Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. bio	Felicia Pearson (1 page)	nd	P6/b(6)
002. bios	Roundtable Discussion Participants (partial) (1 page)	nd	P6/b(6)
003a. memo	Nicole Rabner to Agency Liaison re Request for Assistance (partial) (1 page)	02/12/1998	P6/b(6)
003b. memo	Nicole Rabner to FLOTUS re Home Visitation Event (1 page)	02/11/1998	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Domestic Policy Council (Nicole Rabner)
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FOLDER TITLE:
Home Visiting [1]

2012-1035-S
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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
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P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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ZERO TO THREE, the National Center for Infants, Toddlers and Families, was established in 1977 by internationally renowned leaders in the fields of medicine, child development, mental health, and research science to advance the healthy development of America's babies and young children. We are the nation's leading resource on the first years of life. We support parents, professionals and policymakers by:

- Promoting the discovery of new knowledge
- Translating cutting edge research into language and approaches parents and caregivers can use and understand
- Fostering professional excellence through training, and related activities
- Designing and demonstrating model approaches for working with babies and families

We invite you to celebrate with us, so that together, we can help give children the best possible start in life!

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with an evening of
CONVERSATION, ENTERTAINMENT & INSPIRATION

followed by a buffet supper
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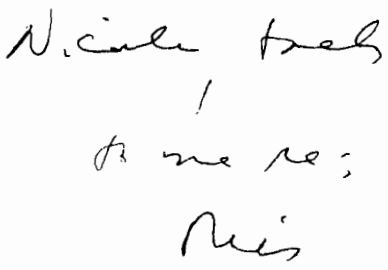
Tuesday, February 10th, 1998

Terrace Theater
The John F. Kennedy Center for the Performing Arts
Washington, D.C.

R.s.v.p.
Card enclosed

6:45 p.m. Reception
7:30 p.m. Performance
8:45 p.m. Cast Party

Melanne Verveer



Britain Plans to Rescue Its Endangered Families

■ Prime Minister Tony Blair, seeing a threat to social cohesion, outlines steps for his government to improve family life.

By Alexander MacLeod
Special to The Christian Science Monitor

LONDON

One in 4 British families is headed by a single parent. More than 1 in 3 births are outside of marriage. Britain leads Europe in teenage pregnancies. The marriage rate is a record low.

Is British social cohesion fraying? Prime Minister Tony Blair thinks so, and he set out a plan last week to return the family to the heart of British life.

Borrowing from the US, adult 'mentors' will counsel teenage girls on the risks of pregnancy.

He wants his Labour-led government to help rebuild faith in marriage and to teach parenting skills across the nation.

Mr. Blair promises to put money into courses on parenting, marriage counseling for couples who plan to wed, tracking of children by family-support services, a one-stop service for families with children under three years old, curfews for pre-teens, and holding parents legally responsible for their children's behavior.

"The family is central to our vision of a modern Britain built on the kinds of rights and responsibilities that we learn in the home," Blair told a Labour Party's annual conference last week. "Strong families mean a strong Britain."

His plan takes him into politically sensitive territory.

See **FAMILIES** *Page 6*

SAMANTHA PEARCE/AP

NEW PRIORITY: *British Prime Minister Tony Blair poses with preschoolers outside his London residence May 6. His government is proposing a range of new programs aimed at strengthening families and improving child-rearing. Britain has the highest teen pregnancy rate in Europe. The marriage rate is at a record low.*

Guidance, Oversight for British Family

FAMILIES from Page 1

Five years ago his Conservative predecessor, John Major, promised to promote family values. But the "back to basics" campaign backfired when several senior supporters were forced to admit to marital infidelity and other indiscretions.

The Labour government, however, is promising to go beyond rhetoric with a series of concrete measures designed to bring parents and their children closer together, and reduce the incidence of teenage pregnancies and single-parent families.

Among key measures in a government action plan to be unveiled this week:

• Creation of a government-funded national family institute to promote family life. The institute will offer parents courses in child rearing and, in a country where 3,000 children every week see their parents divorce, advise couples on how to strengthen their marriages.

• A $918 million dollar "Sure Start" program in 250 areas of Britain. It will bring together services for under-three-year-olds and their parents, including state-funded day care, playgroups, and post-natal advice.

• Arrangements for health visitors, community nurses, and volunteers from family support organizations to monitor the progress of children through school.

Instead of making contact with young mothers and babies only at the time of birth, health visitors will continue to track their charges for several years.

• Borrowing from US experience, a system of adult "mentors" to advise and counsel teenage girls on the risks of pregnancy.

• Marriage registrars to offer guidance to young couples who are not connected with a particular church and might otherwise wed without any marital advice at all. At 279,000 a year, marriages in Britain are at an all-time low, and 58 percent of all weddings are civil ceremonies.

• Stringent new laws giving police powers to pick up children for truancy, and to subject 10-year-olds and under to a 9 p.m. street curfew. Parents will be made legally responsible for their children's behavior, and will be fined if their offspring persistently offend.

'We're talking about the kind of support men and women would have got at times when society was more stable.'

– Health Minister Tessa Jowell

Police say pilot schemes in several British cities have cut youth crime significantly. One such teenage-curfew plan has been running for some months in Hamilton, in the north of England. Chief Constable John Orr says, "The vast majority of parents and most of the children are telling us that they agree with what we are trying to achieve. Various people, including politicians, have been practically banging on my door pleading for the Hamilton scheme to be launched in their own areas."

Blair is pledged to stick to the previous government's spending limits for two years, but it is a measure of his determination to boost the family that he has called on ministers to trim their budgets so that the family initiative can be adequately funded.

Commenting on the planned family institute, which promises to be a centerpiece of the government's program, Health Minister Tessa Jowell says, "We're talking about the kind of support men and women would have got at times when society was more stable and families lived closer together."

The Sure Start program will include literacy classes. It will seek to identify children who need help from an early age. All parents will be visited by a Sure Start representative within three months of the birth of their child.

"We are aiming at a society where children's life chances are handed out on the day they are born," Ms Jowell says.

Britain's opposition Conservatives have been slow to criticize Blair's family initiative, largely because in office they themselves advocated a return to family values.

It is thought likely, however, that opposition leader William Hague will attack Blair's action plan once it is published and the full details are known.

home visiting

NATIONAL RESEARCH COUNCIL
COMMISSION ON BEHAVIORAL AND SOCIAL SCIENCES AND EDUCATION
and the
INSTITUTE OF MEDICINE
BOARD ON CHILDREN, YOUTH, AND FAMILIES
2101 Constitution Avenue, Washington, DC 20418

COMMITTEE ON INTEGRATING THE SCIENCE OF EARLY CHILDHOOD DEVELOPMENT

TELEPHONE: (202) 334-1396
FAX: (202) 334-3829

February 3, 1999

Nicole Rabner
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Nicole:

I am writing to invite you to attend a two-day workshop on Home Visiting Interventions, to be held on Monday, March 8 and Tuesday, March 9, 1999, at the Georgetown University Conference Center. The workshop, which is sponsored by the Board on Children, Youth, and Families of the National Research Council and the Institute of Medicine, will bring together researchers, practitioners and policy makers to address a set of core questions about home visitation interventions, using recent evaluations of this intervention strategy as a departure point. The meeting is funded by the David and Lucile Packard Foundation.

The workshop is timed to coincide with the release of the issue of the Packard Foundation's *The Future of Children* on "Revisiting Home Visiting." In addition, results from a meta-analysis of home visiting interventions commissioned by the Packard Foundation will be presented at the workshop. The goals of the workshop are to portray the diversity of home visiting interventions; place the knowledge base about home visiting in the context of other pertinent basic and intervention research literatures; consider where there is agreement about the conditions under which, for whom, and for which outcomes a home visiting strategy is and is not effective; and identify the most promising avenues for future research and policy.

The Georgetown University Conference Center is located at 3800 Reservoir Road, NW. The workshop will be held on the Main Floor; when you arrive, please check the monitors located directly inside the entrances for the exact room. Directions, a map, and information about parking and public transportation are enclosed, along with an agenda and project summary.

We would be delighted if you could join us for this important workshop. Please let us know by returning the enclosed reply form via fax to 202-334-3829 by Monday, February 15, 1999. If you have any questions, please feel free to contact me at 202-334-1349.

Sincerely,

Deborah

Deborah A. Phillips, Ph.D.
Staff Officer
Board on Children, Youth, and Families

BOARD ON
Children, Youth, and Families

National Research Council/Institute of Medicine

PROJECT SUMMARY

HOME VISITATION

Home visitation has emerged as one of the most popular strategies for promoting maternal and child health, fostering beneficial home environments, and promoting young children's development. Evaluations of home visiting interventions have also proliferated in recent years, bringing a vast store of new information to policy debates at all levels of government. However, this research base remains scattered, and policy makers have expressed uncertainty about the strength and consistency of findings associated with different approaches to home visitation. Ambiguity also exists as to whether home visitation interventions should be targeted to specific at-risk populations or used as a universal health promotion strategy. Even the definition of home visiting remains open, and questions remain as to whether it is the most effective means of accomplishing the desired outcomes.

In this context, the Board on Children, Youth, and Families will hold a two-day workshop on March 8-9, 1999, on home visiting programs. A new synthesis of home visitation evaluations will be presented at the meeting. Authors of several of the major evaluations, as well as experts involved in implementing home visitation programs, will comment on the synthesis. Invited speakers will then address a set of core questions about this intervention strategy: For which outcomes is home visiting most effective? For whom is home visiting most effective? What are the critical staffing issues? What are the critical elements of effective home visiting strategies? What are the biggest barriers to success? Where can we and can we not get a consensus on these issues? What are the frontiers for new research and program development? What are the central messages for public policy?

The workshop will also build on past studies of the National Research Council and the Institute of Medicine that reviewed home visitation interventions in the areas of family violence, the prevention of mental disorders, and maternal and child health. Workshop participants will include experts in maternal and child health and mental health, psychology, sociology, statistics, evaluation research, economics, anthropology, ethics, family law, family and community services, and public policy. A workshop summary will be published.

The workshop is funded by the David and Lucile Packard Foundation.

For further information, please contact Deborah Phillips, Study Director, at 202-334-1396 or <dphillip@nas.edu>, or Nancy Geyelin Margie, Research Assistant, at 202-334-1349 or <nmargie@nas.edu>.

The Board on Children, Youth, and Families was established in 1993 under the joint aegis of the National Research Council's Commission on Behavioral and Social Sciences and Education and the Institute of Medicine. The Board provides a national focal point for authoritative, nonpartisan analysis of child and family issues that center on policy decisions.

BOARD ON
Children, Youth, and Families

National Research Council/Institute of Medicine

Workshop on Revisiting Home Visiting

Monday, March 8 & Tuesday, March 9, 1999
Georgetown University Conference Center
Washington, DC

DRAFT AGENDA

Monday, March 8, 1999

DAY ONE:
WHAT CAN WE NOW SAY ABOUT HOME VISITING STRATEGIES?

8:30 - 9:00 **Welcome, Introductions, and Purpose of the Workshop**

Ruth T. Gross, Professor of Pediatrics, Emerita, Stanford University

(a) To portray the diversity of home visiting interventions
(b) To consider where there is agreement about the conditions under which, for whom, and for which outcomes a home visiting strategy is and is not effective -- where are the opportunities for agreement and where not?
(c) To place the knowledge base about home visiting in the context of other pertinent basic and intervention research literatures
(d) To identify the most promising avenues for future research and policy

9:00 - 10:00 **Perspectives on the Standards of Evidence in Assessing Home Visiting**

David Olds, Kempe Prevention Research Center for Family and Child Health, University of Colorado at Denver

Robert Granger, Manpower Demonstration Research Corporation

Deborah Daro, National Center on Child Abuse and Prevention Research

Moderator: **Ann Segal**, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

10:00 – 11:00 **Summaries of New Efforts to Synthesize Research on Home Visitation**

- Discussion of *The Future of Children*: Revisiting Home Visitation:
  Deanna Gomby, The David and Lucile Packard Foundation

- Discussion of Home Visiting Summit:
  Matthew Melmed, Zero to Three: National Center for Infants, Toddlers and Families

11:00 – 11:15 **BREAK**

11:15 – 12:30 **Presentation of Meta-Analysis of Home Visiting Interventions**

Mark Appelbaum, Department of Psychology, University of California at San Diego

Monica Sweet, Department of Psychology, University of California at San Diego

12:30 – 1:15 **LUNCH**

1:15 – 1:45 **Cost Analysis and Effectiveness of Home Visiting Interventions**

Steven Barnett, Graduate School of Education, Rutgers University
or
Deborah Montgomery, American Institutes for Research

Commentary and Discussion—What Can We Say Today About Home Visiting?

1:45 – 2:30 Home visiting for which outcomes?
Researcher: **Anne Duggan**, School of Medicine, Johns Hopkins University
Practitioner: [To be determined]

2:30 – 3:15 For whom is home visiting most effective?
Researcher: **Mary Wagner**, Center for Education and Human Services, SRI International
Practitioner: **Pilar Baca**, Kempe Prevention Research Center for Family and Child Health, University of Colorado at Denver

3:15 – 3:30 **BREAK**

3:30 – 4:15 What are the biggest barriers to success?
Researcher: **John Landsverk**, Services Research Center, Children's Hospital - San Diego
Practitioner: **Mildred Winter**, Parents as Teachers National Center, Inc.

4:15 – 5:00 What are the critical elements of effective home visiting strategies?
Researcher: **Amy Baker**, The Children's Village
Practitioner: **Tammy Mann**, Senior Program Associate, Zero to Three (invited)

Tuesday, March 9, 1999

DAY TWO:

What can we learn from other research and interventions to inform the future of home visiting?

Research on Family Circumstances: Implications for Home Visiting

9:00 – 9:45 Circumstances of Families in Poverty
Jeanne Brooks-Gunn, Teachers College, Columbia University

9:45 – 10:30 Maternal Depression/Mental Health
William Beardslee, Judge Baker Children's Center, Harvard University (invited)

10:30 – 10:45 **BREAK**

10:45 – 11:30 Child Abuse and Neglect
David Kolko, Department of Child Psychiatry and Psychology, University of Pittsburgh Medical Center, and Child and Parent Behavior Clinic, Western Psychiatric Institute and Clinic

11:30 – 12:15 Cultural and Linguistic Diversity
Delia Pompa, Office of Bilingual Education and Minority Languages Affairs, U.S. Department of Education (invited)

12:15 - 1:00 **LUNCH**

1:00 - 3:00 **What can we learn from other services and intervention strategies?**

- Center-based programs:
  Donna Bryant, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill
- Comprehensive Child Development Program:
  Jean Layzer, Abt Associates, Inc.
- Early Head Start:
  JoAnn Robinson, Kempe Prevention Research Center for Family and Child Health, University of Colorado at Denver
- Family Preservation:
  Ronna Cook, Westat (invited)
  Elyse Kaye, James Bell Associates (invited)
- Moving to Opportunity:
  Jens Ludwig, Department of Public Policy, Georgetown University
- Parent Education Programs:
  Heather Weiss, Harvard Family Research Project, Harvard University (invited)
- Teen Parent Programs:
  Ellen Eliason Kisker, Mathematica Policy Research, Inc.

Moderator: **Jean Layzer**, Abt Associates, Inc.

3:00 - 3:15 **BREAK**

3:15 - 5:00 **Conclusions: Panel Discussion**

Anne Cohn Donnelly, Kellogg School of Management, Northwestern University
Brenda Jones Harden, Department of Human Development, University of Maryland
Lisbeth Schorr, Project on Effective Services, Harvard University

Discussion Points:

- What do we know now that we did not know three years ago?
- What have we learned about how to make sure that home visiting occupies the best possible place on the landscape of service strategies?
- Where can we and can we not get a consensus?
- Where are the best opportunities for future research-program development?
- What are the take home messages for public policy and how can we best convey them?

Workshop on Home Visitation Interventions

sponsored by
Board on Children, Youth, and Families
National Research Council/Institute of Medicine

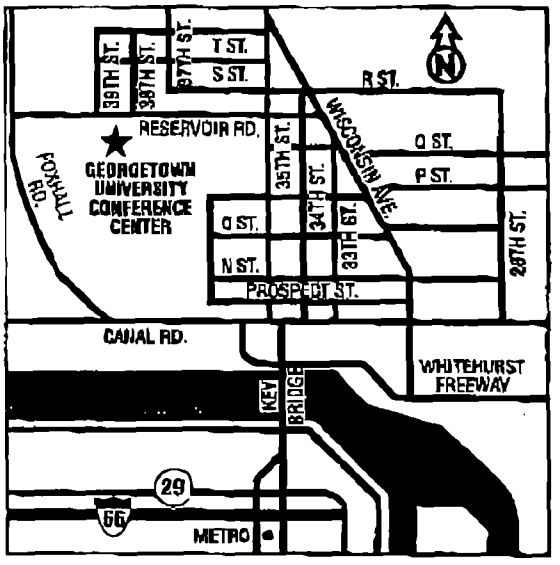
LOGISTICAL INFORMATION

DATES:
Monday, March 8, and Tuesday, March 9, 1999

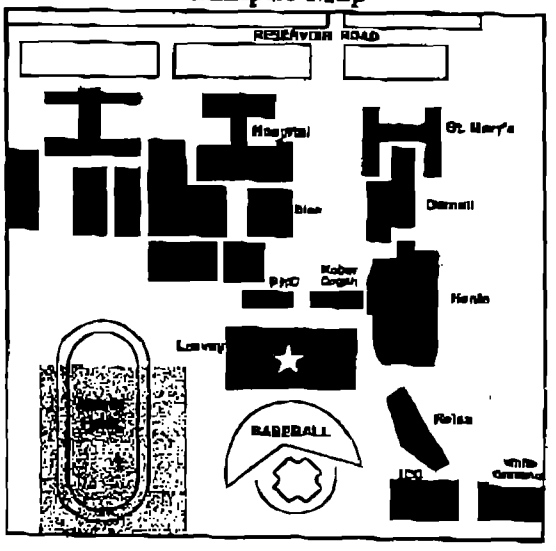
LOCATION:
Georgetown University Conference Center
(a.k.a. The Thomas and Dorothy Leavey Center)
3800 Reservoir Road, NW
Washington, DC 20057
phone: 202-687-3200

BY PUBLIC TRANSPORATION:
The Conference Center is approximately 5 minutes by taxi from the Rosslyn and Dupont Circle Metro stations. Alternatively, the University provides bus service to the Dupont Circle and Rosslyn Metro stations during the week. The Georgetown University Transportation Shuttle (GUTS) leaves from the Conference Center and runs every 20 minutes from 7:00 a.m. to 9:30 a.m. and from 3:30 p.m. to 7:00 p.m., and every 30 minutes from 9:30 a.m. to 3:30 p.m., Monday through Friday. The bus service does not operate on weekends. For free admittance, Conference Center's guests must show their room key or a conference brochure.

BY CAR:
Directions are attached. Covered parking is available on the premises at the rate of $12 per day or $2 per hour.



Campus Map



Directions from the South:

From Richmond & South:
Follow I-95 North, also known as I-395 North. Take exit toward Memorial Bridge. The road will divide, follow signs for Key Bridge. You will want to be in the left lane as you cross over Key Bridge. At the end of Key Bridge take a left at the light. This is Canal Road. Follow the road as it bears to the right. At this point the road will change names and become Foxhall Rd. At the third light take a right onto Reservoir Rd.
(See From Reservoir Rd.)

From National Airport: *(20 Minutes)*
Take the George Washington Parkway North. Follow signs for Key Bridge\Route 50. Follow until Key Bridge Exit. You will want to be in the left lane as you cross over Key Bridge. At the end of Key Bridge take a left at the light. This is Canal Road. Follow the road as it bears to the right. At this point the road will change names and become Foxhall Rd. At the third light take a right onto Reservoir Rd.
(See From Reservoir Rd.)

From Dulles Airport & West: *(40 Minutes)*
Follow Dulles Airport Access road to I-66. Follow I-66 East to the Key Bridge Exit. Exit and stay in left lane. At the third light take a left and stay in one of the middle lanes. You will want to be in the left lane as you cross over Key Bridge. At the end of Key Bridge take a left at the light. This is Canal Road. Follow the road as it bears to the right. At this point the road will change names and become Foxhall Rd. At the third light take a right onto Reservoir Rd.
(See From Reservoir Rd.)

Directions from the North:

From Route 270:
Follow 270 South towards Washington/Virginia. Take I-495 South to Virginia. Follow to Cabin John Parkway Exit 40 (Glen Echo). Continue on the Parkway past Chain Bridge Rd. And take a left at the next light. This is Arizona Avenue. At the top of the hill take a right onto MacArthur Blvd. When the road divides bear left onto Reservoir Road.
(See From Reservoir Rd.)

From BWI Airport, Baltimore & North:
Follow I-95 South to I-495. Take the I-495 West Exit towards Silver Spring. Continue towards Virginia on I-495 South. Follow to Cabin John Parkway Exit 40 (Glen Echo). Continue on the Parkway past Chain Bridge Rd. and take a left at the next light. This is Arizona Avenue. At the top of the hill take a right onto MacArthur Blvd. When the road divides bear left onto Reservoir Road.
(See From Reservoir Rd.)

From Reservoir Road:
Follow Reservoir Road until you get to Entrance #1 of Georgetown University Hospital, turn right. Note that you will not see any Marriott signs, but it will say Georgetown University Medical Center and Conference Center as you enter Entrance #1. Follow the road straight back, it will dead end into an underground parking garage. This is the Leavey Center Building. Enter the parking garage and turn right. In front of you will be the door to the Conference Center Elevator. This is the elevator that will bring you to the Conference Center Lobby. If you need to drive directly to the Conference Center Entrance, you will need to turn right before you enter the parking garage. The entrance is under the green awnings on your left.

Talking It Over

By Hillary Rodham Clinton

Home visitation helps fledgling mothers cope

My daughter, Chelsea, turns 18 this month. How vividly I remember the overwhelming feelings of love and responsibility as she lay in my arms 18 years ago. During the nine months of pregnancy, I had studied and read about parenting, but nothing prepared me for the sheer miracle of having a child.

Despite my efforts, I soon discovered that grasping child-rearing concepts in the abstract and knowing what to do with the baby in your hands are two very different things. Babies don't come with instructions. Even the most fortunate among us need some calm reassurance and a little guidance to get through those scary firsts — breast feeding, diaper changing, bathing that slippery little creature. But what about parents who have known only poverty or neglect? What about parents without a supportive community? And what about those who have grown up trapped in cycles of abuse and low expectations?

When families lived closer together, it was easier for relatives to pitch in during the early months of a newborn's life. When women worked primarily in the home, they provided a neighborhood support system to lend a hand to new mothers. But now, relatives and neighbors aren't as readily available, and programs to help fledgling parents are few and far between.

This week, I visited the home of a single mother in Alexandria. Depressed and scared when she became pregnant, Felicia was referred to a program called Healthy Families Alexandria, which was launched in 1993 when the area began to experience some disturbing trends, including increasingly high rates of child poverty and abuse, teen pregnancy, low birth-weight babies and vaccine-preventable diseases.

At the heart of the program is the family support worker, a trained professional or paraprofessional who visits the new mother on a regular basis, both before and after birth, to offer education, support and a patient ear. Home visitors also help with critical issues such as ensuring that the child receives regular medical attention and nutrition and that the parent is provided with referrals to peer-group activities, transportation, housing, child care, employment and medical care.

With the support of her home visitor, Felicia is now the proud and confident mother of Dominico, a gurgling, smiling and healthy 3-month-old. On the day I visited, Felicia's home visitor was checking the baby's development, offering some age-appropriate toys and answering Felicia's questions and concerns. From her vantage point in the home, the visitor is able both to evaluate the child's growth and development, and to assess whether the child's surroundings are suitable and nurturing. When I asked Felicia if she thought home visits would help others, she said, "Oh, yes, I feel so rich. Having Lynn really helps."

Equipping parents to be the best they can be is critical to the future of our country. Long-term studies tell us that home-visitation programs can help. Researchers have just completed a 15-year study of 324 first-time mothers who participated in the Prenatal and Infancy Nurse Home Visitation Program in Elmira, N.Y. The results are dramatic: significant reductions in government assistance, child abuse, unintended second pregnancies, substance abuse and child hospitalizations. And now that these children are teenagers, there's evidence that this program can reduce incidence of juvenile crime. The costs of the program were fully recovered by the time the children were 4 years old, thanks to less use of government services and fewer subsequent pregnancies.

I believe that one of our greatest challenges is to identify programs like this that work and make them more widely available to families who would benefit from them. This week, I spent some time with the lead researcher on the Elmira study, Dr. David Olds. We agreed that we must invest more in research, replicate proven models and make existing programs better.

Because children's experiences in the earliest years of life are central to their healthy development, the president has proposed increasing our investment in activities that promote early learning and improve the quality of child care in our country. A major element of the president's child care proposal is the Early Learning Fund, which will provide challenge grants to communities that promote early learning, including home-visiting programs.

I don't think I know a mother who hasn't sought help and support in those first months and years after having a child. Most of us have help available, but sadly, too many don't. I met one young woman who told me that, without the advice of her home visitor, she would never have known that talking and reading actually improve the development of her newborn daughter's brain. Raising healthy children is the most important and the hardest job any of us will ever have. Home-visitation programs can make that job easier. And that means healthier children, healthier families and healthier communities.

The Washington Times
THURSDAY, FEBRUARY 12, 1998

February 9, 1998

HOME VISITATION EVENT AND ROUNDTABLE DISCUSSION

Date:	**Tuesday, February 10, 1998**
Location:	**Alexandria, VA**
Time:	**2:00 - 2:30pm Home Visitation**
	3:00 - 3:45pm Roundtable Discussion
From:	**Nicole Rabner**

I. PURPOSE

The purposes of this event are: (1) to spotlight the success of home visitation in strengthening families and promoting healthy child development, and (2) highlight the importance of the President's proposal -- as part of his child care initiative -- to create an Early Learning Fund to support community-based home visitation efforts.

II. BACKGROUND

There are two pieces to this event: you will first accompany a home visitor on a routine home visitation and then participate in a roundtable discussion on the promise of home visitation. The home visit will provide an opportunity for you to learn firsthand about the *Healthy Families Alexandria* home visitation program; the roundtable will provide a forum to discuss the success of home visiting generally in strengthening families and promoting healthy child development and to highlight two approaches to home visitation (*Healthy Families America* and the Elmira, New York program).

Home Visitation

As you know, while there are various different programmatic approaches to home visitation, all share a common thread -- intensive, routine visits by a trained worker to pregnant mothers or new parents who may be at risk of child maltreatment and who generally demonstrate need for parenting support. Not surprisingly, there is considerable debate within the field about which programs best improve child outcomes. There is also debate about the extent to which it is possible to generalize the promising research findings from one program to the field of home visitation generally. Dr. David Olds, the lead researcher of the Elmira study, for instance, questions whether his findings can be used to support the *Healthy Families America* model. Dr. Olds also questions whether *Healthy Families America* has been adequately evaluated. The principal differences between the two programs are that the Elmira study employs nurses as home visitors and serves only unmarried women, while *Healthy Families America* relies on paraprofessionals, *i.e.* trained workers, and serves both married and unmarried mothers.

In order to avoid any discussion of the relative merits of existing programs, the roundtable

discussion should focus on home visitation generally, and on the promise of home visitation for strengthening families and improving child outcomes.

Healthy Families Alexandria -- Healthy Families America

Healthy Families Alexandria is a local arm of the national *Healthy Families America* program, which serves 320 communities around the country, and is promoted by the National Committee to Prevent Child Abuse. *Healthy Families America* was modeled on Hawaii's "Healthy Start" program of comprehensive, intensive home visiting services.

Healthy Families Alexandria serves about 100 first-time mothers in the City of Alexandria who have risk factors that may predispose them to child maltreatment. Prenatal and first-time mothers with a child less than 2 months are eligible for voluntary referral, assessment, enrollment, and services until the child is 5 years old. The *Healthy Families Alexandria* model provides (1) systematic, proactive early identification of at-risk families and (2) home visiting/case management services delivered by trained, largely paraprofessional Family Support Workers. Using "best practices" identified by over 20 years of research and referrals from partners such as the local social services agencies and hospitals, *Healthy Families Alexandria* helps parents enhance their parenting skills, use needed community resources, and better manage their lives to reduce risks leading to child maltreatment.

The program began in Alexandria in 1993 in response to troubling statistics in the Alexandria area: one in four children living in poverty; Virginia's highest rates of child maltreatment and teen pregnancy; higher proportions of low birth weight babies born to non-white women; high rates of vaccine-preventable disease; and alarming increases in proportions of preschool children with developmental delays, handicapping conditions and other difficulties.

In July, 1997, *Healthy Families Alexandria* released a 42-month outcome evaluation report. This independent evaluation showed promising results:

- 82% of women attended all recommended prenatal medical appointments
- 92% of infants were born at healthy birth weight
- 98% of infants had a primary health care provider within 2 months of birth
- 93% of infants received recommended immunizations and well-care
- 87% of mothers did not have another child within 24 months
- 98% of enrolled families had no founded reports of child maltreatment
- 96% of infants showed no developmental delays

The cost of the *Healthy Families America* program is approximately $2,700 annually per family. The program has a range of funding sources; in Alexandria, the funding sources include the City of Alexandria (via its Early Childhood Commission); United Way of Alexandria; the U.S. Maternal and Child Health Bureau; the foundations of Freddie Mac, Phillip Graham, INOVA Alexandria Hospital; and the March of Dimes, Meyer and Winkler.

Elmira, New York Pregnancy and Infancy Nurse Home Visitation Program

The Elmira study, called "Long Term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect," is a fifteen-year follow-up of a randomized trial of home visiting in Elmira, New York. The results were published in the August 27, 1997, issue of *The Journal of the American Medical Association* (attached).

The results show that this early intervention is beneficial both in the short- and long terms. In this voluntary program, nurses begin to visit first-time mothers during pregnancy and continue home visits for two years after the child is born. Nurse home visitors work intensively with families to improve three areas: women's health behavior, including a reduction in substance use; family caregiving for infants and toddlers, including preventive health care and early intervention for emerging health problems; and maternal life-course development, including pregnancy planning, education achievement, and finding work.

The 15 year follow-up study of the low-income, unmarried women in the Elmira program found major program benefits, including:

- 79% fewer verified reports of child abuse or neglect
- 31% fewer subsequent live births
- over 2 years' greater interval between the birth of their first and second child
- 30 fewer months receiving welfare
- 44% fewer behavioral problems due to alcohol and drug abuse
- 69% fewer arrests among mothers
- 54% fewer arrests among their children by the children's 15th birthday (this finding has not yet been published -- it is the subject of a forthcoming paper)

Event Scenario

Home Visit:
You will participate in a routine home visitation of the *Healthy Families Alexandria* model by accompanying Family Support Worker Lynn Kasonovich and Program Director Sally Campbell on a visit to Felicia Pearson and her 3-month old son, Dominico (bios attached). The home visitation will include exercises (using toys) designed to gauge the child's healthy development.

Roundtable Discussion:
After meeting with the program participants, you will proceed to the roundtable discussion. You will make opening remarks, introduce the discussion participants, and introduce the first three speakers: (1) Dr. Matthew Melmed, the Executive Director of the Zero to Three National Center for Infants and Toddlers, who will discuss why the early years of a child's life are so important and describe home visitation generally; (2) Dr. David Olds, lead researcher of the Elmira study, who will provide a brief overview of the Elmira program and its promising findings; and (3) Ms. Betsy Dew, one of the founders of Hawaii's "Healthy Start" program and leading architect of the

Healthy Families America national program, who will talk about the program and its demonstrated success. Ms. Dew will then moderate the discussion with three parents and a Family Support Worker in the *Healthy Families Alexandria* program. Finally, you will turn to Mr. Leland Bresland, CEO of the Freddie Mac Corporation, which has heavily invested in home visitation programs and research, to make some remarks -- Mr. Bresland will emphasize that this effort demands public-private partnership and business leadership. You will then conclude the discussion.

III. PARTICIPANTS

Home Visitation
The First Lady
Ms. Felicia Pearson, mother
Dominico Pearson, 3-month old son
Lynn Kasonovich, Family Support Worker
Sally Campbell, Healthy Families Alexandria program director

Roundtable Discussion
The First Lady
Dr. Matthew Melmed, Executive Director, Zero-to-Three National Center for Infants and Toddlers
Dr. David Olds, Director, Prevention Research Center for Families and Child Health and Lead Researcher of the Elmira Home Visitation program
Ms. Betsy Dew, Director and Senior Training Specialist, The Family Institute of Hawaii Family Support Center and a Founder of the Hawaii Healthy Start Program
Mr. Leland Bresland, CEO, Freddie Mac Corporation
Brandi Church and Antoine Watson, Mother and Father served by Healthy Families America
Jane Rutherford, Single mother served by Healthy Families America
Valator Giliespie-Ballah, Family Support Worker for Healthy Families Alexandria

Roundtable Discussion Audience
Approximately 40 supporters of the *Healthy Families Alexandria* program, local officials and community leaders (see attached list).

IV. SEQUENCE OF EVENTS

- YOU will proceed to home visit site -- the home of Felicia Pearson.
- YOU will join the Family Support Worker, Lynn Kasonovich, and the *Healthy Families Alexandria* program director in the home visitation.
- YOU will depart the home and proceed via motorcade to the roundtable discussion site.

- YOU will meet briefly with the roundtable discussion participants, and proceed to the roundtable discussion.

- YOU will make opening remarks and introduce the first three speakers: Dr. Matthew Melmed, Dr. David Olds, and Ms. Betsey Dew.

- Dr. Matthew Melmed, Dr. David Olds, and Ms. Betsey Dew will each make brief remarks.

- Ms. Betsy Dew will then moderate the discussion among the *Healthy Families Alexandria* parents and Family Support Worker.

- Ms. Betsey Dew will ask Mr. Leland Bresland, CEO of the Freddie Mac Corporation to make remarks.

- Mr. Leland Bresland will make brief remarks

- YOU will make closing remarks and end the program.

- YOU will depart.

V. PRESS PLAN

Home Visit: One Print Reporter -- TBD
Roundtable Discussion: Open Press

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. bio	Felicia Pearson (1 page)	nd	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Domestic Policy Council (Nicole Rabner)
OA/Box Number: 15416

FOLDER TITLE:
Home Visiting [1]

2012-1035-S
kc1055

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

ROUNDTABLE DISSCUSSION ON HOME VISITATION
FEBRUARY 10, 1998
BIOS OF DISCUSSION PARTICIPANTS

Matthew E. Melmed. Executive Director, The Zero to Three National Center for Infants and Toddlers.

Since his arrival in 1994, Mr. Melmed has focused Zero to Three's efforts on promoting prevention and healthy development in early childhood. Under his leadership, Zero to Three helped establish the Early Head Start National Resource Center for the U.S. Department of Health and Human Services which provides training and technical assistance to the new Early Head Start programs nationwide. Zero to Three has also initiated a national public awareness campaign for parents and launched the *Business Leaders for Babies Alliance* -- a corporate effort aimed at involving the business community in Zero to Three's issues. As you know, Zero to Three was very involved in developing the White House Conference on Early Childhood Development and Learning.

Before coming to Zero to Three, Mr. Melmed served for thirteen years as Executive Director of the Connecticut Association for Human Services and Managing Attorney for Connecticut Legal Services. Mr. Melmed is the recipient of a number of awards including the *Child Advocacy Award* from the Collaboration for Connecticut's Children and the *Lewis Hine Award for Exceptional Service to Children and Youth* from the National Child Labor Committee.

David Olds. Professor of Pediatric, Psychiatry and Preventive Medicine at the University of Colorado Health Sciences Center.

Dr. Olds directs the Prevention Research Center for Family and Child Health at the University of Colorado Health Sciences Center where he investigates methods of preventing health and developmental problems in children and parents from low-income families. His original work, carried out in Elmira, New York, examined the effects of prenatal and postpartum nurse home visitation on the outcomes of pregnancy, infant caregiving, and maternal life-course development, and determined the impact of those services on government spending. Dr. Olds had received numerous awards for this research, including the *Charles A. Dana Award for Pioneering Achievements in Health*, and the *Lela Rowland Prevention Award from the National Institute of Mental Health.*

He is currently carrying out an urban replication of the Elmira study in Memphis, Tennessee and another replication of the Elmira and Memphis studies in the Denver metropolitan area.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. bios	Roundtable Discussion Participants (partial) (1 page)	nd	P6/b(6)

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[002]

Betsy Dew. Director and Senior Training Specialist with the Family Institute of Hawaii Family Support Center.

As one of the Founders of Hawaii Family Support Center in 1975, Ms. Dew designed and implemented the Family Assessment/Early Identification program. With Dr. Calvin Sia and colleague Gail Breakey, she pioneered the Healthy Start Program and advocated for state-wide expansion, developing and implementing the state-wide training and technical assistance program. She was involved in the design and development of the Healthy Families America (HFA) initiative. She has conducted numerous conference presentations and seminars on Healthy Start and HFA and has provided consultation in family support program planning, design and implementation for many states as well as Australia, New Zealand, and the Philippines. Ms. Dew is currently working as a consultant to communities developing family support programs and as a trainer for basic and advanced training seminars throughout the U.S. and abroad.

Jane Rutherford. Parent served by Healthy Families Alexandria.

P6/(b)(6)

Leland Brendsel. Chairman and CEO, Freddie Mac Corp.

Before he was elected chairman in 1989, Mr. Brendsel served as president and chief executive officer of Freddie Mac for four years. Mr. Brendsel has played a key role in developing the secondary mortgage market by championing innovative ways of improving lending practices and expanding homeownership opportunities. In 1991 Mr. Brendsel created and is Chairmian of the Board of Freddie Mac Foundation, which works to improve the lives of at-risk children and their families. He runs several times each year in Freddie Mac's Reach Out to a Child 5K walk/runs, which raise money for foster care and adoption programs.

Mr. Brendsel has been the recipient of numerous awards, including: *Washingtonian of the Year* in 1991, the *Washington UNICEF Council Children's Champion* in 1992, and the *Child Welfare League of America's Corporate Advocate of the Year* in 1995.

Brandi Church and Antoine Watson. Parents served by Healthy Families Alexandria.

P6/(b)(6)

Healthy Families for most of their support.

Velator Giliespie Ballah. Family Support Worker, Healthy Families America.

Ms. Ballah has been an HFA support worker for four years, and has done extensive community service work. She is a mother and grandmother.

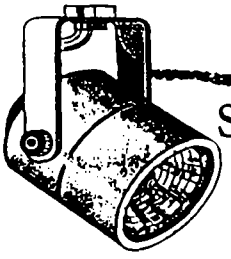
HEALTHY FAMILIES MEET AND GREET
FEBRUARY 10, 1998

1. Linda Dunphy, Director, Healthy Families.
2. Maxine Baker Stokes, Executive Director, Freddie Mac Foundation.
3. Tori Thomas, Chairman, The Winkler Corporation.
4. Catherine Hanley, Chairman, Fairfax County Board of Supervisors.
5. Chris Zimmerman, Chairman, Arlington County Board of Supervisors.
6. Patsy Tiser, Virginia State Senator.
7. Pat Graham, Chairperson, NUFS Board.

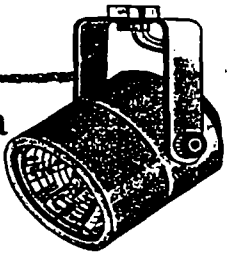
TOGETHER FOR CHILDREN

Prevent Child Abuse, Virginia

Summer 1997



Spotlight on Healthy Families Virginia



Northern Virginia Family Service

Since 1991, Northern Virginia Family Service (NVFS) has been a leader in northern Virginia in working with communities to establish Healthy Families America programs. NVFS has also been an active participant on the state level with the Healthy Families Virginia Network. Through a partnership with the Fairfax County Department of Human Development in 1991, the organization developed Healthy Families Fairfax, which is now operated by the county. In 1993, working with community leaders in Alexandria, the agency implemented Healthy Families Alexandria. After a year-long planning process, NVFS was selected by Healthy Families Prince William Area to help them implement their program in 1996. Most recently, a task force in Arlington, which completed an extensive community-needs assessment, concluded that a Healthy Families initiative was the approach that would best meet the needs identified. NVFS became the agency partner to help plan for implementation.

The agency was awarded a grant from the Freddie Mac Foundation to support the development of a regional infrastructure for the geographic area, including the four localities in northern Virginia, Washington, and several counties in Maryland served by the foundation. Last year, NVFS convened the Healthy Families America National Capital Area Consortium, bringing together public and private agencies from the region.

Healthy Families Alexandria recently received high marks in a report by an independent evaluator. The report found that throughout the 30-month evaluation period: 92% of infants were born at normal to above birth weight; 86% of infants were immunized on time; 96% of infants showed no developmental delay; 92% of families experienced no repeat pregnancy within one year after birth; over 92% of families served indicated they found the program helpful in raising their child and would recommend it to a friend; and 99% of families experienced no founded incidents of child abuse.

Healthy Families Prince William Area began providing service in July 1996 in collaboration with the Prince William Health District, Potomac Hospital, and Prince William Hospital. The program has a strong and active Advisory Council and has recently hired a Father Involvement Specialist to augment its team of experienced family support workers.

NVFS has partnered with the Arlington County Department of Human Services to integrate and implement the Comprehensive Health Investment Project of Virginia (CHIP) and Healthy Families America models. Healthy Families/CHIP Arlington will address the limited access to consistent child health care, the need for parenting support, and child abuse prevention. This will be accomplished by building a system of coordinated health care for young children ages 0-6 and by providing a system of intensive home-visiting support to improve family functioning and parenting skills, and to prevent child abuse and neglect among enrolled families. Families will be assigned to a Healthy Families or a CHIP track, depending on the mix of services needed to address specific family strengths and needs. The Healthy Families component will specifically target pregnant mothers who screen at-risk for child abuse and neglect and who are first-time mothers — the critical window of opportunity for influencing long-term parental behavior.

Based on the results of Healthy Families Alexandria, the support of key community leaders and residents, new and exciting results from research on early childhood brain development, and staff experience, it is expected that Healthy Families programs in Prince William Area and Arlington will yield positive results. Though the service delivery models are slightly different in each jurisdiction due to a variety of factors, the outcome will be the same — healthier families.

For more information on the Healthy Families programs supported by Northern Virginia Family Service, please call Healthy Families Alexandria, Sally Campbell at 703-823-8153; Healthy Families Arlington, Anne VorDer Bruegge at 703-533-2560; or Healthy Families Prince William Area, Sue Hanye at 703-680-3607.

Healthy Families Virginia

Supporting parents....right from the start.
An Initiative Coordinated by Prevent Child Abuse, *Virginia*

The Problem

Serious social and health problems face families today. Economic stress, lack of affordable housing and inadequate health and child care are challenging many parents. The absence of family and social support systems often cause problems to become overwhelming. The consequences for children include poor nutrition, low immunization rates, lack of school readiness and increasing rates of child abuse and neglect.

In 1996, over 3 million children were reported as abused and neglected. The most recent statistics indicate that one in five children live in poverty, one in ten infants lack a routine source of health care and at least 100,000 go to sleep homeless every night.

> "...The time of child-birth presents a golden opportunity for prevention programs."
>
> *...Anne Cohn Donnelly*

The Solution -- Home Visitation Programs

In Creating Caring Communities, a blueprint for Federal policy created by the U.S. Advisory Board on Child Abuse and Neglect, the following recommendation can be found: "The Federal Government should begin planning for the...implementation of a universal, **voluntary**, neonatal home visitation system."

Visitation programs allow localities to address a number of factors that can lead to abusive behavior, therefore confronting the symptoms of child maltreatment before a crisis occurs. Visitors can work with families to ensure that the children receive well-child care and immunizations and that the mothers receive prenatal care and respite care, if necessary. The visitor can teach parents to develop realistic expectations regarding child development and can model positive discipline techniques. The home visits provide an early warning system for families in need of additional assistance. The parents become good consumers of available resources, such as housing assistance, job training programs, substance abuse treatment programs and day care. If visitor services continue for several years, great strides can be made in reducing problems such as developmental, learning and emotional disabilities, runaways, juvenile delinquency, truancy, teen pregnancy, substance abuse and criminal behavior.

Home Visitor Programs Target New, First-Time Parents

In an article entitled "Why Focus on New Parents to Prevent Child Abuse," Anne Cohn Donnelly, National Committee to Prevent Child Abuse Executive Director, states, "The time of childbirth presents a golden opportunity for prevention programs. New parents are typically seeking assistance at this time

and are, therefore, more likely to voluntarily engage in services designed to help them care for their children." She cites a study completed by Dr. David Olds which reports that regular pre- and post-natal home visits by nurse practitioners contribute to a significant reduction in reports of child abuse -- 4% in the treatment group compared to 19% in the control group. A nationwide study, by the National Committee to Prevent Child Abuse, on the existence of statewide parent education and support programs found that most states do have several community based programs. However, few of those programs are statewide, intensive, comprehensive and well coordinated with other federal, state and local programs.

Healthy Families America -- Creating a Nationwide Initiative

Healthy Families America (HFA) was established in 1992 by the National Committee to Prevent Child Abuse in partnership with Ronald McDonald Children's Charities. The goal of Healthy Families America is to lay the foundation for nationwide, voluntary home visitor services for all new parents who need them, through a network of statewide systems. HFA is based on two decades of research and on the experiences of the Healthy Start program in Hawaii, a model that has been called "the most comprehensive statewide effort in the nation" by the U.S. Advisory Board on Child Abuse and Neglect. National partners in HFA include groups as diverse as the American Nurses Association, the American Hospital Association, the National Association for Consumer Credit and the U.S. Bureau on Maternal and Child Health. In the 1993 Annual Report of the NCPCA, it states that virtually every state had an HFA task force at work. By Fall of 1997, thirty-seven states had operational HFA sites.

Characteristics of High Risk Families

- *History of childhood abuse*
- *Emotional deprivation in childhood*
- *Substance abuse*
- *Emotional, mental illness*
- *Post-partum depression*
- *Teenage parents*
- *Single or isolated parents*
- *Unrealistic expectations of infants and children*
- *Violence or criminal history*
- *Continuous and heavy child care*
- *Marital or financial problems*
- *Social isolation*

The Hawaiian Model

"Healthy Start," the much-acclaimed "Hawaii Program" began as a demonstration model of the Hawaii Family Stress Center in 1985. Three years later, an evaluation of the program revealed that not a single case of child abuse had been reported among the project's 214 targeted high-risk families since the demonstration began. By July 1990, Healthy Start services had been expanded to 11 sites throughout the state with a rate of abuse and neglect of less than 1% (vs. the 20% abuse rate found in Dr. Olds's study).

Healthy Start begins services in the hospital with systematic screening of all new, first-time parents to identify those most in need of at-home support and education. Most parents accept the **voluntary** services offered and receive home visits from trained paraprofessionals. Once the family is in the program, the first step is to meet a family's immediate needs. Home visitors may help families to secure emergency food and housing assistance or to complete application forms for health or social service programs. As the visitors get to know the families better they offer emotional support and promote attachment between parents and their child. The visits taper off in frequency as the family's stability improves. Involvement continues until the child reaches age five and enters school. All families are linked to a health care provider to ensure that their children receive ongoing well-child care, are screened for developmental delays and are immunized on schedule.

Healthy Families Virginia -- Coordinating Efforts Across the Commonwealth

In Virginia, as in most states, the groundwork for home visitation programs is already in place. Prevent Child Abuse, *Virginia* has been the catalyst and coordinator for the initiative since its formative stages and will continue in that role.

The Virginia initiative will include assessing needs and coordinating existing efforts. Recognizing that no single prevention or intervention program can address the entire range of families' needs, Healthy Families Virginia sites will link families with various local programs and services, building onto existing resources whenever possible.

As coordinator of the Healthy Families Virginia (HFV) initiative, it is the responsibility of Prevent Child Abuse, *Virginia* to provide training and technical assistance for communities as they organize. The HFV Director will also identify and share information about potential funding sources with communities, as well as coordinating public awareness activities for the advancement of the Healthy Families Virginia initiative. In this way, it is hoped that a single focus will be created in support of families. Prevent Child Abuse, *Virginia* hosts regular meetings so that HFV sites, other communities and advocates can share information about this prevention approach and plan further advocacy strategies.

Joining the National Initiative

Communities may qualify for recognition as a Healthy Families America site by meeting certain criteria. First, a task force with representation from a variety of key community stakeholders must be convened. These stakeholders must engage in a comprehensive planning process which includes a community needs assessment, service identification and coordination, implementation planning, and resource development. They will formally organize themselves to continue administering the initiative once implementation has begun and agree to adhere to the HFA Critical Elements or best practice standards which include the following points. Family assessment services must begin prenatally or at birth. Home visiting services must be intensive (at least weekly) and caseloads limited to 15-25 per home visitor. Attention must be given to child health and school-readiness. The staff and program materials must reflect the cultural, linguistic, racial and ethnic diversity of the population served. The staff must also have intensive, standardized initial training and regular inservice training and all activities must be evaluated.

The Healthy Families Virginia Goal

- *All parents have available support so that they can successfully raise children and create healthy communities.*
- *All children should be born healthy, enter school ready to learn, and become productive, well-adjusted adults.*

SUNDAY, JULY 23, 1995

The Washington Post

PARADE

A model program—which has been copied in more than 20 states—is helping families at risk to raise happier and healthier children.

'We're Breaking The Cycle Of Abuse

AT 23, SUE LYNN AH YUEN fit the profile of a mother who might have problems raising her child: She was single, homeless and an unemployed college dropout when her son, Kainana, was born. But Ah Yuen, a Hawaii resident, got help long before a crisis occurred, thanks to an early intervention program called Healthy Start.

On the day Ah Yuen left the hospital, Healthy Start paired her with a home visitor named Mealii, who found her an apartment and visited every week for seven months. "With Mealii's support, I began to motivate myself," Ah Yuen recalled. "So far, I've finished a clerical program, and my next goal is to get my bachelor's degree in social work." After nearly four years with the program, Ah Yuen is raising a well-adjusted son and has had a second child.

Healthy Start's goal is to help new parents raise healthy and happy children. Its approach—intervening early with personal support for families at risk—has been remarkably effective at reducing child abuse in Hawaii and at helping families who may be dealing with poverty, homelessness, drug or alcohol abuse and chronic unemployment.

"This is a family-empowerment program," said Gail Breakey, one of Healthy Start's founders and the director of the Hawaii Family Stress Center. "All parents want to provide nurturing for their children, but many don't have their lives together, so they aren't able to." And that is where Healthy Start steps in.

The program's workers screen more than half of the 20,000 babies born in Hawaii each year and provide services to more than 3000 families. Almost all accept Healthy Start's aid, and there is less than a 1 percent incidence of child abuse among this group—far lower than the national average of 4.7 percent.

Healthy Start was founded in 1985 and has been copied extensively nationwide. Today, projects based on its approach operate in more than 20 states, and almost every other state has a program in development, said Anne Cohn Donnelly, executive director of the National Committee To Prevent Child Abuse.

Photos by Eddie Adams

Sue Lynn Ah Yuen and her 3-year-old son, Kainana, in Honolulu. For parents like Sue Lynn, Healthy Start offers support without becoming a crutch. Below: Healthy Start staff members (l–r) Vicki Wallach, Gail Breakey, Ha'aheo Mansfield and Betsy Pratt.

Sherri Cox needed help. At age 19, the Hawaii resident had just left a troubled marriage, and she was six months pregnant. Then Healthy Start stepped in.

New parents usually learn about Healthy Start at the hospital, where they are visited by one of the program's employees shortly after their child is born. These chats are not intrusive or judgmental, explained Gail Breakey, and they are conducted solely with the individuals' consent. During the conversation, the worker talks to the parents about their current situation and their past history, all the while listening for warning signs that might indicate potential problems. "We look for parents who were abused or neglected as children," said Breakey. "We know from research that there is an intergenerational pattern."

At the center of Healthy Start's success is the home visitor, who functions as an advocate, confidant without becoming a crutch. To learn more, I accompanied Cammie Hammonds, a home visitor at Family Support Services of West Hawaii, as she went to see Sherri Cox, 21. Cox, who lives with her parents and daughter, Christa, 2—was referred to Hammonds by a clinic when she was six months pregnant, shortly after she had left a troubled marriage.

"Cammie got me a lawyer and went with me to court to start fighting for the divorce," Cox told me. The divorce was granted. And, since Christa's birth, Hammonds has been teaching the young mother how to care for her baby, using a combination of books, role-modeling, direct supervision and visits to clinics.

Healthy Start now operates with an annual budget of $8 million. It is money well spent. "At minimal cost to the state—about $2500 for each family—we are breaking the cycle of abuse," noted Dr. Jack Lewin, the former director of Hawaii's health department, which administers Healthy Start.

The programs based on Healthy Start also are showing positive results. "Children families feel like they're a cut above their peers," observed Carolyn Wisehart of Healthy Families in San Angelo, Tex. "And the *real* payoff will come when these babies have children."

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BY MARGERY STEIN

Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect

Fifteen-Year Follow-up of a Randomized Trial

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Context.—Home-visitation services have been promoted as a means of improving maternal and child health and functioning. However, long-term effects have not been examined.

Objective.—To examine the long-term effects of a program of prenatal and early childhood home visitation by nurses on women's life course and child abuse and neglect.

Design.—Randomized trial.

Setting.—Semirural community in New York.

Participants.—Of 400 consecutive pregnant women with no previous live births enrolled, 324 participated in a follow-up study when their children were 15 years old.

Intervention.—Families received a mean of 9 home visits during pregnancy and 23 home visits from the child's birth through the second birthday.

Data Sources and Measures.—Women's use of welfare and number of subsequent children were based on self-report; their arrests and convictions were based on self-report and archived data from New York State. Verified reports of child abuse and neglect were abstracted from state records.

Main Results.—During the 15-year period after the birth of their first child, in contrast to women in the comparison group, women who were visited by nurses during pregnancy and infancy were identified as perpetrators of child abuse and neglect in 0.29 vs 0.54 verified reports ($P<.001$). Among women who were unmarried and from households of low socioeconomic status at initial enrollment, in contrast to those in the comparison group, nurse-visited women had 1.3 vs 1.6 subsequent births ($P=.02$), 65 vs 37 months between the birth of the first and a second child ($P=.001$), 60 vs 90 months' receiving Aid to Families With Dependent Children ($P=.005$), 0.41 vs 0.73 behavioral impairments due to use of alcohol and other drugs ($P=.03$), 0.18 vs 0.58 arrests by self-report ($P<.001$), and 0.16 vs 0.90 arrests disclosed by New York State records ($P<.001$).

Conclusions.—This program of prenatal and early childhood home visitation by nurses can reduce the number of subsequent pregnancies, the use of welfare, child abuse and neglect, and criminal behavior on the part of low-income, unmarried mothers for up to 15 years after the birth of the first child.

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IN RECENT YEARS, home-visitation services have been promoted widely as a means of preventing a range of health and developmental problems in children from vulnerable families. The US Advisory Board on Child Abuse and Neglect, for example, has recommended that home-visitation services be made available to all parents of newborns as a means of preventing child abuse and neglect.[1]

See also pp 644 and 680.

Many of these recommendations have been based on the results of a randomized trial of a comprehensive program of prenatal and early childhood home visitation by nurses that was conducted in Elmira, NY.[2-11] Findings from this trial indicated that the program reduced the rates of subsequent pregnancy, increased labor force participation, and reduced government spending for low-income unmarried women from the birth

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of the first child through the child's h birthday, ie, through 2 years after the program ended.[8,9] Although the rates of state-verified cases of child maltreatment among high-risk families were reduced while the program was in operation (through age 2 years),[5] the effects were attenuated during a 2-year period after the program ended,[6] most likely because of increased surveillance for child abuse and neglect set in motion among the nurse-visited families.[7] Children's health care encounters in which injuries were detected also were reduced from ages 1 through 4 years.[5,6]

Although this program produced positive effects on maternal and child health from pregnancy through the child's fourth year of life,[4-11] its long-term effects remain unexamined. The present study was conducted to determine the extent to which the beneficial effects of the program instituted early in the life cycle altered the life-course trajectories of the mothers through the child's 15th birthday. We examined the long-term effects of the program on 2 domains of maternal functioning: (1) maternal life course (subsequent number of children, use of Aid to Families With Dependent Children [AFDC], employment, subse abuse, and encounters with the nal justice system) and (2) perpetration of child abuse and neglect. We hypothesized that the program effects, as in earlier phases of the study, would be greater for families in which the mothers experienced a larger number of chronic stressors and had fewer resources to manage the challenges of living in poverty and being a parent.

DESIGN AND METHODS

Setting

The study was originally conducted in and around Elmira, NY, a small city with a population of 40 000 in a semirural area of central New York State (NYS). Patients were recruited from a clinic offering free antepartum services sponsored by the county health department and the offices of private obstetricians.

Participants

From April 1978 through September 1980, 500 consecutive eligible women were invited to participate. Pregnant women were actively recruited for the study if they had no previous live births, could register in the study prior to the 25th week of gestation, and had at least one of the following sociodemographic risk characteristics: young age (<19 years at registration), unmarried, or low socioeconomic status (SES) (Medicaid status or no private insurance). To avoid creating a program stigmatized as being exclusively for the poor, any woman who asked to participate and had no previous live birth was accepted into the study. Approximately 10% of the target population (low income, unmarried, or teenaged) was not recruited because of late registration for prenatal care, and another 10% was not recruited because they were not referred from the offices of private obstetricians.

Four hundred of the 500 women enrolled in the study. All enrollees completed approved informed consent procedures. There were no differences in the age, education, or marital status of women who chose to enroll and those who declined; there was a difference by race, with 80% of white women vs 96% of the African-American women agreeing to participate.

Eighty-five percent of the sample originally recruited had at least 1 of the 3 risk characteristics used for recruitment. Forty-eight percent were younger than 19 years, 62% were unmarried, and 59% were from households classified as low SES[12] at registration during pregnancy. Eleven percent of the sample was African American.

Treatment Conditions

The research design included 4 treatment conditions. Families randomized to treatment 1 (n=94) were provided sensory and developmental screening for the children at 12 and 24 months of age. Based on these screenings, the children were referred for further clinical evaluation and treatment when needed. Families randomized to treatment 2 (n=90) were provided the screening services offered those in treatment 1, plus free transportation (using a taxicab voucher system) for prenatal and well-child care through the child's second birthday. There were no differences between participants in treatments 1 and 2 in their use of prenatal and well-child care (both groups had high rates of completed appointments). Therefore, these 2 groups were combined to form a single comparison group as in earlier reports. Families randomized to treatment 3 (n=100) were provided the screening and transportation services offered those in treatment 2 in addition to being provided a nurse who visited them at home during pregnancy. Families randomized to treatment 4 (n=116) were provided the same services as those in treatment 3, except that the nurse continued to visit through the child's second birthday.

Randomization

Women were stratified by marital status, race, and 7 geographic regions within the county (based on census tract boundaries). At the end of the intake interview, women drew their treatment assignments from a deck of cards and placed them in a sealed envelope. The cards were transferred to a research associate who managed the randomization. The stratification was executed by using separate decks of cards for the groups defined by the women's race, marital status at intake, and, for white women, the geographic region in which they resided. To ensure reasonably balanced subclasses, the decks were reconstituted periodically to overrepresent those treatment groups with smaller numbers of subjects, a procedure similar to the Efron biased coin designs.[13] Women in treatments 3 and 4 subsequently were assigned on a rotating basis, within their stratification blocks, to 1 of 5 nurse home visitors.

There were 2 deviations from this randomization procedure. First, 6 women who were enrolled were living in the same household as were other women who were already participating in the study. To avoid potential horizontal diffusion of the treatment in case of different assignments within households, the 6 new enrollees were assigned to the same treatment as their housemates. Second, during the last 6 months of the 30-month enrollment period, the number of cards representing treatment 4 was increased in each of the decks to enlarge the size of that group and to enhance the statistical power of the design to compare the infancy home-visitation program with treatments 1 and 2 on infant health and developmental outcomes. A thorough analysis conducted at earlier phases of the trial indicated that this slight confounding of treatments with time did not affect the treatment effects.

Program Plan and Implementation

The experimental home-visitation program was administered by Comprehensive Interdisciplinary Developmental Services, Inc, of Elmira. In the home visits, the nurses promoted 3 aspects of maternal functioning: (1) health-related behaviors during pregnancy and the early years of the child's life; (2) the care parents provided to their children; and (3) maternal personal life-course development (family planning, educational achievement, and participation in the workforce). In the service of these 3 goals, the nurses linked families with needed health and human services and attempted to involve other family members and friends in the pregnancy, birth, and early care of the child. The program was based on theories of self-efficacy, human ecology, and human attachment.[14] The nurses used detailed assessments, record-keeping forms, and protocols to guide their work with families, but adapted the content of their home visits to the individual needs of each family. They provided a comprehensive educational program designed to promote parents' and other family mem-

bers' effective physical and emotional care of their children. The nurses also helped women clarify their goals and develop problem-solving skills to enable them to cope with the challenges of completing their education, finding work, and planning future pregnancies. Developing a close working relationship with the mother and her family, the nurses helped mothers identify small achievable objectives that could be accomplished between visits that, if met, would build mothers' confidence and motivation to manage the demands of caregiving and become economically self-sufficient. The nurses completed an average of 9 (range, 0-16) visits during the pregnancy and 23 (range, 0-59) visits from the child's birth to second birthday. Details of the program can be found elsewhere.[14,15]

Overview of Follow-up Study

The present phase of the study consists of a longitudinal follow-up of those 400 families who were randomized to treatment and comparison conditions and in which the mother and child were still alive and the family had not refused participation in earlier phases. The flow of patients from recruitment through the 15-year follow-up is presented in Table 1. As this table indicates, we completed assessments at 15 years on 81% of participants originally randomized and on 90% of women for whom there was no miscarriage, stillbirth, death (infant, child, or maternal), or child adoption. There were no treatment differences in the rates of completed assessments at the 15-year follow-up. Table 1 also shows that reviews of children's Child Protective Service (CPS) records were completed for an average of 13.4 years for those cases on which 15-year interviews were conducted with the mother. There were no treatment differences in the number of years for which we had CPS data.

Statistical Power

Sample size and power were determined by the original design and subsequent attrition of subjects. Power calculations are given here for 3 key outcomes (number of months receiving AFDC, subsequent births, and verified reports of child abuse or neglect) with the assumption of $\alpha = .05$ and $\beta = .20$ (2-tailed tests); sample sizes as realized in the present study; and means and SDs obtained from the comparison subjects in the present study. The calculations were performed for the contrast of women in the comparison condition (treatment 1 + treatment 2) vs those in the nurse-visited-during-pregnancy-and-infancy condition (treatment 4)—for both the total sample and for the unmarried, low-SES subsample.

Table 1.—Profile of the Trial: Flow of Patients From Recruitment During Pregnancy Until 15 Years After Birth of First Child*

	Treatments 1 and 2 (n=184)	Treatment 3 (n=100)	Treatment 4 (n=116)
Program implementation			
Completed prenatal home visits, mean (range)	...	8.6 (0-16)	8.6 (0-16)
Completed postnatal home visits, mean (range)	...	...	22.8 (0-59)
Intervening years			
Fetal, infant, or child death	10	7	9
Child adopted†	7	6	2
Maternal death‡	1	1	0
15-y follow-up study			
Missing (mothers)	12	1	4
Refused to participate§			
Mothers	6	5	4
Adolescents	10	8	7
Completed assessments			
Mothers	148	79	97
Adolescents	144	77	94
Cases with CPS data‖	142	77	95
Years of complete CPS data, mean (SD) [range]	13.4 (3.2) [2.6-15.0]	13.3 (3.1) [2.9-15.0]	13.4 (3.1) [0.7-15.0]

*Of 500 eligible patients, 100 refused participation. The 400 participants were randomized to treatment conditions: treatments 1 and 2 were combined to form a comparison group; treatment 3, nurse visitation during pregnancy; and treatment 4, nurse visitation during pregnancy and infancy. Data are given as number, unless otherwise indicated.

†There were 2 adoptions in which interviews were conducted with the child but not the mother. They are not shown in this table.

‡For both cases in which the mother died, the adolescents were interviewed.

§Refusals include 8 mothers who refused to participate during earlier phases and were not approached for the 15-year follow-up.

‖Child Protective Service (CPS) data were used to determine the number of state-verified reports of child abuse and neglect.

For the number of months receiving AFDC, a normal variable, we can detect a mean difference of 19 months in the total sample and 30 months in the higher-risk sample. For the number of subsequent births, also a normal variable, we can detect differences of 0.36 and 0.57 in the total and high-risk samples, respectively.

For the count of number of verified reports of abuse and neglect, the smallest detectable differences are 0.21 and 0.33, respectively. The actual analyses in this report use more fully specified models than those used for the power calculations, and thus have greater power.

Masking

The mothers were informed that they were being interviewed as part of a follow-up to their participation in a study in which they originally enrolled when they were pregnant with their first child. All data were gathered by staff members who had no access to the families' treatment assignments, except in a few cases in which the mothers inadvertently revealed that they were visited by a nurse. Staff members who gathered data were told that the 15-year follow-up study was designed to assess the long-range effects of prenatal and early childhood services, including home visitation by nurses. The principal investigators and statisticians had access to the families' treatment assignments, although the operationalization of variables was made explicitly without reference to this information.

Assessments and Definitions of Variables

Assessments conducted at earlier phases are specified in previous publications.[5,6,8] Intake interviews, which were conducted with women before randomization, included assessments of women's sociodemographic and personality characteristics (including a short-form measure of the locus of control scale of Rotter[16]), health-related behaviors, and health conditions. Women's household SES was estimated by using the Hollingshead 4-factor method[12]; families were classified into low SES (III and IV) and higher SES (I and II) levels.

At the 15th-year interview, mothers completed a life-history calendar that was designed to help them recall major life events (such as births of additional children, marriages, employment, household moves, and housing arrangements). Women were asked to estimate the number of months that they used AFDC, Medicaid, and food stamps, as well as the number of times that they were arrested or convicted from the time of the birth of their first child to the child's 15th birthday.

Women also were asked a series of questions adapted from the National Comorbidity Survey[17] regarding the impact of alcohol and other drug use on major aspects of their lives since the birth of their child. A variable was constructed

hat summarized a count of 6 domains of men's lives that were affected by their use of alcohol (missing work, experiencing trouble at work, having a motor vehicle crash or traffic violation, having compromised care of their children, having received treatment). The same set of questions was repeated for their use of illegal and prescription drugs. The counts of domains affected by their use of alcohol and other drugs were summarized to create a "substance use behavioral impairment" scale with values ranging from 0 to 12.

Mothers provided consent for the research staff to review CPS records from states in which they resided during the interval from the birth of their first child (focal child) to that child's 15th birthday. All reports involving either the mother or the focal child were recorded.

Substantiated reports were abstracted to ascertain key features of the maltreatment incident. All NYS records were searched, as well as those of most other states in which families resided during the 15-year period. In some states, data were not available for the entire 15-year period because these states expunge their records on a periodic basis. A few other states prohibit the release of case-level information. Six states had fewer than 4 years of CPS data. Although none was indicated for abuse or neglect, they are retained as valid cases for this analysis. As shown in Table 1, our search covered an average of more than 13 years of the 15-year period in each treatment group, and there were no treatment differences in the amount of time searched, either for the sample as a whole or for the low-SES, unmarried subgroups. The primary outcome variable reported herein is the total number of substantiated reports during the entire 15-year period involving the mother as perpetrator.

Mothers' records of arrests and criminal convictions were abstracted from the NYS Division of Criminal Justice Services, after the principal investigator (D.O.) signed a nondisclosure agreement. Controls were matched based on the women's names, birth dates, ethnicity, and Social Security numbers. Data on the number of arrests and convictions and types of offenses were abstracted from this database. Arrests were separated by whether they occurred before randomization or between the child's birth and 15th birthday. (No arrests occurred between randomization and the child's birth.)

Statistical Models and Methods

The study was conducted with an intent-to-treat approach. After examination of a large number of classification factors and covariates, a core statistical model was derived that was consistent with the one used in the earlier phases of this research. It consisted of a 3×2×2 factorial structure and 6 covariates. The classification factors were treatments (1 and 2 vs 3 vs 4), maternal marital status (married vs unmarried, at registration), and social class (Hollingshead I and II vs III and IV, at registration). All interactions among these factors were included. The basic conclusions reported herein were not modified by or limited to one race, and race was not included in final models.

The 6 covariates included in the final model were maternal age, education, locus of control, husband or boyfriend support, mother's employment status, and father's public-assistance status, all measured at registration. These covariates had consistently significant relationships with many of the outcomes examined in this report. All covariates were tested for homogeneity of regressions for the hypothesized contrasts.[18]

Dependent variables for which a normal distribution was assumed were analyzed in the general linear model and low-frequency count data (eg, number of substantiated reports of child maltreatment) in the log-linear model (assuming a Poisson distribution). In the log-linear model, the analysis was performed and estimates obtained in terms of the logs of the incidence. We use the term *incidence* in referring to the actual count or mean of counts over specific periods of measurement.

The distributions of each of the dependent variables were carefully examined, and cases with outlying values (above 20) were truncated to 20 to reduce the likelihood that the differences observed were the result of a few extreme values. This was done for 1 outcome variable, number of days jailed.

All treatment contrasts focused on the comparison of the combination of treatments 1 and 2 (the comparison group) with treatment 4 (the pregnancy and infancy nurse-visited group), because we hypothesized that the greatest treatment effect would be exerted by the combination of prenatal and postnatal home visitation, as found in earlier evaluations.[8,9] We also show treatment effects for the group defined by women's being unmarried and from low-SES households at registration during pregnancy; this constitutes our operationalization of women's experiencing higher levels of chronic stress (being from a low-SES household) and having few personal resources to manage stress (being unmarried).

RESULTS

We conducted detailed examinations of 17 background variables to determine the extent to which the treatment groups were equivalent for families on which 15-year assessments were completed. As indicated in Table 2, the treatment groups were equivalent both for the sample as a whole and for women who were unmarried and from low-SES households at registration.

Rates of Subsequent Births and Use of Welfare

As indicated in Table 3, in contrast to their counterparts in the comparison group, nurse-visited unmarried women from low-SES households had fewer subsequent pregnancies ($P=.03$) and live births ($P=.02$) and greater spacing between first and second births ($P=.001$). In addition, they reported using AFDC and food stamps fewer months than did unmarried, low-SES women in the comparison group ($P=.005$ and $P=.001$, respectively).

Substance Abuse, Criminal Justice Encounters, and Child Abuse and Neglect

Table 4 shows that nurse-visited, low-SES, unmarried women reported being impaired in fewer domains by alcohol or other drug use, having been arrested fewer times, having been convicted fewer times, and having spent fewer days in jail ($P=.005$, $P<.001$, $P=.008$, and $P<.001$, respectively) since the birth of their first child than did low-SES unmarried women in the comparison group. Data from NYS showed that nurse-visited, low-SES, unmarried women had fewer actual arrests ($P<.001$) and fewer convictions ($P<.001$).

New York State arrests were classified into 3 categories: property crimes (eg, theft), person crimes (assault, robbery), and other (eg, vice, major traffic offenses). Overall, 67% of the crimes were for property offenses, 14% were for person crimes, and 19% were for other offenses. The treatment differences for low-SES, unmarried women were present for arrests for property offenses (0.12 vs 0.60; $P<.001$), but not at conventional levels of statistical significance for person offenses (0.02 vs 0.13; $P=.10$), and other offenses (0.02 vs 0.17; $P=.12$) (data not shown).

Table 4 also shows that in contrast to women in the comparison group, those visited during pregnancy and the first 2 years of the child's life were identified as perpetrators of child abuse and neglect in fewer verified reports during the 15-year interval ($P<.001$). This effect was greater for women who were unmarried and from low-SES households at registration ($P<.001$). The effect of the program on number of verified reports was especially strong for the 4- to 15-year period after the birth of the child—ie,

Table 2.—Equivalence of Treatment Conditions on Background Characteristics Measured at Registration for Women Assessed at 15-Year Follow-up*

Dependent Variables	Whole Sample			Low-SES Unmarried Sample		
	Treatments 1 and 2 (n=148)	Treatment 3 (n=79)	Treatment 4 (n=97)	Treatments 1 and 2 (n=62)	Treatment 3 (n=30)	Treatment 4 (n=38)
Unmarried, %	62	59	64	...	...	...
Low-SES household, %	64	70	61	...	...	...
White, %	90	91	86	87	87	77
Smoker (>4 cigarettes/d), %	47	46	58	51	60	59
Male child, %	55	44	55	44	53	49
Mother working, %	39	36	31	24	20	20
Mother receiving public assistance, %	9	10	13	23	29	20
Father working, %	70	70	87	42	50	52
Father receiving public assistance, %	4	3	3	10	6	2
Husband or boyfriend in house, %	58	76	60	21	47	22
Maternal age, mean (SD), y	19.3 (2.9)	19.5 (3.1)	19.4 (3.7)	18.6 (2.5)	19.0 (2.8)	18.2 (3.3)
Maternal education, mean (SD), y	11.2 (1.5)	11.6 (1.5)	11.1 (1.6)	10.7 (1.4)	10.9 (1.4)	10.3 (1.5)
Husband or boyfriend education, mean (SD), y	11.4 (1.4)	11.7 (1.7)	11.5 (1.6)	11.1 (1.4)	11.0 (1.8)	10.8 (1.5)
Grandmother support†‡	100.4 (10.1)	97.7 (9.2)	101.3 (10.3)	101.6 (10.9)	98.1 (10.3)	104.1 (11.2)
Husband or boyfriend support†‡	99.6 (10.5)	102.0 (9.0)	99.0 (9.9)	94.2 (10.6)	98.6 (9.4)	96.8 (9.3)
Locus of control†	99.3 (10.1)	100.6 (9.5)	100.6 (10.2)	97.5 (10.2)	99.2 (10.3)	99.1 (9.9)
Incidence of maternal arrests in New York State prior to randomization§	0.09 (-2.50)	0.13 (-5.41)	0.06 (-8.98)	0.13 (-2.03)	0.13 (-2.02)	0.18 (-1.71)

*See first footnote to Table 1 for explanation of treatment groups. SES indicates socioeconomic status.
†Standardized to mean=100 and (SD)=10.
‡Locally developed scale that assesses degree to which individual provides emotional and material support to mother.
§Incidence (log incidence) represents the mean number of infrequently occurring events within stated period. Individual cases may have values greater than 1, although the range is small.

Table 3.—Adjusted Maternal Life-Course Outcomes From Birth of First Child to 15 Years*

Dependent Variables	Whole Sample				Low-SES Unmarried Sample			
	Mean No.				Mean No.			
	Treatments 1 and 2	Treatment 3	Treatment 4	Estimate† (95% CI), Treatments 1 and 2 vs Treatment 4	Treatments 1 and 2	Treatment 3	Treatment 4	Estimate† (95% CI), Treatments 1 and 2 vs Treatment 4
Subsequent pregnancies	2.1	1.9	1.7	0.4 (-0.1 to 0.8)	2.2	2.0	1.5	0.7‡ (0.1 to 1.3)
Subsequent births	1.6	1.4	1.3	0.3 (-0.0 to 0.6)	1.6	1.4	1.1	0.5‡ (0.1 to 1.0)
Months between birth of first and second child	37.3	39.8	41.7	-4.4 (-14.9 to 6.1)	37.3	46.6	64.8	-27.5§ (-44.1 to -10.9)
Months receiving AFDC	65.9	70.2	52.8	13.1 (-0.9 to 27.0)	90.3	81.8	60.4	29.9§ (9.0 to 50.7)
Months employed	89.7	87.5	96.4	-6.7 (-20.4 to 7.0)	80.0	74.9	95.9	-15.9 (-36.6 to 4.6)
Months receiving food stamps	56.4	62.0	47.9	8.5 (-6.3 to 23.3)	83.5	84.0	46.7	36.8§ (14.6 to 59.0)
Months receiving Medicaid	70.0	71.1	61.8	8.2 (-7.6 to 24.0)	95.4	92.4	72.3	23.1 (-0.6 to 46.8)

*Adjusted for socioeconomic status (SES), marital status, maternal age, education, locus of control, support from husband or boyfriend, working status, and husband or boyfriend use of public assistance at registration. See first footnote to Table 1 for explanation of treatment groups. AFDC indicates Aid to Families With Dependent Children; CI, confidence interval.
†Estimate = (treatments 1 and 2 mean) – (treatment 4 mean).
‡$P<.05$.
§$P<.01$.

the period not assessed in previous reports (data not shown).

COMMENT

In contrast to women in the comparison group, those visited by nurses during pregnancy and the first 2 years after the birth of their first child were identified as perpetrators of child abuse and neglect in fewer verified reports. Among women who were unmarried and from low-SES households at registration, those who were visited by nurses during pregnancy and infancy had fewer subsequent children, months receiving AFDC and food stamps, behavioral impairments from use of alcohol and other drugs, arrests, convictions, and number of days jailed during the 15-year period after birth of their first child. For most outcomes, the group that was visited only during pregnancy exhibited levels of functioning that fell in between the comparison group and the group that was visited during pregnancy and infancy, indicating a dose-response relationship for level of home visitation.

These findings have some limitations. First, most of the positive results were concentrated among mothers who were unmarried and from low-SES households at registration during pregnancy. While we hypothesized originally that the effects would be greater for women who experienced higher levels of stress and who had fewer personal resources, we did not fully operationalize the stress and resource variables prior to the beginning of the trial. We chose to employ characteristics used for sample recruitment as indicators of chronic stress (coming from a low-SES household) and having few personal resources (being unmarried). The marital status and poverty variables chosen to reflect the personal resource and stress constructs, however, are both well-established risk factors for several adverse outcomes. The concentration of program effects in women who are unmarried and

'e 4.—Adjusted Rates of Maternal Substance Abuse, Arrests, Convictions, and Child Abuse and Neglect Reports From Birth of First Child to 15 Years*

Dependent Variables	Whole Sample				Low-SES Unmarried Sample			
	Incidence (Log Incidence)†				Incidence (Log Incidence)†			
	Treatments 1 and 2	Treatment 3	Treatment 4	Estimate‡ (95% CI), Treatments 1 and 2 vs Treatment 4	Treatments 1 and 2	Treatment 3	Treatment 4	Estimate‡ (95% CI), Treatments 1 and 2 vs Treatment 4
Substance use impairments§	0.43 (−1.09)	0.45 (−0.82)	0.34 (−1.33)	0.24 (−0.39 to 0.87)	0.73 (−0.31)	0.61 (−0.49)	0.41 (−0.89)	0.58‖ (0.04 to 1.11)
Ar	0.22 (−2.02)	0.16 (−2.17)	0.09 (−5.21)	3.19 (−99.66 to 106.04)	0.58 (−0.55)	0.36 (−1.01)	0.18 (−1.74)	1.19‖ (0.49 to 1.89)
Convictions	0.13 (−2.29)	0.05 (−9.48)	0.03 (−9.62)	7.33 (−408.24 to 422.91)	0.28 (−1.28)	0.11 (−2.22)	0.06 (−2.74)	1.46‖ (0.38 to 2.54)
Days in jail	0.65 (−4.36)	0.13 (−9.20)	0.01 (−13.36)	9.00 (−481.52 to 499.53)	1.11 (0.10)	0.47 (−0.76)	0.04 (−3.22)	3.32‖ (2.16 to 4.48)
NYS arrests	0.38 (−1.57)	0.34 (−1.12)	0.12 (−5.03)	3.46 (−105.59 to 112.50)	0.90 (−0.11)	0.39 (−0.95)	0.16 (−1.85)	1.74‖ (0.94 to 2.54)
NYS convictions	0.27 (−4.92)	0.28 (−1.32)	0.12 (−5.30)	0.38 (−226.81 to 227.57)	0.69 (−0.37)	0.29 (−1.25)	0.13 (−2.02)	1.65‖ (0.79 to 2.52)
Substantiated reports of child abuse and neglect	0.54 (−0.63)	0.35 (−1.26)	0.29 (−1.40)	0.77‖ (0.34 to 1.19)	0.53 (−0.64)	0.63 (−0.47)	0.11 (−2.25)	1.61‖ (0.87 to 2.35)

*Adjusted for socioeconomic status (SES), marital status, maternal age, education, locus of control, support from husband or boyfriend, working status, and husband or boyfriend use of public assistance at registration. See first footnote to Table 1 for explanation of treatment groups. NYS indicates New York State; CI, confidence interval.
†Incidence represents the mean number of infrequently occurring events within stated period. Individual cases may have values greater than 1, although the range is small.
‡Estimate = (treatments 1 and 2 log incidence) − (treatment 4 log incidence).
§Scale summarizes the counts of behavioral impairments (eg, missing work, motor vehicle crash) reported by women resulting from their use of alcohol and illegal drugs.
‖$P<.01$.

of lower SES suggests that they need these services and benefit from them to a greater extent than do those who are married and of higher SES. Consequently, such services should be made available to communities with high concentrations of low-income, unmarried women.

The second limitation is that several of the outcomes were based on self-report, 'hich may be subject to treatment-related reporting bias. The data on maternal use of AFDC and food stamps, for example, were based on self-reports and covered up to 15-year time periods. We attempted to validate maternal report of welfare use by reviewing state and county records but found that they often were incomplete. Fortunately, we were able to obtain archived data from independent sources on other critical outcomes.

The child abuse and neglect findings, for example, were based on state archived data, which makes them less susceptible to reporting bias. Although we were unable to achieve complete reviews of these archived records for all families, they are substantially complete, and there is no indication that missing data resulted in any b in favor of the nurse-visited groups. It should be noted, moreover, that the effects of the program overrode a tendency for nurse-visited families to be identified for maltreatment at lower thresholds of caregiving dysfunction than were families in the comparison group during the first 4 years of the child's life—a form of detection bias that worked against the hypothesis of program efficacy.[7]

Although it would have been preferable to have criminal records to corrobo-'e the mothers' reports of all arrests and onvictions, the analysis of their arrests and convictions archived in NYS produced a pattern of treatment effects that was even stronger than was found with maternal report. Thus, in spite of the knowledge nurse-visited women had of the purpose of this study, they were at least as accurate in reporting this undesirable behavior as were women in the comparison group.

Finally, one may reasonably question the extent to which the findings of this study may be generalized to a wider range of low-SES, unmarried women today. This question led to a recently completed replication of this trial in Memphis, Tenn, with a sample of predominantly low-income, unmarried African-American mothers and their families.[19] The findings of the replication are congruent with the Elmira trial for the 2-year period after birth of the first child and indicate that the benefits of the program, at least through the first child's second birthday, are not limited by time, geography, or the sociodemographic characteristics of the families served. We believe that the results of these 2 trials now provide sufficient evidence to form a rationale for preliminary stages of program dissemination.

One of the most fundamental considerations in planning program dissemination is cost. As indicated in a forthcoming report, the reduction in family size, use of welfare, incidence of child abuse and neglect, and maternal criminality 15 years after the birth of the first child found for this program will lead to substantial savings to government in several domains of spending.[20] In considering the cost of the program (estimated to be $3300 in 1980 dollars and $6700 in 1997 dollars for 2½ years of service), it is important to note that the investment in the service, from the standpoint of government spending, was recovered for low-SES families before the child reached 4 years of age.[9] It would take longer for the investment to be recovered today because costs for such a program have increased more rapidly than costs of welfare benefits.

It is also important to note that the effects reported herein were produced in the context of a controlled experiment, in which the program was conducted with high levels of fidelity to the underlying theoretical and clinical model.[14] The next challenge is to determine the extent to which this program can be replicated.[21] A modest dissemination effort is currently being conducted under the auspices of the US Departments of Justice and Health and Human Services that will shed light on community and organizational factors that contribute to or undermine fidelity of program implementation in new program sites.

Finally, it should be emphasized that although many different kinds of home-visitation programs have been promoted, it is incorrect to assume that our results can be applied to home-visitation programs that are not based on this model. While some other types of home-visitation programs have shown some promise,[22,23] most have failed.[3] At least 2 well-designed trials of other home-visitation programs are under way that should give us a better understanding of the range of program characteristics that can affect important aspects of maternal, child, and family functioning.[24,25] In the meantime, as health and social welfare policy is redesigned in the near future, we believe that it makes sense to begin with programs that have been tested, replicated, and found to work.

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Nurses' Visits Held Benefits For Children Of the Poor

WASHINGTON, Aug. 26 (AP) — After 15 years, a group of low-income single mothers who had received home visits from nurses during pregnancy and while their children were young was found to have had fewer arrests, less child abuse and less reliance on welfare, two new studies show.

The report gives new hope to those who work with teen-age mothers. Compared with poor unmarried mothers over all, the women in the study had 69 percent fewer arrests, 46 percent fewer reports of child abuse or neglect, 44 percent fewer behavioral problems linked to drug or alcohol abuse and used 30 months less of Aid to Families With Dependent Children.

The follow-up study looked at 324 women and their firstborn children in predominantly white Elmira, N.Y., who had participated in the Prenatal/Early Infancy Project begun there by two researchers in 1977. The new study showed "that the nurse home-visit program has enduring and positive effects," said John Eckenrode, a professor of human development at Cornell University and a co-author of the study.

The Elmira home-visit program spent about $7,000 over two and a half years for each mother. The visiting nurses discussed nutrition, prenatal care and child development, among other issues, with the mothers.

"We knew from earlier studies of the project that the home visits resulted in fewer and less closely spaced pregnancies, fewer cases of child abuse and neglect and fewer emergency room visits," Mr. Eckenrode said.

A companion study of black women in Memphis indicated similar results in preliminary findings. That study, to be published on Wednesday in The Journal of the American Medical Association, was led by David Olds, a pediatrics professor at the University of Colorado Health Sciences Center who worked on the original Elmira project.

In 1990, the program began recruiting young, poor, unmarried pregnant women in Memphis. Nurses visiting the women focused on prenatal health, parenting skills, birth control, education and job skills.

By the time the children were 2 years old, the study found similar effects: children were less likely to be injured or hospitalized and mothers were less likely to have pregnancy-induced high blood pressure.

"It's among the most encouraging evidence we have," said Rebecca Maynard of the University of Pennsylvania, who studies programs for teen-age mothers.

Other home-visit programs have not produced such positive results, and researchers are unsure what makes these programs different.

One factor may be the use of the nurses to offer medical, child-rearing and other skills and advice to poor young women who are pregnant for the first time.

But a companion editorial to Mr. Olds's research questions whether the program's results could be duplicated on a broad scale.

"Will the program still work if it is a large-scale social program run by public agencies, rather than a locally controlled experiment run by scientists who were heavily invested in their theoretical model?" wrote Terrie E. Moffitt of the Institute of Psychiatry in London. Still, Mr. Moffitt called the results "impressive."

The Federal Government is studying the effectiveness of a visiting program that did not use nurses in Chicago, Portland, Ore., and Dayton, Ohio.

To make a real dent in the lives of poor Americans, Ms. Maynard said, the program would have to be disseminated widely. About 400,000 teen-agers give birth for the first time each year.

"All of those teens basically are at very high risk," she said.

February 9, 1998

Zero to Three 20th Anniversary Gala

DATE:	**Feb 10, 1998**
TIME:	**7:45 pm**
LOCATION:	**Terrace Theater Kennedy Center**
FROM:	**Michael O'Mary**

I. PURPOSE

To attend Zero to Three's 20th Anniversary Gala and to read "Goodnight Moon."

II. BACKGROUND

Zero to Three is one of the premier resources on development in the first three years of human life. Established by leaders in a variety of disciplines, this not-for-profit organization is committed to study, understand, and promote the importance of the crucial early years of human life.

Tuesday's Gala celebrates 20 years of Zero to Three's work to improve the lives of America's babies, toddlers, their families and those who serve them. As you may recall, one of the founders of this organization was Dr. Sally Provence, whom you studied under at Yale.

Your role at the Gala will be to read "Goodnight, Moon" and to offer brief remarks about the administration's commitment to early childhood development. Following the performance, you will attend a meet and greet backstage at which you will have your picture taken with the co-chairs, the sponsors, the Board of Directors, and members of the Zero to Three organization. A list of participants is attached.

At last year's brain conference, you launched the Zero to Three national poll. The results of this poll are attached.

Senators Kennedy, Kerry, Dodd, and Jeffords will be present to receive an award in "recognition of enduring commitment and outstanding legislative achievements on behalf of infants, toddlers and their families." Senator Hatch will also be honored, but will not be attending.

Other celebrities and VIPs will have various roles throughout the evening. A list of performances and performers is attached. Secretary Shalala is the only Cabinet Member attending.

You will be seated next to Michael and Carol Berman in theater style seating.

The Executive Director of Zero to Three, Matthew Melmed is scheduled to be a participant in the roundtable discussion you will attend during the afternoon of 2/10.

III. PARTICIPANTS

-The First Lady
-Approx. 400 invited guests.

IV. SEQUENCE OF EVENTS

- The First Lady arrives Kennedy Center and is seated.
- Kenny Loggins performs TBD.
- Ron Silver introduces Jacques d'Amboise.
- Jacques d'Amboise performs a children's workshop segment.
- Ron Silver introduces the First Lady.
- The First Lady reads "Goodnight Moon".
- Ron Silver introduces "The Princess and them Pea-ano" and Award Recipients.
- Upon conclusion of the "The Princess and the Pea-ano", Ron Silver introduces Ann Reinking.
- Ann Reinking performs "Me and My Baby".
- Kenny Loggins sings "Return to Pooh Corner".
- Upon conclusion of the song, the First Lady proceeds to Room TBD for Meet and Greet
- The First Lady departs

V. PRESS

Open press.

VI. REMARKS

Talking Points provided by Christy Macy.

FIRST LADY HILLARY RODHAM CLINTON
REMARKS AT CHILD VISITATION ROUNDTABLE
ALEXANDRIA, VIRGINIA
TUESDAY, FEBRUARY 10, 1998

- Acknowledgments and welcome. I've just visited Felicia Pearson and her 3-month old son Dominico, and took part in the home visit with her Family Support Worker, Lynn Kasonovich, and Sally Campbell, the program director. Appreciation to all who helped arrange this special day, including the Northern Virginia Family Services and those involved in the Healthy Families effort.

- We are all here today because we know our most important responsibility -- as individuals, as communities, and as a nation -- is the care and nurturing of our children. Today, we are putting the spotlight on the critical role that home visiting programs play in carrying out that mission.

- I'd like to begin by introducing today's panelists -- all of whom have been vital voices in promoting the importance of home visits and their benefits for families and children.

  Dr. Matthew Melmed, Executive Director, the Zero-to-Three National Center for Infants and Toddlers;
  Dr. David Olds, Director, the Prevention Research Center for Families and Child Health and Lead Researcher for the Elmira Home Visitation Study;
  Ms. Betsy Dew, Director and Senior Training Specialist, the Family Institute of Hawaii Family Support Center and a Founder of the Hawaii Healthy Start Program;
  Mr. Leland Bresland, CEO, Freddie Mac Corporation;
  Ms. Valator Gilliespie-Ballah, Family Support Worker for Healthy Families Alexandria;
  Brandi Church, Antoine Watson, Jane Rutherford, parents served by the Healthy Families program.

- Community-based home visitation programs like the one I saw today not only help strengthen families but also help promote children's ability to grow and learn during their earliest and most vulnerable years. These programs help give parents the tools they need to succeed in the most important job they have: raising their children.

- I'm delighted that Dr. Olds is here to share with us the exciting results of an Elmira, New York study of low income, single women who participated in a home visitation program. Among its findings: dramatic reductions in reports of child abuse and neglect; fewer subsequent live births; fewer mothers on welfare; and fewer child behavioral problems.

- I first saw the benefits of home visits first hand when I visited Hawaii in 1993, and learned about Hawaii's Healthy Start program of intensive home visiting services. And I've been watching with great interest as Healthy Families America has taken that model and promoted similar programs -- like this one in Alexandria -- in hundreds of communities across America.

- Here in Alexandria, a July 1997 independent evaluation of the Healthy Families program showed similarly promising results over the past 3 years: Among them: 92% of infants born at healthy birth weight; 98% of infants had a primary health care provider within 2 months of birth; 93% of infants received immunizations; 96% of infants showed no developmental delays.

- The President is committed to helping families get the support they need, so that every child's earliest experiences and interactions are positive ones -- ones that will help them to learn and grow and connect with others over an entire lifetime. That's why he has proposed a dramatic increase in our investment in activities that promote early learning and improve the quality of child care in America.

- Central to the President's child care initiative (the largest investment in child care in our nation's history) is the establishment of an Early Learning Fund to provide challenge grants to communities for programs that promote early learning -- as well as improve the quality and safety of child care for children aged five or under. The President has proposed an investment of $3 billion over the next five years for this new effort -- which will support home visiting as well as other activities such as parent education and efforts to improve child care safety and quality, including basic training for child care providers.

- New scientific research now proves what we've known instinctively all along -- that those first interactions with a child -- particularly in the first three years of life -- have a dramatic impact on brain development and learning. To highlight these findings, the President and I hosted the White House Conference on Early Children Development and Learning in April 1997. Later that year, we held a White House Conference on Child Care, to examine the implications of this new research for child care. I believe that home visitation programs can enhance these efforts to ensure children get the care and attention they need to succeed.

- Before I introduce our first panelist, I want to underscore how important it is that all of us in the public and private and non profit sectors work together as partners to promote and expand home visitation and early learning programs. There's no mystery here. We know what works. We know what children need to thrive and grow and learn. We know what parents need to succeed. And we know the terrible consequences when we fail to meet those needs. Let's continue to learn from the effective programs that already exist. But more important, let's work together to replicate these efforts in every community in America.

- And now, I'd like to begin our discussion by turning to our first three speakers. Dr. Matthew Melmed, Executive Director of the Zero-to-Three National Center for Infants and Toddlers, will talk to us about why the early years of life are so important, and describe home visitation visits generally. Then we'll hear from Dr. David Olds, who will tell us about the exciting findings of the Elmira study on the benefits of home visits for parents and children. We will then hear from Betsy Dew, who helped found Hawaii's Healthy Start Program, and has worked with Healthy Families America to spread these model efforts to over three hundred communities across the nation.

Kathy Kell
Time Life

Debbie Brown Anderson
Northern Virginia Urban League

Lynne Ball
Executive Director
Winkler Foundation

Ron Carlee
Director
Department of Human Services
Arlington County

Betty Connal
Perinatal Outreach Services
Inova Fairfax Hospital System

Dona Dei
Director, Program Services
March of Dimes

The Honorable Kerry Donley
Mayor of Alexandria

Dr. Susan Allen
Director of Public Health
Arlington County

Bill Euile
Council Member
Alexandria City Council

Carol Farrell
Director, Office of
Early Childhood Development
Alexandria DHS

Jared Florance, MD
Director
Prince William Health District

Rosalyn Foroobar
Assistant Director of Nursing

Marilyn Gould
Mobil Oil

Pat Graham
Board President
Northern Virginia Family Service

Ellen Grunewald
Assistant Director of Social Services
Loudoun

Katherine Hanley
Chairman
Fairfax City Board of Supervisors

Verdia Haywood
Deputy County Executive for Human Services
Fairfax County

Catherine Winkler Herman
The Mark Winkler Corporation

Joshua Lipsman, MD
Director
Alexandria Health Department

Larry Mcandrews
President & Ceo
National Association of Children's Hospitals

Steve Meyerson
Vice-president
Community Affairs and Government Relations
Inova Alexandria Hospital

Lynda Eubank
Director of Social Services
Arlington County

Meg O'Regan
Director
Department of Human Services
Alexandria

Renette Oklewicz
Manager, Community Relations
Freddie Mac Foundation

Del Pepper
Council Member
Alexandria City Council

Mary Phelps
Program Manager, Prevention Services
Department of Family Services
Fairfax County

Johanna Schuchert
Director
Healthy Families Virginia

Joanna Siegel
Program Officer and Director of Evaluation
Arlington Health Foundation

David Smith
National Field Director
I Am Your Child Campaign

Judith Southard
Director of Public Health Nursing
Alexandria Health Department

Maxine Baker Stokes
Executive Director
Freddie Mac Foundation

Cindy Suarez
Child Protective Services
Prince William County

Tori Thomas
Chairman
The Mark Winkler Co.

Lynn Vlad
Program Director
MotherNet America

Lois Walker
Council Member
Alexandria City Council

Chris Zimmerman
Chair, Arlington County Board
Arlington County

FIRST LADY HILLARY RODHAM CLINTON SPOTLIGHTS HOME VISITATION

February 10, 1998

I believe the President's [child care] proposal will help us all move together in fulfilling our most important responsibility as individuals or as a nation -- the care and nurturing of our children.

First Lady Hillary Rodham Clinton
Announcement of Child Care Initiative, 1/7/98

Today, the First Lady visits Alexandria, Virginia to spotlight the importance of home visiting programs to strengthening families and promoting healthy development in children's earliest years of life. As a part of his ambitious child care initiative, President Clinton has proposed the creation of an Early Learning Fund to foster early childhood development through a variety of family support services, including home visiting. Through a discussion with parents, home visitors, and experts, the First Lady will highlight the importance of investing in community-based early learning efforts to promote healthy child development.

EARLY LEARNING IS CENTRAL TO THE PRESIDENT'S CHILD CARE INITIATIVE. Because children's experiences in the earliest years of life are central to their healthy development, the President has proposed that we dramatically increase our investment in activities that promote early learning and improve the quality of child care in our country. A major element of the President's child care proposal is the Early Learning Fund, which will provide challenge grants to communities for programs that promote early learning and improve the quality and safety of child care for children aged five or under. The President has proposed an investment of $3 billion over five years for this new effort. The Early Learning Fund will improve the quality and safety of child care and ensure that children reach school ready to learn, by supporting a range of activities, including home visiting programs.

CHILDREN'S EARLIEST YEARS OF LIFE ARE CENTRAL TO THEIR DEVELOPMENT. New scientific research shows that experiences after birth -- particularly in the first three years of life -- have a dramatic impact on brain development and learning. To highlight these findings, the President and Mrs. Clinton held *The White House Conference on Early Childhood Development and Learning* in April, 1997. The conference pointed to the importance of children's earliest experiences in helping them get off to a strong and healthy start. In October, 1997, the President and Mrs. Clinton hosted *The White House Conference on Child Care* to examine the implications of the new research for child care. This conference underscored the need to invest in improving child care quality and supporting parents -- the very goals of the President's proposed Early Learning Fund.

LEARNING FROM EFFORTS IN VIRGINIA. Mrs. Clinton visits Alexandria, Virginia to spotlight the home visiting program, *Healthy Families Alexandria*, which is a part of the national home visitation effort, *Healthy Families America.* This program today serves 320 communities around the country and providing intensive home visits to at-risk families during pregnancy and for the first few years of a child's life. Mrs. Clinton will take part in a routine *Healthy Families Alexandria* home visit and then participate in a roundtable discussion with experts and parents. The discussion will also spotlight another home visitation effort that has been proven successful through a 15-year follow-up study-- the Pregnancy and Infancy Nurse Home Visitation Program in Elmira, New York.

NEW PARENT SUPPORT

DeputyAssistant Secretary of Defense
Personnel Support, Families & Education
Office of Family Policy
4015 Wilson Blvd, Suite 917
Arlington, VA 22203-5190
703-696-5733

NEW PARENT SUPPORT

Programs to support new parents contribute to mission readiness, support family adaptation to military life and are designed to enhance the knowledge and skills families need to form healthy relationships and provide safe, nurturing environments for children. The military force is a young force; the Defense Manpower Data Center (DMDC) reports that 42 per cent of active duty personnel are age 25 or younger . Like many civilian couples in American society many DoD personnel have children before they may have completed their maturation into adulthood.

Of 1.4 million active duty military personnel:

- More than 3,500 (3,577) military personnel have had their first child at the age of 19 or younger.
- Twenty-five percent of the first births were to military personnel age 21 or younger.
- The(most frequent) age for military personnel to have their first child was 21.
- The mean and median age of military personnel having their first child was 24.

Since military families are usually separated geographically from thei r families of origin and civilian peers who are now parents, they lack frequent physical access to the hometown social supports and parental models. To address this the four Military Services have developed programs to support new parents during this critical period.

The support provided by the Services for new parents provides improved quality of life for service members and their families.It helps to reduce the potential for both child and spouse abuse during a period of increased strain on relationships. The Services' programs to support new parents are based on research, help new parents adjust to life in the military, offer a full range of comprehensive services, and include appropriate documentation and program evaluation. The Services promote universal availability to increase participation and reduce stigma. Within each Service the level of support is triaged so that more intensive services with highly trained staff are offered to higher risk families.

Within this range of programs, the Services have developed special programs that use trained personnel to visit new parents' homes. Such programs engage new parents in the various activities that support them, and have shown particular promise in reducing the risk for child abuse in new parents deemed at higher risk for child abuse. Such "home visitation" or "home visitor" or "home-visiting based" programs have been studied in the civilian community and have been recommended by:

- The General Accounting Office (1990)
- The U.S. Advisory Board on Child Abuse and Neglect (1991)
- The National Committee to Prevent Child Abuse (Daro, 1988) and
- The Defense Science Board Task Force on Quality of Life (1995)

among others as an effective method to create a healthy start for new parents.

History of DoD New Parent Support Programs

Collectively, DoD home visiting programs for new parents are known as New Parent Support programs. The Services began developing home-visiting based-programs through a joint-Service program at Tripler Army Medical Center in Hawaii in 1984, a program now known as "A Solid Parenting Experience Through Community Teaching and Support (ASPECTS)." The ASPECTS program has used community health nurses as home visitors and parent educators.

By the late 1980's the Army, Navy, Air Force, and Marine Corps were interested in replicating civilian home visiting-based programs, based on the positive results of ASPECTS and comparable civilian programs. The Air Force began the "First Time Parents" program, using Family Advocacy Nurse Specialists, at several sites in 1988. In 1989 the Marine Corps began a pilot demonstration program at Camp Pendleton, California, in partnership with Children's Hospital, San Diego, using paraprofessionals. The same year the Air Force expanded the "First Time Parents" demonstration program to 8 air bases. In 1990 the Navy implemented a home visiting-based program at 10 major naval installations that had large numbers of young families. The Army began its "First Steps" program in the early 1990's.

Initially these programs were authorized through the prevention component of the Family Advocacy Program, and were supported with Family Advocacy Program funds from the Office of the Secretary of Defense and with the respective Service's Operations and Maintenance funds. In FY 1995 the Congress appropriated $20 million for DoD New Parent Support Programs in addition to the amount for the Family Advocacy Program. This additional appropriation spurred the expansion of these programs throughout the Services, and allowed them to develop more comprehensive evaluation strategies. The Congress appropriated $25.6M in FY 1996 and $20M in FY 1997 for these programs, and in FY 1998 the New Parent Support programs became a line item in the DoD budget.

Ingredients of a Successful Home Visiting Program

There has been growing consensus that home visitation services to new families are an effective way to reduce the potential for child and spouse abuse. Home visitation is thought to be a promising strategy but, as David Olds cautioned in 1990, not all home visiting programs are the same and not all programs achieve the same effect. However there are some generally accepted guidelines for the most effective programs. Before reporting on what services were in fact provided by each military Service, it seems reasonable to briefly review these guidelines (Leventhal 1996) since they are the result of some consensus in the field and the DoD model incorporates many of them.

Services should begin early, during the prenatal period or shortly after birth and should extend through the first few years of a child's life. There is no consensus in the literature on the optimal duration or intensity of services. However, current research supports the idea that services should not be a one-shot contact accomplished early in the child's life, but need to be instituted at birth or in the prenatal period, and continue through the first eighteen months to two years for maximum effectiveness.

Current Status of DoD New Parent Support Programs

While each Service has developed unique New Parent Support Programs to meet the needs of its personnel, there are similarities.

DoD New Parent Support Programs are available worldwide.

- In 1996, there were New Parent Support programs at 204 installations, more than 2/3 of the total DoD military installations. These programs served more than 54,000 military families, which is more than 80% of eligible families.

- In FY 1996 the Army had programs at 73 installations in Alabama, Alaska, California, Colorado, Georgia, Kansas, Kentucky, Louisiana, Maryland, Missouri, New York, North Carolina, Virginia, Washington, Germany, and Japan. These represent about 2/3 of Army installations. The Army's program served approximately 7,500 families, including those in its First Steps program

- The Navy has 40 programs at fleet intensive sites in California, Connecticut, Florida, Georgia, Illinois, Maine, Maryland, South Carolina, Tennessee, Texas, Virginia, Washington, the District of Columbia, Guam, Puerto Rico, Iceland, Italy, Japan, and Spain. These represent about 80% of all Navy installations. Of these, 23 use civilian employees, and the remaining 17 are under a contract. The Navy follows the Healthy Families America model, a national initiative sponsored by the National Committee to Prevent Child Abuse. In FY 1996 the Navy's program served approximately 38,600 families.

- The Air Force has programs at 76 (90%) of Air Force installations, but due to staffing constraints it only serves those families expecting their first child. Installations are located in Alabama, Alaska, Arizona, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Kansas; Louisiana, Maryland, Massachusetts, Mississippi, Missouri, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Texas, Virginia, Washington, Wyoming, Germany, Japan, Korea, and the U.K. In FY 1996 the Air Force's program served approximately 8,000 families.

- The Marine Corps has programs at all 18 installations under a contract with Children's Hospital, San Diego. Installations are located in Arizona, California, Georgia, Hawaii, North Carolina, South Carolina, Virginia, and Japan. In FY 1996 the Marine Corps' program served approximately 3,000 families

- The ASPECTS joint service program in Hawaii served appropriately 1,300 families.

The programs emphasize outreach to junior enlisted personnel

In Army and Navy families participating in New Parent support programs in FY 1996, 60% of the sponsors were E-1 to E-4. In the Air Force, 75% were E-1 to E-5. In the Marine Corps, 56% of the fathers and 78 % of the mothers were E - 1 to E-4. In the ASPECTS joint-service program, Hawaii, more than 80% of the spouses were E-1 to E-6.

Participation in the programs is voluntary

Each program offers basic support services to all parents with a child under the age of 6 who request services, although emphasis is placed primarily on families experiencing their first birth and secondarily on families with any newborn child. Parents choose which services they would like to receive. Parents also participate in program evaluation on a voluntary basis.

Families are assessed for child abuse. More intensive services are offered to those at higher risk levels.

Each Service uses its own method to assess new parents, based on research findings from civilian studies, and assigns parents to one of several risk levels. Intensity of services offered is matched to risk levels. In general, Level I families are deemed to be at low risk for child abuse. Level 2 families are those assessed as being at risk for child abuse. In general, very young parents, single parents, parents with disabled or premature infants, and Bi-cultural or socially isolated families are more likely to have been assessed as at higher risk for child abuse. Families with an open case of child abuse may or may not be eligible for the New Parent Support program, depending on the Service. The ASPECTS Joint-Serve program program screens families and emphasizes more intensive services to high-risk families.

A full range of programs and activities are offered.

Prenatal activities include prenatal visitation at the medical treatment facility or home, parenting education classes, referrals to other services and resources, telephone and office contacts. At the time of the child's birth, activities include visitation at the hospital, referrals to other services and resources, and telephone and office contacts. After the child is discharged from the hospital, activities include visitation at the home, parenting education classes, parenting support groups for mothers, parenting classes and support groups for fathers, "play mornings" as a respite for the parent, referrals to other services and resources, and telephone and office contacts.

Short-term and long-term visitation is provided.

While parents can choose the number and frequency of visits, the programs emphasize more frequent visits over a longer period for those assessed at risk of child abuse.

Command also supports the programs. Lt.Gen. George R. Christmas, USMC (ret.), former Deputy Chief of Staff for Personnel, U.S. Marine Corps, has stated that the New Parent Support program is one of the best quality of life programs available for Marines. Rear Admiral Richard Buchanan, USN, stated:

The Navy family is important to us. What could better show how important than by helping to educate our Navy parents about their most important role in life -- raising their children. The Navy's New Parent Support Program is a significant part of that effort.

- *"The New Parent Support Program is a great idea for new parents who are living far away from their families and close friends. It's very reassuring to see a visiting nurse between visits to the doctor."*

- *"I think this is a great program and it should be a program that all Marine Corps families should participate in."*

- *"I give two thumbs up for the program."*

Program Evaluations

Each of the Services conducts ongoing evaluations of its New Parent Support Programs. These rely on the use of standardized instruments administered to parents willing to be evaluated at the beginning and end of their participation in the program. All four Services administer the Child Abuse Potential Inventory (CAP), a measure for risk of child abuse widely used in the field. The Army and Marine Corps also administer the Center for Epidemiological Studies Depression Scale (CESD), the Index of Marital Satisfaction (IMS), the Maternal Social Support Index (MSS) and the Family Environment Scale (FES). The Navy uses several other measures to assess maternal support, maternal bonding, and family environment. The Air Force also uses the clinical nursing assessment protocol.

The programs consistently show reductions in the Child Abuse Potential Inventory by the participants, especially in parents assessed as moderate to high risk. A sample of 357 Air Force parents showed a reduction in the mean abuse potential scores of 13 points for moderate risk parents and 101 points for high-risk parents, with statistically high confidence levels. The Marine Corps data is similar. Of the at-risk families with no known prior histories of abuse, 58% of the participants scores declined in 6 months, and 30% declined below the clinically at-risk level. Of the at-risk families with known prior histories of abuse, 66% of the participants scores declined in 6 months, and 32% declined below the clinical at-risk significant level. After the parents had participated for six months, the Marine Corps' home visitors found decreased percentages of children at risk for excessive corporal punishment, inadequate supervision, inadequate emotional support, inadequate attention to medical needs, protection from others' abuse, and emotional maltreatment.

In addition, other measures show improvement. The Air Force families at moderate and high risk in the sample showed improvement in ego strength, handling distress, flexibility, and happiness. Of the Marine Corps at-risk families with no known prior histories of abuse, 68% showed improvements in depression, marital satisfaction, and social support, and at least 38% declined below the clinically at-risk level. Of the Marine Corps at-risk families with known prior histories of abuse, more than 60% showed improvements in depression, marital satisfaction, and social support, and at least 24% declined below the clinically at-risk level.

Most importantly, the programs find reduced numbers of child abuse reports from at-risk families. Overall, only 4 percent of the at-risk families in the Marine Corps program had reports of family violence (child abuse or spouse abuse). Only 15 per cent of the Marine Corps families with prior histories of abuse who were in the program for more than a year had new child abuse incidents. The ASPECTS program had only a 0.4% rate of substantiated abuse from its high risk families, who had been served an average of 13 months by the program.

DoD Model for New Parent Support

In 1996 the DoD Community and Family Policy Coordinating Committee authorized a joint Service working group to review the Services' implementation of programs to support new parents, develop a DoD model for the New Parent Support program, and recommend a future course of action for funding.

The working group believed that programs to support new parents are needed because a two recent surveys found that a significant number of new recruits have experienced physical abuse or sexual abuse as children. Since research has shown that people tend to parent the way they were parented, such recruits are at high risk to maltreat their children when they become parents. While support is provided with concern for the welfare of the children and parents as the guiding factor, such programs are also cost effective. The average case of child abuse in DoD costs at least $2,000, and the costs can range up to $7,200 for the initial intervention and legal proceedings. Long-term treatment costs would cost significantly more, and costs for discharging the service member and recruiting and training a replacement are even higher. In contrast, New Parent Support cases cost an average of $251 per birth. In short, doing the right thing to support new parents is not only morally rewarding, but makes best use of resources as well.

While the working group recognized the need for variety and flexibility in programs to accommodate the unique requirements of each Service and local needs, it believed that a DoD framework was needed to facilitate fiscal planning, evaluation, training, and equity. In particular, the working group viewed a comprehensive DoD framework of services for new parents as a useful step in ensuring optimum use of resources, promote consistency in concept and range of services offered, and promote efficiency in service delivery.

The working group identified the range of services offered new parents and developed a standardized New Parent Support program model for DoD with three proposed stages: "New Parent Support - Standard," screening for at-risk parents and assessment of their needs, and "New Parent Support - Plus."

New Parent Support – Standard

This program coordinates existing parenting programs available on military installations and from nearby civilian a2encies. These programs include parenting classes sponsored by military medical treatment facilities, family centers, child development centers, Family Advocacy Programs, and chaplains, and by such civilian programs as the Red Cross, YMCA, and public social services agencies. The programs also include crisis counseling and respite programs available from family centers, Family Advocacy Programs, and civilian social service agencies. This program should be available to all parents--to-be and to parents with children age 0-3, whether they live on or off the installation. The primary services are educational, with information and referral to military civilian programs that can support parents.

Screening and Assessment to Identify At-risk Parents and Their Needs

Health care providers routinely assess families during prenatal care, during the birth process, and during well-baby checkups to identify areas where additional health and social support is needed. In addition, staff of programs that assist parents, such as those in the proposed "New parent Support - Standard" level, frequently identify families who can use additional social services. Frequently one or both parents in such families are young, at great geographical distance from families and friends who would otherwise provide face to face emotional support, or experienced abuse and neglect as a child. Other families who can benefit from additional support include those with a child with disabilities, those with bi -cultural marriages, and those with lower incomes. Based on the experience of civilian home visiting -based programs, the working group estimated that 18% of the babies born annually to active duty personnel would be identified as at-risk.

As a result of the screening process, at-risk families will be referred for addi tional services to the proposed "New Parent Support - Plus" program. The referrals will be voluntary, and will emphasize the availability of additional resources that will build upon the parents' strengths. During the referral process, staff will identify the parents' particular needs and seek to address them through referrals for relevant support. For example, parents with high stress levels will be encouraged to enroll their children in respite play programs in addition to having a home visitor. Similarly, extremely young parents who may have experienced abuse during childhood will be offered extra mentoring and modeling of appropriate parenting.

DoD New Parent Support

(*New Parent Support* - Plus)

This level denotes the additional services that should be provided to at-risk parents who have children age 0-3. The program should accept self-referrals in addition to those who were referred as a result of screening. The emphasis should be on voluntary participation in a non-stigmatizing atmosphere that builds upon the parents' strengths. The services offered will be based on intensive home visiting services provided by nurses and/or social workers and paraprofessionals. The services will include role modeling/mentoring, respite care, health care support, parent support self-help groups, individual and group counseling, and tutoring on child development. The services will be offered for up to three years, but the working group estimated that the average at-risk family would participate for six months.

The Family Advocacy Program should be the sponsor of this level, in coordination with other social services and parent support provided on the installation or by local civilian agencies. Based on the experience of civilian home visiting-based programs and the Services' experience, the working group estimated that 90% of the high-risk families would enroll for services, and that the annual caseload of each home visitor should be 50 families.

The working group estimated that existing resources meet the costs of the "New Parent Support - Standard" component and of the screening of parents. The working group estimated resource requirements for the "New Parent Support Plus" component. Based on the experience of Hawaii Healthy Start and the Healthy Families America, which are civilian home visiting-based programs, the working group then estimated that 90% of those families assessed as high risk at the time of the child's birth would enroll during the child's first year of birth. The group estimated that 5% of the families with children age 1-2 who had originally been screened as low risk would be reassessed as high risk and would enroll in the "New Parent Support - Plus" component during the child's second year of life. Similarly, the group estimated that 3% of the families with children age 2-3 who had originally been screened as low risk would be reassessed as high risk and would enroll in the "New Parent Support - Plus" component during the child's third year of life.

Thus, the group estimated that of 1,000 births, 162 high-risk families would enroll in the "New Parent Support - Plus" component during the child's first year of life, 36 would enroll during the child's second year, and, 22 during the child's third year. This totals to an annual caseload of 220 and requires about 4.5 full-time equivalent positions per year for this population. The working group believed that the Services' experience and the civilian groups' experience with high risk groups requires that two-thirds of these positions be filled with people with master's degree level experience, and one third could be filled with people with lower levels of education and experience.

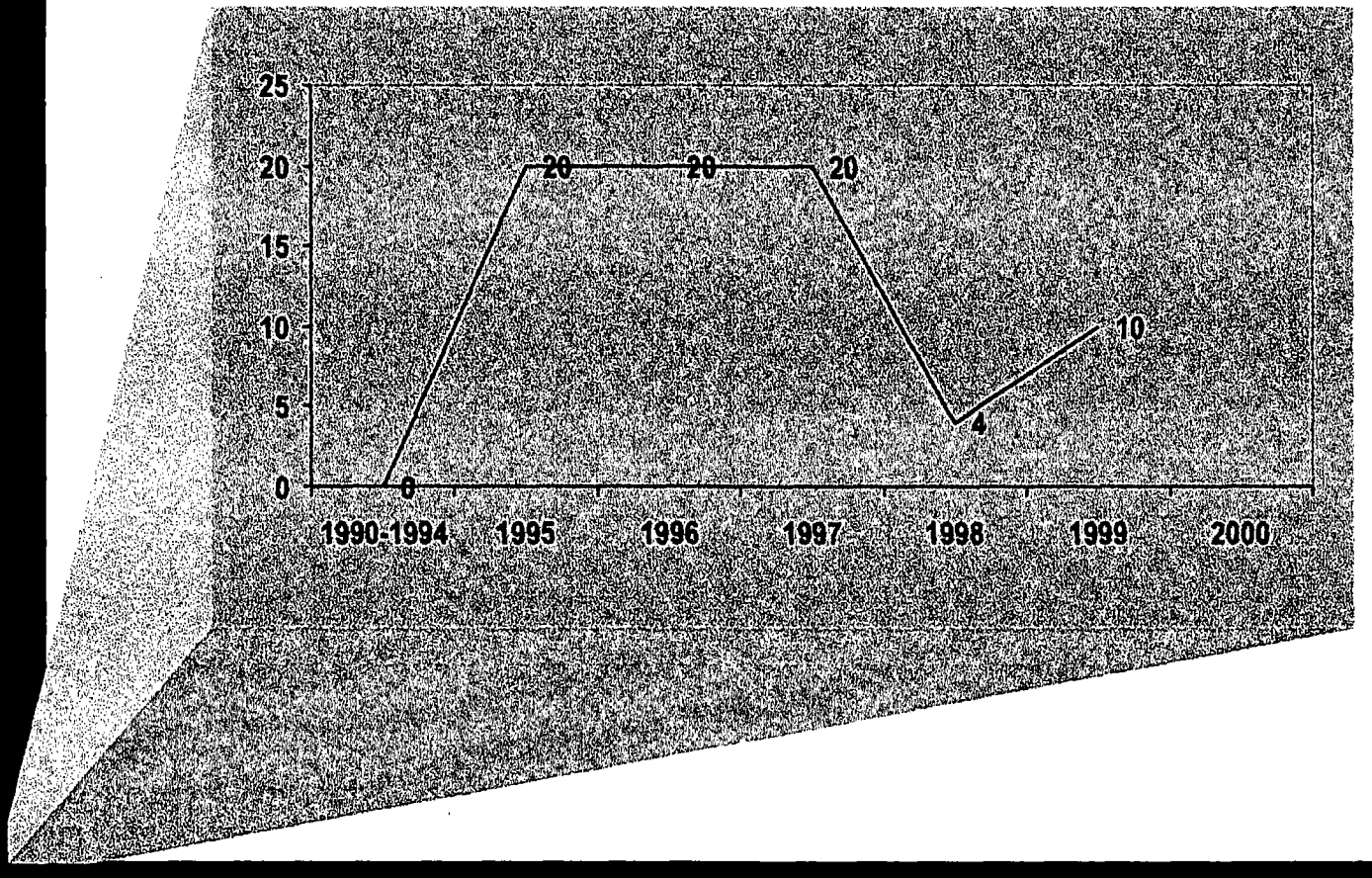
Accordingly, the model for the "New Parent Support - Plus" component requires about $251,000 per 1,000 births annually. The group consulted Defense Manpower Data Center birth data and estimated that $27M in additional resources are required for a DoD population of approximately 109,000 live births annually.

Funding for the OSD New Parent Support Program

As mentioned earlier, Congress appropriated $20M for the New Parent Support program in FY 1995. At that time, an attempt was made to include this program in the FY 1997 and future years DoD budget at the level of $20M, but the effort was unsuccessful. The Congress provided appropriations for the program in FY 1996 and FY 1997. The Defense Budget for FY 1998 included $4M for this program. As a result, the program has had an 80% reduction of funds for FY 1998. The Services have had to cut back the program even though they had wished to begin implementation of the DoD model.

The Presidents budget request for FY 1999 includes $10M for New Parent Support, which will support up to one year of services to approximately 10,000 high risk parents.

OSD New Parent Support Funds to Services



Conclusion

The widespread availability of DoD New Parent Support Programs, their outreach to fathers, and the range of services to young parents explain their popularity with young military families.

The programs reduce the risk of child abuse and neglect by enhancing the knowledge and skills families need to form healthy relationships. Evaluation data from the Services have demonstrated the effectiveness of home visiting-based prevention, especially for high-risk families who receive more intensive services. Reducing child abuse and neglect in military families reduces the need for expensive treatment and rehabilitation programs. By eliminating the need for administrative and legal proceedings, these programs can provide cost savings to DoD. In addition, since children in military families become a significant source of recruits for the Services, raising them in healthy, safe, and nurturing enviroment has an additional benefit to DoD.

The DoD New Parent Support Programs are a wise investment in quality of life for military families. These programs contribute to mission readiness by supporting the adaptation to military life, marriage, and parenthood of young families separated from their extended families and friends by vast geographical distances. The information and emotional support they provide reduce parental anxiety and thus enhance service members' ability to perform the military mission effectively.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003a. memo	Nicole Rabner to Agency Liaison re Request for Assistance (partial) (1 page)	02/12/1998	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Domestic Policy Council (Nicole Rabner)
OA/Box Number: 15416

FOLDER TITLE:
Home Visiting [1]

2012-1035-S
kc1055

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[003a]

THE WHITE HOUSE

WASHINGTON

February 12, 1998

MEMORANDUM

TO: Agency Liaison

FROM: Nicole Rabner
Domestic Policy Council/Office of the First Lady

CC: Alice Pushkar
Office of the First Lady

RE: Request for assistance with health care

On Tuesday, February 10, the First Lady participated in a roundtable discussion in Alexandria, Virginia to spotlight the success of home visiting programs to help support new parents and improve child outcomes.

P6/(b)(6) P6/(b)(6) The First Lady was concerned about what she learned from P6/(b)(6) about her health condition -- she reports that she is in failing health, has been denied Medicaid health coverage because she owns a car, and has no money for medical care.

Mrs. Clinton asked me to bring this woman's case to your attention, and to ask that you follow up with her directly. P6/(b)(6) I would appreciate your letting me know about your progress with the case, so that I may let the First Lady know.

Please feel free to call me at ext. 67263 to discuss this further. Thanks very much.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003b. memo	Nicole Rabner to FLOTUS re Home Visitation Event (1 page)	02/11/1998	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Domestic Policy Council (Nicole Rabner)
OA/Box Number: 15416

FOLDER TITLE:
Home Visiting [1]

2012-1035-S
kc1055

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