

Access and Adequacy of Comprehensive Services
for At-Risk Children in Boston's Early Care and Education Programs:
An analysis of the 2003-2004 Community Profiles data

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Introduction

The success of the model early care and education programs has been built on both boosting children's academic knowledge early, as well as providing comprehensive services for the children and families. For all children, and at-risk children in particular, access to early screening and therapeutic services can enable them to receive the additional supports they need to enter school ready to learn. Child development research has consistently concluded that identification of special needs and treatment in the first few years of life is the most beneficial.

The Community Partnerships for Children At-Risk Enhancement Services (CPCares) is the only Community Partnerships for Children Council in the state focused exclusively on the needs of at-risk children. The mission of CPCares is to both enhance the accessibility of early care and education for at-risk children and to plan and develop comprehensive services and supports for at-risk children in Boston. The purpose of this report is to investigate the state of comprehensive services in Boston using the recently available data from the Community Profiles surveys.

In Massachusetts the public schools carry the mandate to provide services for children with special needs. However the public schools only provide 6% of the currently available early care and education capacity in Boston. The other 94% is provided by Head Start centers, Community-Based centers, Family Child Care, and other license exempt programs. This report will explore the adequacy and availability of comprehensive services in non-public school settings, including Head Start centers, Community-Based centers and Family Child Care. A future report will explore more specifically access (process, length of time, barriers, etc.) to Special Needs services and programs for the large majority of preschool children not in public education.

Due to the pervasive nature of socioeconomic status in a young child's development, and the strong association between poverty and delayed or challenged developmental outcomes, this report will further investigate whether the access and adequacy of comprehensive services varies by the socioeconomic status of children in the early care and education program.

In sum, this report will address:

- Are comprehensive services available to children in Community-Based Centers, Head Start centers, and Family Child Care?
- Are the available services adequately meeting the need of children in community-based programs?
- Does access or adequacy vary by the socioeconomic status of the majority of children served?

Methodology

The data for this report are from the 2003-2004 Community Profiles surveys. The Community Profiles surveys have previously been a required component of the Community Partnerships for Children grant. In Boston, the Boston Early Education Quality Improvement Project (Boston EQUIP) has worked in conjunction with both Boston Community Partnerships for Children Councils to administer the surveys to the entire Boston early care and education system. In the last iteration of the surveys, Community-Based centers, Head Start centers, Family Child Care, Public School Preschools, and teachers were surveyed. Relevant to this report are the Center / Head Start and Family Child Care surveys.

Survey distribution and response rates

For the Community Profiles 2003-2004 Center / Head Start survey, a list of the current licensed Community-Based center and Head Start centers was obtained from the Department of Education in the fall of 2003. Beginning in January 2004, all 211 Community-Based centers and Head Start centers were surveyed. Surveys were sent to 182 Community-Based centers and 29 Head Start centers. The Center response rate was 50% and the Head Start response rate was 86%.

For the Community Profiles 2003-2004 Family Child Care survey, an original list of all licensed Family Child Care providers was provided by the Department of Education in the fall of 2003. This list contained 1027 Family Child Care providers. Recognizing that a high percentage of Family Child Care providers in Boston may be licensed but not active, a list of licensed – active- family child care providers was obtained from the Region 6 child care resource and referral agency, Child Care Choices of Boston (CCCB). It is possible that providers may be actively providing care, but are not interested in being a part of CCCB's active referral system. However, the "active" list was deemed the best reference for discounting the total list of licensed providers to estimate the number of providers actively providing care at that time. This list contained 532 providers. A stratified random sample was taken from this list. Surveys were sent to 320 family child care providers beginning in January 2004. Surveys were available in English and Spanish. The response rate for Family Child Care was 46%.

Several follow-up measures were used to increase the response rates. Initially surveys were mailed with stamped return envelopes, and all participants were offered the opportunity to participate in several raffle drawings. Phone calls were made to programs and providers encouraging them to complete and return the survey. Surveys were resent, faxed, or emailed if the participant requested. Some surveys were completed over the phone. A bilingual (Spanish and English) volunteer called family child care providers and completed several surveys by phone. As well, Family Child Care systems, the Boston Community Partnerships for Children Councils, and other

large child care organizations assisted by encouraging their members to complete and return the survey.

The surveys were cleaned for internal consistencies, and then submitted in May 2004 to the Department of Education, which was responsible for digitizing the survey data. The digital survey data was returned to Boston EQUIP in the spring of 2005 for analysis.

Analysis

First the Head Start center responses were separated from the other Community-Based center. A fundamental component of Head Start's mission is to provide comprehensive services for children. Also by definition, Head Start serves primarily children under 100% of the federal poverty line (\$18,400 for a family of 4 in 2003). Thus a cohort of Head Start centers provided the opportunity to see whether the Head Start responses would align with other Community-Based centers serving a similar income population, or whether Head Start centers would distinguish from the other Community-Based centers based on program priority not population served. The 25 Head Start survey respondents were created into a cohort labeled here as "Head Start Centers". The other 94 Community-Based center responses were separated based on the criteria: 50% or more of families earn less than \$20,000 a year. There were 59 centers meeting this criterion. These were labeled "Low-Income Centers". There were 35 Centers where less than 50% of families earned less than \$20,000 a year and these centers were labeled Non Low-Income Centers.

Respondents to the family child care survey could not be split by the income levels they served, due to an insufficient number of responses to the necessary question on the survey.

Access to Adequate Screening and Therapy Services

Screening Services

The first set of services examined is screening services, as this is an initial step relevant to all children. The specific questions posed were, "Do children have adequate access to screening services, specifically speech and language, vision, hearing, and/or dental screenings, in community-based settings?" and "Does this differ by the socioeconomic status of the majority of the families?" Table 1 presents the percentages of programs that have access to the specified screening services. Speech and language screening services are the most accessible to programs, and dental screening services are the least accessible. In line with Head Start's focus on providing comprehensive services, all Head Start Centers have access to speech and language, vision, and hearing screenings. However, only 62% of Low-Income Centers and 65% of Non Low-Income Centers have

access to vision screenings. Only 65% of Low-Income Centers, and 59% of Non Low-Income Centers have access to hearing screenings. While the difference between the Low-Income and Non Low-Income Centers is small, the difference between these and the Head Starts is substantial.

Table 1: Access to Screening Services

	Head Start Centers	Low-Income Centers	Non Low-Income Centers
Screening services			
Speech and language	100%	84%	71%
Vision	100%	63%	65%
Hearing	100%	65%	59%
Dental	80%	44%	61%

The available service however may or may not adequately meet the need of the children in the program. The respondents were asked to rate the adequacy of the services on a three-point scale: (1) Not Adequate, (2) Partly Adequate, and (3) Fully Adequate. Table 2 presents the average adequacy scores for screening services. The available speech and language services received the highest adequacy scores, whereas the dental screening services received the lowest. Interesting to note, that while Non Low-Income Centers tended to have less access to services than Low Income Centers, it appears that the access in Non Low-Income Centers meets their need to a greater degree than in Low-Income Centers.

Table 2: Adequacy of Screening Services (average score)*

	Head Start Centers	Low-Income Centers	Non Low-Income Centers
Screening services			
Speech and language	2.87	2.35	2.78
Vision	2.94	2.26	2.78
Hearing	2.87	2.30	2.68
Dental	2.17	2.21	2.67

*Scale: 1 - Not Adequate, 2 - Partly Adequate, and 3 - Fully Adequate

Therapy Services

The second set of services assessed was access to therapies, such as speech and language, behavior, and mental health. Table 3 presents these percentages. Nearly all Head Start Centers (96%) have access to speech and language therapy services. Comparatively, only 70% of Low-Income Centers and 67% of Non Low-Income Centers have access to speech and language therapy services. It is interesting to note that fewer programs have access to speech and language therapy services than had access to the screening services. Mental Health therapy services are available to all Head Start Centers, yet substantially fewer Low-Income Centers (61%) and even fewer Non Low-

Income Centers (55%) have access to mental health therapeutic services. Interestingly, again the differences in access between the Low-Income and Non Low-Income Centers is minor, but between these Centers and Head Start centers is considerable.

Table 3: Access to therapy services

	Head Start Centers	Low-Income Centers	Non Low-Income Centers
Therapy services			
Speech and language	96%	70%	67%
Behavior therapy	80%	67%	63%
Mental Health	100%	61%	55%

Similar to the adequacy of the screening services, the available therapy services are more adequately meeting the need in Head Start Centers and Non Low-Income Centers than in Low-Income Centers. However, the type of service with the highest adequacy score differs by the type of program. For Head Start Centers, speech and language services have the highest adequacy score, whereas for Low-Income Centers it's behavior therapy, and for Non Low Income Centers mental health therapy has the highest adequacy score.

Table 4: Adequacy of Therapy Services*

	Head Start Centers	Low-Income Centers	Non Low-Income Centers
Therapy services			
Speech and language	2.86	2.25	2.83
Behavior therapy	2.67	2.26	2.73
Mental Health	2.67	2.04	2.84

*Scale: 1 - Not Adequate, 2 - Partly Adequate, and 3 - Fully Adequate

Services in Family Child Care

Children in family child care settings also need access to screening and therapy services. Providers were asked on the Community Profiles 2003-2004 Family Child Care survey, if they had the resources they need to handle a series of situations and types of children. Seventy-two percent of family child care providers responded that they have the resources to serve children with behavioral issues, whereas fewer providers (57%) reported that they had the resources to provide child abuse and neglect assistance. Interestingly, 12% of providers reported that providing child abuse and neglect assistance did not apply to them.

Table 5: Resources available for Family Child Care Providers

	I have the resources I need	I do not have the resources I need	Does not apply to me
Behavioral issues	72%	20%	8%
Child abuse and neglect assistance	57%	30%	12%

Summary

Overall, screening and therapy services appear to be available to a majority of the programs, although the availability of services varies from 100% in Head Start Centers to less than 59% in Non Low Income Centers for a screening such as hearing. The adequacy of the services also varies, with the services in Head Starts more adequately meeting the need than the services in the other Centers. However, the differences in access and adequacy between the Low-Income and Non Low-Income population is small. The next section will address children with special needs being served in community-based settings and the adaptations and barriers to serving them there.

Special Needs Children in Community-Based Programs

The previous section provided a general description of therapy services available to children in community-based early care and education programs. This section will look more closely at the children who meet the threshold of Special Needs and the service they require. While the public schools provide the large majority of services for children eligible for special education, children with special needs are also being served in community-based settings. This fact may occur because children are in community settings when their special need is identified; because children are dual-placed such as between Head Start and the Public Schools (related to Head Start’s mandate); or because the parent chooses to place their child in a community-based program.

Size of population

In the 12 months prior to the survey, Head Start Centers referred an average of 15¹ children for special education or early intervention services. On average, 11 (or 72%) of the children referred received services. Reasons children did not receive services included parent refused (24%) and scheduling conflicts (12%). On average, approximately 11 children received their special education or disability services through an Individualized Education Plan (IEP).

¹ Numbers rounded to create whole children. Numbers used in table are actual averages.

On average, Low-Income Centers reported that in the twelve months prior to the survey they had referred 5 kids per program for special education or early intervention services. On average, 4 of these kids received services. If a child did not receive services the two major reasons given were parent refused (16.3%), and transportation (11.6%). Low-Income Centers also reported, on average, 4 kids received special education or disability services through an IEP.

Non Low-Income Centers appear to have referred the fewest number of children (4) per program for special education or early intervention services in the twelve months prior to the survey. However, they had the highest percentage of referred children who received services at 87%. Still, if children did not receive services, parent refused was the largest reason (9.8%). Table 6 presents these findings.

These numbers raise the question as to why fewer children are being referred for special education in Non Low-Income Centers even though these Centers have a higher percentage of children receiving services once referred. Are the staff who are making the referrals in Non Low Income Centers more accurately referring children? Or are the problems children are presenting with in Low-Income and Head Start centers not fitting within the definition of Special Needs? Perhaps the most instructive question to ask is why the most frequent reason that children do not receive services is because the parent refused.

Table 6: Children referred for special education / early intervention services and whether they received those services

	Head Start Centers	Low-Income Centers	Non Low-Income Centers
Average number of children referred for special education / early intervention services in last 12 months	14.91	5.11	3.53
Average number of children referred who received special needs services	10.77 (72%)	4.31 (84%)	3.08 (87%)
Average number of children who receive special education or disability services through IEP	10.52	3.73	1.93

Why haven't children referred received services?			
Not available	5.3%	8.0%	3.9%
Transportation	--	11.6%	3.9%
Scheduling conflicts	12%	7.0%	3.9%
Conflicts with care arrangements	--	7.0%	--
Parent refused	24%	16.3%	9.8%

While some of these children referred might transfer to the public schools to continue their early care and education experience, many will remain in their current program. How many kids with diagnosed special needs or diagnosed disability were served in programs, and what were the adaptations required, or barriers to serving these children in community-based settings?

Adaptations

Head Start Centers reported serving an average of 16 kids with a diagnosed disability or special need, which is consistent with the Head Start mandate that 10% of their population be special needs. About half (55%) of these children required an adaptation to the program. Further if any adaptation was required, the most common (52%) required training to serve the children sufficiently. Many kids (44%) alternatively required an adaptation related to the curriculum to be served properly.

Low-Income Centers reported serving an average of 4 children per program with a diagnosed disability or special need, compared to 3 from Non Low-Income Centers. 93% of children with a diagnosed disability or special need in a Low-Income Center required an adaptation. Fewer children in Non Low-Income Centers (77%) required an adaptation than in Low Income Centers (93%). For both types of Centers, the most frequent adaptations required were training, staffing, or curriculum development. Table 7 presents these findings.

Table 7: Children with diagnosed disability or special need served and adaptations to programs required to serve these children for Centers and Head Starts

	Head Start Centers	Low-Income Centers	Non Low-Income Centers
Average number of children with diagnosed disability or special need served	15.75	4.03	2.96
Children with diagnosed disability or special need who required adaptation to program	8.71 (55%)	3.73 (93%)	2.27 (77%)

Adaptations to program required to serve children with diagnosed disability or special need*			
Physical modifications	4.0%	9.3%	13.7%
Staffing	32.0%	25.6%	21.6%
Training	52.0%	37.2%	31.4%
Curriculum development	44.0%	25.6%	29.4%

*Programs could choose as many as applied.

Family Child Care

Children with special needs and/or disabilities may also be served in family child care. Yet, only 28% of family child care providers report that they have the resources to support children with special needs or disabilities. These providers may well be part of family child care systems. Forty-five percent say that they do not have the resources to support a child with special needs / disabilities. Interestingly, about an equal percentage as those who felt they had the resources, felt that this did not apply to them (27%).

Table 8: Percentages of family child care providers who feel that they have the resources they need to support children with special needs/disabilities.

	I have the resources I need	I do not have the resources I need	Does not apply to me
Special needs / disabilities	28%	45%	27%

Barriers

However, some Centers and Head Starts may find that there are barriers to serving special needs in their programs. When asked what these barriers are, 48% of Head Start Centers said none (no barriers to serving children with special needs), and if there was a barrier 28% reported it was staffing. 58% of Low-Income Centers said staffing was a barrier, and 51% said training. 37% of Non Low-Income Centers said staffing and training were barriers. Table 9 conveys these findings.

Table 9: Barriers to serving children with disabilities

	Head Start Centers	Low-Income Centers	Non Low-Income Centers
Barriers to serving children with disabilities			
None	48%	19%	29%
Space limitations	12%	33%	28%
Staffing	28%	58%	37%
Training	24%	51%	37%

When family child care providers were asked what supports they would need to serve children with disabilities or special needs, 66% reported training. 60% reported having an aide to assist and 33% reported having a 1-800 number where they could get advice on working with children in the program.

Table 9: Requested Supports for Family Child Care Providers to Serve Children with Disabilities or other special needs

	Percentage of respondents requesting this support
Training (e.g. an evening course)	66%
An aide to assist me	60%
A 1-800 number where I could get advice on working with children in my program	33%
One on one consultation in my home	32%
Supplies / Equipment	28%
Other	7%

Summary

Overall, children in community-based settings are being referred for special education services, and receiving services, many through IEPs. If children were referred, but did not receive services, one of the most common reasons cited was parent refusal. This reason provokes further questions about why parents are refusing services. Many of the children referred for services are being served in community-based settings, with the most in Head Start Centers and the fewest in Non Low-Income Centers. To serve some of these children in the community-based setting, adaptations such as staffing, training, and curriculum development were required. Less than one third of family child care providers felt that they had the resources to support children with special needs/disabilities in their program. If programs reported barriers to serving special needs children in community-based settings, they were issues of space limitations, staffing, and training. Many of these barriers are issues that community collaborations could work to find ways to alleviate, if necessary. The next section includes a discussion about a different type of population with a special need, children whose primary language is not English.

Other special needs population - Language Minority Children

Another population in early care and education programs with a special need is children whose first language is not English. To get a sense of the population, Table 10 shows the primary language spoken at home and in the classroom of children in Boston’s Community-Based centers and Head Start centers. Table 11 shows the same information about Family Child Care Providers.

Interestingly, in Community-Based centers and Head Start centers, 76% of children speak English in the classroom, yet only 55% speak English at home. Whereas, 11% of children speak Spanish in the classroom, 23% speak Spanish at home. In Family Child Care, there is a closer match between language at home and language in the classroom. Of children in Family Child Care, 63% speak English in the classroom and at home. In the family child care home, 29% speak Spanish, and 26% of children speak Spanish at home.

Table 10: Primary language spoken at home and in the classroom of children in Boston Community-Based Centers and Head Start Centers

	Primary language spoken at home (%)	Primary language spoken in the classroom (%)
English	55	76
Spanish	23	11
Haitian-Creole	6	3
Chinese	6	6
Portuguese	2	1
American Sign Language	0	0
Other	7	2

Table 11: Primary language spoken at home and in Boston Family Child Care

	Primary language spoken at home (%)	Primary language spoken in FCC (%)
English	63	63
Spanish	26	29
Haitian-Creole	6	2
Chinese	1	1
Portuguese	1	1
Vietnamese	2	2
French	-	2
American Sign Language	0	1
Other	2	-

While there are numerous questions about how to support language minority children in early care and education programs, an initial issue is whether or not there are translated materials available for children and families and if they adequately meet the need. Table 12 presents the percentages of programs reporting that they have access to translated materials, and their adequacy scores. Eighty-four percent of Head Start

Centers reported that translated materials were available for children and families, with an adequacy score of 2.5. Only 65% of Low-Income Centers and 57% of Non Low-Income Centers reported that these materials were available. Low Income Centers reported the lowest adequacy score for available translated materials at 2.13. Compared to screening services, translated materials are very population specific. However it is unclear whether the materials are not available because they are not needed by the population that the Center is serving, or that they are needed but not available?

Table 12: Access and Adequacy of Translated Materials*

	Head Start Centers	Low-Income Centers	Non Low-Income Centers
Access to: Translated materials for children and families	84%	65.1%	56.9%
Adequacy of: Translated materials	2.50	2.13	2.50

*Scale: 1 - Not Adequate, 2 - Partly Adequate, and 3 - Fully Adequate

Of family child care providers, 47% report that they have the resources they need to teach children whose first language is not English. Almost a third (30%) report that they do not have the resources they need, and 23% report that this issue did not apply to them. See Table 13 for these results. It is possible that there may be variation based on the primary language of the provider.

Table 13: Access to materials for language minority children in family child care

	I have the resources I need	I do not have the resources I need	Does not apply to me
To teach children whose 1 st language is not English	47%	30%	23%

Summary

In Centers and Head Starts, fully 45% of the families are estimated to speak a language other than English at home. In Family Child Care, 37% of families are estimated to speak a language other than English at home. Yet less than two-thirds of Low-Income and Non Low-Income Centers report that they have access to translated materials. Furthermore, the translated materials are only somewhat adequate for the need. Future work may seek to distinguish if are there specific languages for which there is less access to adequate translated materials, and the barriers to accessing these materials.

Conclusion

Through both Community Partnerships for Children Councils and other community-based services, many resources are currently directed to providing comprehensive services to children in early care and education programs. The data in this report highlight however, that there is still an undersupply of special needs services, and that even the available supply does not fully meet the needs of children. Differences in access and adequacy seem to split based more on program type than on income status of the population served. Further, the findings of this report highlight that children with special needs are being served noteworthy numbers in community-based programs. The supports that programs and providers reported that they would need to serve this population of children, include staffing, training, and curriculum development.

Overall, the findings of this report suggest the following next steps:

- Cultivate and more systematically develop resources to increase the supply of screening and therapy services available;
- Provide trainings on the needs of at-risk children and importance of early interventions, and curriculum development to support these children in the classroom;
- Assist programs and providers to obtain adequate translated materials for children whose primary language is not English.
- Continue to collect data about the supply and demand of comprehensive services in the city of Boston, particularly as more children come online with the implementation of universal preschool.
- Explore more carefully reasons parents refuse special needs services when offered
- Give consideration to a behavioral health hotline for, particularly, independent family child care providers.

This report suggest the incidence of identified special needs children is substantially below identified populations in public K-12. Further identification levels differ depending on the kind of program. This raises a question of whether all children with special needs are being identified.