Kids, Cuts, and Consequences:

How Cuts to Effective Programs Hurt Our Children

Prepared for The Home for Little Wanderers by The Massachusetts Budget and Policy Center

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The Home for Little Wanderers

MASSACHUSETTS BUDGET AND POLICY CENTER

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DECEMBER 2005

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About The Home for Little Wanderers

The Home for Little Wanderers is the nation's oldest and New England's largest, private, non-profit child and family service agency, providing services to thousands of children and families through 20 programs each year. The mission of The Home is to ensure the healthy emotional, mental and social development of children at risk, their families, and communities through an integrated system of prevention, advocacy, research and a continuum of direct services. For more information, visit www.thehome.org.

About the Massachusetts Budget and Policy Center

The Massachusetts Budget and Policy Center provides independent research and analysis of state budget and tax policies, as well as economic issues, that affect low and moderate income people in Massachusetts. The analysis and data in this report were prepared by the Massachusetts Budget and Policy Center and should not be attributed to The Home for Little Wanderers or any of the other organizations acknowledged above.

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Executive Summary

When we think about state government, many of us think about the Golden Dome on Beacon Hill, or faceless bureaucrats, or politicians. In looking carefully at the effects of budget cuts on children, this report goes beyond those images and asks: what does our government do with our tax dollars? Specifically, what does our government do for children in Massachusetts? Does the government improve our children's lives in important ways? What happens to children when government stops doing these things?

The lives of all of our children are improved when our government acts in effective ways:

- Almost one million children attend public schools in the Commonwealth each year. The quality of the education they receive will shape not only their individual economic futures, but also the economic future of Massachusetts.

- State public health programs protect the health and well-being of children across the state by screening children for disease and providing immunizations to keep them healthy.

- Libraries, playgrounds, and parks are used by all of our children throughout the year. They improve the quality of life for all of our families.

Government plays a particularly important role in the lives of those children who face the greatest challenges:

- Close to 450,000 children depend on our government to pay for their health care so they can go to the doctor and be treated when sick.

- Forty thousand of our children whose own home lives are most difficult receive services from the Department of Social Services: counseling and referrals to other services if that is what is needed, and a new home if they can no longer remain safely in their own home.

- More than 100,000 low-income children receive quality care in early education programs that the government helps to finance so that their parents can work and they can be in a safe and enriching environment.

- Roughly 10,500 families are homeless each year, and at any given time about 1,000 children are living in homeless shelters our government funds. Thousands more children have families who have secured permanent housing with help from state subsidies.

As much as government does for children, it is important to ask: What happens when our government stops providing services that children depend on?

- Between 2002 and 2004, Massachusetts cut per pupil state funding for education more than any other state. Within that cut was an 80 percent reduction in remediation programs for children who have trouble learning the reading, writing, and math skills

tested on the MCAS exam. After the budget cuts, the steady progress on MCAS scores seems to have stopped, with actual declines in fourth grade English and math scores.

- When the Department of Social Services' budget was cut, it was forced to lay off critical personnel, including the entire staff who recruited foster parents. Following these cuts, the number of foster parents recruited fell, and finding foster homes for children who need them became more difficult.

- When the state reduced funding for anti-smoking programs by 91 percent, the steady decline in smoking rates among children slowed and illegal cigarette purchases by minors jumped dramatically.

- When funding for teen pregnancy prevention efforts was cut by 38 percent in one year, teen birth rates began to climb in many of the high risk communities that these programs were no longer able to serve.

These are just some of the effects of the budget cuts described in this report. On issue after issue, we see that the cuts in funding have alarming consequences for children and youth in Massachusetts. This is troubling not only because we care about our children, but also because we care about the future of our state. More teen pregnancies will lead to more children growing up in poverty. Less funding for our schools will make it harder for our children to receive the high quality education that can allow them to prosper and to drive our economic growth when they enter the workforce. Cutbacks at the Department of Social Services take away resources that are needed to give children in the most difficult of circumstances a realistic chance to build a better life.

Ultimately, through our government, we make important decisions about what responsibility we have for each other and for our children. Decisions made at one moment in time often have effects that are not recognized until years later. It is important to look back at the decisions we have made and at how those decisions have affected our lives. Understanding how we have arrived at the place we are now can help us to move forward and create the type of future that we want for our children.

Tax cuts led to budget cuts, and these cuts had consequences. During the 1990s our state adopted policies that significantly reduced our taxes. We were among the most aggressive tax-cutting states in the country. Those tax cuts reduced our government's capacity to provide services. Examining the effects of these service cuts on our state's children allows us to understand the connection between tax cuts and the quality of life for children in Massachusetts. Government is not just what happens on Beacon Hill. It is also the many vital services provided in communities across the state that promote and protect our education, health, and well-being.

Kids, Cuts and Consequences
Selected Areas

Service	Kids Served*	Magnitude of Cuts	Selected Effects of Cuts**
Department of Social Services	40,000 children and youth	$8.9 million or 12% (FY01-04)	• Eliminated all foster care recruitment staff
Children's Medical Security Plan	29,000 children and youth	$5.7 million or 31% (FY01-04)	• 14,000 children placed on waitlist • Emergency room, hospitalization removed from benefits • New or increased premiums
Massachusetts Rental Voucher Program	5,000 families	$16.0 million or 40% (FY01-04)	• 1,200 fewer families received assistance
Early Intervention	28,000 children	$5.3 million or 13% (FY01-05)	• Group service hours cut in half • Eliminated public school transition visits
Subsidized Early Education and Care	78,000 children and youth	$36.3 million or 11% (FY02-05)	• 7,700 fewer children received assistance • 1,600 added children to waitlist
Community Partnerships for Children	100,000 children	$44.7 million or 38% (FY01-04)	• 1,500 fewer children served • Reduced coordination with early childhood education programs
K-12 Education	980,000 children and youth	Ch. 70: $238.4 million or 7% (FY03-04) Grants: $235.7 million or 42% (FY01-04)	• Cutbacks in local schools, new fees, shifting costs to property tax
Teen Pregnancy Prevention	9,000 youth	$5.2 million or 83% (FY01-05)	• Progress halted in reducing teen pregnancy

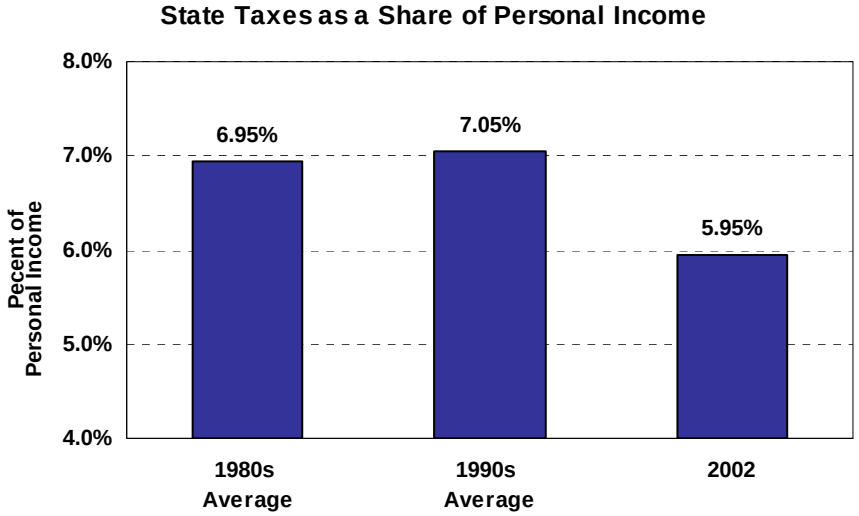
* The number of *Kids Served* represents current level of services.
** *Selected Effects of Cuts* represent the impact of cuts during the fiscal crisis. Some of these programs and services have been restored, as explained in this report.

Introduction

The lives of the 1.6 million children and youth in Massachusetts are profoundly affected by choices we make about how government should support and protect the next generation. Whether in the form of health care, education, enrichment programs, or public health, state government provides valuable programs and services that help children and youth to become productive members of society. While the support doesn't end once they turn 18, this report focuses on the effect the fiscal crisis has had on programs and services that benefit children and youth. Before reporting the effect of these cuts, it is useful first to examine the environment in which the state fiscal crisis evolved.

The state fiscal crisis that began in 2002 was brought about, in part, by the economic downturn which occurred on the national and state levels. It is important to note, however, that the fragile fiscal condition in Massachusetts resulted from policies that the state chose to implement during the prior decade. During the latter half of the 1990s, the Commonwealth experienced a temporary revenue "bubble," taking in significantly more revenue than historical trends would have projected. In response to this temporary phenomenon, the Commonwealth acted, both through statute and voter initiative, to reduce revenue on a permanent basis.[1] Between 1991 and 2001, there were over forty tax cuts in Massachusetts.[2] In fact, Massachusetts was one of the most aggressive tax-cutting states in the nation during that period.[3] All told – and after taking into account the 2002 tax package as well as the closing of some corporate tax loopholes since 2003 – such cuts have reduced the amount of revenue the Commonwealth collects each year by approximately $3 billion.[4] The combined total of all state taxes – sales, income, and other – accounted for roughly seven percent of state personal income in the 1980s and 1990s. By 2002, total state taxes had fallen to less than six percent of total state personal income (Figure 1). When the recession hit in FY 2002, it became clear that the tax cuts had created a structural budget gap. The structural gap was closed, in part, by reducing spending for vital public programs and services that benefit everyone. As children are among the major beneficiaries of the important services that government provides, they are significantly affected by these budget cuts.

Figure 1



As the economy recovers, it is important to recognize that we are not free from the danger of another downturn. Recent calls to lower the personal income tax rate from its current level of 5.3 percent to 5.0 percent could cause these spending reductions to be left in place indefinitely, and could force new cuts in services. There is a direct relationship between the revenues raised by the Commonwealth and the services it provides.

Budget cuts often have a cumulative effect, as children and youth benefit from state services in many ways, including: education and public libraries; public health and health care; environmental protection; playgrounds, parks, pools, and rinks; services for individuals with disabilities; child welfare and other social services; emergency and affordable housing programs; and programs to support families' economic security. This report provides a review of programs and services that were affected by the fiscal crisis, and documents the impact of these cuts on children and youth.

Section I discusses the role of social services, health care, and housing programs in protecting vulnerable children. Sections II and III highlight programs and services that are available to a broader set of children. Section II examines state funding for early childhood programs and Section III describes programs for school aged children and adolescents. Each of these sections provides examples of specific programs and services that help children and youth, highlights the successes that children and youth experienced when such supports were properly funded, and details how budget cuts threaten, and in some cases have reversed, these accomplishments. Each of these sections also features *Gaps in Services and Unmet Needs*, which presents some of the challenges children and youth experience in obtaining the right mix or level of services to support positive development.

Unless otherwise noted, all budget totals are from each year's General Appropriation Act and related supplemental budgets. To show the consequence of funding reductions most accurately, cuts are shown in inflation-adjusted ("real") as well as nominal dollars. This report focuses primarily on the state fiscal crisis and the effect of budget cuts at the state level. Some of the programs and services described in this report are funded from both state and federal money (early education, for example). This report does not distinguish funding sources, but shows overall declines in these areas. It is worth acknowledging, however, that reductions in other funding sources, including the federal budget, have also impacted the quality and availability of programs and services for children and youth.

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[1] Massachusetts Budget and Policy Center, *An Ounce of Prevention is Worth a Pound of Cure*, May 7, 2004, p. 5, available at: http://www.massbudget.org/rdf_amdt.pdf.

[2] Massachusetts Department of Revenue, *FY1992-FY2004 Estimated Value of Tax Cuts Enacted Under Weld/Cellucci/Swift, as of January 2002*, February 2002.

[3] Zahradnik, Robert, *Tax Cuts and Consequences: The States That Cut Taxes the Most During the 1990s Have Suffered Lately*, Center on Budget and Policy Priorities (Washington, DC), January 12, 2005, p. 9, available at: http://www.cbpp.org/1-12-05sfp.pdf.

[4] Massachusetts Budget and Policy Center, *Our Commonwealth: At the Crossroads*, August 2005, p. 28, available at: http://www.massbudget.org/At_the_Crossroads.ppt.

I. Protecting Vulnerable Children

"Of the 1.5 million children and youth living in Massachusetts, 13 percent live below the federal poverty level compared to eight percent of the adult population."

Child welfare agencies are designed to protect children from abuse and neglect or the risk of such treatment and to foster positive development. State agencies, including the Departments of Social Services, Medical Assistance, Public Health, Mental Health, and Transitional Assistance work to this end. Reports have demonstrated the relationship between poverty and increased demand for child welfare services.[5] Massachusetts has a relatively low poverty rate – nine percent overall – but, like the rest of the nation, the poverty rate among children and youth is higher. Of the 1.5 million children and youth living in Massachusetts, 13 percent live below the federal poverty level compared to eight percent of the adult population.[6] Many families face some level of economic insecurity, or experience other challenges with meeting their basic needs, and are likely to benefit from government supports that are designed to promote healthy development and outcomes.

Safeguarding Children from Abuse and Neglect

Child protection is a function of state government which is primarily overseen by the Department of Social Services (DSS), although coordination with other state agencies, social service organizations, and community members is almost always necessary to ensure the highest quality of care for abused or neglected children. By protecting children from harm, the Commonwealth helps to reduce the adverse effects of abuse and neglect. Proper intervention and treatment increases the chances of academic success and improves long-term mental and physical health, and reduces risk factors (e.g., violence, substance abuse, illegal activities).

DEPARTMENT OF SOCIAL SERVICES

The Department of Social Services works to identify and respond to cases of child abuse and neglect; help families resolve their challenges so they can maintain or regain custody of their children; and, when necessary, provide substitute living arrangements in foster care, residential settings, or, when appropriate, adoptive homes. The Department of Social Services, in collaboration with other agencies, works to ensure children's safety in a manner that "holds the best hope of nurturing a sustained, resilient network of relationships to support the child's growth and development into adulthood."[7]

Number of Children and Youth Served

In 2004, nearly 40,000 children and youth receive services through DSS.[8]

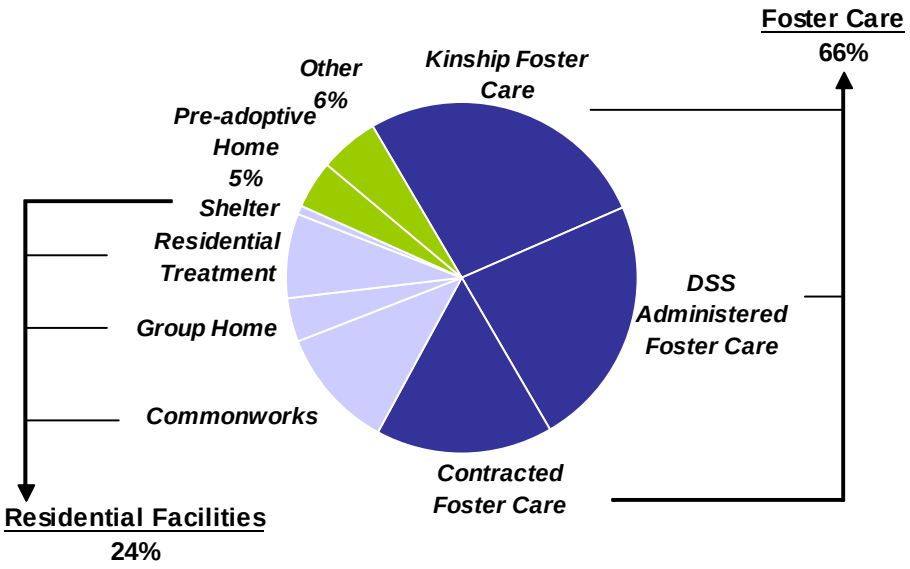
Services Provided

Children who are in the custody of DSS are either being abused mentally or physically, have experienced neglect, or are at risk of such abuse. Although DSS is often seen as an agency that

removes children from their homes, the Department also works in the best interest of children to preserve functioning families by providing or referring them to the proper supports when there is a risk of abuse or neglect. Of the nearly 40,000 children and youth served by DSS as of December 2004, roughly 10,000 were in some type of out-of-home placement because their own homes were deemed unsafe for them.[9] The remaining 30,000 children were left in their homes, and these families receive counseling or other services under DSS' or other state agencies' oversight.[10] The Department also arranges for substitute living arrangements in foster care, residential settings, or adoptive homes. The most common form of out-of-home placements includes foster care and residential placements; ninety percent of children in such placements are in one of these two types of care (Figure 2).[11]

Figure 2

Children and Youth in DSS Custody



Source: Massachusetts Department of Social Services

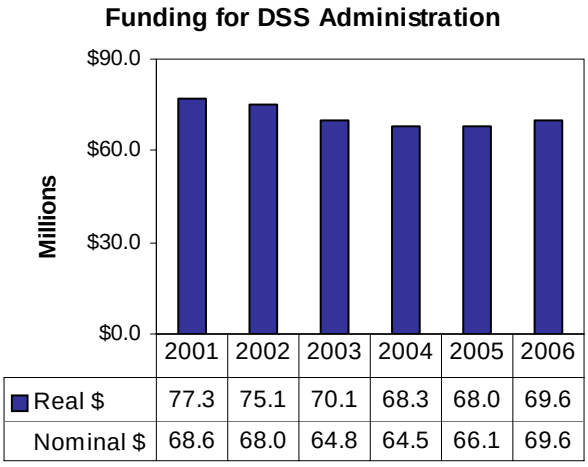
Positive Results

By fostering supportive environments where proper services are provided, whether it is with a foster family, in a residential facility, or in a child's own home, DSS works to improve the well-being of children and youth who have been abused or neglected. Depending on the circumstances, DSS may offer family preservation or reunification services under the condition that families complete appropriate, rehabilitative programs. In fact, 57 percent of children who left DSS placements in 2004 were returned to their families.[12] Of the children who are in the custody of DSS, many are placed in "kinship foster care," meaning that a child is placed with a family member or someone closely connected to the family. Children also benefit from a permanent family. In 2004, DSS placed nearly 2,000 children and youth in adoptive homes.[13]

Effect of Budget Cuts

In times of economic stress, child welfare agencies experience greater demand for services. During the recent economic downturn, DSS experienced such an increase in demand; the total number of children served by this department grew from 38,964 in 2001 to 39,913 in 2004.[14] The overall increase in the budget for DSS reflected this surge in demand. However, while the main supports for children and families were saved from serious cuts in funding, administrative supports suffered major reductions, which led to significant consequences for the Department.

Figure 3



	2001	2002	2003	2004	2005	2006
Real $	77.3	75.1	70.1	68.3	68.0	69.6
Nominal $	68.6	68.0	64.8	64.5	66.1	69.6

Administrative supports to DSS include clerical and office staff, fiscal and policy management, and legal counsel. Administrative personnel play a critical role in helping children and families. For example, the foster care recruitment staff, which is funded by DSS' administrative budget account, helps to increase the pool of available foster parents so that an abused or neglected child has a safe, supportive environment to live. Between FY 2001 and FY 2004, funding for DSS' administrative costs fell from $68.6 million to $64.5 million. In real terms, this represents an $8.9 million or 12 percent drop in funding during these years. Funding began to rebound in FY 2005, but the current level of funding – $69.6 million – is still nine percent below its level in FY 2001, after adjusting for inflation.

When funding for these supports is cut, there is a direct impact on the quality and the level of services available to children and families. When administrative staffing is cut, social workers can be forced to perform time consuming administrative functions and that can reduce their ability to accomplish their core purpose of helping children. When the legal staff is cut, such reductions can, for example, hinder the department's ability to initiate care and protection proceedings that may be needed to protect children who are at risk of abuse or neglect. A 2004 state audit of the Department indicates that budget cuts led to reductions in critical staff functions, including the entire staff which supports foster care recruitment. In the Audit document, DSS states:

> As a result of the reductions in the past few years in the Department's administrative staffing driven by the fiscal crisis of the last three years, **the Department has lost critical staffing in the foster care program, including all foster care recruitment staff**. As a result, the number of foster families has shrunk every one of the last three years. Family resource staff, who are primarily responsible for CORI and relicensing efforts, have been overwhelmed by the task of finding placements for an increasing number of children with rapidly diminishing foster homes. In this crisis, the work of CORI checks and licensing has suffered. [Emphasis added.][15]

While cutting "administrative funding" may sound like a strategy that will not affect children, the reality is that the functions these people perform have a direct effect on the lives of the children served by DSS. When the department is forced to eliminate all of the personnel who recruit foster parents, this had a direct effect on the number of foster parents who are identified and the ability of the state to find appropriate foster homes for children who need them. Recent restorations of some of the DSS administrative funding have permitted the Department to rehire the foster care recruitment staff.

Gaps in Services and Unmet Needs

Reducing Social Workers' Caseloads

In addition to struggling to cope wit the cuts described above, DSS has faced other challenges related to the growing caseload. Although funding for the Department's social workers has grown since 2001, in real terms it has remained relatively level since 2003. Furthermore, the current level of funding is not sufficient to sustain the Department's 18:1 caseload-per-social worker ratio. This target, which itself is higher than the maximum 15:1 ratio recommended in 1993 by the Special Commission on Foster Care and the ratio suggested by the Child Welfare League of America (CWLA), is often exceeded by the Department's social workers.[16] As of June 2005, 40 percent of the Department's social workers exceeded the 18:1 limit.[17]

"When child welfare agencies are understaffed, children's health and well-being are put at risk."

The Department's social workers are on the frontline in connecting children and families with the proper resources. To perform their jobs effectively social workers are required to manage interactions and communicate with myriad stakeholders. Since one case represents one family and not just one child, relationships with parents, schools, counselors or therapists, mental or physical health professionals, and other state agencies providing services to all members of the family are necessary. When child welfare agencies are understaffed, children's health and well-being are put at risk. On the other hand, when state agencies add staff capacity, children benefit directly from these investments.

New York is an example of a state that reduced its caseload-to-worker ratio as part of a larger reform of its child welfare system. A 1998 audit of New York's Office of Children and Family Services showed that the state's child protective caseworkers were managing up to 35 cases at a time, with wide variations depending on the district.[18] The audit further reported that, "excessively large caseloads increase the risks to children, may result in poor social work, and can lead to caseworker burnout."[19] The state's Office of the Comptroller consequently recommended adopting standards suggested by the Child Welfare League of America, which at that time limited 12 to 15 cases to one social worker. The state ultimately invested financial resources to this end, and children experienced positive results. A more recent report shows that such investments in New York City, in addition to changes in practices aimed to serve more children in their home of origin or to place them in safe permanent homes, led to positive practices like increasing family support services and permanent solutions like adoption and family reunification.[20]

Youth Aging Out of DSS Custody

Youth aging out of DSS custody is another challenge for the Department and the children in its care. Generally, once young adults in DSS custody turn 18, they must take responsibility for their own supervision. For some, this means transitioning back to their families, but for others turning 18 may mean losing not only important support structures, but also a place to live. Both scenarios create challenges for young adults and their families, and while some services are available to assist them, funding cuts, waitlists, and ambiguity among agencies make the transition even more difficult.[21]

Of the approximately 15,700 youth between the ages of 12 and 17 receiving services through DSS, more than 5,000 are in the custody of the Department.[22] While a small portion remain voluntarily in DSS custody through the age of 21, most become ineligible for services at 18 years.[23] Without the supports that youth traditionally rely on, including a family and a home or help with rent, health care, or tuition payments, these youth are prone to unemployment and homelessness.[24] Individuals who do not return to their families often face considerable difficulties. The Massachusetts Society for the Prevention of Cruelty to Children has documented the many challenges that youth aging out of foster care face, including limited education, training and employment opportunities, lack of health care coverage, and increased incidence of homelessness.[25]

One bridge offered by the federal government for children aging out of foster care is the McKinney-Vento Homeless Assistance Act, which allows children who become homeless (through aging out or other instances) to maintain their school environment without being forced into a different school district. Under the act, homeless youth must have the same access to a free public education as other people their age.[26] This act gives youth the right to stay in their own district rather than having to move from school to school depending on where they manage to find housing.

There are also several types of educational assistance programs available to youth who have aged out of the foster care system. In Massachusetts, the state Foster Care Child Grant Program and the State College Tuition Waiver, and the William Warren Scholarship Program, which is funded through federal, local, and private monies, all support college scholarships for foster care youth.[27]

A pilot program in Massachusetts, the Lifelong Family Connections Program (LFC), provides a promising model for permanency planning.[28] The program finds adoptive homes for older youth or helps them to establish lifelong family connections with adults to provide both stability and guidance. Preliminary results show that the majority of youth in the program – 16 out of 20 – have been successfully linked with a lifelong family connection, helping them to craft a permanency plan tailored to fit their needs.[29] The potential of LFC has resulted in a federal grant enabling the program to expand their program to serve 125 youth over five years.[30]

Currently the Commonwealth lacks a comprehensive approach to helping older youth approaching adulthood. Furthermore, budget cuts in many areas vital to helping youth transition to adulthood – higher education, health care, housing assistance – have reduced the availability of services.

Aging Out of Children's Services and Transitioning to Adult Systems of Care

Children and youth may receive services from multiple state agencies, which could make transitioning to adulthood without appropriate services all the more difficult as there are different ages at which a youth is no longer eligible for services. Summarized below are additional challenges youth may face as they age out of the care of other state agencies.

Department of Youth Services (DYS) **Typical Transition Age: 18 years**

Approximately 60 to 70 percent of youth in the Department of Youth Services' detention and correction facilities are considered to be clinically in need of mental health care.[31] While they receive some mental health treatment, most care ends when the youth transition out of DYS custody. Thus, youth leave most of their supports behind when exiting DYS, including mental health services, at a time when they are statistically most likely to face arrest. This is particularly true of adolescents with disruptive behaviors, who usually do not qualify to receive adult services through the Department of Mental Health.[32] Meanwhile, a significant portion of youth involved in DYS end up in adult correctional facilities. A 2002 report on recidivism shows that 24 percent of offenders had previous juvenile adjudications, and the recidivism rate for offenders with juvenile adjudications was 61 percent.[33]

Department of Mental Health (DMH) **Typical Transition Age: 19 years**

The Department of Mental Health furnishes approximately 5,000 youth with mental health services. Youth may explore transitioning to adult care, but often face a host of problems. Eligibility for adult care requires meeting more rigorous standards.[34] Adult services also involve increased responsibility from participants, which younger clients may not be ready to accept.[35] Therefore, many young adults in need of treatment are not qualified to continue or choose to leave DMH, despite their continued mental health needs.

Office of Medicaid **Typical Transition Age: 18 years**

The Medicaid/MassHealth and Children's Medical Security Plan programs provide health insurance coverage to children through age 18. At age 19, this coverage is no longer available. Young adults (age 19-24) are disproportionately represented in the population of the uninsured, and often forego preventive and primary care, relying on state-funded emergency "free care." There are close to 600 youth each year who age out of the custody of the Department of Social Services who are particularly vulnerable to having problems accessing medical care. Federal law does allow Medicaid coverage to be extended to age 21 for young people who are in foster care on their 18th birthday, but current Massachusetts law only extends coverage until the 19th birthday.

Department of Education (DOE): Special Education **Typical Transition Age: 22 years**

The Department of Education provides local schools and districts with the means to create specialized education plans for students with disabilities until they graduate high school or reach their 22nd birthday. In 2002, the DOE teamed up with the Massachusetts Rehabilitation Commission (MRC) to work with adolescent disabled students in order to better facilitate their transition into careers.[36] Currently, DOE requires transition services to begin at age 14 in order to focus early on the child's needs and goals.[37]

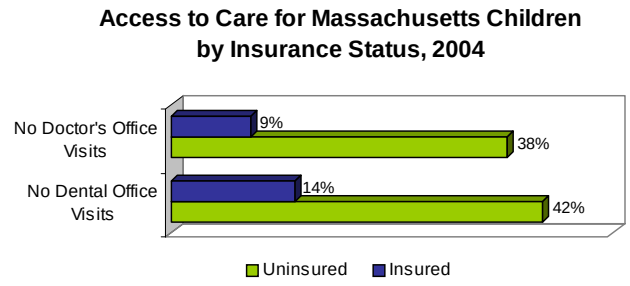
Access to Health Care and Health Insurance

There has been ample research over the years documenting the relationships among health insurance coverage, access to health care, and health status. For children, having access to regular, ongoing and comprehensive primary care is essential to monitoring growth and development, and can have a direct impact on a child's ability to learn. Even though Massachusetts has a relatively low percentage of children who lack health insurance, there are still tens of thousands of children in Massachusetts who lack health insurance – estimates range from just over three percent of children to close to seven percent of children.[38]

"In 2004, 38 percent of Massachusetts children without health insurance did not visit the doctor."

The annual physical is a well-established tradition of childhood, except for children without health insurance. One-third of all uninsured children nationwide did not visit a doctor in the prior year, compared to sixteen percent of children with health insurance. These differences persist even for children who have greater health care needs, such as children who are not in good health, or for children with disabilities.[39] For low-income children in particular, health insurance makes a dramatic difference in access to health care, and there is little difference whether that health insurance is publicly-provided (as in Medicaid), or whether it is insurance provided privately through a parent's employer.[40]

Figure 4



Source: Massachusetts Division of Health Care Finance and Policy

Even in Massachusetts, children who are uninsured have dramatically poorer access to health care than do children with health insurance. In 2004, 38 percent of Massachusetts children without health insurance did not visit the doctor. This is more than four times the rate for children with health insurance. Similarly, 42 percent of Massachusetts children without health insurance did not visit the dentist, compared to 14 percent of children with health insurance (see **Error! Reference source not found.**).

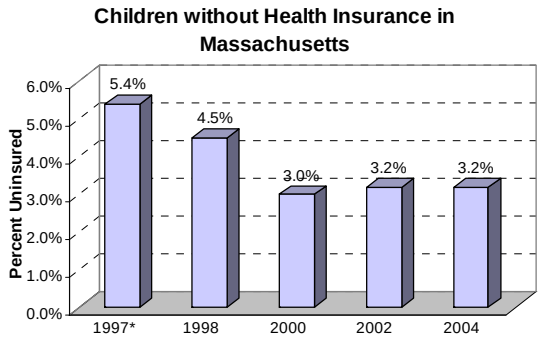
Filling the Insurance Gap with Public Health Insurance: MassHealth and Children's Medical Security Plan

There are two primary public programs essential to filling the health insurance gap for the Commonwealth's children: the Medicaid program (also referred to as MassHealth), and the Children's Medical Security Plan (CMSP). Expansions of these programs in the late 1990's helped to bring about a dramatic decline in the rate of children without health insurance in the Commonwealth – from 5.4 percent in 1997 to 3.0 percent in 2000 (see **Error! Reference source not found.**).[41] Even though there are still thousands of children without health insurance in the Commonwealth, it is important to realize that there are close to 450,000 children who have insurance thanks to the health insurance programs of our state government. These children would be without health insurance were it not for the Commonwealth.

MASSHEALTH FOR CHILDREN

In 1997, Massachusetts initiated a major expansion of the Medicaid program, in part to ensure comprehensive health care coverage for low-income uninsured and underinsured children in the Commonwealth. The Commonwealth targeted children with disabilities for coverage – a group particularly vulnerable to problems of health care access because of their special health care needs. The state expanded Medicaid eligibility to encompass all children under age 19 with incomes up to 200 percent of the federal poverty level.

Figure 5



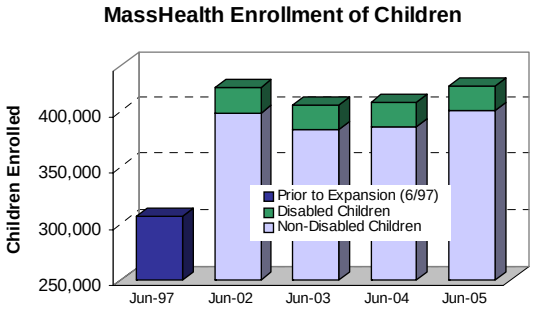
** 1997: ages 0-17; all other years 0-18*

Source: Massachusetts Division of Health Care Finance and Policy; Urban Insitute

Number of Children and Youth Served

The Medicaid expansions have been successful at dramatically decreasing the number of children without health insurance in Massachusetts: there are now more than 430,000 children enrolled in MassHealth, compared to just over 300,000 children in 1997 (see **Error! Reference source not found.**). Although there are still children without health insurance in the Commonwealth, Medicaid expansions were crucial to the Commonwealth's efforts to improve access to health care for all children. Coverage for children during this time was partly financed with funds from a new tobacco tax dedicated to funding expanded health care coverage as well as with federal matching funds.[42]

Figure 6



Source: Massachusetts Office of Medicaid

Effect of Budget Cuts

One of the most significant impacts of the fiscal crisis on the Medicaid program was the decision to rein in costs by increasing premiums charged to enrollees. In March 2003 the Commonwealth implemented premium increases in the Family Assistance and CommonHealth programs, and in November of that year the Commonwealth imposed increases on the premiums charged for children in the MassHealth Standard program and for children of special status immigrants.

"Even slight changes such as 'modest' increases in premiums and co-payments can lead to reductions in access to insurance and health care."

Increasing out-of-pocket costs can have an important impact on access to health care for low- and moderate-income families. Research has documented that even slight changes "that appear modest (such as 'modest' increases in premiums and co-payments) can have cascading effects" on low-income beneficiaries, leading to significant reductions in access to insurance and health care.[43] Other administrative changes made by the Medicaid program during this period, such as requiring that Medicaid members pay their premiums by check rather than by cash, and the discontinuation of providing stamped, addressed return envelopes to participants at the time of coverage renewal, also affected the ease at which some participants were able to maintain their health insurance coverage.[44]

CHILDREN'S MEDICAL SECURITY PLAN

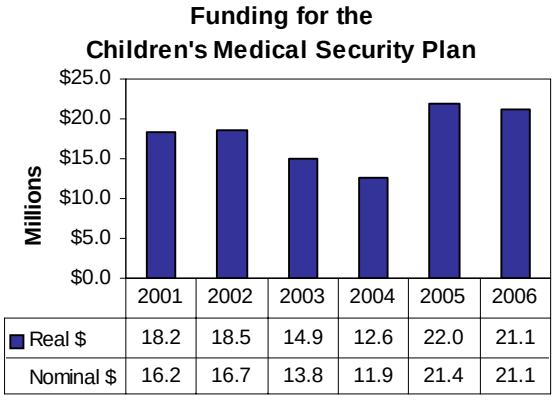
The Children's Medical Security Plan (CMSP) is a health insurance program administered by the Commonwealth to provide health insurance coverage for children under age 19. Unlike MassHealth, CMSP is open to children at any income level, including undocumented immigrants, provided they do not have other health insurance with primary or preventive medical benefits, and provided that the children are not eligible for MassHealth (other than MassHealth Limited). CMSP provides only primary and preventive care. Hospitalization and emergency services are often covered through the Uncompensated Care Pool, also known as "free care."[45]

Number of Children and Youth Served

With the expansion of the Medicaid program in the late 1990's, CMSP enrollment dropped as MassHealth enrollment expanded. In December 1997 CMSP enrollment was approximately 45,000 children, but with the implementation of the MassHealth expansions, by December 1999 this number had dropped to close to 18,500 children. Before the fiscal crisis, enrollment in the program grew to more than 25,000 children. Current enrollment stands at approximately 29,000 children.[46]

Effect of Budget Cuts

Figure 7



	2001	2002	2003	2004	2005	2006
Real $	18.2	18.5	14.9	12.6	22.0	21.1
Nominal $	16.2	16.7	13.8	11.9	21.4	21.1

The Children's Medical Security Plan is a health care safety net for vulnerable children who are not eligible for Medicaid. In spite of a decrease in the number of people with private employer-sponsored health insurance during times of economic recession, the Children's Medical Security Plan was cut during the fiscal crisis.

Between fiscal year 2001 and 2004, funding dropped by 31 percent or $5.7 million in real terms. In addition to this real reduction in funding, during this same period the purchasing power of the program was affected by double-digit health care cost inflation.

In November 2002, the Commonwealth established an enrollment cap for the program, limiting participation to just over 26,000 people. Because of funding reductions, in July 2003, the Commonwealth once again lowered the enrollment cap on the CMSP, and lowered it again in January 2004. By April 2004, more than 14,000 children were on the waiting list for the program.[47]

"In November 2002, the Commonwealth established an enrollment cap for the Children's Medical Security Plan. By April 2004, more than 14,000 children were on the waiting list."

The fiscal crisis brought about other reductions in the program. In December 2002, coverage for emergency room services and hospitalizations were eliminated from CMSP. Not surprisingly, during this period there was a dramatic spike in children's use of the "free care" pool for payment of these services no longer covered by CMSP. Between October 2001 and September 2002, there were close to 18,000 applications for free care by children, and between October 2001 and September 2002, there were more than 40,000 applications for free care by children.[48] In November 2003, the Commonwealth began charging new premiums to families with incomes between 150-200 percent of the federal poverty level, and quadrupled the premiums charged to families between 200-400 percent of poverty. Limitations on outreach efforts and administrative changes that made enrollment and re-enrollment more difficult also increased the likelihood of children dropping off the program roles.

Under-funding of CMSP left thousands of children awaiting enrollment in the health insurance program until fiscal year 2005, when funding rose to $21.4 million from $11.9 million in fiscal year 2004. This increase was sufficient to eliminate the waiting list, and between June 2004 and August 2004, enrollment grew from 20,200 to 32,800 children. Language in the fiscal year 2006 budget rolled back the CMSP premium increases, and established a tiered premium structure in order to make the program more affordable for families.

Gaps in Services and Unmet Needs

Providing Universal Coverage to Children

In spite of recent efforts by the Commonwealth to encourage enrollment in public health insurance programs, there are still challenges to providing universal coverage of children. There is a small percentage of low-income uninsured children whose parents do not perceive a need for health insurance. These families require more than just simple information about the availability of insurance options in order to become insured.[49] There are also families who because of immigration status or language barriers do not know they are eligible or find it difficult to take advantage of public programs.

"In certain parts of the state or for certain medical specialties, finding providers who accept MassHealth insurance can be very challenging."

Inadequate financing for public health insurance has also created barriers to access for vulnerable children, even when those children have health insurance coverage. One of the ways that the Commonwealth reined in health care costs was to limit rates paid to health care providers. Because of these low rates, certain providers refused to

accept patients with MassHealth or CMSP coverage. In certain parts of the state or for certain medical specialties, finding providers who accept MassHealth insurance can be very challenging.

The lack of providers is a particular concern for children with disabilities, or children who require mental health services. Even with MassHealth coverage, many children – particularly foster children and children with special health care needs – are at risk due to "an insufficient number of doctors and dentists willing to accept Medicaid, and . . . a sheer lack of mental health services" among other concerns.[50]

The increasing premiums and other out-of-pocket costs have also limited access to health care. Research has documented that families of children with special health care needs who are covered by public insurance are twice as likely as to have problems paying their medical bills than families with privately insured children with special needs.[51]

"Each year there are close to 600 foster children, uniquely dependent upon the Commonwealth, who lose their health insurance coverage as they turn 19."

Finally, one of the groups in the Commonwealth most at-risk for lacking health insurance coverage is young adults, as they age out of coverage provided to them as children. Young adults make up close to one-half of the uninsured population in the Commonwealth.[52] There is no public health insurance program for young adults who are neither pregnant, disabled, or the low-income parents or caretakers of dependent children. In particular, each year there are close to 600 foster children, uniquely dependent upon the Commonwealth, who lose their health insurance coverage as they turn 19.[53]

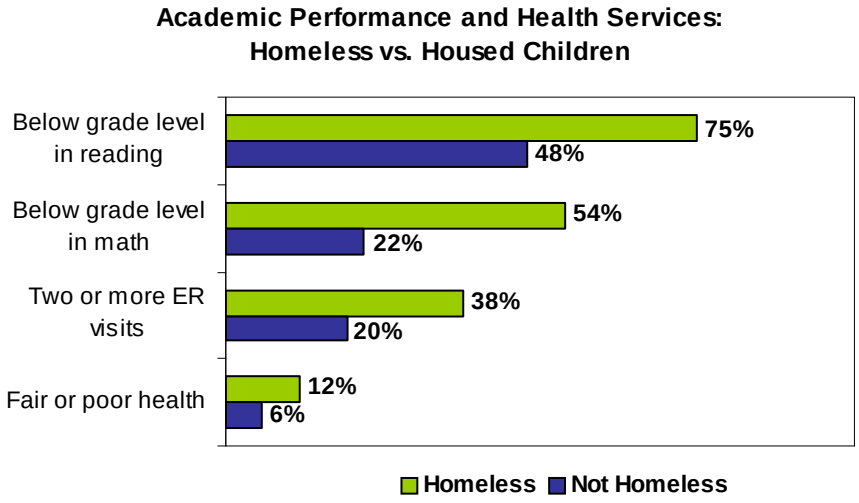
Providing a Home to Children and Families

The limited supply of affordable housing in Massachusetts is a serious problem. A full-time worker needs to earn $20.93 per hour (310 percent of the state's minimum wage) or $43,535 annually to afford a two bedroom unit at the state's Fair Market rent of $1,088.[54] Many parents are forced to devote a substantial portion of their income to housing, leaving little remaining resources for other essential items like food, clothing, and transportation. Other parents may choose less expensive, substandard housing which may compromise their children's health, safety, or aspects of their personal well-being. Low-income families are particularly vulnerable in either instance, as their financial situation is more tenuous. Lack of affordable housing particularly affects families with children. Homeless children are more likely to have their family life disrupted by moving, separation from parents or siblings, or witnessing family violence. A report by the National Center on Family Homelessness showed that, within a single year, 97 percent of homeless children had to relocate their housing, 22 percent were separated from their family to either live with another relative or in foster care, and nearly 25 percent witnessed violence within their family.[55] Research has also shown the negative affects of homelessness on children's academic performance and health (Figure 8):[56]

- Because homeless children often are without transportation, lack proper documentation to enroll in school, and frequently transfer or do not attend school for periods at a time, they are at greater risk of delayed development, poor academic performance, and not receiving appropriate services (e.g., underserved by special education).[57]

- Children who are not in stable permanent housing are also more likely to suffer from various physical and mental health conditions. Homeless children are more likely to experience poor physical health, including increased rates of ear infections, respiratory ailments like asthma, and acute co-occurring illnesses.[58] These children are also more vulnerable to mental and emotional conditions that interfere with daily activities.

Figure 8



Source: American Academy of Pediatrics

EMERGENCY FAMILY SHELTERS

The Department of Transitional Assistance (DTA) is the state agency that oversees the Emergency Assistance program (EA), which provides shelter housing for families. The EA program is designed to house homeless families close to their communities to minimize disruptions to employment, school attendance, and other ties to a family's neighborhood. Current income eligibility guidelines for EA require that a family earn no more than 130 percent of the federal poverty level ($20,917 for a family of three).[59] Provisions enacted in the FY 2005 budget allow families residing in shelters to exceed the income eligibility and remain in the shelter up to six months provided that the surplus income is deposited into an escrow account, which is available to the family upon departure. While permanent housing is preferable, shelters keep children and families from living on the street and reduce the risk of physical harm.

"The EA program is designed to house homeless families close to their communities to minimize disruptions to employment, school attendance, and other ties to a family's neighborhood."

Number of Children and Youth Served

Children and youth make up more than 60 percent of the beneficiaries of family shelter housing, or approximately 2,000 of the 3,400 individuals residing in EA shelters.[60]

Services Provided

For many homeless families, EA shelters are more than a safe place to live. Very often EA shelters operate as part of a larger system of social safety nets. For example, parents struggling with substance abuse may find support through the shelter system which will help them to obtain and receive proper rehabilitation without the risk of losing their children.[61] Shelters also act on behalf of children, providing referrals for food and nutrition programs, educational supports, and physical and mental health services. In Massachusetts, approximately 10,500 families are homeless each year.[62] The Commonwealth has the capacity to serve only a fraction of this total.

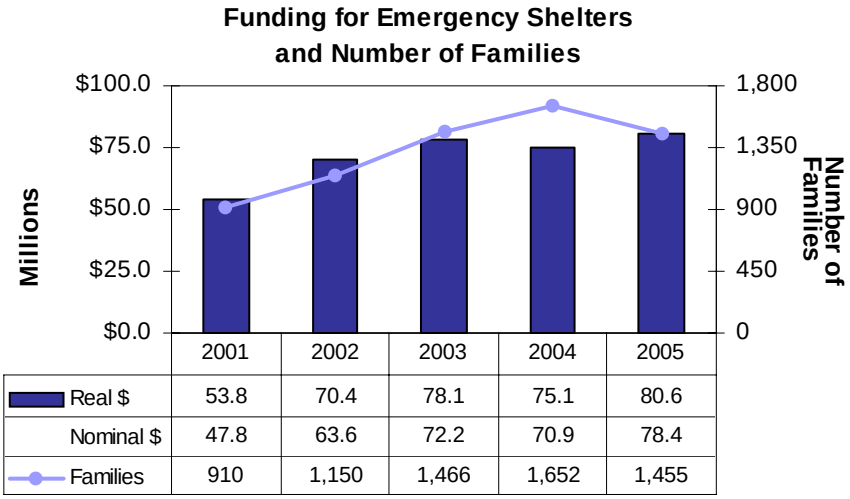
Positive Results

Families with children represent the fastest growing segment of the homeless population,[63] and shelters, with the proper support, can help families move on to permanent housing. Shelters also play a critical role in helping families remain intact and in providing access to other services. In shelter housing children are more likely to receive regular meals, continue to attend school, and receive referrals to appropriate services. Parents are additionally likely to receive supports that will contribute to the family's stability.

Effect of Budget Cuts

During the fiscal crisis, funding for emergency family shelters grew because the need for these services rose. Between FY 2001 and FY 2004, funding for EA increased, in real terms, by $21.4 million or 40 percent (see Figure 9). The number of families, however, grew at a much greater rate; during this same period, the caseload grew from 910 to 1,652, an 82 percent jump. The state also experienced an increase in the population of homeless families in hotel and motel placements. In fiscal year 2000, the growing population of homeless families forced the state to resume the use of such placements, a practice which had been phased out in 1996. Between FY 2001 and FY 2003, hotel and motel placements rose from 17 to 516.[64] Often these temporary residences were far from families' former communities and lacked access to public transportation, disrupting employment, school, and other community supports for families. In FY 2002, the Commonwealth also lowered the income eligibility for the program from 130 percent of the poverty level to 100 percent of this benchmark to deal with the growing population of homeless families. In FY 2006, the state raised the income guidelines for this program back to 130 percent.

Figure 9



	2001	2002	2003	2004	2005
Real $	53.8	70.4	78.1	75.1	80.6
Nominal $	47.8	63.6	72.2	70.9	78.4
Families	910	1,150	1,466	1,652	1,455

Source: Caseloads numbers are from the Massachusetts Department of Transitional Assistance

Gaps in Services and Unmet Needs

Providing Rental Assistance for Families in Transition

Shelters are usually the place of last resort for parents. The Commonwealth has recently established in a program designed to help low-income families maintain permanent housing. The Rental Assistance for Families in Transition (RAFT) program was created in FY 2005 to serve low-income families who are homeless or at risk of becoming homeless. The RAFT program provides up to $3,000 to help families pay for utilities, security deposits, or rent. The FY 2006 budget provides $5.0 million, and raises eligibility for the program from 130 percent of the federal poverty level to 50 percent of area median income. Although funding for RAFT first appeared in FY 2005, the program is similar to another income support called the Emergency Assistance Rent Arrearage Program, which was last funded at $9.1 million in FY 2002.

"Providing financial assistance to families to support permanent housing is more cost effective than shelter housing and is less disruptive to children and families."

Providing financial assistance to families to support permanent housing is more cost effective than shelter housing and is less disruptive to children and families. The Commonwealth pays $21,644 for the average six month stay.[65] Providing $3,000 to a family would likely prevent the use of shelter housing and would provide the stability that a family, and children in particular, need.

THE MASSACHUSETTS RENTAL VOUCHER PROGRAM

Emergency shelters are only temporary housing solutions for families, and they are limited in the ability to solve two facets of the affordable housing crisis: homelessness prevention, which the RAFT program addresses, and access to affordable housing, which is addressed by the state's affordable housing programs. Many factors have contributed to the problem of limited access to affordable housing, including increasing income inequality, the private market's inability to keep pace with demand for affordable housing, and declining support from federal and local governments. Rental assistance programs, like the Massachusetts Rental Voucher Program (MRVP), are one of the chief strategies states can use to assist low-income working families.[66] Such programs help families to find affordable private housing and may decrease the likelihood that parents face additional financial burdens meeting the costs of other basic needs.

Number of Children and Youth Served

In FY 2005, nearly 5,000 households received assistance through MRVP. Although the Department of Housing and Community Development, the state agency which administers this program, tracks households and not families with children, demographic data from the U.S. Census indicate that children are likely to benefit from this program. In Massachusetts, there are at least 317,000 families living below 200 percent of the federal poverty level, which is the income eligibility standard for MRVP.[67] On average, these families have at least one child. Thus, if the families with MRVP vouchers are representative of the income-eligible families, over 5,000 children benefit from this affordable housing program. It is also clear, however, that the level of need is far greater than the resources currently being provided.

Services Provided

The Massachusetts Rental Voucher Program is the main rental assistance program for low-income families in the Commonwealth. This program provides project- and tenant-based subsidies to help families afford private rental housing. Households receiving assistance through MRVP must earn no more than 200 percent of the federal poverty level, or $32,180 annually for a family of three.

Positive Results

Providing housing subsidies through MRVP is one of many policies that Massachusetts uses to help families afford the high cost of housing. Housing voucher programs are effective policies, and children benefit directly from such strategies. By seeking housing in the private market families are likely to find higher quality housing in better neighborhoods. Children may also benefit from their parent's being able to find and secure employment.[68] Despite the evidence in support of rental assistance programs, funding for such programs has declined in recent years.

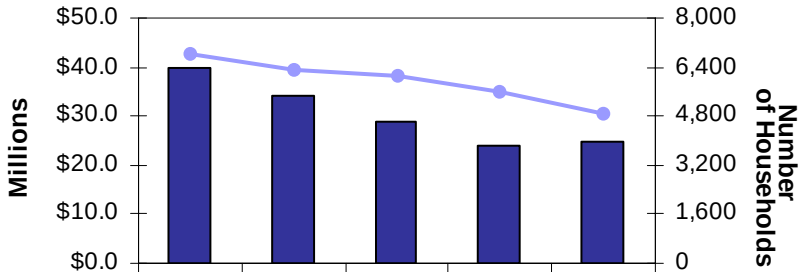
Effect of Budget Cuts

"Providing rental assistance to low-income families promotes families' economic security and contributes to children's health and educational outcomes."

The appropriation for MRVP fell from $39.7 million in FY 2001 to $24.0 million in 2004, a 40 percent cut in real terms. During this same period, the number of households receiving assistance through MRVP fell from 6,831 to 5,607. In FY 2004, due to increasing fiscal pressure, the state implemented a policy to stop re-issuing new MRVP vouchers as families left the program, which reduces the number of vouchers available to families in need of affordable housing; as a result, more than 500 fewer households received assistance from this program in that year. Providing rental assistance to low-income families promotes families' economic security and contributes to children's health and educational outcomes. Budget cuts in this area could likely undermine such accomplishments.

Figure 10

Funding for MRVP and Number of Households



	2001	2002	2003	2004	2005
Real $	39.7	34.2	28.9	24.0	25.0
Nominal $	35.3	31.0	26.7	22.7	24.3
Households	6,831	6,294	6,138	5,607	4,882

Source: Caseload numbers are from the Massachusetts Department of Housing and Community Development

The Commonwealth has a considerable amount of work to do with regard to long-term housing solutions. Although funding for housing has increased slightly over the past two years, the current level of funding is still below where it was in 2001. When adjusted for inflation, the current amount appropriated to the Department of Housing and Community Development is $83.7 million or 48 percent below the FY 2001 level. Adjusting for the combined funding for housing in the Commonwealth's operating and capital budgets shows a slightly smaller decline – $78.1 million or 30 percent. Lack of affordable housing and the limited scale of housing assistance programs for low-income families are among the primary causes of homelessness, and have a direct impact on the well-being of children and families.

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[57] The National Center on Family Homelessness, *Homeless Children: America's New Outcasts*, 1999, p. 10.
[58] Ibid, p. 4.
[59] Income is not the sole criterion for assistance; families must meet other guidelines to enter or continue to live in EA shelter housing.
[60] Massachusetts Department of Transitional Assistance, *Report on the Emergency Assistance (EA) Program for the Second Quarter of Calendar Year 2005*, p. 4.
[61] Although this section focuses on DTA administered shelters, DSS also administers shelters and other services for survivors of domestic abuse. Very often there is overlap in the populations served.
[62] Stone, Michael E. et al., *Situation Critical: Meeting the Housing Needs of Lower-Income Massachusetts Residents*, Center for Social Policy, McCormack Institute, University of Massachusetts Boston, October 2000, p. 8, available at: http://www.mccormack.umb.edu/csp/publications/mccormack%20institute%20report%202000.pdf.
[63] National Coalition for the Homeless, "Homeless Families with Children," NHC Factsheet #7, June 2001, available at: http://www.nationalhomeless.org/families.html.
[64] Massachusetts Executive Office of Health and Human Services, "Update on Homelessness in Massachusetts," available at: http://www.mass.gov/portal/index.jsp?pageID=eohhs2terminal&L=4&L0=Home&L1=Researcher&L2=Basic+Needs&L3=Housing+and+Shelter&sid=Eeohhs2&b=terminalcontent&f=dta_r_housing_homelessupdate&csid=Eeohhs2.
[65] Massachusetts Department of Transitional Assistance, *Report on the Emergency Assistance (EA) Program for the Second Quarter of Calendar Year 2005*, p. 2.
[66] McNichol, Liz and John Springer, *State Policies to Assist Working-Poor Families*, Center on Budget and Policy Priorities, December 2004, p. 23, available at: http://www.cbpp.org/12-10-04sfp.pdf.
[67] Based on data from U.S. Census Bureau, Current Population Survey, 2005 Annual Social and Economic Supplement, "POV46: Poverty Status by State: 2004, Below 185% and 200% of Poverty -- Families," available at: http://pubdb3.census.gov/macro/032005/pov/new46_185200_07.htm.
[68] Sard, Barbara, *Housing Vouchers Should be a Major Component of Future Housing Policy for the Lowest Income* Families, Cityscape: A Journal of Policy Development and Research, Volume 5, Number 2, 2001, p. 93.

II. Early Childhood Programs

Because in the earliest years children have both an opportunity for growth and a particular vulnerability to harm, programs designed to foster young children's health and well-being promote positive outcomes for the long-term. Whether these children are served in formal early education settings or at home, addressing their needs early and helping them to develop cognitively and socially will help to ensure that they start school ready to learn and continue to experience success throughout their lives. There are just over 477,000 children in Massachusetts under the age of six;[69] they are cared for in a variety of settings. The state helps to provide quality early education for many of these children, but there are still others who are not able to access services due to limited capacity and lack of state funding. For example, there are roughly 91,000 licensed early care slots available to approximately 241,000 children between the ages of three and five years of age. Building on the progress of the past decade, the newly formed Department of Early Education and Care, which oversees many of the services available to young children, must address this and other challenges in providing quality services to young children and their families.

Promoting a Healthy Start

Providing young children with programs and services that help improve their health and well-being promotes success for these children later in life. Infants and toddlers benefit from early education programs, but other supports are sometimes needed for young children. Children who are born with a disability or face some other circumstances which might put them at greater risk for developmental delays generally require additional care. In Massachusetts, programs like Healthy Families and Early Intervention are designed to provide the additional help these children and their families need to improve their chances of success.

HEALTHY FAMILIES

Healthy Families Massachusetts is the statewide program modeled after Healthy Families America, a national effort designed to help young families and their children. The program offers services to expectant teen mothers and those with young children, and is designed to: prevent child abuse and neglect; achieve optimal health, growth and development in infancy and early childhood; promote maximum parental educational attainment and economic self-sufficiency; and prevent repeat teen pregnancies.[70] The mothers, not yet adults themselves, are more likely not to complete their schooling and will likely face some level of economic insecurity.[71] Children of adolescent mothers are at greater risk for premature birth, to be born at a low birth weight, and to die as infants.[72]

Number of Children and Youth Served

At least 4,400 children receive services as a result of participating in the Healthy Families program.

Services Provided

The Healthy Families program provides services to first time teen parents under the age of 21. Comprehensive, prevention-oriented services are delivered by trained professionals at or before the child's birth, and until the child is three years of age. Families receive information on childbirth, infant care, and parenting. Based on their circumstances, families are also likely to receive referrals to other services, and home visitors are trained to provide crisis intervention, if needed.

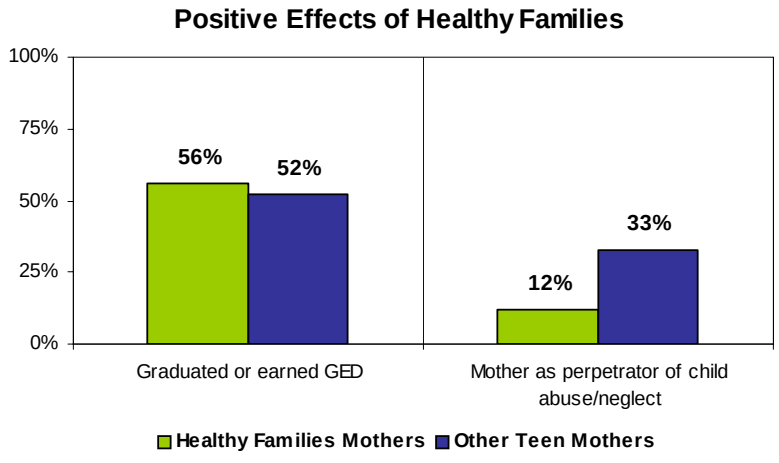
Positive Results

Results from an evaluation of the Healthy Families Program indicate that the program contributes to positive outcomes for children and families (see Figure 11):

- Mothers who are in the program are likely to improve their educational status. At the beginning of the evaluation, 56 percent of the mothers enrolled in the program were enrolled in school or had graduated from high school or a GED program.[73] By the end of the evaluation, 83 percent of the mothers were attending school or had graduated.[74] This statistic compares favorably with results from the National Longitudinal Survey of Youth, which shows that 52 percent of women who became mothers before their 20th birthday graduated from high school or earn their GED by age 25.[75] Educational attainment is a key predictor of poverty or low income, particularly for teen parents, and has a direct impact on the economic well-being on children.

- There is a low incidence of abuse or neglect for the families enrolled in the program. Of the families studied, only 12 percent showed abuse or neglect by the mother.[76] Although there is little data to compare this with nationally, a small study of teenage mothers in Rhode Island reported a 33 percent child maltreatment rate, where the mother is the perpetrator.[77] Furthermore the program's positive effect on the low occurrence of child abuse or neglect is considerable since at least 26 percent of the mothers in the study are victims of abuse themselves and are at greater risk for perpetuating such behavior.[78]

Figure 11



Source: Healthy Families Massachusetts Final Evaluation Report

- Children benefit in other ways from the program. The evaluation revealed that children whose families were receiving services from Healthy Families were progressing within the normal range for a variety of domains, including communication, problem solving abilities, and personal-social development.[79] The low incidence of repeat birth while being enrolled in the program also benefits children. Although the evaluation cannot provide a comparison group on second birth rates, mothers who have more than one child as an adolescent are more likely to drop out of school, making these families more prone to economic insecurity.[80] Of those studied, only 14 percent had another child within two years of their first child.[81]

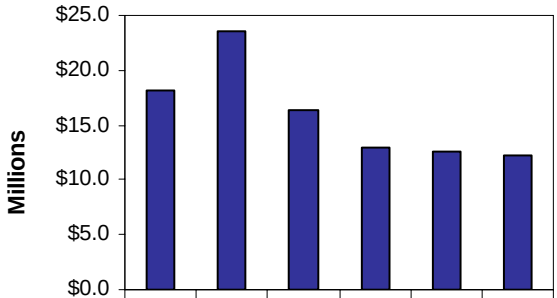
Effect of Budget Cuts

Since FY 2002, funding for Healthy Families has fallen by $11.4 million or 48 percent. Mid-year cuts in FY 2003 led to the elimination of 150 staff positions and roughly 1,000 families were prematurely discharged from the program, shrinking the caseload from 5,402 to 4,442. Since FY 2003, the budget has been relatively level, allowing the program to offer services to just over 4,000 families over the past few years. Budget cuts to this program jeopardized the positive outcomes experience by children and families enrolled in the Healthy Families program. Furthermore, annually more than 6,200 teenagers give birth for the first time in Massachusetts, but the Healthy Families program has never been funded to serve all first time parents for a full three years.

"Annually more than 6,200 teenagers give birth for the first time in Massachusetts, but the Healthy Families program has never been funded to serve all first time parents for a full three years."

Figure 12

Funding for Healthy Families



	2001	2002	2003	2004	2005	2006
Real $	18.2	23.6	16.4	13.0	12.6	12.2
Nominal $	16.2	21.4	15.1	12.2	12.2	12.2

EARLY INTERVENTION[82]

Early Intervention services are provided to children three years of age and under who have or are at risk of experiencing developmental delays due to biological or environmental conditions. The range of services available to the child and his or her family depends primarily on the degree and type of delay. By identifying such risks and providing services at an early age, the Commonwealth helps young children reduce the threat of more severe delays and increase their chances of healthy development.

The Early Intervention system has a diverse funding base which shares cost responsibility among major payers. These services are funded by: private insurers (third party health insurance reimbursement covers medically necessary Early Intervention services up to the maximum benefit cap of $5,200 per year/per child); the Division of Medical Assistance (MassHealth); federal funding through IDEA (Individuals with Disabilities Education Act – Part C); and the

Department of Public Health through state line item appropriations. This diverse funding base ensures that the state is the payer of last resort for Early Intervention services.

Number of Children and Youth Served

In FY 2005, nearly 28,000 infants and toddlers received Early Intervention services.

Services Provided

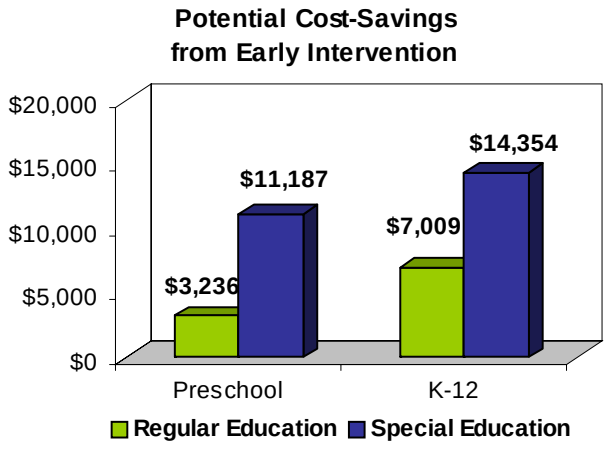
Early Intervention addresses different areas of child development, including cognitive, language, motor, social, emotional, behavioral, and self-help skills. The range of services reflects the range of children needing such assistance. On the one hand, a child's own experiences or environment could put him or her at risk of a developmental delay. For example, a child could receive Early Intervention if he or she faces inadequate levels of health, maternal, or family care or if patterns of physical and social stimulation are limited to the extent that the child shows delayed development.[83] On the other hand, a child may already be experiencing such delays because he or she has a biological disability (visually or hearing impaired, for example) and would benefit from services. In either case, once it is shown through the proper diagnostic assessments, that the child exhibits a risk or is developmentally delayed, a child facing such challenges will receive individualized services in specific areas of child development.

The level of services or therapies that a child needs is determined by the Early Intervention team, which includes the family and a group of interdisciplinary professionals – therapists, psychologists, developmental specialists, or other specialty service providers – and is formalized in the Individualized Family Service Plan (IFSP). The IFSP establishes which services are needed, the duration of such services, and sets measurable outcomes for the child. The services may include occupational, physical, or speech-language therapy, counseling and social supports, or other specialty services. The team provides services in the child's natural environment, which usually includes his or her home or child care center to allow the child to easily participate in routine activities with their peers.

Positive Results

There has been extensive evidence on the effectiveness of Early Intervention. Since there is not one standard in the types of services offered or the children served, these results are not always applicable across systems. Still, overarching research has shown that children who receive Early Intervention need fewer special education and other rehabilitative services later on, are less often retained in a grade, and are, in some cases, indistinguishable from their peers years after.[84] Early intervention is

Figure 13



Source: Massachusetts Department of Education

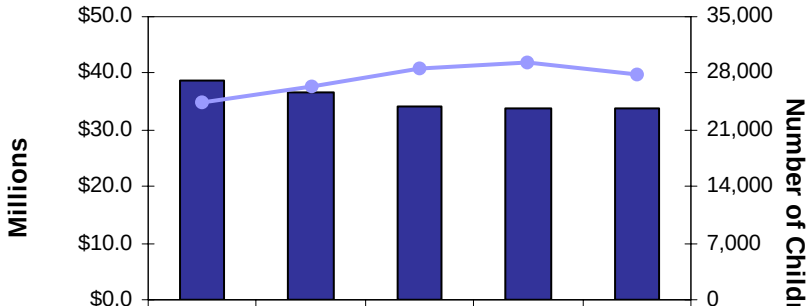
also cost effective in serving children early on, which may reduce some or all of the costs of special education upon entering the public school system. For instance, in Massachusetts the per pupil expenditure for a typically developing child is roughly $7,000 annually; the per pupil expenditure for a special education student is slightly more than two times this amount.[85] At the preschool level, the saving is greater (see Figure 13).[86]

Effect of Budget Cuts

Between fiscal years 2001 and 2005, funding for these services fell, in real terms, by $5.2 million or 13 percent. Meanwhile the caseload for Early Intervention grew by 3,624 or 15 percent during this period (see Figure 14).

Figure 14

Funding for Early Intervention and Caseload Growth



	2001	2002	2003	2004	2005
Real $	38.9	36.5	34.1	33.8	33.7
Nominal $	34.6	33.0	31.5	31.9	32.8
EI Caseload	24,283	26,460	28,646	29,384	27,907

Source: Caseload numbers are from the MassCHIP database and the Massachusetts Department of Public Health.

The Commonwealth implemented several measures to deal with rising demand for services and limited resources. In FY 2003 after being cut from $33.0 million to $31.5 million (including a $365,000 reduction mid-year), the Department of Public Health (DPH) instituted changes in the service delivery system for Early Intervention. Such changes included reducing child group hours from five to two and one-half hours per week, and eliminating transition visits for children turning three who will need special education services. In FY 2004, DPH also tightened the eligibility criteria for services. Consequently, older toddlers would need to show a greater degree of developmental delay to receive Early Intervention. For example, a two and half year old would now have to show a 7.5 month delay in age appropriate behaviors, whereas the older standards required a six month delay in order to receive services. Although changes were designed to maintain the core function of Early Intervention, they will create larger gaps in the service delivery system.

"Although changes were designed to maintain the core function of Early Intervention, they will create larger gaps in the service delivery system."

Gaps in Services and Unmet Needs

Transitioning to the Public School System

Once a child turns three he is no longer eligible for services through Early Intervention, and often will receive services through the public school systems which is legally required to provide supports to children with disabilities. While the benefits of continuing services into a formal classroom are ideal for children who need such assistance, the reality is that continuity between the two systems is not always smooth. For example, parents are not always aware of the required steps, including who to contact within their local school district or how to schedule the appropriate diagnostic assessments, to ensure that their child continues to receive the services that are central to his or her development. Transitional services are important to addressing these issues and are offered to families at varying degrees, in part, because funding for these services has been cut. In other instances, the timing of the child's third birthday can impede the delivery of services. If a child turns three in the spring or summer, it is likely that the child and his or her family may experience a lapse in service for several months until the school year begins. Without the appropriate services, a child may halt progress in a certain area or regress in the development that he or she has experienced as a result of Early Intervention.

Providing Access to Quality Early Education and Care

In 2004, legislation was passed establishing a new state Department of Early Education and Care, which officially opened on July 1, 2005. This Department is charged with overseeing the majority of the states services for young children, combining the former functions of the Office of Child Care Services and the Department of Education's Early Learning Services.[87] Providing one department for early education signals the state's commitment to providing a coordinated system of care for young children. While the new Department faces the work of shaping a new system from existing structures, and tries to improve access to affordable, quality early education and care, the budget cuts implemented during the recent fiscal crisis may add additional challenges to achieving these goals.

SUBSIDIZED EARLY EDUCATION AND CARE

"A family earning $30,000 a year would have to devote a third of its income toward the cost of preschool for just one child."

The cost of early education programs often is a substantial barrier to obtaining quality early care. In Massachusetts, the annual cost of licensed early education ranges between $9,100 for preschool and $12,735 for infant care.[88] A family earning $30,000 a year would have to devote a third of its income toward the cost of preschool for just one child. Parents who cannot afford the high cost of care and are not able to secure subsidies often turn to less expensive, low quality alternatives. Quality early education increases children's cognitive, emotional, and social skills, and contributes to positive outcomes like school readiness.[89] These subsidies also help families obtain and secure employment, which improves the quality of life for their families.

Number of Children and Youth Served

As of March 2004, there were close to 78,000 children receiving quality care with the help of a subsidy.[90] Although funding for subsidized care supports children from infanthood through age twelve, the demand for early education is high. Infants and toddlers represent more than 75 percent of the children on the waitlist for subsidized care.[91]

Services Provided

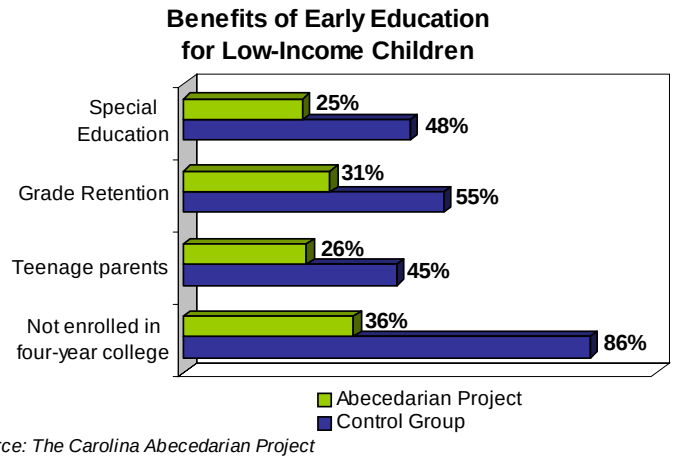
The Department of Early Education and Care provides subsidized care for working families through two different budget accounts. In addition to funding the Community Partnerships for Children program (discussed in more detail below), the state devotes a sizable portion of the budget for early education to subsidized care. In FY 2006, 65 percent of the total budget for the Department of Early Education and Care was appropriated for this purpose.[92]

The Commonwealth subsidizes early education and care for low-income families by contracting directly with providers or by providing vouchers to eligible families. A family must earn no more than 50 percent of the state median income or roughly $30,000 per year for a family of three to be eligible for assistance.[93] All families pay a fee based on a sliding scale that is based on income and family size. Families receive comprehensive services, including transportation and specialized services for at-risk children. Subsidies help defray some of the cost of early education and care programs, which enable low-income families to find or maintain employment and afford the cost of other family expenses.

Positive Results

This support improves access to quality care for children in low-income families. Quality early education and care benefits all children, but is even more crucial for low-income children who often start school at a disadvantage. Quality early education has lasting effects, including positive cognitive development and academic achievement.[94] The Abecedarian Project was a program that demonstrated particularly strong results for low-income children.

Figure 15



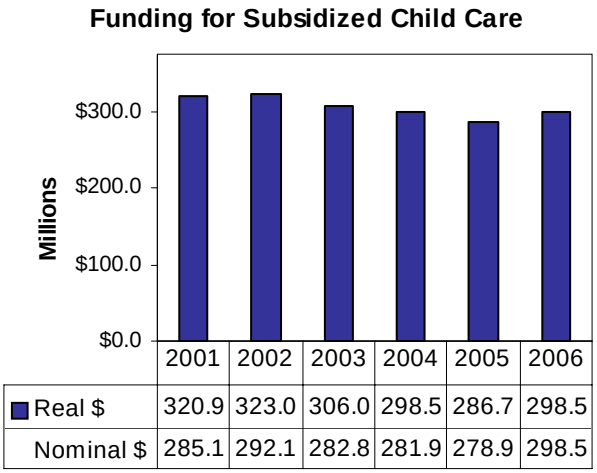
Source: The Carolina Abecedarian Project

Evaluations of this early education program showed specific accomplishments, including lower grade retention rates, decreased use of special education services and higher college enrollment rates.[95] Improving access to such services helps increase positive outcomes for the Commonwealth's youngest children.

Effect of Budget Cuts

Between FY 2002 and FY 2005, funding for subsidized child care fell by $36.3 million or 11 percent, after adjusting for inflation. Budget cuts for these services led to reductions in services for children. For example, between 2002 and 2003 funding was cut, in real terms, by five percent. During this same period, the number of low-income children in subsidized care dropped by 10 percent. Meanwhile, the number of children on the waitlist rose from 17,610 to 19,235. Shrinking the pool of available subsidies puts the benefits of quality early education for low-income children at risk. Parents are likely to turn to less expensive, lower quality alternatives. The employment and economic gains for low-income families that is associated with subsidized care are also compromised by cuts in this area.

Figure 16



	2001	2002	2003	2004	2005	2006
Real $	320.9	323.0	306.0	298.5	286.7	298.5
Nominal $	285.1	292.1	282.8	281.9	278.9	298.5

Gaps in Services and Unmet Needs

Addressing the Waitlist for Subsidized Care

Although the waitlist for subsidized care has shrunk, it still has remained high. As of June 2005, there were 14,407 low-income children on the waitlist for child care; of this total 11,101 or 77 percent were waiting for care in infant, toddler, or preschool programs.[96] Given limited funding for all eligible applicants, Massachusetts, like many other states, gives higher priority to families receiving or transitioning off of welfare.[97] This preferential treatment often creates tension among all low-income families seeking financial assistance for child care. Low-income families who are not receiving or transitioning off of welfare, yet nonetheless eligible for child care subsidies, are at a disadvantage. For example, the $19.5 million nominal increase in funding for subsidized care in FY 2006 includes $6.0 million to support welfare recipients facing new or increased work requirements. While this amount will help more individuals receiving welfare move into the workforce, in recent years there haven't been comparable increases to assist other low-income families. In fact, the rest of the increase in funding for FY 2006, in part, will support removing 2,500 children from the waitlist, which is only a fraction of the 14,000 children whose parents are currently waiting for assistance. It is likely that many low-income families who are eligible for subsidies cannot receive them because there have not been sufficient state supports in place for them.

"As of June 2005, there were 14,407 low-income children on the waitlist for subsidized care"

COMMUNITY PARTNERSHIPS FOR CHILDREN

The Community Partnerships for Children (CPC) program is another source of funding for early education and care. The CPC program was established to develop a universal system of early education for the Commonwealth's three and four year olds. The program is designed to support children of working families by helping to provide accessible, affordable, and quality early care and education programs. Formerly part of the Massachusetts Department of Education's Office of Early Learning and School Readiness, CPC now falls under the purview of the Department of Early Education and Care.

Number of Children and Youth Served

Roughly 100,000 children are enrolled in early care programs that benefit from quality enhancements (e.g., trainings, support with accreditation) provided through the CPC program.[98] Nearly 14,900 children receive scholarships through this program to attend full- or part-time programs with both public and private caregivers.[99]

Services Provided

The CPC program is designed to help both families and providers. A certain portion of the funding for the program is dedicated to subsidies ("scholarships") for families earning up to 125 percent of the state median income. The CPC program also funds comprehensive services for young children, including transportation, literacy development, mental health services, and supplemental services for children with Individualized Education Plans. Early education programs also benefit from grants from the CPC program that fund quality enhancement initiatives like trainings, resource materials, and support with accreditation.

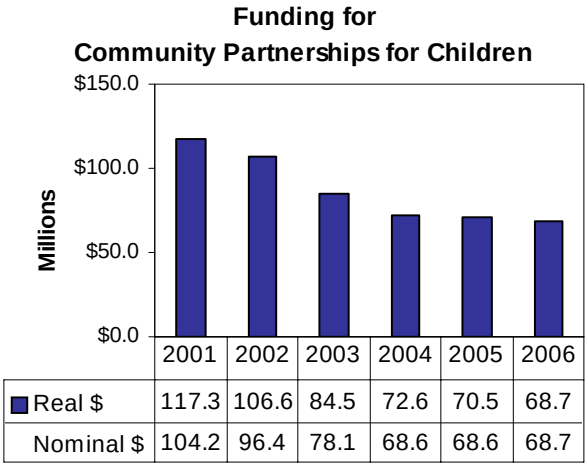
Positive Results

Early education programs participating in the CPC program must be working toward accreditation with the National Association for the Education of Young Children (NAEYC) – a highly regarded standard of quality for center-based programs – and therefore are more likely to demonstrate higher quality care. The Commonwealth ranks first in the nation in the number of NAEYC accredited early education programs; there are nearly 1,000 accredited programs across the state.[100]

A series of four reports on the cost and quality of early education programs in Massachusetts researched various aspects of the state's system of early education. Two of these reports focused separately on private full-day year round programs and publicly administered preschool programs, two systems of care that the CPC program funds. Both studies showed that each of these categories earned average scores that represented "good care." On a scale of one to seven, private classrooms received a 4.94 and publicly administered preschools earned a 5.25.[101,102] The reports also indicated that accredited programs scored higher than non-accredited programs.[103,104]

Effect of Budget Cuts

Figure 17



Between FY 2001 and FY 2004, funding for the CPC program fell, in real terms, by $44.7 million or 38 percent. Since FY 2004 funding for this program has been relatively level. The current budget stands 41 percent below where it was in 2001, after adjusting for inflation. These cuts have led to reductions in services. Between 2003 and 2004, the number of children served through the CPC program fell from 18,100 to 16,600.[105] The program also scaled back its funding for trainings, resource materials, and accreditation supports. For example, support for comprehensive services was cut by 60 percent in 2002, and reduced again in 2003 and 2004 by 15 and 20 percent respectively.[106] Support for quality initiatives was also reduced during the fiscal crisis. In 2002, CPC funding for this purpose dropped by 26 percent and by an additional 21 percent in 2003.

Gaps in Services and Unmet Needs

Moving Toward Universal Early Education and Care

The rationale for universal preschool is simple: early education is key to helping students enter school ready to learn. Achieving this goal is not simple, however. Estimates place the cost of providing universal care at roughly $1 billion annually. Cost is not the only obstacle, however. Improving coordination among the different systems of care and with other state agencies will take a considerable amount of work.

Another challenge in moving toward universal care is getting the early education workforce up to quality standards. A caregiver's educational attainment is often a strong predictor of a program's level of quality. In Massachusetts, there is a wide disparity in the education levels of early education providers. Public preschool teachers generally have the highest level of education since they are required to have earned a bachelors degree, and more than 90 percent have a bachelors, masters, or advanced degree in Education or in a related field.[107] At the other end of the spectrum, licensed Family Child Care providers are least likely to have earned a bachelors degree; only 12 percent of these providers have earned this credential.[108] The FY 2006 budget allocates $1.0 million to fund scholarships for early childhood educators. This is a positive step toward improving the workforce, but more needs to be done in this area.

Despite all of these challenges, providing quality early education and care to the Commonwealth's youngest children would improve the lives and life prospects of these children. Not only will the children themselves benefit, but the state will experience positive returns from such an investment. Several studies have analyzed the fiscal impacts of universal early care. A

recent cost analysis of universal pre-kindergarten in Massachusetts shows that an expenditure of $578 million on early education by the Commonwealth, annually would reap a $680 million fiscal benefit or an 18 percent return on the investment.[109] While one cannot be certain that such benefits can be quantified with this level of precision, it is clear that the benefits would be real, and would include reduced state expenditures on special education placements and grade retention, fewer incidences of abuse and neglect, and reduced crime.[110] Children would benefit directly from improved academic achievement, improved health, nutrition and well-being, and higher employment probability and wages.[111]

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[69] U.S. Census Bureau, 2000 Decennial Census, "P8. Sex by Age – Universe: Total Population, 2000 Decennial Census Summary File 3, available at: http://factfinder.census.gov/servlet/DTTable?_bm=y&-context=dt&-ds_name=DEC_2000_SF3_U&-mt_name=DEC_2000_SF3_U_P008&-CONTEXT=dt&-tree_id=403&-all_geo_types=N&-geo_id=04000US25&-search_results=01000US&-format=&-_lang=en.

[70] Jacobs, Francine et al., *Healthy Families Massachusetts Final Evaluation Report*, Massachusetts Healthy Families Evaluation, Tufts University, April 2005, p. 17, available at: http://ase.tufts.edu/mhfe/reports/FinalEvalReport.pdf.

[71] Federal Interagency Forum on Child and Family Statistics, *America's Children: Key National Indicators of Well-Being, 2005*, Federal Interagency Forum on Child and Family Statistics, Washington, DC, 2005, p. 38.

[72] Ibid.

[73] Jacobs, Francine et al., *Healthy Families Massachusetts Final Evaluation Report*, Massachusetts Healthy Families Evaluation, Tufts University, April 2005, p. 105.

[74] Ibid.

[75] Ibid.

[76] Jacobs, Francine et al., *Healthy Families Massachusetts Final Evaluation Report*, Massachusetts Healthy Families Evaluation, Tufts University, April 2005, p. 109.

[77] Ibid.

[78] Ibid, p. 110.

[79] Ibid, p. 114-115.

[80] Ibid, p. 25.

[81] Ibid, p. 111.

[82] Early Intervention is administered by the Department of Public Health, although coordination with the Department of Early Education and Care is often necessary to provide the best mix of services for young children.

[83] Massachusetts Department of Public Health, Early Intervention Services, *Operational Standards*, July 2003, p. 18, available at: http://www.mass.gov/dph/fch/ei/opst_2003.pdf.

[84] U.S. Department of Education, Office of Educational Research and Improvement, ERIC Clearinghouse on Handicapped and Gifted Children, *Does Early Intervention Help?*, ERIC Digest #455 Revised, ED295399, March 1988, available at: http://www.ericdigests.org/pre-928/help.htm.

[85] Based on Massachusetts Department of Education, "FY04 Per Pupil Expenditures," available at: http://finance1.doe.mass.edu/statistics/pp04.html.

[86] Based on the most recent breakdown of preschool costs for regular and special education from Massachusetts Department of Education, "FY00 Regular Education Expenditures by Grade Level," and "FY00 Special Education Expenditures by Prototype," available at: http://finance1.doe.mass.edu/statistics/pp00.html.

[87] There are other services that fall under the umbrella of "early education and care" but are not administered by this agency.

[88] Massachusetts Child Care Resource and Referral Network as cited in Traill, Saskia, and Wohl, Jen, *The Economic Impact of the Child Care and Early Education Industry in Massachusetts*, National Economic Development and Law Center, April 2004, p. 12, available at: http://www.nedlc.org/MAEIRfull%20.pdf.

[89] For more, refer to: (1) *The Children of the Cost, Quality, an Outcomes Studies go to School*, National Institute of Child Health and Human Development, June 1999. (2) Shonkoff, J. and Phillips, D. eds., *From Neurons to Neighborhood: The Science of Early Childhood Education*, Board of Children, Youth, and Families, Commission on Behavioral Sciences and Education, National Research Council and Institute of Medicine, Washington, D.C., National Academy Press, 2000. (3) *Starting Points: Meeting the Needs of Our Youngest Children*, Carnegie Corporation of New York, August 1994.

[90] Data on subsidized slots are from the Massachusetts Department of Early Education and Care. This figure does not include children in custody of the Department of Social Services.
[91] Massachusetts Department of Early Education and Care, "Waitlists by Age Groupings of Children – June 2005," available at: http://www.eec.state.ma.us/docs/REChildrenWaitbyAgeGrouping.pdf.
[92] The amount for subsidized care for low-income families includes $6.0 million of a $12.0 million reserve created to comply with welfare reform in Massachusetts.
[93] Once enrolled, this cutoff changes to 85 percent of state median income or about $50,000 a year for a family of three.
[94] Campbell, Frances and Elizabeth Pungello, *High Quality Child Care Has Long-Term Educational Benefits for Poor Children*, The Carolina Abecedarian Project, Paper Presented at the Head Start National Research Conference, Washington, DC, June 28-July 1, 2000.
[95] Lynch, Robert G., *Exceptional Returns: Economic, Fiscal, and Social Benefits of Investment in Early Childhood Development*, Economic Policy Institute, October 2004, p. 28-30.
[96] Massachusetts Department of Early Education and Care, "Waitlists by Age Groupings of Children – June 2005," available at: http://www.eec.state.ma.us/docs/REChildrenWaitbyAgeGrouping.pdf.
[97] United States General Accounting Office, *Child Care: Recent State Policy Changes Affecting the Availability of Assistance for Low Income Families*, GAO-03-588, April 2003.
[98] Massachusetts Department of Education, Office of School Readiness, "Community Partnerships for Children: Building a System of Early Childhood Education in Massachusetts," available at: http://www.eec.state.ma.us/x/docs/TACPCFactSheet.pdf. *Note: The Office of School Readiness in the Massachusetts Department of Education was transferred to the Massachusetts Department of Early Education and Care on July 1, 2005.*
[99] Ibid.
[100] Ibid.
[101] Marshall, Nancy et al., *The Cost and Quality of Full Day, Year-round Early Care and Education in Massachusetts: Preschool Programs*, Wellesley Centers for Women and Abt Associates, Inc., 2001, p. 28.
[102] Marshall, Nancy et al., *Early Care and Education in Massachusetts Public School Preschool Classrooms*, Wellesley Centers for Women and Abt Associates, Inc., 2002, p. 32.
[103] Marshall, Nancy et al., *The Cost and Quality of Full Day, Year-round Early Care and Education in Massachusetts: Preschool Programs*, Wellesley Centers for Women and Abt Associates, Inc., 2001, p. 38.
[104] Marshall, Nancy et al., *Early Care and Education in Massachusetts Public School Preschool Classrooms*, Wellesley Centers for Women and Abt Associates, Inc., 2002, p. 8-9.
[105] Figures are from the former Office of School Readiness, Massachusetts Department of Education, as cited in Na'im, Alyssa and Nancy Wagman, *Real Cuts – Real People – Real Pain: The Effects of the Fiscal Crisis on Women and Girls in Massachusetts*, Massachusetts Budget and Policy Center, p. 23, available at: http://www.massbudget.org/Real%20Cuts%20-%20Real%20People%20-%20Real%20Pain.pdf.
[106] Ibid.
[107] Marshall, Nancy et al, *Massachusetts Capacity Study Research Brief: Characteristics of the Current Early Education and Care Workforce Serving 3-5 Year-olds*, Center for Research on Women, Wellesley College, 2005, p. 8, available at: http://www.wcwonline.org/earlycare/workforcefindings9-9-05.pdf.
[108] Ibid, p. 9.
[109] Belfield Clive and Patrick McEwan, *An Economic Analysis of Investments in Early Childhood Education in Massachusetts*, Research paper commissioned by Strategies for Children, Inc., 2005.
[110] Ibid.
[111] Ibid.

III. Programs for School-Aged and Adolescent Children

In Massachusetts, there are more than one million children between six and 17 years of age.[112] Most of these children spend a good portion of their day in public schools acquiring the skills that they need to succeed and become productive members of society. By middle childhood and early adolescence, public health and education programs are increasingly important to ensure healthy development and positive outcomes for youth. For example, anti-smoking and teen pregnancy prevention programs are designed to equip youth with the skills to make decisions that will benefit them in the short and long-term.

Educating Children and Youth

The goal of public education, as established by state law, is to provide all students with "the opportunity to reach their full potential and to lead lives as participants in the political and social life of the [C]ommonwealth and as contributors to its economy."[113] To that end, effective public schools prepare students to excel in institutions of learning, including the elementary, secondary, and post-secondary levels, and to achieve some level of success as citizens of the Commonwealth.

ELEMENTARY AND SECONDARY EDUCATION

Across the Commonwealth, schools vary in the populations and the needs of students, but major policies implemented since the Massachusetts Education Reform Act of 1993 have helped to establish comprehensive, statewide policies for strengthening public schools. This legislation set guidelines for providing accountability for student learning; statewide standards for students, schools, and districts; and greater and more equitable funding of public schools. Students have experienced considerable accomplishments as a result, including increased progress on state standards and substantially high achievement on national benchmarks of academic success. Although there is more work to do to with regard to disparities in performance levels within certain communities, overall results demonstrate that education reform has improved students' capacities to learn and continue their achievement in post-secondary institutions and beyond.

Number of Children and Youth Served

Close to 980,000 children are educated by the Commonwealth's public school system.[114]

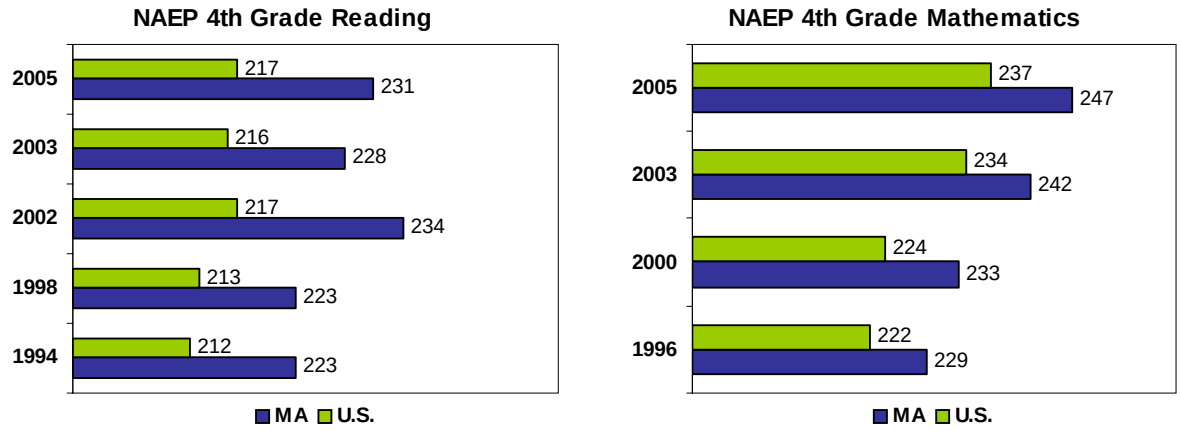
Services Provided

Massachusetts' public schools provide quality education to children from pre-kindergarten through twelfth grade – or later for students with special needs. Students also benefit from educational programs offered outside of school time. These programs not only support positive academic achievement, but also help to foster positive development.

Positive Results

The Commonwealth's students perform well on a variety of measures of academic achievement. Students' performance on the Massachusetts Comprehensive Assessment System (MCAS) is one example. Since its first administration, and until 2004 as discussed below, increasing proportions of students have scored at the "Advanced" or "Proficient" levels of this measure of student performance.[115] Massachusetts' students also lead the nation on the National Assessment of Education Progress (NAEP), a national benchmark of academic success. Recent results reveal that average scale scores for Massachusetts were higher than national averages, receiving substantially higher rankings than the rest of the country. In 2005, for instance, Massachusetts' fourth and eighth graders ranked first in both reading and mathematics (see Figure 18).[116]

Figure 18



Source: National Center for Education Statistics, U.S. Department of Education

The majority of public school graduates are also likely to continue their education at a post-secondary institution, improving the likelihood of economic self-sufficiency. The Massachusetts Department of Education reports that 77 percent of high school graduates from the class of 2003 planned to continue their education at a two- or four-year college.[117] Furthermore, the Commonwealth has the highest share of any state labor force with a bachelor degree or higher. Nearly forty percent of the state's labor force has earned at least a bachelor's degree.[118]

Effect of Budget Cuts

"In many instances, the state has reduced or eliminated funding for a number of services that contribute to students' success."

While the federal government provides financial support for public K-12 education, it is primarily financed through state and local revenue. In Massachusetts, state funding is made up of two sources: Chapter 70 aid and the Department of Education's grants and reimbursement programs. Chapter 70 aid is the largest state allocation to local municipalities for public education. Based on factors including number of students and local economic conditions, Chapter 70 aid provides a fixed allocation to local municipalities for each year. Cities and towns are required to supplement this funding with local revenue. In addition to Chapter 70 aid, the

state also provides funding for K-12 education through the Department of Education's grants and reimbursement programs. From this support, competitive grants are awarded to districts for specific purposes.

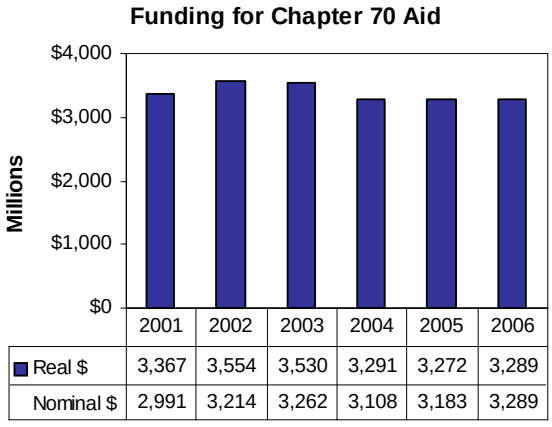
Overall, funding for K-12 education was cut, in real terms, by $311.2 million or 8 percent between fiscal years 2001 and 2004. Examining the two major component of state funding for K-12 education shows that:

- The deepest cuts to Chapter 70 aid occurred between fiscal years 2003 and 2004, when funding was reduced, in real terms, by $238.4 million or seven percent (see Figure 19).

- Funding for the Department of Education's grants and reimbursement programs fell even more dramatically during the recent economic downturn. Between 2001 and 2004 funding for this purpose declined by $235.7 million or 42 percent, after adjusting for inflation (see Figure 20).

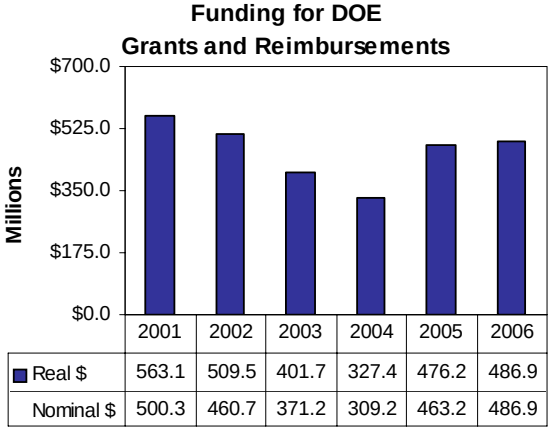
Although appropriations for K-12 education have increased modestly since FY 2004, many budget cuts have not been restored.

Figure 19



	2001	2002	2003	2004	2005	2006
Real $	3,367	3,554	3,530	3,291	3,272	3,289
Nominal $	2,991	3,214	3,262	3,108	3,183	3,289

Figure 20



	2001	2002	2003	2004	2005	2006
Real $	563.1	509.5	401.7	327.4	476.2	486.9
Nominal $	500.3	460.7	371.2	309.2	463.2	486.9

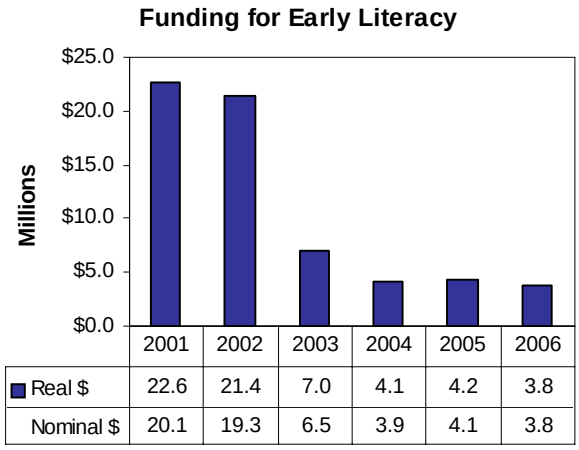
In many instances, the state has reduced or eliminated funding for a number of services that contribute to students' success, including: early literacy programs, after school activities, and services to help students pass the MCAS exam.

Early Literacy

Between fiscal years 2001 and 2004, funding for early literacy programs fell from $21.9 million to $4.0 million, an 82 percent reduction in real terms. This appropriation funds programs focused on improving the reading ability of children in kindergarten through third grade and supports professional development to keep teachers current on the latest research and literacy teaching techniques. Successful early literacy programs improve students' reading proficiency and promote sustained academic achievement. The recent drop in fourth grade English MCAS scores (which is discussed in more detail on the following page), makes the reduction in funding for early literacy programs an even graver concern.

"Between fiscal years 2001 and 2004, funding for early literacy programs fell from $21.9 million to $4.0 million, an 82 percent reduction in real terms."

Figure 21



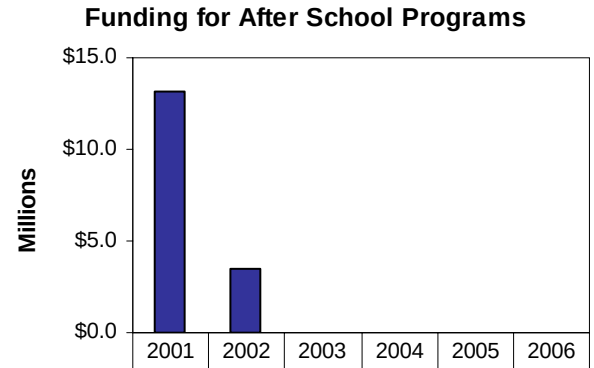
	2001	2002	2003	2004	2005	2006
Real $	22.6	21.4	7.0	4.1	4.2	3.8
Nominal $	20.1	19.3	6.5	3.9	4.1	3.8

After School Programs

Funding for after school programs administered by the Department of Education was cut from $11.7 million in 2001 to $3.1 million in 2002. In 2003, the Commonwealth ended its support for effective programs. Research on after school programs has indicated positive effects on improved academic performance and social development.[119] Reductions in state funding for after school programs also undermine the efforts of the programs' abilities to secure resources from the nonprofit and private sectors. A recent report on the impact of out-of-school time programs on student achievement states, "By failing to maintain its commitment to public/private partnerships, the state has not only taken its support, but also that of many private players, off the table."[120]

"Funding for after school programs administered by the Department of Education was cut from $11.7 million in 2001 to $3.1 million in 2002. In 2003, the Commonwealth ended its support for effective programs."

Figure 22



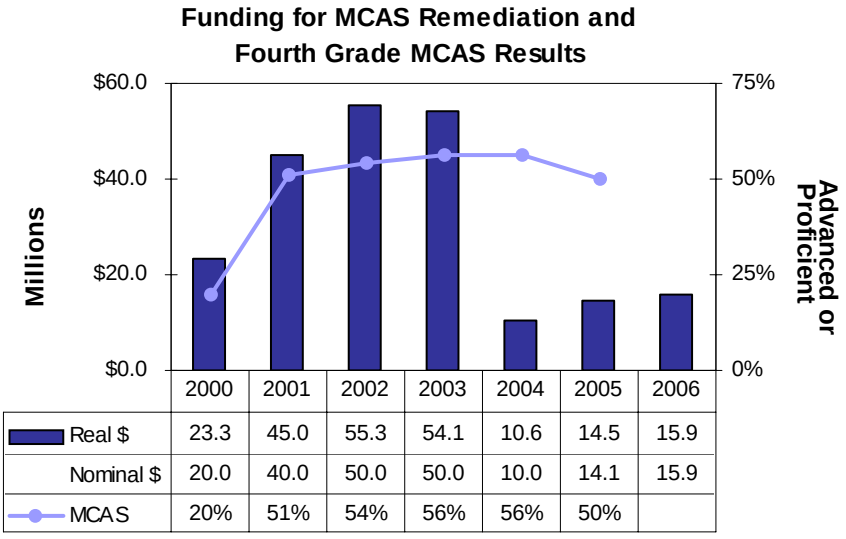
	2001	2002	2003	2004	2005	2006
Real $	13.1	3.4	0.0	0.0	0.0	0.0
Nominal $	11.7	3.1	0.0	0.0	0.0	0.0

MCAS Remediation

Between FY 2001 and FY 2004, funding for MCAS remediation programs fell from $40.0 million to $10.0 million, which, in real terms, represents a $34.4 million or 76 percent decline. The sharpest drop in funding occurred between fiscal years 2003 and 2004 when the Commonwealth reduced funding by 80 percent; this budget cut eliminated the $30.0 million that supported elementary school students and reduced the funding for high school students in half – from $20.0 million to $10.0 million. Recent MCAS results have shown that progress at the elementary levels – the same areas where funding was eliminated – has slowed or reversed in some cases. An analysis of fourth grade English and math scores shows a decline in students scoring at the advance or proficient levels and an increase in those scoring at the warning or failing mark (see Figure 23). In this case, current fourth grade performance in English is approximately where it was four years ago. Since NEAP scores have not declined, the exact meaning of these MCAS declines is unclear. It should be of concern, however, that following deep cuts to MCAS remediation programs, deep cuts to early literacy programs, and cuts to unrestricted education aid, we saw significant declines in fourth grade student performance on the test that our state uses to hold students, schools, and districts accountable.

"Recent MCAS results have shown that progress at the elementary levels – the same areas where funding was eliminated – has slowed or reversed in some cases."

Figure 23



	2000	2001	2002	2003	2004	2005	2006
Real $	23.3	45.0	55.3	54.1	10.6	14.5	15.9
Nominal $	20.0	40.0	50.0	50.0	10.0	14.1	15.9
MCAS	20%	51%	54%	56%	56%	50%	

Source: MCAS scores are from the Massachusetts Department of Education

Preventing Tobacco Use

The programs developed by the Commonwealth to prevent smoking and the use of other tobacco products provide a clear example of how adequately-funded public programming can have a direct and positive impact on the health and well-being of the Commonwealth's children.

THE MASSACHUSETTS TOBACCO CONTROL PROGRAM

According to the U.S. Surgeon General, "tobacco use remains the leading preventable cause of disease and death in the United States," and smoking and the use of other forms of tobacco have demonstrable causal impacts on a variety of respiratory conditions for children and adolescents, including coughing, wheezing and shortness of breath.[121]

Ninety percent of all adults who smoke report that they started smoking before their twenty-first birthday, and half of these adults reported having become regular smokers by the age of eighteen.[122] According to a recent study, adequately-funded smoking and control prevention programs in each state could result in more than $31 billion worth of reduced future health care savings associated with the reductions in youth smoking alone.[123]

During the 1990's, Massachusetts created a model smoking prevention and treatment program within the Department of Public Health known as the Massachusetts Tobacco Control Program (MTCP). Among the four primary goals of the program were: "preventing initiation of tobacco use among youth" and "promoting smoking cessation among young people."[124] During the 1990's, the efforts of the MTCP included a major media campaign with television public service announcements, billboards and other print advertisements.[125] The MTCP also developed community-based programs, working with local boards of health and health departments to combat smoking among children and adolescents. In order to reach children and adolescents at school, the MTCP worked directly with school health departments and school nurses to support their anti-smoking education efforts. The MTCP also developed a system of peer leaders and "youth action alliances" to better target anti-smoking efforts to young people.

Number of Children and Youth Served

Between 1994 and 2000, the Massachusetts Tobacco Control Program reached tens of thousands of young people in the Commonwealth with its media campaigns. Over 1,700 teenagers worked with the MTCP as peer leaders, and dozens of focus groups across the state brought in the perspectives of anywhere from 500 to more than 1,400 teenagers each year from 1994 to 2000. Since 1994, more than 14,000 retailers have been trained in retail tobacco compliance.

Services Provided

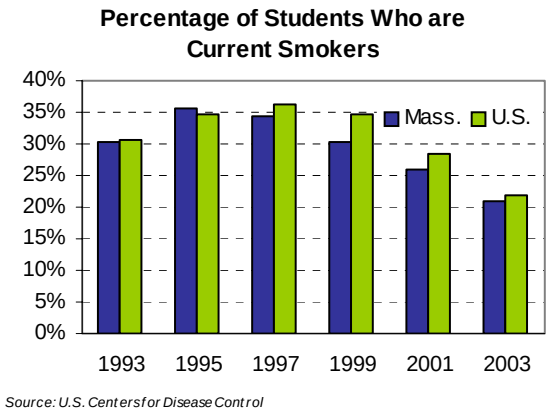
In addition to its smoking prevention efforts, the MTCP also developed a variety of services aimed at motivating current smokers to quit, and then providing the services to help them quit. Included in these services were referrals to smoking treatment programs, direct treatment using evidence-based treatment methods, and telephone- and web-based tobacco treatment counseling services.

The MTCP also has worked with local boards of health to train tobacco retailers in compliance with the laws regarding sales of tobacco products to minors.

Positive Results

There is substantial evidence that the Massachusetts tobacco prevention and cessation programs were successful in reducing smoking rates among youth in Massachusetts. According to the Campaign for Tobacco-Free Kids, the fully-funded Massachusetts program was one of only two programs nation-wide (along with California) that was successful because it was a "long-term and comprehensive public health program."[126]

Figure 24



Source: U.S. Centers for Disease Control

One way to measure the success of the Massachusetts anti-smoking program when it was fully funded is to compare the rate of smoking among teenagers in Massachusetts with the rate of smoking nation-wide. Smoking rates dropped nationally, but in Massachusetts the rates dropped even more.

With the implementation of the Massachusetts Tobacco Control Program, smoking among young people declined in Massachusetts.[127] In 1995, 36 percent of Massachusetts students smoked, compared to 35 percent nation-wide. By 2001, during the period in which the Massachusetts Tobacco Control Program was fully operational, 26 percent of Massachusetts students smoked, compared to 29 percent nationally (see Figure 24.)

Effect of Budget Cuts

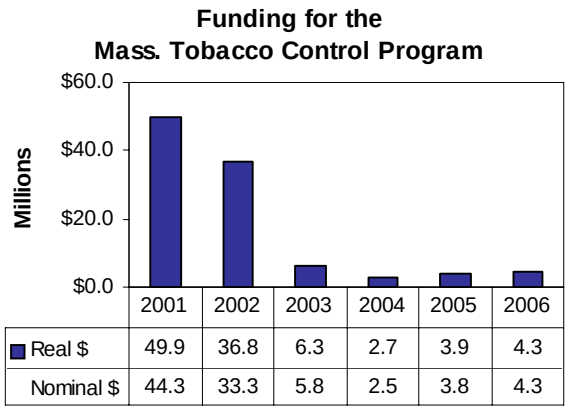
Since the state fiscal crisis began in fiscal year 2002, the Massachusetts Tobacco Control Program has been decimated. From its peak in FY 2000, when the program was funded at $63.2 million in inflation-adjusted dollars, repeated cuts have almost entirely eliminated all aspects of the program. In just one year between fiscal years 2002 and 2003, the Massachusetts Tobacco Control Program lost more than $30 million dollars in real terms, a cut of close to 83 percent. Although the program received a slight increase in funding between fiscal years 2004 and 2006 (from $2.7 million to $4.3 million), FY 2006 funding still represents a 91 percent reduction since FY 2001.

"In just one year between fiscal years 2002 and 2003, the Massachusetts Tobacco Control Program lost more than $30 million dollars in real terms, a cut of close to 83 percent."

Without funding, the Department of Public Health can no longer sustain a program that had been recognized and applauded nation-wide. The MTCP media campaign, community outreach

programs, support for local programming, and broad smoking prevention education programs were eliminated.

Figure 25



	2001	2002	2003	2004	2005	2006
Real $	49.9	36.8	6.3	2.7	3.9	4.3
Nominal $	44.3	33.3	5.8	2.5	3.8	4.3

Once there were significant cuts to the Commonwealth's anti-smoking programs, Massachusetts' progress relative to the nation in reducing smoking rates among young people slowed. Whereas smoking rates among young people had been dropping more quickly in Massachusetts than rates in the nation as a whole, by 2003 the decline in the Massachusetts smoking rate for young people was slowing down, and once again approaching the national rate (refer to Figure 24.)

The reduction in funding for the MTCP may also be allowing an increase in the illegal purchase of cigarettes by minors. Retail compliance is measured by sending a minor under adult supervision into a retail establishment to attempt to purchase tobacco illegally. A recent study conducted by Tobacco Free Mass determined that there was a dramatic increase in the illegal sales of cigarettes to minors in those communities where there were also dramatic reductions in tobacco control funding. Between 2002 and 2003, retail non-compliance jumped from eight percent of attempted undercover purchases to almost 14 percent in those communities with reduced tobacco control programs. When these purchases were attempted in communities that had completely eliminated their local tobacco control programs, the average rate of illegal sales to minors almost doubled – from 7.7 percent to 15.4 percent.[128]

Preventing Teen Pregnancy

One of the nation's top public health priorities – one of its "leading health indicators" – is promoting responsible sexual behavior. Educating teenagers about responsible sexuality and preventing teenage pregnancy have been priorities in the Commonwealth over the past decades as well. In Massachusetts, the Department of Public Health states it intends to "increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active."[129]

There are numerous benefits to reducing pregnancy among teenage girls. Teen pregnancy carries numerous types of risk for both mother and child. Pregnancy during adolescence is a high-risk pregnancy, as teenagers who are pregnant are at greater risk for poor weight gain, hypertension, complications at delivery, and other medical risk factors. Pregnancy has dramatic impacts on the lives of the teenage mothers, since teen pregnancy is closely linked to poverty and single parenthood, and teenage mothers are less likely to ever complete their schooling, which in turn can lead to long-term economic impacts for the mother and child. Less than one-third of

"Less than one-third of teenagers who begin their families before age 18 will ever earn a high school diploma."

teenagers who begin their families before age 18 will ever earn a high school diploma.[130] There are also significant medical risks for the children born of teenage parents. Children born to teenage mothers are at significantly greater risk for low birth weight than children born to older mothers, and are also at higher risk for a wide variety of health and cognitive problems. On top of these medical risks, children of teenage mothers are also at higher risk for inadequate health care during childhood as well as other societal risks.[131]

THE TEEN CHALLENGE FUND PROGRAM

One of the state's targeted programs to reduce teenage pregnancy was the Teen Challenge Fund Program. The state Department of Public Health first established this program in the 1980s in order to improve the health of at-risk teenagers and pre-teenagers in the Commonwealth and reduce the incidence of teenage pregnancy. Specifically, goals of the program were to: increase sexual abstinence among teenagers, and delay the onset of any sexual activity among pre-adolescent and adolescent males and females; reduce the rate of health-related risky behaviors, including risky sexual behavior; decrease the rate of teenage pregnancy, teenage birth, and infection with sexually-transmitted disease.[132]

Because there are a variety of known factors that put particular adolescents and particular communities at more risk for teen pregnancy than others,[133] the Teen Challenge Fund program targeted the most at-risk communities, and targeted adolescent boys and girls most at risk for teen pregnancy. Moreover, the programs worked not only with the teenagers themselves, but involved the families as well, recognizing the crucial role of the family in teen pregnancy prevention.

Number of Children and Youth Served

In FY 2001, the seventeen Teen Challenge Fund coalitions distributed funding to 97 local community agencies, and provided on-going programming for more than 12,000 youth and 12,000 families. One-time events and programs reached an additional 84,000 youth and 44,000 families. The Young Men's Initiative reached more than 5,000 youth and 500 family and community members during fiscal year 2001.[134]

Services Provided

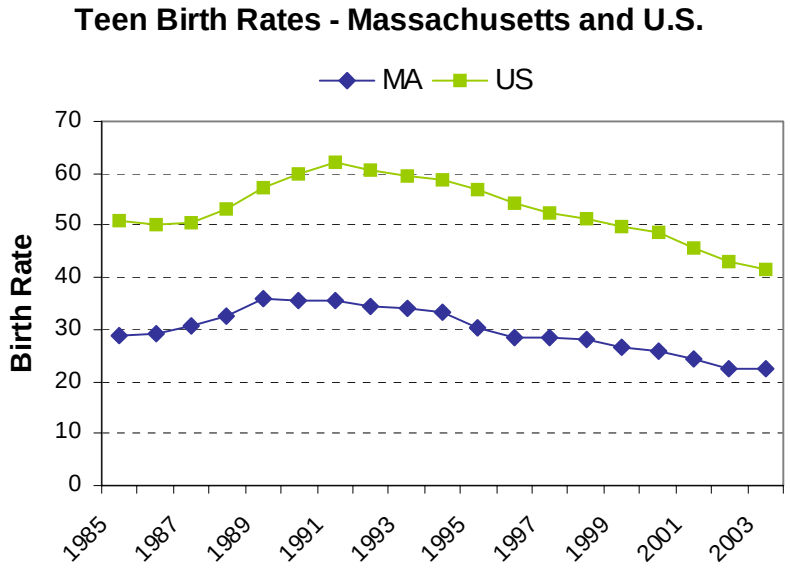
The Teen Challenge Fund programs focused on three types of intervention: access to health care, comprehensive health education, and what is referred to as "youth development." In order to improve access to health care services, Teen Challenge Fund coalitions established a variety of mechanisms to make sure that teenagers had good access to primary health care in school-based clinics or at local community health centers or community hospitals. The Challenge Fund programs worked with local health providers, including school health services, to support comprehensive health education including sex education. In addition to these health-based programs, the Teen Challenge Fund used a "youth development" model that created

opportunities for the adolescents involved to feel successful, including opportunities for leadership and skill-building such as mentoring programs and a variety of after school enrichment activities.[135] Services were also provided that targeted young men in nine communities through the Young Men's Initiative.

Positive Results

The Commonwealth's teen pregnancy prevention services may have had a significant role in the dramatic declines in the teenage birth rate in Massachusetts during the 1990s and into the first part of the twenty-first century. These rates started dropping within a year of the establishment of the Teen Challenge Fund inception in 1988, which was before the national teen birth rate started its decline (see Figure 26).

Figure 26



Rate per 1000 females age 15-19
Source: Massachusetts Department of Public Health

Through the late 1990s, the Massachusetts teen pregnancy rate declined steadily, including drops of nine percent between 1994 and 1995, and seven percent between 2001 and 2002. In fiscal year 2000, the Commonwealth received a $20 million bonus from the federal government for having dramatically reduced teen pregnancy rates without having increased the rate of teenage abortion. In fact, the National Campaign to Prevent Teen Pregnancy cited the programs in Massachusetts as one of five nation-wide as examples of teen pregnancy prevention programs that were effective. Massachusetts was noted for its success in targeting communities with high rates of teenage pregnancy, and implementing programs that were based on research, and on methods that had been successfully evaluated and determined to effective.[136]

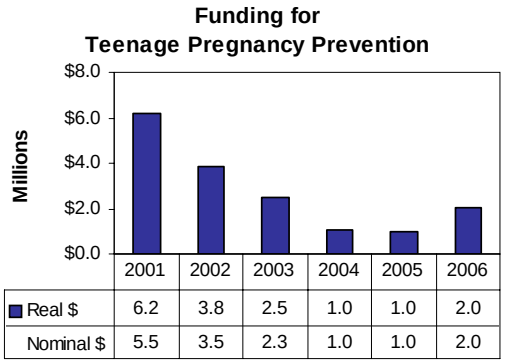
"Through the late 1990s, the Massachusetts teen pregnancy rate declined steadily."

Some of the benefits of programs such as the Teen Challenge Fund can be hard to quantify. In some instances, the building of coalitions in a distressed community can have impacts that go beyond the stated goal of the coalition. The Teen Challenge Fund brought together at-risk teens with their vulnerable families, and created a network of health and human service providers, educators and other community leaders to address common concerns. Research indicates that the "youth development" approach may help keep adolescents in school, keep them involved and help them focus on the future, which in turn has the effect of reducing the likelihood of teen pregnancy.[137]

Effect of Budget Cuts

Although the state's teen pregnancy prevention programming appears to have played an important role in helping reduce the state's teenage birth rate, these programs suffered significant cuts during the fiscal crisis.

Figure 27



	2001	2002	2003	2004	2005	2006
Real $	6.2	3.8	2.5	1.0	1.0	2.0
Nominal $	5.5	3.5	2.3	1.0	1.0	2.0

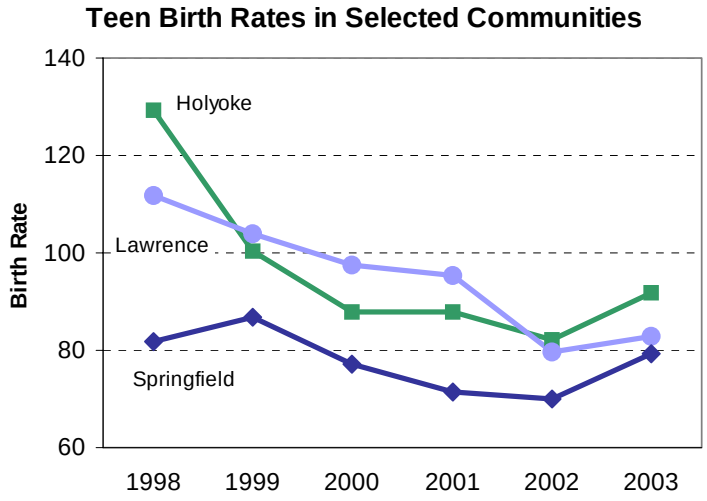
Before the state's fiscal crisis in FY 2001, the state's teen pregnancy prevention programs were funded at $5.5 million dollars, $6.2 million when adjusted for inflation. In just one year, however, between fiscal years 2001 and 2002, the Teen Challenge Fund Program was cut by 38 percent. Continued cuts through FY 2005 brought funding for the program down to $1.0 million. This has represented a real cut of 83 percent since FY 2001. Although some funding was restored in FY 2006 when the budget rose to $2.0 million, this total was still 68 percent less than in FY 2001.

"Between fiscal years 2001 and 2002, the Teen Challenge Fund Program was cut by 38 percent."

The funding cuts had a significant impact on the operations of teen pregnancy prevention services. By FY 2003, programs that targeted young men had been eliminated, and there were estimates that 50,000 children and families lost services.[138]

In 2003 there had been seventeen Teen Challenge Fund Program coalitions operating across the state, targeting the Commonwealth's most vulnerable communities. With the dramatic budget cuts after the state's fiscal crisis, by fiscal year 2004 there was funding for only two western Massachusetts coalitions. The Department of Public Health has since moved away from the coalition model. The fiscal year 2004 and 2005 budgets focused spending on direct services (rather than on the coalition model) in several selected high-risk communities.[139] By fiscal year 2005, teen pregnancy prevention programs were only able to reach approximately 680 individuals through on-going activities, and 8,300 persons in one-time activities.[140]

Figure 28



Rate per 1000 females age 15-19
Source: Massachusetts Department of Public Health

Tracking the impact of pregnancy prevention programs will always involve a time lag. Recent data from the Massachusetts Department of Public Health, however, suggest that coincident with the reduction in teen pregnancy prevention funding, teen birth rates may no longer be declining. Between 2002 and 2003 there was no longer a decline in teen birth rate (refer to Figure 26), although national birth rates were continuing to drop during this period.

"There were dramatic funding cuts between fiscal years 2001 and 2002; between 2002 and 2003, trends in the teen birth rates turned, and rates that had consistently fallen started to rise."

The impact of this change in birth rate was evident in several of the highest risk communities in Massachusetts. There were dramatic funding cuts between fiscal years 2001 and 2002 that would have come into effect starting in July 2001. The 2003 birth rate includes births during the calendar year beginning in January 2003, just eighteen months after teen pregnancy programs shut down. Between 2002 and 2003, trends in teen birth rates turned dramatically. In many instances, rates that had consistently fallen started to rise.

In Holyoke, for example, the teen birth rate had fallen every year since 1998, but between 2002 and 2003 it rose twelve percent in one year, from 82.0 births for every 1,000 females age 15-19 in 2002 to 91.9 births per 1,000 in 2003 (see **Error! Reference source not found.**.) In Lawrence, where the rate had also been dropping since 1998, the rate rose by four percent, from 79.7 births in 2002 to 82.9 in 2003. The single year birth rate rise in Springfield was more than thirteen percent, increasing by 423 teen births in 2002 (a birth rate of 70.1) to 479 teen births in 2003 (a birth rate of 79.3.) The Springfield teen birth rate had been dropping since 1999. Of the twenty-five communities in Massachusetts with the highest number of teen births in 2003, fourteen had single-year increases in their teen birth rates between 2002 and 2003.[141]

[112] U.S. Census Bureau, 2000 Decennial Census, "P8. Sex by Age – Universe: Total Population, 2000 Decennial Census Summary File 3, available at: http://factfinder.census.gov/servlet/DTTable?_bm=y&-context=dt&-ds_name=DEC_2000_SF3_U&-mt_name=DEC_2000_SF3_U_P008&-CONTEXT=dt&-tree_id=403&-all_geo_types=N&-geo_id=04000US25&-search_results=01000US&-format=&-_lang=en.

[113] Commonwealth of Massachusetts, General Laws, § 1, chapter 69.

[114] Based on Massachusetts Department of Education, "Enrollment of General Education Students School Year 2004-05 (Oct. 1)," available at: http://www.doe.mass.edu/InfoServices/reports/enroll/05/dg.pdf.

[115] Massachusetts Department of Education, *Spring 2005 MCAS Tests: Summary of State Results*, September 2005, available at: http://www.doe.mass.edu/mcas/2005/results/summary.pdf.

[116] U.S. Department of Education, National Center for Education Statistics, "The Nation's Report Card: Mathematics 2003," and "The Nation's Report Card: Reading 2003," State Report Cards for Massachusetts Grade 4 Public Schools, available at: http://nces.ed.gov/nationsreportcard/pdf/stt2005/2006454MA4.pdf and http://nces.ed.gov/nationsreportcard/pdf/stt2005/2006452MA4.pdf. *Note: Of the 52 states and jurisdictions, Massachusetts students' average scale scores in mathematics were higher than 48 jurisdictions and not significantly different from those in three jurisdictions. Reading scores were higher than those in 51 jurisdictions.*

[117] Massachusetts Department of Education, "Plans of High School Graduates: Class of 2003," available at: http://www.doe.mass.edu/infoservices/reports/hsg/03/.

[118] Mc Lynch, Jeff, *The State of Working Massachusetts 2004: Down But Not Out*, Massachusetts Budget and Policy Center, September 2004, p. 7, available at: http://www.massbudget.org/State%20of%20Working%20Massachusetts%202004.pdf.

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[120] Massachusetts 2020 and Mass Insight Education, *Schools Alone are Not Enough: How After-School and Summer Programs Help Raise Student Achievement*, May 2002, p. 7, available at: http://www.mass2020.org/FinalMCASPaper.pdf.

[121] U.S. Surgeon General, "The Health Consequences of Smoking: A Report of the Surgeon General," May 27, 2004, p.7, p.10, available at:http://www.cdc.gov/tobacco/sgr/sgr_2004/pdf/executivesummary.pdf.

[122] "Trends in Tobacco Use," American Lung Association, November 2004, p. 5, available at: http://www.lungusa.org/atf/cf/%7B7A8D42C2-FCCA-4604-8ADE-7F5D5E762256%7D/SMK1.PDF.

[123] Computations by Tauras, JA, et al., "State Tobacco Control Spending and Youth Smoking," *American Journal of Public Health*, February 2005, Vol. 95, No. 2, available at: http://www.rwjf.org/files/research/Tauras%20-%20Youth%20Smoking%201-26-05.pdf.

[124] See Massachusetts Department of Public Health, Massachusetts Tobacco Control Program, available at: http://www.mass.gov/dph/mtcp/home.htm.

[125] This description of the MTCP is largely adapted from: Hamilton, W. et al., "Independent Evaluation of the Massachusetts Tobacco Control Program, 7th Annual Report - January 1994 to June 2000," Abt Associates Inc., available at: http://www.mass.gov/dph/mtcp/reports/2000/aptrep_2000.htm.

[126] Campaign for Tobacco Free Kids, "Comprehensive Statewide Tobacco Prevention Programs Save Money," available at: http://tobaccofreekids.org/research/factsheets/pdf/0168.pdf.

[127] Smoking statistics are from the Youth Risk Behavior Survey of the National Center of Chronic Disease Prevention and Health Promotion at the Centers for Disease Control, available at: http://apps.nccd.cdc.gov/yrbss.

[128] Data from the Massachusetts Department of Public Health Compliance Check Project. See "Abstract: Compliance Check Research," Tobacco Free Mass, http://www.tobaccofreemass.org/complianceabstract.php.

[129] Massachusetts Department of Public Health, "Healthy People 2010: Leading Health Indicators for Massachusetts," January 2003, p. 56, available at: http://www.mass.gov/dph/bhsre/resep/healthy2010/lhi_2001.pdf.

[130] The National Campaign to Prevent Teen Pregnancy, "Teen Pregnancy – So What," February 2004, available at: http://www.teenpregnancy.org/whycare/pdf/sowhat.pdf.

[131] Ibid.

[132] Described on the Massachusetts Department of Public Health website at http://www.mass.gov/dph/fch/challengefund.htm.

[133] Kirby, Douglas et al., "Sexual Risk and Protective Factors: Factors Affecting Teen Sexual Behavior, Pregnancy, Childbearing and Sexually Transmitted Disease: Which Are Important? Which Can You Change?" ETR

Associates, August 2005, p. 27-29, available at: http://www.teenpregnancy.org/works/risk_protective_kirby/Kirby_Riskandprotectivefactor_paper.pdf.

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[135] Paradiso, Claire, "Working to Guarantee a Stronger Commonwealth: A Framework of State and Local Interventions by the Teen Challenge Fund Coalitions of Massachusetts," Coalition for Challenge Fund Communities, March 2002, p. 6-8, available at: http://www.glcac.org/TCFREPORT.PDF.

[136] See description at the website of the National Campaign to Prevent Teen Pregnancy at: http://www.teenpregnancy.org/works/StateProfiles.asp#mass.

[137] See Kirby, et al., p. 34.

[138] See Children and Youth Budget Collaborative, "Through a Child's Eyes: The 2003 Massachusetts Child and Youth Budget," p. 26, available at:http://www.csrox.org/cyb/fy03/images/fy03_budget.pdf.

[139] See Children and Youth Budget Collaborative, "FY05 Children and Youth Budget," p. 24, available at: http://www.csrox.org/cyb/images/FY05document.pdf.

[140] Data from the Massachusetts Department of Public Health.

[141] Massachusetts Department of Public Health, "Massachusetts Births 2003," April 2005, p. 54, available at: http://www.mass.gov/dph/bhsre/birth/03/births_03_part1.pdf; "Massachusetts Births 2001," April 2003, p. 46, available at: http://www.mass.gov/dph/bhsre/birth/01/b2001_1.pdf ; "Adolescent Births: A Statistical Profile 1999," January 2001, available at: http://www.mass.gov/dph/fch/asets/tbirth99/sec3-99.pdf; "Adolescent Births: A Statistical Profile 1997," March 1999, available at: http://www.mass.gov/dph/fch/asets/tbirth97/sect3a97.pdf.

Conclusion

The findings from this report demonstrate the effect that the fiscal crisis has had on state-funded programs that help children, youth, and families. Although the budget cuts enacted as a result of the recent economic downturn had an effect on everyone in the Commonwealth, children were especially vulnerable to these budget cuts as they are often the primary beneficiaries of the programs and services provided by the state government. Working parents and their children benefit from the quality early education programs that are funded in part or entirely by the state. Nearly one million children spend a good portion of their day in public schools acquiring the skills needed to become productive members of society. Public health and education programs protect children, and youth in particular, from harm and help them to make decisions that will benefit them in the short- and long-term. Each year, the state helps to protect close to 40,000 children from abuse and neglect. Emergency and affordable housing programs help keep children and families from living on the street. Over the past few years, these accomplishments have been threatened by budget cuts to programs and services that are essential to the education, health, and well-being of the Commonwealth's children.

After cutting taxes by over $3 billion during the boom period of the 1990s, the Commonwealth implemented nearly $3 billion worth of budget cuts during the fiscal crisis. As the economy begins to strengthen, our state must realize the impact of the decisions which fostered this fiscal environment. Cuts in revenue result in cuts in spending, which, in Massachusetts over the past five years, have had a direct effect on the lives of children and youth.

Through our government we make real choices about our goals, our priorities, and the ways in which our state should protect and support children. This report aims to illustrate the effects of those choices and to focus our attention on the importance of making decisions that truly reflect our values and our hopes for our state's children.

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