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• CHAPTER 6 •

Parents as Teachers: Investing in Good Beginnings for Children

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> In every child who is born, under no matter what circumstances and of no matter what parents, the potential of the human race is born again, and in him, too, once more, and each of us, our terrific responsibility toward human life.
>
> —James Agee, *Let Us Now Praise Famous Men*

Our children are our potential and our future, not our problem. Investing in the very beginning of life diminishes the probability of investing later in social costs such as remedial education, juvenile detainment, welfare (or its alternative) dependency, child abuse, and neglect. "If we don't invest in the early rearing of our children, we're going to be paying the bills for the rest of our lifetimes," says University of Wisconsin psychologist Christopher Coe. "The bills will be for mental disorders and physical diseases, and for putting many of these kids in jail" (cited in Kotulak, 1993, p. 32).

Parents as Teachers brings together families, schools, and communities in a three-way partnership to reduce the number of children in need of special or remedial education on entering school and increase the chances all children deserve for healthy, successful

futures. It has grown from a pilot project in a handful of Missouri public schools to an extensive network reaching nearly half a million families in 47 states and 6 countries. Parents as Teachers was one of the first statewide family support and education initiatives emphasizing the child's earliest years and one of the first large-scale home visiting programs. The Parents as Teachers program has captured the attention of educators, health and social service professionals, business leaders, policymakers, and—most important—parents, because it works. As an early intervention effort, Parents as Teachers has demonstrated its success in preventing and ameliorating many of the problems that contribute to underachievement and school failure. It offers a practical way to create an environment of opportunity and growth for all children. Experience has shown that participation in the Parents as Teachers program can result in confident, competent parents and happy, well-rounded, academically able children.

Conceptual Framework

The underlying philosophy of the Parents as Teachers program is perhaps best embodied in words attributed to Plato: "The beginning is half of the whole." Making a quantum leap to the second half of the 20th century, substantive federal and private investments in the 1960s and 1970s in research on human development and in early intervention programs produced findings that confirmed the wisdom of Plato's statement and shaped the conceptual framework of Parents as Teachers.

To cite a few examples of such findings, Benjamin Bloom's review of longitudinal data on human development led him to conclude that 50% of intelligence as measured at age 17 is developed by age 4 and that the greatest change in such a characteristic can be effected during the period of its most rapid growth (Bloom, 1964). The Harvard Preschool Project, directed by Burton White, set out to track the emergence of major abilities and child-rearing practices that influence children during the first three years, concluding that one can predict at age 3, with few exceptions, how a child will look at age 6 in all areas of development (White, Kaban, Attanuci, & Shapiro, 1978). Urie Bronfenbrenner's study of early intervention

programs initiated in the 1960s as part of our nation's social reform efforts concluded that working with the family rather than bypassing parents is critical to helping children get off to the best possible start and to sustaining gains after the program ends (Bronfenbrenner, 1979).

The Parents as Teachers program is based on two simple truths—that babies are born learners and that parents play a critical role from the beginning in determining what their child will become. The program is designed to enhance child development and school achievement by reaching out to families beginning even before the child's birth. Acknowledging that all parents deserve support in laying a strong foundation for their child's success, Parents as Teachers was designed for the voluntary participation of all families.

The program's ten major goals are to:

- empower parents to give their children the best possible start in life;
- help each child reach his or her full potential;
- increase parents' feelings of competence and confidence;
- increase parents' knowledge of child development and appropriate ways to stimulate children's curiosity, language, social, and motor development;
- give children a solid foundation for school success;
- improve parent-child interactions and strengthen family relationships;
- turn everyday settings into learning opportunities;
- deepen a sense of family success;
- prevent and reduce child abuse; and
- develop true home-school-community partnerships.

Parents as Teachers is based on the following assumptions:

- Children are born to learn. We don't have to entice them into learning—they are ready, willing, and able.
- Children learn the most from the people they love—their parents. Whether by accident or design, parents are teaching their child through every action they take and every word they say.
- Parents are the experts on their own children by virtue of their special knowledge and insight that comes from everyday living with them. They should be acknowledged as the real decision makers about their child's rearing.

- Parents as Teachers parent educators are generalists with research-based information on child development who work in partnership with parents to develop strategies that parents may choose to try in their family. They can demystify the schools' expectations and add to parents' understanding of how and why learning occurs.
- A variety of family forms can promote the development of healthy children and healthy adults. Because this program is designed for everyone, there is no stigma attached to participation. Families who are considered to be at high risk are likely to be attracted to Parents as Teachers because they know it is for everybody.
- Ethnic and cultural differences are to be valued. An understanding and appreciation of the history and traditions of the families in a community are essential for a parent educator who seeks to serve them.
- All families have strengths, and all parents want to be good parents. These beliefs are fundamental. Parents do not enroll in this program to be "fixed," but rather to learn to build on their strengths and draw on outside help in giving their child the best possible beginning.

Pertinent Research

Few would argue that all formal education is influenced by the learning experiences of the first years of life. Studies in the 1950s and early 1960s from the fields of developmental psychology, education, and medicine agreed on the importance of the early years for the development of language, intelligence, and emotional well-being.

In his Pulitzer Prize-winning series of articles, *Unlocking the Mind,* Ronald Kotulak (1993) details strides taken toward understanding how the human brain develops. As Kotulak explains, profound discoveries have overturned the previous notion that the brain is a static machine, developing at a steady pace according to a set of predetermined rules. Scientists now know that the brain must receive certain kinds of stimulation to develop such powers as vision, language, smell, muscle control, and reasoning and that it relies on the outside world to send it such stimuli. Genes provide the blueprint, and the environment provides the instructions for final construction (Kotulak, 1993). The wiring along this blueprint is made up of synapses, the connections rapidly forming between brain cells as they compete to find a job to perform and are

stimulated by the outside world. The major bursts of synaptic activity happen in four phases—in fetal development, in newborns, between ages 4 to 10, and thereafter—but these bursts have essentially already started to fizzle out as early as the end of the first year of life. These findings have led scientists to the "use them or lose them" theory of synapses, believing that because the human brain is still being formed and organized after birth, certain kinds of learning must occur at certain stages of development. Meeting these "time windows" with the appropriate stimulation is critical to ensuring that children get the start they deserve and continue their lives equipped with the tools to be successful.

Kotulak (1993) quotes Harvard child psychiatrist Felton Earls, who says, "All infants require milk before they can eat solids. Is there an equivalent state of affairs for the brain? The answer is clearly an affirmative one. It requires stimulation: touch, holding, sound and vision." In the brain's hungriest moments, in the very beginning of life, infants rely on the humans taking care of them for their brain food. There are real consequences of missing the windows of development: if an infant brain does not receive visual experience by the age of 2, the child will never be able to see; if a child does not hear words by age 10, she will lose the gift of language forever (Kotulak, 1993).

In his article "Building a Better Brain for Baby," George Johnson (1994) states, "The implication, apt to incite anxiety among even the most attendant families, is that neglectful parents are guilty not only of a sin of omission—not providing enough mental stimulation—but a sin of commission as well: fating their children to confront the world with underdeveloped brains" (p. 6). By the time children enter preschool, the architecture of the brain has essentially been constructed. The brain will never again match the incredible pace of learning that occurs in the first few years (Clinton, 1996). There are clear indications that parents play a key role during these years in determining how their children will fare in school and in life—a more important role than the formal education system, which encounters the child after his foundation for learning and living has been laid.

The strong evidence presented by neuroscience on early brain development should be driving the nation's policy making, should be prompting reform, so that tomorrow's children aren't forced to rely on a safety net of later interventions that may not be there to

catch them. As First Lady Hillary Rodham Clinton (1996) puts it, "If we . . . decide not to help families develop their children's brains, then at least let us admit we are acting not on the evidence but on a different agenda. And let us acknowledge that we are not using all the tools at our disposal to better the lives of our children" (p. 61).

Description of the Initiative

Laying the Groundwork

Despite its reputation as the "show-me state," in 1984 Missouri became the first state in the nation to mandate that every school district provide parent education and support services from birth to kindergarten entry for all families wishing to participate. A series of events orchestrated by the Missouri Department of Elementary and Secondary Education beginning in 1972 led to the passage of the Early Childhood Development Act by the Missouri General Assembly in 1984, resulting in statewide implementation of the Parents as Teachers program a year later.

In 1972, the State Board of Education adopted a position paper on early childhood education, defining the role and responsibility of the public education system during the years when home is the child's school. A campaign was mounted through conferences and forums to educate state and local decision makers from all sectors, as well as the public at large, on the critical need for children to have optimal beginnings, on the damaging effects of poor parenting, and on the cost-effectiveness of parent-child early education. A blue ribbon committee of influential Missouri citizens, appointed by the Commissioner of Education, took a leadership role in generating interest and support. Governor Christopher S. Bond, who became a first-time father at age 41, became a strong advocate and succeeded in getting bipartisan support for the pending enabling legislation.

Lessons learned from the investment of federal dollars in public school Title I preschool programs for disadvantaged children had shown that intervening at age 3 was already late for many. As a result, the decision was made in 1981 to test out the feasibility of influencing children's education from the onset of learning by partnering with their parents. The pilot Parents as Teachers project was launched that year as a cooperative effort of the Department of Elementary and Secondary Education, four diverse school districts selected on the basis of competitive proposals, and the Danforth Foundation, which funded the consultant services of Burton White. A total of 380 families, who were expecting their first children between December 1981 and September 1982, were enrolled. The families, who were representative of each school district's population, were provided services from the third trimester of pregnancy until the child turned 3. The 1985 results of the independent evaluation of the project's benefits to participating children and parents, as assessed at children's third birthdays (Pfannenstiel & Seltzer, 1985), led to funding for statewide implementation in 1985 and to widespread interest and inquiry about this program that was born in Missouri.

How the Program Works

Service Delivery

Families, schools, and communities share a common goal: to have all children develop to their fullest potential—to be all that they can be. With "beginning at the beginning" as its hallmark, Parents as Teachers was intended as a first step in achieving that goal. This home-school-community partnership supports and assists parents in their role as children's first and most influential teachers, building on family strengths. Now as in the pilot project phase, Parents as Teachers offers the following to all families:

- regularly scheduled personal visits by certified parent educators, who provide timely information on the child's development and who model ways parents can make the most of everyday learning opportunities;
- group meetings where parents share, compare, commiserate, and congratulate;
- monitoring of children's progress by both parent and professional educators to detect and treat any emerging problems as early as possible; and
- linkage with needed services that are beyond the scope of the program.

The intensity of the program varies according to the needs of the family; those who are facing the greatest challenges can receive additional personal visits and help in accessing other support services.

Instructional Home Visits

The personal visit, generally held in the home, is the heart of the Parents as Teachers program. It offers families the special advantage of one-to-one relationships that promote child and adult growth and development. It increases the potential for improving the ecology of family life because of the remarkable insight gained from working in the home on a sustaining basis. The visitor thereby acquires a sense of unmet health, economic, education and social service needs that impinge on parenting (Winter, 1995).

Home visits signal the program's willingness to accommodate family schedules, even when mothers work outside the home, and to operate on the family's turf. This sets the tone for a less formal, more relaxed relationship between the visiting professional and parents. It helps to equalize the balance of power between parent and visitor, which is especially important with families whose prior experiences with school and other agencies have not been positive. Parents who feel isolated and burdened with the demands of parenting respond to visitors who evidence genuine interest and empathy. It is not uncommon for participants to come to regard the parent educator more as a friend or a member of the family than as an outside expert.

Another benefit of home visiting is the opportunity for parents to have their questions and concerns about parenting answered in the privacy of their home. Parents of all social and economic strata want to do a good job, but limited positive experience or knowledge about child rearing can get in the way. They struggle to understand their children's behavior and are anxious to find out if what they observe and experience with their children is normal. Parents are often reluctant in a group setting to ask questions that might suggest ignorance on their part. Receiving assurance from the home visitor that this is normal behavior and hearing praise for the child's

accomplishments give parents a sense of relief and pleasure and bolster their self-confidence.

Finally, children benefit. They are dependent on the key adults in their lives to foster a sense of security, trust, and self-esteem. Children's feelings of self-worth are enhanced when they see that their parents or other primary caregivers are valued and respected by others, particularly by someone whom they come to regard as teacher. Another obvious benefit for children is the opportunity that home visiting affords for all of the caring adults to knowledgeably share observations and insights that help guide the child's development.

Home visits in the Parents as Teachers program are generally one hour in length and are scheduled monthly for most families to allow time for parents to act on the information gained. If family needs warrant, visits may be offered biweekly or weekly. Parent materials, written at two different reading levels, reinforce and expand on the information discussed during the visit.

Group Meetings

Group meetings serve three major purposes: first, to provide a vehicle for additional input from the staff as well as from outside speakers; second, to create opportunities for families to share successes and common concerns about their children's behavior and development; and third, to help parents build support networks. Parent-child activities are provided during many group meetings to reinforce the importance of family interaction. Group meetings may be combined with social events, such as potluck suppers. They are offered at least monthly and are held in the school or community facility during the evening or on Saturdays as well as during weekdays to allow fathers and mothers who work outside the home to participate. Special meetings designed only for dads and other father figures help them to define and enjoy their role.

Drop-in and play times are offered by many programs to provide families the opportunity to use the center's facilities with their children, to visit with other parents, and to talk informally with the parent educator. Fathers as well as mothers, and sometimes grandparents, bring the child to play and interact with other children of a similar age. A parent educator is present during these

sessions of about an hour in length, perhaps working or planning, but available for questions and conversation. She or he may take advantage of opportunities that arise for teaching child development informally around certain child behaviors as they occur.

Monitoring Child Development

A final means of input of information for families and staff is the developmental assessment component of the Parents as Teachers program. The purposes are twofold: first, to reassure parents if the child is developing on target; and second, to identify problems early to assist parents with appropriate interventions. Developmental screening is conducted annually, beginning at age 1. In addition, parents are helped to observe and monitor the child's development on an ongoing basis. Parent and parent educator observations, coupled with periodic screening, serve to safeguard against undetected delays or learning difficulties during the first years of life.

Linkage with Other Services

The Parents as Teachers program was not designed to be all things to all families. The community council is an integral part of the Parents as Teachers program, assisting with planning and implementation, building community support, and recruiting and referring families. Members of the council help to identify resources in the community, including diagnostic services, programs for children with special needs, learning resources for children and parents, health and social service programs, and so forth. Families are helped to link with programs and services they need that are beyond the scope of Parents as Teachers.

Organizational Structure

The most successful Parents as Teachers programs take the program's home-school-community philosophy to heart and use the skills of members from each sector. Local programs are strongly encouraged, though not required, to follow an organizational structure provided in the *Parents as Teachers Program Planning and Implementation Guide* provided as part of the initial Parents as Teachers training.

A school district or agency administrator may serve as overall *program supervisor* along with his or her other administrative tasks. The *parent educator,* in addition to planning for and making personal visits, participates in recruitment activities, screening activities, and group meetings with parents. She or he also keeps records on home visits, reports to the program coordinator on screening results that seem to warrant referral, and supervises children in the center at scheduled times. In programs employing more than one parent educator, it is advisable for one to serve as program coordinator. She or he is a working member of the educational staff as well as the supervisor of the other staff members. A *clerk-typist* is usually essential as well. In addition, programs may find *volunteers,* such as senior citizens and high school child development students, to be very useful in complementing services of regular staff members.

Competencies and Qualities of an Effective Parent Educator

The parent educators are the jewels in the crown of the Parents as Teachers program. Most are parents themselves; all have backgrounds in teaching or early childhood development and have received special preservice training to deliver Parents as Teachers services. They are credentialed on an annual basis by the Parents as Teachers National Center, Inc., contingent on the administrating agency's approval of their service to families and their completion of the required hours of in-service training. Responsibility for the selection and supervision of service personnel rests with the local administrating agency.

Home visiting is demanding work that is best carried out by mature individuals whose life experiences enhance their capacity to help others. Their responsibilities range from discouraging a rural mother from using a dried pig's ear as a teething ring, to making a special nighttime visit to a mother who seems to be "on the brink," to arranging for a hearing test for a child whose language development is delayed. Home visitors need to be outgoing, comfortable with strangers, unflappable in new situations, well organized, nonjudgmental, and tactful. In identifying individuals who will work best as parent educators, the families to be served

must be considered—their backgrounds, their attitudes about children, the cultural values that influence them as parents. Whom would they welcome into their home? Whom would they respect and to whom would they listen?

Home visitors are required to be both child development specialists and family specialists. Candidates need in-depth knowledge of early childhood development and should have had supervised experience working with young children and parents. They should also have strong working knowledge of how adults learn, since their role is to help parents become the best possible teachers and nurturers of their children and to enhance their sense of efficacy as parents. They may come from the fields of education, health care, or social work. Former classroom teachers must be able to make the transition from managing a group of children in a classroom to working with adults and children in someone else's living room.

Programs often choose local community members as key staff contacts with parents. This approach offers the advantages of providing training and employment for community residents, drawing on knowledge of the community gained from living there, and avoiding disparities in culture, language, and values between families and staff. It is not critical that home visitors be of the same ethnicity or culture as the families they serve, but they must understand and respect the values and beliefs of various cultures so that they can respond sensitively.

The quality of the human connection between home visitor and families is probably the best predictor of service effectiveness. "Warm and caring" probably tops the list of characteristics programs look for in choosing home visitors. Other interpersonal qualities that are essential for home visiting include a nonjudgmental, healthy attitude toward families and the ability to set boundaries (e.g., not to become so involved in family stress as to lose the focus of the home visit). The ability to maintain an appropriate sense of humor in the face of stress is not to be overlooked.

Active listening is key to establishing a trusting relationship because it communicates, "I hear what you are feeling, I value your abilities, I am interested and concerned, I am not judging or evaluating." One needs to be comfortable with silence, to ask open-ended questions, to avoid filling in or stepping in, to be sensitive to verbal and nonverbal communication from the family.

It is critical that the home visitor's body language and voice tone convey warmth, respect, and genuine interest.

Because a major purpose of home visiting is to tailor information on child development and child-rearing practices to family needs and interests, home visitors must be able to convey this information in language that is clearly understood, positive in nature, and not condescending. Information and issues addressed, as well as parent-child activities suggested, should be geared to the interests and concerns of father figures as well as of mothers, to nurture male involvement in children's development and learning. Male caregivers have their own special way of interacting with young children that should be acknowledged and encouraged. Every effort should be made to schedule visits when father figures and other significant caregivers can be present.

Observation is one of the most important skills needed by the home visitor and one that must also be fostered in parents. Understanding the organization of the home and the resources available to the family, as well as the interaction among family members, gives the home visitor a base on which to draw in building on family strengths. It is the means by which the visitor identifies parental expectations as well as behavior and development of children in relation to expected norms. Objective, positive observation is essential for documenting the proceedings of a home visit for accountability purposes and for planning the next visit.

Last, but certainly not least, is the ability to empower parents—facilitating or maintaining the family's ability to define its own goals and make its own decisions. Empowerment implies that many competencies are already present or are possible and that new competencies can be learned. This calls for a helping relationship that works continually toward promoting parents' independence in coping and problem solving.

Adaptations: A Program for All Parents

From the outset, Parents as Teachers has faced the challenges of adapting the curriculum to fit special populations, reaching at-risk groups, and providing quality services within budgetary restrictions. The program, which was originally designed for families with children aged birth to 3, was extended upward to age 5 in response

to demand. One of the most important lessons learned from the Missouri experience is that model programs must be crafted and molded to fit the particular demands of local culture and politics.

The widespread interest in Parents as Teachers can be attributed to its many benefits. Health care providers see it as improving children's physical well-being. Mental health, social services, and corrections view it as preventing and reducing abuse and neglect. Churches endorse it as strengthening family life. The corporate world sees its potential for reducing stress and improving quality of life for employees. Schools, of course, realize the benefits of reducing the need for special and remedial education and of forming a positive relationship with families early on.

Because Parents as Teachers is not high in cost and not dependent on a particular setting or agency sponsorship, it can be widely replicated or adapted. Parents as Teachers is offered by public and private organizations as a stand-alone program or as part of a more comprehensive delivery of services as the following examples illustrate.

Parents as Teachers for Teen Parents

The tenet central to the mission of Parents as Teachers that *all* parents deserve to be supported in their critical role as first teachers includes those who are most vulnerable—adolescent parents. With a teen birthrate that is among the highest in the industrialized world, our society is seriously affected emotionally, socially, and financially by teen pregnancy and parenting.

Parents as Teachers for Teen Parents is usually connected with a local secondary school, a connection which allows for optimum accessibility of the program by pregnant and parenting teens. School counselors and nurses advise expectant teens of Parents as Teachers, assuring a smooth and discreet transition into the program.

The curriculum includes adolescent as well as child development information, and issues unique to teenage parents are addressed with honest sensitivity. Techniques and strategies for group meetings with peers, often held during the school day, and personal visits are modified to meet the developmental needs of the adolescent.

Research indicates that a father's involvement in his child's life is highly significant to the developing child. Many teen fathers do not play an active role in raising their babies, if they play any role at all. Parents as Teachers for Teen Parents encourages young fathers to stay involved with their children by providing father support groups in the secondary schools, where they learn about child development. As one St. Louis teen father put it, "The program has helped me to grow up. I had to learn how to cope with a lot of things—my daughter, her mother, and her grandmother. That's really hard. The program helps me know what my rights are, as well as my responsibilities" (Parents as Teachers National Center, 1994, p. 23).

During the home visit, the parent educator makes every effort to draw in all members of the household who share in the caregiving of the child with the goals of developing consistency, providing the child a more stable home environment, building the teen mother's capabilities, and approaching conflicts through dialogue. The multigenerational approach to the teen home visit provides the parent educator with additional information about the teen's situation within the family. This enables the parent educator to help the teen develop coping strategies. At the same time, the teen's family is acknowledged, strengthened, and empowered in its crucial role of providing emotional and practical support for the teen and her baby. Including other family members in home visits allows for many voices to be heard, giving a clearer picture of how caregiving duties are divided, decisions are made, and conflicts are handled. The parent educator is available to discuss each person's questions, concerns, and frustrations relating to the teen and her baby.

The potential for one person to make a difference in a teenager's life should not be underestimated. In the words of Marian Wright Edelman (1995), "hope is one of the best contraceptives to teenage pregnancy" (p. 122). Although national statistics indicate that 50% to 80% of pregnant females drop out of high school, experience has shown that a high percentage of Parents as Teachers parents not only graduate from high school but go on with future vocational or education plans.

Parents as Teachers in the Child Care Center

More than half of our nation's mothers return to the workforce within a year of the baby's birth, and many of their infants and toddlers spend 35 or more hours per week in substandard care (Carnegie, 1994). This makes the search for high quality child care a very real stressor for young families. The Parents as Teachers model was adapted for child care settings to address this growing need. Parents as Teachers in the Child Care Center is a home-center partnership designed to enhance the quality of infant-toddler care and to improve the communication and relationship between the two sets of very important people in a child's life—parents and other caregivers.

Parents as Teachers in the Child Care Center has been implemented in diverse child care settings including corporate, community college, hospital, university, United Way-funded, and private for-profit and not-for-profit centers. The initial personal visit with families is conducted in the home to give child care workers opportunity to see the family environment. Subsequent visits are scheduled at the child care center and allow parents to observe their child interacting with peers, to pick up timely child development information, to partake in planned activities with their child, and to compare observations with those of the caregiver. Regularly scheduled group meetings are offered for parents in the infant and toddler rooms, allowing families of children who are at the same developmental level to form intimate support groups. The program also provides minivisits between the parent and caregiver with a daily exchange of information about the child. All services are scheduled at times that accommodate working parents' schedules.

In 1994, the Public Policy Research Centers, University of Missouri—St. Louis, conducted a developmental assessment of Parents as Teachers in the Child Care Center at six diverse Midwestern sites for the purpose of enhancing training and program design. Primary benefits of the model were found to include increased communication and comfort level between parents and caregivers, changed attitudes on the part of caregivers toward parents and their role, higher level of professionalism and morale of caregivers involved, and increased knowledge of child development on the part of parents of lower socioeconomic and educational levels. The most significant result of this home-center partnership is perhaps one that is not so easily documented—children see the most important people in their lives working together for their benefit (Public Policy Research Centers, 1995).

Parents as Teachers for Native Americans

The average family income in Torreon, New Mexico, is between $3,000 and $5,000 per year. Families depend on Aid to Families with Dependendent Children (AFDC), food stamps, and Women, Infants, and Children (WIC) programs. Local leaders in Torreon estimate that less than 20% of the population has completed high school. Of the children entering kindergarten, 90% speak only Navajo. This community has limited facilities and on-site social services. There is one small general store in town but no gas station. Indian Health Service operates clinics that offer preventive health care, but clinic hours are limited, and emergency health care is problematic. It is unlikely that one program could meet all these needs, but fortunately, Torreon is one of the 23 sites that are home to a program making a difference in the lives of Native Americans.

Searching for solutions, the U.S. Bureau of Indian Affairs created the Family and Child Education program (FACE), the overall purpose of which is to address the problems of underachievement in school and the literacy needs of the family. FACE serves families with children from birth to age 8, based on three national models—Parents as Teachers, Parent and Child Education, and High/Scope—which have been combined to meet the needs of Native American families. Parents as Teachers provides the earliest piece of the program, the home-based component beginning at birth.

Parents as Teachers for Native Americans builds on the strengths these parents possess and is based on their real needs and real-life experiences. Parents become the change agents for themselves and their families. This system gives ownership to the tribes and the communities; in fact, the parent educators are themselves Native American, members of the tribes they serve. The educators are committed to ensuring that the beliefs, customs, values, and language of their respective tribes are validated, respected, recognized, and appreciated. Sites make their activities culturally appropriate

by supporting Native American child rearing practices and weaving Native American language and tradition into the home and group activities. Parents as Teachers program coordinators and parent educators are faced daily with the goal and challenge of working in a close, cooperative manner with parents, tribal elders, and others in the community. The Parents as Teachers curriculum is flexible enough so that parent educators can implement it in a way suitable to the individual Native American communities.

The FACE program, begun in 1990 in six Native American communities, has expanded to 23 reservations in 10 states. A case study commissioned by the U.S. Department of Education to examine the effects of the program reports that active participants from all FACE sites believe that they have improved their parenting skills and consider this the most beneficial program result. Other important changes include an increase in parents' self-worth and confidence, as well as an increased awareness of the importance of education for both parents and children. As for the children, the study shows improved developmental progress and enhanced self-confidence and independence (Schultz, Lopez, & Hochberg 1995).

Parents as Teachers Specialized for Even Start and Head Start

Collaboration with other agencies and programs that serve young families has been integral to Parents as Teachers from the outset, because no single program can respond to all the family problems that impact on the young child's healthy development. Parents as Teachers has provided leadership in the formation and growth of effective partnerships through training, technical assistance, and cooperative implementation. In tenuous political environments, it is imperative that partnerships among agencies and organizations be developed to maximize access to new funding streams and to advocate on behalf of all children and families.

Requests for Parents as Teachers training from Even Start and Head Start programs have steadily increased, and institutes have been designed to specifically meet their needs. Along with the natural fit between Parents as Teachers and these two programs, several factors have contributed to this demand: the downward expansion of Head Start to include service for children from birth to age 3; a recommendation from the Senate Appropriations Committee to the U.S. Department of Education that ways be developed for Parents as Teachers to play a larger role in Even Start; and the inclusion of Parents as Teachers in the Even Start language of the 1994 Reauthorization of the Elementary and Secondary Education Act.

Parents as Teachers shares common goals with Head Start and Even Start, including promoting the healthy development of children, empowering and involving parents, building on family strengths, enhancing family literacy, and establishing links to other community sources of support for families. Parents as Teachers is continually working to nurture these connections by adapting training and curriculum materials to meet the needs of Head Start and Even Start personnel.

Parents as Teachers in Housing Projects

Many of the residents of Hollybrook Homes have little more than subsistence income. Most have not finished high school; many are unemployed. The National Benevolent Association of the Christian Church (Disciples of Christ), funder of the Hollybrook Homes Housing Complex, has implemented a program to help resident families make their way to a better life for themselves and their children. Creating Healthy Activities to Nurture Children through Education (CHANCE) was created based on the belief that no matter what a parent's struggle may be, children still need adequate care and attention during their early years, which in large measure may determine their future. Parents as Teachers is the essential first component of CHANCE. Along with the standard components of home visits and group meetings, mothers residing at Hollybrook come to the Parents as Teachers office for consultation and enrollment, screening, and borrowing books and educational toys from the lending library. Program impact can be measured by what is happening on a daily basis in these homes. Under the guidance of the parent educator, these mothers are reading to their children, teaching them shapes, colors and names, talking with them, listening to their reactions, and encouraging them. The children of Hollybrook Homes are getting the attention they need to develop successfully, and this new focus is making life more meaningful and enjoyable for the parents.

Housing projects are also used by school districts and other agencies as centers of operation for Parents as Teachers.

Proven Effectiveness

True success is measured in terms of changed lives, hence the challenge to continually evaluate the work of Parents as Teachers. Program evaluation has been integral in the evolution of the Parents as Teachers program since it originated, despite financial resource limitations. The studies vary extensively in their sample sizes, type of outcome indicators, and use of comparison groups. Some have investigated Parents as Teachers as a stand-alone program, whereas others have looked at it as part of a more comprehensive initiative. Several studies have been more qualitative, attempting to understand the evolution of Parents as Teachers or the way in which home visits are delivered. All known evaluation reports regarding Parents as Teachers are collected by the Parents as Teachers National Center, Inc., and reviewed by staff and a small group of research consultants. The first independent evaluation of Parents as Teachers was funded by the Missouri Department of Elementary and Secondary Education. Subsequent studies of the Missouri program have been funded by the Department with assistance from the Ford (Pfannenstiel, 1989; Pfannenstiel, Lambson, & Yarnell, 1991), A. L. Mailman (Pfannenstiel et al., 1991), and Smith Richardson Foundations (Smith & Wells, 1990). Studies of the program in other states have been supported by local school districts and private foundations. What follows is a select review of past and current Parents as Teachers evaluations.

The release by the *New York Times* in 1985 of an independent evaluation by Research & Training Associates of results of the Parents as Teachers pilot project generated interest in the program across the United States and around the world. This evaluation showed that at age 3, children of participating families were significantly advanced over the comparison group in language, social development, problem solving, and other intellectual abilities. Project parents credited the program with increasing their confidence and competence in child rearing and knowledge of child development (Pfannenstiel & Seltzer, 1985).

A follow-up study of pilot project and comparison groups showed that Parents as Teachers participant children scored significantly higher on standardized measures of reading and math achievement at the end of first grade. In all behavioral areas assessed by their teachers, Parents as Teachers children were rated more highly than the comparison group children. A significantly higher proportion of Parents as Teachers parents took an active role in their child's schooling (Pfannenstiel, 1989).

Statewide expansion of Parents as Teachers extended the program to include all rather than only first-time parents. A Second Wave evaluation, completed in 1991, focused on 395 randomly selected children and their parents enrolled in programs in 37 diverse school districts including urban, suburban, and rural settings. The Second Wave study indicated that the school districts involved were providing a level of service comparable to the pilot project. Children participating in Parents as Teachers were found to perform significantly higher than national norms on measures of intellectual and language abilities, despite the fact that the sample was overrepresented on all traditional characteristics of risk compared to state and local populations. Parents' knowledge of child development and parenting practices increased for all types of families in the program (Pfannenstiel et al., 1991).

A follow-up study of the Second Wave sample was initiated in 1993 to assess the longer-term impacts of program participation. This study focused on the early school experiences and performance of the Parents as Teachers children and on their parents' involvement in their children's schools and activities to support learning in the home. Parents as Teachers children scored high on measures of complex and challenging tasks. Overall, the levels of achievement children demonstrated at the completion of the Parents as Teachers program were maintained in the first (or second in some cases) grade. This held true despite the broad diversity in children's experiences with preschool, child care, kindergarten and primary grades. The Parents as Teachers parents demonstrated high levels of school involvement, which they frequently initiated (Pfannenstiel, 1996).

Studies of the impact of Parents as Teachers have also been conducted by local Missouri school districts, such as the ones noted here from rural Missouri, Joplin, and Parkway School District. Results of a 1993 study of 516 students entering kindergarten in

22 rural school districts in southwest Missouri show that children who participated in the program at least one year scored significantly higher on the Kindergarten Inventory of Developmental Skills (KIDS), a commonly accepted measure of school readiness, than children who did not participate. Parents as Teachers children scored significantly higher in number concepts, auditory skills, pencil and paper skills, language skills, and visual skills. Of the sample, 224 came from families experiencing financial stress (Wheeler, 1994).

Kindergarten screening results from the Joplin (Missouri) School District indicate that Parents as Teachers children who entered kindergarten in the fall of 1994 clearly outscored children whose parents did not participate. Using the Early Screening Profile from American Guidance Services with 601 new kindergartners, children who had not been in Parents as Teachers had an average score of 55%, whereas those in the program scored 68%. The difference is even greater for those who entered Parents as Teachers as infants; their average score was 73% (Norton, 1994).

Finally, third graders who had participated in Parents as Teachers in the Parkway School District in St. Louis County, Missouri, scored significantly higher on standardized measures of achievement than their nonparticipating counterparts. According to the 1994 study, third graders who had received Parents as Teachers services had a national percentile rank of 81, whereas the nonparticipating students had a rank of 63 on the Stanford Achievement Test, with a significant difference in scores on all subtests. Parents as Teachers graduates were less likely to receive remedial reading assistance or to be held back a grade in school (Coates, 1994).

The rapid expansion of the Parents as Teachers program to other states has resulted in a number of studies of the program's implementation and effectiveness outside Missouri. One such evaluation, Increasing Children's Readiness for School by a Parental Education Program, conducted in the Binghamton, New York School District states, "Results indicate that PAT is a valuable investment for communities, with dividends at least four times the original investment." Their pilot study focused on a small sample of poor, high-needs children to determine if Parents as Teachers augments the effects of Head Start and Title I prekindergarten; the full study focused on all kindergartners in Binghamton. Testing in prekindergarten and again in kindergarten showed that the Parents

as Teachers children had significantly higher cognitive, language, social, and motor skills than nonparticipants. According to the report, "twice as many Parents as Teachers grads are predicted to be ready to learn how to read when they enter school, avoiding special placement or retention in kindergarten."

The study also suggests "that participation in the PAT program is associated with lowered rates of welfare dependence and child abuse." By the children's first birthdays, welfare dependence within the Parents as Teachers group had dropped by 10%, but dependence nearly doubled for the comparison group. The drop indicates "a greater tendency for these parents to seek control over their lives, due to improved self-confidence as parents and interest in their children's future" (Drazen & Haust, 1994).

On the other side of the country, SRI International researchers have been investigating the implementation and effectiveness of several Parents as Teachers programs to discover if Parents as Teachers can help parents in at-risk situations offset the threats to their children by teaching effective parenting approaches that support healthy child development. The Salinas Valley Parents as Teachers Evaluation assessed more than 500 children and their parents from a community that has a large Latino population, high poverty, and high mobility associated with employment of migrant workers in the agriculture industry. The children were randomly assigned to either a Parents as Teachers or a comparison group. Preliminary reports from the Salinas study show consistently positive impacts for parents and children participating in the Parents as Teachers program. Parent and child outcomes were measured through a battery of instruments and procedures administered at or near the children's first birthdays. On the HOME (Home Observation for Measurement of the Environment) rating scale, Parents as Teachers parents consistently scored higher on measures of parenting behavior. These parents also outscored control group parents on the KIDI (Knowledge of Infant Development Inventory) regardless of mother's ethnic background and age (Wagner, 1992).

The continuing growth of Parents as Teachers warrants a long-term evaluation strategy for the program. A multiyear proposal for Advancing the Parents as Teachers Program Through a Comprehensive Evaluation Strategy has been submitted to several potential funders. Phase I of this multisite study, which will focus on families with low income, has been funded by the Carnegie Corporation,

with preparatory activities underwritten by the Danforth and Ewing Marion Kauffman Foundations. The study, which is a collaborative effort with SRI International, proposes to follow Parents as Teachers participants through to kindergarten to examine the extent to which early intervention from birth to age 3 adds value to the benefits of Head Start and other programs in preparing high-needs children for school success. Evaluation findings will be translated into practice by the Parents as Teachers National Center through its training and program development and will serve to inform the field of early childhood education as well.

In today's political climate, widely replicated programs such as Parents as Teachers have to be willing to subject themselves to the scrutiny of academic researchers and professional evaluators to survive. Policy makers and funders want to know "what works." Documentation of the program's effectiveness was a requirement of the Innovations in State and Local Government Award received in 1987 from the Ford Foundation and Kennedy School of Government, Harvard University. This held true also for Parents as Teachers' acceptance into the U.S. Department of Education's National Diffusion Network. But it is truly the words and real experiences of families that linger long after the evaluation data have been analyzed. The benefits of Parents as Teachers can be seen through such examples as a school district reducing its dropout rate for expectant and parenting adolescents to zero; a group of Ozark Mountain parents asking the school to teach them correct English so they can better teach their children; inner-city homeless families living in shelters attending appropriately to their children's developmental needs despite the many stresses they are experiencing; toddlers of mentally retarded mothers developing on target because parent educators gear the program to those parents' level of understanding; and a parent in Rhode Island crediting her PAT parent educator with observations that led to early detection of a brain tumor in her young son.

Cost-Effectiveness

Because preventive and early intervention services receive a small fraction of our nation's resources, cost-effectiveness is a major concern. "Two-generation programs that address the needs of

parents and children have the potential to produce large benefits in the short term as well as in the long term, and therefore appear to be an important focus for economic evaluation" (Barnett, 1993, p. 106). It is difficult, however, to assign dollar values to the life-enhancing outcomes programs strive to produce.

Part of the appeal of the Parents as Teachers program is its low cost—the major expense being the salary and travel of parent educators. At most sites, the program does not require extensive facilities or a large investment in materials. Parents are encouraged to take advantage of learning opportunities that occur in everyday living, using materials that are commonly found in the home. School districts and other sponsoring agencies commonly make in-kind contributions, such as an office and group meeting space, clerical assistance, and program supervision.

Eighty-nine percent of the Parents as Teachers programs that submitted annual program reports to the Parents as Teachers National Center in 1995 indicated an expenditure of less than $1000 per family. Cost varies, of course, according to the number of personal visits provided, amount of travel required, parent educator salaries, administrative cost, and the amount of in-kind contributions. As to cost savings, a school district in Bryan, Texas submitted relevant information on the 15 children who exited the Parents as Teachers program in 1993 at age 4. During the course of the program, the number of children exhibiting delays was reduced from seven to two. The district estimated its savings for the five children who did not require special services at school entry to be $39,440 per year (Parents as Teachers National Center, 1994).

It was the realization that savings in human potential and tax dollars can result from this early prevention program that led Missouri to appropriate state funds to implement Parents as Teachers in every school district in 1985. Funding has increased each year since then, with the goal of enabling all families with age-eligible children to participate by the year 2000.

Conclusion

Parents as Teachers is not intrusive or imposing, nor does it presume to be the cure-all for all populations. Rather, it is designed to be adapted to accommodate the people it serves. The program

respects the diversity of parents and families while uniting them around a universal goal—raising healthy and successful children.

There is an increasing awareness of the importance of this goal at all levels—family, community, state, and federal. The burgeoning growth of Parents as Teachers attests to this fact. It has been recognized by the U.S. Congress as an effective family education and support program in the Goals 2000: Educate America Act, the 1993 Family Preservation and Support Services Act, and the 1994 Reauthorization of the Elementary and Secondary Education Act.

"In our search for excellence [in education] . . . we have ignored the fundamental fact that to improve the nation's schools, a solid foundation must be laid. We have failed to recognize that the family may be a more imperiled institution than the school and that many of education's failures relate to problems that precede schooling, even birth itself . . . One point is clear: in our search for excellence . . . children must come first" (Boyer, 1991, p. 3).

And truly putting children first means investing in good beginnings for them all.

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HEALTHY FAMILIES AMERICA: USING RESEARCH TO ENHANCE PRACTICE

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HEALTHY FAMILIES AMERICA: USING RESEARCH TO ENHANCE PRACTICE

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INTRODUCTION

Child abuse is not a new phenomenon. Since the first parent-child dyad, adult caretakers have struggled with the demands presented by their children.[1,2] In an effort to meet these demands, parents have drawn on the modeling they experienced with their own parents and extended family members, the availability of support and advice from friends, and assistance provided by local services and related resources. Over the past thirty years, prevention advocates have designed and implemented hundreds of interventions to resolve a parent's lack of knowledge and skills, to create extended networks of formal support and to alter normative and societal standards for child rearing and education. Whether one talks about the family support movement, the early childhood movement or child abuse prevention, these and similar efforts have created a plethora of programs that have, in the eyes of many, significantly improved the conditions for children.[3,4,5]

Not all families, however, have equal access to or benefit from early intervention efforts so not all children are being helped.[6,7] Indeed, Healthy Families America (HFA), an initiative developed by the National Committee to Prevent Child Abuse in 1992, grew out of the recognition that prevention had left the most vulnerable of families behind. They saw that although prevention advocates had generated a plethora of programs, many of these efforts had short shelf lives and those that survived over time changed focus and intent in response to shifts in funding sources and staff interests. Also, few communities had the full breadth and depth of services needed to achieve notable change in those families at highest risk.

In response, HFA planners designed an intensive home visitation program in partnership with colleagues at the Hawaii Family Stress Center and others engaged in designing comparable family support and early childhood interventions. From the onset, HFA planners viewed home visitation as only a part of an overall strategy to achieve significant and lasting change in the rates of child maltreatment and other negative outcomes for children. Equally important was creating a program context in which all families would be better able to access the assistance they needed and a research context in which services would be refined based upon emerging research.

The article begins by briefly reviewing HFA's theory of change, its overall goals and objectives and the structure of its intensive home visitation component. The article then reviews the design and status of 29 evaluations currently underway or being planned at HFA programs across the country, highlighting the specific role the HFA Research Network has played in facilitating the development and cross-referencing of these efforts. This summary is followed by a more in-depth presentation of specific outcome findings emerging from 16 of these evaluations. The article concludes by discussing the findings' program and policy implications.

HEALTHY FAMILIES AMERICA: A NEW CONTEXT FOR PREVENTION

Central to the development of Healthy Families America (HFA) was the realization that the prior conceptual framework governing child abuse prevention efforts contained serious flaws. Initially, the vast majority of work in this field assumed that the diversified causal factors associated with maltreatment required an equally diversified response system. Community service planners were encouraged to adopt a broad continuum of services to prevent child abuse, each of which were viewed as equally necessary and equally efficacious.[3,8,9] While promoting this continuum of prevention services was understandable, even logical, it missed an important

aspect underlying the theories of maltreatment on which they were built. Specifically, the roots of child abuse are found not only in the individual contribution of many diverse causal factors but only in the combined impacts of these factors on parental capacity. Preventing abuse and neglect, therefore, was not simply a matter of creating a network of services targeting each individual causal agent but rather creating a system which explicitly recognized the integration of these factors in an individual's ability to adequately care for his or her child.

In essence, prevention advocates needed to shift their paradigm from the horizontal to the vertical and recognize that not all prevention efforts were equal in importance or impact. Rather, prevention efforts are best planned and delivered in a more orderly way, beginning with a strong foundation of universal support available at the time a child is born or a woman is pregnant. Subsequent prevention services are then integrated into this base of support, as necessary in response to emerging needs presented by the growing child or the evolving parent-child relationship.

A key component of this universal foundation is developing strategies that alter not only individual parent-child relationships but also community systems of support.[7,10,11] As such, HFA's theory of change, as described in Figure 1, places equal importance on identifying and impacting both individual and community mechanisms. Expanding the availability of high quality, intensive home visitation services clearly is key to the initiative's success. Equally important, however, is rooting these intensive services in a normative and community context more supportive to all new parents. To succeed, HFA efforts must produce stronger relationships and a sense of mutual reciprocity within families and communities. Accomplishing this dual mission requires universal availability, diversified levels of support, flexible replication procedures and a greater integration across systems and economic sectors. As HFA efforts

expand within communities across the country, the need to establish partnerships and service collaborations at both the national and local levels has intensified.

In practice, however, the majority of HFA activity over the past six years at both the national and local levels has been the design and development of intensive home visitation programs. Because most prevention efforts had not been sufficiently intensive or comprehensive to achieve notable gains with families facing the greatest challenges, this emphasis was both appropriate and essential. In crafting these programs, HFA planners drew on the experiences of many in the early childhood and family support fields. These efforts underscored the importance of developing an initiative which embraced, among others, the following principles: direct services to both the parent and the child; multiple and diverse target outcomes; and sufficient intensity and duration to assist families at greatest risk.[3,10,12,13]

A unique feature of the HFA program development strategy is its commitment to a set of principles or core elements rather than to a single, monolethic approach. These critical elements, summarized in Figure 2, cover three key areas of program development – participant identification and engagement, program content and structure and program staffing and supervision. In each of these areas, literature reviews were undertaken to identify the most common themes emerging from research and practice and then to apply these themes to HFA development. The goal in this process was not to identify a single, successful individual program. Rather, this process sought to identify those program design elements which repeatedly emerged as contributing to positive participant outcomes.[14] In addition to empirical research, the process also drew upon general theories of parent-child interaction, human development and child maltreatment to suggest ways in which programs could improve their abilities to alter participant attitudes, behaviors and skills.[15,16,17]

Collectively HFA state and local efforts have realized remarkable progress. In 1997, an estimated 18,000 families were enrolled in intensive home visitation services offered by almost 270 HFA programs located in 38 states and the District of Columbia. Overall, 30,000 new parents were assessed and provided information on various educational, health and support services. Data from a recent HFA site survey found that about one-third of the families offered intensive home visitation services were enrolled prenatally. With respect to the characteristics of the home visitors themselves, less than one percent of the HFA family support workers (FSW) lack a high school diploma. Indeed, 39% of the FSWs have some college or an associate degree, 35% are college graduates, and 9% have post-graduate training. The most common areas of specialization among the home visitors are child development (25%), social work (20%), education (11%) and nursing (10%).[18] A full description of HFA's accomplishments and program profile is presented in Appendix A. While HFA is not a panacea for all that ails America, we believe it is a promising example of how prevention efforts will need to be structured in the future in order to maximize their impacts on families, communities, and social institutions.

THE HFA RESEARCH NETWORK: A NEW CONTEXT FOR RESEARCH

Historically, very little systematic exchange of information has occurred across researchers conducting highly structured clinical trials of an intervention and those utilizing more quasi-experimental designs on field generated programs. Evaluators, both those with the resources to conduct randomized trials as well as those implementing more modest quasi-experimental designs, have had limited opportunities to exchange information or build upon each others' efforts.

In response to this need, NCPCA requested and received funding from the Carnegie Corporation of New York in 1994 to establish a research network of those evaluating the effectiveness of Healthy Families America pilot sites and other comparable home visitation initiatives. Initially, the Network's outputs or products focused on five major areas: the development of a common data base for describing HFA programs and participants; the encouragement of secondary analyses of existing evaluative data on home visitation; the development of more efficient methods to identify and engage families in appropriate services; the identification of the most efficient and reliable methods for measuring participant change; and the identification of the critical, unmet research questions inherent in documenting and enhancing program outcomes.

In addition, the Network itself was viewed as a subject worthy of empirical study. As noted by others, the Network concept is an experiment in how to build a knowledge base.[19] The HFA Network was a particularly useful variant of this strategy to study because it brought together both those conducting the most sophisticated program evaluation efforts and those conducting quasi-experimental efforts in an action setting. As such, the Network's decision making processes, debating style, language and methods of product development offer useful guidance to those embarking on these types of collaborative relationships. The Network's activities also were viewed as contributing to the ongoing debate of how scientific evidence is or can be utilized in shaping program structure and policy.

At present, almost 50 researchers evaluating programs in 25 states are active members of the HFA Research Network. These individuals are employed in a variety of settings including state agencies, universities and private evaluation firms. While some of the Network members have a long history of establishing and evaluating programs specifically involved in preventing

child maltreatment, others have become involved with local HFA sites as part of an interest in public health initiatives, early childhood programs or general family support efforts. In addition, Network members represent a wide range of disciplines including social work, psychology, public health, child development, and early childhood education. This diversity has protected against the adoption of one theoretical orientation in framing the critical research questions or in developing useful evaluation strategies.

SPECIFIC EVALUATION DESIGNS

Table 1 summarizes key design features of 29 evaluations currently in place at HFA program sites across the country. Six additional comprehensive evaluations are being designed to assess aggregate impacts of large state or community-wide HFA initiatives being undertaken in the states of California, Massachusetts, and Minnesota and the cities of Jacksonville, Florida and Cincinnati, Ohio. As noted in Table 1, Network members conducting current efforts are employing randomized (8) or comparison (9) group study designs in over half these efforts while the remaining studies (12) are employing pre-post test designs. While some of these efforts focus exclusively on assessing the impacts of services on program participants, several also include explicit process components and environmental or community impact assessments. Funding levels for these efforts range from a $10,000 total cost for smaller, pre-post evaluations efforts to almost $4 million dollars for a five year randomized trial of the HFA site in San Diego. Two-thirds of the current evaluation efforts have received at least partial funding from federal, state or local agencies such as the state department of health, the state department of social services, the state general fund or the state Children's Trust Fund. One-third of the studies are fully funded by local or national private foundations. Collectively, these efforts represent an estimated $15 million investment in research efforts throughout the HFA system.

As summarized in Table 1, the outcome measures identified by HFA program evaluators are consistent with the model's overall objectives and the parenting mechanisms it targets for change. Specifically, evaluations are incorporating a variety of methods to assess participant performance in terms of reported rates of child abuse and neglect; maternal and child health (e.g., establishment of a medical home, immunization rates, well-baby visits, maternal health status, etc); parent-child interactions and parental capacity to care for children; the identification and use of informal and formal social supports; and maternal life course choices (e.g., welfare utilization, educational attainment, employment, subsequent pregnancies, etc.). In virtually all cases, evaluators are combining the information from standardized assessment tools, staff assessments and participant feedback to gauge the extent to which intensive home visitation efforts are realizing their stated objectives.

Most HFA evaluations have been ongoing for less than three years and therefore have not produced definitive findings regarding initial or long-term program impacts. Further, some of the efforts' most rigorous evaluation designs are still in the planning stage or are only recently producing outcome findings. In addition, each of the evaluations, like most efforts assessing social service interventions, struggle with issues of funding, sample retention, measurement limitations and theoretical shortcomings.[20,21,22] As such, the current pool of evaluative findings may best be understood as offering guidance to those seeking to create prevention efforts more responsive to the needs of new parents and to the communities in which they reside. From this perspective, these early evaluation efforts have provided some initial indications regarding the positive impacts among program participants; the program or participant factors which might influence these outcome patterns; issues relating to the engagement or retention of program

participants; and other issues or concerns which impact upon the ability to effectively deliver HFA services.

KEY OUTCOME FINDINGS

Although several communities have implemented strong intensive home visitation programs, none of the efforts covered by these early evaluations have been taken "to scale" nor have they fully incorporated the type of community change recommended in HFA's overall theory of change. While in some cases, participant changes have been compared to the performance of those randomly assigned to a no-treatment control group, in most cases comparisons are only available to populations matched to the treatment group on key demographic markers or to performance within the population's general community. As such, the current pool of evaluative findings provide only partial evidence of the initiative's overall impact and the utility of developing programs which embrace HFA's 12 critical elements. Within this context, however, these initial findings suggest that continued program development along the lines implied by the HFA model offer significant hope for reducing child maltreatment rates and enhancing parental capacity.

With respect to child abuse and neglect rates, eleven of the evaluations with data on this variable report very low rates of subsequent maltreatment among program participants. Only one study (in Iowa) did the percentage of participants reported and confirmed for maltreatment exceed 6%. This 6% figure is somewhat higher than the national reporting average of 4.7% of all children under the age of 18.[23] However, studies on the actual incidence of maltreatment among all families report that the risk of harm to children living in families comparable to those enrolled in HFA services (e.g., low income, single mothers, etc) are two to three times higher than the national average.[24] Based upon these comparisons, the low proportion of HFA

participants reported for maltreatment child maltreatment is encouraging. Further, the two evaluations in Arizona comparing the performance of HFA recipients to families who qualified for but were not offered the intervention found statistically significant differences on this measure. In both cases, almost twice as many families in the comparison group than in either treatment groups were reported for abuse or neglect during a two-year observation period. In contrast, neither of the randomized trials that examined this phenomenon reported a significant difference between the number of treatment and control group families involved in confirmed reports. However, the randomized trial conducted on the Hawaii Healthy Start program reported a significant difference in the total *number* of reports made during the two year observation period which involved participants in both groups. In this study, a total of 6 reports, all of which involved "imminent harm" were filed on the treatment group while 13 separate reports, the majority of which involved actual abuse or neglect, were filed on the families in the control group.

These patterns underscore several important considerations in using child abuse reports as an indicator of program success. With respect to methodological issues, the limited sample size in many of the HFA evaluations (e.g., under 150) and the low base rate of child abuse reports make it unlikely a statistically significant difference will be observed between treatment and control or comparison groups. Although the HFA programs are generally located in communities with substantially higher child abuse reporting rates than the national average, infants, because of their limited contact with those outside their immediate family, are less likely than older children to be identified and reported by a professional or concerned private citizen as a maltreatment victim.[24] And, as child welfare systems are asked to respond to a greater number of reports with

stable or decreasing resources, services are limited to those cases which represent the most egregious parenting.[25,26]

On the positive side, home visitation, by definition, increases the odds that a parent will be observed mistreating his or her child or that a child will be observed as being at risk of harm due to parental action or inaction. Indeed, the majority of reports documented by most of the HFA evaluations monitoring this outcome note that the most frequent source of reports on families in the treatment group is their home visitor. Within this context, the findings from Hawaii, for example, are particularly encouraging in that they suggest parents are being referred to the system at an earlier point in time, before actual abuse occurs or before a child is harmed. As noted by other prevention and child welfare researchers, this pattern suggests a more efficient use of the existing reporting system.[27,28]

With respect to health care status and service utilization, preliminary evaluation findings suggest that the vast majority of program participants are securing necessary health care for themselves and their babies. Overall, these early evaluations report 90% or more of the children enrolled in HFA services are up-to-date on their immunizations and are keeping appointments for well-baby check-ups. Further, most participants have identified an appropriate and stable source for their medical care. A pre-post test assessment of HFA participants in Connecticut reported that only 8% of the 183 emergency room visits made by the 386 families during their first year of enrollment in the program were judged by staff as "inappropriate".

Health outcomes appear particularly strong among participants enrolled during the prenatal period. In the Virginia program, participants in the treatment group who were enrolled prenatally experienced fewer birth complications, delivered a greater number of full-term babies, and had fewer low birth weight babies than those in the comparison group who were enrolled

prenatally. These outcomes may partially be explained by the fact that women enrolled in HFA services prenatally receive most of their prenatal health care visits. One of the evaluations which monitored participant performance on this indictor reported that 82% of participants enrolled prentally received all of these scheduled visits. Two additional studies reported a substantial increase in the use of prenatal care among current program participants for subsequent pregnancies. For example, in Oregon, 94% of those who became pregnant during program enrollment received early and comprehensive prenatal care, a health care service only 61% of these women utilized with their first pregnancy. Similarly, 75% of participants in the Tennessee program received prenatal care for their second pregnancy, over the twice the percentage who obtained such care during their first pregnancy.

Less than 10% of the children enrolled in any of the evaluations demonstrated significant development delays or physical difficulties during their first and second years. Indeed, the absence of such difficulties among most participants may in part account for the absence of significant differences between treatment and control groups in the three randomized studies that investigated child development. Further, studies which monitored this outcome (e.g., Florida, Minnesota, and Virginia) reported that all or most of the children identified with suspected or confirmed development delays at birth received additional screening and, if necessary, referral to appropriate therapeutic services.

The most robust findings from this pool of studies are found in the area of parent-child interaction and parental capacity. As summarized in Table 1, data from both the HOME Inventory and NCAST found program participants out performing control or comparison group participants in a number of studies (e.g., Hawaii Healthy Start, Virginia, Arizona and Connecticut). In addition, those engaged in HFA services showed a significant decrease in their

overall potential for maltreatment, as measured by the Child Abuse Potential Inventory or the Adult and Adolescent Parenting Inventory, and parental stress, as measured by the Parenting Stress Index. While the magnitude of these decreases were not always substantial or statistically significant, data from both the standardized measures and qualitative interviews with participants suggest that the provision of home visitation services on a regular basis provide families with greater knowledge regarding alternative forms of discipline; greater sensitivity to their child's cues; greater comfort in understanding their child's development; and less overall distress and rigidity. Further, the strong and consistent findings in this domain reflect the emphasis HFA home visitors place in improving parent-child interactions and parenting skills. Several of the qualitative studies conducted by HFA program evaluators report that program participants are most likely to describe the home visitation services as a parent support program. Participants repeatedly report spending time during the home visits exploring issues of child development, infant care and, as the baby grows, appropriate child behavior management.

A substantial percentage of participants who exhibited difficulties in such areas as education, employment, welfare dependency and domestic violence at the time they enrolled in HFA services saw improvements over time. Specifically, pre-post test assessments in the Alaska, Connecticut, Florida, Arizona, and Virginia programs found improvements in these and similar areas. For example, comparisons in welfare utilization rates in Arizona between HFA program participants and a comparison group comprised of those who qualified for but were not provided services reported that HFA participants spent 121 fewer days on AFCD, had 200 fewer days on food stamps and 73 fewer days on Medicaid, resulting in significant savings to the state. Of the 801 families enrolled in services in Florida, over half moved to better housing, 189 families decreased their dependency on welfare, and 146 showed greater involvement of the father. In

contrast, the Connecticut evaluation did not find notable declines in the use of public assistance programs among HFA program recipients during the initial service year. While the use of cash assistance by this group declined from 59% to 55%, the use of WIC increased from 77% to 85% and enrollment in Medicaid and food stamps remained unchanged.

None of the evaluations completed to date have found significant differences in the use of social supports between treatment and comparison groups. Indeed, a more common finding has been a decrease in the level of social support reported by program participants during the post-intake observation periods. Although scores on standardized measures of social support did not produce significant findings, several of the studies report that program participants found that the home visitor provided a valued and needed source of support. Indeed, this support may have been particularly critical for those who experienced a decline in involvement by family members after the initial post-birth period.

Few consistencies emerged across the evaluations with respect to the salient participant or program characteristics that supported positive outcomes. While several studies have observed better outcomes with teenage participants, others found older mothers more likely to secure well-baby visits and other supportive services. No consistent differences have been observed across all of the evaluations with respect to the point of engagement (prenatally versus at birth) or between women having their first child and women having subsequent births. While those currently assessing HFA efforts are not finding a strong relationship between service intensity and positive outcomes, the quality of staff and their ability to respond to at-risk families in an appropriate and culturally sensitive manner appears to correlate with more positive outcomes. Similarly, there were no distinguishing community characteristics found to have a consistent or uniform impact on outcomes. While some participants enrolled in HFA programs located in

communities with established family support centers which combine medical and social service options within a single structure benefited from this arrangement, others did not find that this type of service integration facilitated service access or produced more positive outcomes.

Those evaluating HFA programs are finding that somewhere between 20 and 30% of those families targeted for service fail to successfully engage in the program. These retention rates are comparable to other early intervention programs which have targeted similar populations and, therefore, may not indicate a unique performance difficulty.[29,30,31,32] They do, however, raise serious questions about the ability of voluntary efforts to provide sufficient coverage of the at-risk population such that measurable change in aggregate indicators of distress is achieved. Factors cited as accounting for this pattern include:

- maternal age (e.g., several sites noted that their teenage participants were more likely to drop out of services while others found young participants easier to engage);
- high mobility in some communities;
- the refusal of the mother's partner or other adult in the home to allow the home visitor regular access; and
- the stability and tenure of the sponsoring agency (e.g., those agencies with a more visible presence in the community may be more successful in engaging and retaining participants).

In contrast, retention rates appeared higher among those programs that conducted their assessments in person while the mother was in the hospital or prenatally in a medical clinic. Several Network participants also reported that offering participants specific incentives to enroll (e.g., gifts for themselves or their newborns) netted a higher retention rate. While far from

universal, a number of the evaluations found that retention was higher among Hispanic and African American participants than among white participants.

Summary

HFA's intensive home visitation efforts are achieving notable change among participant families, particularly in the area of parent-child interaction and parental capacity. The majority of families receiving these services appear better able to care for their children, to access and effectively use health care services, to resolve many of the personnel and familial problems common among low income, single parent families, and to avoid the most intrusive intervention into their parenting, namely being reported for child abuse or neglect. Although the demonstrated benefits of HFA home visitation efforts do not yet include enhanced child development or social supports, such changes may require larger samples or a longer observation period than is currently captured by current HFA research efforts. At a minimum, however, the types of changes observed in some evaluations with respect to maternal life choices, such as greater educational achievement, reduced welfare dependency and delayed second pregnancies will translate into an improved quality of life in the long term for program participants and their children.

We recognize that many of these findings have emerged from quasi-experimental rather than randomized trial research. While we appreciate the unique contribution of randomized trials to the program and policy process, we believe a variety of evaluation designs are needed to fully capture HFA impacts particularly given the initiative's commitment to program flexibility and community ownership. We believe the consistency of some findings across the various HFA studies, despite different methodologies, participant populations and community settings, offer policy and program planners equally valuable insights into how best to support new parents.

Further, the existence of the HFA Research Network offers a critical forum for insuring that these emerging findings are debated and, if consistent and meaningful, are integrated into HFA program and policy development.

IMPLICATIONS FOR FUTURE HFA DEVELOPMENT

Expanded research at HFA sites, coupled with other comprehensive assessments involving intensive home visitation models will have significant impacts on the future structure of home visitation programs, particularly as emphasis is placed on establishing universal support systems for all parents. Considering the existing body of research and the types of studies currently underway, the Network's activities offer a rich data source for both refining the HFA model as well as improving the overall quality and utility of the evaluation process. A central challenge facing Network members is harnessing this diverse and rapidly expanding body of research in a way which maximizes its utility without overstating trends which may at best be preliminary.

With respect to model refinement, the overall HFA initiative provides a natural experiment to explore a wide range of programmatic and policy issues. Unlike many sources of information regarding program effectiveness, HFA programs represent "real programs located in real communities." Consequently, HFA program evaluations are well suited to examining questions of how to form cooperative and collaborative strategies with bureaucratic structures in order to establish and sustain effective home visitation efforts. Further, the size of the overall effort allows for cross-site comparisons and experimentation in a number of pertinent areas such as exploring issues of cultural competence among staff and cultural differences in family functioning and styles.

The preliminary findings from these efforts as well as ongoing discussion among HFA Network members have identified several areas in need of further research. Among the most pressing research questions are:

- questions regarding the **context for establishing programs** such as the relative merits of various collaborating agencies; the productivity of different funding sources and their related legislative and administrative mandates; variation in how HFA pilot sites are initiated (i.e., who had the original idea); and vertical and horizontal mechanisms for communication and collaboration.
- questions regarding **staffing** including ideal content and length of initial and ongoing training; useful strategies in preventing staff turnover and burnout; how to define and achieve a cultural match between staff and participants; and how to achieve and maintain staff compliance with program guidelines.
- questions of **family/participant identification** including the relevance of current screening criteria for all families; the relevance of each screening category to final outcomes (i.e., do families with certain risk profiles do better in the program than others?); the relevance of prenatal screening versus screening at birth; the most common demographic and functioning profiles of participant families; the relationship between bureaucratic structures supporting HFA and the degree to which HFA participants understand and are responsive to these structures; and specific policy changes which might improve the fit between participating families and bureaucratic structures.
- questions regarding the **home visitors** such as the role of the family support worker; the personal characteristics associated with successful staff performance; proof that

compliance with HFA standards produce more positive outcomes for both program participants and staff development; and curriculum or curriculum elements essential for effective staff training and supervision.

- questions regarding **program dropouts** including descriptive characteristics of those failing to fully engage; the relationship between participant dropout rates and key program variables such as the nature of the intake or screening process, the way in which the program was presented, the home visitor's characteristics and tenure and the content of the visits; and the examination of dropout rates between participant groups (e.g., participants recruited pre-natal versus post-natal).

In addressing these questions, HFA research efforts may well continue to find differential performance across constructs and in the degree to which participant characteristics and service delivery elements impact participant progress. The challenge facing all those assessing HFA and comparable programs, therefore, is how best to use these diverse findings to provide effective directives for HFA planners at the local, state or national levels. While some aspects of this differential success story will reflect real limitations in the service model, other aspects may be resolved through changes in the model. For example, NCPCA's evaluation of Hawaii's Healthy Start program suggests that home visitation efforts, as presently designed, may not offer the most promising model for addressing issues of social support and child development. If increasing social support is to remain a primary goal of home visitation efforts, it may be that the model needs to be refined in ways which enhance the parent's interpersonal skills and communicative abilities and increase their attendance at parent groups. Both of these goals may be difficult to achieve. Though social support has been identified as a potential inhibitor of maltreating behavior,[33] methods to integrate individuals into supportive relationships and networks have not

been fully developed. Work on social support needs to identify and explicate these methods in order to achieve gains in this domain.

Similarly, the absence of significant impacts in the area of child development noted in several evaluations of home visitation programs may partially reflect the general short-term nature of these evaluations. Historically, home visiting aimed at preventing child abuse has achieved few discernible effects on measures of child cognitive development and behavior.[34,27] To impact this area, children may require intensive, one-to-one services,[35] suggesting family-focused HFA programs might be well served by coordinating their efforts with explicit early childhood enrichment programs such as Early Head Start. Indeed, this type of service integration is explicitly endorsed within the HFA overall approach.

CONCLUSIONS

No system of universal support for new parents, regardless of scope or quality, will solve the plethora of social ills found in our current society. Despite the best efforts of prevention advocates, some number of children will experience injury or limited social and cognitive development because their parents are unable or unwilling to care for them. In a sense, the more we learn about planning and implementing prevention services the more we realize how little we know about the appropriate scope for these efforts and their ultimate impacts. In this sea of uncertainty, however, the HFA experience has identified several concepts worth incorporating into any large-scale prevention initiative.

First, the new imagery, one that casts prevention services in a vertical rather than horizontal framework, is the correct imagery for future planning. When a social dilemma is multifaceted and rooted in a diverse array of personal, familial and societal causes, prevention advocates will be wise to begin with a strong foundation which offers a certain degree of universal assistance.

Once the specific degree of need is established for each individual or family, more specialized or intensive services can be integrated into this essential foundation.

Second, although quality issues are paramount, prevention efforts need to remain flexible both in establishing new innovations as well as in replicating the most promising of our approaches. No single program or delivery system will be correct for all participants or all communities. Those interested in preventing child abuse and supporting new parents need to draw from the empirical findings and clinical experiences generated by thoughtful program evaluators and practitioners and use this knowledge to craft workable programs for their community and target population. This type of careful and rational planning is necessary if prevention efforts are to be responsive to the uniqueness of a given community and to generate the type of ownership and investment necessary to sustain efforts over the long term.

Finally, prevention advocates need to force themselves to think at a systems level, to understand that it is as critical to build relationships among providers in a given community as it is to build relationships between individual parents and their children. Such integration efforts need to engage a variety of disciplines, professionals and the public at large. Unless such an effort is undertaken, HFA and other large-scale prevention efforts will fail to create the familial and social conditions necessary for the consistent and positive nurturing of children.

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Figure 1
Healthy Families America: Theory of Change

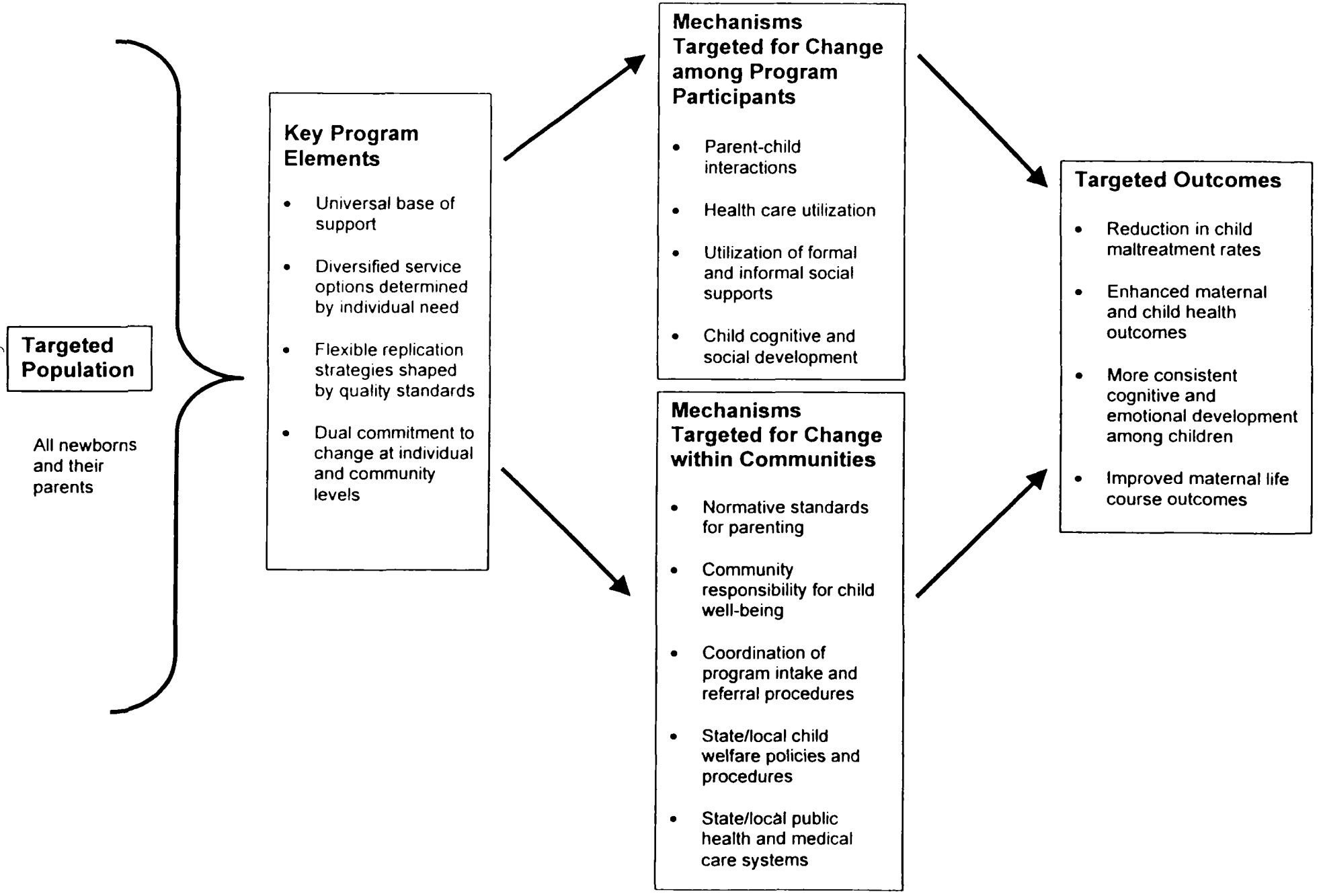

FIGURE 2

HFA'S INTENSIVE HOME VISTIATION PROGRAM: CRITICAL ELEMENTS

SERVICE INITIATION

- Prevention services need to be initiated prenatally or at the time a baby is born.
- In order to ensure the efficient allocation of resources, programs need to implement a standardized process of assessing the needs of all new parents in their target community.
- Services need to be offered on a voluntary basis and use positive, persistent outreach efforts to build family trust in accepting services.

SERVICE CONTENT

- Services for those families facing the greatest challenges need to be intensive (at least once a week) with well-defined criteria for increasing or decreasing the service intensity and must be made available for an extended period (three to five years).
- Services should be culturally competent such that the staff understands, acknowledges and respects cultural differences among participants; materials used should reflect the cultural, linguistic, racial and ethnic diversity of the population served.
- Services should be comprehensive, focusing on supporting the parent as well as supporting parent-child interaction and child development.
- At a minimum, all families should be linked to a medical provider to assure timely immunizations and well-child care. Depending upon the family's needs, they also many be linked to additional services such as school readiness programs; child care;

job training programs; financial, food and housing assistance programs; family support centers; substance abuse treatment programs; and domestic violence shelters.

- Staff should have limited caseloads to assure that home visitors have an adequate amount of time to spend with each family to meet its varying needs and to plan for future activities.

SERVICE PROVIDER SELECTION AND TRAINING

- Service providers will be selected based upon their ability to demonstrate a combination of the requisite personal characteristics (e.g., be nonjudgmental, compassionate, possessing the ability to establish a trusting relationship, empathic) and knowledge base as represented by a specific academic degree or employment portfolio.
- All service providers must receive intensive, didactic training specific to their roles within the HFA service structure as defined by the critical elements and related standards of best practice.
- Program staff should receive ongoing, effective supervision so that they are able to assist families in realizing their service objectives and protect themselves from stress-related burnout.

Table 1. Evaluations of Healthy Families America (DRAFT: revised 8/25/98)

State/ Evaluators	Design	# of Sites/ Current n	Funding	Duration	Key Outcome Measures	Key Findings
Alaska D. Caldera	Pre-post	6 sites HV: 339	State	1/97 - ongoing	Parenting Stress Index Ages & Stages Questionnaire HOME Inventory Parent Interview Welfare Utilization Reported Abuse & Neglect	Among children who had at least one home visit, 94% are abuse-free. 94% have an identified medical home, and 82% of mothers received post-partum care on schedule. Percentage improved in the following areas: employment (21%), high school completion (30%), substance abuse (38%), mental health (68%), domestic violence (43%), social isolation (46%), non-reliance on public assistance (16%).
Arizona E. Holtzapple	Comparison Group (Eligible families not offered services)	14 sites HV: 2000 C: 150	State	1/95 - 1/98	Child Health Data FACES Ages & Stages Questionnaire Child Abuse Potential Inventory HOME Inventory Reported Abuse & Neglect Welfare Utilization	Of families with more than one child and no pre-enrollment reports, program families were less likely to be reported for maltreatment than comparison families (3.3% vs 8.5%). Participants are less likely to rely on public assistance than comparison families (46% vs 54%), spending 121 fewer days on AFDC, 200 fewer days on food stamps, and 73 fewer days of Medicaid. Quality of the home environment increased among program families. Program families exceeded community immunization rates.
Arizona C.LeCroy J. Ashford	Comparison Group (Eligible families outside service area).	3 sites HV: 700 C: 100	State	1992 - 1996	HOME Inventory Interpersonal Support Evaluation List Parental Self Efficacy Parenting Stress Index	Parental stress decreased significantly in service group on total PSI and 10 of 11 subscales. Also, significant improvements in quality of home environment and self-efficacy. No significant change on interpersonal support. Significant differences in reported rates of maltreatment (4.5% of treatment group vs. 8.5% of comparison group). 99% of children with complete birth immunizations, 97% with complete immunizations at 15 months.
California J. Landsverk T. Carrilio	Randomized Trial	1 site HV: 247 C: 241	State & Private	5/95 - 4/00	CES-Depression Scale Maternal Social Support Index RAND Mental Health Inventory Conflict Tactics Scales NCAST-Community Life Skills Substance Use Battery Psych. Maltreatment Rating Scales Reported Abuse & Neglect HOME Inventory Bayley - II NCAST Feeding & Teaching Child Behavior Checklist/2-3 Stanford-Binet Scale of Intelligence	Results not yet available

State/ Evaluators	Design	# of Sites/ Current n	Funding	Duration	Key Outcome Measures	Key Findings
Connecticut T. Black M. Steir	Pre-post	5 sites HV: 386	State & Private	10/95-12/97	HOME Inventory Bayley - II Child Abuse Potential Inventory Maternal Social Support Index NCAST Feeding & Teaching Welfare Utilization Reported Abuse & Neglect	6% substantiated maltreatment (21 neglect, 1 physical abuse). Of 24 families assessed, found significant improvements in home environment from 3 months to 1 year of age on HOME Inventory subscales: Responsivity, Learning Materials, and Involvement. From enrollment to one-year, cash assistance declined 59% to 55%, WIC increased 77% to 85%, food stamp and medicaid use remained similar. Of families with data, 96% of target children are up to date on immunizations, compared to 66% of children on welfare statewide. Also, 92% of all ER visits were appropriate. By 1 year, employment increased from 10% to 40%. High school completion increased from 36% to 48%. Levels of social support similar at 1 year.
Florida S. Carnahan	Comparison Group	1 site HV: 250	United Way	1/95-ongoing	HOME Inventory Family Needs Scale Family Support Scale Family Strengths Checklist Hawaii Early Learning Profile Denver - II NCAST Feeding & Teaching	97% of participants had no reports of child abuse or neglect while enrolled. 89% of participants (92% of teen moms) have not had repeat pregnancies. All two year olds receiving intensive service and 70% of 16-23 month olds were fully immunized and current with well-baby check-ups.
Florida C.Nelson T. Gordon	Pre-post	3 sites HV: 652	County	4/93-ongoing	Ages & Stages Questionnaire Denver - II Family Needs Survey Temperament/Trait Indicators HOME Inventory Attachment/Rejection Checklist Family Satisfaction Survey Welfare Utilization Reported Abuse & Neglect	Less than one percent of 1635 children served by the program (7 per 1000) were reported for child abuse during the study period, compared to county-wide rate of 55.7 per 1000. Of 801 families enrolled, 189 families have decreased their dependency on welfare, 475 have moved to better housing, and 146 show increased father involvement. Also fewer repeat pregnancies than county-wide statistics. 98% of children on target developmentally; 97% received the recommended immunizations by age two; 94% have medical homes. Families report high satisfation with services received.
Georgia J. Chambliss	Randomized Trial	5 sites HV: 36 C: 140	State	1994-3/98	HOME Inventory Maternal Social Support Index Child Abuse Potential Inventory Infant Child Monitoring Questionnaire Parenting Stress Index Adult Adolescent Parenting Inventory Reported Abuse & Neglect	Results available end of 1998.

State/ Evaluators	Design	# of Sites/ Current n	Funding	Duration	Key Outcome Measures	Key Findings
Hawaii D. Daro K. McCurdy	Randomized Trial	2 sites HV: 157 C: 167	Federal & Private	3/93- 9/95	Child Health Data Bayley - II Parent Interview Michigan Screening Profile of Parenting Child Abuse Potential Inventory NCAST Feeding & Teaching Maternal Social Support Index HOME Inventory	Intensive service families received significantly fewer confirmed reports of maltreatment (3.3% vs. 6.8%); all reports in service group were for "imminent harm", while reports in control families included some for neglect. Child abuse potential decreased 3 times faster in intensive service group than control group. Mothers displayed greater involvement and sensitivity to child's cues at six months, and children were more responsive to maternal cues at twelve months. Although MSSI scores did not differ between intensive service and control families, mothers' interview responses demonstrated the importance of support from the home visitor. No differences on cognitive development.
Hawaii A. Duggan L. Fuddy C. Sia et al.	Randomized Trial	6 sites HV: 373 C: 311	Federal, State, & Private	11/94- 1/99	Adult Attachment Questionnaire Parenting Stress Index Maternal Efficacy NCAST-Community Life Skills Stanford-Binet Scale of Intelligence Conflict Tactics Scale-Revised HOME Inventory NCAST Feeding Scale Bayley Scales of Infant Development Maternal Social Support Index CES-Depression Scale Infant Characteristics Questionnaire RAND Social Health Battery Pre-School Language Scale Vineland Scales of Adaptive Behavior Mental Health Inventory	See chapter in this volume.
Illinois R. Schubert B. Dehart	Comparison Grp. (eligible families not served)	14 sites HV: 22 C: 0	State	5/98- 5/03	Child Abuse Potential Inventory NCAST Teaching Scale HOME Inventory	Results not yet available
Illinois K. McCurdy J. Clark	Comparison Group (Refusers, Engagers, Drop-outs)	3 sites HV: 33	Private	6/97- 12/98	Relationship Scales Questionnaire Parental Locus of Control Program Engagement Interviews Maternal Social Support Index Family & Relationship History Interview	Results not yet available

State/ Evaluators	Design	# of Sites/ Current n	Funding	Duration	Key Outcome Measures	Key Findings
Indiana J. Myers-Walls J. Elicker	Pre-post (Time Series)	20 sites HV: 90 with full evaluation battery -- *measures on 543 families	State	3/94-ongoing	*Brief Symptom Inventory *HOME Inventory *Rosenberg Self-Esteem Scale *Multidimensional Scales of Perceived Social Support *Infant Characteristics Questionnaire Everyday Stressors Index Parenting Self-Confidence Scale F-COPES Videotaped Mother-Child play session Parent Interview	Results not yet available
Iowa P. Cowen	Pre-post	6 sites HV: 505	State & Private	10/92-ongoing	HOME Inventory Parenting Stress Index Adult Adolescent Parenting Inventory Resource Scale for Teenage Mothers - Revised Family APGAR Questionnaire Denver - II Neonatal Perception Inventory	Significant improvements in home environment from 4 to 12 months. Parenting distress and life stress decreased significantly by 18 months after enrollment. 11.6% of enrolled families had founded maltreatment reports over a three-year study period. However, aggregate data indicate that these rates are decreasing in served counties, which dropped below state rates for the first time in 1996. 83% of developmental assessments in normal range; 78% of children are up-to-date on immunizations, and more than half of immunization delays due to illness or hospitalization; growth trends indicate that infants achieve higher growth percentiles the longer they are enrolled.
Michigan C. Schellenbach	Randomized Trial	1 site HV: 424	Private	1995-2000	Knowledge about Infant & Child Development HOME Inventory Parenting Stress Index Bayley Scales of Infant Development Maternal Social Support Index Parenting Style, Expectations & Attitudes Child Abuse Potential Inventory Neonatal Behavioral Assessment Scale	Results not yet available
Minnesota R. Chase B. Palmer	Pre-post	1 site HV:148	Local & State	5/93 - ongoing	Family Feedback Adult Adolescent Parenting Inventory Checklist of Risks Family Support & Esteem Risk Factors Assessment HOME Inventory Reported Abuse & Neglect	88% of children within normal developmental limits, 4% have special needs, 8% undiagnosed delays or unknown; 89% of children are fully immunized for age; 5% of children with injuries requiring medical intervention, compared to 22% nationally. 6% of served families with substantiated maltreatment during enrollment; 12% of families with substantiated maltreatment of those who ever enrolled.

State/ Evaluators	Design	# of Sites/ Current n	Funding	Duration	Key Outcome Measures	Key Findings
Montana M. Trankel	Comparison Group	10 sites HV: 603	State	1/95- ongoing	Family Life Survey	Results not yet available
Multi-State K. Harding D. Daro	Pre-post	3 sites HV: 74	Private	5/96- 3/98	Strengths & Risks Form Family Information Form Maternal Social Support Index Child Abuse Potential Inventory Child Medical Needs	Levels of social support remained stable over first year. 60% of mothers made progress toward high school completion in first year; 8% finished GED or diploma by baby's first birthday. Maternal employment increased from 37% to 46% at one year. Repeat pregnancy rate is 10%, mean of 14.4 months after birth of first child.
Nevada S. Martin	Randomized Trial (Not all study participants randomly assigned).	1 site HV: 152 C: 30	State	7/96- 6/01	Child Medical Needs Maternal Social Support Index Child Abuse Potential Inventory Family Resources Scale Family Functioning Style Scale Neighborhood Scale Reported Abuse & Neglect	Results not yet available
New York N. Guterman E. Anisfeld	Randomized Trial	1 site HV: 140 C: 140	Federal, State, & Private	11/95- 9/99	Ainsworth Strange Situations NCAST Teaching Scale CES-Depression Scale Bayley Scales of Infant Development HOME Inventory Rosenberg Self-Esteem Scale Maternal Social Support Index Ages & Stages Questionnaire Medical Records Reported Abuse & Neglect	Results not yet available
New York S. Mitchell-Herzfeld R. Greene	Comparison Group (plus concurrent pre-post only component)	10 sites HV: 475 C: 475 Pre-post only: 450	State & Federal	10/95 - ongoing	Ages & Stages Questionnaire Child Health Data Maternal Social Support Index Report Abuse & Neglect Welfare Utilization Parent Survey	Results not yet available
Oklahoma A.McDonald Culp R. Culp	Matched Comparison Group (from 7 unserved counties)	5 sites HV: 150 C: 150	State	1//97- 2000	Adult Adolescent Parenting Inventory Maternal Social Support Index Maternal Mastery/Control Maternal and Child Health HOME Inventory Videotaped Play Interaction Emotional Availability Home Safety Checklist Peabody Picture Vocabulary Test Use of Community Services	Results not yet available

State/ Evaluators	Design	# of Sites/ Current n	Funding	Duration	Key Outcome Measures	Key Findings
Oregon A. Katzev C. Pratt	Pre-post	14 sites HV: 2051	State	9/94- ongoing	Ages & Stages Questionnaire Parent Survey Family Update Family Stress Checklist HOME Inventory	97.1% of served families are free from maltreatment. Confirmed maltreatment is slightly higher for served families vs. comparable non-served families (29/1000 vs 20/1000). 48% of reports on served families made through program. 98% children have a medical home, and 92% have received regular well-child check-ups. Immunization rates are 96% for two-year-olds, compared to 67% statewide in 1996. Over 93% of children are on target developmentally; all those with developmental disabilities have been referred and are receiving early intervention services. At 1 year, 62% of served families are above the 75th percentile on the HOME Inventory. By age two, 77% of families regularly read to their child. Participating mothers are more likely to obtain early & comprehensive prenatal care for second pregnancies (94% compared to 61% of same group on first pregnancy).
Tennessee K. Kriener-Althen G. Myers	Pre-post	8 sites HV: 1688	State & Federal	5/94- 6/97	Child Abuse Potential Inventory Participant Satisfaction Survey Participant Closure Survey	90% were developmentally on target at most recent follow-up. 96.8% of children were up-to-date by 2 years of age on immunizations, and 92.2% were up-to-date on well-child screenings at most recent follow-up. 39% had late or no prenatal care for first pregnancy, 75% received early prenatal care for subsequent pregnancies. 80% learned new parenting skills; 53.7% learned new child discipline techniques; 75.9% learned new ways to play with their child. 78.6% said they would want their friends to be in the program.
Vermont M. Braner	Pre-post	1 site HV: 20	State	1/97 - ongoing	Ages & Stages Questionnaire HOME Inventory Parenting Stress Index Maternal Social Support Index Social Network Survey Family Assessment Matrix Family Support Worker Checklist	Results not yet available.
Virginia B. Barrett	Pre-post	1 site HV: 145	State, Local, & Private	7/96 - 3/99	Ages & Stages Questionnaire HOME Inventory Child Health Data Reported Abuse & Neglect Family Satisfation Survey	100% of children continued with a primary health care provider over time; 88% received all recommended immunizations; the one child with developmental delays received appropriate services. 100% of families did not have founded maltreatment reports. 97% of parents said the program improved their parenting.

State/ Evaluators	Design	# of Sites/ Current n	Funding	Duration	Key Outcome Measures	Key Findings
Virginia B. Barrett	Pre-post	1 site HV: 267	Federal, State, & Local	10/93 - 3/97	Child Abuse Potential Inventory Revised Gesell Child Health Data Reported Abuse & Neglect Family Satisfaction Survey	82% of prenatal enrollees received recommended prenatal care; most of the remaining 18% missed only 1 visit. 92% of prenatal enrollees had babies weighting 2500+ grams. 98% of children had a primary care provider within 2 months of enrollment, and 93% continued with a provider. 91% received all recommended immunizations. Of 10 children with confirmed developmental delays, 9 received appropriate services (one mother refused services) 87% of mothers enrolled for at least 300 days did not have another child with 24 months of 1st birth; of 13% who had a second child, 54% were teens. 98% of families did not have founded child maltreatment reports; the confirmed reports were for neglect. 80% of families were very satisfied with the program; an additional 16% were satisfied. 95% said the program was very helpful in raising their child.
Virginia J. Galano L. Huntington	Randomized Trial	2 sites HV: 422 C: 197	State & Local	9/92 - 7/97	Child Abuse Potential Inventory Child Health Data NCAST Difficult Life Circumstances NCAST-Community Life Skills Battelle Developmental Inventory HOME Inventory Maternal Social Support Index NCAST Feeding & Teaching Welfare Utilization Reported Abuse & Neglect	No significant difference on confirmed maltreatment (4.1% intensive service group vs. 3.0% comparison group). Birth outcomes include higher rate of full term births (95.7% vs. 74%), fewer birth complications (0.2 vs 0.48), and higher birth weight (3181 g. vs. 3282). Pregnancy risk scores for the intensive service group were also lower (0.2 vs. 0.8). Intensive service group showed greater increase in quality of home environment than comparison group at 1 year, and maintained this increase at two years. Improved parent-child interaction among intensive service group, comparison group decreased 95% of children in intensive service group are within the normal range on developmental screening. Higher immunization rate of 92% vs. 74% control group, 60-74% statewide. Teen repeat births reduced to 10% compared to 35.8% in Hampton, 29.8% statewide. No difference on social support.
Wisconsin A. Keim	Comparison Group (Births prior to program implemntation .	1 site HV: 36 C: 23	Private & Local	10/95 - 6/98	Child Medical Needs Child Abuse Potential Inventory Ages & Stages Questionnaire Maternal Social Support Index HOME Inventory Home Screening Questionnaire	One year outcomes include greater utilization of community resources and regular child health care, less use of emergency room care, and greater identification of possible developmental delays among served families. Also, served mothers scored signif. higher on HomeScreening Q:Maternal Responsiveness subscale, and displayed a trend ($p < .10$) to breastfeed longer. No group differences were found on the HOME Inventory or immunization rates.

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University of Colorado Health Sciences Center

Department of Pediatrics
Prevention Research Center for Family and Child Health

1825 Marion St., 2nd Floor
Denver, Colorado 80218
(303) 864-5200 FAX (303) 864-5236

December 8, 1998

Olivia Golden
Assistant Secretary
Administration for Children and Families, DHHS
370 L'Enfant Promenade, S.W., 6th Floor
Washington, D.C. 20447

Dear Ms. Golden:

Thank you again for attending the meeting on November 17th regarding our plans to replicate the program of prenatal and infancy home visitation by nurses that our group has been testing. I am writing to clarify what we are asking the federal government to do in promoting the replication of the program, and over what time period we are seeking assistance.

First, we are asking for federal assistance in developing a National Center for Nurse Home Visitation that will orchestrate the work of a set of four Regional Replication Centers based in schools of nursing and public health. The National and Regional Centers will promote the development of high-quality programs based upon the model tested in our research by communicating to communities the evidence on which it is based and its clinical foundations, by helping communities develop the funding and organizational readiness to conduct the home visitation program, and by providing training and technical assistance in the clinical operation of the program for 100 sites. These sites will exemplify clinical excellence.

We have estimated that, if we are to ensure program quality, it will take six years to develop the program in 100 communities. After the system of Regional Replications Centers is established, however, the program could be developed with quality in new communities at a much more rapid pace. Our goal is to make this high-quality program available to all low-income, first-time parents in the U.S. We have estimated that this can be accomplished within a 20-year period.

We have submitted a proposal for $40 million to the Robert Wood Johnson Foundation to support the development of this replication system over the next six years (February, 1999 - January, 2005). At some point within the next six years, however, we hope to establish full federal support for the National and Regional Replication Centers. At the meeting, I indicated that the anticipated award from Robert Wood Johnson would be $10 million for the first three years of this six-year initiative. Our proposal to RWJ requested $16.5 million for this initial three-year period (February, 1999- January, 2002). After reviewing the original request, we have decided that we need only about $4.7 million more over this first three-year period, given our own limited capacity to effectively use any more than this. I have attached a set of specific items that have been excised from the budget in the first 3-year period in order to bring our budget into

The University of Colorado Health Sciences Center is committed to equal opportunity and affirmative action

compliance with the $10 million limit. If we were able to find additional support for these activities, the undertaking would be significantly strengthened.

If you have an interest in assisting us with any of the activities that we have had to cut from the Robert Wood Johnson budget during the initial three years, we would be most grateful for your consideration. I'd be happy to provide you a more detailed proposal regarding any of these activities as well as a copy of the Robert Wood Johnson proposal.

Robert Wood Johnson is asking that we work toward finding federal funding partners for the National Center and the Regional Replication Centers in order to ensure sustainable funding once Johnson support ends. The identification of these funding sources would be accomplished by the end of the six-year initiative.

After the initial six-years of support from RWJ, the anticipated number of regional replication centers will increase from 4 to 10 in years 7-20. In year 7, the annual cost of the initiative is estimated at $8 million, but by year 20, the annual cost will rise to $20 million because of the size of the system needed to support new program sites. All of these costs have been adjusted for inflation. At the end of the 20-year period, we expect to have engaged most U.S. communities and trained enough nurses to serve 60% of all families whose income is at or below the federal poverty level. Given the size of the budget for years 7-20, we may need a Congressional appropriation in order to sustain the developing system of replication centers.

As I indicated in the meeting, we also could make good use of in-kind contributions from various federal agencies regarding the identification of potential funding streams and barriers to states' and localities use of existing federal sources of funds, and regarding the use of existing data systems for monitoring the health and well-being of children and families in local programs.

Thank you again for your interest in this work and for your attendance at the November 17th meeting.

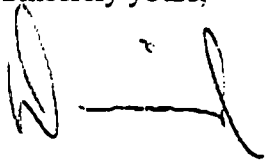
You may write to me at the address on the letterhead or email or phone me as follows:

phone: 303-864-5205

email: olds.david@tchden.org

I am most interested in your thoughts on these issues and would welcome whatever insight or assistance you might provide.

Sincerely yours,



David Olds, Ph.D.
Professor of Pediatrics, Psychiatry and Preventive Medicine
Director, Prevention Research Center for Family and Child Health

INITIATIVE ACTIVITIES CUT FROM ROBERT WOOD JOHNSON PROPOSAL TO ESTABLISH SYSTEM OF REGIONAL REPLICATION CENTERS FOR PROVEN PROGRAM OF NURSE HOME VISITATION

Years 1-3

- A full time policy/financial analyst, who would identify promising sources of federal support for the program that states and localities might use to fund the program. This person would work with federal and state officials to identify constraints on the use of existing sources of funds and ways that those dollars might be freed up to support the program. Examples of possible funding sources include: TANF, Medicaid, the MCH Block Grant, and Title IVE. This person would prepare a "recipe" book that might be used to fund the program in different state and local contexts. Total cost: $ 244,540.

- Development Officer to assist the Director of the National Center with fundraising for the national replication system. Total cost: $188,108.

- Communications Assistant to assist the National Center leadership with development and use of communications strategies and technologies both within the National System (regional center staff, local sites) and outside. Duties include web-page support, developing a newsletter, managing regular conference calls, and creating periodic video-conferences, and handling requests for information. Total cost: $131, 676.

- Contract with Regional Center at University of North Carolina. Important staff involved in training and evaluation have been cut. Total amount cut: $1,688,141.

- Contract with second Regional Center (probably University of California at Los Angeles). Important staff have been cut and timing of startup has been delayed. Total amount cut: $492,993.

- Contract with Regional Center 3 has been eliminated entirely. Total amount cut: $756,884.

- Contract with Regional Center 4 for start-up costs during year 3 has been cut entirely. Total amount cut: $109,000.

- Contract with *Invest in Kids*, a non-profit organization established in Colorado by a group of 25 attorneys to promote evidence-based programs for children in the under 5-age range; 80% of this organization's effort is devoted to the establishment of this program in Colorado. Total amount cut: $458,344.

- Contract with the National Institute of Health Care Management (NIHCM) in which NIHCM will engage managed care organizations (MCO's) in the initiative, will convene a series of biennial meetings to facilitate an exchange of perspectives and to disseminate results among key stakeholders, including MCO's, the policy community, and state, local, and federal officials, and will disseminate project results to a larger audience by producing and distributing a summary "proceedings" that synthesizes key insights from the meetings. Total cost: $645,000.

12/15/98

Dear Nicole,

I am enclosing the letter we discussed with the thought that you could get it to Hillary.

I'm also enclosing some materials re the right wing attacks on home visiting — which [illegible]

Best regards,

CLINTON LIBRARY PHOTOCOPY

PHOTOCOPY
PRESERVATION

NATIONAL COMMITTEE TO PREVENT CHILD ABUSE

A Nationwide Commitment to Preventing Child Abuse Since 1972

I hope you will read and give me your thoughts and reactions.

Thank you, again, for all the help you are giving us.

Best regards,

Ann

"a movement in the U.S. for cradle-to-grave tracking of newborns of first-time parents."

"to provide universal hospital and in-home visits to all first-time parents in America."

"This movement sets a dangerous precedent. While the stated goal is to prevent child abuse, intervention into the lives of all first-time parents is excessive in the extreme. National computerized records are to be compiled on every newborn and their families, to be shared with health organizations and other."

"unfortunately, most members of Congress were not aware of the inherent dangers in this program."

Rep. Henry Hyde (R. IL)
October 1998

National Committee to Prevent Child Abuse

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National Honorary Board
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Bill Cosby
Matilda R. Cuomo
Senator Christopher Dodd
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Bob Hope
Robert Keeshan
"Captain Kangaroo"
Ann Landers
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The Oak Ridge Boys
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Joan F. Entenger
Martha Farrell Erickson, Ph.D.
[illegible]

*Executive Committee

Executive Director
[illegible]

Founder
[illegible]

October 28, 1998

Mr. Irving B. Harris
The Harris Foundation
2 North LaSalle, Suite 400
Chicago, IL 60602-3703

Dear Irving:

I am enclosing the two recent articles that underscore the importance of reaching out to and energizing political moderates on behalf of home visiting programs.

The *Chicago Sun-Times* article about Congressman Henry Hyde's attack on home visiting reminds me of President Nixon's veto message of the child development bill. Nixon said the bill would "Sovietize" American families, the public believed him, and his veto message stopped progress on national support for child development and day care in its track for at least a decade.

And we know why he used that exaggerated ideological rhetoric - just one week before the legislation reached his desk he had announced that he would visit China. That announcement received enormous criticism from the right wing, so he used his veto message to reach out to them, and it worked.

Now Congressman Hyde is under enormous criticism, from the right wing, for not being tougher on President Clinton in chairing the impeachment hearings. Home visiting is a great target for him to attack. And he is considered by many to be a moderate Republican.

We cannot stand by and let this organized minority carry the day. We need to - and we have the chance to - mobilize middle America to support home visiting - so moderate leaders will see that home visiting is known by and popular with main street America.

I just recruited Leslie Wheeler Hortum, a Senior Vice President of the US Chamber of Commerce, to join our board to help us in this effort to isolate the right wing. She could not agree more with the approach and is anxious to start.

I spoke with Phyllis on Monday about the status of my concept paper. She correctly pointed out that it does not include a budget or specific activities. I never intended for it to. I wanted first to see if you agreed with the idea — and if so, I am ready to develop the budget and strategy a proposal needs. Perhaps, if you are interested in pursuing this, the next step might be another more targeted discussion with you and Phyllis. Please let me know when you are available for discussions.

Sincerely,

A. Sidney Johnson III

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web site: http://www.childabuse.org e-mail: ncpca@childabuse.org

National Committee to Prevent Child Abuse

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Ginger M. Sawyer
Jane Smith
A. Clement Stone
Clarice Dibble Walker
Roger E. Wheeler

*Executive Committee

Executive Director
A. Sidney Johnson III

Founder
Clement J. Stone

August 19, 1998

Ms. Phyllis Glink
The Harris Foundation
Two North LaSalle St., Suite 400
Chicago, IL 60602

Dear Ms. Glink:

I am pleased to submit the attached concept paper to The Harris Foundation.

For more than 25 years, the National Committee to Prevent Child Abuse (NCPCA) has been dedicated to creating programs that help America's children get off to a safe and healthy start. But our efforts have become an increasingly frequent target for far-right-wing organizations seeking to swing American public opinion and policy against voluntary home visiting services for first-time parents. These attacks, made in the name of religion and family, threaten our Healthy Families America (HFA) program of home visiting. State HFA legislation across the nation has been held-up, under-funded, or denied funding altogether – its proponents overwhelmed by the organized campaigns of the radical right-wing.

The right-wing's anti-child, anti-family campaigns endanger the health and safety of untold thousands of children and families helped by HFA. *Voluntary early childhood services prevent child abuse and neglect and build healthy families.* We cannot allow the likes of Gary Bauer, Phylis Schlafly, and Pat Robertson to obscure this fact and to shape the debate about child abuse and early childhood programs.

NCPCA invites The Harris Foundation to join us in telling the truth about HFA. We will bring our positive, pro-child, pro-family message to the Elks Clubs, the Lions Clubs, the Junior Leagues, the Key Clubs, the neighborhood organizations, and the faith communities of mainstream America. We will seek their support and participation in our services. We will win the hearts and minds of America for children.

I write with particular passion and urgency because I have been down this road before. From 1971 to 1976 I served as staff director of the U.S. Senate Subcommittee of Children and Youth, chaired by Senator Walter Mondale. In this position, I drafted the first major day care legislation to be adopted by Congress. It was then vetoed by President Nixon with an

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unprecedented right-wing, ideological veto message. In that message, the President denounced the Mondale legislation by claiming it would "sovietize American families." The veto message produced the largest, genuine, opposition mail campaign in memory.

In response, I devoted virtually the next six months to successfully garnering support for day care legislation from a wide range of mainstream issue, service, and religious groups. While effective, this support *followed* – rather than *preceeded* – the right-wing attacks. While it neutralized the issue, it never built the constituency needed to re-enact that important legislation. After this defeat, major national funding for daycare programs would not be enacted for almost fifteen years.

This time – with HFA home visiting – we have an opportunity to act rather than react, to define the issue and rally mainstrean America for children. But we need to act now with a deliberate, planned strategy, before the right-wing propaganda begins to frighten individuals and groups in the political center. We have a chance to educate mainstream America and ensure that an organized minority does not prevail because mainstream America is uninvolved and uninformed.

Thank you for taking the time to consider this concept. We will be in touch in the coming weeks to ensure you have received these materials and to answer any questions. Meanwhile, if you need to contact us for any reason, please feel free to contact me at (312) 663-3520.

Sincerely,

Asd

A. Sidney Johnson III
Executive Director

Thank you, and
Irving, in advance for
your consideration of
this proposal. In many
ways, it applies the "science
of prevention" approach to another
dimension of early childhood issues

Hearts and Minds for Children
A Concept Paper

Introduction

Each year, conservative foundations pour millions of dollars into a broad range of political organizations to promote far-right-wing positions. The Lunde and Harry Bradley Foundation, the Koch Family foundations, the John M. Olin Foundation, the Scaife Family foundation and the Adolph Coors Foundation have bankrolled a variety of campaigns designed to effect major changes in American public opinion and policy. Foot soldiers in these efforts include the Eagle Forum, the Cato Institute, the Goldwater Institute, the Christian Coalition, the Heritage Foundation, the Family Research Council, and Focus on Family.

Increasingly, a target of these efforts has been Healthy Families America (HFA).

Healthy Families America is an initiative developed to help first-time parents meet the challenges that surround the birth of their child. Launched in 1992 by the National Committee to Prevent Child Abuse (NCPCA), in partnership with Ronald McDonald House Charities, HFA is based on over two decades of research and the experience of numerous communities nationwide. Today, there are more than 270 HFA sites in forty states and the District of Columbia.

HFA assists parents by assessing the needs of families prenatally or immediately after the birth of a baby and offering, on a voluntary basis, the services of a home visitor. Home visitors are selected for their ability to develop trusting, nonjudgemental and supportive relationships with parents. They work with families to identify strengths and specific needs, link them to health and social services, and provide family support and parenting education.

HFA works because it makes sense. It makes sense to give new parents the support and education they need before or at the time their children are born. It makes sense to prevent child abuse before it occurs. It makes sense to ensure that children begin life with the set of emotional, physical, and developmental skills necessary to succeed in life.

And HFA *does work.* In Vermont, home visiting has reduced child abuse by more than forty percent in six years. In Arizona, child abuse is down by fifty percent among families served by HFA. HFA sites report improved parent-child relationships, more well-baby health visits, and significant increases in immunization rates.

The experts agree. Support for HFA-type early intervention comes from the American Academy of Pediatrics, the Carnegie Corporation of New York, the Child Welfare League of America, the Committee on Economic Development, the National Commission on Children, the U.S. Department of Justice, and the U.S. Advisory Board on Child Abuse and Neglect.

Opposition

"Home visitation is dangerous because the "visitor" to your home often has a belief system antithetical to your own. It is psychological and humanistic (atheist). You are in danger." - National Association of Christian Educators

Despite – or, more accurately, *because of* – its success, HFA is a natural target for the narrow political agenda of far-right-wing organizations. Groups such as the Christian Coalition, Gary Bauer's Family Research Council, and their partners appeal to *fear* in the name of religion and family. They present home visitation programs as dire threats to parental and church authority. *They seek to win over moderate and mainstream people.* Such support is necessary to acquire electoral and political power. Gary Bauer, for example, is actively considering a run for the presidency of the United States.

Scare-tactic arguments advanced by these groups against HFA's home visitation program include (taken from their literature):

> "Everything is child-centered – not parent-centered. The focus is on complete freedom for every child."

> "Spanking, or even telling a child "No," could be considered repressive and destructive to your child, and therefore abusive."

> "Demand-feeding of babies is promoted, leading to an undisciplined child."

> Your child could be removed from your home at any age, if the social worker checks her report form as a "dysfunctional family."

> "Parents must obey every directive of the social worker or face severe consequences. Parents, basically, will lose control over how to raise (train) their own children."

These arguments, confused and misleading as they may be, can succeed in blocking or stalling the implementation and funding of HFA. They led to reduced funding for HFA in Montana, where the program was labeled "socialism" on the House floor. They contributed to repeated defeats of HFA legislation in Texas,

before passage we finally secured. They were ammunition as extremists fought HFA tooth-and-nails in St. Louis and in Arizona. And they prevent states like Iowa from expanding HFA programs to cover the full state, for fear of antagonizing the opposition and jeopardizing the entire program.

These right-wing campaigns of disinformation put HFA *and* America's children at risk.

A Reasoned Appeal

NCPCA has a moral responsibility to educate Americans about the realities of child abuse and about proven prevention programs such as HFA. We owe that much to the 1,185 children known to have died as a result of child abuse last year. We owe that much to the 3,000,000 children who were reported to be abused or neglected. While we cannot hope to prevail upon our most radical critics, we *can* present our message where it matters most – in mainstream America. We *can* win over the hearts and minds of mainstream America.

NCPCA proposes a grass-roots campaign to counter the aggressive anti-HFA lobbying of the far-right-wing by bringing our message of support for families and children to mainstream America. We will work in partnership with any and all willing membership organizations. We will seek out and nurture alliances with churches, synagogues, and mosques. We will develop non-confrontational, effective communication tools to carry our message. We will speak to all who will listen.

We will identify membership organizations that may be open to our message. Possibilities include:

Kiawanis Clubs
Elks Clubs
Moose Clubs
Lions Clubs
Rotary Clubs
Shriners
Masonic organizations
Chambers of Commerce
Junior Leagues
4H Clubs
Veterans of Foreign Wars
League of Women Voters
Greek societies
Key Clubs
Exchange Clubs
Soroptimist Societies

Extension Service
Fraternal Order of Police
Tribal organizations and governments
Churches, synagogues, mosques, and religious associations
Community coalitions
Ethnic coalitions

We will develop a pro-HFA presentation that our Executive Director, Board members, and state chapter leaders will make to as many of these groups as possible across the nation.

We will develop pro-HFA educational materials to be distributed to these groups.

We will encourage and assist our state and local chapters in forming working partnerships with these groups.

In all of these efforts, we will stress the pro-family, parent-supportive and voluntary nature of HFA. We will develop answers to commonly-asked questions. We will aim for culturally and regionally-appropriate language.

We will avoid language that has proven to be "hot-button" in some communities, including: "intervention," "universal," "program," and "outcome." We will emphasize concepts such as: "voluntary," "optional," "offering," and "support." We will present a positive message and encourage coalition-building. In this way, we will succeed.

Costs

To achieve our goals, we envision a two-year effort involving 10% of our Executive Director's time, as well the full-time efforts of a program staff person. With printing, telephone, travel, and indirect costs factored in, we roughly estimate a cost of $200,000, or $100,000 per year.

Conclusion

NCPCA is tremendously excited about the opportunity to help children by bringing our positive, inclusive message to mainstream America. We are not satisfied to simply surrender that playing field to the likes of Pat Robertson, Phyllis Schlafly, and Gary Bauer. The issue of preventing child abuse is too vital. The stakes are too high.

NCPCA is uniquely qualified to lead this initiative. Our Executive Director, Sidney Johnson, drafted the first major day care legislation adopted by

Congress. After then-President Nixon vetoed the legislation with an unprecedented right-wing veto message, Sid Johnson garnered support for the daycare bill from the very same mainstream groups we will target in our HFA project. But as important as it was to set the record straight about daycare, that was primarily a damage-control, "after-the-fact" campaign. *Now*, we have an opportunity to *act* — rather than *r*eact – by defining the issue of early intervention and rallying mainstream support. But time is of the essence. Like the ads say, "Act now and save!"

We would welcome the support of the Irving B. Harris Foundation in these efforts. We know you share our commitment to the health and well-being of America's children.

National Committee to Prevent Child Abuse

Honorary Chairman
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National Honorary Board
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Bill Cosby
Matilda R. Cuomo
Senator Christopher Dodd
Chris Evert
Patrick Ewing
Vincent J. Fontana, M.D.
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Haim Saban
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Ginger M. Salazar*
John Smith III
W. Clement Stone
Clarice Dibble Walker
Linden E. Wheeler

***Executive Committee**

Executive Director
A. Sidney Johnson III

Founder
Donna J. Stone

Date: December 9, 1998

To: Irving Harris

From: Sid Johnson and Michelle Rieff

Subject: Right Wing

This week NCPCA held meetings with our state HFA leaders. I made a presentation about the right wing issues and from this we held meetings with 13 states to explore their concerns.

The attached identifies the states, issues, emerging strategies and a draft budget outline.

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NCPCA chapter and Healthy Families American leaders from the following states expressed serious concerns about right wing attacks on Healthy Families America and home visiting:

- Alabama
- Alaska
- Arizona
- Florida
- Illinois
- Louisiana
- Maine
- Minnesota
- Montana
- North Dakota
- Texas
- Utah
- Virginia
- Wisconsin
- Wyoming

We desire to work with and learn from others:

- People for the American Way
- Fight Crime, Invest in Kids
- Public opinion pollsters (i.e. Celinda Lake)

Issues:

- Intrusion/Privacy
- Data (will go to CPS, lead to removal of children)
- Anti-parents
- Anti-discipline
- Anti-Bible
- Mandatory
- Assessments
- Universal
- Government

Strategy

- Out flank not convert, the right wing
- Educate organization and mobilize middle-America, mainstsreet
- Promote service, faith, community involvement and participation in HFA activities (Adopt a Caseworker)
- Identify unexpected messengers
  - Chamber of Commerce
  - Corrections officers
  - Junior League, etc.
  - Juvenile court judges
  - Rotary, etc.
  - Sheriffs, police chiefs
- Develop communications tools and prepare messages:
  - brainstorm research information
  - fact sheets
  - generic op-ed pieces (5)
  - legislative talking points
  - sample testimony
  - speeches
- Build on churches adopting welfare family (Texas)
- Make friends before we need them
  - legislators
  - media
  - home visits opinion leaders

PROPOSED BUDGET

Projected Expenses:	First Year	SecondYear
Salaries applicable for grant:		
Sid Johnson, Executive Director	$7,000	$7,000
Michelle Rieff, Adv.Director	$10,000	$10,000
Kevin Kirkpatrick, Comm. Dir.	$10,000	$10,000
50% of new staff person	$25,000	$25,000
Benefits 25% of salaries	$13,000	$13,000
Total Employment	$65,000	$65,000
Consultant Fees	$10,000	$10,000
Three Chapters/Three HFA sites	$24,000	$24,000
Travel	$10,000	$10,000
Telephone/Conference calls	$6,000	$6,000
Materials Development/Printing Costs	$5,000	$5,000
Indirect Costs	$10,000	$10,000
Total	$130,000	$130,000

REPLICATION OF A PROVEN PROGRAM OF HOME VISITATION BY NURSES FOR NEW MOTHERS

This proposal seeks support for the development of a national system for replicating a well-tested program of home visiting by nurses that improves the health and life-course of new mothers and their children. As part of this initiative, the program wil be developed in 100 new communities over a six-year period. The replication system will consist primarily of a National Center based at the University of Colorado Health Sciences Center and a set of Regional Replication Centers based in schools of nursing and public health positioned geographically to serve different regions of the country. The overriding goal of this initiative is to develop the program in new settings with fidelity to the model so that new communities can have greater assurance that the program will reproduce the results achieved in scientifically controlled studies.

Robert Wood Johnson Foundation

A proposal for this $40-million initiative has been solicited by the Robert Wood Johnson Foundation (RWJF). Senior staff at RWJF have requested partnership with a federal agency, including cost-sharing. They have sought this partnership in order to assure continued support for the replication of this program after this six-year initiative terminates.

Potential Role of HHS

It is expected that the federal agency chosen for this role will share the mission of the initiative -- that is, the improvement of pregnancy outcomes, the prevention of health and developmental problems in children, and the promotion of family economic self sufficiency. The agency should demonstrate a strong commitment to and capacity for sustaining evidence-based practice. Assuming continued federal support, the selected agency will administer this national replication system after completion of the six-year initiative.

Background

For several decades, federal, state and local governments and a variety of private efforts have struggled to create interventions that would prevent or at least reduce the incidence of child abuse and neglect, crime, welfare dependency and other severe social problems. Yet our society still faces persistent rates of child and family poverty, births to adolescents, infant mortality, and juvenile crime.

Many of these problems can be traced directly to the behavior of mothers and fathers and conditions in the family home. During the past three decades a variety of preventive interventions to address these problems—including several models of home visitor programs and some programs based in the social welfare system—have been found to produce little success. One program of prenatal and infancy home visitation by nurses, however, has been developed to address many of the programmatic and clinical deficiencies found in programs tested earlier. Scientifically controlled studies of this program in Elmira, New York, and Memphis, Tennessee, have produced a variety of positive outcomes for low-income mothers and their children. These include fewer health problems for the mothers and children, fewer subsequent pregnancies and live births for the mothers, less use of welfare by the mothers, fewer validated cases of child abuse and neglect, less use of substances for mothers and children (including illegal drugs, alcohol, and cigarettes), and fewer arrests and convictions

of mothers and of their children during the 15-year period after delivery of the child. This nurse visitor program also pays for itself with reductions in government spending by the time the children are four years old. Cost-savings to government and society over the child's lifetime are at least four times greater than the cost of the program.

The Program Model

The program consists of nurse home visitors who work with women and their families in their homes during pregnancy and the first two years of the child's life to accomplish three goals:

Improve pregnancy outcomes by helping women alter their health-related behaviors, including reducing use of cigarettes, alcohol, and illegal drugs;
Improve child health and development by helping parents provide more responsible and competent care for their children; and
Improve families' economic self-sufficiency by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

The format for visits follows a standard process, specified in visit-by-visit protocols and reinforced in intensive training undergone by all of the nurse visitors. The nurses typically work for departments of health, visiting nurse associations, or hospitals that provide primary care for mothers and children.

Key differences between the model proposed for replication and other home visitation programs include:

A firm foundation in theories of development and behavioral change and methods to reduce specific risks for poor maternal and child outcomes;
Focus on low-income women bearing first children;
A clinical foundation in health;
Use of nurses;
Initiation of visits during pregnancy and involvement with families for two years postpartum; and
Use of detailed visit-by-visit protocols to guide the nurses in their work with families.

Replication Activities to Date

During the past two years, the Prevention Research Center for Family and Child Health at the University of Colorado (PRC) has instituted the program in 13 new communities and the entire state of Oklahoma, and has begun to serve more than 1,200 new families in non-research settings. The purpose of this preliminary replication effort has been to answer two key questions:

Would local communities be willing to pay for the program out of existing sources of funds?
Would the PRC be able to train new nurses to conduct the program according to the essential elements that have proven effective in the trials?

To date, the PRC has evaluated these replication efforts and found that communities are willing to pay for this program, and that the essential elements of the program are being replicated in new communities. This has served as an impetus to take this work to the next stage to be covered under the proposed initiative.

Work Planned for the Initiative

The proposed initiative has four goals to be achieved over six years:

Create a National Center and a system of Regional Centers capable of managing and supporting program expansion;

Create a national clinical practice foundation of 100 high-quality local programs that are sustainable and successful at improving the health and life-course of low-income children and their families;

Create sustainable funding for the National and Regional Centers and for a growing number of local programs; and

Evaluate the initiative.

The work proposed here will serve at least 10,000 women, children, and their families over the six-year period covered by the current initiative, and will lay a solid foundation for serving as many as 180,000 low-income families per year within 14 years after the end of this six-year initiative.

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HOME VISITING SERVICES DEMONSTRATION

The Home Visiting Services Demonstration is testing whether weekly home visits to teenage parents who receive public assistance can help them transition off welfare. Under the demonstration, paraprofessionals, many of whom are themselves former public assistance recipients, work closely with case managers and teenage parents to improve the family's social, personal, health, and economic conditions.

This initiative is part of the States' employment programs, which help public assistance recipients move from welfare to independence. Launched in September 1994, the demonstration phase will operate through September 1997 in Dayton, Ohio, Chicago, Illinois, and Portland, Oregon, with the evaluation of the initiative expected to be completed in September 1998.

Home visitors provide instruction and guidance in such areas as pregnancy prevention, parenting skills, education and work skills, health care, and sources of help. There is also a strong emphasis on child support, including paternity establishment.

In each city, at least 225 teen parents and their children will receive employment services and home visiting services. Another 200 teen parents in each site will receive such services but no demonstration sponsored home visits.

Young parents under the age of 20 are eligible to participate in the demonstration. Because the demonstration is targeted to young women with their first child, most of the children taking part in it are infants. Unless they leave welfare, families will continue in the program for two years. For those who leave, visits may be provided for a 90-day transitional period.

Visits with the family, which last about an hour, usually take place in the teen's home but occasionally occur at such locations as schools, work sites or public facilities. Visitors complete a strengths and needs assessment for each teen and identify specific areas to be strengthened. In addition, visitors closely monitor perinatal health check-ups for the children and identify any special needs.

In each session, visitors use curricula for teens and children as a means of focusing on a specific topic and addressing immediate needs within the family. Teens are provided with resource materials on such topics as child development and safety.

The Home Visiting Demonstration is a joint initiative of the Department of Health and Human Services' Administration for Children and Families and the Henry J. Kaiser Family Foundation. The Department has pledged over $3 million and the Kaiser Foundation nearly $1 million to test and evaluate the initiative. The project is being evaluated by the University of Pennsylvania.

February 1998

DRAFT

Preliminary Summary of Federal Program Funds Available for Home Visiting

This is a list of the major federal programs for which funds can be used for home visiting services. In addition to a brief description of the program, this list provides examples, where available, of the types of home visiting programs currently operated with federal funds. This information was obtained through communication with staff from administering agencies, downloaded from agency web sites, and pulled from relevant sections of *The Future of Children* report on Home Visiting published by the Packard Foundation, Winter 1993 (see attachment).

Federal Program and Administering Agency	**Description of Federal Program**	**Description of Home Visiting Program**	**Limited Demonstration or Ongoing Program?**
Head Start/Early Head Start (DHHS/ACF/ Head Start Bureau)	Head Start is a comprehensive child development program for low-income preschool children (from ages three to five) and their families. Head Start provides early childhood education which emphasizes cognitive and language development, social and emotional development, physical and mental health, nutrition, social services and parent involvement. Early Head Start provides Head Start's services to younger children (from birth to age three) and their families, and to pregnant women. Early Head Start is designed to enhance the development of the child, increase parents' skills and knowledge of child development, and strengthen the family unit.	Head Start programs may offer variations on the standard program option in which children attend a center-based program five days a week. In addition to the standard option, Head Start programs may offer home-based programs, in which home visitors work with parents and children in their homes one day a week, and bring parents and children in home based programs together weekly for group activities, and monthly for socialization with other families. Local programs may also operate a combination of home-based and center-based programs. During the 1997 reporting period, 5 percent of Head Start children were served by programs that offered the home-based option. Early Head Start programs may also operate home visiting programs or a combination of home-based and center-based models. One component of the national Early Head Start Research and Evaluation Project, currently in progress, will examine both the quality and quantity of key services for children, including child care and home visits. According to the Packard Report, Head Start funds are used to support a range of home visiting program models including Parents as Teachers (PAT). PAT programs also receive Even Start funds and funds from private sources.	On-going

Federal Program and Administering Agency	Description of Federal Program	Description of Home Visiting Program	Limited Demonstration or Ongoing Program?
Community-Based Family Resource Program (DHHS/ACF/ Children's Bureau)	Community-Based Family Resource Program grants are provided to states to develop and implement, or expand and enhance, a comprehensive, statewide system of community-based family resource services. To receive these funds, states must have established or maintained a trust fund or other funding mechanism that pools Federal, state, and private funds and makes them available for child abuse and neglect prevention and family resource programs.	States may choose to use these grants to deliver home-visiting services. According to program staff, states such as Alabama, Ohio, Hawaii and Georgia in particular may be using these grants for home visiting.	On-going
Child Welfare Services/ Title IV-B Part 1 (DHHS/ACF/ Children's Bureau)	The Child Welfare Services Program is a state grant program that helps states improve their child welfare services with the goal of keeping families together. State services include preventive intervention; services to develop alternative placements like foster care or adoption if children cannot remain at home; and reunification so that children can return at home if at all possible.	States may choose to use these grants to deliver home-visiting services.	On-going

Federal Program and Administering Agency	Description of Federal Program	Description of Home Visiting Program	Limited Demonstration or Ongoing Program?
Safe and Stable Families Program/ Title IV-B Part 2 (formerly Family Preservation and Support Services) (DHHS/ACF/ Children's Bureau)	Safe and Stable Families is a state grant program to encourage and enable each state to develop and establish, or expand, and to operate a program of family preservation services and community-based family support services. Family preservation services typically are activities to assist families in crisis, often families where a child is at imminent risk of being placed in out-of-home care because of abuse and/or neglect. Family support services are primarily preventive activities with the aim of increasing the ability of families to successfully nurture their children.	States have flexibility to design their family support and preservation programs. Home visiting is one type of service which may be provided.	On-going
Temporary Assistance for Needy Families (DHHS/ACF/ OSA)	Temporary Assistance for Needy Families (TANF) provides a fixed block grant to states for the provision of assistance to needy children and their families. TANF greatly enlarges State discretion in operating family welfare programs. States may use TANF funds to provide a range of human services programs for families, including those provided through home visiting.	No systematic data is available on how states are using TANF funds to support home visiting services. There is anecdotal evidence that some states are using TANF funds to support nurse home visiting and to monitor TANF cases that are sanctioned and/or terminated. Historically, some Aid to Families with Dependent Children (AFDC) programs used home visiting for purposes of eligibility determination and to provide special intensive services to clients.	On-going

Federal Program and Administering Agency	Description of Federal Program	Description of Home Visiting Program	Limited Demonstration or Ongoing Program?
Healthy Start (DHHS/HRSA/ MCHB)	The objective of the Healthy Start Initiative is to decrease infant mortality in targeted urban and rural communities. It relies on community-based collaborative efforts to provide comprehensive health and social services, as well as individual and community development activities. Components of Healthy Start programs include community involvement; outreach and case management to identify women, bring them into care, refer them to appropriate services, and track them as they obtain services; a variety of other support services such as transportation and nutrition education; enhanced clinical services; and community-wide public information campaigns.	According to the Maternal and Child Health Bureau, there were 85 Healthy Start programs as of 11/20/98. Home visiting services are offered by some Healthy Start programs (see attachment); however, home visiting is not the core activity of the interventions. When used, home visiting is used within the rubric of case management activities. According to MCHB staff assigned to the national evaluation of Healthy Start, 40 percent of the women received 0 or 1 home visit and 20 percent received 6 or more visits.	Demonstrations

Federal Program and Administering Agency	Description of Federal Program	Description of Home Visiting Program	Limited Demonstration or Ongoing Program?
Maternal and Child Health Block Grant (DHHS/HRSA/ MCHB)	Authorized by Title V of the Social Security Act, the Maternal and Child Health Services Block Grant Program is a federal-state partnership with three components: formula block grants to states and territories; Special Projects of Regional and National Significance (SPRANS); and Community Integrated Service Systems (CISS) grants. State Title V block grant programs support such services as prenatal care; child health services including immunizations, well-child examinations, and treatment or referral; school health services and education programs; and specialized health services and family support for children with actual or suspected developmental disabilities or chronic illnesses. Activities supported under SPRANS include maternal and child health improvement projects that support innovative strategies. The CISS program funds projects for the development and expansion of integrated services at the community level.	According to the MCHB, all State Title V block grant programs support some home-visiting services, although these services are extremely limited in many States due to funding constraints. In addition, SPRANS and CISS funds can be used to support home-visiting programs. According to the Packard Report, Resource Mothers is one example of how states are using their Maternal and Child Health Block Grant funds to provide home visiting services. Resource Mothers programs employ paraprofessionals from participating communities to visit pregnant women and children. The Resource Mothers seek to improve birth outcomes, decrease injuries to children, and lower child abuse rates by providing information about maternal and child health and development and by linking mothers with health and other community services. Beyond that, they serve as mentors to the expectant mother throughout her pregnancy, delivery and the first year or more of her child's life. In addition to MCH funds, Resource Mothers may receive federal funding from Medicaid, the Indian Health Service, and Migrant Health Service. In Virginia, Resource Mothers is a statewide program which assists first-time pregnant teens in obtaining prenatal care and other services.	On-going

Federal Program and Administering Agency	Description of Federal Program	Description of Home Visiting Program	Limited Demonstration or Ongoing Program?
Medicaid (DHHS/HCFA)	Authorized by Title XIX of the Social Security Act, Medicaid is a federal-state matching entitlement program to assist States in the provision of adequate medical care to needy persons and families with low incomes and resources. Each state establishes its own eligibility standards; determines the type, amount and duration of services; sets the rate of payment for services; and administers its own program.	States may use Medicaid funds to deliver home visiting services. For example, South Carolina uses home visiting in their targeted case management for pregnant women. In Maryland, state legislation passed in 1998 requires that Medicaid managed care organizations use home visiting programs to assist beneficiaries with various aspects of health care. According to the Packard Report, Resource Mothers is one program which is supported with Medicaid funds. (For more information about Resource Mothers, see the description of the Maternal and Child Health Block Grant.)	On-going

Federal Program and Administering Agency	Description of Federal Program	Description of Home Visiting Program	Limited Demonstration or Ongoing Program?
Starting Early/ Starting Smart (DHHS/ SAMHSA, ACF, HRSA, NIH; and Dept. of Ed.)	Starting Early/Starting Smart (SESS) is a child-centered, family-focused, and community-based initiative to test the effectiveness of integrating behavioral health services within primary care and early childhood service settings for children from birth to seven. Primary care and early childhood grantees provide services such as case management, pediatric primary care, home visitation, dyadic therapy, parent education, support groups, language development, reading readiness, domestic violence treatment and education, in-home support, mental health services, substance abuse intervention and treatment, and specialty services such as speech or physical therapy.	As of 10/98, there were 12 SESS sites. Home visits are conducted in several of the primary care and early childhood study sites. SESS sites offering home visiting services include the University of Miami (Coral Gables, FL), Boston Medical Center (Boston, MA), National Association for Families and Addiction Research and Education (Chicago, IL), University of New Mexico Health Sciences Center (Albuquerque, NM), Asian American Recovery Services (San Francisco, CA), Children's Research Institute (Washington, DC), The Women's Treatment Center (Chicago, IL), Child Development, Inc. (Russellville, AR), State of Nevada (Las Vegas, NV) and the Tulalip Tribes (Marysville, WA). In addition to federal funds, SESS is supported by The Casey Family Program.	Demonstrations

Federal Program and Administering Agency	Description of Federal Program	Description of Home Visiting Program	Limited Demonstration or Ongoing Program?
Even Start (Dept. of Ed./OESE)	The Even Start program offers grants to support local family literacy projects that integrate early childhood education, adult literacy or basic education, and parenting education for parents who are eligible for services under the Adult Education Act, or who are within the compulsory school attendance age range, and their children from birth through age 7. Federal funds are allocated by formula to states, which make competitive grants to local projects.	Projects supply or arrange for early childhood education, adult basic education and literacy training, and parenting education for participating families, often through cooperative agreements with government agencies, colleges and universities, public schools, and Head Start programs. According to OESE, all local Even Start projects must include a home instruction component. According to the Packard Report, Parents as Teachers (PAT), HIPPY and the Mother-Child Program are examples of programs which are supported with Even Start funding. These programs differ in their approaches. Some program models provide parents of preschool-age children with books and activities to enable them to help their children in school; other programs begin prenatally and vary the content of services through the different stages in a child's development.	On-going

Federal Program and Administering Agency	Description of Federal Program	Description of Home Visiting Program	Limited Demonstration or Ongoing Program?
Part A of Title I/ Chapter I (Dept. of Ed./OESE)	Part A of Title I of the Elementary and Secondary Education Act (ESEA) authorizes grants to improve the teaching and learning of children in high-poverty schools. It encourages parental involvement in children's education. Schools may use Part A of Title I funds to provide necessary literacy training for parents, and they are encouraged to work with communities to provide health, nutrition, and social services that are not otherwise available to children being served. These funds may also be used for preschool programs for educationally disadvantaged children.	Local education agencies are allowed to use Part A of Title I funds for home instruction purposes. According to the Packard Report, the Home Instruction Program for Preschool Youngsters (HIPPY) and the Mother-Child Program are examples of programs which are supported with Title I funding.	On-going
Weed and Seed (DOJ/OJJDP, Bureau of Justice Administration and Executive Office of Weed and Seed)	The Office of Justice Programs, Executive Office for Weed and Seed administers the Weed and Seed program, a community-based, multi-agency approach to law enforcement, crime prevention, and community revitalization. Over 100 sites were funded in FY 1997. All sites were operational as of May 1998.	Six Weed and Seed sites in high-crime, urban areas received funding to develop nurse home visiting projects with the assistance of David Olds and his research team at the University of Colorado. These projects are based on the Prenatal and Early Childhood Nurse Home Visitation Program developed by Olds and his colleagues. The sites include Fresno, Los Angeles, and Oakland, CA; Clearwater, FL; St. Louis, MO; and Oklahoma City, OK. The development of the projects has DHHS funding as well as a small amount of juvenile justice funding. Each of the sites will have to identify and obtain funding for actual program costs.	Demonstrations

Federal Program and Administering Agency	Description of Federal Program	Description of Home Visiting Program	Limited Demonstration or Ongoing Program?
Blueprints Project (DOJ/OJJDP)	OJJDP's Division of Training and Technical Assistance is providing funding to researchers at the Center for the Study and Prevention of Violence at the University of Colorado at Boulder to help communities set up "blueprint" projects based on 10 program models which are thought to be effective in preventing violence.	One of the 10 blueprint models is the nurse visitation model. Communities can apply for funding and assistance through the Center for the Study and Prevention of Violence at the University of Colorado at Boulder.	On-going

THE WHITE HOUSE

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FACSIMILE COVER SHEET

TO: Chuck Marr

FROM: Nicole Rabner
Associate Director for Domestic Policy
The White House

FAX #: 62223

PHONE #:

OF PAGES (including cover page) 13

COMMENTS:

ZERO TO THREE[SM]

FAX COVER PAGE

To: Home Visiting Invites	From: Matthew E. Melmed
Fax Number:	ZERO TO THREE
Date: 11/11/98 Pages: 3(incl.cover)	For Information Call: (202) 638-1144
Subject: Home Visiting Summit	Fax Number: (202) 638-0851

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To: Home Visiting Summit Invites
From: Matthew E. Melmed
Re: Home Visiting Summit

I would like to thank all of you for agreeing to participate, on December 17 & 18th, 1998, in an informal summit on home visiting. We all recognize that differences of opinion exist concerning best practices in home visiting, interpretations of findings from studies of home visiting to date, the limitations of the research designs and even a common definition of what we mean when we use the term "home visiting." However, all of us share the desire to address the needs of infants, toddlers, young children and their families. That is what is bringing us together for this summit, and it is also what I hope will guide our discussions.

All of the perspectives you have shared with me are deeply held, sincere and passionate. It is important that we take the time to listen and learn from each other so as to advance the common good.

Based upon my discussions with many of you, I have identified the following goals. They are by no means limited to this list and I welcome your feedback and opinions.

- Develop a common definition of what home visiting *is* and what it *is not*
- Develop a common understanding of the efficacy of home visiting models based upon the current research
- Develop a common understanding of the limitations of the current research, methodology, and conclusions that can be drawn from the current research on home visiting
- Gain a common understanding of the public policy environment in which home visiting programs are and will be operating
- Gain better appreciation of the roles summit members play in influencing the policy environment and each other's work
- Identify, where possible, common messages for policy and practice audiences about home visiting research
- Identify, where possible, common messages about the appropriate use and potential of home visiting

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Formerly the National Center for Clinical Infant Programs

I am very open to receiving input from you all on how to shape the agenda for our meetings. If there are any materials you wish to share with other participants, please feel free to forward them to Beth Duchaine at Zero to Three.

Invited Participants:

Jeanne Brooks-Gunn, Ph.D.;Center for Young Children & Families of Teachers' College, Columbia University
Deanna Gomby,Ph.D, Deputy Director of Children, Families & Communities, The David and Lucile Packard Foundation
Sid Johnson, Executive Director; National Committee for the Prevention of Child Abuse
Brenda Jones Harden; Institute for Child Study, University of Maryland, College Park
Jennifer Klein*, Special Assistant to the President for Domestic Policy, The White House
Joan Lombardi, formerly the Associate Commissioner for Child Care at the Department of Health and Human Services
Tammy Mann, Ph.D., Director of the Early Head Start National Resource Center
Kathryn Taaffe McLearn, Ph.D., Assistant Vice President for Youth Programs, The Commonwealth Fund
David Olds, Ph.D., Professor of Pediatrics & Director of the Kemp Prevention Research Center
Nicole Rabner,*Associate Director for Domestic Policy, The White House
Mildred Winter, Executive Director of Parents as Teachers

*Jennifer Klein and Nicole Rabner will represent the interest of the First Lady in promoting the expansion of home visiting programs. They will help to frame the current policy environment in which home visiting programs operate and the potential impact of our discussions on the policy environment. They will join us only at the beginning of the meeting.

Thank you for agreeing to participate in this very important summit. We worked very hard to accommodate everyone's schedule and selected a date when a significant number of invitees could attend. I ask your appreciation of the fact that we will need to proceed even if we don't have complete participation.

Currently, we do not have funding for this meeting. However, we are attempting to secure a small, discretionary grant to cover the expenses of those of you whose attendance would be precluded due to a lack of funds. Please contact Beth Duchaine and we will do our best to accommodate you.

I am looking forward to talking with you before the summit.

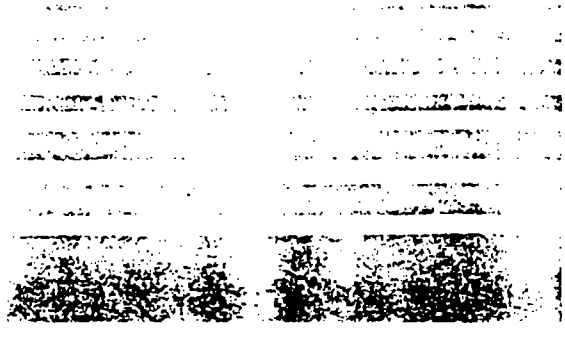
cc: Kathryn E. Barnard

CENTER FOR THE FUTURE OF CHILDREN • THE DAVID and LUCILE PACKARD FOUNDATION

The Future of Children

VOLUME 3 • NUMBER 3 - WINTER 1993

HOME VISITING



Brief Descriptions of Selected Home Visiting Programs

Many home visiting programs are described in this journal issue. This appendix provides brief descriptions of selected home visiting programs, some of which have been mentioned by one or another of the authors in this journal issue and some of which have not. For the sake of organization, we have grouped the programs into three broad categories: (1) those that have a national office to provide technical assistance to agencies wishing to replicate the program model, (2) those selected demonstration projects that have been particularly influential in the home visiting field, or (3) those initiatives that represent a federal commitment to home visiting. The programs and initiatives described here are only a few of the many exemplary efforts that currently operate or have operated in the United States. For example, this appendix does not describe research studies or demonstration projects that were summarized by David Olds and Harriet Kitzman in their review of randomized trials of home visiting programs. For details on these programs, the reader should consult Tables 2–4 in the article by Olds and Kitzman in this journal issue.

Program Models with National Offices

The programs described in this section often began as one small model project. While these programs vary in the extent to which they have undergone evaluation, in all instances, they have expanded far beyond their initial small pilot project status. All have national offices to help other communities start their own similar programs. The national offices offer a variety of services, including training, provision of curricular materials and implementation guides, and advice concerning fund-raising.

Family, Infant and Preschool Program (FIPP)

Begun in 1972, the Family, Infant and Preschool Program (FIPP) in western North Carolina serves families of young children who have been diagnosed as having developmental disabilities, or who are thought to be at risk of developing such disabilities, through home visits conducted weekly or every other week. Home visits may begin immediately following birth and may continue until children are five years old. The home visits are used to assess child and family needs, explore options for meeting needs, develop strategies for implementing interventions, and revise and update

individualized family support plans as needs are met or new needs arise. The assessment and intervention model includes four primary components: specification of family needs, mobilization of intrafamily resources and capabilities, mobilization of extrafamily sources of support and resources to meet needs, and utilization of a variety of staff roles in helping families access resources from their social support networks. Efforts are made to individualize treatments to the needs of family members rather than make families fit predetermined treatment programs; the program is viewed as a distinct set of help-giving principles rather than a specific set of program activities and services. Other services are available to participating families as needed, including case management, parent-child community groups, center-based programs for children, parent support groups, pediatric services, physical therapy, respite care services, equipment for special needs children, and an adult learning center. (See also the article by Powell in this journal issue.)

By 1991, the program had provided services to more than 1,300 children and their families in North Carolina. Currently, 200 to 300 children are served by FIPP. Services are funded through a variety of state, federal, and private sources.

Approximately 27 programs based on the FIPP model exist in other parts of the country and serve more than 5,000 families. FIPP offers training, technical assistance, and consultation throughout the United States to early intervention programs and practitioners, lead agencies, interagency coordinating councils, and other individuals responsible for implementing Part H of Public Law 99-457 within their states. Publications and curricular materials are available from FIPP and its research arm, the Center for Family Studies.

For information about the Family, Infant and Preschool Program or for FIPP materials, contact

Carol Trivette, Ph.D.
Family, Infant and Preschool Program
Western Carolina Center
300 Enola Road
Morganton, North Carolina 28655
704-433-2661

Hawaii's Healthy Start

Healthy Start was established in 1985 by the Hawaii Family Stress Center as a federal demonstration project to prevent child abuse and neglect. Since that time, the program has evolved into a statewide program whose goals now include: (1) assuring that all families have a primary health care provider, (2) assuring the proper use of community resources, (3) promoting positive parenting, (4) enhancing parent-child interaction, (5) enhancing child health and development, and (6) preventing child abuse and neglect. With the support of the Hawaii State Department of Health, Maternal and Child Health Branch, Healthy Start now operates at 13 sites in Hawaii through contracts with seven community-based nonprofits, including the Hawaii Family Stress Center. Total funding for FY 1993 is approximately $7 million, of which 75% is targeted for home visiting services. In FY 1993, 54% of all Hawaii's families with newborns will be screened.

Home visits are conducted by paraprofessionals with emphasis on building a relationship between the family and home visitor, providing child development information, improving parenting skills, modeling parent-child interaction, nurturing the parent, linking the family to primary health care providers, and providing referral to and coordination with other social services. Families for whom a hospital record review suggests the need for possible service are interviewed in the hospital shortly after the infant's birth. Home visiting services are offered to those families who exhibit the need for such assistance based on their scores on a family stress inventory administered during this hospital visit. Initially, home visits are conducted weekly; the frequency is reduced as families meet specific goals. Services begin at the child's birth and continue until children reach five years of age. (For further details, see the article by Powell in this journal issue.)

The National Committee to Prevent Child Abuse is currently conducting a randomized trial evaluation of the Healthy Start program. Funded by the federal Department of Health and Human Services, National Center of Child Abuse and Neglect, the evaluation will assess program effects on parental functioning, child development, parent-child relations, community support, and rates of child abuse and neglect. Results are expected in 1995.

The Robert Wood Johnson Foundation has provided partial funding to re-

searchers at Johns Hopkins University School of Medicine for another randomized trial that will assess the effects of the Hawaii program on child health, education, and social service utilization; family functioning; child abuse and neglect rates; children's physical and mental development; children's health status; and children's school readiness. The Johns Hopkins study will also assess program costs. The five-year study is expected to begin in 1994.

For information about the Hawaii Healthy Start program, contact

Loretta Fuddy, A.C.S.W., M.P.H.
Chief, Maternal and Child Health Branch
Department of Health
741-A Sunset Avenue
Honolulu, Hawaii 98816
808-733-9022

For information about the program evaluations, contact

Leslie Mitchel, M.A.
Deborah Daro, D.S.W.
National Committee for Prevention of Child Abuse
332 S. Michigan Avenue, Suite 1600
Chicago, Illinois 60604-4357
312-663-3520

Anne Duggan, Sc.D.
Assistant Professor
Johns Hopkins University
School of Medicine
600 North Wolfe Street, CMSC 144
Baltimore, Maryland 21287-3144

Healthy Families America

The National Committee for Prevention of Child Abuse (NCPCA) has recently launched Healthy Families America. Funded by the Ronald McDonald Children's Charities, this initiative seeks to develop a voluntary home visiting system across the United States for all new parents, particularly those in difficult circumstances. Through the initiative, NCPCA distributes training materials about how to develop, implement, and operate home visiting programs. This training and technical assistance is being provided through conferences and site visits to state level organizations with the interest and capacity to replicate the program in their states. To date, 46 states and the District of Columbia are either in the planning or development stage. Eleven states (Arizona, Florida, Georgia, Indiana, Iowa, Michigan, Minnesota, New Mexico, Texas, Virginia, and Wisconsin) have or soon will have one or more Healthy Families America project sites. In total, these sites will serve more than 2,000 families per year.

For information about Healthy Families America, contact

Leslie Mitchel, M.A.
Deborah Daro, D.S.W.
National Committee for Prevention of Child Abuse
332 S. Michigan Avenue, Suite 1600
Chicago, Illinois 60604-4357
312-663-3520

Home Instruction Program for Preschool Youngsters (HIPPY)

HIPPY was established in 1969 in Israel as a research and development project for disadvantaged families with preschoolers. With the help of the National Council for Jewish Women (NCJW), the HIPPY model was introduced in the United States in 1984. During each of two years, the program provides 30 weeks of activities for parents, scheduled to coincide approximately with the school year. The program targets parents with limited formal education and their four- and five-year-old children. Paraprofessionals make biweekly home visits to provide parents with books and activity sheets and teach them how to use the materials with their children. Parents and children then work through the materials together for 15 to 20 minutes each day. Activities deal with basic readiness skills, including tactile, auditory, visual, and conceptual discrimination; language development; verbal expression; eye-hand coordination; premath concepts; logical thinking; self-concept; and creativity. On alternate weeks the parents, paraprofessionals, and the program coordinator meet as a large group to role play that week's activities and to discuss parenting and family life issues. The HIPPY paraprofessionals are members of the participating communities, often recruited from the same pool of families who initially enroll in the program. (For further details, see the article by Powell in this journal issue.)

Currently, 61 HIPPY programs operate in 17 states, including a statewide network of programs in Arkansas. Some 10,000 children and their families participate in HIPPY programs each year. Between 10 and 25 more programs are established each year with technical assistance provided by HIPPY USA, a nonprofit agency established in 1992 to offer training and

support for HIPPY sites. HIPPY programs receive funding from public sources, including Chapter I, Even Start, and the Job Training Partnership Act, as well as from private foundations.

NCJW's Center for the Child is currently conducting several evaluations of HIPPY, including both process-oriented implementation studies and a longitudinal outcome evaluation. The latter study will assess HIPPY's effects on both child and parent outcomes.

For information and technical assistance concerning HIPPY dissemination, contact

HIPPY USA
53 West 23rd Street, 5th Floor
New York, New York 10010
212-645-2006

For information concerning ongoing evaluation, contact

Center for the Child
National Council of Jewish Women
53 West 23rd Street
New York, New York 10010
212-645-4048

Mother-Child Home Program

Established by the Verbal Interaction Project in 1965 under the direction of Phyllis Levenstein, the Mother-Child Home Program consists of two visits per week for 23 weeks in each of two years (a total of 92 visits over the course of two years which follow the school calendar). Paid paraprofessionals or unpaid volunteers, all known as toy demonstrators, visit low-income mother-child dyads during the children's third and fourth years of age. The visitor models verbal interaction techniques for the mother which are built around toys and books and are drawn from a structured cognitive curriculum. Twelve books and 11 toys are furnished to the child in each of the two program years. The curriculum consists of two major areas: cognitive (sensory-motor skills, conceptual development, language development) and affective (socioemotional competence and the mother's parenting skills).

Currently, 29 replications of this program serve an estimated 4,000 mother-child pairs throughout the United States. Six more programs are in the planning stages. Operated primarily through school districts and social agencies, these programs are funded through a variety of sources, including Chapter I, Even Start, state funds, and private foundations. Several evaluations of the program have been conducted to measure both short- and long-term effectiveness. (See the article by Olds and Kitzman in this journal issue.)

For additional information about the Mother-Child Home Program, contact

Phyllis Levenstein, Ed.D.
Center for Mother-Child Home Program
3268 Island Road
Wantagh, New York 11793
516-785-7077

Parents as Teachers (PAT)

Missouri's Parents as Teachers (PAT) program began in 1981–1982 as an adaptation of the parent education model developed by Burton White. Home visits are the core activity, with content of the visits varying over the three-year program period. The curriculum begins prenatally and emphasizes various developmental stages (for example, the young child's curiosity, social development, language, and intellectual development during the 8- to 18-month period). In addition to home visits, there are group meetings which afford parents opportunities to discuss common concerns, participate in parent-child activities, and learn about community resources. The program also includes screening of children's vision, hearing, and development; and many sites offer toy, book, and video resource centers, or drop-in and play sessions for parents and children. Specialized curricula have been developed to extend the PAT program to other groups. These curricula include one for teen parents and one for parents with children three to five years old. (See the article by Powell in this journal issue for further details.)

The frequency of home visits varies across PAT program sites. At most sites, home visits and parent group meetings are offered monthly throughout the three years of the program, but other sites offer weekly visits; and Missouri, for financial reasons, only requires that PAT programs operating in the state provide families with four home visits and four group meetings each year.

Staffing also varies across sites. At most sites, home visitors are professionals with bachelor's degrees, but some PAT programs employ paraprofessionals.

More than 1,160 PAT programs currently operate in 42 states, serving approximately 90,000 families per year. The program is offered statewide in Missouri,

where it is funded primarily by state Department of Education dollars, supplemented by many school districts with local dollars. Nationally, PAT programs are financed by a mix of public and private dollars, including federal Head Start and Even Start funds.

The PAT National Center has conducted two evaluations of the program in Missouri, including quasi-experimental studies of the program's effectiveness in the four school districts in which it was piloted in 1981, and as it currently operates throughout the state of Missouri. Other evaluations are ongoing, including two California-based randomized trials of the program's effectiveness, and another follow-up of children and families who have participated in PAT in Missouri.

For information about program replication and the initial evaluations, contact

Parents as Teachers National Center, Inc.
9374 Olive Boulevard
St. Louis, Missouri 63132
314-432-4330

For information about the randomized trials of the PAT program in California, contact

Center for the Future of Children
David and Lucile Packard Foundation
300 Second Street, Suite 102
Los Altos, California 94022
415-948-3696

Portage Project

Established in 1969 in Portage, Wisconsin, this home visiting program serves children who are functioning between the ages of birth and six years and may have diagnosed disabilities or who are developmentally delayed or economically disadvantaged. Visitors (usually teachers by training) make weekly, 90-minute home visits during which they work with parents to plan and implement strategies for addressing the needs of the child as identified through an initial assessment process. These strategies are incorporated into the family's daily routine to help family members become involved in the child's developmental program. The home visitor also works with parents or other family members to develop or strengthen their support network, develop action plans for addressing broader family concerns, and access community resources.

In 1972, the Portage Project received a federal grant to replicate the program at 30 sites. That replication and expansion work has continued with other funding since 1972. For example, the program has increased involvement with Head Start and has become a regional training site for home-based Head Start programs. (See descriptions of Head Start in this Appendix.) In the years from 1985 to 1991 alone, more than 2,800 individuals were trained in the model, some 1,600 of whom actually adopted it, resulting in the enrollment of approximately 50,000 children and their families in programs employing Portage Project methods.

Materials from the program, including a developmental checklist and a set of cards describing activities for parents to use to help their children develop specific behaviors, are available in more than 30 languages. These materials address children's development in five different domains: cognitive, linguistic, self-help, motor, and socialization. The model has spawned sites in several nations, including the United Kingdom and Japan.

For additional information about the Portage Project, contact

Julia Herwig
Portage Project
CESA 5
626 East Slifer Street
Portage, Wisconsin 53901
608-742-8811

Resource Mothers Programs

The first Resource Mothers Program was established in 1980 in South Carolina. Since that time, approximately 300 more Resource Mothers programs have formed across the nation. These programs employ paraprofessionals from participating communities to visit pregnant women and children. The Resource Mothers seek to improve birth outcomes, decrease injuries to children, and lower child abuse rates by providing information about maternal and child health and development and by linking mothers with health and other community services. Beyond that, they serve as mentors to the expectant mother throughout her pregnancy, delivery, and the first year or more of her child's life.

Resource Mothers programs typically enjoy a mixture of public and private funding. Some programs receive reimbursements from Medicaid for providing Early

and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Other programs are funded by Medicaid because they fulfill Medicaid administrative outreach requirements. Still others are funded through federal Maternal and Child Health Services Block Grant, Indian Health Service, or Migrant Health Service funds. Program costs range from $600 to $2,000 per client, depending on factors such as service intensity.

The National Commission to Prevent Infant Mortality, a commission established by Congress in 1987 to create a national strategic plan to reduce infant mortality and morbidity in the United States, has endorsed Resource Mothers programs. In 1991, the commission launched the Resource Mothers Development Project, a national outreach home visiting initiative for families at risk for poor birth outcomes. Through the project, the commission has developed training and implementation guides and provides technical assistance to help communities establish their own or strengthen existing Resource Mothers programs.

For additional information about Resource Mothers programs, contact

Charlotte Swift
National Commission to Prevent Infant Mortality
330 C Street, S.W.
Switzer Building, Room 2014
Washington, DC 20201
202-205-8364

Other Significant Demonstration Projects

The demonstration projects described in this section have been particularly influential models for agencies seeking to serve families and young children. Some of them are still in operation; others have ceased services but have, nevertheless, left an important legacy by contributing relevant research or by providing the inspiration for related programs.

Child Survival/Fair Start Programs

In the early 1980s, the Ford Foundation launched a grants program, the Child Survival/Fair Start program, to "'improve chances for the survival and health development of infants and young children in disadvantaged low-income families.'"[1] Grants were awarded to establish seven demonstration projects, each with a preventive focus on pregnancy and infancy. Each targeted low-income, traditionally underserved families; offered health, nutrition, child development, and social services; and employed community-based paraprofessional outreach workers. Five of the seven programs utilized home visits as their core services. Intensity of services varied across programs. A book published in 1992[2] describes the setting in which the programs operated, the results of the projects' primarily quasi-experimental outcome evaluations, and program implementation and cost.

The following is a brief summary of program effects on outcomes. Of the five home visiting programs, none showed positive effects across all domains (prenatal or child health care utilization, birth outcomes, child development, or parent-child interaction, and home environment), although each showed positive effects in at least one domain. When positive effects were demonstrated, they appeared in the domains on which the programs concentrated and not in other domains. In some instances, effects were limited to a subgroup of participants. In most instances, effect sizes were modest. The authors suggest that "parent support and education programs cannot be expected to alter significantly the social ecology of people's lives; they do not change the basic life situation that confronts low-income families each day. . . . Their measurable effects are modest although not insignificant, and the programs themselves should be viewed as part of a larger array of responses to families' difficulties and support needs."[3]

For further information about Child Survival/Fair Start programs, contact

Mary Larner, Ph.D.
National Center for Children in Poverty
154 Haven Avenue
New York, New York 10032
212-927-8793

Robert Halpern, Ph.D.
Erikson Institute of Advanced Study in Child Development
Loyola University
25 W. Chicago Avenue
Chicago, Illinois 60610
312-280-7302 ext. 428

1. Ford Foundation working paper, as cited in Larner, M., Halpern R., and Harkavy, O., eds. *Fair start for children: Lessons learned from seven*

demonstration projects. New Haven, CT: Yale University Press, 1992.

2. See note no. 1, pp. 1–269.

3. Halpern, R., Larner, M., and Harkavy, O. The Child Survival/Fair Start initiative in context. In *Fair start for children*, p. 251.

The Infant Health and Development Program (IHDP)

The Infant Health and Development Program (IHDP) was an eight-site, multimillion-dollar randomized clinical trial designed to evaluate the effectiveness of a comprehensive early intervention program in reducing the developmental and health problems of low birth weight (â2,500g), preterm (â37 weeks) infants. In this study, 985 infants were randomly assigned to either an intervention or a control group.

Both groups received high-quality pediatric services which included periodic assessments of health and development, with referrals as necessary. The intervention group also received child development and family support services via home visits (weekly for the first year and every other week thereafter), child attendance at a child development center (an enhanced early childhood educational service for children 12 to 36 months old), and bimonthly parent group meetings. All services were provided free of charge and continued until children were three years old.

The investigators assessed the program's effects on children's cognitive development and behavior, children's health status and health care utilization, the home environment, and parent-child interaction. Results indicated that the intervention successfully increased children's cognitive development scores, with babies who were initially heavier benefiting more than babies who were lighter at birth (a gain of 13.2 points versus 6.6 points on standardized tests). Further analyses indicated that the intervention was effective only with children of mothers (whether white or African-American) who had high school education or less. There was no effect on cognitive scores for white mothers with a college education. Children of families that had participated more intensively in home visiting, center attendance, and parent group meetings had higher scores at age three. These cognitive benefits began to appear in the second and third year of the program.

At the end of the program, the home environment of families in the intervention group was more conducive to child development, and mothers in the intervention group were more likely to be employed than were mothers in the control group. There were no major differences between groups in medical care utilization, and both groups of mothers reported similar ratings for their children's health and serious illness. For lighter babies only, the intervention group mothers reported more total illness.

Based on these findings, the Centers for Disease Control and Prevention in 1992 offered Grants for Planning Programs to Prevent Mild Retardation. Applying agencies had to devise programs employing the IHDP model. Eight planning sites have been funded; two additional sites have been selected but have not yet received funding. Each site has received $125,000 per year for the two years ending FY 1993. Federal funding for implementation has not yet been appropriated. If funds are appropriated, the earliest that implementation could begin would be October 1994.

For further information about IHDP, contact

Donna Spiker, Ph.D.
Infant Health and Development Program
Stanford University
Center for the Study of Youth Development
Building 460, Room 110
Stanford, California 94305-2135
415-723-7809

For further information about the CDC program, contact

Joseph Hollowell, M.D.
Developmental Disabilities Branch Chief
Division of Birth Defects and Developmental Disabilities
Centers for Disease Control and Prevention
MS F15
4770 Buford Highway
Chamblee, Georgia 30341
404-488-7360

The High/Scope Perry Preschool Program

The High/Scope Perry Preschool Program was one of the precursors to today's Head Start program. Based on a careful initial design and dedicated longitudinal follow-up, the project has had a large influence on public policy. From 1962 through

1967, some 123 three- and four-year-olds in Ypsilanti, Michigan, were randomly assigned to a treatment group, which received an early childhood education intervention, or to a control group. Children were from low-income, African-American families.

The intervention consisted of 2½ hours of preschool experience five days a week for 7½ months each year for two years (except for one small group of children which received only one year of services). In addition, teachers visited each mother and child at home for 90 minutes once per week during the school year.

The influence of the Perry Preschool Program stems from reports of its long-term results. When children were 19 years of age, those who had participated in the program tended to have higher high school grade point averages; had spent less time in special education classes; had higher rates of high school graduation, academic or vocational training, and employment; and had lower rates of receiving public assistance and contact with the criminal justice system (including arrests). In addition, there was a trend for female teens who had received the Perry Preschool services to have fewer pregnancies than those who had been in the control group.

At age 27, those who had participated in the program had significantly improved lifetime earning and resulting investment in capital goods such as homes and cars, greater family stability with a parallel increase of within-wedlock births, and reduced crime rates.[1] An economic analysis estimated that taxpayers received a return of $7.16 for every dollar spent to deliver Perry Preschool services to participants.

The High/Scope Educational Approach is available throughout the country from 1,200 certified High/Scope Trainers of Teachers. Training includes instruction concerning both in-class and home visiting strategies. The approach is used extensively in foreign countries.

For further information about the High/Scope Perry Preschool Program, contact

High/Scope Educational Research Foundation
600 North River Street
Ypsilanti, Michigan 48198-2898
313-485-2000

1. Schweinhart, L.J., Barnes, H.V., and Weikart, D.P. *Significant benefits: The High/Scope Perry Preschool study through age 27.* Monographs of the High/Scope Educational Research Foundation, no. 10. Ypsilanti, MI: High/Scope Press, 1993.

Major Federal Initiatives

This section describes some of the federal initiatives that feature home visiting. While there are certainly other federal funding streams for home visiting, the following exemplify some of the primary ways in which home visiting is being used to serve families and young children. It should be noted that funding for some federal programs listed in this section may actually be used to support home visiting programs mentioned in earlier sections. For example, Even Start funding may be used to support HIPPY or PAT programs.

Comprehensive Child Development Program (CCDP)

In 1988, Congress enacted the Comprehensive Child Development Act to establish a two-generation, family support program designed both to offer comprehensive and integrated services to children from low-income families from birth to entrance into elementary school and also to provide support services to parents and other family members to enhance their economic and social self-sufficiency. Case management services, typically offered via home visiting, are a required element of all CCDP sites. The Act was authorized for five years, from FY 1988 to FY 1993, at an annual level of $25 million, which has since been increased to $50 million. Annual appropriations have been increased from $25 to $45 million. Twenty-two projects were funded in 1989, two more in 1990, eight more in 1991, and two more in 1992. Of these ten new grantees in 1991–92, five special-emphasis programs enrolled only families with members who were using or had been exposed to alcohol or illicit drugs.

To be eligible, families had to have had annual incomes that were less than the federal poverty guidelines for the years in which they enrolled; mothers had to be pregnant or have a child under one year of age; and families had to agree to participate in the program for five years. For the five special-emphasis programs added in 1991–92, additional eligibility criteria were that family members must be using or have been exposed to alcohol or drugs.

Two evaluations have been launched: a process evaluation by CSR, Incorporated, and a summative evaluation by Abt Associates. The research design includes random assignment of prospective families to CCDP or to a control group. Annual measurements are made of all families in the evaluation, employing parent interviews, child testing, and parent-child observation.

A first-year report from CSR, Incorporated (which is also providing management support for CCDP sites), is available and indicates that more than 2,500 families were initially enrolled into the group that received services in 23 program sites. Site visits to 12 programs indicated that 75% of families were receiving home visits every one or two weeks. Interim results from the Abt Associates study will be available in fall 1993.

For further information about the Comprehensive Child Development Program, contact

Robert D. Ketterlinus, Ph.D.
CSR, Incorporated
1400 Eye Street, N.W., Suite 600
Washington, DC 20005
202-842-7600

Abt Associates
55 Wheeler Street
Cambridge, Massachusetts 02138
617-349-2300

Even Start

The federal Even Start program was first funded in 1989 under legislation included in 1988 amendments to the Elementary and Secondary Education Act of 1965. It is designed to help parents become full partners in the education of their children and to help children reach their full potential as learners. Programs must provide some home-based instructional services to parents and children together.

As a two-generation program, Even Start serves both adults and children. It provides early childhood education for the children and teaches parents how to promote their children's school readiness and how to support their children once they enter school. Even Start projects also provide or arrange for adult basic skills training, including basic literacy skills.

There are currently 340 Even Start projects, each individually created by the community in which it is located. Participating families must have at least one child who is seven years old or younger and lives in a Chapter I–participating attendance area. Approximately 30,000 to 40,000 children are enrolled in these projects, and about half of them are under four years of age. The FY 1993 Even Start appropriation was $89.2 million.

Abt Associates was funded to conduct a national evaluation of the Even Start program. Results are expected to be reported to Congress in late 1993.

For information about Even Start programs, contact

Patricia McKee
Branch Chief
Office of Elementary and Secondary Education
U.S. Department of Education
400 Marilyn Avenue, S.W., Room 2043
Washington, DC 20202-6132
202-401-1692

For information about the evaluation, contact

Bob St. Pierre
Abt Associates
55 Wheeler Street
Cambridge, Massachusetts 02138
617-349-2300

Nancy Rhett
U.S. Department of Education
400 Maryland Avenue, S.W.
Washington, DC 20202
202-401-3630

Head Start

Head Start mandates that every participating family receive at least two home visits, although no regulations govern when visits should take place or who should make them.[1] In addition, although most Head Start programs operate center-based programs, Head Start programs may offer other service delivery options that feature home visiting more prominently.

Home Start

Launched as a three-year demonstration project in 1972, Home Start offers essentially the same services as Head Start but in a home rather than a center. Visits typically take place twice a month and last about 90 minutes each.[2] Based on positive evaluation results,[3] any Head Start program can now offer home-based services. During the 1991–92 operating period, 4,396 home visitors in 578 programs served 44,630 children.[4]

Parent and Child Centers

Initially launched in 1967 to provide comprehensive services for low-income fami-

lies with children under three years of age, Parent and Child Centers can also offer home visits. During 1991–92, there were 106 centers in operation around the country. The primary objectives of the program are to improve child development, enhance parental skills, and strengthen the family unit.

1. Zigler, E., Muenchow, S. *Head Start: The inside story of America's most successful educational experiment.* New York: Basic Books, 1992.
2. U.S. General Accounting Office. *Early childhood and family development programs improve the quality of life for low-income families.* HRD-79-40. Washington, DC: USGAO, 1979.
3. Love, J.M., Nauta, M.J., Coelen, C.G., et al. *National Home Start evaluation: Final report.* Report prepared for Department of Health, Education, and Welfare, Office of Child Development, Office of Human Development, Early Childhood Research and Evaluation Branch. HEW-105-72-1100.
4. Administration on Children, Youth, and Families; Administration for Child and Families. *Project Head Start statistical fact sheet.* Washington, DC: Department of Health and Human Services, January 1993.

Maternal and Child Health Bureau

The Maternal and Child Health Bureau has launched several initiatives that involve home visiting. Two of the most recent are described below.

Children of Substance Abusers Act

The Children of Substance Abusers Act was incorporated into the ADAMHA (Alcohol, Drug, and Mental Health Administration) Reorganization Act of 1991 (Public Law 102-321), which was enacted on July 10, 1992. Title V establishes a home visiting program for pregnant women who are at risk of delivering an infant with a health or developmental complication or for women who have children under three years of age who have or are at risk of having health or developmental problems or experiencing child abuse or neglect, or who have been prenatally exposed to maternal substance abuse. The goal of the program is to promote better parenting skills, improve infant and child health and development, provide support and linkage to social services for their mothers, and promote access to services such as prenatal or other primary health care and substance abuse treatment.

Although up to $30 million was authorized for the home visiting portion of the Act, no funds were appropriated for FY 1993. Nevertheless, the Maternal and Child Health Bureau, at the urging of the Senate Appropriations Committee, decided to commence the program, using existing SPRANS (Special Projects of Regional and National Significance) grant funds and anticipating future funding. The availability of project funds was announced in spring 1993, and proposals were reviewed over the summer. Approximately $500,000 was available to support up to three three-year projects at an average grant award of $165,000 per year.

Community Integrated Service Systems

In FY 1992, the legislatively mandated Community Integrated Service System (CISS) was launched by the Maternal and Child Health Bureau to help communities develop comprehensive, coordinated, culturally sensitive, and family-centered services to address health and related needs for all pregnant women, children, adolescents, and their families. Projects must employ at least one of six service delivery approaches. Maternal and infant home visiting programs are one of those required strategies.

Thirty-two grants were awarded in 1992, and ten in 1993. Awards were for periods up to four years, but continued funding depends on appropriation of additional funds.

The Family Institute

Building Strong Staff...Building Strong Families

February 25, 1998

Nicole Rabner
Associate Director for Domestic Policy
White House
West Wing, 2nd Floor
Washington, DC 20500

Dear Ms. Rabner:

I wanted to write and thank you for all your hard work and wonderful energy in putting together the February 10th home visit and forum with Healthy Families Alexandria at the Northern Virginia Family Service.

It was a tremendous event. Having Mrs. Clinton participate brought additional credibility regarding the importance of supporting new parents and the nation's youngest children.

Having been involved in developing and expanding the Hawaii Healthy Start program, as well as the Healthy Families initiative, it is most exciting to see these programs receive the recognition they deserve for their success in reaching out to overburdened families, promoting child health and development and strong family functioning, and preventing child abuse and neglect.

The White House has played a critical role in bringing the importance of these issues, and the success of these efforts, to the forefront of the political debate. The time is right for continuing this important work, and TFI is positioned to offer its resources, experience and expertise to furthering the Administration's Child Care Initiative.

Linda Dunphy and I would welcome the opportunity to meet with you to continue discussion about the pieces of legislation that have been proposed that include support for home visiting programs, and to strategize on the best ways to move forward with educating members of Congress about the importance of home visiting support for overburdened families.

Please contact me at your earliest convenience at 703-866-4769. Thank you again for your dedication and hard work on behalf of children and families. I look forward to working with you in the future.

Sincerely,

Betsy Dew
Director
enc.

The Family Institute

Betsy Dew M.Ed.
Training Consultant

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HEALTHY START

AN APPROACH TO BUILDING HEALTHY FAMILIES

THE FAMILY INSTITUTE
6170 Forest Creek Court
Springfield, VA 22152
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Outcomes of Intensive Home Visitation Programs

Early and intensive home visitation results in the following outcomes for served families compared to controls:

- Significantly **more nurturing environment** for the infant
- Significantly **more positive parent child interaction**
- Mothers display significantly **greater maternal involvement and sensitivity to child's cues**
- Mothers are significantly **less punishing and restricting** of their children
- **Children** are significantly **more responsive** to their mothers
- **Potential for child abuse and neglect** is significantly **reduced** (from moderate to low risk)
- Significantly **less incidence of child abuse and neglect**:

  ⇒ 4.2% of controls had substantiated CAN report

  ⇒ **0 %** of served families had substantiated CAN report

  ⇒ 2.6% of controls fell within state definition of severe high risk, "Imminent Harm," which, under Hawaii State law, warrants that preventive services be initiated.

  ⇒ 3.3% of served families fell within state definition of severe high risk or Imminent Harm, validating that Healthy Start does indeed serve very high risk families.
  Note: NONE of these served families became a substantiated case of CAN.

Based on NCCAN randomized control study of Hawaii's Healthy Start Program (1997)

Healthy Start Status Among Children Hospitalized for Child Abuse & Neglect

1991 - 1994

N = 198

	%
• Not Eligible for Healthy Start	64.7
• Eligible for H.S., Intake Closed	19.2
• Eligible for H.S., Not Enrolled	13.6
• **TOTAL Not Served by H.S.**	**97.5**
• Eligible and Enrolled in H.S.	2.5
	100.0

CRITICAL ELEMENTS

OF SUCCESSFUL HOME VISITATION PROGRAMS

1. Initiate services at birth or prenatally.

2. Offer services voluntarily and use positive, persistent outreach to build family trust in accepting services.

3. Use standardized assessment tool to differentiate between families who need intensive service and those who don't.

4. Offer home visits intensively (1/wk) with well defined criteria for changing intensity of service and maintaining service over the long term (3-5 years).

5. Services should be culturally competent.

6. Should focus on supporting the parent child relationship and child development as well as supporting the parent.

7. Link families to community services as needed including medical home.

8. Limit caseloads of staff or ensure time and energy for quality services.

9. Select service providers for their personal characteristics which reflect their ability to do this demanding work.

10. All service providers must have a framework for handling the variety of situations they many encounter and therefore must receive training on a broad range of topics.

11. All service providers must receive intensive training specific to their role.

12. Regular, ongoing, effective supervision is required for all staff.

Healthy Growth for Hawaii's "Healthy Start": Toward a Systematic Statewide Approach to the Prevention of Child Abuse and Neglect

by
Gail Breakey, R.N., M.P.H. and Betsy Pratt, M.Ed.
Hawaii Family Stress Center
Honolulu, Hawaii

In July, 1985, a demonstration child abuse and neglect prevention project began in Leeward, Oahu, a multi-ethnic, mixed urban and rural, fairly depressed community, with more than its share of problems—substandard housing, underemployed adults, substance abuse, mental illness, and child abuse and neglect. Three years later, an evaluation of the program revealed that not a single case of abuse among the project's 241 high risk families had been reported since the demonstration began. There was also evidence of reduced family stress and improved functioning among the families served.

By July, 1990, Healthy Start/Family Support services were expanded to 11 sites through appropriations of almost $4 million by the state legislature and reached approximately 52 percent of at risk families of newborns throughout Hawaii.

The success of the 1985-1988 demonstration project was, of course, gratifying. But what may be even more remarkable is the institutionalization of the Healthy Start program within the Maternal and Child Health Branch of Hawaii's Department of Health, and the state legislature's willingness to support the expansion of a program without sacrificing quality. For as Lisbeth Schorr (1987) reminds us:

> The temptation to water down a proven model in order to distribute services more widely is ever present. Agonizingly familiar is the story of a successful program which is continued or replicated in a form so diluted that the original concept is destroyed. . . . Especially when funds are scarce, there are powerful pressures to dissect a successful program and select some one part to be continued in isolation, losing sight of the fact that it was the sum of the parts that accounted for the demonstrated success (p. 275-76).

In this article, we hope to describe the critical elements of the Healthy Start program and also to examine the processes of collaboration and advocacy that have made high quality expansion possible.

The Healthy Start model

The Healthy Start approach is designed to improve family coping skills and functioning, promote positive parenting skills and parent-child interaction, promote optimal child development, and, as a result, prevent child abuse and neglect. Nine complementary features make up the Healthy Start approach.

1. Systematic hospital-based screening to identify 90 percent of high risk families of newborns from a specific geographic area

Paraprofessional "early identification" workers review hospital admissions data for childbirths to determine which families live in the target area and are therefore eligible for services. Using a list of risk indicators developed by the Hawaii Family Stress Center (see figure 1), the early identification workers analyze the records of eligible mothers. If a screened record is positive, the mother is interviewed by a worker who has been intensively trained in basic interview techniques and in use of the Family Stress Checklist developed by the E. Henry Kempe Center and validated by Murphy and Orkow in 1985 (Kempe, 1976; Orkow, B., Murphy, S. and Nicola, R., 1985). Families determined to be at risk are encouraged to accept home visiting services; these are described to the families as home visiting, supportive services to assist with problems discussed during the interview and to share information about the baby's care and development. During the three-year demonstration period, 95 percent of families accepted the offer of services.

Figure 1.
Risk Indicators Used in Early Identification

1. Marital status—single, separated, divorced
2. Partner unemployed
3. Inadequate income (per patient) or no information regarding source of income
4. Unstable housing
5. No phone
6. Education under 12 years
7. Inadequate emergency contacts (e.g., no immediate family contacts)
8. History of substance abuse
9. Late (after 12 weeks) or no prenatal care
10. History of abortions
11. History of psychiatric care
12. Abortion unsuccessfully sought or attempted
13. Relinquishment for adoption sought or attempted
14. Marital or family problems
15. History of or current depression

Systematic identification of at risk families is key to the prevention of child abuse and neglect. The initial Healthy Start demonstration project set up the procedures for screening and risk assessment described above at four major medical centers that served the target population. A quality control review conducted in the third year of the project revealed that it was successfully reaching about 75% of the geographically eligible population as defined by hospital birth records, verified by the Department of Health. Procedures were

FEEDING ME

When I'm hungry, I'm really hungry ... please don't let me wait! I won't understand and I'll get upset and cry.

When you feed me, you'll want to be comfortable. I need this too. Sit in a relaxed position, with your arm supporting me. Please look directly at my face so I can see you ...

Gently brush my cheek and I will turn in that direction for the nipple.

Figure 2

instituted at Kapiolani Medical Center, the Regional Perinatal Center where 50 percent of all births in Hawaii occur, to correct factors, such as inaccurate reporting of addresses and lapses over long holiday weekends, that led to missed cases. This process has resulted in 100 percent coverage of eligible families at this medical center. Work continues with other hospitals to establish similar procedures. The systematic identification process holds great promise for targeting prevention programs to specific geographic areas, such as districts, counties, or states, in a systematic, comprehensive manner.

2. Community-based home visiting family support services, as part of the maternal and child health system

Once a family has accepted the offer of service, a paraprofessional family support worker contacts the mother in the hospital to establish rapport and schedule a home visit. Initial visits are usually devoted to building trust, assessing family needs, and providing help with immediate needs such as obtaining emergency food supplies, completing applications for public housing, or resolving crises in family relationships. Workers focus primarily on providing emotional support to parents and modeling effective skills in coping with everyday problems. Their "parent the parent" strategy allows initial dependence before encouraging independence. "Do for, do with, cheer on" sums up the workers' philosophy.

Workers also model parent-child interaction. They complete the Nursing Care Assessment (NCAST) HOME Feeding and Teaching Scales (Barnard, 1983) when the infant is four months old to identify probl areas, and again at twelve months to determine progr and modify intervention strategies. Workers use Hawaii Family Stress Center's own parent-ch interaction materials (see Figure 2) as well as M Alger's *Mother-Baby Playbook* (1976) and activities fr Setsu Furuno's *Hawaii Early Learning Profile* man (1984).

3. Individualizing the intensity of service based on t family's need and level of risk

A system of "client levels" and "weighted caseloa is designed to ensure quality service for families a prevent burnout among staff. All families enter t program at "Level I" and receive weekly home visi The decision to change a family's level is based criteria such as frequency of family crisis, quality parent-child interaction, and the family' ability to u other community resources. As families become mo stable, responsive to children's needs, and autonomo the frequency of home visits diminishes. A famil promotion to Level IV means quarterly visit status, a quarterly visits continue until the target child is fi years old. Thus service intensity is constantly adjust to the needs of the family, assuring that families w are doing well move along, and those needing mo support are not promoted arbitrarily.

The system of client levels assists in caselo management. In the first year of a program, all famil would be Level I; the caseload for each worker wo be no more than 15 families. In the second year, so families would have progressed to Levels II and III: t

average caseload would be 20 families. By the third year of a program, the average caseload would be about 25 families.

4. Linkage to a "medical home"

As its name suggests, the Healthy Start program emphasizes preventive health care as an important aspect of promoting positive child development. Each family is assisted in selecting a primary care provider, which might be a pediatrician, family physician, or public health nursing clinic. Project staff use a special computer system to track both due dates for well care visits, using the child's age and the schedule of visits recommended by the American Academy of Pediatrics, and for NCAST visits. Each worker receives a monthly printout of the children in her families who are due for visits, and follows up to make sure that the visit is scheduled and the family has transportation. Family support workers routinely conduct RPDQ's and make referrals for follow-up Denver Developmental Screening Tests as indicated. The program's office manager or the family support worker contacts the pediatricians' offices as necessary to obtain results of developmental screening. Case conferences involving the physician, worker, and staff of any other agencies involved with the family have been held as necessary to review cases of significant biological or environmental risk and to coordinate preventive interventions.

Approximately a year after the Leeward Healthy Start project began, a Federal Maternal and Child Health SPRANS (Special Projects of Regional and National Significance) grant funded "piggyback" efforts to enhance pediatricians' involvement with project families. The SPRANS effort was designed to increase pediatricians' awareness of the "new morbidity" and the needs of at-risk children. At the same time, the project educated families about the need for well care, in addition to episodic sick care, and helped them to use physicians' services more effectively.

The Medical Home Project now operates under the auspices of the Hawaii Medical Association. The effort has gained national recognition and a second grant, to further develop the concept of the medical home and to provide technical assistance in initiating similar projects throughout the United States.

5. Coordination of a range of health and social services for at risk families

Coordination of services is a major feature of the Healthy Start program. Because high risk families generally lack trust in people and services and thus do not reach out for help, those families who need service most are the least likely to seek them. As it reaches out to and builds trust with high risk families, Healthy Start is in a position to coordinate a wide range of services to families. The Healthy Start Model (figure 3) illustrates its approach to connecting families to the services most commonly available in communities.

6. Continuous follow-up with the family until the child reaches age five

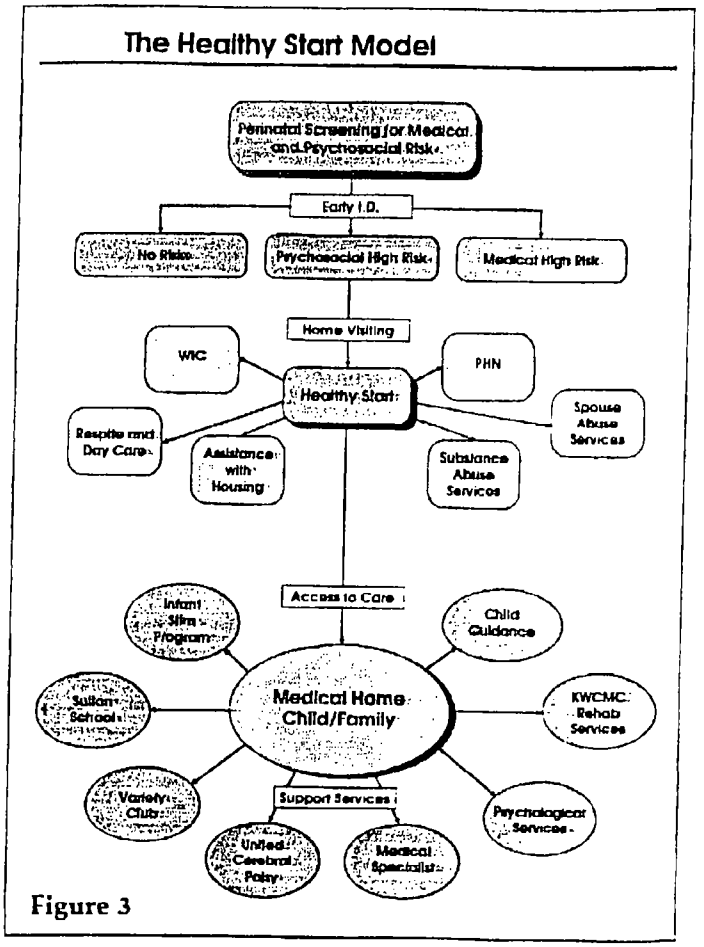

Figure 3

An earlier service program stopped following families once they were no longer considered "high risk." In a number of these families, cases of child abuse and neglect were reported later. Family situations can deteriorate, and the birth of subsequent children can add to family stress. Learning from our earlier experience, we designed the Healthy Start program to maintain follow-up until the target child reaches age five and enters school. At that point, the educational system provides at least some link between the family and the larger community.

7. A structured training program in the dynamics of abuse and neglect; early identification of families at risk; and home visiting

A standardized training program has allowed Healthy Start to share experience with new teams and establish uniform standards of service delivery as the program expands. All training is coordinated through the Healthy Start Training and Technical Assistance (HSTA) Team.

Training is provided in three phases. In Phase I, all new teams participate in a five-week orientation, which includes a core curriculum developed collaboratively by educators, human service providers, medical professionals, home visitors, and social service administrators. During the orientation, managers and supervisors, early identification workers, and home visitors receive training specific to their jobs. Trainees "shadow"

experienced workers and visit community resources. The training for early identification workers typically takes three days of specialized instruction plus several weeks of closely supervised work.

Four to six months after Phase I training, all staff attend a five-day advanced training session. This Phase II training reinforces key concepts and introduces additional concepts that workers would have been unlikely to absorb during the orientation.

After a team's first year of operation, it begins to participate in Phase III, or inservice training. Each team receives four half-days of inservice training per year at its own site, choosing topics from a menu of offerings distributed annually. This mechanism has been particularly useful for programs in remote areas of the state.

A fourth phase of training, "Health Start Supervisor Training," is being implemented this year, following the HSTA Training Team's participation in NCCIP's 1990-91 Training of Trainers Intensive Summer Seminar and follow-up program. This training focuses on the supervisor/home visitor relationship in its broadest sense.

Training for all phases is provided by the HSTA Team and by community consultants who have been identified as both experts in their field and very good presenters. We have found that including consultants has increased awareness of Healthy Start among other community agencies and the University, helping to enhance overall service coordination. The HSTA Team also provides regular technical assistance through visits to all Healthy Start sites, thus assuring standardized practice and clear communication among all teams statewide.

The Healthy Start Network, comprised of managers and supervisors from each team, meets each quarter for planning and program development. This mechanism has resulted in a close network with a shared mission, rather than seven agencies working in isolation.

8. Collaboration with the Hawaii Coordinating Council for Part H of P.L. 99-457 (now P.L. 101-476) to serve environmentally at risk children

The State of Hawaii has included children at environmental risk in its definitions of eligibility for services under Part H of P.L. 99-457 (now the IDEA, Individuals with Disabilities Education Act, P.L. 101-476). Healthy Start staff testified before the legislature as to the need for including environmentally at risk infants and toddlers and for funding care coordinators and a tracking system.

Currently, Healthy Start refers children with identified developmental delays to the local Zero to Three Project (Part H) care coordinator, who arranges with child development centers for early intervention. Healthy Start and Part H staff are working collaboratively to develop a format for the Individualized Family Service Plan.

The Zero to Three project has funded a child development specialist for the Leeward project, who will work with families needing special monitori Legislation is being proposed to add child developm specialists to other Healthy Start staffs as well.

9. Staff selection and retention

Teams consist of 5-8 paraprofessional and super sory staff, based on an agreed upon ratio. This ra is 1:5 for supervisors and 1:3 for managers also carry administrative responsibilities.

For managers, we look for masters level profession who have both clinical experience with dysfunctio families and supervisory experience, preferably w paraprofessional staff. Selecting the right staff for ea role is critical to both program effectiveness and st retention.

We find that home visiting and early identificati offer different job satisfactions, and applicants c usually tell which position would be more suited them. EID workers like the sense of a task complet while home visitors gain satisfaction from ongoi projects. In our interviews, we often use a sewi example: Some people like to sit down and finish project, and hate to have it go over into another da Others like to make quilts, a long-term, slow proje Home visitors are the quilt makers.

We look for similar personal qualities in both hon visitors and EID workers—empathy, compassion, inn strength, high self-esteem, nonjudgmental attitude and status in their neighborhood or family as a natur helper. We have found that people who have exp rienced abuse themselves burn out more quickly tha those who have had more nurturing childhoods; w ask prospective workers the same questions about the childhood experiences that new parents are aske during the EID interview.

Having hired good staff, we work to keep them. Sta members have identified several aspects of the progra that are meaningful incentives to stay:

- Flexible hours (within reason), including time fo family obligations like school conferences;
- An atmosphere of trust and caring through all leve of management;
- Tuition reimbursement for relevant continuin education;
- Emphasis on the significance of the project and th staff's contribution (including prompt feedback abou all evaluation outcomes, linking these to outstandin staff performance);
- A system of salary increases that gives paraprofes sional staff opportunity for advancement; regular raise are linked to demonstrated competence, experience education and leadership qualities.

Evaluation of Healthy Start

We have a word of advice for anyone who hope eventually to expand a model program: Invest i evaluation. Although the temptation to skimp o process and outcome evaluation in order to provid more direct services is ever-present, our advocac

efforts would have been useless without impeccable evaluation data. Our evaluation provided the foundation for our advocacy. A good program, a strong evaluation, and collaborative advocacy were all essential in expansion toward a statewide system.

The Healthy Start demonstration project provided family support services to 241 high risk families. Of these, 176 had received services for at least one year at the time of outcome assessment at the end of the three-year demonstration. The outcome data reflected dramatic success in reaching our goal of identifying families at risk for abuse and neglect, and in preventing abuse and neglect in those families. A study of Child Protective Services (CPS) reports of confirmed abuse and neglect reports revealed:

- No cases of abuse of target children among project families;
- Only four cases of neglect (involving two percent of families) during the three year project, all reported by project staff to CPS;
- No abuse for 99.5% of all families identified by the initial hospital screening as not at risk.

Project staff identified a total of five infants as falling within the "imminent harm" category during hospital intake or later during service. Following Family Court Act provisions, staff referred the families to Child Protective Services; all families were followed by the project.

Although clinical outcomes were not assessed with sufficiently stringent procedures to serve as indices of the project's effectiveness, there are indications of positive outcomes. Early Identification Workers who conducted initial risk assessments completed a second interview with families upon their graduation to Level IV. (Since these workers were not the families' home visitors, their assessments are less likely to be influenced by a close relationship.) Once "non-changeable" risk factors, such as parents' experiences of abuse in childhood or a history of CPS involvement, were eliminated from the analysis of pre and post scores, 88 percent of the 42 clients who were promoted to Level IV in the three years of the program showed a reduction of 40) 100 percent in their risk scores. The families who were promoted to Level IV also showed improvement on the NCAF and HOME scales, thus confirming the home visitors' judgments of their improved functioning.

In 1988 Craig Ramey and Donna Bryant of the Frank Porter Graham Child Development Center conducted an on-site evaluation of the overall program, contextual features, and process variables. They gave the project high marks in administrative organization, training and management of direct service staff, and quantity and quality of service delivery. They found "more esprit de corps among this group of home visitors than among any we have ever encountered, (with) no turnover (p. 28)." Ramey and Bryant described Healthy Start as a good example of cost-efficient public-private partnership, developed and administered by the private sector under purchase of service agreements with the state Maternal and Child Health Branch.

Data have just been analyzed for 1,204 at-risk families enrolled in expanded services state-wide during FY 1987-89. There was only one case of abuse (a 99.99% non-abuse rate), and six cases of neglect (a 99.95 non-neglect rate). In addition, there was no abuse or neglect among fourteen drug-exposed infants and six cases identified as "imminent harm" situations which were reported by the programs to protective services. These results are extremely exciting, as they prove the viability of effective replication of this program.

Statewide expansion

Expansion of Healthy Start toward a statewide system might best be described as an achievement of "collaborative advocacy." Our efforts go back to 1976 and our excitement about results from our first early identification and home visiting program. We started a Statewide Council on Child Abuse and Neglect, with representation from committees from five neighbor islands. Federal and state funds supported a prevention project on each island, but when the federal grant ended in 1980, staffing was cut by half.

We realized that we needed another demonstration project. In 1984, during the Hawaii Family Stress Center's annual lobbying for prevention before the state legislature, we met with Senator Yamasaki, Chairman of the Ways and Means Committee of the Hawaii State Senate. He saw merit in the idea of a demonstration program with comprehensive coverage of one geographic area, a focus on child development and linkage to a medical home, and follow-up to age five. He supported funding for Healthy Start at $200,000 a year, with the intent to expand statewide if the model were successful.

Armed with data showing no abuse among project children during the first 18 months of Healthy Start, we went back to the legislature for support for an incremental approach to statewide expansion. Through quarterly statewide meetings, we had maintained a relationship with the five neighbor island Family Support Programs. They and the two other agencies on Oahu with home visiting experience joined us to develop a statewide plan. Expansion of the Healthy Start model created no turf issues for the five Family Support Programs, since each served a distinct island community. On Oahu, home to 80 percent of Hawaii's population, there were turf issues to be resolved. The Hawaii Family Stress Center and the other home visiting agencies discussed the areas of Oahu that each was interested in serving. We also recognized that long-established programs did not have to adopt every detail of the Healthy Start model, as long as each program included essential features—i.e., intake at birth, creative and sustained outreach, and follow-up to age five.

The Stress Center developed projections and a budget for the expansion proposal, with agreement from the other agencies. We also developed good "visuals" for

our presentation to the legislature, such as a graph comparing the costs of courts and corrections, protective services and prevention services statewide. It is essential to have both impact data and data on the costs of not providing prevention services.

Figure 4.
Proposed Standards for Healthy Start/Family Support Programs

- Intake prenatally or at birth (2-3 months maximum age of infant at intake)
- Intake from defined target area (e.g., census tract) only
- Home visitor service for all infants from defined target area whose families are assessed as high risk by early identification workers, until maximum caseload capacity is reached
- Intensity of service based on needs of family
- Long-term home visitor service for all high risk families (3-5 years)
- Creative outreach approach for a minimum of 3 months to build client trust in accepting services
- Supervisory ratio of one professional to five paraprofessionals
- Defined worker caseloads (15 families in project year one; average of 20 families in year two; average of 25 families in year three)

For this legislative session, we worked with the Health Committee Chairmen of both the House and Senate to begin expansion of Healthy Start. We targeted our educational efforts first toward the chairs of the Health, Finance, and Human Services committees, and then to committee members. Our efforts to educate legislators about the prevention of child abuse had begun in 1976; some ten years later, our work seemed to begin to take hold. There were overnight changes in committee reports and behind-the-scenes maneuvers by at least one opponent of the program. The situation required careful watching, astute lobbying, and no end of patience. By the end of the legislative session, three new programs were funded.

Our major expansion effort came in 1989, after the data from the three-year demonstration project was available. We met with the whole Network and discussed how to prepare target group projections and budgets. Then each agency prepared its own program plans and budgets within the Network's agreed-upon guidelines (see figure 4). Each agency in the Network also participated in the lobbying/advocacy process and in ongoing program development. Our plan envisioned systematic screening and home visitor capacity sufficient to serve all at risk families identified in each geographic area of the state.

At this point, we needed more funding but did not require new authorizing legislation. Support for Healthy Start model increased among legislators, w few suggestions for dilution. In our presentations legislatures we try to make a few points very clea

- Healthy Start is designed to serve each geograp area comprehensively.
- Our model, in its entirety, is what produces outcomes we see.
- Anything less will not get the results.

Figure 5.
Milestones in the Development of Healthy Start

1975	Small screening program; home visiting team of three workers
1976	Established State Council on Child Abuse and Neglect
1977-1980	Established five additional family support programs
1982	Renewed legislative advocacy
1985-88	Healthy Start demonstration project
1988	Expansion of Healthy Start to four additional sites; Healthy Start placed under Maternal Child Health Branch
1989	Expansion to total of 11 sites

Data projections and budget preparation are consta challenges. It is important to develop projections f each geographic area; among other things, this proce allows us to show every state legislature what is need to serve his constituency. We have developed a compl formula that takes into account the current numb of births, projected growth in the birth rate, the numb of families that projects can be expected to screen, ar the number of families unlikely to accept services. T project a program's caseload over five years, we consid the number of newborns expected to enter the progra annually, the number of families carried over from th previous year, and anticipated attrition. There w always be surprises. For example, the housing shorta has resulted in major shifts in the populations of lov income families.

A statewide program: Surviving and thriving

The situation of Healthy Start is unusual: Th impetus for its establishment came from the privat sector, but it is now institutionalized within the publ sector. A statewide program must have a place withi the established structure of state services in order t survive and thrive. Our program was placed in th mental health system from 1982-1988. The arrang ment did not work well in our case, although it coul conceivably work elsewhere. The Maternal Chil Health Branch (MCHB), in contrast, has been tremendous support to the development of Health Start as a statewide program. MCHB has provided

focus for coordination of all agencies, efficient contract management, monitoring, data collection, and advocacy for the program, both within the Department of Health and the larger community.

All members of the Healthy Start Network agree that the program needs to be completely statewide within a few years. Our current legislative effort is focusing upon providing existing programs with sufficient resources to maintain intake of newborns, which requires adding some staff each year, and to recruit and retain qualified staff. Next year or in the next biennium we will again pursue expansion, possibly bringing one or two new service agencies into our Network.

The issue of multiple sources of funding for a statewide program also deserves attention. It is a great deal to ask of a state legislature to fund a program as broadly based as Healthy Start from state revenues alone. Such a strategy would surely result in "dilution" eventually. Instead, we plan to use other funding sources as appropriate and available. For example, case management and potentially home visiting services are reimbursable under Medicaid. Part H may be able to reimburse us for development of Individualized Family Service Plans. We need to look also at the challenge grants within the National Center on Child Abuse and Neglect, which currently provides incentive matching to states through the Children's Trust Funds.

Healthy Start offers a systematic and highly effective approach to prevention of child abuse among the most vulnerable population—infants and toddlers at risk. It creates an excellent opportunity to focus on promotion of child health and development of these children. Moreover, it coordinates a range of services to the most needy families of a community.

In *Within Our Reach*, Lisbeth Schorr defined six challenges to efforts designed to prevent "rotten outcomes" of childhood. Healthy Start offers a solution for the challenges of knowing what works, proving we can afford it, attracting and training skilled and committed personnel, resisting the lure of dilution in replication, "gentling the hand" of bureaucracy, and devising replication strategies. Schorr further challenges programs to develop methods of linking populations at risk with needed services, clearly a major contribution of Healthy Start. We look forward to collaborating with colleagues to meet remaining challenges in accomplishing this most worthy goal, so that all of our children may have a safe and healthy start in life.

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Calls for Papers:

The World Association of Infant Psychiatry and Allied Disciplines (WAIPAD) is accepting submissions for its Fifth World Congress, entitled "A Future for Babies: Opportunities and Obstacles," to be held September 10-12, 1992 in Chicago, Illinois. Submissions are invited for symposia, workshops, clinical teach-ins, posters, and videotaped presentations on three themes: 1) psychological aspects of medical illness and technology; 2) infant-caregiver relationships; and 3) development and psychopathology. **All submissions must be received by August 1, 1991.** For submission forms and information about the Congress, write to Charles Zeanah, M.D., Women & Infants Hospital, 101 Dudley Street, Providence, RI 02905, or call Jo Sawyer, tel: (312) 621-0654.

The Literature Prize Committee of the **Margaret S. Mahler Psychiatric Research Foundation** is now accepting papers to be considered for the 1991 annual prize of $750, which will be awarded to the author of an original paper which deals with clinical, theoretical or research issues specifically related to Dr. Mahler's concepts of separation-individuation in child development. For more information contact Harold Blum, M.D., Acting Chairman, Margaret S. Mahler Literature Prize Committee, 23 The Hemlocks, Roslyn Estates, NY 11576.

Infant-Toddler Intervention, a new journal for early interventionists, invites manuscript submissions from early interventionists in all disciplines. Articles may be based upon empirical or clinical data and should be directly relevant to contemporary issues in early intervention. Manuscripts in APA style may be submitted in duplicate to Louis Rossetti, Ph.D., Editor, Infant-Toddler Intervention, Speech and Hearing Clinic, University of Wisconsin-Oshkosh, Oshkosh, WI 54901.

Healthy Start

This program helps young families develop skills for loving

By Georgette Magnuson
Photography by Augie Salbosa

Jill Lauterbach, Healthy Start client:
"My main goal is for my children to grow up healthy and happy and be good members of society, because I've seen so much bad."

Jill Lauterbach, a 30-year-old mother of two, lay in the hospital three years ago exhausted and anxious. During that time, something happened that changed her life, but she barely remembers it. "I was under so much stress at the time," she says, "I can't remember giving a woman my number, but I must have because she called a week later."

Following three difficult days in labor, Lauterbach took home baby Christina to a man who'd never wanted to be a father. He packed up and left that night. Over the following weeks, the baby cried and cried and didn't want to be touched. And there was her son, Eddie, 9, to attend to as well. Though fatigued and distressed, Lauterbach returned to her housekeeping job immediately because she had no savings. Then the doctor discovered Christina had spinal meningitis and put her in the hospital. At the breaking point, Lauterbach quit her job and applied for welfare so she could care for her baby.

Lauterbach was wary when a woman called a week later. The caller was from Healthy Start, a Hawai'i Family Stress Center program administered by the State Department of Health's Maternal and Child Health Branch. Though the woman said she wanted to help, Lauterbach was uncomfortable. "I was afraid they would have my children taken away or something," she says.

Dannette Lyman, a woman in her 50s with a soothing voice and some progressive ideas about child-rearing, is Lauterbach's current Family Support

Worker. "Many of our clients think they are being set up by the system," Lyman says. "We just try to be as non-threatening as possible."

The Healthy Start program was started in 1985 to help reduce family stress, improve parenting skills, promote child health and development, and prevent child abuse and neglect. With 12 sites statewide, the program is free to eligible families.

Hospital-assigned Healthy Start workers sort through hospital records to reach out to new mothers living in Healthy Start service areas. Follow-up interviews help locate families under severe stress. Typically, these include single parents or others without support of relatives or friends, those with debilitating financial problems, or problems with substance abuse, domestic violence or inadequate housing. Others might be parents who were abused during their childhood. After assessing a need for help, weekly home visiting services are offered. About 90 percent of families offered services accept.

During Lauterbach's first visit from Healthy Start, the worker explained how the program works. From that day on, Lauterbach says, the woman visited every week to make sure she and her baby were all right.

"It was so helpful just to have someone to talk to," says Lauterbach. "It took the pressure off." The worker brought pamphlets on child development, offered information on other state assistance programs, and taught her to locate community resource centers. "They helped me to get

continued...

lamps and tables," Lauterbach says, "necessities I couldn't possibly get on my own at that time." The woman also helped her locate physicians, provided transportation to and from the physician's office when needed, and brought diapers from Healthy Start's emergency supply when Lauterbach couldn't afford them.

When Lauterbach's first support worker was promoted, Lyman was assigned. She will work with Lauterbach's family until Christina is five years old.

"If we give children guidance and stability in their formative years," Lyman says, "they'll be able to make good choices as they grow."

Lauterbach, like many Healthy Start clients, grew up in an unstable environment. Two alcoholic parents struggled to give her and seven siblings a home, but the atmosphere was often tense and unpredictable. At 13, she left school and ran away from home, but drinking and abusive relationships marred the hope she had for a better life. She has no childhood photographs, the benchmarks of happier families.

The lack of healthy role models in childhood makes parenting all the more challenging for families. Domestic violence, substance abuse and financial problems compound the difficulty.

Healthy Start workers, though not required to be social workers, receive intensive training in crisis intervention and family stress issues. According to Gail Breakey, director of the Hawai'i Family Stress Center, Healthy Start workers empower families to get their needs met.

"About 22 percent of the families we work with are homeless, and many others have inadequate housing," Breakey says. "So the first thing a worker does is work with the family to fill their basic needs." That may include helping them fill out papers for public housing, food stamps or Medicaid. They may pick up a newspaper, help them find a better housing arrangement and get the deposit together.

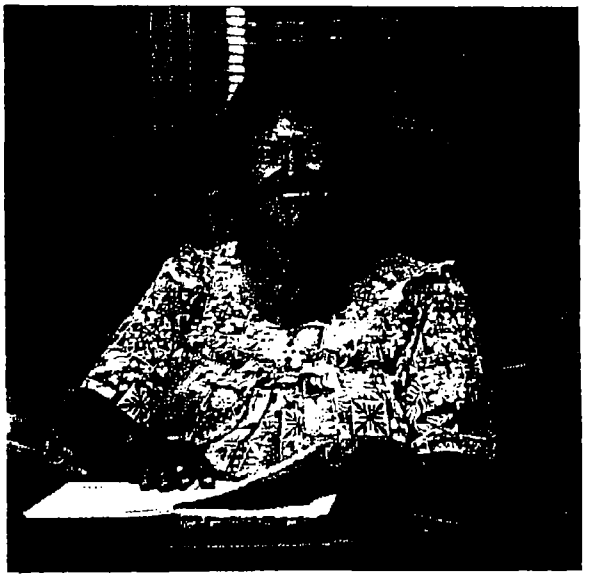
Support workers also model supportive parenting behaviors, cooing and fussing over their client's children to encourage the parent to do likewise. "If a woman has not had her own mother talk and play with her—all those warm, fuzzy interactions—she won't know to do that," says Breakey. "It's very important for language and social development."

The main thing is making sure the children are safe, says Lyman. "From the very first visit," she says, "we let them know that Healthy Start will not tolerate abuse."

Lyman and the other workers teach parents non-physical methods of discipline and help alleviate parental stress through weekly therapy sessions, monthly picnics, weekly play mornings for the whole family, and anger management classes when needed.

It's working. Follow-up studies have shown that 99 percent of Healthy Start families have no abuse or neglect.

It's working in Lauterbach's life,



Family support worker Dannette Lyman: "We were told to get rid of the nylons and briefcase, get rid of the facade and deal with the issues. We need to develop trust in order to help our clients, not intimidate them."

A staff child development specialist visits families' homes to help identify children who are developmentally delayed, so they can be linked with appropriate services. Childhood immunization schedules are tracked by computer, making Healthy Start's immunization record 90 percent, compared to the state's average of 60 percent statewide.

too. "My life has changed since I've been with the Hawai'i Family Stress Center," she says. "I've calmed down and matured."

Today, Jill Lauterbach lives in a small ground-floor apartment flanked by a lovely garden. She hasn't had a drink in five years. Christina is now three years old and son Eddie, 12. Pictures of her children are everywhere.

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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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)

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.

Matthew E. Melmed

Matthew Melmed assumed the leadership and management of ZERO TO THREE: National Center for Infants, Toddlers and Families in late 1994.

ZERO TO THREE is the nation's leading resource on the first three years of life. It is the only national nonprofit organization dedicated solely to promoting the social, emotional, cognitive, and physical development of children from birth through age three, and to supporting their families and caregivers. ZERO TO THREE focuses on the first three years because it is the time of greatest human growth and development. It is also the time of greatest opportunity for adults to positively influence a child's future.

ZERO TO THREE's urgent mission is to advance the healthy development of America's babies and young children. It strengthens and supports professionals, policymakers and parents by:

- Increasing *public awareness* of the critical importance of the first three years of life;
- Fostering *professional excellence* through training and related activities;
- Inspiring *tomorrow's leaders* by identifying and engaging promising young professionals;
- Promoting the *discovery and application of new knowledge, model approaches and "best practices"* concerning early childhood development;
- Stimulating *effective service approaches and responsive policies;* and,
- *Educating* parents and other caregivers about significant differences they can make in the lives of babies and young children.

Since joining ZERO TO THREE, Mr. Melmed has built on the organization's strong track record of success in promoting prevention and healthy development in early childhood. Since his arrival, ZERO TO THREE has successfully competed to 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 that are being established nationwide. Under his leadership, ZERO TO THREE has also initiated a national public awareness campaign aimed at parents, launched the *Business Leaders for Babies Alliance*--a corporate effort aimed to involve the business community in ZERO TO THREE's issues, and designed a long-term initiative to expand ZERO TO THREE's capacity to market information and materials to wider audiences. In addition, he has guided the growth of the organization's budget from two to three million dollars.

Mr. Melmed's responsibilities as Executive Director include: oversight of policy and program development; technical assistance to state and community-based organizations; speaking engagements before a wide array of audiences; and ongoing relations with business leaders, foundation executives, health and social services professionals, and the media.

Mr. Melmed's administrative responsibilities include: formulation and implementation of financial, administrative and personnel policies and procedures; personnel management; budget development and management; strategic planning; initiation and execution of fundraising strategies, and motivation and support of Board and volunteers.

Prior to ZERO TO THREE, Mr. Melmed served for 13 years as Executive Director of the Connecticut Association for Human Services. CAHS is an independent nonprofit education, research and policy development organization. CAHS generates innovative ideas, forms creative partnerships and advances realistic solutions on a broad range of social policy issues. During his tenure, CAHS stature and effectiveness grew and the organization was selected by the Peter F. Drucker Foundation for Nonprofit Management as one of four organizations nationwide to receive special recognition in its first Award for Innovation competition.

Mr. Melmed is a Phi Beta Kappa graduate of Harpur College, State University of New York at Binghamton where he graduated with highest honors. He received his Juris Doctor degree from the Faculty of Law and Jurisprudence at S.U.N.Y., Buffalo and was conferred with a *Special Faculty Commendation for Extraordinary Community Service.*

Prior to joining CAHS, Mr. Melmed worked for Connecticut Legal Services which he joined in 1978 as a staff attorney. He rose 18 months later to direct Project FEAD, a statewide advocacy and technical assistance project addressing hunger and malnutrition. He later became Managing Attorney of the program's largest office where he directed a 25-person legal staff.

Among the honors he has received are the *Child Advocacy Award* from the Collaboration for Connecticut's Children; the *Lewis Hine Award for Exceptional Service to Children and Youth* from the National Child Labor Committee; the *Ralph Gofstein, M.D. M.P.H. Award for Noteworthy Contributions to the Field of Public Health* from the Connecticut Association for Directors of Health; and, the *Community Leadership Award* from Connecticut Legal Services, and recognition by the Connecticut General Assembly for his leadership in human services in that state.

Mr. Melmed is a member of the Federal and Connecticut Bars. He serves as Vice Chair of the Board of Directors of the Food Research and Action Center (FRAC) in Washington, D.C.

Mr. Melmed and his wife, Deborah Rozell, are happily raising their two wonderful little boys, Andrew and Jeremy.

Media Relations
8200 Jones Branch Drive
McLean, VA 22102

FactSheet

Leland C. Brendsel
Chairman and Chief Executive Officer
Freddie Mac

Freddie Mac

Leland C. Brendsel is chairman and chief executive officer of Freddie Mac, a position he has held since November 1989. Before he was elected chairman, Brendsel served as president and chief executive officer of Freddie Mac for four years. He joined Freddie Mac in 1982 as executive vice president and chief financial officer.

Brendsel has been a leader in the development of the secondary mortgage market. He was instrumental in creating the market's first multiclass mortgage security in 1983, for example. He has championed innovative ways to improve lending practices and expand homeownership opportunities, helping to put people into homes they can afford and keep.

Under Brendsel's leadership, Freddie Mac has been consistently profitable and has evolved into a publicly held corporation with a shareholder-elected Board of Directors. Earnings-per-share growth has averaged 18 percent over the past ten years as Brendsel has led the company; return on equity has exceeded 20 percent in each year. Today, Freddie Mac is one of the top ten financial services companies in the US, with nearly $625 billion in mortgage assets financing homes for eight million American families. Its $22 billion market capitalization puts it 74th in the S&P 500.

Freddie Mac has helped make America's housing finance system the best in the world. Because of Freddie Mac, homeowners in communities across the nation can depend on the availability of mortgage money at lower interest rates. Freddie Mac brings continual innovation to the market, from the introduction of conventional mortgage-backed securities in 1971 to the introduction of automated underwriting in 1995.

Brendsel created in 1991 and is Chairman of the Board of the Freddie Mac Foundation, which is dedicated to brightening the future for at-risk children and their families. Brendsel runs several times each year in Freddie Mac's Reach Out to a Child 5K walk/runs, which have become an industry-wide effort to raise money for foster care and adoption programs.

Brendsel has received numerous awards for his commitment to children, including: Washingtonian of the Year (1991), the Washington UNICEF Council Children's Champion (1992), the National Black Child Development Institute's Corporate Citizen of the Year (1993), the New York Council on Adoptable Children's Award (1993), the Child Welfare League of America's Corporate Advocate of the Year (1995) and the Volunteer Emergency Families for Children's Give Your Heart to a Child Award (1997).

Brendsel also sits on the Board of Directors of the Local Initiatives Support Corporation, the nation's largest nonprofit community development intermediary.

Brendsel received his doctorate in finance from Northwestern University after completing undergraduate studies at the University of Colorado. He remains active with Northwestern, serving on the Advisory Board of the J.L. Kellogg Graduate School of Management.

8/97

David L. Olds, Ph.D.
Professor of Pediatrics, Psychiatry and Preventive Medicine
Director, Prevention Research Center for Family and Child Health

David Olds is Professor of Pediatrics, Psychiatry and Preventive Medicine at the University of Colorado Health Sciences Center, where he directs the Prevention Research Center for Family and Child Health. He has devoted his career to investigating 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. A member of the American Pediatrics Society, he has received numerous awards for this research, including the Charles A. Dana Award for Pioneering Achievements in Health, the Lela Rowland Prevention Award from the National Mental Health Association, and a Senior Research Scientist Award from the National Institute of Mental Health. He currently is carrying out an urban replication of the Elmira study in Memphis, Tennessee; a fifteen-year follow-up study of the Elmira sample; and another replication of the Elmira and Memphis studies in the Denver metropolitan area. The Denver trial examines the unique contributions that paraprofessional and nurse home visitors can make toward improving the health of mothers and children from low-income families. Dr. Olds obtained his B.A. from Johns Hopkins University and his Ph.D. from Cornell.

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[003]

Sally Campbell

h P6/(b)(6)

David Olds

303 | 864-5205

3:30 Conf call - WH

4:30 - Conf call -

HRA

DRAFT

Roundtable Discussion on Home Visitation
Participants

The First Lady

1. Dr. Matthew Melmed
Executive Director
Zero-to-Three National Center for Infants and Toddlers

2. Dr. David Olds
Professor of Pediatrics Psychology and Preventive Medicine
Director, Prevention Research Center for Family and Child Health
University of Colorado

3. Dr. Betsy ~~Doo~~ Dew
Founder, Hawaii Healthy Start program
Healthy Families America

4. Parent ~~TBD~~

5. Parent ~~TBD~~

6. Parent ~~TBD~~

7. Home-vistor ~~TBD~~

~~Parent/Home-visitor TBD~~

8. Mr. Leland Brendsel
CEO
Freddie Mac Corp.

To: Noa
Fr: Nicole –

pls do
a paragraph
on each
discussion
participant
and a
separate
page
for
those on
the
home
visit

Bio for Betsy Dew

Betsy Dew, Director and Senior Training Specialist with The Family Institute of Hawaii Family Support Center, currently works out of Virginia 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.

She has a masters in educational psychology. Her professional experience includes family assessment, family counseling, teaching, psychological diagnostic testing, and program and agency management. She has worked with multicultural populations including families from every sector, delinquent and emotionally disturbed teens, preschool, elementary and high school students, and overburdened parents.

As one of the Founders of Hawaii Family Support Center in 1975, she 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 statewide expansion, developing and implementing the statewide 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.

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Leland
Mr. Brendsel
CEO

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8200 Jones Branch Drive
McLean, VA.
22102-3107

FAX COVER SHEET

DATE:	**FROM: Shawn Flaherty**
TO: LINDA DUNPHY	**DEPT: Public Relations**
CO: NVFS	**PHONE: 703-903-4384**
RE:	**FAX: 703-903-2447**

Number of pages including cover sheet: 4

Thanks!

Renette Oklewicz - Our Main Grant Officer Contact
703-903-2417

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W 703-903-2417

- Private sector - how do we make this happen - takes bus/corp. in a community - get sites started.

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FactSheet

Freddie Mac:
Improving the Quality of Life

Freddie Mac

Freddie Mac
Freddie Mac is a shareholder-owned corporation whose people are dedicated to improving the quality of life by making the American dream of decent, accessible housing a reality. Chartered by Congress in 1970 to create a continuous flow of funds to mortgage lenders in support of homeownership and rental housing, Freddie Mac purchases mortgages from lenders and packages them into securities that are sold to investors. Over the years, Freddie Mac has opened doors for one in six homebuyers and two million renters across America.

In these ways, Freddie Mac helps to enable families, with diverse needs and financial capabilities, to live in decent homes in neighborhoods across the country. By financing homes, Freddie Mac improves the quality of life for families and their children. At the same time, we want these homes to be healthy homes and strong communities for families and children. That's where the work of the Freddie Mac Foundation comes in.

The Freddie Mac Foundation
Created by Freddie Mac in 1990, the Freddie Mac Foundation is dedicated to brightening the future of children, youth and families at risk. The Foundation works to strengthen the community by providing funds for a variety of nonprofit organizations serving children and their families, focusing primarily on metropolitan Washington, DC—the location of our corporate headquarters—and the cities of our corporate regional offices. In addition, the Foundation also encourages, supports and coordinates volunteer and giving efforts of Freddie Mac employees.

Over the years, the Freddie Mac Foundation has grown through financial donations, employee involvement, and corporate leadership, expanding our giving from $350,000 in 1991 to more than $12 million in 1997. The majority of our 1997 grants have supported nonprofit organizations in metropolitan Washington, DC. Today, the Freddie Mac Foundation is one of the largest and most respected corporate foundations in metropolitan Washington, DC.

The Foundation focuses on young children and prevention-oriented programs. Typically, grants are awarded to programs building strong families, encouraging early childhood development and education, supporting foster care and adoption, and stimulating systems reform and advocacy efforts.

Employee Volunteerism
Our philanthropic success owes much to the spirit and dedication of Freddie Mac's employees. In 1997, nearly half of our employees—more than 1,500 people—gave their time, talents and charitable contributions by participating in our Employee Volunteer Program.
Through the Employee Volunteer Program, the employees shared their time to help build and repair homes with Habitat for Humanity and Christmas in April. Participating in our three

business school relationships—J.C. Nalle, Hunters Woods, and the School for Contemporary Education, our employees built a playground, mentored students, served as pen pals, ran Junior Achievement programs, went on field trips, and cleaned and fixed-up school grounds. In addition, employees coordinated and ran in many charitable races including our own—the Reach Out to a Child 5K Run, helped with Special Olympics, made food and donated diapers for homeless children, and gave thousands of holiday presents to local families in need.

Corporate Leadership

Through active corporate leadership, the corporation and Foundation further strive to improve the quality of life in the communities in which we live and work. The Foundation does this by encouraging comprehensive programs at the national level that have demonstrated results for children and families. Many of the corporation's officers and employees do this by volunteering their time to be members of boards for charitable and civic organizations—both local and national.

The Foundation has several signature programs that exemplify our corporate leadership on behalf of children and families. One is our commitment to strengthening families by replicating Healthy Families America—the nationally recognized program proven to help first-time parents be successful through intensive home visits—throughout the Washington, DC metropolitan area and beyond. Our commitment goes well-beyond the funding commitment. We sit on the board of the National Committee to Prevent Child Abuse—Healthy Families' organizing body, and our chairman is chairing a nationwide capital campaign for Healthy Families America.

On the educational front, the Foundation and its corporate leaders have focused time and resources on the community school concept, a model focusing on improving educational outcomes and building stronger communities by making schools the hub of a community. Specifically, the Foundation is working to transform J.C. Nalle Elementary School, Freddie Mac's partner school in the District, into a full-service community school—offering a range of services that children and families need. Deepening our commitment to this innovative concept, Freddie Mac co-sponsored, and actively participated in, the 1998 Communities in Schools National Conference.

One final example is the Reach Out to a Child Campaign which has raised awareness about children in the foster care and adoption systems. The campaign has three components: the 5K Run/Walk series held in cities nationwide and coordinated by employee volunteers; foster parent recruitment; and the locally-televised Wednesday's Child adoption program.

A Good Neighbor

Looking ahead, Freddie Mac will continue to open doors for homebuyers, and the Freddie Mac Foundation will continue to open doors for children through their communities. These concerted efforts will brighten the lives of children, youth and families by improving their quality of life today and offering them a future filled with promise and hope. To do so, we believe that we must do more than provide funding, we must also be a partner...a leader... and a good neighbor.

Media Relations
8200 Jones Branch Drive
McLean, VA 22102

Fact Sheet

The Freddie Mac Foundation's Commitment to Healthy Families America

Freddie Mac

- The Freddie Mac Foundation is dedicated to brightening the future for children, youth and families at risk. It fulfills this mission by providing funds to organizations working to strengthen the health, education and welfare of children and youth and to provide family support services.

- Since its creation by Freddie Mac in 1990, the Freddie Mac Foundation has granted more than $32 million to programs in the Washington, DC metropolitan area; Freddie Mac regional cities of Chicago, New York, Los Angeles, Dallas and Atlanta; and for programs that have a national scope.

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- Locally, Foundation funds of nearly $4 million support eight sites with several more in the planning stage. The Foundation also has provided more than $250,000 in support of the Healthy Families America site in Chicago.

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005. fax	cover sheet, Kay Clinkscales to Nicole Radner (partial) (1 page)	02/06/1998	P6/b(6)

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

FOLDER TITLE:
Home Visiting Program [3]

2012-1035-S
kc1054

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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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)]

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[005]

ZERO TO THREE

FAX COVER PAGE

734 15th Street, N.W., Suite 1000, Washington, D.C. 20005-1013 (202) 638-1144 • Fax: (202) 638-0851 • Publications: (800) 899-4301

To: Nicole Radner	From: Kay Clinkscales
Fax Number: 202-456-9412	ZERO TO THREE
Date: 2/6/98 Pages: 3	For Information Call: (202) 638-1144
Subject: Microsoft Word - MMDESCIP.DOC	Fax Number: (202) 638-0851

Nicole,

Attached is Matthew Melmed's Bio. P6/(b)(6)

If you need any thing else, please call me.

Kay Clinkscales

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006. bio	Felicia Pearson (1 page)	nd	P6/b(6)

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007. bio	Jane Rutherford (1 page)	nd	P6/b(6)

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008. bio	Church-Watson family (1 page)	nd	P6/b(6)

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For more information, contact Shawn Flaherty at 703-903-4384 or visit our Website at www.freddiemacfoundation.org.

Freddie Mac:
Improving the Quality of Life

Freddie Mac
Freddie Mac is a shareholder-owned corporation whose people are dedicated to improving the quality of life by making the American dream of decent, accessible housing a reality. Chartered by Congress in 1970 to create a continuous flow of funds to mortgage lenders in support of homeownership and rental housing, Freddie Mac purchases mortgages from lenders and packages them into securities that are sold to investors. Over the years, Freddie Mac has opened doors for one in six homebuyers and two million renters across America.

In these ways, Freddie Mac helps to enable families, with diverse needs and financial capabilities, to live in decent homes in neighborhoods across the country. By financing homes, Freddie Mac improves the quality of life for families and their children. At the same time, we want these homes to be healthy homes and strong communities for families and children. That's where the work of the Freddie Mac Foundation comes in.

The Freddie Mac Foundation
Created by Freddie Mac in 1990, the Freddie Mac Foundation is dedicated to brightening the future of children, youth and families at risk. The Foundation works to strengthen the community by providing funds for a variety of nonprofit organizations serving children and their families, focusing primarily on metropolitan Washington, DC the location of our corporate headquarters—and the cities of our corporate regional offices. In addition, the Foundation also encourages, supports and coordinates volunteer and giving efforts of Freddie Mac employees.

Over the years, the Freddie Mac Foundation has grown through financial donations, employee involvement, and corporate leadership, expanding our giving from $350,000 in 1991 to more than $12 million in 1997. The majority of our 1997 grants have supported nonprofit organizations in metropolitan Washington, DC. Today, the Freddie Mac Foundation is one of the largest and most respected corporate foundations in metropolitan Washington, DC.

The Foundation focuses on young children and prevention-oriented programs. Typically, grants are awarded to programs building strong families, encouraging early childhood development and education, recruiting foster and adoptive parents, and stimulating systems reform and advocacy efforts.

Employee Volunteerism
Our philanthropic success owes much to the spirit and dedication of Freddie Mac's employees. In 1997, nearly half of our employees—more than 1,500 people—gave their time, talents and charitable contributions by participating in our Employee Volunteer Program.

Through the Employee Volunteer Program, the employees shared their time to help build and repair homes with Habitat for Humanity and Christmas in April. Participating in our three business school relationships—J.C. Nalle, Hunters Woods, and the School for Contemporary Education, our employees built a playground, mentored students, served as pen pals, ran Junior

Achievement programs, went on field trips, and cleaned and fixed-up school grounds. In addition, employees coordinated and run in many charitable races including our own—the Reach Out to a Child 5K Run, helped with Special Olympics, made food and donated diapers for homeless children, and gave thousands of holiday presents to local families in need.

Corporate Leadership

Through active corporate leadership, the corporation and Foundation further strive to improve the quality of life in the communities in which we live and work. The Foundation does this by encouraging comprehensive programs at the national level that have demonstrated results for children and families. Many of the corporation's officers and employees do this by volunteering their time to be members of boards for charitable and civic organizations—both local and national.

The Foundation has several signature programs that exemplify our corporate leadership on behalf of children and families. One is our commitment to strengthening families by replicating Healthy Families America—the nationally recognized program proven to help first-time parents be successful through intensive home visits—throughout the Washington, DC metropolitan area and beyond. Our commitment goes well-beyond the funding commitment. We sit on the board of the National Committee to Prevent Child Abuse—Healthy Families' organizing body, and our chairman is leading a nationwide capital campaign for Healthy Families America.

On the educational front, the Foundation and its corporate leaders have focused time and resources on the community school concept, a model focusing on improving educational outcomes and building stronger communities by making schools the hub of a community. Specifically, the Foundation is working to transform J.C. Nalle Elementary School, Freddie Mac's partner school in the District, into a full-service community school—offering a range of services that children and families need. Deepening our commitment to this innovative concept, Freddie Mac co-sponsored, and actively participated in, the 1998 Communities in Schools National Conference.

One final example is the Foundation's efforts to raise awareness about foster care and adoption. The initiative has three components: the 5K Run/Walk series held in cities nationwide and coordinated by employee volunteers whose proceeds go to foster care-related organizations; foster parent recruitment through radio advertisements; and the locally-televised Wednesday's Child adoption program which has assisted in the adoption of 100 children and generated 3,400 viewer inquiries about becoming foster parents.

A Good Neighbor

Looking ahead, Freddie Mac will continue to open doors for homebuyers, and the Freddie Mac Foundation will continue to open doors for children by building strong families and communities. These concerted efforts will brighten the lives of children, youth and families by improving their quality of life today and offering them a future filled with promise and hope. To do so, we believe that we must do more than provide funding, we must also be a partner...a leader... and a good neighbor.

THE WHITE HOUSE

WASHINGTON

February 6, 1998

Dr. David Olds
Professor of Pediatrics Psychology and Preventive Medicine
Director, Prevention Research Center for Family and Child Health
University of Colorado
Via facsimile

Dear Dr. Olds:

Thank you very much for agreeing to participate with the First Lady in the discussion on home visitation on Tuesday, February 10, and for spending time on the phone with me discussing this issue. I found our conversations very helpful.

On Tuesday, we would be grateful if you would come to the White House at 1:15pm. Please enter the White House through the North West Gate, which is located on Pennsylvania Avenue, where you will be directed to the West Lobby. For clearance purposes, please forward your birth date and social security number to me at your convenience. Also, it would be useful to know where you are staying on Monday, in case I need to get a message to you. From the White House, we will drive in the First Lady's motorcade to Alexandria, where the First Lady will, as I mentioned, participate in a home visit. Following the visit, the discussion will take place with the First Lady, yourself, Dr. Dew, Dr. Melmed, as well as a few families and home visitor.

As promised, I am enclosing the recent evaluation and description of the Healthy Families Alexandria program. I am very much looking forward to meeting you and to Tuesday's event. Please feel free to call me at 202/456-7263.

Sincerely yours,

Nicole Rabner

Nicole Rabner
Associate Director for Domestic Policy

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009. personal info	Jane Rutherford (1 page)	nd	P6/b(6)

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