

EARLY EXPERIENCES MATTER



A GUIDE TO IMPROVED POLICIES FOR INFANTS AND TODDLERS



National Center for Infants, Toddlers, and Families

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National Center for Infants, Toddlers, and Families



About ZERO TO THREE

ZERO TO THREE is a national nonprofit organization that informs, trains, and supports professionals, policymakers, and parents in their efforts to improve the lives of infants and toddlers.

Our mission is to promote the health and development of infants and toddlers. We achieve this by translating research and knowledge—specifically information about the kinds of early experiences that help children thrive—into a range of practical tools and resources for use by the adults who influence the lives of young children.

We are unique in our multidisciplinary approach to child development. Our emphasis on bringing together the perspectives of many fields and specialties is rooted in robust research studies that show that all domains of development—social, emotional, intellectual, language, and physical—are interdependent and work together to promote a child's overall health and well-being in the context of family and culture.

About the ZERO TO THREE Policy Center

The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. The Policy Center brings to bear ZERO TO THREE's more than 30 years of research-based expertise on infant and toddler development to ensure that public policies reflect best practices and current research in support of our nation's very young children.

Our agenda is simple: The ZERO TO THREE Policy Center promotes *good health, strong families, and positive early learning experiences* for all infants and toddlers, with special emphasis on those who are the most vulnerable and in need. The Policy Center advances public policy solutions and investments for the health and development of very young children and their families. In doing so, the Policy Center synthesizes and disseminates knowledge, cultivates advocacy leadership, and engages policymakers.



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AGENDA

INFANT & TODDLER POLICY FRAMEWORK

Health:

- Physical Health
- Social & Emotional Health
- Developmental Screening

Family Supports:

- Basic Needs
- Parent Education
- Home Visiting
- Child Welfare
- Paid Family Leave

Early Learning:

- Child Care
- Early Head Start
- Early Intervention

**Good
Health**

**Strong
Families**

**Positive
Early Learning
Experiences**

INTEGRATED PLANNING & ACTION

Services + Infrastructure = System

Accessible

Affordable

High Quality

Culturally Responsive

Regulations & Standards

Quality Improvement

Professional Development

Accountability & Evaluation

Public Engagement

Political Will Building

Governance & Leadership

Financing



National Center for Infants, Toddlers, and Families

MAKING THE CASE FOR A COMPREHENSIVE INFANT AND TODDLER POLICY AGENDA

We are all a product of our earliest experiences, and this means that our early experiences play an important role in who we become and how we contribute to society. Research and clinical experience from a range of disciplines—including neuroscience, behavioral research, program evaluation, and economics—demonstrates that the first experiences and relationships in life play a critical role in a child's ability to grow up healthy and ready to learn.

Yet, while almost every social policy—from welfare reform to education to mental health—affects infants and toddlers, the impact of these policies on very young children is seldom sufficiently addressed. We must translate what we know from research and clinical experience about the needs of infants and toddlers into effective, evidence-based policies and practices.

The purpose of this case statement is to provide an overview of some of the most compelling evidence for investing in and implementing a comprehensive infant and toddler policy agenda. The evidence boils down to six major points, which are described in more detail below.

1. Early experiences, coupled with the influence of genes, literally shape the architecture of the brain.
2. Early experiences take place in relationships.
3. All domains of development are interdependent.
4. Development is cumulative, so early experiences lay the foundation for all that follows.
5. Because early experiences matter, we must intervene with young children who are at risk.
6. Early experiences are a proven investment in our future.

The other tools in the *Policy Guide* serve as a complement to this case statement by providing the details of, and the research behind, the comprehensive policy agenda.

EARLY EXPERIENCES, COUPLED WITH THE INFLUENCE OF GENES, LITERALLY SHAPE THE ARCHITECTURE OF THE BRAIN

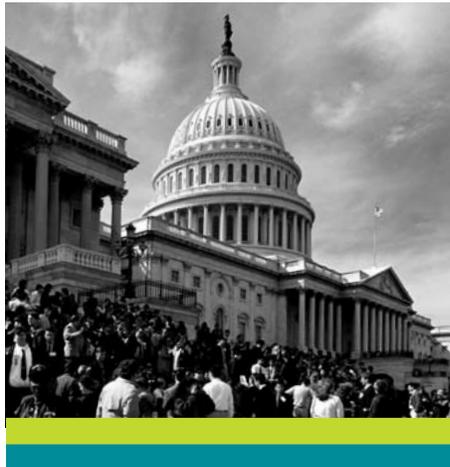
Research shows that it is during the first three years of life when the brain undergoes its most dramatic development. The Center on the Developing Child at Harvard University offers an excellent summary of the science, as quoted and described in the bullets below. As this summary makes clear, the greatest opportunity for influencing a child's life begins on day one, and policy choices at all levels of government should reflect this knowledge.

- **“Brains are built over time, from the bottom up.** The basic architecture of the brain is constructed through an ongoing process” that involves the reciprocal influences of both genetics and early experiences¹ and “begins before birth and continues into adulthood.” Early experiences are much like the construction of a solid, stable building. The neural pathways and connections literally shape the

physical architecture of the brain, forming the strong foundation on which everything else is built. When it comes to the healthy development of infants and toddlers, this means that “the quality of that architecture” directly results in either “a sturdy or a fragile foundation for all of the learning, health and behavior that follows.”²

- **“The interactive influences of genes and experiences shape the developing brain.”**

Neuroscience teaches us that the interactive nature of the relationship between children and their caregivers - termed the “serve and return relationship”³ is essential to the formation of the developing brain. Infants are great communicators, using sounds, facial



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expressions, gestures and body movements to let adults know what they want. “Adults respond with the same kind of vocalizing and gesturing back to them. In the absence of such responses-or if the responses are unreliable or inappropriate-the brain’s architecture does not form as expected, which can lead to disparities in learning and behavior.”¹³

- **“The brain’s capacity for change decreases with age.** The brain is most flexible, or ‘plastic,’ early in life to accommodate a wide range of environments and interactions, but as the maturing brain becomes more specialized to assume more complex functions, it is less capable of reorganizing and adapting to new or unexpected challenges. Early plasticity means it’s easier and more effective to influence a baby’s developing brain architecture than to rewire parts of its circuitry in the adult years.”¹⁴
- **“Toxic stress damages developing brain architecture, which can lead to life-long problems in learning, behavior, and physical and mental health.** Scientists now know that chronic, unrelenting stress in early childhood, caused by extreme poverty, repeated abuse, or severe maternal depression, for example, can be toxic to the developing brain. While positive stress (moderate, short-lived physiological responses to uncomfortable experiences) is an important and necessary aspect of healthy development, toxic stress is the strong, unrelieved activation of the body’s stress management system.” When parents or other caregivers are not able to serve as buffers for toxic stress, it can become

“built into the body by processes that shape the architecture of the developing brain.”¹⁵

EARLY EXPERIENCES TAKE PLACE IN RELATIONSHIPS

Early relationships are formative and constitute a basic structure within which all meaningful development unfolds.⁶ In other words, relationships are the building blocks of healthy development.⁷ If, as very young children, we have positive, predictable relationships with our parents or other caregivers, we will feel safe from harm and secure that our basic needs will be met. Our energy can therefore be spent on exploring the world around us and having the positive early learning experiences that will nurture our developing brains and help us to achieve healthy growth and development.

If, on the other hand, we do not have nurturing relationships with our parents and other caregivers, we are more likely to focus our energies on protecting ourselves and making sure our basic needs are met. In these circumstances, interacting with people and objects in the environment becomes more difficult, and there are greater challenges in our early learning experiences. Without these formative early relationships, we will have a harder time developing healthy relationships in the future.

ALL DOMAINS OF DEVELOPMENT ARE INTERDEPENDENT

Research shows that all domains of development—social, emotional, intellectual, language, and physical—are



If, as very young children, we have positive, predictable relationships with our parents or other caregivers, we will feel safe from harm and secure that our basic needs will be met.

interdependent and work together to promote a child's overall health and well-being. Emotional health and social competence provide a solid foundation for emerging cognitive abilities, and together they are the “bricks and mortar that comprise the foundation of human development.”⁸ This means that how we nurture a child's heart is just as important as how we nurture his mind and his body.

For example, language acquisition depends not only on hearing, the ability to distinguish sounds, and the ability to link meaning to specific words, but also on skills that emerge with social and emotional development—the ability to focus, pay attention, and engage in social relationships.⁹

DEVELOPMENT IS CUMULATIVE, SO EARLY EXPERIENCES LAY THE FOUNDATION FOR ALL THAT FOLLOWS

Neuroscience confirms that the early years establish the foundation on which later development is built. The emergence of basic skills and competencies is directly linked to the later development of more complicated skills and competencies. How, and how well, we think, learn, communicate, concentrate, problem solve and relate to others when we get to school and later in our lives depends in large part on the experiences we have and the skills we develop during the earliest days, months, and years.

School readiness is a good example of this. Research

demonstrates that educational outcomes in the teenage years are related to academic skills at kindergarten.¹⁰ Academic skills at kindergarten, in turn, are related to early experiences that foster the development of capabilities during the earliest years. There is, furthermore, a strong association between children's cognitive skills before they enter kindergarten with achievement in elementary and high school.¹¹ High school completion can even be predicted based on general cognitive ability in the preschool years.¹²

WE MUST INTERVENE WITH YOUNG CHILDREN WHO ARE AT RISK

Although the early years are a time of great opportunity for babies, they are also a time of great vulnerability. A child's development can be seriously compromised by a disability or developmental delay or by environmental influences such as exposure to toxins, extreme poverty, malnutrition, substance abuse, child abuse and neglect, community or family violence, or poor quality child care. As noted earlier, early and sustained exposure to such risks can influence the physical architecture of the developing brain, preventing infants and toddlers from fully developing the neural pathways and connections that facilitate later learning.

Fortunately, program evaluation research demonstrates that quality, research-based early intervention programs that begin early can improve the odds of positive outcomes for the nation's youngest and most vulnerable children well into the adult years.¹³ The following



Emotional health and social competence provide a solid foundation for emerging cognitive abilities, and together they are the “bricks and mortar that comprise the foundation of human development.”⁸

principles, developed by the National Forum on Early Childhood Program Evaluation, provide a framework for understanding what types of interventions will be successful and for which children:

- Access to basic medical care for pregnant women and children can help prevent threats to healthy development as well as provide early diagnosis and

appropriate management when problems emerge.

- For vulnerable families who are expecting a first child, early and intensive support by skilled home visitors can produce significant benefits for both the child and parents.
- For young children from low-income families, participation in very high-quality, center-based, early education programs has been demonstrated to

Examples of effective early intervention programs

The list of factors listed above that may make early intervention effective are based on lessons learned from random assignment evaluations conducted on these programs, as well as from other studies.

Early Head Start

About the Program:

Pregnant women and low-income families with infants and toddlers receive home visits, center-based care, or a combination of the two. Activities focus on healthy prenatal outcomes; the promotion of intellectual, social, and emotional development; and the promotion of healthy family functioning.¹²

Research Findings:¹³

- Statistically significant, positive impacts on standardized measures of cognitive and language development.
- More positive approaches to learning.
- Fewer behavior problems.
- Parents were more involved and provided more support for learning.
- Parents had reduced risk of depression.
- Positive impact on child-father interactions.

For further information, see

[Learning, Thriving, and Ready to Succeed: Infants and Toddlers in Early Head Start](#)

Nurse Family Partnership¹⁴

About the Program:

Vulnerable first-time pregnant women are partnered with a registered nurse early in their pregnancies and receive home visits through their children's second birthday. Activities focus on improving health, well-being, and self-sufficiency of low-income, first-time parents and their children.

Research Findings:

- Improved prenatal health and fewer childhood injuries.
- Mothers had fewer subsequent pregnancies and increased intervals between births.
- Increased maternal employment.
- Improved school readiness for children born to mothers with low psychological resources.
- Mothers had 61% fewer arrests, 72% fewer convictions, and 98% fewer days in jail.
- Children were 48% less likely to be a victim of child abuse or neglect and 59% less likely to be arrested.

For more information visit

www.nursefamilypartnership.org

The Carolina Abecedarian Project¹⁵

About the Program:

Children from low-income families received full-time, high-quality educational intervention in a child care setting from infancy through age 5. Activities focused on social, emotional, and cognitive areas of development with an emphasis on language.

Research Findings:

- Higher cognitive test scores from the toddler years to age 21.
- Higher academic achievement in reading and math from the primary grades through young adulthood.
- More years of education completed and more likely to attend a four-year college.
- Older, on average, when first child was born.
- Mothers whose children participated in the program achieved higher educational and employment status.

For further information visit www.fpg.unc.edu/~abc/

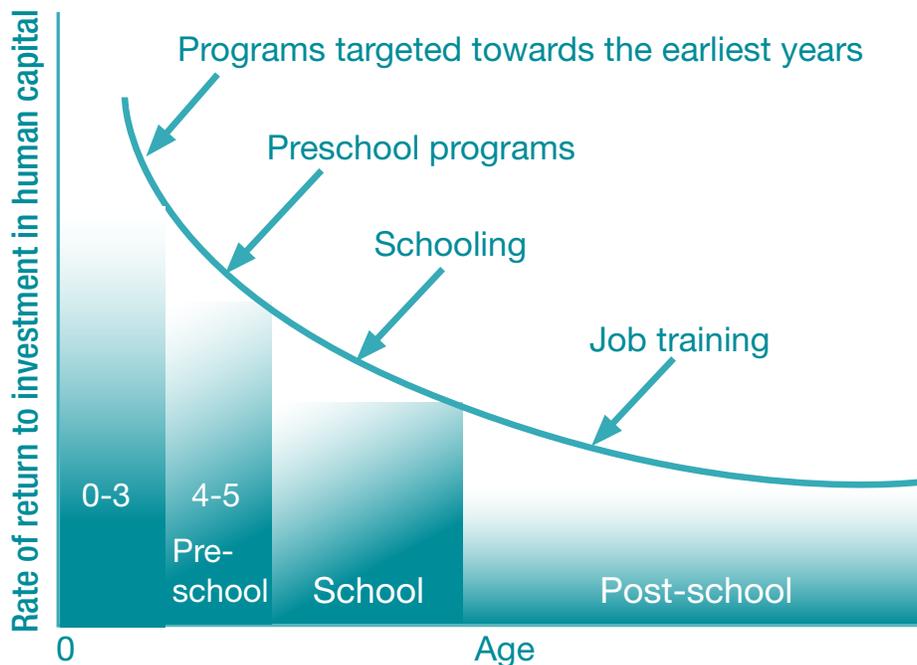
- enhance child cognitive and social development.
- For young children from families experiencing significant adversity, two-generation programs that simultaneously provide direct support for parents and high-quality, center-based care and education for the children can have positive impacts on both.
- For young children experiencing toxic stress from recurrent child abuse or neglect, severe maternal depression, parental substance abuse, or family violence, interventions that provide intensive services matched to the problems they are designed to address can prevent the disruption of brain architecture and promote better developmental outcomes.
- For families living under the poverty level, work-based income supplements for working parents have been demonstrated to boost the achievement of some young children.¹⁴

EARLY EXPERIENCES ARE A PROVEN INVESTMENT IN OUR FUTURE

High-quality, research-based interventions for at-risk infants and toddlers not only benefit individual children but also benefit society in ways that far exceed program costs. Cost-benefit analyses conducted by numerous economists clearly demonstrate the importance of the earliest experiences and interventions for at-risk children.

Economic analysis demonstrates that for every dollar invested in early childhood programs, savings of \$3.78 to \$17.07 can be expected.¹⁶ This is because early interventions for young at-risk children promote school retention, improve the quality of the workforce, help schools to be more productive, raise earnings, strengthen social attachments, and reduce crime, teenage pregnancy, and welfare dependency.¹⁷ While business subsidies may lead to a greater short-

Rates of Return to Human Capital Investment at Different Ages; Return to an Extra Dollar at Various Ages



Heckman, J. "Investing in Disadvantaged Young Children Is Good Economics and Good Public Policy" Testimony before the Joint Economic Committee Washington D.C., June 27, 2007 Reprinted with permission.

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Health:

- Physical Health
- Social & Emotional Health
- Developmental Screening

Family Supports:

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Early Learning:

- Child Care
- Early Head Start
- Early Intervention

Good Health

Strong Families

Positive Early Learning Experiences

term boost to state job growth, early childhood intervention programs provide a greater long-term boost¹⁸ because they lead to a long-run increase in labor force participation, income, Gross Domestic Product, savings, investment, and tax revenues, and to improved health and decreased mortality.¹⁹

The cost-benefit research shows that for at-risk children, playing catch-up later in life is expensive and inadequate. We need to address the needs of vulnerable infants and toddler today. Without effective intervention, children who start behind, stay behind.

CONCLUSION

We know that early experiences lay the foundation for a bright future for all infants and toddlers. Early experiences can enhance or diminish inborn potential and shape the opportunities and risks that young children encounter.²⁰ Because the early years are so critical for future development, we need to invest in and implement a policy agenda that will translate what we know from science and

clinical experience into what we do for our very youngest children and families.

The policy agenda articulated in the *Early Experiences Matter Policy Guide* is grounded in the fact that all infants and toddlers need good health, strong families, and positive early learning experiences. In order to achieve these outcomes, we need policies and programs that promote each of these areas. Specifically, we need policies that promote good physical and social and emotional health and that provide for developmental screening to identify children whose development may deserve closer observation or assessment. We need policies that provide for basic needs, quality parent education, home visiting, child welfare services, and paid family leave. We also need policies that promote good quality child care, the expansion of Early Head Start, and high-quality early intervention services for infants and toddlers with disabilities or developmental delays, as well as for those who are at risk for developmental delays.

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Services + Infrastructure = System

Accessible
Affordable
High Quality
Culturally Responsive

Regulations & Standards
Quality Improvement
Professional Development
Accountability & Evaluation
Public Engagement
Political Will Building
Governance & Leadership
Financing

While the agenda seems straightforward enough, it is actually far more complex. Because all of the domains of development are interrelated for very young children, we need to promote comprehensive and coordinated policies to achieve these outcomes.

The implementation of policies often means the provision of services. To be effective, services must be accessible, affordable, high quality, and culturally responsive. They must be part of an infrastructure that provides for regulations and standards, quality improvement and professional development

opportunities, and accountability and evaluation. Public engagement, political will, strong governance and leadership, and adequate financing are essential elements in the infrastructure. Together the services and infrastructure provide families with the comprehensive, cohesive system they need.

The tools in this *Policy Guide* provide the details of, and the research behind, the comprehensive policy agenda. We hope that you will find them valuable as you work to translate what we *know* into what we *do* for infants, toddlers, and their families.

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About Us

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INFORMING POLICY CHOICES ABOUT INFANTS AND TODDLERS

This piece of the *Early Experiences Matter Policy Guide* provides data to inform state and federal policy choices that will positively impact infants, toddlers, and their families. Use these data as background, context, and/or statements of need for promoting the policy recommendations found throughout the *Policy Guide*.

BASIC NEEDS

FAST FACTS

- 21% of children under the age of 3 are living in poverty, a number that is growing at a faster rate for infants and toddlers than for older children.¹ Between 2000 and 2006, the number of children of all ages who were poor increased by 11%, while the number of infants and toddlers living in poverty increased by 16%.²
- Child poverty costs the United States an estimated \$500 billion a year, due to increased expenditures on health care and the criminal justice system and in lost productivity in the labor force later in life.³
- 56% of poor working families with children spend half or more of their income on rent,⁴ leaving them with too little money to provide for their children's other needs. Children living in low-income families that do not receive a housing subsidy are more likely to suffer from malnutrition and underdevelopment than are children in low-income families that do receive a subsidy.⁵



- Nearly 17% of U.S. households with children younger than 6 are food insecure (limited or uncertain availability of nutritionally adequate and safe foods).⁶ Families with children under the age of 6 are at a higher risk of experiencing food insecurity than those with older children.⁷ Infants and toddlers with noncitizen parents are twice as likely to

experience food insecurity than are those with naturalized citizen parents.⁸

CHILD CARE FAST FACTS

- Each day nearly six million children under age 3 spend some or all of their day being cared for by someone other than their parents.⁹
- 56% of mothers with children under the age of 3 are employed.¹⁰

- More than 40% of infants and toddlers in child care are in classrooms of poor quality.¹¹
- In 2006, the national average wage for a child care worker was only \$9.05 per hour or \$18,820 annually, below the federal poverty rate, and many child care workers do not receive benefits.¹²

CHILD WELFARE

FAST FACTS

- Children between birth and age 3 have the highest rates of victimization.¹³
- Infants and toddlers comprise almost one-third of all children who are abused or neglected¹⁴ and are the largest single group of children entering foster care.¹⁵
- Infants and toddlers removed from their parents' care often move three or more times in their first months in foster care.¹⁶
- Once they have been removed from their homes and placed in foster care, infants and toddlers are more likely than older children to be abused and neglected and to stay in foster care longer.¹⁷

DEVELOPMENTAL SCREENING FAST FACTS

- Approximately one out of every six children in the U.S. faces a developmental disability or a disabling behavioral problem before the age of 18. Yet fewer than 50% of these children are identified before they start school.¹⁸
- Uninsured children are less likely to receive developmental screenings and preventive health care than are children enrolled in public insurance programs such as Medicaid or the Children's Health Insurance Program (CHIP).¹⁹
- One in five children with a disability will not be identified through a single developmental screening. Disabilities are more likely to be picked up if monitoring and screening are continued in all well-child medical care visits.²⁰
- A study of the cumulative costs of special education from ages 0 to 18 found that intervening starting at birth resulted in lower costs over the course of childhood. Total costs of services begun at birth were \$37,273 compared with a total cost of between \$46,816 and \$53,340 if services were not begun until age 6.²¹

EARLY HEAD START FAST FACTS

- Only 3% of all eligible children and families are receiving Early Head Start (EHS) services.²²
- 79,505 children under the age of 3 participated in EHS in fiscal year 2006.²³

- Children who participated in EHS had significantly larger vocabularies and scored higher on standardized measures of cognitive development than did children in a control group who did not participate in EHS. Additionally, EHS children and parents had more positive interactions, and these parents provided more support for learning than did those in a control group.²⁴
- 20 states have expanded or enhanced Early Head Start services to young children and their families.²⁵

EARLY INTERVENTION FAST FACTS

- Approximately 16% to 18% of children have disabilities or developmental delays.²⁶
- Infants and toddlers who have been maltreated are six times more likely than the general population to have a developmental delay.²⁷ Children entering early intervention are far more likely than the general population to be in foster care.²⁸
- More than 50% of children in early intervention had two or more risk factors and 20% had four or more. Research suggests that the potential for negative developmental outcomes increases substantially when a child has multiple risk factors.²⁹
- 37% of the infants and toddlers who received early intervention services did not present with a disability or require special education in preschool. Since the average cost of special education is \$10,031 per

child, early intervention resulted in a savings of more than \$1.2 million in one year.^{30, 31}

HOME VISITING FAST FACTS

- Only 2% of all children birth to age 5 receive home visiting services each year.³²
- 32 states currently operate a statewide home visiting program.³³
- 18 states link home visiting programs to other supports for early childhood development at the state level.³⁴

PAID FAMILY LEAVE FAST FACTS

- 40% of the workforce is currently not covered by the Family and Medical Leave Act.³⁵
- Without access to family and medical leave, employees find themselves reporting to work when ill, resulting in lost productivity that costs the national economy \$180 billion every year.³⁶
- More than three in four eligible employees reported that they could not afford to take needed family or medical leave because it was unpaid.³⁷
- 57 million working Americans do not have paid sick leave.³⁸

PHYSICAL HEALTH FAST FACTS

- 8.1 million children are uninsured in the United States.³⁹ Nearly 11% of children under the age of 3—1.4 million infants and toddlers—lack health insurance.⁴⁰

- In the last 50 years, the number of visits to emergency rooms in the U.S. has increased more than 600%,⁴¹ with children under the age of 3 representing the largest proportion of medical and injury-related emergency room visits in the country.⁴²
- In 2002, one in nine infants was born to a mother who received inadequate prenatal care, which is associated with poor birth outcomes such as prematurity and low birth weight.⁴³
- 14% of children between the ages of 2 and 5 are considered obese.⁴⁴

SOCIAL & EMOTIONAL HEALTH FAST FACTS

- One in five children has a diagnosable mental disorder⁴⁵ but the factors that predict mental health problems can be identified in the early years.⁴⁶
- 75% to 80% of children and youth in need of mental health services do not receive them.⁴⁷
- Babies can show signs of depression (inconsolable crying, slow growth, sleep problems, etc.).⁴⁸
- Maternal depression, anxiety disorders, and other forms of chronic depression affect approximately 10% of mothers with young children.⁴⁹



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A PLACE TO GET STARTED

Doing a jigsaw puzzle can be an exciting but challenging endeavor. There are multiple pieces and any number of ways in which you can begin to put the puzzle together. Some people like to start in one corner of the puzzle and fill it out completely before moving on to other sections. Others find a piece of the picture that is familiar to them and attach puzzle pieces to it, so they see how it connects with the rest of the puzzle. In the end, there is no right or wrong way, but it is important to recognize what process serves you best and how your approach will help reach the end goal.

Sometimes the public policy process can seem like a puzzle as well. There are a variety of ways public policy can be put together to achieve policy goals. And when it comes to the healthy development of infants and toddlers, it is important to use the pieces of the policy puzzle to promote the best start in life for very young children. The complete **Early Experiences Matter Policy Guide** offers you a wealth of policy options and strategies, as well as practical tools to affect policy change for infants, toddlers, and their families. But with all the policy options available, you may be wondering, "How do we approach this policy making puzzle? Where do we start?" There are many paths your state can take to improve the lives of babies and toddlers, and just like with the jigsaw puzzle, there is no right or wrong approach. But it is important to start somewhere and be thoughtful about how your policy choices fit within the context of a broader system of supports for infants, toddlers, and their families.

Without a doubt, our nation's current economic reality is taking its toll on the vast majority of families with young children. Families are even more vulnerable than before, and yet the economic downturn comes at a time in which our country is embracing a commitment to change and a positive outlook for a new future. At times like these, we have the opportunity to shift the



paradigm in which we operate and create the new future we all desire.

At all levels of government, it will be necessary to make hard choices about where to invest limited dollars and how to maximize those funds to keep our economy healthy. Our natural tendency is to pare down and conserve funding for those needs that are most urgent. Yet, the health of our economy is directly tied to the health and well-being of its citizens, especially the very youngest. The **Early Experiences Matter Policy Guide** suggests a different paradigm for making these tough choices, one that promotes policy changes and investments **early** in an effort to dramatically change the life trajectory for future generations. There is great hope in such a paradigm. As James Heckman, Nobel Laureate in economics, notes, "It is a rare public policy initiative that promotes fairness and social justice, and, at the same time, promotes productivity in the economy and in society at large. Investing in disadvantaged young children is such a policy."¹

We have much work to do together, and it is time to begin.



Let's Get Started

A natural **FIRST STEP** in getting started is to assess current infant-toddler policies and the opportunities and challenges for policy change. States can utilize ZERO TO THREE's *Infants and Toddlers in the Policy Picture* to assess the current policies and practices in your state or community. Federal lawmakers can evaluate the ways their funding and policy decisions can best support states and help them be most effective. With that information in hand, the policy options that make the most sense right now are likely to become clearer.

A **SECOND STEP** is to use the sample list of policy strategies below as a jumping-off point for strategic planning. Policymakers may want to consider these policy strategies as a starting point or use them as a guide for putting in motion other policy strategies that are most relevant and opportune. No matter where you get started, the ZERO TO THREE Policy Center is here to support your efforts.

Sample Good Health Policy Strategies

1. Provide infant and early childhood mental health consultation in all child-serving settings.

Connecticut links services through Early Childhood Consultation Partnership

Connecticut's Early Childhood Consultation Partnership (ECCP) employs 20 early childhood mental health consultants across the state and collaborates with community partners to serve children birth to age 5 in center-based early care and education programs. Administered through a nonprofit behavioral health company, ECCP is co-funded by the state Department of Children and Families and the state Department of Education. ECCP's goal is to prevent the suspension and expulsion of young children with mental health and behavioral challenges from their care settings. Consultants receive extensive training in methods of supporting early care and education staff and parents to assist children. ECCP has been successful with 98% of children referred in promoting consistency of care and assisting care professionals to meet each child's unique needs. This work has helped to highlight the importance of consultation to child care settings and has become one of the primary goals of the Governor's Early Childhood Cabinet. In 2008, the Cabinet created five workgroups: health, mental health, education, special education/ELL, and nutrition. Each workgroup included approximately 15 providers, parents, and experts in the specific field who developed the educational levels, competencies, and guiding principles for consultants in their field. The information was presented in a report to the Cabinet and embedded in the state's new quality rating improvement system (QRIS) proposal. Although the QRIS has not yet been implemented, the interim quality project will require that all consultants be included in a state registry. Once the QRIS is implemented, funded programs will be required to use only consultants who meet the stated criteria.^{2,3}

Illinois leverages interagency cooperation for social and emotional health

In 2002, Illinois' Government Interagency Team of the Birth to Five Project reviewed agencies' policies on social and emotional health screening and determined that it was important to provide mental health consultation to early childhood providers in various sectors of the field. The state now provides as much as \$3 million for mental health consultation to providers serving infants, toddlers, and pre-K-age children, with recent efforts aimed at improving access to perinatal depression screening and children's mental health treatment.^{4,5} Mental health consultation is available at all Part C system points of entry. The state Department of Human Services funds child care mental health consultation in 16 service delivery areas of the Child Care Resource and Referral Network across the state. The *Preschool for All* initiative includes funding for early childhood mental health consultation to preschool settings. The Illinois Children's Mental Health Partnership also received grants from the Michael Reese Health Trust and the Illinois Department of Human Services Division of Mental Health to increase the capacity of five community mental health agencies to provide treatment and consultation services for children birth to age 7.⁶ Finally, a small pilot program through the Department of Human Services has started to fund mental health consultation to home visiting programs across the state.⁷



2. Ensure that all infants and toddlers who are eligible for Medicaid and Medicaid-expansion SCHIP programs receive periodic developmental screening under EPSDT that includes physical, mental, and dental health.

New York takes public health approach to screening

As part of New York's Achieving the Promise for New York's Children and Families Initiative, the New York State Office of Mental Health is engaged in a large-scale, collaborative effort to do early identification and assessment of the mental health and wellness of children in normative settings. This effort, called the Child and Family Clinic Plus program, received a \$33 million investment and applies a public health approach to early recognition and intervention. Child and Family Clinic Plus works closely with families to help with early identification of emotional needs by providing free, voluntary screening in community settings like schools, daycare centers, and pediatric clinics. If emotional difficulties are identified, the program works with the child and the family to assess their needs and access appropriate services.⁸

North Carolina Medicaid requires developmental screening in health settings

In 2004, after participating in The Commonwealth Fund's Assuring Better Child Health and Development I (ABCD-I) project to pilot developmental screening of children receiving EPSDT in pediatric and family practices, North Carolina amended its state Medicaid policies to require screening with a standardized tool at all well-child visits between 6 months and 5 years of age. The 15 Medicaid case management regional networks have community care coordinators who assist practices with referrals, link families to community resources, and receive Medicaid reimbursement for making those referrals. This successful project now includes postpartum depression screening and autism screening as well. More than 90% of primary health practices (e.g., pediatric and family medicine) who serve Medicaid-eligible children have integrated developmental and behavioral screening into practice.⁹

Sample Strong Families Policy Strategies

1. Ensure that all families facing obstacles have access to high quality home visiting services as part of a comprehensive and coordinated support system that nurtures their child's healthy development.

Virginia creates home visiting continuum to improve coordination of services

In December 2006, under the auspices of the Governor's Working Group on Early Childhood Initiatives, the Virginia Department of Health convened a meeting of the 10 state-funded early childhood home visiting programs. Meeting regularly as the Home Visiting Consortium, the group developed a home visiting continuum that includes all home visiting programs in the state. The Consortium is crafting a community guidance document with local examples about braiding and blending funding, referral systems, and other relevant topics. To improve the overall quality of home visiting, the Consortium inventoried training offered by each program, created a common introductory training module for all staff, added two modules on mental health and supervision, identified 10 critical training topics required of all home visitors, and structured web-based registration housed at a university to track the home visitors completing the core trainings by 2010. Programs in the Consortium agreed to common indicators for evaluation, including standardized screening tools for parents and children. A common referral form is expected to increase referrals from health care providers and early childhood educators and between programs.¹⁰

Minnesota passes budget to support home visiting

The 2008–2009 Minnesota state budget included \$8.8 million in restored funding for home visiting programs targeted for low-income families. The legislation added school readiness and improved-pregnancy outcomes to the goals of the program, which also include fostering healthy beginnings, preventing child abuse and neglect, and promoting positive parenting, among other outcomes. Funding for the initiative flows to community health boards, which, under the changes, are required to use a multidisciplinary, community-based approach to home visiting and begin the visits with families prenatally, when possible. The state Department of Human Services funds training and technical assistance to the home visitors, including training on early childhood development from birth to age 5. Funds for the initiative, taken from the Temporary Assistance for Needy Families (TANF) federal block grant, are also promised for 2010–2011.¹¹



2. Ensure a permanent placement for infants and toddlers in foster care.

Arizona's First Things First increases investments for infants and toddlers

After voters handily passed Arizona's *First Things First* referendum in 2006, approximately \$150 million in tobacco tax dollars were dedicated to create a comprehensive, statewide early childhood system. As of early 2009, 31 Regional Partnership Councils have developed funding plans for how their portion of the *First Things First* allocation will be invested locally to benefit children birth to age 5. Through their funding, many of the Regional Partnership Councils are prioritizing the healthy emotional development of young children, particularly those most in need. Several regions have designated funds to ensure enhanced services for infants and toddlers in foster care, and nine of the Regional Partnership Councils allocated funding for mental health consultation to early childhood education settings. For example, in Yavapai County, \$145,000 will be dedicated to Best for Babies, an innovative program that brings together the juvenile court and community-based service providers to ensure collaboration and permanent placement for infants and toddlers entering the child welfare system. The funds will support a community coordinator for the program and a public health nurse to do assessments in foster homes.¹²

Oregon's Marion County focuses on partnership to ensure permanency

In Oregon's Marion County, the juvenile court, community partners and the Department of Human Services (DHS) are working together to implement policies and practices designed to ensure permanency for infants and toddlers. In a significant step, the court amended its orders to include a special section for 0- to 5-year-olds that requires appropriate assessments and services, prohibits moving children without a court hearing, and requires a detailed child-centered case plan for each child. The court is also spearheading education for attorneys, court-appointed special advocates, district attorneys, and DHS workers to aid in their understanding of the science of early development. In addition, a special "well-being team" was created at DHS to assist workers, parents, and foster parents in understanding and meeting the developmental needs of infants and toddlers; ensure that assessments are completed and followed up on; and educate caregivers about the need for reciprocal, consistent loving care. It is the hope of the court and DHS that giving workers, parents, and caregivers access to this specialized team will result in better understanding of, and support for, the urgent need for permanency.

Sample Positive Early Learning Experiences Policy Strategies

I. Design quality rating information systems (QRIS) inclusive of infants and toddlers.

Indiana takes local quality rating system statewide

In 2007, Governor Mitch Daniels's administration created a statewide quality rating system for child care based on Paths to QUALITY, a model developed in Fort Wayne and piloted in Fort Wayne, Evansville, and 11 counties in southwestern Indiana. Administered by the Indiana Family and Social Services Administration and the state's Bureau of Child Care, the statewide system is funded by public and private sources, including federal Child Care and Development Block Grant (CCDBG) funds. The four-tiered voluntary rating system includes specific infant-toddler indicators that include continuity of care, primary caregiving, and infant-toddler specific program standards with the highest levels requiring accreditation. Features include an innovative one-on-one mentoring program, professional development incentives for infant-toddler caregivers in child care programs and family child care homes, and a 10-person infant-toddler specialist network providing technical assistance and training. Purdue University is evaluating the rating system throughout the first four years of the project.¹³

Maine weaves together components for an infant-toddler system

After developing "Supporting Maine's Infants and Toddlers: Guidelines for Learning and Development," the state integrated the guidelines into its new four-step quality rating system, Quality for Maine, which includes a focus on infants and toddlers and a tax credit for families enrolled in quality rated programs. The new QRIS was piloted in five counties during spring 2007 and has been available statewide since April 2008. Attainment of accreditation is a component of receiving the highest quality rating. The state's infant-toddler specialist supports the implementation of the QRIS with training and technical assistance. Maine also participated in a strategic planning process to focus on improvement of quality within the informal care of families, friends, and neighbors (FFN). A study committee formed in 2008 surveyed the FFN community to begin outreach to families and caregivers.¹⁴



2. Expand Early Head Start (EHS), and programs modeled on Early Head Start, by increasing federal and state investment to ensure that more eligible infants and toddlers can be served.

Kansas blends funds to expand Early Head Start

In 1998, Kansas began supplementing federal funding to expand the capacity of its existing EHS programs. The Kansas EHS provides services to eligible pregnant women and children from birth to age 4. State funds are combined with federal dollars to reach more income-eligible infants, toddlers, and pregnant women through weekly home visits or full-day, full-year care in community-based child care and family child care facilities. The program is funded with \$11 million of CCDBG quality set-aside dollars, augmented by a transfer of federal TANF funds, state general revenue, and tobacco settlement funds. A new Kansas Early Childhood Block Grant from the Kansas Children's Cabinet and Trust Fund (using tobacco settlement funds) began January 1, 2009. It will support Kansas EHS programs with additional dollars for the current funded slots and expand EHS services. Additional slots and counties are still being determined. Researchers at the University of Kansas are conducting an evaluation of the program.¹⁵

Oklahoma expands Early Head Start through Early Childhood Pilot Program

In 2006, Oklahoma's Early Childhood Pilot Program was established for at-risk children birth through age 3. The program funds existing federal Early Head Start, nonprofit, for-profit and Tribal Government programs that meet quality standards to serve additional children, extend the day of EHS services, and enhance quality. All programs must meet selected EHS performance standards, have the highest level of quality rating, operate full day and full year; and meet additional quality requirements. Some additional requirements include NAEYC Accreditation, training in WestEd's Program for Infant/Toddler Care, at least one bachelor-degreed teacher for every two infant-toddler classrooms, and a pre-K–3rd certified teacher for each class of 3-year-olds. In fiscal year (FY) 2008, 13 agencies served 1,487 children and families in 18 communities across Oklahoma. In FY 2007, \$5 million of state general revenue funds was matched with \$10 million of private dollars. In FY 2008, the Pilot Program was funded by \$10 million from the state and \$15 million in private dollars. Researchers at the University of Oklahoma–Tulsa Early Childhood Education Institute are conducting a three-year evaluation of the program.¹⁶

Sample Collaboration and System Building Policy Strategies

1. Implement a cross-sector early childhood professional development system to support the infant-toddler workforce.

Wisconsin targets professional development of infant-toddler teachers

Wisconsin developed an infant-toddler credential to train infant-toddler caregivers using the T.E.A.C.H. (Teacher Education and Compensation Helps) education model. The curriculum was developed by Janet Gonzales-Mena, a consultant with the Program for Infant/Toddler Care (PITC). Funding is provided by CCDBG infant and toddler earmark money and CCDBG quality set-aside funds. All state technical colleges and universities offer the same curricula for basic courses. Students complete 12 credits of coursework and a "capstone experience" designed to supplement their classroom experience with a personal Infant-Toddler Portfolio. A statewide registry, Wisconsin's Recognition System for Childhood Care and Education Profession, oversees and awards the professional credentials, including the Infant-Toddler Credential, and provides information about professional development training and activities around the state.¹⁷ As of 2000, Wisconsin has awarded infant-toddler credentials to almost 700 early care and education teachers and providers.^{18 19}

Tennessee uses annual provider assessments to promote professional development

Tennessee is moving forward with its commitment to serve the needs of infants and toddlers by ensuring that providers across the state have access to training and technical assistance that promotes developmentally appropriate environments for young children. Through a system of infant-toddler specialists, emphasis is placed on the QRIS for child care providers by mandating annual assessment of all providers through the Infant-Toddler Environment Rating Scale-Revised Edition (ITERS-R). All infant-toddler specialists are required to have completed, or be actively working toward, PITC certification and to complete national Creative Curriculum for Infants and Toddlers training. This model of certification, developed by WestEd and the California Department of Education, allows resource and referral agencies to develop a train-the-trainer model, in which providers get comprehensive training and technical assistance on how to improve the ITERS-R scores for early care and education settings.²⁰



2. Establish collaborative planning and decision-making structures at the federal, state, and local levels to increase coordination across services for infants and toddlers.

Ohio establishes the Early Childhood Cabinet and the Early Childhood Advisory Council

In March 2007, Governor Ted Strickland signed an executive order establishing an Early Childhood Cabinet to set state policy and coordinate programs serving Ohio children from prenatal through kindergarten. The Cabinet is composed of the heads of relevant state agencies and is staffed by a director appointed by the Governor. An Early Childhood Advisory Council was convened in August 2008 to advise the Cabinet on policy and resource development priorities, suggest options for the Cabinet's consideration, assist with communication strategies, and ensure compliance with the requirements of Head Start reauthorization. The 45-member Council includes a diverse array of primarily private stakeholders from early childhood programs, schools, higher education, foundations, and other groups. The Advisory Council also serves as the advisory group for the Head Start State Collaboration and Early Childhood Comprehensive Systems projects.²¹

New Mexico's child development governance sets the bar

For nearly 20 years, New Mexico's Child Development Board has served as the policy advisory body on early learning in the state. Created through statute in 1989 and housed in the Children, Youth and Families Department, the Board is responsible for recommending personnel requirements for individuals working with children birth through age 8, as well as for establishing program standards and managing state-funded child development programs for children birth to 5. The Child Development Board consists of seven members from the private sector appointed by the Governor. New Mexico also has a Children's Cabinet comprised of agency secretaries chaired by Lieutenant Governor Diane Denish. The Cabinet works to meet goals for the well-being of all children, birth to 20, and to improve the coordination of services between departments. The Early Childhood Action Network (ECAN), an appointed advisory committee to the Children's Cabinet, focuses on children birth to 5 and their families. The ECAN involves approximately 40 stakeholders from diverse perspectives and is charged with developing recommendations for systems alignment and New Mexico's Early Childhood Strategic Plan. Activities of the ECAN are funded by the federal Early Childhood Comprehensive Systems Grant (Maternal Child Health Bureau, HRSA, DHHS). Although the Governor has not yet named the State Advisory Council under the Head Start reauthorization, it is expected that the Child Development Board will be designated.²²

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About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at www.zerotothree.org/policy.



National Center for Infants, Toddlers, and Families

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GOOD HEALTH

ENSURING GOOD PHYSICAL HEALTH OF OUR INFANTS & TODDLERS

The need for health care during a child's first 3 years is more crucial than at most other times in life. For the youngest children, routine health care can spell the difference between a strong beginning and a fragile start. This is particularly true for children living in poverty due to their increased likelihood of exposure to environmental toxins, inadequate housing and nutrition, and other economic hardships that are associated with compromised child development.¹ Cognitive, social-emotional, and physical development are inextricably linked during this stage of early growth, so poor health in a very young child can lead to developmental problems in other areas, and vice versa. The first 3 years of life provide an incredible opportunity to promote the healthy development of infants and toddlers, and prevent and treat many of the physical, social-emotional, and cognitive impairments that these young children could face in the future. Policymakers can play a leading role in ensuring that all infants, toddlers, and their families have access to quality, comprehensive, consistent, and culturally appropriate health services; adequate insurance coverage and prenatal care; sufficient quantities of nutritious foods; and periodic health screening and referrals through early childhood programs.



Nearly 17% of all uninsured children are under the age of 3.²

FAST FACTS

● **8.1 million** children are uninsured in the United States.³ Nearly 11% of children under the age of 3—**1.4 million** infants and toddlers—lack health insurance.⁴

● In the last 50 years, the number of visits to emergency rooms has increased more than **600%** in the United States,⁵ with children under the age of 3 representing the largest proportion of medical- and injury-related emergency room visits in the country.⁶

● In 2002, **1 in 9** infants was born to a mother who received inadequate prenatal care, which is associated with poor birth outcomes such as prematurity and low birth weight.⁷

● Nearly **17%** of U.S. households with children younger than six are food insecure (limited or uncertain availability of nutritionally adequate and safe foods).⁸

● **14%** of children between the ages of 2 and 5 are considered obese.⁹



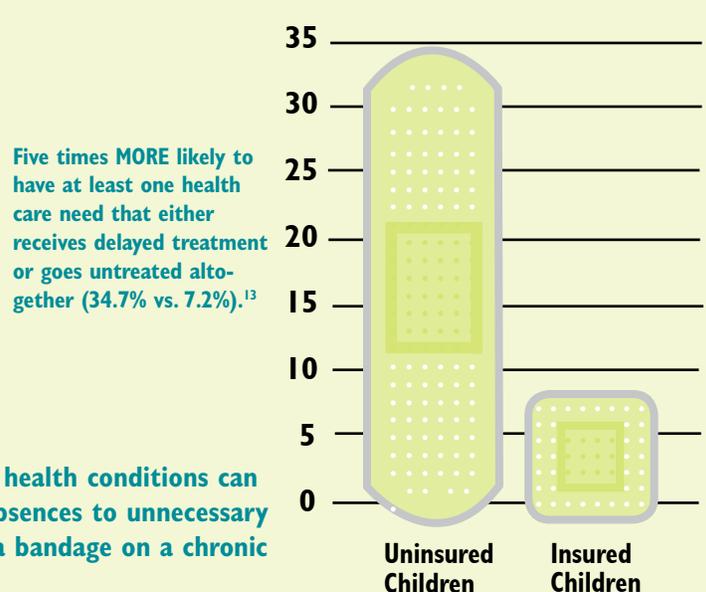
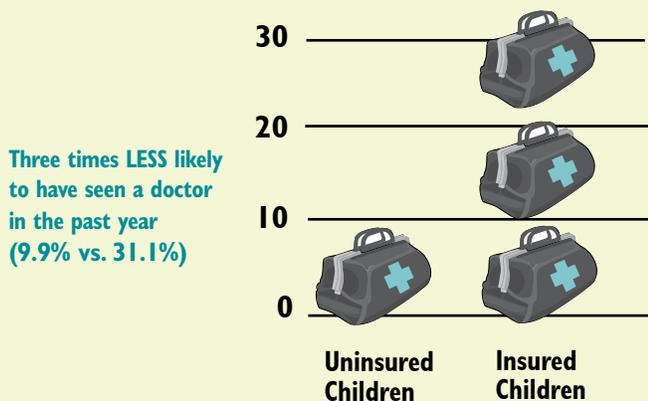
Policy Recommendations

1. Ensure every child has a medical home. When children have a medical home, all aspects of pediatric care can be managed by one consistent pediatrician who knows a child's family and their medical history.¹⁰ This includes well-child visits; immunizations; screenings and assessments; patient and parent counseling about health, nutrition, safety, and mental health; and supervision of care. In addition, when appropriate, a pediatrician can also refer a child to specialized health care providers and early intervention services while coordinating care with other early childhood programs and services. When federal and state policymakers promote reliance on a single consistent health care provider, child health outcomes improve overall. In particular, lower-income families can avoid unnecessary and more expensive treatment in emergency rooms, walk-in clinics, and urgent care facilities, thereby reducing costs to all of society.

2. Provide adequate SCHIP coverage for all eligible infants and toddlers. The State Children's Health Insurance Program (SCHIP), the joint federal-state program that provides health insurance for low-income Medicaid-ineligible children and pregnant women, has dramatically improved the health and well-being of our most vulnerable children.¹¹ Yet, 6 million children currently eligible for SCHIP or Medicaid have not been enrolled in either program.¹² With limited funding, states are forced to freeze or cut enrollment, restrict eligibility, increase premiums or copays, or reduce services and benefits, all at a substantial cost to young children and their families. Federal and state policymakers should ensure adequate funding and outreach efforts are put in place in order to increase enrollment in SCHIP. Doing so will allow more infants and toddlers to receive well-child visits, immunizations, screenings, mental and dental health care, and other forms of preventive care early on, thereby reducing the need for more costly interventions later.

Putting a band-aid on a chronic wound

When compared to insured children aged 2-17, uninsured children of the same age are:



The consequences of failure to prevent or treat childhood health conditions can be catastrophic, ranging from chronic illness and school absences to unnecessary and life-threatening infections or complications. Putting a bandage on a chronic wound just doesn't heal it.



3. Improve access to prenatal care for all pregnant women. Environmental toxins, substance use, malnutrition, domestic violence, and compromised maternal physical and mental health are just some of the many prenatal influences that may have lifelong implications. Mothers who lack health insurance are less likely to receive prenatal care,¹⁴ including screenings and diagnostic tests that are instrumental in improving birth outcomes and reducing medical and nonmedical expenses. In 2005, for example, the Institute of Medicine estimated that preterm births, which account for 12.5% of all births in the United States, cost society at least \$26.2 billion annually, or \$51,600 for every preterm infant.¹⁵ When taking into consideration the special education costs associated with disabilities that are more common among preterm infants (cerebral palsy, mental retardation, and vision and hearing impairments), estimates increase by another \$1.1 billion or \$2,200 per preterm infant.¹⁶ By working to improve access to prenatal care, federal and state policymakers can save taxpayers millions of dollars in long-term health complications and special education services later in life.

4. Allow adequate reimbursement for child development services and quality of care in pediatric visits. With 12 visits recommended in the first 3 years of life for routine well-child care, pediatric offices offer a unique opportunity to reach parents with information about child development and guidance on appropriate parenting practices. Yet, many of these opportunities are missed. In fact, in a national study, nearly all parents surveyed reported that they had one or more unmet needs for guidance or education from their child's pediatrician.¹⁷ Current billing procedures do not permit adequate reimbursement for pediatricians' time or services focused on child development or family-centered care.¹⁸ Furthermore, many providers lack training in child development and are unaware of community resources that may be available for children who are identified with a particular need. Policymakers should ensure that reimbursement for pediatric visits covers the time required to thoroughly focus on child development and family-centered care. In addition, investing in quality programs that link developmental specialists with pediatric offices should be a priority for policymakers.



With 12 visits recommended in the first 3 years of life for routine well-child care, pediatric offices offer a unique opportunity to reach parents with information about child development and guidance on appropriate parenting practices.



5. **Expand access to health consultation in comprehensive early childhood programs.**

Services that currently exist for children and families are fragmented across an array of fields, including health, mental health, early intervention, special education, child welfare, and other social services. Financing of such services likewise cuts across multiple, discrete, and uncoordinated funding streams as well as federal and state programs. Navigating such a complex system can be overwhelming for both families and providers. One method of enhanced coordination of care is expanded access to health consultation in all child-serving settings. For example, Early Head Start, which provides comprehensive services focusing on early learning experiences, health and nutritional status, social-emotional behavior, early intervention, and parent support, offers increased access to health care, well-child exams, immunizations, and screening tests for children enrolled in the program.¹⁹ Federal and state policymakers should ensure that adequate funding is available to integrate health screenings and services into other programs reaching infants and toddlers, including child care settings, nutrition services, home visiting programs, and foster care homes.

6. **Increase federal and state investments in children's nutrition programs and promote greater emphasis on nutrition education, physical activity, and obesity prevention.**

Federal child nutrition programs include the Food Stamp Program (recently renamed the Supplemental Nutrition Assistance Program, or SNAP), the Child and Adult Care Food Program (CACFP), and the Supplemental Nutrition Program for Women, Infants, and Children (WIC). Such programs provide economic supports, nutritionally balanced foods, and nutrition education to many low-income families who are at risk of food insecurity. Not only do food insecure households purchase less food in general, but they are also more likely to purchase low quality food or skip meals altogether.²⁰ Not surprisingly, reliance on less nutritious foods and limited physical activity has resulted in an explosion of childhood obesity which has, in turn, led to a number of health impairments that can have devastating lifetime effects (diabetes, hypertension, asthma, anxiety, and hyperactivity).²¹ Federal policymakers should adequately fund children's nutrition programs and policymakers at both the federal and state levels should invest in additional nutrition education and obesity prevention activities.



Children who lack nutritious foods and have limited physical activity can develop obesity and other health impairments, such as diabetes, asthma, and hypertension.²²



Research

Medicaid and SCHIP improve access to care. Since 1998, thanks to Medicaid and SCHIP, the number of low-income uninsured children has fallen by more than one-third, even as employer-based coverage decreased and the overall rate of uninsured people grew.²³ Furthermore, children enrolled in Medicaid and SCHIP are more likely than uninsured children to have a medical home, which is linked to improved quality and continuity of care.²⁴ Medicaid and SCHIP enrollees also receive more preventive care (including dental and well-child care) and have better access to health care services and providers than uninsured children.^{25, 26, 27}

Lack of adequate health insurance increases the likelihood of delayed or unmet health needs.

Research shows that without adequate health insurance and access to care, infants and toddlers fall victim to a host of poor health outcomes. Uninsured children are almost 5 times more likely than insured children to have at least one delayed or unmet health care need.²⁸ As a result, they are less likely to obtain preventive care or be diagnosed and treated early for illnesses; instead, they wait until conditions are no longer manageable before seeking care in the emergency room of their local public hospital. Estimates of the true cost of pediatric emergency care are difficult to assess; however, costs could range anywhere from \$3.9 billion to \$12.8 billion annually, with an average total cost of \$6.5 billion.²⁹ Furthermore, half of all emergency room charges go uncollected and get passed on to consumers who are covered by private insurance.³⁰

Developmental interventions enhance the quality of early childhood health care. A national evaluation of Healthy Steps for Young Children, a universal program incorporating developmental specialists into pediatric practices, showed improvements in the quality of care for children under 3.³¹ The results of the evaluation demonstrated significant improvements in the quality of care provided in participating pediatric practices, including effectiveness, patient-centeredness, timeliness, and efficiency of care.³² Furthermore, when compared to the control group, families who received the intervention reported improved parenting practices, particularly with regard to more favorable discipline techniques, fewer child behavioral problems, increased likelihood of seeking health care for their children, and more encouragement of reading.³³ When followed up at 5 ½ years of age, all outcomes were sustained.³⁴

Poor health outcomes affect later school success. Health impairments and social-emotional problems also directly affect later school success. Children who are sick or hospitalized miss more days of school and have trouble learning, resulting in lower grades and test scores and poorer cognitive development, school readiness, and success.³⁵ When developmental delays and health impairments are detected and treated early, children have a much better chance of school success. In fact, a study of California's Children's Health Insurance Program found that after one year of enrollment in the program, children were more attentive in class (57% after vs. 34% before) and more likely to keep up with their school activities (61% after vs. 36% before).³⁶

When federal and state policymakers promote reliance on a single consistent health care provider, child health outcomes improve overall.



For more information about the effectiveness of child nutrition programs in preventing food insecurity, see ***Getting Back to Basics: Building the Foundation for Infants, Toddlers, and Their Families.***

For more information about developmental screening, see ***Achieving the Promise of a Bright Future: Developmental Screening of Infants and Toddlers.***

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About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at www.zerotothree.org/policy.



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INFANT AND EARLY CHILDHOOD MENTAL HEALTH

The healthy growth and development of a young child is much like the construction of a strong and stable building. When it comes to infant and toddler development, the neural pathways and connections literally shape the physical architecture of the developing brain, forming the strong foundation on which everything else is built. Social and emotional development is an integral part of the foundation that helps guide a young child into adulthood and is firmly tied to every other area of development—physical growth and health, communication and language development, cognitive skills, and early relationships. Early childhood social and emotional development is influenced by biology, environment and relationships that exist between a small group of consistent caregivers and a child.¹ Because the parent-child relationship is so critical for early development, the mental wellness of adults plays a critical role in how very young children develop. When an infant or toddler's social and emotional development suffers significantly, they can, and do, experience mental health problems as well. But skilled providers can accurately screen, diagnose and treat mental health disorders in infancy and early childhood before they impact other areas of development. Federal and state policymakers can strengthen the foundation being built for infants and toddlers by improving the continuum of services for the promotion and prevention of infant and early childhood mental health problems, as well as the provision of early intervention services for at-risk infants and toddlers.



Social and Emotional Development: What Does It Mean?

Healthy social and emotional development refers to a child's capacity to experience, manage, and express a full range of positive and negative emotions; develop close, satisfying relationships with others; and actively explore environments and learn. Professionals in the field of child development who focus on social and emotional development refer to their area of practice as "infant mental health" or "early childhood mental health."

FAST FACTS

● **1 in 5** children has a diagnosable mental disorder² but factors that predict mental health problems can be identified in the early years.³

● **75% to 80%** of children and youth in need of mental health services do not receive them.⁴

● Babies can show signs of depression (inconsolable crying, slow growth, sleep problems, etc.).⁵

● Maternal depression, anxiety disorders, and other forms of chronic depression affect approximately **10%** of mothers with young children.⁶



Policy Recommendations

- 1. Create or expand initiatives that integrate comprehensive infant and early childhood mental health services into child-serving settings.** Early childhood mental health screenings, services, training, and supports that promote healthy social-emotional development may be provided in a variety of settings—at home, in a child care setting, in a primary health care facility, or in a mental health professional’s office. It is critical that training for staff, parents, and other caregivers on how best to support healthy social-emotional development, as well as screenings and services, are integrated into existing programs that reach infants and toddlers in these different settings. For example, with mental health consultation and training in child care centers, staff can support social and emotional development, prevent behavioral problems, support relationships with families, and identify early warning signs of mental health disorders. Federal and state policymakers should increase funding for services that promote social-emotional health and well-being in young children, as well as prevention services for children and families experiencing, or at high risk of experiencing, situations that might lead to disruptions in social-emotional development. This includes expanding the capacity of federal programs such as Medicaid, Head Start and Early Head Start, Parts B and C of the Individuals with Disabilities Education Act (IDEA), the Child Care and Development Fund (CCDF), and the Maternal and Child Health Block Grant to support early childhood social and emotional development.

Military Families Support Their Babies

For American military families, the social and emotional health of their young children is tied directly to the unique issues they face as a family. Deployment, loss, grief and stress all present challenges and opportunities for military parents as they support the mental health of their young children.

Julie and Matthew Smith¹ are a military couple who faced the trauma of a seven-month deployment early on in Julie’s pregnancy. While Matthew was deployed, Julie found out she was pregnant with twins and went through a very difficult pregnancy that resulted in the premature birth of her babies. Matthew missed the birth of his children and was not able to be home while they spent weeks in the neonatal intensive care unit (NICU) and then came home with a range of medical needs. Julie rose to the challenge as a “single” mom with the help of her mother and community resources, such as a military spouses support group and Early Head Start. When her husband finally returned home, the babies were already 3 months old. As a family, they worked hard to address Matthew’s transition back home, ensuring he had time to bond with the babies. When the babies were 9 months old, Matthew was deployed once again for another year, and the family had to deal with another long separation.

Despite the hardships of separation and deployment, the Smith family is resilient and the social and emotional health of the twins is sound. For military families with young children, the partnership between parents, programs, and policies can make all the difference in their healthy social and emotional development.

¹ Names have been changed to respect the privacy of the family.



2. **Strengthen the capacity of the mental health system to diagnose and treat infants and toddlers.**

Across the country, mental health systems are focusing greater attention on children's mental health, but the services provided are mainly designed for older children. It is critically important that the programs and systems that support mental health services recognize and respond to the unique needs of infants and toddlers who experience mental health problems. Identifying and diagnosing early mental health problems is challenging and is compounded by the lack of skilled practitioners to diagnose and treat infants, toddlers, and their families. Untreated infant mental health disorders can have disastrous effects on children's functioning and future outcomes. Hence, training, technical assistance, and supervision for clinicians is vital to building capacity and expertise in infant mental health. These components assure high quality assessments, consultation, and intervention. Federal and state policymakers should support efforts to expand the number of mental health clinicians who are trained to specifically address infant and early childhood mental health issues by including infant and early childhood mental health in professional development initiatives, developing competencies and credentialing or endorsement systems for early childhood mental health clinicians, and supporting special training projects or programs at colleges and universities.

3. **Improve access to parental mental health services that treat maternal depression, anxiety disorders, substance abuse, and family violence.**

The emotional wellness of parents plays a major role in the mental health of their children. Parents with positive mental health are better able to foster a healthy parent-child relationship than those with mental health disturbances. The absence of a healthy, strong emotional bond between parent and child poses a great risk to a child's development. Adult mental health disturbances, such as maternal depression and substance abuse, disrupt parenting and interfere with their ability and availability to nurture a child's social and emotional development. Improving parental mental health improves both child and adult outcomes. State and federal policymakers should improve access to parental mental health services that treat maternal depression, anxiety disorders, substance abuse, and family violence.



Parents with positive mental health are better able to foster a healthy parent-child relationship than those with mental health disturbances.



4. Provide funding for states to implement requirements to refer infants and toddlers with substantiated cases of abuse and neglect to Part C of the Individuals with Disabilities Education Act (IDEA). Infants and toddlers who have been maltreated and who may be in foster care represent a group of children who are extremely vulnerable to mental health problems. Many have been seriously maltreated which often results in failure to thrive and the exhibition of behavior problems, such as tantrums, self-endangering, aggression, and inability to be consoled. Infants and toddlers who have suffered physical or sexual abuse, neglect, and separation from their parents may also suffer emotional and developmental consequences unless they, and their parents, foster parents, and other primary caregivers are provided with supportive mental health interventions. Congress recognized this need in reauthorizing the Child Abuse Prevention and Treatment Act (CAPTA) and IDEA, requiring infants and toddlers with substantiated cases of abuse or neglect be referred for Part C early intervention services. However, states have had problems implementing this requirement because of lack of funding.⁷ Policymakers should provide funding for states to implement the CAPTA and IDEA mandates for referral to Part C early intervention services for children under three who are involved in a substantiated case of child abuse and neglect.

5. Expand resources for parents and early childhood professionals on early social and emotional development, in order to advance evidence-based practices in infant and early childhood mental health. Parents and caregivers need informational resources to help them understand the importance of social and emotional development in the earliest years. Readily accessible materials for parents help them support their babies' development. In addition, although new research and some promising models for addressing infant mental health concerns are available, parents and professionals are largely unaware of such information. Early childhood programs frequently see infants and toddlers with mental health needs, but staff have no central place to go for information and assistance. Federal and state policymakers should increase the visibility of early social and emotional development by creating educational materials on the subject and providing information, technical assistance, training and other resources to parents and early childhood professionals.

Research

Untreated mental health disorders can have detrimental effects on children's functioning and future outcomes. Unlike adults, babies and toddlers have a fairly limited repertoire of responses to stress and trauma. Mental health disorders in infants and toddlers might be reflected in physical symptoms (poor weight gain, slow growth, and constipation), overall delayed development, inconsolable crying, sleep problems, or aggressive or impulsive behavior and paralyzing fears.⁸ Early attachment disorders (including those resulting from early traumatic separations from parents and placement in foster care) predict subsequent aggressive behavior. Some early mental health disorders have lasting effects and may appear to be precursors of mental health problems in later life, including withdrawal, sleeplessness, or lack of appetite due to depression, anxiety, and traumatic stress reactions.⁹

Early childhood programs frequently see infants and toddlers with mental health needs, but staff have no central place to go for information and assistance.



Healthy social-emotional development is strongly linked to success in elementary school. The emotional, social and behavioral competence of young children is a strong predictor of academic performance in elementary school.¹⁰ Social and emotional development is just as important as literacy, language, and number skills in helping young children prepare for school.¹¹ Those children who are not secure in relating to others are not able to trust adults and, as a result, are not motivated to learn. Furthermore, school-age children who cannot calm themselves or be calmed enough to respond to teaching may not benefit from early educational experiences and will fall behind their peers.

The mental health of parents can affect young children. Maternal depression, anxiety disorders, and other forms of chronic depression affect approximately 10% of mothers with young children.¹² These conditions often disrupt the parent-child bond as parents with mental disorders are less able to provide developmentally appropriate stimulation and parent-child interactions.¹³ Parenting and child development are most affected when depression simultaneously occurs with other factors (extreme poverty, substance abuse, adolescence, maltreatment, etc.).^{14,15} Infants of clinically depressed mothers often withdraw from caregivers, which ultimately affects their language skills, as well as their physical and cognitive development.¹⁶ Older children of depressed mothers show poor self-control, aggression, poor peer relationships, and difficulty in school.¹⁷

Increased training in infant and early childhood mental health is necessary. The lack of a skilled workforce—the professionals needed to conduct the screening, diagnosis, and treatment of mental health problems in very young children—is a major barrier to implementing effective services.¹⁸ Working with young children requires in-depth knowledge of child development systems approaches and diagnostic and clinical skills, as well as multidisciplinary approaches to practicing in the field.¹⁹ When reviewing these criteria, it is evident that there are not nearly enough infant mental health specialists to meet existing needs. In fact, in a 2002 survey in Illinois, 62% of programs reported inadequate mental health resources.²⁰ Increased training has proven to have a positive impact on programs as evidenced by an evaluation of a California early mental health training program which found that the “new skills and knowledge of the clinicians participating in the mental health training were influencing others [in the community agencies] because the [participating clinicians were] better able to help the agency make decisions about some of the difficult social service issues such as reunification and visitation.”²¹



Infants of clinically depressed mothers often withdraw from caregivers, which ultimately affects their language skills, as well as their physical and cognitive development.¹⁶



For more information about developmental screening, see

[Achieving the Promise of a Bright Future: Developmental Screening of Infants and Toddlers.](#)

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DEVELOPMENTAL SCREENING OF INFANTS AND TODDLERS

When an infant is born and we look into his or her eyes, we can see the promise of a bright future for that child and for all of us. For some infants and toddlers, healthy development may not be a clear path, and intervention is needed to achieve that promise of a bright future. Occasionally, there are obstacles that compromise an infant's growth—a medical condition, prenatal or birth trauma, or factors in their environment. Many months may elapse between the time a problem or concern first emerges and when a child is enrolled in appropriate services, which can make a difference in the child's developmental outcome.¹ Developmental screening programs identify children whose development may deserve closer observation or assessment, and children who may be at risk of developmental problems later. Early identification of developmental issues, partnered with a system of supports to intervene, can prevent early challenges from compromising the child's development. Building ongoing developmental screening into services that routinely have contact with infants, toddlers, and their families allows professionals to monitor and support children's development. If concerns are raised by screening, children can be referred for in-depth evaluation and appropriate intervention to improve developmental outcomes. Policymakers can offer a bright future for infants and toddlers by assuring that all children have access to developmental screening, and that follow-up services are available for those children who need more detailed evaluation and treatment.



Finding a Needle in a Haystack

Sometimes, finding what you're looking for is like trying to find a needle in a haystack. You end up searching all over for the missing object, without much clue as to where it might be. When it comes to identifying children who face developmental challenges, we need to do much better than a random search in a haystack. With ongoing developmental monitoring, guidance to parents on typical development, a well-planned referral system, and coordinated developmental screening services, we can identify children with developmental problems much more readily. For the one in four children eligible for Medicaid, EPSDT screening requirements can make it easier to find that needle. We can turn a random search into an effective plan for low-income children if we ensure that every eligible child is enrolled in Medicaid and receives the comprehensive screening, diagnosis, and treatment mandated by EPSDT.



FAST FACTS

- Approximately one out of every six children in the U.S. faces a developmental disability or a disabling behavioral problem before age 18. Yet fewer than **50%** of these children are identified before they start school.³

- Poverty is a strong predictor of poor developmental outcomes in children. Low-income children are more likely than children from other income groups to have poor health and special health care needs that place them at risk of chronic health problems.⁴

- Uninsured children are less likely to receive developmental screenings and preventive health care than children enrolled in public insurance programs such as Medicaid or the State Children's Health Insurance Program (SCHIP).⁵

- **1 in 5** children with a disability will not be identified through a single developmental screening. Disabilities are more likely to be picked up if monitoring and screening are continued in all well-child medical care visits.⁶

Policy Recommendations

- 1. Ensure that all infants and toddlers who are eligible for Medicaid and Medicaid-expansion SCHIP programs receive periodic developmental screening under EPSDT that includes physical, mental, and dental health.** Low-income infants and toddlers are more likely to have poor birth outcomes or experience physical and social-emotional challenges that can lead to developmental delays and disabilities.⁷ Forty-four percent of U.S. children live in poor or near-poor families and are income-eligible for health services under public health insurance programs such as Medicaid and SCHIP that mandate screening through EPSDT.⁸ However, many enrolled children do not receive the full screening to which they are entitled. In 2005, only seven states met the federal benchmark that at least 80% of the children enrolled in Medicaid receive at least one developmental screening annually.⁹ State Medicaid, managed care agreements, and children's health services plans should clearly outline required EPSDT services and other screening mandates, and ensure that these important services are delivered to all eligible children. Children eligible for SCHIP services should also receive EPSDT-like screening, diagnosis, and treatment services regardless of whether the state uses SCHIP funds for Medicaid expansion or for a separate children's health insurance program.

Key Definitions

Surveillance or monitoring refers to the ongoing process of observing a child's development and tracking parents' concerns. Developmental screening is the process of identifying children who may have a developmental problem or a delay in one or more domains of development, or who are at risk of developmental problems in the future. Comprehensive developmental screening should include consideration of the child's physical, cognitive, language, and social-emotional development. Screening tools are measures that gather evidence indicating the probability of or potential for a developmental problem, delay, or risk. Assessment is a more intensive process that evaluates the child's development in depth in order to identify a specific developmental problem and to determine whether the child could benefit from intervention.²

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): Under Medicaid, every eligible child is entitled to periodic developmental screening and treatment for diagnosed conditions in order to ensure that physical and mental conditions that could affect development are identified and corrected. The screening component includes keeping a health history and conducting a physical exam; laboratory tests; developmental and mental health screening; and dental, vision, and hearing screening.

Child Find: The Individuals with Disabilities Education Act (IDEA) requires that states create a system to "find" children from birth to 3 years of age who may be eligible for services provided under Part C of IDEA, and children ages 3–18 years for Part B services. Child Find systems must coordinate with other state agencies and systems in efforts to identify children in need of services.



2.

Require the use of standardized developmental screening tools through regulation, including tools that screen for issues in social-emotional development. Many physicians monitor development by relying on their knowledge of child development and past experience.¹⁰ However, many developmental issues, especially relating to social-emotional development and behavioral health, are not identified easily without the help of standardized screening tools. Screening activities should include consideration of family conditions, such as parental depression or alcohol or substance abuse, that impact the child's development and security. State Medicaid and SCHIP regulations and private health care plans should spell out covered screening, diagnosis, and treatment services and identify appropriate screening tools. In addition, policymakers should make funding available to provide training and technical assistance to support professionals (pediatricians, home visitors, early care and education professionals, and others) to incorporate developmental screening practices into their contacts with infants, toddlers, and families.

3.

Ensure that physicians and mental health professionals are reimbursed adequately to conduct screening. Private insurance and Medicaid/SCHIP coverage for engaging in screening activities may be inadequate, or regulations may limit the time available during a well-child doctor visit to conduct screening along with other health care activities. Policymakers should assure that reimbursement for well-child visits covers the time required to complete screening and other visit activities. Payment should also reimburse for screening activities as a separate activity whenever a concern is suspected between check-ups.¹¹

4.

Support outreach to inform parents about developmental screening and follow-up services. Many parents seek assurance that their children are developing on a typical path. If they have a concern, they often do not know where to reach out for help.¹² Community helpers who enter the lives of infants and toddlers (for example, child care providers, parent educators, home visitors, and health clinic staff) should understand that there are services available for developmental screening, assessment, and treatment and should be able to provide information about these services. Funds should be provided to conduct awareness and outreach campaigns to increase family participation in screening activities, including increased funding for "Child Find" activities under IDEA Part C.



Policymakers should assure that reimbursement for well-child visits covers the time required to complete screening and other visit activities.



5.

Promote linkages between early identification services and a network of treatment services so that children’s developmental concerns are addressed.

Identifying a possible developmental concern is the first step to successful prevention or intervention. Developmental concerns can be recognized early and children’s needs responded to if a strong early identification system is linked to a network of preventive and treatment services and supports. Creating linkages between various programs and services for infants, toddlers, and families ensures that services will reach the children and families who need them. Some valuable linkages include coordinating care through a medical home; strengthening information and referral networks; providing health and mental health consultation to child care; and building collaboration between public health, child welfare, and early intervention services to ensure that children in the child welfare system are screened. Funding should be provided to support increased coordination.¹⁴

Research

Early investments have significant benefit to children and to society at large. ^{15, 16}

An example of this long-term benefit is found in the test to detect congenital hearing problems in newborns. This simple test allows children to be identified and treated beginning in the first months of life and may prevent severe disabilities in communication and language development. Although the incidence of congenital hearing problems is low, its personal and economic cost is great. The Centers for Disease Control and Prevention estimates that the cost of providing services to one year’s cohort of newborns who are disabled due to hearing loss will equal \$2.1 billion in services over their lifetimes.¹⁷ Much of this expense could be eliminated by early detection and treatment. The newborn hearing screening test has been mandated in 31 states, and it is one of the 29 newborn screening tests recommended by the March of Dimes.¹⁸

Low-income children are at greater risk of developmental delays and problems.

Low-income children are more likely to lack health insurance and lack access to dental care.¹⁹ Their mothers are less likely to receive adequate prenatal care. Low-income children are more likely to face



Low-income children are more vulnerable to health and development problems, which requires a more concerted effort to ensure that low-income infants and toddlers receive the screening and services they need.



a number of risks to development such as parental depression, poor housing conditions (contributing to problems like lead poisoning or asthma), or nutritional deficiencies. These conditions make low-income children more vulnerable to health and developmental problems. In addition, the greater risk of exposure to substance abuse in the family, child abuse or neglect, or family disruption among low-income families puts children at greater risk of long-term problems in health and behavior.²⁰

Training and support for pediatricians can improve screening rates and practices.

The Assuring Better Child Health and Development (ABCD) project, designed to incorporate developmental monitoring and screening into pediatric practices and link pediatricians to referral networks, significantly increased the occurrence of developmental screening in 70% of well-child visits in a pilot program in North Carolina. The project also demonstrated strategies for taking these best practices to scale and made policy recommendations to improve practice statewide, such as revising Medicaid payment policies so that reimbursement for screening activities was adequately covered.²¹

Most parents welcome support and guidance. Most parents recognize that the early years are crucial to their child's development. However, many parents also note that they lack important information to guide them in supporting their child's development.²² An evaluation of EPSDT found that parents of eligible children did not understand the purpose of developmental screening, nor were they aware of screening services for which their children are eligible.²³ They look to trusted professionals such as pediatricians and nurses for this support.²⁴

Conditions make low-income children more vulnerable to health and developmental problems. In addition, the greater risk of exposure to substance abuse in the family, child abuse or neglect, or family disruption among low-income families puts children at greater risk of long-term problems in health and behavior.²⁰



An evaluation of EPSDT found that parents of eligible children did not understand the purpose of developmental screening, nor were they aware of screening services for which their children are eligible.²



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For more information about early intervention and the IDEA Part C system, see

[Making Hope a Reality: Early Intervention for Infants and Toddlers with Disabilities](#)

For more information about health benefits for low-income children, see

[Leading the Way to a Strong Beginning: Ensuring Good Physical Health of Our Infants and Toddlers.](#)

For more information about the social-emotional needs of infants and toddlers, see

[Laying the Foundation for Early Development: Infant and Early Childhood Mental Health.](#)

About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at www.zerotothree.org/policy.



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STRONG FAMILIES

BUILDING THE FOUNDATION FOR INFANTS, TODDLERS, AND THEIR FAMILIES

We all know that one of the basic principles of constructing a strong house is building a solid foundation. With babies, building the architecture of the brain works in much the same way: the foundation created in the early years must be strong in order for the child to thrive. All new parents strive to provide a stable environment for their children, but as the costs of basic necessities—such as food and energy—continue to rise, low-income workers are struggling more and more to support their families and remain out of poverty. As their budgets are squeezed, some parents are forced to make difficult and dangerous choices between the very needs that are essential for their baby's health and well-being, such as whether to buy food or pay to heat their home during the cold months. Infants and toddlers are disproportionately affected by the increasing poverty in the United States,¹ and such economic hardship can compromise their healthy development and hinder their ability to succeed in school and in life.² To ensure their babies have a healthy start in life, families must be able to provide a safe home environment, nutritious food, and quality child and health care.³ Policymakers can help families build the foundation that meets their young children's basic needs by increasing food, housing, and energy assistance; supporting health insurance and child care; and targeting tax credits for low-income working families.



Stuck Between a Rock and a Hard Place

Maria and Joe are stuck between a rock and a hard place. They live in El Paso, Texas, with their young children, Tanya, 3 years, and Shawn, 18 months, and they work hard to provide for their children and achieve the American dream.⁴ Maria and Joe both have full-time jobs earning minimum wage and an annual combined income of approximately \$27,000, which is nowhere near enough to pay for current costs of housing, food, health, transportation, and child care in El Paso.⁵ In order to meet these basic needs, they must make a combined income of approximately \$42,000.⁶ Unfortunately, Maria and Joe's story is all too common. A typical American family today needs to make an income of approximately double the federal poverty level just to get by.⁷ Even when they work full-time, the American dream is beyond the reach of too many families.

FAST FACTS

- Compared to children of all ages, the proportion of infants and toddlers living in poverty is increasing more quickly. Between 2000 and 2006, the number of children of all ages who were poor increased by 11% while the number of infants and toddlers increased by 16%.⁸

- Child poverty costs the United States an estimated **\$500 billion** a year, due to increased expenditures on health care and the criminal justice system, and in lost productivity in the labor force later in life.⁹

- Families with children under the age of 6 are at a higher risk of experiencing food insecurity (having limited or uncertain availability of nutritionally adequate and safe foods) than those with older children.¹⁰

- Children living in low-income families that do not receive a housing subsidy are more likely to suffer from malnutrition and underdevelopment than children in low-income families that do receive a subsidy.¹¹



Policy Recommendations

1. **Increase investment in child nutrition programs that reduce food insecurity for young children and ensure that benefits are adequate for a healthy diet.**

Infants and toddlers living in low-income, food-insecure households are 76% more likely than those living in low-income, food-secure households to be at developmental risk,¹² and the need for food assistance is currently on the rise.¹³ By helping to meet the dietary needs of infants and toddlers, child nutrition programs allow families to pay for other basic necessities that are integral to their child's healthy development, such as child care, health care, and the heating or cooling of their homes. Federal child nutrition programs such as the Food Stamp Program (recently renamed the Supplemental Nutrition Assistance Program, or SNAP), the Child and Adult Care Food Program (CACFP), and the Supplemental Nutrition Program for Women, Infants, and Children (WIC) provide food and support to low-income families to ensure that young children have the nutritious diet they need for healthy development. Policymakers should fully fund these programs and expand eligibility to include all young children living in families at risk for food insecurity, as well as expand CACFP to reach more child care centers and family child care homes serving at-risk children. Additionally, the food packages and benefits provided by child nutrition programs should be regularly updated to reflect current nutrition science and fully funded to ensure that benefits adequately cover the cost of a healthy diet.

2. **Provide adequate housing and energy assistance to low-income families.**

Low-income families must balance housing and energy costs with the other needs of their family members. Fifty-six percent of poor working families with children spend half or more of their income on rent,¹⁴ leaving them with too little money to provide for their children's other needs. These families may be forced to move often, disrupting close relationships, and they must make difficult choices between basic necessities. For example, once families pay for expensive housing and energy costs, they have less money to purchase food, possibly interfering with their children's growth and development. Policymakers should ensure that families receive adequate housing and energy support so that they are not forced to make these dangerous choices. Increasing housing subsidies and investment in energy assistance programs like the Low-Income Heating and Energy Assistance Program (LIHEAP) will help to prevent housing and energy challenges for low-income families and reduce the need to make trade-offs that compromise the health and development of their young children.

3. **Implement welfare-to-work policies that support the developmental needs of infants and toddlers.**

Infants and toddlers, particularly those at risk, need dedicated time with their parents to form the critical relationships that will serve as the foundation for healthy social, emotional, and cognitive

Fifty-six percent of poor working families with children spend half or more of their income on rent,¹⁴ leaving them with too little money to provide for their children's other needs.



development. As they shape welfare-to-work policies, federal and state policymakers should consider the unique developmental needs of infants and toddlers and ensure that family-friendly policies are put in place. Excessive mandatory work requirements for low-income parents who receive benefits as part of the Temporary Assistance for Needy Families (TANF) program make dedicated time virtually impossible; states should take advantage of the program option to exempt parents with infants from work requirements. Additionally, single parents should be exempt from the TANF work requirement until their youngest child is at least 1 year old. Finally, research should be conducted to examine the impacts of the TANF program and its work requirements on the well-being of infants and toddlers.

4. Support and expand tax policies for low-income families, including the Earned Income Tax Credit, the Child Tax Credit and the Child and Dependent Care Credit.

Federal and state tax credits for low-income families provide income support to help workers close the gap between their earnings and what they need for their families' basic needs. Federal policymakers should expand and improve upon tax credits, such as the Earned Income Tax Credit (EITC), that provide critical income supplements for low-income workers, especially those with children. While the EITC is fully refundable and can benefit workers with little or no federal tax liability, other tax credits that could provide critical support for very low-income families with young children are not. For example, more than 30% of qualifying children under age 2 live in working families with earnings too low to qualify for the full Child Tax Credit, which is only partially refundable.¹⁵ Making the credit fully refundable would ensure that it serves as income support for those families with the greatest need. Additionally, the Child and Dependent Care Credit should be made refundable, allowing an additional 1.6 million low-income families to use the credit to help pay their child care expenses.¹⁶ To supplement the federal tax structure, states are now building upon federal tax credits for low-income families: 13 states have made their state child care tax credits fully or partially refundable¹⁷ and 24 states have enacted an EITC.¹⁸ State policymakers should continue to build upon federal tax credits to further ease the financial burden of low-income families.

5. Coordinate benefit programs and tax credits to ensure that working families receive the continuum of support needed to keep them out of poverty.

Public assistance programs are often means-tested in order to ensure that the families with the most need can receive benefits. However, the effect is that an incremental increase in earnings can push a family above the income eligibility requirement, resulting in the termination of benefits. Additionally, current TANF rules limit the amount of time an individual is eligible to receive public assistance, as well as the number of months one can spend in activities to improve earning potential, such as acquiring education, learning English, or receiving mental health and substance abuse services.¹⁹ Consequently, many benefit recipients who move from welfare to work or enjoy small increases in earnings can lose benefits before they can afford to pay for their own necessities.

Federal policymakers should expand and improve upon tax credits, such as the Earned Income Tax Credit (EITC), that provide critical income supplements for low-income workers, especially those with children.



These benefit losses are often coupled with increases in income taxes and can effectively leave a family worse off despite their increase in earnings.²⁰ While some benefit programs, such as Food Stamps/SNAP and some child care subsidies, do phase out benefits as families become increasingly economically secure, policymakers should ensure that more public assistance programs gradually decrease benefits, as well as extend some benefits and tax credits into a higher income range. This would reduce a family's marginal tax rate and provide relief as a family works to become financially independent.

6. **Eliminate administrative barriers to participation in benefit programs for low-income families.**

Research shows that infants and toddlers living in low-income families are at increased risk for vulnerabilities that challenge their healthy development.²¹ Federal benefit programs, such as TANF and Food Stamps/SNAP, can help low-income families buffer these risks and meet the needs of their young children. Yet due to the time, travel, and cost associated with the application and participation processes, many children and families are prevented from receiving these critical services. For example, approximately 65% of eligible recipients participate in the Food Stamps/SNAP program,²² 57% of eligible pregnant women and children participate in WIC,²³ and only 42% of eligible families receive TANF benefits.²⁴ Federal and state policymakers should eliminate administrative barriers for families and grant longer certification periods to streamline access and participation. Instituting a standardized application for many benefit programs that support working families, such as TANF, WIC, Food Stamps/SNAP, and the State Children's Health Insurance Program (SCHIP), will reduce administrative burdens and help to increase participation. Additionally, policymakers should invest in technology that will reduce administrative costs and improve access, such as online and phone applications.

Research

Poverty can compromise the healthy development of infants and toddlers and impact later school and life success. One of the most consistent associations in the science of early childhood is between economic hardship and compromised child development.²⁵ The environmental stresses to which children in poverty are more likely to be exposed, such as inadequate nutrition, substance abuse, maternal depression, environmental toxins, and physical and emotional abuse can all negatively impact their development.²⁶ Early and sustained exposure to these risks can influence the physical architecture of the developing brain, preventing infants and toddlers from fully developing the neural pathways and connections that facilitate optimal development and learning. Consequently, when compared to children who are not poor, children who grow up in poverty are less likely to be successful in school and productive in the labor force, while also having increased odds of lifelong health problems and criminal activity.²⁷

One of the most consistent associations in the science of early childhood is between economic hardship and compromised child development.²⁵



Child nutrition programs can prevent food insecurity and promote healthy development.

Growing up in food-insecure households can threaten the healthy development of infants and toddlers and hinder their later school success. Research shows that infants and toddlers who suffer from food insecurity have increased risk for iron deficiency anemia, deficits in cognitive development, and behavior and emotional problems.²⁸ Child nutrition programs are effective deterrents to food insecurity and unhealthy development. Infants and toddlers who participate in the Food Stamps/SNAP program are 26% less likely to be food insecure than eligible children who do not participate.²⁹ Mothers who participate in the WIC program are less likely to have low birthweight or preterm infants,³⁰ whereas infants who do not participate in WIC are more likely to be underweight and perceived as having fair or poor health when compared to infants who do participate in WIC.³¹

The home environment impacts child health outcomes. A stable home is critical during the early years as babies grow and develop. Low-income families often struggle to find safe and affordable housing, as well as heat and cool their homes. Research has shown that infants and toddlers in families that receive a rent subsidy are less likely to have indications of undernutrition than those in families that do not receive a subsidy.³² Additionally, because of their smaller body size, young children are challenged to maintain their body heat and are more likely than older children to get sick from extreme temperatures.³³ Babies and toddlers who live in families that are not able to afford sufficient energy are more likely to be in poor health and have a history of hospitalization, be at risk for developmental problems, and be food insecure.³⁴

Tax credits can ease the financial burden of low-income families. Research shows that the expansion of refundable tax credits such as the EITC and the Child Tax Credit (which is partially refundable) has effectively reduced the tax burden for low-income families.³⁵ For example, the EITC is more effective in helping children move out of poverty than other government programs, and families use the funds to pay for other basic necessities.³⁶ One study also found that the EITC positively impacted younger children's school achievement.³⁷



Infants and toddlers who participate in the Food Stamps/SNAP program are 26% less likely to be food insecure than eligible children who did not participate.²⁹



For more information about the effectiveness of child nutrition programs in preventing food insecurity, see [*Leading the Way to a Strong Beginning: Ensuring Good Physical Health of Our Infants and Toddlers.*](#)

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FAMILY LEAVE IN THE EARLY YEARS

During the earliest days and months of life, babies discover the world through their experiences with their parents and other caregivers. Positive early relationships, especially with a parent, literally shape the environment within which early health and development unfold and early learning takes place.¹ This critical time in a child's life is a unique opportunity for parents to build secure and healthy early attachments with their baby and ensure that they receive vaccinations and appropriate medical attention when ill. But in order to do so, parents must have access to adequate leave—for bonding with their children right from the very beginning of life, and for caring for themselves and their family members when ill. Parents also need time to bring their child to the pediatrician for well-baby visits and to seek medical care. Yet, too often, working parents are unable to take leave from work to provide even the most basic care for their infants, toddlers, and families. Since the federal government is the nation's largest single employer with close to two million civilian employees, and state and local governments employ an additional eight million employees, family leave is a particularly important issue for governmental consideration.² Now is the time for federal and state policymakers to secure the best possible start for young children by ensuring that working families receive paid family and sick leave to support their young children right from the beginning.



Did You Know?

Did you know that when workers who are sick are able to take paid sick days, they are healing the economy too? In fact, for every paid sick day workers receive as a benefit, the economy saves a total of more than a billion dollars due to reduced turnover, increased productivity, and reduction in spread of contagious illnesses. If workers are provided seven paid sick days per year, employers, workers, families, and taxpayers will experience a net cumulative savings of \$8.1 billion.³

FAST FACTS

• **56%** of mothers with children under the age of 3 are employed.⁴

• **40%** of the workforce is currently not covered by the Family and Medical Leave Act.⁵

• Without access to such leave, employees find themselves reporting to work during times when ill, resulting in lost productivity which costs the national economy **\$180 billion** every year.⁶

• More than **3 in 4** eligible employees reported that they could not afford to take the leave that they needed because it was unpaid.⁷

• **57 million** working Americans do not have paid sick leave.⁸



Policy Recommendations

1. Expand access to FMLA to cover more employees. The 1993 Family and Medical Leave Act (FMLA) allows employees to take up to 12 weeks of unpaid, job-protected leave in a 12-month period to care for newborns, newly adopted and foster children, and seriously ill family members, including themselves. Since the law only applies to employers with at least 50 employees, a full 40% of the workforce is currently not covered by the federal law.⁹ However, FMLA does allow states to set standards that are more expansive than federal law. In fact, several states have already passed legislation to cover employers with as few as 10 employees for all leave and even fewer employees for more narrow leave categories.¹⁰ By lowering the threshold of firm size from 50 to 25 or even fewer employees, federal and state policymakers can allow more working parents to take leave to care for their young children and build the healthy attachments newborns, infants, and toddlers need, without worrying that they might lose their jobs.

2. Guarantee paid family leave for working families. Although FMLA has had great success, far too many workers are still unable to take leave because it is unpaid. As is the case with the expansion of unpaid family leave policies, states are also taking the lead in the endeavor to offer paid family leave. For example, California has the country's most comprehensive paid family and medical leave insurance program. Over 13 million workers can receive partial pay (55%–60% of wages) to take up to six weeks of leave a year to care for a newborn, newly adopted or foster child, or to care for a seriously ill family member, and up to 50 weeks of leave a year to recover from their own serious illness, including pregnancy- or birth-related disability.¹¹ By providing for at least partial payment during family leave, federal and state policymakers can reduce employees' economic anxiety by providing job security and consistent income during a time when it is essential for parents to focus on their new baby or ill families rather than worrying about how to make ends meet.

3. Enact state and federal paid sick leave. Working men and women are more productive and loyal to their employers when the benefits they receive support them and their entire family. In particular, when employees receive paid sick leave to recover from their own illnesses, care for sick family members, or attend routine medical and well-child visits for themselves and their family members, they contribute more to the economy through their jobs and through their purchasing power. Federal and state governments are leading the way in terms of providing paid sick leave to their own employees; however, private sector employees lag behind. Maintaining flexibility for working families will ensure that young children have consistent and dependable caregivers present when it matters most—in the earliest years of life. Policymakers should enact legislation to ensure that public and private sector employees have paid sick leave that is all-inclusive of the employee and their family members, which will benefit companies and the overall economy through increased productivity and reductions in staff turnover.

Working men and women are more productive and loyal to their employers when the benefits they receive support them and their entire family.



4.

Expand disability or unemployment insurance to help families take paid leave. In the absence of explicit paid leave policies, states have used creative financing mechanisms to allow employees to draw on income while they are on unpaid leave. Specifically, five states—California, Hawaii, New Jersey, New York, and Rhode Island—and the territory of Puerto Rico offer temporary disability insurance that provides partial wages to employees who are temporarily disabled for medical reasons, including pregnancy- or birth-related reasons.¹² State and federal lawmakers should enact legislation to allow parents (biological, foster, or adoptive) on leave to collect unemployment insurance or state disability insurance to enable them to spend time with their infants and toddlers in the first years of life.

Research

Infants and toddlers need nurturing relationships in order to thrive. We know from the science of early development that early relationships and attachments to a primary caregiver are the most consistent and enduring influence on social and emotional development for young children.¹³ Research demonstrates that forming secure attachments to a few caring and responsive adults is a primary developmental milestone for babies in the first year of life. Infants and toddlers who are able to develop secure attachments are observed to be more mature and positive in their interactions with adults and peers than children who lack secure attachments.¹⁴

Generous periods of leave contribute to the healthy development of infants and toddlers.

Research shows that dedicated time at home with newborns, infants, and toddlers allows parents the time they need to facilitate breastfeeding and ensure that their children receive the immunizations and medical check-ups necessary to lower infant mortality and reduce the occurrence and length of childhood illnesses, which in turn reduce private and public health expenditures.¹⁵ In fact, studies have shown that paid parental leave, in particular, leads to higher rates and longer periods of breastfeeding (which reduces the rates of childhood infections) and less maternal stress.¹⁶ Furthermore, after reviewing family leave policies in 18 countries, researchers found that a 10-week extension in paid leave was predicted to decrease infant mortality by 2.6% and post neonatal (28 days–1 year) infant mortality by 4%.¹⁷ More time at home also allows for bonding between parents and young children which fosters positive social-emotional development.

Benefits of leave policies extend to employers as well as families.

In addition to benefiting employees and their families, leave policies also benefit employers—including federal, state and local governments—by reducing staff turnover and the subsequent training and hiring costs associated with new staff. Such costs can be upwards of 150% of a salaried worker's annual pay or 50%–75% of an hourly worker's annual pay.¹⁸ Other benefits include less transmission of illnesses among co-workers, increased productivity, fewer absences, lower overall health care costs, and increased company loyalty. Presenteeism (lost productivity

Researchers found that a 10-week extension in paid leave was predicted to decrease infant mortality by 2.6% and post neonatal (28 days-1 year) infant mortality by 4%.



resulting from employees being physically present at work, yet unable to be fully engaged due to illness) accounts for 18%–60% of all costs associated with ten leading health conditions.¹⁹ The result is that approximately one-fifth to three-fifths of all spending on common health conditions that employers are faced with could be the result of on-the-job lost productivity.²⁰ Every year, lost productivity costs the national economy \$180 billion.²¹

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About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at www.zerotothree.org/policy.



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INFANTS AND TODDLERS IN FOSTER CARE

The first three years of life represent a time in which the most rapid development takes place. This affords a unique window of opportunity for positive change to occur, particularly for our most vulnerable children. Unfortunately, infants and toddlers comprise almost one-third of all children who are abused or neglected¹ and are the largest single group of children entering foster care.² Because their healthy development is interrupted by the lack of security and attachment from their primary caregivers, infants and toddlers in foster care are extremely vulnerable to the effects of maltreatment and multiple foster care placements. The impact of maltreatment on healthy development can have lifelong implications if not properly addressed. The good news is that intervention in the first three years can make a world of difference in the lives these children will lead. Policymakers can seize the opportunity and act now to assure that vulnerable infants and toddlers in foster care get the best possible start in life.



Imagine This

How many times have you moved to a new city in the last six months? Babies removed from their parents' care often move three or more times in their first months in foster care.³ Just think how disrupted your life would be if you moved three times in six months and had to make new friends and establish new business relationships each time. Now imagine what it must be like for a baby to lose everything familiar over and over again.

FAST FACTS

- Children between birth and age 3 have the highest rates of victimization.⁴

- Maltreatment interferes with the healthy development of the synaptic connections in the brain that are critical to intellectual functioning and to social and emotional well-being.⁵

- Once they have been removed from their homes and placed in foster care, infants and toddlers are more likely than older children to be abused and neglected and to stay in foster care longer.⁶

- A study of the cumulative costs of special education from ages 0 to 18 found that intervening starting at birth resulted in lower costs over the course of childhood. Total cost of services begun at birth was \$37,273 compared with a total cost of between \$46,816 and \$53,340 if services were not begun until age 6.⁷



Policy Recommendations

1. Ensure a permanent placement for infants and toddlers in foster care. Moving children from caregiver to caregiver interferes with the children's healthy growth and development. The very youngest children experience their world through the eyes of their primary caregivers. Their sense of security—which leads them to develop into healthy, curious, loving children—is based on the love and protection offered by those few adults who care for them on a daily basis. Infants grieve the loss of their caregivers. When forced to deal with multiple changes in caregivers, they suffer from depression, anxiety, grief reactions, and other emotional changes that interfere with daily functioning.

2. Implement frequent family visitation for infants and toddlers in foster care. Very young children need to see their parents every day if possible. Current child welfare practice supports just one visit a week. For very young children, infrequent visits are not enough to establish and maintain a healthy parent-child relationship. Close daily contact is critical for the formation of strong relationships between parents and very young children. Babies and toddlers are learning about their parents with every interaction (every feeding, every bath, every diaper change). Parents are learning about their children at the same time. Each time the birth parent misses one of these daily moments, their relationship suffers.

3. Pursue two permanency plans for infants and toddlers in foster care. During the earliest years of a child's life—a time when growth and development occur at a pace far exceeding that of any other period of life—time goes by quickly. Babies can drift for years in foster care. They need stable loving parents as soon as possible. Standard child welfare practice is to seek reunification over the course of months or years; an alternative permanency arrangement is sought only when it is clear that the birth parents are not able to regain custody of their children. In the meantime, the babies have grown up in a series of foster homes and have suffered developmental damage they will carry with them throughout their lives. All members of the family's team need to understand concurrent planning as the legal way to make sure that a child reaches a permanent home as quickly as possible. Babies need at least one person who is crazy about them, and they need stability to support their healthy development. Each day of visitation with their parents triples the odds a baby in foster care will reach permanency within a one-year time period. But each time an infant or toddler experiences a change in placement, their odds of reaching permanency decrease by 32%.

Babies need at least one person who is crazy about them, and they need stability to support their healthy development.



4. Ensure ongoing post-permanency services and supports for all families after permanency has been achieved (i.e., for birth families who have achieved reunification, for permanent guardians, and for adoptive families). Children who leave foster care for permanency with their biological parents, other relatives, or adoptive parents will continue to have developmental and mental health needs. The adults caring for them will be challenged financially, logistically, and emotionally to meet those needs. If these placements are to become truly permanent, ongoing services and supports should be available to all three family types. In assisting families who achieve reunification, the court needs to be aware of the factors that brought the families to the child welfare system in the first place—child abuse or neglect, poverty and homelessness, no job and no marketable job skills, substance abuse, mental health problems, domestic violence, and/or little or no social support network to call upon in times of stress. These are problems that will continue to need attention after the child maltreatment issue is resolved.

5. Ensure that judges are informed about child development and use that knowledge to determine safety and permanence. Juvenile and family court judges across the county have long felt frustrated by the challenges infants and toddlers face in the child welfare system. In particular, many judges have struggled to quickly reunify families or place infants and toddlers in other permanent homes. In order to fulfill their leadership and oversight rules in cases involving infants and toddlers, judges, attorneys, and others must be knowledgeable of the recent scientific advances and be able to apply that knowledge in their judicial decision-making.

6. Assess the mental health needs of infants and toddlers in foster care and provide treatment as necessary. Infants and toddlers, although unable to use words to communicate, experience joy and sadness, anger and fear. From birth, they feel, remember, learn, and communicate. The adults who care for them are the mediators of all their experiences. If parents do not have adequate supports to provide a healthy environment for their child, very young children can suffer depression and other mental health problems.⁸ Without treatment, their mental health concerns will impede their healthy development.

7. Ensure access to early intervention services (Part C of the Individuals with Disabilities Education Act [IDEA]) for children age 3 and younger. Amendments to the Child Abuse Prevention and Treatment Act (CAPTA) of 2003 required states to develop procedures to assure that all children 0–3 who are involved in a substantiated incident of abuse or neglect are referred to Part C services. The IDEA amendments of 2004 also required Part C services for all children who have been maltreated or exposed to domestic violence and illegal prenatal substances. This opened a window of opportunity for ensuring developmental assessments and treatment for infants and toddlers who have been abused or neglected. While Part C is a federal requirement, many local jurisdictions are not aware of the Part C program in their states.

If parents do not have adequate supports to provide a healthy environment for their child, very young children can suffer depression and other mental health problems.



8. Ensure comprehensive and consistent health care that includes dental, vision, and hearing exams. Like all young children, those in foster care need to receive regular medical care that includes the full schedule of immunizations, regular dental exams, and screening for vision and hearing problems. Untreated physical health problems can interfere with a child's ability to develop normally and succeed in school.

9. Expand and designate substantial funding to build preventive services that preserve and support families. The structure of child welfare funding must ensure a continuum of services, beginning with those that can help prevent abuse and neglect and keep families together. Currently such "front-end" services must compete for funding with more crisis-oriented services. Services to preserve and support families are particularly important for families with infants and toddlers who may need extra support in parenting. Of all young children in foster care, 40% were born prematurely or with low birthweight,⁹ often resulting in challenging situations for which parents may lack the skills to cope. Policymakers should designate funding for preventive and supportive services. Such services may include home visiting and family support services that would be available to all families at places they are likely to visit—the obstetrician's office, pediatrician's office, or hospital emergency rooms; local churches; and schools, libraries, and police stations. Staff at all these points of entry would be trained as first responders who would identify families under stress and begin the process of connecting them to service providers who could help them avoid a crisis.

Research

In order to thrive, infants and toddlers need stable nurturing relationships. We know from the science of early childhood development that the first relationships a child forms with adults are the most enduring influence on social and emotional development for young children.¹⁰ Infants and toddlers who are able to develop secure attachments are observed to be more mature and positive in their interactions with adults and peers than children who lack secure attachments.¹¹ Very young children who have been abused or neglected are not able to develop trusting relationships with the adults they depend on for care. This sets the stage for all future relationships and for the child's expectations of what the world holds for them. Outcomes of these damaging early relationships include: elevated rates of aggression even in toddlers; lower IQ scores and diminished language abilities; anxieties, fears, and sleep problems; and a reduced ability to empathize with others.

The structure of child welfare funding must ensure a continuum of services, beginning with those that can help prevent abuse and neglect and keep families together.



Infants and toddlers in foster care are more likely to have fragile health and less likely to receive developmentally appropriate health care. Nearly 40% of young children in foster care are born low birthweight, premature or both—two factors that increase their likelihood of medical problems or developmental delay.¹² They are more likely to have fragile health and disabilities and far less likely to receive services that address their needs.¹³ More than half of these children suffer from serious health problems, including elevated lead blood-levels, and chronic diseases such as asthma.¹⁴ A significant percentage of children in foster care do not even receive basic health care, such as immunizations, dental services, hearing and vision screening, and testing for exposure to lead and to communicable diseases.¹⁵

Visitation is one of the best predictors of successful family reunification. Typically one visit each week is planned between children in foster care and their parents. Every additional day of visitation triples the odds of achieving permanency within a year.¹⁶ The more frequently children and parents spend time together, the more quickly it becomes apparent if the relationship can be healed. Parents who learn from the experience and whose caregiving becomes more sensitive to the child's needs over the course of several visits are demonstrating that reunification is the appropriate permanency goal. Parents who repeatedly skip visits, who show up under the influence of drugs or alcohol, whose friends accompany them on visits and socialize with them rather than with their children, or who behave inappropriately with their children are demonstrating that reunification is not the best outcome for the child.

Infants and toddlers in foster care are at risk for mental health disorders. Early childhood development research shows that infants can experience depression.¹⁷ Infants and toddlers in the child welfare system are disproportionately exposed to early trauma and other developmental risk factors that can result in a variety of mental health disorders. Physical abuse extracts a substantial toll on young children's social adjustment, as seen in elevated levels of aggression that are apparent even in toddlers. Long-term negative outcomes include school failure, juvenile delinquency, substance abuse, and the continuation of the cycle of maltreatment into new generations. Yet, research shows that when young children are removed from harmful conditions, many recover amazingly well. Intervening early can help prevent the cycle of maltreatment from continuing.



The more frequently children and parents spend time together, the more quickly it becomes apparent if the relationship can be healed.



For more information about physical health of infants and toddlers, see [*Leading the Way to a Strong Beginning: Ensuring Good Physical Health of Our Infants and Toddlers.*](#)

For more information about home visiting and parent support programs, see [*Reaching Families Where They Live: Supporting Parents and Child Development Through Home Visiting.*](#)

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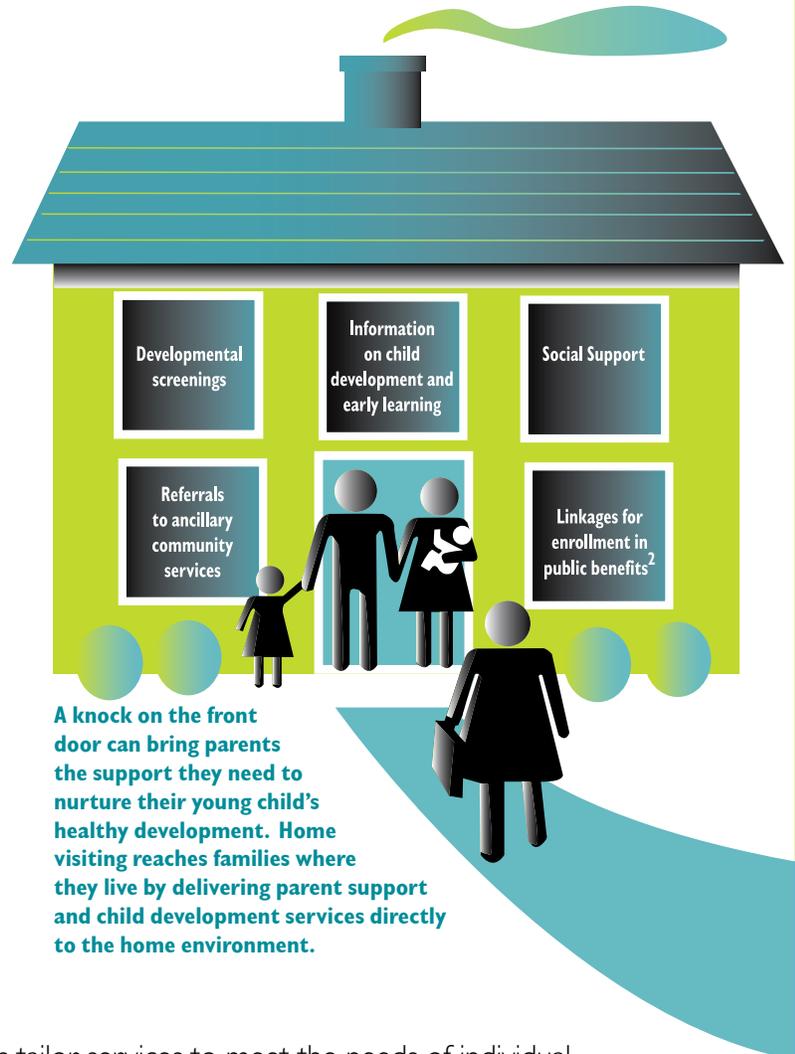
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SUPPORTING PARENTS AND CHILD DEVELOPMENT THROUGH HOME VISITING

Any new parent will likely tell you that parenting is the most rewarding *and* the most difficult thing they have ever done. Especially during the first years of their child's life, parents play the most active and influential role in their baby's healthy development, and it can be difficult to do so without support from others.¹ Unfortunately, many parents face obstacles—such as those caused by stress, language barriers, geographic and social isolation, and poverty—that impact their ability to fully support their baby's development during these critical years. Home visiting can be an effective method of supporting families, particularly as part of a comprehensive and coordinated system of high quality, affordable early care and education, health and mental health, and family support services for families prenatally through pre-kindergarten. These voluntary programs tailor services to meet the needs of individual families, and they offer information, guidance, and support directly in the home environment. While home visiting programs vary in their goals and content of services, in general they combine parenting education, health care education, child abuse prevention, and early intervention and education services for young children and their families. Policymakers should take action to ensure that all families facing obstacles have access to high quality home visiting services as part of a comprehensive and coordinated support system that nurtures their child's healthy development.



FAST FACTS

● High quality home visiting programs can be effective methods of delivering family support and child development services and, depending upon the model implemented, can:

- increase children's school readiness;
- improve child health and development;
- reduce child abuse and neglect; and
- enhance parents' abilities to support their children's healthy cognitive, language, social-emotional, and physical development.³

● **2%** of all children birth to age 5 receive home visiting services each year.⁴

● **32** states currently operate a statewide home visiting program.⁵



Policy Recommendations

- 1. Expand access to high quality home visiting programs that have a proven track record of success.** All parents need support during their child's first years, especially those who face challenges in accessing center-based resources for early care and education, health and mental health, and family support services. Home visiting programs are designed to reach those families who face barriers in supporting their child's healthy development, but many families do not currently have access to high quality research-based programs. Program evaluations have shown promising results for a variety of child and family outcomes for several home visiting models serving infants and toddlers, such as Healthy Families America, the Nurse-Family Partnership, The Parent-Child Home Program, and Parents as Teachers.⁶ Policymakers should expand access and funding for parent support and child development services delivered through home visiting, and they should focus on those models that are grounded in research and have demonstrated successful parent/child outcomes.
- 2. Develop a continuum of care for young children and their families by coordinating home visiting efforts with other child development services in the community.** Thirty-two states are currently operating a statewide home visiting program, yet only 18 states link these home visiting

National Home Visiting Models Serving Infants, Toddlers, and Their Families



Healthy Families America, www.healthyfamiliesamerica.org. Healthy Families America is a national program model built on a set of “critical elements” designed to promote positive parenting, enhance child health and development, and prevent child abuse and neglect for overburdened families. Expectant parents and families with children birth to age 5 participate voluntarily in the program and receive home visiting and referrals from highly trained staff.

The Nurse-Family Partnership, www.nursefamilypartnership.org. The Nurse-Family Partnership is a nurse home visiting program that improves the health, well-being and self-sufficiency of low-income, first-time parents and their children. Each participating mother is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits that continue through her child's second birthday.

The Parent-Child Home Program, www.parent-child.org. The Parent-Child Home Program is a national early childhood literacy, parenting, and school readiness program for families with children 16 months to 4 years who are challenged by poverty and other barriers to school success. The program strengthens families and prepares children for academic success through intensive home visiting focused on building the quality parent-child verbal interaction essential to cognitive and social-emotional development, school readiness, and school success.

Parents as Teachers, www.parentsasteachers.org. Parents as Teachers is an early childhood parent education and family support organization serving families throughout pregnancy until their child enters kindergarten. Delivered through home visits and group meetings, Parents as Teachers' Born to Learn[®] program model is designed to enhance child development, school achievement, and parental involvement through parent education accessible to all families.



programs to other supports for early childhood development at the state level.⁷ Connecting home visiting efforts, particularly those focused on children's well-being and healthy development, with other child and family services in communities will help to ensure that young children and parents have the comprehensive support they need. In instances when parents and children have needs that are not addressed by the home visiting program in which they are enrolled, they should be linked to other resources available in their community, such as high quality child care programs and comprehensive early childhood programs such as Early Head Start, early intervention programs, health assistance programs, and mental health services.

3. Integrate home visiting programs into a broader state early childhood system and infrastructure, and emphasize coordination among home visiting programs.

As policymakers work to expand access and improve home visiting services for young children and their families, they should ensure that services are integrated into a broader state early childhood system, which includes professional development, training, and technical assistance for providers; data collection; program standards; and quality assurance and improvement efforts. Representatives of home visiting programs should work with other such programs within the state and participate in community and statewide collaborative groups to improve the coordination of services for young children and their families across agencies and programs, particularly since some programs have been known to work better for families with certain risk factors. In addition, governors should appoint home visiting representatives to the State Advisory Councils on Early Childhood Education and Care, created by the Improving Head Start for School Readiness Act of 2007, and other state-specific early childhood oversight boards.

4. Ensure that services delivered through home visiting are linguistically and culturally appropriate.

Sixty percent of infants and toddlers with immigrant parents (1.3 million) live in low-income families.⁸ Home visiting may reduce the language and cultural barriers faced by these families and ensure that parents receive the support they need to ensure their child's healthy development. Policymakers and program administrators should ensure that services delivered through home visiting programs are culturally and linguistically appropriate for the children and families served. Program documents should be translated and accessible to families, and home visitors should be trained on the language and cultural needs of enrolled families and be able to work effectively across cultures.



Connecting home visiting efforts with other child and family services in communities will help to ensure that young children and parents have the comprehensive support they need.



5. Assure that all home visiting initiatives incorporate known elements of effectiveness. There is growing consensus on a list of key elements of effective home visiting models that are most likely to achieve outcomes for young children and their families. This list includes: solid internal consistency that links specific program elements to specific outcomes; well-trained and competent staff; high quality supervision that includes observation of the provider and participant; solid organizational capacity; linkages to other community resources and supports; and consistent implementation of program components.⁹ Policymakers should ensure that new home visiting initiatives incorporate these key elements focused on effective design and implementation to ensure high quality and effective service delivery. Additionally, as services are expanded within states, policymakers should ensure that program models are implemented with families that exhibit characteristics similar to those for whom the program has been tested.

6. Support rigorous, ongoing evaluation and continuous improvement efforts for home visiting programs. Program evaluation allows home visitors, supervisors, funders, families, and policymakers to know whether a program is being implemented as designed and how closely it is meeting objectives. This information can be used to continually refine and improve service delivery for young children and their families, as well as provide an evidence-based rationale for the expansion of home visiting programs. When financing home visiting programs, policymakers should ensure that adequate time and funding are included for thorough evaluation.

Research

A growing body of research demonstrates that home visiting can be an effective method of delivering family support and child development services. While home visiting programs share similar overall goals of enhancing child well-being and family health, they vary in their program structure, specific intended outcomes, content of services, and targeted populations. The research presented here highlights the strongest outcomes for infants, toddlers, and their families from the past 10 years of evaluations of several national home visiting models, including Healthy Families America, the Nurse-Family Partnership, The Parent-Child Home Program, and Parents as Teachers.¹⁰ Rather than presenting the research findings by program, we have elected to highlight findings by outcomes to better illustrate the impacts each program has had on children and families.

High quality home visiting programs can increase children's school readiness. The first three years of life are a period of intense intellectual development during which the brain forms a foundation for later learning and development.¹¹ High quality home visiting programs can be an effective service delivery method to support early learning in these years, ensuring that children succeed in school and beyond. When compared to control group counterparts in randomized trials, infants and toddlers who participated in high quality home visiting programs were shown to have more favorable scores for cognitive development and behavior,¹² higher IQs and language scores at age 6,¹³ higher grade point averages and math and reading achievement test scores at age 9,¹⁴ and higher graduation rates from high school.¹⁵ Additionally, two studies using stratified random sampling found that a high quality home visiting program positively impacted school readiness through better parenting practices, increased reading to children at home, and a greater likelihood of enrollment in preschool programs.^{16, 17}



High quality home visiting programs can improve child health and development. The domains of development are inextricably linked during the early years of life, and children need support for their physical, cognitive, and social-emotional development to truly thrive. Randomized trial research demonstrates that high quality home visiting programs can be effective supports for children's healthy development. Compared to control groups, babies of parents enrolled prenatally in home visiting programs had better birth outcomes, and the programs were found to have a positive impact on breastfeeding and immunization rates.¹⁸ In other randomized trials, participating children were found to have a reduction in language delays at 21 months,¹⁹ and fewer behavior problems and increased mental development at age 6.²⁰ Additionally, when compared to control groups, children of teen mothers who participated in a home visiting program showed gains in cognitive development.²¹

High quality home visiting programs can reduce child abuse and neglect. Infants and toddlers need safe and nurturing surroundings in which they can develop and grow. By working with parents in their own environments, home visiting programs can reduce child abuse and neglect. In a randomized trial, a home visiting program reduced physical and psychological abuse after one year of participation and had the greatest impact on first-time and psychologically vulnerable mothers after two years of participation.²² Additionally, compared to control groups, teen mothers who participated in a home visiting program and received comprehensive case management had fewer opened cases of child abuse or neglect.²³ Finally, in an evaluation using pre-post comparisons, home visiting contributed to increasing protective factors associated with the prevention of child maltreatment and neglect in the homes of disadvantaged families.²⁴

High quality home visiting programs can enhance parents' abilities to support their children's overall development. In order to ensure that babies grow up healthy and ready to learn, parents need resources and tools to help them fully support their child's development. In randomized trials, home visiting programs were found to be effective methods for delivering these essential parent support services. When compared to control group counterparts, very low-income parents who participated in a home visiting program were more likely to read aloud, tell stories, say nursery rhymes, and sing with their child.²⁵ Participants in home visiting programs also created more developmentally stimulating home environments,^{26, 27} had more responsive interactions with their children,^{28, 29} and knew more about child development.³⁰ In an evaluation using pre-post comparisons evaluation, positive parent behaviors increased on all indicators for parents participating in a home visiting program, and the number of verbal interactions between parent and child increased significantly during program participation, as did the instances of praise and/or encouragement observed.³¹



In order to ensure that babies grow up healthy and ready to learn, parents need resources and tools to help them fully support their child's development.



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About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at www.zerotothree.org/policy.



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POSITIVE EARLY LEARNING EXPERIENCES

QUALITY INFANT-TODDLER CHILD CARE

With our country facing increasingly tough economic times, and a growing number of mothers entering the labor force to help support their families, child care is more important than ever to families and to the overall health and well-being of our country. Second only to the immediate family, child care is the setting in which early childhood development unfolds for nearly six million children under age 3.¹ Quality child care offers the promise of a solid future by providing our youngest children nurturance, support for early learning and language development, preparation for school, and the opportunity for all infants and toddlers to reach their full potential. Child care is no longer viewed as simply a basic support for parents, but an exciting opportunity to promote the early education of young children. It is also a significant component of the economic infrastructure of states—providing long-term benefits for the government, businesses, and workers in terms of jobs, revenue, and future economic success.²

Research indicates that the strongest effects of quality child care are found with at-risk children—children from families with few resources and under great stress. Unfortunately, at-risk infants and toddlers often receive poor quality child care that can diminish their potential and lead to poor cognitive, social, and emotional developmental outcomes.³ Research suggests that even small improvements in staff ratios and training and modest caregiver compensation initiatives can produce considerable improvements in the observed quality of care for young children.⁴ Yet our nation's child care policies are not being influenced by this knowledge. Federal and state policymakers can act now to ensure that families are able to seize the potential of quality child care for their infants and toddlers.



Continuity of Care

When infants and toddlers are in non-parental care, they need to form a secure attachment to their child care providers in order to thrive. Young children can only form these critical attachments when their child care providers remain stable over time.⁵ Leading experts agree that having one primary caregiver for more than a year, and optimally from entry into child care until the child is at least 3 years of age, is critical for an infant's emotional development.⁶ When a child experiences too many changes in caregivers, it can lead to reluctance to form new relationships.⁷

FAST FACTS

- More than **12 million** infants and toddlers live in the United States—almost half live in low-income or poor families.⁹

- **56%** of mothers with children under the age of 3 are employed.¹⁰

- Each day nearly **6 million** children under 3 spend some or all of their day being cared for by someone other than their parents.¹¹

- More than **40%** of infants and toddlers are in child care classrooms of poor quality.¹²



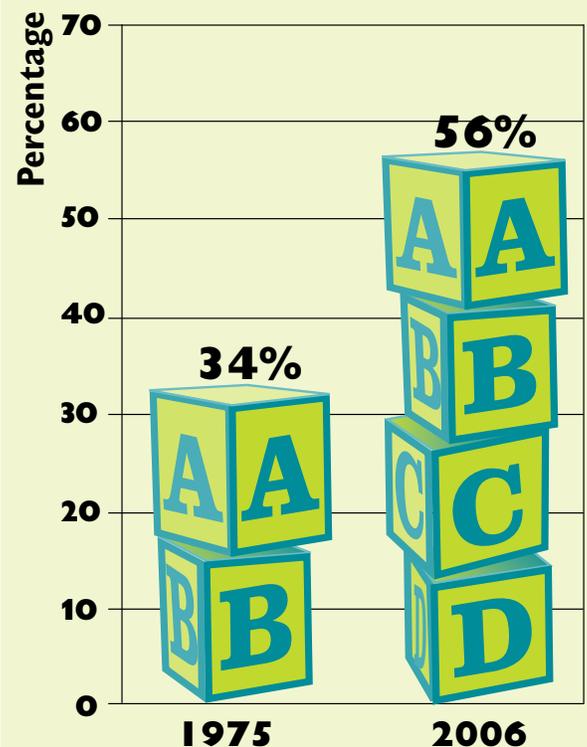
Policy Recommendations

1. Increase funding for the Child Care and Development Block Grant (CCDBG). All babies and toddlers, particularly those living in poverty, need access to quality child care when their parents are at work. Twenty-eight percent of children served through the Child Care and Development Block Grant (CCDBG) are infants and toddlers. Although the recent economic recovery package included 2-year supplemental funding for CCDBG, additional resources will be required to meet increasing demand for services. Federal policymakers should increase funding for CCDBG to help ensure that more low-income infants and toddlers have access to quality child care settings.

2. Substantially increase the infant toddler targeted as funding for CCDBG grows. The infant-toddler targeted funds of the CCDBG, currently allocated through the appropriations process, sets aside funds for activities specifically designed to improve the quality of infant and toddler care. Although the recent economic recovery package included an increase of \$93.6 million to improve the quality of infant and toddler care, additional resources will be required to enhance quality initiatives. Federal policymakers should increase the funds targeted for infants and toddlers and include these funds in the CCDBG reauthorizing legislation to help states invest in specialized infant-toddler provider training, provide technical assistance to programs and practitioners, and link compensation with training and demonstrated competence—all of which enhance quality and, in turn, lead to later school success.

3. Allocate sufficient state funding so that rates can be set at the levels needed for programs to provide high quality infant and toddler care. The amount of funding states choose to make available to pay providers and caregivers for serving subsidized children directly affects the quality of care the children receive, particularly for babies and toddlers.¹⁵ The more funding a regulated child care program or setting receives per child, the more dollars that program can use to attract and retain highly qualified staff and to finance other quality features. High quality licensed infant and toddler care is more expensive for programs to offer,¹⁶ due to additional quality requirements such as fewer children per child care provider; more space per child, special equipment (e.g., cribs), and additional health and safety requirements (e.g., sanitary areas for diaper changing). States should ensure that adequate funding is available so that rates can be set at the levels needed to ensure that programs can provide high quality infant and toddler care.

Percentage of Women in the Labor Force with Children Under 3





4. Improve compensation for providers working with infants and toddlers. Child care programs are struggling to attract and retain well-qualified individuals to work with infants and toddlers because of poor compensation. In 2006, the national average wage for a child care worker was only \$9.05 per hour or \$18,820 annually, below the federal poverty rate, and many child care workers do not receive benefits.¹⁷ Even when child care providers enjoy their work, they often cannot afford to stay in the field. This creates high turnover and instability, which interferes with continuity of care. Federal and state lawmakers should provide more funding to ensure that providers are adequately compensated, which is vital to ensuring the stability of a qualified early childhood workforce.

5. Establish a statewide network of infant and toddler specialists who provide technical assistance and support to individuals who are providing care to children under the age of 3. Many states have created infant-toddler specialist networks to support the infant-toddler caregiver workforce and improve the quality and availability of infant-toddler child care.¹⁸ Infant-toddler specialists typically include child development, mental health, family support, and health professionals. They provide support to caregivers and employ a variety of approaches including mentoring, coaching, consultation, training, technical assistance, and referral.¹⁹ Guidance and support may be provided on issues such as social and emotional health, early development, family support, and program quality. Policymakers should dedicate funds to establish a statewide network of infant and toddler specialists to support the individuals who are providing care to children under 3.

6. Strengthen licensing standards to address the unique needs of infants and toddlers. Licensing standards for regulated child care settings are vitally important to promote key elements needed for high-quality infant-toddler care. Infants and toddlers have unique needs that cannot be ignored when states create their licensing standards. For example, very young children need developmentally appropriate care with higher staff-to-child ratios and smaller group sizes than those for older children. Policymakers should ensure that state licensing standards address ratios/group size, health and safety concerns unique to infants and toddlers, and training specific to very young children, and that state child care agencies monitor and enforce licensing standards.

7. Design Quality Rating and Improvement Systems (QRIS) inclusive of infants and toddlers. Many states are implementing Quality Rating and Improvement Systems (QRIS) to establish a method for both defining and promoting quality in child care settings.²⁰ Importantly, the elements included in the QRIS apply to the care of all children. Given the unique developmental needs of infants and toddlers, their care should be the subject of specialized criteria and standards. For example, states should require that infants are served in smaller group

Policymakers should dedicate funds to establish a statewide network of infant and toddler specialists to support the individuals who are providing care to children under 3.



sizes than toddlers and that principles related to quality care for babies, such as continuity of care and safe sleep policies, are supported. As of May 2008, 17 states had a statewide QRIS—seven of these states required that infants be served in smaller groups than toddlers and six states required lower ratios for infants and toddlers in their QRIS standards.²¹ Policymakers should encourage states to ensure a deliberate focus on babies and toddlers in state QRIS and provide financial resources to help child care providers move toward higher standards.

8.

Provide technical assistance and support for family, friend, and neighbor care (FFN).

Family, friend, and neighbor care (FFN) is the most common form of non-parental care in the United States. Infants and toddlers are most likely to be in relative care as their only non-parental source of care.²² Babies and toddlers from lower-income families are more likely than children from higher-income families to be in FFN care.²³ The quality of FFN care varies. These providers are often isolated and may lack complete—as well as culturally and linguistically appropriate—information about child development. Policymakers should provide technical assistance and support for FFN providers so they can best serve the infants and toddlers in their care.

9.

Support research on assessing infant and toddler child care quality, supply, and demand.

Even though increasing numbers of infants and toddlers are moving into out-of-home care at younger ages and for longer periods of time, we are missing opportunities to continuously improve quality child care that promotes positive child outcomes. Federal and state policymakers should provide funds to support research on assessing infant and toddler child care quality, supply, and demand as well as to help states and communities determine what targeted improvement measures make the most difference for infants and toddlers. In addition, Congress should commission the National Academy of Sciences to determine key components of quality and study the cost of such components in various child care settings.²⁴



The quality of care ultimately boils down to the quality of the relationship between the child care provider and the child; skilled and stable providers promote positive development.



Research

The quality of the relationship between the child care provider and child influences every aspect of young children’s development. The quality of child care ultimately boils down to the quality of the relationship between the child care provider and the child; skilled and stable providers promote positive development.²⁵ A secure relationship between the infant and the caregiver can complement the relationship between parents and young children and facilitate early learning and social development.²⁶ Young children whose caregivers provide ample verbal and cognitive stimulation, who are sensitive and responsive, and who give them generous amounts of attention and support are more likely to be advanced in all aspects of development compared with children who fail to receive these important inputs.²⁷

Quality child care promotes cognitive, language, and social and emotional development. Intensive, high quality, center-based child care interventions that provide learning experiences directly to the young child have a positive effect on early learning, cognitive and language development, and school achievement.²⁸ One of the features that distinguish higher quality care is the amount of language stimulation provided. High quality child care, where providers are both supportive and offer more verbal stimulation, creates an environment where children are likely to show advanced cognitive and language development.²⁹ For virtually every developmental outcome that has been assessed, quality of care also shows positive associations with early social and emotional development.³⁰ Higher quality care is generally related to more competent peer relationships during early childhood and into the school years. It provides environments and opportunities for socialization, problem-solving, empathy building, sharing, and relating.

Quality child care contributes to later school success. Studies that examine children’s development over time have shown that higher quality child care is a predictor of improvement in children’s ability to understand spoken language, communication skills, verbal IQ skills, cognitive skills, behavioral skills, and attainment of higher math and language scores—all of which impact later school success.³¹ Research also indicates that participants in high quality child care and early education programs may also experience lower levels of grade retention and placement in special education classrooms.³²

High quality child care is particularly important to low-income children. Low-income children often start behind their peers when they enter school. When child care is of very high quality (as is the case with model early childhood programs), the positive effects can endure into the early adult years, particularly for children from the poorest home environments.³³ In fact, one study found that children in the second grade who had enrolled in high quality child care demonstrated greater mathematical ability and thinking and attention skills and experienced fewer behavior problems than other children in the same grade.³⁴ Yet, at-risk infants and toddlers often receive child care of such poor quality that it may actually diminish inborn potential and lead to poorer cognitive, social, and emotional-developmental outcomes.³⁵

Research demonstrates that the strongest effects of quality child care are found with at-risk children – children from families with few resources and under great stress.



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INFANTS AND TODDLERS IN EARLY HEAD START

The first three years of life are a period of dynamic and unparalleled brain development in which children acquire the ability to think, speak, learn, and reason.¹ During these first 36 months, children need good health, strong families, and positive early learning experiences to lay the foundation for later school success. Yet not all babies and toddlers are given the opportunities that foster and support their healthy intellectual, social, and emotional development. Young children living in poverty are more likely to face challenges that can negatively impact their development² and create disparities in their cognitive and social abilities well before they enter Head Start or pre-kindergarten programs at age 4. In an effort to ensure that all young children have the same opportunities to succeed in school and life, the federal Early Head Start program was created to support the healthy development of low-income infants, toddlers, and pregnant women. Research shows that Early Head Start makes a positive difference in areas associated with children's success in school, family self-sufficiency, and parental support of child development, but as yet federal funds are reaching only 3% of eligible children and families.³ Given the limited scope of current federal funding, 20 states are now taking action to expand and enhance Early Head Start services to young children and their families.⁴ Policymakers at the federal and state level should build upon these efforts to expand Early Head Start and take leadership roles to ensure that all at-risk infants and toddlers enter school ready to learn and succeed.



What is Early Head Start?

Early Head Start is the *only* federal program specifically designed to ensure that all young children have the same opportunities by improving the early education experiences of low-income infants and toddlers. The mission of Early Head Start is to support healthy prenatal outcomes and enhance the intellectual, social, and emotional development of infants and toddlers to promote later success in school and life. It does so by offering opportunities for early learning experiences, parent support, home visitation, and access to medical, mental health, and early intervention services. This comprehensive approach supports the whole child—physically, socially, emotionally, and cognitively—within the context of the family, the home, and other child-serving settings. All Early Head Start programs must comply with the federal Head Start Program Performance Standards, which were adapted to the unique needs of infants and toddlers when the program was created.

The reauthorization of Head Start and Early Head Start in 2007 provides numerous opportunities to expand and strengthen the program. The new law expands access for infants and toddlers by prioritizing the expansion of Early Head Start as annual appropriations for the overall program grow, and allowing for the conversion of preschool Head Start grants into Early Head Start grants based on local community needs and capacity. The legislation also includes changes to improve the quality of the program, including support for training and technical assistance for Early Head Start grantees, with at least 20% of all Head Start training dollars allocated to Early Head Start programs, and a state-based training and technical assistance system staffed by specialists in infant and toddler development.

FAST FACTS

● **21%** of children under the age of 3 are living in poverty, a number that is growing at a faster rate for infants and toddlers than for older children.⁶

● Low-income infants and toddlers are at greater risk than middle- to high-income infants and toddlers for a variety of poorer outcomes and vulnerabilities, such as later school failure, learning disabilities, behavior problems, mental retardation, developmental delay, and health impairments.⁷

● Children who participated in Early Head Start had significantly larger vocabularies and scored higher on standardized measures of cognitive development than children in a control group who did not participate in Early Head Start. Additionally, Early Head Start children and parents had more positive interactions, and these parents provided more support for learning than did those in a control group.⁸

Policy Recommendations

1. Increase federal and state investment in Early Head Start, and programs modeled on Early Head Start, to ensure that more eligible infants and toddlers can be served.

Unfortunately, only a small portion of low-income children are currently served by federal Early Head Start programs and state Early Head Start initiatives, leaving the majority of eligible infants and toddlers without access to this proven program. Federal and state policymakers should work to expand Early Head Start, so that more at-risk infants and toddlers can receive services early in life when we have the best opportunity to reverse the trajectory of poor development that can occur in the absence of such supports.

2. Establish State Advisory Councils on Early Childhood Care and Education that include a focus on the needs of infants and toddlers.

The Head Start for School Readiness Act of 2007 mandates that governors designate or establish State Advisory Councils to build statewide systems of early care and education for children from birth to school entry. States should examine the existing state coordinating bodies for young children so that they may build upon and coordinate with existing structures and ensure a multidisciplinary membership with both public and private partners. Governors should ensure that infant-toddler issues are a focus of the State Advisory Councils by designating infant-toddler professionals as participants on the councils.

3. Conduct community assessments to determine the needs of eligible children and consider converting preschool Head Start funds to serve more infants and toddlers.

The Head Start for School Readiness Act of 2007 allows for the conversion of preschool Head Start grants into Early Head Start grants based on local community needs and capacity. Since states and communities are increasingly providing services to preschool-age children, some Head Start

Doing The Math

We know that education leads to greater opportunities for success in life. But what if only 3% of the children in our public schools were given the opportunity to learn math? That would significantly limit our children's opportunities to thrive in the workforce, and it would harm our nation's success in an increasingly competitive global market. Early Head Start provides low-income infants and toddlers with opportunities for learning and healthy development that all children need to succeed in school, in the workforce, and in life. Yet federal funding only covers 3% of all eligible infants, toddlers, and pregnant women to receive Early Head Start services.⁵ The math just doesn't add up.





programs no longer have waiting lists and are under-enrolled. Head Start grantees, particularly those in communities served by state pre-kindergarten programs, should assess the needs of eligible children from birth to age 5 and consider converting Head Start funds to serve more infants and toddlers. Programs that apply to provide or are providing services to infants and toddlers with funds previously used for 3- and 4-year-olds should have access to training and technical assistance related to program planning and implementation for infants and toddlers.

4. Ensure high-quality Early Head Start programs through the full implementation of the Head Start Program Performance Standards and staff training and technical assistance.

Research shows that Early Head Start programs that fully implement the Head Start Program Performance Standards have the strongest impacts on both children and parents.⁹ To ensure that high-quality services are provided to young children and their families, federal and state Early Head Start programs should meet all components of the Head Start Program Performance Standards. The federal Department of Health and Human Services and state administrative agencies should provide ongoing training, technical assistance, and professional development for federal and state Early Head Start staff to support their ability to provide services that are reflective of these best practices. Additionally, staff should receive training on the unique social and emotional development of infants and toddlers to help them better identify children at risk for mental health problems.

5. Partner with child care providers to expand Early Head Start services to more children.

Linkages should be built between Early Head Start programs and child care providers to better coordinate federal and state investments and improve the quality of child care. Partnerships make it easier to provide continuity of care for infants and toddlers, allowing them to have a consistent caregiver with whom to build a strong relationship. State Early Head Start initiatives may



Research shows that Early Head Start programs that fully implement the Head Start Program Performance Standards have the strongest impacts on both children and parents.



even provide Early Head Start services through community child care providers, leveraging the federal and state investment in child care and giving providers access to Early Head Start resources, such as training and professional development, which help to improve program quality.¹⁰

6. Support continuous improvement activities through data collection and evaluation.

Continual evaluation of programs is important at the federal, state, and local levels to ensure the maximum effectiveness of Early Head Start. Programs should engage in ongoing data collection and evaluation activities so that they may monitor and improve their implementation of the Head Start Program Performance Standards and the impact of services on participating children and families. State initiatives should ensure that data collection and evaluation requirements are built into state policies to better help programs continually improve their effectiveness and meet the federal Head Start Program Performance Standards.¹¹

7. Conduct research to demonstrate the long-term impacts of Early Head Start.

Without longitudinal research, it is difficult to understand the long-term impacts of Early Head Start on at-risk infants, toddlers, and their families. Funds should be set aside to conduct longitudinal research on Early Head Start, so that federal and state policymakers are able to assess the impact of the program through middle childhood and provide an evidence-based rationale for the expansion of the program.



The reauthorization of Head Start and Early Head Start in 2007 provides numerous opportunities to expand and strengthen the program, particularly for infants and toddlers.



Research

Research demonstrates that Early Head Start is effective. The Congressionally mandated Early Head Start Research and Evaluation Project, a rigorous, large-scale, random-assignment evaluation, concluded that Early Head Start is making a positive difference in areas associated with children's success in school, family self-sufficiency, and parental support of child development. What is most compelling about the Early Head Start data is that they reflect a broad set of indicators across different types of families participating in Early Head Start, all of which show positive impacts. Some highlights of the research include:

- Positive Impacts on Children.** Children who participated in Early Head Start showed statistically significant, positive impacts on standardized measures of cognitive and language development, as compared to control group children eligible for Early Head Start who did not participate. Additionally, Early Head Start children had more positive interactions with their parents than control group children—the children engaged their parents more, and these parents rated their children lower in aggressive behavior than did the parents in the control group.¹² By creating positive outcomes for intellectual and social/emotional development, Early Head Start moves children further along the path leading to greater school readiness.
- Positive Impacts on Parents.** Early Head Start parents were more emotionally supportive of their children and less detached than control group parents, as well as significantly more supportive of language and learning. They also reported less spanking and more positive discipline techniques than parents in a control group who did not participate in Early Head Start. Early Head Start also was found to significantly improve how fathers interacted and related to their children.¹³

A follow-up wave of research demonstrated that a number of the positive impacts for children and parents participating in Early Head Start were still demonstrated two years later, when the children entered kindergarten. Additionally, the follow-up research examined the effects of Early Head Start in combination with pre-kindergarten education, showing that children who attended Early Head Start and formal child development programs between the ages of 3 and 5 experienced the most positive outcomes.¹⁴



By creating positive outcomes for intellectual and social and emotional development, Early Head Start moves children further along the path leading to greater school readiness.



For more information about the State Advisory Councils required by the 2007 Head Start reauthorization, see [*What About the Babies? A Focus on Infants and Toddlers in State Advisory Councils.*](#)

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MAKING HOPE A REALITY

EARLY INTERVENTION FOR INFANTS AND TODDLERS WITH DISABILITIES

The birth of a new baby is a time of great hope and opportunity. This sense of hope is reinforced by science, which has significantly enhanced our knowledge about how infants and toddlers develop and the ways we can support them. We know that the early years establish the foundation upon which later learning and development take place. Although babies grow and develop at different rates, most follow a predictable path and learn to walk, talk, and gain new skills in expected ways. For some young children, however, development unfolds according to a slower timetable or in an atypical fashion. For those infants and toddlers with a disability or developmental delay, intervening early can make all the difference in the world. Early intervention provides services and supports to promote the best possible developmental outcomes, and it enhances the capacity of families to meet their child's needs. For children at significant risk, early intervention can serve as a protective buffer against the multiple adverse influences that may hinder their developmental progress. If the promise of a bright future is to be realized for all young children, policymakers should permanently authorize and adequately fund services of the Early Intervention Program of the Individuals with Disabilities Education Act (IDEA Part C) to ensure the optimal development of infants and toddlers with or at risk of developmental delays.

What Is Part C of the Early Intervention Program for Infants and Toddlers with Disabilities (IDEA)?¹

The Early Intervention Program for Infants and Toddlers with Disabilities, or Part C of the Individuals with Disabilities Education Act (IDEA), is a federal grant program that assists states in operating a comprehensive statewide program of services and supports for children birth through 2 years old with developmental delays, including (at state option) children who are "at risk" of developing a delay or special need that may affect their development or impede their education.

Congress established the Early Intervention program (generally referred to as "Part C") in 1986, and most recently reauthorized the statute in 2004, in recognition of "an urgent and substantial need" to

- enhance the development of infants and toddlers with disabilities;
- reduce educational costs by minimizing the need for special education through

early intervention;

- minimize the likelihood of institutionalization and maximize independent living; and
- enhance the capacity of families to meet their child's needs.

States vary widely in the type of quantitative criteria they use to describe a developmental delay, as well as in the level of delay required for eligibility for Part C services. In addition to identifying children who are experiencing developmental delays or who have a diagnosed physical or mental condition that has a high probability of resulting in development delay, states can choose to provide services to infants and toddlers who would be at risk of experiencing a substantial developmental delay if early intervention services were not provided.

In order for a state to participate in the program, it must assure that early intervention will be available to every

eligible child and his or her family. The governor must designate a lead agency to receive the grant and administer the program and must appoint an Interagency Coordinating Council (ICC) to advise and assist the lead agency. Annual funding to each state is based upon census figures of the number of children, birth through 2 years old, in the general population.

The current IDEA 2004 Statute (P.L. 108-446) for Part C contains many requirements states must meet, and it specifies the minimum components of a comprehensive statewide early intervention system. New proposed regulations for Part C were issued on May 9, 2007, by the Office of Special Education and Rehabilitative Services at the U.S. Department of Education.² These regulations, when issued in their final form, will reflect the changes resulting from IDEA 2004 and provide guidance to states on how Part C is to be implemented.



Policy Recommendations

1. Expand and enhance early identification of infants and toddlers to include greater coordination and collaboration among early childhood providers. The earlier children are identified and provided with carefully designed intervention and family supports, the more they benefit by gains in cognitive, language, and social development, and later in higher academic and life achievement.³ These services and supports best serve children when they are coordinated and collaborative. For example, early screening and identification should include:

- (a) developmental screenings for low-income infants and toddlers under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program;
- (b) the use of standardized screening tools by primary care physicians to monitor child development;
- (c) coordination of screening efforts through a medical home;
- (d) improved information and referral networks;
- (e) health and mental health consultation to child care; and
- (f) collaboration between public health, child welfare and early intervention services to ensure children in the child welfare system are screened.⁴ Additional funding should be provided to support increased screening and referral efforts.

2. Permanently authorize and fully fund Part C of the Individuals for Disabilities Education Act (IDEA). The 2004 reauthorization of IDEA continued Part C as a discretionary grant program without permanent authorization. Additionally, Part C funding is unusually designated as payor of last resort, requiring that all federal, state, local and private resources be exhausted prior to using Part C funds. As states continually struggle with the need to adjust or expand the array of resources to support an integrated early intervention system, they are faced with financing systems that are unstable, inadequate, and complex. It is important to permanently authorize the Part C program with a sufficient and stable base of funding. Doing so will ensure responsive and effective services and supports for infants and toddlers with or at risk of developmental delays or disabilities and their families—significantly boosting the promise of a bright future for children, families, and communities.

FAST FACTS

- Approximately **16%** to **18%** of children have disabilities or developmental delays.⁵

- Infants and toddlers who have been maltreated are six times more likely than the general population to have a developmental delay.⁶ Children entering early intervention are far more likely than the general population to be in foster care.⁷

- More than **50%** of children in early intervention had two or more risk factors; one in five children had four or more. Research suggests that the potential for negative developmental outcomes increases substantially when a child has multiple risk factors.⁸



- 3. Include at-risk infants and toddlers in the state’s definition of eligibility for Part C services.** Part C allows states to provide services to infants and toddlers who are at risk of developmental delay. States may include children with a history of significant biological or medical conditions (e.g., low birth weight or failure to thrive) and/or children who are at risk due to environmental factors such as poverty, homelessness, substantiated child abuse or neglect, parental age, parental illegal substance abuse, and parental mental illness. As of February 2008, only five out of 56 states and territories serve at-risk children, even though it is well documented that young children with multiple risk factors are the most vulnerable to poor health and development.⁹ States should expand their definitions to include these at-risk infants.

- 4. Fully implement the Part C and the Child Abuse Prevention and Treatment Act (CAPTA) mandates requiring states to refer to Part C all children under the age of 3 with substantiated cases of abuse, neglect, and drug exposure.** Both the IDEA 2004 and CAPTA 2003 reauthorizations require state early intervention and child welfare systems to establish coordinated procedures for the referral of substantiated cases of abused, neglected, or illegal drug-exposed infants and toddlers to Part C services.¹⁰ Infants and toddlers who have been maltreated are far more likely than the general population to have a developmental delay.¹¹ States should take steps to fully implement these mandates by structuring collaboration between Part C and child welfare agencies and by increasing staff training.

- 5. Expand access to inclusive early care and education experiences for infants and toddlers across diverse settings.** Infants, toddlers, and their families thrive when they are able to live, learn, and play in the “natural environments” in their own communities—including the settings in which children without disabilities participate. To ensure inclusive experiences, children with disabilities and developmental delays should have full access to early care and to education, health, social, and recreational services. Successful inclusion requires collaboration at all levels, appropriately trained personnel, cultural responsiveness, and a framework that emphasizes parent-child and peer interactions in typical routines and natural environments.¹²



1 in 3 infants and toddlers who received early intervention services did not later present with a disability or require special education in preschool.¹³



6. Invest in the professional development of the early intervention workforce. Research clearly links well-trained and qualified providers to better child outcomes. Expert consultation and training for providers is necessary to effectively support infants, toddlers, and their families who confront significant child developmental disabilities, experience special health care and mental health needs, or face the stresses of poverty, substance abuse, and child maltreatment.¹⁴ Training should be targeted to (a) building expertise in early social-emotional development and mental health; (b) training providers from different cultural, ethnic, and racial backgrounds and preparing them to meet the needs of diverse populations; and (c) developing and implementing a set of standards for early intervention practice.

Research

Earlier identification and intervention is more effective and less costly. The science of early development highlights the remarkable opportunities to optimize child development. During the earliest months and years of life, the architecture of the brain is being built at an unparalleled rate in response to nurturing early experiences.¹⁵ Early identification and intervention for children with developmental delays or disabilities can improve cognitive and social skills, lead to higher achievement and greater independence, and promote family competence and well-being.¹⁶

Supporting a family's capacity to understand and enhance their baby's unique development positively influences both parents and children. Supportive and caring relationships between babies and caregivers have a significant and enduring influence on young children's growth and development.¹⁷ Many studies have documented the link between early loving, secure relationships and a child's self-esteem, confidence, and ability to communicate, deal with stress, develop positive relationships, develop a conscience, and learn.¹⁸ We know that families are central to their children's development. It is through relationships



During the earliest months and years of life, the architecture of the brain is being built at an unparalleled rate in response to nurturing early experiences.¹⁵



that babies discover who they are and how to interact with others. Families of young children with developmental disabilities can be confronted with many challenges and stressors that can compromise their ability to foster their child's health and development. Child development, as well as parental well-being, is enhanced when parents and other caregivers are encouraged to understand each child's unique characteristics and respond with sensitivity and warmth.

Programs that combine support for families with carefully designed services for young children appear to have the greatest impact. Intervention is most effective when approached from a whole-child perspective. Multigenerational programs that focus on relationship-building and parent-child interactions, while providing carefully and individually designed programs for young children, can positively impact both children and parents.¹⁹ Comprehensive services in home and community settings provided by highly qualified staff, tailored to individual child and family needs and interests, embedded in typical family routines, and coordinated across agencies and systems have the most promise for the best developmental and societal outcomes.²⁰

For more information about developmental screening of infants and toddlers, see [*Achieving the Promise of a Bright Future: Developmental Screening of Infants and Toddlers.*](#) For more information about infants and toddlers in foster care, see [*Securing a Bright Future: Infants and Toddlers in Foster Care.*](#)



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SYSTEMS

COMPREHENSIVE, COORDINATED SYSTEMS

America's future success is directly tied to the healthy development of today's youngest children. The early experiences of our young children will shape the architecture of their brains in enduring ways and build the foundation—whether strong or weak—for their own development and that of our nation. To ensure a good start in life, all children need access to high-quality and affordable early care and education, physical and mental health, and family support. Programs and services that address these areas are essential, yet they are only as strong as the infrastructure that supports them. To be effective, programs must be organized within cohesive systems that coordinate and align a broad array of services. We envision a nation that supports the healthy development of all children within their states and communities by providing comprehensive, coordinated, well-funded systems of high-quality, prenatal-to-5 services that foster success in school and life.¹ Federal and state policymakers can help make this vision a reality so all children will have a good start in life.



Programs and Services for Infants and Toddlers

A model early childhood system includes the following interrelated programs and services for infants and toddlers:²

Physical and mental health services:

- Health insurance coverage
- Prenatal care
- Primary and preventive care, such as well-child visits
- Guidance for parents to support children's healthy development
- Developmental screenings to identify physical and behavioral needs

Family support services:

- Parenting education
- Economic supports to meet families' basic needs
- Supportive work and family policies such as paid family leave
- Special supports for families in crisis

Early care and education:

- Quality child care programs in a variety of settings
- Early Head Start
- Early intervention for children with special needs

Beyond a simple menu of programs, however, services must be high quality, culturally responsive, accessible and affordable to all children and families who need them, and seamlessly integrated within an early childhood system.³ Any effective approach to developing services for infants and toddlers must be grounded in a comprehensive vision of the prenatal-to-5 system.



The Need for a System

The decisions we make now directly impact our children and our children's children. If we hope to leave things better for the next generations, we must ensure the healthy early development of all our children. In addition to increasing the availability of high-quality, affordable services for young children, it is essential that we develop the infrastructure that supports them. A comprehensive system is key to assuring that:

Families with young children can rely on a coherent system of supports to aid their development. Currently, child care, health care, and other family supports and services are rarely coordinated and are too frequently divided by where families live, how rich or poor they are, and whom they know.⁴ For example, a child with delays in development may go to a well-child health care visit but may not be referred to an early intervention program. Or, parents with a child in a child care center may not know that there are parenting education and family support programs to help them handle their child's behavior issues. If services and supports are made widely available, all children will be more likely to achieve success in school and life.

Families can access needed services. If a system is in place, families will have the necessary information to find appropriate services for their babies and themselves. High-quality programs will be open to all who need them, will be available at convenient locations and times, and will take into account the family's cultural values. The proven effectiveness of prevention programs will be widely recognized.

Programs are integrated, coordinated, and well-funded. Programs to serve young children and their families have historically been developed in "patchwork" fashion in response to specific needs. They frequently are underfunded and have separate funding sources, standards and regulations, and governance structures. Then, when a different need arises, the process is repeated. Over time, a labyrinth of discrete programs has developed, with conflicting policies, inconsistent quality and accountability, and uneven investment.⁵ In a well-aligned system, programs will be seamlessly integrated and supported by stable and sufficient funding.

A comprehensive array of services is available for infants, toddlers, and their families.

No one intervention can provide the wide range of services needed to ensure that all infants and toddlers develop to their full potential. In addition to individual programs, comprehensive systems of quality services, supportive policies, and coordinating infrastructure must be established.⁶ Creation of a system to support infants and toddlers has lagged, and babies are still frequently an afterthought. However, intentional focus on building systems of services can ensure that our very youngest children thrive and succeed.

Policymakers increasingly want to know if children are learning, if programs are effective, and if public funds are being spent wisely.



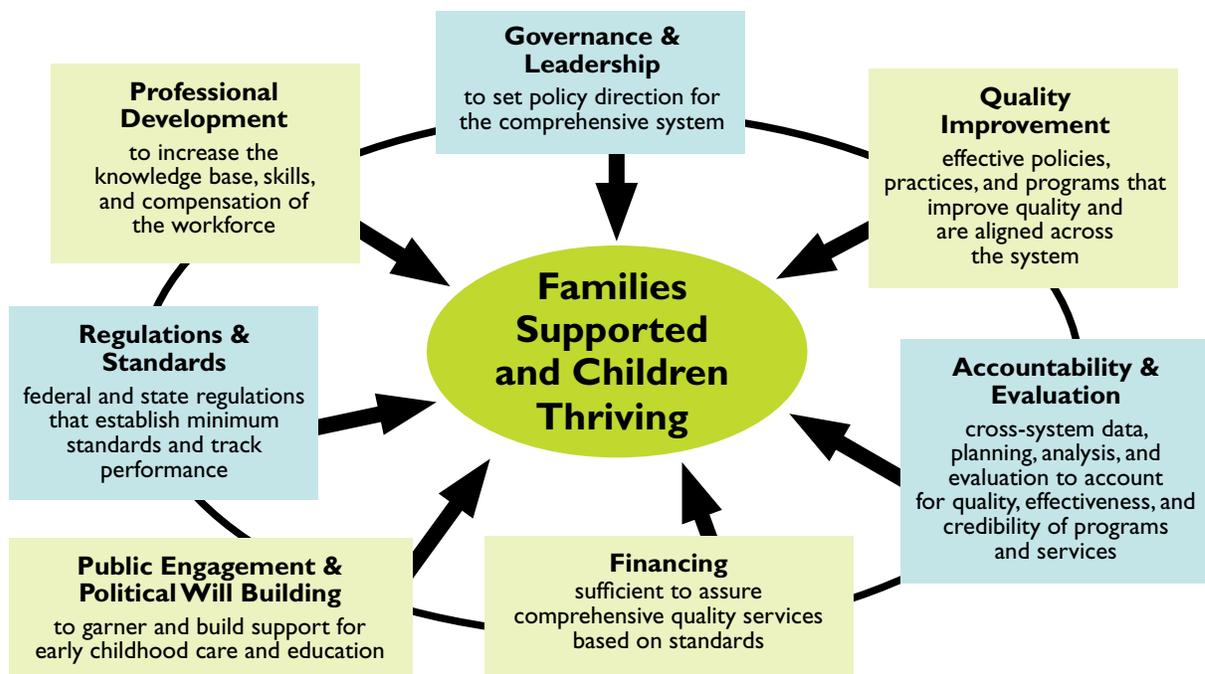
Elements of a System

To work in a coordinated fashion, services for infants and toddlers must be supported by an infrastructure that includes the following core elements:

Governance and Leadership establishes an overall vision and sets policy direction for the comprehensive system. It refers to the structures and people charged with planning, implementing, and managing early childhood services and programs. Such structures must have sufficient authority to ensure cross-agency collaboration. Some states are trying to better coordinate governance by: (a) combining agencies/divisions into a new state early childhood department; (b) establishing state-level cross-agency Children’s Cabinets, commissions, or councils to plan, coordinate, and integrate programs and services; (c) creating public-private partnerships in which state government partners with private entities to fund early childhood initiatives; and (d) establishing local early childhood governance structures.

Quality Improvement refers to state policies and practices that improve the quality of services and programs for young children and their families. Quality improvement initiatives should be aligned across the system. Examples include: (a) requiring high quality program standards; (b) establishing early learning guidelines that clarify what young children are expected to know and do; (c) establishing a Quality Rating and Improvement System (which includes infants and toddlers) to assess, improve and communicate the level of quality in an early care and education setting by awarding quality ratings and funding based on quality standards; (d) creating networks of Infant-Toddler Specialists to assist programs in caring for young children; and (e) providing health and mental health consultants to offer specialized expertise to programs.

Core Elements of an Early Childhood Development System



Adapted by ZERO TO THREE from the Early Childhood Systems Working Group slide



Accountability and Evaluation includes cross-system planning, data collection and analysis, and evaluation. It refers to how states and the federal government account for the quality, effectiveness, and credibility of early childhood programs and services. Policymakers increasingly want to know if children are learning, if programs are effective, and if public funds are being spent wisely. Strategies include: (a) setting standards by which to measure program quality; (b) assessing quality through program evaluation and monitoring; (c) assessing children's development; (d) using data in decision-making; and (e) developing and implementing a cross-agency early childhood data system to track and evaluate outcomes.

Financing refers to all the funding sources and mechanisms that support both services and infrastructure. Many federal, state, local, and private financing supports are used, such as block grants, discretionary funding, project-specific funding, tax strategies, lottery proceeds, set-asides, endowments, loan funds, and public-private funding partnerships. It is important to have sufficient and flexible funding to assure comprehensive and quality services. Financing sources must be coordinated to leverage resources and best meet the needs of young children.

Public Engagement and Political Will Building refers to policies and strategies employed to garner public and political support for infant and toddler services. Strategies include: (a) developing public engagement campaigns with effective, strategic, and evidence-based messages for various audiences; (b) engaging "unlikely" or new partners, such as the business, economic development, law enforcement, and labor communities; (c) developing public-private partnerships; and (d) collaboratively engaging in strategic planning to develop a policy agenda and be ready to take advantage of opportunities.

Regulations and Standards refers to federal and state requirements that establish minimum standards for programs and services and monitor performance. Federal legislation governs Head Start and early intervention programs. State regulations govern child care programs, and there are state regulations to meet federal early intervention requirements. Monitoring by the appropriate authorities provides a way to track program performance and results based on the standards.

Professional Development increases the knowledge base, skills, and compensation of the early childhood workforce through adequate and appropriate pre-service and in-service coursework and training. Examples of professional development strategies include: (a) Infant-Toddler Credentials; (b) statewide professional development systems that include a set of core competencies and a career pathway; (c) training programs linked to college credit; (d) scholarship and wage enhancement strategies; and (e) enhanced higher education and articulation programs.

Programs and services
for infants and toddlers
are only as strong as
the infrastructure that
supports them.



Policy Recommendations

1.

Create a shared systemic vision for supporting our youngest children and their families.

States and our nation as a whole will benefit when we make a collective commitment to build an early childhood system that promotes high-quality services, coordinates programs for infants and toddlers across agencies, strengthens professional development, and simplifies access to services for families. To do this, we need broader public and political support for a systems approach to expanding and improving services.

2.

Increase federal and state investments in building a coordinated system of services for infants, toddlers, and their families.

It is important to balance investments across various types of services and system elements and to provide adequate and stable funding. Funding for existing evidence-based programs must be increased and protected. New funding streams should fill identified gaps, be less categorical and more flexible, and include dollars for infrastructure as well as services.

3.

Establish collaborative planning and decision-making structures at the federal, state, and local levels to increase coordination across services for young children.

Collaborative structures are strongest when they involve diverse representation from stakeholders interested in infants and toddlers from both public and private sectors. In some states, the collaborative entities are public-private partnerships, which bring additional resources and promote a focus on accountability and continuous improvement. Connections between federal, state, and community collaborations build capacity, maximize resources, and promote policies that support a shared vision.

4.

Develop comprehensive early childhood plans, which include a focus on infants and toddlers, at state and community levels.

When early childhood plans are comprehensive, they address all types of services and system elements and place the necessary emphasis on the unique needs of infants and toddlers. Plans should include action steps, which focus on incremental strategies aligned to the overall plan. Plans become “living documents,” allowing states and communities to review and update them regularly to reflect changing needs and priorities.



Collaborative structures are strongest when they involve diverse representation from stakeholders interested in infants and toddlers from both public and private sectors.



- 5. Establish desired outcomes for infants and toddlers, and monitor key indicators associated with these outcomes.** Measures of young children’s health, development, and well-being transcend multiple programs and services. As such, it is critical that cross-agency information systems are developed and maintained to monitor outcomes and provide data for continuous improvement. With ongoing program evaluation, it is possible to demonstrate accountability and effectiveness.
- 6. Implement a cross-sector early childhood professional development system to support the infant-toddler workforce.** Since services for infants and toddlers are provided through a variety of programs in diverse settings, workforce development must cross all service sectors. An integrated professional development system incorporates personnel preparation and training around evidence-based core competencies, articulates into college degrees, includes alternative pathways to credentials, and links higher levels of training to increased compensation.
- 7. Promote linkages between various programs and services for infants, toddlers, and families.** Bridges can be built between programs that traditionally operate in silos through approaches such as Early Head Start/child care collaborations, health and mental health consultants to early childhood programs, and child development specialists in the child welfare system. Linkages should also be made to help families, particularly those with at-risk children, access needed services and supports.
- 8. Align new programs with existing services rather than creating parallel efforts.** As new initiatives are proposed, it is helpful to assess the potential opportunities and possible consequences so alignment and comprehensiveness are in place from the beginning. When efforts are well integrated, support for one program or element can translate into support for the system at large.

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About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at www.zerotothree.org/policy.



1 Jennifer Doctors, Barbara Gebhard, Lynn Jones, et al., *Common Vision, Different Paths: Five States’ Journeys toward Comprehensive Prenatal-to-Five Systems*. Washington, DC: ZERO TO THREE and Pre-K Now, 2007.
 2 The Early Childhood System Builders’ Workgroup, a group of national organizations and experts, conceptualized what a comprehensive system would look like, and ZERO TO THREE’s vision of a system is adapted from their work.
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A FOCUS ON INFANTS AND TODDLERS IN STATE ADVISORY COUNCILS

During the first years of their child's life, parents play the most active and influential role in their baby's healthy development, and yet that can be difficult without support from others.¹ Particularly in these difficult economic times, a substantial number of young children live in families facing financial and social stresses that place them at risk developmentally. Policymakers at both the federal and state levels are recognizing these challenges and the need to create a comprehensive system of services for young children. However, while the concept of providing pre-K is readily grasped, the needs of infants, toddlers and their families are not as widely understood. Just as a baby's needs and abilities are far more complex than is readily apparent, a comprehensive approach to ensuring their optimal development is equally multifaceted and crosses several domains—health, mental health, education, and social services.

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Moreover, a system for very young children must provide support for parents as they take on the challenging task of raising children. States struggle to promote coordination among the multiple services and supports for young children and their families, as well as to improve their quality and make them available to all who could benefit.

Therefore, as part of the Head Start reauthorization bill passed into law in 2007, federal lawmakers required the creation of State Advisory Councils on Early Childhood Education and Care. This paper provides an overview of states' current coordinating and governance structures and lessons learned from analyses done by leading organizations. It describes the new requirements for State Advisory Councils and related decisions to be made by states. The paper offers guidance to states on including a focus on infants and toddlers as they make decisions about the formation of State Advisory Councils and the activities of those Councils. The State Advisory Councils in four states—Connecticut, New Mexico, Ohio, and Virginia—are profiled as examples of varying approaches taken to meet the requirements in the Head Start reauthorization law.

Current Early Childhood Coordinating and Governance Structures

Over the years, states have established various planning and governance structures, including task forces, commissions, councils, cabinets, public-private partnerships, and new state agencies or departments. The specific scope, purposes, and functions differ from state to state and among different structures in the same state. Some are focused on a particular population or type of program. Some manage a new initiative or funding stream. Others aim to improve coordination and integration of a wide variety of services and supports.

Many states have established early childhood advisory councils to promote cohesive services for young children. The National Governors Association Center for Best Practices surveyed states in the fall of 2007 regarding the presence and nature of state early childhood advisory councils. Of the 36 states that responded, 31 reported having an early childhood advisory council; 6 of the 31 had multiple coordinating entities. Over two-thirds (68%) were established after 2000. The primary focus of most councils is coordination, and their most prevalent activities are related to professional development, early learning outcomes and standards, and assessment of the availability of high-quality birth to 5 services.²

The 2007 Head Start reauthorization directs the Governor of each state to designate or establish a State Advisory Council on Early Childhood Education and Care for children from birth to school entry.



Lessons Learned from Analyses by Leading Organizations

There is no “right” approach or structure to establishing an early childhood coordinating and governance entity, but leading organizations in the field offer some guidance for states.

Attributes

The State Early Childhood Policy Technical Assistance Network and the Build Initiative recommended that a governance structure have five attributes:

1. **Representative**—involving those whose perspectives, talents, and positions are needed to make effective decisions
2. **Legitimate**—regarded as a fair and appropriate locus for decision-making by those affected by the decisions made
3. **Enduring**—sustainable across changes in membership and in state or local political leadership
4. **Effective and flexible**—organized and structured for continuous learning and quality improvement
5. **Authoritative**—capable of holding the system accountable³

Critical Elements, Change Strategies, and Structural Characteristics

The Forum for Youth Investment’s Ready by 21™ Change Model identified two critical elements for children’s cabinets and councils—**stakeholder engagement** and **shared accountability**—and four integrated change strategies:

1. **Engage youth and their families.**
2. **Increase demand.**
3. **Align policies and resources.**
4. **Improve services.**

The Forum asserted that a council’s effectiveness is also influenced by its structural characteristics: **scope and mission, organizational home, authority, staffing and resources, composition and scale,** and **parallel local structures.**⁴

Lessons on Collaborative Work

In *State Advisory Councils: Creating Systems of Early Education and Care*, Pre-K Now profiled early childhood advisory councils in four states (Illinois, Nebraska, New Mexico, and Wisconsin) and described eight lessons from their collaborative work:

1. **Begin with a broad vision.**
2. **Cultivate champions.**
3. **Seek broad support and state legislation.**
4. **Build on successes; don’t reinvent the wheel.**
5. **Nurture strong relationships between individuals.**
6. **Balance collaborative leadership with results.**
7. **Stimulate and respond to local innovation and lessons.**
8. **Build broad public awareness and support.**⁵

An overarching or umbrella structure, which has the authority and leadership needed to ensure a coordinated approach across organizational entities, can effectively plan, promote, and implement a comprehensive agenda for young children. Recent federal requirements offer an opportunity to establish a new structure or enhance an existing one to assure collaboration among various early childhood programs.



State Advisory Councils on Early Childhood Education and Care

The Improving Head Start for School Readiness Act of 2007 (Head Start reauthorization) directs the Governor of each state to designate or establish a State Advisory Council on Early Childhood Education and Care for children from birth to school entry. Governors may designate an existing entity to serve as the State Advisory Council, and representatives are to be appointed at the Governor's discretion. To the maximum extent possible, membership must include the State Head Start Collaboration director and representatives from the state child care agency; the state educational agency; local educational agencies; institutions of higher education; local providers of early childhood education and development services; Head Start agencies, including migrant and seasonal Head Start programs and Indian Head Start programs; the state agency responsible for programs under section 619 or Part C of the Individuals with Disabilities Education Act; the state agency responsible for health or mental health care; and other entities determined to be relevant by the Governor.

Responsibilities of the State Advisory Council include the following:

- **Conducting a periodic statewide needs assessment concerning the quality and availability of early childhood education and development programs and services for children from birth to school entry**
- **Identifying opportunities for, and barriers to, collaboration and coordination among federally funded and state-funded child development, child care, and early childhood education programs and services**
- **Developing recommendations for increasing the overall participation of children in existing child care and early childhood education programs**
- **Developing recommendations regarding the establishment of a unified data collection system for public early childhood education and development programs**
- **Developing recommendations regarding statewide professional development and career advancement plans for early childhood educators**
 - **Assessing the capacity and effectiveness of 2- and 4-year public and private institutions of higher education to support the development of early childhood educators**
 - **Making recommendations for improvements in early learning standards and undertaking efforts to develop high-quality comprehensive early learning standards**

A baby's needs and abilities are complex, and therefore a comprehensive approach to ensuring their optimal development must be equally multifaceted and cross several domains – health, mental health, education and social services.

Councils are required to hold public hearings that offer an opportunity for public comment and to submit a statewide strategic report. The State Advisory Council must meet periodically to review implementation of the report's recommendations.



The 2007 Head Start reauthorization also included a provision for one-time, three-year start-up grants to be awarded to states on a competitive basis. Grants would be \$500,000 or more and would require a 70% state match. Funds could be used to develop or enhance high-quality systems of early childhood education and care by:

- **Encouraging families and caregivers to support their children's development and early education**
- **Supporting professional development, recruitment, and retention of early childhood educators**
- **Enhancing existing early childhood education and development programs and services**
- **Carrying out other activities consistent with the state's plan**

Eligible states would submit an application that would include the statewide strategic report.⁶

Grants will be available only in years when the Congressional appropriation for Head Start is sufficient to cover a variety of essential program activities. No funding for State Advisory Council grants was made available in FY 08. Regulations providing greater detail about State Advisory Councils and other requirements in the 2007 Head Start reauthorization have not yet been released by the U.S. Department of Health and Human Services as of December 2008.





Establishing State Advisory Councils: Implications for Infants and Toddlers

RECOMMENDATIONS IN BRIEF

- **Take a broad view in defining the existing system.**
- **Assure that the Council's organizational home and staff have knowledge of infant-toddler issues.**
- **Appoint some Council members with specific infant-toddler expertise.**
- **Promote the inclusion of infant-toddler representation on local coordinating and planning bodies.**

State Decisions in Establishing Councils

When Head Start was reauthorized in 2007, the Improving Head Start for School Readiness Act required the governor of each state to designate or establish a State Advisory Council on Early Childhood Education and Care for children from birth to school entry. While the legislation includes a number of requirements for State Advisory Councils (see pages 4-5), each state has the latitude to make decisions about the actual implementation of its Council. Many of the decisions that states must make relate to structural characteristics, as identified by the Forum for Youth Investment.

Scope and mission: Although federal law directs Councils to cover birth to school entry, states may choose a broader age range. They may include prenatal, at one end of the age continuum, and/or children through 8 years or a particular grade, at the other end. Decisions about scope and mission also relate to the breadth of the early childhood system to be addressed by the State Advisory Council. The Early Childhood System Builders' Workgroup, a group of national organizations providing technical assistance to state leaders on building early childhood systems, has conceptualized a comprehensive system as including health, mental health, and nutrition; family support; early learning; and special needs/early intervention. States should clarify the relationship of the State Advisory Council to other existing coordinating bodies such as Part C early intervention interagency coordinating councils, advisory committees to the Early Childhood Comprehensive Systems planning or the Head Start State Collaboration Project, or P-16/20 councils. The scope and mission must be clearly articulated and understood.

Organizational home: States will need to decide where the State Advisory Council will be housed. If an existing entity is designated, its organizational home may have already been determined. Councils may be housed in the Governor's Office, another state agency, or a freestanding organization outside government. If a council is associated too directly with a single state agency, its neutrality may be compromised. Other factors to consider in choosing an organizational home are its ability to offer credibility, legitimacy, leadership, and capacity.⁷

Authority: The State Advisory Council's authority relates to two aspects: the creation of the body and its power to influence decisions. Although the Governor must designate the Council, he/she may do so through legislation or executive order. Establishing the Council in statute creates investment by the legislature and can increase the Council's permanence, while an executive order may give the Council more flexibility.⁸ Optimally, the State Advisory Council will be given the authority to make planning and implementation decisions, influence policy, and direct resources.⁹

STATE PROFILE: CONNECTICUT

Early Childhood Education Cabinet



With Governor M. Jodi Rell as champion, Connecticut's legislature passed a bill in 2005 creating the Early Childhood Education Cabinet. The goals of the Cabinet are to ensure that babies born in 2006–07 and beyond:

- Reach age-appropriate milestones each year, birth to 5
- Enter kindergarten healthy and ready for school success
- Achieve the state's expected academic goal for reading performance in the fourth grade

The Cabinet began working in September 2005 to develop a multi-year early childhood investment framework for children from birth to age 9.

Members of the Early Childhood Education Cabinet include the heads of major state agencies, legislators, and representatives from the Connecticut Commission on Children, the School Readiness Council, and the Head Start Association. The Cabinet is co-chaired by the Governor's Senior Policy Advisor for Children and Youth and the Commissioner of Education. An Office of the Cabinet is staffed by three persons, and the Department of Education serves as the fiduciary agent. The work of the Cabinet is funded through state appropriations as well as co-investors from the philanthropic sector.

In February 2006, Governor Rell issued an executive order to create the Governor's Early Childhood Research and Policy Council, a 31-member panel of public and private leaders staffed by the Connecticut Economic Resource Center. The Council was tasked with creating a multi-year early childhood investment plan based on the priorities of the Cabinet. In addition, the Council was charged with advising the Cabinet on research findings, policy solutions, and strategic financing opportunities related to early childhood.

In July 2006, the Cabinet adopted Ready by Five, Fine by Nine: Connecticut's Early Childhood Investment Framework, which prioritized 50 action items related to the goals into 10 top priorities. The Research and Policy Council then developed a five-year cost-modeling plan, the Connecticut Early Childhood Investment Plan: Part I, adopted in November 2006.

The Cabinet's accomplishments include:

- Establishing minimum and a range of higher quality standards for early childhood programs receiving state funds
- Completing an early childhood workforce development plan
- Developing an accountability plan anchored in Results Based Accountability
- Designing an early childhood information system that includes child, teacher, and program data
- Making recommendations on data interoperability
- Partnering with foundations to support statewide parent leadership training and the development of early childhood strategic plans in 24 communities

Much of the Cabinet's work has been done through workgroups, one of which focused on the development of a birth to 3 systems framework. Its report, *First Words, First Steps: Connecticut's Infant-Toddler Systems Framework*, contains policy recommendations in the areas of maternal health, family support, physical and mental health, early care and education, early literacy, and systems innovation. The framework was reviewed at local forums, introduced during the Governor's Summit on Early Childhood, and approved by the Cabinet in September 2008. Some of the recommendations are already being implemented, such as the development of early learning guidelines for infants and toddlers that are aligned with standards for older children.

This work will continue through the newly established Standing Committee for Birth to 9 Services Integration, which will also function as the State Advisory Council on Early Childhood Education and Care under the Head Start Act of 2007. This committee has been charged by the Cabinet with building systemic relationships across areas of service and support. The committee will examine the systems implications of various Cabinet policy reports, present information on best practices in systems development at the community level, and identify policy issues related to developing an early childhood system that require Cabinet or agency attention.

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Staffing and resources: Federal statute requires that the Governor designate an individual to coordinate the activities of the State Advisory Council. Having sufficient staff, who have an understanding of both early childhood and the collaborative process, is critical to moving the Council's work forward. Staff may be designated from a state agency or other organization as an in-kind contribution but must be given adequate time and authority to manage the work. Resources to support the staffing and other costs may come from state funds or in-kind contributions (potentially from multiple state agencies), private foundations and donations, and/or federal funds such as the Early Childhood Comprehensive Systems grant, Head Start State Collaboration Project, Part C of the Individuals with Disabilities Education Act, or the quality portion of the Child Care and Development Fund.

Composition and scale: Federal law specifies particular state agencies and other programs that must be represented on the State Advisory Council. The only position specifically named is the **state director of Head Start Collaboration**, but representatives of state agencies responsible for the following programs must also be included:

- Child care
- Education
- Programs under section 619 (3 to 5 years) or Part C (0 to 3 years) of the Individuals with Disabilities Education Act
- Health or mental health

The Governor must also appoint representatives of:

- Local educational agencies
- Institutions of higher education
- Local providers of early childhood education and development services
- Head Start, including migrant and seasonal Head Start and Indian Head Start programs



State advisory councils should appoint some Council members with specific infant-toddler expertise.



States may add other members determined by the Governor to be relevant to the Council's work.¹⁰

Decisions about additional members should consider an appropriate mix of public and private stakeholders, expertise to cover all areas of the Council's mission and tasks, geographic and cultural diversity, and liaisons with other related efforts. In his "Template for Creating State Advisory Councils on Early Education and Care," Regenstein suggests including representatives from different levels of the policy process:

- **Powerful elected and appointed officials (legislators, state school superintendents or board members)**
- **Political translators (gubernatorial and legislative staff, lobbyists)**
- **Policy translators (state early childhood staff, policy analysts at advocacy and membership organizations)**
- **Program personnel and line staff (direct service providers)¹¹**

Size of the Council is another consideration. Councils must balance the need for inclusivity with the desire to manage the work without becoming too unwieldy. One way to involve others without creating an overly large Council is to develop committees, workgroups, or advisory councils that include individuals who are not members of the Council itself.

Parallel local structures: State Advisory Councils can help ensure that collaboration occurs at the community level, where most services are ultimately delivered. At a minimum, Councils need to be aware of and seek input from local coordinating and planning bodies. They may choose to intentionally support the development of such structures through resources and technical assistance. Strong partnerships between the Council and local bodies can give communities a voice in state-level decision-making and serve as laboratories for testing new state-local approaches to service planning and delivery.¹²



Unless the needs of infants and toddlers receive specific attention, they are often left out of more general discussions.



Focusing on Infants and Toddlers in Establishing Councils

Many of the considerations in establishing State Advisory Councils pertain to the broad system covering all children from birth to school entry. However, unless the needs of infants and toddlers receive specific attention, they are often left out of more general discussions. The following recommendations assist states in focusing on very young children as they create or designate councils.

Take a broad view in defining the existing system. Just as a baby's growth encompasses social and emotional as well as physical and cognitive development, the programs and services to meet their needs include health, mental health, and family support in addition to early care and education. In considering the Council's scope, states should define the system broadly.

Assure that the Council's organizational home and staff have knowledge of infant-toddler issues.

While Councils' auspices will vary between states, it is critical that the agency or organization sponsoring the Council have some expertise related to very young children. Likewise, staff should be knowledgeable about the needs of infants, toddlers, and their families.

Appoint some Council members with specific infant-toddler expertise. The Council should include stakeholders involved in the infant-toddler field from both public and private sectors. They might include:

- Practitioners working directly with babies and their families through child care centers, family child care, and family, friend and neighbor care; Early Head Start; home visiting; Part C early intervention; or other programs
- Clinicians whose practices specialize in infants and toddlers, such as pediatricians or infant mental health specialists
- Researchers and academicians studying or teaching infant-toddler development
- Families with children under 3 years

Any committees or subgroups established by the Council should also include infant-toddler representatives.

Promote the inclusion of infant-toddler representation on local coordinating and planning bodies.

Similarly to state-level Councils, local collaborative groups should involve programs and individuals with infant-toddler expertise. If the State Advisory Council provides resources to parallel local structures, this can be required. If not, the Council can still serve as a model for involving infant-toddler representatives and considering issues related to our youngest children.

STATE PROFILE: **NEW MEXICO**

The Child Development Board



As a result of a task force recommendation, in 1989 the New Mexico legislature enacted a statute creating the Office of Child Development within the State Department of Education along with a Child Development Board to provide direction and oversight for its activities. The office and board were given the authority to identify the personnel requirements for individuals working with children birth through age 8 as well as to establish program standards and manage state-funded child development programs for children birth to 5. When the Children, Youth and Families Department was established in 1992, both the office and the board were transferred to that agency. In 2008, the Department was restructured to create an Early Childhood Services Division.

The Child Development Board consists of seven members from the private sector appointed by the Governor. Its work is supported by state general funds and staffed by employees of the Early Childhood Services Division, which includes state-funded pre-K and other early childhood development programs, child care quality initiatives, Head Start State Collaboration, home visiting, professional development certification, and the quality rating and improvement system. The Board has established two standing committees: the Early Childhood Higher Education Task Force and the Early Learning Committee. Ad hoc groups are created as needed.

The Child Development Board has served as a policy advisory body on early learning for almost 20 years. Its accomplishments include:

- A fully articulated competency-based career lattice with multiple pathways and levels of licensure and certification for all early childhood personnel working with children birth through third grade
- A quality improvement and rating system with corresponding differentiated subsidy rates applied to all licensed child care programs
- A state-funded child development program for children birth through 3 complemented by a mixed-delivery pre-K program for 4-year-olds

The board is developing an early learning plan for children birth through third grade to address the alignment of early childhood programs and serve as a framework for the establishment of a “system of systems.”

New Mexico also has a Children’s Cabinet formed through an executive order of Governor Bill Richardson in February 2003 and then established in statute in 2005. It is comprised of agency heads chaired by Lieutenant Governor Diane Denish. The Cabinet works to improve the coordination of services between departments. The Early Childhood Action Network (ECAN) is a committee of the Cabinet focused on children birth to 5 and their families. Its membership includes about 40 stakeholders from diverse perspectives. This group has been developing New Mexico’s early childhood strategic plan and action agenda since 2004 with funding from the federal Early Childhood Comprehensive Systems grant. Child Development Board members are active ECAN participants, representing early learning issues.

Some of the Child Development Board’s recent activities focused on infants and toddlers include:

- Adding a new Family Infant Toddler career lattice pathway for those mentoring and coaching adults who work with infants and toddlers
- Incorporating infant mental health competencies into the Family Infant Toddler specialization
- Establishing state-issued Associates and Bachelors degree certifications for those in the Family Infant Toddler career pathway, especially for early interventionists and home visitors
- Creating criteria and expected outcomes for home visiting programs
- Developing early learning outcomes for infants and toddlers as part of an early learning continuum for children birth through kindergarten

Although the Governor has not yet named the State Advisory Council under the Head Start reauthorization, it is expected that the Child Development Board will be designated. When designated, the board will expand its membership for this function and utilize ad hoc and standing committees for various Advisory Council activities.

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Activities of State Advisory Councils: Implications for Infants and Toddlers

RECOMMENDATIONS IN BRIEF

- **Assess the needs of and services for infants, toddlers, and their families.**
- **Examine the status and needs of the infant-toddler workforce.**
- **Develop and implement early learning guidelines for infants and toddlers.**
- **Focus at least one of the state's short-term priorities specifically on infants and toddlers.**
- **Address the needs of infants and toddlers within 0 – 5 strategies.**
- **Include outcomes for infants and toddlers and gather the data needed to evaluate progress.**

State Decisions about Council Activities

Although State Advisory Councils are created under Head Start reauthorization, their charge is much broader than Head Start programs. State Advisory Councils are responsible for all of the policies and services that comprise a system of early childhood education and care designed to promote school preparedness. Each state's Council is to develop a statewide "strategic report," incorporate public comment, and then periodically review its implementation.

One of the first steps in creating a comprehensive state plan is to develop a clear vision for young children and their families and a set of basic values or principles around which the group can unite. Federal law requires periodic statewide needs assessments of the quality and availability of early childhood education and development programs for children from birth to school entry. A thorough analysis of the needs of the state's young children, current services and resources, and successes on which to build will assist Councils in focusing their efforts. The creation of a long-term plan, with a timeline over a period of years, must be paired with an implementation plan that outlines incremental strategies as the focus of more immediate action. Kagan refers to the creation of aligned long-term and implementation plans as "having a dream *and* developing sequentially and systematically the process to achieve it."¹³ Councils should establish benchmarks and track progress toward meeting their long-term outcomes.

The creation of aligned long-term and implementation plans are like "having a dream *and* developing sequentially and systematically the process to achieve it."¹³

Improved coordination of programs and supports for young children is a major purpose of State Advisory Councils. Federal statute specifies that Councils identify opportunities for, and barriers to, collaboration and coordination among various programs and services, including the responsible state agencies. The National Governors Association's 2007 survey of state early childhood advisory councils found that all seek to increase coordination with early care and education programs, and



most coordinate with health (97%), mental health (90%), home visiting (90%), and early intervention/special education (87%) services. Ninety percent of the councils identify or address barriers to the integration of federal and state early education and care services.¹⁴

Other federally required tasks of State Advisory Councils relate to:

- *Availability and access*—increasing the participation of children in existing child care and early childhood education programs, including outreach to underrepresented and special populations
- *Data*—establishing a unified data collection system for early childhood education and development services
- *Quality*—developing or improving high-quality, comprehensive early learning standards
- *Professional development*—establishing statewide professional development plans for early childhood educators and assessing the capacity and effectiveness of institutions of higher education toward supporting the development of early childhood educators¹⁵

Most existing early childhood advisory councils engage in these same types of activities. According to the National Governors Association survey:

- Nearly three-quarters (74%) of councils assess the availability of high-quality pre-kindergarten and child care programs.
- Over half (52%) assess the availability of other child development services such as health, mental health, and home visiting.
- 77 percent focus on early learning outcomes and standards.
- Almost all (92%) create early childhood professional development plans and assist institutions of higher education with articulation agreements.
- Other common activities include communication (77%), professional development and training (74%), technical assistance (71%), and service coordination (71%).¹⁶



Existing early childhood advisory councils engage in quality improvement, professional development, and planning to improve services and coordinate the various sectors that interact with families of infants and toddlers.



Other tasks may be assigned to the State Advisory Council at the Governor's discretion. States may wish to include activities such as:

- Public awareness and engagement campaigns
- Development and use of program standards across various early childhood programs
- Support to collaborative groups at the local level
- Development and implementation of quality rating and improvement systems
- Creation and use of a common set of outcomes and indicators for young children
- Establishment of a new financing mechanism

Focusing on Infants and Toddlers in Council Activities

State Advisory Councils will have many priorities competing for attention. Unless there is an intentional focus on the youngest children, their needs may not rise to the top. As Councils develop statewide plans and the priorities on which they will concentrate, the following recommendations can assure that issues related to infants and toddlers receive adequate attention.

Assess the needs of and services for infants, toddlers, and their families. Councils should pay particular attention to gathering both demographic data and information about the availability and quality of services for infants and toddlers. It may be more difficult to break out information by age groups, but it can lead to rich data about how well the needs of the state's youngest children are being met. This knowledge can be used to inform the planning process and choose focus areas where improvement is most necessary.

Examine the status and needs of the infant-toddler workforce. Caring for infants and toddlers, especially in group care settings, requires a level of specialized knowledge and skill that is unique to the developmental needs of these early foundational years. Yet, those who are working with infants and toddlers and



State Advisory Councils should examine the status and needs of the infant-toddler workforce because they require a specialized level of knowledge and skill that is unique to the developmental needs of the early foundational years.

STATE PROFILE: OHIO

Early Childhood Cabinet and Early Childhood Advisory Council



In March 2007, newly elected Governor Ted Strickland signed an executive order establishing an Early Childhood Cabinet to set state policy and coordinate programs serving Ohio children from prenatal through kindergarten. This action united key state agencies around a common goal of promoting school readiness. The Cabinet is composed of the heads of the Departments of Alcohol and Drug Addiction Services, Education, Health, Job and Family Services, Mental Health, and Mental Retardation and Developmental Disabilities. The Governor also appointed a director to staff the Cabinet.

An Early Childhood Advisory Council was convened in August 2008 to advise the Cabinet on policy and resource development priorities, suggest options for the Cabinet's consideration, assist with communication strategies, and ensure compliance with the requirements of Head Start reauthorization. The Council merged an early childhood group assisting with Governor Strickland's transition and the Build Ohio board, with the addition of some new members to meet the Head Start requirements. The 45-member Council includes a diverse array of primarily private stakeholders from early childhood programs, schools, higher education, foundations, and other groups.

Beginning in September 2008, directors of the Head Start State Collaboration and the Early Childhood Comprehensive Systems projects began to share the responsibility of staffing the Advisory Council and Cabinet, along with the director of the Cabinet. The Advisory Council will also serve as the advisory group for both projects.

The Early Childhood Cabinet and its Advisory Council work in tandem to ensure that all children have access to high quality early childhood experiences so that every child is socially, emotionally, physically, and intellectually prepared to use his or her capabilities to succeed. They have adopted the comprehensive definition of a system from the national Early Childhood System Builders' Workgroup. Support for their work is provided by a combination of federal funds (Temporary Assistance for Needy Families administration, Head Start Collaboration, and Early Childhood Comprehensive Systems) and private funds (Build Initiative and local foundations).

The Cabinet and Advisory Council are implementing the

recommendations from a number of previous plans. They have developed a visual framework, which includes principles, goals, outcomes, and system strategies to guide their work.

Work groups of the Cabinet are focusing on:

- *Articulation*—advising the Board of Regents in developing a seamless articulation pathway for early education practitioners through the 2-year and 4-year higher education system
- *Interagency child identifier*—initiating a common unique identification number for children entering Ohio's early childhood programs to facilitate linkages across state agency information systems
- *Fiscal model*—developing a fiscal model on the costs of improving quality through Ohio's quality rating and improvement system
- *Professional development*—integrating qualifications and training requirements for early care and education teachers, technical assistance and coaching supports, and multiple professional databases
- *Social and emotional development*—providing a comprehensive continuum of care for young children, which includes promotion, prevention, early and periodic screening, assessment, early intervention, treatment services, and supports to ensure appropriate individualized service delivery

Infants and toddlers are at the center of several initiatives of Ohio's Cabinet and Advisory Council, including:

- Conducting ongoing training on Ohio's infant-toddler early learning guidelines
- Developing implementation guides and training on program standards for out-of-home settings serving infants and toddlers
- Reviewing the Help Me Grow early intervention and home visiting program and making recommendations
- Deciding how the state can better support prenatal health and provide child development information during pregnancy

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supporting their families frequently lack training and mentoring specific to this period of development. As Councils assess workforce needs and design and implement a professional development system, they should pay particular attention to the education, support, and compensation of their state's infant-toddler professionals.

Develop and implement early learning guidelines for infants and toddlers. Early learning guidelines describe expectations about what infants and toddlers should know and be able to do during specified age ranges. At least 22 states have developed early learning guidelines for children birth to 3 or birth to 5/kindergarten, and other states are in the process.¹⁷ State Advisory Councils in states that have not embarked on this process should take the lead and should ensure that standards for infants and toddlers are included. States can assure widespread use of the guidelines by disseminating them to infant-toddler professionals, providing training, and creating incentives through professional development and quality rating and improvement systems.

Focus at least one of the state's immediate priorities specifically on infants and toddlers. In addition to developing or revising and implementing early learning guidelines for infants and toddlers, states may wish to consider strategies for immediate action such as:

- Expanding access to Early Head Start by extending the day or year of existing Early Head Start services, increasing the number of children and pregnant women served by Early Head Start programs, helping child care providers deliver services meeting Early Head Start standards, or supporting Early Head Start-child care partnerships to improve the quality of care¹⁸
- Designing and implementing an infant-toddler credential, which formally recognizes individuals working with infants and toddlers who complete specialized education and training requirements¹⁹
- Developing an Infant-Toddler Specialist Network of individuals who offer training and support to professionals who provide early care and education to infants and toddlers
- Establishing a new financing mechanism, such as a set-aside or endowment, to specifically fund services for infants, toddlers, and their families

Address the needs of infants and toddlers within 0–5 strategies. As State Advisory Councils choose activities on which to focus, it is key that the strategies intentionally include an emphasis on infants and toddlers. For example:

- Leverage increases in public awareness and political will to invest early into improved services for infants and toddlers.
- Include quality indicators for infants and toddlers in the various elements of the state's quality rating and improvement system—standards, accountability measures, program and practitioner outreach and support, financial incentives, and parent/consumer education efforts.²⁰
- Reach out to family, friend, and neighbor providers who care for infants and toddlers.

STATE PROFILE: VIRGINIA

The Governor's Working Group on Early Childhood Initiatives



As former Governor Mark Warner was proposing his final budget in December 2005, he launched the Virginia Early Childhood Foundation as a public-private partnership to foster Smart Beginnings for all young children in Virginia. Governor Tim Kaine, who succeeded Warner, embraced the mission of the Smart Beginnings initiative. In August 2006, Governor Kaine issued an executive directive establishing the Governor's Working Group on Early Childhood Initiatives. This multi-agency policy group is part of the Governor's Office, chaired by the Secretary of Education, and staffed by the Director of the Office of Early Childhood Development. The executive directive specified that the Working Group include the Secretaries of Education, Finance, Health and Human Resources, and Commerce and Trade; the State Superintendent of Public Instruction; the Commissioners of Health, Mental Health, Medical Assistance, and Social Services; as well as the heads of the community college system, the higher education council, and the state's economic development partnership. Other representatives have been added: the Head Start Collaboration director and chairs of the Start Strong Council, Virginia Early Childhood Foundation, School Readiness Task Force, and Star Quality Advisory Team. Responsibilities of the Working Group are to coordinate the Governor's early childhood initiatives, advise on the Start Strong four-year-old pre program, identify opportunities to maximize resources, and strengthen partnerships to build commitment to early childhood education.

Virginia has merged seven statewide plans, including the Early Childhood Comprehensive Systems plan, into Virginia's Plan for Smart Beginnings. Co-led by the Governor's Working Group and the Virginia Early Childhood Foundation, the plan serves as a roadmap for the early childhood agenda. Each of the plan's five goals includes system and child outcomes and data elements to measure progress.

Other current initiatives of the Governor's Working Group include:

- Piloting Virginia's quality rating and improvement system, which is aligned with their early learning

guidelines/program standards and professional competencies

- Increasing collaborative efforts among early childhood home visiting programs, including common training modules and shared indicators for evaluation
- Designing an effective system for defining and assessing school readiness
- Developing a coordinated system of professional development for the early childhood workforce

Issues related to infants and toddlers have been part of the Working Group's agenda. The Commissioner of Health is a pediatrician, and the Secretary of Health and Human Resources has a strong interest in infant mortality. Some of the group's accomplishments related to very young children are:

- Initiating an Infant Toddler Specialist Network
- Piloting the toddler CLASS (Classroom Assessment Scoring System) instrument in the quality rating and improvement system
- Developing early learning guidelines
- Piloting a common referral form through the Part C early intervention program, which is now being adapted by other programs

As Virginia looks toward implementing the requirement for a State Advisory Council, the membership of the Working Group will be analyzed to determine whether other members need to be added.

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Include outcomes for infants and toddlers and gather the data needed to evaluate progress.

Development of a core set of outcomes and indicators for young children and their families provides a means of shared accountability. While Councils alone cannot be held accountable for improving children's lives, they can focus stakeholders on working together to achieve results. Outcomes that include the many areas of a young child's development should be included and mechanisms should be developed to collect the data necessary to track progress.

Moving Ahead

In establishing State Advisory Councils under the 2007 reauthorization of Head Start, states have an opportunity to build a comprehensive system for young children, including infants and toddlers. As states create or designate Councils and undertake planning and implementation, the following guidance is offered to promote a cohesive approach.

Review existing state-level coordinating and governance structures and consider streamlining.

Many states have multiple planning and governance structures at the state level. The requirement to establish a State Advisory Council on Early Childhood Education and Care can offer the opportunity for states to take stock of these collaborative groups, map out how they relate to one another, consider possible consolidation, and decide whether an existing body can serve as the Council with or without some modifications in its charge and membership.

Build on previous work. In most cases, states will not need to "start from scratch" in developing a comprehensive system for young children. The Council's needs assessment process should examine existing plans such as the Early Childhood Comprehensive Systems plan, recommendations from previous reports, programs and initiatives with proven effectiveness, and local innovations that might be brought to scale at a state level.

Promote alignment and integration. As Councils develop new programs or initiatives, the best strategy is to align them with existing systems rather than creating parallel efforts.²¹ The charges of Councils present an opportunity to better integrate various services for young children by developing common standards for programs and personnel. Councils may also choose to work on increasing the alignment between initiatives such as early learning and program standards, professional development, and quality rating and improvement systems.

Focus explicitly on infants and toddlers. While Councils are charged with covering children from birth to school entry, infants and toddlers have unique needs. Without a particular emphasis on this age group, services and policies to support their development may be patchy at best.

Ensure balanced investments across the system. States cannot stop with one specific age group or issue. Focusing does not mean ignoring other parts of the system or advancing one at the expense of another. Councils should prioritize strategically, avoid compromising existing programs, and balance investments across the system over time.²²



Conclusion

The science of early childhood confirms the importance of the earliest years of life in setting a developmental course for children. States are exploring the expansion of services for young children, but a comprehensive system to promote the development of infants and toddlers is far from established. The 2007 reauthorization of Head Start offers an opportunity to put infants and toddlers at the forefront through State Advisory Councils on Early Childhood Education and Care. These Councils can improve the availability, quality, and coordination of services for young children. When undertaken strategically, such planning and coordinating structures can be a means of achieving positive outcomes for infants, toddlers, and their families.





For more information about Early Head Start and the 2007 Head Start reauthorization, see ***Learning, Thriving, and Ready to Succeed: Infants and Toddlers in Early Head Start.***

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About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at www.zerotothree.org/policy.



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A Self-Assessment Checklist for States

All infants and toddlers need *good health, strong families, and positive early learning experiences*. Furthermore, young children benefit most from an early childhood system that is built through collaboration. These goals form the framework for a policy agenda that creates a comprehensive range of services and supports that honor the needs and choices of families for their children.

This self-assessment checklist is based on research about effective policies and best practices in states. The following questions are intended to spark discussion about the needs of infants, toddlers, and their families and to lay the foundation for building an effective early childhood development system in your state.

If your state uses the checklist, ZERO TO THREE would like your feedback on the tool, the process, and the results in your state. Please contact Barbara Gebhard at bgebhard@zerotothree.org for more information.

Suggested Process for Using the Checklist

- **Involving key stakeholders:** This self-assessment checklist is most useful when completed by a diverse group of key public and private stakeholders concerned with the needs of infants, toddlers, and their families in your state. Thinking through who might have knowledge about each of the questions is a good way to make sure no key stakeholders have been left out. It is important to offer an opportunity for all points of view to be shared so that group members are aware of what the state is currently doing and are invested in the choice of policy priorities.
- **Preparing to use the checklist:** All group members should receive the checklist before the discussion so they can be prepared. You may want to contact specific people ahead of time to alert them to be ready to share information around particular items. Another way to prepare for the discussion would be for a sub-group to draft answers to the items for feedback from the larger group.
- **Completing the checklist:** For each item, check **no**, **none**, **some**, **most**, or **yes/all**, and add any clarifying comments. The checklist is not meant to provide a quantifiable rating of infant-toddler services. Since the self-assessment process is somewhat subjective, time to discuss the response choices should be included as part of the process. The checklist should then be completed using discussion and relevant information sources, such as service utilization data and child care licensing regulations, to establish the ratings for each item. A second meeting or conference call may be needed to analyze the results, especially if more information needs to be gathered for some items or a compilation needs to be circulated to all group members. The process could be done over the course of several meetings or calls or through a more intensive day-long retreat. It is also possible to use the checklist with stakeholders through a web-based survey such as Zoomerang or Survey Monkey.
- **Using the results:** After completing the checklist, choose one to three priorities for state action in each of the four goal areas: **good health, strong families, positive early learning experiences, and collaboration and system building**. Regardless of exactly how the self-assessment is completed, it is important to reflect on the results and identify your state's policy priorities. Once priorities are established, it is critical to develop an action plan with assigned responsibilities, a timeline, and measurable outcomes. The priority actions will also need to be incorporated into relevant state plans that will be reviewed by an oversight group on a regular basis.



National Center for Infants, Toddlers, and Families

GOOD HEALTH	No/None	Some	Most	Yes/All	Comments	Priority
Physical Health						
1. All pregnant women have access to prenatal health care.						
2. All infants and toddlers have health and dental insurance coverage.						
3. Income eligibility for Medicaid/SCHIP is at or above 200% of the federal poverty level for pregnant women, infants, and toddlers.						
4. The state provides temporary coverage for pregnant women, infants, and toddlers under Medicaid/SCHIP until eligibility can be formally determined.						
5. All infants and toddlers have an identified medical home (a designated primary care provider).						
6. Primary care providers are reimbursed adequately for the time to provide child development guidance in well-child visits.						
7. All infants and toddlers receive immunizations appropriate to their age, development, and medical status.						
8. All eligible women and children have access to the Women, Infants, and Children (WIC) program.						
9. State funds supplement federal funding for nutrition programs that reduce food insecurity for young children.						
10. Various health and safety initiatives are available statewide:						
a. oral health						
b. nutrition						
c. obesity prevention						
d. environmental hazards						
e. car seat safety						
f. Back to Sleep						
g. Shaken Baby Syndrome						
11. All infant-toddler caregivers and programs can access health care consultation.						

GOOD HEALTH		No/None	Some	Most	Yes/All	Comments	Priority
Social-Emotional Health							
1. All pregnant/postpartum women have access to maternal depression screenings and mental health services as needed.							
2. The state provides resources and training for parents and professionals on the social-emotional development of infants and toddlers.							
3. All infants and toddlers with social-emotional or behavioral issues and their families have access to trained professionals to assess, diagnose, and treat them.							
4. The DC: 0–3R is used to diagnose the mental health and development of infants and toddlers for Medicaid reimbursement.							
5. All infant-toddler caregivers and programs can access mental health consultation.							
Developmental Screening							
1. All newborns are screened for hearing deficiencies and for the 29 metabolic disorders recommended by the March of Dimes.							
2. All infants and toddlers have access to regular developmental screenings and referrals as needed.							
3. At least 80% of children on Medicaid receive an annual health and developmental screening under EPSDT.							
4. The state requires the use of standardized developmental screening tools and reimburses adequately for their use.							
Additional Good Health Comments							

STRONG FAMILIES	No/None	Some	Most	Yes/All	Comments	Priority
1. All families can find the services they need for their infants and toddlers through cross-program referrals and information and referral agencies.						
2. All families receive information and services responsive to their home culture and language.						
Basic Needs						
1. All families who need education, skill training, job opportunities, and work supports to move into stable work that generates a livable wage can access them.						
2. Adequate housing options and energy assistance are available to low-income families.						
3. TANF policies: a. Allow post-secondary education to fulfill the work requirement						
b. Exempt single parents from the work requirement until their youngest child is at least 1 year old and reduce work requirements until the child is 6 years old						
c. Allow families to receive child support without reducing cash assistance						
4. The state minimum wage exceeds the federal minimum wage.						
5. The state supports family-friendly tax policies such as a refundable Earned Income Tax Credit, a refundable Dependent Care Tax Credit, and exemption of single parents below the federal poverty level from personal income tax.						
Parent Education/Home Visiting						
1. All families with infants and toddlers can access evidence-based home visiting, family support, and parent education services.						
2. Evidence-based home visiting supports extend to families, friends, and neighbors caring for children with working parents.						
3. All families who wish to increase their leadership and advocacy skills can access leadership initiatives.						

STRONG FAMILIES		No/None	Some	Most	Yes/All	Comments	Priority
Child Welfare							
1. All families with babies who face multiple risk factors (such as very low income, homelessness, and family violence) can access programs and services that work together to support them.							
2. All families at risk of child maltreatment can access a network of respite care.							
3. Concurrent planning is practiced to ensure that infants and toddlers in foster care are expeditiously moved into permanent placement.							
4. Infants and toddlers in foster care visit with their parents multiple times each week as long as there are no safety concerns.							
5. Child welfare workers and judges are knowledgeable about child development and use that knowledge to guide their work with infants and toddlers in the child welfare system.							
6. All families (birth families, permanent guardians, and adoptive families) have access to continued post-permanency supports, such as adoption subsidies and therapeutic services, after permanency has been achieved.							
Family Leave							
1. All working families can access paid family leave, including paid sick leave, so parents can have time off after birth or adoption or when a child is sick.							
2. Parents who stay home to care for their babies can access financial support for at-home infant care.							
3. The state encourages businesses to provide work-life benefits to employees through tax incentives, promotional campaigns, legislation promoting family-friendly practices, etc.							
Additional Strong Families Comments							

POSITIVE EARLY LEARNING EXPERIENCES						Comments	Priority
	No/None	Some	Most	Yes/All			
Early Intervention							
1. All infants and toddlers who have experienced abuse, neglect, or family violence are referred to Early Intervention for evaluation.							
2. At-risk infants and toddlers are included in the state's definition of eligibility for Early Intervention.							
3. All eligible infants and toddlers have access to Early Intervention.							
4. All infants and toddlers with disabilities can access supports needed to participate in early care and education programs.							
Early Head Start							
1. The state supplements federal Early Head Start funds with state or other federal funding to increase the number of families served and/or improve the quality of care.							
Child Care							
1. All families in need of child care for their infants and toddlers can access quality care.							
2. The state's Child Care and Development Fund (CCDF) plan includes specific measurable goals for infant-toddler programs or initiatives.							
3. Strategies to achieve the CCDF infant-toddler goals are reviewed and revised, if necessary, for each biennial plan period.							
4. Family eligibility for child care subsidies is at or above 85% of state median income or 200% of the federal poverty level.							
5. Child care provider reimbursement rates are within 75% to 100% of market rate.							
6. Child care subsidy co-payments do not exceed 10% of family income.							
7. The child care subsidy re-determination process for family eligibility is one year or longer, in order to allow infants and toddlers to remain in consistent caregiving arrangements.							

POSITIVE EARLY LEARNING EXPERIENCES

	No/None	Some	Most	Yes/All	Comments	Priority
8. State licensing regulations require that infants and toddlers in child care programs are assigned a primary caregiver.						
9. The caseloads of state child care licensing staff do not exceed 75 programs per inspector.						
10. A network of child care resource and referral (R&R) agencies helps families identify their needs and refers them to appropriate services.						
11. Family, friend, and neighbor (FFN) caregivers have access to supports such as training, consultation, lending libraries, etc.						

Additional Positive Early Learning Experiences Comments

Empty space for additional comments.



COLLABORATION AND SYSTEM BUILDING						No/None	Some	Most	Yes/All	Comments	Priority
Collaboration											
1. Early childhood system development efforts involve diverse representation from stakeholders interested in infants and toddlers from both public and private sectors. These include families, child care centers, family child care, FFN care, Head Start and Early Head Start, public schools, Early Intervention, health, mental health, family support, child welfare, economic assistance, advocates, business, etc.											
2. The state encourages collaborative partnerships among early childhood programs.											
3. Transition policies ensure continuity of services between early childhood settings.											
4. Mechanisms exist to coordinate among infant and toddler programs and to link them with other services such as health, mental health, education, child welfare, family support, etc.											
5. The state encourages collaborative partnerships between early childhood programs and community institutions such as libraries, museums, parks and recreation, the faith community, etc.											
Governance and Leadership											
1. A state-level governance entity oversees and coordinates early childhood services and programs.											
2. The State Advisory Council on Early Childhood Education and Care includes a focus on the needs of infants and toddlers.											
3. There are champions for building an early childhood system who can reach a range of constituent bases.											
4. The state supports connections between state and local system-building efforts.											
Accountability and Evaluation											
1. Early childhood system-building efforts are informed by research and data on infants, toddlers, and their families.											

COLLABORATION AND SYSTEM BUILDING						Comments	Priority
	No/None	Some	Most	Yes/All			
2. The state has an integrated, comprehensive early childhood plan that includes a focus on infants and toddlers, and the plan is reviewed and updated regularly.							
3. The state has identified desired outcomes for infants and toddlers and monitors key indicators associated with these outcomes.							
4. The state supports research and evaluation efforts aimed at continuous improvement of services for infants, toddlers, and their families.							
Regulations and Standards							
1. Health and safety licensing standards for all child care settings incorporate recommendations from <i>Stepping Stones: Caring for Our Children</i> .							
2. State licensing and program standards support family input and involvement in early care and education programs.							
3. State licensing and program standards meet the recommended NAEYC program standards and/or National Health and Safety Performance Standards for infant-toddler care (ratios, relationships, health and safety, programming, etc.).							
4. The state has done a cross-walk to compare various sets of early childhood program standards and assure that the needs of infants and toddlers are met.							
Quality Improvement							
1. The state offers incentives to programs and their staff to promote high quality care and early learning for infants and toddlers.							
2. The state has developed early learning guidelines for infants and toddlers that are flexible, age-appropriate, and applicable across all settings.							
3. The state has a Quality Rating and Improvement System that includes quality indicators related to infants and toddlers.							

COLLABORATION AND SYSTEM BUILDING						Comments	Priority
	No/None	Some	Most	Yes/All			
4. A network of infant and toddler specialists supports infant-toddler caregivers and programs.							
5. Various quality improvement strategies (early learning guidelines, program standards, Quality Rating and Improvement System, professional development, etc.) are aligned rather than parallel efforts.							
Professional Development							
1. The state has a professional development system that supports the infant-toddler workforce across all service sectors.							
2. The state's professional development system incorporates personnel preparation and training around evidence-based core competencies.							
3. The infant-toddler workforce has access to credit-bearing training opportunities that articulate into college degrees.							
4. The state has an infant-toddler credential tied to higher education credit.							
5. Higher levels of training and increased competencies are linked to better compensation.							
Financing							
1. Services for infants, toddlers, and their families have adequate and stable funding.							
2. Available funding sources are used strategically to promote system-building capacity.							
3. The state addresses the needs of infants and toddlers when investing in pre-K initiatives.							
4. The state has an initiative to offer grants or loans to early childhood programs to renovate or construct facilities to serve infants and toddlers.							

COLLABORATION AND SYSTEM BUILDING

No/None Some Most Yes/All

Comments

Priority

Public Engagement and Political Will Building

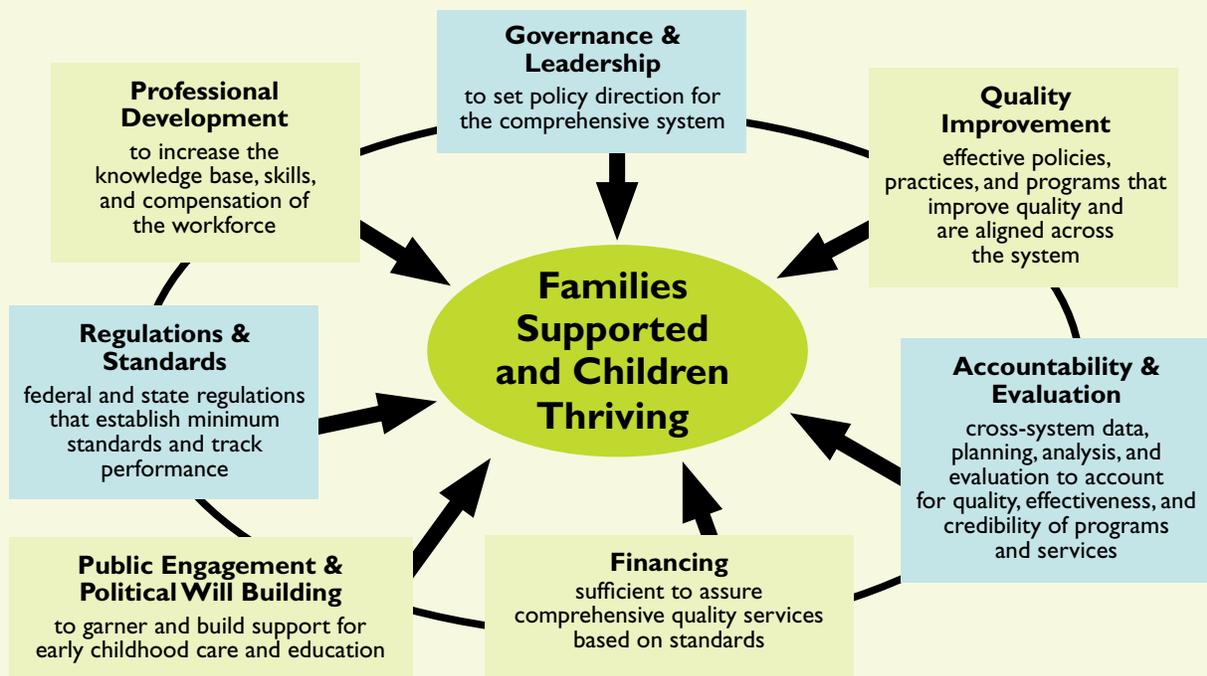
1. The state has a shared systemic vision for supporting young children and their families.

2. Public awareness efforts build public and political will around the needs of infants and toddlers.

3. Influential state policymakers are supportive of early childhood system-building efforts.

Additional Collaboration and System Building Comments

Core Elements of an Early Childhood Development System



Adapted by ZERO TO THREE from the Early Childhood Systems Working Group slide



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About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at www.zerotothree.org/policy.



National Center for Infants, Toddlers, and Families

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