

Collaboration and Community Change in the Children's Futures Initiative



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During the course of the 20th century, the federal government and private foundations financed numerous community-wide social efforts. These ranged from attempts to improve housing and economic opportunities for the urban poor to programs to improve education and social services. Government economic initiatives have achieved some success, but the improvements have often increased the cost of living in the targeted communities, forcing poor residents to leave. Other programs have achieved focused, specific goals but have failed to address corresponding concerns, so, for example, we have seen school buildings improve but not necessarily children's educational outcomes. Recognizing that single-pronged efforts make little headway in solving the problems of low-income communities, funders in the 1990s focused on broad efforts that addressed multiple social problems simultaneously. Unfortunately, these efforts also showed little success.

What does the lack of evidence about the effectiveness of community-change initiatives mean? Have many of the previous efforts been overly broad and diffuse, resulting in limited action? Or is contemporary urban life simply so complex that intentional efforts to impose community-wide social change are bound to fail?

Asking themselves these questions, most funders have backed away from financing community initiatives. The Robert Wood Johnson Foundation, however, has taken another approach with Children's Futures (CF), a program to improve the health and well-being of children from birth to age three throughout Trenton, NJ. Believing that broad-based initiatives are too diffuse to achieve results, the Foundation staff decided to focus efforts on a particular population within a community and rely on specific strategies that had shown evidence of effectiveness in the past.

Because many American cities are Trenton's size—fewer than 100,000 people—the initiative could have important ramifications for citywide efforts throughout the country. This report, and its

companion, *Early Outcomes in a Community Change Effort to Improve Children's Futures*, examine the promise of CF strategies. This report focuses particularly on program implementation, participant recruitment and collaborations among Trenton's agencies. The second report examines programmatic improvements and early outcomes for CF families. Major findings from both are compiled in *Children's Futures' First Five Years*; all three documents are available at www.ppv.org.

Children's Futures

Ultimately, CF seeks to prepare youngsters for success in school by ensuring they are healthy—physically and developmentally—from the very beginning of their lives. To accomplish this goal, Children's Futures, Inc. (CF, Inc.)¹, a nonprofit organization created to organize the effort and disburse funds, has provided resources to fund direct services for children and their parents; assistance to Trenton-area organizations to improve existing services to children and parents; and advocacy efforts to improve the policy and funding climate for such services.

In designing the initiative, CF, Inc., made three choices that have proven to be critical to the initiative's progress since it began in 2003. It elected to:

- Include all neighborhoods of the city as well as agency, city and state leaders;
- Target efforts and resources on changing institutions and services that benefit children from birth to age three, including prenatal care for mothers to ensure strong birth outcomes; and
- Emphasize local context in selecting which issues to address, not in picking which strategies to use.

The Foundation chose to focus on the entire city and include agency and government leaders to leverage resources. In contrast, many community initiatives target only a few neighborhoods, an approach that makes sense logistically and financially but offers limited influence with policymakers and funders—and meaningful improvements generally require both policy changes and additional resources.

Second, by targeting only children in the first three years of their lives, the Foundation has been able to make focused choices about how to spend its resources.²

The third choice—where to emphasize local context—has presented a significant challenge to community initiatives in the past. Often, community members, believing their area unique, conclude they should design an initiative from the ground up and spend several years trying and discarding or revising strategies as the initiative founders. The approach demands time and resources for program design, implementation and revision, and it can sour relationships among community members by making some feel slighted or ignored. In contrast, by selecting strategies that have evidence of effectiveness, CF limited the trial-and-error period and the resentments that often come with it.

Like all community initiatives, CF will take several years to develop, making any current analysis of the initiative's effectiveness premature. We can, though, discuss CF's progress in implementation, the strategies used to avoid problems common in many previous community initiatives and the challenges that remain. As Patricia Auspos and Anne Kubisch from the Aspen Institute Roundtable on Community Change pointed out in 2004, too little clarity exists on what community change is and how to achieve it. Case studies, such as this one, can be instrumental in expanding our understanding (Auspos and Kubisch, 2004).

What Does Children's Futures Hope to Achieve?

At its most general level, CF's founders hope that additional resources will strengthen organizational leadership and practices in Trenton's institutions; that strong organizational practices will contribute to high-quality programs and high levels of participation in programs and services offered to Trenton's children and families; and that, in turn, participation in services will improve infant and toddler health and parenting practices—ultimately helping to reduce family violence, improving language skills among young children and preparing children to enter school ready to learn.

Children's Futures' Activities

Three main components—prenatal and parenting education; child-care quality; and father involvement—form the core of CF's efforts. Attempts to make improvements in each area are carried out through three primary types of activity.

The Components of Children's Futures

Four parent-child centers financed by CF, Inc., and the city form the foundation of the project's prenatal and parenting education component. Each center is run by a different agency and serves about 60 mothers in home-visiting programs with a director, two family assessment workers (usually one nurse and one social worker) and four family support workers. The assessment workers evaluate mothers and then refer them to a support worker for services. The parent-child centers also hold regular activities on prenatal care, parenting, child development and behavioral health as well as social gatherings like Thanksgiving dinners and Christmas parties. These social activities are open to everyone in the neighborhood, not just to the mothers served in the home-visiting programs.

Child Care Connection (CCC), which runs the state's child-care resource and referral center in the Trenton area, provides the technical assistance in CF's effort to improve child care. CCC works with five child-care centers and 20 family child-care providers, providing on-site technical assistance, as well as materials and equipment, and holding training sessions and yearly quality assessments. The agency has dedicated five staff members to the initiative: a director and four technical assistance specialists—two for the center-based efforts and two for the family child-care efforts.

A fatherhood center was created inside Union Industrial Homes, which runs Operation Fatherhood, a job referral source for men. Three mentors each serve 10 fathers, and other staff members provide case management for up to 200 men at any one time. The program holds parenting classes and father-child activities at the center as well as father-child activities and trainings off premises.

The Types of Activity

CF engages in three broad categories of activity: direct services to children and their parents; assistance to Trenton-area organizations to improve services to these groups; and overall efforts to improve the policy and funding climate for the services.

In the first category, direct services, CF offers home-based and center-based support and programming for parents and helps other agencies develop referral networks to provide medical, dental and psychological care for the families. Direct services are generally offered through the parent-child centers, which house home-visitor staff members and host activities, and the fatherhood center. The initiative's strategies include:

Home-visiting programs. Nurses or paraprofessionals visit pregnant women and mothers of newborns to educate them about prenatal care, child development and effective parenting practices. Three home-visiting models are used in Trenton: Healthy Families America; the Nurse-Family Partnership; and a program that uses public health nurses employed by the Division of Health to serve women who are ineligible for the other two programs and who have serious health needs.

Center-based prenatal and parenting education programs. Staff members from the centers and partner agencies organize parenting groups, music and literacy programs, and other activities designed to strengthen parenting skills and children's language development; they also provide other behavioral health and support services.

- Efforts to improve parents' access to, and use of, healthcare for themselves and their children.
- Behavioral health services and substance abuse treatment.
- Intensive case management for fathers and referrals to social services (including employment, educational and behavioral health) that may enhance the fathers' abilities to care for their children.
- Mentoring of young fathers to encourage them to become more involved in their children's lives.

Second, CF also provides a range of technical assistance efforts to improve or enhance services to families and children in Trenton. The initiative has relied on a mix of national, state and local organizations to provide training and other supports to service providers. Relying heavily on local and state organizations, CF recognizes the important role that local organizations already play in the delivery of services and attempts to strengthen that role. Major technical assistance activities include:

- An effort to improve the quality of developmentally appropriate services in child-care centers and family child-care homes;
- Work to improve the efforts of pediatric and family practices with lead screening, on-time immunizations, and child-abuse awareness, identification and prevention;
- Training to improve recognition and treatment of domestic violence;
- Training to increase small agencies' organizational capacity; and
- A strategy to improve prenatal care by identifying best clinical and administrative practices among healthcare providers.

Finally, staff from CF, Inc., and its agency partners work together to improve the policy environment for healthcare, child care and parenting education. Their efforts include:

- Persuading the state to expand the State Children's Health Insurance Program to parents and change eligibility requirements; and
- Expanding behavioral health services for pregnant women.

Children's Futures Research

Public/Private Ventures (P/PV) set out to determine if the strategy undertaken by CF offers a promising approach to improving the health and well-being of an entire community. We focused on the three core components listed above, assessing the implementation of the strategies, the collaborations necessary to implement the initiative effectively and the initiative's success in changing institutional policies and garnering resources necessary to achieve its goals.

This report addresses the following major questions:

- How has CF fared in achieving its early implementation goals to provide and improve services for young children and their families?
- What lessons about collaboration and community change can be drawn from CF's efforts?

Research Methods

To collect information, P/PV used a “mixed-method” research design that included biannual site visits to Trenton to interview agency personnel, parents and community leaders; surveys of community residents and child-care providers; home-visiting intake and participation information; administrative records, such as birth data from the state; and ethnographic research. (See Appendix A for more detail.)

Structure of the Report

In Chapter II we discuss the community of Trenton to offer background on its residents and its climate for social services. We have organized Chapters III, IV and V around the initiative's three major components: prenatal and parenting education; child-care quality improvement efforts; and father involvement. Chapter VI focuses on CF as a community initiative, examining its collaborative efforts in light of characteristics that research has identified as important to successful implementation of community initiatives. Our conclusions are offered in Chapter VII.

In deciding to base Children's Futures in Trenton, the Foundation took into consideration the city's location, size, population and preexisting services. Those characteristics—plus the community's culture—have influenced how the initiative has developed.

Trenton's Demographics

Trenton's history reflects that of many eastern US cities: Once a booming industrial center with a prime location on the Delaware River, Trenton is now a Rust Belt city with a largely poor and minority population. Earlier waves of immigrants from Eastern and Southern Europe gave way in the 20th century to African Americans, Puerto Ricans and, most recently, Central and South Americans. In 2000, according to the census, 52 percent of Trenton residents were black, 32 percent were white and 22 percent were Hispanic; however, the true proportion of Hispanic residents was probably higher because, Trenton officials say, the census failed to capture the city's many undocumented workers. Hispanic residents made up an even larger proportion of the city's younger population; the census found that one quarter of all children under the age of 18 were Hispanic. Since 2000, the proportion of Hispanic babies born to Trenton mothers has increased steadily.

The census counted 85,403 residents. Among families with children younger than age five, 47 percent were led by single mothers. Twenty-eight percent of families with children younger than five were living in poverty, and the median family income in the city was \$36,681, significantly less than in the surrounding towns of Mercer County, where Trenton is located.

Because of the residents' poverty, Trenton struggles to pay for basic services, such as education, police and fire. However, its location as the state capital provides the city with stability and resources, and Trenton is less needy in many respects than some of its counterparts in New Jersey, such as Camden. These resources made Trenton attractive to the

Foundation, as did its location close to Princeton, the Foundation's home. Although the Robert Wood Johnson Foundation finances many national programs, its staff wanted to make a commitment to a local city.

Local Culture

Substantial differences exist between the culture and dynamics of Trenton's institutions and its population. Strong, occasionally fractious networks characterize the local political and service community. According to representatives of social service agencies, Trenton feels like a small town where "everybody knows everybody else." Agencies have a history of competition, though a few successful collaborations have occurred in the past, particularly regarding maternal and child health.

Given the agencies' histories, CF, Inc.'s staff members have navigated relationships carefully, but they also have enjoyed a base on which to build. Overall, the advantage of preexisting networks has far outweighed the drawbacks.

The small-town feeling that exists among agency staff does not trickle down to Trenton's residents—instead, residents view Trenton as a city of neighborhoods with specific boundaries that community members often hesitate to cross. The residents also report feelings of isolation. In 2002 and 2003, when P/PV first spoke with residents, they reported feeling relatively safe if they "kept to themselves," but fear has grown with skyrocketing gang activity.

Everyday Stress of Survival

In addition to community strains, many families in Trenton face significant economic hardship. Of all mothers who gave birth in Trenton in 2003, 71 percent were unmarried and almost 40 percent had not finished high school. Seventeen percent of all mothers were 19 or younger. (See Table 2.1.)

Access to public healthcare also presents challenges to many of the city's poor. Half of surveyed parents reported that their children were covered under Medicaid or the State Children's Health Insurance Program. Until Summer 2005, the agency administering public insurance required families to prove every six months

Table 2.1
Trenton Mothers Who
Gave Birth in 2003

(n=1,507)	
Race	
African American (not Hispanic)	51%
White (not Hispanic)	13%
Hispanic	35%
Other	1%
Mother's Education	
Less than high school	37%
High school graduate	39%
More than high school	24%
Unknown	1%
Mother's Age	
Less than 18 years	6%
18-19 years	11%
20-34 years	74%
Over 34 years	9%
Mother Is First-Time Parent	
Yes	25%
No	75%
Marital Status	
Single, never married	71%
Married	29%

Source: Data downloaded from the public use data sets on the New Jersey Center for Health Statistics website in 2005. <http://nj.gov/health/chs/vitalevents/index.shtml>.

Note: Numbers do not add up to 100% due to rounding.

that they remained eligible or risk losing coverage. As a result, many families went to medical appointments only to discover they lacked insurance. Pediatric and family practitioners reported with considerable frustration that families often encountered difficulty reinstating their coverage. In addition, many families were enrolled in an insurance plan not accepted at local clinics and hospitals.

Parenting Practices

During the planning period, staff at CF, Inc., and leaders in the Trenton community determined that parents needed help in learning how to

more effectively prepare their children for school. Information P/PV collected through a survey of community residents and ethnographic observations during home visits suggests that almost all parents provide their children with affection, but many lack knowledge about providing physical care and sufficient stimulation to babies. Just a little more than half of the parents reported reading to their children or playing with them at least five days a week, and only 30 percent said they took their children to a park or playground more than once or twice a week—all parenting practices that support cognitive and physical development in children.

Given the rising rates of childhood obesity and Type 2 diabetes in the US, teaching parents about nutrition and the importance of physical activity and play—both for themselves and for their children—may be a critical contribution of CF. In the community survey, less than half of all non-Hispanic black and white women (45 percent) breast-fed their babies and only 13 percent did so for seven or more months. Rates among Hispanic mothers were considerably higher—73 percent of Hispanic mothers breast-fed their babies for at least some time and 26 percent did so for seven months or more.

Based on the community survey findings, other parenting domains that CF hopes to affect include discipline, negative feelings about parenting, and the involvement of biological fathers in their children's lives. Fourteen percent of surveyed parents reported that they spanked, hit or slapped their children as a form of discipline, and three quarters of those said they had struck their child at least twice in the month before the survey. Almost a fifth reported feeling trapped by their responsibilities to their children. Hispanic parents most frequently reported feeling trapped (27 percent); according to agency officials, Hispanic mothers are primarily low-income undocumented residents, sometimes in abusive relationships or with men who want them to remain at home. Finally, a significant proportion of Trenton's fathers—25 percent—rarely or never see their young children, and half do not provide financial support. Almost a third see their children every day or almost every day, and another 29 percent see them several times a week.

Conclusion

The preexisting relationships among service providers in Trenton provided a good foundation for forming a cohesive, interactive network that could avoid duplication of services while providing an array of programs designed to meet residents' needs. CF, Inc.'s staff and partners identified many areas of need among Trenton's families: birth outcomes, child well-being, school readiness, parenting practices, parent behavioral health, prenatal and pediatric care, and quality child care.

Improving Access to Healthcare; Strengthening Parenting

Chapter III

To support the vision that “every child in Trenton enters preschool healthy and ready to learn,” the prenatal and parenting component of CF provides services ranging from home visits to activities for the entire community, all through four centers located around the city. In terms of the number of agencies involved, the number of children who can potentially be reached, the grant resources being devoted and the scope of activities, the prenatal/parenting component represents the most comprehensive of the initiative’s major components.

The prenatal/parenting component has six goals:

1. Reduce the number of women in Trenton receiving no prenatal care;
2. Increase the number of women receiving prenatal care in the first trimester;
3. Increase the number of eligible women enrolled in health insurance and linked with a source of primary health services;
4. Reduce the number of unplanned pregnancies;
5. Increase breast-feeding rates; and
6. Increase parents’ knowledge of child development.

Improving Prenatal Care and Parenting Practices

CF, Inc., and the city’s Division of Health provided grants to four lead organizations to run the cornerstone of this component—four community centers. The centers house the initiative’s major home-visiting program, Healthy Families, as well as parenting education and support activities.

Before the initiative, two home-visiting programs served Trenton: Healthy Families supplied long-term home visitors for approximately 60 families,³ and nurses working out of the city’s Division of Health provided occasional visits to new mothers on an as-needed basis. CF substantially expanded

Healthy Families, which now operates at capacity, serving about 60 families at each of the four centers and 60 through the original program, which covers the entire city. The Division of Health public health nurses continue to provide home visits to mothers who have other children with health problems that are better addressed by nurse home visitors than by the family support workers of Healthy Families.

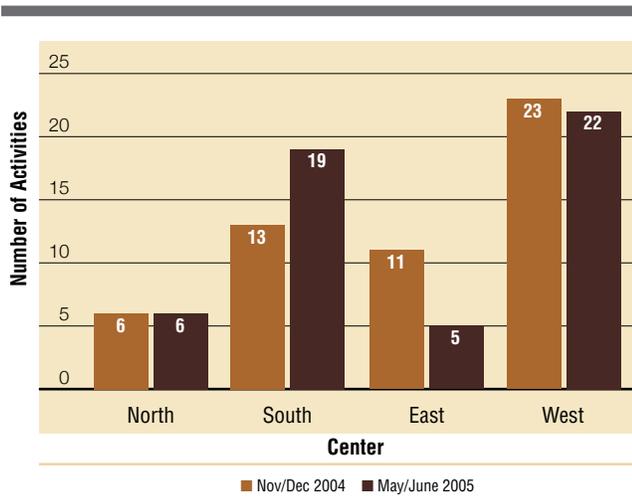
A third home-visiting program to serve 125 first-time mothers came through the leverage of CF funds by the Division of Health, which won a grant from the state Department of Law and Public Safety for creation of a Nurse-Family Partnership program. Although this initiative was not financed by the Robert Wood Johnson Foundation, the city staff involved in planning the initiative considered the Nurse-Family Partnership part of CF and a complement to the existing programs.

The Nurse-Family Partnership began enrolling pregnant women in Fall 2002, and the four center-based Healthy Families programs began operations in December 2002. By the end of their second year, the programs were all close to reaching capacity, and two had actually done so. These intensive home-visiting programs served close to 600 families from January 2003 to June 2005, representing an estimated 16 percent of the Trenton families with newborns during that period.

CF also implemented a variety of center-based activities, including support groups for English-speaking mothers, Spanish-speaking mothers and teen mothers; nutrition classes; and parent-child activities such as music and literacy circles. Figure 3.1 shows the number of activities across the centers during two months at different times of the year. It varied greatly, from a low of five sessions to a high of 23.⁴ The average number of participants also varied considerably, from 5.5 to 11.1 (see Figure 3.2). Participants represented a mix of mothers enrolled in home visiting and other neighborhood residents.⁵

The center staffs initially struggled with balancing center-based activities and home visiting, partially because of the time involved in training family support and assessment workers as the project got under way. Behavioral health activities proved especially challenging: Greater Trenton Behavioral Health

Figure 3.1
Number of Activities Held at Parent-Child Centers for the Periods Nov/Dec 2004 and May/June 2005, by Ward



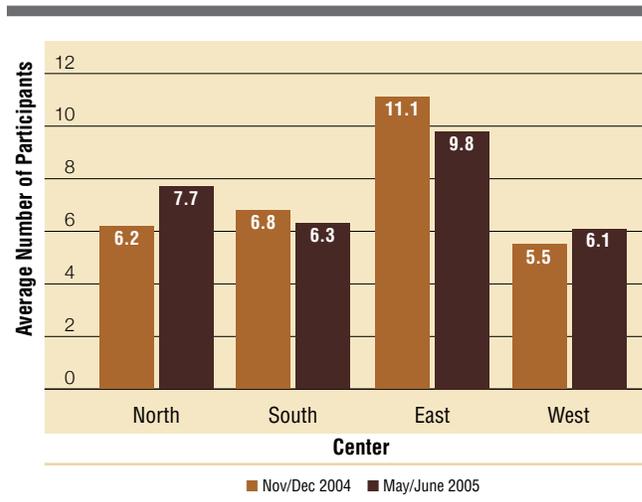
Center struggled to recruit participants, and mothers were slow to attend support groups because of the stigma associated with mental illness. The agency addressed recruitment challenges by offering a range of activities that allowed the mothers to get to know each other before addressing their problems and by hiring a counselor fluent in Spanish.

Implementing the Healthy Families Home-Visiting Curriculum

Ensuring fidelity to effective program components presents a challenge when adopting evidence-based strategies. Overall, CF implemented the Healthy Families model faithfully with one major modification: the addition of center-based activities and an additional family-assessment worker to help coordinate those activities. The two assessment workers and four family service workers in each center share responsibilities for providing support to staff members from other agencies running center-based activities.

In addition to ensuring that the staffing levels match the requirements set by the Healthy Families model, CF requires that anyone conducting home visits must first receive Healthy Families training from Prevent Child Abuse New Jersey. In addition, CF has provided a wide array of other training to staff members, including instruction on the Nurturing Parents curriculum, which is used in

Figure 3.2
Average Number of Participants per Activity for the Periods Nov/Dec 2004 and May/June 2005, by Ward

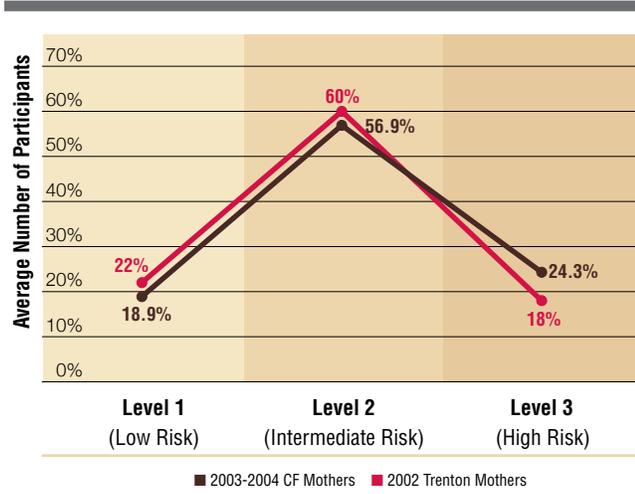


center-based activities, and training on domestic violence, gangs and personal safety, availability of county social services, child custody issues and father involvement. Although the training has better prepared the centers' staffs, the required time commitment has also resulted in stress, with members reporting that they find their responsibilities overwhelming at times.

Finally, observations of home visitors indicated that they faithfully use the required curricula for their model. Home visitors clearly convey messages about positive parenting techniques, show parents how to play with small babies and talk with parents about discipline techniques and feeding practices. They also encourage parents to let their babies explore their environments and show parents how to minimize safety hazards in their homes.

The need for intervention in Trenton is clear. In 2002, about 14 percent of the babies born in Trenton had at least one adverse birth outcome (preterm labor and/or low birth weight), twice the rate found in the wealthy and middle-class suburbs outside of the city in Mercer County. Trenton mothers were twice as likely (at 16 percent) to have smoked cigarettes and 10 times as likely (at 4 percent) to have used illegal drugs during pregnancy, compared with Mercer County mothers (New Jersey Center for Health Statistics 2005).

Figure 3.3
Distribution of Mothers' Risk Profiles



But not even a very well-funded program like CF can serve the mothers of all 1,500 children born in Trenton each year. To determine if the initiative reaches those most in need, P/PV developed a scale to measure a mother's risk of delivering a preterm or low-weight baby, taking into account the woman's age, race, marital status and health problems (see Appendix B for a full discussion on this scale). Women in Level 3 were several times more likely to have adverse birth outcomes than women in Levels 1 or 2. As seen in Figure 3.3, with Level 1 representing the lowest risk and Level 3 the highest, the initiative served a disproportionate number of mothers at the highest risk level.

Characteristics measured in program records and public birth data offer only a partial profile of risk. Beyond demographic and behavioral characteristics associated with poor outcomes, mothers in the home-visiting programs suffered a range of problems that could pose barriers to receiving adequate prenatal care and to providing a stable and positive environment for their children.

Family support workers say two thirds of their clients have trouble getting to doctors' appointments for lack of transportation; about a third live in overcrowded or temporary housing, report strained relationships with their child's father or are unemployed; a fourth face child-care issues;

and a fifth report behavioral health difficulties, such as depression. Domestic violence affects more than 10 percent of the clients.

Conclusion

No data yet exist to measure CF outcomes—we would not expect to see changes in 2003, the first full year of operations, and 2004 birth data for the city of Trenton were not available in Fall 2006, when this report was being prepared.⁶ Evidence from similar programs, however, suggests that well-implemented initiatives help increase breast-feeding, reduce unplanned pregnancies and improve parenting, particularly with respect to lowering rates of child abuse (Pugh et al. 2002; Kitzman et al. 2000; Love et al. 2002; Hardy et al. 1989).

Many benchmarks point to CF as a well-implemented program. Staffing levels meet or exceed the national standards set by Prevent Child Abuse America. Families meet eligibility requirements for both Healthy Families and the Nurse-Family Partnership, and the required curricula are regularly used in each home-visiting model.

Analyses also indicate that CF serves many high-risk mothers with a range of services. The quality of home-visiting services appears strong, with family support workers delivering messages and information from a curriculum with success. Each Healthy Families program operates at or near capacity.

Importantly, the evidence suggests that many of CF's clients are at higher risk of adverse birth outcomes than the general population of Trenton women. The influence of this program may even be stronger than we can measure now because of the additional unknown number of women served through center-based activities.

Improving the Quality of Child Care

Chapter IV

Working to improve child care for youngsters up to the age of three presented a natural fit for Children's Futures. Researchers generally agree that high-quality child care can make an important contribution to children's development and school readiness (National Research Council and Institute of Medicine, 2000), especially among children with developmental delays—some researchers have estimated that up to 35 percent of low-income urban children may have measurable developmental delays before they reach kindergarten.

Nationally, the need to improve the quality of developmentally appropriate child care is substantial, especially in low-income communities. Significant barriers exist, though, particularly when the high cost of quality infant and toddler care is compared with the low subsidy rates that are available. According to a survey conducted in 2001 by the New Jersey Association of Child Care Resource and Referral Agencies, the market rate in Mercer County for full-time care for an infant totaled \$224 a week (NJACCRRRA, 2001). Payments to providers for subsidized care are substantially lower: From July 1, 2004, to June 30, 2005, reimbursement rates for full-time infant and toddler care in licensed centers totaled \$152.20 per week⁷—less than 70 percent of the 2001 market rate.

Much of the cost of child care goes directly toward salaries. The low salaries paid in disadvantaged communities result in high turnover and low levels of training, both of which contribute to poor-quality child care. The high turnover fostered by low wages also hinders the development of stable relationships among staff members and the young children in their care. Of the full- and part-time infant and toddler staff surveyed in Trenton, 89 percent made less than \$20,000 per year: Forty-two percent reported annual salaries of less than \$10,000 in 2004, and 47 percent indicated they made \$10,001 to \$20,000 per year.

Child Care Connection (CCC), the local child-care resource and referral agency, leads CF's quality improvement effort, which initially involved 7 of the 14 centers licensed to serve infants and toddlers in Trenton. The organization focused on enhancing training and education of child-care providers and creating safe and healthy environments for the 260 youngsters that the centers served at any given time.

As a prelude to developing individualized plans, CCC rated the quality of the seven centers using the widely accepted Infant Toddler Environmental Rating Scale (ITERS), which consists of 35 items to measure the quality of center-based care for children up to the age of two and a half years.⁸ None of the 20 infant and toddler classrooms assessed in Spring 2003 received a "good" rating, and 10 failed to reach even minimal standards of care. The assessments showed problems involving parent-staff interactions, staff-child interactions, hygiene, safety and the amount and quality of toys, books and equipment. For example, providers left milk out of refrigerators for long periods of time and then fed it to infants; they did not wash their hands after diapering; and they left electrical outlets uncovered.

In addition to the centers, about 90 providers offer private and subsidized care to children in home settings. In assessing 20 homes for the program, CCC found uneven quality, noting many providers saw their job as "babysitting" and failed to offer stimulating and age-appropriate developmental care.

In evaluating the implementation of this critically needed component, we asked three questions:

1. What strategies have been used to improve the quality of child care in Trenton, both in child-care centers and in family child-care homes?
2. What progress has been made and by what means?
3. What challenges have been faced?

Strategies and Progress to Improve Child Care in Trenton

Although both family and center-based care share the same goals for children, the two settings place very different demands on caregivers, leading CCC to develop separate strategies for each.

Child-Care Centers

CCC provided assistance to center directors and staff members individually and in groups. The agency helped each center develop a quality improvement plan based on the ITERS scale to guide monthly technical assistance visits. The centers also received small grants from CF, Inc., to enhance their materials and equipment. In addition, CCC trained directors and staff members in topics ranging from the highly regarded High/Scope infant-toddler curriculum to strategic management and age-appropriate practices for younger children and infants.⁹

Child-Care Centers' Progress in Improving Program Quality

Five centers with a total of 13 classrooms made good progress in improving care during the first two years of the program (CCC dropped the two other centers because the directors were unwilling to invest time in the effort). Follow-up ITERS assessments made between Winter 2003 and Fall 2004 showed ratings jumping from “minimal” to “good” in three classrooms and care improving to mid-range scores in four others.

Improvements occurred in all areas, including hygiene, age-appropriate techniques for play and discipline, room arrangements more suitable for effective learning and play, increased interaction and communication with children, improved staff teamwork, more toys and materials for dramatic play and nature activities, and attempts to reach out to parents.

Improvements occurred even at the two centers that eventually left the program. Of the 10 classrooms failing to meet even minimal standards at the beginning of the program, seven were housed in those two centers; before those centers left CF, five of the seven classrooms met minimal care standards.

Center directors said they have found the initiative helpful in critical areas. They said the training led to a newfound understanding of child development and appropriate child-care practices. Several directors also indicated feeling more comfortable with the idea of firing employees who do not respond to direction on good child-care practice. Also, directors say they gained an understanding of the value of modeling positive practices for their staffs.

One CF center has even earned accreditation from the National Association for the Education of Young Children (NAEYC), a rarity among child-care centers serving low-income families in the Trenton area. Two centers participated in a NAEYC accreditation support project in 2005, and two others planned to begin the accreditation process in 2006.

Improvements in Staff Qualifications

Staff qualifications—experience, education, job tenure, training and attitudes—are critical to the quality of child care. Despite significant financial limitations, the centers have made progress in improving staff quality. Surveys conducted in Spring 2004 and a year later¹⁰ show that the percentage of staff members with at least two years' experience working with young children increased from 61 percent to 68 percent. In addition, twice as many caregivers (14.8 percent, compared with an earlier 7 percent) reported that they were currently in college. About half the caregivers hired in 2004 reported previous experience in child care or elementary education; this figure increased to 67 percent in 2005.

The level of training also increased in many categories from year to year. As Table 4.1 shows, the changes exceeded 10 percent in seven categories, primarily those relating to child physical health and safety, violence prevention and improving communications and relationships; almost all fell into categories directly related to CF's goals, such as reducing child abuse, encouraging literacy, improving parent involvement and fostering diversity.

In other areas, however, efforts fell short of hopes. Tenure remained low; almost two thirds of caregivers in 2005 had worked in the centers less than a year. Also, as Table 4.1 on the next page shows, little change occurred in six categories—five concerning child development and care—and training in child observation and assessment dropped significantly: 13 percentage points.

Changes in Attitudes about Appropriate Care for Children

Early in the initiative, CCC staff set a goal of increasing the affection that teachers and assistants exhibited and the encouragement for exploration and independence they offered to children. A survey of caregivers showed modest improvements between 2004 and 2005 with respect to encouraging

Table 4.1
Trainings Received by Caregivers in Child-Care Centers

	2004 (%)	2005 (%)
Physical health and safety		
<i>CPR/First Aid</i>	79.1	89.3
Health and safety	87.5	82.1
<i>Recognizing/reporting child abuse</i>	57.1	70.4
Child development and care		
Child development	74.4	72.0
Guiding behavior	60.0	65.4
Special needs	52.5	56.0
Curriculum planning	59.5	60.0
Room arrangement	63.9	68.0
<i>Emerging literacy</i>	44.4	56.5
<i>Child observation and assessment</i>	70.0	57.7
Other		
<i>Diversity</i>	33.3	50.0
<i>Violence prevention</i>	35.9	61.5
<i>Conflict resolution and team building</i>	40.0	65.4
<i>Parent involvement/communication</i>	52.6	66.7

Note: *Bold italic* represents categories in which there was a change of 10% or more in the proportion of caregivers who had ever received training.

exploration and independence. Overall, 28 percent improved in this area.¹¹ We saw virtually no improvement with respect to affection.

Family Child-Care Homes

To address quality in family child-care homes,¹² CCC developed a network of 20 providers (the agency ultimately hopes to recruit 30) to work with one of two family child-care coordinators. The agency, concerned about attracting providers committed to their work and improvement, recruited them from an existing program of the New Jersey Division of Youth and Family Services—Children Under the Protective Services (CPS) Family Child Care Network. Participation from these providers

stands to benefit the children CF hopes to help most: Research indicates that children from abusive backgrounds may experience developmental delays before they enter school (Cicchetti, Toth 2005), and that high-quality developmental care can be effective in preventing some delays (Burchinal et al. 2000; Peisner-Feinberg et al. 1999).

CCC gives the providers training and education on a one-to-one and group basis in the areas of early care and education, infant and toddler development, business development, CPR/first aid and support services. The agency offers transportation to the sessions. Two CCC family child-care specialists offer technical assistance biweekly using quality improvement plans developed from each home's

Family Day Care Environmental Rating Scale assessments and observations. Each provider also receives grants of up to \$1,000 annually for materials for infants and toddlers; the amount depends on the provider's progress through the quality improvement plan.

CCC wanted at least half of the family child-care providers to become nationally accredited or earn a credential in child development from the Council for Early Childhood Professional Recognition by the end of 2006, a goal that was not met. The agency also offers providers financial support to attend an early childhood or special education conference and to participate in the New Jersey Professional Development Center for Early Care and Education's New Jersey Registry for Childhood Professionals.

CCC provides formal group training in providers' homes on evenings and Saturdays at no cost to the providers, who enjoy seeing each others' setups. Topics, suggested by the providers, have included setting the environment and making room for infants; stories to use at creative-circle time; and junk art. CCC also offers providers supervised, self-instructional training based on a successful child-care strategy known as The Creative Curriculum, which covers the same topics presented in the courses for the child development credential. Providers set their own pace, contacting the coordinator to schedule a test after each chapter.

All but four providers made time to attend group training. Of the other 16, one provider completed all the trainings within six months, with several others close behind. About half completed half the trainings. The four providers unable to attend group sessions received primarily at-home training.

Six of eight providers who were reassessed a half year after joining the program showed improvement, in some cases significant. The biggest increases came in learning activities (scores rose an average of 17.5 percent), the use of space (16 percent) and efforts to develop language and reasoning (16 percent). Providers also improved their skills in the area of understanding and nurturing children's social development.

Providers say they have derived a range of benefits from the initiative and repeatedly report making specific changes in response to the technical assistance. The providers also emphasize that the trainings have helped them better understand children's development and capacities, and they express pleasure in observing children's responses to activities. In addition, the providers say, the coordinators' concrete advice and support have been critical in helping them put what they read or learn into practice.

Finally, the providers emphasize their appreciation for the respect and kindness they received from the coordinators. As isolated workers caring for children alone in their homes all day, they like the recognition the program provides.

Confronting Challenges in Improving Child Care

Although CCC has recorded solid progress, improving the quality of child care has been difficult, and the agency continues to face challenges.

Child-Care Centers

The improvements in child-care centers stand as a testament to the determination of the CCC staff to overcome obstacles. Owners, directors and center staff members have exhibited varied levels of enthusiasm for the program. Some have shown little interest in using new curricula in child development or in changing classroom layouts to foster learning, even going so far as to undo changes by CCC coordinators or refusing to use new equipment. Some centers employed staff members not trained in child care, and some directors felt so busy running their centers that they resented additional work.

Despite the challenges, CCC has established good personal relationships with center directors and staff and has achieved progress by working around the obstacles in several ways:

- Focusing on standards. Although this component has made steady strides, CCC members never express real satisfaction with the accomplishments. They always mention more work that can

be done, more support they can provide and more strategies for connecting with the other CF components.

- **Displaying persistence.** CCC staff members make very frequent contact by phone and in person with the centers. Just days before a training or workshop, they call with reminders and then call anyone who fails to arrive on time.
- **Engaging in advocacy.** In many ways, staff members demonstrate their strong support of the centers' needs and their willingness to get them support. CCC holds meetings with the centers' executive directors and owners to advocate for them, earning respect from directors and staff.
- **Making a time commitment.** By choosing to be involved in day-to-day operations, CCC shows it has not given up on centers. Staff members continue to rearrange rooms and provide materials and equipment even when they are not readily accepted. Over time, the child-care providers have noticed how the changes improve their rooms, their centers and the care they can provide children, building trust with CCC.

Family Child-Care Homes

The first approach that CF tried with family child-care providers was met with failure. Initially, CF, Inc., asked CCC to contract with three child-care centers to form home-care networks and provide technical assistance and training to the providers. CCC chose this approach to develop concrete links between centers and home-care providers to encourage cross-referrals, giving families alternatives when space was unavailable at their first choice of care. Each center hired a family child-care specialist responsible for recruiting providers, assessing the quality of the homes and providing technical assistance and group training.

The effort got off to a strong start with recruitment of 20 providers, technical assistance for each two to three times a month and training on a variety of relevant issues. Eventually, however, many of the recruited providers showed a lack of commitment to the field of home-based care and attended trainings only sporadically. The specialists also attended the trainings inconsistently, often pressed for time because the centers expected them to take on responsibilities outside of CF's requirements.

The centers also reported to CCC on an inconsistent basis, creating gaps in information about the providers' progress, causing the specialists and providers to seem disconnected from the CF initiative. And, finally, CF, Inc., dedicated only limited resources to this component.

Although restructuring when the implementation stage is well under way risks slowing whatever progress has been made, CF, Inc., and CCC jointly decided to make major changes to address these shortcomings. In June 2004, CCC assumed the role of sole overseer of the component. The results have been promising, with several specific factors contributing to the improvements:

- As a well-established agency with an extensive training component, CCC has been able to identify and hire coordinators with experience in training, working with community members and child development;
- The child-care specialists focus full-time on family child care;
- The program offers providers very clear training opportunities, and the coordinators actively encourage participation; and
- New recruitment strategies created a network of providers with a greater commitment to their work.

Conclusion

CF has made good progress in improving child care in Trenton. By late 2005, the five centers and 23 family child-care homes in the program were serving approximately 300 children under the age of three. The quality of centers and family child-care homes has improved, the centers are hiring more experienced staff and many of the providers remain enthused and committed. Finally, the people running the projects have shown willingness to make changes as needed while still maintaining their ultimate vision to improve child care in Trenton.

Serious obstacles to improving the quality of care persist, and many are outside the direct control of CF's participating organizations. Inadequate subsidies for child care represent perhaps the biggest barrier to improving the quality because of the limits they place on salaries and equipment.

Improving Fathers' Involvement with Their Children

Chapter V

Sobering statistics led CF to focus on strengthening and sustaining the involvement of fathers in their children's lives: Seventy-one percent of Trenton's babies are born to single women—more than twice the national average—and a quarter of those children will never, or just very rarely, see their fathers, if current trends hold.

These children face higher odds of problems in the years ahead than youngsters living with both parents. In the US, almost two thirds of the children born outside of marriage live in poverty, compared with only 8 percent of children from two-parent households (Drummond, Reich 2001). Whether because of the conditions associated with poverty, the absence of close ties with a father or both, children from single-parent homes do not perform as well in school and are more likely to suffer emotional and behavioral problems than other children. They are more likely to commit a crime and less likely to find and keep a job as adults and to attend college. Girls, in particular, are more likely to become sexually active at a younger age (Sylvester, Reich 2000; McLanahan 2001).

With the assumption that to become more involved in their children's lives, fathers need help addressing economic and social problems, such as joblessness, low educational levels, substance abuse and violence, CF brought together 25 community agencies to form the Trenton Men's Collaborative (TMC). As the lead agency, the Union Industrial Home for Children (UIH) convenes collaborative meetings and conferences, engages in community education about the importance of fathers and provides direct services to them. The wide range of services makes the fatherhood component far less focused than the other two.

In many ways, it also has been the least successful: Many of the participants come through the court system, not the parenting/education component of the program, as hoped, and few fathers receive the services they need because services do not exist or fathers are not eligible for the ones that do.

Follow-up data on most fathers involved in the TMC are not available, making analysis of the initial effects impossible.¹³ Our research focused on four questions involving the implementation:

- What are the component's specific goals?
- How successful has the component been in recruiting fathers, and how has it done so?
- Who are the fathers involved in the component?
- What services do fathers receive?

Goals

The TMC developed a comprehensive set of goals for the fathers involved in CF, including increased knowledge of child development, better relationships with mothers, increased financial support for children and improved employment rates. In addition, the collaborative hopes to eventually reduce fathers' substance abuse, criminal behavior and involvement in unplanned pregnancies. To meet these goals, the TMC:

- Refers fathers to a network of health, education, training and social services, including UIH's structured fatherhood program, Operation Fatherhood, which provides employment services;
- Offers a parenting education course to fathers; and
- Provides group and one-on-one mentoring by volunteers.

How Many Fathers Have Been Recruited, and How?

UIH has met its goal of recruiting approximately 100 fathers a year. Initially, CF hoped to involve the partners of mothers receiving home visits, but the women, many in strained relationships, have refused to talk with their partners about getting involved. In addition, many of the fathers believe the mothers bear sole responsibility for the children's care, according to staff at the parent-child centers.

In modifying the recruitment strategies, UIH staff members presented information about the program to directors of child-care centers, developed

father-child activities and trips in conjunction with Head Start and offered services to the local courts. In March 2005, UIH staff members invited family support workers from CF's parent-child centers to attend their annual fatherhood conference and offered training in their curriculum, National Partnership for Community Leadership, to help other agencies better serve fathers. A large number of men have come to the program through court orders requiring them to attend an emotional abuse course that includes parenting issues as well as strategies for negotiating difficult relationships with the children's mothers.

Who Are the Fathers Involved?

According to initial intake data, participants range in age from 17 to 50 and are primarily single, African American men. Eight percent of the men were expecting a child; 44 percent of the men had one child; and 38 percent had two or three children.

The men report a fairly high level of involvement with their children: Seventy-one percent report spending 15 or more hours per week with their children, about 10 percentage points more than the number of surveyed fathers who said they saw their children at least several times a week. Thirty-three percent read with their children, 36 percent play games with them and 24 percent share musical activities.

In the intake surveys that UIH administers to fathers, about 40 percent describe their relationship with their child's mother as "strained," "hostile," "okay" or "nonexistent," and 41 percent say they never participate in activities with both mother and child.

A significant minority of fathers also report using drugs or alcohol: Thirty percent of the fathers report using drugs, 67 percent of whom say they use them several times per week or every day. Thirty-nine percent say they use alcohol, though only four percent indicate that they use it every day. Thirty-two percent report that they do not practice safe sex.

What Services Do Fathers Receive?

UIH dedicates two full-time employees to CF case management, identifying fathers' needs, making referrals and following up. The staff makes referrals

to collaborating agencies for problems with substance abuse or behavioral health, housing, employment and other social needs.

In the first two years, 17 percent of fathers were referred to housing services, 5 percent to courts for custody or child support arrangements and 15 percent to behavioral health or substance abuse services. Another 17 percent were referred to the Mercer County Board of Social Services and 4 percent to other CF partners, including CCC and the parent-child centers.

Despite the referrals, many fathers received no services at all. Housing is among the most serious challenges: With a shortage of affordable housing, many fathers go on the city's long waiting list, and without a permanent address for the men, UIH finds connecting them with other services difficult. Other challenges include getting the fathers to keep their referral appointments, dealing with waiting lists at other city agencies and matching resources with needs. Substance abuse and behavioral health services in particular were in short supply; UIH went a year without a referral agency for drug addictions other than heroin.

Mentoring Services

Three part-time, paid workers serve as mentors for up to 30 men. They offer a role model as fathers, employees and citizens. Much of their job involves making phone calls to fathers, usually every other day, and dropping by their homes. The mentors also accompany fathers and their children on social trips and activities.

In addition, the mentors assist their clients with child support issues, working with the courts to establish a payment system to allow the children to receive support without overburdening the fathers.

Activities for Fathers and Their Children

UIH also holds activities at its center and takes groups of men on trips outside Trenton. At the center, activities have included the parenting education course as well as workshops focusing on infant CPR and first aid, financial literacy and emotional abuse/anger management. Outside activities occur

once or twice a month, including trips to the circus, the Franklin Institute in Philadelphia and the Baltimore Aquarium.

During the activities, the staff not only provide lessons on how to interact with young children but also work to change the culture of father parenting. As one staff member said:

So much info that men are never exposed to because of the way we are socialized [is included. The curriculum] teaches men to feel, to share in the raising of their children, to be equal with their mothers. A lot of them think to share in the rearing is unnatural.

The field trips teach fathers how to be prepared for outings with their children, how to appropriately interact with their children and how to guide their children's learning experiences. The trips also have offered an unexpected benefit to the men, as one mentor noted:

We went to the Franklin Institute [in Philadelphia] with their kids and significant others. We spent the whole morning [there]. You would be surprised that a lot of these guys haven't been out of Trenton. It's great to see their horizons broadened; they really start to grab ahold of it.

Conclusion

The initiative has reached its goal in the number of fathers recruited, but many come to the program through court orders, not through the education component. Once in the program, the fathers needing additional social services rarely receive them because of limited service availability in Trenton. Another major challenge is that the fatherhood center and the parent-child centers, which serve primarily mothers, largely operate independently of one another. Although the UIH staff has made significant efforts to ameliorate the lack of cross-center cooperation, staff members at the parent-child centers report that some fathers of the mothers involved in the centers do not want to be involved in what they see as "women's activities." Also, strained relationships between mothers and fathers, domestic violence and drugs often mean that mothers may not want the fathers of their children to be involved—and in some cases staff agree.

It is difficult to see how noncustodial fathers can become more involved in their children's lives if they (and the mothers) do not negotiate the terms of the involvement together. Yet, in its design, the onus of greater father involvement in Children's Futures rests with the men. Although these men may need better access to services in order to gain the stability necessary to parent effectively—such as employment, anger management, substance abuse and legal assistance—these services may not be sufficient if expectations to involve fathers are not placed on mothers too.

Community Collaboration in Children's Futures

Chapter VI

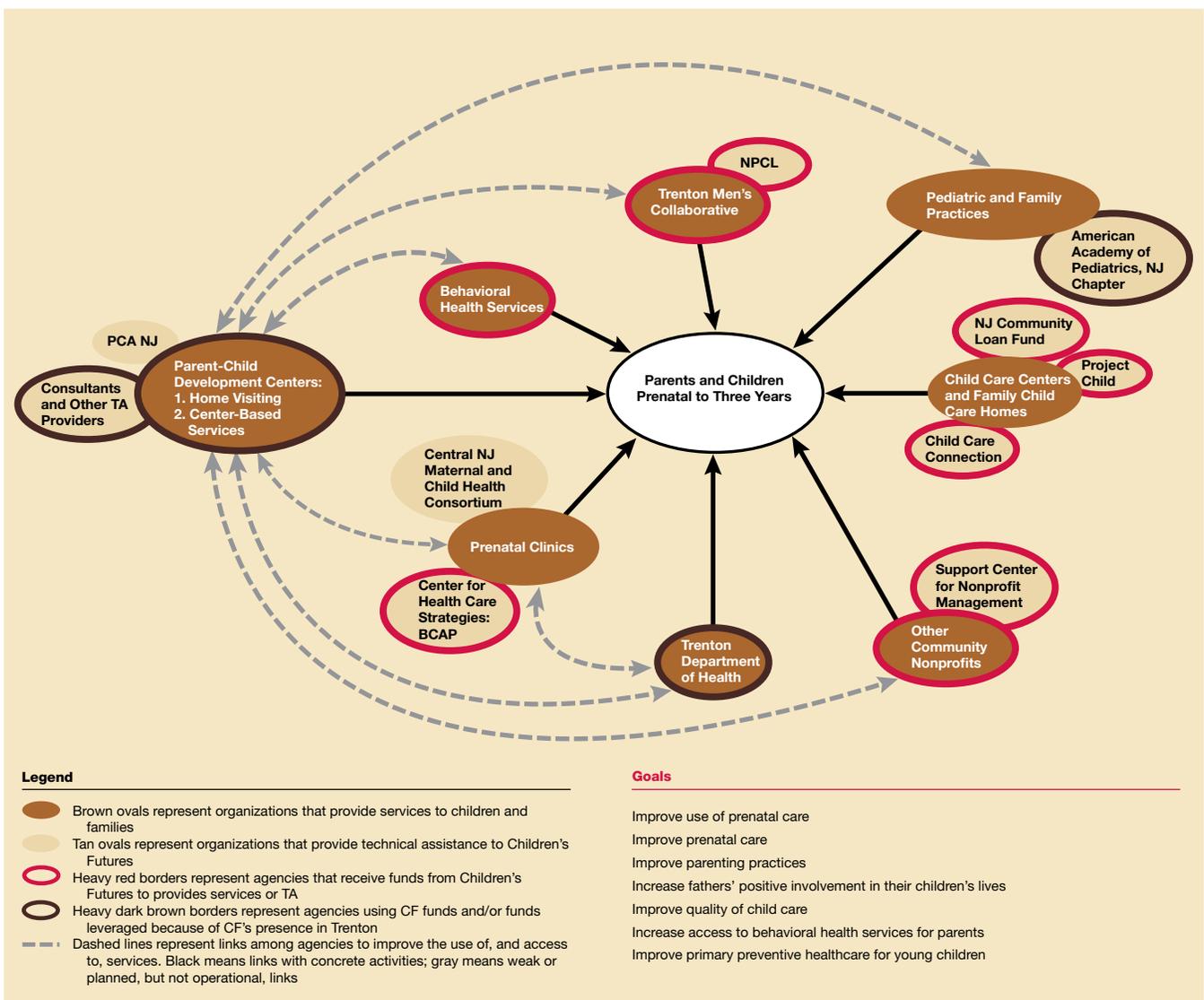
Children's Futures has shown promise in creating and maintaining partnerships among Trenton-area organizations, a formidable task in many respects. From the beginning, the initiative's designers—in particular staff members from CF, Inc., and the Trenton Division of Health—recognized the need to include local agencies, institutions and residents in their plans. Initiative leaders worked with the Central New Jersey Maternal and Child Health Consortium and the Division of Health to convene meetings with

organizations, and CF, Inc., staff members held focus groups with residents and community and faith-based leaders to discuss Trenton's needs.

To examine the specific benefits that have arisen from the partnerships, we addressed several questions:

- To what degree have new relationships among agencies been formed or existing relationships strengthened?
- What are the promising strategies for successful collaboration, and what has CF accomplished with respect to each strategy?
- What benefits, if any, have been observed from the use of the strategies?

Figure 6.1
Children's Futures Strength of Collaborations 2004



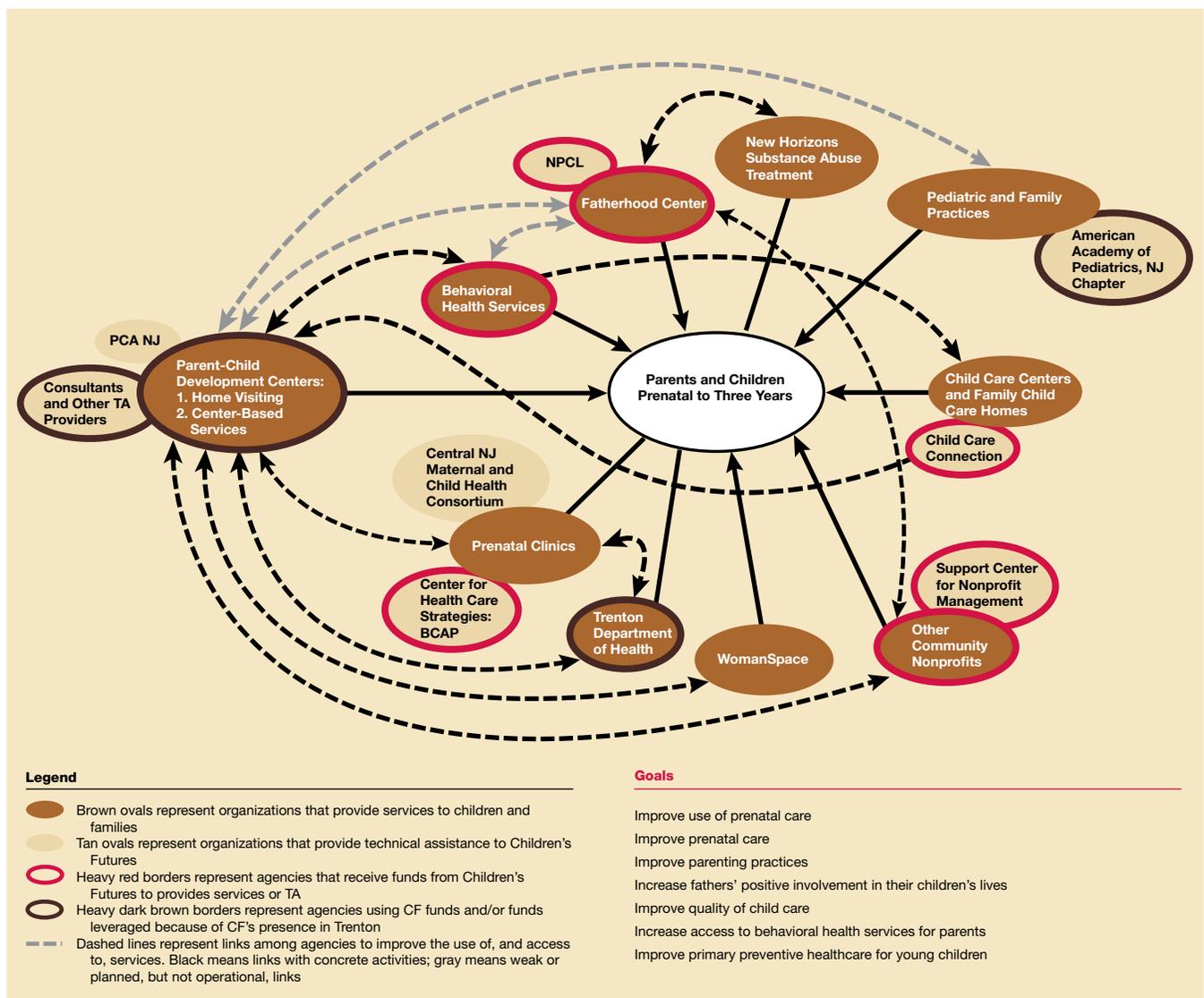
The Growth of Collaborations Among Trenton Agencies Over Time

As Figures 6.1 and 6.2 show, the number of collaborations in place in 2005 represented a significant increase over the number originally envisioned and established during the first year or so of the project. In some cases, collaborations failed to materialize, but agencies compensated by forging new partnerships. For example, both figures show that collaborations between the parent-child development centers and the Fatherhood Center never jelled, but the Fatherhood Center then formed a partnership with other community agencies, including Head Start.

Components of Successful Collaboration

Despite the challenges foundations encountered with community initiatives in the 1990s,¹⁴ the programs led to some success in limited areas, allowing researchers to identify key strategies in forming collaborations.¹⁵ We examined CF's success in implementing seven of those strategies. As we did, we kept in mind CF's definition of its "community" initiative: a place-based, citywide program that hopes not only to improve and expand services to Trenton's families but also to change parents' attitudes and behaviors about child-rearing.

Figure 6.2
Children's Futures Strength of Collaborations 2005



Build on an understanding of the community—its needs, its culture and its dynamics, including the degree of social cohesion present and its levels of safety (Brown 1997; Chaskin 1999; Jellinek 2004; Walker and Kotloff 1999; Walker and Arbreton 2004).

Without knowledge of the local community, initiatives run the risk of adopting strategies ill-suited to the community's level of readiness, population or culture.

Before implementation, staff members from CF spent about a year assessing Trenton's needs, capacities and community. They interviewed political and religious leaders, agency executives and residents. They commissioned a report from New York University's Wagner School of Public Service that compared levels of adverse outcomes across several New Jersey cities. They also talked extensively with staff from the city's Division of Health.

The research gave CF a clear picture of the agency landscape, and knowledge gained about inter-agency competition helped CF develop strategies to limit it. Staff members also have been mindful of the community's distrust of outsiders, whom residents perceived as touting—but not following through on—new initiatives. And the founding president of CF did not lose sight of the fact that, as a white man from Texas in Trenton, he must be very sensitive to the politics of race.

Develop an explicit strategy for action, monitor it and make adjustments as necessary (Auspos and Kubisch 2004; Brown 1997; Chaskin 1999; Schorr 1997; Walker and Kotloff 1999; Walker and Arbreton 2004).

Successful social programs must be clear about what they want to accomplish, how they hope to do so and why they think their strategies will result in their goals. Although obvious, this planning presents challenges for complex undertakings such as community-change initiatives. CF has a mixed record in clarifying its strategies but has been successful in monitoring itself and being flexible in adjusting approaches as needed.

While preparing proposal requests at the beginning of the initiative, CF staff members asked the evaluators to determine (through a literature review)

whether or not the proposed strategies would lead to the desired outcome. On the evaluators' advice, CF fine-tuned the requests, which went to agencies and organizations in a position to oversee the initiative's three main components. After receiving the proposals, CF worked with the agencies to refine their strategies in line with the initiative's goals.

As the initiative progressed, challenges led to changes in strategies and goals. The most comprehensive changes involved the fatherhood component. The broad goals the program established—addressing homelessness, substance abuse and behavioral and physical health—were out of sync with the services available in the city. As a result, after 18 months, CF worked with the agency to refocus its effort on involving fathers in their children's lives instead of addressing many of the challenges facing the fathers' attempts to find housing or address health problems.

When possible, CF staff members revisit the alignment of goals and strategies during the annual grant process. However, the city's large financial role in the parent-child centers—through two federal Healthy Start grants—makes revisions there difficult. City staff focus on home visiting, leaving little time for outreach to women in early pregnancy. The program now relies on prenatal clinics for referrals, so it is unlikely that two initial goals—substantially reducing the number of women with no prenatal care and increasing the number receiving early care—will be reached.

Generate belief in and commitment to the initiative's vision and goals (Brown 1997; Chaskin 1999; UHI Communications 2003a; VanderWood 2003b; Walker, Kotloff 1999; Walker et al. 1999; Walker, Arbreton 2004).

CF has nurtured the widespread commitment needed from agency and political leaders to sustain the initiative over the long term. By the end of the first phase of implementation, agency personnel remain enthusiastic about CF's vision and goals. Even the occasional strains that emerge from collaborations among people unaccustomed to working together did not result in any disagreements about CF's goals; disagreements, when they emerged, focused on how to achieve the goals.

Establish strong leadership, clear roles and responsibilities and clear decision-making processes (Brown 1997; Chaskin 1999; Walker, Kotloff 1999; Walker et al. 1999; Walker, Arbreton 2004).

Because initiatives require commitment, community members often feel a sense of ownership and expect involvement in decision-making. Although some comprehensive community initiatives begun in the early 1990s strove for consensus, achieving it is very difficult, if not impossible, with multiple organizations and a wide variety of people. Disagreements and turf battles often result (Brown 1997, Chaskin 1999, Walker and Arbreton 2004, Fleming et al. 2000). For these programs to achieve their goals, it is important to have clarity from the outset as to how decisions will be made, when and by whom (Chaskin *ibid*).

CF incorporates both approaches. In general, CF staff members convene meetings with a range of people from community agencies to discuss the advantages and disadvantages of options for specific aspects of the program. If the groups fail to reach a consensus, CF staff and board members, sometimes in conjunction with city officials, make the final decision, taking the discussions into consideration.

CF has experienced few of the leadership struggles common to other community initiatives for two reasons: The program's design reflects the opinions and views of a wide range of community members and leaders in Trenton, and CF's power over the funding gives the initiative authority. CF staff members also have won respect by taking community concerns seriously; when a variety of agency leaders complained about three large organizations getting the lion's share of grants coming into Trenton, CF offered grants to small agencies in recognition of their important contributions to the initiative.

The CF leadership has moved relatively quickly to address the few challenges that have arisen. In most cases, CF's response has eased concerns; for instance, when agency leaders complained about not being kept abreast of developments, CF initiated thrice-yearly meetings. In two key cases, hard feelings remain: CF refused to consider a proposal for a parent-child center that differed greatly from the request; the organization reluctantly revamped

the proposal and joined the initiative. In a second case, the major hospital in the city expressed interest in being more involved in decision-making (such as by having a position on CF's board of directors) but was rebuffed by CF's then president. These examples, although important, are exceptions to CF's record of generally strong relations with local agencies.

Finally, roles and responsibilities of both people and agencies have varied in clarity. Generally, the initiative has offered individuals well-defined roles. The responsibilities of the three components in relation to one another have been less clear. For example, the home visitors had hoped Child Care Connection would provide subsidies for child care to their clients, but CCC funds for providing such subsidies were limited, and long waiting lists existed. In addition, undocumented residents are ineligible for child-care subsidies from the state and federal governments, a rule that affected many home-visiting clients. CCC and CF staff members continue pursuing avenues for collaboration between CCC and the parent-child centers.

As new needs and activities arise in the initiative, occasional questions about roles inevitably emerge. In general, personnel across agencies have been thoughtful and responsive to the confusion.

Invest in community capacity and community building (Brown 1997; Center for Community Research and Service 2003; Chaskin 1999; Walker, Kotloff 1999).

The initiative has been very focused on building community capacity across a wide range of agencies through grants, improvement of healthcare practices and clinic efficiency, and awareness of domestic abuse.

Capacity-Building Grants

Working on a small scale at the beginning of the initiative, CF provided grant-writing training to agencies and then offered small grants for the projects the agencies proposed. Although a few community members complained the grants failed to address CF's explicit goal to improve school readiness, they were very much related to building capacity among smaller local agencies, also a CF goal.

In addition, organizations participating in the effort became aware of CF's efforts, further enhancing the initiative's reach in the community.

Efforts to Improve Healthcare Practice in Pediatric and Family Practices

CF has cofinanced a program with the New Jersey Chapter of the American Academy of Pediatrics (NJ-AAP) to improve healthcare in pediatric and family practices, with 11 of the 13 practices that serve the city's children participating. The NJ-AAP has provided technical assistance in lead screening, immunizations, and identification and prevention of child abuse. According to the NJ-AAP's baseline assessment, only about 50 percent of Trenton's children were tested for lead in 2002, and the city ranked seventh in the state in lead poisonings. To increase the screening rate, NJ-AAP provides kits to physicians' offices.

Training occurs at the practices and involves all staffers to underscore the importance of everyone's contribution to the healthcare team. One person other than the physician serves as each practice's liaison with the program.

Best Clinical and Administrative Practices

Best Clinical and Administrative Practices (BCAP) is a program designed to improve clinical practice. It was initially financed by the Robert Wood Johnson Foundation and the Commonwealth Fund, and implemented by the Center for Health Care Strategies (CHCS). Originally designed for managed-care companies and other health insurers, it focuses on producing cost efficiencies and improving the quality of care for patients with Medicaid and State Children's Health Insurance. Participants use data to monitor their progress in reaching self-defined outcomes, and CHCS provides technical assistance in using a quality framework that helps insurers organize and implement their plan.

CF asked CHCS to carry out a BCAP initiative in Trenton that focused on women's prenatal health needs but to target healthcare providers instead of insurance plans. The efforts failed. Two primary challenges emerged: Local health providers are not as motivated by cost efficiencies as managed-care plans, possibly because health insurers can reap large gains through their large client bases, and BCAP requires significant staff time.

CF then decided to adopt a statewide strategy, devising a plan for BCAP to work with five health maintenance organizations, which, in turn, would bring in major healthcare providers around the state as partners. The CF staff hoped that Horizon Health, the HMO serving Trenton, would involve the federally qualified health clinic in the city as well as Capital Health Systems, a major provider. The CF board approved funds for the work in Trenton alone, along with a portion of the "central expenses." CHCS subsequently identified funds to support the rest of the statewide effort, which began in 2006. This is one example of how CF has generated ideas and leveraged resources that support efforts not only within Trenton but also at the state level. Ultimately, statewide activity can support the political will to sustain efforts that aid Trenton residents.

Domestic Violence Awareness and Prevention

In Fall 2004, WomanSpace, a Mercer County agency, launched a technical assistance effort to increase awareness among family service workers of domestic violence and how to address it. The partnership allows WomanSpace to work directly with CF staffers in close contact with the city's families, as well as to work more strategically with Latinas, who—particularly if they are undocumented—often fear using needed services. In addition, a CF grant will allow the organization to get more materials translated into Spanish.¹⁶

Bringing WomanSpace into the initiative filled a critical gap. In many activities at the parent-child centers, women speak in groups about violence in their families. Family service workers also report on violence against mothers. The partnership with WomanSpace not only gives the workers more information on how to deal with the problem but also gives them a referral source for abused women.

Nurture connections among people, institutions and ideas (Center for Community Research and Service 2003; Jellinek 2004; VanderWood 2003a; VanderWood 2003b; Walker, Kotloff 1999; Walker et al. 1999; Walker, Arbretton 2004; Watson 2002).

Nurturing connections can encompass a wide variety of activities involving communication, collaboration, partnerships and integration. Because

the report already has addressed a broad array of collaborations and partnerships, we examine communication and integration here.

Communication

Effective communication allows organizations to share knowledge and information that are critical in community initiatives. CF has greatly increased communication in two important areas but has failed in two others.

Staff members in Trenton agencies, and even in the county and state governments, agree CF has significantly increased communication among agencies. This kind of communication, which involves participants at similar levels of authority, can help identify and resolve challenges while establishing common goals and language. CF convenes monthly meetings with project directors, executive directors and "key communicators," people less involved in the direct work of CF but very involved in providing services in Trenton.

CF also has fostered a significant increase in communication among experts who impart knowledge to others in hopes of changing behaviors. This type of communication has occurred between service providers and Trenton residents and in the trainings for agency staff members.

CF has fallen short in communication between community members and agency staff. Although CF consulted with community members while planning the initiative, few exchanges to identify and resolve challenges have occurred since. This oversight could cause problems in reaching the initiative's goal of altering some cultural practices around parenting.

To achieve change, we speculate the initiative will need cultural "translators" from the community who have moral authority, can understand the logic of the proposed change and communicate its importance to the community in meaningful terms (Walker, Kotloff 1999). CF will be unable to win over many ambassadors without a healthy exchange of ideas between community members and agency staff.

In addition, little vertical communication exists among community residents and agencies. Greater vertical communication has the potential to increase the reach of CF's work: Community

residents who support and further the initiative's work may be able to reach residents who avoid involvement with social service agencies.

Integration

At its most complex, nurturing connections can mean the intentional integration of services. CF has been relatively successful in establishing integration within each of its various components and in making use of the standard protocols that exist for referrals to behavioral health services and home-visiting programs. Integration across the components, however, has been less successful, in part because it was not part of the initial design.

Use information in ongoing learning and assessment to improve practice (Brown 1997; Jellinek 2004; VanderWood 2003b; Walker, Kotloff 1999; Walker, Arbreton 2004; Watson 2002).

CF has used information from the start of the initiative to assess community assets and needs and to improve implementation practices. In addition to comparing Trenton's birth statistics and educational outcomes to other New Jersey cities, it has relied on data from home-visiting programs to assess progress and on implementation information provided by the evaluation. It has also relied heavily on responses from partners who are implementing programs.

What Have Been the Benefits of CF?

CF has done well in creating collaborations, but what value has emerged from the process? Considerable cost goes into maintaining relationships in community initiatives, and concrete results often make expenditures more palatable. To measure the benefits, we asked a question: If CF encompassed a collection of grants to discrete agencies in one city to provide services, what elements would probably be lacking that exist in the community initiative? Three come to mind:

- Multiple stakeholder groups that meet regularly;
- Formal partnerships among agencies; and
- Significant presence in the community.

What are the benefits of those elements as they currently exist in CF?

The creation of multiple stakeholder groups has enhanced provider networks, expanding support networks for staff in high-stress roles, interagency trainings and providers' knowledge of community referral sources.

CF convenes regular monthly meetings that bring together directors of the parent-child centers and other lead agency projects. Executives of the lead agencies meet as a group with CF three times a year. Family support and family assessment workers meet somewhat less regularly to talk about the initiative's progress, but they often go to group trainings together. In addition, CF staff members host a monthly "key communicators" meeting for faith and social service leaders and others to share information about services and inform the community about CF's work. These venues for people to meet have expanded providers' networks.

Family support workers say the knowledge of community resources they have gained has helped them better serve their clients with referrals and that other agencies often give CF clients preferential treatment. Much of this knowledge sharing occurs indirectly when CF brings together staff members for other purposes, such as trainings, workshops or focus groups for the program evaluations.

Directors of parent-child development centers report that knowing others who face similar responsibilities and challenges has been an important support. Of the original four directors, three remain, and they have provided welcome advice and support to the newest director. Not only do directors meet in groups, they also have developed informal professional relationships.

In addition, frequent communication and meetings among partners has also increased interagency training. CF has provided training, underwritten by Healthy Start and the Robert Wood Johnson Foundation, by national experts and local agencies in child health, domestic abuse and child development. Directors of parent-child centers and other agencies increasingly report that they rely heavily on staff from partnering agencies to provide additional trainings. Several agencies in Trenton, including CCC and WomanSpace, have extensive training programs that predate CF; the initiative has allowed other agencies to tap into those resources.

Formal partnerships among agencies have led to creative thinking about how to deliver services more effectively.

One example of creative thinking involves the delivery of behavioral health services, a major challenge identified early in the initiative. According to staff at Greater Trenton Behavioral Health Center (GTBHC), many low-income people, particularly African Americans, find behavioral health services stigmatizing and avoid them. At the same time, many of the low-income women seen by staff at the parent-child development centers exhibit signs of stress and depression. Initially, GTBHC planned to serve women with short-term services while they were being matched with agencies that could provide longer-term care. Unfortunately, many women needing services went without them because, even without the influence of social stigma, the large number of women referred for services exceeded local capacity. GTBHC took another tack, developing group activities in partnership with the centers to help mitigate the isolation many of the women felt and to identify mothers needing more targeted, longer-term treatment. This change in service delivery has helped GTBHC reach more women and focus in-depth services on those most in need.

The participation of a variety of agencies and providers has helped the initiative develop a strong presence in the community, giving the initiative weight in statewide policy discussions and facilitating the intervention of home visitors on behalf of their clients.

The initiative's good reputation in Trenton and visibility has helped the organization develop useful partnerships with state agency personnel and political leaders. For example, CF's efforts with the NJ-AAP came to the attention of legislators, who then sought the advice of CF staff about healthcare reform in the state. The bill signed by the governor in July 2005 contained two provisions advocated by CF staff members: expansion of the State Children's Health Insurance Program and changes in eligibility regulations, both designed to increase children's access to healthcare.

The strategies CF chose and the flexibility the program embraced has allowed the initiative to achieve short-term success rarely seen in community-wide programs. Challenges remain and only quantitative research in the years ahead will show whether CF reaches its ultimate goal—preparing Trenton's children for success in school. But early signs show that CF has made an impact just a few years into the program.

CF's success rests with several decisions made early in the process: The initiative relied on previous research and practice to guide local strategies and then developed new tactics as the need arose. CF staff designed the program based on thorough research of Trenton, including its political structure, agencies and residents, and consulted extensively with local leaders. To keep efforts—and funding decisions—focused, the initiative centered efforts on one domain of action and one target group: health and well-being for children up to the age of three.

Achievement of Implementation Goals

Under the theory guiding the initiative, resources provided by CF will strengthen organizational leadership and practices in Trenton's institutions. These organizational practices will contribute to high-quality programs and to high levels of participation in programs and services offered to Trenton's children and families. Participation in these services will contribute to improved infant and toddler health and improved parenting practices. To accomplish these goals, CF has provided resources to direct services for children and their parents; assistance to Trenton-area organizations to improve existing services; and advocacy efforts to improve the policy and funding climate for such programs.

The programs in CF rapidly got up to speed. After just one year of operations, the new home-visiting programs quadrupled the number of women previously served. The fatherhood component met its goals of recruiting 100 men a year. Half of the 14

child-care centers providing infant/toddler care and 23 of the 90 family child-care homes in Trenton have received technical assistance from the lead agency for the child-care component, CCC. Eleven of thirteen private pediatric and family-practice offices are participating in an effort to improve their care in four key areas: on-time immunizations, lead screening, child abuse awareness, and identification and prevention of child abuse.

Data indicate the home-visiting programs serve women at higher risk for adverse outcomes than present in the general population, and early information suggests that outcomes for babies born to women involved in the programs may be better than for other Trenton women at similar levels of risk. Almost all of the children being served have health insurance and immunizations. More Trenton fathers are being referred for needed services than previously, and the child-care centers still involved in the initiative are making modest but steady improvements in their centers.

Strategies

During the year of background research on Trenton, CF staff members identified the local leaders needed for help in planning and the gaps in resources the initiative could fill. An examination of lessons from previous initiatives led planners to focus efforts on young children and to rely on proven strategies to avoid an extensive trial-and-error period. These efforts contributed to a quick and successful implementation, as did responsiveness and flexibility in adjusting strategies.

By focusing on the entire city of Trenton and including social service leaders from the city, county and state governments, CF has developed the resources and political capital needed to achieve meaningful changes. In past programs, researchers have found that focusing on neighborhoods in larger cities leads to limited influence with potential funders and policymakers, making it difficult to create the changes needed to strengthen a community. Additionally, by including a broad range of local agencies in the planning and implementation of the initiative, CF reduced the tension, disagreements and turf battles common to community initiatives. CF's dual role as funder and technical assistance provider also limited the struggles that

typically hinder community initiatives while enhancing the organization's ability to keep spending in line with goals.

Rather than focusing on broad changes in Trenton, CF has focused singularly on the health and well-being of children ages zero to three. Broad efforts often become too diffuse and attract extensive political challenges around the legitimacy of their goals. Challenges to CF's goals have been very limited and have focused only on implementation strategies.

CF's flexibility has allowed the initiative to stay focused on its goals by quickly adapting and developing new strategies. The organization's ability to listen to partners and make quick but thoughtful adjustments has been an asset to the initiative. Though not all components are being implemented as successfully as others, the progress of the initiative has been impressive, reinforcing the community's understanding of the leadership's commitment to the effort.

Looking Ahead

Children's Futures will continue its efforts to improve the health and well-being of Trenton's youngest children with a second five-year grant from the Robert Wood Johnson Foundation. In addition to many of the activities in which it is currently engaged, it faces new challenges and opportunities. New opportunities include funds from the state because of CF's reputation in New Jersey as a strong, well-implemented initiative. New challenges include countering the increasing gang violence in Trenton and the likely relocation of the city's major hospital to a nearby town.

From its inception CF has been run by staff from local agencies. Residents' roles have largely been restricted to being agencies' clients or paid staff. They have not been very involved in shaping the initiative, acting as emissaries for the initiative with hard-to-reach residents or conveying the messages about nutrition, effective discipline, father involvement, early literacy practices or any of the other areas in which CF hopes to change parenting practices in Trenton. Without expanding residents' roles, the cultural changes that need to take place to support and sustain CF's goals over time are

unlikely to occur. To achieve its goals for Trenton's children, CF hopes to expand resident involvement in the initiative's work.

In addition, in preparation for the period beyond the next five years, the CF organization will develop plans for future sustainability.

Endnotes

- 1 We refer to the overall initiative as Children's Futures (CF) and the organization set up to run it as Children's Futures, Inc. (CF, Inc.) to help the reader distinguish between the two.
- 2 The Robert Wood Johnson Foundation—with a \$20 million allocation for the first five years—has funded CF at a higher level than is typical of many community initiatives. Although this is a substantial amount of money, choices about how to best invest it must still be made.
- 3 The capacity of the program depends on the mother's need for services, and thus there can be more than 60 women active at a given time if some of the mothers are receiving only monthly visits.
- 4 The figure for the North Ward is an underestimate of activities (it excludes a weekly activity that is not funded under the CF grant but is provided to CF participants; the addition of that activity would raise the North Ward's figures by four to six for each period). In addition, the May/June figure for the East Ward is lower than typical for the ward because the center experienced a flood, needed significant renovations and did not provide activities for June and July 2005.
- 5 We have no information about the proportion of attending mothers who are home-visiting clients and those who are not. We do know from observations that there is a mix.
- 6 The lack of city-level data for 2004 means that cross-city and time-series comparisons are not possible.
- 7 The figure came through personal communication with a CF project director at Child Care Connection.
- 8 The 35 items are organized into seven categories: Space and Furnishings, Personal Care Routines, Listening and Talking, Learning Activities, Interaction, Program Structure and Parents & Staff (Adult Needs). Each item is presented on a seven-point scale, with descriptors for 1 (inadequate), 3 (minimal), 5 (good) and 7 (excellent). The quality measures found in the ITERS coincides with the Criteria for Quality Early Childhood Programs stated by the National Academy of Early Childhood Programs (NAEYC, 1984) and with Child Development Associate (CDA) requirements (Harms et al. 1990).
- 9 More than 60 directors and staff members had participated in training sessions by the end of 2004.
- 10 In Spring 2004, staff members returned 45 of 61 surveys handed out, for a response rate of 74 percent; in 2005, 53 of 64 staff members filled out surveys, for a rate of 83 percent.
- 11 We measured caregiver attitudes by administering questions adapted from a parenting instrument developed by Wendy Goldberg and Ann Easterbrooks (Goldberg, Easterbrooks 1988).
- 12 This category is defined as a child-care arrangement for no more than five youngsters in the home of a nonrelative.
- 13 UIH plans to gather data in the future that P/PV will examine to determine if the program has affected the fathers' relationships with their children and the youngsters' mothers.
- 14 An early initiative, the Annie E. Casey Foundation's New Futures, resulted in a report detailing the challenges in the undertaking (*The Path of Most Resistance: Reflections on Lessons Learned from New Futures*, 1995. Baltimore: The Annie E. Casey Foundation. Downloaded 9/16/04 from: <http://www.aecf.org/upload/publicationfiles/the%20path%20of%20most%20resistance.pdf>). The Aspen Roundtable on Community Change also detailed the potential benefits and challenges to implementing such broad efforts (1995, 2004).
- 15 Most of the lessons are drawn from qualitative implementation studies that compared the effectiveness of different strategies across several communities. Although not definitive, the research led several authors to draw similar conclusions based on comparative case study analyses.
- 16 Although getting Spanish translations would seem to be a modest expense, a staff member from WomanSpace indicated that she had long wanted to do so but did not have the resources.

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Appendix A

To collect information, P/PV used a “mixed-method” research design that included site visits to Trenton to interview agency personnel, parents and community leaders; a baseline community survey of community residents; three annual surveys of child-care providers; home-visiting intake and participation information; administrative records, such as birth data from the state; and ethnographic research.

Interviews and focus groups were conducted twice a year with agency personnel involved in the initiative, local and state government leaders that funded parts of the initiative, and parents. These interviews and focus groups were designed to assess the initiative’s progress in implementing programs with evidence of effectiveness and in coordinating activities across agencies within the city of Trenton.

A baseline community survey was conducted on the telephone in Fall 2002 with 654 Trenton parents of children from birth to age 5 to assess parents’ involvement in their children’s lives, parenting practices (such as the frequency that parents reported reading to their children, taking them to parks or other parent-child activities), and self-reported parent and child health.

Annual surveys of child-care providers were conducted in the 5 to 7 child-care centers involved in the initiative. The surveys were intended to assess child-care providers’ work experience, credentials and other training, along with their attitudes toward caring for children, particularly with respect to nurturing children’s independence and discipline practices. Initially, seven centers started in the initiative. Over time, however, two centers closed due to severe financial problems, and the number of centers dropped to five.

2003 individual level birth data for Trenton were downloaded from the State of New Jersey Center for Health Statistics website in 2005. Those data are geocoded for mother’s residence and are available on a municipal level for New Jersey cities.

Ethnographic research was conducted in 2003 to better understand Trenton’s living environment for its residents. The researcher conducted a scan to identify discrete neighborhoods and better understand who lived in them (primarily with respect to race, ethnicity and length of time living in Trenton). As part of this scan, he talked with a number of Trenton residents about their perceptions of the neighborhoods and the city.

Appendix B

To measure the risk of a Trenton mother giving birth prematurely or to a low-weight baby, we examined the 2002 state birth data for Trenton mothers and found five categories that contributed significantly: age, race, marital status, health and prenatal care.

Using the characteristics in Table B.1, we defined three risk levels, from low risk to very high risk, of having a baby with a poor birth outcome. Table B.2 defines each level and provides the odds of a Trenton mother having a low-birth-weight or preterm baby given that she is in a particular risk category, compared with not having any risks. For example, mothers in level 2 are more likely to have a low-birth-weight baby but not a preterm baby, compared with mothers in level 1. However, mothers in level 3 are more likely to have both a low-birth-weight and preterm birth.

Table B.1
Odds of Poor Outcomes among Trenton Mothers Who Gave Birth in 2002

	Low-birth-weight baby	Preterm birth
Adolescent	1.8*	1.3
Minority	3.7*	1.3
Single	1.8	1.2
Health problems	2.6***	2.3***
Late prenatal care	0.8	0.9

*p<0.1; **p<0.05; ***p<0.001

Table B.2
Levels of Risks and the Odds that Trenton Mothers Who Gave Birth in Each Level Will Have Adverse Birth Outcomes

Risk Level	Definition	Low-birth-weight baby	Preterm birth
1	Mothers in category have 1 or none of 5 risk factors; if they have 1 risk, they are still considered very low risk for adverse outcomes.	Category used for comparison	
2	Mothers have 2 to 4 risk factors, none of which is considered a health risk.	4.8***	NS
3	Mothers have 1 to 5 risk factors, including at least 1 health risk.	9+	1.9***

* p<0.1; **p<0.05; ***p<0.01; +p<0.001; NS=difference not significantly different from comparison category



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