BIPARTISAN POLICY CENTER

A Bipartisan Case for Early Childhood Development

October 2017

Early Childhood Initiative
Co-Chaired by Former U.S. Representative George Miller and Former U.S. Senator Rick Santorum

EARLY CHILDHOOD INITIATIVE

George Miller
Co-Chair, BPC Early Childhood Initiative
Former U.S. Representative, California

Rick Santorum
Co-Chair, BPC Early Childhood Initiative
Former U.S. Senator, Pennsylvania

BPC STAFF

Julie Anderson
Senior Vice President

Robert Traynham
Vice President of Communications

Linda Smith
Director of Early Childhood Policy

Faye Powers
Executive Assistant

Caitlin Krutsick
Project Manager

CONSULTANTS

Mary Bissell

Ruth Friedman

Regina LaBelle

Stephanie Monroe

ACKNOWLEDGMENTS

BPC would like to thank Marika Tatsutani who played a significant role in writing and editing this report. We appreciate all the generous support that made this initiative possible including grants from the W.K. Kellogg Foundation.

DISCLAIMER

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TABLE OF CONTENTS

Letter from the Co-Chairs

Since we first met as members of Congress more than two decades ago, we have watched our nation undergo profound changes, particularly in the realm of work and family life. Many of those changes have been positive, bringing new prosperity and greater diversity to the fabric of American life and society. But we have also seen changes that create new challenges for parents who are trying to give their children the best possible start in life. Meanwhile, rapid advances in brain science have given parents, educators, and policymakers new appreciation for the importance of the earliest years of life in terms of providing the foundation for healthy emotional, cognitive, and social development.

Against this backdrop, we have become increasingly concerned about the difficult trade-offs facing millions of families and young children in America. Whether parents are able to stay at home or have to arrange for child care outside the home so they can work, many aren't able to make the choices they believe would ensure their young children receive the quality care and learning opportunities that are critical for healthy early development. We teamed up to chair the Bipartisan Policy Center's Early Childhood Initiative because we think few policy challenges are more important to our nation's future than helping families overcome these barriers so that all American children can get the strong start they need to grow into successful, productive adults.

> *"Few policy challenges are more important to our nation's future than helping all American children get the strong start they need."*

For some families, of course, good options are especially scarce and the disadvantages especially great. We now know that starting at birth, and indeed even during pregnancy, exposure to adverse influences—from poor nutrition and lack of parental nurturing to family trauma and substance abuse—can have lifelong effects. This means that many of our most vulnerable children have already fallen behind long before they enter school. There is little systemic or coordinated support to catch them or to help parents better engage and fulfill their essential role as their child's first and most important teachers.

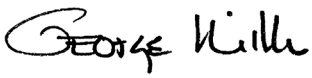
Our interest in early childhood development is rooted in our own experiences, personal and professional: We're both fathers and former legislators—in fact, one of us is raising seven kids and the other served for a decade as chairman or ranking member of the House Education and Labor Committee, witnessing firsthand how government could work to help expand opportunities for children. And while we certainly had our share of policy differences when we served in Congress, both of us remember a time when it was possible for Democrats and Republicans to work together on critical issues of national interest. Early childhood development, we believe, is clearly that type of issue—one that ought to unite lawmakers across the political spectrum given the enormity of the stakes and our shared interest in better early childhood outcomes.

BPC's Early Childhood Initiative has been asking: How can parents, childcare providers, educators, doctors, business leaders, public officials, and lawmakers work together to ensure that children are equipped to succeed—in school, in life, and in the workforce? Is it possible to provide a stronger and more comprehensive network of tools and support to help moms and dads give young children the developmental foundation to realize their full potential as adults? And can existing programs be enhanced and improved to produce more bang for the buck?

"Early childhood development is the type of issue that ought to unite lawmakers across the political spectrum given the enormity of the stakes."

Many states and communities have recognized the importance of children's earliest years and are innovating to better support families and build stronger communities. They are trying new approaches to support early childhood and enlisting a broader range of stakeholders, even as they deal with new crises like the current opioid epidemic. It's incumbent on us to learn from these efforts, to collect the data and ask the hard questions, so the best ideas can be replicated and their impact expanded.

This report describes some of what we have learned about early childhood development and about opportunities to make a difference in the lives of young children. We also offer recommendations for advancing a federal policy agenda that is specifically focused on enhancing the quality of early childhood experiences. We are confident that bipartisan support can be found for such an agenda. After all, in the search for effective strategies to secure the long-term health and prosperity of our democracy, America's youngest children, keepers of our common future, are an obvious place to start.



George Miller
Former U.S. Representative, California

Rick Santorum
Former U.S. Senator, Pennsylvania

Summary of Recommendations

Supporting Families

Increase the value of and access to the federal Child Tax Credit.

- Establish a young child tax credit of $1,500 per eligible child for all families with children through age 5 (for a total credit of $2,500).
- Begin phasing in the credit at the first dollar earned and develop an approach that phases in the credit at a faster rate than current law.

Continue and build on effective home visiting models to provide critical support for families with infants and young children.

- Reauthorize the existing Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program for five years at (at least) the current level of federal funding.
- Expand state and local home visiting needs assessments to focus on integrating home visiting services into the broader continuum of early childhood support services.
- The Department of Health and Human Services (HHS) should work with states to innovate and support promising program models that add to the evidence base for home visiting interventions.
- HHS should complete and follow up on the Home Visiting Career Trajectories Project, which is focused on how to build career pathways for home visiting professionals.

Encourage further innovation, both in developing a broader array of effective, evidence-based strategies for supporting families with young children and in unlocking resources for implementing these strategies.

- Establish a national advisory committee to identify strategies to expand public and private insurance coverage for home visiting and other innovative family support interventions.
- The Innovation Center at HHS, in coordination with the Department of Education, should test innovative models of care that include "school readiness" as a quality measure.

Develop and adopt a new, national policy on paid leave.

Making Child Care Affordable for Families

Double federal Child Care and Development Block Grant (CCDBG) funding for children ages 0 to 5.

Increase the value of and access to the federal Child and Dependent Care Tax Credit.

- Double the amount of child care expenses eligible for the credit from $3,000 to $6,000 for one child (0 to 5) and from $6,000 to $12,000 for two or more children (0 to 5).
- Make the credit fully refundable.

Prioritizing Early Care Workforce Quality

Require states to provide expanded CCDBG resources at a 75 percent reimbursement rate.

Create a new, competitive grant program to encourage states to design state-level tax programs that increase access to high-quality early childhood programs for children ages 0 to 5.

The Department of Education should ensure that early childhood workers have access to Pell grants and other forms of tuition assistance for higher education.

The Department of Labor should prioritize the development of a child care apprenticeship program that focuses on improving the competency of child care managers and directors.

Encourage states to establish minimum levels of training and competencies for their child care workforce and to improve professional development systems for the child care workforce in ways that have been shown to impact child outcomes.

Addressing the Impact of Opioid and Substance Use Disorders on Young Children and Families

Align Title IV-E of the Social Security Act (Federal Foster Care Payments) with Child Abuse and Prevention Treatment Act (CAPTA) requirements to:

- Develop and implement a "plan of safe care" for substance-exposed infants and young children and their families.
- Report annual data to the federal government on the number of substance-exposed infants, young children, and families for whom a plan of safe care was developed, and report service referrals.

Require HHS to identify and share model strategies to support state and local implementation of "plans of safe care" and data collection and reporting.

Require the Substance Abuse and Mental Health Services Administration to encourage and provide guidance on how the Substance Abuse and Mental Health Services Block Grant (SABG) can be used to address treatment and recovery service needs for parents and their infants and young children, and integrate this funding with other available federal funding streams.

Amend Part C of the Individuals with Disabilities Education Act (IDEA) to improve linkages among services for early intervention and substance use disorders.

Introduction

The Bipartisan Policy Center established the Early Childhood Initiative with former Representative George Miller and former Senator Rick Santorum to draw public attention to the very serious issues and challenges surrounding early childhood development in the United States, and to offer some bipartisan solutions. Supporting early childhood development is an issue that can and should unite both political parties. Building on insights and perspectives from experts and stakeholders in this area, the initiative focused on five distinct but essential aspects of the early childhood development challenge:

1. Providing support for parents who are their children's first and most important teachers.
2. Addressing the affordability of child care.
3. Improving the overall quality of care for young children regardless of where that care takes place.
4. Addressing the impact of the opioid crisis on children and their families.
5. Ensuring that public investments are improving programs for young children and achieving better early childhood outcomes.

This report is organized as follows. The opening section provides background and context, reviewing the latest findings on the importance of the earliest years—and especially the quality of early experiences and interactions with parents and caregivers—in terms of children's developmental outcomes. The second section focuses on supporting families as the first and most important influence on a child's well-being and early development. The next section addresses the enormous challenge of making child care affordable for families followed by a discussion on the issue of child care workforce quality as an essential element of ensuring quality care. The final section examines the impacts of the current opioid crisis on young children.

In each section, a discussion of key issues and challenges is followed by a set of recommendations. Together, we believe these recommendations can unite policy makers and stakeholders from across the political spectrum in meaningful steps toward improving the well-being and life chances of America's youngest children.

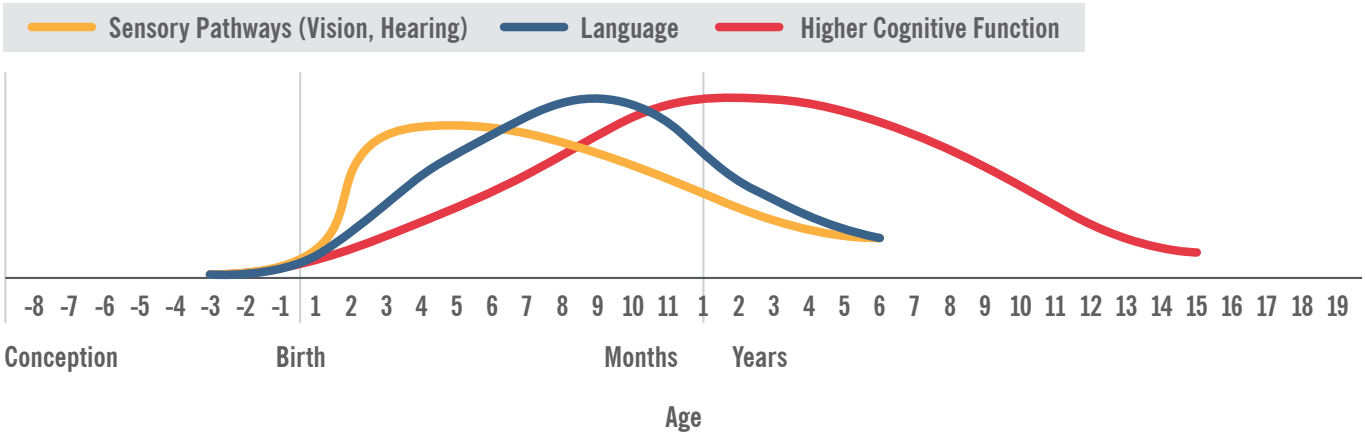
Background and Context

Of the 73.6 million children in the United States today, almost 20 million are under age 5.[1] Though not yet in school, these very young children are already progressing through foundational periods of learning and brain development. As summarized in a major report issued by the National Academy of Sciences in 2000, an "explosion" of research in the neurological, behavioral, and social sciences over recent decades has given parents, educators, and policy makers:

> *. . .a much deeper appreciation of the importance of: (1) the importance of early life experiences, as well as the inseparable and highly interactive influences of genetics and environment, on the development of the brain and the unfolding of human behavior; (2) the central role of early relationships as a source of either support and adaptation or risk and dysfunction; (3) the powerful capabilities, complex emotions, and essential social skills that develop during the earliest years of life, and (4) the capacity to increase the odds of favorable development outcomes through planned interventions.*[2]

These and other findings from the rapidly expanding literature on early childhood development (see text box), have prompted a robust debate about how to support families so that all children get the healthy start in life that will enable them to realize their full potential and become productive and responsible adults. Historically, policy interventions aimed at fostering children's learning and development have largely focused on the K-12 school years. We now know that foundational growth and change in the human brain begins long before children enter school—at birth, and indeed even before birth.

Figure 1. Human Brain Development: Synapse Formation Dependent on Early Experiences



Source: Nelson, C. A., in *Neurons to Neighborhoods* (2000). Shonkoff, J. & Phillips, D. (Eds.)

Core Concepts of Development

In a 2007 review of the current state of scientific understanding concerning early child development, the National Scientific Council on the Developing Child articulated six "core concepts of development" that have important implications for policy and practice in this area:

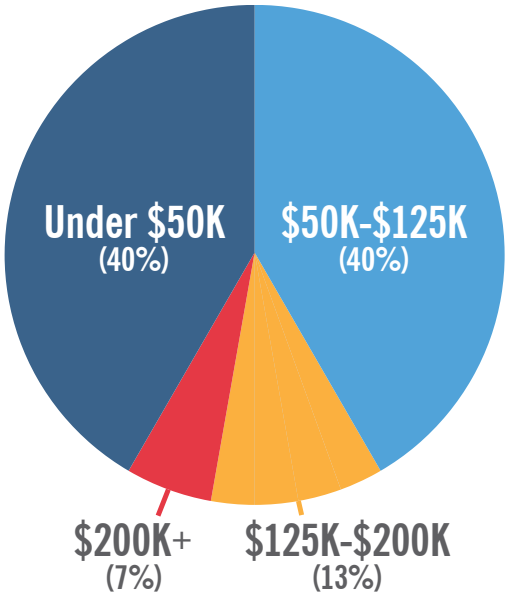
- Child development is a foundation for community development and economic development, as capable children become the foundation of a prosperous and sustainable society.
- Brains are built over time, through an ongoing process that begins before birth and continues into adulthood. Through this process, early experiences create a foundation for lifelong learning, behavior, and both physical and mental health.
- The interactive influences of genes and experience literally shape the architecture of the developing brain, and the active ingredient is the "serve and return" nature of children's engagement in relationships with their parents and other caregivers in their families or communities.
- Both brain architecture and developing abilities are built from the bottom up, with simple circuits and skills providing the scaffolding for more advanced circuits and skills over time.
- Toxic stress in early childhood can lead to persistent effects on the nervous system and stress hormone systems that can damage developing brain architecture and lead to lifelong problems in learning, behavior, and both physical and mental health.
- Creating the right conditions for early childhood development is likely to be more effective and less costly than addressing problems at a later age.

Source: National Scientific Council on the Developing Child. *The Science of Early Childhood Development.* 2007. Available at: http://www.developingchild.net.

Growing awareness of the critical, lifelong influence of early experiences and learning has coincided with a growing realization that major economic and social shifts are having a profound effect on the circumstances under which America's youngest children are growing up. More primary caregivers are working and many parents are working longer and more non-traditional hours. The challenges are especially acute for those children who are growing up in single-parent households and in families that are stressed by financial pressures, food or housing insecurity, poor health, or exposure to substance abuse or violence. Multiple studies point to a clear link between disparities in income, parental educational attainment, and other family circumstances and later academic achievement and economic opportunity. These disparities emerge early: Researchers have identified measurable differences in vocabulary size between children from more and less affluent households at ages as early as 18 months. These differences persist through the preschool years.[3] And children who start kindergarten behind their peers tend to stay behind their peers throughout their educational careers.

According to Child Trends, a national non-profit research organization that tracks data on children and families, recent years have seen continued improvement in the major economic indicators for American families and children, although it remains the case that many families have not yet recovered fully from the Great Recession of 2008-2009. Fewer children are living in poverty, more parents are employed and fewer families are living with a housing cost burden.[4] Nonetheless, as Child Trends points out, one in five American children lived in poverty in 2015. And a significantly larger portion, approximately 40 percent, of American children under age 5 are growing up in low-income households—that is, in families getting by on an income of less than $50,000 per a year. The sobering conclusion from current research is that many of these youngsters will start school at a significant disadvantage compared with their more affluent peers—this disparity, moreover, is not only very difficult to overcome, it tends to widen rather than diminish in later years.[5]

Figure 2. Household Income Distribution: Children Under Age 5



Source: Katharine B. Stevens. American Enterprise Institute using data from the U.S. Census Bureau. 2017.

A better understanding of early child development and its influence on outcomes later in life also puts a new focus on the quality and affordability of out-of-home care for very young children. This is a critical issue given that 12.5 million American children under age 5—more than half the total under-5 population—are involved in some type of formal child care arrangement (among this group, time spent in child care averaged 33 hours per week).[6] Fewer than one in three children have a parent who stays at home full-time.[7] The costs of child care, meanwhile, have been rising rapidly such that, in 33 states and D.C., infant care costs now exceed the average cost of in-state college tuition at public four-year institutions.[8] High child care costs are a particular burden for low-income families: According to one source, families making less than $1,500 per month spend, on average, half their income on child care expenses.[9] For these families, expenses for child care must compete with expenses for other basic necessities such as food, housing, and health care. And despite these high costs, child care itself remains a low-paying occupation for those who provide it. After accounting for demographic differences, child care workers are more likely to be in poverty than similar workers in other occupations.[10]

Parental substance use and addiction adds another dimension to the risks facing many young children in America today, both because of the developmental consequences of prenatal exposure and because of the impact on the caregiving capacities of parents. While recent policy and media attention has raised awareness of the devastating consequences of the current opioid epidemic, it is important to remember that many parents of young children also struggle with alcohol addiction and other illicit drugs. The most recent reports from the Substance Abuse and Mental Health Services Administration show that an estimated 400,000 to 440,000 infants (1 in 10 births in the U.S.) are affected by prenatal alcohol or illicit drug exposure.[11] And in a reflection of the rapidly growing opioid crisis, opioid use among women who had given birth increased from 1.19 to 5.63 per 1,000 hospital births per year between 2000 and 2009.[12] Substance abuse, including opioid addiction, has multiple devastating consequences for children: Prenatal exposure can lead to a host of increased health risks and later developmental and behavioral problems, and even more lasting harm may come from growing up with the chaos and parental neglect often associated with substance abuse. According to a recent analysis, nearly a third of the children who entered foster care in the U.S. in 2015 did so at least partially because of parental drug abuse.[13]

The good news is that, when designed and implemented appropriately, investments in early childhood development have been shown to produce meaningful results—for example, studies of high-quality early learning programs for low-income children have pointed to returns as high as $4 to $9 for every dollar invested.[14] Other studies have found that every dollar invested in high-quality, birth-to-5 early childhood education for disadvantaged children delivers a 13 percent annual return on investment, significantly higher than the 7 to 10 percent return delivered by preschool alone.[15] And there is a growing body of evidence-based research on effective programs and interventions, from home visiting programs that provide voluntary, in-home support to new parents, to programs that work with pediatricians to deliver screening and preventative services, as well as parental education and support, to programs that combat substance use disorders.

Historically, most public investment in early childhood programs, interventions, and support has come from the federal government. But the last two decades have seen a huge increase in activity and investment at the state and local level as awareness of the potential return on investment has grown alongside a belief that states and communities should do more to support parents' efforts to raise their children. A recent report by the U.S. Chamber of Commerce noted that "America is facing a childcare challenge that threatens the productivity and strength of the workforce of today—as well as the quality of the workforce of tomorrow. . . .[and that] U.S. businesses lose $3 billion annually due to employee absenteeism as the result of childcare breakdowns."[16]

Nonetheless, despite these increased investments, the need remains larger than the resources being directed to early child development and many children and families are still unable to access programs that have demonstrated effectiveness, meet their needs, and fit within their budgets.

In sum, there is a clear need for a greater, more effective, and integrated system of support to address the challenges facing millions of young children and families with young children in America. This requires a sustained commitment to exploring new approaches, figuring out what works, leveraging resources, and investing thoughtfully in programs and policies that can make a meaningful difference in early childhood outcomes. The recommendations offered in this report are intended to contribute to the stronger response on which our children's well-being, and the long-term economic and social health of our nation, depends.

Supporting Families

Parents and families are the first and most important influence on a child's well-being and early development. The notion that parents and families are critical partners and must be integrally involved in any effort to improve early childhood outcomes is captured in a recent policy statement from the Department of Health and Human Services (HHS) and the Department of Education:

> *The lives and experiences of young children are intertwined with those of their families. Families are children's first and most important teachers, advocates, and nurturers. Strong family engagement in early childhood systems and programs is central—not supplemental—to promoting children's healthy intellectual, physical, and social-emotional development; preparing children for school; and supporting academic achievement in elementary school and beyond.*[17]

Recognizing that the most important early child "experts" are a child's own parents, and the most influential learning environment is the child's own home, suggests that effective early childhood policies—rather than focusing narrowly on the child alone—must also address the needs and well-being of families as a whole.

Parents and caregivers must have the knowledge, the skills, the time, and the opportunity to promote healthy cognitive, social, and emotional development in their young children. As a leading organization on early childhood put it:

> *Secure and responsive relationships with adults (and with other children), coupled with high-quality positive learning interactions and environments, are foundational for the healthy development of young children. Conversely, adults who are underinformed, underprepared, or subject to chronic stress themselves may contribute to children's experiences of adversity and stress and undermine their development and learning.*[18]

An important point that emerged throughout the Initiative's discussions is that nearly all parents—however varied their cultural background and economic circumstances—express a strong desire to help their children reach their full potential, and a corresponding belief that they know what is best for their families. In a 2016 survey of national attitudes, about 90 percent of parents with young children said that

they are working hard to be a more effective parent. In the same survey, approximately 80 percent agreed strongly that good parenting can be learned, and 69 percent said they would use more positive parenting strategies if they knew what those strategies were.[19]

In practice, however, many parents struggle to meet the needs of their infants after they leave the hospital,[a] and many lack good child care options or feel unable to make the choices that would be best for their young children's development in the years before they enter school. Raising young children can feel overwhelming for any parent and can present many challenges and stresses for families. To start with, most parents, nearly two-thirds of those with children under the age of 5, are in the workforce, either full- or part-time—some by choice, others by necessity. For many, the challenges of finding infant care begin almost immediately since relatively few parents—only 13 percent of Americans, according to the Bureau of Labor Statistics—are able to take paid time off after the birth of a child.[20] The fraction is even lower, only 5 percent, for low-wage workers who are less likely to have employer-provided parental-leave benefits.[21] As a consequence, about a quarter of American women return to work as early as 10 days after giving birth, cutting short a critical time for bonding with a newborn and establishing breastfeeding, which has demonstrated benefits for infants' health and later development. Research also suggests that lack of access to paid leave increases new mothers' risk of postpartum depression and increases the likelihood that women eventually drop out of the workforce, resulting in a loss of income to the household as a whole.[22]

Beyond the immediate demands of caring for a newborn during the first weeks or months of life, working parents face the ongoing challenge of sustaining consistently supportive interactions with their young children. As discussed in the next section, low- and middle-income families are especially likely to struggle to afford high-quality child care, particularly since the characteristics of low-wage work often increase the difficulty of making stable, high-quality care arrangements.[23] Addressing the affordability of child care is therefore a critical aspect of supporting families; we focus on this subject in the next section. Studies show that when parents are financially stressed or overworked, this can negatively affect their children's development. And when families are further stressed by unemployment, poor health, housing insecurity, substance abuse, or exposure to violence, children are even less likely to thrive. A substantial body of research confirms the link between financial stability in the early years and academic achievement, behavior problems, and mental health in children.[24] Similarly, multiple studies have shown that early development suffers when children lack access to basic needs like safe housing, health care, and nutritious food.[25]

Targeted child tax credits and paid leave are two broad policy options for relieving some of the economic stress on families and enabling parents to spend more time with their young children, either by staying at home full- or part-time, or helping them to afford the high cost of quality out-of-home care. Given the substantial cost differential between infant and toddler care, job-protected paid leave during the critical first months is especially important—for financial reasons as well as for the well-being of parent and infant at an important developmental time. Additional strategies can be effective in helping to ensure that parents also have the support, skills, and information to better understand and meet their children's early development needs. An example of one promising support is home visitation. Research shows that home visits by a nurse, social worker, early childhood educator or other trained professional during pregnancy or in the early years of a child's life delivers substantial benefits in terms of child development and family well-being.[b]

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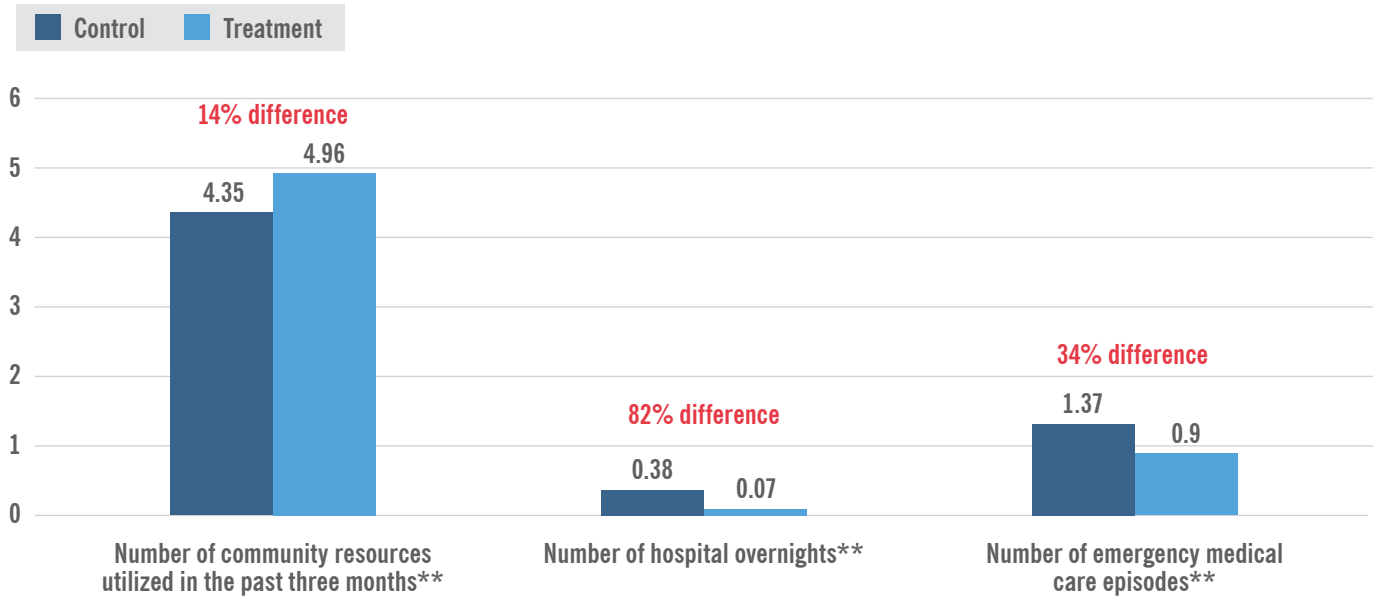
[a] Of course, many parents experience anxiety about whether they will be equipped to meet their child's changing needs well before the delivery date. But expectant parents may feel uncomfortable voicing this anxiety and may not know how and who to ask for help even if they are willing to seek it. Thus efforts to support and inform new parents are important even during pregnancy and effective interventions need not wait until after birth.

[b] According to sources cited by HHS, the evidence-based research shows that "home visiting helps prevent child abuse and neglect, supports positive parenting, improves maternal and child health, and promotes child development and school readiness. Research also shows that evidence-based home visiting can provide a positive return on investment to society through savings in public expenditures on emergency room visits, child protective services, special education, as well as increased tax revenues from parents' earnings." Source: mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf.

Figure 3. Effects of Home Visiting on Child Outcomes in the First Year of Life



Source: Dodge, Kenneth A., W. Benjamin Goodman, Robert A. Murphy, Karen O'Donnell, Jeannine Sato, and Susan Guptill. "Implementation and Randomized Controlled Trial Evaluation of Universal Postnatal Nurse Home Visiting." American Journal of Public Health (2013): E1-E8.
**Significant at the 0.01 level

The federal government currently provides grants to states to support voluntary home visits through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.[c] In FY2016, MIECHV-supported voluntary home visiting programs served 160,000 parents and children in 893 counties in every U.S. state, D.C., and five territories. Performance data from MIECHV grantees show that 98 percent of funded programs were able to document improvements in at least four of the six benchmark areas outlined in the MIECHV authorizing legislation, including maternal and newborn health; child injuries, child maltreatment and emergency-department visits; school readiness and achievement; crime or domestic violence; family economic self-sufficiency; and service coordination and referrals for other community resources and supports.

Home visiting programs are just one example of an innovative, evidence-based strategy for supporting families. Other initiatives have used pediatrician visits (e.g., HealthySteps) and other opportunities to provide support and connect families with information and resources. In Tulsa, Oklahoma, for example, the Birth through Eight Strategy for Tulsa (BEST) aims to break the intergenerational cycle of poverty by connecting families to a network of programs and services that together allow families to access a "seamless continuum of support" (see text box). Other recent initiatives are making innovative use of technology to give parents and caregivers crucial information and tools to nurture early learning and healthy brain development. These efforts should be continued and evaluated with the aim of continually expanding the toolkit of options available for supporting families with young children.

[c] Within HHS, the MIECHV Program is administered by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF).

The Birth through Eight Strategy for Tulsa (BEST)

Funded through the George Kaiser Family Foundation and Blue Meridian Partners, BEST is a comprehensive, continuous, and integrated approach to breaking the cycle of intergenerational poverty for families in Tulsa, Oklahoma. The program is building a network of services to create a continuum of support from preconception through third grade, including personalized guidance from qualified staff. BEST has outlined four main goals linked to later prosperity and life security; specifically, it aims to increase the percentage of children in Tulsa who are:

1. Born healthy;
2. Raised in safe and nurturing homes;
3. Ready to enter kindergarten; and
4. Achieving success by third grade.

BEST's preconception services will focus on reducing teen and unplanned pregnancies to improve healthy birth outcomes. Once a woman is pregnant, BEST will seek to improve use of prenatal care and parenting education. Through a navigation system known as ConnectFirst, pregnant women will receive personalized support, including engagement with physicians to ensure that they receive referrals to doctors and services. The rollout will include Bright Beginnings, an initiative through which all women who give birth in Tulsa County will receive a literary-focused baby gift from a registered nurse who also discusses positive parenting practices with them. Building on that initial visit, BEST will implement Family Connects, an evidence-based model developed at Duke University that provides families with home visits by registered nurses. Family Connects will also introduce parents to a Family Advocate and Community Connector to help them navigate and identify which early childhood and parent-engagement programs fit their needs. Another component of the program will focus on school-age children and how to develop their math, literacy, and social-emotional skills. Undergirding all stages of the program will be a focus on data collection and coordination.

Technology Helping Parents of Young Children

New public and private efforts are exploring innovative ways of applying technology to assist and empower parents and other care providers. Technologies can put the latest early childhood information directly into the hands of parents who can use these tools to understand and help support their child's development. Innovative use of technology and data can also support teacher training, more effective early childhood practices, and continuous program improvement. Several examples follow:

- Text 4 Baby is a federally funded program that is available to all pregnant and new mothers. The text-based format allows parents to receive free personalized text messages on nutrition, child development, doctor visits, and key health information throughout their pregnancy and up to their baby's first birthday.
- Vroom is a non-profit initiative designed by a group of scientists, community leaders, and families to provide parents with technology tools and worksheets to nurture brain development and learning based on children's ages and developmental phases.
- CLI Engage is a comprehensive e-learning platform in Texas that houses online professional development, child progress monitoring strategies, and classroom observation tools. The platform is available free to Texas public schools, Head Start programs and other certified early childhood providers.
- Bedtime Math includes a website and apps designed to help children learn real-life math skills in the same way they practice reading and give parents access to the tools they need to make math part of the family learning routine.

Recommendations

Increase the value of and access to the federal Child Tax Credit.

- ***Establish a young child tax credit of $1,500 per eligible child for all families with children through age 5 (for a total credit of $2,500).***
- ***Begin phasing in the credit at the first dollar earned and develop an approach that phases in the credit at a faster rate than current law.***

The young child tax credit would be in addition to the existing $1,000 child tax credit (for a total credit of $2,500 for children through the age of 5). This recommendation represents a substantial increase in federal support for young children and their families to better reflect and respond to the very high financial burden of providing care in the critical early years. It is intended to give parents greater choices when considering whether to stay in the workforce versus provide care for an infant or young child at home, and to help parents afford high-quality care, if needed, outside the home.

Under existing policy, a family whose income tax liability is less than the value of their child tax credit may be eligible for a partially refundable credit, an *additional child tax credit,* that is calculated using the earned income formula. Under this formula, a family is eligible for a refund equal to 15 percent of their earnings in excess of the $3,000 refund threshold. We recommend that the new young child tax credit be provided in addition to the existing $1,000 child tax credit, for a total tax credit of $2,500, and that the total credit not be subject to the $3,000 income threshold, meaning the credit would begin to phase in with the first dollar earned. We believe that

this approach continues to support workers while helping parents at a time when raising children is often most expensive. With respect to the phase in rate for the young child tax credit, we encourage Congress to develop an approach that phases in the credit at a faster rate than current law.

Adding a young child tax credit at the level proposed would help to address an existing disconnect between resources and needs when it comes to public investment in children. A recent issue brief by the Council of Economic Advisors (CEA) found that local, state, and federal spending to support families—including spending on child care, education, nutrition, health care, and other forms of investment—is lowest precisely when families are likely to face the greatest economic challenges in raising children. In fact, average public investment is substantially lower for children ages 3 to 5, and even lower for children ages 0 to 2, than it is for children ages 6 to 13 who have aged into the public school system where the bulk of public investment occurs. As the CEA authors point out, this means that the share of child care hours that families must finance with their own time, money, and social networks is highest when children are youngest.

In sum, this recommendation helps families and young children at a time when they are particularly vulnerable, economically and developmentally. The estimated cost would total approximately $32 billion per year. At a time when there is enormous pressure and competition for existing federal resources, this recommendation, combined with others below, is ambitious. But we believe it also reflects the level of investment that is needed to support our nation's young children.

Continue and build on effective home visiting models to provide critical support for families with infants and young children.

This recommendation includes four discrete proposals, summarized below.

- ***Reauthorize the existing Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program for five years at (at least) the current level of federal funding.*** As discussed in the previous section, MIECHV funding is being used to incentivize states, territories, and tribal entities to develop and implement evidence-based voluntary home visiting programs. The program has reached growing numbers of families in recent years: According to HHS, the reported number of children and parents served has increased nearly five-fold in 2012, and the number of home visits provided increased more than five-fold to nearly 1 million visits in FY2016, with nearly 43 percent of those served in FY2016 (a total of 69,000 families) consisting of new enrollees. While the demand for home visits nationally far outstrips available resources at present (nearly 4 million babies are born in the U.S. each year), this program is highly cost-effective, is making a meaningful difference in the lives of hundreds of thousands of families, and is providing useful evidence-based insights into the needs of families with young children and options for effectively addressing those needs.[d]

- ***Expand state and local home visiting needs assessments to focus on integrating home visiting services into the broader continuum of early childhood support services.*** MIECHV currently requires state grantees to conduct statewide assessments to identify high-needs communities, identify the capacity of existing programs for home visiting, evaluate existing capacity to provide substance use treatment, and coordinate with needs assessments and other provisions of Title V, Head Start, and the Child Abuse and Prevention Treatment Act (CAPTA). To develop new and innovative approaches that more comprehensively meet the needs of families with young children and to ensure a continuity of services beginning prenatally through school entry, the statewide assessment should require a broader

[d] HHS is currently conducting a large-scale, random assignment evaluation of the effectiveness of the MIECHV Program. Known as the Mother and Infant Home Visiting Program Evaluation (MIHOPE), this evaluation will use scientifically rigorous research methods to estimate the effects of home visiting on a wide range of outcomes, study variations in program design, and conduct a cost analysis. In addition, according to HHS, "MIHOPE will examine what components of home visiting programs work, for whom, and why, to provide all programs and models with information they can use to promote even greater positive outcomes for families."
Source: mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf.

assessment of the current capacity and gaps for *all* birth-to-5 needs and services. While home visiting is one successful strategy for meeting the needs of children and families, there are other important opportunities for delivering core early childhood services that should be considered in building a strong continuum of supports and services (for example, expanded service delivery at pediatric well baby visits and programs offered at community-based organizations and local health clinics).

- ***HHS should work with states to innovate and support promising program models that add to the evidence base for home visiting interventions.*** MIECHV provides grants for a number of evidence-based home visiting interventions that are critical for ensuring that federal funds are used to support programs that have been proven to improve outcomes for young children and their families. At the same time, the MIECHV program should also do more to incentivize local communities to identify and rigorously evaluate new and promising models for delivering high-quality, cost-effective early childhood services. A balanced approach that both requires a strong evidence base and creates a pathway for new and upcoming programs to prove their effectiveness will not only expand the quality of existing home visiting models (e.g., improve capacity to meet the needs of families with substance use disorders), it will also help seed other successful delivery models that can be better customized to meet local community needs.

- ***HHS should complete and follow up on the Home Visiting Career Trajectories Project, which is focused on how to build career pathways for home visiting professionals.*** The goal of the Home Visiting Career Trajectories Project is to examine the state of home visiting careers with a view to understanding how people enter the field, perceived and actual pathways for professional advancement and tenure, and reasons for field attrition. By addressing the paucity of data on the home visiting workforce, the hope is to better understand how high-quality staff can be recruited and retained. The project is designed to provide two specific types of information: (1) information about the state of the home visiting sector and the career trajectories of home visitors, along with recommended strategies for building a pipeline of well-qualified home visit professionals and supervisors; and (2) information about the professional development system that supports home visits to families with young children, including through training and technical assistance.

Encourage further innovation, both in developing a broader array of effective, evidence-based strategies for supporting families with young children and in unlocking resources for implementing these strategies.

This recommendation includes two discrete proposals, summarized below.

- ***Establish a national advisory committee to identify strategies to expand public and private insurance coverage for home visiting and other innovative family support interventions.*** Voluntary home visiting services delivered through MIECHV and other programs such as Healthy Steps (which is focused on leveraging regular well-child visits with the pediatrician) are just two examples of evidence-based interventions that deliver early childhood support services in innovative and cost-effective ways, but these and other programs do not currently meet the high level of need. To truly scale up programs and to sustain them over time, such interventions and supports will need to be covered by health insurers. To begin these important conversations, we recommend that HHS convene a national advisory committee consisting of leaders from the Centers for Medicare and Medicaid Services (CMS), private insurers, early childhood programs, health care policy and program experts, and representatives from national, state, and local service delivery models such as the Nurse-Family Partnership, Durham Connects, Healthy Steps and others with expertise in this arena. The goals of the committee would be to help expand access to family support models like home visiting, pediatric well-visit interventions, and other effective programs; identify strategies to scale these supports to serve more children and families; demonstrate the long-term cost savings of these types of interventions; and identify ways to leverage public and private health insurance dollars and philanthropic sources to support the committee's policy recommendations.

- ***The Innovation Center at HHS, in coordination with the Department of Education, should test innovative models of care that include "school readiness" as a quality measure.*** The Center for Medicare and Medicaid Innovation (Innovation Center) has authority to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. CMS has expressed interest in innovative pediatric models of care focused on improving the health of children covered by Medicaid and CHIP through state-driven integration of health care and health-related social services. This recommendation would encourage the Innovation Center to work with states to develop models of care that include social supports for both parents and children that better prepare children for school and include "school readiness" as a quality measure within the integrated care model. Models of care would be evaluated based on improvement in health outcomes, with readiness as an outcomes measure. CMS should coordinate with the Department of Education in approving appropriate evidence-based metrics for school-readiness.

By way of example, New York is testing a pilot program that bridges the health and education silos by requiring routine assessment of children's developmental progress in the pediatrician's office. The goal is to reward pediatricians with higher Medicaid payments if their patients enter kindergarten healthy and ready to learn.

Develop and adopt a new, national policy on paid leave.

As noted in the previous section, the vast majority of working Americans do not receive paid leave to care for a newborn or even a critically ill child. The only existing federal policy in this area, the Family and Medical Leave Act (FMLA), applies to fewer than 60 percent of U.S. workers and provides only unpaid, job-protected leave. Unfortunately, many people who are eligible for maternity or paternity leave under FMLA can't afford to take it.

Recently, interest in paid leave programs has grown, within the business community as well as among states and cities (as of this writing, five states—California, New Jersey, New York, Washington, and Rhode Island and the District of Columbia—have adopted paid leave policies). These policies range from four to twelve weeks for family, parental, and medical leave for employees who have established a base level of earnings. Some programs are financed by the employee, some by the employer, and some are funded jointly. Since the mid-2000s, Democrats have championed a national paid family and medical leave policy in some form or other. Republicans have long opposed a government mandate requiring paid leave, instead supporting tax and other incentives for employers who voluntarily offer paid and unpaid leave to their employees as well as some other workplace flexibility options. In addition to an increasing number of notable companies designing voluntary leave packages for their employees, a number of large, multi-state companies and small businesses also recently expressed support for the FAMILY Act, a national paid family and medical leave plan supported by a diverse cross-section of Democrats and Independents in Congress. President Trump's promotion of paid parental leave ideas during the 2016 election campaign and in the administration's FY2018 budget has expanded the space to have a bipartisan conversation about the need for new federal policy in this area.

We agree that men and women need to time to care for newborns, adopted and/or foster children. We also agree that any paid leave policy should be designed to work for low- and middle-income workers who are less likely to be covered by employer-provided benefits. We endorse the concept of a national paid leave policy but stop short of endorsing the specific scope or other details of a new policy.

While we agree on the need to provide paid parental leave to mothers and fathers, we disagree on whether Congress should consider paid parental leave apart from paid medical leave. A more detailed elaboration of our individual views on this issue can be found in the Appendix. More broadly, we look forward to working with Congress and stakeholders to explore paid leave policies that support the needs of working families as they endeavor to promote their children's early development, while also supporting the needs of businesses.

Making Child Care Affordable for Families

The cost of child care has emerged as a major challenge for millions of American families as rapid changes in family structure have coincided with profound shifts in the economy and in the U.S. labor market. Women, who have always taken primary responsibility for caring for young children, now account for nearly half (47 percent) of the nation's workforce.[26] Among mothers with preschool-aged children, 64 percent are in the workforce and among working moms, about three-fourths are employed full time.[27] One result of these trends, as previously noted, is that today more than two-thirds of American children under the age of 5 are growing up in households where all resident parents are in the workforce. At the same time, more than 35 percent of all American children under the age of 18 live with a single parent—usually the mother.

For many working families, child care is not a luxury, it is a basic necessity—and often an expensive one. In fact, in families with young children, child care costs are often one of the largest items in the household budget. Average costs for child care now exceed average housing costs in 24 states and average college tuition costs in 30 states; they exceed transportation and food costs across all regions of the U.S.[28] Child care costs, like housing and other living costs, vary widely around the country, but one recent analysis finds that the cost of center-based care for a single infant exceeds 12 percent of the median income for a married couple in 22 states and the District of Columbia (it exceeds 10 percent of median income for a married couple in another 18 states).[29] Another study that analyzed family budgets for 10 metro areas in different parts of the country found that typical child care costs for an infant and a 4-year old averaged between 20 and 30 percent of the total household budget required to "secure a modest yet adequate standard of living" for a two-parent, two-child family in these areas.[30]

These findings reflect an untenable situation in which the total cost of child care can easily exceed a family's ability to pay, putting pressure on the family's financial stability, and often requiring families to sacrifice quality or even child safety to make ends meet. In one recent survey of more than 1,000 parents nationwide, nearly one in three families (32 percent) reported spending 20 percent or more of their household income on child care. Nearly two out of three parents surveyed (63 percent) said that child care costs influenced their career decisions; approximately 30 percent said they changed jobs or asked for a more flexible work schedule, and

more than 20 percent switched to part time or left the workforce to save money on child care. Finally, among working parents, large majorities reported having to use sick days or being late to work to cover child care needs.[31] These findings help explain the business community's growing interest in affordable child care as an issue with direct implications for labor force participation and worker productivity.

Child care, particularly for infants and young children, is costly in large part because it is inherently labor intensive: High-quality care requires low child-to-caregiver ratios, which translates to high staffing demands. According to one analysis, up to 80 percent of child care business expenses are for payroll and related expenditures.[32] Affordability concerns can also complicate efforts to improve child care quality through, for example, policies to boost pay for child care workers and to increase workforce training and qualifications. Thus, the interaction of affordability and quality presents a critical policy challenge, as high-quality child care in the early years is essential for children's healthy development and poor-quality care has been shown to be damaging to early development.[33] (The importance of child care quality and related policy options are discussed at greater length in the next section.) Though parents express a high level of concern about the quality of the care their children receive outside the home, studies find that other considerations—notably cost, but also convenience and hours—often play a larger role in the selection of child care providers.[34] In sum, many parents, especially those struggling to make ends meet through a patchwork of part-time and/or low-wage jobs, simply don't have the luxury of prioritizing quality or in some cases safety in their child care arrangements.

The federal government currently provides assistance with child care expenses through two primary mechanisms: (1) The Child Care and Development Block Grant (CCDBG), which provides grants to states, primarily for vouchers that help families afford and access child care, and (2) the tax code, in the form of the child and dependent care tax credit (CDCTC) and flexible savings accounts (FSAs) that allow employees of participating employers to set aside part of their income, free of income and payroll taxes, for child care expenses. A brief overview of these programs follows.

Funding under CCDBG, both mandatory and discretionary, is combined at the federal level in the Child Care Development Fund (CCDF). At the state level, other funds are added, including the required state match, funds transferred from the Temporary Assistance for Needy Families (TANF) program, and other state resources. These funds are used to help low-income families cover child care expenses for children under the age of 13.[e] Typically, CCDF funds are distributed in the form of vouchers that families can use with the provider of their choice, whether a relative, family child care provider, child care center, or after-school program.

Under the requirements of CCDBG, states have significant flexibility to determine who is eligible for child care assistance and what rates the state will pay for care. When setting eligibility caps, states may restrict or expand who is eligible as long as recipients do not exceed 85 percent of state median income for a family of the same size. Many states choose to restrict eligibility to much lower income levels to avoid long waiting lists. In addition, states have flexibility in setting reimbursement rates for child care providers. CCDBG requires states to certify that these rates are sufficient to ensure that eligible children have equal access to child care that is comparable to the child care available to children who are not eligible. However, recent data indicate that very few states are setting their reimbursement rates at levels sufficient to ensure equal access.[35]

More broadly, the funds available through the CCDF are not adequate to meet the need for assistance, given the high burden of child care expenses. As a result, these funds reach only a fraction of lower-income families, and even fewer middle-income families, who need help. According to a December 2016 report by the

[e] The term "Child Care Development Fund" is not established by statute, rather the term was coined in regulation by HHS. Funds that are added to CCDBG funds include state "maintenance of effort" and matching funds, and funds authorized under sections of the Social Security and TANF programs. As noted in the main text, CCDBG funding includes both mandatory (entitlement) funding and discretionary funding that is subject to annual appropriations. For a fuller discussion of the CCDF, CCDBG, and TANF programs and the interaction between them see: fas.org/sgp/crs/misc/R44528.pdf.

Government Accountability Office (GAO), 11 percent of children who are eligible for child care assistance under federal rules received it. A preliminary analysis of the use of CCDF funds in FY2015 found that approximately 1.4 million children in 847,400 families received child care assistance in an average month during that year.[36] Of the families served, nearly half earned below the federal poverty level of $20,090 household income for a family of three. Another 27 percent of families who received assistance had incomes between 100 and 150 percent of the federal poverty level. Of the children who received child care subsidies, more than half (54 percent) were below the age of 5. CCDF subsidies were used to cover care from a variety of types of providers, but the vast majority of children who received subsidies (nearly 90 percent), were cared for in a regulated setting—most commonly a child care center (73 percent) or family child care home (23 percent). As the HHS Office of Child Care points out, however, "States have a great deal of flexibility to establish child care subsidy policies to meet their needs. Thus, national data on the characteristics of families served masks a large degree of variation across individual States."[37]

Comprehensive data on overall state and federal spending to subsidize child care for low-income families are difficult to compile given the different funding streams involved, but a 2016 analysis of CCDF funding by the Congressional Research Service estimated total expenditures of $8.6 billion in FY2012, the most recent year for which complete data were available at the time. In the same fiscal year, states spent an additional $2.8 billion in TANF-direct child care expenditures that were not subject to CCDBG rules. Looking at the 12-year period from FY2000 to FY2012, the same analysis concluded that total combined CCDF and TANF spending on child care (federal and state) increased by 12 percent in nominal dollars but decreased by 17 percent in constant dollars (i.e., dollars adjusted for inflation). Federal spending accounted for roughly 70 percent of all expenditures, with state contributions making up the remaining roughly 30 percent.[38]

The other major federal source of financial support specifically targeted to child care expenses is the CDCTC, which provides an income tax credit worth between 20 and 35 percent of child care costs up to $3,000 for a child under age 13.[f] Eligible child care expenses are limited to $6,000 per family.[g] However, the credit is nonrefundable, which means it can only be used to offset income taxes owed (any amount in excess of income taxes owed is forfeited). In other words, consider a family that, based on its income and eligible child care expenses, is entitled to a $2,000 dependent care tax credit. If the family owes only $1,000 in federal income taxes, it can use only $1,000 of the credit; the remaining $1,000 is forfeited. For this reason, the CDCTC generally does not benefit low-income families who owe little or no income tax. Families where only one household partner works or goes to school are also ineligible to claim the credit.

An analysis by the Urban-Brookings Tax Policy Center estimated that approximately 12.7 percent of American families with children benefited from the CDCTC in 2016. For those who benefited, the average income tax reduction totaled $551—roughly the same across all income categories, except for families in the lowest quintile (20 percent) of the income distribution. These families, as already noted, generally do not benefit at all because they owe little income tax and the credit is nonrefundable.[39] Finally, it is worth noting that the CDCTC is not indexed to inflation, thus its value erodes over time.[40]

Recommendations

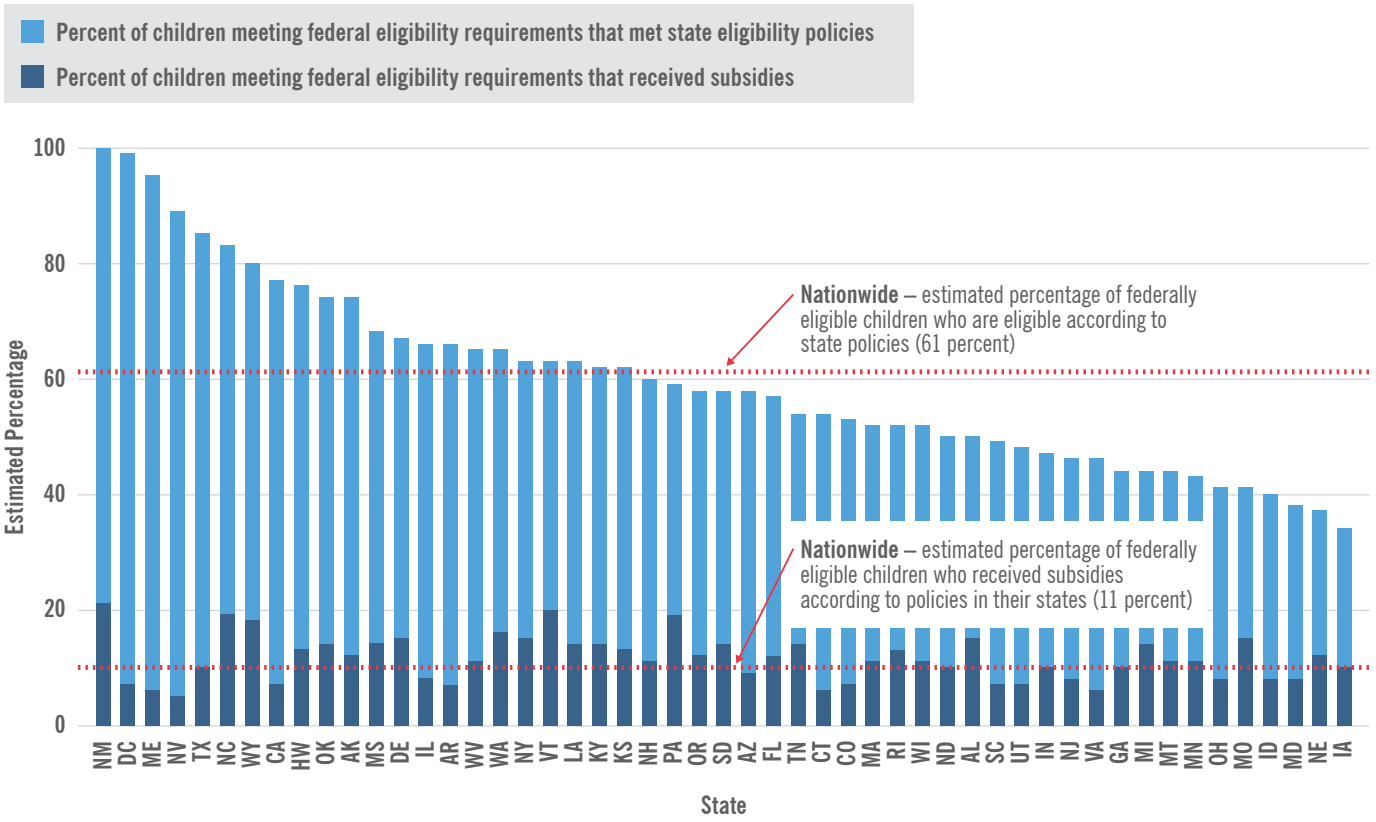
Double federal Child Care and Development Block Grant funding for children ages 0 to 5.

The CCDBG program is the largest direct source of federal support for families who need child care for their young children. But because the overall level of funding for this program is insufficient, it is reaching only a small fraction of the families who qualify for it.[41] Expanding CCDBG resources is an effective and efficient

[f] Besides children under age 13, the credit is also available for other dependents who are physically or mentally incapable of self care.

[g] The amount of available credit varies with household adjusted gross income (AGI), such that only families with incomes below $15,000 qualify for the full 35 percent credit. The rate falls by 1 percentage point for each additional $2,000 of income, or part thereof, until it reaches 20 percent for families with AGI of $43,000 or more.

Figure 4. Percentage of Children Eligible for Federal Child Care Subsides Who Also Qualify Under State Policies and Receive Assistance



Source: GAO Analysis of Urban Institute Transfer Income Model, version 3 data in Department of Health and Human Services (HHS) *Estimates of Child Care Eligibility and Receipt for Fiscal Year 2012,* page 13 and of HHS data.

mechanism for ensuring that scarce federal resources are delivered directly to families who need it most. States' existing CCDBG systems are relatively cost-efficient in funding parents directly; allow assistance to be distributed monthly, when parents need it most; and allow parents to choose from a variety of caregiver arrangements (center-based, family homes, or "family friend and neighbor" care). Additional funding would help to address the current mismatch between available resources and need. Looking at nationwide data for an average month in 2011–2012, the GAO found that about 1.5 million children received CCDF subsidies, whereas about 8.6 million children under 13 would be estimated to qualify for support. Given that the CCDF funds available fell considerably short of the estimated need, child care officials interviewed by the GAO reported using wait lists and other strategies to manage caseloads. In some cases, states stopped taking applications from all or some types of eligible families, or lowered the income threshold for eligibility.[42] Figure 4 illustrates both the effect of stricter state policies and the overall inadequacy of CCDF resources relative to need. For example, it shows that in some states, fewer than half of the children who would be considered eligible according to federal guidelines qualify for assistance under state rules. And across all states, CCDF funds are reaching only a fraction—typically between 5 and 20 percent—of all children who meet federal guidelines for assistance.

Our recommendation to double federal CCDBG funding for children under 5 would allow states to serve a larger number of children and families (we estimate that an additional 364,800 families with

children under 5 could be served).[h] Specific impacts would vary from state to state because of the variation in population and child care costs across different regions. The cost estimate for this recommendation is approximately $4 billion per year.[i] We also recommend that states be required to provide the expanded resources at a 75 percent reimbursement rate so that parents have a greater ability to access higher-quality child care. This portion of the recommendation is discussed in greater detail in the next section.

Increase the value of and access to the federal Child and Dependent Care Tax Credit.

- ***Double the amount of child care expenses eligible for the credit from $3,000 to $6,000 for one child (0 to 5) and from $6,000 to $12,000 for two or more children (0 to 5).***
- ***Make the credit fully refundable.***

These recommendations would substantially increase the value of the CDCTC, particularly to low-income families who are especially burdened by high child care costs. As noted in the discussion, these costs—particularly for infants and for children under the age of 5—are much higher than the current per-child and per-family limits on eligible expenses reflect. Moreover, many low-income households don't qualify for the tax credit because they pay low or no income taxes. For example, a single-parent household with a full-time minimum wage worker would be ineligible for the credit as it is structured now. And even among those households that do receive the credit, the average benefit is on the order of $500 per year, a modest sum relative to typical child care costs for young children in most parts of the country. Doubling the limit on eligible expenses would better reflect the financial realities of providing child care for most families, while making the credit fully refundable—similar to the earned income tax credit—would more efficiently direct scarce resources to working families who need help with child care costs. The cost estimate for this recommendation is approximately $1.5 billion per year.

[h] To estimate the cost and impacts of this recommendation, we began by estimating the fraction of current CCDBG funding that goes to children ages 0 to 5 based on the 0-to-5 age group as a share of all children served by the program. (Note that this calculation is likely to somewhat *understate* the actual share of CCDBG funds that goes to children under the age of 5, since child care costs are relatively higher for younger children.) This approach yields an estimate of $4 billion in current federal CCDBG funding for children ages 0 to 5. To estimate how many *additional* children could be served by doubling this level of funding, we applied a 75 percent provider reimbursement rate—consistent with our recommendation (discussed in the section headed Addressing Early Care Workforce Quality) to address quality concerns—to the $4 billion in new funding that we are recommending.

[i] See footnote h.

Prioritizing Early Care Workforce Quality

As discussed in previous sections, research and brain science has made a compelling case for the significance of children's earliest years in terms of providing the foundation for their development and success over the rest of their lives. The fact that children begin learning at birth, or even before, places great responsibility on the adults who shape their early experiences. A skilled and competent early childhood workforce is essential for child care, home visiting, pre-K, and other early childhood programs to provide young children with the care and support they need.

A 2009 report by the National Scientific Council on the Developing Child highlights the critical importance of adult-child relationships:

> *Young children experience their world as an environment of relationships and these relationships affect virtually all aspects of their development—intellectual, social, emotional, physical, behavioral, and moral. The quality and stability of a child's human relationships in the early years lay the foundation for a wide range of later developmental outcomes that really matter—self-confidence and sound mental health, motivation to learn, achievement in school and later in life, the ability to control aggressive impulses and resolve conflict in non-violent ways, knowing the difference between right and wrong, having the capacity to develop and sustain casual friendships and intimate relationships, and ultimately to be a successful parent oneself.*[43]

The parent-child relationship is obviously foundational, but for children who spend significant amounts of time being cared for by adults other than their parents, the quality of their interactions with these adults also matters a great deal. More broadly, child care programs and other programs designed for young children must provide high-quality learning environments, as less supportive environments can result in major missed opportunities for healthy growth and development and, in some cases, can even be harmful.[44] There are many components to the delivery of high-quality early learning programs, but a competent and skilled workforce is essential. Consistency and stability also matter: Children need sustained exposure to high-quality environments and stable relationships with caring and supportive adults.[45]

Given that more than half of American children under age 5 spend more than 36 hours per week, on average, in child care settings outside the home, high-quality child care is critical to strong early childhood outcomes. An influential 1999 study that explored the connections between child care cost, quality, and child-development outcomes found clear correlations, not only between child care quality and basic cognitive skills (language and math), but also in terms of critical social skills, which likewise have a large impact on children's later ability to take advantage of the opportunities available in school.[46] Specifically, children who were exposed to higher-quality classroom practices (75th percentile of quality scores) had better language and math skills, while children with closer teacher-child relationships in child care exhibited better classroom social and thinking skills, language skills, and math skills. Importantly, these benefits lasted from the preschool years into the elementary school years.[47]

An important corollary finding from this research is that children who have traditionally been at risk of not doing well in school are especially sensitive to the quality of the child care they receive in their early years. As measured by outcomes such as math skills and problem behaviors, children whose mothers had lower levels of education were more sensitive to the negative effects of poor-quality child care but received more benefits from high-quality child care compared with children whose mothers had higher levels of education.[48]

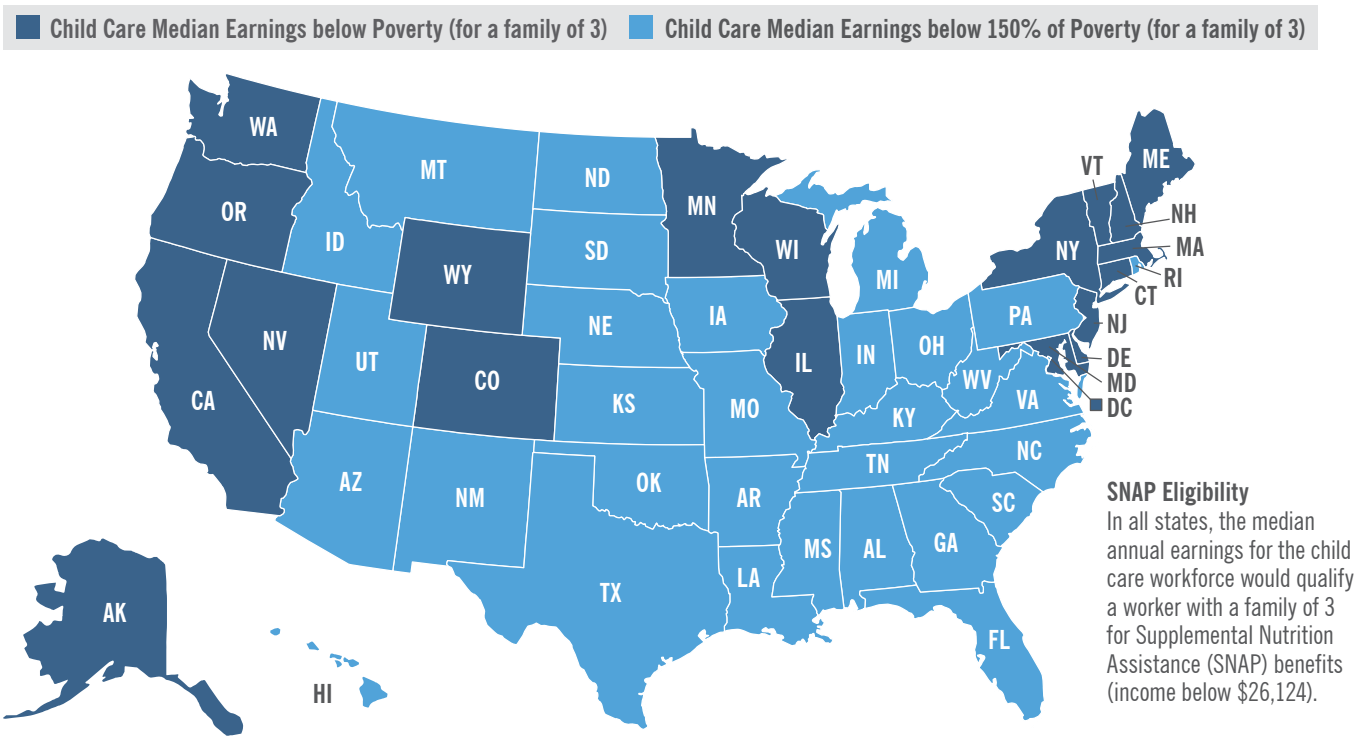
The skill and competence of caregivers and educators are clearly key determinants of the overall quality of child care. As one study observed, "The essence of quality in early childhood services is embodied in the expertise, skills, and relationship-building capacities of their staff."[49] The skilled individuals who could offer these capacities and provide the best early learning environment for young children, however, are unlikely to be attracted to work in the child care field if it does not offer financial security, employment stability, and job satisfaction.

Historically, however, caring for infants, toddlers, and preschool-age children has not been viewed as a promising, well-remunerated career path—the job requires little training and because the pay is low, child care positions tend to have high turnover. Studies of this issue have found that early childhood educators are among the most poorly paid professionals, earning much less than kindergarten or elementary school teachers, on average.[50] According to one study, even relatively well-paid pre-K teachers in school-sponsored settings with bachelor's degrees earn, on average, only 80 percent of the compensation of comparably educated kindergarten teachers, while in community-based public pre-K and Head Start programs, teachers with bachelor's degrees earn only two-thirds of what kindergarten teachers earn.[51] Private child care workers earn even less than public pre-K teachers: Their wages often fall below poverty guidelines and below that of workers whose jobs involve taking care of animals or cooking for fast food establishments.[52] Almost half of child care workers were themselves part of households enrolled in at least one of the following public support programs: the federal Earned Income Tax Credit, Medicaid, the Children's Health Insurance Program, the Supplemental Nutrition Assistance Program, and Temporary Assistance for Needy Families.[53] Relative to teaching older children, child care is also perceived as having other disadvantages in terms of length of the work year, benefits, and hours of work."[54]

The need for attention to workforce quality in the field of early child care is well summarized in a 2015 report by the National Academy of Sciences (NAS):

> *The science of child development and early learning makes it clear how important and complex it is to work with children from infancy through the early elementary years. Yet despite their shared objective of nurturing and securing the future success of young children, those who provide for the care and education of children from birth through age 8 are not acknowledged as a cohesive workforce, unified by the shared knowledge and competencies needed to do their jobs well. Expectations for these professionals often have not kept pace with what the science indicates children need, and many current policies do not place enough value on the significant contributions these professionals make to children's long-term success.*[55]

Figure 5. Child Care Workforce Median Annual Earnings Relative to Poverty Level



Source: Bureau of Labor Statistics. 2015.

As the NAS report further observed, the highly diverse and decentralized provision of early child care services makes it difficult to address workforce challenges in a systematic or coordinated way. Variable and often unpredictable funding streams and separation between preprimary and elementary educators exacerbates these challenges, leading to wide variation in training and quality, and a distinct hierarchy of educators at different levels.[56] These findings are borne out by an earlier study of the child care workforce in California, which found large variation in the educational profile of care providers, high turnover, and a substantial earnings gap between early childhood and kindergarten teachers.[57] Nonetheless, the NAS concluded that efforts to improve higher education and ongoing professional learning for child care workers, strengthen qualification requirements, and promote evaluation "aimed at continuously improving professional practices" could provide a foundation for higher workforce quality and better child care environments—with commensurate benefits in terms of early child development outcomes.[58]

Our recommendations on workforce quality, summarized in the next section, focus on creating stronger incentives for quality child care while simultaneously improving career options, developing alternative career pathways and credentials, and strengthening education and training—including through skill-based learning and apprenticeship models—for early child care professionals. Many of these recommendations echo proposals that have circulated for some time, including ideas put forward in the 1999 *Cost, Quality and Child Outcomes* report, which proposed redesigning child care subsidy systems to provide incentives for providing high-quality care and using tax incentives to encourage higher-quality care and education, and improving training for teachers who work in early care and education settings.[59] We urge continued congressional attention to these issues and support for continued innovation in this area more broadly, including support for state efforts to promote quality improvements in early child care staffing and services (see text box).

State Efforts to Improve School Readiness

Several states are using tax policy to support families with young children and promote improvements in the quality of early child care and education at the state level. Two such efforts, being undertaken by Louisiana and Nebraska, specifically focus credits toward improving school readiness.

Louisiana School Readiness Tax Credits: Louisiana's program provides four different tax credits to parents, child care providers, child care directors and staff, and businesses that support child care centers participating in the state's quality rating and improvement system (QRIS). The program is designed to incentivize early child providers to participate in QRIS and to encourage parents to use it to guide their child care decisions. Eligibility for the tax credits, which are relatively valuable, is tied to QRIS ratings. For example, families with a child under 6 years old enrolled in child care receive a tax credit provided the child care center receives a rating of at least two stars (the tax credit increases with higher QRIS ratings). Similarly, child care centers that participate in the QRIS receive a tax credit worth between $750 and $1,500 per eligible child depending on their star rating, while teachers and directors who work for a QRIS-participating center can qualify for a credit between $1,658 and $3,315 based on their level of education. More information at: http://www.policyinstitutela.org/school-tax-credits.

Nebraska School Readiness Tax Credits: Beginning in the 2017 tax year, Nebraska is offering two tax credits totaling up to $5 million per year for early childhood programs and qualified early childhood professionals participating in the state's Step Up to Quality program.[60] Eligible early childhood programs will receive a non-refundable credit of up to $750 per child served based on a five-step program rating. Eligible early childhood professionals will be able to claim refundable credits ranging from $500 to $1500 based on their education levels, training, and work histories.[61]

Other state initiatives include **Oregon's Child Care Contributions Tax Credit**, which is designed to encourage individual and corporate taxpayers to donate to projects that improve the quality of the state's early childhood system and **Pennsylvania's Educational Improvement Tax Credit**, which provides tax credits to businesses that donate to scholarship funds. Contributions under the Oregon program are placed in a pooled fund that supports community-based efforts to enhance provider compensation, strengthen subsidies for low-income families, and improve the quality of care.

Recommendations

Require states to provide expanded CCDBG resources at a 75 percent reimbursement rate.

As described earlier, we recommend doubling CCDBG funding for children 0 to 5. We also recommend that states provide these expanded funds at a much higher reimbursement rate. This reform is essential for parents to have true choice in finding high-quality child care. HHS, through multiple administrations, has recommended that states set their child care provider reimbursement rates at 75 percent of the market rate. In 2014, only two states set their rates at this level and most states set them substanitally lower.[62] When reimbursement rates are set lower than the cost of high-quality care, providers are unable to provide high-quality programs or to accept children with CCDBG assistance into their programs. Persistently low wages for child care work undermine providers' ability to hire and retain competent and skilled staff, and reliance on inadequate subsidies and parent fees makes it difficult to deliver higher wages and professional development. Nearly half of child care workers are themselves dependent on some form of public assistance because their wages are so low.[63] Raising CCDBG reimbursement rates is central to providing high-quality care for young children and for ensuring that parents have true choice in selecting care settings for their children. Applying the higher reimbursement requirement to the new funds we propose is an important first step toward providing the resources needed to support a more skilled and competent child care workforce.

Create a new, competitive grant program to encourage states to design state-level tax programs that increase access to high-quality early childhood programs for kids ages 0 to 5.

The program would use new federal discretionary child care funds authorized by the CCDBG Act to allow up to 10 states to implement a package of tax credits designed to increase access to high-quality child care programs, modeled after the Nebraska and Louisiana school readiness tax credits. The state-designed program would need to include tax credits that support higher workforce quality. Participating states would have to provide a 50 percent match. The estimated cost of this proposal is $150 million per year, limited to five years.

The goal of this recommendation is to encourage states to leverage federal dollars to create incentives for improvements in the quality of child care programs, while simultaneously addressing issues of access and affordability for families.

The Department of Education should ensure that early childhood workers have access to Pell grants and other forms of tuition assistance for higher education.

The relatively low pay earned by caregivers, directors, administrators, and teachers of preschool-age children makes it difficult for individuals interested in this career path to attend college. As a result, the early child care workforce often lacks the knowledge needed to implement successful programs. Encouraging the Department of Education to prioritize early childhood teachers for grants and scholarships could help support a higher-quality workforce.

The Department of Labor should prioritize the development of a child care apprenticeship program that focuses on improving the competency of child care managers and directors.

There is a growing body of research that calls for the child care workforce to demonstrate both knowledge as well as competency (skill) in working with young children. More specifically, those who manage child care programs often have little training or experience in business and human resource management, which are necessary skills for efficient high-quality program administration. Apprenticeships can provide a combination of on-the-job-training with related instruction. The Department of Labor supports a program under which apprenticeship programs that meet certain

standards are registered with state and federal government agencies. These apprenticeships ensure that those participating, the program sponsors and the public have a clear understanding of the training content and the measures that are in place to ensure ongoing quality. Furthermore, the 2014 Workforce and Innovation Opportunity Act defined specific career pathways and supported the concept of apprenticeships. These apprenticeships can provide a pathway for child care directors and managers to obtain higher skill levels in the areas of business and human resource management while maintaining an adequate income.

Encourage states to establish minimum levels of training and competencies for their child care workforce and improve professional development systems for the child care workforce in ways that have been shown to impact child outcomes.

Seventeen states do not even require a high school diploma for lead teachers in child care centers, only 18 states and the District of Columbia require more than a high school diploma, and only one state requires a bachelor's degree for directors of child care programs.[64] As a result, many child care providers lack the knowledge and skills (competency) or programmatic support to successfully implement high-quality early learning programs that support strong and healthy early childhood development. The report issued by the National Academy of Sciences in 2015 highlights the importance of both knowledge and competency in the early child care workforce as critical to successful early learning. Targeted professional development, such as supportive coaching models for teachers, can improve program quality and child outcomes but may be difficult to implement when programs have to rely on parent fees. Relevant education, experience, and specialized training is also especially important for directors and administrators of early child care programs, given their critical role in attracting and retaining effective staff, promoting ongoing quality improvements, and overseeing other key aspects of program operation.[65]

In sum, improving the competency and management skills of directors and establishing minimum levels of training and competency for child care workers while also improving professional development opportunities are important components of an effective strategy for improving the quality of child care services.

Pre-K and Head Start

Although this Initiative focused primarily on parent supports and child care, we would be remiss if we did not acknowledge the significant role of the federal government in supporting opportunities for high-quality pre-K as well as states' growing commitment to pre-K. In the years since its inception, Head Start has served over 34 million children and families living in poverty. At present, about 1 million children and families are served each year by Head Start, including Early Head Start, which serves children from birth to age 3. In 2014, Congress also began funding Preschool Development Grants, which are competitive grants to states to support their development or expansion of high quality pre-K programs for 4-year-olds from families with incomes under 200 percent of the poverty level.

Head Start has long been a leader in supporting the early development of vulnerable children and is often considered the gold standard for other early care and learning programs. However, as with any program, Head Start continues to work to ensure improvement, relevance, and effectiveness as a recipient of scarce federal resources and as a partner in some of the nation's poorest communities. As part of its reauthorization of the program in 2007, Congress directed HHS to introduce competition in the Head Start grant process in an effort to improve program quality; Congress also directed HHS to update program standards and apply science-based education standards. These reforms were important to ensure the continued program improvement of Head Start. We encourage HHS to study results and impacts from the initial phase-in of these changes and to continue to explore strategies for promoting continuous quality improvement, strengthening outcomes for children and families in Head Start, and aligning Head Start delivery with other state early childhood programs. We also encourage HHS and the Institute for Educational Sciences to fund research projects that help inform implementation of high-quality early learning programs that yield strong outcomes for young children.

From 2014 to 2017, Congress provided $1 billion in Preschool Development Grants for states to expand or develop their high-quality pre-K programs. This funding was intended to supplement the large increases in investments states had made over the prior decade in their own pre-K programs. Despite this significant investment, only 32 percent of 4-year-olds were being served by state pre-K programs by 2016.[66] Congress directed these grants to prioritize both quality and better access. Congress further signaled the connection between pre-K and achievement in elementary and secondary education by including authorization for Preschool Development Grants in the Every Student Succeeds Act, which passed with bipartisan support in 2015. Recent congressional appropriations reflect continued support for these efforts. We encourage the relevant federal agencies to work closely with states to ensure that Preschool Development Grant resources are being effectively used to support high-quality pre-K programs that meet the local needs of children and families.

Addressing the Impact of Opioid and Substance Use Disorders on Young Children and Families

Children have always been among those most directly affected by adult substance use disorders. When parents are unable to provide a safe, loving, and stable home environment, children are the first to feel the effects, often in ways that cast a long shadow over their own adult lives. That parental impairment—whether due to mental illness, alcohol, or other substance use disorders—has adverse impacts on early childhood development is not news, of course. But the recent, explosive increase in opioid abuse in America means we must refocus attention and efforts, not only on the adults who are struggling with opioid use and addiction, but on the epidemic's extensive and potentially long-lasting impacts on children.[j]

Impacts on children have, to date, received too little attention in the policy debate about how to address the current opioid crisis. But the urgency is difficult to overstate. The harm being done to children occurs both through prenatal exposure in cases where mothers misuse opioids or other drugs[k] during pregnancy, but also—and perhaps more importantly—as a result of growing up in families affected by substance use disorders. Helping children and parents access effective treatment and the full range of supports they need is critical to enable children to experience healthy early development and to increase families' ability to stay together and out of the child welfare system.

Current data on the impact of the opioid crisis on America's children are difficult to assemble given that the epidemic itself is unfolding so rapidly. According to one source, both the quantity of prescription opioids sold and the number of deaths from prescription opioid overdoses have nearly quadrupled in the United States since 1999. In 2015, the number of people who misused or

[j] At the same time, it is important not to lose sight of regional patterns of drug use around the country and the impact of substances other than opioids. For example, methamphetamine use continues to be a significant problem in communities in the western United States.

[k] Though not the subject of this discussion, it should be noted that excessive alcohol use during pregnancy can also be very damaging; in fact, fetal alcohol syndrome has been linked to permanent adverse effects on cognitive function. Given that exposure to alcohol during pregnancy remains a significant problem nationally, it is important to remember that the prevalence and impacts of exposure to alcohol are even greater than for opioids. See, for example: pubs.niaaa.nhi.gov/publications/fasdfactsheet/fasd.pdf.

had an opioid use disorder (including prescription opioids[l] and illicit opioids, such as heroin and fentanyl) was estimated at more than 2.5 million. This is only a fraction of the estimated 20.5 million Americans 12 years or older estimated to have a substance use disorder in 2015.[67] But opioids have emerged as a particularly deadly form of substance abuse, and one result of the current epidemic has been a dramatic rise in deaths from drug overdose.[68] In fact, the estimated death toll from drug overdoses in America in 2016 was 64,000, up 20 percent in just one year from the record-setting 52,400 overdose deaths recorded in 2015, and more than double the number of overdose deaths in 2005.[69] Among overdose deaths, nearly two-thirds involved prescription opioids, heroin, and synthetic opioids such as fentanyl.[m] As a result of these trends, drug overdose is now the nation's leading cause of accidental death, claiming the lives of 175 Americans every day, on average (based on figures for 2016) and substantially exceeding deaths from motor vehicle crashes (approximately 40,000 in 2016).

More adults affected by substance use disorders translates to more children at risk. According to the National Survey on Drug Use and Health, in each of the years between 2002 and 2007, an estimated 2.2 million American children under the age of 18 lived with a parent who was dependent on or used illicit drugs (the survey did not provide a specific estimate for opioid use).[n] Given the rapid rise in opioid misuse since 2007, a more current estimate would likely be higher. Moreover, for the period from 2007 to 2012, the same survey found that an estimated 21,000 pregnant women (ages 15 to 44) annually misused opioids during the month prior to being surveyed.[70]

A substantial body of evidence links maternal misuse of drugs during pregnancy with a range of physical, behavioral, and cognitive problems in exposed infants. Infants who are born with prenatal exposure to opioids often experience neonatal abstinence syndrome (NAS), which is characterized by symptoms such as tremors or seizures, vomiting, fevers, excessive crying, poor feeding, and rapid breathing.[71] According to the Centers for Disease Control and Prevention (CDC), the incidence of NAS in 28 states with available data increased by 300 percent over the four-year period from 1999 to 2013—from 1.5 per 1,000 live births to 6 per 1,000 live births. In 2012, an infant with NAS was born every 25 minutes in the United States.[72] Research on the longer-term developmental effects on children born with NAS is still being conducted, but documented near-term effects include longer hospital stays[73] and a higher risk of admission to neo-natal intensive care units.[74]

The effects of parental substance misuse are, as we have already noted, multi-faceted and extend well beyond direct exposure in utero: Children whose parents misuse drugs or alcohol are at higher risk of maltreatment or neglect. Their emotional, mental, and physical health may suffer directly, as a result of physical abuse, for example, or indirectly, as a result of growing up with a parent who, due to his or her substance use disorder, cannot provide the stability, adult attention, and engagement needed to nurture healthy emotional attachment and brain development.

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[l] Prescription opioids, which are typically prescribed to relieve pain, include oxycodone, hydrocodone, codeine, and morphine. See National Institute on Drug Abuse. 2015. Drugs of Abuse: Opioids. Bethesda, MD: National Institute on Drug Abuse. Available at: http://www.drugabuse.gov/drugs-abuse/opioids.

[m] Of the deaths attributed to opioid overdoses in 2015, 20,101 overdose deaths involved prescription pain relievers and 12,990 involved heroin. See: Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. MMWR Morb Mortal Wkly Rep 2016;65:1445–1452. Available at: http://dx.doi.org/10.15585/mmwr.mm655051e1.

[n] According to the same survey, another 7.3 million American children were estimated to live with a parent who abused or was dependent on alcohol during this period (2002-2007). Source: Child Welfare Information Gateway. Available at: www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm.

Common Symptoms of Neonatal Abstinence Syndrome

- Blotchy skin coloring (mottling)
- Diarrhea
- Excessive crying or high-pitched crying
- Excessive sucking
- Fever
- Hyperactive reflexes
- Increased muscle tone
- Irritability
- Poor Feeding
- Rapid Breathing
- Seizures
- Sleep problems
- Slow weight gain
- Stuffy nose, sneezing
- Sweating

Source: U.S. Department of Health and Human Services. *Supporting the Development of Young Children in American Indian and Alaska Native Communities Who Are Affected by Alcohol and Substance Exposure.* Policy Statement. 2017. Available at: https://www.acf.hhs.gov/ecd/tribal-policy-statement.

In the near-term, infants born into families where one or both parents have a substance use disorder may have distinct needs that pose additional challenges for their caregivers. Babies with NAS, in particular, are known to be overly sensitive to stimulation, including physical touch and sound, and can also be inconsolable. They frequently resist breast-feeding, which may have other long-term implications. All of these factors can interfere with parental bonding, making it important to support and work with new mothers to help them understand their babies and not feel rejected by them. Beyond the infant phase, as children continue to grow and develop, myriad other impacts of growing up in a substance-affected household may come into play—often with lasting consequences (see text box). Studies have shown that children of parents with substance use disorders are themselves at higher risk for developing a substance use disorder [75] and for experiencing other adverse outcomes later in life.[76]

Parental substance use is also frequently a factor in cases of child neglect or abuse and in foster care placements. Children whose parents suffer from a substance use disorder are more likely to enter the child welfare system and to stay in the system for longer periods of time. In October 2016, the Administration for Children and Families reported that the number of children in foster care nationwide increased for the third consecutive year and that parental substance use and neglect accounted for much of this increase.[77] According to the Adoption and Foster Care Analysis and Reporting System, 32 percent of new entries into foster care in 2015 were at least partly due to substance misuse by a parent, although the rates reported by states vary widely.[78] In 2005, 22 percent of new entries were due to substance misuse.[79] Because federal child welfare data do not indicate what type of drug is involved when a child enters the foster-care system for reasons of parental drug abuse, it is difficult to establish a direct link to increasing rates of opioid misuse specifically, but given the scale of the current epidemic it seems likely that these trends are related.[o]

The current opioid crisis is drawing increased attention from policymakers at all levels of government; several states have introduced new policies or guidelines to curb opioid prescriptions, and numerous efforts are underway to implement innovative or evidence-based strategies to help families and combat substance use disorders.[p] Family-based treatment and family drug courts, in which the entire family unit is recognized as important to successful recovery, are indicative of a willingness to try new approaches and reflect a growing recognition that families as well as individuals need support to overcome the effects of substance use disorders. In fact, research findings suggest that treatment programs that engage the whole family, and treatment facilities that allow parents to stay with their children, achieve better

[o] According to Child Trends: "In 2005, 22 percent of children who entered foster care did so at least partially because of parental drug abuse; in 2015 that number was 32 percent, according to Child Trends' analysis of 2015 Adoption and Foster Care Analysis and Reporting System data. Neglect–the most common reason for foster care entry–is intertwined with substance use, and has also increased in recent years." Source: http://www.childtrends.org/child-trends-5/5-things-know-opioid-epidemic-effect-children/.

[p] The Trump administration has established a commission, led by New Jersey Governor Chris Christie, to address the issue; the National Governors Association has been working with states to establish comprehensive plans to address the epidemic; and the National League of Cities and National Association of County Officials have developed a blueprint to guide local government approaches.

treatment outcomes.[q,80]

At the same time, important policy debates are underway, both about the need for increased public resources to combat the epidemic and about the efficacy of applying a disease-and-public-health-oriented, rather than criminal-justice-oriented, model of prevention and treatment.[81] Research has shown that for every $1 invested in substance use treatment there is a return on investment between $4 and $7 in reduced drug-related crime, criminal-justice costs, and theft alone. Factoring in savings in health care costs, the benefit-to-cost ratio exceeds 12 to 1.[82] A comprehensive discussion of, and response to, the opioid crisis is beyond the scope of this report, but in the section below we offer

[q] According to the 2010 National Survey of Substance Abuse Treatment Services (N-SSATS), only a small fraction (less than 10 percent) of substance use disorder treatment centers currently provide child care or, in the case of residential facilities, beds for clients' children.

Effects of Growing Up with Substance Use Disorders

Substance misuse has many devastating ripple effects on families, communities, and the broader society, but perhaps no group is more vulnerable and more intimately affected than the dependent children of the individuals involved. The Children's Bureau of the Department of Health and Human Services has identified several ways that a parent's substance use disorder can lead to ineffective or inconsistent parenting, with adverse effects for early childhood development:

- Physical or mental impairments caused by alcohol or other drugs.
- Reduced capacity to respond to a child's cues and needs.
- Difficulties regulating emotions and controlling anger and impulsivity.
- Disruptions in healthy parent-child attachment.
- Spending limited funds on alcohol and drugs rather than food or other household needs.
- Spending time seeking out, manufacturing, or using alcohol or other drugs.
- Incarceration, which can result in inadequate or inappropriate supervision for children.
- Estrangement from family and other social supports.

In sum, family life when one or both parents misuse drugs or alcohol can be chaotic and unpredictable, and can result in children's basic needs—for nutrition, supervision, and nurturing—going unmet. These families are also at higher risk for problems of mental illness, domestic violence, unemployment, and housing instability that also affect parenting and contribute to higher levels of stress.

Source: Child Welfare Information Gateway. *Parental Substance Use and the Child Welfare System*. Bulletins for Professionals. 2014. Available at: www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm.

Examples of Innovative Treatment Programs and Facilities

Lily's Place, in Huntington, West Virginia, was founded by two local nurses to provide specialized care for infants with neonatal abstinence syndrome (NAS) due to prenatal exposure to opioids. The facility, which was designed for this purpose, uses proven therapeutic handling methods and the latest techniques to help infants with NAS through the weaning process. It also works with the mothers of these infants and provides care in a nurturing, non-judgmental environment. Lily's Place opened in October 2014 and currently serves approximately 100 infants per year.

The **RAINBOW** (Residential Rehabilitation for Pregnant and Postpartum Women) program in Nashville, Tennessee is one of a growing number of family-centered substance use treatment models that address the needs of mothers and their young children. Its trained professionals specialize in both addiction medicine and pre- and post-natal care and recovery. In addition to residential, intensive in-patient and out-patient treatment services, the program also provides wrap around services for parents and their children, including child care, social-service referrals, and other early childhood supports. **Renewal House** is another example of a treatment program, also located in Nashville, that provides both in-patient and out-patient treatment for women and their children.

several targeted recommendations aimed specifically at addressing impacts on young children and their families. As noted at the outset, we believe these impacts have received too little attention in the urgent effort to develop policy responses to the current crisis.

Recommendations

Most current federal policy proposals to address the opioid epidemic have focused primarily on expanding resources to support law enforcement and adult substance use treatment strategies. While these are important priorities, more comprehensive efforts are needed to ensure that substance-exposed infants, children in substance-affected families, and parents get the services they need to stay healthy, work towards recovery, and stay together as a family.

Align Title IV-E of the Social Security Act (Federal Foster Care Payments) with Child Abuse and Prevention Treatment Act (CAPTA) requirements to:

- ***Develop and implement a "plan of safe care" for substance-exposed infants and young children and their families.***
- ***Report annual data to the federal government on the number of substance-exposed infants, young children, and families for whom a plan of safe care was developed, and report service referrals.***

Under CAPTA, states are required to develop and implement a "plan of safe care" for children at risk that coordinates action among hospitals, child welfare and substance use treatment agencies, and others to keep children safe and connect parents to appropriate treatment. It also requires states to collect data on these efforts. While these goals are laudable, state implementation of CAPTA-required "plans of safe care" has been poor, mostly due to confusion about the roles and duties of the various partners, and lack of awareness about the law's requirements. In addition, states

receive relatively little funding to implement the CAPTA mandates—annual federal funding for CAPTA is currently only $26 million for all 50 states—and there has been little enforcement of CAPTA requirements by HHS.

In contrast with CAPTA, which is largely focused on prevention and treatment, the foster care system is focused on working with children after there is a crisis in the family. Title IV-E of the Social Security Act governs federal foster care and adoption assistance payments for children in foster care; it is the single largest source of federal funding for foster care, providing between $4.5 and $5 billion to states annually. To receive funding under Title IV-E, states must submit an annual plan certifying their compliance with basic child protection requirements, including requirements to make "reasonable efforts" to prevent placement of children in foster care and to ensure that children return home as safely and quickly as possible.

The goal of this recommendation is to align the requirements in CAPTA's prevention-focused "plan of safe care" with Title IV-E state plans for children and families involved in the child welfare system. Aligning these two requirements would ensure more robust implementation and support for substance-exposed infants and young children and their families. It would also reduce the necessity, length, and cost of foster care placements. Because states are already required to implement plans of safe care in CAPTA, this alignment should not result in an additional burden to the state. In addition, our recommendation includes a data collection and reporting requirement that aligns with CAPTA provisions intended to ensure that the federal government, state agencies, and other stakeholders can track and improve "plan of safe care" implementation over time and identify key service delivery gaps.

Require HHS to identify and share model strategies to support state and local implementation of "plans of safe care" and data collection and reporting.

Recent studies have pointed to a lack of technical assistance to help states implement effective plans of safe care and a lack of clarity about the roles and responsibilities of multiple agencies. This recommendation would require HHS to identify and share the latest research and model practices (including best practices for helping new parents, especially mothers, understand and respond to their infants if they are born with NAS) to support states in effectively designing and implementing plans of safe care and accurately reporting on service delivery to infants and young children and their families.

Require the Substance Abuse and Mental Health Services Administration to encourage and provide guidance on how the Substance Abuse and Mental Health Services Block Grant (SABG) can be used to address treatment and recovery needs for parents and their infants and young children, and integrate this funding with other available federal funding streams.

SABG is the federal government's largest substance abuse prevention and treatment program. It provides formula-grant funds to states to plan, implement, and evaluate activities aimed at preventing and treating substance use disorders. The SABG program accounts for almost 30 percent of all public funds spent in this area. Each state and jurisdiction has the flexibility to distribute SABG funds on a wide range of substance use prevention, early intervention, treatment, and recovery support services, including services that assist substance-exposed infants, young children, and their families.

Despite this flexibility, however, treatment and child welfare systems have tended to work in siloes. Therefore, our recommendation aims to expand this scope by providing guidance and encouragement for states to use SABG funds to *also* deliver services and approaches that meet the needs of affected children and families, including others who may care for infants born with NAS, such as grandparents and child care providers, particularly in the critical early childhood years. In addition, agencies involved in

substance abuse, child welfare, early childhood, self-sufficiency, and public health at the state level should be encouraged to work together to blend additional federal funding streams more effectively.

Amend Part C of the Individuals with Disabilities Education Act (IDEA) to improve linkages among services for early childhood intervention and parental substance use disorders.

Under IDEA Part C (program for Infants and Toddlers with Disabilities), the federal government provides grants to states to operate comprehensive statewide programs that deliver early intervention services for infants and toddlers with developmental delays and disabilities, ages birth through 2, and their families. The purpose of the program is to support early identification of potential developmental problems and to deliver early interventions to enhance young children's healthy development, minimize the need and cost of special education services, and boost the capacity of families to meet their children's needs.

The 2004 IDEA reauthorization required states to establish policies and procedures for referrals for a child under the age of 3 affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure. States are not uniformly implementing the IDEA referral requirements primarily because Part C early intervention providers are not trained in or routinely connected to resources in the child welfare, early childhood, and substance abuse treatment communities. This recommendation is designed to improve those critical linkages, ensure more robust implementation of the new referral requirements, and improve early childhood outcomes for infants and young children affected by prenatal drug exposure.

Conclusion

Children are America's most important asset: the future innovators, entrepreneurs, workers, and leaders upon whom our nation's long-term security and prosperity depends. But children are also a vulnerable asset, and in today's America tens of millions of youngsters are growing up in environments and under circumstances that prevent them from developing to their full potential. For most of these children, the disadvantages they face start at birth and even before. As new research has increased our understanding of learning and brain development at very young ages, while also highlighting the lifelong effects of early exposure to stress and trauma, substance abuse, poor nutrition, and other adverse conditions, it has become clear that the achievement gap, and indeed the opportunity gap, begins well before children enter school. Closing that gap so that all of America's children have a fair shot at growing into successful, productive adults is among the most difficult and consequential public policy challenges of our time.

> *"Making sure all our nation's children start the journey of life equipped for what lies ahead is central to the American ethos of equality of opportunity."*

The recommendations outlined in this report are a call to action by a variety of actors: Congress, administration officials, public officials serving in state and local governments, the private sector, and other stakeholders. As Representative Miller and Senator Santorum have said: "Making sure all our nation's children start the journey of life equipped for what lies ahead is central to the American ethos of equality of opportunity—the notion that America is a place where everyone, regardless of background and circumstance, has a chance at achieving success. Through our work with BPC, we also hope to demonstrate the possibility of developing meaningful solutions that can bridge political and ideological divides. We owe our children nothing less."

Appendix

Elaboration of Co-Chair Views on Paid Leave

George Miller

I believe that paid parental leave is critical for the healthy physical and emotional development of a newborn, newly adopted or newly placed foster child. However, I also believe that all types of family and medical leave are relevant to the health of our children and the well-being of working families. Young children need healthy parents—and parents may themselves need family or medical leave to be healthy, economically secure, and present for their children. In a nation where the birthrate is falling, the population is aging, and care burdens for special needs children and older family members are rising, it does not make good policy sense to construct a parental-leave program without addressing all of the well-established Family and Medical Leave Act (FMLA) reasons. We already have an established baseline of 12 weeks for parental, family care, medical leave, and military caregiving purposes. We know that a majority of FMLA leaves are for family care and personal medical leave reasons.[r] This is not the time to divide young and old to favor leave for some reasons but not others.

I have long supported an approach[s] where we pay for a national paid family and medical leave through small employee and employer payroll deductions that reflect the values of shared responsibility and shared benefits. For small employers, this removes the full burden of providing leave while ensuring small business employees have the financial security they need. It is no wonder that 70 percent of small businesses[t] support a national paid family and medical leave plan that provides 12 weeks of leave for all FMLA purposes, funded through shared payroll deductions model. And, according to a bipartisan team of pollsters, more than three-quarters of the voting public, including two-thirds of Republicans, 75 percent of Independents, and more than 90 percent of Democrats—does too.[u]

Arguments about cost, first steps, and predictability should be set aside so that the United States can join the rest of the world in ensuring our working people and families need no longer miss their child's first smile or holding the hand of a dying parent. The United States has strong, successful state-based examples and private-sector data showing the benefits of paid family and medical leave, while a strong majority of employers support these state programs and do not report burdensome costs or implementation challenges. For all these reasons, it is time to examine the evidence, do what's right for families, and support a national paid family and medical leave plan.

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Rick Santorum

There is unquestionably universal support for some sort of family and medical leave for our nation's children and multi-generational families. A majority of employers recognize this and already, without a federal mandate, provide benefits to their employees—some offering it with full or partial salary replacement, others permitting employees to use other accumulated leave benefits or workplace flexibility options requested by and designed to meet the unique needs of the employee.

I agree our country needs to do more to support families raising children, however, I have concerns about the impact on employers and employees with the institution of a paid federal leave statute. When dealing with the family, the foundation of our society, we have seen that well-meaning federal intrusions into family life have resulted in unintended and at times devastatingly negative consequences. We must learn from those forays and thus proceed with caution in instituting other remedial solutions.

This report highlights the vital importance of parental bonding in the physical and mental health of children and the relative lack of support all levels of government provide to working families with very young children. It also recognizes the high and increasing cost for most families raising young children. That is why I support the development of a paid policy limited to birth, adoption, or foster-care leave.

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Notes

Notes

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