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ABSTRACT

A coordinated continuum of comprehensive, community-based services that help Minneapolis parents meet the developmental needs of their children from birth through the fifth year is proposed as a way to increase children's readiness for school. After an executive summary and brief introductory chapter, contents of the document focus on: (1) key themes related to intervention, implementation, delivery services, planning and evaluation, and other topics; (2) the conceptual framework of the plan; (3) dimensions of the plan; (4) implementation guidelines; and (5) related issues. The conceptual framework covers such topics as school readiness, an ecological perspective, a prevention-oriented approach, targeted services, prenatal outreach services, family support, home visits, and means of enhancing the parent-child relationship. The plan for the early childhood school readiness program consists of five components: community linkages, a direct services continuum, public education and outreach, education and training, and research and evaluation. Implementation is discussed in terms of organizational structure, timeline, cost and funding. Issues concerning mobility are also considered. Six appendices provide related materials, such as an article on early prevention, and a description of Minnesota's early childhood family education programs. (RH)

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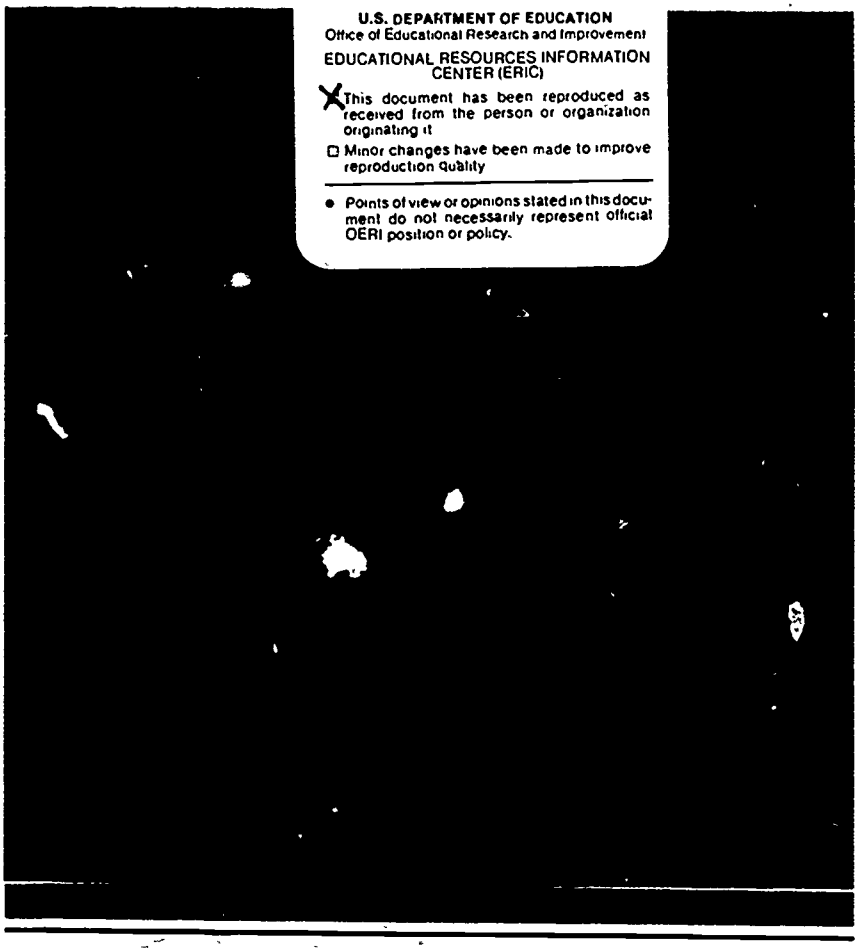

WAY TO GROW

A PROPOSED PLAN TO PROMOTE SCHOOL READINESS OF MINNEAPOLIS CHILDREN

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Way to Grow

A Proposed Plan to Promote School Readiness of Minneapolis Children

Prepared for the
Minneapolis Youth Coordinating Board
by Karen Kurz-Riemer, Marilyn Larson,
and Joyce Lynum Flournoy

December 1987

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Minneapolis Youth Coordinating Board

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design: Robert W. Schmitt

Contents

Executive Summary of WAY TO GROW:

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A proposed plan to promote school readiness of Minneapolis children by coordinating a continuum of comprehensive, community-based services that support and assist all parents in meeting the developmental needs of their children from conception through age five.

There is a current wave of interest in early childhood issues nationwide. Both the public and private sectors have been involved in issuing a flurry of recent reports, which point to the rising numbers of children at risk for school failure and all its attendant social problems.

A related issue is also receiving national attention. This is the issue of prevention versus treatment. It is becoming increasingly apparent that school failure, juvenile delinquency, teen pregnancy, and related social problems are difficult to remedy. These problems, in turn, often lead to lifelong dependency on our systems of public support.

In 1985, the Minneapolis Community Business Employment Alliance (MCBEA) convened a task force and issued a report called *Preventing Unemployment: A Case for Early Childhood Education*. Its central conclusion was that the employability of adults is related to their school performance and overall development as children. It recommended that the Minneapolis Youth Coordinating Board develop a comprehensive plan for the delivery of early childhood services in Minneapolis. After completing a preliminary study called *Three Plus* in December 1986, the MYCB sought and received a planning grant from the McKnight Foundation to develop an early childhood school readiness plan for the city of Minneapolis.

Covering a six-month time period from mid-May to December 1987, the planning process for **Way to Grow** involved over 200 persons representing public and private agencies and organizations throughout Minneapolis and the State, as well as selected experts nationwide. That input, combined with an intensive review of research and programming in this country and others, produced **Way to Grow**.

Way to Grow combines prevention and intervention for **all** Minneapolis families of children from conception to kindergarten enrollment, with a continuum of services based on need. It supports and strengthens the existing variety of services for children and parents in Minneapolis.

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Way to Grow has five components:

1. Community Linkages

which provides centralized information, referral, and service coordination for families and service providers citywide, and identifies gaps in existing services;

2. A Direct Services Continuum

as described above, which features a citywide expansion of home visits to families of newborns through trained paraprofessionals working within Minneapolis communities;

3. Public Education/Outreach

which employs comprehensive and ongoing strategies to gain the participation of all Minneapolis families and service providers in **Way to Grow**, and promotes public education to assure the healthy development of all children;

4. Education/Training

which trains the paraprofessional home visitors employed by communities to offer basic support, education, screening, and referral services to families of newborns, and also provides consultation and continuing education to service providers throughout Minneapolis; and

5. Research/Evaluation

which works toward effective implementation of **Way to Grow** and its intended outcomes of school readiness and overall healthy development of all Minneapolis children.

The Minneapolis Youth Coordinating Board would implement **Way to Grow** through a Management Board, composed of representatives from selected public and private City and State organizations, as well as members-at-large who are parents of young children. A central office with professional and support staff would carry out **Way to Grow** activities and Management Board directives.

Way to Grow aims to prevent the estimated 75 percent of mental retardation that is linked to adverse environmental conditions in early childhood. It intends to help families deliver to Minneapolis schools a generation of children who are prepared to succeed.

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Birthright (Balloon Lovin' Child)

by Phyllis J. Sloan

My Friend
have a baby
a sweet caressing
momma-missing baby
a soft
Johnson&Johnson
smelling baby
a slow to grow
full childhood baby
a balloon lovin' child

rock-a-bye your baby to sleep each night
let him nurse of your breasts
lounge in your lap
read early to him
sing to him melodies----warm tunes
and whisper of your love to him

bring to earth a gentle child
filled with wonder
amazed by mysteries
competent for challenge
fed physically and mentally
with nature's finest

My Friend
have a baby
hurry
bring to us a child

"Ring-Around-The-Rosy"

by Phyllis J. Sloan

"ring around the rosy
pocket full of posy
ashes ashes
we all fall down"

broken children
wounded children
bits and pieces of little hearts
beat fast
on guard at all times

broken children not knowing how
to play carefree "childlike"
scream: "someone's always messin' with me'
and strike out with cobra's venom
flinch at extended hand
victims of victims
society's : outcome products results

broken children
ring 'round us
wounded children
of every age

BIOGRAPHICAL NOTE:

Phyllis J. Sloan is director of a Special Needs Child Development Center for low-income families in Minneapolis, Minnesota. She is also an author and editor with Guild Press Publications in Robbinsdale, Minnesota. A collection of her poems was published in an 1987 anthology entitled "Three Women Black". Ms. Sloan attended Minneapolis public schools and received her college education in Chicago, Illinois.

Introduction

The preceding poems illustrate stark contrasts of childhood and parenting. "Birthright" talks about a planned for, longed for child, fed "physically and mentally with nature's finest". "Ring-Around-the-Rosy" mourns the "broken children" who are "victims of victims". It isn't hard to predict which type of child is likely to to be more competent and prepared to enter the public school system at age five.

Indeed, there is an increasing body of research which points to formation of early parent-child attachment as being more predictive of social competence than any other factor. Social competence, or the ability to take risks and solve problems in a wide variety of situations, is closely tied to a sense of self-esteem, or pride in oneself. For a child, learning to be proud of who you are requires the encouragement and support of one or more caring adults. Parents who feel overwhelmed or powerless themselves will find it most difficult to support, encourage, and be sensitive to the needs of their children. The same will be true of child care providers if they feel overworked, underpaid, and generally discontented.

In the Minneapolis Public Schools, kindergarten teachers are becoming alarmed at the increasing numbers of children who are coming to school functioning less like 5-year-olds than 3-year-olds, and insecure 3-year-olds at that.[1] These children are easily frustrated, lack persistence in learning tasks, are noncompliant or defiant with teachers and other children, and generally exhibit low self-control and self-esteem. Children who are oriented to failure tend to be unwilling to accept the risks and opportunities that formal learning presents.

Nationally, it is estimated that 30 percent of children are facing major risk of educational failure.[2] Children who experience failure so early in the formal school system are most certainly at risk for many social ills later, including juvenile delinquency, chemical dependency, teen pregnancy, unemployment, and potential lifelong dependency.

In Minneapolis, kindergarten benchmark tests, which are designed to measure student achievement of basic language and mathematics skills, are administered in the spring at the completion of the school year. In 1986, 19 percent of kindergarten students citywide failed the benchmark test. Thirty-five percent of minority kindergartners failed, compared with seven percent of white students.[3]

Minneapolis is lucky. Its public school and city problems don't match the severity of those of many other large cities. Yet the problems are no less real or painful by being less widespread.

"Way to Grow is based on the belief that the raising of our children is a public trust vital to our city's future."

Minneapolis is also fortunate in that it has a wide variety of human service agencies. There is a strong progressive tradition in this city and state. Yet some experts argue that if services are not integrated and coordinated, much of the effort spent is lost in fragmentation, in not reaching the most needy, and in losing people in the cracks and gaps between services.

This notion provided the impetus in December 1985 for the formation of the Minneapolis Youth Coordinating Board (MYCB). Created by a joint powers agreement among the City of Minneapolis, the Minneapolis Public Schools, Hennepin County, the Minneapolis Park and Recreation Board, and the Minneapolis Public Library Board, the MYCB's purpose is to maximize developmental opportunities for the nearly 88,500 children and youth (ages 0-20) residing in Minneapolis.

At about the same time the MYCB was being created, the Minneapolis Community Business Employment Alliance (MCBEA) concluded a task force study of the relationship between early childhood development and the

later employability of adults. Its findings were published in a December 1985 report called *Preventing Unemployment: A Case for Early Childhood Education*. MCBEA's central conclusions were that high quality early childhood development programs improve future employability for low-income children, and that this community must address employability from birth. A major recommendation of the report was that the MYCB assume leadership in developing a comprehensive policy plan for the delivery of early childhood services in the city of Minneapolis.

In November 1986, the MYCB contracted with Scotty Gillette to propose a means of connecting existing resources for better service delivery to Minneapolis children prebirth to age three. Her report, *Three Plus*, created the rationale and impetus for an MYCB request to the McKnight Foundation for a six-month planning grant to develop an early childhood school readiness plan. The planning grant was approved in late February 1987. Karen Kurz-Riemer was hired as a consultant by the MYCB and began work on this plan in mid-May 1987.

The first step in the development of the plan was to conduct structured interview (Appendix B) with over 100 individuals representing local, metropolitan, and state agencies that serve or have an impact upon Minneapolis families. The purpose of the interviews was to begin to identify: (1) barriers to agencies accomplishing their organizational missions, (2) success factors relative to accomplishing agency missions, (3) the target population for a comprehensive school readiness plan, (4) the critical elements of such a plan, and (5) outreach strategies to ensure the success of the plan. Most of the interviews were conducted in small groups, allowing for discussion among the participants and contributing an added dimension to the information received.

Concurrent with the interview process, an extensive literature search was undertaken to find the latest thinking, research, and model programs around the country and elsewhere in the world.

Way to Grow is a synthesis of information coming from the structured interviews and from the literature search. In most cases, opinions expressed in the interviews coincided with the findings in the literature.

There was a crucial third step in this planning process. Once a skeletal first draft was developed in early August, reactions were sought from the original interviewees, as well as from additional professionals in Minnesota and other parts of the country. That feedback was incorporated into a second draft of the plan, which was presented in October for reactions through a large group meeting and a mailing to over 200 persons.

This report, then, is the result of a sincere effort by many individuals whose opinions were graciously and thoughtfully given. (See Appendix A.) It represents the best thinking of many creative minds: academicians, service providers, policy makers, and recipients. While there was not consensus on every point, there were major themes that surfaced time and again. These themes are presented as "Key Findings" in Chapter 2. Chapter 3 provides the conceptual framework and rationale for **Way to Grow**. Chapter 4 describes the plan itself. Further details related to implementation of **Way to Grow** follow in Chapter 5. Issues which emerged or are likely to emerge in relation to **Way to Grow** are discussed in Chapter 6.

Way to Grow is based on the belief that the raising of our children is a public trust vital to our city's future. All families need support and assistance to raise their children well. The foundation of attachment, parent-child interaction, and overall mental and physical health laid down between the time of conception and age six will determine the degree of each child's school readiness. And school readiness, in turn, lays the foundation for competence and success in school and in life.

Let us act on the belief that all citizens have the same "Birthright"--the right to be lovingly cared for as children, so that as adults they can provide the same legacy of caring to children of their own.

Chapter 2

Key Findings

1. *The developmental process of school readiness begins at conception. Efforts to promote school readiness must also begin here.*

If school readiness is defined broadly to include a child's intellectual, physical, social, and emotional preparedness for kindergarten and first grade, the process of developing readiness begins at a child's conception. It follows that school readiness efforts should begin with promotion of early and regular prenatal care in order to prevent low birth weight. Low birth weight babies account for 60 percent of all deaths before one month of age and 20 percent of deaths between one month and one year.[1] In Minneapolis, the overall infant mortality rate (number of infant deaths per 1,000 live births) jumped from 9.2 in 1985 to 12.5 in 1986.[2] For infants who survive the first year of life, low birth weight is associated with cerebral palsy and other developmental disabilities. Premature, low birth weight babies are ten times more likely to be mentally retarded than normal infants.[3]

This city's future is dependent upon the healthy development of its children. Therefore, information on the importance of prenatal care and other positive practices that will promote healthy development must be aggressively presented in education campaigns aimed at raising public awareness in the general population. Barriers to obtaining early and regular prenatal care must be examined and addressed.

2. *Intervention to resolve or reduce developmental risks should be offered as early as possible.*

Just as in the medical field where the earlier diseases are detected and treated, the better the long-term prospects of full recovery, early intervention with children at risk for developmental problems is critical. Benjamin Bloom from the University of Chicago suggests that 50 percent of intelligence measurable by age 17 is developed by the time a child is four years old. Up to 80 percent is developed by the time a child is seven or eight.[4] Although research indicates that traits such as temperament and activity level are biologically determined, it is becoming increasingly clear that many characteristics are shaped by the people, objects, and events in a child's environment. The General Accounting Office estimated that 75 percent of mental retardation can be attributed to adverse environmental conditions during early childhood, and thus may be preventable.[5]

Ongoing opportunities for screening and assessment of overall development from birth are the starting point for families and service providers to address physiological or environmental factors which might affect school readiness. The provision of a continuum of services based on need from so-called "low risk" to "high risk" is also essential.

3. *The promotion of school readiness should be approached comprehensively through ongoing coordination of existing prevention and intervention services in Minneapolis.*

Although there are many services available in this city, most respondents indicated a need for improvement in the area of coordination, collaboration, and referral among these services. To maximize the effectiveness of existing services, it is critical that public, nonprofit, and for profit agencies find a vehicle for working more closely together, as opposed to competing with each other. Occasionally, innovative agency partnerships will produce needed programming without requiring new resources. Where the need for new resources is clearly indicated, the united front collaborating agencies can present in advocacy efforts will be more effective than piecemeal, multiple, and often conflicting requests for new funds.

4. *Whenever possible, services should be located within the communities in which families of young children reside.*

The preference for neighborhood based services was expressed frequently throughout the planning process. Families are more likely to utilize services offered in conveniently located, familiar locations. Although some highly specialized services are only feasible when offered at a central location, many providers could better serve families by decentralizing as much as possible. Community locations for a variety of family services more closely approximate natural helping systems of kith and kin, which have been weakened by the high mobility of both young adults and their parents.

It is particularly important to locate child care sites close to homes or workplaces in order to strengthen the parent-provider partnership which is essential for the healthy development of young children.

5. *Any system that intends to promote collaboration of public, nonprofit, and for profit agencies must assure adequate planning and evaluation, both preliminary and ongoing.*

Although in theory, if agencies work more closely and cooperatively together, their services will be more effective and their work more rewarding, things are not this simple in practice. Each agency has its own entry criteria, operating procedures, and internal politics. Until providers strive to offer an accessible continuum of services through close coordination with other providers, however, many children will continue to fall through the cracks and never reach their developmental potential.

To accomplish this end, interagency collaboration must accommodate a process for planning which will enable staff people to work together more productively and purposefully. Also important is an ongoing process for evaluation, which will improve service delivery, as well as measure service outcomes.

6. *Professionals and trained paraprofessionals should offer home visits for support, education, informal assessment, and service referral to all families of newborns.*

There seems to be strong agreement that the birth of a baby initiates upheaval in all families. What makes a difference in the outcome are the resources a family has to cope with this major life event. A 15-year-old single mother is likely to face more difficulty in adjusting to her new baby, for example, than a two-parent family of adults who are reasonably well educated and financially stable. Yet, one cannot assume that the latter family will cope well, and that all helping resources should be channeled to the former family. Statistics on the incidence of child abuse and developmental and learning disabilities remind us that childrearing problems are not confined to low income families.

New parents and their infants are all vulnerable, and all can benefit from basic support and assistance. In most European countries, home visits are a routine service provided to all families of newborns.[6] There is some evidence that initiating home visits before birth for high risk families can be even more effective. See Appendix C for a discussion of prevention services for the general population from the National Governors' Association.

7. *All family service programs should be designed to identify and build on the strengths of the family and individual family members, rather than focusing exclusively on deficits.*

A cornerstone of the sense of competence, or ability to meet challenges and solve problems, is a sense of self-esteem, or pride in oneself. Self esteem is nurtured when children are loved unconditionally by their parents and/or caregivers, and when they are recognized for their individual strengths and achievements as they grow.

Similarly, programming that reinforces the strengths of families will support the development of parent-child attachment, will be sensitive to ethnic/cultural and other differences, and will promote the self-esteem and competence of all family members. Parents who feel competent will be better able to support the healthy growth of their children. And children who have a strong sense of self-esteem and competence will be ready for the formal learning experiences of school, as well as the challenges beyond.

8. *Any collaboration to promote the healthy development of young children must take into account the primary needs of families for food, shelter, clothing, employment, health care, and child care.*

Parents who are unable to provide for their own or their children's physical needs will find it most difficult to promote the healthy development of their children. It is therefore imperative that policy makers think comprehensively about the impact of their decisions on families. Integrated social programs must work toward total family competence through initiatives such as welfare reform, health and child care benefits, and parental leaves.

The need for these major social reforms must not paralyze us, however, and keep us from undertaking less sweeping approaches to prevention of social problems. Dr. James Garbarino of Chicago's Erikson Institute puts it well:

> We cannot wait for all the big problems to be solved before we tackle smaller ones. One way to deal with the issue of prevention is to take both positions. We can continue supporting programs that help children and families while we work toward greater social reform and a better society. Children cannot wait.[7]

The research and other literature underpinning the key findings discussed above are reviewed in Chapter 3 of this report. Supporting reports are listed in Appendix E.

The Conceptual Framework

The Need

Statistics on family disorganization and dysfunction are sobering. In our industrialized western nation, one would expect children and families to be better off than they are. We have not been successful in eradicating high infant mortality or child maltreatment rates.[1] Out of the 6,299 babies born in Minneapolis in 1984, the Department of Health estimates that approximately 30 percent (1,890 infants) could be considered "at risk".[2] The failure rate for the Minneapolis kindergarten "benchmark test" in 1986 was 19 percent. Minority failure rate was 35 percent, as compared to 7 percent for white students.[3]

Although the Minneapolis population is 38 percent of Hennepin County's total population, the Minneapolis portion of Child Protection Services portion in 1986 was 65.3 percent of the county total. The Minneapolis portion of Child Welfare Services caseload was 58.9 percent. From December 1975 to June 1986, the monthly AFDC caseload in Minneapolis increased by 1,330 cases; Hennepin county's monthly caseload decreased by 119 cases. The Minneapolis share of Hennepin County's AFDC caseload in 1975 was 65.7 percent. In 1986, it was 75.3 percent.[4]

Since 1981, the proportion of births to unmarried mothers in the city has increased to approximately one in three. Specifically, 80 percent of American Indian, 70.3 percent of black, 20.9 percent of white, and 20 percent of Asian/Pacific Island births were to unmarried women in 1985.

That same year, the proportion of Minneapolis women receiving prenatal care in the first trimester of pregnancy was only 71.3 percent overall. These rates range from 78.2 percent for whites down to slightly over 42 percent for American Indians and Asian/Pacific Islanders. This does not compare well with the Surgeon General's goal of ensuring that 90 percent of all pregnant women obtain care within the first three months of pregnancy.[5]

Currently, the overall rate of low birth weight babies (less than 5.5 pounds) in Minneapolis is 6.8 percent. The black rate, however, is 11.7 percent. These percentages have remained consistent over the last ten years. At this rate, it is concluded that Minneapolis will not reach the Surgeon General's goal of decreasing the rate of low birth weight babies to five percent in 1990.[6]

Minneapolis trends are similar to national trends, where poverty rates are higher than they have been for more than 20 years. Poor families have become poorer, and white children are beginning to catch up to black children in risk factors.[7] Nationally, low birth weight incidence has improved only slightly in the last 35 years.[8]

"Our main problem is not our lack of knowledge about how to help families; it is the need for commitment to the provision of high-quality family services."

This is in contrast to ten western European countries, all of whom have lowered their low birth weight rates and are doing a better job at infant survival.[9]

How have we arrived at this point--a nation with tremendous technological sophistication that seems stymied by an inability to solve some basic social ills? As a nation, we have given "lip service" to concern for the plight of children since the early 1900's. Between the New Deal initiatives of the 1930's and the Great Society Programs of the 1960's, programs in maternal/infant health and nutrition, early childhood education (Head Start) and income supports to women and children were instituted.[10] But they have not been able to keep pace with the numbers of children in poverty and at risk.

One way to explain the plight of children is to blame the family. Ours is not the first generation to lament the breakdown of the American family. Hareven reports that for several generations back in our history, the demise of the family was predicted.[11] The family is under siege today, however, in situations where environmental and political forces have erected barriers and posed difficulties.[12]

In addition to societal conditions, however, there are also strong belief systems that operate against the family today. Current belief systems grew out of the 19th century transition to industrialization and urbanization. This transition removed economic roles from women whose daily labors had been essential to family survival and glorified motherhood as a full time career. The revised expectations of parenthood that followed have created tensions between the ideals and the reality of family life. Myths have grown up around the family as private, independent, and self-sufficient. From the pre-industrial family, who often took in either relatives or strangers as boarders who participated in the family economy, we have moved to a "glorification of the home as a retreat from the outside world" and placed an "exaggerated emphasis" on nurturance, intimacy, and privacy.[13]

The emphases on privacy and on total parental rights have combined to isolate the family from needed social support systems.[14] We need to rethink these emphases and to consider the idea that while parents have primary responsibility for the well-being of their children, the community also has a responsibility, that is to support the parents. If indeed we could shift in our beliefs from that of the self-sufficient family to that of families connected to each other by community and other social supports, then it follows that we could commit to the social and economic well-being of all families.[15] As Kaplan explained: "Our main problem is not our lack of knowledge about how to help families; it is the need for commitment to the provision of high-quality family services."[16]

School Readiness

School readiness is a term that implies certain prerequisites for school entry besides proper enrollment age. Being ready for school means being ready to succeed at school work. It means meeting certain developmental attainments that are considered to be crucial to school success. Being "not ready" means being at risk for failure.

For many reasons, readiness for formal learning is necessary to guarantee success in school. Today, more than ever before, there is pressure from several arenas to increase educational standards and requirements.[17] Children who enter school unprepared to meet the challenges are indeed starting with two strikes against them.

Because school success is considered to be so important in our culture, both in itself, and as the means to later life success, one of the major tasks of parents is to ready their children for the school experience and to continue to facilitate their achievement.[18] What does the "ready child" look like? An even more basic question is, what do the parents of the "ready child" look like? There are certain things that parents do with and for their children that promote school readiness and eventual school success. According to Garbarino and Asp,[19] the following conditions help to assure children a good start:

- Parents communicate that school is a positive, necessary experience by displaying a use for written materials and by being motivated themselves to look competent in the eyes of the school. This involves modeling reading and language fluency, as well as valuing schooling.
- The parent-child relationship includes opportunities for parents to convey a regard for "academic culture," by communicating and encouraging conceptual language in problem-solving and manipulation of symbols.
- Parents' interaction styles with their children teach and encourage the pro-

social behavior needed to adapt to school: mainly delay of immediate gratification and accommodation to rules and expectations. Style and manners are crucial to school adjustment.

The other prerequisite for school success is, of course, a developmentally sound child, or an "undamaged organism".[20] It is important that children be free from neurological and psychological damage or disturbances. It is the above authors' contention, however, that most children are capable of school success, and that failure comes more from a lack of motivation, support, and appropriate school-like behaviors.

One can infer from this information, then, that to support the family in readying its children for school means to offer the following assistance:

- Early screening of children to prevent and/or offer early treatment for neurological or psychological damage.
- Support and information for parents that helps them to provide a cognitively stimulating and pro-social home environment for their children.
- A program of transition to kindergarten that helps children learn to function within school expectations and helps parents feel comfortable at school and with school personnel.

These recommendations are consistent with those of the Governors' 1991 Report on Education.[21] In the report from the Task Force on Readiness, parent education is mentioned in two arenas: assistance to first-time parents and information regarding successful parenting practices.

It is an established fact that low income children are educationally at risk. However, adequate academic stimulation can help overcome some of the debilitating effects of poverty.[22] Therefore, it makes sense that a readiness effort combine both assistance to parents in providing adequate academic experiences and programs for children which augment home experiences.

Looking at school readiness as a problem whose roots lie mainly outside the child's capabilities to do successful school work, means looking at the family and the school and "measuring the fit." Much can be done to help the family adjust to school expectations. And much can be done by the school to adjust expectations to meet the culture of the family.[23]

An Ecological Perspective

The overriding theme in the conceptual framework is that of an ecological approach toward defining need, desired outcomes, and services implemented to affect those outcomes. The development of this perspective began with the work of Dr. Urie Bronfenbrenner. His model of the human ecosystem clearly sets forth the need to consider the organism, not alone, but as part of an ever-widening ring of interactions with other organisms.[24] Bronfenbrenner's model is useful because it helps us to maintain a developmental perspective when defining needs of families and children. It allows us to broaden the concept of services to include working to change those systems that are most harmful to parents as they try to meet the needs of their children.

What is an ecological perspective as applied to families and children? It is a broad view that looks at the child within all the developmental contexts that impinge on that child's development: immediate family, extended family, friendship groups, neighborhoods, schools, communities, and larger configurations of society. These are "regularly occurring environmental settings that can affect development by presenting risks or opportunities".[25]

This view includes an observation of the interactions between the child and the subsystems or contexts in which that child develops. Do parents understand the child's needs? Is there an extended family that is supportive? Is the neighborhood safe for children? Does the mother have a friend or two she can call when she needs to talk? Is the neighborhood school attuned to the cultural and economic conditions that exist for

children? Are there child and maternal services offered in the community? Are there playgrounds or parks close by? The result of all these forces acting on the child is termed "environmental press," which refers to the combined influences that occur from all of the child's environments. That press, combined with the child's own inner resources, is what shapes behavior and development.[26]

Why is an ecological perspective useful? It is useful as a model because it helps us to make sense out of the forces that affect children. It helps us to understand why, in identical economic conditions, some families thrive and help their children develop optimally, while others seem unable to rear successful children. It keeps us from putting all the blame for poverty and/or debilitating lifestyles onto the victims, because it is clear to see that environment plays a big role in producing those conditions. And it helps us to design programs and services for families that deal with environmental impoverishment and systems change.

When designing services for families using the environmental perspective, we place the child in the middle of an ever-widening ripple of environmental contexts. Alone, the child cannot survive. So, the smallest target group to consider is the family. Everything that happens to small children is filtered through or mediated by the family, most often a parent. To have an effect on the child's life necessitates affecting the family. Therefore, the family, rather than the child, is considered to be the appropriate target of services.[27]

The family's link to friends, extended family, and neighbors is also a possible target. If there are too few participants in the child's immediate world (for example, an isolated single mother) there may be insufficient nurturance and feedback to keep the parent-child relationship a positive growth-producing one. Or, the available adults may not be "free from drain" and thus be unable to offer the necessary support.[28] If parents lack nourishing relationships with other adults, this may be the ecological intervention point.

Families also need to make their way in the community by forging connections with those institutions such as school, church, health care, or child care that exist to offer needed services.[29] If these connections are strong ones, and positive for the family, the child is developmentally enhanced. If parents are unable to forge those links, the child's development suffers. Garbarino and his colleagues offer the home-school link as an example.[30] If parents are able to orient the child to the world of school (academic culture), the child will be able to take full advantage of the school's services. For some families, then, the appropriate intervention point is here: providing services to help the family forge positive connections to institutions.

The larger community can provide either stressors or support to families. A good neighborhood "enhances development by providing the kind of multiple connections and multiple situations that permit children to make the best use of their intellectual and social equipment. It gives them a sense of familiarity and belonging, a territorial base. A strong neighborhood also offers a sense of security and peace of mind for the parent, feelings that translate into a more relaxed and positive stance toward the task of child rearing and toward the child in particular".[31] Especially in low income neighborhoods, where parents are without the resources needed to transcend location, the availability of support and of natural helping systems is crucial. Here then, is another level of intervention, with efforts to enhance neighborhood services in order to increase habitability.

Finally, there are societal forces at work that serve to undermine the family in its childrearing role. Some of the most damaging forces are: (1) a tacit social acceptance of domestic violence; (2) an emphasis on individualism; (3) a tolerance of sexism and racism; and (4) an emphasis on material gain at all costs.[32] An ecological approach works to change the "big picture" as well as the child in the family. Intervention at this level works at widespread public education and some quasi-social engineering projects that help to combat some of our more destructive values.

With this emphasis on human ecology, it

is clear that a plan to serve families will include a multi-tiered approach to defining the desired outcomes and then determining at which level(s) the intervention will be most effective.[33] The intervention plan might target all or a combination of the following: affecting individual behavior change; affecting interpersonal interaction change; providing resources or creating support systems; and advocating for social change.[34]

Prevention vs. Treatment

Universally offered preventive services are the baseline in a comprehensive array of programs for families. Prevention sounds good. It is hard to argue with the concept. And yet it continues to take a back seat to remedial services. Part of the reason is a series of fallacies that prevail when considering preventive services.

The first fallacy is the common belief that all services to young children and families are preventive. The truth is, only efforts that are aimed toward groups of unaffected people, who show no signs of the problem, are preventive. Other services that look at "risk" groups are secondary prevention; those that remediate can be classified as early intervention, treatment, and rehabilitation.[35]

"It is to accomplish in a systematic approach to strengthening the family what has already been accomplished in the medical and dental field (prevention of many diseases) and other community services, such as preventive sanitation."

The second fallacy is the belief that prevention is impossible without knowledge of specific causes. In actuality, there is evidence to support the strategy of providing educational services that: (a) promote stress-resistant capabilities; and (b) help people by increasing supportive services when they need them.[36] [37] [38]

The idea that prevention lacks a "technology" is fallacy number three. Actually, there are at least four preventive methods that have a history of success, particularly when applied in combination. They are: education, promotion of competency, community and systems modification, and support for natural caregiving systems.[39]

Another myth identified by Albee and Gulotta relates to the belief that evidence is lacking on the effectiveness of prevention; therefore, it shouldn't be tried. Medicine, however, has successfully relied on correlational data, and researchers have established relationships between stress and both physical disease and mental ilness. Relationships have been discovered between mental disorders and the mitigating and protective benefits of providing support.[40]

The last fallacy deals with the belief that prevention is too expensive and that it takes money away from needed treatment. However, it is commonly accepted that treatment programs aren't always successful.[41] And at least in some cases, prevention has been estimated to save many times the cost in later remedial efforts. This is particularly true in benefits of quality early childhood education to low income children[42] and in low birth weight prevention.[43] [44]

Even though the argument for prevention often begins with a discussion of the cost benefit ratio, there are other considerations. These concern the concept of family stability and the high cost to overall cultural well-being when preventable deficiencies continue to develop. Most other developed nations, particularly in the

West, have adopted a model of family support based on a mode of prevention. They use readily available strategies that have reduced their infant mortality rates.[45]

Prevention consists primarily of improving the community resources that can strengthen the functioning of all families and children.[46] Areas that are often cited as maternal and child health problems to be addressed by preventive services are: adolescent and other unwanted pregnancies; low birth weight babies; birth defects; injuries; dental caries; developmental emotional and learning problems; and family dysfunction that leads to maltreatment.[47]

The causes (or correlates) of the above problems, which are found in all segments of society, are multiple and interwoven. Poverty does, however, correlate most highly. Isolation and alienation from sources of support is a recurring theme. Other stressors might include emotional problems or parental mental illness; racial or other discrimination; chronic physical illness; or recent loss by death or divorce.[48] Lack of information about childbirth and childrearing can also contribute to problems.[49]

The task, then, is to "focus on whole communities and the relationship between families and their current environments."[50] It is to work for change in community practices that add to problems. It is to educate and support. It is to enhance naturally occurring support systems. It is to accomplish in a systematic approach to strengthening the family what has already been accomplished in the medical and dental field (prevention of many diseases) and other community services, such as preventive sanitation.[51]

Universal vs. Targeted Services

A service continuum, according to Brown,[52] begins with prevention, moves to early intervention, problem solving and crisis intervention, and ends with rehabilitation and restoration strategies. Ideally, it is easier and cheaper to prevent problems from happening. But problems are not prevented overnight, and there is still the question of what to provide in situations where the problem already exists--where prevention is too late. The argument can be made that it is best to allocate resources to all points along the continuum, with some prevention services being available universally.

This continuum approach, with some universal services, is countered by those who believe that all resources should go toward helping those most in need--those whose situations are on the special needs or critical end of the continuum. However, there are drawbacks to this targeted approach. When a particular population is singled out as possessing some deficiency to eradicate, they are labeled to the rest of the population as different or lacking. Labeling can undermine confidence, create anxiety or create dependency, because to solve the problem is to lose the service.[53]

Another drawback to targeting is that often the individual targeted is perceived as causing the problem. Thus, there is no impetus to see that problem as part of an ecological system that has fostered it.[54]

Targeting also assumes a sophistication and accuracy in choosing a deserving population. This is not necessarily the case. When predicting at risk children from perinatal problems, Sameroff and Chandler[55] found that although retrospective studies give a clear impression that risk is predictive, prospective studies of the same variables yielded a very large population of children who displayed perinatal problems, but developed normally. As Chamberlin has noted, either one begins with a very large group of at-risk population, most of whom may not retain those characteristics in the long run, or one narrows the characteristics to eliminate over-identification, and serves a very small percentage of the total group who develop problems. He has observed that "the longer one follows a group of given children, the more likely they are to develop characteristics similar to the social/cultural milieu in which they are being reared."[56]

There seems to be a lack of clear-cut criteria for determining eligibility for an at-risk population of children and families. Poverty still plays the largest role.[57] [58] Poor social/environmental conditions tend to amplify other problems.[59] So, rather than search for just the right criteria, that in combination with low income and social deprivation produce an at-risk population, it is suggested instead to offer the community services necessary to prevent some problems and remediate others.[60]

Collaboration

Collaboration is the "buzz word" of the late 1980's. Alliances are being forged to create voluntary, yet binding collaborations to circumvent many of the roadblocks in established agencies and bureaucracies. The goal is to devise service delivery systems that make more sense for families. Most services today, at all levels of government, have individual eligibility criteria and delivery systems. Institutionalization brings with it "bewilderment, powerlessness and alienation" that can overwhelm parents seeking help, particularly low income parents.[61] And yet, as Edelman[62] has recently pointed out, there are few social problems that can be tackled by one agency or one program that will yield comprehensive results. In designing a new approach to services, then, it makes sense to avoid creating another bureaucracy that restricts and entangles. What is called for is a more responsive collaboration of the key players in services to families, and an opportunity to enfold more minor actors as well.

This approach has been the focus of several new initiatives in support programs for families. In designing the Interdepartmental Coordinating Committee for Preschool Handicapped Children, the state of Maine pulled in three departments (Human Services, Mental Health & Retardation, and Educational & Cultural Services) to form a multidisciplinary steering committee to oversee their new initiative.[63]

In designing the Center for Successful Child Development, a Chicago based program which offers comprehensive services to families in order to foster positive health, social, and educational outcomes for their children, planners created a collaborative effort between several private and public agencies that could offer expertise and resources to the project. Local support networks were identified, as were locally offered services. All have been pressed into a collaborative effort to strengthen existing services and expand where needed.[64]

In St. Paul, the Wilder Foundation has built a collaborative model to fill a "critical service gap" working with high risk young families to prevent child abuse. The foundation began by convening interagency project planning meetings to design a program that utilized the skills and resources of the participating agencies. In this case key players, in addition to Wilder, are Ramsey County Public Health, St. Paul Schools Early Childhood Family Education, and Ramsey County Human Services.[65]

"What is called for is a more responsive collaboration of the key players in services to families..."

Agency collaboration during planning and implementation stages should insure streamlined service deliveries and offer opportunities for creative problem solving, while maintaining agency integrity and mandated procedures. Brown refers to this approach as "linkage management."[66]

Community-Based Services

The concept of neighborhood-based services is not new. In the early 1920's and

1960's, especially, there was support for neighborhood organization and neighborhood workers.[67] Recently there has been a rekindling of support, and several innovative program models for community-based services have been developed. The assumption is that children and families can best be helped by strengthening the primary and secondary support systems within their community.[68]

The antithesis of a community-based model is one where clients come to services which are centrally located. The problem with this approach, as identified by Brown, is that "when client contacts are limited to set periods of time and office interviews, professional practice frequently excludes understanding and utilization of the social environment, or the launching of preventive or corrective interventions at the neighborhood level."[69] Centralized services are usually bureaucratic, and often designed for ease of delivery from the provider's point of view.

In order to be more client-centered, providers of services need to take into account certain elements of a client's neighborhood in order to understand needs. These elements are: socioeconomic characteristics, race/ethnicity, cultural patterns, types and density of dwellings, history, other unique features, and whether it is viewed as a desirable or undesirable place to live.[70] The development of a community-based service model must begin with a thorough assessment of these community elements and of the current service offerings (who is doing what for whom).

A continuum of services can then be developed, "ranging from supportive assistance available to any family coping with crises or with problems in daily living, to protection of children at risk and rehabilitation of seriously disordered families ... The dual aims of service provision are to enhance the quality of family and neighborhood life and to safeguard children."[71]

A service model must also take into account the functions of a neighborhood, as set forth by Warren and Warren[72] and make decisions as to which functions are strengths of community life and which need to be enhanced or developed. These functions are:

- Arena for sociability: Residents develop a network of friends and acquaintances.
- Arena for interpersonal influence: Residents share opinions, offer and receive advice and adhere to community norms.
- Source of mutual aid: Residents offer emergency help and material resources (borrowed tools, shared labor, babysitting exchanges).
- Organizational base: Residents join together for PTA, neighborhood associations, Scouting, etc.
- Reference group: Residents feel a sense of shared identity and belonging.
- Arena for status and recognition: Residents perform valued roles within the community and share news of achievements.

Most neighborhoods do not perform all six functions. However, "the variety and intensity with which these functions are carried out serve to differentiate life within neighborhoods and suggest the extent to which a particular neighborhood is nourishing and sustaining for families".[73]

What about the community that is not "nourishing and sustaining" for families? Garbarino and associates[74] have characterized "high risk neighborhoods" as places where neighbors don't help each other; there is a high level of suspicion; and the community norms and behaviors increase family weaknesses, rather than strengths. These factors lead to social impoverishment, which can correlate with high rates of child maltreatment.[75]

There is no doubt that low income neighborhoods have a tendency to be impoverished. However, Garbarino et al.[76] have developed a model that looks at high risk neighborhoods in light of degree of impoverishment. They have found that, within similar low income areas, there can be large differences in social richness and support factors. The impoverished neighborhoods have even

higher rates of child maltreatment than would normally be predicted, given the economic conditions.

What does all this mean for program planning?

- It means that in neighborhoods that are socially impoverished, and where parents do not receive the nurturance, feedback, and support they need, children are at risk for maltreatment.[77]
- It means that attempts to provide services to those children and families must begin with efforts to understand the social environment and how it influences the success or failure of services.
- It means a thorough assessment of involvement of residents in community betterment projects.
- It means using professional resources to help identify indigenous community leaders and natural helpers and give them support to enhance their roles.[78]
- It means designing a service delivery system that will work with the environmental forces in operation rather than against them.

Prenatal Outreach Services

The incidence of low birth weight (less than 5.5 pounds) babies is a serious public health problem in this country. Low birth weight contributes directly to the infant mortality rate, which is lower in 16 other countries.[79] Low birth weight babies are 40 times more likely to die within the first 28 days of life. They are 20 times more likely to die within the first year. Low birth weight children who survive infancy are at three times greater risk for incurring lifelong disabilities such as cerebral palsy, mental retardation, hearing and vision impairment, and learning disabilities.[80]

Quality prenatal care is necessary to prevent low birth weight and to ensure healthy babies.[81] Unfortunately, not all women receive prenatal care. And of those that do, many don't receive it soon enough. The disparities in prenatal care rates between racial groups are widening. Women who are at greatest risk of bearing low birth weight infants are often least likely to receive adequate, needed care. This is especially true of teens and blacks.[82]

Birth weights and infant survival rates are much higher in Western Europe. Favorable pregnancy outcomes are achieved in both rural and urban areas. Even though the U.S. has a higher percentage of its gross national product going to health care than at least ten European countries, its statistics are worse. This holds true even when the statistics are disaggregated by race and compared for white populations only. Rates of teen pregnancy, teen abortion, and teen childbearing are much higher in the U.S. than in most western European countries. Teen pregnancy declined rapidly in the 1970's in western Europe, even as financial benefits for childbearing were expanding. Miller found that "Without in any way minimizing the urgency for reducing poverty rates, especially in households with children, a compelling case can be made that selective and direct approaches for improving pregnancy outcomes are both feasible and desirable, even within the present income structure of the United States."[83]

"The incidence of low birth weight (less than 5.5 pounds) babies is a serious public health problem in this country."

Women fail to seek and/or receive adequate prenatal care for many reasons. The barriers to care can be classified into four major categories: financial; health policy and health care system deficits; service and program disincentives; and individual and group health care attitudes. A plan to increase the utilization of

care must address all four categories of barriers to that care.[84]

Financial barriers are real. Not every pregnant woman has adequate insurance coverage. Many fall through the cracks because they are working poor. It is adequately documented that if financial barriers are removed, it is possible to reach the poor and near-poor.[85]

Problems within health care systems are varied. As a group, obstetricians are the least likely among primary care physicians to accept Medicaid.[86] Programs and benefits are rarely coordinated to ensure easy access and optimal benefits to clients. Different eligibility requirements, travel to different sites for services, and complicated documentation requirements all serve to discourage the users.[87]

Service and program barriers range from accessibility of services to provider practices and attitudes. The following all serve to deter participation in prenatal care:[88]

- Low Medicaid enrollment rates;
- Lack of transportation;
- Location of services;
- Lack of child care;
- Service hours;
- Service delays; and
- Provider practices and attitudes.

The individual's attitudes or her identity group's orientation toward health care can also prevent the seeking and utilization of prenatal care. Teenagers feel shame and fear. Some people may lack knowledge of the health care system or may have conflicting cultural beliefs.[89] Low income women may not realize the importance of prenatal care and may have been dissatisfied with earlier health care experiences.[90] [91]

If utilization of prenatal care is to be improved, barriers must be attacked from all sides. It is obvious that financial barriers are overriding when they exist. But even in cases where the financial barriers are removed, others remain. These must be addressed first. The delivery of services in a more comprehensive, less fragmented way will require cooperation and commitment from agencies and programs. Neighborhood locations or transportation to and from central locations is important. Health care providers must become increasingly sensitive to cultural differences and to people's fear of medical procedures. Prompt, courteous service is necessary.[92]

Once the major barriers are reduced or eliminated, then comprehensive, coordinated outreach strategies must be employed to recruit women for prenatal care. Marketing strategies might include a massive public education campaign utilizing culturally sensitive materials and models.[93] Telephone "healthlines" provide information in a non-threatening way and can even be used to set up initial appointments. Outreach workers can be effective in reducing personal fear and alienation.[94] They can also provide the emotional and social support necessary to compensate for a lack of such support in the mother's life and enable mothers to continue their care.[95] [96]

There are many good examples of successful prenatal outreach programs in the United States. The Obstetrical Access Pilot Project at selected sites in California was successful in reducing the percentage of low birth weight infants by 33 percent for program participants at a cost of only five percent over the average cost of care provided by Medi-Cal. That suggests a great reduction in long-term public expenditures to care for low birth weight infants in neonatal intensive care and other hospital costs.[97] Locally, preterm birth prevention programs offered by Group Health Inc. and Hennepin County Medical Center have shown significant reductions in rates of premature births. Both the Maternity and Infant Outreach Project (Hartford, Connecticut) and Central Harlem Outreach Project (New York) have demonstrated success in reaching pregnant women and seeing them through pregnancy. Two programs particularly successful in providing social support to pregnant women are the Prenatal/Early Infant Program (Elmira, New York) and the Better Babies Project (Washington, D.C.).[98] The Infant Health Promotion Coalition of Detroit has demonstrated successful mass media and other marketing

strategies through Community Baby Showers that combine both case finding and prenatal education, and through a telephone referral service, 961-BABY.[99]

One last reason to involve women early in prenatal care is to create access to the family for later intervention. Project STEEP, designed after a ten-year project at the University of Minnesota studied low income mothers and their first borns, enrolls women in their last trimester of pregnancy. It attempts to teach basic development, help mothers be better "perspective takers" when interacting with their infants, and to be supportive and meet mothers' emotional needs. "We believe there are strong indicators even before the baby's birth that a mother is unlikely to provide the sensitive responsive care necessary for the infants' optimal development."[100]

The First Two Years

Infants Can't Wait. As the title of a publication of the National Center for Clinical Infant Programs suggests, infancy is a crucial time, physically and emotionally. The human capacities for loving and learning are rooted in experiences of the first two years. Impoverishment during this period shows up later as emotional and developmental disorders.[101] [102] [103] And yet 25 percent of all babies in the U.S. are born into poverty.[104] Twenty percent are born to single mothers.[104]

We do know what babies need for optimal development. We know what danger signs to look for. And we know what parents need for their own fulfillment.[105] And we know also that the earlier the intervention the better.[106] Ramey and Bryant[107] choose age two as the time marker distinguishing prevention from risk. They argue that the prevention of mild mental retardation depends on early identification of high risk factors and the intensity of treatment. Researchers at the University of Minnesota have found during a ten year study of 267 high risk families of first born children, that the earlier that maltreatment occurs, the more severe the consequences. Maltreating parents often find infancy and toddlerhood a trying time, and seem unable to find a balance between adequate nurturing and allowing sufficient autonomy, both of which are crucial parental tasks for optimal child development.[108]

The National Center for Clinical Infant Programs, in their publication *Infants Can't Wait,*[109] proposes two major initiatives for services to parents and their infants and toddlers. The first is to establish "a basic floor of integrated services" that includes preventive health care, provision for economic well-being, family support, and quality daily care that enhances and facilitates development. Secondly, they recommend an expansion of specialized services for parents and their infants and toddlers with special health and developmental problems. The tasks of providing for their infants' needs falls chiefly to parents, but in contemporary America the support once afforded by stable neighborhoods or closely knit extended families may not be available. Instead, stressed parents must often negotiate a system of fragmented

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services to find help, and too often services they need are not within reach. While there are, to be sure, examples of excellent general and highly specialized services that address the needs of infants, they are too few in number and are not well coordinated. The inadequate patchwork of services that exists to promote healthy development in the critical first months and years of life is in sharp contrast to our broad-based system of public education for older children, which is seen as an opportunity guaranteed to every American child.[110]

For infants and toddlers to grow optimally, they need sensitive, responsive caregiving from their parents. Some parents need additional help and support in order to provide what their children need. Programs that are designed to offer comprehensive, integrated services need to consider the human element in those services. Change does not occur simply by learning new information or being taught new skills. "Change can only occur through integration of the experiences of child-rearing and relations with others, such as a concerned worker with adequate time to provide care to both the mother and child".[111]

Family Support

To paraphrase, "No family is an island." Parents who attempt childrearing in isolation, even in the middle of a large urban area, are cut off from necessary nurturance and feedback from others. Their stress levels increase. They live impoverished lives.[112]

For many, support is an integral part of everyday existence, with ties to one or more social networks that provide information, emotional reassurance, physical or material assistance, and a sense of self as a person worthy of the regard of others.[113] For others, community life does not offer the opportunities for enriching support networks. There are not enough available people who are "free from drain" to create a give-and-take. Often, for those families whose life circumstances put them in most need, the support is not there.[114]

Current research on social networks and social support is encouraging. Evidence is accumulating that suggests that adequate social support can help to prevent and/or alleviate a variety of social and developmental ills, including low birth weight, life stress, and negative parent-child interactions. It can be argued that a family support component in an early childhood program both attracts parents to the service and is important to the effectiveness of that service.[115]

Any proposed plan of services must, then, integrate and provide for support services which enhance the family's ability and desire to participate. The goal of providing support is to give families what they need to function competently and to meet the developmental needs of their children. This can be done by creating "formal support systems that generate and strengthen informal support systems, that in turn reduce the need for the formal system."[116]

There are several questions to consider when designing a program of support to families:

- What constitutes support?
- Who is best equipped to provide support?
- How can we possibly afford to provide support to every family that needs and wants it?

It seems evident that, for several reasons, professionals alone cannot do the whole job. They are too costly, and relationships with professionals are not ongoing, enduring, or based on mutual give-and-take. Unless they are careful, professionals may unwittingly create dependence on their services and thwart self-help initiatives.[117] It would appear, then, that the

"It seems evident that, for several reasons, professionals alone cannot do the whole job."

professional's role in a community-based, comprehensive program of services with emphasis on support will need to be redefined.

What seems to be called for in designing services is the creation of a framework that integrates the benefits and services from the community's naturally occurring informal helping systems with professional services. The idea is to help families plug into social support networks and to support already existing relationships in order to enhance, complement, and offer alternatives to the conventional human service approaches.[118] In order to achieve this integration of professional and naturally occurring support, more resources need to be directed toward providing primary social support.[119]

How does this integration take place? Professionals work with existing social support networks to achieve a rich environment for families. They recognize the complementarity of personal and social resources and seek to strengthen both.[120] They recognize the limits of professionalism and define their roles to both facilitate the development of informal networks and use their expertise to treat special problems and intervene in crises. If professionals are committed to working within the existing social fabric and to performing in a consultative role, they can continue to serve an important function in the delivery of services.[121]
Some new helping roles of professionals can be:

- Consultant to informal family support systems and natural helping networks[122];
- Treatment agent, providing face-to-face, therapeutic intervention;
- Teacher-counselor, providing advice, information, and skill development;
- Broker of services/resources, providing the services of a "case manager";
- Family advocate, acting as intermediary with agencies and services[123]; and
- Leader of a team of paraprofessional home visitors and community workers, providing supervision and training.[124]

Whittaker[125] outlines the potential barriers to this integrative approach. They are:

- Bureaucratic restrictions;
- Economic self-interest of professionals;
- The narrow, technical focus of the professional role;
- The hierarchical structure of professional-paraprofessional-volunteer roles; and
- Institutional mandates that define services.

These barriers point to the need for commitment from agency heads and policy makers to the importance of support in the lives of families. Services need to be designed in ways that support families rather than reflecting "what professionals and institutions know how to do, or have funding to do".[126]

Home Visits by Paraprofessionals

The paraprofessional home visitor idea is one that is resurfacing in family support literature. Its history is rooted in the late 19th century, when upper class women volunteered to be "friendly visitors" to poor families to offer moral guidance. From there, as the field of social work was professionalized, social workers and public health nurses worked out of settlement houses in the early 1900's to try to integrate professional services into the community. In the late 1960's and early 1970's, a new twist was added: finding talented, skilled, non-professional members of a targeted community to work with families.[127] In the 1980's, research is accumulating that once again points to the efficacy and value of training paraprofessionals to visit families at home to help parents provide an optimal environment for their children's development.

The concept of home visits to families of newborns to be discussed here is **not** one of a treatment or educational plan to be delivered on the family's own turf. Rather, it is a concept that looks at the home visit as an opportunity to bridge the gap between professional service agencies and the community.[128] It is an opportunity to accomplish an initial, mostly

informal, assessment of what kinds of support and information families may need in order to be effective parents. And finally, it is a mechanism to offer support and to encourage parents to utilize the services available to them. When home visits are available at an initial level to all families, the stigma usually attached to being singled out for service is removed, and each new parent can know that there is help available if needed.[129] [130]

The utilization of paraprofessionals in the context described above makes good sense. A person, preferably a mother from the community who can "befriend" the family at a time of vulnerability (as transition to parenthood is), is in a unique position to offer support and nurturance.[131] [132] The community resident can provoke less suspicion, exhibit a cultural familiarity and respect, draw from personal experience, and more closely resemble a natural helping relationship.[133] Problems are more likely to come to the attention of a home visitor in an atmosphere of trust. And there is sufficient evidence to suggest that trained paraprofessionals are capable of determining which children and families are at risk.[134] [135]

"When home visits are available at an initial level to all families, the stigma usually attached to being singled out for service is removed, and each new parent can know that there is help available if needed."

The goals to be accomplished by the paraprofessional home visitor are multiple, and need to be tailored to each particular family. The list below identifies the realm of possibilities:

- To "befriend" the parents and serve as an ally in times of stress.[136] [137]
- To educate in basic skills such as: health care[138]; accident prevention[139]; and feeding and nutrition.[140]
- To help parents link up with appropriate preventive and treatment services.[141] [142]
- To serve as a model for positive interpersonal relation-ships, particularly parent-child interactions.[143] [144]
- To conduct informal assessments of possible risk factors.[145] [146] [147] [148]
- To help parents understand their role in promoting socially and intellectually competent behaviors in their children, and learn techniques to perform this role.[149] [150] [151]
- To help parents understand the importance of utilizing their own natural helping systems.[152]

The task of the home visitor then, is to shift back and forth among the above objectives based on her assessment of priorities and needs. For many families, a few visits will be enough. For others, an ongoing plan can be developed that includes continued home visits as well as other professional support services.

There are many examples of successful home visit programs. A Montreal program showed that home visits begun prenatally contributed to reduced accident rates; higher assessments on home environment and maternal behavior scales; lower prevalence of interaction or feeding problems; and a higher prevalence of involved fathers.[153] In a Cambridge, Massachusetts program (Family Support Project), families were randomly assigned to either a paraprofessional home visitor with occasional parent meetings or to a professionally staffed group process with professional home visitors. There were no significant differences between the outcomes of the two services; if anything, the paraprofessionals appeared to be rated more favorably by participants.[154]

A similar finding came from the comparison of a

traditional home visit program with an agency based rehabilitation program which included several components. Both models attempted to enhance the mother-child relationship with mentally ill mothers. Both interventions exhibited "marked improvements" in mother and child, with no measurable differences.[155] A study conducted in Aberdeen, Scotland concluded that a home visit assessment can serve as an accurate predictor of home and parent factors that lead to subsequent child health and/or maltreatment factors.[156] A Denver hospital offered home visits by paraprofessionals as a routine part of pediatric health care. Visits were judged successful in identifying families who were at risk for maltreatment and who needed long-term services.[157]

The effectiveness of paraprofessional home visitors is dependent on effective recruitment, training, and supervision of visitors.[158] [159] [160] It is also important to understand the need for clear role definition; for recognizing the tensions confronting the home visitor in negotiating between community loyalty and professional expectations[161]; and to provide an effective professional back-up system.[162]

A Focus on Family Strengths

A program model consists of at least two parts: **what** the services will be; and, **how** they will be delivered. The "how" describes approach. The approach recommended here is to focus on family strengths and enhance development in specific ways. The antithesis to this approach is to focus on deficits or weaknesses. A problem is identified, a diagnosis is made, and a treatment prescribed. The target is usually an individual; it is more difficult to prescribe for a system.[163] Some assumptions are implicit in this approach: there is a minimal acceptable level of functioning which is the goal for this person or family; and once the dysfunction is remedied or minimized, services are no longer needed.[164] Another assumption is that experts (professional social workers, health care providers, teachers) are needed to help "fix" the situation or remedy the deficit.[165] The problems with a deficit approach are: (1) being labeled "sick" or dysfunctional is detrimental to one's sense of competence; (2) needing professional help may create dependency[166]; and (3) many families may be left functioning only marginally.[167]

A non-deficit approach, on the other hand, works to identify strengths and increase competence. It focuses on identifying inner resources as well as environmental resources. Assessment and intervention are directed equally to the person or family and to the situation.[168] There is a presumption of potential and ability to change. It employs a democratic approach, with professionals as partners.[169] The focus is on skill development, motivation, and environmental fit.[170]

One of the major benefits of using a non-deficit approach with families is that the emphasis on identifying strengths is consistent with promoting a positive self concept for all family members. Satir[171] identifies four potential problem areas in families: self worth, communication, rules, and the nature of the family's link to society; with self worth being primary, because of its pervasiveness. If one member's esteem suffers, the family suffers. Garbarino[172] defines positive self regard as one of the basic tools of healthy development. It is very important then, to build a method of working with families on a foundation of esteem-building.

Enhance the Parent-Child Relationship

The early infant-caregiver attachment relationship provides a "prototype" of later relationships. Once established or not established, this pattern is difficult to change and seems bound to repeat itself in later relationships, particularly if the cycle is negative.[173] If attachment is thwarted by an abusing, neglectful, or psychologically unavailable mother, or by one who is chronically depressed, the child's development is at risk.[174] [175] Depression, low

self esteem, being an abuse victim, and experiencing multiple stressors in relative isolation are all factors that seem to thwart formation of a strong maternal-child bond.

The results of an insecure attachment or emotionally unresponsive parent-child relationship appear to be devastating, as much or more so than a physically abusive relationship.[176] [177] Impairment in language and cognitive skills, considerable negative affect, low self esteem, poor impulse control, and non-compliance are all demonstrated in children whose mothers are psychologically unavailable or abusive.

"The results of an insecure attachment or emotionally unresponsive parent-child relationship appear to be devastating, as much or more so than a physically abusive relationship."

The implications for intervention when the parent-child (mother-child in particular) relationship is dysfunctional are many. Working to identify areas of competent mothering is necessary. Building a sense of confidence by providing information about children's needs is important. Working to enhance the mother's self esteem and to meet the mother's own emotional needs by providing support is crucial.[178] [179]

The field of parent education and support is not a highly developed discipline. Research on efforts to work with and/or "change" parents yields mixed results. There is currently scant evidence of long-term change of parental behaviors due to educational intervention.[180] When the task is approached from an academic or training framework, it is difficult to pinpoint what will produce change. Change agents are not methods or curricula; they are people. In a program they are teachers, social workers, paraprofessionals, nurses, or counselors. The relationships they build with parents "provide the scaffolds for building or re-building parenting strength."[181]

In essence, in families where the parent-child relationship is likely to be or already is in trouble, the tasks are: (1) to begin by parenting (re-parenting) the parent; (2) to develop a partnership based on mutual respect and collaboration; and (3) to provide a model relationship where the staff person is accepting, accessible, reliable, patient, persistent, consistent, and communicates a pervasive sense of caring.[182]

Chapter 4

The Plan

Way To Grow

Mission Statement

A proposed plan to promote school readiness of Minneapolis children by coordinating a continuum of comprehensive, community-based services that support and assist all parents in meeting the developmental needs of their children from conception through age five.

Goals

- Encourage families to make better use of existing community services.
- Help families to build a network of friends, relatives, and community people to support them in raising children.
- Expand very early identification of physiological and environmental factors which can be deterrents to school readiness.
- Identify needed services for families and children and find ways to support them.
- Raise public awareness about the importance of healthy child development from conception on and about practices that will promote healthy development.
- Raise the quality of community services by providing programs with information, technical assistance, and incentives for coordination.

Program Components

Component 1: Community Linkages

In order to increase the accessibility and utilization of existing services for Minneapolis families and children, **Way to Grow** would build a referral network. Families of children prebirth through age five would be able to call the central number at the **Way to Grow** office and get information on resources and services available to them in the Minneapolis area. Service providers would be able to call the central number and get specific information on other agencies, such as services offered, cost, openings, waiting lists, etc. This information would be updated at least quarterly. Simple forms and procedures would be developed for referral and follow-up of families by service providers throughout the Minneapolis area. **Way to Grow** would work closely with the Minneapolis and Minnesota Departments of Health in examining the need for and feasibility of an infant and child tracking system.

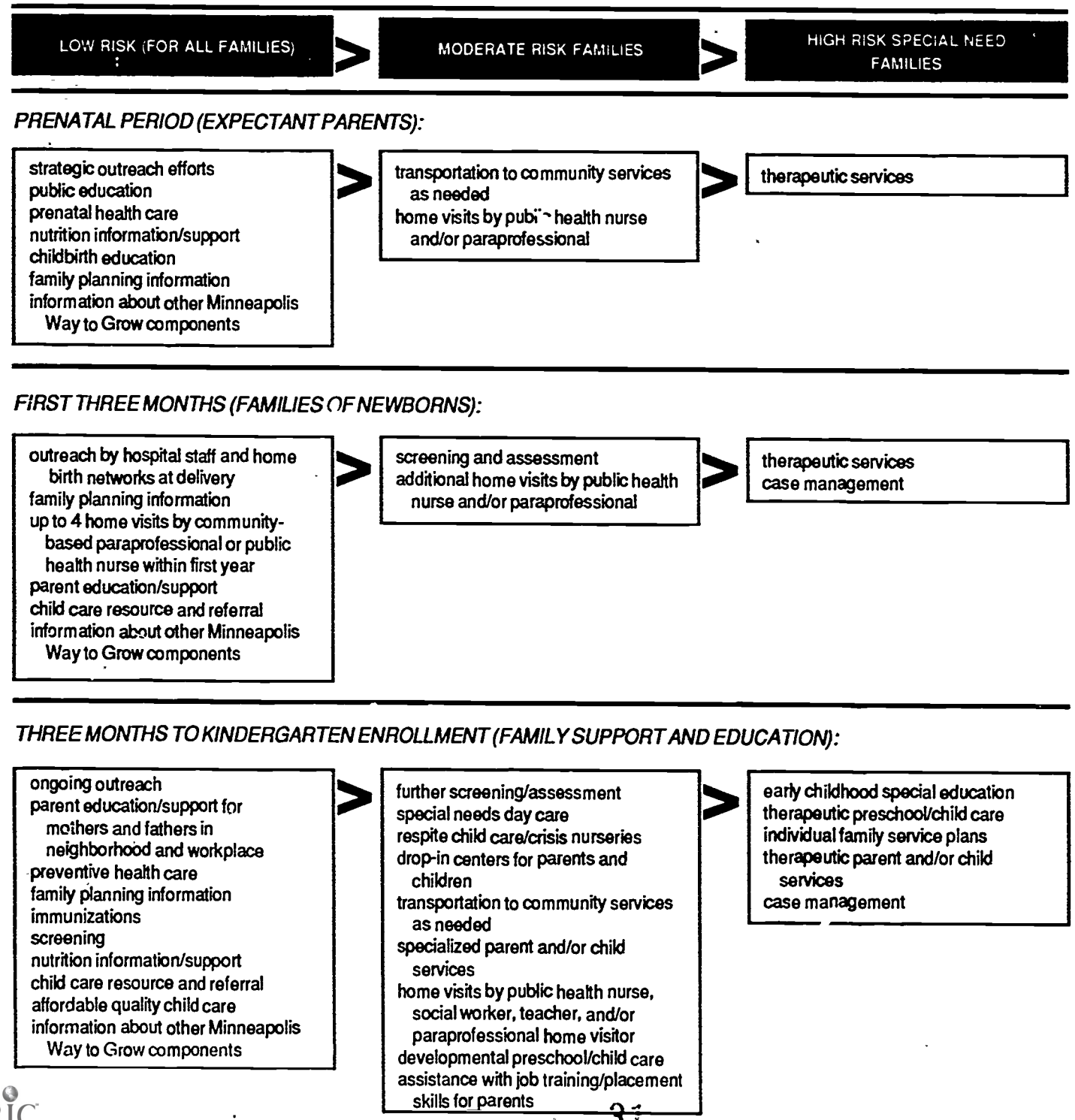
The process of collecting and updating information for this referral system would also identify needed services for Minneapolis families. **Way to Grow** would develop plans to expand existing resources to meet these identified needs. Innovative partnerships among service agencies would supply some needed services. In areas where the need for new funding is clearly indicated, **Way to Grow** would actively seek those resources.

Component 2: Direct Service Continuum

Way to Grow proposes a continuum of direct services for families of young children from conception through age five. This continuum would be available to all community residents, with service level based on identified need. See Figure 4.1.

Figure 4.1

Minneapolis Way to Grow Direct Service Continuum



Most services on this continuum are already offered by public and private providers in Minneapolis. (See Appendix D for a partial list.) Many need to be expanded and/or better coordinated to make this continuum a reality for all Minneapolis families. **Way to Grow** would provide this coordinating function, as well as identify and address needs for expansion or development of new services.

One area of need has already been clearly identified through the interviews, literature review, and other planning activities for **Way to Grow**. This is the need of **all** families for support and information in raising children. An excellent entry point for these services is the birth of a child. Currently, the Metropolitan Visiting Nurse Association (MVNA), which operates out of the Minneapolis Health Department, employs 25 public health nurses and five paraprofessional Parenting Aides. In 1986, MVNA visited 2,766 families in Hennepin County, of which 760 were identified as high risk. Most of this total were families of newborns.[1]

Home health care nurses from several hospitals and a few HMO's, such as Group Health Inc., make single home visits for maternity followup on request. They then will often refer families in need of further services to MVNA.

In 1986, 6,564 babies were born to Minneapolis residents. Of these, 36 percent were born to unmarried mothers. Sixty-eight percent were white; 31% were non-white. Twenty-two percent of the mothers had less than 12 years of education; educational levels were unknown for 19 percent of the mothers. Only 70 percent of the mothers began prenatal care within their first three months of pregnancy. The remainder began prenatal care later or were uncertain in which trimester they first sought care. Some received no prenatal care at all.[2] (See Figure 4.2.)

As discussed in Chapter 3, the home visits to families of newborns proposed for the first major **Way to Grow** initiative are an opportunity to bridge the gap between professional service agencies and the community. They also provide an initial, informal assessment of what kinds of support and information families may need. Finally, they are a mechanism to offer support and encourage parents to utilize services available to them in Minneapolis.

It is important to offer and promote these home visits to all families of newborns, both to accomplish the ends noted above and to reduce or remove any stigma currently attached to the use of outside support and assistance following the birth of a child. Nurses from both Hennepin County Medical Center and the Metropolitan Visiting Nurse Association acknowledge that they are not always able to gain access to the homes of high risk families. By employing trained community residents as home visitors and promoting the service to all families, **Way to Grow** hopes to significantly expand the number of families receiving home visits after the birth of a child.

To accomplish this, **Way to Grow** would issue a request for proposals for 11 small planning grants citywide to nonprofit agencies. The purpose of the planning grants would be to provide incentives for agencies to collaborate in seeking **Way to Grow** home visit funds for their communities. The 11 communities will be defined by boundaries used by the Minneapolis Planning Department, since much demographic information is already collected using these defined areas. (See Figure 4.3.) Operating grants would be provided to collaboratives in each community that offered a cooperative, well-organized, feasible, and sensitive approach to delivering home visit services as evidenced in the proposals resulting from their planning grants. The home visit expansion would be phased in gradually, beginning in about four communities the first year.

A community grantee for operating funds would be required to assemble a supervisory team for the paraprofessional home visitors who will work out of its collaborative. This team would include individuals such as a public health nurse, a social worker, and a Minneapolis Public Schools Early Childhood Family Education teacher. A community organizer/outreach worker would also be on the staff. The team would then recruit and hire paraprofessional home visitors

Figure 4.2

Minneapolis Resident Live Births, 1986
By Community By Selected Characteristics
Age Group: All Ages

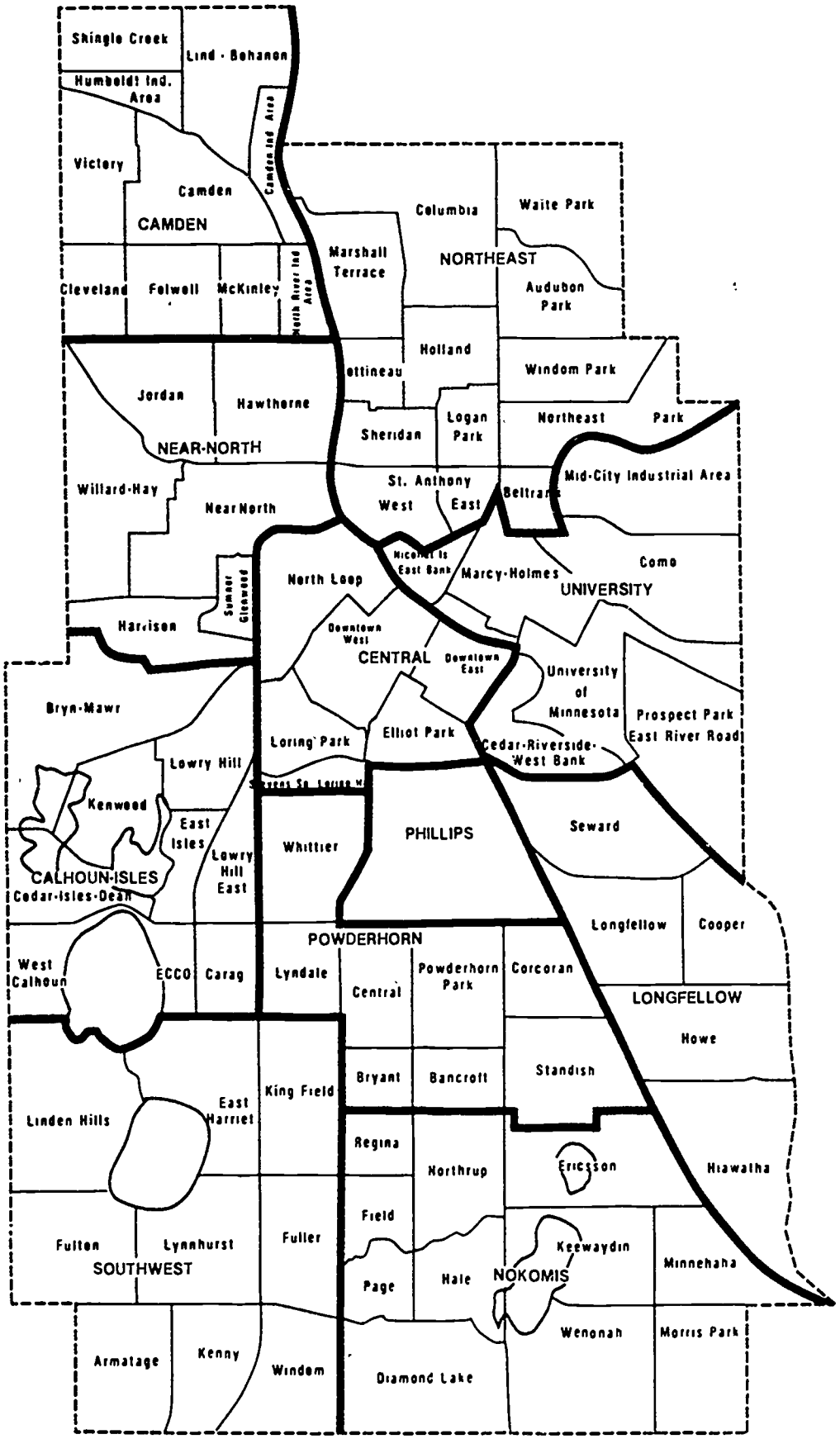
CHARACTERISTICS	MPLS TOT.	CAM. AREA	N.E. AREA	N.N. AREA	CEN. AREA	UNV. AREA	C.I. AREA	PHL. AREA	POW. AREA	LNG. AREA	NOK. AREA	S.W. AREA	UNK. AREA
TOTAL LIVE BIRTH	6564	574	679	968	198	297	313	471	1120	510	660	758	16
LEGITIMACY													
YES	4202	423	496	370	89	224	237	165	576	385	552	675	8
NO	2362	150	183	598	109	72	76	306	543	126	107	84	8
UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0
RACE													
WHITE	4426	490	637	350	85	189	266	120	591	435	574	681	7
BLACK	1236	40	8	475	70	48	30	112	321	22	55	48	7
AM. INDIAN	475	22	22	68	21	12	9	158	112	27	14	6	2
ASIAN/PAC IS	357	14	6	68	20	38	8	72	81	17	13	17	0
OTHER	2	0	0	0	0	0	0	1	1	0	0	0	0
UNKNOWN	68	7	7	7	0	8	2	9	12	8	4	4	0
BIRTH WEIGHT													
0-2000 GR.	185	12	13	50	7	9	8	18	31	11	13	10	2
2001-2500 GR.	336	31	29	70	18	11	16	22	60	22	25	22	2
2501 + GR.	6021	526	633	844	169	276	288	430	1016	478	622	725	12
UNKNOWN	22	6	5	3	3	0	0	1	2	0	0	2	0
MOTHER EDUCATION													
<8 YEARS	116	3	2	32	3	1	2	36	31	3	1	2	0
8-11 YEARS	1041	79	81	315	46	17	17	141	214	61	34	34	7
12 YEARS	1582	196	173	289	40	40	50	117	293	120	159	100	4
13+ YEARS	2513	195	225	198	67	191	164	77	323	241	343	483	5
UNKNOWN	1305	99	198	136	40	46	80	99	262	87	121	137	0
GESTATION													
<35 WEEKS	230	16	25	63	8	8	12	16	42	13	12	15	0
35 WEEKS	110	9	14	26	3	4	8	4	17	10	7	7	1
36 WEEKS	175	13	9	30	5	10	6	21	38	9	11	20	2
37+ WEEKS	4516	419	404	673	134	215	202	295	714	370	513	565	11
UNKNOWN	1533	115	227	178	46	61	82	137	310	106	119	151	2
PRENATAL CARE													
NONE	153	4	13	25	8	6	3	25	34	17	9	7	2
1ST TRIMESTER	3678	389	381	493	91	185	194	138	516	308	460	513	8
2ND TRIMESTER	1104	72	66	233	43	44	39	140	231	73	76	82	5
3RD TRIMESTER	300	12	14	74	18	10	7	53	73	17	9	12	0
UNKNOWN	1329	96	206	144	36	51	69	116	265	95	105	144	1
PRENATAL VISITS													
NONE	153	4	13	25	8	6	3	25	34	17	9	7	2
1- 2	128	3	7	40	10	1	0	28	25	5	6	3	0
3- 4	244	14	10	68	9	6	5	40	60	19	6	6	1
5- 6	324	17	28	72	14	11	9	52	73	20	13	14	0
7- 8	584	46	37	117	18	17	20	49	129	42	53	50	6
9-10	958	113	103	177	21	41	44	62	129	74	85	109	0
11-12	1269	134	118	159	34	66	59	51	192	102	162	189	1
13-14	896	75	81	102	29	53	58	34	124	73	126	140	1
15+	634	67	64	75	15	33	42	21	96	56	78	86	1
UNKNOWN	1374	101	221	134	39	60	71	107	256	104	122	154	4

NOTE: SUMMATION OF INTERNAL VALUES MAY NOT EQUAL TOTALS DUE TO ROUNDING

SOURCE: Minnesota Department of Health Statistics, November 1987

Figure 4.3

Minneapolis Communities and Neighborhoods



from the community, with special efforts made to attract qualified persons who reflect the demographic makeup of that community. Guidelines for the recruiting and hiring process would be provided by the central **Way to Grow** Board.

Once home visitors are hired, 120-180 hours of pre-service training, as well as ongoing in-service training, would be coordinated by the central **Way to Grow** staff. The community **Way to Grow** team would provide daily supervision and support for the home visitors, with a specific supervisor identified for each home visitor. The team would also help determine when a family should be referred for additional assessment or services, or when a family might benefit from direct visits from the public health nurse, social worker, or Early Childhood Family Education teacher.

Home visitors would provide a variety of services to families in their community, with the bulk of their time devoted to home visits in the first year of an infant's life. Services would include: (1) parent education; (2) enhancement of informal support systems; (3) information about available community services; (4) suggestions as to what further assessment or services the family may need; and (5) provision of some basic advocacy functions for families who use a large number of services.

Intensive outreach would be conducted by the central **Way to Grow** office and the community collaboratives through their community organizers/outreach workers. This ongoing, strategic outreach would begin through prenatal health care providers, hospital obstetrics staffs, and well-child health care providers citywide. It would also reach out to other service providers, the general public, and directly to families of newborns, working in close cooperation with the Minneapolis Health Department.

Home visitors would begin contact with most families on request after the birth of their child. But for women identified to be at risk, they would offer home visits during pregnancy, encouraging women to begin or continue regular prenatal health care and realistically prepare for the baby to come. When appropriate, the home visitor might facilitate small groups of parents or expectant mothers at community sites. Parents would be encouraged to participate in the Minneapolis Public Schools Early Childhood Family Education program (See Appendix F) or other parent education programs in their community as soon as they are comfortable doing so.

Home visitors would continue to act as resource persons to families (including contacts by telephone) as needed until the children enter kindergarten, or the family moves to a different community. In the latter case, families would be referred to the **Way to Grow** office in their new community, and a new home visitor could resume contact with them. The original home visitor would remain involved with the family through the transition period and until this contact is established.

Component 3: Public Education/Outreach

In order to reach and involve all Minneapolis families of children prebirth to kindergarten enrollment, **Way to Grow** would implement comprehensive, ongoing outreach strategies citywide. Obstacles to participation of both families and service providers would be identified and addressed. The **Way to Grow** central office would also assist local agencies in developing outreach plans for their communities.

Public education strategies to promote the healthy development of children and families would be employed through posters, newsletters, brochures, billboards, public service announcements, etc. An obvious first focus would be the promotion of early and regular prenatal care, which could be offered in cooperation with the March of Dimes Foundation.

Way to Grow would report annually to the Minneapolis Youth Coordinating Board and other appropriate policymakers on its activities and on family service needs identified through **Way to Grow.**

Component 4: Education/Training

A primary function of **Way to Grow's** training component would be 120 to 180 hours of pre-service and ongoing in-service training of paraprofessional home visitors hired through community collaboratives. Current curricula and consultant trainers from a variety of disciplines will be combined carefully and supplemented as necessary with new training modules to be delivered by **Way to Grow** staff and others. The goal will be to create a comprehensive package of pre-service and in-service training uniquely suited to the **Way to Grow** home visit expansion. Training will include a blend of theory and technique, offered through readings, visual aids, lecture, discussion, role playing, etc., to engage paraprofessionals with a variety of learning styles.

Consultation and support for child care homes and centers and other early childhood agencies will be provided by **Way to Grow**, again utilizing training provided by existing agencies whenever possible.

Finally, **Way to Grow** would promote (when available) and develop (when needed) pre-service and continuing education on early childhood topics for professionals such as pediatricians, obstetricians, family practitioners, nurses, social workers, child protection workers, etc. The content would be focused on areas such as: an overview of Minneapolis **Way to Grow**, normal child development, parent-child attachment and interaction, developmental issues, ethnic and cultural sensitivities, and traits of healthy families.

Component 5: Research/Evaluation

Research and evaluation of **Way to Grow** activities will be a critical part of **Way to Grow** administration. Evaluation efforts would focus initially on establishing data collection systems for both formative (process) and summative (outcome) evaluation. It is important to begin with formative evaluation, because it is futile to look at outcomes of a service delivery system without first determining how well the system is operating. Formative evaluation efforts would include measurement of parent and service provider satisfaction with **Way to Grow** activities.

Assuming this base of formative evaluation, summative evaluation could include assessment of outcomes such as:

- use of community services by families;
- availability of support systems for families (involvement of fathers, other relatives, friends, service providers, etc).;
- birth weights of babies;
- child accident rates;
- rates of prenatal care obtained within first trimester;
- public awareness of early childhood
- is. ues;
- reported cases of child abuse;
- rates of screening and assessment; and
- kindergarten benchmark scores.

Evaluation and research efforts would be shared. The evaluation would be designed by central **Way to Grow** staff, with expert consultation. The University of Minnesota and Wilder Research Center could potentially assist in research design. Implementation would be a joint effort of community collaborative staff, central **Way to Grow** staff, and where appropriate, independent evaluators. The Minneapolis City Planning Department would continue to collect descriptive data from each of the 11 communities.

The outcomes listed above, as well as factors such as parent-child attachment and interaction styles, nutritional practices, parental knowledge and attitudes, coping skills, and home environments of **Way to Grow** home visit recipients would be measured and compared where possible with measures of families not receiving home visits at the birth of their child. Since the **Way to Grow** home visit expansion is likely to be phased in gradually, control group populations will be available within Minneapolis for a time and then could be drawn from nearby

communities.

Instruments such as: the H.O.M.E. scale by Caldwell and Bradley; the Nursing Child Assessment Screening Tool (NCAST) by Barnard; the Community Interaction Checklist by Wahler; the Family Coping Inventory by McCubbin et al.; the Family Support Scale by Dunst et al.; the Parental Attitude Checklist by Boyd and Stauber; the Parenting Stress Index by Abidin; the Strange Situation by Ainsworth and Wittig; and child screening instruments such as the Preschool Screening Inventory by Ireton would be possibilities for outcome assessment measures.

The Implementation

Organizational Structure

We recommend that the Minneapolis Youth Coordinating Board assume primary responsibility for implementing **Way to Grow**. Community Linkages, Public Education/Outreach, Education/Training, and Research/Evaluation (Components 1, 3, 4, and 5) would be implemented by **Way to Grow** staff, operating out of a central office. Services listed for Component 2, Direct Service Continuum, would be implemented by public and private providers citywide, with linkages and some support services provided by **Way to Grow** staff.

Way to Grow staff would report directly to a 30-member **Way to Grow** Management Board, which would be appointed by the Minneapolis Youth Coordinating Board. To keep the Management Board to a workable size, it is necessary to limit the number of organizational entities represented on the Board. The Board would have the authority to create advisory task forces and ad hoc groups for specific program direction, allowing for the input of additional organizations and agencies.

We suggest staggered terms of two to three years for representatives of the following:

American College of Nurse Midwives
American College of Obstetricians and Gynecologists
Community Clinic Consortium
Greater Minneapolis Chamber of Commerce
Greater Minneapolis Council of Churches
Greater Minneapolis Day Care Association
Hennepin County Community Services Department
Hennepin County Medical Center
Indian Health Board of Minneapolis Inc.
Minneapolis Children's Medical Center
Minneapolis Early Intervention Committee
Minneapolis Health Department
Minneapolis Public Schools Early Childhood Family Education Program
Minneapolis Public Schools Special Education Programs
Minnesota Association for the Education of Young Children
Minnesota Chapter of the American Academy of Pediatrics
Minnesota Council of Health Maintenance Organizations
Minnesota Council on Foundations
Parents in Community Action Inc. (Head Start)
United Way of Greater Minneapolis Board of Directors
United Way Council of Agency Executives (5 representatives)
Urban Coalition of Minneapolis
Four Members-at-Large, all parents of young children

Since the Management Board will be awarding grants for home visit services to community collaboratives which may involve organizations that are also members of the **Way to Grow** Board, bylaws and proposal review procedures must be developed to address potential conflicts of interest.

Estimated staffing needs for the central **Way to Grow** office include the following:

1 FTE Program Director:

Responsible for overall management of **Way to Grow**. Reports to and works closely with **Way to Grow** Management Board and Executive Director of Youth Coordinating Board. Advocates for **Way to Grow** activities with policymakers and funders. Supervises central **Way to Grow** staff.

1 FTE Community Linkages Coordinator:

Responsible for establishing and updating central information and referral network for families of children prebirth through age five and service providers who work with these families. Identifies areas of service needs. Works closely with support staff delivering information and referral services.

1 FTE Education/Training Coordinator:

Responsible for coordinating pre-service and in-

service training of paraprofessional home visitors. Offers consultation to other early childhood service providers in Minneapolis. Promotes and develops pre-service and continuing education modules on early childhood issues for professionals from other human service disciplines. Designs public information efforts in cooperation with Communications Coordinator. Works cooperatively with other training agencies and consultants citywide.

1 FTE Communications Coordinator:

Responsible for citywide outreach for **Way to Grow**. Assists community collaboratives in developing local outreach plans for their home visit expansion. Responds to requests for information about **Way to Grow**. Works closely with Education/Training Coordinator in public education efforts.

1 FTE Planning/Evaluation Coordinator:

Responsible for designing and implementing research and evaluation efforts in collaboration with Program Director, other **Way to Grow** staff, and consultants. Assists community collaboratives in planning data collection efforts. Responsible for annual planning and reporting process, in cooperation with Program Director and other **Way to Grow** staff.

1 FTE Administrative Assistant:

Responsible for overall office management and operation of computerized referral system. Supervises office support persons. Works closely with Program Director.

2 FTE Office Support Persons:

Respond to telephone requests for information from families and service providers. Perform clerical tasks for **Way to Grow** staff.

Relationships among the Minneapolis Youth Coordinating Board, **Way to Grow** Management Board, **Way to Grow** staff, Minneapolis Early Intervention Committee, staff of public and private agencies and organizations citywide, and the general public are illustrated in Figure 5.1.

Timeline

The suggested timeline for the start-up of **Way to Grow** and the home visit expansion is shown in Figure 5.2. The tasks listed in the left column would be undertaken by the **Way to Grow** Management Board and staff unless identified otherwise. Community linkages and Public Education/Outreach (Components 1 and 3) would begin in December 1988 and be ongoing. **Way to Grow** home visits to families by trained paraprofessionals would begin in January 1990, with interim time devoted to requests for proposals, proposal planning and technical assistance, proposal review, set-up, and training for home visitors. This amount of time is necessary for effective implementation of the **Way to Grow** home visit expansion.

Timelines for other **Way to Grow** activities would be established by its Management Board, based on priorities which emerge from work performed for Component 1, Community Linkages.

Costs and Funding

The estimated annual cost for the central office and staff for **Way to Grow** is between $360,000 and $495,000. This includes five professionals and three support staff; contracted services (for training, research and evaluation design, data collection, etc.); and miscellaneous expenses such as computer hardware, software, and other equipment, printing, telephone, postage, office rental, etc. (See Figure 5.3.) Based on an approximate number of 28,000 children ages birth through four in Minneapolis, this is an annual cost of less than $16 per child.

Initially, these funds should be sought

Figure 5.1

Relationship of Way to Grow to Established Boards, Agencies, and Constituencies

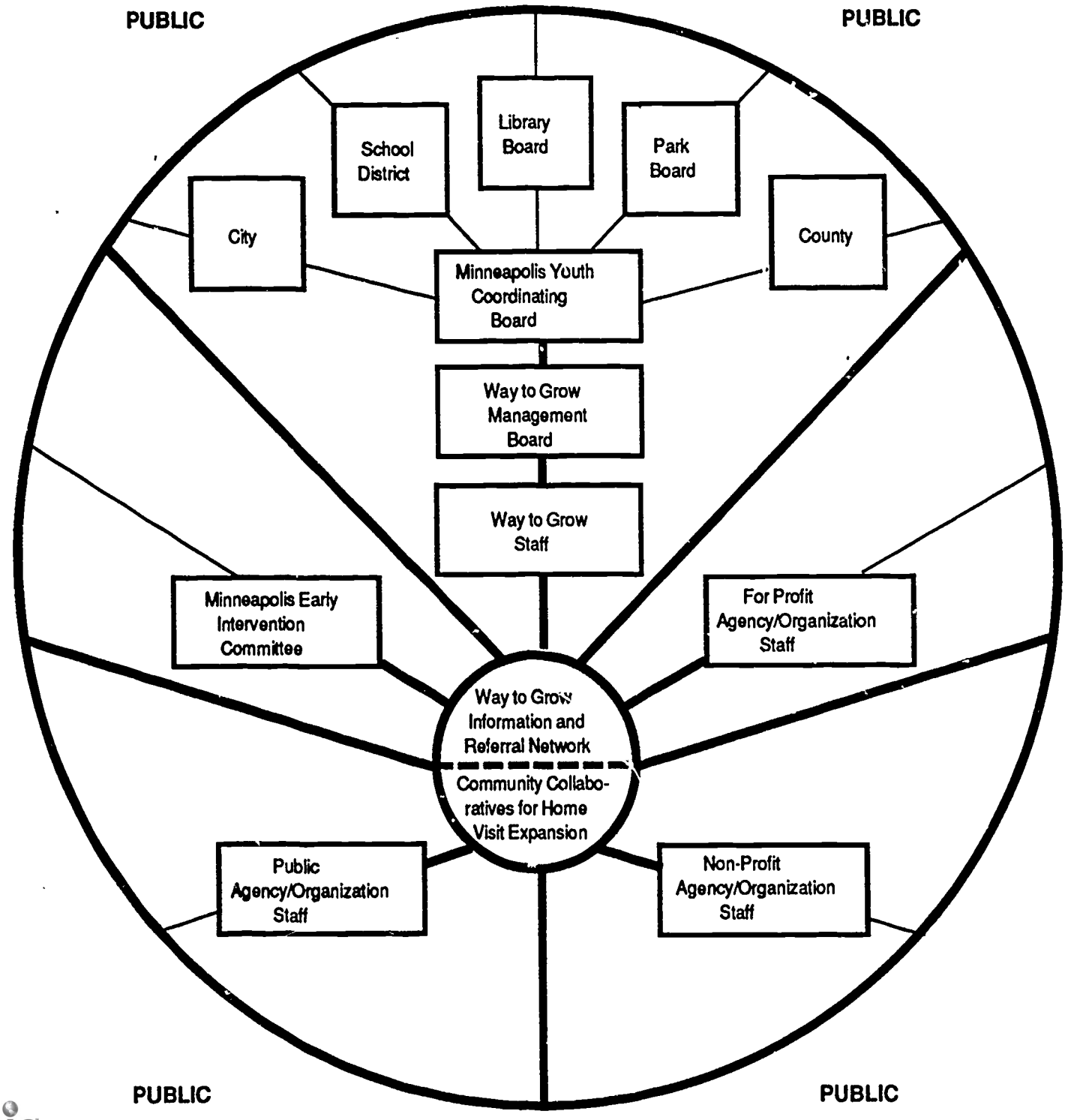


Figure 5.2

Way to Grow Start-up Timeline

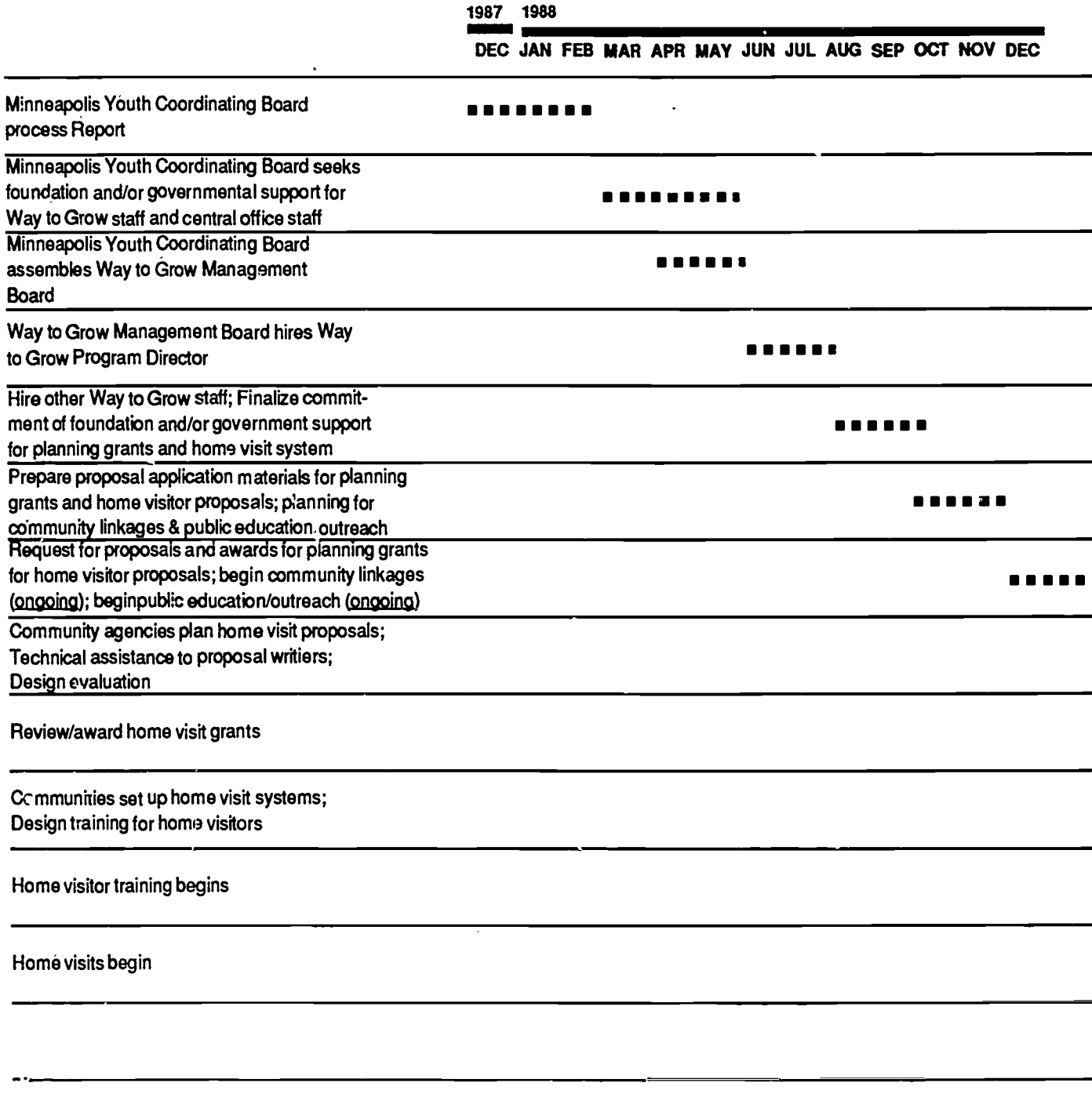


Figure 5.2

Way to Grow Start-up Timeline (continued)

	1989 JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	1990 JAN
Minneapolis Youth Coordinating Board process Report													
Minneapolis Youth Coordinating Board seeks foundation and/or governmental support for Way to Grow staff and central office staff													
Minneapolis Youth Coordinating Board assembles Way to Grow Management Board													
Way to Grow Management Board hires Way to Grow Program Director													
Hire other Way to Grow staff; Finalize commitment of foundation and/or government support for planning grants and home visit system													
Prepare proposal application materials for planning grants and home visitor proposals; planning for community linkages & public education/outreach													
Request for proposals and awards for planning grants for home visitor proposals; begin community linkages (ongoing); beginpublic education/outreach (ongoing)	■	■	■										
Community agencies plan home visit proposals; Technical assistance to proposal writiers; Design evaluation		■	■	■	■	■	■	■	■	■	■	■	
Review/award home visit grants						■	■	■	■	■			
Communities set up home visit systems; Design training for home visitors								■	■	■	■	■	■
Home visitor training begins											■	■	■
Home visits begin													■

Figure 5.3

Way to Grow Central Office Estimated Budget

Salaries

Program Director	$40,000 -55,000
Community Linkages Coordinator	30,000 - 45,000
Education/Training Coordinator	30,000 - 45,000
Communications Coordinator	25,000 - 40,000
Planning/Evaluation Coordinator	25,000 - 40,000
Administrative Assistant	20,000 - 35,000
2 Office Support Persons	30,000 - 60,000

Fringe Benefits

Health, Dental, Life	21,000 - 21,000
FICA (7.2%)	14,400 - 23,040
Workers Compensation (1%)	2,000 - 3,200
Staff Development (2%)	4,000 - 6,400

Other Expenses

Contracted Services (Research Design, Data Collection, Training, etc.)	30,000 - 30,000
Mileage @ $0.21 Per Mile/Parking	3,500 - 3,500
Office Rental (3,000 sq. ft. @ $7 per sq. ft.)	21,000 - 21,000
Telephone	1,900 - 1,900
Copying	5,000 - 5,000
Printing/Keylining	35,000 - 35,000
Postage	5,000 - 5,000
Materials and Supplies	2,500 - 2,500
Equipment	2,500 - 2,500
Multi-User Microcomputer with 3 Terminals, Printer, Software, and Training	15,000 - 15,000
TOTAL	**$362,800 - 495,040**

primarily from private foundations, since they are new expenditures and have the potential of effecting systemic change in the way families are served in this city. Foundation support could be conditional on development of a plan for conversion to "hard" funding within five years. This plan would identify means of ongoing public and private support.

The average annual cost per community to implement the expanded home visit services is estimated at about $220,000 to $255,000. This includes salaries for a public health nurse, social worker, a halftime Early Childhood Family Education teacher, a community organizer/outreach worker, one clerk, six paraprofessional home visitors, and computer capacity. (See Figure 5.4.) It should be pointed out that up to $80,000 of this may not require any new money, but be covered by reassigning currently employed personnel to new community locations.

Full-time home visitors would be expected to visit four families per day for four days of the week, with the fifth day devoted to record-keeping, staff meetings, etc. Staff development would be scheduled periodically during time usually allocated for home visits. Sixty-six home visitors citywide should be able to handle the approximate 6,600 births per year, since the service is voluntary and not all families will choose to participate. The number of home visitors in each of the 11 communities will vary, however, based on need and demand within each community. This means that the budgets will also vary from one community to another.

Initial potential funding (dollar and/or in kind) sources for **Way to Grow** could include: private foundations, both Minnesota foundations and others; Minneapolis Public Schools Early Childhood Family Education and Early Childhood Special Education; Hennepin County Community Services Department; and Minneapolis Health Department.

Federal funding possibilities for these and other **Way to Grow** activities include sources such as: Maternal and Child Health Block Grant; WIC; Head Start; Medicaid; Even Start; Child Abuse and Neglect Prevention and Treatment.

Figure 5.4

Way to Grow Community Collaboratives Average Estimated Budget

Public Health Nurse	$25,000 - 32,000
Social Worker	25,000 - 32,000
0.5 Early Childhood Family Education Teacher (Tutor)	16,000 - 16,000
Community Organizer/ Outreach Person	14,560 - 20,800
6 Home Visitors @ $14,560 Each (average number per community)	87,360 - 87,360
Office Support Person	14,560 - 20,800
Fringe Benefits @ 20%	36,496 - 41,792
Terminal and Modem to Link to Central Computer	1,000 - 1,000
Telephone	1,600 - 1,600
Mileage/Parking	2,000 - 2,000
TOTAL	**$223,576 - 255,352**

Act; National Institute of Child Health and Human Development; U.S. Departments of Health, Human Services, Agriculture, and Education; Public Law 99-457; National Institute of Mental Health; and Title XX.

At full implementation, employing 66 paraprofessional visitors citywide, with a professional supervisory team, support staff, and related expenses in each of 11 communities citywide, the total annual cost would be about $2.8 million for the home visit component. (Again, not all of this should require new money.) This averages about $400 per newborn, or $100 per child birth through age four in Minneapolis. This system has the potential, however, for performing outreach, basic screening, and preventive programming for public and private service agencies citywide.

For the first operating year, if the home visit expansion is phased in at four of 11 community sites, the total cost would be less than $1.5 million, including all costs of the central **Way to Grow** office, and 11 planning grants at $3,000 each (a one-time cost).

Chapter 6

Some Issues

Issues Regarding Organizational Structure

It is difficult to conceptualize an organizational structure when planning a system that involves the collaboration of several major institutions and the cooperation of many individual players. In the case of **Way to Grow**, the major institutions are the Minneapolis Public Schools, Minneapolis Health Department, and Hennepin County. However, a wide variety of public, nonprofit, and for profit agencies and organizations are involved as additional players. Therefore, when alternatives for the so-called "lead agency" were examined, none of these agencies seemed appropriate. Each of the three major collaborators has an already established mission, clientele, and public image. **Way to Grow** must have its own identity in order to succeed in serving all families of children pre-birth through age five. Additionally, if any one of these institutions assumed principal responsibility, it would be natural for the other two, as well as other agencies and the general public, to assume that ultimately **Way to Grow** was a Health or Public School or County program. This could impair the collaboration required for **Way to Grow**.

The Minneapolis Youth Coordinating Board (MYCB) appears to be a logical group to implement Way to Grow. Language in the 1985 joint powers agreement among Hennepin County, the City of Minneapolis, the Minneapolis School District, the Minneapolis Park and Recreation Board, and the Minneapolis Library, which establishes the Minneapolis Youth Coordinating Board, reads as follows:

> It is the purpose of the Parties to this Agreement in creating a Youth Coordinating Board to improve the ability of public agencies and services to promote the health, safety, education, and development of the community's youth and to create an organizational structure to improve coordination among the agencies and services and to accomplish that objective by strengthening cooperation and providing an improved means to identify and remedy conditions which hinder or prevent the community's youth from becoming healthy, productive members of society.

Three issues emerge when considering the MYCB as lead agency. The MYCB has not been perceived as an organization involved in direct service; its membership does not include any non-public representatives; and its focus is on youth from birth to age 20.

Another option could be to create a new public/private nonprofit agency whose sole purpose would be the implementation of **Way to Grow**. There was almost no support for this option from our respondents. They felt that the new agency could become a new bureaucracy with questionable operating authority.

Therefore, this plan suggests that the MYCB assume organizational responsibility for the implementation of **Way to Grow**. To address the limitations of this option, the MYCB would appoint a Management Board composed of public and private providers and consumers to hire staff and to direct Way to Grow operations. This proposal seems to maximize the advantages and minimize the disadvantages of all available choices.

Issues Regarding Mobility

During our interview process, many respondents expressed concern about two related issues which act as barriers to effective service delivery: lack of transportation to services and residential mobility. Families with infants and small children without access to a car are at the mercy of the elements year-round while waiting for and transferring between buses to get to their destinations. This takes a fairly high level of motivation to surmount. Some parents will opt out of the struggle and not participate in preventive health care for themselves or their children, to say nothing of other community services such as parent education.

The second issue relates to the fact that some families, for a variety of reasons usually

related to poverty, move frequently from one living situation to another. It can be very difficult for service providers to reach or stay in touch with these parents and children.

Way to Grow has no easy answers to these issues because none exist. However, it would address them through its diverse management board; its expansion of home visits; its promotion of community locations for delivery of a wide variety of services; its referral network for public and private agencies; and its coordinated approach to resolving problems in service delivery.

Related to the client mobility issue is the interest of some providers in the establishment of a tracking system for infants, children, and families. Models for such systems exist in North Carolina and other states and are embryonic within agencies here in Minnesota. Many questions arise when conceptualizing a tracking system which could be used across a variety of agencies. These include: What kinds of data will be collected and in what form? Who will handle the data? Who will have access to the data? How will access be controlled? How long will data be retained? How will family and individual rights to privacy be protected? How will individual agency autonomy be balanced with collective data management? These and other questions were not resolvable within this six-month planning period.

The Minneapolis Health Department has been meeting with State Health Department officials regarding development of a tracking system in Minneapolis. The **Way to Grow** Management Board could participate actively in any collaborative development of a tracking system with these and other agencies.

Cost Issues

The activities proposed for the **Way to Grow** system, as well as the central office and staff to implement those activities, will cost money. As the Committee for Economic Development points out: "Any plan for major improvements in the development and education of disadvantaged children that does not recognize the need for additional resources over a sustained period is doomed to failure."[1] Since **Way to Grow** is designed to prevent deterrents to school readiness, locating the funds may be a challenge. Prevention is not glamorous or dramatic, just as routine prenatal care seems a bit "ho-hum" compared with the dramatic life and death activities of a neonatal intensive care nursery. Yet there is no question that the **per person** cost of preventive care or education is less than rehabilitative and therapeutic approaches.

For instance, prenatal care (excluding labor and delivery) costs about $400, compared with an average of $14,700 for each low birth weight infant.[2] The latter figure refers only to costs of neonatal intensive care services, and does not include any other costs related to disabilities resulting from low birth weight. A $1.00 investment in quality preschool education returns $4.75 because of lower costs of special education, public assistance, and crime.[3] It is reasonable to assume that over time, investment in **Way to Grow** will allow us to recycle increasing amounts of money from treatment into prevention, with better results and eventual cost returns.

Prevention is a quiet approach to human problems. It is also an eminently sensible one. The public has accepted basic health and sanitation procedures to prevent or limit disease. Yet there continues to be reluctance to invest in broad prevention activities for the general population to assure school readiness, as well as to prevent school failure, teen pregnancy, juvenile delinquency, and child abuse and neglect. In 1986, the nation spent $264 billion on education for children age six and older, while it spent only about $1 billion for educating children age five and younger.[4] But as the Committee for Economic Development states:

> Failure to educate is the true expense--for both society and individuals. The most recent estimates suggest that each year's class of dropouts will cost the nation more than $240 billion in lost earnings and foregone taxes over their lifetimes. This does not include the billions more

for crime control and for welfare, health care, and other social services that this group will cost the nation.[5]

The costs in human suffering of school failure and all its attendant problems are immeasurable. It's time to follow through when we say that our children are our greatest resource. It's time to ride the current wave of interest in early childhood issues from both the public and private sectors nationwide. It's time to listen to the overwhelming support of those involved in the planning process for **Way to Grow** over the past six months.

It's time to listen to the children.

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Appendix B

Discussion Questions for Structured Interviews June and July 1987

1. What do you see as your organizational mission?

2. What do you feel are the biggest barriers to your accomplishing this mission?

3. Think about a success story relative to your mission -- an individual who benefited from your (agency's) services or something that worked well for you. What do you think led to this success?

4. If you were to design a plan for comprehensive, coordinated services for Minneapolis families and their children, prebirth to age six, how would you define the target population?

5. What would you include in this plan?

6. How would you make sure that these services reach the target population as you define it?

Appendix C

Reprint: "Focusing on Prevention in the First Sixty Months"

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Point of View

Focusing On Prevention In The First Sixty Months

by
Michael N. Castle
Governor Of Delaware
Chairman, Committee On
Human Resources and Task Force On Welfare
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The first sixty months are the most critical years in a person's life, a time when the foundations of personality, physique and character are developed. Yet, they are also the forgotten months, when many people unprepared for pregnancy and/or lacking parenting skills, find themselves raising a child. The result, children who are not provided the important health, education and social opportunities needed to maximize their future potential.

Problems not identified and addressed during this stage of life often cannot be completely and permanently corrected during adolescence and adult life. For that reason we need to change the focus of our present human and social service system which only addresses the symptoms of problems.

By focusing on prevention and early identification of potential problems, by involving parents and others who have close contact with young children, we have the opportunity to treat the causes, to make good on the promise of opportunity for the next generation, and to remove barriers to self-sufficiency and productivity.

As Chairman of the National Governors' Association's Human Resources Committee, I initiated an early childhood project entitled—"Focus on the First Sixty Months"— in the fall of 1985. The project grew out of my belief that we are not doing enough to solve the problems associated with early childhood because we are still treating symptoms when we could as easily be attacking their causes. In February, 1986, the committee held a national conference, featuring presentations by individuals from public and private institutions at the state and local levels. These speakers described successful programs aimed at preventing health, education and social problems among children zero to five years of age. (See *Zero to Three*,September, 1986 for the remarks of Irving B. Harris.) At the close of the conference, I called on the NGA to develop a handbook of prevention activities for young children to present to each Governor. In July, 1987 this report, *Focus on the First Sixty Months*, was published.

At the same time, the nation's Governors concluded a year-long effort of five task forces to develop comprehensive state action plans to enhance human potential and bring down the barriers to self-sufficiency. Two fundamental conclusions emerge in the report of the five task forces, *Making America Work: Bringing Down the Barriers.*

- First, human barriers often share common root causes including unmet needs for food, clothing, shelter and medical care, and inadequate basic academic skills, leading to diminished self-esteem and life options.
- Second, the earlier intervention begins the more likely it is to meet with success.

A prevention strategy for young children

For children, the challenge is to prevent the cycle of dependency from claiming another generation. Key elements of a sound prevention strategy for children include ensuring adequate health care, nutrition, family nurturing, and educational, social, and physical development.

Prenatal health care

Prenatal care, including medical care, nutrition, and healthy life habits, is truly an ounce of prevention worth a pound of cure. Early and continuing maternity care is essential. It should include regular medical exams and treatment, nutrition counseling and the food to provide a healthy diet, and safe and appropriate delivery and support services.

Children's health care

Children need decent health care at every stage of development, and health care is critically important as a transition service when individuals move from welfare dependency to self-sufficiency. Good health care begins with comprehensive care early in the mother's pregnancy, throughout labor and delivery, and continues throughout childhood, with a focus on the child's prevention, acute, and chronic health needs.

Preventive and primary health care for children can

detect and treat problems that develop during infancy. Providing primary and preventive health care is expensive, but it costs less—both in economic and human terms—to prevent illness and hunger than it does to treat the results.

At a minimum, primary and preventive health care should include:

- Well-baby clinics that provide early, periodic screening, diagnosis, and treatment;
- Full immunization against all preventable childhood disease;
- Supplemental nutrition assistance;
- Medicaid coverage to women and young children with family incomes less than the federal poverty level but over a state's AFDC eligibility levels; and
- Comprehensive adolescent health care services.

Family resource programs

The American family structure has changed over the last fifty years, and many young parents feel a sense of isolation and frustration as they try to work *and* successfully raise children. Parents need to know that they are not alone and that the larger community will support their efforts.

Diverse, independently funded programs have quietly emerged in the last ten years in all kinds of communities to address these needs. Family resource programs can offer parents education, information, advice, and emotional support. Common characteristics of these programs include: child development classes; information and referral services; nutrition counseling; hotlines; peer support groups; parent-child communication skills; and positive discipline techniques.

Child care

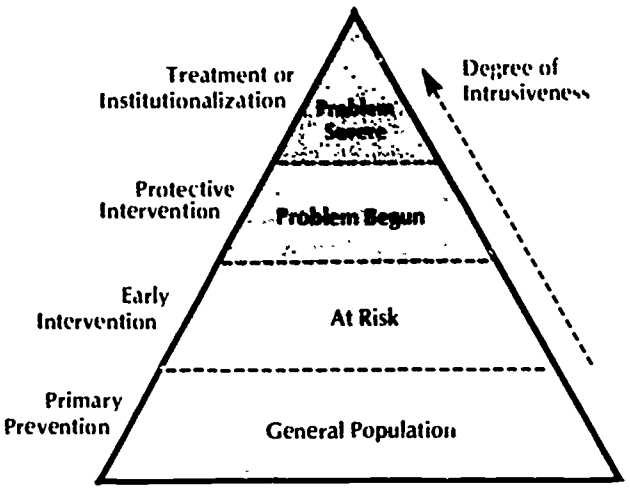
Child care is a critical ancillary service as individuals move from welfare dependency to independency. It is also a critical element in a prevention strategy for children. Quality child care not only provides a safe environment for children while their parents participate in training or work; it also offers valuable education and social opportunities.

What constitutes quality child care? Research suggests the following elements of a "quality" child care program: small group size, high staff-to-child ratios, good health and nutrition standards, parental involvement, and training requirements for caregivers.

Further, as child care strategies are developed, states need to address child care needs in a cohesive, coordinated effort that uses unified standards of availability, quality, and affordability.

A continuum of intervention

As a nation, we have tended to permit the tragedy of treatment needs—the crisis—to overshadow the potential of prevention. Governors, human service agencies, professionals, parents and citizens must begin to refocus their thinking and redirect some of their resources toward prevention programs for some of our youngest citizens. Refocused thinking depends upon a working definition of prevention. This, in turn, helps a state to sort out how many of its current resources can be devoted to true prevention relative to those directed at treatment. A continuum of prevention/intervention can be viewed as a triangle.



Movement from the base of the triangle, the general population, to its apex, severe problems, involves smaller and smaller groups in the population but ever increasing degrees of intrusion into a person's life. As problems become more severe, intervention strategies become more intrusive, more costly, and less effective. Why does a focus on intensive treatment still persist in health and human services programs? First, there are no advocacy groups clamoring for state government to appropriate funds for the general population. Yet, through our past immunization programs, for example, fatal and crippling diseases such as diphtheria, pertussis, congenital rubella, smallpox, and polio were nearly eradicated. Nevertheless, for each of the past four years, the number of children immunized by public programs has dropped by at least 20 percent. Second, there is a longer delay in demonstrable benefit from primary prevention and early intervention than there is from protective intervention and treatment. Removing a young child from an abusive home today and placing him with a foster family is a short-term intervention which can show immediate results. Sending family therapists to that same home for twenty hours per week for several months to prevent removal and placement is a lengthier effort. Waiting another six months for follow-up to demonstrate to legislators and others that early intervention has worked—that removal remains unnecessary—requires patience. Third, service providers who have been trained to provide treatment and have spent their careers doing so, are not easily persuaded to become ardent supporters of prevention.

Patterns of successful prevention

As the handbook *Focus on the First Sixty Months* was prepared, diverse programs were identified from states and localities in every part of the country that have taken a preventive approach and that show promise

of success. The nineteen programs selected for inclusion in the handbook address child care, parent-infant relationships, the development of infants and toddlers with disabilities, teenage parents and their children, adoption of special needs children and health care for mothers and infants.

A number of elements seem to be part of the pattern of success of these prevention efforts. Effective programs, we discovered:

- reach out to multiple agencies, whether public or private, in order to deliver an array of needed services;
- often go into families' homes, rather than expecting participants to report to agency offices;
- target multiple problems, albeit a single problem is the initial focus;
- mix funds from public and private, state and local sources;
- include some evaluation effort, to measure the extent of the program's impact and learn whether or not the delivery model needs refinement;
- maximize parent involvement so parents ultimately can be the service providers and advocates for their children; and
- focus on the lower two rungs of the prevention triangle—the general and at-risk populations—where the greatest benefit is likely to be achieved for the least cost and with the least intrusion.

Conclusion

Helping children and families to overcome barriers to healthy development and productive self-sufficiency is a complex process. Multiple points of intervention may be required during a person's lifetime, with approaches from a variety of programs and institutions.

Our Governors' focus on the first sixty months has convinced us that prevention *must* begin early, and that, to be effective, preventive approaches demand commitment and collaboration from all who care about our nation's children and their families.

Our children are the world's greatest resource and our greatest hope for the future. Their ability to build a better future will depend on the foundation we lay for them.

Focus on the First Sixty Months: A Handbook of Promising Prevention Programs for Children Zero to Five Years of Age is a joint product of the National Governors' Association Committee of Human Resources and Center for Policy Research. The 43-page illustrated publication is available for $12.50 per copy. *Making America Work: Bringing Down the Barriers,* contains an overview and reports from Governors' task forces on welfare prevention, school dropouts, teen pregnancy, adult literacy and alcohol and drug abuse. The cost of the 133-page report is $15, with bulk rates available. Purchase orders or checks may be made payable to the National Governors' Association and sent to NGA, Hall of the States, 444 North Capitol Street, Washington, D.C. 20001-1572.

Appendix D

Partial List of Existing Services for Direct Service Continuum

Prenatal and Preventive Health Care

(includes immunizations, health education, and family planning information.)

Abbott-Northwestern Hospital, Inc.
Beltrami Health Center
Cedar Riverside People's Center
Community-University Health Care Center
Fairview Hospitals
Family Medical Center
Fremont Community Health Services
Group Health Inc.
Health Etc. -- Your Neighborhood Clinic
Hennepin County Child Health Clinic
Hennepin County Medical Center
Indian Health Board of Minneapolis
Med Centers Health Plan
Metropolitan Medical Center
Minneapolis Children's Medical Center
Minneapolis Health Department
Minneapolis Public Schools Adolescent Health Care Programs
North Memorial Medical Center
Park Nicollet Medical Center
Pilot City Health Center
Private physicians and health care providers
Share Health Plan
Southside Community Clinic
Teen Age Medical Service (TAMS)
University of Minnesota Hospitals and Clinics
Uptown Community Clinic

Nutrition Information

Birth Community Inc.
Healthy Beginnings
Metropolitan Visiting Nurse Association
Minneapolis Health Department
Minneapolis Public Schools
Minneapolis Public Schools Early Childhood Family Education Program
Minnesota Extension Service, University of Minnesota
PACE Program
Phyllis Wheatley Community Center
Pillsbury United Neighborhood Services Inc.
Special Supplemental Food Program for Women, Infants and Children -- WIC
Sumner-Olson Residents Council
many health care providers

Childbirth Education

Childbirth Education Association
Some health care providers

Transportation to Community Services as Needed

Courage Center
Family Medical Center
Louise Whitbeck Fraser Community Services
Indian Health Board of Minneapolis
Minneapolis Family School
Minneapolis Health Department
MICE Program
PACE Program
PICA Head Start
Pilot City Health Center
Pilot City Regional Center
Ramsey Preschool
Reuben Lindh Learning Center
Survival Skills Institute
University of Minnesota Hospitals and Clinics

Home Visits

Courage Center
Fraser School
Group Health Inc.
Healthy Beginnings
Hennepin County Community Services Department
Home health services of hospitals and other private agencies
Metropolitan Visiting Nurse Association
Minneapolis Public Schools Early Childhood Family Education Program
Ramsey Preschool
Project STEEP

Parent Education/Support for Mothers and Fathers in Neighborhood and Workplace

Abbott-Northwestern Hospital

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Catholic Charities
Childbirth Education Association
Children's Home Society of Minnesota
Chrysalis Center for Women
Division of Indian Work
Family and Children's Service
Genesis II for Women, Inc.
Glenwood Lyndale Community Center
Group Health Inc.
Indian Health Board of Minneapolis
Lutheran Social Service
March of Dimes Birth Defects Foundation
MELD
Metropolitan Visiting Nurse Association
MICE Program
Minneapolis Area Vocational Technical Institute
Minneapolis Children's Medical Center
Minneapolis Public Schools Early Childhood Family Education Program
Minneapolis Urban League Early Childhood and Family Education Program
Minnesota Extension Service, University of Minnesota
Neighborhood Involvement Program
Options Program
PACE Program
Parents Anonymous
Phyllis Wheatley Community Center
PICA Head Start
Pillsbury United Neighborhood Services Inc.
Pilot City Health Center
Pilot City Regional Center
Project STEEP
Southside Child Care Committee
Survival Skills Institute
Washburn Child Guidance Center
YMCA
YWCA
many churches, hospitals, health care providers, preschool and child care programs, and others

Child Care Resource and Referral

Greater Minneapolis Day Care Association
Southside Child Care Resource Center

Screening and/or Assessment

Child Behavior and Learning Clinic
Group Health Inc.
Minneapolis Children's Medical Center
Minneapolis Health Department
Minneapolis Public Schools
Minneapolis Public Schools Adolescent Health Care Programs
Minnesota Department of Health
Ramsey Preschool
Reuben Lindh Learning Center
University of Minnesota Hospitals and Clinics
Washburn Child Guidance Center
many health care providers

Child Care

Licensed centers and family day care homes throughout Minneapolis--affordability and quality vary and there is a shortage of infant and toddler care citywide

Special Needs Day Care

Children's Home Society of Minnesota
East Side Neighborhood Service
Glenwood Lyndale Community Center
Hennepin County Special Needs Day Care in licensed centers and family day care homes
MICE Program
Phyllis Wheatley Community Center
YWCA Children's Center

Respite Child Care/Crisis Nurseries

Harriet Tubman Battered Women's Shelter
Incarnation House
Minneapolis Crisis Nursery
YWCA Children's Center

Drop-In Centers for Parents and Children

Catholic Charities
Glenwood Lyndale Community Center

Minneapolis Public Schools Early Childhood Family Education Program
YWCA Children's Center

Specialized Parent and/or Child Services/Classes

Catholic Charities
Centro Cultural Chicano
Children's Home Society of Minnesota
Family and Children's Service
Genesis II for Women, Inc.
Glenwood Lyndale Community Center
Greater Minneapolis Council of Churches
Lutheran Social Service
MELD
MICE Program
Minneapolis Children's Medical Center
Minneapolis Family School
Minneapolis Health Department
Minneapolis Public Schools Early Childhood Family Education Program and Special Education Programs
Minneapolis Urban League Early Childhood and Family Education Program
Minnesota Indian Women's Resource Center
PACE Program
Pacer Center Inc.
Parents Anonymous
PICA Head Start
Pilot City Health Center
Preschool Mental Health Program
Project STEEP
Southside Family Nurturing Center
Survival Skills Institute
Washburn Child Guidance Center

Developmental Preschool/Child Care

Audubon Early Learning Center
Genesis II for Women, Inc.
Phyllis Wheatley Community Center
PICA Head Start
Reuben Lindh Learning Center
Shingle Creek Early Learning Center
Southside Family Nurturing Center
Urban League Early Childhood and Family Education Program
some licensed nursery schools, child care centers, and family day care homes

Assistance with Job Training/ Placement Skills for Parents

Career Beginnings
Catholic Charities
Center for Asians and Pacific Islanders
Centro Cultural Chicano
CHART
Family and Children's Service
Katahdin: A Workshop for Youth
Lutheran Social Service
Minneapolis Area Vocational Technical Institute
Minneapolis Employment and Training Program
Minneapolis Urban League
Minnesota Indian Women's Resource Center
Neighborhood Employment Network
Options Program
Phillips Job Bank
PATHS
Pillsbury United Neighborhood Services, Inc.
Project Self-Sufficiency
Sumner-Olson Resident Council
WINGS
YWCA

Early Childhood Special Education and Therapeutic Preschool/Child Care

Courage Center
Louise Whitbeck Fraser Community Services
Minneapolis Children's Medical Center
Minneapolis Crisis Nursery
North Metro Day Activities Center
PICA Head Start
Ramsey Preschool
Reuben Lindh Learning Center
St. Anthony Developmental Learning Center
Southside Family Nurturing Center
Survival Skills Institute
Washburn Child Guidance Center

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Therapeutic Parent and/or Child Services

Abbott-Northwestern Hospital
Catholic Charities
Children's Home Society of Minnesota
Courage Center
Crisis Intervention Services
Division of Indian Work
East Side Neighborhood Service
Family and Children's Service
Fremont Community Health Services
Genesis II for Women, Inc.
Group Health Inc.
Harriet Tubman Battered Women's Shelter
Hennepin County Community Services
Hennepin County Medical Center
Hennepin County Mental Health Center
Incarnation House
Indian Health Board of Minneapolis
Judson Family Center
Louise Whitbeck Fraser Community Services
Lutheran Social Service
Minneapolis Children's Medical Center
Minneapolis Crisis Nursery
Minneapolis Family School
Minnesota Department of Health
Minnesota Indian Women's Resource Center
Neighborhood Involvement Program
Parents Anonymous
Private therapists and counselors
Phyllis Wheatley Community Center
Reuben Lindh Learning Center
Southside Family Nurturing Center
Survival Skills Institute
Washburn Child Guidance Center

Individual Family Service Plans/Case Management

Courage Center
Hennepin County Community Services
Metropolitan Visiting Nurse Association
Minneapolis Family School
Ramsey Preschool
Reuben Lindh Learning Center
Southside Family Nurturing Center

Appendix E

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Appendix F

Description of Minnesota's Early Childhood/Family Education Programs

Reprinted with permission from the from the Family Resource Coalition, 230 North Michigan Avenue, Suite 1625, Chicago, Illinois 60601 (312/726-4750).
The Family Resource Coalition is a national network of people and organizations which uses advocacy, public education, and publishing activities to promote the development of programs to strengthen families.

Minnesota Legislation an Exemplary Commitment to Families

by Karen Kurz-Riemer

"The goals of Early Childhood Family Education are to:

- *Support parents in their efforts in raising children*
- *Offer child development information and alternative parenting techniques*
- *Help create effective communication between parents and their children*
- *Supplement the discovery and learning experiences of children*
- *Promote positive parental attitudes throughout their child's school years"*

Minnesota Department of Education

It's a chilly February morning in Minneapolis. The sidewalks and streets, wet from the previous week's thaw, are glazed and treacherous. But inside the Early Childhood Family Education Center at Wilder Elementary School, a group of parents and their infants are attending the weekly "Babies" class. The activities begin with babies and mothers sitting in a circle on the floor singing a hello song to each child and discussing any new developments that infant has made in the preceding week. The babies' eyes light up as group attention is focused upon each of them in turn. When the group separates, babies remain in the infant environment and parents go nearby to discuss topics they have mutually selected at the beginning of the eight-week class series. Both parents and baby groups are facilitated by licensed parent educators and pre-kindergarten teachers.

In Onamia, a small community located near the Mille Lacs Indian Reservation in north central Minnesota, Early Childhood Family Education (ECFE) services involve family education sessions, home visits to parents of infants, and special events offered at various community school sites, both in town and on the Reservation itself. Many of the services emphasize Ojibwa cultural awareness. Loans of toys and reading materials are available to help parents maintain a stimulating home environment for their children.

These programs share the common goal of strengthening families while illustrating some of the ways such a process can be introduced and assisted. Whether raising the self-esteem of children by the use of focused, individual attention, or reinforcing parents through peer support and information sharing, ECFE is helping parents provide for their own and their children's learning and growing. The Minnesota Legislature, having recognized the connection between optimum child development and effective parenting, has initiated and gradually increased its support for Early Childhood Family Education from pilot efforts to a statewide program expansion.

History of the Legislation

Minnesota's ECFE legislation was developed by Senator Jerome M. Hughes. As its main author and a prevention proponent, his attitude is, "A dollar spent early is the best dollar spent, for the benefit of the child, the family and society. The money is returned later through savings in the rehabilitation and repair budgets."

Originally passed in the 1974 session of the state legislature, an initial amount of $230,000 was appropriated to fund a minimum of six pilot programs. Coordination of the program grants was entrusted to the Minnesota Council on Quality Education (CQE), which has played a central role in ECFE's development.

CQE was established in 1971 to act as a source of state funds for helping local school districts try out cost-effective and innovative ideas in all areas of education. The Council reviewed proposals, awarded grants, provided in-service training, and monitored the growth and expansion of programs during a ten-year period. Composed of nineteen members, the majority are appointed by the Governor from all areas of the state, with the remainder designated by various state educational associations.

The Council was assisted in its administration of ECFE by a nine-member Advisory Task Force, with a majority of parents, and persons knowledgeable in the fields of health, education, and welfare. Appropriations rose gradually from 1974 to 1984, resulting in a growth of 6 to 36 pilot programs located throughout Minnesota. In fiscal '81, appropriations were tapped in the amount of $1,767,000; however, the money crisis that occurred during the early '80s recession resulted in a reduction of that figure.

In 1984, the Minnesota Legislature took a major policy step, transferring ECFE from grant funding under the Council on Quality Education to formula funding through the community education system. Community education funds include a mix of state and local dollars that may be supplemented by fees and funds from other sources.

By the fall of 1985, approximately 60% of Minnesota's 435 school districts will be offering Early Childhood Family Education through their community education services. During 1985-86, it is estimated that 120,000 parents and children will participate in programs at a predicted cost of $12,704,945, through a combination of state aid and local levy.

Program Perspective

The central purpose of ECFE is to enhance and support the competence of parents in providing the best possible environment for the healthy growth of their children during the formative years from birth to kindergarten enrollment.

Each program is planned to be locally controlled and responsive to the unique needs of its community. In Minneapolis, for example, the monthly program newsletter offers class opportunities such as: "Toddlers", "Three to Five, Will I Survive?", "Single Parents", "Black Parents", "Raising Brothers and Sisters", "Hmong Parents", "Blended Families", and "How to Talk So Kids Will Listen".

There are also listings of one-time events such as field trips to a fire station, bakery, and flower show; speakers on topics ranging from selecting child care to toilet training; and a series of information nights at neighborhood schools for parents of prospective kindergarten students. The program services are offered at various locations throughout the city.

Although local programs vary in the services they provide, 1985 Minnesota statute clearly states that substantial parental involvement is required in all ECFE programs: parents must be physically present much of the time in class with their children or in concurrent classes; parent or family education must be an integral part of every program; and that appropriations cannot be used for traditional day care or nursery school programs.

Senator Jerome Hughes, developer of Minnesota's ECFE legislation and currently President, Minnesota Senate.

Program Characteristics

Combinations of the following service components have become widely characteristic of the programs:

- Parent and family education through discussion groups, workshops, or home visits
- Parent-child interaction opportunities
- Guided play and learning activities for children
- Early screening and detection of children's health and developmental problems
- Lending libraries of books, toys, and other learning materials
- Special events for the entire family
- Information on related community resources for families and young children

An important feature of Minnesota's approach to Early Childhood Family Education is its universal access. The programs must be offered on a voluntary basis and are intended to reach parents of all income levels regardless of race, sex, age, or marital status. This universal intent, however, requires strong and constant outreach efforts on the part of program staff. Word-of-mouth has consistently been the most productive form of reaching families and this obviously requires competent, caring staff people and high quality programs. Staff members are licensed parent educators and pre-kindergarten teachers assisted by trained aides and volunteers.

Additionally, local programs must closely coordinate their services with those of other community agencies in order to reach a cross-section of their local population. Parent advisory councils must be appointed for each program with a majority of parent members. Community persons from fields such as health, education, welfare, and child care are suggested for the remaining membership positions.

The Research Base

Evaluation efforts have been intensive since 1974, largely formative or process oriented in nature. These efforts, such as the development of a comprehensive description of quality criteria for ECFE have been critical to the growth and development of the program. Summative or outcome evaluations, however, have been much more difficult. Voluntary participation and local programming variations in particular, along with the unperfected measurement of parental "inputs" relative to child "outputs", have been problematic for research efforts. Yet findings of the national Consortium for Longitudinal Studies and Michigan's Perry Preschool Project strongly suggest positive long-term effects of a program such as Minnesota's Early Childhood Family Education.

Without specific, definitive research outcomes to promote the program, the reactions of parent participants to Early Childhood Family Education have been crucial. These women and men have worked diligently over the past ten years, testifying before legislative committees, hosting policymakers at program sites, writing letters, telephone calling, and generally lobbying for continued support and expansion of the programs. Their efforts, along with those of dedicated and competent local staff have paid off for Minnesota families.

Investing in the Future

At the same time ECFE programs see their ultimate benefit as strengthening families, they are also reinforcing the role of parents as teachers. There is enough data from the Minnesota evaluations, and from similar programs around the country, to imply potential for reducing later learning problems of children. The research shows participating children tend to require fewer special services and experience more success during their school years.

Encouraging parents to get involved early in the education cycle benefits everyone—the parents themselves who report increased satisfaction in their roles, the children who discover the joy of learning, the schools that gain greater parent participation, and the education system that becomes more cost-effective.

It can take a long time, as it did in Minnesota, for policymakers to fully understand the concept of Early Childhood Family Education. As Senator Hughes put it, "Enduring change comes slowly." But generally speaking, with understanding comes support. And with that support, grows an investment in human capital—the children of today and the adults of tomorrow.

Helpful Information

- *A Guide for Developing Early Childhood Family Education Programs* (Cat. #B518). Aimed at professionals in parent education and program planning, this is a practical resource for starting programs and running them on a limited budget. Extensive appendix with resources in audio/visual materials for parent educators. Chapters on outreach, staffing, group process, volunteers, community coordination, etc. Loose-leaf notebook format. Order from: Minnesota Curriculum Services Center, 3554 White Bear Avenue, White Bear Lake, MN 55110, 612/770-3943. $16 ppd, $12 for MN residents.
- A Council on Quality Education publication titled, *A Study of Policy Issues Related to Early Childhood Family Education in Minnesota* details the program's history, its base in research, evaluation strategies and results, and some cost analyses. Available from: Lois Engstrom, Specialist, Early Childhood Family Education, Minnesota State Department of Education, 651 Capitol Square, St. Paul, MN 55101, 612/297-2441. Programmatic concerns should also be addressed to Ms. Engstrom.
- Requests for copies of the current Minnesota ECFE legislation and questions on legislative issues can be addressed to: Senator Jerome Hughes, 328 State Capitol, St. Paul, MN 55155, 612/296-4183.

Karen Kurz-Riemer is on parental leave as an instructor in St. Cloud State University's Center for Child and Family Studies. She was Assistant Coordinator for the Minnesota Council on Quality Education from 1976 to 1982, working intensively with the developing Early Childhood Family Education programs. A graduate of Chicago's Erikson Institute, Karen is working toward a doctoral degree in educational administration at the University of Minnesota. She lives in Minneapolis and is the stepmother of a son, 14, and mother of two daughters, 4 and 11 months.

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