The Future of Children
PRINCETON-BROOKINGS

POLICY BRIEF SPRING 2019

Achieving Broad-Scale Impacts for Social Programs

Ron Haskins, Kenneth A. Dodge, and Deborah Daro

To make a serious dent in the nation's social and health problems, the child welfare system—and others—must develop strategies that have broad impact on people and contexts. That is, they must seek to make a difference at the level of entire populations, rather than targeting only the individuals and families at highest risk. In this brief, Ron Haskins, Kenneth A. Dodge, and Deborah Daro call for a system of psychosocial care for young families, akin to the existing health care system, in which well-baby visits are universal and spaced out across the early lifespan, not triggered by an illness or medical diagnosis. As an example of what such a strategy could accomplish, they highlight the Family Connects program, designed at Duke University and first implemented in Durham, NC. Family Connects aims to reach every family with a newborn child in a given community through a system that combines *home visiting* by trained nurses; *community alignment* through a directory of services to connect families to the resources they need; and *data and monitoring* through an electronic data system that acts as a family-specific psychosocial and educational record. After experimental trials showing that Family Connects could achieve impressive results with a broad array of families—and, crucially, that the results could be replicated—the program is now in place or in development at 16 sites in the United States.

Ron Haskins is the Cabot Family Chair in economic studies and co-director of the Center on Children and Families at the Brookings Institution. Kenneth A. Dodge is the Pritzker Professor of Public Policy and a professor of psychology and neuroscience at Duke University. Deborah Daro is a senior research fellow at Chapin Hall at the University of Chicago.

How do we reduce child maltreatment, poor health outcomes, and other problems among all children? This policy brief accompanies the Spring 2019 issue of *Future of Children*, which explores universal social programs designed to serve entire communities as they move toward achieving population impact in reducing child maltreatment, strengthening parental capacity, and improving infant health and development. This issue heralds a policy shift away from responding to abuse and neglect (through such steps as emergency placement) only after children have been reported to child welfare officials. The seven articles in the issue focus primarily but not exclusively on home visiting, and they describe programs that serve hundreds or in some cases thousands of children and

families with the aim of achieving large-scale impact in reducing child maltreatment and promoting development.

To make a serious dent in the nation's social and health problems, the child welfare system—and most other areas of social intervention, such as preschool education, children's health, and juvenile delinquency prevention—must develop strategies that have broad impact on people and contexts. Though some researchers and program designers assert that we've already developed such programs, this claim is premature. Nor have scientific leaders who study social programs fully embraced the move toward population impact. In fact, in the past 10 years, as scientists scrambled to identify genetic and neuroscientific mechanisms for disorders, the proportion of NIH-funded projects with the words "public" or "population" in the title has declined by 90 percent.

The recent Mother and Infant Home Visiting Program Evaluation (MIHOPE), which studied four nationally renowned targeted home-visiting programs, reminds us once again that it's hard to take evidence-based programs to scale while maintaining consistently high quality. Its findings underscore the need for new thinking about how to configure the network of prevention services. Among families in the MIHOPE study, the impact on an array of outcomes was modest. To the surprise of many, few of either the treatment-group or control-group families were ever reported to child welfare agencies, suggesting that these programs aren't reaching families with a high probability of entering the child welfare system. Either the eligibility criteria aren't targeting the right risk factors, or high-risk families are opting not to participate in these voluntary programs.

In contrast, several programs described in the *Future of Children* offer models that come close to universal reach. To manage costs, they rapidly evaluate families so that expensive interventions are delivered to a smaller group, within the context of universal care. This strategy might be called a system of psychosocial care for young families, akin to the existing health care system, in which well-baby visits are universal and spaced out across the early lifespan, not triggered by an illness or medical diagnosis. Well-baby visits encompass preventive interventions (such as immunizations and tips for parents), screenings for undetected problems (like genetic disorders and growth delays), and referrals to specialists. A system of well-baby health care is thought to promote healthy development and prevent illness and death. It's so valued that health insurers pay for it readily and encourage families to participate. The models offered in this issue of *Future of Children* move us toward such a universal system for psychosocial care.

As one example, the Welcome Baby program in Los Angeles County offers families as many as nine contacts, from pregnancy through an infant's ninth month. Welcome Baby has served more than 59,000 families to date, and the county is working to expand it to reach all families. At the same time, leaders are encouraging systemic change among county and private providers. A second example is the First Born Program in New Mexico, an effort to bring universal home visiting to all first-time parents in many communities. Pregnant women enrolled in the program may receive up to 40 home visits over their babies' first year of life, with additional services continuing as needed until the child's third birthday. First Born also works to improve links across local support services and to strengthen the community safety net for all parents. Although evaluations of Welcome Baby, First Born, and other programs reviewed in *Future of Children*, such as Triple P and Healthy Steps, have produced mixed results, the models are promising; these programs are being refined and improved as they expand.

Among the programs reviewed in the issue, the one that comes closest to showing a broad impact on communities is Family Connects, designed by Kenneth Dodge and his team at Duke University. First implemented in Durham, NC, Family Connects aims to reach every family with a newborn child in a given community. After families are identified in the birthing hospital, the program and its purpose are explained to the mothers (and their partners, if present) and an appointment is scheduled to visit the family at home in the first few weeks of the child's life. The home interview, which lasts one and a half to two hours, is conducted by a trained nurse who uses a protocol to determine whether the family has special needs in 12 key areas; these include substance use, child care, the parent-infant relationship, maternal depression, and infant

health. Each area is scored from 1 to 4 on a scale of increasing risk calling for increasing levels of intervention.

The same nurse then works with the family to get them the community services they need. This is a vital part of the Family Connects approach: connecting parents and their babies with community agencies. It's assumed that nearly every community has multiple agencies offering help to families with various levels of need, often at reduced cost or even free, depending on circumstances. Part of the genius of Family Connects is to align community agencies through an annotated and constantly updated electronic directory of services that support young families. Durham's directory lists more than 400 agencies, including high-quality, evidence-based programs such as long-term home visiting; government and professional services like food stamps and Medicaid; and unregulated resources such as faith-based programs and food pantries. After helping to connect families with these resources, the home-visiting nurse follows up to encourage them to keep participating.

An important part of the Family Connects model is its sophisticated system of electronic record keeping. A family case record, created from birth reports, documents the nurse's clinical interviews, screening instrument responses, scoring of risk, referrals to community agencies, programs in which the parents participated, and the parent's satisfaction with services as indicated in follow-up calls. By integrating information, the case records guide decision-making about treatment and help the nurse match family needs with interventions in the community. They include information about whether the family entered the intervention and made progress. And if parents agree, the information can be shared with the infant's pediatrician. The file thus serves as a psychosocial health record, much like electronic health records in the health care system.

Community leaders also use the information to map population-level family needs, assets, and gaps in service. With identifying information removed, the files are aggregated and used to judge population-level indicators of family needs, and the directory of services is used to map community assets that respond to those needs. Leaders can compare the two to identify gaps and redundancies in services, allowing them to deploy community resources efficiently. They also use this population-level information to determine how successfully the interventions deal with the family problems identified.

Researchers generally agree that effective implementation is one key to creating programs that can be replicated. The Dodge team used three measures to determine whether Family Connects could be implemented at scale while maintaining quality: penetration rate (the percentage of families with newborns that were recruited and successfully completed the program); fidelity of implementation (the portion of families for whom quantitative scores were completed while the nurses adhered to the protocol); and connection rates (the share of families for which an external agency connection was proposed and successfully established). About 80 percent of the approximately 2,300 families offered the program in Durham agreed to participate; 86 percent of these families completed the program, including receiving referrals. Independent quality-control experts accompanied nurses on 116 home visits to obtain measures of fidelity of implementation. They documented whether nurses correctly completed each of the 62 model elements, finding that the nurses adhered to 84 percent of the elements. In addition, 94 percent of families were scored as having one or more needs that merited intervention. Program staff called families a month after completing the program to find out whether they'd successfully made a community connection. Of the families contacted, 79 percent reported that they'd followed through to establish a connection. And 99 percent of families said they would recommend Family Connects to a new mother.

Of course, the Family Connects program would be cast into doubt if it failed to produce impacts on parents and babies. The team evaluated impact by comparing outcomes for families randomly assigned to receive Family Connects with families assigned as controls. The following measures were used to determine whether the program was producing impacts:

- *Connectedness.* Six months after the birth, mothers in the intervention group reported 16 percent more community

connections than mothers in the control group.

- *Parenting and parental mental health.* Mothers in the intervention group reported more positive parenting behaviors and higher-quality father-infant relationships than did control group mothers. Mothers in the intervention group were 28 percent less likely to exhibit signs of clinical anxiety.

- *Infant health and wellbeing.* Mothers in the intervention group reported 35 percent fewer serious infant injuries or illnesses that required emergency department care or hospitalization. Records from the two community hospitals in which the babies were born showed that infants in the intervention group had 59 percent fewer emergency medical episodes from birth to six months of age than did control infants; between six and 12 months, intervention infants had 31 percent fewer medical episodes.

- *Outcomes at five years.* The team collected data on involvement with the Child Protective Services Department over the first five years of the children's lives. After adjusting for several factors, they found a 39 percent reduction in the rate of child protective service investigations for suspected abuse or neglect among families in the intervention group.

To test whether the Family Connects program could be replicated, the Dodge team conducted it a second time, again in Durham. This replication involved slightly fewer parents and babies but produced similar results with regard to both the implementation and impact measures. The team also conducted a benefit-cost analysis, finding that every dollar invested in Family Connects saved a little more than $3 in spending on other intervention programs. Further analysis showed that in cities of similar size to Durham, with about 3,200 births a year, an annual program investment of $2.2 million would produce community health care savings of around $7 million in the first two years of children's lives. Thus Family Connects passed the first major test on the route to becoming an evidence-based program with a wide reach. The two Durham trials showed that it could achieve impressive results with a broad array of families, and that the results could be replicated—a step that's often a major problem with programs shown by a single study to produce impacts. The research also demonstrated that few new parents will refuse help with navigating the complex needs of caring for a newborn.

After the replication study, the Family Connects team began working with several foundations on a plan to offer the program to communities across the nation. As of early 2019, Family Connects is operating in various stages of development in 16 jurisdictions, and still expanding.

What key steps were undertaken to expand the program? To date, the Family Connects national office hasn't actively marketed the program. Instead, it responds to inquiries from communities and states across the country. Family Connects has three missions: to disseminate the program to diverse communities; to innovate and evaluate implementation and impact in those communities; and to help guide policy when it comes to emerging systems, financing, and ways to improve universal programs. Although the idea of a universal system of psychosocial care makes sense, Family Connects is still young and surely needs further replication and improvement.

When approached by a community, the team's response has usually followed three stages. The first stage, offered for free and funded through philanthropy, involves consulting with the site to describe the program, understand the local context, evaluate prospects for community support and funding, and determine whether there's a good fit between the program and the community. In some cases, the community doesn't wish to commit to the requirements of implementing an evidence-based program (for example, the site might not want to adhere to quality standards, funding levels, or population-wide reach). In other cases, the community prefers a more targeted approach that focuses only on high-risk or low-income families. The commitment to employing nurses is essential because of their favorable public reputation; community leaders must evaluate whether they share that vision. Finally, the community must determine whether it has the

funding to implement and sustain the program. It does little good to start a program but drop it within a few years for lack of money.

If the decision leans toward implementing Family Connects, the next stage is a planning period, often funded by a small grant from philanthropy or the community. The rollout plan might begin with a small number of hospitals or staff members and grow slowly, which helps ensure high-quality hiring and training, and allows financing and community confidence levels to develop over time. A budget and a financing plan are devised. Almost every community implementing Family Connects combines funding from more than one source, including local tax dollars; state grants; federal Medicaid and Maternal, Infant, and Early Childhood Home Visiting program funds; philanthropy; for-profit health care entities; and even private health insurance.

At every site, evaluation plans are discussed with the Family Connects team and then put into place. Electronic records should, at the very least, enable the site to evaluate implementation penetration, reach, quality, and success in achieving the goal of connecting families with community resources. Some communities might wish to evaluate impact through a new randomized trial; others might innovate by adding a modular component that addresses a local issue (such as early literacy, adverse childhood experiences, social determinants of health, or preventing physical punishment). In cases of innovation, a plan is developed to rigorously evaluate impact. All sites develop a community relations plan to market the program in a clear and accurate way.

The third stage is an implementation contract in which the site commits resources to start the program and establishes a contract with the Family Connects national team for training and supervision of the three components (nurse home visiting, community agency alignment, and data systems). The national team also mentors the local director in community relations, quality control, and plans for sustaining the program.

This typical staged plan evolves as a community raises new issues, as funding sources and levels change, and as the policy landscape shifts. Because Family Connects is a public health system of universal reach, brief intervention, and connection to longer-term community resources that include more-intensive home-visiting programs, the program must be understood as a way to facilitate the mission and reach of other evidence-based programs, rather than to compete for limited resources.

The brief history of early home-visiting programs in the United States has shown remarkable collaboration among evidence-based programs, with occasional competition for resources. If we're to move forward, program developers, scholars, and policy leaders must all work together to focus on the broader mission of supporting evidence-based population impact on children and families rather than simply seeking program-specific goals.

Additional Reading

Karen Appleyard et al. "Preventing Early Child Maltreatment: Implications from a Longitudinal Study of Maternal Abuse History, Substance Use Problems, and Offspring Victimization." *Prevention Science* 12 (2011): 139–49. https://doi.org/10.1007/s11121-010-0193-2.

Ronald Bayer and Sandro Galea. "Public Health in the Precision-Medicine Era." *New England Journal of Medicine* 373 (2015): 499–501. https://doi.org/10.1056/NEJMp1506241.

Deborah Daro and Kenneth A. Dodge. "Creating Community Responsibility for Child Protection: Possibilities and Challenges." *Future of Children* 19, no. 2 (2009): 67–93.

Kenneth A. Dodge et al. "Toward Population Impact from Home Visiting." *Zero to Three* 33 (2013): 17–23.

Diana Epstein and Jacob Alex Klerman. "When Is a Program Ready for Rigorous Impact Evaluation? The Role of a Falsifiable Logic Model." *Evaluation Review* 36 (2012): 375–401. https://doi.org/10.1177/0193841X12474275.

Family Connects, http://www.familyconnects.org/evidencebase.

First 5 LA, https://www.first5la.org/.

Ron Haskins and Greg Margolis. *Show Me the Evidence: Obama's Fight for Rigor and Results in Social Policy.* Washington, DC: Brookings Institution Press, 2015.

Laura and John Arnold Foundation. "How to Solve U.S. Social Problems When Most Rigorous Program Evaluations Find Disappointing Effects (Part One in a Series)." *Straight Talk on Evidence*, March 21, 2018. http://www.straighttalkonevidence.org/2018/03/21/how-to-solve-u-s-social-problems-when-most-rigorous-program-evaluations-find-disappointing-effects-part-one-in-a-series.

Charles Michalopoulos et al. *Impacts on Family Outcomes of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation.* Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, US Department of Health and Human Services, 2019. https://www.acf.hhs.gov/opre/resource/impacts-family-outcomes-evidence-based-early-childhood-home-visiting-results-mother-infant-home-visiting-program-evaluation.

Fred Wulczyn et al. *Beyond Common Sense: Child Welfare, Child Well-Being, and the Evidence for Policy Reform*. New Brunswick, NJ: Transaction, 2005.

The Future of Children
PRINCETON-BROOKINGS

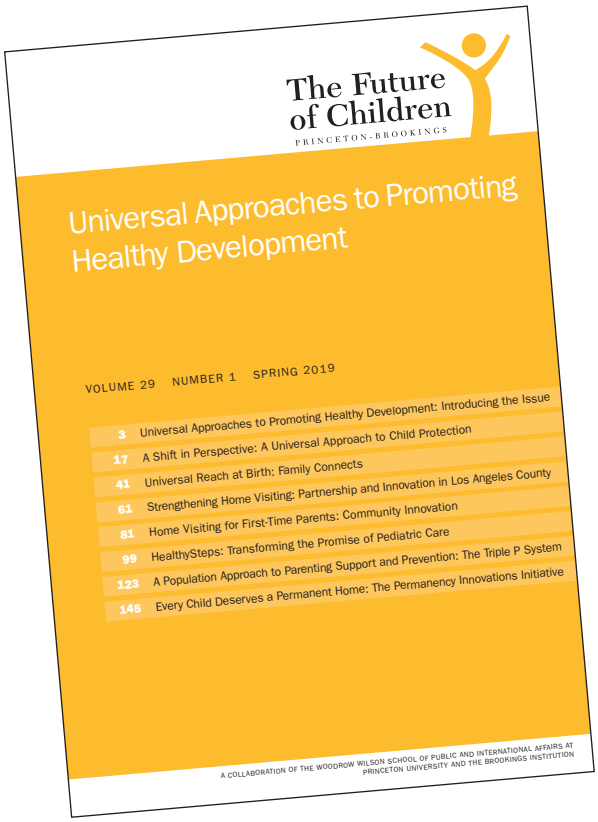
The Future of Children promotes effective policies and programs for children by providing timely, objective information based on the best available research.

The Future of Children
PRINCETON-BROOKINGS

The Future of Children
Princeton University
267 Wallace Hall
Princeton, NJ 08544

CHANGE SERVICE REQUESTED

NONPROFIT ORG.
U.S. POSTAGE
PAID
PERMIT NO. 4
HANOVER, PA



This policy brief is a companion piece to Universal Approaches to Promoting Healthy Development, *which can be found at no charge on our website, www.futureofchildren.org. While visiting the site, please sign up for our e-newsletter to be notified about our next issue,* University-Agency Partnerships to Strengthen Preschool, *as well as other projects.*

The *Future of Children* would like to thank The Duke Endowment, the Annie E. Casey Foundation, First 5 LA, and Cynthia King Vance for their generous support.