Statement of Mathew E. Melmed, ZERO TO THREE: National Center for Infants, Toddlers, and Families

Ms. Chairman and Members of the Committee, I am delighted to have the opportunity to appear before you today on behalf of ZERO TO THREE: National Center for Infants, Toddlers and Families to discuss the special needs of infants and toddlers in child care. I am Matthew Melmed, Executive Director of ZERO TO THREE, a national non-profit organization that has worked to advance the healthy development of America's babies and young children for over 20 years. I would like to start by commending Congresswoman Johnson's role in championing the Family and Medical Leave Act for more than a decade—your efforts have made a profound positive contribution to the healthy growth and development of our youngest children.

You have no doubt been hearing a great deal about the critical brain development that occurs in the first three years of life and its impact on all that follows. How, and how well, we think, learn, control our emotions and relate to others for the rest of our lives—in short what makes us human—depends on the nature of the interactions and attachments we have as very young children with our parents and caregivers.

In 1990, nearly half of all children under the age of three were being cared for by someone other than their parents.[1] As welfare-to-work requirements affect families with very young children, the demand for out-of-home care for infants and toddlers is rising. At the same time, concern about the quality of infant/toddler child care is growing. Although detailed information about child care arrangements for very young children is sparse, the research that has been done raises serious questions about the quality of many child care settings that serve children under three.

As more and more infants and toddlers are moving into child care, for longer and longer periods of time, it is important that we understand how early caregiving experiences profoundly influence cognitive, social, and emotional development. Recent neuroscientific research has provided us with this greater understanding.

Brain Development: The Lasting Effects of Early Relationships

Until recently, neuroscientists didn't know that infants' brains were so active and complex. They had always assumed that brain structure was genetically determined by the time babies are born. Now, we know differently. New imaging techniques provide non-invasive ways to study the brains of living people, and allow scientists to see a baby's brain developing—not just growing bigger, but forming microscopic connections responsible for such things as feeling, learning, and memory.

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[1] Endnotes follow Statement.

While genes give you certain predispositions, for example, to have a certain type of temperament, these predispositions are vitally influenced by a wide range of experiences as you grow. The old debate over "nature vs. nurture" is dead. We now know that they work hand in hand to guide future development.

At birth, the brain is in a highly unfinished state. During the first 3 years, it forms most of the synaptic connections, the basic wiring of the brain, that it will keep for life. PET scans show us that by 12 months, a baby's brain qualitatively resembles an adult's in terms of basic architecture. The brain of a two-year-old is as active as an adult's. This is visual proof that very young children are primed for learning.

All learning takes place in the context of important relationships. During the earliest days, months, and years, children learn about the world through their own actions, and their caregiver's reactions. They are learning about who they are, how to feel about themselves and what they can expect from those who care for them. Such basic human capacities as the ability to feel trust, to experience intimacy with, and cooperate with others, develop from the earliest moments of life. Early experiences—positive and negative—have a decisive impact on who we become as adults.

Research has found that a strong secure attachment to a nurturing caregiver has a protective biological function, helping the child learn to cope with stress and control emotions. What research also tells us is that day-to-day interaction between babies, their parents, and other caregivers are learning partnerships with very high stakes. That's because babies and young children experience their environment almost completely through their relationships with their primary caregivers. They need us to survive and thrive.

When a toddler plays with, talks to and listens to his parents or child care provider, he learns to focus and concentrate, to recognize the familiar and explore the unfamiliar, to communicate, to take pleasure in learning. These same processes allow a first grader to focus on a book, quiet down, filter out noise in a classroom, feel motivated to try a new challenge, and feel good about learning to read.

Loving a baby is important, but parents and caregivers must also be able to read a child's individual signals and respond appropriately. Every baby is unique. By nature babies vary greatly in how they react to sensations. Some are more sensitive to sound ... others to touch. These variations in how they learn affect how they understand their world.

Babies also have different temperaments and different ways of showing their needs, moods, and preferences. The key to successful development lies in how well caregivers—parents and child care providers—respond to a baby's signals, and how well they nurture them and mediate their environment, in order to mesh with the child's own physical characteristics, sensitivities, abilities, temperament, and mood.

Any policy decisions about infants and toddlers in child care must be premised upon and support the central fact that it is through continuous, day-to-day relationships with parents, child care providers, and other caregivers that children develop intellectually, socially, and emotionally.

The key to quality child care is the quality of relationships—relationships between the infant and her family, between child and caregiver, between caregiver and family, and among adults in the child care setting. Child care quality depends on caregivers who are knowledgeable and skilled, and committed to creating and sustaining these relationships.

QUALITY MATTERS

Over the past 15 years a number of studies have examined the effects of varying levels of quality on children's behavior and development. Each reached the same conclusion: A significant correlation exists between program quality and outcomes for children.[2] In longitudinal research currently underway, The NICHD Study of Early Child Care has found that among children under three, in a range of child care settings chosen by their families, higher quality care is related to better mother-child relationships, higher cognitive performance, higher language ability, a higher level of school readiness, and fewer problem behaviors reported by caregivers.[3]

Inadequate care poses serious and potentially fatal risks to the current well-being and future development of infants, toddlers and their families. Recent empirical research suggests that unfortunately, inadequate care is a widespread phenomenon. The national Cost, Quality and Outcome study of center-based infant/toddler care showed that "child care at most centers in the United States is poor to mediocre, with almost half of the infants and toddlers in rooms having less than minimal quality." It found that fully 40 percent of the rooms serving infants in centers provided care that was of such poor quality as to jeopardize children's health, safety, or development.[4]

A study of family and relative care in three communities revealed similar patterns in family child care programs and home-based care. Using the Family Day Care Rating Scale (FDCRS), this study rated only 9 percent of the homes as good quality (meaning growth-enhancing) while 56 percent of homes were rated as adequate/custodial (neither growth-enhancing nor growth-harming), and 35 percent were rated as inadequate (growth-harming).[5]

The National Center for Early Development & Learning, supported by the Institute on Early Childhood Development and Education, Office of Educational Research and Improvement, US Department of Education, recently reviewed six studies that had each rated the quality of a sample of programs for young children using either the Early Childhood Environment Rating Scale or the Infant-Toddler Environment Rating Scale. All studies reported average quality ratings below the minimum rating for reasonable quality, and infant programs were always rated lower than preschool programs.[6]

WHAT IS QUALITY CARE?

Parents, providers, and child development experts may use different words to describe elements of quality, but they tend to agree about what is essential:

- health and safety;
- small groups for infants and toddlers, with caregivers responsible for no more than three young or mobile infants and no more than four children 18 months–3 years old;
- primary caregiver assignments;
- continuity of care;
- responsive caregiving and planning;
- cultural and linguistic continuity;
- meeting the needs of the individual within the group context; and
- the physical environment.[7]

At the National Leadership Forum on Quality Care for Infants and Toddlers, sponsored by the Child Care Bureau and Head Start Bureau last year,[8] J. Ronald Lally, a pioneer in the field of infant/toddler child care and a founding member of ZERO TO THREE, observed that good child care for infants and toddlers is a blend of science and art. The science of child care, he explained, encompasses knowledge of health and safety, developmental stages in the first years of life, and temperament and other individual differences. The art of child care is the ability to respond to the child—and to a group of children—in the moment, in a way that will support development and learning.

Lally has identified seven "gifts" that a good child care program offers babies and very young children—nurturance, support, security, predictability, focus, encouragement, and expansion. He groups these gifts in two clusters, each providing a distinct set of benefits for very young children's development. Predictability appears in both clusters, serving as a bridge on which the young child can travel from the comfort of the familiar to the adventure of discovery. Before young children can explore their environment purposefully and develop their intellectual potential fully, they must feel safe. Once they find security, they can seek challenges.

In Lally's conception, the gifts of nurturance, support, security, and predictability let children know that they can count on being loved and cared for in the child care setting. Predictability, focus, encouragement, and expansion facilitate the young child's intellectual development. But the ability to offer children these gifts rests on the structural elements of quality—small groups, appropriate staff-to-child ratios, primary caregiving, and continuity of care from responsive, knowledgeable adults who are well trained and feel supported by their colleagues and work environments.

USING STANDARDS, LICENSING AND REGULATION, AND ACCREDITATION TO ACHIEVE QUALITY IN INFANT/TODDLER CHILD CARE

In a July, 1998 analysis of using standards to ensure high-quality child care, The United States General Accounting Office distinguished two major dimensions of quality—structural and interactive.[9] Structural dimensions include measurable aspects of the child care setting, including caregiver education and training, child-to-staff ratios, group sizes, and safety and health standards. Interactive dimensions focus on the child's experiences during the day. These experiences largely reflect the quality of interaction among all the children and adults who are part of the child care environment. The GAO found that staff turnover (that is, how many staff left a setting during a year) and compensation of caregivers were identified by the literature and experts to be critical determinants of the quality of child care, since these issues affect interactions between the child and caregiver.

State licensing standards for infant/toddler care tend to focus almost exclusively on structural dimensions of quality. Using the database of the National Resource Center for Health and Safety in Child Care (NRC) at the University of Colorado, which contains child care standards for 50 states and the District of Columbia, the GAO report found that the extent to which state standards reflect the standards set by the National Association for the Education of Young Children and the National Health and Safety Performance Standards developed by the Maternal and Child Health Bureau vary. Maryland requires a 1:3 ratio for infants 0–18 months, a 1:6 ratio for toddlers 18–24 months, and a 1:10 ratio for 3 and 4 year olds. Child care standards in over half the states stipulated staff/child ratios that were the same as the NAEYC standard for younger children (6 weeks through 18 months). Fewer states incorporated these standards for older children. Not all states have standards for group size. Thirty-two states have state standards stipulating group size for children ages 6 weeks through 18 months. According to the Center for Career Development in Early Care and Education, as of 1995, 35 states had no preservice training requirement for center-based child care providers; 46 states had no preservice training requirement for family child care providers.[10]

Systems of accreditation for center-based and family home child care generally examine a range of quality indicators including: relationships among adults, as well as those between adults and children; the physical environment of the child care setting; developmental learning goals, curriculum and activities; safety and health; staff qualifications and professional development; and administrative and business practices. The process of accreditation tends to involve a number of steps, including self-assessment; parent surveys; systematic efforts, as needed, to improve program quality; on-site evaluation by an accreditation team; review; and ongoing monitoring and renewal of accreditation to ensure maintenance of quality. There are 6 national systems that accredit child care programs and providers. In addition, some states are establishing accreditation systems as a way to improve the quality of child care. A number of local, state, and national initiatives are underway to encourage individuals and child care programs to go through the accreditation process.

The *Revised Head Start Program Performance Standards,* which govern the operation of all Early Head Start and Head Start grantees and delegate agencies, address both structural and interactive dimensions of infant and toddler care. Performance standards describing the Head Start Program's child development and education approach for infants and toddlers, staff qualifications, staff-child ratios, and group size provide the rationale for each standard, guidance, and related information. As the Early Head Start Program expands and efforts are made to place infants and toddlers of participating families in community-based child care settings, relevant performance standards will be applicable to community-based settings, as well as to child care provided directly by Early Head Start grantees.

Several sections of the Revised Head Start Program Performance Standards and guidance specifically address the care of infants and toddlers in groups.

• *Infant and toddler staff qualifications:* Early Head Start and Head Start staff working with infants and toddlers must have obtained a Child Development Associate (CDA) credential for Infant and Toddler Caregivers or an equivalent credential that addresses comparable competencies by January 1, 1999 or within one year of hire as a teacher of infants and toddlers. Staff training must develop knowledge of infant and toddler development, safety issues in infant and toddler care, and methods for communicating effectively with infants and toddlers, their parents, and other staff members. When a majority of children speak the same language, at least one classroom staff member interacting regularly with the children must speak their language.

• *Staff-child ratios and group sizes:* Each teacher working exclusively with infants and toddlers must have responsibility for no more than 4 infants and toddlers. No more than eight infants and toddlers may be placed in any one group. If State, Tribal or local regulations specify staff-child ratios and group sizes more stringent than this requirement, the State Tribal, or local regulations must apply.

• *Child development and education approach:* Standards require grantee and delegate agencies to:

• encourage the development of secure relationships in out-of-home care settings for infants and toddlers by having a limited number of consistent teachers over an extended period of time. Teachers must demonstrate an understanding of the child's family culture and, whenever possible, speak the child's language.

• encourage trust and emotional security so that each child can explore the environment according to his or her developmental level.

• encourage opportunities for each child to explore a variety of sensory and motor experiences with support and stimulation from teachers and family members.

• Promote an environment that encourages the development of self-awareness, autonomy, and self-expression.

• support the emerging communication skills of infants and toddlers by providing daily opportunities for each child to interact with others and to express himself or herself freely.

• Support the development of infants' and toddlers gross motor skills and create opportunities for fine motor development.

PUBLIC INVESTMENTS FOR QUALITY

Neuroscientific and child development research that highlights the importance of sensitive, responsive care during the earliest years, combined with evidence documenting the dearth of such care in many infant/toddler child care settings, has led to important initial public investments from all levels of government and the private sector. Unfortunately, the disparity between the demand for quality infant/toddler child care, and the capacity to meet those needs given resource limitations, continues to increase.

In order to meet the increasing need for quality infant and toddler child care we must:

1. Examine licensing and regulatory standards to promote child development and ensure health and safety for all children by reducing group size and ensuring appropriate staff/child ratios for infants and toddlers and staff qualifications.
2. Raise the level of training expected of all infant/toddler caregivers; expand and improve training opportunities.
3. Increase compensation and benefits to infant/toddler child care providers, linking increases in compensation to completion of training, demonstrated competence, and commitment to the field.
4. Create child care environments that are models of comprehensive services, based on child-centered, family-focused efforts that make multiple services families may need easily accessible and linked through the child care setting.
5. Promote linkages within the child care and Head Start communities and forge new partnerships with groups and organizations typically seen as "outside" the child care community to improve the quality of infant/toddler care.
6. Involve parents, employers, legislators, and other stakeholders and decision-makers in public awareness and engagement campaigns designed to create and sustain societal commitment and investment in quality care for infants and toddlers.
7. Use all currently available funding streams and allocate new financial resources to supplement and maximize efforts that support quality infant/toddler child care.

Experts in the field agree that structural elements of child care—group size, staff/child ratios, and staff training—are essential to support quality. Adequate compensation and benefits for workers is essential to minimize turnover and ensure the professional development of staff over time. Until salaries and benefits are high enough to attract and keep competent staff in the field, training becomes an endless cycle of basic courses for beginning workers. More importantly, from the perspective of children's development, the turnover in staff that inadequate compensation makes inevitable destroys the secure, intimate, growth-promoting relationships in the child care setting that are the goal of all quality improvement efforts.

Child care for infants and toddlers can serve as a central element in an array of community-based health, parenting education and social supports that all families with very young children require.

The connection between public engagement and imaginative financing has become increasingly clear. We must build public support for the idea that protecting and promoting the healthy development of all very young children is the responsibility of communities as well as families. Increased public awareness of the importance of the earliest years can lead to the mobilization of public and private resources for the significant, sustained community investment required to finance the true cost of quality care.

PROMISING APPROACHES

Many states and counties are blending federal, local, state, and private funds and are forming creative partnerships that are allowing them to maximize the impact of each dollar they spend to improve the quality of infant and toddler child care.

They have recognized that responsive care for infants and toddlers requires trained caregivers who stay on the job. So they look for ways to make training affordable and financially rewarding to individual caregivers, as well as reimbursement mechanisms that will increase the resources of centers and family child care homes that recruit and retain well-trained staff.

California

In California for example, federal funds are being used to enhance more than a decade of investment in increasing the number of slots and improving the quality of care. In 1986, the California Department of Education (CDE) and WestEd (formerly Far West Laboratory) created a partnership, the Program for Infant/Toddler Caregivers (PITC) and created a comprehensive, high quality, multi-media training system for center-based and family child care providers.

With CDE and private funds, trainer-of-trainer institutes were created. Participants could become certified by completing a training plan. At that time, however, participants were required to pay the full cost of the institutes.

When Child Care and Development Block Grant quality improvement funds became available in 1991, the CDE designated funds to provide institute participants with scholarships to cover the cost of the training, plus lodging and meals. In return, participants are expected to fulfill certification requirements and to provide 25 hours of training to other providers in their county during the two years after completion of the training.

The goal is to have a cadre of certified graduates in each county to provide training on an ongoing basis at the local level to program directors and caregivers and to provide critical information to local policymakers about the components of quality infant/toddler services.

The Federal Infant Capacity Building funds made available to the states in FY 1998 provided the additional funding required to, among other things, coordinate and expand training efforts at the regional and local level and provide grants for start-up costs for new infant/toddler programs that meet PITC program standards (such as small groups and continuity of care).

Michigan

In Michigan more than half of the families leaving the welfare rolls are placing their infants and toddlers in informal care, either in the homes of relatives or with aides, who provide care in the family's home. To qualify as a provider of state-subsidized care, an aide or relative must only fill out a simple form and be checked against a child abuse/neglect protective services data base.

Concerned by the growing number of providers with little knowledge about child development, and little incentive to stay in the field (aides coming into the home earn $1.35–$1.60 per hour/per child) if other opportunities arise, Michigan's 4-C resource and referrals agency approached the state legislature about the need for better outreach to aide and relative care providers. Beginning this year, free training will be opened to aides and relatives. Aides and relatives who complete 15 hours of free training and provide child care for 3 months to Michigan Family Independence Agency-funded children will receive a one-time bonus of $150.

Many aides and relatives who have completed this training are choosing to pursue a CDA credential and have become either a licensed family child care provider or a center-based employee. Of these providers many have chosen to pursue further training, with some working to open their own family child care homes.

Oklahoma

With significant savings from reduced welfare rolls, the Oklahoma First Start initiative was requested by the Oklahoma Legislature and approved by the Commission on Human Services. Administered by the Oklahoma Department of Commerce, funds are used to provide full day/full year services for 191 infants and toddlers, 0–3 years of age, to families who are employed or are moving from welfare to work.

A competitive bidding process made funds available statewide to public and private child care programs that are able to blend funds from different sources. The seven grantees utilized funding sources that included the state child care subsidy system, the Child Care Food Program, foundations and corporations. First Start grantees must commit to meeting the Early Head Start Performance Standards—which govern the operation of all Early Head Start programs and address both structural and interactive dimensions of infant and toddler care—and to receiving national accreditation within 24 months.

The largest Grantee is the Tulsa Children's Coalition, which administers the grant and contracts with non-profit and for-profit child-care providers to serve 92 children. The Coalition, an organization that includes Tulsa's Chamber of Commerce, Tulsa Public Schools, United Way, Community Service Council and the Head Start Agency, has been very successful in finding creative ways to access new resources and build child care capacity. For example, the Coalition joined with Tulsa's anti-poverty agency, the Community Action Project (CAP), to establish two family child care homes in resource-poor neighborhoods. Through CAP's family home own-

ership program, women who had experience in child care were provided assistance in purchasing homes in public housing developments. Another example is two new centers in Tulsa Housing Authority (THA) communities where THA provided space and other resources. The United Ways and a private foundation provided funding for necessary renovations and supplies for these new centers.

The three states that I've highlighted represent just some of the many bold and creative initiatives that states have undertaken to improve the quality of infant and toddler child care. Unfortunately, these initiatives are enhancing the lives of only a small fraction of our youngest children. The disparity between the demand for quality child care, and the capacity to meet those needs given resource limitations, continues to increase.

CONCLUSION

New developments in brain and child development research shows us what infants and toddlers need. Our challenge is to ensure that every child receives it. It is for this reason that I am here today, to ask you on behalf of America's babies and families to commit to allocating the additional resources, and to forming the new partnerships at all levels of government, with child development experts and the private sector that will nurture the healthy growth and development of our country's youngest citizens. Thank you.

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