

Section IV

The Current System: Florida's Investments in Families and Young Children

Since they do not have health insurance, Tim and Tara are making small monthly payments to the hospital and doctor's office to pay for prenatal care and Eddy's delivery. Although they will be making the payments for at least two years, both are thankful that they have this option. They were not aware of any other supports available in the community during Tara's pregnancy.

Tara found out about Florida KidCare, a state children's health insurance program, from a co-worker. For the most part, Tim and Tara have been satisfied with the program. There were some problems when they first signed up – their paperwork identifying a doctor and the program's letter assigning them to a doctor crossed in the mail, and they had to change doctors – but since then, things have been fine. Tara would like to see the same doctor each time and have more time to ask questions, but she does not complain.

In order to get her children to the doctor, Tara takes the bus. With only one car in the family, transportation is a constant challenge. After traveling with two small children by bus and walking to and from appointments, Tara becomes exhausted and so do the children.

Tim and Tara know few of their neighbors and do not venture outside after dark due to safety concerns. They know there is a community center down the street, but the building and playground is run-down, and they doubt it has much to offer. There have been times when knowing where to call for help would have been welcomed. Tara had tried to find assistance with locating housing but gave up after spending over an hour on the telephone and getting recordings, other numbers to call, and being told she had called the wrong place or no one was available to help her.

Although Florida can highlight the accomplishments of the last three decades by pointing to increased state investments and better outcomes in child care, maternal and child health, and prevention and intervention programs for child abuse and neglect, it is unclear whether the increases have kept pace with inflation and population growth and changes. Many children and their families who have need of these services have not been reached. Furthermore, information, supports, and financial assistance that families with young children need in order to nurture their child's growth and development are, in many cases, disjointed and difficult to access.

Incremental progress has been accomplished in a climate of increasing devolution. In several areas (e.g., foster care and adoptions, school readiness, workforce readiness), administrative and management decisions have moved from centralized state level public agency responsibility to local-level public and private agencies and boards. These changes appear to reflect a general belief that local communities and agencies know community needs best rather than a distrust of public agencies. In most cases, authority remains with public agencies but at the local level. For example, in several areas, voters have approved increases to their own taxes to support the activities of children's services councils. Whether this shift to local governance has resulted in more efficient or effective services is still unclear. For the most part, fiscal and policy decisions have remained centralized, and in some cases, have prevented creativity.

This chapter takes a look at present services and service delivery mechanisms in Florida for families with young children. Economic, health care, early care and education, and parenting supports are examined. The picture that emerges is primarily one of fragmented services for families. The chapter concludes with a discussion of the overarching inefficiencies and gaps in the present service delivery system and the promising programs that can help Florida move toward integrated services that approach families holistically.

Economic Supports

The current welfare system rewards states for moving families off the rolls, but not for ensuring that those families gain steady employment and earn an adequate income. To encourage states to develop better approaches to helping families keep their jobs and increase their earnings, an expansion of welfare's goals is needed.

Shields & Behrman in Children and Welfare Reform, 2002

Consistent with the philosophical and budgetary priorities that shape Florida's social policies, funding for social welfare supports is typically lower than the national average (see Table 10). For example, even though the Florida Workforce Innovation Act establishes an income cutoff for receipt of child care subsidies at 185% of the federal poverty level and federal policy authorizes states to provide subsidies up to 85 percent of state median income, the actual cutoff in 1999 was 144 percent of poverty or 53 percent of state median income.

Also note that between 1996 and 2000, there were no increases in the maximum monthly benefits families received, despite inflation and state economic prosperity. Remarkably, the last time there was an increase in the monthly benefit was 1992, and the maximum monthly benefit in Florida for a family of three remains at \$303 in 2003 (G. Scott, Department of Children and Families, personal communication, April 29, 2003) providing a benefit that is less than 24% of the federal poverty level. Since implementation of WAGES in 1996, the total number of families receiving cash assistance dropped 66 percent, and the number of TANF cases that included an adult recipient declined 80 percent. Spending limitations are not surprising

given Florida's low tax base. Florida is ranked 45th in state taxes and 43rd in per capita state taxes.²⁰³

Table 10. The Safety Net in Florida, in National Context

Program	Florida	United States
Welfare Benefits – Maximum Monthly Benefit (Family of 3, no income)		
1996 (AFDC)	\$303	\$415 (median)
1998 (TANF)	\$303	\$421 (median)
2000 (TANF)	\$303	\$421 (median)
Ratio of Children Receiving Welfare to All Poor Children		
1996 (AFDC)	50.4%	59.3%
1998 (TANF)	30.3%	49.9%
Income Cutoff for Children's Eligibility for Medicaid/State Children's Health Insurance Program (% of Federal Poverty Level)		
1998	200.0%	178.4%
2000	200.0%	205.1%
Income Cutoff for Children's Eligibility for Child Care Subsidy(% of State Median Income/ Federal Poverty Level)		
1998 (January)	53% / 150%	57% / 182%
1999 (June)	53% / 144%	59% / 178%

Source: Botsko, Snyder, & Leos-Urbel, 2001, Urban Institute

Florida's social welfare spending restrictiveness has continued during the implementation of its welfare reform legislation. The state enforces tiered-time limits shorter than the five year federal maximum and has established strict rules regarding program participation, income assistance, children's school attendance, immunization requirements, and family size. Although the immediate result has been a drastic reduction in the state welfare caseload (dropping 49% compared to 30% nationwide between 1996 and 1998), many families may be experiencing negative outcomes. This possibility is compounded by the finding that as many as 40 percent of families that have left welfare are not working or receiving cash benefits and food stamps.²⁰⁴

Florida has developed a comprehensive workforce development system with the goal of promoting economic growth through workforce development. Utilizing four key elements — welfare-to-work programs, one-stop career centers, school-to-work programs, and high-skill/high-wage jobs programs — the state formally linked services under a "workforce development" umbrella. The Agency for Workforce Innovation administers the program, and Workforce Florida, Inc., a public-private partnership, serves as the chief policy organization. Regional boards, consistent with Florida's focus on local control, provide local oversight, planning, and policy development. In many areas, welfare reform coalitions and workforce development boards have blended in order to more closely coordinate efforts. Furthermore, one-stop career centers strive to co-locate an array of community services (e.g., information and referral, subsidized child care, housing assistance, education and training).²⁰⁵

²⁰³ Florida Tax Watch, 2001

²⁰⁴ Holcomb et al., 1999

²⁰⁵ Workforce Florida, Inc., 2002

Health Care

We don't have to guess about the benefits of early health care; indeed, in no other area of social policy can costs and benefits be calculated so precisely. For example, every dollar spent on childhood immunizations saves ten dollars in (avoided) later medical costs

Carnegie Task Force on Meeting the Needs of Young Children, 1994

The health of Florida's children and families, although improving in several major indicators, remains of great concern. The percent of low birth weight babies in 2001 (8.2%)²⁰⁶ was above the national average and has increased since 1990 (from 7.4% in Florida and 7.0% in the U.S.²⁰⁷). Florida's infant mortality rate (deaths per 1,000 live births) dropped from 7.4 in 1999 to 7.0 in 2000 and then increased to 7.3 in 2001 (compared to 6.9 in 2000 in the U.S.). The rate for nonwhite infants (12.2) was more than double the rate for white infants (5.5) in 2001.²⁰⁸ The child death rate in 2000 (deaths per 100,000 children ages 1-14) was 26 compared to 24 for the nation. Fewer of Florida's children are immunized. Seventy-five percent of 2-year-olds were immunized in 2000 compared to 78 percent for the nation.²⁰⁹

Health Insurance

The health care market in Florida is one of the most competitive and entrepreneurial in the nation. Managed care has grown rapidly as have for-profit hospital systems.²¹⁰ Many argue that managed care has reduced medical care for the uninsured poor.²¹¹ The state has built-in limits on tax revenues, a state expenditure cap, and a fiscally conservative governmental philosophy. The result is that state support of the safety net for medically needy is limited, and Florida counties have been a significant, yet insufficient, source of support for the indigent.²¹²

Medicaid does provide access to health care for many Floridians. Two groups are eligible for services: low-income children and mothers and the aged, blind, and disabled. There are income and asset limits, and these vary by category.²¹³ Poor children covered by Medicaid are more likely than uninsured children to have health visits as recommended.²¹⁴

²⁰⁶ Thompson, Simmons, & Graham, 2002

²⁰⁷ Kids Count, 2002

²⁰⁸ Florida Department of Health, 2002b

²⁰⁹ Kids Count, 2002

²¹⁰ Lipson, Norton, & Dubay, 1998

²¹¹ Reich, 2000

²¹² Lipson et. al, 1998

²¹³ Florida Department of Health, 2002a

²¹⁴ Brooks-Gunn, Duncan, & Maritato, 1997

Nonetheless, Florida is in the bottom ten states in the percentage of total low-income population covered by Medicaid.²¹⁵ Even though the state has historically had very low Medicaid income eligibility levels for adults, recent economic downturns resulted in further reductions in eligibility and services. Unlike efforts in several states, there has been no significant movement in Florida to pursue public coverage expansions through such mechanisms as SCHIP “family coverage” waivers or sector 1931 Medicaid expansions.²¹⁶

Most families rely on private health providers for medical care. Many families, however, lack health insurance and thus, do not have a doctor they see for most of their medical needs and are at jeopardy of receiving inadequate health care. Fortunately Florida KidCare, the State Children’s Health Insurance Program (SCHIP), has enrolled more than 1.4 million previously uninsured children.²¹⁷ There remains, however, a considerable number of unenrolled, but eligible, children across the state - approximately 26 percent of children living under 200 percent of federal poverty level — and many children who are ineligible and uninsured — approximately 9 percent (see Table 11). In all comparisons, as shown in the table, the rate of uninsured children and adults in Florida significantly exceeds the national average for all incomes as well as for families with incomes above 200% of the Federal Poverty Level (FPL).

Table 11. Health Insurance Coverage for Children and Adults in Florida and Nationwide, 1999*

Family Income	% of Children (ages 0-18) in FL	% of Children (ages 0-18) in US	% of Adults (ages 19-64) in FL	% of Adults (ages 19-64) in US
Below 200% of FPL				
Employer-sponsored	34.8	38.7	41.6	41.7
Medicaid/SCHIP/state	35.3	35.2	12.6	14.7
Other coverage	4.4	3.8	10.1	8.8
Uninsured	25.5	22.4	35.8	34.9
Above 200% of FPL				
Employer-sponsored	<i>76.4</i>	85.3	<i>77.7</i>	83.7
Medicaid/SCHIP/state	6.5	3.8	0.8	1.1
Other coverage	8.2	4.9	9.5	5.8
Uninsured	8.9	6.0	12.0	9.4
All Incomes				
Employer-sponsored	<i>57.9</i>	66.7	<i>67.4</i>	72.3
Medicaid/SCHIP/state	19.3	16.4	4.2	4.8
Other coverage	6.5	4.5	9.7	6.6
Uninsured	16.3	12.5	18.8	16.3

* Most recent data available at this level of specificity; collected during the National Survey of America’s Families; the second wave of the survey is currently being analyzed & publication is anticipated in 2004.

Note: Figures in bold are significantly higher than the national average. Figures in italics are significantly lower than the national average.

Source: Yemane & Hill, 2002, *The Urban Institute*

²¹⁵ Holcomb et. al, 1999

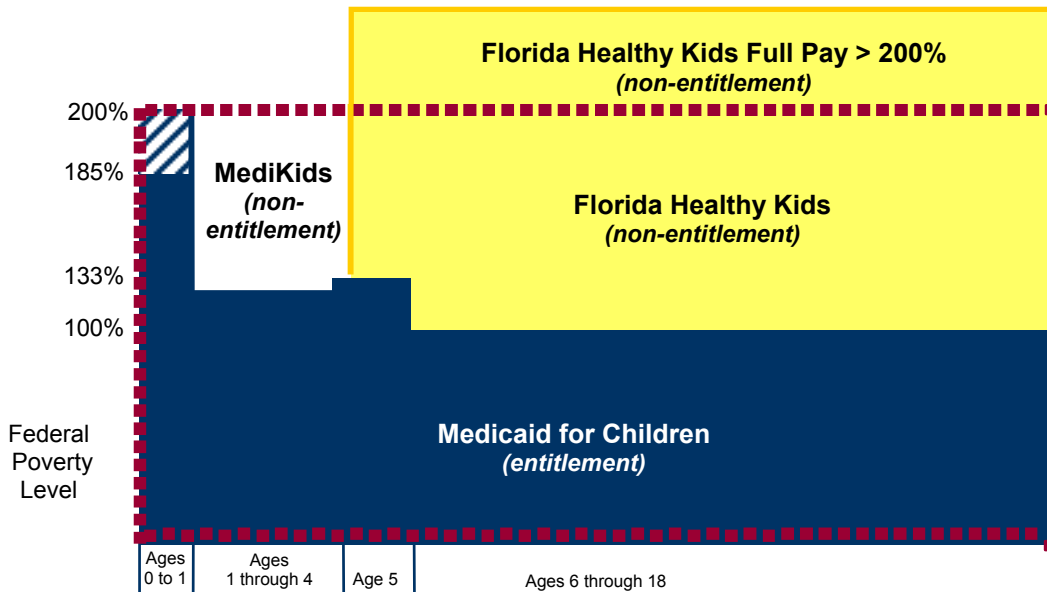
²¹⁶ Yemane & Hill, 2002

²¹⁷ Florida KidCare, 2002

Florida's child health insurance system is complex. The roots of Florida KidCare can be traced back to 1990 and the creation of Healthy Kids. Healthy Kids was a school-based child health insurance initiative established through a partnership between Florida government and private industry. The success of this venture was one of the factors in the development of the complex "combination program" now known as Florida KidCare with the passage of SCHIP at the federal level in 1998. The very large expenditure increases that occurred under Medicaid during the 1980s and a general resistance to entitlement programs were other key factors in the configuration of Florida KidCare.

Florida KidCare encompasses four programs — Medicaid expansion, MediKids, Healthy Kids, and Children's Medical Services.²¹⁸ During the enrollment process, eligible children may be identified and enrolled in Medicaid, an uncapped federal entitlement program, or determined eligible for one of the Florida KidCare programs (see eligibility guidelines in Table 12). Unfortunately, eligibility for Medicaid does not always guarantee services even though it is an uncapped program. Reimbursement levels have not kept pace with actual expenses, and pediatricians, dentists, and, recently, obstetricians are often reluctant to provide services.

Table 12. Florida KidCare Programs



Source: Florida KidCare Coordinating Council, 2003

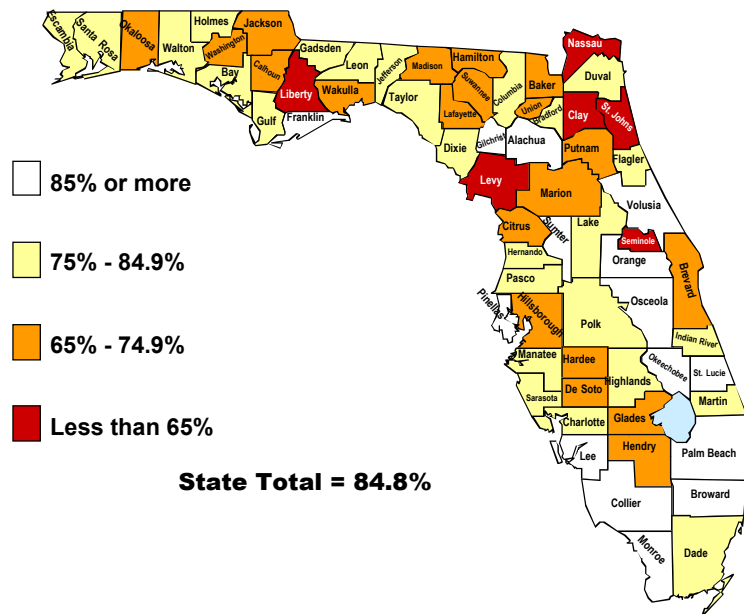
Medicaid:
 Title XIX-Funded
 Title XXI-Funded
 CMS Network

²¹⁸ Hill, Lutzky, & Schwalberg, 2001

Eligibility in a non-entitlement program does not guarantee service; service is dependent on funding availability. The Medicaid expansion extends Medicaid coverage to infants and teens that meet the family income requirements. MediKids offers Medicaid-type benefits to children under age 5 who live in families with incomes below 200 percent of poverty. Healthy Kids extends health benefits to school-age children, and Children’s Medical Services (CMS) is a specialty network providing primary and specialty services for children with special health care needs. CMS provides full Medicaid benefits plus early intervention, respite, genetic testing, genetic and nutritional counseling, parent support and care coordination. Children above 200% of the federal poverty level may also be served through CMS with state dollars; however, funding is limited. A provider network, developed specifically for CMS through a credentialing process, delivers services.

Not surprisingly, Florida KidCare can be confusing to families. It is difficult to understand the differences in programs and eligibilities as well as the relationships between programs. Not all service providers serve children in all four programs. As shown in Figure 3, as of January 2003, there were six counties in which less than 65 percent of eligible children were enrolled in KidCare. It is possible that many of these children could be covered under non-KidCare insurance.

Figure 3. Percent of Children Under 200% of Poverty Enrolled in KidCare, January 2003



Source: www.floridakidcare.org, January 2003

Note: Includes Titles XIX and XXI (Medicaid, CMS, MediKids and Healthy Kids) plus self-pay Healthy Kids. The remainder are not necessarily uninsured. Some children may be covered under non-KidCare insurance.

The combination of programs has also created administrative challenges. The Florida Agency for Health Care Administration oversees Medicaid and MediKids. The Department of Health administers the Children's Medical Services program, and the Department of Children and Families is responsible for eligibility determination for Medicaid. In addition, the not-for-profit Healthy Kids Corporation oversees eligibility determination for the KidCare program and manages Healthy Kids.²¹⁹

An additional challenge for Florida KidCare has been the local match requirement. Established as a guiding principle connected to devolution, the local match started at 5 percent of total funding for the first year, but was slated to increase by 5 percent each year until it reached a cap of 20 percent of total funding. During 1999 and 2000, thousands of eligible children were put on waiting lists as counties struggled to raise the local match. After a legislative waiving of the match requirement in 2001 and a legal challenge to the waiver by Governor Bush, the legislature revised the statute to waive the local match requirement for one year in the December 2001 special session.²²⁰ During the 2002 Legislative Session, the "Silver Bill" removed local matching funds as a requirement of receiving Title XXI (SCHIP) funding, making local matching funds voluntary for counties that choose to cover non-Title XXI eligible children.²²¹

Children's health is also impacted by the health and well-being of their parents.²²² In Florida, adults are more likely to be uninsured than children (see Table 10). Low-income working parents are at-risk of not having access to employer-sponsored health insurance and of making wages slightly higher than the eligibility cut-off for Medicaid services. Large numbers of parents at all income levels also take part in risky behaviors (e.g., smoking, heavy drinking, and being overweight and sedentary) that are harmful to their own health and are likely to harm the health of their children.²²³

Mental Health Services for Children

Florida's current mental health system for children includes several components. Mental health and substance abuse services are available to children eligible for Medicaid and any one of the Florida KidCare programs.²²⁴ Potential limitations to services include duration of service guidelines, availability of community mental health care providers for children, and reimbursement rates. Regardless of income, children may be identified for services through the CMS Network if they are found to have a condition that is expected to last 12 months and requires special therapies or treatment.

²¹⁹ Yemane & Hill, 2002

²²⁰ Yemane & Hill, 2002

²²¹ Florida KidCare Coordinating Council, 2003

²²² National Research Council & Institute of Medicine, 2000

²²³ Bridgeman, 1999

²²⁴ Florida KidCare, 2002

Florida has also implemented the Behavioral Health Specialty Care Network (referred to as the Behavioral Health Network) with Title XXI funds to provide a comprehensive array of services for children with serious mental health issues. With an estimated of approximately 7.9 percent of children under the age of 18 in Florida with a serious emotional disturbance, the Behavioral Health Network is already at capacity and has a waiting list. In FY 2002-2003, enrollment was expanded for the first time from 303 to 335 slots. As of January 2003, 95 children were on a waiting list for services, and the waiting list is expected to grow monthly²²⁵.

According to the Florida Commission on Mental Health and Substance Abuse²²⁶, Florida's mental health and substance abuse system is a diffuse array of service settings and providers with no one entity responsible for integrating services and efforts. In addition, the current focus of mental health services is crisis intervention, and prevention is a low priority. The Commission, created in 1999 to review and make recommendations for change and improvement, has proposed the establishment of a statewide leadership body to develop a unified mental health and substance abuse system.

In addition to the work of the Commission, the Florida Infant Mental Health Initiative (FIMHI) launched by the Center for Prevention and Early Intervention has also identified strategies to build a stronger system of integrated mental health services. Unlike the Commission, which focuses on mental health services for all Floridians, the FIMHI focuses on young children. Their recommendations include connecting children's mental health care with a variety of health services, child care, and other service providers/entry points.²²⁷ The recommendations of the Commission and FIMHI have yet to be implemented.

Healthy Start

Healthy Start is a highly regarded maternal and child health care program designed to prevent and minimize adverse birth outcomes. In addition to federal funding in selected areas, the State of Florida provides additional funding to ensure services statewide. Currently, 31 regional coalitions provide Healthy Start services in 65 of 67 counties²²⁸. Since its inception in 1991, Florida's infant mortality rate has dropped from 8.9 deaths per 1,000 live births to 7.3 in 2001, with a decline in the non-white population from 15.6 to 12.2²²⁹. Although Healthy Start is unlikely to be the only explanation for this decline, both proponents and independent reviewers acknowledge that it has been a primary factor.²³⁰ Other evaluation findings include:

- ❖ The percentage of women beginning prenatal care during the first trimester rose from 75 percent in 1991 to 83 percent in 2000.

²²⁵ Florida Kidcare Coordinating Council, 2003

²²⁶ Florida Commission on Mental Health and Substance Abuse, 2002

²²⁷ Center for Prevention and Early Intervention Policy, 2000

²²⁸ Florida Department of Health, 2002a

²²⁹ Florida Department of Health, 2002b

²³⁰ Florida Department of Health, 2002a

- ❖ The percentage of two-year-olds completing their immunizations rose from 63 percent in 1991 to 86.6 percent in 2000.
- ❖ The rate of birth to teens ages 15-17 dropped from 4.4 percent in 1991 to 3.3 percent in 2000.
- ❖ Tobacco use among women has declined from 12.2 percent in 1996 to 9.4 percent in 2000.
- ❖ The infant screening criteria has been refined and is better able to identify infants at risk of post neonatal death²³¹.

Healthy Start has also forged a partnership with Healthy Families Florida. Healthy Families Florida is a voluntary parent support and abuse prevention program, and one service focus is the facilitation of access to health care for its participants. The partnership has resulted in a joint screening tool, co-location of services, joint case staffing, joint training, joint family visits, and reduced duplication.²³²

Despite its successes, Healthy Start funding is estimated to provide services that meet only 50 percent of identified needs statewide.²³³ Comprehensive case coordination services, associated with significant positive outcomes for women and children, are not available to all participants. Inter-conception care, needed to prevent unintended repeat pregnancies, is not a focus of the program. In addition, universal screening has not yet been achieved. The recent approval of Florida's Medicaid waiver application to extend coverage for Healthy Start services enhances Florida's ability to increase the duration and intensity of services. The waiver provides an estimated additional \$9 million dollars for at-risk pregnant women and children.²³⁴

Other Health Issues and Supports

Nutrition

Nutrition, for the mother and child, is a major factor in child health. When a child's body experiences a food or "fuel" shortage, food energy is dedicated to survival (maintaining crucial organ functions) and then to physical growth. Social activity and cognitive development become low priorities. Thus, undernourished children often have low energy levels and appear to lose interest in people and activities.²³⁵

Poverty is often associated with substandard nutritional status among U.S. children, but it is unclear whether malnutrition occurs because families cannot afford to provide a nutritionally adequate diet (e.g., fresh fruits and vegetables cost more) or if other factors like knowledge of nutrition, accessibility to nutritious foods, neighborhood characteristics, and health care availability are the cause.²³⁶

²³¹ Florida Association of Healthy Start Coalitions, 2001

²³² Williams, Stern & Associates, 2001

²³³ Florida Association of Healthy Start Coalitions, 2001

²³⁴ Florida Department of Health, 2002a

²³⁵ Shore, 2000

²³⁶ Korenman & Miller, 1997

Nonetheless, the poor are frequently criticized for their diets. Ehrenreich²³⁷ found, however, that circumstances often dictated diets. Many low-wage workers live in hotels without access to a kitchen. She also found that charities tended to distribute foods high in salt and sugar with many empty calories.

Immunizations

Florida's Immunizations Program works to reduce morbidity and mortality resulting from childhood diseases that are preventable through immunization.²³⁸ The program provides free vaccines to county health departments and private health care providers for children who are enrolled in Medicaid, uninsured, underinsured, and American Indians. Immunizations required for school entry are available at county health departments for all children through the 12th grade.

Healthy Child Care Florida

Healthy Child Care Florida, administered by the Florida Children's Forum, and Healthy Child Care America have created models awaiting development and funding. One promising model, utilized in a few areas of the state, is the health care consultant who visits child care programs providing information, on-site health assessments, and resources. Partnerships with other health care organizations, such as the Florida Pediatric Society, are in the early developmental stage.

Health Care in Rural Areas

Health care in rural areas is another health issue. There are unique concerns regarding health in rural areas of the state. The departure of a health care provider has potentially greater consequences in rural areas since there are scarce alternative sources of care. Recruitment and retention of health care professionals in rural areas can be challenging as the population required to support a given service or a particular physician practice is spread over a much greater area. Low volume translates to higher costs, a factor not always taken into account in reimbursement. In fact, some reimbursements are based on the faulty assumption that costs are lower in rural areas. Finally, employer-sponsored health insurance is less common in rural areas, and more limited benefits are common.²³⁹

Other Needs

Although there are many quality maternal and child health programs and services in Florida, there are additional needs. The Department of Health Needs Assessment 2001 identified the need for increased access to quality health care, particularly in rural areas; noted that birthing centers are often too distant; and recommended improved public transportation in areas where services are limited or non-existent. Access to care must also address family planning and nutrition

²³⁷ Ehrenreich, 2001

²³⁸ Florida Department of Health, 1998

²³⁹ Ormond, Wallin, & Goldenson, 2000

services. According to the report, only 32 percent of women in need of family planning services were being served and 33 percent of those eligible for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) received services. By September, 2002, the Florida WIC Program was serving 68% of eligible women and children (J. Menges, personal communication, April 4, 2003).

Furthermore, according to the Commission on the Study of Children with Developmental Delay²⁴⁰, there is a gap in services to provide screening, identification, and early intervention for all children under the age of 3 with developmental delays. Although there are successful early intervention screening efforts (e.g., Healthy Families Florida conducts developmental assessments on all participating children and developmental screening of children receiving school readiness services is a priority), information regarding appropriate screening and assessment instruments, increases in collaborative partnerships, shared data, and additional funding are needed.

Early Care and Education

The unfolding research on the brain is unequivocal testimony to the fact that the future of any community literally rests on the laps of those who nurture its youngest members.

Karr-Morse & Wiley in Ghosts in the Nursery, 1997, p. 297

Families with young children frequently struggle to access and afford quality child care. It is a problem that is particularly acute for low-income working families; there are 273,000 children in the state eligible for public funding for child care that are not being served and over 164,000 of those children have working parents.²⁴¹ Families whose income exceeds the official poverty level by a wide margin may also struggle to afford child care of even a minimal quality. Full-time care for a child under five is twice as expensive as paying a child's tuition for a year at a four-year public college. It is not unusual for parent to pay over \$6,000 a year for care in a licensed center.²⁴²

Although federal and state subsidies are available, they are limited primarily to families moving from welfare to work; do not reach all eligible families; provide no assistance for middle-income families (except through a small tax credit); and utilize low reimbursement rates.²⁴³ The level of reimbursement for child care subsidies in Florida is, at best, one-third the cost of quality care. High quality care costs more and is elusive for programs that can only afford to pay staff just over \$7 an hour on average (typically without health and retirement benefits).²⁴⁴

²⁴⁰ Florida Partnership for School Readiness, 2001a

²⁴¹ Florida Partnership for School Readiness, 2001b

²⁴² Schulman, 2000

²⁴³ Helburn & Berman, 2002

²⁴⁴ Lavery, Siepak, Burton, Whitebook, & Bellm, 2002

Access

Increases in child care funding in Florida were tied to welfare reform to improve access. From 1995/96 to 1998/99, there was a 55 percent increase in child care funding (without adjustments for population growth or inflation), and the funding expansion included a significant investment of additional state revenue.²⁴⁵ From FY 1999-2000 to FY 2002-2003, funding increased 19.6 percent from 569.2 million to 681.3 million, primarily from federal sources.²⁴⁶ Increases have primarily been used to serve more children, and reimbursement rates (a potential mechanism for increasing the quality of care) have remained relatively stable. There are a total of 19,895 early childhood programs (i.e., centers, family child care, Head Start, Early Head Start, and Prekindergarten programs) in the state. Of these, 17,590 are in urban areas and 2,305 are in rural areas.²⁴⁷

Eligibility for public assistance for child care costs does not ensure access to care. Many eligible families are not served due to funding limitations and eligibility priorities (see the following section on affordability). Even though the Workforce Innovation Act of 2000 authorized child care subsidies for families below 185 percent of federal poverty level, funding shortfalls and waiting lists have limited the impact of the law.²⁴⁸ The application process for subsidies also deters many families. The process requires time from work or family, documentation, parent fees, and selection of a care provider. In addition, families must meet deadlines, provide additional documentation, and often take more time off of work to retain subsidies. Low-income workers are more likely to experience job and schedule changes and changes in residence, further complicating the process of maintaining subsidies.²⁴⁹

Parents have the most difficult time accessing care for infants and before/after school care for their older children. Twenty-five percent of calls to Florida's Child Care Resource and Referral Network during 2000 were requests for school-age care, 18 percent were requests for infant care, and the remaining calls were requests for care for children ages 1 - 5. More than 5,000 parents requested evening and overnight care, and almost 5,000 parents requested weekend care. Between 1,000 and 2,500 early childhood programs statewide offered care during these hours.²⁵⁰

In response to the growing numbers of women working outside the home, families have pieced together a patchwork quilt of alternative caregiving arrangements (See Figure 4). Families with working mothers in Florida are most likely to use center-based care arrangements (36% in 1999). Other choices for primary child care arrangements include relative care (24%), parent care (20%; this arrangement occurs when parents' work schedules are different and one parent cares for the children while the other works), and family child care (14%). Nanny/baby-sitter

²⁴⁵ Holcomb et al., 1999

²⁴⁶ Florida Partnership for School Readiness, 2003

²⁴⁷ Florida Children's Forum, 2003

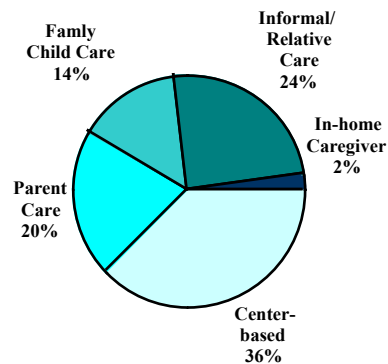
²⁴⁸ Botsko, Snyder, & Leos-Urbel, 2001

²⁴⁹ Adams, Synder, & Sandfort, 2002

²⁵⁰ Florida Children's Forum, 2003

care accounted for only 2 percent of the arrangements.²⁵¹ Families with incomes above 200 percent of poverty are more likely than low-income families to use center-based settings (40% compared to 29%), and families with incomes below 200 percent of poverty are more likely than higher-income families to use parent care (26% compared to 20%).

Figure 4. Child Care Arrangements in Florida



Source: Sonenstein et al., 2002

Affordability

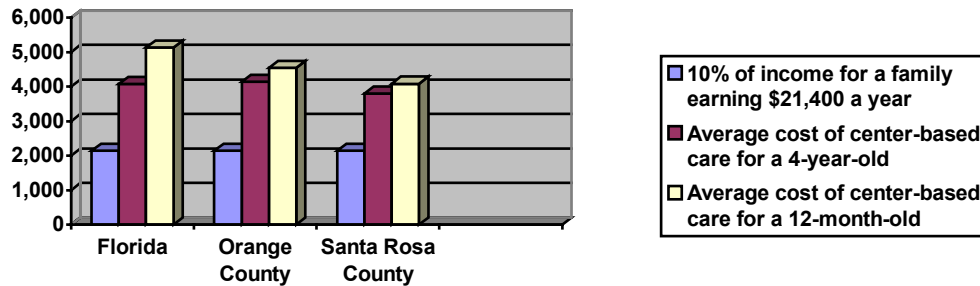
Parent fees fund the great majority of early care and education in Florida even though families with young children tend to be young and economically vulnerable. As a result, child care is a major expense for young families. Schulman²⁵² calculated that if two adults working at minimum wage full-time, making \$21,400 a year, spent 10 percent of their income on child care (10% is a higher percentage than non-poor families spend on average), they would have \$2,140 available for this purpose. Unfortunately, that amount is thousands short of the actual cost of care for one child (see Figure 5 below). Considering average annual cost of care in an urban area, there would be a shortfall of \$2,115 between what 10 percent of income buys and the cost of care for one child. For two children, the shortfall rises to \$7,823. Low income families (those with earnings no more than 200 percent of the federal poverty level) in Florida spend 16.2 percent of their earnings per month on child care compared to 5.5 percent paid by higher-earning families. Thirty-four percent of low income families pay more than 20 percent of their income for child care.²⁵³

²⁵¹ Sonenstein et al., 2002

²⁵² Schulman, 2000

²⁵³ Giannarelli & Barsimantov, 2000

Figure 5. A Comparison of Income Levels and Average Costs of Early Care and Education for 4-year old and 12-month old Children



Source: Giannarelli & Barsimantove, 2000

In every state, the average yearly cost of child care exceeds the average yearly cost of public college for families. Florida is among one-quarter of the states where the average cost of child care for a 4-year-old is more than twice the cost of public college tuition; the difference in the remaining states is less. The average infant care rate in Florida is almost three times the average college tuition rate. Families, on average, spend more in four years for child care than families with young adults pay in tuition for four years of college. Using Orange County as an example of an urban county in Florida, for a 4-year period, the cost to families for child care averages \$19,925 and the cost to families for public college tuition averages only \$8,088.²⁵⁴ Although the average costs of care are a bit lower in Santa Rosa County, presented as an example of a rural county in Florida, the patterns are very similar to that of urban counties and for the state. The reason for this is that in higher education, families pay about 25 percent of the cost, state government pays about 42 percent and 35 percent is contributed by federal and private grants. Contributions from the major revenue sources for child care include 39 percent from government sources, 1 percent from the private sector, and 60 percent from families.²⁵⁵

A set of federal and state early childhood programs (i.e., Head Start, Early Head Start, and School Readiness Programs) provide access to early care and education for low-income families, however, funding provides access to only a fraction of those eligible (see Table 13). The need is great; one in three children (under the age of 5) lives in a family at or below 150% of the federal poverty level and close to half of Florida's children in this age group are at or below 200% of the federal poverty level. Even the increased subsidies associated with changes in welfare policy have not met the need. In 2001, 134,511 children ages 0 to 4, or 33 percent of those eligible, were served in publicly funded school readiness programs. Proportionally, infants and toddlers were far less likely to be served than preschool-age children.

²⁵⁴ Schulman, 2000

²⁵⁵ Mitchell, Stoney, & Dicher, 1997

Table 13. Utilization of School Readiness Services by Age of Child.

Total Population January 2001	Under 1	Age 1	Age 2	Age 3	Age 4	Total 0-4	Percent of Total 0-4 Population
Total Population of Children	195,160	193,978	190,733	187,854	187,028	954,852	
Children – Family Income Below 150% of Federal Poverty Level	66,586	66,183	65,171	64,198	63,978	326,116	34%
Children – Family Income Below 200% of Federal Poverty Level	83,222	82,719	81,440	80,185	79,900	407,466	43%
Children Eligible & Served	7,141	14,930	18,485	34,331	59,624	134,511	
Percentage Eligible & Served	9%	18%	23%	43%	75%	33%	
Children Eligible & Not Served – Family Income below 200% FPL	76,081	67,789	62,955	45,854	20,276	272,955	
Percentage Eligible – Not Served	91%	82%	77%	57%	25%	67%	
Children Eligible – Not Served whose Parents are Working	45,801	40,809	37,899	27,604	12,206	164,319	

Source: Florida Partnership for School Readiness, Readiness Estimating Conference, March 2001.

Priority for receipt of public assistance for child care is given to children under Protective Service care as a child abuse and/or neglect prevention service. Migrants, teens, and families with incomes below 100 percent of the federal poverty level are another eligibility priority, many served through Head Start and Early Head Start programs. Families moving from welfare to work are also given priority for school readiness services.²⁵⁶ The burden of poor quality and limited choice falls most heavily on low- and middle-income working families whose financial resources are too high to qualify for subsidies yet too low to afford quality care.²⁵⁷

Quality of Care

Of particular concern and importance across the state, is the quality of early care and education. Researchers have found that the effects of non-maternal child care can be either good or bad depending on the quality of the care, the number of hours of care, and the quality of maternal care provided in the home as the alternative.²⁵⁸ Although the effects of child care are modest overall when compared to the stronger influence of the home environment, when access to high quality child care is available, it is especially effective in improving outcomes for children at risk due to poverty or other factors.²⁵⁹

Defining Quality

The definition of quality is based upon two components:

- ❖ Structural — adult-to-child ratios, group sizes, health and safety standards, staff preparation and qualifications, wages and benefits.
- ❖ Process — caregiver-child interaction, child-to-child interactions, staff-to-staff interactions, parent involvement.

²⁵⁶ Florida Partnership for School Readiness, 2003

²⁵⁷ Phillips et al., 1994

²⁵⁸ Shields & Behrman, 2002

²⁵⁹ National Research Council & Institute of Medicine, 2000

Research has consistently found positive relationships between these indicators, quality of care, and outcomes for children.^{260,261,262,263} Licensing requirements address many of the structural components of quality but rarely address process components. The voluntary system of accreditation (e.g., accreditation by the National Academy of Early Childhood Programs, a branch of the National Association for the Education of Young Children-NAEYC) is more likely to address these elements.

Research on NAEYC accreditation has found that accreditation results in higher quality care, teachers more attuned to children, more child-initiated activities, activities more suited to age groups, staff more involved in decision-making, higher morale and job commitment, more innovative programs, better-defined goals, more staff development opportunities, and lower staff turnover rates.²⁶⁴ Based on these findings, accreditation by the National Academy of Early Childhood Programs can be a helpful tool for parents trying to identify high-quality programs for their children. As of March 1, 2003, there were 647 programs accredited by NAEYC in Florida.²⁶⁵

The Benefits of Quality Care

Although quality child care is particularly beneficial for low-income children, there are benefits for all children. Across all levels of maternal education and child gender and ethnicity, children's cognitive and social development is positively related to the quality of their child care experience.^{266,267}

Studies have found both short-term and long-range benefits associated with high quality child care. Short-term benefits include less anxiety, less hostility and conflict, more secure attachment relationships with caregivers, more positive social interactions and pro-social behaviors with peers, higher scores on school readiness assessments, higher scores on standardized language tests, and higher cognitive competence. The short-term effects of poor quality care include less competent play behaviors, more negative interactions with peers, more identified behavior problems, lower cognitive and social development scores, less positive self-perceptions, lower scores on school readiness assessments, lower scores on intelligence tests, and lower scores on receptive and expressive language assessments.^{268,269,270,271}

²⁶⁰ Howes, Shinn & Galinsky, 1995

²⁶¹ National Research Council, 2001

²⁶² Peisner-Feinberg et al., 1999

²⁶³ Whitebook, Howes, & Phillips, 1989

²⁶⁴ Ethiel, 1997

²⁶⁵ National Association for the Education of Young Children, 2003

²⁶⁶ National Research Council, 2001

²⁶⁷ Peisner-Feinberg et al., 1999

²⁶⁸ Kontos et al., 1995

²⁶⁹ National Research Council, 2001

²⁷⁰ Peisner-Feinberg et al., 1999

²⁷¹ Whitebook, Howes, & Phillips, 1989

Long-term outcomes associated with high quality child care include improved school readiness, receptive and expressive language skills, higher cognitive development, better math skills, higher social skills, fewer behavior problems, greater academic achievement, fewer special education placements, fewer grade retentions, higher graduation rates, higher rate of college attendance, fewer criminal arrests, higher earnings, higher property wealth, and greater commitment to marriage. Effects are even greater for children at-risk of not doing well in school.^{272,273,274,275}

Quality child care can also have positive impacts on parental work and work environments. Parents who are comfortable about the child care choices they have made are more productive workers. Conversely, parents who are anxious regarding the care their child is receiving miss more days of work, are late to work more often, have lower worker productivity, and have a greater likelihood of dropping out of welfare to work programs if enrolled.

Quality of Care in the Nation and in Florida

Despite this evidence, a very limited number of programs in the nation or state are likely to be of high quality. The Cost, Quality, and Child Outcomes in Child Care Centers study (a national study across four states — California, Connecticut, Colorado and North Carolina) found only one in seven centers providing good quality care that promotes healthy development and learning. Infant and toddler care is less likely to be of high quality. Forty percent of infant care rooms were rated poor and placed infants' health, safety and development in jeopardy.²⁷⁶ In the Family Child Care and Relative Care Study²⁷⁷, researchers found only 9 percent of family child care rated good and 35 percent rated inadequate or poor. In addition, parents may choose informal care arrangements that are unlicensed and unregulated and likely to be of lower quality.^{278,279}

Although the care of infants and toddlers requires specialized skills and environments, there are few licensing requirements specific to care for these ages.²⁸⁰ Although there is a state infant/toddler training module, infant and toddler caregivers are not required to complete it and often take whichever 10-hour training module is readily available (e.g., preschool-age training module, school-age training module). Furthermore, infant care is particularly expensive to provide due to the low adult-to-child ratios that are required.

²⁷² Kontos et al., 1995

²⁷³ National Research Council, 2001

²⁷⁴ Peisner-Feinberg et al., 1999

²⁷⁵ Whitebook, Howes, & Phillips, 1989

²⁷⁶ Helburn et al., 1995

²⁷⁷ Kontos et al., 1995

²⁷⁸ Kontos et al., 1995

²⁷⁹ Shore, 2000

²⁸⁰ Ghazvini & Mullis, 2000

No state in the nation has worse adult-to-child ratio standards for child care programs than Florida, and state licensing regulations provide no group size limitations. It is all too common to find 20 or more babies in one room. Low salaries and benefits result in high turnover rates, and there are few incentives for professional development. States with more demanding licensing standards have fewer low quality programs and have more programs adhering to additional standards (such as accreditation).²⁸¹

Staff turnover, annually, averages between 30 percent and 40 percent nationwide. The field is 98 percent female, many of whom are parents of young children themselves. Occupations requiring nurturing skills, such as child care, are the most systematically underpaid relative to education and skill demands.²⁸² Indeed, child care employees are better-educated than the general population, are more likely to be women of color than other professions, and suffer a higher concentration of poverty-level jobs than almost any other occupation in the U.S. Other fields with similar education and training are better able to successfully retain skilled staff.²⁸³

The Gold Seal Program, unique to Florida, recognizes programs that have been accredited by one of eight different accrediting bodies. According to the Florida Children's Forum, 951 child care providers (excluding school-based Pre-K programs) were accredited and identified as Gold Seal providers in 1999-2000, accounting for only 16 percent of programs statewide. In 2001, there was a decrease in Gold Seal providers to 890, despite increases in the total number of programs statewide. The number of Gold Seal providers accounted for only 9 percent of all programs in the state.²⁸⁴

The vast majority of accredited programs are in urban counties (only 2% of those accredited were in rural counties), and 65 percent were in the 14 counties that exceed state minimum licensing standards either by accepting responsibility for licensure or requiring licensure of all family child care providers (see Table 14). Hillsborough and Palm Beach Counties, long known for their commitment to improving the quality of child care, have 10 percent of the total accredited programs in the state.²⁸⁵ In terms of saturation, it is notable that Clay and St. Johns Counties have by far the largest percentage of Gold Seal programs in their counties. In Clay County, one in every five programs is a Gold Seal accredited program. In St. Johns County one in every seven programs is a Gold Seal accredited program.

²⁸¹ Peisner-Feinberg et al., 1999

²⁸² Crittenden, 2001

²⁸³ Lavery et al., 2002

²⁸⁴ Florida Children's Forum, 2003

²⁸⁵ Ghazvini & Foster, 2001a

**Table 14 Gold Seal (Accreditation) Programs in Counties
that Require Early Care and Education Programs
to Exceed State Minimum Standards**

County	# Gold Seal in County	% Gold Seal in County
<i>Hillsborough</i>	110	7%
<i>Palm Beach</i>	96	8%
Miami-Dade	73	3%
<i>Pinellas</i>	63	4%
<i>Broward</i>	51	4%
<i>Duval</i>	48	4%
Brevard	26	5%
Leon	24	6%
<i>Sarasota</i>	19	5%
<i>St. Johns</i>	18	15%
<i>Polk</i>	17	3%
<i>Alachua</i>	14	3%
<i>Clay</i>	9	20%
<i>Nassau</i>	7	9%

Note: Counties in **bold** have accepted responsibility for licensure; counties in *italics* require licensure of all family child care homes; and seven counties do both.

Source: *Charting the Progress of Child Care and Early Education 2000-2002, Florida Children's Forum, 2003*

Improving the Quality of Care

Attaining quality, however, is costly. Vandell and Wolfe²⁸⁶ calculated the increased costs for child care programs associated with improving quality of care. Holding wages constant and using the average size center with 60 children as an example, they found the following impacts on variable costs (e.g., supplies, equipment, education and training):

- ❖ To improve the quality of a center from mediocre to good, the total variable costs would increase by approximately 10 percent — approximately \$20,700 per year or \$345 per child.
- ❖ To lower the adult-to-child ratio by one child (e.g. from 1:11 to 1:10) the total variable costs would increase by approximately 4.5 percent — approximately \$306 per child annually.
- ❖ To employ a child care worker with an additional year of education, the wages for that employee would increase by approximately 5.8 percent.

Federal law requires states to earmark four percent of the Child Care and Development Fund dollars for quality enhancements, but this amount is too little to build the infrastructure needed for a high-quality system of early care and education.²⁸⁷ Local school readiness coalitions have developed quality enhancement plans and the School Readiness Partnership has sought additional funding for implementation of the plans, however, additional state funding has not been forthcoming and is not expected in the near future. The School Readiness Act also mandates that coalitions continue to serve the same number of children, further limiting spending for quality enhancements.

²⁸⁶ Vandell & Wolfe, 2000

²⁸⁷ Shore, 2000

As previously reviewed, there have been some efforts to integrate child health and early care and education or parenting supports and early care and education as a means to improving the quality of care. Head Start and Early Head Start provide the most comprehensive services in the field, but such services reach a small number of Florida families and children (e.g., only 33,434 children were served in Head Start and Early Head Start programs statewide in 2001).²⁸⁸ Given the high numbers of young children that participate in some form of early care and education, it seems logical to replicate Head Start's coordination of health and family supports with early care and education settings.

Administering Early Care and Education Services

In an attempt to provide better coordination and improve school readiness, the 1999 Florida Readiness Act established the Florida Partnership for School Readiness, an entity designed to adopt and maintain “coordinated programmatic, administrative, fiscal policies and standards for all school readiness programs...” (s. 411.01(4)(a), Florida Statutes). The Act was intended to integrate early care and education programs and services with a focus on all children birth to age five.

Since its inception, the Florida Partnership for School Readiness has made significant strides in bringing the diversity of early childhood programs to the same table and establishing performance standards for early childhood programs. Fifty local/regional school readiness coalitions serving all 67 counties in Florida have built local commitment, and a few have secured non-state dollars to enhance services (e.g., Palm Beach and Sarasota coalitions have secured private foundation dollars for special projects).

These accomplishments have not occurred without challenges. In a mandated review of the program, the Florida Legislature Office of Program and Policy Analysis and Government Accountability²⁸⁹ found the program had not been fully implemented, its effectiveness had yet to be determined due to delays in implementing an assessment system, and several local coalitions were making limited progress. OPPAGA, like many in the field, also raised concerns regarding the participation (or potential loss of participation) of local school districts. Local coalition members have also voiced concerns regarding fiscal and policy mandates that prevent local flexibility.

The November 2002 election saw the passage of the universal prekindergarten constitutional amendment. Although the current school readiness system has not been in place long enough to assess outcomes, the implementation of the universal prekindergarten initiative as well as the rewrite of Florida Statute 411 (containing the School Readiness Act) will result in changes to the system. Although members of the early childhood community agree on many ideas, there is a high level of disagreement in several critical areas pertaining to implementation of universal prekindergarten. Development of an effective system is further hampered by the lack of data on school readiness indicators in Florida.

²⁸⁸ Florida Partnership for School Readiness, 2001b

²⁸⁹ Office of Program and Policy Analysis and Government Accountability, 2002

Parenting Support Services

The hard truth is that millions of American families and their children need help. What is required is a fundamental reconsideration of the social compact, restoring the balance between private and public responsibility.

R. Shore in Our Basic Dream, 2000

Early experiences, particularly the ability to bond and relate to others, lay the groundwork for future parenting behaviors, and good parenting can overcome some of the risks of poverty. In comparing the effects of good parenting practices between two-parent poor and non-poor households, researchers have found more beneficial outcomes for poor children than for non-poor children.²⁹⁰ Praising, hugging, and high parental aspirations affect the well-being of poor children more strongly. These findings suggest warmth, support, and high expectations buffer children from the negative consequences of economic distress. In one-parent households, parenting practices tend to benefit children who are not poor more than those that are poor, suggesting that children's capacity to respond positively to good parenting practices may be reduced when their living conditions include both poverty and the absence of one parent.

Parenting and Adolescents

Florida requires that all high school students complete a half credit course entitled "Life Management Skills". The course provides information on human growth and development, family life education, responsible decision-making, and personal health and well-being. Although there is no comparable mandatory course at the middle school level, a course entitled "Personal, Career, and School Development" has been developed and is designed for children of middle-school-age that are at-risk of school failure. The course includes a component on family relationships.²⁹¹

Supports for Florida's youngest parents are often difficult to access and of questionable quality. State law requires every school district to provide a Teenage Parenting Program (TAP). TAP programs offer regular academic classes so students can continue their educational program in addition to providing classes in child growth and development, nutrition, and parenting skills. Auxiliary services, which include health services, social services, child care, and transportation, designed to meet the special needs of pregnant or parenting students and their children are provided.²⁹²

The Teenage Parenting Program frequently struggles at the local level. School district administrators and board members are sometimes hesitant to address the needs of pregnant and parenting adolescents. Services may be provided at one site in the school district and lengthy bus rides are required for participating teen parents and their young children. Child care services have been found to be of poor to mediocre quality.²⁹³ The Florida Partnership for School Readiness, in

²⁹⁰ Hanson, McLanahan, & Thomson, 1997

²⁹¹ Florida Department of Education, 2002

²⁹² Center for Prevention and Early Intervention Policy, 2002

²⁹³ Center for Prevention and Early Intervention Policy, 2002

partnership with the Center for Prevention and Early Intervention Policy, has implemented a training and technical assistance project to improve the quality of care in TAP child care sites.

Furthermore, young parents are often isolated, living away from extended family, and uninformed regarding community resources. Traditional neighbor-to-neighbor supports seem to be eroding.²⁹⁴ Finding help is difficult. Lots of calls are often required and many lead to recorded messages, referrals to call other numbers, leading to more calls and waiting, and further referrals. Ehrenreich²⁹⁵ obtained \$7.02 worth of food after 70 minutes of calling and driving. It cost her \$2.80 for the calls not to mention the cost of the gas and lost work time costs.

Home-Visiting Programs

A variety of home-visiting programs are provided across the state. Healthy Families Florida works to address the complicated issues surrounding child abuse and neglect prevention and operates 37 projects serving targeted areas in 49 counties. Twenty-five of the counties are rural and considered high-risk, and the remaining 24 counties provide services in the highest risk zip codes within their counties. There are 18 counties, all rural and high-risk, that remain unserved. Healthy Families Florida is a comprehensive and holistic program that builds upon natural family supports. The program has been recognized for its success in reducing child maltreatment rates by promoting positive parent-child relationships, facilitating access to medical care and other supports for its participants, and increasing immunization rates (see Table 15).

Table 15. Healthy Families Florida Evaluation Findings

Dates of Study	Evaluation Design	Major Findings	Evaluation References
1/1999 – 9/2000	Multi-site with Comparison Groups	<ul style="list-style-type: none"> ✓ 98% of children had no verified indication of child maltreatment within 18 months of program completion ✓ Child abuse rate of 1.4% for Healthy Families Florida (HFF) participants compared to 2.4% for entire HFF target service areas and 2.0% for entire state 	Williams, Stern & Associates <i>Healthy Families Florida Statewide Evaluation: Summative Report 2001</i>
1998 – 2000	Single Site with a Single Group	<ul style="list-style-type: none"> ✓ 99% had no reports of child maltreatment for 12 months following target child's birth 	Edwards, C.D., Tripp, L., Purcell, L., & Evans, G.D. (2001). <i>Healthy Families Jacksonville Final Evaluation Report</i> . Gainesville, FL: UF
2000 – 2001	Single Site with a Single Group	<ul style="list-style-type: none"> ✓ 35% of participants ended dependence on public assistance ✓ 19% obtained GED/job training ✓ 64% obtained employment ✓ 41% obtained better housing ✓ 99% of children were on-schedule with immunization by age 2 ✓ Child maltreatment rate for participants was 1.6% compared to 4.5% for general population in county ✓ Knowledge or skills developed or enhanced through participation in program retained 6 months later 	Nelson, C. E., Gordon, T. & Hoffman, K. (2001). <i>Healthy Families Pinellas Evaluation</i>

²⁹⁴ Reich, 2000

²⁹⁵ Ehrenreich, 2001

Despite these impressive successes, Healthy Families Florida is not available statewide due to funding limitations. Services are limited to high-risk areas, and families voluntarily choose to participate. Furthermore, although services are provided through local agencies, the program is administered according to eligibility criteria and overall procedures that are established at the state level. These requirements limit local flexibility.

The Family Builder program and the Intensive Crisis Counseling Program are two additional home-visiting and/or in-home care models funded through the Department of Children and Families for child abuse and neglect prevention, family preservation, and family reunification. Funds are funneled from the state office to district offices to local service providers for delivery of the programs. Intensive Crisis Counseling is a six-week program designed to prevent out-of-home placements. Family Builders is a program of at least three months that focuses on reuniting families in which children have been placed in foster care or other out-of-home placements. Although all DCF districts receive funding for these programs, they, too, are limited in area, scope, and funding.²⁹⁶

Administered through the Partnership for School Readiness, Florida First Start also provides home visits with a focus on supporting parents in their role as a child's first teacher. Trained parent educators provide hands-on activities, information, and guidance to parents during monthly home visits. Florida First Start is available in less than half of Florida's counties to a limited number of families, and local school readiness coalitions now receive First Start funds and have discretion regarding their use.

Even Start Family Literacy Program, also administered through the Partnership for School Readiness, provides some home-based services in approximately 25 sites around the state. Unlike First Start, Even Start funds are distributed through a grant application process. Educators find both these programs to be extremely helpful to participating children and their families, and many counties have indicated their desire to have access to Florida First Start and Even Start Programs. Neither program, however, has the funding to support expansion, nor is information readily available regarding program outcomes.

The Home Instruction Program for Preschool Youngsters (HIPPY) is a home-based parent education program providing parents opportunities to help their children with school readiness. Neighborhood paraprofessionals, also with preschool-age children, provide teaching materials, activities and games for parents to use with their children. HIPPY has grown from 10 sites in 1996-97 to programs in 20 counties in 1999-2000. Nonetheless, sites may serve only one community within a county.

²⁹⁶ Team Florida Partnership, 2002

Parent Support and Skill-building

All of the aforementioned home-visiting programs include parent education and support activities and resources. One of the curricula used by Healthy Families Florida and developed by the FSU Center for Prevention and Early Intervention Policy is receiving national attention. In some places, Even Start and Florida First Start are utilizing the Parents as Teachers curriculum, a nationally recognized and researched program with demonstrated positive outcomes. These valuable resources, however, are provided to a relatively small number of families in Florida.

Head Start and Early Head Start have been recognized for their parent support and skill-building components. Parents can access a wide range of supports including literacy training; parent skill-building workshops; assistance with GED courses; resource and referral services; and assistance for child health, mental health, and dental care. A recent study of Early Head Start found that parents of enrolled children were more likely to read to their children, be emotionally supportive, help with language and learning, engage in more positive parenting behaviors, and participate more in education and employment-related activities.²⁹⁷

A number of Child Care Resource and Referral Agencies provide Parent Services Projects (PSP). Like other parent education programs connected to child welfare agencies and court systems, these services are limited in availability, scope, and success. These efforts are further hindered by lack of coordination.

“Parenting supports” are limited by the stigma many parents attach to “needing help”. Perhaps this is explanation for why there are so few promising programs and practices highlighted in the state and nation. With the notable exceptions of a few programs, like Healthy Families Florida, Head Start, and Parents as Teachers, few efforts have widespread appeal. Even these are not known to the general parenting population and are limited in availability and scope. Thus, even though “the best treatment is holistic and incorporates school, family, and community resources”²⁹⁸, parents find few such resources where they live.

Limitations to Current Efforts

Although Healthy Families Florida has developed numerous partnerships, coordination mechanisms are rare in parenting support programs. The challenge for family support professionals is to move beyond a system of multiple, disconnected models that serve similar populations in similar ways to a system of integrated services that incorporates the active agents of change in the current models. Coordination is needed not only among different family support components but also between family support, child health, and early care and education services. The Whole Child Project in Manatee is an example of efforts in one county to coordinate and integrate services for families. Meeting the diverse needs of families with young children will require concerted efforts across the state.

²⁹⁷ Love et al., 2002

²⁹⁸ Pipher, 2002, p. 298

Overarching Inefficiencies and Gaps in Service Delivery

Comprehensive approaches are built upon a foundation of principles that respect families and respond to their developmental needs. They are premised upon the idea that families' needs and aspirations, not bureaucratic processes, should be the driving forces behind the availability, accessibility, affordability, and quality of opportunities in each community.

Watson & Westheimer, 2000, pg. 3

Children in families with adequate resources are more likely to do better in school, be healthy, graduate from high school, and earn higher incomes as adults.²⁹⁹ For families without adequate resources, interventions typically focus on “fixing” problems rather than on helping people become able to meet their own needs. Social capital, the resources and opportunities that develop capacity and self-sufficiency in individuals and local institutions, is called for to enact real family and community enhancement.³⁰⁰

Models for comprehensive, community-based integrated support systems are rare. Indeed, “New Futures”, an ambitious five-city initiative launched by the Annie E. Casey Foundation over a decade ago struggled to develop such models. In assessing the effort, Casey President Douglas W. Nelson noted that it is important not to assume that cities or counties necessarily know what a comprehensive, community-based integrated support system looks like.³⁰¹ For those communities that participated in the project and have continued their efforts, there are continuing struggles with reaching that goal.

Florida’s system of children’s services councils is one model with great potential for integrating services at the local level. Chapter 125 of the Florida Statutes gives local communities the authority to establish special districts (i.e., children’s services councils) and empowers local voters to levy local property taxes designated for children’s services. There are 15 children’s services councils across the state and 8 of them are independent special taxing districts. With varying degrees of success, children’s services councils strive to coordinate services for the children of the county.

Typically, programs serving children and families are funded through countless federal, state, and local government channels, as well as through private sources. Every one of these programs has a unique set of standards, rules, and requirements about how funds may be used and who is eligible to receive them. Programs are run independently and managed separately. Their procedural requirements differ. Direct service providers are typically very knowledgeable about the particular rules and regulations connected to the services they provide to children and families; however, it is likely that they are not aware of many other services those same children and families could also receive.³⁰²

²⁹⁹ Shields & Behrman, 2002

³⁰⁰ Annie E. Casey Foundation, 1999

³⁰¹ Walsh, 2000

³⁰² Orland, Danegger, & Foley, 1995

Separate rules and administrative structures make it all but impossible to design and deliver services that are responsive to the needs of children and families. Current systems ignore two fundamental tenets of effective service delivery for children – 1) children with multiple needs require comprehensive and coordinated service strategies, and 2) local communities are the most likely places to effectively link programs and resources across agencies and public and private institutions.

Currently eligible families are not accessing benefits, and the differences across programs in income, assets, citizenship, and recertification standards create confusion and errors in determining eligibility. As families leave the welfare system, there is a tendency for their participation in other supports, for which they are eligible, to decline. For example, in one study, 57 percent of families leaving welfare were not accessing food stamps even though they were eligible, and similar findings have been noted in regard to Medicaid and child care subsidies.³⁰³

The federal government has enormous influence on how services for children and families are delivered. Although states and localities may spend more overall on children and families, the federal government has come to shoulder unique responsibilities in supporting children and families with high levels of need, and the federal government establishes the rules by which its financial assistance will be forthcoming, thus driving the basic design of services and supports.³⁰⁴

Many federal programs have limited goals (e.g., reduce families' dependence on welfare) rather than long-term goals that support family self-sufficiency and well-being. The current financing system inhibits the development of comprehensive, community-based services for children and families through:

- ❖ Centralized governance – localities are far removed from the decision-making process and have few choices regarding implementation.
- ❖ Categorical funding – local flexibility and holistic service delivery are limited.
- ❖ Treatment orientation – few dollars are earmarked for prevention services.
- ❖ Fragmentation – each problem is treated individually, without regard to family circumstances.
- ❖ Process orientation – funding encourages maintenance of caseloads, spending without careful planning and a long-range view, and a focus on procedures not progress.

Service providers, their administrators, and advocates make it no less difficult to integrate services. Turf issues make players reluctant to work together. Separate and rigid funding streams fuel the dissension. In the Casey “New Futures” initiative, directors found that a top-down strategy brought limited success because agency leaders protected one another more often than they held each other accountable for outcomes.³⁰⁵ Without incentives to integrate resources and services, the message and the messengers continue to cry categorization.

³⁰³ Shields & Behrman, 2002

³⁰⁴ Orland et al., 1995

³⁰⁵ Walsh, 2000

Early childhood policies and practices are highly fragmented. Entry points for families are complex and confusing, especially for underserved segments of the population and those with special needs. Despite recent efforts by the Partnership for School Readiness, the integration of the early childhood infrastructure remains elusive. Without integration, it is difficult to advance a prevention-oriented initiative for children and families and to coordinate services for those with complex problems. There are similar issues in the health care field. Families and children often have complex health care needs that require various types of expertise. Communication and coordination between health experts is rarely efficient; thus resources are not used effectively and important needs are unmet.³⁰⁶

³⁰⁶ National Research Council & Institute of Medicine, 2000