Early Childhood Intervention and Teen Pregnancy Prevention White Paper

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Prepared for

THE FOUNDATION FOR A HEALTHY HIGH POINT
Leadership for change
Executive Summary

This report to the Board of Directors of the Foundation for a Healthy High Point was prepared as the Foundation considers strategic investments in early childhood and pregnancy prevention to best support young families and optimize early child development and education. These are critical levers for improving the health, social, and economic well-being of the High Point Region. Investing in early childhood will yield short-term results (such as improved school readiness, decreased utilization of emergency services) but the long-term results are even more important. By investing in early childhood, the foundation can help set the stage for decreased childhood adversity, school success, career success, delayed pregnancy, and decreased juvenile delinquency and criminal behavior. Teen pregnancy shares many overlapping risk factors with poor social and development outcomes in childhood. Many of the best programs for early childhood are well documented to delay subsequent pregnancy of the teen mother, as well as a future first pregnancy of the infant being served (e.g. Nurse Family Partnership). However, teen pregnancy prevention, especially first pregnancy prevention, may require a different set of strategies including in-school and afterschool programming and access to affordable, confidential, contraception.

The report that follows will review both the problems and potential solutions to these issues developed in a public health framework. We will then review available data both at the community, county, and High Point region level as it applies to these issues. We will review the findings from two stakeholder focus groups, and then conclude with a series of recommendations for investment from the foundation.
# Table of Contents

Executive Summary .................................................................................................................. 2

Intended Use and Users .......................................................................................................... 5

Purpose and Introduction ......................................................................................................... 5
  Public Health Model and the Spectrum of Prevention ............................................................. 6
  Investing in Early Childhood .................................................................................................. 9

Scope of the Problem ................................................................................................................ 9
  Early Childhood Well-being ................................................................................................. 10
    School Readiness .................................................................................................................. 10
    Quality of Care in North Carolina ....................................................................................... 13
    Parent-Child Relationships ................................................................................................. 14
  Teen Pregnancy .................................................................................................................... 14
  Special Populations and Health Disparities ......................................................................... 17

Evidence Regarding Risk and Protective Factors .................................................................. 19
  Child Poverty and Socioeconomic Status ............................................................................ 19
  Minority Status ...................................................................................................................... 19
  Early Childhood Well-being ................................................................................................. 19
  Teen Pregnancy .................................................................................................................... 20

Evidence-Based Interventions ................................................................................................. 21
  Early Care and Education ...................................................................................................... 22
  Early Childhood Interventions ............................................................................................... 24
    Universal Prevention ............................................................................................................ 24
    Selective Prevention ............................................................................................................ 26
    Indicated Prevention ............................................................................................................ 28

Examples of Evidence-Based Programs .................................................................................. 29
  Triple P ................................................................................................................................... 29
  Home Visitation (Nurse-Family Partnership) ........................................................................ 31
  Parent-Child Interaction Therapy .......................................................................................... 35
  Teen Pregnancy Prevention .................................................................................................. 36
    Long-Acting Reversible Contraceptives (LARC) ................................................................. 36

Collective Impact ...................................................................................................................... 37

Greater High Point Area Needs Assessment ........................................................................... 38
  Methodological Approach ..................................................................................................... 38
    Secondary Data Analysis .................................................................................................... 38
  Description of the Geographic Region .................................................................................. 39
  Services Available in the Greater High Point Area ............................................................... 52
  Focus Group Methodology .................................................................................................... 57
    Focus Group Results .......................................................................................................... 58

Current Activities of Other Foundations .................................................................................. 63

Conclusion ............................................................................................................................... 64
Intended Use and Users

The intended user of this document is the Board of Directors and staff of the Foundation for a Healthy High Point (herein “the Foundation”). This white paper was developed based on a specific request for proposal. The information herein is intended to inform the investments of this foundation. However, the review of the research and recommendations may be particularly useful for other providers and stakeholders in the Greater High Point area. Although the information and recommendations may be applicable to other settings, it is intended for a specific audience.

Our efforts were guided by the mission statement identified on the Foundation website:

The Foundation for a Healthy High Point exists to encourage, support, influence and invest in efforts that improve health and wellness throughout Greater High Point. Our tagline, “Leadership for change,” exemplifies our intent to be a leader in collaboration, supporting initiatives that improve the long-term health of our community. We accomplish this by examining health issues and identifying evidence-based practices to improve health and wellness in Greater High Point.

Purpose and Introduction

The purpose of this White Paper is to provide a summary and analysis of the current science and practice in early childhood intervention and teen pregnancy prevention with attention to the system and services in the High Point region. The emphasis of the Foundation on these topic areas is quite consistent with other activities across the state. Investing public and private funds into our children ensures the future success of our state. Children and parents in North Carolina face many challenges. It is our collective responsibility to use efforts such as the one currently being undertaken by the Foundation to make wise decisions in how these resources are invested.

Governor Pat McCrory recently signed an executive order reestablishing the North Carolina Early Childhood Advisory, the organizing group guiding state policy for early childhood efforts. The executive order included the following points, which are
particularly salient to the future efforts of the Foundation and can serve as a guiding framework for these efforts in High Point:

- North Carolina remains committed to developing a new early childhood system-building initiative, drawing on the State’s public and private sector strengths and expertise and bringing together talented specialists, educators and citizens to provide innovative leadership to ensure a quality system to benefit young children and their families.

- Quality programs and services, particularly for young, at-risk children, can help reduce demands on our criminal justice system and the need for social service intervention; and can improve college attendance, future employment and wage prospects.

- It is important to improve North Carolina’s efficiency and effectiveness in serving young children and their families.

- North Carolina can improve programs and services by taking a comprehensive, integrated approach to supporting young children and families, including early childcare and education, health care, and family strengthening and support services.

**Public Health Model and the Spectrum of Prevention**

The focus of this report and that of the Foundation is on improving community health with an emphasis on public health prevention. We begin by briefly introducing the public health framework and key terms related to prevention to frame the remainder of the report. The public health framework begins by first utilizing epidemiological surveillance data to understand the scope of the problem. Second, the modifiable causes of health problems are identified by exploring risk and protective factors. Third, programs and policies that target prevention are developed and rigorously evaluated. Finally, a public health approach encourages widespread adoption of the approaches that have strong empirical support. Preventive interventions are defined as “strategies or a series of
strategies that are implemented with the goal of preventing, reducing, or ameliorating injuries.\footnote{Doll, L. S., Saul, J. R., & Elder, R. W. (2007). Injury and violence prevention interventions: An Overview. In L. Dolls, S. Bonzo, D. Sleet, & E. Mercy (Eds.), Handbook of injury and violence prevention (pp. 21-33).}

Previously, preventive interventions were categorized using terms from clinical medicine and disease prevention as either \textbf{primary} (preventing new cases), \textbf{secondary} (reducing established cases), or \textbf{tertiary} (decreasing disability in cases) levels of prevention. An updated classification system based on population risk levels is more commonly used among public health researchers emphasizing prevention and health promotion.\footnote{Gordon, R. S. (1983). An operational classification of disease prevention. Public Health Reports, 98(2), 107-109.} This system targets populations based on level of risk and includes \textit{universal} (general population), \textit{selective} (populations with increased risk), and \textit{indicated} (populations already exposed or with above average risk) preventive measures. Within this rubric, universal prevention efforts are provided to all families in the general population (all parents or all teenagers in High Point), selective interventions target families with somewhat higher risk (first-time parents or low-income adolescents), and indicated interventions engage individuals or families already known to have a given outcome (children with developmental delays or pregnant teens). Universal and selective approaches can be seen as proactive or “before-the-fact” and indicated approaches are more reactive or “after-the-fact” approaches.\footnote{Stagner, M. W., & Lansing, J. (2009). Progress toward a prevention perspective. The Future of Children, 19(2), 19-38.}

The following figure identifies the role of prevention in the continuum of healthcare. It is important to develop a system that spans all aspects of this continuum. Interventions do not always fit into one specific category. Some outcomes that are the targets of treatment are also risk factors for other outcomes that are the targets of prevention. For example, treating a new mother’s behavioral health disorder would be seen as treatment for that disorder, but the intervention would also serve to promote infant mental health and prevent child disorders.
An often-repeated mantra of community prevention and health promotion expert is “prevention is prevention is prevention.” This is simplified way of re-stating a finding that has emerged in recent decades of work exploring the social determinants of health outcomes: most health outcomes share common risk and protective factors if you look far enough “upstream”. So, whether the focus is on preventing cancer, diabetes, or teen pregnancy effective prevention, interventions often include similar components. The goal of prevention is not to treat symptoms but to empower individuals to change the way they think and act and structure communities in such a way that people are able to make these healthy choices. For example, with regard to maltreatment prevention, the goal of the Centers for Disease Control and Prevention is “to create a social context in which child maltreatment is not tolerated, and in which prevention and intervention services are evidence-based, effective, widely available, and socially valued”.  

Investing in Early Childhood

Recent research has highlighted the importance of the early childhood experience as one of the key social determinants across a range of health outcomes. Due to rigorous epidemiologic and intervention research, we now know that the highest return on investment is found in programs that target early intervention. Many have accepted the importance of early education and preschool, but experts continue to push efforts earlier to include programs beginning in infancy, the prenatal period, and preconception. The following figure, often referred to as the “Heckman curve” describes the principle that “the earlier the investment, the greater the return”.

![Heckman Curve Diagram]

Source: James Heckman, Nobel Laureate in Economics

Figure 2

Scope of the Problem

The purpose of this section is to describe the scope of the public health problems that are addressed. We first describe these problems broadly at a national level. Later
sections describe the scope of the problems specific to the High Point region. When considering the prevention of teenage pregnancy, the desired outcome is fairly clear. When describing early childhood well-being, there are a range of outcomes that can be included. We focus largely on two areas in regards to understanding early childhood outcomes: child abuse and neglect and access to childcare. Child abuse and neglect (child maltreatment) is one of several “adverse childhood experiences” known to greatly impact child outcomes. One reason we focus on child maltreatment is that it is entirely preventable given the availability of a host of evidence-based strategies.

**Early Childhood Well-being**

The promotion of child well-being and healthy development is an investment in the future of the child, his or her family, and society. Intervening with families during a child’s first months and years may provide the best way to keep families together, prepare caregivers for effective parenting, and promote lifelong health. Early and recurrent maltreatment has been shown to disrupt brain development and damage regulatory systems essential for normal functioning. Early childhood maltreatment poses a serious risk to biological and psychosocial development warranting a significant public health priority to support prevention. The National Scientific Council of the Developing Child has developed categories of “positive, tolerable, and toxic” levels of stress that impact children. Child abuse and neglect fall under the “toxic” category of stress alongside extreme poverty, severe maternal depression, parental substance abuse, and family violence. This level of stress is noted for its disruption to brain architecture, effects on other organs systems, and increased risk for stress-related disease and cognitive impairment.

**School Readiness**

Early childhood is a key developmental period, with infants, toddlers, and preschoolers rapidly acquiring new knowledge, developing skills and language, and making

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new neuronal connections. Stimulating environments with stable and nurturing relationships can improve brain development and language acquisition, in contrast to environments in which children experience toxic stress and the accompanying adverse effects.\(^8\)

A broad research base has taught us that infants acquire a range of abilities related to language, human interaction, counting, spatial reasoning, causality and problem solving. There is some data to support specific types of stimulation by parents for many aspects of infant development. For example, preschool language skills and vocabulary size have been related to the amount that parents talk to infants and young children.\(^9\)

Speech qualities, including explaining, giving choices, and listening, are more predictive of language development than sheer volume of talking. In a large study of 5-year-olds followed over time, vocabulary comprehension at age five ranged from that of a typical two-year-old to that of a typical ten-year-old, and these differences persisted over time. One study demonstrated that five-year-old children of low socioeconomic status (SES) had lower language test scores and lower development of a brain region highly involved in language known as Broca’s area than those of higher SES.\(^10\) The authors postulated that it was not SES per se that ‘caused’ Broca’s area to be less developed, but that this was due to decreased opportunities to learn. Children of low SES backgrounds may have fewer such opportunities in early childhood. As children’s academic success at age five serves to predict future academic achievement, early care and education provide key opportunities for intervention.

High quality, center-based care can augment the social and developmental nurturing provided in the home, and improve school readiness and future academic and workplace success. This is particularly important for low-income families that may not have the same resources or skills to provide an enriching academic home environment. For example, families with low SES have been shown to have fewer children’s books in the home than


those of higher SES. However, high quality childcare is in short supply in many communities and the cost of high quality, center-based care may be prohibitive to many families. Though many poor and near poor families may be eligible for childcare subsidies, subsidy waitlists preclude many needy families from the opportunity for high quality, center-based care. The North Carolina Institute of Medicine Task Force on Essentials for Childhood determined that both improving the quality of center-based care and improving access to this care were key priorities for North Carolina’s children and families.

Second to the home, the early care and education environment is the place where young children spend the most time. In 2011, approximately 24% of children birth to age five were enrolled in licensed care in North Carolina in any given month. Many more children spend some portion of the year moving in and out of care as parents’ work schedules change. Nationally, 83% of children spend some time in non-parental care or education arrangements and 64% of children spend some time in formal early care or education the year before kindergarten. Because so many young children spend time in formal childcare or preschool arrangements, these settings are important opportunities for learning, nurturing, and early brain development.

Early care and education settings are able to influence children’s development through nurturing and stimulation. For example, the state can set caregiver ratios, teacher education requirements, a behavioral support system and a curriculum in center-based care. The state can also set criteria for quality ratings that focus on social and emotional development, language acquisition, and teacher/child interactions. The Task Force examined the current quality rating system in North Carolina and focused on policy recommendations around improvement and enhancement of this system.

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12 Foundation for a Healthy High Point – Early Intervention and Teen Pregnancy Prevention
Quality of Care in North Carolina

Childcare quality has been rated using a star system in NC since 1999. All licensed childcare programs received a star rating from one to five stars based on program standards and education standards. The program standards are rated using an observation scale [Early Childhood Environment Rating Scale (ECERS), Infant/Toddler Environment Rating Scale (ITERS), and Family Child Care Rating Scale (FCCERS)]. These rating scales include observations of sufficient space, variety of play materials, clean and comfortable play area, interactions between adults and children, interactions between children, and interactions of children with activities and material. The education standards component of the star rating includes education and experience of lead administrators and the level of education and experience of classroom teachers. The rating system was significantly revised in 2005. Since moving to a more rigorous system, most licensed facilities have improved in quality and are now licensed as 4 or 5 star centers or family childcare homes (Table 1).

Table 1: NC Child Care Program Star Ratings

<table>
<thead>
<tr>
<th></th>
<th>Center (Number/%)</th>
<th>Home (Number/%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td>85 (2%)</td>
<td>390 (16%)</td>
</tr>
<tr>
<td>**</td>
<td>37 (1%)</td>
<td>282 (11%)</td>
</tr>
<tr>
<td>***</td>
<td>946 (20%)</td>
<td>748 (30%)</td>
</tr>
<tr>
<td>****</td>
<td>1153 (24%)</td>
<td>716 (29%)</td>
</tr>
<tr>
<td>*****</td>
<td>1929 (41%)</td>
<td>326 (13%)</td>
</tr>
<tr>
<td>Other</td>
<td>570 (12%)</td>
<td>12 (1%)</td>
</tr>
<tr>
<td>Total</td>
<td>4720</td>
<td>2474</td>
</tr>
</tbody>
</table>

Childcare programs include licensed childcare centers and family childcare homes.

(NC DHHS special data request, 2011)

16 Ibid.
Parent-Child Relationships

Abuse and neglect is known to have a profound singular impact on child development. Research on neural plasticity suggests that early brain development depends upon interaction and stimulation from the environment, directly implicating infant abuse and neglect with neurobiological consequences.\textsuperscript{17,18,19} Intellectual delays can occur from lack of appropriate stimulation, while disruptions in emotional and cognitive processing systems are likely linked to neurochemical responses to the stress of maltreatment.\textsuperscript{20,21} Early childhood is a fragile period of time where the groundwork for lifelong health and well-being is established.

The high cost of failing to support at-risk caregivers is gaining considerable attention in education and economics. Early interventions that shift the childhood experience away from early adversity and seek to create “safe, stable, and nurturing environments” can improve outcomes and potentially avoid lifelong costs associated with impairment.\textsuperscript{22} Highlighting this return on investment in prevention is critical to the success of programs such as home visiting that seek to divert future costs. A recent book, “How Children Succeed” by Paul Tough (2012), details the recent advances in developmental neuroscience to provide a strong rationale for focusing on the home environment during infancy in order to close the achievement gap in educational outcomes.

Teen Pregnancy

Teen pregnancy presents significant challenges and negative outcomes for the adolescent parent, the subsequent child, and society in general. The increased stress and

\begin{thebibliography}{9}
\end{thebibliography}
responsibility experienced by adolescent mothers as a result of their untimely pregnancy manifests in many ways. These mothers have poorer school performance, lower levels of education, increased risk for mental health problems, higher rates of homelessness, less social support, greater socioeconomic challenges, increased risk of substance use, higher rates of depression, low self-esteem and other emotional difficulties, and increased risk of mortality as a result of pregnancy and childbirth. Additionally, teen parents may experience competing demands in terms of those implied by their new child, their peers, and their parents, particularly if their parents are less supportive of their circumstance. Further, this added responsibility deters many teen mothers from completing their education or obtaining a full-time job creating increased financial burden and decreased social mobility. Additionally, mothers who experience multiple teen pregnancies have lower rates of prenatal care, education, economic self-sufficiency, self-esteem, and autonomy, and higher rates of abortion outcomes, sexually transmitted infections, and other early-childbearing health risks.

Children born to adolescent parents often experience negative health, developmental, and psychosocial outcomes, as well. These children have higher rates of low birth weight, preterm delivery, stillbirths, infant deaths, lower rates of breast feeding, increased risk of illness, accidents, injuries, emotional and behavioral problems and other poor health outcomes. Children of adolescent parents are abused and maltreated neglected at higher rates and therefore experience additional negative outcomes associated

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with child maltreatment, partly due to the lack of parenting skills and knowledge and increased negative outcomes experienced by their parents. Children born to teen parents also have poorer education and socioeconomic outcomes with subsequent vocational difficulties. Further, these children are at increased risk of becoming adolescent parents themselves.

Unintended teen pregnancy is costly to societies as well. This population receives increased public income assistance and other governmental subsidies, require psychosocial interventions and economic empowerment programs, are less self-sufficient, and create a loss in tax revenues due to their decreased workforce participation. In North Carolina in 2012, $54 million was spent on incarceration of sons born to teen parents, while $105 million was lost in tax revenue as a result of less earnings and spending from this population.

The teen birth rate in North Carolina in 2012 was 31.8 births per 1,000 females aged 15-19. North Carolina was ranked 22nd nationwide on 2012 teen births rates among females aged 15-19 (with 1 representing the highest rate). North Carolina was ranked 21 in pregnancies to females aged 15-19 in 2010. As discussed later in this report, teen births are a much bigger problem in the High Point region, at 87.2/1000 and a particularly important problem in the 27260 zip code with a rate of 201.5/1000 or nearly seven times the state average.

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Special Populations and Health Disparities

A racial disparity of teen pregnancy is experienced in the High Point region, North Carolina, and the nation.\textsuperscript{28,32} ZIP codes in the northwest and southeast rural and suburban areas of Guilford County experience the lowest rates of teen pregnancies with higher rates in ZIP codes with lower income levels and increased marginalization.\textsuperscript{32} Hispanic adolescent females experience teen pregnancy at higher rates than any other race or ethnic group, with the highest rates in the High Point region in Davidson County.\textsuperscript{32} African-American adolescent females have the second highest teen pregnancy rates in a race or ethnic group with as much as twice as many as whites and the greatest differences in Guilford and Forsyth counties.\textsuperscript{32} Nationally, these race and ethnic disparities continue and higher rates of teen pregnancy are experienced in the South.\textsuperscript{28}

In attempting to explain health disparities that exist among vulnerable populations, research has focused on describing the biological processes, pathology, and the socio-

environmental roots of disease that determine whether diseases will exist disproportionately in a given subgroup.\textsuperscript{33} Theorists and researchers are beginning to explore the possibility of the social environment directly causing disease over time through biological stress pathways. While much of the work in health disparities have focused on minority groups based on race and gender, disparities that exist based on life experience can also be considered. It has been shown that dysregulation of hormones such as cortisol as a result of chronic stress lead to greater risk for a variety of diseases including cardiovascular disease, diabetes, and cancer. These same disorders and their stress-related precursors exist disproportionately in vulnerable populations directly contributing to health disparities. Broader preventive interventions at the family and community level that target several domains of healthy child development and parental empowerment are needed to begin to address many of these issues. This solution is opposed to the current approach that commonly focuses on minimizing the downstream symptoms that are most likely caused by these upstream deficits.

A change in thinking regarding health disparities is evolving that considers the impact of stressful life events such as discrimination and child maltreatment. In order to address existing health disparities, the gap in resources, protective factors, and resilience within disadvantaged populations must be decreased. This new approach to public health is centered on a life-course and multi-level perspective that reflects the truly complex, non-linear system of interactions and adaptation between the individual and their environment. Simple explanations from genetic to cultural differences are rarely broad enough to capture the cause of health disparities. Further, the reduction of health disparities is a major goal of health policy in America.

Evidence Regarding Risk and Protective Factors

Child Poverty and Socioeconomic Status

Children in lower socio-economic groups are more likely to have poor pediatric health trajectories beginning with higher risk for infant mortality\(^{34}\) and poor infant health outcomes\(^{35}\) then higher rates of childhood injury\(^{36}\) and developmental delay.\(^{37}\) For example, the infant mortality rate for children born to mothers with less than a high school diploma is over twice that of mothers with a bachelor’s degree or higher.\(^{38}\)

Minority Status

Similarly, although there have been important declines in teen childbearing across all racial and ethnic groups, particularly among blacks and (more recently) Hispanics, there remain large differences. And while attention and policy in the past have often focused on the high rates of teen childbearing among blacks, Hispanic teens have the highest birth rates since the mid-1990s. Roughly 34 percent of all teen births in the country occur to Hispanics. Among Hispanics there is notable variation; Hispanic teens of Mexican origin have birth rates that are almost three times higher than teen women of Cuban origin, for example.

Early Childhood Well-being

Based on empirical literature, five protective factors that decrease the risk for maltreatment have been identified by the Children’s Bureau and are being infused in many prevention models. The Center for the Study of Social Policy incorporated these protective

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factors into a prominent model termed the Strengthening Families Approach. The five protective factors are: 1) parental resilience, 2) social connections, 3) concrete supports, 4) knowledge of parenting and child development, and 5) social and emotional competence of children. These factors are known to play an interconnected role in reducing parenting stress and improving positive parenting skills. Home visiting programs, and other preventive interventions, often seek to develop or strengthen these specific protective factors.

Figure 4

Teen Pregnancy

Though adolescent parents come from all backgrounds, racial and ethnic groups, and socioeconomic statuses, some subgroups experience higher rates of teen pregnancy than others. Adolescent mothers often have abusive or antisocial partners, live in deprived neighborhoods, have lower levels of education, engage in substance use, and come from disadvantaged backgrounds. Community, faith, and school attachment, community

norms, family and peer influences, age differential and contraceptive negotiation of romantic partners, workforce participation, sports involvement, cognitive, personality, and mental health traits, and sexual beliefs, attitudes, and skills are additional indicators of teen sexual behaviors. Teen moms are also at an increased risk to have additional pregnancies in their adolescent years. In fact one in five teen mothers will give birth to at least one more child before they reach adulthood, in North Carolina, this number increases to one in four.

Over 75% of adolescents will engage in sexual activities before they reach their 20\textsuperscript{th} birthday.\textsuperscript{29} Additionally, nearly a quarter of high school students across the US indicated they have had four or more sexual partners before graduation, yet only around 60\% of these students used a condom during their last sexual encounter\textsuperscript{40}, in North Carolina only 54\% of teens used a condom during their last sexual intercourse (Adolescent Pregnancy Prevention Campaign of North Carolina, 2012). Although sexual behaviors do not guarantee pregnancy, the risk of pregnancy is significantly increased when consistent contraception is not used.

**Evidence-Based Interventions**

Evidence-based programs are those programs which have proven successful, through studies with experimental or quasi-experimental designs, in reducing child risk factors, promoting protective factors, treating children and families suffering from trauma, and ultimately preventing child maltreatment.\textsuperscript{41} Communities can support the implementation of evidence-based programs that have been tested and proven effective; programs that focus on effective parenting and behavior management skills for parents and caregivers. Many programs have succeeded in helping establish and promote safe, stable, and nurturing relationships and environments for North Carolina’s children. High Point and counties in this region are already investing in parenting and other family support programs. New investments should be made with particular attention to evidence based programs. However, there may be, at times, good reasons to invest in promising practices. In some cases, the cost of an evidence-based program is prohibitive or trained and skilled


staff may not be available. Further, in some settings, culturally appropriate evidence-based programs may not be available. High Point stakeholders should review the programs in which they invest to ensure they are evidence-based. If they are not, it may be necessary to redirect funds from strategies that are not evidence-based or to enhance infrastructure to ensure capacity for evaluation and implementation support and program fidelity.

In addition to evidence-based programs, some organizations consider evidence-informed practices when making funding and implementation decisions. Programs and evaluations fall on a spectrum of evidence, and individual organizations often decide to pursue programs that are currently under evaluation and may not (or may not yet) meet the criteria to be considered evidence-based. For both evidence-based and evidence-informed programs, programs must be shown to be not harmful, be generally accepted, utilize a logic model, have a written protocol, and have a commitment to evaluation and continuing quality improvement. Organizations may choose to implement an evidence-informed program rather than an evidence-based program for a variety of reasons: cost, target population, availability of evidence-based alternatives for program objectives, and organizational needs and culture.

Two high quality resources to help organizations in identifying appropriate evidence-based and evidence-informed programs are the California Evidence-Based Clearinghouse for Child Welfare and the Substance Abuse and Mental Health Services Administration National Registry of Evidence-Based Programs and Practices.42

**Early Care and Education**

There has been substantial research into the impact of high quality childcare programs on early childhood development and academic success. The sentinel studies, the Perry Preschool Project, the Abecedarian Project and the Head Start Impact Study merit special attention.

The Perry Preschool Project randomized 123 poor African-American children in Ypsilanti, Michigan in high quality center-based care or control conditions (usually home or relative care). Children have been followed through age 40. Children who were in centered-based care were enrolled in full time childcare for two years from approximately ages 3-5.

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42 [http://www.cebc4cw.org/ratings/scientific-rating-scale/](http://www.cebc4cw.org/ratings/scientific-rating-scale/)
43 [http://nrepp.samhsa.gov/AboutNREPP.aspx](http://nrepp.samhsa.gov/AboutNREPP.aspx)
Most teachers had a master’s degree and all had completed training in child development. There were no more than 16 children in a class with two lead teachers as well as a teacher’s assistant. The preschool classes followed one of three specific theory-based curricula. Children were matched on gender, intelligence quotient (IQ), and socioeconomic status. The average IQ for children in both groups when starting the study was 79. The IQ for children in the treatment group rose to 102 (control 83) after one year in the preschool and was 92 at age 10 (controls 85). As adults, children who participated in the preschool program have higher incomes, are more likely to have jobs and completed high school, and have committed fewer crimes than those in the control group.\textsuperscript{44}

The Abecedarian Program followed four cohorts of children enrolled in full time early care and education from infancy through age five in Chapel Hill, NC. Children had individualized educational programs and low teacher ratios. The curriculum focused on education as play in the curricular areas of social, emotional and cognitive development, with a special emphasis on language skills. Children were followed through age 21. Children in the intervention group had higher IQs starting as toddlers through age 21, higher academic achievement in reading and math through young adulthood, were more likely to attend college, and were more likely to have their first child at a later age. Not only are the results of this program impressive for the young children, but mothers of intervention preschoolers were more likely to go further in school and have better employment than controls.\textsuperscript{45}

The Head Start Impact Study was a large-scale attempt to evaluate the Head Start national program that serves many low-income children. In the 2012-13 academic year, 1,130,000 children were served by Head Start for at least some time during the year.\textsuperscript{46} Head Start serves mostly three and four year olds from low-income families. The Head


\textsuperscript{46} Head Start Fact Sheet Retrieved from \url{http://eclkc.ohs.acf.hhs.gov/hslc/data/factsheets/docs/hs-program-fact-sheet-2013.pdf}
Start Impact study included 4,667 newly entering three and four year olds. There were modest gains over the course of the year in cognitive and socio-emotional development; however, findings generally did not persist beyond the Head Start Year. This study highlights real world challenges of large-scale implementation of early care and education. Compared to the smaller Abecedarian and Perry Preschool projects, the quality was less consistently high. In the Head Start Impact Study, 70% of children were in high quality programs; 60% with curriculum that emphasized language and math, and 60% of children had teachers with an associate's degree or bachelor's degree.

The sum of evidence from these and other studies on formal early care education indicate that earlier childcare (birth to age 2) has more short- and long-term impact on cognitive development and school performance. Furthermore, full time childcare, longer-term childcare, low teacher ratios, high quality, specific curriculum emphasizing math and literacy, and higher teacher education all support school readiness and long-term academic success.

**Early Childhood Interventions**

**Universal Prevention**

Universal child maltreatment prevention strategies are targeted at the general population of children, parents, families, or even society as a whole. The best example of an evidence-based universal population-level prevention program is the Triple P program. The developers of this program argue that a population-level approach is needed to reorient the focus away from examining treatment outcomes for interventions directed at children and families already identified for maltreatment that have become involved with the child protective system. The shift would be to an approach that is not limited to at-risk families in order to support all caregivers in developing positive parenting skills and changing perceptions of their child’s behavior. It should be highlighted that changing the focus of prevention from families known to be at-risk to the general parenting population represents a paradigm shift in the field of child welfare.
Before adopting a universal, population-level approach, there are two keys issues that should be addressed to ensure that strategies are effective. First, a better understanding of the actual rates of child maltreatment and associated outcomes in the wider population is needed. Official rates of maltreatment provide an indication of risk in communities. However, parenting practices that do not reach the level of suspected maltreatment may not ever be referred for parenting interventions. In one study, anonymous, maternal self-reports via telephone yielded incidence rates of physical abuse that were 40 times greater and sexual abuse rates 15 times greater than official reporting rates in two states. Also in this study, the rate of harsh physical discipline was not significantly different in households of different incomes levels, contradicting the association between poverty and child maltreatment found in studies of official reports. This suggests that further exploration should disentangle the disparities seen between actual and reported rates of maltreatment to better understand the community in question and the potential impact of universal prevention.

Secondly, a universal system requires a set of evidence-based interventions that are culturally appropriate and widely available. Interventions must demonstrate that outcomes can be sustained over time, can be delivered with high quality, and are cost-effective. A better understanding of different cultural norms is required to tailor population-based strategies to respect different cultural values with regards to family dynamics and caregiving practices across diverse communities. Also, barriers to accessing and utilizing these services need to be identified to ensure that all families have the opportunity to benefit. Families that are isolated and economically disadvantaged are at higher risk for poor outcomes and are also less likely to access existing services. Strategies for engagement that eliminates barriers potentially through the use of media and technology should be pursued.

Selective Prevention

Prevention programs that are delivered to universal populations can also be applied to targeted populations by directly adapting the intervention or narrowing the focus to a subgroup determined to be at increased risk for maltreatment. There are some that believe that a hybrid universal/targeted approach can be accomplished by implementing programs that are delivered to an entire population but targeted to those known to be at higher risk.49 The same materials and information can be used just with different strategies to increase the access for communities or families that are known to be higher risk for maltreatment.

Many group-based programs are open to all parents but are targeted to specific groups. Group-based programs are those in which a community location is used to provide multiple caregivers with facilitated education or skills training or support. Group-based parenting skills programs generally focus on improving parenting techniques and increasing awareness of child development and appropriate behavior for individual parents and families. Several of these programs have demonstrated success in improving children’s school readiness, increasing parents’ appropriate discipline techniques, and decreasing problem behaviors.50,51,52

Considerations such as funding constraints, service availability, and political context will play a major part in whether a universal or targeted approach is taken. If a community provider can only deliver a fixed number of family information sessions or brochures, for example, decisions regarding which families will receive these services must be made. A common approach would then be to maximize the resources that are available by delivering them to families that would benefit the most. The political climate in the United States favors individual rights and family privacy and often reflects a mistrust of government programs and social services agencies to have the best interest of its citizens in mind. This may discourage some policymakers from supporting universal programs that

50 http://incredibleyears.com/download/administrators/implementations/incredible-years_ncusmart-start_5-08.pdf
51 http://ncpat.org/for_pat_professionals/documents/pat-returnoninvestment_2_19_08.pdf
attempt to provide services to all families in favor of a less intrusive approach that limits the intervention to those demonstrating need.

Another key concern centers on determining what types of programs are most effective for which populations. The highest risk for poor outcomes exists in families with other risk factors such as mental health, substance abuse, and partner violence. We do not yet know which programs work best for whom, particularly in these high-risk groups. This issue also demonstrates the need to position prevention programs and strategies within a system of care linking existing services and domains of care for both the parent and the child thereby eliminating service “silos”. There are similar objectives across early intervention services that include areas such as maternal health and reproductive care, home visiting, childcare, and early education programs. In order to develop a continuum of services, communities need increased attention to workforce development, administrative data collection, and multi-sector partnerships in addition to the implementation of single-program models.

Most early childhood prevention programs fall under the selective category. Home visiting programs, such as Nurse-Family Partnership, that target first-time, high-risk mothers are one example. These programs would not be available to all parents but only those families that a nurse, doctor, or social worker determines might need additional services, perhaps during prenatal visits or while in the hospital setting. A determination of need is often made through standard screening approaches, but in many cases, it is a clinical judgment call. This calls into question the manner in which determination of “high risk” is made. One approach would be to have parents self-select for services by simply having programs and information available, and those who consider themselves in need of services can access them. This has many shortcomings and is likely not an effective method of capturing the majority of families who are, indeed, at a higher risk. On the other hand, an approach that targets subgroups is not always a preferable method of assessing risk and can lead to discriminatory practice and stigmatized services.

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Indicated Prevention

In this context, indicated prevention interventions are those designed to prevent recurrent maltreatment or to intervene with children identified with a developmental concern. These interventions were the first to be tested among the tiers of prevention through federally mandated child protective services systems. At the base level, the system operates through a network of mandated reporting by professionals who interact with children and families such as teachers, social workers, and health professionals. Once the system has been notified that a suspected case of maltreatment has occurred, one potential preventive intervention that may be utilized is the removal of a child from the home into out-of-home foster or kinship care. In most cases, if a determination is made that a child is not in immediate danger, the family may be referred to family preservation services (FPS). In making the determination for what type of response is most appropriate, a family assessment is typically conducted to examine the risk and protective factors and examine to what extent the factors can be altered in a short period of time.54 There has been much scrutiny concerning placement decisions and family reunification given the disproportionate effect on families of color and low-income families.55 One of the primary goals of child welfare services is to reduce the risk for a future victimization. It is unclear in the literature whether child welfare services in general are effective in reducing recidivism.

Family preservation service programs have been widely implemented in the US beginning in the 1980s to slow the number of children drifting into foster care by serving families reported for maltreatment through brief and intensive interventions.56 To avoid out-of-home placements, improve family functioning, and stabilize families during crisis, these programs have been supported strongly by policymakers due to the explicit goal of keeping the family together and the cost savings compared to foster care.

In a more recent review of intensive FPS conducted by Washington State Institute for Public Policy (2006), medium to large effects were found in states that specifically adhere to the Homebuilders program model (North Carolina’s *Intensive Family Preservation Services Program*). This report estimated that the programs produced $2.59 of benefits for each dollar of cost. These results were important in that they supported the value of this intervention when implemented with fidelity. The defining feature of this program centers on a caseworker providing highly concentrated and focused attention to the reported family. In North Carolina, there was a medium effect with 81% of the intervention group and 56% of the comparison group avoiding placement one year after services. These findings underscore the importance of ensuring fidelity in program implementation.

**Examples of Evidence-Based Programs**

The following section describes several examples of evidence-based programs in early childhood intervention and teen pregnancy prevention. An exhaustive detailed review is beyond the scope of this report. However, these examples describe several interventions that have some of the most rigorous findings supporting the effectiveness of the intervention. These are all interventions that are widely used in North Carolina.

**Triple P**

Triple P (Positive Parenting Program) is a parent training program that has gained much attention, primarily for its range of delivery formats and comprehensive population-based public health approach. Triple P was developed in Australia and is currently being delivered in at least 20 other countries. The program consists of a multilevel design with varying intensity levels to provide the appropriate level of intervention (“minimally sufficient”) required for each family with the widest population reach. The program focuses on enhancing parental competence by altering dysfunctional parenting practices through a range of interventions.

There are five core components of the Triple P intervention: 1) ensuring a safe, engaging environment, 2) promoting a positive learning environment, 3) using assertive

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discipline, 4) maintaining reasonable expectations, and 5) taking care of oneself as a parent.\textsuperscript{58} The five levels of Triple P increase in intensity and narrow in population reach. Level 1 (Universal) consists of media and communication campaigns targeting all parents. For example, in Australia and the United Kingdom Triple P has worked with major network television to develop reality programs that address the challenges of parenting and incorporate the principles of the intervention. Level 2 (Selected) involves primary care professionals providing 1-2 session group seminars or individual discussions regarding child developmental, child behavior, and parenting tips. Level 3 (Primary Care) is a brief but more intense behavioral intervention over four sessions. This level begins to incorporate active skills training, modeling, coaching, and goal setting. Level 4 (Standard) is a ten-session intervention that provides a complete range of educational and behavioral approaches. Parents learn the causes of child behavior problems and strategies for managing misbehavior through assertive discipline. This level is delivered in both group and individual formats. Home or clinic formats also include behavioral observations of parent-child interactions with subsequent self-directed feedback sessions. Other sessions cover high-risk situations and developing planned activities. Level 5 (Enhanced) Triple P is delivered to families who need additional support after completing all or a portion of Standard Triple P. One example is Pathways Triple P. Pathways is a Level 5 intervention that adds an additional four-session component aimed at preventing child maltreatment. These sessions directly address parents’ attributions for child behavior and the role of anger in effective parenting. Skills are developed by the parent in techniques to manage their own emotions and reframe the way that they think about and react to their child’s behavior. There are two meta-analyses that have assessed the effectiveness of Triple P. Findings indicate significant improvements in parent-reported child behavior problems.\textsuperscript{59}


Pathways Triple P has been demonstrated to be effective with parents identified at risk of maltreating their children.\textsuperscript{60}

The most compelling evidence thus far of the promise of Triple P as a broad-based public health approach to maltreatment prevention has been in the randomized population trials in South Carolina.\textsuperscript{61} This study matched 18 counties based on population size, poverty rate, and child abuse rate and compared implementation of Triple P to services as usual. As a population trial, no families entered the study per se, but entire county systems were trained to incorporate Triple P into their existing infrastructure, which involved extensive recruitment and dissemination through training of 649 service providers. In this study, population-level indicators (rates of maltreatment investigations, substantiated maltreatment, out-of-home placements, and injuries) showed differential and positive results for the treatment counties compared to the comparison counties for the estimated 8,000 to 14,000 families that received the intervention. Before the intervention about 5\% of families across conditions were aware of Triple P. After two years, an estimated 17\% of all families in the Triple P counties reported awareness of the Triple P program compared to 5\% of all families in the comparison counties.

**Home Visitation (Nurse-Family Partnership)**

Home visiting programs provide services to families at their homes. This type of program has demonstrated success in child and family outcomes, including reduction in child maltreatment and improved infant and maternal health. Programs in which nurses or other health care professionals visit parents and children in their homes to assess health and other family status, can also reduce parental stress, improve families’ economic self-sufficiency, and decrease medical costs for families.\textsuperscript{62,63}


\textsuperscript{62} http://education.uci.edu/brownbags/Dodge_Durham_Connects_report.pdf

Home visitation is simply a method of service delivery, therefore there is much variation across early childhood home-visiting programs on theoretical approach, target families, services offered, home visitor role, and program.\textsuperscript{64} Home visiting programs targeting new mothers often have specified outcomes other than maltreatment prevention but most center on maternal and child health. The US Department of Health and Human Services recently commissioned the Home Visiting Evidence of Effectiveness evaluation to review the literature and examine the effectiveness and implementation guidelines of all existing home-visiting programs.\textsuperscript{65} The evidence regarding home-visiting models is updated regularly and summaries are posted online.\textsuperscript{66}

Each model is examined across a set of criteria to determine if it has: been in existence for at least three years, an association with a national organization or institute of higher education, a minimum number of visits, a minimum education requirement for staff, a supervision requirement for home visitors, pre-service training requirements, fidelity standards local agencies must follow, a system for monitoring fidelity, and specified content and activities for home visits. Although all models have been in existence for at least three years, NFP was the only model to achieve all of the criteria set forth by the evaluators. We will provide an overview of the NFP model due to its use in North Carolina and since it is considered by many to be the most “mature” home visiting program, particularly in terms of its evidence-base.

As one variation of the home visitation model, NFP’s popularity and support has been bolstered by the rigorous and extensive longitudinal evaluation of outcomes. NFP has been tested in three randomized control trials across a fairly diverse range of samples and demographic regions. The goals of NFP are quite ambitious, seeking to alter the “adverse maternal health-related behaviors during pregnancy, compromised care of the child, and stressful conditions in families’ homes” and thereby prevent “the most pervasive and


\textsuperscript{66} \url{http://homvee.acf.hhs.gov/}
intractable problems faced by young children and parents”. To help caregivers provide adequate physical care, parents are taught to monitor signs of illness and ensure child safety in the household environment. To enhance emotional care for the child, nurses deliver information aimed to develop a positive parent-child interaction style and promote development through stimulating play.

The NFP model consists of home visits by registered nurses to first-time mothers beginning prenatally and continuing until the child’s second birthday. The frequency of visits is set by the stages of pregnancy and childhood with some leeway to adapt to the family’s needs. First-time mothers are enrolled during the second trimester and visits occur weekly for one month. Visits are then scheduled for every other week until birth, then postnatal visits become weekly for six more weeks. Visits occur twice a month from two to 21 months, and then are tapered to once a month until the second birthday. Mothers in the first trial had an average of nine prenatal and 23 postnatal visits, with variation between mothers. Nurses carry a caseload of 20 to 25 families and visits last 75 to 90 minutes. The three major aims of the activities in the home visits are to: 1) promote improvements in women’s (and other family members’) behavior thought to affect pregnancy outcomes, the health and development of the children, and parents’ life course, 2) help women build supportive relationships with family members and friends and 3) link women and their family members with other needed health and human services.

The first study site for NFP was in Elmira, New York. The design consisted of a 4-arm randomized controlled trial. Four-hundred pregnant women with no previous live birth and at least one risk factor (less than 19 years old, single, low socioeconomic status) were randomized to four conditions which consisted of increasing layers of service beginning with developmental screenings only, then free transportation for prenatal and well-child care, home visits during pregnancy, and finally home visits during pregnancy and until second birthday. Data was collected during interviews, observations in the home,

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and reviews of administrative health and social service records with a follow-up at the child’s 15th birthday.

By the child’s second birthday the results showed a reduction in official abuse and neglect reports and emergency department visits compared to control groups. These findings include a marginally-significant 80% reduction in maltreatment among single, low-income, teen mothers. The 15-year follow-up indicated that the difference in official reports increased between the group receiving prenatal and postnatal visits compared to the controls.

The evaluation of NFP was then replicated with a lower-income sample of African-American women receiving services through an existing health department in Memphis, Tennessee. Another later trial in Denver, Colorado consisted of a large sample of Hispanics and had a specific focus on examining outcomes for nurse-visited mothers compared to those served by paraprofessionals instead of nurses. In both Memphis and Denver, the rate of state-verified reports of child abuse and neglect were too low (3-4%) to adequately address the impact of the program on maltreatment prevention. The Memphis trial had a 23% reduction in health-care encounters and 79% fewer hospitalizations for injuries compared to the control group. Recent follow-ups of children now at age 12 have demonstrated less use of cigarettes, alcohol, and marijuana and less prevalence of internalizing disorders. Additionally, nurse-visited children scored higher on reading and math tests than the control group. Children in the Denver trial at age 4 had improved developmental outcomes including advanced language, executive functioning, and behavioral adaptation.

The benefits of NFP are also found in outcomes for the mothers, which provide many direct benefits to the child. As this program targets low-income and often single mothers, this intervention has potentially profound impacts on spending for programs

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designed to assist these families. One study found less impairment due to drug and alcohol use, longer partner relationships, and greater sense of mastery among the same mothers 12 years after the intervention. These changes translate to less government spending on food stamps, Medicaid, and Aid to Families with Dependent Children. These long-term savings are greater than the invested cost of the program per family. Two economic analyses estimated an approximate savings of $17,000 per family across the three trials of NFP. Not only are these programs effective in reducing harmful outcomes for both the child and the parent, an important aspect of developing sound health policy is promoting programs that are proven to be cost effective.

**Parent-Child Interaction Therapy**

PCIT is an evidence-based parent training program was designed to primarily focus on young children with behavioral or emotional problems and places an emphasis on improving the quality of the parent-child relationship by changing parent-child interaction patterns. PCIT is now widely used to target families who have experienced, or are at risk for, emotional abuse, physical abuse, and physical neglect. PCIT is considered a parent-mediated intervention. The program targets change in young children with behavioral or emotional problems by improving the quality of the parent-child relationship and changing parent-child interaction patterns. In PCIT, parents are taught specific skills to establish a nurturing and secure relationship in order to increase their child’s prosocial behavior.

With PCIT, therapists coach parents during interactions with their child to teach new parenting skills. These skills are designed to strengthen the parent-child bond, decrease harsh and ineffective discipline control tactics, improve child social skills and cooperation, and reduce child negative or maladaptive behaviors. The average length of treatment is between 12 and 14 weeks. Evidence regarding the effectiveness of PCIT has been found in a number of clinical studies. One meta-analysis of 13 PCIT studies reported medium to large effects for child behavior change and parenting behaviors.

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Teen Pregnancy Prevention

Though many prevention and intervention programs have been developed to address teen pregnancy, very few have been studied with enough rigor to deem them “evidence-based,” though most are certainly evidence-informed. What is known, however, is that effective teen pregnancy prevention programs must have not only a depth of content, but more importantly a breadth. Programs addressing sexual risk-taking, including discussion of abstinence and contraception, self-esteem and self-confidence, personal growth and development, and job training have been found to be effective.

It should also be noted that research overwhelmingly shows that abstinence-only education does not impact teen pregnancy rates and discussing safe sex does not increase teen pregnancy rates. Because teen mothers are at an increased risk for a subsequent adolescent pregnancy, intervention programs should encompass the same principles as prevention programs but with significant emphasis on parenting skills and child development, and a return to education and the workforce. Additionally, whole-community approaches have been found to be most effective, specifically the involvement of schools, pediatric and physician practices, government entities, and philanthropic efforts.

**Long-Acting Reversible Contraceptives (LARC)**

Although European teens are just as likely to be sexually active as U.S teens, adolescent pregnancy rates are significantly lower in Europe, partially due to European teen’s increased use of long-acting reversible contraception or LARCs. LARCs include highly effective, minimum maintenance-required methods such as long-acting hormonal injections and intrauterine devices (IUDs). When presented with a comprehensive list and description of all contraception methods, teens are more likely to choose more effective and reliable methods such as LARCs. Further, use of LARCs reduce the risk of a teen’s chance of getting pregnant by up to twenty-fold. The success of LARCs can be partially attributed to their reduction in user-error as they require little or no responsibility of remembering and adhering to a regimented schedule like other contraceptives and also

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require no action from a partner as is necessary when using a condom. These benefits make LARCs a significant intervention option in pregnancy prevention, particularly in the teen population while they are still developing their self-image and maturity.

Wider-spread use of LARCs is a potentially effective means of teen pregnancy prevention. However, several barriers exist, and these barriers vary by method. The three main LARC methods are injectable hormones (i.e. Depo-provera), implantable hormones (i.e Nexplanon), and intrauterine devices (IUDs). Nexplanon and Depo-provera have significant side effects with abnormal bleeding and weight gain. Nexplanon and IUDs require office-based, invasive procedures with associated pain. They can also require significant upfront investment, particularly for the under- or uninsured, but if this cost is amortized over the life of the device, they are very cost effective methods. IUD insertion also carries a very small risk of medical complications. Because of these risks and costs, access to LARCs is highly variable by community, and health care providers may have variable enthusiasm for recommending the use of LARCs. Depo-provera tends to be the most available LARC, but require the user to present to a medical facility every three months, creating an intermittent opportunity for user error.

**Collective Impact**

The High Point region should consider a collective impact process to develop cross agency collaboration, a common agenda with shared outcomes and shared measures, shared vision and mobilization of public will and funding.\(^{75, 76}\) The following steps highlight the measures needed for a robust collective impact process.

1) Common agenda: Participating organizations have a shared goal and understanding, and a commitment to using agreed-upon solutions for addressing problems and challenges. Differences between organizations in definitions of problems and desired outcomes are discussed and resolved.

2) Shared measurement system: Consistent data collection and measurement across systems and organizations maintains common goals and ensures

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consistency. While organizations’ different activities may require different types of measures, common data collection and measurement systems allow organizations to review and learn from each other’s outcomes.

3) Mutually reinforcing activities: Collective impact requires coordination of goals and outcomes, and organizations’ different program activities serve to support other programs’ work. Activities are consistent with the common agenda and are supported by shared measurement.

4) Continuous communication: Multiple meetings and communication between meetings is necessary to develop trust, support coordinated efforts, and maintain commitment to the common agenda.

5) Backbone support organization: In order to have the greatest success, a collective impact process must have a dedicated organization and staff to serve as the infrastructure through the course of the initiative. The backbone organization must commit to handling the logistic and administrative work of the collective impact process, as well as mediate conflicts and oversee technical issues, inter-organization communication, data collection, and analysis/reporting.

Greater High Point Area Needs Assessment

Methodological Approach

We used two strategies to assess the needs and current service array in the Greater High Point area. First, we used available secondary data to describe the population in the targeted geographic region. Second, we conducted focus groups with local stakeholders to assess perceptions.

Secondary Data Analysis

The focus of the secondary data analysis was to cull available information that would help to quickly describe the population of interest. This included a variety of data sources. We first present the number of child abuse and neglect investigations in Guilford County broken down by age of the child over recent years. This data is not available at

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lower levels of geography. Descriptive information for ZIP codes and Census tracts came from the following sources: U.S. Census Bureau, Census 2010 Summary File 1 and U.S. Census Bureau, 2009-2013 5-Year American Community Survey.

Data regarding childcare and Pre-K facilities came from the NC Department of Health and Human Services Division of Child Development and Early Education search site. We also requested additional information regarding childcare providers in the identified ZIP codes. Data was provided from the subsidy payment system (through February 2015) and enrollment data from the regulatory system (through April 2015). Prevent Child Abuse-North Carolina provided information regarding services in Guilford County based on an environmental scan report the agency conducted. The total number of teen pregnancies and births from 2011-2013 in the identified ZIP codes were provided by the NC State Center for Health Statistics.

**Description of the Geographic Region**

The focus of the Foundation is on the Greater High Point area, which includes the city of High Point as well as Jamestown, Archdale, and Trinity. The following tables provide demographic and socio-economic indicators of the region, with specific emphasis on children populations and the teenage, female population. We first provide a map created by the Guilford County Department of Health and Human Services for the Foundation. Following the ZIP level table, we provide several maps that further describe the area at the small, Census-tract level. This provides further description of the variation in these indicators within the ZIP code level. Note the large economic and socio-demographic variation and disparities that exist within the service population across the identified geographic region.

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[78](http://ncchildcaresearch.dhhs.state.nc.us/)
<table>
<thead>
<tr>
<th>Year</th>
<th>0-5 years</th>
<th>6-12 years</th>
<th>13-17 years</th>
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<td>1615</td>
<td>997</td>
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Figure 5

Source: NC State Center for Health Statistics, 2012; U.S. Census, 2010; Map prepared by the Guilford County Department of Health and Human Services
### Table 2. Population size by age and gender in selected ZIP codes in Greater High Point area

<table>
<thead>
<tr>
<th>ZIP code</th>
<th>City</th>
<th>Total population</th>
<th>Under 5 years</th>
<th>Under 5 years (%)</th>
<th>15 to 19 years</th>
<th>15 to 19 years (%)</th>
<th>Female population 15 to 19 years</th>
<th>Female population 15 to 19 (%)</th>
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<td>1,398</td>
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### Table 3. Race/ethnicity of total population (%)

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<th>Zip code</th>
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<th>Black or African American</th>
<th>Asian</th>
<th>Hispanic or Latino</th>
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42  Foundation for a Healthy High Point – Early Intervention and Teen Pregnancy Prevention
### Table 4. Selected economic indicator estimates (2013)

<table>
<thead>
<tr>
<th>Zip code</th>
<th>Median Household Income</th>
<th>Per Capita Income</th>
<th>Income Below Poverty Level for Families with Children &lt;18 years</th>
<th>Income Below Poverty Level for Families with Children &lt;5 years</th>
<th>No Health Insurance Coverage &lt;18 years</th>
<th>Percent Unemployed</th>
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<tr>
<td>27260</td>
<td>$21,528</td>
<td>$11,367</td>
<td>56.3%</td>
<td>67.5%</td>
<td>14.3%</td>
<td>24.8%</td>
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<tr>
<td>27262</td>
<td>$39,867</td>
<td>$22,889</td>
<td>28.9%</td>
<td>39.7%</td>
<td>7.8%</td>
<td>11.5%</td>
</tr>
<tr>
<td>27263</td>
<td>$39,681</td>
<td>$19,829</td>
<td>22.1%</td>
<td>33.1%</td>
<td>8.5%</td>
<td>10.4%</td>
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<tr>
<td>27265</td>
<td>$53,386</td>
<td>$28,470</td>
<td>11.7%</td>
<td>5.4%</td>
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<td>8.8%</td>
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<td>27282</td>
<td>$70,463</td>
<td>$32,905</td>
<td>10.3%</td>
<td>20.0%</td>
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<tr>
<td>27370</td>
<td>$47,948</td>
<td>$23,720</td>
<td>17.0%</td>
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<td>0.4%</td>
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<td>NC</td>
<td>$46,334</td>
<td>$25,284</td>
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### Table 5. Household Types with own children under 18 years old

<table>
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<tr>
<th>Zip code</th>
<th>City</th>
<th>Of Total Households (%)</th>
<th>Husband-wife family</th>
<th>Male, no wife present</th>
<th>Female, no husband present</th>
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<td>10.5</td>
<td>2.9</td>
<td>19.1</td>
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<td>High Point</td>
<td>26.8</td>
<td>14.8</td>
<td>1.9</td>
<td>10.1</td>
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<td>27263</td>
<td>High Point, Archdale</td>
<td>30.3</td>
<td>19.1</td>
<td>2.9</td>
<td>8.2</td>
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<td>High Point</td>
<td>31.1</td>
<td>21.9</td>
<td>2.0</td>
<td>7.1</td>
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<tr>
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<td>Jamestown</td>
<td>33.0</td>
<td>25.8</td>
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<td>5.6</td>
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<td>Trinity</td>
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<td>23.1</td>
<td>2.4</td>
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Table 6. Household composition of children in households with incomes below poverty

<table>
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<tr>
<th>Zip code</th>
<th>Living with two Parents</th>
<th>Two native parents</th>
<th>Two foreign-born parents</th>
<th>One Parent</th>
<th>One Native Parent</th>
<th>One Foreign-Born Parent</th>
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<td>27260</td>
<td>21.8%</td>
<td>7.1%</td>
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<td>64.6%</td>
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<td>20.4%</td>
<td>6.0%</td>
<td>14.4%</td>
<td>79.6%</td>
<td>51.5%</td>
<td>28.1%</td>
</tr>
<tr>
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<td>53.4%</td>
<td>37.2%</td>
<td>16.2%</td>
<td>46.6%</td>
<td>44.9%</td>
<td>1.7%</td>
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<td>15.6%</td>
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<tr>
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<td>15.3%</td>
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<td>69.9%</td>
<td>59.2%</td>
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Table 7. Children by household composition living in households receiving public benefits*

<table>
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<tr>
<th>Zip code</th>
<th>City</th>
<th>Children Living in Households using Public Benefits</th>
<th>Married-couple Family</th>
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<th>Female, no husband present</th>
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<td>27260</td>
<td>High Point</td>
<td>64.8%</td>
<td>14.3%</td>
<td>1.7%</td>
<td>48.8%</td>
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<tr>
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<td>16.6%</td>
<td>7.2%</td>
<td>22.9%</td>
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<tr>
<td>27263</td>
<td>High Point, Archdale</td>
<td>36.8%</td>
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<td>5.4%</td>
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<td>High Point</td>
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<td>11.3%</td>
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<td>Jamestown</td>
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<td>0.5%</td>
<td>5.9%</td>
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<tr>
<td>27370</td>
<td>Trinity</td>
<td>24.8%</td>
<td>13.0%</td>
<td>0.0%</td>
<td>11.9%</td>
</tr>
<tr>
<td>NC</td>
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<td>29.4%</td>
<td>10.5%</td>
<td>2.8%</td>
<td>15.8%</td>
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*Supplemental Security Income (SSI), cash public assistance income, or Food Stamps/SNAP in the past 12 months
<table>
<thead>
<tr>
<th>Zip code</th>
<th>City</th>
<th>Teen Births (15-19) 2011-2013</th>
<th>Teen Pregnancies (15-19) 2011-2013</th>
<th>Female population 15 to 19 years</th>
<th>2011-2013 Teen Birth Rate per 1,000</th>
<th>2011-2013 Teen Pregnancy Rate per 1,000</th>
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<tr>
<td>27260</td>
<td>High Point</td>
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<td>217</td>
<td>948</td>
<td>201.5</td>
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<td>High Point, Archdale</td>
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<td>74</td>
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<td>1427</td>
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<td>25</td>
<td>488</td>
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<td>51.2</td>
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<td>Trinity</td>
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<td>60</td>
<td>512</td>
<td>105.5</td>
<td>117.2</td>
</tr>
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<td>604</td>
<td>5518</td>
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<td>22,557</td>
<td>28,341</td>
<td>321,320</td>
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<td>88.2</td>
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</table>
Percentage of Children in Public School by Census Tract

High Point, North Carolina

Zip Codes
Percent in Public School
25% or less
25.1% - 75%
75.1% - 90%
90.1% - 100%

High Point, North Carolina
Percentage of Households Headed by Single Mothers by Census Tract

High Point, North Carolina

Zip Codes
Single Mother Households
5% or less
5.1% - 10%
10.1% - 15%
15.1% or greater

Foundation for a Healthy High Point – Early Intervention and Teen Pregnancy Prevention
Services Available in the Greater High Point Area

In a 2014 environmental scan of programs serving North Carolina’s children and families, Prevent Child Abuse North Carolina (PCANC) identified 579 programs dedicated to serving and strengthening families, implemented through 237 agencies. Of these programs, PCANC identified 59% as evidence-based or promising, with an additional 26% identified as evidence-informed. These programs are categorized as group-based, home visitation, case management, multi-strategy, or other. There were no services for the following subpopulation: languages other than English or Spanish, middle school, adolescents, or fathers.

79 Prevent Child Abuse North Carolina. PCANC. An Environmental Scan of North Carolina Family Strengthening Programs. Published November 2014
<table>
<thead>
<tr>
<th>Program Name</th>
<th>Location</th>
<th>Spanish</th>
<th>Prenatal</th>
<th>Age 0-3</th>
<th>Age 3-5</th>
<th>Elementary</th>
<th>Teen Parents</th>
<th>New Parents</th>
<th>Low Income</th>
<th>Children with Special Needs</th>
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<td>Early Head Start</td>
<td>Guilford Child Development</td>
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<td>Yes</td>
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<td>No</td>
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<td>Healthy Start/Baby Love Plus</td>
<td>Piedmont Health Services and Sickle Cell Agency</td>
<td>No</td>
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<td>Parents as Teachers</td>
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<td>YWCA of High Point</td>
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<td>Yes</td>
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</tr>
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<td>Parents as Teachers</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partners for a Healthy Baby (APP)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy Care Management</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal Newborn Home Visits</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The only services identified operating out of organizations located in High Point were *The Incredible Years* parenting program (Family Services of the Piedmont Fairview Family Resource Center) and Adolescent Parenting Program using Partners for a Healthy Baby curriculum (YWCA of High Point), Expanding the search to services provided in Guilford yielded a greater number of programs. The following were home-based services available throughout Guilford County: Healthy Start home visiting (Family Service of the Piedmont), Early Head Start/NFP (Guilford Child Development), Parents as Teachers (PAT Guilford County), Universal Newborn Home Visits and Pregnancy Care Management (Guilford Health Department), and Healthy Start/Baby Love Plus (Piedmont Health Services and Sickle Cell Agency). Family Support Network was also available across all four counties that High Point spans.

The following table presents the number of children enrolled and those receiving subsidies for licensed facilities in the greater High Point area.

<table>
<thead>
<tr>
<th>Stars</th>
<th># Enroll</th>
<th># with Subsidy</th>
<th>% Subsidized</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>2</td>
<td>48</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>3</td>
<td>399</td>
<td>164</td>
<td>41.1%</td>
</tr>
<tr>
<td>4</td>
<td>1,401</td>
<td>424</td>
<td>30.3%</td>
</tr>
<tr>
<td>5</td>
<td>864</td>
<td>284</td>
<td>32.9%</td>
</tr>
</tbody>
</table>

Table 12. Childcare enrollment and subsidy for the High Point area in licensed facilities including centers and homes
Focus Group Methodology

To gain a better understanding of the local perspective of the target issues, we conducted two focus groups, separately focusing on early childhood intervention (n=8) and teen pregnancy prevention (n=12). The Foundation staff invited participants who were involved in service provision in the Greater High Point area in those areas. Two focus groups were held at the Foundation office in downtown High Point on April 16, 2015. The authors of this report facilitated the focus groups, and Foundation staff members were not present during the discussion. Focus groups were conducted in a closed conference room and were audio-taped. One author moderated the focus groups and the other documented notes during the discussion. In the role as moderator, the author facilitated the discussion, prompted participation from all members of the group, and encouraged participants to talk to each other. A semi-structured focus group guide was used to lead the discussion (see Appendix). Each focus group lasted about an hour and a half.

Sources of data for this analysis were from two sources: (1) notes taken by the moderator during the focus group and (2) audio-recording of the focus group sessions. This note and recording-based analysis approach was used as opposed to transcript-based approach given the need to balance feasibility and rigor for this evaluation. In addition to
the detailed notes taken during the focus group, the evaluator produced an abridged transcript for the audio-recording. This allowed the evaluator to focus the analysis on the aspects of the discussion most pertinent to the evaluation questions.

A constant comparison (grounded theory) approach was used to analyze the notes and abridged transcript. This analytic approach was selected due to the purpose of the evaluation questions to uncover the perceptions of the participants and better understand how they make meaning of the related issues. The analytic process consisted of three stages. First, open coding was used to attach a descriptor to relevant units of data. Second, axial coding was used connect to group the individual codes into categories. Third, selective coding was used to develop themes that interpret the content and meaning of the focus group data. Selective coding is used to develop a story that explains and connects categories. The data were analyzed separately for each focus group using an emergent-systematic focus group design. We used multiple group analysis to determine whether themes from one group also emerged in other groups. This process helps to determine whether “saturation” was reached.

Focus Group Results

Theme #1: Adult population in High Point area lacks future orientation and reinforces negative historical expectations, perpetuating a negative cyclical, intergenerational impact on children and adolescents. When broadly asked about the sources of social problems related to teen pregnancy and early child outcomes, “poverty” was immediately forwarded in both groups as the key concern. When asked to unpack this term further, participants suggested that the current adult (parent) population has had historical pressures towards lack of interest in investment in personal or community development.

This sentiment was partially attributed to the nature of the economy in the area, particularly the furniture industry. This sector’s reliance on cheap labor via an unskilled, uneducated workforce has had ripple effects that are still quite noticeable today, despite the effect of globalization and the more recent economic downturn. Participants provided many examples of how this manifests in the community. At the individual and family level, there is a perception of a lack of emphasis on education. On an economic development level, the lack of a vibrant downtown in the High Point area is attributed to reliance on the
To follow-up on this point raised during the focus groups, we attempted to determine whether there was quality information on the impact of the furniture industry on High Point. A recent study by the Duke University Center on Globalization, Governance, & Competitiveness calculated the economic impact of the High Point Market. The findings can be interpreted to estimate the economic benefit generated due to the Market, which would not have existed otherwise. The following excerpt from the report highlights the size of the economic impact:

The results indicate that the High Point Market as a whole directly employs 21,461 people each year. In addition to these jobs within the market itself, 7,413 jobs are supported in related industries and 8,742 additional jobs are supported due to the increased household spending resulting from the direct and indirect jobs... In addition to outright employment impacts, the market contributes over $5.39 billion in economic output to the overall regional economy, which includes $1.51 billion of labor income. To put this figure in perspective, the total output of 5.39 billion is approximately equivalent to 1.3% of the total gross state product (GSP) of North Carolina.

The findings of this report are for 30 counties within a 75-mile radius of the Market, and it is not known what percentage of this economic activity is specific to the Greater High Point area. However, the study estimated that about $25 million is generated each year in tax revenues to Guilford County ($123 million in state revenue). It should be noted that the High Point Market Authority receives about a third of its budget ($1.8 million) from state appropriation support annually for transportation during the event and marketing.

The impact of the furniture industry may have mixed effects on the local community, particularly depending on time horizon of the benefits. While the economic impact each year in terms of economic activity and spending is considerable, the long-term social impact may have unintended negative consequences. The types of jobs that are generated may be low-paying, seasonal jobs in the service industry that may not provide sufficient

wages to support a family or opportunity for future advancement in a long-term career. Of course, one could argue whether other jobs would be available at all if not for the furniture industry.

Focus group participants perceived that adolescents and teenagers receive little encouragement to achieve better outcomes or set higher goals than those that were encouraged for previous generations. Participants suggested that this messaging comes from an adolescent’s family, school, and broader community. One participant described this as an “institutionalized” feeling that for many young girls in particular sets up a trajectory with one possible option that “you are going to become a parent at a young age”. This is perceived as the only avenue for success in life. One participant stated that “mothers are happy when teen daughters get pregnant”, because they are following a similar path and will have a purpose. When asked about ways to break this cycle, participants suggested that further economic development that is sustainable and allows career paths other than the furniture industry are needed. Participants suggested that adolescents and young parents need other examples of success and achievement in their community.

**Theme #2: Business sector is an untapped resource.** Perhaps stemming from the first theme, there was a sense that local businesses could be doing more to support the local community. One participant described the business community as an “untapped resource” for community development.

**Theme #3: High Point University offers a very promising opportunity for positive impact in the community.** In both groups, the potential benefits of the growth and development of High Point University (HPU) was discussed. The discussion of HPU was entirely unprompted by the facilitators and in general there was wide consensus that HPU had in recent years moved in a direction that was quite positive for the local community. There were several examples of how HPU is impacting High Point. One participant mentioned that there is a push by the HPU administration for new faculty to live in the city of High Point. Given concerns about the public schools, some university faculty and staff have elected to live in areas outside of High Point. The goal is to encourage/require new faculty to live in the city with the hopes of fostering individual investment and involvement in the community. There was also mention of involvement of students in local volunteering, activism, and service learning as part of their academic experience at HPU. According to the
HPU website, 79% of undergraduate students are from out-of-state. HPU does offer first
generation scholarships to public school students from High Point. There is also a Bonner
Leader Program, “a service-learning and leadership program, that allows students to
promote social justice through their intern-like experience with local non-profit and
community-based organizations.”

These recent efforts are largely attributed to the leadership generated by HPU
President Nido Qubein’s focus on service and involvement. According to the HPU website,
“Amidst his successful career, he dedicated time to serve as a director or chairman of many
organizations including YMCA of the USA, which oversees 2,600 YMCA’s across the country,
the High Point Chamber of Commerce, the United Way of Greater High Point, the High Point
Economic Development Corp., and the High Point Community Foundation.” Although the
participants did not identify any concrete activities or opportunities that would link HPU to
early childhood intervention or teen pregnancy prevention, there was a shared sentiment
that HPU could provide leadership and human capital to these issues.

Theme #4: Social problems in High Point have shared root causes; positive
social change will require diverse stakeholders at the table. Participants in the focus
groups described the social outcomes under question (early childhood development and
teen pregnancy) as well as others prevalent in the community (e.g. hunger and
malnutrition, sexually transmitted infections, drug use, low education) as overlapping with
similar root causes. Services are often directed at the symptoms and do not seem to
address the underlying issues plaguing the community. Service providers often feel
isolated from the larger governmental and public systems that, perhaps unknowingly, are
contributing to the problem. In order to address the numerous downstream outcomes, the
group suggested that the upstream determinants must be identified and a diverse
community of stakeholders must come together to address these issues. Several examples
were given. Participants consistently described the lack of transportation as an issue
affecting the community, particularly the outlying rural areas. Participants also mentioned
a general lack of extra-curricular activities and community resources available for children
and youth in the community. There was a perception that there was little to do in the
community, and the activities that are available to youth are inaccessible to large parts of
the community due to lack of transportation. Participants suggested that these issues
would require input and buy-in from city and county Parks and Recreation and Transportation departments. The decisions they make may impact the community and the outcomes of concern for the service providers, but they may not be aware of how important their policies are. Participants suggested that there should be more options for activities and shared long-term strategies to build a sense of community.

**Theme #5: Despite a shared county, there is a large gap in available services, resources, and investment in High Point when compared to Greensboro.** This theme was something that was mentioned from the outset of the discussion and came up several times throughout the discussion. As part of the focus group guide, the facilitators mentioned at the outset of the discussion that the focus would be on the Greater High Point area. We specifically stated that we wanted to hear about High Point and although many services are organized at the county level, we were not focused on Greensboro. In both groups, this comment generated some surprise and contentment that High Point was going to be the exclusive focus. Both groups discussed the overall state of the community, particularly the built environment, community activities, public resources, etc. and commented on it being quite noticeable that while things have closed up in High Point, new things seem to be opening and community events happening frequently in Greensboro. Many of the participants work in both Greensboro and High Point and likely make frequent trips between the two cities. The stark contrast between the two areas was commented upon numerous times. One specific example related to teen pregnancy prevention was the Partners for a Healthy Youth organization. This is a coalition of 40-50 organizations serving Guilford County. However, there was a perception that despite the countywide focus, this organization was “heavily Greensboro”.

**Theme #6: Perception that much more work is needed to engage the public school system with broader community and social service efforts.** In the focus group related to teen pregnancy prevention, there was an underlying perception that the public school system was not a viable partner with community-based organizations. There was a general perception that the public schools in this area specifically are inflexible on conversations to promote comprehensive sex education. Some partners shared anecdotes of spending a great deal of time and energy attempting to work with the schools with little to no results. Some felt that attempting to engage with the schools was a waste of time.
Theme #7: Need to better understand services in the community. In both groups, there was a stated and observed lack of knowledge regarding the existing service system. When asked questions regarding the availability and quality of services and the state of the broader service system, focus group participants were not able to provide a consistent description and many had questions themselves about what was available and what providers were delivering what services. One specific example was a discussion regarding access to contraception in the community, particularly long acting reversible contraceptives (LARC). There was some indication that the health department in High Point is the major point of access for contraceptive and reproductive health services. However, some indicated that it was not an ideal setting and not really supported by the community and that range of available LARCs may be limited.

Although some indicated that more funding is a constant need, many participants indicated that it was the organization of services and the efficiency of the system, or how what is currently available is being used, that could be a priority for focus. In the early childhood focus group, there appeared to be a lack of understanding regarding early childhood services such as home visitation. When asked about the universal home visiting program offered by Guilford County, the program was dismissed as not being very effective due to a 40% acceptance rate and the low dosage of services (one visit in most cases).

Theme #8: There is a perceived lack of access to high quality, affordable childcare. Overall, there was a perception that families in High Point struggle with accessing childcare. There was concern expressed with the ability of most parents to be critical consumers of childcare and make an informed decision regarding how to choose a provider. One participant suggested that parents just choose the cheapest or most convenient option. Participants also suggested that there is a great deal of unregulated care used in the community. Therefore, many children may not be receiving high quality childcare or have someone advocating for greater quality.

Current Activities of Other Foundations

Many statewide and regional foundations have made significant investments in early intervention and teen pregnancy prevention in the last decade. These include The Duke Endowment, the Kate B. Reynolds Charitable Trust, the Z. Smith Reynolds...
Foundation, Blue Cross Blue Shield of NC Foundation, and the Cone Health Foundation, among others. Local and family foundations can be an important way to leverage local resources. The Cemala Foundations investment in Ready for School, Ready for Life is one such example. Important themes from foundation funders in this area have included investing in evidence-based programs, investing in infrastructure, evaluation, implementation, and planning, replication of community wide model programs (such as the Harlem Children’s Zone replication in East Durham and Durham Connects replication in Eastern North Carolina). NC foundations have also been interested in leveraging community resources, partnering with community businesses, and supporting community-wide planning such as Collective Impact (e.g. United Way Mecklenburg).

**Conclusion**

The High Point region has some particular challenges and opportunities. Specific neighborhood and ZIP code-level entrenched, intergenerational poverty, with associated dropouts, teen pregnancies, and vulnerable youth are particularly apparent. In addition, the region has two, large immigrant groups (Latino and Asian) with challenges that include acculturation and limited English proficiency. Also, the region has historically been dominated by the furniture industry, but the exodus of manufacturing from the area (without replacement by new opportunities) has left the region economically vulnerable.

There are several important opportunities within the region. The growth of and investment in High Point University represents an important opportunity for the community in terms of education, economic development, community investment, and partnership. The new partnership of High Point Hospital with UNC Hospitals and the capital investment in both the Foundation and in health services represents another opportunity for the region. The third opportunity is the engaged and committed residents, the ongoing array of services, and high quality evidence-based programs that are available. By increasing community collaboration, enhancing partnership with the university, and making strategic investments in evidence-based programs, we believe that the foundation has a key opportunity to improve the well-being of the region and its residents in the short and long term.
Appendix

Focus Group Guide for Foundation for a Healthy High Point (Early Intervention)

Good morning and welcome. Thank you for taking the time to join our discussion. Our names are Paul Lanier and Adam Zolotor and we are from the University of North Carolina at Chapel Hill. As you know, we would like to talk with you for about an hour about understanding issues in the High Point area related to early intervention.

During our discussion we'd like to hear your opinions and views about your perceptions and experiences. You can speak from your personal or professional experiences. Although you were identified because you are an organizational leader, we don't expect you to speak on behalf of your organization, but for yourself. There are no wrong answers, but rather differing points of view. Please feel free to share your point of view even if it differs from what others have said. We are interested in negative as well as positive comments, and at times what may seem like a negative comment can be the most helpful.

Before we begin, let me suggest some things that will make our discussion more productive.

1. Please speak up and remember; only one person should talk at a time.
2. We are taping the session because we don't want to miss any of your comments. So, we ask that you try to speak clearly. No one other than us will listen to these tapes.
3. We'll talk on a first-name basis, and in later reports there will be no names attached to your comments. What you say will remain confidential. We've placed name cards on the table in front of you to help us remember each other's names.
4. Our role is to ask questions and listen. We really won't be participating in the conversations, but we want you to feel free to talk with one another. We'll be moving the discussion from one question to the next.
5. Sometimes there is a tendency in these discussions for some people to talk a lot and others not to say much. But it is important to hear from each of you because you have different experiences. So, if one person is sharing a lot, we may ask you to let others talk. And if you aren't saying much, we may ask your opinion.
6. There are differing definitions of “early intervention” depending on the type of services, funding source, or population. We are thinking broadly about services, education, and support for young children and their families for children who are at risk for poor developmental outcomes. So, we are not just talking about Part C special education services but a continuum of programs and services. By young children, people typically think about infants and toddlers, ages zero to three. Some consider early intervention beginning prenatally and others think about early intervention extending up to age 6.
7. The Foundation is interested in the Greater High Point Area. We realize that some programs are organized at the county, regional, or state level. As best as you can, please try to tailor your responses and comments to this geographic area.

A. Opening Question:
[I would like each of you to take turns answering this first question]:
1. Please introduce yourself then describe some early intervention programs or services that you or your organization provides for young children in High Point?

**B. Introductory Question – scope of problem:**
1. What do you consider to be the main risks to healthy child development broadly?
2. How big of a problem do you consider this to be in your community?
3. Are there any aspects of the services you provide where you think you or your organization could be doing more?

**C. Transition Question – continuum of services:**
1. What do you think of the continuum of early intervention services for High Point Families?
2. What are the key services, programs, or interventions that do the “heavy lifting” in this community?

*Prompts: (if not directly mentioned in response to above question)*

a) What are we doing well as a community?
b) What populations or communities are we best at serving?
c) Are there any groups that get consistently left out?
d) Where are the gaps in the services?
e) What is the typical trends in waitlists for services?
f) What about service penetration? Are families aware of services? How are recruiting and identification efforts?

**D. Transition Question – quality of services and interventions:**
1. What is your perception of the quality of early intervention services that are provided?

*Prompts:*

a) Are manualized or evidence-based programs delivered with fidelity to the model?
b) Are programs receiving and accessing support from national models?
c) Do you think programs are getting the same outcomes as promised by the model? Why or why not?

**C. Transition Question – coordination of services:**
1. How would you characterize the ability of early intervention providers to make a collective impact? By this we mean things like having shared goals and outcomes, a common agenda, alignment of efforts, and common measures of success.

*Prompts*

a) Is there a lead or backbone organization in this community for early intervention? This is a group that guides the vision of early intervention services, advances policy change, and fosters public will.

**C. Transition Question – funding of services:**
1. What do you see as the key funding resources and funding challenges?

*Prompts*

a) What are opportunities for funding in the community from other public or private sources?

**E. Ending Questions:**
1. Of all the issues we’ve discussed today, which one is most important to you?
2. If you were a funder interested in improving early intervention services, where would you focus your efforts?
3. Who do you think was not at the table today that should have been?
4. Is there anything we should have talked about but didn't?

[Thank individuals for participating]