THE BROOKINGS INSTITUTION

PREVENTING CHILD ABUSE IN AN AGE OF BUDGET DEFICITS

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P R O C E E D I N G S

MR. HASKINS: My name is Ron Haskins. I'm a senior fellow here at Brookings along with Belle Sawhill.

Together we run the Center on Children and Families and we often sponsor events like this, so we're glad that you're here.

We also have an online audience. I don't think we've ever done this before, but we probably have at least a million people on line who are listening to this event, and there's a way that they can as questions. So for those of you online who can hear me in Spokane or wherever you happen to be, we will welcome your questions. And we have Reza or someone, if you see someone, running up here during the event, it's because they're bringing questions to me that the people online might want to ask.

We've also planned this event in cooperation with Voices for America's Children. It's a nonprofit organization that lobbies for children at all levels of government, and we're going to be joined online by a number of their affiliate organizations around the country. We also have received financial support from the Doris Duke Foundation; we're grateful for that.

Here's the issue that we want to explore today: Every year there are on the order of 800,000 cases of abuse and neglect in the United States that are confirmed. There are something like 3 millions reports, but there are 800,000 confirmed cases, and they lead to 1,500 deaths. I think it's useful to think of this in terms of 1,500 people in this room. I think the chairs are set up today for maybe 110. So if we filled this room 15 times, that's how many kids are killed usually by their parents, almost always by close relatives or close friends, so this is a serious issue.

And we have good evidence that abuse and neglect can be prevented or at least halted at an early stage with appropriate intervention, and we have a number of scientifically valid random assignment studies that show that, and even several analyses by different organizations, not all of the advocates, that show that these interventions are even cost beneficial in the sense that they save more money in outcomes than they cost. We're going to talk some more about this later.

Now by some measures we're in the worst recession that we've been in since the Great Depression, and so the question arises, with states and local governments cutting programs and social programs included on the blocks. A number have been cut already, child care, for example, and preschool programs have been cut in some states. So the question to policymakers is, if you cut these programs on abuse and neglect, would it cost you more money in the long run? Is it -- in other words, is it foolish in benefit-cost terms to cut these programs? And that's what we want to explore today: the consequences of cutting these programs both in benefit-cost terms and in -- more in human terms.

So let me give you a quick overview of the event. I'm going to introduce speakers, then we're going to have an overview of the future children volume that goes in some detail to prevention from a number of different angles, including this cost-benefit thing I told you about by Chris Paxson.

Then we're going to have an opening statement by each of the speakers, and then I'm going to ask them some questions, and we're going to call that part of the show "Stump The Panel." And then we're going to give a chance for the audience to ask questions, and we will also take some questions from the online audience.

You have biographical materials of all the speakers, so here at Brookings

we specialize in very brief introductions. So now in the next eight seconds I'm going to introduce four speakers.

First Chris Paxson, my good friend, who's the dean of the Woodrow Wilson School at Princeton now for the last year, and a senior editor of *Future of Children*, and a widely noted scholar of health services in her own right.

Then David Olds, who's a professor of pediatrics at the University of Colorado. He's the inventor of the Nurse/Family Partnership Program, widely known; probably everybody, you know, already knows David. I would say it's a fair claim that David has had more influence on public policy, now that we have Obama starting a nurse visiting program, than any social scientist in our time, I believe. Anyway, he's had a very substantial impact on public policy.

Richard Barth, who's the dean of the School of Social Work at the University of Maryland. He certainly has to be one of the most widely published scholars of child protection in the country. Whenever I have a question on child protection, I pick up the phone and I call Rick Barth.

And then we're very fortunate to be joined by Darrell Armstrong, who's the pastor of the Shiloh Baptist Church in Trenton, New Jersey. He's also the director of the Division of Prevention and Community Partnerships for the New Jersey Department of Children and Families. And in that regard he's responsible for developing a statewide plan to prevent maltreatment, so obviously directly on our subject.

And then Mary Coogan, who's a lawyer. This is D.C., after all. What kind of panel would you have without having at least one lawyer on it?

We don't have an -- oh, yes, we do have an economist, we even have a -- so we're all set. We have a lawyer and an economist, we're all set.

So Mary Coogan, a lawyer, is the assistant director of the Association for Children of New Jersey, and she runs most importantly for our purposes, the Children's Legal Resource Center there, so she's one of the leading experts in New Jersey and perhaps the country on legal issues having to do with families, including child protection.

So we will begin with Chris Paxson.

MS. PAXSON: Hey, thank you, Ron, and thank the panelists for coming. It's really great to see all of you.

I would like to start with an overview of the volume on *The Future of Children Journal* on preventing child abuse. It's outside, and for people who are on the web, you can go on our website. It's *Future of Children*, pretty easy to find, and there's a full volume that covers these topics. And I'll tell you a little bit about what we did and some of the key findings, and then turn it over to the panelists who will focus on the more specific issue that Ron outlined.

Just to give you a little bit of background, *The Future of Children Journal* is a joint venture between Princeton and Brookings. We look at lots of different topics -- social issues, education issues, health issues -- and what we're really trying to do is to promote effective policies and programs for children by informing policymakers, practitioners, other researchers, the medias, with really the best evidence that we have out there on any given issue of importance to children.

So the volume that we've produced for, on to help maltreatment prevention, is no exception. It has a collection of really super articles that look at a bunch of different topics, a great lineup of authors, and I would encourage you to take a look at it.

The panel today represents both research and practice, and it's going to

have this specific focus which is how we should think about maltreatment in the age of economic austerity currently, and also probably going forward, unfortunately.

Now let's talk a little bit about the problem of child maltreatment. Some of the statistics that I was going to say Ron already said, but I think they're actually worth highlighting, which is this is a big problem. Child maltreatment is distressingly common. More than 1 in 100 children are substantiated for child maltreatment each year. People think that that's probably a lower bound and that a lot of kids who are maltreated are not substantiated. And, as Ron say, it's ruled to be the cause of death for about 1,500 children a year. Fifteen hundred child deaths per year.

The other thing that I think that's important to know and will be very salient for the discussion that comes later is that child maltreatment imposes large costs on society. Now, it's hard to sort of total up all of the costs across the entire country because a lot of this is done at the state level, the local level; it's hard to get good numbers.

But the best estimates that we came up with in *The Journal* are that child welfare agencies spend about $25 billion dollars per year. That includes the cost of foster care. And then if you add in costs for hospitalization, mental health care, law enforcement, you come up to a total of about $33 billion a year. Now those are the direct costs of dealing with maltreatment in real time.

Now, the other thing that I think is probably equally, if not more, important is that child maltreatment has substantial long-term adverse consequences for children, and these may add further to the costs of child maltreatment, the social costs of child maltreatment. So there's a range of evidence -- and I'm sure many of you are familiar with it -- the documents, the relationship of child maltreatment to later mental

health problems, social problems, behavioral problems, involvement with juvenile justice systems, things like that that happen down the road for children who are maltreated. And, like I said, none of these are in the $33 billion, but they're clearing very important social costs.

The other issue that I think is very important to stress, especially in economic times like these, is that child maltreatment is countercyclical. This is something that I've done research on myself with a colleague, Jane Waldfogel, where we looked at states and looked at whether substantiated cases of maltreatment rises, family incomes rise and fall, you know, how they vary with the business cycle. And there's pretty clear evidence that states become poorer, child maltreatment cases rise.

There are a number of possible reasons for this. One is that families are under more financial stress, parents who are unemployed are home with children, which is usually good thing, but if you're really stressed that may not be such a good thing. And so during recessions, I think we worry more about child maltreatment than we might otherwise do.

The other thing that cuts into this is that, as we all know, during tough economic times state revenues -- and states are largely paying for the costs of preventing and responding to child maltreatment -- state revenues are really tight, and their budgets rise and fall with the macroeconomic cycle just in a way that makes it, you know, the least possible to pay for dealing with child maltreatment at time when it's likely to be worse.

So these are the kind of issues I think that really highlight the importance of prevention, because if you have good prevention programs in place, then when you hit the next recession, maybe rates won't rise as much; maybe you won't have to spend as much dealing with the consequences of maltreatment if you can avoid some cases to

begin with.

Now what we do in this volume, we focus really on primary prevention, which is stopping maltreatment before it happens. It turns out that a lot of the programs that are good for primary maltreatment prevention are also good for secondary prevention, which is preventing the recurrence of maltreatment. But again, we really wanted to focus in on primary prevention. The volume looks at a wide range of initiatives, community-wide initiatives, parenting programs, home visiting programs, programs that deal with parents who have substance abuse problems, and also the issue of sexual abuse as well as the role of the child protective service system in child maltreatment.

Just to give you a couple big picture things that we focus on in the volume, one is we focus a lot on the effectiveness of prevention methods, really looking at the data, looking at the scientific evidence to see what works and what doesn't work. And this is actually very important, especially in tight economic times. You really want to pay attention to effectiveness.

A lot of evidence in *The Journal* comes from what we think of as the gold standard, which is randomized design assessments to look at how well prevention programs work. As we'll see, and maybe we'll get into some of this in the discussion, the details of program designing implementation can actually complicate the interpretation of randomized control trials where you get seemingly similar programs sometimes producing that looks like very different results. So that while they are and remain the gold standard, it's not always the easiest types of evidence to deal with.

The other issue that I want to talk about a little bit which I think is important, and maybe won't be covered by the panelists, is the issue of targeting. There's a very good chapter in the volume by Fred Wulczyn. He's at the University of

Chicago, and what he does is he presents data on the incidence and distribution of maltreatment as measured by CPS cases and really takes a hard look at the risk factors, the things that we think are correlated with maltreatment that maybe put children at risk of being maltreated.

The risk factors I think are ones that most people know who were involved in this literature, research, or practice, but I'll say them anyway. The most important risk factors that he identifies are young age -- infants and one-year-olds are at the highest risk of maltreatment; poverty, which is correlated with race; single parenting, large families, families with substance abuse problems, mental illness, domestic violence. And another issue that I think that's important that may come up later is the role of child conduct problems, child conduct disorders and putting them at risk for being maltreated.

I think the upshot of this chapter really is that accurate lists assessment is really important, and we have pretty good data about what types of families and possibly what types of communities' prevention strategies might be most effective in, because the risk of child maltreatment is highest. And again in tight economic times, I think targeting programs carefully is something that we probably need to pay a lot of attention to.

Two findings that came out of *The Journal* that I'm just going to briefly touch on because I think they were important and I think to me very interesting and maybe I learned something from them that I hadn't known before and I hope the panelists touch on these, one is the problems of preventing maltreatment in families with substance abuse problems. This seems like a huge issue, and I think one of the problems that was identified is that a lot of drug treatment programs are not that effective. So -- and they take time to work.

And what this does is it poses some real problems for the prevention community because, you know, substance abuse prevention is difficult. It's often accompanied by other problems -- mental illness, homelessness, domestic violence -- and so we really have to ask ourselves some hard questions about whether, you know, at what level of substance abuse should children be removed from home? Are there things that we can do to prevent substance abusing parents from preventing children -- preventing child maltreatment even if they continue possibly to abuse substances.

I think one of the great pieces of news that came out of *The Journal* -- and again, I think this is something that we'll touch on later -- was very strong data that suggested that some community-wide prevention programs hold a lot of promise. And by community-wide prevention programs, what we mean are programs that try to blanket an entire community but target programs and services to different types of families in different ways.

So one example is the Triple-P program which has a media campaign, which is sort of low-cost and touches a lot of people, group treatment for families who are at medium levels of risk, and then individual treatment for the highest risk families. And these are programs that I think are interesting because they can incorporate the kind of parenting, home visiting programs that we'll be hearing about, and also really take this idea of targeting very seriously in a way that is something that we really have to be thinking about.

So despite the growing evidence base, there are still numerous questions about which programs are the most effective, and where we should be investing our resources. And so I am looking forward to hearing the recommendations of the members of our panel.

Thank you. (Applause)

MR. OLDS: Ron and Chris, thanks for inviting me. I'm going to be talking about the nurse-family partnership. The nurse-family partnership is a program of prenatal and infancy home visiting by nurses for, as you'll see in a moment, low-income mothers having their first babies. I think one of the ways in which the program achieves its impact is by activating what all of us as human beings have in terms of our instinctual drive to protect ourselves and our children. The program itself most fundamentally makes sense to parents, and I think that nurses are viewed by veritable families as people who bring confidence and care and respect to the service context.

The program model that the nurses follow in the conduct of this program focuses on critical features of early development that have long-lasting impacts on the children's subsequent health and development, as you'll see in a moment. We've taken a position that this kind of program ought to be tested rigorously, and by that we mean in the form of randomized control trials.

This program focuses on low income pregnant women having their first babies. And by virtue of focusing on that segment of the populations, it serves large portions of women who are teens and who are unmarried and, as you've just heard, this is a group that's at particularly high risk for maltreatment. It focuses on mothers having their first babies because those going through the transition to parenthood have a greater sense of vulnerability about what labor and delivery is going to be like, what the care of my baby is going to be like, and that makes them more receptive to offers of help and especially offers of help from nurses.

The nurses have three major goals. The first is to help women improve the outcomes of pregnancy by helping them improve their prenatal health.

The second is to help parents improve their children's subsequent health and development by helping them provide more competent care of the baby in the first two years of life.

And the third is to help parents become more economically self-sufficient by helping them develop a vision for what life might be like and then to start making wise choices for themselves about staying in school, finding work, and, most critically, planning the timing of subsequent pregnancies.

We've tested the program in three separate scientifically-controlled studies over the last three decades. The first was conducted in Elmira, New York, with a sample of 400 primarily low-income white families. We subsequently tested the program with a large sample of African Americans living in Memphis, Tennessee, and, more recently have tested the program in Denver, Colorado, with a large -- with a sample that includes a large portion of Hispanics.

In our third trial, we systematically compared the relative impact of the program when delivered by nurses versus paraprofessional visitors, people hired from the community who shared many of the social characteristics of the families that they were serving. There's a theory out there that people who share the social characteristics of the families that they serve ought to have greater impact. So we tested that question by randomly assigning families to receive comparison services, paraprofessional visitation, or nurse visitation in the third trial conducted in Denver.

This slide shows those outcomes that we have the greatest confidence the program can effect because we've seen consistent impacts when it has been -- the program has been tested with different populations living in different contexts and different points in our country's history. We are confident that we can help women

improve their prenatal health and, especially, reduce their prenatal use of tobacco and reduce the rates of pregnancy-induced hypertension.

We see significant reductions in children's injuries. Injuries are the leading cause of death among children in Western societies from age one through young adulthood. And, of course, some of those injuries are due to maltreatment. We see significant reductions in the rates of subsequent pregnancy in the first two years after delivery of the child and increases in the intervals between the births of first and second children.

This is important because it means the parents were able to focus their scarce resources on the care of the first child, and it also makes it easier for them to stay in school and find work because there are fewer challenges with child care. We see significant increases in father involvement and including stability of mothers' part relationships with partners. We see significant increases in women's participation of the work force, especially in the second year of the child's life.

In our first two trials, prior to welfare reform and when economic conditions were not unlike what we're seeing today, we see significant reductions in welfare and food stamp use, and we see significant improvements in children's academic achievement. And, in general, these findings are greatest for families where the mothers are most susceptible to the problems that we're talking about.

Here we see, for example, that the treatment control difference in the rates of state-verified reports of child abuse and neglect are greater where there is concentrated social disadvantage. In our first trial conducted in Elmira, we found that the impacts on the rates of child abuse and neglect extend over the first 15 years of the child's life, and we see a nearly 60 percent reduction in their own rates of arrest and a

very large reduction in their adjudications as persons in need of supervision.

In our Memphis replication of the study, we see significant reductions in children's injuries revealed in the medical record, and, in particular, an 80 percent treatment control difference, the number of days that children are hospitalized for injuries. This slide shows the three children who were hospitalized with injuries in the nurse-visited condition. We see that all of the children hospitalized in our Memphis trial for injuries or ingestions were 12 months of age or older, and 2 of these children were hospitalized with ingestions.

This slide with the control group is twice as large as the nurse-visited condition of the postnatal version of the trial, shows that in the control group 58 percent of the children were hospitalized with serious trauma, and 44 percent of these children are hospitalized before 6 months of age. So they were not mobile in creating risks for themselves.

We see at age six in the nurse-visited condition that the rates of -- that in the control groups the rates of behavioral and mental health problems at school entry are about three times higher in the control group than the nurse-visited condition, and that by the time the children are nine the rates of infant and childhood mortality are over four times higher in the control group than the nurse-visited condition. This effect is only a trend that the likelihood that this is due to chance is 8 percent.

Look at the nature of the deaths in the control group, though. Three of the deaths are due to prematurity, three of the deaths are due to sudden infant death syndrome, and three of the deaths are due to injury. Two of those three deaths due to injury are due to firearms in the control group. The one nurse-visited child who died, died because of a chromosomal abnormality. One of the children who died in a control group

died because of multiple congenital anomalies.

Most, more recently, we've conducted a 12-year follow-up, and there's been another death in the nurse-visited condition due to a brain tumor. By the time the children in the Memphis trial were 12 years of age, the rates of tobacco use were substantially reduced in the nurse-visited condition, and the rates of depression and anxiety were also substantially reduced. Both of those conditions are both significant predictors of later mental health disorders and violence, by the way. And there are corresponding huge costs to these early childhood problems.

We see in the Memphis trial by the time the children are 12 years of age that the cost of AFDC Medicaid and food stamps are substantially reduced over that 12-year period, so that this slide shows the cost to the intervention group and the control group expressed in $2,006. And what this amounts to is about a $12,300 cost savings, appropriately discounted, expressed in $2,006. The cost of the program in $2,006 was about $11,500. So in these budgets alone the program costs are recovered.

In the Denver trial, we see that the cost-savings, or the program impact for the nurses, is about twice as high as what we see for the paraprofessional-visited group. The Washington State Institute for Public Policy has estimated that the program returns per family about $17,000 on a per-family basis.

In recent years, we have been helping new communities around the country develop the program outside of research context, and we've thought very deeply about what it will take to develop those programs with quality so that we can have some assurance that what gets delivered in community settings is going to reproduce what we've seen in the randomized control trials.

Today the program is operating in about 380 counties, 32 states, serving

about 20,000 families per year, and with the new congressionally-passed Affordable Health Care Act, there is a provision in that legislation for evidence-based home visiting, and we think that those family partnerships is likely to leverage significant state-level investment of the program over the next few years.

So thank you very much. (Applause)

MR. BARTH: Thank you, David. That was quick, and I will have to be quick, too. It is a privilege always to come to Brookings and an opportunity -- and this opportunity to talk about parent education programs and what I call "just enough parent education campaigns" is one that I've been looking forward to, and I also look forward to your response to the ideas I preset today.

What I'm going to try to do is talk about this notion of campaigns of effective, targeted parenting education programs, use Triple-P as an example of the most important campaign, I think, that's going on around the world; talk a little bit about cost-effectiveness -- not to resolve all the issues related to cost-effectiveness and how they fit into our current economy, but to address some of them and then make the case that we need a different way to think about parent education programs to study them and to fund them.

So parent education programs and child welfare services alone, we have estimated respond to about 800,000 children who have had contact in child welfare services. They've also -- they're very much a part of the world of children's mental health services and trying to reduce conduct problems, and also to a certain extent juvenile justice system issues. And yet most of them, as much as the need is there, they do not have a strong evidence based -- David's, obviously, being an important exception.

One of the things we have to think about is, what is the likelihood of any

intervention we propose is going to actually address the risks that are there. A nice new paper that's come out has tried to, has made an effort to, compare more of an ecological model of risk that includes all kinds of social factors -- poverty, social cohesiveness, and so on -- to more of a parent-focused model of risk. And their analysis was that a more parent-focused model of risk is actually more effective -- and I'll make the case that it's more parsimonious as well, providing, therefore, a better basis for implementation in an expansion.

One thing that we certainly all have been talking about already is targeting. We've been talking about it for a long time. Cost-effectiveness is known to be improved by targeting. One of the best studies of that in the children's mental health area is something called "Fast Track," which was a multilevel community-based preventive intervention, and they did demonstrate in that program which was very much a parenting-focused although it was a school component, that they had a cost benefit, especially for the higher-risk families, not for all the families but for the higher-risk families.

And that's why I described this as a just-enough approach. You want to have a certain amount of services that meets the needs of a family but doesn't exceed them, because if you exceed them, you're less likely to achieve cost benefit. And their analysis in Fast Track was that they had provided too many services to some families.

The other thing that is very interesting about Triple-P is that it has levels in this campaign which I'll describe to you, but within those levels there's also variability, because families come in so many different ways. The things that it has in common are very important, though. Imagine a world where we had a common language to talk about parenting; where we had cross-professional and cross-agency consistency in the way they responded to parenting issues; and where we could actually show some positive

benefits at each of these levels of intervention or for the entire campaign. And although we don't have proof at every one of the levels, independently, there's growing evidence now that this overall campaign is cost-effective.

So this is sort of the way it works. I'll start at the top in this slide, and the next slide I'll go to the bottom so you get it both ways. At the highest level, you have Level 5 in Triple-P, which is for kids in families where they have the most distress and where they really need individualized attention and everything else that we currently try to provide in the best of parenting programs.

And then you work down from that, you have groups, you have primary care, which are short interventions, you have individual support groups for families that basically that don't have so many problems, and then you begin at the bottom level of this pyramid with a large media campaign.

Thinking about it from the parents' perspective, which is important to do, some parents will only participate in Triple-P as a media intervention. They'll hear slogans, they'll see media advertisements about this program. Some of them will go to a seminar, some will go to a four-lesson program that's a bit more individualized for their situation. If they're teens, or if they've been families of divorce, or they're single parents or something like that with a special needs child, some will attend a more intensive group, and some will actually have that group plus some home visiting, plus some individualized parent training.

So these are the levels. Triple-P is only one example of these campaigns. Of course they're in many other fields as well, but as the best example now replicated in four or five different countries, that is, that we have seen.

The results in the best U.S. trial, from Ron Prinz's article in *Prevention*

Science I'll flash up here, too small for you to see, so but just to prove that there is some good hard numbers there, it's actually a very interesting study where they randomize it by county. So they took some counties and they implemented the whole campaign, and they took a comparable number of counties and did not implement the campaign. And then the compared the rates on a variety of different child welfare indicators, not all child abuse but also related to foster care. And what they found is that in the Triple-P counties they had a small increase in child maltreatment cases, 8 percent absolute increase, but it was significantly smaller than in the control counties.

In terms of kids who went into out-of-home care, as an indicator of severity of maltreatment they had a 12 percent absolute reduction, whereas the control counties. had a substantial increase in the children's injuries, kids coming to the emergency room with child maltreatment injuries. They had an 18 percent absolute reduction, and there was also an increase in the comparison counties that you can see if you go back and look at those numbers.

Now what I want to do is shift gears a little bit because Triple-P was not designed as a child maltreatment prevention program; it was really designed as a conduct problem intervention. And that's really important. And what I want to do is try to make the case for the remainder of my time that these things are so overlapping that to do any real cost-effectiveness analysis you have to consider both.

One of the things we know from our national survey and child analysis well-being is that more than 40 percent of the kids who come to the attention of child welfare have conduct problems, at least according to their parents, and that the special education, mental health and related costs of these conduct problems are pretty well documented. They're actually better documented, I think, than the child abuse and

neglect cost. People have been working on it longer.

And what I would argue, then, is that as we think about these things we ought to be thinking about effective parent training and effective parent education and service programs as having pathways, three pathways, really, to reducing service costs. One of them is directly through child maltreatment reduction; one of them is directly through reduction of conduct problems; and then -- it's really four pathways -- the other are between those things. So kids who were abused have more conduct problems. Kids who have conduct problems tend to be more abused, so you really have four ways of reducing service costs if you think about this more broadly and not in just a child maltreatment framework.

So what are the costs of a campaign like this? We don't yet have a good cost study. Michael Foster did some work preliminary to the South Carolina rollout and estimated that the media campaign costs only about a dollar per child. Training service providers to use the concepts to teach this program to parents costs about $11 on a per child basis. And their rough estimates were that you only needed to move about 10 percent of kids from an unsafe situation to a safe situation to recover the costs of this kind of campaign in a single year.

Now, I would argue that he underestimated what the percentages that you need to move, but it's not too far off. The other thing that people really talk about is the short-term costs, but given what Ron charged us to think about, which is how much budget impact we have in the current year, which is the political year, one of the ways to think about that is not how much we save from kids not going onto prison or something like that over a lifetime but what are the actual service costs.

The best work, I think, on this is, is Mark Chaffin's work in Oklahoma,

where he showed that just the cost of having kids investigated, sending an investigator out, going to court, all those short-term costs were quite significant: $3,600 per child, he figured out, was the cost of just evaluating new re-abuse reports when they came in, whether they were in prevention side or in the treatment side. And the study that they did there using parent-child interaction therapy, there were many more of those reinvestigations in the control side. So that's an important way to think about cost savings.

That's sort of an errant slide. It's a good one you can look back at it, but it's not in place.

Long-term costs of child abuse we are still struggling to come up with. The volume that Chris talked about certainly has estimates overall. What we really need to do better at is looking at individual level costs, to be able to track what real kids cost in real time getting real services. There are a number of people who have worked on that problem. One reasonable estimate is that it would be somewhere around $100,000 per child, $186,000 per family, if you could prevent child maltreatment. Their estimate is -- of course, so on first estimate is a little lower than Chris's estimate. Theirs is $65 billion.

The reductions in South Carolina are not yet, as I say, evidenced. What I wanted to do is just say a little bit more about the appeal of parent education-wise. I think this is a good time for us to be working on it and moving it forward. There's a lot of discussion in the media about parent education, about parenting, and if you've seen *The Nanny* or *The Wife Swap* or *Teen Mom*, you know that this has penetrated the public's interest. And I also think that the public really understands what the impact of parenting is and poor parenting.

The last argument I'll make, and I'm out of time so I'll let you -- I'll refer

you to the slides -- is that as long as we chop up parenting education by child abuse prevention and preventing conduct problems and so on, we're not really going to advance the field adequately; we're not going to understand the costs or what the research needs are. We need to integrate that work. They've started to do that in the U.K., and I think it's something we really need to consider here as having a more singular or integrated approach to understanding parent education.

Thank you. (Applause)

REVEREND ARMSTRONG: Good morning. We are grateful -- or good afternoon, I should say. We are grateful for the opportunity to stand here with these world renowned experts with parenting training and home visiting as well as child maltreatment.

My name is Darrell Armstrong, and I bring perhaps a different focus to the conversation today's. How do we take these kinds of programs and most make them effective and applicable in the community context? You're going to hear a little bit later about some of the work that was undertaken in New Jersey in child welfare reform by my colleague Mary Coogan.

But what I would like to start my conversation off with today is to talk from the vantage point of my three years of serving as the director of the Division of Prevention and Community Partnerships. I want to correct Mr. Haskins, respectfully, and say that just as of '09 my tenure as the director of the division ended. And so I am no longer the current director of the Division of Prevention, but spent three years from 2006 to 2009 in that post, and very grateful for the opportunity to deal with large-scale public policy and implementation of child abuse prevention programs from a primary perspective.

In 2006, when Governor Corzine entered the governor's office, New Jersey was under a child -- federal child welfare consent order. It had been settled and we were negotiating a modified -- or modifying a settlement agreement between children's rights, which is effectively going around the country and engaged in legal conversation with other states around child welfare reform. In 2006, when Governor Corzine started, we were in the front-end throes of promoting a front-end public policy around child abuse prevention and trying to build a community infrastructure to make that happen.

We are grateful that three years into Governor Corzine's administration that we ended with an amazing array of community resources. What you will be hearing about a little bit later, as I mentioned, from Mary Coogan that is in your program, much of that centered around, how do we promote stronger home visiting and community-based services for families and children? Governor Corzine came into office saying that he wants to prevent child abuse and neglect. The conversation then turned to, how do you prevent child abuse and neglect? And the simple answer was by making families stronger.

The question then is, how do you make families stronger? By providing them resources that are easily, accessible in their communities long before crises situations emerge in their families. If somehow, as the old adage says, if we can go upstream and figure out why the children are in the water, then perhaps we don't have to spend as much money on the back-end down the stream trying to excavate and pull the children out of the water.

How do you make families stronger then became our mantra within the State of New Jersey, and we began a series of investigations and blueprint programs

from SAMHSA as well as evidence-based programs that were documented at the federal and state level.

In the Division of Prevention, we fielded five offices. One was the Office of Early Childhood Services; second was the Office of Family Support Services; a third was the Office of Domestic Violence Services; the fourth was the Office of School-Based Youth Services; and then the fifth was the Office of County Welfare Services. All five of those offices we sat around, my team and I sat around, all of the directors, each week in weekly staff meetings trying to not only determine what is best for early childhood service and school-based services and family support services, but then how to integrate those five offices so that we're not operating in silos.

One of the biggest issues that we heard from families in community from a survey that we conducted was accessibility to services and the isolation of those services. And so how do you begin to collocate services? How do you begin to integrate services again became a targeted approach of our work in the Division, although not amazing when you look at the amount of money New Jersey invested in child abuse preventions -- excuse me -- in child maltreatment intervention services, but the Division of Prevention had at the time of my tenure about $100 million worth of front-end primary, secondary, and some tertiary prevention services. And we began to say: How can we make those services most effective?

We were very fortunate that over those three years that amount of money that was needed -- and all of us know that when economic times are difficult, the front-end prevention programs often are the ones that re on the cutting block first. And so not only did we have a mandate to prove the effectiveness of these services but to do so in a very timely fashion. With the Office of Early Childhood Services we were quick to

grasp onto strengthening families an approach that is promulgated by the Center for the Study of Social Policies.

Some of you know Frank Farrow and Judy Langford and Jean McIntosh, and other good folk at the Center for the Study of Social Policy. Their promulgation of protective factors began. We embraced, we said we need to change the paradigm on how we think about child maltreatment not only from the risk factors, but how do you promote the positive protective factors such as parental resilience, parenting knowledge, healthy social and emotional development of children -- concrete supports in times of need as well as social connections. And we've thought about that work.

We literally took each of those five protective factors and began to match them to each of our five offices and say there's a link here, right? Childhood development and early emotional and healthy development of children, Office of Early Childhood Services; our work with concrete supports in times of need, Office of County Welfare Services; our parental resilience work are Office of Family Support Services; our parenting knowledge also linked in our Family Support Office as well as dealing with our Office of Domestic Violence Services.

So we tried to link, be very intentional about linking the protective factors to the body of work we have. We quickly only embrace the Center for the Study of Social Policies protective factor approach but also, obviously, Dr. Olds' nurse-family partnership, but also try to advance an agenda of a unified home visiting approach that included nurse-family partnership, healthy families, and parents as teachers as not coequal but each of them bringing unique attributes and contributions to the conversation around home visiting.

And then the thing that I think I and we are most proud of is the

promulgation of 40 to a statewide network of what we call family success centers. And those success centers again were one-stop shops in community that allowed families in Newark, Camden, Jersey City, Trenton, Millville, Bridgeton -- you name it -- anywhere in the 21 counties of our state to gain access to resources before their families get into need.

Primary prevention, right? No racial qualification, no economic qualification, no geographic qualification, the richest of families and the poorest of families can all access those family success centers understanding that different families have difference access to resources but no family should ever be turned away from gaining opportunities to figure out how to make families stronger.

So when I left state government, I then left -- while doing that I was also pastoring my church of about 2,000 members in the heart of Trenton, and it gave me a rich laboratory, Dr. Olds, of somehow figuring out, how do I get those lofty services, right, that are state-mandated, some state-funded, fairly endorsed, SAMHSA endorsed down to mother and father in the Shiloh Baptist Church at 340 Reverend S. Howard Woodson Way in the heart of Trenton? How do I make those services real for families? Now, not that they weren't real in the delivery of those services through social service agencies, but often the -- left out of the conversation are faith-based institutions and houses of worship that can make tremendous contributions as front-line advocates.

I then started something called the Institute for Clergy Training, believing that if I train clergy, I can help them become front-line advocates for family support and family strengthening. I then took what every church that I know of, Dr. Olds, has: every church I know has a men's ministry, a women's ministry, a children's ministry, a marriage ministry. And I began to say to the marriage -- to the men's ministry to those clergy: Link

your men's ministry with responsible fatherhood engagement programs. Link your women's ministry with maternal child health programs. Link your children's ministry also to programs that offer them access to some of the resources that we're talking about. And now I am training clergy on how to understand some of the language of those programs and better integrate them into their congregation.

A 2003 -- and I'll close on this -- a 2003 study from the Yale School of Medicine and published in the American Psychiatric Association's publication stated that African-American urban clergy are often the only mental health professionals that many in urban communities will ever access. If that is true, then what is my responsibility and our responsibility of better training those men and women of faith? Not just Christian and Baptists, not just African-American Baptists, but Jewish, Muslim Islamic, you name it across the religious spectrum. We can be better advocates for strengthening families because, after all, every Saturday and Sunday, when clergy leaders look out, they have access to families in their congregations.

So that is my new mantra, and I'm quite excited about the opportunities of making clergy home visitors and great parent trainers. (Applause)

MS. COOGAN: As I said earlier to my colleagues, I always hate to follow Reverend Armstrong.

I'm Mary Coogan, it's a pleasure to be here. I want to thank the Brookings Institute for inviting me. My main focus at the Association for Children of New Jersey is child welfare, foster care. So I look at prevention as a way that I can end my work at AC&J, because we don't want children to be in foster care because it's not a place to grow up.

New Jersey, like every other state, is facing budget deficits, and in tough

economic times we need to focus prevention dollars where they will be most effective. We need to incorporate as much of the research, some of which you've heard about already, that we can into our prevention efforts.

We need to inform the research by setting aside dollars in our grants for rigorous evaluation. We need to coordinate efforts between state departments and agencies, but also then between the government work that's being done, whether it's state level or county level, with community providers. And we need to involve more parents, giving them more of a leadership role in the process. And we need to bring in the private funders who can make up some of the shortfall when government can't provide the funding. Prevention, as Reverend Armstrong said, was part of our child welfare reform in New Jersey, and it was maintained in the modified settlement agreement. That made it easier for us compared to some other states because there was that recognition, that prevention was important, and there were going to be dollars put towards it.

Recently, New Jersey updated its State Plan on Prevention. I think there's a link to this document on the web cast page. It is located on our state web site, it's the New Jersey Child Abuse and Neglect Prevention Plan for 2010/2013. It was something Reverend Armstrong mentioned. I want to talk a little bit about some of the programs that New Jersey is implementing which we're hoping will reduce our foster care numbers.

New Jersey has in this plan set forth its goals and its principals in the way of preventative strategies that they are implementing through a community based delivery system. Government is working with community and private funders to increase the availability of evidence based prevention programs for parents. The first is home

visitation, and that is a priority in New Jersey. We do have the three main models that we're using, the nurse family partnership, healthy families and parents as teachers, and then also for those who are eligible for TANF and general assistance, there is what we call the TANF Initiative of Parents, or TIP, which is based on the healthy families model.

New Jersey was fortunate to be one of 17 grantees to get the federal funding from the Administration for Children and Families, which has allowed the state to start to build an infrastructure to implement home visitation statewide.

Part of this grant is actually going to involve piloting a standard one page prenatal screening form which will link pregnant women and their families through a central intake point to an evidence based home visitation program and then to other community services that are deemed to be needed during the pregnancy. And they have selected Johns Hopkins to conduct the statewide evaluation of the impact of that visitation initiative.

I am happy to report that those working on that evaluation have put in outcome indicators and also some cost effective indicators. So they're halfway through the process, so hopefully, in a couple of years, if funding doesn't get reduced, we'll be able to report something positive. As Reverend Armstrong said, we have the strengthening family's model in New Jersey, it is now operating in childcare centers in all of our counties, approximately 170 centers. It is through a Memorandum of Understanding between our Department of Human Services and the Child Referral Agency in each county, which now agrees to go out and train center-based staff on the strengthening families model so that when they're interacting with families, you are focused on those protective factors, but also the strengthening families changing from looking for deficits and risk to finding family strength and resiliency factors.

Those numbers are increasing. We still need to build a lot of capacity, but in Fiscal Year 2008, there were about 8,000 families who accessed this service, and by the end of Fiscal Year 2009, over 12,000 families had access to service.

On the parenting programs, you heard prior speakers talk about the other risk factors, and that question of whether -- do we have the parenting programs specifically address a risk factor like substance abuse or mental illness, or do we try to improve the parents overall skills of parenting so that that lessens the other problems. I would say in New Jersey we have several things, I guess the jury is still out in terms of effectiveness, because I don't know that they're being evaluated, but for children that have emotional and behavioral problems, we do have a whole system of behavioral health services, part of which incorporates family support organizations, and these are family run, county-based nonprofits that actually provide direct advocacy, education and information to other parents of children who have behavioral and emotional problems.

And I think that support service is invaluable to those families who access it, from what they tell me. I guess we still have to wait to see the cost effectiveness of it, but there were attempts to cut at the last budget cycle and they survived, so somebody does believe in that system.

The family success centers are alive and well in New Jersey. According to the last Monitors Report, there have been over 50,000 families who have accessed our family success centers since mid 2007. They do provide an array of services from housing and life skills to enrollment of kids who are uninsured into our public health insurance system, New Jersey Family Care. Some of the family success centers are actually located within a larger agency, a community based agency that may provide parenting skills which allows the family success center to make a direct link to the parent

to get them enrolled in a parenting program, which is helpful.

A couple of the other centers, primarily those in Newark, their staff is trained in EPIC -- Every Person Influences Children -- and they do a little bit of a different focus where the staff actually run small discussion groups for parents, where parents can discuss parenting techniques, problems that they might be having or concerns they might be having, and they're finding some success with that.

Clearly, more evaluation is needed. I think there is concern always that people remain faithful to the models. My understanding is, a lot of these programs are as good as the staff that implement them, so there's -- as there's turnover, you're always going to have ongoing training issues.

I had a discussion with Dr. Olds before in terms of making sure that people feel committed to the program and sort of have that *esprit de corps*, which sometimes is lacking in my world in the child welfare system, and I think that's important.

I guess I would just leave you with a thought in terms of people need to keep pushing for these prevention efforts even if we don't have all the evidence to show that they are cost effective yet, I think that will come in time, because I think all of us, in our guts, know that these services are helpful to families, but we do need to get practical about this in lean times, because those who are writing the checks at the government level will not be able to write those checks if we can't prove that the systems work.

Thank you.

MR. HASKINS: So thank you to the panel. Okay. While he's finishing up, I think we'll start -- same time. I want to deal with one thing first with the panelists, and I hope we can do this quickly. Several presenters mentioned, and we've gotten questions from the online audience, and also I had at least one inquiry before this event

held by e-mail from someone who's interested, and that is the idea that during recession, parents are under more pressure and, therefore, they're more likely to be violent. So domestic violence in general, but violence against children also rises during a recession. Is that true? What does the evidence say?

MS. COOGAN: Well, the evidence is actually stronger for neglect than it is for physical abuse.

MR. HASKINS: So there is evidence that during a recession, kids are more likely to be subject to neglect, but not to abuse?

MS. COOGAN: The -- I'm trying to remember the numbers, but --

MR. HASKINS: You can't prove the negative, but, I mean --

MS. COOGAN: Yeah, it's a much smaller association. Yeah.

MR. HASKINS: Do you agree with that?

MR. BARTH: I agree with that.

MR. HASKINS: Okay, good. So, as always, social science rains on the parade a little bit. Neglect is a serious problem, but it's interesting that during a recession, you know, it seems such a logical conclusion. Nonetheless, we've also made the point that the needs are huge and that the country has a huge problem with domestic violence and with abuse of children.

Now, the second question, David, I would especially like you to weigh in on this because, in some respects, you probably know as much about this as anybody, but I hope the rest of you do, too, and especially at the local level. I'm very glad that both of you came because we often sit up here and, you know, talk about broad, big studies and so forth, and we don't touch the real world, so that's what you all are supposed to bring to this thing, all right. And if you think we're full of something, you need to say it.

MS. COOGAN: Okay.

MR. HASKINS: And this is one of those questions, because you could have the best program in the world that you implement in Elmira or somewhere else, and then someone comes along and says, boy, that thing is great, we're now going to have that in 10 other cities. And now I go around and I look at those 10 cities and I say, this is the Olds -- it doesn't look at all like the one I saw.

So the question is, how can we make sure that these programs, including Triple-P -- Triple-P -- I don't think anybody actually said what that stands for, positive parenting program, Triple-P. So what can we do to make sure that these programs are effective and -- because if they're not, they're not going to be effective and then they're not going to be cost beneficial.

MR. OLDS: Yeah, I'm glad you asked that question. It's a major issue, and I think that in the case of -- partnership, what the national office has done is to invest in a series of activities that increase the likelihood that the program is going to be delivered with fidelity, the model that was tested in the original trials. First, every organization that implements the program signs a contract with the national nonprofit organization that manages the program, the expansion program that says we will adhere to 18 models of program -- elements of program fidelity to ensure that the structure at least is consistent with the model tested in the trials.

There is a lot of investment put into organizations and communities to make sure that those organizations and communities are well prepared to deliver the program well.

Each nurse goes through onsite training. There are detailed visit by visit guidelines that help nurses structure the work with the families that they serve. There is

a web-based information system in which data are entered on every visit that's completed and also on features of maternal and child health at periodic intervals that's put into a national data base with identifiers stripped, but that information is fed back to sites in the form of, if you want, fidelity reports, and that information is used to serve as a foundation for continuous quality improvement. I expect, by the way, that there will be some attenuation of the program as it gets ruled out on a large scale, it's almost inevitable, but I also believe that there is a good likelihood that there will be communities where the program actually will be conducted better than it was in the original randomized control file.

So if we do this properly, I think that, over time, we can actually improve this program, but we have to be systematic about that.

MR. HASKINS: Mary, have you ever seen in court that a judge or the opposing lawyer or anybody brought up this issue about, if you implement programs effectively at the local level?

MS. COOGAN: Once you get into court, it's been my experience that what you're looking for is a change in outcome by the parents. So the judge is not that concerned, nor is our child protective service agency, have you completed the parenting program. And a lot of parents say, I have my certificate, I completed the parenting program. They're looking, has your behavior changed? They're not saying have you completed the substance abuse program? Although it's important that you show up, they're looking to make sure your urine screens are clean. So it's -- and once you're into litigation, it's outcome based as opposed to the program base. I think with some education, people might get a little bit more savvy about referrals that they make, if they understand that you're going to get a better outcome -- the nurse family, you know, that

program versus another program that's not evidence-based.

MR. HASKINS: Right.

MR. BARTH: Ron, I just wanted to add one thing, which is that I think the work that David has done has been groundbreaking. I think some of the other major initiatives to prevent child abuse and neglect conduct problems like multisystemic therapy and long stays in foster care and so on have also really advanced this issue of fidelity management and implementation.

Implementation science is now one of the journals that's getting cited more rapidly than any other, so this is a very important growth area, but it does have significant cost implications.

It is difficult for programs to get up and running to achieve this fidelity and to maintain it with the turnover. And so, therefore, it's going to drive the cost of hiring people and retaining them up, I think, over time, although there's at least some evidence that once you do get that level of fidelity, you will be more likely to stay in your job because it's more satisfying to deliver an evidence based practice than treatment as usual.

MR. HASKINS: Another question for the local level. We talk here about benefit cost figures. I think I would kind of like to be a lawyer preparing for court in one of these situations, because I think I can build a fairly persuasive case that we have a lot of evidence, these programs actually work if they're well implemented, and that you would save money.

Some of the studies that you mention -- and by the way, all the studies we mentioned almost are referenced in the material that we've given you, so if you want to actually read the studies where these various estimates come from.

So I think you could build a pretty strong case. Has anybody ever done that? Do you hear that in court or do you hear that in your, you know, New Jersey Commission? Do people say these studies are a benefit, you know, cost beneficial? Is that a useful thing to be able to argue?

MS. COOGAN: Well, I mean, again, in court you're arguing about an individual parent, and so it's really about the outcome. But I will also -- going back to what Dean Paxson talked about, you know, substance abuse treatment, because I think courts and attorneys are frustrated with an ability or perceived inability to return children back to parents in the substance abuse area, which I guess would be secondary prevention. They got a technical assistance grant where they're actually trying to work between the child protective service agency, the courts, and the substance abuse treatment providers to really coordinate their efforts so that you don't have these missteps, where if somebody is in the detox for 30 days, that they get right to their, you know, inpatient long-term rehab and that they get to their after care, and also so that all those different entities understand each others jargon and lingo so that they know the timeframes they're up against in terms of getting the treatment.

And we might start to see some movement, because I think the research is interesting in terms of how long does a parent have to be drug-free before you can return a child. And I think you may see some arguments being made using the research and mapping, which I think would be interesting, that, you know, my child is an active participant -- my client is an active participant in this program, and all indicators are that there's going to be a positive outcome, and, therefore, their child should be returned with those protective supports in place. And I could see that argument being made.

MR. HASKINS: Darrell, how about you? Did benefit-cost and logic

influence the group that you headed?

REVEREND ARMSTRONG: It certainly does, Ron. And I would add to what Mary was saying with regards to legal engagement. There are a number of courts who will ask if our congregation and our 501(c)(3) organization that's affiliated with our congregation would do some kind of parent intervention and/or parent training.

So to be able to write in a letter back to the court to say that we have been trained in functional family therapy or multisystemic therapy, that we've had some experiences with family development credential out of University -- out of Cornell certainly gets the judge's attention and says to that judge, I see that at least what you're getting trained in has been nationally recognized and sustainable.

So I think, you know, my being able to write that in a letter back to a magistrate or to a court certainly gains his or her attention.

MR. HASKINS: And policymakers, too, I would assume that --

REVEREND ARMSTRONG: Absolutely.

MR. HASKINS: -- you know, you may -- the problem is that policymakers hear this all the time, whether it's true or not, you know, this program has been proven to be cost beneficial, so you -- there has to be some way to distinguish, you know, to separate out the weak from the -- Darrell, you brought up an issue that I'd like to have the panel talk about.

You said that there were five main offices delivering services in New Jersey bearing directly on child protection. So if you're trying to deal -- I've had experience dealing with one agency, and it was not easy. If you're dealing with five, it would seem that there are something like structural barriers in what already exists in the states to try to do something effective and efficient, which is a crucial part of benefit cost.

Are you worried about that? Are you worried about what it takes to change an administrative structure to most effectively deliver a program without all of the barriers and everything you talked about?

REVEREND ARMSTRONG: Absolutely so. There's certainly great consideration when, in 2006, the Department of Children and Families was created. So remember now, the Department of Children and Families did not exist prior to July of 2006. It was really by decree that Governor Corzine took a billion and a half dollars out of the Department of Human Services, which was the largest state department, $15 billion, so he pulled a billion and a half out, created a new department, which gave the focus on Children and Families the rightful attention that it needed. And some was arguing that it was getting lost in the $15 billion monstrosity of bureaucracy.

Now, you know, there's pros and cons to having those systems in one department, but I think to say out of 19 divisions which was formerly the Department of Human Services, to carve out now 3 or 4 divisions allows for a streamlining of services.

So Child Protective Services got 150 million of that 1.5 billion, Child Behavioral Health Services got about 250 million, and then Prevention -- Division of Prevention got about a million. So every day that commissioner, then Kevin Ryan and three or four -- and since his departure have focused on how do we make these three divisions talk to each other at the state level, as well as at the ground level.

Now, fortunately, New Jersey is not a county-based system, it's a state unified system that allows for conversations and I think certain implementation strategies that emanate out of the Governor's Office and into our local Department of Children and Families. So the five offices that were housed in the Division of Prevention, we were talking to make sure that our programs were talking.

So if I had a -- services program that was running a parent linking program for keeping girls in high school who have had pregnancies, how do I then have that program talk to my Maternal Child Health program and my Nurse Family Partnership program? If we were doing that within the Division of Prevention, we can then better do it around the table of DYFS or our CPS system, as well as our Child Behavioral Health system.

So I mean every system of government I think has to wrestle with systems integration. I think we did it well, not great, but well in New Jersey and we got off to a great start.

MR. HASKINS: Three is better than 15, right?

REVEREND ARMSTRONG: That's right.

MR. HASKINS: David, Darrell has argued -- he didn't talk much about whether it was successful, but I assume by the fact that he brought it up, that it might have been, that ministers could play a real role here, and it immediately brought to my mind your experience with ministers or professionals, but from the perspective of child protection work, they could be considered paraprofessionals, and your experience with paraprofessionals is not necessarily great. Are you worried about -- what would you think about having ministers play a big role in implementing programs for abused and neglected kids?

MR. OLDS: Well, first of all, I think that -- I love this idea of getting the faith-based community involved in this kind of work. I think that the faith community can play a huge role in both raising the issues in communities, helping with educating communities about the available services that are out there, and I think the point that members of the clergy are sort of front line providers of mental health services in

communities is really important.

I know that our nurses will try to understand the religious needs and interest of the families that they serve and will make referrals to ministers and churches and other religious organizations within their communities as part of the work that they do in making sure that family's needs are being met. So in all of those respects, I think that the faith community has a very important role to play in this.

MR. HASKINS: Yeah, go ahead, Darrell.

REVEREND ARMSTRONG: If I may, Ron, I certainly would be remiss if I didn't -- and we all didn't know that 2010, the National Zero to Three office put out their recent study on parenting norms and parenting surveys which documented heavily that parents relied on their faith communities when it came to knowledge of parenting.

And so it is I think well-documented both in recent studies. Dr. Froma Walsh, former president of the American Association of Marriage Family Therapy, former professor at the School of Social Practice and Social Work at the University of Chicago, she has really been one of the pioneers in this area to talk about the integration of faith and spirituality and mental health services such as family therapy and other such disciplines.

So I think there are great pioneers out there who are substantiating the work, but it is always a fear in folks hearts when you strike up the issue of religion, faith and spirituality, about that separation of -- and state, be it first amendment, and I respect that, but I think there's a respectful way to have this conversation that takes advantages and leverages those folk in our houses of worship, talking about social connections, what do faith institutions do, but bring folk together, talking about concrete support in times of need. It is often times intrinsic at least, families are turning to our congregation when

times are economically strained. So again, leverage those resources as partners.

MR. HASKINS: David seemed to imply this, but he didn't directly say it, so let me clarify this and see what you think of it, Darrell. I gathered from your answer that there are a bunch of roles here that churches and ministers in particular could play, but not necessarily the actual delivery of services that they would be referred to programs that are sponsored by local agencies or whatever.

MR. OLDS: Well, I think that when it comes to counseling, if you want, I don't have a good enough appreciation for the variation that might exist in the quality of spiritual counseling, but I also -- but I think that -- my guess is that if it follows the kinds of guidelines that Reverend Armstrong talks about, I think that it probably can be done really well. But I think it would be useful to know more about its impact. I think we -- I don't know that we -- I know you mentioned this Yale study, I really don't know what the evidence says about this.

MR. HASKINS: Yeah, that's a good point. So time for the audience, questions from the audience. Let me caution you first that we're more interested in fairly succinct questions than long statements, because I think most people came here to hear the panel, so with that caveat, right here in the front. Wait until the microphone -- tell us your name and --

MS. SCRIBBIN: Donna Scribbin. I just moved here from California, and, of course, we have many problems out there, too. I'm just wondering if you have seen a distinct difference from 100 years ago. I mean, is this something that television has brought on, the increase, or all the money -- all the programs created and money spent, do we see, you know, a significant difference say 100 years ago, 1910?

MR. OLDS: Donna, I'm sure that Ron can answer the 100 years

question. (Laughter)

MR. HASKINS: Yeah. Thank you, David. I could see that coming. Well, I remember when --

MS. SCRIBBIN: I mean, why is there more?

MR. HASKINS: (inaudible) 100 years ago --

MS. SCRIBBIN: If there is more abuse today, why?

MR. HASKINS: I don't think we have to -- wait, ma'am, I think this is a great question. I don't think we have to go to 100 years ago. I mean, I think even 40 years ago, certainly 50 years ago, we had virtually no federal programs, you talk that's at least $6 or $7 billion of the money. So what is the question? And did you -- we certainly have a lot more services than we had in the past.

MR. BARTH: Oh, we have much more infrastructure, more services, more detection. We have -- I think one thing we're pretty clear about now is that we have managed to decrease the amount of child sexual abuse, both reported and probably unreported, so that's a positive finding that's been gradual over the last 30 years. We've gradually changed the norms in our society that allows as much child sexual abuse as there have been. David Finkelhor's work on that is I think very striking.

It's more difficult to tell whether we've changed neglect or abuse, because we just don't have very much historic information about that. But parenting is probably much less harsh now than it was 30, 40, 50, 70 years ago in general, would be my assumption.

MR. OLDS: Certainly the National Child Abuse and Neglect Data System will document that, you know, 1993, when I was graduating from college, the official numbers were somewhere around 350,000, 400,000 kids who were in placement,

substantiated placement cases; now the number is already 800,000. So if you looked at that simple statistic, the numbers have gone up. But you also have to look at the evolution of laws of mandatory reporters and how reporting has come around federal and state laws, and so that maybe there are more numbers because there's more reports and more mandatory reporters.

So the question I think, you know, one has to look at causality and all of the other things around statistical science, but I think -- is it not true to say the numbers have certainly gone up, for what reason?

MR. BARTH: Yeah, I guess I wouldn't say that it's fair to say because there's just been such a mixture of kids. So in the '70s, brought a lot of kids in because they were beyond parental control, into foster care, for example, we don't do that as much anymore. So the reasons why you come in have changed, a lot of things have changed. It's difficult I think to get that sense. In the last few years, there certainly have been -- there's a reduced number of kids entering foster care because of severe maltreatment, I think that would be fair to say.

MR. HASKINS: If you look at the federal data that the states have to report to the federal government, if you look at the federal data, which they have organized by both the cases that get federal support, which means they're low-income families, and then total number of cases, both of those have declined. So there are fewer kids in foster care now that -- I mean, that's a little ways down the ladder, so that may not be the full answer to your question, but I think it's -- most people regard that as a good thing, that it's not good to have kids in foster care. If you can keep kids in the family, it's generally better. In fact, there are very good studies on this, right?

MR. OLDS: There are some good studies that are showing the certainly

unnecessary foster care that -- where it could have been prevented, may have negative adverse effects over time.

SPEAKER: The foster system in California just before I left, half of the homes weren't registered and half of the ones that were registered were uncredited. I mean, that just absolutely terrified me.

MR. HASKINS: Let's go back here.

MR. SANTOOLIE: Hi, my name is Chris Santoolie. I'm an administration student at Columbia and I'm working with children's rights at the moment. I had a question.

Reverend Armstrong's remarks spoke briefly about the strengthening the families approach and attempting to reach all families as necessary and be very -- sort of, excuse me, providing services to all families, and Dean Barth talked briefly about targeting services to the highest risk. And in just sort of looking at the research among prevention, it's sort of a -- it's almost scary to see how little consistency the research shows among the effectiveness of different approaches sometimes. Is there much research between -- that shows the difference between targeting and a sort of, excuse me, the targeted services approach and the strengthening families delivering services to all families or making services available to all families?

MR. BARTH: Good question. Let me try to clarify a bit of my intention in talking about targeting and then also this campaign approach. The campaign approach is at the very bottom of that pyramid, to get positive parenting messages out in a broad scale to a lot of families, to be able to do some general family strengthening, but then to have more intensive, more effective services available that builds on those same messages at the top of the pyramid. So I don't think it's inconsistent with the notion that

at the family support level, maybe the second level of that pyramid, that you would have a broad set of services that could be effected.

That said, I don't think the strengthening families program, although it's, you know, it's still emerging, has yet proven itself to be very effective. So I think we need to continue to look for these lower intensity programs, because, for the most part, they haven't demonstrated that much impact, and to continue to work on the top of the pyramid where we serve the more intensive families, and then hope that we can put all that together to have a greater overall impact, and that's what they're showing in Triple-P trials in Australia and now this first one in South Carolina.

MR. OLDS: And certainly if I can just add to that, I think it's both and not either/or. It's how do you, again, take advantage of allowing the message to be sent that any family, regardless of socioeconomic status and geographic region and so forth, have stressors and have needs for resources, but also acknowledge that some families do have better access to certain resources? And so families in Princeton versus families in Trenton, only 20 minutes away, you know, they are pockets of Princeton that clearly have real issues that are likened to greater pockets of Trenton, and yet there are other families in Princeton that certainly should not be overlooked with accessibility of resources or accessibility of services.

So it's both "and," and not "or." And I think our approach to New Jersey has tried to focus on universal primary prevention, universal accessibility, without targets, as well as the very high intensity as Dr. Barth has talked about, targeted programs.

MR. HASKINS: I think you could think of your congregation in Triple-P terms. If you're in pulpit on Sunday and you look out and there are 2,000 people there, there are several hundred, well over 1,000 that could use a little help here and there, but

they don't have a serious problem. But then there are other couples that do have a specific problem, it may be not huge, but they'd like some help with it, they'd like to go to group, they're willing to have some follow-up. And then there's some that really have serious trouble that they actually are abusing their kids or each other and they really need intense help. So, I mean, that's the concept of Triple-P, to match a level of services with the level of the problem, trying to figure out what the level of the problem is.

MR. OLDS: And the neat thing about strengthening families approach, you know, let's take parent -- for example, which is a huge piece of the model of the approach for strengthening families, it's about word of mouth being the message, the most effective purveyor of the message of access to services and social connections and allowing those parents to take a bottom up approach of really galvanizing their energy within local settings is really I think, you know, one of the wonderful things that I most appreciate about strengthening families.

And again, I think in 20 -- 32-plus states right now, this approach is really gaining true momentum and energy in addition to other approaches.

MR. HASKINS: Over here.

MS. SLAZINIK: Joan Slazinik, National Association of Social Workers.

This, you know, panel is really great, and it's great to focus on cost-effectiveness, as well as some of the innovations that have gone on in New Jersey after there were some horrendous situations for kids, so this is sort of the outgrowth. So I guess I'd really like to hear from the panel some thoughts about how we can create some of these issues without it happening to be a response to something bad happening, because I think certainly the $500 million for home visiting, evidence-based home visiting programs, including nurse-family partnerships and others, is one important step in putting

that more in a public health realm is important.

But I think part of the dilemma we have is several-fold. One is that we have a very reactionary child welfare system and we get improvements only after horrible things happen, then things kind of slip away for a while, then it gets horrible again, and then we get improvements again.

We have this combination of federal, state, and other funding that kind of funds these programs, much of which is at the state level and not exactly the money that we think is funding it. And the third piece is that we have sort of a model, like nurse-family partnerships, where there have been these randomized research programs. So we have lots of other parenting programs that every agency around the country is doing, but we haven't had the same support for research in child welfare that we have as we, you know, look at sort of some other models. So I'd be really interested to hear the panel sort of thinking about prevention, not just in terms of those kids and families, but more of a preventive approach to child welfare service delivery.

MR. HASKINS: David, are you --

MR. OLDS: I appreciate that comment. I'm -- my thought is that there's a real important place in all of this to -- for rigorous intervention development and systematic research on various types of interventions. I mean, in health, we've had -- we've made some really miraculous strides in reducing things like childhood leukemia over the last 50 or 60 years, but that was because clinicians made the decision that they were going to invest in randomized control trials or different treatment interventions for children with leukemia, and over time, the result of that has been that what's been sorted out is what works and what doesn't.

And so now what was once a lethal disease is now almost completely

curable. And so I think that poor children, vulnerable children deserve similar kinds of investment. And a lot of -- my sense of things is that -- unfortunately, is that sometimes there are really wonderful programs that are operating at community levels, sometimes the programs are not as well developed clinically and operationally, as we all in this room would like to see. So I think we need a combined effort that brings together really rigorous, thorough going intervention development with really rigorous research, and then if we do that, we can start to weave these interventions together in a system of services that will improve impact.

I think the idea of building a system is really terrific, but I think that the elements of that system have to be really clinically rigorous and they have to be tested.

MR. HASKINS: I would add to that, not to exceed the moderator's role here, but what the Obama Administration is doing now with teen pregnancy and with home visiting, even though there were certain scuffles here in Washington behind the scenes, some of them even made the paper on which -- and all that, is doing immensely more exactly in response to your question than any previous administration, namely, they are trying to identify the successful programs, make sure those are the ones that are implemented, and yet leaving money to develop new programs, and to test those programs, as well. So I think what the administration is doing is an exact response to your question. Next question, yes, right here on the edge, right there.

MR. GORMLEY: Bill Gormley from Georgetown University. A question for David Olds.

Could you tell us in more specific terms based on your Denver study what are the benefits that flow from a visit by a nurse as opposed to a paraprofessional? And also, to put that in perspective, could you give us a rough sense of the price

differential between those two kinds of visits?

MR. OLDS: Yes, thanks for that question, Bill. Two things. First of all, it's often really hard to engage vulnerable families. Given the fact that they often are living under extraordinarily stressful circumstances, they may have histories of maltreatment and harsh treatment of their own lives, it makes them sometimes distrustful of service providers, they're often on the run.

And I think that the question is, from the family's perspective, am I going to invest my time and energy in showing up for these visits, and the data from our Denver trial show that families showed up more regularly for visits with nurses than they did with paraprofessional visitors. The families visited by paraprofessionals dropped out of the program more frequently. And it's not that the paraprofessionals weren't visiting as much, they were making attempts to complete visits, the families simply didn't open the door as frequently for paraprofessionals as they did for nurses.

On top of that, nurses are able to address issues that are I think of real practical concern to pregnant women and parents of young children: What does this back pain mean? What does this discharge mean? What does -- what's labor and delivery going to be like? Am I going to be able to care for that vulnerable newborn? All of those kinds of issues that nurses are authentic providers of services for are often very difficult for paraprofessional visitors from the community to be able to address with authority.

So on top of that, it's not just a question of the family's perception of what the nurse is going to be able to deliver versus a paraprofessional visit, it's a question of whether she's actually going to be able to deliver on that implicit promise. And it's through rigorous clinical training and guidance that nurses are able to put together the

entire package of physical health, behavioral health, paying attention if the family is functioning that's crucial I think in distinguishing what the two types of services are able to provide.

MR. HASKINS: Any difference in cost?

MR. OLDS: And the difference in cost, there was a recent report that said that one of the home visiting programs that is not delivered by nurses cost about $4,000 per family in today's environment on an annual basis, the nurse family partnership costs about $4,500. And part of that is because some of the programs that are delivered have smaller caseloads in order to be able to manage the complexity of the caseloads that they're dealing with.

So there is both an offset with respect to caseload size, and in the case of the -- our Denver trial, we found that there was even greater turnover among our paraprofessional visitors than in our nurse visits, and that also increases cost.

MR. HASKINS: David, I would never be skeptical, but if I were, I might say, you mean to tell me that you pay $4,000 for a paraprofessional and $4,500 for a nurse?

MR. OLDS: No, we didn't do that, not in our Denver trial. The cost -- those are national statistics based on other home visiting programs that I --

MR. HASKINS: That's per family?

MR. OLDS: Per family. No, in our Denver trial, and I have to -- let me see if I can just ballpark this. The cost was about two-thirds in our Denver trial, because the paraprofessionals in our Denver trial had the same caseload size as our nurses did. So the difference in cost was -- total cost was -- the paraprofessional program cost about two-thirds. I can get those data to you if you really want to follow through on that.

MR. HASKINS: Two-thirds, okay. Yes, right here.

MS. HARE: I'm Isadora Hare. I'm with the Maternal and Child Health Bureau within HRSA. And this is a kind of follow-up question, because I've always been interested in the fact that your model refers specifically to nurses.

So my first question is, what is the level -- how do you define a nurse? What is the level of qualification that they require to participate in your program? Because we know there are many different levels at which nurses can function, so that's the first question.

And the second question is, I appreciate, of course, the research that you've done comparing nurses to paraprofessionals, but have you done all -- has anybody done any research that compares the services offered by nurses with services offered by other professionals?

MR. OLDS: Let me answer these two questions. The standard for the Nurse Family Partnership National Service Office in terms of nurse qualifications is that nurses need to have bachelor's preparation, okay. There will be some exceptions to that in remote rural communities where the availability of bachelor's prepared nurses is limited, but that needs to be negotiated with the national office and they need to make sure that the composition of the team is going to be such that they will -- it will be able to deliver the program well.

And the reason for that is that a bachelor's preparation helps nurses learn how to make decisions on the fly, in the field, and they have community health preparation that puts them at a fairly high level so that they're able to take advantage of the training that's offered.

There are associates degree nurses in the system of sites around the

country, and actually they're doing a reasonable job, but the real standard is bachelor's preparation.

The question about tests that compare nurses with other providers is one that I think needs to be done. In terms of our work, I've decided that there are lots of reasons why nurses are the right providers of care during pregnancy and the early months after delivery of the child for the reasons that I just indicated.

Can other service providers be equally effective or maybe even more effective than nurses as home visitors at other points in the development of the family? My guess is, yes, but we don't know the answer to that question. We haven't done the kinds of trials that will be needed to allow us to sort that out.

MR. HASKINS: David, when you answered the question about the images of having a nurse, you mentioned a lot of professional stuff, medical stuff and so forth. It occurs to me and it always occurred to me that a lot of the messages that nurses bring to the mothers are value based, almost judgmental, don't smoke, don't drink, get a job, you know, and not everybody can talk like that to a family. Do you think that the fact that they're nurses gives them kind of a standing that the families will listen to these more behavioral-based messages?

MR. OLDS: I think that given that they're nurses, they do have legitimate authority in addressing some specific issues, but I want to clarify how the nurses work with families. The way this program operates is that they really try to understand what families concerns, mother's concerns are, and to help them reflect on those concerns. Often those concerns come back to some things that are very practical, but ultimately they're concerned about their own wellbeing and health, they're concerned about their baby's wellbeing and health.

And it's through a process of education and helping families understand the consequences of their behavior and guiding them and making decisions that are going to be protective for themselves and their babies.

It's not a question of saying you ought not to do this, it's a question of helping understand their concerns and providing the kind of guidance that will lead to adaptive behavioral change, and it's that strategy for producing behavioral change that feels incredibly respectful to the families.

In England, the families spontaneously -- the program is ruled out in 50 sites in England right now, and of qualitative evaluations, families have said this is not usual health visiting. They spontaneously said this, you know, this is much more -- the nurses in this program are much more respectful to me, and that respect I think is crucial in defining why the -- helping to explain why the nurses were effective.

MR. HASKINS: Last question, in the back.

MS. BARBER: Good afternoon. I'm Asia Barber from Michigan State University, a grad student there and working at Voices for America's Children on internship.

Giving the fact that families of color are disproportionately represented in the child welfare system, I'm wondering what these programs at the state level and some of the other programs that have been identified today are doing to address reducing the disproportionate representation of families of color in the system.

MR. HASKINS: (inaudible) stump the panel.

MR. OLDS: I'll wade into this. You know, I think --

MR. HASKINS: Careful.

MR. OLDS: I think to the extent that we focus on -- unfortunately,

families of color are more likely to be living in poverty. And to the extent that we are able to improve family functioning in poverty in general, it means that there is likely to be a reduction in the proportion of children of color who end up in, let's say, child welfare or any other system of services that none of us would like to see children in.

MR. BARTH: I would just add to that that I do think there's at least some evidence that African-American mothers use more harsh parenting techniques, as they self-report those techniques, not as other people report them, but if you ask them, which was done in the National Survey of Child and Adolescent Wellbeing. And there's a very nice monograph on that by Trish Cole on the Casey Race Alliance website, when they talk about good parenting, they use harsher techniques, and they're not afraid to say that, that's something they're comfortable with saying.

But it also means that their parenting is sometimes getting them closer to the line that we call child abuse and neglect. So insofar as any of these parenting programs provide clear, sensible alternatives, something that is culturally syntonic, but is farther back from that line, and it's effective, and that they find out that they can enjoy and be successful at, then it's helpful.

MR. HASKINS: Mary.

MS. COOGAN: I would just add, I guess, again, it's probably more at the secondary level of prevention. I know in New Jersey, the whole issue of disproportionality is a big one; I think it is in a lot of other states. And I know our Administrative Director of the Courts, Judge Grant, this has been a focus of his for a while. Some of the things, what they're doing in terms of training, people kind of doing self-assessments of the decision-makers who are involved in this process once kids come into care, but I also know at a national level, a lot of states have model courts. And

there's a movement to start using decision-making tools, and they're calling them benchmark cards, that they've been thinking about introducing in testing to see if, when kids are coming into care, if some of the decisions that there isn't an institutional bias built into the system, that we need to reevaluate how we make those decisions.

I also know our child protective service agency is looking at this trying to get a handle on the numbers, because even though we've had a tremendous reduction in the number of kids who are in foster care, we still have an over representation of children in color.

So we've been trying to push for kinship care placements, kinship in the guardianship to get the kids out of care. It's not, again, at the primary prevention, but I think there -- I know in New Jersey, in some other national groups, they're trying to at least move the kids out of care once they come in.

MR. HASKINS: Do you want to add something?

SPEAKER: I do, and this is certainly -- given long thought to, you know, why is it the concentration of poverty in a state like New Jersey is where it is, in the court urban areas of Newark, and Trenton, and Camden, and where resources are becoming more and more scarce?

And I think it -- at the highest level, it must be approached with an ecological approach to say, right, are we concentrating poverty by moving jobs to certain places, but not providing transportation opportunities to get to those jobs for families that live in (inaudible)? Housing stock, employment opportunities, as well as issues of public safety all complicate and compromise family wellbeing, and how -- the environment in which children are being raised?

So do we have high stressors in places like Newark and Trenton? I

would think we do, and I think that can be certainly well-documented. And are those stressors causing more abuse and disintegration and lack of family functioning, healthy family functioning? Absolutely, they are.

And so, you know -- and yet just a single approach on issues of child protection and child welfare isn't going to increase and strengthen family functioning when it comes to public safety issues, housing issues, educational issues, medical issues. It must be a total approach from an ecological approach as to what's causing family decay in family functioning. And I think until we get to that point where we are literally integrating all these approaches and systems, we're going to continue to operate in a silo.

MR. HASKINS: Please join me in thanking the panel. (Applause)

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