

Mississippi's Human Capital: Today's Children----Tomorrow's Workforce

Stella Fair, Ph.D. and Anne M. Stanberry, Ph.D., CFLE, CFCS

The University of Southern Mississippi

This chapter discusses the state of Mississippi's children. The universal concern is children, who are the future workers of Mississippi, needing a healthy start. They need nurturing and support, education and time, with competent parents and caregivers.

Children, Mississippi's human capital, live in families. We cannot improve our human capital unless we consider both children and families. So, who are today's children and families in Mississippi? According to Kids Count (2002):

Children, Mississippi's human capital, live in families. We cannot improve our human capital unless we consider both children and families.

- the median income of families with children in 1999 was \$36,800
- 32 percent of female-headed families received child support or alimony in 1999
- In 1999, 9 percent of children lived in extreme poverty; their family income was 50 percent below the poverty level
- 22 percent of children under 18 were in working-poor families in 1999

Of the children in Mississippi in 2000:

- 52 percent were white
- 45 percent were black
- 1 percent were Asian/Pacific Islander
- 2 percent were Hispanic
- less than .5 percent were American Indian

In 1998:

- 52 percent of 4th graders and 39 percent of 8th graders scored below basic reading levels
- 26 percent of 8th graders scored below basic writing levels

In 1999:

- 15 percent of our children did not have health insurance
- 21 percent of those in working-poor families lacked health insurance

In 2001:

- 10 percent of our children did not have health insurance (Urban Institute, 2002 report on SCHIP)

Child Well-being

On every indicator of child well-being, Mississippi children scored worse than the national average.

- 26 percent of our children live with parents who do not work full time
- 24 percent of our children live in poverty
- 35 percent of Mississippi's children live in homes headed by single parents
- 12 percent of our children are high school drop outs
- 10.3 percent are low birth-weight babies
- 10.1 per 1,000 live births result in death
- 40 per 100,000 children ages 1-14 die
- 83 per 100,000 teens 15-19 years old die by accident, homicide, and suicide
- 45 per 1,000 teens 15-17 give birth
- 12 percent of teens do not attend school or work

These figures are for all children in Mississippi (Kids Count, 2002). Many of our children have developmental disabilities. Developmental disabilities are a diverse group of physical, cognitive, psychological, sensory, and speech impairments that begin anytime during development up to age 18 years. In most instances, the cause of the disability is not known. What we do know are factors that increase the chance that a child will have a developmental disability and what can be done to prevent or improve the condition. Nationally, 17 percent of children under age 18 have a developmental disability. Approximately 2 percent of school-aged children in the United States have a serious developmental disability, such as mental retardation or cerebral palsy, and need special education services or supportive care. Some of the most common known causes of mental retardation are Down syndrome, fetal alcohol syndrome, and fragile X syndrome, all of which occur before birth.

Developmental disabilities are a diverse group of physical, cognitive, psychological, sensory, and speech impairments that begin anytime during development up to age 18 years.

Table 1.

Examples of current DD prevalence estimates (www.cdc.gov/ncbddd)	
.6%	Autism spectrum disorder (6 in 1,000*)
.125%	Down syndrome (1 in 800)
.1%	neural tube defect (1 in 1,000)
.22%	fetal alcohol syndrome (2.2 in 1,000)
.4%	cerebral palsy (1 in 230)
* personal communication, National Center for Birth Defects, Dec. 2002	

8.92% US children 6-21 received special education in schools (23rd Annual Report to Congress, 1998-99) 8.32% US children 3-21 (23rd Annual Report to Congress, 1998-99)

13.2% (6,195,113) children 0-21 received special education, 1999-2000 (Digest of Education Statistics, 2001)

State and federal education departments spend about \$36 billion each year on special education programs for individuals with developmental disabilities who are 3-21 years old (National Center for Birth Defects, October 1999, NCEH Pub. No. 99-0443)

The rural and low economic conditions of the state increase the likelihood that children will have more health and nutrition issues and more developmental disabilities.

The Numbers and Mississippi

It is challenging to obtain reliable and clear estimates of the prevalence of disabilities among children, no matter which state is in question. This is due to differences in the definition of disability and differences in how data are gathered and combined across ages, locations, services, and so forth. For example, children may have multiple disabilities that influence development in different ways. We know there is a high rate of identified and potential disabilities among children in Mississippi. The rural and low economic conditions of the state increase the likelihood that children will have more health and nutrition issues and more developmental disabilities. A February 2000 study on the Status of Mississippi Medicaid Children indicated our children have a high level of chronic health problems that include:

- asthma
- speech/language delays
- vision problems
- otitis media
- hearing impairments
- mental retardation
- respiratory disorders
- epilepsy
- other conditions.

A 2001 independent study conducted by the Civitan International Research Center indicated 80 percent of children under 3 in five delta counties had at least one risk factor for future special education placement (MSDH, 2002). Also, the Center on Emergent Disability has reported an expected, and increasing, 11 percent disability rate for children living below the poverty level (Fujiura & Yamaki, 2000). An underlying dynamic was suggested in economic status and disability: single-parent households. The authors concluded that there is a growing relationship between poverty status and risk for disability.

80 percent of children under 3 in five MS delta counties had at least one risk factor for future special education placement.

Using the 2000 U.S. Census statistic of 27 percent of children (206,450) under 18 living below poverty in Mississippi, and assuming the 11 percent rate of disabilities for children under 5, **approximately 3 percent of children under 5 in Mississippi** can be expected to have some type of developmental disability by virtue of their poverty status. This translates to 6,001 of Mississippi's poor children who can be expected to have some type of developmental disability.

It is clear that unless we do something about our human capital, we will continue along the same road of having the worst scores on many, if not all indicators.

Research on crime, costs and early childhood

Research clearly shows the value of prevention and early intervention efforts through quality child care/early childhood and family support programs. An important outcome is positive social behavior. Recently, the Mississippi Department of Corrections announced for fiscal year 2002,

- cost per day per inmate for a 1,000-bed facility totaled \$45.45. (Miss. Business Journal, 1/8/03)

The research is very clear in indicating prevention and early intervention programs reduce juvenile delinquency. The High/Scope Perry Preschool Project in Ypsilanti, MI, the Yale Child Welfare Project, the Houston Parent Child Development Center and the Syracuse Family Development Research Program all found a high quality early childhood program, and family support reduced the number of juvenile delinquents among program participants (Juvenile Justice Bulletin, October, 2000). The High/Scope Perry Preschool Project found that at age 27, program participants had fewer arrests (5 percent vs 35 percent), including crimes of drug making or dealing (7 percent vs 25 percent) (Schweinhart, Barnes, & Weikert, 1993).

The research is very clear in indicating prevention and early intervention programs reduce juvenile delinquency.

How many young children is Mississippi serving through early intervention and special education?

Special education in the United States has grown tremendously in the last decade, increasing from 4.6 million to 6.2 million. In Mississippi, approximately 4.45 percent of students are identified with a specific learning disability in 1999 and 5.58 percent in 2001, a category that has increased by 45 percent in the United States in the last decade.

According to the most recently available report to Congress, Mississippi schools served 8.01 percent of children 6-21 and 7.65 percent of children 3-21 through a variety of special education services (23rd Annual Report to Congress, 1998-

1999). In 1999-2000, 6,812 (3.33 percent) children 0-5 were reportedly receiving special services (Digest of Educational Statistics, April 2001; US Census 2000). This number was up slightly in the December 2001 count, i.e. 6,894.

The number of children under 3 receiving early intervention services is increasing.

The number of children under 3 receiving early intervention services varies as children move in and out of the program. During the last two years, numbers have been increasing and currently there are approximately 2,000 children receiving service coordination and 1,500 are usually being tracked because of concerns. The majority of these children are Medicaid eligible (MSDH, personal communication, 2002). How many children a state program serves derives from the interaction of the state's prevalence rates, the capacity to find the children, its eligibility criteria, and its ability to provide services. Mississippi's criteria, i.e. 25 percent delay in one area of development or a diagnosed condition known to lead to a delay, is typical of most states' definitions (Shackelford, 2002). Most referrals to the program come from health care professionals or the child's family (MSDH, 2002).

In the last report available (reporting figures for 1998-99), 28.42 percent of the children exiting the early intervention program entered public school special education services (MDE, 2002). Mississippi currently provides services to about 1.8 percent of children under 3 with developmental delays or risks. The United States Department of Education sets the minimum standard for required services at 1.6 percent. The recent agency self-assessment conducted by the First Steps Early Intervention Program for Infants and Toddlers in Mississippi reported the following statistics for services (MSDH, Oct, 2002):

As of October 2002:

- 1,539 children under 3 with delays or conditions known to cause delays were served
- 1,016 under 3, although classified as "at-risk" received tracking services only

Issue:

Inadequate funding with current Individuals with Disabilities Education Act (IDEA) formula for the number of children in need under age 3.

The Mississippi Department of Health is spearheading an effort to access other funding sources. A new system of reimbursement for targeted case management using Medicaid dollars for children under 3 with special needs is being implemented. This is expected to generate new revenue to offset some costs. Efforts are being made through the State Interagency Coordinating Council to coordinate the funds more effectively and better utilize TANF and preschool IDEA monies. (R. Hart, personal communication, December 2002).

Issues:

Lack of Properly Trained Personnel to Meet the Needs of Young Children with Special Needs

Lack of Adequate Access to Child Care

Although the right to services in "natural environments" or the "least restrictive environment" and the right to services that are centered around the family have been supported as best practices and legislated, the actual practice has lagged behind in most states and these opportunities have remained elusive for many children (Berres & Knoblock, 1987; Rose & Smith, 1994; U.S. Department of Education, 2000).

There is a need for an emphasis on inclusion in child care quality improvement efforts. It is important to offer services that minimize stress for families and maximize developmentally appropriate, normalized experiences for children at-risk, such as those who are exposed to violence, drug abuse, and maternal depression (Knitzer, 1999). A number of seminal studies (e.g., Bricker & Bricker, 1971; Bricker, Bruder & Bailey, 1982; Cooke, Ruskus, Apolloni, & Pack, 1981; Hoyson, Jamieson & Strain, 1984; Guralnick, 1984) have shown that children with disabilities show positive developmental and social gains as a result of participating in a mainstreamed or inclusive setting. Others (e.g., DeKlyen & Odom, 1989; Diamond, Hestenes, & O'Connor, 1994; Peck, Carlson, & Helmstetter, 1992; Twardosz, Nordquist, Simon, & Botkin, 1983; Smith & Rapport, 1999) have shown that inclusion benefits children without disabilities as well. Studies have examined the effects of varying levels of quality on children's development. Each reached the same conclusion: *a significant correlation exists between program quality and outcomes for children* (Frede, 1995).

There is a need for an emphasis on inclusion in child care quality improvement efforts.

Mississippi Services and Training Data: Despite the prevalence of literature supporting the practice of bringing services into typical settings for young children; lack of knowledge, experience, and fears on the part of administrators, staff, and parents has discouraged many early childhood programs from accepting or including children with disabilities, particularly if those disabilities were severe, or required special equipment. The awareness of the need for training was evident from responses to the Institute for Disability Studies' (IDS) spring 2000 surveys of Mississippi training needs.

- Ninety-two percent (92%) of the early childhood educators who responded stated a desire to learn more about early intervention and children with disabilities.

Furthermore, other survey results and experiences from previous IDS project interviews indicated that private child care and preschool programs will gladly accept children with even severe disabilities if provided professional support and training. *In one survey conducted in the local area by IDS, only one child care center out of more than 40 was unwilling to accept children with special needs if given support.* These findings are in keeping with those reported by demonstration projects in other parts of the country (Mulligan-Gordon et al., 1992; Sullivan, Shuster, & Sheriff, 1987).

References

- Annie E. Casey Foundation. (2002). Kids count census data online. Retrieved January 8, 2002, from <http://www.aecf.org/kidscount/>.
- Berres, M. S. & Knoblock, P. (1987). Introduction and Perspective. In M. S. Berres & P. Knoblock (Eds.). *Program models for mainstreaming: Integrating students with moderate to severe disabilities*. Rockville, MD: Aspen Publications.
- Bricker, D. D. & Bricker, W. A. (1971). Toddler Research and Intervention Project Report-Year 1. *IMRID Behavioral Science Monograph No. 20*. Nashville, TN: Institute on Mental Retardation and Intellectual Development.
- Bricker, D. D., Bruder, M. B., & Bailey, E. (1982). Developmental children, *Analysis and Intervention in Developmental Disabilities, 2*, 207-222.
- Children's Defense Fund (2001). *The State of America's Children 2001*. Washington, D.C.: Children's Defense Fund.
- Cooke, T. P., Ruskus, J. A., Apolloni, T., & Peck, C. A. (1981). Handicapped preschool children in the mainstream: Background, outcomes, and clinical suggestions. *Topics in Early Childhood Special Education, 1*, 73-83.
- DeKlyen, M. & Odom S. (1989). Activity structure and social interaction with peers in developmentally integrated play groups. *Journal of Early Intervention, 13*, 342-351.
- Diamond, K., Hestenes, L. & O'Connor, C. (1994) Integrating young children with disabilities in preschool: Problems and promise. *Young Children, 49*(1), 68-75.
- Frede, E. (1995). The role of quality in producing early childhood program benefits. *Future of Children, 5* (3), 115-132.
- Fujiura, G.T. & Yamaki, K. (2000). Trends in demography of childhood poverty and disability. *Exceptional Children, 66*, 187-199.
- Guralnick, M. J. (1984). The peer interactions of young developmentally delayed children in specialized and integrated settings. In T. Field (Ed.), *Friendships between normally development and handicapped children* (pp. 139- 152). Chicago: Society for Research in Child Development.
- Hoyson, M., Jamieson, B. & Strain, P. (1984). Individualized group instruction of normally developing and autistic-like children: The LEAP Curriculum. *Journal of the Division for Early Childhood, 8*, 157-172.

- Juvenile Justice Bulletin (October, 2000). The High/Scope Perry Preschool Project: Program and Policy implications. Retrieved from the World wide web, January 8, 2003 http://www.ncjrs.org/html/ojdp/2000_10_1/page5.html
- Knitzer, J. (February, 1999). Children and Welfare Reform: Promoting Resilience. *Issue Brief No. 8*. New York, New York: National Center for Children in Poverty or www.nccp.org.
- Mississippi Business E-Journal (January 8, 2003). *PEER releases cost per inmate day survey*. www.msbusiness.com
- Mississippi Special Education Steering Committee (October, 2002). *Special education in Mississippi: Keeping the promise for students with disabilities and their families: A self-assessment report*. Jackson, MS.
- Mississippi State Department of Health & State Interagency Coordinating Council (October, 2002). *Statewide Part C self-assessment: Continuous improvement monitoring process report*. Jackson, MS.
- National Center for Children in Poverty. (2000). *Map and track: 2000 Edition*. <http://cpmnet.columbia.edu/dept/nccp/state/mt00ms.html>
- Peck, C. A., Carlson, P., & Helmstetter, E. (1992). Parent and teacher perceptions of outcomes for typically developing children enrolled in integrated early childhood programs: A statewide survey. *Journal of Early Intervention, 16*(1), 53-63.
- Peck, C. A., Killen, C. C., & Baumgart, D. (1989). Increasing implementation of special education instruction in mainstream preschools: Direct and generalized effects of nondirective consultation. *Journal of Applied Behavior Analysis, 22*, 197-210.
- Pokempner, J. & Roberts, D. (2001). Poverty, welfare reform and the meaning of disability. *Ohio State University Law Journal, 62*(1).
- Report from the Center on Emergent Disability. (1997). University of Illinois at Chicago, Institute on Disability and Human Development. URL: www.ncddr.org/rr/emerging
- Rose, D. & Smith, B. (1994). Providing public education services to preschoolers with disabilities in community-based programs: Who's responsible for what? *Young Children 49*(6), 64-68.
- Schoen, T.M., Auen, J., & Arvanitis, M.A. (January, 1997). Children blossom in a special and general education integration program--a private child care center and a public school collaborate. *Young Children, 52*(2), 58-63.
- Schweinhart, L., Barnes, H. & Weikart, D. (1993). The High/Scope Perry Preschool study through age 27. *Monographs of the High/Scope Educational Research Foundation, 10*.

- Shackelford, J. (2002). State and jurisdictional eligibility definitions for infants and toddlers with disabilities under IDEA. *NECTAC Notes*, 11.
- Smith, B. J. & Rapport, M.J. (1999). *Early childhood inclusion policy and systems: What do we know?* Center for Collaborative Leadership. Denver: CO.
- Twardosz, S., Nordquist, V. M., Simon, R., & Botkin, D. (1983). The effects of group affection activities on the interaction of socially isolate children. *Analysis and Intervention in Developmental Disabilities*, 3, 311-338.
- Urban Institute (2002) Covering Kids State Project: Mississippi. Retrieved January 9, 2002 from <http://www.coveringkids.org/projects/coverage.php3?StateID=MS>.
- U.S. Department of Education. (2000). *The twenty-second annual report to congress on the implementation of the Individuals with Disabilities Education Act*. Washington, D.C.: U.S. Department of Education. Government Printing Office.

