HAWAII FAMILY STRESS CENTER

Gail Breakey, R.N., M.P.H.
Director

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

A Program of Kapiolani Medical Center For Women and Children

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U.S. crime rolling up huge tab

$450 billion includes cost to victims

Associated Press

NEW YORK — Crime costs Americans at least $450 billion a year, according to the most comprehensive survey ever done on the price of violence, The New York Times reported.

The survey is the first to try to measure the cost of child abuse and domestic violence along with crimes like murder, rape and robbery. It is also the first to estimate the mental health care costs and reduced quality of life for victims of crime, the Times reported in today's editions.

"The estimate of $450 billion for crime is an amazing number which tells us just how heavy a burden that crime and the fear of crime place on our society," said Rep. Charles Schumer of New York, the ranking Democratic member of the House subcommittee on crime.

The study, "Victim Costs and Consequences: A New Look," was done by the National Institute of Justice, the research arm of the Justice Department.

It calculates the out-of-pocket costs of items such as legal fees, lost work time and police work as well as intangibles such as the affection lost for a murder victim's family. The authors devised a formula for the intangibles.

The study excludes the cost of running the nation's prisons, jails, and parole and probation systems, which would add $40 billion, bringing the total annual cost of crime to almost $500 billion, according to Justice Department statistics.

The authors of the new report point out that ignoring the intangible benefits of crime reduction "can lead to a misallocation of resources."

For example, the average rape incurs "out-of-pocket costs" to the victim of $5,100, less than the $20,000 annual cost of a prison cell, the authors said. But when the rape's effect on the victim's quality of life is calculated, the cost soars to $87,000, many times greater than the price of a prison cell, the study concludes.

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

Study links caring parents, healthy children

By Marilyn Elias
USA Today, July 1996

College students' perceptions of how much their parents care about them predict how healthy they will be in their mid-50s, shows a study to be reported this month.

The pioneering, 35-year study follows 87 Harvard College men into middle age.

The healthiest at age 55: those who reported in written assessments at age 20 that their parents were most caring.

Young men who said their parents were less loving, and especially those who saw their parents as unjust, were most apt to have such illnesses as heart disease and hypertension by 55. The link is independent of key risk factors - family history of illness, age and smoking. Harvard psychologist Linda Russek will tell the American Psychosomatic Society in Williamsburg, Va.

Parents are the main support anchors in a child's life, "and when a kid feels cared about, it reduces the moment-to-moment stress in his life," says co-author psychologist Gary Schwartz of the University of Arizona, Tucson.

The perception of being loved may lower stress hormones and improve immune function, setting the stage for a healthier adulthood, he adds.

"The take-home message," says Russek, "is to talk to your child and find out if he does feel loved. This is not about buying them stuff. It's about accepting the child's perception of their relationship with you as the truth," and acting in a way "that your child may experience you as just and loving."

The long-term health payoff suggests health maintenance organizations would be smart to emphasize good parent training programs. Schwartz says, "We could save a hugh amount in health-care costs by these preventive steps."

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Economic Scene | Peter Passell

Teen-age childbearing: the cost is put at $8.9 billion a year.

AN ambitious study issued last week by the Robin Hood Foundation in New York called "Kids Having Kids" will no doubt convince any remaining skeptics that teen-age childbearing is an economic as well as a social disaster.

But the research will disappoint those who assume that anyone going to the trouble to document these costs must have a fix in mind. "We haven't got the slightest idea what to do about teen-age pregnancy," said Douglas Besharov, a resident scholar at the American Enterprise Institute who was an adviser to the authors of the study.

Nor, for that matter, do social scientists hold out more than a glimmer of hope that public intervention can offset the economic consequences once the teen-agers give birth. The latest findings from Ohio's experiment in using financial incentives to keep teen-age mothers in school, reported last month by the Manpower Demonstration Research Corporation, are only marginally encouraging.

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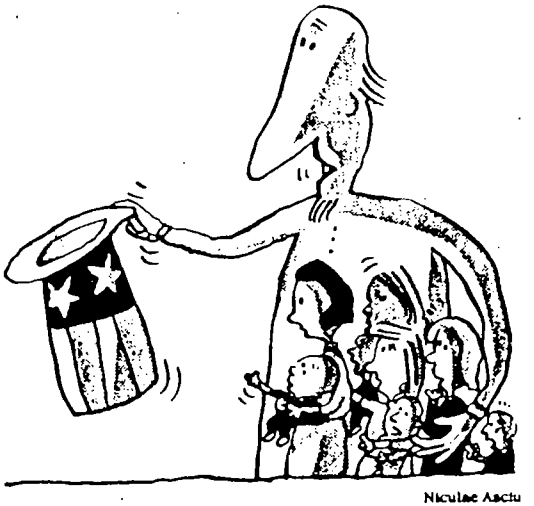
The Robin Hood Foundation, a New York-based charity dedicated to reducing poverty, commissioned a series of research papers on teen-age motherhood and hired Rebecca Maynard, an economist at the University of Pennsylvania, to put the pieces together. The story she tells is not pretty.

In 1993 some 175,000 babies were born to girls 17 or younger. Just 3 percent of the babies were put up for adoption. And since fewer than one in six of the mothers were married or well educated, most of the children were left to grow up in impoverished, single-parent families.

To those children, the mere fact that they were born to teen-age mothers will influence the rest of their lives. Extrapolating from recent history, teen-age mothers will be only marginally more dependent on welfare than their socioeconomic counterparts who wait an extra four years to give birth. But their children will be 50 percent more likely to repeat a grade in school, 42 percent more likely to drop out, 13 percent more likely to end up in prison, 30 percent more likely to be unemployed as young adults and 22 percent more likely to bear children themselves before the age of 18.



Nicolae Asciu

Ms. Maynard calculates that the problems associated with adolescent childbearing — as distinct from the general problems of growing up in poor or dysfunctional families — will cost taxpayers about $7 billion this year. That comes mostly from higher outlays on foster care, medical treatment and criminal justice, plus lost tax revenues. The overall costs to society, including the estimated productivity lost by the mothers, add up to $8.9 billion.

In Mr. Besharov's view these figures undoubtedly underestimate the economic consequences of teen-age pregnancy: parental age may matter, he says, but marital status matters even more. "A married teen-age mother is less likely to go on welfare than an unmarried 25-year old mother," he says.

Ms. Maynard agrees that the numbers are conservative, but for different reasons. A good chunk of the real cost, she argues, is borne by the young parents and their children, and is thus not easily measurable. Much of the rest, the cost to the nation of tolerating chronic poverty in the midst of plenty, is spiritual rather than economic.

By Mr. Besharov's reckoning, that tolerance is less a matter of public indifference than frustration. The common approaches to deterring early pregnancy — better access to contraception and abortion, intervention to support teen-agers' self-esteem and hope for economic advancement — are "insufficient to turn the tide."

And what about mitigating the damage, once girls become mothers? Some 20 states now demand that young mothers on welfare go to school. Ohio goes a step further, adding $62 to the monthly checks of those who attend and subtracting $62 from the checks of dropouts.

But the Manpower Demonstration Research Corporation's analysis of Ohio's LEAP experiment suggests that the impact has been modest. Compared with a control group, the percent of mothers employed in the previous three months was somewhat higher and the percent on welfare lower. "If the employment rate holds up it's very promising," said Judy Gueron, the president of M.D.R.C. But the high school graduation rate, probably the best single indicator of the economic prospects of teen-agers, rose in only one city, Cleveland. And once mothers do drop out, the evidence from Ohio and elsewhere points to unhappy endings. "You have to do more than change welfare incentives," Ms. Gueron concludes.

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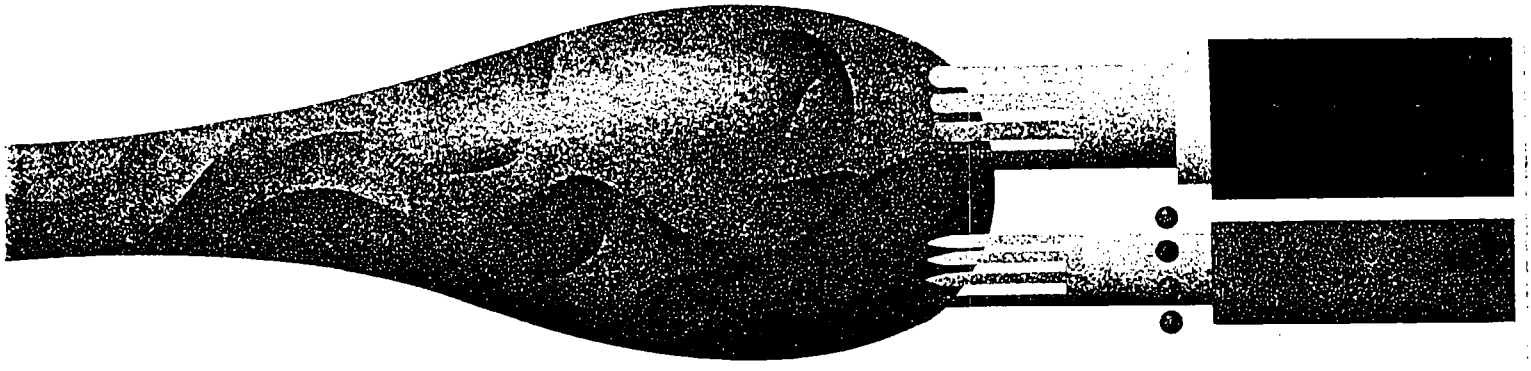
The problem of early pregnancy resists easy solution. But surely one mark of a healthy society is that defeat does not lead to defeatism. Hence the virtue of reminding Americans of the dimensions of the scourge. "The real value of looking at the narrow dollars and cents calculation," Ms. Maynard concludes, "is that people will pay attention."

A baby's brain is a work in progress, trillions of neurons waiting to be wired into a mind. The experiences of childhood, pioneering research shows, help form the brain's circuits—for music and math, language and emotion.



Your Child's Brain

BY SHARON BEGLEY

YOU HOLD YOUR NEWBORN SO HIS SKY-blue eyes are just inches from the brightly patterned wallpaper. *ZZZt:* a neuron from his retina makes an electrical connection with one in his brain's visual cortex. You gently touch his palm with a clothespin; he grasps it, drops it, and you return it to him with soft words and a smile. *Crackle:* neurons from his hand strengthen their connection to those in his sensory-motor cortex. He cries in the night; you feed him, holding his gaze because nature has seen to it that the distance from a parent's crooked elbow to his eyes exactly matches the distance at which a baby focuses. *Zap:* neurons in the brain's amygdala send pulses of electricity through the circuits that control emotion. You hold him on your lap and talk . . . and neurons from his ears start hard-wiring connections to the auditory cortex.

And you thought you were just playing with your kid.

When a baby comes into the world her brain is a jumble of neurons, all waiting to be woven into the

ILLUSTRATIONS BY TERRY ALLEN

intricate tapestry of the mind. Some of the neurons have already been hard-wired, by the genes in the fertilized egg, into circuits that command breathing or control heartbeat, regulate body temperature or produce reflexes. But trillions upon trillions more are like the Pentium chips in a computer before the factory preloads the software. They are pure and of almost infinite potential, unprogrammed circuits that might one day compose rap songs and do calculus, erupt in fury and melt in ecstasy. If the neurons are used, they become integrated into the circuitry of the brain by connecting to other neurons; if they are not used, they may die. It is the experiences of childhood, determining which neurons are used, that wire the circuits of the brain as surely as a programmer at a keyboard reconfigures the circuits in a computer. Which keys are typed—which experiences a child has—determines whether the child grows up to be intelligent or dull, fearful or self-assured, articulate or tongue-tied. Early experiences are so powerful, says pediatric neurobiologist Harry Chugani of Wayne State University, that "they can completely change the way a person turns out."

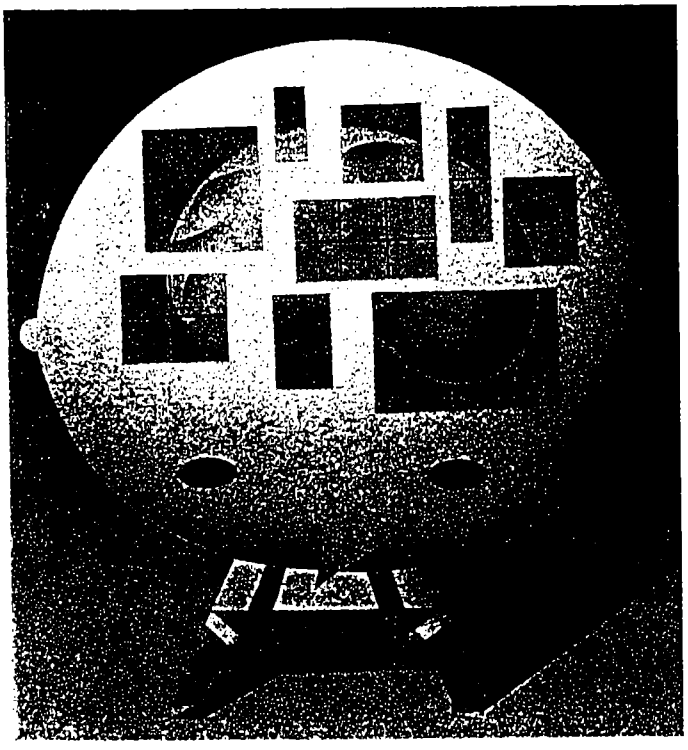
By adulthood the brain is crisscrossed with more than 100 billion neurons, each reaching out to thousands of others so that, all told, the brain has more than 100 trillion connections. It is those connections—more than the number of galaxies in the known universe—that give the brain its unrivaled powers. The traditional view was that the wiring diagram is predetermined, like one for a new house, by the genes in the fertilized egg. Unfortunately, even though half the genes—50,000—are involved in the central nervous system in some way, there are not enough of them to specify the brain's incomparably complex wiring. That leaves another possibility: genes might determine only the brain's main circuits, with something else shaping the trillions of finer connections. That something else is the environment, the myriad messages that the brain receives from the outside world. According to the emerging paradigm, "there are two broad stages of brain wiring," says developmental neurobiologist Carla Shatz of the University of California, Berkeley: "an early period, when experience is not required, and a later one, when it is."

Yet, once wired, there are limits to the brain's ability to create itself. Time limits. Called "critical periods," they are windows of opportunity that nature flings open, starting before birth, and then slams shut, one by one, with every additional candle on the child's birthday cake. In the experiments that gave birth to this paradigm in the 1970s, Torsten Wiesel and David Hubel found that sewing shut one eye of a newborn kitten rewired its brain: so few neurons connected from the shut eye to the visual cortex that the animal was blind even after its eye was reopened. Such rewiring did not occur in adult cats whose eyes were shut. Conclusion: there is a short, early period when circuits connect the retina to the visual cortex. When brain regions mature dictates how long they stay malleable. Sensory areas mature in early childhood; the emotional limbic system is wired by puberty; the frontal lobes—seat of understanding—develop at least through the age of 16.

The implications of this new understanding are at once promising and disturbing. They suggest that, with the right input at the right time, almost anything is possible. But they imply, too, that if you miss the window you're playing with a handicap. They offer an explanation of why the gains a toddler makes in Head Start are so often evanescent: this intensive instruction begins too late to fundamentally rewire the brain. And they make clear the mistake of postponing instruction in a second language (page 58). As Chugani asks, "What idiot decreed that foreign-language instruction not begin until high school?"

Neurobiologists are still at the dawn of understanding exactly which kinds of experiences, or sensory input, wire the brain in which ways. They know a great deal about the circuit for vision. It has a neuron-growth spurt at the age of 2 to 4 months, which corresponds to when babies start to really notice the world, and peaks at 8 months, when each neuron is connected to an astonishing 15,000 other neurons. A baby whose eyes are clouded by cataracts from birth will, despite cataract-removal surgery at the age of 2, be forever blind. For other systems, researchers know what happens, but not—at the level of neurons and molecules—how. They nevertheless remain confident that cognitive abilities work much like sensory ones, for the brain is parsimonious in how it conducts its affairs: a mechanism that works fine for wiring vision is not likely to be abandoned when it comes to circuits for music. "Connections are not forming willy-nilly," says Dale Purves of Duke University, "but are promoted by activity."

Language: Before there are words, in the world of a newborn, there are sounds. In English they are phonemes such as sharp ba's and da's, drawn-out ee's and ll's and sibilant sss's. In Japanese they are different—barked *hi*'s, merged rr/ll's. When a child hears a phoneme over and over, neurons from his ear stimulate the formation of



The Logical Brain

SKILL: Math and logic

LEARNING WINDOW: Birth to 4 years

WHAT WE KNOW: Circuits for math reside in the brain's cortex, near those for music. Toddlers taught simple concepts, like one and many, do better in math. Music lessons may help develop spatial skills.

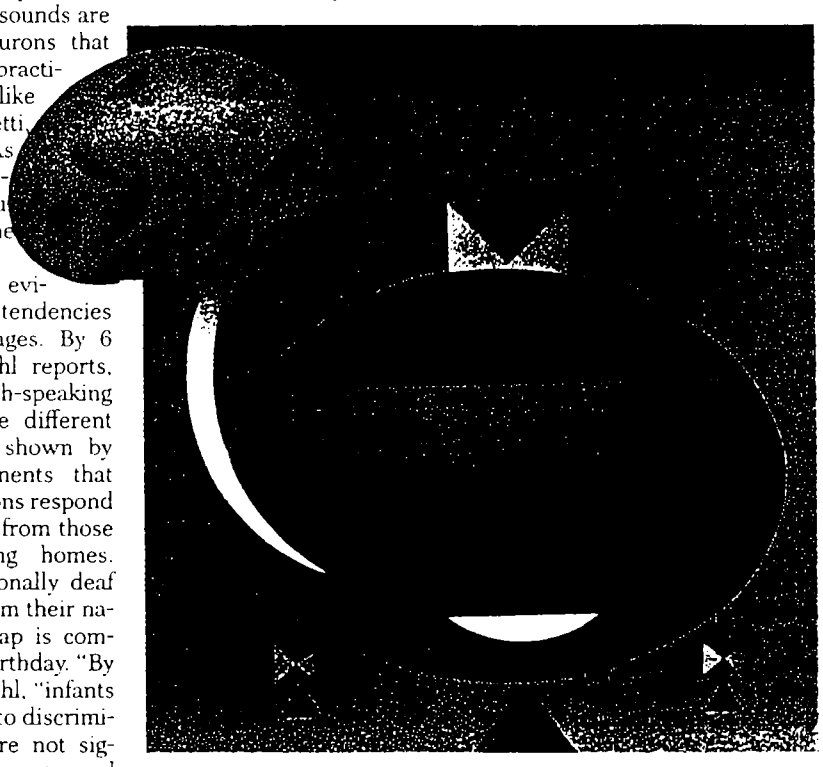
WHAT WE CAN DO ABOUT IT: Play counting games with a toddler. Have him set the table to learn one-to-one relationships—one plate, one fork per person. And, to hedge your bets, turn on a Mozart CD.

dedicated connections in his brain's auditory cortex. This "perceptual map," explains Patricia Kuhl of the University of Washington, reflects the apparent distance—and thus the similarity—between sounds. So in English-speakers, neurons in the auditory cortex that respond to "ra" lie far from those that respond to "la." But for Japanese, where the sounds are nearly identical, neurons that respond to "ra" are practically intertwined, like L.A. freeway spaghetti, with those for "la." As a result, a Japanese-speaker will have trouble distinguishing the two sounds.

Researchers find evidence of these tendencies across many languages. By 6 months of age, Kuhl reports, infants in English-speaking homes already have different auditory maps (as shown by electrical measurements that identify which neurons respond to different sounds) from those in Swedish-speaking homes. Children are functionally deaf to sounds absent from their native tongue. The map is completed by the first birthday. "By 12 months," says Kuhl, "infants have lost the ability to discriminate sounds that are not significant in their language, and their babbling has acquired the sound of their language."

Kuhl's findings help explain why learning a second language after, rather than with, the first is so difficult. "The perceptual map of the first language constrains the learning of a second," she says. In other words, the circuits are already wired for Spanish, and the remaining undedicated neurons have lost their ability to form basic new connections for, say, Greek. A child taught a second language after the age of 10 or so is unlikely ever to speak it like a native. Kuhl's work also suggests why related languages such as Spanish and French are easier to learn than unrelated ones: more of the existing circuits can do double duty.

With this basic circuitry established, a baby is primed to turn sounds into words. The more words a child hears, the faster she learns language, according to psychiatrist Janellen Huttenlocher of the University of Chicago. Infants whose mothers spoke to them a lot knew 131 more words at 20 months than did babies of more taciturn, or less involved, mothers; at 24 months, the gap had widened to 295 words. (Presumably the findings would also apply to a father if he were the primary caregiver.) It didn't matter which words the mother used—monosyllables seemed to work. The sound of words, it seems, builds up neural circuitry that can then absorb more words, much as creating a computer file allows the user to fill it with prose. "There is a huge vocabulary to be acquired," says Huttenlocher, "and it can only be acquired through repeated exposure to words."



The Language Brain

SKILL: Language

LEARNING WINDOW: Birth to 10 years

WHAT WE KNOW: Circuits in the auditory cortex, representing the sounds that form words, are wired by the age of 1. The more words a child hears by 2, the larger her vocabulary will grow. Hearing problems can impair the ability to match sounds to letters.

WHAT WE CAN DO ABOUT IT: Talk to your child—a lot. If you want her to master a second language, introduce it by the age of 10. Protect hearing by treating ear infections promptly.

Music: Last October researchers at the University of Konstanz in Germany reported that exposure to music rewires neural circuits. In the brains of nine string players examined with magnetic resonance imaging, the amount of somatosensory cortex dedicated to the thumb and fifth finger of the left hand—the fingering digits—was significantly larger than in nonplayers. How long the players practiced each day did not affect the cortical map. But the age at which they had been introduced to their muse did: the younger the child when she took up an instrument, the more cortex she devoted to playing it.

Like other circuits formed early in life, the ones for music endure. Wayne State's Chugani played the guitar as a child, then gave it up. A few years ago he started taking piano lessons with his young daughter. She learned easily, but he couldn't get his fingers to follow his wishes. Yet when Chugani recently picked up a guitar, he found to his delight that "the songs are still there," much like the muscle memory for riding a bicycle.

Math and logic: At UC Irvine, Gordon Shaw suspected that all higher-order thinking is characterized by similar patterns of neuron firing. "If you're working with little kids," says Shaw, "you're not going to teach them higher mathematics or chess. But they are interested in and can process music." So Shaw and Frances Rauscher gave 19 preschoolers piano or singing lessons. After eight months, the researchers found, the children "dramatically improved in spatial reasoning," compared with children given no music lessons, as shown in their ability to work mazes, draw geometric figures and copy patterns of two-color blocks. The mechanism behind the "Mozart effect" remains murky, but Shaw suspects that when children exercise cortical neurons by listening to classical music, they are also strengthening circuits used for mathematics. Music, says the UC team, "excites the inherent brain patterns and enhances their use in complex reasoning tasks."

Emotions: The trunk lines for the circuits controlling emotion are laid down before birth. Then parents take over. Perhaps the strongest influence is what psychiatrist Daniel Stern calls attunement—whether caregivers "play back a child's inner feelings." If a baby's squeal of delight at a puppy is met with a smile and hug, if her excitement at seeing a plane overhead is

mirrored, circuits for these emotions are reinforced. Apparently, the brain uses the same pathways to generate an emotion as to respond to one. So if an emotion is reciprocated, the electrical and chemical signals that produced it are reinforced. But if emotions are repeatedly met with indifference or a clashing response—Baby is proud of building a skyscraper out of Mom's best pots, and Mom is terminally annoyed—those circuits become confused and fail to strengthen. The key here is "repeatedly": one dismissive harrumph will not scar a child for life. It's the pattern that counts, and it can be very powerful: in one of Stern's studies, a baby whose mother never matched her level of excitement became extremely passive, unable to feel excitement or joy.

Experience can also wire the brain's "calm down" circuit, as Daniel Goleman describes in his best-selling "Emotional Intelligence." One father gently soothes his crying infant, another drops him into his crib; one mother hugs the toddler who just skinned her knee, another screams "It's your own stupid fault!" The first responses are attuned to the child's distress; the others are wildly out of emotional sync. Between 10 and 18 months, a cluster of cells in the rational prefrontal cortex is busy hooking up to the emotion regions. The circuit seems to grow into a control switch, able to calm agitation by infusing reason into emotion. Perhaps parental soothing trains this circuit, strengthening the neural connections that form it, so that the child learns how to calm herself down. This all happens so early that the effects of nurture can be misperceived as innate nature.

Stress and constant threats also rewire emotion circuits. These circuits are centered on the amygdala, a little almond-shaped structure deep in the brain whose job is to scan incoming sights and sounds for emotional content. According to a wiring diagram worked out by Joseph LeDoux of New York University, impulses from eye and ear reach the amygdala before they get to the rational, thoughtful neocortex. If a sight, sound or experience has proved painful before—Dad's drunken arrival home was followed by a beating—then the amygdala floods the circuits with neurochemicals before the higher brain knows what's happening. The more often this pathway is used, the easier it is to trigger: the mere memory of Dad may induce fear. Since the circuits can stay excited for days, the brain remains on high alert. In this state, says neuroscientist Bruce Perry of Baylor College of Medicine, more circuits attend to nonverbal cues—facial expressions, angry noises—that warn of impending danger. As a result, the cortex falls behind in development and has trouble assimilating complex information such as language.

SCHOOLS

Why Do Schools Flunk Biology?

BY LYNNELL HANCOCK

BIOLOGY IS A STAPLE AT MOST American high schools. Yet when it comes to the biology of the students themselves—how their brains develop and retain knowledge—school officials would rather not pay attention to the lessons. Can first graders handle French? What time should school

start? Should music be cut? Biologists have some important evidence to offer. But not only are they ignored, their findings are often turned upside down.

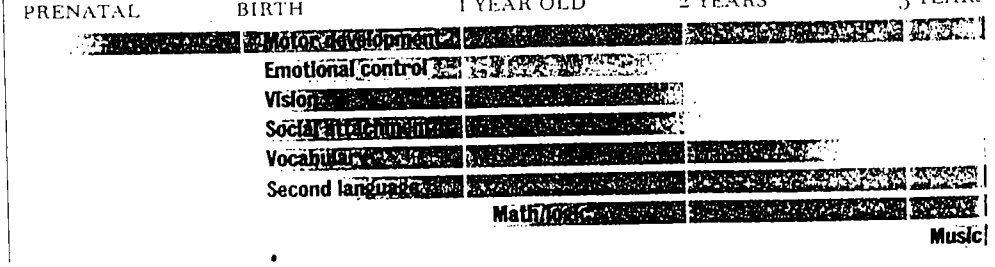
Force of habit rules the hallways and classrooms. Neither brain science nor education research has been able to free the majority of America's schools from their 19th-century roots. If more administrators were tuned into brain research, scientists argue, not only would schedules change, but subjects such as foreign language and geometry would be offered to much younger children. Music and gym would be daily requirements. Lectures, work sheets and rote memorization would be replaced by hands-on materials, drama and project work. And teachers would pay greater attention to children's emotional connections to subjects. "We do more education research than anyone else in the world," says Frank Vellutino, a professor of educational psychology at State University of New York at Albany, "and we ignore more as well."

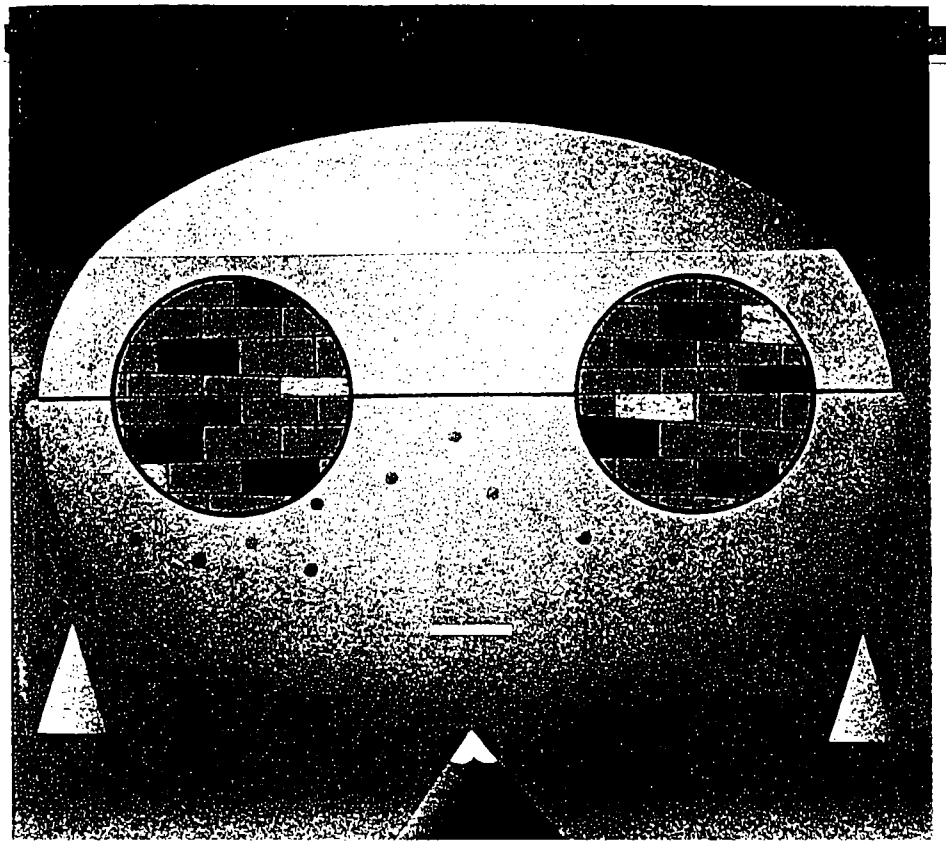
Plato once said that music "is a more potent instrument than any other for education." Now scientists know why. Music, they believe, trains the brain for higher forms of thinking. Researchers at the University of California, Irvine, studied the power of music by observing two groups of preschoolers. One group took piano lessons and sang daily in chorus. The other did not. After eight months the musical 3-year-olds were expert puzzlemasters, scoring 80 percent higher than their playmates did in spatial intelligence—the ability to visualize the world accurately.

This skill later translates into complex math and engineering skills. "Early music training can enhance a child's ability to reason," says Irvine physicist Gordon Shaw. Yet music education is often the first "frill" to be cut when school budgets shrink. Schools on average have only one music teacher for every 500 children, according to the National Commission on Music Education.

Then there's gym—another expendable hour by most school standards. Only 36 percent of schoolchildren today are required to participate in daily physical education. Yet researchers now know that exercise is good not only for the heart. It also juices up the brain, feeding it nutrients in the form of glucose and increasing nerve connections—all of which make it easier for kids of all ages to learn. Neuroscientist William Greenough confirmed this by watching rats at his University of Illinois at Urbana-Champaign lab. One group

The Windows of Opportunity





did nothing. A second exercised on an automatic treadmill. A third was set loose in a Barnum & Bailey obstacle course requiring the rats to perform acrobatic feats. These "supersmart" rats grew "an enormous amount of gray matter" compared with their sedentary partners, says Greenough.

Of course, children don't ordinarily run such gantlets; still, Greenough believes, the results are significant. Numerous studies, he says, show that children who exercise regularly do better in school.

The implication for schools goes beyond simple exercise. Children also need to be more physically active in the classroom, not sitting quietly in their seats memorizing subtraction tables. Knowledge is retained longer if children connect not only aurally but emotionally and physically to the material, says University of Oregon education professor Robert Sylwester in "A Celebration of Neurons."

Good teachers know that lecturing on the American Revolution is far less effective than acting out a battle. Angles and dimensions are better understood if children chuck their work sheets and build a complex model to scale. The smell of the glue enters memory through one sensory system, the touch of the wood blocks another, the sight of the finished model still another. The brain then creates a multidimensional mental model of the experience—one easier to retrieve. "Explaining a smell," says Sylwester, "is not as good as actually smelling it."

Scientists argue that children are capable of far more at younger ages than schools generally realize. People obviously continue learning their whole lives, but the optimum "windows of opportunity for learning" last until about the age of 10 or 12, says Harry Chugani of Wayne State University's Children's Hospital of Michigan. Chugani determined this by measuring the brain's consumption of its chief energy source, glucose. (The more glucose it uses, the more active the brain.) Children's brains, he observes, gobble up glucose at twice the adult rate from the age of 4 to puberty. So young brains are as primed as they'll ever be to process new information. Complex subjects such as trigonometry or foreign language shouldn't wait for puberty to be introduced. In fact, Chugani says, it's far easier for an elementary-school child to hear and process a second language—and even speak it without an accent. Yet most U.S. districts wait until junior high to introduce Spanish or French—after the "windows" are closed.

Reform could begin at the beginning. Many sleep researchers now believe that most teens' biological clocks are set later than those of their fellow humans. But high school starts at 7:30 a.m., usually to accommodate bus schedules. The result can be wasted class time for whole groups of kids. Making matters worse, many kids have trouble readjusting their natural sleep rhythm. Dr. Richard Allen of Johns Hopkins University found that teens went to sleep at the same time whether they had to be at school by 7:30 a.m. or 9:30 a.m. The later-to-rise teens not only get more sleep, he says; they also get better grades. The obvious solution would be to start school later when kids hit puberty. But at school, there's what's obvious, and then there's tradition.

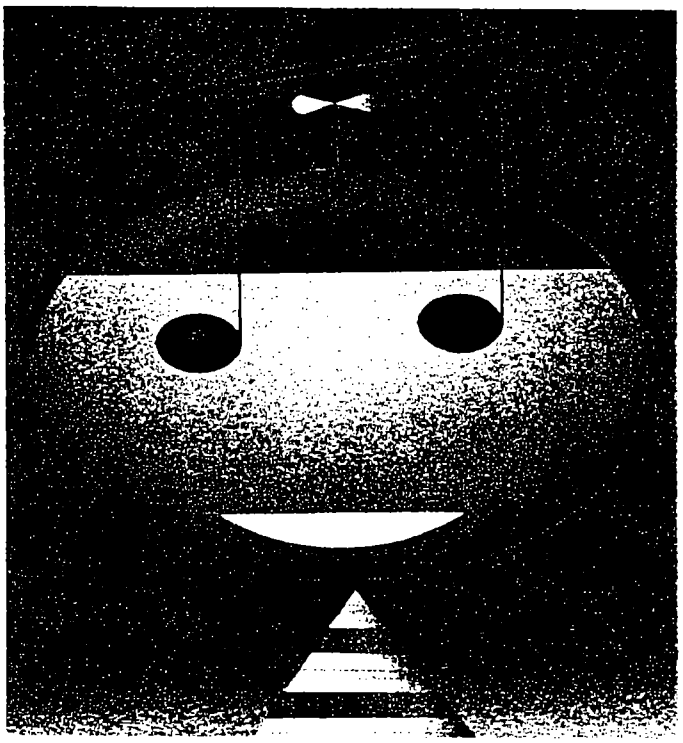
Why is this body of research rarely used in most American classrooms? Not many administrators or school-board members know it exists, says Linda Darling-Hammond, professor of education at Columbia University's Teachers College. In most states, neither teachers nor administrators are required to know much about how children learn in order to be certified. What's worse, she says, decisions to cut music or gym are often made by noneducators, whose concerns are more often monetary than educational. "Our school system was invented in the late 1800s, and little has changed," she says. "Can you imagine if the medical profession ran this way?"

With PAT WINGERT *and* MARY HAGER *in Washington*

Circuits in different regions of the brain mature at different times. As a result, different circuits are most sensitive to life's experiences at different ages. Give your children the stimulation they need when they need it, and anything's possible. Stumble, and all bets are off.

4 YEARS 5 YEARS 6 YEARS 7 YEARS 8 YEARS 9 YEARS

Movement: Fetal movements begin at 7 weeks and peak between the 15th and 17th weeks. That is when regions of the brain controlling movement start to wire up. The critical period lasts a while: it takes up to two years for cells in the cerebellum, which controls posture and movement, to form functional circuits. "A lot of organization takes place using information gleaned from when the child moves about in the world," says William Greenough of the University of Illinois. "If you restrict activity you inhibit the formation of synaptic connections in the cerebellum." The child's initially spastic movements send a signal to the brain's motor cortex: the more the arm, for instance, moves, the stronger the circuit, and the better the brain will become at moving the arm intentionally and fluidly. The window lasts only a few years: a child immobilized in a body cast until the age of 4 will learn to walk eventually, but never smoothly.



The Musical Brain

SKILL: Music

LEARNING WINDOW: 3 to 10 years

WHAT WE KNOW: String players have a larger area of their sensory cortex dedicated to the fingering digits on their left hand. Few concert-level performers begin playing later than the age of 10. It is much harder to learn an instrument as an adult.

WHAT WE CAN DO ABOUT IT: Sing songs with children. Play structured, melodic music. If a child shows any musical aptitude or interest, get an instrument into her hand early.

THERE ARE MANY more circuits to discover, and many more environmental influences to pin down. Still, neuro labs are filled with an unmistakable air of optimism these days. It stems from a growing understanding of how, at the level of nerve cells and molecules, the brain's circuits form. In the beginning, the brain-to-be consists of only a few advance scouts breaking trail: within a week of conception they march out of the embryo's "neural tube," a cylinder of cells extending from head to tail. Multiplying as they go (the brain adds an astonishing 250,000 neurons per minute during gestation), the neurons clump into the brain stem which commands heartbeat and breathing, build the little cerebellum at the back of the head which controls posture and movement, and form the grooved and rumpled cortex wherein thought and perception originate. The neural cells are so small, and the distance so great, that a neuron striking out for what will be the prefrontal cortex migrates a distance equivalent to a human's walking from New York to California, says developmental neurobiologist Mary Beth Hatten of Rockefeller University.

Only when they reach their destinations do these cells become true neurons. They grow a fiber called an axon that carries electrical signals. The axon might reach only to a neuron next door, or it might wend its way clear across to the other side of the brain. It is the axonal connections that form the brain's circuits. Genes determine the main highways along which axons travel to make their connection. But to reach particular target cells, axons follow chemical cues strewn along their path. Some of these chemicals attract: this way to the motor cortex! Some repel: no, *that* way to the olfactory cortex. By the fifth month of gestation most axons have reached their general destination. But like the prettiest girl in the bar, target cells attract way more suitors—axons—than they can accommodate.

How does the wiring get sorted out? The baby neurons fire electrical pulses once a minute, in a fit of what Berkeley's Shatz calls auto-dialing. If cells fire together, the target cells "ring" together. The target cells then release a flood of chemicals, called trophic factors, that strengthen the incipient connections. Active neurons respond better to trophic factors than inactive ones, Barbara Barres of Stanford University reported in October. So neurons that are quiet when others throb lose their grip on the target cell. "Cells that fire together wire together," says Shatz.

The same basic process continues after birth. Now, it is not an auto-dialer that sends signals, but stimuli from the senses. In experiments with rats, Illinois's Greenough found that animals raised with playmates and toys and other stimuli grow 25 percent more synapses than rats deprived of such stimuli.

Rats are not children, but all evidence suggests that the same rules of brain development hold. For decades Head Start has fallen short of the high hopes invested in it: the children's IQ gains fade after about three years. Craig Ramey of the University of Alabama suspected the culprit was timing: Head Start enrolls 2-, 3- and 4-year-olds. So in 1972 he launched the Abecedarian Project. Children from 120 poor families were assigned to one of four groups: intensive early education in a day-care center from about 4 months to age 8, from 4 months to 5 years, from 5 to 8 years, or none at all. What does it mean to "educate" a 4-month-old? Nothing fancy: blocks, beads, talking to him, playing games such as peek-a-boo. As outlined in the book "Learningames,"* each of the 200-odd activities was designed to enhance cognitive, language, social or motor development. In a recent paper, Ramey and Frances Campbell of the University of North Carolina report that children enrolled in Abecedarian as preschoolers still scored higher in math and reading at the age of 15 than untreated children. The children still retained an average IQ edge of 4.6 points. The earlier the children were enrolled, the more enduring the gain. And intervention after age 5 conferred no IQ or academic benefit.

*Joseph Sparling and Isabelle Lewis (226 pages. Walker. $8.95).

All of which raises a troubling question. If the windows of the mind close, for the most part, before we're out of elementary school, is all hope lost for children whose parents did not have them count beads to stimulate their math circuits, or babble to them to build their language loops? At one level, no: the brain retains the ability to learn throughout life, as witness anyone who was befuddled by Greek in college only to master it during retirement. But on a deeper level the news is sobering. Children whose neural circuits are not stimulated before kindergarten are never going to be what they could have been. "You want to say that it is never too late," says Joseph Sparling, who designed the Abecedarian curriculum. "But there seems to be something very special about the early years."

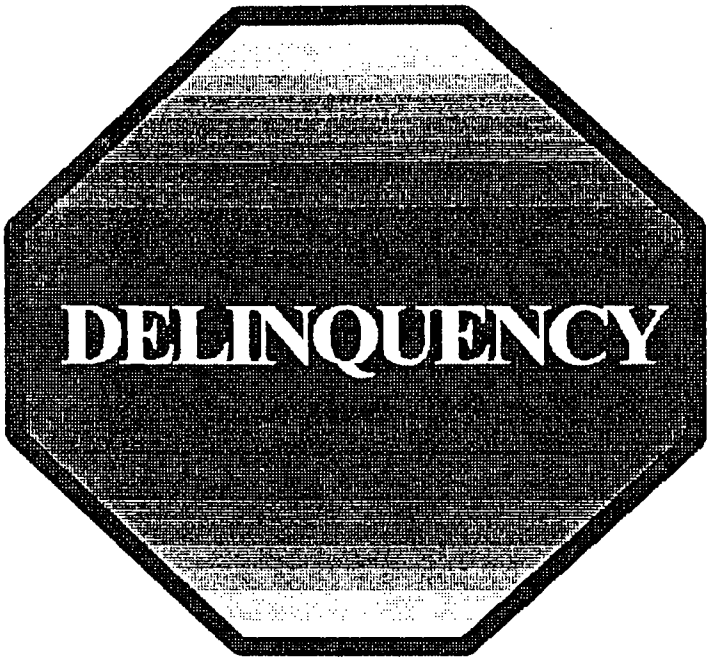
And yet . . . there is new evidence that certain kinds of intervention can reach even the older brain and, like a microscopic screwdriver, rewire broken circuits. In January, scientists led by Paula Tallal of Rutgers University and Michael Merzenich of UC San Francisco described a study of children who have "language-based learning disabilities"—reading problems. LLD affects 7 million children in the United States. Tallal has long argued that LLD arises from a child's inability to distinguish short, staccato sounds—such as "d" and "b." Normally, it takes neurons in the auditory cortex something like .015 second to respond to a signal from the ear, calm down and get ready to respond to the next sound; in LLD children, it takes five to 10 times as long. (Merzenich speculates that the defect might be the result of chronic middle-ear infections in infancy: the brain never "hears" sounds clearly and so fails to draw a sharp auditory map.) Short sounds such as "b" and "d" go by too fast—.04 second—to process. Unable to associate sounds with letters, the children develop reading problems.

The scientists drilled the 5- to 10-year-olds three hours a day with computer-produced sound that draws out short consonants, like an LP played too slow. The result: LLD children who were one to three years behind in language ability improved by a full two years after only four weeks. The improvement has lasted. The training, Merzenich suspect, redrew the wiring diagram in the children's auditory cortex to process fast sounds. Their reading problems vanished like the sounds of the letters that, before, they never heard.

Such neural rehab may be the ultimate payoff of the discovery that the experiences of life are etched in the bumps and squiggles of the brain. For now, it is enough to know that we are born with a world of potential—potential that will be realized only if it is tapped. And that is challenge enough.

With MARY HAGER

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



PREVENTION WORKS

OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION

June 1995
Program Summary

FOREWORD

Youth violence in our country has risen dramatically in the past decade. Among teenagers 15 to 19 years old, the escalation of gun violence is particularly alarming: one of every four deaths of a teenager is attributable to a firearm injury. What are the causes of this epidemic of violence? And how can we solve it?

Law enforcement efforts and court interventions are essential to our ability to respond swiftly and appropriately to teens who commit serious, violent crimes. But so is work in the area of prevention. There are prevention programs that work to keep those not currently involved in deviant and delinquent behavior out of trouble and to keep those involved in the juvenile justice system out of the criminal justice system. They are based on solid research and sound principles. They reflect the Administration's belief that prevention requires systematic efforts to reduce the opportunities and incentives for delinquent and criminal behavior and to increase the opportunities and incentives for responsible behavior.

The Office of Juvenile Justice and Delinquency Prevention (OJJDP), one of five program agencies in the Office of Justice Programs (OJP) at the Department of Justice, has compiled this report to assist states and jurisdictions in their prevention efforts. *Delinquency Prevention Works* provides a synthesis of the most current information on programs and strategies which seek to prevent delinquency. The theory of risk-focused prevention is explained and correlated to stages of youth development and areas of focus (e.g., family and community). To ground these programs and provide a context for their successful implementation, reference to relevant research and evaluation is also provided. Another recent OJJDP publication, *What Works: Promising Interventions in Juvenile Justice* (OJJDP, 1994) addressed a broad range of juvenile justice intervention programs. This report is designed to provide corresponding information in the area of delinquency prevention.

Practitioners and community residents are seeking answers to the problem of youth violence. They need the best information available on programs and strategies that have the greatest chance to succeed if implemented in their jurisdictions. The President's Crime Prevention Council, created as a part of the 1994 Violent Crime Control and Law Enforcement Act and chaired by the Vice President, is charged with assisting communities and community-based organizations seeking information regarding crime prevention programs and information on integrated program service delivery. This report is one of several that has been or will be produced by the Council or its member Departments that presents information on research, programs, or strategies for addressing delinquency, youth violence, safe and drug-free schools, and other related issues.[1]

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[1] The President's Crime Prevention Council, chaired by the Vice President, is comprised of the Attorney General; the Secretaries of Education, Health and Human Services, Housing and Urban Development, Labor, Agriculture, Treasury, and Interior; and the Director of the Office of National Drug Control Policy. Contact the President's Crime Prevention Council for a list of related documents.

The information in this report was gathered by OJJDP in conjunction with OJP'S National Institute of Justice, Bureau of Justice Assistance, Office for Victims of Crime, and Bureau of Justice Statistics. *Delinquency Prevention Works* incorporates written documentation from each of the listed programs and, through follow-up telephone calls to program directors and staff, researchers, practitioners, and other experts, adds the latest information from the field related to the prevention of delinquency.

We want to thank the staff of OJJDP, the agencies of OJP, and staff from other Department of Justice components who contributed to the development of this document. A special commendation goes to Joan Hurley, Acting Director of OJJDP's Research and Program Development Division, as the primary author of *Delinquency Prevention Works*.

Shay Bilchik
Administrator
Office of Juvenile Justice
and Delinquency Prevention

Karen Pittman
Executive Director
President's Crime Prevention Council

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INTRODUCTION

The number of juvenile violent crime arrests will double by the year 2010 if current arrest and population trends continue. Can our communities bear another 260,000 such arrests each year? Can we afford to lose a generation of youth to crime and violence? Can we bear the costs to the victims of juvenile violence?

If we are to increase public safety in our society, an aggressive, proactive response to juvenile crime and violence is needed. We know the following about effective delinquency prevention strategies:

- Juvenile crime—and ultimately adult crime—can be prevented and reduced.

- Lasting reductions in crime and violence require a long-term national investment in both law enforcement and prevention activities.

- Decades of research have provided a strong foundation for effective delinquency prevention. We know what to do and how to do it.

IT'S TIME TO PROTECT OUR COMMUNITIES

Effective delinquency prevention interrupts the processes that produce youthful deviant and delinquent behavior and encourages those processes that support healthy development of children. Understanding the roles of risk and protective factors helps us understand how we can prevent delinquency. The greater a child's exposure to risk factors, the greater his or her chances are of becoming delinquent. However, even a child exposed to multiple risk factors can avoid delinquency if he or she is shielded by enough protective factors. Our challenge is to help communities recognize both types of factors and to aid them in establishing programs that reduce risk and help youth become productive, law-abiding adults.

EFFECTIVE PREVENTION PROGRAM APPROACHES ARE AVAILABLE TO ASSIST COMMUNITIES

Community policing prevents delinquency. Higher levels of drug problems and juvenile delinquency and violence occur in communities where people feel little attachment to the community and where there is low surveillance of public places. Community police officers can bridge this gap by connecting high-risk youth to delinquency prevention programs.

Safe and effective schools prevent delinquency. Strategies that encourage commitment to school and academic success reduce delinquency among high-risk students. Promoting reading skills helps reduce delinquency because reading failure as early as first grade has been found to increase the likelihood of delinquent behavior. Enhancing school safety by eliminating guns and other weapons that create a climate of fear is fundamental to creating an effective learning environment.

Family strengthening prevents delinquency. Prevention strategies that help families develop good family management practices—including providing clear expectations and consistent discipline to children—can work with high-risk and dysfunctional families. Home visitation programs that offer intensive support to mothers at risk of abusing their newborns have produced a 75 percent reduction in cases of child abuse and neglect, thus breaking a violent cycle in which the abused too often grow up to become violent offenders.

Youth development programs prevent delinquency. Nine out of 10 juveniles involved in gangs for 3 or more years reported committing serious crimes, compared with only 3 out of 10 nongang youth in positive peer pressure environments. Programs that introduce at-risk youth to positive peer pressure environments can have a significant impact on their lives. Boys and Girls Clubs of America target high-risk youth in 64 public housing complexes across the Nation, and their programs have helped reduce the juvenile crime rate in these areas by 13 percent.

THE ROLE OF THE U.S. DEPARTMENT OF JUSTICE

The Department of Justice (DOJ) is committed to helping improve law enforcement and criminal and juvenile justice systems at the State and local levels. Achieving public safety requires a comprehensive strategy that combines increased enforcement and sanctions with effective prevention programs that reduce risk factors and increase protective factors for juveniles. DOJ's delinquency prevention activities focus on the following areas:

- Protecting public safety.
- Conducting research and developing and evaluating model State and local programs.
- Disseminating information about effective and promising approaches and juvenile crime trends.
- Providing training and technical assistance to State and local groups.

- Facilitating Federal, State, and local coordination, both "top down" and "bottom up."

Because of its focus on the full perspective of the justice system, DOJ is uniquely positioned to provide leadership in this area. In each State and community, the justice system must work in concert with other systems, including health, human services, and education. All of these partners share a goal to prevent juveniles from becoming involved in the juvenile and criminal justice systems. This common objective is why delinquency prevention is—and should be—the business of DOJ, just as health promotion and disease prevention is the business of the Department of Health and Human Services.

Because resources are limited, all systems must work together to serve juveniles under their purview. Coordinated efforts by health, human services, education, and justice agencies can provide a comprehensive approach to prevention that meets the needs of juveniles and their families effectively and economically.

Comprehensive efforts to save our children from delinquency and violence must be pursued with the same vigor we apply to preventing other life-threatening conditions. It is only through such a commitment that we can hope to stem the tide of violence and delinquency plaguing young people and communities across this Nation.

OVERVIEW

America is facing a juvenile violence crisis. The number of violent arrests of youth under age 18 has increased dramatically: 36 percent between 1989 and 1993, more than 4 times the increase reported for adults. During that period, juvenile arrests for homicide increased by 45 percent, while adult homicide arrests increased by only 6 percent (FBI, *Uniform Crime Reports,* 1994). In order to assist State and local governments in ensuring public safety, the Department of Justice must aggressively support enforcement of laws as well as effective efforts to prevent delinquency.

As the chief Federal agency dealing with the administration of justice for both adults and children, DOJ, through its enforcement programs, U.S. Attorneys, and the Office of Justice Programs and its five program bureaus, has developed an extraordinary network of programs and services to help States and local communities throughout the Nation prevent delinquency and deal with juvenile offenders in the most constructive ways possible. Through both research and practical experience in the field, DOJ programs help to identify effective strategies and approaches for working with juveniles who are at risk of delinquency or who are in the juvenile justice system.

PREVENTION IS THE KEY TO PUBLIC SAFETY

Today's epidemic of juvenile violence requires a national investment in public safety. This investment must include more community-oriented policing efforts, more corrections space, and prevention that works. Delinquency prevention represents a long-term investment in reducing delinquency and crime and is a critical component of a comprehensive approach to crime control and increased public safety.

As noted earlier in this report, if we allow juvenile violence rates to rise at the same pace as they have over the last decade, it is estimated that by the year 2010 the number of juvenile arrests for violent crime will more than double the 1992 level (National Center for Juvenile Justice, 1995). Public safety will be threatened if we do not implement effective delinquency prevention programs now. Otherwise, prohibitive levels of funding will be necessary to incarcerate these youth, a less effective and more costly solution than investment in prevention.

We recognize that increased law enforcement efforts and the transfer of some violent or intractable juveniles to adult criminal court are necessary to protect public safety. Research has demonstrated, however, that these steps need to be components of a well-balanced plan of action that includes prevention. While the short-term goal of controlling juvenile crime can in part be achieved through enhanced law enforcement and prosecution efforts, a long-term solution to achieving public safety is possible only by preventing juveniles from becoming involved in crime and violence in the first place.

This report highlights effective prevention programs and strategies, outlines the roles of DOJ and its component agencies, and illustrates ways in which interagency prevention efforts can address delinquency and its prevention. The discussion of these strategies demonstrates that preventing delinquency begins even before the child's birth, that it requires an interdisciplinary approach, and that many agencies outside DOJ must be part of the prevention effort.

Successful delinquency prevention interrupts the processes that may otherwise produce deviant and delinquent behavior. Delinquency prevention also seeks to keep youth who become involved in the juvenile justice system out of the criminal justice system. When delinquent juveniles move on to the adult criminal justice system, the cost to society is great in both human and financial terms. Any intervention that prevents a juvenile from becoming involved in the justice system saves our society money, prevents more people from becoming victims (with all the attendant costs), and helps prevent the next generation from becoming offenders.

In the early 1970's, many observers of the juvenile justice system thought that few or no effective delinquency prevention programs existed. We now know, however, that a

number of programs have been effective in preventing juvenile delinquency and violence through reducing risk factors and increasing protective factors. According to Alan Kazdin (1994) of Yale University, "Within the last decade . . . a number of programs have shown that antisocial behavior can be reduced with preventive interventions. Improved results appear to have resulted from better understanding of the emergence of antisocial behavior, implementation of comprehensive and protracted intervention programs, and more careful evaluation of long-term intervention effects." This report describes many such programs.

We know that prevention can be effective. We now have the scientific knowledge base to identify factors that put children at risk of becoming delinquent as well as protective factors that help them become and remain law-abiding and productive citizens. Research conducted over the last 30 years has identified those factors. Delinquency prevention based on a risk-focused model maximizes our chance of success. Outcome-focused planning can help ensure that programs not only reduce risk factors and increase protective factors, but also hold programs accountable for changing the levels of risk they are designed to address.

Delinquency prevention is cost effective. The total cost of the violent crime career of a young adult 18 to 23 years old is estimated to be $1.1 million (Cohen, 1994). The average cost of incarcerating a juvenile for one year is approximately $34,000. By contrast, Head Start's preschool intervention program costs only $4,300 per year per child. Perry Preschool, a program based on Head Start, has been shown to be an effective delinquency prevention program. Research on delinquency prevention programs in California (Lipsey, 1984) showed that every $1.00 spent on prevention produced direct savings of $1.40 to the law enforcement and juvenile justice system.

WHAT ARE THE PRINCIPLES FOR EFFECTIVE DELINQUENCY PREVENTION AND EARLY INTERVENTION?

The following principles are based on findings from thorough evaluations and well-designed research studies. Effective delinquency prevention efforts:

- Address the highest priority problem areas and identify strengths (risk and protective factors) to which children in a particular community are exposed.

- Focus most strongly on populations exposed to a number of risk factors.

- Address problem areas and identify strengths early and at appropriate developmental stages.

- Address multiple risk factors in multiple settings such as family, schools, and peer groups.

- Offer comprehensive interventions across many systems, including health and education, and deal simultaneously with many aspects of juveniles' lives.

- Are intensive, often involving multiple contacts weekly or even daily with at-risk juveniles.

- Build on juveniles' strengths rather than focus on their deficiencies.

- Deal with juveniles in the context of their relationships to and with others rather than focus solely on the individual.

Programs that embody these principles are discussed in OJJDP's *Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders* (Howell, 1995). This guide lays the foundation for a national commitment of public and private resources to reduce juvenile violence and victimization in our Nation. It includes both prevention and early intervention components. Prevention should be available throughout childhood and adolescence, and it should address both at-risk populations and at-risk youth. At-risk youth may need intervention services early in their delinquent careers to prevent further involvement in the juvenile justice system. Collaboration between the juvenile justice system and other service systems, including mental health, health care, child welfare, law enforcement, and education, is essential in this process.

Simultaneously, three particularly important protective factors must be increased: individual characteristics, such as having a resilient temperament or a positive social orientation; bonding through positive relationships; and healthy beliefs and clear standards of behavior set by families, schools, and peer groups (Hawkins and Catalano, 1992).

WHAT ARE RISK AND PROTECTIVE FACTORS?

Thirty years of research has shown that the most effective prevention strategies are those that focus on risk and protective factors in five broad categories: the juvenile, the community, the family, the peer group, and the school (Hawkins, 1995). Moreover, these factors tend to accumulate and interact with one another over time.

Risk factors. There is no single risk factor for delinquency or for violent behavior. Many risk factors have been identified, and they can be grouped into four major categories: community, family, school, and individual/peer (Hawkins and Catalano, 1992).

Community-related risk factors:

- Availability of drugs.
- Availability of firearms.
- Community laws and norms favorable toward drug use, firearms, and crime.
- Media portrayals of violence.
- Transitions and mobility.
- Low neighborhood attachment and community disorganization.
- Extreme economic deprivation.

Family-related risk factors:

- Family history of problem behavior.
- Family management problems.
- Family conflict.
- Favorable parental attitudes concerning crime and involvement in crime.

School-related risk factors:

- Early and persistent antisocial behavior.
- Academic failure in elementary school.
- Lack of commitment to school.

Individual and peer-related risk factors:

- Alienation and rebelliousness.
- Friends who engage in problem behavior.
- Favorable attitudes toward problem behavior.
- Early initiation of problem behavior.
- Constitutional factors. (For example, the makeup of an individual, including the role of heredity in addiction.)

Figure 1 (see page 9), based on Hawkins and Catalano's work (1995), summarizes 30 years of research on risk factors for co-occurring problem behaviors, including delinquency. A check mark indicates that empirical research clearly supports the presence of a risk factor increasing the chances an adolescent will exhibit a particular

problem behavior. The lack of a check mark indicates that this item is under study and that a definitive answer is not yet known (Hawkins and Catalano, 1995).

Protective factors. Some juveniles exposed to multiple risk factors do not become juvenile delinquents, school dropouts, or teenage parents. There are important aspects of their lives that protect them against risk factors. Protective factors either reduce the impact of risks or change the way a person responds to them. One key strategy to counter risk factors is to enhance protective factors that promote positive behavior, health, well-being, and personal success. Research suggests three basic categories of protective factors (Hawkins and Catalano, 1992):

- Individual characteristics, such as having a resilient temperament or a positive social orientation.

- Positive relationships that promote close bonds. Warm relationships with family members, teachers, and other adults who encourage and recognize a youth's competence and close friendships with peers fall into this category.

- Schools, families, and peer groups that teach their children healthy beliefs and that set clear standards. Examples include believing it is good for children to be drug- and crime-free and to do well in school.

Hawkins and Catalano (1992) developed a system of procedures that organizes knowledge about prevention strategies into a comprehensive approach communities can use to make a systematic analysis of local risk factors. Through this analysis, strategies can be developed to reduce risks and enhance protective factors. These methods typically consist of prevention programs known to be effective in reducing risk factors for delinquency and for other co-occurring problem behaviors.

Researchers (Thornberry et al., 1995) in OJJDP's Program of Research on Causes and Correlates of Delinquency found that, individually, each protective factor had only a small impact on reducing delinquency. Collectively, however, the presence of multiple protective factors had a sizeable impact on reducing delinquency. Of the high-risk juveniles (those with five or more risk factors in their environment) in the Rochester, New York, site, 80 percent with fewer than six protective factors reported involvement in serious delinquency. In contrast, only 25 percent of nonrisk juveniles with nine or more protective factors in their environment reported involvement in serious delinquency.

These data demonstrate that while increased law enforcement efforts and vigorous prosecution are necessary, they must be components of a well-balanced action plan that includes prevention. Short-term prevention goals can be achieved partially through

Figure 1.

Risk Factor	Adolescent Problem Behaviors				
	Substance Abuse	Delinquency	Teenage Pregnancy	School Dropout	Violence
Community					
Availability of Drugs	✔				
Availability of Firearms		✔			✔
Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime	✔	✔			✔
Media Portrayals of Violence					✔
Transitions and Mobility	✔	✔		✔	
Low Neighborhood Attachment and Community Organization	✔	✔			✔
Extreme Economic Deprivation	✔	✔	✔	✔	✔
Family					
Family History of the Problem Behavior	✔	✔	✔	✔	
Family Management Problems	✔	✔	✔	✔	✔
Family Conflict	✔	✔	✔	✔	✔
Favorable Parental Attitudes and Involvement in the Problem Behavior	✔	✔			✔
School					
Early and Persistent Antisocial Behavior	✔	✔	✔	✔	✔
Academic Failure Beginning in Elementary School	✔	✔	✔	✔	✔
Lack of Commitment to School	✔	✔	✔	✔	
Individual/Peer					
Rebelliousness	✔	✔		✔	
Friends Who Engage in the Problem Behavior	✔	✔	✔	✔	✔
Favorable Attitudes Toward the Problem Behavior	✔	✔	✔	✔	
Early Initiation of the Problem Behavior	✔	✔	✔	✔	✔
Constitutional Factors	✔	✔			✔

Source: Catalano and Hawkins, Risk Focused Prevention. Using the Social Development Strategy. 1995. Seattle: Developmental Research and Programs, Inc.

enhanced law enforcement, but in the long term, public safety is best served by preventing juveniles from ever becoming involved in crime.

WHAT SYSTEMS ARE RESPONSIBLE FOR IMPLEMENTING DELINQUENCY PREVENTION?

Service systems available to youth include health care, human services, education, and justice. Each has a unique but important role in delinquency prevention. In an environment of shrinking resources, a cost-effective and efficient comprehensive system of services to meet juveniles' needs is essential.

The health system is responsible for disease prevention through health education, immunization, and prenatal care. The human services system is responsible for preventing child abuse through family preservation, parental training, and substance abuse counseling. The education system prevents illiteracy through reading programs and learning readiness strategies. The labor/employment system prevents unemployment through job training and employment assistance. The juvenile justice system prevents delinquency through comprehensive strategies and interdisciplinary prevention efforts (see Figure 2, page 11).

Unfortunately, these systems are too often fragmented, locally directed, and funded and mandated by States with a modest Federal overlay. State and local jurisdictions have responsibility for dealing with the immediate manifestations of delinquency problems. The longer term impact is felt not just locally, but nationally as well, and it reaches far beyond the administration of justice, juvenile or adult.

The justice system has a unique perspective and responsibility to work with the other systems to develop strategies that provide a continuum of care for children and that prevent juveniles from becoming involved in the juvenile justice system or graduating to the criminal justice system. The Federal Government, through DOJ, has a critical and unique role in translating research into practice and coordinating Federal efforts at the State and local levels to disseminate information, provide training and technical assistance, and conduct research on promising programs.

All of these systems must work together to serve juveniles under their purview. Major new prevention initiatives that are comprehensive in scope must be supported at all levels of government and across all disciplines. They must be centered in the community and feature a commitment to defeat juvenile crime and violence comparable to the effort this country has made when faced with life-threatening childhood diseases such as polio.

Figure 2. # HOW PREVENTION SYSTEMS WORK

HEALTH HUMAN SERVICES EDUCATION LABOR JUVENILE JUSTICE

↘ ↘ ↓ ↙ ↙

CHILDREN

↓

PREVENTING

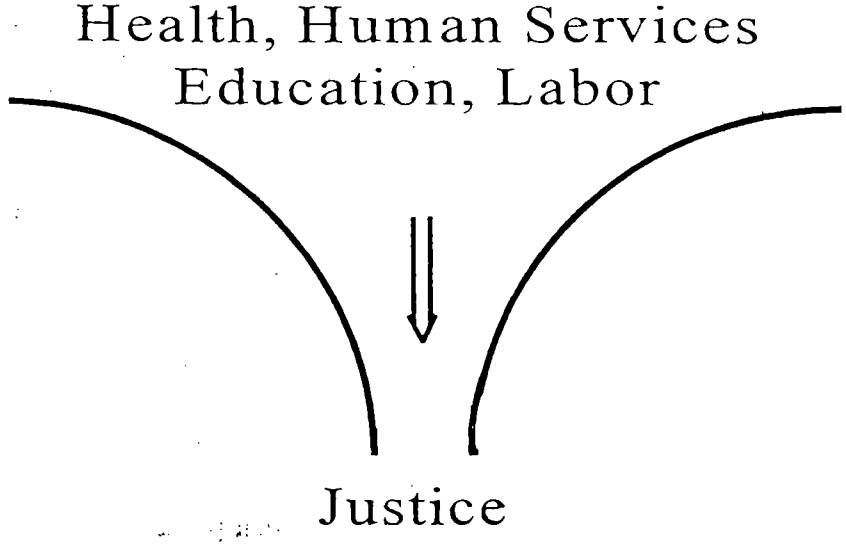
↙ ↙ ↓ ↘ ↘

WHAT:	Disease	Child Abuse	Illiteracy	Unemployment	Delinquency
HOW:	Health Education Immunization Physical Examination Prenatal Care	Family Preservation Parent Training Substance Abuse Counseling Support Services	Capacity Building Teaching Reading Learning Readiness Addressing Learning Disabilities	Job Training Employment Assistance	Comprehensive Strategies Interdisciplinary Prevention Efforts

↘ ↘ ↓ ↙ ↙

RESULTING IN HEALTHY YOUTH

The above diagram shows how prevention systems help develop healthy youth, Justice often gets the failures of the other systems.



WHAT WORKS IN DELINQUENCY PREVENTION?

Research shows that many delinquency prevention programs are effective. Other programs show evidence of success, but they have not been evaluated. Some delinquency prevention programs are not effective or require support from multiple systems to be truly effective, and if implemented inappropriately, they can be counterproductive.

Prevention involves a continuum of care that starts at the beginning of a child's life and continues through late adolescence. This continuum can be described in terms of a developmental stage in the life cycle (e.g., ages 0 to 4) or by the focus of the strategy (e.g., individual or community). This report frames prevention in terms of developmental stages of the individual and emphasizes strategies aimed at the school, the family, and the community that can be effective at each developmental stage. Research supporting effective and promising programs is summarized and model programs are noted. A program or strategy was placed in the promising rather than effective category if there was any question as to the sufficiency of the scientific evidence of its effectiveness. We chose to err on the side of stringency. Programs or strategies were also selected as promising if they were based on risk/protective factors, showed positive results from their evaluations, or received Gould-Wysinger awards. The report then turns to the need for broad-based school, community, and family programs that serve multiple stages and gives examples of effective programs in each setting. The energies and attention of a wide range of agencies and organizations are clearly required if the promise of prevention is to be realized.

DEVELOPMENTAL STAGES

According to Hawkins (1995), risks affecting children from conception through age 6 are related to the individual, the family, and the community. Increased exposure or exposure to more risk factors, especially early in childhood, increases risk of crime and violence exponentially.

Some of the prevention programs noted in this review are under the purview of health, human service, or other nonjustice systems. These programs have shown a powerful effect on adolescent delinquency or on predelinquent behavior and its correlates among younger children. DOJ views these programs as part of a complete delinquency prevention continuum that crosses system lines at all levels of government.

The most dramatic of these prevention programs are early interventions targeting children and their families in the first 5 years of life (Mendel, 1995). Tolan and Guerra's (1994) review of violence research suggests that predatory and

psychopathological violence may be more effectively treated by early interventions and that family-focused interventions are among the most promising to date. Community-based risk factors are also known to influence children throughout childhood. Children living in economically deprived areas characterized by extreme poverty, poor living conditions and high unemployment are more likely to engage in crime. Children living in disorganized neighborhoods with high rates of crime, high population density, physical deterioration, lack of natural surveillance of public places, and low levels of attachment to the neighborhood are more susceptible to violent and other criminal behavior. Prevention strategies for children from conception to age 6 should target families and children in these neighborhoods (American Psychological Association, 1994).

The earliest stage at which delinquency prevention can be effective is when a child is still in the womb. At the earliest stages, conception to age 6, prevention strategies can be effective in preventing criminal and violent behavior in adolescence and young adulthood. Prevention efforts must also continue during later childhood and adolescence to reinforce the benefits of these early prevention programs.

The first three developmental stages are centered in the family. The last two stages include family services, but emphasize the increasing influence of schools, peers, and communities.

STAGE 1: PRENATAL/PERINATAL

Healthy Families, Healthy Babies

Research

Prebirth and newborn prenatal and perinatal difficulties are statistically related to increases in crime in later life. Some of those difficulties include preterm delivery, low birth weight and anoxia, and minor physical abnormalities. Brain damage from infectious disease, traumatic head injury, or prenatal and postnatal exposure to toxins such as heavy metals, alcohol, tobacco, or other drugs are also risk factors. Brain damage impairs reasoning and impulse control, which may be a factor in increased delinquency. Poor parenting skills are evident early in a child's life and also contribute to risk through early abuse and ineffective parenting.

Strategies to reduce these risks include community-level services such as prenatal care and family interventions such as treatment for maternal substance abuse, parent training, and home visitation. For example, prenatal and infancy nurse home visitation improved a wide range of maternal and child health outcomes among poor unmarried teenage women bearing first children in Elmira, New York (Olds, 1993). Home visits

lead to teenage mothers having heavier babies, and postnatal home visits decrease recorded physical abuse and neglect of children during the first 2 years of life.

The prevention value of these strategies is clear. Being physically abused or neglected as a child predicts later violent offending (Thornberry, 1994; Widom, 1989).

Effective Programs

- Prenatal and perinatal medical care has been shown to reduce delinquency-related risk factors such as head injuries, exposure to toxins, maternal substance use, and perinatal difficulties.

- Intensive health education for pregnant mothers and mothers with young children has been associated with significant reductions in risk factors.

- Prenatal and infancy nurse home visitation has been shown to decrease child abuse and enhance effective parenting in Elmira, New York (Olds, 1993).

Promising Programs

Healthy Start in Hawaii. Reduces child abuse by offering prenatal and post-birth counseling to high-risk parents. Research by NIJ.

Anti-Drug Initiative in Chicago Housing Authority. Reduces drug use and related violence in public housing. Research by NIJ.

Project New Beginnings in Los Angeles, California. Offers substance abuse counseling to pregnant women and early intervention services to children. (Appears in PAVNET.)

STAGE 2: BIRTH TO AGE 4

Family and Child Bonding, Parenting Skills, Learning Readiness, and Social Skills Development

Research

Prevention programs for this age group have a potentially enormous effect on adolescent delinquency and predelinquent behavior among younger children. Interventions targeting families and children in the first 5 years of life may be the most powerful delinquency prevention strategies that exist (Mendel, 1995).

The most important factor in this age group is the family environment. A healthy family environment promotes attachment, effective family functioning, and social and academic readiness. Poor family management practices can result in children being at increased risk of crime. These practices include parents' failure to establish clear expectations for children's behavior, failure to supervise and monitor children, and excessively severe, harsh, or inconsistent punishment or child abuse and neglect. Parent training can reduce poor family management and a child's early aggressive behaviors and "conduct" problems. Programs designed to enhance parent-child interactions promote attachment and bonding to the family. These services are particularly critical in disadvantaged settings with scarce resources and low levels of community support.

This section looks at three risk factor areas: health risks, parenting skills, and learning readiness.

Health risks. Health education for mothers of young children may reduce mothers' substance abuse, resulting in healthier, less-impaired babies.

Immunization protects children against many of the diseases that can result in associated brain damage.

Parenting skills. Home visitors' promotion of social service use and assistance to mothers in achieving their educational and occupational goals can help counter families' economic deprivation (Olds, 1993).

Violent or aggressive family conflict increases risk for crime and violence. Children who grow up in an environment of conflict among family members are more likely to exhibit problem behaviors.

Parental attitudes and involvement in crime affect the attitudes and behavior of children. Children whose parents are aggressive and who witness or are victims of violence in the home are more likely to become aggressive and violent when they become adolescents and young adults.

Learning readiness. Cognitive development activities that help children prepare to enter school can be carried out with a home visitor or with a parent. These activities emphasize language development or a variety of other conceptual skills. Providing children toys or books through an early education program can help improve learning readiness.

Effective Programs

Unless otherwise noted, the following programs were reviewed by Hawkins and his colleagues.

High/Scope Perry Preschool Program Model. Fosters social and intellectual development in children ages 3 to 4. Participants were far less likely to commit crime than controls: 7 percent arrested compared to 35 percent of controls (High/Scope Educational Research Foundation, 1993).

Behavioral Training. Decreases negative parenting and the coercive style of interacting that promotes child aggression and delinquent behavior later in life (Tolan and Guerra, 1994).

The Home Visiting Program in Elmira, New York. Provides a wide range of maternal and child health services to poor, unmarried teenage women bearing first children in this semi-rural county. An investment in this type of home-visitation program for low-income women and children can pay for itself by the time the child is 4 years old. The prenatal and postpartum program costs about $3,200 for 2 1/2 years of home visitation. Low-income women (those most likely to use government services) used $3,300 less in other government services during the first 4 years after delivery of their first child than did their low-income counterparts in the comparison group. About 80 percent of the cost savings were from reduced Food Stamp and Aid to Families with Dependant Children payments. One-third of the cost saving came from the reduction in unintended subsequent pregnancies.

Promising Programs

Parents as Teachers. Parents learn parenting activities and children are screened for health problems.

STAGE 3: AGES 4 TO 6

Learning Readiness and Social Competence

Research

Early antisocial behavior predicts later criminal behavior and violence. Children who display antisocial behavior, including aggression, negative moods, and temper tantrums have a higher risk of criminal and violent behavior (Institute of Medicine, 1994).

Laws and norms favorable to crime and substance abuse; availability of weapons, alcohol, and other drugs; transitions and mobility; and exposure to media violence can also have an adverse effect on children in this age group.

Another predictor of delinquency is academic failure. Efforts to promote cognitive development from ages 4 to 6 have a lasting effect on academic performance. Learning readiness programs, such as Head Start, help promote protective factors.

Effective Programs

Unless otherwise noted, the following programs were reviewed by Hawkins and his colleagues (1995).

Reductions in Class Size for Kindergarten and First Grade. Helps improve school performance.

Promoting Alternative Thinking Strategies (PATHS) Curriculum. Reduces early antisocial behavior by integrating emotional, cognitive, and behavioral skill development in young children.

STAGE 4: AGES 7 TO 12

Education and Good Family Support = Successful Child

Research

According to Brewer and Hawkins (1995), transitions from elementary school to middle school can influence delinquency for youth ages 7 to 12. Increased availability of firearms increases the chance that youth in this age range will become involved in homicide rather than fist fights and verbal arguments. Moreover, young people failing academically and lacking commitment to school are more likely to engage in delinquent behavior than those seeing academic success as valued and viable.

Alienation and rebelliousness, association with peers who engage in delinquency and violence, favorable attitudes toward delinquency, early initiation of delinquency and violence, alcohol intoxication, and constitutional factors all can be precursors to delinquent behavior.

Beyond avoiding negative influences, young people need to bond to a social unit. To do so, they need the following forms of support:

- Skills necessary to effectively take advantage of the opportunities with which they are provided.

- Meaningful, challenging opportunities to contribute to their family, school, peers, and community in developmentally appropriate ways.

- Recognition of their efforts to both signify their individual worth and to provide an incentive to continue those efforts.

Effective Programs

Unless otherwise noted, these programs were reviewed by Brewer and Hawkins (1995).

Cooperative Learning. Students help each other learn and assess one another's progress in preparing for tests and teacher assessments by working in a team of four to five members with mixed skill levels.

Tutoring. One-on-one remedial and preventive tutoring of elementary and middle school students.

Promising Programs

Drug Abuse Resistance Education. Prevents substance abuse among youth through education programs taught by police professionals. Research by BJA.

Family Ties. Strengthens family functions by offering intensive services to youth in their homes.

Cambodian Family Youth Program. Develops self-esteem and life skills among youth ages 5 to 12. Reviewed by OJJDP.

Child Development Project. Fosters competencies and commitments in children that they will need to eventually live out adult roles in a competent, caring, and responsible manner.

Second Step Curriculum. Teaches skills in empathy, appropriate social behavior, interpersonal problem solving, and anger management through discussion, modeling, and role playing of particular skills.

Success For All. A comprehensive restructuring plan designed for the use of elementary schools that serve disadvantaged students. This program attempts to instill basic skills successfully the first time they are taught so that a child will not fall behind.

Preparing For the Drug Free Years. Workshop that teaches parents how to reduce critical risk factors that are important during the late elementary and middle school years.

Caring Communities Programs (CCP). Provides home-school therapy to youth at risk of being removed from home.

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Administration for Children and Families
U.S. Advisory Board on Child Abuse and Neglect

CREATING CARING COMMUNITIES:

BLUEPRINT FOR AN EFFECTIVE FEDERAL POLICY

ON CHILD ABUSE AND NEGLECT

EXECUTIVE SUMMARY

Second Report

The U.S. Advisory Board on Child Abuse and Neglect

September 15, 1991

September 1991

1991 REPORT OF THE U.S. ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

EXECUTIVE SUMMARY

The U.S. Advisory Board on Child Abuse and Neglect was established under provisions of Public Law 100-294, the 1988 Amendments to the Child Abuse Prevention and Treatment Act. The mission of the Board is to evaluate the nation's efforts to accomplish the purposes of the Act and to make recommendations on ways in which those efforts can be improved.

I. INTRODUCTION

The Board begins Part I of the 1991 report by reminding the citizens of the United States of the key words in the 1990 report:

> ***[C]hild abuse and neglect in the United States now represents a national emergency.***[1]

One year after the release of that report, the emergency remains.

In this, its second report, the Board has chosen to focus on the nature of the response of the Federal Government to child maltreatment. Knowing that the management of Federal programs is a subject that would seem to be remote from the lives of maltreated children and their families, Part I presents a composite description of "Anna" and her mother, "Beth," which graphically illustrates the critical difference that an effective Federal response could make in a typical case of child maltreatment.

For at-risk children to be adequately protected and for their parents to acquire the skills and support needed to care for them adequately--**the Federal Government must begin to facilitate community efforts to protect children.** That change in Federal perspective implies a new commitment, a new comprehensiveness, a new investment in knowledge generation and diffusion, and greater leadership and flexibility--all features of the Board's blueprint for a new Federal policy and actions to implement it.

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[1]U.S. Advisory Board on Child Abuse and Neglect, Child Abuse and Neglect: Critical First Steps in Response to a National Emergency (1990) (available from the Superintendent of Documents, U.S. Government Printing Office; Stock No. 017-092-00104-5). Appendix D of this report contains the complete set of 1990 recommendations.

Part I then summarizes the contents of the 1990 report. In declaring a ***national emergency***, the Board made three broad findings on the basis of its examination of the child protection system:

- *...[I]n spite of the nation's avowed aim of protecting its children, each year **hundreds of thousands** of them are still being starved and abandoned, burned and severely beaten, raped and sodomized, berated and belittled.*

The Board noted further that many children will suffer the consequences of this maltreatment for the rest of their lives and that **hundreds**--perhaps **thousands**--each year will have their lives cut tragically short because of abuse or neglect. It is simply cruel, the report said, when adults responsible for the care of children use their authority "to degrade or exploit them."

When 2.5 million cases of suspected child maltreatment are reported each year, such numbers are simply stunning--a situation that should shock the conscience of the nation. In view, then, of the seriousness of child abuse or neglect, the Board found the sheer scope of the problem to merit a declaration of a national emergency.

- *...[T]he **system** the nation has devised to respond to child abuse and neglect **is failing.***

It is not, the Board stated, a question of "acute failure of a single element of the system." Instead, the child protection system is plagued by "chronic and critical multiple organ failure." No matter which element of the system that it examined--prevention, investigation, treatment, training, or research--it found a system in disarray, a societal response ill-suited in form or scope to respond to the profound problems facing it. It was forced to conclude that the child protection system is so inadequate and so poorly planned that the safety of the nation's children cannot be assured.

- *...[T]he United States spends **billions** of dollars on programs that deal with the **results** of the nation's failure to prevent and treat child abuse and neglect.*

The Board estimated that billions of dollars are spent each year in direct expenditures on a child protection system that is failing to protect children adequately. Child maltreatment results in costs for law enforcement, the courts, out-of-home care, and the treatment of adults recovering from child abuse. The indirect costs of child maltreatment are even greater. It noted that the nation continually pays for the social and personal costs of substance abuse, eating disorders, depression, adolescent pregnancy, suicide, juvenile delinquency, prostitution, pornography, and violent crime--all of which may have "substantial roots in childhood abuse and neglect."

The Board concluded that the costs of child abuse and neglect are so grave that the emergency represents a ***threat to national survival***: *such negligence threatens the integrity of a nation that shares a sense of community, that regards individuals as worthy of respect, that reveres family life, and that is competent in economic competition.* Child maltreatment tears the social fabric; moreover, each incident weakens the fabric further, disconnects children and parents from the community, and increases the likelihood of further abuse and neglect and other personal and social problems.

Although the adverse consequences of child maltreatment are themselves sufficiently serious to warrant declaration of a national emergency, the Board warned against missing the most fundamental reason for making child protection a matter of the highest national priority:

> ***Child abuse is wrong. Not only is child abuse wrong, but the nation's lack of an effective response to it is also wrong. Neither can be tolerated. Together they constitute a moral disaster....[c]hild neglect is also wrong.***

In such a context, the Board proclaimed, ***[a]ll Americans share an ethical duty to ensure the safety of children.*** As recognized by the United Nations in its Convention on the Rights of the Child, protection from harm is a basic human right essential to the preservation of children's dignity. Therefore, it argued, ***[a]ll Americans should be outraged by child maltreatment.*** All should join, it said, in resolving that its continued existence is intolerable and demanding that public officials immediately take whatever action is necessary to repair the nation's child protection system.

In examining the existing child protection system in its 1990 report, the Board observed that past investment in solutions to the problem of child abuse and neglect has been inadequate. Too often the solutions offered have been based on incomplete analyses of the many facets of the problem. Thus, the Board suggested that the nation needs an approach to child protection that not only is expanded but also is different:

> *...the replacement of the existing child protection system with a new, national, child-centered, neighborhood-based child protection strategy.*

Central to an understanding of the Board's proposed strategy to deal with child maltreatment is its definition of the term **child protection system**. The child protection system includes but is not limited to ***State or County child protective service (CPS) agencies***, the public agencies mandated by law to protect abused and neglected children. **Other components of the child protection system include law enforcement, education, public health, mental health, court, and private non-profit agencies and organizations.**

As a cornerstone of the new national strategy, the Board believes that the Federal role in child protection[2] must be comprehensive and sufficiently flexible to allow for such planned experimentation. **Through provision of a blueprint for the Federal Government's role, this report is intended to identify the critical next steps** toward a new national strategy for child protection.

Notwithstanding the intensity and size of the challenge to alleviate the crisis, the Board is still convinced that if America establishes a new child protection system, **beginning with major reform of the Federal child protection effort,** a recurrence of the national emergency can be prevented. It believes that the President and the Congress now have the opportunity and the responsibility to undertake major policy reforms that will assist in alleviation of the American child protection emergency. These reforms will provide the foundation for planned implementation of a new child protection system.

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[2]The Board recognizes that, in talking about the Federal role in child protection, the context usually implied is the relationship between the Federal Government and State and local governments. Defined in that way, the term wrongfully excludes the unique status of Indian Tribes under American law as political entities and sovereign governments.

II. THE PERFORMANCE OF THE FEDERAL GOVERNMENT IN CHILD PROTECTION

In examining the existing child protection system in its 1990 report, the Board observed that emergency conditions exist in every part of the system:

- The child protection system has a poorly defined sense of mission. Too often the system seems to disregard the needs of children.

- Increasing numbers of children are living in poverty in communities so drained that individual families often lack support.

- Family life has become increasingly diverse and complex, and young families and families headed by women are increasingly and disproportionately subject to economic and social stressors.

- Modes of service delivery have failed to change in proportion to changes in family life.

- The number of foster children has increased dramatically, and their needs are becoming increasingly serious and complex, but the number of foster parents is shrinking.

- Whether the focus is prevention, investigation, adjudication, or treatment, resources have failed to grow at a rate anything close to the explosive rise in the number of reports of child maltreatment or the parallel increase in the complexity of reported cases.

- Child protection has been perceived as primarily the responsibility of CPS agencies, with the result that an ever-increasing proportion of resources in the child protection system has gone to investigation of allegations of child abuse and neglect. Indeed, in some States and counties, it may be said that the public child welfare program of services to children and their families is CPS.

- Maltreated children, even when receiving care or supervision from a governmental body, rarely receive treatment.

- Interventions that disrupt families are more readily available than those that preserve families in crisis or that prevent serious problems which threaten children's safety from occurring at all.

- The data system on child protection is too poorly developed to give an adequate picture of the scope of the problem of child abuse and neglect and the nature of the child protection system's response. In general, child abuse and neglect is one of the most inadequately studied major social problems, and the knowledge that does exist has rarely been systematically diffused and applied in practice.

- Major deficits exist in the number of trained professionals in child protection.

- Child protection policy is largely unplanned; it has consisted primarily of ad hoc responses to crises.

- Coordination is a serious problem at all levels.

The Board believes that many of the shortcomings in the nation's child protection system can be traced to deficiencies in the Federal response to child maltreatment. The nature of that response and how it developed are described in Part II of this report.

Part II of the report recounts the early history of the Federal Government's involvement with child maltreatment, principally through the Children's Bureau. By 1963 the Bureau, without any specific Congressional mandate, had compiled a comprehensive national inventory of child protective service agencies, held a series of meetings and planning sessions on steps needed to control the problem of child abuse, and promulgated one of the most influential pieces of model State legislation ever produced in the United States: a model child abuse mandatory reporting law.

However, by the late 1960s, the focus on child maltreatment within the Children's Bureau was gone, the health programs of the Children's Bureau transferred to the Public Health Service and most of the Bureau's child welfare research budget eliminated. In response, in 1973 Senator Walter Mondale introduced S. 1191, the proposed Child Abuse Prevention and Treatment Act (CAPTA). Although immediately opposed by the Nixon Administration, on January 31, 1974 President Nixon signed CAPTA into law.

The major Federal child protection law is CAPTA.[3] The Federal agency that is the focus of CAPTA is the National Center on Child Abuse and Neglect (NCCAN) within the Department of Health and Human Services (DHHS). A specific office or center for child protection programs does not exist in any agency other than within DHHS.

From 1974 until now, the implicit mission of NCCAN has been to administer grant programs, to identify issues and areas needing special focus for new research and demonstration project (R&D) activities, and to serve as a focal point for the collection of information, the improvement of programs, and the dissemination of materials and information on best practices to States and localities. The majority of funds appropriated under the Act to date have been earmarked for R&D grants, including funds to support a national information clearinghouse, various national resource centers, national data collection efforts, and periodic national "incidence studies."

In addition to the R&D grant program, the original CAPTA legislation created a categorical child abuse and neglect State formula grant program. These unrestricted grant-in-aid funds to State child welfare agencies, ranging from less than $4 million in 1977 to approximately $19.5 million in 1991, are conditioned on State compliance with a number of statutory standards for State child abuse and neglect laws and child protective service agency operations.

In recent years this grant program (known as the Basic State Grant Program) has been complemented by three additional State grant programs. The first is a grant to assist State child maltreatment prevention efforts (known as the Challenge Grant Program.) The second is a grant focused on State programs to improve the investigation and prosecution of child abuse, particularly child sexual abuse (known as the Children's Justice Act Grant Program.) The third is a grant designed to help States deal with cases involving the withholding of medical care from disabled infants (commonly called the Medical Neglect/Baby Doe Grant Program.) No State can receive a CAPTA Basic State Grant or a Children's Justice Act Grant, if it fails to comply with the enumerated CAPTA State eligibility criteria.

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[3]The Congressional authorization for the several grant programs of CAPTA expires on September 30, 1991. Reauthorization of those programs is anticipated. (The text of CAPTA, current as of August 31, 1991, is found in Appendix C of this report.)

The State grant programs that NCCAN administers--the Basic State Grants, Challenge Grants, and the Children's Justice Act Grants--have been used in a number of ways to help States improve their laws and programs. This is in part due to the leadership of NCCAN in bringing State grantees together for periodic discussions of current concerns in the field and how State and local agencies are dealing with them. The National Center has encouraged the networking of State child protection agency leaders so that they can assist each other in addressing common barriers.

Since 1974, successive reauthorizations of CAPTA have consistently enlarged NCCAN's subject matter jurisdiction. Added has been: "sexual exploitation" of children; the withholding of medically indicated treatment from disabled infants with life-threatening conditions; the abuse of children in day care centers and by family day care providers; specific studies on the relationship between child abuse and family alcoholism and child abuse and children with disabilities; child maltreatment-related substance abuse; and child maltreatment-related homelessness.

The legislative history of the Act classically illustrates the phenomenon described by the Board in its 1990 report, a governmental response to increased reports of maltreatment which "was and continues to be fragmented, often simplistic, ill-conceived,...crisis oriented...symbolic and driven by political expediency." Moreover, by constantly adding new areas of concern and duties for the NCCAN staff, without also adding sufficient funding support, Congress has contributed to the difficulties faced by this small agency.

The Board believes that the NCCAN staff deserves to be commended for its hard work in turning the ever-expanding Congressional mandates into programmatic action. Because of the efforts of that staff, the nation is more aware of the problem of child maltreatment, and more is known about its causes and the steps that may be taken to reduce its incidence and consequences. Faced with extremely trying working conditions, the NCCAN staff has consistently performed in an admirable manner.

Despite NCCAN's accomplishments and its assumption of expanded responsibilities, there have been a number of Congressional reviews of NCCAN that have produced critical findings. The Board's analysis of the current condition of NCCAN echoes, and expands upon, many concerns previously addressed by those who have examined the agency's operations.

- Despite an ever-increasing number of Congressional expectations for NCCAN, as well as a dramatic growth in public awareness of the national emergency, the size of the NCCAN budget does not permit the agency to address the scope of the nation's child protection needs adequately.

- Even after the current effort to raise the staff complement of NCCAN to 20 is completed, the number of NCCAN staff will remain woefully inadequate when measured against the agency's responsibilities.

- The 1982 DHHS Reduction-in-Force (RIF) and subsequent staff attrition during the 1980s resulted in the loss of considerable staff competency within NCCAN.

- According to staff, in recent years NCCAN's support for the States was reduced substantially.

- The National Center lacks a visible and coherent planning process, tending to diffuse its energy in too many directions at once instead of concentrating on a circumscribed set of achievable objectives.

- To date, NCCAN has been unable to develop an effective strategy for leveraging the dollars of better-funded Federal public health, mental health, education, justice, community development, and volunteer agencies, which has had adverse consequences for the total Federal child maltreatment research, training, and service delivery effort.

- Placement of NCCAN within the social services component of DHHS impedes its ability to influence the public health component of the Department to take significant steps in the prevention of child maltreatment.

- Paradoxically, within the social services component of DHHS, NCCAN has had remarkably little impact on the huge Title IV-B, Title IV-E, and Title XX programs which provide the largest Federal share of State and local CPS funding. Moreover, although the recent elevation of NCCAN to an organizational level comparable to the Children's Bureau was generally praised by the child protection field nationally, the National Center is still not high enough to effect significant policy changes but is now uncoupled from the Federal agency responsible for foster care, a system in which three-quarters of the children it deals with are abused or neglected.

- The NCCAN knowledge building effort has been consistently hampered by inadequate funds, undistinguished ad hoc review panels, yearly announcements which do not build on the work of previous years, and the absence of an ongoing mechanism which taps the expertise of scientists in the overall evolution of program direction.

- Over the last decade, most NCCAN demonstration projects have not had a scientifically sound evaluation component. Nor has NCCAN created a mechanism for assuring that the results of those few demonstrations that have had an evaluation component are translated into practice.

- The National Center has not built a comprehensive system for data collection and analysis. Neither has it developed the capacity for accurate, consistent, uninterrupted diffusion of information to the child maltreatment field.

- National resource centers, which replaced regional resource centers in 1984, have not been able to achieve the level of visibility and access provided by the regional centers.

In summary, the general picture of NCCAN is of an agency that, given its inadequate support, has had unrealistic expectations placed on it as the volume and complexity of child maltreatment reports have increased.

The Federal Inter-Agency Task Force on Child Abuse and Neglect is the sister body of the Board. Also created under the 1988 amendments to the Child Abuse Prevention and Treatment Act, the Task Force consists of approximately 30 member agencies drawn from eight Cabinet departments and the Office of Personnel Management. The Director of NCCAN is the statutory Chairperson of the Task Force.

Although the Task Force has served several useful purposes, the Board believes that the Task Force has not yet realized its full potential. It has not yet addressed such important issues as the Federal role in motivating the nation's education system to become a more significant actor in child protection activities or collaborative funding efforts between Federal substance abuse- and child maltreatment-focused agencies. Nor has it yet devised a comprehensive strategy, including points of measurement, for guiding Federal activities related to child protection.

The Board notes that the Task Force participants are essentially technical experts who are, for the most part, not the decision-makers in their respective agencies. Task Force deliberations, therefore, have suffered because the participants do not have the authority to commit the resources of their agencies to joint ventures related to child protection.

In considering the future Federal role in child protection, it is important to identify and understand the problems in existing Federal child protection policy. Unfortunately, the general picture is one of an absence of a coherent Federal policy.

Federal child protection planning has been relatively non-existent. By its omissions and its actions, the Federal Government--both Congress and the Executive Branch--has fostered a national child protection system that is fragmented, inadequate, and often misdirected.

The Federal Government has failed to exert the necessary leadership in child protection. Federal leaders--both in Congress and the Executive Branch--generally have failed to acknowledge publicly the seriousness of the problem of child abuse and neglect and to exhort the nation to assume responsibility for protection of children. Concerted Federal leadership is needed to help create a well-informed media focus on child maltreatment, to motivate and inspire the public to action, and to place child protection on the agenda of every civic, philanthropic, business, labor, and religious organization in the nation's communities.

Since the problem of child abuse and neglect has multiple dimensions--justice, health, mental health, education, community development, substance abuse, developmental disabilities--Federal agencies responsible in multiple areas must be involved in formulating their own efforts and responses, in working collaboratively to promote the integration of services, and in developing and disseminating knowledge to the State and local agencies to which they provide guidance and funding. For the most part, this has not happened.

The approach which the Federal Government has pursued in child protection--vesting a small agency with authority for Federal leadership--has led to the inadequate involvement in child protection efforts by public health, mental health, substance abuse, developmental disabilities, justice, education, and community development agencies. No one agency can be expected to deal adequately with a problem as complex as child abuse and neglect, even if it is labeled as "national."

The lack of coordination among agencies administering Federal funding streams has impeded communities at the local level in their efforts to develop cohesive family services structures. Too often, regulations promulgated by different programs limit use of funds to one segment of a family's problem.

Federal policy provides fiscal incentives for removal of children from their homes. Absent in Federal policy are parallel, stronger incentives in the form of intensive child protection services that may prevent removal of maltreated children from their homes or may prevent the maltreatment altogether. There is a clear need for Federal leadership in moving the predominant response to child abuse away from investigation and foster care toward services to help families overcome the stresses in their lives.

The Federal Government's lack of leadership has also manifested itself in the small amount of funds that have been invested in knowledge building activities. Federal agencies, other than NCCAN, have in recent years not seen as part of their mission the development and diffusion of models for the prevention and treatment of child abuse and neglect. These agencies, as well as NCCAN, have also not seen as part of their mission the support of significant research about the nature, prevention, and treatment of child abuse and neglect, nor the preparation of trained personnel to conduct such research.

In addition, Federal agencies have not incorporated into their mission the development of the capacity to generate basic statistical information about the prevalence of child maltreatment and the adequacy of the child protection system's response--a gap that has impeded timely response to changes in the problems faced by child protection agencies. Nor has the Federal Government provided adequate attention to rigorous evaluation and has funded demonstration projects that lack a strong conceptual and empirical foundation.

Moreover, as illustrated by the low visibility of the Clearinghouse on Child Abuse and Neglect Information and the incompleteness of its data base, Federal agencies have often not diffused the knowledge that is available. Finally, the Federal Government has only to a limited extent provided support for the training of specialists in child protection or stimulated the infusion of information about child maltreatment into the basic curricula of the various professions serving children and families.

The result is a level of practice in which critical decisions that affect the lives of children and families are often made with little scientific foundation. The state of practice in the child protection system is rarely state-of-the-art, and the state of the art is frequently uninformed.

The Federal Government is the nation's largest single provider of child protective services in that it has jurisdiction over cases involving the maltreatment of the children of uniformed service members as well as the children of Native Americans. However, even in that role, the Federal Government has not provided the nation's CPS agencies with leadership by example.

The CAPTA State Grants not only fail to touch programs outside of State and County child welfare agencies, but they also do not encourage comprehensive State and community child protection planning. Even within State and County child welfare agencies, there is no requirement that plans developed under the CAPTA Basic State Grant Program be integrated with plans for the use of funds available under the Children's Justice Act Program, the Challenge Grant Program, or the Medical Neglect/Baby Doe Grant Program.

Just as Federal policy implicitly focuses on investigation more than prevention and treatment, Federal child protection efforts have given more attention to State compliance with procedural requirements than fulfillment of substantive expectations for child protection and family preservation. The several recent and pending Federal Court decisions about State failures to provide minimally adequate "safety net" services for children and families illustrate the consequences of Federal enforcement efforts that focus more on whether procedural requirements than whether children were provided with services to promote their safety and strengthen their families.

The Board looks now for the exercise of political will at the highest levels of the Federal Government--in both the Executive Branch and Congress--to develop and implement a coordinated, comprehensive reform of Federal child protection efforts. To that end, it offers a blueprint for such reform.

III. RECOMMENDATIONS FOR CHANGE

The Board believes that the Federal statutory framework for child protection policy and programs should provide for the facilitation of community efforts, comprehensive planning at all levels of government and in the community, and the promotion of flexible, integrated approaches to child protection in all of the systems of service (e.g., health, education, justice, mental health) for children and families. Part III of the report contains a series of recommendations which identify the specific actions needed to erect such a framework.

The recommendations are divided into six major areas of reform:

- **DEVELOPING AND IMPLEMENTING A NATIONAL CHILD PROTECTION POLICY;**
- **PREVENTING AND REDUCING CHILD MALTREATMENT BY STRENGTHENING NEIGHBORHOODS AND FAMILIES;**
- **PROVIDING A NEW FOCUS ON CHILD ABUSE AND NEGLECT AND STRENGTHENING FAMILIES IN ALL RELEVANT FEDERAL AGENCIES;**
- **ENHANCING FEDERAL EFFORTS RELATED TO THE GENERATION, APPLICATION, AND DIFFUSION OF KNOWLEDGE CONCERNING CHILD PROTECTION;**
- **IMPROVING COORDINATION AMONG FEDERAL, STATE, TRIBAL, AND PRIVATE SECTOR CHILD PROTECTION EFFORTS; AND**
- **IMPLEMENTING A DRAMATIC NEW FEDERAL INITIATIVE AIMED AT PREVENTING CHILD MALTREATMENT: PILOTING UNIVERSAL VOLUNTARY NEONATAL HOME VISITATION.**

Most recommendations conclude with at least two "options for action." Although the Board has deliberately refrained from recommending specific approaches to implementation, that decision should not be construed as a position that not implementing a recommendation is acceptable. **Implementation of each recommendation is essential.** While all of the recommendations in Part III of the report are important, two are especially critical to the Board, the promulgation of a national child protection policy and piloting universal voluntary neonatal home visitation. These are the first and the last recommendations in the report. A summary of each recommendation follows. **The complete text of all of the recommendations and options for action can be found in Appendix A of Part VI of the report.**

Developing and Implementing a National Child Protection Policy

The Policy

In ***Recommendation B-1*** the Board calls upon the Federal Government to ***establish a national child protection policy which, incorporated into the United States Code as an intrinsic part of the Child Abuse Prevention and Treatment Act, should drive the child protection-related actions of all Federal agencies***. The Board believes that the time has come for a Federal policy based on respect for the inherent dignity and inalienable rights of children as members of the human community. That policy should be rooted in the companion ideas that the family (whether biological, adoptive, or foster) is the unit in society most likely to secure children's safe and healthy development and that children have a meaningful right to live safely in a family environment.

Federal child protection policy should encourage concerted community action to protect children. As such, aiming at being comprehensive, it should model and support multidisciplinary involvement in child protection. It should stimulate and support a comprehensive emphasis in the diverse programs that affect children and families and that are directly or indirectly Federally funded. It should provide the knowledge base for the effective provision of help by State and community programs, regardless of whether they are public or private, professional or volunteer, formal or informal.

Child protection should be an ongoing function of community life. Federal leadership and resources should facilitate neighbors helping neighbors.

Federal child protection policy should support voluntary access to help for families. That help should be easily accessible in the various settings where children and parents live and work or study. Moreover, Federal policy should aim at assisting those communities in greatest distress to make voluntary access to help available.

As the primary Federal statute on child abuse and neglect, CAPTA is the obvious starting point in construction of a new comprehensive, child-centered, family-focused, and neighborhood-based Federal child protection policy, particularly given that a new system will require the restructuring of existing programs (part of which are now authorized by CAPTA) as well as the development of new ones.

A **comprehensive** child protection system would integrate the contributions of social service, legal, health, mental health, and education professionals and would assure the protection of children while in each of these systems. Such a system also would provide for positive roles of (1) private child welfare and mental health agencies, (2) civic, religious, and professional organizations, and (3) individual volunteers, whether in organized programs or "natural" helping relationships. It also would provide for coordination of policy across levels of government.

A **child-centered** child protection system would (1) take children seriously as individuals, (2) give primary attention to their best interests, as reflected in their needs and experiences, (3) provide opportunities (including legal representation) for children to be heard in proceedings affecting them, and (4) respond flexibly to the diversity of children's cultural backgrounds and of the circumstances in which they find themselves.

Unfortunately, current policy and practice too frequently have been distorted by an inattention to the meaning of State action to children themselves. The result is the obsession with investigation--checking off what parents have or have not done, both prior to adjudication of child maltreatment and after a disposition--with a loss of concern for children's own experience. Accordingly, maltreated children themselves (1) rarely receive therapeutic services, (2) often are given minimal information about the decisions affecting their lives, (3) often are essentially unrepresented in legal proceedings and other official actions, (4) find themselves the subjects of well-intended but fragmented and misdirected reform efforts that often seem isolated from the matters most significant to the children themselves, and (5) are often left in unsafe homes or placed in foster homes equally as dysfunctional as their natural homes.

A **family-focused** approach is consistent with the concept of a child-centered system. Taking the perspective of the child will lead in most instances to a concern with strengthening families. Indeed, the ethical foundation of a strong family policy and concern for family preservation rests in the significance of the family for the development of children. The Board believes that serious attention to the perspective of the child would lead to a substantial increase in supports for families and a concomitant decrease in the inappropriate removal of children from their homes of origin.

Nonetheless, the Board also recognizes that some parents are so unable to provide a secure and safe environment for their children that coercive State intervention, sometimes including removal from the home, is necessary. At the same time, the Board believes that coercive intervention should not be the centerpiece of the child protection system. An effective child protection system should begin with the general question of how best to promote the security of children and their families, not with the specific question of when such a goal requires the coercive power of the State. Use of the latter question as the starting point leads policymakers down the path of disproportionate concern with the investigatory process.

In sketching the blueprint for a new system to ensure the safety of children, the Board is convinced that an additional focus should be on the community. It uses the term **neighborhood-based** to refer to strategies that are focused at the level of urban and suburban neighborhoods and rural communities. It is concerned not only with development of social and economic supports for troubled families and children at the neighborhood level (where **neighborhood** is defined by geographic boundaries) but also with the provision of both formal and informal services (e.g., self-help programs) that are based on the principle of **neighbor helping neighbor**, regardless of whether access to such services is determined by specific place of residence. Such a principle also embraces the idea of people from diverse groups coming together to focus on a specific problem.

Treatment and secondary prevention programs are best organized at the neighborhood level. Help should be easily available and accessible, whether for children who have suffered maltreatment or for families that have experienced maltreatment or are on the brink of such incidents. For those families at highest risk, intensive home- and community-based services that integrate many elements to deal with multiple social, economic, and psychological problems have the best documented effectiveness. Such an approach necessarily involves flexible, individualized case planning at the community level. Similarly, the best validated preventive measure--neonatal home visitation--involves a community response to the needs, in that instance, of young families in general as well as the families under the most stress and with the fewest resources.

The Federal Government should not erect artificial barriers to the integrated, coordinated implementation of the strategy at the State, Tribal, and community level through unnecessary restrictions on eligibility for and use of funds. The Federal Government should refrain from tacitly or expressly dictating the specific methods that a community is to use in implementing a child protection plan in the various settings (e.g., the schools) that should be involved in the effort.

A national child protection policy should reflect Congressional intent in establishing the several CAPTA programs. It should go further, however, to guide the Federal Government--acting in cooperation with State, Tribal, and local governments and other concerned public and private organizations--in all of its activities to protect children from abuse and neglect.

Undoubtedly, there are many possible approaches to the content of a national child protection policy. **The approach preferred by the Board** can be found in the text of Recommendation B-1 within the report.

Relationship of The Policy to Child Welfare Reform Efforts

The vitality of the nation's child welfare, family support, health, education, justice, and mental health systems are key determinants of the ability of society to protect its children from abuse and neglect. In ***Recommendation B-2***, therefore, the Board calls upon the Federal Government to ***assist in building a supportive service delivery system for all families, troubled or otherwise, thereby providing a critical foundation for the prevention of child maltreatment and the protection of children.***

Clearly, child welfare services and family resource and support services are the most critical to the prevention of child maltreatment. Regrettably, the quantity and quality of both sets of services are inadequate to meet the needs generated by the stressors that are a prominent feature of contemporary family life.

The Board hopes that changes in the Federal child welfare services and family resources and support services programs will quickly be made. To the extent possible, the reforms of the child protection system which it is proposing in this report, especially the promulgation of a national child protection policy, should be harmonized with such changes. In seeking this integration of policies and programs, it should be recognized that improving the delivery of child welfare services and family resources and support services will not alone respond to the child protection emergency.

Relationship of The Policy to the Elimination of Corporal Punishment

Article 28 of the Convention on the Rights of the Child, adopted by the United Nations in 1989, addresses the need for schoolchildren to be disciplined in a manner reflecting their inherent dignity as human beings. The Board believes that the use of corporal punishment in schools is intrinsically related to child maltreatment. It contributes to a climate of violence, it implies that society approves of the physical violation of children, it establishes an unhealthy norm. More than 22 States have prohibited it by law. Its outright abolition throughout the nation must occur immediately.

In **Recommendation B-3**, consonant with the intent of its proposed National Child Protection Policy, the Board calls upon the Federal Government to ***take all necessary steps to eliminate the use of corporal punishment in all activities, programs, institutions, and facilities which receive Federal financial support of any kind***. Such activities, programs, and facilities would include (but are not limited to) foster care, day care, juvenile correctional facilities, runaway and homeless youth shelters, and programs providing treatment to youthful substance abusers. The Board recognizes that in some situations caretakers in schools, residential institutions, and other situations that care for children may lack skill and familiarity with alternative, non-violent methods of discipline. In many instances, therefore, reorientation and retraining will be needed by caretakers, foster parents, and others.

Determining the Cost of the Policy

Recommendation 30 in the Board's 1990 report called for the determination of "...the cost of developing and implementing a comprehensive national program for the prevention and treatment of child abuse and neglect, as well as the projected cost of not developing such a program." In the context of the recommendation in this report that a national child protection policy be enacted, in **Recommendation B-4** the Board calls upon the Federal Government to ***commission an appropriate Federal research agency to determine the cost of implementing a national child protection policy and the cost of not implementing such a policy***. This latter point is especially important because many child protection experts believe that the cost of not implementing a new child protection policy could be far greater than implementing that new policy.

The Board further believes that existing Federal expenditures in many instances are inconsistent with the proposed policy. Presented with thorough cost-benefit analyses, the leaders of the Federal Government may find it possible to reallocate funds from less useful programs to the admittedly costly programs being herein recommended.

Preventing and Reducing Child Maltreatment by Strengthening Neighborhoods and Families

The Role of Neighborhoods in Preventing Child Maltreatment

Children growing up in dysfunctional neighborhoods are virtually becoming a form of endangered species. The Board believes that the nation should show no less concern for the environments its children live in than it does for the environments of endangered species of wildlife. Accordingly, in **Recommendation C-1** the Board calls upon the Federal Government to ***take all steps necessary to facilitate the development of neighborhood improvement initiatives to prevent child maltreatment, including neighborhoods in urban, rural, and Native American communities***.

Neighborhood quality is highly related to the rate of child maltreatment. Physical factors--such as deterioration of housing--and social factors--such as an increase in social isolation--result in a decrease in neighborhood quality and, therefore, an increase in the rate of child maltreatment because of an unraveling of the social fabric. Unsafe physical environments create conditions that make injuries from child neglect more likely.

Fostering neighborhood improvement initiatives is a critical element of a new national strategy for child protection. In such initiatives, ecological approaches for the strengthening of neighborhoods and communities with inadequate environments for families and children would be developed and tested. Local governments would work with community residents, religious institutions, voluntary organizations, and businesses to develop and implement the initiatives.

The Role of Volunteers in Preventing Child Maltreatment

Volunteer programs have obvious relevance in any neighborhood-based service delivery system. They link directly to a reduction of social isolation among families with children, provision of grassroots social support, and strengthening of neighborhoods through the efforts of the residents themselves. Volunteer programs are exemplary of the principle of **"neighbor helping neighbor"** in its most literal form. In addition, volunteers gain opportunities to: develop new skills; broaden their perspectives; achieve greater cultural competence and understanding; develop possible career interests; and foster compassion in themselves and others. Accordingly, in **Recommendation C-2** the Board calls upon the Federal Government to ***take all steps necessary to facilitate the development of volunteer programs for the prevention and treatment of child abuse and neglect.***

Evaluation research on child and family services has established that the effect of such programs is enhanced through the use of volunteers and paraprofessionals. Achievement of such effects has occurred, however, in programs where volunteers obtained a high level of training and professional supervision and consultation--resources that would likely be especially important in assistance to families with serious multiple problems, where maltreatment has occurred or is at high risk of occurring. Thus, although volunteer programs obviously are cost-effective, most do require financial support for recruitment, training, and supervision of volunteers.

The Role of Religious Institutions in Preventing Child Maltreatment

Many different kinds of voluntary organizations have important roles to play in the nation's efforts to restore its neighborhoods and communities. In this report the Board has chosen to single out the role of religious institutions in the prevention of child maltreatment by calling upon the Federal Government in **Recommendation C-3** to ***provide the religious community with information about ways that it can assist in the prevention of child maltreatment***.

The Board believes that, because of their broad base and deep historical roots, as well as their accessibility to children, family, neighborhood, and community, religious institutions often possess a unique capacity to initiate those activities necessary for the promotion of a responsive community child protection system. Although responsibility for solving the complex problem of child maltreatment cannot be placed at the doorstep of the nation's religious institutions, the Board believes that--because they have been, and will continue to be, an integral part of neighborhood and community life--their potential as agents of positive change in connection with child maltreatment needs to be tapped more effectively.

To that end, the Board believes that national organizations of religious institutions should adopt proactive measures that:

- place the "national emergency" of child maltreatment at the very top of their national as well as congregational agendas;
- increase the level of awareness among their congregations;
- aggressively pursue critical linkages and partnerships with the professional community to foster educational initiatives that, over time, can diffuse within both congregations and neighborhoods; and
- develop strategies that lead to a proactive and preventive approach to the many families who find themselves in crisis.

The Federal Government can provide religious organizations with information useful to them in fulfilling such tasks. Because of the Establishment Clause of the First Amendment of the United States Constitution, in its provision of such information, the Federal Government needs to be appropriately sensitive to Constitutional concerns.

Providing a New Focus on Child Abuse and Neglect and Strengthening Families in All Relevant Federal Agencies

Redefining the Mission of the National Center

For 17 years the implementation of CAPTA has required that NCCAN, acting largely as a **surrogate for the entire Federal Government**, attempt somewhat valiantly to carry out a set of activities that are comprehensive and affect all relevant disciplines involved in child protection. That approach has led to other Federal agencies not assuming their fair share of the burden of Federal child protection activities.

Worse yet, in trying to carry out those activities, NCCAN has not been able to devote adequate attention to the function of **providing leadership for State, Tribal, and local CPS activities** as well as the function of **planning and coordination of the entire Federal effort.** This leads the Board in **Recommendation D-1a** to call upon the Federal Government to ***redefine the mission of the National Center on Child Abuse and Neglect so that the exclusive focus of the agency becomes either: (1) providing leadership for all Federal efforts to strengthen the State and local CPS function; or (2) planning and coordinating the entire Federal child protection effort.*** To the Board, because of the overriding importance of these two functions, the choices of a mission for NCCAN come down to either one or the other.

In NCCAN's current form it is unrealistic to expect adequate fulfillment of either role--aggressive leadership for child protection within the social services system or forceful leadership within the child protection system as a whole. Thus, either choice necessarily entails restructuring the agency and moving it to another location within the Executive Branch. (Either choice also probably means renaming the agency). For example, a choice of the CPS function suggests merging NCCAN again with the Children's Bureau. A choice of the planning and coordination function suggests moving the agency to the highest reaches of DHHS. Whichever choice is made, a corollary decision will be required concerning what should happen to the existing NCCAN grant and contract programs.

If NCCAN is transformed into the Federal leader of CPS improvement efforts, the Federal Government should designate a separate entity to lead the planning and coordination of Federal child protection efforts (see Recommendation F-1). If NCCAN is transformed into the planning and coordination entity, the mission of the Children's Bureau should be expanded to include support for the CPS activities of the child welfare system (see Recommendation D-2).

Common Responsibilities of Other Federal Agencies

A basic premise of the Board is that the bulk of Federal responsibility for child protection should not be vested in a single agency. Even if that were possible, it is not desirable. It follows, therefore, that multiple agencies need to assume much greater responsibility than they are now doing. Recommendations D-1.b through D-8 speak to that necessity.

In **Recommendation D-1.b** the Board calls upon the ***administrators of all Federal agencies operating programs which are or could be relevant to addressing one or more aspects of child abuse and neglect to ensure that those programs are capable of making full, meaningful, measurable, and visible contributions to the total Federal effort.*** The Board believes that, whether one is talking about treatment programs for incarcerated child molesters, in-service training programs for elementary school teachers focused on early recognition of child abuse, or research on the childhood causes of chronic substance abuse among adults--a substantial capacity for child maltreatment-related activity exists, or could exist, **throughout** the Federal Government.

For this capacity to be successfully realized, however, the existence within multiple Federal agencies of **specially targeted efforts** is required. In Recommendations D-2 through D-8 the Board makes a series of recommendations about aspects of child maltreatment directly relevant to each of the agencies administering **specially targeted efforts.**

The Board believes that, in implementing these efforts, each of the agencies should carry out a set of **common functions.** These functions--tailored, of course, to the specific program concerns of each effort--are:

- the exercise of national leadership in activities related to the strengthening of families and child protection, including the prevention of child maltreatment;
- the generation of knowledge about child abuse and neglect, through support for knowledge building efforts, including data collection and program evaluation;
- the diffusion of knowledge about child abuse and neglect to professionals within the program's constituency;
- the provision of technical assistance to State, Tribal, and local governments, including legislative bodies, in the development and implementation of activities related to child protection, including the prevention of child abuse and neglect;

- the development of models of, and of support for, the training of professionals, paraprofessionals, and volunteers in activities related to child protection, including the prevention of child abuse and neglect;

- the development and dissemination of guidelines for the design and delivery of services related to child protection, including the prevention of child abuse and neglect;

- the gathering and diffusing of information about the child protection activities of States, Tribes, and local authorities and private organizations, so that child protection officials may be informed about innovative approaches in other jurisdictions;

- the provision of financial assistance to States and Tribes for services in the child protection system, including services designed to prevent child abuse and neglect; and

- the participation in inter-agency collaborative endeavors which will ensure that the overall Federal effort related to child maltreatment is comprehensive, planned, and coordinated.

Obviously, some of the functions are more readily applicable to certain agencies than others. Nonetheless, the Board believes that all of the agencies can and should carry out all of the functions.

Federal programs which are, or could be, relevant to the total Federal effort are authorized through myriad Congressional committees and subcommittees. This multiplicity of jurisdictions constitutes a major barrier to the implementation of this recommendation. Overcoming this barrier will require extraordinary Congressional leadership.

Providing Leadership to State and County CPS Agencies

Although the Children's Bureau is the DHHS unit most involved with the administration of State and local public child welfare services, the Children's Bureau pays scant continuing attention to the administration of the State and local CPS function. The National Center also plays virtually no role in the administration of CPS agencies.

The DHHS neglect of the CPS function exists side by side with the series of problems which the Board identified in Recommendations 18-22 in its 1990 report. Whether focusing on the lack of professional status for CPS case workers, the absence of suitable minimum educational requirements for these workers, the lack of adequate training, the lack of appropriate caseload controls, or the lack of an adequate number of culturally competent staff--the problems persist.

Clearly, DHHS must organize itself more effectively in this regard. The State, Tribal, and local CPS function requires: forceful Federal leadership; much more continuing attention from DHHS senior management; the involvement of much more DHHS staff expertise; more knowledge development effort focused specifically on CPS; and far greater collaboration between the Children's Bureau and NCCAN.

In **Recommendation D-2** the Board calls upon the Federal Government to ***take all necessary measures to ensure that, within the nation's system of public social services, State, Tribal, and local CPS agencies deliver high quality services. Such services should include:***

- ***the development of linkages with other service providers and community resources to ensure that children and families are receiving coordinated, integrated services;***
- ***the development of a focus on prevention and early intervention with high-risk families;***
- ***the prompt, thorough, and family-sensitive investigation of cases of suspected maltreatment;***
- ***the appropriate use of risk assessment in cases of suspected or substantiated child abuse and neglect;***
- ***the assessment and management of such cases (including in-home crisis services and other services designed to increase children's safety, strengthen families in crisis, and prevent unnecessary out-of-home placements);***
- ***relating CPS to respite and other out-of-home care for the purpose of child protection; and***
- ***relating CPS to permanency planning and adoption services for children who have been removed from their families due to maltreatment.***

Providing Leadership to State and County Mental Health Agencies

Although some maltreated children have no apparent lasting effects of their abusive experiences, few phenomena are as likely to have adverse consequences on mental health. In **Recommendation D-3b** the Board calls upon the Federal Government to ***take all necessary measures to ensure (a) that effective mental health treatment is available and accessible to abused and neglected children and their families (including biological, adoptive, and foster families) and (b) that mental health programs for children and families collaborate with other agencies and community groups in the prevention of child maltreatment.***

That mental health treatment of abused and neglected children remains a relatively rare practice is intolerable. Similarly, the Board is concerned about the common lack of application of mental health professionals' expertise in behavior change to the problem of prevention of child abuse and neglect.

The Board believes that a major initiative is necessary to improve the availability and accessibility of mental health services for abused and neglected children and their families and for families at risk of child abuse and neglect. At a minimum, such an initiative requires a significant investment in the development of States', Tribes', and communities' capacities to provide such services.

Given the complexity of the problem, there needs to be provided not just more but **different** mental health services for maltreated children and their families. Similarly, preventive mental health services must take into account both specific psychological needs (e.g., parental needs for self-esteem) and the diverse "reality" needs (e.g., the need for safe housing) faced by many families at risk of child abuse and neglect.

Addressing the Connection between Substance Abuse and Child Maltreatment

Fortunately, the national trend in use of illicit drugs, especially cocaine, is downward. Although this trend is encouraging, the challenge that the problem of substance abuse raises for the child protection system remains formidable. Drug abuse remains common, and the drop in use has been limited largely to occasional users. Alcohol abuse may be an even greater threat to child health.

In short, although the National Drug Control Strategy appears to be having some effect, hundreds of thousands of drug- and alcohol-exposed babies are born each year. Although publicity has focused on major coastal cities, the problem is a national one.

Although much remains to be known about the effects of pre- and postnatal exposure to illegal drugs, research on short-term effects of such exposure and on short- and long-term effects of heavy prenatal exposure to alcohol indicate high risk for drug-exposed children. The potential negative effects of parental substance abuse on children are obvious and alarming.

The problem is not just one of pre- and postnatal exposure. Many children experience neglect as a result of their parents' being physically or psychologically absent while seeking alcohol and other harmful drugs or under their influence. Intoxication also is a precipitating factor for every kind of abuse. Moreover, for parents already having difficulty in caring for their children, the problem is exacerbated when the child is relatively unresponsive or uncooperative because of the developmental effects of pre- and postnatal exposure to alcohol or other harmful drugs.

Nonetheless, as the Board noted in its 1990 report, services for substance abusing parents and substance-exposed children are unacceptably inadequate in most parts of the nation. Even the policy that should be followed is unclear.

States have moved rapidly to enact new legislation to deal with these problems. However, no consensus has emerged about the optimal policy. This lack of consensus is at least partly the result of the complexity of the problem.

Accordingly, in **Recommendation D-3b** the Board calls upon the Federal Government to **take all steps necessary to ensure that substance abusing parents have access to both effective programs for the prevention and treatment of child abuse and neglect as well as substance abuse itself. To be effective, Federal efforts must include initiatives to increase (1) the availability and accessibility of prevention and treatment programs and (2) knowledge about the relationship between substance abuse and child maltreatment, including the effects of various policies and programs designed to prevent children's pre- and postnatal exposure to alcohol and other harmful drugs.**

Child Protection and the Schools

Traditionally, American society has expected the family unit to raise, nurture, and motivate children to become confident, caring adults. While the Board believes that families must retain the primary responsibility for childrearing, a growing number of families need support. Because of their universality and access to children, elementary and secondary schools are uniquely situated to provide such assistance in an easily accessible, non-stigmatizing manner.

The Board believes that the educational system has the potential to be the linchpin of community-based efforts to protect children from maltreatment. That system cannot, however, be expected to take on extensive family support responsibilities without additional funding and professional back-up.

Federal support to assist in building the schools' capacity to fulfill such a role is critical. There is no national standard for data collection within schools on child maltreatment. The Federal Government, therefore, knows very little about the programs and procedures for identifying child abuse and neglect in school settings across the nation, the effectiveness of these programs, and the nature and extent of school-identified maltreatment.

Accordingly, in **Recommendation D-4a** the Board calls upon the Federal Government to ***take all necessary measures to ensure that the nation's elementary and secondary schools, both public and private, participate more effectively in the prevention, identification, and treatment of child abuse and neglect. The objective of such measures should be the development and implementation by State Educational Agencies (SEAs) in association with Local Educational Agencies (LEAs) and consortia of LEAs, of:***

- ***inter-agency multidisciplinary training for teachers, counsellors, and administrative personnel on child abuse and neglect;***
- ***specialized training for school health and mental health personnel on the treatment of child abuse and neglect;***
- ***school-based, inter-agency, multidisciplinary supportive services for families in which child abuse or neglect is known to have occurred or where children are at high risk of maltreatment, including self-help groups for students and parents of students;***
- ***family life education, including parenting skills and home visits, for students and/or parents; and***
- ***other school-based inter-agency, multidisciplinary programs intended to strengthen families and support children who may have been subjected to maltreatment.***

Family Life Education as a Preventive Tool

Family life education can be an effective technique for preparing adolescents and young adults to assume the responsibilities of parenthood. Through such education, younger persons can be taught qualities which characterize competent parenting such as nurturance, discipline, and coping. Such education cannot only be successful prior to parenthood but also can be a remediating measure for young parents not previously exposed to good parenting models.

In particular, family life education programs of the Cooperative Extension Service of the Department of Agriculture have considerable potential for serving as an effective prevention measure, especially when systematically directed toward families in crisis. Accordingly, in **Recommendation D-4b** the Board calls upon the Federal Government to ***stimulate new family life education initiatives specifically aimed at adolescents and young adults which have as their underlying purpose the prevention of child maltreatment.***

Child Protection and Health

The recognition and substantiation of physical and sexual abuse often relies heavily on an accurate medical diagnosis. Linkages are required by CPS workers with those who conduct such evaluations.

Too often health professionals are weak links in the multidisciplinary network required in communities to deal with child abuse and neglect. Surveys have shown that health professional schools provide little training on child maltreatment issues at the undergraduate, graduate or post-graduate levels. Although the number of pediatricians working at least part-time in the field of abuse and neglect has grown appreciably, there are few family physicians, emergency room, or other specialist physicians contributing to the field. The same is true in nursing, dentistry, the allied health professions, and alternative health care providers.

The public health sector, especially through the federally funded Community Health Center programs and Indian Health Service and other State and city health clinics, provides care to millions of children. This public health involvement is especially important given the already-high rate of alcohol-related child neglect and increased reports of sexual abuse involving Native American children. The erosion of the traditional supportive role of the public health nurse and its concomitant replacement by disease oriented activities has left a void in the **prevention** of child abuse and neglect.

Thus, in **Recommendation D-5** the Board calls upon the Federal Government to ***take all necessary measures to ensure that the nation's health care system plays a more effective role in the prevention and treatment of child abuse and neglect. In planning for involvement of the health care system in child protection, attention should focus on the roles of community health centers, public health authorities (including visiting nurse programs), general and pediatric hospitals, primary health care providers, self-help support networks, and alternative health delivery systems. In addition, attention should be given to reducing the prevalence of child maltreatment among children with disabilities, amelioration of the health consequences of child maltreatment, and provision for coordinated responses to child maltreatment fatalities.***

Child Protection and the Justice System

Although much of the nation's legal literature and training related to child protection was originally produced with the assistance of DHHS financial support (largely through NCCAN), the Department of Justice (DoJ), particularly since the mid-1980s, has increasingly been involved in support of activities related to child maltreatment. In the opinion of the Board, there will never be a total national investment in the response to child maltreatment by legal institutions until DoJ undertakes more visible Federal leadership in this area.

Support of DoJ activities related to child maltreatment has been fragmented among many divisions of the Department. Consequently, grants have been awarded by the Department's many entities without any effort of Department-wide planning or coordination.

Coordinated Federal leadership by DoJ is also critical in view of the recent enactment of several Federal laws addressing such topics as the: involvement of the Federal courts in cases involving child witnesses; mandatory reporting obligations of professionals working with children on Federal lands (including collaboration with the Bureau of Indian Affairs which is implementing requirements for child abuse reporting on Indian Reservations); criminal record screening of prospective employees of Federally-operated facilities serving children; and the response system to child abuse occurring on Indian Reservations. Without a planned, focused response to these new Federal statutory responsibilities, the Board fears that their implementation will be unduly slow and chaotic.

Thus, in **Recommendation D-6** the Board calls upon the Federal Government to ***take all necessary measures to ensure that the nation's courts, attorneys, law enforcement agencies, probation departments, parole agencies, and correctional institutions provide a prompt, sensitive protective response to all forms of child maltreatment. Such a response should involve improving the administration of civil and criminal justice related to child maltreatment, advocacy on behalf of abused and neglected children, and treatment for and monitoring of offenders both in communities and correctional settings. The measures should ensure that cases involving allegations of child maltreatment in family settings, in the community, and within residential institutions are all given an adequate focus.***

Funding Child Protection Efforts

Appropriations for child protection programs have increased at a rate nowhere close to the increase in suspected and substantiated cases of child maltreatment. Indeed, support actually has declined in the aggregate in real dollars. Action to provide a fiscal foundation for an improved child protection system is overdue.

In **Recommendation D-7** the Board calls upon the Congress to ***authorize and appropriate for each new specially targeted effort recommended in this report an amount necessary to implement the effort at a reasonable level.*** In this regard the Board urges the Federal Government to consider the reallocation of existing resources for child welfare services from a focus on supporting the costs of out-of-home placement to a focus on "front-end," intensive, home-based services.

Also, in the award of Federal child protection funds, the Board urges the Federal Government to give due attention to geographic variations in need. Because of (a) the link between poverty and child maltreatment and (b) the limited resources available in impoverished communities, Federal aid for child protection should be distributed with due regard to relative financial need of States, their political subdivisions, Tribes, and Community Mental Health Center catchment areas.

As do all citizens, the Board understands the fiscal difficulties faced by the Federal Government and the necessity of the Office of Management and Budget (OMB) to act with zeal to keep Federal expenditures under control. Nonetheless, the Board believes that OMB is taking too narrow a view of the full and extended costs to the nation over time of the child protection emergency.

Staffing Child Protection Efforts

A conclusion which leaps out of the Board's review of the Federal role related to child protection is the imperative to strengthen the resource base of all Federal agencies involved in the child protection effort. Without doing so, the possibility of these agencies accomplishing their child protection mission is minimal.

It is important that staff of all relevant Federal agencies involved in child protection efforts have the expertise and the resources necessary to fulfill their assigned tasks. It is also important that those staff possess credentials of sufficient stature--including graduate and professional education, experience, and professional certification--to make them credible leaders in the field.

Thus, in Recommendation D-7 the Board urges that, ***for each new specially targeted effort recommended in this report, all program staff, excluding clerical and grants management staff, should have demonstrated professional competence in the field of child abuse and neglect. Moreover, program staff should possess at least those professional credentials generally recognized as necessary for competent practice or research in their disciplines. The number of program staff and the support available to those staff should be sufficient to fulfill their technical assistance mission and to achieve the visibility necessary for national leadership in the various disciplines in the child protection field.***

Enhancing Federal Efforts Related to the Generation, Application, and Diffusion of Knowledge Concerning Child Protection

Need for More and Better Data

For an adequate data base for Federal, State, Tribal, and local planning, information is needed about the actual and reported incidence and prevalence of child maltreatment. Information is also needed about the systemic response to child maltreatment, not only in the public child welfare system, but also in the public judicial, educational, health, and mental health systems, as well as in the private, non-profit sector.

In Recommendation E-1a the Board calls upon the Federal Government to ***create a comprehensive, mandatory, 50-State and Tribal, aggregate and case-specific child abuse and neglect data collection system. This system should be administered collaboratively by several Federal agencies. In total, it should yield an accurate, uninterrupted, comprehensive picture of child abuse and neglect, as well as the response to it, throughout the nation.***

The Board believes that a new data collection system should collect data on child maltreatment from: CPS; foster care and adoption agencies; residential facilities other than foster homes caring for children, such as juvenile training schools and residential child care facilities, including juvenile training schools, group homes, and psychiatric hospitals; mental health clinics; schools; courts; law enforcement agencies; hospitals, on both emergency room admissions as well as in-patient discharges; and physicians' offices. The system should also incorporate data on "home-based" services provided through child welfare agencies at the State, Tribal, and local level.

The Board believes that a new data system should be designed by the Bureau of the Census in conjunction with the several Federal agencies presently collecting data. A one-time grant should be available to the States and Tribes to develop or enhance their capability to comply with new data collection and reporting requirements.

Need for More and Better Research

The performance of the Federal Government in child protection research has been inadequate. Given the seriousness and magnitude of the problem of child abuse and neglect and the dearth of knowledge necessary for program planning and decision-making in the lives of individual children and families, the lack of a major Federal program for research on child maltreatment is appalling.

That is why, in **Recommendation E-1b**, the Board calls upon the Federal Government to ***take all steps necessary to promote systematic research related to child abuse and neglect. Such steps should include establishing a new program within the National Institute of Mental Health (NIMH) as the primary Federal research effort concerned with the causes, precipitants, consequences, prevention, and treatment of child abuse and neglect, as well as vesting responsibility in that program for the provision of Government-wide leadership concerning research.***

The term "primary" should not be construed as "only." As the Board envisions it, the NIMH program would be a complement to--not a substitute for--research efforts in other agencies relevant to the Federal child protection role (i.e., child welfare; education; justice; etc.) Those efforts would not only continue, they would be considerably strengthened because of the leadership role of the NIMH program. Leadership would focus on such issues as long-range planning for the entire Federal research effort, budgeting that effort, and the quality and quantity of research personnel in knowledge-building institutions throughout the nation.

Need for More and Better Evaluation

When caseworkers and administrators are constantly beleaguered, inattention to evaluation and to application of the research that is available is understandable. Nonetheless, if the nation is serious about ensuring that its children are protected, such an approach cannot be tolerated.

For example, CPS agencies investigate at least several million cases a year. In every such case, they make initial judgments about the level of risk entailed if the child is to remain at home, and they must decide what combination of services is likely to reduce risk appreciably. Often such judgments are repeated multiple times in a given case; similar judgments must be made about reunification of children who have been placed in foster care. Yet, almost nothing is known about worker decision-making, and relatively little is known about the effectiveness of standard protocols for risk assessment.

Even when evaluation studies of adequate quality have been conducted, they rarely have been followed up. Demonstration projects typically have not built on previous efforts, and evaluation researchers rarely have contributed multiple studies.

Given the seriousness of errors in judgment, it is impossible to defend a situation in which so little care has been taken in systematically recording workers' decisions and evaluating their validity. Thus, in **Recommendation E-1c** the Board calls upon the Federal Government to ***ensure that child protection activities supported with Federal funds are subjected to rigorous evaluation and that findings of such studies are applied in the design and implementation of programs in the child protection system.***

Need for More Skilled Professional Staff

In its 1990 report the Board presented evidence that the nation's entire child protection system is operating under a terrible crisis. All parts of the system are understaffed, underpaid, undertrained, and often underqualified.

It is not just an increase in numbers that is needed. Child protection professionals need to be competent. In a decade where, for example, the interpretation of certain medical findings as "diagnostic" for sexual abuse has changed, it is imperative for professionals to maintain their qualifications through changing times.

There is a clear need to increase dramatically the numbers and qualifications of all professionals in the field of child protection: CPS workers, physicians, nurses, law enforcement officers, lawyers, judges, and mental health professionals of all types. That is why, in **Recommendation E-2**, the Board calls upon the Federal Government to ***expand incentives and grant programs significantly to increase the numbers and qualifications of professionals available to work in the child protection system.***

Need for Implementation of Standards of Practice

Like the States and Counties, the Federal Government has a clear duty to provide services to the families who reside, or are governed, under its jurisdiction. The Board believes that those families should be able to benefit from the very best professional protective response that American society can offer. Developing exemplary services has an added benefit. In the process of providing support for the improvement of the state of the art in child protection, the Federal Government assists the States and Tribes by providing them with models that they can adopt.

The development and implementation of Federal standards of practice, and the careful evaluation of their implementation, would go far toward making the child protection system that operates within Federal jurisdiction an exemplar of good practice. Thus, in **Recommendation E-3** the Board calls upon the Federal Government to ***take all necessary measures to ensure that each Federal agency directly providing services in the child protection system meets standards of competent practice. The first of these measures should be commissioning the development of national standards of competent practice for the various professionals and agencies involved in child protection cases at the State, Tribal, and local levels.***

Need for the Provision of Technical Assistance to State and Tribal Child Protection Efforts

In the late 1970s, ten DHHS regions harbored Regional Resource Centers on Child Abuse and Neglect, Child Welfare, and Adoption--30 centers in all. In 1982, funding for these centers was dramatically cut, and ten centers were funded to cover the three topic areas for each region. Two years later, all the centers were dropped.

In 1985-86, ACYF, the Children's Bureau and NCCAN rediscovered resource centers, but instead of funding programs in 10 regions, they decided to fund "National Resource Centers"--one for each of ten topical areas. In the 1988 CAPTA reauthorization, Congress required that DHHS develop resource centers to serve "defined areas." The FY 1991 Coordinated Discretionary Fund announcement solicited proposals for two national resource centers--one to cover child abuse (e.g., physical abuse and neglect), the other to cover sexual abuse.

During the last decade, while resource centers focused exclusively on child abuse and neglect were reduced five-fold (from 10 to 2), the number of reported cases nationally increased four-fold (from 669,000 to 2.5 million). In view of the increased complexity of investigating and treating child sexual abuse, and the recognition of newer forms of abuse, the need for a significant expansion in resource centers is clear.

In **Recommendation E-4** the Board calls upon the Federal Government to ***establish a mechanism to stimulate development of State or regional resource centers for training, consultation, policy analysis, and research in the field of child protection. Such centers should be interdisciplinary and should involve collaboration between universities and relevant State and Tribal agencies, including opportunities for university-based sabbaticals for senior State and Tribal officials and agency-based sabbaticals for university professors.*** The investment in State resource centers is apt to be repaid many times over in increased quality of child protection services and in the level and diffusion of knowledge about child abuse and neglect.

Need for the Diffusion of Knowledge

The Board believes that it is particularly important to increase both public and professional sophistication about child abuse and neglect. To that end, there should exist within the Federal Government an entity capable of serving as a source of accurate, comprehensive information about child maltreatment.

That entity should be designed so that its staff can itself answer virtually any general question about child protection, both in terms of its current manifestations as well as its past manifestations, and can refer any technical question it may receive quickly and accurately. Further, that entity should be so prominent, so well-known, that it would be the obvious first place for a questioner to turn. In a time when it can take hours to explain to a reporter from the news media what the child protection system is and how it works, the entity which the Board envisions must be proactive rather than reactive, including as an important part of its mission the education of public opinion shapers on the problem of child abuse and neglect.

There is another important task for such an entity. The public has increasingly perceived reporting to a hotline as the solution not only for child abuse, but for other problems too, including some that would have been handled on a neighborly basis in an earlier era. It is time now to focus public attention not only on when to report, but also on when not to report and on what to do instead.

For many years NCCAN has attempted to accomplish the information diffusion function through a series of contracts. Although the contractors have been quite capable, the scope of the contracts has not embraced the mission which the Board believes must be undertaken. Moreover, as the contract periods have concluded, the responsibility has been shifted from one contractor to another. This practice is unwise, because it inevitably disrupts the continuous flow of information when the contracts end.

That is why, in **Recommendation E-3**, the Board calls upon the Federal Government to ***develop a highly visible entity that takes whatever steps are necessary to ensure that practitioners, policymakers, and the general public (especially parents) have ready and continuous access to comprehensive, state-of-the-art information on child abuse and neglect.*** The Board believes that the information diffusion function should no longer be contracted out but, rather, be carried out by Federal employees.

Improving Coordination among Federal, State, Tribal, and Private Sector Child Protection Efforts

Establishing a Structure for Planning and Coordination at the Federal Level

Far greater coordination of Federal activities than now exists is required. That coordination needs to extend to Federally-supported activities at the State, Tribal, and local levels. Recommendations F-1 through F-3 speak to the issue of coordination.

In Recommendation F-1 the Board calls upon the Federal Government to ***establish an agency or entity to plan and coordinate the accomplishment of the goal of reducing the prevalence of child abuse and neglect. The agency or entity should be mandated to develop--in concert with the agencies throughout the Federal Government whose programs constitute the collective Federal effort--both a long-range strategy for accomplishment of the goal as well as short-term approaches leading toward that end. The agency or entity should also be required to set forth that strategy and those approaches in the form of a readily achievable, comprehensive plan.***

In addition to developing the plan, the agency or entity should:

- assist the President, the Secretary of Health and Human Services, and the heads of other relevant agencies in enlisting opinion leaders in efforts:
  - to reduce societal influences that may increase the probability of family violence, child abuse and neglect, and violent crime;
  - to increase social and material support for families that will decrease child abuse and neglect and other forms of family dysfunction; and
  - to increase social support for children that will ameliorate the effects of abuse and neglect when maltreatment does occur;
- identify problems related to child abuse and neglect that are receiving inadequate national attention;
- convene meetings to facilitate the active and constructive response to such problems:
- support educational campaigns designed to increase the sophistication of citizens of the nature and complexity of child abuse and neglect and to inform them about alternative steps that they may take to increase the safety of children;
- develop public/private partnerships aimed at enhancing the role of the private sector in the prevention and treatment of child abuse and neglect;
- coordinate the provision of technical assistance to Federal, State, and Tribal agencies;

- coordinate the multi-agency review of the single comprehensive State and Tribal plans described in Recommendation F-2;
- monitor policy and program implementation at all levels of government; and, as necessary
- convene key actors from throughout the Federal Government for collaborative policy formulation, program design, and investment in joint funding ventures.

The agency or entity should be located at an appropriate organizational level. It should be vested with authority commensurate with the nature of its responsibilities. It should be given adequate resources.

Establishing a Structure for Planning and Coordination at the State and Tribal Level

The unplanned nature of Federal child protection policy is unfortunately replicated in most States, Tribes, and communities. A Federal mandate for comprehensive State, Tribal, and community planning is an appropriate exercise of leadership to ensure that Federal, State, Tribal, and local resources are used effectively and efficiently. If crafted sensitively, such a mandate will permit flexibility so that plans will be responsive to State, Tribal, and local needs. A planning requirement and the flexibility of funding that accompanies it provide the opportunity for developing an integrated approach in the child protection programs of States, Tribes, and communities. Indeed, many States are already voluntarily developing variants of such plans.

That is why, in **Recommendation F-2**, the Board calls upon the Federal Government to ***require any State or Tribe receiving any formula grant for child protection (including--but not limited to--any grants legislated in response to this report, grants pursuant to CAPTA, the existing Social Services Block Grant, and Titles IV-B and IV-E of the Social Security Act) to submit a comprehensive three-year plan for multidisciplinary investigation, prevention, and treatment of child abuse and neglect. This single comprehensive plan should be a major eligibility requirement for these Federal formula grants, providing States and Tribes with the opportunity to make a single application to the agency or entity described in Recommendation F-1 for funds from several agencies. That agency or entity should be authorized to exercise discretion in waiving discretionary grant requirements that may impede the blending of Federal funds. As an alternative to full-scale implementation of the comprehensive State or Tribal planning requirement, the Federal Government should initiate a multi-year series of pilot projects aimed at testing the core concepts underlying the requirement.***

A major feature of the planning requirement would be that, by meeting it, States and Tribes would entitle themselves to "one-stop shopping" for Federal funding for their child protection efforts. Currently, States and Tribes attempting to integrate such efforts must run the gauntlet of meeting myriad Federal grant requirements. That task is a principal barrier to the development of integrated approaches. Yet, the nature of child protection demands those very approaches.

Managing this "one-stop shopping" feature will be one of the two chief responsibilities of the agency or entity described in Recommendation F-1 (the other being the management of coordinated Federal planning). While not attempting to minimize the obstacles to the effective discharge of this responsibility, the Board believes that the advantages to cooperating Federal agencies will quickly become manifest.

In proposing this requirement, the Board is not asking States and Tribes to "do more with less." Although the major responsibility for designing the particular strategies to be used in a given child protection effort properly belongs to the States and local communities, the Federal Government should assist States in the development of the capacity to construct and fulfill a comprehensive child protection plan. Some of that assistance should be technical in nature. Often it also should be financial.

The proposed planning requirement may be too big a dose for the Federal, State, and Tribal Governments to swallow at one time. If that proves to be the case, the Board proposes a series of coordinated pilot projects to study the barriers to coordinated action by State governments aimed at the development and implementation at the neighborhood level of comprehensive, multi-agency, multidisciplinary, private-public "model" programs for the improvement of prevention, investigation, identification, intervention, and treatment of child abuse and neglect.

Providing for Comprehensive Federal Planning and Coordination in Response to Child Maltreatment Fatalities

The 1990 report of the Board directed the nation's attention to the tragic reality that thousands of American children are estimated to die each year as a result of child abuse and neglect. The exact numbers are unknown due to inadequate case identification and a lack of uniform data gathering. The Board noted that by carefully reviewing these tragic deaths, important lessons can be learned by Federal, State, Tribal, and local policymakers and administrators that can guide the improvement of all systems addressing the problem of child abuse and neglect. Moreover, this is an area with important practice implications for health care, legal, educational, and social services professionals.

Thus, if there is one area where the value of effective coordination by States, Tribes, and communities in responding to child maltreatment is most clearly demonstrated, it is in the review of child deaths due to child maltreatment. The report presents four actual case examples from a local child death review team to prove this point.

The Board believes that at the Federal level it is essential for relevant agencies of DHHS and the Department of Justice to be significantly involved in child fatality-related efforts. Other Federal agencies that are responsible for the provision of direct services to families must also address this subject. It is especially critical for all relevant Federal entities to pay attention to the barriers, such as confidentiality laws and agency regulations, that may inappropriately inhibit the effective review of child death cases at any level of government.

In Recommendation F-3 the Board calls upon the Federal Government to ***ensure that issues related to child deaths resulting from abuse or neglect are properly addressed by all relevant Federal agencies, acting collaboratively. Such collaborative efforts should address such issues as:***

- ***the review of Federal statutes and regulations that may create barriers to inter-agency, multidisciplinary collaboration at the Federal, State, Tribal, and community level in the investigation, intervention, and review of suspected child fatalities;***

- ***the development of model protocols and procedures for both individual State, Tribal, and local agencies, as well as for inter-agency, multidisciplinary collaboration in the investigation, intervention, and service provision in cases of child fatalities;***

- ***the development of uniform national data gathering and analysis related to child fatalities; and***

- ***the on-going funding of research and training relating to the responses of the Federal, State, Tribal, and local governments to the problem of child fatalities, including how such responses contribute, if at all, to the prevention of child maltreatment in general as well as child maltreatment fatalities.***

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

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.

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 focus the Federal Government's efforts in home visitation.

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." 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 Board presents a case study to illustrate this tragedy. The hospitalization for the baby'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 the baby 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. That is why in Recommendation C-1 the Board calls upon the Federal Government to ***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.***

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. The Board believes that a more limited, targeted effort 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.

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.

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

IV. WHAT DIFFERENCE WILL IT MAKE? FROM POLICY TO ACTION

In its 1991 report, without a doubt, the Board is asking for a major commitment by the Federal Government to resolving the national emergency in the child protection system and preventing its recurrence. Indeed, it is going further to demand adoption in law of a policy obligating Federal agencies "to act with due urgency" and "to use all means practicable" so that "all steps necessary will be taken to **ensure that every community in the United States has the resources...required to develop and implement a child protection strategy that will ensure the safety of children**" and in fact will "prevent child maltreatment, whenever possible."

In view of the Federal Government's lack of comprehensive, concerted involvement in child protection thus far, skeptics may reasonably ask whether this blueprint really would make a difference in the lives of children and families. How can changes made "inside the Washington, D.C. Beltway" translate into caring communities across America? Will a major Federal initiative not result simply in new layers of bureaucracy and new reams of paperwork rather than an increase in the level of protection available to children?

The Board's answer is two-fold. First, it makes no apology for the scale of the reform that it is advocating. The scale of the problem of child maltreatment is enormous, its nature is complex, and its significance is profound, both for individual children and families and for the nation.

Second, although the Board concurs that Federal action alone is insufficient for the social transformation that is necessary for the protection of children, it is also clear that such fundamental change cannot occur on a national scale without a reformation of Federal policy. Indeed, it is clear that community change--even more basically, comprehensive services for individual maltreated children and their families--will remain difficult to accomplish without Federal reform.

The Board asks the nation's leaders to consider the changes that will occur at the community level if the Board's recommendations are fully implemented.

- **Local program administrators and practitioners in the child protection system will be guided by a coherent sense of mission.**

- **Neighborhood-based strategies for child protection will be developed in a comprehensive community plan.**

- Communities will have substantial new fiscal resources for prevention treatment of child abuse and neglect, and they will have great flexib planned integration of such funds.

- Communities will have substantial new human resources for the purp child protection.

- Services will be comprehensive.

- Services will be of substantially higher quality.

- Child protection will be high on the community agenda.

Part IV of the Report explains in detail what each of these changes will m individual communities.

Federal action can make a difference in community life. Ultimately, though, th of the efficacy of reform is the difference that it can make in the lives of indi children and families. The 1990 report of the Board presented a composite sc of how the current child protection system functions. That illustration describe young "J" endured a multi-level, complex and lengthy process, driven primarily agendas of CPS, law enforcement and the judicial system. This report began w story of "Anna" and "Beth." That story graphically illustrates why a coordi comprehensive, community-based child abuse prevention, identification and trea system must begin with the child.

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.

Photo 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.

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

- Strengthen family functioning
- Enhance parent/child interaction and positive parenting
- Promote optimal child development
- Assure a health care home and full immunization
- Assure use of community resources including family planning
- Avert 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 the 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:

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

Program Success

- 99% accurate identification of low-risk families
- 99.3% non-abuse for families served
- 98.6% non-neglect for families served
- 90% of two year olds are fully immunized
- 95% of families with identified medical homes
- 90% of families receiving timely family planning information
- All children receiving developmental screening
- 85% of children are developmentally age appropriate

Cost Per Family

$2,500 dollars per family for assessment, home visitation services, client tracking data system, monitoring, and administration.

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)

COMPARISON OF H.S. OUTCOMES
WITH NON-INTERVENTION OUTCOMES AMONG AT RISK FAMILIES

	CHECKLIST SCORES	DIRECT EVIDENCE ABUSE/NEGLECT	MILD NEGLECT
MURPHY/ORKOW STUDY *	40 +	52%	24%
	25-39	5%	31%
HEALTHY START PROJECT	40 +	0	2%
	25-39	0	

* MURPHY, ORKOW, NICOLA, "PRENATAL PREDICTION OF CHILD ABUSE AND NEGLECT; A PROSPECTIVE STUDY", 1985, (THIS STUDY VALIDATED THE FAMILY STRESS CHECKLIST).

c:outcomes.hs

Program gives troubled families chance for a 'Healthy Start'

BY HELEN ALTONN
Star-Bulletin

ANY doubts that Hawaii Healthy Start is helping troubled families dissolve when one hears Anna Andaya's story.

Many associated with the program joined the 36-year-old in choking back tears when she told them, "I truly, honestly, believe if it didn't pick me up, my daughter and I probably would be dead.

"Don't give up," she told those attending an anniversary luncheon this week at the Kahala Mandarin Oriental Hotel for the Hawaii Family Stress Center and Healthy Start Program.

"If you think someone's too tough, a situation too difficult, ask about me, where I came from."

She grew up in an environment where drinking and violence were a way of life, the Ewa Beach woman said in an interview. "People got beaten up and the next morning everything was OK."

So she traveled the only road she knew, marked by drugs, welfare, abusive men and escape to emergency shelters. When drug rehabilitation failed, state Child Protective Services workers took her children.

Today, Andaya has the equivalent of a high school diploma and attends Leeward Community College. She works for the Department of Education and supports her son, 9, and daughters, 8 and 6, without welfare. And she has been sober for four years.

BY DENNIS ODA, Star-Bulletin

Allessondra Andaya-Kepa, center, is hugged by her mother, Anna Andaya, and Kalei Kahapea, a family support worker from the Hawaii Family Stress Center.

She traces her rebirth to the birth of her daughter, Allessondra, in 1987.

They were the first selected for services after the Family Stress Center piloted Healthy Start in 1985 in Ewa as a child abuse and neglect prevention program.

Seven private agencies now have programs in 11 communities across Hawaii and Healthy Start has been adopted as a national model. It has spread to 30 states.

Honored for starting and sustaining Healthy Start were Dr. Calvin C.J. Sia, retired Maui Sen. Mamoru Yamasaki and Stress Center leaders Gail Breakey and Betsy Dew. Sia, Breakey, Dew, Patti Lyons, Barbara Naki and Linda Honda pioneered the Stress Center in 1975.

Of more than 2,000 Healthy Start families in 1992, no abuse occurred in 99.3 percent and no neglect in 98.6 percent.

When Allessondra was born, Andaya said, the Stress Center's Healthy Start workers visited her at Kapiolani Medical Center and asked if she wanted help with her child's development.

"The situation I was in wasn't healthy, but they didn't know that until after the fact," Andaya said. They learned later she had an ugly relationship with drugs and violence, she said.

But it was a long time before she admitted she had a problem, she said, even after she went to a shelter and her kids were taken away because she was still using drugs.

Her family support worker, Kalei Kahapea, said, "She had a choice — to do something positive for herself or lose the kids. She got help."

His role was to give her support, he said. "She needed somebody to be there for her. That's what the program is all about.

"We teach them to believe in themselves and, if they fall down, don't be afraid to take one more step. We're always there, even at 3 in the morning."

He stuck by her even when she went to court for restraining orders, then went back to her battering common-law husband, she said. He went with her when she kicked the man out of her life because she feared he would abuse her.

She realizes now "how close to death we were. Not just me, but my children."

She re-entered a drug rehabilitation program and was accepted into the state's JOBS program to educate and train welfare recipients for jobs. She went off welfare last August.

Zero to Three

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HEALTHY GROWTH

FOR

HAWAII'S "HEALTHY START"

Contents:

National Center for Clinical Infant Programs *2000 14th St., North, Suite 380, Arlington, VA 22201-2500* *(703) 528-4300*

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

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

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

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

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

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

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

The Healthy Start model

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

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

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

Figure 1.
Risk Indicators Used in Early Identification

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

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

FEEDING ME

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

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

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

Figure 2

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

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

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

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

3. Individualizing the intensity of service based on the family's need and level of risk

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

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

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

4. Linkage to a "medical home"

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

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

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

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

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

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

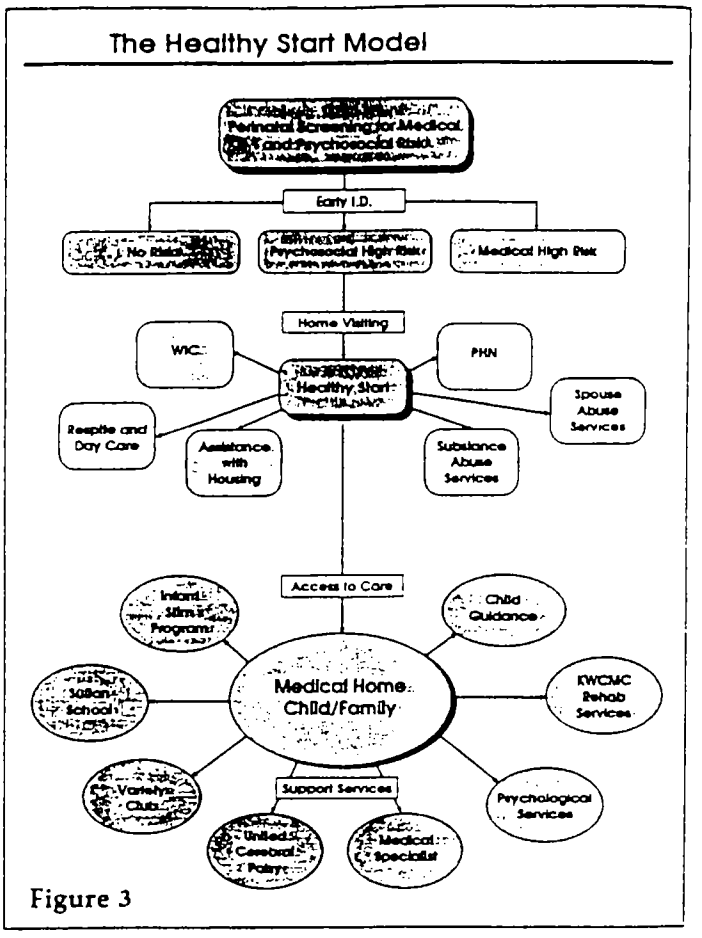


Figure 3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Staff selection and retention

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

For managers, we look for masters level professionals who have both clinical experience with dysfunctional families and supervisory experience, preferably with paraprofessional staff. Selecting the right staff for each role is critical to both program effectiveness and staff retention.

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

We look for similar personal qualities in both home visitors and EID workers—empathy, compassion, inner strength, high self-esteem, nonjudgmental attitudes, and status in their neighborhood or family as a natural helper. We have found that people who have experienced abuse themselves burn out more quickly than those who have had more nurturing childhoods; we ask prospective workers the same questions about their childhood experiences that new parents are asked during the EID interview.

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

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

Evaluation of Healthy Start

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

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

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

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

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

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

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

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

Statewide expansion

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

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

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

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

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

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

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

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

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

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

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

Figure 5.
Milestones in the Development of Healthy Start

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

Data projections and budget preparation are constant challenges. It is important to develop projections for each geographic area; among other things, this process allows us to show every state legislature what is needed to serve his constituency. We have developed a complex formula that takes into account the current number of births, projected growth in the birth rate, the number of families that projects can be expected to screen, and the number of families unlikely to accept services. To project a program's caseload over five years, we consider the number of newborns expected to enter the program annually, the number of families carried over from the previous year, and anticipated attrition. There will always be surprises. For example, the housing shortage has resulted in major shifts in the populations of low-income families.

A statewide program: Surviving and thriving

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

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

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

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

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

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

References

Alger, Mary (1976) *Mother-Baby Playbook*. Honolulu, HI.

Barnard, Kathryn E. (1983) *Child Health Assessment: A Literature Review*. Seattle, WA.

Breakey, Gail; Fox, L. (1985) *Mothers and Babies Working Together*. Honolulu, HI.

Furuno, Setsu (1984) *Hawaii Early Learning Profile*. Palo Alto, CA: VORT Corporation.

Kempe, Henry E. (1976) *Child Abuse and Neglect: Family and Community*

Orkow, B.; Murphy, S.; and Nicola, R. (1985) *Child Abuse and Neglect*, Vol. 9, pp. 225-235.

Ramey, Craig T.; Bryant, Donna M. (1988) Program Evaluation of a Healthy Start. Chapel Hill, NC: Ramey and Associates.

Calls for Papers:

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

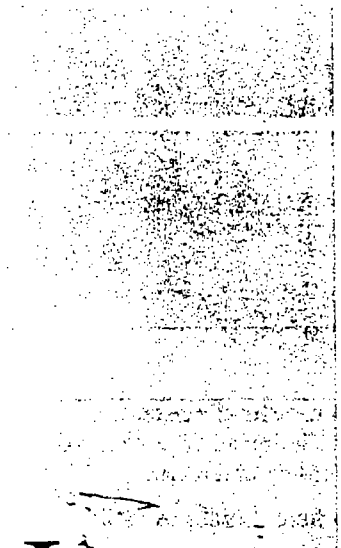
The Literature Prize Committee of the **Margaret S. Mahler Psychiatric Research Foundation** is now accepting papers to be considered for the 1991 annual prize of $750, which will be awarded to the author of an original paper which deals with clinical, theoretical or research issues specifically related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

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

Healthy Start

This program helps young families develop skills for loving

By Georgette Magnuson
Photography by Augie Salbosa



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

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

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

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

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

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

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

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

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

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

continued...

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 Families America

Healthy Families America
Fourth Year Progress Report

January, 1996

Introduction

Four years have passed since the National Committee to Prevent Child Abuse (NCPCA), in partnership with Ronald McDonald Children's Charities, launched the Healthy Families America Initiative (HFA). The goal of HFA then and now, was to ensure that all new parents, particularly those facing the greatest challenges, receive the education and support they need at the time their baby is born.

The evolution and expansion of Healthy Families America is unprecedented. In its inception, HFA drew largely from existing research and the knowledge and experiences of the Hawaii Healthy Start program. While HFA has always been an approach to service delivery based on best practice standards - rather than the replication of a distinct program model - many of the examples provided in training are reflective of Hawaii's program. As the HFA initiative evolved and our knowledge and experience base has grown, we have been able to add examples of good practice from a growing number of communities. We have been able to refine the critical elements and training materials, as well as develop new, innovative partnerships and program ideas. In only four years, HFA has grown to represent 154 sites in 28 states and the District of Columbia. While using the Healthy Start program as a frame of reference, each of these sites has adapted the model to build on the strengths and meet the needs of the communities they serve. As a result of this new knowledge and experience, Healthy Families America is an initiative now guided by the experiences of numerous communities, vast research and innovation developed throughout the country.

In addition to the rapid expansion of sites across the country, a cadre of researchers has been assembled, representing the first Research Network of its kind in the field of child abuse prevention. Over the past four years we have implemented a multifaceted approach at the policy and program level, moving us closer to our goal of providing education and support services to all new parents. Our accomplishments are many. The challenges that lie ahead are significant. To respond to the continued demand for Healthy Families America and assure that our response is of quality, five year goals for the initiative include:

- ensuring that all states have a multi-disciplinary task force comprised of public and private agency representatives working to institutionalize Healthy Families at the state level;
- establishing at least one HFA site in every state;
- ensuring that all states with more than one HFA site have the capacity to provide training and technical assistance internally;
- ensuring that 10 states are reaching at least 50% of all new parents with Healthy Families related services;

- multiplying by a factor of eight the number of high risk new parents receiving intensive home visitation nationwide; and
- continuing to reduce expected rates of child abuse by 75% in the population served.

In the coming years, therefore, we will work to establish state capacity to sustain Healthy Families through the development of state plans, state training facilities and the like; establish quality control mechanisms; improve our knowledge base on how to tailor HFA to different communities while evaluating our activities; increase public participation through national education campaigns and the development of community and statewide corps of volunteers who will work to bring Healthy Families America into every neighborhood; and develop long-term, institutional funding streams for Healthy Families America sites.

A. Implementing Programs:

1) Collaborating at the National Level:

Accomplishments: The broad nature of the Healthy Families America vision - seeking to address the health, educational and social needs of families - necessitates an approach that reflects comprehensiveness. To succeed, HFA must work in tandem with others who are focusing on these areas. In essence, HFA must be recognized and dealt with as one component, albeit an essential one and most logically the entry point, in any approach to supporting families. To assure that HFA planning teams and direct service programs establish formal linkages with other agencies and organizations working to support families and prevent child abuse, we have continued to make the establishment of new partnerships and the fostering of existing partnerships a priority.

Since the inception of HFA, partnerships have been developed with twenty organizations. They are: the American Academy of Pediatrics; the American Hospital Association; the American Nurses Association; many of the Children's Trust and Prevention Funds; Dutch Boy; Effective Parenting Information for Children; Freddie Mac; First Steps; Home Instruction Program for Preschool Youngsters; Illinois Department of Public Health; National Association of Public Child Welfare Administrators; National Basketball Association; National Child Abuse Coalition; National Foundation for Consumer Credit; National Head Start Association; National Indian Child Welfare Association; National Parent Aide Network; Ronald McDonald Children's Charities; U.S. Department of Agriculture, Cooperative Extension System; U.S. Department of Health, Maternal and Child Health Bureau; and U.S. Navy, New Parent Support Teams.

Initially, the nature of the partnerships ranged from joint mailings to members, to authoring articles for each others newsletters, to speaking at each others conferences. Ultimately, though, we are seeking concrete ways for each partnership to contribute to a specific aspect of HFA. With some partners, such as First Steps and Cooperative Extension, we are working to enhance the way services are provided to families by expanding the scope of programs to incorporate the

components of an HFA system. With others, such as the American Hospital and Nurses Associations, we have demonstrated the necessity of a broad-based coalition and the important contributions that each partner brings to the whole. As a result, these relationships also have been successfully established at the state and local levels.

Plans for the Future: Even as we plan to dramatically expand the number of HFA partners over the next five years, we also plan to work with them toward assuming a significant role in the overall effort. We expect to double the number of our partners and to have tangible evidence of the contributions they have made to the effort. Examples follow:

The various national professional associations we have been working with -- including the American Academy of Pediatrics, the American Hospital Association and the American Nurses Association -- each have critical roles to play as representatives of the health profession and health institutions. From training their own members to assisting with third party payor coverage of home visitation services, these groups are critical to HFA's success. We will continue to work with their leadership at the national level so that our joint messages are effectively communicated to our state counterparts. It is through the state planning teams that these representatives will have the greatest impact.

To assure that our partnerships reflect the diversity of the populations served by Healthy Families America, we will work to reach out to organizations such as the National Medical Association, the National Black Child Development Institute, the National Council of the La Raza, and the National Indian Child Welfare Association. Each of these organizations will have important contributions to make as we implement HFA in communities with diverse socio-cultural compositions. Our work with these organizations will: assist our trainers in providing culturally specific information when training service providers; enhance program curriculums and other materials utilized with families in their homes; and provide effective training and technical assistance to advocates and community planning groups across the country.

In addition, if the gains made by families participating in HFA services are to endure, we must establish linkages with organizations able to assume a role in a continuum of support. To that end, we will continue working with institutionalized programs like Head Start. Along with home-based services, most families will need to connect with center-based services as they become less isolated, more autonomous and ready to reach out into the community for assistance. For families receiving home visitation services from an HFA site beginning prenatally or at the birth of their child, a Head Start program provides a smooth transition to a center-based program when the child is 3 or 4 years old. By working together, Head Start and HFA can also benefit from collaborating on training, sharing their expertise and limited resources, and coordinating their services. The addition of the Early Head Start program, a comprehensive child development and family support program for families with children under age three, provides still more opportunities to collaborate in supporting families right from the start. Clearly, Head Start programs and HFA sites have overlapping missions which can be coordinated to make the provision of services more comprehensive and more efficient for families.

Likewise, the myriad of family support programs found across the United States are all crucial to HFA's success. Unless the various family support efforts work in a unified or integrated way at the local level, the longer term benefits for families could be diminished. To further this goal, we are planning joint-trainings with other family support programs, as well as joint demonstration projects to assure quality service integration at the community level, and maximum utility of existing training facilities as HFA sites expand in number. For example, the Healthy Families America site in Chicago's North Lawndale community is in the process of building the HIPPY program onto its current services. Plans are underway to engage HIPPY and other quality home based programs in discussions about the HFA critical elements, so that we can collectively agree on a set of best practice standards for home visitation and other family support services.

2) Establishing State Level Plans:

Accomplishments: The fundamental goal of the Healthy Families America approach - to assure that all new parents get off to a good start through the establishment of a universal home visiting program - can only be achieved by implementing comprehensive strategic plans for HFA services statewide. Our ability to impact upon both the quantity and quality of home visitor services nationwide is contingent upon strong state leadership and solid capacity at the state level.

The planning processes needed to establish an effective statewide effort are critical and differ significantly from state to state depending upon the focus of leadership, the political situation, and the way in which human services function. The reasons for engaging in such a process include:

- to achieve an informed and committed constituency among providers, policy makers, decision makers, and the community at-large, which includes an understanding of the strategic importance of supportive services from the time of a child's birth for all families, and particularly those at-risk;
- to achieve consensus and commitment among key decision makers for implementation of HFA in their state; and
- to advocate for legislation and funding streams to support an HFA statewide initiative over a defined time period.

Since HFA's inception, states have been mobilizing planning teams or task forces that engage state-level administrators and policy makers in their Healthy Families planning process. Creating a successful, sustained statewide HFA effort requires the involvement of a broad array of local officials both within and outside the traditional child abuse prevention network. In order to coordinate and ensure that planning is compatible rather than in conflict with other child and family advocacy efforts, it is important to obtain input and/or involvement from these sources prior to defining or implementing an HFA action plan. Both Wisconsin and Georgia provide excellent examples of coordination-in-action. In 1994, the Wisconsin Governor signed the *Right From the Start* initiative, with the goal of offering all families home visitation and family resource center services. The money allocated for this initiative allows funding for home

visitation services that begin at birth or less intensive support services, depending upon the needs of the family. In doing so, Wisconsin has pooled two innovative ideas together, with the intention of providing a continuum of care for any and all families in the state. In Georgia, the Georgia Council on Child Abuse recognized the limitations of short-term new parent support programs and sought expansion of the services they provide statewide. As a result, the Georgia Council built Healthy Families sites onto existing First Steps sites. The partnership has quickly expanded HFA because much of the groundwork was already put in place by First Steps.

Healthy Families leadership in nearly all fifty states has been successful in bringing together a broad range of public and private agencies to promote the implementation of state-wide home visitor services. In many states, task forces are created to develop a long-range strategic plan for implementing HFA support services statewide. In Illinois, for example, a statewide task force was established by the legislature to study home visitation and HFA and develop a state plan. The Governor appointed a 38-person task force comprised of representatives from the state departments of Public Health, Public Aid and Corrections, as well as members of professional associations, HFA sites, advocacy groups, and Prevent Child Abuse-Illinois. Even after submitting a report to the Governor, the Healthy Families Illinois Steering Committee continues to meet and discuss statewide implementation of the plan.

In most cases, these state task forces have been an effective vehicle for cultivating HFA leadership; leadership that is essential if a statewide strategy is to become a reality. Among the activities engaged in by state leadership are: establishing demonstration sites and coordinated training and technical assistance; forming partnerships; pursuing legislative initiatives; and coordinating services with existing home visitor programs from throughout the state.

To advance the efforts of the Healthy Families America state task forces, we provide these groups with on-site technical assistance. Over 40 states and the District of Columbia have already received on-site assistance from HFA staff and a network of experienced state leaders from around the country. States have found considerable value in hearing from other HFA state leaders with experiences similar to their own. For instance, interested individuals in Alaska received on-site technical assistance from an Arizona state leader in order to develop legislative strategies and conduct strategic planning. Such visits typically serve to promote collaboration among family support providers, help program planners with service implementation, or assist in legislative strategies. In addition, technical assistance often comes in the form of presentations at statewide conferences. Recently, Healthy Families America has been the theme of conferences in: Arkansas, Florida, Illinois, Kansas, Louisiana, Massachusetts, Missouri, New Mexico, New York, Ohio, Oklahoma, Rhode Island, Virginia, and Wyoming.

Throughout the past four years, we have developed a variety of supportive materials for use by state planning teams. Among the most recent documents include a *Public Relations Guide*, an *Advocacy Kit*, a *Needs Assessment Guide*, *Building a Healthy Families America System: A Summary of Costs and Benefits* and an *Evaluation Guide*. These materials, along with relevant articles and other information, are disseminated to a mailing list of nearly 500 HFA colleagues

on a quarterly basis. In addition to these mailings, information produced for HFA can be accessed on the Handset computer network, which maintains a roster of over 3000 users, or on a newly created Home Page on the Internet.

Plans for the Future: Given the current political climate and the desire of Congress to give states more authority over how their funds are allocated, the need for cultivating state leadership is keener than ever. States must have the capacity to determine how the Healthy Families America approach should work in their state, how it will integrate with other family support efforts and the means through they will assure that all new parents receive support.

Consequently, we plan to make sure that every state has a fully functioning statewide HFA Task Force which brings together all the key players (e.g., the Departments of Health, Social Services, and Education and key private institutions such as the Children Trust Fund and our chapter) and has adopted a state plan to fully implement HFA. This plan will include time lines for development of sites, strategies for integrating HFA within existing services, a legislative agenda, plans for funding and training, as well as quality control. While a given task force may have a clear understanding of the initiative conceptually, it may be less clear to some groups exactly how to analyze the opportunities and barriers within their locale, how to deal with opposition, if there is any, and how to formulate short and long term goals. Therefore, technical assistance from another state or national representative can be an excellent catalyst for clarifying and motivating a group to move forward. We will continue to offer such assistance through on-site visits.

In addition to the on-site visits, a meeting of HFA state leaders has been planned for March 1996 as a mechanism for cultivating leadership within each state. As evidenced by the unprecedented turnout at our Healthy Families America Conferences, - over 600 in October 1995 - people want to share their experiences and discover how others engaged in similar work have overcome challenges. Opportunities for informal dialogue often provide the most ideal setting for learning. Therefore, the March 1996 meeting of state leaders will afford HFA leaders from throughout the United States a chance to share experiences and discuss collaboration and coalition building, statewide training capacity, HFA advocacy and legislative efforts, funding issues, and program planning consultation. The role of the state leader is a crucial one. Each state leader serves a unique and important role in developing HFA and securing its long-term stability within their state. State leaders, through meetings and technical assistance, will become the experts in every HFA-related subject, from budget and staffing projections to legislative advocacy.

3) Developing Training and Technical Assistance Capacity Nationwide:

Accomplishments: The planning stage for any new family support program is important because it not only lays the foundation for effective operational functioning, but establishes the collaborative relationships necessary for long-term success. For Healthy Families America sites, the planning phase is even more critical because there are a myriad of objectives included in the

HFA approach. From the initial planning stage through actual program implementation, the value of being able to consult with individuals who have implemented similar programs cannot be over-emphasized.

To assure that such assistance is available, a cadre of trainers has been developed at the national and state level. When the effort was first launched, we relied heavily on our colleagues at the Hawaii Family Stress Center who have great expertise in training others how to operate a successful home visitor program. With the intense demand for such expertise early on, we quickly realized that the strength of HFA in the long term depends upon the degree to which regions and states can develop their own capacity to develop and conduct training for HFA sites. Initially our challenge was to establish capacity at the national level to help state and local communities get started. Over the past two years, however, we have been working to help states build the capability internally to secure the training and support they need.

To that end, three "Train the Trainers Institutes" have been convened. For these institutes, state agencies and NCPCA chapters have identified individuals to serve as the trainers for their state. Individuals invited to participate in the institutes are enrolled in one of two components: Family Assessment Worker Trainers, or Family Support Worker Trainers. A primary objective therefore, is for each state to maintain at least two trainers, each with a solid understanding of the essential components of HFA but each with their own area of programmatic expertise. As a result of the Institutes convened thus far, we have increased the training corps from 2 to several dozen trainers and designees. Developing this network not only allows us to respond more efficiently to requests for on-site assistance but begins the process of building in-state training capacity that is able to assess and meet their own needs.

Plans for the Future: Over the next five years, we plan to further develop qualified trainers across the country, so that eventually each state will have its own capacity to do training. By continuing the "Train the Trainers Institute" during the next several years, our pool of trainers will grow. At the same time, we will begin focusing our efforts on helping states develop financial resources so that they can eventually employ a pool of trainers full time. Arizona, Georgia and Indiana are already doing so, and most other states with established sites have expressed both an interest and a need to do so. As the number of sites within an individual state grows so does the need for more training resources. In addition to helping develop new programs and train new staff, state trainers need to be available on an ongoing and coordinated basis to respond to crises, provide training following staff turnovers, institute policies and procedures that all sites in a given state will follow, and organize networking sessions and retreats for different sites to share experiences. Centralized state training facilities must be in a position to anticipate local needs and respond to them appropriately and with quality..

To facilitate the creation of state training and technical assistance systems, we plan to convene annual meetings of the state leaders to promote networking and disseminate a variety of prototypes for state leaders to draw from as they design strategies. Since HFA is based on a set

of principles - as distinct from a model - we recognize and support the fact that every community will have different training and technical assistance needs. To that end, the prototypes will include general recommendations regarding intervals for technical assistance, a range of issues/topics that typically surface within Healthy Families programs, and a variety of mechanisms for presentation (e.g., didactic training, shadowing of other service providers, conferences, etc.). By coordinating this support at the state-level, every site will be offered the assistance it needs, while maintaining the overall elements of the HFA initiative. HFA sites that have begun with statewide training and technical assistance have been able to avoid ongoing program difficulties and, as such, have represented successful examples of HFA in action. To assure that this capacity is maintained over time, we will also advocate for the inclusion of family support training certification programs at community colleges and universities nationwide. Securing university support for the training of home visitor program staff is a critical first step in achieving public support for the importance of home visitor services.

Underscoring all of our training and technical assistance efforts is the recognition that it is a dynamic process. As research studies unfold new information regarding how to best achieve positive outcomes with families, the nature and emphasis of our training will be updated to reflect these knowledge gains. For instance, research and the experiences of the 150+ HFA sites has demonstrated that budgets, staffing projections, and assessment of families can be approached in a variety of ways. As our knowledge base expands, we must enhance our use of available tools and determine the method(s) which are most useful to sites. Likewise, as more HFA sites developed in conjunction with existing services, we plan to integrate our training procedures with those offered by the coordinating programs. By working with partners such as the Cooperative Extension System (CES), we have been able to clarify ways HFA and CES trainings complement one another and can be enhanced to train more completely. Ultimately, we will be able to offer "joint trainings" with a variety of our partners, including Head Start, CES and others.

4) Assisting Local Sites:

Accomplishments: For communities seeking to establish HFA services, Healthy Families America trainers provide training in how to take the principles of effective services, as identified by research in the critical elements, and put them into practice, as demonstrated by the Hawaii Healthy Start Program and the more than 150 HFA sites. The underlying goal is to build on local strengths and meet local needs. As with the assistance provided to state planning teams, much of the initial technical assistance to local communities is done through distribution of materials and assistance via telephone. Among the materials provided to agencies prior to service implementation are: the rationale behind the Healthy Families America Critical Elements, sample budgets and staffing projections, guidelines for recruiting service providers, examples of funding options, and core concepts to incorporate into an orientation training. Critical factors for starting an HFA site include commitment, appropriate professional skills, and a willingness to persevere through the inevitable obstacles of innovation. During this phase, program planners

often elect to visit an operational HFA site or consult with an existing program manager for additional insight.

Once the HFA-site or state-planning group has planned the program, received the funding, and hired staff, HFA trainers also provide on-site training to assure that all service providers understand the HFA approach and their specific role in the effort. Training is provided to direct service providers, supervisors, and program managers. As a result of widespread interest and commitment, more than 150 communities are providing HFA services - all have received on-site HFA training.

HFA program sites serve several functions. First, they serve as a showcase for effectiveness of the approach within a state. Second, they are viewed as a "model" for other communities, acting as a resource for further replication within a state. Finally, the planning groups involved in the organization of these sites are often the catalysts for statewide advocacy efforts.

In addition to helping communities operationalize quality programs, we are also working to assure that the quality of services provided by these sites is maintained. To that end, HFA trainers are always available for one-on-one phone consultation and mechanisms are being put into place to standardize a number of follow-up procedures (e.g., a technical assistance survey 6 months after initial training). To facilitate cross-site experience sharing, we will continue to arrange periodic conference calls for sites at similar stages of development, as well as facilitate meetings of program managers.

Plans for the Future: Over the next five years, we will continue to offer all new sites assistance in the implementation stages of their program as well as training for their family assessment workers and home visitors. We estimate this will include more than 250 sites over the next five years. In addition, we are developing advanced training for all sites -- first after they have been operational for nine to twelve months and then again at the two year mark. Rather than sending trainers on-site to assist with the advanced training (as we do with preliminary training), our plan is to offer Advanced Training Institutes throughout the year for Program Managers and Supervisors. As more and more states develop training teams, these institutes might be held regionally. Throughout this phase we will, of course, continue to "package" both the preliminary and advanced training in written form, and perhaps on video, for more efficient use by the sites. As our knowledge from research and program experience grows, we will continue to update our training materials appropriately. Likewise, the annual HFA Conference will allow sites from across the country to come together and share their knowledge and expertise with one other.

To facilitate state-level capacity, the state leaders meetings will focus on the essentials in program planning. State leaders will become experts in all aspects of the HFA program, as well as the overall HFA approach. By training state leaders in program planning, sites will be able to seek in-state expertise regarding budgeting for a site, funding resources, hiring a staff, and much more. In addition, we will encourage state leaders to facilitate quarterly meetings of sites within a state or, if appropriate, regional meetings of HFA sites. State, local, and regional issues play a

significant role in the provision of services and the expansion of HFA. Some states/communities have already begun such a process. For example, Indiana sites have found participation in the quarterly technical assistance meetings extremely valuable. States such as New York and New Jersey and the District of Columbia, Virginia, and Maryland are exploring ways to pool their resources regionally. As these new training mechanisms are developed, we will assist state leaders in their efforts to convene such meetings as a means of discussing important state or regional matters.

5.) Establishing Innovative Demonstration Projects:

Accomplishments: In January 1995, an innovative demonstration project was launched with the national Cooperative Extension System of the U.S. Department of Agriculture (CES). The goal of the effort, funded by the Kellogg Foundation, is to develop a collaborative project which would demonstrate the feasibility of building an HFA program upon the CES delivery system. To that end, partnerships were established between the NCPCA chapter and CES system in three states: Nevada, Oklahoma, and Wisconsin. The primary work during the first year of this project involved various processes: site selection, collaboration and program development, working through differences that exist between small not-for-profit agencies and a large governmental bureaucracy, and building a program upon existing services. Even with a focus on process issues, some initial outcomes have been identified. Among the major lessons that emerged in the first year are:

- The development of a site selection process which allowed the selection committee to develop the collaborative relationship at the national level and a refinement and clarification of the original vision for the project.
- New understanding about the building blocks necessary for successful collaboration, as well as new appreciation for the time-intensive nature of this process.
- A more concrete understanding of how organizations change policies and systems to create a collaborative, stream-lined service system and new insight into how difficult it is for an organization to change existing policies and systems.
- Identification of the operational differences between a small, private not-for-profit agency and a large, governmental bureaucracy; and as the collaboration between CES and the local chapter unfolds, a method for resolving organizational differences which takes the best elements of both systems to create better solutions.

In January 1995, another Healthy Families America pilot site was launched in the North Lawndale community of Chicago, initiated by a challenge grant from the Freddie Mac Foundation. The site was one of the first established in the inner-city and, as such, should provide the overall HFA effort with useful information for future urban sites. Healthy Families North Lawndale is a collaborative effort between NCPCA, Family Focus (a family resource service center in place for over 13 years), Mt. Sinai Hospital and Lawndale Christian Health Center. The program is currently providing intensive home visitor services to 30 families with

plans to expand in the coming months.

Plans for the Future: Even as we continue to implement these innovative demonstration projects, we also plan to disseminate preliminary outcomes and process strategies to our colleagues in the field and make sure that the lessons learned are integrated into our overall approach, helping to further the Healthy Families America initiative. For example, while the CES project was launched at three sites, there is tremendous potential to build HFA programs onto additional CES programs. Since CES is in every county across the country, there is a strong likelihood that this demonstration project could have a very significant impact upon the CES service delivery system.

Demonstration projects also provide us with opportunities to maintain on-going direct links or hands-on connections with actual programs. As these projects continue to develop over the next five years, we will use the experience gained from such direct contact to inform our policies and practice. Insights into program development, training, collaboration and more will help us enhance the materials and technical assistance we are able to offer to the field.

Given the important role of fathers in a family and the dearth of materials or attention devoted to them in the current pool of family support programs, we are planning to initiate a third special project within HFA focused exclusively on fathers. In conjunction with HFA trainers and program managers, a special curriculum will be developed that is designed to teach family assessment workers and home visitors how to reach out and engage fathers and surrogate fathers in parent education and support programs. Once the curriculum is developed, it will be pilot-tested at a representative number of sites and incorporated into our training package. To support the project, we will enlist a group of fathers to serve as advisors. Finally, in conjunction with Marvel Comics, we will produce a new Spiderman Comic Book addressing the demands of fatherhood and the needs of being a new dad.

B. Assuring Program Quality:

Accomplishments: Key to the success of HFA is the degree to which the program is implemented with quality. The Healthy Families America approach to home visitation is defined by a set of critical elements as suggested by repeated evaluations of early intervention programs with new parents. Adherence to these critical elements is essential, because over two decades of research has shown that they contribute to better program outcomes. Although the temptation to water down the approach is substantial, we have been committed from the outset to ensure that this does not happen.

A strong quality assurance component is central to the long-term viability of the HFA initiative. While continuing to emphasize the importance of the critical elements during training, a new focus on ongoing quality assurance will reinforce the need for HFA sites to adhere to the critical

elements over time. As the number of sites continues to grow dramatically, the need for a specific credentialling mechanism to help all those involved in the HFA initiative monitor adherence to the elements is critical. The purpose of the quality assurance/credentialling mechanism is to:

- protect the name Healthy Families America, and thus the nationwide movement, by ensuring that it represents a given set of principles;
- protect each local effort by ensuring that anyone using the name adheres to the set of principles; and
- allow HFA sites and state leadership to engage in independent and on-going quality management.

Only sites which adhere to all criteria, as determined through the credentialling program, will be entitled to use the Healthy Families America name which is trademarked. As with our approach to other components of the overall effort, we will continue to support and in fact, promote flexibility in service design and delivery as long as the adaptations are made in the context of what we know contributes to positive outcomes.

In order to be successful, the credentialling system must be developed with the full participation of all those who will be affected by credentialling. To that end, once the self assessment tool was developed in partnership with the Council on Accreditation of Services for Children and Families, it was sent to all HFA sites and state leaders and revised based upon their feedback. Next, a group of individuals involved in the HFA initiative met to make recommendations regarding the major issues in the development of a credentialling system. Currently, a committee is developing the measurements, scoring, and outcomes for the self assessment tool. The committee consists of HFA site managers, HFA trainers, and members of the HFA research network. Final recommendations from this group will be completed by April 1996.

Plans for the Future: Currently, a collaborative credentialling model is being developed for HFA. The Council on Accreditation of Services for Children and Families (hereafter referred as "the Council") will continue to work with us to develop a system through which credentialling will occur. The Council will be managing the self assessment/peer review process for the HFA initiative. Technical assistance will be offered to HFA sites by those state HFA leaders with the capacity and interest in doing so or coordinated through NCPCA, in conjunction with other affiliates. In this way, an arms-length is provided between training and quality assurance. Finally, we will be seeking endorsements for this process from a variety of HFA partners. Already, the American Academy of Pediatrics has indicated interest in giving this credentialling system their "seal of approval."

In addition to the completion of the self assessment tool, site visits will be a part of the credentialling process. There is consensus that, without site visits, credentialling will not be as reliable nor carry as much weight. Peer reviewers verify on-site the self assessment completed by the HFA program. The pool from which peer reviewers will be drawn is: state HFA leaders, HFA

programs, and an "other" group consisting of individuals who work in the field and are familiar with the HFA approach. Peer reviewers will be selected through a nomination process, primarily through the chapter network. We will issue a call for nominations in February 1996. Once selected, peer reviewers will be trained through a joint training with the Council. The goal of training is to equip reviewers with the confidence to do a review. It will cover refresher material on the HFA critical elements, confidentiality, limits of responsibilities, etc. We will conduct the first peer reviewer training in June 1996.

In the next year, 20 sites will go through the entire credentialling system (self assessment and site visit). Based upon the feedback from these first visits, adjustments will be made in the credentialling system, if needed. Beginning in January 1997, a full scale roll-out of credentialling will occur. A site will not undergo the credentialling process until it has been operational for one full year. Since credentialling will not be done every year, sites will complete an annual report during the interim years, to monitor the major development changes which could affect the quality of the program (e.g., a change in leadership, budget, etc.).

Along with the credentialling system, we will continue to offer teleseminars - a cost effective and efficient way of offering follow-up assistance to HFA programs. Other components of our overall plan to ensure quality include: one-on-one follow-up between a trainer and a site; meetings of program managers and supervisors; and advanced trainings. All of these strategies, in combination with the general assistance we are offering sites, should help guarantee levels of quality at most if not all sites.

C. *Improving Our Knowledge Base While Evaluating Our Activities:*

Accomplishments: NCPCA's National Center on Child Abuse Prevention Research plays a central role in coordinating the wide range of program evaluations currently being conducted at many HFA sites. With funding from the Carnegie Corporation of New York, the Center recently established a *Research Network* of those evaluating the effectiveness of Healthy Families America pilot sites and other home visitation initiatives. This funding provides an excellent opportunity for researchers assessing individual programs to come together to address a broad range of methodological and policy concerns. The overall goals of the Research Network are to improve the quality, comparability and relevance of evaluations of HFA-type programs, and to ensure they lead to a distinct improvement in our knowledge about how to most effectively deliver such services, particularly as efforts attempt to become universal. Through ongoing communication and collaboration, the Network will make significant contributions in the following areas:

- the identification and use of more common data elements to describe HFA recipients and services;
- stronger "research" overall, including more randomized trials and more focused attention to those research questions surrounding service delivery and client identification;
- greater comparability of outcome as well as descriptive data and thus greater ability to compare and contrast findings across programs and populations;
- a uniform Program Information Management System (PIMS) for emerging HFA sites and other home visitor programs;

- a more realistic and appropriate interpretation of findings both positive and negative from individual sites;
- better dissemination of findings from individual sites to program managers and policy makers interested in home visitation programs in other locations across the country;
- more useful or relevant research findings leading to stronger programs, built upon those research findings; and
- expanded resources to support comprehensive evaluations of HFA efforts as funders respond to the increased degree of collaboration and joint research designs emerging from the Network's activities.

The Center's work has expanded the field's understanding of the impacts of home visitation services in a variety of community settings. In addition to several other wide-scale evaluations, the Center is conducting a comprehensive assessment of Hawaii's Healthy Start program. This three-year study, which will conclude in March, includes a controlled experiment, a follow-up assessment of families who terminated intensive services, and a periodic assessment of families identified as not being at-risk for maltreatment at the time of their child's birth. In addition, comprehensive evaluations have been completed on dozen's of prevention programs around the country including agencies in the Greater Philadelphia community, agencies in various neighborhoods within Chicago and the U.S. military. These findings have been used to clarify those program characteristics most likely to produce positive outcomes, as well as the types of families most likely to benefit from early interventions.

Plans for the Future: The Research Center will continue to play a central role in improving our understanding of how best to structure, monitor and evaluate home visitation efforts. To accomplish this mission, primary attention will be placed on conducting a greater number of controlled experiments of home visitation programs in a variety of settings; expanding the Research Network and developing specific products for wide dissemination throughout the field; and developing the PIMS to systematically document the expansion of HFA efforts nationwide.

Evaluation Activities

In terms of additional evaluations, we will initiate at least two controlled experiments involving HFA sites in the coming year. The first involves a comprehensive assessment of the HFA site in Chicago's North Lawndale community. Implemented in partnership with a local hospital and community service agency, the effort will test the efficacy of the HFA model in an urban community where many of the social problems of concern to city officials exist (e.g., substance abuse, violence, poor service systems, high infant mortality and child abuse rates, etc.).

The second evaluation will involve three HFA sites being developed in partnership with the U.S. Cooperative Extension System (CES). These three sites, located in Wisconsin, Oklahoma and Nevada, are building upon the CES existing family support system in providing intensive home visitation services to new parents in their respective catchment areas. Over the coming year, we will conduct a detailed process study of this initiative as well as a comprehensive outcome study. At all sites, a longitudinal approach will be used to assess changes in participating families on key dimensions, such as child abuse potential, parental stress, parent-child interactions, child development, and service utilization. Given the severely overburdened target populations of the demonstration sites, these changes are expected to occur gradually and have a lasting impact on

family health. Therefore, outcome assessments will take place at multiple points throughout a family's tenure in the program, with the greatest degree of change expected after one year or more of involvement.

Research Network Activities

In the future, the HFA Research Network will continue to focus on three primary areas of interest to the field - risk assessment strategies, measurement issues and research questions, and design issues. Network members are interested in evaluating risk assessment protocols and risk reduction measures and suggesting a profile for risk assessment that might be more useful for HFA sites across the country. While a wide range of measures will be needed to adequately address all of the issues being targeted through HFA services, the group has given highest priority to examining measures in the areas of child development, family outcomes (including parent-child interactions, parental attitudes, parental discipline practices, parental decision making and overall parenting skills), health care utilization, child abuse and neglect and social support. Other areas of high priority include developing some standardized system for describing the demographic characteristics of participants and for determining a program's cost effectiveness.

As noted above, a wide range of research questions surround the development of HFA. Among the issues Network members feel are most critical to address are:

- Questions regarding the context for establishing programs; including collaborating agencies; funding sources and security; legislative and administrative mandates; the impetus for the effort (who had the original idea); and, mechanisms for communication and collaboration.
- Questions regarding staffing, including content and length of initial training; content, length and timing of ongoing training; staff turnover; staff support; cultural match between staff and participants; and, insuring staff comply with program guidelines.
- Questions of family/participant identification, including relevance of screening criteria for all families; relevance of serving only first-time parents; relevance of each screening category to final outcomes (i.e., do families with certain risk profiles do better in the program than others?); relevance of prenatal screening versus screening at birth; and, common characteristics of participant families.
- Questions regarding the home visitors, including role of the family support worker; characteristics associated with successful staff; FSWs level of compliance with all program guidelines; and, successful curriculum or curriculum elements/topics.
- Questions regarding program drop-outs, including descriptive characteristics of drop-outs; primary reasons given for dropping out; and, relationship between dropping out and other program variables, such as nature of the intake or screening process, way in which the program was presented, characteristics of the home visitor, the content of the visits, etc.

Over the coming months, Network members plan to solicit more detailed descriptions of current efforts to serve as a starting point for determining the degree to which each of the areas outlined above is currently being addressed or might potentially be addressed by ongoing HFA evaluation efforts.

Monitoring Activities

Finally, the Research Center will move forward on developing a Program Information Management System (PIMS) to assist in monitoring HFA's service development and participant coverage. This system will be well integrated with HFA's credentialling system, as well as build upon efforts already underway in a number of states (e.g., Virginia and Indiana). As designed, the PIMS will allow us to monitor the development of HFA sites nationwide in terms of staffing plans, partnerships and funding sources; to document the specific levels of service and service referrals being provided to families enrolling in HFA programs; to document the descriptive and socio-economic characteristics of those families being served by HFA programs and how these characteristics change over time; and to provide an initial assessment of participant outcomes. In partnership with Anderson Consulting, the Center plans to develop an automated, personal computer driven system whereby program staff would utilize a specialized software package to input program, service and participant data as well as to generate descriptive reports on program development and impacts. These data would be transported to the Center, thereby allowing us to generate a national HFA profile.

D. *Increasing public participation:*

Accomplishments: While the public's knowledge about the child abuse problem has increased over the last decade, so has pessimism over what individuals or society as a whole can do to prevent child abuse. At the same time, the success of HFA depends upon an educated public, a public willing to see the vision of HFA realized and a public committed to helping achieve that vision. As such, a fundamental strategy for expanding HFA lies in educating the public about the possibilities for preventing child abuse, specifically through HFA.

Central to our efforts in public education is the work we do with the Advertising Council (Ad Council). In 1995, we launched a new campaign designed to get the public involved in prevention, particularly through HFA efforts in their states. With the tag line: "*The more you help, the less they hurt*", viewers are told that now there is a way to prevent child abuse where you live, and viewers are encouraged to call our toll-free 800 number (1-800-CHILDREN) to get more information on HFA. Increasingly, when viewers call the 800 number, they are connected directly to the NCPCA chapter in their state, rather than the national office. (With the majority of NCPCA chapters leading the HFA efforts in their state, our goal is to have the 800 number totally localized in this way.)

In addition to our efforts with the Ad Council, we work to educate the public about child abuse prevention and Healthy Families America in a variety of other settings - ranging from conferences, town meetings, and cause-related marketing ventures to television and radio talk shows, television magazine segments, television specials, focused newspaper stories, and special publications. In the past year alone, we have expanded the materials available to the general public and more specifically parents, through the publishing of two new pamphlets targeted at new mothers and new fathers.

Once educated, it is important to have tangible ways for concerned citizens to participate in bringing HFA to their communities, and specifically, to help as volunteers at HFA sites.

No matter what kind of funding HFA sites have, they will always be short-staffed - they are, after all, working with high risk, and thus, very demanding families. Well-trained and well-placed volunteers can go a long way in dramatically expanding the reach and impact of sites. The success of HFA depends on more than paid staff. Ultimately, enhancing the knowledge base of the general public, as well as finding roles for the public to play, will result in better program outcomes.

Plans for the Future: During the next five years we intend to dramatically improve the public's understanding of how child abuse can be prevented and increase the number of members of the general public involved in efforts like HFA. In other words, we plan to mobilize a corps of individuals who can help make the vision of HFA a reality in every state and community.

To do so, first we need to better educate the public about prevention and HFA. Our new national media campaign with the Advertising Council with its 800 number can do just that. That campaign will continue to be conducted over the next five years or more with the 800 number designed to allow callers to get directly in touch with the HFA efforts in their own states. The messages of the campaign will change over this time period in keeping with what our annual public opinion polls tell us the public is most ready to hear next. In addition, state leaders and task forces will serve as coordinators for community education about HFA in their state. By organizing HFA conferences, developing an HFA brochure, or promoting the media campaign, state leaders will help initiate a "call to action" for home visiting and supports for new parents.

Second, we need to establish and maintain worthwhile opportunities for the public to further HFA. To this end, we will develop a series of specific jobs volunteers can carry out on behalf of HFA (e.g., the toy lending library manager, a home visitor aide, a child care support worker, transportation aide). We will develop samples of task descriptions and training curriculum for each position which can be used in preparing volunteers for their tasks. HFA state leaders will be able to offer the assistance communities need, so that sites can most effectively utilize those concerned citizens who want to assist with HFA.

At least one body of volunteers will emanate from the program participants. As the amount of governmental support for social programs declines, the need to diversify funding strategies and staffing patterns increases. In order to maintain government funding and maximize its gains, programs will need to develop opportunities for participants to give as well as receive. In other words, we need to develop a mechanism for achieving reciprocity within programs. Parents who have been in a program for one or two years, for example, may assume the role of "parent mentor" offering peer-to-peer support to a newly enrolled participant in conjunction with a home visitor. Over the next few years, we plan to incorporate this philosophy into our training programs and materials.

E. Building for the future:

Accomplishments: As a means of expanding HFA across the states and helping states to maintain their efforts over time, we have worked to secure stable funding sources. Both private monies and federal, state and local funding sources can generate resources for HFA. While foundation grants often provide seed money for new programs and research, long term funding is needed if HFA is to become part of a state's infrastructure. Through the technical assistance provided to statewide task forces, we have continued our efforts to build stable funding mechanisms at the state level.

State legislative initiatives also help to guarantee stability for HFA services. To aid states with their advocacy efforts, we produced a document that compares the costs and benefits of providing prevention services to all new parents with some of the most obvious costs associated with child maltreatment. This conservative analysis has been a useful tool for state leaders in educating their policy makers. In fact, over a dozen states have passed some type of legislation relative to increasing the availability and quality of home visiting services for families with newborns. In the state of Arizona, for instance, legislation was adopted as part of a popular *Success by Six* initiative which combined prenatal care, Healthy Families services to 12 new sites, and comprehensive preschool programs. The bill, which had widespread support as well as vocal critics, ultimately passed the Arizona General Assembly during a special session called by the Governor and $3.7 million was appropriated to Healthy Families for two years. The legislative experience in Arizona provides many lessons to other HFA state leaders, from timing of advocacy efforts to how to address opposition from varying ideological viewpoints.

Federal legislative measures also impact the manner in which states provide services to their citizens. As such, we have consistently provided HFA colleagues with pertinent information and legislative strategy support so that their views are expressed to federal policy makers. In 1994, we focused on the implementation of the Family Preservation and Family Support Program and were able to provide our HFA colleagues with concrete strategies for assuring that significant portions of these new funds go to support home visiting efforts. In 1995, our attention has been focused on the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) and the potential impacts of the proposed block grants of child protection programs. Action Alerts, sample letters to members of Congress, and one-to-one technical assistance are some of the ways we have interfaced with HFA state leaders.

Plans for the Future: Throughout the coming years, we will continue to assist states in the drafting and advocating for HFA-related legislation. Such legislation typically provides funding to launch an HFA initiative, legitimize a task force to study the feasibility of a statewide effort, and/or establish training capacity. Further, proposed changes in federal policy are leading to a reduced national commitment toward children and families and a greater emphasis on state-level decision making. With reduced federal funds for children's services, demands to scale back state services will increase and competition for available dollars will increase as well. In light of these changes, we will be focusing a great deal of attention on cultivating skills in state leaders that are necessary to meet these new demands. We will provide training and technical assistance

regarding community needs assessments, state and local level cost-benefit analyses, and advocacy strategies.

In the absence of federal health care reform legislation, many states have pursued independent reform efforts. As a result, we plan to expand our efforts to develop partnerships between HFA and managed health care systems (e.g., Blue Cross/Blue Shield), Medicaid and other health insurance formats. As hospitals, providers and insurance companies become increasingly concerned about releasing new mothers and their infants within 12 to 24 hours of delivery, we plan to demonstrate the long-term benefits and the relative low cost of home visitor services in monitoring after-care. In such partnerships, for example, a managed health care organization could cover the initial family assessment for all new parents and if necessary, three or four home visits at particularly critical times for the family. Already a few sites, including ones in Michigan, Oregon, and Virginia, have been able to receive reimbursements from third party payors or managed care organizations for their paraprofessional home visitor services. As we continue to document their experiences, we plan to develop guidelines that sites can use to receive managed care and other third party payor support. By offering health care coverage or Medicaid reimbursement for home visiting services, health care organizations would ensure that all families are assessed and offered the services necessary to guarantee improved parenting skills and positive health outcomes. This type of comprehensive partnership would secure long-term funding for HFA services and bring us even closer to achieving the fundamental goal of Healthy Families America.

Conclusion

In just four years, the Healthy Families America initiative has evolved at an extraordinary pace due to the remarkable efforts of state and local communities. Representatives from public and private agencies, as well as committed civic volunteers, have sent a message that they are ready to invest in prevention. Broad-based coalitions have come together and have committed resources to make services more responsive to the needs of families and children. State leaders and program managers have convened conferences, addressed interested groups, and participated in strategic planning in virtually every state. As a result of this hard work across the nation, over 150 communities have implemented HFA services. HFA continues to grow, and planning to insure that these services are included as part of a state's long term strategy for supporting families is underway in nearly all fifty states.

As the movement continues to thrive, our challenges are many. First, we must keep the HFA vision at the core of our efforts by striving for the institutionalization of home visitor services nationwide. Second, we must maintain a focus on quality which will assure that all new parents receive and benefit from the services they need. And third, we must assist the movement to continue to grow so that the vision of "universal" support for all new parents can one day become a reality.

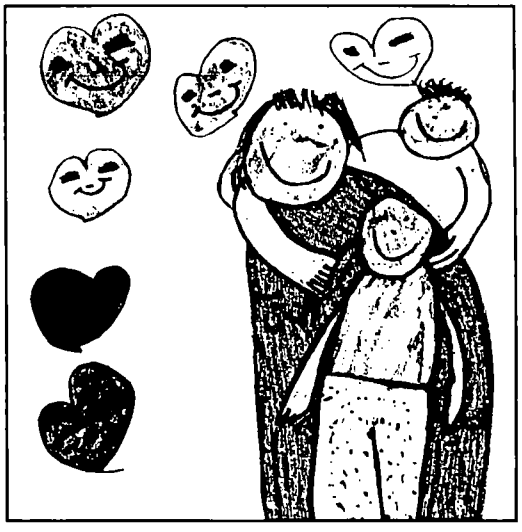
Jeremy/Lyn: This is very interesting! CLK

CHILD PROTECTION LEADER

July, 1996

Family Group Decision Making: A Promising New Approach for Child Welfare

Family group decision making is a promising model for a family-centered approach to planning and providing for the safety and best interests of children at risk for abuse or neglect. The model offers a new approach to resolving allegations of abuse or neglect in a manner that many of us would choose to seek solutions for our own families, that is, through a family meeting. Although that somewhat oversimplifies the practice, it correctly states the premise of the model, that most of the time, families, with appropriate supports, are best able to reach and implement the right decision for their own children.



Drawing by Kelli Wilmoth, 9 years old
Title: Caring for Kids

There are two primary models of family group decision making currently in use worldwide in child welfare: family group conference and family unity meetings. The family group conference model was developed and implemented legislatively in New Zealand in 1989. It has since been adapted for use in communities in the United States and Canada. The family unity model has been used selectively in Oregon since 1990.

In New Zealand, both families and professionals view the family group conference model as the preferred method of working with families in which there are concerns about abuse or neglect. A family is referred for a conference if the public child welfare agency performs an initial investigation and determines that a child is in need of care and protection, or if a judge or private agency makes the same determination. A specialized child welfare worker known as a care and protection coordinator then makes arrangements for the conference or family meeting.

Typically, a family group conference is attended by the child's parents, extended family members from throughout the country, the family's significant close friends, and tribal elders, if appropriate. Travel expenses of geographically distant family members are paid by the government because this expense is far less than the cost of long-term foster care placement of children. The investigating social worker, teachers, psychologists, and other professionals who are working with the family also typically attend the conference, but do not participate in the family's decision-making process.

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A family group conference is generally organized in three stages. First, during the information-giving stage, the social worker and other professionals explain the child's situation to the family and answer any questions posed by family members. Next, a family meeting is held privately to determine whether the family agrees that the child has been abused or neglected or is otherwise in need of care and protection (they generally do agree), and, if so, to develop a plan to meet the child's needs. The last stage of the conference is decision making, when the family presents their plan for the child to the care and protection coordinator, investigating social worker, and the child's attorney (if one is involved). Family decisions are often fleshed out or modified by these professionals, but they are seldom vetoed by them or by others with legally recognized veto power such as parents or custodians.

Typically, cases referred for a family group conference do not end up in court, unless court action is required to formalize the family's decision. This may involve granting a legal change of custody, prohibiting interference from an offending parent, or providing the child's custodian with legal rights to take such actions as arranging for the child's schooling or medical care. In cases where the court has already taken emergency action such as removing the child from the home, the family's decision is automatically submitted for court approval and there is periodic court review of the case.

Politically, the family group conference model has been popular with the indigenous Maori people of New Zealand because they have a strong extended family and tribal structure. The chance to help a grandchild, niece, or nephew who is experiencing abuse or neglect has, however, been valued by families of all ethnic backgrounds to whom the law equally applies. Another beneficial effect has been a substantial reduction in the number of out-of-home placements in New Zealand as extended family members have shown increased willingness to care for the family's abused or neglected children themselves. The number of children placed outside of their own racial or ethnic group has also fallen in New Zealand.

In Oregon, anecdotal observations indicate that the family unity meeting approach to child protection decisions has met with similar success. As one Oregon Children Service's administrator was told, the Department "has not been the lightning rod it was last year in terms of dissatisfaction. There must be something right happening out there!" In addition, after implementation of family unity meetings, Oregon experienced a decrease in foster care placements which had risen for three years previously, and an overall drop in the number of children in out-of-home care.

Family unity meetings operate similarly to family group conferences, but are not formally structured in the same manner. First, family unity meetings need not validate the conclusion that the child has been abused or neglected; the initial goal of a family unity meeting is simply to brainstorm options for the care and protection of a child. Professionals are not excluded from the decision-making stage of family unity meetings, but are instead expected to attend and to facilitate the family's expression of the options for the child in the form of a concrete plan. Also, unlike the family group conference model, family members are invited to participate in the unity meeting by parents (rather than by a professional coordinator) and parents can limit participation by other family members. Family unity meetings are structured around a meeting outline of "touchpoint" issues of concern designed by a professional to focus on the strengths of a particular family, but for liability reasons, the child protection agency retains control of final decisions affecting the child.

Both family group decision-making models present alternative practices for child protection that are well worth serious study and consideration. By forging a new direction for resolving some of our most serious concerns around the well-being of children and families, these models may well help to invigorate and reform our child protection system. New avenues are needed to prevent the system from being overwhelmed, and sometimes ineffectual, when it is needed most.

References and research information from: Merkel-Holguin, Lisa. (May, 1996). Family Group Decision Making. (unpublished manuscript), Englewood, CO: American Humane Association; Hardin, Mark. (1994). Family Group Conferences in New Zealand, *ABA Juvenile and Child Welfare Law Reporter* 13:43; Graber, Larry and Nice, Jim. (Fall, 1991). The Family Unity Model: The Advanced Skill of Looking for and Building on Strengths. *Prevention Report*.

Further information on the family group conference and family unity meeting models will be available in a monograph from the Children's Division of the American Humane Association in late 1996. Monograph copies can be ordered from AHA at 1-800-227-4645.

American Humane Association, Children's Division, is a membership organization. For information on membership, contact Christine Race at 1-800-227-4645.