

Home Visiting in Texas: Current and Future Directions

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Executive Summary

Some of Texas' costliest social problems—child abuse and neglect, premature deliveries, school failure, unemployment, and crime—are rooted in early childhood. Research also establishes that the brain develops most intensely during the first three years of children's lives, and the brain builds itself in response to children's experiences.¹ Brain circuits that a child uses during these formative years are strengthened, but those not utilized diminish. Home visiting programs provide an opportunity to aid families and children during this critical time in their lives.

Home visiting involves trained personnel providing targeted services for parents and their children in their homes. These programs take a whole-family, or two-generation, approach: The goal is to aid parents and their children at the same time. Evidence-based, voluntary home visiting programs demonstrate potential benefits to children, families, and the State.² Mothers involved in these programs can learn to better care for themselves, and they can have healthier – and safer – relationships with the father. Parents also can learn how to better care for their children, thereby enabling their children to live in safer and more stimulating homes. These positive parenting practices ultimately can lead to improved child health, academic performance, and overall adjustment for children. In sum, evidence-based, voluntary home visiting can reduce many costly social problems, such as low-weight births, emergency room visits, and children in the social welfare, mental illness, and juvenile corrections systems.

In times of scarce financial resources, the positive outcomes possible from effective, high-quality home visiting programs can create measurable savings for the State.³ According to independent economic reviewers, many of the programs show a particularly favorable return on investment, especially when focused on high-risk families.⁴ Moreover, although the financial benefits accrue over time, it is possible to start seeing financial gains within just a couple of years from inception of investment. For instance, according to a report by Correa and colleagues with Children at Risk⁵, if the Triple P pilot program about to begin in Houston proves as effective as in a previous South Carolina trial, the net-benefit for implementing the program is over \$12 million in just two years through reductions from child maltreatment costs alone (i.e., the total cost is about \$13.7 million, and the total benefit is projected to be \$26.2 million).

Having a portfolio of high-quality home visiting programs is beneficial for serving the diverse needs of Texas children and families.⁶ In Texas, 13 different home visiting programs currently serve 19,213 families with children under age 6. Seven of these programs clearly are evidence-based, and one

program is on the border between being an evidence-based and promising program. Four of the 13 programs in Texas are considered promising, and one program has not yet been tested.⁷

The definitions of evidence-based and promising programs are derived from Texas Senate Bill 426.⁸ Generally speaking, however, evidence-based programs use the best empirically derived information and already have demonstrated to successfully aid parents and children.⁹ Promising programs also have evidence supporting their effectiveness, but they have not yet undergone all the rigorous testing required of evidence-based programs. Nevertheless, promising programs are how we grow in the field – by supporting innovation and new thinking.

The 19,213 families served by home visiting represents only 9% of the highest-need families in Texas,^a and the State only provides funding for about 13% of the programs currently operating in Texas.¹⁰ Thus, evidence-based and promising home visiting programs need to be expanded to meet the demand. Our goal by 2023 is to serve at least half - approximately 113,000 - of the highest-need families with children under age 6 in Texas.^b To reach this goal, we calculated that funding across all sources (i.e., federal, state, local, and private) should serve approximately 30% more families each year over the next biennium and then grow at approximately 20% each subsequent year until 2023. Thus, during the 2014-2015 biennium, the state will need to invest an additional \$27,462,494 to keep on pace with its portion of this growth (this amount includes the cost for HHSC to oversee the programs, provide support for the necessary infrastructure, and for outcome evaluations).¹¹ Compared to the cost of doing nothing, this amount is low because of the potential for high-quality home visiting programs to reduce a wide array of the costly problems previously mentioned.

Of course, these benefits and saving can only be realized if the State places priority on programs with evidence supporting their effectiveness and holds programs accountable for producing the outcomes shown in previous research. Therefore, it is recommended to:¹²

1. Ensure that at least 75% of the state investment funds evidence-based home visiting programs.
2. Encourage innovation by investing up to 25% of state funds in promising programs.
3. Hold programs accountable for their outcomes.
 - a. *Ensure Model Fidelity* - programs are only proven to the extent that they follow the model tested in research. For example, programs should be evaluated to ensure that professionals implementing these programs use consistent dosing (e.g., frequency and

^a The highest-need families with children under age 6 total approximately 211,926 families living below 50% of the Federal poverty threshold; additional high-need families total 476,969 families living below 100% of the Federal poverty threshold

^b Accounting for projected population growth, in 2023, the highest-need families with children under age 6 will total approximately: 225,005 families living below 50% of the Federal poverty threshold (i.e., extreme poverty); additional high-need families total 509,958 families living below 100% of the Federal poverty threshold

duration of visits) and adhere to the curriculum content of the tested model. Without this quality assurance, programs may not attain the positive outcomes from prior trials.

- b. *Evaluate Short- and Long-Term Outcomes* – Some short-term outcomes, such as fewer premature deliveries, have long-lasting effects. Other outcomes, such as reduced child abuse, need testing after the program ends to confirm the sustainability of the effects. In addition, the only way to garner confidence that programs work as effectively in Texas as documented in prior scientific trials is through evaluations of outcomes.

Of course, programs will fail to reach the level of effectiveness shown in other locations if communities do not have resources and local programs to which home visitors can refer families, and there are ways that home visiting programs can expand to better serve families and the community. For example, home visiting programs should emphasize the important roles of fathers in families and children's lives. Some programs have indeed shifted the focus to both parents, but historically programs emphasized the role of mothers in their children's lives. In addition, home visiting programs may enhance child and family well-being in other currently unknown ways as well. Outcomes such as child sexual abuse rates, paternity establishment, and child support payments remain relatively untested in home visiting research.

With thoughtful implementation and careful evaluation of outcomes in home visiting, Texas can expect to receive back considerably more money than initially invested. More importantly, this investment can serve to protect our most vulnerable population and start these high-risk children on a path to become educated, psychologically healthy, and productive adults.

Definitions

Term	Definition
Home Visiting Program	Voluntary-enrollment program in which early childhood and health professionals (such as nurses, social workers) or trained and supervised paraprofessionals repeatedly visit - over a period of at least six months - the homes of pregnant women or families with children under the age of six who are born with or exposed to one or more risk factors.
Risk Factors	Factors that make a child more likely to encounter adverse experiences leading to negative consequences, including preterm birth, poverty, low parental education, having a teenaged mother or father, poor maternal health, and parental underemployment or unemployment.
High-Risk Families OR At-Risk Families	Families (or children) with one or more of the risk factors listed above.
SB 426	Texas Senate Bill 426, filed by Senator Jane Nelson on February 7, 2013, also known as the “Home Visiting Accountability Act” - this bill requires that at least 75% of state funding for home visiting be invested in evidence-based programs and that up to 25% fund promising programs. The bill also delineates the outcomes Texas intends to achieve with its investment and requires outcomes’ monitoring and measurement to ensure effectiveness.
Evidence-Based Program	As proposed in SB 426, evidence-based programs: (1) are research-based and grounded in relevant, empirically based knowledge and program-determined outcomes; (2) are associated with a national organization, institution of higher education, or national or state public health institute; (3) have comprehensive standards that ensure high-quality service delivery and continuously improving quality; (4) have demonstrated significant positive short-term and long-term outcomes; (5) have been evaluated by at least one rigorous randomized controlled research trial across heterogeneous populations or communities, the results of at least one of which has been published in a peer-reviewed journal; (6) follow with fidelity a program manual or design that specifies the purpose, outcomes, duration, and frequency of the services that constitute the program; (7) employ well-trained and competent staff and provides continual relevant professional development opportunities; (8) demonstrate strong links to other community-based services; and (9) ensure compliance with home visiting standards.
Promising Programs	As proposed in SB 426, promising programs: (1) have an active impact evaluation or can demonstrate a timeline for implementing an active impact evaluation; (2) have been evaluated by at least one outcome-based study demonstrating effectiveness or a randomized controlled trial in a homogeneous sample; (3) follow with fidelity a program manual or design that specifies the purpose, outcomes, duration, and frequency of the services that constitute the program; (4) employ well-trained and competent staff and provides continual relevant professional development opportunities; (5) demonstrate strong links to other community-based services; and (6) ensures compliance with home visiting standards.
High Quality Home-Visiting Programs	A home visiting program that has evidence supporting its effectiveness and is implemented in accordance to the research model. A promising program can be high-quality, and an evidence-based program can be low quality if it is not carefully implemented.
Randomized-Control Trial	Design of research study whereby willing participants are randomly assigned to either the treatment group (i.e., group who will receive services and have outcomes monitored) or to the control group (i.e., group who will <i>not</i> receive services but still have outcomes monitored).
High-Need Families	Families with children under age 6 living below the 100% federal poverty threshold.
Highest-Need Families	Families with children under age 6 living below the 50% federal poverty threshold.

I. Home Visiting Defined and Why Texas Needs Home Visiting Programs

A new baby in the home presents unique challenges to all families, but some parents have more challenges than others. These new parents – who are often young and may have been abandoned, abused, or neglected themselves as children - may find themselves overwhelmed and uncertain of how to provide for their child. Early intervention with these families is crucial to break intergenerational cycles of violence, abuse, neglect, dysfunction, and lack of economic independence by preventing child abuse and neglect, improving maternal and child health, increasing child cognitive development in preparation for school, and to support a families' economic self-sufficiency.¹³ Strong home visiting programs have the potential to affect all of these areas and can serve to improve outcomes for children, parents, and society as a whole (see section III for additional details).

Home visiting involves trained personnel providing targeted services for parents and their children in their homes. These programs take a whole-family, or two-generation, approach: The goal is to aid these at-risk parents and their children at the same time – resulting in greater impact with taxpayer dollars. It also is likely that these programs provide strong benefits to families because many: (a) target parents of young children, (b) focus on at-risk families, and (c) are evidence-based.

The Importance of Reaching Young Children

Programs – like home visiting – that target young children offer the best opportunity to reach parents during a critical time in their child's brain development. As shown in Figure 1¹⁴, research establishes that the brain develops most before a child reaches age five, and the brain builds itself in response to children's experiences.¹⁵ During these important years, a child's brain develops about 700 synapses (the neural connections that transmit information) every second, which equates to 42,000 every minute or 18,720,000 synapses in just one day.¹⁶ Brain circuits that a child uses during these formative years are strengthened, while those not utilized diminish.¹⁷ Importantly, early traumatic experiences can damage these synapses.

Figure 1. Brain Synapse Formation and Retraction by Child Age

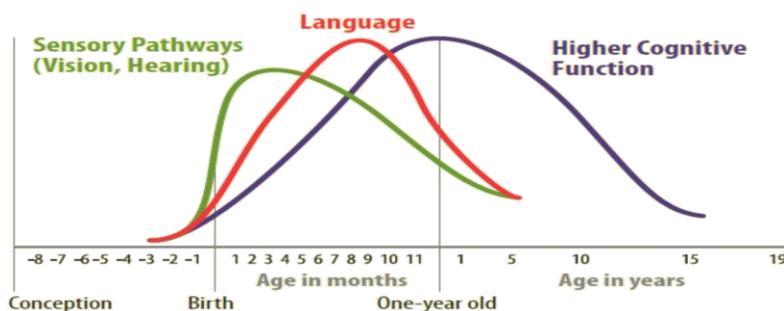
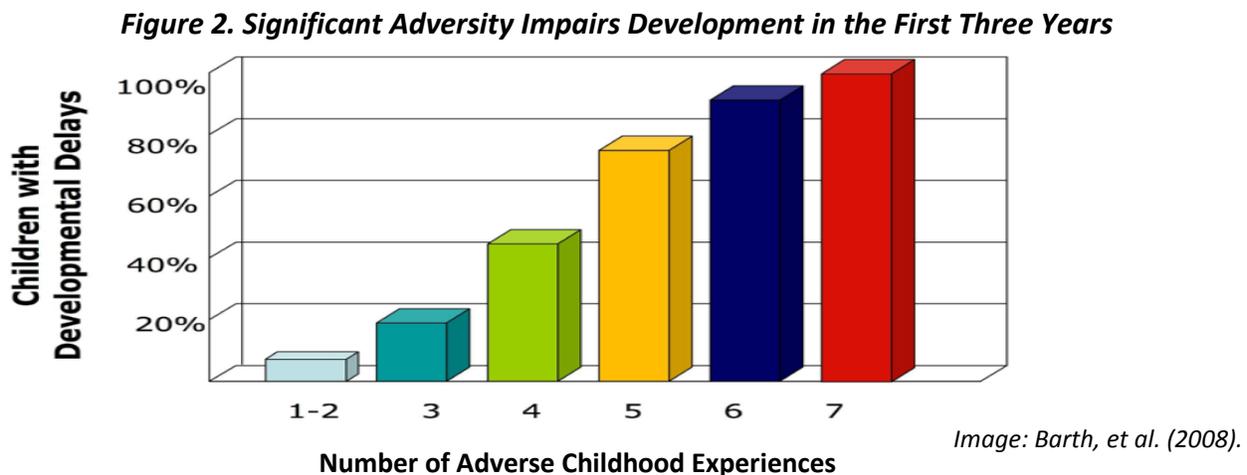


Image adapted Nelson, C.A. (2000).

Research conducted by the Center on the Developing Child at Harvard University shows that the executive function of the brain also is developed during early childhood. This portion of the brain allows people to focus thinking, to hold onto and work with information, and to filter distractions.¹⁸ People with strong executive function show greater school achievement, positive behaviors (including reduced engagement with the criminal justice system), better health, and more successful experiences in the paid labor force.

All children are born with the potential to develop these skills, but it is the quality of the interaction with those around them that provide and strengthen these skills. If children do not get what they need from their relationships with close adults, or, even worse, if the adults and environment around them are a source of toxic stress, the development of these skills can be seriously impaired. If a child is traumatized from abuse or does not receive adequate mental stimulation during this formative period, the child may be harmed in a manner that can never be fully reversed and likely will require significant expenditures in physical and mental healthcare, education, judicial, legal, employment training, and corrections systems.

The Adverse Childhood Experiences (ACE) Study of more than 17,000 participants also provides an illustration of how childhood stress can have lasting effects. Adverse childhood experiences include multiple types of stressors, including abuse (psychological, physical, and sexual), neglect (emotional and physical), as well as other forms of household dysfunction (e.g., parental divorce, substance abuse, battered mother, criminal involvement, and/or mental illness). As the number of ACEs increase, so do the deleterious effects. For example, children with high ACEs are more likely to suffer from allergies, arthritis, asthma, bronchitis, high blood pressure, ulcers, heart disease, cancer, obesity, and liver disease.¹⁹ Consider the relationship between the number of ACE events and corresponding developmental delays shown in Figure 2.²⁰



Reaching High-Risk Populations

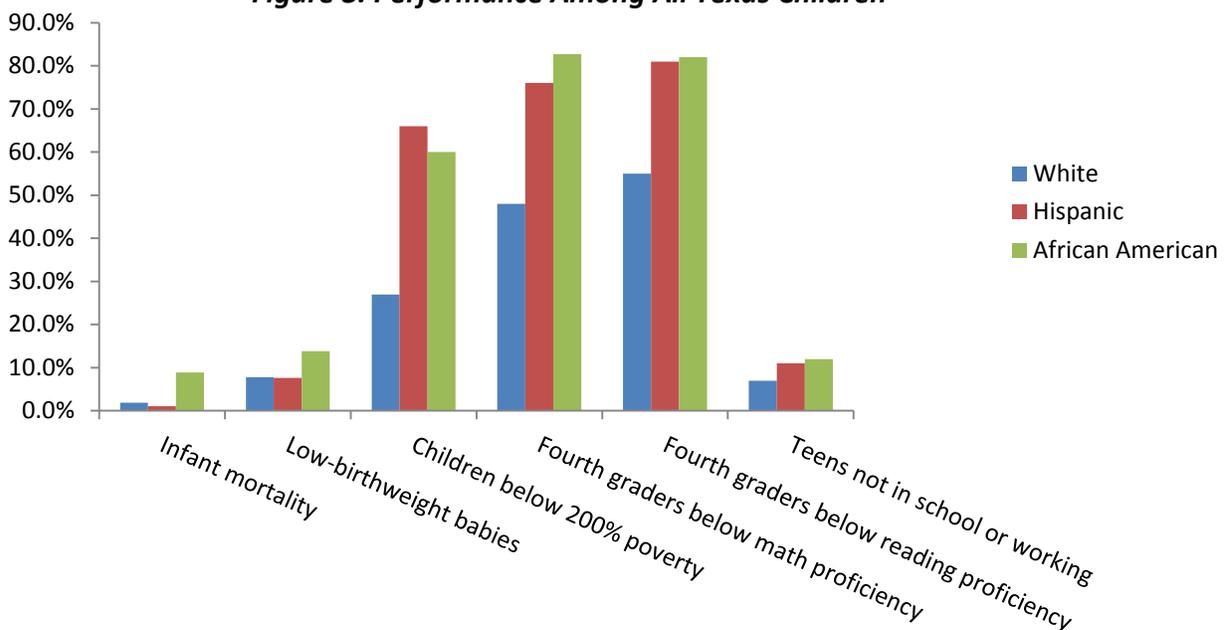
A plethora of research demonstrates that children in high-risk families are the ones most likely to cost society in the long-term. These children, for example, are more likely to be abused and neglected.²¹ They also are:

- 25% more likely to drop out of school²²
- 40% more likely to become a teen parent²³
- 50% more likely to be placed in special education²⁴
- 60% more likely to never attend college²⁵
- 70% more likely to be arrested for a violent crime²⁶

Texas accounts for one of every eleven children born in the country,²⁷ and many of these children are raised in high-risk households. In Texas' urban sector alone, approximately one in five people live in poverty, and Texas has four of the five poorest metro areas in the country.²⁸ In addition, children in Texas are more likely than children at the national level to live in a family headed by a parent who: (a) is a teenager,²⁹ (b) is single³⁰ (c) lacks a high school diploma, and/or (d) lacks secure employment.³¹

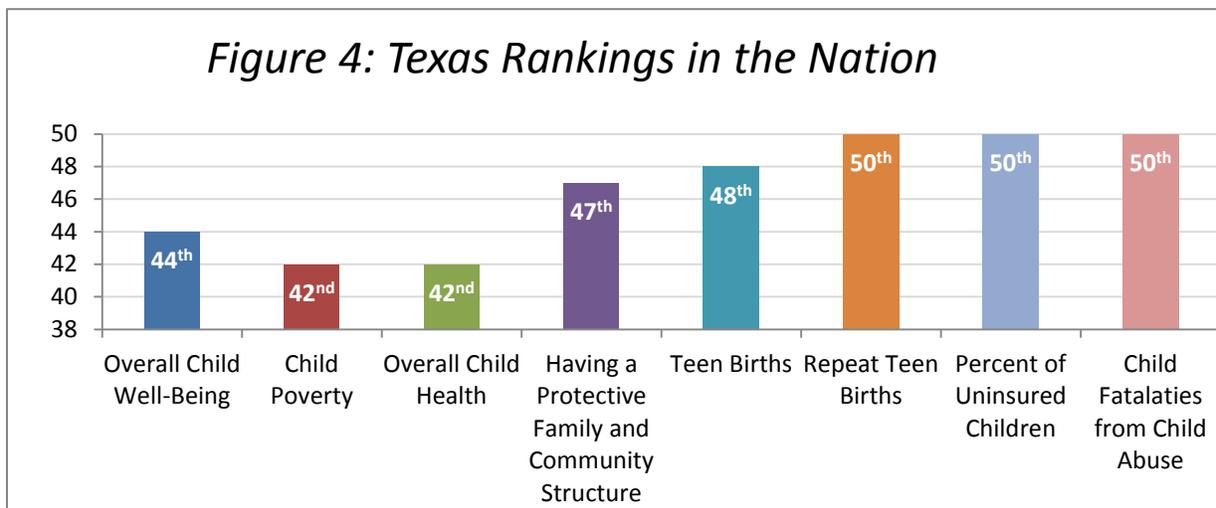
Children clearly feel the effects of these conditions, and some Texas children fare worse than others (see Figure 3).³² To date, interventions have not done enough to help the diverse families of Texas. Current projections from the *Texas Early Childhood Education Needs Assessment* show that by 2015, the majority (50.2%) of children under age 12 in Texas will be Hispanic,³³ so it is exceptionally important that future interventions be more responsive to the culture and unique needs of the Texas population.

Figure 3. Performance Among All Texas Children



The majority of children who read below grade level at the end of third grade will not graduate from high school.³⁴ As shown in Figure 3 above, over half of children in Texas struggle with reading by the end of fourth grade, and this number is considerably higher for Hispanic and African American children. Most children who have difficulty reading in the fourth grade struggled in school from the start; disadvantaged children can start kindergarten up to 18 months behind more advantaged peers.³⁵ Thus, focusing on young, at-risk children shrinks this achievement gap - before it occurs.

Texas can do better to protect and support our most vulnerable population. As shown in Figure 4, **Texas is currently ranked as the 44th state in overall child well-being:**³⁶



Evidence-based Home Visiting Programs

Evidence-based home visiting programs provide an opportunity to better serve these vulnerable children. A program that is evidence-based uses the best empirically derived information and has strong empirical support that the program successfully aids parents and children.³⁷ That being said, a universal definition of evidence-based is lacking, which is perhaps why so much confusion exists. For example, the Federal government lays out one set of criteria,³⁸ but even their definition lends itself to interpretation of what constitutes the “high-quality or moderate-quality impact study” necessary to establish a program as evidence-based. Plus, other sources use different criteria.³⁹

Texas legislators are currently considering legislation that will – among other things – define what evidence-based means for home visiting programs in Texas. Senate Bill (SB 426) defines evidence-based using a more conservative test of evidence-based than is used federally (see definition section).

Thus, the remainder of this report uses the Texas definition of evidence-based. For example, a program is only evidence-based if it has at least one randomized controlled trial (RCT), which is considered the gold-standard in scientific tests of causation.^c This technique allows for greater confidence in stating that the “intervention” enhances parenting, family functioning, financial self-sufficiency, and optimal growth and brain development in young children.

The outcomes of the programs differ depending on the model and families served, but as a whole the positive outcomes derived from these programs create measurable savings for the State (see section IV). When deciding how to allocate scarce resources, it makes sense to focus on programs that already have a record of successful intervention.

^c This approach – when done properly - removes potential selection effects. For instance, if one compared families receiving home visiting services with a comparable population who never agreed to participate in the home visiting program (a common scientific technique when random assignment is not possible), it could never entirely be known whether the home visiting program itself leads to positive effects. The possibility would remain that willing participants may have experienced more favorable results than others with similar demographic profiles regardless of the intervention because these are the parents most motivated to improve the well-being of their family. Random assignment of willing participants, however, removes this possibility because all involved desire these services.

II. Home Visiting Programs in Texas

Having a portfolio of evidence-based home visiting programs is beneficial for serving the diverse needs of Texas children and families.⁴⁰ Some communities may have high rates of teen pregnancy; others may have greater difficulty getting their children prepared academically for school. Families also may encounter different challenges, such as maternal depression, domestic violence, or child disability. It is important to have programs that address these unique needs.

As shown in Appendix A, a multitude of home visiting programs currently operate in Texas, each with unique goals and implementation strategies, thereby providing opportunities for a range of services to high-risk families. For the purposes of this report and to be included in Appendix A, a home visiting program must: (a) provide home visits to at least a portion of the participants enrolled in the program, (b) be offered to pregnant women or families with children ages 0 through 5 (or upon kindergarten entry), and (c) be willing to provide ongoing visits to these families over a period of at least 6 months. Programs only able to provide 1-2 visits shortly after birth were omitted. Also excluded were the Early Childhood Intervention^d (ECI; part of the Texas Department of Assistive and Rehabilitative Services) services that occur in the home because these services are more individual case management for children and families with developmental delays and disabilities.⁴¹

Evidence-based Home Visiting Programs

A total of seven programs clearly meet the Texas definition of an evidence-based program:^e

- (1) Parents as Teachers (PAT)
- (2) Nurse-Family Partnership (NFP)
- (3) Home Instruction for Parents of Preschool Youngsters (HIPPIY)
- (4) Early Head Start-Home Visiting (EHS)
- (5) Healthy Families America (HFA)
- (6) Positive Parenting Program (Triple P)
- (7) Incredible Years

^d ECI served more than 1.6 million children ages 0-3 last year, and their services sometimes overlap with home visiting services. However, ECI targets only families with disabilities or developmental delays and does not follow a specified curriculum. For example, if a child had heart surgery at 6 months of age, ECI would teach the caretaker modified ways to interact with the child to promote the child's development. These services clearly are important, but they differ from the structure of the home visiting programs in this report.

^e There are a total of 13 programs that currently meet the federal definition of an evidence-based home visiting program, of which *eight operate – or recently operated - in Texas*:^e Child FIRST, *Early Head Start-Home Visiting (EHS)*, Early Intervention Program (EIP) for Adolescent Mothers, Early Start (New Zealand), Family Check-Up, *Healthy Families America (HFA)*, *Healthy Steps*, *Home Instruction for Parents of Preschool Youngsters (HIPPIY)*, *Nurse-Family Partnership (NFP)*, *Parents as Teachers (PAT)*, *Play and Learning Strategies (PALS) Infant*, *SafeCare Augmented*, and The Oklahoma Community-Based Family Resource and Support Program.

In addition, three other evidence-based programs either recently operated in Texas or currently operate in Texas but do not provide the full home-visitation format (see discussion below for details):

- (8) Play and Learning Strategies (PALS) Infant
- (9) SafeCare (the Augmented version)
- (10) Healthy Steps

Finally, one other program in Texas is on the border between being an evidence-based and a promising program.

- (11) AVANCE Parent-Child Education Program^f

Parents as Teachers (PAT). PAT aims to increase parenting knowledge of early childhood development, improve parenting practices, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness and school success. Parents receive one-on-one home visits from degreed professionals and paraprofessionals who have previous experience working with children or families. Parents also have access to monthly group meetings, developmental screenings, and information about other resources available to their family. The PAT curriculum provides structure (e.g., personal visit plans and guided planning tools), but it also can be individualized to meet the diverse needs of families. PAT professionals receive training in the PAT model, on-line curriculum access, a toolkit to help facilitate interactions with families, and annual professional development and recertification. Local sites offer a minimum of 12 home visits annually, with at least 24 visits offered to families with two or more high-need characteristics. PAT services can be provided to families from pregnancy until the child enters kindergarten, with at least 2 years of service being optimal. Individual sites may set other enrollment criteria (e.g. income level of parents). PAT started in Missouri during the 1970's and is now located in all 50 states and internationally, serving 200,000 families annually.⁴² In Texas, PAT provides services to 5,308 families across 39 counties (see Appendix B).^g

^f This program seemingly meets all Texas criteria of being evidence-based except possibly the requirement for testing in heterogeneous populations or communities. AVANCE has one randomized controlled trial demonstrating positive effects in a low-income, Mexican American sample in San Antonio. The program also has other unpublished and more descriptive (not randomized-control) studies in different Texas populations, and other longitudinal studies are being conducted in various parts of the country. Thus, it could be argued that the program has indeed verified its findings in other populations, but one also could argue the results need published. Regardless of the current status, it is likely this program will move clearly into the evidence-based category in the near future.

^g Data on the families served (and financial contribution) were collected during September – December 2012 by contacting home visiting programs listed in the 2010 *Texas Needs Assessment*, program leads from each Federally-Defined Evidence-Based home visiting model in Texas, multiple providers (e.g., all Texas locations of United Way, Any Baby Can, Catholic Charities, Parenting Cottage, etc.), and state departments that may fund home visiting (i.e., DARS, DFPS, TEA). Our attempt was to create an exhaustive list of all programs currently in Texas meeting our home visiting definition, but it is possible that other programs are currently in the state and not affiliated with the programs and providers contacted.

Nurse-Family Partnership (NFP). David Olds, a professor of pediatrics, psychiatry, and preventative medicine, started the NFP program in 1970 as a voluntary home visiting program for low-income, first-time mothers and their children. NFP aims to improve pregnancy outcomes, child health and development (including provision of a home environment free from abuse), maternal life course development, and the economic self-sufficiency of the family. Specially trained, registered nurses with Bachelor's degrees (Master's degrees preferred) provide ongoing home visits that start while the mother is pregnant and continue until the child reaches age two. Like PAT, the curriculum provides both structure and flexibility. Guidelines are provided for each visit, but nurses use a variety of developmental screenings and diagnostic tools to tailor the program to the specific needs of each family. Willing participants must be low-income, first time mothers willing to receive their first home visit by the 28th week of pregnancy. These mothers initially receive home visits every week for the first month after enrollment and then every other week until the baby is born. Once the baby is born, families receive visits weekly for the first six weeks, and then every other week until the baby is 20 months. The last four visits are monthly until the child is 2-years-old. These visits typically last 60 to 75 minutes, but the schedule may be adjusted to meet client needs. During these visits, nurses help ensure that mothers receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children, and become economically self-sufficient.⁴³ As of September 2012, the program operates in 42 states, 445 counties, and serves almost 23,000 families.⁴⁴ NFP serves 2,650 families across 29 counties in Texas (see Appendix B).

Home Instruction for Parents of Preschool Youngsters (HIPPY). The HIPPY program began in 1969 as a research project in Israel.⁴⁵ HIPPY aims to: (a) prepare children for success in school and all aspects of life, (b) empower parents to be their child's first teacher, and (c) provide parents with the skills, confidence, and tools needed to successfully teach their child in their home. The ultimate goal is to help parents provide educational enrichment for their preschool child (aged 3 – 5) and promote children's school readiness. HIPPY targets parents who are primarily in at-risk communities and lack confidence in their own abilities to instruct their children, perhaps because these parents struggled academically, do not speak English, and/or did not graduate high school. HIPPY services include weekly, hour-long home visits for 30 weeks a year, and two-hour group meetings monthly (or at least six times a year) offered by paraprofessionals, who hold a GED or higher degree. The HIPPY curriculum uses role play as the method for teaching parents the skills needed to implement the curriculum with their child. Parents receive 30 weeks of activity packets and storybooks to use with their children. Parents work on these activities with their children during the home visits and also are instructed to spend 15 to 20

minutes a day completing the activities. Since its inception in 1969, HIPPIY has expanded to serve more than 22,000 families in 13 countries and across 23 US states.⁴⁶ HIPPIY began in Texas in 1988 and now helps 1,496 families across nine counties (see Appendix B).

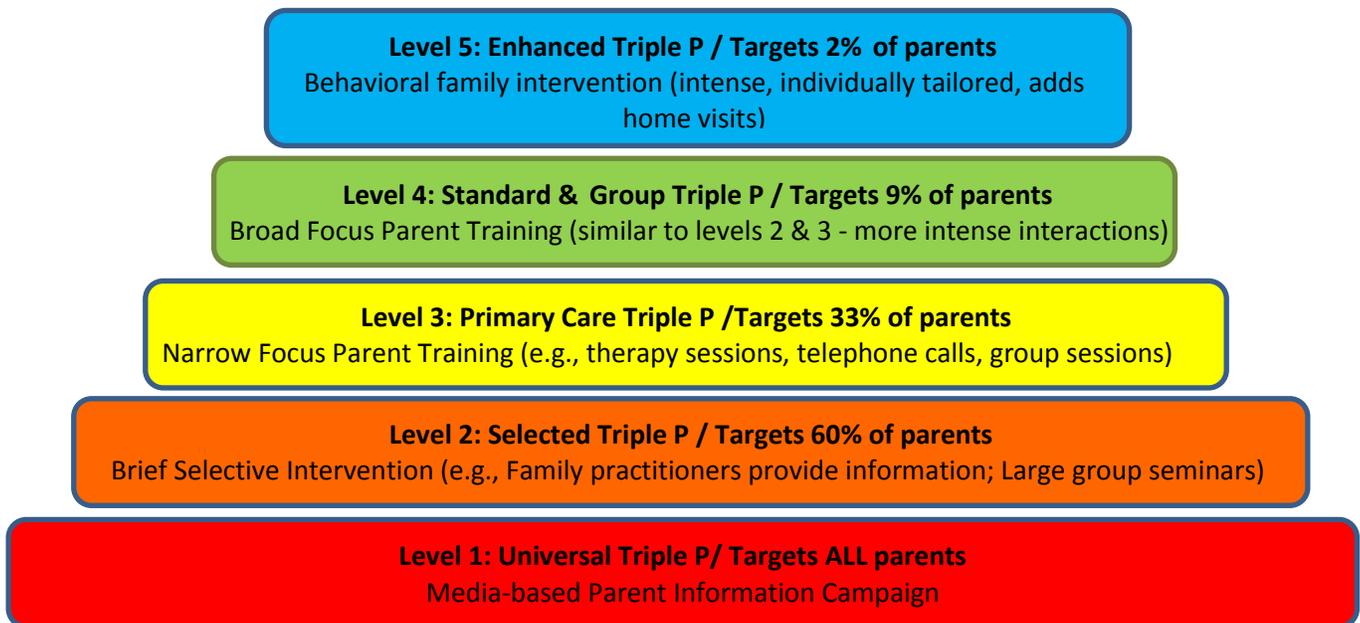
Early Head Start-Home Visiting (EHS). EHS is a federal program that began in 1995 for low-income pregnant women and families with infants and toddlers up to age three. The EHS program focuses on providing high quality, flexible and culturally competent child development and parent support services. It aims to: (a) promote healthy prenatal outcomes for pregnant women, (b) enhance the development of young children, and (c) stimulate healthy family functioning. EHS can be offered in a center-based or home-based based format. In the home-based format referred to in the remainder of this report, EHS home visitors have a Child Development Associate (CDA) credential plus knowledge and experience in child development and early childhood education, principles of child health, safety, and nutrition, adult learning principles, and family dynamics. EHS services include a weekly, 90-minute, home visit and two group socialization activities per month for parents and children. However, there is no set curriculum for EHS visits. Each site determines the curriculum used.⁴⁷ For instance, in Texas, some of the EHS sites use curriculum from PAT, some use the Play and Learning Strategies (PALS) curriculum, and so forth. EHS has grown in the last few years due to additional funding from the 2009 American Recovery and Reinvestment Act that included \$2.1 billion for Early Head Start and Head Start; nearly half of that funding serves prenatal mothers and children up to the age of three.⁴⁸ By the end of 2011, EHS provided services in all 50 states (plus DC, Puerto Rico, and the U.S. Virgin Islands) and served over 147,000 children.⁴⁹ EHS serves 1,221 families across 37 counties in Texas (see Appendix B).

Healthy Families America (HFA). The HFA model, developed in 1992 by Prevent Child Abuse America,⁵⁰ targets at risk families to help them cultivate and strengthen parent-child relationships, promote healthy child development, and enhance family functioning by reducing risk, building protective factors, and focusing on building strengths rather than correcting weaknesses. To receive services, families must be enrolled while the mother is pregnant or shortly after birth, and they must complete a comprehensive assessment to ascertain the presence of risk factors (the Kempe Family Stress Checklist is commonly used). Individual providers determine other criteria for enrollment, such as being a single parent or suffering from substance abuse or mental health issues.⁵¹ Services are provided by paraprofessionals who typically have experience working with families who have multiple needs (and home visiting supervisors hold at least a bachelor's degree). These visits are initiated prenatally or within the first three months of birth and include weekly visits until the child is 6-months old, at which point the visits may become less frequent depending on the needs of the family. Services can continue

until the child is three to five years old.⁵² Similar to EHS, there is no set curriculum in HFA (and they also use PAT curriculum in some Texas locations). HFA only requires that providers use an evidence-based curriculum (like PAT). The HFA program is currently in 40 states, Washington DC, and all five United States territories.⁵³ In Texas, the program currently serves 530 families in five counties (see Appendix B).

Positive Parenting Program (Triple P).^h Triple P is an international education and training program used in 25 countries that started about 30 years ago.⁵⁴ Through a public health approach, Triple P aims to prevent child emotional, behavioral, and developmental problems. Professional practitioners with a post-secondary degree (in fields such as health, education, or social services) provide education, training, and support to parents and families so that they have the skills, knowledge, and confidence to parent effectively.⁵⁵ The Triple P program consists of five levels of services, each differing in terms of intensity and modes of assistance (see Figure 5).⁵⁶ Only participants receiving level 5 obtain home visits. In Texas, the program currently serves 175 families in two counties (see Appendix B). Triple P also operates in the Dallas area, but this location does not offer the home visiting level of intervention. A pilot study of Triple P is set to begin in Houston in 2013.

Figure 5. Triple P Levels of Intervention



^h Triple P is not classified as a *home visiting* program by the Federal government because it does not meet their requirement that programs offer home visiting services to the majority of their participants. Triple P is a public health model, and thus only the highest risk families receive home visits. However, Triple P does meet the Texas definition of home visiting, which only requires that home visits be provided to families with children under the age of six who are born with or exposed to one or more risk factors.

Incredible Years.ⁱ The Incredible Years is an evidence-based curriculum, which is sometimes used in a home visiting format. Dr. Carolyn Webster-Stratton, a licensed clinical psychologist, nurse-practitioner, and Director of the Parenting Clinic at the University of Washington, designed this series of three separate, multifaceted, and developmentally based curricula for parents, teachers, and children. The goal of this curriculum is to promote social-emotional competence and to prevent, reduce, and treat behavior and emotional problems in young children. The parent, teacher, and child programs can each be implemented individually, or they may be combined. For the parent and child programs, there are both treatment and prevention versions for high-risk populations.⁵⁷ The parent programs are grouped according to age: Babies & Toddlers (0-3 years), BASIC Early Childhood (3-6 years), BASIC School-Age (6-12 years), and ADVANCED (6-12 years).⁵⁸ Clinicians with a master's degree (or equivalent) and who are certified by Incredible Years after training, deliver the curriculum. The Incredible Years intervention is currently in 15 countries.⁵⁹ In Texas, the program currently serves 75 families in three counties through the home visiting format (see Appendix B).

Play and Learning Strategies (PALS) Infant. The PALS curriculum is currently offered in Texas as part of several EHS programs, but it does not presently operate as a stand-alone home visiting program.⁶⁰ The PALS program aims to strengthen parent-child bonding and stimulate early language, cognition, and social development in children. The infant curriculum targets families with children ages 5 months to 1 year, and the toddler curriculum is for families with children between 18 months and 3 years of age. Trained parent educators typically hold at least an associate's degree in early childhood (or a related field) or work experience commensurate with education, and supervisors hold at least a bachelor's degree in early childhood education (or a related field) and have 3 to 5 years of experience in parent education. These educators provide both curriculums through 90-minute weekly sessions.⁶¹

SafeCare Augmented.^j SafeCare (previously Project 12-ways) served a small number of families in Amarillo and Lubbock as recently as last year, but the program is no longer providing services in Texas due to funding cuts in the Department of Family and Protective Services, Division of Prevention and Early Intervention (PEI). The SafeCare program aims to prevent and address the factors associated with child maltreatment by specifically targeting parents who are at-risk for child abuse or neglect or parents

ⁱ Similar to Triple P, Incredible Years is not classified as a home visiting program by the Federal Government because it is an evidence-based curriculum that is only sometimes used in a home-visiting format. However, the Incredible Years program does include a protocol for those using the curriculum in a home visiting format, so this report includes the home-visiting version of this program.

^j To Note: SafeCare Augmented is the only version of this program that is currently considered evidence-based by the federal definition. The Augmented version contains a motivational and domestic violence component that is offered to families as needed – in addition to the normal curriculum.

who have already been reported for child maltreatment. Paraprofessionals trained and certified by SafeCare work with these parents to plan and implement activities with their children, respond appropriately to child behaviors, improve home safety, and address health and safety issues.⁶² Most studies to-date exclusively focused on parents with a history of maltreating their child.

Healthy Steps. Healthy Steps is currently being offered in Texas by one provider at the Texas Tech Medical School, but due to limited funding - which is currently all private dollars - the provider is no longer offering the program in a home visiting format. The goal of Healthy Steps is to support the physical, emotional, and intellectual growth and development of children during the first three years of their life.⁶³ In the home-visiting model, a team of medical practitioners and a Healthy Steps specialist (holding at least a bachelor's degree in child development, family studies, nursing, or psychology) deliver anywhere from 2-5+ visits during the first three years at key developmental stages for the child. They provide: (a) well-visits with clinicians, (b) child development and family healthy check-ups, (c) written material to parents on topics such as toilet training, discipline, and nutrition, (d) access to a child development telephone line, (e) age-appropriate books for children, and (f) referrals to other health (physical and psychological) services.⁶⁴

Program on Border of Evidence-Based Criteria^k

AVANCE Parent-Child Education Program (PCEP). Derived from the Spanish word for advancement or progress, AVANCE began in 1973 with the goal of providing a culturally appropriate parenting education, empowerment, and community building program to underprivileged children and their families in low-income and impoverished communities throughout the US.⁶⁵ As shown in a randomized-control trial of low-income Hispanic families in San Antonio, this program offers promise for a growing demographic in Texas.^l Parents, partners, or caregivers with children from birth to age three (or starting during pregnancy) receive monthly home visits and attend weekly small-group classes lasting 3 hours and spanning from September to May. These interactive sessions include toy making, parent education, and access to community resources. Fathers (or male caregivers) also participate in the PCEP classes or Fatherhood classes specifically geared toward them. In addition, families receive transportation to and from program services and meals during class time. Program graduates are

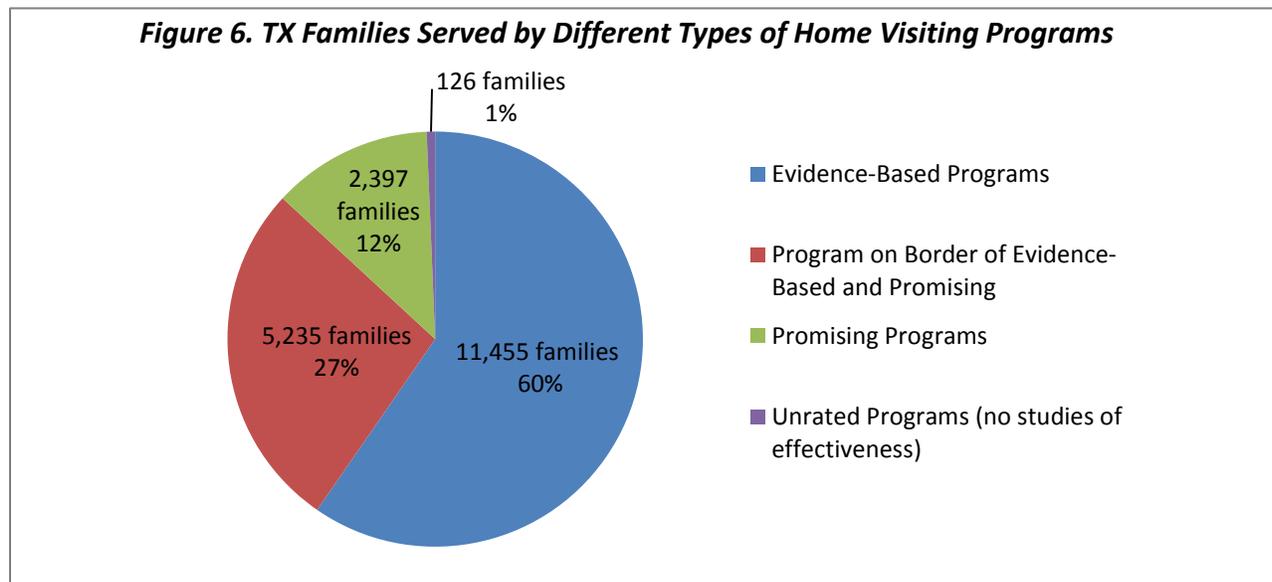
^k As mentioned, we use the definitions of evidence-based and promising programs from the proposed SB 426 in Texas. However, other groups rate programs as well, which is displayed in Appendix C.

^l As noted in Section I, it is expected that the majority of young and school-age children in Texas will be Hispanic by 2015. Moreover, the grants manager with AVANCE notes that although AVANCE has historically worked with predominantly low-income, Latino communities, preliminary research from the National Institute of Early Education Research (NIEER) confirms that AVANCE's PCEP is adaptable across diverse ethnic communities.

encouraged to continue participating in the second phase of AVANCE that focuses on adult education.⁶⁶ AVANCE currently provides services to families in 10 states and the District of Columbia⁶⁷ and to 5,235 participants across seven counties in Texas (see Appendix B).

Promising Programs

Other home visiting programs that show some evidence of effectiveness – though not as rigorous as in evidence-based programs - are considered “promising programs” (see definition section of this report). Promising programs in Texas (see Appendix B) include Healthy Start, Nurturing Parenting Program (NPP), Exchange Parent Aide, and Systematic Training for Effective Parenting (STEP). These programs may prove extremely beneficial to children and families in Texas, but as with all the promising programs, more research is needed to establish their effectiveness.



Current Supply of Home Visiting Programs Compared to Need

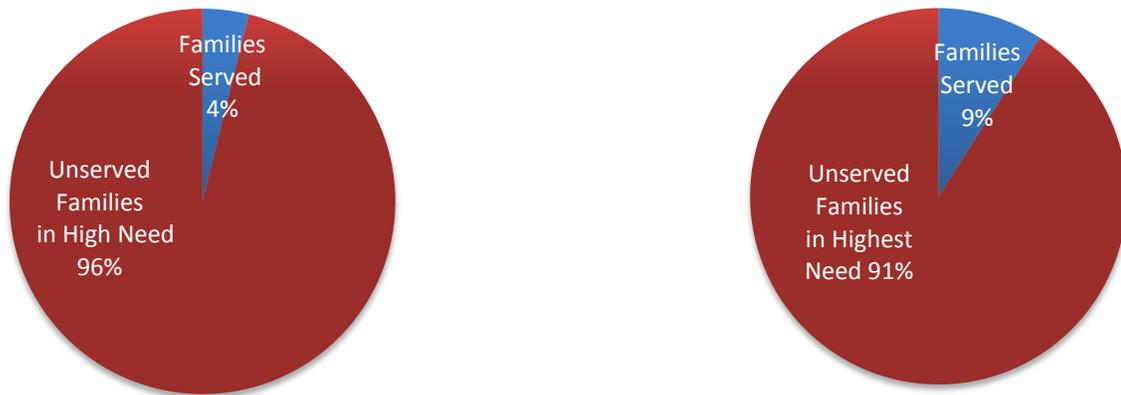
As shown in Appendix B, Texas serves 19,213 families^m with home visiting programs (per the definition previously described for home visiting programs). This amount represents only a small portion of the families in need of service. Although a multitude of risk factors could be used to identify families in need of services, poverty (and extreme poverty) acts as a strong proxy because of its significant relationship to other risk factors.⁶⁸ Currently, Texas has almost 477,000 familiesⁿ with children under age 6 in “high need” of home visiting services (defined as living below the 100% federal

^m Data on families served were collected between September 2012 and December 2012

ⁿ To calculate the number of families in Texas with children under age 6 living in poverty, we used 2010 Census data on the number of children in Texas in poverty (below <100% and below 50% of the Federal poverty threshold) as well as the percent of families with: one child under age 6, two children under 6, or three or more children under 6. From there, we created an algebraic equation to convert individuals into families because home visiting can serve more than one child at a time when visiting families with siblings under age 6. More details about these calculations are available from the first author if desired.

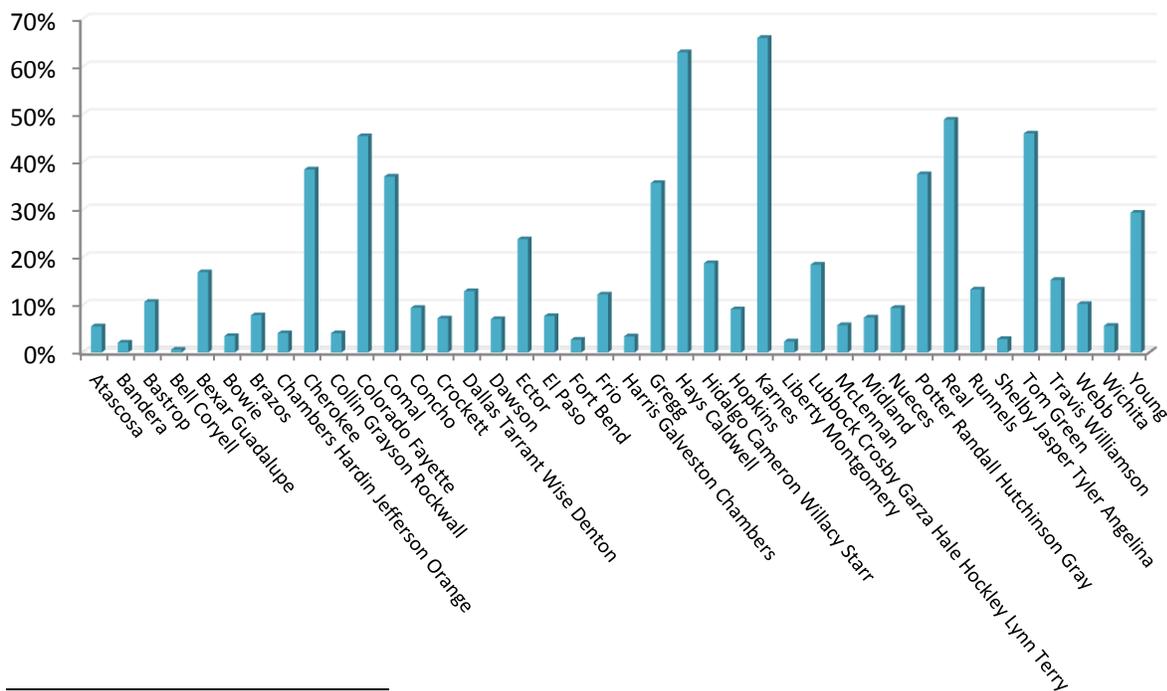
poverty threshold). Texas currently serves about 4% of those families. If we consider only rates of extreme poverty (i.e., the “highest need families” living below the 50% federal poverty threshold), Texas serves 9% of the almost 212,000 families that could benefit from home visiting programs (see Figure 7).^o

Figure 7. Percent of High-Need and Highest-Need Families Served in Texas



At the county level, only two counties (or county-areas) serve at least half of the highest-need population, and most serve less than 20% of families in highest need (see Figure 8).^p

Figure 8. Percent Served Versus Need



^o As an example of the different poverty levels, the annual income for a family of four living below: (a) the 100% poverty threshold is ≤ than \$23,050 annually, and (b) the 50% poverty threshold is ≤ \$11,525 annually. Income also includes all cash assistance (e.g., welfare/TANF payments and supplemental security income). It does not include in-kind assistance such as medical care, child-care subsidies, food stamps, or loan money.

^p Some providers could not isolate the number of families served in a specific county and only provided the range of surrounding counties, as shown in Figure 8. For those areas, the authors included the total number of highest need families for all counties listed in a particular group compared to the total number served.

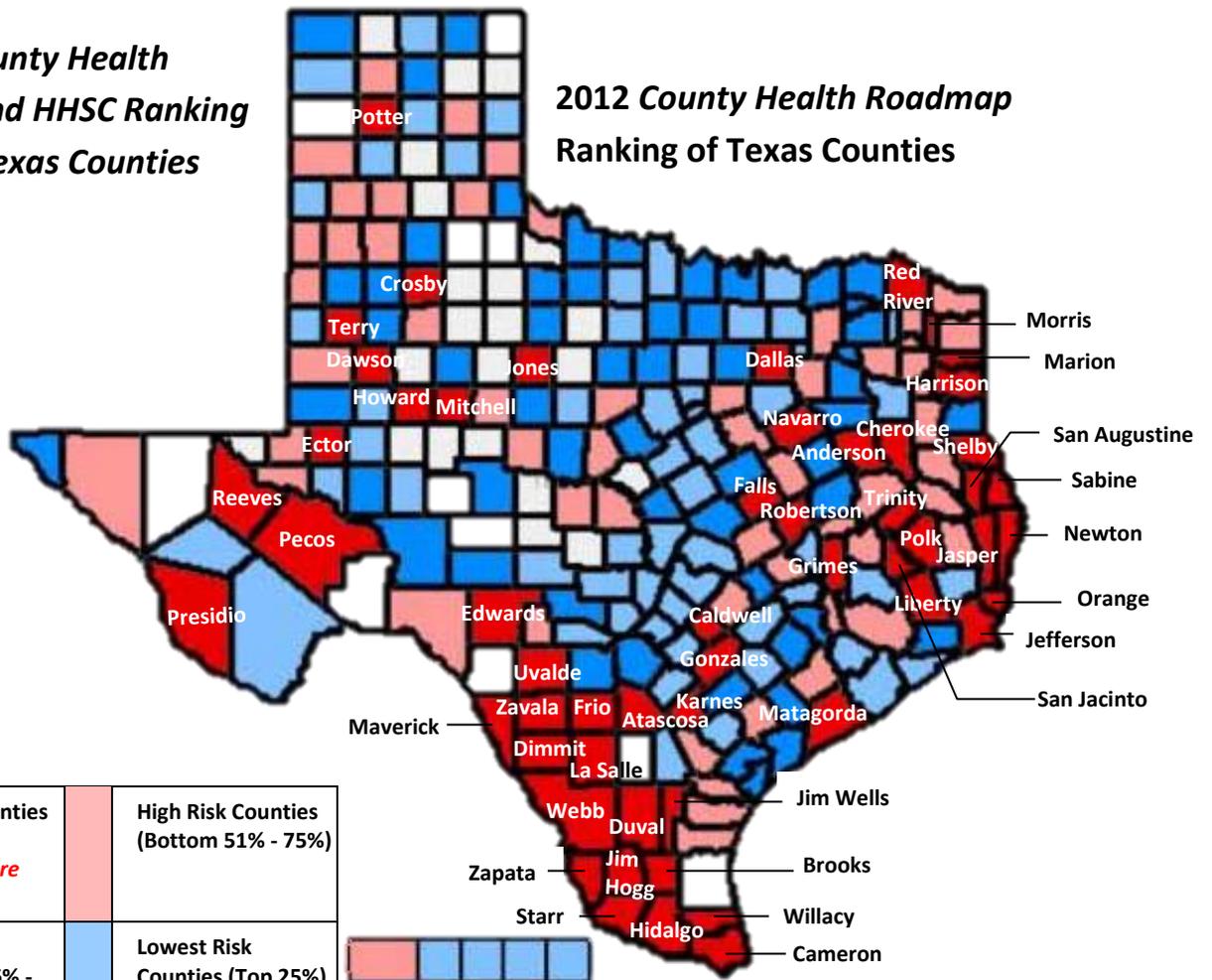
Although poverty is certainly a strong risk factor to indicate families in need of home visiting services, others risks exist (see section I), and risk factors vary greatly by county in Texas. The Texas Health and Human Services Commission (HHSC, as part of their allocation of federal funding to home visiting programs) and the *County Health Roadmap* (a collaborative effort between the Robert Wood Johnson Foundation and University of Wisconsin) provide rankings by risk level for counties in Texas. HHSC⁶⁹ ranked counties based on how many people live in the county and the prevalence of: poverty, preterm births, low birth weights, live births, infant mortality, crime, juvenile crime, family violence incidents, shelter usage, homelessness, high school dropouts, unemployment, confirmed child abuse and maltreatment, and drug and alcohol usage. Gillespie (which houses the city of Fredericksburg) and Montgomery (north of Houston) Counties have the most favorable ranking whereas Willacy County (in the lower Rio Grande area) is the highest-risk community.

The *County Health Roadmap*⁷⁰ ranks communities in Texas on *health factors*. Health factor rankings are calculated by taking a weighted combination of health behaviors (e.g., obesity, smoking, excessive drinking, sexually transmitted diseases, teen birth rate, etc.), clinical care (e.g., uninsured rate, preventable hospital stays, diabetic screening, etc.), social and economic factors (e.g., high school graduation, unemployment, children in poverty, children in single-parent homes, etc.), and the physical environment of the neighborhood (e.g., violent crime rate, air pollution, etc.). Almost all counties in Texas received a ranking, aside from some with too much missing or unreliable data. Kendall County (about 30 miles northwest of downtown San Antonio) has the most favorable health ranking, whereas Starr County (in the lower Rio Grande area) is the highest-risk community of those rated.

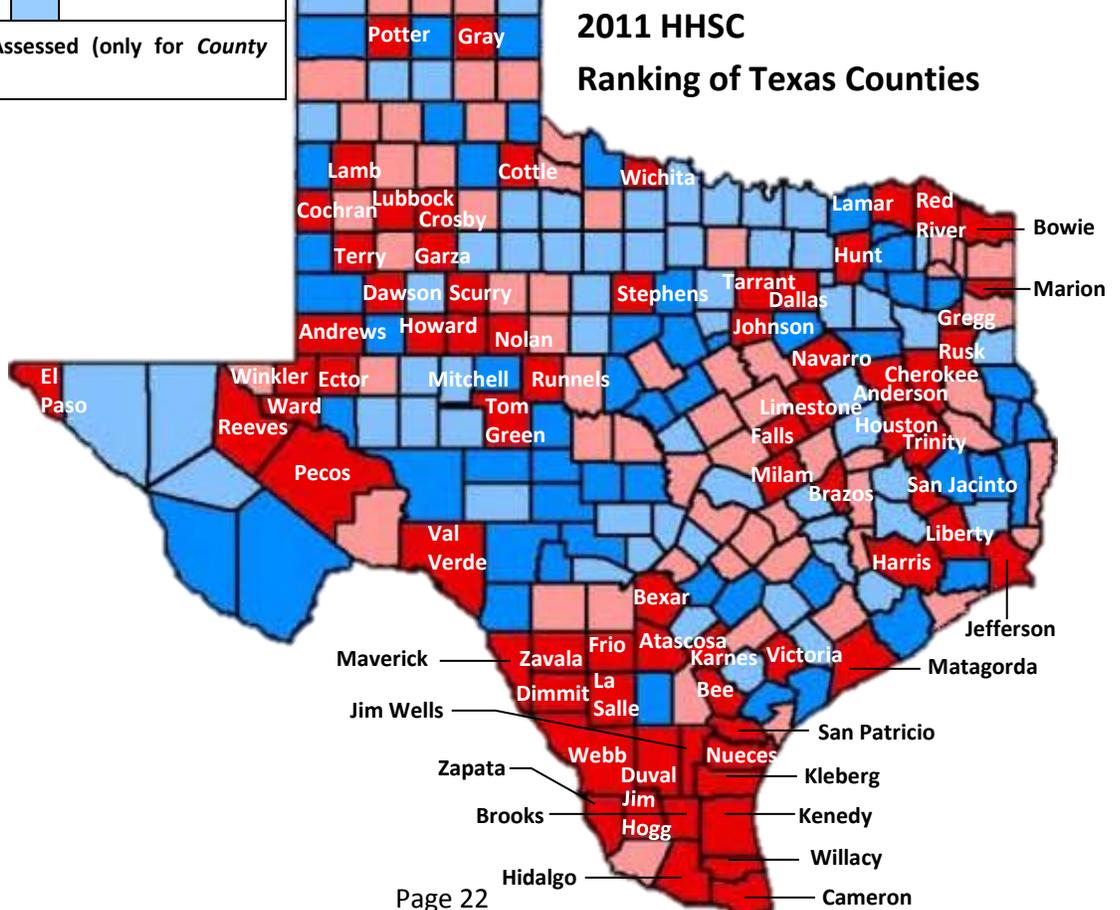
In 91% of cases, the HHSC and County Health rankings at least agreed about whether counties belonged in the higher-risk half or lower-risk half of Texas counties, and 62% of the time, the two groups rated counties within the same quartile of risk (see images below). Overall, as one ranking increased, so did the other (and vice-versa; $r = .63, p < .01$). Thus, the counties in red and pink in Figure 9 are truly high risk – even when considering different types of risk factors.⁹

⁹ The maps for Figure 9 were created by grouping into quartiles the ranking data provided by HHSC and the County Health Roadmap.

Figure 9. County Health Roadmap and HHSC Ranking of Risk for Texas Counties

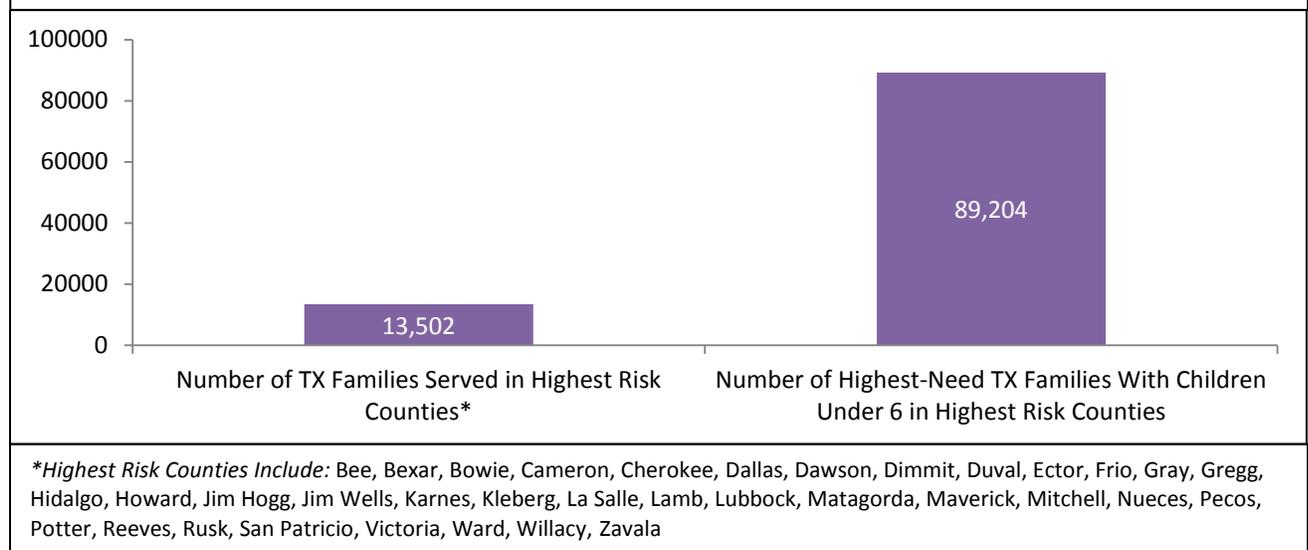


Highest Risk Counties (Bottom 25%) <i>These counties are labeled on maps</i>	High Risk Counties (Bottom 51% - 75%)
Moderate Risk Counties (Top 26% - 50%)	Lowest Risk Counties (Top 25%)
Risk Unable to be Assessed (only for County Health Roadmap)	



Within those counties that HHSC considers in the top 10% of risk (i.e., the highest of the high-risk counties), 200,765 families live in poverty (<100% of the federal poverty threshold); Texas provides home visiting services to only 7% of these families. Texas also serves about 15% of those families in highest need (families living <50% of the federal poverty threshold; see Figure 10).

Figure 10. Highest-need families served in counties HHSC ranked as highest-risk counties (top 10%)



III. Outcomes of Home Visiting Programs Currently in Texas

Researchers have attempted to rigorously evaluate home visiting programs for the past 30 years, which has increased knowledge about what works. Results across programs demonstrate that having a portfolio of high-quality home visiting programs provides potential benefits across a wide-range of issues that affect children, families, and the broader society. Through these home visiting programs, parents can learn how to better care for their children and themselves. In turn, children are safer, healthier, better prepared to learn, and are more successful as adults (p. 1).⁷¹

Evidence of Improved Maternal and Family Improvement through Home Visiting Programs

Looking across programs, we see that home visiting programs potentially can promote maternal economic self-efficiency, curb criminal involvement, improve mother’s psychological well-being, and lead to longer spacing between children so that families have time to effectively prepare for the next child.^r For example, as shown in Figure 11, at least one study in the programs below has shown.^s

Figure 11. Examples of Potential Maternal and Family Improvements as Shown in at Least One Study

Outcome	Program(s) Showing Outcome
Greater maternal feelings of (a) competency and (b) happiness caring for their child	(a) AVANCE ⁷² , HFA ⁷³ , Triple P ⁷⁴ , and (b) PAT ⁷⁵
Reduced (a) maternal depression and (b) stress/anxiety	(a) EHS ⁷⁶ , Incredible Years ⁷⁷ , and (b) Exchange Parent Aide ⁷⁸
(a) Less maternal reliance on government programs such as Medicaid, food stamps, and TANF (b) greater maternal employment when their child is age 2-4	(a) NFP ⁷⁹ (b) NFP ⁸⁰
(a) Increased spacing between children’s births and (b) knowledge about family planning	(a) NFP ⁸¹ and (b) AVANCE ⁸²
Decreased maternal (a) alcohol and (b) tobacco usage	(a) HFA ⁸³ and (b) NFP ⁸⁴
Fewer maternal arrests and adjudications	NFP ⁸⁵
Reduced conflicts between parents on child-rearing topics	Triple P ⁸⁶
Fewer injuries from intimate partner/family violence	HFA ⁸⁷ , NFP ⁸⁸

However, many programs do not measure all possible outcomes. For example, some home visiting providers do not assess the psychological well-being of mothers. Yet, mothers in low-income families are at an elevated risk of mental health problems (clinical depression is the most common), and

^r Many of these benefits are particularly strong for the highest-risk mothers.

^s These are *examples* of favorable outcomes; not all studies are represented here, and other programs may show comparable results in some outcome areas. Moreover, this list indicates that a particular program has shown a favorable result in this area *in at least one study*. Some programs may have more than one study supporting this finding or other studies showing no effects. Thus, the list of outcomes should be considered as potential positive effects from high-quality home visiting programs.

children of clinically depressed mothers experience a variety of negative outcomes, including developmental delays, attachment insecurity or reactive attachment disorder, and cognitive impairments.⁸⁹ As shown, however, home visitors potentially can curb this negative trend by referring mothers to mental health professionals, and mothers who participate in these programs do sometimes report better mental health than the mothers in control groups.⁹⁰ Thus, recognizing signs of mental illness - including clinical depression - in parents should continue to be an important training component for home visitors.

Evidence of Improved Parenting Outcomes in Home Visiting Programs

Families who receive home visits also can demonstrate a variety of improved parenting practices. For example, programs listed below have at least one study showing:

Figure 12. Examples of Potential Parenting Improvements as Shown in at Least One Study

Outcome	Program(s) Showing Outcome
Improved quality of parent-child interaction and/or parent sensitivity	AVANCE ⁹¹ , EHS ⁹² , Healthy Steps ⁹³ , HFA ⁹⁴ , HIPPY ⁹⁵ , Incredible Years ⁹⁶ , NFP ⁹⁷ , Nurturing Parenting Program ⁹⁸ , PALS ⁹⁹ , PAT ¹⁰⁰ , SafeCare ¹⁰¹ , STEP ¹⁰² , Triple P ¹⁰³
Provision of a (a) safer and (b) more stimulating home environment	(a) Healthy Steps ¹⁰⁴ , NFP ¹⁰⁵ , SafeCare ¹⁰⁶ , Triple P ¹⁰⁷ and (b) AVANCE ¹⁰⁸ , EHS ¹⁰⁹ , Healthy Steps ¹¹⁰ , HFA ¹¹¹ , HIPPY ¹¹² , NFP ¹¹³ , PAT ¹¹⁴
Elevated parental knowledge	Exchange Parent Aide ¹¹⁵ , HFA ¹¹⁶ , Incredible Years ¹¹⁷ , Nurturing Parenting Program ¹¹⁸ , PAT ¹¹⁹
Enhanced father involvement in complex play with child	Early Head Start ¹²⁰
Fewer substantiated reports of child abuse	Exchange Parent Aide ¹²¹ , NFP - rates lower after child age 4 through age 15 ¹²² , Nurturing Parenting Program ¹²³ , SafeCare (recidivism) ¹²⁴ , Triple P ¹²⁵
Fewer out-of-home placements from abuse	Triple P ¹²⁶

Thus, across programs, we see that children in home visiting programs potentially live in safer and more stimulating homes and may have more responsive and knowledgeable parents. These parents also may be less likely to use harsh forms of punishment, which may contribute to the decreased rates of abuse and neglect shown in some studies.

Measuring reductions in child maltreatment is challenging. For one, most programs lack access to data on substantiated child maltreatment because data about specific cases typically require restricted access and are not part of the public dataset. Parent self-reports are problematic, however,

because parents in the home visiting programs are trained on appropriate parenting and thus may be more likely to recognize abuse and neglect. These trained parents may recognize, for example, that leaving a child unattended in a car is neglectful and thus admit to their mistake, whereas untrained parents may not even realize this is a form of neglect. Even if researchers monitor substantiated child maltreatment through CPS, the possibility remains that families in home visiting programs may have more reports of abuse simply because they are monitored more closely than families without a home visitor (i.e., they are the ones more likely to be observed in an abusive or neglectful act).¹²⁷ Indeed, some studies have shown no effect on abuse or even increased rates of abuse during the home visit time-span. However, 5 of the 6 programs assessing this outcome also show declining rates in at least one study, suggesting that these programs have promise for abuse prevention over the long run. Moreover, all of the evidence-based programs show declines in some factors associated with abuse (e.g., harsh parenting, non-sensitive parenting styles, unsafe home environment) in at least one study. Thus, home visiting programs offer evidence of maltreatment prevention and strong promise for reducing a variety of the risks associated with abuse, but more research is needed to address this complex issue.

Evidence of Improved Child Outcomes

Home visiting programs also can demonstrate a wide-array of benefits to the children involved. For example, at least one study in the programs mentioned below has shown:

Figure 13. Examples of Improvements in Child Outcomes as Shown in at Least One Study

Outcome	Program(s) Showing Outcome
Decreased rates of preterm or low birthweight babies	Healthy Start ¹²⁸ , HFA ¹²⁹ , PAT ¹³⁰
Increased (a) breast-feeding, (b) child-immunizations, and (c) well-visit exams	(a) HFA ¹³¹ , (b) Healthy Start ¹³² , PAT ¹³³ , (c) Healthy Start ¹³⁴
Decreased child mortality from preventable causes	NFP ¹³⁵
Increased physical activity	STEP ¹³⁶
Fewer language or cognitive delays	EHS ¹³⁷ , NFP ¹³⁸ , PALS ¹³⁹
Elevated school readiness	HIPPY ¹⁴⁰ , PAT ¹⁴¹
Enhanced cognitive or academic performance	AVANCE ¹⁴² , EHS ¹⁴³ , HFA ¹⁴⁴ , HIPPY ¹⁴⁵ , PAT ¹⁴⁶ , STEP ¹⁴⁷
Improved child behavior and/or social-emotional development	EHS ¹⁴⁸ , HIPPY ¹⁴⁹ , Incredible Years ¹⁵⁰ , PALS ¹⁵¹ , PAT ¹⁵² , STEP ¹⁵³ , Triple P ¹⁵⁴
Decreased likelihood of engaging in crime as a 15-year old adolescent	NFP ¹⁵⁵

Thus, across programs, we see that children from home visiting programs potentially have fewer language or cognitive delays and can show marked improvement in health (prenatal and later), school readiness, and academic performance. These children also may behave more positively overall, both in terms of fewer negative behaviors and more positive pro-social behaviors. For example, the children of home-visited families sometimes are less likely to get in trouble in school, which perhaps lends itself to decreased juvenile delinquency later.

Future Directions

As mentioned, high quality home-visiting programs have the potential to positively affect a wide-array of outcomes. Communities that provide multiple home-visiting models are likely to be the most successful at ensuring that the diverse needs of families are met; indeed, no one program can do all that is needed for every family. As described, home visiting programs as a whole improve child and family well-being, but some programs are geared more toward child health, whereas others are geared toward improving parent-child interactions, and still others focus on preparing children for school, and so forth.

Despite all the favorable results shown by home visiting programs, these programs are not a cure to all of society's ills. Some risks exist that home visiting programs seem to offer only limited success to-date. For example, home visiting can potentially improve economic self-sufficiency of parents, but the programs do not provide a "cure" to poverty. Similarly, few programs have shown positive effects in curbing domestic violence, which is a major risk factor for child maltreatment. Even within a single program, findings can be inconsistent across evaluations whereby some show a positive impact and other studies find limited evidence of impact. Fidelity to the program model is vitally important to realize the expected outcomes. Moreover, providers should continue to monitor outcomes over time to ensure consistent results. Programs also should test their outcomes in different populations because some techniques may be more effective in certain areas. Through legislation – such as the proposed SB 426 – the state can provide the supportive infrastructure necessary to enable success (see section VI for further discussion of future directions).

IV. Home Visiting: A Sound Investment

The positive outcomes possible from effective, high-quality home visiting programs can create measurable savings for taxpayers. For instance, a total of 34,137 babies were born underweight in 2009.¹⁵⁶ Each low birthweight (LBW) baby is estimated to cost an additional \$14,500 in hospital costs compared to a baby born with a healthy weight.¹⁵⁷ One study of Healthy Families reduced LBW by almost half among at-risk families.¹⁵⁸ If all families in Texas were able to enroll in this type of high-quality home visiting program - and Texas programs demonstrated the same level of effectiveness as the previous trial on at-risk families - such a reduction could mean 16,454 fewer LBW babies in a single year and savings of almost \$240 million in hospital expenses, of which it is estimated that slightly more than \$100 million of that total stems from savings in Medicaid.¹⁵⁹

Appendix D provides a summary of the costs and monetary benefits associated with programs currently in Texas that have published information on the Return on Investment (ROI).^t Collectively, the possibility exists that home visiting programs may show even greater returns than indicated in Appendix D. Providers in Texas currently funded through the federally-funded Maternal Infant Early Childhood Home Visiting Program (MIECHV; see next section), for instance, meet as a group to discuss a variety of matters – including information about upcoming trainings for home visiting professionals, piloting a coordinated intake and referral system for families, and other mutually beneficial activities that can enhance the efficiency and effectiveness of the home visiting system. The hope is that this type of collaboration – combined with careful implementation of programs - will lead to even better services for families, thereby further increasing potential returns. Moreover, as more families in Texas are served by these programs, there may be a spillover effect whereby families not in the home visiting programs may receive benefits because families currently served by home visiting share information with other family members, friends, and neighbors. These potentials are worthy of testing in future research.

Notable Examples for Return on Investment (based on data to-date)

Economists show that home visiting programs can demonstrate a particularly favorable return on investment. Triple P, for example, may save considerable money through preventing child abuse and neglect. Foster and colleagues demonstrate that the cost of building the Triple P infrastructure can be recovered in a single year by reducing abuse in the population by 10%.¹⁶⁰ In a randomized controlled

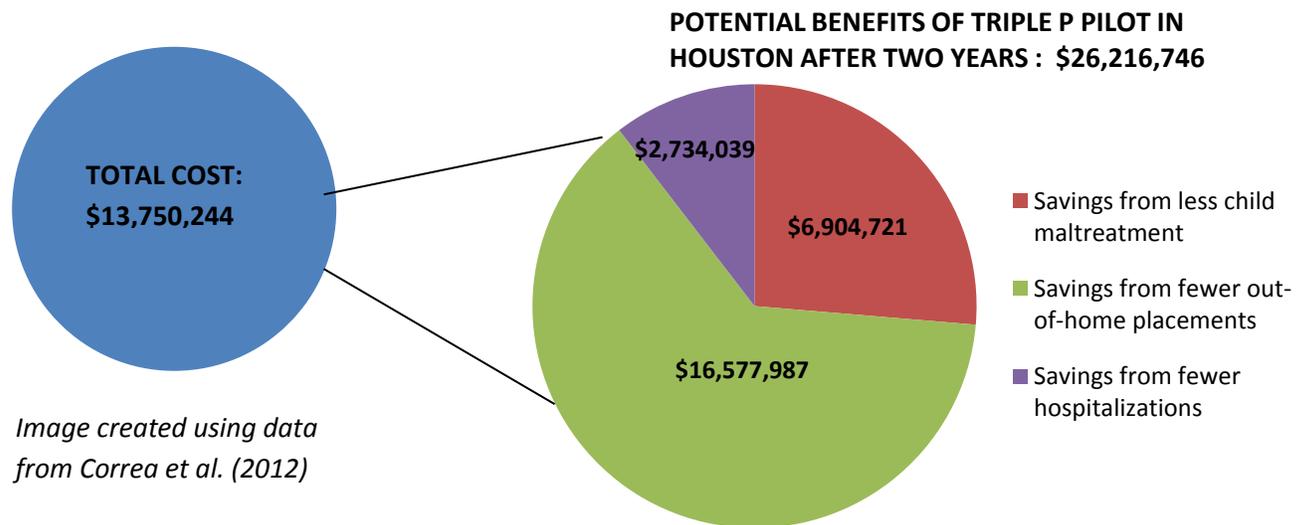
^t While ROI studies include several areas of savings, sources often focus on different aspects. Moreover, even within an organization analyzing savings (e.g., the Rand Corporation), they rely on published studies for each program, and, as already noted, some programs have not measured possible outcomes. Therefore, ROI calculations cannot be compared directly across programs. Nevertheless, even with limited data, the potential savings to the State are noteworthy in many programs.

trial of Triple P in South Carolina, counties where Triple P was enacted, compared to counties without the Triple P system, showed during the first year of implementation a:¹⁶¹

- 28% reduction in substantiated cases of abuse,
- 44% reduction in out-of-home placements, and
- 35% reduction in hospitalizations and emergency room visits for child injuries.

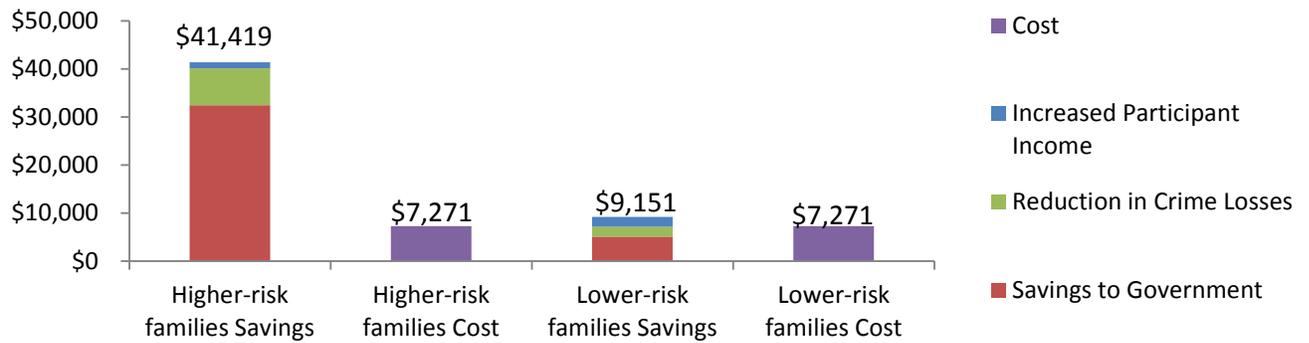
Furthermore, a pilot study of Triple P is scheduled for implementation in Houston. According to a report by Correa and colleagues with Children at Risk, if the Houston program proves as effective as the South Carolina trial, the net-savings for implementing Triple P in Houston is over \$12 million in just two years through reductions from child maltreatment costs alone (see Figure 14):¹⁶²

Figure 14. Two-Year Benefits of Triple P Pilot in Houston if Effects are Consistent with South Carolina Trial



Monetizing the costs and benefits of the Nurse-Family Partnership program also provides an illustration of how programs may return even more when focused on serving high-risk families (although low-risk families provide a positive, albeit lower, ROI). According to RAND economists, the Nurse-Family Partnership can return over five times the original investment with high-risk families (see Figure 15).¹⁶³

Figure 15. Rand Corporation Cost-Benefit Analysis of Nurse-Family Partnership

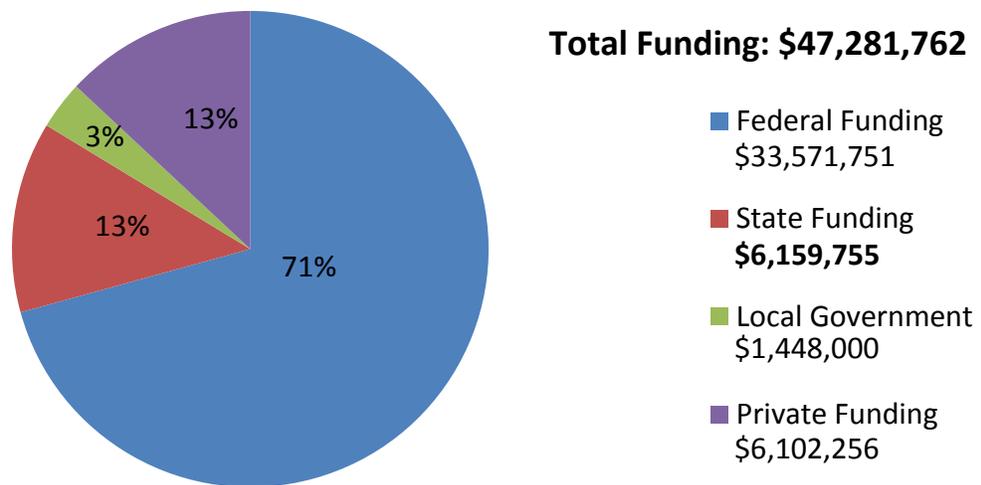


Other evidence-based programs also demonstrate positive returns, but, of course, the only way the savings from home visiting programs can be garnered is if programs prove as effective as in some of their previous trials, which is why outcomes need measuring and monitoring over time. Nevertheless, high quality home visiting programs clearly have the potential to positively benefit children, families, and taxpayers. These programs can not only empower families and help protect our most vulnerable population – children – but they also have potential to save the government millions of dollars each year.

V. Current Spending on Home Visiting Programs in Texas

Despite the wide-array of potential benefits from investing in high-quality, evidence-based home visiting programs, most high-risk families do not receive services (see section II), and the State only provides about 13% of the funding for the programs currently operating in Texas. As shown in Figure 16, the majority of funding for home visiting programs in Texas is provided through the Federal Government (e.g., Federal Head Start Program, Title I, Title II, Children’s Bureau, Maternal, Infant and Early Childhood Home Visiting Program, Federal Healthy Start initiative, etc.).^u

Figure 16. Total Estimated Spending on Home Visiting Programs in Texas by Source



HHSC Office of Early Childhood Coordination

As shown in Figure 17, the Texas HHSC Office of Early Childhood Coordination (OECC) manages funding from State Senate Bill (SB) 156 / House Bill (HB) 424 and separately, the Federal Maternal, Infant, & Early Childhood Home Visiting Program (MIECHV).

In 2007, TexProtects helped craft and facilitate passage of SB 156 (sponsored by Senator Florence Shapiro) and HB 424 (sponsored by Representative Jerry Madden), which expanded the Dallas-

^u Annual funding amounts were provided to us by state offices for programs receiving state-funds, HHSC OECC for MIECHV funded programs, state-leads for several program models, and individual providers around the state. In some cases, providers did not know their annual budget and provided an estimate or left the funding amount blank. In cases where no estimates were available, the authors calculated the average cost per family using data for that program model in other parts of the state. Thus, the funding amounts should be considered as the *best available estimates* as of early December 2012.

piloted Nurse-Family Partnership program to serve more than 2000 families in 11 communities throughout Texas.^v

MIECHV is a federal initiative to facilitate collaboration and partnership at federal, state, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.¹⁶⁴ Texas was awarded \$28 million in formula awards over three grant cycles (\$7.4, \$10.5, and \$10.5 million; Aug. 2011 – Sept. 2014). HHSC anticipates receiving two additional grant cycles (through 2016) for \$10.5 million each.¹⁶⁵ Through a competitive procurement process, HHSC has thus far awarded funding from the formula awards to four evidence-based home visiting programs in Texas (i.e., Parents as Teachers, Nurse-Family Partnership, Home Instruction for Parents of Preschool Youngsters, and Early Head Start home-based). In addition, the Positive Parenting Program (Triple P) was funded in Galveston County from the Federal Administration for Children and Families grant that was later merged with MIECHV.

The formula awards also are used, in part, to build the early childhood comprehensive system (ECCS) in targeted communities across the state. The goal of this system is to create a coordinated network of comprehensive services and supports in recognition that optimizing child and family outcomes necessitates that families have access to other services, such as housing, jobs, parental education, health care, and adult mental health services.^{166w} Under this system, the various community programs work together to create an uninterrupted continuum of care for families in the community¹⁶⁷ (see Recommendation 9 in Section VI for additional information about why this system is beneficial).

In addition, \$6.6 million in competitive funding was awarded over two grant cycles (\$3.3 million each, Sept. 2012 – Sept. 2014) to enhance the early childhood comprehensive system (ECCS), create local systems to connect families to home visiting services, and to increase father's participation in home visiting services as well as father's involvement with their children during those early years.¹⁶⁸ To enhance the ECCS, communities use the Early Development Instrument (EDI), a population-based measure of how well the community prepared children in their area for school. The EDI serves to identify strengths, needs, and resiliencies of the population of kindergarten students and maps those

^v The Nurse-Family Partnership Act enabling legislation received bipartisan support from both chambers (*Senate Authors: 9 Republicans / 8 Democrats; House Authors: 11 Republicans / 14 Democrats*) and unanimously passed all committees and floor votes.

^w University of California Los Angeles Center for Healthier Children, Families, and Communities and United Way Worldwide provide technical support for the ECCS through the TECCS (Transforming Early Childhood Community Systems) process, including how to use EDI and other data in community planning.

findings, along with other factors and community services, on a neighborhood-level. This allows the local ECCS to strategically plan areas of the community to target services.^{169x}

Figure 17. Home Visiting Programs Housed in HHSC Office of Early Childhood Coordination¹⁷⁰

Texas Home Visiting Program	Source of Funding	Annual Federal Contribution ^y	Annual State Contribution	Number of Families Served
Nurse-Family Partnership	SB 1/ HB 1 ^z and MIECHV	\$3.25 million MIECHV \$3.3 million TANF ^{aa}	\$5.6 million GR ^{bb}	625 (MIECHV) 2025
Parents as Teachers	MIECHV	\$1.95 million	\$0	799
Home Instruction for Parents of Preschool Youngsters	MIECHV	\$1.38 million	\$0	716
Early Head Start	MIECHV	\$300,000	\$0	34
Triple P	ACF/MIECHV	\$673,300	\$0	80
Early Childhood Comprehensive System of Care	MIECHV	\$2.90 million		
Home Visiting Infrastructure^{cc}	MIECHV	\$3.34 million		
TOTAL:		\$17,100,000	\$5,600,000	4,254

Grand Total: \$22,700,000

All State Funding for Home Visiting Programs in Texas

If we consider only the state portion of the spending (from the pie chart in Figure 16), we see that the total \$6,159,755 (see Figure 18) is distributed across the HHSC Office of Early Childhood Coordination (OECC), the Prevention Early Intervention (PEI) division of Department of Family Protective Services (DFPS), and as part of the Healthy Babies Initiative in the Department of State Health Services (DSHS).

^x The Transforming Early Childhood Community Systems (TECCS) provides the EDI services in the United States.

^y The MIECHV amounts represent funding released to the sites from October 2012 – September 2013; Funding amounts from SB 156/ HB 424 represent half of the biennium award.

^z SB 156 / HB 424 were the enabling legislation for this funding.

^{aa} TANF is included as part of Federal funding here, but a case could be made that it is actually state funding.

^{bb} NFP also provides a 10% local, private match; The total state contribution includes \$174,020 for NFP infrastructure costs.

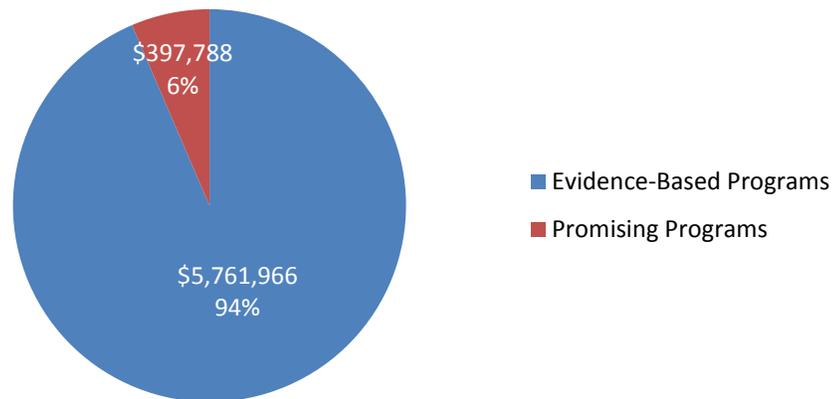
^{cc} Infrastructure also includes costs for contract administration, data system, training and technical support, personnel, etc.

Figure 18. Total Annual State Funding for Home Visiting ¹⁷¹

Texas Home Visiting Program	Funding Department/ Source	Annual Amount from State
Nurse-Family Partnership	HHSC as part of Budget Bill (SB1 & HB1)	\$5,526,580
Parents As Teachers	DFPS (PEI Division)	\$99,925
Healthy Families	DFPS (PEI Division)	\$102,374
Triple P	DFPS (PEI Division)	\$33,087
Nurturing Parenting Program	DFPS (PEI Division)	\$297,788
Healthy Start	DSHS (Healthy Texas Babies Initiative)	\$100,000
TOTAL:		\$6,159,755

Considering all annual state funding for home visiting, approximately 94% of funding is directed toward evidence-based programs, and the remaining 6% of funds go to promising programs (see Figure 19).

Figure 19. Allocation of annual state funding to evidence-based and promising programs



Prevention Early Intervention Division at Department of Family Protective Services (PEI of DFPS)

As shown in Figure 20, the PEI division of DFPS spent \$533,174 of state money on home visiting programs this past year. In addition, they allocated federal funding to – Parents As Teachers, Healthy Families, Triple P, Nurturing Parent Program, and Systematic Training for Effective Parenting (STEP).

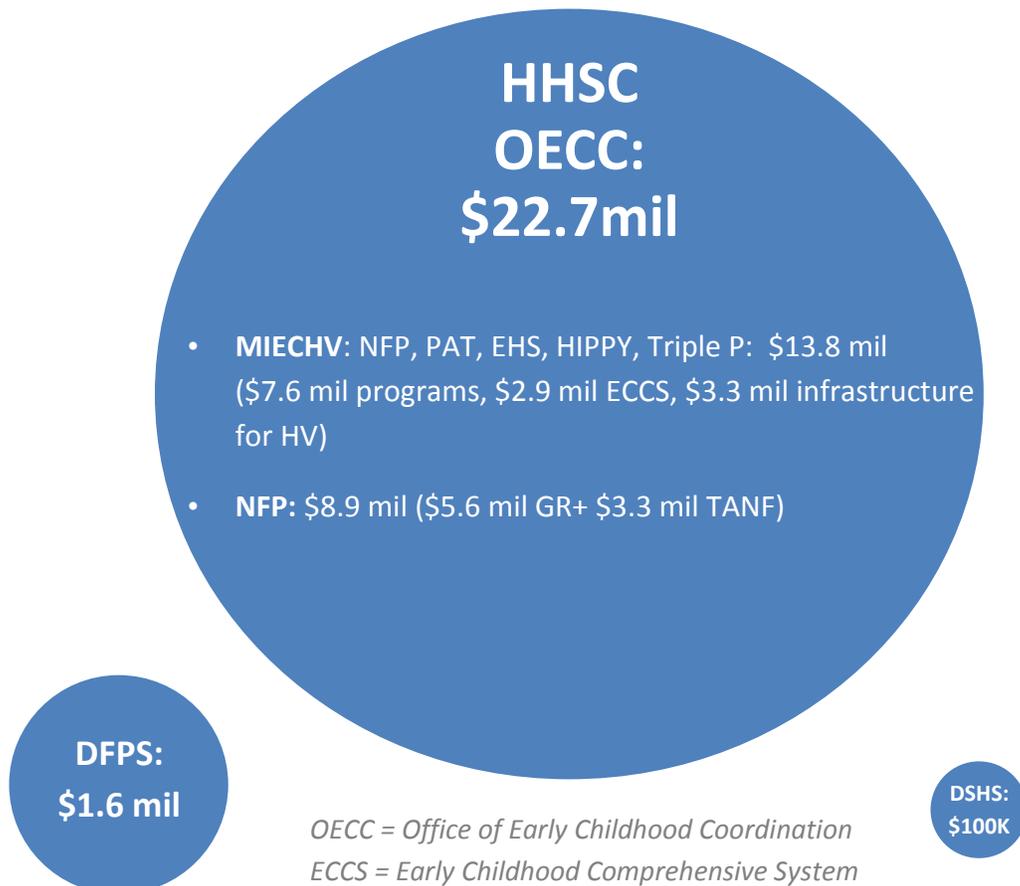
Figure 20. Home Visiting Programs Housed in the PEI Division of DFPS - Annual Funding¹⁷²

Texas Home Visiting Program	Total Federal Funding	Total State Funding
Parents As Teachers	\$497,393	\$99,925
Healthy Families	\$307,123	\$102,374
Triple P	\$99,262	\$33,087
Nurturing Parenting Program	\$91,670	\$297,788
Systematic Training for Effective Parenting (STEP)	\$86,318	\$0
TOTAL:	\$1,081,766	\$533,174

Grand Total: \$1,614,940

Thus, the HHSC Office of Early Childhood Coordination is the state office that currently manages the majority of the home visiting programs. It also is the only state office that has developed a home visiting infrastructure combined with the creation and management of the early childhood comprehensive system of care (see Figure 21).

Figure 21. Home Visiting Programs Housed under Texas State Agencies - Annual Funding



VI. Recommendations for Future Direction of Home Visiting in Texas

The home visiting programs described thus far clearly benefit Texas children, families, and citizens as a whole. Yet, more can be done to improve current services and expand the reach of home visiting to address the broad needs of children in at-risk households.

Recommendation 1: Expand Home Visiting Services

As previously detailed, the demand for home visiting programs is much greater than the supply. Many of our highest-risk families and counties have almost no services available to them, and without the support of home visiting programs, these families may cost the state billions of dollars annually in expenses associated with negative social outcomes that might be avoided. Despite the fact that Texas has the most to gain financially from serving these families with young children, the State currently spends only 13% of the total amount invested in Texas home visiting programs. Yet, as described, the possible savings from home visiting programs is substantial. These programs potentially can reduce the rate of premature and low birthweight babies, child abuse, juvenile delinquency, welfare dependence, and a whole host of other costly outcomes (see Sections III and IV). Clearly, more state funding for these high-quality prevention programs is needed (see Section VII).

Recommendation 2: Promote Evidence-Based Programs

As explained, evidence-based programs already have established their potential to enhance parenting, family functioning, financial self-sufficiency, and optimal growth and brain development in young children. It seems obvious, therefore, to focus investments in programs that have a record of successful intervention and demonstrated savings to the government over time.

Recommendation 3: Encourage Innovation

Clearly, investing in evidence-based programs is important, but promising programs are how we grow in the field – by supporting innovation and new thinking. Thus, Texas should spend a portion of funds on promising programs. For example, new programs or modifications to existing programs may prove more successful at:

- *Reaching families previously unwilling to accept services or in hard-to-reach rural areas*
- *Engaging fathers in the emotional, social, and financial well-being of their children*
- *Enhancing cooperation and safer relationships between parents*
- *Decreasing the rate of child sexual abuse*

Recommendation 4: Emphasize Father Involvement in Home Visiting Models

Home visiting programs historically emphasize the role of mothers in their children's development, but fathers are a critically important and influential part of children's lives. Children with involved fathers, for instance, demonstrate greater cognitive development, academic achievement, and psychological adjustment.¹⁷³ These children also are less likely to use illegal substances or engage in other risky behaviors as adolescents.¹⁷⁴ Involved fathers are more likely to provide financial support for their children – even if they do not live with the child's mother – thereby decreasing a family's need to rely on state welfare. Thus, getting fathers involved early can have lasting, positive effects for children and society. Plus, fathers can benefit from the parent training provided by home visitors. Involving (and training) fathers is an important area to emphasize and expand across all programs.

Recommendation 5: Ensure Model Fidelity

Programs are only proven to the extent that they follow the program model tested in research. To sustain model fidelity, for example, professionals implementing these programs should use consistent dosing (e.g., frequency of visits, duration of visits, etc.), adhere to the curriculum content of the proven model (while maintaining flexibility to meet the unique needs of families), and train and hire home visitors based on their skills, experience, and ability to connect with families in need. Previous research has shown that programs may not achieve the favorable outcomes intended if they are not implemented with fidelity to the research model.¹⁷⁵ If Texas wants to get the most value out of its investment and best protect children, a process evaluation should be conducted to ensure that programs are implemented according to their verified guidelines.

Recommendation 6: Evaluate Short- and Long-Term Outcomes Using Independent Evaluations of Programs

As discussed, research shows a variety of home programs can be effective. However, it remains unknown whether these programs will demonstrate the same rates of effectiveness in Texas over time. By requiring that programs report their data and analyze it in a uniform way, we can ensure that programs work as well in Texas as they did in prior scientific trials. Another benefit of these evaluations - if conducted by a single entity - is the usage of standardized measures to test outcomes, thus allowing for comparison across programs and families. Just as in any business, it is recommended that this evaluation be conducted by an independent research group with no ties to a particular home visiting program. The LBJ School at The University of Texas, for instance, is conducting the current evaluation of

the programs funded through MIECHV. However, their research is confined to MIECHV funded programs. State funded programs need impact-outcome and process-outcome evaluations.

It is imperative to have solid data to measure outcomes, but we also need the data to enhance program quality and to continue to clarify and understand where and how home visiting programs are most effective. For example, are there differences in outcomes between rural and urban settings? Which programs achieve the strongest outcomes with specific types of families? The only way to optimally target services, strengthen outcomes, and enhance the rate of return on investment is to collect and analyze data.

Recommendation 7: Consider New Outcomes Not Previously Tested

Despite the range of positive outcomes already shown, home visiting programs may enhance child and family well-being in other ways as well. For instance, the extent to which these programs prevent sexual abuse remains unknown. In addition, almost nothing is known about the ability of these programs to enhance father involvement – in terms of paternity establishment, time spent with child, quality of time spent with child, or child support payments. As programs move to involve fathers, it also will be important to consider whether fathers derive the same potential benefits as mothers (e.g., improved physical and psychological health, reduced unemployment, etc.). These are outcomes worthy of future exploration.

Recommendation 8: Develop Resources and Standardized Implementation of Care

Home visiting programs can only successfully expand into new areas of Texas with sufficient time and resources. Having a flexible application - depending on the needs and resources of a particular community - of standardized, evidence-based practices will minimize many of the problems currently experienced by some home visiting programs. Some locales, for instance, may not have enough trained personnel (e.g., nurses, social workers, parent educators) to serve all the families in a particular area, and other communities may simply lack information about how to start a home visiting program in their area. Programs also need sufficient time to recruit and train home visiting professionals, enlist families to participate, and coordinate with other resource providers in the community (see next recommendation).

Recommendation 9: Develop Community Programs and Resources for Families

Home visiting programs alone cannot address all the needs of each at-risk family. In fact, one reason that evidence-based home visiting programs are successful likely is because home visitors effectively refer families to other resources in the community. For example, a home visiting professional

may recognize signs of mental illness or drug addiction in a family member and refer that person to a quality mental health or drug rehabilitation facility. However, effective referrals and treatments can only happen in communities that offer these services. It is imperative that communities offer affordable, accessible, quality child care, in addition to resources like adequate respite care, substance abuse services, access to basic necessities, and employment training for parents to become economically self-sufficient. Home visiting programs likely will be considerably less effective at helping families if home visiting professionals cannot refer families to important services in the community. Of course, even if services are available, programs need to coordinate with their community to know what services are available to families. As previously mentioned, one feature of the current MIECHV funding is the development and expansion of the early childhood comprehensive system (ECCS) managed under the HHSC Office of Early Childhood Coordination. Long-term, the goal should be to implement this type of system statewide (see Figure 22¹⁷⁶).

Figure 22. An Early Childhood Comprehensive System

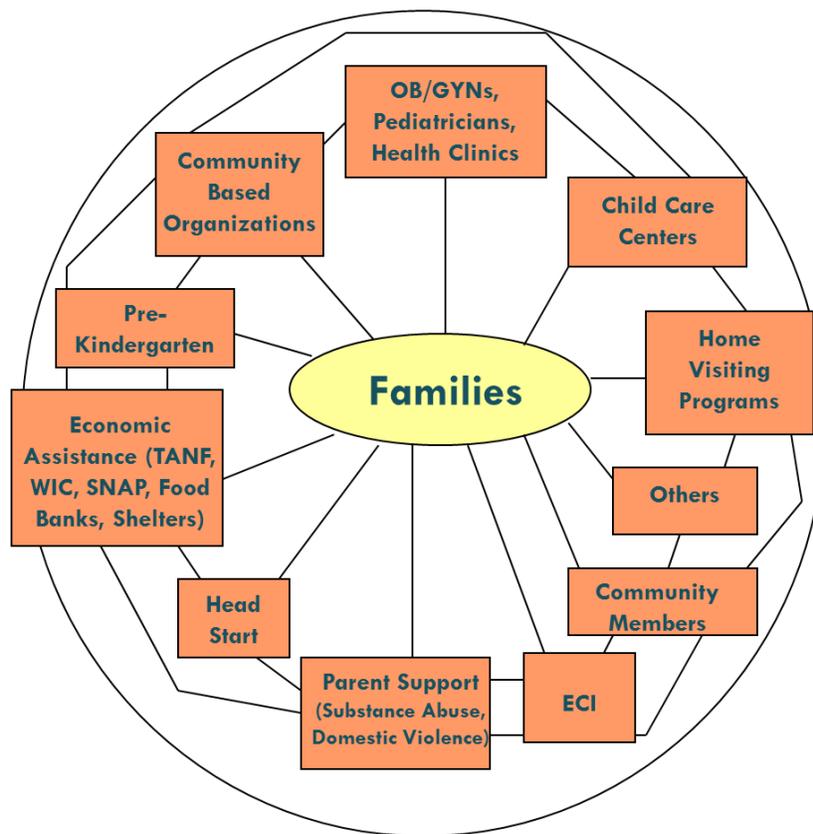


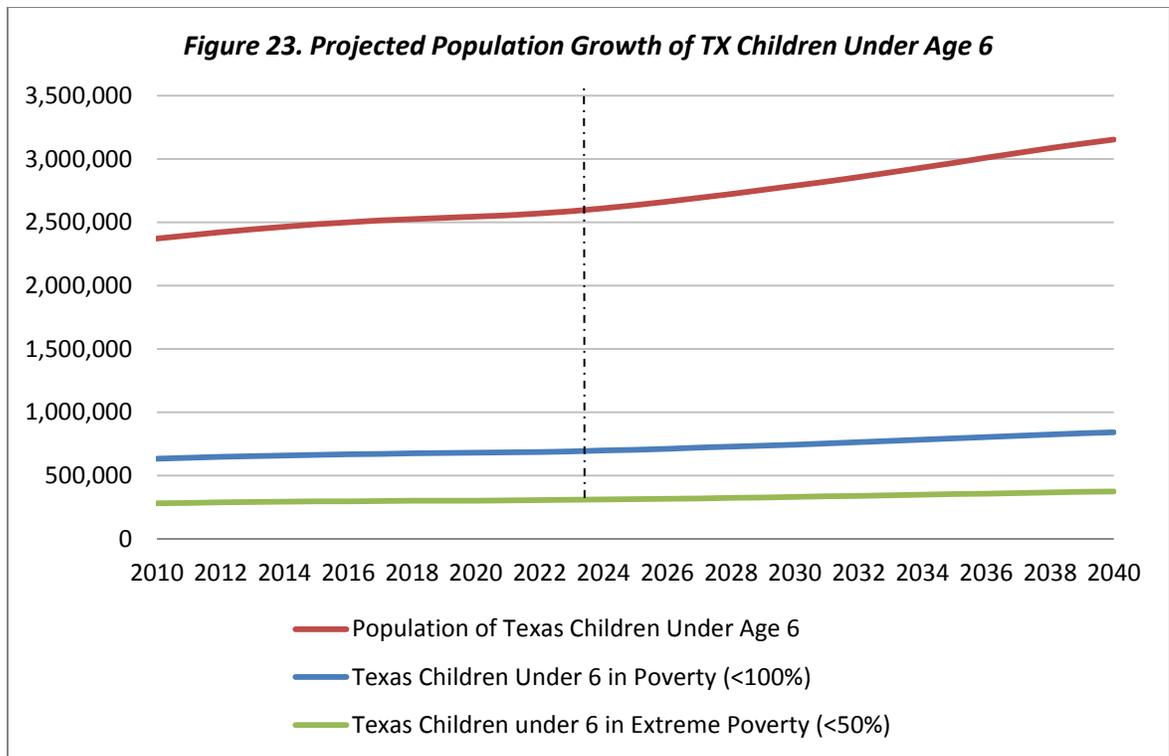
Image from a presentation on September 25, 2012 by David Willis, MD, MPH Director, HRSA Division of Home Visiting and Early Childhood Systems Commission

VII. Concluding Thoughts and Next Steps

Texas spends billions of dollars each year as a consequence of the trauma and strain placed on many young children, but home visiting programs provide a solution to curb this spending trend. Home visiting programs potentially can improve health outcomes of parents and children, prevent child abuse, enhance children's cognitive functioning and academic performance, curb criminal behavior in mothers and children, and improve the economic self-sufficiency of the family as a whole. In essence, these programs may counteract many of the deleterious effects shown for parents and children in at-risk families.

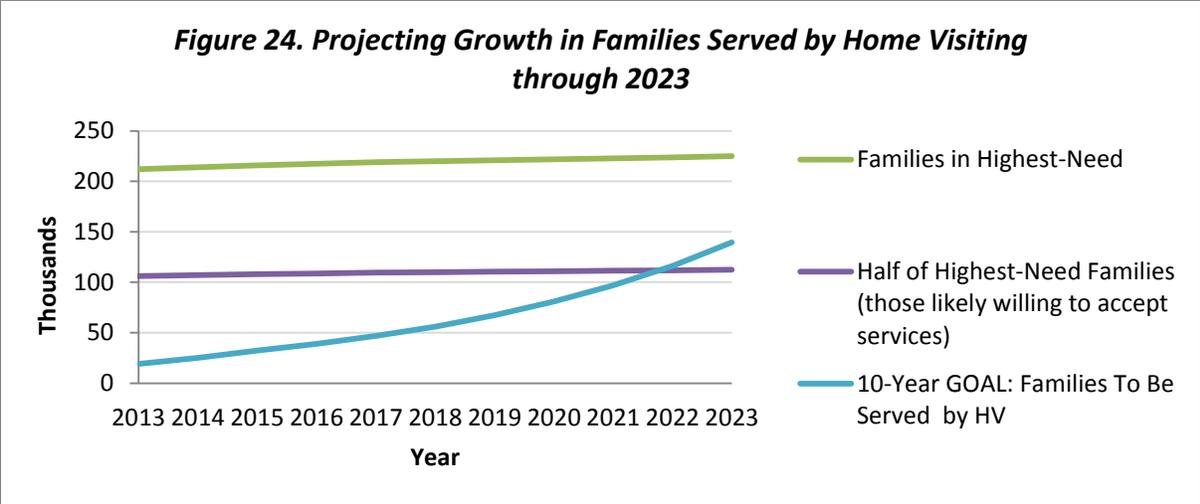
As discussed, prevention serves as the best way to protect children and gain economic ground. A multitude of nationally recognized economists have concluded that home visiting programs, in particular, provide a noteworthy reduction on the economic burden to taxpayers. These savings do not even account for the fact that children receiving these services likely will be more prepared to provide secure, stable environments and foster well-adjusted children, thereby reducing government spending on the next generation of families. In the words of one home visiting champion, the Honorable Texas State Representative Jerry Madden, home visiting "...does things that make differences in what is going to happen in our public over a long period of time. We are making a difference – and a big difference maker - for the State of Texas, for the future, so that 20 years from now, 40 years from now, we will have a population that is even less likely and less prone to drop out of school. They will be much more educated - much more highly educated - because of these programs..."¹⁷⁷

With the goal of cutting long-term spending in Texas, we created a 10-year plan to provide prevention services to as many of these at-risk families as possible. The population of children under 6 in Texas is expected to increase by over 8% in the next 10 years and almost 33% over the next 30 years.¹⁷⁸ Currently, a projection for the number of at-risk children in this group is lacking and would require access to secured datasets. However, child poverty can be used as a proxy for the number of at-risk children because many (though not all) children with other risk factors also live in poverty.¹⁷⁹ Some demographers and economists expect the child poverty rate in Texas to increase, but for the sake of a conservative estimate, we assumed a steady rate of child poverty (See Figure 23).



As shown, by the year 2023, it is estimated that 305,061 Texas children will be in highest-need (<50% poverty) and can benefit from home visiting services. Of course, home visiting programs can serve more than one child at a time when visiting families with multiple children under age 6. Thus, we converted the number of children to the number of families (see Section II for our methodology). Approximately 225,005 families will be in highest-need and can benefit from home visiting services in 2023, and it is estimated that about half of these at-risk families will be willing to accept the voluntary services (i.e., 112,503 families).¹⁸⁰ Of course, it is worth noting that projections estimate that 509,958 families with children under age 6 will be living in poverty (<100%; about 225,005 of whom may accept services), so the need is even greater. Nevertheless, our minimum goal over the next 10 years is to serve the highest-need families who are likely to accept these voluntary services.

As discussed, Texas currently serves slightly more than 19,000 families; services should increase by about 30% per year (assuming an equal distribution) during the next biennium and then by 20% each subsequent year to reach more than half of those families in highest need of services by the end of 2023 (see Figure 24).



In an effort to reach this goal, we recommend **maintaining previous spending** and **increasing** the State biennium investment by approximately \$27.5 million (see Figure 25).^{dd}

Figure 25. Additional biennium investment needed by state in effort to reach 10-year goal.

% INCREASE IN FAMILIES SERVED		Current Number of Families Served By State	2014 -2015 Additional Families Served By State	End of 2015 Total Families Served By State	Total Amount of Additional State GR Funding Needed for FY 14-15
2014 AND 2015	SUBSEQUENT YEARS				
30%	20%	2,295	7,446	9,741	\$27,462,494

Compared to the expense of doing nothing, this amount is low. As discussed, high-quality home visiting programs can reduce costly problems, including low-weight births, emergency room visits, and children in the social welfare, mental health, and juvenile corrections systems. Moreover, by assisting families with young children to get off to the right start, we help ensure that these children go on to be healthy, successful parents themselves.

Disclaimer: The views and opinions expressed in this report are those of the Texas Association for the Protection of Children and do not necessarily reflect the views and opinions of any other organizations.

^{dd} This estimated value includes the costs for HHSC oversight, outcome evaluations, and other implementation costs (as provided to us by the HHSC Office of Early Childhood Coordination). The estimate of the total families served was calculated by taking the average cost of the evidence-based home visiting programs in Texas (\$3,361 per family each year) and assuming that the Federal Government, State Government, local governments, and private funding all will contribute to the 30% of overall growth. For this calculation (and future projections to reach the 10 year goal), it also was estimated that the Federal Government would fund 40% of the home visiting programs in Texas; the State would fund 30%, private (non-government) groups would fund 18%, and local governments would fund 12% of home visiting programs. Of course, all of these are estimates and thus should be updated over time to reflect current values. For example, if the Federal government is unable to increase its investment, than the State and local governments and private foundations will need to further increase their investment, or new projections will be necessary spanning more than 10 years.

Appendix A. Description of Home Visiting Programs in Texas.

Texas Home Visiting Program	Enrollment Criteria	Age of Child Served	Program Goals	Service Intensity/ Duration	Home Visitor Credentials	Curriculum
Parents As Teachers	Sites can determine specific eligibility requirements for enrollment	Prenatal to kindergarten entry	(1) Increase parent knowledge of early childhood development and improve parenting practices, (2) Provide early detection of developmental delays and health issues, (3) Prevent child abuse and neglect, (4) Increase children's school readiness and school success	At least 12 home visits annually; families with 2 or more high need characteristics receive 24 visits for at least two years	Degreed professionals or at least high school diploma/GED; 2 years experience with children or parents; Complete PAT trainings; Annual certification renewal	Curriculum includes: <ul style="list-style-type: none"> • Personal visit plans • Guided planning tools • Individualization for families • Toolkit to facilitate interactions
Nurse-Family Partnership	Low-income, 1 st time moms willing to receive a home visit by end of 28th week of pregnancy	Prenatal to age 2	(1) Improve: (a) pregnancy outcomes, (b) child health and development, and (c) economic self-sufficiency of the family, (2) Reduce domestic violence, (3) Promote father involvement	Approximately 64 home-visits for 60-75 minutes (weekly, every other week, then monthly)	Registered nurse with a BA (MA preferred); 3 Pre-service core NFP education sessions; Annual education supplements	Visit-by-visit guidelines available, but nurses use variety of developmental screening and diagnostic tools to tailor program to fit unique needs of family
Home Instruction for Parents of Preschool Youngsters	Parents with limited formal education with young children	Age 3 to age 5	(1) Help parents prepare children for success in school and all aspects of life, (2) Empower parents to be child's first teacher, (3) Provide parents with skills, confidence, and tools needed to successfully teach their child in their home	30, 1-hour, weekly home visits during school year; Parent group-meetings occur at least 6 times per year	High school diploma/GED; Receive on-going training; Live and work in community they serve	Activity packets - 30 weeks: <ul style="list-style-type: none"> • Uses role play to teach parents • Uses books to teach skills, concepts, and experience to ready kids for school
Early Head Start	Low-income families with children ages birth to 3	Prenatal to age 3	(1) Promote healthy prenatal outcomes for pregnant women, (2) Enhance the development of young children, (3) Promote healthy family functioning	Weekly, 90-minute, home visits for at least a year; 2 socialization events monthly	Must hold a Child Development Associate (CDA) credential and be trained in early child development	Varies by site and needs of community; Three primary programs are Center-Based, Family Child Care, and Home-Based program
Healthy Families America	Recruited prenatally or soon after birth; other requirements site specific (e.g., low-income)	Prenatal to age 5	(1) Build and sustain community partnerships to engage overburdened families, (2) Strengthen parent-child relationship, (3) Promote child health and development, (4) Enhance overall family functioning by reducing risk and increasing protective factors	Weekly home visits until child is at least 6-months-old; then home visits occur less often until child is age 3 to 5	No specific education requirements; Recommended they have experience working with families with multiple needs	Site not required to use a specific curriculum, but must use some research-based curriculum
Play and Learning Strategies Infant	Families with children ages 5 months to age 1	5 months to age 1 year	(1) Strengthen parent-child bonding, (2) Stimulate children's early language, cognitive, and social development	Weekly, 90-minute home visits for 10 weeks (PALS Toddler available after PALS Infant completion)	Associate's degree in Early Childhood or comparable experience; Train at Children's Learning Institute	Parent Educators use PALS Infant curriculum (until toddler, then uses PALS Toddler curriculum)

Texas Home Visiting Program	Enrollment Criteria	Age of Child Served	Program Goals	Service Intensity/ Duration	Home Visitor Credentials	Curriculum
SafeCare Augmented	Families at risk or with history of child abuse and/or neglect	Birth to age 5	To improve: (1) Infant and child health care, (2) Home safety, and (3) Parent-child interactions	Weekly or biweekly home visits delivered over 15-18 weeks for 60-90 minutes	No specific education requirements; Experience in child development and/or parent training preferred	Home visitors follow structured protocols that cover three modules – each in 5-7 sessions (health, home safety, parent-child/infant interactions);
Healthy Steps	Families must be receiving services from a pediatric or family medicine practice implementing the program	Birth to age 3	Emphasizes a close relationship between health care professionals and parents to address the physical, emotional, and intellectual growth and development of children	(1) High-intensity sites: min of 5 home visits at ages birth–1, 9–12, 18, 24, and 30 months; additional visits as needed; (2) Medium-intensity: 3 home visits at ages birth–1, 9–12, and 18 months; (3) Low-intensity: 2 visits at ages birth–1 and 9–12 months	Bachelor’s degree with training or education in child development, family studies, nursing, or psychology; Must complete 3-day Healthy Steps training institute	Curriculum - Strategies for Change: Child Development in Primary Care for Young Children: <ul style="list-style-type: none"> • Parent given handouts on child development and child-rearing topics • Prompt sheets, newsletters, and questions parents may ask during well-child visits
Positive Parenting Program	Parents or caregivers of a child ages birth to 9-16 (depending on location) who are at risk for child maltreatment	Birth to age 16	(1) Promote: (a) family independence and health, (b) non-violent, protective and nurturing environments, and (c) child development, growth, health and social competencies, (2) Reduce child abuse, mental illness, behavior problems, delinquency and homelessness, (3) Enhance parent competence, resourcefulness and self-sufficiency	Varies depending on needs of family; Home visits may consist of one consultation to more than 10 visits	Professional practitioners with a post-secondary degree in a field such as health, education, or social services; Accredited training courses for services	Flexible curriculum offered at five different levels of intervention; Services may be delivered individually, face-to-face, in group meetings, with telephone assistance, or self-directed
Incredible Years	Parents, teachers, and children; Prevention version for high-risk populations	Birth to age 12 (targets ages 0-3 and 3-6)	(1) Promote emotional and social competence, (2) Prevent, reduce, and treat behavior and emotional problems in young children, (3) Improve parent-child interactions, (4) Improve teacher classroom management skills and teacher-parent partnerships	One, 2-hour, weekly visit; 8-20 sessions total depending on program; Typically 14 visits for prevention	Master's level (or equivalent) clinicians with mandatory certification by program	Designed for group setting; Sometimes implemented via HV; Two curriculums: Babies and Toddlers (ages 0-3) & BASIC Early Childhood (ages 3-6 which includes homework)
AVANCE Parent-Child Education Program	Parents or caregivers with children ages birth to 3, pregnant women and/or their partners	Birth to age 3	(1) Increase parent understanding of child development so they are better able to foster optimal child development, (2) Empower parents to view themselves as their child’s first and most important teacher and the home as the first classroom, (3) Increase school readiness	Monthly 30-60 minute home visits for 9 months; Additional weekly small group sessions (mothers, fathers, and children involved)	Varies by level of Home Educator from HS Diploma to BA in Education, Social Work or related field; All required to complete initial and annual training.	Parents: curriculum consists of 11 units and 27 lessons Kids: toy making to model parent-child interaction and reinforce school readiness skills

Texas Home Visiting Program	Enrollment Criteria	Age of Child Served	Program Goals	Service Intensity/ Duration	Home Visitor Credentials	Curriculum
Healthy Start	Families at risk for child abuse and/or neglect	Prenatal to age 2	To promote the development of community-based maternal and child health programs, particularly those addressing the issues of infant mortality, low birth weight and racial disparities in perinatal outcomes	Frequency and length varies greatly by provider; Home visits occur for two years after delivery	Paraprofessionals under professional supervision; Minimum high school diploma or equivalent; Trained in Parents as Teachers	Varies; Healthy Start selects a curriculum that is appropriate for population served
Nurturing Parenting Program	Families at risk for child abuse and/or neglect	Birth to age 18 (targets birth to age 5)	(1) Prevent recidivism of families receiving social services, (2) Lower rate of teenage pregnancies, (3) Reduce rate of juvenile delinquency and alcohol abuse, (4) Stop intergenerational cycle of child abuse by teaching positive parenting behaviors	48-50 weekly home visits for up to 90 minutes; Frequency and length vary depending on family needs	Para- or professionals trained in fields such as social work, education, or psychology	Varies; 2 programs target families with kids ages 0-5: Nurturing Program for Parents and their Infants, Toddlers, and Preschoolers; Nurturing Skills for Families
Systematic Training for Effective Parenting	Families with children ages birth to 5	Birth to age 12 (targets birth to age 5)	To provide parents with the necessary skills to improve their parent/child communication and overall family functioning	Weekly meetings for 90 minutes; Typically presented in a group format for 7-9 weeks;	Counselors, social workers or other trained professionals implement the group format	Multi-component parent education program; 4 versions of curriculum: Early Childhood STEP for birth to age 5 - includes a Resource Guide, Parent's Handbook, DVDs, and a drug prevention education component
Exchange Parent Aide	Families with children ages birth to 12 who are considered at risk for abuse and/or neglect	Birth to age 12	To replace patterns of abusive behavior with effective skills for nonviolent parenting	1-2 weekly home visits continuing for at least one year	Volunteers, para- or professionals supervised by professional staff; Parent Aides credentialed through National Club Exchange Foundation	No specific curriculum; Services are family-centered and focus on child safety, problem solving skills, parenting skills, and social support
Parents and Children Together	Varies by program location	Varies; all serve at least some families with children under age 5	Varies by program location; no specific goals listed across programs	Varies by program location	Varies by program location	Varies by program location

Appendix B. Families and Counties Served by Home Visiting Programs Currently in Texas.

	Texas Home Visiting Program	Texas Counties Served ^{ee}	Texas Families Served ^{ff}
Evidence-Based Programs	Parents As Teachers	Atascosa, Bandera, Bexar, Cherokee, Colorado/Fayette, Comal, Crosby, Dallas, Ector, Fort Bend, Frio, Gregg, Hale, Harris/Chambers, Hays/Caldwell, Hockley, Hopkins, Karnes, Lubbock, Lynn, McLennan, Midland, Nueces, Potter/Hutchinson/Swisher, Real, Tarrant/Wise/Denton, Terry, Travis, Willacy/Hidalgo, Williamson, Young	5308 ^{gg}
	Nurse-Family Partnership	Bexar, Chambers/Hardin/Jefferson/Orange, Dallas/Tarrant, Ector, El Paso, Galveston/Harris/Fort Bend, Gregg, Hale/Hockley/Lamb/Terry/ Lubbock/Crosby/Floyd/Garza/Lynn, Nueces, Potter, Travis/Williamson, Webb, Willacy/Hidalgo	2650
	Home Instruction for Parents of Preschool Youngsters	Cherokee, Dallas, Ector, Gregg, Harris, Nueces, Potter, Willacy/Hidalgo	1496
	Early Head Start ^{hh}	Bastrop/Lee, Bell/Coryell, Bexar, Bowie, Brazos, Dallas, Dawson, Garza, Grayson/Collin/Rockwall, Gregg, Harris, Liberty/NE Harris/Montgomery, Lubbock, McLennan, Nueces, Potter/Randall/Deaf Smith/Hutchinson/Gray, Shelby/Sabine/San Augustine/Jasper/Tyler/Newton/Angelina, Terry, Travis, Webb, Wichita	1221
	Healthy Families America ⁱⁱ	Concho, Dallas, Runnels, Tom Green, Travis	530
	Positive Parenting Program	Galveston, Tarrant (Plus Dallas location that does <i>not</i> currently offer HV and a pilot location soon to begin in Houston)	175 ^{jj}
	Incredible Years	Hays/Travis/Williamson	75 ^{kk}
*	AVANCE Parent-Child Education Program	Bexar, Dallas, El Paso, Harris, McLennan, Travis, Willis/Starr/Hidalgo/Cameron	5235
Promising	Healthy Start	Bexar, Dallas, Harris, Hidalgo/Cameron/Willacy/Starr/Zapata, Tarrant, Webb	1580
	Nurturing Parenting Program	Bexar, Concho, Crockett, Guadalupe, Runnels, Tom Green, Travis	656 ^e
	Systematic Training for Effective Parenting	Bexar	111 ^e
	Exchange Parent Aide	Dallas	50
	Parents and Children Together	Collin, Fort Bend, Travis	126
TOTAL:			19,213^{ll}

*AVANCE is on the border between being an evidence-based and promising program

^{ee} In some cases providers could not isolate the county they serve, so they grouped all counties together, as shown

^{ff} Information for this table was provided by DFPS (for state-funded programs), HHSC (for MIECVH and DSHS programs), state program leads for EHS, HIPPI, NFP, PAT, and by other program providers, local program coordinators, and funders.

^{gg} The state office for PAT/ Mental Health America provided data for this table, but they acknowledge that they were unable to obtain some data from other providers in Texas who also may offer PAT services. In addition, PAT provides the curriculum for other programs listed in this table (EHS and HFA) – these are *not* included as part of the PAT total so as not to double-count families

^{hh} The PALS and PAT curriculums are currently used in some of the EHS locations.

ⁱⁱ The *Dads Make a Difference* curriculum is currently used in the HFA San Angelo location. This program also can be offered as a stand-alone HV program. The PAT curriculum also is used in some HFA locations throughout Texas.

^{jj} This value does *not* include families served in Dallas (67 families - none received HV) or Houston (not yet started)

^{kk} This represents the number of families served in a HV format.

^{ll} This total does *not* include upcoming Houston pilot study, Triple P in Dallas, or individual case management.

Appendix C. Levels of Evidence Supporting Home Visiting Programs in Texas.

		Levels of Evidence Support						
Texas Home Visiting Program	Federally-Defined EB Visitation Program	California EB Clearinghouse ¹⁸¹ Ratings ^{mm}	University of Houston EBP ¹⁸² Score ⁿⁿ	NREPP-SAMHSA ¹⁸³ Ratings ^{oo}	Center for the Study and Prevention of Violence ¹⁸⁴ / Blueprints ^{pp}	OJJDP ¹⁸⁵ Rating ^{qq}	Crime Solutions ¹⁸⁶ Rating ^{rr}	Promising Practices Network ¹⁸⁷ Rating ^{ss}
Parents As Teachers	Yes	3	29 [Family Care Connection] also 25, 26	3.0 - 3.4				Promising
Nurse-Family Partnership	Yes	1	33 [YWCA of Metropolitan Dallas]	3.2 - 3.5	Model	Exemplary	Effective	Proven
Home Instruction for Parents of Preschool Youngsters	Yes	2						Other: Not yet rated (review started)
Early Head Start	Yes	3				Promising		Proven
Healthy Families America	Yes	1: Child Well-Being 4: Prevention of Child Abuse / Neglect	29 HFA [Healthy Families San Angelo, Inc; Parenting Center] 26 HFA			Effective	Promising	Proven: HF New York
Play and Learning Strategies Infant	Yes							
SafeCare Augmented	Yes	2 : SafeCare Program 3: HV						

^{mm} Rating Scale: 1 = Well-supported by research evidence; 2 = Supported by research evidence; 3 = Promising research evidence; 4 = Evidence fails to demonstrate effect

ⁿⁿ This scale ranges from 9-33; higher numbers indicate stronger evidence support; the mean rating was 23.1

^{oo} Research quality rated on a scale from 0.0 to 4.0; higher numbers indicate stronger support

^{pp} Programs are rated as “Model” or “Promising”

^{qq} Programs are rated as “Exemplary,” “Effective,” or “Promising”

^{rr} Programs are rated as “Effective,” “Promising,” or “No Effects”

^{ss} Programs are rated as “Proven,” “Promising,” or “Other Reviewed Programs”

Texas Home Visiting Program	Federally-Defined EB Visitation Program	Levels of Evidence Support						
		California EB Clearinghouse Ratings	University of Houston EBP Score	NREPP-SAMHSA Ratings	Center for the Study and Prevention of Violence / Blueprints	OJJDP Rating	Crime Solutions Rating	Promising Practices Network Rating
Positive Parenting Program	No ^{tt}	1		2.9 - 3.0	Promising	Effective	Effective	Promising
Incredible Years	No ^{uu}	1		3.6 - 3.7	Model	Exemplary	Effective	Proven
AVANCE Parent-Child Education Program ^{vv}	No	3	25 [AVANCE Dallas; AVANCE Rio Grande Valley-Cameron County]					
Healthy Start	No		10 [Dallas Hospital]					Promising
Nurturing Parenting Program	No	3	31 [DePelchin Children's Center] also 25, 27, 28, 30	2.9 - 3.2				
Systematic Training for Effective Parenting	No	3	29 [DePelchin Children's Center]	2.6 - 3.2	Promising for Youth 10-14		Effective for Youth 10-14	
Exchange Parent Aide	No							
Parent and Children Together	No							

^{tt} Does not meet the federal definition of home-visiting because the majority of services for all clients do not occur in the home

^{uu} This is an evidenced-based curriculum that is sometimes used in a home visiting format

^{vv} AVANCE was also awarded the Awarded E. Pluribus Unum Prize for exceptional work with Hispanic communities (2009); for additional information, see <http://www.migrationinformation.org/integrationawards/winners-avance.cfm>

Appendix D. Cost and Investment Return for Home Visiting Programs in Texas.

		Benefit / Return on Investment (ROI; maximum return per dollar estimated to date in red)			
Texas Home Visiting Program	Estimated Annual Program Cost per Family¹⁸⁸	Pacific Institute for Research and Evaluation¹⁸⁹	RAND Corporation¹⁹⁰	Washington State Institute for Public Policy¹⁹¹	Other
Parents As Teachers	\$1,400 - \$1,500			Long-term net return of \$765 per person; \$1.18 return per dollar	
Nurse-Family Partnership	\$4,500 (national average; range of \$2,914 - \$6,463)	Net savings per child, through age • 5: \$3,270 • 9: \$8,036 Government receives 54% return on investment	\$5.70 return for every dollar invested on high-risk families by the time the child reached age 4; \$1.26 return for lower-risk families	Long-term net return of \$13,181 per person; \$2.37 return per dollar	
Home Instruction for Parents of Preschool Youngsters	\$1,200-\$2,000 per child		Long-term net return of \$1,351 per person; \$1.80 return per dollar		
Healthy Families America	\$3,214-\$3,892			Long-term net loss of \$2,011 after accounting for costs; \$0.56 return per dollar	Women in NY returned of \$0.15 for every dollar invested; women in the highest risk group (RRO) produced a \$3.16 return per dollar¹⁹²
Early Head Start	\$10,000			Long-term net loss of \$8,156; \$0.22 benefit per dollar of cost <i>for all EHS: not just home-based</i>	Head Start returns between \$7-\$9 per dollar¹⁹³ cost <i>for all Head Start (with EHS)</i>
SafeCare Augmented	\$2,275			Total benefits after costs is \$1,399 (2012); \$14.65 benefits per dollar	
Positive Parenting Program	Varies depending intervention level: \$1-\$12 per child in community of 100,000 ¹⁹⁴			Long-term net return of \$722 per person; \$6.06 return per dollar	PPP pays for itself by averting .5% of child conduct disorder; total cost savings of \$12,466,502 projected for Houston pilot; Rate of ROI: 8% ¹⁹⁵
Incredible Years	\$2,579-\$2,868 per child			Long-term net return of \$408 per person for parent training; \$1.20 return per dollar	

		Benefit / Return on Investment (ROI)			
Texas Home Visiting Program	Estimated Annual Program Cost per Family	Pacific Institute for Research and Evaluation	RAND Corporation	Washington State Institute for Public Policy	Other
Healthy Steps	Range from \$290.22-\$412.95 (higher end with HV)				Benefit of \$100-\$317 per family each year ¹⁹⁶
Play and Learning Strategies Infant	\$2,500	NO ROI INFORMATION AVAILABLE			
AVANCE Parent-Child Education Program	Varies; generally \$3000 to \$3500	NO ROI INFORMATION AVAILABLE			
Exchange Parent Aide	\$3,000	NO ROI INFORMATION AVAILABLE			
Nurturing Parenting Program	Varies; Average is \$800-\$1,200 for 15 week program; Approximately \$2,000 for highest level of intervention	NO ROI INFORMATION AVAILABLE			
Systematic Training for Effective Parenting	Approximately \$350 per family	NO ROI INFORMATION AVAILABLE			
Healthy Start	Information not available	NO ROI INFORMATION AVAILABLE			
Parent and Children Together	Information not available	NO ROI INFORMATION AVAILABLE			

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- ¹⁰ See Section IV
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Any Baby Can	Texas Healthy Start Alliance
Lifeworks	Communities In Schools
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