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HEARING ON PROPOSALS TO PROVIDE FEDERAL FUNDING FOR EARLY CHILDHOOD HOME VISITATION PROGRAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON INCOME SECURITY AND FAMILY SUPPORT

OF THE

COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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HEARING ON PROPOSALS TO PROVIDE FEDERAL FUNDING FOR EARLY CHILDHOOD HOME VISITATION PROGRAMS

TUESDAY, JUNE 9, 2009

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON INCOME SECURITY AND FAMILY SUPPORT,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:03 a.m., in room B–318, Cannon House Office Building, Hon. Jim McDermott (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON INCOME SECURITY AND FAMILY SUPPORT

FOR IMMEDIATE RELEASE
June 02, 2009
IFSF–3

CONTACT: (202) 225–1025

McDermott Announces Hearing on Proposals to Provide Federal Funding for Early Childhood Home Visitation Programs

Congressman Jim McDermott (D–WA), Chairman of the Subcommittee on Income Security and Family Support of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing to review proposals to provide funding for grants to States to support early childhood home visitation programs. **The hearing will take place on Tuesday, June 9, 2009, at 10:00 a.m. in B–318 Rayburn House Office Building.** In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled to appear may submit a written statement for consideration by the Subcommittee and for inclusion in the record of the hearing.

BACKGROUND:

Early childhood home visitation programs provide instruction and services to families in their homes. These programs are designed to enhance the well-being and development of young children by providing: information on child health, development, and care; parental support and training; referral to other services; or a combination of these services. Typically visits begin during pregnancy or shortly after a child's birth and may last until a child is age four. Home visits are conducted by nurses, social workers, other professionals or paraprofessionals.

A growing body of research has found strong evidence that early childhood home visitation programs are effective in reducing the incidence of child abuse and neglect, and in improving child health and development, parenting skills, and school readiness. A majority of States currently provide early childhood home visitation services to a relatively small number of families. President Obama's FY 2010 budget includes a proposal to support States in creating and expanding evidence-based home visitation services. Consistent with the President's budget proposal, Subcommittee Chairman Jim McDermott (D–WA) and Representative Danny Davis (D–IL) are introducing legislation today, *The Early Support for Families Act*, that would provide mandatory funding to States to create and expand early childhood home visitation programs. The McDermott-Davis bill would support rigorously evaluated programs that utilize nurses, social workers, other professionals and paraprofessionals to visit families, especially lower-income families, on a voluntary basis.

In announcing the hearing, Chairman McDermott stated, **"Home visitation programs have a proven track record of increasing the chances that a child will have a safer, healthier, and more productive life. There is considerable interest in expanding these programs to reach more families. I look forward to working with all of my colleagues to advance a proposal that will achieve that goal."**

FOCUS OF THE HEARING:

The hearing will focus on proposals to provide mandatory funding for grants to support State efforts to establish and expand early childhood home visitation programs.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "Committee Hearings". Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, complete all informational forms and click "submit" on the final page. **ATTACH** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Tuesday, June 23, 2009.** Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

Chairman MCDERMOTT. This Subcommittee has a mission of working on a bipartisan basis to ensure the safety and well-being of children, and I hope today marks the beginning of our next step toward that goal.

Last year, we produced major legislation to help relatives caring for foster children to provide support for tens of thousands of children who are now aged out of foster care on their 18th birthday,

to improve the oversight of health and educational needs in children and to increase the support for adoption assistance.

When we passed that bill, I said at the time our job is far from done. We still have a child protection system that is designed primarily as a response program, rather than a prevention and response program.

Along with Danny Davis and Todd Platts, I put forward legislation last week to take a more proactive approach to helping families. The Early Support for Families Act, H.R. 2667, would provide Federal funding for home visitation programs to reduce child maltreatment as well as to improve children's health and school readiness. As the Federal Department of Health and Human Services declared under President Bush, quote, "There is a growing body of evidence that some home visitation programs can be successful as a child maltreatment prevention strategy." I agree and I think we ought to proceed down that road.

The Early Support for Families Act follows President Obama's budget recommendation to provide grants to States to help them establish or expand their voluntary home visitation programs for families with young children and families expecting children. Only programs using evidence-based models that have demonstrated positive effects on important child and parenting outcomes would be eligible for the funding. Home visits could start during pregnancy and could be conducted by nurses or social workers or trained paraprofessionals. The visits would focus on providing information on child health, development and care, on parental training and support, and on referrals to other services.

Many States have home visitation programs funded with State dollars and/or a hodgepodge of Federal funding. According to the Pew Center on the States, less than 15 percent of families needing home visitation are now served. The legislation we put forward would provide a dedicated funding source to ensure many more children receive the benefits of home visitation.

Although my colleague, Danny Davis, who is not here yet, I want—he is at the Congressional Black Caucus Summit on Health. He authored a home visitation bill in the Education and Labor Committee during the last Congress, and the principles of that legislation—are really a guiding force in the bill we put forward here together. I don't believe home visitation would be so squarely on our agenda without his efforts.

I also want to add that there is some talk about adding this provision to the health care reform bill that is presently being massaged through the Congress. Whether or not that happens or not remains to be seen.

But I would now like to recognize my Ranking Member, Mr. Linder.

Mr. LINDER. Thank you, Mr. Chairman.

Today's hearing offers a timely reminder of the differences between the fantasyland of Washington, D.C., and the reality of the rest of America. Here in fantasyland, we will discuss adding one more multibillion dollar entitlement program. This would be on top of the new higher education entitlement program created this year, and of course, our current health care and retirement entitlement

programs whose looming insolvency recently led President Obama to say "we're broke."

But we are actually worse than broke. We are massively in debt, and it is getting deeper every day. USA Today reported last week that in 2008 the average U.S. household owed almost $550,000 in Federal debt. That is four times what the same average household holds in mortgage, car loan, credit card and other debt combined. And that is before this year's trillion-dollar orgy of so-called stimulus spending.

Meanwhile, in the real world, the recession is forcing States to cut current spending. And California, the Governor proposes eliminating the welfare-to-work program and health insurance for nearly 1 million low-income kids. After their 2009 budgets passed, 42 States enacted emergency spending cuts totaling $32 billion.

These are not minor adjustments. Yet the legislation we will discuss today breezily assumes States will find $3 billion in new money over the next decade to finance their part of this new entitlement. Where will that money come from? The tooth fairy? Being a dentist, I can tell you something about that, but I won't say it out loud.

I don't often agree with Robert Greenstein, the head of the liberal Center on Budget and Policy Priorities. But last week in the New York Times he said, "A budget tsunami is coming. That threat should be taken a hell of a lot more seriously than it is now ". In the current budget crisis, he called for "scrapping marginal programs to save the most essential."

Today we are ignoring that coming tsunami and strolling along the beach contemplating another program. Several of our witnesses will discuss how some home visitation programs have shown some positive effects. We know that from programs already operating, often with Federal and State program money. But obviously our colleagues think it is not enough because it is never enough.

If you added up all the Federal and State funds. States could spend on home visitation, it is an incredible $244 billion a year. Obviously States don't spend all that money this way, having other priorities or now needing to cut other priorities. So we in Washington will create a new program that forces them to. Not a program that increases child abuse prevention funds that may be spent on home visitation, but a program whose funds must be spent on home visitation, and nothing else.

And if States won't spend this money, or can't come up with their own share, the Federal cash will be given to another State. So it is Washington's way or the highway. Except the children will be the ones who will really pay when the upcoming budget tsunami washes this and other programs away.

Mr. Chairman, all of us are interested in making sure every child gets a good start in life. I support reviewing current home visitation programs that fall under the Committee's jurisdiction and how they can be improved. However, at this time of massive and growing Federal and State deficits, I simply cannot support the creation of a new entitlement that would send another $8.5 billion in unpaid-for Federal spending out the door.

To help illustrate the current economic situation, in closing I ask unanimous consent to insert three documents into this record at this point.

The first is an Associated Press article from last week that lists the massive spending cuts under consideration in California today to bring its budget into balance.

[The information follows:]

SFGate.com

Schwarzenegger's proposal for Calif deficit

By The Associated Press
Tuesday, June 2, 2009

(06-02) 16:54 PDT , CA (AP) --

Gov. Arnold Schwarzenegger has proposed a mix of spending cuts, borrowing from local governments and ways to generate revenue to close a deficit projected at $24.3 billion for the fiscal year that begins July 1.

Almost two-thirds of the deficit would be addressed through spending cuts under his latest plan, which is making its way through the legislative process. Here are the highlights of the governor's proposals:

SPENDING CUTS

_ Cut $5.2 billion from K-12 schools.

_ Eliminate CalWORKS, the state's welfare-to-work program, to save $1.3 billion.

_ Eliminate Healthy Families, a program that provides health insurance for 930,000 low-income children, to save $366 million. Because the state receives a federal match, it would lose roughly $500 million in federal money.

_ Reduce inmate rehabilitation programs such as substance abuse counseling, vocational training and educational programs, to save $789 million. Save another $120 million by reducing time served for some prisoners.

_ Commute sentences one year early for offenders considered nonviolent and who were not convicted of sex crimes, for a savings of $121 million.

_ Reduce Medi-Cal eligibility for newly qualified legal immigrants to save $125 million.

_ Eliminate the general fund contribution, about $70 million, for state parks.

_ Cut $1.9 billion from the University of California and California State University system budgets, and another $663 million from the 110-campus community college system.

_ Phase out CalGrants, the state's college fee assistance program, to save $173 million.

_ Eliminate funding, for the coming year only, to replace equipment for the California Department of Forestry and Fire Protection, saving $17 million.

_ Reduce funding for AIDS testing by $55.5 million; eliminate funding for HIV education and prevention to save another $25 million.

_ Eliminate Adult Day Health Care program, for a savings of $117 million.

_ Cut $20 million from domestic violence prevention programs.

_ Deport illegal immigrants being held in state prisons, saving $182 million.

_ Cut salaries of more than 200,000 state employees by an additional 5 percent, for a savings of $470 million. Most state employees already are being furloughed two days a month.

OTHER MEASURES

_ Borrow nearly $2 billion from local governments' property tax revenue, money that would have to be repaid with interest in three years.

_ Speed up collection of 2010 personal income taxes, bringing in $1.7 billion earlier than anticipated.

_ Take $744 million in gasoline taxes from local governments to pay off debts.

_ Charge homeowners an average of $48 a year to boost funding for emergency services, generating $76 million.

_ Allow limited expansion of oil drilling off the coast of Santa Barbara, bringing in $100 million.

_ Shift $60 million in cigarette tax revenue to help fund Medi-Cal.

_ Sell off part of the State Compensation Insurance Fund, which the administration values at $1 billion.

_ Assume federal officials will waive certain Medi-Cal match requirements, saving $250 million.

Source: California Department of Finance.

http://sfgate.com/cgi-bin/article.cgi?f=/n/a/2009/06/02/state/n165424D15.DTL

Mr. LINDER. The second is a Wall Street Journal article from last week titled States' Budget Woes Are Poised to Worsen.

[The information follows:]

MarketWatch

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THE WALL STREET JOURNAL.
WSJ.com

JUNE 3, 2009

States' Budget Woes Are Poised to Worsen

by AMY MERRICK

(See Corrections & Amplifications item below.)

State budgets look bad now, but they are set to get worse.

The bulk of funds from the federal government's stimulus package will be allocated by 2011, but tax collections aren't likely to be enough to take their place -- even if the economy is recovering.

The drop in tax revenue is set to be deeper and last longer as collections have become more sensitive to business cycles in recent years. At the same time, states face growing health-care costs and the need to replenish pension programs funded by decimated investments. And some of the stimulus funds expand programs that will require state money to sustain them after the federal largesse runs out.

"There are so many issues that go way beyond the current downturn," said Scott Pattison, executive director of the National Association of State Budget Officers. "This is an awful time for states fiscally, but they're even more worried about 2011, 2012, 2013, 2014."

Already, acrimony is building as states grapple with budget problems. In Illinois, lawmakers failed to pass a budget Sunday after rejecting the tax increases that Gov. Pat Quinn, a Democrat, said were needed to close an $11.6 billion spending gap. The Texas Legislature adjourned Monday in disarray, without approving funding needed to keep the state's transportation and insurance agencies running.

In Arizona, Gov. Jan Brewer, a Republican, on Monday released a controversial budget proposal that would temporarily raise the sales tax and partly revive a state property tax.

And in California, Republican Gov. Arnold Schwarzenegger warned Tuesday that lawmakers have until June 15 to close the state's budget deficit, or California will be unable to borrow the cash it needs to pay its bills after July.

With most governors busy stanching the current budget bleeding, only a few have taken steps to head off future problems.

Tennessee Gov. Phil Bredesen, a Democrat, in March laid out a four-year plan to balance the budget without using rainy-day funds. In Oregon, Democratic Gov. Ted Kulongoski has called for a "reset" of state government, arguing that voters must reconsider 1990s ballot measures that shifted school funding from property taxes to income taxes and that imposed mandatory minimum prison sentences. Gov. Schwarzenegger is proposing lasting cuts to health care and prisons.

Altogether, states face aggregate budget shortfalls of at least $230 billion from fiscal 2009 through fiscal 2011, said Mr. Pattison. For most states, that covers the period from July 1, 2008, to June 30, 2011.

That aggregate figure is nearly double the roughly $130 billion in federal stimulus funds that states can use flexibly over three years. (About $120 billion in further stimulus funding comes with stricter requirements, and sometimes new, costly mandates.)

When today's federal assistance peters out, a number of state budget officers don't expect new tax revenue to replace it. As the recession grinds on, states are posting significant declines in revenue from their three major sources: sales, personal-income and corporate taxes.

About a quarter of states saw their economies contract last year, the Commerce Department said Tuesday. Alaska's gross domestic product -- the total value of all the goods and services it produced -- slipped the most in 2008, falling an inflation-adjusted 2% from the previous year largely because of declining oil output.

The Great Lakes states of Michigan, Ohio and Indiana posted some of the steepest GDP drops, as the woes of Detroit's auto makers hurt manufacturers throughout the region.

North Dakota's GDP gain of 7.3% topped the nation. Its largely agricultural economy has been well shielded from the housing bust, financial crisis and manufacturing decline that have weighed on the overall U.S. economy.

Still, in general most forecasters see a very slow recovery, which suggests a commensurately slow upturn in state revenues. Federal Reserve officials, for instance, see unemployment, at 8.9% at last report, averaging between 9% and 9.5% next year and remaining elevated through 2011; some private forecasters are more pessimistic.

State tax collections could take five years or more from when the recession began in December 2007 to recover to prerecession levels, says Donald J. Boyd, senior fellow at the Nelson A. Rockefeller Institute of Government at the State University of New York.

In addition, revenues appear to have grown more sensitive to the business cycle in the past decade, in part because capital-gains taxes have become a bigger component of tax bases, according to new research by Federal Reserve Bank of Chicago economists Leslie McGranahan and Richard Mattoon. That could prolong the effect of the downturn and, by increasing volatility, make it harder for states to plan budgets.

The best outcome they can imagine, some state officials say, is that the stimulus funding allows them to make spending cuts gradually: for example, by relying more on attrition and less on layoffs to cut payrolls. (Unlike the federal government, states generally are required to balance their budgets.)

That's sparking tough choices. In April, Tennessee's sales tax revenue was 9.9% below the previous year, and total tax revenue for the month was nearly $200 million less than the state's forecast.

The state expects general-fund tax revenue to rise about 4.4% in the fiscal year beginning July 1, 2010, from a year earlier. But that entire increase is expected to be eaten up by inflation in education costs, increased Medicaid enrollment, and funding a pension plan whose nominal value has dropped from $32 billion to $25 billion.

So the state is looking to make long-lasting spending cuts. It plans to eliminate 1,373 jobs. Some economic-development projects are potentially on the chopping block.

"This is not simply trimming around the edges," said the state's top budget officer, Dave Goetz. "This is entire programs."

States also can raise taxes and fees, of course, but if residents continue to hold down their spending, that thriftiness

will limit additional sales-tax revenue. Massachusetts state Treasurer Timothy P. Cahill, a Democrat who is considering a run for governor next year, has been critical of discussions in the Legislature to raise the sales-tax rate.

"This is such a consumer-based recession that I think you'd be compounding the problem by increasing a tax on consumer spending," he said.

—Stu Woo, Justin Lahart and David Wessel contributed to this article.

Write to Amy Merrick at amy.merrick@wsj.com

Corrections & Amplifications

The Texas Legislature adjourned Monday after failing to pass a measure to keep some state agencies running after Sept. 1, 2010. This article incorrectly said the legislature failed to approve funding for the agencies.

Printed in The Wall Street Journal, page A2

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Mr. LINDER. And the third is the latest summary of the Federal budget situation by the Congressional Budget Office showing that the Federal deficit was $180 billion just in the month of May.

[The information follows:]

MONTHLY BUDGET REVIEW

Fiscal Year 2009

A Congressional Budget Office Analysis

Based on the *Monthly Treasury Statement* for April and the *Daily Treasury Statements* for May

June 4, 2009

The federal budget deficit was $984 billion for the first eight months of fiscal year 2009, CBO estimates, $664 billion more than the deficit recorded through May 2008. That estimate includes outlays for the Troubled Asset Relief Program (TARP) of about $130 billion to date for fiscal year 2009, recorded on a net-present-value basis (adjusted for market risk, as required by the Emergency Economic Stabilization Act, which created the TARP). Revenues have fallen by about 18 percent compared with the amounts collected in 2008; in contrast, outlays have grown by more than 18 percent.

APRIL RESULTS

The Treasury reported a deficit of $21 billion for April, about $2 billion higher than CBO's estimate on the basis of the *Daily Treasury Statements*.

ESTIMATES FOR MAY
(Billions of dollars)

	Actual FY2008	Preliminary FY2009	Estimated Change
Receipts	124	121	-3
Outlays	290	302	12
Deficit (-)	-166	-181	-15

Sources: Department of the Treasury, CBO.

CBO estimates that the Treasury will report a deficit of $181 billion for May, about $15 billion more than the deficit recorded in May 2008.

Receipts in May were about $3 billion (or 3 percent) lower than receipts in May 2008, CBO estimates. That decline would have been much greater but for the $32 billion in rebates paid to individual taxpayers in May 2008 in accordance with the Economic Stimulus Act of 2008 (Public Law 110-185). Withheld income and payroll taxes fell by $16 billion (or 11 percent), primarily because of recent legislation and the effects of the recession. CBO estimates that more than one-third of the decline in withholding resulted from provisions in the American Recovery and Reinvestment Act of 2009 (ARRA), notably the Making Work Pay credit. Nonwithheld income and payroll taxes declined by about $3 billion (or 38 percent). Refunds decreased by about $25 billion, but would have risen by about $7 billion if not for last year's rebates.

Net corporate receipts are usually not a significant source of revenue in May. However, they continued to show weakness in May 2009, with a decline of $8 billion from May 2008. Net corporate receipts were negative; refunds were larger than gross receipts. The quarterly payment due in June should provide more information about the strength of corporate receipts for the 2009 tax year.

Estimated outlays for the TARP totaled about $12 billion in May, measured on a net-present-value basis. Payments stemming from ARRA increased outlays for Social Security by $13 billion in May (for one-time payments to program recipients) and accounted for most of the $4 billion increase in Medicaid spending compared with that of last May. Outlays for unemployment benefits were $8 billion higher than in May 2008. Some of those increases were offset by lower spending by the Treasury Department, which paid $15 billion last May to individuals whose tax rebates under the Economic Stimulus Act of 2008 exceeded their federal income tax liability. Additionally, changes in the estimated costs of certain credit programs increased spending in May 2008 by almost $6 billion.

BUDGET TOTALS THROUGH MAY
(Billions of dollars)

	Actual FY2008	Preliminary FY2009	Estimated Change
Receipts	1,674	1,377	-297
Outlays	1,993	2,361	367
Deficit (-)	-319	-984	-664

Sources: Department of the Treasury, CBO.

CBO estimates that the Treasury will report a deficit of $984 billion for the first eight months of fiscal year 2009, compared with a shortfall of $319 billion for the same period last year.

Note: Unless otherwise indicated, the figures in this report include the Social Security trust funds and the Postal Service fund, which are off-budget. Numbers may not add up to totals because of rounding.

RECEIPTS THROUGH MAY
(Billions of dollars)

Major Source	Actual FY2008	Preliminary FY2009	Percentage Change
Individual Income	769	596	-22.6
Corporate Income	178	70	-60.6
Social Insurance	610	609	-0.2
Other	116	102	-12.0
Total	1,674	1,377	-17.7

Sources: Department of the Treasury; CBO.

Receipts in the first eight months of this fiscal year were about $1.4 trillion, almost $300 billion (or 18 percent) lower than in the same period last year. Corporate receipts fell by $108 billion (or 61 percent) during the period. Continued weakness in corporate profits, recently enacted legislation (most notably bonus depreciation), and the ability of firms to use current-year losses to reduce tax liabilities from previous years all contributed to lower corporate receipts.

Declines in individual income and payroll taxes of $175 billion account for almost 60 percent of the overall decrease. Nonwithheld receipts of individual income and payroll taxes, consisting mainly of quarterly estimated payments made in January and April and final payments for 2008 made during the February–May tax-filing season, fell by about $101 billion (or 28 percent) in the first eight months of the year. The decline probably stems in part from a substantial drop in nonwage income in 2008.

Withholding of income and payroll taxes fell by about $68 billion (or 6 percent), largely because of the ongoing effects of the recession on wages and salaries. A $4 billion (or 2 percent) increase in refunds of individual income taxes added to the net decrease in total receipts, as did a decline of $14 billion (or 12 percent) in other tax receipts.

Outlays through May have reached nearly $2.4 trillion, CBO estimates, $367 billion more than those in the first eight months of 2008. More than half of the increase results from the TARP ($130 billion) and from payments to Fannie Mae and Freddie Mac ($60 billion as reported on a cash basis by the Treasury Department). No outlays occurred for those purposes in 2008. Net interest on the public debt has decreased by 26 percent ($45 billion) compared with outlays at this time last year, primarily because of lower costs for inflation-indexed securities and a decline in short-term interest rates. Spending for the rest of the federal government increased by about $222 billion (or nearly 14 percent).

OUTLAYS THROUGH MAY
(Billions of dollars)

Major Category	Actual FY2008	Preliminary FY2009	Percentage Change: Actual	Percentage Change: Adjusted[a]
Defense—Military	394	419	6.3	7.5
Social Security Benefits	401	434	8.0	8.0
Medicare[b]	265	278	4.7	9.2
Medicaid	136	164	21.2	21.2
Other Activities	628	752	19.7	21.1
Subtotal	1,824	2,046	12.2	13.6
Net Interest on the Public Debt	169	125	-26.4	-26.4
TARP	0	130	n.a.	n.a.
Payments to GSEs	0	60	n.a.	n.a.
Total	1,993	2,361	18.4	19.8

Sources: Department of the Treasury; CBO.

Notes: TARP = Troubled Asset Relief Program
n.a. = not applicable
GSE = government-sponsored enterprise

a. Excludes the effects of payments that were shifted because of weekends or holidays.
b. Medicare outlays are net of proprietary receipts.

The fastest-growing categories of spending through May were Medicaid and a variety of "other activities." Medicaid spending is up by 21 percent (or $29 billion) through May. Around $19 billion of that increase stems from a provision in ARRA that increased the federal government's share of Medicaid payments. In addition, outlays for unemployment benefits are 140 percent ($41 billion) higher than they were at this time last year. Increased lending to credit unions, lower earnings credited to certain government funds, and increased payments for food and nutrition programs also contributed to growth in "other activities." The net growth in that category also reflects the $13 billion paid to Social Security recipients under ARRA in May 2009 as well as the $19 billion disbursed through May in 2008 to individuals whose tax rebates exceeded their federal income tax liability.

Social Security benefit payments unrelated to the stimulus legislation were up by 8 percent (or $32 billion), partly because of a large cost-of-living increase in January. Adjusting for shifts in the timing of certain payments, defense spending rose by 7 percent ($29 billion) and Medicare spending grew by 9 percent (or $23 billion).

Prepared by Barbara Edwards, Daniel Hoople, Joshua Shakin, and Camille Woodland.
This *Monthly Budget Review* and other CBO publications are available at www.cbo.gov.

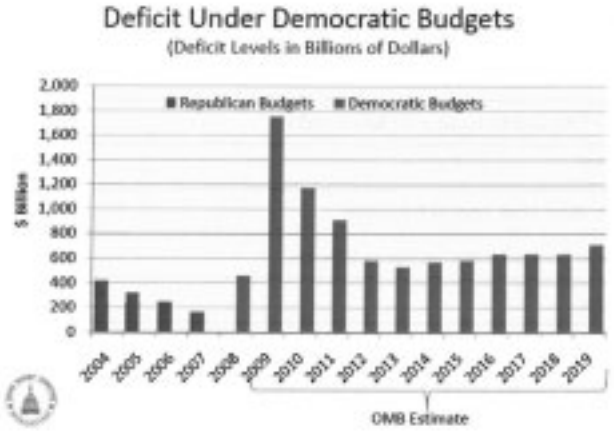
Mr. LINDER. Thank you, Mr. Chairman.
[The prepared statement of Mr. Linder follows:]

Opening Statement of Ranking Member John Linder (R-GA)
Ways and Means Subcommittee on Income Security and Family Support
Hearing on Proposals to Provide Federal Funding for Early Childhood Home Visitation Programs
June 9, 2009

(Remarks as Prepared)

Today's hearing offers a timely reminder of the difference between the fantasyland of Washington, D.C and the reality of the rest of America.

Here in fantasyland, we'll discuss adding one more multi-billion dollar entitlement program. This woul be on top of the new higher education entitlement program created this year, and of course our current health care and retirement entitlement programs, whose looming insolvency recently led President Obar to admit "we're broke."



But we're actually worse than broke. We're massively in debt, and it's getting deeper every day. USA Today reported last week that in 2008 the average U.S. household owed almost 550 thousand dollars in Federal debt. That's four times what the same average household owes in mortgage, car loans, credit card, and other debt combined. And that's before this year's trillion-dollar orgy of so-called stimulus spending.

-OVER-

Meanwhile, in the real world, the recession is forcing States to cut current spending. In California, the Governor proposes eliminating the welfare-to-work program and health insurance for nearly one million low-income kids. After their 2009 budgets passed, 42 States enacted emergency spending cuts, totaling 32 billion dollars.[1] These are not minor adjustments.

Yet the legislation we will discuss today breezily assumes States will find 3 billion dollars in new money over the next decade to finance their part of this new entitlement. Where will that money come from? Pixie dust?

I don't often agree with Robert Greenstein, the head of the liberal Center on Budget and Policy Priorities. But last week in the New York Times he said: "A budget tsunami is coming. That threat should be taken a hell of a lot more seriously than it is now." In the current budget crisis he "called for scrapping marginal programs to save the most essential."

Today we are ignoring that coming tsunami, and strolling along the beach contemplating another program.

Several of our witnesses will discuss how *some* home visitation programs have shown *some* positive effects. We know that from programs already operating, often with Federal and State program money. But obviously our colleagues think it's not enough, because it's never enough.

Currently Available Funding for Home Visitation ($Billions)	
Program	*Expected FY 2010*
Health (Medicaid, CHIP, and Maternal and Child Health)	$191
Cash Welfare (TANF)	$28
Healthy Start, Early Head Start, Special Education	$18
Child Welfare, Social Services, and Community Services	$4
Child Care and Other	$3
Total	**$244**

But if you added up all the Federal and State funds States *could* spend on home visitation, it's an incredible 244 billion dollars per year. Obviously States don't spend all that money this way – having other priorities, or now needing to cut other priorities. So we in Washington will create a new program that forces them to. Not a program that increases child abuse prevention funds that *may* be spent on home visitation, but a program whose funds *must* be spent on home visitation, and nothing else.

And if States won't spend this money, or can't come up with their required share, the Federal cash will be given to another State. So it's Washington's way or the highway. Except the children will be the ones who will really pay when the coming budget tsunami washes this and so many other programs away.

[1] See Table 1 in http://www.nasbo.org/Publications/PDFs/FSSpring2009.pdf

Mr. Chairman, all of us are interested in making sure every child gets a good start in life. I support reviewing current home visitation programs that fall under the Committee's jurisdiction, and how they can be improved. However, at this time of massive and growing Federal and State deficits, I simply cannot support the creation of a new entitlement that would send another 8.5 billion dollars in unpaid for Federal spending out the door.

To help illustrate the current economic situation, in closing I ask unanimous consent to insert three documents into the record at this point.

The first is an *Associated Press* article from last week that lists the massive spending cuts under consideration in California today to bring its budget into balance.
http://www.sfgate.com/cgi-bin/article.cgi?f=/n/a/2009/06/02/state/n165424D15.DTL&type=politics

The second is a *Wall Street Journal* article from last week titled "States' Budget Woes Are Poised to Worsen." http://online.wsj.com/article/SB124398568837379031.html

And the third is the latest summary of the Federal budget situation by the Congressional Budget Office, showing the Federal deficit was $181 billion – just in the month of May.
http://www.cbo.gov/ftpdocs/102xx/doc10259/06-2009-MBR.pdf

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Chairman MCDERMOTT. Without objection, those articles will be entered into the record. Thank you, John.

The first witness will be Joan Sharp, who is the executive director of the Council for Children & Families of Washington, my home

State, one of the few States that has actually an organization set up for the specific purpose of trying to prevent child abuse.

Ms. Sharp.

STATEMENT OF JOAN SHARP, EXECUTIVE DIRECTOR, COUNCIL FOR CHILDREN & FAMILIES, SEATTLE, WASHINGTON

Ms. SHARP. Thank you, Chairman McDermott, Ranking Member Linder, honorable Members of the Committee. My name is Joan Sharp. I am the Executive Director of the Council for Children & Families in Washington State. We are a small State agency, an office of the Governor.

We also serve as the Children's Trust Fund of Washington and the Washington Chapter of Prevent Child Abuse, America. Our mission is to prevent child abuse and neglect before it occurs. We strongly support this Committee's efforts to advance home visiting legislation.

I am here today to share with you our experience and expertise in funding, monitoring and supporting evidence-based home visitation programs. From our 27 years of leading child abuse and neglect prevention in Washington State, this is what we have come to know with great certainty: Child abuse and neglect are preventible.

To ensure a better future for Washington's children, we work to increase public understanding of child abuse in order to engage individuals, families, communities and systems in becoming part of the solution. In the last 5 years, we have increasingly focused on evidence-based home visiting as our preferred strategy to decrease child maltreatment.

In 2006, the Council for Children & Families proposed to the Washington State legislature a substantial expansion of evidence-based home-visiting programs. This request followed a period of significant preparation.

First, we had quantified the need. Our research suggested that 50 percent of families under 185 percent of poverty, of the Federal poverty level, with children birth-to-5, or a total of about 25,000 families annually in Washington, would be eligible for appropriate for and would voluntarily participate in the home visiting program.

We also convened a research advisory Committee of academicians, providers and other informed stakeholders to set the criteria that we would use to establish a reasonable yet rigorous evidentiary threshold. We are then able to identify a number of home visiting models that met these criteria.

In addition, we conducted statewide outreach. We wanted to ensure that communities understood evidence-based programs before they embarked on their own process to determine local interest, resource availability and which model might best meet community needs and conditions.

In 2007, the Washington State legislature appropriated $3.5 million over a 2-year period to fund evidence-based home visiting. We then implemented a request for proposal process, identified the strongest applicants serving high-need communities and initiated performance-based contracted to implement an array of evidence-based home-visiting programs serving diverse communities across the State.

We have since begun to see the very positive outcomes that these programs are developing with Washington's vulnerable children and families. We have also seen that if the strong benefit of these programs is to be widely felt, State and local resources alone will not get us to our goal.

The Council for Children & Families supports an array of evidence-based home visiting models. While we want for our children and families only the strongest programs, the truth is that with limited research dollars available, many promising home-visiting programs have not yet had the opportunity to conduct the gold standard research.

The multiple randomized control trials and longitudinal studies necessary to prove their effectiveness. And the fact is no one size fits all. Families need and want a variety of supports and services and communities need and want the strategies that fit best for them.

We also are very concerned about the implementation challenges that many organizations have in learning to deliver these evidence-based programs with fidelity to the model. This is an area that requires the technical assistance and training that the legislation allows for in the set-aside for those services. There are many implementation challenges in moving our field to these goals.

In conclusion, I would like to thank Chairman McDermott, Ranking Member Linder and the Committee Members for inviting us to speak with you today. We fully support your efforts to advance home visiting legislation and are happy to provide more information as needed to inform your deliberations around House Resolution 2667.

Thank you again.

[The prepared statement of Ms. Sharp follows:]

Statement of Joan Sharp, Executive Director, Council for Children and Families of Washington, Seattle, Washington

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Written Testimony of
Joan Sharp
Executive Director, Council for Children & Families

Before the
Subcommittee on Income Security and Family Support of the
Committee on Ways and Means
United States House of Representatives

June 9, 2009

Chairman McDermott, Ranking Member Linder, Honorable Members of the Committee:

My name is Joan Sharp and I am Executive Director of the Council for Children & Families in Washington State. We are a small state agency, an office of the Governor. Our mission is to prevent child abuse and neglect before it occurs.

We strongly support the committee's efforts to advance home visiting legislation and the interest in investing in evidence-based home visitation programs that reduce child abuse and neglect and prepare children for success in school and life. I am here today to share with you our expertise and experience in funding, monitoring and supporting evidence-based home visitation programs. Discussing home visiting in the context of health care reform make sense. Research has shown the negative health outcomes of child abuse and neglect and also the positive health outcomes that result from home visitation.

OVERVIEW OF THE COUNCIL FOR CHILDREN & FAMILIES

From our 27- year experience in leading prevention of child abuse and neglect in Washington, this is what we have come to know with great certainty:

- Child abuse and neglect *are* preventable.
- In Washington, we estimate that for every $1 spent on child abuse and neglect prevention in Washington, at least $300 is spent on after-the-fact services like foster care and treatment.
- Child abuse prevention strategies that emphasize both the developmental needs of children and the importance of community-based supports for families provide a clear example of how approaches such as home visiting can close the gap between science and practice for our most vulnerable young children.

This is the work we do to ensure a better future for Washington's children:

- We invest in research- and evidence-based community programs with high potential to deliver, measure and document desired outcomes.
- We fund innovative programs and support them with technical and outcome evaluation assistance to assist them in developing the evidence base for their model.
- We work to increase public understanding of child abuse and neglect in order to engage individuals, families, communities and systems in becoming part of the solution.
- We provide the knowledge and tools needed to advance more effective practice, programs and policies.
- We work across systems and through partnerships and collaborations to leverage resources and find new ways to meet needs and overcome barriers.
- We draw in private dollars to our Children's Trust Fund

We know that investing limited Washington State resources wisely now with an eye to the long term will strengthen families, promote optimal child development and reduce the huge public costs related to the consequences of child abuse and neglect.

HOME VISITING AS A STRATEGY

Home Visiting as a Preferred Strategy to Decrease Child Abuse and Neglect. Home visiting is a voluntary early childhood intervention that can enhance parenting and promote the optimal growth and development of young children. High quality home visiting programs implemented with fidelity have been shown not only to prevent child abuse and neglect but also to increase the odds that children from at-risk families will enter kindergarten socially, emotionally and physically ready to learn.

Evidence-based home visiting is used to achieve a multitude of outcomes. Some models focus on enhancing the health outcomes as measured by vaccination rates, weight gain, and use of preventative medical care. Other programs focus on preventing child abuse and neglect by increasing parenting skills, parent-child attachment, and knowledge of child development. Home visiting is also utilized to ensure school readiness as measured by acquisition of early literacy skills. What we have learned is that home visiting can be effective in achieving these and other outcomes depending on how the program is implemented and the population targeted.

Home Visiting in Washington State. As legislators and other funders develop increased interest in evidence-based programs and those that save taxpayers money through prevention of expensive remedial and "deep-end" services, home visiting programs have become a more visible and compelling part of the policy agenda..

In 2006, the Council for Children & Families requested $25 million in state funding to substantially expand evidence-based home visiting programs in Washington. Because of the multiple outcomes from home visiting, this effort was supported by prevention advocates and those seeking effective early learning approaches for at-risk infants and toddlers. The $25 million represented our estimate of what it would take to reach 25 percent of the at-risk families appropriate for these voluntary services. The Legislature appropriated $3.5 million for the 2007-2009 biennium.

From there, we developed a research advisory committee composed of academicians, providers and other informed stakeholders to formulate the criteria for determining which home visiting programs meet the evidentiary threshold. This committee identified a number of home visiting models that met these standards.

Statewide outreach to inform communities about evidence-based home visiting programs and answer their questions and concerns preceded our Request for Proposal (RFP) process. The RFP required documentation of need, evidence of the organization's capacity to undertake evidence-based home visiting and a 20% local funding match. Even within these substantial requirements, the RFP process turned up substantially more qualified applicants than we were able to fund within the available resources. Performance-based contracting for

a range of evidence-based home visitation programs began in the summer of 2007. We have since seen evidence of the very positive impact that these programs are having on Washington's vulnerable children and families.

Despite a tough economic climate and declining state revenues, the state legislature maintained 70% of home visitation funding for the 2009-2011 biennium. In State Fiscal Year 2009-10, we will be funding ten evidence-based home visiting programs across Washington State.

Scope of the problem. In Washington in 2004, 6,730 children were officially substantiated as being victims of abuse and neglect; the best estimate of the real number each year is over 13,000. From 2000 to 2004, 61 Washington children were officially documented as having died from abuse or neglect.

Current Context. For purposes of providing an adequate and simple estimate for the legislature, the Council for Children & Families and our partners in the Washington Home Visiting Coalition estimate that 50% of families under 185% of federal poverty level with children ages birth to five (a total of 25,000 families annually) would be eligible for and would be likely to voluntarily participate in an evidence-based home visiting program. This "rolled up" estimate takes into account the following demographic indicators:

- 176,979 children (or 38%) from birth through age 5 who are low-income.
- 48% of these children live in a single parent household.
- 49% of young children in urban and rural areas live in low-income families.

A CHILD ABUSE PREVENTION TOOL AND AN EARLY LEARNING STRATEGY

Research about what promotes school readiness overlaps the research on what works to prevent child abuse and neglect. For example:

- Enhanced knowledge about child development is BOTH a child abuse prevention strategy AND a school readiness/early learning strategy.
- Nurturing and attachment promote a child's social emotional development, which is a critical part of school readiness AND a core child abuse prevention strategy.

COST EFFECTIVENESS & PUBLIC INVESTMENT

The evidence shows that many home visiting programs are cost effective with varying returns on investment. The 2008 Washington State Institute for Public Policy Report, 'Evidence-Based Programs to Prevent Children from Entering and Remaining in the Child Welfare System: Benefits and Costs for Washington," suggests an opportunity for long term savings from investment in a variety of home visitation programs. As an example, this report concluded that the Nurse Family Partnership program has a $3.02 return on every dollar invested. Other cost benefit studies show similar returns on investment.

AN ARRAY OF QUALITY SERVICES

Based on our 27-year history of studying the research and measuring the impact of our child abuse and neglect prevention investments, the Council for Children & Families has come to believe that providing an array of research- and evidence-based services is the best way to meet the diverse needs of at-risk families and to provide support for parents who are seeking information and new skills. No one program or service type represents a "silver bullet." Families need and want a variety of supports and services; communities need and want strategies that fit best for them, and that they can sustain over time. And while we want for our families and children only the strongest programs, the truth is that with the limited research dollars available, many promising research-based home visiting models have not yet had the opportunity to conduct the 'gold standard' research – the

multiple randomized control trials and longitudinal studies – that absolutely prove their effectiveness. We value programs that have had access to this level of research. For these reasons, we fully support having a continuum of voluntary evidence-based home visitation services.

The evidence also points to the efficacy of a number of different paths to the goal of safe and healthy children well prepared for success in school and life. The focus regarding any and all of these programs should be on whether the program is being implemented with fidelity to the model, whether the program quality and outcomes are improving over time, and whether the program is meeting the needs and desires of the communities they are serving. At the Council for Children & Families, this is the focus of our capacity-building and evidence-based practice work.

EVIDENCE-BASED HOME VISITATION MODELS

These are some evidence-based home visiting programs that the Council for Children & Families has funded or has experience with that could be categorized as both a "child abuse prevention" and "early learning/child development" home visiting model.

Program	Program-Identified Outcomes	Clarification
Nurse Family Partnership	• Improved prenatal health • Fewer childhood injuries • Fewer subsequent pregnancies • Increased intervals between births • Increased maternal employment • Improved school readiness	Longitudinal research has shown that Nurse Family Partnership is effective at reducing the risk of abuse and neglect. It has also shown that NFP improves children's school readiness.
Parents As Teachers	• Increase parent knowledge of early childhood development and improve parenting practices • Provide early detection of developmental delays and health issues • Prevent child abuse and neglect • Increase children's school readiness	Parents as Teachers include both prevention of child abuse and neglect and parent awareness of early childhood development as outcomes. Prevention is a separate outcome, but research demonstrates that knowledge of child development reduces the risk for child abuse and neglect as well.
Parent-Child Home Program	• Early Literacy • Increased school readiness • Enhanced social-emotional development • Strengthen parent-child relationship	This program identifies enhanced social-emotional development as one of the outcomes. This is a known protective factor to prevent child abuse and neglect.
Parenting Partnership	• Improved Child Health and Development • Prevention of Child Maltreatment • Healthy Parent-Child Attachment	This is one example of an Intensive Home Visiting Program for At-Risk Parents. This program is focused on children who are medically fragile, but has both prevention of child abuse and improved child development listed as intended outcomes.

INFRASTRUCTURE AND CAPACITY BUILDING

The Council for Children & Families administers evidence-based home visiting funds directed to us by the Legislature. We monitor, evaluate and provide technical assistance to these funded programs. Most national offices also support and monitor the replication of their models to ensure fidelity.

One of the greatest challenges facing organizations providing evidence-based home visiting services is implementing that program with fidelity to the model. Fidelity in this sense means operating the home visiting program in the same manner it was proven effective. Implementing with fidelity yields effective practice and desired outcomes. Buying an evidence-based home visiting model "off the shelf" and implementing it in a local community does not necessarily guarantee the outcomes that evidence-based home visiting programs are capable of producing are achieved. Each local implementing organization has specific capacity needs that can negatively impact outcomes if not addressed. There is a tremendous need to allocate resources to analyze, reflect on and respond to data collected from these programs to inform continuous quality improvement.

A number of factors influence how a model is implemented:

- Eligibility / target population, (i.e. enrollment during pregnancy, income level, single parenthood, age of parent, etc.).
- Staff education / training level (i.e. nurse, social worker, paraprofessional, or volunteer).
- Curriculum or protocol and the level of adherence required.
- Outcome focus (child health, parenting skills, secure parent-child relationship, child development, individual goals, early literacy skills, etc.; in general programs impact multiple factors to some degree).
- Frequency, intensity and duration of services (how much, how often and for how long a program is implemented).

Other challenges that often must be overcome if an organization is to deliver the desired outcomes from its home visiting program include improving its capacity for best practices such as developing meaningful logic models, collecting basic demographic data, complying with contracted performance requirements, and improving its ability to accurately report outputs.

In recognition of these implementation and capacity building challenges, the Council for Children & Families focuses on both funding and providing technical assistance to programs with the goal of improving outcomes for children and families. We have teamed with the Washington State University Area Health Education Center to study the elements of effective implementation of evidence-based home visiting programs. This project will evaluate the impact of key program implementation variables on individual child and parental outcomes. We also seek from this research to learn the specific ways that we can increase the capacity of funded home visiting programs to collect model-specific outcome information.

PARTNERSHIPS AND THE HOME VISITING COALITION

The Washington State Home Visiting Coalition was formed in 2008 with three goals: build infrastructure, increase federal funding, and increase the state commitment to home visiting. The coalition is comprised of statewide agencies and organizations that have an interest in expanding and improving evidence-based home visitation services in Washington.

Steering Committee partners include:

- Business Partnership for Early Learning
- Children's Alliance
- Children's Home Society of Washington
- Council for Children & Families
- Fight Crime: Invest in Kids
- Nurse-Family Partnership
- Parent-Child Home Program
- Parents as Teachers/Parent Trust for Washington Children

- Thrive by Five
- United Way of King County
- United Ways of Washington
- Washington State Association of Head Start and Early Children Education Assistance Program

Supportive coalitions include:

- Child Welfare Advocacy Coalition
- Early Learning Action Alliance
- Post-Partum Depression Awareness Leadership Group Legislative Committee

The Washington Home Visiting Coalition has been critical to the preserving funding for evidence-based home visitation in Washington as well as to planning how to address the infrastructure needs of these programs. In addition to the Steering Committee partners, the Coalition includes stakeholders across the state: government entities, implementing agencies, supportive organizations, and parents interested in preventing child abuse and neglect and promoting optimal child development.

CONCLUSION

The Council for Children & Families and our partners in Washington State would like to thank Chairman McDermott, Ranking Member Linder and the United States House of Representatives Subcommittee on Income Security and Family Support of the Committee on Ways and Means for inviting us to speak with you today. We are delighted to have the opportunity to provide you with information on our experience funding, implementing, and monitoring evidence-based home visitation programs. CCF fully supports the committee's efforts to advance home visiting legislation and we are happy to provide more information as needed to inform deliberations around House Resolution 2667.

The increase of child abuse and neglect cases in Washington State and nationally is a sobering sign that our efforts to date are insufficient. We must give families the tools needed to parent effectively and to provide the environments that create the foundation for children's lifelong success. Now is time to make that commitment to ensuring that as many children as possible can stay healthy and happy in their homes.

Thank you again for this opportunity to testify. I welcome your questions.

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THE COUNCIL FOR CHILDREN & FAMILIES IS THE WASHINGTON STATE CHAPTER OF:

Prevent Child Abuse America

NATIONAL ALLIANCE of CHILDREN'S TRUST & PREVENTION FUNDS

preventchildabuse.org ctfalliance.org

Chairman MCDERMOTT. Thank you for your testimony.

I forgot to say at the start, your entire testimony will be entered into the record, and we ask you to limit your comments to 5 minutes. And you were 5 minutes and 6 seconds which is almost perfect.

So I am not putting anything on anybody that I wouldn't put on my home State. And I hope that you will all—will try to get to whatever else is in your testimony through the questioning period.

Dr. Daro, who is the research fellow at Chapin Hall at the University of Chicago. Welcome. I trained at the University of Illinois. So there is a little bit of rivalry, I suppose, although Chicago is a big city; they have two baseball teams.

STATEMENT OF DEBORAH DARO, PH.D., RESEARCH FELLOW, CHAPIN HALL AT THE UNIVERSITY OF CHICAGO, CHICAGO, ILLINOIS

Ms. DARO. You also grew up very close to where I live.

I want to thank you, Chairman McDermott and the Committee, for inviting me this morning to have this opportunity to discuss with you about what this important legislation.

The President's decision to invest in home visitation for newborns and the Congress' willingness to act on this decision demonstrates a commitment to an evidence-informed public policy, a commitment essential if we are to successfully confront complex problems such as child maltreatment. Although no legislation comes with absolute guarantees, the Early Support for Families Act builds on an impressive array of empirical evidence and creates an implementation culture that emphasizes quality and continuous program improvement.

In my time this morning I want to briefly summarize this evidence base, talk about the program elements associated with more positive outcomes, and underscore the importance of using this legislation not simply to deliver a product, but also to enhance learning.

With respect to the evidence, confidence in the efficacy of early, home-based interventions rests on a diverse and expanding number of high-quality program evaluations. This includes the seminal work of David Olds and his colleagues, showing initial and long-term benefits from early nurse home visitation when provided to first time moms early in their pregnancy, the expanding research including both randomized clinical trials and other strong research designs that support the efficacy and efficiency of several national home visitation models serving more diverse populations and the ongoing investment and experimentation at the State and local level across this country to create the infrastructure necessary to ensure such services are sustainable and integrated into existing health and early education systems.

The consistent message from this large and growing body of research is that the chances of success, regardless of the model, are improved when programs have certain features. It is improved when programs have:

Solid internal consistency that links specific program elements to specific outcomes;

Strong provider/participant relationships that extend for a significant period of time to accomplish meaningful change in a parent's knowledge levels, skills and an ability to establish a positive attachment with her infant;

Well-trained and competent staff;

High-quality supervision that includes observation of the home visitor interacting with the parent;

Solid organizational capacity among those community agencies delivering this service; and

Appropriate linkages to other community resources and supports.

As Congress moves forward toward developing this legislation, these parameters, rather than the utility of a given model or research design, should guide your thinking. Unless all of the interventions supported by this initiative are structured around these types of core practice principles, the odds of success, regardless of the model you use, are greatly diminished.

Second, defining the evidentiary base necessary for estimating the potential impacts of a given intervention is complex. As noted in a recent memo to OMB by the American Evaluation Association, "There are no simple answers to questions about how well programs work, and there is no single analytic approach or method that can decipher the complexities that are inherent within the program environment and assess the ultimate value of public programs." Given this reality, this legislation should direct States to consider a model's full research portfolio, not simply count the number of randomized clinical trials that have been done. Knowing a program can be implemented under ideal circumstances is not the same as knowing a program will achieve comparable effects when broadly implemented with a more challenged population and in communities that are more poorly resourced.

Fortunately, the research base on which this legislation draws is much wider and more nuanced than a handful of clinical trials. State planners should be directed to consider all facets of this database in identifying those evidence-based programs best suited to their service delivery context, their community challenges and their at-risk populations.

Finally, the act's emphasis on evaluation and data documentation is perhaps its most important feature. Home visitation, while promising, does not produce consistent impacts in all cases. Not all families are equally well served by the model. Retention in long-term interventions can be difficult. Identifying, training and retaining competent service providers is challenging, particularly when the strategy is made widely available to diverse populations.

Addressing these and similar questions requires that evidence-based interventions be implemented not only in light of what we know, but also in humble recognition of our obligation to do better. Improving our ability to identify, engage and effectively serve new parents facing the most challenging circumstances requires more than implementing a program. Doing better requires a research and policy agenda that recognizes the importance of linking learning and practice. Initiatives must be implemented and assessed in a manner that maximizes both the ability of researchers to determine the efforts efficacy and the ability of program managers to draw on these data to shape their practice and policy decisions.

The Early Support for Families Act encourages and rewards innovation by providing State planners important incentives to expand the pool of evidence-based programs in ways that will strengthen outcomes for family, improve service efficiencies and maximize social savings.

Thank you.

Chairman MCDERMOTT. Thank you very much for your testimony.

[The prepared statement of Ms. Daro follows:]

Statement of Deborah Daro, Ph.D., Research Fellow, Chapin Hall Center for Children at the University of Chicago, Chicago, Illinois

Early intervention efforts to promote healthy child development have long been a central feature of social service and public health reforms. Today, prenatal care, well-baby visits, and assessments to detect possible developmental delays are commonplace in most communities. The concept that learning begins at birth, not when a child enrolls in kindergarten, has permeated efforts to improve school readiness and academic achievement (Kauffman Foundation, 2002). Recently, child abuse prevention advocates have applied a developmental perspective to the structure of prevention systems, placing particular emphasis on efforts to support parents at the time a woman becomes pregnant or when she gives birth (Daro & Cohn-Donnelly, 2002).

Although a plethora of options exist for providing assistance to parents around the time their child is born, home visitation is the flagship program through which many states and local communities are reaching out to new parents. Based on data from the large, national home visitation models (e.g., Parents as Teachers, Healthy Families America, Early Head Start, Parent Child Home Program, HIPPY, and the Nurse Family Partnership), it is estimated that somewhere between 400,000 and 500,000 young children and their families receive home visitation services each year (Gomby, 2005). Although the majority of these programs target newborns, it is not uncommon for families to begin receiving home visitation services during pregnancy, to remain enrolled until their child is 3 to 5 years of age, or to begin home visits when their child is a toddler. Given that there are about 23 million children aged 0–5 in the U.S. (and about 4 million births every year), the proportion of children with access to these services is modest but growing.

This expansion of home visitation services has been fueled by extensive work on the part of several national models to both strengthen their research base and improve their capacity to provide ongoing technical assistance and monitoring to local agencies adopting their approach. Equally important has been the work in over 40 states that have invested not only in home visitation but also in the infrastructure necessary to insure services are implemented with high quality and integrated into a broader system of early intervention and support (Johnson, 2009). Until now, this expansion has been largely supported through innovative state funding mechanisms and private investment.

The Early Support for Families Act dramatically increases federal investment in home-based services. The President's decision to invest in home visitation for newborns and the Congress's willingness to act on his decision demonstrate a new and important commitment to prevention and to the type of evidence-informed public policy essential for maximizing impacts on important child and family outcomes. Although no legislation comes with absolute guarantees, the Early Support for Families Act builds on an impressive array of knowledge regarding the efficacy of home visitation programs and creates an implementation culture that emphasizes quality and continuous program improvement. Among the bill's most important features are the following: mandatory funding to the states to strengthen the strategy's sustainability; channeling these dollars to programs demonstrating strong evidence of effectiveness; requiring states to identify how these programs will complement and draw upon existing community efforts; and requiring the collection and use of information to enhance practice and policy.

In my time this morning I want to summarize the evidence supporting the expansion of home visitation programs for newborns, identify those program elements associated with more positive outcomes, and underscore the importance of using this legislation not simply to deliver a service but also to enhance learning.

The Broader context of Early Learning

The rapid expansion of home visitation over the past 20 years has been fueled by a broad body of research that highlights the first 3 years of life as an important intervention period for influencing a child's trajectory and the nature of the parent-child relationship (Shonkoff & Phillips, 2000). A child who can avoid trauma and experience consistent and nurturing caregiving in their early years has a better chance of successfully transitioning to adulthood (i.e., will more likely be physically and emotionally healthy, well educated, employable, and engaged in positive social

exchange and civic life) than one whose early years are filled with violence and turmoil.

In addition, longitudinal studies on early intervention efforts implemented in the 1960s and 1970s found marked improvements in educational outcomes and adult earnings among children exposed to high-quality early intervention programs (Campbell, et al., 2002; McCormick, et al., 2006; Reynolds, et al., 2001; Schweinhar, 2004; Seitz, et al., 1985). These data also confirm what child abuse prevention advocates had long believed—getting parents off to a good start in their relationship with their infant is important for both the infant's development and for their relationship with parents and caretakers (Cohn, 1983; Elmer, 1977; Kempe, 1976).

The key policy messages from this body of research are that learning begins at birth, and that to maximize a child's developmental potential requires comprehensive methods to reach newborns and their parents. Individuals may debate how best to reach young children; few dispute the fact that such outreach is essential for insuring children will have safer, healthier, and more productive lives. Over time, these individual benefits translate into substantial societal savings on health care, education, and welfare expenditures (Heckman, 2000).

Why Home Visitation?

A central feature of this emerging developmental approach to addressing child abuse and other negative outcomes for children is an increased focus on expanding the availability of home visitation services to newborns and their parents. Drawing on the experiences of western democracies with a long history of providing universal home visitation systems and emerging evidence of the model's utility in the United States, the U.S. Advisory Board on Child Abuse and Neglect concluded that "no other single intervention has the promise of home visitation" (U.S. Advisory Board, 1991: 145). The seminal work of David Olds and his colleagues showing initial and long-term benefits from regular nurse visiting during pregnancy and a child's first 2 years of life provided the most robust evidence for this intervention (Olds, Sadler & Kitzman, 2007).

Equally important, however, were the growing number of home visitation models being developed and successfully implemented within the public and community-based service sectors. Although initially less rigorous in their evaluation methodologies, these models demonstrated significant gains in parent-child attachment, access to preventive medical care, parental capacity and functioning, and early identification of developmental delays (Daro, 2000). This pattern of findings, coupled with Hawaii's success in establishing the first statewide home visitation system, provided a compelling empirical and political base for the initial promotion of more extensive and coordinated home visitation services.

The Evidence of Success

Over the past 15 years, numerous researchers have examined the effects of home visitation programs on parent-child relationships, maternal functioning, and child development. These evaluations also have addressed such important issues as costs, program intensity, staff requirements, training and supervision, and the variation in design necessary to meet the differential needs of the nation's very diverse new-parent population.

Attempts to summarize this research have drawn different conclusions. In some cases, the authors conclude that the strategy, when well implemented, does produce significant and meaningful reduction in child-abuse risk and improves child and family functioning (AAP Council on Child and Adolescent Health, 1998; Coalition for Evidence-Based Policy, 2009; Geeraert, et al., 2004; Guterman, 2001; Hahn, et al., 2003). Other reviews disagree Chaffin, 2004; Gomby, 2005). In some instances, these disparate conclusions reflect different expectations regarding what constitutes "meaningful" change; in other cases, the difference stems from the fact the reviews include different studies or place greater emphasis on certain methodological approaches.

It should not be surprising to find more promising outcomes over time. The database used to assess program effects is continually expanding, with a greater proportion of these evaluations capturing post-termination assessments of models that are better specified and better implemented. In their examination of 60 home visiting programs, Sweet and Appelbaum (2004) documented a significant reduction in potential abuse and neglect as measured by emergency room visits and treated injuries, ingestions or accidents (ES = .239, $p < .001$). The effect of home visitation on reported or suspected maltreatment was moderate but insignificant (ES = .318, ns), though failure to find significance may be due to the limited number of effects sizes available for analysis of this outcome ($k = 7$).

Geeraert, et al. (2004) focused their meta-analysis on 43 programs with an explicit focus on preventing child abuse and neglect for families with children under 3 years of age. Though programs varied in structure and content, 88 percent (n = 38) utilized home visitation as a component of the intervention. This meta-analysis, which included 18 post-2000 evaluations not included in the Sweet and Appelbaum (2004) summary, notes a significant, positive overall treatment effect on reports of abuse and neglect, and on injury data (ES = .26, $p < .001$), somewhat larger than the effect sizes documented by Sweet and Appelbaum.

Stronger impacts over time also are noted in the effects of home visitation on other aspects of child and family functioning. Sweet and Appelbaum (2004) note that home visitation produced significant but relatively small effects on the mother's behavior, attitudes, and educational attainment (ES ≤ .18). In contrast, Geeraert et al. (2004) find stronger effects on indicators of child and parent functioning, ranging from .23 to .38.

Similar patterns are emerging from recent evaluations conducted on the types of home visitation models frequently included within state service systems for children aged 0 to 5. Such evaluations are not only more plentiful, but also are increasingly sophisticated, utilizing larger samples, more rigorous designs, and stronger measures. Although positive outcomes continue to be far from universal, families enrolled in these home visitation programs, as compared to participants in a formal control group or relevant comparison population report fewer acts of abuse or neglect toward their children over time (Fergusson, et al., 2005; LeCroy & Milligan, 2005; DuMont et al., 2008; Old, et. al., 1995; William, Stern & Associates, 2005); engage in parenting practices that support a child's positive development (Love, et al., 2009; Zigler, et al., 2008); and make life choices that create more stable and nurturing environments for their children (Anisfeld, et al., 2004; LeCroy & Milligan, 2005; Wagner, et al., 2001). Home visitation participants also report more positive and satisfying interactions with their infants (Klagholz, 2005) and more positive health outcomes for themselves and their infants (Fergusson, et al., 2005; Kitzman, et al., 1997). One home visitation model that initiates services during pregnancy has found that by age 15 the children who received these visits as infants reported significantly fewer negative events (e.g., running away, juvenile offenses and substance abuse) (Olds, et al., 1998).

Home visits begun later in a child's development also have produced positive outcomes. Toddlers who have participated in home visitation programs specifically designed to prepare them for school are entering kindergarten demonstrating at least three factors correlated with later academic success—social competency, parental involvement, and early literacy skills (Levenstein, et al., 2002; Allen & Sethi, 2003; Pfannenstiel, et al., 2002). Longitudinal studies of home visitation services that begin at this developmental stage have found positive effects on school performance and behaviors through sixth grade (Bradley & Gilkey, 2002) as well as lower high school dropout and higher graduation rates (Levenstein, et al., 1998).

A prime consideration for the unique emphasis on nurse home visitation within the President's proposal is the long-term cost savings found in Nurse Family Partnership's (NFP) initial trials. These savings were primarily realized through a reduction in the subsequent use of Medicaid and other entitlement programs as a result of women receiving the intervention entering and remaining in the workforce. Although comparable data have not been collected on the other home visitation models, the range of outcomes achieved by many of them suggests similar savings could accrue from them as well. Additional areas for potential savings include stronger birth outcomes among families enrolled prenatally in a sample of Health Families New York programs (Mitchel-Herzfeld, et al., 2005), higher monthly household earnings among those who access Early Head Start services (Love, et al., 2009), and better school readiness and a reduced need for special education classes among children enrolled in PAT or Parent Child Home Program (Ziegler et al., 2008; Levenstein, et al., 2002).

In short, confidence in the efficacy of early home-based interventions with newborns and their parents rests with numerous randomized control trials, quasi-experimental evaluations with strong counterfactuals, and detailed implementation studies that have demonstrated both the efficacy and efficiency of this approach. Perhaps the most compelling use of these data is not to simply highlight a given model's efficacy but rather to underscore the importance of high-quality implementation and service integration. The full volume of research data across various models clearly shows that the chances of success are improved when any program embraces certain features such as:

- Solid internal consistency that links specific program elements to specific outcomes

- Forming an established relationship with a family that extends for a sufficient period of time to accomplish meaningful change in a parent's knowledge levels, skills, and ability to form a strong positive attachment to the infant
- Well-trained and competent staff
- High-quality supervision that includes observation of the provider and participant
- Solid organizational capacity
- Linkages to other community resources and supports

As Congress moves toward developing legislation to act on the President's promise to provide early intervention services to those children facing the most significant obstacles, these parameters—rather than the utility of a given model or given workforce structure—should guide policy development. Unless all of the interventions supported by this initiative are structured around core practice principles, the odds of success, regardless of the model implemented, are greatly diminished.

Defining Standards for Evidence-Based

Defining the evidentiary base necessary for estimating the potential impacts of a given intervention is complex. In general, two lines of inquiry guide the development of program evaluations: Does the program make a measurable difference with participants (efficacy)? And, does a given strategy represent the best course of action within a given context (effectiveness)? Randomized control trials are often viewed as the best and most reliable method for determining if the changes observed in program participants over time are due primarily to the intervention rather than to other factors. Maximizing the utility of program evaluation efforts, however, requires more than just randomized clinical trials. As noted by the American Evaluation Association in a February, 2009 memo to OMB Director Peter Orszag:

There are no simple answers to questions about how well programs work, and there is no single analytic approach or method that can decipher the complexities that are inherent within the program environment and assess the ultimate value of public programs. (AEA Evaluation Policy Task Force, 2009).

Well-designed effectiveness evaluations are needed to improve the quality of home visitation programs and their successful replication. However, knowing that a program is capable of achieving effects under ideal conditions is not the same as knowing it will achieve effects when broadly implemented with more challenged populations or in more poorly resourced communities. In the real world, the success of a home visitation program will depend on how local parents from all points on the risk continuum view early intervention services, on what service and provider characteristics will attract new parents into these programs, and on the relation between these efforts and other elements within a community's existing service continuum.

In many respects, the core features of a well-done randomized trial—a highly specified intervention, consistent implementation, and a specific target population—limit the ability to generalize its findings to diverse populations and diverse contexts. In determining which programs constitute the highest level of evidence, states should examine a model's full research portfolio. Although randomized clinical trials are excellent for assessing impacts, they offer little guidance in terms of how to integrate such efforts into existing healthcare and educational systems, the vehicles through which a truly comprehensive national effort to support new parents needs to be based. The knowledge and assurances needed to build this type of integrated system for at-risk children and their parents will be found in the evidence being generated by diverse analytic and research methods such as those that have been and are being incorporated by a number of home visitation efforts throughout the country.

Assuring Continuous Program Improvement

The emphasis it places on evaluation and program monitoring is an important feature of the Early Support for Families Act. Under this legislation, states will be required to provide annual reports outlining, among other things, the specific services provided under the grant; the characteristics of each funded program, including descriptions of its home visitors and participants; the degree to which services have been delivered as designed; and the extent to which the identified outcomes have been achieved. This type of systematic data collection and monitoring is particularly critical as home visitation programs become more widely available. Home visitation, while promising, does not produce consistent impacts in all cases. Not all families are equally well served by the model; retention in long-term interventions can be difficult; identifying, training, and retaining competent service providers is challenging, particularly when the strategy is designed to be offered widely and integrated into existing early intervention systems. Finally, although home visitation

programs are substantial in both dosage and duration, even intensive interventions cannot fully address the needs of the most challenged populations—those struggling with serious mental illness, domestic violence, and substance abuse as well as those rearing children in violence and chaotic neighborhoods. Addressing these and similar questions requires that evidence-based interventions be implemented in light of what we know along with a determination to do better.

Identifying the appropriate investments in home visitation programs will require a research and policy agenda that recognizes the importance of linking learning and practice. It is not enough for scholars and program evaluators, on the one hand, to learn how maltreatment develops and what interventions are effective and for practitioners, on the other, to implement innovative interventions in their work with families. Instead, initiatives must be implemented and assessed in a manner that maximizes both the ability of researchers to determine the effort's efficacy and the ability of program managers and policymakers to draw on these data to shape their practice and policy decisions. Most of the major national home visitation models recognize this objective and have engaged in a series of self-evaluation efforts designed to better articulate those factors associated with stronger impacts and to better monitor their replication efforts. For example, the Nurse Family Partnership maintains rigorous standards with respect to program site selection. Data collected by nurse home visitors at local sites is reported through the NFP's web-based Clinical Information System (CIS), and the NFP national office manages the CIS and provides technical support for data entry and report delivery. Since 1997, Healthy Families America's (HFA) credentialing system has monitored program adherence to a set of research-based critical elements covering various service delivery aspects, program content, and staffing. And, after 3 years of extensive pilot testing and review, Parents as Teachers (PAT) released its Standards and Self-Assessment Guide in 2004.

In fulfilling their reporting obligations under the Early Support and Education Act, state planners should be encouraged to draw on these systems in developing a coordinated database that will allow them to look across the models they are implementing. This integrated data system can be used to determine the constellation of models and collaborative efforts needed to better identify, engage, and effectively serve the communities and families in facing their greatest challenges.

Achieving Broader Outcomes

Home visitation is not the singular solution for preventing child abuse, improving a child's developmental trajectory, or establishing a strong and nurturing parent-child relationship. However, the empirical evidence generated so far does support the efficacy of the model and its growing capacity to achieve its stated objectives with an increasing proportion of new parents. Maintaining this upward trend will require continued vigilance to the issues of quality, including staff training, supervision, and content development. It also requires that home visitation be augmented by other interventions that provide deeper, more focused support for young children and foster the type of contextual change necessary to provide parents adequate support. These additions are particularly important in assisting families facing the significant challenges as a result of extreme poverty, domestic violence, substance abuse, or mental health concerns.

All journeys begin with a single step. The Early Support for Families Act provides states an important vehicle for identifying the best way to introduce home visitation into its existing system of early intervention services. Chapin Hall's review of this process suggests states are already responding to this challenge by requiring that any model being replicated reflect best practice standards, embrace the empirical process, and be sustainable over time through strong public-private partnerships (Wasserman, 2006). The ultimate success of this legislation will hinge on the willingness of state leaders to continue to support data collection and careful planning and on the willingness of program advocates to carefully monitor their implementation process and to modify their efforts in light of emerging findings with respect to impacts.

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Chairman MCDERMOTT. Our next witness is Dr. Brooks-Gunn, who is a graduate of Connecticut and Harvard and the University of Pennsylvania. She has written four books.

And, Dr. Gunn, we appreciate your testimony.

STATEMENT OF JEANNE BROOKS, PH.D., PROFESSOR OF CHILD DEVELOPMENT AT TEACHERS COLLEGE AND THE COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY, NEW YORK, NEW YORK

Ms. BROOKS-GUNN. Thank you very much. It is a pleasure to be here addressing the Members of this Committee. Thank you, Chairman McDermott and Ranking Member Linder.

I am a developmental psychologist by training. I have been spending 30 years following families over time to see what circumstances help them do better and what circumstances impede success for both parents and children. I have also been involved in the evaluation and design of three different programs that are relevant to this hearing today: the Infant Child and Development Program, the Early Head Start National Evaluation and the Home Instruction For Parents of Preschool Youngsters, affectionately known as HIPPY.

For understanding the review of literature, what we know about how home visiting works, I would suggest that all of you turn to The Future of Children. This is a particular set of volumes that has been looking at what programs are effective for children and families. The Future of Children has an issue on home visiting in 1993, 1999, 2005 and 2009. I was involved in coauthoring the articles in 2005 and 2009. But it gives you a really great history over time of what we found.

What I want to do today is talk about the different strategies that we have for enhancing young families' lives. I am particularly interested in young, first-time mothers. They are the most vulnerable, as are their children, for later problems in life. I would like you to consider also several different kinds of outcomes that programs can have.

What we are concerned about for what I will just call first-time young mothers and their education success. Clearly, we have to be worried about if we can enhance their education, if we want long-term impact on them or on their children.

The second is their parenting capabilities and capacities, and home-visiting programs do address this. Part of this is child abuse and neglect, but there are other aspects of parenting capabilities that we are interested in.

And, of course, the third is children's school readiness.

So how do these strategies that we all have been looking at over the years stack up in terms of the outcomes that we think are important? First, home-visiting programs that offer—are in conjunction with center-based care do seem to have the ability to increase these young mother's education. That is very important. Programs that are just home-visiting programs alone, in general, do not increase parents' education; the nurse home visiting program is an exception to this.

Almost all the programs that you will hear about do seem to influence parenting capabilities and capacities. This is very important when you look at the range of programs that exist. These programs—these effects are modest, but they are consistent across programs.

Very few programs actually reduce the incidence of child abuse and neglect, and there are a variety of reasons for that that we can talk about later.

In terms of school readiness for the children, when we are focusing on the children, some, but not all, home-visiting programs have shown that they can change the school readiness of children. Home-visiting programs often also target child and health safety and seem to do a good job of targeting this.

Some programs are able to change maternal mental health, although that is very, very difficult to change in general. So I also focus on the effectiveness factors in programs to try to get the outcomes that we want, the effectiveness factors that I think are important from my review of the literature. Specific curriculum, very intensive services, home-visiting programs that provide services less than weekly in general are not likely to be effective. There are a couple of exceptions to that. But, in general, if it is not intensive, it is probably not going to have an effect.

We need well-trained staff. This includes ongoing evaluation during the home visits themselves. This is typically not done. We need well-educated staff. My read of the literature is, the programs using paraprofessionals are, in general, not likely to be effective when we compare these to programs that use professionals and more educated staff.

And the services provided is very important. Even in programs that are designed to be intensive, we have to make sure that people receive the expected number of home visits.

So, in summary, we can make differences.

What kinds of programs should we be putting in place? There are some home-visiting programs that look like they will do what we want them to do. I also would urge the Committee to allow States to do some sort of demonstrations to see what happens when you combine home visiting with programs that offer these young moth-

ers educational supports so that we can get the mothers to increase their education. Since this is a poorly educated group, these first-time, young mothers.

States could also try combination programs, if possible, that combine the best of home visiting with child care. Otherwise, if we don't try both to keep the effectiveness factors in place, we will not be able to impact the families that are being served.

Thank you.

Chairman MCDERMOTT. Thank you very much for your testimony.

[The prepared statement of Ms. Brooks-Gunn follows:]

Statement of Jeanne Brooks-Gunn, Ph.D., Professor of Child Development at Teachers College and the College of Physicians and Surgeons, Columbia University, New York, New York

It is a pleasure to be here today, addressing the members of the House Ways and Means Subcommittee on Income Security and Family Support. I will be considering the evidence for the effectiveness of programs for young, first-time mothers, both in terms of their impacts on the mothers themselves and their infants, toddlers and preschoolers. A developmental psychologist, I have spent the last 30 years examining the life courses of families, both parents and their children, with a special focus on what might be termed vulnerable families. These would include families whose parents are young, are poor, are unmarried, and/or have low educational levels. I am interested in identifying what conditions are likely to enhance the success of parents who are rearing their children under the often difficult circumstances. I have also designed and evaluated a set of programs which aim to enhance the well-being of parents and children. These include the Infant Health and Development Program, the Early Head Start National Evaluation, and the Home Instruction for Parents of Preschool Youngsters (HIPPY).

References and documentation of the comments made in this testimony may be found in articles in The Future of Children (www.futureofchildren.org) from Issue 15 (2005, on Racial and Ethnic Gaps in School Readiness, edited by C. Rouse, S. McLanahan and J. Brooks-Gunn), Issue 9 (1999, on Effectiveness of Home Visiting, edited by D. S. Gomby), and Issue 19 (2009, article by K. S. Howard and J. Brooks-Gunn on The Role of Home-Visiting Programs in Preventing Abuse and Neglect). A list of publications by Brooks-Gunn is available at www.policyforchildren.org.

The Problem

The families being considered today are those with young, first-time mothers. Each year, almost one-half of a million children are born into these families. Young, first-time mothers, as a group, have relatively low levels of education, which limits their access to stable, well paid employment. These mothers, often living in precarious economic circumstances, are also more likely to exhibit harsh parenting, inconsistent parenting, and insensitive parenting, all of which are associated with lower cognitive and emotional capacities of their children than mothers who are older and have more education. The children of young mothers are also more likely to experience child abuse or neglect than those born to older, more educated parents. In brief, young, first-time mothers are likely to have low levels of education and more financial hardship as well as to exhibit less optimal parenting. Their children, in turn, are less likely to develop the capacities necessary for success in school and in later life. All three outcomes (maternal education, parenting behavior, and child capabilities) have been, and should be, targets of intervention.

Enhancing the Lives of Young Mothers and Their Children

Is it possible to help young mothers improve their educational status and/or their parenting capabilities? The answer, from both longitudinal studies and intervention programs, is yes.

Is it possible to improve directly the educational success of their children (most often measured by how well prepared their children are for entry into school)? The answer is yes. Well-developed early childhood education programs do so.

Is it possible to enhance school readiness of young children by improving maternal education and/or parenting capabilities of young mothers? The answer is yes. It is most likely that such enhancements will occur if both the young mothers and the children are both provided intervention services.

Strategies for Enhancing Young Family's Lives

Several different types of programs have been developed for improving young mothers' education and parenting capabilities as well as their children's school readiness. Each has demonstrated effectiveness, although not every program has been effective.

Maternal education programs provide supports and incentives for the continued education of young mothers. Welfare demonstration programs focusing on maternal education report small to modest impacts on education, as have some home visiting programs and some programs offering home-visiting services to the parents and center-based educational services to the children.

A variety of programs, usually home-based, demonstrate modest consistent effects on parenting capabilities (reductions in harsh parenting and increases in sensitive parenting). Many but not all programs provide such evidence.

Some programs also have, as their aim, preventing child abuse and neglect. Of those programs that look at child abuse and neglect directly (i.e., substantiated cases), only a few have reduced child abuse and neglect. However, given the incidence of child abuse and neglect, program evaluations often do not have the power to detect such differences (while they do have the power to detect differences in parenting capabilities).

Home-visiting programs often target child health and safety, child cognitive development, and maternal mental health. Child health and safety have been enhanced by several programs. Fewer home-visiting programs have altered child cognitive development (unless they are coupled with center-based child care; but see, for exceptions, the Nurse Family Partnership in Denver and Memphis and Early Head Start and one Healthy Families evaluation).

Effectiveness Factors

Effective programs for families with young children (indeed, for programs generally) have the following characteristics——

Specific curricula with clearly defined goals and educational methods to achieve such goals

Intensive services (home-visiting programs that provide services less than weekly in general are not effective; although see Early Start as an exception)

Well-trained staff (training prior to implementation as well as on-going training including evaluation during home visits themselves)

Well-educated staff (programs using paraprofessionals are less likely to be effective than those using professionals and more educated staff)

Services provided (some programs are designed to be intensive, even though most families do not receive the expected number of home visits; programs in which the delivered dose is low are likely not to be effective)

Best Bets for Investments

Based on the current literature, young first-time mothers seem to benefit most from home-visiting programs. Thus, targeting this group is a good bet.

Also, home-visiting programs (if well-developed) are most likely to alter parenting practices than child abuse and neglect. Several of the programs also have the potential to enhance school readiness.

It is likely that two-generation programs, that combine home-visiting programs with child care, will be necessary to alter maternal education. Programs might also need to provide other specific educational supports (help in the navigation of post-secondary education institutions in a specific community, tuition assistance or conditional tuition assistance).

It would be ideal if states were allowed to mount demonstration programs that combine educational and parenting supports to see if combinations of services provide greater impacts on parents and children than just parenting support alone. The same might be true if parenting capabilities were enhanced via home-visiting and, at the same time, child care assistance were provided.

In general, any programs that are implemented must be able to document and continue documenting, fidelity to the effectiveness factors outlined above. Otherwise, the investments are unlikely to impact the families which are being served.

National Center for Children and Families (www.policyforchildren.org)

Chairman MCDERMOTT. Our next witness is Cheryl D'Aprix, who brings a combination of having been a recipient of some visitation as well as now being a home visitor herself.

Ms. D'Aprix.

STATEMENT OF CHERYL D'APRIX, SENIOR FAMILY SUPPORT WORKER, STARTING TOGETHER PROGRAM, CANASTOTA, NEW YORK

Ms. D'APRIX. Thank you and good morning, Mr. Chairman and distinguished Members of the Committee. My name is Cheryl D'Aprix and I am a family support worker in the Healthy Families America program serving Madison County in New York. It is an honor and a privilege to be here today to share my experience, first as a participant in Healthy Families America and now as a home visitor for the program.

In 1993, my husband, Jeff, my 3-year-old daughter, and I were presented with a new challenge. I received the news that we would be expecting another baby and could welcome him in about 7½ months. I gently broke the news to my husband and together we sat in silence, each struggling with our own fears and thoughts.

Jeff had his mind on the already-insufficient funds and how we were going to replace all the baby furniture we had just given away because we were convinced that we were already blessed and would not have any more children. I was busy thinking about having to go through postpartum depression with another baby.

I had suffered with PPD for more than a year after the birth of my daughter. I had no clue what was happening to me, but I made it through that year with the patience of my husband and kind words from my family. I was petrified of going through it again and the possibility of it worsening. I had heard the horror stories in the news, and I prayed that I could remain well enough to take care of our children and hold things together at home.

Visiting with a friend, I expressed some of my concerns, and she recommended I check into a home visiting program that was available in our county through the Community Action agency. The program is called Starting Together, which is part of Healthy Families America, New York. The program partners with families who have children, prenatal to 3 to 5 years of age.

During my pregnancy, she would meet with me weekly, and Jeff would join us whenever he got the chance. She listened to me and she shared information with me. She gave us the support I needed to not only feel like a competent parent to the child I already had, but she helped me gain the confidence I needed to talk with my doctor about the postpartum depression. I was afraid that whichever doctor happened to be on call that day would either just dismiss my concern or tell me it is normal to have the baby blues after a baby comes.

Through the information she brought me, I knew it was much more than the baby blues; and I was able to get the help I needed with medication and strong shoulders, and I was on my way to a healthier life and a more secure attachment with my son.

Once Damian was born, our home visitor brought us curriculum on the stages of development, books and videos on basic care and information on community resources that helped our family stay afloat. She left information on fatherhood for Jeff so he could feel more confident and strong in the vital role that he played in our lives. Throughout the course of 3 years, we spent time together

doing activities with the kids, setting attainable goals for my family and spending countless hours just talking. We talked about everyday stresses, and at that point there were plenty of those.

We also spent time about talking my life and what it was like growing up. She gave me the opportunity to tell my story, and I came to see that I too was worth listening to. She laughed with me on the good days and she let me cry on the bad days that were so overwhelming that I could barely get one foot on the floor. But I put that foot on the floor because I knew she was coming to visit. It meant so much to me that she understood the importance of nurturing the parent as well as the child.

When Damian turned 3, my family graduated out of the program. Jeff was working two jobs, I was now working full time and our daughter was honing the skill of bossing her baby brother around. The job I was doing was unfulfilling, but it helped pay the bills.

On our last home visit, our support worker encouraged me to apply for an open position at the program as a home visitor. After all she had taught me and all the ways our family had benefited from the program, I was excited about applying for the job. I was anxious to start lending a helping hand and a supportive ear to other parents. One of the greatest gifts she gave me was the belief in myself, and I was lucky enough to have the program see my strengths, as well, and I was offered the position.

My home visiting career started out with many, many months of training and researching community resources so that I could be equipped to meet the diverse needs of each family. The very heart of Healthy Families America is promoting healthy parent-child interaction and child development. While on the floor doing activities together, we also discussed life challenges such as housing, employment, accessing medical care or transportation.

Offering referrals and brainstorming ways to remove the barriers that families feel interfere with their success is the key part of our visits. One recent example is, I visited a young, single mother with relationship challenges and insufficient income. I referred her to a child care center which she enrolled her child in, enabling her to go to work. Once she had a stable income, we were able to connect her to a first-time home buyers program, which provided her with a financial education to make sure homeownership was appropriate for her.

I am happy to report that she is still successfully employed and does own her own home. Outcomes can be amazing when supports are identified and goals are attainable.

So, here I am 8 years and a few home visits later, and I am still learning about the benefits and the power of preventive programs, and my passion to partner with families is as strong as ever. I home visit with low-income families, no-income families and middle-class families who are now finding themselves in positions they have never been in before. They all had a multitude of stresses and some just need another adult to talk to, each having their own story worth listening to, each craving the opportunity to learn and grow and each deserving to be nurtured.

The common bond with each and every one of these families, including myself, is their child. We all want the best for them and

we want more than anything in the world to be the ones to give it to them.

I have seen both sides of what a home visiting program can accomplish, and it is so much more than life changing. It is life enhancing. So I thank you today from the bottom of my heart for your time and your own supportive ears.

Thank you.

Chairman MCDERMOTT. Thank you very much for telling your story to us. It is tough.

[The prepared statement of Ms. D'Aprix follows:]

Statement of Cheryl D'Aprix, Senior Family Support Worker, Starting Together Program, Canastota, New York

Good morning Mr. Chairman and distinguished members of the committee. My name is Cheryl D'Aprix, and I am a Senior Family Support Worker with the Healthy Families America program serving Canastota, New York. It is an honor and a privilege to be here today to share my experience, first as a participant in the Healthy Families America program, and now as a home visitor for the program.

In 1993, my husband Jeff, our 3-year-old daughter and I were presented with a new challenge. I received the news that we would be expecting another baby and could welcome him into our world in about 7½ months. I very gently broke the news to my husband and together we sat in silence each struggling with our own fears and thoughts. Jeff had his mind on the already insufficient funds and how we were going to replace all the baby furniture we had just given away because we were convinced we were already blessed and would not have any more children. I was busy thinking about having to go through post partum depression with another baby. I had suffered with PPD for more than a year after the birth of our daughter. I had no clue what was happening to me but I made it through that year with the patience of my husband and kind words from my family. Now I was petrified of going through it again and the possibility of it worsening. I had heard the horror stories in the news and I prayed that I could remain well enough to take care of our children and hold things together.

While visiting with a friend, I expressed some of my concerns and she recommended that I check into a home-visiting program that was available in our county through our Community Action agency. The program was called Starting Together, which is part of Healthy Families America, NY. The program partners with families who have children prenatal to three to five years of age. After much thought and a lengthy conversation with Jeff I reluctantly gave the program a call. I have to say that it was really scary and unnatural to invite a stranger into my home but after just a few minutes of meeting with our home visitor I knew that we had made the right decision for our family.

During my pregnancy she would meet with me weekly and Jeff would join us whenever he got the chance. She listened to me and shared information with me. She gave me the support I needed to not only feel like a competent parent to the child I already had but she helped me gain the confidence I needed to talk with my doctor about the post partum depression. I was afraid that whichever doctor happened to be on call that day would either just dismiss my concern or tell me it's normal to have the blues after a baby comes. Through the information she brought me I knew that it was much more than the baby blues. I was now able to get the help I needed and with medication and strong shoulders, I was on my way to a healthier life and a more secure attachment with my son.

Once Damian was born, our home visitor brought us curriculum on the stages of development; books and videos on basic care and information on the community resources that helped our family stay afloat. She left information on fatherhood for Jeff so that he could also feel competent and strong in the vital role he played in our lives. Throughout the course of three years, we spent time together doing activities with the kids, setting attainable goals for my family and spending countless hours of just talking. We talked about everyday stresses and there were plenty of those. We also spent time talking about my life and what it was like growing up. She gave me the opportunity to tell my life story and I came to see that I too, was worth listening to. She laughed with me on the good days, and she let me cry on the bad days that were so overwhelming I could barely get one foot on the floor. But I put that foot on the floor because I knew she was coming to visit. It meant so much to me that she understood the importance of nurturing the parent as well as the child.

When Damian turned three, my family graduated out of the program. Jeff was working 2 jobs, I was now working full time, and our daughter was honing the skill of bossing her baby brother around. The job I was doing was unfulfilling but it helped pay the bills. On our last home visit our support worker encouraged me to apply for an open position in the Starting Together program as a home visitor. I jumped at the chance. After all she had taught me, and with all the ways our family had benefited from the program I was excited about applying for the job. I was anxious to start lending a helping hand and a supportive ear to other parents. One of the greatest gifts our home visitor left with me was the belief in myself and I was lucky enough to have the program see my strengths as well and I was offered the position.

My home visiting career started out with months of training and researching community resources so that I could be equipped to meet the diverse needs of each family. The very heart of Healthy Families America is promoting healthy parent/child interaction and child development. While on the floor doing an activity together we will also discuss life challenges such as housing, employment, accessing medical care or transportation. Offering referrals and brainstorming ways to remove barriers that the family feels may interfere with their success is a key part of our visits. As one recent example, I visited with a single mother with relationship challenges and insufficient income. I referred her to a child care center, which she enrolled her child in, enabling her to go to work. Once she had a stable income, we were able to connect her to a first-time homebuyers program, which provided her with financial education to make sure home ownership was appropriate for her. I am happy to report that she is still successfully employed and owns her own home. Outcomes can be amazing when supports are identified and goals are attainable.

So here I am eight years and a few home visits later. I am still learning about the benefits and the power of preventative programs and my passion to partner with families is as strong as ever. I home visit with low-income families, no income families and middle class families who are now finding themselves in positions they have never been in before. All who have a multitude of stresses and some that just need another adult to talk to. Each having their own story worth listening to, each craving the opportunity to learn and grow, each deserving to be nurtured. The common bond with each and every one of these families (including myself) is their child. We all want the best for them and we want more than anything in the world, to be the ones to give it to them.

But despite all the many proven benefits of home visiting, benefits that I witness everyday, the lack of resources in most communities limits the reach of home visiting services to the lucky few. A federal investment in evidence-based home visiting, as proposed by Chairman McDermott, Congressman Davis, and Congressman Platts, will ensure that more families in communities across the country are given the opportunity to participate in this valuable service. I urge every member of this committee to support an investment in evidence-based early childhood home visitation services and to move quickly and thoughtfully on legislation authorizing new federal funding.

I have seen both sides of what a home visiting program can accomplish and it's so much more than life changing. It's life enhancing. I thank you from the bottom of my heart today for your time and your own supportive ears.

Thank you.

Chairman MCDERMOTT. Our next witness is Sharon Sprinkle, who is a program manager for the Nurse Family Partnership Program. And she has been doing it for 8 years and has probably seen a lot.

Ms. Sprinkle.

STATEMENT OF SHARON SPRINKLE, NURSE CONSULTANT, NURSE-FAMILY PARTNERSHIP, DENVER, COLORADO

Ms. SPRINKLE. Thank you. Good morning, Mr. Chairman, Ranking Member Linder, and Members of the Subcommittee. Thank you for the opportunity to testify on behalf of the Nurse-Family Partnership program in support of evidence-based early childhood home visitation.

I am Sharon Sprinkle and I work as a nurse consultant for the Nurse-Family Partnership National Service Office. I have been fortunate to serve in many different capacities for Nurse-Family Partnership, as a nurse home visitor, a nurse supervisor and now as a nurse consultant, integrating the knowledge and skills from my earlier roles to help guide and support our nurses, administrators and agencies to successfully deliver program services. I am here in support of the Obama Administration's proposed initiative to create a new evidence-based home visitation program for low-income families.

I would like to thank Chairman McDermott, Congressman Davis and Members of the Subcommittee for their commitment to improving the health and well-being of children with dedicated funding for evidence-based home visitation. The Nurse-Family Partnership program model has served almost 100,000 families to date, and we currently have over 18,000 first-time families enrolled in 28 States.

Our voluntary program provides home visitation services by registered nurses to low-income, first-time mothers beginning early in the pregnancy and continuing through the child's second year of life. The children and families we serve are overwhelmingly young, poor and minority. Our families are at the highest risk of experiencing significant health, educational, and employment disparities that have lasting negative impacts on their lives and communities.

Nurse-Family Partnership has three major goals; they are to improve pregnancy outcomes, improve child health and development, and improve parents' economic self-sufficiency. Nurse-Family Partnership is an evidence-based program with multigenerational outcomes that have been demonstrated in three randomized controlled trials conducted in both urban and rural locations, and with Caucasians, African Americans and Hispanic families.

A randomized controlled trial is the most rigorous research method for measuring the effectiveness of an intervention. The Nurse-Family Partnership model has been tested for over 30 years with the ongoing research, development and evaluation activities conducted by Dr. David Olds. Evidence from one or more of these trials demonstrates powerful outcomes, including a 79-percent reduction in preterm deliveries of women who smoked, 56-percent reduction in emergency room visits for accidents and poisonings, 46-percent increase in fatherhood involvement in the household, 59-percent reduction in arrests of a child at age 15, and 72-percent reduction in arrests by the mother of the child at age 15.

As the Nurse-Family Partnership model has moved from science to practice, great emphasis has been placed on building the necessary infrastructure to ensure quality and fidelity to the research model during the replication process nationwide. Independent evaluations have found that investments in the Nurse-Family Partnership model lead to significant returns to society and government. For example, the Pacific Institute for Research Evaluation released a report in March of 2009 which found a 154-percent return on Federal Medicaid investment over 10 years from the Nurse-Family Partnership model based on findings from the Memphis trial that showed reduced enrollment in Medicaid and food stamps.

I would like to take this opportunity to share an experience I had as a nurse home visitor while working with a client named Alice

in Greensboro, North Carolina. Alice became pregnant when she was 14 and was caring for her child while living in an apartment with six siblings and her two parents. She called me one morning because no one in her family could take her to her local WIC appointment—Women, Infants and Children. During the car ride, Alice informed me that her household had not had power for a week, but she didn't seem too upset by this development.

I knew immediately that Alice and her family needed assistance identifying and connecting to community resources. I called the Department of Social Services, but did not get much of a response. So I decided to contact the few local community nonprofits that would assist low-income families who are unable to pay for food and other vital services. Two organizations agreed to jointly cover the electric bill.

When I drove Alice home, I told her that she could tell her father that the power would be restored the next day. Up until this point, in my relationship with Alice and her family, Alice's father was not very engaged during my visits. After the electricity was restored to the house, this proud man said to me, "A lot of people say they will help, but you are the one that really did it."

This is one of the many stories about the impact that Nurse-Family Partnership has. We can help break the cycle of poverty by empowering young mothers to become knowledgeable parents who can care for their children and guide them along a healthy life course.

The Nurse-Family Partnership urges the Subcommittee to devote resources to assist States in implementing and expanding their home visitation programs to serve even more vulnerable families. We encourage the Committee to target taxpayer resources to the poorest communities that often lack the critical maternal and child health and social resources to ensure that the most at-risk families succeed.

I would like to thank the Subcommittee for inviting me to testify. And I would also like to thank Chairman McDermott and Congressman Davis and Platts for their leadership on behalf of the Early Support for Families Act.

Chairman MCDERMOTT. Thank you very much for your testimony.

[The prepared statement of Ms. Sprinkle follows:]

Statement of Sharon Sprinkle, RN, Nurse Consultant, Nurse Family Partnership, Denver, Colorado

STATEMENT OF
SHARON SPRINKLE
NURSE CONSULTANT FOR THE SOUTHEAST REGION
NURSE-FAMILY PARTNERSHIP

BEFORE THE
HOUSE COMMITTEE ON WAYS & MEANS
SUBCOMMITTEE ON INCOME SECURITY & FAMILY SUPPORT

JUNE 9TH, 2009
MORNING SESSION

Good morning Mr. Chairman, Ranking Member Linder, and Members of the Subcommittee. Thank you for the opportunity to testify on behalf of the Nurse-Family Partnership (NFP) program in support of evidence-based early childhood home visitation.

I am Sharon Sprinkle and I work as a Nurse Consultant for the Nurse-Family Partnership. As a nurse consultant, I provide technical assistance and guidance to our programs in the Southeastern Region which includes Alabama, Arkansas, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia. I have been fortunate to serve in many different capacities for Nurse-Family Partnership, including as a nurse home visitor, a nurse supervisor, and now a nurse consultant, using the knowledge and skills from my various roles to help guide and support our nurses, administrators and agencies successfully deliver program services. I am here in support of the Obama Administration's proposed initiative to create a new evidence-based home visitation program for low-income families. On behalf of the mothers, children and families served by Nurse-Family Partnership, I want to thank Chairman McDermott and Congressman Davis and the Members of this Subcommittee for their commitment to improving the health and well-being of children with dedicated funding for evidence-based home visitation. Your work is paving the way for a healthier, brighter future for at-risk children and families.

Every year, approximately 650,000 first time low-income mothers become pregnant with their first child. Nationwide, the Nurse-Family Partnership (NFP) model has served almost 100,000 families to date, and currently has over 18,000 first-time families enrolled in 28 States. National expansion of this program will dramatically improve the lives of at-risk families and yield returns to society in more stable and productive families. For every 100,000 families served by NFP, research demonstrates that 14,000 fewer children will be hospitalized for injuries in their first two years of life; 300 fewer infants will die in their first year of life; 11,000 fewer children will develop language delays by age two; 23,000 fewer children will suffer child abuse and neglect in their first 15 years of life; and 22,000 fewer children will be arrested and enter the criminal justice system through their first 15 years of life, among other outcomes.

NFP is a voluntary program that provides nurse home visitation services to low-income, first-time mothers by registered nurses beginning early in pregnancy and continuing through the child's second year of life. The children and families NFP serves are overwhelming young, poor, minority and at the highest risk of experiencing significant health, educational and employment disparities that have lasting negative impacts on their lives and communities. Nationally, 27 percent of families served by Nurse-Family Partnership are Hispanic; 22 percent are African-American; and 40 percent are Caucasian.

NFP nurses and their clients make a 2 ½ year commitment to one another, and develop a strong relationship over the course of 64 planned visits that focus on the strengths of the young mother and on her personal health, quality of care giving, and life course development. NFP nurses undergo more than 60 hours of training prior to receiving their caseload of no more than 25 families. Their partnership with families is designed to help them achieve three major goals: 1) improved pregnancy outcomes; 2) improved child health and development; and 3) improved parents' economic self-sufficiency. By

achieving these program objectives, many of the major risks for poor health and social outcomes can be significantly reduced.

When I was a nurse home visitor with the NFP program in Greensboro, North Carolina, I worked with a young client named Alice. Alice became pregnant at the age of 14 and was caring for her child while living in an apartment with her parents and 6 siblings. Alice needed someone to take her almost every time she had to transport her baby. She called me one morning as no one in her family could drive her to her appointment with her local Women, Infants, and Children (WIC) Program. During the car ride, I asked how things were going at home, expecting a simple "Fine" response. Instead, Alice informed me that her house hadn't had power for a week, but didn't seem too upset about this development.

I immediately had a multitude of questions such as "How have you been eating? How have you been doing your homework? When will the power go back on?" to which Alice's common reply was a simple shrug of the shoulders. After I dropped Alice off at her WIC appointment, I recognized that Alice and her family needed assistance identifying and connecting to community resources. After placing a call to the Department of Social Services without much response, I decided to contact a few local, community non-profits that assist low-income families who are unable to pay for food and vital services. Two organizations each agreed to cover half the electric bill, and when I drove Alice home, I informed her that she could tell her father that power would be restored the next day. Up until this point in my relationship with Alice and her family, Alice's father was not very engaged with my visits to the household. After electricity was restored to the house, this proud man said to me "A lot of people say they will help you, but you're the one who really did."

Another young mother, 18 year old Janice, enrolled in the Nurse-Family Partnership in Guilford County, NC early in her pregnancy. During the visit, it is my practice to review the signs and symptoms of preterm labor and also provide each participant with a binder that contains the NFP visit guidelines. At 6 ½ months pregnant, Janice began experiencing preterm labor. She went to the health department where she was receiving prenatal care and the provider assessed her and gave her instructions to go home, drink fluids and rest.

At home, Janice's preterm labor symptoms intensified. She was convinced that something was wrong but ambivalent because she had been to her healthcare provider earlier in the day. Janice decided to consult the Nurse-Family Partnership visit guidelines. After reading the visit guidelines she was certain that she needed to go to the emergency room. She went to the emergency room and was transported to a hospital that had a level three nursery and could manage babies with complex medical needs. Despite the efforts of the medical staff to halt labor, Janice gave birth to a 1 lb. 8 oz baby boy and he was admitted to the neonatal intensive care unit, where incubators, respirators, and other life-sustaining high tech equipment is the norm.

Baby boy Allen remained in the neonatal intensive care unit for approximately 2 ½ months. During his hospital term, I assisted Janice in finding transportation to the hospital to visit Allen; the hospital was some 30 miles from where she lived. During and after Allen's release from the hospital, I continued to support Janice by providing information, finding resources, facilitating her competence in parenting and offering reassurance. When the time was appropriate, Allen started Early Head Start at the suggestion of the NFP nurse and Janice returned to work and began contemplating going to college.

These two stories are just a glimpse into the impact that Nurse-Family Partnership has on first time, low-income families. NFP can help break the cycle of poverty by empowering young mothers to become knowledgeable parents who are able to care for their children and guide them along a healthy life course. NFP nurses use a client-centered approach, which means the nurse is constantly adapting to the needs of the family, ensuring that each visit is relevant and valued by the parent(s). NFP nurses also continue to monitor the model's progress in the field through data collection which nurses submit to the national database, and receive quarterly and annual reports evaluating the local program's ability to achieve sizeable, sustained outcomes. Each NFP implementing agency's goal is not only to improve the lives of first-time families, but also replicate the nurse home visitation model that was proven to work through rigorous research.

NFP is an evidence-based program with multi-generational outcomes that have been demonstrated in three randomized controlled trials that were conducted in urban and rural locations with Caucasian, African American and Hispanic families. A randomized controlled trial is the most rigorous research method for measuring the effectiveness of an intervention because it uses a "control group" of individuals with whom to compare outcomes to the group who received a specified intervention. The NFP model has been tested for over 30 years through ongoing research, development, and evaluation activities conducted by Dr. David L. Olds, program founder and Director of the Prevention Research Center for Family and Child Health (PRC) at the University of Colorado in Denver.

Dr. Olds and his research team have conducted three randomized, controlled trials with diverse populations in Elmira, NY (1977), Memphis, TN (1987), and Denver, CO (1994). Evidence from one or more of these trials demonstrates powerful outcomes including the following (in connection to each of NFP's program goals):

Improved pregnancy outcomes

- Reductions in high-risk pregnancies as a result of greater intervals between first and subsequent births, including a 28-month greater interval between the birth of first
    - 31% fewer closely spaced (<6 months) subsequent pregnancies,
    - 23% reduction in subsequent pregnancies by child age two, and
    - 32% reduction in subsequent pregnancies for the mother at child age 15 (among low-income, unmarried group)
- 79% reduction in preterm delivery among women who smoked
- 35% fewer hypertensive disorders during pregnancy

Improved child health and development

- 39% fewer injuries among children (among low-resource group)
- 56% reduction in emergency room visits for accidents and poisonings
- 48% reduction in child abuse and neglect
- 50% reduction in language delays of child age 21 months
- 67% reduction in behavioral and intellectual problems at child age 6
- 26% improvement in math and reading achievement test scores for grades 1-3
- 59% reduction in arrests at child age 15
- 90% reduction in adjudication as PINS (person in need of supervision) for incorrigible behavior

Increased self-sufficiency of the family

- 61% fewer arrests of mothers at child age 15
- 72% fewer convictions of mothers at child age 15
- 20% reduction in welfare use
- 46% increase in father presence in household
- 83% increase in labor force participation of mothers at child age 4

As the NFP model has moved from science to practice, great emphasis has been placed on building the necessary infrastructure to ensure quality and fidelity to the research model during the replication process nationwide. In addition to intensive education and planned activities for nurses to conduct in the home, NFP has a unique data collection and program management system called the Clinical Information System (CIS) that helps NFP monitor program implementation and outcomes achieved. It also provides continuous quality improvement data that can help guide local practices and monitor staff performance. The CIS was designed specifically to record family characteristics, needs, services provided, and progress towards accomplishing NFP program goals.

NFP's replication plan reflects a proactive, state-based growth strategy that maximizes fidelity to the program model and ensures consistent program outcomes. NFP urges Congress to support a wide range of home visitation models that meet the highest level of evidentiary standards in order to ensure the largest possible economic return on investment. NFP applauds President Obama for his Administration's commitment to funding programs proven to work through rigorous, scientific evidence and research.

Independent evaluations have found that investments in NFP lead to significant returns to society and government (Washington State Institute for Public Policy, 2004 & 2008; 3 RAND Corporation studies 1998, 2005, 2008; Blueprints for Violence Prevention, Office of Juvenile Justice and Delinquency Prevention; and Pacific Institute for Research & Evaluation). Blueprints identified NFP as 1 of 11 prevention and intervention programs out of 650 evaluated nationwide that met the highest standard of program effectiveness in reducing adolescent violent crime, aggression, delinquency, and substance abuse. The RAND and Washington State reports weighed the costs and benefits of NFP and concluded that the program produces significant benefits for children and their parents,

and demonstrated a savings to government in lower costs for health care, child protection, education, criminal justice, mental health, government assistance and higher taxes paid by employed parents. The Pacific Institute released a report in March 2009 which found a 154% return on federal Medicaid investment (over 10 years) from the NFP model based on findings from the Memphis trial showing reduced enrollment in Medicaid and Food Stamps. Recent analyses indicate that the costs of NFP compared to other home visitation programs fluctuate by region, and even though the NFP model is more intensive than other programs, it is not always more expensive.

The Nurse-Family Partnership urges this Subcommittee to devote resources to assist States in implementing and expanding their home visitation programs to serve more families. We encourage the Committee to target taxpayer resources to the poorest communities that often lack critical maternal and child health and social resources to ensure the most at-risk families succeed. I would like to thank the Subcommittee for inviting me to testify, and I would also like to thank Chairman McDermott and Congressmen Davis and Platts for their leadership on behalf of the Early Support for Families Act. Thank you again, Chairman McDermott, Ranking Member Linder, and Members of the Committee, for the opportunity to testify before you today.

Chairman MCDERMOTT. I am going to start, I think, by letting Mr. Linder ask the first question, because I want to think a little bit about—you opened up so many possibilities, I am not quite sure

that the staff questions are quite what I want to do. So I am going to wait.

Mr. LINDER. Thank you very much. I would like to ask a question of Ms. Sprinkle.

I have seen numbers of 6,000 children are born to girls 14 and younger each year in this country. Is the prospective mother your client or is the family your client?

Ms. SPRINKLE. The mom is the client, because when you improve parenting capacity, the child reaps the benefits.

Mr. LINDER. The pregnant mother is the client?

Ms. SPRINKLE. Yes. We enroll clients prenatally before they are 28 weeks pregnant. With first-time moms there is a window of opportunity in which they are receptive to the education and are willing to make a change and are committed and motivated to make the change for a better life for their child.

Mr. LINDER. The program, as proposed, is going to try and help 450,000 people a year and I am told that there is about 1.5 million in the same boat.

Who picks and chooses? Ms. Sharp?

Ms. SHARP. Well, from our point of view as a State agency, we look at a number of factors, but the primary one is the capacity of the local community, the implementing organization, to be able, from their perspective using data that is available on all sorts of measurements, to be able to target the resources, and services to those most at need most able to be positively impacted.

So, from our point of view, it is a local decision that we would be guiding.

Mr. LINDER. Dr. Daro, as a scientist evaluating programs, Ms. Sharp said in her testimony that for every dollar spent, $3.02 is saved.

How does a scientist or an examiner make that decision?

Ms. DARO. The cost savings are determined by looking at a group of people who receive the service and those that didn't receive the service generally, randomly assigned to these two conditions; and then you look at their experiences in utilizing public resources going forward.

In the case of the Nurse-Family Partnership, they have 18, 20 years of evidence. And what you find in the individuals who have received services, is less welfare utilization, less use of public health care dollars because there is greater employment. And that occurs because, as Jeanne noted, they stay in school longer and they complete their education.

So it begins a cycle of investment in themselves such that the social savings can be realized down the line.

Mr. LINDER. Mr. Chairman, I ask unanimous consent to put in the record the fiscal year 2010 budget conference agreement. A CRS memo describing on page 2 includes a provision establishing a deficit-neutral reserve fund for establishing or expanding home visitation programs.

[The information follows:]

Congressional Research Service

MEMORANDUM June 8, 2009

To: House Ways and Means Committee
Attention: Matt Weidinger

From: Emilie Stoltzfus, Specialist in Social Policy, 7-2324
Karen Lynch, Analyst in Social Policy, 7-6899

Subject: **Home Visitation Proposals and Funding for Home Visiting**

This memorandum responds to your request for information about current and recent proposals to funding home visitation for families with young children or those expecting a child. You also asked that we discuss any current federal, state or other support for home visiting. We trust this discussion will be useful. Please let us know if you have additional questions.

Introduction

Home visiting for families with young children and those expecting children is a strategy for delivering in-home support and services to families. Home visitors typically aim to offer family support and to have positive impacts on maternal and child health, as well as early childhood development and education. Based on particular service models developed over several decades, these visitors may be specially trained nurses, other professionals, or paraprofessionals. Visits may begin during a woman's pregnancy or later (depending on the model) and may continue, regularly, until age two, or, again depending on the model, until a child enters school. Participation on the part of the families is voluntary.

During the home visits, the nurse, other professional, or paraprofessional discusses specific health, early childhood development and education, and parenting topics, and may also use role play or parent coaching. Among others, topics covered may relate to pre- or postnatal health (e.g., importance of refraining from smoking); maintaining a safe home environment for infants and toddlers to prevent unintentional injuries; expected developmental milestones for infants and young children, including age-appropriate expectations and discipline strategies; and/or positive parenting behaviors and skills to reduce the risk of maltreatment and to improve parent-child interaction and children's cognitive development. In addition, the home visitor is usually expected to refer or link families to community-based or other services and supports that the family may need. For example, services to prevent or respond to domestic violence; treat mental illness and/or substance abuse; provide mutual support to parents; or offer job, training, or education skills.

Recent Administration and Congressional Proposals to Support Home Visiting

In late April 2009 the House and Senate approved a conference agreement on the FY2010 budget resolution (S.Con.Res. 13), which reconciles separate FY2010 budget resolution proposals passed earlier that month, by the House (H.Con.Res. 85) and Senate (S.Con.Res. 13). The FY2010 budget resolution is designed to set federal funding priorities across all purposes for the upcoming fiscal year. According to the conference report on the budget resolution (H.Rept. 111-89), the agreement includes a "deficit neutral reserve fund" for establishing or expanding home visitation programs.

A variety of proposals to provide greater support for home visitation programs to families with young children or those expecting children have been offered in recent years. The discussion below will focus on four current or recent proposals that would provide additional federal funds to states for the support of these home visitation programs, including a proposal in the FY2010 budget by the Obama Administration. This discussion will be followed by a short review of other proposals that would (or would have) supported competitive grants to local, community-based, or other entities (public or private) to support home visiting. Please note that the discussion of legislative proposals is limited to those bills that have been introduced in the House. However, some similar or identical proposals have been, or are currently, introduced in the Senate.

Proposed Federal Funding for State Programs

As described above, home visiting seeks to positively impact child and family well-being across a range of domains, including health, early childhood development and education, and family functioning/support. The proposals to provide federal funding to states for home visitation programs, discussed below, each seek to achieve outcomes across a range of domains and they would use or create different program authorities and funding strategies to do this.

Healthy Families and Children Act (H.R. 3024/110th Congress)

The Healthy Families and Children Act would have amended the definition of "medical assistance" for purposes of Medicaid (Title XIX of the Social Security Act) and the definition of "child health assistance" for purposes of the State Children's Health Insurance Program (CHIP, Title XXI of the Social Security Act) to include "nurse home visitation services." Under Medicaid, states share in the cost of providing Medicaid coverable services to program beneficiaries. For each dollar of state spending, the federal government makes a matching payment. Program funding is referred to as an "open-ended" individual entitlement because states are entitled to receive a portion of reimbursement for all "medical assistance" provided on behalf of program enrollees and program enrollees are entitled to Medicaid covered services as outlined in the state plan. Like Medicaid, CHIP is a federal-state matching program. Under CHIP, states may enroll targeted low-income children in a CHIP-financed expansion of Medicaid, create a new separate state CHIP program, or devise a combination of both approaches. However, no such individual entitlement exists for targeted low-income children covered in separate CHIP programs. CHIP does not establish an individual entitlement to benefits. Instead, CHIP entitles states with approved state CHIP plans to pre-determined federal allotments based on a distribution formula set in the law. Targeted low-income children covered under a CHIP-financed expansion of Medicaid are, however, entitled to the benefits offered under that program as dictated by Medicaid law. The Medicaid and CHIP programs are

administered by the Centers for Medicare and Medicaid (CMS) within the Department of Health and Human Services.

Under the Healthy Families and Children Act states would have had the option to receive federal reimbursement for the cost of providing "nurse home visitation services" which would have been defined to include only services that met certain evidence standards and which were offered on behalf of a subset of otherwise eligible individuals. Specifically, the bill would have expanded the definitions of both "medical assistance" (under Medicaid) and "child health assistance" (under CHIP) to include "Evidence-based nurse home visitation services (such as services related to improving prenatal health, pregnancy outcomes, child health and development, school readiness, family stability and economic self-sufficiency, reducing child abuse, neglect, and injury, reducing maternal and child involvement in the criminal justice system, and increasing birth intervals between pregnancies)." However, the legislation would have also stipulated that these services would only be eligible for federal reimbursement (under Medicaid or CHIP) if they were provided "in accordance with outcome standards that have been replicated in multiple, rigorous, randomized controlled trials in multiple sites." Finally, in order to be eligible for reimbursement under the Medicaid program the services would need to have been provided for any otherwise Medicaid eligible individual who is a "first-time pregnant woman" or a child under the age of 2 years who "is the first live birth of a biological mother." Similarly, to be eligible for reimbursement under the CHIP program the nurse home visitation services would need to have been provided to a "targeted low-income child (CHIP-eligible child) who was under age 2 and "is the first live birth to a biological mother."

H.R. 3024 was introduced by Rep. DeGette in the 110th Congress and was referred to the House Energy and Commerce Committee.

Education Begins at Home Act (H.R. 2205/111th Congress)

The Education Begins at Home Act would authorize a new formula grant program to states, territories, and tribes to expand quality programs of early childhood home visitation to eligible families. The purposes of this funding, as stated in H.R. 2205, include the promotion of "positive outcomes for children and families including: readiness for school, improved child health and development, positive parenting practices, reductions in child maltreatment, and enhanced parenting abilities to support their children's optimal cognitive, language, social-emotional, and physical development." Funding would be authorized on a discretionary basis at $150 million for FY2010 and at "such sums as may be necessary" for each of FY2011-FY2014. It would be administered on the federal level by HHS in consultation with the U.S. Department of Education. After reservation of funds for tribes, territories, evaluation, training/technical assistance, and federal administration, HHS would be instructed to allot the remaining funds to each state based on its relative share of children under age 6 who live in families with income below 100% of the poverty line. H.R. 2205 would require the governor of each state to designate a lead agency to administer the early childhood home visitation program in his/her state and suggests as possibilities the state educational agency or the state health and human services agency.

Families eligible for early childhood home visitation are defined by H.R. 2205 as pregnant women (including fathers-to-be when available) and the parents or primary caregivers of children under the age of entry to kindergarten. States that received funds would be required to use them to provide early childhood home visitation to as many eligible families as practicable. The services would need to be provided on a voluntary basis, in the home of the individual (or a mutually agreed upon location in the community), and must be provided no less frequently than once a month (or more often if an eligible family has greater needs). Only early childhood home visitation programs meeting certain criteria could be supported with these grant funds. Among other criteria, any program that would be supported with these grant funds must have a clear and consistent research-based model for providing home visitation

services that is grounded in empirically-based knowledge related to home visiting and child health or child developments, must be associated with a national organization or institution of higher education that has comprehensive home visitation program standards, must have been evaluated with results published in a peer-reviewed journal and must have been in existence at least 3 consecutive years.

To receive funds, states would need to submit a grant application including specified assurances, a state needs assessment, and a state plan for supporting early childhood home visitation programs. A peer review panel (appointed by HHS with representatives of certain groups as specified in H.R. 2205), would review applications to ensure their completeness and to recommend to HHS whether or not to approve the plan based on the quality of the needs assessment, quality of programs to be funded, the state's plan to enhance and improve collaboration across agencies, programs and services; its plan to prioritize service to high need communities; and its plan to deliver effective training and technical assistance. States with an approved grant application would be entitled to receive their allotment of any appropriated funds, provided that 1) HHS determined that the state spent no less for "quality programs of early childhood home visitation" in the fiscal year prior to the fiscal year for which the grant would be awarded than it did in the second year prior to the fiscal year for which the grants are to be awarded and 2) the state spent an amount of its own funds (non-federal) for early childhood home visitation programs of no less than 10%, 20% and 30% of its allotment amount in FY2011, FY2012 and FY2013, respectively.

H.R. 2205 was introduced by Rep. Danny Davis and has been referred to the House Education and Labor and House Armed Services Committees. It is largely identical to legislation reported by the House Education and Labor Committee in the 110th Congress (H. Rept. 110-818). H.R. 2205 includes additional funding authorizations that would fund more targeted home visiting services, related to families with English language learners and military families. See discussion below in "Other and Related Proposals Concerning Home Visiting."

Obama Administration's FY2010 Budget Proposal

As part of its FY2010 budget request the Obama Administration proposes a new capped entitlement program to support formula grants to states, territories and tribes for the establishment and expansion of "evidence-based" home visitation programs for low-income mothers and pregnant women. The program is expected to "create long-term positive impacts for children and their families, as well as generate long-term positive impacts for society as a whole."[1] Mandatory funding for the newly proposed home visitation program is proposed at $124 million in FY2010 (budget authority; $87 million in outlays), gradually rising to annual funding of $710 million (outlays) by year five of the program (FY2014) and to $1.753 billion in outlays in year ten (FY2019).[2] The Administration notes that priority will be given to funding models "that have been rigorously evaluated and shown to have positive effects on critical outcomes for families and children." Accordingly, states, territories and tribes seeking matching grants under the proposed home visitation program would be required to submit a plan describing, among other things, the program model they will follow, evidence for the effectiveness of the program model, and how the state will ensure that the proven program model is adhered to (model fidelity).[3] Funding related to programs with strong research evidence demonstrating their effectiveness would include technical assistance,

[1] U.S. Department of Health and Human Services, Administration for Children and Families (ACF) *FY2010 Justification of Estimates for the Appropriations Committee* (hereinafter FY2010 ACF budget justifications), p. 267.

[2] Office of Management and Budget, Updated Summary Tables, May 2009, p. 24. According to the FY2010 ACF budget justifications, this funding is expected allow home visiting services to 50,000 families in the initial year of the program, rising to 450,000 new families by FY2019.

[3] FY2010 ACF budget justifications, p. 267 – 269.

monitoring and evaluation to ensure fidelity of the model and for "evaluating effectiveness of these models as conditions change over time." The Administration also anticipates that additional funds will support "promising programs" such as those based on some research evidence and those that are adaptations of previously evaluated programs. Funding for these programs would also include technical assistance, monitoring, and evaluation that focuses on developing these promising models and on "rigorous (random assignment) evaluations of effectiveness."[6]

Based on its inclusion in the Administration for Children and Families (ACF) budget justifications, this HHS agency is expected to administer the program. At the same time, the FY2010 budget request notes an effort to coordinate planning for the proposal across HHS agencies to ensure the most effective program structure; it also suggests a wide range of goals for this program. These include reductions in child abuse and neglect, improvements in children's health and development and their readiness for school, and improvements in the ability of parents to support children's optimal cognitive, language, social-emotional, and physical development. It notes one model of home visitation that used nurses was found to produce Medicaid savings in several randomized control trials and it assumes implementation of this home visiting program would result in savings to the Medicaid program (via reductions in pre-term births, emergency room use, and subsequent births) totaling $77 million in the first five years and $664 million over the entire 10 years.[7]

Implementation of this proposal would require Congressional action to pass authorizing legislation. As of early June 2009, the Administration had not provided formal legislative language to Congress for this purpose.

Early Support for Families Act (H.R. 2667/111th Congress)

The Early Support for Families Act would appropriate capped mandatory funds for a new formula grant program to states, territories, and tribes to establish and expand quality home visitation programs for families with young children and families expecting children. The purpose of this support, as stated in H.R. 2667, is to improve the well-being and development of children. The bill would appropriate $100 million for home visitation in FY2010, $250 million for FY2011, $400 million for FY2012, $550 million for FY2013 and $700 million for FY2014. These funds would be administered by HHS. After reservation of funds for evaluation and training/technical assistance, and for tribes, HHS would be instructed to allot the remaining funds to each state based on its relative share of children who live in families with income at or below 200% of poverty line. H.R. 2667 would establish this new program to support home visitation by adding a new subpart to a part of the Social Security Act that authorizes funds for child and family services (Title IV-B). Programs authorized under Title IV-B are currently administered by state child welfare agencies, however, H.R. 2667 does not specify that the child welfare agency must administer the home visitation program it would authorize.

States would be able to seek partial federal reimbursement for the cost of providing home visitation services to as many families with young children and families expecting children as practicable or for an amount that was equal to their full allotment under the program, whichever was less. To be considered an eligible expenditure, the home visitation must be offered on a voluntary basis, and must be used to 1) implement or expand programs of high quality that, among other things, adhere to clear evidence-based

[6] Ibid, p. 267.

[7] Ibid; Office of Management and Budget, Budget of the U.S. Government Fiscal Year 2010, Updated Summary Tables, May 2009, p. 24; and U.S. Department of Health and Human Services (HHS) Fiscal Year 2010 Budget in Brief, p. 84.

models of home visitation that have demonstrated significant positive effects on important child and parenting outcomes (e.g., reducing abuse and neglect and improving child health and development), employ well-trained, competent staff with high quality supervision, have the organizational capacity to implement the program, and establish appropriate links to other community resources and supports; and 2) for training, technical assistance and evaluations related to those programs. The legislation further provides that states may count (as eligible expenditures) a declining share of their spending for home visitation programs that don't adhere to a model of home visitation "with the strongest evidence of effectiveness. Specifically in FY2010, 60% of a state's eligible expenditures under the program could be for this purpose but by FY2014 no more than 40% of such state spending would be considered eligible for federal reimbursement.

To receive home visitation that would be appropriated by H.R. 2667, states would need to submit a grant application including a description of the home visitation programs that are expected to be supported with the funds, results of a state needs assessment, and specified assurances. States with an approved grant application would be entitled to receive the lesser of their total allotment under the program or 85% of their eligible expenditures for home visitation in FY2010, 80% in FY2011 and 75% in FY2012 and in all subsequent years. States would not be permitted to use other federal funds to meet their portion of the program costs. Further, beginning with FY2011, a state could not receive funds under this home visitation program unless HHS determined that in the fiscal year prior to the fiscal year for which the grant would be awarded, the state's total spending for quality programs of home visitation to families with young children and those expecting children was no less than the total amount it spent for those purposes in the second fiscal year preceding the year for which the grants are to be made.

H.R. 2667 was introduced by Rep. McDermott and has been referred to the House Ways and Means Committee.

Other and Related Proposals Concerning Home Visiting

The proposals described above would provide federal support to states for home visitation programs, via formula grants or through open-ended reimbursement of eligible expenditures. Some other recent proposals have included competitive grant funding for more targeted home visitation programs. These include:

Section 1704 of the Reducing the Need for Abortion and Supporting Parents Act (H.R. 1074/110th Congress) would have authorized HHS to make grants to local health departments to support home visits by registered nurses to first-time mothers with children no older than 12 months and to mothers who are under the age of 20 and whose child is not more than 12 months old. During these visits the registered nurse would be expected to provide information on child health and development, parenting advice, information on parenting resources, upcoming parenting workshops in the local region, and on programs that facilitate parent-to-parent support services, and factual and medically complete information about contraception. H.R. 1074 would have authorized $3 million in discretionary appropriations for this program. The bill (which included many provisions) was referred to the House Energy and Commerce, House Education and Labor, and House Ways and Means Committees.

Section 5 of H.R. 2205 (Education Begins at Home Act) would authorize HHS in consultation with the Education Department to make grants to local education agencies and to eligible public or private community-based organizations, to expand quality programs of early childhood home visitation so that they more effectively reach and serve English language learners (including individuals not born in the United States or whose native language is not English, individuals whose lack of fluency in English may hinder their educational achievements or their participation in society, or certain American Indian/Alaska

Native individuals). The bill would authorize discretionary appropriations of $20 million for FY2010 and "such sums" for FY2011-FY2014.

Section 6 of H.R. 2205 (Education Begins at Home Act) would authorize the Defense Department in consultation with the Education Department and HHS to make competitive grants to local education agencies; certain schools, including those operated for defense dependents, and to community-based organization serving families in the Armed Forces. The purpose of these grants would be to expand quality programs of early childhood home visitation to more effectively reach and serve families serving in the military. The bill would authorize discretionary appropriations of $20 million for FY2010 and "such sums" for FY2011-FY2014.

Related Current Federal Programs or Initiatives

Several current federal programs, including Early Head Start, and Healthy Start, explicitly provide home visitation (based on a unique model) as a part of other services offered. In addition the Administration for Children and Families (ACF) began supporting a home visitation initiative in FY2008. These programs, as they relate to home visitation, and the current ACF home visitation initiative are briefly described below.

Early Head Start

Authorized under the Head Start Act, Early Head Start provides early childhood services to families expecting children and families with children under age three. Early Head Start programs seek to promote healthy prenatal outcomes, enhance the development of infants and toddlers, and promote healthy family functioning. In FY2007, Early Head Start programs received $689 million in federal Head Start funds to serve about 61,700 children under the age of three.[6] Generally, participating families must have incomes below the poverty line, though some may also be eligible based on other categorical circumstances (e.g., homelessness or eligibility for Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), or foster care).[7] Early Head Start services may be provided through center-based programs, home-based programs, and programs that combine center-based and home-based services. In home-based programs, children and their families are supported through weekly home visits of at least 90 minutes and bimonthly group socialization experiences. Early Head Start is administered by the Office of Head Start within the Administration for Children and Families (ACF) at HHS.

Healthy Start

Healthy Start is authorized under the Public Health Services Act (P.L. 106-310). It serves nearly 100 communities, and in recent years has received annual funding (discretionary appropriations) of about $100 million.[8] Healthy Start funding is provided to support "community-designed and evidence-supported

[6] See FY2008 Head Start Program Fact Sheet.
http://ecliks.ohs.acf.hhs.gov/hsis/About%20Head%20Start/dHeadStartProgr.htm;a2a5berNo

[7] There are some exceptions to these eligibility requirements. For instance, the Head Start Act allows up to 10% of children to be from families exceeding the poverty guideline. This law further allows that an additional 35% of children may be from families with incomes "below 130 percent of the poverty line," provided these children are not given higher priority than children who are homeless or living below the poverty line.

[8] U.S. Department of Health and Human Services, Health Resources and Services Administration, *FY2010 Justification of* (continued...)

strategies" to reduce infant mortality and improve health outcomes for infants and their mothers. Special attention is given to African American and other minority communities where rates of infant and maternal death are disproportionately high. Healthy Start grantees design their own services. However, they generally make available a core set of services including case management (home visiting and links to health care and other needed services); direct outreach and peer mentoring by training community members; screening and referral for perinatal/postpartum depression; and strong coordination and access to critical services for high-risk women and families, substance abuse and domestic violence counseling and support, mental health services, early intervention, parenting education, smoking cessation, housing and employment.[9] Healthy Start is administered by the Health Resources and Services Administration (HRSA) within HHS.

Current ACF Home Visitation Initiative

Beginning with FY2008, HHS, through its Administration for Children and Families (ACF) has provided support for testing effective implementation of home visiting programs to prevent child maltreatment. Funding for this initiative was initially requested by the Bush Administration ($10 million as a set aside from the discretionary activities account of the Child Abuse Prevention and Treatment Act, CAPTA) in its FY2008 budget. At the time, the Bush Administration sought this funding to "expand existing programs that utilize proven effective models of nurse home visitation; upgrade existing programs to follow proven effective models of nurse home visitation; build the infrastructure to initiate a program based on a proven effective model of nurse home visitation."[10] Congress provided $10 million for the initiative in FY2008 but provided that the funds were made available to support improved implementation of a range of evidence-based home visiting models.

On September 30, 2008, HHS/ACF awarded grants to 17 grantees in 15 states for supporting evidence-based home visiting to prevent child maltreatment. These grantees intended to help implement or enhance and study a variety of home visiting models (alone or in combination), including the Nurse Family Partnership, Healthy Families America, Parents as Teachers, Safe Care, and others. In addition, HHS awarded funds to Mathematica Policy Research, Inc., and Chapin Hall Center for Children to conduct a cross-site evaluation of the grantees' programs, including (1) an implementation study; (2) a fidelity and outcomes study; and (3) a cost study. Mathematica and Chapin Hall must also establish and coordinate a peer learning network to facilitate information sharing and will provide evaluation technical assistance to grantees and their local evaluators through this network.[11]

For FY2009, Congress directed that $13.5 million be set aside to "support continuing and new competitive grants to states to encourage investment of existing funding streams into evidence-based home visitation models that have been shown to improve the health, well-being, and self-sufficiency of low-income, first-time parents and their children."[12] The Obama Administration has requested continued funding for this initiative at $13.5 million for FY2010.

(...continued)
Estimates for the Appropriations Committee, p.166.

[9] National Healthy Start Association, Inc. (http://www.healthystartassoc.org/).

[10] ACF justifications FY2008.

[11] See "Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment," at http://www.acf.hhs.gov/programs/cb/programs_fund/discretionary/visitation/chhv_project_description.pdf.

[12] See *Congressional Record*, February 23, 2009, H2228. The statement further provides: "As in fiscal year 2008, ACF shall (continued...)

Existing Federal State and Local Funding for Home Visiting

There are many home visiting program "models." These models can be differentiated by, among other things, who they intend to serve, the intensity and duration of services, staff qualifications and training, specific program goals, and the exact services or curricula they use in working with families. At least five privately originated home visiting program models have been widely implemented: Healthy Families America (operating in 36 states and the District of Columbia, 430 sites);[13] Parents as Teachers (50 states and the District of Columbia, more than 2,813 sites);[14] Nurse-Family Partnership (28 states, 161 sites);[15] Home Instruction for Parents of Preschool Youngsters (25 states and the District of Columbia, 146 sites);[16] and the Parent-Child Home Program (15 states and the District of Columbia, at least 143 sites).[17]

Beyond those five models, many other home visiting models, some consciously blending aspects of the models listed above and others that were independently developed, are also in use. Most home visiting programs use a blend of federal and state funding streams, with some additional support coming from local public funds or private sources.[18] For instance, support for Healthy Families America (HFA) programs in 2004 came from an average of 2.4 federal funding sources, 2.0 state funding sources, and 2.7 local funding sources by state.[19]

While an effort has been made to be thorough in compiling these data, please note that information on funding sources (particularly at the state and local levels) may not be comprehensive.

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ensure that these funds support models that have been shown in well-designed, randomized controlled trials to produce sizeable, sustained effects on important child outcomes such as reductions in abuse and neglect..."

[13] See http://www.healthyfamiliesamerica.org/about_us/faq.shtml#location. Note that there is some discrepancy about how many states are participating. Rather than data reported in the website Q&A, CRS determined state participation from information reported in a site survey (see http://www.healthyfamiliesamerica.org/downloads/hfa_site_survey.pdf).

[14] See http://www.parentsateachers.org/ut/c/0%7B00812BCA-A71B-4C2C-8FF3-8F16A5742EEA%7D/PAT%BELD_SITEMAP_AUGUST07.PDF. Numbers cited above represent participation within the United States only; Parents as Teachers also operates in several other countries.

[15] See http://www.nursefamilypartnership.org/content/index.cfm?fuseaction=showMap&mapID=17. Numbers cited above represent participation within the United States only; the Nurse Family Partnership currently has several international collaborators as well.

[16] See http://www.hippyusa.org/site/view/135863_HIPPYLocations.html. Note that there is a discrepancy between the total number of participating states and sites cited in text on this page compared to the numbers displayed in the accompanying map. CRS used total states and sites based on a tally of those displayed on the map. Numbers cited above represent participation within the United States only; HIPPY also operates internationally.

[17] See http://www.parent-child.org/localsites/index.html. Note that Ohio is listed as a Parent-Child Home Program (PCHP) state, but no information is provided about number of participating sites within the state. For purpose of this document, CRS assumes the minimum of one site operating in Ohio. Numbers cited above represent participation within the United States only; PCHP also operates internationally.

[18] For more information, see Kay Johnson, *State-based Home Visiting: Strengthening Programs through State Leadership*, National Center for Children in Poverty, Mailman School of Public Health, Columbia University, February 2009 (hereinafter Johnson, *State-based Home Visiting Programs*, 2009); Wasserman, *Implementation of Home Visitation*, 2006; and Healthy Families America, "Chapter 8: Funding," *State Systems Development Guide*, 2003 at http://www.healthyfamiliesamerica.org/downloads/sdg8.pdf

[19] See Healthy Families America, http://www.healthyfamiliesamerica.org/network_resources/hfa_state_of_state_systems.pdf

Federal Funding Sources

Current and/or past sources of federal funding for home visiting have come from programs administered by several different federal agencies, most commonly the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Education (ED). Support from existing federal programs comes in several different ways. Some programs, such as Early Head Start, operate what amounts to their own home visiting model. For other programs, such as the Maternal and Child Health Block Grant, home visiting services are explicitly permitted by statute, but as one of many activities that are eligible to receive a share of program funding. Finally, there is a larger pool of federal programs, including Medicaid and Temporary Assistance for Needy Families (TANF), which may support specific home visiting services under broadly stated program authorities. In the latter case, the statute does not explicitly focus on home visiting initiatives; rather, some or all of the activities provided under home visiting programs can be considered to be appropriate, allowable strategies for accomplishing the program's overall goals.

Many HHS programs have provided funding to support home visiting programs, including: Medicaid (Title XIX of the Social Security Act); the Children's Health Insurance Program (CHIP, Title XXI of the Social Security Act); TANF (Title IV-A of the Social Security Act); Child Welfare Services (Title IV-B, subpart 1 of the Social Security Act); Promoting Safe and Stable Families (Title IV-B, subpart 2 of the Social Security Act); the Community-Based Child Abuse Prevention Program (CBCAP, Title II of the Child Abuse Prevention and Treatment Act, CAPTA); Early Head Start (Head Start Act); the Social Services Block Grant (Title XX of the Social Security Act); the Child Care and Development Block Grant (Title IV-A of the Social Security Act and the Child Care and Development Block Grant Act); the Community Services Block Grant (Community Services Block Grant Act); the Maternal and Child Health Block Grant (Title V of the Social Security Act); Healthy Start (Section 330H of the Public Health Service Act); and the Adolescent and Family Life Care Demonstration Grants (Title XX of the Public Health Service Act).[30]

ED programs that support home visiting have included: programs under the Individuals with Disabilities Education Act (Part C); Even Start (Title I, Part B, Subpart 3 of the Elementary and Secondary Education Act); Education for the Disadvantaged (Title I, Part A of the Elementary and Secondary Education Act); and the Parental Information and Resource Centers (PIRC, authorized in Title V, Part D of the Elementary and Secondary Education Act).

In addition to HHS and ED, several other federal agencies have provided financial support for home visiting programs. Among these are the Office of Juvenile Justice and Delinquency Prevention (OJJDP) at the U.S. Department of Justice, which supports home visiting through programs such as Safe Start;[31] the Corporation for National and Community Service, which supports home visiting through AmeriCorps

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[30] CRS consulted many sources, including: Healthy Families America, "How are Healthy Families America Programs Funded?," 2002; and Kay Johnson, *No Place Like Home: State Home Visiting Policies and Programs*, Johnson Consulting Group, Inc. with support from The Commonwealth Fund, May 2001 (hereinafter *No Place Like Home*, 2001); Steffanie Clothier and Julie Poppe, *Early Care and Education State Budget Actions FY2007 and FY2008*, National Conference of State Legislatures, April 2008 (hereinafter Clothier and Poppe, *Early Care and Education*, 2008).

[31] See information on the Dayton, OH, Safe Start community, which uses a Nurse Family Partnership model (as well as other intervention strategies) at http://www.safestartcenter.org/pdf/safestartbooklet.pdf.

programs;[22] and the Department of Defense, which funds home visiting efforts as part of its New Parent Support Program for families with children ages 0-3.[23]

State and Local Funding Sources

State level funding sources for home visiting include state general revenues, TANF maintenance of effort (MOE) funds, and state funds allocated to match federal grant programs.[24] One study published in 2001 found that 44 percent of the reported home visiting program budget dollars came from state revenues.[25] In addition, programs often tap into state tobacco settlement dollars to support home visiting programs. This may be due to fortuitous timing, as the tobacco settlement of 1998 awarded funding to 46 states at a time when home visiting programs were rapidly emerging across the country. The tobacco settlement required five tobacco manufacturers to make annual payments to states (allocated by formula) in perpetuity. Approximately thirteen bills were then enacted by state legislatures targeting children's services with tobacco settlement funds, and home visiting organizations have encouraged programs to tap into these resources when seeking state funds.[26]

While federal and state sources typically provide the largest contributions to program budgets, local public funds (such as county taxes or school funds) and private funds (such as those from charitable foundations) also support home visiting efforts.[27]

Funding Sources by Home Visiting Model

While most home visiting programs are funded by multiple sources, the breakdown of funding sources appears to vary by program model and, in some cases, has varied within program models over time.

A 2004 Healthy Families America survey, for instance, found that 54% of program funding came from the federal government, 38% came from the state, and 8% came from local sources.[28] This is a switch from 2002 and 2003, when HFA survey data suggested that higher contributions came from state, rather than federal, funding streams. In 2004, the bulk of federal funding for HFA programs came from TANF (86%), with smaller contributions from Title IV-B programs, CAPTA,[29] and other federal sources. This also represents a switch from prior years. HFA data indicate that in FY2003, the sources of federal funding were more balanced, with Title IV-B programs representing about 35% and TANF accounting for about 28% of total federal funding.[30] Results from these annual HFA surveys also suggest that funding for HFA

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[22] Data in the HIPPY 2005-2006 End-of-Year Report indicate that 35 HIPPY sites received federal funding from AmeriCorps in that year.

[23] See an overview of the New Parent Support Program on the military homefront online at http://www.militaryhomefront.dod.mil/portal/page/mhf/MHF/MHF_HOME_1?section_id=20.40.500.420.0.0.0.0.0.

[24] See Johnson, *State-based Home Visiting*, 2009, pp. 10-11; Johnson, *No Place Like Home*, 2001, pp. 12-13; Laura Galbraith, *Proactive Funding Strategies for Home Visitation: A Resource for Counties*. National Association of Counties and Healthy Families America, 2007, pp. 9-10 (hereinafter Galbraith, *Proactive Funding*, 2007).

[25] Johnson, *No Place Like Home*, 2001.

[26] Galbraith, *Proactive Funding*, 2007.

[27] Johnson, State-based Home Visiting, 2009.

[28] Healthy Families America, in general, includes responses from 33 of 45 states, with a site sample of 398. See http://www.healthyfamiliesamerica.org/network_resources/hfa_state_of_state_systems.pdf.

[29] Although this HFA document does not specify this, CAPTA funds are most likely those provided under Title II of that Act as part of the Community-Based Grants for the Prevention of Child Abuse and Neglect (CBCAP).

[30] See http://www.healthyfamiliesamerica.org/network_resources/hfa_state_of_state_systems.pdf. Note that FY2003 results are

(continued...)

programs has decreased over time, from nearly $296 million in FY2002 to almost $185 million in FY2004. Notably, results from these surveys represent only a subset of all HFA programs (due to a response rate of about 73%).

While survey data may provide useful insight into HFA budgets, they should not be interpreted as reflecting a comprehensive picture of HFA funding. Moreover, the results of these HFA surveys should not be generalized to other home visiting program models, as the sources of federal funding may differ across programs, depending on the program model's origin and primary focus. Healthy Families America, for example, was launched in 1992 by Prevent Child Abuse America (formerly known as the National Committee to Prevent Child Abuse)[31] with an explicit emphasis on preventing child abuse and neglect. Given this, it is not surprising that many HFA sites appear to receive more support from HHS human services programs (e.g. Title IV-B programs, TANF, CAPTA), while programs like the Nurse Family Partnership, by contrast, report significant support from public health programs at HHS (e.g., Medicaid, Maternal and Child Health Block Grant).

In fact, the original Nurse Family Partnership (NFP) trial study, launched in Elmira, NY, in 1978, was funded by the Maternal and Child Health Bureau at HHS.[32] In subsequent years, the Maternal and Child Health Bureau remained a common source of funding for NFP programs, though federal support grew to include the National Institutes of Health, as well as programs such as TANF and Medicaid. Recently, David Olds, founder of the NFP, reported during Congressional testimony that Medicaid was a growing source of funding for NFP programs, while the use of TANF funds was decreasing.[33] He indicated that states had used TANF funds more during the program's start-up phase, but that they now rely more on Medicaid funding. In his testimony, Olds also pointed to the Maternal and Child Health Block Grant as a common source of federal support for NFP programs.

In contrast to both HFA and NFP, Parents as Teachers (PAT) and Home Instruction for Parents of Preschool Youngsters (HIPPY) have both reported significant financial support from ED programs, such as Title I, Even Start, and PIRC.[34] For instance, the 2005-2006 HIPPY USA End-of-Year Report notes that 120 HIPPY sites received federal funding from ED programs, compared to only eight sites reporting federal support from HHS (this split is roughly consistent with data in prior year reports).[35] The Parents as Teachers model, meanwhile, originated largely due to support from the education community. PAT started in 1981 with a pilot project in Missouri, funded by the state Department of Elementary and Secondary Education and the Danforth Foundation. Four years later, the Missouri Department of Elementary and

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reported slightly differently in another HFA report (http://www.healthyfamiliesamerica.org/downloads/nsfg8.pdf). The other report also shows funding from CAPTA outstripping TANF, but the percentages vary, with CAPTA representing 38% and TANF representing 31% of federal funds in that fiscal year.

[31] Prevent Child Abuse America launched HFA in partnership with Ronald McDonald House Charities. HFA also credits the Freddie Mac Foundation with being instrumental in supporting ongoing development of the program.

[32] Andy Goodman, *The Story of David Olds and the Nurse Home Visiting Program*, Robert Wood Johnson Foundation, July 2006.

[33] See the testimony of David Olds, in U.S. Congress, House Committee on Ways and Means, Subcommittee on Income Security and Family Support, Health Care for Children in Foster Care, hearings, 110th Cong., 1st sess., July 19, 2007, H-Hrg. 110-(Washington: GPO, 2007). http://waysandmeans.house.gov/hearings.asp?formmode=view&id=7147

[34] Wasserman, *Implementation of Home Visitation*, 2006. On page 3, Wasserman notes that PIRC grantees are required to use a minimum of 30% of their awards to establish, expand, or operate early childhood parent education programs such as PAT and HIPPY.

[35] HIPPY USA End-of-Year Report, 2005-2006 at http://www.hippyusa.org/site/view/136428_HIPPYEndofYearMISReport.pml.

Secondary Education had expanded the PAT program to all school districts across the state. Today, more than 160 Local Education Agencies (LEA) are using Title I funds from ED to support PAT programs.[36]

[36] See PAT Fact Sheet at http://www.parentteachers.org/ut/Ut%7B00812ECA-A71B-4C2C-8FF3-8F16A574GEEA%7D/PAT%20and%20Title%20I%20ARRA.pdf

Mr. LINDER. The bill before the Committee, we are told, will cost about 2 billion dollars over 5 years. The proposal in the Obama budget would cost 9 billion dollars over 10 years in just Federal funds for this new program.

Today, the President is going to speak on urging us to pay for all new entitlements. So can anyone tell us how we are going to pay for this?

Mr. Chairman? Mr. Davis? Do you have offsets?

Chairman MCDERMOTT. Are you asking us or are you asking the witnesses?

Mr. LINDER. I am asking you how it is going to be paid for.

Chairman MCDERMOTT. My policy basically, Mr. Linder, is this: One should decide what good public policy is and once you have decided what good public policy is, then you decide how you are going to pay for it.

I think what we are trying to do here today is determine, what is the best public policy. And you are correct, finding the money for it is going to be a real problem.

Mr. LINDER. Dr. Brooks-Gunn, can any of the money in this program be used for anything else? Can it be used for drug treatment? I assume you read the proposal. Is this a mandate for just nurse visitations, if the State has a bigger problem in another area, can it be used there?

Ms. BROOKS-GUNN. I think the State options—you guys are the ones that will have to decide if there is some State——

Mr. LINDER. Flexibility.

Ms. BROOKS-GUNN. Flexibility, thank you. Flexibility in terms of how the money is spent now.

Mr. LINDER. There isn't now?

Ms. BROOKS-GUNN. At the moment, most home-visiting programs, because of the cost, do not offer drug treatment, although people certainly try to link up their clients with what might be available in their community for mental health services and for drug treatment services.

Mr. LINDER. Thank you.

Thank you, Mr. Chairman.

Chairman MCDERMOTT. My question is this, and it really comes off what John has said. And I read all your testimony before you came in; and I want you for 1 minute to think about the perfect program and what it would look like.

Because as I look at it, you can do prevention, you can sort of say there is a high-risk bunch over there, let's focus on them; or we can sort of, one, look for the ones like Ms. D'Aprix, who have had some problems and put their hand up and said, I am high risk—there are a lot of different ways to go at this.

And are you looking at first-time mothers?

If you had limited dollars, where would you put the program and what would it look like? I would like to hear as much as you can give me, so you can start anywhere.

Anyone want to put their hand up and go on that?

Ms. DARO. Never shy.

I think if I were starting with some dimensions, I would certainly begin to look during pregnancy, begin to—and do a systematic risk assessment, not necessarily use demographic markers for this, because I think—as we heard from Cheryl's testimony—using the demographic markers is going to miss a number of women that are facing significant challenges.

So it would be prenatally. Remember, these programs are all voluntary. So you need to present them in a way that is most welcoming and encouraging for families to come forward. So I would start with the systematic assessment at all prenatal clinics. I would engage OB–GYNs so they were asking a set of questions when women came to them and then make this service available to people.

Again—I think I have outlined the parameters of what a successful program would look like, but the idea of targeting simply on demographics, I think does a great disservice to the nature of the problem and to the nature of our ability to really reach those families that are most challenged.

Chairman MCDERMOTT. How would you—I will leave the question alone for a second.

Go ahead, Dr. Gunn.

Ms. BROOKS-GUNN. I would probably start with the first-time and young mothers, because I think that is a group at most risk.

Chairman MCDERMOTT. Is your microphone on?

Ms. BROOKS-GUNN. Yes, it is on.

I would actually target first-time and young mothers. That is the group that is most at risk, and programs such as these ones that we are discussing today are most likely to make an impact overall on that group of mothers. Consequently, I like the way the bill has focused on that particular group of mothers.

It doesn't mean other families might not be at risk. But it is a group that on the aggregate is more at risk than probably any other group.

Again, the education of the mother and the school readiness of the children is for both generations. My ideal program would focus on both generations. That is why I would love to see some experimentation in States, in terms of combining home visiting with child care services, and/or combining home visiting with some of the new approaches that are being tested right now to help moms go back to school or stay in school.

Chairman MCDERMOTT. Do you know any program that has had any kind of positive predictive capacity to pick out child abuse situations before they happen?

Ms. DARO. The Healthy Families America model has a screening tool that they use for assessing risk. It examines a variety of conditions such as asking if the mom used prenatal care perhaps, or if she is under a great deal of stress.

When they follow these families forward, the families with the highest number of stresses and risks during pregnancy, by the time they give birth, are far more likely to show up in child abuse reporting systems.

I will just say, to follow up on what she said, when we look at families reported for child abuse, we look at the proportion of the population of those children coming into child welfare. It is not necessarily the first-time, teen moms that show up in child welfare. It is the woman who is in her 20s, who is having her second or third child. Those were the big welfare users; those are the families in the child welfare system.

You should not limit the program only to first-time parents. It is great if we catch them when they are first-time parents, but if

we missed them and there is no other option on the table to provide services. We know that a second and third child just adds to the stress of the family situation.

Chairman MCDERMOTT. Ms. Sprinkle, you are out in the field. What would be the ideal program to deal with what you have seen?

Ms. SPRINKLE. Chairman McDermott, I don't think there is——

Chairman MCDERMOTT. Your microphone is not on.

Ms. SPRINKLE. I don't think——

Chairman MCDERMOTT. Just swallow it.

Ms. SPRINKLE. My experience, I don't believe that there is one home visitation program that fits all the needs of families.

Programs that have been proven to be effective and have long-term impacts are where I would place my emphasis and at the same time recognize that there are multiple families out there who are not first-time parents. If you really want to make a positive impact on preventing child abuse and neglect or reducing it, you must catch the first-time parent and teach her what is happening with her body and the ways to cope with the stresses in her life and to put her in touch with resources to reduce some of those stressors.

I agree with you that education is very important. Education is the key out of poverty in my estimation. So, if you can provide wraparound services or support services to those first-time moms and help her get connected or attached, if you will, during pregnancy, then she is less likely to be abusive to her child because she will understand or have been taught what to look for when she is stressed and how to support and nurture a child who is difficult to console.

Ms. SHARP. I would like to add a note.

I think it is important that we keep an R&D function associated with these programs so that we can build the pipeline of programs that can eventually get the research and evaluation to establish their effectiveness. I agree otherwise with these other commentators.

Chairman MCDERMOTT. Thank you.

Dr. Boustany.

Mr. BOUSTANY. Thank you, Mr. Chairman. Listening to all of you and having read the testimony, I gather that programs administered by nurses seem to be more effective than programs administered by those who are not nurses. Is that correct, based on current literature?

Ms. SPRINKLE. I can only share what my experience has been with Nurse-Family Partnership. Dr. David Olds, before doing the randomized clinical trials of which there were three across three different decades using three different ethnic groups—Caucasians in Elmira, New York; African Americans in Memphis; and Hispanics in Denver, Colorado.

He did a focus group, if you will, asking potential participants or Members in a community who would be most trusted in terms of letting you into their homes, and overwhelmingly it was nurses. Nurses have the trust of the community and are seen as nurturing individuals who were there to support them and have the medical and scientific knowledge to support them during such a critical time in pregnancy.

Mr. BOUSTANY. Do you all agree with that?

Ms. SHARP. I will make a quick comment, and I would just like to say that certainly nurse-delivered programs have been proven very effective.

I will just reiterate the point in my testimony which is, many programs have not had the opportunity to have the same level of rigorous evaluation. So I think that there is some evidence still out on that issue.

Mr. BOUSTANY. Thank you.

Dr. Brooks-Gunn, did you want to comment?

Ms. BROOKS-GUNN. Yes.

If we can expand to other countries besides the United States, my read of the literature is that what is important is a professional, not necessarily a nurse. It depends on the goals of the program.

The Nurse-Family Partnership has very specific goals, and so the nurse makes sense. But I think that there are demonstrations in the literature where social workers, educators, folks with B.A.s with terrific training can have some of the impacts that we want to see.

My read of the literature is that the paraprofessionals—in general, those are the programs that are least likely to succeed.

Mr. BOUSTANY. Thank you.

Dr. Daro.

Ms. DARO. I would just add that we don't have to go overseas. There are evaluations here in the United States. New York State—the last time I checked, it was in this country—has had success with paraprofessionals. A lot of the success of the paraprofessionals, though, hinges on the quality of training they receive and the supervision they receive.

So it is not sufficient to say what is the characteristic of the provider, it is the way you embrace—surround that provider with certain supports; and I think with certain support, they certainly can be effective.

Mr. BOUSTANY. I gathered from reading your testimony that there are a number of programs that are of questionable effectiveness; others have been shown to be very effective. And it seemed to me that programs administered by nurses had a more proven track record, or at least more consistent track record.

Would you want to comment on that?

Ms. DARO. With the outcomes—as Jeanne noted, if the program is designed toward certain outcomes, such as the Nurse-Family Partnership, nurses may be effective, but their own randomized trial comparing nurses and paraprofessionals found some mixed results.

There were actually some outcomes where the paraprofessionals did better by the time the child was 4—areas like maternal employment, areas like enrolling a child in an early education program. Those are important outcomes to consider when we are thinking about long-term potential savings.

Mr. BOUSTANY. I know our Ranking Member talked about the cost and how all this would be paid for, given the current deficits. There was also another cost factor in all this that I don't think has been discussed, particularly if we are looking at nurses. That is the

acute nursing shortage we have in this country and given current circumstances.

So if we expand with a new entitlement program that is going to be heavily reliant upon nurses, then there is going to be the expense of getting more nurses available and trained to do this. I am not sure if that is included in the cost analysis that has been provided.

I don't know if you want to comment on that.

Ms. BROOKS-GUNN. That is one reason that many of us want to see some experimentation with different programs. So, as an example, we have a grant pending at NIH—we will see if we get it—to take the nurse home visiting model and have nurses come into the home two or three times over the 3 years and then have folks with a B.A. delivering the services. The idea was to get what you get from a nurse home visiting program, but make it cheaper so that a nurse—we want to leverage it. And this is something that—again, as the field evolves, we have to keep looking to see what makes sense.

To me and David Olds, who is going to help us with this, this seems like a really good bet to see if this would work. But stay tuned.

Mr. BOUSTANY. One last question if you don't mind.

There are a lot of different programs out there, a lot of different funding sources. Given the variation in effectiveness, has there been any systematic look at some of these programs that are really not effective? How do we combine resources rather than create a whole new mandatory spending program?

Ms. DARO. The way the legislation is crafted, which is actually very instructive and very useful, is to direct States toward investing in stronger and stronger program models as the legislation goes forward; and I think that is important. I think States themselves, local communities as a field, we need to be able to recognize those programs that are not working and then move them off the plate so those resources can be invested in programs that have stronger evidence.

Mr. BOUSTANY. Before increasing spending again in a new mandatory spending program, shouldn't we look at the current resources and try to make a more efficient use of those?

Ms. SHARP. I would like to state, as someone responsible for administering public dollars, that we did in fact cut funding from programs in our State based on lack of performance; and I think a responsible administering entity would be looking at those—this is after some attempts were made to make sure they had the capacity—and build the capacity to be able to deliver programs effectively. When that became—when it became clear that was not going to be the case, then we were able to remove funding based on these performance-based contracts.

Mr. BOUSTANY. How many programs did you eliminate?

Ms. SHARP. A relatively small number of the total portfolio and in some cases it was an issue at the community level in terms of local capacity to continue to come up with the resources to match our dollars.

But there are also just some straight-out not delivering program with fidelity to the model, as a matter of fact, being—straining far

afield and those are the kind of things that a funder or administrator would want to make sure they were looking at along with the data about the outcome.

Chairman MCDERMOTT. Mr. Davis of Illinois will inquire.

Mr. DAVIS of Illinois. Thank you very much, Mr. Chairman.

You know, as you were making your earlier comments, I was reminded myself of the fact that you did go to medical school in Illinois; and that perhaps is one of the reasons that I was in agreement with your comments. Let me thank you for your leadership on this as well as a number of issues that relate to the well-being of children and ultimately to the well-being of our country.

I have always believed that all of us are the sum totals of our experiences. I have spent at least 500 home visits with visiting nurses, with community health aides, with nurse practitioners, with individuals in training to become nurse practitioners; and I agree with you, Ms. Sprinkle. I don't think that there is any one set of individuals who necessarily get the information or see certain kind of needs or can make use of those needs in such a way that we ultimately reduce the likelihood that children growing up or that their families are going to cost society more than they would if we provide these services to them.

My question is, based upon each one of your experiences, who do you think are the people that are most likely to make use of this program and these services once we pass the bill, find the money, and get it established? Who are the people who are going to make use of it?

Perhaps we will just begin with you, Ms. Sharp.

Ms. SHARP. Okay, I will start with that. My read of the literature and understanding of the program services, one issue becomes very clear and that is the issue of engagement. If families, if individuals, families, moms, dads, are not brought into the program consistent with the values within the program, in other words, respect and honesty, all those other things that go along with this, then you are not going to have success in the program by any measure because engagement is a critical part of that and retention is the other side of the engagement process. So I think the programs, all of these programs, are challenged by those issues of reaching out and finding the people who would have the greatest benefit.

But I do trust the local implementers of these programs to know their communities well enough to be able to reach deeply into the community to find those with the greatest need who would experience the greatest benefit.

Mr. DAVIS of Illinois. Dr. Daro.

Ms. DARO. You know, having done several surveys on the idea of the social exchange process, people are twice as likely to offer help as they are to ask for help. So one of the things we have to do with voluntary prevention programs is create a context in which parents are comfortable asking for help.

So who should ask for help? I think parents that have questions about their own capacity to care and meet the needs of their child, a first-time parent that may not have the information they need or the knowledge available in how to nurture and support that child or meet just basic care conditions, families that are going through

some particular stress in their own lives, women that are concerned about their own safety. There is a whole constellation of issues that need to be brought to the table.

But I would put the responsibility on both creating a context in which an offer of assistance will be receptive to someone hearing this and then make it broadly available. Let people know, again, starting at pregnancy through birth. Many of the programs that have been most successful in reaching high-risk families do a universal offer of assistance, a universal visit, if you say while women are in the hospital delivering, outlining a set of conditions, and again making that offer available to them.

Mr. DAVIS of Illinois. Dr. Brooks-Gunn.

Ms. BROOKS-GUNN. My answer is similar to Dr. Daro's.

Mr. DAVIS of Illinois. Ms. D'Aprix.

Ms. D'APRIX. From a personal perspective, I don't think there is a parent out there that doesn't want to learn, that doesn't want to experience someone supporting them, whether it is your first child, your second child.

I visit with a family who now is on their sixth child, with two sets of twins under two, and really asking for support. And through the temp assessment we partner with every doctor's office, every hospital so that we can be there and available to offer services to every family.

Mr. DAVIS of Illinois. Ms. Sprinkle.

Ms. SPRINKLE. I think the families that benefit the most from this type of intervention will be those families from low income, vulnerable populations who don't have the advocates in place or the resources needed to ask for assistance or even know to ask for assistance. So increasing an awareness of services that are available to them in the community will make great strides in getting families the services that they need.

Mr. DAVIS of Illinois. Thank you, Mr. Chairman.

Chairman MCDERMOTT. Thank you.

Mr. Roskam from Illinois.

Mr. ROSKAM. Thank you, Mr. Chairman; and thank each of you for your time today.

And, Ms. D'Aprix, thank you very much for sharing your journey. It is helpful, and it is insightful.

As we are sitting here listening, I am reminded of my older brother who has no discernment when it comes to movies. You call him up. "Steve, should I go see this movie?" "Oh, yeah", he says. "It is great. You will like it". You go see it, and it is not very good. And you call him up later and you say, "I thought you said this was good;" and he says, "well, it was entertaining." He has no discernment whatsoever.

You call my wife and say, "should I see this movie?" And she says, "no. No magic, no plot line. They ran out of money. They ended it too fast. Don't waste your time."

So as I am here today, I am trying to discern, are you more like my brother or are you more like my wife? The question is a serious one. Because here you are, three of you. You all gave great testimony. Three of you sort of hit a particular theme, and I stopped writing down the number of times that you referred to an evi-

dentiary threshold or peer review or those sorts of themes. And that was you, Ms. Sharp, and you, Dr. Daro, and you, Ms. Sprinkle.

Implicit in your testimony when you use an evidence-based argument is that there are programs that you have looked at in this environment where you have said, "That is a loser. We are not going to do that."

You mentioned a minute ago, Ms. Sharp, that there was a program or some kind of de minimis program—I am putting words in your mouth a little bit—but some that stuff because of a local match you kind of waived off on. But I guess, Dr. Daro or Ms. Sprinkle, are there programs that you have looked at in this arena and you just said, "This is not going to cut it?" I will get to you, because I sense you have got something to say.

Ms. DARO. There certainly are. I think there are programs that are not well conceived. They are going to accomplish everything in the world with the family. What are these programs offering? They claim they can accomplish these broad outcomes with three home visits. That is a no-brainer for me. It is not going to happen.

So I think you can look at the internal consistency of a program, their logic model, I think; and then you look at outcomes. If time and time again they can only engage a handful of the people they want to bring into the program, they only retain people for a fraction of the time they want to keep them, I think that kind of ongoing data management should begin to tell you this program needs to go back and retool. It is not ready for prime time.

And there are, unfortunately, a number of programs that just crop up. We call them homegrown programs. They are not attached to any of the national models. They just exist because somebody thinks it is a great idea.

I think in this environment we can't fund everybody's great idea. We need to be able to pull the plug.

Mr. ROSKAM. Thank you.

Ms. Sprinkle.

Ms. SPRINKLE. I am supportive of programs that will improve lives of families in general, particularly low-income minority families, because we know that they are at risk for the worst outcomes in terms of economics and health.

Most certainly you want to put your resources where you are going to get the greatest benefit, those programs that have a data tracking system, that look at client characteristics, that look at the quality of the home, that look at content and have a curriculum or protocol with the desire and intent to make a positive impact outcome.

Mr. ROSKAM. I don't want to cut you short. I want to refocus you on this question. Have programs come across your desk that are home visitation programs that have those characteristics that you have looked at and you said, " we are not going to do that?" Or have you liked every home visitation program that you have heard about?

Ms. SPRINKLE. My experience has been exclusively with Nurse Family Partnership.

Mr. ROSKAM. Thank you.

Ms. Sharp.

Ms. SHARP. I did want to get back to your question about being more like your brother or your wife.

Mr. ROSKAM. Choose well.

Ms. SHARP. And I guess think of me as your sister-in-law.

Mr. ROSKAM. Fair enough.

Ms. SHARP. Yes, we have definitely come across programs that we did not find the evidence persuasive as to their effectiveness, and we did not include them on the list of those that we would fund. And we are committed to reviewing the literature and new evidence as it comes along, but clearly there are some programs that may even do harm.

Mr. ROSKAM. One quick final word. Ms. Sprinkle, you mentioned that, in that example of the 14-year-old that you gave, that there were people that the family had reached out to that weren't willing to help. And I guess part of the concern that some of us have is how do we direct programs that are actually getting toward that particular need? So implicit in that is that some program is failing this family, right? A well-intentioned, good program is failing this family. I am going to share with you one quick quote, and it is from President Obama's inaugural speech.

He said, "The question we ask today is not whether government is too big or too small but whether it works. And where the answer is no, programs will end."

In closing, our challenge, in light of the President who tells us that we are broke, is how do you properly allocate resources? How do we all properly allocate resources so that those families that really need the help are helped and that there is not a great deal of waste? I think that is what Dr. Boustany was driving at, taking a step back, looking at the totality of these programs and trying to move forward where there is a great deal of consensus.

I think my time has expired.

Chairman MCDERMOTT. Since we have good experts here, I thought we would go a second round, if anybody would like to.

Mr. Davis.

Mr. DAVIS of Illinois. Thank you very much, Mr. Chairman. I had a couple of additional questions.

I guess part of my experiences have been that I am old enough to remember when a lot of things didn't really exist. Physician assistants, I happen to have been a Member of the new career section of the American Public Health Association when many of the ancillary groups who now provide certain kinds of services did not exist.

I wanted to ask two questions. Dr. Daro, I wanted to ask you, we have talked a great deal about stable funding. Although I agree with Chairman McDermott, if we come up with good social policy, then we can determine how to get the money once we decided that it is good. But why is a stable funding stream so important in the development of a program like this one?

Ms. DARO. I think when you are talking about investing in newborns and their parents and you are trying to do it on a scale large enough to impact the population-based indicators that most distress you, like reducing child abuse, like making sure children arrive at school ready to learn, families need to know that this isn't a program that is going to be here today and gone tomorrow. They need to know that it is going to be here for them when they have

their first child or their second child, that they can refer their neighbors to it.

And too often programs that are quite good—I mean, one of the problems is it is not just poor programs in the marketplace, it is good programs in the marketplace that have way too many families that they can't possibly reach or serve. It is good programs in the marketplace that lose their foundation funding so they have to close their doors. That does a disservice to the communities, and that is why the stable funding is so important.

Mr. DAVIS of Illinois. So we talk a great deal about these things but do them much less. I mean, I was saying that after all is said and done, more is generally said than done. So there is a lot of conversation, not movement to the action.

My last question, Ms. Sprinkle. I notice that you placed a great deal of emphasis on low-income people. Why did you place so much emphasis, on low-income, disadvantaged individuals?

Ms. SPRINKLE. Low-income, disadvantaged individuals typically don't have the advocates needed to help them get the resources to meet their needs.

My experience, growing up here in Washington, D.C., within walking distance from the Capitol here is an experience in which I grew up in a low-income environment; and those are the families that can benefit greatest from this type of service.

Mr. DAVIS of Illinois. So you are saying that if we don't create special attention for these individuals for as long as they live, as long as their children live, and as long as their population group lives, they will still be low-income, disadvantaged people?

Ms. SPRINKLE. When families are presented a program that helps meet their needs, hopefully it breaks the cycle of poverty and has a positive multi-generational impact.

Mr. DAVIS of Illinois. Thank you very much.

Thank you, Mr. Chairman.

Chairman MCDERMOTT. Dr. Boustany.

Mr. BOUSTANY. Ms. Sprinkle, are the nurses in your programs RNs or LPNs or both?

Ms. SPRINKLE. The nurses in the Nurse Family Partnership are registered nurses, predominantly baccalaureate prepared registered nurses.

Mr. BOUSTANY. My son is a counselor. He does home visits. He finished with a master's degree and jumped into one program, and it was very disorganized. A lot of people were quitting. There was no continuity of care with the families. He went to another one, the same sort of thing. Now he is doing something different in counseling, but he was very frustrated. He said, "We are not going to make a dent in any of this because we are not measuring outcomes properly."

The continuity issue is a real problem. There was just no structure to any of the programs. I was thinking, "Okay, that is two programs in my home State of Louisiana, a lot of it being funded by Medicaid dollars." States are struggling with their budgets across the country. How many more of these kinds of programs are out there, and how do you root them out? You talked about having a way of doing it in your home State. But are the other States equipped to do this? Are they doing a good job?

Ms. SHARP. I guess I would just like to add that our ability to sort through and make these performance-based contracts work, along with the capacity building, goes back 20 years to our focus on outcome-based evaluation. We felt that, as a funder, our best value add for these local organizations was to help them understand how to be outcome-based and to know how to measure and report those results. And so that has been the key to their sustainability.

So it is part of our learning organization way of doing business to sort of focus on those kind of things. And those can—while it sounds very specific to a reporting process, it actually is what builds the organizational capacity to deliver programs with effective service delivery models.

Mr. BOUSTANY. Thank you.

I know Senator Moynihan has talked about all this back in the seventies, and breaking this cycle of poverty is something I am certainly interested in. I have got a high degree of poverty in my district. I am frustrated because it seems like we throw a lot of money into programs, but we never weed out the bad ones, consolidate the good ones, and focus the resources, as my colleague, Mr. Roskam, was saying earlier.

I guess I have one final question, in the spirit of Father's Day, which is approaching. What share of households have the fathers in the picture in this? And can you talk to me about some of the best practices of what is happening there?

Ms. DARO. Almost all of the models now have explicit instructions to visitors when they go in the home to engage as many as they can. And I think the Nurse Family Partnership does a wonderful job with fatherhood. I know Healthy Families America does as do many of the other programs that are out there. I mean, people recognize that dads are a big part of the picture, and they need to be there at the beginning, hopefully engaged in the pregnancy, if at all possible.

Mr. BOUSTANY. Thank you.

Ms. BROOKS-GUNN. The best way to do that, actually, could be programs that really start in the hospitals. We talk about the magic moment, and that is when the child is born. And you can often get fathers very engaged at that point whether or not they are in the household or they are living elsewhere.

Ms. SPRINKLE. In my experience working in Greensboro, North Carolina, operating a Nurse Family Partnership program, we had a fatherhood component where the services were designed exclusively for the dad, to get him involved in the life of the child early on; and you can see the positive impacts it has on the child when the dad is involved, if not physically present in the home, emotionally present in the child's life in a positive way.

Mr. BOUSTANY. So you do make efforts to reach out when the dad is not in the home to make contact with him? And so that is, in effect, a separate visit, or at least phone calls?

Ms. SPRINKLE. He can be included in the visit during the time of the home visit in Nurse Family Partnership. There are some programs that are specifically designed to serve fathers outside of that relationship with the mother, because they have their own needs and resources.

Chairman MCDERMOTT. If the gentleman will yield, Ms. D'Aprix, you are sitting there rocking your head, but you are not saying anything. Come on.

Ms. D'APRIX. I am. We have a fatherhood program within the Starting Together Program for Madison County. When we go out to visit a family for the first time, we take the information about him; and we set up a visit for the family to meet with him. And that is every single family.

Mr. BOUSTANY. What kind of outcomes are you getting with trying to get the father involved? Do you have some metrics on that? I mean, success rates? Is the trend good or bad or neutral?

Ms. SPRINKLE. Nurse Family Partnership has been able to demonstrate a 46-percent increase in fatherhood involvement within the Nurse Family Partnership program.

Ms. SHARP. I will have to get back to you on that one.

Ms. BROOKS-GUNN. It is going to have to be anecdotal. There is not much in the literature about what is happening to the father as a function of home visiting programs.

Mr. BOUSTANY. Should that be part of the metrics, though?

Ms. SHARP. I mean, it goes back to my point about building the pipeline. Because we are funding some very exciting programs that are showing very strong outcomes related to father engagement, et cetera. But they are not at this point evidence-based programs.

Chairman MCDERMOTT. Thank you.

I would just close by saying in my training back in 1965, the Mental Health Act had passed in the U.S. Congress and the first mental health centers were opening across the country of Illinois, the money went—in every State, it went to the Governor, except in Illinois. Mayor Daley got a chunk of it.

I was at the University of Illinois, and it was there where we started the first mental health center in the Woodlawn area south of the University of Chicago. It was an area that was troublesome to the Mayor; and he said, well, what they need is a mental health center. So they sent a group of us down there to start a mental health center in the Woodlawn area.

And when they got together with the community, they said to them, what do you want this mental health center to do? And they said, well, it is over for us as adults, but we care about our kids. We want this mental health center to focus on the kids.

And we did research for a number of years there around what affects school performance and how kids do and so forth. And getting the parents involved and actually going up to school and actually seeing what the kids did really was the most effective thing, because suddenly they knew their parents cared about what was going on.

That research was done 1965, 1966, 1967, 1968. I don't think there has ever been a program funded off of it. And what a struggle I think our Subcommittee has is to figure out which one of these evidence-based programs or how we should put the money out there so that States will look at it in that way that that is—we ought to take things that have already been researched and implement them and give them a solid funding base, which is really what Mr. Davis is talking about. We start them, stop them. And one gets going and looks good and then we defund it.

So I think that is what the Committee on both sides of the aisle is really looking at, it is how can we figure out where the best place to put the money is and actually fund things that we know have had positive effect. So I am thankful and we are all thankful for your coming here and spending the time trying to educate us and we will see what works out in the future.

Thank you. The meeting is ended.

[Whereupon, at 11:27 a.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]

Statement of Alice Kitchen

My name is Alice Kitchen. I am a social worker and the Principal Investigator for the Team for Infants Endangered by Substance Abuse (TIES) sponsored by Children's Mercy Hospitals and Clinics in Kansas City, Missouri. We strongly support passage of the Early Support for Families Act (H.R. 2667) because we too have experienced and documented the impact of home visitation on mothers, infants, and young children.

TIES has been in existence for over 18 years, with most of those years having been funded by the Administration of Children Youth and Families Children's Bureau Abandoned Infants Administration. TIES is an intensive in-home intervention program serving high risk parenting women abusing drugs and alcohol while pregnant or after delivery in the urban Kansas City, Missouri area. Our support for this federal legislation is based on our years of experience that adds to the body of experience and research stated in the legislation. Our experience provides evidence that early childhood community based in-home interventions are effective tools for not only reducing out of home placement and child abuse/neglect but providing skill building in the areas of parenting, reducing drug use, promoting physical and mental health, securing economic stability, and maintaining housing.

The TIES evaluation was conducted by the Institute for Human Development (IHD) affiliated with the University of Missouri-Kansas City (an Applied Research and Interdisciplinary Training Center for Human Services) led by Kathryn L. Fuger, Ph.D. and her team. TIES has been a grant awardee for four cycles of four years through the U.S. Department of Health and Human Services Children's Bureau Abandoned Infants Assistance Program, Grant # 90–CB–0139/04.

Participants in the TIES Program were rated in five goal areas: (1) becoming drug free, (2) improving parenting, (3) accessing appropriate child health care, (4) gaining economic stability, and (5) maintaining adequate housing. The goal attainment for each of the five areas ranged from 1 (poor) to 5 (optimal) parenting outcomes.

TIES participants were rated initially (Time period 1), at 3 months after enrollment (Time period 2), at the child's age of 13 months (Time period 3), and at discharge (Time period 4). Participants showed gains in all five primary goal areas, with improvements reaching statistical significance in all areas except housing. The evaluation team findings include:

- Regarding the goal of becoming drug free, women initially were below the expected outcome. They improved consistently between Time 1 and Time 3 to reach the expected outcome level, with a slight decline at Time 4.
- Goal ratings on improved parenting increased from Time 1 to Time 2, and then remained at roughly the expected outcome level for the other time periods.
- Regarding the goal of providing children with health care services, ratings improved from the expected level initially to better than expected for all other assessment times. The majority of participants were rated above the expected outcome from 3 months until discharge.
- Regarding the goal of economic stability, only 13% of participants were at or above the expected outcome at intake, but significant improvement was seen in all analyses of change over time. Even with these gains, mean scores only rose to 2.4 on the 5-point scale when comparing those assessed at all four time periods.
- Goal ratings on the adequacy of housing for participating families ranged from very poor to very good each time period. By Time 3, some improvements in mean ratings occurred, but did not reach statistical significance. Of the 5 goals, it appeared that adequate housing took longer to achieve.

The level of engagement over time was a factor in the success of goal attainment, as seen by these statistically significant associations:

- Child health and housing ratings at intake were associated with the level of engagement with program staff at 3 months.

• The goal ratings of becoming drug-free, parenting, child health, and housing at 3 months and at discharge were associated with the level of engagement at 3 months.

• Parenting and economic stability ratings were also associated with the level of engagement at 13 months.

Relative caregivers tended to improve in child health care, economic stability, and housing as they progressed through the TIES Program and stabilized at discharge, suggesting they were providing a more stable, healthy environment for the children in their care. (E–3 Executive Summary, TIES Report to AIA, CB, DHSS, December, 2008)

Our experience is based on an intensive community based model using social workers in the role we call *Family Support Specialist*. The two most important ingredients that are essential for success are 1.) early intervention in the home, and 2.) a selection of high quality experienced professional staff who are comfortable in the setting and have strong social work skills.

As you can tell from the research findings, the social workers are very adept at establishing relationships with the mothers and using their interpersonal skills to draw out the strength in each mother and her family. Given the risk factors this population presents, this is an enormous challenge for any professional staff. Careful attention has been paid to hiring staff that are of the same ethnic population, have extensive experience in child welfare with our local population and have proven they are skilled and comfortable in a high risk environment. Social workers add value to this proven model in that their education and practicum go beyond developing skills in work with the individual, the families, and the community. Social workers start where the person/family is and help to empower the family members to develop their own strengths. Social workers also are expected to work simultaneously to change the environment and the policies that keep families from helping their children survive in highly toxic environments.

Our TIES complete December 2008 evaluation is available upon request. We will be pleased to assist in any manner we can to support the Early Support for Families Act (H.R 2667).

Witness Information:

Alice Kitchen, LCSW, MPA

Director of Social Work and Community Services

Children's Mercy Hospitals and Clinics

Statement of Children and Family Futures

Children and Family Futures thanks you for the opportunity to submit this written statement for the record of the June 9, 2009 Hearing on Proposals to Provide Federal Funding for Early Childhood Home Visitation Programs held by the House Committee on Ways and Means Subcommittee on Income Security and Family Support. Our comments reflect the views of our own organization and do not represent those of any of our funders or sponsors.

Children and Family Futures (CFF) is a non-for-profit organization based in Irvine, California. Our mission is to improve the lives of children and families, particularly those affected by substance use disorders. CFF consults with government agencies and service providers to ensure that effective services are provided to families. CFF advises Federal, State, and local government and community-based agencies, conducts research on the best ways to prevent and address the problem, and provides comprehensive and innovative solutions to policy makers and practitioners.

We thank the Subcommittee for its leadership in this critical area. Home visitation is a strategy for ensuring good parenting and preventing child maltreatment, and as research has demonstrated, appears to show considerable promise towards improving the well-being of low-income families and their children. The typical home visitation program involves a trained worker—a nurse or sometimes a paraprofessional—who visits families in their homes and provides parent education and support services. Sometimes the program begins during prenatal visits, in other cases it begins in the hospital after a birth or with a referral of an at-risk family. A recent publication on State home visitation programs summarized the approach:

Home visiting for families with young children is a longstanding strategy offering information, guidance, risk assessment, and parenting support interventions at

home. The typical "home visiting program" is designed to improve some combination of pregnancy outcomes, parenting skills and early childhood health and development, particularly for families at higher social risk . . . When funded by government, such programs generally target low-income families who face excess risks for infant mortality, family violence, developmental delays, disabilities, social isolation, unequal access to health care, environmental exposures, and other adverse conditions.[1]

This list of risk factors underscores an important question about home visitation programs: what problems do they screen for among target families and how do they intervene to improve outcomes in those problem areas?

The impact and co-occurrence of substance abuse

The impact of substance abuse on families with younger children is well-documented to have major effects on a significant number of these children and families, and to co-occur with other, closely linked problems, including mental illness, developmental delays, and family violence. One in eleven children—a total of six million—live in families in which one or more caretakers are alcoholic or chemically dependent on illicit drugs. Another group of children living with the effects of parental substance abuse are the estimated 500–600,000 infants who are born each year having been prenatally exposed to alcohol or illicit drugs. Only about 5% of them are identified at birth, and even fewer are referred to child protective services and removed from their families. Cumulatively, this means that nine million children and youth under 18 were prenatally exposed and are at risk due to that exposure and the co-occurring problems that accompany exposure.[2]

The omission of substance abuse

But despite their emphasis upon risk factors and prevention of poor outcomes, many home visitation programs de-emphasize parental substance abuse and prenatal exposure far below the relative importance of these factors. Several reviews of home visitation programs have cited the downplaying or omission of substance abuse as a risk factor. One recent summary of home visitation programs as they affect child maltreatment has a full chapter on substance abuse, which includes a detailed review of how home visitation programs tend to minimize substance abuse as an issue in working with families. The author concludes that most home visitation programs simply list substance abuse as one of many problems in a screening and risk protocol and refer clients out to substance abuse programs when they self-report.[3] This source documents the importance of screening for substance use disorders in home visitation programs by citing the literature that found that substance abuse is "a strong predictor for physical abuse and neglect, tripling the risk for later maltreatment."

Early home visitation services have rarely reported tailored or integrative service protocols for home visitors working with families also contending with substance abuse."... Home visitation programs still face a need to augment their intervention strategies to effectively address the ongoing and intertwining problems of substance and child abuse risk...[4]

Another recent evaluation of a widely used program in California concluded:

Moreover, substance abuse specific interventions have not been developed for use within this model. Indeed, when substance abuse is identified to occur, the individual is referred to a substance abuse provider in the community, or is denied from

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[1] K. Johnson (2009) *State-based Home Visiting: Strengthening Programs through State Leadership.* National Center for Children in Poverty. 3, 5

[2] The assumptions underlying these estimates include:

500–600,000: This is a conservative estimate based on recent prenatal screenings in multiple sites, as well as prevalence studies based on screening at birth. N. Young et al., (2008) *Substance-Exposed Infants: State Responses to the Problem.* National Center on Substance Abuse and Child Welfare, Irvine, CA. A May 2009 report based on the National Household Survey on Drug Abuse indicated that 19% of pregnant mothers used alcohol in their first trimester of pregnancy; projecting this number to the 2007 total of births would raise the estimate of prenatal exposure to 820,000 annually. Substance Use among Women During Pregnancy and Following Childbirth, SAMHSA May 21, 2009. http://oas.samhsa.gov/2k9/135/PregWoSubUse.htm

5% prenatally exposed identified: the 5% figure is the product of comparisons of infants reported to CPS in several jurisdictions to available data about overall prevalence of prenatal exposure [Orange County study: http://www.ochealthinfo.com/docs/public/2007–Substance-Expose-Baby.pdf; N. Young et al., op.cit.

6 million: National Household Survey on Drug Abuse, June 2003, *Children Living with Substance-Abusing or Substance-Dependent Parents,* SAMHSA. http://www.oas.samhsa.gov/2k3/children/children.htm

[3] Neil Guterman, (2001) *Stopping Child Maltreatment Before It Starts: Emerging Horizons in Early Home Visitation Services,* Sage Publications.115–120

[4] Ibid 120.

enrolling . . . if the substance abuser is not enrolled in a substance abuse program . . . Therefore, although the intervention components. . . appear promising, the investigators do not recommend its use for substance abuse issues.[5]

Finally, a review of home visitation outcomes concluded:

While many program evaluations show positive effects on primary prevention by improving daily reading, parent communication skills, discipline strategies, and parent confidence, fewer have shown impact on maternal depression, family violence, and substance abuse. Some limited success was shown with highly tailored models for specific concerns such as substance abuse, as opposed to multi-risk families. Opportunities exist to improve the training and supervision for home visitors, as well as to create enhanced interventions that engage and embed more highly trained professionals from the social work, mental health, or substance abuse fields.[6]

How can substance abuse be addressed?

Guterman sets forth four practice principles that would improve the capacity of home visitation programs to address substance abuse in greater depth.

- "Home visitors should routinely and sensitively assess the presence and role of substance and/or alcohol use and abuse early in their work with families."
- When substance abuse has been identified, home visitors should work to reduce the risks and harm on the developing child and family.
- "Home visitors must intensively and persistently orchestrate formal supports to maintain essential health, economic, and social supports" for substance-abusing mothers
- Home visitors should work with substance-abusing parents to develop informal support networks to reduce both substance and child abuse risk

Building on Guterman's comments and other reviews of HV as they address substance abuse, there are at least five critical questions in home visitation with respect to substance abuse:

1. As clients enter the program, is the possibility of substance abuse explored in depth through screening by trained staff using proven screening protocols?
2. If services begin with prenatal visits, are adequate screening tools used and followed up with adequate interventions when substance abuse is detected?
3. Is prenatal exposure a trigger for referring clients and establishing clients' need for prevention and treatment services?
4. Is substance abuse used as a factor to screen some clients out of the program?
5. Do clients who are less likely to enroll or be retained in voluntary services due to their substance abuse problems receive adequate engagement and retention efforts that address those problems?

What do current models do?

In determining what current home visitation programs do to address substance use, we reviewed information on four models in wide use throughout the country: Healthy Families America (HFA), the Home Instruction for Parents of Preschool Youngsters (HIPPY) Program, Nurse-Family Partnership, and Parents as Teachers. Early Head Start and the Parent-Child Home Program are also included in some listings of the most frequently adopted programs but were not part of this review.

In assessing how each of these home visitation programs seek to address substance use disorders, it is difficult to conclude how adequately the models accomplish this, since most of these models refer to substance abuse as one of a series of risk factors but do not provide descriptive details on how it is to be handled. Evaluations of these models are also of limited value, since substance use outcomes are not included routinely in most evaluations of the results of home visitation. It is also worth noting that sometimes these models are combined; for example, 136 Parents as Teachers sites are combined with HFA programs.

Healthy Families America (HFA)

The base model for HFA does not emphasize substance abuse; a summary of services content simply says:

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[5] Donohue, B., Romero, V., & Hill, H. H. (2006). Treatment of co-occurring child maltreatment and substance abuse. *Aggression and Violent Behavior, 11* (6), 626–640.

[6] K. Johnson op.cit, 15 A.Butz, et al. 2001. Effectiveness of a Home Intervention for Perceived Child Behavioral Problems and Parenting Stress in Children With In Utero Drug Exposure. *Archives of Pediatrics & Adolescent Medicine* 155(9): 1029–37. Eckenrode, et al. 2000. Preventing Child Abuse and Neglect with a Program of Nurse Home Visitation: The Limiting Effects of Domestic Violence. *Journal of the American Medical Association* 284(11): 1385–91.

A single home visit may cover between 5 and 9 different topics, with a median of about 6 topics. Topics are grouped into broad areas such as parent-child interaction or child development.[7]

A fifty-eight page chapter on HFA program design mentions substance abuse briefly as one of many conditions that may need to be addressed. One of the state evaluations indicated that fewer than 1% of the clients were referred for substance abuse services.[8]

However, one of the HFA models in the District of Columbia was awarded a three-year *Starting Early, Starting Smart* (SESS) grant by the Substance Abuse and Mental Health Services Administration (SAMHSA) in partnership with the Casey Family Programs. This national partnership was designed to support the integration of mental health and substance abuse services into primary health care and early childhood settings serving children ages 0–5 years and their families/caregivers. This site used the SESS model to supplement the HFA base model with these special services. While outcomes of this project are not available, the project shows that the HFA model can be adapted to include greater attention to substance abuse issues.

Home Instruction for Parents of Preschool Youngsters (HIPPY)

The HIPPY model uses home visitors and family group sessions targeted on younger children to improve parent involvement and school readiness outcomes. Its research summary does not refer to substance abuse.[9]

Nurse-Family Partnership

Under the Nurse-Family Partnership program, nurses conduct a series of home visits to low-income, first-time mothers, starting during pregnancy and continuing through the child's second birthday. Some NFP research cites reductions in smoking, but there are few references to use of alcohol or other drugs. In one of the most recent evaluations of NFP, conducted by the program's original designers, substance use by mothers was assessed and summarized:

Earlier reported impacts of the Elmira program on 'maternal behavioral problems due to substance abuse' [was] . . . no longer statistically significant in the new analysis.[10]

Parents as Teachers

Although Parents as Teachers (PAT) models emphasize equipping parents to understand child development and include developmental screening, there is no reference to prenatal exposure or substance abuse-related outcomes in the research summaries published by (PAT).[11] However, a recently issued guide to working with children with special needs briefly discusses fetal alcohol effects.

Why substance abuse must be addressed

Because substance abuse affects developmental outcomes and school readiness

Home visitation programs often cite school readiness as a major goal. In seeking to serve children and families with high risk factors, the overlapping group of children living with substance-abusing parents and those who were prenatally exposed are at considerably greater risk for developmental delays, behavior problems, and difficulties as they enter school. A recent study of children whose school attendance is substandard noted that parental substance abuse can be a contributing factor in poor attendance;[12] again, one in eleven children lives in a family where substance abuse is serious enough to be classified as alcoholism or chemical dependency. But with the exception of the above-mentioned HFA program that was linked to Starting Early, Starting Smart, there are few examples of home visitation models that directly address these risks.

As the exception makes clear, that gap is not for lack of models. Home visitation programs that are formally linked with center-based early childhood education can

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[7] http://www.healthyfamiliesamerica.org /downloads/hfa__impl__service__content.pdf

[8] http://www.healthyfamiliesamerica.org /downloads/eval__hfm__tufts__2005.pdf

[9] http://www.hippyusa.org/refId,28036/refDownload.pml

[10] http://www.nursefamilypartnership.org /content/index.cfm?fuseaction=showContent&contentID=4&navID=4

[11] http://www.parentsasteachers.org /atf/cf/%7B00812ECA–A71B–4C2C–8FF3–8F16A5742EEA%7D/ Research—Quality—Booklet.pdf

[12] H. Chang, and M. Romero, (2008) *Present, Engaged, and Accounted For: The Critical Importance of Addressing Chronic Absence in the Early Grades.* National Center for Children in Poverty. N. Connors, et al. 2004. Children of Mothers with Serious Substance Abuse Problems: An Accumulation of Risks. *American Journal of Drug and Alcohol Abuse* 30(1): 85–100. http://www.nccp.org/publications/pub__837.html

address the substance abuse issues by using one of the two widely recognized programs designed for linking substance abuse services and early care and education: Starting Early, Starting Smart or the Free to Grow model developed by the Head Start program. Both of these are promising approaches that should be encouraged further as means of improving the focus of early childhood programs on substance abuse effects impacting millions of children.

Because substance abuse is intergenerational

Because substance use disorders are inherently intergenerational, with a genetic component, a component that is affected by multi-generational family patterns, and effects of both organic and environmental exposure on children, family-centered home visitation must provide services to parents and children that specifically address substance use disorders.

Because home visitation addresses other problems that co-occur with substance use disorders.

To address mental illness, family stress, domestic violence, and other conditions that co-occur with substance use disorders as though they were each separable ignores the reality of co-occurring disorders. It is not possible to neatly separate the mental health and family violence portions of family risk factors from substance abuse.

Approximately one half of the people who have one of these conditions—a mental illness or a substance abuse disorder—also have the other condition. The proportion of co-morbidity may be even higher in adolescent populations . . . Availability of integrated treatment for mental health and substance abuse problems is currently the exception rather than the rule.[13]

Because home visitation appears to benefit higher-risk families more than lower-risk ones

The finding that "home visiting appears to carry more benefits for high-risk families than for low-risk ones"[14] raises the issue of which risks are being addressed. Combined with the finding that high—quality programs are more likely to assess family needs and link them with community resources, this suggests that identifying substance abuse as it affects both parents and children is a necessary component of addressing major risk factors to promote strong families and healthy child development.

Identifying those parents needing treatment would also help to reduce the sizable gap between those needing and those receiving treatment. Based on the National Survey on Drug Use and Health (NSDUH) data, in 2007 of the 23.2 million persons over 12 who needed treatment for illicit drug or alcohol use, only 2.4 million received treatment.

To the extent that home visitation programs have been shown to have the highest payoff for families with higher at-risk profiles, the families affected by co-occurring substance abuse, mental illness, and domestic violence-related trauma are those that would benefit most from home visitation programs designed to respond to these challenges.

Legislative Options

The legislation emerging from Congress can build upon these lessons drawn from the recent history of home visitation, in recognizing the importance of substance abuse as a critical risk factor. We thank Chairman McDermott for your leadership in this critical area through your sponsorship of the Early Support for Families Act of 2009 (H.R. 2667) along with Representatives Danny Davis and Todd Platts. We also commend Representatives Davis and Platts for their sponsorship of similar legislation, the Education Begins at Home Act of 2009 (H.R. 2205). These important pieces of legislation offer a significant opportunity to States and Tribes to create and expand early childhood home visitation programs. However as currently drafted, the Early Support for Families Act of 2009 (H.R. 2667) does not specifically mention nor speak to the issue of substance abuse. Similarly, in the Education Begins at Home Act of 2009 (H.R. 2205), substance abuse is mentioned only once as one of the agencies that should be collaborating with the central program organization. It is left out of lists of several risk factors, is left out of a list of agencies to which families should be referred for services, and is left out of a list of technical assistance topics.

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[13] California Mental Health Services Oversight and Accountability Commission Report: Co-Occurring Disorders, March 2007.

[14] "Home Visiting: Strengthening Families by Promoting Parenting Success," Policy Brief No. 23, National Human Services Assembly. November 2007.

To ensure that substance abuse is given appropriate attention in home visitation models, we offer the following recommendations on provisions that could be included in legislation:

1. Require that state or local plans for home visitation programs that are developed also include the prevalence of substance abuse in a formal needs assessment and indicate how substance abuse agencies will be actively engaged in program design and services effectively coordinated, how the training of home visitation personnel will include training on proper risk and safety assessment techniques that include substance use, and include information on the program's outcomes including how effective the program model has been in conducting risk assessments, the number of parents (when appropriate and necessary) referred for treatment, and the outcomes of treatment for those referred.

2. Require that home visitation programs that begin with prenatal visits include a proven risk assessment and safety model that identifies substance use and links pregnant women with treatment services in effective agencies that are full partners with the home visitation programs.

3. Require that parents with substance use disorders receive continuing care following treatment.

4. Require that children of substance-abusing parents receive developmental screening and are given eligibility for intervention services in the case of developmental delays, linked with Individuals with Disabilities Education Act (IDEA) eligibility.

5. Require that any set-asides for training and technical assistance also require funds to support the development and dissemination of risk and safety assessment protocols that at a minimum address substance abuse to expand the capacity of existing and promising home visitation models in addressing substance abuse among these high-risk families.

6. Require that the Secretary of the U.S. Department of Health and Human Services in administrating this home visitation program to States and Tribes implement a multi-agency approach including participation by the Administration for Children and Families, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, *as well as any other agencies the Secretary determines may be appropriate* to ensure a coordinated system of family support is implemented.

Again, we thank the Committee for holding this important hearing and for the opportunity to submit this statement for the record. We look forward to working with you as this legislation moves forward to ensure that the promise of home visitation is realized for low-income families, and in particular, that home visitation strategies seek to improve the lives of families and children impacted with substance use disorders.

Statement of the Children's Defense Fund

The Children's Defense Fund (CDF) appreciates the opportunity to submit written testimony for the record for the Hearing on Proposals to Provide Federal Funding for Early Childhood Home Visitation Programs held on June 9, 2009, by the Subcommittee on Income Security and Family Support.

The Children's Defense Fund has worked very hard for 36 years to ensure every child a Healthy Start, a Head Start, a Fair Start, a Safe Start, and a Moral Start in life and successful passage to adulthood with the help of caring families and communities. CDF seeks to provide a strong, effective and independent voice for *all* the children in America who cannot vote, lobby, or speak for themselves, but we pay particular attention to the needs of poor and minority children and those with disabilities. CDF encourages preventive investments in children before they get sick, get pregnant, drop out of school, get into trouble, suffer family breakdown, or get sucked into the dangerous "Cradle to Prison Pipeline."

CDF works to ensure a level playing field for every child and recognizes that for every minute we waste, we lose another child. Consider that a child is born into poverty every 33 seconds, a child is born without health insurance every 39 seconds, and a child is abused or neglected every 40 seconds. CDF has for decades advocated for improvements in child welfare policies that would help to enhance outcomes for vulnerable children and families across the country.

We want to begin by thanking the Subcommittee for its bi-partisan leadership in the 110th Congress, which led to the enactment of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110–351). These reforms for abused and neglected children in foster care, the most significant in more than a decade,

hold the promise of greater stability and permanence and enhanced well-being for tens of thousands of children and youths across the country.

We are very pleased that you now are focusing attention on the front end of the child welfare system to expand opportunities to prevent problems from occurring, such as developmental delays, poor child health, and child abuse and neglect, all of which can bring children to the door of the child welfare system. The need for prevention has long been ignored, and the Early Support for Families Act (H.R. 2667) represents a significant step forward in establishing and expanding home visiting programs that can reach hundreds of thousands of children.

We applaud the efforts of both Chairman McDermott and Representative Danny Davis, as well as Representative Todd Platts, to highlight home visiting as an important strategy to strengthen outcomes for both children and parents. The Early Support for Families Act builds on both the evidence-based home visitation initiative included in President Obama's Fiscal Year 2010 budget and on the reserve clauses in both the House and Senate-passed 2010 Budget Resolutions. It recognizes how children could positively benefit from a significant expansion of quality home visitation programs that improve multiple outcomes for children and families, both in the short term and over time.

In our statement for the record, we want to emphasize the multiple ways that children and families can benefit from home visitation, describe the lack of coordinated attention to home visiting that currently exists at the federal level, and then highlight the most important features of the Early Support for Families Act and several ways it might be further strengthened.

First-time pregnant women, parents of young children with disabilities, teen parents having a second or third child, and single fathers raising children and others can all benefit from different models of home visitation programs. Thousands of parents like these are looking to the Subcommittee to push forward this year an investment in quality evidence-based home visitation that can have real positive impacts for them and their children.

Investments in Quality Home Visiting Programs Are Essential for Improving Outcomes for Children quality home visiting programs offer congress an opportunity to build on what we know works.

Under the Early Support for Families Act, programs with the strongest level of evidence will be able to expand to reach more children and families with different needs, and emerging programs will also be able to prove their effectiveness with children and families over time.

Home visiting is a program model and a family engagement strategy that has a long track record and has evolved over the years. As elaborated below, there are at least five national models of home visitation programs, all of which are associated with a national organization that has comprehensive standards that ensure high quality service delivery and continuous program quality improvement. They all have been operating in some form for at least a decade and in some cases two or three decades. There are also other models and approaches being used that hold promise. And still others that have come and gone over the years. When Rep. Roskam asked the hearing witnesses on June 9, if they had ever met a home visitation program they didn't like, the answer for most was a resounding "yes." The witnesses recognized the challenges in operating quality programs and the need to target ongoing federal support to programs that meet at least the basic requirements spelled out in the Early Support for Families Act.

Research from the five national home visiting program models, described only briefly below, demonstrates that quality home visiting programs can improve outcomes for children and parents by preventing child abuse and neglect, improving school readiness, increasing positive parenting and parental involvement, and improving child and maternal health. The randomized controlled trial of the Nurse Family Partnership, one of the five models, was first conducted in 1977, more than 30 years ago. Since then several subsequent randomized controlled trials have been conducted, and each of the national models has had at least one randomized controlled trial.

Healthy Families America (HFA), a program of Prevent Child Abuse America, is a voluntary home visiting model designed to help expectant and new parents get their children off to a healthy start. The program works with participants starting prenatally or at birth up to the time the child reaches three to five years of age to promote positive parenting, enhance child health and development and prevent child abuse and neglect.

• A study published in the March 2008 issue of the journal *Child Abuse and Neglect* indicated that Healthy Families New York (HFNY) decreased the incidence of child abuse and neglect during the first two years of life, and reduced the use of

aggressive and harsh parenting practices, particularly among first-time mothers under age 19 who were offered HFNY early in their pregnancy.[i]

• Two randomized control trial studies of HFA found that participation in the program positively impacted children's cognitive development when measured on the Bayley Scales of Infant Development (which measures developmental function of infants and toddlers and assists in diagnosis and treatment planning for those with developmental delays or disabilities).[ii]

Home Instruction for Parents of Preschool Youngersters (HIPPY) is a voluntary home-based, family focused, parent involvement program that provides solutions that strengthen families and helps parents prepare their three-, four-, and five-year-old children for success in school and beyond.

• A two-site, two-cohort longitudinal study of children's school performance through second grade found that children participating in HIPPY scored higher on standardized achievement tests, were perceived by their teachers as being better prepared, and had better school attendance than those who did not receive HIPPY services.[iii]

Nurse Family Partnership (NFP) is a voluntary program that provides home visitation services by registered nurses to low-income first-time mothers, beginning early in pregnancy and continuing through the child's second year of life.

• In a 15-year follow-up to a randomized control trial, there were 48 percent fewer officially-verified child abuse and neglect reports for the families served by NFP as compared to the control group; and women served by NFP had experienced 19 percent fewer subsequent births than those in the control group.[iv]

• In another randomized control trial, children who were served by NFP at age two had spent 78 percent fewer days in the hospital for injuries or ingestions compared to those in the control group.[v]

Parent-Child Home Program (PCHP) is a voluntary early childhood parent education and family support model serving families throughout pregnancy until their child enters kindergarten, usually at age five. It is designed to enhance child development and school achievement through education delivered by parent educators, who all have at least a bachelor's degree. It combines home visiting and group meetings, is accessible to all families and has been adapted to fit differing community and family needs.

• More than 5,700 public school children from a stratified random sample of Missouri districts and schools were examined at kindergarten entry and at the end of third grade. Path analysis showed that participation in PAT, together with preschool, positively impacted children's school readiness and school achievement scores and also narrowed the achievement gap between children in poverty and those from non-poverty households.[vi]

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[i] DuMont, et al. (2008). Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. *Child Abuse & Neglect*, 32(3), 295–315.

[ii] Caldera, et al. (2007). Impact of a statewide home visiting program on parenting and on child health and development. *Child Abuse & Neglect,* 31(8), 829–852. Landsverk, Carrilio, et al. (2002). *Healthy Families San Diego Clinical Trial: Technical Report.* Child and Adolescent Services Research Center, San Diego Children's Hospital and Health Center.

[iii] Baker & Piotrkowski, 1996, National Council of Jewish Women Center for the Child (U.S. Department of Education funded study of HIPPY).

[iv] Luckey, Dennis W., David L. Olds, Weiming Zhang, Charles Henderson, Michael Knudtson John Eckenrode, Harriet Kitzman, Robert Cole, and Lisa Pettitt, "Revised Analysis of 15-Year Outcomes in the Elmira Trial of the Nurse-Family Partnership," Prevention Research Center for Family and Child Health, University of Colorado Department of Pediatrics, 2008. Olds, David L., Charles R. Henderson Jr, Robert Cole, John Eckenrode, Harriet Kitzman, Dennis Luckey, Lisa Pettitt, Kimberly Sidora, Pamela Morris, and Jane Powers, "Long-term Effects of Nurse Home Visitation on Children's Criminal and Antisocial Behavior: 15-Year Follow-up of a Randomized Controlled Trial," *Journal of the American Medical Association*, vol. 280, no. 14, October 14, 1998, pp. 1238–1244. Olds, David L., John Eckenrode, Charles R. Henderson Jr, Harriet Kitzman, Jane Powers, Robert Cole, Kimberly Sidora, Pamela Morris, Lisa M. Pettitt, and Dennis Luckey, "Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect: 15-Year Follow-up of a Randomized Trial," *Journal of the American Medical Association*, August 27, 1997, vol. 278, no. 8, pp. 637–643.

[v] Olds, David L., Harriet Kitzman, Carole Hanks, Robert Cole, Elizabeth Anson, Kimberly Sidora-Arcoleo, Dennis W. Luckey, Charles R. Henderson Jr, John Holmberg, Robin A. Tutt, Amanda J. Stevenson and Jessica Bondy. "Effects of Nurse Home Visiting on Maternal and Child Functioning: Age-9 Follow-up of a Randomized Trial," *Pediatrics*, vol. 120, October 2007, pp. e832-e845.

[vi] Zigler, E., Pfannenstiel, J.C., & Seitz, V. (2008). The Parents as Teachers Program and School Success: A Replication and Extension. *Journal of Primary Prevention*, *29*, 103–120.

• In a randomized control trial, children participating in PAT were much more likely to be fully immunized for their given age and were less likely to be treated for an injury in the previous year than children in the control group.[vii]

Parent-Child Home Program (PCHP) is a voluntary early literacy, school readiness, and parenting program serving families with two- and three-year-olds who are challenged by poverty, low levels of education, language and literacy barriers and other obstacles to educational success. The model uses intensive home visiting to prepare families for school success.

• Indiana University of Pennsylvania's independent evaluation of PCHP replications in two Pennsylvania counties indicates that positive parent behaviors increased dramatically as a result of program participation. Half of the children identified as "at risk" in their home environments at the start of the program were found to no longer be at risk at the completion of the program.[viii]

• A longitudinal randomized control group study of PCHP found that low-income children who completed two years of the program went on to graduate from high school at the rate of middle class children nationally, a 20 percent higher rate than their socio-economic peers and 30 percent higher than the control group in the community.[ix]

Quality home visitation programs impact children and families in multiple ways.

Home visiting recognizes the uniqueness of individual children and families and acknowledges that a single program strategy may have different impacts on the same children and families over time and different impacts on children and families with differing needs. As demonstrated above, it is not unusual for home visiting programs to have multiple impacts on children and families perhaps most notably improved child health and development, enhanced school readiness, and the prevention of abuse and neglect. The five major models described above also have had an impact on parents and their parenting skills and leadership. Perhaps most significant, several of these models have had even greater impacts when coupled with other early childhood programs.

A number of states have established multiple models of home visiting programs or combined program model elements to create blended programs, recognizing that families' needs vary. For example, the Illinois Department of Human Services and the New Jersey Department of Children and Families are both beginning to use the Nurse Family Partnership, Healthy Families America and Parents as Teachers models to prevent child abuse and neglect. Such an approach allows them to reach families with multiple needs and gives staff helpful discretion in matching the needs of families with the strengths of a particular model. New York is also implementing the Nurse Family Partnership, Healthy Families New York, and Parents as Teachers.

There are many other examples of states using multiple programs in different parts of a community or parts of a state. For example, 60 percent of Medicaid-financed births, a proxy here for low-income births, are to women who already have one child, ruling out a model that is limited to first-time births. Models that serve parents after the birth of a child are often needed to respond to the thousands of low-income women in our country who receive no prenatal care, yet could benefit from quality home visiting models with their babies.

Home visiting programs also are intergenerational and can impact more children than the one who is seen as the recipient of the service. All five national models, for example, track both child and parent specific outcomes. Few, however, have examined the impact of such programs on the future or existing siblings of the child being served. It is not a stretch to think that programs like these may well impact the trajectory of family's lives, foster improvements in health, safety and well-being over time, and can affect multiple children.

[vii] Wagner, M., Iida, E. & Spiker, D. (2001). The multisite evaluation of the Parents as Teachers home visiting program: Three-year findings from one community. Menlo Park, CA: SRI International. Obtained from www.sri.com/policy/cehs/early/pat.html.

[viii] Knickebein, B. (2005). *The Parent-Child Home Program Final Report*, Center for Educational and Program Evaluation, Department of Educational and School Psychology, Indiana University of Pennsylvania.

[ix] Levenstein, P., Levenstein, S., Shiminski, J. A., & Stolzberg, J. E. (1998). Long-term impact of a verbal interaction program for at-risk toddlers: An exploratory study of high school outcomes in a replication of the Mother-Child Home Program. Journal of Applied Developmental Psychology; 19, 267–285.

Home visiting programs have been proven to result in long-term benefits when their impact on children and families can be tracked over time

The Nurse Family Partnership Program has longitudinal data documenting the fact that for every public benefit dollar invested in a local Nurse Family Partnership program, communities can realize more than $5.00 in return. In fact, in its very earliest study in Elmira, New York, initiated in 1977, researchers found that the community could recover the costs of the program by the time the child reached the age of four, and additional savings accrued after that. Data from the 15-year follow-up of this same study show positive effects for the nurse visited families for more than 12 years after the visits had concluded.

While the other models generally do not have results from longitudinal studies, a number do have documented outcomes for children and families, which can be linked to long-term cost savings related to special education, health care, and child welfare and criminal justice system involvement. Increased school readiness, for example, can help to prevent the need later for extra support or investments in sometimes costly special education programs. There are also data that show the benefits of child abuse prevention, by contrasting it with the adverse impacts of child abuse and neglect on later problems in adulthood—problems that result in lost opportunity costs and costly treatment. Similarly, increases in healthy births can help to offset the costs of low birth weight babies. The cost of hospitalization for a preterm or low birth weight baby is 25 times that of when a healthy baby is born. Children born at low birth weight are twice as likely to have clinically significant behavior problems, such as hyperactivity, and are 50 percent more likely to score below average on measures of reading and mathematics by age 17.

Access to the funding in the Early Support for Families Act will help grantees to continue to assess outcomes and also offer the opportunity for additional longitudinal studies to document long-term cost savings.

There is currently no targeted guaranteed funding stream for prevention in young children.

Currently there is no targeted guaranteed funding stream for prevention in young children. President Obama's evidence-based home visitation initiative and The Early Support for Families Act are intended to do just that to help expand the reach of home visiting to children and families across the country, and to continue to document their benefits to the children and families served.

This Committee's Promoting Safe and Stable Families Program was first established in 1993 and then given its current name in 1997. It includes some funding from family support and family preservation programs, but it also includes dollars to help children in foster care be safely reunified with their families or to be supported in adoptive families. Similarly, some funds from the Temporary Assistance for Needy Families Program and the Maternal and Child Health Program are also used for home visiting, but since both of these are fixed amount block grants, home visiting must compete with many other activities. There are also programs, like Early Head Start, where home visiting is one of a multitude of activities provided to participating children and families.

New dedicated funding for home visitation will promote the coordination of this current patchwork of funding and enable states to assess how best to complement existing programs with new investments to continue to make progress in reaching all the children and families who can benefit from home visiting programs. Currently, the Nurse Family Partnership is in 28 states across the country, serving about 18,000 families. The Parents as Teachers Program is in all 50 states, but in some there are only a small number of programs, most often established in school systems. Healthy Families America is in 35 states. And both the Parent-Child Home Program and HIPPY are smaller with programs in 16 and 23 states respectively. Clearly more new programs and expanded programs that build on successful models are needed to reach more young children and families.

The Early Support for Families Act Moves Toward a System of Quality Evidence-Based Home Visitation Programs

The grant program established by the Early Support for Families Act seeks to establish in states a coordinated system of quality evidence-based home visitation programs. It is more than just another funding stream for these programs. It takes important steps toward establishment of a system of quality, evidence-based home visitation that will build on and coordinate with existing early childhood programs. It focuses on models with the strongest level of effectiveness, requires states to conduct a statewide needs assessment to describes programs already underway, who they are serving, how they are funded, gaps in service, and the training and technical assistance already in place to support the goals of home visitation. It also requires

federal evaluations of the effectiveness of home visitation on parent and child outcomes and on different populations. Congress must also be kept informed about the service models being used, the target communities and families served, and outcomes reported, as well as the cost of the program per family served. Much of this information, which now is generally not very accessible within or across programs, will be made available within and across program models so effective planning can be done to best serve children.

In closing, these are three areas that we want to mention briefly that we believe are important to strengthen in the Early Family Support Act as it moves forward.

• **Further definition of strongest level of effectiveness.** To help provide consistency and continuity for states and programs as the grant program is developed and implemented over time, we believe it is important for the statute to establish parameters to make clear what a program must do to get any funding under the bill and then to distinguish between models with the strongest level of effectiveness and others. Such parameters will also send a useful message about the standard to which home visiting models just getting underway will be held accountable as their work progresses.

Beginning with the strongest level of effectiveness, we would like to recommend that the Subcommittee consider language that was developed and has been agreed to by members of the Steering Committee of the Home Visiting Coalition of which CDF is a member. It defines the "strongest level of effectiveness" in relation to the research standard for evidence-based home visitation that will distinguish those models that are eligible for funding from those with the strongest level of effectiveness. Over time all funded programs will aspire to reach this level of research. The standard developed reads:

Evidence-based home visitation programs with the strongest level of effectiveness are those that have demonstrated positive outcomes for children and families consistent with the outcomes being sought (for the populations being served) when evaluated using well-designed and well-conducted rigorous evaluations, including but not limited to randomized controlled trials, that provide valid estimates of program impact and demonstrate replicability and generalizability to diverse communities and families.

The members of the Home Visiting Coalition supporting this definition include, in addition to CDF, the five home visiting models described above (Healthy Families America/Prevent Child Abuse America, HIPPY, Nurse Family Partnership, Parents as Teachers and the Parent-Child Home Programs) as well as six other national organizations (Child Welfare League of America, CLASP, Fight Crime Invest in Kids, National Child Abuse Coalition, and Voices for America's Children).

• **Increased coordination at all levels.** The Early Support for Families Act recognizes the importance of quality evidence-based home visiting as a part of a larger coordinated service effort to meet the needs of young children and their families. In addition to supporting the expansion of home visiting models, the bill also offers support to ensure programs can meet the multiple needs of at risk families by connecting them to service delivery systems at multiple levels. Connections can be made at the federal, state and local levels; and processes should also be in place to link individual families to what they need. We believe that there are a number of ways coordination could be strengthened, and ask the Subcommittee to consider them.

• At the federal level, it would be helpful to require that the Secretary of Health and Human Services consult with the Secretary of Education in determining what to require with regard to state applications for funding under the program, since some home visiting programs are funded through the federal Department of Education.

• At the state level, states should be required to consult with other state agencies that currently support home visiting programs for young children. This would help ensure that the new federal support for home visitation would build on any existing infrastructure to strengthen services for young children and families across the state. Home visiting should also be coordinated in states with child care services, health and mental health services, income supports, early childhood development services, education programs, and other child and family supports.

• At the individual model level, each model funded under this new federal program must be required to establish appropriate linkages and referrals to other community resources and supports, such as those listed above, to ensure that children and families will have access to all the services they need in their local communities.

• Further recognition of the need for multiples types of research and evaluation. We are pleased that the Early Support for Families Act highlights the importance of evaluation. It makes evaluation an eligible use of funds for grantees and sets aside funds for a national evaluation by the Department of Health and Human Services. Given that the goal of this program is to fund quality evidence-based programs, it is essential to ensure that evaluation and research to maintain fidelity to program models and adapt models to new populations be funded appropriately. As the proposal is being finalized, the funds set aside for evaluation—of all home visitation models and the new federal program itself—must be significant enough to serve the needs of the models in proving that they meet the strongest level of evidence to continue receiving funding and assess the federal monitoring of overall quality.

The Children's Defense Fund is supportive of the Early Support for Families Act and steps taken to move toward a major guaranteed investment in quality evidence-based home visiting and we look forward to working with you as the bill progresses. Thank you again for your leadership on behalf of vulnerable children and families.

Statement of Dan Satterberg

Chairman McDermott and members of the subcommittee, thank you for holding this important hearing, and for the opportunity to submit this testimony for the Record. I also wish to thank Chairman McDermott, Representative Danny Davis and Representative Todd Platts for introducing the "Early Support for Families Act" (H.R. 2667).

My name is Dan Satterberg, and I am the Prosecuting Attorney of King County, Washington. I worked in the Prosecuting Attorney's Office for more than 20 years before being elected Prosecuting Attorney in 2007.

I submit this testimony as a member of Fight Crime: Invest in Kids, an organization of over 5,000 police chiefs, sheriffs, prosecutors, other law enforcement leaders, and victims of violence—including 215 in Washington—who have come together to take a hard-nosed look at the research about what really works to keep kids from becoming criminals. My colleagues and I know from the front lines in the fight against crime—and the research—that among the most powerful weapons against crime are quality investments in kids that give them the right start in life.

As a criminal justice leader, I am proud to support the "Early Support for Families Act," which invests $2 billion over 5 years in guaranteed funding to establish and expand programs providing voluntary, quality home visiting to assist families with young children, and families expecting children, especially in high-need communities. These are programs that my colleagues and I in Washington State have advocated for, both with the Governor and in our Legislature.

Child Abuse Leads to Later Crime and Violence

In 2007, there were 794,000 confirmed cases of child abuse and neglect in the United States. In my home state of Washington, there were more than 7,000 confirmed cases of child abuse and neglect. This statistic is alarming enough on its own, but it cannot account for the thousands of additional cases that either go unreported or unconfirmed by overburdened State child welfare agencies. Research shows the true number of victims nationwide, including those never reported to authorities, may be well over 2 million.

Child abuse and neglect killed 1,760 children nationwide in 2007. In Washington, there were an average of 12 deaths a year between 2002 and 2006 that stemmed from child abuse or neglect.

Even though the majority of children who survive abuse or neglect do not become violent criminals, these children carry the emotional scars of maltreatment for life, and many do go on to commit violent crimes. Best available research, based on the confirmed cases of abuse and neglect nationwide in just one year, indicates that an additional 30,000 children will become violent criminals and 200 may become murderers as adults as a direct result of the abuse and neglect they endured.

Evidence-Based Home Visiting Programs Help Reduce Child Abuse and Later Crime and Violence

Fortunately, research also indicates that evidence-based home visiting programs can prevent abuse and neglect and reduce later crime and violence. These programs offer frequent, voluntary home visits by trained professionals to help new parents get the information, skills, and support they need to raise healthy and safe kids. While there are many models of home visiting, all are dedicated to helping young

children get a good start in life and improving outcomes for family. Research shows that these programs work.

Evidence-Based Home Visiting Programs Are Sound Investments That Result in Substantial Cost Savings

Prevent Child Abuse America estimates that child abuse and neglect cost Americans $104 billion a year. Research has demonstrated that quality, evidence-based home visiting programs offer significant returns for money invested. For example, a 2008 study by Steve Aos of the Washington State Institute for Public Policy found NFP produced $18,000 in net savings per family served and saved three dollars for every dollar invested. Other home visiting models have also demonstrated positive cost savings.

I urge this Committee to make investments in high quality, evidence-based home visiting programs. These programs should be a priority as you work on health care reform. Investments made in programs with a proven ability to produce positive outcomes for children and their families will result in safer communities and cost savings.

Current Funding Does Not Meet the Overwhelming Need

Existing guaranteed funding streams, such as Medicaid, State CHIP, and TANF, as well as discretionary programs such as Healthy Start, Early Head Start, Head Start, Special Education, Child Welfare, Social Services, Community Services, and others, have not been able to provide meaningful investments in quality, evidence-based home visiting programs. We can no longer afford to wait for a patchwork of partial funding from multiple programs to meet the overwhelming need for these services. We must have dedicated, guaranteed funding for this proven-effective approach.

Every year in the United States, over 600,000 low-income women become mothers for the first time. 1.5 million women who are pregnant or have a child under the age of two are eligible for NFP at any given time. However, due to lack of funding, the program is only able to serve about 20,000 mothers annually. Other home visiting programs serve an additional 400,000 families, many of whom are not in high-need communities. The result of inadequate funding is hundreds of thousands of at-risk families nationwide do not have access to quality home visiting.

Early Support for Families Act (H.R. 2667)

I applaud the introduction of the "Early Support for Families Act," based on President Obama's initiative in his FY 2010 proposed budget. By investing $2 billion in guaranteed funding over 5 years, H.R. 2667 takes a significant step forward toward meeting the as-yet-unmet need for quality, evidence-based home visiting programs.

Funds will be distributed using a two-tiered approach. First-tier programs—those with the strongest research evidence of effectiveness—will receive the majority of funding. First-tier programs must adhere to clear evidence-based models of home visitation that have demonstrated significant positive effects on important child and parenting outcomes, such as reducing abuse and neglect and improving child health and development. A second tier of promising program models—those with some research evidence of effectiveness and adaptations of previously evaluated programs—will have a chance to upgrade to the first tier if they are proven to be effective through rigorous evaluations.

The "Early Support for Families Act" also prioritizes investments in high-need communities. States will be required to identify and prioritize high-need communities, especially those with a high proportion of low-income families or a high incidence of child maltreatment. To receive funding, States must submit (1) the results of a comprehensive, statewide needs assessment; (2) a grant application describing the high quality programs supported by the grant, including evidence supporting the effectiveness of the programs; and (3) an annual progress report, including the outcomes of programs supported by the grant.

To ensure federal funds support quality, evidence-based home visiting programs, this legislation provides an annual set-aside of $10 million for federal evaluation and technical assistance to the States.

Conclusion

Investments in quality, evidence-based home visiting programs work. Research has shown that these programs can help achieve profound reductions in child abuse and neglect, crime, and violence while at the same time producing significant cost savings for the public. The "Early Support for Families Act" makes an important—and necessary—commitment to expanding access to these programs for at-risk families.

We urge you to make these proven investments in kids that help them get the right start in life and in turn reduce later crime and violence.

Thank you again for introducing the "Early Support for Families Act," and for the opportunity to submit this testimony. The law enforcement leaders of Fight Crime: Invest in Kids look forward to working with you to achieve enactment of such legislation, through health reform this year.

Letter from David Mon

I wanted to address the issue of Social Security beneficiaries returning to work and have earnings that are significant enough to reduce the monthly SSI and or SSDI to which they are entitled who report the work earnings in a timely manner but continue to receive benefits to which they are not entitled because SSA lacks the necessary representatives to input the reported changes.

As a community work incentive coordinator who works with beneficiaries on a one-to-one basis who return to work, I advise the beneficiaries that I work with that reporting the earnings are the first step. It is necessary for them to carefully track, with my assistance, work earnings that result in a reduction of benefits, and SSDI monthly payments to which they are no longer entitled, and to make arrangements to return this money, even before SSA makes a determination that an overpayment has occurred.

Advising beneficiaries on proper reporting and steps to prevent overpayments before they occur has become standard practice in the area of Work Incentive Planning and Assistance.

Sincerely,

David Mon
Community Work Incentive Coordinator
Center for the Independence of the Disabled
San Mateo, CA

Statement of Every Child Succeeds

Chairman McDermott, Ranking Member Linder, and members of the Subcommittee on Income

Security and Family Support of the Committee on Ways and Means, on behalf of Every Child Succeeds in Southwest Ohio and Northern Kentucky, I am happy to submit this testimony in support of H.R. 2667, the Early Support for Families Act. We would like to thank the sponsors of this legislation, Representatives Jim McDermott (D–WA), James McGovern (D–MA), Lynn Woolsey (D–CA), Mazie Hirono (D–HI), Jim Cooper (D–TN), Danny Davis (D–IL), and Todd Platts (R–PA).

Every Child Succeeds (ECS) is a voluntary home visiting program whose aim is to improve the health and development of at-risk children in the Cincinnati region. Our prevention/early intervention program is founded upon the knowledge that what happens in the earliest days and months of life has profound implication for the lifetime course of parents and children. ECS has provided home visiting services to nearly 16,000 families during the past ten years, with the goal of helping these children get off to a good start in the most critical period of their lives—prenatal to age 3. We and the communities we serve believe that home visiting is an effective and important way to support high risk families and help them succeed in parenting.

The mission of ECS is to ensure an optimal start for children by helping families achieve positive health, parenting and child development outcomes. The goals of home visitation, as provided by ECS, are: (1) to improve pregnancy outcomes through nutrition education and substance use reduction, (2) to support parents in providing children with a safe, nurturing, and stimulating home environment, (3) to optimize child health and development, (4) to link families to health care and other needed services, and (5) to promote economic self-sufficiency.

Public-private partnership has been at the center of our approach to financing and delivering services. ECS was founded by Cincinnati Children's Hospital Medical Center, United Way of Greater Cincinnati and Hamilton County Community Action Agency/HeadStart and began operation in July, 1999. The program has thousands of community stakeholders and contracts with more than 30 social service and health agencies, and all local birth hospitals. Our board and advisors include a variety of business leaders and experts who have helped to guide our program and our quality improvement efforts.

Funding for ECS also is provided through a blend of public (50 percent) and private (50 percent) dollars. The level of private funds for ECS from the United Way of Greater Cincinnati has been continually increased based on outstanding performance and outcomes, as well as the demonstrated need for ECS services. Funding from the Temporary Assistance to Needy Families (TANF) program has been essential in the development of ECS in four counties in Southwest Ohio through the State "Help Me Grow" program. Public funds are available for our three Kentucky counties to fund the state HANDS program through Medicaid and proceeds from the Kentucky state tobacco settlement.

The ECS program matches at risk, first-time pregnant women or new mothers with infants under three months of age with a network of trained professional home visitors who work with them and their young children for up to 3 years. Families are recruited primarily through prenatal clinics or birth hospitals. Program elements include care coordination, health promotion, medical liaison, child development assessment, and goal-setting through the Individual Family Service Plan (IFSP).

ECS uses two national models of home visitation, namely, Nurse-Family Partnership ® (NFP) and Healthy Families America (HFA). Both NFP and HFA models, and research about them, have had value in improving the quality of the ECS approach. In a series of studies, Olds and colleagues have found that home visiting for first time mothers by nurses reduced smoking during pregnancy, decreased preterm birth rates for smokers, increased birth weights among adolescent mothers, and decreased rates of child abuse and accidental injuries in children. (Olds et al.) Studies of HFA inform us about how to serve a broader array of families, including those whose risks are identified following the birth of a baby. (Healthy Families America) In addition, our own ECS quality studies, evaluative research, and randomized clinical trials are guiding us to state-of-the-art, evidence-based practice.

Mothers eligible for ECS have one or more of four risk characteristics, including; (1) unmarried, (2) inadequate income (up to 300% of poverty level, receipt of Medicaid, or reported concerns about finances), (3) 18 years of age, or (4) suboptimal prenatal care. Women are enrolled either during pregnancy (before 28 weeks for NFP) or before their child reaches 3 months of age (HFA only). Regular home visits are provided by social workers, child development specialists or related professionals (82%), trained nurses (12%), or paraprofessionals (6%). Home visits are made until the child reaches 2 years (NFP) or 3 years (HFA) of age, starting with weekly or more-frequent visits and tapering to fewer visits as the child ages.

ECS is an evidence-based model with a comprehensive ongoing evaluation component. The ECS research and evaluation system provides ongoing data about process and outcomes. To date, we have achieved and can reliably report the following results.

Infant Mortality

– Infant mortality rate for ECS families is 4.7 per 1,000 live births, significantly below those for Ohio (7.8), Kentucky (6.9), Hamilton County (9.7) or the City of Cincinnati (17.4). (See Figure 1.)

– An analysis of 1,655 mothers and babies enrolled in ECS between 2000—2002 and a comparison group of 4,995 non-participants from the same region, showed that non-participants were 2.5 times more likely to die in infancy, compared with those enrolled in ECS.

Child Health and Development

– 95% of children are developing normally in language, physical coordination, and social abilities.

– 98% of babies have a medical home

– 76% of children are fully immunized by age two

Maternal Health and Well-being

– Of the 33% of mothers with clinically significant levels of depression, 52% improve after 9 months in home visitation. Using a grant from the Health Foundation of Greater Cincinnati, ECS developed an in-home treatment for depressed mothers through a unique Maternal Depression Treatment Program that is currently being studied in randomized clinical trials through a grant from the National Institute on Mental Health.

– After 6 months in the program, 77% of mothers are in school or are working.

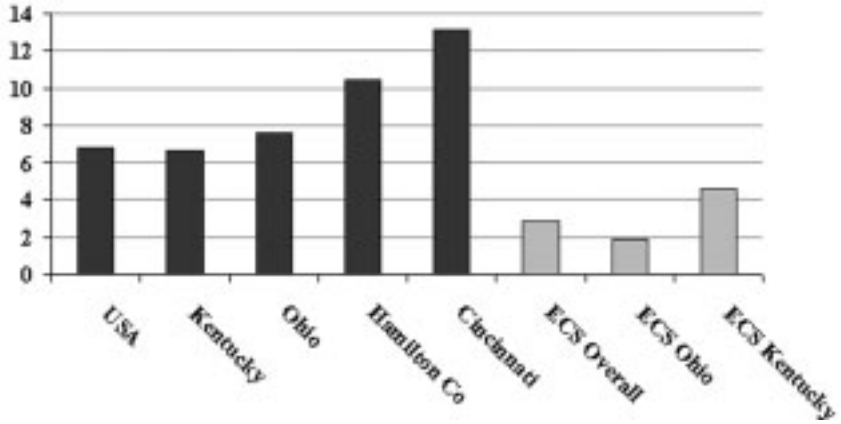
– 80% of mothers report high levels of social support, a factor associated with effective parenting and maternal mental health

– Of those ECS mothers who smoke during pregnancy, 94% quit or substantially reduce their tobacco use by the time of the baby's birth. ECS home visitors help mothers decrease smoking and reduce second hand smoke in the baby's environment

through the Assuring Smoke Free Homes (ASH) Project (funded by a grant from the Ohio Tobacco Use Prevention and Control Foundation).

Figure 1. Comparison of Infant Mortality Rates

(rate per 1000 live births)



Perhaps the most important aspect of the ECS design is continuous quality improvement guided by evidence-based practice and data about our providers and clients. We believe, as described by Daro, that the quality of home visiting programs is based in having self-evaluation in each program and in applying what we know about quality.

"Greater positive impacts among a broad range of home visitation models reflect, in part, two trends—improved program quality and improved conceptual clarity. With respect to quality, the six major national home visitation models are each engaged in a series of self-evaluation efforts designed to better articulate those factors associated with stronger impacts and to better monitor their replication efforts"

As Congress moves to adopt legislation that can support and guide home visiting programs across the country, we make three recommendations.

1. Provide funding for the core work of home visiting programs. To date, home visiting programs—ECS included—have had to cobble together a variety of funding sources and keep families on waiting lists until funds become available. Current federal funding streams such as TANF and Medicaid are not designed to fund home visiting. In trying to use these existing funding streams, programs often must divert effort or change the structure of service delivery to families. With a more reliable and continuous source of federal funding, ECS and other programs can optimize private, as well as state and local, resources.

2. Support outcomes-driven programs that make evidence-based decisions. Expand policy and operational programs that have credible evaluations and that are shown to work. We do not recommend relying on a tiered funding approach that tends to reward high performers while limiting dollars available for innovation, quality improvement and improved implementation among other good programs.

3. Focus on quality, not one model. Taken together, the body of research knowledge about home visiting tells us that successful programs have well-trained staff, solid supervision, ongoing relationships with families, a design that fits the specific program activities to desired outcomes, and linkages to other community programs such as child care and health care. Ongoing data collection analysis and evaluation, as well as training activities, are essential to achieving desired results. Congress and the Obama Administration have an opportunity to provide a framework such as that used in Head Start or Community Health Centers, through which performance standards and program guidelines help local programs deliver quality services and outcomes. This could be created out of the thousands of existing programs, including 40 state-based home visiting programs in operation today. (Johnson)

Recognize that home visiting programs target multiple outcomes. A new federal home visiting program should aim not only to prevent child abuse and neglect; but also aim to improve an array of outcomes that affect early childhood

health and development. ECS has shown that a single program can have impact on infant mortality, parenting skills, maternal depression, well-child visits, smoking reduction, and more. Congress should expect quality programs that provide quality services and data to show their results in multiple areas.

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Statement of The Family Violence Prevention Fund

Chairman McDermott, Ranking Member Linder and Members of the Subcommittee, thank you for the opportunity to comment on the value of home visitation programs and specifically the Early Support for Young Families Act.

The Family Violence Prevention Fund is a national non-profit organization based in San Francisco. We were founded almost 30 years ago with a simple mission: to end violence against women and children. Like many domestic violence organizations at the time, we began by focusing on the criminalization of violent behaviors by men toward their wives and girlfriends. However we quickly came to focus on the strong link between the safety and well-being of mothers and the safety and well-being of their children.

That is why we emphasize prevention and the critical need to ensure that all family members are safe and healthy. We have identified early supports for young and vulnerable families as an essential strategy both for preventing initial perpetration of violence and for early identification of children living in violent homes. Importantly, these early interventions can also mitigate the effects of the violence on children and provide support to the non-abusing parent, typically the mother, to improve her and her children's safety and stability.

We commend the Committee for its commitment to the safety and well-being of children and families and particularly for your focus on home visitation programs. As you well know, home visitation is one of the few documented, well-evaluated interventions that works to prevent child abuse and maltreatment. While there are several models out there—and we would support funding for multiple types of programs—the Nurse-Family Partnership model is probably the most rigorously evaluated. This intervention targets younger and lower-income pregnant women, and has been shown to significantly reduce reported rates of child abuse throughout childhood and into adolescence. One of the most—if not the most—significant barrier to the success of home visitation, however, is domestic violence. That is the focus of our comments.

Domestic Violence Limits Effectiveness of Home Visitation

While we strongly support home visitation as an effective strategy for improving health outcomes for children and reducing child abuse and neglect, we are convinced that home visitation programs must address domestic violence. The first reason is simply that domestic violence is so prevalent. Approximately 15.5 million children witness domestic violence each year in their homes. This means that almost one-third of American children cared for by married or cohabitating parents are exposed to domestic violence.

The consequences of children's exposure to domestic violence are well-documented. Children who witness domestic violence display a host of problematic behaviors at far greater rates than children not exposed to violence. These include being more likely to become a perpetrator of such abuse (for boys) as well as higher rates of violence, aggression, suicide, school failure and mental health problems. The effects of witnessing abuse on children may be equal to, or in some cases worse, than the direct experience of being abused. However, it also is important to note that many children who witness adult domestic violence do just fine. Often the reason is the child's strong relationship with her or his mother, even if that mother is experiencing abuse, because it serves as a protective factor. Home visitation programs are thus critical in identifying these children, helping them be safe and cope with what they have witnessed, linking abused mothers to helpful community resources, and supporting strong relationships between mother and child.

We also recommend that home visitation programs address domestic violence because it serves as a major—if not *the* major—barrier to the effectiveness of these programs. Research reported in the *Journal of the American Medical Association* in 2000 detailed the most convincing rationale: first, about half the mothers participating in the well-known Nurse-Family partnership study experienced domestic violence; and where domestic violence did exist, the effectiveness of home visitation to reduce abuse and improve child outcomes diminished. Among mothers experiencing the higher rates of and more severe abuse, the beneficial effects of the program disappeared entirely.

This research appears consistent with other studies that show varying impact and effectiveness of home visitation programs, though few have teased out as clearly the impact of domestic violence. Because domestic violence rates are so high and because they hinder the effectiveness of the programs, it is essential that home visitation programs tailor their interventions and provide training to staff on how to talk to young parents about violence and its effects on children, and how to recognize and respond to families already experiencing violence.

Home visitation programs have the ability to not only help families when domestic violence is occurring, but also to provide primary prevention of both child abuse and domestic violence. Healthy, non-violent relationships are fundamental to healthy parenting.

Specifically, we strongly recommend that any home visiting legislation include the following four components:

1. State plans and/or assessments should include information on how domestic violence will be addressed and how programs will safely and confidentially refer women to domestic violence services when necessary;
2. Training and technical assistance for home visitation programs should be funded and should include:
   a. information on how to safely assess for domestic violence in the families being served,
   b. promotion of healthy and non-violent partnering as helpful to a child's health and development,
   c. how and when to talk to men and fathers who use violence about how domestic violence can affect parenting and how to get help;
3. Community-based service providers referenced should include domestic violence, fatherhood and batterers intervention programs so families are given the information and referrals they need; and
4. Women living in domestic violence shelters should be eligible for services, assuming these services can be provided in a safe and confidential manner.

Thank you for the opportunity to comment on this critical legislation. For additional information, please go to www.endabuse.org; or contact our Washington, D.C. office.

Statement of First 5 Alameda County Home Visitation Programs: A Multidisciplinary Approach

Background

First 5 Alameda County Every Child Counts (F5AC), funded by revenues from the California 1998 Proposition 10 tobacco tax, works to ensure that every child reaches his or her developmental potential. F5AC focuses on children and families from prenatal to age five years.

Alameda County is the seventh most populous county in California with a population of 1,454,159 (American Community Survey Demographic Estimates, 2005–2007) and one of the most ethnically diverse regions in the United States. It is a county with sprawling urban areas as well as agricultural centers, and is as large as many states with over 821 square miles.

In 2007, 125,450 children aged 0–5 years lived in Alameda County. Young Latino and Asian children are the fastest growing populations accounting for approximately 33% and 25% of all births, respectively (State Department of Finance, Demographic Research Unit, 2007).

Race/Ethnicity	Alameda County Population (1)	Birth Population (2)
African American/Black	13.0%	11.0%
Asian	24.6%	24.5%
Caucasian/White	24.4%	22.0%
Latino	21.4%	42.2%
Native American	0.6%	0.2%
Pacific Islander	0.8%	–
Multiracial	3.6%	–
Other/Unknown	11.7%	0.1%

Sources: American Community Survey 2006 (1); Alameda County Public Health Department Vital Stats, 2007 (2)

Overall, in 2006, an estimated 3,149 (3.0%) of all children ages 0–5 in Alameda County were foreign born, and 2,483 (2.4%) were not U.S. citizens (American Community Survey, 2006). Linguistically, 43.5% of the 5+ population speak a language other than English at home and 19.1% speak English less than very well. Among these 19.1%, 45.1% speak Spanish and 42.5% speak Asian and Pacific Islander languages (American Community Survey, 2006).

As evidenced by the data above, Alameda County needed to address a variety of factors in developing programs to meet the needs of a large and diverse county. F5AC began planning for the implementation of a voluntary home visitation strategy in 1999. F5AC explored several best practice home visitation models in existence at that time: Hawaii's Healthy Start, Healthy Families America, The Nurse Family Partnership-Olds Model and Parents as Teachers. F5AC decided **not** to utilize one particular model, but rather embraced the best practice standards that were emerging by creating a set of tenets to infuse into F5AC home visitation programs for the prenatal to five population in Alameda County.

FSS Tenets provides a framework for continuous quality improvements to meet evolving needs in targeted populations.

1. **Family-centered:** acknowledges the reciprocal nature of family well-being and child development, and includes support to the family as a whole rather than restricted to child-level services.
2. **Relationship-based services:** Emphasizes that the family-provider relationship is the most important tool for provider and addresses the need for staff to be supported to "reflect" on her/his responses to individual cases.
3. **Child development focused:** Expects the service provider to continually observe and use opportunities to help families understand their child's behavior in the context of child development; incorporates a "child find" strategy for early identification and intervention by requiring completed developmental screenings/assessments throughout the period of services.
4. **Appropriate caseload ratios:** Maintains a case ratio of 1:20–25 per case manager (and 1:13 for families at risk for child abuse) to support the manageability and intensity of family support services by individual staff.
5. **Reflective supervision:** Supports staff to understand the importance of reflection as a tool in their intervention work with families. Supervisor/staff relationships parallel the provider/family relationship.
6. **Multi-disciplinary approach:** Emphasizes the use of a variety of professional disciplines to meet family needs.

Implementing home visitation models in Alameda County also relied on key operational factors: the ability to access a large number and diverse pool of nurses to serve our diverse community; the cost of using PHNs to provide services; capacity to address language and cultural continuity for parents; the need to utilize existing programs; the desire to avoid investing in unsustainable programs; the capacity to meet diverse and multiple family risk factors.

- **Relying on the nursing supply in Alameda County severely limited the number and diversity of families able to receive home visits:** Of the approximately 21,000 annual births in Alameda County, 7,000 were to very low-income mothers qualifying for California's Medicaid and Healthy Families programs; 1,504 were born low birth weight; 1,325 to teen mothers. The number and cost of Public Health Nurses who had both linguistic capacity and reflected the cultural backgrounds of our community could not possibly meet the demand for services.
- **The high risk nature of clients targeted by F5AC required multi-disciplinary approaches to engage difficult-to-reach families:** F5AC families targeted to receive home visitation included pregnant and parenting teens, parents of infants discharged from the neonatal intensive care unit due to severe and long-term health issues at the time of birth, and children at-risk of neglect or abuse due to substance use, mental illness or other unstable family environments. Up to 36% of mothers experienced postpartum depression, 7% of children were exposed to substance use, and 9% of families were involved with Child Protective Services. Each significant risk factor necessitated immediate attention by a multi-disciplinary team of providers who were most able to offer timely support services—which were pre-requisites for maintaining a quality, trusting and continuous relationship between a home visitor and the family.
- **Meeting culturally and linguistically diverse needs of families necessitated an agile and culturally responsive workforce:** Community organizations offered comparative advantages by staffing the programs with home visitors who reflected the face of the county's community. A children's hospital

and family services department of Alameda County Public Health provided a mix of nurses and paraprofessional community health workers who effectively addressed long-term health and child development issues of children discharged from the Neonatal Intensive Care Unit. Multi-lingual and bi-cultural specialists helped families navigate community resources and medical specialists critical to the stability and health of the families. Community-based organizations that focused on reaching teen parents worked with schools and Social Services Agency to help young parents remain on track with high school requirements and to assist in obtaining services to which they are entitled to give their children a healthy start. Three community-based organizations demonstrated success in offering alternative response intensive case management to families already known to the Child Abuse Hotline but who did not qualify for immediate investigation by Child Protective Services.

Over the past 9 years, F5AC collected individual client level case management and outcomes data to support a robust accountability framework of continuous program quality assurance and impact measurement. F5AC's home visitation models produced impressive outcomes.

§ **Children stayed healthy and up-to-date on preventive care**: Over the last 8 years, F5AC home visiting programs consistently reported 86–99% of children had health insurance; 94–98% were up-to-date with immunizations; 92–97% had an identified primary pediatric provider (medical home); 95–98% had all the appropriate well-child visits for age.

§ **Early identification and treatment of maternal depression**: Early identification of mental health issues and referral to appropriate supports and treatment options provided the necessary foundation for a socially and emotionally secure parent-child relationship. F5AC implemented a county-wide standard to screen every at-risk parent for depression. 20–36% of mothers who received home visits screened positive for maternal depression. Those who screened positive for depression were also more likely to have children who screened "of concern" in at least one developmental domain.

§ **Anticipatory guidance and early screening and support for children's development**: Home visitors used their encounters with families to help parents learn what to expect as their baby grows. A county-wide strategy to promote developmental screening of every child helped identify 20–63% of children with developmental concerns.

§ **Positive breastfeeding trends**: In addition to promoting bonding between parent and child, 56% of teen parents and 63% of parents of children discharged from the NICU breastfed or used breast milk as the primary source of nutrition for their babies. Of those who breastfed, over 30% did so for more than six months.

§ **Low incidence of ER visits and hospitalizations for preventable illnesses and intentional injuries**: Less than 1% of children without chronic medical conditions visited the emergency room while fewer than 4 per 100,000 suffered intentional injuries.

§ **Teen parents stayed in school or graduated**: Almost 60% of teens who received home visits remained in school or graduated from high school.

Summary

In implementing home-based early intervention services, First 5 Alameda County had to take into account the particular demographic needs and workforce issues within our community. A key to successful program implementation was staying true to F5AC family support tenets while structural and demographic changes continuously shifted in the county. We were guided by evidence-based practice, but above all else, needed to have the flexibility to use the evidence base tailored to the circumstances of the populations to be served (pregnant and parenting teens, infants discharged from the neonatal intensive care unit, children referred to child protective services, parents in need of family support during the transition to parenthood). Each one of these populations had different needs in reference to dosage, single discipline versus multidisciplinary, and type of professional providing the intervention. What unified our providers in the provision of home-based services was the common language we developed over the years, the ongoing training and support to staff, and continuous monitoring and quality improvement measures put in place to assure we were having an impact on families.

Statement of Gaylord Gieseke

I, Gaylord Gieseke, as the Interim President of Voices for Illinois Children, would like to submit the following in support of the Early Support for Families Act (H.R. 2667). Voices for Illinois Children builds better lives by working across all issue areas to improve the lives of children of all ages. We envision Illinois as a place where all children have the opportunity to grow up healthy, happy, safe, loved and well educated.

The importance of starting early

"One of the most valuable things I can say I learned through the home visits is that I am the example my children will follow; therefore, I have to take the lead."[i] Spoken by Monica, a teen mother participating in an Illinois home visitation program, this statement communicates the motivation and hope many mothers are able to find with the support of a home visitor.

Home visiting participants come from all walks of life, but often they resemble the story of a 17-year-old high school student who unexpectedly became pregnant. Enrolling in a home visitation program, she learned about healthy nutrition and then chose more healthy foods for herself and her growing baby. Although the mother had a difficult birth, she and the baby bonded well—the home visitor provided encouragement and education about how to interact with a fussy baby during sleepless nights, and helped the mother identify signals the baby may give to indicate what he likes and doesn't like. Initially unsure about how to talk to doctors or social workers, the mother has become an advocate for both herself and her baby, having observed and practiced communicating her needs effectively with the home visitor. Since graduation, the mother has started work as a Certified Nursing Assistant, obtained a driver's license, and started saving for a car, which would enable her to begin taking courses at a nearby community college. In preparation for college, the home visitor is helping the mother find and fill out scholarship applications.

With the support of a home visitor, teen parents are accessing the resources they need to build better lives for their children. Recognizing the importance of the parenting role and that learning begins at birth, home visitation programs around the country offer in-home services designed to strengthen parenting skills, assist in the development of a safe and nurturing home environment, and promote early learning for children, from the months before birth to age five.

The importance of interventions in early childhood—including the months before birth—has been supported many times over by an impressive quantity of research on children's brain development. Brain scans indicate that the brains of well-cared for babies are fundamentally different from those of neglected infants, with lasting implications for each child. Beginning in the 1980s and continuing to the present day, researchers consistently find that brain development happens in the context of the child's environment and is not a stand-alone biological phenomenon.[ii,iii]

As a child bonds with a caregiver, builds vocabulary, plays with toys, and otherwise engages the broader world around him through his five senses, he increases brain activity, which in turn preserves neurons to be used in future learning. Without these experiences, or when a young child is exposed to stress without supportive relationships to mitigate its impact, the brain pares down neurons, creating future learning challenges for the neglected child.[iv,v] Acting in this critical window for development, early childhood interventions support the creation of an environment in which infants may develop a secure attachment to a responsive caregiver—science tells us this enhances brain development. All later interventions work with the brain function already established in infancy and early childhood.

The Education Continuum: Beginning Earlier with Home Visiting Programs

Although the continuum of education has traditionally been P–12 (kindergarten through high school), brain research makes it clear that age five is much too late to first offer educational supports to the child and family. A child's experiences before entering kindergarten may hinder or promote her chances of successfully finishing high school and reaching college. Recognizing the need to expand the education continuum to include much, much younger ages, professionals around the country began developing programs, known as "Home Visiting Programs," to fill the early childhood gap and to support parents of young children.

For all programs, participation is entirely voluntary; program models are generally designed to include weekly or biweekly home visits, which last two to five years. By having nurses or paraprofessionals visit families in their homes, home visiting programs reduce the obstacles that may otherwise prevent a family from accessing services. Seven nationally recognized home visiting programs are Early Head Start, Healthy Families America, Nurse-Family Partnership, Parents as Teachers, the Parent-Child Home Program, Parents Too Soon, and Home Instruc-

tion for Parents of Preschool Youngsters (HIPPY). HIPPY and Parents as Teachers are universal access programs, while the others target teen mothers, single mothers, low-income parents, or families with some other significant risk factor.

Several home visiting programs are designed to engage families when children are at their earliest ages—during pregnancy and infancy. Home visitors provide or link women to prenatal care and assist the family with establishing a medical home and making and attending the baby's well-being appointments. Doulas may work with a mother to prepare for delivery and begin breastfeeding. Furthermore, home visitors talk with parents about caring for the baby, discuss the child's developmental stages, and help moms and dads develop practical and appropriate parenting skills and strategies. Overall, these programs emphasize the importance of family health, economic self-sufficiency, and parenting skills—factors that significantly affect the home environment and the child's developmental foundation.

As children reach the toddler and preschool years, home visiting programs build on healthy development and empower parents to be their child's first and most important teacher. Arriving with an educational toy or book, visitors teach or model parent-child interactions that stimulate brain development, and they encourage parents to take advantage of preschool. Reading, talking with the child, and promoting age-appropriate exploration and choices contribute to the development of the child's burgeoning vocabulary, self-confidence, and ability to reason. Parent involvement in nurturing verbal, reasoning, and social skills in the informal home environment is critical to preparing children to learn in the more formal school environment. These programs also provide parents with information about their child's development and related capabilities and limitations.

Illinois' commitment to Home Visiting

As a state, Illinois has long recognized the benefits associated with home visitation and has been investing in programs since 1982. On average, these programs serve 15,880 children each year in Illinois through the Healthy Families, Parents as Teachers, Parents too Soon, and Nurse Family Partnership models.[vi] However, especially in these difficult economic times, the current level of programming is not meeting the need for home visiting. As financial pressures increase for a family, so does the risk of child abuse and the need for preventive services. Including children receiving Medicaid assistance, Illinois currently serves only 48 percent of the 35,000 infants born each year who are most likely to benefit developmentally and academically from home visitation.[vii] There are still many children and families yet to be served.

However, this is also an exciting time, as Illinois has a critical opportunity to broaden the reach and strengthen the quality of home visiting in Illinois through the Strong Foundations Project. The Illinois Department of Human Services, along with the Department of Child and Family Services and the State Board of Education, has received a $500,000 five-year federal grant for this project. Having previously and independently funded home visiting programs, these agencies are working together and with service providers and advocacy groups to support and expand home visiting across the state.

Specifically, Strong Foundations will operate under the Illinois Early Learning Council as a new committee—the Home Visiting Task Force. The Early Learning Council is charged with the coordination of services for young children, and the Home Visiting Task Force will coordinate resource allocation, community capacity-building, training, data collection, monitoring, and technical assistance across the three state agencies and more than 150 home visiting programs involved in the project. This project will support high-quality service delivery, and to this end will develop special trainings to help home visitors serve particularly vulnerable populations, such as those experiencing mental illness, substance abuse, domestic violence, or developmental disability.

Research has clearly identified the importance of a nurturing family environment during early childhood brain development. Moreover, evaluations have affirmed the effectiveness of home visiting as a means to improve child and family outcomes on a number of health, safety, economic, academic, and social indicators. Though the needs are great in these economic times, the passage H.R. 2667 would demonstrate the national commitment to enhancing children's well-being through a wide array of approaches, of which home visiting is clearly an integral part. It is critical that the recognition and support of home visitation is established in sound federal policy as our nation seeks to improve the educational and developmental outcomes for our nation's children.

If you would like additional information regarding home visiting in Illinois, please contact Gaylord Gieseke.

Letter from Gladys Carrión, Esq.

Thank you for your recent legislative effort to subsidize and support evidence-based home visitation programs. The legislation, the Early Support for Families Act, adds Subpart 3 to Title IV–B of the Social Security Act to provide grants to states to establish or expand quality home visitation programs for families with young children and those expecting children.

The National Association of Public Child Welfare Administrator's (NAPCWA) discusses briefly in its submission for the record, that New York State currently administers an evidence-based home visitation program with positive outcomes. That program, the Healthy Families New York (HFNY) home visitation program has successfully provided child abuse prevention services to low-income families for many years. As Commissioner of the New York State Office of Children and Family Services (OCFS), I wholeheartedly agree with Congress' decision to make home visitation an important part of its investment strategy for preventive services.

The economic downturn has forced many states to reduce substantially their investment in home visitation and other prevention programs in order to preserve dwindling resources for mandated child welfare services. In New York State, despite strong evidence from a randomized controlled trial demonstrating the effectiveness of HFNY, the program sustained an 8% cut in SFY 2008–2009 and maintained that cut in SFY 2009–2010. The availability of significant federal funding for home visiting purposes will likely allow states to continue to invest in this strategy and permit more families to participate. In 2003, Healthy Families America (HFA) programs alone assessed 71,000 families and provided home visiting services to 47,500 families across the country.

Based on the Healthy Families America home visitation model, HFNY targets expectant parents and parents with an infant less than three months of age who have characteristics that place them at high risk for child abuse or neglect and live in vulnerable communities marked by high rates of poverty, infant mortality, and teen pregnancy. Specially trained paraprofessionals, who typically live in the same communities as participating families and share their language and cultural background, deliver home visitation services until the child reaches five or is enrolled in Head Start or kindergarten. HFNY's home visitors provide families with support, education, and linkages to community services designed to address the following goals: 1) to prevent child abuse and neglect, 2) to enhance parenting skills and parent-child interactions, 3) to provide optimal prenatal care and promote child health and development, and 4) to increase parents' self-sufficiency. Since its inception in 1995, HFNY has provided more than 600,000 home visits to over 20,000 families.

HFNY has been rigorously evaluated using a randomized controlled trial. The evaluation has reported positive program effects in terms of childbirth outcomes, child abuse and neglect, parenting practices, and access to health care. A study published in the January 2009 issue of the American Journal of Preventive Medicine showed that mothers who are enrolled in HFNY before their 31st week of pregnancy were only half as likely to have low birth weight babies as mothers in a control group. HFNY was particularly effective in reducing low birth weight among African-American and Hispanic mothers, groups that persistently experience high levels of poor birth outcomes. For example, 3.1 percent of the African-American mothers in the HFNY group delivered low birth weight babies, compared to 10.2 percent of the African-American mothers assigned to the control group. In addition to the impacts on low birth weight, HFNY has been shown to increase access to health care, particularly among African-American and Hispanic women. A study published in the March 2008 issue of the journal Child Abuse and Neglect indicated that HFNY decreased the incidence of child abuse and neglect during the first two years of life, and reduced the use of aggressive and harsh parenting practices, particularly among first-time mothers under age 19 who were offered HFNY early in pregnancy. Finally, HFNY has been found to promote the use of positive parenting skills that support and encourage children's cognitive and social development (Published Report/Working Paper, 2008, available at www.ocfs.state.ny.us).

Based on the evaluation's rigorous random assignment design and the program's significant and positive effects on a range of outcomes, HFNY was designated as a "proven program" by RAND's Promising Practice Network and an effective program by both *Child Trends* and the Office of Juvenile Justice and Delinquency Prevention. In addition, the evaluation received grants from both the National Institute of Justice and the Doris Duke Charitable Trust Foundation to support the extension of the randomized trial into its seventh year.

HFNY and other evidence-based home visiting programs that rely on paraprofessionals and those professionals other than nurses to deliver home visitation services

can help address the serious shortage of nurses in low-income communities and the under representation of minorities in the nursing field.

I applaud Congress on their sensitivity to this issue. I urge you to consider funding this program in a manner that does not impose unfunded mandates or administrative burdens. In addition, please consider restructuring the matching and Maintenance of Effort strategies so that states may be better prepared to participate in this federal funding program in these times of economic distress. I look forward to the success of this legislation's intent and am willing to offer my assistance to you in achieving this goal.

Sincerely,

Gladys Carrión, Esq.

Statement of Healthy Families Florida

On behalf of our network of 38 community-based service providers and the more than 13,000 Florida families they serve annually, Healthy Families Florida is grateful for this opportunity to provide testimony in support of federal investment in early childhood home visitation.

This testimony will briefly explain the value of home visiting services to Florida families and how Healthy Families home visiting services are being effectively implemented in Florida to prevent child abuse and neglect in our state's highest risk families before abuse ever happens.

Federal Investment in Home Visiting to Promote Positive Parent-Child Relationships and Healthy Child Development Makes Sense

Early childhood experiences, especially interaction with parents and caregivers, influence a child's developing brain and provide the foundation for all future development. While stable, nurturing experiences can help children develop the resilience to overcome typical adversities in life, experiencing child abuse and neglect can be devastating to child development, often setting in motion a chain of events that has lifelong consequences as children grow to adulthood. In addition to increasing the likelihood of delinquency, criminal involvement, substance abuse and low educational achievement, child abuse and neglect has a long-term impact on physical and mental health.

Research shows that the added stress low-income families face during economically depressed times causes child abuse and neglect to increase. The human and monetary costs of child abuse and neglect are unconscionable, especially compared to the low cost of effective prevention.

Prevention services, like those offered through Healthy Families Florida and other evidence-based home visiting programs in Florida, support healthy child development and family stability at a fraction of the cost of providing services that intervene after abuse and neglect have occurred.

About Healthy Families Florida

Healthy Families Florida is a statewide, nationally accredited, voluntary home visiting program that is proven to prevent child abuse and neglect before it ever starts. The program is modeled after Healthy Families America, an evidence-based initiative of Prevent Child Abuse America. Healthy Families America is recognized by the U.S. Office of Juvenile Justice and Delinquency Prevention as an "effective prevention program, demonstrating empirical findings using a sound conceptual framework and an evaluation design of high-quality." Healthy Families New York, which implements the same model, is also acknowledged as a successful and proven program by the Rand Corporation, a non-profit institution that addresses the challenges facing the public and private sectors around the world.

Healthy Families Florida equips parents and other caregivers with the knowledge and skills they need to create stable home environments free from child abuse and neglect so their children can grow up healthy, safe, nurtured and ready to succeed in school and in life. Highly trained home visitors provide parents and other caregivers information, guidance and emotional and practical support by:

- Modeling positive parent-child interaction to enhance their child's development.
- Providing education on child health and development and the importance of immunizations and well-baby check-ups.
- Teaching about safe and unsafe sleeping environments for infants, coping with crying and other prevention topics.
- Conducting child screenings for developmental delays.

- Connecting families to medical providers and making referrals to other community services.
- Teaching how to recognize and address child safety hazards in and around the home, in the car, in and around water and in other environments.
- Helping to develop appropriate problem-solving skills and identify positive ways to manage stress.
- Promoting personal responsibility for their future and the future of their families by helping them to set and achieve goals, such as furthering their education and acquiring stable employment.

Who do we serve?

Research shows that the key to preventing child abuse and neglect is intervening early, during pregnancy or shortly after the birth of a baby. Healthy Families services begin during pregnancy or within three months of a baby's birth and can last for up to five years depending on the unique needs of each family. Healthy Families uses a validated assessment tool to determine which families are experiencing a variety of difficult circumstances that place their children at high risk for abuse and neglect and other adverse outcomes that are preventable through intensive home visiting services.

Most Healthy Families participants are low-income single parents with less than a high school education and little awareness of appropriate discipline options for their children. Participants often experienced abuse or neglect during childhood. Other common participant risk factors include:

- Late or inadequate prenatal care
- Multiple children under five years of age
- Prior involvement with Child Protection Services
- Inappropriate coping mechanisms
- Current maternal depression or history of mental illness
- Unrealistic expectations about child development
- Limited contact with close friends and/or family
- History of, or current, domestic violence or other abuse
- Raised in an unstable home
- History of, or current, substance abuse

Healthy Families services are available in all of Florida's 67 counties; in some throughout the entire county and in others only in targeted high-risk zip code areas.

How do we know it works?

Healthy Families Florida has undergone a rigorous five-year quasi-experimental study conducted by independent evaluators to determine whether the program makes a measurable difference in participants' lives. The evaluators concluded that HFF has a significant impact in preventing child abuse and neglect and achieves positive outcomes for both parent and child:

- Before their second birthday, children in families who received intensive HFF services experienced 58 percent less child abuse and neglect than children of the same age in families who received little or no HFF services.
- Children whose families did not receive HFF services were nearly four times more likely to suffer maltreatment before their second birthday than children of the same age in families who completed the program.
- Participants who completed the program were more likely to be employed within 36 months than those in the comparison group who received little or no service.
- Mothers who participated in HFF for three or more years were significantly more likely to read to their children.
- 93 percent of children participating in HFF services were fully immunized by age two.
- 92 percent of mothers participating in HFF services did not have a subsequent pregnancy within two years.
- 81 percent of participants who completed the program improved their education level, received job training or became gainfully employed while enrolled in the program (measures of increased self-sufficiency).

HFF has sustained high performance in promoting positive outcomes for parents and their children since its inception in 1998.

Why is Healthy Families So Successful?

Key elements that contribute to Healthy Families success include:

- Services are voluntary, which empowers families to make positive changes in their behaviors and the way they lead their lives.
- Home visits are frequent and long-term. Families start out with weekly visits for at least six months. As families progress in establishing stable, safe and

nurturing environments for their children, the frequency of the visits decreases to bi-weekly, then monthly, then quarterly.

- Services are available during non-traditional hours, including evenings and Saturdays, to accommodate families' work and school schedules.
- Intensive training prepares staff for their roles and responsibilities and helps them succeed in their work with families.
- Quality supervision allows supervisors to review the progress of families with staff on a weekly basis in order to provide guidance and clinical support and develop the skills of the home visitors.
- Low caseloads allow home visitors to spend the time they need to meet the individual needs of each high-risk family.
- A strong statewide system that includes a central office that provides annual quality assurance visits to ensure accountability and fidelity to the Healthy Families program model; ongoing technical assistance and training; fiscal oversight and data management; and ongoing evaluation that identifies progress toward measurable outcomes and areas in need of improvement or change.
- Strong community partnerships provide families with additional services such as child care, mental health counseling, substance abuse treatment and domestic violence intervention.

Conclusion

In closing, the value of public investments in young children and their families is obvious when looking at the long-term societal benefits. According to the Center on the Developing Child at Harvard University, "the empirical data from cost-benefit studies presents a compelling case for early public investments targeted towards children who are at greatest risk for failure in school, in the workplace, and in society at large." Home visitation is an effective, evidence-based, and cost-efficient way to bring families and resources together, and help families to make choices that will give their children the chance to grow up healthy and ready to learn. Florida recognizes that an array of home visiting services is needed to meet the diverse needs of families throughout our state. We believe that HR 2667 is an important step towards ensuring that families have access to these valuable services so that all children have the opportunity to grow up in a safe, healthy, and nurturing environment.

Contact Information:
Carol McNally, Executive Director
Healthy Families Florida

Statement of Howard S. Garval

What could be more important than preventing child abuse and strengthening families? Nothing. That is why I am writing in strong support of HR 2667 The Early Support for Families Act and I urge passage of this important bill.

Hawaii invented **Healthy Start**, an evidence-based model of home visiting for parents of newborns who are at various levels of risk of child abuse. Healthy Start led to the replication in over 35 states of similar programs under the **Healthy Families America** umbrella. In Hawaii we have had a longstanding partnership with Johns Hopkins University as the evaluator for this statewide effort. Child & Family Service is one of six providers in the state and also the largest provider of Healthy Start services. In Hawaii we added Child Development Specialists and Clinical Specialists to the team with paraprofessional family support workers because we found that the severity of many of the families dealing with substance abuse, mental health problems and domestic violence were beyond the competency of the home visitors. By adding these positions and providing increased training by a seventh organization here, we have strengthened the program and more recent evaluations have been very encouraging. For several years now we know that for families that stay one year or more in this voluntary program there has been a success rate of over 99% as defined by no report of child abuse/neglect. 50% of families stay a year or more and Hawaii's results compare favorably to many programs in other states. For a voluntary program, 50% retention after one year is a good result. We are also beginning to define more clearly where the current model is especially successful; i.e. with anxious moms. We continue to look at ways we can make the program even more effective and Hawaii was recently one of only 17 states to be awarded a $2.5 million grant by ACF to work on further improvements to the program and to share the results of these efforts nationally. ACF recognized all that Hawaii has done in

this area and wants us to share what we are learning and will learn with the rest of the country.

There is a growing body of evidence from research that shows the effectiveness of home visiting programs to prevent child abuse. There is also abundant research to show the importance of early childhood experiences in future outcomes for children. The ACE (Adverse Childhood Experiences) study is one good example that actually shows that many costly and serious medical problems are more prominent in adults who as children suffered adverse childhood experiences like the trauma of child abuse. We also know the huge cost in human, social, and economic terms of not preventing child abuse. In this economic downturn where states are cutting back services, more children and families are at risk of serious negative outcomes. This legislation could not come at a better time for this reason, but at any time this is a smart and good investment in resources that will pay huge dividends in the years to come. It will offer hope to the youngest and most vulnerable in our communities and strengthen the family as the foundation for healthy child development.

I urge you to strongly support HR 2667 The Early Support for Families Act.

Thank you for the opportunity to submit testimony.

With much Aloha,

Howard S. Garval, MSW

Statement of Kansas Children's Service League

Kansas Children's Service League (KCSL) thanks the Chairman and the other distinguished members of the U.S. House Committee on Ways and Means Subcommittee on Income Security and Family Support for this opportunity to provide the organization's perspective on the need for a federal investment in early childhood home visitation. In particular, we would like to thank Chairman McDermott, Representative Danny Davis and Representative Todd Platts for their leadership on this issue, as most recently demonstrated with their introduction of the Early Support for Families Act of 2009 (HR 2667).

Kansas Children's Service League (KCSL) is a not-for-profit agency standing on 116 years of tradition serving children and families throughout the state of Kansas, strengthened by a mission to protect and promote the well being of children. KCSL serves as the Kansas Chapter of Prevent Child Abuse America; is a charter member of the Child Welfare League of America; and has achieved national accreditation from the Council on Accreditation and Healthy Families America. Our collective efforts are aimed at keeping children safe, families strong and communities involved. Through this testimony our organization will identify the value of the Healthy Families home visitation programs in Kansas along with our full support for federal investment to enhance and expand our nation's ability to promote healthy early childhood experiences.

KCSL fully supports and reiterates testimony submitted by Prevent Child Abuse America on June 9, 2009 to the U.S. House of Representatives Committee on Ways and Means. In the 13 years of our Healthy Families intensive home visitation programs in Kansas, our experience tells us that this program keeps children healthy and free from abuse and neglect. Our results mirror those found among our sister programs across the nation including:

- 96% of the children served are current on immunizations;
- 84% of the families served have a primary medical provider;
- 87% have smoke free homes;
- 99% receive nutrition and physical activity information and training; and
- 99% are free of abuse and neglect.

This is incredible given that these families enter the program facing numerous (often 4 or more) risk factors heightening the potential chance of child maltreatment.

We would like to take this opportunity to share with you the story of one of our families. Maria's baby, Jennifer, was born with only one functioning kidney. Maria, a 22-year-old first time single parent entered our program unemployed, without stable housing and less than a high school education. Her own childhood had been somewhat disruptive. Maria stated that her grandmother did most of the caretaking because her father came and went and her mother "worked hard to put food on the table". Maria admits to being a very strong willed child and to being hit with a switch "or anything she could get her hands on" when she wouldn't listen to her mother. The KCSL Healthy Families worker completed weekly home visits and developmental screens to make sure Jennifer was doing well with her physical, social

and emotional development. The developmental screen performed by the KCSL Healthy Families worker confirmed a possible delay and the family was connected with an area Infant/Toddler program so that she could receive home-based speech therapy.

Over the 3.5 years that the family has been in the program they have met nearly 90% (8/9) of their goals. These goals have been focused on a variety of needs including: Jennifer's medical condition; employment; healthy relationships; stable housing; and parenting. Jennifer has received a clean bill of health from her medical provider and kidney specialist and is on target or ahead of the developmental milestones for her age. Maria is proud as she reviews all of her family's progress thus far. She will graduate from the Healthy Families program this summer as Jennifer prepares to enter preschool in the fall. The smile on Maria's face shows this pride as well as the knowledge that she is doing everything she can to help her child remain healthy and thrive.

As you can see, the home visitation and services of Healthy Families is vital to the well-being of children and their families. Thank you for this opportunity to submit testimony and please accept our full support for the Early Support for Families Act of 2009 (HR 2667).

Statement of Kathee Richter

I am the Child Development Director of Neighborhood House, a non-profit organization serving the Seattle/King County area in Washington State.

Our organization is strongly in support of the Committee's efforts to advance legislation supporting investments in evidence-based home visiting programs that enhance early learning and reduce child abuse and neglect.

For the last four years, Neighborhood House has delivered the Parent-Child Home Program (PCHP) to 80 immigrant and refugee families a year with strong outcomes for both the parents and the children ages 2 and 3 who are the program participants. PCHP is one of the major national home visiting programs. Substantial research exists supporting its ability to improve school performance, lower high school dropout rates and improve high school graduation rates.

We employ paraprofessional home visitors who are bilingual or multilingual and from the cultures of the families served. I do not believe we would have been able to engage or effectively serve these families if our staff did not speak their language or was not from the same culture.

Overview of Neighborhood House

The mission of Neighborhood House is to help diverse communities of people with limited resources attain their goals for self-sufficiency, financial independence, health and community building.

From our earliest beginnings serving Jewish immigrants in the 1900s to our work today with people from numerous countries and cultures, Neighborhood House has helped generations of families fulfill the promise of America—an education for their children, self-sufficiency for their families and a meaningful place in a caring community.

Our case workers, teachers, volunteers and tutors (many of whom are bilingual or multilingual) work in neighborhoods across King County. We provide tutoring, citizenship classes, early learning programs, job training, case management, community health programs and transportation to more than 11,000 low-income people each year.

Selection of Neighborhood House for Funding from Business Partnership for Early Learning

Neighborhood House was selected in a competitive request for proposal in 2005 to receive a grant from the Business Partnership for Early Learning (BPEL). BPEL is a group of business and philanthropic leaders in King County investing in closing the school achievement gap for those children most likely to arrive at kindergarten with a "preparedness gap" they may never be able to overcome and for those parents are the most isolated.

Neighborhood House was selected because BPEL knew from public school data that a sizable proportion of the students with low school success and graduation rates are those who are English Language Learners and whose families live in poverty. Neighborhood House has a success track record of serving immigrant and refugee families from all over the world in its family support and early learning programs.

Overview of the Parent-Child Home Program

The Parent-Child Home Program is a research-based school readiness home visiting program for 2- to 3-year-olds and their parents. Paraprofessionals provide home visits twice weekly over a two-year period and bring gifts of books and educational toys. The home visitors provide parent coaching by modeling behaviors that stimulate early learning and help the parents experience the intrinsic rewards of seeing their child enjoy learning.

Description of Families Served with PCHP

- None of the 160 families a year that we serve have English as their home language.
- As many as 75 percent of parents have limited literacy levels and cannot easily read English or their home language.
- Among the more than a dozen languages spoken by the families are Vietnamese, Chinese, Cambodian, Cham, Spanish, Somali, Amharic, Oromo, and Tigrinya.
- Almost 90 percent of our families have an annual income of $25,000 or less; 40 percent have an income of $10,000 or less.
- Many parents are unfamiliar with the notion of children as young as age 2 being able to learn or engage with books.

Description of our Staff for the Parent-Child Home Program

We have two Program Coordinators who hire, train and supervise the home visitors. One coordinator has a Bachelor of Arts degree and speaks Tigrinya, Tigre, Amharic, Arabic and English. The other coordinator was a medical doctor in Cambodia and has a Masters Degree in social work and population leadership on reproductive and child health programs. She speaks Cambodian/Khmer, Thai, Lao, French and some Vietnamese. We employ 9 home visitors. Their ethnicity and the languages they speak are as follows: Mexican (Spanish), Somali (Somali), Cambodian (Khmer), Vietnamese (Vietnamese, Cham), Ethiopian (Amharic, Tigrinya, Oromo, Afari, Arabic)

The Success of Parents and Children in Our Parent-Child Home Program

In each of the four years we have delivered the Parent-Child Home Program, both the children ages 2 and 3 and their parents have achieved, based on a third-party outcome evaluation, statistically significant increases from baseline to end of Year 1 and from end of Year 1 to end of Year 2 on all items observed by coordinators.

Parents reported an increased understanding of their role in helping prepare their child for school, increased parenting skills and a greater commitment to participate in the education of their child. Children increased their use of behaviors that are beneficial for school readiness, including social skills, learning skills, and pre-literacy skills.

We have achieved a 90 percent or higher retention rate over the two-year program. Families only leave the program if they move out of our service area or for another reason that precludes them from continuing.

Our programs were certified by The Parent-Child Home Program's national office in 2008 as meeting all requirements of its replication agreement and implementing those components with fidelity and quality.

We also believe PCHP helps prevent child abuse and neglect, as it builds the protective factors in both parents and children that are known to prevent child abuse and neglect. We know that positive parent-child interaction, one of the key outcomes of PCHP, is a critical factor in the prevention of child abuse. However, we do not have the capacity or resources to track reduction in child abuse and neglect for our families who receive PCHP services.

Factors Influencing Our Successful Implementation of PCHP

We consider it absolutely essential to employ home visitors who share the language and cultural backgrounds of the families they visit. This is required because:

- Facilitates communication with families for recruitment, enrollment and service coordination.
- Home visitors are able to quickly establish trust and relationships with families.
- Home visitors are accepted and considered to be trusted, credible sources of information about parenting and child development.
- Home visitors understand and are able to effectively talk with parents regarding beliefs about parenting and child development shaped by cultural background and experience.

- Supports parents who may not be strong readers in feeling competent and confident to share books with their children by modeling techniques such as "picture reading" (telling a story through description of pictures instead of reading verbatim from a book). Parents are then more likely to share books with their children on their own.
- Supports parents' belief in their children's ability to learn, so parents are more likely to become invested in their role as "first teacher" and help their child prepare for school.
- Facilitates communication and understanding regarding how fathers might be involved in sharing books and toys with children, even if this is not a traditional parenting role.

Each home visitor receives 16 hours of initial training and a minimum of two hours of supervision each week. In addition, home visitors attend local classes and workshops in early learning and receive extensive coaching and problem-solving support from the Program Coordinators.

Community Need to Continue and Expand Parent-Child Home Program

We are contacted regularly and asked to serve additional families both within our service area and outside it. We currently do not have the resources to serve any more families.

We believe there are hundreds of families just in the Seattle/King County area who would greatly benefit from participation in PCHP.

We know that about 45 percent of Washington State children ages 0 to 5 are at home with their parents and another 21 percent are cared for by relatives, friends and neighbors. This means that about two-thirds of young children statewide are largely overlooked and underserved by investments in child care centers and preschools. Many of those children will not be ready for school if we do not go where the children are and engage their parents in ways that are effective and culturally appropriate.

Conclusion

Thank you for the opportunity to provide you with information on the success of our replication of the Parent-Child Home Program, using paraprofessionals who speak the languages and are from the cultures of the diverse immigrant and refugee families we serve.

We believe these home visiting programs, and other evidence-based programs, are essential to giving all young children a fair chance to succeed in school and life. In turn, they make our communities stronger and reduce the cost of bad outcomes for our children.

Kathee Richter
Child Development Director, Neighborhood House
Seattle, Washington

Statement of Lenette Azzi-Lessing, Ph.D.

Dear Congressman McDermott and Subcommittee Members:

I am writing to provide testimony on proposals to provide federal funding for early childhood home visitation programs. Last week, the subcommittee heard testimony on the Administration's plan to target $8.6 billion—over the next 10 years—for home-visiting programs for disadvantaged families with young children. Early childhood advocates strongly support this policy direction, given the damaging impact that poverty has on children's long-term ability to learn and succeed in school and in life.

In recent years, home visiting programs for poor families have won the backing of political leaders on both sides of the aisle as well as that of business leaders and economists. Much of this support stems from expectations that these programs will reduce the likelihood that poor children will fail in school, become delinquent or need welfare. Economic analyses indicating that home visiting programs can deliver an excellent return on investment by shrinking public expenditures for juvenile justice and welfare programs have caught the attention of members of Congress as well as of President Obama, who, as a candidate, pledged to extend these services to 570,000 families a year.

The President deserves high praise for allocating substantial resources to improve the life chances of young children in poverty. However, not all home-visiting programs are alike and it is critical that these new funds are targeted towards strategies that hold the greatest promise. Much of the return on investment argument is

based on the results of a study conducted 30 years ago, in which nurses provided home-visits to a relatively small group of first-time mothers living in rural parts of Elmira, New York. This program, known as Nurse Family Partnership (NFP), utilizes nurses to support and educate new mothers during their pregnancy and throughout their child's first two years of life. Babies born to NFP-participating mothers in Elmira were healthier at birth, and their families were on welfare for substantially shorter periods of time than families not enrolled in the program.

What set NFP apart from other home visiting programs was its rigorous evaluation, in which families were randomly assigned to participate in NFP or to be in a control group. Similar to procedures used by the FDA for testing new medications, this type of evaluation is considered the gold standard for measuring program effectiveness. The compelling results from the Elmira program, along its the stringent evaluation methods won support for NFP as a "proven" program that is now a frontrunner for expansion with the new federal funding.

Receiving far less attention are the results of two subsequent tests of NFP that were conducted in the 1990's with larger groups of poor women and their babies in the inner cities of Memphis and Denver. Many of the benefits experienced by the Elmira participants faded or disappeared altogether for the families in these two studies. The diminished outcomes in later evaluations of NFP point to the pitfalls inherent in attempting to apply a one-size-fits all model of intervention to an increasingly diverse array of families. It is likely that the families in the Memphis and Denver studies were more vulnerable than those in Elmira, due to high crime rates and other stresses of inner-city life and the shrinking safety-net that culminated in the mid 1990's with the passage of welfare reform. NFP's capacity to help was probably outstripped by the multiple challenges facing these more contemporary families.

More-recent evaluations of home-visiting programs provide critical information about was does and doesn't work in intervening with today's vulnerable families. Programs that combine group learning opportunities for infants and toddlers—like those offered in the best childcare centers—with home visits to educate and support parents, appear to hold the most promise for improving poor children's learning abilities. Moreover, home visiting programs that offer a flexible range of services that can be customized to meet the unique needs of each family served are often most effective. In order to significantly improve the prospects of disadvantaged children, however, interventions must get at the root cause of their plight, which is poverty. This means providing poor parents with education and job training as well as subsidizing their childcare and health care costs as they work their way up from low-paying, entry-level jobs.

Developed 15 years ago by the nation's top experts in child development, the federal Early Head Start program incorporates many of these recent findings. This program aims to help poor infants and toddlers reach their full learning potential while assisting their parents with employment, housing, mental health and a range of other needs. Like NFP, Early Head Start utilizes nurses, but the program also draws upon the expertise of early childhood educators, social workers and mental health specialists to offer a more comprehensive array of services.

Early Head Start has the capacity to provide a customized mix of home visits and services delivered to children in daycare centers—making the program accessible to working families. Moreover, the program works with families that have more than one child and can be adapted to serve infants and toddlers with disabilities as well as those placed in foster care—children at particularly high risk for poor outcomes. Evaluation of Early Head Start—utilizing methods as rigorous as those used by NFP—is currently underway in 17 sites across the country and results are encouraging. Participating children are showing improvements in mental and emotional development; these gains are especially strong for children receiving a combination of home and center-based services.

Dollars allocated to home-visiting in the proposed federal spending plan should go towards expanding Early Head Start and for rigorously evaluating other comprehensive but smaller-scale approaches operating in a number of communities. Currently funded at $1 billion year, Early Head Start serves only about 3% of the low-income infants and toddlers who are eligible for the program. The stimulus package allocates an additional $1.1 billion that will double the number of children participating in Early Head Start; but reaching only 6% of the youngest, poorest and most vulnerable children in America is an anemic example of change we can believe in.

Members of the Committee must recognize the complex and recalcitrant nature of the factors that threaten the future prospects of disadvantaged, young children—factors made worse by the current recession. These children need and deserve the

most promising interventions we have: those that are proven to work under the extraordinarily challenging conditions confronting poor families today.

Lenette Azzi-Lessing, Ph.D., is on the faculty of the School of Social Work and Family Studies at Wheelock College, Boston. She has 25 years experience in developing, operating and evaluating programs for disadvantaged, young children and their families and is currently writing a book on strategies for eliminating childhood poverty in the United States. She can be reached at lalessing@wheelock.edu.

Statement of Marcia Slagle

In 1998 the Anderson County Health Council received a three-year demonstration grant from Covenant Health to implement Healthy Start of Anderson County. In 1995 and 1998 Anderson County did not qualify for funding from the Division of Maternal and Child Health (Tennessee Dept of Health) because money was directed to areas with the lowest income and highest minority population. Although Anderson County's average income looks high (due to Oak Ridge), many areas of the county reflect the surrounding area's isolation, poverty of income and opportunity.

Healthy Start of Anderson County is credentialed by Healthy Families America, the parent organization. The goals are set by the national organization and are as follows:

- promote positive parenting
- encourage and improve child health and development
- prevent and/or reduce child abuse and neglect.

These goals are met by providing in-home education for the parents. The weekly visits involve teaching age-appropriate curriculum for the baby, mentoring of good parenting skills, monitoring the baby's growth and development, and providing referrals for community resources. Parents at greater risk to use inappropriate child-rearing techniques are those who lack basic resources, support and information about effective child-rearing and have limited educational and work experiences. When children from these families grow up, they are at increased risk to develop serious problems with truancy, drug abuse, delinquency or mental illness. The positive outcomes of prevention programs, with even relatively small reductions in the rate of child maltreatment, demonstrate that **prevention can be cost-effective**. Most of the investments in prevention, particularly as they apply to investments in families with young children, are likely to have "payback curves" that extend over a long period of time, with much of the savings occurring when the child reaches a healthy, productive and nonviolent adulthood.

Research shows that about 25,000 children are abused or neglected every year in Tennessee. The Department of Children's Services recently stated that "every foster child in state's custody costs the state $50,000 a year." A recent news article stated that Tennessee taxpayers pay approximately $850,000,000 yearly in costs related to child abuse. There is legislation before Congress now called "Education Begins at Home Act" (s.503). The bill would provide $500 million in federal funds over three years to establish and/or expand home visitation programs in all 50 states. Anderson County has had a program like this for **10 years** and that program is **Healthy Start**!

The Healthy Start advocacy committee was formed in 2007. This committee has helped introduce the residents of Anderson County to the important work of Healthy Starts. A "Blue Ribbon Campaign" in April was held in conjunction with Prevent Child Abuse Awareness Month. Proclamations from the County Commission as well as local city governments designated April as prevent child abuse awareness month. There were two social events held (one in Clinton and one in Oak Ridge) to spread awareness of Healthy Start. The committee has completed a letter campaign to raise funds. The committee also saw a need to hire a part-time grant writer to help secure more funding. The grant writer searches for foundations and other funding sources to apply for monies. The League of Women Voters continues to be our advocate to the local and state leaders to find new funds. In October 2006, we began a collaboration with the Oak Ridge Unitarian Church congregation to provide volunteers to assist with our families. The members of this congregation have supported us this past year with transportation needs, hauling furniture, and meeting emergency financial needs of our families as they arise.

On December 5, 2007, the Centers for Disease Control reported that "for the first time in 14 years, the number of teenagers having babies in the United States rose." It was also stated that one reason for the teen birth rate rise might be partly a result of not reaching hard-to-reach teens. Many programs addressing teen pregnancy

had been eliminated because teen pregnancy and teen births had lessened consistently since 1991. Healthy Start had to eliminate the job of the Family Support worker serving the rural parts of Anderson County because of cuts in funding in 2005. All of the participants served in the rural areas prior to 2005 were teenagers (ages 14–19). One of the goals for Healthy Start in 2009 is to hire a Family Support worker to serve the first-time parents in the rural parts of the county again.

Description of Agency:

The Anderson County Health Council was chartered as a private non-profit agency in 1968 for the purpose of promoting and assuring the highest level of health obtainable for every resident of Anderson County. 501(c)(3) status was received November 29, 1972. The volunteer Board of Directors consists of twenty-seven residents (nine residing in Oak Ridge), who serve on different committees which give focus and determine the direction of the Health Council's efforts. The Anderson County Health Council receives funding from United Way of Anderson County; private, state and federal grants; local governments; and private donations.

Services Offered:

To qualify for the Healthy Start program a family must be a first time parent, meet the risk assessment that documents need for the program, and be a resident of Anderson County. Services include, but are not limited to: educational and supportive home visits; developmental testing of babies; group support meetings; parent and baby transportation to health and social services; used maternity and children's clothing; emergency formula, diapers and food; lending library of baby equipment and car seats; monthly age-appropriate children's books; referrals to community services; and staff attendance at birth of baby when appropriate.

June 9, 2009

Mr. Chairman and Members of the Subcommittee:

I am pleased to submit the following written testimony to the Subcommittee on Income Security and Family Support on behalf of ZERO TO THREE. My name is Matthew Melmed and for the last 14 years, I have been the Executive Director of ZERO TO THREE, a national non-profit organization that has worked to advance the healthy development of America's infants and toddlers for over 30 years. I would like to start by thanking the Subcommittee for its interest in examining the issue of early childhood home visiting programs and for providing me the opportunity to address the interaction between these programs and other policies and programs that focus on infants and toddlers.

Any new parent will likely tell you that parenting is the most rewarding *and* the most difficult job they have ever had. Especially during the first years of their child's life, parents play the most active and influential role in their baby's healthy development, and it can be challenging to do so without support from others.[1] Unfortunately, many parents face obstacles—such as those caused by stress, geographic and social isolation, and poverty—that impact their ability to fully support their baby's development during these critical years.

Almost half (43 percent) of all infants and toddlers live in low-income families (below 200% of the federal poverty level), and 21 percent live in poor families (below 100% of the federal poverty level).[2] One of the most consistent associations in developmental science is that between economic hardship and compromised child development.[3] Infants and toddlers in low-income families are at greater risk than infants and toddlers in middle-to high-income families for a variety of poor outcomes and vulnerabilities that can jeopardize their development and readiness for school, including learning disabilities, behavior problems, mental retardation, developmental delays, and health impairments.[4]

Fortunately, intervening early in the life of a child at risk for poor development can help minimize the impacts of these risks. While you are focusing today on a specific method of delivering services, I urge you to think in terms of developing a comprehensive system of services that provide a prenatal through pre-kindergarten continuum and place home visitation squarely in that context rather than establishing

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[1] National Research Council and Institute of Medicine, From Neurons to Neighborhoods: The Science of Early Childhood Development. Jack Shonkoff and Deborah A. Phillips, eds. Washington, DC: National Academy Press, 2000.

[2] Ayana Douglas-Hall and Michelle Chau. *Basic Facts about Low-Income Children: Birth to Age 3.* National Center for Children in Poverty, 2008, http://www.nccp.org.

[3] National Research Council and Institute of Medicine, *From Neurons to Neighborhoods.*

[4] Ibid.

it as an isolated program. Such a system would ensure that the critical needs of vulnerable infants and toddlers—regardless of the setting in which they might be reached—are included in early childhood planning. That system would help parents and early childhood professionals promote healthy development across all domains. Services in this system should support parents in forging bonds with their children since developing strong attachments provides the needed foundation for a child to explore and learn as well as to regulate their emotions as they interact with others (social and emotional development). Such services should also help parents and babies engage in play, reading, and other activities that foster early language skills (cognitive development) and they should promote good nutrition and attention to well-child care (physical development).

Supporting Parents and Child Development through Home Visiting

Voluntary home visiting programs tailor services to meet the needs of individual families, and they offer information, guidance, and support directly in the home environment. While home visiting programs, such as Healthy Families America, the Nurse-Family Partnership, the Parent-Child Home Program, and Parents as Teachers, share similar overall goals of enhancing child well-being and family health, they vary in their program structure, specific intended outcomes, content of services, and target populations. Program models also vary in the intensity of services delivered, with the duration and frequency of services varying based on the child's and family's needs and risks.

A growing body of research demonstrates that home visiting programs that serve infants and toddlers can be an effective method of delivering family support and child development services, particularly when services are part of a comprehensive and coordinated system of high quality, affordable early care and education, health and mental health, and family support services for families prenatally through prekindergarten. Research has shown that high quality home visiting programs serving infants and toddlers can increase children's school readiness, improve child health and development, reduce child abuse and neglect, and enhance parents' abilities to support their children's overall development.[5] The benefits of home visiting, however, vary across families and programs. What works for some families and in some program models will not necessarily achieve the same success for other families and other program models.

Home Visiting within a Comprehensive Early Childhood Program: The Early Head Start Example

Comprehensive programs serving families with young children may incorporate a strong home-based component even though they are not described as home visiting programs; one such model is Early Head Start (EHS). EHS programs can use a home-based approach, a center-based approach, or a combination of the two. The Early Head Start evaluation results for home-based programs showed that, when compared to a control group, parents in the programs demonstrated more positive impacts with regard to providing more stimulating environments, gaining a greater knowledge of child development, and reporting less parental stress. Children in the program showed stronger vocabulary development at age 24 months compared with control group children, were more engaged with their parents during play at this age, and, in programs that fully implemented the Head Start Program Performance Standards, showed positive impacts on child cognitive and language development at age 36 months.[6]

It is important to note, however, that other approaches to supporting parenting and early childhood development can have a positive impact as well. Center-based programs, by themselves, have proven to have impacts on child cognitive development at both 24 and 36 months of age, as well as on other child and parenting outcomes, but without a consistent pattern.[7] On the other hand, Early Head Start programs using a mixed approach, a combination of center- and home-based approaches, showed strong impacts at both 24 and 36 months for parenting and child

[5] Elizabeth DiLauro, *Reaching Families Where They Live: Supporting Parents and Child Development through Home Visiting.* Washington, DC: ZERO TO THREE, 2009.

[6] U.S. Department of Health and Human Services, Administration for Children and Families, *Research to Practice: Early Head Start Home-Based Services.* U.S. Department of Health and Human Services, 2003, http://www.acf.hhs.gov.

[7] Ibid., fn. 3.

outcomes. *In fact, the national evaluation found the strongest pattern of impacts on children and families in mixed-approach programs.*[8]

One issue that surfaced in the examination of Early Head Start when services are delivered through the home is that families with more risk factors (e.g. teen parents, parents with depressive symptoms, parents with high school diplomas) tended to have visits that spent more time on parent-development needs with less time aimed at child-focused activities. More time spent on child-focused activities was associated with better outcomes in the areas of cognitive and language development and increased parental ability to support development. This finding underscores the idea that program models must be prepared to tailor services such that the needs of children and parents are carefully balanced. Programs that are serving families with high needs require staff who are capable of addressing such needs while also being able to maintain a strong focus on the child and the parent-child relationship. It is also quite possible that these children might benefit from center-based services to further enhance development and support families.

Translating Research into Practice: Recommendations for a New Home Visiting Initiative

ZERO TO THREE is pleased to see that the Administration and Members of Congress have continued to shine a spotlight on high quality home visiting initiatives. As stated earlier, home visiting is an important way to deliver services within a prenatal-to five-system of early childhood development. In considering legislation to promote a two-tiered mandatory funding approach to creating and expanding home visiting programs in the states, we recommend that the Subcommittee take into account the following recommendations based on the science of early childhood development:

1. Integrate home visiting programs into a broader state early childhood system and infrastructure, and emphasize coordination among home visiting programs. As policymakers work to expand access and improve home visiting services for young children and their families, they should ensure that services are not established in isolation, but are integrated into a broader state early childhood system that incorporates a strategy to reach all vulnerable young children in a coordinated way. Such a system should reach children in a variety of settings and include professional development, training, and technical assistance for providers; data collection; program standards; and quality assurance and improvement efforts. Thirty-two states are currently operating a statewide home visiting program, yet only 18 states link these home visiting programs to other supports for early childhood development at the state level.[9] Representatives of home visiting programs should work with other such programs within the state and participate in community and statewide collaborative groups to improve the coordination of services for young children and their families across agencies and programs, particularly since some programs have been known to work better for families with certain risk factors.

Federal legislation establishing state home visiting programs should ensure that such linkages occur by requiring that they be part of the planning and implementation efforts of the State Advisory Councils on Early Childhood Education and Care, created by the Improving Head Start for School Readiness Act of 2007, as well as other state-specific early childhood oversight boards. Governors should appoint home visiting representatives to the Councils. The Councils are tasked with, among other things, conducting a periodic statewide needs assessment concerning the quality and availability of early childhood education and development programs; identifying opportunities for, and barriers to, collaboration and coordination among federally-funded and state-funded child development, child care, and early childhood education programs and services; and developing recommendations for increasing the overall participation of children in existing early childhood education programs. Given their role in coordinating and planning state-level activities for very young children, home visiting representatives are a logical fit with the Councils' activities.

2. Develop a continuum of care for young children and their families by coordinating home visiting efforts with other child development services in the community. No one single home visiting program, by itself, is a silver bullet for all children, all families, and all communities. Connecting home visiting efforts, particularly those focused on children's well-being and healthy development, with other child and family services at the community level will help to ensure that young children and par-

[8] U.S. Department of Health and Human Services, Administration for Children and Families, *Early Head Start Benefits Children and Families*. U.S. Department of Health and Human Services, 2002, http://www.acf.hhs.gov.

[9] National Center for Children in Poverty, *United States Early Childhood Profile. National Center for Children in Poverty, 2007, www.nccp.org.*

ents have the comprehensive support they need. In instances when parents and children have needs that are not addressed by the home visiting program in which they are enrolled, they should be linked to other resources available in their community, such as high quality child care programs and comprehensive early childhood programs such as Early Head Start, early intervention programs, health assistance programs, and mental health services.

3. Ensure that all home visiting initiatives incorporate known elements of effectiveness and use a model appropriate to the needs of the targeted population. There is growing consensus on a list of key elements of effective home visiting models that are most likely to achieve outcomes for young children and their families. This list includes:

- solid internal consistency that links specific program elements to specific outcomes;
- well-trained and competent staff;
- high quality supervision that includes observation of the provider and participant;
- solid organizational capacity; linkages to other community resources and supports; and
- consistent implementation of program components.[10]

Policymakers should ensure that a new home visiting initiative incorporates these key elements focused on effective design and implementation to ensure high quality and effective service delivery. Additionally, as services are expanded within states, policymakers should ensure that program models are implemented with families that exhibit characteristics similar to those for whom the program has been tested. Not all families will need the same level or intensity of services. In a review of state-based home visiting initiatives, 31 states operating 55 programs reported using different approaches for different families, providing more intensive services to families with greater risks and needs.[11] We must ensure that the most at-risk families receive the most intense supports available, while ensuring appropriate services for those with fewer risks for poor developmental outcomes.

4. Support rigorous, ongoing evaluation and continuous improvement efforts for home visiting programs. Program evaluation allows home visitors, supervisors, funders, families, and policymakers to know whether a program is being implemented as designed and how closely it is meeting objectives. This information can be used to continually refine and improve service delivery for young children and their families, as well as provide an evidence-based rationale for the expansion of home visiting programs. We know, based on research, that many programs and models have made a difference in the lives of those most at-risk. We need to continue to build on this research and provide adequate funding to allow promising models and strategies the chance to conduct more rigorous research. We must keep in mind, however, that not all programs can be delivered under the ideal situations in which rigorous evaluations are conducted. Not all populations will look identical to those for whom evaluation data was collected and expansion efforts should allow for innovation in serving harder to reach populations, including families living in rural areas or those who are homeless. When financing home visiting programs, policymakers should ensure that adequate time and funding are included for thorough evaluation of existing programs as well as sufficient funding to incentivize the development, expansion, and evaluation of demonstration projects for harder to reach families.

Conclusion

All young children should be given the opportunity to succeed in school and in life just as all parents should receive the support they need to nurture their children's development. While vulnerable children may have greater challenges to overcome, we should not assume that those challenges can only be addressed with services later in life. Instead, we should invest in a continuum of programs, starting from the prenatal period forward, when our investment can have the biggest payoff and help prevent problems or delays that become more costly to address as they grow older.

Home visiting is an important strategy in providing services to at-risk infants, toddlers, and their families. By investing in programs proven to be effective, and integrating those successful programs into a broad range of services that touch the

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[10] Deborah Daro, *Home Visitation: Assessing Progress, Managing Expectations.* Ounce of Prevention Fund and Chapin Hall Center for Children, 2006, www.chapinhall.org.

[11] Kay Johnson, *State-based Home Visiting: Strengthening Programs through State Leadership.* New York, NY: National Center for Children in Poverty, 2009.

lives of infants, toddlers and their families, we can make great strides in early childhood development and education and lay the foundation for later school success.

Thank you for your time and for your commitment to our nation's infants, toddlers and their families.

WITNESS INFORMATION

Name: Matthew Melmed

Title: Executive Director

Organization: ZERO TO THREE: National Center for Infants, Toddlers and Families

Washington, DC

References

Statement of Nancy Ashley

I am the Project Director of the Business Partnership for Early Learning (BPEL). BPEL is a group of business and philanthropic leaders in King County, Washington State that is investing in a home visiting program to close the school achievement gap for those children in isolated families that are most likely to arrive at kindergarten with a "preparedness gap" they may never be able to overcome.

Overview of the Business Partnership for Early Learning

The Business Partnership for Early Learning is a group of 20 Seattle area businesses that together have invested $4 million into a five year early learning program that is reaching 400 two and three year old disadvantaged Seattle children. Among our major investors are the Bill & Melinda Gates Foundation, The Boeing Company, Safeco Corporation, Group Health Cooperative, The Seattle Foundation, and United Way of King County.

Why the Business Partnership for Early Learning is Investing in Early Learning

BPEL believe s that investments in early learning have a very high rate of return, and can simultaneously help kids and raise workplace productivity. Before investing, the founders of BPEL carefully researched the return on investments in early learning and concluded that for them and for the state, it offers the highest return of any social investment.

Why the Business Partnership for Early Learning is Investing in the Parent-Child Program Home Visiting Model

BPEL investors wanted to demonstrate that an effective intervention could be found that would reduce the achievement gap for vulnerable children by identifying young children from the most hard-to-reach families and providing the parents with the tools, motivation and confidence to get their children ready for school.

They selected the Parent-Child Home Program because it was designed for high-risk families and it targets the intervention to the parent-child dyad. All home visits must take place with the parent and the child together.

PCHP serves families challenged by poverty, low levels of education, language and literacy barriers and other obstacles to educational success. Many of them are isolated both physically and mentally by poverty, lack of transportation, and parental stress.

In addition, the Parent-Child Home Program had 40 years of research and evaluation behind it that confirmed the program's long-term impact on children who complete the program. The PCHP curriculum is designed to engage parents in non-threatening, playful activities on a predictable schedule with a trusted, friendly Home Visitor. The Program's approach is both research-based and research-validated: it is an early intervention model, it focuses on early literacy both within a social-emotional and cognitive/language development context, and it emphasizes both the parental bond and parental responsibility.

BPEL Project Demonstrates that Home Visiting is a Powerful Strategy for School and Life Success

BPEL provides grants to two nonprofit organizations in King County to deliver the Parent-Child Home Program to 160 families a year. The program reaches low-income families speaking over 15 languages, and brings gifts of books and toys to the homes to model how parents can guide their children's development. A large proportion of the families are immigrants and refugees who are unfamiliar with the concept that children can learn before they go to school and who do not understand

the role of the parent in preparing a child for school. Many families have no books or educational toys in their homes.

Both nonprofit agencies employ paraprofessional home visitors who speak the languages and reflect the cultures of the families they serve.

Evaluation of BPEL's project has concluded that diverse families and children (1) can be effectively reached in their homes, (2) the parents can be coached to become the child's first and ongoing teacher, and (3) the children can make substantial cognitive and pre-literacy gains.

Specific results are shown on the following page, for parents and children who completed the two-year program in 2008.

Expanded Home Visiting Efforts Needed in King County

Participants in BPEL know that growth in the skill level of our work force has declined and that a greater percentage of the future workforce will come from minority populations where levels of educational attainment are lower. These trends can be reversed by investing early in the lives of children from those populations, via agencies that are trusted and respected by their diverse communities. Research indicates that improving the quality of the parenting environment of young disadvantaged children will bring the most powerful results.

Many families who would benefit greatly from effective home visiting programs are not being reached. We have very little state funding to support home visiting, as almost all early learning funds now are devoted to the one-third of children who are in preschools or licensed child care centers.

Conclusion

The Business Partnership for Early Learning is strongly in support of the Committee's efforts to advance legislation supporting investments in evidence-based home visiting programs that enhance early learning and reduce child abuse and neglect.

BPEL believes that evidence-based home visiting programs are essential to giving all young children a fair chance to succeed in school and life, so they can provide us with the skilled workforce we need in this global economy.

Nancy Ashley
Program Director, Business Partnership for Early Learning
Seattle, Washington

Statement of The National Child Abuse Coalition

The National Child Abuse Coalition, representing a collaboration of national organizations committed to strengthening the federal response to the protection of children and the prevention of child abuse and neglect, supports the introduction of H.R. 2667, the Early Support for Families Act, legislation to provide home visitation services with mandatory funding available to promote an array of research- and evidence-based home visitation models that enable communities to provide the most appropriate services suited to the families needing them. We applaud the leadership taken by Chairman Jim McDermott with Representatives Danny Davis and Todd Platts to carry forward the initiative proposed by President Obama to create the first dedicated federal funding stream for the establishment and expansion of voluntary home visitation programs for low-income parents with young children.

The most effective strategy for preventing child maltreatment before it occurs is to provide new parents with education and support. Home visitation has long been identified as an approach that works to prevent the abuse and neglect of children. In 1991, the U.S. Advisory Board on Child Abuse and Neglect recommended as the highlight of its report, *Creating Caring Communities,* the establishment of universal voluntary home visitor services.[1] More than a decade later, the same conclusion was drawn by the Centers for Disease Control (CDC) Task Force on Community Preventive Services. Its 2003 report evaluating the effectiveness of strategies for preventing child maltreatment "recommends early childhood home visitation for pre-

[1] Panel on Research on Child Abuse and Neglect, Commission on Behavioral and Social Sciences and Education, National Research Council (1993). Understanding child abuse and neglect. Washington, D.C.: National Academy Press.

vention of child abuse and neglect in families at risk for maltreatment, including disadvantaged populations and families with low-birth weight infants."[2]

Voluntary home visitation is an effective and cost-efficient way to ensure that all children have the opportunity to grow up healthy, safe, ready to learn and able to become productive members of society. Investing in this research-proven approach now will mean savings down the road in costs associated with health, education, child maltreatment and criminal justice. The McDermott-Davis-Platts bill would support rigorously evaluated programs that utilize nurses, social workers, other professionals and paraprofessionals to visit families, especially lower-income families, on a voluntary basis. We look forward to adding our collective voice to support this initiative as it moves toward enactment in Congress.

An Imperative for Prevention

According to the most recent data released in April this year by the U.S. Department of Health and Human Services (HHS),[3] over 3 million referrals of possible child abuse and neglect cases were made to state child protective services (CPS) agencies in the United States in 2007. Close to 2 million of those referrals were accepted by CPS for an investigation or assessment, resulting in some 800,000 children found to be victims of child abuse and neglect.

Almost one-quarter of those child victims had a history of prior victimization. The HHS report says: "For many victims, the efforts of the CPS system have not been successful in preventing subsequent victimization." Indeed, over one-third (37.9 percent) of child victims reported to CPS in 2007 received no services following a substantiated report of maltreatment. The lack of available services, a gap desperately in need of attention, leaves children at risk of harm.

The youngest children continue to suffer the highest rate of victimization. Infants from birth to 1 year of age are the most vulnerable victims of abuse and neglect at the rate of 21.9 per 1,000 children of the same age group, representing 12 percent of all abuse and neglect victims. Nearly 32 percent (31.9%) of all victims of maltreatment were younger than 4 years old.

Fatalities due to child maltreatment remain high. An estimated 1,760 children died in 2007 as a result of abuse or neglect, up from 1,530 in 2006 and 1,460 in 2005. The rate of child fatalities was 2.35 deaths per 100,000 children, compared to a rate of 2.05 deaths per 100,000 children in 2006 and 1.96 in 2005. Again, the most endangered are the youngest: more than 40 percent (42.2 percent) of all fatalities were children younger than 1 year and three-quarters of children who were killed (75.7 percent) were younger than 4 years of age.

The incidence of child abuse and neglect is beyond the capacity of our current system of protective and treatment services to be of much help. Our system of treating abused and neglected children and offering some help to troubled families after the harm has been done is clearly overworked and inadequate to the task. Prevention is an imperative and an investment in home visiting services can focus our resources on preventing child abuse from happening in the first place.

Home visiting programs are often targeted to serve specific groups in a community: families with low-income; young parents; first-time mothers; children at risk for abuse or neglect; or low birth weight, premature, disabled, or developmentally compromised infants—those children who are most at risk of serious harm, as shown by the annual HHS data on child maltreatment reports.

Home visiting educates families and brings them up-to-date information about health, child development, parenting, literacy and school readiness, educational and work opportunities, and connects them to critical community services.

A Cost-Effective Strategy

Voluntary early childhood home visitation programs offer training to parents designed to enhance the well-being and development of young children by providing information on prenatal and infant care, child health and development, parental support and training, and referral to other community services, such as day care, respite care, and parent support groups. Home visits are conducted by nurses, social workers, other professionals or paraprofessionals.

A growing body of research has found strong evidence that early childhood home visitation programs are effective in reducing the incidence of child abuse and ne-

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[2] Hahn, Robert A., Ph.D., First Reports Evaluating the Effectiveness of Strategies for Preventing Violence: Early Childhood Home Visitation, Morbidity and *Mortality Weekly Report*, Centers for Disease Control and Prevention (Atlanta, GA, October 3, 2003 / 52(RR14);1–9.

[3] U.S. Department of Health and Human Services, Administration on Children, Youth and Families. Child Maltreatment 2007 (Washington, DC: U.S. Government Printing Office, 2009). U.S. Department of Health and Human Services, Administration on Children, Youth and Families. Child Maltreatment 2007 (Washington, DC: U.S. Government Printing Office, 2009).

glect, and in improving child health and development, parenting skills, and school readiness. While a majority of states currently provide early childhood home visitation services to a relatively small number of families, the challenge has been to take this proven effective prevention approach to scale. The enactment of the legislation proposed here can help to move toward that goal.

Investing in evidence-based early childhood home visitation is a cost-effective way to address a range of issues impacting healthy child development and later success in life at annual costs generally averaging $1,500 to $4,000 per family served, depending upon the type of home visiting service offered. The variation in program costs depends on such factors as differences in the cost of living in the communities being served, the frequency of home visits required for a family, the inclusion of evaluation costs in the calculation, and the staffing requirements of the program.

This modest investment leads to improved outcomes for children and families and long-term cost savings related to special education, child welfare, health care, criminal justice, and additional social services. The consequences of child abuse and neglect often continue well into adulthood with life-long effects. Research shows a strong correlation between child abuse and neglect and debilitating and chronic health consequences, mental health illness, and drug dependency.[4] Studies have demonstrated the link between childhood victimization and delinquency, criminal behavior.[5] Research has shown that abused and neglected children are more likely to suffer poor prospects for success in school.[6]

Home visiting programs link families to health care resources and focus on healthy outcomes. Through a strong emphasis on prenatal care significant costs associated with pre-term births, and developmental disabilities are reduced. Linking families to consistent primary care and immunizations means reduced emergency room costs and reduction in chronic illness.

Current child welfare expenditures are heavily skewed toward spending on foster care and adoption subsidies. For every federal dollar spent on out-of-home care, the federal government spends just fifteen cents on prevention and child protection. Implementing proven, effective strategies to prevent child abuse and neglect can save on the high cost of doing nothing until intervention later is inevitable. According to a study conducted by Prevent Child Abuse America,[7] the direct costs of child maltreatment for foster care services, hospitalization, mental health treatment, and law enforcement amount to more than $33 billion annually. Indirect costs of over $70 billion include expenditures related to chronic health problems, special education, and the criminal justice system as well as loss of productivity—for an expenditure of close to $104 billion per year.

Home visitation programs provide the supports necessary for families to meet the needs of their children, to address risk factors for abuse and neglect and educate parents to improve their skills while seeking support and guidance. Addressing some of the characteristics of parents who are at risk of abusing their children, we see that home visitors are there to confront a symptom before it becomes a crisis. While no single factor accounts for abusive behavior by parents, in combination, these features of troubled families are more likely to create greater risk for harm to children.

- Social isolation: the lack of social supports, the isolation from a community and effective support systems, the lack of a social network to set good examples of parenting. The home visitor reduces a family's sense of isolation through regular visits that draw new parents into a sense of community and belonging.
- Unprepared parents: new mothers and fathers with unrealistic expectations about their children and little knowledge about normal child development. The home visitor builds parenting skills and works to create better bonds between parents and their children.
- Characteristics of the child: a premature low birth-weight child, a mentally or physically disabled child, or an ill child difficult to nurture, all present difficulties to parents coping with a new baby. The home visitor arranges primary medical care, so that infants get to the pediatrician for checkups and immunizations.
- Personal stress and economic difficulties: parents with low self-esteem who are vulnerable to stress, parents addicted to alcohol or drugs, families hit by unemploy-

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[4] Felitti, VJ, Anda, RF, Nordenberg, D, Williamson, DF, Spitz, AM, Edwards, V, Koss, MP, & Marks, JS. (1998). The relationship of adult health status to childhood abuse and household dysfunction. American Journal of Preventive Medicine, 14, 245–258.

[5] C.S. Widom & M.A. Ames (1994). Criminal Consequences of Childhood Sexual Victimization. Child Abuse and Neglect. Washington, DC: National Institute of Justice.

[6] S.R. Morgan (1976). The Battered Child in the Classroom. Journal of Pediatric Psychology.

[7] Wang, CT, & Holton, J (2007). Total estimated cost of child abuse and neglect in the United States. Chicago, IL: Prevent Child Abuse America.

ment or inadequate housing. The home visitor assures that all families have full access to community agencies that can support families coping with problems and stresses.

Research Supports Positive Outcomes

Numerous researchers have documented the positive impact of home visitation programs on child development, parenting practices, and parent-child relationships. The results from a variety of randomized control trials, quasi-experimental evaluations, and implementation studies have shown positive effects in the reduction in child maltreatment, improved parenting practices, birth outcomes, and health care. Here is a sample.

- In a randomized control trial, adolescent mothers who received case management services and home visitors were significantly less likely to be subjected to child abuse investigations than control group mothers who received neither.[8]
- A large, randomized control trial found less physical and psychological abuse for parents receiving home visitation services than control parents at one year.[9]
- Families who received home visiting services were found to be more likely to have health insurance and a medical home, to seek prenatal and well-child care, and to get their children immunized.[10] Another study showed that 93% of participating families, children were fully immunized by age two compared to the statewide average of 77%.[11]
- Babies of parents enrolled prenatally in home visitation services have shown fewer birth complications in one randomized control trial and higher birth weights in another randomized control trial.[12]

By providing critically important prevention services to families with young children, home visiting programs make a real difference in families' lives. We commend the sponsors of H.R. 2667 for their leadership in moving forward with ensuring significant support to home visiting programs in service to children and families across the country.

Member Organizations: Alliance for Children and Families, American Academy of Pediatrics, American Bar Association, American Humane Association, American Professional Society on the Abuse of Children, American Psychological Association, American Public Human Services Association, Association of University Centers on Disabilities, CHILD Inc., Child Welfare League of America, Children and Family Futures, Children's Defense Fund, Every Child Matters Education Fund, Family Violence Prevention Fund, First Focus, First Star, National Alliance of Children's Trust and Prevention Funds, National Association of Children's Hospitals, National Association of Counsel for Children, National Association of Social Workers, National Center for Child Traumatic Stress, National Center for State Courts, National CASA Association, National Education Association, National Exchange Club Foundation, National Network to End Domestic Violence, National Organization of Sisters of Color Ending Sexual Assault, National PTA, National Respite Coalition, Parents Anonymous, Prevent Child Abuse America, Stop It Now!, Voices for America's Children

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[8] Wagner, M.M. & Clayton, S.L. (1999). The Parents as Teachers Program: Results from Two Demonstrations. The Future of Children: Home Visiting: Recent Program Evaluations, 9(1), 91–115.

[9] Mitchell-Herzfeld et al. (2005). Evaluation of Healthy Families New York: First year program impacts. Office of Children and Family Services.

[10] Berkenes, J.P. (2001), HOPES Healthy Families Iowa FY 2001 Services Report; Klagholz & Associates (2000), Healthy Families Montgomery Evaluation Report Year IV; Greene et al. (2001), Evaluation Findings of the Healthy Families New York Home Visiting Program; Katzev, A., Pratt, C. & McGuigan, W. (2001), Oregon Healthy Start 1999–2000, Status Report.

[11] Williams, Stern & Associates (2005). Healthy Families Florida Evaluation Report, January 1, 1999–December 31, 2003.

[12] Galano & Huntington (1999). Evaluation of the Hampton, Virginia Healthy Families Partnership 1992–1998. Center for Public Policy Research, The Thomas Jefferson Program in Public Policy, The College of William and Mary, Williamsburg, VA. Galano et al. (2000). Developing and Sustaining a Successful Community Prevention Initiative: The Hampton Healthy Families Partnership. Journal of Primary Prevention, 21(4), 495–509.; Mitchell-Herzfeld et al. (2005).

Statement of the National Indian Child Welfare Association
Portland, Oregon
Association on American Indian Affairs
Rockville, Maryland
National Congress of American Indians
Washington, DC
Submitted to the House Ways and Means Subcommittee on
Income Security and Family Support
Regarding H.R. 2667, the Early Support for Families Act
June 23, 2009

The National Indian Child Welfare Association, the Association on American Indian Affairs and the National Congress of American Indians jointly submit this statement in support of H.R. 2667, the Early Support for Families Act. The voluntary early childhood home visitation programs envisioned by the bill would be an important component in building community-based programs whose goal is to help keep families intact and strong. We are delighted to see that the provisions of H.R. 2667 have been included in the House Democratic draft health care reform proposal.

We appreciate that the bill would provide a guaranteed stream of funding for early childhood home visitation programs and would allocate three percent of funds for distribution to tribes. The funds would be distributed via formula to tribes who submit eligible applications, similar to the distribution of the Social Security Act's Title IV–B (Child Welfare) funds. Some tribes—primarily very small tribes—do not apply for IV–B funds because the amount would be so miniscule as to not make the application feasible. In those instances the funds are re-allocated among tribes that have submitted eligible applications. H.R. 2667 provides for reallocation of unused state funds among states; similarly, unused tribal funds should be reallocated among eligible tribes. The bill is not clear on this point, and *we ask for an amendment that would make it clear that unused tribal funds would be reallocated among eligible tribes*.

We also strongly support the provision that authorizes the Secretary, except for the application process and eligible use of funds, to modify requirements for tribes. This provision represents a good faith effort to try to make the program really work for tribal governments who by and large do not have the sources of revenue or economy of scale that states possess. We point out that tribes do not have access to the Title XX Social Services Block Grant which states use largely for child welfare purposes. Tribes also receive very little funding under the Child Abuse Prevention and Treatment Act, sharing a one percent allocation with migrant programs under one discretionary grant program. And not all tribes receive Title IV–B funds, either because the funding is not available to them or the amounts are so small that it makes administration of the program unfeasible.

The voluntary home visitation assistance that would be provided in H.R. 2667 is to be geared toward low income families with young children and toward areas which are especially at risk for child maltreatment. Indian Country has a young population and suffers from the problems attendant with high rates of unemployment and poverty.

Services geared toward children are particularly important in Native American communities, which are younger, on average, than the general population. Statistics from the 2000 census confirm that nearly 33 percent of the American Indian and Alaskan Native population is below the age of eighteen, compared to a national average of 26 percent.[1] Furthermore, the median age of American Indians who live on reservations is 25, while the median age of the same population who live elsewhere is 35.[2] Similar figures hold true of the Alaska Native demographic.[3]

Funds directed to programs in Indian Country not only target a population that is younger than average, but also target a population that is relatively poorer. American Indians and Alaskan Natives are twice as likely to live in poverty as members of the general population.[4] Children within that population are also more likely to face other problems. According to the Administration on Children, Youth

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[1] Stella U. Ogunwole, *We the People: American Indians and Alaska Natives in the United States*, p. 5 (U.S. Census Bureau, February 2006). *Available at*: http://www.census.gov/population/www/socdemo/race/censr-28.pdf

[2] Id. at 15.

[3] Id.

[4] Id. at 12 (finding that more than 25% of American Indian and Native Alaskan people lived in poverty, compared to 12.7% of the U.S. population as a whole).

and Families, roughly 14.2 out of every 1000 American Indian or Alaska Native children are victimized or maltreated.[5]

The funds this bill would make available could be used to establish new programs, to strengthen current home visitation programs, or to utilize existing programs. There is a major health home visitation program in Indian Country—the Community Health Representative (CHR) program. The program does not provide the services envisioned under H.R. 2667, but is an example of a successful home visitation program operating throughout Indian Country. The CHR programs are funded and overseen by the Indian Health Service, pursuant to the Indian Health Care Improvement Act (as amended, Public Law 100–713, dated November 23, 1988). This program trains community members as health paraprofessionals and provides funding to deliver health services through integrated home visitation programs. These services are culturally competent and community-based and offer a model that can be helpful in the context of providing in-home services to young children and their families as envisioned in this legislation.

The CHR program illustrates how service providers that value human interaction and supportive relationships may yield better results than traditional delivery methods. These home visitation programs include a broad range of services, from patient care and case management to health education and transportation. Paraprofessionals trained under the CHR program also engage in injury prevention activities and educate patients about best health practices. Though not targeted specifically for children, these programs are proven models that advance self-determination and deliver healthcare services to underserved households who often live in very rural, geographically isolated areas where health services in general are not always easily accessible. They also raise community awareness of ongoing health issues in tribal communities and the steps that are being taken to address them. Whether used as a model on which to create a home visitation program or an initial foundation from which to build, the success of the CHR program is clear evidence that home visitation programs targeting children will be effective in tribal communities.

While the CHR program holds promise for home visitation programs envisioned in H.R. 2667, the legislation specifically identifies the need to use evidence-based models, especially those with the strongest evidence of effectiveness. Because research dollars and projects often do not reach Indian Country it would be helpful to add a provision that directs the Secretary of DHHS to collaborate and consult with tribes and tribal organizations that have experience in this area. They could evaluate the inclusion of tribal populations in current home visitation models, assess the ability to adapt existing mainstream models for implementation in tribal communities, identify tribal home visitation programs that are working well in Indian Country, and develop recommendations on how to strengthen the development and dissemination of tribal home visitation models. Such a provision would help advance the purposes of the bill and ensure that tribal home visitation programs benefit from evidence-based approaches too.

The home visitation programs envisioned in this bill would benefit American Indian and Alaska Native children and the young family households in which they are being raised. As a source of services and education, these programs are tools that Native families can use to improve well-being, help prevent child abuse and neglect and advance their children's development.

We thank Chairman McDermott and the Members of this Subcommittee for their active interest in the welfare of children, and look forward to working with you on this and related legislation. And we thank you once again for the enactment last year of the Fostering Connections to Success Act (PL 110–351) which brought long overdue eligibility for tribal governments to administer the Title IV–E Foster Care and Adoption Assistance programs.

If you have questions or comments regarding this testimony, please contact NICWA Government Affairs Director, David Simmons at desimmons@nicwa.org or AAIA Executive Director, Jack Trope at jt.aaia@verizon.net.

Statement of Oneta Templeton McMann

My name is Oneta Templeton McMann and I am a social work manager in a regional pediatric center. In that capacity, I oversee the operation of two home based intervention programs for families with a pregnant women and/or young child. I support H.R. 2667 Early Support for Families Act because I see first hand the value

[5] Administration on Children, Youth and Families, *Child Maltreatment Study 2007*, p. 25.

of early involvement with families of young children in supporting that parenting relationship and thereby expanding the range of opportunities for the children.

We work with low income, urban families who are struggling to meet their everyday needs; and who, without support, cannot focus on the early parenting and development of newborns and infants. While they possess amazing strengths, those resources must often be directed to keeping the rent paid, the utilities on and food enough for all to eat. Without assistance, it is difficult to concentrate on the maternal-infant dyad, building attachment and stimulating cognitive and emotional development. Well child check ups and developmental assessment often give way to survival issues in the families' priorities. The social work and other staff who partner with families in their homes can enhance these parenting relationships and teach and model how to incorporate child development strategies into their usual routines.

While the families with whom we work are financially and environmentally stressed, they desire the same positive outcomes for their children and themselves as parents that all families desire. With information, modeling, and support families can learn to engage in behaviors that promote safety, stability, and stimulation in the caregiving relationship. Even when, by necessity, there are disruptions—housing instability, community violence, multiple caregivers, parental stress—parents can build skills that increase their own parenting capacity, enhance their young child's development, and begin to make the positive parenting role integral to the family's functioning.

It's not quick and easy work and cannot be successful in a vacuum. Quality community child care is needed for infants and young children, for many single mothers—and married ones—must work to support their families even when their children are very young. Quality early childhood and pre-kindergarten services are imperative, ones that will link families to their school systems and provide a smooth transition to school. As necessary as those services are, the relationships that are built in the home at birth and before will be paramount.

Many times, in our experience, the role models parents have are not adequate. They may have been parented largely by older siblings, in multiple extended family households, with their own parents compromised by poverty or challenged by mental health, substance abuse or other disabling conditions. Some have spent years of childhood in foster care, residential placements or other alternative care. To interrupt multi-generational poverty, child abuse, neglectful or absent parenting long-term, intensive work in the home is needed by professionals trained to partner with parents to help meet their own emotional and other needs in order to teach them how to meet their children's.

For parents whose custody of their children has been disrupted by incarceration, family violence, foster care, substance abuse or mental illness, these services are particularly important and necessary. The parent must feel absence of judgment, recognition of their own strengths, willingness to hear them and an intentional desire to partner from the home visiting professional. This is not simply a matter of providing information and education. The relationship established enables the parent to assimilate new information, try out new skills, provide honest feedback about their attempts and to be offered encouragement to try again when attempts do not go well. In a home-based partnership, parents are supported in their own eco-system, recognizing their interpersonal networks, their community values, the barriers they must address and the strengths and resources they possess. They are not viewed simply as parents, but as individuals within a family system who have many roles and responsibilities. And services are provided to address multiple areas in their lives so that they can improve the outcomes for their children.

When I was a first (and second!) time mom, I benefited greatly from the information, support, and demonstration of behaviors to promote my child's development that I received from the parent educator from my local school district. It reduced my anxiety, increased my confidence and enhanced my competence as my child's first teacher. In addition to that monthly visit, however, I had access to financial resources, paid time off from my employment, support of a spouse and other extended family members and the benefit of living in a safe, affordable home. Many of the families our programs see do not have any of those, and the intensity of the intervention they need is much greater.

The two programs I manage are a HRSA Healthy Start subcontract for both English speaking and Spanish speaking families and a program formerly supported by the Children's Bureau Abandoned Infants Assistance program for families affected by alcohol and other drug abuse and/or HIV. The families served face multiple challenges and often live in very high risk situations. Home-based contact with the family must be frequent, and a comprehensive array of services is needed. Caseloads must be small to build that intense, positive partnership and individualize services to each family's situation. Physical and mental health care, basic needs, his-

tories of family or community violence, housing, and economic stability must all be addressed in order for parents to reach their potential in promoting their infants' development.

So, while this early intervention with high risk families in not without significant cost, it is an excellent investment in getting children ready for success in school, building stronger families to support ongoing accomplishments, and helping replace unhealthy family patterns with positive parenting whose benefits will extend well into the future.

We have research findings available for each of the programs noted here that we would be happy to provide for review. We are anxious to help support this legislation in any way possible. Thank you.

Witness Information:

Oneta Templeton McMann, LCSW
Social Work and Community Services Department
Children's Mercy Hospitals and Clinics

Testimony of the Ounce of Prevention Fund

The Ounce of Prevention Fund applauds the Committee's progress in achieving the vision laid out for young children and families by President Obama. The Ounce of Prevention Fund is highly encouraged by this progress, specifically by H.R. 2667, the Early Support for Families Act, which would commit a substantial investment to home visiting programs in the states. The Ounce of Prevention Fund is committed to advocating for, designing and providing high quality early childhood programs. We believe that high quality programs, including home visiting programs, can and do make a real and sustained difference in the lives of vulnerable children and families. In order to ensure that this legislation creates a high quality system of home visiting programs that meet the needs of the full range of at-risk infants, toddlers, and their families, we offer the following comments and suggestions.

The legislation should include a definition for what constitutes the "strongest evidence of effectiveness." We recommend the following language, developed by the National Home Visiting Coalition, be adopted in statute to define the "strongest evidence of effectiveness:

Have demonstrated significant positive outcomes for children and families consistent with the outcomes being sought (for the populations being served) when evaluated using well-designed and well-conducted rigorous evaluations, including but not limited to randomized controlled trials, that provide valid estimates of program impact and demonstrate replicability and generalizability to diverse communities and families."

Again, we are highly encouraged by and supportive of this important legislation that would help our most vulnerable children get a chance for a better start in life. Please feel free to contact me should you have any questions or need additional information.

Statement of Parents as Teachers

Chairman McDermott, Ranking Member Linder, and members of the Subcommittee:

The National Center for Parents as Teachers appreciates the opportunity to submit written testimony on H.R. 2667, the Early Support for Families Act. We strongly support the framework put forth in the bill: to establish a mandatory federal funding stream to support evidence based home visitation programs. We are grateful to Chairman McDermott, Representatives Davis and Platts for sponsoring this important legislation.

Parents as Teachers Background

Parents as Teachers is an evidence-based, voluntary parent education and family support program designed to increase child development and school readiness during the crucial early years of life. Established as a Missouri pilot program in 1981 to serve 380 families, Parents as Teachers has grown exponentially since that time. Through programs operating in every state, Parents as Teachers currently serves more than 330,000 children nationally. Since its inception, Parents as Teachers has helped millions of American families by providing specialized home visitation services using our research-based curriculum.

The Parents as Teachers curriculum is based on brain development and neuroscience research. The program model consists of four service delivery components: personal home visits by a certified parent educator; parent group meetings about early childhood development and parenting; developmental, health, vision and hearing screenings for young children; and connections to community networks and resources.

Parents as Teachers programs serve families with children from before birth up to kindergarten-entry age. Our programs deliver services to families of all configurations, including single parents, teen parents, two-parent families, grandparents raising grandchildren, and foster parents. The families we serve deal with a range of challenging life circumstances such as poverty, military service, low literacy levels, substance abuse, mental health issues, incarceration, English language challenges, and unemployment. We work with families regardless of whether they are in their first trimester with their first child or are raising multiple children, for example, such as a mother in Southeast Missouri with nine children from four different fathers. Three of her children under 5 participate in Parents as Teachers. Because the needs of the families we serve vary greatly, the intensity of our services also varies—from a minimum of monthly visits to as frequently as weekly visits.

Reflecting the rich diversity of the families we serve, the Parents as Teachers home visitors (parent educators) also come from varied backgrounds. Our programs employ people with backgrounds ranging from early childhood education and social work to nursing. In addition, some programs hire experienced paraprofessionals who bring invaluable linkages to a local cultural community or language skills that are essential to successfully connect with non-English speaking families. Prior to serving families, every parent educator must complete a week-long in-depth training on the Parents as Teachers Born to Learn® curriculum, demonstrating an understanding of the material with a daily assessment. Within three to six months of this initial training, each parent educator goes through an additional day-long follow up training to monitor implementation progress and answer any questions.

Additionally we are expanding our training through distance learning applications to further increase our ongoing connection with parent educators in the field.

Program Implementation

Parents as Teachers programs thrive in a variety of local settings including school districts, Head Start programs, human service agencies, health departments, mental health agencies, family resource centers, child care centers and local United Way agencies. In some communities the Parents as Teachers program operates as a stand-alone entity, but the more common approach is for Parents as Teachers services to be woven into an organization as a core family service delivery component. We take pride in the adaptability of our model while maintaining a commitment to model fidelity as evidenced by our quality standards.

Beyond our partnerships with host organizations, we also collaborate with other home visiting programs such as Healthy Families America, HIPPY, Parent Child Home, Nurse Family Partnership and other programs operating in individual states. These local partnerships enhance the services provided to families and further strengthen the continuum of care available to families in a particular community.

Parents as Teachers Research Outcomes

Parents as Teachers has a long history of independent evaluations demonstrating positive outcomes for young children and their families. More than two dozen research reports have been completed that show the Parents as Teachers model produces positive outcomes in terms of school readiness, prevention of child abuse and neglect, parental involvement, school success and child health. Included among these studies are four randomized control trials and five studies that have been published in peer reviewed journals. A sampling of these research results show that:

- Parents as Teachers children showed better school readiness at the start of kindergarten, higher reading and math readiness at the end of kindergarten, higher kindergarten grades, and fewer remedial education placements in first grade.[i]
- Participation in Parents as Teachers helps to close the achievement gap between children living in poverty and those from non-poverty households.[ii]

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[i] Drazen, S., & Haust, M. (1995). The effects of the Parents and Children Together (PACT) program on school achievement. Binghamton, NY.; Drazen, S. & Haust, M. (1996). Lasting academic gains from an early home visitation program. Paper presented at the annual meeting of the American Psychological Association, August 1996.

[ii] Zigler, E., Pfannenstiel, J.C., & Seitz, V. (2008). The Parents as Teachers Program and School Success: A Replication and Extension. Journal of Primary Prevention, 29, 103–120.

• In a randomized trial, adolescent mothers who received case management and Parents as Teachers were significantly less likely to be subjected to child abuse investigations than control group mothers who received neither case management nor Parents as Teachers.[iii]

• In another randomized trial, adolescent mothers in an urban community who participated in Parents as Teachers scored lower on a child maltreatment precursor scale than mothers in the control group. These adolescent mothers showed greater improvement in knowledge of discipline, showed more positive involvement with children, and organized their home environment in a way more conducive to child development.[iv]

• Children participating in Parents as Teachers were much more likely to be fully immunized for their given age, and were less likely to be treated for an injury in the previous year.[v]

• PAT parents were more involved in children's school activities and engaged their children more in home learning activities, especially literacy-related activities.[vi]

Parents as Teachers embraces research and evaluation of our model not only to document effectiveness, but also as the basis for quality improvement. We are particularly supportive of the commitment to research and evaluation included in H.R. 2667. This set-aside evaluation funding will allow Parents as Teachers, and other home visiting programs, to use these evaluation results as an integral part of our continuous quality improvement process to enhance our curriculum and training to ensure that our materials remain up-to-date and meet the changing needs of the families we serve.

Defining Evidence Based Home Visitation Programs

Parents as Teachers recognizes the importance of investing public funds in proven, "evidence-based" home visiting programs. However, at present there is no widely agreed upon definition of evidence-based home visitation programs in scholarly writings, statutes, and regulations.

Some strong advocates argue that the optimal definition of evidence-based programs should require multiple randomized control trials. While the Parents as Teachers research portfolio includes studies that use randomized control designs (as described in the previous section of this statement), we believe a definition that relies exclusively on this single approach is potentially counterproductive and can dissuade program innovation. A number of notable scholars, including Dr. Deborah Daro who testified before the Subcommittee on June 9th to discuss H.R. 2667, argue that while randomized control trials provide insight into a program's impact on participants under ideal circumstances, this approach does not provide critical information about real world applications in diverse environments.

We believe the overall quality of home visiting services would improve and associated outcomes for children and families would increase if programs were encouraged to select research methodologies designed to measure the outcomes their programs were intended to achieve. In addition to randomized control trials, programs could also utilize research studies that use quasi experimental designs, including regression discontinuity design which compares two groups separated by a cut-off point (such as child's birthday to enroll in Kindergarten), and the interrupted time series method which compares trends in pre-implementation achievement data to post-implementation achievement data.

Standard of Evidence in H.R. 2667

Although H.R. 2667 includes language that establishes priority funding for home visitation programs with the "strongest evidence" [section (f)(2)], the bill does not provide a definition or criteria for what constitutes this strongest level of evidence. As a result, we conclude that the administering federal agency will be responsible for developing this critically important definition or criteria that will have over-

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[iii] Wagner, M.M. & Clayton, S.L. (1999). The Parents as Teachers Program: Results from Two Demonstrations. The Future of Children: Home Visiting: Recent Program Evaluations, 9(1), 91–115.

[iv] Pfannenstiel, J., Lambson, T., & Yarnell, V. (1991). Second wave study of the Parents as Teachers program. Overland Park, KS: Research & Training Associates.

[v] Wagner, M., Iida, E. & Spiker, D. (2001). The multisite evaluation of the Parents as Teachers home visiting program: Three-year findings from one community. Menlo Park, CA: SRI International.

[vi] Albritton, S., Klotz, J., & Roberson, T. (2004) The effects of participating in a Parents as Teachers program on parental involvement in the learning process at school and in the home. E–Journal of Teaching and Learning in Diverse Settings, 1(2), 108–208. http://www.subr.edu/coeducation/ejournal/Albritton%20et%20al.Article.htm.

arching implications for implementation of this new federal home visitation program. We therefore encourage Congress to adopt the following definition of programs with the "strongest evidence":

Have demonstrated significant positive outcomes for children and families consistent with the outcomes being sought (for the populations being served) when evaluated using well-designed and well-conducted rigorous evaluations, including but not limited to randomized controlled trials, that provide valid estimates of program impact and demonstrate replicability and generalizability to diverse communities and families.

We believe that this definition provides a rigorous standard that would ensure that only proven home visitation programs would be eligible to receive the funds outlined in this section. At the same time, this definition would allow states to develop home visitation implementation plans that incorporate one or a combination of evidence-based programs that can best meet the needs of families in their state and build on existing service infrastructures at the state and local level.

Conclusion

We congratulate the Committee for scheduling the hearing on this important proposal and for advancing the Administration's home visiting initiative in Congress. The National Center for Parents as Teachers, along with our programs across the country, are enthusiastic about the prospect of a dedicated federal mandatory funding stream of mandatory funds that will allow us to provide quality home visitation services to more families and stand ready to work with Congress and the Administration to make this new program a become a reality.

Statement of Prevent Child Abuse America

Prevent Child Abuse America and its network of 47 state chapters and over 400 Healthy Families America program sites thanks the Chairman and the other distinguished members of the U.S. House Committee on Ways and Means Subcommittee on Income Security and Family Support for this opportunity to provide the organization's perspective on the need for a federal investment in early childhood home visitation. In particular, we would like to thank Chairman McDermott, and Representatives Danny Davis and Todd Platts for their leadership on this issue, as most recently demonstrated with their introduction of the Early Support for Families Act of 2009 (HR 2667).

Through this testimony our organization will identify the value of home visiting and the positive outcomes that a federal investment will achieve to enhance our nation's ability to promote healthy early childhood experiences.

About Prevent Child Abuse America

Prevent Child Abuse America was founded in 1972 and is the first organization in the United States whose sole mission is "to prevent the abuse and neglect of our nation's children." We undertake our mission by advocating for the full range of services needed to promote healthy child development and provide parents with the information they need to be the caring and effective parents they want to be. Based in Chicago, the National Office and our networks manage over 375 different locally based strategies to meet the mission of the organization, including 2,900 home visitation workers, supervisors and program managers who oversee and implement Healthy Families America, a voluntary home visitation service.

The Importance of Fostering Healthy Child Development

When we invest in healthy child development, we are investing in community and economic development, as flourishing children become the foundation of a thriving society. Healthy child development starts a chain of events that follow a child into adulthood. Unfortunately, children are sometimes exposed to extreme and sustained stress like child abuse and neglect, which can be devastating to a child's development. This toxic stress damages the developing brain and adversely affects an individual's learning and behavior, as well as increases susceptibility to physical and mental illness.

Research shows a strong correlation between child abuse and neglect and debilitating and chronic health consequences. The *Adverse Childhood Experiences Study (ACE)*, conducted by the CDC in collaboration with Kaiser Permanente's Health Appraisal Clinic in San Diego, found that individuals who experienced child maltreatment were more likely to engage in risky behavior, such as smoking, substance abuse and sexual promiscuity, and to suffer from adverse health effects such as obesity and certain chronic diseases. Over 17,000 adults participated in the ACE study,

making it the largest investigation examining the links between child maltreatment and later-life health and well-being ever conducted.[1] The ACE findings are supported by numerous studies, including a recent population-based survey that collected data from over 2,000 middle-aged men and women in Wisconsin. This study found that adults who experienced abuse or neglect during childhood are more likely to suffer from negative health consequences as adults including asthma, bronchitis, and high blood pressure.[2]

As ACE and similar studies demonstrate, getting prevention right early is less costly to the nation, and to individuals, than trying to fix things later. Prevent Child Abuse America estimates that implementing effective policies and strategies to prevent child abuse and neglect can save taxpayers $104 billion per year. The cost of not doing so includes more than $33 billion in direct costs for foster care services, hospitalization, mental health treatment, and law enforcement. Indirect costs of over $70 billion include loss of productivity, as well as expenditures related to chronic health problems, special education, and the criminal justice system.[3] An international study by the United Nations Children's Fund (UNICEF, February 2007) placed the United States next to last on child well-being, among the 21 wealthiest nations in the world. Although only one indicator of child well-being, rates of child abuse and neglect are ultimately tied to a nation's investment in its children.

This is where an investment in home visitation, as contemplated by HR 2667, provides the country with a great opportunity to enhance child development, support communities, reduce child abuse and neglect, and ultimately have a profound impact on the health and productivity of future generations.

Role of Early Childhood Home Visitation

All expectant parents and parents of newborns have common questions about their child's development. Early childhood home visitation provides a voluntary and direct service in which highly trained home visitors can help parents understand, recognize and promote age appropriate developmental activities for children; meet the emotional and practical needs of their families; and improve parents' capacity to raise successful children.

Research has shown that voluntary home visitation is an effective and cost-efficient strategy for supporting new parents and connecting them to helpful community resources. Quality early childhood home visitation programs lead to proven, positive outcomes for children and families, including improved child health and development, improved parenting practices, improved school readiness, and reductions in child abuse and neglect.

Healthy Families America

Healthy Families America is Prevent Child Abuse America's nationally recognized, signature home visitation program. Through Healthy Families America, well-respected, extensively trained assessment workers and home visitors provide valuable guidance, information and support to help parents be the best parents they can be. Healthy Families America focuses on three equally important goals to: 1) promote positive parenting; 2) encourage child health and development; and 3) prevent child abuse and neglect.

A review of 34 studies in 25 states, involving over 230 Healthy Families America programs allows us to say with confidence and conviction that the benefits of Healthy Families America are proven, significant, and impact a wide range of child and family outcomes.[4] In particular, Healthy Families America:

Improves Parenting Attitudes. Healthy Families America families show positive changes in their perspectives on parenting roles and responsibilities.

Increases Knowledge of Child Development. Healthy Families America parents learn about infant care and development; including child care, nutrition, and effective positive discipline.

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[1] Felitti V, Anda R, Nordenberg D, Williamson D, Spitz A, Edwards V, et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. American Journal of Preventive Medicine 1998;14(4):245–58.

[2] Springer, K.W., Sheridan, J., Kuo, D., & Carnes, M. (2007). Long-term Physical and Mental Health Consequences of Childhood Physical Abuse: Results from a Large Population-based Sample of Men and Women. *Child Abuse & Neglect, 31*, 517–530.

[3] (1) Wang, CT, & Holton, J (2007). Total estimated cost of child abuse and neglect in the United States. Chicago, IL: Prevent Child Abuse America. http://www.preventchildabuse.org/about_us/media_releases/pcaa_pew_economic_impact_study_final.pdf.

[4] Study designs include 8 randomized control trials and 8 comparison group studies. More information on the studies can be found in the Healthy Families America Table of Evaluations at ** www.healthyfamiliesamerica.org/research/index.shtml.

Supports a Quality Home Environment. Healthy Families America parents read to their children at early ages, provide appropriate learning materials, and are more involved in their child's activities, all factors associated with positive child development.

Promotes Positive Parent-Child Interaction. Healthy Families America parents demonstrate better communication with, and responsiveness to, their children. This interaction is an important factor in social and emotional readiness to enter school.

Improves Family Health. Healthy Families America improves parents' access to medical services, leading to high rates of well-baby visits and high immunization rates, and helps increase breast feeding, which is linked to many benefits for both babies and moms. Healthy Families America has also been found to significantly reduce low birthweight deliveries.[5] By one estimate, each normal birth that occurs instead of a very low birthweight birth saves $59,700 in the first year of care.[6]

Prevents Child Abuse and Neglect. Healthy Families America has a significant impact on preventing child maltreatment, particularly demonstrated in recent randomized control trials.

In addition to our stewardship of Healthy Families America, Prevent Child Abuse America partners with other effective home visiting models working in communities across the country to create nurturing environments for children. Our national home visiting partners include Home Instruction for Parents of Preschool Youngsters (HIPPY USA), the Nurse-Family Partnership, The Parent-Child Home Program, and Parents as Teachers.

Together, we have accepted the responsibility to improve the home visitation field. Together, we share research findings and best practices, and together, we work toward common goals, and create areas for cross-program cooperation and learning that strengthens the home visit field as a whole, as well as enhances individual programs. At the local level, Healthy Families programs partner with other home visiting models to reach a broader population of families, to ensure that families are receiving the home visiting service model best suited to their needs, and to maximize limited resources.

The Need for Reliable Funding and a Coordinated Approach

Despite the many proven benefits of home visitation, home visitation services across the country struggle with unreliable and unsustainable funding. The current patchwork of funding results in a home visitation system that serves only a small percentage of families. By one estimate, approximately 400,000 children and families participate in home visitation services each year.[7] A report by the National Center for Children in Poverty estimates 42% of young children (more than 10 million children in 2005) experience one or more risk factors associated with poor health and educational outcomes, and 10% (nearly 2.4 million children) experience three or more risk factors.[8]

The Early Support for Families Act (HR 2667) will address the home visiting funding crisis by establishing a new federal mandatory grant program dedicated solely to home visitation. HR 2667 authorizes $2 billion over 5 years in grants to states to provide evidence-based home visitation services to support families with young children and families expecting children. The legislation empowers states to fund home visitation services that best suit the needs of their communities, while putting important parameters in place to assure quality of services. Programs funded through the new grant must:

- Adhere to clear evidence-based models of home visitation that have demonstrated significant positive effects on program-determined outcomes;
- Employ well-trained and competent staff with high quality supervision;
- Show strong organizational capacity to implement a program; and
- Establish appropriate linkages to other community resources.

The flexibility the legislation provides to states is supported by a compelling body of research demonstrating the effectiveness of a range of evidence-based models em-

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[5] Eunju Lee, PhD, Susan D. Mitchell-Herzfeld, MA, Ann A. Lowenfels, MPH, Rose Greene, MA, Vajeera Dorabawila, PhD, Kimberly A. DuMont, PhD (2009). Reducing Low Birth Weight Through Home Visitation: A Randomized Controlled Trial. *American Journal of Preventive Medicine, 36, 2,154–160.*

[6] Rogowski, J. (1998). Cost-effectiveness of Care for Very Low Birth Weight Infants. PEDIATRICS Vol. 102 No. 1 July 1998, pp. 35–43.

[7] Gomby, D. (2005). Home Visitation in 2005: Outcomes for Children and Parents. Invest in Kids Working Paper No. 7. Committee for Economic Development: Invest in Kids Working Group. Available at www.ced.org/projects/kids.shtml.

[8] Stebbins, Helene, & Knitzer, Jane (2007). State Early Childhood Policies: Improving the Odds. NY: National Center for Children in Poverty.

ploying a diverse and highly skilled workforce. For example, Healthy Families America has documented success, as outlined above, utilizing home visitors who are selected based on their personal characteristics, such as the ability to establish a trusting relationship, and their educational and experiential background in child health and development, child maltreatment, and parenting. HFA home visitors typically live in the same communities as participating families and share their language and cultural background.

The legislation also requires that a state conduct a needs assessment prior to receiving funding to assess the reach and scope of existing early childhood home visitation efforts and identify gaps in services. States would have to provide an annual report on their progress in implementing the program. The report would include important indicators to help assess the state's effectiveness in implementing the program, including the annual cost per family, the outcomes experienced by recipients, the training and technical assistance being provided to programs, and the methods to determine whether a program is being implemented as designed.

Recommendations

HR 2667 sets a strong foundation for a new home visiting program, however opportunities do exist to further strengthen the grant program authorized by the bill.

Ensuring Quality

The legislation stipulates that states should prioritize funding home visiting programs that adhere to models with the strongest evidence. States may also direct some funding to home visiting programs utilizing models that have not yet achieved the strongest level of evidence. We recommend adding more specificity to:

1. The standards that all programs must meet to qualify for funding; and
2. The standards that programs must meet to be given priority for funding.

We are concerned that the overall quality of the services being provided cannot be assured without setting standards that all programs must meet. We believe that all programs funded under this grant should be home visiting programs that adopt and demonstrate fidelity to a clear model that:

1. Is research-based;
2. Is grounded in empirically based knowledge related to home visiting and child health or child development;
3. Is linked to program-determined outcomes;
4. Has comprehensive home visitation program standards, including standardized training, ongoing professional development; and high quality supervision; and
5. Has been in existence for at least three consecutive years prior to the program being funded under the Act.

In addition to meeting the criteria above, we recommend that home visiting models achieve the following research standard in order to be considered a program with "the strongest evidence of effectiveness:"

[the model must] *Have demonstrated significant positive outcomes for children and families consistent with the outcomes being sought (for the populations being served) when evaluated using well-designed and well-conducted rigorous evaluations, including but not limited to randomized controlled trials, that provide valid estimates of program impact and demonstrate replicability and generalizability to diverse communities and families.*

Improving Coordination

Home visitation services are most effective when they are linked to other services for children and families operating in the state, and when there is coordination amongst the various home visiting services provided in the state. We recommend strengthening language to ensure greater coordination among the various models of early childhood home visitation and between the home visiting programs and the broader child-serving community. This can be done by:

1. Adding an assurance that the state has consulted with all of the state agencies that currently support home visiting programs with young children.
2. Adding criteria that the state develop a plan for coordinating and collaborating in the delivery of home visitation services with child care services, health and mental health services, income supports, early childhood development services, education agencies, and other related services. This might include, where applicable, collaborations with an early childhood coordinating body instituted for the purpose of coordinating services and supports for young children and parents.

Taking this approach to implementation will lead to a more efficient use of resources and a greater assurance that families are receiving the most appropriate and effective home visiting services to meet their needs. This model allows for a clear outcome driven national public policy that promotes consistent results and allows states to manage the services in accordance with their specific existing service delivery systems, on-going best practices and existing public-private partnerships.

Conclusion

Home visitation is an effective, evidence-based, and cost-efficient way to bring families and resources together, and help families to make choices that will give their children the chance to grow up healthy and ready to learn. While no one piece of legislation can prevent child abuse and neglect, we believe that HR 2667 is an important step towards ensuring that all children have the opportunity to grow up in a safe, healthy, and nurturing environment. The new funding proposed in HR 2667 does not represent an expenditure, but rather an investment in our children and families, and in our future. We look forward to working with members of this Subcommittee in moving HR 2667 towards enactment.

Contact Information:

James M. Hmurovich, President & CEO, Prevent Child Abuse America
Bridget Gavaghan, Senior Director of Public Policy, Prevent Child Abuse America

Statement of Robin Roberts

To the Honorable Members of the House Ways and Means Committee,

I am submitting a statement for record concerning the Early Support for Families Act. I am so very pleased that the important role parents play in their child's learning and development is being recognized and supported through this legislation. I am the state leader for North Carolina Parents as Teachers Network. Last year we served approximately 10,000 children, birth to age five, through supporting parents as their child's first and most influential teacher. This legislation will allow us to serve even more families in need of support, thus ensuring North Carolina's children have the best possible start in life.

While I support this legislation, there is a concern that I would like to express. In the current legislation the language limits the types of family support services that will be available to families. I would ask you to consider the following:

- Incorporate the definition of "evidence-based" proposed by the National Home Visiting Coalition.

Have demonstrated significant positive outcomes for children and families consistent with the outcomes being sought (for the populations being served) when evaluated using well-designed and well-conducted rigorous evaluations, including but not limited to randomized controlled trials, that provide valid estimates of program impact and demonstrate replicability and generalizability to diverse communities and families.

Members of the national home visiting coalition steering committee include: Children's Defense Fund, Child Welfare League of America, Center for Law and Social Policy, Fight Crime Invest in Kids, National Child Abuse Coalition, HIPPY USA, Parent-Child Home Program, Prevent Child Abuse America/Healthy Families America, Voices for America's Children and the National Center for Parents as Teachers.

- Understand that effective home visitors come from a range of backgrounds, including nurses, social workers, and early childhood educators.
- Build on existing state and local home visiting infrastructures as the federal government develops implementation plans for this new initiative.
- Recognize the range of evidence-based home visiting programs, including Parents as Teachers, that have a long history of providing effective services to diverse families across the country.

Research has shown that Parents as Teachers programs produce measurable outcomes in a range of areas including school readiness, prevention of abuse and neglect, parental involvement, later school success and child health. The Early Support for Families Act will allow programs such as Parents as Teachers to ensure the well-being of our children and will lay the critical foundation for success in

school and life learning. Thank you for supporting this important piece of legislation and your priorities on families and the earliest years for all of our children.

Sincerely,

Robin Roberts

Statement of Stephanie Gendell

My name is Stephanie Gendell and I am the Associate Executive Director of Policy and Public Affairs at Citizens' Committee for Children of New York, Inc. (CCC). CCC was founded by Eleanor Roosevelt 65 years ago to be a non-profit, independent, multi-issue child advocacy organization that blends civic activism and fact-based advocacy. CCC's mission remains ensuring New York's children are healthy, housed, educated and safe. We are grateful to Congressmen McDermott and Rangel and the members of the Subcommittee on Income Security and Family Support of the House Ways and Means Committee for holding a hearing on federal funding for early childhood home visiting programs and we appreciate having the opportunity to submit testimony.

We strongly support the Committee's efforts to secure federal funding for home visiting programs, support the McDermott-Davis *Early Support for Families Act*, and agree that it is logical to discuss home visiting programs in the context of health care reform.

Throughout the country, and specifically in New York, it is widely recognized, as well as proven, that home visiting programs are cost-effective interventions that help to produce good outcomes for children. Specifically, these programs have been shown to reduce child abuse and neglect, language delays, emergency room visits for accidents and poisonings, arrests of children, and behavioral and intellectual problems for children.[1] The Rand Corporation has found that there is a $34,148 net benefit per family served by Nurse-Family Partnership, equaling a $5.70 return on every dollar invested.[2] While New York's typical home visiting programs, such as Healthy Families New York and Nurse-Family Partnership, cost approximately $4000-$7000 per family, in New York juvenile detention costs $200,000 per child per year; foster care costs an average of $36,000 per child per year; and special education costs an average of $22,000 per child per year. Not only are home visiting programs cost-effective, but they help produce the outcomes that America's children deserve—to be healthy, housed, educated and safe.

Both New York State and New York City have been innovative in their approaches to developing home visiting programs and funding streams for these programs, but continued progress has been stymied by budget shortfalls and budget uncertainties.

The types of programs currently available in New York are varied and differ in their intensity, scope and duration. These programs range from 1–2 visits by health workers, to three years of visits by nurses or social workers that often begin during pregnancy, to Early Head Start programs. While the scope, duration, intensity and eligibility differ, all of theses programs have produced improved outcomes for the children.

As part of New York City's Center on Economic Opportunity (CEO) initiative to reduce poverty, the City developed a "universal" newborn home visiting model. In 7 high risk communities[3] in the City, all new mothers are offered 1–2 visits by a health worker. Approximately 15,000 such home visits are conducted each year. While the program is voluntary, over half of mothers agree to participate after they are either contacted in the hospital upon giving birth or soon afterwards by phone or mail. During the home visit the health worker provides information on breastfeeding, SIDS/safe sleeping, attachment, smoking cessation and health insurance; screens for potential health or social problems (e.g. post-partum depression,

[1] Outcomes from Nurse-Family Partnership include a 48% reduction in child abuse and neglect, 56% reduction in emergency room visits for accidents and poisonings, and a 67% reduction in behavioral and intellectual problems for the child at age six. Nurse-Family Partnership. *Overview.* June 2008. http://www.nursefamilypartnership.org/resources/files/PDF/Fact_Sheets/NFP_Overview.pdf; Nurse-Family Partnership. *Benefits and Costs: A Program with Proven and Measurable Results.* June 2008. http://www.nursefamilypartnership.org/resources/files/PDF/Fact_Sheets/NFP_Benefits&Cost.pdf.

[2] L. Karoly, R. Kilburn & J. Cannon. *Early Childhood Interventions: Proven Results, Future Promise.* (Rand Corporation 2005).

[3] These communities are Bedford-Stuyvesant, Brownsville, Bushwick, and East New York in Brooklyn; East Harlem and Central Harlem in Manhattan; and the South Bronx.

housing instability or domestic violence); and assesses the home environment for hazards such as lead paint, missing window guards, or missing smoke/carbon monoxide detectors. In addition, if the family needs a crib, the home visitor will arrange for a free crib.

While this newborn home visiting program is meeting the needs of many families, the City is currently unable to provide these services in Queens or Staten Island. CCC has long advocated for this program to be truly universal and serve any new mother in any of the City's 52 community districts, but without federal funds it is unlikely that the City could support this in the near future.

New York City, like other counties, has also been paying for more long-term and intensive home visiting programs such as Healthy Families and Nurse-Family Partnership. Many of these programs throughout the state are paid for through a state matching program whereby the counties pay 35% and the state pays 65%. Due to state budget deficits this match has been reduced to 33.7% for the past two state fiscal years. In this past budget cycle, the Governor proposed eliminating the state's matching funds for these programs, but luckily the Adopted Budget restored these funds. Furthermore, State and City legislatures have identified home visiting programs as cost-effective and proven interventions that improve outcomes for children and families so annually they support these community-based programs through legislative additions that are therefore in jeopardy during each year's budget cycle. For example, in just the past year, Healthy Families New York has received a 2% cut followed by a 6% cut and then threatened with a 25% cut that was ultimately not implemented.

While New York State and New York City elected and appointed officials understand the value of home visiting programs, the budget deficits and negotiations create uncertainty and instability for the community based organizations and agencies that provide these invaluable services. Federal support for these programs, such as the federal match proposed in the *Early Support for Families Act*, would bring stability to programs that already exist and enable states and localities to expand the services to additional high-needs communities and families.

In addition to the financial assistance created by a federal investment in home visiting programs, the federal commitment will have an invaluable impact on the credibility of this cost-effective, proven intervention and thus lead to an extensive expansion of home visiting programs—this would undoubtedly improve outcomes for the next generation of New Yorkers and Americans.

Thank you for this opportunity to submit testimony on federal funding for early childhood home visiting programs. We look forward to working with Congress and the Obama Administration on ensuring all of America's children are healthy, housed, educated and safe.

Statement of The National Conference of State Legislatures

The National Conference of State Legislatures (NCSL) applauds your commitment to federal funding for early childhood home visitation programs designed to enhance the well-being and development of young children. Such programs are particularly important during the economic downturn, when they can help mitigate some of the consequences of parental stress and lack of resources by supporting parents and monitoring the health, safety and development in children's critical early years.

NCSL has long supported home visiting programs as a means of improving child well-being during their crucial early years. Many years of research demonstrate that such programs positively impact childhood development, promote child well-being, strengthen the family unit and significantly reduce the incidence of child abuse and neglect.

States have adopted a variety of innovative ways to reach these outcomes. Recognizing this, NCSL believes that federal action in this area should recognize this diversity of approaches and support all types of programs that have proven effectiveness.

Working together on this critical issue, and maintaining state flexibility in tailoring their home visitation programs to meet local needs, we can move forward to improve the lives of America's children.

Sincerely,

Representative Ruth Kagi
Washington
Chair, NCSL Human Services and Welfare Committee.

Statement of The Parent-Child Home Program, Inc.

The Parent-Child Home Program and its network of 150 community-based sites across the country thanks the Chairman and the other distinguished members of the U.S. House Committee on Ways and Means Subcommittee on Income Security and Family Support for this opportunity to provide testimony on the importance of a federal investment in early childhood home visitation. We would like to thank Chairman McDermott, and Representatives Danny Davis and Todd Platts for their leadership on this issue and for introducing the Early Support for Families Act of 2009 (HR 2667).

Through this testimony, The Parent-Child Home Program will highlight the value of home visiting for low-income, at-risk families and how a federal investment in home visitation services will promote healthy early childhood experiences and enhanced school readiness opportunities for families in need across the country.

As a nation, we will never achieve our goal of "No Child Left Behind" until we have successfully ensured that "No Child Starts Behind". Today, too many families in the United States do not receive the early support they need to ensure that their children have appropriate and healthy early childhood experiences that will enable them to enter school ready to be successful students, Today, too many children enter school unprepared both "academically" and social-emotionally. Much of this lack of preparation can be ameliorated simply by providing parents the support they need to supply their children with a language and literacy-rich environment that includes high quality and quantity parent-child interaction. Too many students enter school never having seen or held a book, without the basic literacy, language, or social emotional skills they need to participate successfully in the classroom. As a result their teachers in pre-kindergarten and/or kindergarten have to slow or stop the curriculum they had planned, to help these children catch up. Unfortunately, the data shows us that most children who start behind will never catch up. Children who do not know their letters when they enter kindergarten are behind in reading at the end of kindergarten, at the end of first grade, and are still having trouble reading at the end of fourth grade.[1]

We also know that preschool is not the sole solution to this lack of readiness. Children arrive in pre-kindergarten not ready just as in the past they arrived in kindergarten not ready. Children are more likely to be ready at any age when they have a family that knows what it needs to do to help them get ready. All families want their children to be successful, to do well in school and life, but many families do not know how to prepare their children for success. If you are not educated yourself, did not grow up in the American education system, do not have access to early childhood and parenting support services and/or do not have the means to purchase books and educational toys, you may benefit from guidance to help you prepare your child for a successful future. You may need support to provide a healthy developmentally appropriate environment to raise your children in and to develop the skills to support your child's growth and development. The Early Support for Families Act (H.R. 2667) is designed to do just that by ensuring that families receive the supports they need to encourage their children's healthily development, and prepare their children to enter school ready to be successful students and to go on to graduate from high school.

Each of the evidence-based home visiting programs that would be supported by this legislation provide services to families that enable them to achieve the outcomes outlined in the bill, including prevention of child maltreatment, healthy child development, school readiness and connection to community services. Among the different evidence-based home visiting models, different programs may be more focused on particular outcomes or a particular target population, and for this reason the ability to implement a number of evidence-based programs to meet the needs of their diverse populations is vital to the success of a national home visiting policy.

[1] "A Policy Primer: Quality Pre-Kindergarten," Trust for Early Education, Fall 2004.

The Parent-Child Home Program is a research-based, research-validated early literacy, school readiness, and parenting education home visiting program developed in 1965. For over 40 years, the Program has been serving families challenged by poverty, limited education, language and literacy barriers, and other obstacles to school readiness and educational success. The Parent-Child Home Program currently serves over 6,500 families through more than 150 local sites in 14 states. Many more families could be served in each of these communities, as all of our sites have waiting lists at least equal to the number of families they are currently serving. And many more families remain in need of these services in communities across the country that have not been able to develop funding streams for this critical early childhood support service.

The Parent-Child Home Program works with a broad range of families whose children are at risk of not receiving the early childhood supports they need to enter school prepared to be successful: teen parent families, single parent families, homeless families, immigrant, refugee, and non-native English-speaking families, and grandparents raising grandchildren. Working with parents and children in their own homes helps families create language-rich home environments and lays the foundation for school readiness and parental involvement as parents prepare their children to enter school. Parents are able to continue to build their children's language, literacy, and social-emotional skills after the Program finishes and their children enter school ready to succeed. The Program erases the "preparation gap" and prevents the "achievement gap."

The funding that would be provided by the Early Support for Families Act is critical to ensuring that quality evidence-based home visiting programs are able to reach families in need of services and enable children to enter school ready to be successful students. The families reached by home visiting are families that are isolated by poverty and other obstacles. They are not accessing center-based early childhood or school readiness services, including the library, play groups, parenting workshops, and/or other community-based supports. They do not have transportation or access to transportation to get to these services; the services are not open or available when the parents are available to attend; they have language or literacy barriers; and/or they have no money to pay for programs.

We appreciate this opportunity to provide you with some specific background information on The Parent-Child Home Program to highlight the extent of its evaluation and validation and the depth of the Program's experience working with high needs families across the country. For over 40 years, we have been utilizing home visiting to improve outcomes for children and their parents, in particular preparing young children and their families to enter school ready to be successful. As a result, four decades of research and evaluation demonstrates that Parent-Child Home Program participants in communities throughout the country enter school ready to learn and go on to succeed in school. In fact, peer-reviewed research demonstrates that program participants go on to graduate from high school at the rates of middle-class children nationally, a 20% higher graduation rate than their socio-economic peers nationally and a 30% higher rate than the control group in the study. From the first day of school, Program participants perform as well or better than their classmates regardless of income level. This research, published in peer-reviewed journals, demonstrates not only the immediate, but also the very long-term impacts of home visiting.

Not only do child participants perform better in school, but their parents also become actively involved in their education, as noted by principals and teachers at the schools they attend. In addition, the parents go on to make changes in their own lives as well, obtaining their GEDs, returning to school, and improving their employment situations. At least 30% of our Home Visitors across the country are parents who were in the Program as parents; for many of them, this is an entry into the workforce. All of these changes have significant ramifications for their children's futures. The Parent-Child Home Program proves that when programs are available to support parents and children from an early age, delivering services in a way that is accessible and meaningful to them, we can ensure that economically and educationally disadvantaged families are able to support their children's healthy development and prepare their children to enter school ready to be successful. These families will never experience the achievement gap and will attain high levels of academic success.

The Program's primary goal is to ensure that all parents have the opportunity to be their children's first and most important teacher and to prepare their children to enter school ready to succeed. The Program's hallmark is its combination of intensiveness and light touch. Each family receives two home visits a week from a trained home visitor from their community who models verbal interaction and learning through reading and play. The families receive a carefully-chosen book or edu-

cational toy each week so that they may continue quality play and interaction between home visits and long after they have completed the Program. Often the books are the first books in the home, not just the first children's books, and the toys are the first puzzles, games or blocks that the child has ever experienced. The materials are the tools the parents use to work with their children. The materials ensure that when these children enter pre-kindergarten or kindergarten they have experience with the materials that teachers expect all children to know.

Most importantly, the Program is fun for families, demonstrating for parents both the joy and the educational value of reading, playing, and talking with their children. Children's language and early literacy skills progress rapidly, and parents find an enormous sense of satisfaction in the progress that comes from their work with their children. This combination of fun and the dramatic changes families see in their children are the reason that on average 85% of the families who start in the Program complete the 2 years. The majority of families who do not complete the Program fail to do so because they move to a community where it is not available.

We know The Parent-Child Home Program is successful because of the changes we see in the families and the success the children have when they enter school. We also know it is successful because of the positive responses from the local community sponsors, including school districts, family resource centers, community health clinics, and many community-based organizations, and from the way the Program is continuing to expand across the country. We see that home visiting is a service delivery method that is able to reach families whose children would otherwise show up in pre-K or kindergarten never having held a book, been read a story, engaged in a conversation, been encouraged to use their imagination, played a game that involves taking turns, or put together a puzzle.

We also know from over 40 years of practice in the field accompanied by extensive research and evaluation that home visiting is a critical and effective way to reach immigrant and non-native English-speaking families and ensuring that they have access to all the tools they need to ensure their children's healthy development and future success. We have also seen the value of utilizing home visitors who are a language and cultural match for families, and, in making these matches, how well-trained and well-supervised paraprofessional home visitors can be very effective and vital to reaching certain difficult to access communities.

Immigrant and refugee families with young children often do not access early childhood or family supports available in the communities where they live.[2] In addition, because of language and cultural barriers, they often do not utilize community institutions like public libraries, public schools, or community centers. They are not familiar with the options for early childhood education for their children and often miss accessing center-based programming because they are unaware that it is available or that their children are eligible. Even if they are aware of programs, families may not trust the institutions, might not approach them because of language barriers, and may prefer that their children be cared for at home by parents or extended family. These families are often very isolated, particularly from the educational system that their children will soon be entering, and from what they and their children need to know before they enter school. Home visiting is an ideal way to reach these families as it meets them where they are most comfortable, in their own homes, can provide services in their own language and can adjust to their literacy levels. It also can be the most effective service for impacting the home environment in ways that will not only benefit the children's development and preparation for school but also will support them as they continue on with their education.[3]

Home visiting as a service delivery method is particularly effective with high risk, socially and linguistically isolated families.[4] In The Parent-Child Home Program model, the Home Visitor's role is specifically focused on demonstrating ways that parents/primary caregivers can use the curricular "tool" of a children's book or educational toy to interact with their young child to build language and early literacy skills. The goal of the home visits is to increase verbal interaction between parent and child, as both a cornerstone of early literacy[5] and a way to support and strengthen the attachment between parent and child. This approach helps to mitigate potential child abuse/neglect by increasing protective factors in the home, sup-

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[2] Bruce Fuller, Sharon L. Kagan, Gretchen L. Caspary, and Christiane A. Gauthier, "Welfare Reform and Child Care Options for Low Income Families," *The Future of Children: Children and Welfare Reform* 12.1 (2002): 97–119.

[3] Jeanne Brooks-Gunn, "Do You Believe in Magic? What We Can Expect From Early Childhood Intervention," *Social Policy Report: Giving Child and Youth Development Knowledge Away* 17.1 (2003): 3–14.

[4] Brooks-Gunn 3–14.

[5] Lev Vygotsky, *Mind in Society: The Development of Higher Psychological Processes* (Cambridge: MIT Press, 1978).

porting the children's social-emotional growth through appropriate parent-child verbal interaction, and preparing children for school success.[6] Other outcomes, such as the parent pursuing their own educational goals or improving their employment or housing situations, often occur as a result of these intensive visits. The Program also plays a critical role in connecting families to other programs and support systems as requested by the participating parent, such as referrals for evaluation for possible early childhood developmental delays, or connections to GED or ESL programs for adult family members. Local Program sites form partnerships with public libraries, introducing families to library services and resources.

Many Parent-Child Home Program sites have been able to hire home visitors from the communities they are serving who speak the languages of the families they are serving and come from the same, or similar, cultures. These multi-cultural staffs work best when they work as a team, on an ongoing basis, under supervision, sharing their own cultures and helping each other understand the cultural nuances that make a difference to the families they are serving. Often the site coordinator or supervisor can best train her staff by seeking guidance and cultural knowledge from the home visitors s/he is supervising. Utilizing techniques of reflective supervision and relationship-based practice, this information and expertise-sharing can be facilitated over time.

Matching families and home visitors based on language and/or culture is critical to successful outcomes with high-risk families. A language/cultural match of home visitor to family helps to overcome the cultural barriers often encountered when working with immigrant families. The language match allows home visitors to fully understand and communicate with family members. The cultural match enables home visitors to understand nuances of behavior and address them, when needed, from a common viewpoint.

VOICES FROM THE FIELD—"In our program, all our home visitors are familiar with the cultures they are serving. If somebody else was doing the home visits, I could imagine some conflicts—we understand the language and the priorities and choices our families have. We know to take things slow and understand that if the parents never went to school, they don't know what sort of help and support to offer their children." (Saadia Hamid, Parent-Child Home Program Coordinator, Seattle, WA)

The issue of trust is especially important when providing a home visitor to an immigrant or refugee family, particularly if the family has experienced the trauma of political betrayal or war in their home country, or is still going through a period of adjustment in a new community in the U.S. The ability to communicate and demonstrate understanding of these issues regarding family history and adjustment is key to establishing a foundation of trust. The home visitor must be well-trained and well-supervised in home visit strategies, early childhood development, parenting, appropriate expectations, and boundary issues; however, it is the home visitor's ability to communicate with the family, to understand the cultural nuances of the family's behavior and attitudes toward parenting, and to connect with the parent/caregiver in a mature, warm, and non-judgmental way, that provides the foundation for trust, growth, and change.

We would just like to share with you a brief anecdote demonstrating the long-term impact of home visiting on the families, and in particular an immigrant family. We have been fortunate to have followed program participants through high school graduation and beyond and have many wonderful examples of the Program's impact on children's lives. The long-term success of the Program is clearly depicted by an interview that was conducted recently with a program graduate from a New York Parent-Child Home Program site, which has been implementing the Program for over 35 years. The son of immigrants from Columbia, he noted that of the forty native Spanish-speaking students in his grade, only three went on to college. He observes that all these children went through the same schools, the only difference was The Parent-Child Home Program. He says it got him on the right track early; he entered school ready to learn and has soared ever since. He still has vivid memories of how confident he felt when he started kindergarten, how the books and toys were familiar and how he was the only native-Spanish-speaking child in his class who knew the words to London Bridge is Falling Down. For him, the Program was a critical bridge to the rest of his education and for his mother it was empowering. She went back to school herself, and he noted she regularly would call his teachers to tell them to give him more homework because what they had given him was too easy. This young man is now a corporate lawyer in New York City, and he is the

[6] Phyllis Levenstein, Susan Levenstein, and Dianne Oliver, "First Grade School Readiness of Former Child Participants in a South Carolina Replication of the Parent-Child Home Program," *Journal of Applied Developmental Psychology* 23 (2002): 331–353.

first Program graduate to serve on The Parent-Child Home Program's national board of directors. His story is both extraordinary and typical of the kinds of success parents and children can achieve when home visiting is available to reach them where they are most comfortable and help them build the language, literacy, and social-emotional skills they need to be successful.

The Early Support for Families Act (H.R. 2667) will ensure that many more families in need receive home visiting services by establishing a new mandatory federal grant program dedicated solely to home visitation. H.R. 2667 authorizes $2 billion over 5 years in grants to states to provide evidence-based home visitation services to support families with young children and families expecting children. The legislation empowers states to fund those home visitation services that best suit the needs of their communities, while putting in place important parameters to assure that families receive high quality services. Programs funded through H.R. 2667 must:

- Adhere to clear evidence-based models of home visitation that have demonstrated significant positive effects on program-determined outcomes;
- Employ well-trained and competent staff with high quality supervision;
- Show strong organizational capacity to implement a program; and
- Establish appropriate linkages to other community resources.

We strongly support the flexibility the legislation provides to states to select the combination of home visiting services most suited to its needs. This flexibility is supported by a compelling body of research demonstrating the effectiveness of a range of evidence-based models employing a diverse and highly skilled workforce. As noted above, The Parent-Child Home Program has documented successful outcomes utilizing home visitors who are selected based on their personal characteristics, such as the ability to establish a trusting relationship, and their educational and experiential background in early childhood development and parenting education. Parent-Child Home Program home visitors typically live and/or have previously worked in the same communities as Program families and share the language and cultural background of the families with whom they are working. In addition, The Parent-Child Home Program works with families when their children are 16-months to 4 years; often reaching families who were not able to access other home visiting services or picking up with the literacy, language and school readiness focus as other home visiting services are ending.

Recommendations

The Early Support for Families Act of 2009, H.R. 2667, establishes a strong foundation for a new home visiting program. We do, however, believe that there are opportunities to further strengthen the grant program authorized by the bill. The legislation calls for states to prioritize home visiting programs that adhere to models with the strongest evidence, but also allows states to direct some funding to home visiting programs that utilize models that have not yet achieved the strongest level of evidence. We support adding more specificity to both the standards that all programs must meet to qualify for funding; and the standards that "evidence-based" programs must meet to be given priority for funding.

In order to ensure the overall quality of the services being provided, we believe that legislation should establish standards that all programs must meet. All programs funded under this grant should be home visiting programs that have been in existence for at least three consecutive years prior to being funded under the Act, and are:

- Research-based;
- Grounded in empirically based knowledge related to home visiting and child health or child development;
- Linked to program-determined outcomes; and
- Serving families based upon comprehensive home visitation program standards, including standardized training, ongoing professional development; and high quality supervision.

In addition to meeting the criteria listed above, we recommend that home visiting models achieve the following research standard in order to be considered programs with "the strongest evidence of effectiveness:"

[the model must] *Have demonstrated significant positive outcomes for children and families consistent with the outcomes being sought (for the populations being served) when evaluated using well-designed and well-conducted rigorous evaluations, including but not limited to randomized controlled trials, that provide valid estimates of program impact and demonstrate replicability and generalizability to diverse communities and families.*

We are pleased to be part of a national coalition of national home visiting organizations and advocates for early childhood and family support services that have been working together for a number of years to achieve federal home visiting legislation and are pleased to support The Early Support for Families Act.

Thank you for holding this hearing and for introducing The Early Support for Families Act which will provide funding to support vital services for children and families who would otherwise miss their opportunities to experience healthy development and quality parent-child interaction and to enter school prepared and ready to be successful. Thank you for your support for ensuring that all parents struggling to help their children succeed receive the support they need to bring parent-child interaction, a supportive home environment, healthy development, and the joys of reading, playing, learning, and school success into their children's lives. Providing families with high quality, research-validated home visiting services is a critical component of successful school readiness, early childhood education, and parent support efforts. It is truly a cost-effective way to ensure that all children and their parents have the opportunity to be successful.

Thank you for the opportunity to submit testimony.

The Parent-Child Home Program
Contact:
Sarah E. Walzer
Executive Director
The Parent-Child Home Program, Inc.
Garden City, NY

Statement of The Pew Center on the States

Pew Center on the States appreciates the opportunity to submit written testimony in support of quality, evidence-based home visiting programs. We fully support President Obama's budget recommendation to help states implement, expand and establish quality voluntary home visiting models, and commend this Subcommittee for convening a panel of experts in order to raise awareness of the major issues surrounding home visitation. Pew would like to recognize Chairman McDermott and Representatives Davis (IL), and Platts (PA) for their continued leadership on this very important strategy that can help ensure that new and expectant families are given the tools that they need to become healthy, productive citizens.

HIGH-LEVEL OVERVIEW

Strong families create strong communities. Federal guidance and support can help lead, refine and focus state efforts so that state and federal investments in home visiting have measurable, positive outcomes. In this testimony we outline recommended principles for establishing a federal evidence-based home visiting policy, including:

1. Rigorous research findings should guide federal home visiting resource allocation.
2. Federal guidance and federal funding are critical to strengthen and expand evidence-based state home visiting programs.
3. States should have flexibility to utilize public health insurance as part of home visiting finance strategy.

Below are a description of Pew's home visiting initiative and federal policy recommendations.

BACKGROUND:

The Pew Center on the States Home Visiting Campaign

Responsible and responsive parenting is not just good for children, it's good for society. Recent research has proven the common sense notion that experiences in early childhood—good or bad, starting even before a baby is born—can last a lifetime. Families who create a nurturing, safe and healthy environment endow their children with protective factors that set them on a path toward lifelong success. Public investments that help strengthen new and expectant families yield long-term benefits by eliminating need for costly remedial services associated with poor childhood development.

The Pew Charitable Trusts applies the power of knowledge to solve today's most challenging problems. The Pew Center on the States, a division of the Pew Charitable Trusts, advances effective policy approaches to critical issues facing states by raising issue awareness and advancing effective policy solutions through research,

advocacy and technical assistance. Pew's home visiting campaign, led by Project Director John Schlitt, was created to provide states with an in-depth, data-driven look into the urgent need to expand access to quality, evidence-based home visiting programs for new and expectant low-income families.

In January 2009, Pew launched a national campaign to increase low-income families' access to quality, proven home visiting programs. This five-year effort includes a dual focus on research and advocacy.

Home Visiting Research Agenda

In partnership with the Doris Duke Charitable Foundation, we will consider and commission research to help policymakers answer critical questions about the ever expanding home visiting evidence base. This research will include a 50-state report of home visiting policies, programs and funding to be published in 2010 as a baseline for marking states' progress, and to provide policymakers with an in-depth, data-driven look into the urgent need to expand access to quality, research-based home visiting programs to low-income families.

State Policy Advocacy Campaigns

Simultaneously, Pew will engage in advocacy campaigns in 4–6 states to encourage public investment in proven home visiting services that help low-income parents fulfill their role as their child's first and best teacher. We will prioritize our work in states that have committed to assuring expansion of quality home visiting programs to all eligible low-income families.

The Case for Home Visiting

Policymakers and other leaders across the country should be concerned about the widespread, resonating effects of negative experiences, maltreatment, and neglect in childhood. A 2008 report from the Centers for Disease Control and Prevention (CDC) states that intense, repeated negative experiences can disrupt early brain development to the point of permanently impairing the nervous and immune systems and, in extreme cases, cause the child to develop a smaller brain.[i] Similarly, researchers from the National Scientific Council on the Developing Child at Harvard University have shown that when a child is exposed to intense stress early in life—due to abuse, neglect or prolonged lack of nurturing—high levels of hormones produced in the brain can lead to increased chances for cognitive and emotional deficits.[ii]

Federal, state and local leaders are challenged with addressing the social and financial effects of maltreatment and negative childhood experiences. As they seek to build a healthy, productive citizenry, our leaders are increasingly aware of the growing costs of bad outcomes for adolescents and adults—in criminal justice, health care, foster care and more—and of the direct relationship between interventions in the earliest stages of life and children's chances of becoming successful adults.

Child maltreatment and neglect is a serious issue that warrants public attention. Both men and women who reported experiencing multiple types of abuse during early childhood were more likely to be a part of unintended pregnancies before the age of twenty. Children born to teenage mothers have higher health care costs and are more likely to become part of the foster care and juvenile justice systems. A report by the National Campaign to Prevent Teen Pregnancy, authored by the chairman of the economics department at the University of Delaware, showed that the taxpayers' tab for teen childbearing in 2006 alone was calculated at over $9 billion.[iii] Children born at low birth weight and without health insurance experience dramatically poorer health as adults, a result that is likely to generate significant costs in terms of medical care and lower productivity.[iv]

Low birth weight, child abuse and neglect, school failure and incarceration are devastating to families, put a tremendous strain on state budgets and are often preventable. A preponderance of evidence supports the fact that an ounce of prevention may be worth much more than a pound of cure. Early intervention is absolutely nec-

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[i] Middlebrooks JS and Audage NC "The Effects of Childhood Stress on Health Across the Lifespan." Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (2008).

[ii] National Scientific Council on the Developing Child. "Excessive Stress Disrupts the Architecture of the Developing Brain. Working Paper No. 3" (2005) http://www.developingchild.net/pubs/wp/Stress_Disrupts_Architecture_Developing_Brain.pdf. (Accessed June 17, 2009).

[iii] Hoffman, S, "By the Numbers: The Public Costs of Teen Childbearing" (2006). National Campaign to Prevent Teen and Unplanned Pregnancy. Available online at: http://www.thenationalcampaign.org/resources/reports.aspx#costs.

[iv] Lewit, EM., et al, "The Direct Cost of Low Birth Weight," The Future of Children, 5 (1), (1995). http://www.futureofchildren.org/information2826/information_show.htm?doc_id=79879 (Accessed June 17, 2009).

essary if we want to ensure the health, stability, and vitality of our children, our families, our communities and our nation.

Quality, Evidence-Based Home Visiting Works

Quality evidence-based home visiting programs offer families a social support network that—when properly implemented and matched to family need—can dramatically decrease negative outcomes. Pairing new and expectant families with trained professionals to provide parenting information, resources and support during pregnancy and throughout their child's first three years serves to strengthen parent-child relationships, increase early language and literacy skills and reduce child abuse and neglect—significant outcomes that can help ease the strain on state budgets.[v] Economists have calculated a pay-off of up to $5.70 on each dollar invested in the Nurse Family Partnership, a high-quality home visitation program serving at-risk families.[vi]

That said, not all home visiting efforts are created equal: research shows that poorly designed and inconsistently implemented programs will not offer the same return on a state's investment, nor necessarily result in positive outcomes for families. The most significant cost-savings from home visiting occur when low-income families are served by proven programs that employ well-trained professional home visiting staff.

DETAILED RECOMMENDATIONS

Pew believes that public investments in social capital should be backed by strong evidence—that is, programs should show evidence of effectiveness supported with rigorous, well designed evaluations of program implementation and outcomes.

Particularly in difficult economic times, when stress on families and state budgets is heightened, states can benefit greatly from federal leadership and support in creating and implementing effective home visiting programs. States need support in order to set quality standards for home visiting programs, monitor and assess program fidelity and track program resources and outcomes.

While states will choose to implement home visiting models that best fit their individual needs, they face several universal challenges in attempting to identify and support quality, evidence-based home visiting programs. Such challenges provide an opportune moment for federal leadership in setting standards for public investment in home visiting.

To determine what warrants substantial public investment in large-scale implementation or program replication, Pew supports prioritized funding to programs that have demonstrated positive outcomes with randomized controlled trial or rigorous quasi-experimental design with equivalent comparison groups. While programs with the strongest evidence are best positioned for scaled-up implementation, additional support is needed to help promising programs meet the high evidentiary standard necessary for large-scale investments.

The state of Washington, for example, uses evidentiary standards to prioritize funding allocations for home visiting programs. The state adopted criteria for assessing home visiting evaluation research on child abuse and neglect prevention outcomes and then established three levels: best, good and promising. This evidence-based approach allows the state to:

- Prioritize program funding to programs proven to yield the highest return on investment;
- Support research for promising programs with a sound theoretical basis but lower evidentiary standards to determine program efficacy; and
- Continuously monitor programs for quality improvement.

Pew proposes the following to guide state and federal investment in the home visiting arena:

1. Rigorous research findings should guide federal home visiting resource allocation.

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[v] See, for example, Sweet, MA and Appelbaum, M "Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children." *Child Development* 75(5):1435–1456, (2005).; U.S. Department of Health and Human Services. *Youth Violence: A Report of the Surgeon General*. Washington, DC: Department of Health and Human Services, (2001).; Kendrick D, et al. "Does home visiting improve parenting and the quality of the home environment? A systematic review and meta-analysis." *Archives of Disease in Childhood,* 82(6):443–451. (2000).

[vi] Karoly, Lynn A., et al. *Investing in Our Children: What We Know and Don't Know about the Costs and Benefits of Early Childhood Interventions*. (Santa Monica, CA: RAND, 1998).

• Only high-quality, evidence-based home visiting programs will garner significant cost-savings in the future, as well as an improved quality of life for our children.

• Federal policy should support states in implementing evidence-based programs.

• Federal policy should establish standards for state evaluations to rigorously assess home visiting child and family outcomes that document program impacts.

• Priority should be given to models that meet the highest evidentiary standards and ensure fidelity in implementation.

• Federal and state policy should support rigorous evaluation of promising programs that may not fully meet the standard of evidence needed to warrant large-scale investments.

2. Federal guidance and federal funding are critical to strengthen and expand state home visiting programs.

• The federal government should provide states with financial support to strengthen and expand effective home visiting.

• States should be supported in their critical role of ensuring that communities implement evidence-based home visiting programs with fidelity. Specifically, federal funding should support state infrastructure for: 1) the coordination of home visiting policies and resources across state public health, child welfare, and early education programming for new and expectant parents; 2) evaluation and monitoring of quality and outcome performance measures; 3) program implementation support; and 4) home visiting staff training.

• A significant secondary outcome of a federal home visiting initiative should be to influence the quality of all home visiting services across the states, whether federally funded or not. States can establish uniform quality standards and performance measures for all home visiting programs such as well tested parent education curricula, target populations, core process and outcome data elements, staff qualifications, service duration and frequency, training, intake and referral.

3. States should have flexibility to utilize public health insurance as part of home visiting finance strategy.

• Public health insurance for low-income families should cover home visiting services to help new and expectant families appropriately access medical, mental health and dental services, monitor the health and wellbeing of mom and baby, and identify early any potential developmental delays. As federal policymakers look toward healthcare reform and modernization, they should include Medicaid and SCHIP provisions that support home visitation as a preventive program.

Conclusion

Voluntary evidence-based home visiting programs are proven to strengthen parent-child relationships, increase early language and literacy skills and reduce child abuse and neglect—positive outcomes that can help ease the strain on state budgets.

Pew's Home Visiting Initiative will advance nonpartisan, pragmatic state policy solutions in home visiting. We would be pleased to serve as a resource to your committee as this issue moves forward. We sincerely thank the Subcommittee for the opportunity to submit testimony in full support of federal funding for quality voluntary evidence-based home visiting programs.

Statement of Voices for America's Children

Chairman McDermott, Ranking Member Linder and all members of the subcommittee, Voices for America's Children thanks you for the opportunity to submit comments for the June 9th hearing examining proposals to provide federal funding for early childhood home visitation programs. This hearing, and the associated legislation, continues the subcommittee's efforts to ensure that all children are safe, free from harm, healthy and able to thrive in their homes and communities.

Voices for America's Children (Voices) is a national child advocacy organization committed to speaking up for the lives of children at all levels of government. Comprised of 60 multi-issue member organizations across 45 states the Voices network seeks the promotion of effective public policies that improve the lives of children at the local, state and national level. It is the vision for Voices that all public policies must further the positive and healthy development of all children.

To achieve this vision requires:

• **Equity and Diversity:** All children achieve their full potential in a society that closes opportunity gaps and recognizes, and values, diversity;

• **Health:** All children receive affordable, comprehensive, high-quality health care;
• **School Readiness:** All children, and their parents, receive the services and supports to enable them to start school prepared for success;
• **School Success:** All children have an equal opportunity to attend an adequately and equitably financed public school meeting rigorous academic standards aligned with the needs of the 21st Century workforce;
• **Safety:** All children are safe in their homes and communities from all forms of abuse, neglect, exploitation and violence, avoid risky behaviors, and contribute to community well-being; and
• **Economic Stability:** All children live in families that can provide for their needs and make investment in their future.

The opportunity of home visiting, and of the *Early Support for Families Act*, is a strong avenue to assist in achieving this vision.

Voices applauds the efforts of Chairman McDermott, along with committee member Danny Davis and Representative Todd Russell Platts in crafting legislation that advances with President Obama's announced commitment to reach 450,000 families with evidence-based home visitation services within the next decade when fully implemented. Representatives Davis and Platts should also be acknowledged for their continued efforts and commitment in previous congressional sessions championing the Education Begins At Home Act—the precursor to the *Early Support for Families Act.* This bipartisan effort, along with Senators Kit Bond, Patty Murray and former Senator Hillary Rodham Clinton served as the galvanizing forces for this new opportunity.

Voices for America's Children (Voices) salutes Chairman McDermott, and other committee members, for maintaining their commitment in noting that "more needs to be done" following the passage of the *Fostering Connections to Success and Increasing Adoptions Act (P.L. 110–351)* that is now providing permanency options for thousands of children currently in foster care. The legislation now pending before the subcommittee, *The Early Support for Families Act (H.R. 2667)* seeks to improve the lives of children and families before they are in harm's way, and allow for optimal development of health and early learning. Voices enthusiastically supports the offered legislation for the opportunity of mandatory funding for the establishment, or expansion, of high quality evidence-based home visitation programs that will make lasting impacts on children, families and communities.

As the Congress continues efforts to fulfill the president's goal of ensuring that every child enters school ready to succeed, effective home visiting must be a part of this picture, though must not be the only component. These supports must be provided in conjunction, and coordination with Head Start and Early Head Start, the Child Care Development Block Grant, and high quality Pre-K opportunities for children, and assurances must be made that these programs are funded at levels to dramatically increase outreach and service delivery.

Home visiting services provided in isolation will not achieve the goal of ensuring that every child has a safe start in life and enters school ready to learn.

Voluntary home visiting provides early education and support to families where they are—in their homes and communities—in a non-threatening environment allowing for optimal outcomes. The growth of home visiting services over the past two decades is driven through a solid evidence base, and community focus, as an effective early-intervention strategy to enhance child well-being. The president's initiative, and the offered legislation, begins to follow through on recommendations initially developed by the United States Advisory Board on Child Abuse and Neglect in 1991 calling for voluntary, universal home visiting for every family in the country. As part of their findings, the Advisory Board noted that "no other single intervention has the promise of home visitation." [1]

As the Congress undertakes health reform this year, Voices urges all members to make children paramount in this debate while acknowledging that child maltreatment is a major public health concern. The Adverse Childhood Experiences Study (ACES), with 17,000 participating adults, finds that adults with exposure to adverse childhood experiences including abuse, physical or emotional neglect, or household dysfunction, are more likely to have negative health outcomes as adults. These outcomes include greater likelihood of alcoholism and illicit drug use, risk for intimate

[1] U.S. Department of Health and Human Services, U.S. Advisory Board on Child Abuse and Neglect (1991). *Creating caring communities: Blueprint for an effective federal policy for child abuse and neglect.* Washington, DC: U.S. Government Printing Office.

partner violence, sexual promiscuity, smoking, suicide attempts and unintended pregnancies.[2]

Investing in home visiting was also recommended by the United States Centers for Disease Control and Prevention (CDC) Task Force on Community Prevention Services as an effective strategy to combat child maltreatment.[3] Just last year, the CDC's National Center for Injury Prevention and Control cited home visiting as an effective strategy for the prevention of adverse childhood experiences.[4]

The evidence surrounding the effectiveness of home visiting services continues to grow since the initial Advisory Board report was released in 1991. Analysis of home visiting programs have shown less occurrence of child maltreatment, family engagement in positive parenting practices for optimal child development, and stable, nurturing environments for children.[5]

Longitudinal studies of programs also demonstrate a reduction in later adverse experiences for children including juvenile crime delinquency and substance abuse use, as well as improvements in school performance and increased graduation rates.[6] Other studies show that participating children demonstrate improved early literacy, language development, problem solving, social awareness and competence, and basic skill development.[7]

Home visiting services also demonstrate cost savings across a number of social factors. Significant savings are found through reduced Medicaid expenditures, reduction in the need for special education services,[8] stronger birth outcomes[9] and reduction in low birth-weight babies,[10] and substantial increased work potential.[11]

Analysis from Prevent Child Abuse America estimates that the combined direct and indirect costs of child maltreatment alone exceed $104 billion each year. This includes more than $33 billion in direct costs associated with foster care, hospitalization, mental health services and law enforcement. Another $70 billion is spent each year for indirect costs including the loss of work productivity, chronic health problems, special education, and involvement within the criminal justice system.[12] For every federal dollar spent for children in out of home care, a meager 15 cents of federal supports is focused on child maltreatment prevention and protection. With the current federal child welfare financing system providing little in op-

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[2] Felitti, V.J., Anda, R.F., et al. (1998). *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults.* American Journal of Preventative Medicine, 14 (4); 245–58.

[3] Hahn, R.A. (2003). *First reports evaluating the effectiveness of strategies for preventing violence: Early childhood home visitation.* Morbidity and Mortality Weekly Report. 52(RR14);1–9. Atlanta, GA: Centers for Disease Control and Prevention.

[4] Middlebrooks, J.S., Audage, N.C., *The effects of childhood stress on health across the lifespan.* Atlanta, GA. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

[5] Daro, D. (2009). *Home visitation: The cornerstone of effective early intervention*. Public testimony provided to the U.S. House Ways and Means Subcommittee on Income Security and Family Support on proposals to provide federal funding for early childhood home visitation programs. June 9, 2009.

[6] Ibid.

[7] Administration for Children and Families (2003). *Research to practice: Early head start home-based services.* Washington, DC: Department of Health and Human Services; New York University Study on School Readiness of Parent-Child Home Program Participants (2003); Coleman, M., Rowland, B., & Hutchins, B., (1997) *Parents-As-Teachers: Policy implications for early school intervention.* Paper presented at the 1997 annual meeting of the National Council of Family Relations, Crystal City, VA, Nov. 1997.

[8] Hevesi, A.G., (2001). *Building foundations: Supporting parental involvement in a child's first years.* Report from the New York Office of the Comptroller; Lazar, I., Darlington, R., Murray, H., et al. (1982). *Lasting effects of early education: A report from the consortium for longitudinal studies.* Monographs of the Society for Research in Child Development, 47, 2/3; Pfannenstiel, J., Lambson, T., & Yaarnell, V. (1991). *Second wave of the parents as teachers program.* Overland Park, KS: Research and Training Associates.

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[10] Eunju, L., Mitchell-Herzfeld, S., Lowenfels, A.A., Green, R., et al. (2009). *Reducing low birth weight through home visitation: A randomized controlled trial.* American Journal of Preventative Medicine, 36, (2), 154–160; Rogowski, J. (1998). *Cost-effectiveness of care for very low birth weight infants.* PEDIATRICS, 102, 1, 35–43.

[11] Hevesi, A.G., (2001). *Building foundations: Supporting parental involvement in a child's first years.* Report from the New York Office of the Comptroller; Bartik, T.J., (2008). *The economic developments of early childhood.* Partnership for America's Economic Success: Washington, DC.

[12] Wang, C.T. and Holton, J. (2007). *Total estimated costs of child abuse and neglect in the United States.* Chicago, IL: Prevent Child Abuse America.

portunities to provide primary prevention activities, and with greater supports only available only after a child is removed, the opportunity for states to access the proposed supports included within the *Early Support for Families Act* will serve as the greatest mandatory investment in child abuse prevention services in federal history.

Voices supports provisions within the *Early Support for Families Act* that will provide up to $2 billion of mandatory funding when fully implemented. These funds, to be administered through the creation of a new Title IV–B, Subpart 3, would provide state-based grants for the expansion, or establishment of evidence-based home visitation programs following the completion of a statewide needs assessment.

As efforts to adopt the legislation advance through Congress, potentially as part of the health reform debate, Voices hopes that the funding for programs determined to meet the "strongest evidence of effectiveness" are determined through those programs who have continued to demonstrate significant positive outcomes for children and families that are consistent with the outcomes being sought as measured through findings of well-designed rigorous evaluations. In order to maintain the development of high-quality programs, Voices also hopes that those programs seeking federal supports meet, at a minimum, core requirements related to prenatal health or positive child healthy development, promote appropriate social emotional development, enhance school readiness and academic success, increase family stability or economic stability, lead to reductions in child maltreatment or involvement within the juvenile justice system, or other demonstrated outcomes that improves a child's well-being.

These programs should also ensure that ongoing, organized training and professional development is provided for employees, and that the models themselves are continually seeking to improve program delivery.

To achieve the president's commitment of promoting to the highest available standard for the programs involved, Voices also hopes that efforts are made that allow continued training and technical assistance are available via the Department of Health and Human Services to assist states in their implementation efforts. Voices also seeks a set aside of federal monies to assist states in their ongoing program development and evaluation of funded programs.

On behalf of child advocates across the county, and the children and families we speak for, Voices again applauds the efforts to date to establish a new federal program dedicated for high quality home visitation programs with associated mandatory funding. Voices looks forward to working with the committee, and all members of congress, to ensure adoption of this critically important legislation. Please let us know if we may be of any assistance in this endeavor.

Prepared Child Welfare League of America

HEARING ON EARLY SUPPORT FOR FAMILIES ACT

UNITED STATES HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON INCOME SECURITY
AND FAMILY SUPPORT

June 9, 2009

2345 Crystal Dr, Suite 250, Arlington VA 22202-4813
Phone 703-412-2460; Fax 703-412-2481, www.cwla.org

Chairman McDermott, Ranking Member Linder, and members of the Subcommittee on Income Security and Family Support of the Committee on Ways and Means, the Child Welfare League of America (CWLA) submits this statement in support of H.R. 2667, the Early Support for Families Act. We would like to thank the sponsors of this legislation, Representatives Jim McDermott, Danny Davis, Todd Platts, and James McGovern.

CWLA represents hundreds of state and local direct service organizations including both public and private, and faith-based agencies. Our members provide a range of child welfare services from prevention to placement services including adoptions, foster care, kinship placements, and services provided in a residential setting. CWLA's vision is that every child will grow up in a safe, loving, and stable family and that we will lead the nation in building public will to realize this vision.

As we have stated in other Congressional settings, CWLA believes the best way to ensure children are safe from all forms of maltreatment is to provide comprehensive, community-based approaches to protecting children and supporting and strengthening families. Public and private agencies, in collaboration with individual citizens and community entities, can prevent and remedy child maltreatment, achieve child safety, and promote child and family well being. There is no solution to addressing child abuse in our society short of a comprehensive approach that begins with preventive efforts and assures that we have a safe and permanent place for children who are the victims of abuse and neglect.

PREVENTION

We support of the Early Support for Families Act, because home visitation provides an important component in the continuum of care that all children need. These programs also assist in improving education and health outcomes for children. One of the greatest challenges and debates with regard to our nation's child welfare system is over how we can prevent abuse and neglect from taking place. Everyone would prefer a system that can help a family before they become part of the millions of reports of abuse and neglect filed annually and certainly before they become one of the 800,000 children who are substantiated as neglected and or abused each year.

We recognize the value both in human and economic terms, and the great benefits to our nation and to vulnerable families and children of enacting policies that prevent the need for ever placing a child in foster care. There is no simple model for prevention of child abuse and in fact we believe that a commitment to preventing child abuse will involve multiple efforts and strategies.

All families benefit from information, guidance, and help in connecting with resources as they meet the challenges of parenting and family life. For families with limited resources, or those that face additional challenges such as health and mental health care, the need for support and assistance is even greater. Children develop the ability to lead productive, satisfying and independent lives in the context of their families; therefore families are central to child safety and well-being. Family ties are critical in the development of a child's identity. Through interaction with parents and other significant family members, children learn and come to

subscribe to their most cherished personal and cultural values and beliefs. They learn right from wrong, and gain competence and confidence. Family relationships must be nurtured and maintained to meet the needs of children for continuity and stability, which support healthy development.

Evidence shows that children who experience maltreatment are at greater risk for adverse health effects and risky health behaviors when they reach adulthood. Many parents involved in the child welfare system do not intentionally harm their children; rather their lack of knowledge, skills, or resources has led them to harm their children. [1] Quality early childhood home visitation programs lead to several positive outcomes for children and families, including a reduction in child maltreatment.

Annual data indicates that roughly 40% of the 800,000 children who are substantiated as abused and neglected never receive follow-up services.[2] Reasons for this include the way in which data is collected, how states provide services, shortage of caseworkers to provide services resulting in families to be placed on waiting lists, and in some instances the reluctance on the part of some families to access services. Still, with such a high and consistent percentage going without follow-up help, adequate front-end services are not being provided. For some, that may mean they will return to the system. It also tells us we are not doing enough to prevent these children from coming into care or being brought to the attention of child protective services (CPS). More widely available and implemented home visitation could help address this drastic shortcoming. Perhaps more serious is the fact that of the estimated 1,760 child deaths in 2007, 75.7% were younger than age 4. Of the perpetrators of child maltreatment, nearly 70% of child fatalities were caused by one or more parents.[3]

Prevention of child abuse and neglect is perhaps the greatest challenge in the continuum of the child welfare system. All too frequently, prevention of abuse and neglect is an add-on service instead of a core component of the range of needed services. The issue of providing or addressing prevention too often is conditioned on whether a child welfare agency or department can free up appropriations or funds by reducing the other costs, including what some would describe as back-end services, typically foster care. In fact, what is required is an investment in the range of services.

Part of the challenge in prevention is how we define and measure it. Prevention can encompass some services as basic as access to child care and a range of other services that can help families reduce the stresses of parenting by providing a needed respite for parents and ensure a child's well-being when parents are working, in school, or caring for other children.

Over the years CWLA has partnered with other national child-serving organizations to advocate for the expansion of programs and services for at-risk children and families, in a comprehensive effort to reduce the level of child abuse and child neglect. Beyond these most critical programs that affect families, we want to focus attention on those programs that have as their mission, at least in part, the prevention of child abuse. The federal government provides some limited funding intended to provide services that can prevent or remedy potential neglect and abuse situations. That funding, however, is severely limited.

CWLA recognizes the value of prevention in human and economic terms as well as the great benefit to our nation and to vulnerable families and children. Policies that prevent the need for placing a child in foster care have a human, economic, and moral impact. The challenge is that no simple model exists for prevention of child abuse and child neglect that applies to all. CWLA believes a commitment to preventing child abuse will involve multiple efforts and strategies. Greater investment and support for specific models and programs such as home visitation is one critical part of such a strategy.

HOME VISITING BACKGROUND

Home visiting refers to different model programs that provide in-home visits to at-risk families. Home visiting programs—either stand-alone or center-based—serve at least 400,000 children, between the ages of zero through 5, annually. The eligible families in these home visiting programs may receive services as early as the prenatal stage. Nurses, social workers, child development specialists, and other trained members of the community conduct home visits on a weekly, bimonthly, or monthly basis. Program goals include promoting positive parenting practices, improving the health of the entire family, increasing the family's ability to be self-sufficient and enhancing school readiness for the children. Research shows that a child's early years are the most critical for optimal development and provide the foundation necessary for success in school and life, therefore home visiting can really make a lifetime of difference.

Research has shown that home visitation programs reduce abuse and neglect and juvenile delinquency, and ultimately save taxpayers over $50 billion annually.[4] Greater investment and support for home visiting is a critical part of such a strategy. Currently home visitation programs rely on a range of federal, state and local funds. Unfortunately these funding sources can be unreliable, even for programs that are demonstrating effectiveness in a range of areas. In recent years *states* have utilized various funding sources including the Social Services Block Grant (SSBG), Title IV-B part 1, Child Welfare Services, Title IV-B part 2, Promoting Safe and Stable Families (PSSF), the Child Abuse Prevent and Treatment Act (CAPTA) state grants, The Title V Maternal and Child Health (MCH) Block Grant and Community-Based Family Resource and support grants. All of these funding sources are used to fund a range of other services, and all have been subject to reductions or proposed reductions in each of the last five budgets. This highlights the need for specific funding for home visiting programs to strengthen and stabilize the funding.

CWLA's commitment to home visiting spans back over half a decade when we first went on record for supporting legislation to expand Parents as Teachers and other early childhood home visiting programs. In past Congress[5] we have also supported the Education Begins at Home Act introduced by Congressman Danny Davis.

Home Visiting Models
Some of the national home visitation models include Healthy Families America, Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse Family Partnership, Parent-Child Home Program, and Parents As Teachers. Healthy Families America exists in more than 450 communities; HIPPY is in 167 sites in 26 states; the Nurse Family Partnership has over

1,000 home visitors in 28 states; the Parent-Child Home Program has 137 sites nationally and 10 sites internationally; and Parents as Teachers is located in all 50 states and serves more than 400,000 children.[7]

Results from Home Visiting Studies
Home visiting services stabilize at-risk families by significantly affecting factors directly linked to future abuse and neglect. Research shows that families who receive at least 15 home visits have less perceived stress and maternal depression, while also expressing higher levels of parental competence.[8] Home visiting programs may also reduce the disproportionality or overrepresentation of children and families of color in the child welfare system, while improving outcomes for these families. Research shows that participating children have improved rates of early literacy, language development, problem-solving, and social awareness. These children also demonstrate higher rates of school attendance and scores on achievement and standardized tests.[9] Studies show that families who receive home visiting are more likely to have health insurance, seek prenatal and wellness care, and have their children immunized.[10]

A study of the Missouri-based Parents As Teachers home visiting program examined the children enrolled in the program and found that by age 3, they were significantly more advanced in language, problem-solving, and intellectual and social abilities than children in comparable groups.[11] A study of the Nurse-Family Partnership showed a 79% reduction in child maltreatment among at-risk families compared to other families in a control group. That same study also indicated a number of other benefits in the areas of health, employment, and behavior.[12]

EARLY SUPPORT FOR FAMILIES ACT

CWLA Applauds the Introduction of HR 2667
CWLA endorses HR 2667 and is pleased that the President and Congress have taken a stand for home visiting and that legislation has now been introduced to make mandatory funding for home visiting a reality. We are equally pleased that the Early Support for Families Act will establish the first federal funding stream dedicated solely to home visiting programs. The bill builds off of previous bipartisan legislation that had been introduced in both the House and Senate that would support rigorously evaluated programs that utilize nurses, social workers, other professionals and paraprofessionals to visit families, especially lower-income families, on a voluntary basis. We are truly thankful for the continued commitment to the prevention of child abuse and neglect.

Under the Early Support for Families Act, states are directed to use the grants to supplement current funding for home visiting programs. The funding would start at $100 million in 2010, increasing to $700 million by 2014. The bill would require a state match of 15 percent in the first year, 20 percent in year two, and a 25 percent match by year three. The legislation does not dictate which, or how many, home visiting models may be used. A state's grant funding award would be based on the number of children in the state whose families live below the poverty line, with emphasis on communities with a high proportion of low-income families or a high incidence of maltreatment.

Certain aspects of the bill indicate Congress' strong commitment to the states. For example, the state match described in the bill signals a dedication to states facing the dilemma of having to cut critical services for children and families by not requiring a large match upfront but by gradually increasing it over the years. The bill also allows for the re-allotment of funds not used by the state for the given fiscal year. If enacted, the bill would fulfill one of President Obama's first initiatives in the area of zero to five early childhood policy.

Recommendations

Coordination
To the extent that these mandatory funds are placed under the authority of the child welfare agency as is the case with IV-B 1 & 2, we strongly recommend a directed coordination at both the federal and state level to ensure proper targeting of funds.

On the federal level, the Department of Health and Human Services should work and consult with the Department of Education during the grant process. This same coordination and communication should also be evident throughout HHS in working with the various early childhood and child health programs within that Department. This federal approach would provide an important message to state and community programs about the need to work together.

On the state and local levels, all potential partnerships should be examined as a way to ensure that the best home visiting initiatives are employed so that family and community needs are met. Within the Education Begins at Home Act, an earlier version of this legislation, language was included that promoted collaboration among a broad range of child- and family-serving programs, including--

- early childhood home visitation programs
- early childhood care and education programs;
- programs carried out under part C of the Individuals with Disabilities Education Act
- child abuse prevention and treatment programs
- State and local child protection systems
- Medicaid and State Children's Health Insurance programs
- parental substance abuse, mental health and prevention and treatment programs

As well as many additional programs including child support, the Temporary Assistance for Needy Families (TANF) program and other service programs.

The concern is that if there is not a directive with at least some specificity as to who the state child welfare agency must coordinate with, this could become a home visiting initiative that will only be used for families that have already become involved with child welfare (i.e. abuse substantiated). That means this will not be a true "prevention" initiative and funds could supplant current use of SSBG, TANF, IV-B part 1 and part 2 as those dollars are re-allocated to address other issues.

Coordination is important to assure that this new funding addresses prevention of child abuse. While its not possible to expand to "universal" with this funding it is important that it address

families at-risk of entering the court and child welfare systems—at least if the goal is to create a funding source for prevention.

Model Fidelity
When applying for grants through this initiative, we believe that applicants should link to a national model or be able to assure fidelity to a home visitation model, and as a measure to ensure that the proposed program adheres to standards. We are concerned that there may be some programs that will apply under the home visiting umbrella that do not adhere to the basic/core components of a home visiting program. CWLA supports the potential of this funding structure in the bill that will allow for innovation but we would recommend that there be some assurance that both funding streams now included in the bill be allocated towards program models that exhibit the core components of evidence-based home visitation services.

CONCLUSION

CWLA commends the Committee for its hearing today on home visiting—highlighting the programs successful outcomes for children and their families. Such successful outcomes of home visiting contributing to familial continuity, educational enrichment, as well as physical and mental health will be expanded by increased federal support. CWLA hopes that the Administration's proposal along with this legislation and this hearing today, is merely the next step toward passage of the bill before you. This commitment will make the benefits of home visiting services accessible to many more families and improve outcomes for many more children. Thank you for all you do to ensure children are a national priority.

ENDNOTES:

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Prepared Fight Crime

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FIGHT CRIME: Invest in Kids

5,000 Police Chiefs, Sheriffs, Prosecutors, other Law Enforcement Leaders, and Violence Survivors Preventing Crime and Violence

June 8, 2009

VIA FACSIMILE

The Honorable Jim McDermott
Chairman, Subcommittee on Income Security & Family Support
Committee on Ways & Means
B-317 Longworth House Office Building
Washington, DC 20515

The Honorable Danny Davis
2159 Rayburn House Office Building
Washington, DC 20515

The Honorable Todd Platts
2455 Rayburn House Office Building
Washington, DC 20515

Dear Representatives McDermott, Davis and Platts:

On behalf of the more than 5,000 police chiefs, sheriffs, prosecutors and victims of violence of FIGHT CRIME: INVEST IN KIDS, thank you for your ongoing efforts to promote investments in kids that help prevent crime. We know from the front lines in the fight against crime – and the research – that targeted investments in children are critical to our nation's public safety. One such investment in kids – home visits to coach parents of young children – will be expanded through your "Early Support for Families Act" (H.R. 2667). **We are deeply grateful for your bipartisan leadership in introducing this important legislation, and are proud to endorse the "Early Support for Families Act."**

In 2007, there were 794,000 confirmed cases of child abuse and neglect. Research shows the true number of victims, including those never reported to authorities, may be well over 3 million. Child abuse and neglect killed 1,760 children in 2007. Children who survive abuse or neglect carry the emotional scars for life. The best available research indicates that, based on the confirmed cases of abuse and neglect in just one year, an additional 30,000 children will become violent criminals and 200 will become murderers as adults as a direct result of the abuse and neglect they endured.

Fortunately, evidence-based home visiting programs can prevent abuse and neglect and reduce later crime and violence. For example, one program, the Nurse-Family Partnership (NFP), randomly assigned interested at-risk pregnant women to receive visits by nurses starting before the birth of a first child and continuing until the child was age two. Rigorous research, originally published in the *Journal of the American Medical Association*, shows the program cut abuse and neglect among at-risk kids nearly in half. In addition, children of mothers who received the coaching had 60% fewer arrest bys age 15 than the children of mothers who were not coached.

Other home visiting models also produce positive results. For example, a study of the Healthy Families home visiting program in New York (HFNY) found that mothers in the program reported committing one-fourth as many acts of serious physical abuse as the mothers not receiving services did. A study of the Parents as Teachers (PAT) model found that when teen mothers received PAT services, combined with referrals to needed

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psychological, health, nutritional, or educational services, the percentage of participating families investigated for child abuse or neglect was zero (compared with 2.4% of non-participating families).

We are pleased that the "Early Support for Families Act" (H.R. 2667) will invest $2 billion in mandatory funding over 5 years to implement the initiative proposed by President Obama to establish and expand quality programs providing voluntary home visiting to assist families with young children, and families expecting children, especially in high-need communities. We are also pleased that this legislation prioritizes investments in high-quality home visiting programs with a proven ability to produce positive outcomes for children and their families.

Thank you again for your leadership on critical investments in kids that reduce crime. We look forward to working with you to achieve enactment of this legislation.

Sincerely,

David S. Kass
President

Miriam Rollin
Chief Operating Officer

Nick Alexander
Federal Policy Director

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Prepared Sharon Sprinkle

SUPPLEMENTAL TESTIMONY OF
SHARON SPRINKLE
NURSE CONSULTANT
NURSE-FAMILY PARTNERSHIP

BEFORE THE HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON INCOME SECURITY AND FAMILY SUPPORT

JUNE 9, 2009

In addition to my written testimony, I would like to address several aspects of the Nurse-Family Partnership program model that were areas of interest in today's hearing.

The Nurse-Family Partnership (NFP) serves first-time, low-income mothers and their families, a population facing the highest risk of suffering health care, educational and employment disparities that have lifelong negative consequences. The median age of the mothers we serve is 19 with an average annual household income of $13,500. NFP has over 30 years of research that show multi-generational outcomes – the program has demonstrated outcomes that improve the health and well-being of first-time mothers, their children and families.

Our program is not limited to the mothers and their first child but extends to the entire family involved in caring for the child. NFP encourages the involvement of the child's father or father figure within the household. Additional family members are encouraged to participate in the home visits and learn about caring for the new baby as a family. NFP nurses work to improve families' economic self-sufficiency by helping parents to envision their own future, plan future pregnancies, continue their education, and secure long-term employment.

An important component of the NFP program model is the qualifications and training of NFP nurses. All nurses are specially trained, registered nurses, many of whom have experience in the public health sector and enjoy being able to work within the community. Many NFP nurses left the nursing field after becoming "burned out" and have returned because NFP offers an opportunity that resonates with why they became nurses in the first place. NFP nurses undergo a rigorous 60-hour training by the NFP National Service Office's professional development team. Currently, over 1,000 registered nurses are administering the NFP program model nationwide.

NFP recognizes the registered nurse shortage in many areas of the country, and supports the development of solutions to overcome this challenge. NFP anticipates working closely with Congress, nursing leaders, health care advocates and community organizations, colleges and universities to address the nursing shortage and, in particular, to increase the percentage of racially diverse nurses in the workforce. Nonetheless, NFP anticipates an adequate supply of registered nurses to expand NFP nationally over the next ten years.

Most of the local NFP implementing agencies are city or county health departments. The NFP National Service Office has a contract with each local implementing agency that delineates each party's obligations, and specifies what the local agencies must do to meet NFP quality and reporting standards. Subject to regional salary variations, it costs approximately $500,000/year/100 families to deliver the NFP model, with some efficiencies of scale achieved for programs with over 200 families.

Our research has shown that targeting our model of home visiting services to the most vulnerable, low-income pregnant women, children, and families has the greatest impact on outcomes and cost savings to society. Low-income families have significantly fewer

resources to advocate for their needs and often live in communities with fragile health care delivery systems and scarce social services. NFP can help break the cycle of poverty – empowered, confident mothers become skillful parents who are able to prepare their children for successful futures, and their children grow into healthy, productive citizens. Evidence from the randomized controlled trials of NFP indicate that children and families living in poverty have more than their share of challenges, which compromise the health and well being of parents and their children. The trials also indicate that first-time families living in poverty gain the most from NFP in terms of their health, life course development, and the associated reduction in government costs.

○