

FEDERAL RESERVE BANK OF MINNEAPOLIS COMMUNITY DEVELOPMENT REPORT

Report No. 2018-1

Early Childhood Development in Montana

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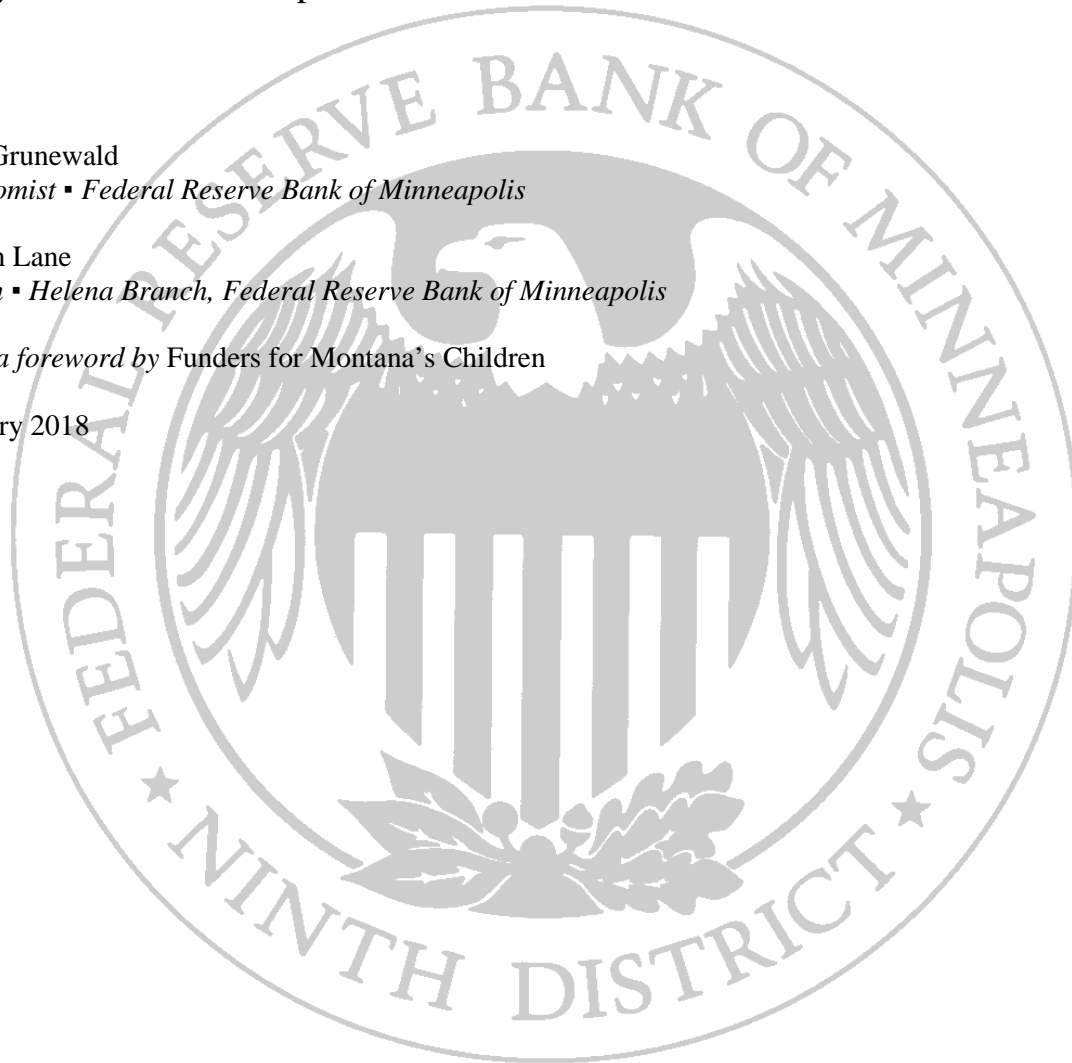
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With a foreword by Funders for Montana's Children

January 2018



A report series from the Community Development Department of the Federal Reserve Bank of Minneapolis.

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January 2018

By Rob Grunewald and Tegan Lane

Abstract

This report provides detailed statistics and information about early child health and development, child care quality, access to preschool, and other important indicators of success for Montana's youngest children. Building on the significant scholarship the Federal Reserve Bank of Minneapolis has contributed on the issue, the report also outlines opportunities for new investments to support Montana's children, particularly those who are most vulnerable. Research shows that early intervention and prevention programs can produce savings to state and local governments, including reduced costs related to remedial education, social services, and crime.

Key highlights from the report include: (1) The share of Montana's infants enrolled in Medicaid with evidence of perinatal drug exposure more than doubled from 2010 to 2016, putting more of Montana's young children at risk for health problems and developmental delays. (2) While Montana has made gains in reaching low-income families and young children with opportunities to attend high-quality early learning programs, less than 50 percent of 4-year-old low-income children and less than 10 percent of low-income children under age 3 have access to such programs. (3) In addition to supporting child development when children are cared for outside the home, the ability to access high-quality child care can help parents enter the workforce and be productive at their jobs. More than 60 percent of Montana children under age 6 have all of their parents in the workforce. (4) Partnerships among state and local stakeholders, nonprofit and public agencies, foundations, and the private sector offer opportunities for innovation and progress.

Foreword: The State of Early Childhood Development in Montana

Recent studies reinforce decades of research demonstrating that children’s early experiences, relationships, and environments have a strong link to health, well-being, and future life success. The combination of rich and safe environments at home and in the community, parents who are knowledgeable and nurturing, and high-quality early education lays the foundation for healthy and productive citizens.

Business leaders everywhere know that the success of their company and their country depends on the ability of people to solve problems, work in teams, and develop new ideas.¹ The foundation for these capacities starts in the earliest years of life. Research from the Center on the Developing Child at Harvard University shows that early childhood is a time of rapid brain development as well as growth in other biological systems. Children’s experiences and environments have powerful influences on their development and subsequent functioning.²

The return on investment (ROI) on early childhood programs is well documented. Investments in early childhood strengthen the economy, increase earnings, and contribute to the development of a skilled workforce while decreasing costs for health care, public assistance, and criminal justice. Nobel laureate economist James Heckman’s newest research finds an annual average 13 percent ROI for comprehensive, high-quality, birth-to-five early education. The research analyzes a wide variety of life outcomes, such as IQ, schooling, health, crime, income, and gains in maternal income due to stable child care.³

Montana has a number of early care and education, professional development, home visiting, and health and nutrition resources. Yet many of the most vulnerable children—who live in persistent poverty, unsafe environments, low-opportunity communities, or with unstable or unresponsive adults—are isolated from conditions that ensure healthy development.

¹ Ready Nation International. *Developing the Global Workforce of Today and Tomorrow: Investing in Early Childhood Development*.

² Center on the Developing Child at Harvard University. *The Foundations of Lifelong Health Are Built in Early Childhood*, July 2010.

³ The Heckman Equation. “13% ROI Tool Kit.”

Discussions with Montana business leaders over the past months have provided powerful insights into how the private sector views the science of human development and economic research on early childhood. They understand that early development impacts individual and community vitality as well as economic prosperity. Data show that one of the most effective strategies for economic growth is investing in the development of young children.⁴

Montana business leaders report they are motivated to get involved with early childhood issues when the solutions are clear and tangible, have a high probability of success, and complement existing early childhood initiatives. They understand that lending their leadership, ideas, and influence to early childhood efforts can provide significant momentum toward creating a strong workforce and a positive business climate. They also believe it is the right thing to do for their communities.

Partnerships among state and local stakeholders, nonprofit and public agencies, foundations, and the private sector offer exciting opportunities for innovation and progress. The group of foundations that make up Funders for Montana’s Children,⁵ the Federal Reserve Bank of Minneapolis, and the Minneapolis Fed’s Helena Branch office share the common goals to provide information about early childhood data and resources in Montana and foster cross-sector partnerships to address key issues facing young children and their families.

The purpose of this report is to help provide context about child population and health and education data in Montana, as well as the health, nutrition, and early learning resources available for children and families. This information can help inform discussions about early childhood policy and program development.

—Funders for Montana’s Children

⁴ The Heckman Equation. “Make Greater Investments in Young Children to See Greater Returns.”

⁵ The following foundations are members of Funders for Montana’s Children: Arthur M. Blank Family Foundation, O.P. and W.E. Edwards Foundation, Dennis and Phyllis Washington Foundation, Lora L. and Martin N. Kelley Family Foundation Trust, and First Interstate Bank Foundation.

Introduction

The first few years of life are a sensitive period for child development. Supportive and enriching early experiences shape the architecture of a child’s brain and help set a trajectory toward success in school and life. A strong start not only benefits children, it leads to a stronger economy and society.

As in other parts of the U.S., a substantial share of the youngest residents in Montana face challenges during these early years, as reflected in early development and health data. In response, Montana has made a number of health and education resources available for children and families. However, many eligible families don’t have access to these programs due to a lack of funding.

The purpose of this report is to provide data on Montana’s young children and their families, as well as an inventory of early childhood programs and resources in the state. This information can help inform discussions on how Montana can better serve young children and families.

The report has five sections. The first section presents research on the high return on investing in young children. Second, the report highlights data on Montana’s early childhood health and development. These data help identify children who are at risk for arriving at kindergarten behind their peers. The third section describes resources available for families with young children, including parenting, health, and nutrition programs; early learning programs; and resources for children and families in American Indian communities. Where data are available, the report shows the number of children and families served. The fourth section describes system-level supports through the Best Beginnings Advisory Council and other organizations that work at the state level. The report concludes with considerations regarding future investments in Montana’s young children.

Section 1: Investments in Young Children Yield High Public Returns¹

Neuroscience and developmental psychology research describes the type of early experiences that help children thrive, including stable and nurturing relationships with caregivers, language-rich environments,

¹ Adapted from Rob Grunewald. “Investments in Young Children Yield High Public Returns.” *Cascade*. Federal Reserve Bank of Philadelphia, September 2016.

and encouragement to explore through movement and senses. With supportive early experiences, children are more likely to arrive at kindergarten prepared to succeed in school.

Research also describes the experiences that hinder healthy development: poverty; exposure to violence, abuse, or neglect; and having an incarcerated or mentally ill parent. Adverse experiences, or “toxic stress,” can lead to a brain wired for negligence or threat, which can impair learning, memory, and the ability to self-regulate.

The impact of early adversity is observed in children well before they arrive at kindergarten. One research study documented that, by the age of 3 years, children in high-income families have twice the vocabulary of children in low-income families.²

Early adversity not only affects school success, but also is associated with mental and physical health issues later in life. According to an analysis of data collected in the Adverse Childhood Experiences study, adults who suffered multiple adverse experiences in childhood were more likely to suffer from heart disease compared with adults who did not have an adverse experience.³

The importance of early childhood development programs

In response to research on this issue, early childhood development programs seek to nurture healthy development from the earliest years. Programs that offer enriched experiences for children and involve parents and other caregivers provide benefits for all children but have the strongest impact on children from disadvantaged environments.

Prominent studies of early childhood education, including those of the Perry Preschool Project in Michigan (ages 3–4 years),⁴ the Chicago Child-Parent Centers program (ages 3–4 years),⁵ the Carolina

² Betty Hart and Todd R. Risley. *Meaningful Differences in the Everyday Experience of Young American Children*. Baltimore: Brookes Publishing, 1995.

³ Maxia Dong, Wayne H. Giles, Vincent J. Felitti, et al. “Insights into Causal Pathways for Ischemic Heart Disease: Adverse Childhood Experiences Study,” *Circulation*, 110(13), pp. 1761–1766, 2004.

⁴ James J. Heckman, Seong Hyeok Moon, Rodrigo Pinto, Peter Savelyev, and Adam Yavitz. “The Rate of Return to the HighScope Perry Preschool Program.” *Journal of Public Economics*, 94(1-2), pp. 114–28, 2010.

⁵ Arthur J. Reynolds, Judy Temple, Barry White, Suh-Ruu Ou, and Dylan L. Robertson. “Age 26 Cost-Benefit Analysis of the Child-Parent Center Early Education Program.” *Child Development*, 82(1), pp. 379–404, 2011.

Abecedarian Project in North Carolina (ages 3 months through 4 years),⁶ and the Prenatal/Early Infancy Project in Elmira, New York (home visits by a registered nurse; prenatal to age 2 years),⁷ demonstrate that children from disadvantaged environments can make gains from participating in a high-quality early learning program, and that the benefits extend well into adulthood.

Benefits include lower social costs (e.g., lower crime costs) and higher school achievement, educational attainment, and earnings. Analysis also shows health improvements, such as reductions in smoking and lowered risks for heart disease and diabetes. Benefit-cost ratios from these projects range from \$7 to as high as \$16 returned for every \$1 invested. In addition, across the four studies, public benefits from reduced societal costs and increased tax revenue were larger than private benefits to children and their families.⁸

In addition to these long-term studies, more recent research also finds benefits from investments in young children. In North Carolina, an evaluation of two resources—a statewide preschool program for disadvantaged 4-year-olds and a county-level partnership network called Smart Start that funds a variety of services for young children—found positive effects on third grade reading and math test scores, and reductions in the likelihood of special education placement.^{9, 10}

Meanwhile, results from a study of the Tulsa (Oklahoma) Public Schools Pre-K program for 4-year-old children show enduring effects into middle school, including higher math achievement test scores and enrollment in honors courses, and reductions in grade repetition.¹¹ An analysis of the Abbott Preschool program offered in New Jersey’s most disadvantaged school districts found evidence of gains in language arts and literacy, math, and science by fifth grade. Test score gains were larger for children who attended

⁶ Jorge Luis García, James J. Heckman, Duncan Ermini Leaf, and María José Prados. “The Life-Cycle Benefits of an Influential Early Childhood Program.” Human Capital and Economic Opportunity Working Paper Series. The University of Chicago, 2016.

⁷ Lynn A. Karoly, Peter W. Greenwood, Susan S. Everingham, Jill Houbé, M. Rebecca Kilburn, C. Peter Rydell, Matthew Sanders, and James Chiesa. *Investing in Our Children: What We Know and Don’t Know About the Costs and Benefits of Early Childhood Interventions*. Santa Monica, Calif.: RAND Corporation, 1998.

⁸ James J. Heckman, Rob Grunewald, and Arthur J. Reynolds. “The Dollars and Cents of Investing Early: Cost-Benefit Analysis in Early Care and Education.” *Zero to Three*, 26(6), pp. 10–17, July 2006.

⁹ Clara G. Muschkin, Helen F. Ladd, and Kenneth A. Dodge. “Impact of North Carolina’s Early Childhood Initiatives on Special Education Placements in Third Grade.” *Educational Evaluation and Policy Analysis*, 37(4), pp. 478–500, December 2015.

¹⁰ Helen F. Ladd, Clara G. Muschkin, and Kenneth A. Dodge. “From Birth to School: Early Childhood Initiatives and Third-Grade Outcomes in North Carolina.” *Journal of Policy Analysis and Management*, 33(1), pp. 162–187, 2013.

¹¹ William Gormley, Deborah Phillips, and Sara Anderson. “The Effects of Tulsa’s Pre-K Program on Middle School Student Performance.” *Journal of Policy Analysis and Management*, 37(1), pp. 63–87, 2018.

two years of preschool compared with those who attended for one year. The study also indicated reductions in grade repetition and special education.¹² Not all evaluations of early learning programs point to sustained gains, but the preponderance of research shows that investments in high-quality early learning can have a long-term impact.¹³

Not only can investments in young children reduce societal costs and increase tax revenue, they can boost future labor force productivity, a key ingredient of economic growth. The skills employers look for—including ability in math and language, working well in teams, critical thinking, self-motivation, and persistence—are shaped during the first few years of life. With demographic trends showing almost no growth in Montana’s population age 20 to 64 over the next 20 years,¹⁴ the effectiveness of early learning, as well as primary, secondary, and postsecondary education, will be important to help meet demands for labor.

A high-quality early learning system also helps parents enter the workforce. And once they find a job, such a system makes it less likely that working parents will be absent or less productive because of unreliable child-care arrangements. In Montana, 60 percent of children younger than 6 years old have all parents in the workforce.¹⁵ Research shows that parent absenteeism and productivity reductions due to child-care breakdowns cost U.S. businesses more than \$3 billion annually.¹⁶ Furthermore, access to quality child care can be challenging, particularly for families with infants and toddlers and those living in rural areas.

Despite the lack of supply in some areas, the early learning sector is a relatively large industry and employer in Montana. For example, total receipts among early care and education programs in Montana, including center-based child care, family child care, Head Start, and programs sponsored by public school districts, is larger than industries such as air transportation and radio and television broadcasting. As of 2008, early care and education programs employed more than 6,600 workers, more than in nursing care.¹⁷

¹² W. Steven Barnett, Kwanghee Jung, Min-Jong Youn, and Ellen C. Frede. *Abbott Preschool Program Longitudinal Effects Study: Fifth Grade Follow-Up*. National Institute for Early Education Research, March 2013.

¹³ Rob Grunewald, “Sustaining early childhood education gains.” *Community Dividend*, Federal Reserve Bank of Minneapolis, February 2016.

¹⁴ Montana Department of Commerce. *Montana Total Population by Gender and Age Group, 1990–2060*, April 2013.

¹⁵ U.S. Census Bureau, 2015 American Community Survey, 5-Year Estimates.

¹⁶ Karen Shellenback. “Child Care and Parent Productivity: Making the Business Case.” Linking Economic Development & Child Care Research Project, Cornell University, December 2004.

¹⁷ INSIGHT Center for Community Economic Development. *Montana Means Business: Investments in Early Childhood*, May 2008.

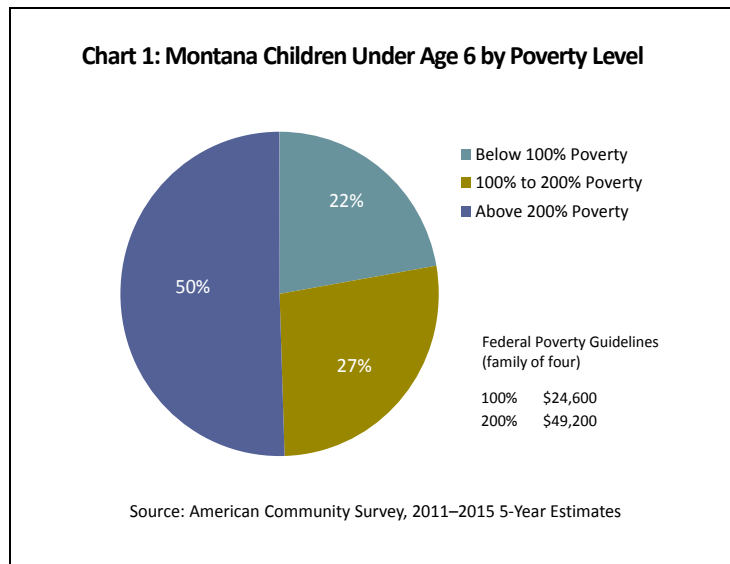
Research also shows that relative to many other industries, early learning providers tend to buy a greater share of services and materials from local businesses, and staff tend to spend more of their earnings locally, helping to foster local economic development.¹⁸

Section 2: Data on Montana’s Youngest Children

Population size and demographics

Montana has 73,242 children under age 6.¹⁹ Of these children, 22 percent live below the Federal Poverty Guideline, while almost 50 percent live below 200 percent of the poverty guideline. (See Chart 1.)

As discussed in Section 1, poverty is associated with stressors that can adversely impact child development. Children whose family incomes are below 200 percent of the poverty line are the focus of Montana’s recent federal Preschool Development Grant, a benchmark that identifies children who are at risk due to relatively low levels of family financial resources.²⁰

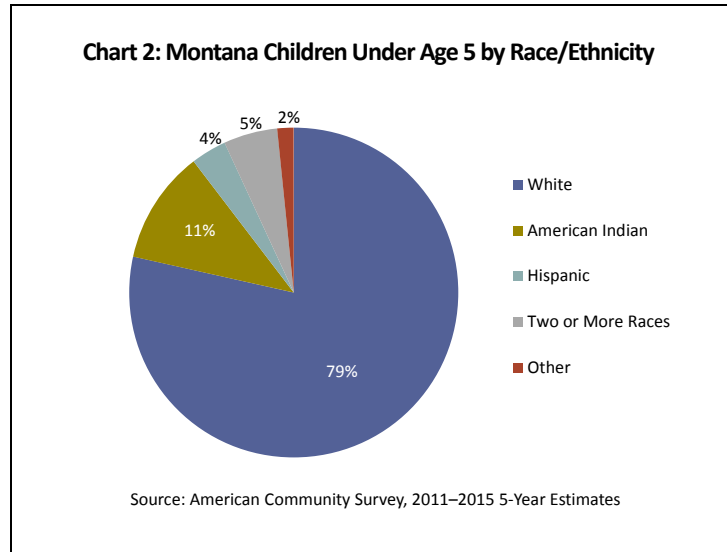


¹⁸ Mildred Warner. “Child Care Multipliers: Stimulus for the States.” Linking Economic Development and Child Care Research Project, Cornell University, 2009.

¹⁹ American Community Survey, 2011-2015 5-Year Estimates.

²⁰ 185 percent of the Federal Poverty Guideline, \$45,510 for a family of four, is the threshold used to identify children eligible for free or reduced price lunch in public schools.

Among children under age 5, American Indian is the largest minority population in Montana at 11.1 percent. (See Chart 2.) More than half of children identified as two or more races (5.3 percent of children under age 5) are American Indian in combination with one or more other races. Young Hispanic children make up 3.5 percent of the population.



Health and nutrition

Infant mortality. In 2015, Montana recorded 75 infant deaths, or 6 out of 1,000 children under the age of 1, similar to the U.S. rate. The infant mortality rate has decreased from just above 7 out of 1,000 during the early 1990s.²¹

Birth weight and gestation. Low birth weight is associated with increased risk for complications during infancy and later health problems. In 2015, 887 births were low-weight, or less than 2,500 grams (5.5 pounds). That figure represented 7.1 percent of all births, which was lower than the 8.1 percent rate for the U.S. In Montana, the share of low-weight births increased from 6.2 percent in 1990.²² During 2011–2013, preterm birth rates in Montana were highest for American Indian infants, at 15.9 percent, compared with 10.1 percent for whites.²³ Preterm birth is a condition that contributes to low-weight birth.

²¹ KIDS COUNT Data Center: A Project of the Annie E. Casey Foundation. Centers for Disease Control and Prevention, National Center for Health Statistics, “Infant Mortality,” May 2017.

²² KIDS COUNT Data Center. “Low Birth Weight Babies.”

²³ March of Dimes Foundation. *Born Too Small and Too Soon in Montana*, March 2015.

Drug abuse during pregnancy. Drug abuse during pregnancy can lead to birth complications, developmental problems, and even addicted babies. The Montana Health Care Foundation reported that the share of infants under age 1 enrolled in Medicaid with evidence of perinatal drug exposure increased from 3.7 percent in 2010 (less than 200 affected infants) to an estimated 12.3 percent in 2016 (more than 500 affected infants). A small but growing number of Montana newborns are diagnosed with neonatal abstinence syndrome (NAS), which is associated with physical dependence on drugs and subsequent withdrawal, most often seen with opioid exposure. During 2009–2013, average hospital charges for Montana newborns with NAS were \$34,000, versus \$6,800 for those without NAS.²⁴

Tobacco use. Tobacco use during pregnancy increases risks for premature and low-weight births.²⁵ In Montana, 18.5 percent of women age 18 and over were tobacco smokers in 2015.²⁶

Access to prenatal care. In 2008–2012, 86 percent of pregnant women in Montana accessed adequate or more than adequate prenatal care, while 72 percent of American Indian pregnancies accessed adequate or more than adequate prenatal care.²⁷ Fetal, neonatal, and infant death was 5 to 9 times higher for women who received no care at all.²⁸ A 2015 report showed that in Montana and the U.S., 6 percent of mothers who gave birth had prenatal care only in the third trimester of pregnancy or had no prenatal care.²⁹

Teen birth rate. The Montana teen birth rate decreased from 48 per 1,000 births in 1990 (1,331 total) to 25 per 1,000 births in 2015 (770 total). Nationwide, the teen birth rate was 22 per 1,000 births in 2015.³⁰

Breastfeeding initiation. Breastfeeding supports an infant’s immune system and proper weight gain, and helps prevent sudden infant death syndrome. At hospital discharge in 2014, 89 percent of Montana mothers were breastfeeding, higher than 79 percent for the U.S. However, breastfeeding initiation was only 71 percent for American Indian mothers in Montana.³¹

²⁴ Montana Health Care Foundation. *Medicaid’s Role in the Delivery and Payment of Substance Use Disorder Services in Montana*, March 2017.

²⁵ Association of Maternal and Child Health Programs. *Women’s Health Watch*, November 2008.

²⁶ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. “BRFSS Prevalence & Trends Data,” 2015.

²⁷ National Center for Health Statistics. *Adequacy of Prenatal Care Utilization: Pregnancy Outcomes, Montana, 2008–2012*.

²⁸ Charmel Burke and Ari Laurel. *Montana Racial Equity Report*. YWCA of Missoula, 2017.

²⁹ KIDS COUNT Data Center. “Births to Women Receiving Late or No Prenatal Care by Race and Ethnicity.”

³⁰ KIDS COUNT Data Center. “Total Teen Births.”

³¹ Anna G. Walker. *Breastfeeding at Hospital Discharge in Montana, 2014 Racial and Socioeconomic Differences*. Montana Department of Public Health and Human Services, Office of Epidemiology and Scientific Support, August 2015.

Adverse Childhood Experiences (ACEs) include: frequent socioeconomic hardship, parental divorce or separation, parental death, parental incarceration, family violence, neighborhood violence, living with someone who was mentally ill or suicidal, and living with someone who had a substance abuse problem or racial bias. Research shows ACEs are associated with risky health behaviors and chronic health conditions. Based on results from the National Survey of Children’s Health, in 2015–2016, 26 percent of children in Montana under age 18 were identified as having two or more adverse experiences as children (below age 18), higher than the national average of 22 percent.³²

Food insecurity. During 2003–2011, there were 9 percent of Montana households with children in which children experienced low or very low food security, compared with 9.4 percent for the U.S.³³ Low food security refers to a lack of consistent access to adequate food at some point during the previous year, including reduced quality, variety, or desirability of diet. A smaller share of children experienced very low security, or multiple indications of disrupted eating patterns and reduced food intake. Nationally, in 1 percent of households with children, one or more of the children experienced very low food security.³⁴

Developmental delays and behavior problems. In 2012, parents of 35,000 Montana children age 2 to 17, or 18 percent of the total, reported that a doctor told them their child has autism, developmental delays, depression or anxiety, ADD/ADHD, or behavioral problems, compared with 17 percent nationwide.³⁵

Asthma and obesity. About 6 percent of Montana children under age 18 reported having asthma problems in 2011–2012, compared with 9 percent nationwide.³⁶ Among teens age 10–17 in Montana, 29 percent were overweight or obese in 2011–2012, compared with 31 percent nationwide.³⁷

³² KIDS COUNT Data Center. “Children Who Have Experienced Two or More Adverse Experiences.”

³³ Alisha Coleman-Jensen, William McFall, and Mark Nord. *Food Insecurity in Households with Children: Prevalence, Severity, and Household Characteristics, 2010-11*. EIB-113, U.S. Department of Agriculture, Economic Research Service, May 2013.

³⁴ Ibid.

³⁵ KIDS COUNT Data Center. “Children Who Have One or More Emotional, Behavioral, or Developmental Conditions.”

³⁶ KIDS COUNT Data Center. “Percent of Children with Asthma Problems.”

³⁷ KIDS COUNT Data Center. “Children and Teens Overweight or Obese By Gender.”

Education

School readiness. Children attending preschool programs funded by Montana’s Preschool Development Grant are assessed in the fall and spring. Based on results from a sample of children assessed during spring 2016, 58 percent were considered kindergarten-ready. From fall 2015 to spring 2016, scores of sampled children increased from the 38th percentile to the 50th percentile, referenced to a national normative average. American Indian children increased from the 26th percentile to the 40th percentile.³⁸ Montana is in the process of developing and implementing a kindergarten-entry assessment that will provide more comprehensive information about the school readiness of Montana kindergarteners.

Fourth grade test scores. In 2015, 63 percent of Montana fourth grade reading test scores in the National Assessment of Educational Progress were below proficiency, compared with 65 percent nationally.³⁹ In 2015, 59 percent of Montana fourth grade math test scores were below proficiency, compared with 61 percent nationally.⁴⁰

Section 3: Programs and Resources for Montana’s Young Children and Their Families

Family support, parenting, health, and nutrition programs

Montana Maternal and Child Health Home Visiting Program. Home visiting programs support vulnerable families with pregnant women and young children by providing in-home counseling by health, social service, and child development professionals on topics such as maternal and infant health and nutrition, parent-child bonding, and family self-sufficiency. Research shows that home visiting programs are associated with improvement in maternal and newborn health; reductions in child injuries, abuse, and neglect; and improved school readiness.⁴¹

During 2015, family and child home visitors in Montana made 10,153 home visits to 1,937 parents and children in 954 families.⁴² The program is funded in part through the federal Maternal, Infant, and Early Childhood Home Visiting Program.⁴³

³⁸ Preschool Development Grants. *2016 Annual Performance Report: Montana*, August 2017.

³⁹ KIDS COUNT Data Center. “Fourth Grade Reading Achievement Levels.”

⁴⁰ KIDS COUNT Data Center. “Fourth Grade Math Achievement Levels.”

⁴¹ Health Resources and Services Administration, Maternal and Child Health Bureau. *Home Visiting*, June 2017.

⁴² Health Resources and Services Administration. “Home Visiting Program: Montana,” 2016.

Montana uses the following evidence-based models: Nurse-Family Partnership (nurse-based model for first-time at-risk pregnant women), Parents as Teachers, SafeCare Augmented (children at risk for neglect or abuse), Montana Healthy Families, and Family Spirit (American Indian families).⁴⁴

Montana Women, Infants, and Children (WIC) is a federally funded public health program that targets low-income families to improve maternal and child health and developmental outcomes. WIC offers supplemental nutrition education programs on breastfeeding and healthy eating. Over the 12-month period ending in September 2017, an average of 17,444 women and children per month participated in WIC in Montana.⁴⁵

The child welfare system is “a group of services designed to promote the well-being of children by ensuring safety, achieving permanency, and strengthening families to care for their children successfully.” States have the primary responsibility for child welfare services, while the federal government provides funding and legislative initiatives.⁴⁶ In 2015, there were 12,414 Montana children younger than 18 years old whose circumstances prompted an investigated report in the child protection system, a rate of 55 per 1,000 children, which is higher than the national rate of 45 per 1,000 children.⁴⁷ In 2015, there were about 1,310 children under age 6 in Montana’s foster care system.⁴⁸

Parental drug abuse, particularly of methamphetamines, is responsible for at least two-thirds of foster care cases.⁴⁹ The Montana Health Care Foundation reported that the number of children in foster care due to abuse or neglect related to parental substance abuse grew from 851 in 2010 to 1,658 in 2016.⁵⁰ In Montana, more than 6,600 grandparents are raising their grandchildren. Some grandparents are providing care due to parental substance abuse.⁵¹

Health insurance. Medicaid and Healthy Montana Kids draw on federal funding to reach children with health insurance. Medicaid provides health insurance to families that earn below 130 percent of the

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Montana Department of Public Health and Human Services. *Montana WIC Program Participation Report*, September 2017.

⁴⁶ Child Welfare Information Gateway. “How the Child Welfare System Works.”

⁴⁷ KIDS COUNT Data Center. “Children Who Are Subject to an Investigated Report.”

⁴⁸ KIDS COUNT Data Center. “Children in Foster Care by Age Group.”

⁴⁹ Lindsey Ford. “Meth’s Impact on Montana’s Foster Care System.” KTVH, May 2017.

⁵⁰ April Grady, Deborah Bachrach, and Patti Boozang. “Medicaid’s Role in the Delivery and Payment of Substance Use Disorder Services in Montana.” Montana Healthcare Foundation, March 2017.

⁵¹ Sandra J. Bailey, et al. *Grandparents Raising Grandchildren: Parenting the Second Time Around*. Montana State University Extension, February 2016.

federal poverty threshold annually. During second quarter 2017, 36,545 Montana children were eligible for Medicaid.⁵² Healthy Montana Kids, Montana’s Children’s Health Insurance Program that offers free or low-cost health insurance plans for eligible children up to age 19, provides health insurance for families earning up to about 250 percent of poverty.⁵³

Children with disabilities. Less than 1 percent of Montana children ages 0 to 4 have a physical disability: 0.2 percent have a visual disability, 0.4 percent a hearing disability, and 0.4 percent another disability.⁵⁴ For children under the age of 18 in Montana, 6,763 reported having special health care needs.⁵⁵

Montana Milestones is the federally funded Part C Early Intervention Program for Infants and Toddlers for children ages 0 to 3 with disabilities, part of the Individuals with Disabilities Education Act (IDEA). Children eligible for the Intervention program are consulted with a team to develop an Individualized Family Service Plan.⁵⁶ For the years 2015 through 2016, a total of 721 children ages 0 to 2 who were enrolled in Part C were receiving home and community-based services.⁵⁷

Special Education Preschool is available through the federally funded IDEA Part B. More than 1,600 children ages 3 to 5 are served annually by school districts in Montana.⁵⁸

Early learning programs

A variety of early learning programs provide education and care for young children in group settings, including licensed preschools, child care centers, and family child care; and informal care arrangements through family members, friends, and neighbors. Similar to other states, Montana has a diverse array of providers from the government, nonprofit, and for-profit sectors. The majority of funding for early care and education programs comes from tuition payments from families.

⁵² Montana Department of Public Health and Human Services. *Quarterly Charting: All Medicaid Eligibilities Including Medicare Savings Plan Only*, May 2017.

⁵³ Montana Department of Public Health and Human Services. *Healthy Montana Kids*. 2017

⁵⁴ W. Erickson, C. Lee, and S. Von Schrader. *2011 Disability Status Report: Montana*. Employment and Disability Institute at the Cornell University ILR School, 2012.

⁵⁵ KIDS COUNT Data Center. “Children With Special Health Care Needs.”

⁵⁶ Montana Department of Public Health and Human Services. *Montana Milestones Part C Intervention*, 2017.

⁵⁷ Montana Department of Public Health and Human Services. SSS IDEA Part C Child Count and Settings Release 4.0, 2015–2016.

⁵⁸ Legislative Services Division. *Preschool Building Blocks in Montana*, November 2017.

Preschool for 4-year-olds. In 2014, Montana received an annual \$10 million Preschool Development Grant from the U.S. Department of Education, renewable for four years. The grant provides preschool to children with family incomes below 200 percent of poverty (\$49,200 for a family of four). In 2016, grant funds were distributed to 18 sub-grantees located in 46 high-needs communities, including 8 American Indian communities. During the 2015–2016 school year, preschool programs served 462 children; in 2016–2017 they served 763 children.⁵⁹

The first-ever state investment in publicly funded preschool, proposed by Governor Steve Bullock, was passed with bipartisan support by the legislature in 2017. For the next two years, \$3 million per year was allocated for STARS Preschool pilot programs that will expand access to quality early childhood education for 4-year-olds. Prior to this appropriation, Montana was one of seven states that did not provide state funding for preschool.⁶⁰ Public schools, Head Start programs, child care providers serving 4-year-olds, private preschools, and community-based preschools were eligible for competitive grants of up to \$150,000 to participate in the STARS preschool pilot program. Programs in 16 communities were selected and will reach 285 4- and 5-year-old children.⁶¹

Head Start, Early Head Start (EHS), and EHS-child care partnerships promote school readiness for children ages 0 to 5 who live in low-income families. Head Start and EHS provide comprehensive services, including early childhood education, health, and family resources.

Local grantees receive Head Start and EHS funding from the federal government. While some states provide general revenue to supplement federal EHS and Head Start funding, Montana does not.

Children ages 3 to 5 whose family incomes are below 100 percent of poverty (\$24,600 for a family of four) are eligible to attend Head Start prior to entering kindergarten. However, availability is constrained by funding. In 2016, Head Start funded 4,068 slots (spaces) in Montana, reaching about 41 percent of eligible children.⁶²

⁵⁹ Preschool Development Grants. *2016 Annual Performance Report: Montana*, August 2017.

⁶⁰ Education Commission of the States. *50 State Review*, January 2016.

⁶¹ State of Montana Newsroom, Montana Government News. “Governor Bullock Announces Preschool Opportunities in Communities Across Montana,” July 2017.

⁶² National Head Start Association. *2016 Montana Head Start Profile*, 2016.

Children ages 0 to 2 whose family incomes are below 100 percent of poverty are available for EHS. EHS serves children either through center-based or home visiting programs, or in combination. EHS funded 866 children in Montana during 2016, about 13 percent of eligible children.⁶³

In 2016, EHS-child care partnerships provided services at 29 locations in Montana, serving 5,270 children. Twelve of these programs were for American Indian communities.⁶⁴ Montana's funding for Head Start, EHS, and EHS-Care Partnerships was estimated at just over \$28 million in 2016.⁶⁵ The partnerships help boost quality of child care programs, which also benefits the non-EHS children enrolled in the program.

Montana's child care system provides key infrastructure that allows parents to enter the workforce and also supports child development while children are cared for outside the home. Over 60 percent of Montana children under age 6 have all of their parents in the workforce.⁶⁶ Montana supports access to child care through subsidies for low-income working parents and initiatives to boost the quality of programs.

The formal child care system comprises child care centers, which often have multiple classrooms, and family-based child care programs operated out of a home. In Montana there are 251 centers and 655 family-based providers.⁶⁷ Many children also attend child care provided in informal arrangements, which are referred to as Family, Friend, and Neighbor care.

Child care bills for a family can rival the cost of university tuition. In Montana the average child care tuition for a 4-year-old in full-time care is \$7,994 per year; average tuition is higher for infants, at \$9,096.⁶⁸ For comparison, undergraduate tuition at Montana State University is just over \$7,000 per year.

In Montana, **child care subsidies** are available to families who earn below 150 percent of the poverty level, or \$36,900 for a family of four, through the Best Beginnings Child Care Scholarship program.

⁶³ Ibid.

⁶⁴ Ibid.

⁶⁵ Montana Budget and Policy Center. "Child Care in Montana: Access to Affordable and Quality Care," September 2016.

⁶⁶ U.S. Census Bureau, American Community Survey, 2015 5-Year Estimates.

⁶⁷ Child Care Aware of America. *2017 State Child Care Fact Sheets in the State of: Montana*, 2017.

⁶⁸ Ibid.

According to data from 2014, only 14 percent of the more than 34,000 eligible low-income children received Best Beginnings subsidies.⁶⁹ In fiscal year 2016, Montana spent \$22.7 million on child care.⁷⁰

Child Care Aware Montana provides child care resources to providers and families, including referral services for parents looking for child care.

Montana's Quality Rating and Improvement System (QRIS), STARS to Quality, uses a set of standards or checklists to rate participating providers from 1 to 5 stars. The highest-rated programs must enroll a certain share of children with high needs, such as children who have teenage parents, a Best Beginnings subsidy, are enrolled in a tribe, or are homeless. The voluntary program rates providers on five categories: Education, Qualifications, and Training; Staff/Caregiver-to-Child Ratio and Group Size; Family/Community Partnerships; Leadership and Program Management; and High-Quality Supportive Environments.

Parents can visit the STARS website to search for providers by their rating. The web tool is designed to provide parents with accessible information on provider quality and guidance on finding quality child care programs.⁷¹

The STARS QRIS was field tested in 2011; the program is now available statewide with 229 rated providers.⁷² However, participation in STARS is limited due to a lack of funding.

The Early Childhood Services Bureau, within the Montana Department of Public Health and Human Services (DPHHS), created the rating criteria through the Best Beginnings Advisory Council. STARS offers incentives to programs through quality improvement awards and tiered reimbursement for serving children with a Best Beginnings subsidy. The quality improvement awards range from \$625 for a family-based provider that achieves a STAR 1 rating (\$2,063 for a large center), to \$1,563 for a STAR 5 family-based provider (\$5,000 for a large center). Tiered reimbursement for child care subsidies starts at 5

⁶⁹ Montana Budget and Policy Center. "Child Care in Montana: Access to Affordable and Quality Care," September 2016.

⁷⁰ Department of Public Health and Human Services. "Child Care State Fiscal Year 2016 Managerial Reports," 2016.

⁷¹ Montana Department of Public Health and Human Services. *Best Beginnings STARS to Quality Guidance and Procedure Document*, April 2017.

⁷² Montana Department of Public Health and Human Services. *Montana - Quality Rating & Improvement System Resource Guide*, 2017.

percent for STAR 2 providers, increasing to 10 percent for a STAR 3 providers, 15 percent for STAR 4 providers, and 20 percent for STAR 5 providers.⁷³

Child care programs can receive funding to provide meals and snacks through the federal **Child and Adult Food Program**. Funding is allocated to programs based on the number of children enrolled from low-income families.⁷⁴

Resources for American Indian children and families

American Indian children represent 11 percent of Montana’s children under age 5. Early childhood development (ECD) programs in Native communities can help children start strong, even as many young Native families face challenges associated with poverty. Evidence suggests that Native ECD programs that integrate the culture and language of indigenous communities can support child development and sustain Native approaches to living.⁷⁵

Family Spirit home visiting is an example of a culturally reflective program for families and young children. Native paraprofessionals or licensed staff use a curriculum that includes topics such as prenatal care, breastfeeding and nutrition, parenting skills, child development, and substance abuse prevention. The Family Spirit model has demonstrated improvements in parenting and parental mental health, such as increases in maternal knowledge and reductions in parental stress, maternal depression, and substance abuse. In addition, at 1 year of age, children enrolled in Family Spirit exhibit fewer behavioral issues.⁷⁶

Head Start and EHS are available in tribal communities, with flexibility to incorporate tribal culture and language. Several American Indian communities in the country, including in Montana, have implemented **language immersion programs** that begin in early childhood care and education settings. These programs have helped boost children’s Native language acquisition and skills needed to succeed in school.⁷⁷ In 2012, the Administration for Native Americans awarded a three-year grant to the Crow Nation Apsaalooke Pre-School Language Immersion Project and in 2015 a three-year grant to the Salish

⁷³ Ibid.

⁷⁴ Ibid.

⁷⁵ Rob Grunewald. “The promise of early childhood development in Indian Country.” *Community Dividend*, Federal Reserve Bank of Minneapolis, November 2017.

⁷⁶ U.S. Department of Health and Human Services. “Implementing Family Spirit & Regulations and Program Model Overview.”

⁷⁷ Rob Grunewald. “Early childhood Native language immersion develops minds, revitalizes cultures.” *Community Dividend*, Federal Reserve Bank of Minneapolis, August 2016.

Language Preservation project.⁷⁸ The latter includes creating a Salish language learning nest environment on tribal lands for children ages 0 to 3 and their parents and caregivers.⁷⁹

The **Indian Health Service** (IHS) sponsors a targeted early childhood dental program, Early Childhood Caries, designed to enhance knowledge about early childhood caries prevention among dental and healthcare providers and American Indian communities. The program promotes preventative and restorative dental care for American Indian children under age 6.⁸⁰

The **Indian Child Welfare Act** sets policy regarding placement of foster children in American Indian reservations. According to ICWA, caseworkers are required to make active efforts with the child's family, notify the child's tribe and parents of the child custody proceeding, actively involve the tribe and parents in the proceedings. The National Indian Child Welfare Association supports tribes in building the capacity to prevent child abuse and neglect and provide information on American Indian and Alaska Native child welfare.

As an example of support from state legislators, Montana passed a 2015 bill to assist a school district in implementing an American Indian language immersion program.⁸¹

Section 4: System- and State-Level Supports

Established in 2011, the **Best Beginnings Advisory Council** (BBAC) serves as the state's comprehensive early childhood advisory council and collaborating entity for the early childhood system. The Early Childhood Services Bureau within DPHHS serves as the home for the BBAC. The council includes representation from interested constituent groups, governmental agencies, the public at large, child care providers, state and local government, and tribal communities.

⁷⁸ Administration for Native Americans. "ANA Grantees as of October 2013. Native American Language Preservation and Maintenance—Ester Martinez Initiative."

⁷⁹ Administration for Native Americans. "Active Grants in Native Languages—Esther Martinez Immersion."

⁸⁰ Indian Health Service. "IHS Early Childhood Caries Collaborative."

⁸¹ Alyssa Rafa. "State and Federal Policy: Native American Youth." *Policy Analysis*, Education Commission of the States, November 2016.

The BBAC collaborates with 20 Montana-based coalitions statewide to regulate and improve early learning. Local Best Beginnings coalitions implement initiatives to increase coordination across early childhood systems at the grassroots level in towns, counties, and regions.⁸²

The BBAC's objectives include:

1. Children have access to high quality early childhood programs
2. Families with young children are supported in their community
3. Children have access to a pediatric medical home⁸³ and health insurance
4. Social, mental, and emotional health needs of young children and families are supported.⁸⁴

Montana Early Childhood Project (MECP) is an outreach program through Montana State University's Department of Health and Human Development. The program's mission is to improve the quality of early care and education services for young children and their families by providing an integrated professional development system to build a knowledgeable, competent, and stable early childhood workforce.⁸⁵

Montana Project LAUNCH is a federal initiative implemented by DPHHS with a five-year, \$800,000 annual grant awarded in 2014 from the Substance Abuse and Mental Health Services Administration. The program engages the state's early childhood partners to improve systems and access to mental health services for young children and families. Evidence-based practices are also piloted in Gallatin and Park counties for children from birth through age 8. Based on findings from the pilots and system-level work, the program's goal is to develop a comprehensive system of early childhood mental health supports that can be replicated in communities throughout the state.

Montana Early Learning Standards were released in 2014, designed to guide the work of early childhood professionals to ensure that children from birth to age 5 have the skills and knowledge to achieve success in learning and reach their full potential. The standards were developed by a task force of

⁸² Montana Department of Public Health and Human Services. "Best Beginnings Advisory Council."

⁸³ According to the American Academy of Pediatrics, "A pediatric medical home is a family-centered partnership within a community-based system that provides uninterrupted care with appropriate payment to support and sustain optimal health outcomes. Medical homes address preventative, acute, and chronic care from birth through transition to adulthood. A medical home facilitates an integrated health system with an interdisciplinary team of patients and families, primary care physicians, specialists and subspecialists, hospitals and healthcare facilities, public health and the community."

⁸⁴ See footnote 82.

⁸⁵ Montana Early Childhood Project. "About Us."

early childhood experts and leaders across Montana. The project was sponsored by DPHHS, BBAC, and MECP.⁸⁶

Healthy Mothers Healthy Babies (HMHB) works to improve the health, safety, and well-being of Montana families by supporting mothers and babies from age 0 to 3. HMHB advocates for supportive policies at the local, state, and federal levels and builds partnerships to create an integrated network of support for maternal and child health services. The organization works with local BBAC coalitions to share strategies and use common messaging.

Two initiatives in Montana apply a *collective impact framework* to early childhood issues, which is a structured approach to collaborate across government, business, philanthropy, nonprofits, and citizens to address complex social problems. The **Montana Early Childhood Collective Impact Initiative** works to advance collaborative capacity and align local service delivery efforts by providing training to community and state-level early childhood leaders. A new project, the **Montana Children’s Health Data Partnership Project**, will bring together public and private sector partners, including local early childhood coalitions, to develop actionable early childhood measures to improve the social determinants of health for Montana children.

Section 5: Moving Forward with Early Childhood Investments

While Montana has a number of resources available for young children and their families, a substantial share who live in low-income households remain unserved. For each of the resources described in Section 3, there are opportunities to expand reach and, for some services, increase quality and intensity.

Family support, parenting, health, and nutrition programs

Home visiting programs reached about 1,000 families in 2015. This represents about 37 percent of Montana children born each year into families with income below 100 percent of poverty, or 17 percent of children born into families with incomes below 200 percent of poverty. However, since some home visiting models serve families for longer than one year, the percent of children served is likely lower. Some states allocate general revenue toward home visiting programs to augment federal funding for home

⁸⁶ Montana Department of Public Health and Human Services, Best Beginnings Advisory Council, and Montana Early Childhood Project. *Montana Early Learning Standards*, 2014.

visiting. For example, in 2017 the Minnesota legislature passed \$12 million for the 2018–2019 biennium and \$33 million for 2020–2021 to expand evidence-based home visiting.⁸⁷

Early learning programs

As discussed in Section 3, Montana has a number of resources for young children to attend an early learning program, including preschool, Head Start and EHS, and child care subsidies. However, as a whole, many low-income children remain unserved. Current preschool funding reaches just over 1,000 4-year-old children, equivalent to 17 percent of children whose family incomes are below 200 percent of poverty. As noted in Section 3, Head Start and EHS reach 41 percent and 13 percent of the eligible population, respectively, while Best Beginnings subsidies reach 14 percent of eligible children. Public preschool, Head Start, and 4- or 5-star-rated child care combined reach less than 50 percent of 4-year-old children whose family incomes are below 200 percent of poverty in Montana, while EHS and 4- or 5-star-rated child care reach less than 10 percent of children from birth to age 3 whose family incomes are below 200 percent of poverty.

Research suggests that increasing access to early learning programs should correspond with efforts to maintain or improve program quality. Montana’s STARS to Quality can serve as a tool to support quality improvement across program types and provide information to parents about searching for quality programs. Like some other states, Montana could conduct a validation study to determine whether STARS to Quality rating tiers correlate with independent measures of quality and child outcomes. Based on such an evaluation and input from stakeholders, policymakers and program administrators can determine whether any changes are warranted.

Early learning scholarships are one strategy for providing targeted and flexible funding for early learning combined with a quality rating scale. As discussed in *The Minnesota Model for Early Childhood Education*, state funding for early learning scholarships is paired with a quality rating system.⁸⁸ The scholarships can be layered with child care subsidies and preschool funding streams and are designed to empower parents with information and high-quality choices across a variety of program types, including public and private preschools, Head Start, child care centers, and family child care programs.

⁸⁷ Minnesota Coalition for Targeted Home Visiting. “Evidence-Based Home Visiting Grant Program Request For Proposals,” December 2017.

⁸⁸ Sharon J. Rolnick and Arthur J. Rolnick. “The Minnesota Model for Early Childhood Education.” University of Minnesota, February 2017.

Intersection between child welfare system and early childhood development services

Children who are involved in the child welfare system are some of the most vulnerable in Montana and are where investments in prevention have the potential to produce high public returns. These children should have access to early childhood development services and receive screening and support for mental health issues. As a local example in Montana, the Butte Child Evaluation Center (CEC) with its multi-disciplinary team of public and private agencies, provides support for child victims of sexual and physical abuse. Child interviews and medical exams are conducted at the CEC, which also provides victim advocacy and mental health services.⁸⁹

Parental drug addiction

A finding that stands out in the Montana data is the increase in drug use by expectant mothers and parents of young children. Over the past few years, this has contributed to an increase in adverse birth outcomes and reasons why children are involved in the child welfare system. Efforts to curb drug addiction would help both adults and children. Resources through DPHHS and IHS can help support such initiatives.

Health and dental care

As discussed in Section 3, there are a number of health insurance resources for young children and families. However, health insurance is often not enough to support the well-being of young children. Programs that support care continuity, such as pediatric medical homes, and ensure that well-child visits happen are important supports for child health. In addition, dental care during the first few years of life is crucial to avoid painful oral complications that can impair early learning and development. Head Start and EHS provide support for early health and dental care, as well as IHS. Other state- and community-level programs can also aid young children and families.

Connecting healthy and local food sources with early learning programs

Early learning programs that serve low-income children can access resources from the Child and Adult Food Program to provide meals. Sometimes early learning programs need assistance in putting food

⁸⁹ Butte Child Evaluation Center. "Butte Child Evaluation Center, Multi-Disciplinary Team: What Works in Montana Project 7," Montana Healthy Communities Conference, November 1–2, 2017.

preparation infrastructure in place in order to draw on these federal funds. In addition, early learning programs could be incorporated into emerging local farm-to-school programs.

Initiatives in American Indian communities

As discussed in Section 3, there are a number of early childhood and family initiatives under way in American Indian communities. In each of the domains listed in this concluding section, there are opportunities to work with tribal communities to implement and expand programs that incorporate indigenous language and culture.

Public-private partnerships and the business sector

Across the country, a number of ECD initiatives at the state and local level have moved forward by leveraging funding and in-kind resources from philanthropy and businesses. While foundations and private sector resources are not enough to fill the gap in the need for ECD services, public-private partnerships can play an important role in piloting new initiatives and scaling successful models.

Business leaders also have much to gain from early investments, including access to consistent and high-quality child care for their employees who are parents. Some business leaders in the country are volunteering their expertise and advocacy to improve child care quality and access. For example, in Minnesota a nonprofit founded by business leaders has helped the state's QRIS by piloting the model in four communities, providing in-kind marketing, and funding an evaluation. Business leaders have also mentored child care operators who often don't have formal business training. Finally, some businesses also support their own parent employees by providing flexible work schedules and resources to help them access child care.

In some states, business leaders have been active in helping move ECD policy forward. For example, the Pennsylvania Early Learning Investment Commission, New Mexico Early Childhood Development Partnership, and Minnesota Early Learning Foundation are all examples of business-leader-led organizations that have helped move ECD investments forward in their respective states.

In Montana, Funders for Montana's Children is a group of philanthropic foundations from across the state that have joined forces to increase the awareness of and the will to advance investments in high-quality early childhood programs by expanding partnerships. Funders include the Arthur M. Blank Family

Foundation, Dennis and Phyllis Washington Foundation, O.P. and W.E. Edwards Foundation, Lora L. and Martin N. Kelley Family Foundation Trust, and First Interstate Bank Foundation. As discussed in the report foreword, Funders for Montana's Children, the Federal Reserve Bank of Minneapolis, and the Minneapolis Fed's Helena Branch office share the common goals of providing information about early childhood data and resources in Montana and fostering cross-sector partnerships to address key issues facing young children and their families.