Statement for the Record

Children and Family Futures

Hearing on Proposals to Provide Federal Funding for
Early Childhood Home Visitation Programs
U.S. House Committee on Ways and Means
Subcommittee on Income Security and Family Support
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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 visiting 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 visiting 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 visiting 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 visiting 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 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 visiting 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 visiting 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 visiting. 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

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; 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 visiting programs that are formally linked with center-based early childhood education can 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 visiting must provide services to parents and children that specifically address substance use disorders.

Because home visiting 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.

Because home visiting 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”\textsuperscript{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 visiting 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 visiting programs designed to respond to these challenges.

\textit{Legislative Options}

The legislation emerging from Congress can build upon these lessons drawn from the recent history of home visiting, 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 (HR 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.

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

\begin{enumerate}
\item Require that state or local plans for home visiting 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.
\end{enumerate}
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.

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 visiting 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.
NOTES

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 $80,000 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.


4  Ibid 120.
9 http://www.hippyusa.org/refld,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