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

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

Robert Wood Johnson Foundation

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

Potential Role of HHS

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

Background

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

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

children, fewer subsequent pregnancies and live births for the mothers, less use of welfare by the mothers, fewer validated cases of child abuse and neglect, less use of substances for mothers and children (including illegal drugs, alcohol, and cigarettes), and fewer arrests and convictions of mothers and of their children during the 15-year period after delivery of the child. This nurse visitor program also pays for itself with reductions in government spending by the time the children are four years old. Cost-savings to government and society over the child's lifetime are *at least four times greater than the cost of the program.*

The Program Model

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

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

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

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

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

Replication Activities to Date

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

Would local communities be willing to pay for the program out of existing sources of funds?

Would the PRC be able to train new nurses to conduct the program according to the essential elements that have proven effective in the trials?

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

Work Planned for the Initiative

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

Create a National Center and a system of Regional Centers capable of managing and supporting program expansion;
Create a national clinical practice foundation of 100 high-quality local programs that are sustainable and successful at improving the health and life-course of low-income children and their families;
Create sustainable funding for the National and Regional Centers and for a growing number of local programs; and
Evaluate the initiative.

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

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nurse home visitation on children's criminal and antisocial behavior: 15-year follow-up of a randomized trial. The Journal of the American Medical Association. In press.

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ZERO TO THREE℠

FAX COVER PAGE

To: Home Visiting Summit Invitees	From: Matthew Melmed / Beth Duchraine
Fax Number:	ZERO TO THREE
Date: 12-3-98 Pages: 4	For Information Call: (202) 638-1144
Subject:	Fax Number: (202) 638-0851

Attn: Jennifer Klein & Nicole Rabner

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ZERO TO THREE℠

National Center for Infants, Toddlers and Families

TO: Invitees, Home Visiting Summit

FROM: Matthew E. Melmed

DATE: December 2, 1998

RE: Preparations for December 17-18 meeting

Thank you all for agreeing to participate in the informal summit on home visiting scheduled for December 17-18 in Washington, D.C. This memorandum contains logistical information and a list of confirmed participants. I am also asking you to provide us with several pieces of information **no later than Friday, December 11**, some which we will distribute to participants in advance of the meeting and others that we will synthesize before the meeting begins. Our time together will be brief and precious; we want to use it as well as we can.

Logistics

The meeting will be held at the Marriott Hotel at Metro Center at 775 12th Street, NW, in Washington, D.C. A block of rooms is being held for out-of-town participants at a nightly rate of **$109**, but reservations must be made by December 8th to guarantee this rate. If you wish to make a reservation, please call **(202) 737-2200** and let them know that you are attending the Home Visiting Summit. The fax number at the hotel, should you need it, is (202)824-6106.

The summit will begin at 6 p.m. on Thursday, December 17 with dinner in the Montreal Room at the hotel. On Friday, we will spend the entire day, from 8 am to 4 pm, listening to and learning from each other and, we hope, coming to consensus on some key issues.

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If you have any questions about logistical arrangements, special dietary requests, or other needs, please call Beth Duchaine at ZERO TO THREE, (202) 638-1144.

Confirmed participants

Kathryn Barnard, R.N., Ph.D., Center on Human Development and Disability, University of Washington
Jeanne Brooks-Gunn, Ph.D., Center for Young Children & Families, Teachers' College, Columbia University
Deanna Gomby, Ph.D., Deputy Director of Children, Families & Communities, The David and Lucile Packard Foundation
Sid Johnson, Executive Director, National Committee for the Prevention of Child Abuse
Brenda Jones Harden, Institute for Child Study, University of Maryland
Christopher Heinecke, M.D., Professor of Psychiatry, UCLA Family Development Project
Jennifer Klein*, Special Assistant to the President for Domestic Policy, The White House
Joan Lombardi, former Deputy Assistant Secretary for Children and Families at the Department of Health and Human Services
Tammy Mann, Ph.D., Director, Early Head Start National Resource Center
Kathryn Taaffe McLearn, Ph.D., Assistant Vice President for Youth Programs, The Commonwealth Fund
David Olds, Ph.D., Professor of Pediatrics & Director of the Kemp Prevention Research Center
Deborah A. Phillips, Ph.D., Committee on Integrating the Science of Early Childhood Development, Board of Children, Youth and Families, National Research Council and Institute of Medicine
Nicole Rabner,*Associate Director for Domestic Policy, The White House
Lisbeth B. Schorr, Director, Harvard Project on Effective Interventions
Mildred Winter, Executive Director, Parents as Teachers National Center, Inc.

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

I will serve as facilitator throughout the meeting. Emily Fenichel, Stefanie Powers, and Beth Duchaine of the ZERO TO THREE staff will also attend to support the work group.

Preparing for the summit **-- Materials requested by December 11**

Responses to questions
Please think about and respond in writing to the following questions to help me synthesize your responses and various perspectives before our in-person discussion begins.

1. How do you define home visiting?
2. What are the most promising uses of home visiting? For which populations?
3. What research evidence to support this view do you find most convincing?

4. What are your most significant concerns about the use of home visiting?
5. What do you see as limitations of current research methodologies and the conclusions that can be drawn from existing research on the impact of home visiting?
6. If you have direct experience operating and/or evaluating home visiting programs, please provide a description of the program(s), including the population(s) served and the qualifications of home visitors used. What research supports the efficacy of these program models?

If some of these questions are best answered in program descriptions, published articles, and/or research summaries, please send or fax these so that they can be distributed to participants in advance.

Additional materials
Please feel free to send or fax one or two additional articles or other materials that you think other invitees would benefit from reading before the meeting.

Your biography
Please send or fax no more than one page of biographical information about your background, training and experience. This will be distributed in advance to all participants so that you can be familiar with each other's wealth of knowledge and experience.
Please send all materials to Beth Duchaine by mail, fax (202/638-0851) or email (b.duchaine@zerotothree.org) no later than Friday, December 11.

Again, my thanks for taking the time to prepare for and attend the home visiting summit. I look forward to seeing you all in two weeks and to thinking together with you about this important issue.

ZERO TO THREE
National Center for Infants, Toddlers and Families

Matthew E. Melmed
Executive Director

Dear Jen –

Nicole had Emil call us.

Here is what we put together –

rather fast.

Thought it may be of interest.

My best

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National Center for Infants, Toddlers and Families

MEMORANDUM

TO: Emil Parker

FROM: Matthew Melmed

DATE: November 3, 1998

RE: Policy Options for Improving the Cognitive Development of Infants and Toddlers

CC: Jenifer Klein and Nicole Rabner

Thank you so much for inviting us to make some suggestions on how new Federal resources could be allocated to improve the cognitive development of infants and toddlers. Many parents, professionals and opinion leaders are still unaware of how ***early caregiving experiences profoundly influence cognitive development. Any policy initiative must be premised upon and support the central fact that it is*** **through relationships** ***with their parents and other important caregivers that children learn.***

In this memo we will briefly explain what children need for optimal cognitive development, and then propose five initiatives that could help fulfill these needs. We view our suggestions as enhancements to the bold Child Care Initiative offered by the President last year; it is our premise and hope that the suggestions here will be added to the Initiative when it is re-introduced. We have also included a short "vision" piece written by an African-American new mother who works at ZERO TO THREE, to help you see the issues and initiatives through the eyes of a consumer of services.

Given the quick turn-around time requested we include only limited information here. We would be happy to provide further details or answer any questions. We look forward to hearing from you.

WHAT DO INFANTS AND TODDLERS NEED TO PROMOTE COGNITIVE DEVELOPMENT?

- **access to affordable, comprehensive health care.** Children's cognitive development may be severely compromised by prenatal exposure to drugs or alcohol; premature birth; low birthweight; malnutrition; and exposure in infancy to lead and other toxins. Comprehensive, culturally competent screening, diagnosis, and treatment, beginning prenatally and including sustained outreach efforts to isolated families, can offer a reliable "medical home" to young children and parents, where preventive and acute care can be provided cost-effectively.
- **adequate income to meet basic needs.** Infants and toddlers require safe and supportive environments. The poverty rate among very young children remains alarmingly high. Not only are individual children and families in jeopardy, but concentration of poverty poses additional risks in many communities, where endemic poverty increases stress and the incidence of domestic and

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community violence is high. Evidence abounds that many small children in poverty are exposed to violence, directly or as a witness, and suffer irreparable harm to their emotional and intellectual development. Adequate and safe housing -- now beyond the economic reach of many young families -- can benefit children's health and families' ability to parent.

- **unhurried time with responsive parents, family members, and caregivers.** Research demonstrates that forming secure attachments to a few caring, responsive adults is a primary challenge of the first year of life. Infants and toddlers need ample *unhurried time* with those who are important to them to form these important relationships. Within the circle of security formed by these important relationships, infants can explore their world and practice rapidly emerging skills. "Everyday moments" with parents and caregivers in this secure environment nourish the infant's developing brain.
- **parents with appropriate developmental information and support.** When parents of young children seek information or advice on kids and parenting, they tend to rely on informal networks, turning most frequently to their own families, friends and neighbors. Beyond this network, pediatricians are the first professional group parents look to for information about how to stimulate their child's cognitive, social, and emotional development. Growing numbers of parents are also turning to books, magazines, newspapers and the Internet for up-to-date information on infant and toddler care.
- **stability of trained child care providers over time.** More and more children are moving into child care, at younger ages, and for longer periods of time. What they need is a special kind of care. It's not baby-sitting and it's not school. It is a continuing relationship with a small number of caring and skilled people in an intimate setting. Just as they need parents who can read and respond to their signals and who give them the sense of being important, so infants need this from one or two particular child care providers.
- **the responsive understanding of child care providers.** Researchers, since the early studies of group care in the 1930s to today, have pointed to the *knowledge, skill and practice* of caregivers as the most important ingredients in quality care and education of young children. Infants and toddlers need child care providers with the specialized skills and knowledge to promote their cognitive, social, and emotional development.

POSSIBLE INITIATIVES

Every community needs a system of supports for families with infants and toddlers that reflects its unique mix of resources, priorities, and challenges. There are a number of ways that the Federal government can help communities help families provide the early caregiving experiences that profoundly influence the cognitive development of infants and toddlers.

1. **Adequate funding of basic social safety net programs.** While likely beyond the scope of this current inquiry, the cognitive development of millions of American children continues to be at risk while their basic needs for food, security, decent housing and access to affordable health care remain unmet. Any Presidential initiative should reflect the fact that healthy social, emotional and cognitive development require a solid foundation. Building this foundation for all American children would require full funding of such programs as WIC, Food Stamps, Child Nutrition Programs (including the Child Care Food Program), SCHIP, and affordable housing. TANF should also be amended to allow parents of very young children to participate in comprehensive parent support and education programs, like Early Head Start, that will build their self-sufficiency and parenting skills; time spent in training and nurturing activities could be credited toward fulfillment of parents' work requirements.

2. **Well trained and adequately compensated child care providers.** Wages for child care providers are at near-poverty levels. Child care centers report high levels of job turnover and serious difficulty in finding qualified teaching staff, leading to problems of inconsistent care, understaffing, and the strong potential for unsafe conditions for children. Programs like T.E.A.C.H. Early Childhood, an educational scholarship and compensation program begun in North Carolina and now operating in several states, has demonstrated how better training and pay has led to lower turnover for child care teaching staff. Expanding the Child Care Development Block Grant and doubling the Infant/Toddler quality set-aside could make innovative programs that support caregivers in their critical work with infants and toddlers available throughout the country.
3. **Child Developmental Specialists in pediatric settings.** Individuals trained in child development from a number of disciplines can play a critical role in providing parents with information and support. These Developmental Specialists can be trained in number of fields--social work, early childhood education, nursing, and other related fields-- and should be available for parents in early pediatrics, child care and other settings where parents seek information and support. Title 19 (Medicaid) and Title 21 (SCHIP) should be used to support the services of Developmental Specialists and states should be encouraged to require managed care providers to provide these services to state funded recipients of care.
4. **Training and support for decision makers in the child welfare system.** Infants and toddlers are now the fastest growing category of children entering foster care. In fact, children less than four years old are twice as likely to enter foster care than those ages 5 to 17. Sudden separation from parents, added to the experiences that precipitated placement, may leave young children traumatized and can severely stunt their cognitive, social, emotional, and even physical growth and development unless they receive appropriate evaluation and care. Unfortunately, many of the professionals who work with and make key decisions about the lives of young children in foster care do not understand and appreciate their unique developmental needs, and services to meet the complex needs of very young children, foster parents, and birth parents are scarce. An initiative to improve the situation might include mental health evaluation and services for all young children in foster care as well as a campaign to better educate the professionals who work with and make key decisions about their lives (e.g. judges, child welfare case workers, foster parents, police officers, etc.).
5. **A Family Resource Center on "every corner."** Much of the "state-of-the-art" knowledge on how adults can best help young children thrive and reach their full potential is not disseminated effectively to parents. Challenge grants could be given to communities to integrate a Family Resource Center-- a place for all families to come for information and support about the healthy cognitive, social, and emotional development of their young children – into an existing setting (pediatric setting, child care center, Early Head Start site, library, etc.) that many parents frequent.

A NEW MOTHER'S PERSPECTIVE -- "MY VISION"

When conceptualizing programs and policies it is critical that policymakers understand the needs they are trying to address through the eyes of the intended beneficiaries. Here is the response to ACF's question from an African-American staff member at ZERO TO THREE who is the mother of a 5-month-old daughter:

MY VISION

If I had unlimited resources, I would not limit them to low income families. I would create a system(s) which support cognitive development for **all** children birth to 3.

PRECONCEPTION- I would love to have all adolescents go through a pre-parenting curriculum. I would like them to understand the commitment and responsibility and cost involved as well as how they could support cognitive development. It would provide a head start on thinking about parenting and could help them become better older siblings, cousins, or babysitters. It could also serve to prevent teen pregnancy.

PRENATAL- This system would start during the prenatal period because that is a good beginning point. For families excited about a new arrival, first time parents starved for information, new grandparents, and any woman receiving prenatal care- this is a wonderful "teachable moment." During this period I would offer parenting/infant development classes and information that can be thoughtfully shared during prenatal visits. Outreach to OB/GYN offices would be critical in this regard. A major focus of this effort would be to help parents understand the unique needs and preferences of babies and how to "read their cues." These sessions can be offered at a variety of community centers and religious institutions to limit transportation issues.

A BABY IS BORN- During this time I would have nurses spend just a little time with parents describing what an infant can do and learn during the early weeks.

After going home I would offer periodic home visits by home visitors trained in early development. I would also set up drop-in centers that parents could visit and ask any question about child development (physical, cognitive, and emotional) as well as post-partem issues. This is a time to develop relationships.

For parents returning to work, I would invest a lot of time and money in training and paying child care providers properly. Money needs to be invested to increase availability of care as well as improve the quality. Child care providers can serve as a vital link for parents. They spend a great deal of time with babies. They learn their capacities and preferences and can do a lot to guide parents about what they can do (activities, actions, words, etc.) to stimulate cognitive development in their individual child. Parents that do not work can visit the drop-in center and meet other parents as well as skilled parent educators who can model suggested activities, actions, etc. that parents can do for their individual child.

This would mean training child care providers, parent educators, and medical professionals. This may mean improving local community college programs so the above professionals have a place to go for training. This would also mean investments in salaries for those who care for babies and work with parents. These individuals need to earn an income which allows them to pursue training/ education and stay in the field, and sustain their families, too.

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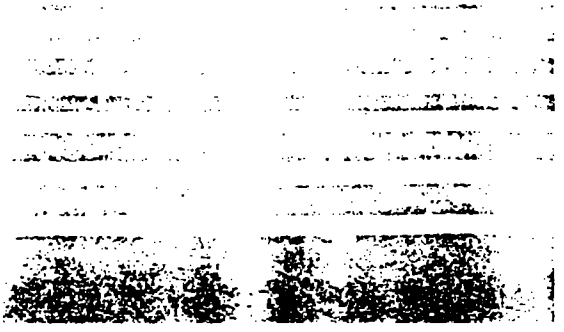
The Future of Children

VOLUME 3 • NUMBER 3 - WINTER 1993

HOME VISITING



Brief Descriptions of Selected Home Visiting Programs

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

Program Models with National Offices

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

Family, Infant and Preschool Program (FIPP)

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

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

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

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

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

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

Hawaii's Healthy Start

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

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

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

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

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

For information about the Hawaii Healthy Start program, contact

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

For information about the program evaluations, contact

Leslie Mitchel, M.A.
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332 S. Michigan Avenue, Suite 1600
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Anne Duggan, Sc.D.
Assistant Professor
Johns Hopkins University
School of Medicine
600 North Wolfe Street, CMSC 144
Baltimore, Maryland 21287-3144

Healthy Families America

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

For information about Healthy Families America, contact

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

Home Instruction Program for Preschool Youngsters (HIPPY)

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

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

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

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

For information and technical assistance concerning HIPPY dissemination, contact

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

For information concerning ongoing evaluation, contact

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

Mother-Child Home Program

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

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

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

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

Parents as Teachers (PAT)

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

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

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

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

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

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

For information about program replication and the initial evaluations, contact

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

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

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

Portage Project

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

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

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

For additional information about the Portage Project, contact

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

Resource Mothers Programs

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

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

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

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

For additional information about Resource Mothers programs, contact

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

Other Significant Demonstration Projects

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

Child Survival/Fair Start Programs

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

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

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

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154 Haven Avenue
New York, New York 10032
212-927-8793

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

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

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

2. See note no. 1, pp. 1–269.

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

The Infant Health and Development Program (IHDP)

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

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

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

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

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

For further information about IHDP, contact

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

For further information about the CDC program, contact

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

The High/Scope Perry Preschool Program

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

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

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

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

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

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

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

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

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

Major Federal Initiatives

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

Comprehensive Child Development Program (CCDP)

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

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

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

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

For further information about the Comprehensive Child Development Program, contact

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

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

Even Start

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

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

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

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

For information about Even Start programs, contact

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

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Washington, DC 20202
202-401-3630

Head Start

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

Home Start

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

Parent and Child Centers

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

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

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

Maternal and Child Health Bureau

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

Children of Substance Abusers Act

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

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

Community Integrated Service Systems

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

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

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

OJJDP
Shay Bilchik, Administrator
November 1998
JUVENILE JUSTICE BULLETIN

Prenatal and Early Childhood Nurse Home Visitation

David Olds, Ph.D., Peggy Hill, and Elissa Rumsey

To prevent youth crime and delinquency, it is important to understand how antisocial behavior develops and design programs to interrupt that developmental pathway. The most serious and chronic offenders often show signs of antisocial behavior as early as the preschool years (American Psychiatric Association, 1994). Three important risk factors associated with early development of antisocial behavior can be modified: adverse maternal health-related behaviors during pregnancy associated with children's neuropsychological deficits, child abuse and neglect, and troubled maternal lifecourse.

The Prenatal and Early Childhood Nurse Home Visitation Program, developed by David Olds and his colleagues (Olds, Kitzman et al., 1997; Olds, 1988; Olds and Korfmacher, 1997), is designed to h p low-income, first-time parents start their lives with their children on a sound course and prevent the health and parenting problems that can contribute to the early development of antisocial behavior. Several rigorous studies indicate that the nurse home visitation program reduces the risks for early antisocial behavior and prevents problems associated with youth crime and delinquency such as child abuse, maternal substance abuse, and maternal criminal involvement.

Recent evidence shows that nurse home visitation even reduces juvenile offending (Olds, Henderson et al., 1998). Beginning in the mid-1970's, a series of randomized clinical trials was designed to develop and test the program model (Olds, Kitzman et al., 1997; Olds, 1988;

The original research on this program was supported by the U.S. Department of Health and Human Services (HHS) and the Robert Wood Johnson, the W.T. Grant, the Ford, the Commonwealth Foundations. The most recent research has been supported by HHS and the National Institutes of Health. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) is currently funding a demonstration and evaluation of the project in six sites.

From the Administrator

A stitch in time saves nine. An ounce of prevention is worth a pound of cure. Folk wisdom is replete with such adages for a good reason—because they are true. Clearly, in the realm of delinquency and child abuse, prevention is always better than picking up the pieces. For 20 years, Dr. David Olds and his colleagues have been developing and testing a prevention program that helps low-income, first-time mothers deliver healthy babies, give them proper care, and avoid substance abuse and criminal behavior. More important, this program of prenatal and early childhood home visitation also reduces juvenile offending.

A major factor in the program's success that distinguishes this model from other, similar programs is its use of trained, experienced nurses, one of several key program components. In addition, the authors discuss the program's impact on risks for developing antisocial behavior in childhood. They also report estimates of impressive cost savings: four times the initial expenditure by the time high-risk children reach age 15.

This Bulletin offers exciting news that holds great promise for children who would otherwise come into a world of significant risks and bleak prospects. I hope that policymakers and other concerned citizens will support replication of this effective program in areas where it is sorely needed.

Shay Bilchik
Administrator

Olds and Korfmacher, 1997). In each of these studies conducted in Elmira, NY, and later in Memphis, TN, women were randomly assigned to either home visitation by nurses during pregnancy and the first 2 years of their children's lives or comparison services such as free transportation for prenatal care and developmental screening and referral for their infants. Results from the Elmira and Memphis studies indicate that this program of nurse home visitation can promote healthy maternal and child functioning early in life (Olds, Henderson, Tatelbaum et al., 1986, 1988; Olds, Henderson, Chamberlin et al., 1986) and reduce the li ood that children eventually will develop serious antisocial behavior (Olds, Eckenrode et al., 1997; Olds, Pettitt et al., 1998) including criminal offending (Olds, Henderson et al., 1998). A third trial conducted in Denver, CO, which is nearing completion, compares the results achieved when employing trained paraprofessionals instead of nurses when following the same program model.

This Bulletin describes the model nurse home visitation program and explains how it successfully reduces the risks for early development of antisocial behavior and l ernal and juvenile offending. Evidence is also presented detailing the program's effectiveness in reducing those risks. Most striking, this Bulletin shows how a program of prenatal and early childhood nurse home visitation has reduced both maternal and juvenile offending.

Program Overview

Nurses begin visiting low-income, first-time mothers during pregnancy and continue visits until a child is 2 years old. These visits help pregnant women improve their health, which makes it more likely that their children will be born free of neurological problems. Parents receiving home visits also learn to care for their children and to provide a positive home environment. This means making sure children are nurtured, live in a safe environment within and around the home, are disciplined safely and consistently, and receive proper health care. Nurses also teach young parents to keep their lives on track by practicing birth control and planning future pregnancies, reaching their educational goals, and finding adequate employment.

Key Program Components

The elements of the nurse home visitation program have been refined over the past 20 years, with visit-by-visit written protocols to guide nurse home visitors. Research and experience indicate that the following elements of the program are fundamental to its effectiveness:

- The program focuses on low-income, first-time mothers.
- Trained, experienced, mature nurses with strong interpersonal skills make home visits.
- Home visits begin during pregnancy and continue for 2 years after a child is born.
- Home visitors see families at home every 1 to 2 weeks.
- Home visitors focus simultaneously on the mother's personal health and development, environmental health, and quality of caregiving for the infant or toddler.
- Home visitors involve family members and friends in the program and help families use other community health and human services when needed.
- A full-time nurse home visitor carries a maximum caseload of 25 families.
- A nursing supervisor provides supportive guidance and oversees program implementation.
- Detailed records are kept on families and their needs, services provided, family progress, and outcomes.

Reducing Risks for the Development of Antisocial Behavior in Childhood

How does the nurse home visitation program reduce risks for antisocial behavior that begins in childhood? This section summarizes how the program reduces three major risk factors: adverse maternal health-related behaviors during pregnancy that are associated with neuropsychological impairment in children, child abuse and neglect, and a troubled maternal life course.

Neuropsychological Impairment

Children who exhibit antisocial behavior very early in life are more likely than other children to have impaired neurological functioning. Signs of neurological impairment include poor motor functioning, attention deficits, hyperactivity, impulsivity, and impaired language and cognitive functioning (Moffitt et al., 1996). In many cases, these problems can be traced to poor prenatal health conditions that interfere with the development of the fetal nervous system (Olds, 1997; Wakschlag et al., 1997; Fergusson, Horwood, and Lynskey, 1993; Milberger et al., 1996; Weitzman, Gortmaker, and Sobol, 1992).

The nurse home visitation program helps pregnant women improve their diet and cut down on cigarette smoking or the use of alcohol or illegal drugs that can hurt the developing fetus (Olds, Henderson, Tatelbaum et al., 1986). Cigarette smoking during pregnancy is especially dangerous because it is related to intellectual impairment in young children. In the Elmira trial, which served primarily Caucasian families, the 3- and 4-year-old children of women who did not receive a nurse home visitor and who smoked 10 or more cigarettes per day during pregnancy had impaired intellectual functioning compared with children of women who did not smoke (Olds, Henderson, and Tatelbaum, 1994a). Children of mothers who smoked 10 or more cigarettes when they signed up for the program and then received a nurse home visitor during pregnancy were not intellectually impaired. Data indicate that these women improved their diets and reduced their smoking by approximately three cigarettes a day (Olds, Henderson, and Tatelbaum, 1994b).

Cigarette smoking by a mother during pregnancy also has been linked to an infant's compromised neurological func-

tioning. Compromised neurological functioning makes it harder for infants to signal their needs and regulate their emotions and behavior (Olds, Pettitt et al., 1998). When asked to evaluate how fussy and irritable their children were at 6 months of age, mothers who did not receive nurse home visitors and who smoked 10 or more cigarettes per day during pregnancy reported more fussiness and irritability in their children than did nonsmoking mothers without a nurse home visitor. In contrast, mothers who smoked 10 or more cigarettes per day when they started the program and who received home visits by a nurse during pregnancy reported far less irritability and fussiness in their children than did their counterparts in the control group (Olds, Pettitt et al., 1998). These findings suggest that the guidance mothers received from their nurse home visitors not only helped them cut down or stop smoking, it also improved their infants' soothability, which made infant care much easier.

Child Abuse and Neglect

Abused and neglected children are at higher risk for developmental pathways marked by persistent behavior problems and academic failure, followed by chronic delinquency, adult criminal behavior, antisocial personality disorder, and violent crime (Widom, 1989; Maxfield and Widom, 1996; Kelley, Loeber et al., 1997; Kelley, Thornberry, and Smith, 1997). The program studied in the Elmira clinical trial has reduced the rates of child abuse and neglect and less serious forms of caregiving problems by helping young parents deal with depression, anger, impulsiveness, and substance abuse problems. It also helped them reflect on how they were parented themselves; learn about normal child development; and develop the skills needed to "read" their baby's signals, anticipate their baby's needs, and parent effectively (Olds, Henderson, Chamberlin et al., 1986; Olds, Eckenrode et al., 1997).

For children from birth through age 15, the Elmira program reduced State-verified cases of child abuse and neglect by 79 percent among mothers who were poor and unmarried (Olds, Eckenrode et al., 1997). In the second year of life (age 13 to 24 months), nurse-visited children had 56 percent fewer visits to an emergency room for injuries and ingestions than children not receiving home visits by nurses (Olds, Henderson, Chamberlin et al., 1986). During the 2-year period after the program ended (from the second through the fourth year of life), children from nurse-visited families were 40 percent less likely to be seen in a physician's office for injuries, ingestions, or social problems, and they had 35 percent fewer visits to the emergency room.

In the Memphis test of the program, which served African-American families, corresponding positive effects on parental caregiving and reductions in childhood injuries were seen during the first 2 years of the children's lives. Because Memphis has a very low rate (approximately 3 percent) of officially verified cases of child abuse and neglect, it was not possible to make valid and reliable comparisons between program participants and control group families. The data obtained from the nurse-visited families, however, strongly suggest a reduction in poor caregiving practices or behavior, including a reduction in child abuse and neglect (Kitzman et al., 1997).

Troubled Maternal Life Course

A mother's personal development and lifestyle choices influence whether her child will develop antisocial behavior. Young women who become parents as adolescents and have recent welfare experience are more likely to have children who engage in a variety of antisocial and delinquent behaviors and who are expelled from school than are their low-income, nonwelfare, adolescent–mother counterparts (Furstenberg, Brooks-Gunn, and Morgan, 1987). Mothers who are unmarried, do not graduate from high school, and have three or more children are more likely to have children who exhibit behavioral problems.

The nurse home visitation program reduces these risk factors by helping young parents develop the confidence and skills necessary to set and achieve goals such as completing their education, finding work, and avoiding unplanned subsequent pregnancies (Olds, Eckenrode et al., 1997). The nurses help young parents consider multiple options, make good choices about the environment in which they will raise their children, and take steps to create the kind of lives they want for themselves and their children.

During the first 15 years after delivery of their first child, low-income, unmarried women in the Elmira trial who received nurse home visits had fewer subsequent children (1.1 versus 1.6), longer intervals between the births of the first and second children (65 versus 37 months), 30 fewer months on welfare (60 versus 90 months), 44 percent fewer behavioral problems because of their use of drugs and alcohol, 82 percent fewer arrests, and 81 percent fewer convictions than those in the control group, as shown by State records. Results of the first phase of the ongoing Memphis replication study indicate that the program's effects on maternal life course (especially reductions in the rates of subsequent pregnancies and births) are being reproduced (Kitzman et al., 1997).

Cumulative Risk

The kinds of problems described above often combine to increase the total risk for the development of antisocial behavior in childhood. The figure on the next page presents an overview of the factors that can increase risk early in a child's life and shows how a program of

home visitation by nurses may prevent such a negative developmental process from unfolding.

For example, subtle damage to the developing fetal nervous system can interfere with children's capacity to respond effectively to their parents' efforts to care for them. This establishes patterns of frustration and anger that interfere with the development of secure attachment (Rodning, Beckwith, and Howard, 1989; Sanson et al., 1993; Moffitt, 1993a, 1993b). To compound the problem, the parents of children with neuropsychological impairment are more likely to provide inconsistent discipline and may themselves be impatient and irritable. There are many possible causes for such dysfunctional caregiving, including genetic links, overwhelming stress, or substance abuse (Moffitt, 1993b). Poor parenting practices can lead to vicious cycles of interaction in which the child's problems with emotional and behavioral regulation contribute to parental child abuse or neglect that further intensifies the child's emotional and behavioral imbalances.

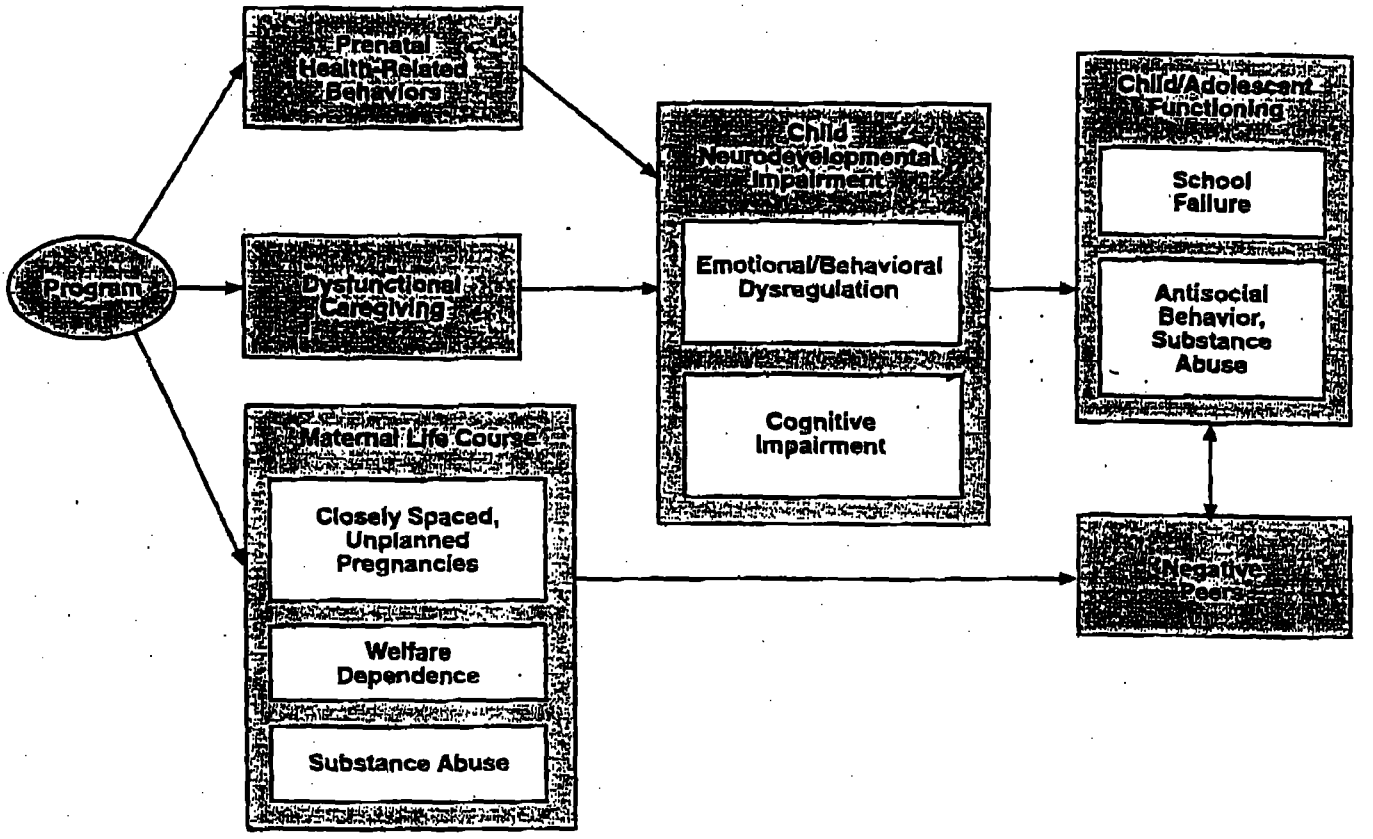
Poor caregiving occurs more frequently when parents experience financial difficulties (Conger et al., 1993) and have larger families (Hirschi, 1994). In such cases, children's risks for antisocial behavior are further increased by their exposure to environments that are often associated with poverty and that may surround them with criminal influences (Felner et al., 1995; Hirschi, 1994; Moffitt, 1993a, 1993b).

Children from low-income households that are characterized by aggression and include family members with a history of school failure are more likely to be placed in low-level reading groups. This placement tends to worsen their aggressive behavior and academic problems, because these groups are likely to be made up of other children with similar problems and include classroom disruptions that interfere with education (Eder, 1983). Vulnerable children then become even more susceptible to rejection by prosocial peers and to negative peer influences (Dishion et al., 1995; Cole et al., 1995). When parents with limited social skills are confronted by school officials about their children's disruptive school behavior, they are more likely to harshly reject their children, which pushes the children further toward delinquency and crime (Cole, 1996).

Preventing the accumulation of risk factors from such a wide variety of sources is possible through comprehensive programs like the model of nurse home visitation described in this Bulletin. By attending to health, social, and environmental issues all at once, nurse visitors can help families get off to a strong start that enables their children to develop and mature into healthy, productive individuals. In some cases, the positive skills families develop seem to neutralize the negative influence of other risk factors that are harder to reduce or eliminate.

Moreover, for the first time there exists solid, scientifically validated evidence that prenatal and early childhood nurse home visitation services prevent crime

Model of Program Influences on Conduct Disorders, Antisocial Behavior, and Crimes



and delinquency (Olds, Henderson et al., 1998). As described in a 15-year followup of the Elmira nurse home visitation program, the long-term effects of the program on children's criminal and antisocial behavior are substantial and have groundbreaking implications for juvenile justice and delinquency prevention. Adolescents whose mothers received nurse home visitation services over a decade earlier were 60 percent less likely than adolescents whose mothers had not received a nurse home visitor to have run away, 55 percent less likely to have been arrested, and 80 percent less likely to have been convicted of a crime, including a violation of probation (Olds, Henderson et al., 1998). They also had smoked fewer cigarettes per day, had consumed less alcohol in the past 6 months, and had exhibited fewer behavioral problems related to alcohol and drug use.

Program Costs and Cost Savings

The nurse home visitation program costs an estimated $3,200 per family per year during the startup phase (first 3 years) and $2,800 per family per year once nurses are completely trained and working at full capacity. Costs vary from site to site, depending primarily on nursing salaries in the community where the program is run. When the program focus on low-income women, the government's costs to fund the program are recovered by the time the first child reaches age 4, primarily because of the reduced number of subsequent pregnancies and related reductions in use of government welfare programs (Olds et al., 1993). A report from The RAND Corporation estimates that by the time children from high-risk families reach age 15 the cost savings are four times the original investment because of reductions in crime, welfare expenditures, and health care costs and as a result of taxes paid by working parents (Karoly et al., 1998).

Growing National Interest

Many States and cities have expressed an interest in adopting the nurse home visitation program because it has proven so successful in preventing crime and violence and other serious health and social problems. Three components of the U.S. Department of Justice's Office of Justice Programs—the Office of Juvenile Justice and Delinquency Prevention (OJJDP), the Bureau of Justice Assistance, and the Executive Office for Weed and Seed—are supporting implementation of the program in six high-crime, urban areas as part of its national Weed and Seed and Safe Futures initiatives. By summer 1998, agencies serving low-income neighborhoods in Fresno, Los Angeles, and Oakland, CA; Clearwater, FL; St. Louis, MO; and Oklahoma City, OK, were implementing the nurse home visitation program.

OJJDP also funds an initiative at the Center for the Study and Prevention of Violence at the University of Colorado, which recently named the nurse home visitation program 1 of 10 "blueprint" programs after a rigorous evaluation demonstrated its effectiveness in preventing violence and success in replication across sites. The center is developing instructions to help communities plan and implement blueprint programs. OJJDP will provide the center with approximately $5 million over 3 years to assist selected communities in implementing blueprint programs.

Summary

This cost-effective program of home visitation by nurses, tested over the past 20 years, has the proven ability to reduce the development of antisocial behavior in childhood and later crime and delinquency. It has been effective in reducing three major categories of risk related to antisocial behavior: adverse maternal prenatal health-related behaviors; child abuse and neglect; and troubled maternal life course (unintended successive pregancies, reduced work-force participation, welfare dependence, substance abuse, and criminal behavior).

For Further Information

For further information about the nurse home visitation program and the research demonstrating its effectiveness, contact:

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For further information about OJJDP's Blueprints Violence Prevention Project publications or training and technical assistance program, contact:

Center for the Study and Prevention of Violence
Institute of Behavioral Science
University of Colorado at Boulder
Campus Box 442
Boulder, CO 80309–0442
303–492–8465
303–443–3297 (Fax)
Web site: www.Colorado.EDU/cspv/blueprints/
E-Mail: cspv@colorado.edu

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As evidence showing the effectiveness of this program mounts, many States and localities are expressing interest in adopting the model. As part of its national Weed and Seed and SafeFutures initiatives, the Office of Justice Programs is supporting implementation of the program model in six high-crime, urban areas in Fresno, Los Angeles, and Oakland, California; Clearwater, Florida; St. Louis, Missouri; and Oklahoma City, Oklahoma. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) is overseeing replication of the program at the Weed and Seed sites. In addition, OJJDP has partnered with the U.S. Department of Health and Human Services to evaluate the six sites, with OJJDP managing outcome studies of each site. This evaluation will enable an analysis of factors at the community level that affect how the program is carried out in accordance with the original program model.

Another OJJDP-funded initiative, known as the Blueprints project, is being spearheaded by the Center for the Study and Prevention of Violence at the University of Colorado. The Center has named the nurse home visitation program as 1 of 10 Blueprints programs, which have demonstrated both effectiveness in preventing violence and the ability to be replicated with integrity. The Blueprints provide step-by-step instructions to help communities plan and implement model programs.

It is the goal of this Bulletin to increase the public's awareness of this effective program, the opportunities for replication, and the role of the Department of Justice in facilitating such efforts. The Bulletin also provides information about how this program is being replicated nationwide and how communities can contact the Blueprints project.

TIMETABLE: This document will be released beginning 14 days from the date of this memorandum to Federal chief judges, Native American tribal leaders, U.S. Attorneys, State attorneys general, State juvenile justice advisory groups, State chief justices, State public defenders, State court administrators, prosecutors, Governors, mayors, sheriffs, criminal justice agency heads, OJJDP juvenile mentoring programs, Weed and Seed sites, SafeFutures sites, Title V recipients, County chief officials, local juvenile and family court judges, the Academy of Criminal Justice Sciences, and the American Society of Criminology.

If additional information regarding this document is needed, I may be reached at 202–307–5911.

Attachment

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

OJJDP
Shay Bilchik, Administrator
November 1998
JUVENILE JUSTICE BULLETIN

Effective Family Strengthening Interventions

Karol L. Kumpfer, Ph.D. and Rose Alvarado, Ph.D.

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) is dedicated to reversing trends of increased delinquency and violence among adolescents. These trends have alarmed the public during the p decade and challenged the juvenile justice system. In 1996, the Federal Bureau of Investigation reported that of all arrests, 19 percent—2.9 million—were juvenile arrests. It is widely accepted that increases in delinquency and violence over the past decade are rooted in a number of interrelated social problems—child abuse and neglect, alcohol and drug abuse, youth conflict and aggression, and early sexual involvement—that may originate within the family structure. The core principle of OJJDP's prevention strategy is to strengthen the family as a unit and provide resources to families and communities. This Bulletin, the first in OJJDP's Family Strengthening Series, focuses on the Office's Strengthening America's Families Initiative and covers such topics as the effectiveness of family intervention programs, behavioral parent training, family therapy, and family skills training. Subse- nt Bulletins will examine specific methods for improving family structure and reducing delinquency and will highlight successful programs and current research.

Delinquency, alcohol and drug abuse, youth violence, gangs, early sexual involvement, and other problem behaviors in youth are causes for grave concern in this country. According to the Federal Bureau of Investigation (FBI), an estimated 2.9 million juveniles were arrested in 1996, accounting for 19 percent of all arrests. Although there was an encouraging 6-percent decline in juvenile arrests for Violent Crime Index offenses, the juvenile arrest rate for these offenses was still 60 percent higher than the 1987 level (Snyder, 1997). Additionally, in 1995, more than 1.7 million delinquency cases were processed in juvenile courts in the United States, representing a 7-percent increase in cases since 1994 (Sickmund, 1997). Although less than one-half of 1 percent of all juveniles are arrested, aggressive and defiant behavior predictive of later delinquency is increasing among our youngest children (Campbell, 1990; Webster-Stratton, 1991). Substance abuse is a significant factor in youth violence and delinquent behavior. More than one-third of all arrests in the United States are related to drug and alcohol use. In 1995, 13 percent of these arrests involved juveniles; between 1991 and 1995, juvenile arrests for drug abuse violations increased 138 percent (Bellamy et al., 1997). The Monitoring the Future study reveals a leveling off of drug use among American youth in 1997 following the steady increases found throughout the 1990's (Johnston, O'Malley, and Bachman, 1997). Although marijuana use among older teens continues to rise slightly,

From the Administrator

As we work to improve our juvenile justice system, we should never forget that behind the numbers there are children—children who need love and nurturing to become caring and productive adults. Let us also recall that each of us was once a child, whose healthy development depended on our ability to trust our environment, in particular, our first environment—our family.

As the Federal agency charged with the responsibility of preventing juvenile delinquency and protecting children from abuse and neglect, OJJDP is committed to helping children and their families. Indeed, working to strengthen families is the linchpin in our delinquency prevention strategy.

That is why I am especially pleased to announce OJJDP's newest publication series, the Family Strengthening Series. This inaugural Bulletin, *Effective Family Strengthening Interventions*, will inform you of the latest research detailing the crucial role played by the family and will describe OJJDP's Strengthening America's Families initiative.

After reading these pages, you will better understand the need for this type of prevention program and the principles of effective family strengthening interventions. Such interventions can reduce delinquency and child abuse. Better yet, they can help ensure that a child's first environment is one that will contribute to the bright future we wish for every child.

Shay Bilchik
Administrator

use among younger teens is beginning to abate.

The increasing levels of aggression and defiant behavior in very young children m n that without prevention efforts, even higher percentages of juveniles are likely to become violent juvenile offenders. Many citizens blame the weakening of the American family for these increases. Although research supports the popular opinion that negative influence from law-violating peers is a major source of problem behaviors (Kumpfer and Turner, 1990/1991), parents can have a positive influence, even on adolescents (Resnick et al., 1997). Programs must acknowledge that almost all families have strengths and must build on th strengths, rather than devote time only to what troubles children, their fami- l and the communities in which they live. Programs also must recognize that children do not exist in a separate micro- c n; focusing on the child alone ignores an entire support system already in place (Levine, 1997). For these reasons, strengthening the ability of families to raise children to be law-abiding and productive citizens should be a critical public policy issue in the United States.

Focus on the Family

The delinquency and violence that plague society have roots in a host of interrelated social problems—a rising tide of substance abuse, child abuse and neglect, family violence, transience (absence of community ties), gun availability, gangs, uneducated and undereducated children and youth, teen parents, latchkey children, poor parenting—and a corresponding decline in resources, opportunities, and support (Office of Juvenile Justice and l nquency Prevention, 1995). Many of t social problems are intimately connected to the weakening of the family's care for children. Because more children are being raised in stressed families, child abuse and neglect are increasing dramatically (Kelley, Thornberry, and Smith, 1997; Kumpfer and Bayes, 1995). A clear link has been established between witnessing and experiencing family conflict and violence and later violent delinquent acts, poor school performance, poor mental health, and increased teen pregnancy (Thornberry et al., 1994). Personal victimization, hopelessness, and depression are also associated with later violent behavior in youth (DuRant et al., 1994). The family has the primary responsibility to instill moral values and provide guidance

and support for children. When the family does not fulfill this responsibility, communities must take responsibility for ensuring that the family is supported in ways that improve its care of children.

Results of Etiological Studies

Three developmental pathways to delinquency have been reported in longitudinal studies of delinquency: (1) the early authority conflict pathway begins with stubborn behavior, then becomes defiant behavior, and develops into avoidance of authority figures (e.g., truancy, running away, staying out late); (2) the covert pathway begins with minor covert behaviors (e.g., shoplifting, frequent lying, stealing) and moves on to damaging property and later delinquent acts (e.g., fraud, theft, burglary); and (3) the overt pathway begins with minor aggression (e.g., bullying, teasing) and leads to physical fighting and later violent acts (e.g., physical attack, rape, assault, and battery) (Huizinga, Loeber, and Thornberry, 1995; Kelley et al., 1997). Youth on more than one pathway self-report more crimes. Poor family attachment and poor parenting behavior were found to have an impact on these developmental pathways to delinquency. Higher levels of delinquency and drug use were associated with both family risk factors.

Patterson and Joerger (1993) posited that two groups of youth are involved in delinquent behaviors: the early starters who individually follow a pathway to delinquency and the late starters who are more influenced by peers. Although increased problem behaviors in youth are correlated with their decreased disapproval of violent, aggressive, or delinquent acts, research studies suggest that parents can have an early influence (Kumpfer and Turner, 1990/1991). While many tested theories of problem behaviors (Newcomb, 1992, 1995; Oetting, 1992; Oetting and Beauvais, 1987) found that peer influence is a major reason to initiate drug use or delinquency, parental disapproval has also been shown to be a major reason not to engage in delinquent acts or to use drugs (Coombs, Paulson, and Richardson, 1991). Family variables are a consistently strong predictor of antisocial and delinquent behaviors.[1] According to Bry and colleagues (in press): "The critical role of family factors is acknowledged in virtually every psychological theory of substance abuse."[2]

Parental support has been found to be one of the most powerful predictors of reduced delinquency and drug use in minority youth (King et al., 1992). Also, increased parental supervision is a major mediator of peer influence (Dishion, French, and Patterson, 1995; Hansen et al., 1987). Models developed to finely test the aspects of family dynamics related to youth problem behaviors (antisocial behavior, substance abuse, high-risk sex, and academic failure) find that family conflict associated with reduced family involvement significantly predicts inadequate parental supervision and associations with deviant peers. While the model just described includes mediating variables, Ary and colleagues (in press) found direct paths from inadequate parental supervision and peer deviance to problem behaviors. These etiological research studies suggest parenting and family interventions that decrease family conflict and improve family involvement and parental monitoring should reduce problem behaviors (Mayer, 1995).

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[1] See Loeber and Stouthamer-Loeber (1986); McCord (1991); Tolan and Loeber (1993); Tolan, Guerra, and Kendall (1995a, 1995b).

[2] Such theories can be found in Brook and colleagues (1990); Bry (1983); Catalano and Hawkins (1996); Dembo and colleagues (1979); Dishion, Reid, and Patterson (1988); Elliot, Huizinga, and Menard (1989); Hawkins and colleagues (1992); Jessor (1993); Kandel and Davies (1992); Kaplan and Johnson (1992); Kellam and colleagues (1983); Kumpfer (1987); Newcomb and Bentler (1989); and Wills, Vaccaro, and McNamara (1992).

Family Protective and Resilience Factors

The likelihood of a youth developing problems increases rapidly as the number of risk factors increases in comparison with the number of protective factors (Dunst and Trivette, 1994; Rutter, 1990, 1993). The goal of family-focused prevention programs should be not only to decrease risk factors, but also to increase ongoing family protective mechanisms. According to Bry and colleagues (in press) and many other researchers, the five major types of family protective factors are:

- Supportive parent-child relationships.
- Positive discipline methods.
- Monitoring and supervision.
- Families who advocate for their children.
- Parents who seek information and support.

A longitudinal study of urban delinquency, which was funded through OJJDP's Program of Research on the Causes and Correlates of Delinquency with supplemental funding through the National Institute on Drug Abuse (NIDA) (Huizinga, Loeber, and Thornberry, 1995), found that parental supervision, attachment to parents, and consistency of discipline are the most important family protective factors in promoting resilience to delinquency in high-risk youth.

Resilience researchers (Kumpfer and Bluth, in press; Luthar, 1993; Werner, 1986) and those researchers focusing on family strengths (Dunst and Trivett, 1994; Gary, 1996) also specified similar family protective mechanisms. The characteristics of strong resilient African-American families have been found to be a "strong economic base, a strong achievement orientation, adaptability of family roles, spirituality, strong kinship bonds, racial pride, display of respect and acceptance, resourcefulness, community involvement, and family unity" (Gary et al., 1983:11). The challenge to family intervention researchers is to develop and test interventions that effectively address such a broad range of family protective factors.

Although some vocal skeptics say nothing works in prevention, the research literature contains examples of many effective programs,[3] including family interventions for the prevention of delinquency and drug abuse.[4] Many family intervention researchers believe that improving parenting practices is the most effective strategy for reducing delinquency and associated problem behaviors (Bry et al., 1991; Szapocznik et al., 1988).

The Strengthening America's Families Initiative

This Bulletin summarizes the results of an OJJDP-funded training and technology transfer program that focuses on strengthening families for the prevention of delinquency. According to OJJDP Administrator Shay Bilchik: "Working to strengthen families is a linchpin in OJJDP's overall delinquency prevention strategy" (Office of Juvenile Justice and Delinquency Prevention, 1995). Although many effective programs have been developed, few of the researchers and practitioners who developed them have had the time to disseminate the results effectively. The compilation and dissemination of these program results are paramount (University of Utah, Department of Health Education, 1997).

Through a 1987 cooperative agreement with OJJDP, Dr. Kumpfer and her associates at the University of Utah conducted a national search for effective family strengthening programs. During that search, 25 programs were selected from the more than 500 that had been nominated. An OJJDP publication was developed to highlight these 25 programs (Kumpfer, 1993). The project culminated in a national conference held in Salt Lake City, UT, in December 1991. Through an additional cooperative agreement with OJJDP, awarded in 1995, Dr. Kumpfer and her associates continued work begun in 1987 to disseminate information on model family approaches through a four-phase technology transfer process:

- **Phase 1: National search, literature review, dissemination through the Web.** This effort included a national search for programs focusing on children (at all ages) and families with a range of problems. After the programs were scored on content, dissemination capability, and outcome results, the top programs in each category were selected from the more than 126 nominated programs by a national review panel of family research experts. This search identified 11 exemplary family programs, 14 model programs, and 9 promising programs for a total of 34 top programs (see table 1, p. 4) matrixed by age and level of prevention programming (see table 2, p. 5): universal (general population), selective (high-risk population), and indicated (in-crisis population) prevention (Gordon, 1987; Mrazek and Haggerty, 1994). One-page descriptions of each program were created for the project's Web site: medstat.med.utah.edu/healthed/ojjdp.htm.
- **Phase 2: Two national conferences.** Strengthening America's Families conferences were held in Snowbird, UT, in October 1996 and in Washington, D.C., in March 1997. More than 600 people attended the two national conferences, which showcased the 34 programs found useful for reducing risks for delinquency in many different ethnic and cultural groups.
- **Phase 3: Regional training of trainers.** Ten 2- to 3-day workshops were held for the eight most popular parenting and family programs. The programs selected were identified by national conference attendees as the prevention programs they wished to be trained in and to implement locally. The workshops were free and stipends were offered for training workshops for an additional 11 programs.
- **Phase 4: Technical assistance and publications.** During phase 4, currently in progress, technical assistance is being offered to agencies implementing the programs for which regional training was held and for which stipends were offered. Process and outcome evaluations also will be conducted for a limited number of agencies, which receive minigrants to promote high-quality program implementation. In addition, OJJDP has begun this Bulletin series to periodically publish the history, program content, format, and results of these promising family programs.

The Need for Effective Prevention Programs

A number of research-based prevention programs, already tested by prevention scientists, showed reductions in behavioral

[3] See Falco (1992); Kumpfer (1997); National Institute on Drug Abuse (1997); Office of Juvenile Justice and Delinquency Prevention (1995); Tobler and Stratton (1997); Wright and Wright (1995).

[4] See Bry et al. (in press); Kumpfer (1993, 1997); Kumpfer and Alvarado (1995); Kumpfer et al. (in press).

problems and delinquency in youth. If these proven solutions are not disseminated and implemented soon, a substantial number of youth currently being raised in high-risk family situations will face dire academic, social, and economic consequences because of their antisocial behavior.

The national search discussed earlier also found growing evidence that the effectiveness of many of the most popular and well-disseminated programs has not yet been demonstrated. According to Taylor and Biglan (1998), "Parenting books and parenting programs have become a multimillion dollar business, and most books and programs are sold without careful evaluation of their effectiveness." The most marketed family and parenting programs may even be counterproductive (Norman and Turner, 1993; Taylor and Biglan, 1998). A number of popular parenting programs, such as Parent Effectiveness Training (P.E.T.) (Gordon, 1970) and Systematic Training for Effective Parenting (S.T.E.P.) (Dinkmeyer and McKay, 1976), were disseminated widely before being evaluated.

If widely adopted parenting or family programs are later proved ineffective, garnering support to implement more effective interventions could become difficult. Support may come from entities such as States, counties, courts, family service agencies, insurers, or healthcare providers. In general, the search found that parent education or parent support approaches were considerably less effective than highly structured approaches, such as behavioral parent training, family skills training, family therapy, or comprehensive family support programs. Each approach is described in greater detail in this Bulletin. According to Norman and Turner (1993), potentially counterproductive approaches include interventions based on information-only models and a few of the alternative activities that involve youth with adults or with peers who have antisocial norms (Swisher and Hu, 1983). Prevention programs that aggregate high-risk youth in youth-only groups without experienced adult leadership also have been discovered to produce negative effects (Dishion and Andrews, 1995). Additionally, using child-centered psychodynamic interventions only, rather than structural family interventions, can result in a deterioration of family functioning (Szapocznik, Rio, et al., 1989). According to Szapocznik (1996), interventions that do not work with the total family have the potential to weaken the family and lead to increased delinquency and drug use.[5] Because child-only interventions, so popular in prevention, have the potential to produce iatrogenic effects (changes induced as a result of therapy) on family protective factors, more experts in the field are calling for family-focused prevention interventions.

Table 1: Top Programs

Name	Type
Exemplary Programs	
Functional Family Therapy	Family therapy
Helping the Noncompliant Child	Parent training
Iowa Strengthening Families Program for Families With Pre and Early Teens	Family skills training
Multisystemic Therapy Program	Comprehensive
Parents and Children Training Series	Comprehensive
Prenatal and Early Childhood Nurse Home Visitation Program	Family in-home support
Preparing for the Drug Free Years	Parent training
Raising a Thinking Child: I Can Problem Solve Program	Parent training
Strengthening Families Program	Family skills training
Structural Family Therapy	Family therapy
Treatment Foster Care	Parent training
Model Programs	
Center for Development, Education, and Nutrition (CEDEN) Healthy and Fair Start Program	Family in-home support
Effective Black Parenting Program	Parent training
Families and Schools Together (FAST)	Comprehensive
Focus on Families	Parent training
Healthy Families Indiana	Comprehensive
Home Instruction Program for Preschool Youngsters (HIPPY)	Family in-home support
Home-Based Behavioral Systems Family Therapy	Family therapy
HOMEBUILDERS	Comprehensive
MELD	Parent training
Nurturing Parenting Program	Family skills training
Parents Anonymous	Comprehensive
Parent Project	Parent training
Parenting Adolescents Wisely	Parent training
Strengthening Hawaii Families	Family skills training
Promising Programs	
Bethesda Day Treatment	Comprehensive
Birth to Three	Parent training
Families in Focus	Family skills training
Family Support Program	Parent training
First Steps	Family in-home support
Health Start Partnership	Comprehensive
Home Base Program	Comprehensive
Project SEEK (Services to Enable and Empower Kids)	Comprehensive
Strengthening Multi-Ethnic Families and Communities	Parent training

[5] This point also was repeated at J. Szapocznik's Cultural Competency and Family Program Implementation plenary session, which was presented at the Third National Training Conference on Strengthening America's Families, Washington, D.C., March 23–25, 1997.

The Search for Effective Family Interventions

Many different types of family strengthening activities exist, and they are as

Table 2: Strengthening America's Families Program Matrix

Age	Levels of Prevention Programming: Universal (general population)	Selective (high-risk population)	Indicated (in-crisis population)
0–5	Birth to Three Eugene, OR First Steps Canon City, CO HIPPY New York, NY MELD Minneapolis, MN	Health Start Partnership St. Paul, MN Healthy Families Indiana Indianapolis, IN Raising a Thinking Child: I Can Problem Solve Program Philadelphia, PA	CEDEN Healthy and Fair Start Program Austin, TX Prenatal and Early Childhood Nurse Home Visitation Program Denver, CO
6–10	Preparing for the Drug Free Years Seattle, WA	Parents and Children Training Series Seattle, WA Strengthening Families Program Salt Lake City, UT Strengthening Hawaii Families Honolulu, HI	Focus on Families Seattle, WA Helping the Noncompliant Child Seattle, WA
11–18	Iowa Strengthening Families Program for Families With Pre and Early Teens Ames, IA	Families in Focus Salt Lake City, UT Family Support Program Rocky Mount, VA FAST Madison, WI	Functional Family Therapy Salt Lake City, UT Home-Based Behavioral Systems Family Therapy Athens, OH Multisystemic Therapy Program Charleston, SC Structural Family Therapy Miami, FL Treatment Foster Care Eugene, OR
0–18	Parents Anonymous Compton, CA Parent Project Round Lake, IL	Effective Black Parenting Studio City, CA Nurturing Parenting Program Park City, UT Strengthening Multi-Ethnic Families and Communities Los Angeles, CA	Bethesda Day Treatment Milton, PA Home Base Program Huntington, NY HOMEBUILDERS Federal Way, WA Parenting Adolescents Wisely Athens, OH Project SEEK Flint, MI

diverse as the families they serve. They vary from highly focused programs with written curriculums to open-ended parent support groups.

Based on the extensive national search for promising programs, it can be concluded that there are a number of effective family-focused prevention strategies for a variety of targeted family needs and a variety of family types (e.g., biological families, foster families, adoptive families, single-parent families, ethnic families, families with criminally involved members, families in which the parents are physically or sexually abusive or abuse drugs, working families, rural families, or inner-city families).

There is considerable empirical support in the research literature for the

effectiveness of family interventions (Alexander, Holtzworth-Munroe, and Jameson, 1994; Liddle and Dakof, in press; Szapocznik, 1996). These parenting and family-strengthening strategies are effective in preventing delinquency, teenage pregnancy, academic failure, substance use, and arrest (Gordon et al., 1988). Etiological research (Ary et al., in press) suggests common family and peer influence factors for all of these problem behaviors; hence, it is not unexpected that family interventions effective in improving family relations, parental monitoring and supervision, and parent-child attachment should make an impact.

These findings also suggest that there are no simple short-term solutions. The most effective prevention approaches involve complex and multicomponent programs that address early precursors of problem behaviors in youth. The most effective approaches often are those that change the family, school, or community environment in long-lasting and positive ways. Skills training programs are more effective than didactic, lecture-style programs (Tobler and Stratton, 1997). Information alone has not been found to have an impact on behavior unless combined with discussion time, experiential practice, role-playing, and homework to solidify behavioral changes.

Additional findings show that comprehensive family programs that combine social skills and life skills training in youth to improve social and academic competencies with parent skills training programs to improve supervision and nurturance have a greater impact on a broader range of family risk and protective factors (Kumpfer, 1996a) than programs that ignore context and work only with youth. These programs have been found, in some cases, to damage family relationships (Szapocznik, Rio, et al., 1989). Such programs often bring high-risk youth together and can have negative contagion effects unless skillful adult leaders are employed to control group norms and acting-out behaviors (Dishion and Andrews, 1995).[6]

Three Effective Program Types

To enhance substance abuse prevention efforts nationwide, the Center for Substance Abuse Prevention (CSAP) developed Prevention Enhancement Protocol Systems (PEPS) in 1992. PEPS was designed to identify current research, synthesize findings, develop recommendations for practitioners and others in the field, and compile the information into a manual for dissemination. A search of the literature was conducted by the national PEPS expert panel, cochaired by Jose Szapocznik, Ph.D., from the University of Miami and Karol Kumpfer, Ph.D., on family centered approaches to prevent substance abuse. The panel found only three family approaches that appear to meet the criteria of the Agency for Health Care Policy and Research for a "strong level of evidence of effectiveness" (Depression Guideline Panel, 1993). The three family intervention strategies effective in reducing risk factors and increasing protective factors are behavioral parent training, family therapy, and family skills training or behavioral family therapy. Interventions for which there is insufficient evidence of effectiveness for school-aged youth (5 years and up) at this time include parent education characterized by didactic, knowledge-only approaches and affect-based parent training (Substance Abuse and Mental Health Services Administration, 1998). Although there is sufficient evidence of the effectiveness of family support programs in families with children ranging in age from infancy to 5 years (Yoshikawa, 1994), there does not appear to be evidence of similar effectiveness with older children at this time.

[6] Leona Eggert, personal communication, November 1996.

An analysis of family programs (Kumpfer, 1996b) revealed that outcomes differ by the type of family intervention approach (parent education, parent support, family preservation, behavioral parent training, family skills training, and family therapy). For instance, training in parenting skills often reduces negative behavioral problems by improving parental monitoring and supervision but only indirectly improves family relationships. Family interventions tend to have a more immediate and direct impact on improving family relations, support, and communications and on reducing family conflict. In-home family support and parent support programs help build a more supportive environment by enhancing the capacity of the family to access information, services, and social networks (Yoshikawa, 1994). In-home or office-based case management is effective in increasing the family's access to needed family services. Parent education programs are effective in improving parents' knowledge and awareness of parenting issues but do not necessarily change behaviors—the most important test of an effective program (Falco, 1992). Children's social skills training added to parenting and family programs improves children's prosocial skills (Kumpfer, Williams, and Baxley, 1997).

Behavioral Parent Training

This training stresses that parents use effective discipline techniques and ignore disruptive or coercive child behaviors. Many research studies demonstrate its effectiveness in reducing coercive child-parent interactions[7] and in improving parental monitoring.[8] If these programs are of sufficient length (45 hours for high-risk families), they are generally effective in reducing a child's conduct disorder (Kumpfer, 1996b). Examples of exemplary behavioral parent training programs that were selected for dissemination through OJJDP's Strengthening America's Families Initiative include Parents and Children Training Series (Webster-Stratton, 1981), a video-based parenting program[9];

[7] See Patterson, Reid, and Dishion (1992); Webster-Stratton (1981, 1982, 1990b); Webster-Stratton, Kolpacoff, and Hollinsworth (1988).

[8] See Dishion and Andrews (1995); Dishion, Kavanagh, and Kiesner (1996); Dishion et al. (1996).

[9] This was demonstrated at C. Webster-Stratton's Video-Based Parent Training Program, a workshop presented at the Second National Training Conference on Strengthening America's Families, Salt Lake City, UT, October 12–14, 1998.

Treatment Foster Care Program (Chamberlain, 1994; Chamberlain and Reid, 1991) for foster parents; and Helping the Noncompliant Child (Forehand and McMahon, 1981), a behavioral parent training program that includes time for parents to practice learned skills with their own children under trainer supervision.

Family Therapy Interventions

Family therapy interventions are used with families in which preteens or adolescents are already manifesting behavioral problems. Research has demonstrated that family therapy improves family communications, family control imbalances, and family relationships (Substance Abuse and Mental Health Services Administration, 1998). A number of family therapy programs were selected as exemplary family programs because of their effectiveness in reducing delinquency and drug use in preteens and adolescents. These programs include Functional Family Therapy (Alexander and Parsons, 1982), Structural Family Therapy (Szapocznik, Scopetta, and King, 1978), and Multisystemic Therapy (Borduin et al., 1994; Henggeler, 1997; Henggeler and Borduin, 1990).

Family Skills Training

Family skills training is currently gaining popularity. Approaches are frequently targeted to high-risk groups of children and families and are primarily classified as selective prevention programs. These multicomponent interventions include behavioral parent training, children's social skills training, and behavioral family therapy or role-playing with special coaching by the trainers (Kumpfer and Alvarado, 1995). According to an outcome analysis conducted by the author (Kumpfer, 1996a), family skills training appears to affect the largest number of measured family and youth risk and protective factors.

Examples of family skills training programs include Kumpfer's 14-session Strengthening Families Program (SFP) (Kumpfer, DeMarsh, and Child, 1989a, 1989b, 1989c, 1989d, 1989e), which has been effective with substance-abusing parents and ethnic parents; the 7-session Iowa Strengthening Families Program (Molgaard and Kumpfer, 1994), a universal family program based on resilience principles that is held in the school for preteens to early teens and their parents; the 33-session Focus on Families (Haggerty, Mills, and Catalano, 1991) for parents receiving methadone maintenance therapy and their children; the 14-session Nurturing Program (Bavolek, Comstock, and McLaughlin, 1983) for physically and sexually abusive parents; Families and Schools Together (FAST) (McDonald et al., 1991) for high-risk students in schools; and Family Effectiveness Training (FET) (Szapocznik et al., 1985) for Hispanic adolescents.[10]

One distinguishing feature of family skills training programs is that they provide structured activities that help to improve parent-child bonding or attachment (Bowlby, 1982). For example, parents are coached in special therapeutic play, such as "Child's Game," which has been found effective in improving parent-child attachment (Egeland and Erickson, 1987, 1990). Through observation, direct practice (with immediate feedback by trainers and videotape), and trainer and child reinforcement, parents learn how to improve positive play by following the child's lead and not correcting, bossing, criticizing, or directing.[11] Teaching parents therapeutic play has been found to improve parent-child attachment and improve child behavior in families with psychiatrically disturbed and behaviorally disordered children (Egeland and Erickson, 1990; Kumpfer, Molgaard, and Spoth, 1996). Therapeutic play may even help improve brain development. Nash (1997) found that infants who are rarely touched or played with develop brains that are 20- to 30-percent smaller than normal for their age. As found in prior SFP studies, these programs encourage family members to increase family unity and communication and reduce conflict.

Principles of Effective Family-Focused Interventions

Because these reviews suggest that there is no best family intervention program, providers in the field must carefully select the best program for their target population, and guidelines must be provided to help in this selection. Parenting and family interventions must be tailored to the developmental stage of the child and the types of risk factors in the families served. Many interventions ultimately fail to have a long-term impact on delinquency and drug use in special high-risk populations because the programs are not sufficient to address the large number of risk factors and inadequate number of protective factors that affect these children. NIDA (1997) has specified a number of principles for prevention that can be used to guide the selection process. The principles discussed in the following sections are useful in reviewing and selecting family programs for implementation.

Comprehensive Interventions

Comprehensive interventions attend to the entire range of developmental outcomes of the child (cognitive, behavioral, social, emotional, physical, and spiritual) through improvements in all environmental domains (society/culture, community/neighborhood, school, peer group, and family/extended family) and demonstrate positive developmental changes in youth. Research suggests that many programs are effective in the areas they target for changes in youth, parents, or families, but many have limited results because they are too narrowly focused (Kumpfer, 1996a).

Family-Focused Programs

Family-focused programs are more effective than programs that focus solely on the child or the parents. The first wave of child development interventions taught therapists, teachers, prevention specialists, and other youth workers to provide enrichment or therapeutic experiences for children of deficient parents. To maximize program length while reducing cost, the second wave focused on training the parent or caretaker to better nurture and care for the child. As the concept of comprehensive prevention or treatment interventions dealing with many different precursors emerged, interventions addressing the child, parents, and interactive family system became more popular. Research comparing the effectiveness of these three types of programs has found the combined approach of all three programs most effective when dealing with antisocial and prosocial behavior in young people (DeMarsh and Kumpfer, 1985). A

[10] For more extensive descriptions of these programs and the research literature, the reader is referred to other OJJDP publications on the Strengthening America's Families initiative, such as Kumpfer (1993, 1994). These documents are available from the NCJRS clearinghouse or on the project's Web site: www-medlib.med.utah.edu/healthed/ojjdp.htm.

[11] These intervention strategies were developed by Kogan and Tyler (1978) and Forehand and McMahon (1981).

number of reviews of early childhood education programs also concluded that comprehensive, family-focused programs are the wave of the future and should be the primary target of future research (Mitchell, Weiss, and Schultz, 1993; Yoshikawa, 1994).

Long-Term Programs

Family programs should be long term; short-term interventions with families at high risk or in crisis are only bandages on family dysfunction. They do not result in functional changes within the family that allow long-term solutions rather than temporary reductions of the external symptoms. Although recruitment for long-term programs can be very difficult, once high-risk families are involved in a family intervention, they often do not want to stop participating.

Intensity of Programs

Sufficient program length and intensity are critical for effectiveness. The needier the family in terms of the number of risk factors or processes, the more time is needed to modify those dysfunctional processes. Time must be allotted for developing trust, determining the family's needs, providing or locating support servic for basic needs, and comprehensively addressing deficit areas (Center for Substance Abuse Prevention, 1993). To produce longitudinal effectiveness, the family intervention must be of sufficient length (at least 45 hours for high-risk families). Kazdin (1987) estimated that at least 30 to 40 contact hours of family programs are needed for a positive and ing impact, particularly because high-risk families frequently miss sessions and have difficulty implementing the newly ned skills at home (Kumpfer and Alvarado, 1995; Kumpfer and DeMarsh, 1985). Some parent and family programs to have much impact because they do not spend enough time on each skill or principle taught. Skills training interventions need to build on skills learned previously and require demonstration of those skills while new skills are being learned. Many parent education or training interventions fail with high-risk families because they are too short to really reduce risk-producing processes and behaviors and increase protective processes and behaviors in these parents. Short-term parent education programs are essentially for normal families. These programs stress that they must be short to attract parents to attend. Although this assumption may be true for busy working parents of children with few problems, it is not as true of high-risk or in-crisis families who want help.

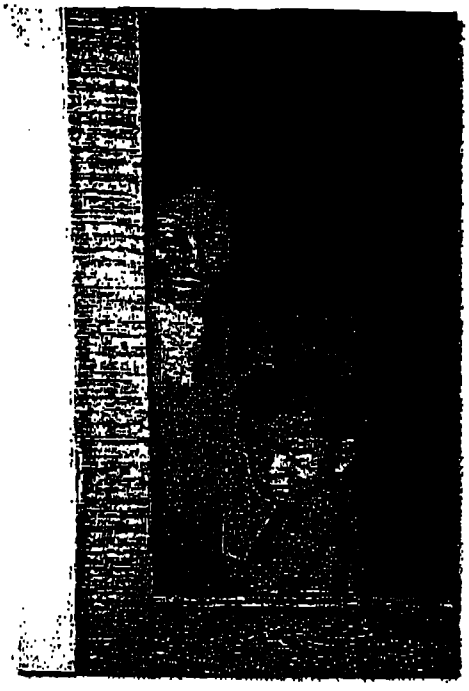
Cultural Traditions

Tailoring the parent or family intervention to the cultural traditions of the families involved improves recruitment, retention, and outcome effectiveness (Kumpfer and Alvarado, 1995). Many ethnic groups believe in using physical punishment, chastising children frequently, and having extremely high expectations for their performance. Understanding why these parents hold these values and beliefs about children helps program developers and group leaders improve the program's effectiveness. For instance, interviews with Pacific Islander parents participating in the Utah Community Youth Activity Project revealed that parents believed that Pacific Islander children have "stronger blood" than white children and need physical punishment (Harrison, Proschauer, and Kumpfer, 1995). Interviews with African-American parents participating in the Detroit SFP Safehaven program revealed that they believed that their children must be more obedient because of the potentially lethal dangers of inner-city streets. Because of differences in cultural ideas and lack of understanding of the psychological principles underlying many parent education programs, many so-called high-risk or dysfunctional parents may actively reject the underlying assumptions of intervention efforts or merely take more time to really understand them.

Ethnic families want culturally relevant parenting and family programs developed specifically for their parenting issues, family needs, and values. Kazdin (1993) recommended finding culturally relevant principles to guide modifications of existing model programs rather than developing separate models for each ethnic group. Unfortunately, few existing model family programs (e.g., those developed and tested within NIDA and the National Institute of Mental Health (NIMH) clinical research trials aimed at preventing drug use and delinquency) have been modified for ethnic minorities to the extent of providing culturally appropriate training and parent-child handbooks, videotapes, films, or evaluation instruments translated into different languages. Research-based exceptions include Szapocznik's individual structural family therapy model (Szapocznik et al., 1990) and Family Effectiveness Training or the Bicultural Effectiveness Training Program (Szapocznik et al., 1986; Szapocznik, Santisteban, et al., 1989) for high-risk preadolescents and adolescents; Alvey's Confident Parenting Program for African-American and Hispanic Families (Alvy et al., 1980); and Kumpfer's Strengthening Families Program for rural and urban African-Americans, Hispanics, Asian-Americans, Pacific Islanders, English or French Canadian families, and Australian families (Kumpfer, Molgaard, and Spoth, 1996). In any case, cultural modifications need to be guided by an organized, culturally sensitive, theoretical framework (Ho, 1992).

Developmentally Appropriate Interventions

It is important to address developmentally appropriate risk and protective factors or processes at specific times of family need when participants are receptive to change. Tailoring the intervention to specific family needs can be done on an individual family assessment basis (L'Abate, 1977) or can be based on focus or research assessment data from similar families in the special population being addressed. Occasionally, a very short-term program can have a greater impact on some participants if the material covered exactly addresses a major need of the parent or child. In addition, research demonstrates that interventions are most effective if the participants are ready for change (Spoth and Redmond, 1996a,



1996b). Parents in the Iowa Strengthening Families Program were targeted for a family intervention when their children were in the sixth grade, because at this age even normally well-adjusted youth begin having problems with behavioral and emotional adjustments (Molgaard and Kumpfer, 1994). Parents are ready to participate and change because they already begin to see oppositional behavior. Outcome results suggest that the Iowa Strengthening Families Program was effective in reducing risk factors for drug use (Spoth, Redmond, and Shin, 1998).

Different types of parenting interventions appear to be developed with an eye on the cognitive and developmental competencies of children at different ages and on parenting tasks. For instance, in-home parent support and cognitive/language development exercises are most effective with children from birth to 3 years of age (Yoshikawa, 1994). Professional medical support, through home visits by a nurse, is most often used with high-risk families from the child's conception to age 3 (Olds and Pettitt, 1996). Behavioral parent training programs, family skills training programs, and behavioral family therapy (involving the parent and child in structured skills training activities) are most effective with children 3 to 12 years of age (Substance Abuse and Mental Health Services Administration, 1998). Family therapy or family skills training combined with behavioral parent training that stresses parental monitoring is most effective with early adolescents and adolescents (Kumpfer, 1996b).

Family Dynamics

Family programs that produce changes in ongoing family dynamics and environment are the most effective in the long term. Evidence suggests that programs that encourage families to hold weekly family meetings after the program ends are effective for the longest period because they change internal family organization and communication patterns (Catalano et al., 1996; Kumpfer, 1996b). Improving parenting skills produces ongoing intervention that is more effective over time than short-term interventions with children or adolescents only.[12] The effectiveness of family interventions decays gradually with time (Harrison and Proschauer, 1995) but probably can be strengthened with new developmentally appropriate booster sessions as recommended by Botvin (1995).

An Early Start

Trying to improve parenting in the families of problem junior or senior high school students is an uphill battle. If parents are very dysfunctional, interventions beginning early in the child's lifecycle (i.e., prenatally or in early childhood) are more effective. For every family program that has been implemented and evaluated, there is always the wish that for some children, the intervention had begun earlier. After the initial NIDA SFP clinical trials, the methadone maintenance clinic of Project Reality, an agency located in Salt Lake City, UT, that provides treatment and prevention services for a diverse population, began targeting pregnant drug-abusing women for interventions to improve parenting skills. Because pregnancy is generally a time when many women are willing to decrease drug use and sign up for parenting classes, many Federal and State programs for drug-abusing women, such as those offered by CSAP, the Center for Substance Abuse Treatment (CSAT), NIDA, and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), target pregnant women for recruitment and family interventions. Improved outcomes resulting from the availability of more services to this population have been documented, but long-term improvements have not yet been demonstrated (Rahdert, 1996).

Program Components

Effective parent and family programs address family relations, communication, and parental monitoring. Although research has shown that the final pathway to delinquency and drug use is through peer influence (Kumpfer and Turner, 1990/1991; Newcomb, 1995; Swaim et al., 1989), the family precursors are lack of parental monitoring moderated by parental caring and positive parent-child relationships (Ary et al., in press; Brook et al., 1984, 1990). Effective programs improve the parent-child relationship and then focus on family communication, parental monitoring, and discipline (Kumpfer, 1996b). The more effective training programs in behavioral skills are distinguished from parent education because they include a structured and sequenced training series in parenting skills. These skills are taught through role-playing exercises and practiced in the group or in homework assignments, resulting in increased success in the implementation of such skills.

Recruitment and Retention

Although many family intervention providers have a poor turnout for their first attempts at implementing programs, high rates of recruitment and retention are possible. An 80- to 85-percent retention rate is possible for most programs if transportation, meals or snacks, and childcare are provided (Aktan, 1995). The intervention should be located in a nonthreatening environment and provided by sensitive, trained, and caring professional staff. Recruitment rates will vary with program type, incentives, types of clients targeted, and time of day offered (Spoth and Redmond, 1996b). The length of the program generally is not an issue with high-risk families, because many do not want the program to end once they have attended more than three sessions. An ongoing parent support group and booster sessions can help address this need for program continuation.

Use of Videos

Video-based programs that show good and bad parenting skills in videotaped vignettes are proving significantly effective over the long term, even when self-administered (Webster-Stratton, 1990a, 1990b; Webster-Stratton, Kolpacoff, and Hollinsworth, 1988). Families generally want to see videos that include local issues that reflect their ethnicity, culture, and/or background. Having the children watch the parenting videos or the parents watch the children's videos improves generalization and implementation of the video content. Interactive computer videos, which allow for self-pacing, self-testing, and selection of major content areas based on need, may be even more effective.[13]

The Trainer

The effectiveness of the program is highly dependent on the trainer's efficacy and characteristics. Although little data exist on how much of the effectiveness of a family program can be attributed to the trainer versus the standardized

[12] This was demonstrated in R. McMahon's Helping the Compliant Child workshop presented at the Second National Training Conference on Strengthening America's Families, Salt Lake City, UT, October 12–14, 1996.

[13] This was demonstrated at D. Gordon's Parenting Adolescents Wisely workshop presented at the Second National Training Conference on Strengthening America's Families, Salt Lake City, UT, October 12–14, 1996, and at the Third National Training Conference on Strengthening America's Families, Washington, D.C., March 23–25, 1997.

curriculum, estimates indicate that program effectiveness is 50- to 80-percent dependent on the quality of the trainer. Qualitative evaluations of trainer effectiveness, participant satisfaction rating, and long-term followup interviews with participants (Harrison, Proschauer, and Kumpfer, 1995) delineated nine important staff characteristics for program effectiveness:

- Communication skills in presenting and listening.
- Warmth, genuineness, and empathy, which were first detailed in studies of therapists' effectiveness by Carkhuff and Truax (1969).
- Openness and willingness to share.
- Sensitivity to family and group processes.
- Dedication to, care for, and concern about families.
- Flexibility.
- Humor.
- Credibility.
- Personal experience with children as a parent or childcare provider.

Staff who share the same general philosophy as the program are most effective. Personable, caring, empathetic, and experienced staff receive the highest ratings from program participants, retain families better, and produce better results. The best family and parenting programs are only as effective as the quality of the staff delivering the program.[14]

Recommended Future Research

Family-Focused Versus Child-Focused Interventions

Major questions still exist in the research literature about whether to focus scarce prevention resources on child only, parent only, or total family programs (Kumpfer, 1996a). Many providers prefer to work only with children in school or community programs. Family intervention researchers strongly believe that to have a lasting positive effect on the developmental outcome of a child, it is essential to create more nurturing and supportive parent-child interactions. Support and guidance by prosocial, well-adjusted parents provide a sustaining positive influence on children's developmental pathways and risk status for delinquency.

As previously discussed, there is evidence that suggests that bringing a group of at-risk youth together in a child-only group can create a negative contagion effect (Gottfredson, 1987). Dishion and Andrews (1995) randomly assigned 119 at-risk families who had 11- to 14-year-old children to one of four interventions: parent focus only, teen focus only, parent and teen focus, and self-directed change. Their results showed positive longitudinal trends in diminished substance use in groups that focused on parents only but suggested negative effects in the groups that focused on teens only. These results stress the importance of involving parents and reevaluating strategies that aggregate high-risk youth, particularly in groups in which insufficiently trained staff cannot control or improve group norms or influences. Social learning theory (Bandura, 1986) suggests that youth need positive adult role models (e.g., parents and group leaders) who can provide both opportunities for learning behavior skills and social competency and exposure to a higher level of moral thinking (Levine, Kohlberg, and Hewer, 1985).

Additionally, evidence from the original 1982–1985 NIDA SFP research (DeMarsh and Kumpfer, 1985; Kumpfer, 1987; Kumpfer and DeMarsh, 1985) suggested that increased exposure to high-risk peers with poor social competency and moral reasoning skills reduced the positive gains observed in the parent training only group more than it reduced the gains found in the parent plus children's skills training group. The true experimental design included random assignment of experimental families to one of the following groups: parent training (PT) only, PT plus children's skills training (CT), PT plus CT plus family training (FT), and a no-treatment control group. Unfortunately, there was no children's skills training only group in the prior NIDA research or in the six CSAP demonstration/evaluation grants on programs with cultural modifications (reviewed in Kumpfer, Molgaard, and Spoth, 1996). Hence, this critical research about the effects of increased exposure to high-risk peers has not been addressed with children younger than 11 years of age (Dishion's study included 11- to 14-year-olds).

Longitudinal Studies of Family Intervention Effectiveness

Few family intervention studies have been funded for longitudinal followup studies, which are critically needed to determine an intervention's impact on depression, conduct disorders, aggression, delinquency, and drug-use rates. This is particularly applicable if studies involve very young children. In a 5-year followup to the study of the Utah Community Youth Activity Project (Harrison, Proschauer, and Kumpfer, 1995), the survey data collected from abbreviated interviews suggested amazing longevity of positive family functioning and maintenance of program principles and behaviors. However, the data collection did not include the full parent and youth outcome assessment so critically needed to determine the true long-term impact on youth. With parents working more hours and latchkey children becoming more prevalent, youth are increasingly being isolated from positive adult role models. According to Richardson and colleagues (1989), this type of isolation is associated with an increased risk for substance abuse. It is clearly worth testing whether family skills training can significantly modify these trends longitudinally.

Cost-Benefit and Cost-Effectiveness Analyses

Including comparative cost-benefit analyses on these major prevention interventions would help providers make better decisions on where to allocate scarce resources (Werthamer-Larsson et al., 1996). Arresting, processing, incarcerating, and rehabilitating criminals is costly. It has been estimated that the total cost of the violent criminal career of a young adult (18–23 years) is $1.1 million (Cohen, 1994). In contrast, family and preschool interventions are very inexpensive, such as the $4,300 per year spent on Head Start or the Perry Preschool Program, both of which have been shown to be effective delinquency prevention programs. Although early family or school programs are not likely to result in crime-reduction benefits for many years, immediate cost savings accrue from reduced medical and social service costs and reductions in foster care placements (Greenwood et al., 1996). Additionally, a RAND Corporation research study (Greenwood et al., 1996) found that "programs that provide

[14] See Aktan (1995) for some guidelines on hiring high-quality staff for family programs.

parental training and therapy for families whose children have shown aggressive behavior in their early school years avert almost three times as many serious crimes."

Very few prevention studies include cost-benefit or cost-effectiveness analyses; however, research on delinquency prevention programs in California (Lipsey, 1984) demonstrated that for each $1.40 spent on law enforcement and the juvenile justice system, $1 was spent on prevention. More cost-benefit studies are needed. By comparing the cost-benefit results of child only, parent only, and family skills training, insight into efficient use of limited resources is possible. Tolan and Guerra (1994) stress the need to tie funding to programs that have been demonstrated to be effective.

Conclusion

What can be done to reduce delinquency? There are proven solutions now. Family strengthening programs can curb crime and delinquency. To be maximally effective, delinquency prevention programs must start as early as possible, train parents and other caretakers in effective discipline strategies and ways to improve parent-child communication and relationships, and teach parents effective, nonviolent coping skills (American Psychological Association, 1996). If high-risk families are provided intensive and repeated family and youth interventions by professionals, aggressive and violent behavior in youth can be reduced (Mendel, 1995). The dissemination and adoption of these model strategies must be supported in lieu of ineffective but glitzy "fun and games" approaches currently being marketed by commercial companies. Although many social scientists feel that marketing their programs is selling out to commercialism, those researchers willing to risk their own money on the up-front costs are doing the prevention field a major service. Through such efforts, high-quality prevention products are getting to practitioners. These efforts are helping to bridge the gap between science and practice, which is needed to reduce delinquency.

Researchers are not completely to blame for not being better marketers. The juvenile courts and community providers also must begin asking hard questions about whether the prevention or treatment programs they are considering really work. They need to request evaluation information on the type of experimental design (true experimental, quasi-experimental, or only a nonexperimental design) and control groups that were used. It also is important to know whether aggressive, violent, or delinquent behaviors actually changed or just participant knowledge or satisfaction with the program. Policymakers and funders should require that research-based prevention programs be selected for implementation if their funds are to be used.

OJJDP supports the dissemination and adoption of theory-based and effective programs through a four-phase technology transfer process. Through its Strengthening America's Families Initiative, OJJDP has funded searches for the most promising programs and aided in the dissemination of information about such programs, held conferences that showcased these programs, held training sessions, and is offering training and technical assistance in implementing the best family and parenting programs for the prevention of delinquency. More work in this area is needed. Research-based programs must be provided more effectively or gang leaders and drug dealers will continue to influence many of the Nation's children. Collaborations with marketing specialists could help social scientists improve the dissemination of strategies for research-based family interventions.

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

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

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

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

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

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

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

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

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

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Preliminary Summary of Federal Program Funds Available for Home Visiting

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

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