternatives for Program Implementation in the States* (ECS Report No. 22, June 1971: $1.00)

*Early Childhood Programs for Migrants: Alternatives for the States* (ECS Report No. 25, May 1972: $1.00)

*Establishing a State Office of Early Childhood Development: Suggested Legislative Alternatives* (ECS Report No. 30, December 1972: $1.00)

*Early Childhood Planning in the States: A Handbook for Gathering Data and Assessing Needs* (ECS Report No. 32, January 1973: $1.00)

*Implementing Child Development Programs: Report of a National Symposium August 1974* (ECS Report No. 58, December 1974: $2.00)

*Early Childhood Programs: A State Survey 1974-75* (ECS Report No. 65, April 1975: $1.00)

*The Very Young and Education: 1974 State Activity* (ECS Report No. 68, May 1975: no charge)

*Child Abuse and Neglect: Model Legislation for the States* (ECS Report No. 71, July 1975: $3.00)

*Day Care Licensing Policies and Practices: A State Survey, July 1975* (ECS Report No. 72, August 1975: $2.50)

*State Offices of Child Development* (ECS Report No. 55, September 1975: $3.00)

*State Services in Child Development: Regional Conference Highlights* (ECS Report No. 75, November 1975: $1.00)

*The Role of the Family in Child Development: Implications for State Policies and Programs* (ECS Report No. 57, December 1975: $3.50)

*Children's Needs: The Assessment Process* (ECS Report No. 56, January 1976: $2.00)