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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Meeting (3 pages)	ca. 02/1998	P1/b(1)
002. talking points	Points to be Made in Meeting (1 page)	ca. 02/1998	P1/b(1)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Jennifer Klein
OA/Box Number: 13526

FOLDER TITLE:
Home Visitation

2014-0536-S
ms767

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
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TALKING IT OVER
BY HILLARY RODHAM CLINTON
FOR IMMEDIATE RELEASE

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

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

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

This week, I visited the home of a single mother in Alexandria, Va., not far from the White House. Depressed and scared when she became pregnant, Felicia was referred to a program called Healthy Families Alexandria, which was launched in 1993 when the area began to experience some disturbing trends, including increasingly high rates of child poverty and abuse, teen pregnancy, low birth-weight babies and vaccine-preventable diseases.

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

With the support of her home visitor, Felicia is now the proud and confident mother of Dominico, a gurgling, smiling and healthy 3-month-old. On the day I visited, Felicia's home visitor was checking the baby's development, offering some age-appropriate toys

and answering Felicia's questions and concerns. From her vantage point in the home, the visitor is able both to evaluate the child's growth and development, and to assess whether the child's surroundings are suitable and nurturing. When I asked Felicia if she thought home visits would help others, she said, "Oh, yes, I feel so rich. Having Lynn really helps."

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

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

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

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

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February 10, 1998

February 9, 1998

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: **Brenda Costello**
SUBJECT: **Briefings for Tuesday, February 10**

Tea with the First Lady of Bulgaria
-Briefing
-Talking points
-Bio
-Background on "Children's Art Bridge"

Early Learning Event
-Briefing
-Home visit bio
-Roundtable bios
-Meet and Greet list
-Article: "Together for Children: Spotlight on Healthy Families Virginia"
-Article: *The Washington Post*, "We're Breaking the Cycle of Abuse."
- "Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect: Fifteen-Year Follow-up of a Randomized Trial." By Dr. David Olds et. al.
-Article: *The New York Times*, "Nurses' Visits Held Benefits for Children of the Poor."

Zero to Three 20th Anniversary Gala
-Briefing
-Program
-Meet and Greet list
-Press release

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ANTONINA STOYANOVA

Biography

Antonina Stoyanova was born in the capital Sofia but she grew up in Plovdiv, the second biggest city in Bulgaria, where her parents moved soon after her birth.

As an excellent student and after a successful entrance exam she enrolled in the Plovdiv English language school which she graduated with flying colours.

In 1972, having received the necessary credits in the qualifying exams she went on to study international economics law in Leipzig, Germany. In 1976 she earned a PhD from the University of Leipzig after defending with honours her dissertation on "The legal will of international organizations in framing the international legal norms."

Returning to Bulgaria, she had a year of practice at the Plovdiv district court and in 1979 she joined the Bar. She was engaged mainly in civil law cases. After the opening of the profession in 1992 she began to take on trade litigation cases.

In 1992 Mrs. Stoyanova specialized in the Southern Illinois University (human rights in the new democracies) on a three-month scholarship sponsored by USIA. In 1994 she had an internship with a law-firm practising trade law in Cologne, Germany.

In 1994 she joined the Ministry of Foreign Affairs, the International Law department. Her area of expertise covered: problems arising for Bulgaria from implementing the two Vienna Conventions on the diplomatic and consular relations, bilateral and multilateral treaties and agreements for legal assistance, protection for Bulgarian citizens and legal persons abroad, international legal problems in the area of human rights.

Antonina Stoyanova represented Bulgaria at the Vienna session of the UN Crime Prevention Commission and the World Ministerial Meeting in Naples on combating cross-border crime.

In 1995 Mrs. Stoyanova joined the diplomatic service and was posted to London as first secretary at the Bulgarian embassy.

She terminated her diplomatic service in January 1997 when her husband Petar Stoyanov took office as President of the Republic of Bulgaria.

In addition to her public responsibilities as wife of the President she engages in charitable activities. She is the Patron of the Future for Bulgaria Foundation created in late 1996 and designed to assist orphanages and nursery homes. The Foundation organized a considerable amount of help for the most vulnerable part of the population in Bulgaria during the severe economic crisis in the winter of 1997 and to this moment.

Mrs. Stoyanova is a founding member of the Bulgarian Women's Union. Recently, she founded a non-profit organization for the promotion of Bulgarian culture, art and education abroad.

The presidential couple have two children: a son Stephen, born in 1979 and a daughter Fanny, born in 1990.

Mrs. Stoyanova is fluent in English and German.

The Travelling Museum

Children's Art Bridge

Background

The purpose of Children's Art Bridge is to promote peace and mutual understanding throughout the world and concerning children and adults. The art and creative projects of children and teens, often "at risk" in areas of civil or economic strife, serve as a bridge between peoples. Educational, mobile displays, slide and video presentations combine art, creative writing, photography and informative narration for building creative bridges internationally. The tremendous networking potential of this work has made it possible for CAB to facilitate medical and material aid for participant groups. Most recently, they are working as liaison between US military base closing personnel in Germany to donate US closing base school supplies to Eastern European schools and institutions. This work goes far beyond the material. It creates real bonds of friendship and love. The groups who view Travelling Museum exhibits are challenged to get involved, connecting with the children they meet through the art in ways that range from letter writing and sharing their art, to raising funds or actually visiting the regions, offering hands-on assistance through existing relief organizations.

Founding the project in January 1993, human rights organizer and artist, Alana Hunter and photojournalist, Clara Pascal shared a deep concern for the effects of violence on children. The heart of their efforts have been what they call "love intervention" with an emphasis on creativity as a means for encouraging resilience, non-violence, and teaching of tolerance. They offer exhibitions, conferences, presentations, videos and slide shows in exchange for donations. Non-Profit deductions are available in most cases.

Currently Available Presentations and Exhibitions

- **Palestinian Children and their Art &**
  Israeli and Palestinian Children's Visions of Hope (a new Post-Accords project)
- **Washington DC First Graders: Happy and Sad in our Neighborhood**
- **Russian Children's Art Bridge**
- **Lithuanian Children's Visions of Independence**
- **Yugoslavian Children and Families (including Bosnian, Croatian, and Serbian refugees as well as those inside the war-zone)**
- **Peace and Justice-Robinson Square Newsletter Project, USA**

Contact:
Alana Maubury Hunter
P.O. Box 4735, Arlington, VA 22204 USA tel.& fax 703-521-6609

February 9, 1998

HOME VISITATION EVENT AND ROUNDTABLE DISCUSSION

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

I. PURPOSE

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

II. BACKGROUND

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

Home Visitation

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

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

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

Healthy Families Alexandria -- Healthy Families America

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

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

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

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

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

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

Elmira, New York Pregnancy and Infancy Nurse Home Visitation Program

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

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

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

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

Event Scenario

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

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

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

III. PARTICIPANTS

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

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

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

IV. SEQUENCE OF EVENTS

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

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

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

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

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

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

- Mr. Leland Bresland will make brief remarks

- YOU will make closing remarks and end the program.

- YOU will depart.

V. PRESS PLAN

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

BIO FOR HOME VISIT MOTHER
FEBRUARY 10, 1998

Felicia Pearson. Parent served by Healthy Families Alexandria.

Felicia Pearson is a thirty year-old African American receptionist with a high-school diploma. Shen was self referred to Healthy Families after a suggestion from the psychiatric social worker at George Washington University Hospital when she was five months pregnant. Ms. Pearson was hospitalized from her 6th through her 19th week of pregnancy for depression. The doctors warned that she would likely suffer from post-partum depression. At the time she was afraid that she would not be able to love or pay attention to her baby once he was born.

Lynn Kasonovich, her Family Support Worker, started visiting Ms. Pearson when she was five months pregnant. They discussed the effects of depression on parenting and how it could potentially affect her relationship with her new baby. Ms. Pearson expressed insecurity in her ability to take care of her baby and fear that her depression might overwhelm her.

Ms. Pearson's baby, Dominico was born November 3, 1997. She is on maternity leave for four months and will return to her job as a receptionist. Ms. Kasonovich reports that Ms. Pearson's worst fears were not realized and appears to be delighted with her newborn. The two meet once a week and discuss Dominico's growth and development, his most recent well care visit with his pediatrician, and her concerns about how she will care for him when she returns to work.

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.

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.

Jane Rutherford is a 38 year-old single mother of a three month-old baby. Ms. Rutherford was referred to Healthy Families/CHIP through a housing program when she was seven and a half months pregnant and working as a legal secretary. After enduring a difficult pregnancy riddled with illness and fear of becoming a mother, Ms. Rutherford lost her job due to her recurring illnesses. With the help of her Family Support Worker and Public Health Nurse, Ms. Rutherford is said to be feeling greater comfort in her role as a new mother.

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.

Brandi and Antoine are unmarried but live together and are the parents of one-and-half year-old Deija. Ms. Church stays at home and Mr. Watson changes jobs frequently. Their families are unhappy with their biracial relationship and as a result offer little help with Deija. They rely on

Healthy Families for most of their support.

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

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

HEALTHY FAMILIES MEET AND GREET
FEBRUARY 10, 1998

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

TOGETHER FOR CHILDREN

Prevent Child Abuse, Virginia

Summer 1997

Spotlight on Healthy Families Virginia

Northern Virginia Family Service

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

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

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

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

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

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

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

Healthy Families Virginia

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

The Problem

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

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

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

The Solution -- Home Visitation Programs

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

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

Home Visitor Programs Target New, First-Time Parents

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

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

Healthy Families America -- Creating a Nationwide Initiative

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

Characteristics of High Risk Families

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

The Hawaiian Model

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

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

Healthy Families Virginia -- Coordinating Efforts Across the Commonwealth

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

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

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

Joining the National Initiative

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

The Healthy Families Virginia Goal

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

SUNDAY, JULY 23, 1995

The Washington Post

PARADE

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

'We're Breaking The Cycle Of Abuse

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

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

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

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

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

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

Photos by Libbie Adams

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

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

BY MARGERY STEIN

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

At the center of Healthy S t's s cess is the home visitor, who functi as an advocate, confidant without becoming a crutch. To le more, I accompanied Cammie H monds, a home visitor at Fam Support Services of West Ha she went to see Sherri Cox, 21. Co who lives with her parents dau ter, Christa, 2—was referred to H monds by a clinic when she was months pregnant, shortly after she left a troubled marriage.

"Cammie got me a lawyer w with me to court to start fi g for divorce," Cox told me. The divorce granted. And, since Christa's bi Hammonds has been teaching the r mother how to care for her baby, us a combination of books, role-modeli direct supervision and visits to clin

Healthy Start now operates with annual budget of $8 million. It is m ey well spent. "At minimal cost to state—about $2500 for each

we are breaking the cycle of a noted Dr. Jack Lewin, the former rector of Hawaii's health departme which administers Healthy Start.

The programs based on Healthy St also are showing positive results. "C families feel like they're a cut abo their peers," observed Carolyn Wi heart of Healthy Families in San Ange Tex. "And the *real* payoff will co when these babies have children."

For more information, write: He Families America, National C To Prevent Child Abuse, F Dept. P, Chicago, Ill. 606

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

Fifteen-Year Follow-up of a Randomized Trial

David L. Olds, PhD; John Eckenrode, PhD; Charles R. Henderson, Jr; Harriet Kitzman, RN, PhD; Jane Powers, PhD; Robert Cole, PhD; Kimberly Sidora, MPH; Pamela Morris; Lisa M. Pettitt; Dennis Luckey, PhD

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

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

Design.—Randomized trial.

Setting.—Semirural community in New York.

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

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

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

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

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

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

See also pp 644 and 680.

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

From the University of Colorado Health Sciences Center, Denver (Drs Olds and Luckey); Cornell University, New York, NY (Drs Eckenrode and Powers, Mr Henderson, and Ms Morris); the University of Rochester, Rochester, NY (Drs Kitzman and Cole and Ms Sidora), and the Department of Psychology, University of Denver (Ms Pettitt).

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

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

DESIGN AND METHODS

Setting

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

Participants

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

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

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

Treatment Conditions

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

Randomization

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

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

Program Plan and Implementation

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

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

Overview of Follow-up Study

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

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

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

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

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

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

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

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

Statistical Power

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

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

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

Masking

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

Assessments and Definitions of Variables

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

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

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

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

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

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

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

Statistical Models and Methods

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

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

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

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

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

RESULTS

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

Rates of Subsequent Births and Use of Welfare

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

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

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

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

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

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

Dependent Variables	Whole Sample			Low-SES Unmarried Sample		
	Treatments 1 and 2 (n=148)	Treatment 3 (n=79)	Treatment 4 (n=97)	Treatments 1 and 2 (n=62)	Treatment 3 (n=30)	Treatment 4 (n=38)
Unmarried, %	62	59	64	...	...	...
Low-SES household, %	64	70	61	...	...	...
White, %	90	91	86	87	87	77
Smoker (>4 cigarettes/d), %	47	46	58	51	60	59
Male child, %	55	44	55	44	53	49
Mother working, %	39	36	31	24	20	20
Mother receiving public assistance, %	9	10	13	23	29	20
Father working, %	70	70	67	42	50	52
Father receiving public assistance, %	4	3	3	10	6	2
Husband or boyfriend in house, %	58	76	60	21	47	22
Maternal age, mean (SD), y	19.3 (2.9)	19.5 (3.1)	19.4 (3.7)	18.6 (2.5)	19.0 (2.8)	18.2 (3.3)
Maternal education, mean (SD), y	11.2 (1.5)	11.6 (1.5)	11.1 (1.6)	10.7 (1.4)	10.9 (1.4)	10.3 (1.5)
Husband or boyfriend education, mean (SD), y	11.4 (1.4)	11.7 (1.7)	11.5 (1.6)	11.1 (1.4)	11.0 (1.8)	10.8 (1.5)
Grandmother support†‡	100.4 (10.1)	97.7 (9.2)	101.3 (10.3)	101.6 (10.9)	98.1 (10.3)	104.1 (11.2)
Husband or boyfriend support†‡	99.6 (10.5)	102.0 (9.0)	99.0 (9.9)	94.2 (10.6)	98.6 (9.4)	96.6 (9.3)
Locus of control†	99.3 (10.1)	100.6 (9.5)	100.6 (10.2)	97.5 (10.2)	99.2 (10.3)	99.1 (9.9)
Incidence of maternal arrests in New York State prior to randomization§	0.09 (−2.50)	0.13 (−5.41)	0.06 (−8.98)	0.13 (−2.03)	0.13 (−2.02)	0.18 (−1.71)

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

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

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

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

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

COMMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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Nurses' Visits Held Benefits For Children Of the Poor

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

February 9, 1998

Zero to Three 20th Anniversary Gala

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

I. PURPOSE

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

II. BACKGROUND

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

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

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

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

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

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

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

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

III. PARTICIPANTS

-The First Lady
-Approx. 400 invited guests.

IV. SEQUENCE OF EVENTS

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

V. PRESS

Open press.

VI. REMARKS

Talking Points provided by Christy Macy.

CONVERSATION, INSPIRATION AND ENTERTAINMENT

Master of Ceremonies	Ron Silver
Where the Wild Things Are by Maurice Sendak	Avery Brooks
Oh, The Places You'll Go by Dr. Seuss	Faith Prince
"Rainbow Connection"	Kenny Loggins Chris Rodriguez, guitar Donn Wyatt, piano
Poems by Children	Jacques d'Amboise Betsy Abraham Julie Abraham Caroline Burt Nora Greenstein Joshua Mann Jeremy Melmed Christina Thompson

Princess and the Pea-ano

Narrator	Avery Brooks
King	Sen. Christopher Dodd
Queen	Barbara Harrison
Prince	Erik Todd Dellums
Princess	Rita Braver
Princess	Rep. John Dingell
Princess	Kate Lehrer
Sleeping	Sec. of HHS
Beauty	Donna Shalala
Counselor	Al Hunt
Counselor	Robert Novak
Counselor	Mark Shields
Visiting King	Sen. James Jeffords
Visiting King	Sen. Edward Kennedy
Visiting King	Senator John Kerry

"Me and My Baby" from *Chicago*	Ann Reinking Jim Borstelman James Valcq, piano
"Return to Pooh Corner"	Kenny Loggins

Names of VIPs we hope can get a photograph with the First Lady:

Co-Chairs
Michael & Carol Berman
Martha Naismith & husband (will check to see if he's coming?)
Senator & Debbie Dingell
Richard & Gahl Burt (check with Carolyn regarding this)
Tim Boggs & James Schwartz
(5)

Sponsors
Andrea Alstrup & Katherine Armstrong (Johnson & Johnson)
Tom Gunnigle, Thelma Lager, Karl Weiskopf (KIDS II)
(2)

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Rebecca Shahmoon Shanok & Linda Gilkerson
Harriett & Ulrich Meyer
Joy & Howard Osofsky
Arnold Sameroff & Susan McDonough
Kyle & Marcia Pruett
Bob Harmon& Gloria Johnson-Powell
Barry Zuckerman & Jack Shonkoff
Sam & Alice Meisels (will find out name)
Stanley Greenspan & Serena Wieder
(9)

ZERO TO THREE
Matthew Melmed & Debbie Rozell, Andrew & Jeremy Melmed
Haida & Frank McGovern & Tandis Sale (daughter)
20th Anniversary Team: Matthew Melmed, Carol Berman, Haida McGovern, Lynette Ciervo, Joan Melner, Gail Roache and Abbey Griffin.
(3)

(19) total

ZERO TO THREE

National Center for Infants, Toddlers and Families

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Executive Director
Matthew [illegible]

Associate Directors
[illegible]

Embargoed for Release:
April 17, 1997
7 a.m.

Contact: Lynette Ciervo
202/638-1144
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Parents of Babies and Toddlers Face "Information Deficit" on Healthy Child Development:

National Poll Reveals Less Knowledge about Emotional, Social and Intellectual Development

Washington, D.C. -- A national survey released today by ZERO TO THREE revealed that parents of babies and toddlers have much less knowledge and information about their children's emotional, intellectual and social development than about their physical development. Parents thirst for more information on how to promote their young children's healthy development.

The national poll of more than 1,000 parents, conducted by Peter Hart Research Associates between March 21 and April 1, 1997 and funded by the Heinz Family Foundation, found that while parents know they have an important influence on their children's development, they do not fully understand how their *day-to-day interactions* with their babies and toddlers affect early child development and learning.

Also, while parents believe that what they do as parents has the greatest influence on their children's emotional development, they also say they have the least information in this area.

For example, the majority of parents of children under three (53 percent) feel "totally sure" that they know what signs to watch for to see if their child's physical development is on track. But only 38 percent of parents feel totally sure that they can tell if their young child's emotional development is healthy and about right for his or her age. About two in five parents (44 percent) feel totally sure that they can tell if their infant or toddler's intellectual development is on track; 37 percent feel this way about milestones of social development.

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Almost all parents (95 percent) understand the central message of recent child development research -- that babies are learning from the moment they are born. But parents of infants and toddlers are confused about important details. Many parents **don't** know that:

- *"Stimulation" isn't always good for children.* 87 percent of parents thought that the *more* stimulation a baby receives, the better off he or she is. (In fact, parents and caregivers need to carefully match the amount and kind of stimulation they offer to a baby to that child's level of development, special interests, temperament, and mood at the moment.)

- *Too many changes in caregivers can slow a child's development and leave children reluctant to form new relationships.* Half of all parents thought that the *more* caregivers a child has before age three, the better that child will be at adapting and coping with change. (In fact, when very young children switch repeatedly from one caregiver to another, the time they spend grieving the loss of the old caregiver and learning the new caregiver's ways may slow down their overall development.)

- *Parents' and caregivers' interactions with babies and toddlers influence children's intellectual abilities.* One in four parents either thought or was unsure whether every baby is born with a certain level of intelligence, which cannot be either increased or decreased by how parents interact with him or her. (In fact, parents' involvement and support can enhance young children's problem-solving skills, increase children's curiosity about their environment, and build children's confidence in their own ability to learn.)

- *Babies less than six months old can get depressed.* Less than two-thirds of parents (65 percent) realize that this statement is true. (In fact, experts in child health and development can now identify many emotional problems in very young children and work with families to treat these difficulties.)

In addition, parents' uncertainties lead to a strong desire for more information:

- Though 39 percent of parents believe that they have the **greatest influence** over their children's emotional development (compared to intellectual, social, or physical development), more than one in four parents (26 percent) said that they had the **least information** about emotional development (compared to intellectual, social and physical development).

--more--

- Sixty percent of parents report being extremely or very interested in information on brain development and how young children learn. An additional 21 percent said they were fairly interested.

- Nearly half of all parents of infants and toddlers (46 percent) report they pay serious attention to news reports and newspaper articles about early childhood development issues. In addition, 36 percent regularly look for information in magazines and 39 percent say they pick up literature in their pediatrician's office on a very or fairly regular basis.

Two major barriers exist to better parenting: "an information deficit" and a time crunch:

- One in 5 parents say they feel the need to improve as a parent because they find it hard to understand their child's feeling and needs (19 percent), or don't know how to handle difficult situations with their child (19 percent).

- Almost two in five parents (37 percent) say that one of the chief reasons they may need to improve as parents is that they don't spend as much quality time with their child as they'd like to.

- Half of all parents say they end most days feeling that they spent less time than they wanted to with their young child -- either a lot less time (20 percent) or a little less time (27 percent). With more than 10 million children age birth-to-three in this country, this means that five million infants and toddlers have parents who personally feel they don't spend enough time with them, including two million kids whose moms or dads say they get a lot less time together than they want.

Caregivers other than mothers and fathers play a major role in the lives of young children.

- Only 1 in 5 babies and toddlers have been cared for exclusively by their father or mother since birth.

- Sixty percent of all children under age three are currently cared for on a regular basis by someone other than their parents. This is true for 48 percent of babies from birth to 8 months, 59 percent of children from 9-18 months, and 66 percent of children from 19 months to 3 years old.

- Grandparents are the regular caregivers for 23 percent of babies and toddlers; other family members care regularly for an additional 9 percent of young children.

--more--

- Overall, 16 percent of children from birth to three are in child care centers (8 percent of infants from 0-8 months, 21 percent of children from 19-36 months). 9 percent of infants and toddlers are in family day care.

Survey findings reveal that while parents understand that their children's earliest years powerfully shape later development and learning, they are often unsure about what they should be doing to promote healthy emotional, social, and intellectual development *The scientific community, communications media, and health and development professionals need to translate research and practice findings into clear, practical messages for parents.*

"Parents need to trust themselves -- they know their children better than anyone else," says Matthew E. Melmed, ZERO TO THREE executive director. "They also need to understand that how they 'are' with their baby has a tremendous impact on the emotional, intellectual and social development of that child. Parents can benefit from the growing knowledge base in these areas."

Parents, grandparents, other family members, and professional caregivers are all sharing the care of today's infants and toddlers. *Child development researchers, families, health care providers, and the early care and education community must share their expertise and experience, and, with the active support of the business community, promote public and private policies that support the healthy development of our nation's infants, toddlers and families.*

ZERO TO THREE, which for 20 years has served as the nexus of the multidisciplinary "infant/family" field, is committed to these goals. ZERO TO THREE will continue to translate scientific research and disseminate it to a wide variety of audiences -- including parents. ZERO TO THREE will also continue to assist individuals, organizations, and policymakers working to address the needs of America's infants, toddlers and families.

Funding for communicating the importance of the earliest years to parents through a ZERO TO THREE public education initiative is being provided by: AETNA Foundation, Inc.; Gerber Companies Foundation; Lynn and Philip Straus; Fannie Mae Foundation; The Harris Foundation; Glickenhaus & Co.; and the McCormick Tribune Foundation.

ZERO TO THREE is a national nonprofit dedicated to advancing the healthy development of babies and young children through training infant/family professionals, disseminating scientific and public information, and promoting policy relevant to infants, toddler and their families.

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

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

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

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

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

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

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

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

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

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

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

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

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

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