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ABSTRACT

The text of a hearing on successful efforts to prevent child abuse and strengthen families is presented in this document. After an opening statement by chairwoman Representative Patricia Schroeder, statements are presented by Representatives Robert E. "Bud" Cramer, Jr., Neil Abercrombie, Blackwell, Gerry Sikorski, Matthew Martinez, Frank Wolf, Lamar S. Smith, Barbara-Rose Collins, and Curt Weldon. Statements and/or prepared materials are included from these individuals: (1) Gail Breakey, director, Hawaii Family Stress Center, Honolulu, Hawaii; (2) David Chadwick, director, Center for Child Protection, Children's Hospital and Health Center, San Diego, California; (3) Anne Cohn Donnelly, executive director, National Committee for Prevention of Child Abuse, Chicago, Illinois; (4) Wade Horn, commissioner, Administration for Children, Youth, and Families, U.S. Department of Health and Human Services, Washington, D.C.; (5) Susan Kelly, program director, Families First, Michigan Department of Social Services, Division of Child and Family Services, Lansing; (6) David Mills, president, National Alliance of Children's Trust and Prevention Funds, Lansing, Michigan; (7) David L. Olds, associate professor, Department of Pediatrics, University of Rochester School of Medicine and Dentistry, Rochester, New York; and (8) Bernard Watson, president and chief executive officer, The William Penn Foundation, Philadelphia, Pennsylvania. (ABL)

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KEEPING KIDS SAFE: EXPLORING PUBLIC/PRIVATE PARTNERSHIPS TO PREVENT ABUSE AND STRENGTHEN FAMILIES

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, APRIL 2, 1992

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KEEPING KIDS SAFE: EXPLORING PUBLIC/PRIVATE PARTNERSHIPS TO PREVENT ABUSE AND STRENGTHEN FAMILIES

THURSDAY, APRIL 2, 1992

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC.

The committee met, pursuant to call, at 9:45 a.m., in room 2226, Rayburn House Office Building, Hon. Patricia Schroeder (chairwoman of the select committee) presiding.

Members present: Representatives Schroeder, Sikorski, Martinez, Sarpalius, Collins, Cramer, Wolf, Weldon, Smith, Walsh, Machtley, Camp.

Also present: Representatives Blackwell and Abercrombie.

Staff present: Karabelle Pizzigati, staff director; Jill Kagan, deputy staff director; Julie Shroyer, professional staff; Carol Statuto, minority deputy staff director; Mary Jordan, research assistant; and Joan Godley, committee clerk.

Chairwoman SCHROEDER. If I can, I think we'll go ahead and begin the hearing, because we have kind of a busy, busy, busy day, and I want to say how pleased I am that we have such a distinguished panel this morning, although one of our panel is still on an airplane, so we hope she makes it through okay.

First of all, this is a very important meeting, because April is Child Abuse Prevention Month. It's a very fitting time to renew the commitment we have in investing in families and reevaluate the current approaches to protecting children and sustaining families.

Today, we are going to hear about some successful efforts, because with the bad news that is out there, as we look at the statistics, the successful efforts are very important.

New statistics have come out today: The National Committee for Prevention of Child Abuse is going to show that, in 1991, the number of child abuse reports climbed to over 2.6 million, which is tragic, and child abuse fatalities rose by 11 percent over just last year. That, too, I find very, very tragic, and I think it points to the urgency of the situation.

As we know, the budget dollars are tighter than ever. Yesterday, or earlier this week, we were not able to bring the walls down on the budget, so the flexibility is not there, but when you look at these abuse statistics and how they are rising, we know business just cannot go on as usual.

So, today, we are going to explore the federal role in converting social welfare programs into family investment programs, such as family preservation, family visiting programs, strengthening and supporting families, and whatever else we can do.

The interesting thing is many of these programs not only save money, but appear to avert costly, out-of-home placements and unnecessary institutionalization.

Recently, Bill Moyers had the screening of "Families First," and that special pointed out the reduced need for out-of-home placement by getting more services early on to families in crisis. That's what we are talking about, how we give people survival skills. We have some states that have been out front on this, and we are going to be very, very pleased to have them here, and we have members from those states here today too, because they are very proud of them, and rightfully so.

I'm going to put the rest of my statement in the record, because we are going to hear from the witnesses themselves, which I think is very, very important to have, and we really want to get on to it.

[Opening statement of Hon. Patricia Schroeder follows:]

OPENING STATEMENT OF HON. PATRICIA SCHROEDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO AND CHAIRWOMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

Welcome to this important hearing. April is Child Abuse Prevention Month—a fitting time to renew our commitment to investing in families and to reevaluate our current approaches to protecting children and sustaining families.

We will hear today about successful efforts to promote and strengthen families, but as a nation, we have failed to champion these efforts to ensure that all families who need support are able to benefit.

As a result, child abuse reports continue to escalate and we now are faced with a national emergency. Today, the National Committee for Prevention of Child Abuse will release its latest figures on abuse reports and fatalities. In 1991, the number of child abuse reports climbed to over 2.6 million, and reported child abuse fatalities rose by almost 11% just since last year. These numbers emphasize the urgency of the situation.

Budget dollars are tighter than ever. This week, the House failed to bring the walls down between defense and domestic programs in the budget. The walls came down in Berlin and the Soviet Union, but not in Washington. I am going to have to tell my constituents who are coming to Washington, who think we are going to be able to do something this year to help families and children, to forget it. Save your airline tickets, because there is no money.

Business cannot go on as usual. Today we will explore the federal role in converting social welfare programs into family investment programs, such as family preservation and home visiting programs. Strengthening and supporting families not only is more responsive to their needs, but also saves money in the long run by averting costly out-of-home placements and unnecessary institutionalization.

Recently, Senator Rockefeller and I, and Members from Missouri, Michigan and Kentucky, the States which have pioneered family preservation efforts, sponsored a screening of "Families First With Bill Moyers," a documentary which highlights family preservation efforts that have reduced the need for out-of-home placement of children from troubled homes.

"Families First" showed that investing in families works. Teaching families survival skills and providing them with the support and resources they need save us all money and heartache. We will have testimony today from one of the programs featured in the film—the Michigan Family First program. Eighty percent of the families at risk of separation who were given short-term intensive home-based services were kept together safely, saving money and fostering confidence, motivation and autonomy among families served.

Today our witnesses also will shed new light on how we can prevent abuse, preserve families, and see a return on our investment at the same time through home visiting. As we will hear today, the average cost of Hawaii's Healthy Start program is less than $2,500 per family compared with $30,000 to shelter a runaway youth or

to incarcerate a juvenile or adult offender, or $123,000 to provide foster care to the age of majority for an abused child.

Additional research presented today will show that nurse home visits result in healthy births, and significant reductions in child abuse and neglect after birth. The program paid for itself through reductions in AFDC and Food Stamp payments by the time the children were four years old.

We will hear about the role that businesses have played in public/private partnerships to end abuse, and how foundations stimulate innovative and successful prevention strategies, but turn to state and federal government for leadership to maintain those programs.

In the face of all this evidence, I plan to take action immediately. Shortly, I will be introducing legislation, the "Family Investment Program." My plan offers a basic floor of support that all families need to survive from the time their children are born until they become young adults with safe and secure futures. It includes job-guaranteed family leave; full funding for Head Start, WIC and Childhood Immunization; a family preservation initiative; and assistance for families struggling to pay for their children's college education.

Later this morning I hope you'll join me at a rally organized by the Child Welfare League of America to urge Members of Congress to make children's issues a top priority this election year. Also, I invite you to attend a staff briefing on home visitor services, sponsored by the National Child Abuse Coalition later this afternoon. This briefing will take place in Room 430 of the Senate Dirksen Building from 2:00 to 3:30 p.m.

Thank you all for coming. I look forward to your testimony.

Chairwoman SCHROEDER. I just want to make one more comment. Soon, I am planning to introduce a family investment bill that I hope many members join me in, and what we're going to do is try and find the programs that are most efficient for families, dealing with family preservation, trying to get more flexibility into family programs, the other areas, such as full funding of Head Start and things like that, that really fill in the gaps and try and put it out there.

Hopefully, we can make a real emphasis on how important it is to invest in families. I think too often people have thought these are giveaways, and I think our panel today is going to show it's an investment and it's an investment well worth making.

Also, I'd like to invite members of the panel to go to the rally later on this morning. They are going to be having a rally out there dealing with putting children first, and any of you who want to join us, I think that would be a very good idea, and we are also having some other briefings that we'll let the panel members know about.

But let me be quiet at this point and yield to the distinguished gentleman from Alabama who almost wrote the book on child abuse, and we're so glad to have his expertise here. So, Congressman Cramer?

KEEPING KIDS SAFE: EXPLORING PUBLIC/PRIVATE PARTNERSHIPS TO PREVENT ABUSE AND STRENGTHEN FAMILIES

FACT SHEET

FAMILY PRESERVATION PROGRAMS KEEP FAMILIES TOGETHER/PROVE TO BE WISE INVESTMENT

- Studies have shown that on average 80% of the families receiving family preservation services (based on original Homebuilder model program) have remained together one year after the intervention has ended. (Edna McConnell Clark Foundation [EMCF], 1992)

- While the estimated annual cost of care in institutional settings ranges from $10,000 to $50,000 per child nationwide, family preservation services range from $2,500 to $5,000 per family, and even less per child. (Center for the Study of Social Policy [CSSP], 1991)

- Between 1988 and 1990, new foster care placements in Michigan rose by 28% in counties without Families First -- the State's comprehensive family preservation program -- and declined by 10% in counties with family preservation services. The Michigan Department of Social Services estimates that without Families First, from 904 to 1,532 more children would have been in foster care on September 30, 1990, than were actually in care, a savings to the State of $9 million to $15 million. (CSSP, 1991)

- In New York City, the average cost of family preservation services was $5,000 per child, compared with $13,500 per year in foster care. (CSSP, 1991)

- In Denver, Colorado, 93% of families remained together six months after receiving family preservation services and 83% were still together one year post-services. (Denver Family Preservation and Reunification Program, 1991)

COMPREHENSIVE, EARLY HOME VISITATION PROGRAMS WORK AND SAVE MONEY

- From 1987-89 Hawaii's statewide home visitation program, Healthy Start, reached 1,204 families at an estimated cost of $2,200 to $2,500 per family (may include more than one family). By contrast, the average cost of one child in protective services to

the age of majority is $123,000. Healthy Start had a 99.7% success rate in stopping abuse and a 99.5% success rate in ending neglect. (Hawaii Department of Health, 1992; Breakey, 1992)

- In a comparison study of 400 women at risk for poor pregnancy and child health outcomes, there was an 80% reduction in the incidence of state-verified cases of child abuse among poor unmarried teenagers who received nurse visitation during the first two years after the delivery of the first child. Low-income women who were visited by nurses used $3,300 less in other government services during the first four years after delivery of the first child than did their low-income counterparts in the comparison group. (Olds, 1992)

- In Oregon, 10% of all children in families with teen parents were abused. If these families had been served by the Oregon Children's Trust Fund Teen Programs, which include home visiting, parenting classes, and support groups, it is projected that only 2% would have been abused or neglected. (Oregon Children's Trust Fund, 1991)

WITH LIMITED PREVENTION RESOURCES, SYSTEMS OVERWHELMED/OUT-OF-HOME PLACEMENTS SOAR

- From the start of 1986 to the end of 1991, there was a 49% increase in out-of-home placements, from 273,000 to 407,000.[1] In 1988, minority children constituted 46% of those placed out-of-home. (American Public Welfare Association, 1991)

- Between 25% and 50% of all child abuse fatalities occur in families that are known to the local child protection agency. (Martinez, 1986)

- Federal funding for foster care increased almost 600% between 1981 and 1991, while funds for prevention rose only 78%. When Federal and state funds are added together, more than $9 billion was spent on out-of-home placement in 1991. (U.S. Department of Health and Human Services, 1991; EMCF, 1992)

- In 1991, of 44 states providing funding information, almost one-sixth experienced cuts and half the states had no increase in their

[1] Out-of-home placements include family foster care, group homes, child care facilities, and emergency shelter care.

1991 child welfare budgets. (National Committee for Prevention of Child Abuse [NCPCA], 1992)

DRUG AND ALCOHOL ABUSE FUEL THE CHILD ABUSE CRISIS

- A 10-state survey of public child welfare agencies revealed that in 1991, 36.8% of 305,716 children served were from families in which a family member abused alcohol or drugs. In a survey of not-for-profit child welfare agencies nationwide, 57.4% of 111,927 cases involved alcohol or drug use. (Child Welfare League of America, 1992)

- Estimates from 14 states show that in 1991 approximately 32% of substantiated child abuse cases involved substance abuse. (NCPCA, 1992)

- According to a 1990 Pennsylvania study of parents who neglected their children, 30% stated that someone in their home had a drug or alcohol problem in the last three years; 28% of the parents had been assessed as having substance abuse problems at the time of intake. (National Resource Center on Family-Based Services, 1990)

- In a 1989 study of African-American children in foster care, drug abuse was listed as a contributing factor in 36% of the placements. (National Black Child Development Institute, 1989)

MILLIONS OF YOUNG CHILDREN ABUSED EACH YEAR

- In 1991, there were more than 2.6 million reports of child abuse, an increase of more than 6% since 1990 and 40% since 1985. Nearly 1,400 children were fatal victims of maltreatment, almost an 11% increase in child abuse fatalities since 1990. Almost 80% of children who died as a result of abuse or neglect were under age 5; 56% were infants one year or younger. (NCPCA, 1992)

- Estimates of national child abuse and neglect substantiation rates vary from 35% to 53%. In 1987, there were 700,000 substantiated cases, up from more than 400,000 cases in 1980.[2] (American Association for Protecting Children, 1991)

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[2] "Substantiated case" implies a degree of certainity that a child involved is at-risk and, in many states, that some level of intervention is warranted in the child's behalf.

- A 1991 state survey of child maltreatment indicated that 25% of reported abuse cases were due to physical abuse, 48% to neglect, 15% to sexual abuse, and 6% to emotional maltreatment or other (abandonment and dependency). In 26 of the responding states, less than 1% of reported abuse cases took place in a foster care or child care setting. (NCPCA, 1992)

- In 1989, there were 7,224 confirmed victims of child abuse and neglect in Colorado, a decrease of 4% from the previous year. Between 1987 and 1988, however, child abuse reports increased 24%. Of confirmed reports, 36% were due to physical abuse, 37% to neglect, and 7.7% to sexual abuse. From 1985 to 1990, there were 255 child abuse fatalities. (Colorado Police Academy Team on Families and Children at Risk, October, 1990)

April 2, 1992

Mr. CRAMER. Thank you, Madam Chair. I have a statement for the record, but very quickly I want to say that I am honored to be in the presence of this very distinguished panel and am honored to be a member of this committee as well.

In my prior life, I was able to meet many of you and know about your good work and worked with you in the field, so I think this is a unique opportunity for me. It's a unique time for us to convene a panel like this, with April being designated by Congress as National Child Abuse Prevention Month.

On this panel of members here, my colleague to my right, Neil Abercrombie, and I introduced a bill yesterday, joined with Senator Nichols, to introduce a bill that will further the Children's Advocacy Center concept, which some or many of you know about as well, so I look forward to working with you.

In this day and time, we need to hear from programs that work, and I know with my colleague Neil Abercrombie's program there in Hawaii that I have heard about before and heard this morning about on TV, we look forward to perpetuating that program and seeing it working in all states in this country.

Thank you, Madam Chair.

Chairwoman SCHROEDER. Great.

And, Gail Breakey, I want to say that your Congressman is very, very happy to have you here, so happy he wanted to come and introduce you, so let me yield to Neil Abercrombie.

Mr. ABERCROMBIE. Well, thank you very much, Pat.

I do have the opportunity, and I'm pleased to have the indulgence of you and your membership to be able to do this.

Not only is Gail Breakey here, but she's accompanied by Betsy Pratt, I'm happy to see. I just want to indicate to those in the audience and those on the panel who may not be totally familiar with Gail, that she has been the moving force behind the Healthy Start Program in Hawaii, and while it says here Hawaii Family Stress Center, I want to indicate that when I had the good fortune to be the Human Services Chair in the State Senate in Hawaii in the early 1980s, Gail and her colleagues came together with me and gave me the opportunity to also get on television for reasons having other to do with finances and so on, finances in the right way by forming the Child Abuse and Neglect Coalition.

And out of this coalition came an increase in funding in programs with respect to child abuse and neglect across the board, including the establishment of a statewide shelter program for abused spouses and children.

Gail Breakey is the catalyst. She's embarrassed already, I can see, because she does not put herself forward. She leaves that to people like me to take credit for the work that people like Gail and Betsy do.

I'm very pleased to have her here today, and I know that the testimony that she's going to give to your committee will be insightful, it will be practical, it will give all the members of this committee, and by extension the Members of the Congress, an opportunity to understand how a successful program not only comes into being, but keeps on going and receives the support of the community, as well as the Legislative and Executive Branches of government, because it works, because it gets the job done for children.

Thank you very much.

Chairwoman SCHROEDER. Thank you.

I'm going to skip over, because I know Congressman Blackwell came because he wanted to brag about Doctor Watson. Congressman, we welcome you.

Mr. BLACKWELL. Thank you, Madam Chairperson, and other members of the committee.

It is indeed an honor for me to introduce Doctor Bernard C. Watson. Doctor Watson is representative of so many things worthy of mentioning. The difficulty for me as I begin Doctor Watson's very lengthy list of accomplishments, because I can find no one thing any less substantial than the other. Over the years, Doctor Watson has done so many great things for so many people.

In my estimation, one of Doctor Watson's grandest accomplishments was that of gaining employment in the 2nd Congressional District, thus providing me with this opportunity to brag about him this morning. No doubt Doctor Watson is the kind of citizen that every Member of Congress dreams of attracting and keeping, for he would indeed serve as a pillar, not only in the Philadelphia community, but in any part of the world that he chooses to make his home.

Under the leadership of Doctor Watson as the Chief Executive Officer of the William Penn Foundation, the Foundation continuously demonstrates a commitment to improving the quality of life in the Delaware Valley.

No doubt, Doctor Watson has done an astonishing job, and for that I am most appreciative. Under Doctor Watson's leadership, the Foundation has provided valuable and limitless services. As a result a lot of the problems that plague children and youth have been arrested, and for that I'm eternally grateful.

Among other roles, Doctor Watson is an educator, an administrator, the list is never ending.

With that bit of information, it is my honor to bring to you a citizen of the Second Congressional District of Pennsylvania, Dr. Bernard C. Watson.

Chairwoman SCHROEDER. Sure.

Mr. BLACKWELL. Thank you, Madam Chairperson, for this valuable opportunity.

Chairwoman SCHROEDER. Thank you.

Congressman Sikorski, do you have anything you'd like to——

Mr. SIKORSKI. I just want to thank you and thank the panel members for coming here. I'm really revved up after hearing these introductions and ready to go.

Chairwoman SCHROEDER. We've got some fine folks here.

Mr. SIKORSKI. Thank you.

Chairwoman SCHROEDER. Congressman Martinez, did you have anything you wanted to add?

Mr. MARTINEZ. Not really, Madam Chair. I just want to commend you for holding these hearings.

I just recently conducted some field hearings on this very same issue. We visited Boys Town USA, who have a wonderful program much like the one that is mentioned here in this release.

The one thing that's become apparent to my subcommittee on holding hearings is that there, indeed, is a lot of child abuse out

there, and a lot of it occurs because families themselves don't get the kind of counseling they need to make the family units work.

Boys Town is engaged in that, not only in the Boys Town environment in Omaha, Nebraska, but also they have started field offices all over the United States, New York, California, various states, and I visited one of those extensions of Boys Town where the basic premise of it is to provide family counseling and try to get the young disturbed person back into the home. They also provide mental health care, which is a very important thing for many of these young people.

They are also doing parent training of new foster parents, which is a very important thing, something that I don't think has really been brought to the attention of the American public as it should, the abuse that takes place in foster homes, because most states really do not have qualified, either screening procedures for foster parents, or any foster parent training.

Chairwoman SCHROEDER. Right.

Mr. MARTINEZ. Omaha, Nebraska is one of those progressive states that has, as a matter of state law, provided foster parent training for foster parents. I think that's a very important thing. I would like to see that on the national—established on a national level, because that's certainly a lot of the problem with children that we see in our society today come out of those foster homes, where they are not well taken care of, and although they are paid to be taken care of.

But we are spending money doing that when I think that we need to be spending some money actually ensuring that they are well taken care of. But there is child abuse in real families where they are not foster parents, and much of that doesn't come to light until the child himself, because of that, gets into some kind of a problem and trouble, and then many times, of course, look at the child as the problem, not at the home. Sometimes valid court orders are being violated by these young people and they are being then sent to detention homes, or institutional settings, where there is no corrective procedures there either, and so it just compounds the problem rather than finding out what the real problem is before they decide that.

Now, I know it all is based on the availability of funds to do these things, but I think that somewhere in our priority here in Congress we are going to have to establish that there are going to have to be funds directed for this and this has to be one of our priorities if we are to fulfill the promises of our speeches, that the children are our future.

Chairwoman SCHROEDER. Sure. Thank you very, very much.

Congressman Wolf?

Mr. WOLF. I have no statement, just to thank you for the hearing, and I want to apologize for having to leave. I'm ranking on an Appropriations Committee that meets at 10:00 with OPM.

Chairwoman SCHROEDER. Wednesdays and Thursdays are a nightmare around here.

Mr. WOLF. Thank you.

Chairwoman SCHROEDER. Congressman Smith?

Mr. SMITH. Thank you, Madam Chair.

Like my colleagues, I look forward to hearing from the witnesses today, and I'm particularly interested in hearing what they have to say in regard to prevention and in regard to the strengthening of families, the subject of today's hearings.

I think there's a great temptation to talk about how bad the problem is without talking about the solutions, and I'm looking forward to what our panelists have to say about the solutions.

Thank you, Madam Chair.

Chairwoman SCHROEDER. Thank you, a very, very good point.

Congressman Walsh?

Mr. WALSH. Thank you. I have no opening statement.

Chairwoman SCHROEDER. Okay.

And Congressman Weldon?

Mr. WELDON. Thank you, Madam Chair. I apologize for being late. I am also very interested in the issue today, especially in light of the absolutely outrageous situation we've just experienced in Philadelphia, where the individual known as "Uncle Eddie." Press reports indicate that as many as 5,000 young children may have been exposed to the outrageous acts of this individual. Perhaps the panel has some ideas and suggestions as to what we can be doing to better alert people to report these incidents when they are first noticed, as opposed to allowing them to go on for a ten-year time period.

Thank you.

Chairwoman SCHROEDER. Well, I want to welcome this distinguished panel. We hope Susan Kelly can join us. She's, as I said, in the air coming from Michigan, but some of you had your members and the rest of you get me, but we want to tell you that doesn't mean that we don't recognize you as leaders in this area, because we know what you've been doing and we're so pleased to get some solutions. You rarely get this many members, especially when there's about 100 different hearings going on, so I think it tells how this Congress is desperate to get some answers.

I think we'll do the whole panel as we go down. Let's start with Wade Horn. Wade, do you want to kick off? He is the Commissioner for the Administration for Children, Youth, and Families in the U.S. Department of Health and Human Services, and no stranger to the committee. We welcome you, we are happy to have you, and the floor is yours.

STATEMENT OF WADE F. HORN, PH.D., COMMISSIONER, ADMINISTRATION FOR CHILDREN, YOUTH, AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. HORN. Thank you, Madam Chair, and I welcome the opportunity to testify on this very important topic of preventing child maltreatment.

It's not difficult for me to articulate my vision about what every child needs to grow up healthy, happy, and secure. They need physical and mental well-being, sufficient opportunity, affirmation, and support to enable one to develop the full range of his or her potential, friendship, love, and protection from harm.

For most children in America, childhood is a time when these fundamental needs are being met, most importantly, by parents.

Indeed, one of the major findings in the final report of the National Commission on Children, upon which I served, is that it's a good time to be a child, usually. Tragically, however, far too many children, not all, not most, but certainly too many, suffer when their parents, families, neighborhoods, and communities renege in their obligation to provide them with their birthright of caring. It is simply unacceptable that over a million children each year suffer from abuse and neglect.

Changing this grim picture will require American citizens to build coalitions of concern, cooperative alliances that include government as a partner, but which also ought to involve community associations, the corporate sector, the educational establishment, religious organizations, parent groups, every one who has a stake in the future of our children. Clearly, that is every American.

In the Department, we view our efforts to prevent child abuse and neglect in the larger context of helping to develop healthy families, for strong families form the foundation of a healthy society. That's one reason why the Bush Administration has so aggressively pursued the expansion of the Head Start Program, perhaps our most effective family strengthening program, and as such an indispensable part of our efforts to eradicate child abuse and neglect.

We support expanding Head Start, because we know that it is much better to build a child than to repair an adult.

The National Center on Child Abuse and Neglect is doing its part by reaching out, not only to the traditional sources of child welfare services, but to all segments of society to join in preventing child maltreatment. In fact, since 1975, NCCAN has funded almost 300 projects devoted to prevention, including 47 demonstration projects targeted to pregnant teenagers.

Another way in which NCCAN supports the development of prevention strategies is through the Challenge Grant Program. With federal seed money, states are showing us what can be done when widespread community support is enlisted to fight child abuse.

In addition to these activities, Secretary Sullivan has created an initiative on child abuse and neglect within the U.S. Department of Health and Human Services. Indeed, Secretary Sullivan is the first Cabinet Secretary in the history of the United States to make the prevention of child abuse and neglect a personal priority.

Now well underway, this initiative has several components. First, increasing public awareness of the problem of child maltreatment. Second, promoting intra- and interagency coordination of child abuse and neglect activities. And, third, encouraging all sectors of society to cooperate in combating child maltreatment.

In support of the role of forging new partnerships with all segments of society, Secretary Sullivan held a national meeting in Washington on December 6th of last year to challenge leaders from the public and private sector to join in a coordinated effort to prevent child maltreatment. Already this effort is paying dividends, as groups as diverse as the Kiwanis Clubs International, the Sunday School Board of the Southern Baptist Convention, and the National Conference of Bishops have begun to disseminate information to their membership on the prevention of child abuse and neglect.

I am especially pleased to be here today with several experts who will testify on the issue of the effectiveness of home visiting pro-

grams, programs which send trained workers into the home to counsel, support, assist, and educate young families. We are aware of the promising results of home visiting programs, such as the Healthy Start Program in Hawaii, the Resource Mothers Program, and the Prenatal and Early Infancy Program originated by Doctor David Olds, along with whom I am honored to be a member of the panel this morning.

While we are impressed with the early evidence of the effectiveness of home visiting programs, in terms of increasing attendance in preventative prenatal care, encouraging healthy behaviors, and reducing the incidence of accidents, abuse, and neglect, we do not believe that home visiting should be viewed as a panacea for the prevention of abuse and neglect. Indeed, Doctor Olds, who has done the best research on this subject, has written, "While home visitation is a promising strategy, many home visitation programs simply do not work. Consequently, it is especially important to know what kinds of home visitation programs work best for pregnant women and young children."

In addition, I am unaware of any research that indicates home visitation programs prevent or reduce the incidence of the fastest growing category of child maltreatment, child sexual abuse.

I'm sure, Madam Chair, that you recall as I do the heartbreaking testimony of Marilyn Van Derbur Atler, a former Miss America, at the September hearing of this committee in Denver, as she described the years of incest that began when she was five years old. It is unclear to me how a home visitation program, in the first year of life, could have prevented that kind of abuse.

Therefore, we believe that home visiting is a mechanism that may be effective when used as part of a comprehensive effort to support mothers, families, and children. Indeed, we have required that each of the nine comprehensive, preventative programs that we funded in 1989 in communities throughout this country, include a home visitation component. We look forward to more evaluation research and demonstrations in this area.

In conclusion, I want to thank the select committee for this opportunity to present our views on this very important topic. We look forward to a continuing dialogue with you, as we move forward toward achieving our mutual goal, a nation where every child is ensured a childhood that is free from maltreatment.

Thank you.

Chairwoman SCHROEDER. Thank you very much, Doctor Horn. I do remember Marilyn Van Derbur saying, at least they could have seen the switches that were up over every door if there had been home visits, so it's very interesting.

[Prepared statement of Wade F. Horn, Ph.D., follows:]

CHILDREN, YOUTH AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Thank you, Madame Chair, for the opportunity to testify on the issue of preventing child maltreatment. My name is Wade F. Horn, Ph.D., and I am the Commissioner of the Administration on Children, Youth and Families. I am joined today by David W. Lloyd, the Director of the National Center on Child Abuse and Neglect (NCCAN).

It is not difficult to articulate my vision of what every child needs: physical and mental well-being; the opportunity, affirmation and support to develop the full range of his or her potential; friendship; love; and protection from harm. For most children in America, childhood is a time when those fundamental needs are met, and childhood and adolescence are happy times of growth and development. One of the major findings in the final report of the National Commission on Children is that it is a good time to be a child -- usually. The opening paragraph of the Commission's report states, "Most American children are healthy, happy, and secure. They belong to warm, loving families. For them, life is filled with the joys of childhood -- growing, exploring, learning, and dreaming -- and tomorrow is full of hope and promise." And later, the report says, "The majority of young people emerge from adolescence healthy, hopeful, and able to meet the challenges of adult life.... They are progressing in school, they are not sexually active, they do not commit delinquent acts, and they do not use drugs or alcohol."

Tragically, though, all too many children and adolescents suffer when their parents, families, neighborhoods, and communities renege

on their obligation to provide every child a birthright of caring. Some of these children suffer silently, from emotional abuse and neglect or from sexual abuse. Others bear visible scars on their bodies from physical abuse. Still others express their pain through self-destructive or socially destructive behavior.

About 1.5 million cases of child maltreatment are substantiated every year. About 60% of these children are educationally, physically, or emotionally neglected. Approximately 40% are physically, emotionally or sexually abused.

Changing this grim picture will require American citizens to build coalitions of concern, cooperative alliances that include government as a partner, but which also involve community associations, the corporate sector, the educational establishment, religious organizations, parent groups--everyone who has a stake in the future of our children. Clearly, that is every American. I see collaboration between government and the people through partnerships as key to achieving a decline in child maltreatment. And that is why this hearing is so timely -- we must keep children safe and we must use every resource -- public and private -- at our disposal to do so. We must work to reshape our service system so that it is an integral part of a caring society, something in which everyone can participate, in whatever small way. We strive for a system in which many people have a sense of ownership, rather than a sense that helping others is somebody else's problem. We look forward to the time when, confronted with child abuse, people will

look inward and say, "If I don't help, who will?" and "If not now, when?"

I believe that through a number of significant activities, we are moving toward the goal of developing a society where child maltreatment will not only be unthinkable, but also where everyone will have taken some personal responsibility to reach this goal. We view our efforts in the larger context of helping to develop healthy families, for such families form the foundation of a healthy society. To be successful, society needs strong families to accomplish many of its most important cultural and social tasks: (1) nurturing the development of children and providing intergenerational care for elderly family members; (2) parenting and socializing children and adolescents; (3) ensuring the basic economic self-sufficiency of the family unit; and (4) transmitting moral and ethical values and attitudes, including the importance of work and personal responsibility, to the next generation. The importance of personal responsibility cannot be overstated. It lies at the root of our form of government. And families, as the primary educators of children, lay the foundations of character in their children.

Our emphasis is on <u>prevention</u> of family dysfunction and the recognition that the causes of child abuse and neglect are interrelated. This approach is evident in key programs throughout the Administration for Children and Families, programs that, when viewed broadly, can be seen as integral to eradicating the root

causes of child abuse by promoting the growth of strong families. For example:

- Head Start continues to evolve away from a simple child development program into a program of comprehensive design, aimed at building solid families and communities. It not only addresses the developmental, health and nutrition needs of low-income children, it also works with parents to improve parenting skills, to discourage drug and alcohol abuse, and to train parents for and help them to find jobs. Further, involvement in Head Start often draws parents out of patterns of isolation and alienation that can lead to child maltreatment and into the active, connected, community-oriented life of the Head Start center. As teachers' aides, volunteers, and members of the governing boards, many acquire their first and most important lessons in belonging to a community, along with the rights and responsibilities that go with it. Indeed, Secretary Sullivan often cites Head Start as the best model of his call for a new culture of character and communities of concern.
- Recent reforms in Aid to Families with Dependent Children and child support enforcement were aimed directly at some of the unintended consequences of these programs, suggesting a shift away from entitlement and toward the assumption of personal responsibility. We know that children are unlikely to flourish in families that are caught in a cycle of long-term dependency. The JOBS

program (a work and training program for AFDC recipients to help them become self-sufficient) and child support enforcement thus play a critical role in improving the lives of children and preventing abuse by building parents' sense of self-worth. Becoming self-supporting strengthens a family in ways that long-term government assistance never will.

PREVENTION EFFORTS SPONSORED BY THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

Let me turn now to the subject of this hearing -- successful prevention strategies and public/private partnerships to prevent child abuse. This subject is particularly compelling at a time when the growing needs of families and children compete with many other constituencies for scarce governmental resources. Today more than ever we are called upon to develop strong alliances between the public and private sectors and to focus on prevention, in order to ensure the healthy futures of our children. At NCCAN, we are trying to do just that by reaching out not only to the traditional sources of child welfare services, but to all segments of society asking them to join together in preventing child maltreatment.

Prevention of child abuse does not occur in a vacuum, but rather within a framework of existing public policy, laws and regulations, economic conditions, values, attitudes, assumptions and research findings. We are willing to challenge old ideas about prevention

with new approaches derived from research and empirical experience. And above all, we emphasize the importance of personal involvement and responsibility in child abuse prevention.

OVERVIEW OF PREVENTION EFFORTS

Since 1975, we have funded 284 projects devoted to prevention, including 47 demonstration projects targeted at pregnant teenagers. For example, our 94 Emergency Child Abuse Prevention Services grants address the prevention of child abuse and neglect by parents who use illicit drugs and abuse alcohol. Findings from these projects point out that the presence of active prevention programs is most critical in designing a community system to combat child maltreatment.

From its inception, NCCAN has recognized the importance of community-wide systems and coordinated multidisciplinary approaches to the identification, prevention and treatment of child abuse and neglect. In late 1980, NCCAN funded 14 three-year service improvement demonstration projects for the management and treatment of intrafamilial child sexual abuse cases. These projects were designed to develop specific approaches to deal with such cases and to coordinate the resources of at least three agencies to improve case management. An article by Martha Kendrick describes what we learned from these models of community responses to intrafamilial child sexual abuse.

The key to success in every single community was the degree to which the program established strong cooperative working relationships with other agencies.

Thus, it has been clear for many years that effective prevention requires community-wide support and participation.

Building on that knowledge, in late 1989, NCCAN awarded nine five-year demonstration grants to support the planning and development of model comprehensive community-based physical child abuse and neglect prevention programs to address local needs in a number of urban, suburban, and rural communities across the country. The nine grantees are in Pittsburgh and Philadelphia, Pennsylvania; Ithaca, New York; Cumberland County, Maine; Dorchester, Massachusetts; San Juan, Puerto Rico; Fairfax County, Virginia; Chicago, Illinois; and Columbus, Ohio. These grantees have forged a number of public-private partnerships to prevent abuse. For example, in support of Child Abuse Prevention Month this year:

- The Columbus project is working with the local McDonald's restaurants to prepare a special calendar with hints on positive parenting techniques. Restaurant coupons will be included as an incentive.
- In Maine, supermarkets are being asked to print child abuse information on their grocery bags, and a number of businesses are encouraging their employees to wear blue ribbons as an emblem of child abuse awareness.

These grantees are also reaching out to all sectors of society, including those not ordinarily involved in child abuse prevention, to recognize their responsibility and get involved.

CHALLENGE GRANT PROGRAMS

Another way in which the National Center supports the development of prevention strategies is through the Challenge Grant Program. The Challenge Grant Program was enacted to encourage States to establish trust funds or other funding mechanisms to support child abuse and neglect prevention activities. States derive these Children's Trust Funds with revenue from such sources as surcharges on marriage license fees and private donations. For eligible States, Federal funds are awarded to Children's Trust Funds or, in States with dedicated appropriations, to the State liaison agency. The Federal funds awarded match either 25% of the amount collected and distributed the previous fiscal year by the State's Children's Trust Fund or 50 cents per child in the State, whichever is lower. In fiscal year 1992, nearly $5.4 million Federal dollars have been appropriated for the Challenge Grant Program.

Most grantees use Challenge Grant Program funds to award grants or contracts to community organizations. In turn, the organizations carry out projects aimed at preventing child abuse and neglect in designated areas of priority. Some of the funded projects are narrow in focus, offering a specific service to a specific target population. Other projects are very comprehensive, providing a

full range of services to families or to the public. Challenge Grant Program funds are also used directly by grantees for various prevention activities. Many of these activities are broad in scope, encompassing more than one service category.

These projects run the gamut of prevention strategies, from parenting education, to media campaigns, to the creation and performance of plays about child abuse prevention, to programs specially tailored for the needs of Cambodians or the Amish or the people of the Cherokee Tribe. These programs stand as examples of innovation and commitment to developing a range of activities, showing sensitivity to cultural differences, targeting at-risk populations, and collaborating with related public and private organizations in the community. With small amounts of Federal seed money, States are showing us what can be done when widespread community support is enlisted to fight child abuse. The Challenge Grant program allows States to think and act locally, using Federal funds to tap the talent and energy that resides in every American town.

We understand that dissemination of this good work to others who can adapt it for their own needs is essential. We hold annual meetings for our grantees in which we not only provide technical assistance, but allow the grantees to share their good ideas and methods with each other. In ten days, we will be hosting three sets of grantees in Washington. For the first time, experts working on the Children's Justice Act program, Challenge grants,

and medical neglect will come together to share information and exchange knowledge. In addition, we are in the process of disseminating summary reports of Challenge Grant activities to a wide range of service providers, child protective service agencies, and the general public.

SECRETARY'S INITIATIVE ON CHILD ABUSE AND NEGLECT

Another activity leading to some exciting results in forging new prevention partnerships is Secretary Sullivan's Initiative on Child Abuse and Neglect. This Initiative aims at involving all segments of society in the fight against child abuse. Now well underway, the Initiative has several components: 1) increasing public awareness of the problem of child maltreatment; 2) promoting intra- and inter-agency coordination of child abuse and neglect activities; and 3) encouraging all sectors of society to cooperate in combatting child maltreatment.

In support of the goal of forging new partnerships with all segments of society, a national meeting was held in Washington on December 6, 1991. The purpose of the meeting was to challenge leaders from business, social services, professional associations, criminal justice, education, the public sector and religious organizations to join in a coordinated effort to prevent child maltreatment. These leaders represent thousands of others around the nation whose activities they are in a position to influence. During the meeting, small groups composed of the representatives of

each sector met to exchange ideas on strategies they can pursue within their organizations at the local and State levels to become more effective in the battle against child maltreatment.

The meeting was a success and participants went home to enlist their counterparts in this effort. We have some results already:

- For 1992-1993, Kiwanis Clubs International is making child abuse and neglect a national priority. They plan to ask their members to incorporate child abuse prevention activities into their plans for the year.
- The Sunday School Board of the Southern Baptist Convention has made numerous presentations and mailed out material to ministers and church staffers in more than 40 States as a result of the December meeting. Additional dissemination of materials will take place throughout the rest of the year.
- Similarly, the National Conference of Catholic Bishops is working with clergy and education directors and has alerted 170 dioceses to Child Abuse Prevention Month and provided them with information from the National Committee for Prevention of Child Abuse.

We are encouraged by this evidence of grass-roots commitment. The Department of Health and Human Service's (HHS) role in the next phase is to host nine regional meetings during the month of April and one in June, which largely replicate the national meeting, but which involve State and local, rather than national representatives. We expect that these meetings will lead to an

increase in individual and collective responsibility-taking for a unified fight against child abuse.

In addition, HHS is working with seven other Cabinet departments to increase coordination and enhance the scope of each agency's activities in the area of child maltreatment. Last December, the Secretaries of Housing and Urban Development (HUD), Agriculture, Labor, Interior, Defense, Education, HHS and the Attorney General signed a Memorandum of Understanding pledging cooperation and the formation of new intragovernmental partnerships. We are excited about some of the specific ideas that have resulted from the Memorandum, for example:

- The Department of Labor is examining its role in the prevention of child maltreatment. Since adults who were abused as children often function poorly in the workplace, the prevention of child abuse is directly relevant to assuring that our workforce remains competitive in the years ahead. Thus, the Secretary of Labor will be speaking out about the importance of prevention efforts and written materials will be disseminated. These messages will reach an important audience--the future employers of our children. They will learn that they, too, have an important stake in preventing child abuse.
- The Department of Agriculture, through its Extension Service programs, reaches into the daily lives of many Americans. Extension Service agents such as home

economists and 4-H programs are excellent case-finders and identifiers of families at risk. In recognition of this, Agriculture will be working closely with HUD and HHS to incorporate child abuse education and prevention into their existing programs which focus on young children.

HOME VISITING PROGRAMS AND CHILD ABUSE PREVENTION

I am pleased to be here with several experts who will testify on the issue of the effectiveness of home visiting programs -- programs that send trained workers into the home to counsel, support, assist, and educate young families -- in the prevention of child maltreatment. We are aware of the fine results of the Healthy Start program in Hawaii, a program whose impetus came from the private sector and is now institutionalized within the public sector. Other examples, such as the Resource Mothers Program, the Rural Alabama Pregnancy and Infant Health Program, and the Prenatal and Early Infancy Program originated by Dr. Olds have made important contributions to the health and care of mothers and children.

There is evidence that home visiting programs can increase attendance in preventive prenatal care, encourage healthy behaviors, help families care for their children, and reduce the incidence of accidents, abuse and neglect. However, we do not believe that home visiting programs are a panacea for the problem

of child abuse and neglect. Even Dr. Olds, who has done the best research on the subject, has stated that:

> ... although home visitation is a promising strategy, many home-visitation programs simply do not work. Consequently, it is especially important to know what kinds of home visitation programs work best for pregnant women and young children.[1]

In addition, although the tradition of home visiting is well established in many European nations, it is not clear that the critical factor in reducing the incidence of abuse and neglect in Europe is a result of home visiting per se or is due to other considerations.

You will recall that at the September hearing of this Committee in Denver, held at the Ninth National Conference on Child Abuse and Neglect, we heard heart-wrenching testimony from Marilyn Van Derbur Atler, a former Miss America, as she described years of incest that began when she was 5 years old. Indeed, reports of child sexual abuse grew at a faster rate during the last decade than other types of abuse or neglect. Yet, I am unaware of any research that indicates home visitation programs prevent or reduce the incidence of child sexual abuse.

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[1] David L. Olds, Ph.D. and Harriet Kitzman, Ph.D.; "Can Home Visitation Improve the Health of Women and Children at Environmental Risk?; Pediatrics; Vol. 86 Number 1, July, 1990, page 108.

Therefore, we believe that home visiting is a mechanism that can be effective when used as part of a comprehensive effort that links mothers, fathers, and children to medical and social supports in the context of other prevention efforts. We look forward to more evaluative research and demonstrations in this area as we strive to reduce the incidence of child maltreatment.

In conclusion, I want to thank the Select Committee for this opportunity to present our views on this important topic. We look forward to continued dialogue with you as we move toward achieving our mutual interest -- a childhood free from harm for all children.

I would be pleased to answer any questions you may have.

Chairwoman SCHROEDER. Next, we move to Doctor Anne Cohn Donnelly, who we are very, very happy to have with us this morning. Anne is the Executive Director of the National Committee for Prevention of Child Abuse in Chicago, Illinois.

Anne, the floor is yours, and we'll be happy to hear what you have to say.

STATEMENT OF ANNE COHN DONNELLY, D.P.H., EXECUTIVE DIRECTOR, NATIONAL COMMITTEE FOR PREVENTION OF CHILD ABUSE, CHICAGO, IL

Ms. COHN DONNELLY. Thank you, Madam Chairwoman.

It is a great pleasure to be able to provide testimony at this hearing. I'm going to divide my testimony into two pieces. The first I will provide a summary of the newest data that we have available on statistics related to child abuse and neglect, and then I'd like to describe a new initiative related to home health visitors.

I will submit my full testimony for the hearing record.

Chairwoman SCHROEDER. Without objection.

Ms. COHN DONNELLY. Annually, the National Committee for Prevention of Child Abuse conducts a survey of all 50 states. We've been doing so since 1986, in order to track child abuse reports, child abuse fatalities and other facets of the Children's Protective Service System.

We have some surprising and unsettling information based on our 1991 survey, which we are releasing in conjunction with this hearing.

First of all, with respect to child abuse reports, in 1991, there were 2,694,000 reports of suspected child abuse and neglect. This is a six percent increase over last year, a 40 percent increase over 1986.

While, in some states changes in the numbers of child abuse reports have to do with changes that have been implemented in the state with respect to how reports are counted or accepted, when the states were asked "what do you attribute these increases to?" in addition to a willingness on the part of the public to report cases of child abuse, most states cited severe economic stress that families across the country are facing as a factor contributing to increased numbers of child abuse reports.

The story on fatalities is different and even more distressing. In 1991, there were 1,383 documented child abuse fatalities. The actual numbers are undoubtedly larger than that. This represents a ten percent increase over last year. One hundred thirty more children were documented of dying from child abuse in the last year than in the previous year. These increases parallel increases that we have seen in the child homicide statistics across the country.

This means that, essentially, four children a day die as a result of child abuse. This is the single largest increase that we have seen since 1986. There has been over a 50 percent increase in documented child abuse fatalities since 1986.

These increases are due, in part, to better counting. Thirty-three states now have death review committees, which certainly improve their ability to document cases of child abuse fatalities. But states

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also cite severe economic stress in families and the substance abuse problem as two factors leading to these increases in child abuse deaths.

I'd like to note that 40 percent of these deaths were in families that were known by, and most often clients of, children's protective service agencies. Seventy-eight percent of the children were under the age of five. Fifty-six percent were under the age of one.

With respect to funding and service provision, 13 states last year saw increases in funds available to offer services to the families that they are seeing. In other words, the vast majority of states saw no increases or saw decreases in the number of funds that they have available to respond to the increasing number of reports.

The result in 1991 is a major decrease in the number of confirmed cases of child abuse that actually are receiving services. In fact, in 1991, states estimate that 63 percent of the cases where child abuse was confirmed receive some kind of service.

In the previous year, the figure was 78 percent. That amounts to 15 percent fewer families where child abuse has been confirmed actually getting services after the fact to repair the damage.

At the National Committee for Prevention of Child Abuse, we are deeply concerned about these increases in numbers. We are deeply concerned about the increased inability of the system to respond after the fact. We believe it is time to dramatically increase our focus on preventing child abuse before it occurs, in order to spare the hurt, to save lives, to save dollars.

Child abuse is a very complex problem. There are many different causes, there are many different forms of child abuse. We are going to talk today about an intervention which is not the only thing we need to do to prevent all types of child abuse, but it is an intervention for which we have some very exciting information with respect to physical abuse and neglect of young children.

This last September, the U.S. Advisory Board on Child Abuse and Neglect, in acknowledging the national emergency that child abuse is in this country, in acknowledging that there are many different things that we need to do to prevent the problem, said if we need to start someplace, the place to start is with new parents to help them get off to a good start. We agree.

The U.S. Advisory Board recommended a national voluntary universal program of home visits to new parents and their babies. We agree.

Home visiting has widespread appeal, and it also has convincing evidence relative to its ability to prevent physical abuse and neglect.

Home visiting provides us with an opportunity to work with families in their environment, in the family context, to tailor services to the specific needs of the parent and the child. It is a way to reach reticent or isolated families.

The growing body of knowledge indicates that home visitor services, when crafted in particular ways, can be particularly effective in reducing child abuse and neglect—you'll hear a little bit more about that from Doctor Olds.

Basically, home visitor services, when provided to parents as close to birth as possible, and preferably before birth, when provided in an intensive way, we are not talking about one or two visits,

but intensive visits, at least once a week for at least six months, when offered to high-risk families, families most likely to abuse, can, indeed, result in fewer children being injured.

We are very impressed with the home visitor approach. We are very impressed with the ways in which we can make a difference in children's lives. We are so impressed with the notion that, with intensive home visitor services offered to high-risk families, we can make a dent in the amount of child abuse that we have launched a national initiative that we are calling Healthy Families America. It's an initiative that we are launching in partnership with the Ronald McDonald's Children's Charities. Its purpose is to take a program that exists in Hawaii, which you'll hear about from Ms. Breakey, where home visitor services are being offered to high-risk families on an intensive basis, and where great success has been realized in reducing physical abuse and neglect.

Our goals are in the next three years: (1) in at least 25 states, to initiate the replication of what is going on in Hawaii; (2) to double the number of new parents who are receiving intensive home visitor services; and (3) to reduce by at least 75 percent the amount of physical abuse and neglect in the population served.

The public is ready for this program. Recent data that we are also releasing today shows that 86 percent of the public think it's appropriate to offer home visitor services to new parents, and 74 percent of the public approve of government spending money on home visitor services. The states are ready to move ahead as well.

Since January of this year, just a few short months ago, we've been in touch with all 50 states. In 36 states, the State Department of Maternal and Child Health, our State Chapter, and the State Children's Trust Fund, and some other public and/or private state agencies, have expressed an interest in moving ahead with the replication of the Hawaii program.

Twenty states have already made a commitment to get a pilot up and going in the next year, and several states, including Virginia, Arizona, New Mexico, and Nebraska, already have pilot programs in place.

We do plan to do an in-depth evaluation of this effort. Although we know a lot about home visitor services, there's a lot more we need to know in order to do an even better job of offering these kinds of services to new parents.

We do intend to pursue our goals vigorously. After all, with the number of deaths that we're seeing, with the number of serious reports of child abuse we are seeing, it is time to take action and not time to study the problem any longer.

Thank you.

Chairwoman SCHROEDER. Thank you very much, Doctor Cohn Donnelly, that was very sobering.

[Prepared statement of Anne Cohn Donnelly, D.P.H., follows:]

PREPARED STATEMENT OF ANNE COHN DONNELLY, D.P.H., EXECUTIVE DIRECTOR, NATIONAL COMMITTEE FOR PREVENTION OF CHILD ABUSE, CHICAGO, IL

My name is Anne Cohn Donnelly and I am Executive Director of the National Committee for Prevention of Child Abuse (NCPCA), a volunteer-based organization dedicated to preventing child abuse in all its forms. NCPCA includes a network of chapters in all 50 states representing some 120,000 concerned citizens.

It is a great pleasure to present testimony to the Select Committee on Children, Youth and Families regarding "Keeping Kids Safe: Exploring Public/Private Partnerships to Prevent Abuse and Strengthen Families." I am particularly pleased to have an opportunity to describe to you a new national prevention initiative "Healthy Families America" which we have just launched in partnership with the Ronald McDonald Children's Charities (RMCC). The initiative has already tapped into considerable interest across the country to invest now in prevention by helping all new parents get off to a good start with the provision of intensive home visitor services. Before I describe "Healthy Families America", I would like to present to you the latest child abuse and neglect statistics, including the 1991 child abuse reporting and fatality data which we are releasing at this hearing, and present background information on why we should focus on new parents to prevent child abuse and why intensive home visitor services are the preferred approach.

LATEST CHILD ABUSE AND NEGLECT STATISTICS

A. Child Abuse Reports and Fatalities

Since 1982, the National Committee for Prevention of Child Abuse (NCPCA) has conducted an annual national telephone survey of child protective service (CPS) agencies in all 50 states. The initial surveys focused exclusively on increases in the number of reports and the effects of budget cutbacks. Beginning in 1986, NCPCA developed a more standardized instrument which focused on the number and characteristics of child abuse reports, the number of child abuse fatalities and changes in the funding and scope of child welfare services. This instrument, which has been utilized for the past five years, provides more reliable estimates of the number of reports and fatalities across time and across states.

It is a pleasure to have the opportunity to formally release the 1991 figures at this hearing. A full report on the findings is being submitted with my testimony.

The total number of child abuse reports increased once again in 1991, climbing to over 2.6 million reports or 42 reports for every 1,000 children in the United States. This figure is over 6% higher than the number reported in 1990, and 40% higher than the number reported in 1985.

Overall, child abuse reports have maintained a steady growth between 1985 and 1991, with annual increases of about 6%. This growth rate, while significant, is roughly half the annual rate of growth reported in the first half of the decade.

Dramatic increases or decreases in reports (i.e. plus or minus 10%) in any given two year period generally reflect changes in a state's data collection system. For example, the 42% increase in reports noted in Georgia last year reflect the fact that all reports, not simply those reports that are investigated, are now documented. Administrators in states that have experienced gradual increases over the past several years, however, cite several primary factors for this trend. First, economic stress due to poverty, unemployment and related work concerns were cited by almost half of the administrators as contributing to increased reports. Second, roughly one-third of these administrators saw the increase as stemming from increased public awareness and willingness to report suspected cases of maltreatment.

Reported child abuse fatalities rose last year by over 10% over the number reported in 1990. A total of 1,383 children were officially registered as fatal victims of maltreatment last year, 130 more than were reported in 1990. The 1991 statistic is a projected number based on data from 36 states comprising 75% of the U.S. child population.[1] This represents essentially four children a day.

Looking across the full seven year reporting period, the rate of child abuse fatalities has increased 54%. Throughout this period, the characteristics of these cases have remained fairly constant. Approximately 40% of these deaths occur to children known to the local child welfare system either as prior or current clients. As for the cause of death, 40% of the deaths result from physical neglect while 60% are the result of physical abuse. Each year the vast majority of these cases have involved young children. In 1991, 78% of the victims were under five years of age and 56% were one year or younger. Increases in deaths may be due to better counting in some states in part due to the introduction of death review teams. The prevalence of substance abusers, economic factors and the paucity of prevention services for these families are also significant factors. With respect to funding for CPS, in 1991 only 13 states show increases in funding; seven experienced decreases and 26 reported no change in funding level. Overall, the system continues to face growing demands without adequate increases in resources.

B. The Publics Opinions about Child Abuse, its Prevention and Home Visitor Services

Since 1986, the National Committee for Prevention of Child Abuse has commissioned national public opinion polls to determine the public's attitudes and actions with respect to child abuse prevention. Each survey has involved a representative telephone survey of 1,250 randomly selected adults across the country of whom approximately 36 to 38% are parents with children under 18 living at home.[2]

This year, as in the past five years, we found that the vast majority of the public see physical punishment and repeated yelling and swearing as detrimental to a child's well-being. In the most recent survey, 80% of the public felt that physical punishment can lead to injury and 93% of the public believed that repeated yelling and swearing can lead to long-term emotional harm.

In the most recent survey, 45% of parents reported that they had insulted or swore at their child and 53% reported that they had spanked or hit their child in the past year. While similar to the figures obtained in last year's survey, these findings compare favorably to the patterns observed in 1988. Compared to 1988, 10% fewer parents are reporting the use of insulting or swearing and 11% fewer report the use of spanking as methods of discipline. This is an important and very positive shift in parenting practices across the country.

For the first time since 1988, both the general public and parents expressed greater optimism in their ability to prevent child abuse. In the most recent survey, over two-thirds of the general public and over three-quarters of the parents felt they could make a notable contribution to prevention. Further, as in past, one in four individuals and one in three parents report having taken personal action in the past year to prevent child abuse.

The public is quite interested in specific prevention interventions as well. Seven percent of the 445 parents interviewed in the most recent survey indicated that they had received a home visit within the first six months after giving birth. In two-thirds of these cases, only a single visit was provided. Of those who received the services 69% reported that the visit was helpful in learning how to care for their child. Interestingly, over three-quarters of those parents who did not receive the service felt such a service would be useful for parents like themselves. Seventy-four percent of all the respondents approved of the government supporting the provision of home visits for parents.

THE CASE FOR PREVENTION

Child abuse hurts -- the after effects, which are well documented, are devastating. Abused children suffer a wide variety of emotional and developmental as well as physical problems -- both acute and chronic. Some children die. These problems often become evident in the emergence of other social ills -- eg. teenage runaways, teen prostitution, alcohol and drug abuse, school problems, juvenile delinquency. For these reasons, child abuse costs us dearly -- from a humane perspective in the injury of a child and from a financial perspective in the ongoing costs associated with responding to the problems which emanate from child abuse.

The case for working to prevent child abuse before it occurs is clear. Prevention spares the hurt and can save lives; prevention also saves money. For those concerned about when intervention can make the biggest difference, researchers have documented the effectiveness of various prevention services as well as treatment services after abuse has occurred; prevention approaches are more likely to be successful (Cohn and Daro, 1988). This, too, supports the case for prevention. And, for those concerned about just how overwhelmed the treatment system currently is, the work of prevention may be the best way to reduce this burden.

Table I: Goals of Prevention Efforts

- increase future parents' knowledge of child development and the demands of parenting
- enhance parent-child bonding, emotional ties, and communication
- increase parents' skills in coping with the stresses of infant and child care
- increase parents' skills in coping with the stresses of caring for children with special needs
- increase parents' knowledge about home and child management
- reduce the burden of child care
- reduce family isolation and increase peer support
- increase access to social and health services for all family members
- reduce the long-term consequences of poor parenting

HOW TO PREVENT

Child abuse is a complex problem with many underlying causes having to do with both individual (eg. a parent's lack of understanding of child development) and environmental (eg. poverty) factor. To be successful, prevention efforts must ultimately take account of the variety of underlying causes -- both personal and societal. Such a comprehensive approach would include public awareness efforts to educate the public about the magnitude of the problem and how to get involved in its prevention while addressing attitudes about parenting. Certain key prevention services should be put in a place to help all new parents to get off to a good start and to make sure that all parents under stress have access to various crisis and support services, all victims get the therapeutic assistance they need to break the cycle of abuse and all children the opportunities to learn how to protect themselves from abuse. In addition, efforts must be directed at certain societal barriers to abuse such as the use of corporal punishment in schools or the amount of media violence. Finally, issues such as substance abuse, poverty, family and community violence, and cultural diversity must all be addressed. The consensus in

Table II: Comprehensive Approach to Prevention

- support programs for new parents
- education for parents
- early and regular child and family screening and treatment
- child care opportunities
- programs for abused children and young adults
- life skills training for children and young adults
- self-help groups and other neighborhood supports
- family support services
- community organization activities
- public information and education on child abuse prevention

the field is clear -- no single approach, no single program will be enough to prevent abuse; all elements of a comprehensive approach ultimately need to be in place (Cohn, 1983).

WHERE SHOULD PREVENTION EFFORTS BEGIN

In 1991, after a year of study of how the United States should respond to the national child abuse emergency, the U.S. Advisory Board on Child Abuse and Neglect declared that while there are dozens of important things to do, a logical place to start is with new parents, helping them get off to a good start before abuse patterns begin (U.S. Advisory Board, 1991). With new parents, especially first time parents, we have the opportunity to encourage and if necessary to teach good parenting practices before bad patterns are established. New parents are often characterized as "like sponges", anxious and ready to learn anything they can about their new babies and how to care for them. Second, most reported cases of physical abuse and neglect occurs among the youngest children (eg. under age 5) (AAPC, 1988). By focusing on new parents we are reaching the target population where the incidence of physical abuse and neglect is likely to be the greatest. Our knowledge about the effects of working with new parents and the prevention of sexual abuse is scant (Musiak, Bernstein, Percansky, and Stott, 1987); working with new parents may not be among the most important first steps in prevention with this form of abuse as it is with physical abuse and neglect.

WHAT APPROACH TO NEW PARENTS SHOULD WE TAKE

The U.S. Advisory Board on Child Abuse and Neglect recommends a voluntary program of home visits to new parents and their babies as the desired approach. Many others have expressed similar views. There are a number of reasons why this is so.

First, home visiting has widespread appeal. It affords an opportunity to work with individuals in the family context or environment, enabling the professional or volunteer visitor to learn first hand the conditions of life for the parent and child and to respond to them. In other words, to provide the opportunity to tailor the service (eg. home visit) to the needs and characteristics of the parent and the child in their own natural setting.

Home visits uniquely provide a way to reach isolated families, families that typically do not participate, families that are too distrustful or too disorganized to make their way to a center based program or a workers office. In this sense, home visiting provides a unique opportunity to engage dysfunctional families.

The public is most supportive of the home visitor concept. A public opinion poll conducted in 1991 by the National Committee for Prevention of Child Abuse showed that 86% of the respondents thought it appropriate to offer home visits, and other supportive services to all first time parents.

An additional indicator of just how widespread the appeal is of home visitor services, is the number of such programs which already exist. The National Parent Aide Association, for example, has documented over 650 community-based programs across the country which provide home visitor - type services to parents (Bryant, 1991). Further, national surveys of hospital administrators conducted by NCPCA find that over one-quarter of all hospitals report offering home visiting services to high-risk new mothers (Daro, 1991).

In addition to the widespread appeal of home visitor services, there is a solid and expanding evaluative data base on the efficacy of the approach. The studies date back over two decades (Daro, 1988).

In the early 1970's, the C. Henry Kempe National Center of for the Prevention and Treatment of Child Abuse conducted a controlled experimental design study of nurse practitioner home visitors with a sample of high risk new parents. The study documented enhanced mother/infant relationships and a reduction in child abuse among the experimental group (Grey, Cutler, Dean and Kempe, 1979).

From the mid 1970's through the early 80's a number of large scale evaluation studies of federally funded child abuse service programs, which included high risk as well as abusive clients, were conducted (Cohn, 1979; Cohn and Daro, 1988; Daro, 1988). The studies compared the relative effectiveness and cost effectiveness of different service interventions. The home visiting services of parent aides, coupled with group services such as group therapy or Parents Anonymous, and homemaker services significantly reduced child abuse potential in contrast to those clients receiving basic counseling or only out-of-home assistance.

Dr. David Olds and his colleagues (1986, 1990) have conducted the longest and perhaps most thoroughly designed and carefully controlled studies of the home visitor model from the scientific perspective. In his first study 400 first time mothers were randomly assigned to four groups one of which received: (a) intensive pre and post natal visits by a nurse practitioner; (b) parent education on fetal and infant development; (c) involvement of the mothers friends and family in child care and support of the mother and (d) linkages to health and human services. This experimental group showed 4% abuse at the end of the study in contrast to 19% in the control group; the experimental group also demonstrated fewer accidents, less required use of the emergency room, less need to punish and discipline their children longer spacing between children. Dr. Olds is cautious in generalizing his findings to populations beyond the young, low income single mothers served.

Other less controlled studies support the value of home visitor services in various settings. Lutzker and Rice (1984, 1987) conducted a study of Project 12 Ways, a multifaceted home-based service program in Southern Illinois in which home visits to new parents were offered by graduate students. At the end of the program abused had been detected in 2% of those receiving the home visits in contrast to 11% in the control groups. The relative effectiveness of the program continued for at least one year. In a one year follow-up, abuse was found in 10% of the experimental group and 21% of the control group.

Seitz and her colleagues (1985) studied the impact of intensive home visits to first time mothers for 20 months after birth. Follow ups were conducted on 15 of 17 matched sets of families up to 10 years after the program. Seitz documented steady improvements in parenting and family life over the 10 year period.

In addition, Hawaii has conducted several studies of its universal voluntary Healthy Start program in which paraprofessionals intensively visit new parents identified at risk of abuse for up to 5 years after birth. The program includes the provision of other health and child development services as well. Of over 1,000 high risk parents served, and studied, abuse was reported for only .8% (Breakey and Pratt, 1991).

The studies done on home visitor services consistently suggest that this service approach has significant benefits in the prevention of child abuse and other related problems. The studies done have not been perfect. Many questions still remain unanswered with respect to home visitor services and should indeed be addressed. And yet, the evidence is convincing enough for the U.S. Advisory Board, the National Committee for Prevention of Child Abuse and others to pursue the delivery of home visitor services for all new parents. As the late Dr. Ray Helfer said often "if you wait for all the research to come in you'll never accomplish anything."

WHAT DO WE KNOW ABOUT WHAT HOME VISITOR PROGRAMS SHOULD LOOK LIKE?

As with outcome data, our information base about what home visitor programs should look like its growing, albeit still limited. On some program dimensions our common sense at this point may be as important as any research results.

(a) *General Models*

There are at least two distinct models which have been used for home visitor programs. In the first (described as primary prevention) an effort is made to provide education and support to all parents at the time of birth, either by targeting all births or a given hospital or in a given geographic area. One or a few contacts with the parents are used to impart information, acquaint the parent with community resources, and make referrals if indicated. In the second, certain parents are identified and targeted for service because they are believed to be at higher risk to abuse. Such programs (dubbed secondary prevention) may target all first time parents, all teen parents etc. Typically home visits are offered on a more intensive basis and for a long period of time. Research evidence tells us that the more intensive approach with high risk parents is more effective than widespread low intensity services in ameliorating the personal conditions which contribute to abusive behavior. Yet, common sense tells us that in an ideal world we would probably both blanket all new parents with some information and support and provide more intense home visitor services for those at greatest risk to abuse.

(b) *General Purpose*

The purpose of the home visitor program can vary dramatically from those which focus on the parent and the improvement of parenting skills to those which focus on the child, child development and school readiness and to those which focus on the family as a unit and its needs (eg. housing, medical care, job). Once again, research has not been done to establish if one of these approaches is more effective in preventing child abuse; indeed such research would be difficult since most programs seem to do a bit of each. However, common sense guides us a bit here -- for example, a parent overwhelmed with housing problems may not be ready or able to absorb important parenting information. Family needs have to be tended to in order to be able to address parent and child concerns. And ultimately, the focus on parenting skills must be seen as an essential component in preventing child abuse.

(c) *General Format*

In addition to where the focus is, programs can vary by their general format. Some home visitor programs are built around a curriculum or fixed set of information. This more didactic approach can be contrasted with those programs in which the content of services is tailored to the individual needs of the parent and child, eg. the format is flexible. Modest research done here suggests that an individualized approach is likely to have the bigger payoffs in preventing child abuse. While more effective, however, the individualized approach is much more difficult, particularly when visitors have big caseloads or lack appropriate, in-person supervision.

(d) *Role of the Home Visitor*

What role should the home visitor play in the parents life? Is the visitor a friend? a teacher? a social worker? a nurse? Should the visitor take a more conventional approach in defining the relationship? (eg. "the parent has deficits which I can help fix") or a collaborative approach (eg. "we have things to learn from each other"). Once again, research here is limited but supports the collaborative approach. Perhaps at times the visitor will play any one of a number of roles but the most important one appears to be "friend", a person who can establish a trusting relationship with the parent. To the extent a visitor cannot play all roles (eg. social worker or nurse) she should be able to get the family access to such services (Daro, Jones et al 1992).

(e) *Do Visitors Need to be Professionals*

There are very different and very strongly held views about whether or not visitors need to be professionals. There is no one study that I am aware of that compares the relative effectiveness of the different approaches (eg. nurse practitioner, paraprofessional, neighborhood volunteer) so we really don't "know" which approach is best. What we do know is that the studies which have been done of individual approaches result in evidence suggesting each approach can work. Dr Olds' successful program is conducted by nurse practitioners (Olds and Henderson, 1990). In 1990 a review of randomized trials of home visitation found that the more effective programs employed nurses who began visiting during pregnancy and for a significant (eg. 2 years) period of time thereafter (Olds and Kitzman, 1990). In Hawaii's Healthy Start, highly trained, well supervised paraprofessionals are effectively used. In the Ford Foundation's "Child Survival Fair Start Initiative" parent volunteers were used effectively to increase parents' ability to get and use medical care, discuss problems and use community resources (Halpren and Larner, 1987).

Many operating home visitor programs have suggested that the following are the most important characteristics of successful home visitors: has an active interest in people; has an ability to engage people socially; has her own stability; and accepts other peoples life situations without judgement (Larner, 1990). At least one study confirms that staff members acceptance of and expectations of parents have a lot to do with the extent young mothers benefit from services (Musiak, et al, 1987).

(f) What About Service Planning and Supervision

There are ample questions about how much supervision home visitors need to be provided, particularly given that they are working with high risk families. Research on child abuse treatment programs suggest that workers need high quality, ongoing, in person supervision. The same should certainly be true for home visitors, particularly lay or paraprofessional workers. One study emphasizes this point with service planning as well (Cohn and DeGraff, 1982; Cohn, 1979): Once again this was a study of child abuse treatment programs; we assume the findings translate to prevention. The study, a 3-year evaluation of federally funded demonstrations, found that the more qualified the intake worker (eg. the more skilled the person doing the initial diagnosis and service plan) the more likely services would be effective. By putting the most qualified staff up front to help develop an individualized service plan for a family, the more likely home visitor services can be effective.

(g) When Should Services Begin

There appears to consensus that services should begin as early as possible. Research supports this view. Larson (1980) found the earlier the prenatal intervention the more positive the parenting later. NCPCA had similar conclusions. Initiate as to close or as soon before birth as possible.

(h) How Long and How Intense Should Services Be

Clearly, the length and intensity of services will of necessity vary from one person to another. However, research findings are fairly consistent about the norm. Earlier studies of child abuse treatment programs showed that contact at least once a week and preferably three times a week for at least six months was important in order to see a reduction in the likelihood a parent would reabuse. More recent studies of prevention programs by NCPCA suggest the same -- while it is often possible to change a parents knowledge quickly, at least six months of intensive contact is necessary to change attitudes, strengthen skills and thus improve parenting behavior (Daro, Jones et al 1992). Much longer is probably beneficial in many cases, particularly for the higher risk parent. Many believe services should continue until the child in school (age 5) or preschool (age 3). We conclude that in general, home visitor programs should continue for a long period of time and should offer intensive services.

(i) Should Services Be Voluntary

All of the prevention programs we are aware of in the United States are in fact voluntary. Data thus do not exist on what outcomes can be expected from parents who would not volunteer to receive a visitor in their home but would be mandated to do so. Given the preventive nature of the intervention it may be hard if not impossible to craft a program which would mandate a home visitor service; however, such services could be made universally available.

(j) Where Should Home Visitor Services Be Housed

Once again, we have no research on where the best home for home visitor services would be. Public or private agency? Health or Social Service Sector? The potential for debate here is great. There probably is no one right answer. We have seen programs work effectively in a variety of settings. Some things are clear: private agencies have an easier time providing flexible, individualized

services and public agencies are in a better position to ensure consistent training, funding and so on across sites. Health agencies will have a much easier time making sure families get the immunizations, well child visits and other medical care services truly needed. (Whatever other needs a family has, access to medical care for immunizations, well child visits, etc. is critical to a child's development.) Social Service agencies have the close ties to the child abuse professionals who work with abuse once it occurs and to public assistance programs. A collaborative approach or partnership that creates roles in which all these agencies work together is the approach most likely to result in effe. .e services for families.

WHAT THEN ARE THE ESSENTIAL ELEMENTS OF HOME VISITING WHICH ARE IMPORTANT IN REPLICATION

This review of the literature and other observations about home visitor services results in the identification of a number of elements which would appear to be essential in the successful provision of such services:

- start at least the time of birth, or earlier if possible
- universal provision of some service to all new parents
- screen for high risk (by highly qualified workers)
- offer follow-up home visitor services on a voluntary basis, especially to high risk parents
- offer services in the home, at least initially, where one has complete access to the parents and child
- offer intensive services: at least once a week for the first six months
- offer services for a long period of time: at least six months; up to five years
- tailor services to a family's specific needs
- focus on friendship, trust, social support
- maintain close ties for the family to the health care system and, if necessary, increase support services
- ensure that visitors receive intensive, ongoing training and supervision

THE HAWAIIAN APPROACH

A wonderful model embracing these dimensions which reaches all first time parents with intensive home visitor services already exists in the State of Hawaii. There, over the past seven years, the state's Maternal and Child Health Program has pilot tested, evaluated and now put into place for over 50% of their new parents a program called "Healthy Start." Visits by paraprofessionals to all new parents begin in the hospital at the time of birth and for high risk parents continue during the critical first months and if necessary, first years of the child's life. The services thus far have resulted in the physical child abuse in the population served. The visits are voluntary; very few of the at risk parents refuse the services. The home visits are complemented by an impressive array of medical, child development and social services. The home visitors receive intensive training and ongoing supervision. The program is a public/private sector partnership with the state administering the program and private agencies delivering the services. The state's goal is to serving 100% of new parents within the next several years.

HEALTHY FAMILIES AMERICA

Because of the U.S. Advisory Board's recommendation, because of the general interest in the field in helping new parents get off to a good start, because of the growing data base showing the effectiveness of the home visitor approach, because of our own belief in it, the National Committee for Prevention of Child Abuse, in partnership with the Ronald McDonald Children's Charities (RMCC), has now launched a national initiative entitled "Healthy Families America". The initiative seeks to make sure that all new parents, especially those at high risk, get off to a good start by replicating the Hawaii model across the country. We are working in conjunction with the Hawaii Family Stress Center and Hawaii's Maternal and Child Health Departments and other interested state and national organizations.

The project goal is to lay the foundation for a nation-wide, voluntary neo-natal home visiting program with a network of state level organizations that are willing to establish home visitor services. NCPCA is providing assistance to help states do so. Specifically we will distribute training materials on how to develop, implement and operate an Hawaiian "Healthy Start" type program including legislative, funding and operational considerations and we will provide training and technical assistance through conferences, teleseminars and on-site visits to state level organizations identified with the interest and capacity to replicate the program in their state.

The following kinds of outcomes are sought after three years:

- more than 25 of the states will have initiated statewide home visitor-type services for all new parents modeled after Hawaii's Healthy Start Model; numerous community agencies will have done the same
- at least twice as many at risk new parents will be receiving intense home visitor services than did at the outset of the effort
- child abuse will be reduced by at least 75% in the population receiving intensive home visitor services

An in-depth evaluation of the effort will be conducted to measure accomplishment of the expected outcomes. To date, a tremendous amount of activity has already occurred reflecting the level of excitement about Healthy Families America:

- In 36 states, some combination of state-level public and private agencies have made a commitment to work together over the next 3 years to replicate the Hawaii experience -- typically this includes the state's Maternal and Child Health Division, the state's Children's Trust Fund and our own state Chapter.
- Twenty-four of these states had 2 or more representatives from their state-wide teams in Hawaii in early February for a first hand introduction to the Hawaii program.
- Since then, in less than two months, 25 states have held at least one and in a number of cases several team meetings to explore next steps at the state level.

- Twenty states have already established the goal of implementing one or more pilot programs in the next 12 months; wherever possible evaluation efforts will be built in.
- Five states have or are very close to having secured funding for pilot programs.
- A few states are discussing the development of a statewide plan in the next 12 months; several more intend to introduce statewide legislation.
- Thirty-five have already committed to help gather baseline data on the current availability of Healthy Families America type services.

In the next few months, training including on-site visits will begin and baseline information will be gathered. In addition, RMCC will be educating its 70 or so local affiliates about Healthy Families America and encouraging them to participate. Both organizations believe that the provision of educational and support services to parents via home visitation does prevent child abuse. And, they share the goal of helping as many states as possible to build a network of people and organizations who are willing to establish home visitor services. This is a unique and we think exemplary example of a partnership investing in prevention.

CONCLUSIONS

Child abuse reports and, most tragically, documented child abuse fatalities have risen once again in the last year. The child abuse problem remains a national emergency. As a nation we spend in excess of $2 billion responding to the problem after it has occurred. We spend over $2 billion investigating whether or not abuse has occurred and offering unproven and generally ineffective services to families already crushed by abuse. It is time for change. It is time for major change. It is time for a major investment in the prevention of child abuse before it occurs. For two decades we have been accumulating evidence on the desirability of offering new parents intensive home visitor services to prevent child abuse. The evidence now in tells us that this is an effective and indeed cost effective approach. It is time for the nation to invest in a national program of neo-natal home visitation especially for our highest risk new parents.

ENDNOTES

1. Estimates for earlier years are based upon at least 85% of the child population. If data were available from all 50 states and the District of Columbia for all seven years, the actual rate of change and total scope of the problem could vary somewhat from these projections.

2. The sampling error for the entire sample is plus or minus 3 percentage points, assuming a 95% confidence level.

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CURRENT TRENDS IN CHILD ABUSE REPORTING AND FATALITIES: NCPCA'S 1991 ANNUAL FIFTY STATE SURVEY*

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OVERVIEW

In an attempt to better determine the volume of child abuse reports and the availability of child welfare resources, the National Committee for Prevention of Child Abuse (NCPCA) initiated an annual national telephone survey of child protective service (CPS) agencies in 1982. The initial surveys focused exclusively on increases in the number of reports and the effects of budget cutbacks. Beginning in 1986, NCPCA developed a more standardized instrument which focused on the number and characteristics of child abuse reports, the number of child abuse fatalities and changes in the funding and scope of child welfare services. This instrument, which has been utilized for the past six years, provides more reliable estimates of the number of reports and fatalities across time and across states.

This document summarizes the key findings from the most recent survey. These data represent the only available estimate of the number of child abuse reports and fatalities reported in 1991.*

REPORTING RATES

The total number of child abuse reports increased in 1991, climbing to over 2.6 million reports, or 42 reports for every 1,000 children in the United States. As presented in Table 1, this figure, based on data from 45 states, is six percent higher than the number reported in 1990, and 40 percent higher than the number reported in 1985.

Overall, child abuse reports have maintained a steady growth, increasing an average of six percent annually since 1985. This growth rate, while significant, is roughly half the rate of growth reported in the first half of the decade, when reports increased over 11% annually.

Dramatic increases or decreases (i.e. plus or minus 20 percentage points) over a one-year period generally reflect changes in a state's data collection system. For example, the 42 percent increase in reports noted in Georgia last year resulted from an expansion in countable reports. In the past, only investigated cases were counted in the state's central reporting system. Today, all reports, not simply those reports that are investigated, are documented.

* A more complete discussion of these and other findings can be found in D. Daro and K. McCurdy Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1991 Annual Fifty State Survey available from NCPCA.

Administrators in states that have experienced gradual increases over the past several years cited two primary factors for this trend. First, economic stress due to poverty, unemployment and related work concerns were cited by almost half of the administrators as contributing to increased reports. Second, roughly one-half of these administrators saw the increase as stemming from increased public awareness and willingness to report suspected cases of maltreatment.

CHILD ABUSE FATALITIES

Reported child abuse fatalities rose last year by over 10 percent compared to the number reported in 1990. As presented in Table 2, a total of 1,383 children were officially registered as fatal victims of maltreatment last year, 130 more than were reported in 1990. The 1991 statistic is a projected number based on data from 36 states comprising 75 percent of the U.S. child population. Estimates for earlier years are based upon at least 85 percent of the child population. If data were available from all 50 states and the District of Columbia for all seven years, the actual rate of change and total scope of the problem could vary somewhat from these projections.

Looking across the full seven-year reporting period, the rate of child abuse fatalities has increased 54 percent. Throughout this period, the characteristics of these cases have remained fairly constant. Approximately 40 percent of these deaths occur to children known to the local child welfare system either as prior or current clients. As for the cause of death, 40 percent of the deaths result from physical neglect, while 60 percent are the result of physical abuse. Each year, the vast majority of these cases have involved young children. In 1991, 78 percent of the victims were under five years of age and 56 percent were one year or younger.

While this increase partially reflects changes in reporting and documentation procedures, the pattern is comparable to trends in child homicides. According to the National Center on Health Statistics, the homicide rate for children under one year old rose 55 percent between 1985 and 1988, climbing from 5.3 per 100,000 children to 8.2 per 100,000 children. Those factors most commonly cited as contributing to increased fatalities include economic stress, substance abuse and community violence.

SUBSTANCE ABUSE AND CHILD ABUSE

Almost every state liaison cited substance abuse as a major presenting problem among their caseload. Despite concern over this issue, less than half of the states routinely collect information regarding a family's history of substance abuse when

investigating a child abuse report. In the majority of these cases, this information is available only to the caseworker and is not submitted to a state's central registry in any uniform manner.

Based on data from 14 states, an average of one-third of all substantiated cases involved parental substance abuse. Wide variation in this figure was noted across these states, with the percentage of cases involving substance abuse ranging from 5% to 50%. Thirteen states reported a total of 9,006 drug-exposed infants, a number considered by most to seriously under count the problem. Only one state, South Carolina, requires uniform drug testing of all infants at birth. As of 1991, 21 states require the reporting of drug-exposed infants while three states (District of Columbia, Rhode Island and Washington) mandate the reporting of pregnant substance abusers.

CHILD WELFARE FUNDING

Funding for child welfare services continued to lose ground in 1991. Of the 44 states who provided funding information, only 13 (28%) received an increase in their 1991 child welfare budgets. Seven states (Colorado, Delaware, Florida, Indiana, Massachusetts, Michigan and Washington) experienced budgets cuts. In contrast, only one state, Mississippi, reported a budget cut in last year's survey. While the remainder of the states maintained stable funding, this funding level prohibited needed staff or service enhancements, particularly in the area of child abuse prevention.

National Committee for Prevention of Child Abuse (NCPCA)
April 1992

Table 1

CHILD ABUSE AND NEGLECT REPORTS
ANNUAL PERCENTAGE CHANGE

State	85-86	86-87	87-88	88-89	89-90	90-91
Alabama	-5	4	7	7	-1	14
Alaska	16	NA	-3	-5	0	N.C.
Arizona	12	1	12	22	6	4
Arkansas	13	1	NA	0	2	4
California	16	7	29	13	3	3
Colorado	-6	11	24	-4	14	NA
Connecticut	2	9	NP	-1	-2	3
Delaware	-2	NA	0	-6	0	9
District of Columbia	21	6	0	20	-4	13
Florida	-2	0	6	19	12	-3E
Georgia	17	26	-8	26	1	42
Hawaii	10	-2	-18	-6	12	NA(-)
Idaho	5	0	1	1	11[a]	.2
Illinois	1	30	3	9	1	4
Indiana	3	-16	5	29	27	22
Iowa	3	0	4	4	7	1E
Kansas	-9	25	-12	-4	0	NA(-)
Kentucky	13	8	5	2	7	9
Louisiana	22	-14	0	1	-1	10
Maine	-4	-14	NP	-8	-9	0E
Maryland	24	5	8	5	2	8
Massachusetts	5	1	17	15	17	7
Michigan	15	-2	-3	2	4	-4
Minnesota	12	11	1E	-3	-8	-1E
Mississippi	23	18	9	0	8	4
Missouri	5	1	-8	7	2	4
Montana	10	6	-1	7	8	7
Nebraska	-1	-3	-2	-2	2	10
Nevada	10	3	31	12	12	NA(+)
New Hampshire	4	9	5	13	12	15
New Jersey	7	0	13	3	-7	NA(-)

State	85-86	86-87	87-88	88-89	89-90	90-91
New Mexico	-9	-2	9	49	17	21
New York	14	10	17	7	0	0
North Carolina	7	19	NP	31	15	33
North Dakota	NA	NA	NA	3	12	7
Ohio	4	1E	6E	3	20	-5
Oklahoma	9	4	1	0	9	-15
Oregon	8	3	6	15	-5	-1
Pennsylvania	-1	-2	9	6	4	NA(-)
Rhode Island	3	-2	11	16	24	1
South Carolina	12	-2	-1	3	9	-3
South Dakota	12	6	3	2	1	-1
Tennessee	3	NA	NA	6	1	-2
Texas	8	-4	NP	12	13	10
Utah	9	-1	-1	12	2	13
Vermont	1	-9	7	9	-8	0
Virginia	-4	0	5	5	-18	13
Washington	7	-8	NP	2	0	5E
West Virginia	5	1	3	1	-7	-2
Wisconsin	11	2	6	11	12	NA
Wyoming	59	12	3	2	10	2
Average Percentage Change	+8%	+3%	+4%	+7.3%	+5.6%	+6.2%

Estimated Number of Reported Child Victims[b]	1985	1986	1987	1988	1989	1990	1991
	1,919,000	2,086,000	2,157,000	2,243,000	2,407,000	2,537,000	2,694,000
Per 1,000 U.S. Children	30	33	34	35	38	39	42[c]

E Estimate

NA Not Available

NA ( ) Indicates direction of expected change, i.e. (-) decrease, (+) increase.

a This is largely due to a change in Idaho's counting procedures. They counted unduplicated cases in 1988 and duplicated cases in 1989.

b In 1986, AAPC counted the total number of reported child victims (AAPC, 1988). This number (2,086,000) is the base upon which the 1987 - 1991 estimated numbers of reported child victims are derived (e.g., in 1987, the 2,157,000 estimate represents a three percent increase over 2,086,000).

c Estimate based on 1989 census data.

National Committee for Prevention of Child Abuse (NCPCA)
April 1992

Table 2

REPORTED CHILD ABUSE AND NEGLECT RELATED FATALITIES[1]

State	1985	1986	1987	1988	1989	1990	1991
Alabama	NA	NA	NA	NA	NA	NA	NA
Alaska	NA	6	NA	NA	14	14	N.A.
Arizona	NA	NA	NA	13	14E	14E	18E
Arkansas	9	6	5	10	14	9	7
California	18	27	83	120	97	78	109
Colorado	12	18	18	26	23	28	28
Connecticut	6	9	NA	6	6	17	5
Delaware	2	1	NA	1	4	1	1E
Dist. of Columbia	NA	2	5	9	NA	NA	NA
Florida	NA	47	43	48	47	54	48E
Georgia	NA	NA	NA	4	5	12	13E
Hawaii	1	1	2	2	7	2	1
Idaho	5	3	6	3	6	4	6
Illinois	53	79	54	98	102	75	87
Indiana	29	38	17	27	29	52	48
Iowa	14	9	9	13	9	6	9
Kansas	9	12	12	7	6	9	NA
Kentucky	10	9	16	15	8	19	18
Louisiana	50	57	30	31	20	22	26
Maine	0	1	3	1	NA	3	NA
Maryland	8	17	23	20	29	16	39
Massachusetts	13	15	13	25	19	16	NA
Michigan	11	15	NA	NA	NA	NA	NA
Minnesota	6	10	7	9	13	14	NA
Mississippi	NA	7	14	10	14	12	24
Missouri	25	18	19	28	20	25	31
Montana	2	3	7	2	6	9	8
Nebraska	2	2	2	5	1	2	4
Nevada	6	4	7	5	NA	NA	NA
New Hampshire	NA	NA	NA	NA	NA	NA	NA
New Jersey	21	12	26	34	30	38	NA

State	1985	1986	1987	1988	1989	1990	1991
New Mexico	10	7	11	8	13	8	6
New York	117	101	166	198	191	193	179
North Carolina	4	3	6	6	7	30	22E
North Dakota	0	0	1	0	1	0	0
Ohio	37	50	75	NA	61	52	67E
Oklahoma	13	24	31	23	25	18	38
Oregon	8	18	24	17	19	14	9
Pennsylvania	34	44	44	40	55	58	NA
Rhode Island	5	4	4	0	NA	6	7
South Carolina	21	25	13	11	14	20	22
South Dakota	4	2	10	2	1	2	1
Tennessee	NA	NA	NA	NA	NA	NA	NA
Texas	113	129	97	77	94	112	97
Utah	8	3	4	5	12	10	12
Vermont	1	1	2	0	0	0	2
Virginia	14	14	27	25	34	28	34
Washington	27	37	24	21	8	8	NA
West Virginia	NA	NA	NA	NA	3	1	3
Wisconsin	15	9	18	11	30	31	NA
Wyoming	3	3	0	5	3	3	4
Total Fatalities	749	992	978	1021	1114	1145	1033
% of Child Population Under 18	85.3	91.0	85.3	86.5	90.9	91.4	74.7[b]
Total Projected Fatalities Nationwide	878	1079	1147	1181	1230	1253	1383
Per 100,000 Children	1.4	1.71	1.81	1.89	1.92	1.95	2.15[b]
% Change from previous year		22.3%	5.8%	4.4%	1.6%	1.6%	10.3%

E Estimate. These numbers are reported as estimates because some child deaths are still under investigation.

NA Not Available

a These figures represent the total number of child fatalities reported to or confirmed by each state's child protective service agency. Unlike previous surveys, these numbers only include confirmed cases from states which count both reported and confirmed fatalities. 1985 through 1988 statistics are derived from earlier surveys conducted between 1985 and 1989.

b Estimate based on 1989 census data.

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NCPCA'S 1992 PUBLIC OPINION SURVEY: KEY TRENDS*

Deborah Daro, DSW
Director, Center on Child Abuse Prevention Research

Overview

Since 1986, the National Committee for Prevention of Child Abuse (NCPCA) has commissioned national public opinion polls to determine the public's attitudes and actions with respect to child abuse prevention. The first survey, in December, 1986, was conducted by Louis Harris and the subsequent surveys by Schulman, Ronca and Bucuvalas of New York City. The purpose of this document is to compare findings from the 1992 survey to those obtained in previous years in three areas: the public's attitudes toward specific parenting behaviors; the frequency of various discipline practices; and the public's optimism toward and involvement in child abuse prevention. In addition, information obtained regarding the prevalence and attitudes toward home visiting services to new parents are provided.

Each survey has involved a representative telephone survey of 1,250 randomly selected adults across the country of whom approximately 36 to 38% are parents with children under 18 living at home.

The sampling error for the entire sample is plus or minus 3 percentage points, assuming a 95% confidence level. Consequently, differences greater than 3% in response patterns to the same question across years suggest a statistically significant change. In those instances where only a portion of the sample is analyzed, the sampling error increases to plus or minus 5 percentage points.

Attitudes Toward Parenting Behaviors

This year, as in the past five years, the vast majority of the public found physical punishment and repeated yelling and swearing as detrimental to a child's well-being. In the most recent survey, only 20% of the public felt that physical punishment never leads to injury and only 7% of the public believed repeated yelling and swearing never leads to long-term emotional harm.

Parenting Practices

In the most recent survey, 45% of parents reported that they had insulted or swore at their child and 53% reported that they had spanked or hit their child in the past year. While similar to the figures obtained in last year's survey, these findings compare favorably to the patterns observed in 1988. Compared to 1988, 10% fewer parents are reporting the use of insulting or swearing and 11% fewer report the use of spanking as methods of discipline.

* A more complete discussion of these and other findings can be found in Public Attitudes and Behaviors with Respect to Child Abuse Prevention 1987 to 1992 available from NCPCA.

This year, as in 1991, 3% of the parents surveyed reported that they kicked, bit or punched their child in the past year and 8% reported that they hit or tried to hit their child with an object such as a belt, paddle or wooden spoon.

Public Commitment to Preventing Child Abuse

For the first time since 1988, both the general public and parents expressed greater optimism in their ability to prevent child abuse. In the most recent survey, over two-thirds of the general public and over three-quarters of the parents felt they could make a notable contribution to prevention. Further, as in the past, one in four individuals and one in three parents report having taken personal action in the past year to prevent child abuse.

Home Visiting Services

Seven percent of the 445 parents interviewed in the most recent survey indicated that they had received a home visit within the first six months after giving birth. In two-thirds of these cases, only a single visit was provided. Of those who received the services, 69% reported that the visit was helpful in learning how to care for their child. Interestingly, over three-quarters of those parents who did not receive the service felt such a service would be useful for parents like themselves.

Seventy-four percent of the respondents approved of the government supporting the provision of home visits for parents. Of these respondents, one-third felt funding should be provided by the federal government, 28% supported funding by state government and 26% supported funding by local government (i.e. city or county).

(Prepared 3/26/92/DD/jt)

Table 1
Public Attitudes Toward Parental Behaviors:
Results by Percent
N = 1,250

	1987	1988	1989	1990	1991	1992
How often do you think physical punishment of a child leads to injury to the child?						
Very Often/Often	40	33	36	35	31	36
Occasionally	31	38	35	37	44	38
Hardly Ever/Never	24	23	21	19	18	20
Not Sure	5	6	8	9	7	6
How often do you think repeated yelling and swearing leads to long-term emotional problems for the child?						
Very Often/Often	73	72	73	76	75	74
Occasionally	17	18	18	15	18	17
Hardly Ever/Never	7	8	6	6	5	7
Not Sure	2	2	2	3	2	2

Table 2
Emotional and Physical Violence Toward Children
1988 to 1991

	Rates per 100 Children				
In the past 12 months, did you:	1988	1989	1990	1991	1992
Insult or swear at your children?	55	51	40	44	45
Spank or hit your children?	63	61	51	52	53
Hit or try to hit your child with something?	x	x	x	8	8
Kick, bite or punch your child?	x	x	x	3	3
N =	490[1]	513[1]	459[1]	480[1]	445[1]

[1] Source: NCPCA's Annual Public Opinion Polls. Data based on interviews with caretakers (including single parents) with children under 18 in the home.

x Question not asked

Table 3
Attitudes Toward Prevention Potential

How much do you think you can do to prevent child abuse?	1987	1988	1989	1990	1991	1992
Results by Percent for the General Public	N=1250	N=1250	N=1250	N=1250	N=1250	N=1250
A Lot/Some	66	66	63	58	57	64
Only a Little	24	24	22	27	28	25
Nothing	8	8	10	10	11	9
Results by Percent for Parents	N=(500)	N=(490)	N=(513)	N=(459)	N=(480)	N=(445)
A Lot/Some	76	80	77	68	68	77
Only a Little	19	14	18	22	24	17
Nothing	4	4	4	6	6	4

Table 4
Involvement in Prevention Activities

Have you done anything personally to prevent child abuse in the past year?	1987	1988	1989	1990	1991	1992
Results in Percent for the General Public	N=1250	N=1250	N=1250	N=1250	N=1250	N=1250
Yes	23	25	25	23	27	26
No	77	74	73	74	71	72
Results in Percent for Parents	N=(500)	N=(490)	N=(513)	N=(459)	N=(480)	N=(445)
Yes	32	35	39	32	37	37
No	68	63	59	64	60	62

Table 5

Prevalence and Support for Home Visits

	Parents		Non-Parents	
	n	%	n	%
Received Home Visit at Child's Birth	29	7%	x	
Frequency of Visit	n = 29		x	
Once	19	66%		
More than Once	9	31%		
Don't Know	1	3%		
Utility of Service	n = 29		x	
Very/Somehwat Useful	20	69%		
Not Very/Not at all Useful	8	28%		
Don't Know	1	3%		
Potential Utility*	n = 416		n = 809	
Very/Somewhat Useful	323	78%	603	75%
Not Very/Not at all Useful	86	21%	183	23%
Don't Know/Refused	7	2%	23	2%
	n = 445		n = 809	
Supports Government Paying for Service	365	82%	591	69%
Level of Government Most Responsible	n = 445		n = 809	
Federal	165	37%	246	30%
State	117	26%	234	29%
Local	118	27%	211	26%
Combination	20	4%	32	4%
Don't Know	24	5%	85	11%

* Question asked of respondents who had not received a home visit service.

x Question not asked

Chairwoman SCHROEDER. Next, we have Gail Breakey, and I want to say how very pleased we in Colorado are that Hawaii took Doctor Kempe and dealt with him seriously. Doctor Kempe came from Colorado and the Kempe Center, and later in life became—had a heart problem, moved to Hawaii. In Colorado, we let him remain private; in Hawaii they listened to him and made him public, and you've got some fabulous statistics, I think, and some real hope for the statistics that we just heard.

So, Gail, we welcome you, and we're very anxious to hear about Healthy Start in Hawaii.

STATEMENT OF GAIL BREAKEY, R.N., M.P.H., DIRECTOR, HAWAII FAMILY STRESS CENTER, HONOLULU, HI

Ms. BREAKEY. Thank you very much, Representative Schroeder, and I would like to comment that Henry Kempe was certainly the mentor for the beginning of the Hawaii Family Stress Center, and that the work that he began in the early 1970s is very much the background of the work we have been carrying on for the last 15 years and that the Healthy Start Program is based on.

Before I begin, I'd like to introduce another member of our Healthy Start Network contingent, Ruthanne Quitiquit, who is sitting right behind me.

Okay. I'd also like to comment to Doctor Horn's remarks, that I think a number of us are aware that all home visiting programs don't work, that it's very important to have the intensity of training, and the intensity of home visits, and the intensity of service intervention, and that we hope that as the Nation does look at these kinds of programs that they would concentrate on providing the levels of training and technical assistance support that will be necessary to carry out home visiting in the proper way.

I'll be focusing my remarks on the Healthy Start Program and its expansion into a statewide program. I'd like to begin by saying that we truly do not need to have the levels of abuse and neglect in this country that we currently have. We do have the knowledge and the technology to prevent a great deal of it.

The Healthy Start Home Visiting Program starts very early in life, at the birth of a new child, and it follows a high-risk family and that infant, that target child, until the child is five years of age.

Our demonstration project showed very exciting data. We looked at 241 families over a three year period, from 1985 to 1988. We saw that amongst those families there was no abuse and only four cases of mild medical neglect during that time period.

Based upon these outcomes, 100 percent non-abuse and a 98 percent non-neglect rate, our state legislature made the investment of expanding the program over the last four years to reach half of infants in the state. We have a total of 12 sites that are operating statewide, and seven private agencies are involved under purchase of service with our Maternal Child Health Branch.

The program begins with hospital-based assessments that are conducted at the time of birth. We are operating in all of the major hospitals in Hawaii that do have obstetrical services. We identify

families that are at risk, and we refer them to a home visiting team that is located in the neighborhood where they live.

Our data shows that 85 to 95 percent of families do accept services, which is quite remarkable, considering that the program is voluntary.

Services are provided by very carefully trained paraprofessionals. Paraprofessionals are selected for their qualities of being very nurturing and also being natural helpers.

They are supervised by an MSW or a public health nurse, and they are provided with five weeks of intensive pre-service training before they start working with families. Then they have weekly supervision from their manager and also monthly in-service training.

Home visiting services are provided, obviously, in the home. The workers go in and spend a considerable amount of time establishing a trusting relationship with the family. These families are very service resistant, non-trusting of other people. Many of them were abused and neglected themselves as children. They are focusing on role modeling, coping skills and everyday problem solving. They are providing emotional support, and they are on call to their families 24 hours a day.

They help to meet some of the survival needs of families. Many of our families are homeless or in very substandard housing. They would link them with better housing, help them to move, link them with the WIC program for emergency food supplements. They also make a concerted effort to get the family linked with a primary health care provider, usually a pediatrician, or also a public health nursing clinic.

They promote bonding and attachment, which is extremely important for establishing a very strong, positive relationship between the mother, primarily, and the baby, and also the father and the baby.

Then, on an ongoing basis, they provide intensive parent/child interaction activities that they teach the mother in the home.

They conduct developmental screening, using the Revised Parental Development Questionnaire. They refer children who do have developmental delays to child development clinics.

A number of our families are involved in spouse abuse. They will provide the mother with the shelter telephone number, and they'll be available in crisis.

We also do refer families for drug abuse treatment services.

A new component that we have introduced into the program is a child development specialist. That person works with the workers in terms of providing intensive training in child development, so that there is a very strong focus on the child as well as the whole family. Those workers conduct the nursing care assessments, which are parent/child observations, and train the workers in interventions. They monitor growth and development. They make at least two home visits a year, and they assist in referring children to the child development centers and to preschool services, such as Head Start.

Regarding replication data, the Department of Health looked with us at the information coming from the expanding program, looked at information for 1,204 families that were enrolled in the

program between 1987 and 1989. There was no abuse for 99.7 percent of the families, and no neglect for 99.5 percent of the families.

Now, what was very exciting and encouraging about that was that meant it wasn't just our program, that other agencies could very successfully replicate the program with good training.

In terms of costs, this home visiting program costs an average of $2,200 to $2,500 a year per family. That may sound like a lot, but consider that we spend $30,000 a year on shelter care services for a runaway kid, about the same or more for incarcerating a youth in our juvenile detention facilities, or adults in our prisons. We spend probably $200,000 for foster care for a child until the age of majority, who cannot live with his parents. We spend close to $900,000 to a million dollars for the life of a brain damaged child.

In terms of our statewide data, we have a chart that we show our legislators which shows that we are spending $40 million a year on child protective services. We are spending $183 million a year on our courts and correction. Currently, we are spending $6.2 million for our Healthy Start Program. When it's fully up and running, which we hope will be in two years, we will be reaching close to 100 percent of all families, and it will cost about $12 million. We believe that's a real bargain for the State of Hawaii, and I think that our legislators do as well.

Lisbeth Schorr, in "Within Our Reach," makes a very well-documented, researched, and clear case for early intervention with high-risk children, and she makes a strong plea that these services be able to reach all at-risk children.

She also noted that a recent Harris Poll showed that most Americans want to provide services to children, especially low-income and at-risk children, and Liz Schorr has said this really looks like a situation in which compassion and enlightened self-interests have joined, and the American public is very, very concerned about this issue.

She also noted that a major step that is needed is to educate the American public and policymakers to the fact that we do have the technology to do this, to prevent rotten outcomes of childhood, and that this really can and must be done.

Thank you.

Chairwoman SCHROEDER. Thank you very, very much, and that is, indeed, a very optimistic and wonderful record that Hawaii has put together.

[Prepared statement of Gail Breakey, R.N., M.P.H., follows:]

PREPARED STATEMENT OF GAIL BREAKEY, R.N., M.P.H., DIRECTOR, HAWAII FAMILY STRESS CENTER, HONOLULU, HI

Representative Schroeder, Members of the Select Committee on Children, Youth and Families, thank you for inviting me here today. I am Gail Breakey, Director of the Hawaii Family Stress Center, testifying in regard to the efficacy of preventing child abuse based on our experience with the Hawaii Healthy Start Program.

As noted by a recent Children's Defense Fund article, America is the least safe "civilized" country in which a child can grow up. At least one in five American infants are born into homes where they immediately face abuse, neglect, poverty, lack of medical care; - situations in which their physical and perhaps worse, their emotional needs are not met. The toll in suffering of so many children is bad enough, but it doesn't end there. Many of those who survive the first few years grow up to be dysfunctional, dependent, and often dangerous adults. This blight is tearing apart the fabric of our society.

A few statistics:

In Hawaii, review of data on deaths due to child abuse showed that all deaths were under age 5.

Nationwide, the median age of death is age 2.6

A study of 100 consecutive first time offenders in Denver showed that 86% had been abused before age two.

A recent national report on education showed that 18% of all children do not graduate from high school.

Current research on early child development shows that the foundations of personality - the way a child relates to himself and others, is established in the first two years of life. Key emotional and social developmental events occur in the first weeks and months of life through interaction with the primary caregiver called bonding and attachment, which lays the foundations for future relationships. These are years of rapid, critical growth. Abuse and serious emotional neglect in this time period is devastating for the developing psyche, causing damage which is very difficult to reverse. It is imperative that children come through these early years safely.

We don't need to have the levels of child abuse and neglect that exist in this country today. We have the technology to prevent nearly all of it.

Hawaii's Healthy Start is a home visiting program aimed at preventing abuse and neglect, and also at providing a range of supportive health and social services to at risk infants and their families. It begins with hospital based screening and assessment to identify all at risk families of newborns from a specific geographic area, and refers at risk families to a home visiting team, where they are followed supportively until the child is five years old.

The demonstration program saw 241 families over a three year period from 1985 - 1988. There was no abuse and only four cases of mild neglect among these families, for a 100% non-abuse and 98% non neglect rate. There was also no abuse for 99.7% of families identified as not at risk. Based on these outcomes, our state legislature supported expansion of this program to current levels at which 12 program sites reach 50% of at risk newborns in the state. Services are provided under purchase of service agreements with seven private agencies through the state department of health. Data obtained in 1990 for 1204 families enrolled in the expanding program from 1987-89 showed that replication worked - there was no abuse for 99.7% of families (four cases) and no neglect for 99.5% (six cases). It must be noted that Healthy Start has been funded as a direct service program under purchase of service from the start, without funds for sophisticated studies. We are currently exploring foundation funding for a control group study which would focus on a number of issues including cost savings. Preliminary information on children graduating at age five from the demonstration program showed that these children had received WIC services, were immunized, and two-thirds of them had been enrolled in Head Start by the program. Family functioning had improved considerably for most of these families on several indices.

I will summarize services and key issues for this program. A more in depth article is attached to my testimony. Hospital based assessment is conducted in all the hospitals of the state providing obstetrical services. This screening process is aimed at identifying all at risk families of newborns while in the hospital and linking them with the home visiting program located in their neighborhood. Between 85-95% of families needing services accept, a high rate considering the program is voluntary.

Services are provided by paraprofessional home visitors, under the supervision and case management of an experienced professional, usually an MSW or Public Health Nurse. Paraprofessionals with a high school diploma are selected for nurturing, non-judgmental and "natural helper" qualities. Home visitors first work to establish a trusting relationship which is important as at risk families are usually alienated and mistrustful of other people and services. This relationship enables the direct services of the worker as well

as important referrals. The worker initially assists the family to enroll in WIC and public housing if needed. Linkage is also made to a primary care provider for continuity of well and sick care for the infant, spouse abuse services as needed, and other services as appropriate.

A child development specialist is ideally a part of the team, to provide training and support to the worker in effectively focusing on child development issues, to monitor developmental status of children and to intervene in direct activities to facilitate child development. The home visitor focuses on ensuring good bonding and attachment as the foundation for positive child development, followed by teaching parents developmental stages of the child, child care and parent child interaction activities. The worker also conducts developmental screening using the Revised Parental Developmental Questionaire (RPDQ), and follows up with the physician and Zero to Three program to assure assessments and referrals on developmental delays. This is important, given difficulties in and overall poor implementation of the EPSDT program generally, and the fact these children are at environmental risk for developmental delays.

In summary, Healthy Start has become a comprehensive approach for systematically addressing the needs of at risk young children and their families. It provides a grassroots network of maternal child health services, well linked with primary care providers and the states Zero to Three program under Part H, PL 99-457. Its' strengths lie not only in being systematic and effective in preventing abuse, but also in addressing issues across categories... prevention of child abuse, prevention and early intervention with developmental delays, promotion of child health and strengthening high risk families.

The cost averages from about $2,200-2,500 per family. We have two cost charts which we share with our legislators. One points out the fact that it costs about $30,000 a year for a runaway shelter slot, or to incarcerate a juvenile or adult offender. Foster care services to the age of majority for an abused child in child protective service custody costs well over $123,000 (1978 data). Services for a brain damaged child to age 18 costs more than $720,000. We also have a chart which shows the annual budget for corrections, child protective services and for the Healthy Start program. Last year, these costs were about $183,000,000 for corrections, $40,000,000 for child protective services and $6,400,000 for Healthy Start. When fully implemented, Healthy Start will cost about $12,000,000. This approach is a real investment and a true bargain for any state... we cannot afford not to establish this kind of an early intervention system.

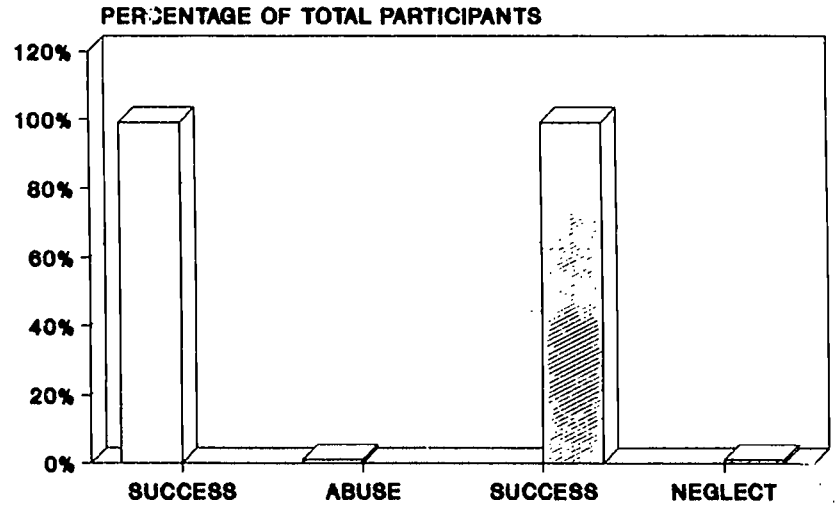
Lizbeth Schorr in "Within Our Reach" makes an extremely well researched and clear case for early intervention with at risk children - which would reach all at risk children. She also noted that a recent Harris Poll showed that most Americans want and are willing to support services for needy children. As Ms. Schorr has

well said, a major step needed is to educate the American public and policy makers to the fact that we do have the technology to prevent rotten outcomes of childhood, and that this really can and must be done.

Attachments: Healthy Growth for Hawaii's "Healthy Start"
DOH Evaluation Data 1990
Costs Information Chart for Hawaii

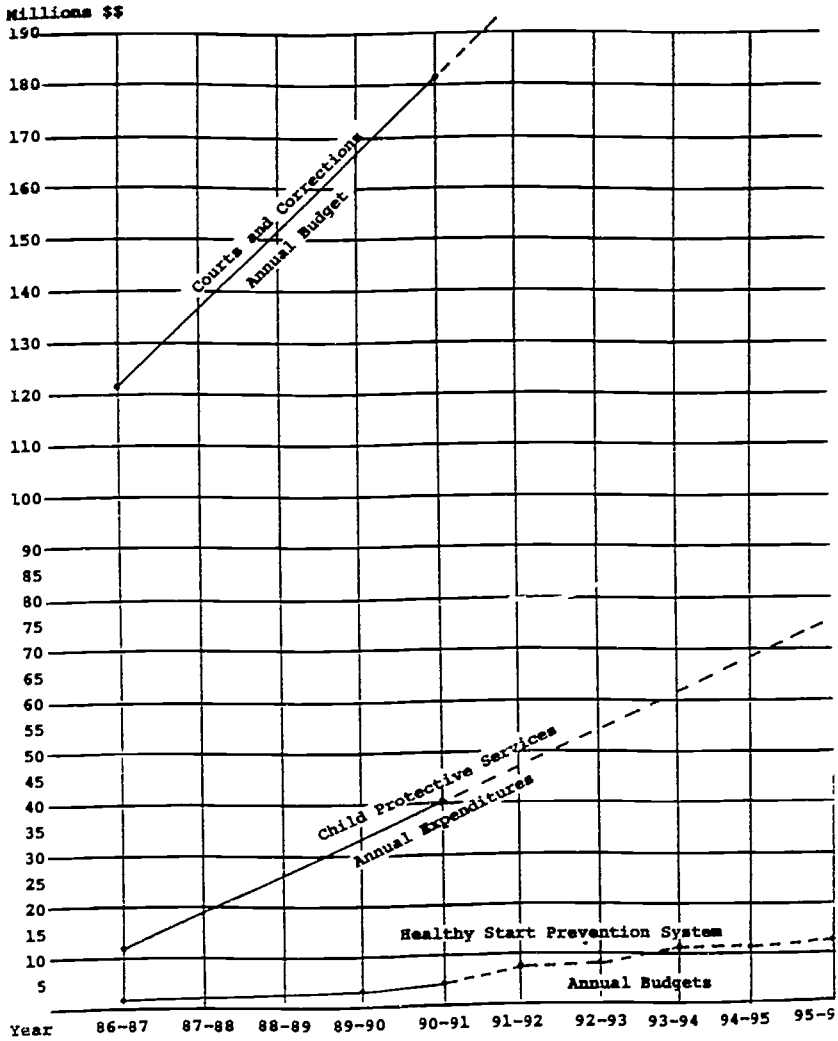
A:KeepKids.Saf

HAWAII HS/FS PROGRAM EVAL
STATISTICS OF 1,204 PARTICIPANTS



NINE SITES STATEWIDE 1987-1990

COMPARATIVE COSTS: Prevention, Treatment, and Consequences of Abuse



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

by

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

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

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

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

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

The Healthy Start model

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

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

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

Figure 1.
Risk Indicators Used in Early Identification

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

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

FEEDING ME

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

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

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

Figure 2

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

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

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

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

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

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

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

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

4. Linkage to a "medical home"

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

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

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

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

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

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

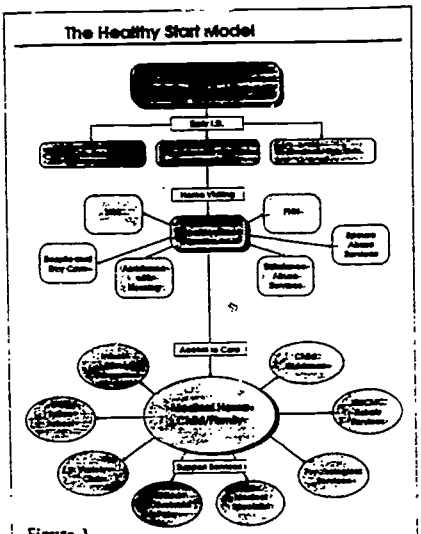

Figure 3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Staff selection and retention

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

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

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

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

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

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

Evaluation of Healthy Start

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

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

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

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

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

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

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

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

Statewide expansion

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

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

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

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

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

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

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

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

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

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

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

Figure 5.
Milestones in the Development of Healthy Start

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

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

A statewide program: Surviving and thriving

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

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

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

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

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

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

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Calls for Papers:

The World Association of Infant Psychiatry and Allied Disciplines (WAIPAD) is accepting submissions for its Fifth World Congress, entitled "A Future for Babies: Opportunities and Obstacles," to be held September 10-12, 1992 in Chicago, Illinois. Submissions are invited for symposia, workshops, clinical teach-ins, posters, and videotaped presentations on three themes: 1) psychological aspects of medical illness and technology; 2) infant-caregiver relationships; and 3) development and psychopathology. **All submissions must be received by August 1, 1991.** For submission forms and information about the Congress, write to Charles Zeanah, M.D., Women & Infants Hospital, 101 Dudley Street, Providence, RI 02905, or call Jo Sawyer, tel: (312) 621-0554.

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

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

Chairwoman SCHROEDER. Next we have the very distinguished Doctor David L. Olds, who is the Associate Professor of the Department of Pediatrics at the University of Rochester School of Medicine and Dentistry in Rochester, New York.

Doctor Olds, we are very honored to have you this morning, and the floor is yours.

STATEMENT OF DAVID L. OLDS, PH.D., ASSOCIATE PROFESSOR, DEPARTMENT OF PEDIATRICS, UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE AND DENTISTRY, ROCHESTER, NY

Mr. OLDS. Thank you, Madam Chairwoman, for the opportunity to be here and testify on this extremely important topic.

For the past 15 years, I've carried out research to find out whether community health nurses, who visit families during pregnancy and the early years of the child's life, can improve the health and well-being of women and children. A substantial portion of this work has been concerned with preventing child abuse and neglect.

My colleagues and I have carried out a large-scale randomized trial of pregnancy and infancy nurse home visitation for parents having first children. Our randomized trial allows us to determine with considerable scientific confidence whether this service is effective.

Most of the parents we studied were either poor, unmarried, or teenaged. We found that such services can reduce pre-term delivery and low birthweight in women at risk for these problems.

As you probably know, pre-term delivery and low birthweight are the leading causes of infant mortality in our society, and make it difficult for parents to care for their children in the early months of the child's life.

We also found that at-risk women who were visited by nurses returned to school more rapidly after delivery. They participated in the work force 83 percent more, and had 43 percent fewer unintended subsequent pregnancies than their counterparts in the control group.

Obstructed educational and occupational achievements, and rapid successive pregnancies, contribute to the intergenerational cycle of poverty and make it difficult for parents to provide adequate care to their first child.

Perhaps, most importantly, we also found that nurse-visited at-risk families had 80 percent fewer cases of child abuse and neglect during the first two years of the child's life.

In 1980 dollars, the program cost about $3,200 per family, for two and a half years worth of work. That comes out to about $1,400 or less per year.

By the time the children were four years of age, compared to their counterparts in the control group, low-income families used $3,300 less in other government services, such as AFDC, Food Stamps, Medicaid and Child Abuse and Neglect-related services.

When focused on low-income families, the cost of the program was recovered with a small dividend before the children were four years of age. Most of these savings were due to reduced AFDC and Food Stamp expenditures, rather than the reductions in child

abuse and neglect, and about a third of the savings were due to the reduction in subsequent pregnancy.

I'd like to note again that the findings of this study are scientifically credible because it was carried out in the form of a randomized trial.

We've also reviewed all of the other well-designed studies of pregnancy and infancy home visitation for pregnant women and parents of young children and, as Doctor Horn noted, we concluded that some programs have considerable promise, but many don't work. Programs vary tremendously in terms of their specific objectives, their approach to working with families, the timing and duration of the visits, the background and training of the visitors, and their corresponding effectiveness.

Based on this research, I have the following comments on the recent recommendations of the U.S. Advisory Board on Child Abuse and Neglect. I agree with the Advisory Board that abuse and neglect of our children has become a national emergency, and that home visitation is the best documented approach to preventing child maltreatment.

I disagree with the Board, however, on three counts. First, they recommend the development of a national home visitation program that would be offered to all new parents. Our research and the evidence derived from other well-designed studies show that the benefits of home visitation are greater for low-income, at-risk families. To provide such services for all parents would dilute scarce resources and diminish their availability for those at greatest need.

Second, the Advisory Board recommends the establishment of a paraprofessional home visitation initiative. Our review of the best evidence shows that those programs that have been most effective are those that have employed well-prepared home visitors who are able to address a number of family needs simultaneously. Most of these programs have employed nurses. We have very little scientific evidence that paraprofessionals can prevent maltreatment, and this is more than academic hair splitting. There are significant differences between what nurses and paraprofessionals can do with families.

Third, the program promoted by the Advisory Board would be offered to parents beginning in the newborn period. Our evidence suggests that such programs are likely to be more successful if they begin during pregnancy. Moreover, a number of major policy advisory groups, such as the Infant Mortality Commission and the Expert Panel on Prenatal Care, have encouraged the development of prenatal home visitation for at-risk pregnant women. I believe that these types of initiatives ought to be integrated into one cohesive program that simultaneously addresses the multitude of needs expressed by low-income, at-risk families.

The federal government can facilitate this kind of integrated approach by convening a conference made up of representatives from the Advisory Board on Child Abuse and Neglect, the Infant Mortality Commission, the Expert Panel on Prenatal Care, researchers who are involved in this work, and state and federal representatives to develop an approach or an agenda that makes sense in light of the available evidence and resources.

One final note. I believe that we need to take decisive action now, but that whatever initiative is undertaken should include a major program evaluation component that relies heavily on randomized trials.

We simply don't know as much as we should about how effective different types of programs will be. Now, this shouldn't prevent us from using the best scientific evidence available to guide the development of a sensible initiative to support at-risk families early in the life cycle. We just need to be prepared to make mid-course corrections along the way.

Chairwoman SCHROEDER. Thank you very, very much.

[Prepared statement of David L. Olds, Ph.D., follows:]

PREPARED STATEMENT OF DAVID L. OLDS, PH.D., ASSOCIATE PROFESSOR, DEPARTMENT OF PEDIATRICS, UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE AND DENTISTRY, ROCHESTER, NY

Thank you for the opportunity to testify on this important topic. For the past 15 years, I have carried out research to find out whether community health nurses who visit families during pregnancy and the early years of the child's life can improve the health and well-being of women and children. A substantial portion of this work has been concerned with preventing child abuse and neglect. I will direct my comments today toward what we know about home-visitation as a means of preventing child maltreatment and improving other aspects of family functioning and child health. My comments will have greater meaning if I review briefly the recent history of home-visitation services for women and children in the United States.

Prior to the 1970's, community health nursing was an integral part of the US public health strategy to address the needs of at-risk children and their families. In the last two decades, such services have been reduced severely. Where home-visitation services have been provided, they have been focused almost exclusively on pregnant women and children with identified health problems. Few home-visitation services have been devoted to prevention and health promotion.[1] In part this is because third-party payers have been willing to reimburse for tangible services such as long-term care of the elderly and of disabled children, while they shied away from disease prevention and health promotion. It did not help that early evaluations of home-visitation services were not promising.[2] In spite of the reticence of third party payers to support preventive services and the equivocal results of early research, home visitation is once again being promoted as a means of preventing the death and damage of our most vulnerable children.[3-9] This renaissance of interest in home-visitation is the result of an increased appreciation for prevention in all aspects of health, as well as an accumulation of scientifically credible evidence that home-visitation can indeed make a difference in lives of vulnerable families and children. This increased interest is reflected in the recommendations of several policy advisory groups.

The U.S. Advisory Board on Child Abuse and Neglect has declared child maltreatment a national emergency; has identified home-visitation the most promising method of addressing this problem; and has called for the development of a national home visitation program for all new parents.[3-4] The National Commission to Prevent Infant Mortality has included home-visitation as a central part of its strategy to improve the outcomes of pregnancy and reduce infant mortality and morbidity.[5-6] The Public Health Service Expert Panel on the Content of Prenatal Care has recommended that home-visitation be included as part of an augmented set of services for low-income, at-risk women.[7,8] And the General Accounting Office issued a report in 1990 encouraging Congress to increase their level of support for home-visitation services through expansion of Title XIX of the Social Security Act.[9] At least five legislative initiatives currently before Congress include provisions for expanding federal support for home-visitation services. In the meantime, at least 24 states have recently begun to increase their support of home-visitation services through a variety of medicaid service categories.[9] Some of the scientific evidence to support the promise of home-visitation has come from research that my colleagues and I have carried out in Upstate New York.

I would like to review the findings from the randomized trial of prenatal and infancy nurse home-visitation that we carried out in Elmira, New York in the late 1970's and early 1980's.[11-13] I also will examine evidence from other randomized trials,[10] and analyze those findings in relation to the proposals of major advisory groups and current legislative initiatives.

The Elmira Study

Problems Addressed by Program. The nurse home-visitation program that my colleagues and I tested in the Elmira trial was based on the premise that many of the most pervasive, intractable, and costly health problems faced by high-risk women and young children in our society are a consequence of adverse maternal health-related behaviors (such as cigarette smoking, drinking and drug use during pregnancy), dysfunctional infant caregiving, and stressful environmental conditions that interfere with individual and family functioning.[14-16] These maternal and child health problems include:

- Preterm delivery and low-birthweight, the leading determinants of infant mortality in the United States;[17]
- Child abuse and neglect, a condition that some believe has grown to a national emergency;[3]
- Childhood injuries, the leading cause of death among children from one to 14 years of age;[18]
- Unintended and closely spaced subsequent pregnancies, a factor that reduces child health and leads to the enmeshment of families in poverty.[19,20]
- Obstructed educational and occupational achievements on the part of parents, factors that reduce family economic resources and self-sufficiency, and that contribute to the intergenerational cycle of poverty.[21]

Setting. Elmira is a small city of about 40,000, located in a semi-rural county of about 100,000 residents in Upstate New York. The community was beset with extremely difficult economic conditions during the period of the study. In 1980 it was rated the worst Standard Statistical area in the United States in terms of its economic conditions.[22] Moreover, from the early 1970's through the mid 1980's the community had highest rates of reported and verified cases of child abuse and neglect in New York State.[23]

Sample. We actively recruited into the study women who were having first children and who were at risk for poor pregnancy and child health outcomes by virtue

of their being either poor, unmarried, or teenaged. Ninety percent of the 400 women registered were white, and all of the major findings reported apply to this group.

Research Design. The participating families were assigned at random to receive either 1) transportation for prenatal and well-child care and sensory and developmental screening for their children at 1 and 2 years of age (the comparison services); or 2) nurse home-visitation services (plus or screenning and transportation). The nurses visited from pregnancy through the second year of the child's life. During pregnancy the nurses visited about once every two weeks. After delivery, the nurses visited about once a week for the first 6 weeks after delivery, and then on a schedule of diminishing frequency so that by the time the children were 2 years of age, the nurses visited about once every 6 weeks.[11-13]

The Program. Epidemiologic evidence suggests that parental behavior is the most immediate, powerful, and potentially alterable influence on child health during pregnancy and the early years of the child's life.[24,25] In light of this evidence, during their visits, the nurses helped women improve their health-related behaviors, qualities of infant caregiving, and personal development. They helped women do this by encouraging them to set small achievable goals and to use problem-solving methods to gain control over the difficulties they encountered. The women's accomplishments, in turn, enhanced their sense of competence in managing future problems. In an effort to create a home environment that was more conducive to optimal health behavior, the nurses involved other family members and friends in the pregnancy, birth, and early care of the child, and they linked families with other needed health and human services. They carried out this work in the context of their establishing a long-lasting, therapeutic relationship with the mother and family by emphasizing individual and family strengths.[14-16]

Improvement of Pregnancy Outcomes. For the prenatal phase of the trial, we found that in contrast to women in the comparison group, women who received a nurse reduced the number of cigarettes smoked, improved the qualities of their diets, had fewer kidney infections, experienced greater support from family members and friends, and made better use of the WIC nutritional supplementation program and childbirth education. The positive effects of the program on birthweight and length of gestation were concentrated on two groups at risk for these problems: nurse-visited smokers bore 75% fewer preterm babies, and nurse-visited young adolescents bore babies who were nearly a pound heavier at birth than did their counterparts in the comparison group.[11]

Improvement of Caregiving. During the first two years after delivery, we found that among poor unmarried teenagers, the incidence of state-verified cases of child abuse and neglect during the first two years of life was 19% in the comparison group and 4% in the group that received nurse visitation -- an 80% reduction. These findings were corroborated by observations of the women's treatment of their children and

conditions in the home. The homes of nurse-visited poor, unmarried teens were filled with more educationally stimulating play materials, and the mothers used less punishment and restriction in interacting with their children. Moreover, during the second year of life (when childhood injuries increase), nurse-visited children (irrespective of risk status) were seen in the emergency room 32% fewer times for any reason and 56% fewer times for injuries and ingestions.[12]

Improvement of Maternal Life-Course Development. During the first four years after delivery, low-income, unmarried women who received a nurse showed an 82% increase in the number of months that they were employed, had 43% fewer subsequent pregnancies, and postponed the birth of a second child an average of 12 months longer than did their counterparts in the comparison group.[13] The impact of the program on maternal caregiving cannot be interpreted fully without acknowledging that nurse-visited high-risk women had fewer children for whom they were responsible.

Effect on Government Spending. An investment in his type of home-visitation program for low-income women and children can pay for itself (from the standpoint of government spending) by the time the children are 4 years of age. On average, the prenatal and postpartum nurse visitation program cost about $3200 for two-and-half years of home-visitation. Low-income women (those most likely to use government services) used $3,300 less in other government services during the first four years after delivery of the first child than did their low-income counterparts in the comparison group. About a third of the cost savings for low-income families came from the reduction in unintended subsequent pregnancies, and about 80% of the cost savings were concentrated in reduction in Aid to Families with Dependent Children (AFDC) and Food Stamp payments.[26] The cost savings may very well continue as the children grow older, but the families have not yet been followed beyond the children's fourth year of life.

Generalizability of Findings. In interpreting the findings from the Elmira trial, it is important to keep in mind that the results derive from one study carried out in a small, semi-rural community with a white sample in the late 1970's and early 1980's. We do not yet know whether these findings apply to minorities living in major urban areas in the 1990's. The Elmira trial is being replicated in Memphis, Tennessee (with support from a variety of federal and private funding sources) with a sample of 1100 low-income black families to determine the generalizability of the findings. The report of program effects on the outcomes of pregnancy for the Memphis trial will be produced in the Spring of 1993.

Another way to determine the generalizability of the findings is to examine the findings of other randomized trials of home-visitation for pregnant women and parents of young children and see whether the general pattern of results is the same as we observed in Elmira.

Other Trials of Home-Visitation

We recently reviewed all of the randomized trials of pregnancy and infancy home visitation programs aimed at preventing health and developmental problems in pregnant women and young children.[10] We found that programs vary tremendously in terms of their objectives, target populations, structure, the background of the visitors, and their corresponding effectiveness. Some home-visitation programs simply do not work. The more successful programs focus their services on families at greater need for the service, use nurses who visit frequently beginning during pregnancy and who continue at least through the second year of the child's life. The nurses promote positive health-related behaviors and qualities of infant caregiving, and reduce family stress by improving the social and physical environments in which families live. In other words, the programs are based on comprehensive service models.[10]

Policy Initiatives In Home Visiting

Few of the legislative initiatives currently before Congress or other home-visitation proposals contain all of the programmatic features necessary for program success. The U.S. Advisory Board on Child Abuse and Neglect, for example, calls the development of a national home-visitation program using paraprofessional home-visitors who begin following families in the newborn period.[4] Similarly, the National Commission to Prevent Infant Mortality emphasizes paraprofessional programs with postnatal follow-up through the first year of life.[5,6] Evidence from the Elmira study and other randomized trials suggests that the more successful programs use nurses who begin during pregnancy, who follow families through the second year of life, and who focus their work on families at greatest need.[10-13] While the Child Abuse Advisory Board may be concerned about stigmatizing families unless the program is developed as a universal entitlement, the evidence suggests that scarce resources will be diluted, undermining the effectiveness of the initiative if it is made universally available. The viability of a nurse home-visitation initiative also has been questioned because of the nursing shortage, but recent evidence indicates that nursing school enrollments have increased in recent years and that the nursing shortage is declining.[27,28]

With the exception of a recent study in Baltimore of a single non-nurse home-visitor who was able to reduce the incidence of hospitalizations and child maltreatment and improve health-care utilization in a sample of low-income parents,[29] there is little scientifically credible evidence from randomized trials of paraprofessional home-visitation to indicate that such programs improve maternal or child outcomes of clinical importance. This is not to say that such programs do not or cannot work. The evidence of paraprofessional program effectiveness is simply limited. Moreover, there is tremendous variability in what constitutes a paraprofessional worker.

The Baltimore study tested a single college-educated home-visitor who followed families through the second year of the child's life using a multi-problem,

comprehensive approach to working with families.[29] Most of the proposals for paraprofessional home visitation call for community women to carry out this work with more limited objectives and for shorter durations. The efficacy of the more narrowly defined approaches, using paraprofessionals simply is not yet well established. The evidence suggests that the full potential of home-visitation will not be realized unless the program employs well-prepared visitors (we believe that nurses are best) who begin during pregnancy and who continue to follow families at least throughout the second year of the child's life.[10]

It is important to note that about a third of the cost savings realized in the Elmira trial came from the reduction in unintended subsequent pregnancies, and about 80% of the cost savings for low-income families were accounted for by the reduction in Aid to Families with Dependent Children (AFDC) and Food Stamp payments.[25] This finding emphasizes the importance of designing such programs with a broad multi-problem focus if they are to be economically viable. The multi-problem focus probably also adds to the power of such programs, in that improvements in one aspect of maternal or child functioning makes it easier to facilitate improvements in others. Most of those programs currently proposed focus on single domains (e.g., improvement of pregnancy outcome, reduction in child abuse) and thus fail in this regard.

The one home-visitation legislative initiative that comes closest to containing those programmatic features that show greatest promise is the Healthy Beginnings Act (H.R. 1244).[30] It calls for prenatal and infancy nurse home-visitation that would continue at least through the child's second year of life. The program would be focused on those communities with the highest rates of infant mortality in the country, and the services would be based on a comprehensive model designed to address simultaneously a multitude of maternal and family needs. The bill also calls for continuous examination of these initiatives in the form of additional randomized trials. In spite of the difficulties encountered in carrying out randomized trials of complex interventions, they are especially important because we need to continuously refine our understanding of the extent to which such programs produce positive effects.

Conclusions

Several major policy groups have recommended that home-visitation services be developed on a much broader scale than currently exists to address the needs of parents and young children in our society. Because home-visitation programs vary so much in their design and corresponding effectiveness, considerable attention should be given to formulating an approach that is consistent with the evidence on what program features are most likely to produce program success. The direction that is set now will determine the structure and success of such a program for decades.

In light of the diverse home-visiting approaches being promoted, I think that Federal policy makers should consider convening a conference of representatives from the Infant Mortality Commission, the U.S. Advisory Panel on Child Abuse and

Neglect, relevant members of the research community, and federal and state governments to forge an approach that makes sense in light of available evidence and resources. We must move quickly and carefully.

I agree with the Advisory Board on Child Abuse and Neglect that we are facing a national emergency because of the dissolution of adequate support for parents. The ensuing abuse, neglect and disability of our children ultimately endanger us all and pose a greater threat to our national security than any foreign enemy in our history.[3] Our children's future and the future of our society depend on our taking decisive action. We must embark on this journey, however, with full awareness that the course is still far from well marked, and that we may need to make mid-course corrections along the way.

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Chairwoman SCHROEDER. Our final witness this morning, who has already been introduced to us, but we must tell you how honored we are to have you here, Doctor Watson, is Doctor Bernard Watson, who is the President and Chief Executive Officer of The William Penn Foundation in Philadelphia.

So the floor is yours, and thank you.

STATEMENT OF BERNARD C. WATSON, PH.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, THE WILLIAM PENN FOUNDATION, PHILADELPHIA, PA

Mr. WATSON. Thank you very much, Madam Chairwoman, and ladies and gentlemen on the committee.

I'm not an expert in the area that we are talking about today. Although I've been President of The William Penn Foundation for 11 years, I continue to be, and have always been, an educator first and foremost. I have an earned Ph.D. from the University of Chicago. I've worked in public schools, elementary and secondary level. I've held appointments in three departments at four universities, and I served as Academic Vice President of Temple University. So I come at this as a representative from the private sector trying to support those who are experts in this area to deal with what I consider one of the most devastating elements in our society today.

Our initiative started with what we hoped would be an intelligent approach to trying to support people who knew what they were doing. For three years before any grants were made by our Foundation, the staff engaged in a detailed study of the local and national situation with regard to child abuse. A Foundation survey showed that, although the combined budgets of two of the largest Philadelphia agencies providing child preventive and child protective services totaled more than $15 million, only $35,000 of that total was available for child abuse prevention.

Our next step was to appoint an ad hoc committee of local experts to develop a framework for a community-based child abuse prevention program.

After consulting with national experts, including Doctor David Olds, from whom you've already heard, we, in January of 1988, issued a request for proposals to organizations in Philadelphia and the five surrounding counties outlining the goals and objectives of our initiative in child abuse prevention.

In July of 1988, the Board of Directors approved three-year grants totaling nearly $6 million to 14 agencies, five in suburban counties and nine in Philadelphia. The projects that we funded had three major components: parenting education, family support in crisis situations, and support for isolated parents.

A few of the examples of the types of services provided in these various programs include: first-time parents being reached while the mother and baby were still in the hospital; parents attending biweekly group sessions to study a nationally recognized curriculum and involving home visits, a toy library, and a drop-in child center; teenage first-time mothers received 15 to 20 visits by trained home visitors and followed by a nurse; and Hispanic mothers participated in a ten-week program which incorporated cultural

values and psychological concepts, as well as other better known ways of preventing child abuse.

One of the things that foundations learned how to do, at least the good ones, is how to evaluate how well your money was spent and how the programs were carried out. So we decided that we needed an excellent evaluation methodology and, following a lengthy search for an external evaluator, the Foundation engaged the Center on Child Abuse Prevention Research of the National Committee for Prevention of Child Abuse to carry out a multifaceted study of the greater Philadelphia area program.

The further evaluation had two major thrusts, to measure behavioral change in the clients served by the agencies, and to investigate the way in which agencies deliver their services.

Results of the evaluation are as follows. According to the National Committee evaluation report, all 14 of the Foundation's projects can be considered successful in reducing parental potential for maltreating children and in teaching effective parenting skills. Moreover, the positive effects of project activities were retained and enhanced following the conclusion of the participation.

In 12 of the 14 projects, over 50 percent of the families were at the highest risk of abuse and, according to the National Committee, in their experience, this degree of risk in the client population of prevention programs had not been seen.

The evaluation revealed, however, that high-risk clients in the Foundation-sponsored program showed the most dramatic improvements.

There were certain recommendations which came out of the programs which should have a positive impact, particularly on high-risk clients. Maintain an intensive level of contact with the client, which means at least once or twice a week. Offer multiple types of interventions, rather than a single one. Engage in aggressive community-based outreach methods. Include direct services to children and parent/child interaction, and to make sure that agency staff is both competent and empathetic, and to integrate prevention programs into a broader network of social services, many of which have been recommended by previous speakers on the panel this morning.

We plan to continue the Foundation program, because the problem continues to be urgent. From 1988 to 1992, the Foundation awarded a total of over $7.1 million for its child abuse prevention programs, including grants to agencies for the evaluation and for a small agency training program.

In order to continue the program through 1995, the Foundation expects to spend an additional $4.7 million or more, bringing its overall investment in child abuse prevention to nearly $12 million over a seven-year period, and that is out of a grant budget this year which will total in the neighborhood of $36 million.

There are several reasons why the Foundation is willing to commit such large resources to the program. Child abuse prevention is cost-effective, and family preservation is more humane than the alternatives, most of which have been indicated by the previous speakers on the panel.

It is my conviction that the best hope for the future lies in the establishment and strengthening of partnerships between the pri-

vate and public sectors. It is obvious that the governments at every level are not able or willing to provide the necessary funds, despite the cost effectiveness, and it seems to me that those of us who are in the private sector who have funds which we can put at risk when we are not sure whether they are going to work or not need to enter into partnerships to continue programs of this sort.

Thank you very much, Madam Chairwoman.

Chairwoman SCHROEDER. Thank you very much.

[Prepared statement of Bernard C. Watson, Ph.D., follows:]

TIVE OFFICER, THE WILLIAM PENN FOUNDATION, PHILADELPHIA, PA

Introduction

I am Bernard C. Watson, President and CEO of the William Penn Foundation in Philadelphia. The Foundation was established in 1945 by Otto and Phoebe Haas, and its principal mission is to help improve the quality of life in the Delaware Valley. Under this general rubric, the Foundation makes grants in four areas: culture, environment, community fabric, and human development. The largest percentage of its giving--which in 1991 totalled $30.5 million--is devoted to the problems of children and youth.

Although I have been President and Chief Executive Officer of the William Penn Foundation for 11 years, I continue to be, first and foremost, an educator. I earned my Ph.D. at the University of Chicago. I have served as teacher and administrator in the Gary, Indiana, public school system; as deputy superintendent of schools in Philadelphia; and as professor and academic vice president at Temple University. Throughout my professional life, I have been deeply concerned about children and have supported all efforts to guarantee their birthrights: health, emotional and physical security, and the opportunity to develop their abilities to the highest extent possible.

The Foundation's Child Abuse Prevention Initiative

Planning and Development. For three years, before any grants were made, members of the Foundation staff engaged in a detailed study of the local and national situation with regard to child abuse. Perhaps the most significant discovery was the fact that public policy, reinforced at least in Pennsylvania by state law, focussed on intervention after abuse had occurred; no public funds were available for measures designed to assist families at high risk of neglecting or abusing their children. A Foundation survey showed that although the combined budgets of 12 of the largest Philadelphia agencies providing child protective services totalled more than $15 million, only $35,000 was available for child abuse prevention.

The Foundation then appointed an ad hoc committee of local experts to develop a conceptual framework for a community-based child abuse prevention program. Six months later, Youth Services, Inc., was asked to expand on the committee's report by undertaking a more thorough literature review, visiting exemplary programs across the country, and consulting with national experts--including Dr. David L. Olds, who is also testifying before the House Select Committee today. In January 1988, the Foundation issued a Request for Proposals to organizations in Philadelphia and five surrounding counties, outlining the goals and objectives of the Initiative.

Grants Awarded. In July 1988, the Board of Directors approved three-year grants totalling nearly $6 million to 14 agencies, five in suburban counties and nine in Philadelphia. All the agencies were located in or planned to target neighborhoods where there was a high incidence of verified child abuse. Although the agency projects varied in approach, the goal of each was to prevent abuse from happening by focussing on family well-being, encouraging positive parent-child relationships, and enabling parents to cope effectively with their responsibilities. (Note: Additional grants totalling more than $800,000 enabled the projects to continue through April 1992.)

The projects had three major components: 1) parenting education, which covered such topics as child development, health care, and appropriate discipline; 2) family support in crisis situations such as death, job loss, or marital difficulty; and 3) support for isolated parents. Services were offered in a variety of ways, including home visitation, parenting groups, respite care, and family or individual therapy. Two of the agencies awarded grants were Hispanic with bilingual staff. The projects served a combined

population of 12,000--urban and suburban, black and white, Hispanic and Asian.

Here are a few examples of the types of services provided:

- First-time parents were reached while mother and baby were still in the hospital. In the following three years, personal contacts included seven home visits and six group sessions.
- Parents attended biweekly group sessions to study a nationally recognized curriculum describing the cognitive and physical development of the child up to two years. Other project components: home visits, a toy "library," and a drop-in child care center.
- Teen-age first-time mothers received 15-20 visits by trained home visitors and five by a nurse.
- Hispanic mothers participated in a ten-week program which incorporated cultural values and psychological concepts.

Evaluation Methodology. Following a lengthy search for an external evaluator (including an all-day consultation with four evaluation experts: Dr. James Gambarino, Dr. Ruth S. Kempe, Dr. Leonard LoSciuto, and Dr. Howard Dubowitz), the Foundation appointed the Center on Child Abuse Prevention Research of the National Committee for the Prevention of Child Abuse to carry out a multifaceted study of the greater Philadelphia area program. The Committee agreed to provide a report in early 1992. Throughout the nearly four-year grant period, regular monitoring of the program was conducted by Foundation staff in numerous ways: through site visits, group meetings, written reports, and telephone contacts.

As the National Committee noted in its report,* the Foundation Initiative provided a unique opportunity for comparative study of intervention strategies. The formal evaluation had two major thrusts: to measure behavioral change in the clients served by the agencies, and to investigate the way in which the agencies delivered their services. In order to carry out the impact study, a group of 1,078 parents was selected to complete the nationally-normed Child Abuse Potential Inventory, to be assessed by agency staff, and to participate in other activities, including interviews, designed to reveal the effects of program services.

Results of the Evaluation

According to the National Committee evaluation report, all 14 of the Foundation's projects can be considered successful in reducing parental potential for maltreating children and in teaching effective parenting skills. Moreover, the positive effects of project activities were retained and enhanced following the conclusion of participation. Children also benefitted from the program, as indicated by several measures of development and of cognitive and social functioning.

It should be noted that a significant percentage of the families served by the program were at the most extreme end of the risk continuum. In 12 of the 14 projects, over 50 percent of the families were at the highest risk of abuse. (In the experience of the National Committee, this degree of risk in the client population of prevention programs had not been seen.) The evaluation revealed, however, that high risk clients in the Foundation-sponsored program showed "the most dramatic improvements."

The evaluation report does not list specific aspects of the program which should be replicated. Rather, it points out that no single intervention

is equally successful with all individuals. Based on its analysis of both qualitative and quantitative data obtained on the Foundation-sponsored projects, the National Committee made the following recommendations for programs which would have a positive impact, particularly on high-risk clients:

- Maintain an intensive level of contact with the client (at least once or twice a week)
- Offer multiple types of interventions rather than a single one
- Engage in aggressive community-based outreach methods
- Avoid didactic group-based approaches to parenting education
- Include direct services to children and parent-child interactior
- Make sure that agency staff is both competent and empathetic
- Integrate prevention programs into broader network of social services

Continuation of the Foundation Program

The problem of child abuse continues to be urgent. The results of the Foundation Initiative appear to give a sound basis for hope that it can be dramatically reduced, but public funds are simply not available to address the critical issue of prevention. Consequently, Foundation staff members are now planning another round of grants to nine of the agencies involved in the first program. It is expected that recommendations will be taken to the Board of Directors for action at its May meeting.

From 1988 to 1992, the Foundation awarded a total of over $7.1 million for its child abuse prevention program, including grants to agencies, for the evaluation, and for a small agency training program. In order to continue the program through 1995, the Foundation expects to spend an additional $4.7 million or more, bringing its overall investment in child abuse prevention to nearly $12 million over a seven-year period. There are several reasons why it is willing to commit such large resources to this program.

- Child abuse prevention is cost effective. Providing support and education for at-risk parents is, quite simply, cheaper than intervention after abuse has occurred. Removing a child or children from the home and paying for foster care is an expensive proposition. Last year, the foster care system cost American taxpayers $9 billion. Moreover, prevention can pay long-term dividends: improving parent-child relationships in one generation increases the likelihood of success when that child becomes a parent him- or herself.
- Family preservation is more humane than the alternatives. The severe tensions experienced by at-risk families exact a heavy toll. How much more devastating the psychological consequences--for all concerned--when parents are driven to inflict serious injury or even death on their children.

Public/Private Partnership in Child Abuse Prevention

Foundations can--and do--initiate programs, test alternatives, demonstrate that some approaches work better than others, publicize the results of their research and evaluation. But even though the William Penn Foundation is the second largest funding source in Philadelphia, its impact on

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the grave social problems of our time--child abuse, teen pregnancy, inadequate education, violence, to name only a few--is limited at best. Broad implementation of measures to prevent, ameliorate, or cure these problems is and will remain the responsibility of government at every level.

Although the United States likes to think of itself as a country which loves and invests in its children, it is the only Western industrial nation which has no significant policies in support of children and families--and which is reluctant to find adequate funding even for such proven educational programs as Head Start. In her recent book, When the Bough Breaks,** Sylvia Ann Hewlett gives incontrovertible evidence of the gap between our rhetoric and the reality, and issues a powerful challenge to take up our collective responsibility for the youngest citizens among us. Organizations like the William Penn Foundation can underwrite demonstration programs and provide useful information about promising new directions. But these valuable findings will be lost unless they are adopted and funded on a large scale by government.

It is my conviction that our best hope for the future lies in the establishment and strengthening of partnerships between the private and public sectors.

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* A copy of the executive summary of the impact study is attached. House Select Committee staff members have copies of the full three-volume report.

** Published by Basic Books, 1991.

EVALUATION OF THE WILLIAM PENN FOUNDATION CHILD ABUSE PREVENTION INITIATIVE, PREPARED FOR THE WILLIAM PENN FOUNDATION BY THE CENTER ON CHILD ABUSE PREVENTION RESEARCH, NATIONAL COMMITTEE FOR PREVENTION OF CHILD ABUSE, CHICAGO, IL

EXECUTIVE SUMMARY
WILLIAM PENN PREVENTION INITIATIVE EVALUATION

OVERVIEW

In 1989, the William Penn Foundation awarded the National Committee for Prevention of Child Abuse a three year grant to evaluate the relative effectivess of 14 child abuse prevention programs in the greater Philadelphia area. This evaluation included eight study components, each of which explored a specific aspect of program impact. Four of these components, the adult client impact study, the follow-up adult client impact study, the study of services to children and the study of high-risk clients, examined the degree to which the 14 grantees changed the specific parenting practices, personal functioning and parent-child interaction patterns of the participants. The remaining components (cost study, process study, systems impact study and provider study) investigated the service delivery system and staffing patterns utilized at each site along with the degree to which the programs influenced the scope of child abuse prevention services in their immediate areas. This executive summary presents the results of the impact study components.

The comprehensive nature of this study afforded the opportunity to improve upon prior evaluation efforts in three major areas. First, the study employed consistent outcome measures across a number of intervention strategies. This method facilitates the direct comparison of different interventions in order to identify the most promising techniques. While numerous evaluations have assessed the impact of a single intervention, few evaluations have systematically compared different service delivery systems and service content. Second, the study utilized a combination of quantitative and qualitative research methods. Quantitative methods allow for the utilization of rigorous multivariate analyses which can pinpoint the statistical effect of different intervention strategies. In addition, the integration of qualitative or descriptive information not only provides a more enriched interpretation of these statistical findings, it can help explain how these strategies produced an impact. Finally, the nature and size of the client sample provided an opportunity to determine whether different types of clients receive the same benefits from similar interventions. Unlike the typical prevention program evaluation which relies on small samples of similar, low-risk clients, this study involved large numbers of participants with a sizable group of high-risk clients. Findings from this evaluation can help guide program planners in choosing the most effective intervention for their potential client base.

THE SAMPLE

The study consisted of a systematic evaluation of the services provided by 14 different programs targeting parents at risk for maltreating their children in the four county region surrounding Philadelphia. Nine of these programs served communities within

Philadelphia while five programs provided services at surburban locations. The programs provided a mix of services ranging from a single intervention such as home visits, to multiple interventions such as a combination of home visits, parent education classes, parent support groups and counseling. Programs also varied by service length. Five of the 14 programs engaged families in services for an average of two to three months. In contrast, families served by the remaining grantees received services, on average, for six months or longer. Over and above length of services, the grantees also differed in service intensity. The average contact program staff had with families ranged from less than once a month to more than twice a week.

A total of 1,078 parents served by these programs between March 1990 and July 1991 participated in this research effort. On average, these participants are more likely to be older, female, single and less educated than the U.S. adult population. Additionally, the study sample consisted of three times more African-Americans, twice as many individuals with incomes below $15,000, and ten times more individuals on Public Assistance than the American population. This pattern may reflect the concentration of sites in urban areas. In fact, participants at city sites were statistically different from their suburban counterparts. Specifically, clients at Philadelphia sites were more likely to be African-American, single, low-income and receiving public assistance than those in the surrounding suburbs.

THE METHODS

The present research incorporated a variety of methods to determine the relative impact of the intervention strategies. The adult client and children's services impact studies primarily relied upon a multiple group comparison design to measure effect. This quasi-experimental method utilizes a pre-test/post-test design to assess client change. In the absence of a formal control or comparison group, the data from each site are merged allowing the creation of comparison groups on a number of dimensions such as site, intervention strategy, risk category or length of involvement. For those adult clients at programs unable to obtain pre-tests, a modified time series design was used with data collected on every client participating in any intervention during five one-week periods throughout the evaluation period.

The follow-up and high risk study components largely relied upon qualitative methods; in particular, semi-structured interviews with clients. For the high risk study, the interviews with clients were conducted after the client had completed or dropped out of services. The follow-up study also included an additional post-test for clients at the time of the interview. These interviews occured three months after service completion.

A number of data sources and instruments were used in these four studies. For the adult impact study (excluding the time series component) standardized information on client demographics,

initial functioning, and likelihood for maltreatment was obtained through staff assessments within 30 days of entry to the program. Clients also completed the Child Abuse Potential Inventory (CAP) during this same time period. Programs lasting less than six months collected final client functioning, benefit to client and service data within one week of termination; the longer term programs collected this data every six months and within one week of termination. Again, clients completed CAPs and satisfaction with services forms during this same time frame.

In the time series design, clients completed the same client demographic information required in the overall adult impact study and a CAP during each data collection period. At this same time, they provided information on service utilization and satisfaction with services.

The follow-up and high risk study components utilized all of the data collected in the overall adult impact study. In addition, follow-up clients completed another CAP and answered open-ended questions regarding parenting practices and parent-child interaction patterns, informal and formal social supports, family stresses and client self-concept. The high risk clients described program impacts on parenting behaviors, knowledge of child development, and expectations for the child. In addition, they answered questions regarding how they heard about the program and why they remained in the program.

The children's study obtained data on both the adult and child participants. Basic demographic information was obtained through client self-report or a staff assessment. Adults completed a measure of child development knowledge while staff assessed child functioning with the Denver Developmental Screening Test. Staff also assessed the parent-child interaction and the child's health. All measures were completed within two weeks of entry to the program and within one week of termination of services.

THE FINDINGS

As a group, the 14 demonstration projects significantly reduced their clients' levels of risk for maltreatment as measured by the Child Abuse Potential Inventory (CAP) and staff assessments. On average, participants decreased their CAP scores by almost 11 points with high risk clients showing the most dramatic improvements. In addition, staff rated almost 70% of the adult participants as having benefitted from services. In terms of specific at-risk behaviors, clients were significantly less likely to use corporal punishment, to inadequately supervise their children or to ignore their child's emotional needs at termination.

More importantly, these gains were retained and enhanced over time. The follow-up sample reported continued improvements in their methods of discipline and an increase in positive interactions with their children. For those clients completing a follow-up CAP, child abuse potential had continued to decline with

the average score decreasing 26 points between termination and follow-up.

Children as well as adults benefitted from participation in services. The children's study found that therapeutic child care and parent-child play groups not only improved the child's functioning, but also enhanced parent-child interactions and the parent's knowledge of child development. Overall, the percentage of children scoring in the normal range on the Denver Developmental Screening Test increased from 69% at intake to 87% at termination. Similarly, almost three-quarters of the children demonstrated improved cognitive and social funtioning at the end of services.

While it is tempting to present a list of service components or delivery features which have universal positive impacts on clients, the findings from this effort suggest such a miracle does not exist. In fact, both the quantitative and qualitative data reinforce the findings of others that no single intervention is equally successful with all individuals. However, certain program features did emerge as having a substantial impact on specific types of outcomes:

- **Intensity of service best predicted overall client outcomes.** The greater number of weekly contacts a client had with a program, the higher the likelihood that he or she would be identified by staff as having benefitted from the program and having reduced the likelihood of committing potentially abusive behaviors. A similar pattern emerged in the children's impact study where clients with the greatest participation rate achieved the most notable gains in child and adult functioning.

- **Receiving multiple types of interventions reduced the risk of maltreatment for high risk clients.** For a number of high risk clients, participation in a combination of service types such as parent-child play groups, parent support groups and parent education classes, reduced their CAP scores more than clients receiving a single intervention.

- **Successfully engaging and retaining the highest risk clients was best done with aggressive community-based outreach methods.** Prevention programs which depended on other social and health services agencies to identify high risk clients had a hard time engaging and retaining these clients. High risk clients engaged through direct outreach such as door-to-door canvassing, general community presentations and advertising in the media were more likely to remain in the program and complete specific service cycles.

- **Length of time in service did not predict successful client outcomes.** Merely enrolling a client in a service program for an extended period of time was not associated with program success.

- **Group-based, didactic services proved particularly ineffective with the low to moderate risk clients.** Parent education and discussion groups limited to parenting issues did not improve client outcomes in terms of CAP scores or staff assessments. Additionally, clients identified these types of services as the least helpful.

THE IMPLICATIONS

Effectively utilizing this research to enhance child abuse program planning will require more than replicating a promising intervention. This process involves careful attention to the context in which the program will be placed, the proposed target population it will serve, the program's organizational auspices and ability to deliver services, and finally, the broader social service environment in which it will operate. Rather than offering clear models for replication, research on child abuse prevention programs more often provide service planners with numerous building blocks for constructing the most relevant service system for their particular situation.

The 14 programs evaluated under this effort do not capture every prevention model currently in place for at-risk families. However, they do represent the range of interventions commonly implemented by community-based agencies to serve this population. In addition, the participants in these programs covered a broad spectrum of possible client types, thereby increasing the likelihood that these findings will apply in a variety of settings. The results from this evaluation afford policy and program planners specific guidelines for shaping more effective prevention efforts. Based upon the quantitative and qualitative data gathered under this initiative, specific consideration should be given to the following service characteristics:

- Effectively preventing child abuse requires an intensive level of service contact. These data suggest services be provided, on average, at least once or twice a week.

- Prevention services need to do more than merely transfer specific parenting or child development knowledge. Enhancing parenting skills can be achieved only if a program addresses both personal as well as parenting needs of its clients.

- Direct services to children, either through parent-child play groups or therapeutic child care, is an important component of effective prevention systems. Not only do these services result in notable changes in child functioning, they also provide opportunities for supervised parent-child interactions.

- A decision to utilize home-based versus center-based services should be based upon client characteristics and staff skills. These data suggest either form is equally effective in producing positive client outcomes providing the service is of sufficient intensity and breadth.

- Competent and empathic direct service staff are the linchpin for successful prevention efforts. In selecting staff, project directors need to evaluate applicants not only in terms of their educational and technical qualifications, but also in terms of their ability to relate to clients in a non-judmental and supportive manner. Such relationships are key to attracting and retaining high risk clients.

Finally, no prevention program can be all things to all clients. Given the level of concrete and emotional needs of this population, even the most organized and extensive program will not be able to fulfill the variety of demands that will be placed upon it. In order to secure the service capacity necessary for this clientele, a prevention program needs to be well-integrated into the broader network of services within its local community. It is the creation of these comprehensive service networks, such as the one now in place in Philadelphia, which will turn the tide in the struggle to prevent child abuse.

Chairwoman SCHROEDER. I think now we are going to proceed to questioning. I think we'll use the five-minute rule, if that's okay, and we'll do it in order as people appear on the committee on each side, if that's all right.

So, Congressman Martinez, do you want to kick off?

Mr. MARTINEZ. Thank you, Madam Chair.

Ms. Cohn Donnelly and Ms. Breakey, you both talked about at-risk families. Ms. Breakey, you identified in your statement—you identify at-risk families when the mother is in the hospital having the child.

There have to be other ways of identifying at-risk families other than just that single way. Could you delineate some of the other ways that you identify?

Ms. BREAKEY. I'd like to begin by saying that the reason that we identify families while they are in the hospital is that is the most systematic. If we want to really reach all the high-risk families in our county, in our state, that's the time when you are going to see all families, because almost everyone, at least in our state, delivers in a hospital.

It would be—we are using Henry Kempe's Family Stress Checklist, which has been quite well validated by subsequent studies—it would be possible to do the same kind of screening in a prenatal clinic. It would be very possible to have regional perinatal systems, if you will, in which pediatricians—not pediatricians, but obstetricians would have screening checklists that they could use when they are seeing people for prenatal care. That would not deal with families who do not seek prenatal care, and often high-risk moms don't seek prenatal care.

Does that answer your question?

Mr. MARTINEZ. Yes.

Ms. COHN DONNELLY. I think the beauty of working through hospitals is exactly what Gail has said, it assures one the opportunity of interacting with every new parent, except for those that don't give birth in the hospital, which is a very small percentage.

But, certainly, the programs that Doctor Watson described in Philadelphia, all of which serve very large numbers of high-risk programs, most of which do not attract their client base from interviews at birth, but rather a variety of other mechanisms, suggest that there are a lot of other ways of identifying and attracting high-risk parents to services that they will benefit from and that they will find very attractive.

Mr. MARTINEZ. Let me try to explain why I'm asking the question, is because, Boys Town has over 500 troubled and abused children in the Boys Town in Omaha, Nebraska. Most of those came about, well, several ways, one, what they call a "pilgrim," someone who is so abused at home that they won't take it anymore and they show up there at the door, and they call them "pilgrims," for varied reasons. I met one young lady there that, I asked her why she had come there, why she sought that particular facility out, and she said because she just ran out of somebody to love her anymore, and she had heard about Boys Town, and she showed up there.

But that's what happens with a lot of kids when they are getting abused by their parents. They just feel that there's nobody to love them.

But, if you reach these young people at childbirth, I mean, you are really beginning at the beginning, and I agree that should be done, but I'm wondering if, in the process, we don't neglect a lot of others that mostly come to the attention of programs because of referrals of courts.

There was another young man I visited with who, 11 years old, the nicest young man you ever saw in your life, you couldn't wonder why would a parent abuse a child, well-mannered, but it got so bad at his house that, think of the ingenuity this young man used in finding a car, finding a way to hot wire it, where he had never done it before, stole the car to get away. Of course, he was caught by the Highway Patrol, and when he told them the problems why he stole the car, they took matters into their own hands in seeking a judge's order to have him placed in a program, because they realized that he was being abused at home, and they placed the parents in a program, too.

So maybe something will—he's getting ready to leave that program and go back home, but lately I've been seeing a lot of this at that age, and especially foster kids, who your programs, the Hawaii plan, I think, is a wonderful plan that we ought to apply maybe nationally, but what I'm concerned about is, how about the others, other than those that—like I say, catching them early on is one of the best things we can, because that prevents it from ever getting to the point where this 11-year-old boy is.

But how do we—what do we do about the others?

Ms. COHN DONNELLY. The tragedy about how, as a nation, we've responded to the child abuse problem is that we haven't guaranteed that children who are abused get the therapeutic and developmental supports that they need to get beyond the scars of abuse.

If the one million children that are reported to the system each year and confirmed had comprehensive diagnostic testing and they got therapeutic services we would go a long way in alleviating a lot of social problems that we face as a country. Abused children's scars get acted out in a variety of ways, such as running away from home, juvenile delinquency, trouble with alcohol and drugs, and so on.

Mr. MARTINEZ. I think, if anything, there's got to be some kind of a national requirement across the country, even for the juvenile courts, for early evaluation of these people and why they are committing these offenses, because I think that often goes neglected. As a result, we are mishandling the kids. We are not doing the right things with them, and I think what you've just said is very important.

One last question. The problems that you see at that age, other than the ones you get early on, which, like I say again, is early preventative measures are the best. You know, when we passed the Juvenile Delinquency and Prevention Act in 1974, we did it because we realized that, locally, there weren't enough resources, or technical expertise, or all of the things that it takes to really handle the situation, and in all these years we really haven't improved the situation that much. And most of the monies that have

gone to those programs have been really to deal with the situation after it occurs. You know, a big part of it was deinstitutionalizing young people from adult prisons and that involvement with adults.

And some of the states have done a real great job. More recently, Omaha, Nebraska, just last year, used all of the money because they weren't in compliance with the federal mandate of deinstitutionalization, and used all of the money to deinstitutionalize, and they are now in compliance. And now, this year, they are going to use most of the money they get for prevention, and I think it's that prevention that we need to stress here for this.

Would you like to comment on that?

Ms. BREAKEY. Well, what's interesting is that we developed this program very much in a partnership with the Chairman of our Ways and Means Committee in Honolulu, Senator Yamasaki, and he was looking for a delinquency prevention strategy. And, when we talked with him about the relationship between child abuse and delinquency, a Kempe study that found that 86 percent of consecutive first-time offenders had been abused before the age of two, a San Quentin study by the Psychological Association showed that 100 percent of most violent inmates at San Quentin had been abused as children, he saw this correlation and he was looking at the mounting costs, all kinds of social ills, mental health problems, teenage pregnancies and so on, and he saw this as a first step, I think, in dealing with this.

But I agree with you that we need better services for children when they are in their teens. We need better—more shelters, more programs for youth. Also, if they have been victims of abuse, or of just neglect of preparing them for adulthood, that there should be the resources to help them with jobs, and with finding their feet and becoming productive adults.

Mr. MARTINEZ. Thank you.

Chairwoman SCHROEDER. Thank you very, very much.

Congressman Smith?

Mr. SMITH. Thank you, Madam Chair.

Ms. Cohn Donnelly, I appreciate the effort your organization has made to conduct that survey.

I wanted to follow up on a couple of statistics that you mentioned, but first of all, I would like to ask how many of the child protective service agencies are there in the United States? I'm just curious.

Ms. COHN DONNELLY. This is a survey of the state level agency, so 50 states.

Mr. SMITH. So we'd just call each state in that case, and then they, in turn, will have collected the data from the agencies within their organization.

The figure that you mentioned that caught my attention was the 40 percent of the deaths among the 1,300 children that die either because of child abuse or neglect. Forty percent of those deaths or cases are known to the local child welfare system as clients, former or current clients. That's an incredible figure, and a very disturbing figure to me, when you consider, not to minimize it, but overall 1,300 is such a minuscule part of the population, yet 40 percent of those individuals are known to the system.

Why aren't we doing more to prevent those deaths from occurring? What is wrong with the system when almost half are known and, yet, the deaths occur anyway?

Ms. COHN DONNELLY. There are an awful lot of factors I could talk about, but let me just cite a few. Over the last decade, reports have increased exponentially, and the resources available to the system have not.

The qualifications of workers, the training available to workers, the supervision available to workers, but most importantly, the ability of workers to give services to the clients they are working with has diminished dramatically. So you have a situation in which a system is literally overwhelmed. It is unable to do the very things that the workers themselves know that they would most like to do and need to do to help.

Mr. SMITH. Are there any common elements to those 1,300 children such as is there any way to target particular families as being very at risk, and you give them more attention or not?

Ms. COHN DONNELLY. I think a lot of states and the local protective service agencies are attempting to do that through different kinds of risk assessments.

Mr. SMITH. Okay.

Ms. COHN DONNELLY. It's a little bit difficult, because one can't always predict what's going to influence a given person's life, when there's going to be a crisis, when they are going to lose a job, when a new person——

Mr. SMITH. It just seems to me that we ought to be able to learn some lessons from that incredibly high figure, that 40 percent who are known to the system, and maybe come out with some solutions from that.

Doctor Horn, I wanted to ask you, you didn't bring it out in your testimony, but in regard to the HHS budget, as far as funds spent on abuse and neglected children, has the budget been increasing, and, if so, how much, or what's been the change in the budget?

Mr. HORN. In the Department, we view efforts to both prevent and intervene with children who are maltreated or at risk for maltreatment in a broader context than simply the budget of the National Center on Child Abuse and Neglect. The total budget for NCCAN this year is about $69 million.

If you look at the Children's Bureau, for example, we spend about $2.9 billion, that's $2.9 billion, on child welfare services, and then we spend an additional $2.2 billion on Head Start, which we think, as I mentioned, is a good prevention program for child abuse.

Mr. SMITH. Does that represent an increase, say, from two years ago and, if so, how much of an increase?

Mr. HORN. Certainly, particularly in terms of Head Start. In 1989, when the Bush Administration first took office, the Head Start budget was $1.2 billion. And, just three short years later, it's $2.2 billion, and this year we've asked for the largest one-year increase in the history of the Head Start program, $600 million, which, if fully appropriated, will get us to $2.8 billion.

In terms of child welfare services, we've also seen dramatic increases in the amount of money being spent over the last four years, particularly in Title IV-E.

The problem, in my view, is that there is a lot of money out there in the system, but I'm not convinced we are spending it correctly. We're spending over $2 billion a year for children who are taken out of the home and placed in foster care. About half of that is spent on maintenance payments for the kids in out-of-home care, and half of that is spent in administrative costs and training expenses, but primarily for children who are already placed in out-of-home care. In contrast, we are spending $274 million for general child welfare services.

Now, if you have a system that's putting over $2 billion into kids who are already taken out of homes, and only $274 million to try to prevent that situation from occurring, what would you expect? You'd expect what we have, an increasing number of kids being placed out of the home.

And so, one of the things that we're trying to do this year, and we have a legislative proposal that we have now sent to the Congress, is to fundamentally change that system, so that state agencies and local agencies can use greater flexibility in how they use all the money that we spend in child welfare.

So, to answer your specific question, I think that we should look more broadly than simply at NCCAN's budget, because we are spending a lot of money on children's services. I just think that, particularly in terms of child welfare, we are putting most of it at the back end——

Chairwoman SCHROEDER. Would the gentleman yield a moment?

Mr. SMITH. I'd be happy to yield, yes.

Chairwoman SCHROEDER. Isn't it, I mean Title IV-E, which is what goes into foster care, that is not capped by the federal government, right?

Mr. HORN. That's right.

Chairwoman SCHROEDER. So what you are trying to say is that part isn't capped, and that's been exploding, just exploding, because the whole system seems to be driven that way, because we don't cap that one, and other services there are caps on, right?

Mr. HORN. That's right. And, in our proposal, we would continue to maintain an open-ended entitlement for maintenance payments for kids who are put into foster care. After all, we don't want to penalize the state if there is an increasing need to place kids in out-of-home care. So we want to continue an open-ended entitlement for that.

But what we are trying to do with this legislative proposal is allow much better flexibility in terms of the administrative cost portion of the IV-E program, which has risen exponentially over the last ten years.

The problem is that the title IV-E administrative costs program drives paper work. It's a crazy system. What it says, for example, is you can't spend any of that money on services for kids, but you can spend unlimited amounts of money to develop referred networks to refer kids to services that don't exist.

What we are trying to do is say to the states, look, let's allow you greater flexibility so that you can use this money for actual services for children. Let's take away the paper work requirements, let's take away the burdensome oversight mechanics that we currently have in place—the burdensome cost allocation plans and all

the hoops that states have to jump through in order to get to the money. Let's allow, as Doctor Cohn Donnelly has said, the social workers to do what they are trained to do and what they want to do, which is social work and helping families, particularly families at risk.

Mr. SMITH. Doctor Horn, I have one final question. That is, you mentioned and referred to the national meeting held in Washington in December of 1991, in which leaders from business, social services, professional associations and so forth, were challenged to participate in this coordinated effort to prevent child maltreatment.

I am just curious. You have a number of organizations represented here today, the National Committee for Prevention of Child Abuse, Families First, The William Penn Foundation. Were you able to get their support and help?

Mr. HORN. Yes. In fact, we're already seeing new initiatives that these organizations are taking. For example, the Kiwanis Club has already distributed a great deal of information on the problem of child abuse and neglect.

Mr. SMITH. You mentioned that in your testimony. I wanted to thank you for your answers and also, while my time is up, encourage you in, perhaps, answers to other questions, to work in a little more of Doctor Sullivan's culture of character, if you can emphasize that later today as well.

Thank you, Madam Chair.

Chairwoman SCHROEDER. Thank you very much.

Congresswoman Collins?

Ms. COLLINS. Thank you, Madam Chairwoman, and thank you for calling this hearing.

[Opening statement of Hon. Barbara-Rose Collins follows:]

OPENING STATEMENT OF HON. BARBARA-ROSE COLLINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Madame Chairwoman, I would like to thank you for convening this extremely important hearing of the Select Committee on Children, Youth, and Families, "Keeping Kids Safe: Exploring Public/Private Partnerships to Prevent Abuse and Strengthen Families".

Since April is Child Abuse Prevention Month, this hearing is an excellent opportunity for Members of Congress and the American people to learn ways to combat the crises that at-risk children and families face everyday. As you know, reports of child abuse have doubled in the past ten years, and as a result, more and more at-risk youth are turning to our foster care system for help. I do not believe that the current foster care system is functioning at an optimum performance level. Until we have a system that completely and selflessly serves the needs of our children—our future—we must strive to implement the best methods of social welfare that will keep these innocent young people safe.

Again, thank you for calling this hearing. I look forward to learning more about what Members of Congress can do to better serve those in our society who are less able to help themselves. I also look forward to the testimony of today's witnesses and would like to thank them in advance.

Thank you Madame Chairwoman.

Ms. COLLINS. Ms. Cohn Donnelly, I am concerned about the quality. I wonder if you'd differentiate between, I'll call it "accidental fatalities," say, due to neglect, between the violent, or, I don't want to say premeditated, but violent fatalities. Will you differentiate?

Ms. COHN DONNELLY. Yes. Most states, but not all, maintain data that would allow us to know the percentage of one versus the other,

and as best we can tell at the national level about 60 percent of all child abuse fatalities are a result of physical abuse. So, the other 40 percent would be a result of neglect.

In some states they don't even count the neglect. They just count the physical abuse.

Ms. COLLINS. And, when you build with child abuse in your statistics, I wonder if you'd differentiate between cultural or ethnic mores. We have, in Michigan, a great influx of Eastern European people. In some cases, the family tradition of the father, the patriarch, has resulted in death of the children, teenagers, for disobeying orders or directions. Do you have many of those across the nation, and do you compile those stats separately?

Ms. COHN DONNELLY. Some states would be able to give you those statistics separately. I think what's important here is an increasing awareness in this field, as in so many other fields, about the issues of cultural diversity and cultural competence, and a true need to be very sensitive to the different ways in which cultures or subpopulation groups think about raising their children, and to be sensitive to those, but to not let those dictate what we define as serious abuse.

In fact, this new data we've just released tells us that 33 states last year actually offered specialized training for their workers on these issues of cultural diversity and cultural competition.

Ms. COLLINS. I bring that up not to give an excuse for the abuse, but just to point out that there has to be a different method of addressing that type of cultural abuse. For instance, you won't get those cases through hospitals at birth, because many of them come to this country already with the family set in that mode, and we see quite a bit of it in Michigan. In Mr. Dingell's district, Madam Chairwoman, you have Moslem groups, where the children are now Americanized, but the parents still have their traditional values. As the children are trying to assimilate into their schools, other children laugh or make fun of their traditional dress and so forth.

I think that that's a powder keg that's happening in that particular district. In my own district, we have an Albanian population that has large family groups living together, and dictating down to the children, and in that case we've had some fatalities among the teenagers by the father. I don't mean one incident, I mean several incidents, and I don't know if the rest of the country has the same problem. To me, it's very frightening and very disturbing, and I don't see much happening to address that kind of abuse.

Ms. COHN DONNELLY. I think that, across the country, one sees this issue, certainly on both coasts, certainly in Chicago, certainly in major cities across the country where there are a variety of different population groups living.

I think this field has been slow to respond, but is starting to

Ms. COLLINS. Do you think that there is specified training being tried? Ms. Breakey, does Hawaii show lower statistics of child abuse?

Ms. BREAKEY. No. We also have a wide racial mix and a wide variety of child bearing practices, and ours are as high as anywhere else.

Ms. COLLINS. But the home visitation services have almost 100 percent success, and it's universal.

Ms. BREAKEY. Well, it's only—right now we are reaching 50 percent of the families in the state. That's only been true for a little over a year.

It's going to take a little while. The data we're able to show right now is the data for the families that we're reaching. It's going to take us a little while for that data to show up in the statistics.

Ms. COLLINS. It's available to all families?

Ms. BREAKEY. It's available——

Ms. COLLINS. If identified, and most of your identification is occurring in the hospitals?

Ms. BREAKEY. That's right. It's available to all families that are identified as high risk. We are serving probably about 2,600 families right now.

Ms. COLLINS. That's in all the islands?

Ms. BREAKEY. That's in all the islands. Our coverage is pretty much 100 percent on the neighbor islands, which is unusual, and it's about 40 percent on the island that has the main population base, Oahu. I think it's going to take us several more years to really see the impact of this program in terms of statistics overall, and we're very much looking forward to having those.

Ms. COLLINS. I really do support home visitation services. I remember the old visiting nurses. When a first-time mother had a baby, the nurse came to show the mother how to bathe the baby and take care of the baby, even though they had their own families showing them. Nevertheless, this was a professional, and I think that we were better off for it.

And I think we're seeing now the results of cutting those programs.

Finally, Doctor Horn, I am very mystified at all of your great numbers on Head Start. When I remember the fights that we had under the leadership of our Chairwoman to have full funding for Head Start, and not getting it through, or was it vetoed, Mrs. Schroeder?

Chairwoman SCHROEDER. Yes. It was taken out of the Dire Emergency Supplemental Appropriations bill through the President's objection.

Ms. COLLINS. And we are still fighting that battle.

Mr. HORN. I guess I have a different perspective on that history. Back in 1989, in the President's first budget request to Congress for Head Start, he asked for a $250 million increase, which was, at the time, the largest single-year increase in the history of the Head Start Program.

Congress, in 1989, only appropriated $151 million of that request. That is, Congress underfunded the President's first budget request for an increase in Head Start by $99 million.

Consequently, in his second budget request to Congress for Head Start, he asked for a $500 million increase in Head Start, which was sort of, I guess, to get people's attention that we were serious about expanding Head Start.

Ms. COLLINS. What did he ask for last year?

Mr. HORN. We asked for $100 million last year. The reason for the kind of breather year last year is, we were getting information from the Head Start community that they were having trouble ab-

sorbing the kinds of large increases that we had seen over the last two years. In fact, the Inspector General——

Ms. COLLINS. They had too much money——

Chairwoman SCHROEDER. Would the gentlewoman yield? I mean, the thing that's so troubling to this community is that the Inspector General for Health and Human Services concluded that the grantees could successfully meet expansion goals.

Mr. HORN. And, in fact, the Inspector General for HHS did that study at our request, because we wanted to make sure that, as we expanded, we didn't just simply throw money at the problem, but rather did it in a considered way, in a way such that local communities could, in fact, absorb the monies effectively.

So, because of concerns that we were hearing from the Head Start community, we asked the Inspector General of HHS to go out and to determine whether, in fact, the Head Start grantees were able to absorb these kinds of very large increases.

But, in point of fact, in 1991, 5 percent of Head Start grantees did not apply for all of the expansion monies that they were entitled to under the formula that we put together to distribute the expansion funds, and preliminary analyses indicate that between 15 percent and 20 percent of grantees will not apply for their full expansion allotment in FY '92.

But we have been, to some degree, reassured by the IG's study. We have also, in the meantime, increased the staffing levels in both headquarters and the regional office so that we can better manage this rapid expansion of the Head Start program. And, consequently, this year we went back to a rapid expansion of Head Start.

So, I think my view of the history may be a little bit different, and what I see is a President who, in the first two years of his administration, asked for the two largest one-time increases in the Head Start Program budget in the 25-year history of the program. We took a breather year, asked for a study by the IG, worked out some difficulties, staffed up in headquarters and the regional offices, so we could manage the program better and the expansion better, and then this year asked for the largest increase in the history of the Head Start program.

So, I think we have an extraordinary record on expanding Head Start.

Ms. COLLINS. What are you asking for in 1992?

Mr. HORN. You mean in 1993, the proposal for 1993?

Ms. COLLINS. Yes.

Mr. HORN. $600 million, which is the largest one-year increase in the history of the Head Start program.

Ms. COLLINS. And you expect to have full funding by 1994?

Mr. HORN. I have learned never to talk about budgets that have not yet been delivered to Congress, so I can't comment on what the 1994 budget might look like.

Ms. COLLINS. I thought I heard you say that was the goal for funding by 1994.

Mr. HORN. The President had a very clear goal for expanding Head Start. When he came into office he said that he will seek enough funding for Head Start so every income eligible child will

be able to enroll in Head Start or Head Start-like programs for at least one year prior to their entry into elementary school.

And, in point of fact, if the $600 million is fully appropriated, that goal will have been reached, but I can't comment on——

Chairwoman SCHROEDER. Excuse me, I thought it was 60 to 80 percent of the eligible four-year-olds.

Mr. WATSON. That's correct.

Mr. HORN. No. There are 825,000 income eligible children in any age cohort so, in other words, there's 825,000 three year olds, and 825,000 four year olds, that are eligible for the Head Start Program using the income guidelines.

With the $600 million request, we'll be able to enroll about 790,000 children. Now, you say that's less than 825,000. How do you get to that figure?

The reason is, because 35 states in this country today fund in their states a state-run preschool program targeted to the same population that Head Start serves. It seems to us a very inefficient way of expanding services to low-income children to not take into account the vast amounts of money that 35 states are now contributing to the exact same population.

And, consequently our experience is that, when you get to coverage of 80 percent of any age cohort, 80 percent of 825,000 is approximately 600,000 children, that you have achieved full coverage for that age cohort in terms of providing services for that year, because some families, for example, the Amish, don't send their kids to Head Start, even though they are income eligible, and some kids, many kids are enrolled in state-run preschool programs.

Washington, DC is a wonderful example of this. They have universal preschool for four year olds.

Now, we shouldn't be double funding——

Ms. COLLINS. Excuse me, so it's 80 percent now instead of full funding.

Mr. HORN. Well, I mean, unless you——

Ms. COLLINS. Whatever the reasons for it, it's 60 to 80 percent?

Mr. HORN. Oh, no, it's not 60 to 80 percent. It is fully 80 percent of the four year olds.

Ms. COLLINS. Fully 80 percent from——

Mr. HORN. Plus 120,000 three year olds enrolled in Head Start.

Now what we could say is that all 779,000 children will be four year olds, which gets you to higher than 80 percent, but that would be ignoring the fact that 35 states do have their own state-run preschool programs.

Ms. COLLINS. Doctor Horn, just to clarify for me, is that 825,000 three year olds, 825,000 four year olds?

Mr. HORN. That's right.

Ms. COLLINS. That comes to 1,650,000, but we're funding 700,000.

Mr. HORN. 779,000.

Ms. COLLINS. Okay, roughly, 800,000 we are funding. We are calling that full funding?

Mr. HORN. No, that's not what I said. What I said was——

Ms. COLLINS. Wait just a moment, I'm just trying to clarify things. You speak so quickly.

Mr. HORN. I have too much to say.

Ms. COLLINS. I understand you feel that 39 states have great programs, putting a great deal of money in, and I'd like to know where those states are, because I know Michigan is hurting, and most states are not putting a great deal of money into preschool programs. They are asking the federal government for money.

Mr. HORN. I'd be very happy to provide you with a study that we did on states that do provide money for state-administered preschool programs for disadvantaged children.

Ms. COLLINS. I'd be very happy to receive that.

Mr. HORN. We'll provide it to you.

Ms. COLLINS. And I think, though, to really clarify things, that we should use real numbers, that out of 1,650,000 children, we are attempting to serve 779,000, which is not full service.

Mr. HORN. Again, you use the term "full service." What I said was that the $600 million request, if fully appropriated, would allow us to attain the goal that President Bush set for this Administration in the first four years, which was to get enough money into the system so that every income eligible child would be afforded the opportunity to enroll in Head Start, or Head Start-like programs, for at least one year prior to entry into elementary school.

Now, we have done that. That's not playing around with numbers. It's not playing around with words.

Chairwoman SCHROEDER. Doctor Horn, if we could, let's get this for the record, because I think we really are very interested in that, plus the 39 states all tell us they feel they are doing what the federal government is doing, and if the federal government were to do more they would have more money for other services. So, I mean, we can go around, and around, and around on this, but, meanwhile, the gentlewoman's time has expired, and we would like to have more details on that, and let me now yield to the gentleman from Pennsylvania, Mr. Weldon.

Mr. WELDON. I thank you, Madam Chairwoman, and I want to thank each of you for coming in today. I enjoyed your testimony, and feel that you have made some valuable contributions to this debate on the Hill that will allow us to make better decisions about the dollars that we're making available for these vital services.

I have a few comments and I have a couple of questions. I want, first of all, to acknowledge Doctor Watson. I'm very familiar with the Foundation, and the good work that you've done. Your organization is an example of what can be done around the country, where the philanthropic community, in particular, the foundations, the kind that you head up, have really played a vital role in developing innovative solutions that then can be modeled by government and the private sector working together. So, Doctor Watson, we are especially proud of what you've done, and I've seen it personally.

My approach to this is somewhat unique. I'm an educator by profession. I taught in one of the poorest communities in my county, and was the Mayor of the second most depressed community in my county. I also ran a Chapter I program for five years in a poor community adjacent to the City of Philadelphia and am very much aware of the efforts to deal with economically and educationally deprived children.

I've also served on the board of the hospital in my county that services, one of perhaps, the five poorest cities in the country, and deals with the issue of those who are in the greatest need of health services.

I just want to make a few comments at the outset that, in terms of the services that I think could best be coordinated, in terms of prenatal work and with pregnant women, and through birth, and follow-up, or the hospitals. The problem that we have in the case of the hospital that I served on the board of and every other major inner-city hospital, is the amount of unreimbursed care today is so great that they just don't have the resources. I think it is somewhat unrealistic to throw an additional responsibility on the hospitals, when they are not even adequately supported at any level of government.

I know the hospital I've been on the board of is on the verge of bankruptcy, just because of the amount of unreimbursed care. That is typical of any inner-city hospital.

The second point I want to make is, that following the identification of these families by the hospitals and through programs like WIC and Head Start, I think the schools should be the next focal point. And one of the things that we did in my own school district was to establish an ombudsman's program to better coordinate the various networks that should be there to help identify children who are at risk when it comes to the issue of being abused.

What I found is that there are a number of services out there, but there's no coordination. They were already providing a number of services through the Justice Department, through the Juvenile Assistance Program of our courts, through welfare programs, social workers, and through the schools, but they weren't talking to one another. You had a teacher dealing with a child during the day. You had the social worker at night and on Saturdays, and you had the juvenile counselor, perhaps, if the child were in the courts, but none of them talking in a real way in terms of that child's well-being.

We started a model program by putting an ombudsman in the school that would be the point person for each of those entities, and I think this ties in with what you were saying, Doctor Horn, about more flexibility.

The federal government has a good knack of mandating things, and wanting to have things go down a straight and narrow path, but I am one that believes we should be allowing those decisions to be made at the local level, where they have the best handle on what will work best in that particular school district, that particular city, or that particular neighborhood.

So, I support that concept, and I would hope you would give me a copy of any legislative proposals that you've sent up on the Hill that would do exactly that, to provide greater flexibility.

But, let me get back to the schools. In Pennsylvania, the state law mandates the state to fund 50 percent of the cost of basic education. This year, it has dropped to the lowest point in the history of our Commonwealth, to 38 percent. So, here we are funding 38 percent of the cost of basic education, we are laying off teachers, we are creating turmoil into our districts, especially in areas such as guidance counselors and other support services. I just don't

know where the dollars are going to come from if we are going to establish an aggressive program that I, too, think is necessary to deal with the issue of abuse.

And, the states have got to realize that they have the basic responsibility for public education, and states like Pennsylvania have got to stop this downward spiral and this negative trend, when, in fact, their state laws and regulations require them to fund a certain percentage of basic education.

Now, to get to my questions. Even though I've made my little sermon here and speech, I definitely enjoyed and appreciated your comments.

Ms. Breakey, I was really impressed with what you've done in Hawaii, and we'll go through your testimony in detail. You mentioned the term "high-risk family," and I don't really have a full comprehension of how you define that. Would you give me your definition? Then I'd like to have Doctor Olds, perhaps, respond to that definition and, perhaps, his own feelings, and any others, Ms. Cohn Donnelly, or Doctor Horn, or Doctor Watson, but, Ms. Breakey, would you define what is, in fact a high-risk family?

Ms. BREAKEY. We're using an interview schedule that was developed by Doctor Kempe and his colleagues in Denver. I can give you some of the characteristics.

The things that we are looking for are teen parents, single parents, families that have very little support, people who—also families who have a history of violence, there may have been abuse previously for another sibling, parents who may have been abused or neglected themselves as children, and there also is the issue for some families of mental illness, current or past, and sometimes substance abuse.

And we obtain this information in quite an amazing discussion with the family, in which they are actually probably relieved that someone has cared enough about them to come and talk about their present life and their past life.

In terms of your comments, I wanted to respond regarding hospitals. We recognized early on the burdens upon the staffing patterns of hospitals and recognized that, at least in our state, it wouldn't be feasible to have hospital nurses, social workers to do this interviewing. So we have agreements with all of the hospitals in Hawaii for our workers to come in to work closely with the nursing staff, with social work staff. We have very clear protocols, in terms of working in the hospitals to doing the actual risk assessment, so it is not at this point a burden to the hospitals.

Mr. WELDON. Doctor Olds, would you comment on the definition of a "high-risk family"?

Mr. OLDS. First of all, I think it's important to distinguish our approach from others presented today, in that we are concerned with more than just preventing child maltreatment. We are concerned with improving the outcomes of pregnancy, women's own personal life course development, other aspects of family functioning. So, I suppose we have a broader set of objectives and, therefore, the types of risks for adverse outcome may be a little broader.

There is one crosscutting risk factor, though, that I think we all need to acknowledge. That is poverty. I think that it is at the root of all of these problems. If you look at the evidence on poor preg-

nancy outcomes, child abuse and neglect, or many other childhood illnesses, low-income families have much higher rates of most types of problems that we are concerned about preventing.

The reason for these higher rates of problems among low-income families is that parents are more likely to have poor health-related behavior during pregnancy such as smoking, or abusing drugs or alcohol. Those behavioral risks constitute some of the most immediate definitions of being at risk during pregnancy.

After the birth of the child, we are concerned about beliefs and attitudes about children that are likely to lead to severe punishment, that are likely to lead to a failure to provide appropriate stimulation to the child. Many of these types of beliefs and behaviors are connected to family environments. For that reason, we think that it's important to pay attention to such things as whether there is criminal activity in the home, whether the survival needs of the family are being met, such as housing and income. Those conditions can create stresses in the family that undermine adequate health-related behaviors during pregnancy and qualities of care once the baby is born.

It's that constellation of conditions, behavioral risks and conditions in the home, that we use to identify families that are at greater risk for the broad array of problems that we've been talking about.

Mr. WELDON. Has that definition been crystallized, and has it been universally accepted? What I'm hearing is that, perhaps——

Chairwoman SCHROEDER. Congressman Weldon, could I just—would you yield for just a moment?

Doctor Watson, I understand you may have to leave for a train.

Mr. WATSON. I do.

Chairwoman SCHROEDER. And, if you do, feel free to go, and we really appreciate your being here.

Secondly, I wanted to say, Congressman Weldon is very humble, but he's one of the great fathers around here, I think, and one of the most impressive things to me about Healthy Start, which Ms. Breakey can tell us more about, is also the intervention with fathers in the hospital. They don't leave that part out, and I assume none of the rest of you do, either.

So, after we talk about mothers, mothers, mothers, but they do fathers also.

Mr. WELDON. Yes, that's an important point, and I appreciate the Chairwoman——

Mr. WATSON. I just wanted to, before I leave, to compliment you on your making a more comprehensive approach, Representative Weldon, to the issues we're discussing. Poverty is clearly one of the crosscutting elements in defining high risk. We also have episodic high risk, in times of a downturn in the economy, when people's families and lives are disrupted because they lose jobs, and, as you know, even in your area, and in some of the wealthier suburbs, we've had an increase in spouse abuse and in child abuse because of those kind of violent changes in lifestyle and whatever.

I just have to say this, and I mean no disrespect to anybody, Representative Schroeder, but we have enough data to know how to help people get a head start in this country. We have longitudinal

data which is unassailable on what the advantages are of Head Start and early childhood programs.

And, to be discussing in 1992 whose responsibility it is to have funded fully programs for children which clearly work, and which are clearly cost effective, and which clearly strengthen families, offends me. It doesn't make any difference who proposed it, and who provided or did not provide the money.

If we are interested in fiscal responsibility, it is cheaper and more cost efficient to give children a good head start with the proper nutrition so that they get a head start in school. That's one of the goals about which there is no disagreement in this country. We know that if we provide those kinds of things, like the WIC program and others, that children achieve the level of performance by grade four, and we ought to be doing that. We know that it costs a fraction of what it costs to keep a person on welfare. We know that it costs a fraction of what it costs to keep a person in prison. We know that we can send a person to an Ivy League college for what we are spending on jail cells. Understanding those things and not doing what all of us need to do about that is something we ought to be ashamed of.

We'll support these kinds of programs. We are talking about hospitals. Many children in this country are not born in hospitals. As you know, Representative Weldon, we have a program that we are funding, $4.5 million, at Temple University, just to make sure that parents—that mothers have the prenatal care, the proper nutrition, and that their children will be born in hospitals, so we can do something about the low birth weight. We can do something about not just prenatal, but perinatal and post-natal care, to give the children a head start.

All of the things that have been talked about here today, about what generates child abuse of whatever kind, whether it's neglect, or whether it's violence, are things which we can do something about. They are not simple, as Doctor Olds has said, they are complex. The remedies work for different groups in different ways.

What I would urge this committee to do, and what I sincerely beg the Congress and the Administration to do, is to get our priorities straight of how we deal with children so that all of the money that's going into trying to do something about child abuse after it occurs, all of the money that we spend trying to deal with neglect which could have been prevented, gets converted to trying to give children and their parents and their families a healthy start. It will save us money. It will improve the life chances of young people. It will strengthen families, and it will enable us to hold our heads up as Americans again, to say that we are doing for children and those who need it most what they have a right to expect when they are born.

And, I thank you for giving me the opportunity.

Chairwoman SCHROEDER. Hear, hear. I couldn't say it better, Doctor Watson. Thank you. Thank you, Doctor Watson, we really appreciate that.

If I could intervene, we lost one witness and got another.

Mr. WELDON. Do you want me to finish with my line of questioning? I wanted to follow up on Doctor Watson's comments first.

Chairwoman SCHROEDER. Well, the chair hasn't asked questions either. We've got two Michiganders and the Michigan witness here, but go ahead.

Mr. WELDON. Okay. I just wanted to say that I agree with much of what Doctor Watson said. The problem we have in this country, in terms of health care, is spending 13 to 14 percent of our GNP, which is twice any other industrialized nation. It's not a question of the dollars, it's a question of coordination, it's a question of flexibility, it's a question of putting our resources where the priorities are. The concern of the American taxpayer, is that we not just throw more dollars, but that we spend the dollars we are already spending in a wiser manner. We should give the flexibility locally that needs to be given locally. Where we need resources, additional resources, we should supply those resources whether it is in WIC, or Head Start, or in the kinds of initiatives that we're talking about today.

I did want to get into one other issue. I will hold this, Madam Chairwoman, but I would like to have the response of the panel at some point in time to a situation that has occurred, that frequently occurs. I don't know how you would deal with it or prevent it, or even identify it. Such a situation is currently unfolding in Philadelphia, where we have a very wealthy businessman who has, in fact, been suspected and charged with molesting up to 5,000 young children over a ten-year period, over a ten-year period, in his residence, in an affluent area of our city. He is accused of paying thousands of dollars for underwear and socks for these children, and committing sexual acts with them. So, I'd like to have the feelings at some point in time during the discussion, how do we deal with an "Uncle Eddie"? How do we deal with someone who has been there for ten years, when no one in society was able to do anything? Uncle Eddie by the way, has AIDS, and has dealt with all of these children and, perhaps, has passed the HIV Virus on to these young children. He had been suspected of having been doing this, but because of privacy regulations, was not able to have been dealt with in a fair manner to protect those 5,000 children who, in fact, have been approached and, perhaps, have been affected by this individual.

Chairwoman SCHROEDER. Thank you, and that is probably one of the most haunting stories I think any of us have. So, I thank you, Congressman Weldon. We are going to hold the record open for two weeks, so anybody who has got some ideas, please put it in.

Mr. MACHTLEY. I have to leave, Madam Chairman, for another committee hearing.

Chairwoman SCHROEDER. Oh, yes.

Mr. MACHTLEY. Could I just ask one question?

Chairwoman SCHROEDER. Sure.

Mr. MACHTLEY. Because I think it's really important, following what Doctor Watson has indicated.

The CBO has estimated that if the program of home visits was, perhaps, optional, it would be $95 million; if mandatory, $625 million.

Now, the question I have is, from the Hawaii experience, you are spending about $3,200 to $3,500 per family, as I understood you.

Ms. BREAKEY. $2,500.

Mr. MACHTLEY. Your total estimate is about $8 to $10 million. Do you have research? As I read this one article, it indicated that you had in the 1990 study of 6,500 families—you estimated that three had documented cases of abuse, that the norm for that targeted population would have been 11.

How much is really being achieved? Now, no one up here wants child abuse to occur. I was a guardian ad litem when I was in private practice for many of these kids. Many of the ones which I saw, and I may have been an unusual, just anomaly, were not in that first couple of years.

Now, I advocate strongly that we have a much better prenatal and a much better early years intervention program.

I guess the question is, if we spend all this money, are we merely getting a much smaller return for our dollars on the number of the people, or are getting other things? It's very hard to just talk about the issue of child abuse as a separate entity without talking about wellness for all these other mothers. And so, the question is, how do we assess, as a Congress, how do we assess the return for our investment? Have you been able in Hawaii to deal with this?

Ms. BREAKEY. I'd like to respond to several things that you said, and then, hopefully, to the last thing.

First of all, our costs are about $2,200 to $2,500 per family.

Mr. MACHTLEY. It may have been the other family——

Ms. BREAKEY. Right, in his state it was over two and a half years, so that's as good or better.

Second of all, you mentioned 11 cases would have been averted. That data is in error. It would have been three times that much, because that particular data that you are looking at was compared with the general population, and we're looking at an at-risk population.

I can quote you another study that was done on the validation of our Family Stress Checklist that was done in Denver by some highly regarded researchers for Yale, that looked at a cohort of families that were identified as high risk with exactly the same instrument, and that did not receive any intervention services. And, I believe that about 24 percent of them did abuse or neglect.

Some of the other studies, it seems to range for the high-risk families between 19 percent and 24 percent.

So that we are averting a sizeable percent of abuse, and we are also averting a very high level of neglect among the families that we're intervening with. Our first demonstration study, we prevented for 100 percent, our later cohorts we prevented for 99.7 percent. So, we are having a very high level of success in preventing abuse amongst high-risk families that we're intervening with.

Then, in terms of what are you actually getting for that, what I did not mention in my testimony clearly enough I think is that this is not just a categorical child abuse prevention program. The program is really quite broad. It's addressing a wide range of health and social issues for these children.

First of all, we're systematically identifying the families that need the service the most, so it's not diluted. We are taking the scarce resource, if you will, and aiming it at the families in our neighborhood that need it the most.

Second of all, we are linking them initially with a health provider, making sure that these families do have a doctor, and that's an accomplishment in itself, because many of the families don't.

Second of all, the program is now completely integrated into our Maternal Child Health Branch, which means it's really, instead of being a little child abuse program, it's a grassroots maternal child health program. In our contracts, our requirements, that we not only link them with a health care provider, that we monitor whether or not these children have all of their immunizations and try to make sure they get to the doctor, we do periodic screening so that we're linking our children then with the developmental Zero to Three program within our state.

And so that, the service is really quite comprehensive.

Mr. MACHTLEY. Thank you.

Madam Chairman, the reason I wanted to raise this question is because I think it's very possible to do, in the abstract, a mathematical equation which says you are spending $8 to $10 million for eight people, for eight families, and I think it's important as we're having this hearing to discuss the fact that, while these programs are costing dollars, they are not exclusively for the prevention of child abuse.

Chairwoman SCHROEDER. Yes.

Mr. MACHTLEY. And, if we leave this room and the numbers are only dealt with in the abstract, we may have a skewed vision of what is happening.

I frankly think that there are many other things that we should be covering in this, and that child abuse is one, and that they are all so inextricably linked that there is a danger because the focus of this hearing is on child abuse——

Chairwoman SCHROEDER. Sure.

Mr. MACHTLEY [continuing]. To think that these programs are dealing with a very small segment, and, therefore, are not worth the monies that we are spending.

So I hope that, as we're getting additional testimony, that you would share with us in your testimony what else is accomplished by the expenditure of this money, because I know that there are many other things which are very worthwhile, and there is a danger to look at this very narrowly because of the topic.

Ms. BREAKEY. Could I add quickly to what you said, and, that is, we are wanting to—we are beginning to incorporate the parents/teachers concept which was developed in Missouri and Minnesota. We are focusing, as I mentioned, on bonding and attachment issues, which have very much to do with the emotional health and the cognitive abilities of the child, if the child is emotionally well-grounded.

We are also working on school readiness. We have not had money for research, so we don't have outcomes on that point.

Mr. MACHTLEY. Thank you.

Chairwoman SCHROEDER. Thank you very much.

Susan Kelly, we welcome you, and we are sorry you had plane trouble. As you can see, we've lost most of our group here this morning, and we're about to go in session very shortly.

So, what I'm going to do is put your testimony in the record.

[Prepared statement of Susan A. Kelly, M.S.W., follows:]

PREPARED STATEMENT OF SUSAN A. KELLY, M.S.W., PROGRAM DIRECTOR FOR FAMILIES

Madam Chairwoman and Members of the Committee:

My name is Susan Kelly. I am director of the Michigan FAMILIES FIRST program within the Department of Social Services. My testimony today is both a tribute and a challenge.

A TRIBUTE to the more than 8,000 Michigan children and their families, who over the past three years, have demonstrated in dramatic ways, that most high-risk multi-problem families can resolve their own crises safely with appropriate support and help, and ought to be given the opportunity to do so in their own homes, neighborhoods and communities. This makes good human sense and good fiscal sense.

A CHALLENGE to each of you, as members of this committee, to be pro-active in your commitment to change the child welfare system. There are areas that so desperately and dramatically need change. I urge you not to support the status quo. It is entrenched in the popular myth that we do not have sufficient research or data to support the changes necessary to make the system better; the myth that to make the system better demands more costly resources. What is true is that far too little attention has been given to the needs of the current child welfare system, especially in the area of family preservation services. As the National Commission on Children stated in Beyond Rhetoric: "If the nation had deliberately designed a system that would frustrate the professionals who staff it, anger the public who finance it, and abandon the children who depend on it, it could not have done a better job than the present child welfare system."

A PROBLEM

Too many children have journeyed through the child welfare system with the promise that their needs would be better met in the foster care system than if they had remained with their family of origin. What they, and many experts, painfully remind us is that this has not necessarily been true. The lives of many children were not better when they were removed from their families. Many children are not safer outside their homes. Placement includes risks of its own. A 1984 study funded by the National Council or Child Abuse and Neglect reported that for every 1,000 children in foster care 30 were abused. Placement can damage the fragile bonds among family members in such a way that these bonds can never be repaired. The self-esteem and sense of identity are traumatized when a children are taken from their families, even if it is for their own good.

The United States has a strong record of funding a system of substitute care beginning with the Social Security Act in 1935. By that act, children in every state were entitled to be removed temporarily if they were in grave harm or if their parents were unable or unwilling to care for them. Today, children in all fifty states are entitled to protection from abuse and neglect. The federal government's policy, budget, and laws entitle children to these rights of protection and removal. What children are not entitled to today is the right to be safely cared for by their parents and family in their own home. The federal and state governments have given disproportionate incentives and attention to removing children and too little attention to removing the risks.

As early as the 1970's, when congress began to hold hearings on foster care, it was recognized that it was a system quietly out of control. Many children were being removed from their homes without sufficient reason. That trend has continued.

Today over 500,000 children are in foster care and the numbers are growing annually at unprecedented rates. Over half of these children will be kept away from home for a year or more, perhaps in multiple placements. Some will never live with any permanent family. In 1991 we, the tax payers, spent over nine billion dollars on out of home care. The investment in fiscal terms has not yielded a return comparable to the investment. I do believe by strategically investing some of the available dollars differently and by equalizing the fiscal incentives some needed changes can occur.

This testimony is not a call for the dismantling of the foster care system. Foster care is a necessary resource which is needed, as a last resort, to protect some children. I am convinced, however, it is often used as a first resort, beginning a chain that permanently alters the lives of a children and their families. While it is true that some of the events triggered by a removal may be appropriate, many of them are not. The decision

to remove a child from her home is a serious one, one we have perhaps taken too lightly.

A POSSIBLE SOLUTION

THE NEED FOR A LEVEL PLAYING FIELD

In Michigan, with a commitment to redirect less than 10% of our state out-of-home dollars, the FAMILIES FIRST program has yielded a sound return for that investment. This has been accomplished without federal reimbursement. As a cost avoidance program, eighty percent of the families at risk of separation have been able to stay together safely, given short term intensive home based services. Costly out-of-home placements were averted for many of these children.

More importantly, the graduates of FAMILIES FIRST, the families with whom we have worked, have told us time after time that by helping their families stay together we helped build confidence, parental autonomy, motivation, and a desire to change their lives for the better. That indeed might be our role: to foster self- sufficiency and self-determination. FAMILIES FIRST, which is described in the attached pages, is less costly than a typical out-of-home placement. Probably most unique is that it takes as its client the entire family, not just the child. This practice supports the reality that families are much more than a collection of individuals. Families are systems held together by bonds that we ought to respect rather than sever. We must realize if we separate families we will do so at a tremendously high cost.

Federal dollars are not equally available to support intensive home based services as an alternative to removing children from the home and placing them in foster care. We need federal support to equalize the availability of monies for family preservation services. The yet unpassed family preservation legislation would help create a more level playing field. Children ought to be entitled to remain at home safely with the same intensity of service as foster care attempts to provide. Currently that is not possible. Rigid funding structures and inadequate legislation support the use of federal dollars for placement not for a family preservation option. Do not continue to support the practice th . makes it easier to separate families than it does to strengthen and preserve them. Too many children have had their lives disrupted and damaged because the tax dollar was available to help pay the bill to remove them from their parents care.

SUMMARY

There are no alternatives to families. Strong families are the hope of this country. Children need their families. When children are at risk or in danger is this really a hopeless family or have we not looked carefully enough for their strengths? Have we helped this family find its own power? Have we helped families change their behaviors to provide safe care for their children? Have we helped them learn how be effective parents? Have we taken time to consider the child's perspective? If we remove this child from her family are we putting her on a path leading to self-confidence, emotional security and success or are we putting her on a road of emotional distancing, mistrust, and isolation? Most importantly, we need to ask: "who can be family for the child that is removed"?

This committee can be a spokesperson and advocate for vulnerable children and families by supporting the family preservation legislation. This legislation will ensure equal incentives for treatment of vulnerable and high risk children. The federal government should not fiscally reward the disruption of families unless it is absolutely necessary and in the best interest of the child. All treatment interventions should follow a family's need, it should not be determined by the potential of reimbursement.

We in Michigan have had enough experience with intensive home based family preservation services to say with assurance that, if family preservation services are made available to families in crisis in the same proportion as foster care services, hundreds and thousands of families can learn to safely remain together.

Family preservation services are not a panacea or an answer for all problematic families. However, family preservation services can make a real difference in the lives of families. Family preservation services stand on the continuum of services as a reasonable alternative which provides families with enough skill and confidence so that placement does not have to occur.

EACH CHILD HAS A RIGHT TO HEAR FROM US:

"...come on, I'll stay with you
until you're somewhere safe.

I'll help you find the best way home."

(Mercedes Lawry, National CASA Association)

Thank you!

ATTACHMENT #1

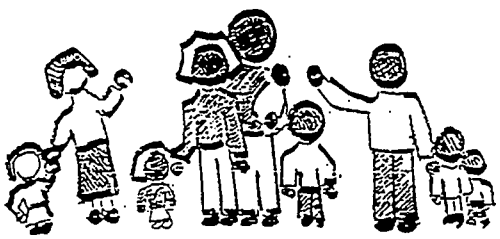
FAMILIES FIRST
of MICHIGAN

successfully working to

KEEP FAMILIES TOGETHER

A NATIONALLY RECOGNIZED PROGRAM
OF THE

MICHIGAN DEPARTMENT OF
SOCIAL SERVICES



Michigan Department of Social Services
Gerald H. Miller, Director
235 South Grand Avenue
Lansing, MI 48909

OVERVIEW
MICHIGAN FAMILIES FIRST PROGRAM

Purpose

Families First provides intensive emergency services in a family's home. It's purpose is to keep families safely intact and avoid high cost out of home care.

The program is designed to strengthen families and avoid long term dependence on government support.

Families First is:

Time Limited:	A maximum of 6 weeks, an average of 5 weeks.
Intense:	A minimum of 8 hours of services in the home each week.
Accessible:	Staff are available to families 24 hours a day, 7 days a week.
Practical:	Families are trained and assisted in solving their own problems.

Eligibility

To be eligible for Families First a family must:

- Have at least one child who is at imminent risk of removal.
- Be referred by a protective services, foster care, delinquency, or community mental health professional, or by a probate court.
- Have at least one adult family member who will volunteer for the service and commit themselves to work to keep the family together.

Number Served

The Michigan Families First Program began in 1988. In Fiscal Year 1991, 2,026 families were served. There were 4,862 children in these families.

attachment #3

To date, a total of 3,887 families have been served. There were 8,538 children in these families. Based on the most current data available 79 percent of the families served were still intact one year after the service.

Currently families are referred to Families First for the following reasons:

40% involved neglect
20% involved abuse
22% involved abuse and neglect
9% involved reunification
9% involved delinquency
100%

Eighty percent of the families served were receiving AFDC. Fifty-four percent of the mothers with health conditions had substance abuse problems. Forty-one percent of the fathers had criminal histories or had been in prison.

Cost

The average cost per family for Families First is dropping. The program averaged $4,900 per family in 1989. By the end of FY-92 this is expected to drop to $4,000.

The minimum cost per year for family foster care is $10,000 and for institutional care: $35,000. It currently costs $86,000 for one youth to complete an average stay in a state training school for delinquents.

In FY-91, Families First expended $8,900,000 and covered 34 counties. By the end of FY-92 the program will be implemented in all Michigan counties with projected expenditures of $12,000,000, rising to around $16,000,000 in FY-93.

FAMILIES FIRST

attachment #4

MISSION

"The mission of the Department of Social Services is to help meet the financial, medical, and social needs of individuals and families unable to provide for themselves; to assist those who are capable of becoming self-sufficient through skill building, opportunity enhancement, and family-focused services; and to help protect children and vulnerable adults from abuse, neglect, exploitation, and endangerment."

FAMILIES FIRST is a program designed to further the MISSION and PHILOSOPHY of the Department of Social Services.

Currently, in Michigan 16,000 children are separated from their families, living in foster homes, mental institutions or juvenile detention centers. Last year, Michigan taxpayers spent almost 200 million dollars on out-of-home care for these children. The cost in human terms is impossible to determine.

As Michigan families suffer mounting pressures of disintegration, the Department of Social Services institutionalized AMILIES FIRST as a way to help families remain intact based on the thesis that "preventing the breakup of a family is easier than reconstituting a family that has broken up."

FAMILIES FIRST works with families enduring the most extreme pressure -- those in danger of losing their children, or those families who have children placed in institutional care. Families First is directed at keeping families together and safe by providing intensive therapeutic interventions to resolve major parenting problems and to assist families in learning to adequately care for their children.

FAMILIES FIRST is:

Responsive - a home visit, within 24 hours of referral to Families First.

Intensive - a minimum of 5 hours per week of direct service and up to 20 hours or more per week, if Necessary.

Accessible - families can contact staff directly 24 hours, 7 days a week.

Focused on Family Strengths - to overcome weaknesses.

Goal Oriented - 2 to 4 objectives developed with the family to address problems that led to the crisis.

Skill-Building-teaches positive practical ways to handle life's Problems and family dynamics.

Family Centered-ability to work with all members of the family network.

Practical - hands-on assistance to cope with every-day demands as well as the immediate crisis.

Time Limited - 4 to 6 weeks of intensive service.

Thorough -follow-up 3, 6, and 12 months after completion of the FAMILIES FIRST program.

The FAMILIES FIRST program currently serves forty-four Michigan counties and seven federally recognized Indian Reservations. All other counties will be operational by September, 1992.

ATTACHMENT #5

FAMILIES FIRST

- CHILDREN HAVE A RIGHT TO THEIR FAMILY.
- THE FAMILY IS THE FOCAL POINT OF CHILD WELFARE SERVICES.
- OUR FIRST AND GREATEST INVESTMENT IS TO THE CARE AND TREATMENT OF CHILDREN IN THEIR OWN HOMES.
- THE FAMILY IS THE FUNDAMENTAL RESOURCE FOR THE NURTURING OF CHILDREN.
- PARENTS SHOULD BE SUPPORTED IN THEIR EFFORTS TO CARE FOR THEIR CHILDREN.
- IT IS IN THE BEST INTEREST OF THE CHILD FOR HIS OR HER FAMILY TO REMAIN INTACT IN THE ABSENCE OF COMPELLING EVIDENCE TO THE CONTRARY.
- FAMILIES ARE DIVERSE AND HAVE A RIGHT TO BE RESPECTED FOR THE SPECIAL CULTURAL, RACIAL, ETHNIC, AND RELIGIOUS TRADITION THAT MAKE FAMILIES DISTINCT.
- CHILDREN CAN BE REARED WELL IN DIFFERENT KINDS OF FAMILIES AND ONE FAMILY FORM SHOULD NOT BE DISCRIMINATED AGAINST IN FAVOR OF ANOTHER.

Keeping Families Together

DEPARTMENT OF SOCIAL SERVICES

235 S. Grand Ave., P.O. Box 30037, Lansing, Michigan 48909

ATTACHMENT #6

VALUES AND BELIEFS

- SAFETY IS OUR FIRST CONCERN
- CHILDREN NEED FAMILIES
- WE CAN'T TELL WHICH FAMILIES ARE HOPELESS
- TROUBLED FAMILIES CAN CHANGE
- CLIENTS ARE OUR COLLEAGUES
- WE MUST RESPECT OUR CLIENTS' VALUES AND BELIEFS
- IT IS OUR JOB TO INSTILL HOPE
- A CRISIS IS AN OPPORTUNITY FOR CHANGE
- INAPPROPRIATE INTERVENTION CAN DO HARM

A basic principle of the child welfare system in the United States is that every child is entitled to grow up in a permanent family. Inherent in this principle is the need to make all reasonable efforts to keep families together and to place children out of their homes *only* if their well-being cannot be protected within their families.

Keeping Families Together

ATTACHMENT #7

PROGRAM CHARACTERISTICS

- FOCUS ON FAMILY STRENGTHS - NOT PROBLEMS
- LIMITED TO CHILDREN AT RISK OF IMMINENT PLACEMENT
- IMMEDIATE RESPONSE (WITHIN 24 HOURS)
- HIGHLY FLEXIBLE SCHEDULING (24-HOUR, 7-DAY/WEEK AVAILABILITY)
- SMALL CASELOADS (2 FAMILIES) PER WORKER
- INTENSIVE INTERVENTION (5-20 HOURS/WEEK AS NEEDED)
- SERVICES DELIVERED IN CLIENT'S HOME AND COMMUNITY
- TIME-LIMITED AND BRIEF (4-6 WEEKS)
- "HARD" AND "SOFT" SERVICES DELIVERED BY A SINGLE WORKER WITH SAFETY BACKUP
- ECOLOGICAL APPROACH (WORKS WITH FAMILY AND COMMUNITY INTERACTION)
- GOAL-ORIENTED, WITH "LIMITED" OBJECTIVES
- FLEXIBLE MONEY
- EVALUATION

Values and Beliefs, Program Characteristics
Adopted from:

BSI - "Homebuilders"
Federal Way, WA

ATTACHMENT #8

SERVICE DELIVERY CONTRASTS

Traditional	Family Preservation Services
Services in office	Clients home
Waiting list	Immediate response
50 minute hour	As long a session as needed
Weekly or less	Frequent - often daily
Available during business hours	7 days a week & 24 hours per
Cream cases	Accept almost all
Worker defined solutions	Family selects solutions
Open ended	Closed end (predetermined
Large caseloads (12-50)	Small caseloads (2-4)
Long Term	Short Term
Focus on individual	Focus on family system
Concentrate on immediate symptom	Concentrate on underlying skills & interactions
Soft services only	Blend hard & soft services
No special use of crisis	Use crisis as teachable moment
Solve problem for client	Help client solve own problems

ATTACHMENT #9

Transferability

Family Preservation Services

- **Cross-sector Application**
  (Mental Health • Social Services • Juvenile Justice)
- **S vices Integration**
  (Hard / Soft • Complementary Continuum)
- **Flexible Financing**
  (Soften Placement $ Incentive)
- **Decate rization of Funding**
  (Rethin ditional Focus: Separate, Fragmented, Specialized)
- **Reach "Unreachable" Families**
  (Designed to Help the Most Resistant and Disadvantaged)
- **Family Empowerment**
  (Reduce Inappropriate Dependency and Increase Problem-solving Skills)
- **Establish Contrarian Principles**
  (Characteristics & Values that are Building Blocks for Reform: Time-limited, In-home, Sequential Attention, Etc.)

Apply Principles To Other Populations and Problems

An Integrated, Client-driven Service System

Chairwoman SCHROEDER. And one of the things that Doctor Horn was talking about before you got here was the Administration's proposal to deal with Title IV-E and Title IV-B, and I know you probably have had an incredible amount of experience dealing with that in the State of Michigan.

So one of the things that I think might be interesting would be maybe the two of you talking about what's coming up and will this work, because we can use your expertise now that you are here.

My understanding, Doctor Horn, is that you are talking about bringing over legislation, and it isn't here yet, is that right?

Mr. HORN. It has been delivered.

Chairwoman SCHROEDER. It has been delivered.

Mr. HORN. Yes.

Chairwoman SCHROEDER. And this legislation is going to allow some of the IV-E money to be spent on IV-B, or—my understanding is, Title IV-B is capped, and those are kind of the family preservation services that I believe Susan Kelly, and we're going to give you a chance to correct me if I'm wrong, I believe you are saying could be used to help prevent expenditures in IV-E, which is foster care. Is that where we are going to go? Could you explain the legislation, and then let me see where Susan goes.

Mr. HORN. Okay.

Essentially, what the legislation would do is, it would take Title IV-E, the administrative costs and Title IV-E training costs, and create a new capped entitlement called "comprehensive child welfare services." That capped entitlement would be allowed to grow over the next five years by the same rate of growth in the current title IV-E program as estimated in the budget agreement, which is somewhere between 18 to 20 percent per year.

The advantage of doing this, creating this new capped entitlement, is that there would no longer be any restrictions on how a state or local agency could spend that money. That money could be used for things that right now are completely prohibited, things like family preservation services and reunification services.

And the real key here is recognizing that this is not a cost savings proposal. What we are suggesting is that this new capped entitlement will grow at the same rate of growth as the current Title IV-E program is estimated over the next five years, which again is 18 to 20 percent per year. Consequently, if this legislative proposal were enacted today, the amount of money available in this new capped entitlement program for the states and local agencies in FY 1993 to use however they want is $1.2 billion, and within five years that money would grow to $2.2 billion.

Now, what's nice about this is that under the terms of the budget agreement, if one were to, for example, ask for additional money simply in title IV-B, let's say an extra $600 million, you'd have to go find that money someplace. You'd either have to raise taxes or cut some other program.

Under this proposal, this growth is already built into the base line projections over the next five years. Consequently, you don't have to find it anyplace else. You don't have to raise taxes. You don't have to cut other programs. You simply have to say, "Let's pass this legislation."

The interesting thing that's happening is that the rate of growth in the title IV-E administrative cost program has moderated in the last couple of years. In fact, if we had enacted this legislation last year, instead of this year, there would be more money available than there is this year. CBO estimates are that the moderating effect in title IV-E administrative costs is actually quite significant, and their estimates over the next five years are even lower than our estimates in terms of the escalation in that program.

And, in addition to allowing greater flexibility, we would totally take away any requirement to do cost allocation plans in terms of administrative costs or training, and we would do away with IV-E administrative and training financial audits, which I think the states will admit are somewhat burdensome, difficult, and not exactly the most enjoyable way of spending an afternoon.

Chairwoman SCHROEDER. Sure.

Okay, Congressman Weldon and I want flexibility. We want to get where you want to go, and, Susan Kelly, you are the Director, tell me, does this work, or asking questions or whatever, because we are lost.

Ms. KELLY. Well, I haven't had an opportunity to see that legislation or that proposal. What I do know, and I think it's very important for you to hear, in terms of family preservation, or programs that will strengthen families, is that we start with a very, very unequal playing field here because of the fiscal realities.

Whether we are talking about IV-B or IV-E, we are talking about having spent last year over $9 billion on out-of-home or substitute care for children. There are few incentives in the federal budgets to really create a more level playing field; one in which states would be reimbursed for keeping families together safely rather than removing them.

In other words, there are no incentives for states right now to make a judgment about putting resources into a family that will strengthen that family, will help resolve crises, and keep families safe together. The reward is for placing children out of their homes.

I'm not sure, but I think that will keep us still on an unequal playing field.

What I can tell you is, that in the State of Michigan, with redirecting—we're redirecting less than ten percent of our budget for out-of-home care to in-home care, without federal support, we were able to serve over 8,000 children and their families successfully in 80 percent of the cases, resolving or diminishing the risk, and keeping them safely together. We followed them well after a year that they've been closed out to services.

What that's done for us is that we've been able to reduce new admissions to out-of-home care in our largest metropolitan area, which is Wayne County, including the city of Detroit, by over 14 percent. Family preservation services cost one-third of what it costs for one child to leave his home for one year in our least expensive out-of-home placement. That makes good fiscal sense, but it probably makes much better human sense not to separate children from their families, unless it's really as a last resort.

I suspect that we still aren't creating, by the administration's proposal, a level playing field.

Chairwoman SCHROEDER. Okay, Doctor Horn, where is the level playing field?

Mr. HORN. Well, it is precisely the concern that you express.

Chairwoman SCHROEDER. Right, she's concerned that it isn't level yet.

Mr. HORN. It is level in the sense that right now, today, the federal government provides the states, on a formula grant basis, with $274 million to provide a broad range of child welfare services, including family preservation and services.

What this legislative proposal would do is add $1.2 billion on top of the $274 million Title IV-B program to support a broad range of child welfare services. And the new capped entitlement program would grow over five years from $1.2 billion to $2.2 billion.

But, rather than saying states must use all of that money for family preservation services, what we say, I think, to your concern, Congressman, is that the states and local agencies would have total flexibility to decide how best to spend that money. For some communities that might be family preservation services. For others it might be something else, whatever those local needs are.

But, the point is, right now, and I think we agree, the money is driving paper work, and that doesn't make any sense. There's an old saying, "You get more of what you subsidize, and you get less of what you tax." What we pay for right now in child welfare is putting the kids in out-of-home care and putting down a lot of things on paper, and that's what we get. We've got a lot of that. We've got over $2 billion of that, and only $274 million of something else, and what we're saying is, we need to give the States greater flexibility. The states need to have greater flexibility, and that's what we want give them through this legislative proposal.

Chairwoman SCHROEDER. Right.

Now, Susan, did you get it?

Ms. KELLY. I think I couldn't comment appropriately without looking at the proposal, but what I do know is that children today, in all 50 states, are entitled to be protected from abuse and neglect. They are entitled to be removed if parents are unwilling or unable to care for them, or if there's abuse or neglect. What they are not entitled to, where there is not an equal playing field, they are not entitled to be protected and serviced by their parents in their own home. And, I think that that's the equal playing field.

There are not incentives to helping families at a much less costly manner to keep their children together safe in their homes.

Chairwoman SCHROEDER. So your concern is that it's still capped at the other end to some extent, although, it's certainly better.

Could we get the legislation for you, and, as I say, we are going to keep the record open for a couple weeks, I think——

Mr. WELDON. Would the gentlelady yield?

Chairwoman SCHROEDER. I'd be happy to. It would be very helpful if we could get comments from people.

Mr. WELDON. Ms. Kelly, I appreciate you coming in, and I stuck around because I knew you were late, and I wanted you to know that we are interested in what you have to say and the good job that you are doing out in Michigan. We appreciate your leadership.

In a summary, wouldn't it be helpful to you if you had more flexibility within your state, in terms of where you would put the money, in terms of your priorities in Michigan?

Ms. KELLY. Absolutely. At this point, we are reimbursed 50 cents on every dollar for placing a child out of his home.

Mr. WELDON. So, the key thing is to have you look at this legislation, see if it does what, in fact, Doctor Horn is saying, and Congresswoman Schroeder and I, and the rest would look at that also. If it does, in fact, then you would be supportive of that kind of concept to give you that additional flexibility.

Ms. KELLY. I think there are some already introduced, but, yet, unpassed pieces of family preservation, legislation that speaks to, perhaps, creating a more level playing field by looking more carefully at IV-B.

And, I would encourage you to look at those pieces of legislation, the Downey bill or the Bentsen bill, too.

Chairwoman SCHROEDER. And, that's Congressman Downey's and Senator Bentsen's?

Ms. KELLY. And Senator Bentsen's bill.

Chairwoman SCHROEDER. If we could have comments on those, I think that could be very helpful.

Ms. KELLY. Yes.

Chairwoman SCHROEDER. Because the committee kind of likes to be the conscience of the Congress.

Ms. KELLY. But I think what's important, before we end this discussion, is that we are no longer in a pilot phase, or no longer in small demonstration phases. We have served well over 8,000 children and their families in a very short time, and we say, in a more cost efficient way, and a more reasonable way, we can protect children safely in their own homes. We need some support to create a more level playing field to ensure that that happens, and not to burden the states as we have in the past couple of years.

Chairwoman SCHROEDER. You are right.

Ms. KELLY. Many years, decades.

Chairwoman SCHROEDER. Yes, I hear you loud and strong, and, as I say, the committee is trying to figure out, where's the best place to go on all of this, as we look to putting a very key component of family investment being family preservation, and we are trying to figure out which piece fits the best in that.

Gail Breakey and Doctor Olds, did I hear a dispute between the two of you on paraprofessionals?

Ms. BREAKEY. I'm not sure.

Chairwoman SCHROEDER. I'm not sure either, and I want to see if we can get this record clear. I want to have you in agreement, and I want to make sure that you weren't having——

Ms. BREAKEY. I think certainly we recognize too that professionals, nurses, particularly, perhaps, public health nurses, are very effective in home visiting.

I think we chose a model that we had because we believed at the time we were doing it that we would have—be able to use the manpower, that it would be less expensive, that it would be a cost effective way to go.

We have certainly seen that for us it's very efficient and very effective, because we have had results. We are agreeing with Doctor

Olds, and we have had discussion off and on, about this. We are certainly agreeing with him as to the need for structure in home visiting programs, to be clear what the goals are, to be clear about training and the specific activities that are conducted in the home.

Chairwoman SCHROEDER. Doctor Olds?

Mr. OLDS. Yes. I agree with everything that Gail has said, with the following additional point: the evidence on the effectiveness of paraprofessional home visitation programs is not as solid as it is for nurses.

What I'm talking about is a difference in levels of scientific certainty. As I stated in my personal testimony, I don't think it's simply academic hair splitting. But I don't want that viewpoint to be construed as saying we shouldn't move ahead with a home visitation initiative. I think we should move ahead, and I think we should move ahead with paraprofessional programs. But I also believe that we should acknowledge that the evidence is not as solid, and that we, therefore, have a responsibility to the children and families we serve and to society to test it systematically. We need to get Gail Breakey's program and programs that are like Gail's, articulated in a very complete way, so that it can be put to a test. We need to know more definitively just how effective paraprofessional programs really are. It's our responsibility to acknowledge the limitations of our knowledge and to continue testing our programs as we deal with this problem.

Chairwoman SCHROEDER. But, I mean, you have been testing it, right?

Ms. BREAKEY. Well, we've had very little evaluation money, we certainly have not been able to do a randomized trial.

We know that we are effective against abuse and neglect. I think that that's quite undisputable. We don't know, as I said, some of the details in terms of how effective we are in terms of child development or health teaching. I think that we'd like to know that. We are looking for support for a control study.

But, I think that it can't be emphasized that paraprofessionals can be very effective against abuse, and that's a major thing we're talking about.

Chairwoman SCHROEDER. And, Doctor Cohn Donnelly, and I apologize that your name tag got wrong, and all the members kept reading the name tag, and I can't apologize enough, but I thought I detected some disagreement between you and Doctor Olds on targeting. Am I right?

Ms. COHN DONNELLY. I think that we agree. I think in the ideal world it would be wonderful if all new parents not only had an initial screen in the hospital to determine if they were at high risk but, perhaps, another visit or two at home.

The most recent public opinion poll that we're releasing shows that seven percent of the parents across the country have received such services, and they do find them helpful. They are given information on parenting and help getting off to a good start. But the key is in the hospital to screen those parents who are at highest risk for abuse and some of these other issues, and for those to be provided with the intensive ongoing home visitor services.

And I won't speak for Doctor Olds, but I think he might agree with me.

Mr. OLDS. Yes. I think that we're pretty much in agreement on that point.

What I would like to follow up, though, on is the whole point about what constitutes adequate evidence in this field about effectiveness of these types of interventions.

I respect what Gail is saying about the prevalence of maltreatment in the families that she has served. But this is not scientifically credible evidence of program effectiveness. It should not serve as a basis for a widespread dissemination of the program. The Hawaii program has not been adequately evaluated.

Chairwoman SCHROEDER. Sure.

Mr. OLDS. There are many types of biasing factors that might produce the low rates observed in her sample, such as the selection of the sample, that is who gets registered in the program, that can distort the picture of effectiveness. I think it's important for all of us who are involved in this work to recognize that those types of biases are present unless you have well-conducted randomized trials.

We need to put these kinds of programs to these kinds of tests, in my view, because of the enormity of the problem and because our responsibility to the families that we are serving.

Chairwoman SCHROEDER. But don't you think, Doctor Olds, when you have a program that shows that at least you've cut way back on physical abuse, that's important, and it's very hard to ever have anything in this area be quite as scientific as it is in medical research? And, finally, Hawaii itself admits it may have been more successful than other states, only because it is very hard to flee Hawaii unless you have a lot of money, or you are very good at canoeing.

And so, you know, one of the problems a lot of states have is people can easily flee over the state lines and escape, and Hawaii has a little more, I don't want to say control, but it's a little more difficult to flee that type of thing.

Mr. OLDS. I do think that it's possible to do controlled trial work with these types of programs, perhaps more than with many of other types of Health and Human Services. I also believe that we need to see publications on the Hawaii findings. Their results should undergo scientific scrutiny, so that we can really know how credible their findings are. I think it's our responsibility to have these findings before we move ahead.

Chairwoman SCHROEDER. But Doctor Watson was saying no more grant junkies, I think, no more studies, no more, we know, we know, we know. You disagree then basically with Doctor Watson, who is not here to defend himself, is that right?

Mr. OLDS. It's a matter of approach. I think we do need to move ahead, but I think that we need to do so with an awareness that the way is not as well marked as some people believe. I think that there is lots of room for refinement and improvement in what we do as we move ahead.

That's really the message that I'd like to communicate.

Chairwoman SCHROEDER. Gail?

Ms. BREAKEY. I'd like to say just a couple of things.

First of all, I'd like to remind all of us that Henry Kempe, back in the 70's, did do a randomized contr[illegible], and that he did have—he

used paraprofessionals in his intervention, and that he did have similar outcomes.

I would agree with Doctor Olds that we should keep researching. I think that any opportunities that we have to look very closely at what we're doing are really important.

I would almost liken it to maybe 50 years ago, the washing machines that we had that made life easier, and made life work, were pretty rugged, and that we have wonderful ones now. I think we need to remember that people didn't stop producing and using washing machines because they weren't perfect.

I think we need to use the technology that we have to make life better for families, and any time we learn something better that we all need to incorporate that into our programs and upgrade them.

We did do that with our Healthy Start Program. We began with a very simple program and have made it more broadly based, more health focused. That's been really positive, and I think that we need to keep on doing those kinds of things.

Chairwoman SCHROEDER. But, with the horrifying statistics that we have out there, anything that works, even though it may be rudimentary and we may not have all the answers, you know, I think we would be lax not to try and use it if at all possible.

Is there anything else? I think we've pretty much come to the end. Did anybody hear any other disagreements between each other that they want to try and straighten out or, if not, you've got two weeks to think about it.

We would like to have as strong a consensus as possible that this country is no longer going to tolerate the increasing child abuse rates that we saw this year.

I mean, when I read those, it's very sobering and very chilling, and I remember the first bill I introduced when I got here was with Senator Mondale, and it was on child abuse and going to the Kempe Center, and here we are 20 years later and it looks to me like we've just scratched the surface.

So I apologize, Doctor Olds, if I sound impatient, but it's like, please, how much longer do we have to work on this?

And I'm especially looking forward to Doctor Horn and Ms. Kelly's back and forth on how we get this bill going, because this committee does want to introduce a comprehensive family investment package that I think starts talking about families as the cinder block of the society, and I think that's what it is.

And I thank all of you for your patience, your long endurance, and your sitting there, but I think the attendance this morning showed how eagerly we are to get on with this.

Thank you very, very much, and with that the hearing is adjourned.

I do want to announce that the Child Welfare League of America is having a children's rally in the Senate Park, and it's going on right now, and this afternoon at 2:00 and, at 4:30 in Dirksen, the National Child Abuse Coalition will have a staff briefing for members and staffs on home visiting.

Thank you very much, and with that we adjourn.

[Whereupon at 12:00 noon, the hearing was adjourned.]

[Material submitted for inclusion in the record follows:]

TRUST AND PREVENTION FUNDS, LANSING, MI

My name is David Mills and I am the President of the National Alliance of Children's Trust and Prevention Funds. I also serve as the Executive Director of the Michigan's Children's Trust Fund. On behalf of the National Alliance of Children's Trust and Prevention Funds, I would like to applaud this committee's commitment to preventing child abuse and neglect.

Children's Trust and Prevention Funds have, in the past decade, become a driving force in our nation's efforts to strengthen families and halt the devastation resulting from child abuse and neglect. Since the first children's trust fund was established in the State of Arkansas in 1980, nearly all states have established similar organizations to prevent child abuse and neglect. The National Alliance of Children's Trust and Prevention Funds was formed in 1990 to provide support for states' common needs and goals.

Common features of children's trust and child abuse prevention funds include strong public-private partnership, public education, and funding for community-based prevention services. Funding mechanisms for children's trust and prevention funds vary from state to state, and may include voluntary contributions designated on state income tax returns; dedicated fees on marriage licenses, divorce decree filings, and vital records; private funding; and, in some states, a line item state appropriation.

Children's trust and prevention funds encourage creative programs at the community level which reach families through a comprehensive array of services before child abuse and neglect have occurred, but, in many cases, after certain warning signs have been identified. Services funded by children's trust and prevention funds are voluntarily provided to families and children, and emphasize the development and enhancement of positive parenting skills and family relationships.

Examples of services funded by children's trust and prevention funds include:

- **home visitor programs**, which have proven to be successful in providing in-home support, teaching appropriate parenting skills, relaying parenting knowledge, and identifying related problems which can be addressed by other community resources;
- **sexual abuse prevention education programs** for young children, which, through linkage with the educational system, teach children about body safety and what to do if they are approached sexually;
- **parenting skills classes and support groups** for the general population as well as special populations. Special curriculum have been developed for groups such as parents recovering from substance abuse, teen parents, the chronically mentally ill, and parents of developmentally disabled children;
- **crisis nurseries** for families under stress and at risk of endangering their children because of that stress;
- **life skills training for adolescents**, including such topics as responsible decision making, pre-parenting, and non-violent conflict resolution;
- **prison-based parenting skills** development for incarcerated parents who will be returning to the parenting role upon release; and
- **church-based prevention education programs** for parents and families.

While this is a sampling of prevention services supported by children's trust and prevention funds, it is in no way exhaustive. Significant advances have been made in evaluation of outcomes of services provided, and, through the National Alliance successful programs can be replicated in other communities throughout the nation.

States which have established children's trust and prevention funds are eligible for Federal Challenge Grants administered through the National Center on Child Abuse and Neglect. The current federal appropriation for the challenge grant program is just over $5 million, far less than the amount that would be needed to actually

match states' investment in prevention according to the formula detailed in the federal challenge grant legislation (CAPTA). Over $30 million is collected each year by children's trust and prevention funds from private donations, dedicated fees, and line item appropriations.

One of the most successful aspects of children's trust and prevention funds is the public-private partnership that is created when government and the business sector combine forces to battle a cause. In Michigan, a corporation has partnered with its health insurance provider to study whether provision of prenatal care to the insured actually reduces the need for future medical intervention. This effort could reduce future costs to the insurer in reduced medical costs, to the employer in less time lost from work, and to the insured. In Missouri and Texas, the Children's Trust Funds have arranged for use of VISTA volunteers to promote and expand the child abuse prevention effort. These volunteers, in most cases, are residents of the neighborhoods in which they work, and have proven to be effective catalysts for establishing parent education support groups and increasing the social support network of families. In North Carolina, the Children's Trust and Prevention Fund partnered with a private foundation to promote the Parents As Teachers program. This model, which originated in the state of Missouri, is a support and education program for parents of children from birth to three. It provides monthly individual home visits to families, group meetings for parents, and periodic health and developmental screening for children. The Trust Fund received a substantial grant from the foundation to establish two national training sites for Parents As Teachers in North Carolina, and the foundation and Trust together have joined in supporting local programs.

Most children's trust and prevention funds, while governmental entities, are governed by a board or commission of private citizens, often appointed by the governor of the state. Most also include other significant private participation through advisory groups, corporate funding, and volunteer involvement. Services funded are generally planned and developed at the community level, based upon

community needs rather than prescribed at the state or national levels. State children's trust and prevention funds provide technical assistance and consultation services as needed.

One of the great strengths of Children's Trust Fund is the ability to stimulate and fund a comprehensive array of prevention efforts on the community level based on community needs rather than those prescribed at the state or national level. The Alliance believes that no one prevention model is a panacea. Rather, we believe and encourage your support of comprehensive community-based efforts to address the needs of families in a way that will result in prevention of child abuse and neglect. We encourage your support of the new CAPTA community-based prevention grants and appropriations commensurate with the authorized spending levels.

Thank you for your commitment to children and families as evidenced by your work in the past and your participation in this hearing. We look forward to continuing to provide information about the exciting work of Children's Trust Funds in the future.

PREPARED STATEMENT OF DAVID L. CHADWICK, M.D., DIRECTOR, CENTER FOR CHILD PROTECTION, CHILDREN'S HOSPITAL AND HEALTH CENTER, SAN DIEGO, CA

Madame Chairwoman and members of the Subcommittee, I am Dr. David Chadwick, Director of the Center for Child Protection at Children's Hospital and Health Center in San Diego, California. I appreciate the opportunity to testify before you today about the benefits of public-private partnerships, particularly as they relate to family support services. For those of us who have been engaged in the provision of in-home support services to families for many years, it is exciting to see a growing interest in Washington in the public-private partnerships which can successfully address many family support needs.

For many years, in many places, parent-aide programs have worked to prevent the isolation of families that tends to lead to abuse, and to help families learn positive ways of dealing with their infants and children. These programs often operate with minimal funding and usually with the participation of volunteers.

Children's Hospital in San Diego initiated its Parent Aide Program in 1976, and is the physical abuse/neglect prevention component of the Center for Child Protection. Our program serves identified "high risk" and abusive/neglectful parents and their children. It is offered free to parents as a community serves, and although initially supported by the hospital, it is now entirely supported by individuals and community organizations, with major

support by the San Diego Child Abuse Prevention Foundation. It is a model of service in the owrk it does. The program has received recognition from the San Diego Community Child Abuse Coordinating Council, the 1988 Award of Excellence in Community Youth Services from the San Diego Community Foundation, United Wat recognition of community service by Parent Aides, and National Parent Aide Association recognition of Parent Aides for their dedication to the fight against child abuse. These awards confirm that the program has become a model emulated by many public and private organizations throughout the United States.

In our program, we discovered that when the parent-aide became trusted by the mother, that overt abuse and neglect could almost always be prevented as long as the parent-aide remained in close touch. Our County Department of Social Services discovered the same thing and has pretty much monopolized all of the in-home services programs in the community for the last ten years. However, the Department has been referring more and more dysfunctional families in which abuse or neglect had already been reported.

Filling up the programs has been easy because they are all small. They are small because they depend either on limited funding from State Children's Trust Funds administered (in California) through county contracts or upon private charity and the donated services of volunteers. The seriously disabled families referred to our program in recent years tie up the parent-aides for long periods, and while these programs cost less than a third of what foster care might cost if the children were removed from their natural parents, they remain *interventions* introduced after abuse rather than *prevention*.

Home visitor programs have the potential of far greater benefits if they are utilized as preventive measures for families of infants in which a significant social or health risk factor has been identified. Families identified in this way are likely to be able to utilize services much more effectively and avoid the problems that lead to health problems including child abuse.

Over the years, we have continued to review County child abuse records in an effort to assess the success of our efforts. We have found through our long-term connections with families that it is possible to reduce the incidence of child abuse in very high-risk populations. For example, a 1988 record review reflect a reduction in reports filed from 38 percent before entering the program down to 6 percent at termination from the program to the date of the record check. In these cases, there have been no fatalities or severe abuse reported. Pre-and post-Family Functioning Evaluations and program evaluations completed by graduated clients indicate an increase in parenting and coping skils, more appropriate expectations of their child and most importantly, the increased ability to recognize their problems and reach out for help.

In the last two years, we have been fortunate enough to work with the U.S. Marine Corps in the development of a home visitor program for the isolated families of young children. The armed forces, in general, may be developing more interest in expanding such services.

Home visitors might be most effective if they could be made available to visit all families with new babies who accept such a service, even though many families would need only one visit. Even low risk families with good social supports can benefit by a health-oriented visit of an experienced and sensitive person who understands the special needs of new parents and their babies.

Whether a home visitor program works with families with risk factors or with families where abuse has been reported, there are a few absolutely essential characteristics of visitors and programs that seem to make the difference between success and failure. For the individual visitors these characteristics include:

1. A credible knowledge and understanding of parenthood based upon personal successful experience.
2. The formation of a trusting relationship between the client family and the visitor.

For the programs these characteristics include:

1. A careful, deliberate method for the selection of home visitors by experienced program professionals.

2. A well-designed and thorough training program covering all aspects of the work that the visitors will do and the things that they will need to know to be helpful to their client families.

3. Close ongoing support which serves to assist in managing the myriad of individual problems and situations which inevitably arise, and to provide continuing education.

4. Intimacy warmth and friendship between supervising professionals and visitors which can be conveyed into the relationships that develop between client families and visitors.

There are many other important components of knowledge and skill that are very important including understanding of many of the things that can go wrong in families and in infants and children, including a good, practical and general knowledge of the health care system for children and how to use it effectively. The health connection is embodied in the Children's Hospital's comprehensive program, and it is one of its greatest strengths.

Because friendship, warmth, trust and intimacy are important components of successful home visitor programs, it is unlikely that such programs can be successfully operated by large governmental agencies such as the Departments of Social or Health Services operated by States and large counties. For example, Hawaii's Health Start Program which utilizes home visitors in a preventive approach, appears to be succeeding because the State Department of Health contracts the actual provision of home visitor services to much smaller non-profit entities that are virtually neighborhood-based. The fact that the Hawaii

program can be understood as a preventive *health* program, rather than a specific child abuse prevention program may be another factor in its success.

A considerable degree of local autonomy also appears essential to the success of home visitor programs, as well as adaptation to local conditions, local languages and local cultures.

The task of defining the appropriate Federal role and Federal policy which would encourage the development of much more widespread, but still intimate and effective home visitor programs is interesting. We would recommend a policy which encourages the flow of funding into such programs from a variety of streams including, but not limited to, foster care funds, general social service funds, maternal and child health funds, child abuse prevention funds, health care service funds such as Medicaid and EPSDT, and possibly even juvenile justice and delinquency prevention funds. All of these streams can anticipate reductions in future needs for funds if home visiting programs become widespread.

The manner in which funds might be made available to the small and medium-sized organizations, which are best suited to provide home visiting services, is more challenging. Hawaii has met the challenge by using a subcontracting method through its State Department of Health. This is certainly one feasible way to get the job done, but it may not work in all states. Generally, funding home visitors as a preventive maternal and child health service is more likely to be acceptable and efficient than funding the programs through departments of social services at State and County levels. It also appears to be desirable that some programs

be able to apply directly for Federal pilot program funds, and here again, it may be best to place the funding through a health oriented Federal agency.

STATE OF MICHIGAN

JOHN ENGLER, Governor
DEPARTMENT OF SOCIAL SERVICES
235 South Grand Avenue, P.O. Box 30037, Lansing, Michigan 48909
GERALD H. MILLER, Director

April 15, 1992

The Honorable Patricia Schroeder
Chairwoman, Select Committee on
Children, Youth and Families
U. S. House Office Building Annex 2
Washington, D. C. 20515-6401

Dear Chairwoman Schroeder:

I was pleased to have the opportunity to participate, albeit briefly, in the Select Committee's hearing on April 2, 1992, "Keeping Kids Safe: Exploring Public/Private Partnerships to Prevent Abuse and Strengthen Families." I am sorry that my delayed flight prevented me from sharing more about Michigan's FAMILIES FIRST program, but I hope you will have a chance to review my written statement.

I wanted to get back to you with some additional comments on the Administration's child welfare reform proposal that Commissioner Horn outlined at the hearing. Although I still have not seen the formal proposal, I wanted to outline some principles that I hope you will consider when planning ways to increase federal resources to prevent abuse and strengthen and support families.

- The need to level out the playing field. The problem in child welfare, as I mentioned at the hearing, has been the lack of a level playing field. While on the one end we have had open ended funding available for out-of-home care, on the other we have had only very limited funds available for family preservation and other family supported services. Thus, there has been little incentive for states to expand family preservation services to prevent unnecessary out-of-home placements. As I understand the Administration's proposal, it would not address the current inequity, but merely suggest to states that they might divide the field differently, capping not only services but a portion of the foster care dollars as well. The proposal would provide no new dollars. Rather, it would take dollars that states are already expected to need (based on CBO projections) for activities related to foster care, and expect that states could use those already committed funds for family preservation and other alternative services. It would give

them no additional help with ongoing administrative and training costs related to foster care. I suspect that in many states, such a proposal would result in little new activity on the field.

- **New entitlement funds are needed for family preservation services.** As I have traveled around the country, I have heard administrators in many states talk repeatedly about the difficulties they face in finding funds for family preservation. Most states have not been as fortunate as mine in terms of the state investment that has been made in this area. It is my sense that without a significant infusion of new federal entitlement funds ensured for family preservation services and related activities, that we will not see states able to expand investments in services to strengthen and preserve families. Flexibility alone is not sufficient to enable states to move forward in this direction, particularly given the fiscal constraints under which many state social service departments are operating.

- **Documenting progress in the development of family preservation services.** Commissioner Horn did not address the extent to which the Administration's proposal would require states to document the progress they are making in expanding resources to preserve and strengthen families. Certainly in Michigan, one of the ways we have been able to expand our activities has been our ability to track carefully what the impact of the FAMILIES FIRST program has been in the counties in which it is operating. It is critical that any reform proposal require states to track and evaluate the impact of their efforts to use funds more flexibly and to establish expanded services to preserve families.

- Training and technical assistance. I also hope that the Administration's proposal recognizes the critical need for federally supported training and technical assistance as states begin to develop and expand family preservation services and other preventive efforts. In Michigan we have been fortunate to have developed a wonderful cadre of Families First workers, but in order to do so we have made a significant investment in training of both FAMILIES FIRST workers, and other staff who are referring families to the program and serving families who have been in the program. States will only be able to develop successful programs if increased dollars are available for these purposes. Yet it is just these types of activities that get cut back in tight budget years. As I remember it, the proposal outlined by Commissioner Horn did not address this issue adequately.

I would be pleased to assist you or your staff further as you continue your consideration of the Administration's proposal, and hope that in the meantime these comments will be helpful. Thank you for your commitment to protecting children and strengthening families.

Sincerely,

Susan A. Kelly, MSW
Program Director
FAMILIES FIRST Program
Division of Family Preservation
Initiatives

SK/ds

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