Rutgers Center for State Health Policy

Analysis of Maternal and Child Services in Trenton, New Jersey

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Executive Summary

Introduction

At the request of Children's Futures, Rutgers Center for State Health Policy interviewed state policymakers in an effort to improve early childhood programs in Trenton, New Jersey. The interviews focused on current state funding policies and priorities in four key areas:

- Improving birth outcomes, including an emphasis on substance abuse treatment for pregnant women;
- Strengthening quality of childcare for both home-based and licensed day care centers;
- Developing effective parenting education, which includes both home and center-based parenting education components; and
- Promoting paternal involvement in early childhood.

Through this project, we identified top policy priorities including: major state and federal initiates, areas of need, barriers to services, relevant demonstration projects, and the ways in which Children's Futures can inform policy to improve the health of children zero to three in Trenton, and statewide.

Methods

The Center for State Health Policy staff identified as potential respondents 41 officials (32 were interviewed) from the Department of Health and Senior Services (DHSS) and the Department of Human Services (DHS). Within these departments, we spoke with persons from various divisions and offices including the Divisions of Family Health Services, Addiction Services, Medicaid, Family Services, Youth and Family Services, and the Office of Prevention of Mental Retardation and Developmental Disabilities.

Results

Major Crosscutting Policy Issues

Although policymakers specifically addressed issues in the areas of birth outcomes, childcare, parental education, and paternal involvement, they voiced three major themes that are relevant across all four of these program areas. These themes include:

- The importance of including the community providers and clients in program design and implementation of services;
- Effective leadership and coordination of services; and
- Quality evaluation of outcomes and clear demonstration of goals and accomplishments.

Major State Policies and Initiatives

Improving Birth Outcomes

Major programs to improve birth outcomes include: Healthy Start; Black Infant, Better Survival; Healthy Mothers, Healthy Babies; Risk Reduction for Perinatal Addictions; and Planned Parenthood. Major programs for women and children are Health Start, EPSDT, Medicaid Managed Care, Newborn Biochemical screening, Lead and Asthma programs, and Prevention Oriented System for Child Health.

Suggested top priorities to improve birth outcomes in Trenton and across New Jersey over the next 3-5 years include:

- Improve general health for women of childbearing age;
- Encourage early entry into prenatal care including preconception care;
- Increasing access and use of services by immigrant population by making services more culturally and linguistically sensitive;
- Having primary care providers (including private practitioners) screen all clients for substance abuse and depression;
- Expand substance abuse treatment opportunities for pregnant women, especially residential treatment;
- Reduce racial disparity;
- Decrease vertical transmission of HIV from mom to baby;
- Prevent teen pregnancy and delay subsequent pregnancies; and
- Improve children's physical and social environment.

When asked what changes would improve birth outcomes, policy-makers and staff mentioned three general recommendations:

- Comprehensive or holistic approaches to providing care, essentially "One-stop shopping";
- Improvements in health care delivery especially regarding substance abuse and depression; and
- Quality evaluation to demonstrate the impact of services and show program leadership where and how improvements can be made.

Childcare

New Jersey has several active state and federal initiatives in the area of childcare for children 0 to 3. The majority of the funding goes to childcare subsidies with about 4% of the total money from the Child Care and Development Fund going toward improving quality childcare.

The most frequently named top priorities were:

- Staff training for both home-based and center-based providers on the
- growth and development of infants and toddlers;
- Providing health consultations and information to childcare staff;
- Providing support and technical assistance to childcare administrators;
- Increasing parental involvement in childcare selection;
- Increasing childcare workers salaries;
- Creating safe facilities; and
- Providing case management to at-risk children and families who attend childcare.

A few general recommendations made by policymakers and staff include:

- Stronger licensing regulations for center-based childcare and mandatory licensing for family day care providers; and
- Mandatory training for childcare staff in terms of child growth and development and health.

Parent Education

Many of the programs that address strengthening effective parenting provide a multitude of services in addition to parenting education. However, some key programs that provide this service include: Healthy Families, Parents As Teachers, SBYS-Teen Parenting Program, and FACES.

Policymakers and community leaders suggested several top priorities in the area of strengthening effective parenting. Specifically, they suggested:

- Providing parent education as a prevention strategy rather than intervention;
- Providing mental health services for parents and children, especially to overburdened families; and
- Addressing the unmet concrete needs of families such as housing, appropriate income, transportation etc.

Recommendations were consistent with the high priority issues and included:

- Increasing funding for programs that incorporate parent and family education; and
- Quality evaluation, particularly for prevention programs

Increasing the Involvement of Fathers

Fatherhood initiatives have begun to gain momentum in several different areas, but are still behind in terms of funding and implementation. However, a few known programs include Operations Fatherhood in Trenton, a fatherhood component in the Babyland program in Newark, and POSSE from Parents Anonymous of NJ Inc.

A number of key issues mentioned as top priorities in the next 3 to 5 years were:

- Teaching fathers co-parenting skills and involving them early on in children's lives;
- Provide work/career training to fathers; and
- Focus on the health and mental health of fathers.

General recommendations made for involving fathers programmatically include:

- Incorporating fatherhood components in such large programs as the Healthy Mothers/Healthy Babies initiative; and
- Providing education to the public on the responsibility of both parents.

Conclusion

These findings and recommendations are not really suggesting "new" ideas or initiatives, but changes that many people not only agree need to take place but are working to achieve. What can Children's Futures do to assist policymakers overcome these barriers and improve the health of children in Trenton and possibly beyond? That was our last question to policymakers. These responses underscore the broad themes detailed earlier:

- Think broader than the traditional medical model- include improvements in housing, employment, and nutrition;
- Include partners from the broader community and clients who access these services;
- Develop effective coordination at local level;

- Look at what works and what doesn't; you need quality data to change policy and even then it doesn't happen overnight;
- Provide clear outcome measures; and
- Recognize that programs don't always have immediate impact; getting results takes time, often starting prenatally and as an infant.

To obtain the greatest impact and improve current activities, policymakers and community leaders need to work together toward a common goal. As one respondent affirmed, "Policy [makers] and providers need to work together. Without funding and resources to implement programs, policy will fail."

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Introduction

At the request of Children's Futures, Rutgers Center for State Health Policy interviewed state policymakers in an effort to identify opportunities to improve early childhood programs in Trenton, New Jersey. The interviews focused on current state funding policies and priorities in four key areas:

- Improving birth outcomes, including an emphasis on substance abuse treatment for pregnant women;
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Through this project, we identified top policy priorities including: major state and federal initiatives, areas of need, barriers to services, relevant demonstration projects, and the ways in which Children's Futures can inform policy to improve the health of children from birth to three years in Trenton, and statewide.

Methods

The Center for State Health Policy staff began with a list of key policy officials to contact; during the course of our conversations, these initial respondents identified additional state policymakers and staff members who could also provide insight into these issues. We identified as potential respondents 41 officials from the Department of Health and Senior Services (DHSS) and the Department of Human Services (DHS). Within these departments, we spoke with persons from various divisions and offices including the Divisions of Family Health Services, Addiction Services, Medicaid, Family Services, Youth and Family Services, and the Office of Prevention of Mental Retardation and Developmental Disabilities.

Each potential respondent was sent a letter outlining the project and requesting his or her participation in a 30-minute telephone interview. The interview focused on identifying needs in Trenton, important barriers to care, major initiatives, funding information, and opportunities for Children's Futures to inform policymakers. While the questionnaire was designed to be used as a guide for the interview, respondents were offered the opportunity to include other issues that they considered relevant to the project's goals.

In addition to interviewing appropriate state officials, Center staff also reviewed key literature regarding relevant programs in the Trenton and Mercer County area, as well as other literature on state demonstration projects that addressed Children's Futures' four main goals.

Results

Center staff interviewed a total of 32 policymakers and staff.[1] This group consisted of a wide range of professionals including senior policymakers and program staff. The diversity of this group provided high-level views from policymakers as well as detailed perspectives from "front-line" program staff. Although the interview could be completed in 30 minutes, most respondents contributed nearly an hour to the interview. Additionally, many followed up regarding additional information and program specifics.

The results of these interviews are provided in the following sections. First, major crosscutting policy issues are detailed. Echoing the perspectives of the senior policymakers, these fundamental issues affect all four major areas and therefore should be considered in any comprehensive efforts to improve services. Second, an overview is presented of the major State and Federal initiatives. This overview includes a summary of funding mechanisms and a short description of the programs and a status on their progress. Finally, there is a discussion that focuses on the needs, barriers, and relevant policies in each target area.

Major Crosscutting Policy Issues

Although policymakers specifically addressed issues in the areas of birth outcomes, childcare, parental education, and paternal involvement, they voiced three major themes relevant across all four program areas, including:

- The importance of including the community providers and clients in program design and implementation of services;
- Effective leadership and coordination of services;
- Quality evaluation of outcomes and clear demonstration of goals and accomplishments.

Inclusion of Community Providers and Clients

Community providers and clients can contribute tremendous insight into how local individuals prioritize their needs for services. They can promote cultural and language sensitivity, and also help identify and eliminate barriers to efficient utilization of care. In addition to understanding community providers and clients, there is also a need to consider how county and city public officials influence the provision of services. These public officials often have great influence in shaping not only the available health services but also the other types of services that are needed to support and facilitate state and federal efforts. Although it may be challenging to include community providers and clients and to deal with local governments, reaching out to these constituencies and getting their perspectives and cooperation is fundamental to affecting a change in the community's health status.

During our interviews, policymakers discussed the importance of gaining these community perspectives or what is known as "community-based priority- setting." In essence, providers need to understand how clients balance a number of competing priorities and challenges, because their priority-setting will influence their patterns of utilization of care and services. For instance, women may delay seeking prenatal care because they face other daily challenges such as employment and childcare demands. Understanding how clients prioritize the demands in their lives would enable providers to design programs and services to better accommodate their clients' needs. Thus, factors in people's lives that prevent care or challenge their ability to further their children's health should not be minimalized, but rather taken in to consideration as a larger part of program design.

Having services be responsive to the community is also related to making services culturally and language sensitive. Although many service providers strive to include multilingual staff, training service providers to be sensitive to clients' cultural and language requirements is vital. Trenton, in particular, is home to many different cultural and ethnic groups who have their own health belief systems. These beliefs and practices should be considered in program design to make clients more likely to use services, better able to evaluate and judge the quality of services, and actively participate in educational programs. In addition, undocumented persons should also be considered, as fear of immigration reprisal may prevent them from applying for needed services. As one policymaker stated, "Reaching this population and gaining trust may require reaching deep into the community, from engaging trusted community leaders to working with the respected person in the neighborhood."

The community of providers is also important to include in discussion of how to improve services. Having an understanding of the barriers that providers face may offer insights in ways to overcome them. Inadequate and inconsistent funding and lack of stable, long-term funding are seen as ongoing problems for most providers. Another barrier that some providers face is a lack of

flexibility or creativity in ways to address other competing issues that some families face. This lack of flexibility is inherent in some grants because the grant parameters often dictate the scope of work. As discussed, improving one area often requires consideration and simultaneous improvement in other areas. With a multitude of competing and interrelated issues, it is critical to involve providers as well as clients in determining the best possible approaches that will maximize the opportunity for benefits.

Effective Leadership and Coordination of Services

Effective leadership is needed to manage program resources. Program management should carefully review how and where their funds are spent to ensure that resources are targeted where they can be the most effective. In addition to quality leadership, inter- and intra- agency coordination of services is also critical. As one person stated, "The system is fragmented. There is a need for 'one-stop' shopping for families to receive all services in one place. This would help families prioritize health care needs as well as raise the parents' awareness." Although program management should develop more collaborative and comprehensive approaches to providing services, one barrier is that they frequently must work with bureaucracies that are also often compartmentalized or "siloed" into service areas. This "siloing" of services often requires that providers as well as clients interface with multiple agencies. For instance, multiple agency involvement may be needed to improve the birth outcome of a pregnant woman who needs substance abuse treatment. The intervention must include not only coordinated care between the substance abuse treatment program and the prenatal care provider, but could also involve help with childcare and other domestic problems, and assistance in identifying educational and financial opportunities (e.g., job training). However, agencies and providers in each of these categories are often not well connected with each other. Program leaders who are striving to improve one area must often provide or coordinate other supportive services, and therefore must interface with a number of different agencies or providers.

Quality Evaluation of Outcomes and Clear Demonstration of Goals and Accomplishments

The need for quality and careful evaluation was a predominant theme across all program areas. Policymakers stated very specifically that in order for the programs to be considered successful, they would need to appropriately identify, measure and demonstrate their outcomes. Additionally, program expectations should be clear and achievable. This requires that the program does not "oversell" its potential impact. This is critical when one considers how difficult it is to demonstrate that significant outcome changes are attributable to particular interventions. Providers do not often have the same level of skill and resources available to them to plan and execute an

effective outcome evaluation. Therefore, the measures of success need to be carefully considered. An additional barrier is that although many problems require long-term commitments of time and money, many programs addressing these issues receive only short-term support. While these smaller, shorter-term efforts can contribute to the goals and outcomes of a given program, it is difficult to demonstrate a significant change based on improving only one or two of the numerous factors affecting the larger picture of big change. Process outcomes that enumerate the intervention's activities are useful, but insufficient unless other research has demonstrated the causal relationship between the process and the outcome such as the use of antiretroviral therapies (Zidovudine) and the decrease in perinatal transmission of HIV. Additionally, while policymakers considered evidence-based models important, they pointed out that even replicating a good model needs careful consideration as the effects of the population and changes in the model may not yield the same level of effects.

Major State Policies and Initiatives

To better target their efforts, Children's Futures must understand the community's needs, what programs are available and what might be forthcoming from the State. While this project does not include a needs-assessment for Trenton, several indicators of child well-being are presented in Table 1. Taken from US Census and State data, these indicators provide information on birth outcomes and children's well-being for Trenton and selected cities in New Jersey. Additionally, policymakers provided information about major state and federal initiatives that serve the Trenton and Mercer County area (see Tables 2 and 3), how well these programs are working, and if any new initiatives are planned.

While State officials provided this information, it is not a comprehensive inventory of all state programs or policies that might reach our target area, as it is not always possible to capture the proportion of statewide and regional programs that serve the Trenton area.[2,3] Where appropriate

Table 1. Selected Characteristics of Trenton and other New Jersey Cities

Characteristic	Trenton Profile	Newark Profile	Camden Profile	New Brunswick Profile
Race/ Ethnicity of Children 3 and Under years[1]	12.1% White (n=625 not Hispanic or Latino) 55.2% Black (n=2,844 not Hispanic or Latino) 28.7% Hispanic or Latino (n=1,479 any Race) 4.0% other (n=207)	9.0% White (n=1,529 not Hispanic or Latino) 53.5% Black (n= 9,051 not Hispanic or Latino) 33.6% Hispanic or Latino (n=5,674 any Race) 3.9% other (n=650)	2.3% White (n=133 not Hispanic or Latino) 47.2% Black (n=2,733 not Hispanic or Latino) 46.2% Hispanic or Latino (n=2,675 any Race) 4.3% other (n=244)	4.6% White (n=226 not Hispanic or Latino) 22.4% White (n=620 not Hispanic or Latino) 64.9% Hispanic or Latino (n=1,795 any Race) 4.0% other (n=126)
Births with Low Birth Weights[2]	178 11.7% of all Births 48.2% share of County Total	673 13.2% of all Births 48.7% share of County Total	233 13.0% of all Births 38.1% share of County Total	69 8.4% of all Births 10.1% share of County Total
Births with No Prenatal Care[2]	47 3.1% of all Births 76.9% share of County Total	413 8.1% of all Births 70.2% share of County Total	69 3.9% of all Births 69.7% share of County Total	17 2.1% of all Births 33.3% share of County Total
Infant Mortality[2]	19 12.4 rate per 1,000 Births 48.0% share of County Total	68 13.3 rate per 1,000 Births 59.6% share of County Total	32 18 rate per 1,000 Births 53.3% share of County Total	12 14.6% rate per 1,000 Births 26.1% share of County Total
Births to Teens (15-19)[2]	290 75.1% share of County Total	960 64.6% share of County Total	502 58.0% share of County Total	134 25.8% share of County Total
Children Receiving TANF[2]	3,895 89.6% share of County Total	21,392 69.0% share of County Total	7,806 71.7% share of County Total	873 25.2% share of County Total
Children Receiving Food Stamps[2]	6,114 90.8% share of County Total	32,446 68.6% share of County Total	13,065 70.6% share of County Total	1,527 25.6% share of County Total
Child Abuse Substantiated Cases[2]	275 74.7% share of County Total	1,443 66.3% share of County Total	596 54.6% share of County Total	97 15.8% share of County Total
Family Problems[2]	1,812 71.1% share of County Total	2,046 45.3% share of County Total	1,071 41.7% share of County Total	381 12.8% share of County Total
Substance Abuse Treatment Admissions (1998)[3]	528 for Heroin 852 for Alcohol 598 for Cocaine 289 for Marijuana 25 for Others	4493 for Heroin 420 for Alcohol 529 for Cocaine 282 for Marijuana 73 for Others	704 for Heroin 363 for Alcohol 275 for Cocaine 178 for Marijuana 12 for Others	278 for Heroin 133 for Alcohol 67 for Cocaine 70 for Marijuana 7 for Others

[1] Summary File 2(SF 2) 100-Percent Data· Percentages were calculated by number of children identified as X racial or ethnic group/total population of children 0-3
[2] County profiles of Child Well-Being: Kids Count 2000, www.acnj.org
[3] Jersey Municipalities with the Highest Number of Substance Abuse Treatments Admissions in 1998, ADADS Supplementary Tables, 1998

however, we do include statewide programs such as Medicaid and the Substance Abuse Treatment - Set-Aside money for pregnant women, since these programs serve our target population. Additionally, the financial details regarding some of these programs could not be obtained. For instance state officials were unable to provide exact financial data because the program serves a larger area, and therefore, the proportion that reaches Trenton could not be determined without contacting the grantees. In addition, certain programs such as Medicaid and NJ FamilyCare are large, comprehensive medical coverage programs operated through independent Health Maintenance Organizations (HMOs) that cover a large population and provide a wide array of services. As the focuses of these programs are not limited to our goal areas, it was not feasible to determine the amount of money spent on these four project areas. Rather, overall budgets are provided and where possible, Medicaid-funded specific programs are detailed.

Improving Birth Outcomes

The State of New Jersey has a large number of programs directed towards improving birth outcomes, and for the most part these programs utilize federal funds. Providing care for pregnant women and infants cuts across the departments with DHSS overseeing most of the specific maternal and child programs, while DHS oversees the Medicaid funds. While Medicaid provides comprehensive medical insurance coverage to pregnant women and children, other programs are specifically targeted such as case management for child or adolescent pregnancy prevention programs. The major programs include: Healthy Start; Black Infant, Better Survival; Healthy Mothers, Healthy Babies; and Risk Reduction for Perinatal Addictions. The range of programs demonstrates not only the depth but also the breadth of issues being addressed in the Trenton area.

For the most part, determining how well programs are meeting their goals and improving health is problematic because there is a real need for quality evaluation. At the current time, the State does not have the capacity to adequately evaluate the multitude of programs they offer or fund, nor do the programs have the capacity and expertise to evaluate themselves. For example, one senior program official cited the resources that have been allocated to evaluate Healthy Start, but these evaluations have not been implemented by the communities. That said, there is some program level data, mostly consisting of process outcomes such as enrollment of women in prenatal care and increases in the number of visits, that suggest programs are appropriately addressing their goals and serving their target populations.[4] Based on successes with individual child outcomes such as children having a medical home, being screened for lead, and receiving immunizations on time, a program manager felt the PORCHE program seems to be working. Using a home-visiting model, this program provides prevention-oriented services for high-risk families with children under five. Decreases in the number of children with elevated lead levels also seem to infer that lead program activities are

successful. Based on early reports from a recently concluded evaluation, state officials reported that the Adolescent Parenting Program seems to be successful in reducing repeat pregnancies and improving access to care. This program works to reduce 2nd pregnancies and improve primary care for adolescent moms and their babies. Emphasis is on identifying interventions that will achieve health outcomes that will be measured by immunization rates, lead levels, nutritional status, reaching growth and development milestones, parent and child interactions, and strengthening primary care linkages.

Although there are limited data, the incorporation of Health Start into the Medicaid Managed Care program is considered a sign of its success. Health Start is a comprehensive package of prenatal care for pregnant women who meet the financial eligibility. Health Start includes medical care, nutrition, and social services in a package of care. Presumptive eligibility is also an important part of Health Start - women can receive care during the eligibility process. For many years this was the standard of care given to Medicaid eligible pregnant women. Although no specific outcome data was provided to support its success, one senior policy official felt that the incorporation of the Health Start program into the Medicaid Managed Care Program is the ultimate sign of success. However, substance abuse treatment programs for pregnant women are not felt to be reaching their goals. Although there are federal MCH Block grant set aside funds designated for treating pregnant women, policymakers report that these slots are not always being used for pregnant women. Additionally, the WorkFirst program is also considered underutilized. Although Trenton has not seen the same "boarder baby" problem as other areas in New Jersey, the lack of appropriate treatment options clearly needs to be addressed.

At this juncture, there are fewer new state initiatives intended to improve birth outcomes. Activities seem to be focused on maintaining the existing programs and recently developed programs such as Newborn Biochemical Screening. Although the new administration is currently developing their plan, there is an emerging focus on school-based health centers. As demonstrated in a pilot program in Newark, these school-based health centers are intended to go well beyond the traditional "school nurse" approach; rather, they are designed to give children a medical home. As these potential programs are in the discussion phase, there might be opportunities to incorporate programs and services such as adolescent pregnancy prevention and parenting education that are needed to improve birth outcomes in the creation of these school-based health centers. For younger children, the school-based health center may provide needed health services, but a rigorous evaluation of health outcomes has not taken place.[5]

Childcare

New Jersey has several active state and federal initiatives in the area of childcare for children 0 to 3. The majority of the funding goes to childcare subsidies. New Jersey offers childcare subsidies to families of various low-income levels through the WorkFirst NJ initiative, the New Jersey Cares for Kids initiative, the Kinship childcare subsidy, and several other programs. All receive funding through state and federal dollars, and all are available in Trenton. In fact, from October 2001 to September 2002, $9.5 million was allocated for childcare in Mercer County, with approximately 80 percent going to Trenton.

Other major statewide childcare initiatives include the Early Childhood Education (ECE) Program in Abbott districts, which involves a mandatory pre-school program targeting 3 and 4 year olds, and Early HeadStart, which in some areas is blended with Abbott dollars. While the Abbott ECE program has no income eligibility, Early HeadStart does. Additionally, the Abbott ECE program mainly focuses on educational services with only some Abbott centers contracting for parent education services (e.g. the Parent As Teachers program), while Early HeadStart includes not only childcare but also social, nutrition, and health services. Early HeadStart also aims to include services for the whole family, including fathers. Although the program is still new, a few Early HeadStart sites have succeeded in serving close to 100 families. Currently there are 12 grantees statewide that have Early HeadStart. Trenton has recently obtained funding for an Early HeadStart program but are still in the planning stages.

Several other programs exist that specifically focus on quality of childcare. The Department of Human Service, Division of Family Development, through the Child Care and Development Fund sets aside 4 percent of the money towards improving quality childcare (this is estimated to be about $5,467,440). Activities that are currently being put into place using this funding include the Child Care Warm Line, a toll-free number that childcare providers and parents can call for health-related information and the Map to Inclusive Child Care Project, which promotes the inclusion of children with special needs in regular childcare. Other activities funded through this initiative are education of consumers as well as childcare providers, one example being the Better Baby Care Campaign.

In addition, programs like Family and Children Early Education (FACES) incorporate improving quality childcare as part of a number of services they deliver. There are 11 FACES sites throughout the state and each site provides four main services: family literacy, prenatal health, parent education, and quality childcare. In Trenton, the FACES program site spent a total of $358,633 in the federal fiscal year 2002, with $30,800 going towards quality childcare.

Although a number of programs exist in Trenton and Mercer County that address quality childcare, policymakers and community leaders have suggested other programmatic activities that would address the needs of both childcare providers and consumers. One senior State official said,

"Childcare centers should be a focal point for families to get lots of different services not just childcare and these services can include health and social services." Additional suggestions for improving quality childcare include:

- Programs that reduce the turnover rates of childcare workers such as creating an incentive system;
- Programs that improve the physical environment of childcare centers; i.e., creating safe facilities;
- Evaluation of programs, including both outcome indicators and process indicators; and
- Programs that educate parents in selecting quality childcare and participate in childcare activities.

Parenting Education

Many of the programs that address strengthening effective parenting provide a multitude of services in addition to parenting education. For example, the statewide Healthy Families program, which operates through Mercer Street Friends in Trenton, provides not only parent education but also education in child abuse prevention, child development, and family attitudes and beliefs. It also provides ongoing support to parents of children up to age 5. A recent comprehensive evaluation of this program has shown that it's been successful in changing parents' attitudes and beliefs, improving the child's home environment, and providing important assessment techniques in detecting childhood delays. A complete evaluation of the Healthy Families program was recently conducted and the report can be obtained from Prevent Child Abuse NJ.[6]

Another program that provides parent education is the Parents as Teachers program, which receives funding through the NJ Office of Prevention of Mental Retardation and Developmental Disabilities and FACES (through DYFS referrals) as well as obtaining contracts with Abbott centers. This program has 10 sites in New Jersey including Trenton and its main goal is supplying in-home parent education to new parents. The program focuses on giving information on child development and growth, relationship building, age appropriate activities, and positive discipline. It also integrates a literacy component. Although no formal evaluation has been done on the PAT program, it has successfully served close to 185 families. In addition, through pre-test and post-test measures, PAT families have shown improvement in knowledge of child development and in parent and child interactions.

A number of parenting programs target adolescent parents. The School Based Youth Services Program (SBYSP) parent education component is a good example of an effective program that is available statewide, including Trenton. Although Trenton has not demonstrated its effectiveness, the

Plainfield site has shown a significant impact in reducing parenting stress, improving parent and child interactions, and increasing knowledge of child development and positive discipline. In some areas not including Trenton, SBYSP also provides childcare services so that teens can continue with their schooling. SBYSP operates with minimal funding, most coming from the Department of Human Services (about $250,000 with an additional $100,000 if the site has a childcare component), the Board of Education (in kind by providing the salary for the Head Teacher of the program), and community fund-raising efforts (at the Plainfield site, $60,000 is raised every year by the Plainfield Teen Parenting Program Inc.).

Generally, parenting programs that are few in number in Trenton are those that solely target parent education as a preventive measure. Most programs incorporate a preventive piece to their service delivery such as those programs that focus on delaying repeat pregnancies among current teen parents. Although important, by focusing on prevention after intervention, programs tend to be more reactive and not proactive enough to stop the crisis from occurring.

Involvement of Fathers

Fatherhood initiatives have begun to gain momentum in several different areas, but are still behind in terms of funding and implementation. One of a few programs in Trenton that focus on this area of child development and health is Operation Fatherhood through Union Industrial Home. This program is funded by the Department of Human Services, Division of Family Development and it incorporates three specific components: 1) job training and employment services, 2) peer support, and 3) child support collection. They have recently included services for fathers related to health issues, but are still looking to expand this program within the community. Total funding received by this program equals to $414,000; however, according to the Director of the program the cost of running the program usually reaches $550,000 per year.

Other programs that include components for fathers include Babyland in Newark and Parents Anonymous of New Jersey. The Babyland program in Newark incorporates child and family services as well as a specific service for incarcerated fathers to become involved in their children's lives. The Babyland program has a 7.7 million dollar budget, with the majority of funds coming from state sources (44.2%) such as the Department of Community Affairs and the Department of Health and Senior Services.

Parents Anonymous of New Jersey has a specific group that targets young minority fathers called the Parenting Our Successors in Society Effectively (POSSE). Parents Anonymous groups are self-facilitated groups of parents who desire to break the cycle of abuse. Participation is free and the program is community based. Parents Anonymous receives funding from multiple sources because of the array of services they provide, but the POSSE group receives funding specifically from the

Department of Corrections.[7]. Both Babyland and the POSSE are successful programs, with Babyland in Newark becoming a model for other communities within New Jersey and nationally.

Gaps, however, still exist in programs for fathers in New Jersey and specifically in Trenton. Some important needs are broadening the scope of programs and services for fathers to include such services as developing father and child bonding and addressing health issues that affect fathers and thereby impact the entire family. Getting fathers involved early during pre-natal care would facilitate not only the importance of fathers being involved in a child's life from the beginning but also provide the necessary support to the mother during this important period.

Moreover, a need exists for programs that link services for families. Many agencies tend to ignore fathers altogether. Many families are not even aware of those resources, and only when they are involved in a multitude of agencies does the probability of accessing father services exist. Therefore, public awareness of existing programs for fathers in addition expanding fatherhood programs must be addressed.

Table 2: Department of Health and Senior Services: Major Health Initiatives for Children Zero to Three

Agency/Name of Program	Funding Source (Federal or State)	Annual Budget	Description of Program
Adolescent Parenting Projects	State	$700,000 statewide	Enrolls women during prenatal, follows up to 3 years. Includes home visits; goal to reduce 2nd pregnancy and improve primary care for mom and baby
AIDS Ryan White Funds	Federal	$2 million statewide	To the AIDS Division and Family Health Services to reduce HIV transmission
Black infant mortality reduction (Black Infants Better Survival: BIBS)	Federal	$192,518 for Trenton	Awarded to the Central MCHC, these funds are intended to used to reduce Black infant mortality by focusing efforts on stress reduction and related issues in pregnancy
Birth Defects Registry	Federal	$1 million statewide	CDC for the Center for Excellence in Birth Defects
Family Planning at Mercer Planned Parenthood	Federal & State	$649,000 for Mercer County	Services for pregnant women

Table 2: Department of Health and Senior Services: Major Health Initiatives for Children Zero to Three *Continued*

Agency/Name of Program	Funding Source (Federal or State)	Annual Budget	Description of Program
Healthy Child America: partnership between DHSS, DHS, and NJ Academy of Pediatrics	Federal	$100,000 statewide	Uses paid coordinators and volunteer consultants to provide education and technical assistance to licensed centers and family providers
Healthy Mothers/Healthy Babies	State	approx. $190,000 for Trenton 1.83 million statewide	Provide educational programs for professionals; Host community events; provide educational literature to women participating in parenting programs, provide funds to community agencies that address access to prenatal care and provide outreach and education on accessing services to postpartum women and infants. Grant goes through the NJ Central Maternal and Child Health Consortia
Healthy Start	Federal	$700,000 for Trenton	Case management for pregnant women.
Mercer Mental Health	Federal & State	$321,000 for Mercer County ($250,000 from state, remainder federal dollars)	Traumatic loss services
Mercer Special Services, Birth-3 years	Federal	$1,425,000 for Mercer County	For early intervention for developmentally delayed
Newborn Biochemical Screening	State	$3 million statewide	Screens newborns for specific types of conditions, provides follow-up, treatment and education
Perinatal Addictions/Fetal Alcohol Syndrome	Federal & State	$800,000 statewide ($500,000 from state, $300,000 from federal)	Provide substance abuse treatment for pregnant women and education to staff and clients in various prenatal centers in Trenton

Table 2: Department of Health and Senior Services: Major Health Initiatives for Children Zero to Three *Continued*

Agency/Name of Program	Funding Source (Federal or State)	Annual Budget	Description of Program
Prevention Oriented System for Child Health (PORCHE) Includes Childhood Lead Poisoning Prevention Program	Federal & State	$125,000 for Trenton ($70,000 from the MCH Block grant and $55,000 for Childhood Lead Poisoning Prevention)	Uses home visiting model Focus on the under 5; provides comprehensive prevention, oriented outreach, and case management system that focuses on low-income families.
Tobacco control/outreach	State	$58,564 for Trenton	Smoking prevention and education programs
Trenton Department of Health and Human Services: Asthma Program	Federal & State	$100,000 for Trenton	Mercer Partnership Childhood Asthma Project. Case management, an asthma clinic, education, and outreach
Trenton Department of Health and Human Services: Lead Program	Federal & State	$136,428 for Trenton	Case management of Services for high-risk children especially children affected by lead Poisoning
Substance Abuse Treatment Block Grant-set aside for pregnant women	Federal	$200,000 for Mercer County; $6.5 million statewide (approximate $)	Operated statewide, across 35 agencies; Mercer Treatment Center in Trenton
Women, Infants and Children (WIC)	Federal	$689,000 for Mercer County (administrative costs does not include food costs)	Provides Food to Eligible women and children

Table 3: Department of Human Services: Major Health Initiatives for Children Zero to Three

Agency/Name of Program	Funding Source (Federal or State)	Annual Budget	Description of Program
Abbott Districts: Early Childhood Education for the City of Trenton:	State (blended dollars from DHS and DOE)	$19.9 million in Trenton for FY'03 for an estimated total of 2827 children and for 225 days per year. Last fiscal year; the amount per child was $9000, higher than this coming year.	Funding covers in-district (centers associated with schools) and out of district centers (community providers). NJ's the only state with a court mandated pre-school program through Abbott. Includes 3 and 4 year olds
Angel's Wings	State	$320,000 from DYFS annually in Trenton ($441,500 from Robert Wood Johnson Health Initiative Program for 4 years)	Several services are provided by this faith-based program: 1) respite care to DYFS children in transition to foster families while "fostering" foster families through outreach by volunteers and 2) substance abuse treatments and other counseling to DYFS families.
Child Care and Development Fund	Federal & State	$136, 686,000 statewide (includes TANF, $56,433,000 state match)	Developed since 1996 as part of the Personal Responsibility and Work Opportunity Reconciliation Act, it is primarily used for child care availability; however, 4% must go to quality childcare activities. Includes 11 Center-based care sites in Trenton
Children's Trust Fund (staffed and located in, but not of, the DHS.)	State	$122,249 for Trenton/Mercer	Grants money to programs designed to prevent child abuse and neglect. Current Trenton/Mercer Grantees: Children's Home Society of NJ; Mercer Street Friends; Epilepsy Foundation of NJ; and HomeFront
DYFS: for Boarder Babies	Federal	$450,000 Statewide	Provided caseworkers devoted to overseeing the care of boarder babies and their families. Also some money was designated to develop foster homes
Early HeadStart	Federal	$10,000 per child	Provides services for children 0 to 5. There are 12 grantees statewide with Trenton recently obtaining funding.

Table 3: Department of Human Services: Major Health Initiatives for Children Zero to Three *Continued*

Agency/Name of Program	Funding Source (Federal or State)	Annual Budget	Description of Program
Family and Children Early Education Services (FACES) combination of DHS.	Federal (SSBG funds) State, and Local (local school districts)	Maximum combined grant of $500,000. In Trenton for FY'02, it was $358,633.	FACES provides services in 4 areas: Family literacy, pre-natal health, quality childcare, and parenting education. Currently there are 11 programs operating statewide.
Family Day Care Network	State	$60,000 for Mercer County	For children under protective services through DYFS
Family Intervention and Empowerment Program (FIEP)	State & local matched funds.	$90,000 for Trenton	Program provides support for teens at risk for pregnancy and substance abuse.
First Steps: infant and toddler child care quality improvement initiative	State	$53,250 statewide	Provides technical assistance to childcare centers and
Healthy Families	Federal & State	$160,000 per site with a % of in kind dollars from the lead agency ($80,000 from DYFS referral contracts)	Program provides screening, assessment, and referral to pregnant and parenting women as well as parent education, counseling and support to families with children up to age 5. There are 19 sites throughout the state. One being in Trenton.
HeadStart	Federal	$12,000 per child	Provides services for children 3 and 4 year of age.
HITOPS: Targeting to Reduce Unintended Pregnancy	State	$36,000 for Mercer County	Trains a target tem of high school students to become peer educators for the purpose of reducing the risk of unintended pregnancy in Mercer County
Kinship care subsidy	Federal & State	$12.6 million statewide	Relatives who have legal guardianship of a child receive a monthly stipend of $250 per month.
Kinship Navigator Program	State	$500,000 statewide	It is a telephone resource and referral service for relatives caring for children.

Table 3: Department of Human Services: Major Health Initiatives for Children Zero to Three *Continued*

Agency/Name of Program	Funding Source (Federal or State)	Annual Budget	Description of Program

Kinship wraparound program and child care subsidy	State	$5.7 million statewide.	Assists related persons who take care of children with childcare costs and other basic needs such as furniture, clothing, rent etc. The latter is through the wraparound program.
Medicaid/ Health Start: these programs provide medical coverage to low income women and children	Federal (Title XIX) & State	$3,073,945,016[1] statewide FY2001 ($1494,401,959 total state share, $1,492,458,411 total Federal share)	Covers direct payments; includes money for prenatal care, infant medical care, other medical and psychological services, Includes EPSDT services. From 7/1/01 to 12/31/01, 5179 children aged 0 to 4 in Trenton made a Medicaid claim. 1999 Medicaid expenditures were: $62,836,822 for under 1 $230,576,887 age 1-5 $316,867,185 age 6-14 $164,157,190 age 15-18 $ 60,110,145 age 19-20 $1,013,159,821 age 21-44
NJFamilyCare: waiver to the SCHIP Federal Program to expand coverage to families.	Federal (Title XXI) & State	$168,993,395 statewide ($107,196,562 state share, $60,673,766 Federal share, and $1,123,077 Employer/individual share)	Covers direct payments; includes money for prenatal care, infant medical care, other medical and psychological services. As of 11/20/01, there were 9483 persons in Mercer County enrolled in FamilyCare, with 3314 of them being children.
NJKIDCARE: Part of the SCHIP Federal Program to provide health insurance coverage to low income children not eligible for Medicaid	Federal (Title XXI) & State	$90,438,601 statewide ($31,731,316 state share, $58,707,285 Federal share)	Children's Health Insurance program for low-income families who are not able to secure health insurance in the private sector. Rolls Children into the Medicaid program; Covers infant medical care, other medical and psychological services;
NJ Cares for Kids	State & Federal	$3,066,000 for Mercer County (about 80% of this goes to Trenton)	Childcare subsidies for working families 200% above poverty level. Funds are distributed through the Child Care Connection

[1] Breaking out the budget for pregnant women and children zero to three in Trenton was not feasible. This includes all the payments made through the Medicaid program statewide including those to other localities and to all populations. For instance, this figure includes $116,371,710 for Medicare premiums.

and

provided an overview of the major state and federal policy initiatives. In this section we present the specific information for each program area. Senior policymakers and staff were asked to discuss specific issues that need to be addressed, barriers to success, and what lessons demonstration

projects could provide. Although Children's Futures is targeting the needs of children in Trenton, valuable lessons can be learned from demonstration projects in New Jersey as well as experiences from other key states. By asking senior policymakers and program staff to respond to these questions for each particular area, we hoped to collect specific suggestions that Children's Futures could use to better direct their efforts.

Improving Birth Outcomes

Top Priorities

To inform Children's Futures, we asked policymakers to identify the top three priorities to improve birth outcomes in Trenton and across New Jersey over the next 3-5 years and determine the appropriate priority level for funding. While common themes of improving access and quality of care were voiced, very specific areas were detailed. These areas included:

- Improving general health for women of childbearing age;
- Increasing early entry into prenatal care including preconception care;
- Increasing access and use of services by immigrant population by making services more culturally and linguistically sensitive;
- Having primary care providers (including private practitioners) screen all clients for substance abuse and depression;
- Expand substance abuse treatment opportunities for pregnant women, especially residential treatment;
- Reduce racial disparities in health;
- Decrease vertical transmission of HIV from mothers to babies;
- Prevent teen pregnancy and delay subsequent pregnancies;
- Improve children's physical and social environment.

Although these areas are currently being addressed, more work is needed. Improving women's health in general, and increasing early entry into prenatal care and pre-conception care, in particular, are critical along a number of fronts. Educating women on the importance of both prenatal and preconception care is vital to improving the outcome for their babies. General women's health is important as these women may already have children they are taking care of and need to maintain good health and/or they may become pregnant, and should begin their pregnancy in good health. Although there are education programs (by HMHB and the Maternal Child Health Consortium), more needs to be done to reach women and encourage them to enter care. Outreach is

also important to bring women into care. One suggested strategy was to publicize and provide free pregnancy testing as a method to attract women into early prenatal care.

The quality of prenatal care also needs improvement. During prenatal care, more depression and substance abuse screening needs to be done using effective and quality instruments. Beyond the screening, providers should work more effectively with substance abuse providers to better manage and coordinate women's obstetrical care and substance abuse treatment. There is a critical need for more substance abuse treatment opportunities, especially residential treatment. Along with efforts to improve access to prenatal care, services need to also be made more culturally and linguistically accessible.

Children's Futures should also consider efforts to decrease teen pregnancy rates and reduce the vertical transmission of HIV. While there are some educational programs to reduce teen pregnancy and delay subsequent pregnancies, these efforts need to be expanded. Regarding the vertical transmission of HIV, required HIV counseling during prenatal care and current drug therapies could almost eliminate perinatal transmission; however, this would require women engaging in prenatal care.

One challenge is that some problems are more difficult to resolve than others. For instance, although there are a number of efforts to reduce racial disparity, blacks continue to have higher infant mortality rates and lower birth weight babies than do whites. As this problem extends beyond both Trenton and New Jersey, much research has been conducted to understand what factors drive racial disparities. While some factors such as smoking and proper prenatal care have been correlated to birth outcomes, other factors are more challenging to identify and resolve such as the effects of long-term and intergenerational racial discrimination on psychosocial and physicial well-being (Guest, Almgren & Husey, 1998; Laveist, 1993; Williams, 2001). Improving children's social and physical environments is also a great challenge that includes improving the quality of housing, decreasing violence and drugs in the neighborhood, and addressing the poverty that shapes many children's worlds. While these tasks may be large, even small in-roads can lead to positive changes in lead and asthma rates. While Children's Futures may not be able to resolve these issues, they should be aware of them.

Barriers to Progress

Although there is a need for quality outcome evaluation, a number of identified barriers exist that limit progress in the area of birth outcomes. These barriers include:

- Insufficient and inconsistent funding;
- Extensive unmet needs;

- Lack of substance abuse providers or treatment opportunities;
- Improving the quality of care through educating and training of providers and supervision and evaluation of services, including having culturally and linguistically sensitive providers and services; and
- Compartmentalized services both in the provider arena and in state government.

Lack of sufficient, consistent, and long-term funding hampers programs in numerous ways. First, programs must spend time and effort in looking for funding to sustain core programs. Secondly, if a provider obtains demonstration funds to creatively address a problem, these funds are typically non-renewable and short-term. Third, service providers are sometimes constrained as to how they may provide services. Large-scope funding opportunities such as federal grants often have guidelines that specify how services are to be provided. While this ensures a consistency of services, it often limits agencies to creatively address problems. While small grants may offer more flexibility, these grantees are limited in how far they can engage a woman and support systems. Finally, there is a real shortage of funds to address all those who could use the services, as well as providing the comprehensive set of services that some people need. For example there are no funds to pay for lead clean up even through lead poisoning is a priority. Although there seems to be a number of services and programs designed to improve birth outcomes, there are still women and children who are unable to obtain health care because there are not enough services available.

Substance abuse treatment for pregnant women is an area that seems to have significant challenges. Services are either not accessible (program requirements that discourage women from enrolling) or not available (lack of detoxification and residential treatment programs for women in Trenton). For example, Medicaid pays for drug rehabilitation services only, not residential services. Other factors such as reluctant providers, women who don't admit substance abuse for fear that their baby and possibly other children will be taken away, and lack of case management and coordination between providers are creating situations that also keep women from getting services.

An additional barrier to success is the need to improve the quality of medical providers' care. Specifically, competent, skilled and properly trained staff must provide services. Programs cannot succeed, if they are not able to properly serve their clients. This means that they must be able to educate parents about what a child needs and how they can prevent illness. Lack of training in the area of cultural and language competency is an especially significant barrier. As previously discussed, these cultural and linguistic differences keep some women from accessing care and make it difficult for them to receive quality care. Many women also perceive being undocumented as a barrier. Some are fearful of being deported, while other women may have documentation, but are

unable to demonstrate their status because the papers are not available (e.g., being held by a spouse).

While policymakers identified these barriers, they were also asked if there were gaps between policy and what community leaders, providers, and advocates propose to improve birth outcomes. Most policymakers agreed with advocates and community leaders, but felt that they work within a system that is very compartmentalized or layered and often constrained by budget issues. These bureaucratic characteristics often make it difficult to respond quickly and to identify who is or should be accountable. As previously discussed, state agencies and providers are compartmentalized or "siloed" thus making issues of accountability and effective coordination of care very difficult.

Demonstration Projects and Key States

Although Children's Futures is focusing their current efforts in the Trenton area, lessons can be learned from demonstration projects from other areas as well as other key states. Larger demonstration projects include Healthy Start, PORCHE, and Healthy Families. Another successful program that specifically targets hard-to -reach, substance abusing pregnant women is the Matriarch program in Newark. Known as "boarder babies" these children remain in the hospital because they are abandoned by their mothers, with no foster care available. As these babies are born to hard-to-reach women who often have little if any prenatal care, this program uses extensive outreach methods to get these women into substance abuse treatment and prenatal care. Additionally, they work with the pregnant woman to help locate a suitable placement, possibly with a family member, and provide the necessary tools to prevent or delay a subsequent pregnancy for up to two years. With three staff persons and a budget of $120,000, this program has had significant positive outcomes, not only for the babies (of 41 births only 2 in the first six months became boarder babies), but also in delaying a subsequent pregnancy.

One key state, New York, has implemented mandatory HIV screening that does not require patient permission. Since the program's inception in 1997, the state saw a decrease in the HIV transmission rate from 25 percent to three percent. Policymakers also mentioned Vermont, Ohio, New York, California, and North Carolina as states they consider leaders. Although policymakers point to these states, a lot of caution is used as there are always concerns as to how well these states' populations compare to New Jersey. While policymakers look to states that resemble New Jersey, there is a clear understanding that New Jersey is very diverse, not only culturally, but also geographically in terms of its rural, urban, and suburban makeup.

Recommendations

It is not surprising that the discussions on priority of needs, barriers, and existing programs all echo the same messages. The question remains: What more needs to be done to improve birth outcomes? To answer this question, we asked policymakers and staff what changes would improve birth outcomes. Specifically, they mentioned:

- Comprehensive or holistic approaches to providing care, essentially "One-stop shopping." This includes:
  - A medical home;
  - Pregnancy care for women as well as health care for the entire family;
  - Access to other services and supports;
  - Educating parents to recognize the importance of health care and have the information on where and how to access services; and
  - Expanding and enhancing existing programs for children's health insurance to improve their effectiveness.

- Improvements in health care delivery especially regarding substance abuse and depression. The improvements include:
  - Standardizing assessment tools;
  - Screening all women for substance abuse and depression;
  - Coordination across care providers;
  - Education of care providers including hospitals, clinics, private physicians, and other treatment programs;
  - Additional substance abuse treatment including inpatient, and more appropriate placements; and
  - Culturally and linguistically competent providers

  - Quality evaluation to demonstrate the impact of services and show program leadership where and how improvements can be made.

These specific recommendations should guide program leaders as they attempt to improve birth outcomes and the health of children zero to three in Trenton.

Childcare

Top priorities

Policymakers and staff named several top priorities in the area of childcare for the next 3 to 5 years. Most frequently mentioned was staff training for both home-based and center-based providers on the growth and development of infants and toddlers. Staff training ranged from providing formal education such as university credits in child development to obtaining certification in such health-related activities as medication management. Not only was there a concern for the skill and knowledge level of many childcare workers, there was also a concern on the impact of these skill deficits on the quality of childcare provided. As one respondent stated, " We need to provide training to staff, particularly in the areas of child development, communication, programming, relationship with parents, and children's health. Many of these childcare workers bring their own parenting skills to the job and that may not always be appropriate."

In addition to training, other priorities included:

- Providing health consultations and information to childcare staff;
- Providing support and technical assistance to childcare administrators;
- Increasing parental involvement in childcare selection;
- Increasing childcare workers salaries;
- Creating safe facilities; and
- Providing case management to at-risk children and families who attend childcare.

Better program planning and implementation can address some of the above-mentioned issues, but most of these issues can be addressed only by additional funding. In fact, when asked, most respondents named the same issues listed above as the areas that were under-funded in Trenton. Issues such as staff training, health consultations for infant and toddler centers, and an increase in pay rates for childcare staff were named most frequently and emphatically by respondents.

Barriers to Progress

Lack of funding and the higher cost of quality care for infants and toddlers were named several times as a barrier to progress in this area of children's health and development. As one respondent stated, "The cost of infant and toddler care is high. Money is required for equipment [such as playpens, mats etc.] and the ratio of provider to children has to be a lot lower than older children [therefore requiring more staffing]."

In addition to funding, other barriers to success in this area include:

- Shortage of quality staff;
- Limited childcare vouchers, especially for those most in need;
- Lack of understanding between what constitutes quality care and poor care by both childcare providers and parents; and
- Lack of model standards on what comprises quality childcare.

Some policymakers and community leaders agreed that there is a gap between policy and community activities, and that this gap is another barrier to progress in the area of improving quality childcare. For example, many felt that policy is only focused on current trends and does not take seriously other issues that impact childcare delivery, such as lack of staff professionalism, low wages, and the lack of standards for childcare centers.

Demonstration Programs and Key States

Improving the quality of childcare has been a national focus. Other states have created programs that are effective in addressing childcare issues. For example, North Carolina, through the Smart Start program, has developed a rated licensing program for both center-based and family childcare. The North Carolina Division of Child Development awards star-rated licenses to providers based on total points earned in program standards, staff education, and compliance to regulations. Measures of program standards include the use of instruments that measure global quality, one of which is the Early Childhood Rating Scale (ECRS), modeled after the National Association for the Education of Young Children (NAEYC) standards. The number of stars a childcare facility receives (a range of 1 to 5), is based on the number of points accumulated (range is 3 to 15 points) by that facility from each category (e.g., staff education, compliance to regulations etc.). For example, if a facility earns 8 to 10 points, it will receive 3 stars. The accumulation of points affects not only licensing but the level of consumer utilization. Childcare facilities are then held accountable to maintain certain standards. New Jersey has a similar process but it is not as effective. The NJ Accreditation Project uses NAEYC standards to accredit certain centers; however, it is voluntary and currently, there are only 200 centers in NJ that have NAEYC accreditation.

North Carolina, Washington, Pennsylvania and Colorado all have childcare health consultant initiatives similar to New Jersey. North Carolina and Washington, however, have paid licensed and unlicensed consultants, while NJ uses volunteers. Pennsylvania has approximately 1,000 paid and unpaid consultants who provide health consultations to childcare providers, while New Jersey has significantly fewer, but active within their counties, especially in Mercer County. Pennsylvania also

has multiple funding sources for the childcare health consultation project, while New Jersey currently uses only federal funding. Connecticut and Colorado have both instituted a medical training curriculum as part of the children health and safety standards. This curriculum is used to train childcare providers in health and safety standards. New Jersey is looking to incorporate this initiative as part of their standards as well, but have not yet done so.

New Jersey compares well with other states regarding improving quality care. Many of the demonstration projects created such as the Families and Children Early Education Services (FACES) and the Approved Home Initiative have been in existence for a number of years, and are still continuing. Other projects such as the Quality Enhancement Project, which involves consultants and coordinators working together to create a best practices for childcare, is in the beginning stages and won't be available for a while.

Recommendations

Several recommendations were made that would improve childcare delivery in both home-based and center-based care. Areas of change focused on both licensing standards and service delivery. Specifically, respondents suggested:

- Stronger licensing regulations for center-based childcare by including health and safety standards;
- Mandatory training for health-related activities among childcare staff
- Mandatory licensing for family childcare providers; and
- Mandatory training for family childcare providers on all child growth and development issues.

Parent Education

Top Priorities

Policymakers and community leaders suggested several top priorities in the area of strengthening effective parenting. Specifically, they suggested:

- Providing parent education as a prevention strategy rather than intervention;
- Providing mental health services for parents and children;
- Addressing the unmet concrete needs of families such as housing, appropriate income, transportation etc.; and

- Increasing the number of programs that support overburdened families such as family support workers.

Both preventive and intervening programs were suggested as top priorities. This is not a surprise since prevention programs such as early (at the time of birth) parent education supplies the necessary knowledge and skills to assist parents in raising their children. At the same time, programs that address a problem after it occurs are necessary because they provide the support needed to restore the stability of the family. Both are equally important because they provide separate outcomes. Intervention programs show more impact because of the observable effects, while prevention programs are not as immediate in their impact, but are eventually more cost effective. (See Flannery, 1998; Holtgrave & Pinkerton, 2000; Kahn, 1998; Meenan, Stevens, Hornbrook, La Chance, Glasgow, Hollis, Lichtenstein, & Vogt, 1998 for examples of cost effective analyses of prevention programs.)

Consequently, one of the main priorities suggested by policymakers and community leaders is to strengthen the under-funded prevention programs. As one person stated, "[What I consider high priority but under-funded is] prevention, teaching, and education. We spend so much money on when things go wrong and not on education and prevention."

Other areas considered high priority are the unmet concrete needs of families. Many families do not have their basic needs met, such as a safe living environment, an appropriate income that they can live on, transportation for work and medical appointments, childcare, and so forth. These unmet needs lead to a number of consequences, one of which is the inability to seek and participate in what most consider nonessential services (e.g., parent education classes).

Barriers to Progress

Policymakers and community leaders named several barriers to increasing progress in the area of effective parenting. These included:

- Funding for programs that solely target parent education;
- A lack of policy that focuses on improving progress in this area;
- A lack of understanding of the importance of the early years by parents and policymakers; and
- Parents' limited time and effort in receiving parent education.

Policy has still not established parent education as an important need in the community. There is an expectation that agencies should provide this service in addition to other services, and are

particularly focused on those families that have already entered the "system" with a problem, rather than preventing the problem. As one contributor stated, "Policy focuses on control and 'getting tougher' rather than finding out how to solve the problem."

Demonstration Projects and key states

Healthy Families is national program that exists in several states, including Hawaii, Oklahoma, and New Jersey. In Hawaii, the Healthy Families program has expanded to include a partnership between nurses and families. New Jersey is currently applying for funds for nursing, so that the state can provide nurse home visitors for first-time mothers. Although Hawaii can provide information, they have a lower at-risk population, and longer funding commitments.
Other states such as Alabama, Georgia, and Texas have considered providing early support to new parents in the hospital by providing them with books and newsletters on child development and growth and Mozart audiotapes. New Jersey has programs that focus on early parent education and support, but they do not target parents as early as the postpartum hospital stay.

Recommendations

Recommendations were consistent with the high priority issues especially those that are under-funded. Policymakers stated that overall funding and clear-cut policy initiatives need to exist in order to improve effective parenting programs. Specifically, they mentioned:

- Increasing funding for programs that incorporate parent education, particularly increasing Medicaid's contribution to some programs in Trenton;
- Providing parent education; and
- Quality evaluation, particularly for prevention programs.

Increasing the Involvement of Fathers

Top Priorities

In the area of strengthening the involvement of fathers in families, a number of issues were mentioned as top priorities in the next 3 to 5 years. Specifically, they highlighted:

- Teaching fathers co-parenting skills;

- Provide work/career training to fathers;
- Involve fathers early on in their children's lives; and
- Focus on the health and mental health of fathers.

Teaching fathers co-parenting skills as opposed to parenting skills would take into consideration the variation in family composition. Fathers, who are not the sole caretakers of children, should also participate in the parenting of their children. This would require not only learning parenting skills but also learning how to coordinate these skills with the mothers' skills, even when they are not romantic partners. Targeting all fathers, as opposed to only single fathers, not only strengthens the involvement of fathers but also the family unit.

Another frequently mentioned priority is work and career training for fathers. Although programs addressing this area exist, they are mainly in conjunction with the WorkFirst NJ initiative, which primarily targets custodial parents. Only 15 percent of this funding goes to non-custodial parents. Another priority is more funding for programs that help fathers train for and obtain careers so they may contribute to their families financially, either directly or through child support. One individual felt that the "entire fatherhood initiative was not well-funded," and felt that educating the public on the importance and responsibility of both parents in a child's life would get fathers more involved with their children early on.

Barriers to Progress

Two primary, but very specific, barriers that hinder progress in this area are funding and cultural norms. A lack of funding is especially prevalent for initiatives that focus on strengthening paternal involvement. Direct funding is almost non-existent, with most of these services incorporated through other programs.

The other barrier is the cultural perception of fathers and their involvement in the family. Fatherhood and the importance of fathers in the family unit are de-emphasized in our society. Typically, fathers are perceived as nonessential in the family unit, beneficial if they are present but not necessary. This biased cultural perception hinders any major development in fatherhood programs. Until this perception can be dispelled, programs will continue to target mothers only, and fathers will continue to stay away from their responsibility. As one individual stated, "It takes time to change people's attitudes about the importance of fatherhood. Men don't necessarily come to the table, nor do we seek them out."

Demonstration Projects and Key States

The National Center on Fathers and Families has done a great deal in making the importance of fathers a national focus. States have begun their own initiatives that focus on fathers. For example, Massachusetts has made this initiative a governor's initiative several years ago, and since then have included services to fathers through the MA Department of Revenue, Division of Child Support Enforcement. They also held a responsible fathers summit in June 2000, a job fair for fathers, and other statewide awareness campaigns. New Jersey has done similar activities, including a fatherhood conference and a media campaign titled "Child Support, It's More than Just Money" through the NJ Office of Child Support and Paternity Programs.

New York has doubled the Adolescent Pregnancy and Prevention Services 2000 budget through TANF and has made one time appropriations of funding to the Harlem and Bedford-Stuyvesant program and the Family Support New York Conference: Linking New Yorkers through Family Support.

Pennsylvania, on the other hand, has supported fatherhood initiatives by providing funding for several programs through the collaborative efforts of a number of state departments. Programs that were funded included the Male Achieving Responsibility Successfully Program, the Employment Opportunity & Training Center of Northeast Pennsylvania, the Community Action Program of Lancaster County, the Lycoming County Responsible Fatherhood Program, the Our Creating Healthy Individuals and Loving Dads Program (Our CHILD), and the Long Distance Dads program which helps incarcerated fathers become more involved parents.

Georgia, Connecticut, Maryland, New Hampshire, Rhode Island and Maine also have fatherhood initiatives but are all at various levels of development. Similar to New Jersey, most have programs for fathers that include employment services and enforcement of child support. Very few programs include parent education for fathers (unless the focus is teen fathers) and involvement of fathers as part of the family unit.

Recommendations

The general recommendation for the issue of father involvement is more funding for programs that involve fathers just as much as mothers. Specific recommendations include:

- Incorporating fatherhood components in such large programs as the Healthy Mothers/Healthy Babies initiative;
- Providing education to the public on the responsibility of both parents;
- Providing a linkage of services for the entire family; and

- Providing supports for those fathers who are involved in the family unit.

Conclusion

These findings and recommendations are not really suggesting "new" ideas or initiatives, but changes that many people agree need to take place, and are working to achieve. The problem is that changes take time, money and involve many agencies and stakeholders. Programs and services also exist in a political landscape that is often layered with bureaucracy and compartmentalized services, under-funded in comparison to the magnitude of the problems, and hoping to resolve long-term problems over a short time period. So what can Children's Futures do to assist policymakers overcome these barriers and improve the health of children in Trenton and possibly beyond? That was our last question to policymakers. These responses underscore the broad themes detailed earlier:

- Think broader than the traditional medical model- include improvements in housing, employment, and nutrition;
- Include partners from the broader community and clients who access these services;
- Develop effective coordination at local level;
- Look at what works and what doesn't; you need substantial data to change policy and even then it doesn't happen overnight;

- Provide clear outcome measures; and
- Recognize that programs don't always have immediate impact; getting results takes time, often starting prenatally and as an infant.

To obtain the greatest impact and improve current activities, policymakers and community leaders need to work together toward a common goal. As one respondent affirmed, "policy [makers] and providers need to work together. Without funding and resources to implement programs, policy will fail." Finally, as one policy person stated "if Children's Futures can actually accomplish specific things by 'doing' this shows policymakers things can change. Trenton is the demonstration-- the world is watching-- do well."

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Endnotes

[1] A consultant was also used to interview staff regarding programs designed to improve birth outcomes. This consultant was selected because of her knowledge and background in the area of maternal and child health.

[2] Most of the program and financial information came from the respondents and not verified or validated by audited reports.

[3] To obtain this level of expense in the Trenton area, each program would have to provide that level of detail.

[4] These data are used by DHSS, but may not be currently available in public reports. Some evaluations under but the results has not been finalized are in public report.

[5] The Center for State Health did conduct an evaluation of some of the Newark School-based health centers and found that while some children were indeed receiving services at school, most children also used physicians in the community.

[6] We requested a copy of this report, but had not received it as of the completion of this report.
[7] Parents Anonymous of New Jersey was unable to provide the exact funding amount for POSSE.