

Home Visiting for At-Risk Families: A Primer On a Major Obama Administration Initiative

By Heather D. Boonstra

Nearly 40 years ago, David Olds was working at the Union Square Day Care Center, located in the basement of a church in West Baltimore. The center served low-income children aged 3–5, and although Olds' time there was brief, the center would play a significant role in propelling him toward his life's work. "Inner-city Baltimore in the early 1970s was a rough place," said Olds in an interview for a 2003 anthology of programs funded by the Robert Wood Johnson Foundation, "and it was frustrating working with kids who had experienced so much trauma in their lives that what we were able to do for them was too little and too late." So when Olds entered graduate school a few years later, he started thinking about how to reach kids early in their development. "The conclusion I came to was that we needed to start with the mothers, to really focus on helping a mother be a better parent from the time her child was born." Olds came up with the idea of a nurse home visiting program and, in 1978, launched the first test of his model in Elmira, New York.

Today, what used to be known as the "Olds Model" and is now known as the Nurse-Family Partnership has blossomed into a full-fledged industry, currently serving more than 17,000 families in 28 states. It has been shown to have numerous long-term benefits for children and families, including reductions in child abuse and neglect and improved birthspacing. Olds' work has also inspired the creation of other home visiting models, using public and private dollars, which have been implemented in hundreds of communities around the nation.

In Washington, expanding home visiting programs has emerged as a key priority for President Obama, both as a component of health care reform and as part of his "common ground" strategy around abortion. With all this attention—and potentially large sums of money—going toward home visiting programs, it is worth asking what models have been developed over the years for these programs; what is their potential for improving the health and well-being of mothers and children; what is known about their costs and benefits; and, going forward, what are their political prospects?

What Models Have Been Developed?

Home visiting is an early-intervention strategy that pairs new families, particularly those that are disadvantaged, with trained professionals who provide parenting information, resources and support throughout their child's first few years. This type of intervention dates back to the 1880s, when public health nurses and social workers were hired to provide in-home education and health care to urban women and children. In the last quarter of the 20th century, home visiting programs gained renewed interest as a strategy to prevent child abuse and neglect, and to reduce health disparities. In 1978, C. Henry Kempe, renowned author of *The Battered Child Syndrome*, called for a home visitor for every pregnant woman and preschool-aged child; that same year, Olds initiated his nurse home visiting program with families at risk in Elmira.

Today, a variety of home visiting programs with multifaceted goals are operating across the nation. Most programs focus on improving par-

enting skills; many also seek to prevent child abuse and neglect, promote positive child development, and improve the lives of women by helping them to delay future pregnancies and to become self-sufficient through schooling and employment. Some programs use professional nurses, social workers or other individuals with a master's degree as their home visitors; others use trained paraprofessionals, who are often members of the target community and culturally linked with the families they visit.

Programs also differ in the onset, intensity and duration of services, and in the populations they serve. Under some programs, scheduled visits start during pregnancy, whereas in others they begin at birth or later. The visits continue for 2–5 years and range in frequency from weekly to monthly. Although almost all home visiting programs focus on at-risk households—such as low-income, single-parent families—some are designed to work with all families in a defined geographic area with a concentration of such households, whereas others use eligibility criteria to target those households.

What Are the Health and Social Benefits?

It is not surprising that, given the many different home visiting models, it is difficult to provide a general summary about the benefits of these programs. According to a 1999 review of six home visiting models that had been evaluated in rigorous randomized trials, several models produced benefits in parenting skills and perhaps in the prevention of child abuse and neglect. But the benefits for other aspects of child health are less clear. Only one program demonstrated reductions in preterm births and in the proportion of low-birth-weight babies. Changes in children's development and behavior are also mixed and, where positive, often modest in magnitude.

The results from this 1999 review are consistent with those from other, more recent analyses of home visiting programs. An examination of 60 home visiting programs, published in the October 2004 issue of *Child Development*, found relatively small, but statistically significant, effects on parents' behavior, attitudes and educational attainment, and documented a significant reduction in

potential abuse and neglect. Another meta-analysis of 43 early prevention programs—including 38 home visiting interventions—considered the effects of these programs for families with young children at risk for physical abuse and neglect. This analysis, published in the August 2004 issue of *Child Maltreatment*, notes a decrease in abuse and neglect, and positive effects on other aspects of child and family functioning, such as interactions between parent and child.

A 2009 American Academy of Pediatrics policy statement on the role of home visiting programs in improving child health and development outcomes acknowledged that the body of evidence substantiating their impact was limited.

“Although much energy, effort, and research have gone into the development of home-visiting programs, the extent of potential benefits is still inadequately delineated and understood.”

Nevertheless, the academy concluded that “sufficient evidence exists to endorse home-visiting services by nurses to prevent child abuse and neglect for at-risk families,” and “substantial evidence exists to support the use of home visiting as a strategy for addressing inequities in children's health status, school readiness, and development.” For her part, Deborah Daro, associate professor and research fellow at the Chapin Hall Center for Children at the University of Chicago, stresses the importance for program effectiveness of program quality—including ongoing staff training and supervision, cultural competency, family-centered approaches and appropriate intensity and duration. Speaking at a hearing in June 2009 before the House Ways and Means Committee's Subcommittee on Income Security and Family Support, Daro suggested that “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.”

Luckily for those interested in women's sexual and reproductive health, there is strong evidence of benefits to women for one of the best studied and most widely recognized home visiting programs. The Nurse-Family Partnership was first studied formally in 1978 in the largely white, semirural community of Elmira. Nurses visited

the homes of low-income, pregnant young women (half of whom were younger than 19) for approximately two and a half years. The visits were designed to help the young women improve their health-related behaviors and parenting skills. They also emphasized life-course development, including educational achievement, participation in the workforce and the importance of pregnancy planning. Over the course of 15 years after the births of their children, women who were visited by a nurse had experienced fewer subsequent pregnancies and births, were more likely to defer their second births, spent fewer months on welfare or receiving food stamps and were more likely to participate in the labor force, compared with women participating in a control group.

The Nurse-Family Partnership has shown such benefits in several randomized trials conducted over many years in different populations and different contexts. The most recent findings were among a population of low-income, young black women (two-thirds of whom were younger than 19) living in Memphis. As reported in the October 2007 issue of *Pediatrics*, nine years after the birth of a first child, women who had been visited by a nurse had a longer interval between the births of their first and second children, fewer subsequent births per year, and longer relationships with current partners, compared with women in a control group. The study also found decreased welfare dependency and increased rates of employment.

Importantly, it appears that only those interventions that adopt an overall health focus—and have a strong family planning component—are successful in reducing subsequent pregnancies and increasing birthspacing. In a review of various care programs for teenage mothers, Rebecca Maynard, trustee professor of education and social policy at the University of Pennsylvania, emphasizes that the effectiveness of such interventions depends on a counselor's ability to help a young mother to understand the importance of waiting to become pregnant until she is better able to care for herself and her family, to set goals (including goals involving contraceptive use) and to be committed to achieving those goals. This, she says, entails speaking in an

authoritative way about contraception and providing teenage mothers with the support and guidance they need to avoid contraceptive failure (rates of which are extremely high among this subpopulation of teenagers). In the case of the Elmira study, Maynard writes, “nurses are trained to follow strict service delivery protocols and to be much more direct than welfare caseworkers in their dealings with clients. The nurse home visitors in these programs may simply have been more willing to tell clients to use birth control and to follow up to ensure they were not only using contraceptives but using them correctly.”

What Are the Costs and Savings?

Not surprisingly, home visiting programs are expensive. Successful programs involve extensive staff training and supervision, and the development of protocols and quality controls. Proponents consider the nonmonetary benefits of home visiting programs to be sufficient to justify public expenditures on them, whereas others may be reluctant to invest public funds without also seeing some evidence of potential savings.

Economic analyses of home visiting interventions are limited but promising. According to a 2005 RAND Corporation study that examined the benefits and costs of various early childhood interventions, when results are combined across multiple evaluations of home visiting programs and even when conservative assumptions are used, home visiting programs are estimated to generate about \$6,000 in net benefits per child, or \$2.24 for every dollar invested. For some programs, the savings may be even greater. In the Nurse-Family Partnership program, for example, the return for each dollar invested was \$5.70 for higher-risk families (those with single mothers and low incomes). Importantly, changes in the lives of women who participated in the Nurse-Family Partnership program—such as fewer months spent on welfare and increased tax revenues as women entered and remained in the workforce—accounted for much of the program's net savings to the government. Nonetheless, RAND researchers point out that although the benefits may exceed costs, the costs accrue immediately, whereas the benefits are realized only years down the road.

Although comparable data have not been collected and published on other home visiting models, researchers contend that the range of outcomes achieved by many of these programs suggests similar savings could accrue from them as well. The savings from reduced emergency department visits, foster care assignments, hospitalizations and child protective services expenditures could be substantial. And, of course, improved contraceptive use is a proven cost-saver: According to the most recent Guttmacher Institute estimates, publicly funded family planning services, in addition to their benefits to women and families, save the government four dollars in Medicaid-funded maternity and infant care for every dollar spent (related article, Winter 2009, page 19).

What Is the Outlook for Federal Policy?

Current funding for home visiting programs is often pieced together from a variety of sources. According to a survey published in February 2009 by the National Center for Children in Poverty, a division of the Mailman School of Public Health at Columbia University, 40 states support 69 home visiting programs. Of these, 52 programs rely on federal funding. Medicaid, the Maternal and Child Health Block Grant, and Temporary Assistance for Needy Families (TANF) are the largest and most common sources of federal support. Typically, these federal funds are combined with funds generated by the state. (For example, some states use tobacco settlement funds to support home visiting programs.) In the National Center's survey, 31 states, accounting for 55 programs, were able to report their annual home visiting program budgets; those states reported total federal and state expenditures of approximately \$250 million.

Advocates of home visiting programs contend that this level of funding allows programs to serve only a small fraction of the estimated 600,000 low-income women who become first-time mothers each year and, moreover, that even the current level of funding is unreliable. Indeed, no current federal law or program provides ongoing, dedicated support for home visiting programs. But it would appear that all this may be about to change—and, potentially, quite radi-

cally. The president's federal budget request for FY 2010 calls on Congress to fund a major new home visiting initiative—\$8.6 billion over the next 10 years—to provide states with funding primarily to support home visiting models that have been proven through rigorous evaluation to have positive effects on critical outcomes for children and their families. Additional funds would be available to support program models that have demonstrated promise.

In Congress, meanwhile, various home visiting measures have been proposed over the last several months. The Early Support for Families Act, introduced by Rep. Jim McDermott (D-WA), would amend TANF to provide grants to states—totaling \$2 billion over five years—to establish home visiting programs. Another proposal would build off Medicaid and give states the explicit option of covering nurse home visiting programs. A major potential avenue for authorizing a significant expansion of home visiting dollars this year is health care reform. Indeed, home visiting provisions have been included in the House Democratic leadership's health care reform proposal and have a good chance of being included if and when reform legislation is enacted.

One reason home visiting programs have received so much attention of late is that this type of activity falls neatly under President Obama's "common ground" agenda. Addressing the graduating class at the University of Notre Dame, Obama said, "when we open up our hearts and our minds to those who may not think precisely like we do or believe precisely what we believe—that's when we discover at least the possibility of common ground.... So let us work together to reduce the number of women seeking abortions, let's reduce unintended pregnancies. Let's make adoption more available. Let's provide care and support for women who do carry their children to term." Indeed, expanding home visiting programs, at least theoretically, should be a classic example of an effort that partisans on both sides of the abortion debate can get behind. These programs have demonstrated modest but important benefits for children and significant benefits for women, both

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in human and economic terms—and some of these benefits may be long lasting.

Certainly for progressive prochoice advocates, whose concerns go far beyond abortion rights, there is nothing not to like about home visiting. Some on the antiabortion side, however, have balked at the price tag of these programs. During the June hearing on home visiting programs, ranking member Rep. John Linder (R-GA) blasted his colleagues for ignoring a coming budget tsunami while “strolling along the beach” contemplating another program. “All of us are interested in making sure every child gets a good start in life. I support reviewing current home visitation programs....However, at this time of massive and growing Federal and State deficits, I simply cannot support the creation of a new entitlement.”

Indeed, a major challenge for President Obama in gaining support for his common ground agenda over the longer term is the fact that most, although by no means all, antiabortion lawmakers are fiscal as well as social conservatives who tend to oppose the creation or expansion of what they deride as “social spending” programs. As they consider these programs under the aegis of an agenda aimed at “reducing the need for abortion,” a major question will be whether their putative concern for the well-being of mothers and children will trump or be trumped by their conservative economic views. On the narrower question of home visiting in the shorter term, however, it would certainly appear that the notion of expanding these efforts has gained some real and well-deserved traction.

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