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To: Carol Rasco and Jennifer Klein by telefax: 202 456-2878 11 pages
From: Anthony Robbins, MD, Editor
Subject: **Parental Schooling and Children's Health,** an article to appear this week in *Public Health Reports.*

Sara Rosenbaum suggested that I fax you two this article that will appear this week in *Public Health Reports*, the journal of the US Public Health Service. Sara and I thought that both the President and the First Lady would be interested in these results.

If you need more information or I can help in any way, please let me know.

Tony

SYNOPSIS

NEARLY ONE IN every four children in the United States is born to a mother who has not finished high school, and more than one in eight is reared by such a mother during the critical preschool period. Large-scale studies show that the health and welfare of children are linked to the education level of their parents, with parent education often being a stronger predictor of child well-being than family income, single parenthood, or family size. Higher parent education levels make it more likely that children will receive adequate medical care and that their daily environments will be protected and responsive to their needs. Average parent education levels have risen over the last 30 years, but progress has slowed because of high rates of immigration from countries with lower educational standards and the tendency of more advantaged women to have children later than less advantaged women.

The education system and community organizations must provide young people who are not doing well in school with positive alternatives to low-education, high-risk parenthood. Health care providers should be proactive, teaching parents with few resources how best to promote their children's growth and development. The changing global economy makes it more important than ever that current and future generations of children be reared by parents who have adequate skills and training to be competent members of society and effective and responsible parents.

Parental Schooling

PHOTO BY RICK FALCO © 1995/BLACK STAR

Nicholas Zill, PhD

Despite heartening advances in some areas of child health over the last three decades, there has been a troubling lack of progress or even retrogression in other areas. Death rates for infants and young children have declined dramatically, but those for teenagers and young adults are almost the same as they were 30 years ago. Youthful deaths due to homicide and suicide have been increasing. Childhood diseases that were common in the 1950s and 1960s—diphtheria, German measles, mumps, polio—have been eradicated or greatly reduced in frequency, but because of inadequate immunization, there have been resurgences in measles, whooping cough, and other infectious diseases. No progress has been made over the last decade in reducing the number of low-birthweight babies or the proportion born to mothers who did not receive timely prenatal care[1].

What is the greatest obstacle to improving the health status of children in the United States? Some would say it is persistent and increasing economic inequality in American society, which brings with it high rates of child poverty and less than adequate health care for many youngsters[2]. Some would cite family breakdown, noting the million and a half children whose lives are affected by parental separation and divorce each year and the 1.2 million who are born each year to unmarried mothers[3–6]. Others would point to the detrimental effects on children of environmental pollution[7] or of

& Children's Health

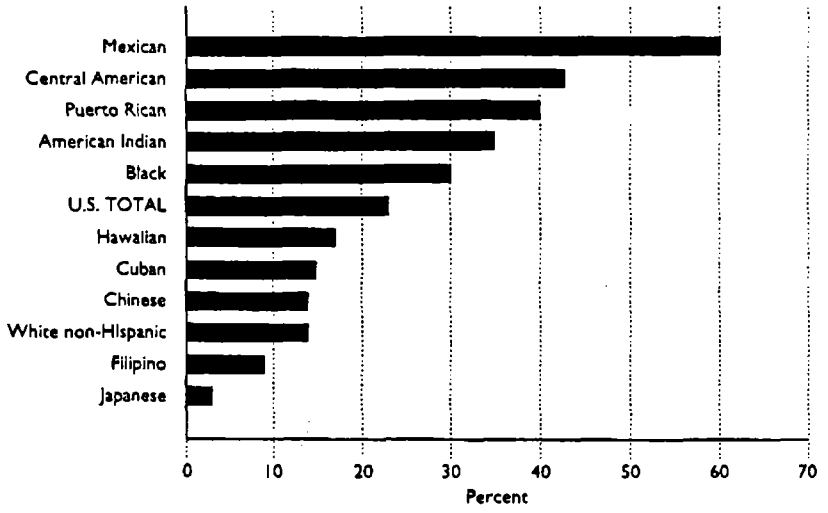
PHOTO BY RICK FALCO © 1995/BLACK STAR

the interconnected epidemics of drug abuse, violence, and AIDS[8,9]. Still others would mention the need for further advances in basic biomedical knowledge, especially regarding the genetic origins of many childhood disorders.

The Demographics

All of these claims have merit. But there is another childhood risk factor—one that has received far less public attention than any of those mentioned above—that may be a greater threat to children's health and well-being. That factor is the substantial minority of U.S. children who are born to or raised by parents with low levels of formal education. In 1993, 23.3% of all births in the U.S. were to mothers who had less than 12 years of schooling[10]. Some of these mothers go on to finish high school or get GEDs by the time their infants are ready to start school. Nonetheless, in 1993, 13% of all 4-year-old preschoolers in the U.S. were being cared for by mothers who had not finished high school or earned equivalency diplomas[11]. Thus, nearly one in every four children in the U.S. is born to a mother who has not finished high school, and more than one in eight is reared by such a mother during the critical preschool period.

Figure 1. Percentage of births within each ethnic group that are to mothers with less than 12 years of schooling, U.S., 1993.



Source: Ventura, S.J., et al.; Advance report of final natality statistics, 1993. Monthly Vital Statistics Report 44: Tables 10–11 (1995).

Twenty-three percent of all births in the United States in 1993 were to mothers with less than 12 years of schooling. The proportion of children born to these mothers varies greatly across ethnic groups, with the highest rates found among Hispanic groups. Many Hispanic parents are recent immigrants from countries where educational opportunities are more limited than in this country.

Ethnic differences. Birth certificate data show that the proportion of children born to mothers with low levels of education differs greatly across ethnic subgroups of the U.S. population. The highest rates are found among Hispanic

PHOTO BY RICHARD HUTCHINGS © PHOTOEDIT

Parent education is linked to children's economic well-being, their social development and emotional well-being, and their physical health.

American groups (Figure 1), partly because many Hispanic parents are recent immigrants from countries where educational opportunities are more limited than in the United States. Overall, 53% of Hispanic women in the United States who gave birth in 1993 had less than a high school education. The percentage of births in 1993 to mothers with less than a high school education was twice as high among African American women—30%—as among non-Hispanic white women—14%. Rates for the major Asian American groups were generally lower than the national average[10].

Although births to Hispanic women comprised 16% of all births in the U.S. in 1993, they accounted for 38% of the births to women with less than 12 years of education. White non-Hispanic women accounted for 37% of low-education births, and black women, 20%[10].

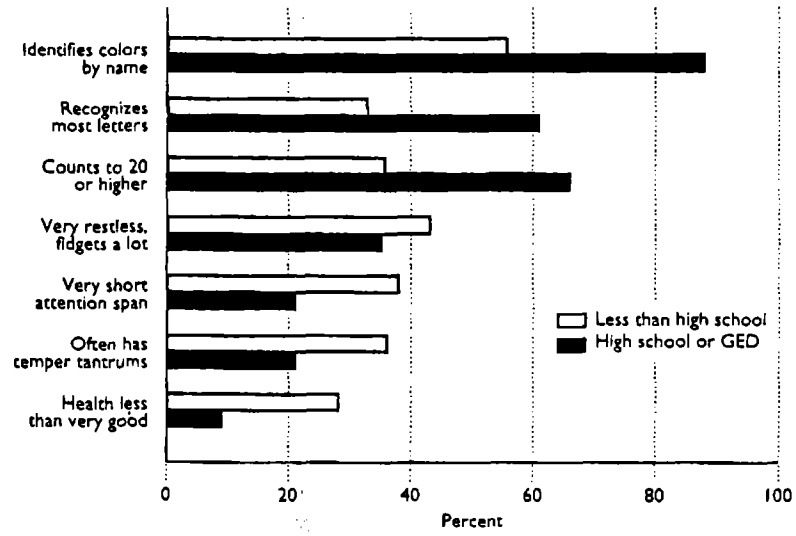
Not just teen mothers. Women who have less than a high school education when they give birth are younger, on average, than more educated mothers. But not all—or even most—are teenagers. Overall, 36% of the 916,388 births in the United States in 1993 to mothers with less than 12 years of schooling were to women in their teens. Thirty-one percent were to women ages 20 to 24, and 33% were to women ages 25 and older. However, the majority of births to older mothers with low levels of education were second or higher-order births; i.e., they were subsequent births to women who began having children in their teens or early 20s. Two-thirds of *first* births to low-education mothers occurred in the teen years[12].

Among African American women, the majority of mothers with less than a high school education—51%—were teenagers. Roughly one-quarter (23%) were women ages 25 and over. Among births to white women with less than 12 years of schooling, one-third were to teenagers and 35% were to women ages 25 and over[10].

The Link Between Parent Education and Child Well-Being

A number of large-scale studies have found evidence that the health and welfare of children are linked to the education level of their parents. Of the various aspects of child development and well-being, parent education is associated most closely with cognitive development and academic achievement. But parent education is also linked to children's economic well-being, their social development and emotional well-being, and their physical health. For example, a recent study of a nationwide sample of 2,000 4-year-olds who had not yet attended kindergarten found 12% to be in less than very good or excellent health. Among preschoolers whose mothers had a high school diploma or more education, the proportion in less than optimal health was 9%, while among those whose mothers did not have a high school diploma or equivalency certificate, the proportion was three times greater, 28% (Figure 2). Low maternal education continued to be associated with suboptimal preschooler health status when additional risk factors—such as family poverty and single parenthood—and other child and family characteristics—such as sex, race, Hispanic origin, and family size—were controlled by means of multiple regression analyses[11].

Figure 2. Developmental accomplishments and difficulties of 4-year-old preschoolers, by mother's education, 1993



Source: Zill, N., Collins, M., West, J., and Germino-Hauken, E.; Approaching kindergarten: A look at preschoolers in the United States, U.S. Department of Education, National Center for Education Statistics, Washington, DC (1995).

Compared to preschoolers whose parents have more schooling, 4-year-olds whose mothers have not completed high school are three times more likely to be in less than optimal health. They are less likely to display signs of emerging literacy and numeracy and are more likely to exhibit short attention spans and behaviors that can create problems when children reach kindergarten and first grade.

The national study of preschoolers also found that 4-year-olds whose mothers had not finished high school were less likely than other 4-year-olds to display signs of emerging literacy and numeracy and more likely to exhibit short attention spans, extreme restlessness, and other behaviors that can create problems when children get to kindergarten or first grade (Figure 2). For example, only 33% of the children whose mothers had not finished high school could recognize most letters of the alphabet, while 61% of the other four-year-olds could do so. Also, 38% of the children whose mothers had not finished high school were reported to have

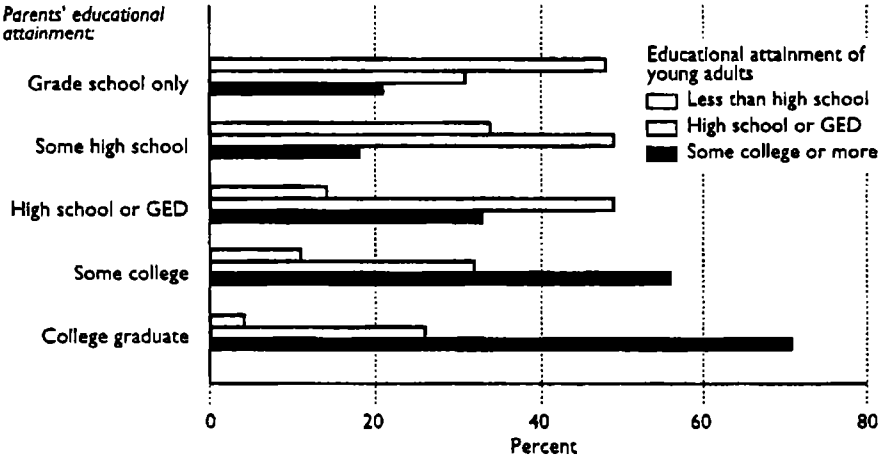
short attention spans in contrast to 21% of the other 4-year-olds. Again, limited maternal education was associated with lower literacy and higher problem behavior in preschoolers when other risk factors and child and family characteristics were controlled in multiple regression analyses[11].

Other studies of school-aged children have found the connection between parent education and child well-being is often stronger than the association between family income and child well-being. For example, the research organization Child Trends prepared a special set of tabulations from the 1976 National Survey of Children (a study of 2301 children ages 7 to 11) for the 1981 report of the Select Panel for the Promotion of Child Health[13]. For seven of nine well-being measures (vocabulary test score, school performance ratings, a practical skills index, child-reported misbehavior, child's feelings of rejection by parents and rejection by peers, and the child's level of fears and worries), parental education was a stronger predictor than family income.

Having low-education parents substantially increases the chances that a young person will experience academic difficulties by the time he or she reaches adolescence. The 1988 National Health Interview Survey on Child Health, for example, found that one-third of young people ages 7 to 17 whose parents had not finished high school had to repeat a grade in school. This rate was two-thirds higher than the grade repetition rate for young people whose parents had finished high school—20%—and twice as high as the rate for those whose parents had had some college education—14%. Parent education was a stronger predictor of grade repetition than poverty status, ethnicity, coming from a single-parent family, or family size[14].

In the National Adult Literacy Survey conducted by the National Center for Education Statistics in 1992, young adults ages 20–29 whose parents had dropped out of high school were twice as likely—34% versus 14%—to have received less than a high school education themselves, compared to young adults whose parents did get a high school diploma or GED (Figure 3). Young adults whose parents had some postsecondary schooling or a college degree were even less likely to have dropped out of high school—11% and 4%, respectively. Adults whose parents had less than a high school education were two to three times more likely than the offspring of high school graduates to score in the lowest category in the tests of functional literacy that were administered as part of the survey. Such low scores meant that they lacked the skills to function effectively as citizens and consumers in modern society[15].

Figure 3. Educational attainment of young adults ages 20–29 by educational attainment of their parents, U.S., 1992



Source: National Center for Education Statistics: Unpublished data from the 1992 National Adult Literacy Survey, Table 2.56P. Educational Testing Service, Princeton, NJ (1995).

Young adults whose parents were high school dropouts are twice as likely not to finish high school themselves as those whose parents did get a high school diploma or GED. Young adults whose parents had some college education or a college degree are even less likely to become dropouts.

Parent Education and Children's Health

The link between parent education and children's health status is at least partly explained by findings that higher parent education makes it more likely that children will receive adequate medical care and that their daily environments will be protected and responsive to their needs. Analyses of data from the 1975–76 National Health Interview Survey prepared by Mary Grace Kovar showed that children of better educated mothers were more likely to receive medical or dental care than children of mothers with little education, regardless of the family's income or whether the child lived with a mother only. A child with a poorly educated mother in a middle-income family was no more likely to have received medical and dental care than a child with a poorly educated mother in a low-income family[13,16].

Similar results were found a decade later in the 1988 National Health Interview Survey on Child Health. Thirty-one percent of children of parents with less than a high school education had not seen a dentist in two years, while only 19% of children of high school graduates (including those who had had some college) and 10% of children of college graduates had not seen a dentist in two years (Figure

4). A multivariate analysis found parent education a stronger predictor of a child's receiving dental care than income, welfare or poverty status, parents' marital situation, family size, or race[17].

The same survey found that 19% of children whose parents had less than a high school education lacked a regular source of routine medical care, as opposed to 8% of children whose parents had more education. They were also more than twice as likely not to have a regular provider for sick care (37% versus 16%). Multivariate analyses showed that family income and welfare or poverty status were significant predictors of children having no regular providers of routine care or sick care. But parent education was also a significant determinant and exerted an independent effect after income and welfare and poverty status were controlled[17].

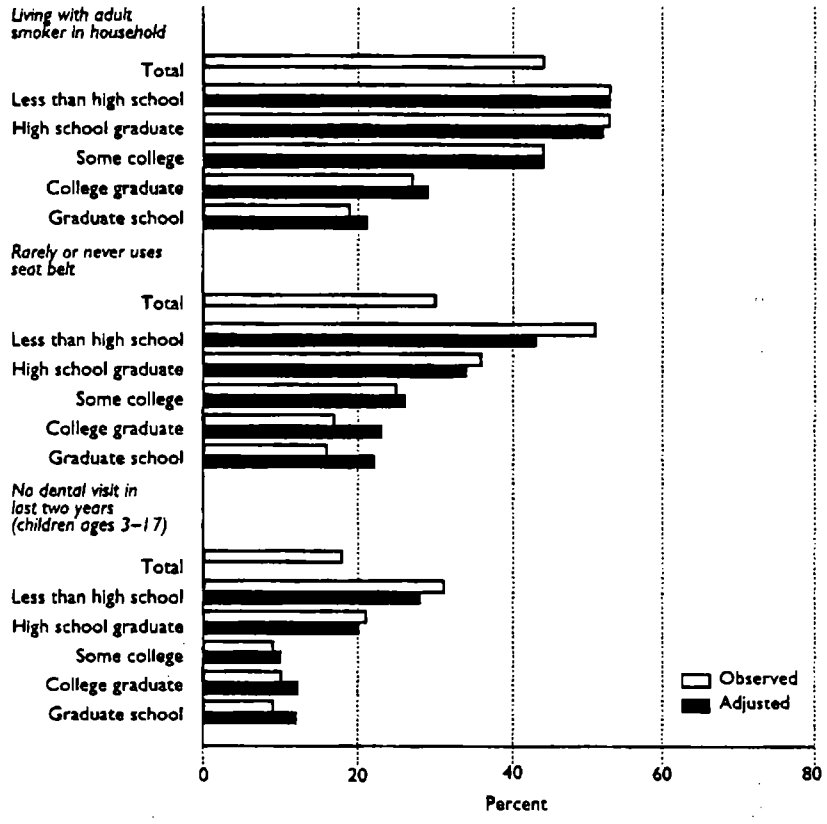
Health-related aspects of the child's daily environment. In terms of child health, parent education seems to make the greatest difference with respect to health-related aspects of the child's daily environment. Mothers and fathers with higher levels of education may be more likely to practice good health habits themselves and to take precautions to insure that their children's surroundings are safe and supportive. For example, the 1988 National Survey on Child Health (NHIS-CH) found that 58% of children whose parents had not completed high school lived with a smoker in

The research findings do not support the contention that parent education level is just a surrogate for other measures of social class or socioeconomic status.

PHOTO BY ROB NELSON © 1990/BLACK STAR

their household, compared to 49% of those whose parents were high school graduates (including those who had had some college), and 23% of those whose parents were college graduates (Figure 4). Parent education was a more important determinant of parental smoking than region, urban-rural residence, welfare or poverty status, family income, marital status, or ethnicity[17].

Figure 4. Percentage of children younger than 18 with selected health risks, by parent education level, 1988



Source: Coiro, M.J., Zill, N., and Bloom, B.; Health of our nation's children; United States, 1988 (DHHS Pub. No. 95-1519), Hyattsville, MD (December 1994).

Nearly 60% of children whose parents did not finish high school have an adult smoker in their household. Half rarely or never use seatbelts when riding in a car, and nearly a third have not been to the dentist in two years or more. Children of more educated parents are more likely to have healthful daily environments and adequate health care. This is true even when family income and other related factors are controlled (adjusted percentages).

Another finding of the 1988 NHIS-CH was that the use of seatbelts or child restraints varied substantially by parent education level (Figure 4). The proportion of children who rarely or never wore seatbelts was 51% among those whose parents had not completed high school, 32% among those whose parents were high school graduates (including those with some college), and 17% among those whose parents were college graduates. Again, parent education was a more important determinant of seatbelt use than other demographic or socioeconomic characteristics of the family[17].

Many of the health problems that affect today's children stem from or are exacerbated by high-risk behaviors on the part of parents. Several kinds of adult behavior that can have detrimental effects on the health and development of children have been found to be more common among high school noncompleters than among parents with more schooling. These include inadequate supervision that leads to unintentional child injuries[18,19], harsh punishment[20], failure to get children immunized[21], and parental alcohol or drug abuse[22,23]. Sexual activity without consistent contraception is also more common among school dropouts[24]. Such unprotected sexual activity may be hazardous for the offspring because of the spread of sexually transmitted diseases or the birth of siblings who are too closely spaced for the optimal development of each[24,25].

Implications for Public Health Programs for Children

Many observers believe that low family income and lack of resources are *the* key factors behind disparities in child health status across ethnic and income groups. The results of the research summarized above do not support this view. Nor do the research findings support the contention that parent education level is just a surrogate for other measures of social class or socioeconomic status. To be sure, parents who lack a high school education are less likely to be steadily employed than those with higher educational attainments and, when employed, earn substantially lower wages and have fewer benefits. But parent education has been found to have an independent effect on the quality of children's daily environment and on their medical care and health status after income, welfare and poverty status, race and ethnicity, and marital status are controlled.

These findings indicate that it is not just a lack of financial resources, or ethnic discrimination, that are at work in impeding progress and producing group differences in children's health status. Rather, they suggest that lack of knowledge and unhealthful parental attitudes and behavior patterns, among other factors, are contributing to the elevated rates of childhood illness and injury that are observed among young people from disadvantaged groups and areas.

PHOTO BY MARK RICHARDS © /PHOTOEDIT

Acknowledging this is not "blaming the victim" but recognizing a reality that must be changed if children's health is to be improved.

Part of the reason why parent education is often a better predictor than family income of medical care use and children's health status is that public programs such as Medicaid, food stamps, and WIC have succeeded in making medical care and adequate nutrition available to most young people from low-income families. Poverty in the United States for the most part is not like poverty in Bangladesh or Ethiopia; a total lack of medical care and extreme malnutrition are thankfully quite rare in this country, although, unfortunately, not unheard of. If child health and nutrition programs were to be abolished or severely curtailed, the relative importance of economic and educational factors as determinants of ill health in children might well be altered[26].

Providing alternative pathways. Girls and boys who become parents while they are still of school age are not a random subset of all young people, or even of young people from disadvantaged backgrounds. Rather, they are predominantly those with low test scores and grades, who are disengaged from school or in active conflict with parents, teachers, or school authorities[27,28]. As journalist Hedrick Smith has stated, in most American high schools there are two tracks, the track to college and the track to nowhere[29]. Most school-age parents are on the track to nowhere. Improving both curricular and extracurricular programs for the so-called "forgotten half" of students, namely those who are not college bound, is not only essential for strengthening the future labor force and making the U.S. more competitive in the global economy. It is also likely to reduce the number of babies born to low-education parents[30,31].

Continued schooling for low-education parents. Even if vigorous preventive efforts are mounted, significant, though hopefully reduced, numbers of children will be born in the forseeable future to teenagers and adults who have not completed high school. These parents should of course have opportunities to obtain more education, either immediately after the birth of their children or later. But women and men with less than a high school education are far less likely to get additional job-related training or other forms of adult

education than those who have completed high school or attended college[32].

New approaches to raising the functional literacy levels of adults with limited education are called for, especially approaches that tie instruction to the real-life challenges and demands that these adults are facing every day. It makes little sense simply to offer more of the same to individuals who have not done well in regular school and often hate school. There is a growing body of evidence from welfare-to-work evaluation studies that first getting a welfare mother into a job and then providing basic skills education or job-related training works better than the reverse sequence[33]. It also seems logical to blend basic skills education with instruction in childrearing for new parents who have a lot to learn in both areas[34]. Unfortunately, demonstration programs that have provided comprehensive education and social services to disadvantaged young mothers and their children have thus far produced only modest results[35,36].

Education programs for school-age mothers and fathers must be designed to function in ways that do not inadvertently condone or even encourage parenthood. It is not helpful to deterrence efforts for school systems to offer little to those who are doing the right thing (in this case, not having sex or at least not getting pregnant) and then to lavish special attention and services on those who have gone astray. Continuing education for low-education parents should come with some stipulations, one of them being that the people involved are taking specific steps to avoid getting pregnant (or making someone pregnant) again.

Progress Made; Progress Yet to Be Made

Striking changes have occurred in the United States over the last half century as the average years of schooling rose among all young adults. During the last 30 years, educational expectations and opportunities have increased, especially for girls and young women, for both men and women from minority groups, and for those from low-income families. However, the pace of progress has been slower in the last decade than in prior decades[37].

The current high rates of legal and illegal immigration from less developed countries with lower educational standards is one of the factors that statistically increases the number of births attributable to mothers with less than a high school diploma.

Another societal change is the increased tendency of women who are performing well academically and have good employment prospects, whether white, black, Hispanic, or Asian, to postpone childbearing until their late twenties or thirties, after they have gotten their business or professional careers well launched. The two-child family is now a norm in nearly all socioeconomic and cultural groups in the United States. However, the intergenerational interval for disadvantaged groups is only 16 to 20 years, while the intergenerational interval for more advantaged groups is 28 to 35 years. Disadvantaged groups will contribute more than their proportionate share to the child population. This disparity in the intergenerational interval exists within virtually all ethnic segments of the population[38]. Thus postponing parenting continues to be a choice of the economically well off, regardless of ethnicity.

Our rapidly changing economy is affording less and less in the way of gainful employment opportunities to young women and men with low skills and limited educational attainments[39]. From the standpoint of economic rationality, these changing conditions should be making it less likely that these adults will become parents; it is getting harder and harder for them to support a family. Ironically, though, the changing economy is probably making it more likely that young adults with low skills will become parents because they have so few attractive alternatives to parenthood as a way of gaining some measure of adult status and societal respect.

The rapid and profound changes occurring in the global economy may make it harder to change both the lives of children born to parents with less than a high school degree and the likelihood that at-risk individuals choose parenthood over education. The education system and community organizations must provide young people who are not doing well in school with positive alternatives to low-education, high-risk parenthood. Health care providers should be proactive, teaching parents with few resources how best to promote their children's growth and development by structuring a healthier and more suitable home environment, obtaining immunizations and other preventive care, and using sick care services appropriately. The changing global economy makes it all the more important that current and future generations of children be given the best possible chance to develop in healthy and productive ways. That means, first of all, being reared by mothers and fathers who have adequate skills and training to be competent members of modern society and effective and responsible parents.

Dr. Zill is Vice President and Director of the Child and Family Study Area at Westat, Inc., in Rockville, MD, and a member of the National Committee on Vital and Health Statistics.

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National Association of
Children's Hospitals
and Related Institutions

NACHRI

April 24, 1997

Ms. Pauline Abernathy
Office of The First Lady
The White House
Washington, DC 20500

Dear Pauline:

Just a short note to thank you again for your assistance in the Prescription for Reading event and the early childhood development conference.

I hope you were pleased with both events and the complimentary news coverage. We certainly thought both initiatives were a huge success, and I greatly appreciated your efforts to include us.

One way we are promoting both early reading and the importance of supporting young children is through the enclosed publication, *Healthy Children in Healthy Families,* being released this week. It features successful parent and family support programs operating nationwide at children's hospitals, including Reach Out and Read (see page 17). This publication may be helpful to you in identifying sites or programs that Mrs. Clinton or other administration officials might want to visit in their travels or highlight in speeches.

Please let us know if there are other ways NACHRI can be of assistance. We look forward to continuing to work with you. And again, thank you for all your assistance and support to date.

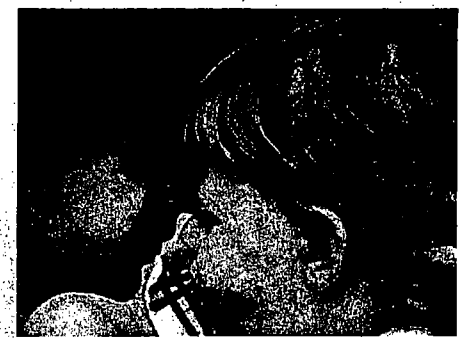
Sincerely,

Lisa M. Tate
Vice President, Public Affairs

Enclosure

P.S. Would it be possible to get the invitation list, with addresses, from the child development conference? We'd like to distribute this publication to those leaders.

401 Wythe Street, Alexandria, VA 22314
(703) 684-1355 Fax (703) 684-1589



Healthy children in healthy families

Improving child health by supporting parents

NACHRI

National Association of Children's Hospitals and Related Institutions

Published by
National Association of Children's Hospitals and Related Institutions
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Copies of this publication are available from NACHRI for $10 (includes shipping and handling).

National Association of
Children's Hospitals
and Related Institutions

NACHRI

LAWRENCE A. McANDREWS, FACHE
President & Chief Executive Officer

April 1997

Dear Colleague:

In recognition of Child Abuse Prevention Month, NACHRI is pleased to release *Healthy Children in Healthy Families: Improving Child Health by Supporting Parents.*

There has been unprecedented attention paid recently to the importance of the early years of life and how experiences during this period—both good and bad—have a decisive and lasting effect on a child's later development. We also know the critical role that parents play in this process.

The programs outlined in this report espouse the recommendations of the seminal 1994 Carnegie Corporation report, *Starting Points: Meeting the Needs of Our Youngest Children,* which stressed that when men and women are prepared for the opportunities and responsibilities of parenthood, they are more likely to provide the care and create the conditions that promote healthy child development. Specifically, this report profiles programs that:

- *Expand education about parenthood in health care settings, schools and communities,* including programs that reach out to employed parents and adolescent parents, as well as those that educate young people before they become parents.
- *Offer home visiting services to disadvantaged families,* including programs that work with poor, drug-affected, and other highly vulnerable families.
- *Create family and child centers to provide services and support to families,* including programs that offer integrated health, educational and social services.

Few jobs are more vital to the well-being of children and society as a whole than being a parent; yet few jobs are undertaken with so little solid information and training. Much of the parent training in years past was conducted informally among large extended families and close-knit communities, however these resources are no longer within the reach of many Americans. As health care providers and advocates for children and families, we can and should fill this void.

I hope this report inspires you to develop parent support and training programs or improve upon your existing efforts. My best wishes for all your health promotion efforts in 1997.

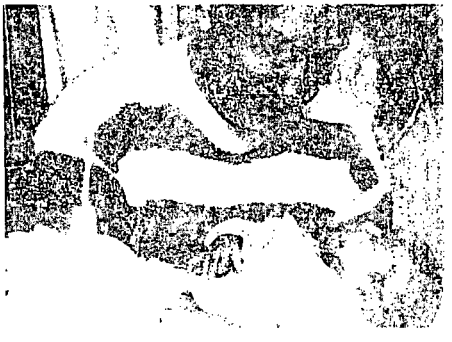
Sincerely,

Lawrence A. McAndrews

Lawrence A. McAndrews

401 Wythe Street, Alexandria, VA 22314
(703) 684-1355 Fax (703) 684-1589

Contents



Facts about America's children and families

Facts about America's children and families

• More than half of all infants and toddlers (56 percent) have mothers in the workforce full or part time.

• Nearly a third of infants and toddlers in two–parent families (31 percent) have parents who both work full time at paying jobs.

• In a recent Commonwealth Fund survey, more than half of all parents report that they would like to spend more time with their children. Employed parents feel this tension most strongly; eight out of 10 parents who work full time wish for more time with their children.

• A national insurance research survey estimated that in 1992 American businesses and their employees paid $5.6 billion through their health benefits for unhealthy birth outcomes of mothers and infants.

• Each year, teenage girls give birth to nearly 500,000 babies. Today 3.3 million children live with adolescent mothers.

• One in four infants and toddlers under the age of three—nearly 3 million children—lives in a family with an income below the federal poverty level.

• The United States now leads the world in fatherless households. In 1960, 17 percent of American children lived apart from their fathers; in 1996 the figure was 40 percent.

• There were an estimated 2.8 million cases of child abuse and neglect reported in the United States in 1993, up from 1.4 million cases in 1986.

• Almost 60 percent of the pregnancies in the United States are unintentional, either mistimed or unwanted altogether.

• Children born to mothers who have less than 12 years of education have a fourfold increased risk of mental retardation.

• For every $1 spent on prevention, $2 are saved in costs associated with treating and managing the consequences of child abuse and neglect.

Expanding education about parenthood in health care settings, schools and communities

M.A.L.E.S.—Men Are Living Examples of Strength

Abstract

M.A.L.E.S. is a school-based curriculum designed to teach 12- to 14-year-old boys the responsibilities of fatherhood and reduce the future incidence of child abuse and neglect. The program was founded at Spain Middle School in Detroit. Since the school population is primarily African American, a culturally sensitive approach was developed for implementing the curriculum.

History

In Detroit, as in most U.S. cities, there are few educational programs to prepare boys for responsible parenting, according to a recent Michigan conference on fatherhood. Most child abuse is perpetrated by men, and many children with social and emotional problems reside in families with uninvolved fathers. In response, the Children's Hospital of Michigan developed the M.A.L.E.S. curriculum to inform boys about the realities of fatherhood before they become sexually active.

Target population

The program is geared to seventh and eighth grade African-American boys at a middle school adjacent to the hospital.

Program design and features

The 16-week curriculum is presented in 50-minute sessions to groups of 15 to 20 boys who are selected by their teachers. The M.A.L.E.S. program coordinator recruits professional men—all of whom are actively involved with their children—to present on various subjects (see box). The teaching approach is highly interactive and the subject matter is presented through group exercises, role play, music and video. The format encourages the presenters to serve as role models to these young men.

Community partner

Detroit Public Schools

Budget and funding sources

The salary of the part-time program coordinator and related administrative expenses (approximately $800) are included in the hospital social work department budget.

Evaluation and outcomes

The boys are given a pre- and post-program test. Among the six groups that have completed the curriculum, results indicate improved understanding of the

Contact information

M.A.L.E.S.—Men Are Living Examples of Strength
Children's Hospital of Michigan
3901 Beaubien Boulevard
Detroit, MI 48201-2196

Contact:
David Allasio, M.S.W.
Child Protection Team Coordinator
(313) 993-7106

Subject matter

- The image of fathers in society
- Definition of male strength
- Male and female sexuality
- Relationships
- Goal setting
- Planning for responsible fatherhood
- Developmental needs of small children
- Child abuse prevention/non-violent discipline
- Financial needs of children
- Spirituality and fatherhood

subject matter. Both teachers and students report a high regard for the program.

Lessons learned and advice to others

Present the curriculum in a manner that appreciates the socio-cultural characteristics of the group to gain credibility and acceptance of the program among the students.

Next steps

- Pursue grant funding to expand the program to other Detroit middle schools.
- Develop a program for seventh and eighth grade girls on the role of the father and how adult parents can support each other.

Replicability

The program is replicable at children's hospitals or other organizations that work closely with schools. The M.A.L.E.S. program materials are available upon request.

Young Fathers Program

Abstract

The Young Fathers Program is a case management and educational program that promotes fathers' early and consistent involvement in their children's lives.

History

For many years, the Children's Hospital of Columbus has offered clinical and educational services to teen mothers and their children. In response to the growing body of literature showing negative outcomes for children with uninvolved fathers—namely school failure, persistent poverty and increased likelihood of incarceration—the hospital proposed a program to address the needs of young fathers and promote responsible parenting. This program was launched in 1995.

Target population

The program is open to fathers age 15 to 24 residing in Columbus, with priority given to fathers whose infants are cared for in the hospital's teen parent clinic and home visiting program.

Program design and features

Through a combination of individual counseling, peer support groups and case management, the program offers the following services:

- Positive role modeling
- Educational and employment assistance
- Child development and parenting education
- Relationship and family guidance
- Life skills training
- Sexual responsibility instruction and family planning services
- Referrals to substance abuse treatment services

Community partners

- Columbus Private Industry Council and temporary employment agencies, for job training and employment assistance
- Columbus Public School's teen parent program, area hospitals and prenatal clinics, for client recruitment
- Columbus Council on Alcoholism, for substance abuse treatment
- Franklin County Child Support Enforcement Agency, for paternity establishment

Budget and funding sources

The program is funded through a $50,000 grant from the Columbus Foundation. Program expenses include salaries for the coordinator and

Contact information

Young Fathers Program
Children's Hospital
700 Children's Drive
Columbus, OH 43205

Contact:
Charles Campbell, MSW, LSW
Program Coordinator
(614) 722-2452

Objectives for participants

- To provide financial and emotional support for their children
- To play a visible role in their children's lives
- To establish official paternity
- To complete education and/or vocational training
- To secure employment
- To prevent repeat pregnancies

secretary, staff and client transportation costs and related program expenses.

Evaluation and outcomes

In the past year, participating fathers have demonstrated improved financial support for their children and parenting knowledge, and more regular visitation with their children. More than two-thirds of participating fathers are involved in school, vocational training or work and there have been no reported subsequent pregnancies.

Lessons learned and advice to others

• *Don't expect instant receptivity.* This is not an easy population to engage and establishing trust can take considerable time because these young men are often skeptical of programs offering assistance.

• *Don't limit your program to a young age group.* If your funding source permits, make your program available to older fathers as well.

• *Use welfare reform to make the case for this service.* The new federal law will increase the demand for programs aimed at improving fathers' financial support of their children. Establishing a Young Fathers Program could be a hospital's proactive response to the potential negative effects of the new welfare reform law.

Next steps

The hospital recently hired a coordinator for all community adolescent services, including the Young Fathers program, teen parent clinic and home visiting program, to integrate programming and fund-raising efforts.

Replicability

The program is best replicated at children's hospitals and other institutions that offer services to teen mothers and/or have strong ties to prenatal programs.

The Parenting Place

Abstract

The Parenting Place is an educational program that promotes positive discipline and effective communication skills for parents.

History

In 1990 the National Center on Child Abuse and Neglect (NCCAN) awarded the Children's Hospital of Pittsburgh a $70,000 grant to create an educational program to decrease parents' physical punishment of children. The grant was one of nine programs that were funded nationwide. A $100,000 grant from the Children's Trust Fund of Pennsylvania in 1992 expanded the program to serve 300 percent more parents.

Target population

The program is open to all parents in Allegheny County—the hospital's primary service area—as well as four surrounding counties.

Program design and features

The Parenting Place uses trained community volunteers to present a parent education curriculum developed by the hospital. Because volunteer instructors interact with class participants in the communities in which they live and work, parents often view the instructors as local resources whom they may approach with questions about parenting issues. A 12-hour volunteer training is offered twice a year.

The parenting course consists of six presentations addressing self-esteem for children and their parents, discipline, effective listening, communication and sibling rivalry. An optional presentation is available on communicating with children about human sexuality and substance abuse prevention. Program staff is also developing new curricula about parenting teenagers and children with special health care needs.

The Parenting Place has two full-time staff members—a curriculum development coordinator and a volunteer coordinator. In addition to their regular duties, Parenting Place staff are frequently asked to give radio and TV interviews on child development and parenting topics.

Community partners

To expand the reach of the program, the Parenting Place collaborates with local libraries, schools, religious organizations, health centers, YMCAs and work places, which serve as host sites for the classes.

Contact information

The Parenting Place
Children's Hospital of Pittsburgh
One Children's Place
3705 Fifth Avenue
Pittsburgh, PA 15213

Contact:
Jim Bozigar
Coordinator of Community Relations
(412) 692-8665

Budget and funding sources

The annual budget for the program is $110,000, which is derived from participant fees and grants from the local Presbyterian Church (which funds child care during parenting classes), Allegheny County Children and Youth Services, local school districts (which use federal "drug free schools" funding) and the American Foresters Association.

Evaluation and outcomes

A pre- and post-program test measurement has indicated a statistically significant drop in parents' use of corporal punishment as a discipline technique. The Parenting Place has trained 140 volunteer instructors and presented the parenting course to over 6,000 parents. The program has been presented at more than 200 locations in Western Pennsylvania.

Lessons learned and advice to others

- *Always charge a fee for your parent education course.* Paying even a nominal fee will improve the likelihood that parents will remain in the program until completion of the course.
- *Recognize that parents' behavioral and developmental concerns about their children are universal.* The techniques you recommend for dealing with these concerns will not change significantly among different socio-economic groups.

Next steps

- Secure corporate underwriting for the program.
- Replicate the program at area hospitals.

Replicability

Staff are available to train other children's hospitals in the use of the Parenting Place curriculum.

Parent Warmline

Abstract

The Parent Warmline is a telephone consultation service that provides support, encouragement, practical advice and resource referral to parents of young children who have questions about their child's development or behavior.

History

The Parent Warmline was created in 1987 in response to the many calls received by various hospital departments related to child development issues. At that time, nurse advice lines and triage services were available in the Minneapolis/St. Paul area, but there was no central telephone consultation service for behavioral and developmental concerns. Using a model presented at the Chicago-based Family Resource Coalition, the manager of the hospital's primary care clinic, along with a pediatrician and a parent educator, launched the Parent Warmline program with an 18 month start-up grant from the hospital foundation.

Target population

The Parent Warmline is open to all Minnesota residents.

Program design and features

The Warmline receives calls 24 hours a day through a voice mail system. Working from home, volunteers check the voice mail system periodically throughout the day and respond to callers. Calls focus on a range of child development topics. Two-thirds of callers' concerns are addressed on the phone; one third of callers are referred to pediatricians, literature or other community resources, such as counseling and mental health programs.

The hallmark of the Parent Warmline is its corps of volunteers, all of whom are professionals with at least a bachelor's degree in child development or a related field. Volunteers receive an intensive three-day orientation and attend bimonthly continuing education seminars thereafter. The program trains 10 to 12 new volunteers a year and has an average volunteer base of 40. Each volunteer is asked for a minimum commitment of one year of service, working three to four shifts per month.

A program coordinator manages all volunteer recruitment, training and retention activities, as well as program development and evaluation functions. A program assistant is responsible for administrative duties.

The Warmline is consulted frequently by the local print and broadcast media on parenting concerns. Warmline staff and volunteers also present at health fairs, early childhood education programs and professional training conferences.

Contact information

Parent Warmline
Children's Health Care
2525 Chicago Avenue South
Minneapolis, MN 55404

Contact:
Linnea Grey, M.S.
Program Coordinator
(612) 813-6160

Community partners

- Area pediatricians/physicians
- Counseling and parent education programs
- Day care centers
- Churches
- Other community hospitals

Budget and funding sources

The annual budget is approximately $40,000, which covers the salaries of a program coordinator and a program assistant, and volunteer expenses (orientation, training, etc.). The program is fully funded by the hospital through the Family Resources Department.

Evaluation and outcomes

In 1995 the Warmline service received 2,300 calls, averaging 19 minutes in length, from 125 zip code zones throughout the state. A recent telephone survey indicated that 95 percent of parents reported they were "highly satisfied" with the program and that their conversation with the Warmline representative relieved the immediate stress of their issue.

Objectives

- To provide current and accurate information regarding child development and behavior to parents of infants and young children.
- To provide a link to existing community resources for parents who might not otherwise have access to such services.
- To prevent child abuse by increasing parental knowledge and ability to cope with normal parenting concerns.
- To serve as a professional clearinghouse for information relating to the health and development of children.
- To promote awareness of Children's Health Care within the medical, mental health and lay communities.
- To collaborate with area pediatricians by addressing the parenting, developmental and behavioral concerns of their patients.

Lessons learned and advice to others

- *Understand how volunteerism works.*
- *Hold regular volunteer recognition events and high quality in-service training with CEU credits.*
- *Position this service as a community resource and partnership*—not necessarily as a marketing tool or primary feeder program for the hospital.

Next steps

Expand the Parent Warmline to serve non-English speaking clientele, particularly Hmong and Spanish-speaking families.

Replicability

The program is highly replicable. Parent Warmline staff offer training and consultation for children's hospitals and other organizations.

Partners with Parents

Abstract

Partners with Parents is a workplace parent educational program for Wisconsin employers.

History

In an effort to become more visible with the Wisconsin employer community, the Children's Hospital of Wisconsin's planning and education departments developed a program to provide parenting education for employees of those businesses. Statistics indicating that 70 percent of Wisconsin children have both parents in the work force and that over 6,600 children are hospitalized in Wisconsin annually for preventable injuries provided compelling evidence in support of the program. In 1995 the hospital pilot tested Partners with Parents with the businesses represented on the hospital foundation board. Shortly thereafter, the hospital introduced the program to employers around the state.

Target population

The program is open to all Wisconsin employers.

Program design and features

Employers participating in the program receive free or low-cost services for their employees with children. The education department designs these items in consultation with clinical experts in the hospital. Services include:

- *Workplace educational seminars*—available as one-time lectures or in series format. Conducted at the work site by the hospital's community educator, the seminars address pertinent issues such as stress, communication, discipline and other topics of concern to parents.
- *"Parenting Works" newsletter*—published three times a year, featuring general parenting articles and conversations with working parents from Wisconsin businesses.
- *Health tip sheets*—published quarterly in camera-ready format (suitable for employee newsletters and payroll envelopes), featuring family health and safety information.
- *Community education newsletter*—published three times a year, listing educational classes sponsored by the hospital.
- *Booklets and brochures*—on a variety of subjects, including child day care, discipline, drugs and alcohol, and injury prevention.

Planning department staff meet regularly with human resource directors and small business owners around the state to promote the program. The program is also marketed through chamber of commerce newsletters and through outreach to Wisconsin's 17 employer coalitions

Contact information

Partners with Parents
Children's Hospital of Wisconsin
9000 West Wisconsin Avenue
P.O. Box 1997
Milwaukee, WI 53201

Contact:
Pat Gruenwald
Planning and Marketing Department
(414) 266-6175

(business federations that are organized to address health care issues). The Partners with Parents advisory board, which includes participating employers, meets twice a year to provide feedback and direction to staff.

Budget and funding sources

The hospital funds the program's $150,000 budget, which covers materials, travel expenses and the following staff: a program coordinator from the planning and marketing department, clerical and public relations support. Education staff time is assumed by that department. Fees from materials and classes partially offset expenses.

Evaluation and outcomes

The program has been well received by employers—150 of whom now participate at some level. On average, parents rate highly the format and content of the workplace educational seminars. The hospital plans to conduct a thorough evaluation of the program in the future.

Lessons learned and advice to others

- *Make the program a partnership between the hospital's marketing and education departments.*
- *Utilize talents of both departments to make the program successful.*

Next steps

- Work with employers to identify their most prevalent pediatric insurance claims and design specific health education or disease management services to address those issues. The hospital intends to pilot test this approach with employers on the Partners with Parents Advisory Board.
- Distribute educational materials to pediatrician, OB-GYN, and family practice offices around the state.
- Develop specialized programs and materials for single mothers in Wisconsin, 81 percent of whom are in the paid work force.

Replicability

The program is highly replicable. Partners with Parents staff are available for consultation to other children's hospitals seeking to implement similar programs.

Reach Out and Read

Abstract

Reach Out and Read (ROR) is a pediatric early literacy program that integrates parent education on literacy development into regular preventive health care for children between the ages of six months and six years.

History

Reach Out and Read began as a collaboration between pediatricians and early childhood educators. The program is based on the connection between reading and children's well-being—and is rooted in the belief that illiteracy is the catalyst for other negative child health outcomes such as school failure, substance abuse and teen pregnancy. Launched at Boston Medical Center in 1989, the program seeks to change the culture of ambulatory pediatrics by making literacy development an integral part of anticipatory guidance. Today, there are over 80 ROR sites across the country, including 11 at children's hospitals.

Target population

The program targets socially and economically disadvantaged families, whose children are most at-risk for reading and school failure.

Program design and features

The program has three basic components. In the clinic waiting room, volunteers engage children with books, reading aloud and modeling book-related interactions for parents. Then in the examining room, the pediatrician or nurse practitioner introduces an age-appropriate children's book into the visit, commenting on the child's response and offering information to the parent or guardian on how to use books to support the child's healthy development. At the end of each visit, the child is given a new, culturally and developmentally appropriate book to take home. The accumulation of these books in the home encourages reading as a regular feature of the family's routine.

Staff for an ROR site typically includes a part-time program coordinator and a medical consultant.

Partnerships

To support their efforts, ROR projects often collaborate with local service organizations, such as the Junior League and Kiwanis. Many ROR sites also work with local bookstores, which can contribute new or overstocked books and can sponsor fund-raising events.

Contact information

Reach Out and Read

- Children's Mercy Hospital, Kansas City, MO
- Hughes Spalding Children's Hospital, Atlanta, GA
- Children's Hospital of Michigan, Detroit, MI
- Children's Health Care, Minneapolis, MN
- Rainbow Babies and Childrens Hospital, Cleveland, OH
- Children's Medical Center, Tulsa, OK
- Children's Hospital of Philadelphia, PA
- University of Virginia Children's Medical Center, Charlottesville, VA
- Children's National Medical Center, Washington, DC
- Phoenix Children's Hospital, Phoenix, AZ
- Children's Hospital of New Mexico, Albuquerque, NM

Contact:
Abby Jewkes
National Program Administrator
Reach Out and Read National Training Site
Boston Medical Center
(617) 534-5701

Budget and funding sources

ROR projects are typically supported by grants and donations. On average, it costs $30 per child to provide books at each primary care visit for the first five years of life. A hospital that provides books at both its primary care and specialty clinics can expect to spend an average of $20,000 a year on the project.

Evaluation and outcomes

An evaluation of the pilot program at Boston Medical Center in 1991 found that mothers who participated in the program were four times more likely to read aloud to their children than were mothers from similar socioeconomic backgrounds who had not participated in the program.

Next steps

- Expand the program to more hospitals and clinics around the country.
- Create a stronger research and evaluation component for the program.
- Expand the program to target new parents at the time of delivery.

Replicability

The program is replicable at any children's hospital offering ambulatory care. A comprehensive program manual is available for prospective Reach Out and Read sites. For more information, contact Abby Jewkes, National Program Administrator, Reach Out and Read National Training Site at Boston Medical Center at 617-534-5701.

Young Moms Program

Abstract

The Young Moms Program is a prenatal education and support program for expectant teens.

History

In 1989 a group of obstetricians, nurses, a perinatologist and concerned individuals from various community agencies serving teens came together in response to the growing number of young, high-risk mothers who were delivering in the Children's Hospital at Johnson City Medical Center's maternity unit. Based on their collective experience that expectant teens did not receive care until late in pregnancy, and national data indicating that traditional channels of prenatal care and education did not reach this population, the hospital developed the Young Moms Program.

Objectives

- To improve teen pregnancy outcomes
- To prevent school dropout
- To prevent repeat teen pregnancies

Target population

The program is open to pregnant teens under 21 residing in the hospital's eight-county service area.

Program design and features

The program receives referrals from area OB-GYN and family practice physicians, local health departments, school nurses, counselors, teachers and court systems. Each week for 18 weeks, expectant teens come to the hospital for a "one stop" visit. They attend a prenatal education and support class taught by hospital staff and volunteers from the community (see box); have an opportunity to visit a social worker; and receive referrals to community resources. They also receive nutritional counseling and can apply for and receive WIC vouchers. At each class, moms receive refreshments and vouchers as incentives for attendance that can be "cashed in" at a baby store run by volunteers. They also receive a convertible safety seat for completing the program. Each year, the program hosts a reunion and/or holiday party for all program alumni.

Community partners

In addition to its network of referral partners, the Young Moms Program has organized a coalition of service providers, including representatives from city and county schools, hospitals, health departments, mental health agencies, legal and social service departments, job training

Contact information

Young Moms Program
The Children's Hospital at Johnson City Medical Center
400 State of Franklin Road
Johnson City, TN 37604

Contact:
Pam King, R.N.C., B.S.N.
Prenatal Education Coordinator
(423) 461-6183

agencies and early childhood development programs. The coalition meets quarterly to coordinate efforts for pregnant teens and new mothers in Johnson City and the surrounding areas.

Budget and funding sources

The annual budget for the Young Moms Program is $33,000, which includes salaries for a program coordinator and a social worker and other program expenses. The hospital funds the program with help from a grant from the state to purchase child safety seats and a grant from the March of Dimes to purchase educational supplies and snacks.

Evaluation and outcomes

To date, more than 1,000 mothers and support persons have been served. The program has been effective in lowering the rate of low birth weight (LBW) infants delivered by program participants. While teens nationally give birth to 10 percent of all LBW births, only 4 percent of babies born to mothers who participated in the program in the first three years were LBW. The hospital's costs for providing care for these patients were lowered significantly during the first three years of the program's operation.

In 1992, the Young Moms Program was designated a model adolescent service program by the Tennessee Commission on Children and Youth. In addition, the program has received an Outstanding Achievement Award from the National Organization for Adolescent Pregnancy and Parenting and a Secretary's Award for Excellence in Community Health Promotion from the U.S. Department of Health and Human Services in 1993.

Educational topics

- Options for pregnant teens
- Reducing risk factors during pregnancy
- Goal setting for education and employment
- Physical and emotional changes
- Labor and delivery
- Father involvement
- Sexually transmitted diseases
- Contraception
- Nutrition
- Newborn care
- Child development
- Parenting skills
- Injury prevention
- Coping skills/Stress management
- Self-esteem

Lessons learned and advice to others

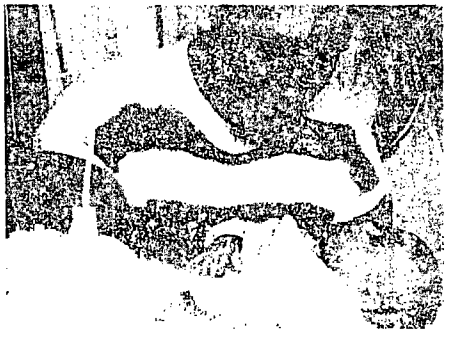
- *Rely on adolescent experts to guide and administer your program.* Expectant teens are a very challenging group and it takes special skills to deal with them.
- *Secure strong administrative support.* Staff members credit the ongoing, visible support of upper management for the hospital's continued funding of the Young Moms Program.
- *Use clients as advocates for the program with funders, community leaders and the media.* They can provide the most compelling argument in support of special services for pregnant teens.

Next steps

- Provide follow-up and ongoing parenting support to mothers after the birth of their babies.
- Improve the participation of fathers in the program.
- Use alumni as mentors for new program participants.

Replicability

The program is replicable at children's hospitals with linkages to maternity hospitals.



Offering home visiting services to disadvantaged families

Healthy Families America

Abstract

Healthy Families America (HFA) is a national home-visiting initiative that seeks to ensure that all new parents, particularly those facing the greatest challenges, receive the education and support they need prenatally or at the time their baby is born, and continuing throughout the first years of life.

History

Healthy Families America—an initiative of the National Committee to Prevent Child Abuse (NCPCA)—is built on 20 years of research and the experience of numerous communities, beginning with the Hawaii Healthy Start program at Kapiolani Medical Center. HFA was launched in 1992 with a start-up grant from the Ronald McDonald House Charities. Currently, over 250 local HFA sites are operating in 37 states and the District of Columbia. To date, nine children's hospitals are sponsors or co-sponsors of HFA programs in their communities.

Target population

All new parents can benefit from parenting education and support services. However, due to fiscal constraints, most HFA sites offer services to those new parents facing the greatest challenges, such as poverty and social isolation.

Program design and features

All HFA sites adhere to a set of core elements that assist program planners in developing and implementing comprehensive services, while enabling the program to be tailored to the community. The basic approach is as follows:

1. Families are assessed prenatally or at the time of a child's birth to identify those most in need of services. Program enrollment is voluntary.
2. Visits begin weekly and gradually progress to bimonthly, monthly and quarterly. Families may remain in the program for up to five years.
3. Parents learn appropriate parent-child interaction, healthy infant and child development and a host of other parenting and life skills, depending on the needs of the family. Parents work closely with the home visitor to develop an individual family support plan outlining goals and expectations.
4. All families are linked to a medical home to assure optimal health and development and are referred to other appropriate community services, as necessary.
5. Services are provided by staff with limited case loads (i.e., for most communities, no more than 15 families per home visitor).
6. Home visitors receive intensive training and on-going effective supervision.

Contact information

Healthy Families America

- Kapiolani Medical Center for Women and Children, Honolulu, HI
- Children's Hospital and Health Center, San Diego, CA
- Le Bonheur Children's Medical Center, Memphis, TN
- Driscoll Children's Hospital, Corpus Christi, TX
- Connecticut Children's Medical Center, Hartford, CT
- Children's Hospital at the University of Texas Medical Branch, Galveston, TX
- Hughes Spalding Children's Hospital, Atlanta, GA
- Tampa Children's Hospital at St. Joseph's, Tampa, FL
- Arnold Palmer Hospital for Children and Women, Orlando, FL

Contact:
Training and technical support for HFA programs:
Anna Loftus
NCPCA
(312) 663-3520

Specific HFA children's hospitals representatives:
Stacy Collins
NACHRI
(703) 684-1355

Community partners

HFA places a high priority on community collaboration. Children's hospitals' HFA sites work closely with social service agencies, health departments, other hospitals and health care providers and school systems.

Some hospitals have more integrated arrangements. For example, Connecticut Children's Medical Center sponsors an HFA program jointly with three community-based agencies, with each contributing staff and other resources. Other hospitals collaborate with existing HFA sites by offering specific services. For example, All Children's Hospital in St. Petersburg, FL provides evaluation and treatment of children with developmental delays in the Pinellas County Healthy Families program.

At the national level, NCPCA has developed a partnership with NACHRI to advance the HFA model to children's hospitals across the country.

Budget and funding sources

Most hospitals' HFA programs are grant-funded, through private or public sources, or both. Public sources include state departments of health or social services, state Title V programs and children's trust funds. Private sources include hospital foundations and foundations created as the result of for-profit conversions in the health care industry (e.g., the California Wellness Foundation). Hospitals also receive Medicaid reimbursement for certain services.

Conversely, some hospitals have chosen to become involved in HFA as funders. The Children's Hospital of Wisconsin provides support to nine HFA projects in Wisconsin through its Child Abuse Prevention Fund, which receives its funding through employee contributions and private donations.

Evaluation and outcomes

Research over the last 20 years has consistently confirmed that providing education and support services to parents around the time of a baby's birth—and continuing for several months or years thereafter—significantly reduces the risk of child abuse and contributes to positive, healthy child-rearing practices.

Families receiving this type of intensive home visitor service also demonstrate other positive changes, such as consistent use of preventive health services, including immunization; increased high school completion rates (for teen parents); higher employment rates; lower welfare use and fewer subsequent pregnancies. Children's hospitals involved in HFA are also evaluating specific institutional measures, such as emergency room use and rates of pediatric subspeciality care referrals.

Next steps

- Ensure that all states have a multidisciplinary task force of public and private agency representatives working to institutionalize Healthy Families at the state level.
- Implement the HFA credentialing system for all current and future HFA sites.
- Advocate for funding to ensure a permanent nationwide infrastructure for home visitor services.

Replicability

HFA can be tailored to any community.

Healthy Connections

Abstract

Healthy Connections is an infant mortality reduction program, providing intensive perinatal nursing services, with community outreach and home visits, to families who use the hospital's primary care clinics.

History

In reaction to the alarming infant mortality rates among African-American and Hispanic infants, the city of Boston in 1991 undertook an in-depth study of all infant deaths in the city in the preceding 24 months. Results indicated that infant deaths occurred when the care system was fragmented, when it provided no outreach to at-risk families and when it offered few opportunities for patient involvement. In response, Children's Hospital designated $5 million for research and health service programs, including Healthy Connections, to improve outcomes for at-risk newborns.

Target population

Each year the program serves approximately 1,000 mothers and newborns from poor, largely minority Boston neighborhoods with high infant mortality rates.

Program design and features

In-hospital intervention

Healthy Connections works with two Boston maternity hospitals that deliver most of the infants receiving care at Children's primary care sites. Those mothers who indicate they will be using Children's for primary care are visited by a Healthy Connections perinatal nurse within 24 hours of delivery.

The in-hospital visit is a comprehensive intervention that includes assessing family strengths regarding infant care knowledge and availability of support networks; identifying needs, including health insurance, nutrition, primary care for all family members, housing, transportation, mental health and substance abuse treatment; educating families on all aspects of newborn care and post-partum adjustment; and an interactive physical exam and behavioral assessment of the baby.

Every mother receives a Polaroid picture of herself and her baby to place in a booklet containing the infant's appointment record and infant care information. The low literacy booklet, *Your New Baby,* was prepared by the Healthy Connections staff and is available in Spanish, Haitian-Creole and Vietnamese (see Resources chapter for information). An initial well-baby appointment is scheduled and all hospital information is transmitted directly to the primary care provider.

Contact information

Healthy Connections
Children's Hospital
300 Longwood Avenue
Boston, MA 02115

Contact:
Constance Keefer, M.D.
Child Development Unit
(617) 355-6948

Community outreach
The perinatal nurse telephones the mother 48 hours after discharge to assure the infant's health and the parents' adjustment. If a family misses its well-baby appointments, the program's community health liaison makes a home visit to re-establish the family's connection to primary care. The community health liaison can assist with transportation, housing, welfare benefits and other immediate needs of the family.

Community partners

In addition to the maternity hospitals, Healthy Connections staff work closely with prenatal care clinics and the Visiting Nurse Association of Boston to identify at-risk pregnant and post-partum women. With most client families residing in public housing, the program has also established partnerships with the Boston Housing Authority on injury prevention and health education initiatives and the Massachusetts Union of Public Housing Tenants to train neighborhood perinatal outreach workers.

Budget and funding sources

The program's budget of $112,000, financed by the department of pediatrics, covers the salaries of a nurse practitioner and a registered nurse, data management and support services, and supplies. The salaries of the community health liaison and the medical director are funded through other departments.

Evaluation and outcomes

The program has documented a 75 percent decrease in the rate of emergency room visits in the first month of life (roughly $50,000 in savings per year); a dramatic increase in the rate of kept well-baby visits at two, four, and six months; and an increase in immunization rates. Newborn health records are now available at virtually 100 percent of first well-baby visits and primary care providers report increases in their efficiency and effectiveness during first visits with the newborn and family.

Objectives

- To develop secure attachment between the family and primary care provider
- To identify and reduce barriers to care
- To provide comprehensive, in-hospital assessments of mother and newborn
- To provide infant care information in useable form for parents.

Lessons learned and advice to others

- *Keep good cost data on your program.*
- *Demonstrate the savings from reduced emergency room usage and improved efficiency among the primary care practitioners.* Such data provides evidence for continued funding of perinatal outreach programs.

Replicability

The program is replicable at children's hospitals that offer primary care services.

Parent Aide Program

Abstract

The Parent Aide Program is a child abuse prevention and family support project providing lay home visitation, parent education and peer support groups for young families at risk for abuse and neglect.

History

Launched in 1976, the Parent Aide Program was developed as a follow-up service for at-risk families discharged from the Children's Hospital and Health Center's inpatient and intensive care units. As the only hospital-based early response system for at-risk families in San Diego at that time, the Parent Aide Program quickly became a referral source for other hospitals, pediatricians and social service providers in the area.

Target population

The program targets single, isolated parents, particularly those with childhood histories of abuse or neglect; parents of medically fragile or special needs children with few support systems; mothers with alcohol and other drug use histories; and teen parents.

Program design and features

Upon entering the program, families are offered both individual and group services, depending on their needs. Services include a 10-session parent education course and a bimonthly mothers' support group. Services are offered at the hospital and free, on-site child care is provided. Families needing more intensive help are matched with a parent aide—a trained community volunteer who works with the family in the home to provide emotional support, good parent modeling and help in securing community resources.

The unique feature of the Parent Aide Program is its incorporation of volunteers into all program services. Parent aides are asked to give a one-year commitment to the program, during which they serve an average of six hours per week. Parent aides receive 27 hours of initial training, weekly supervision and monthly in-service education. Volunteers also serve as child care workers and as "special friends" (a big brother/big sister style relationship) for children in the program. Most volunteers are college-educated professionals under the age of 30.

Community partners

The Parent Aide Program's referral partners include area hospitals, physicians, social service agencies and the county child protective services system. The Parent Aide Program has also formed a partnership with the San Diego Child Abuse Prevention Foundation to jointly sponsor

Contact information

Parent Aide Program
Children's Hospital and Health Center
3020 Children's Way
San Diego, CA 92123

Contact:
Diana Champion
Center for Child Protection
(619) 576-5910

community educational programs and volunteer training workshops. The San Diego Exchange Club/National Parent Aide Network has also recently joined with the program to help recruit volunteers, provide financial support and expand community parenting classes.

Budget and funding sources

The program budget is approximately $50,000, which supports a program administrator/volunteer coordinator, a parent educator and a part-time secretary. Revenue sources include parenting class registration fees, the hospital's foundation, the San Diego Child Abuse Prevention Foundation and other private sources.

Evaluation and outcomes

Mothers participating in the program have shown decreased maternal stress and improved understanding of appropriate discipline, with a resulting decrease in reports of child abuse.

The program was named the 490th "Point of Light" by President Bush in 1991, and received the 1991 American Hospital Association "Program of Excellence" award.

Lessons learned and advice to others

- *Start small.*
- *Secure strong administrative support for the program.*
- *Involve a broad cross-section of hospital staff in planning.*
- *Collaborate with as many community agencies as possible.*
- *Demonstrate the value you place on your volunteers* through in-service training, quality supervision and regular recognition events.

Objectives for participating families

- To reduce the level of risk for child abuse and neglect
- To increase ability to establish trusting relationships and utilize community resources
- To reduce children's isolation through individual and group services
- To enhance health and lifestyle habits of family members
- To increase ability to view children as individuals with separate needs and feelings
- To demonstrate use of age-appropriate discipline
- To enhance help-seeking behavior during stressful times

Next steps

Secure additional foundation funding—a challenging task, given the trend in the child welfare community toward staff model home visiting programs.

Replicability

The program is replicable and specific program materials, including staff and volunteer job descriptions and training outlines, are available on request.

Family Network

Abstract

Family Network is a community and home-based intervention program for pregnant and parenting women, infants and families who are at very high risk for poor birth outcomes, developmental delay and child abuse and neglect.

History

Boston is one of 22 cities involved in "Healthy Start," a federal grant program for rural and urban communities with infant mortality rates 1.5 to 2.5 times the national average. The city is working to reduce the infant mortality rate by changing the way health care is delivered to at-risk groups. With funding from the Boston Healthy Start Initiative, the Children's Hospital and the Visiting Nurses Association developed a program to serve the often invisible population of pregnant and parenting women who do not access or appropriately utilize the health and ancillary services available.

Target population

The program is aimed at pregnant and parenting women residing in the service area of Children's primary care clinic—the Martha Eliot Health Center—who have no regular source of health care.

Program design and features

The Family Network program is based on a team approach involving a registered nurse—who coordinates the family's medical care—and a paraprofessional family health advocate—who conducts on-going home visits with the family, arranges for needed psychosocial and other ancillary services, teaches parenting and nurturing skills, and, most importantly, provides the vital link between the family and the health care system. A mental health professional also provides support to clients in need.

Referrals are accepted on clients who are discharged from other programs for lack of compliance and women who are hard to engage due to multiple problems such as substance abuse, family violence and transient living arrangements. Family health advocates also conduct outreach in neighborhoods and at public events. A unique aspect of Family Network is the staff's commitment to remain accessible to women who normally reject intervention or services. Repeated and persistent attempts to contact at-risk women results in 95 percent of them eventually accepting help.

Services, offered in both the home and health center, include a full range of case management and primary health care services (see box). Clients receive on-going services based on the levels of risk and need, during the perinatal period and up to one year after birth.

Contact information

Family Network
Children's Hospital
300 Longwood Avenue
Boston, MA 02115

Contact:
Francine Azzara
Martha Eliot Health Center
(617) 971-2301

Community partners

The Family Network program relies on the Visiting Nurse Association of Boston for skilled nursing services. Family Network staff also coordinate services and advocacy efforts with other Boston Healthy Start grantees.

Budget and funding sources

The program's budget of $244,000 is funded through grants from the Boston Healthy Start Initiative and the Massachusetts Department of Public Health.

Evaluation and outcomes

Of babies born to program participants,100 percent are immunized, 100 percent have an identified primary care provider and 64 percent are breastfed.

The program has also improved self esteem of the mothers, birth outcomes and compliance with care, and decreased use of the hospital emergency room for routine care. Family Network has been selected as a model home visiting program by the Massachusetts Department of Public Health.

Lessons learned and advice to others

- *Make a long-term commitment to the program.* Families with multiple problems need continuous care to improve their lives. Moreover, communities depending on outreach programs often lose trust in the sponsoring institution when the program suddenly disappears for lack of funding.
- *Build in adequate support and training for the staff.* Staff working with families with multiple needs are often at risk for burn out and need regular recognition, professional supervision and quality continuing education.

Services

- Prenatal, postpartum and pediatric nursing care
- Health assessment and monitoring
- Parent education
- Developmental screening
- Breast-feeding instruction and support
- Nutrition counseling
- Mental health counseling
- Substance abuse services
- Subsidized housing referral

Next steps

- Hire an educational specialist to work with mothers in the program to improve their literacy skills.
- Secure funding for a teen life center, where pregnant and parenting teens can receive life skills and parenting instruction.
- Conduct pregnancy prevention education with pre-teens.

Replicability

The program is replicable at children's hospitals that offer primary care.

HIPPY—Home Instruction Program for Preschool Youngsters

Abstract

The Home Instruction Program for Preschool Youngsters (HIPPY) is a home-based early intervention program that helps parents provide educational enrichment for their preschool age children.

History

HIPPY was developed in 1969 by a team of early childhood educators at Hebrew University of Jerusalem in Israel. Since its inception, HIPPY has grown into a worldwide movement adapting a curriculum—originally designed for undereducated parents in Israel—to local communities on five continents. Introduced in the United States in 1984, the HIPPY program is now used in 28 states. The Children's Hospital of Arkansas sponsors the nation's only HIPPY State Training and Technical Assistance Center, providing services to 30 HIPPY sites throughout the state.

Target population

The HIPPY program is designed for parents with preschool age children (ages 3 to 5) who may not feel confident in their own abilities to teach their children.

Program design and features

The HIPPY curriculum, presented over the course of two years, is primarily cognitive-based, focusing on language development, problem solving, logical thinking and sensory discrimination skills. Every other week, paraprofessionals make home visits to role play HIPPY activities with parents.

On alternating weeks, group meetings are held. During group meetings, paraprofessionals and parents role play the week's activities and an enrichment activity focusing on parenting and family life issues is offered. Parents enrolled in the program commit to spending 15 to 20 minutes a day doing HIPPY activities with their children.

In Arkansas, HIPPY programs are sponsored by a variety of organizations, including schools, educational cooperatives, universities, Head Start agencies and other community-based organizations. The role of the State Training and Technical Assistance Center based at the hospital is to provide initial training for all new HIPPY home visitors, sponsor in-service training and regional and statewide seminars on early childhood issues and provide a networking forum for HIPPY coordinators.

Contact information

HIPPY—Home Instruction Program for Preschool Youngsters
Arkansas Children's Hospital
1120 Marshall Street
Little Rock, AR 72202

Contact:
Barbara Gilky
Arkansas State HIPPY Director
(501) 320-3671

Community partners

HIPPY programs work closely to coordinate services with other community agencies, including health departments, school districts, human service departments and literacy councils.

Budget and funding sources

Costs are approximately $1,000 to $1,500 per child each year over two years. This estimate is based on an average of 60 families in the first year and 120 families in the second year. Most HIPPY programs are staffed with a full-time coordinator and one paraprofessional home visitor for every 12 participating families. Arkansas HIPPY programs receive funding from several private and public sources, including Title IV, Head Start, Even Start and the Americorps Program.

Evaluation and outcomes

Extensive research in Israel shows HIPPY benefits children by improving academic achievement and adjustment to school, reducing the need for children to repeat grades and increasing the rate of school completion. Parents become more involved in their children's education, develop higher self-esteem and pursue further education for themselves. The U.S. Department of Education is now funding the first systematic evaluation of HIPPY in the United States. Preliminary findings of first grade teacher ratings suggest that participating in HIPPY may have a positive effect on children's ability to adapt to the classroom, an important component of school success.

Next steps

The national parent organization—HIPPY USA—is committed to on-going curriculum development integrating current research in emergent literacy and the experience of HIPPY program providers and parents. An advisory group consisting of academicians, practitioners, parents and paraprofessionals has been established to support this process.

Replicability

The HIPPY program is highly replicable. HIPPY USA has produced a start-up manual and a guide to fund-raising for prospective HIPPY sites. For more information, contact HIPPY USA at (212) 678-3500.

Creating family and child centers to provide services and support to families

Family Care Connection

Abstract

The Family Care Connection (FCC) is a network of four neighborhood-based drop-in centers providing primary and preventive health care, respite care, parenting education, substance abuse treatment and other support services to at-risk families.

History

The Family Care Connection was established in 1989 when Children's Hospital of Pittsburgh received grants from the U.S. Department of Health and Human Services, the Howard Heinz Endowment and the Scaife Family Foundation to establish a family support program for at-risk families in Allegheny county. The program was inspired by a local pediatrician, who had worked in a neighborhood health clinic and believed poor families needed more than traditional medical care to ensure the healthy development of their children. Her vision led to the development of the first "drop-in" center, offering family support services as well as preventive health care. The model's success in improving maternal and child health led to the opening of three other centers. This network of community-based drop-in centers forms the Family Care Connection program.

Target population

The Family Care Connection targets families in four communities in Allegheny County—Rankin, Braddock, Wilkinsburg and Turtle Creek/East Pittsburgh—which were selected for their high rates of poverty, low birth weight and inadequate prenatal care. All families residing in these targeted communities are eligible to participate in the FCC program. The program serves approximately 1,000 families a year.

Goal and objectives

- The goal of the FCC program is to improve the health of children and families in low-income neighborhoods. Its objectives are:
- To improve access to health care for children in poor communities.
- To provide medical, mental health and social services to enhance the health of children and families.
- To enhance child development and prevent infant mortality and low birth weight.
- To prevent child abuse and neglect.
- To prevent and treat parental drug abuse.
- To provide emergency respite care for at risk children.

Contact information

Family Care Connection
Children's Hospital of Pittsburgh
One Children's Place
3705 Fifth Avenue
Pittsburgh, PA 15213

Contact:
Cindy Graffius
Manager, Prevention Programs
(412) 692-8666

Program design and features

Each FCC project is located within a well-established community agency that has invited the FCC to be located on-site. The host agency provides free space and works to complement its program and staff with those of the FCC. This collaboration with an existing agency helps to ensure that community residents do not view the FCC program as foreign or transient. The four centers are located at a Boys and Girls Club and other community service agencies.

FCC staff includes a physician, site coordinators, nurses, a substance abuse services coordinator, family support workers and lay parent educators. The FCC also contracts for licensed substance abuse, respite care, literacy and mental health professionals to provide services at the drop-in centers and/or in the home.

The hallmark of the FCC program is its flexibility in providing services. Families can choose the services they like, how often they will participate and in many cases, whether they receive the services in their home or at the drop-in center. The four centers are located within walking distance of most families in the community.

Services

Services provided by the FCC

- Family case management
- Nurse home visiting
- Pediatric primary care
- Developmental assessment
- Child development and infant stimulation
- Overnight respite care for children
- Clothing
- Transportation assistance
- Substance abuse treatment
- Housing assistance
- Parenting and health education
- Individual and group counseling

Services provided by the host agency

- Food bank
- Energy assistance
- Job training and literacy programs
- Recreational activities for older children

Community partners

The FCC and its host agencies in each neighborhood are true partners, coordinating their work with families and offering an array of services that would not otherwise be as extensive. The FCC also works closely with the public health department to identify and provide services to pregnant women.

Budget and funding sources

The FCC's annual budget of $940,000 is funded through a mix of private foundation and federal grants. Foundations include Alcoa, Hearst, Heinz Endowments and the Scaife Family Foundation. Federal grant sources include the Maternal and Child Health Bureau, HHS Office of Community Services and NCCAN. The program receives third party payments for selected services and also has a contract with the Allegheny County Children and Youth Services to provide home visiting.

Evaluation and outcomes

The FCC has contributed to reductions in infant mortality and low birth weight and improvements in first trimester use of prenatal care in the communities it serves.

Lessons learned and advice to others

- *Hire a grant writer for your program.*
- *Find partners with similar philosophical principles and compatible working styles.*
- *Hire your staff from the communities you serve.*
- *Seek revenue streams in addition to grant funding.*

Next steps

- Seek third-party payment for more services.
- Create designated funding streams for each FCC site.
- Work to promote the FCC as a model for systemwide change in Allegheny County.

Replicability

The program has been replicated in the state of Pennsylvania. Technical assistance is available for other children's hospitals wanting to replicate the program in their own service areas.

The Parenting Center

Abstract

The Parenting Center is a primary prevention program offering support and education to parents of children from birth through adolescence.

History

The concept of a Parenting Center serving New Orleans families began to take shape in 1977, when the local Junior League chapter conducted a community-wide needs assessment. Input from more than 60 civic, religious, judicial, social service and educational leaders indicated a need for a primary prevention program focused on parent training.

The Junior League approached Children's Hospital and together they developed a proposal for a parenting center, funded with a 4-year $90,000 start-up grant from the League. An advisory board, composed of five hospital board members, five Junior League members and five community representatives, was formed to oversee the operations of the center. Following two years of development and preparation, the Center was opened to the public in the summer of 1980. In 1982 the Parenting Center became a department of the hospital and is now considered a major component of the hospital's mission.

Objectives

- To promote confidence and competence in parents.
- To encourage optimal child development.
- To enhance the well-being of the family as a whole.

Target population

The program is open to all parents in New Orleans and surrounding communities.

Program design and features

The Parenting Center has attained broad public appeal because of its emphasis on programming to address universal concerns of parents. Most programs are conducted at the Parenting Center, which is located at the hospital. Parents have the opportunity to become members of the Center and receive reduced class fees, resource library privileges, a newsletter subscription and use of the drop-in play space for parents and children under 4.

Programs and services include:

- *Parent/infant/toddler program* (ages up to 4), including classes, a drop-in center, support/play groups, a resource library, on-site child care for class participants, daily summer enrichment activities and individual counseling.

Contact information

The Parenting Center
Children's Hospital
200 Henry Clay Avenue
New Orleans, LA 70118

Contact:
Donna Newton, M.Ed.
Director
(504) 896-9365

- *Warmline,* a volunteer-run telephone advice service for parenting concerns.
- *Brown bag seminars* for working parents, offering work site parenting classes for area employers.
- *Evening parenting classes* on discipline, child development, communication, and age-specific topics (e.g., for parents of toddlers, school-age children and adolescents).
- *Step family programs,* including specialized support groups and classes.
- *Separation and divorce counseling,* to help parents address child behavior and adjustment issues.
- *Community outreach seminars* for Head Start programs, public schools, churches and other organizations.
- *Public relations activities,* including periodic interviews with and articles submitted to the print and broadcast media.

Community partners

The Parenting Center has established a variety of community partnerships for time specific and on-going projects. For example, using a grant from the Louisiana Trust Fund in 1995, the Parenting Center joined with the Catholic Archdiocese and the New Orleans Family Services to sponsor a five-week parenting series on the local public television station. Examples of on-going partnerships include the Step Family Association of Southeast Louisiana, with whom the Parenting Center coordinates education events and support programs; and maternity program at other hospitals, for whose patients the Parenting Center provides specialized classes.

Guiding principles

- Parents know their children best.
- Parenting skills are not instinctive—but can be learned and developed.
- Parenting education is crucial for optimal child development.
- Parenting education is essential for the prevention of child abuse and neglect.
- Information about child development is eagerly sought by new parents.
- Many parents do not have access to extended family and other traditional support systems.

Budget and funding sources

The Parenting Center's $200,000 annual budget is derived from individual membership fees, program fees, foundation support and fund-raising events, and general hospital funds. The budget includes the salaries of a director, an assistant director, two parent educators and support staff.

Evaluation and outcomes

Evaluations are conducted following each educational program and periodic satisfaction surveys are conducted for Warmline customers. Overall, evaluations indicate a high degree of satisfaction with Parenting Center services.

Lessons learned and advice to others

• *Target your services to highly motivated groups,* such as first time parents, parents of pre-adolescents and step-parents. Although most parents will find instruction helpful, the Louisiana experience demonstrated that these particular audiences have the highest degree of interest and are therefore a reliable revenue stream for the program.
• *Give your parenting education program an actual identity.* The credibility and visibility of your program will be enhanced if it is a stand-alone project—like the Parenting Center—and not an activity of an existing hospital department.

Next steps

• Explore the possibility of marketing the Parenting Center's services to HMOs and other insurers. The Parenting Center may be offered as part of the hospital's package of pediatric services.
• Offer more professional training. Staff plan to broaden the effectiveness of the program by training professionals who interact regularly with children and families, including teachers, day care staff, youth development workers, and mental health specialists.
• Explore the development of a web site on the Internet.
• Work with television stations to develop public service announcements and other programming to reach more parents.

Replicability

The program is highly replicable and Parenting Center staff are available for consultation and technical assistance to other children's hospitals.

Decker Family Development Center

Abstract

The Decker Family Development Center is a comprehensive program providing predominantly low-income families with young children with a convenient "one-stop" location for social, mental health, medical and educational services.

History

In the late 1980s health and social service providers in the Akron area formed a coalition to explore ways to overcome the problems created for poor, multiple-risk families when these services are bureaucratically and geographically scattered. The 25-member group—called the Akron-based Coalition for Early Intervention—set out to develop a model for the ideal program to provide all the services at-risk families need. According to a community assessment, problems—such as lack of transportation for families and lack of coordination among service providers—were particularly acute in Barberton, an economically distressed community with some of the highest teen-pregnancy and school-drop-out rates in Summit County.

The coalition, led by a team of representatives from the Children's Hospital, the University of Akron and the Barberton City Schools, prepared a proposal for a comprehensive family service center, which would be housed in a vacant elementary school. The coalition was awarded a $1 million grant from the Ohio Department of Education as part of its school drop-out prevention initiative, and the Decker Center opened its doors to families in 1990.

Goals

- To enable parents to recognize that they are the first and most significant teachers in their children's lives.
- To provide parents with the support, parenting skills and education to help their children reach their developmental potential.
- To work with children as infants, to promote their self-esteem and to enhance the probability that they will remain in school and complete their education.
- To have all preschool children developmentally ready to enter kindergarten.
- To provide multidisciplinary services to special needs children so that they may reach their full potential.
- To provide encouragement, education, training and support services to families, to enable them to become self-sufficient members of society.

Contact information

Decker Family Development Center
Children's Hospital Medical Center of Akron
One Perkins Square
Akron, OH 44308

Contact:
Mary Frances Ahern, L.I.S.W.
Program Director
(330) 848-4264

Target population

The program is designed for parents on public assistance with children under age 5. Decker currently serves approximately 150 parents and 200 preschool children.

Program design and features

The Center's holistic, family-centered approach provides parents and their preschool age children with the opportunity to access medical/health, educational and social support at a single site. Many services are offered at the Decker Center to benefit participating parents and their preschool children (see box).

In addition to being one of the nation's first comprehensive family service centers, Decker is also distinct as a truly collaborative model between a hospital (Children's), a school system (Barberton), and a university (Akron). Representatives from the three institutions comprise the senior management team for the Center. Each institution also provides staff and services: Children's Hospital provides the center's director, nurse practitioner, pediatrician, social workers and mental health personnel; the University of Akron's Department of Elementary Education provides the early learning and preschool instruction staff and evaluation services; and Barberton City Schools provides the facility crew, adult education and training staff and serves as the fiscal agent for the program.

Services

Services for parents

- Child care
- Parent education classes
- Family literacy and GED classes
- Case management services
- Legal and financial assistance
- Public assistance determination
- Mental health services
- Nutrition education
- Pre-employment training
- Home visitor and outreach service

Services for children

- Pediatric health care
- Parent/child play groups
- Infant and toddler stimulation program
- Head Start
- Special needs preschool
- Developmental kindergarten
- Foster grandparenting
- Speech and hearing services
- Occupational therapy and physical therapy services

Community partners

The core Decker Center partnership is augmented with extensive programming support from 20 other community agencies, including the Barberton Health Department, the Akron Metropolitan Housing Authority, the Barberton Public Library and others.

Budget and funding sources

The Decker Center's $1.6 million budget is supported primarily by grants and contracts from state and federal sources including the Ohio Department of Education, Head Start, the JOBS (Jobs Opportunity Basic Skills) program, and the U.S. Department of Education's "Even Start" (family literacy) and Adult Basic Education programs. Additional funding sources include Medicaid, state child care contracts and foundation grants.

Evaluation and outcomes

Data from the Decker Center's first five years of operation indicate important health and education gains. All of the children are up to date with their immunizations; on average, children who participate in programming grow 22 percent beyond normal (non-intervention) rates. Children have also improved in their social and cognitive skills and fewer Decker Center children require special education classes at the elementary school level than do their non-intervention counterparts. During any one year, 10 percent of the adults exit the program with a GED and 11 percent leave with a job or move on to college or trade school.

The Decker Center has received numerous awards in the past three years, including an American Hospital Association NOVA award (1994), a Barbara Bush Family Literacy Award from the Barbara Bush Foundation (1994), a Secretary's Award for Excellence in Community Health Promotion from U.S. Department of Health and Human Services (1995), an Ohio Best Practice Award for Educational Partnerships (1995), and an award from the National Center for Community Education as an exemplary community/school partnership (1996).

Lessons learned and advice to others

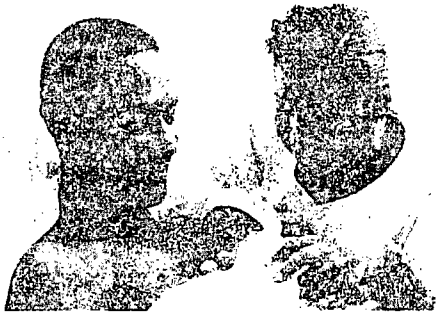
Decker Center staff credit their success on a model for collaboration they have coined "DISNI," which requires participating organizations to:
Devoid yourself of organizational territorial issues.
Increase communication.
Share authority and power.
Negotiate goals and objectives, then work toward their successful implementation.
Have an **I**ntense sense of shared ownership in the collaborative model that is publicly displayed.

Next steps

- Undertake a building enlargement and remodeling project that will create more classroom and medical space.
- Advance the Decker Center nationally as the prototype for family and child services of the future.

Replicability

The Decker Center model is highly replicable. Program staff routinely present the Decker model and results of research at professional meetings and conferences and are available for individual consultation.



Resources

Resources

Children's hospitals' resources

Great Kids Program, developed by the Children's National Medical Center, Washington, D.C., is a working parents' seminar designed to teach step-by-step solutions to common parenting problems, encourage parents to make real changes to improve the quality of family life and help parents obtain the skills needed to raise well-adjusted children. Parents learn essential survival tips, ways to develop their children's self-discipline and the know-how to reduce the stress of parenting, especially within a two career family. The slide program and script can be presented at work sites over the course of four, one-hour sessions. To order, contact Ellie Runion at (202) 884-2338.

Your New Baby, written and designed by the staff of the Division of General Pediatrics at Children's Hospital, Boston, is an illustrated guide for the care of the newborn in the first year of life. The easy-to-read booklet, originally written for the hospital's Healthy Connections program, was also commissioned by the Boston Healthy Start Initiative for free distribution to community clinics in Boston. The booklet is available in English/Spanish, English/Haitian Creole and English/Vietnamese versions. The cost is $1.25 per copy and $1.10 per copy for orders of 100 or more. To order, contact Joan Lowcock at (617) 355-6714.

The Family Institute at Kapiolani Medical Center for Women and Children provides training and technical assistance for home-based family support programs, conducted by trainers with extensive professional experience with culturally diverse groups in the United States and abroad. The Family Institute has also published its own parent education curricula, which were designed for Hawaii's Healthy Start home visiting program and are available for purchase. For information, call (808) 944-9000.

Other resources

Healthy Steps for Young Children, sponsored by the Commonwealth Fund, is a national initiative to help parents foster the healthy growth and development of their very young children. With support from the Commonwealth Fund, as well as matching funds from local donors, 15 sites across the country are participating in a national evaluation to test a new approach to pediatric care that offers an expanded set of services, emphasizing the role of parents in nurturing their children's physical,

emotional and intellectual development. A number of children's hospitals, including those in Houston, Pittsburgh, Honolulu, Asheville and Los Angeles, are participating in this program. The Healthy Steps for Young Children Program has a home page on the World Wide Web (www.healthysteps.org) that contains background information on the program, provides details about current and on-going activities and links Web users with program documents. For more information, contact the Commonwealth Fund at (202) 606-3840.

Parents as Teachers (PAT) is an award-winning early childhood parent education program for parents of children up to age 5. The PAT program is based on the belief that experiences in the beginning years of a child's life are critical for laying the foundation for school success and that parents are their children's first and most influential teachers. PAT offers families regularly scheduled personal visits by certified parent educators who provide information on the child's development and ways to encourage learning, group meetings with other parents and periodic screening for early detection of developmental problems. The PAT initiative has spread to 47 states and five foreign countries. In St. Louis, Missouri, a parent educator from the local PAT program meets regularly with NICU staff from Cardinal Glennon and St. Louis Children's Hospital to identify families who might benefit from the program. For information about Parents as Teachers, or to inquire about PAT programs in your state or community, contact Kate Ball at the Parents as Teachers National Center at (314) 432-4330.

National Center for Family Literacy (NCFL) is a training and research organization that seeks to break the inter-generational cycle of under-education and poverty by improving parents' basic skills and attitudes toward education, their parenting skills and their children's pre-literacy and school readiness skills. NCFL has an extensive publication list and offers a wide array of workshops and technical assistance. For information, contact NCFL at (502) 584-1133.

The mission of NACHRI is to promote the health and well-being of children and their families through support of children's hospitals and health systems that are committed to excellence in providing health care to children. It does so through education, research, health promotion and advocacy.

As part of its recently expanded mission, NACHRI builds public support for improving children's health, education, safety and security and works in alliance with others in the health care profession and the public to advance an accessible and medically appropriate continuum of care for children.

National Association of
Children's Hospitals
and Related Institutions

401 Wythe Street
NACHRI Alexandria, VA 22314

April 1997

cc: Jen K.
Nicole R
(+ return)

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May 9, 1997

The Honorable Elena Kagan
Deputy Assistant to the President
for Domestic Policy
The White House
Washington DC 20500

Dear Ms. Kagan:

Many of the nation's most daunting problems concern the segment of our population that carries our greatest hopes for the future—our children.

The quandaries cut across class and economic lines. Poverty may be the most massive—it is jolting to realize that one of every five American children lives below that line—but middle class parents also face tough challenges these days. All of us worry about the threats of drugs, violence, teenage pregnancy and sexually-transmitted diseases. All of us struggle to give our children and grandchildren access to good schools, decent day care and quality health services.

RAND has been working on these very issues for over a quarter of a century, always in the same fact-based, nonpartisan vein and always with the goal of identifying policies that can succeed. This timely edition of RAND Research Review describes some of our recent projects and findings. It appears just as welfare reform is taking effect, as a child health care bill is being debated, and as the other issues noted above remain in the headlines. I trust it will enrich your own efforts to improve the lives of our young people.

Sincerely,

JAT:sm

Enclosure

RAND RESEARCH REVIEW

Spring 1997 | Focus on Children | Volume XXI, Number 1

'We are in desperate need to learn about what works'
—Douglas Nelson, Annie E. Casey Foundation

Preschool Years: As the Twig Is Bent

Day care, and its effects on child development, is shaping up to be one of the most crucial and emotionally charged issues of welfare reform. If the reforms work as intended, many more mothers who now stay home with their children will be joining the workforce.

Recent research on brain development provides dramatic proof of the importance of a nurturing, secure and stimulating environment in the first three years of life. If mothers are out working, however, the quality of child care provided by others will largely determine how well the children fare. To care for their children, many mothers will rely on relatives and friends, some of whom will be loving and attentive and some of whom will not.

Also, the strain on the day-care system is a matter of grave concern to child-development and child-care experts. A recent study found that 40 percent of day-care centers for infants and toddlers gave less than the minimal standard of care. Problems ranged from safety hazards to unresponsive caregivers to a lack of toys.

Another newly published study finds that child care for the working poor in California can cost up to 90 percent of a parent's minimum-wage income. And the system—

Head Start—for poor kids, a much-needed leg up in a highly competitive world.

even before the effects of the reforms are felt—is unable to meet much of the state's need, particularly for the care of infants.

The challenge for state governments, which now have the lion's share of responsibility for day-care programs, is to oversee and subsidize child care in such a way as to increase the likelihood of good outcomes for children. This is true regardless of welfare reform, of course. Bad day care can harm the development of any child. Research has shown that children benefit when caregivers are trained and the ratio of staff to children is high. But high-quality care is expensive, and states will have less money to subsidize day care as block grants replace the more generous federal entitlements that were swept away in the tidal wave of welfare reform.

In deciding how to invest their smaller share of federal funds, states may wish to emulate already established programs specifically aimed at helping the development of young children. The most notable of these models is Head Start.

High-quality day care. A crucial difference.

"Americans want to help poor children without subsidizing their parents, and that's tough." A children's advocate.

Children and Welfare: Investing in What Works

In the ideological wars now raging over the impact of welfare reform on poor children, it is easy to forget that risks to young people in our society know no class or economic boundaries. Violence, drugs, teenage pregnancy and sexually transmitted diseases are problems that haunt the dreams of middle-class and poor parents alike. So, too, are mundane, but no less troubling, issues of access for their offspring to health care, good schools and high-quality day care.

No matter how parties to the debate see the problems—as systemic or essentially confined to the poor—there is no doubt that a large segment of America's children are in trouble. Consider these statistics: 21 percent of U.S. children currently live in poverty. That's a 46 percent increase since 1975, and higher overall than any comparable rate in another Western country or in Japan. Our children have neither the financially stable families of Japan, where only 1 percent of births occur out of wedlock, nor the abundant state support that is provided in Europe. Many children are simply falling through holes in the safety net. Reported and confirmed cases of child abuse and neglect are increasing rapidly—from 700,000 substantiated cases in 1990 to 850,000 just two years later—and though some of the rise is due to more stringent reporting requirements, it is still an alarming statistic. For children between 5 and 15, homicide rates have tripled and suicide rates have quadrupled since 1950.

Such trends have disturbing implications for the nation's future health and prosperity, and they raise an inescapable question: What investments must we make in these children as they grow to adulthood to prepare them to be parents, to work productively, and to share in mainstream aspirations?

Social policy research has a vital role to play in guiding the vast changes that are now under way as Congress and the Clinton administration seek to cut welfare spending by $54 billion over seven years. But assessing the patchwork quilt of state and national programs directed at children presents an immense challenge for researchers, even without the sweeping changes welfare reform will introduce. Since so many policies are changing at once—all with potential effects on employment, childbearing and family incomes—figuring out which questions to ask may be as difficult as finding the answers. And the swirling political currents over race, economics and values—for example, cutting property taxes versus investing in schools—make determinations of "success" or "failure" highly subjective.

"We are in desperate need to learn about what works," said Douglas Nelson, executive director of the Annie E. Casey Foundation, a Baltimore-based philanthropy known for its generous support of research on children's issues.

In such a climate, RAND can make a uniquely valuable contribution because of its long tradition of empirical, bipartisan research on domestic social issues—or, put less formally, a reputation for sticking to the facts and staying clear of politics. Examining what RAND researchers have already learned—in relatively calm waters—about the effects on children of current programs and policies will help to establish a baseline from which to gauge the impact of the reforms. It will also take us a considerable distance toward answering questions about what works and what doesn't. In this issue of the *RAND Research Review*, we survey the results of some of those studies.

The Editor

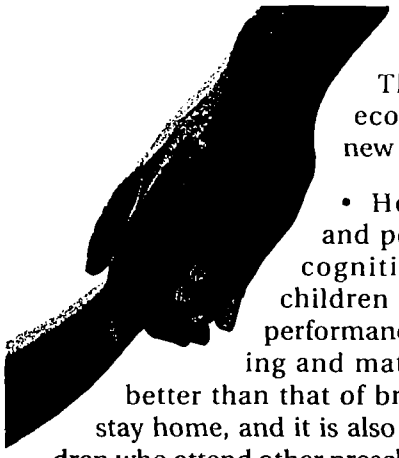
Does Head Start Make a Difference?

Head Start is a federal matching grant program that aims to improve the learning skills, social poise, and health of poor children so they can start school on an equal footing with their more advantaged peers. Begun in 1964, Head Start has long been regarded as the jewel in the crown of anti-poverty programs, enjoying great public and bipartisan support. By 1993, 622,000 children—about 28 percent of eligible 3- to 5-year-olds—were being served at a cost of $2.2 billion a year.

The many past evaluations of Head Start, while generally upbeat in their assessment of the program's effects on school attendance and children's health, have uncovered a troubling issue. Gains in cognitive test scores appear to disappear after a few years. This fade-out effect has led some critics to label the program a scam, arguing that it has little, if any, long-run benefit for children.

A recent RAND/UCLA study reexamines the program's effectiveness using a large national database and rigorous methodology. Researchers Janet

IN THIS ISSUE



Currie, a RAND consultant, and Duncan Thomas, a RAND staff economist, provide some new and useful insights.

- Head Start has positive and persistent effects on the cognitive achievement of children in the program. Their performance on vocabulary, reading and math tests is significantly better than that of brothers and sisters who stay home, and it is also better than that of children who attend other preschool programs.
- Unlike previous studies of Head Start that have demonstrated the fading of gains on test scores, the RAND/UCLA analysis distinguishes children by race and ethnicity. It shows that, for white children, the positive effects on test scores persist well into adolescence. Further, Head Start attendance lowers their chances of having to repeat a grade in elementary school.
- African American children who complete a Head Start program also have large and significant test score gains—on a par with their white schoolmates. But the gains are quickly lost. Moreover, for them, participation in the program has no effect on the probability of grade repetition.
- Regardless of race, children attending Head Start or other preschools benefit from greater access to preventive health services than children who do not attend. Immunization rates are higher, for example. However, there is no measurable effect of Head Start on longer-run indicators of health and nutritional status, such as child height-to-age measures.
- In a subsequent analysis, Currie and Thomas found that Head Start participation also resulted in large gains for Hispanic children. Compared with their stay-at-home siblings, Hispanic children in Head Start programs were able to narrow the test-score gap with white children by at least one-quarter and close the gap in the probability of having to repeat a grade by two-thirds.

But just as there are differences between whites and African Americans, so there is variation in how well subgroups of Hispanic children fare. For example, children of Puerto Rican mothers reap little benefit from Head Start, even if the mothers are American-born, but the gains of children of Mexican mothers, whether born here or in Mexico, are substantial and persistent.

In sum, these studies show that for white children and for most Hispanics, Head Start is a true success story, giving poor kids a much-needed leg up in a highly competitive world. But the puzzle of why some groups benefit less than others remains. Perhaps the answers lie elsewhere—in the quality of the programs they attend, in the families and neighborhoods they live in, or in the schools they subsequently attend. As important as those questions are, they will go unanswered until better, more richly detailed data become available.

How Do Parents Choose?

Obviously, day care is not solely a problem for the poor; it is a matter of vital concern to working parents no matter where they stand on the economic ladder.

A study led by RAND economist Arleen Leibowitz sheds some light on how working parents choose among various child-care options. The findings have important implications for crafting government policies that affect not only day care but schooling generally.

Parents have three basic day-care choices—care at home, care in someone else's home (family day-care), and center-based care. Parents who are making choices may weigh many features of child care that have little or nothing to do with its quality for the child. They may care about the cost of care, about its reliability, about location, or about the hours that care is available. Thus, the more that can be learned about the role these considerations play in the child-care choices parents make, the more sensibly government subsidies can be tailored.

The research team learned that parents who value the educational components of child care choose center-based care, while parents for whom hours, location, and cost of care are important choose care at home. Choice of family day-care increased if parents thought it was important that the child know the caregiver. Several key determinants (such as mother's education) affect choices, primarily by increasing the importance that parents place on the various characteristics of care.

Ron Chapple/FPG

A nurturing, secure and stimulating environment.

Policy Signposts

What is more, the study found that tax breaks for child care stimulate parents to choose day-care centers over other types of care. This is probably a consequence of how tax credits have been structured—the Internal Revenue Service will usually allow the credit if children are in day-care centers or in licensed day-care homes but balks at allowing the credit for less formal arrangements with relatives or friends in which the child-care provider does not report the payments to the IRS.

Many studies have shown that day-care centers with appropriate educational programs and trained staff promote child development in positive ways. Thus, Leibowitz and her colleagues suggest, it *might* be a good idea if government policies encourage care in such centers so that children will get an optimal amount of education during their preschool years. But the recently enacted Child Care and Developmental Block Grant does not promote center care over other types of child care; 75 percent of the funds authorized under this act will go to direct subsidies to poor families for child-care services from all types of providers, not only those that enhance children's development.

On the other hand, given the current tax system's bias against home day care, the block-grant approach may not be bad policy. We really won't know, say the researchers, until we answer the question of whether subsidies tied to the use of developmental care are preferable to those that subsidize care of the parents' choice, regardless of what that choice might be.

The answer has direct implications for debate on other public policies, such as vouchers for schooling, which would enable parents to send children to any school they choose. Additional research on how parents structure their decisions about the care and education of their children would help us understand the issues and form policies more clearly.

Can We Learn from the Military?

At first glance, the military seems an odd place to look for insights into day-care issues, but first impressions can be misleading. The military operates a vast child-care enterprise, with spaces for more than 162,000 preschool-age children in 831 child-development centers (CDCs) and in 9,810 family child-care homes around the world. The CDCs offer centralized day care at lower cost than is available in the civilian sector and provide care not offered there. In each family care home, a trained military spouse is authorized to care for up to six children in her (or his) government quarters.

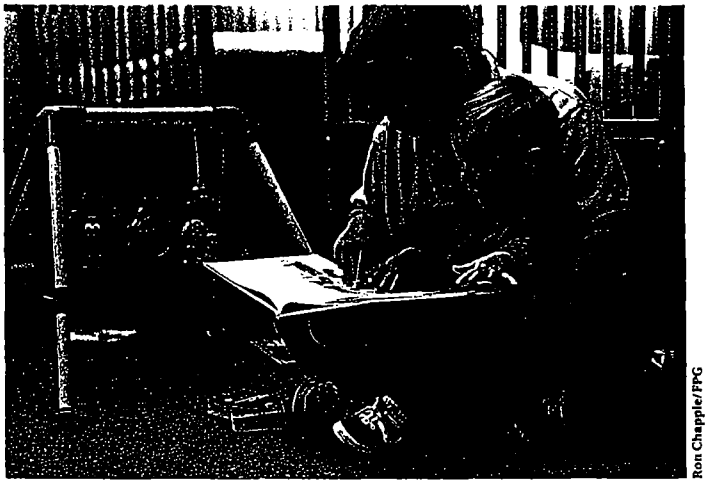
Responding to a push from Congress, the military has worked hard to improve the quality and availability of its day-care services. Changes required by the Military Child Care Act of 1989 in the staffing, training, compensation and funding of the CDCs were implemented in typically thorough military fashion. The centers undergo four rigorous, unannounced inspections a year, which result in Department of Defense (DoD) certification if successfully completed.

Congress also required at least 50 centers to be accredited in accordance with the standards of a "national accrediting body" for early childhood programs. The 50 accredited centers were to serve as a demonstration program from which other nonaccredited centers could learn about best practices.

Explicit Guidance for Staff

Congress provided funds for an evaluation to determine whether accreditation, in addition to DoD certification, was worth the additional cost and effort. RAND undertook this evaluation. The scope of the analysis was limited to examining the accreditation process itself, exploring its perceived impact on staff and children, and assessing the added value of accreditation over DoD certification. The important question of whether accreditation produces better child outcomes could be addressed only indirectly.

Nonetheless, Congress's provision for an evaluation was unprecedented. In the larger society, accreditation is entirely voluntary (only a minuscule 4 percent of state-licensed centers are accredited), and there has never been a national study of its effects on child development. While not definitive, the RAND analysis sheds important light on that issue.



Ron Chapple/FPG

A critical shortage: Day care for the very young.

Project leader Gail L. Zellman, a research psychologist at RAND, and Anne S. Johansen, a RAND consultant and health policy analyst with the European Union Commission in Luxembourg, found that accreditation complements and expands the benefits of military certification in important ways.

"Does Head Start Make a Difference?" Janet Currie and Duncan Thomas, *The American Economic Review*, Vol. 85, No. 3, 1995, pp. 361–364 (RAND reprint, RP-440, no charge).

Does Head Start Help Hispanic Children? Janet Currie and Duncan Thomas, RAND/DRU-1528-RC, 1996, 40 pp., no charge.

"The Importance of Child-Care Characteristics to Choice of Care," Anne S. Johansen, Arleen Leibowitz, and Linda J. Waite, *Journal of Marriage and the Family*, Vol. 53, No. 3, August 1996, pp. 759–772 (RAND reprint, RP-582, no charge).

Examining the Effects of Accreditation on Military Child Development Center Operations and Outcomes, Gail L. Zellman, Anne S. Johansen, and Jeannette Van Winkle, RAND/MR-524-OSD, 1994, 46 pp., ISBN 0-8330-1598-2, $7.50.

To gain accreditation, CDCs must meet the standards set by the National Association for the Education of Young Children (NAEYC), the only national organization with the authority to grant accreditation for early childhood programs.

The NAEYC requirements for day-care centers, like those maintained by the military, cover space, equipment and safety needs, group size, staff-to-child ratio, caregiver training and the like. However, the association goes well beyond these largely functional measures to provide explicit guidance for caregiver-child interactions—qualities that are closely associated with gains in a child's cognitive development, language skills and social development.

For example, the standards specify that staff express affection and respect through holding and talking with children, that they speak to children in a friendly and positive manner, that the children be encouraged to express their feelings, and that staff encourage cooperative behavior and use positive guidance techniques to cope with negative emotions. The NAEYC also stresses the need to provide continuity of care and minimize the shuffling of children among classrooms and caregivers.

It is this emphasis on qualitative issues and appropriate educational programs that most distinguishes accreditation from military certification. Although certification standards are extensive and rigorous, they basically constitute a checklist for meeting DoD regulations and ensuring overall compliance with the mandates of the legislation. Certification is, in fact, much like state licensing procedures in its focus on health, fire and safety issues.

Zellman and Johansen find ample evidence that accreditation provides a range of additional benefits over the DoD certification process alone. Nearly everyone involved in the process judged the effect of accreditation to be overwhelmingly positive. Seventy-five percent cited higher staff morale, better-defined goals, and higher-quality programs among the chief benefits.

Given the small add-on costs of accreditation and the substantial apparent benefits, the researchers conclude, universal accreditation of military day-care centers is a desirable and achievable goal.

Are there lessons in the military's experience for the larger society?

Zellman believes there are: "The military certification process closely parallels state licensing procedures for civilian day-care centers. Both are mainly concerned with functional requirements—what is needed in the way of space and staff—and with health and safety issues. We found these to be necessary, but not sufficient, conditions for high-quality day-care programs that emphasize child development. Our study convinced the military that accreditation brought extra benefits that justified the additional cost. There is every reason to assume these benefits would carry over to civilian day care."

Accreditation takes a big step toward assuring high-quality, developmentally sound day care.

The message for states seems clear: Licensing ensures only that day-care centers meet minimal standards of structure, health and safety; accreditation takes a big step toward assuring high-quality, developmentally sound programs.

However, accreditation in the civilian world would be far more costly than the same process in the military. And that creates a dilemma. Anything that increases the cost of day care to parents—be it the developmental enrichment of programs or more stringent state regulations—may discourage poor women from enrolling their children. This, in turn, may affect their ability and willingness to work. Thus, two worthy goals—getting women off welfare and into jobs and providing developmentally sound programs for their offspring—are in danger of canceling each other out.

Zellman suggests a possible solution: The new federal block grant for child care and development includes a "set aside" to improve care. This might be used to support accreditation efforts, thus lowering the cost to parents. But she adds that as long as parents do not insist on or understand the importance of high-quality programs, day-care centers will have only weak incentives to seek accreditation.

Children's Health: s Insurance a Panacea?

Children's health is another front-burner issue in the welfare reform debate. Turning up the flame is concern over the millions of children who lack health insurance.

The United States spends about $7 billion a year, or 12.6 percent of the Medicaid budget, on health care for poor children. Since the introduction of Medicaid in 1965, this investment has paid off in lower infant mortality rates and increases in hospitalization rates and doctor visits for poor children. Despite these advances, however, America's children remain in poor health relative to those in other industrialized countries.

At 10 per 1,000, the infant mortality rate in the United States is still the highest in the developed world. Compared with Canadian children, American kids are sicker, with 28 percent more disability days and 44 percent more bed days. Mortality rates of American children are also much higher than in Canada—14 percent higher for infants and 8 percent higher for children one to four years of age. There are also dramatic racial differences in health and the use of health care services. The infant mortality rate among African Americans is double that among whites and, in some states, rivals the mortality rates of developing countries. All of this suggests that poor children in this country, particularly poor black children, are not receiving the same quantity or quality of health care as children in other wealthy countries.

Many concerned observers blame this disparity on the rising number of children who are not covered by insurance—in 1995, 9.8 million children, almost 14 percent of children under 18, were uninsured for the entire year, according to the U.S. Bureau of the Census. President Clinton is reported to be considering a $750-million-a-year program to help extend insurance to "gap kids."

Poor children, especially poor black children, are not getting the same quantity or quality of care as children in other wealthy nations.

But would extending medical coverage to all children solve the problem? The RAND/UCLA research team of Currie and Thomas investigated the issue. Using a large national database, they compared the medical care received by children covered by Medicaid, by private health insurance, and those with no insurance coverage at all.

Insurance Effects Differ by Race

"If high rates of sickness and death are solely the result of an inability to pay for care," they write, "we would expect to find that Medicaid coverage has the same effect on the use of care as private insurance coverage, and that white and African American children with similar insurance coverage have similar rates of use."

Mark Harmel/FPG

Despite the advances, a poor health report.

Instead they found that private health insurance and Medicaid are not interchangeable in their effects on the medical care of children, and that racial differences in the use of care persist regardless of family income and type of insurance coverage. Based on two measures of care—routine checkups and visits to the doctor for illness—the researchers found that

- Medicaid-covered children in general are more likely to have routine preventive checkups than children with private insurance or no insurance at all. However, white children covered by Medicaid get more attention from the health care system—both more routine checkups and more doctor visits for illness—than children of other races, even if those children are covered by private insurance.
- For black children, neither Medicaid nor private insurance coverage is associated with an increase in the number of visits to the doctor for illness. Moreover, black children with private insurance are no more likely to have routine checkups than children without coverage.

- These differences in levels of care of black children and white children persist across income levels. That is, regardless of type of insurance coverage or lack of it, poor black children see a doctor less often than poor white children, and middle-class black children less often than middle-class white children.

If lack of insurance is not the culprit in the unequal care of black children, what is? The researchers' data could not help them answer that question, but drawing on evidence from other studies, they suggest an alternative explanation: Because of residential segregation, black children may lack access to providers of quality care. Studies have found that areas with a large residential concentration of Medicaid patients have fewer doctors willing to serve them. In addition, doctors with a high share of black patients may provide lower-quality care. Black children are twice as likely as white children to receive care in a clinic or emergency room rather than from a private provider, health maintenance organization (HMO), or group practice.

Coverage is not, in itself, a guarantee that the children who most need care will get it.

Other factors not bearing on racial differences help to explain why the poor need more than insurance coverage as their passport to the health care system. Many states limit the services available to Medicaid patients; for instance, in 1986, Texas did not cover clinic services, Connecticut did not cover emergency services and New Hampshire restricted Medicaid patients to 12 outpatient visits per year. Finally, bureaucratic delays may pose a significant barrier to timely care—the average delay in processing Medicaid applications is four weeks.

The message of this study is that expanding health insurance coverage is likely to yield substantial benefits in terms of improved health for children. But expanding Medicaid is not, in itself, the solution that will assure that those who most need health care will get it.[1]

Poor Children and HMOs

Recently, Congress has been pondering legislation that would channel poor people on Medicaid into HMOs as a way of curbing costs without creating new health care barriers for the poor.

But a big question mark hovers over how HMOs achieve their vaunted efficiencies. Do they hold down costs by eliminating only unnecessary care or do they scrimp on needed care as well, cutting services indiscriminately? The answer is particularly important as it affects poor children, one of the largest and most vulnerable segments of the population.

To find out, economist Leibowitz and her colleagues examined how medical care obtained by children in one HMO differed from that obtained from traditional physicians in fee-for-service practice.

The results of the study were encouraging: Children in both the fee-for-service and prepaid (HMO) plan had roughly the same number of routine doctor checkups, but children in the HMO had significantly fewer visits for illness.

This does not mean that children in the HMO were getting too little care, the researchers said. On the contrary; because the reduction in acute care visits was concentrated in a particular group—children with no health problems at the start of the experiment—it suggests that the HMO is doing a good job of targeting resources on kids with the greatest health care needs rather than merely rationing services across the board. ■

"Medical Care for Children: Public Insurance, Private Insurance and Racial Differences in Utilization," Janet Currie, and Duncan Thomas, *The Journal of Human Resources*, Vol. 30, No. 1, Winter 1995, pp. 135–162 (RAND reprint, RP-397, no charge).

"Rationing or Rationalizing Children's Medical Care: Comparison of a Medicaid HMO with Fee-for-Service Care," Arleen Leibowitz, Jane Mauldon, Joan L. Buchanan, Cheryl Damberg, and Kimberly A. McGuigan, *American Journal of Public Health*, Vol. 84, No. 6, June 1994, pp. 899–904 (RAND reprint, RP-353, no charge).

Funding for the studies described in this and the previous article was provided by the National Science Foundation, the Alfred P. Sloan Foundation, the Office of the Secretary of Defense, the National Institute of Child Health and Human Development, The Robert Wood Johnson Foundation, the Health Care Financing Administration, and the National Governors Association.

[1] Other RAND studies bear on the question of expanding Medicaid coverage for poor children and their mothers. See the bibliography in this issue, pp. 14–15, for studies by Currie and Gruber and by Halfon et al.

A desperate need to be 'cool'

Adolescence: Forgotten Age, Forgotten Problems

Adolescence is a forgotten age, its problems largely ignored in the clamor for attention to competing societal concerns. So argues Phyllis Ellickson, a senior RAND analyst who has devoted much of her career to the study of young people in the years between childhood and maturity.

"Perhaps that is because adolescents are so often perceived as troubled kids or troublemakers," she observes, "unlike younger children for whom it is easy to get a sympathetic hearing."

A worry to their parents and teachers, teenagers are often touchy, obsessed with the approval of their peers, and seemingly indifferent—or downright hostile—to the views and values of adults. Ellickson's research has shown that even good students from financially secure homes can go off track when they reach junior high school.

Ellickson, a social policy analyst, finds the years between 12 and 18 are an "extremely vulnerable" time in the lives of young people.

"They desperately want the approval of their friends, to be perceived as 'cool,' and they will do dangerous and just plain dumb things to gain that status." Unfortunately, temptations to drink, take drugs and engage in precocious sex arise long before adolescents have developed skills to cope with the forces that are whipsawing them. Violent behavior and emotional problems, such as depression, which may be the precursor of a lifelong disability, may worsen during this period as well.

It may seem odd to think of adolescence as a major public health issue, but that is exactly how Ellickson sees it. "I believe that adolescent health encompasses far more than the absence of physical disease or disability. It includes mental and social, as well as physical, well-being."

Diane Baldwin/RAND

The new morbidity. Twenty percent of high school seniors smoke; about 30 percent are binge drinkers.

A Disturbing Portrait

In a recent report, Ellickson and colleagues Maria Elena Lara, Cathy D. Sherbourne and Bonnie Zima unveil a disturbing portrait of the adolescent condition.

Adolescents start out in good health relative to the rest of the population: Expected deaths for 10- and 11-year-olds are lower than those for any other age. As adolescents grow older, however, their risk of dying increases; the mortality rate for 15- to 19-year-olds is three times that for 10- to 14-year-olds. These differences reflect the fact that more older adolescents engage in high-risk behavior and are the victims of violence.

Seventy-five percent of all adolescent deaths are due to three causes: unintentional injuries (particularly from automobile accidents), homicide and suicide. Each is more likely to occur among older adolescents. Each is also linked to various risk-taking activities, such as drug use or drinking and driving, or to negative emotional states, such as depression or conduct disorders, or to some combination of these.

Other threats to the health of American adolescents arise from what scholars are calling the "new morbidity." By this they mean illness associated with drug use (including alcohol and cigarettes), violent behavior, unsafe sexual activity, and mental disorders. Such problems often go together: Drug use raises the risk of unsafe sexual behavior, teens with mental health problems often use drugs, and teens who use drugs are often violent or have mental health problems.

More than one-fifth of the nation's high school seniors smoke every day, and about 30 percent are binge drinkers—practices that put them at risk of developing long-term addictions to tobacco and alcohol.

Over half of the nation's high schoolers are sexually active, but few use condoms consistently. As a result,

about one million teenage girls become pregnant each year and the risk of contracting AIDS or other sexually transmitted diseases (STDs) is rising. In addition, about one in five adolescents suffers from a diagnosable mental disorder, which can develop into life-threatening problems or severely impede the young person's ability to negotiate the shoals that separate adolescence from adulthood.

Young people from all ethnic and demographic groups are prey to the new morbidity, but its consequences are particularly severe for teenagers who lack the resources to get help. About one-third of poor and near-poor adolescents have neither Medicaid nor private health insurance coverage. A surprisingly large portion of middle-income teenagers also lack coverage—almost 30 percent of uninsured adolescents live in families with incomes 200 percent or more above poverty levels.

The ABCDs of Sex

Access to medical help for teenagers is further restricted by limitations on coverage (particularly for preventive and mental health services), by payment policies that promote expensive hospitalization over less costly community- or family-based treatment, and by adolescent concerns about confidentiality. The frequent failure of physicians to identify emotional and behavioral problems in adolescents, plus the adolescents' own failure and that of their parents to seek help, are also factors.

Doctors also need to be more aggressive in discussing sexual matters with teenagers. A RAND survey of 2,000 high school students found that about half of the physicians who treat these adolescents do not discuss sex and sexual risk prevention with them. This is the case even though professional medical organizations uniformly urge such counseling and an overwhelming majority of the young people say they would find such discussions helpful.

As Dr. Catherine D. DeAngelis, editor of the *Archives of Pediatric and Adolescent Medicine*, puts it, "Discussing the B's (birds and bees) with adolescents was never easy for physicians or parents. Now that we've added the A's (AIDS), C's (condoms) and D's (diseases of sexual transmission), it's even more challenging and important."

Too Little Known

To overcome these barriers to care, a number of systems that specialize in adolescent health have sprung up across the country. Comprehensive health care centers that provide multiple services at a single site ("one-stop shopping") have been the most thoroughly studied. While they appear to be an effective strategy for reaching poor teenagers and for getting them needed care, the researchers observe, not much is known about their effect on improving adolescent health over the long term.

Against this backdrop of rising need and limited access, Ellickson worries that too little is known about the effectiveness of intervention programs. Evaluations of drug treatment programs have largely ignored adolescents; they have also focused on such substances as heroin, which few adolescents use. Moreover, studies of mental health services for teenagers have been plagued by methodological flaws that make it difficult to identify program-induced gains.

Before trouble with the law closes down their horizons.

"We still lack solid evidence about what treatment regimes work, how long the effects last, and which problems and which adolescents are helped," she says.

Drugs and Other Risky Business

Studies by Ellickson and others have found that school-based prevention programs can curb drug use in middle school. The programs are more effective at delaying or reducing cigarette and marijuana use than drinking; they also work better for nonusers and experimenters than for committed users. Once the lessons stop, however, program effects begin to wear off. Thus discontinuing these programs in high school is a big mistake.

"We need to keep these programs going after kids make the transition to high school," Ellickson argues. "Each year that we hold off initiation buys kids more time to get some life experience under their belt. And if they do experiment later on, they are much less likely to become addicted or to mess up their lives because of drug use. The name of the game in prevention is delay, delay, delay."

Programs aimed at reducing sexual activity and teenage pregnancy have modest influence, she acknowledges, but those that provide condoms and foster their use may be more successful at curbing both pregnancy rates and the spread of STDs.

The relatively modest results of treatment and prevention efforts should come as no surprise. Ellickson

blames them, in part, on the complex nature of the problems and on the blurring of cause and effect. Drug and alcohol use are linked to risky driving, death by accident, violence, suicide and unsafe sex, while poor mental health and violent behavior may be either the cause or the consequence of drug use. Added to that are influences on teenagers as diverse as belief in their own invincibility, difficulties at school, societal and parental attitudes that condone high-risk behavior, family problems and genetic vulnerability.

Risk factors that are bound up with family dynamics, community and social norms, or school experience are difficult to modify, Ellickson notes. Certainly, sorting out these tangled influences is beyond the province of

Diane Baldwin/RAND

Temperature-taking the newfangled way. Base programs in schools, because that's where the kids are.

health care providers, who see adolescents only when they happen to show up in their office or clinic.

That is why viewing the new morbidity as a public health problem is important, she maintains. Only then can the door be opened to coordinated prevention and treatment efforts that involve families, schools, community agencies, and the media, as well as health professionals.

"Rather than fostering hospitalization as the dominant strategy for treating teenagers with mental health or substance abuse problems," she says, "we need to promote community-based or school-linked systems of care that recognize the interrelatedness of many adolescent problems."

Including schools in a coordinated program is particularly important, she adds. Schools are where most children can be found and where problems can be identified before they become critical. Moreover, some school environments exacerbate emerging problems, whereas others provide countervailing mores or rewards for productive behavior. Hence, efforts to modify school practices and norms may help curb high-risk behavior.

Better training in adolescent medicine, including how to communicate with teenagers, would go a long way toward improving health professionals' ability to identify and cope with mental disorders, sexually at-risk teens, and drug abuse. Being able to see the doctor in a friendly and familiar setting (teen clinics, school-linked health

Children can't be protected forever, but there are things society can, and should, do to help them through the high school years.

clinics, community-based centers) clearly helps teens talk more freely about personal matters, respond more positively to the doctor and feel more satisfied with the quality of care they receive.

If they lack the insurance coverage to get through the door, however, few teens will benefit from greater professionalism and more coordinated services. Although removing cost barriers to care is not a panacea, expanded insurance coverage is an important piece of the mosaic. Ellickson recommends that current efforts to reform the health care system should aim at both reducing the number of uninsured and underinsured adolescents and providing a basic floor of preventive and mental health services for this group.

"I'm not arguing that children can be protected forever. They can't. But there are things we as a society can and should do to help them through the high school years," Ellickson contends, "before their horizons close down and mistakes like pregnancy or trouble with the law cut them off from a good job or college." ■

Forgotten Ages, Forgotten Problems: Adolescents' Health, Phyllis L. Ellickson, Maria Elena Lara, Cathy Donald Sherbourne, and Bonnie Zima, RAND/MR-141-RC, 1993, 55 pp., ISBN: 0-8330-1409-9, $13.00.
This study was funded by RAND.

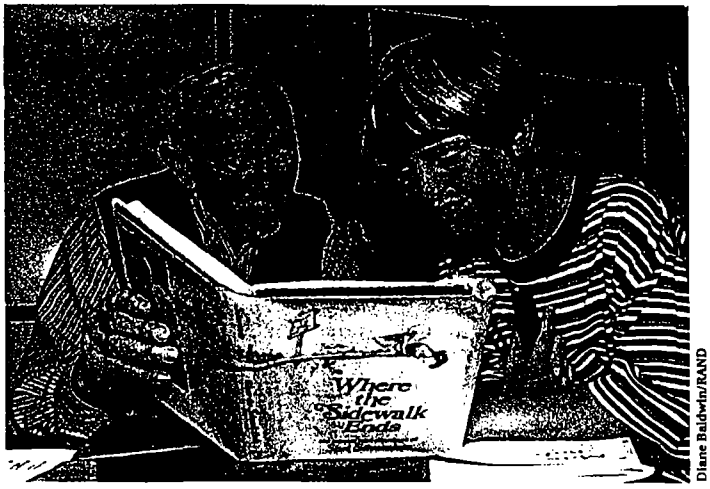
"Communication Between Adolescents and Physicians About Sexual Behavior and Risk Prevention," Mark A. Schuster, Robert M. Bell, Laura P. Petersen, and David E. Kanouse, *Archives of Pediatrics and Adolescent Medicine*, Vol. 150, No. 9, September 1996, pp. 906–913 (RAND reprint, RP-569, no charge).
This work was supported by The Robert Wood Johnson Clinical Scholars Program, the American Foundation for AIDS Research, the Agency for Health Care Policy and Research, and RAND.

H e ping Chi dren in a Downsizing World

"The challenge is to take the array of forces at our disposal and put them to work in a downsizing environment—to actually change welfare systems for the better, not just hack away at benefits and services. In short, we must learn how to do more with less."

—Nick Bollman,
James Irvine Foundation, to researchers at a RAND conference on the new federalism, May 1996.

That imperative—to do more with less—has led RAND to look not only at massive welfare programs like Aid to Families with Dependent Children, but beyond them at a broad array of other less famous (and less studied) efforts. The search has been for programs and strategies that not only help children but that may have outsized payoffs for the dollars invested. These include investigating novel or overlooked approaches to the problems of children and exploring untapped resources in neighborhoods, communities and the family itself.



Diane Baldwin/RAND

Grandparents as the 'second line of defense.'

Among many other child-focused projects, in recent years RAND has carried out major, scientifically rigorous studies of the effectiveness of school-based drug prevention programs and of the influence of the family on children's school performance.

A multi-site drug prevention experiment funded by the Conrad N. Hilton Foundation proved successful in curbing marijuana and tobacco use among seventh and eighth graders. The two-year program yielded positive effects in highly diverse environments, including urban, suburban, and rural communities and in schools with both high and low minority attendance. After the lessons ended, however, the benefits of the program eroded, suggesting the need for continued prevention efforts during high school. Reinforcing the anti-drug message in high school via "booster" programs could further delay for many the initial use of these substances, the researchers said. And that would be no small victory: Children cannot be protected forever, but postponing initiation until after high school buys them time to develop more mature judgment and skills in resisting the multifarious pressures to use drugs.

The student achievement study found that, contrary to mainstream opinion, student test scores are rising for all students—and rapidly, in the case of minorities. From about 1975 to 1990, the average math and reading scores of students 13 to 17 years old increased 3 percentage points for white students, 11 points for Hispanic students and 19 points for African American students. A major part of the explanation is improvements in the family environment, notably, smaller family size and a dramatic increase in the education levels of African American mothers.

New efforts are planned or under way in other areas: studies of programs that seek to improve parenting skills by involving inner-city parents in their children's schooling; studies of the role of grandparents as the "second line of defense" in protecting and caring for their grandchildren; and a large-scale investigation of every aspect of neighborhoods that may be important in the lives of children—from schools, churches, libraries, recreational programs, clinics and hospitals to the social, economic and cultural characteristics of neighborhood interactions. (Also see the box accompanying this article for an account of RAND's involvement in the "Early Childhood Public Engagement Campaign.")

Perhaps the most promising news comes from a recent study of strategies aimed at keeping high-risk youth out of trouble with the law. A RAND research team found intriguing evidence that crime might be reduced more cost-effectively by these strategies than by the longer prison sentences that are currently in vogue.

Dollar for dollar, the analysts found, programs using financial and other incentives to induce disadvantaged high school students to graduate avert five times as many serious crimes as the stiffer prison terms stipulated by California's "three-strikes" law. Programs that provide 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.

RAND's earlier study of the effects of the three-strikes law found that full implementation will produce a 21 percent overall reduction in crime at a cost to the state of an additional $5.5 billion per year in spending on the criminal justice system, notably for prison operation

Many child-related studies under way

Multidisciplinary Efforts a Hallmark of RAND Programs

RAND is conducting many more studies concerned with the health and well-being of children than can be reported here. The work draws on the expertise of researchers in the fields of social policy, sociology, economics, demography, statistics, criminal justice, education, medicine, health care policy, health care finance and school finance. Research is carried out in four programs, which cooperate in cross-disciplinary efforts. The programs and individuals to contact for additional information are listed below.

The Labor and Population Program

Lynn Karoly, Director

Telephone: 310-393-0411, ext. 7359

Web address: http://www.rand.org/organization/drd/labor/

The Criminal Justice Program

Peter W. Greenwood, Director

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Web address: http://www.rand.org/centers/icj/

The Health Program

Robert H. Brook, Director

For information on adolescents' health, contact

Phyllis Ellickson

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Web address: http://www.rand.org/organization/drd/health/

The Institute on Education and Training

Roger Benjamin, Director

For information, contact

Kathleen Shizuru

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and construction. The new work indicates that a combination of graduation incentives and parent training could achieve a similar amount of crime reduction for less than $1 billion.

"None of this suggests that incarceration is the wrong approach," emphasize authors Peter W. Greenwood, Karyn E. Model, C. Peter Rydell and James Chiesa. The point, they explain, is that policies that allocate huge sums to imprison career criminals and little for targeted efforts to discourage such careers are "lopsided."

Directed by Greenwood, the team analyzed numerous pilot programs employing four different approaches.

- Home visits by child care professionals beginning before birth and extending through the first two years of childhood, followed by four years of day care.
- Training for parents and therapy for families with young children who have shown aggressive behavior in school.
- Four years of cash and other incentives to induce disadvantaged high school students to graduate.
- Monitoring and supervising high-school-age youth who have exhibited delinquent behavior.

A preliminary assessment of these programs found that home visits reduce crime by 50 percent; parent training, by 60 percent; graduation incentives, by 70 percent; and delinquent programs, by 10 to 20 percent.

Large-scale, multimillion-dollar demonstrations of these promising programs 'would be an investment worth the cost.'

However, in the "real world" these benefits can be expected to decrease. The RAND team subtracted a percentage for relatively new and untested programs and another percentage for the decay of effects over time. Another factor is how well the programs target the population most likely to eventually commit crime. Not surprisingly, the later the intervention—such as with graduation incentives and programs aimed at delinquents—the better the targeting.

Diverting Children from a Life of Crime: Measuring Costs and Benefits, Peter W. Greenwood, Karyn E. Model, C. Peter Rydell, and James Chiesa, RAND/MR-699-UCB/RC/IF, 1996, 82 pp., ISBN: 0-8330-2383-7, $15.00. The text appears in its entirety on the World Wide Web (http://www.rand.org/publications/MR/MR699/). The research is summarized in a one-page brief, RB-4010.

"Drug Prevention in Junior High: A Multi-Site Longitudinal Test," Phyllis L. Ellickson and Robert M. Bell, *Science*, Vol. 247, pp. 1299–1305, 1990.

"Preventing Adolescent Drug Use: Long-Term Results of a Junior High Program," Phyllis L. Ellickson, Robert M. Bell, and Kimberly McGuigan, *American Journal of Public Health*, Vol. 83, No. 6, 1993, pp. 856–861 (RAND reprint, RP-208, no charge).

The studies described in this article were supported by the Conrad N. Hilton Foundation, the Lilly Endowment Inc., the James Irvine Foundation, and RAND.

Weighing all the factors, the analysts estimated the number of serious crimes prevented per million dollars spent for each program. The options with the most immediate crime-reduction effects appear to be parent training and graduation incentives.

Greenwood and his colleagues are cautious about their findings, pointing out the need for better data about the results of such programs when they are implemented on a much broader basis. However, their analysis showed that the cost-effectiveness advantage of the best of these programs will hold up even if further study reveals somewhat weaker program results than those reported here.

Large-scale, multimillion-dollar demonstrations of these promising programs "would be an investment worth the cost," the authors conclude. ■

High-Voltage Media Campaign to Spotlight Importance of First Three Years of Life

RAND Analyzing Benefits, Costs of Early Childhood Programs

An unprecedented and sustained media blitz by prominent entertainers, national media experts, leading foundations and experts on early childhood has been launched to focus public attention on the importance of the first three years of life and on what families and communities can do to enhance children's healthy development during these years.

The "Early Childhood Public Engagement Campaign" plans to go beyond a media call for action, however. A sustained push, over many months and in many venues, is under way to foster and promote child-focused programs at every level of government—from Washington, to state capitols to city halls.

Diane Baldwin/RAND

The effectiveness of the campaign will depend in large part on its ability to show the public concrete evidence regarding the importance of the first three years of life for the individual child and its family, the implications of these early years of development for the larger community, and the capacity of public- and private-sector programs to turn this development in a positive direction.

With funding from the California Wellness Foundation, RAND will analyze existing evidence in these three areas and provide an objective assessment of the strength and implications of that evidence. RAND's task is to define and quantify—in highly specific terms—the potential benefits of early childhood interventions to children, to their parents and to society at large.

A team of researchers, led by Peter W. Greenwood and Lynn A. Karoly, will first review the many studies that have documented the impact of these programs. Using computer models and other analytic tools, they will then pull together the findings to show the specific nature of the expected benefits; the magnitude in dollar, or other, terms; and the time stream of each benefit (whether it comes early or later in life). This synthesis will be published in a form that is both understandable to a lay audience and supportable by science.

The following are examples of potential benefits of early childhood programs:

- For the child: improved health, educational attainment, enhanced cognitive growth, avoidance of substance abuse and other antisocial behavior; and in adulthood, increased income
- For parents (because many programs target them): enhanced job success, greater educational attainment, better mental health, improved marital stability, fertility control, and avoidance of substance dependence and child abuse
- For the community and society: increased economic participation by parents and the consequent boosts to tax receipts, lower welfare costs, increased public safety, lower costs to the justice system, and reduced expenditures on a wide range of public programs, such as special education, foster care and children's protective services.

An interim report will be available by the end of April, in time for the campaign kickoff—an hour-long, ABC Prime Time Special on the first three years of life, being produced and directed by Rob Reiner. Some of RAND's findings will be highlighted in the program.

Additional Publications

Day Care and Head Start

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Hotz, V. Joseph, and Rebecca Kilburn, *Regulating Child Care: The Effects of State Regulations on Child Care Demand and Its Cost,* RAND/DRU-956, 1995, 65 pp., no charge.

Johansen, Anne S., Arleen Leibowitz, and Linda J. Waite, *Parents' Demand for Child Care,* RAND/DRU-741-NICHD, 1994, 41 pp., no charge.

Kilburn, M. Rebecca, and Lingxin Hao, "The Impact of Federal and State Policy Changes on Child Care in California," *The New Fiscal Federalism and the Social Safety Net,* James Hosek and Robert Levine, eds., RAND/CF-123-RC, 1996, 200 pp., ISBN: 0-8330-2411-6, $15.00.

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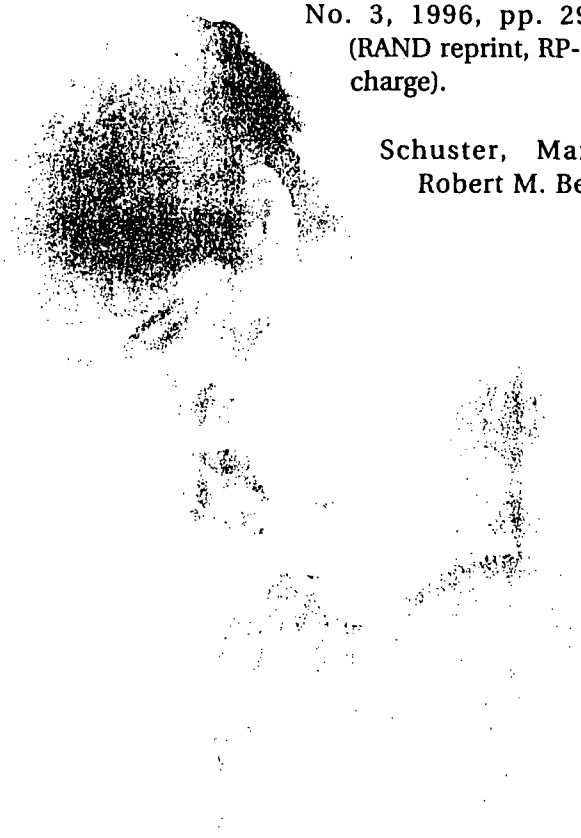

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