HAWAII FAMILY STRESS CENTER

Gail Breakey, RN, MPH
Director

Hawaii Family Stress Center
1833 Kalakaua Ave., Suite 1007
Honolulu, Hawaii 96815
Ph: (808) 944-9000 Fax: (808) 944-2751

Hawaii Family Stress Center

A Program of Kapiolani Medical Center For Women and Children

HAWAII FAMILY STRESS CENTER
A Program to Promote Healthy Families

Kapiolani Medical Center For Women And Children
1833 Kalakaua Ave., Suite 1001, Honolulu, Hawaii 96815 Phone (808) 944-9000 FAX (808) 944-2751

Hawai'i Healthy Start

FACT SHEET

Program Description

Healthy start is an early intervention program administered through the Department of Health, Personal Health Services Administration, Family Health Services Division, Maternal and Child Health Branch. The program offers systematic screening for families around the birth of a newborn. Families identified with high risk factors are offered weekly home visitation services. Families are followed until the child reaches age five.

Healthy Start Program Goals Are To:

- o Strengthen family functioning
- o Enhance parent-child interaction and positive parenting
- o Promote optimal child development
- o Assure a health care home and full immunization
- o Assure use of community resources including family planning
- o Prevent child abuse and neglect

Current Level of Services

The Department contracts with seven private community agencies to provide services to each of the neighbor islands and parts of Oahu including Big Island YMCA, Family Support Services of West Hawaii, Maui Family Support Services, Molokai General Hospital, Hawaii Family Stress Center, Parents & Children Together, and Child & Family Service.

More than 8,000 civilian families are screened annually for risk factors and 2,800 are currently enrolled in home visitation services:

- o 47% of families are of Native Hawaiian ancestry
- o 60% are Medicaid eligible
- o 38% of the families have a history of substance abuse
- o 43% have a history of domestic violence
- o 22% are homeless

Program Success:

- o 99% accurate identification of low risk families
- o 99.3% non-abuse for families served
- o 98.6% non-neglect for families served
- o 90% of two year olds are fully immunized
- o 96% of families with identified medical home
- o 90% of families receive timely family planning information
- o All children receive developmental screening
- o 85% of children are developmentally age appropriate

Cost per Family:

$2,400 per family for home visitation services, client tracking data system, monitoring and administration.

Healthy Families America

Healthy Families America
Fact Sheet

May, 1994

Healthy Families America is an initiative to establish a universal, voluntary home visitor system for all new parents nationwide to help them get off to a good start.

Why is Healthy Families America Needed?

- In 1993, there were more than 2.9 million cases of suspected child abuse reported by CPS agencies and more than 3 children a day died from child abuse and neglect (McCurdy and Daro, 1994). Yet, 65 percent of child abuse fatalities were UNKNOWN to child protective services.

- According to a report released by the Carnegie Corporation of New York, "the earliest years of a child's life are society's most neglected age group, yet new evidence confirms that these years lay the foundation for all that follows" (April 1994).

- Child abuse prevention programs save money. For every $3 spent on prevention, we save at least $6 that might have been spent on child welfare services, special education services, medical care, foster care, counseling, and housing juvenile offenders (Bryant and Daro, 1994).

Why is the Healthy Families America Approach Successful?

- Healthy Families America is an effort to prevent child abuse and other poor childhood outcomes that is based on **two decades of research** and the experiences of a successful statewide home visitor program (Hawaii's Healthy Start). The Healthy Families America approach incorporates the elements of home visitation programs that are essential for program success, while at the same time, promoting flexibility so that services can be tailored to meet the needs of each community. The idea is that all new parents receive some services and those at greatest risk receive intensive support.

- New parents are eager to learn how to care for their babies. In a 1993 public opinion poll conducted by the National Committee to Prevent Child Abuse (NCPCA) , 80 percent of parents thought home visitation programs were a "good idea" to help them care for their child.

- Healthy Families America programs collaborate with other organizations and agencies providing family support programs in order to utilize scarce resources, provide a comprehensive array of services to families, and avoid duplication of services.

- The goals of the initiative go beyond the establishment of pilot programs with the vision that prevention education and supportive services for all new parents become institionalized within each state.

The Healthy Families America Team

Healthy Families America (HFA) is an initiative of NCPCA in partnership with Ronald McDonald Children's Charities. Over the past three years, NCPCA has worked with the Hawaii Family Stress Center to pass on knowledge to the mainland regarding why this approach to child abuse prevention works in one area (Hawaii) and how it can be successfully tailored to meet the needs of other communities across the United States. The HFA team works together to provide training and technical assistance on a variety of operational issues, including legislative advocacy and program development. At the heart of the effort, is the notion that home visiting services at the time of birth or earlier can be the gateway for all families, and most especially high risk families, into the variety of services and supports to ensure the health, safety and successful emotional and intellectual development of a child.

Progress to Date

Partners

The success of the Healthy Families America initiative depends, at least in part, on whether or not HFA programs build onto already existing service delivery systems. HFA must by definition, work in partnership with and be a partner of other existing early childhood efforts. To that end, NCPCA, our state chapters, and HFA sites have developed partners at the national, state, and local levels. Some of these partnerships include: members of the National Child Abuse Coalition, the American Hospital Association, the America Nurse's Association, many of the Children's Trust Funds, the First Steps program, the National Parent Aide Network, the Cooperative Extension system and many more.

Task Forces

Most states have developed statewide task forces in order to coordinate legislative strategies for the implementation and funding of HFA; conduct a statewide needs assessment of existing parent education and support programs to determine the gaps in services and to avoid duplication of efforts; and most importantly to build collaboration among state agencies, community-based organizations, and consumers of services.

Sites

Healthy Families America has evolved at an extraordinary pace. Broad based coalitions have come together and committed resources to make services more responsive to the needs of families and communities. The Healthy Families America approach has been incorporated into a number of diverse communities (in terms of cultural diversity, population density, and geographic location) representing all regions of the United States. While HFA promotes flexibility to meet the specific needs of a given community, all sites embrace the basic program attributes that research has found to contribute to program success. As of spring 1994, over 45 communities have HFA programs.

Legislation

NCPCA has been working to create stable funding mechanisms at the state level. Several states have passed some type of legislation relative to increasing the availability of home visiting services for families with newborns or creating task forces to plan for the implementation and/or coordination of home visitation programs. For example, Oregon passed legislation appropriating $3.3 million over a two-year period (1993-1995) to establish four community-based, intensive, neonatal home visitation programs based on the Healthy Families America approach.

For more information, please contact the National Committee to Prevent Child Abuse, Healthy Families America, at 332 S. Michigan Ave., Suite 1600, Chicago, IL 60604, or call (312) 663-3520.

Healthy Start Outcomes

Data below compares Healthy Start outcomes on major child health indices with state averages or national data.

		Healthy Start	Comparison
1.	Incidence of child abuse and Neglect	.7% (A) 1.2% (N)	20%
2.	Immunizations by Age 2	90.0%	60%
3.	Developmental screens, assessments	90.0%	11%*
4.	Mothers pre-natal care first trimester	**	67%
5.	Consistent medical care	95.0%	+

1. Occurrence of abuse and neglect among Healthy Start families is compared with occurrence among families at risk not receiving services, as reflected in three major studies. These studies showed occurrence of abuse/neglect among at risk, non-served families to be 19%, 20% and 24%.

2. Immunizations for Healthy Start high risk children by age two are compared with the state average for all children. (Clearly, the immunization rate among disadvantaged families would be lower than 60%)

3. Completion of developmental screening among Healthy Start high risk children are compared with utilization of EPDST for Medicaid eligible children, i.e percentage of eligible children enrolled with an EPSDT provider. Services received are comparable, i.e screening, referral for diagnostic testing and followup. (48,000 children of Hawaii are Medicaid eligible). The Healthy Start program population is about 60% Medicaid eligible; however all our families are less likely to seek services.

4. Program target number is 90%; we do not yet have reliable outcome data on this as yet. The state average is 76%.

5. Information we have is anecdotal, however it is corroborated by reports on medical care of disadvantaged children. This collective experience is that most children in dysfunctional families do not received regular child well care, and that families routinely use emergency rooms for child illness.

(B:HSdatleg.J29)

Information on Cases Hospitalized at Oahu Hospitals for Serious Abuse and Neglect During 1991, 1992, 1993
April, 1994 Report n=180

Service Status of Family	Number	Percent
Total Families Not Eligible for Healthy Start Services	157	87.2%
* Families residing outside of Healthy Start geographical catchment areas	(71)	(39.4%)
* Military families	(24)	(13.3%)
* Families within H.S. area, but child was born before H.S. was initiated in the area	(33)	(18.3%)
* Families within H.S. area, but intake was closed due to insufficient funds	(23)	(12.6%)
* Families active with CPS at time of birth, active with DHS	(5)	(2.8%)
* Family active with another home visiting program	(1)	(.6%)
Families eligible but not served by Healthy Start	19	10.6%
* Not screened in hospital	(6)	(3.4%)
* Unable to locate family	(1)	(.6%)
* Refused interview	(2)	(1.1%)
* Screened negative, no interview	(2)	(1.1%)
* Appeared not at risk at interview	(3)	(1.7%)
* Refused Healthy Start services	(2)	(1.1%)
* Accepted, never participated	(1)	(.6%)
* Non-target child	(1)	(.6%)
* Brief services, family moved to non-Healthy Start area	(1)	(.6%)
Actually served by Healthy Start	3	1.7%
Number of families with insufficient data	1	.6%
Total	180	100%

Information on Cases Hospitalized at Oahu Hospitals
for Serious Abuse and Neglect During 1994

N = 70

SERVICE STATUS OF FAMILY	NUMBER	PERCENT
Total Families for whom Healthy Start Services not available	**56**	**80.0%**
* Families residing outside of Healthy Start geographical catchment areas	12	17.1%
* Families within H.S. area but child was born before H.S. was initiated in the area	12	17.1%
* Families within H.S. area but intake was closed due to insufficient funds for home visitors	10	14.3%
* Families active with CPS at time of birth, active with DHS	5	7.1%
* Military Families	11	15.7%
* Families with child presumed born on mainland. No record of birth at Oahu hospitals or Dept. of Health birth certificate records.	6	8.6%
Families Eligible But Not Served by Healthy Start	**10**	**14.3%**
* Not screened in hospital	2	2.8%
* Refused interview (see Note #1)	2	2.8%
* Screened negative, no interview (Note #2)	6	8.5%
Actually Served by Healthy Start (Note #3)	**3**	**4.3%**
Number of Families with Insufficient Data	1	1.4%
Total	70	100.0%

See notes on attached page.

February, 1995

Note #1 A total of over 12,500 families were offered Healthy Start family assessment interviews during the time period in which these hospitalized children were born. Healthy Start services were available in one area from 1985, expanding after 1987 to 13 sites. Less than 1% and usually less than 0.5% of families have refused interviews over the last 10 years on Oahu.

Note #2 A total of over 25,000 births were screened by Healthy Start during the time period covered by this report. About 12,500 of these screens were negative. Healthy Start evaluations have shown that less than 0.5% of families with negative screens evidence child abuse or neglect.

ANALYSIS OF CHILDREN HOSPITALIZED at OAHU HOSPITALS for SERIOUS ABUSE AND NEGLECT DURING 1994 RELATIVE TO HEALTHY START SERVED & NON-SERVED AREAS

During Calendar year 1994 there were seventy (70) children hospitalized at Oahu hospitals for serious abuse or neglect. In order to compute a crude child abuse hospitalized rate for healthy start served and non-served areas several calculations were made based on these numbers.

First: As healthy start screens newborns, analysis was limited to children under the age of two, or those children hospitalized with birth dates in 1993 & 1994; 40 children.

Secondly: Denominator is the number of births for the two year period within the healthy start and non-served areas; military births were added into the non-served areas.

Thirdly: Within healthy start covered areas, some of the families do not receive services because of limited program capacity, missed screening or refusal.

Given the following assumptions, **In 1994 it appears that the incidence of children under age two hospitalized for abuse is at least 4 times more likely to occur in non-served rather than healthy start communities.**

	Cases	/ Births	x 100,000 = Rate
Non-Healthy Start Areas	31	18778	165.1
Healthy Start Areas	9	20828	43.2

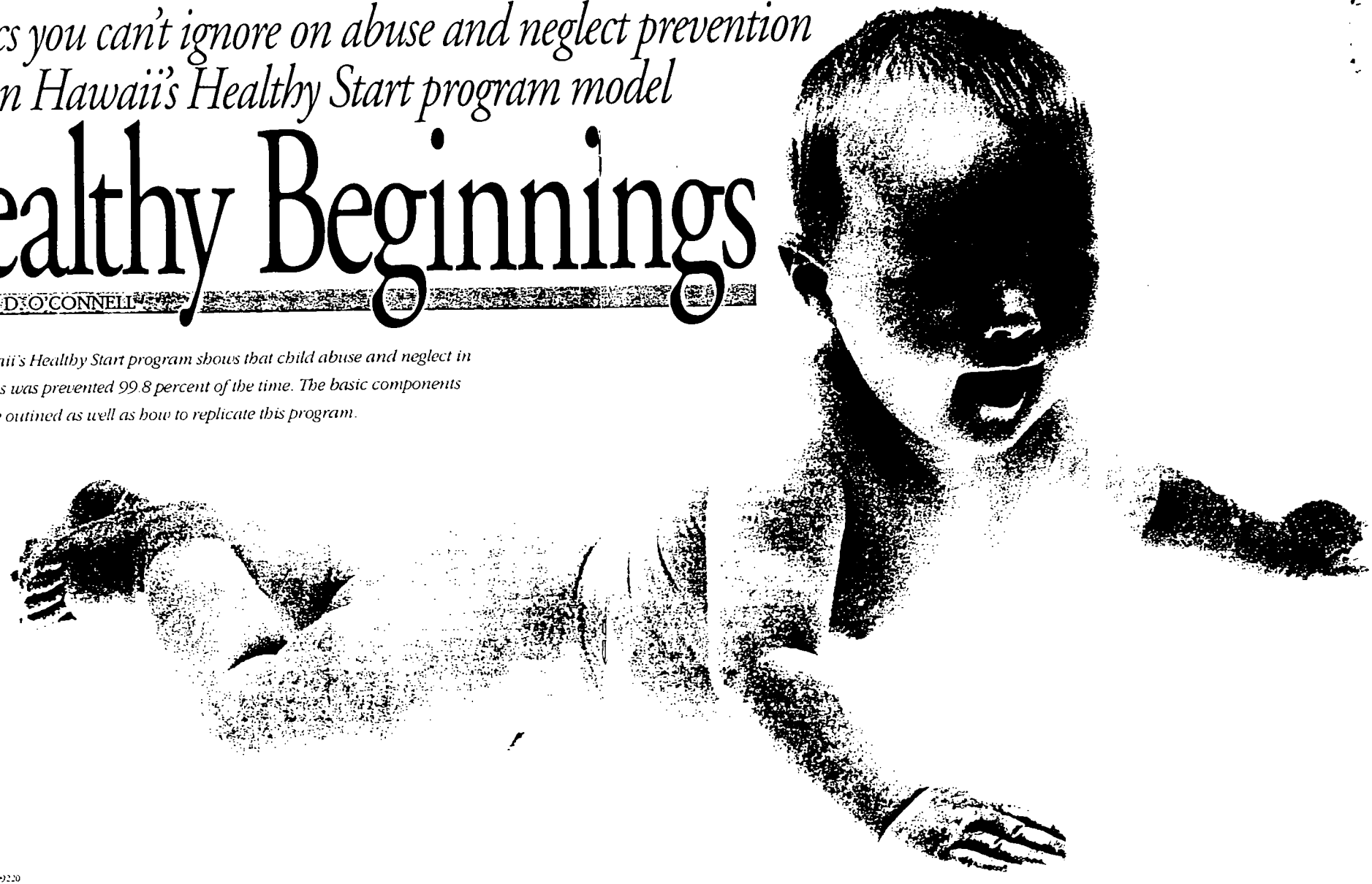
It should be noted that this is a conservative projection as of the nine children within the healthy start community only 3 actually received healthy start services.

Statistics you can't ignore on abuse and neglect prevention based on Hawaii's Healthy Start program model

Healthy Beginnings

BY ROBERT D. O'CONNELL

Data from Hawaii's Healthy Start program shows that child abuse and neglect in high-risk families was prevented 99.8 percent of the time. The basic components of this model are outined as well as how to replicate this program.



Robert O'Connell is Administrator of the Family and Children's Center in La Crosse, Wisconsin.

Children Are Not Safe

The U.S. Advisory Board on Child Abuse and Neglect has declared that the maltreatment of children in the United State now represents a state of emergency. Moreover, surveys consistently show that large proportions of cases of suspected child abuse remain unreported.

The system our nation has devised to deal with this problem is broken. The elements of the system—investigation, prosecution, treatment—are in such a state of disarray that the Advisory Board concluded that the safety of the nation's children cannot be assured. The child protective system is ill suited in form and scope to respond to the magnitude of the problem it was designed to answer.

Billions of dollars are spent each year on programs to deal with the "rotten outcomes" of child abuse and neglect. The direct dollar costs of child abuse are seen in law enforcement, the court system, out-of-home placement and the adult prison system. (Seventy five percent of prison inmates experienced abuse as children.) The indirect costs of child maltreatment are even greater—substance abuse, depression, adolescent pregnancy, juvenile delinquency, suicide, violent crime and school failure. All of these have roots in childhood abuse and neglect.

The Advisory Board concluded that America is at a point of crisis in providing services to children. A fundamental change is needed in the way in which child abuse and neglect are thought about and dealt with. It is time to do more than just report and investigate the problem. The first and most important step in responding to this crisis is to focus on preventing child abuse before it occurs. And the model of prevention the Advisory Board recommends is a voluntary home visiting service for all new parents.

The Home Visitor Model

Over the past thirty years considerable research has been done on the complex problem of child abuse and neglect. Literature has shed some light on programs that have successfully reduced the risk for or outcomes of maltreatment. Some of these programs are:

- Traditional methods of psychotherapy for either victim or perpetrator;
- Home visiting services, particularly those offered at birth and continuing for more than a year;
- Self-help groups such as Parents Anonymous;
- Family resource centers that serve as a clearinghouse for various educational and support services used by at-risk families; and
- Crisis intervention services and respite care.

In addition to direct services, research also indicates that broader efforts to change the environmental conditions in which children are raised are needed. Eliminating poverty, access to jobs and housing for families, early childhood education, increased medical care and reducing exposure to violence are important considerations in preventing child abuse and neglect.

More recent investigation into the child abuse and neglect field shows that the single, most effective strategy for preventing child abuse is to provide parents with education and support around the time a child is born. Early intervention programs that are home-based have a solid and expanding evaluative and theoretical basis on which to build and replicate. Data from such programs suggest that the risk of child abuse and neglect can be significantly reduced if a continuum of support, education and therapeutic services are made available. Research further indicates that effective services are designed with flexible working hours and small caseloads and designed to be practical and intensive. Such services were found to be more critical to positive outcomes than specific techniques such as teaching communication skills, helping with the expression of feelings or altering behavior.

An Effective Home Visitor Model: Hawaii's Healthy Start

Based on studies done in Denver on the home visitor model in the late 1970's, Hawaii's Healthy Start model of child abuse and neglect prevention was formalized in 1985. It began modestly in 1975 as a small, hospital-based effort established by the Hawaii Family Stress Center. With a budget of less than $100,000, the Stress Center provided both screening and home visitor services for mothers deemed "at-risk" when a child was born. This program was quite successful, with no abuse and only a few cases of neglect among high risk families over several years. Due to Healthy Start's high impact on the prevention of child abuse and neglect, the project expanded in the following years.

Data from the Healthy Start demonstration project (1985-88) and from the expanded Healthy Start program (1987-90) show that abuse and neglect was prevented in families identified as "high-risk" 99.8 percent of the time. Control group studies indicate that abuse and neglect occurs in up to 20 percent of high-risk families who do not receive services. Incredible as it may sound child abuse and neglect were all but eliminated in those families served by the Healthy Start model.

For families identified by the project as "not at-risk" there was a 99.8 percent accuracy rate in correctly identifying the families.

It is interesting to note that in the Healthy Start model a family is either "at-risk" or "not at-risk." Families who were considered "on the edge" and fell below the cut-off level for services on the assessment tool did not move into the "at-risk" category up to five years later. Becoming "at-risk" following the assessment was measured by referral to Child Protective Services before the age of five. (Eighty percent of all severe abuse occurs to children before they are five years old.)

Healthy Start is a voluntary program. Only five percent of the identified families refused services. This was in large part due to the persistent efforts of the Healthy Start Early Identification Specialists and the Family Support Workers to "hook" resistant families by offering simple support services, e.g., babysitting, trips to the doctor or the grocery store.

The goals of the Healthy Start program are to:

- Advance optimal child development;
- Provide positive parenting;
- Enhance parent-child interaction;
- Assure proper medical care; and
- Prevent child abuse and neglect.

Replicating Healthy Start

Healthy Start is representative of the best practice standards suggested by the repeated evaluations of the home visitor model. The elements are:

Systematic Hospital-Based Screening
The initiative of services in the hospital following the birth of a child minimizes the stigma associated with the intervention since the majority of women, regardless of income or social standing, deliver at the hospital. Using hospital records, families are screened through assessing risk indicators *(see Figure 1)* developed by the Family Stress Center. If a screen is positive, the mother is personally interviewed to determine the presence of risk. If the risk of abuse is present, the family is encouraged to accept home visitor services.

Figure 1

Healthy Family Screening Record

- ❑ Marital status: single, separated, divorced
- ❑ Partner unemployed
- ❑ Inadequate income; no information regarding income source
- ❑ Unstable housing
- ❑ No phone
- ❑ Education under 12 years
- ❑ Inadequate emergency contacts
- ❑ History of substance abuse
- ❑ Late prenatal care (later than 12 weeks), poor compliance or no prenatal care
- ❑ History of abortions
- ❑ history of psychiatric care
- ❑ Abortion unsuccessfully sought or attempted
- ❑ Relinquishment for adoption sought or attempted
- ❑ Marital or family problems
- ❑ History of, or current depression.

Community-Based Home Visiting by a Paraprofessional
Once the family has accepted the offer of in-home services, a paraprofessional home visitor contacts the mother in the hospital and schedules a home visit. The home visitor is often a parent from the community in which the "at-risk" family lives and has on-the-job rather than professional training. Initial visits are devoted to building trust, assessing family needs and providing help with immediate problems. The visitor focuses primarily on providing emotional support and modeling effective parenting skills. "Do for, do with and cheer on" sums up the visitor's approach to the family.

Linkage to Appropriate Medical Care
Preventive health care is stressed as an important aspect of promoting positive child development. Each family is assisted in selecting a primary health care provider and in following through with appointments and immunizations.

Services Are Intense, Long-Term and Flexible
A "development plan" is established for each family based on level of need and risk. As family relationships become more stable and the family members become more independent in using other community resources, the frequency of home visits reduces. Home visitation can continue for up to five years and be as intense as weekly, if needed. Healthy Start defines four levels of need with families at the fourth level being the most independent and receiving only quarterly visits from the Family Support Worker. Some families remain at the first level for five years receiving weekly home visits. The focus of the intervention is always the child and what it takes to keep him or her safe.

Case Management and Interagency Coordination
Coordination of services is of primary importance. Because at-risk families generally lack trust in people and services and thus do not reach out for help, those families who need services are the least likely to seek them. As the home visitor gains the confidence of the family, he or she is in a position to coordinate a wide range of services.

Intensive Training and Supervision
The caseloads of the Family Support Workers are low (15 for families on level I) and supervision is provided on a one-to-one basis at least weekly. Group supervision and support is also extended. A regular review of case (development) plans is important. Pre-service and in-service training in family systems theory, addiction, family violence and child development are mandatory.

Healthy Families America

Healthy Families-America (HFA) is an initiative by the National Committee for the Prevention of Child Abuse (NCPCA) in connection with the Ronald McDonald Children's Charities to replicate Hawaii's Healthy Start home visitor program nationwide. At the end of May, 36 states had efforts underway to introduce HFA. These efforts typically involve the state bureau on Maternal and Child Health, NCPC state chapters and the state's Children's Trust Fund. Early plans in the states range from setting up one or more pilot projects in the coming year, to establishing a statewide plan, and to introducing legislation for a statewide program.

The goal of HFA is to lay the foundation for a universal, voluntary neonatal home visiting program across the United States. The specific outcomes expected after three years include:

- At least 25 states will have initiated statewide home visitor services with all new parents modeled after Hawaii's Healthy Start.
- At least twice as many at-risk new parents will be receiving intensive home visitor services than did at the beginning of the effort.
- Child abuse will be reduced by at least 75 percent in the population receiving intensive home visitor services.

Private Sector Response

To say that child abuse and neglect are a "national disgrace" does not overstate the current state of affairs for America's children. The exponential rise in child abuse and neglect over the last decade is also an embarrassment for child welfare agencies in the private sector. Over the past 125 years, the timely and generous response of the private sector to crises involving children has had profound, positive impact. However, despite all the dollars spent and good efforts of the government and private agencies now, there continues to be a big gap in the nation's child welfare services. Abused and neglected children are falling through it. What will the response of the private sector be to Healthy Families America and the development of home visitor programs along the lines of Hawaii's Healthy Start?

The current crisis presents the private sector with the opportunity to make a fundamental change in child welfare services for abused and neglected children. While the home visitor model is by no means a panacea, no other approach has the promise it demonstrates. We know what to do for the epidemic of child abuse. If we care about America's future, the time to begin is now! ■

References

Cohn, A. "An Approach to Preventing Child Abuse: The Home Visitor Model."

National Committee for the Prevention of Child Abuse. "Healthy Families America: An Effort to Establish Home Visitor Services for All First Time Parents Nationwide."

National Committee for the Prevention of Child Abuse. "An Approach to Evaluating the Replication of Hawaii's Healthy Start Nationwide."

INFORMATION SHEET

NATIONAL CHILD ABUSE COALITION
733-15th Street NW • Suite 938 • Washington • DC 20005 Phone 202 • 347-3666

TO: National Child Abuse Coalition/WASHINGTON MEMORANDUM

FROM: Tom Birch

DATE: August 23, 1995

Take Action!

CAPTA/WELFARE REFORM PENDING SENATE VOTE

Legislation to reauthorize the Child Abuse Prevention and Treatment Act (CAPTA) will be part of the welfare reform legislation the Senate is expected to consider after the Labor Day recess beginning the week of September 5. Unlike the House-passed welfare reform measure, the Senate bill does not contain a child protection block grant that combines foster care, adoption assistance, CAPTA and other child protection programs. The House bill also repeals CAPTA>

With only a couple of days of debate before the recess began, Republican majority leader Sen. Bob Dole (KS) pulled the welfare reform issue off the Senate floor.

Because of broad opposition to his bill from across the ideological spectrum, Dole called off consideration of welfare reform soon after it began rather than face scores of time-consuming, debilitating amendments from Republicans and Democrats dissatisfied with his proposal. Since then, Dole has worked to create a new welfare reform package.

Republican governors appeared to offer the Senate Republican leader a path to consensus on some of the thornier welfare reform issues: maintenance of effort and child care. By recommending proposals that would require states to continue spending their own funds on AFDC cash benefits and by suggesting that states should pay for child care when mothers on AFDC are required to work, the governors appeared to address two major issues cited by Republican moderates, the Clinton administration and Senate Democrats as objections to the Dole welfare reform plan brought to the Senate floor in the week before adjournment for the August recess.

Unfortunately, on closer inspection the new provisions on maintenance of effort and child care are scarcely adequate to satisfy all of Dole's

critics, and Democrats may remain unified behind a rival plan developed by Sen. Tom Daschle (D-MT). With Dole's changes, states would be required to maintain their funding effort only for two years, and then only at a level of 75 perc t of state spending on cash welfare payments. The child care provision does no more than exempt from work participation families with a child under age 1 if no child care is provided. The welfare reform legislation passed by the House in March contains neither a state funding requirement nor a child care guarantee.

If Dole's welfare reform package does not pick up forward motion after Labor Day, the legislation — including the CAPTA reauthorization piece — would likely be attached to an omnibus budget reconciliation bill aimed at balancing the budget, which may become the vehicle for a long list of bills awaiting floor action.

ADVOCACY ALERT: HOUSE ACTION NEEDED ON CAPTA

Advocacy attention is focused on the House to prepare for conference committee on welfare reform in an effort to convince House members to reauthorize CAPTA and to give up the idea of a child protection block grant, separating issues of protecting children from the reform of welfare to assist poor families.

Advocates are urged to contact Republican Representatives on the House Ways and Means Committee and the Economic and Educational Opportunities Committee who might be members of the House-Senate conference committee on welfare reform, with jurisdiction over the reauthorization of CAPTA. Ask legislators to commit to reauthorizing CAPTA and dropping the child protection block grant.

1. **Reauthorize CAPTA**

   - o The Senate welfare reform bill includes S.919, sponsored by Sen. Dan Coats (R-IN), which affirmatively reauthorizes CAPTA.
   - o S.919 changes CAPTA to reduce bureaucracy and improve state flexibility. The bill:
     - continues essential protections for children.
     - streamlines CAPTA's state plan and reporting requirements for grants to improve CPS systems.
     - authorizes a scientific research program in child maltreatment.
     - establishes a narrower minimum definition of child abuse and neglect to afford states more flexibility in CPS responsibilities.
     - consolidates five programs into one community-based family resource grant for child abuse prevention activities.
     - repeals two categorical programs (Temporary Child Care and Crisis Nurseries Act and McKinney Homeless Assistance Act Family Support Centers.)
     - reauthorizes the Adoption Opportunities Act, the Abandoned Infants Assistance Act, the Missing Children's Assistance Act, and the Victims of Child Abuse Act.

2. Drop the Child Protection Block Grant

- The protection of abused and neglected children is not an issue of poverty to be addressed in the context of welfare reform.
- The block grant eliminates the ultimate safety net with no adequate funding guaranteed to protect the most vulnerable children.
- Congress should wait to assess the true impact of welfare reform measures on children and families before deciding on changes in the child protection system.
- The block grant reduces funding by $3.5 billion that cuts into resources states need for protecting children.
- The block grant eliminates any focus on prevention, including the new Family Preservation and Family Support Program grants. States will be forced to devote limited funding to crisis intervention.
- The block grant fails to continue all the protections for children contained in CAPTA.
- The block grant shortchanges the federal leadership role in research, training, technical assistance, data collection and information dissemination.

Contact your Representatives listed below. A House-Senate conference committee on welfare reform and CAPTA could meet by late September at the earliest.

Key Republicans on the House Ways and Means Committee.

Connecticut - Nancy Johnson
Florida - Clay Shaw
Illinois - Philip Crane
Louisiana - Jim McCrery
Michigan - David Camp
Minnesota - Jim Ramstad
New York - Amo Houghton
Ohio - Rob Portman
Pennsylvania - Phil English
Texas - Bill Archer
Washington - Jennifer Dunn

Key Republicans on the House Economic and Educational Opportunities Committee.

California - Duke Cunningham
Delaware - Mike Castle
New Jersey - Marge Roukema
Pennsylvania - Bill Goodling
Jim Greenwood
Wisconsin - Steve Gunderson

Address letters as follows: Honorable _____
U.S. House of Representatives
Washington, D.C. 20515

Place calls through the Capitol operator at 202-224-3121.

AHA EXAMINES 20 YEARS OF CAPTA

The American Humane Association (AHA) has released an 86-page report entitled "Twenty Years After CAPTA: A Portrait of the Child Protective Services System." The study, funded in part by the Edna McConnell Clark Foundation, is a retrospec

tive analysis of what has occurred in the child welfare field since the passage of CAPTA by Congress in 1974.

The report examines the impact of CAPTA as well as the Adoption Assistance and Child Welfare Act passed in 1980, focused on foster care and adoption funding and practices, and the effects of the newly enacted Family Preservation and Support Act of 1993. In addition, the report reviews the evolution of aspects of the child welfare system, including system management structure, preparation of CPS staff, structure of services, access to the child welfare system, children and families in child welfare, types of interventions, and outcomes for children and families.

Copies of the report may be ordered from AHA by calling the Children's Division at 800-227-4645.

CONFERENCE NEWS

The National Association of Counsel for Children (NACC) presents its 18th National Children's Law Conference, "Children's Law, Policy and Practice", September 14-16, 1995 at the Boston Marriott Cambridge Hotel in Boston, Massachusetts. The conference is designed for professionals from the fields of law, medicine, social work and education, with a focus on the practice of children's law and advocacy through interdisciplinary training and education. For information, please contact NACC at 303-322-2260.

The 7th Annual Mid-Atlantic Conference to Prevent Child Abuse will be hosted by the Child Abuse Prevention Committee of Central Pennsylvania, November 2-3, 1995, in Lancaster, Pennsylvania. The conference will focus on prevention, legal aspects, treatment and other issues beneficial to therapists, child protection workers, law enforcement officials, and medical professionals. For information, please contact the Child Abuse Prevention Committee office at 717-560-8847.

* * * * * * *

Subscriptions to WASHINGTON MEMORANDUM, published monthly, are $35 a year. Please mail your check payable to: National Child Abuse Coalition, 733 15th Street, N.W., Suite 938, Washington, D.C. 20005

- -

Enclosed is my check for $35 for a subscription to WASHINGTON MEMORANDUM

Name _____

Address _____

City _____ State _____ Zip _____

ECONOMY

Welfare Reform Could Bump Into Fed Policy

AS Peter Barth drives about San Francisco, he frequently sees men or women holding signs at stoplights or drive-on ramps asking for money, food, or work.

Those few could turn into crowds of beggars and street vendors if welfare "reform" passes Congress, says the senior fellow at a new think tank. "We are going to be like Brazil. It is the inevitable consequence of what is going on in Washington."

This view stems from a failure of legislators to see the "realities" in the welfare picture, says Mr. Barth of Redefining Progress in San Francisco. The goal of bills in both the Senate and House is to turn welfare back to the states, giving them a block grant. The House would require strict work requirements and limits on benefits. The Senate would allow states to set such strictures. Some states have already moved toward requiring able-bodied welfare recipients to work for their benefits.

DAVID R. FRANCIS

A basic problem with this plan is the explicit policy of the Federal Reserve to keep unemployment around 6 percent as necessary to keep inflation under control, notes Barth.

Only this week, the Fed decided not to drop interest rates further lest the economy pick up so much steam that unemployment, now at about 5.6 percent, drop even further below what Fed economists call the Non-Accelerating-Inflation Rate of Unemployment.

Economists figure that about 3 percent unemployment, or about 3.5 million of the 7.4 million jobless in the nation, are "frictionally" unemployed. That is, they are people changing jobs, often voluntarily, and out of work for only a short time. They may be construction workers awaiting a call for the next project, or managers looking for more challenge and money.

But the jobless picture for the remaining nearly 4 million out of work is more serious. Added to these are millions more adults who have exhausted any unemployment benefits and are too discouraged to seek work. That means, according to Barth, that capitalism requires roughly one-tenth of its potential workers to be jobless for the sake of price stability.

So if the states, under federal law or otherwise, decide to require adults on welfare to go to work after a limited period of benefits, say two years, where will they find jobs?

There are not quite 5 million welfare cases in the country, so at least that many adults are on welfare. Many presumably aren't fit for work for various reasons. But say 2 million were forced to seek work and found it. That would mean 2 million employed workers would have to lose their jobs if the Fed insisted on keeping unemployment at 6 percent of the labor force.

"What you will get is a shuffling," says Dean Baker, an economist at the Economic Policy Institute in Washington. Because many on welfare lack good job qualifications, they will often be competing for minimum wage or other low-paying jobs. A study by that institute, soon to be released, indicates wages of those with high school education or less could be depressed by 18 percent by competition from ex-welfare recipients. This would exacerbate a worsening distribution of income in the nation.

Many ex-welfare recipients couldn't support their families in such low-paying, often part-time, jobs. Yet business generally objects to measures that would raise the minimum wage.

Thus Barth charges that capitalism requires an army of workers living at bare subsistence level as well as an army of unemployed. He sees welfare children suffering inadequate nutrition and health care, perhaps joining their parents on the streets in a burgeoning subterranean economy.

The approach of President Clinton on welfare reform called for a two-years-and-out rule, but with funds for child care, job training, health insurance, and jobs of last resort. Finding work isn't left entirely to the availability of jobs in the private sector, which is subject to Fed monetary policy. New York City, among others, has put some welfare people to work cleaning up the city.

If the states are given full responsibility for welfare, many will be reluctant to take on the extra expense of providing government jobs and child care for single mothers or others on welfare. Rather, history suggests, many states will attempt to keep welfare benefits so low that welfare families will move to other states with more generous benefits – or wash windshields.

The Honolulu Advertiser Thursday, April 14, 1994

Suffer the little children

ROBERT RENO

Newsday columnist on politics and economics

If one in three victims of physical abuse were corporation presidents, it'd be considered a national crisis. If 60 percent of aged people weren't getting shots that could save their lives, it'd be a scandal. If 3 million police officers were so poorly paid that their families were living in poverty, we'd do something about it. And if the U.S. mortality rate for Olympic athletes was vastly higher than that of 19 industrial nations, we'd suspect something was dreadfully wrong.

Yet we have an astonishing capacity as a nation to absorb and shrug off all these enormities when they happen to infants and small children.

Indeed, the most shocking thing about this week's report of the Carnegie Corp. — which documented high rates of poverty, mortality and abuse, as well as low rates of immunization among children under 3 — is that nothing in it is shocking. Appalling, maybe, but not shocking because these figures have all been abundantly reported in the social and medical literature for several years.

What's shocking is that nowhere on the urgent agenda of Congress is there an omnibus child welfare reform act with $25 billion in new funds behind it. There is, of course, a crime bill in each house, both of them top-heavy with money and punitive remedies that will make it easier to deal with today's infants when they reach adolescence. They are packed with measures to speed up the efficiency with which we will herd them into penitentiaries and execution chambers. The annual costs per prisoner will be 100 times the public burden of adequately supporting and encouraging a poor household with small children.

And, of course, we have a concerted drive in Washington to "end welfare as we know it," which appeals greatly to conservatives who imagine that the problem is fiscal, not social, and that public assistance has become nothing but an incentive for poor women to have more children.

Truth is, we have already ended welfare as we knew it. Because they are so rarely adjusted for inflation, the purchasing power of welfare benefits in America is about 20 percent less than it was a generation ago. We have appreciably reduced the financial incentive to go on welfare. We have restricted and discouraged access by the poor to contraception and abortion. And — surprise, surprise — as the Carnegie report shows, we have moved the nation into last place in the industrial world in virtually every statistical measure of infant welfare. If we made such a showing in the Olympics, we'd go into a patriotic swoon.

The arithmetical result of such neglect is easy enough to calculate. And God forbid we should help little children for sentimental reasons.

But unless I'm missing something isn't it shameful for a great nation t have to crunch numbers to bestir itself to do something about the disproportionate suffering of the littlest and weakest of its citizens? It used to be something you were moved to do because you were a civilized nation.

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

'We're Breaking The Cycle Of Abuse'

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

BY MARGERY STEIN

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

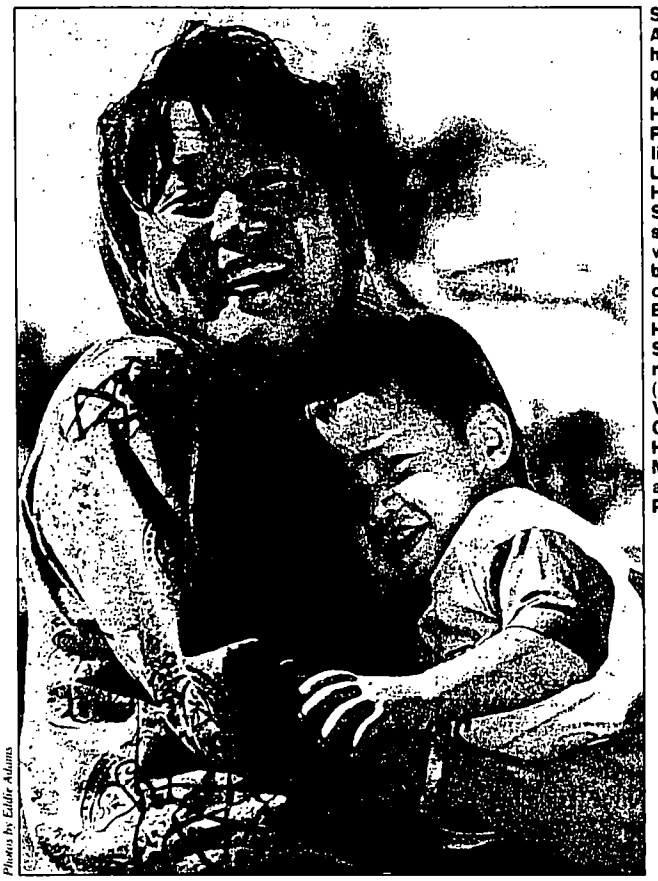
On the day Ah Yuen left the hospital, Healthy Start paired her with a home visitor named Mealii, who found her an apartment and visited every week for seven months. "With Mealii's support, I began to motivate myself," Ah Yuen recalled. "So far, I've finished a clerical program, and my next goal is to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

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

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

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

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



Photos by Eddie Adams

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

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

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

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

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

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

For more information, write: Healthy Families America, National Committee To Prevent Child Abuse, P.O. Box 2866, Dept. P, Chicago, Ill. 60690.

G. Implementing a Dramatic New Federal Initiative Aimed at Preventing Child Maltreatment--Piloting Universal Voluntary Neonatal Home Visitation

RECOMMENDATION G-1

PILOTING UNIVERSAL VOLUNTARY NEONATAL HOME VISITATION

> ***The Federal Government should begin planning for the sequential implementation of a universal voluntary neonatal home visitation system. The first step in the planning process should be the funding of a large series of coordinated pilot projects. Instead of reaffirming the efficacy of home visiting as a preventive measure--already well-established--these projects should aim at providing the Federal Government with the information needed to establish and administer a national home visitation system.***

The health system in the United States, unlike those in Europe, Canada, or other developed countries, is neither nationalized nor universal. There are, therefore--as the National Commission on Children recently pointed out--large numbers of pregnant women and children who have no access to the health care system, and many of these children are born with or develop chronic illnesses and disabilities. Although it did not reach unanimity on the recommendation, the Commission called for the development of a universal system of health insurance for pregnant women and children that builds upon the current combination of employment-based and public coverage.

The Board agrees that all children should have access to appropriate health care and follow-up. It believes that an important component of that care should be universal voluntary neonatal home visiting and that, irrespective of the fate of the Commission's recommendation, piloting for a national system of home visiting should begin immediately.

Thirty years ago, C. Henry Kempe and his colleagues focused national attention on the "Battered Child Syndrome." It was a problem then thought to affect 447 children in the United States. Reporting laws were passed and the development of multidisciplinary approaches to the recognition and treatment of abuse and neglect was stimulated by private and public funds.

Twenty years ago, research was begun which showed that one could identify families at high risk for physical abuse and neglect of children in the perinatal period. Fifteen years ago, the use of lay home visitors was shown to prevent the abuse of infants in high risk families.

Beginning 17 years ago, the Federal Government funded three successive waves of demonstration projects to test alternate approaches to treating and preventing child abuse and neglect. Intensive evaluation of those projects showed that, of the several techniques which the projects tested, support by parent aides--a form of home visiting--was among the most effective.[18]

Five years ago, David Olds of the University of Rochester and his colleagues demonstrated again the effectiveness of home visitors, using public health nurses for a high-risk adolescent parent population. Not only was abuse prevented, but the use of costly emergency health services declined, immunization rates improved, and, perhaps most significantly, subsequent pregnancy was delayed for two years longer than in the comparison group which had a second baby within the next year.

Subsequently, the Olds group found evidence of other positive benefits of home visitation programs. Such programs increase parental educational achievement and income; they decrease parental reliance on public assistance.

Recently, the U.S. General Accounting Office (GAO) reviewed home visiting. After GAO studied and documented the characteristics of successful home visitor programs, the Comptroller General of the United States, the head of GAO, found home visiting to be "an effective service delivery strategy" and called on the Secretary of Health and Human Services to coordinate and focus the Federal Government's efforts in home visitation.

---

[18] *When NCCAN funding for the third wave of demonstration projects ended ten years ago, most of the programs ceased to exist.*

Last year the Board noted that "the best documented preventive efforts are for home visitation sources for families of infants which are universal in many developed countries but are not now widely available in the United States." Further, it found that "it has become far easier to pick up the telephone to report one's neighbor for child abuse than it is for that neighbor to pick up the telephone to request and receive help before the abuse happens." In the year that has ensued since its first report, hundreds more infants throughout the United States have died or been severely damaged, in part because the nation has again delayed implementing what is known to work.

The following case of **Baby Joshua** illustrates this tragedy.

> **Baby Joshua**[19] **was** born in January 1991, 13 weeks premature. He weighed 1-1/2 pounds. His mother was 16 and unmarried but lived with her 19 year old boyfriend in a basement apartment.
>
> Baby Joshua required several days of respirator assistance and had several medical problems during his three-month stay in the premature intensive care nursery. His parents rarely visited, and when they did, they were noted by the nurses to argue and shove each other physically. The hospital social worker reported her concerns about the family to the County CPS agency, but since no abuse had occurred, the agency felt there was nothing that it could do.
>
> At the end of April, now 5-1/2 pounds and healthy, Baby Joshua was discharged home. His hospital bill, paid by Medicaid, exceeded $125,000.
>
> Four weeks later Baby Joshua was admitted to the hospital in a coma with massive brain and eye hemorrhages and a fracture of his leg. Two weeks earlier, according to his parents, he "had caught his head in the crib bars" and had bruised his head. There was no history of trauma before this admission, but it was clear that he had been violently beaten and shaken.
>
> As of now, Baby Joshua is visually impaired. He is expected to live, but there is a high probability that he will be blind as well as significantly developmentally delayed.

---

[19] *Details about this child have been slightly changed to protect its identity.*

The hospitalization for Joshua's brain injury is expected to cost $75,000, and his life-long long-term care will cost $20,000 to $50,000 per year depending on where he can find placement. There are also the costs of civil and criminal court proceedings against his father brought by the County.

The provision of home visitor services to Joshua and his parents, at an estimated cost of $2000 in this case, might have prevented his abuse and subsequent disability. It also might have kept his father from facing criminal prosecution and incarceration for felony child abuse at an estimated cost to the State of $200,000.

Since the publication of its 1990 report, many public officials, the media, and private citizens have asked the Board to prioritize among that report's 31 recommendations. While it believes all are required, it also believes that the single most important recommendation in the 1990 report dealt with the prevention of maltreatment through home visitation.

Through a home visitation system, as the Board envisions it, services would be made available to **all** new parents who requested it. The system would also accept referrals from health and child welfare agencies of families who are at risk of developing--but have not yet developed--abusive behavior.

Some will wonder about the wisdom of a voluntary, universal approach. Targeted efforts at high-risk families would potentially be more cost-effective. The Board believes, however, that a more limited, targeted effort (similar to an actual effort undertaken in the late 1970s) would be stigmatizing. Moreover, it believes that all new mothers and fathers need some help and support, and that the judicious use of volunteer lay home visitors for families at low risk for abuse is a good screening mechanism for identifying those at high-risk who may need extra, professional services.

The system could build on existing public and private, professional and volunteer programs currently operating throughout the nation. For example, these networks could be linked to parent self-help groups which have a twenty year history of utilizing trained volunteer professionals. Important Federal components would be the DHHS National Health Service Corps, Community Health Centers, and Indian Health Service outreach programs utilizing community health representatives, Alaska community health aides, and public health nurses.

Low-risk families could be served through networks of volunteers recruited by religious, business, corporate, neighborhood, and voluntary organizations and groups. High-risk families could be served by expanded public health nurse and/or parent aide teams.

The Board does not wish to oversell universal voluntary neonatal home visitation. It understands: (1) that there is evidence for negative side effects of home visitation programs among families that were already well-functioning; (2) that the positive effects are limited largely to "high-risk" families; (3) that some of the effect sizes are small; and (4) that the level of intervention that is necessary is substantial. (For example, the Hawaii Healthy Start Program, which is clearly the "star" among home visitation programs in the U.S., continues to age 5.)

The Board also understands that a universal voluntary neonatal home visitation program will not be accomplished easily. The Hawaii program still *screens* substantially less than 100 percent of the births in that State and then provides a home visitor to only those who are determined to be at high risk. That program, which has taken a while to get off the ground in a small State with a geographically concentrated population, costs $6 million per year, with indigenous paraprofessionals (not public health nurses) as the home visitors.

Moreover, the nations that have adopted home visitation typically have not had programs of the intensity of the Olds approach. They also have national health services.

Complex problems do not have simple solutions. While not a panacea, the Board believes that no other single intervention has the promise that home visitation has.

That is why the 1991 report calls upon the Federal Government to begin the immediate planning for the sequential implementation of a universal voluntary system of neonatal home visitation services. The first step in the planning process should be a large series of coordinated pilot projects to provide information which the Federal Government would need in the establishment and administration of a system.

Among the matters to be studied by the projects would be: costs; the level of program intensity required by families presenting various levels of risk; the optimal size of programs; data collection; staffing needs; training requirements; and differences in program design necessitated by various population groups and geographic locations. To ensure that the information obtained is accurate on a national scale, in the series should be State-wide, Reservation-wide, County-wide, city-wide, and neighborhood-wide units.

At the same time that the pilot projects are being conducted, several additional efforts related to the implementation of a home visitation system should be undertaken by the Federal Government. One such effort would involve stimulating the development of "Caring Community Programs"--networks of volunteers who, in each community throughout the nation, would be available to the system to provide support to all new

parents who request it. Another such effort would involve persuading insurers to include home visitation as part of the health maintenance services provided to children in the first two years of life for which the insurers will pay. A third such effort would involve ensuring that home visitation services are available to Native American as well as military families.

OPTIONS FOR ACTION

- *SECRETARY FOR HEALTH AND HUMAN SERVICES:* Direct the Administration for Children and Families, the Public Health Service, and the Health Care Financing Agency (HCFA) to launch the pilot projects. Possible sources of funding for the pilots might be the NCCAN Demonstration Grants Program, the Maternal and Child Health Block Grant Program, and the Medicaid Program.

- *SECRETARY FOR HEALTH AND HUMAN SERVICES:* Direct appropriate components of the Department, in collaboration with ACTION and the Points of Light Foundation, to stimulate the development of "Caring Community Programs."

- *SECRETARY FOR HEALTH AND HUMAN SERVICES:* Direct appropriate components of the Department, in collaboration with the American Academy of Pediatrics and the National Child Abuse Coalition, to attempt to persuade insurers, including those serving Federal employees, to cover the costs of home visiting.

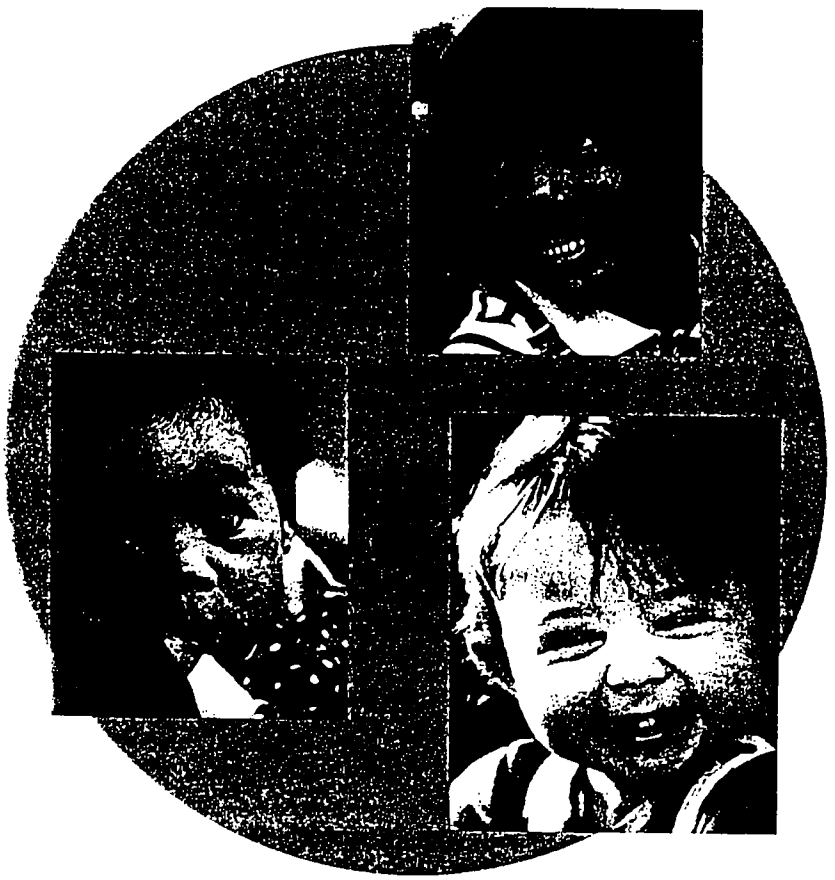
- *SECRETARY FOR HEALTH AND HUMAN SERVICES:* Direct the Assistant Secretary for Health to ensure that home visitation services are provided through the health care programs of the Indian Health Service.

- *SECRETARY FOR HEALTH AND HUMAN SERVICES:* Direct the Assistant Secretary for Health to attempt to persuade the Department of Defense to provide home visitation services to military families.

- *CONGRESS:* Use the next CAPTA reauthorization to authorize the sequential implementation of a universal voluntary system of neonatal home visitation services as well as to require DHHS to launch the pilot projects, to develop Caring Community Programs, to approach insurers aggressively, especially the insurers of Federal employees, to provide home visitation through the Indian Health Service, and to work with the Department of Defense on the provision of home visitation to military families.

STARTING POINTS

MEETING THE NEEDS OF OUR YOUNGEST CHILDREN



THE REPORT OF THE CARNEGIE TASK FORCE ON

MEETING THE NEEDS OF YOUNG CHILDREN

Executive Summary

Starting Points: Meeting the Needs of Our Youngest Children

Our nation's infants and toddlers and their families are in trouble. Compared with most other industrialized countries, the United States has a higher infant mortality rate, a higher proportion of low-birthweight babies, a smaller proportion of babies immunized against childhood diseases, and a much higher rate of babies born to adolescent mothers. Of the twelve million children under the age of three in the United States today, a staggering number are affected by one or more risk factors that undermine healthy development. One in four lives in poverty. One in four lives in a single-parent family. One in three victims of physical abuse is a baby under the age of one.

These numbers reflect a pattern of neglect that must be reversed. It has long been known that the first years of life are crucial for later development, and recent scientific findings provide a basis for these observations. We can now say, with greater confidence than ever before, that the quality of young children's environment and social experience has a decisive, long-lasting impact on their well-being and ability to learn.

The risks are clearer than ever before: an adverse environment can compromise a young child's brain function and overall development, placing him or her at greater risk of developing a variety of cognitive, behavioral, and physical difficulties. In some cases these effects may be irreversible. But the opportunities are equally dramatic: adequate pre- and postnatal care, dependable caregivers, and strong community support can prevent damage and provide a child with a decent start in life.

Researchers have thoroughly documented the importance of the pre- and postnatal months and the first three years, but a wide gap remains between scientific knowledge and social policy. Today, changes in the American economy and family, combined with the lack of affordable health and child care and the crumbling of other family supports, make it increasingly difficult for parents to provide the essential requirements for their young children's healthy development.

More than half of mothers of children under the age of three work outside the home. This is a matter of concern because minimal parental leave is available at the time of birth, and child care for infants and toddlers is often hard to find and of poor quality. Most parents feel overwhelmed by the dual demands of work and family, have less time to spend with their children, and worry about the unreliable and substandard child care in which many infants and toddlers spend long hours. These problems affect all families, but for families living in poverty, the lack of prenatal and child health care, human services, and social support in increasingly violent neighborhoods further stacks the deck against their children.

These facts add up to a crisis that jeopardizes our children's healthy development, undermines school readiness, and ultimately threatens our nation's economic strength. Once a world leader and innovator in education, the United States today is making insufficient investments in its future workforce—our youngest children. In contrast to all the other leading industrialized nations, the United States fails to give parents time to be with their newborns, fails to ensure pre- and postnatal health care for mothers and infants, and fails to provide adequate child care.

The crisis among our youngest children and their families is a quiet crisis. After all, babies seldom make the news. Their parents—often young people struggling to balance their home and work responsibilities—tend to have little economic clout and little say in community affairs. Moreover, children's early experience is associated with the home—a private realm into which many policymakers have been reluctant to intrude.

The problems facing our youngest children and their families cannot be solved through piecemeal efforts; nor can they be solved entirely through governmental programs and business initiatives. All Americans must take responsibility for reversing the quiet crisis. As the risks to our children intensify, so must our determination to enact family-centered programs and policies to ensure all of our youngest children the decent start that they deserve.

Recommendations for Action

The task force concluded that reversing the quiet crisis calls for action in four key areas that constitute vital starting points for our youngest children and their families.

Promote Responsible Parenthood

Our nation must foster both personal and social responsibility for having children. To enable women and men to plan and act responsibly, we need a national commitment to making comprehensive family planning, pre-conception, prenatal, and postpartum health services available, and to providing much more community-based education about the responsibilities of parenthood. To promote responsible parenthood, the task force recommends

- Planning for parenthood by all couples to avoid unnecessary risks and to promote a healthy environment for raising a child
- Providing comprehensive family planning, pre-conception, prenatal, and postpartum services as part of a minimum health care reform package.
- Delaying adolescent pregnancy through the provision of services, counseling, support, and age-appropriate life options
- Expanding education about parenthood in families, schools, and communities, beginning in the elementary school years but no later than early adolescence
- Directing state and local funds to initiate and expand community-based parent education and support programs for families with infants and toddlers

Guarantee Quality Child Care Choices

For healthy development, infants and toddlers need a continuing relationship with a few caring people, beginning with their parents and later including other child care providers. If this contact is substantial and consistent, young children can form the trusting attachments that are needed for healthy development throughout life. Infants and toddlers should develop these relationships in safe and predictable environments—in their homes or in child care settings. To guarantee quality child care choices the task force recommends

- Strengthening the Family and Medical Leave Act of 1993 by expanding coverage to include employers with fewer than fifty employees, extending the twelve-week leave to four to six months, and providing partial wage replacement
- Adopting family-friendly workplace policies such as flexible work schedules and assistance with child care
- Channeling substantial new federal funds into child care to ensure quality and affordability for families with children under three and making the Dependent Care Tax Credit refundable for low- and moderate-income families
- Providing greater incentives to states to adopt and monitor child care standards of quality
- Developing community-based networks linking all child care programs and offering parents a variety of child care settings
- Allocating federal and state funds to provide training opportunities so that all child care providers have a grounding in the care and development of children under three
- Improving salary and benefits for child care providers

Ensure Good Health and Protection

When young children are healthy, they are more likely to succeed in school and, in time, to form a more productive workforce and become better parents. Few social programs offer greater long-term benefits for American society than guaranteeing good health care for all infants and toddlers. Good health involves more than health care services. Being healthy means that young children are able to grow up in safe homes and neighborhoods. To ensure good health and protection, the task force recommends

- Making comprehensive primary and preventive care services, including immunizations, available to infants and toddlers as part of a minimum benefits package in health care reform
- Offering home-visiting services to all first-time mothers with a newborn and providing comprehensive home visiting services by trained professionals to all families who are at risk for poor maternal and child health outcomes
- Expanding the Women, Infants and Children (WIC) nutritional supplementation program to serve all eligible women and children
- Making the reduction of unintentional injuries to infants and toddlers a national priority

- Expanding proven parent education, support, and counseling programs to teach parents nonviolent conflict resolution in order to prevent child abuse and neglect, and implementing community-based programs to help families and children cope with the effects of living in unsafe and violent communities
- Enacting national, state, and local laws that stringently control the possession of firearms

Mobilize Communities to Support Young Children and Their Families

Broad-based community supports and services are necessary to ensure a decent start for our youngest children. Unfortunately, community services for families with children under three are few and fragmentary. To reverse the crisis facing families with young children, the old ways of providing services and supports must be reassessed, and broad, integrated approaches must be found to ensure that every family with a newborn is linked to a source of health care, child care, and parenting support. To mobilize communities to support young children and their families, the task force recommends

- Focusing the attention of every community in America on the needs of children under three and their families, by initiating a community-based strategic planning process
- Experimenting broadly with the creation of family-centered communities through two promising approaches: creating family and child centers to provide services and supports for all families; and expanding and adapting the Head Start model to meet the needs of low-income families with infants and toddlers
- Creating a high-level federal group, directed by the President to coordinate federal agency support on behalf of young children and to remove the obstacles faced by states and communities in their attempts to provide more effective services and supports to families with young children
- Funding family-centered programs through the Community Enterprise Board in order to strengthen families with infants and toddlers
- Establishing mechanisms, at the state level, to adopt comprehensive policy and program plans that focus on the period before birth through the first three years of a child's life

A Call to Action

The task force calls upon all sectors of American society to join together to ensure the healthy development of our nation's youngest children.

- We ask the *President* to direct a high-level federal group to review the findings of this report and to ensure the adequacy, coherence, and coordination of federal policies and programs for families with young children.
- We urge *federal agencies* to identify and remove the obstacles that states and communities encounter as they implement federally funded programs or test innovative solutions.

We call upon *states* to review their legislative and regulatory frameworks, particularly with regard to child care, in order to raise the quality of services for children under the age of three.

We call upon *community leaders* to assess the adequacy of existing services for families with young children (especially those with multiple risks), to recommend steps to improve and coordinate services, and to introduce mechanisms for monitoring results.

We call upon the *private and philanthropic sectors*, including foundations, to pay more attention to families with children under three and to expand their support of initiatives that give our youngest children a decent start in life.

We urge *educators*, to incorporate services to children under age three in their plans for the schools of the twenty-first century, to increase their efforts to educate young people about parenthood, and to provide more training and technical assistance to child care providers.

We call upon *health care decision makers* to include, in any plan for national health care reform, comprehensive prenatal care for expectant mothers and universal primary and preventive care for young children and to consider establishing a specific standard of coverage and service for young children.

We urge *service providers* in child care, health, and social services to work together by taking a family-centered approach to meeting the needs of young children and the adults who care for them. We ask them to offer staff, parents, and other caregivers opportunities to learn more about the needs of families with young children, about child development, and about promoting children's health and safety.

- We call upon *business leaders* to support policies that result in family-friendly workplaces in businesses of every size, for example strengthening the Family and Medical Leave Act of 1993 and introducing flexible work schedules.
- We call upon the *media* to deliver strong messages about responsible motherhood and fatherhood, to promote recognition of the importance of the first three years, and to give us all insight into the quiet crisis.
- We call upon *mothers and fathers* to secure the knowledge and resources they need to plan and raise children responsibly. When these resources are not available, we urge them to make their needs known to government representatives, community leaders, and service providers.

All Americans must work together, in their homes, workplaces, and communities, to ensure that children under the age of three—our most vulnerable citizens—are given the care and protection they need and deserve. Nothing less than the well-being of our society and the future of its vital institutions is at stake.