

National Impact Evaluation of the Comprehensive Child Development Program

Executive Summary

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Prepared for

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PREFACE AND ACKNOWLEDGMENTS

This document is the executive summary of the final report from the National Impact Evaluation of the Comprehensive Child Development Program (CCDP). The “impact” evaluation was confined to an assessment of the effects of CCDP on participating parents, children, and families in 21 of the “Cohort 1” CCDP projects. A separate “process” evaluation provides an assessment of the implementation and costs of CCDP projects, and the services offered to and received by participants.

Two earlier reports about the first cohort of CCDP projects, *Comprehensive Child Development Program—A National Family Support Demonstration: First Annual Report* and *Comprehensive Child Development Program—A National Family Support Demonstration: Interim Report to Congress*, were released by the Administration on Children, Youth, and Families (ACYF) in December 1991 and in May 1994, respectively. The 1991 report was descriptive in nature, focusing on the characteristics of CCDP, of individual projects, and of program participants. The 1994 report to Congress described the implementation of CCDP and its short-term effects on participating families about two years after enrollment in the program.

The current evaluation has been completed, and the data base from the study has been documented and delivered to ACYF for use by the research community. The data base includes copies of all questionnaires and data collection measures used in the evaluation. In addition, Abt Associates Inc. is conducting an evaluation of the second cohort of CCDP grantees. This related study, for which Abt Associates is conducting both a process study and an impact evaluation, was funded in 1993 and is due to be completed in 1998.

The CCDP impact evaluation was a large, long-term study which required the ongoing assistance of CCDP projects across the country. We offer our thanks to all of the CCDP Project Directors and their staff who cooperated with the evaluation.

The impact evaluation benefitted from the input of many individuals. Technical Advisory Panel members and other key consultants included Lawrence Aber from the National Center for Children in Poverty, Kathryn Barnard from the University of Washington, Thomas Cook from Northwestern University, Nicholas Ialongo from the Johns Hopkins University, Anthony Mannarino from the Western Psychiatric Institute, Miriam Martinez from the Family Mosaic Project in San Francisco, Vonnie McLoyd from the University of Michigan, David Olds from the University of Rochester, Harold Richman from the University of Chicago, Aline Sayer from Pennsylvania State University, Neal Schmitt from Michigan State University, and Judith Singer from Harvard University. Two CCDP Project Directors served as representatives on the panel: Sebastian Striefel from the University of Utah, and Loretta Alexander of Project Family in College Station, Arkansas.

Staff of the Department of Health and Human Services were responsible for providing technical input and for oversight of the evaluation. As Project Officers for the National

Preface and Acknowledgments

Impact Evaluation being conducted by Abt Associates Inc., Michael Lopez (and earlier, Soledad Sambrano) oversaw all planning, implementation, and reporting activities for the evaluation. Trellis Waxler (and earlier, Mary Bogle and Allen Smith) was Project Officer for CCDP's Management Support Contract, which was conducted by CSR, Incorporated, and oversaw all activities related to the implementation and management of the CCDP projects.

Finally, several staff members at Abt Associates Inc. played important roles in the project. Key staff at Abt included Robert St.Pierre, Ian Beckford, Lawrence Bernstein, Maureen Cook, Gabriela Garcia, Lynne Geitz, Barbara Goodson, Maria Guevara, Mary Ann Hartnett, Jean Layzer, Marc Moss, Cristofer Price, Michael Puma, Anne Ricciuti, Christine Saia, Michael Vaden-Kiernan, and Kathryn Vargish. Abt Associates also employed staff members located in regional offices and in each CCDP site who were responsible for data collection from parents and children.

EXECUTIVE SUMMARY

The Comprehensive Child Development Program (CCDP) was an innovative attempt by the Administration on Children, Youth, and Families (ACYF) to ensure the delivery of early and comprehensive services with the aim of enhancing child development and helping low-income families to achieve economic self-sufficiency. This executive summary reports on the extent to which CCDP met these goals in 21 projects across the country.

THE CCDP MODEL

The CCDP demonstration was administered by ACYF within the U.S. Department of Health and Human Services. CCDP grantees included universities, hospitals, public and private non-profit organizations, and school districts. The original Comprehensive Child Development Act of 1988 authorized the establishment of a set of programs to operate for five years at an authorization level of \$25 million per year. Twenty-two CCDP projects were funded in fiscal year 1989 and two additional projects were funded in fiscal year 1990. Of these 24 projects, 21 participated in the impact evaluation conducted by Abt Associates Inc.

A key assumption underlying the design of CCDP was that all low-income families have a complicated set of needs, and that CCDP ought to be designed to ensure that all of those needs are met. In particular, each local CCDP grantee was to:

- intervene as early as possible in children's lives;
- involve the entire family;
- ensure the delivery of comprehensive social services to address the intellectual, social-emotional, and physical needs of infants and young children in the household;
- ensure the delivery of services to enhance parents' ability to contribute to the overall development of their children and achieve economic and social self-sufficiency; and
- ensure continuous services until children enter elementary school at the kindergarten or first grade level.

Since many services are available within local communities, CCDP projects were designed to build on these existing services instead of creating a wholly new set of services. However, CCDP projects were supposed to create new services when necessary to meet the needs of families or to ensure provision of high-quality services. To accomplish this goal, CCDP relied heavily on an approach in which a case manager was responsible for coordinating the service needs of a group of CCDP families. Case managers provided some services directly (e.g.,

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counseling, life skills training) while, at the same time, organizing the provision of other services through individual referrals and brokered arrangements.

DESIGN OF THE CCDP DEMONSTRATION

The CCDP demonstration was designed to provide a fair and unbiased test of the effectiveness of the CCDP model. Grants were made through a competitive process which emphasized selection of the most qualified bidders, with the strongest staff, and the best track record of providing comprehensive services.

To the extent possible in a federal context, ACYF did its best to implement a centrally-run, closely monitored program where variation among projects was minimized to provide a strong test of a single, coherent model. Federal staff negotiated with prospective grantees at the proposal stage to ensure that each potential project's model met ACYF's standards and specifications.

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Once in operation, the activities of each CCDP project were governed by a clear set of federal compliance standards which were enforced through a series of monitoring mechanisms that were implemented by ACYF and its technical assistance contractor (CSR, Incorporated). Some of the monitoring mechanisms included analysis of data from a Management Information System (MIS), production of quarterly compliance reports which provided information on the degree to which each grantee met requirements in 15 compliance areas, monthly telephone contacts to provide technical assistance, three-day grantee meetings held three times a year in Washington, DC, and annual site visits by staff from ACYF and CSR, Incorporated. In this way, ACYF located control over program implementation at the federal level, and provided strong centralized management, a clear vision of the model desired by the government, and detailed programmatic regulations and guidance.

DESIGN OF THE IMPACT EVALUATION

The legislation which created CCDP called for an evaluation of the impact of the funded projects. Given this charge, ACYF devised a two-pronged evaluation strategy. Under one contract, CSR, Incorporated was given the responsibility of providing programmatic training and technical assistance in implementing projects to the CCDP grantees, designing and implementing an MIS, and designing and implementing a process evaluation—to help understand who participated in CCDP, what services were offered, how each project was implemented, and the costs of CCDP. Under a second contract, Abt Associates Inc. was given responsibility for designing and implementing an independent evaluation of the impacts

of the CCDP projects—to find out what difference participation in CCDP made in the lives of children and their parents.

Although the grantees were selected competitively, rather than randomly, the presumption is that the CCDP projects implemented by this group of grantees are reasonably representative of the kinds of projects that would be implemented under a broader program of CCDP grants. This is a reasonable assumption—the CCDP projects were implemented in urban and rural areas, in many different states, under many different auspices, and serving many different populations. Though the findings of the impact evaluation cannot be generalized to any larger population on a strict statistical basis, consumers of this research can feel safe in the knowledge that the demonstration projects provided a test of CCDP under a wide set of conditions that adequately reflect the types of settings in which CCDP projects might be implemented if the program were expanded.

The impact evaluation was conducted in 21 of the original 24 CCDP projects.¹ Grantees in urban areas were asked to recruit 360 eligible families at the start of the program (120 to participate in the program, 120 for the control group, and 120 for the replacement group), while

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grantees in rural areas were asked to recruit 180 families (60 for each of the three groups). Across the 21 projects, 4,410 families were included in the evaluation—2,213 families were assigned to CCDP and another 2,197 families were assigned to the control group. CCDP families could not be “forced” to take part in the program, and an analysis of participation patterns shows that there were some program families that participated for a very brief period (i.e., six months or less), others that participated for a moderate amount of time (i.e., two or three years), and still other families that participated in CCDP for five full years.

To provide Congress and other policy makers with information in a timely fashion, the CCDP impact evaluation was put in place as early as possible in the life of the program. All of the 21 CCDP grantees included in the impact evaluation received funding for the first year of a five-year grant in the fall of 1989. The impact evaluation was funded in the spring of 1990, families were recruited by CCDP projects during 1990 and were randomly assigned to CCDP or to the control group, projects began to deliver services during 1990, and data collection for the impact evaluation started in the fall of 1991. An intensive data collection

Data were collected annually over a five-year period on more than 100 different outcome measures for participating mothers and children. High response rates were obtained by well-trained data collection staff, who lived in each of the 21 sites.

¹ One project was not able to randomly assign families, a second project was not able to maintain appropriate records on recruited families, and a third project joined CCDP a year late and hence was not included in the impact evaluation.

took place annually over a five-year period on more than 100 different outcome measures for mothers and “focus” children, while lesser amounts of data were obtained from fathers, and about children born subsequent to the focus child. High response rates were obtained by well-trained data collection staff, who lived in each of the 21 sites. The study was well-designed and well-executed, and there is little doubt that the findings from the evaluation accurately reflect the true impacts of CCDP on families and children.

SUMMARY OF SAMPLE CHARACTERISTICS

The data presented below represent baseline measures on families as of 1990, the year during which most of the recruiting for the CCDP evaluation took place. The analyses are based on data from families that were part of the analytic sample in the CCDP impact evaluation.

- **Race/Ethnicity:** Forty-three percent of the children in the sample are African-American, 26 percent are Hispanic, 26 percent are white, 3 percent are American Indian, and 1 percent are Asian/Pacific Islander.
- **First Language:** Eighty-four percent of the children in the sample use English as their primary language, 14 percent use Spanish, and 2 percent use some other primary language.
- **Teenage Mothers:** More than one-third (35 percent) of the mothers in the sample were teenagers (under age 18) when they first gave birth.
- **Education Level:** More than half (51 percent) of the mothers in the sample had not graduated from high school when recruited into CCDP.
- **Household Income:** Forty-four percent of households in the sample had a total income under \$5,000 and 85 percent had a total income under \$10,000 at the time of recruitment.

PROGRAM IMPACTS AND COSTS

Changes Occurred in the Lives of Both CCDP Families and Control Group Families. We measured many changes over time in the lives of CCDP families. Examples of these changes were increases in children’s vocabulary and achievement scores, in the percentage of mothers in the labor force, and in mother’s average income. On the other hand, we saw decreases over time in the percentage of families relying on AFDC and Food Stamps, and in the percentage of mothers who were depressed. We saw similar patterns of positive change on many other variables. These patterns are consistent with the findings reported in local evaluations

conducted by many of the CCDP grantees, and if we analyzed data only on families who participated in CCDP we might have concluded that the program had worked quite well.

However, this would have been a mistaken conclusion, because analyses of data collected on control group families showed that *exactly the same changes observed in CCDP families occurred in control group families*². Vocabulary and achievement scores increased for children in the control group, just as they did for children in CCDP. Also, mothers in the control group found employment and earned more

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money, the percentage of control group families receiving AFDC and Food Stamps decreased, and fewer control group mothers were depressed. This pattern of findings tells us that in a five-year study, control group families cannot be assumed to be static or unchanging. Rather, children in the control group progress through developmental stages, and their mothers continue their education and find jobs. In general, these changes are not as large or as positive as the normal changes that occur for children and mothers from higher-income families (for example, CCDP and control group children do not gain as much on the PPVT or K-ABC as children in the norms groups for those measures), but still, the lives of low-income families do change over time, and generally in a positive direction.

These findings point out the need for a randomly assigned control group. Data collected only on CCDP families would have given the misleading impression that the observed improvements in the lives of low-income families were attributable to participation in the program. When we see that the same types of improvements happen for control group families, we realize that we are observing normal changes in the lives of families—changes that cannot be attributed to CCDP.

CCDP Did Not Produce Any Important Positive Effects on Participating Families. We compared outcomes for CCDP families with outcomes for control group families over a five-year period and reached the following conclusions:

2 CCDP's developers hoped that the time and energy devoted to coordinating existing services would eventually lead to community-level improvements in service delivery systems. If community-level changes did happen, the services received by control group families might have been improved, diminishing the observed effects of CCDP on families in the program. However, changing community service systems takes a substantial amount of time, so that even if long-term improvements in the community service mix did result from CCDP, these changes could not have had an effect on the services received by control group families within the time-frame of this evaluation.

- Five years after the program began, **CCDP had no statistically significant impacts on the economic self-sufficiency of participating mothers, nor on their parenting skills.** Mothers in the control group performed as well on these measures as CCDP mothers.
- Five years after the program began, **CCDP had no meaningful impacts on the cognitive or social-emotional development of participating children.** Children in the control group performed as well on these measures as children in CCDP. Nor did CCDP have any impacts on children's health or on birth outcomes for children born subsequent to the focus children.
- **CCDP had no important differential effects on subgroups of participants** (e.g., teenage mothers vs. older mothers, mothers who entered CCDP with a high school diploma vs. mothers who entered without a high school diploma, mothers living with a partner vs. mothers living without a partner, male vs. female children). There was a scattering of differential impacts for some subgroups on some outcomes, but there was no systematic pattern which would allow us to conclude that CCDP worked better for some subsets of participants than for others.

Thus, when the data were analyzed across all of the CCDP projects, we see a very convincing and consistent pattern—on average, CCDP did not make a measurable difference in the lives of program participants. Early data from the CCDP process study (ACYF, 1994) showed that two years into the program, there were high levels of service participation on the part of CCDP families. A complementary finding based on early data from the impact evaluation (ACYF, 1994) showed that CCDP families received significantly higher levels of some services than control group families, although many control group families found and participated in a wide range of services without the benefit of CCDP.³ Subsequent data from the CCDP process study (CSR, Incorporated, 1997) showed that CCDP families continued to participate at high levels in many different types of services. Thus, CCDP clearly was successful at organizing and delivering services to families. However, the evidence presented in this evaluation shows that the services did not have the intended impacts on mothers and their children.

One CCDP Project Had Important Positive Effects. The main focus of the impact evaluation was to assess the overall effectiveness of CCDP, measured across multiple

3 For example, CCDP mothers were more likely than control group mothers to receive a range of services from a case manager, to participate in academic or vocational classes, and to participate in parenting education classes; and CCDP children were more likely than control group children to participate in child care programs.

projects. What is most desired in the assessment of social programs is the ability to demonstrate a model which is robust, which works in a variety of locations, under different circumstances, with different populations. It is of lesser interest to show that a program or model works only in a few special sites. Of course, there is an understandably keen interest in whether and how CCDP's effects vary on a project-by-project basis, especially in light of the fact that this evaluation has shown no significant overall program-level effects.

We examined the effectiveness of CCDP in each of the sites that participated in the evaluation. Because there were no overall effects of CCDP, it is no surprise that almost all of the CCDP projects had no positive effect on more than 30 different outcome variables. However, one site, identified in this report as Site #2, had statistically significant and moderately large positive effects in several different outcome domains: children's cognitive development; families' employment, income, and use of federal benefits; and parenting attitudes.

One of the 21 sites in the study had statistically significant and moderately large positive effects in several different outcome domains: children's cognitive development; families' employment, income, and use of federal benefits; and parenting attitudes.

In terms of child cognitive development, Site #2's effect on the PPVT was 9.4 points, equal to an effect size of 0.63 standard deviation units (a moderately large effect), and Site #2's effect on the K-ABC was 3.9 points, an effect size of 0.26 standard deviation units (a small but non-trivial effect). With respect to income and employment, Site #2 increased by 22 percentage points the average amount of time that either the mother or partner in the household was employed (from 47 percent in the control group to 69 percent in CCDP), decreased by 20 percentage points the number of mothers who were on AFDC at the end of the study (from 65 percent in the control group to 46 percent in CCDP), and decreased by 19 percentage points the average amount of time that families received food stamps (from 74 percent in the control group to 55 percent in CCDP). Finally, Site #2 families had higher annual household incomes than control group families—\$17,029 vs. \$13,407, respectively. All of these differences represent moderately large effects.

With respect to parenting, CCDP in Site #2 had positive effects on two of four scales of the Adult-Adolescent Parenting Inventory (AAPI) that are indicative of abusive parental behaviors. CCDP parents scored higher on the scale measuring parents' empathetic awareness of their child's needs (raw score difference of 1.6 points, equal to 0.37 standard deviations), and higher on the scale measuring the appropriateness of parents' expectations for their child (raw score difference of 1.3 points, equal to 0.35 standard deviations). The AAPI defines cutoff scores for each of its four scales. Parents scoring below the cut off are deemed "at risk" for abusive behavior toward their children. In Site #2, 67 percent of the CCDP parents were not at risk of abusive behavior on any of the four AAPI subscales, compared with 46 percent of the control group parents. These are small to medium-sized effects, but given the difficulty that most interventions have in changing parent behaviors, the positive effects in Site #2 are worth noting.

It is one thing to identify an effective site. It is quite another to explain why this site was effective when other sites, sharing many of the same characteristics, were not effective. There are several possible explanations as to why CCDP in Site #2 was more effective than in other sites.

The population served was somewhat less at risk than the population served in many (but not all) other sites; the site is located in a state that provides a relatively high level of support to low-income families, and benefits from the combination of being a small city in a rural area where program families were not seen as being “inferior” to or qualitatively “different” from program staff; with a school district as the grantee, the site had a clear focus on children and their education; the site had a particularly strong project director and senior staff, all of whom stayed with the project for many years; and finally, site staff appear to have done an especially good job of collaborating with local agencies, attributable in part to support for these activities at the state level and from the project’s executive director. None of these factors can be singled out as “the reason” why CCDP was more effective in Site #2 than in other sites. The circumstances and context of Site #2 were probably unique, and certainly acted in concert to produce the positive effects documented in this report.

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Length of Enrollment in CCDP Did Not Make an Important Difference to Outcomes. One assumption made by CCDP’s developers was that it would require multiple years (from birth until entry to school) to ensure that children would be ready for school and that parents would become economically self-sufficient. The length of time that a family was enrolled in CCDP is a crude but basic measure of a family’s overall level of participation in the program.

Analyses were conducted to compare CCDP’s impacts using the full sample of CCDP families, as well as the subset of CCDP families that participated for three or more years, and the subset that participated for four or more years. The results of these analyses lead us to

conclude that the length of time that a family was enrolled in CCDP was sometimes associated with a statistically significant difference in the outcomes achieved by that family, but those differences were not educationally or substantively meaningful.

The length of time that a family was enrolled in CCDP was not associated with educationally or substantively meaningful outcomes for families.

Amount of Center-Based Care Made a Small Difference to Outcomes. A common research question for studies of programs which provide educational, social, and health services is “Did families that received more intensive services have better outcomes?” Hence, we examined the role played by center-based care in mediating child development outcomes.

First, we found that CCDP children received many different types of early childhood education and care. At the same time, families in the control group used many of the same set of care options for their children. While we know little about the quality of the care provided to children in this evaluation, we did find that CCDP children received more center-based care than did control group children--42.8 vs. 25.3 hours per month between birth and age 5.

As expected in light of the absence of an overall CCDP impact on children, there was no consistent relationship between CCDP's impact on amount of center-based care and CCDP's impact on several different child outcomes. We found that CCDP's impact on achievement test scores increased as CCDP's impact on number of hours per month of center-based care increased. While statistically significant, this relationship was not strong enough to be educationally important.

CCDP's is a Costly Intervention. By any yardstick, CCDP is an expensive program. Data from CCDP's process evaluation (CSR, Incorporated, 1997) show that the total cost of CCDP averaged \$15,768 per family per year (excluding the costs of participating in mandated research and evaluation activities), or about \$47,000 for each family in the evaluation, given an average length of participation of more than 3 years. CCDP projects spent an average of 43 percent of their personnel costs on "direct intervention services" (80 percent of direct intervention service monies were spent on case management) and 57 percent on "program support services".

The cost of CCDP services averaged \$15,768 per family per year; a total of about \$47,000 for each family in the evaluation given the average length of participation in CCDP of more than three years.

As a way to judge the magnitude of these costs, consider the per family per year costs of a few related programs: Head Start (\$4,500 per family per year; ACYF, 1995), the Infant Health and Development Program (\$10,000 per family per year; Ramey, 1994), the Even Start Family Literacy Program (\$2,700 per family per year; St.Pierre, et al., 1995), Avance Family Support and Education Program (\$1,600 per family per year; Johnson & Walker, 1991), David Olds' Nurse Home Visiting Program in Elmira, NY (\$2,300 per family per year; Olds, et al., 1993), Child Survival/Fair Start (\$1,600 to \$2,800 per family per year; Larner, et al., 1992), and New Chance (\$8,300 per family per year; Quint, et al., 1994).

Cost comparisons are difficult to make because the dollars allocated to social programs are often used to buy very different sets of services, and these examples are not intended to provide an exhaustive comparison of the costs incurred by similar social and educational programs. Rather, the point of this brief comparison is to point out that the comprehensive nature of the services provided by CCDP make the annual cost per family relatively high when compared with other social programs that have similar aims.

Can We Expect to Find Future Positive Effects and Associated Cost Savings? An obvious question that arises is "Might we find positive effects on CCDP children or mothers at some future time?" This question arises because some evaluations have found that the most

important benefits of early childhood programs did not become apparent until many years after the program had been completed and children had been followed into the public schools and beyond (most notably, the Perry Preschool Study (Schweinhart, Barnes & Weikart, 1993). Several reviews supporting the contention that long-term effects of early childhood programs exist have appeared in the recent literature (e.g., Yoshikawa, 1995; Barnett, 1995). However, these studies were following children who had participated in intensive early childhood programs and *who had first derived large short-term cognitive benefits* from those programs. Further, Yoshikawa (1995) suggests that the most impressive long-term effects are associated with programs that demonstrated short-term effects both on childrens' cognitive development and on mothers' parenting skills and behaviors.

Neither of these short-term outcomes (improved short-term cognitive benefits for children or improved parenting behaviors for mothers) were found for CCDP children and their mothers. CCDP's early childhood experiences were not intensive, coming first in the form of weekly one-hour in-home parenting education programs when children were under 3 years of age, and moving to Head Start or other center-based or home-based child development programs for children 3 to 5 years of age. CCDP children received an average of 28 hours per month of center-based care from birth to age 3, and 45 hours per month from 3 to 5 years of age. This is substantially less than the 80 to 180 hours per month received by children in high-intensity programs such as the IHDP. Given the lack of an intensive early childhood program and the lack of short-term or medium-term effects in CCDP, there is no reason to hypothesize long-term positive effects for children who participated in CCDP.

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But what about the possibility of long-term effects on mothers? There is scant research in this area, and we know of no literature pointing to the existence of long-term effects of anti-poverty programs on mothers, similar to those found for children who participated in intensive early childhood programs.

If long-term effects of CCDP exist at all, there is reason to think that they would become evident for children born subsequent to the focus child. CCDP's approach of providing child development through parenting training was unlikely to have a major impact on focus children since most of them were born prior to the beginning of parenting training, and focus children had to pass through many important developmental stages before parenting skills had a chance of improving. Children born after the parenting training was provided had a better chance of benefitting from any improved parenting skills. Unfortunately for this line of reasoning, this evaluation showed no improvements in the parenting skills of CCDP mothers.

WHY WERE THERE NO PROGRAM IMPACTS?

This is a disappointing set of findings—a consistent pattern which calls for an explanation. In this section we hope to provide a better understanding as to why CCDP had no effects.

Perhaps the Program Was Poorly-

Defined. Past studies of social programs have found that sometimes a program was so ill-defined that staff at the local level had no idea of what to implement or how to implement it. This was not the case for CCDP. Rather, ***the CCDP program was clearly and carefully defined by ACYF*** so that it could be understood and implemented locally. ACYF provided a detailed definition of the program, strong centralized management and oversight, and associated programmatic regulations and guidance. Program details were fully spelled out in written compliance standards that were clearly communicated to all local grantees. A management information system was put in place by CSR, Incorporated to help monitor service provision and to identify technical assistance needs. Monthly telephone calls were made to local projects and ongoing oversight and technical assistance were provided by CSR, Incorporated, grantee meetings were held three times a year to facilitate the exchange of information and to discuss compliance issues, quarterly progress reports were prepared by each local project, and annual site visits to each project were conducted by ACYF and CSR, Incorporated to assess compliance and provide technical assistance.

Relative to other demonstration projects and other federal programs, there is little question that the CCDP model was well-defined at the federal level, clearly communicated to local grantees in a variety of settings, and closely monitored. This is the first step in constructing a strong demonstration program.

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Implemented. Given a well-defined program, it still is possible that local grantees were unable or unwilling to do a high-quality job of implementing the program. Past evaluations have shown

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that some programs failed due to poor implementation. Could this have been the reason for CCDP's lack of effects? Not at all. Instead, there is compelling evidence that ***CCDP projects were well-implemented by local grantees***. As reported by ACYF (1994) and CSR, Incorporated (1997), CCDP served the families that it was intended to serve, coordinated the efforts of thousands of service agencies nationwide, and delivered a wide range of services to a high proportion of participating families. CCDP intended to provide up to five years of

continuous service to low-income families, and families recruited for the CCDP demonstration and evaluation participated for an average of more than three years. Compared with other demonstration programs, which often have annual dropout rates of 50 percent or more, CCDP was relatively successful in retaining substantial numbers of families from a traditionally difficult-to-serve section of the population.

The CCDP local grantees deserve credit for successfully implementing a very difficult demonstration project. The grantees showed that it was possible for a wide variety of local agencies to work with the federal government to put a complicated program in place in many locations around the country. Of course,

The CCDP grantees showed that it was possible for a wide variety of local agencies to work with the federal government to put a complicated program in place in many locations around the country.

the implementation of CCDP was not perfect, and there were initial start-up difficulties as well as site-to-site variation in the timing and quality of program implementation. But given the high degree of technical assistance and monitoring that was provided to local CCDP grantees by the federal government, CCDP's implementation in this demonstration was far better and more standardized than would be expected if the CCDP model were to be implemented widely, without any special mechanisms for ensuring the fidelity of each project to the model defined by ACYF. Put another way, the implementation of CCDP in this demonstration project is as good as can be expected in any large-scale demonstration of a comprehensive intervention program.

Perhaps the Theory and Assumptions Underlying CCDP Were Faulty. The above findings—good program definition at the federal level, and strong implementation by local grantees, followed by the finding that, on average, the program has made very little difference in the lives of participating families—call into question the theory and assumptions underlying the program. We cannot account for the lack of program impacts by pointing to faulty program definition—the federal government provided clear and careful specifications for how to implement the CCDP model. We cannot say that the program was poorly implemented—the process study (CSR, Incorporated, 1997) shows that local grantees did a good job of adhering to the government's compliance standards and of delivering the planned services to participating families. We cannot say that families did not participate long enough for effects to become evident or that all of the “success story families” left early—the average family participated for more than three years which is much longer than families participate in almost any other social intervention (even though program services were available for up to five years). We cannot account for the lack of impacts by saying that the evaluation was poorly designed or poorly implemented. The research design was strong, the measurement battery was broad, and response rates were high.

Having ruled out these hypotheses for a lack of effects, we must rethink the basics of the program design—the theory and assumptions underlying the CCDP model. Let us address some of the questions raised by this disappointing pattern of findings.

Were Services of Sufficiently High Quality? CCDP was developed under the assumptions that most of the services needed by low-income families already existed in most communities and that these services were of sufficiently high quality to address the needs of low-income families.

CCDP built on services that already existed in each community. It is possible that these local services were of poor quality, so that CCDP arranged for the delivery of services that were ineffective.

It is possible that these assumptions are incorrect and that the problem lies with the services provided through CCDP—perhaps local services were of poor quality, or maybe they were not the services needed by participating families, or maybe they were not sufficiently intensive. If this was the case, then CCDP may have been very good at delivering services that were nonetheless ineffective. While the process study (CSR, Incorporated, 1997) does not include information about the quality of services provided through CCDP, it does present data on the extent to which parents reported that services allowed them to meet the goals that they and CCDP staff set for themselves. Although many different goals were set by CCDP families, only a small percentage of parents reported that they actually attained those goals (e.g., 37 percent reported that they obtained adequate housing, 11 percent reported that they increased their parenting skills, 24 percent reported that they obtained health care, 13 percent reported that they obtained social support, 17 percent reported that they furthered their education, 14 percent reported that their children had enhanced cognitive and social development, and so on; CSR, Incorporated, 1997, Exhibits 3-28, 3-29). This suggests that the great majority of participating parents did not think that CCDP helped them achieve the goals they set at the beginning of the program.

Were Services Too Diluted to be Effective? One of the findings that is emerging from studies of child development and family literacy programs with some degree of consistency is that the best way to achieve positive effects is

None of the services may have been provided on a sufficiently intensive basis to be effective.

to provide intensive services directly to the individuals that you hope to affect (Yoshikawa, 1995; Ramey & Ramey, 1992). CCDP did not take this approach. Rather, CCDP funds were used to provide a wide variety of services to all family members, and the approach was broad-brush rather than intensive in nature. The idea of “comprehensive services” as implemented in CCDP meant that a great number of services were provided, but none of the services may have been provided with sufficient intensity to be effective.

Did CCDP Rely Too Heavily on Indirect Effects? One of CCDP’s key assumptions is that the best way to improve child outcomes is to focus on improving parents’ ability to parent their children, rather than providing an educational intervention directed at the child. Our findings raise the possibility that CCDP relied too heavily on the “indirect effects” method of

There is little research evidence that CCDP’s focus on parenting education (instead of direct service to children) was the best way to improve child outcomes.

producing impacts on children. During the first three years of the program, until children reached Head Start age, CCDP's main child development efforts were focused on teaching parents to understand child development and interact appropriately with their children, in the hope that parenting skills would be improved with a resulting enhancement in child development.

Recent literature on the ability of parenting education to affect child development (Ramey & Ramey, 1992; Barnett, 1995; Wasik, et al., 1990) casts doubt on the efficacy of this approach. At the same time, there is substantial research evidence that the best way to achieve large effects on children is to provide intensive services directly to children over an extended period of time (Ramey & Ramey, 1992). This research does not dismiss the importance of the parent's role in child development. In fact, there is widespread agreement that competent parenting is related to positive child development. However, research provides few answers to several key questions related to the potential effectiveness of parenting education: Which aspects of parenting are both (1) important to child development and (2) amenable to timely change? At what point in the parent's life is a parenting intervention most likely to be effective? What parenting education strategies are likely to be most effective?

Could Families Obtain Services Without CCDP? CCDP's developers assumed that low-income families were unable to access existing services efficiently without assistance—perhaps because the service delivery systems in most communities are too complicated, or perhaps because mothers simply do not understand that they are entitled to certain services. CCDP also assumed that once services were identified, they needed to be coordinated. That is, it is not sufficient to inform low-income families about the existence of services. Rather, it was assumed that a case manager was needed to coordinate and ensure service delivery.

Evidence from this evaluation partly refutes this assumption. The evaluation's interim report (ACYF, 1994) showed that during the first two years of the program, control group families were able to access many of the same basic services as CCDP families. Typically, a larger percentage of CCDP families than control group families reported that they received any given service, but in many cases the differences were not large, certainly not as large as we might expect for a program that spent more than \$15,000 per family per year to ensure that services were delivered. For example, equal percentages of CCDP and control group families visited a doctor for checkups, received acute medical care, and received dental services.

While CCDP was successful at increasing the use of some services by participating families, many control group families were able to obtain services on their own.

Early in this evaluation (i.e., about two years into the program), more CCDP mothers than control group mothers participated in parenting classes (34 percent vs. 11 percent), academic classes (38 percent vs. 26 percent), and vocational classes (18 percent vs. 13 percent), and more worked toward a GED (12 percent vs. 8 percent), an associate's degree (7 percent vs. 3 percent), or a bachelor's degree (6 percent vs. 3 percent). CCDP children were more likely than control group children to participate in work-related child care (66 percent vs. 53

percent), to use formal child care (36 percent vs. 16 percent), and to use nonwork-related child care (25 percent vs. 13 percent). The point is that while these differences were statistically significant, indicating that CCDP was successful at increasing the use of some services by participating families, many control group families were able to obtain services on their own. The resulting impact on the amount of services received by CCDP families may not have been large enough to result in important differences on outcome measures.

These data raise questions about the necessity of the case management structure that was provided through CCDP. If the same percentage of control group families as CCDP families received health services, and roughly half as many control group families as CCDP families received educational services (across all of the educational variables listed above), then either the case management model was not particularly effective at ensuring that services were delivered, or the assumption that low-income families have difficulties accessing services may be ill-founded.

Perhaps the Case Management Model is an Ineffective Approach. The CCDP demonstration and associated evaluation provided a fair test of an important model for combating the deleterious effects of poverty on families with young children. It is the largest test of the currently popular model of case management combined with integrated service provision. A few other examples of this approach are described below, along with associated evaluation findings.

At the federal level, the Even Start Family Literacy Program provides three main programmatic components: early childhood programs for children, and parenting training and adult education for parents. Although it offers fewer services over a shorter period of time and is

This evaluation, as well as other high-quality studies, provides no evidence that the case management approach is effective in enhancing outcomes for parents or children.

substantially less intensive and expensive than CCDP, Even Start projects do have staff acting in the role of case manager (family worker, family advocate, etc.) and are mandated to use local existing services to avoid duplication of effort. A national evaluation (St.Pierre, et al., 1995) found that program participants changed over time (children's test scores increased, mothers became less depressed, etc.) but there were few positive program effects when program participants were compared with children and mothers in a randomly assigned control group (the major positive effect was that Even Start adults were more likely than control group adults to obtain a GED).

The case management model has been tried in other fields. For example, the Fort Bragg Child and Adolescent Mental Health Demonstration, funded by the U.S. Army, was an \$80 million program which delivered mental health and substance abuse services using a coordinated case management approach to involve various service agencies. An evaluation of this program (Bickman, 1996) reached many of the same conclusions as the current study—the demonstration had a systematic and comprehensive approach to planning treatments, more parental involvement, strong case management, more individualized services, fewer treatment

dropouts, a greater range of service, enhanced continuity of care, more services in less restrictive environments, and a better match between services and needs. In the face of these positive implementation findings, no positive effects were found on a wide range of child-level outcome measures. Comparison group children who participated in a less expensive, fragmented system of care, without case management, did as well clinically as children in the demonstration. This pattern of findings—good implementation of an integrated case management service delivery system, followed by no effects on program participants—has been seen in other recent studies of child and adolescent mental health services (e.g., Burns, et al., in press; Cauce, et al., 1995; Huz, et al., 1995).

CONCLUSIONS

The CCDP demonstration was a success. At the start, nobody knew whether providing intensive case management was the best way to help low-income families. The demonstration and evaluation were developed to answer this question. Everyone involved in the demonstration and evaluation should be regarded as having an investment in helping low-income families, but not as people who are tied to any particular solution (this was one of Donald Campbell's (1971) most important messages in his seminal article on the "experimenting society"). Instead of being advocates for a particular program, we need to be advocates for solving the problem. Instead of advocating in the absence of research evidence, we need to be intellectually curious about finding the best approaches.

There is no question that this six-year effort provided a fair test of this key policy alternative. It has produced important findings—findings showing that the case management approach does not lead to improved outcomes for parents or children. This is an important piece of information in the fight against poverty.

So was CCDP a waste of money? Of course not. As a demonstration program, CCDP was a respectable and respectful use of public funds, and it accomplished exactly what it was designed to do—find out whether an important approach to serving low-income families works. The fact that the answer is "no" does not diminish the utility of the demonstration or the fine efforts of everyone involved.

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