THE BROOKINGS INSTITUTION

PREVENTING CHILD MALTREATMENT

Washington, D.C.

Thursday, October 1, 2009

PARTICIPANTS:

Introduction and Overview:

RON HASKINS
Co-Director, Center on Children and Families
Senior Fellow, The Brookings Institution

Keynote Speakers:

THE HONORABLE JIM McDERMOTT (D-Wash)
Chairman, Subcommittee on Income Security and Family Support, House Ways and Means Committee, United States House of Representatives

NANCY JOHNSON
Senior Public Policy Advisor, Baker Donelson
Former Member (R-Conn), United States House of Representatives

Panel:

ISABEL SAWHILL, Moderator
Co-Director, Center on Children and Families
Senior Fellow, The Brookings Institution

ROBERT GORDON
Associate Director for Education, Income Maintenance, and Labor, Office of Management and Budget

JEANNE BROOKS-GUNN
Virginia and Leonard Marx Professor
Teachers College, Columbia University

JULIA ISAACS
Child and Family Policy Fellow, Center on Children and Families, The Brookings Institution

DAVID OLDS
Director, Prevention Research Center for Family and Child Health, University of Colorado - Denver

HEATHER WEISS
Director, Harvard Family Research Project, Harvard University

* * * * *

P R O C E E D I N G S

MR. HASKINS: Welcome to Brookings. My name is Ron Haskins. I'm a Senior Fellow here and along with Belle Sawhill sitting here in the front row, whom you'll meet later, Co-Director of the Center on Children and Families. And we've assembled today. We're glad to have you here, because we're going to release three items today. The first is another issue of our Future of Children volume.

I have a reason for wanting to have this with me, because this is -- it must be our tenth or eleventh on child protection. I'll talk in just a minute about that. So, that's the first thing.

And Elizabeth Donohue is here. She's hiding somewhere I guess. Oh, there she is, right in front. And Elizabeth Donohue is more famous than all the other people involved from Brookings and Princeton, because she invented this wonderful color. No one can think of what to call it. I called it pumpkin once and she assaulted me, so it's not pumpkin -- I know that -- but whatever it is, it's a great color. And this is a fascinating volume I think.

The second thing is a policy brief written with Richard Barth, who's the dean at the University of Maryland School of Social Work, on parent training and then a policy brief that will be the focus of our attention

today entitled Social Science Rising, and we'll say a little bit more about that in a few minutes.

I want to acknowledge Doris Duke Foundation's financial support for this volume.

Elizabeth is right here. She has email at Princeton. I'm not sure if it's on our materials, but if it isn't you can call us. We like to work with other groups in outreach for all of our volumes, so if there are any of you interested in sponsoring events or having any of us involved, we'd be happy to do that.

So, here's a word about the volume. I have the outline on the PowerPoint here, and I just want to mention a few of these chapters. Prevention is a fascinating issue. It made such great sense, but you have to be able to do two things to have a successful prevention program. You have to be able to know who's at risk, and then you have to have effective prevention treatments; and in many, many fields, despite the logic, it doesn't work very well for one or the other reason. And this volume I think would convince even skeptics that there are a number of favorable ways to identify people who are at risk, and we do have effective treatment. So let me mention a few of them.

The chapter by Fred Wilson on epidemiology shows that there are clearly five risk factors that include age, race, poverty, parental

drug use, and single parenting; and the more of these risk factors people have the more they're at risk. So, if you wanted to focus on neighborhoods, for example, you can identify using various national or local datasets -- areas that are at high risk.

The chapter by Daro and Dodge is really interesting to me, because it's about communitywide initiatives which heretofore were thought to be, you know, wonderful and it sounds great but how in the world do you intervene with a whole community? Well, there's a program called Triple P -- it's also discussed some in Barth's policy brief -- that actually does have very interesting and I would call it persuasive data that you can produce impacts on a whole community using a five-stage approach. It's really interesting research.

Another chapter by Howard and Brooks-Gunn. Brooks-Gunn is here, and we'll talk on the panel so I'm not going to say much about this chapter anyway since it's the focus of this event, because it's on home visiting, and David Olds, surely the best known program designer of home-visiting programs, is here. He's here primarily to keep an eye on Brooks-Gunn, so we'll have a lot of fun when they're together on the panel.

And also I would commend you to use the chapter by David Finkelhor on child sexual abuse, because it is full of surprises. I was

amazed myself by what we know in this area, and most of it is things that we thought we know -- we don't really know very well. The image of, you know, these monster sexual abusers who are constantly preying on children -- there are people like that, but that is not the typical case. The typical case is far different, and we need to know that and understand it if we're going to have effective treatment.

Similarly, the treatments that are most favorable and popular, especially among policymakers -- like registration and notifying communities when people live in those communities -- there's almost no evidence that they have any effects. So, we need better ideas about how to deal with this.

And then I also want to mention the chapter by Jane Waldfogel. I love this chapter, because it is the first thing I've ever seen that you can look at one flowchart and see the whole field of child protection -- how it's organized and what it does. It shows you in step-by-step fashion and you start -- it's from 2006 -- with six million reports of abuse, and it gets whittled down until finally there are 220,000 children removed from their homes; and there are kids whose cases are not substantiated who get treatment and kids whose cases are substantiated who don't get treatment. Go figure. So, altogether this find is quite fascinating and I think probably the most -- if I could just say one thing

about it, it would be there's room for optimism. There are effective treatments or things that we know. We could do much better, especially if we could organize these programs better and spend our money where we should be spending it now.

Just a few words about the policy briefs. The brief with Richard Barth that I mentioned shows that we know a lot about parenting programs. There are fascinating random assignment studies -- not just one or two but quite a few -- that show that we can really have impacts; and, again, there's plenty of room for optimism here, and especially if these parenting programs are integrated with the kind of communitywide initiatives that I mentioned a few minutes ago and that are reviewed by Daro and Dodge. And in this chapter we present a specific plan for implementing these programs on a larger scale -- Barth and I do.

All right, and then the second brief with Brooks-Gunn and Chris Paxson of Princeton examines the fascinating role that social science evidence is now playing in policy decisions in the Obama administration and in the Congress, and, as many of you know, Mr. McDermott will be here to talk about that and Nancy Johnson is here to talk about it. And since we're going to deal with this in some detail, that's all I'm going to say about this chapter.

So, we're very pleased with the volume. We're please that you came today. And now let me introduce Nancy Johnson. I want to tell you that things are a little bit "iffy" at the beginning here. Chairman McDermott has a difficult schedule. We think he's going to show up sometime between 9:25 and 9:30. He's going to give a brief statement. He's going to answer a half a question and then, "peow," he's gone, because they have a hearing at 10 o'clock and he has to make an opening statement.

So, Nancy Johnson -- I've worked with Nancy Johnson for many years, and I won't tell you any inside stories nor will I tell you my great fondness for her. Let me just say that both Nancy Johnson and Mr. McDermott have done one very important thing, and that is they've continued the tradition -- for those of you who've been in Washington, the subcommittee that used to be Human Resources Subcommittee and now the Democrats changed the name to Income Security and Family Support -- this is the go-to place for social policies especially affecting children in America. That's where most legislation starts and that's where it either gets off to a good start or is buried, and Nancy was a spectacular chairman of the subcommittee and so was Mr. McDermott.

So, Nancy Johnson, thank you so much for coming.

MS. JOHNSON: -- and then as Jim comes in and his time allows, we'll be able to switch back and forth.

First of all, this is a wonderful volume that you've researched and gotten together, and it's an important time for this volume to be published.

If there's one thing that we are learning through our health care system, it's that we can no longer afford a view of health that focuses on illness and treatment. The real underlying challenge in my mind -- the recent health reform really is on everyone's mind and agenda -- is that they understand that once (inaudible), it's almost too late. They want to be helped to prevent illness or to manage illnesses. So before we had the ability to sustain people with chronic illness, we really didn't think about living with illness so much or quality of life with multiple illnesses. And now there's a lot research on that; there's a lot of information about it; and the ordinary person sees it in their own family over and over again. And the combination of both a more holistic approach to the concept of a health system plus making mental health parity, mental health a parity benefit, and an increasing understanding of addiction as an illness does give us an opportunity here to look at abusive relationships as part of the illness of addiction, mental health disease, and other aspects of our health system. And as we emphasize preventive benefits, we need to really

understand these kinds of programs as part of preventive health in building healthy families and healthy children.

So, I think there's an opportunity here, and I'm very glad that Jim is taking it, and I congratulate him on his leadership in these issues. He was always extremely interested in the disadvantaged and the child who comes into this world in difficult circumstances and is faced with challenges that we as adults would often fail to be able to meet.

So, I think this is a really terrific bill. First of all, it is true that often public policy is based on sort of the fickleness of fashion, and what is funded is just often what is popular and this effort to look carefully at programs and what is their real impact and to target populations, because different populations need different kinds of attention, and if we try to have one size that fits all, we'll fail everybody. So, I think the science that we now have about various approaches in various circumstances will help us tremendously in directing funding, but it is also a pleasure to me to see that in the bill there is money for things that are unproven, because it's a long time before you can actually prove that what you're doing is powerful and we don't want to keep new ideas out, and we particularly don't want to define out a lot of things that we are encouraging to happen as we try to integrate the social service sector of social service health job training and economic support efforts in municipalities.

So, there are many opportunities ahead of us as we think more about integration and early intervention, both extraordinarily powerful concepts which, oddly enough, for the last 40 years have been not part of the thinking. What's been part of the thinking as medical science has developed and social science has developed is we're actually rather targeted particularly when we're specialists, subspecialists. It's easier to see in medicine than in social services. But this effort to move that to a more integrated holistic view, both health and family strength, is, in my mind, what gives this volume a particular relevance to us; and the fact that it's science based is very refreshing and would be very helpful to the members of Congress as they struggle to focus on what really works as opposed to what might be popular or have a loud voice.

So, it's a pleasure to be here. I look forward to hearing your remarks.

MR. HASKINS: What a radical and shocking idea basing policy on data, thank you.

And now we're very fortunate to have Chairman McDermott here.

I've already introduced you, Chairman McDermott. While you go to the podium, let me just repeat one thing I said, and that is that you clearly have continued the vision. It goes all the way back for I think

at least 25 years -- that your subcommittee is clearly the go-to place in Washington for social policy, especially policy for children. Thank you.

MR. McDERMOTT: Thank you, Ron, and it's good to be here. I'm sorry I'm late, and I'm sort of on a galloping horse, because we're working on something called health care, as you may have heard. And one of the things about this bill is that it got folded into the health care bill, became a lightning rod for a certain part of our country about the invasion of the home by the government to tell us how to raise our children. So, it's not without it's objections.

And I think that there's a growing body of evidence. I started in my training in Chicago in 1966 in the Woodlawn Health Organization or in the Woodlawn Mental Health Center in Chicago looking at the effects of poverty on children, and when they asked the parents in that original group in 1966 what do you want us to do, they said this society has failed for us but save our children. And we've been gathering data for many, many years about what needs to be done in this whole area of prevention of child abuse and failure in school and all the rest, and I think that what's exciting about this is that we have a President who is saying hey, let's put it into the budget or let's do it and actually begin to implement what some of the information or some of the data that we really know.

Now, the whole area of brain research has developed over the last few years, and more and more of the evidence keeps accumulating that early intervention and support for low-income families and their children is an effective way to keep families together and prevent the problems of later life.

Now, not only is keeping families together in the best interest of the children, but it really is in the economic interest of the country. If you don't even want to talk about human beings and humanity and all that stuff, let's just talk money. If you're going to talk money, it makes sense to do what we're talking about here in the bill.

Now, targeting money for prevention and support pays dividends by saving money on health care, drug rehabilitation, and even incarceration. Some of you may know I'm a child psychiatrist, and I can tell you from personal experience that this is widespread effects, because you're taking kids at the very beginning and trying to prevent what ultimately we will spend in incarceration and all the other things that go on in this society.

So, promoting programs is really an investment in our future, and I think it's important to keep that out there, because one of the things about this country is the fact that we have begun to withdraw our investment, not only in youngsters but in college students and in all sorts

of places in this society where investment is really required if we're going to be the kind of country we want to be.

Now, reliable estimates say that only about 15 percent of families get this kind of home visitation. That kind of math doesn't add up, because that means 85 percent who could benefit from it are not getting access to it. And as the saying goes, you either pay me now or pay me later -- the old Fram commercial. It's short-sided and I think very incorrect not do it.

I've always thought -- the reason I went into child psychology was that I knew if I treated a kid at age 10 I would have benefits for 20, 30, 40, 50, 60 years -- who knows. Picking up an adult and treating him at 20 or 30 when you've already got a well-developed problem is a very inefficient way to deal with the early developmental stages. Ignatius said give me a boy the age of 6, and after that you can have him. He could have said a girl. But the fact is that those early years are when it all happens, and it's really very important, I think, for us to keep that in mind.

Now, the President's budget proposed to fund a new initiative based on the nurse family partnership model, or the Olds model, which was piloted in the '70s in New York. Dr. Olds wasn't real eager to do this very quickly. He wanted to let the evidence carry what he was doing. So, he hasn't been -- he was not pushing it to become widely

distributed across the country until he had really good solid evidence, and I think when this came out then I started to hear from the healthy families of America and parents, as teachers, and parent/child home programs, a lot of other programs began to say, what about us.

And these models all serve slightly different groups. Some employ teachers, social workers, (inaudible) professionals, but they all have some evidence of supporting the fact that they improve outcomes for adverse families and youngsters. These programs said hey, look, if you just do what the President is talking -- just this nurse thing -- what about the breadth here and will we be left out of it and I really agreed with them, and that's why I worked with some of the members of the Ways and Means Committee to put together the early support for Family Act.

The bill's language was introduced in both the Senate and the House. Got little less funding over in the Senate but -- a little less than the President had asked for -- but the bill will allocate money to states for the creation of a new competitive grant program to support voluntary, and I underline "voluntary" -- okay? It is not the state invading homes -- voluntary home-visitation programs for pregnant women and families with pre-school-age children in order to improve the well-being and health.

It's amazing as you have, you know, gone through life and had the experience and realized what happens in this country when you

don't have more than a nuclear family in a city. A baby is born, and if there's not a mother or a grandmother or somebody around who can go in and help the new mother with the child, all kinds of things happen that could be prevented by somebody coming in once a week and talking to the mother and finding out what's going on, and you -- I watched my own grandchildren being born and watched my wife go over and that process that sort of -- informal process of being a home visitor is terribly important, especially for the first kid but even for the second or third, because each kid is different. You have one that's easy to live with and then you have one that isn't easy to live with, and you have to learn to be -- you thought you had it all wired, because the first one was easy and then the second one comes and you say oh, my, whose kid is this? They must have switched them at the hospital. Well, having somebody come in and be able to sit and talk about that is extremely important, and I think that programs that haven't had a 30-year track record like the nurse program do have good responses.

When I was in the legislature actually, I was involved with a program that was in Tacoma, Washington, and some people had put it together, and it was a home visitation trying to keep families together and deal with these sorts of youngsters. And it's been going on all over the country. And I know that my friends on the right -- and I don't consider

Nancy on the right. Now, Nancy was one of the really good ones on the other side to work with on these issues. Some of them are a little bit difficult to work with, but Nancy was never a problem, and I was pleased to see that she was on the dais today with me, because we had good experiences.

When the Republicans were in charge, things still moved forward in this area, and I think that there is a group of people who understand children. Children aren't Democrats and Republicans. They're -- you know, they're just children, and I think we have often accused the Democrats for throwing money at things, so what's really kind of exciting is that now we're going to put something based on evidence.

Now, nobody in Congress likes to be restrained by evidence. You can watch it in this debate that's going on in health care. Sitting in my office watching the Senate describe -- working up their bill, I'm thinking to myself does anybody over there know anything about anything?

But, nevertheless, if you base it on evidence you have to be patient, and it takes a lot of hard work to get that done. And as the Princeton-Brookings policy brief states, the process that led up to the early Support for Families Act must be counted as a victory for social science that federal policy now hinges importantly on evidence. It is a victory for us to actually have some evidence and say this is the evidence, and we're

going to do this because that's what the evidence shows. Now, if we could get that connected to foreign policy and farm policy and tax policy, we'd have a great country.

Thank you.

MR. HASKINS: Well, thank you. I wanted especially to thank you for coming. I know your schedule is bad, and anybody that comes from the (inaudible) and deeply involved in health care as you are could talk about social issues and kids, that's quite a remarkable statement I think. So, thank you. We really appreciate it.

We have time for just one question, because both members have to go -- the member and former member. So, let me ask you this. You actually foreshadowed the question, and that is it sounds great to us that we're going to actually have members of Congress who are going to be reading journals and reading memos from their staff, and they're going to know all this evidence and they're going to base their votes on evidence. I was out there a long time, and I know members have opinions and they have views and trying to separate them from the views when the thing is based on something flimsy, like evidence, is difficult. Do you think this is written -- do you really expect that there will be an impact -- not just this bill, then there'll be a movement in Congress toward paying more attention to evidence?

MR. McDERMOTT: Winston Churchill said that he could always count on the Americans to do the right thing -- but only after they've done everything else, and I really think that if you look at the problems of our society and our cities and the immigration and all of the questions about work force and what's going on in our country -- that's why I raise the question of investment -- I think it's become evident that it isn't just soft-hearted, bleeding liberals like me who think that maybe this is a good thing to do because it's good for the kids and the families. But it actually has a much wider impact on the society. For that reason, I think there is a good opportunity this year to actually move forward on something like this.

This is not unusual in Europe. You go to Sweden or Denmark or Germany or all these other countries in the industrialized world, and you find these kinds of visitation programs all over the place. It's only us who said you know, a kid's born in the family and it's the family's responsibility and we'll only step in when things are so bad that we have to reach in and take the kid out and put him in foster care. That kind of model has gotten us to the point where -- I don't know what it was when Nancy was there, but I'm the godfather for 500,000 foster kids in this country, which are examples in most instances of a failure to deal with these issues when they should have been dealt with. And I think that the

cost-effectiveness question alone will demand the Congress to begin to begin to look at this. And there's plenty of evidence from (inaudible) states that have been very good at this, that it actually works. So, I'm positive.

I guess if you weren't positive, you wouldn't get up in the morning and go up on the Capitol.

MR. HASKINS: No matter what the facts are, that's a great answer. Thank you.

Nancy Johnson, you have two minutes, so.

MS. JOHNSON: I didn't realize that this had entered the home invasion (inaudible). In the 1970s -- the later '70s -- when I served in the State Senate, one of the first bills I introduced was working with foster care agencies to create exactly this kind of program to try to prevent the placement of children outside the home. And so this has a long, honorable history. The work that you have done has put more science behind it, and I'd be happy to help you disentangle some of the Republican thinking from sort of modern bumper sticker labels to what it really means to family and children. And it's profoundly harmonious with the recognized need in our health system to move to a more preventive care management, holistic health system and away from just illness treatment. Until then, we're just illness treatment. We wait until they get

really bad, and then they get in the system. But they don't get really bad. They don't get in the system until they either get really bad or they just live their life in that Neverland and they're a failure.

I do want to mention one short thing while Jim is here. There's enormous work going on in health care on measurement issues, because we know, really, not much about measuring quality, and I've been very involved in it compared to the (inaudible). It's imperative that the social science community be knowledgeable about that, get involved in it, because measuring quality -- wherever -- is hard, and a lot of these programs' outcomes depend on our ability to measure improvements in interpersonal relationships. This is really hard. I mean, measuring the development of mutual respect and self-confidence is hard. But in the end, you're not a good parent if you don't have any respect for yourself or anyone else. So, I just mention that. I haven't thought about that until I read this volume and began thinking about this. But we need to pull -- we need to find a way to get you together with people like Caroline Clancy and let's see what are you doing versus what are we doing, because the science of measurement has an opportunity to advance by leaps and bounds in the next few years because of health information technology, and electronic health records are going to enable us to identify a lot of these things early. I just saw a health information technology system that

can identify the early signs of a never-event in the hospitals. Well, think what you could do with this in the hands of good pediatricians who are sensitive to both addiction and mental health issues as well as physical issues. So, anyway, I look forward to working with you.

MR. HASKINS: Let the record show that the Brookings Institution, in 30 minutes, had two members -- a member and a former member of Congress -- speak and cover miles of territory, made outcomes with important points, and we're finishing on time, and you can make your airplane, and you make your (inaudible). Thank you so much for coming.

MR. McDERMOTT: All right.

MR. HASKINS: Okay. Thank you. Thank you, Nancy.

Right now if you all stay in your chairs, we're going to switch very quickly. The panel will come up here. My colleague, Belle Sawhill, will be in charge, and everything will turn over well.

MS. SAWHILL: I noticed that these mics were a little hard to hear. Can everybody hear me okay? All right. Everybody else all tied up here?

Okay, I thought that was a wonderful introduction to this volume, and now we're going to have an opportunity to hear from a group of people who are extraordinarily knowledgeable or involved in this area,

and I think we are particularly gratified that Robert Gordon could be here today, because he has a very important job.

There are a lot of child advocates as well as experts that I see out there in the audience, Robert, and I know that they appreciate the fact that you now sit on billions and billions of dollars.

So, smile at him, everyone.

I happen to have had a similar job in the Clinton administration. He's an associate director of OMB, so I know something about how tough his life is and how busy he is.

Next to him is Jeanne Brooks-Gunn, who is one of the most knowledgeable people that I know in the entire country on early childhood programs. She's a professor at Columbia University, and she is one of the authors of one of the chapters in the volume we're here to discuss today, and I think it's just a superb summary of all of the evidence on home-visiting programs done with a colleague at Columbia.

On my right is David Olds, who, as I think you all know, is the original developer and I consider the godfather of the nurse-family partnership, and one of the things that David has long stood for is the importance of rigorous evaluation and understanding what we know about a program and replicating it with fidelity.

Next to him is Heather Weiss, who is the founder and director of a Harvard Family Research Project, and she, too, has taken a tremendous interest in this whole question of learning what works.

And last, but definitely not least, is my colleague Julia Isaacs, who's the Child and Family Fellow here at Brookings who has written a great deal on these topics and has, in particular, done a wonderful synthesis of some of the research on what we know about early childhood programs-- not just the home-visiting programs, but also programs for infants and toddlers and for preschoolers and how they all fit together, and she, along with my colleague, Ron Haskins, I think had been particular interested in the issue of the continuum of services for children from birth all the way up to school age and how do we coordinate all the efforts that are out there.

And if I can make one more introductory comment before turning this over to the panel, it would be that the big scene here is prevention, and I would say prevention in two senses. First is the sense in which I think Congressman McDermott was talking about, which is that if you invest early you get a payoff for many, many years added to the future. In other words, we can think of these programs as investments. Good for all kinds of reasons but also very valuable because they have long-term effects.

The second sense in which we're focusing on prevention is because in the particular area that this volume focus on -- child abuse and neglect -- there has been in the past anyway I think too much emphasis on foster care and what we do once children are in the child protective system, and the great value and distinction that I think this volume has is that it focuses on what we can do to prevent children from getting into that system in the first place,.

So, with that, let's turn to the panel. They're each going to make a relatively brief opening statement and then we will have some Q&A and interaction between them. So, let me start, Jeanne, with you.

MS. BROOKS-GUNN: Great. Thanks a lot, Belle.

I want to make three quick points. Of course at Brookings they always have to be quick points. The first has to do with the review that I did with my post-doc, Kimberly Howard. The second has to do with how we make decisions about funding. And then the third is a plea for new approaches, which goes a little beyond the McDermott bill as it's done, but I think it could be changed.

The first -- in the article that we wrote you will find there a table that we did summarizing the results on one little page from the home-visiting programs that we deem have been evaluated appropriately over time. And if you look at that, you'll see we looked at different kinds of

outcomes. One has to do with substantiated cases of child abuse and neglect. We then also moved to looking at observations of parenting -- actually going in and observing what parents are doing. We then also have measures of self-reported parenting and then, finally, child outcomes.

When you look at this, you will see that we have very little evidence of substantiated child abuse in neglect cases. The one example, really, is David Olds' original study in Elmira. Now, there are a lot of reasons for this that we could discuss if you want to know, but there are issues about how you get at substantiated data and also whether you'd expect reductions if you have a home visitor in the home. They maybe more likely could find a case than in our control group where nobody's observing the family. So, we have that problem in infant help and development program, which is one of those listed there, in which I should say I was an evaluator. That and Early Head Start have put, I guess, my biases, although as an evaluator I try not to be biased. But I was involved in two evaluations.

We've shown much better evidence at changing observed parenting. I think this is very important. When you look at the table, a variety of programs have actually changed what mothers are doing with their kids. And it isn't just mothers saying I'm spanking less. It's actually

observing whether or not they're harsh, whether or not they're spanking when you're in a home visiting program -- when the person is there evaluating the home environment.

I think this is the strongest evidence, in my opinion, that home visiting programs, the well-evaluated ones, do work. We also have measures of depression and parenting stress. I'd like to point out, because people worry a lot about mothers' depression, that in general the programs have not reduced the incidence of maternal depression, something we can all talk about. Maybe we're not doing the right things. Clinical depression is intractable in many senses, and I think we need very different approaches to try to change maternal depression than are being used in the home visiting programs currently. So, that's the table.

We've got evidence -- in terms of what we should fund since that's something that, again, is I do think a triumph for social science that we're considering the evidence as this bill is being marked up. And I do refer you to the piece that Ron, Chris Paxson and I wrote on Social Science Rising. Ron gets the lion's share of credit for this brief I must say, but we really feel this is a triumph, that we're actually arguing about different programs with good evaluations. It's unbelievable. In my entire career as an evaluator, I've never seen this happen before. So, I'm really excited about that, and I think that the fact that some programs show more

consistent effects than others is important, and that's why we're so happy that for whatever gets funded, assuming some sort of bill does pass, that we will be evaluating different approaches, and we probably will be able to do better comparisons across approaches than we've done in the past.

And what we do right now is I might evaluate Early Head Start or Infant Health and Development Program. David is evaluating the Nurse Partnership Program. Deb Daro is evaluating Healthy Families America. It would be much better if we had some more head-to-head comparisons, as well as I think better across programs fidelity checks about what's really happening.

Having been involved in other home visiting programs that aren't included in our chapter, some home visiting programs -- when you go in and actually observe what the home visitors are doing, it's a very variable. At one point, we did videotapes of home visits, and not to (inaudible) program. Again, that is not in here. And the variability was shocking in terms of what was going on. So, the fidelity to the implementation is critical. David has done a great job focusing on fidelity in his program. We need to do better across programs.

My final -- and this kind of is a segue -- I'm really interested, if it's possible, in the new bill to be trying new approaches, not just the approaches that we have already done, and my example I'll give and it will

be depression. We don't do a great job with mom depression. Okay, we need to start thinking about why that is and develop new programs.

My second plea for new approaches is what I just said, which is more head-to-head comparisons embedded in fidelity studies so we can really understand what's being delivered.

Thank you.

MS. SAWHILL: Thank you, Brooke.

Robert, unbelievable but social science is now influencing policy?

MR. GORDON: Well, thank you. And thanks, Ron. Thanks for the nice -- thanks -- I mean, it doesn't have much to do with it, but thank you for the nice introduction. When I started my job, I had a very helpful lunch with Belle, and she gave me a lot of good advice, and one of the key bits of advice was to tell me what I heard. A lot of us thought it was particularly powerful coming from Belle, which is when you work at OMB if you want a friend, get a dog. And by and large, in many spheres, that has been my experience. And actually this has been a happy exception where, I think, we have -- working with HHS, working with a lot of organization. Many faces I see in the room are from -- I think we've been able to move forward with an initiative that has improved as it's gone forward and that I think at this point we're just -- we're very excited about

it. We're hugely grateful for the work that's gone on in Congress by (inaudible) and Senate by both Democrats and Republicans. Congressman McDermott obviously has worked closely with us, but he's not (inaudible) Republican. Congressman Waxman and the Senate, the Senate Finance Committee's been very engaged. You have Senator Bond, Senator Snell. It's been -- it is a rare area. I don't want say "rare," but it is an area where we're just seeing engagement across the spectrum, and I think that has made our product stronger and we just look forward to that process going forward.

I'm going to talk a little bit more generally about evidence-based policymaking as the administration sees it and in particular at PRR Sax sees it. I think we are really trying hard across a range of programs to build in incentives to act on -- one, to act on the best evidence and, two, to generate new knowledge and to make sure that that new knowledge in turn is incorporated into practice.

And so there are sort of two big buckets of ways that we do that. One, and it's just by funding more rigorous program evaluation, and evaluations of all kinds, not only impact evaluations but accompanying evaluations that work, that help people figure out that that's what it is that make programs work or what they can do better. And so if you look across agencies -- I only talk about the ones that I work with, because

that's what I know best -- but I think you would see this elsewhere as well. We have had significant increases in funding that were in our budget that I think will show up in 2010 when we're done with the process against (inaudible) education sciences, Department of Labor, Evaluation Shop at the Corporation for National Service; and so that's something that I think over time will just generate and warrant useful information.

I think our sense is that that's necessary but not sufficient, because too often what happens is you have sort of evaluation proceeds on one track and policymaking proceeds on another track, and you can have the most rigorous, wonderful evaluations in the world, but if the policy process doesn't pay attention to them -- more frankly, if they're not relevant and related in what -- in where the money's going, it's only so useful, at least from the government's perspective.

So, what we've tried to do is to bake into programs incentives for the use of evaluation, and so in the programs that -- in home visiting but not only in home visiting, one of the things that we've talked about is sort of a tiered structure where you say that where's there's the most evidence that's where the most dollars should go. But you also provide funding for programs that are supported by lower levels of evidence. And there's a lot of ways to do that, and I don't mean to say this is the only one. But that's one approach that we've talked about.

And that way you sort of acknowledge -- you put a little bit of thumb on the scale of the programs that are best supported, but you don't -- and that's one of the -- it seems like you don't at all say we're done because we're nowhere near done -- and you continue to encourage it eventually bout evaluation.

And so some other spheres where we've talked and used approaches like that -- if you look at the administration's Teen Pregnancy Prevention Initiative -- what -- which is I think likely to get funded, knock on -- knock-knock -- wood -- will get funded this year. We had two tiers of funding in the way that I described -- one for programs more supported by evidence, one for sort of what we didn't promise in programs with some evidentiary support but not necessarily a ton.

Go to another totally different neck of the woods -- education. The Recovery Act provided $650 million for innovation fund and the Department is still working on it, but one thing that -- we don't yet have our public proposal, but the department has talked about multiple tiers of grants that sort of track the description that I've just given.

So -- and we're sort of, as we start the FY11 process again -- looking at these terms. Obviously, the high-level description I just did embeds a lot of hard questions that I'm kind of glossing over, like when you say higher standard, what do you mean? And how good does the

research have to be? What kind of fact sizes are you talking about? What kinds of sustained impacts are you talking about?

There's a second set of questions again that you touched on, which are how important are the -- you don't -- well, this conversation about research is hugely important. It's not enough. And you can have something that purports to be based on the best program in the world, and it it's not implemented well and if the program leadership isn't up for the job, then really you'd be better off with a well-run, really good operation that didn't necessarily have evidence at that level. So, we're trying to keep those thoughts in our heads as well.

And I guess the last thing that I'd say is that we're also trying to be cognicentive where the (inaudible) in the state of knowledge sits so that in a field where there has been relatively more research and building of evidence, it may make sense to use when thinking about those tiers or that structure to set higher standards if you're in a field where we don't really know a lot but we still want to do something. It may not make sense. And when I said don't know a lot and I don't know how much we really know about a lot of these jobs. It's really hard. But when we don't know anything, it may make sense. It's unclear if you want to do the tier idea at all, because you may be setting up sort of an upper tier that's an empty SAT, at least for the moment. And what does that mean?

So, those are the questions we're thinking about and the (inaudible) we're taking, and I'll look forward to the discussion.

MS. SAWHILL: Thank you, Robert. I think that's a very thoughtful set of comments what is a difficult area.

I'm going to turn now to Julia.

MS. ISAACS: Thank you, Belle.

I'm pleased to be here today to address this important topic of home visiting. As others have said, it's an exciting time that we are giving serious thought to designing a new program and explicitly basing it on research evidence.

So, in my remarks I want to make four points about my reading of what the research evidence tells us about designing successful home visiting programs.

My first point is that it would be a mistake to just give the money to the states and let them choose any program they want. So, why do I say this? Quite simply because if you look at the research literature, a fair number of home-visiting programs don't work. By not work, I mean that children who are visited by home visitors do not have significantly different outcomes from those who have not been provided (inaudible) intervention.

That so, we often think that the federal government should be the (inaudible) of discretion to states and local governments. I think this is an area where if we did that, we would end up funding a lot of home-visiting programs that did not have the significant positive impacts for children that we all want.

So, I think we do need to make some decisions at the federal level, and of course as always we don't have as much social science evidence as we would like. I'm sure we're all eager to know the results of the ACF evaluation of the programs that were funded last year. We don't know those results for five years, so we need to look at the evidence that's around and see what we can say.

I come now to my second point. I think home visiting programs are more likely to be successful if they enroll mothers early, even before the birth of their child, rather than starting at ages 3 or 4. We don't have as much direct evidence where you've taken a program and compared enrollment at different ages, but let me outline my thinking here. So, the program with the strongest evidence for nurse-family partnership does indeed enroll women during pregnancy typically during the second trimester, and some of its positive outcomes, such as improving birth outcomes and delaying second births, can't occur if you wait until age 3 to work with the mother and child.

We also know that child abuse and neglect rates are highest for infants, another reason to come into the home early. There's also the growing body of research showing the importance of brain development in early years in adapting children skills as early as age 3.

Then you may think well, we have the economically disadvantaged 3- and 4-year-olds. What should we do with them? Well, we do have good evidence that center-based -- high-quality, center-based programs work quite effectively with this age group, so I would encourage us to continue focusing on high-quality, center-based care for the older children and focusing our probably limited home visiting funds on serving pregnant women and infants.

In an ideal world, I would see referral of the home visiting program as occurring when women went to their public health agencies to sign up for the WIC program. We know that WIC has very high participation among pregnant woman who are below 185 percent of poverty. Why couldn't it be a gateway for home visiting as well?

As a side note, I do think we should link home visiting models to center-based programs, and Early Head Start is a place where we might get some guidance there.

My third point -- I would say that programs targeted to low-income mothers or otherwise at-risk mothers deliver more bang for the

buck than universal programs. I think we have some direct evidence here in the Nurse-Home Visiting Program in Elmira, where the program was more cost-effective for low-income mothers than for the more general population of first-time mothers.

More generally, when I look at the cost savings from different early childhood interventions beyond home visiting, a lot of the savings come from avoiding that outcome, such as high-school dropouts, criminal behavior, and imprisonment, which are more concentrated in low-income populations so you have more chance for saving if you target the interventions there.

So, my fourth and final point is that there are a lot of areas where we have some evidence but not enough to really come down firmly as to how to design programs. For example, with regard to home visitor qualifications and training, we do have one carefully designed study that showed that nurses were more effective than para-professionals, at least in delivering the nurse's home visiting services, we don't know if one type of professional is more effective than other. We have a good sense that dosage and intensity matter, but we don't really know the right dosage or intensity or how long a program should last. We also have a lot of work remaining at how to engage clients so that they do not drop out of the program. It may be stating the obvious, but if you only start off for three or

four weeks, the chance of having an impact with that client is quite small, and I think that's a major issue in the whole area in a lot of social programs, including home visiting.

And another big area we don't really know is what teaching style and which home visiting curricula are most effective. So, given all these areas of unknown, I would support the administration's approach of focusing the majority of funds on programs that do have the research evidence and positive effects but leaving some funding for testing new results, new areas.

I would, however, guard against letting go of restrictions on how the funds are spent. This is not an area we want to just let a thousand flowers bloom. I guess what I would suggest is that I wonder if a friendly amendment to the proposal to improve the likelihood of funding successful programs, which would be to encourage or even require that home visiting programs focus a majority of their services on low-income pregnant women. And I do wonder if linkages to the WIC program might be an effective way to do that.

MS. SAWHILL: Thank you, Julia. I think that Congressman McDermott made the point that politicians in Congress don't like to be constrained by the evidence and I would say here at Brookings we don't like to be constrained by politics. And so I'm very glad that we have as

our next panelist here, someone who has been passionately dedicated to both collecting and believing in evidence, David.

MR. OLDS: Thanks, Belle, I'm going to use my time to talk about the approach we've taken with the Nurse-Family Partnership and also then address the question about whether services should be universal or targeted. Some of you know, but I'll repeat it, that the Nurse-Family Partnership is a program of prenatal and infancy home visiting by nurses for low income mothers having their first babies.

This constitutes about – women having their first babies in our society constitute about 40 percent of all live births. The nurses have three major goals; the first is to help improve the outcomes of pregnancy by helping women improve their prenatal health, including health behavior such as cutting down on the use of tobacco and alcohol, illegal drugs and so forth.

The second major goal is to help parents improve the subsequent health and development of their children by helping them provide more competent care for the baby in the first two years of life, and especially – we're especially concerned about reducing the rates of injuries and child maltreatment. And the third major goal for the nurses is to improve the family's economic self-sufficiency by helping them develop a vision for their future and start making appropriate choices about

planning future pregnancies, staying in school, finding work, and, in general, to find ways of accomplishing the kinds of lives that they want for themselves and their children.

Now, we've conducted a series of randomized controlled trials of this program over the last 32 years or so, and we've conducted these trials with different populations, living in different contexts, in different points in our country's history, and we've done these studies with nearly entire populations in the communities in which we've conducted research, and we've conducted these programs through local institutions, including in the Memphis trial in the -- through the Memphis Shelby County Health Department and – the nursing shortage, so where there was turnover among nurses.

So we have -- all of these approaches to conducting these trials increase our confidence that the program will produce effects in local communities, in populations in our society, with low income whites, low income blacks, Hispanics living in urban and rural areas and so forth. And also in what we call our measurement designs for these studies, we have focused our limited resources on measuring outcomes that are of relatively unequivocal public health importance. These are outcomes that all of us in this room would agree are important on the U.S. Domestic Policy agenda.

Now, this approach over time has given us increased confidence that the program will have an impact with vulnerable populations if delivered with fidelity through the model that was tested. And some of you may know that we have, over the years, as Congressman McDermott said, declined invitations to replicate the program outside of research context until we had confidence that the evidence was sufficiently clear to warrant scaling up and that we were confident that we even had nailed the program well, that we understood what are its essential elements, we have confidence that we could reliably reproduce it in new community context.

Now, this began, this community replication work began in 1996/'97 at an invitation through the U.S. Justice Department. They asked us to help them set up a program in high crime neighborhoods, and we have been reluctant to – we entered into that work with a lot of apprehension, because we were concerned, we knew that there would be lots of pressures to water down the program and to compromise it in the process of scaling it up. But we – and we also weren't sure at that time that we really understood its essential ingredients and how to reliably reproduce it through training and technical assistance and guidelines so that we could reproduce it effectively.

So we built an infrastructure to help replicate the program throughout the United States that's currently conducted – supported by the Nurse Family Partnership National Service Office. They pay attention to communities and organizations to make sure that they're well supported to develop – implement the program. There are structured guidelines that nurses follow to work with families. There's a web based information system that allows us to monitor the performance and use that for continuous quality improvement.

And we think of the program as a work in progress. We don't believe that this is the answer by any means. We think that there are vulnerabilities in the programs themselves, we need to figure out how to do this work more effectively over time. We have research going on, how to design – improve participant retention to address -- to improve broader enrollment, to improve the qualities of – help nurses improve the parents care of their children. All this kind of research we think is essential to improve the program model itself.

Finally, I'd like to say that in any policy context, we're operating under conditions of limited resources. And I think that it's important for us to recognize that all the bad things that we're concerned about with children and families are concentrated, whether it's concentrated social advantage.

And the evidence from our trials, as well as other trials of effective preventative interventions, indicate that they are more effective when they are delivered to families where there is greater need.

I think that there's been some talk about developing a system of service – services for families. I believe that developing a system of services is really smart, it's really important. But I believe that that system needs to be populated with individual programs -- strong evidentiary foundations.

We need to develop individual programs that can be linked together, but those individual programs need strong evidentiary foundations. I don't believe that any of the things that we're concerned about in this room can be accomplished with a single piece of legislation. I think that it's important for us to recognize that we have limited dollars, we need to focus them where we know that we can make a difference. And I feel that the Nurse Family Partnership is at a point where we can contribute to developing that system. So thank you.

MS. SAWHILL: Thank you, David. Heather.

MS. WEISS: Thanks; I'm here because I and three colleagues wrote a letter about the proposed legislation this summer. My colleagues, Deborah Daro, Ed Zigler, and Ken Dodge wrote a letter saying that we thought the legislation should cover more than the Nurse Family

Partnership, and you heard Congressman McDermott talk about the fact that that's now happening.

We are in agreement with the Future of Children policy document, that the assessment of the evidence, and all four of us have looked at a lot of the evidence, suggest that no one program dominants the rest, therefore, we need legislation that's going to bring a number of evidence based programs into the kind of system that David just described. We argue that the new federal investments have a strong evidence base so it's warranted to scale up home visit legislation, that's from the intervention base. I also, as somebody and others on this panel I think, as well, know the literature on the importance of parenting for kids overall learning and development from cradle to career.

So I think another argument I would make is that if that more than 40 years of evidence points to the pivotal importance of parenting for a variety of child outcomes, including education outcomes, we cannot afford not to intervene to support parenting and strengthen parenting if we're going to have the kind of education and other kinds of outcomes we want for kids.

The question is before us, how are we going to do that well? So in the letter we argue that new federal investments and scaling home visiting should support an array of evidence based programs that are

nested within a system of early childhood in maternal and child health services.

We argue that home visit programs should be available universally, on a voluntary basis, with special provisions for identifying and matching particular groups with particular models and intensity of duration services. We also argue for continued commitment to research and evaluation within a framework of continuous improvement and transparent accountability. We argue these things because we believe they will increase the chances -- the new legislation and state implementation of the legislation will not simply add a few more home visit programs that will lead to the kind of transformational changes that are necessary to have real impacts on maternal and child health, child abuse and neglect prevention and enhance school readiness and continued school success.

So I've set the bar high if you think about those kinds of outcomes, and I think we're going to need the kind of systems and transformational changes that are implied by going to a systems approach if we're going to reach really powerful, large scale outcomes from this increasingly large investment and home visit program.

Now I want to put sort of two provocative questions on the table. Many of my fellow panelists have talked I think about home visit programs. I now want us to think about if we get this money, what are we

going to do with it and how are we going to try to make sure, beyond the kinds of things that the other panelists have suggested, we're going to really get the payoff that warrants continued public investment in home visitation. And I think – I want to point out two things, first of all, to underscore what David said about the importance of embedding home visits and using them as a driver and a component of systems of early childhood and maternal and child health services for children.

Twenty years ago almost, I did an issue of – the first issue of the Future of Children focused on home visiting, and I argued then, based on the evidence in 1991, that home visit programs are necessary, but not sufficient, and I still believe that. Nothing has happened since then that hasn't convinced me that they needed to be nested within a system.

I also have come to believe, based particularly on the evidence from early Head Start, that for low income, disadvantaged kids, it's going to be important to couple them very carefully with high quality early childhood education services.

I think this offers an opportunity for states to begin to align a system of early childhood services that creates what I think is going to be critically important for education outcomes – teaching a school of education and look at how we're going to improve education performance, and that's to create a continuous cradle to career pathway of family

involvement and kids learning and development. Home visits are perfectly positioned to be the beginning of parents understanding about the pivotal role that their behaviors and engagement in their kids learning and development plays, not just in the early years, but right through to high school.

As somebody who tracks the evaluations and the developmental research on the importance of parent involvement, I can tell you that research is showing that that engagement, nurturing parenting, involvement with kids learning and development continues to be important and predictive up through high school and probably beyond.

The second thing I think that we need to do is have an honest conversation about the limits of what we know about how to take successful interventions, whether they're done with random control trials or not, to scale, and get outcomes of scale.

I think that conversation is going on within the Department of Education. I will turn you to a paper by Mike Smith, who was former Deputy Assistant – Deputy Secretary of Education in the Clinton years, a paper Mike has written on research in the policy process. He talks in that about increased understanding of the intersection of a program that's context and the kinds of infrastructure that are necessary to get any proven intervention, proven in the small model demonstration – control

sense to scale with the possibility that you'll get positive outcomes at scale.

The final thing I'd say is, I think that it's incredibly important, and I never thought I'd live to see the day when evidence was actually informing policy. This administration is walking the talk of that. It's fine to find evidence based programs and scale them. I think the next challenge is how to continue to demonstrate that they continue to add value.

And I go back to a story from Head Start in Montgomery County years ago, where the county was making a decision about investing in Head Start, the evidence was – preschool project, the County Commissioner said, fine, we want to know how it works right here in Montgomery County, and we want you to be able to demonstrate that it continues to work.

So this gets to the kind of stuff David is doing with developing his clinical information system, which, if – then work that into ongoing and transparent accountability, as we are now requiring of schools, we would know what our investments and home visitation and renovation surrounding that around a continuous improvement framework are continuing to pay back their public investment, I think that's the next challenge we face. How do we show and do the necessary continuous improvement innovation so these things continue to pay back on our

public investments in home visitation and these systems of early childhood services.

MS. SAWHILL: Thank you. I think all of you have addressed in an interesting way, if from different perspectives, a lot of the broader issues that this volume of the Future of Children raises. So let me ask a few questions that get to the broader question, and the broader – the way I would frame the broader question is as follows; if we want a system of early childhood programs that does as good a job as we can do at making children school ready by about age five, what would we need to put in place and what do we need to work on?

Heather, you've just really addressed that, and all of you have to one extent, so think of that as the goal. I won't get into the conversation about how we define school readiness, but we're doing a little bit of work here at Brookings right now in which, on a preliminary basis anyway, we're finding that about 40 percent of all children are not school ready by age – about age five, and that's a lot. And that then has implications for their success later in school and in life. So what sort of – and Robert is in a position to begin to influence of all this. So let me pose it this way, what are the one or two things that you would want Robert to take away from this meeting and go back to his staff and his colleagues in the administration and say here's what you need to think about more or work

on more in order to have more children school ready by about age five. Who wants to start? Okay, David.

MR. OLDS: I think that Julia mentioned this earlier. My sense of things is that if we have prenatal and really early home visiting programs that have very strong evidentiary foundations, that's a beginning, and the other piece is really high quality preschool programs.

The challenge, as Heather mentioned, is that there's often a large gap between what we know from the scientifically controlled studies of these interventions and what actually gets conducted in practice. There are huge gaps between – preschools impact on – impacts on intellectual functioning and the recent trial of Head Start. So I think that we need to be thinking about building infrastructure, among other things, trying to understand – think carefully about what kinds of infrastructure we need to translate research based programs into practice. In the U.S., we've done this with the Nurse Family Partnership National Service Office that has tried to think systemically about what it would take to move an evidence based program into practice with some reliability and standards of quality.

In Australia, we've been invited to do this work by the Australian government, and they've funded this kind of work also outside of government. They've created what's essentially the Australian Nurse

Family Partnership National Service Office. They don't believe that that kind of work can be done while – within government.

We're doing work with – we've done work with – and -- administrations to the cabinet office and now the Department of Health through the UK, and they have tried, at least for the first 50 sites or so that they've developed for the Nurse Family Partnership, they've developed an infrastructure within government.

So I think that – thinking carefully, thoughtfully about where that kind of infrastructure – recognizing that we need that kind of infrastructure, and then thinking carefully about how to fund that infrastructure would be really important. I think about it with respect to home visiting. I think we need something – some counterpart to that when it comes to quality preschool, as well.

MS. SAWHILL: Brook, what are your takeaways for Robert?

MS. BROOKS-GUNN: Okay. I'm going to start with slightly older children, and my – with four and then move down, which is a slightly different way to do it. I actually am pretty impressed by the new data that are coming out suggesting that preschool, actually irrespective of quality, makes a difference in terms of how kids are ready for school. There's some analyses being done that are pretty amazing.

Okay. So what that suggests to me is that, in terms of system of care, we ought to be moving, and I think we are moving to universal pre-K programs in this country. Those are primarily being funded, of course, by states at the moment.

MS. SAWHILL: And you want them universal, not targeted?

MS. BROOKS-GUNN: Yes, this is for fours. I get targeted when I get younger.

MS. SAWHILL: Okay.

MS. BROOKS-GUNN: Okay. In part, I would do the universal for the fours because we have such a high percentage of kids anyway, especially our middle income families. So the fact of the matter is, four year olds who aren't in pre-K at the moment, the biggest bulk happened to be immigrants and Hispanic American kids. So if we want to reduce the disparity at age five, we've got to figure out at the state level how to get more kids in at four. Then what I would do is, I would, of course, this is pie in the sky, if I were the Czar of everything –

MS. SAWHILL: Lots of –

MS. BROOKS-GUNN: I would like to see Head Start, as we become more universal for four year olds, Head Start focus on three year olds. And I know that isn't particularly popular in terms of the Head Start Association, but I actually think as we move to more of a pre-K, four year

system, and we're seeing more and more of this with teachers, many of whom are certified to teach kindergarten, as well, that Head Start should be moving, this is where I want to be targeted, the three year olds, but that's what Head Start does already. But I would expand Head Start for threes, I would not expand Head Start for fours at all, and I would link some of this also to the standards that states have set up. Head Start, of course, has its own standard system, but we've done some work with three -- kids in preschool at age three in 12 states, and you find that the regulations that are in place in the state for three year old preschool actually has an influence on the quality of care, which we may be the first – there may be one other study that's shown that, but that's really terrific.

So you can really do a lot at the state level for threes and fours. I think fours, again, are a slightly different, the quality is higher for fours overall than it is for threes. So I would be doing something with Head Start, and I'd be doing something with standards in Head Start, given the state data that we've seen.

But the pre-K, Heather said something interesting, excuse me, for the prenatal, if you go down further in her letter, her group was advocating for universal home visiting, I would not advocate for universal home visiting.

I love Julia's idea of linking it with WIC, I think that would be the best way to get the population that we want. So I'm really thinking much more of targeted programs, starting prenatal, but targeted probably through age three or up to age four and then going universal. Thirty years from now, whoever is sitting in this room 30 years from now, you know, maybe we'll be at a point where we've done so well with the threes that we'll be expanding preschool for threes to universal, I just don't think it's realistic right now. And I want to start to reduce the disparities in school readiness.

Your 40 percent, I assume, are the kids in the bottom – for most case, the bottom two quintiles of the income distribution, so figure 40 –

MS. SAWHILL: Well, we're actually using, you know, measures like cognitive and behavior.

MS. BROOKS-GUNN: Yeah.

MS. SAWHILL: Behavioral competency.

MS. BROOKS-GUNN: Right, but they probably overlap.

MS. SAWHILL: Yes, I'm sure they do.

MS. BROOKS-GUNN: Right; we're going to overlap, which is another argument for the targeted early, and again, using WIC to get in is terrific. So I'm going to leave it at that for now.

MS. SAWHILL: Julia.

MS. ISAACS: Yeah, I guess we're having some agreement here. I'll go from zero to five.

MS. SAWHILL: Well, agreement, if we have it, is good to surface, not a long list, just one or two things.

MS. ISAACS: Right, so –

MS. SAWHILL: So home visiting.

MS. ISAACS: And I would advise, I just think that evidence – I'm not saying you couldn't have an evidence based effective program with three and four year olds, but I would make the bar higher because I have not seen as much evidence there, so targeting more of the funds to low income pregnant women, and I agree with what people have said about the pre-K.

I guess I'll just raise up – but I'm not sure we know about the transition, the two year olds. At least in the Nurse Family Partnership model, it stops on the child's second birthday, so that age three, maybe they're going to Head Start. So what's happening – so I would highlight that as an area where we don't know.

MS. SAWHILL: Good point; Heather.

MS. WEISS: I guess I would ask you to think about three things; one is –

MS. SAWHILL: We're going to ask you to respond.

MS. WEISS: Yes; one is to think longitudinally, so we've developed a system that goes from birth to five and I want to push it up. The National Child Care Study – analysis from the National Child Care Study shows that one third – about one third of the – achievement gap of school entry is through the parenting.

Longitudinal results of that study suggest by grades five and six, that parenting is still the strongest predictor of kid's academic and socio emotional development in school. So I push on this notion of, we've got to create a pathway, and I think you can create information and expectations and support systems for parents in the system we're talking about that continue to reinforce the message about the importance of your involvement as your kid enters and continues through school.

MS. SAWHILL: Can I just ask, what is the – how do we measure good parenting? Is this – these kinds of observational things of how harsh the parenting is or is it something else –

MS. ISAACS: It's a range of things which I think we can – we understand a lot now about what nurturing parenting looks like, the transactions, the interactions, the behaviors. It's not just punitive punishment, it's also the verbal interaction. There's a whole set of things that constitute good parenting, and I think we have increasingly specific

information about what that means, and we are getting better and better measures of it, and Brooke would speak to this, as well.

MS. SAWHILL: Do you agree with that, Brooke? I just think this is such an important topic, I want to pause on it for a moment.

MS. BROOKS-GUNN: Yes; we have really good measurement of what parent are doing and the different dimensions that seem to be important. The problem is that to do this, we really do need to videotape and code. We have not come up with a good, live coding system, and that costs money.

MS. SAWHILL: Right.

MS. BROOKS-GUNN: Ron and I disagree on this. I just think you cannot do self-report, having parents tell you what they're doing, and get a good feel for what they're doing and if – intervention, we've changed behavior.

MS. SAWHILL: And do both of you or any of you who've looked at it agree with the article that's in the journal about the programs that have been effective at improving parents, because there's been a long history here of people saying parenting is important, but we don't know how to change it, it's very, very hard to change. Are you optimistic about that, the two of you?

MS. ISAACS: Yes, I am.

MS. BROOKS-GUNN: Yeah, I am, too. I actually think that, at least with mothers of young children, the strongest effects across different home-visiting programs are changing – and harshness. We actually do a pretty good job of that, or can do a pretty good job, excuse me. That's not speaking of the scale issue.

MS. SAWHILL: So – I interrupted you.

MS. BROOKS-GUNN: That's fine, hey, go for it. I think the second point I would say to OMB is that I would do the equivalent of the race to the top competition to encourage states to apply for money to create systems of early childhood services. And perhaps this is the early childhood fund in play now, but this means that states have to say we are going to get this money, there's a set of conditions that we agree to in order to maximize the chances that we're going to create an effective system of early childhood services. That also means the feds need to get their house in order in terms of some of the interagency linkages that are going to be necessary. I'm optimistic because Joan Lombardy and ACWF's job description includes interagency coordination and helping to build an early childhood system.

So this may be the administration that helps us break down some of the silos in the federal government that will enable the states to create the assistance that we're talking about, to that's the second thing.

MS. SAWHILL: Okay. I want to move on, because I think that's a very similar recommendation to what David had said, so that's nice.

SPEAKER: Can I make one last thing?

MS. SAWHILL: All right, short.

SPEAKER: That's to encourage innovation. And I think we need to be encouraging innovation, like we are in the Department of Ed, where we're looking at trials of things like Nurse Family Partnership in zero to two, connected to really heavy emphasis for low income families, around language and literacy development, through something like the HPE program or the maternal child program, and then connected to some things they're doing in California, which is teachers doing home visits to increase parent information and involvement, that would be one thing I'd try. The second thing I'd try is, I would look at home visiting within the hope neighborhoods, I guess hope or promise neighborhoods, the next generation of the Harlem Children Zone.

We need a more intensive emphasis on both the family and the early years and the family pathway in that set of experiments that we're about to spend big money on.

MS. SAWHILL: Okay. Robert, you could respond now or I can bring people in from the audience and you can go last; do you have a preference?

MR. GORDON: Very briefly.

MS. SAWHILL: Yeah.

MR. GORDON: I'll just say a little bit about the rest of the administration's early learning agenda which we're also really excited about. The Recovery Act included $2 billion for Head Start and early Head Start. Proportionally, it's a much larger expansion. In early Head Start, we were particularly excited about reaching younger children, and so those are both getting more kids into those programs which we're excited about and proud of.

But we've also said that while expanding access is really important, improving quality is extremely important. And the President, in his campaign, had the proposal to create an earlier learning challenge fund. I actually think is kind of a race to the top around early learning. And I think it is a serious measure of the administration's commitment to this program that we had proposed.

Initially in our budget, we proposed I think $300 million in discretionary funding, and because of a bunch of stuff that's sort of too complicated to get into, what we ended up doing is saying that, in the

vehicle of a higher ed bill that has a lot of savings generated from eliminating – basically cutting out the middle man in student loan programs and making loans directly to students which can achieve some of the same quality and performance that billions of dollars lower cost, but we would take a significant chunk of the savings from that program, we propose to take a billion dollars a year, and dedicate them to this early learning challenge fund, and those are dollars that will be – I shouldn't say will be, that we hope will be, cause it's passed the House and now we're hoping for the Senate, dollars that would be computed to states based on their commitment to a range of quality activities, that are the kinds of things that folks have been talking about. And I think we're very hopeful that that, in conjunction with the money – the support position that's already out there. And I should mention – obviously – enormous amounts of money and very serious quality issues in the child care system that we are hoping to begin to be able to drive improvements in the field.

MS. SAWHILL: I'm glad to hear you talk about the need for offsets, you naturally would from OMB, but I think some of us, Ron and myself in particular here at Brookings have tried to think hard about where we need to expand and how we're going to pay for it, because it's just not realistic in this day and age with the fiscal challenges we face as a country once this recession is over, to think about expanding these systems

without finding ways where we can save some money, whether it's in other childhood programs or other social programs for the young or whether it's from maybe beginning to reallocate some funds from programs for the elderly or other groups to – families and their children for whom there can be a payoff because it is an investment in the future.

Julia Isaacs, who's been doing quite a lot of work on this question of intergenerational equity, as I call it, and I've done some work on it, as well, and we'll be having an event at some point to discuss exactly that set of issues, which should be interesting. Okay. I want to open this up now to all of you. And, Mr. Allen.

MR. ALLEN: Thank you very much.

MS. SAWHILL: Introduce yourself.

MR. ALLEN: Ben Allen of Public Policy and Research Director at National Head Start Association. I want to thank you, Robert, for your expansion of Head Start and early Head Start. We view Head Start as a birth to five programs, because the science supports continuity of care. And also I want to thank Jeanne Brooks-Gunn for including early Head Start as an evidence based home visitation program. And I also want to thank Heather and Julia for your remarks about Head Start and early Head Start.

The question I have for Julia is kind of a research question. You mentioned there's a report from ACF coming out in five years, about the programs that were funded last year; I was wondering if you could elaborate on what that might be, or did I misunderstand?

MS. ISAACS: I don't have more to say. I just know the legislation was – I believe a contract has gone out to an association, and someone here may know more, exactly which groups are evaluating.

MS. SAWHILL: -- Mathematica and –

MS. ISAACS: So that they have – they will be overseeing implementation. And then I – I'm just assuming they have outcomes in their evaluation – implementation. And I mean five years – it just – the thing has to get on the ground and you have to measure things and you have to wait a couple of years and you have to write the report, so five years is just a ballpark.

MR. ALLEN: I was just wondering what it was about, that's all.

MS. SAWHILL: To create a system – for those states to create a system of home visit services with the infrastructure necessary to support quality. Back here, back row.

MS. NOLAN: Thank you. My name is Catherine Nolan and I'm the Director of the Office on Child Abuse and Neglect within the

Children's Bureau. And my office manages the program that you're referring to, it's the evidence based home visiting program that was competed last summer, so those grants literally a year ago today were awarded. We have 17 grants across the country. They've been working very hard with my staff and with our colleagues over at Mathematica. They did win the competition to have the support contract, to provide technical assistance to those grantees, as well as to help them set up their cross side evaluation. They've been working very hard this year on their planning phase, as well as selecting elements that they would all be willing to collect data on.

So it is a five year grant program. Normally, with our grant clusters, when we have the – side evaluation as part of the project, it takes another year after the grant program is completed to actually finish up all of the analysis and the writing. So probably, in terms of a final report, we're looking at five years from now. I'm happy to talk with anyone afterwards if you need more information.

MS. SAWHILL: Thank you. Nice to have that kind of resources right here in the audience; thank you so much. Yes, right here.

MS. SILVA: Hi, I'm Julia Silva, I'm the Director of the Violence Division, Office of the American Psychological Association, and I'm pleased to see Jeanne here today, and David. The APA had a

working group last year to do a literature review and a discussion about the integration of, you know, programs addressing child maltreatment prevention and behavioral and mental health issues, and proposing an integrated – that, you know, Jeanne was talking about, you know, how to address mental health issues that many parents involving child maltreatment have.

So what our report, and I brought some copies here and I will be happy to give to some of you, address what's the evaluation of many of, you know, those programs that, you know, you are discussing here in terms of how it is effective – could be effective to take child treatment prevention interventions, combined with screening for mental health, you know, issues, and mental health services at community health centers and help families who go there for their regular primary care, so providing this integration that we are now more and more talking, that the association is very involved in. I'd like to hear from you if you have any – about that, any thoughts about that.

And we also have a bill that was introduced in the Senate to do that, to fund the – pilots in ten community health centers to pass, you know, this model. Thank you.

MS. SAWHILL: Very interesting. I remember, Jeanne, being in another meeting with you a number of years ago in which I think I

asked the question, if you could wave a magic wand and do one thing to improve children's lifetime prospects, what it would be, and you can correct me if my memory is faulty here, but I believe you said, and it's always stuck in my mind, the most important thing we could do would be to figure out how to effectively address maternal depression, I mean serious clinical depression; is that correct?

MS. BROOKS-GUNN: And I put substance abuse in there, as well.

MS. SAWHILL: Right.

MS. BROOKS-GUNN: Those would be the two, if we're talking about young children and brain development. I mean even since I said that, more and more research has come out suggesting when you have moms with these physio problems, the way to interact – is, you really are effecting the emotional regulation of the brain, not good.

Years ago, Susan Mayer and I wanted to do an intervention, and I'm hoping, with – this can be built into this still, we wanted – I hope you can get some randomized trial evaluations in, because we really need to see what programs might work for very depressed moms or substance abusing moms. MBRC has a contract, and I don't know the results, maybe someone here in the room does, they call them not hard to treat, but hard to get into program mothers, somebody help me, and they were –

MS. SAWHILL: Disconnected –

MS. BROOKS-GUNN: -- disconnected, and what they were doing is trying to find places around the country where they could actually put into early childhood education services some much better mental health services for the moms.

And they were working with early Head Start sites I think in Kansas. You can tell I'm vague on where they were doing it. And I thought, what a great model. And I don't know what's happened to that evaluation, except I know it was really hard to implement. Why? Because these are our most disorganized moms. These are the moms that are really hard to engage.

In any case, what Susan Mayer and I wanted to do was do a trial where we actually were offering not just psychotherapy, but anti-depression drugs to moms and then having – we had this whole thing forearmed, where you were getting psychosocial intervention, home visiting, as well as drugs, and see if you could really move some of these moms into a less depressed state, A, and how much that would make a difference for their kids. Believe it or not, the literature isn't very good yet, just a – history study saying if we get a mom that cannot be clinically depressed, is that changing her child, I can't believe we don't have that data.

MS. SAWHILL: Does anybody want to say more about substance abuse or depression in the mothers?

SPEAKER: I do; I agree that mental illness and substance use are significant problems for – children and families in our society. And in the trials of the Nurse Family Partnership, one of the consistent findings has been that women who have high rates of depression and anxiety, lowered -- functioning or a loaded sense of – control over a lot of circumstances we've created an index that characterizes in a way the ability to cope with living in poverty or managed effective care of their children.

In the control group, as vulnerability increases, the rates of bad things increase, and that would include child maltreatment, injuries to children, hospitalized, children with – more problems with executive functioning, language development, all of these things are all problems in these areas, are concentrated in children born to mothers who are more vulnerable with respect to those dimensions that I just described to you. And while we've seen no impact in our trials on weights of depression in the mothers themselves, they're managing the care of their children more effectively, and this is a consistent finding across our trials, that is, essentially what we're saying is, we've improved their functioning with

respect to caring for their children, but not necessarily the depressive symptomotology.

And I think that as we think about what's most important, I think we should be thinking about ultimately the functioning, not just – I mean ultimately we'd like them to feel better, but if they're managing the care of their children better, that's what's most important to us.
And, again, this is a consistent finding across trials.

MS. SAWHILL: And doesn't this discussion we're having now raise the question of whether or not those young mothers who are depressed, let's say, really plan to have a child or whether these are unintended pregnancies and we should be going back, and I think you talked about this in your chapter, to thinking more about how we present teenage pregnancy and other very young, unplanned pregnancy as another step, going even further back in the prevention chain here. And does anybody want to say anything about that? Julia.

MS. ISAACS: Yes, I didn't favor going back, but also I'd say that one of the things that struck me about, and this is from the Nurse Family Partnership model, was the delay in a second birth or some – in some locations we do think second birth, so that I'm in favor of primary teenage prevention, but I also think once you have a young mother who's struggling to take care of one child, if you can help her delay or plan her

second birth, you're improving outcome for the first child, and then doing that primary prevention for the second child.

MS. BROOKS-GUNN: I might just say that in my – looking at all the different programs, David's is the only program, somebody else jump down my throat on this, but I think your program is the only one who's actually been able to prevent second births – helping develop – delay –

MS. SAWHILL: How about Vicky Sites I think – but she did – yeah, but she still did – yeah.

MR. OLDS: Is that a trial?

SPEAKER: Yeah.

MR. OLDS: A randomized control trial?

SPEAKER: But she was – but that's one thing about the nurses, and I've always thought, that may be why the nurse is competitive advantages, since we think about who's going to deliver the services. Maybe when you go into a house and talk about contraception right after the birth of a child, which nurses do, maybe having the nurse be the person who is talking about that, is really important. I don't know – always have thought that was the case on that piece of prevention.

SPEAKER: If I may, I think that, first of all, the nurses begin talking about these issues related to pregnancy planning before the first

child is even born. So what they're really doing is starting to help them establish what kind of life they want for themselves and this first child. And it's in that context of having a vision for what life might be like that they start to introduce not just issues of contraception, but thinking about, most importantly, what is my life going to be like.

And so the discussions about – it's not just whether you're going to use contraception, it's whether you're going to have sex with this guy or not and when. And so I think that all of that fits into this envisioning process. And the other piece is that I think that by – I think one of the strengths of nurses is that they're – by virtue of their being nurses, they're able to address issues of physical health more generally with pregnant women, and they have a certain kind of legitimacy I think with pregnant women around issues about what labor and delivery are going to be like, what this back pain means, and what the care of this fragile – physically fragile newborn is going to be like.

And I think that, as we think about any kind of preventative intervention, I think the challenge for all of us is figuring out why would parents want to show up for any of these kinds of programs.

MS. SAWHILL: Okay.

MR. OLDS: What's the – and I think unless we can address that question about why vulnerable parents would show up, I think that we

have to think very, very carefully about what are our grand designs about improving parenting are really going to have an impact if they – we may know what parents need to do, the question is, can we engage them and can we support the effective development of those competencies that I think we can all agree are important.

The real question from my perspective is, engagement and effective guidance and behavioral change.

MS. ISAACS: I agree.

MS. SAWHILL: I think what I – I want to bring Theodora Ooms in next, but I think what I've learned from talking to people like Kathy Eden is that the way you engage the mother is through the children. I mean they really do care about their kids and doing well by their kids, and if a nurse, and I'd love to have a discussion up here about the whole question in these programs, of whether we need professionally trained people at a high level, and therefore, more expensive program or whether we can get away with training paraprofessionals to do this, that's another topic. Theodore, let's bring you in.

MS. OOMS: I wanted to raise one question – I'm sorry, a wonderful panel.

MS. SAWHILL: Introduce yourself.

MS. OOMS: Theodore Ooms, I'm currently a consultant, and I wanted to raise an issue. David mentioned two words, guy and father, but nobody else has said anything –

MR. OLDS: Guide and what?

MS. OOMS: Guy, you said guy a minute ago, and you said –

MR. OLDS: Oh, guy.

MS. OOMS: -- you said father, and I think something that I would love more of you to talk about is what is the role of the men the fathers, the men who may be the sexual partners, may be cohabitating. Fragile families suggest that they are important in the lives of the children. This might connect if you can get the father involvement, father engagement movement, which is beginning to have quite a bit of momentum, I think President Obama is really interested, and say is this the next wave of the early intervention to integrate the fathers into this whole thing and what are your thoughts about that. Also, do we have – what kind of data do we have to show that this is important?

SPEAKER: I've got two quick comments on that; one, I am involved in the fragile family study, so I spend a lot of time looking at that data. One thing that's starting to come out from that data is that what may matter more or equally, I'm actually about to say more I think, we'll see

what Sarah McClanahan or – and I are doing a book, so we'll see where we come out when we've done all our analysis.

But it's looking like the instability of couple relationships may matter more than whether you're a cohab or you're not cohabitating, if you're a single parent, and in some cases you're very unstable cohabitating partnership. So there's a stability issue, and that becomes really hard to address, that's my second point, if you're doing an intervention. I'm thinking now of early Head Start, and you're working with a family, because if you do have perhaps, and in some cases an unstable situation, so the father is leaving, I mean in fragile family, the cohabs, I think by age five, half of the cohabitating families are no longer cohabitating.

But they're now – how many partners changes there are. But there are a lot that seems to have a very negative effect on kids, and to me, these new findings are explaining what we found in early Head Start, which was the majority of the 17 programs that were evaluated, the original 17, had a fathering component in them, and we tried to measure what was going on in those programs and then to get some fathering outcomes, right, in the evaluation.

There is separate – there's a subgroup of the early Head Start people looking at it. What I found amazing was how hard it was for

the programs to engage the fathers. Whenever you'd go on the site visits to see what was happening, it was just so difficult, and it really makes me think – and I think – the 17 sites would say this, we need to think about different ways to engage the dads because the typical ways we tried in many cases weren't working, or you'd only get a very small sub sample of dads who would come, that was the other thing that the staff would tell us, right, you'd get this little group, but in terms of reaching all the dads of the early Head Start family, we didn't do a very good job. So it's a huge issue to figure out what to do is my kind of bottom line.

MS. SAWHILL: I think we can't solve it today, and we're running out of time. I want to make sure that – whether there's anybody else on the panel who wants to make one final very brief comment, and if there is, you may. I don't see any –

SPEAKER: I'm going to take that, if I may.

MS. SAWHILL: Okay.

SPEAKER: The involvement of fathers has been one of the strategies that the Nurse Family Partnership has used from the very beginning of the – trial. And there's evidence of having to share it with this group from the various trials about increases in cohabitation, stability of partner relationships, and this data have been published. So I agree that we need to do a lot more in this area, and the changes that we see are not

enough just for our – what all of us in this room would want to accomplish, but it gives me some hope that we can make some incremental change in the right direction in terms of involving fathers.

And the related piece to this is that sometimes – making decisions about to disassociate themselves from men who are really dangerous, who are abusive, who are involved in criminal activities, and they're making the decisions to disengage from these guys because they see that this is not good for themselves or for their children, so it's a complex issue.

MS. SAWHILL: Join me in thanking this terrific panel. And Ron wants to make an announcement or two.

MR. HASKINS: Before you leave, I just want to make a brief announcement about our next event. On October 27th, I want you to know that Belle and I lost a lot of sleep and sacrificed our health and almost endangered our friendship to co-author a book called Creating an Opportunity Society, it's available on Amazon for $19, worth at least $20.

We're going to have an event in this room, E.J. Dionne is going to moderate, Juan Williams, David Brooks and Linda Gibbs from New York City are going to be here, so we look forward to seeing all of you on October 27th. Thank you.

* * * * *

CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

/s/Carleton J. Anderson, III

Notary Public in and for the Commonwealth of Virginia

Commission No. 351998

Expires: November 30, 2012